Contents

1. Quality report ........................................................................................................... 5
   1.1 Statement of quality from the Chief Executive .................................................. 5

2. Introduction ............................................................................................................. 7
   2.1 2014/15 Activity .................................................................................................. 8
   2.2 Working together to monitor quality ................................................................. 9
   2.3 Never Events .................................................................................................... 9

3. Priorities for improvement in 2015/16 and beyond ............................................ 10
   3.1 Our vision and priorities .................................................................................. 10
   3.2 How will we measure our success? .................................................................... 11
   3.3 Priorities and targets ....................................................................................... 11
   3.4 Statement of assurance ................................................................................... 15
   3.5 Independent assurance report ............................................................................ 26
   3.6 Reviewing performance against last year’s priorities for improvement .......... 30
   3.7 Improving safety and reducing harm – harm-free care .................................... 30
   3.8 Improving the reliability of care – delay-free care ......................................... 32
   3.9 Improving the experience of our patients – person centre care ................. 35
   3.10 Providing clinically effective care ................................................................. 37
   3.11 Staff as partners ............................................................................................ 38

4. Reviewing and setting local and national indicators and targets ..................... 40
   4.1 National quality indicators ................................................................................ 40
   4.2 CQUINs ........................................................................................................... 40
   4.3 National targets ................................................................................................ 40
   4.4 Feedback on the quality report and accounts .................................................... 41

Annex 1: Statement of directors’ responsibilities in respect of the quality report 42
Annex 2: Statements by stakeholders ........................................................................ 44
Annex 3: our 2015/16 priorities in detail ...................................................................... 50
Annex 5: Quality Account indicators 2014/15 performance ....................................... 61
Annex 6: CQUINs 2014/15 performance 31March 2015 ............................................. 63
Annex 7: National Targets – 2014/15 .......................................................................... 68
Annex 8: Specialties at Cambridge University Hospitals NHS Foundation Trust 69
Annex 9: Glossary of terms used in quality report ..................................................... 71
1. Quality report

1.1 Statement of quality from the Chief Executive

‘Quality has to be the fabric of the organisation, not part of the fabric.’

As Chief Executive, nothing is dearer to me than the quality of services of care and services we provide to our patients. I made quality the absolute priority for the Trust on taking up my appointment and last year’s Quality Report set out the progress and action taken by the Board and staff. I am delighted that once again, we are able to demonstrate another strong year of performance on this vital area. The decision by Monitor in the summer of 2014 that we had met their concerns and were no longer in ‘breach’ of our operating licence was testament to our dedication to improving the quality of our organisation. I would like to thank everyone who works here at the hospital for continuing to focus on driving up quality, despite the many other challenges we face day-to-day.

Quality runs through everything we do, through every interaction with a patient, from the start to the end of their treatment. An important way of improving, and monitoring, quality is having efficient systems in place. This year, we introduced eHospital, our largest ever single investment in quality in the Trust’s history. This electronic patient record improves quality in a number of ways. It provides all members of a patient’s care team with instant access to real-time notes and information, reducing delays and duplication. It flags up important safety issues around medication and allergies. As importantly, it provides us with far more data than the systems it replaced which will be a huge help in further understanding how we can drive up quality.

The implementation of such a large scale investment has been a real challenge for the Trust, but the quality gains are already being seen in many areas and will grow as the system becomes fully optimised. I am pleased that the Trust took the decision to implement eHospital, as this proved our long-term commitment to improving quality, outweighing other short-term considerations.

Following engagement with our staff, we have refreshed and relaunched our corporate values, which focus on working together to provide safe, kind and excellent care. The additional emphasis on placing ‘safe’ first reflects the view that whilst there are many components that make up quality care, ultimately, it starts and ends with the safety of our patients.

Refreshing the values has also provided an opportunity to reinforce many of our key policies and procedures which underpin quality care, including new statutory obligations such as the Duty of Candour. This builds on the work of the Francis steering group which has been hugely effective in driving the quality agenda across the Trust.

Like other Trusts, our inspection by the Care Quality Commission offers an opportunity for external scrutiny of the quality of our services, care and leadership. I am looking forward to the inspection report as it will provide valuable feedback on areas of outstanding practice, and areas where we will need to improve.
Overall, we maintain our position as one of the strongest performers in the Shelford group (a group of 10 leading Teaching Hospitals) on many quality metrics, including hospital acquired infections and death rates. The quality of many of our specialist services are rightly recognised regionally, nationally and internationally as best in class. We continue to invest in retaining and recruiting highly skilled and dedicated clinical and nursing professionals from across the globe to support our vision to be one of the best healthcare providers in the world.

Last year, I ended this introduction by saying that I give permission to every member of staff to put quality front and centre. This has not changed and nor should it. It is what the public expects, and it is the reason I and the staff here at CUH work for the NHS.

To the best of my knowledge the information in this document is accurate.

Dr Keith McNeil
Chief Executive
Cambridge University Hospitals
2. Introduction

Cambridge University Hospitals in context
CUH is many things: a teaching hospital for a world-famous university; a centre for international research; a specialist centre for treatment and most importantly to our patients it is the district general hospital for Cambridge and the surrounding area through our hospitals – Addenbrooke’s and the Rosie. These combined strengths offer our community the benefits of international care on their doorstep as we translate work from the laboratory directly into new treatments and therapies in clinics, theatres and wards.

In October 2014, eHospital, our largest ever investment in improving healthcare quality, went live. On a daily basis now, the system is used by approximately 3,000 staff members to care for each and every one of our patients. Working through the immediate post go-live period and beyond has been challenging for our staff, not least because of the simultaneous demand and capacity issues experienced by the Trust, who collectively have worked extremely hard and conscientiously to make the deployment of the system a success. There are currently nine stabilisation work streams working across the hospital to further refine, stabilise and optimise the system to support our staff in delivering high quality care and realising the benefits that a true hospital-wide electronic healthcare system can bring.

We recognise that communication with external partners particularly GPs has been difficult through this period. We apologise for this and are working hard to address these issues, meeting with GPs to hear their of and act on their continuing concerns.

In relation to the 3 referral to treatment (RTT) targets, we have been transparent in discussions with our regulator Monitor about the impact of our Electronic Patient Record, and the challenges in reconciling all our reporting in the new system. Since eHospital go-live RTT monthly submissions continue to reflect the challenges with data accuracy, and we continue to see variances in monthly clock stops, and an inflated incomplete pathways position. The figures continue to be unreliable as an assessment of the Trust’s current performance against these standards, but compared to the initial November submission we have seen continued progress with a reduction in incomplete pathways and an increase in non-admitted pathway clock stops.

We have a continued focus on this issue through a formal programme of work with our suppliers, and are taking action to rectify it as soon as possible. Additional validation resource has been recruited to support these ongoing efforts. Our lead CCG attends a weekly assurance meeting where the programme to rectify the situation is discussed. We are also considering the engagement of external expertise and now had a second meeting with Cymbio, who have also reviewed our current validation process and are due to make recommendations as to the cost benefit that can be achieved by engaging their expertise.

Our ability to track and expedite Cancer pathways has been impacted by our eHospital implementation, but Patient Tracking List reporting meetings having been running well since the start of the year.
Our aim is to provide quality healthcare and a first-class service through collaboration with research, academic and healthcare colleagues and engagement with the community, families, carers and patients.

As well as our staff, we are proud of our strong relationships with our stakeholders: the involvement of patients through focus groups, surveys questionnaires and comment cards, the public, governors, our local Healthwatch, and health system partners is central to how we provide care and how we develop services for the future.

For an explanation of terms please see the glossary set out in annex 9

2.1 2014/15 Activity

During 2014/15 we treated more patients than ever before; the following table sets out key activity numbers.

Patients treated: comparison of 2013/14 and 2014/15

<table>
<thead>
<tr>
<th></th>
<th>For year 2013/14</th>
<th>For year 2014/15</th>
<th>Increase or decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>• no of visits to outpatients</td>
<td>575,087</td>
<td>592,288</td>
<td>↑3.0%</td>
</tr>
<tr>
<td>• no of births</td>
<td>5,764</td>
<td>5,716</td>
<td>↓0.8%</td>
</tr>
<tr>
<td>• day cases</td>
<td>118,855</td>
<td>116,360</td>
<td>↓2.0%</td>
</tr>
<tr>
<td>• total inpatients</td>
<td>63,707</td>
<td>61,400</td>
<td>↓3.4%</td>
</tr>
<tr>
<td>elective</td>
<td>(15,540)</td>
<td>(12,361)</td>
<td>↓20.4%</td>
</tr>
<tr>
<td>emergency &gt; 85 years old</td>
<td>(5,241)</td>
<td>(5,694)</td>
<td>↑8.6%</td>
</tr>
<tr>
<td>emergency &lt; 85 years old</td>
<td>(35,032)</td>
<td>(35,628)</td>
<td>↑1.7%</td>
</tr>
<tr>
<td>maternity</td>
<td>(7,894)</td>
<td>(7,717)</td>
<td>↓2.2%</td>
</tr>
<tr>
<td>• A&amp;E attendances</td>
<td>102,670</td>
<td>105,804</td>
<td>↑3.1%</td>
</tr>
<tr>
<td>Total</td>
<td><strong>866,083</strong></td>
<td><strong>881,568</strong></td>
<td>↑1.8%</td>
</tr>
</tbody>
</table>

The increase in the total number of patients seen has and will continue to challenge us in terms of having sufficient beds and staff to deliver the quality of care we aspire to provide. The acuity of patients has increased, and as can be seen from table 01 there has been a significant increase in the number of patients aged 85 or older admitted as emergencies. This in turn has had an effect on our ability to deliver elective activity.

We have robust systems and processes to manage peaks in demand, but recognise these will be put to the test in the coming 12 months.
2.2 Working together to monitor quality

Our governors are involved throughout the year in monitoring and scrutinising our performance and discuss this in detail with directors in a joint working group on quality and public engagement. There is also strong governor representation on our patient experience committee.

The governors demonstrate their commitment to fulfilling their role as elected representatives of patients, public and staff through their direct activity in the community.

During the year, we have continued to work with our commissioners GP’s, Cambridgeshire and Suffolk Healthwatch, and other stakeholders. Trust representatives regularly attend and participate in meetings on subjects important to the community’s health in all the relevant fora. Concern about the number of patients whose discharge is delayed awaiting social or health care provision in the community have continued this year, and integrated care remains a priority.

The creation of UnitingCare, responsible for providing all older people’s healthcare and adult community services throughout Cambridgeshire and Peterborough from 1 April 2015 is a positive step.

2.3 Never Events

Introduced by the Department of Health, a “never event” is defined as serious, largely preventable incidents that should never happen if the right measures are in place.

As with all serious incidents these events need prompt reporting and detailed investigation. During 2014/15, the Trust had three never events, these all being in the wrong implant / prosthesis category. Two involved the use of incorrect eye lenses and one an incorrect hip prosthesis.

Detailed investigations were completed for each of the Never Events, actions taken to minimise recurrence with the actions being monitored by the patient safety team to ensure they are implemented and remain effective.
3. Priorities for improvement in 2015/16 and beyond

3.1 Our vision and priorities

In October 2013 the Trust Board approved the Trust’s first 5 year quality strategy; this was formally launched in January 2014 and a full copy of the Quality Strategy is available at www.cuh.org.uk/quality-strategy

Our aim is simple: all patients treated at CUH will receive the safest, highest quality care, personalised to their needs, in a hospital that compares well with the best in the world and has a strong academic approach to improving quality. To achieve this, we have identified five key priorities:

- improving the experience of our patients – **person-centred care**
- improving staff engagement – **workforce as partners**
- improving safety and eliminating avoidable harm – **harm-free care**
- improving the reliability of care – **delay-free care**
- providing **clinically effective care**

The five priority areas are inter-linked and inter-dependent, and we will only achieve our ambition if all five domains are present equally and simultaneously. Delivering just one or two in isolation will not be good enough.

Achieving our quality vision to be one of the best academic healthcare organisations in the world is something that will require leadership, staff engagement and a willingness to innovate. **A key part of this strategy will be the establishment of a quality and safety academic unit at CUH.**
We want to measure up against the best nationally, and aim to be in the upper decile for all key performance indicators used by our regulators. Going beyond that, we will start to set our standards and measure our performance using global comparators. **By 2018 we will have submitted CUH for an external assessment through, for example, Joint Commissioning International (JCI) or an equivalent detailed assessment programme.** We will work to gain membership of Dr Foster global comparators, seeking to benchmark our performance against other leading medical institutions and looking beyond national boundaries to international standards of leading clinical practice.

### 3.2 How will we measure our success?

Some aspects of our success will be qualitative, whilst others will have quantitative measures. Both are important in assessing the progress we are making and to know whether the strategy has been successfully implemented. A simple test of whether we have improved quality will be whether the right thing to do, is always the easiest thing to do.

We will measure progress against:

- **Each of the five priorities** identified in the section above, and quality indicators within these domains
- **National quality indicators** as mandated by regulators and NHS England
- **National standards and targets**, for example on waiting times
- **CQUINs** (Commissioning for Quality and Innovation) agreed with Commissioners (increasingly we will seek for these to be aligned as closely as possible to our over-arching quality priorities)
- **Accreditation** – achievement of JCI or equivalent
- **Establishment of an academic quality and safety unit**

### 3.3 Priorities and targets

**Person Centred**

Every patient is treated as a person, not a number, with dignity and respect, and is fully involved in their treatment and care. “No decision about me without me.”

Placing the individual at the centre of any discussion about quality is crucial. Each patient we treat is unique, with their own experience of their health, illness and care, and a key partner in shared decision-making. Increasingly patients manage their own health and illness through support and access to information for them, their families and carers. Successfully keeping the person at the heart of all we do means providing care that is responsive to individual personal needs, preferences and values, and assuring that patient values guide all clinical decisions.

We want patients to consistently report that the care they received, met, or was above their expectations. That said, we always welcome compliments, constructive feedback and complaints, as these help to identify areas where we can improve and
are one indication of the level of quality we are providing. Seeking and receiving feedback on how we are doing is a very important component of the continuous improvement culture we want to strengthen.

**In 2015/16 our priorities are as follows:**

- (i) 90% of inpatients rate their experience as at least 7/10
- (ii) 88% of outpatients would recommend our clinics
- (iii) Our Friends and family test score to be greater than 65

- Complaints to be less than 0.1% of patient contacts

- (i) 90% of staff are aware of the trust’s values and behaviours
- (ii) An increasing proportion of staff feel they are able to deliver the Trust’s values and behaviours in their work

A detailed explanation of each measure is included in annex 3

**Workforce as Partners**

A fully engaged, skilled, trained and competent workforce delivering care of the highest quality. An organisation that is well-led at all levels with clear and effective communication.

Investment in our workforce is investment for the future: allowing for turnover, over two thirds of the people who will deliver our services in 2018 are working here already. Recruiting the new third will involve a national and international recruitment programme. Individual patients and their families rely upon staff working in teams to provide high quality care. We are committed to developing all our staff, listening to and learning from their experiences, and investing in the leaders of today and tomorrow as described in the Berwick Report CUH will make an explicit commitment to provide education and training opportunities for all staff which will include specific training in quality. An engaged, motivated and well-trained workforce is key to providing high quality care. We will continue to be an organisation that our staff are proud to work for and would recommend to their families and friends.

We want to be an organisation where there is a single and shared understanding of what we mean by quality, with all staff, irrespective of their role, behaving in a kind, safe and excellent way.

**In 2015/16 our priorities are as follows:**

- (i) Improve the trust’s staff engagement score in the NHS staff survey
- (ii) An increasing proportion of our staff recommend us as a place to work
- (iii) An increasing proportion of our staff recommend us as a place to receive treatment
• (i) An increasing proportion of staff have confidence in the people who lead CUH
(ii) An increasing proportion of staff have confidence in the people who lead their area of work

• (i) Deliver a maximum vacancy rate of 5% and 8% for registered nurses and HCAs respectively
(ii) Have a plan in place to mitigate the risks regarding junior doctor rota’s

A detailed explanation of each measure is included in annex 3

**Harm Free**
Patients will suffer no avoidable harm.

Patients rightly expect CUH to be a safe place and that the healthcare we provide will help them. We must protect our patients from unintentional harm whilst they are in our care. This includes hospital-acquired infections, medication errors, surgical infections, pressure ulcers and other unintended injuries resulting from, or contributed to by clinical care (including the absence of indicated treatment or best practice). In addition, we aim to provide an appropriate, clean and safe environment for all patients at all times. For 2015/16 we want to improve how we share learning from incidents.

**In 2015/16 our priorities are as follows:**

• (i) Care measured by the Safety Thermometer audit to be 98% or above
(ii) Less than 0.2% of patient contacts should result in an incident report where patient harm is recorded
(iii) We will strive for no avoidable infections. There will be zero hospital acquired MRSA bacteraemia and the number of cases of hospital-acquired Clostridium difficile will be less than the agreed ceiling of 49

• HSMR to be less than 85 in aggregate for the Trust

• A monthly programme of safety and quality learning to commence by June 2015

A detailed explanation of each measure is included in annex 3

**Delay Free**
Care delivered on time and to time cost efficiently, meeting or exceeding all national standards in relation to providing timely care.

We all dislike having our time wasted, and in a clinical environment treating patients promptly and appropriately can positively influence outcomes for individual patients. Consistently providing reliable, timely care also improves the experience of patients.
This includes reducing avoidable cancellations of appointments or surgery and at the end of a patient’s hospital stay ensuring there are no delays to their discharge from hospital caused by factors within our control. These things will only happen when we treat our patients’ time as more valuable than our own.

**In 2015/16 our priorities are as follows:**

(i) 95% of patients who attend our Emergency Department are seen within four hours. We have agreed a recovery trajectory with our Clinical Commissioning Group to return to this performance level by August 2015.

(ii) 92% of our patients waiting on a referral to treatment pathway will have waited less than 18 weeks. We have declared to Monitor that we will return to this performance level by Quarter 4.

(iii) 85% of patients are treated within 62 days of their GP urgent cancer referral. We have agreed a recovery trajectory with our Clinical Commissioning Group to return to this performance level by Quarter 2.

The number of operations cancelled on or after the day of admission is less than 1%

The number of bed days lost to assessment for patients medically fit to leave, to be less than 20 per week

A detailed explanation of each measure is included in annex 3
As the local hospital for our community, a national centre for specialist treatment, a comprehensive biomedical research centre, a major teaching hospital and one of only five academic health science centres in the UK, CUH prides itself on providing evidence-based medicine, soundly grounded in academic research. We want all care we provide to be clinically effective care, following national and international best practice, with each patient receiving the most appropriate treatments, interventions, support and services. Reducing avoidable variations in practice will not only improve outcomes for patients, but will also allow us to use scarce NHS resources optimally.

**In 2015/16 our priorities are as follows:**

- Trust patient related outcomes (PROMS) to be above the national average
- At least 85% patients aged 75 and over admitted as emergencies have a Clinical Frailty Score screen performed within 72 hours of admission
- Improve the identification and treatment of patients with sepsis with at least 90% compliance with the sepsis antibiotic bundle
- A detailed explanation of each measure is included in annex 3

### 3.4 Statement of assurance

**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 report 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 services

During 2014/15 Cambridge University Hospitals NHS Foundation Trust provided and/or sub-contracted 117 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 117 of these relevant health services.

The income generated by the relevant health services reviewed in 2014/15 represented 99% of the total income generated from the provision of relevant health services by the Cambridge University Hospitals NHS Foundation Trust for 2014/15.

Participation in clinical research

CUH continues to work strategically in partnership with other NHS organisations, universities, research councils, research charities and industry to provide an outstanding infrastructure that builds research capacity and supports excellence in clinical research that will benefit patients.

Strengths in biomedical science are harnessed and translated into clinical research through the National Institute for Health Research (NIHR) Cambridge Biomedical Research Centre (BRC), a partnership between CUH, and the University of Cambridge. Support for clinical trials is provided by the Cambridge Clinical Trials Unit (CTU), established in 2010 and now a fully accredited CTU with the NIHR Clinical Research Network.

Outstanding facilities for experimental and clinical research also exist within the Addenbrooke’s Clinical Research Centre.

CUH is keen to ensure that patients and the public are both kept informed of and able to engage in research activities. Our website has a page dedicated to public involvement and engagement in research see www.cuh.org.uk/research, and includes details of how to become a member of the patient and public involvement panel.

A unique opportunity for the public to participate in research is provided by the Cambridge BioResource, which now includes almost 15,000 local volunteers who have provided clinical information and samples that allow them to be invited according to their genetic makeup for clinical research studies; see www.cambridgebioresource.org.uk

The number of patients receiving relevant health services provided by or subcontracted by CUH in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 12,966 compared with 11,205 in 2013/14.
**Education and training**

One strand of our tripartite mission are our activities in the field of education and training, which support excellence in the care which our staff provide for patients. We work closely with the University of Cambridge to train the next generation of doctors through the University Clinical School. The Postgraduate Medical Centre (PGMC) continues to deliver the Health Education East of England Learning Development Agreement (LDA). The Centre has expanded its activities to deliver over 350 days of training which is primarily for postgraduate medical education, including a Practice Nurse Education Programme, GP Primary Care Programme, and a Dental Programme. The High Fidelity Medical Simulation Centre run by PGMC continues to deliver multiprofessional and team based training and has been successful in attracting funding for training programmes in many of the acute specialties from Health Education East of England (HEEoE). Last year 1,154 delegates attended the Simulation Centre for their multiprofessional training. The PGMC manage The Evelyn Cambridge Surgical Training Centre which is a state-of-the-art facility providing advanced education to health professionals. The Centre has reached its second year of activity, and has delivered 46 courses attracting 826 national and international attendees. PGMC have conducted a number of postgraduate exams on behalf of the Royal Colleges, and will continue to do so in the future.

The high standard of healthcare education and training is evidenced by the recent report to the Trust from HEEoE following their multiprofessional Quality and Performance Visit to CUH. At the recent HEEoE Performance Visit CUH was congratulated on a number of areas of notable practice. These included: strong and effective leadership for education and training in a wide range of professional groups, the medical academic training programme, excellent clinical supervision and excellent training programmes in pharmacy and radiography.

The Education Quality Assurance Framework demonstrates the provision of excellent multi professional student and continuing professional development at CUH as evidenced by the robust processes in place, evaluations of programmes, and student and staff feedback.

The Trust is committed to the training and development of over 600 pre-registration students including nurses, midwives, radiographers, physiotherapists, dieticians, occupational therapists, operating department practitioners and healthcare scientists whilst on clinical placements at CUH, to ensure they meet the needs of the future workforce and patient care.

Healthcare support workers (HCSW) form an integral part of clinical teams and are trained using a programme that meets national Care Certificate standards and utilises a competency based approach. The Trust is working with Health Education England to pilot a programme to provide prospective nursing students with a year programme as a HCSW.

Band 1 to 9 continuing education is managed via a plan agreed with HEEoE and supports the provision of safe and effective patient care, the development of new and existing services and developing leadership capability across all staff. Many
speciality programmes are well regarded and delivered by Trust experts using blended learning and simulation approaches.

Unlocking the potential of existing staff in bands 1 – 4 as well as bringing in new talent via apprenticeships continues to underpin the Trust’s commitment to deliver high quality, safe patient care whilst increasing the diversity and opportunities to enable people to improve and progress within and beyond bands 1-4.

The Trust continues to provide a range of leadership and management development programmes and interventions as well as encouraging our leaders to access to national and regional development programmes.

The Trust has a Multi Professional Education and Training Group that provides a forum for the development of strategic priorities to support excellent in education and training with membership from the post graduate medical education centre, and representatives from professional groups and services.

**Participation in national confidential enquiries**

During 2014/15 2 national confidential enquiries covered NHS services that CUH provides. CUH participated in both of these.

### Participation in national confidential enquiries

<table>
<thead>
<tr>
<th>Confidential enquiry title</th>
<th>Numbers to submit</th>
<th>Numbers submitted (100% unless otherwise stated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Surgical Clinical Outcome Review programme – National Confidential Enquiry into patient outcome and death</td>
<td>Lower Limb Amputation</td>
<td>31 cases were forwarded, 7 were selected for detailed review.</td>
</tr>
<tr>
<td></td>
<td>Tracheostomy</td>
<td>60 cases were submitted, 2 were requested for further review.</td>
</tr>
<tr>
<td></td>
<td>Sepsis</td>
<td>4 patient records were requested for review.</td>
</tr>
<tr>
<td></td>
<td>Gastrointestinal Haemorrhage</td>
<td>38 cases were submitted, about 5 were reviewed.</td>
</tr>
<tr>
<td>Maternal, Infant &amp; Newborn Clinical Outcome Review Programme (MBRRACE-UK)</td>
<td>all deaths that fit criteria</td>
<td>34</td>
</tr>
</tbody>
</table>
## Participation in clinical audits

During 2014/15 42 national clinical audits covered NHS services that CUH provides. CUH participated in all of these.

### Participation in clinical audits

<table>
<thead>
<tr>
<th>Audit title</th>
<th>Numbers to submit</th>
<th>Numbers submitted (100% unless otherwise stated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adherence to British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow testing - ORGANISATION</td>
<td>1 service questionnaire</td>
<td>1 questionnaire</td>
</tr>
<tr>
<td>Adherence to British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing - CLINICAL DATA</td>
<td>All Ulnar neuropathy patients</td>
<td>2562</td>
</tr>
<tr>
<td>Head &amp; neck cancer (DAHNO) national audit 2014</td>
<td>All new diagnoses with procedures</td>
<td>181</td>
</tr>
<tr>
<td>HQIP &amp; BSR Rheumatoid and Early Inflammatory Arthritis Clinical Data 2013/14</td>
<td>All patients with REIA treated</td>
<td>19 patient records</td>
</tr>
<tr>
<td>HQIP Adult UK Inflammatory Bowel Disease Organisation Audit 4th Round 2013 to 14</td>
<td>1 service questionnaire</td>
<td>1 questionnaire</td>
</tr>
<tr>
<td>HQIP Cardiac Rhythm Management Audit (Cardiac Arrhythmia) 2014 to 15</td>
<td>All</td>
<td>62</td>
</tr>
<tr>
<td>HQIP Elective Surgery - Patient Reported Outcome Measures (PROMs) 2014</td>
<td>All seen</td>
<td>67</td>
</tr>
<tr>
<td>HQIP Gastrointestinal Haemorrhage 2013/14 by NCEPOD Clinical Data</td>
<td>30</td>
<td>38</td>
</tr>
<tr>
<td>HQIP Gastrointestinal Haemorrhage 2013/14 by NCEPOD Organisational Data</td>
<td>1 service questionnaire</td>
<td>1 questionnaire</td>
</tr>
<tr>
<td>HQIP MINAP - 2014/15 (Myocardial Ischemia National Project)</td>
<td>All MINAP patients</td>
<td>247</td>
</tr>
<tr>
<td>HQIP National Audit of Dementia 2014 : Organisational Data</td>
<td>1 service questionnaire</td>
<td>Pending</td>
</tr>
<tr>
<td>Programme</td>
<td>Database/Case</td>
<td>Details</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>---------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>HQIP National Audit of Dementia 2014 : PART A - Clinical Data</td>
<td>Pending</td>
<td>Pending</td>
</tr>
<tr>
<td>HQIP National Audits - Bowel cancer 2015</td>
<td>All BC patients seen in period</td>
<td>215</td>
</tr>
<tr>
<td>HQIP National COPD Discharge 2014 to15 - Secondary Care Clinical data</td>
<td>All COPD seen in period</td>
<td>80</td>
</tr>
<tr>
<td>HQIP National COPD Discharge 2014 to15 Secondary Care Organisation Data</td>
<td>1 questionnaires</td>
<td>1 questionnaires</td>
</tr>
<tr>
<td>HQIP National Diabetes Inpatient Audit - 2014 to 15 NADiA</td>
<td>All inpatients on audit day</td>
<td>134</td>
</tr>
<tr>
<td>HQIP National Heart Failure Audit 2014 to 15</td>
<td>All Heart failure patients seen</td>
<td>466</td>
</tr>
<tr>
<td>HQIP National Hip Fracture Database FFFAP 2015</td>
<td>All Hip Fractures in the year</td>
<td>460</td>
</tr>
<tr>
<td>HQIP Transfusion in Children and Adults with Sickle Cell Disease</td>
<td>All sickle Cell patients</td>
<td>Pending</td>
</tr>
<tr>
<td>HQIP Transfusion in Children and Adults with Sickle Cell Disease (ADULTS)</td>
<td>All sickle Cell patients</td>
<td>Pending</td>
</tr>
<tr>
<td>HQIP: Sentinel Stroke National Audit Programme (SSNAP) 2014 to 15 -</td>
<td>1 questionnaires</td>
<td>1 questionnaires</td>
</tr>
<tr>
<td>Organisation data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HQIP: Sentinel Stroke National Audit Programme for Clinical Data (SSNAP)</td>
<td>All stroke patients treat in the period</td>
<td>168</td>
</tr>
<tr>
<td>2014 to 15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive Care National audit &amp; Research Centre (ICNARC) Case Mix Programme 14/15</td>
<td>All admissions in the audit period</td>
<td>1995</td>
</tr>
<tr>
<td>Initial Management of fitting Child (Care in Emergency Departments)</td>
<td>40 to 50 treated cases</td>
<td>41</td>
</tr>
<tr>
<td>MBRRACE UK Maternal and Perinatal Mortality 2014</td>
<td>All maternal &amp; perinatal deaths</td>
<td>36</td>
</tr>
<tr>
<td>Mental Health (Care in Emergency Departments)</td>
<td>all MH patients seen in ED</td>
<td>29</td>
</tr>
<tr>
<td>National BTS Adult Community Acquired Pneumonia Audit 2014 to 15</td>
<td>Minimum of 20 pneumonia</td>
<td>50</td>
</tr>
<tr>
<td>National Clinical Audit &amp; Patient Outcomes Programme: (HQIP) National lung cancer audit (NLCA) 2014</td>
<td>All patients seen in audit period</td>
<td>63</td>
</tr>
<tr>
<td>Organisation</td>
<td>Description</td>
<td>Details</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
<td>---------</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion - Patient Information &amp; Consent (2013-14) (Haematology)</td>
<td>All patients given consenting information.</td>
<td>240</td>
</tr>
<tr>
<td>National Diabetes Foot Care 2014</td>
<td>All diabetes patients seen in clinic</td>
<td>On-going</td>
</tr>
<tr>
<td>National Neonatal Audit Programme (NNAP) 2014</td>
<td>All Neonates treated in the year</td>
<td>936 babies</td>
</tr>
<tr>
<td>National Oesophago-gastric cancer Audit 2014</td>
<td>All diagnosed patients in the year.</td>
<td>145</td>
</tr>
<tr>
<td>National Paediatric diabetes audit 2014-15 NPDA</td>
<td>all children seen in paediatric diabetes clinics (up to age of 24yrs)</td>
<td>281</td>
</tr>
<tr>
<td>National Renal Registry UK 2014</td>
<td>All Renal patients treated in the year</td>
<td>4016</td>
</tr>
<tr>
<td>Older People (Care in Emergency Departments)</td>
<td>All older people treated in ED</td>
<td>101</td>
</tr>
<tr>
<td>PICANet Annual Performance Audit 2014/5</td>
<td>All paediatric intensive care admissions in the year</td>
<td>681</td>
</tr>
<tr>
<td>Provision of Mental Health Care in Acute Hospital : 2015 NCEPOD</td>
<td>All MH patients treated in the year</td>
<td>Starts April 2015</td>
</tr>
<tr>
<td>Renal Transplantation (NHSBT UK Transplant Registry) 2014</td>
<td>All renal transplant patients</td>
<td>250</td>
</tr>
<tr>
<td>The British Thoracic Society Pleural Procedures 2014 Clinical Data</td>
<td>Minimum of 20 procedures undertaken between June and July 2014, of which at least 8 should be chest drains.</td>
<td>23</td>
</tr>
<tr>
<td>The British Thoracic Society Pleural Procedures 2014 Organisation Data</td>
<td></td>
<td>1 Organisation Questionnaire</td>
</tr>
<tr>
<td>The Trauma Audit &amp; Research Network (TARN): 2014 audit of Orthopaedic Injuries</td>
<td>All Traumatic Orthopaedic Injury patients in the year</td>
<td>735 (still entering)</td>
</tr>
<tr>
<td>The Trauma Audit &amp; Research Network (TARN): 2014 audit of Thoracic, Abdominal and Shocked patients</td>
<td>All trauma Thoracic, Abdo &amp; shocked injury patients</td>
<td>680 (still entering)</td>
</tr>
<tr>
<td>The Trauma Audit &amp; Research Network (TARN): 2014 Head Injuries</td>
<td>All trauma head injury patients received for treatment in Addenbrooke’s</td>
<td>750 (still entering)</td>
</tr>
<tr>
<td>UK Inflammatory Bowel Disease Audit 5th round (4rd for paeds) IBD 2014-2016</td>
<td>All or 50 Paediatric IBD patients admitted for over 24 hours in Jan to Dec period</td>
<td>8</td>
</tr>
<tr>
<td>National Prostate Cancer Audit</td>
<td>1 organisation Questionnaire &amp; All newly diagnosed and radical prostatectomy (procedure), prostate cancer patients.</td>
<td>1 Organisation questionnaire</td>
</tr>
</tbody>
</table>
**BTS: National Adult Non-Invasive Ventilation Audit 2015**  
Postponed to 2016 by BTS  

<table>
<thead>
<tr>
<th>Audit</th>
<th>Description</th>
<th>Postponed to 2016 by BTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCEPOD Sepsis</td>
<td>4 patients that is identified as having sepsis in May 2014</td>
<td>4</td>
</tr>
<tr>
<td>National Joint Registry</td>
<td>All patients who had joint replacement procedures in the year</td>
<td>602</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA) 2014/15</td>
<td>All individuals receiving chest compressions and/or defibrillation and attended by the hospital-based resuscitation team or equivalent in the year.</td>
<td>115</td>
</tr>
<tr>
<td>National Vascular Registry (NVR): A National Prospective Audit 2013/14</td>
<td>All vascular surgery patients</td>
<td>289</td>
</tr>
</tbody>
</table>

The reports of 31 national clinical audits were reviewed by the Trust in 2014/15 and CUH has taken a number of actions to improve the quality of healthcare provided. Examples include:

**Lower Limb Amputation NCEPOD Study 2014**
- The trust now has 2 consultants who provide liaison services for frail elderly surgical patients upon request and a team of specialist nurses to provide liaison work and expertise to ward staff in the surgical areas – the SAFE team.
- Pre-operative assessment clinics have now been initiated for frail older adults and are holding 2 multi-disciplinary clinics weekly. Many amputees who may be appropriate to attend such a clinic can now be seen as part of a PRIME pre-op assessment.
- The trust now has in place, in addition to the Diabetes Foot Clinic Team, a Diabetes Outreach Team to see every patient with diabetes within 24 hours of admission. They are contacted whenever glucose control becomes an issue—either hypoglycaemia or persistent hyperglycaemia. This is a team of diabetes educators lead by a Consultant Physician.
- A specific Diabetes and Insulin Safety Board has been set up to take a hospital wide view of insulin prescribing. With the recent introduction of eHospital, a separate working group has been set up to ensure the previously embedded safe practice crosses over in to e-prescribing.

**National Adult Non-Invasive Ventilation Procedures Audit**
- Training has been offered to the East Anglia Ambulances Service Teams and the Emergency Department to address previously identified over oxygenation of patients. Regular monitoring through use of incident forms with discussion at quarterly COPD & Clinical Governance meetings has been imbedded into the Trust’s practice in the Respiratory Specialty.
- A new pathway now being used with the Respiratory Support and Sleep Centre and introduction of Temporary Home Mechanical Ventilation have helped in addressing the previously identified prolonged length stay.

**National Bowel Cancer Audit**
• Funding for the post of Data Clerk post was secured and the position filled as a way of ensuring that data accessed from EPIC is developed for submission and fit for purpose.
• Access to emergency theatre and perioperative care has been improved by securing a morning emergency list in the new build, in addition to the regular general emergency list.

**National Diabetes Inpatients Audit**
• There is now a consultant in post to lead the Diabetes Outreach Team, (DOT). This has transformed the ability of the team to deliver an appropriate and targeted service. This was done as part of reviewing the referral process for patients requiring the diabetes team and how the whole inpatient service is structured.
• A protocol for assessments of inpatients with foot risk in now in place and through the DOT, there is now a way of ensuring that all patients coming with diabetes have their feet checked.

**National Paediatric Diabetes Audit**
• The Paediatric Diabetes transition team has now been expanded to include an additional half time nurse plus half time dietician for transition with pending allocation of adult consultant time (1PA).
• Through maintaining a key worker system by developing a more structured education package - especially for the transition age group which has the highest HbA1c - the Paediatric Diabetes Team is now handling admissions more proactively for stabilisation and involving relevant agencies.

**National Falls and Fragility Audit**
• A National Osteoporosis peer review exercise was undertaken in 2014 and the Osteoporosis Steering Committee Group set up is currently working on plans to develop the Fracture Liaison Service.
• Hip fracture patients at Addenbrooke’s now being assessed and commenced on treatment unless a DEXA is required. All DEXA results and management plans are being sent to primary care as part of the metabolic bone service.

**National Sentinel Stroke National Audit Program**
• Therapy time to assessment is now being correctly documented in patient records if patient is not suitable for therapy as a shared responsibility between the medical and therapy teams.
• Funding for the acute nurse bleep which was recommended in 2009 by the Royal Colleges in a peer review – without which the service cannot manage, has now been secured.
**Use of the CQUIN payment framework**

The CQUIN framework is a national framework for locally agreed quality improvement schemes. 2.5% of CUH income in 2014/15 was conditional upon achieving the CQUINS agreed with NHS Cambridgeshire for the provision of NHS services. The potential CQUIN income available if the Trust had met all its targets across all commissioners’ contracts was £11,191,448. CUH received a CQUIN payment in 2014/15 of £10.438m. The corresponding CQUIN value for 2013/14 was £11,021,485, with the Trust achieving £10,634,225.

Full details of each CQUIN and the performance achieved during the year are set out in annex 6.

**Care Quality Commission registration and compliance**

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered without any compliance conditions. The Care Quality Commission has not taken any enforcement action against CUH during 2014/15.

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

The Trust continues to monitor compliance against all of the CQC essential standards of quality and safety on an ongoing basis. The board of directors and the quality committee are updated monthly via the integrated quality report.

A CCQ planned inspection of CUH took place in April 2015 and their written report is awaited.

**Data quality**

Data quality refers to the information recorded by the hospital on computerised systems about patients. This includes:

- name, date of birth, address
- GP information
- attendance at clinics
- related specialties
- procedures undergone

We undertake regular audits to make sure that data held on the system is accurate. The hospital follows national guidelines about how this data are collected and stored, and we carry out regular audits to ensure we are compliant with what is expected.

We also share data with partners as appropriate, for example clinical commissioning groups (CCGs). This data are used to plan and review the healthcare needs of the area.
Part of data quality is the use of the NHS Number. This is the only national unique identifier which is a strictly safe way of sharing information about a patient with other clinicians and healthcare staff, especially across organisational boundaries. It is therefore essential that the data quality work within CUH incorporates this number.

CUH submitted records during 2014/15 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 99.2% for admitted patient care, 99.9% for outpatient care, and 96.4% for accident and emergency care. The percentage of records in the published data which included the patients’ valid general practitioner registration code was 100% for admitted patient care, 100% for outpatient care and 99.9% for accident and emergency care.

The following tables show this, and additional information.

### Information governance – clinical information assurance

<table>
<thead>
<tr>
<th>Data Quality Results</th>
<th>All SHAs</th>
<th>EOE SHA</th>
<th>Addenbrooke’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted Patient Care</td>
<td>95.8</td>
<td>94.1</td>
<td>95.6</td>
</tr>
<tr>
<td>Outpatients</td>
<td>95.8</td>
<td>94.2</td>
<td>91.2</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>97.0</td>
<td>97.8</td>
<td>96.8</td>
</tr>
<tr>
<td>Births</td>
<td>91.3</td>
<td>97.3</td>
<td>94.6</td>
</tr>
<tr>
<td>Delivery Events</td>
<td>95.0</td>
<td>97.7</td>
<td>95.0</td>
</tr>
<tr>
<td>Other Birth Events</td>
<td>93.3</td>
<td>97.6</td>
<td>97.3</td>
</tr>
<tr>
<td>Other Delivery Events</td>
<td>96.5</td>
<td>97.9</td>
<td>97.9</td>
</tr>
<tr>
<td>Maternity Data Quality Score</td>
<td>1.013</td>
<td>0.991</td>
<td>1.013</td>
</tr>
<tr>
<td>Adult Critical Care</td>
<td>98.6</td>
<td>99.0</td>
<td>98.2</td>
</tr>
<tr>
<td>Paediatric Critical Care</td>
<td>98.9</td>
<td>99.8</td>
<td>99.8</td>
</tr>
<tr>
<td>Neonatal Critical Care</td>
<td>97.5</td>
<td>99.9</td>
<td>99.8</td>
</tr>
</tbody>
</table>

### Data quality report

<table>
<thead>
<tr>
<th>Data Quality Results</th>
<th>All SHAs</th>
<th>EOE SHA</th>
<th>Addenbrooke’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered GP Practice:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admitted Patient Care</td>
<td>99.9</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Outpatients</td>
<td>99.9</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>99.2</td>
<td>99.9</td>
<td>99.9</td>
</tr>
<tr>
<td>NHS Number:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admitted Patient Care</td>
<td>99.2</td>
<td>99.4</td>
<td>98.1</td>
</tr>
<tr>
<td>Outpatients</td>
<td>99.3</td>
<td>99.4</td>
<td>99.3</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>95.2</td>
<td>97.8</td>
<td>93.0</td>
</tr>
</tbody>
</table>

Information Source: NHS Information Centre – data quality dashboards
Based on SUS April–March 14/15 data at the month 10 inclusion date.
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. Acute trusts are assessed against 45 requirements and can achieve a level score of between 0-3. All trusts must reach a 'level 2' in all requirements, which is then assessed as a satisfactory score.

The CUHFT Information Governance Assessment Report overall score for 2014/15 was 84% (113 out of 135) achieving a level 2 or 3 against all requirements and was graded a satisfactory green rating.

A&E clinical coding
CUH was not subject to the Payment by Results clinical coding audit during 2014/15 by the Audit Commission

3.5 Independent assurance report

INDEPENDENT AUDITOR’S REPORT TO THE COUNCIL OF GOVERNORS OF CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

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 2015 (the “Quality Report”) and certain performance indicators contained therein.

Scope and subject matter
The indicators for the year ended 31 March 2015 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- Emergency readmissions within 28 days of discharge from hospital.

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 Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:
the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;

the Quality Report is not consistent in all material respects with the sources - specified in the Detailed Guidance for External Assurance on Quality Reports; and.

the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance 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 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 2014 to May 2015;
• Papers relating to Quality reported to the Board over the period April 2014 to May 2015;
• Feedback from Commissioners dated May 2015;
• Feedback from Governors dated May 2015;
• Feedback from local Healthwatch organisations dated May 2015;
• Feedback from Overview and Scrutiny Committee dated May 2015;
• The Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2014/15;
• The 2014/15 national patient survey;
• The 2014/15 national staff survey;
• Care Quality Commission intelligent monitoring report; and
• The 2014/15 Head of Internal Audit’s annual opinion over the Trust’s control environment.

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, to assist the Council of Governors 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 2015, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Cambridge University Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.
Assurance work performed

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

- 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.
- 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 thereof, 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.

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 2015:

- 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;
- the Quality Report is not consistent in all material respects with the sources specified above; 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.

KPMG LLP, Statutory Auditor
Botanic House, 100 Hills Road, Cambridge, CB2 1AR
21 May 2015
3.6 Reviewing performance against last year’s priorities for improvement

An overall summary of performance against our priorities for improvement is set out in annex 5.

3.7 Improving safety and reducing harm – harm-free care

Our goal was that care delivered would be safe and harm-free, measured by the following indicators:

**Safety Thermometer**

The Safety Thermometer, a nationally mandated method of assessing the safety of care provided in hospitals. It uses an audit of every inpatient once a month to assess four elements of care to determine how many patients have received ‘harm free care.’ The four elements are:

- the existence of pressure ulcers
- urine infections in patients with catheters
- falls within the last 72 hours
- a venous thromboembolism

Our aim was that care, as measured by the monthly audit should be 98% harm-free.

Did we achieve our aim in 2014/15? - Yes - we achieved an aggregate 98.4% harm free care, 0.1% higher than 2013/14. The rate excluding old harm (where the patient had the harm prior to coming under our care) has been greater than 98.3% over the year.

Harm rates

The hospital has in place a well developed incident reporting process which requires staff to report incidents, irrespective of whether harm occurred. We recognise that...
the system does rely on identifying that an event which is reportable has taken place, and reporting it, however around 10,000 patient-related incidents were reported in 2014. Good reporting is viewed as an indication of a positive safety culture. We measured the rate of harm as a percentage of patient contacts each month. Patient contacts are the number of inpatients admitted, outpatient, day case and Emergency Department attendances.

Our aim was that less than 0.2% of patient contacts should result in an incident report where patient harm is recorded.

Did we achieve our aim in 2014/15? Yes – aggregate for the year was 0.14%, 0.01% lower than 2013/14. In 2014/15 a total of 10,562 patient safety incidents were reported, compared with 10,368 in 2013/14. The actual number of incidents reported each month where some degree of harm was reported ranged between 96 and 156.

Minimising Infection

We committed to reduce the number of all avoidable infections and the harm they cause and in particular to keep the number of patients who acquire *C. difficile* or a MRSA bacteraemia in hospital to a minimum. By reducing the numbers of affected patients to a minimum, we reduced the need for a prolonged length of stay, surgery or admission to an intensive care unit as a result of the infection. During 2014/15 we focussed on environmental cleaning standards, isolation, antibiotic prescribing, hand hygiene and staff education as part of the programme to help reduce and prevent healthcare associated infections. In 2015/16 we will continue to ensure we achieve high standards in the prevention of infection control including: effective screening, environmental cleaning, hand hygiene and isolation, alongside the judicious use of antibiotics and monitoring of all aspects of infection control performance via regular audits, monthly performance reports whilst also developing the ability to fully utilise the benefits of eHospital.

Our aim was to minimise the number of avoidable hospital acquired infections and to meet our contractual ceilings for these infections during 2014/15. The ceiling for hospital acquired MRSA bacteraemia was zero and 61 for hospital-acquired Clostridium difficile cases.

Did we achieve our aims in 2014/15?

MRSA- Yes - In 2014/15 there were no MRSA blood stream infections compared to four in 2013/14,

C. Difficile – Yes - In 2013/14 there were 54 cases of C. Difficile infection, compared to 50 in 2013/14, although we are disappointed that this is 4 above the 2013/14 number.
3.8 Improving the reliability of care – delay-free care

Our goal was that care delivered by the hospital would be reliable and timely, measured by the following indicators. 2014/15 has been a challenging year for the NHS in terms of patient demand and CUH is no exception, we have treated a greater number of patients than ever before. Similar demands have been made on our partners in Social Care and this has contributed to our inability to discharge patients who no longer need medical care.

In October 2014 we implemented eHospital, one of the largest IT projects of its kind in the NHS that will, once fully optimised improve the quality and safety of the care we provide to our patients. The implementation, as we had planned, did disrupt the smooth running of the hospital.

Emergency Department waiting time
In excess of 102,000 patients attended the emergency department at Addenbrooke’s in 2014/15. There is a nationally mandated target to see 95% of patients within four hours.

**Our aim was to meet this target each quarter.**

**Did we achieve our aim in 2014/15? - No – we did not meet the target in any quarter, the average for the year was 83.7%, a significant reduction on the 94.7% achieved in 2013/14.**

- Admissions via the emergency department were up 2% (690 patients)
- Attendances for 2014/15 up by 3.1% (3134 patients)
We continue to look at ways in which we can improve our performance so that we can meet the 4 hour target. These include the design of the Emergency Department, the GP out of hour’s service, and redesign of our triage processes.

We have appointed a further 2 consultant posts and continue to try and recruit additional Band 7 nurses, although finding suitable applicants remains challenging.

Admission within 18 weeks of GP referral
We recognise the importance for patients to be admitted in a timely manner following referral by their GP.

**Our aim was that 90% of our patients who require admission would be admitted within an 18-week timeframe.**

**Did we achieve our aims in 2014/15? – No** - We achieved this standard at Trust level for 6 of the 12 months of the year, the aggregate score being 87.3% compared with 10 of the 12 months and 93% in 2013/14.

**Treatment within 62 days of an urgent cancer referral**
We recognise the importance for patients of being treated in a timely manner following urgent referral by their GP where cancer is suspected.

Our aim is that 85% of patients are treated within 62 days of referral.
Did we achieve our aims in 2014/15? No – we achieved this standard for 2 out of the 12 months of the year, the aggregate score being 79.9% (excluding any agreed re-allocations from late-referring trusts).

62 day cancer waits - standard urgent referrals

Did we achieve our aims in 2013/14? – No – We just missed our target, the aggregate score for the year was 1.34%, compared with 1.02% in 2013/14.
3.9 Improving the experience of our patients – person centre care

Our goal was that care delivered by the Trust would be a positive experience and not result in the need to raise a formal complaint, measured by the following indicators

Inpatient Experience

We surveyed patients each quarter using a questionnaire to seek views of the care received. The questions covered topics that include infection control, cleanliness, privacy, safety, nursing and medical care received, being informed and involved in the care provided, and food.

Our aim was that 90% of patients who respond to the surveys answer questions as ‘yes,’ ‘met expectations’ or ‘above expectations’.

Did we achieve our aims in 2014/15? – Yes – the aggregate score for the year was 94.6%.

Outpatient Experience

We surveyed patients who attend outpatients twice during the year using a 23 point questionnaire to seek views of the care received. The questions covered the quality of experience pre, during and post appointment. Topics include timeliness, information provided and clarity about next steps.

Our aim was that 90% of patients who respond to the surveys answer questions as ‘strongly agree’ or ‘agree’.

Did we achieve our aims in 2014/15? – Partially - Outpatient surveys were undertaken in July 2014 and February 2015. The results of the July 2014 survey gave a score of 89.7%, with the February 2015 survey recording 90%.

Friends and Family Test

This is an NHS wide initiative to gather feedback about patients’ experiences. In simple terms it is seeking to answer the question ‘is the care I received good enough for my friends or family?’

Our aim was to improve the 2013/14 score by 10% and achieve a score of greater than 57/100.

Did we achieve our aims in 2014/15? – Yes Under the new scoring system 61.1% of our patients told us they would recommend our services if they had friend and family who required similar care and treatment.
The Department of Health changed the scoring system during the course of the year. Patients are now asked to rate a hospital on a 5 point scale ranging from extremely likely to extremely unlikely. They are also given the option of don’t know.

During the course of the last year we have rolled out iPads that enable our patients to give real time feedback. These are now in the majority of inpatient wards and are starting to be placed within the clinics. We also have the surveys on our website for outpatients to access when they get home should they prefer. In the year ahead we will be intruding the surveys into children’s & young adults services and aim to improve the way we seek feedback form our patients who attend one of our day units or day or surgery units. We aim to make real time feedback quick and easy for our patients, whenever they wish to give us feedback. We aim to maintain our high score.

**Patient complaints**

We always embrace complaints as these help identify areas where we can improve and are a way of measuring the level of quality we are delivering. We measured the complaint rate as a percentage of patient contacts, patient contacts are the number of inpatients admitted, outpatient, day case and emergency department attendances.

**Our aim was that the number of formal complaints received should be less than 0.1% of patient contacts.**

**Did we achieve our aims in 2014/15? - Yes –** The monthly rate as a percentage of patient contacts ranged between 0.04% and 0.08%. In 2014/15 a total of 523 formal complaints were received, compared with 465 in 2013/14.
3.10 Providing clinically effective care

Our goal was that care delivered by the Trust would be effective, in simple terms it delivers what it says it will, measured by the following indicators:

Hospital Standardised Mortality Ratio (HSMR)

This is a nationally calculated ratio prepared by Dr Foster where a score of 100 would mean actual deaths were in line with expected. An HSMR of less than 100 indicates fewer patients than expected died, a figure of greater than 100 indicated more than expected died.

Our aim was to have an HSMR that placed the hospital in the top 10% of our peer group and have an aggregate hospital HSMR of less than 90.

Did we achieve our aims in 2014/15? - Yes – The HSMR for the latest 12 months available (to December 2014) was 84.8, compared with 77.7 in 2013/14. The graph below sets out HSMR performance, note however that data is always 3 months in arrears.

Patient related outcome measures (PROMS)

These are nationally mandated and provide a patient perspective of the effectiveness of the care they received, in simple terms the health gain or loss following the procedure. They cover surgery undertaken in respect of hips and knees, groin hernia and varicose veins. The information is collated nationally and therefore data for 2012/13 has only recently been made available.

Our aim was that for 2014/15 our results 2012/13 are above the national average.

Did we achieve for 2014/15? – Partially – The information so far available in 2014/15 identifies an improvement on 2013/14 and the results are above the national average in one out of the three measures, where sufficient procedures were undertaken at CUH. The Trust did not undertake enough varicose vein procedures to submit data.
The Trust was above the national average for hernia, but below for hip and knee surgery.

**Clinical Frailty score for patients aged 75 or above**

Care of the frail elderly: The Trust is seeing and admitting an increasing number of frail elderly patients (those aged 75 and over). We recognised that developing services to better serve this group of patients is central to improving both quality of care and developing sustainable services for the future.

A key element of their admission is that they undergo a proper screening using the clinical frail score tool within their first 72 hours in hospital to identify their treatment requirements.

Our aim was that in 2014/15 at least 85% of patients aged 75 and over, admitted as emergencies had a CFS screen performed within 72 hours of admission.

Did we achieve for 2014/15? – Yes – we achieved a CFS screening rate of 86.5%.

### 3.11 Staff as partners

Our goal was that all our patients would receive high quality care, provided by an engaged, motivated and well trained workforce, measured by the following indicators.

**Staff turnover**

Staff turnover is measured for each staff group on a monthly basis and is calculated using the number of leavers and joiners as a percentage of the workforce.

Our aim was to reduce average staff turnover by 10% during 2013/14.

Did we achieve for 2014/15? – No – The annualised staff turnover rate for the year has varied between 12% and 13%. Whilst our turnover rate is in line with the national average it is higher than we would have wished for. The last 12 months have been extremely challenging for all staff groups and all areas of the Trust with sustained levels of higher than planned activity and the implementation of eHospital. We will continue to focus on retention and recruitment in 2015/16 and a Retention Plan has been agreed with the aim of reducing the turnover rate.

**Staff appraisal**

We believe it is important that all staff who work for the Trust should have an annual appraisal meeting with their manager to discuss objectives, performance and any other issues relating to their employment.

Our aim was to ensure that over 90% of staff had an annual appraisal in 2014/15.
Did we achieve for 2014/15? – Yes – 96.5% of staff had an appraisal during the year. This was a significant achievement.

Staff engagement

Having an engaged workforce is something we want to achieve. The Trust undertakes its own internal staff engagement survey each year and we set ourselves an ambitious target for 2014/15.

Our aim is to improve staff participation in the survey to 55%

Did we achieve for 2014/15? – No – Only 25% of staff took part in the 2014 National Staff survey which we want to improve on in 2015/16. In 2014 we changed from issuing the questionnaire to a sample of staff (approx 800) to issuing it to all staff. Therefore although the response rate was lower we have feedback from significantly more staff, approximately 2000 staff, than in previous National Staff Surveys. The survey was undertaken during the critical go-live period for Epic which undoubtedly will have had an impact on the response rate.

Sickness absence

Reducing and keeping sickness absence low is an NHS wide challenge. CUH’s rate is already below the NHS national average, however we want to make sure it is as low as possible.

Our aim was to have an overall Trust sickness absence rate of 2.85%

Did we achieve for 2014/15? – No – The overall rate was 3%. The aim was ambitious given the Trust’s already relatively low sickness absence rate. We have comprehensive policies, processes and support mechanisms in place and will continue in 2015/16 to support staff to have excellent attendance at work.

Staff Friends and Family test

One of the key elements of the national Friends and Family programme is to ask staff their views regarding the care delivered at the hospital in which they work. In simple terms is its good enough for them or their family.

Our aim was to implement the test during the year in line with national guidance

Did we achieve for 2014/15? – Yes– The Staff Friends & Family Test was introduced successfully to the Trust in 2014. We integrated it into the Trust’s staff engagement surveying cycle. In Quarter 1 (June) and Quarter 2 (September) the Trust achieved a 90% score for staff who would recommend the Trust as a place for treatment (exceeding the national average score); and the Trust achieved 61% scores for staff who would recommend the Trust as a place for work (matching the national average score). All trusts are exempt from Quarter 3 and the Trust is awaiting results for Quarter 4 (March 2015).
4. Reviewing and setting local and national indicators and targets

As well as us setting our own priorities for improvement, shown in section 6, there are a number of mandated requirements and indicators set for the NHS as a whole. These are as follows:

4.1 National quality indicators

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

Where data is available from the Health and Social Care Information Centre, a comparison has been included of the numbers, percentages, values, scores or rates of each of the Trust’s indicators with:

- the national average for the same
- those NHS trusts and NHS foundation trusts with the highest and lowest of the same

Full details of each National Indicator and the performance achieved during the year is set out in annex 4.

4.2 CQUINs

The CQUIN framework is a national framework for locally agreed quality improvement schemes. 2.5% of CUH income in 2014/15 was conditional upon achieving the CQUINS agreed with NHS Cambridgeshire for the provision of NHS services. The potential CQUIN income available if the Trust had met all its targets across all commissioners’ contracts was £11,191,448. CUH received a CQUIN payment in 2014/15 of £10,438m. The corresponding CQUIN value for 2013/14 was £11,021,485, with the Trust achieving £10,634,225.

Full details of each CQUIN and the performance achieved during the year is set out in annex 6.

4.3 National targets

Set by the Department of Health, these targets reflect the NHS Operating Framework which sets out the main planning framework, key financial assumptions and national targets for the NHS across all areas of activity.

Full details of each National Target and the performance achieved during the year is set out in annex 7.
4.4 Feedback on the quality report and accounts

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

Trust Secretary
PO Box 146, Cambridge University Hospitals NHS Foundation Trust, Cambridge Biomedical Campus, Hills Road, Cambridge, CB2 0QQ

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

This document is also available on request in other languages, large print and audio format – please phone 01223 274648.
5. **Annex 1: Statement of directors’ responsibilities in respect of the quality report**

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

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

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

- the content of the quality account meets the requirements set out in the ‘NHS Foundation Trust Annual Reporting Manual’ 2014/15
- the content of the quality account is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2014 to March 2015
  - papers relating to quality reported to the board over the period April 2014 to March 2015
  - feedback from commissioners dated 14/05/2015
  - feedback from governors dated 14/05/2015
  - feedback from local Healthwatch organisations dated 21/05/2015
  - the Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 27/05/2015
  - latest national patient survey dated 02/12/2014
  - latest national staff survey dated 24/02/2015
  - the Head of Internal Audit’s annual opinion over the Trust’s control environment dated 20/05/2015
  - CQC Intelligent Monitoring Report dated December 2014
- the Quality Account presents a balanced picture of the NHS foundation trust’s performance over the period covered
- the performance information reported in the Quality Account 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 account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

the quality account has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality account

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:

Dr Keith McNeil
Chief Executive

Jane Ramsey
CUH Chair
6. Annex 2: Statements by stakeholders

Governors’ statement on the quality account 2014/15

The Council of Governors greatly values the opportunity which Governors have to be involved in the development of the Trust’s quality priorities for the coming year, and to comment on the quality account for 2014/15.

During this year, the Governors have continued to scrutinise the integrated report on quality, finance and performance. The Governors welcomed the improved openness and transparency of the Trust’s reporting arrangements, particularly the public Board of Directors sessions and high level of Executive involvement in the Council of Governors meetings and Director Governor working group meetings. As in previous years, the Governors and Directors will have the opportunity to discuss together, the Trust’s quality performance at the Governor/Director working groups. We will continue to monitor the Trust’s progress towards the aims which it has set itself, and offer necessary but constructive challenge if we consider that this is not progressing as planned. Governors will also work hard to ensure that the Trust membership are kept informed and engaged in progress against these objectives.

Governors were pleased that the Trust achieved a number of its quality account metrics, but are disappointed that aims for improvement in some areas which are particularly important to our patients and public experience, have not been fully achieved in this year. Although Governors recognise the especially challenging healthcare environment in which the Trust operates and our generally excellent patients outcomes, the Trust must ensure that quality account aims are delivered to plan.

Governors welcomed the quality priorities which the Trust has set out for the forthcoming year.
Cambridgeshire and Peterborough Clinical Commissioning Group (the CCG) has reviewed the Quality Account produced by Cambridge University Hospitals NHS Foundation Trust (CUHFT) for 2014/15.

The CCG and CUHFT work closely together to review performance against quality indicators and ensure any concerns are addressed. There is a structure of regular meetings in place between the CCG, CUHFT and other appropriate stakeholders to ensure the quality of CUHFT services is reviewed continuously with the commissioner throughout the year. In addition, the CCG has carried out announced and unannounced visits to CUHFT to observe practice and talk to staff and patients about quality of care, feeding back any concerns so the Trust can take action where required.

These visits included a review of processes for ensuring patients are discharged from the hospital in a smooth and timely way. There were some issues raised about the systems in place on the day of discharge and the Trust has been working to improve these. One of CUHFT’s five key priorities is delay-free care and the Trust is part of a whole system focus on delayed transfers of care. A new priority to manage the number of days lost to assessment for patients medically fit to leave has been added for 2015/16. The Trust also needs to continue its focus on discharge process as highlighted by feedback from patients, and aim for a significant improvement in this area following action taken over the past two years.

Capacity and increasing demand has also been highlighted as a concern in the CUHFT Quality Account and the CCG has been working with the Trust to address these issues. The Trust was unable to meet the national target for patients seen in the Emergency Department within four hours in the last two quarters of 2014/15. This remains a priority for 2015/16. There were also issues identified in relation to waiting times in orthopaedics and ophthalmology.

CUHFT is monitored by both the Care Quality Commission and Monitor, independent regulators of NHS Trusts. The Trust is compliant with all Care Quality Commission requirements. An announced inspection is planned for April 2015. In summer 2014, Monitor agreed the Trust was no longer in breach of its authorisation. However, the regulator is now reviewing further information following breaches of the Emergency Department, cancer and referral to treatment targets and deterioration in the Trust’s financial position. The CCG is working with CUHFT to drive improvements and continues to monitor how the Trust is addressing the required improvements.

In autumn 2014, CUHFT started the implementation of its eHospital electronic patient record system. Considerable planning and training had been carried out to minimise disruption in the implementation period. Unfortunately, significant performance and quality concerns were raised with targets not delivered in several areas including Venous Thromboembolism assessment, outpatient bookings, Emergency Department waiting times, and referral to treatment times. In addition GPs reported an increase in inaccurate and incomplete discharge summaries, and problems with pathology services.
There have also been concerns in relation to Safeguarding Children’s training, and the Trust has put in place systems to improve access to this training, including a new eLearning package. CUHFT faced a significant Safeguarding Children’s incident in regards to a member of staff. The Trust responded appropriately and is continuing to seek to learn from the incident in order to ensure that as far as they are able children are safeguarded when attending the Trust.

CUHFT has put in place a detailed action plan to recover from the eHospital implementation problems and increase support for staff. The CCG is working with the Trust to support recovery and has carried out a series of visits which gave assurance that quality of care has not been compromised by the eHospital problems. The Trust is one of the first healthcare providers to carry out such a significant change and the new system will be a driver for improvements in patient care. The Trust will also be able to share the learning from their implementation with other providers who are moving towards an eHospital system.

The statement of the Chief Executive acknowledges the importance of the staff in the work of the Trust, and this is emphasised in a range of national reports, particularly in relation to safe staffing. The requirement to report staffing ratios on ward and carry out regular workforce establishment reviews was introduced in 2014, and CUHFT has implemented these requirements, setting up a system of monitoring and escalation to ensure safe staffing. The safe staffing levels have been affected by increases in capacity driven by urgent care pressures and a high vacancy rate for Registered Nurses. The Trust is implementing a range of options to manage staffing levels but these are unsustainable in the longer term, and the capacity issues need to be addressed urgently.

There are also systems to support engagement of staff and allow staff to raise concerns. However, the results of the 2014 national staff survey showed a significant fall in the overall staff engagement score. The survey was carried out between September and November 2014 which overlapped with the launch of eHospital and the Trust feels that the results reflect the associated capacity pressures caused by this implementation. The Trust is engaging with staff to identify and implement improvements at organisational, divisional and service level. A new Workforce Experience Committee has been established to co-ordinate the Trust’s approach to improving staff experience and engagement. CUHFT has set additional priorities for 2015/16 focusing on the ‘Workforce as Partners’ key priority stream which should provide assurance as to the success of the measures being put in place to improve staff engagement.

CUHFT’s priority to ensure patients suffer no avoidable harm includes a focus on hospital-acquired Clostridium difficile. The Trust set a local ceiling for this infection of 50 for 2014/15 which was achieved. However, there were some concerns about the timeliness of isolation and prompt sending of specimens and the Trust continues to monitor processes to ensure compliance and improvement. The ceiling set for Clostridium difficile for 2015/16 is 49; however, the CCG would expect the Trust to aim for a more significant reduction in cases.

The CUHFT Quality Strategy set out priorities for 2014/15 which covered improving patient experience, staff engagement, safety and reliability of care, eliminating avoidable harm and providing clinically effective care. Eight of the fourteen priorities were achieved in full. The majority of these priorities have been carried forward into 2015/16. However, most targets have not been changed from the 2014/15 levels (with several of these also not increased from those for 2013/14). The CCG would like to see the Trust set more stretching targets to drive improvement, rather than aiming for a static position.

The Quality Account sets out three positive initiatives that will support quality improvement going forward; a monthly programme of safety and quality learning, the establishment of a quality and safety academic unit, and looking at global comparators for quality. The CCG
applaud these projects and look to the Trust to ensure learning from these is fed into the health economy and drives improvement in care.

Quality Accounts offer a transparent way for trusts to report on innovation, education and research. CUH’s Account shows the strength of the Trust’s partnerships for research, and the range of education initiatives for clinical professionals. There are good examples of the way the Trust has learnt from its Clinical Audit programme. However, learning from the incidents reported in the Trust is not included.

The CUHFT Quality Account is presented in an understandable and consistent format. The priorities for the Trust are set out clearly, with rationale for inclusion for the 15/16 goals. The report includes all the nationally mandated sections. However, a list of services and specialties provided by the Trust is not given or signposted. The CCG has reviewed the data presented in the Quality Account and this appears to be in line with other data published.

Cambridgeshire County Council Health Committee
No statement was received.

Statement from Cambridgeshire Healthwatch
The Trust continues to deliver generally good quality care for patients and takes prompt action when concerns are raised. As a world leader in many fields the Trust is to be commended for its outstanding performance in various specialisms. Healthwatch Cambridgeshire has a positive relationship with the Trust and we are pleased with the priority placed upon patient experience and person centred care.

In previous Quality Accounts Healthwatch Cambridgeshire has highlighted the benefits that could be gained from deeper analysis and year on year comparisons of both PALS and complaints data. The Trust could do more to demonstrate this and how learning from feedback takes place.

The rollout of the EPIC eHospital system has been difficult for staff and patients, despite the planning and training that was put in place, it has impacted upon communications with patients. Healthwatch Cambridgeshire stresses the need for the Trust to be certain that it is addressing all areas requiring improvement. Healthwatch Cambridgeshire is also concerned that delays in elective care will inevitably increase waiting times.

Healthwatch Cambridgeshire is aware that the Trust has shortages of staff in many areas. The Trust’s workforce do a wonderful job, very often under difficult circumstances, and all staff are thanked for their commitment to patient care. The 25% return rate for the staff survey is very low and the Trust needs to take steps to ensure morale does not slip further.

Healthwatch Cambridgeshire is pleased that an NHS organisation successfully tendered for the Older People’s and Community Services contract and looks forward to the Trust playing a significant role in integrating services in the coming year.
Healthwatch Suffolk response to Cambridge University Hospitals NHS Foundation Trust (CUHFT) Quality Account 2014/15

Addenbrooke’s Hospital has an outstanding reputation for delivering high quality care, which is safe and evidenced based. Seen by the public as a ‘specialist’ hospital many patients feel safer just knowing they are attending this hospital above other local providers.

This perception of exceptional care is for the most part reflected in the evidence highlighted in the quality account. Whilst challenging, the introduction of eHospital is now functional and will add value to the patient experience in a variety of ways.

It is pleasing to read that you are no longer in breach with Monitor, demonstrating the commitment made to drive up standards in the Trust.

Whilst the priorities and targets set in the quality account were identified in partnership with directors and senior staff, there is no evidence of involving other staff at lower grades whose experience and knowledge could prove valuable.

The trust has proved it can provide safe care, as highlighted by the safety thermometer results, harm rates and infection rates and the HSMR (Hospital Standardised Mortality Ratio) although there is still room for improvement and three ‘never events’ were logged. It would be interesting to know what action was taken as a result of these never events and any learning that resulted.

The increasing demand for service and delayed discharges are a concern and this is reflected in some of the negative comments raised by patients who report delays in accessing treatment (waiting longer than the 18 weeks RTT) and delayed discharges or inappropriate discharges resulting in stress to the patient and their family/carers, particularly when the discharge has not been properly planned or communicated to all who need to know.

The cancer urgent referral waiting times are disappointing, given that any potential for a diagnosis of cancer will undoubtedly impact on the patient’s mental health and ability to function whilst waiting for a diagnosis, prognosis and treatment.

Patient experiences of out-patient clinics appear to be very positive overall, as shown in the results of the outpatient survey, which shows that the vast majority of patients are satisfied with the care they receive.

Whilst complaint levels remain low and well within the Trusts target level, 465 formal complaints should still be seen as a concern as this is likely to be the tip of the iceberg, with many other complaints being verbal or not raised with the hospital at all. For a hospital that prides itself on its reputation, complaint handling should be a priority.

Staff turnover is higher than the trust would like to see, as is sickness levels. There is also a low response to staff surveys. This may reflect a workforce that is overstretched and attention needs to be given to ensuring staff are treated fairly, supported and well led. Whilst 90% of staff would recommend the hospital as a place to receive treatment, only 61% recommended it as a place to work.

There is evidence of annual appraisals, but this provides only statistical information. It is unclear how staff view the quality of the appraisal process and there is no evidence of more regular supervision and support for staff. A healthy workforce is essential for delivering the targets set by the trust and it would be good to see a commitment from the Board to ensure that all staff receive support and guidance at all stages of the employment.
Most complaints relate to staff attitudes and the public’s perception of whether or not staff are caring, compassionate, empathetic and do what they say they are going to do. Complaints are therefore often about individual staff rather than system failures and as such all staff need to share the pride of the Trust and uphold its values and standards.

Anecdotal reports to Healthwatch Suffolk have indicated patients who have had positive experiences of their care. One individual reports the staff in A+E as lifesavers, however, the person was subject to many procedural difficulties, such as being moved after 3 hours and 59 minutes to ensure A&E was not in breach, only to be pushed around the hospital on a bed for some time until a bed was available in coronary care.

One individual made a formal complaint about the care they received, which should have been kept confidential, but was disclosed to the next doctor who was treating them and this resulted in a further negative experience.

On the whole the Trust is proving itself to attract local, regional, national and international recognition and praise. At a time of increasing demands and reductions to funding, the Trust is providing care that most people would regard as good or very good.
7. Annex 3: our 2015/16 priorities in detail

**Person Centred**

Every patient is treated as a person, not a number, with dignity and respect, and is fully involved in their treatment and care. “No decision about me without me.”

This will be measured through:

Inpatient experience: We survey in one month each quarter using a 24-point questionnaire to seek views of the care received. The questions cover topics that include infection control, cleanliness, privacy, safety, nursing and medical care received, being informed and involved in the care provided, and food.

Our aim is that over 90% of patients who respond to the surveys rate their experience as at least 7/10.

Outpatient experience: We survey patients who attend outpatients on a six monthly basis using a 23 point questionnaire to seek views of the care received. The questions cover the quality of experience pre, during and post appointment. Topics include timeliness, information provided, clarity about next steps etc.

Our aim is that over 88% of patients would recommend our clinics.

Friends and family test: This is an NHS wide initiative to gather feedback about patients’ experiences. In simple terms it is seeking to answer the question ‘is the care I received good enough for my friends or family?’ The rating system uses a score out of 100.

Our aim is to that our score is greater than 65.

Patient complaints: We always welcome complaints as these often help identify areas where we can improve and are a way of measuring the level of quality we are delivering. We will measure the complaint rate as a percentage of patient contacts each month, patient contacts are the number of inpatients admitted, outpatient, day case and emergency department attendances.

Our aim is that the number of formal complaints received should be less than 0.1% of patient contacts.

Staff values and behaviours: This is a new measure for 2015/16 and recognises the reaffirmation of the Trust’s values *Together, safe, kind and excellent*. We will use the staff survey to gain staff’s views as to whether they treat patients in a way that is consistent with our values and behaviours.
Our aims are that in 2015/16

**90% of staff report they are aware of the trust’s values and behaviours**

**an increasing proportion of staff feel they are able to deliver the Trust’s values and behaviours in their work. The survey result in 2015/16 will establish an initial figure**

**Workforce as Partners**

A fully engaged, skilled, trained and competent workforce delivering care of the highest quality. An organisation that is well-led at all levels.

This will be measured through:

**Workforce engagement:** The Trust takes part in the annual NHS staff survey.

Our aim is to have a 2015/16 engagement rate above that of 2014/15.

**Staff Friends and Family test:** One of the key elements of the national Friends and Family programme is to ask our staff their views regarding the care delivered at the hospital in which they work. In simple terms is its good enough for them or their family. We will measure this using the staff survey.

**Our aims are that in 2015/16**

**An increasing proportion of our workforce recommend us as a place to work**

**An increasing proportion of our workforce recommend us as a place to receive treatment**

**Leadership.** This is a new measure for 2015/16. We want those who lead and manage our workforce to have the confidence of the staff they lead and manage. We will measure this via the staff survey.

**Our aims are that in 2015/16**

**An increasing proportion of staff have confidence in the people who lead CUH**

**An increasing proportion of staff have confidence in the people who lead their area of work**

**Workforce planning:** This is a new measure for 2015/16. Ensuring we have sufficient staff now and in the future is crucial to delivering the high quality care we aspire to. We have identified two measures, the first relates to nurses and health care assistants, the second to medical staff.
Our aims are that in 2015/16

We have a maximum vacancy rate of 5% for registered nurses and 8% for HCA

We have a robust plan by in place by the end of 2015/16 to mitigate the risks regarding junior doctor rota’s

Harm Free
Patients will suffer no avoidable harm.

This will be measured through:

Safety Thermometer: The Safety Thermometer is a nationally mandated method of assessing the safety of care provided in hospitals. It uses an audit of every inpatient once a month to assess four elements of care to determine how many patients have received 'harm free care.' The four elements are:

- the existence of pressure ulcers
- urine infections in patients with catheters
- falls within the last 72 hours
- a venous thromboembolism

Our aim is that care received in hospital, as measured by the monthly audit should be 98% harm-free

Harm rates: The hospital has in place a well-developed incident reporting process which requires staff to report incidents, irrespective of whether harm occurred. We recognise that the system does rely on identifying that an event which is reportable has taken place, and reporting it, however around 10,000 patient-related incidents were reported in 2012. Good reporting is viewed as an indication of a positive safety culture. We will measure the rate of harm as a percentage of patient contacts each month. Patient contacts are the number of inpatients admitted, outpatient, day case and Emergency Department attendances.

Our aim is that less than 0.2% of patient contacts should result in an incident report where patient harm is recorded.

Minimising infection: We will work with our partners strive to reduce the number of avoidable infections and the harm they cause and in particular to keep the number of patients who acquire C. difficile or MRSA in hospital to a minimum. By reducing the numbers of affected patients to a minimum, we will reduce the need for a prolonged length of stay, surgery, admission to an intensive care unit, or causing serious harm. During 2014/15 we will continue to focus on cleaning standards, antibiotic prescribing
and staff education as part of the programme to help reduce and prevent healthcare associated infections.

Our aim is to minimise the number of avoidable hospital acquired infections and to meet our contractual ceilings for these infections during 2014/15. The ceiling for hospital acquired MRSA bacteraemia is zero and for hospital-acquired Clostridium difficile cases is 61.

Hospital standardised mortality ratio (HSMR): This is a nationally calculated ratio prepared by Dr Foster (http://www.drfosterhealth.co.uk/) where a score of 100 would mean actual deaths were in line with expected. An HSMR of less than 100 indicates less patients than expected died, a figure of greater than 100 indicated more than expected died.

**Our aim is have an aggregate hospital HSMR of less than 85.**

Improve how we share learning: This is a new measure for 2015/16. Although CUH has a positive reporting culture and investigation process, we recognise that we can improve the way we learn to minimise the risk of recurrence. Therefore we will develop a Trust wide programme of learning.

**Our aim is that a monthly programme of safety and quality learning will commence by June 2015.**

**Delay Free**

Care delivered on time and to time cost efficiently, meeting or exceeding all national standards in relation to providing timely care.

**This will be measured through:**

Emergency department waiting time: In excess of 102,000 patients attended the emergency department at Addenbrooke’s in 2014/15. There is a nationally mandated target to see 95% of patients within four hours.

**We have agreed a recovery trajectory with our Clinical Commissioning Group to return to this performance level by August 2015.**

92% of our patients waiting on a referral to treatment pathway will have waited less than 18 weeks. A referral pathway refers to the time from a referral being received to Consultant led treatment starting.

**We have declared to Monitor that we will return to this performance level by Quarter 4.**

Treatment within 62 days of an urgent cancer referral: We recognise the importance for patients of being treated in a timely manner following urgent referral by their GP where cancer is suspected.

**Our aim is that 85% of patients are treated within 62 days of referral.** We have agreed a recovery trajectory with our Clinical Commissioning Group to return to this performance level by Quarter 2.
Cancelled operations: Once a date is set for an operation, we will do our best to ensure that date is kept to, while recognising there will be occasions when emergencies impact on routine operating.

**Our aim is that the number of operations cancelled on or after the day of admission is less than 1%.**

Bed days lost to assessment for patients who are medically fit to leave: Minimising the number of patients who are medically fit to leave, but who remain in our care is important. It is in patients interests to be cared for in the most appropriate care setting, and for CUH it is a significant factor in being able to admit and treat patients requiring inpatient hospital care.

**Our aim is that the number of bed days lost to assessment for patients medically fit to leave is less than 20 per week.**

### Clinically Effective

Care that achieves the best outcome possible for each patient and which is delivered using the latest evidence based techniques.

This will be measured through:

Patient-related outcome measures (PROMS): These are nationally mandated and provide a patient perspective of the effectiveness of the care they received, in simple terms the health gain or loss following the procedure. They cover surgery undertaken in respect of hips and knees, groin hernia and varicose veins.

**Our aim is that for 2015/16 our results are above the national average.**

Care of the frail elderly: The Trust is seeing and admitting an increasing number of frail elderly patients (those aged 75 and over). Cambridgeshire local authority population forecasts predict a 3.6% year on year growth of the population aged 85+, which equates to a doubling over the next 20 years. We recognise that developing services to better serve this group of patients is central to improving both quality of care and developing sustainable services for the future.

A key element of their admission is that they undergo a proper screening using the clinical frail score tool within their first 72 hours in hospital to identify their treatment requirements.

**Our aim is that at least 85% of patients aged 75 and over, admitted as emergencies will have a CFS screen performed within 72 hours of admission.**

Improve the identification and treatment of patients with sepsis:

Sepsis is a time-critical condition that can lead to organ damage, multi-organ failure, septic shock and eventually death. It is caused by the body’s immune response to a bacterial or fungal infection. There is considerable evidence that clinical staff may fail to recognise sepsis, underestimate the severity of the illness and the initiation of treatment is frequently delayed.
Our aim is to achieve at least 90% compliance with the sepsis antibiotic bundle.

| Indicator | 2013/14 (or previous reporting period to latest available) | 2014/15 (or latest reporting period available) | CUHFT considers that this data is as described for the following reasons... | CUHFT intends to take/has taken the following actions to improve this proportion/ score/rate/number, and so the quality of its services, by...
|
|-----------|----------------------------------------------------------|-------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| **Summary Hospital-Level Mortality Indicator (SHMI)** | 85.6 from July 2012 to June 2013 placing the Trust in Band 3 | 85.5 from July 2013 to June 2014 placing the Trust in Band 3 | The Trust has a robust process for clinical coding and review of mortality data so is confident that the data is accurate. | The Trust reviews SHMI data and always looks at how it can be reduced further.
|
| | 17 Trusts were in Band 3 | 15 Trusts were in Band 3 | | |
| | 9 Trusts were in Band 1 | 9 Trusts were in Band 1 | | |
| **Note 100 = average performance** | | | | |
| **% of patient deaths with palliative care code** | 14.2% July 2012 to June 2013 | 21.0% July 2013 to June 2014 | The Trust has a robust process for clinical coding and review of mortality data so is confident that the data is accurate. | The Trust percentage is better than the national average so no further action is being taken at present.
|
| | The national average is 20.3% | The national average is 24.6% | | |
| **PROMS relating to:** | April 2012 to March 2013 | April 2013 to March 2014 | The Trust has processes in place to ensure that relevant patients are given questionnaires to complete. | The use of PROMS data within the Trust is reviewed and reported in the Integrated Report to the Quality Committee each month. Where our
<table>
<thead>
<tr>
<th>Indicator</th>
<th>2013/14 (or previous reporting period to latest available)</th>
<th>2014/15 (or latest reporting period available)</th>
<th>CUHFT considers that this data is as described for the following reasons…</th>
<th>CUHFT intends to take/has taken the following actions to improve this proportion/ score/rate/number, and so the quality of its services, by…</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Groin hernia surgery</td>
<td>Trust 0.106</td>
<td>Apr – Sep 14</td>
<td>However it has no control over their completion and return.</td>
<td>data is applicable, the Trust is better than the national average in the latest reporting period.</td>
</tr>
<tr>
<td></td>
<td>Ave 0.085</td>
<td>Trust 0.086</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Varicose vein surgery</td>
<td>Trust N/A</td>
<td>Apr – Sep 14</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ave 0.09</td>
<td>Trust N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hip replacement surgery</td>
<td>Primary – Trust 0.460</td>
<td>Apr 13 – Mar 14</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ave 0.438</td>
<td>Trust N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Revision – Trust N/A</td>
<td>Apr 13 – Mar 14</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ave 0.272</td>
<td>Trust N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Knee replacement surgery</td>
<td>Primary – Trust 0.323</td>
<td>Apr 13 – Mar 14</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ave 0.319</td>
<td>Trust N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Revision – Trust N/A</td>
<td>Apr 13 – Mar 14</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ave 0.251</td>
<td>Trust N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readmission within 28 days of</td>
<td>Trust rate was 8.36% for 2011/12 placing the Trust in</td>
<td>No further update available. Trust rate was</td>
<td>The Trust has a robust process for clinical coding so is confident that the data is</td>
<td>The Trust rates for 0-14 and 15 plus ages re-admissions show some improvement on last year and are both</td>
</tr>
<tr>
<td>discharge (i) aged</td>
<td>band B1, meaning</td>
<td>8.36% for 2011/12</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>2013/14 (or previous reporting period to latest available)</td>
<td>2014/15 (or latest reporting period available)</td>
<td>CUHFT considers that this data is as described for the following reasons…</td>
<td>CUHFT intends to take/has taken the following actions to improve this proportion/ score/rate/number, and so the quality of its services, by…</td>
</tr>
<tr>
<td>-----------</td>
<td>----------------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>0-14</td>
<td>significantly better than the national average at the 99.8% interval.</td>
<td>placing the Trust in band B1, meaning significantly better than the national average at the 99.8% interval.</td>
<td>accurate.</td>
<td>better than the national average. The Trust looks at how it can be reduced further.</td>
</tr>
<tr>
<td></td>
<td>National average rate was 10.01%</td>
<td>National average was 10.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readmission within 28 days of discharge (ii) aged 15 or over</td>
<td>Trust rate was 10.64% for 2011/12 placing the Trust in Band B1</td>
<td>Trust rate was 10.64% for 2011/12 placing the Trust in Band B1</td>
<td>Undertaken independently as part of the annual national inpatient survey.</td>
<td>The score for 2014/15 is an improvement on 2013/14 and has improved relative to the national average. We continue to use feedback from surveys and complaints to address areas of performance which fall short of our standards.</td>
</tr>
<tr>
<td></td>
<td>National average was 11.45%</td>
<td>National average was 11.45%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsiveness to inpatients’ personal needs</td>
<td>Trust score was 70.5 in 2012/13</td>
<td>Trust score was 72.1 for 2013/14</td>
<td>Undertaken independently as part of the annual national inpatient survey.</td>
<td>The Trust remains vigilant to ensure that this performance is sustained. It is monitored by the Trusts VTE Committee.</td>
</tr>
<tr>
<td></td>
<td>National average was 68.1</td>
<td>National average was 68.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% risk assessed for VTE</td>
<td>Trust achieved 98.7% in 2013/14</td>
<td>Trust achieved 90.7% in 2014/15</td>
<td>The Trust has a robust process assessing VTE risk assessment of patients and this is also part of the monthly Safety Thermometer.</td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>2013/14 (or previous reporting period to latest available)</td>
<td>2014/15 (or latest reporting period available)</td>
<td>CUHFT considers that this data is as described for the following reasons…</td>
<td>CUHFT intends to take/has taken the following actions to improve this proportion/ score/rate/number, and so the quality of its services, by…</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Acute Trust average was 95.8%</td>
<td>Acute Trust average was 95.9%</td>
<td></td>
<td>audit. Compliance levels did drop (from above 96% to 80%) when we implementated eHospital in October 2014. However we have seen an improvement since, with 85.9% in month of March.</td>
<td></td>
</tr>
<tr>
<td>Cases of <em>C. difficile</em> infection per 100,000 bed days</td>
<td>Trust rate was 23.5 in 2012/13 (73 cases)</td>
<td>Trust rate was 15.9 in 2013/14 (50 cases)</td>
<td>The Trust has in place robust mechanisms to record cases of C. Diff</td>
<td>A number of wide ranging actions involving both the Trust and wider health economy are in place.</td>
</tr>
<tr>
<td>Trust rate was 17.3</td>
<td>Acute Trust average was 17.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient safety incidents</td>
<td>(i) Trust number for October 2012 to March 2013 5,955</td>
<td>(i) Trust number for October 2013 to March 2014 6,218</td>
<td>Data is submitted to the National Reporting and Learning System in accordance with national reporting requirements.</td>
<td>The Trust has a positive reporting culture. Reducing harm to patients is a one of the key elements of our quality account and quality strategy.</td>
</tr>
<tr>
<td>(i) Number</td>
<td>(ii) Rate per 100 admissions 9.09</td>
<td>(ii) Rate was 9.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Rate per 100 admissions 9.09</td>
<td>(iii) Number and percentage resulting in severe harm/death, 0.35% of incidents</td>
<td>(iii) 19 resulted in severe harm/death, 0.31% of incidents</td>
<td>Note: these figures relate to incidents reported via the Trust incident reporting</td>
<td></td>
</tr>
<tr>
<td>(iii) Number and percentage resulting in severe harm/death, 0.35% of incidents</td>
<td>(iii) 19 resulted in severe harm/death, 0.31% of incidents</td>
<td>(iii) 19 resulted in severe harm/death, 0.31% of incidents</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Indicator | 2013/14 (or previous reporting period to latest available) | 2014/15 (or latest reporting period available) | CUHFT considers that this data is as described for the following reasons... | CUHFT intends to take/has taken the following actions to improve this proportion/ score/rate/number, and so the quality of its services, by...

Friends and Family Test – Staff  
% of staff recommending the trust to family or friends |

- 83% in 2013 survey, placing Trust in best 20% of trusts
- 76% in 2014 survey, placing Trust in best 20% of trusts

| Acute trust average 64% | Acute trust average 65% |

| Friends and Family Test – Patient (not statutory) |

- Inpatient Net Promoter Score for March 2014 is 49.4. This is based on 785 responses and the score is an increase from 45.1 in February. The score for the overall 2013/14 financial year is 51.7.
- Inpatient Net Promoter Score for Feb 2015 is 61.1. This is based on 803 responses and the score is an increase from 45.1 in Feb 2014. The score for the overall 2014/2015 financial year to date is 61.1.

- Undertaken independently as part of the annual national staff survey.
- Already in the top 20% and looks to at least sustain this position.

- System which relies on the reporter identifying that an incident has occurred.

### OUR PRIORITIES FOR IMPROVEMENT - How are we doing?

**As at the end of MARCH 2015**

### PERSON CENTRED

**Improving the experience of our patients**

<table>
<thead>
<tr>
<th>How we measure this</th>
<th>Our target</th>
<th>How are we doing?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Last month (comparison to last month)</td>
</tr>
<tr>
<td>Inpatient experience (data from July 2014 patient survey)</td>
<td>90%</td>
<td>⇓</td>
</tr>
<tr>
<td>Outpatient experience (data from February 2015 patient survey)</td>
<td>90%</td>
<td>⇧</td>
</tr>
<tr>
<td>Friends and family test (Patient survey)</td>
<td>&gt;57</td>
<td>60.6</td>
</tr>
<tr>
<td>Patient complaints (data to end of February 2015)</td>
<td>0.10%</td>
<td>0.06%</td>
</tr>
</tbody>
</table>

### STAFF AS PARTNERS

**Ensuring an engaged and well managed workforce**

<table>
<thead>
<tr>
<th>How we measure this</th>
<th>Our target</th>
<th>How are we doing?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Last month (comparison to last month)</td>
</tr>
<tr>
<td>Staff turnover (12 month cumulative to February 2015)</td>
<td>reduce by 10% on 2013/14</td>
<td>⇧</td>
</tr>
<tr>
<td>Appraisal rate (for current year)</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Participation in staff engagement survey (Participation rate for survey that closed on 1 December 2014)</td>
<td>55%</td>
<td>⇩</td>
</tr>
<tr>
<td>Sickness absence rate (rolling 12 months)</td>
<td>&lt;2.85%</td>
<td>3.00%</td>
</tr>
<tr>
<td>Friends and family test (included in 2014 survey)</td>
<td>Implement</td>
<td>Complete</td>
</tr>
</tbody>
</table>
## HARM FREE CARE

### Improving safety and reducing harm

<table>
<thead>
<tr>
<th>How we measure this</th>
<th>Our target / ceiling</th>
<th>How are we doing?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care delivered Harm Free (Safety Thermometer)</td>
<td>98%</td>
<td>98.4% ↓</td>
</tr>
<tr>
<td>Harm Rates (as reported on incidents)</td>
<td>&lt; 0.2%</td>
<td>0.16% ↓</td>
</tr>
<tr>
<td>Minimise Infection - MRSA</td>
<td>0</td>
<td>0 ↔</td>
</tr>
<tr>
<td>Minimise Infection - Clostridum Difficile</td>
<td>61</td>
<td>4 ↑</td>
</tr>
</tbody>
</table>

## DELAY FREE CARE

### Improving the reliability of care

<table>
<thead>
<tr>
<th>How we measure this</th>
<th>Our target</th>
<th>How are we doing?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department waiting time (4hr target)</td>
<td>95%</td>
<td>75.9% ↓</td>
</tr>
<tr>
<td>Admission within 18 weeks of GP referral</td>
<td>90%</td>
<td>76.4% ↑</td>
</tr>
<tr>
<td>Seen within 62 days of urgent cancer referral (February 2015 data)</td>
<td>85%</td>
<td>80.8% ↑</td>
</tr>
<tr>
<td>Cancelled operations</td>
<td>&lt; 1%</td>
<td>0.62% ↓</td>
</tr>
</tbody>
</table>

## CLINICALLY EFFECTIVE CARE

### Improving the effectiveness of care

<table>
<thead>
<tr>
<th>How we measure this</th>
<th>Our target</th>
<th>How are we doing?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Standardised Mortality Ratio (HSMR) (latest month available is December 2014)</td>
<td>&lt; 90</td>
<td>94.3 ↓</td>
</tr>
<tr>
<td>Patient Related Outcome based on health gain (above national average or not) (data to end of March 2014)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip</td>
<td>CUH 21.3</td>
<td>Nat Av 21.3</td>
</tr>
<tr>
<td>Knees</td>
<td>CUH 15.3</td>
<td>Nat Av 16.2</td>
</tr>
<tr>
<td>Hernia</td>
<td>CUH 0.1</td>
<td>Nat Av 0.09</td>
</tr>
<tr>
<td>Varicose Veins</td>
<td>Insufficient procedures performed</td>
<td></td>
</tr>
<tr>
<td>Clinical Frailty Score for patients aged 75 or above</td>
<td>85%</td>
<td>88.60% ↑</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal Number</th>
<th>Area</th>
<th>CQUIN</th>
<th>Indicator description</th>
<th>Senior Lead</th>
<th>Q1 Actual</th>
<th>Q2 Actual</th>
<th>Q3 Actual</th>
<th>Q4 target</th>
<th>Q4 Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Friends and Family Test</td>
<td>Implementation of Staff Friends and Family Test</td>
<td>Implementation of Staff FPT as per guidance, according to the national timetable</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1b</td>
<td>Friends and Family Test</td>
<td>Early Implementation - meet national roll out plan milestones (outpatients)</td>
<td>Early implementation</td>
<td>Helen Balsdon/ Fiona Thompson</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2</td>
<td>Friends and Family Test</td>
<td>Increased or Maintained Response Rate</td>
<td>Increased or maintained response rate (20% in A&amp;E, 30% for inpatients)</td>
<td>Helen Balsdon/ Fiona Thompson</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3</td>
<td></td>
<td>Increased Response Rate in acute inpatient services</td>
<td>Increased or maintained response rate (40% or more for March 2015 for inpatients)</td>
<td>Helen Balsdon/ Fiona Thompson</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1a</td>
<td>Safety Thermometer</td>
<td>NHS Safety Thermometer - Reduction in the prevalence of pressure ulcers (threshold to be confirmed)</td>
<td>Reduction in the prevalence of pressure ulcers</td>
<td>Sharon McTaily</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1b</td>
<td></td>
<td>NHS Safety Thermometer - Support for partner agencies</td>
<td>RCA forms communicated to partner agencies</td>
<td>Sharon McTaily</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td>NATIONAL Dementia</td>
<td>% of emergency admissions aged 75 who have been asked the dementia case finding question</td>
<td>Sharon McAllay</td>
<td>April: 96% May: 94.9% June: 95% Q1: 95.3% July: 95% Aug: 95% Sept: 97% Q2: 96% Oct: 90.23% Nov: 95% Dec: 96.7% Q3 = 94%</td>
<td>Jan: 97.3% Feb: 97.3% Mar: 97.3% Q4 = 97.3%</td>
<td>64</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2</td>
<td>NATIONAL Dementia</td>
<td>% of the number of patients above who answered positively to the case finding question who have had diagnostic assessment</td>
<td>Sharon McAllay</td>
<td>April: 98.7% May: 96.8% June:100% Q1: 98.1% July: 98% Aug: 99% Sept: 100% Q2: 98% Oct: 98.33% Nov: 84.3% Dec: 90.3% Q3 = 90.6%</td>
<td>90% for each element (25%)</td>
<td>64</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3</td>
<td>NATIONAL Dementia</td>
<td>% of patients who had a positive of inconclusive assessment outcome who were referred on to specialist services</td>
<td>Sharon McAllay</td>
<td>April: 98.6% May:100% June: 100% Q1: 99.5% July: 100% Aug: 100% Sept: 100% Q2: 100% Oct: 100% Nov: 100% Dec: 100% Q3 = 100%</td>
<td>Planned training programme undertaken</td>
<td>64</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>LOCAL 1</td>
<td>2WW Dermatology Education and Feedback process - 2 WW referral feedback and training provided</td>
<td>Trained sessions will be carried out where consultants provide feedback on 2WW referrals that they receive and also provide training on different dermatological conditions.</td>
<td>Liz Hurt</td>
<td>Meeting held. Reports and educational material distributed.</td>
<td>Joint MDT was delivered 26/11/14 with appropriate handouts. Draft MDT report and educational material submitted (awaiting comments from CCG).</td>
<td>Joint primary/secondary care MDT meeting held. Report &amp; educational materials produced. (15%)</td>
<td>Q4 requirements completed. (awaiting confirmation)</td>
<td></td>
</tr>
<tr>
<td>1.2</td>
<td>LOCAL 2</td>
<td>Dermatology new clinical thresholds and development of a community telehealth service</td>
<td>Development and implementation of new clinical thresholds and development of a community telehealth service</td>
<td>Liz Hurt</td>
<td>Q1 and Q2 actions completed.</td>
<td>On track</td>
<td>Q1-Q4 actions completed. (15%)</td>
<td>Q4 requirements completed. (awaiting confirmation).</td>
<td></td>
</tr>
<tr>
<td>1.3</td>
<td>LOCAL 3</td>
<td>Dermatology new clinical thresholds and development of a community telehealth service</td>
<td>Milestone has been entered and moved to Q4. (spot audits instead of telehealth service).</td>
<td>Liz Hurt</td>
<td>Milestone has been entered and moved to Q4. (spot audits instead of telehealth service).</td>
<td>Milestone has been entered and moved to Q4. (spot audits instead of telehealth service).</td>
<td>Milestone has been entered and moved to Q4. (spot audits instead of telehealth service).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>LOCAL 2</td>
<td>Joint Primary and Secondary Care Clinical Incident reviews</td>
<td>Quarterly review meetings to take place to discuss a single case by a learning</td>
<td>Nick Toff</td>
<td>Q2 meeting held</td>
<td>3rd review held in Nov.</td>
<td>Meeting held &amp; report submitted. (15%)</td>
<td>Q4 requirements completed. (awaiting confirmation).</td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>LOCAL 2</td>
<td>Joint Primary and Secondary Care Clinical Incident reviews</td>
<td>Actions completed</td>
<td>Nick Toff</td>
<td>Actions completed</td>
<td>On track</td>
<td>Q4 actions completed. (10%)</td>
<td>Q4 requirements completed. (awaiting confirmation).</td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td>LOCAL 3</td>
<td>Frail Elderly: Enhanced Discharge Summary - roll out of enhanced summary across surgical wards for frail elderly patients. Clinical frailty score to be completed for frail elderly patients.</td>
<td>To include the clinical frailty score and enhanced summary in discharge letters</td>
<td>Clara Moore</td>
<td>On track for Q3</td>
<td>Q4: 100% compliance Nov/Dec N/A - Discharge summary field is not currently mandatory in EPIC. 50% CFS/advanced discharge summaries included in discharge letters. (5%)</td>
<td>EPIC issues persist</td>
<td>Q4 requirements completed. (awaiting confirmation).</td>
<td></td>
</tr>
<tr>
<td>3.2</td>
<td>LOCAL 3</td>
<td>Enhanced discharge summary</td>
<td>Meeting held. Following agreement with CCG, report to be discussed in Nov CCG meeting.</td>
<td>Clara Moore</td>
<td>Meeting held. Following agreement with CCG, report to be discussed in Nov CCG meeting.</td>
<td>Meeting scheduled for Dec</td>
<td>Joint primary/secondary care review meeting held &amp; report submitted. (10%)</td>
<td>Q4 requirements completed. (awaiting confirmation).</td>
<td></td>
</tr>
<tr>
<td>3.3</td>
<td>LOCAL 3</td>
<td>Enhanced discharge summary</td>
<td>Complete appropriate actions</td>
<td>Clara Moore</td>
<td>Q1 and Q2 actions completed.</td>
<td>On track</td>
<td>Q4 actions completed. (10%)</td>
<td>Q4 requirements completed. (awaiting confirmation).</td>
<td></td>
</tr>
<tr>
<td>Local Area 4</td>
<td>Ophthalmology Triage and Education Process</td>
<td>Liz Hunt</td>
<td>Q1 Project documentation agreed. 95% agreed to be paid now, 98% to be moved to Q3 and Q4 outcome measures and paid on achievement of these. Pilot completed.</td>
<td>CAS in place (10%)</td>
<td>CAS Report submitted and discussed at meeting (2%). 90% inappropriate referrals triaged in Q3 &amp; 4 rejected, measured by end Q4 audit. (4%)</td>
<td>Q4 requirements completed, awaiting confirmation).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>----------------------------------------</td>
<td>---------</td>
<td>--------------------------------------------------------------------------------</td>
<td>------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>___________________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ophthalmology Triage and Education Process</td>
<td>Liz Hunt</td>
<td>Outcome measure - reduce inappropriate referrals.</td>
<td>CAS in place</td>
<td>Audits on referrals have been arranged.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>An Ophthalmology Clinical Assessment Service to be developed and quarterly training sessions to be provided.</td>
<td>Liz Hunt</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Area 5</td>
<td>Outpatient pathway review and risk stratification of patients under the providers care</td>
<td>Julie Smith</td>
<td>Clinical forums to review pathways held for all 5 specialties.</td>
<td>In working progress</td>
<td>Gynae remains behind due to shortage of staff.</td>
<td>Jointly review pathways in T&amp;O, Cardiology, Urology, Gastroenterology &amp; Gynaecology. Q3 actions completed. (8%)</td>
<td>Virtual Fracture Clinic is now operational. Other pathways signed off and published.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Joint (primary/secondary care) Clinical forum to review pathways</td>
<td>Julie Smith</td>
<td>Project support identified, TOK written and all project documentation and action plans produced for all 5 specialties.</td>
<td>Ø/Ø/4 data challenges persist (Q4). The team is working to provide alternative ways of showcasing impact.</td>
<td>Ø/Ø/4 agreed follow up rate reduction/other agreed activity changes achieved. OR completion of additional specialty reviews, if agreed. (25%)</td>
<td>Data challenges persist (Q4). The team is working to provide alternative ways of showcasing impact.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Achievement of reduction in follow up rates or other activity changes</td>
<td>Julie Smith</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Area 6</td>
<td>Diabetes Virtual Telephone Case Review</td>
<td>Liz Hunt</td>
<td>21 slots offered 8 booked (4 sessions completed and 4 cancelled by GP) Free slots remaining</td>
<td>Further slots have been offered to encourage participation.</td>
<td>&gt; 10 virtual teleconference case reviews completed in Q4. 39 in total for Q2-4. (20%)</td>
<td>Q4 requirements completed. (awaiting confirmation).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Virtual telephone multi-disciplinary case reviews are to take place 1st hour teleconferences per week for 39 weeks/year.</td>
<td>Liz Hunt</td>
<td>Learning and feedback sheet for the sessions have been created and disseminated.</td>
<td>On track</td>
<td>Summary report of learning and actions for Q4 to be presented &amp; shared. (50%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>LOCAL 7</td>
<td>Heart Failure</td>
<td>Percentage of heart failure patients who are given a personalised mgt. plan that is shared with them, their carer(s), and their GP (NICE quality standard 10)</td>
<td>Liz Hunt</td>
<td>April: 77% May: 75% June: 76% Q1: 76% July: 78% Aug: 78% Sept: 78% Q2: 78% Oct: 79% Nov: 80% Dec: 81% Q3: 80% Improvement on Q1 (25%)</td>
<td>Jan: 85% Feb: 84% Mar: tba</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>LOCAL 8</td>
<td>Specialised Services</td>
<td>Ensuring providers embed and routinely use the required clinical dashboards developed during 2013/14 for specialised services. The Area Team is responsible for agreeing the relevant dashboards with the providers.</td>
<td>Joe Ghosh</td>
<td>Reporting date to be after Q1. 5 dashboards completed. For the remaining 12 dashboards a report has been completed including reporting dates and issues. Use of dashboards process map completed. Data for Q3 against all the agreed dashboards submitted.</td>
<td>Submit data for Q4 against all the agreed dashboards Provide brief summary of use of dashboard products in CUH B. Identify key issues. (25%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>LOCAL 9</td>
<td>Highly specialised services collaborative audit workshop and Provider report.</td>
<td>Providers of Highly specialised services will hold a clinical outcome collaborative audit workshop and produce a single Provider report.</td>
<td>Tom Bennett</td>
<td>Dates for clinical audit meetings have been agreed for 7 out of the 8 Highly Specialised Services.</td>
<td>On track Submission of appropriately analysed outcome data and attendance at all HSS workshops (50%) Single report covering all CUH HSS. (50%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>LOCAL 10</td>
<td>Implementation of CRG proposed QIPP plans and joint development of in year proposals.</td>
<td>Ed Smith</td>
<td>Confirmation from NHSE of agreement to £400k against H3V received. Delivery programme updated.</td>
<td>On track Implementation of all agreed QIPP initiatives in line with agreed timescales. (50%) after £700k removed Savings to the value of £400k from pathway changes or savings against the agreed NHSE income plan. £400k Emergency threshold funding allocated by NHSE £300k</td>
<td>Q4 requirements completed. (awaiting confirmation).</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## 11. Annex 7: National Targets - 2014/15

### 2014/15 National targets

<table>
<thead>
<tr>
<th>National target</th>
<th>2013-14 Actual</th>
<th>Current Month</th>
<th>2014/15 Financial Year</th>
<th>2014/15 Target</th>
<th>Data up to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of MRSA Bacteraemias</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Clostridium difficile infection in the 2 and over age group</td>
<td>50</td>
<td>4</td>
<td>54</td>
<td>61</td>
<td>Mar-15</td>
</tr>
<tr>
<td>A&amp;E - % of Patients who have waited less than 4 hours</td>
<td>94.5%</td>
<td>76.0%</td>
<td>83.7%</td>
<td>95%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Cancer 2 week wait from urgent referral to first seen</td>
<td>96.9%</td>
<td>76.7%</td>
<td>92.5%</td>
<td>93%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Cancer 2 week wait for Breast symptoms</td>
<td>95.5%</td>
<td>94.4%</td>
<td>92.7%</td>
<td>93%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Cancer 3 day wait for first treatment from diagnosis</td>
<td>97.6%</td>
<td>94.3%</td>
<td>95.7%</td>
<td>96%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Cancer 3 day wait for subsequent treatment - Anti cancer drugs</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>98%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Cancer 3 day wait for subsequent treatment - Surgery</td>
<td>95.3%</td>
<td>94.9%</td>
<td>92.4%</td>
<td>94%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Cancer 3 day wait for subsequent treatment - Radiotherapy</td>
<td>96.6%</td>
<td>97.7%</td>
<td>98.7%</td>
<td>94%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>Cancer 62 day wait for first treatment from Standard urgent referral</td>
<td>85.0%</td>
<td>79.5%</td>
<td>79.9%</td>
<td>85%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>(with agreed reallocations for late referral)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Feb-15</td>
</tr>
<tr>
<td>Cancer 62 day wait for first treatment from Screening service urgent referral</td>
<td>92.1%</td>
<td>93.8%</td>
<td>89.2%</td>
<td>90%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>18 weeks from GP referral to hospital treatment - Admitted patients</td>
<td>93.0%</td>
<td>76.4%</td>
<td>85.5%</td>
<td>90%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>18 weeks from GP referral to hospital treatment - Non-admitted</td>
<td>97.7%</td>
<td>85.6%</td>
<td>85.2%</td>
<td>95%</td>
<td>Mar-15</td>
</tr>
<tr>
<td>18 weeks from GP referral to hospital treatment - Incomplete</td>
<td>97.5%</td>
<td>84.7%</td>
<td>91.7%</td>
<td>92%</td>
<td>Mar-15</td>
</tr>
</tbody>
</table>

**Key:**
- Adverse to absolute target or a deterioration in performance
- Adverse to target, but an improvement from 13/14 year
- Favourable to target
12. Annex 8: Specialties at Cambridge University Hospitals NHS Foundation Trust

There are 5 clinical divisions, each of which manage individual specialities through clinical directorates, as set out below

**Division A**

<table>
<thead>
<tr>
<th>Musculoskeletal</th>
<th>Digestive Diseases</th>
<th>Intensive Care Unit / Perioperative services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>Upper Gastrointestinal</td>
<td>John Farman Intensive Care Unit</td>
</tr>
<tr>
<td>Trauma and Orthopaedics</td>
<td>Lower Gastrointestinal</td>
<td>Neurosurgery Critical Care Unit</td>
</tr>
<tr>
<td>Pain Management</td>
<td>Intestinal Failure</td>
<td>Operating Theatres</td>
</tr>
<tr>
<td>Hand and Plastics</td>
<td>Endoscopy</td>
<td>Anaesthetics</td>
</tr>
<tr>
<td>Orthogeriatrics</td>
<td>Gastrointestinal Medicine</td>
<td></td>
</tr>
</tbody>
</table>

**Division B**

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Laboratories</th>
<th>Imaging</th>
<th>Clinical Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>Genetics</td>
<td>Radiology</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Haematology Oncology</td>
<td>Histopathology</td>
<td>Nuclear Medicine</td>
<td>Outpatients</td>
</tr>
<tr>
<td>Oncology</td>
<td>Blood Sciences</td>
<td></td>
<td>Occupational Health</td>
</tr>
<tr>
<td>Oncology Plastics</td>
<td>Virology</td>
<td></td>
<td>Medical Physics / Clinical engineering</td>
</tr>
<tr>
<td>Breast Unit</td>
<td>Haemato-Oncology Diagnostic Services</td>
<td></td>
<td>Medical Photography</td>
</tr>
<tr>
<td>Gynaecology Oncology</td>
<td>Microbiology</td>
<td></td>
<td>Therapies &amp; Dietetics</td>
</tr>
<tr>
<td></td>
<td>Tissue Typing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Division C**

<table>
<thead>
<tr>
<th>Acute Medicine</th>
<th>Inflammation/ Infection</th>
<th>Transplant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department</td>
<td>Genito-Urinary Medicine</td>
<td>Nephrology</td>
</tr>
<tr>
<td>Acute Medicine</td>
<td>Infectious Diseases</td>
<td>Transplant Surgery</td>
</tr>
<tr>
<td>Clinical Pharmacology</td>
<td>Immunology</td>
<td>Hepatology</td>
</tr>
<tr>
<td>Department of Medicine for the Elderly</td>
<td>Respiratory Medicine</td>
<td>Hepatobiliary Surgery</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>Allergy</td>
<td></td>
</tr>
</tbody>
</table>
### Division D

<table>
<thead>
<tr>
<th>Neuro-science</th>
<th>Ear Nose Throat/ Head &amp; Neck/ Plastics</th>
<th>Cardiovascular / Metabolic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation</td>
<td>Dermatology</td>
<td>Orthotics</td>
</tr>
<tr>
<td>Neurology</td>
<td>Ear Nose Throat</td>
<td>Diabetes / Endocrine</td>
</tr>
<tr>
<td>Stroke medicine</td>
<td>Oral / Maxillofacial</td>
<td>Metabolic Medicine</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>Plastics</td>
<td>Medical Genetics</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td></td>
<td>Podiatry</td>
</tr>
<tr>
<td>Psychiatry</td>
<td></td>
<td>Vascular Surgery</td>
</tr>
<tr>
<td>Psychology</td>
<td></td>
<td>Medical Haematology</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cardiology</td>
</tr>
</tbody>
</table>

### Division E

<table>
<thead>
<tr>
<th>Paediatric Medicine</th>
<th>Paediatric Critical Care</th>
<th>Paediatric Surgery</th>
<th>Obstetrics &amp; Gynaecology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes &amp; Endocrine</td>
<td>Paediatric Intensive Care</td>
<td>Ear Nose Throat</td>
<td>Foetal Medicine</td>
</tr>
<tr>
<td>Acute Medicine</td>
<td>Acute Neonatal Transport Service</td>
<td>Orthopaedics</td>
<td>Obstetrics</td>
</tr>
<tr>
<td>Allergy</td>
<td>Neonatal Intensive Care</td>
<td>Paediatric Surgery</td>
<td>Maternal Medicine</td>
</tr>
<tr>
<td>Respiratory Medicine</td>
<td>Cleft</td>
<td></td>
<td>Gynaecology</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Ophthalmology</td>
<td></td>
<td>In Vitro Fertilisation (IVF)</td>
</tr>
<tr>
<td>Neurology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haematology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oncology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiology</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annex 9: Glossary of terms used in quality report

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.

CFS (Clinical Frailty Score)
An assessment tool used to determine the frailty of patients aged 75 and over admitted as emergencies. The assessment tool uses a 9 point scoring system.

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.

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.

Dr Foster
Dr Foster Intelligence is a joint venture with the Department of Health. They have developed pioneering methodologies that enable fast, accurate identification of potential problems in clinical performance and also in areas of high achievement.

eHospital
eHospital is an exciting programme that is changing the way we work and how we care for our patients using latest technology. Every member of staff has access to the information they need, when they need it, without having to look for a piece of paper, wait to use a computer or ask the patient yet again. It went live in October 2014.

HSMR (Hospital standardised mortality ratio)
This is a nationally calculated rate prepared by Dr Foster
http://www.drfosterhealth.co.uk/ where a score of 100 would mean actual deaths were
in line with expected. An HSMR of less than 100 indicates less patients than expected died, a figure of greater than 100 indicated more than expected died.

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:

HRG (Healthcare Resource Group)
Within the English National Health Service (NHS), a Healthcare Resource Group (HRG) is a grouping consisting of patient events that have been judged to consume a similar level of resource. For example, there are a number of different knee-related procedures that all require similar levels of resource; they may all be assigned to one HRG.

Joint Commission International
Joint Commission International (JCI) works to improve patient safety and quality of health care in the international community by offering education, publications, advisory services, and international accreditation and certification.

Monitor
The Foundation Trust regulator

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. The full name of MRSA is meticillin-resistant staphylococcus aureus. You may have heard it called a superbug.

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, these measures are outlined below.

'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 (NHSBT) is a Special Health Authority who manages blood and organ transplantation.
**Palliative 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.