Cambridge University Hospitals
NHS Foundation Trust

Quality Report 2022/23

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The quality report

Part 1 - Introduction

Statement from the Chief Executive

The quality of the care we provide to our patients lies at the heart of our CUH strategy. This sits alongside supporting our staff and building for the future.

Through the challenges and pressures of the past three years, and the ongoing legacy of the Covid-19 pandemic, we continue to be driven by a passion to provide safe, kind and excellent patient care across all of our local, regional and national services.

This Quality Account describes some of our key areas of focus over the past year, including some where we have made significant progress and others where there remains much more to do.

Following the intense operational pressures of the Christmas and new year period, we have made positive progress in improving access to urgent and emergency care and diagnostic services. But we need to go further in these areas to reduce waiting times and improve patient experience, alongside the work we are doing to reduce very long waiting lists for planned care. The additional bed and theatre capacity which we will be opening later this year will be an important next step on this journey.

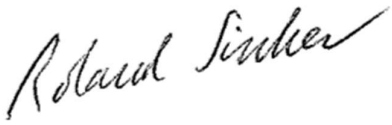
We have made good progress during 2022/23 on our ward accreditation programme which will support continued quality improvement, and we have seen excellent examples of innovation and teamwork which are improving quality of care including the Virtual Ward, increased use of robotic surgery and breaking new ground in the clinical use of artificial intelligence. In many cases, this is being achieved through effective collaborative working with our health and care partners in Cambridgeshire and Peterborough and beyond.

Looking ahead, the report sets out some of our key quality improvement priorities for 2023/24 aligned to the delivery of high quality, effective, safe and patient-centred care. We will seek to achieve these priorities through more effective patient engagement and co-production and with an important focus on health inequalities.

As I say in my introduction to the Trust's 2022/23 Annual Report, there is a lot to look forward to in the months ahead, much of which has been driven by the extraordinary effort of teams across the Trust this year, alongside our friends and colleagues across health and care, local government and the Cambridge Biomedical Campus.

And importantly, of course, we are grateful for the continued support of and feedback from our patients.

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



Roland Sinker
Chief Executive

Activity in 2022/23

During the 2022/23 year we saw a slight increase in total admissions of 1.67% compared to the same period in 2021/22. This was the net result of an increase in day cases and in-patient elective admissions offset against lower maternity and emergency admissions (for under 85's) in addition to a lower number of births. During 2022/23 the Trust continued to manage high levels of infectious illness including COVID and Respiratory syncytial virus (RSV), with influenza levels rising significantly during December 2022. There were high levels of occupancy across the period.

Two specific points should be noted in relation to the activity below:

- The growth in A&E attendances of 5.43% was primarily driven by the significant increase in paediatric attendances (year-on-year) compared to a more modest growth in adult attendances. This is likely to have been caused in part by higher levels of paediatric respiratory viruses including RSV, in addition to pre-hospital factors such the availability of timely appointments in primary care.
- The increase in day cases (+2.92%) and elective in-patients (+3.43%) reflects the Trust's commitment to continue to increase elective care despite the challenges caused by high occupancy and the on-going impact of high rates of infectious illness. During 2023/24 we will continue to build on this performance through the introduction of dedicated elective capacity in newly-built theatres and in-patient beds.
- The Trust has committed to expanding capacity achieving over 3000 additional admissions compared to the previous year (+1.67%) and caring for an additional 4630 patients this year (including virtual ward activity), whilst continuing to strive to maintain or improve quality, safety and experience for our patients.

The following table sets out an overview of our operational activity.

Table: Activity Comparison 2021/22 vs. 2022/23

	2021/22 April - Mar	2022/23 April - March	Change 21/22 to 22/23 (%)
A&E attendances* (excluding MIU)	130,729	137,827	5.43%
Visits to outpatients	868,889	862,874	-0.69%
Births	5,573	5,445	-2.30%
Day cases	131,796	135,650	2.92%
Total inpatients	**58,086**	**57,626**	-0.79%
– *elective*	*11,866*	*12,273*	3.43%
– *emergency > 85 years old*	*6,059*	*6,214*	2.56%
– *emergency < 85 years old*	*33,349*	*32,489*	-2.58%
– *maternity*	*6,812*	*6,650*	-2.38%
Total	**1,195,073**	**1,199,422**	0.36%

A&E - Not including Minor Injury (MIU) attendances

Total Admissions (IP / DC / Births)	***195,455***	***198,721***	1.67%

Virtual Ward Admissions (Available from Nov 22)	**-**	**281**	N/A

Improving Patient Flow

Patient Flow remained a priority for the Trust during 2022/23, with a focus on improving patient experience, meeting non-elective demand and supporting the elective recovery programme. Key areas of focus included driving early discharges through use of the discharge lounge and streaming patients to Same Day Emergency Care (SDEC) areas as an alternative to admission. Alongside these initiatives, divisional plans to reduce long length of stay were reviewed, with benchmarking performed against other acute trusts to identify opportunities. The Trust also commenced a phased roll out of the national 'criteria to reside' programme across a number of wards to identify and resolve blocks to patient flow. This roll-out is continuing and will cover all wards across the Trust by the end of 2022/23.

The specific projects introduced during 2022/23 included the following:

- Commencing a model of patient flow for non-elective pathways based on the approach taken by North Bristol Trust. In adopting this model the Trust initiated a nurse-led model to support early flow from the ED; scheduled admissions from the Emergency Department to in-patient wards, matching these against expected discharges for the day. This supported a reduction of crowding in the ED and, consequently, a reduction in delayed ambulance handovers during a period of significant demand
- Introducing a daily virtual review of all patients with a clinically fit date of 'today' to identify and resolve any blocks to discharge in real time. This provided staff with the opportunity to challenge why patients could not be discharged home, modelled along the national 'Home First' programme, and to expedite confirmed discharges to realise them earlier in the day
- Working with the South Integrated Care Partnership to streamline complex discharges, including simplifying the referral process and using the Trust's central Discharge Planning team to coordinate the timely discharge of patients needing a package of care.
- Reintroducing internal monitoring against the 4 hour emergency care standard from 27th March 2023, ahead of external reporting from May. This followed nearly four years of the Trust being part of the national CRS pilot of alternative emergency metrics during which time the 4 hour standard was not reported. Performance against the 4 hour standard improved significantly since reintroducing monitoring and we have developed a detailed plan to sustain and improve performance further. This will continue to be a core focus for the Trust in 2023/24.

The 'Improving Patient Flow' group, chaired by the Deputy Chief Operating Officer, provided governance across patient flow initiatives across 2022/23 and reported to the Urgent & Emergency Care Taskforce (UEC) led by the Chief Operating Officer. The 'Ward Processes' group supported this meeting, convening weekly and composed of deputy heads of nursing to drive improvements at ward level.

To support the considerable work on-going to drive patient flow the Trust introduced a new post – (Associate Director of Patient Flow), from December 2022. We are also expanding the capacity of the Operations Centre with an additional Operational Matron post to support the management of ED and in-patient wards from March 2023.

Patient First

Patient FIRST is a support tool designed by clinicians and the Care Quality Commission. The framework includes suggestions that all emergency departments could consider. The CQC advocate that implementing it supports good, efficient and safe patient care - for both adult and paediatric care. It also includes guidance for senior leaders at Trust and system level. It is perceived that it will support the Trust in identifying, supporting and implementing priorities for improvement that align with regulatory requirements and provide a platform for monitoring our urgent & emergency care improvement journey by the Quality Committee and Board.

It is known that there is a correlation with long waits in urgent care and harm.

We developed

- a process to monitor our organisational harm risk profile, through thematic review and also
- to identify and mitigate risk of harm to our individual patients facing long waits in the ED.
- This will be monitored through an existing governance framework and to share learning.

However, the key to reducing the organisational risk of harm is to reduce the frequency of long waits altogether – this ultimate goal is supported by work ongoing with the Patient FIRST CQC toolkit, and the ongoing work to improve patient flow, overseen by the Trust 'Urgent and Emergency Care' Board.
The Patient FIRST toolkit is a precursor to 'PEOPLE FIRST' a recently published resource to help wider system leaders and service providers to embed the principles of person-centred, urgent and emergency care within (and between) integrated care systems and encourage innovation and share examples of good practice.

Virtual Wards

The virtual ward has provided a service to over 294 patients releasing at least 686 bed days since it opened on the 31st October 2022. The service is managed by a lead nurse, clinical director, operational manager and experienced nurses with a variety of nursing backgrounds within the trust and is overseen by the division C governance structure.

The ward is open 24/7, the patients have access to a nursing team during their admission 24 hours a day to ensure all of their care needs are managed efficiently and effectively to provide safe excellent care. We have regular contact with the parent teams, updating the teams with any concerns, results that need reviewing and input for discharge planning from the virtual ward.

To improve our service we have introduced twice a day huddles to discuss our patients and their care needs. During this time we create action plans including what we can do to on-board patients to our service to help with flow and capacity across the trust. Patients are asked to complete a satisfaction survey when discharged from the virtual ward so we can review and respond to patient experience concerns. The ward utilises the Datix incident reporting system to ensure lessons are learnt and embedded into practice to prevent recurrence of similar incidents. Themes around discharge and diagnostics incidents are emerging. However, at this time, there have been no major risks identified, and a limited number of 'no harm' incidents reported due to the limited time these wards have been operational.

Maintaining high quality care, adapting and expanding capacity

This year has been exceptionally challenging to meet the demands placed on our services. Whilst working together across partner organisations and utilising a variety of approaches to cater for the needs of our service users, (often with significant and rapid changes whilst in addition facing workforce challenges) undoubtedly places additional strain on existing quality systems and performance. This directly impacts the aspirational targets we set ourselves to improve. These challenges have remained at the forefront of our planning, and ensured that we retain a keen focus on risks and risk mitigation where required. In addition supporting staff to develop their leadership skills, and providing a corporate hub of specialist nursing skills, developing a framework for fundamentals of nursing care to protect our core functions and an unwavering determination to keep patients safe during these exceptional challenges.

Staff Leadership Skills and Training

The Trust's approach to leadership development is focused on building leadership capability across the organisation, including leaders' roles in strengthening our culture of inclusion and in developing an improvement culture within CUH, along with supporting the ICS leadership agenda to enable effective system working.

Through 2022/23, a range of leadership development training programmes have been provided for leaders at various degrees of experience, from aspiring and new team leaders to the commencement of a fifth cohort of the CUH Senior Leadership Programme for director and associate/deputy director level leaders, which will continue into 2023/24. Tailored leadership programmes have been delivered for a number of specific service areas and for Trust-wide professional groups, including matrons and senior nurses, AHPs and consultants. Leaders across the Trust have also been supported to attend ICS leadership programmes such as the Springboard Women's Development Programme, the Mary Seacole programme and the Leading Beyond Boundaries systems leadership programme.

A new series of interactive, reflective Compassionate Leadership workshops were launched in November and continued throughout winter 2022/23. These workshops provided practical guidance and specific skills to help managers lead their teams through continued complex challenges during the pressured winter period.

During 2022, work began on the creation of a framework for talent management that will equip leaders at all levels with tools and guidance to develop their staff and team capabilities, encourage career progression and improve staff retention. This will be rolled out across CUH during 2023 and be incorporated into major leadership programmes.

Also over the last year, work was undertaken to successfully create and launch a career development pathway framework for the AHP staff group, working in conjunction with senior AHP leaders. This will actively contribute to the talent management and staff retention priorities for the Trust. It is intended that this approach will be replicated with other clinical and non-clinical staff groups, and will be aligned to future design of leadership skills training.

Ward Accreditation

A yearly rolling programme of ward accreditation has been implemented in October 2022. This consolidates several quality monitoring tools under the nursing quality assurance framework at CUH, and applies to all areas providing nursing and midwifery care across the organisation. The purpose of the accreditation programme is to provide a clear process of assurance regarding the quality of nursing care and workforce and supports matrons and senior nurses in strong leadership of their ward areas.

The framework is based on the continuous improvement principle of standardisation, recognising, sharing and complying with best practice in the interests of patient care, and fundamentally that quality improvement can be driven at all levels of nursing across the Trust. The key performance measures are developed in line with Trust and national guidance, and may continue to evolve.

Our clinical areas will progress through white, bronze, silver and gold standards as they achieve their designated targets for consistently achieving high levels of practice and performance. Bronze, silver or gold awards are celebrated and a certificate of achievement presented to the team, and visible within the clinical setting for staff and patients to see.

Pilot trials were carried out in May and June 2022 and work is ongoing to improve the accreditation process following feedback.

By quarter 4 2022/2023, at least 10 ward areas were visited by a ward accreditation team (three obtaining 'gold' status, two obtaining silver status, four obtaining bronze, and one area continues to work attain accreditation).

The ward accreditation process is also helping to strengthen the ward to board governance on the quality of nursing care being provided to patients across CUH. The outcomes and action plans post accreditation are discussed at Divisional Quality meetings.

Going forward, work is continuing on the digital dashboard (CHEQS) providing key performance data directly to nursing teams and internal accreditation assessors. Furthermore the scheme will be extended to clinical trials areas, maternity and the outpatients department in 2023.
It is anticipated all inpatient ward areas, ED and adult critical care will be accredited by September 2023.

Infection Prevention and Control

The Medical Director (MD) is the Trust designated Director of Infection Prevention & Control (DIPC) and is supported in this role by one of the Deputy Medical Directors who acts as Deputy DIPC.

The infection prevention & control team (IPCT) comprises medical and nursing infection prevention control professionals who are responsible for the day-to-day operation of the infection control service including:

- surveillance and mandatory reporting
- the provision of IPC policies
- an audit programme to ensure that key policies and practices are implemented appropriately

and provision of advice to clinical and management colleagues including:

- monitoring of infection risks
- on-going staff education and training
- appropriate advice in response to major outbreaks of communicable infections

The IPCNs have designated areas of responsibility across the organisation and members of the IPCT provide a 24 hour on-call service for provision of infection control advice to clinical and managerial colleagues.

The IPCT reports to the Infection Prevention Control Committee (IPCC) and is directly accountable to the Corporate Head of Nursing and the DIPC.
The DIPC is responsible for leading the IPCT and reports directly to the chief executive and the board of directors.

The IPCT is responsible for day to day management of infection control and liaises closely with the DIPC as required

- With respect to antimicrobial stewardship CUH was faced with additional challenging targets for 2022/23, including a National Contract target to reduce broad and last resort antibiotic use (Watch and Reserve) by 4.5% compared to the 2018 calendar year baseline, and two CQUINs on the management of urinary tract infections and community acquired pneumonia.
  The strategic priorities for 2022/23 included:
- Focus on the National Contract and CQUIN targets

- Continued engagement with the EPIC team to improve on reporting and feedback of antimicrobial consumption, infection and resistance rates at directorate and specialty level
- Continued engagement with the EPIC team and relevant specialties to update antibiotic order sets
- Expand educational activities targeting prescribers
- Increased engagement with the System wide Antimicrobial Network Group and the nascent East of England Antimicrobial Prescribing and Medicines Optimisation Subgroup to facilitate regional and national priorities and quality improvement initiatives

Safeguarding

Healthcare organisations must ensure that those who use their services are safeguarded and that staff are suitably skilled and supported to manage safeguarding responsibilities well. All health care organisations have a duty outlined in legislation to make arrangements to safeguard and to co-operate with other agencies to protect individuals who are at risk from harm, abuse or neglect. The intercollegiate documents 'Adult Safeguarding: Roles and Competencies for Health Care Staff (2018)' and 'Looked after Children: roles and competencies of healthcare staff (2019)' provides a clear framework for all organisations that provide or commission health care.
Collectively, the safeguarding team consists of three specialist teams who are responsible for children (including the unborn baby), adults and women at risk of abuse in maternity services. In 2023, a new Head of Safeguarding was appointed to support the teams. These teams report via the deputy chief nurse to the chief nurse who is the executive lead for safeguarding. The teams work jointly with partner agencies to develop and promote safe systems and practise for all groups in challenging and ever changing landscapes. In order to ensure oversight and assurance of safeguarding activity within the trust, the teams report to trust board via the joint safeguarding committee and Quality Committee.

The Children's Safeguarding training level 1 and 2, and Safeguarding Adults level 1 has been steadily maintained over 90% for the final months of the reporting year. Safeguarding Adults level 2 has marginally reported below 90% consistently although work has been ongoing this year to improve Trust oversight of safeguarding training for staff who completed their training outside of CUH through systems such as 'E-learning for Health'.

Any safeguarding incidents within the trust are managed via the Datix incident management system. When an incident or safeguarding concern is identified, a safeguarding panel meeting is convened with key internal stakeholders. From this a detailed action plan is identified to address any concerns identified. Where required, the safeguarding team will link with external partner agencies such as the Local Authority Designated Officer (LADO), Police, and Integrated care board members to share safeguarding information to safeguard the vulnerable.
CUH are represented at system wide multi-agency meetings such as the safeguarding adults/children partnership boards, multi-agency review panels.

Mental Health

In 2020, Cambridge University Hospitals NHS foundation trust (CUH) undertook a programme of work to develop its strategy to improve services provided to patients with mental health needs. Four strategic priorities were agreed between CUH and Cambridge and Peterborough Foundation trust (CPFT), which have also been signed off at the CUH executive board, these are:

1) Internal and external Governance
2) Patient pathways
3) Workforce – skills and education
4) Strategy

CUH hosts a quarterly mental health joint governance meeting with CPFT which is attended by CPFT stakeholders including but not limited to the psychiatric liaison team and CUH divisional representation. This governance meeting reports quarterly to the mental health committee to provide assurance of the progress made with each strategic priority and to escalate risk. This committee in turn reports assurance to the Quality Committee.

Developing mental health risks and incidents are included as a standing agenda item on divisional governance meetings and the mental health joint governance meeting with escalation to the mental health committee as required.

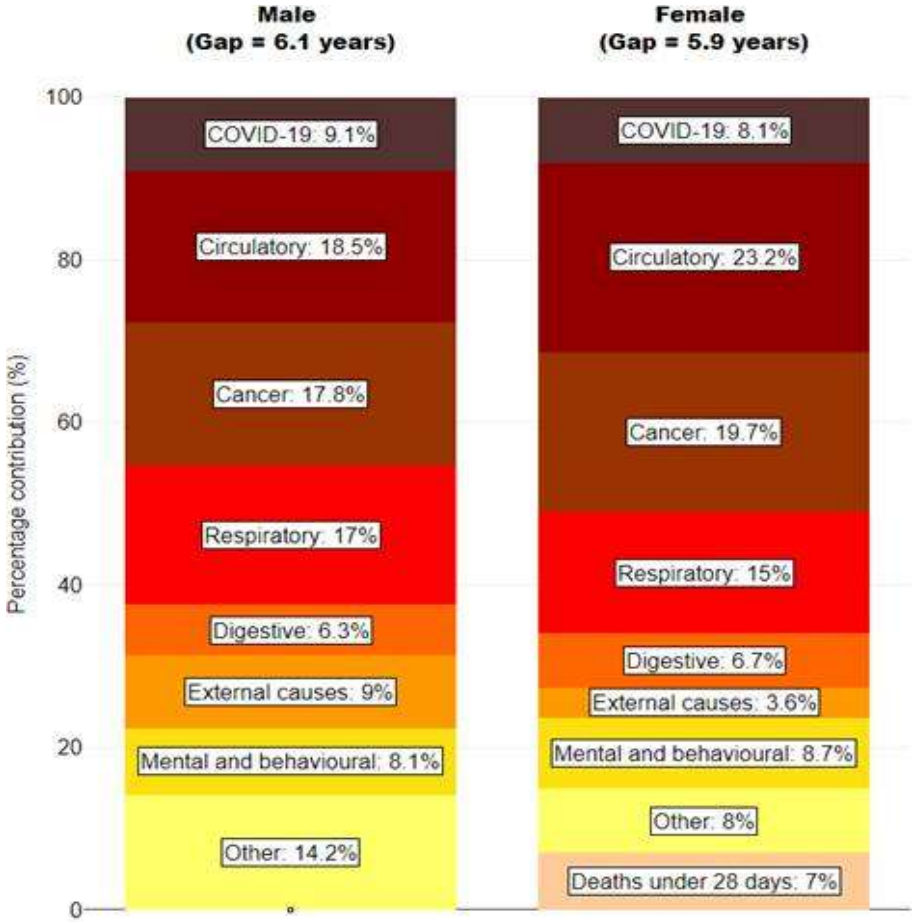
Health Inequalities

In 2022-2023 Cambridge University Hospitals has, as members of the Cambridge & Peterborough Integrated Care System, been working with partners across the public and voluntary sector to help address the underlying causes of healthcare inequalities.
The Medical Director is a member of the Integrated Care Health Inequality Board established in 2022, and the Corporate Head of Nursing is a member of the associated operational group to support delivery of the published Cambridge & Peterborough Integrated Care System Healthcare Inequality Strategy which includes:

- A system-wide approach to addressing health inequalities, underpinned by population health management methodology
- Addressing inequalities through needs-based commissioning through the allocation of NHS funding proportionate to need
- Tackling inequalities in cardiovascular disease through targeted action on hypertension and diabetes

In the region, we know that people in our most deprived areas have lower life expectancy. In 2020/1, the gap in life expectancy between the most and least deprived quintiles in Cambridgeshire was around six years, the causes of which are set out below:

Histogram to show the gap in life expectancy between the extremities of deprivation quintiles



Source: Public Health England Segment Tool

Work is underway to address the opportunities to improve healthcare in these areas, including case finding of patients with raised blood pressure, atrial fibrillation and elevated cholesterol levels; smoking cessation programmes targeted at pregnant patients and inpatients; improved access to mental health care; and increasing the uptake of screening programmes (particularly abdominal aortic aneurysm, breast cancer and cervical cancer).

The breast cancer screening programme has cleared the backlog of 20,000 referrals accrued during the coronavirus pandemic, which is a remarkable achievement. Also, 98% of women are seen within the 36 month screening target, whilst working to increase screening uptake in Ethnic, Gypsy, Roma and Traveller communities.

A smoking cessation programme underpinned by the 'Treating Tobacco Dependency Plan 2021-2024' developed by Cambridge & Peterborough ICS, and led locally by a consultant midwife in the Rosie Maternity Hospital has resulted in the recruitment of a Smoke free Pregnancy Practitioner role to provide a service to support mothers with smoking cessation. This is in order to meet the national ambition to reduce smoking in pregnancy to below 6% against a national rate of 9.5% of mothers designated as a smoker at the time of delivery in 2020-21. At CUH the 2021-22 average rate was 6.9%. Monitoring monthly from March 2022 to date CUH has succeeded in reaching the national target, with the exception of July 2022, December 2022 and January 2023 where the smoking rate peaked at 8.25%, 7.34% and 6.41% respectively for mothers birthing in that month. However CUH remained below the national average

throughout the year, and improved upon the previous year with an average rate of 5.2% for 2022 to 2023.

Equality, Diversity and Inclusion

In 2023 CUH is undertaking a strategic review of Equality Diversity and Inclusion. The aim of the review is to strategically bring together three core pillars of the agenda, Patient Equity, Workforce Diversity and Inclusion, and Health Inequalities. The new strategy will provide the opportunity to integrate and align all three pillars, and create a joined up approach which facilitates an acceleration of progress.

The Trust have developed an outline Patient Equality, Diversity & Service User Inclusion work-plan for 2023-2025 to support delivery of the CUH Trust strategy. This plan will inform the development of the integrated EDI/HI strategy for CUH. In order to progress our work, an Equality, Diversity and Inclusion Operational Group (EDIOG) has been established to focus on patients, service users and visitors. Members of the group are staff from within the Trust who lead services directly contributing to delivery of our EDI agenda/work and have wider links with voluntary groups and patient networks. The group meets monthly and is chaired by a corporate Head of Nursing as part of the Chief Nurse's portfolio of service delivery and patient experience. This mirrors the existing Workforce EDI strategy enabling our patients, service users and visitors to have:

- Equity of Access
- Equity of Patient Experience
- Equity of Outcomes
- Every person counts

Examples of the work progressed to date include the development of a Sensory Impairment working group, reviewing the AccessAble website, improving estates and facilities for those with sensory impairment:

At a local level within the Trust, work has been ongoing this year to raise the profile of our patients with protected characteristics and their needs within a healthcare environment. We identified that at a fundamental level we needed an improved understanding of our own local profile of our patient population. Our existing data sets required improvement to then allow us as an organisation to develop an appropriate strategy and plan for improvement that reflected our patients and service users adequately. We included a measure in our Quality Account this year, which targeted improvement of our digital data recording ethnicity in patient electronic records. In 2021 14% of our patients had no ethnicity recorded, and we set out to reduce this by half.

We upgraded the electronic patient record to implement that religion and ethnicity were mandatory fields for completion for all patients. Patients now have ownership and access through 'My Chart' to record or modify data on their religion and ethnicity. We have reduced the ethnicity data gap in our records to 10.8% in 2022-2023 helping us to understand the profile of our minority patient population better. This work could underpin stratification of incidents, complaints and quality data to target our improvement priorities appropriately to improve patient experience.

In March 2022, the CQC undertook a national independent voice review of patients with a learning disability or autism at CUH alongside eight NHS acute trusts. The aim of the review was to understand where good practice makes a positive difference to patient experience and by listening to patients and staff sharing experiences. This led to a national publication by the Care Quality Commission to report on the experiences of people being in hospital with learning disability or autism. The "Who I am matters" report was published November 2022.

Learning Disability and Autism

National evidence has shown that people with learning disabilities and autism have poorer health than others and are more likely to experience several health conditions. Not getting the right access/support they require can increase the chances of avoidable harm and premature death. The Equality Act 2010 places legal requirements for providers to ensure barriers are removed to enable access to right care/treatment and improve patient experience.

In June 2018, NHS improvement published the national learning disability improvement standards for NHS trusts. These standards are intended to ensure that NHS organisations are delivering high quality services for people with learning disabilities and autism. Each year the trust has committed to yearly NHSI benchmarking submission of organisational data and staff and patient feedback to measure improvement against the national standards.

The Learning Disability lead role for Children has since been appointed in the Trust in autumn 2022, and jointly the adult and children's leads have refreshed the Trust learning Disability improvement plan, incorporating the learning from the recent CQC review and aligning with the new Trust strategy in prioritising the delivery of actions over the next 3 years.
The re-enforced LD services improvement plan, in addition to plans to ensure the Oliver McGowan Mandatory Training on Learning Disability & Autism will be rolled out through the Trust going forward.
The progress and delivery is monitored through the joint safeguarding committee with oversight from the trust Quality Committee.

Visual Impairment

Up to a third of our patients are recorded as visually impaired. The Trust has an Eye Clinic Liaison officer (ECLO) working to help meet the ever increasing volume of patient need. In addition to patient-facing work, the ECLO role broadly covers many other areas related to advocating for the needs of visually impaired patients; improving accessibility of information and the environment; visual impairment awareness training for staff; connecting with community groups and individuals to improve patient experience for both inpatients and outpatients across the Trust. This role is a positive example of system wide working, establishing strong networks across all sectors to ensure the patients receive optimal care and support.

AccesAble

The CUH website was ranked in the top 45 NHS Trust websites in the country with an overall accessibility score of 84 out of 100 in 2022. The score improved to 85 by March 2023, although decreased in the rankings to position 85 nationally (https://index.silktide.com/uk-nhs-trusts/cambridge-university-hospitals-nhs-foundation-trust).

The ReciteMe Accessibility tool is providing inclusive and accessible content to over 1,100 people on average each month. Their needs vary from:

- listening to our content using text-to-speech software
- translation into other languages such as Arabic, Spanish, polish, and French
- changing the website appearance so fonts appear larger, or the screen is magnified.

In 2022 we published at least 1,400 digitised patient information leaflets https://www.cuh.nhs.uk/our-services/introduction-to-patient-information/ into accessible web pages. By providing them through an A to Z on our website we have by default made each of patient information leaflet accessible to our patients.
This was a massive undertaking by both the Trust documents team and digital communications. The outcome is that patients are now able to view patient information leaflets online in an accessible and inclusive format. Patients can use the 'ReciteMe' accessibility tool to customise how they receive the content, enabling them to listen to the content, translate the content,

and modify its appearance, whilst still having the option to print the information. We are one of the first Trusts in the country to do so on this scale. However, as content was copied into the new format exactly (wording not specifically optimised for reading age for example), this has impacted our rating in the short term, but over time the ambition is to work with authors to review the wording in the new platform. For this reason, we have unfortunately been unable to realise our overall ambition to enter the top 20 position nationally, however, it is something we continue to strive for.

Other examples include gender neutral signage for toilet facilities on site, a wayfinding app and working with digitally excluded patients, including implementing PC tablets to support translation services.

Data and terms used in this report

Unless stated otherwise, the data presented in this report is the latest available at 31 March 2023.

For an explanation of terms and abbreviations please see the glossary set out in *Appendix D*.

Part 2 - Priorities for improvement and statements of assurance from the board

Please note: Reviewing performance against 2022/23 priorities for improvement are given in detail in **Part 3** of this document.

CUH Vision, Strategy and Values

Throughout the COVID pandemic, the Trust focused its strategy on key areas of work to safeguard the delivery of care to our patients, both for those with and without COVID. Our staff and partners went to extraordinary lengths to serve our patients, living our values of Together – Safe, Kind and Excellent.

During 2022, we took the opportunity to plan further forward and, through wide consultation and engagement with colleagues, patients and partners, set an ambitious new strategy agenda for the next three years. This included a refreshed vision to deliver a healthier life for everyone through care, learning and research.

We seek to achieve this as a Trust, as a wider health and care system, as part of a dynamic biomedical campus and through our role locally, regionally, nationally and internationally.

We have retained our three key strategic priorities – **Improving patient care**, **Supporting our staff**, and **Building for the future** – and identified 15 commitments aligned to these, reflecting ongoing priorities and specific opportunities. These commitments include:

- Tackling the backlog and long waits for planned care;
- Providing emergency care to a growing and ageing population;
- Building a culture of continuously improving outcomes, experience, value and equity;
- Working more closely with primary, community and social care partners, and using technology, to help patients to stay well at home;
- Tackling inequalities in access to, experience of, and outcomes from our services between different patient groups;
- Ensuring we are sufficiently staffed, and that all our staff feel equally valued and can thrive;
- Delivering major new hospital builds on the Cambridge Biomedical Campus;
- Conducting world-leading research with academic, charitable and industry partners;
- Working more closely with other hospitals in our region to increase local access to specialised services;
- Reducing our carbon emissions on the way to NHS net zero to tackle the climate emergency.

We have outlined our ambitions for each of these commitments and are now adding further quantification where appropriate, ensuring we have the capability to deliver.

Work is ongoing across the organisation to increase understanding of and engagement in delivering the strategy. This includes building capacity in divisions through the provision of divisional strategy implementation resource and supporting teams to drive the strategy at a local level as key contributors to its delivery.

In implementing our previous strategy, particularly during the COVID pandemic, we have learned a huge amount about how we can work effectively over the next three years and have identified five priorities that articulate the mind-set, behaviours, skills and capabilities required to implement our strategy:

- **Creating strong foundations** including our staffing position, relationships with partners, the quality and safety of our services, and ensuring we harness the diverse talents that exist across the CUH community;
- **Supporting front-line leaders** through reducing bureaucracy, devolving power to teams and enabling service improvement initiatives;
- **Communicating and engaging** with staff, patients and partners, including co-production of solutions;
- **Working in partnership** with the NHS, charities, academia and industry, locally, regionally and nationally, to allow us to innovate faster;
- **Using resources wisely**, maximising investment value and pursuing transformative shifts in care delivery.

Progress on delivering our objectives is overseen by our Management Executive, and we report regularly to the Board with a formal strategy update. In addition, we undertake detailed horizon scanning alongside discussions at senior management and Board meetings on strategic and operational priorities, adopting a patient centred perspective. The output of these are used to monitor our strategy as we move forward to ensure that we are well-positioned to respond to new challenges as they emerge.

Supporting the Trust to deliver improvements in outcomes, experience and value

Improving the monitoring of patient outcomes

Clinical audits and registries provide a transparent picture nationally for NHS Trusts to understand, acknowledge and address outcomes relating to singular key specialities or provisions for patient care such as stroke or end of life care. These are then broken down into standards (targets) that provide a target for this type of care.

Under the banner of improving together and sustainable continuous improvement, the patient outcomes team have created and implemented an internal national clinical audit database that provides oversight and comparative data on national audits and registries the Trust participates in. The internal database stemmed from our aim to improve support for clinical teams by providing a centralised supportive view of outcomes data with the aim to encourage discussions regarding outcomes and how to share knowledge between staff and generate improvements.

Once a national audit is published by Healthcare Quality Improvement Partnership, the data is entered and therefore clinicians can access all of CUH's patient outcome data in one place. Data is displayed as dashboards and is available to all staff via the intranet 24/7.

Outcomes data support clinical governance, assurance and shared learning

The outcomes and compliance data is used within governance reports and discussed routinely at the Clinical Audit Committee and Clinical Effectiveness Group; this drives improvement by discussing areas for improvement as well as compliant and outstanding outcomes.

Improvement drivers cover several categories:

a) Transparency of data – Clinically relevant data for the last 3-5 years is captured to show trend progression and analysis.

b) Comparisons are provided for the entire organisation as well as oversight of where outcomes improve or decline.

c) Data is utilised live at the clinical audit committee to encourage discussion about outcomes, learning with regards to good practice, improvement and a supportive

conversation with regards to audit results where a decline in performance is detected.

d) Oversight within division of trending performance used to support divisional governance.

e) Oversight of regulatory compliance for national clinical audit outliers. This supports identification of both positive and negative outliers.

f) The data allows quick escalation of any identified concerns which leads to a more robust governance structure.

Improving Together

We will always be patient focussed and responsive to need, placing quality at the heart of what we do. Our vision is to support and enable staff to deliver continuous quality improvement (QI) throughout all services, clinical and non-clinical. We will do this by creating a supportive and empowering leadership culture, providing training in QI skills and coaching, enabling improvement to become part of what we do and how we work across all our services. We know that, by creating the right conditions, we can make significant improvements for our patients, staff, organisation and wider health and care system.

The remit of the improvement and transformation team is to co-create with our staff, patients and system partners a culture of sustainable continuous QI throughout the Trust and beyond.

The Board and Management Executive have prioritised QI as key to supporting the delivery of the Trust's strategy and future sustainability.

We have partnered with the Institute for Healthcare Improvement (IHI), to help us undertake a number of key enabling activities, including building QI capability and capacity, which will, over time, allow all of our staff to develop and deliver improvements independently. Clinical and non-clinical staff who have already led improvements will also continue to support others to improve, thereby helping to build and grow our QI capability and capacity.

This significant investment in our staff is facilitating the use of a consistent QI approach across the Trust and developing a cadre of QI champions throughout clinical and corporate divisions. This also enables the central improvement and transformation team to support strategically agreed improvement priorities.

Through co-production with our staff, patients and system partners, we will embed a culture of sustainable continuous QI and by following 6 pillars of our QI strategy:

1. **Embed a vision and strategy for QI**: All staff will understand what it means for their work, themselves and the Trust to work within a culture of sustainable continuous QI.
2. **Support the evolution of CUH's leadership to develop a culture of learning and improvement**: To develop the appropriate leadership behaviours in order to drive the Trust towards a culture of sustainable continuous QI.
3. **Build continuous QI capability**: All staff will have the skills and knowledge appropriate to their role and the resources available to support them to implement QI projects.
4. **Develop the infrastructure to support QI**: The Trust will be able to identify, develop, support, implement, monitor and evaluate QI projects at all levels within the organisation.
5. **Develop an approach to QI research**: To undertake and publish original learning in the field of healthcare QI.
6. **Develop a sustainable QI strategy**: To have a self-sustaining culture and approach to continuous QI.

The aim of the improvement and transformation team is to enable everyone to continuously improve outcomes, experience and value for our patients, staff, hospital and wider system, utilising a robust and consistent QI approach. We use QI skills and knowledge to support others

to generate change ideas and to test, sustain and spread change, utilising data to highlight opportunities for improvement and to demonstrate the impact of any changes made. Whilst doing so, we coach and support colleagues to use our agreed QI methodology (the Model for Improvement) that underpins successful continuous QI. By utilising data for improvement, we are able to understand our opportunities to make improvements and understand whether a change leads to an improvement through the use of run chart and statistical process control charts.

Our 'Improving Together' programmes

The improvement and transformation team has continued to work on building QI capability and capacity across the Trust and beyond, with the Trust now into our third and final year of our partnership with the IHI.

The second wave of the improvement coach programme has concluded and a celebratory event was held on 29 November 2022, with participants presented with their certificates. In total, 33 improvement coaches graduated and join the 41 coaches from the first wave in supporting colleagues from across the Trust and wider system to take forward QI projects.

The first wave of the improvement programme for teams concluded with a celebratory event in April 2022 for 18 teams and the second wave of this programme commenced in September 2022, with a further 19 teams taking part. The QI project topics for the wave two team's focus on either making a better day at work for staff, or on deteriorating patients, to prevent patients deteriorating, or to identify and treat deterioration more promptly. Wave two will conclude in June 2023.

The first wave of the leading for improvement programme has concluded, with 10 senior leaders from across the organisation graduating in April 2022. Recruitment for the second wave of the programme occurred from January 2023 through to May 2023, with 30 places available for clinical and non-clinical senior leaders.

Each QI programme will have an annual intake, thereby helping to build QI capability and capacity across the organisation and wider system. Wave three of the programmes will be delivered by Trust staff, being coached by IHI colleagues, so that we are self-sustaining beyond the life of the contract with the IHI.

The improvement and transformation team continues to support colleagues to test and implement QI projects aligned to the Trust's agreed strategic priority areas, which also help to support our annual productivity and efficiency requirement(s). These priority areas include virtual wards, urgent and emergency care, outpatients, high volume low complexity procedures, frailty and digital transformations. In addition, a number of QI projects are being sponsored by members of Management Executive and include making improvements for staff with disabilities in conjunction with the Purple Network, reducing sickness absences and improving the complaints process; an additional project is currently being scoped in relation to reducing the number of hospital-acquired pressure ulcers.

Going forward we aim to regularly measure staff awareness of Improving Together to ensure that we are embedding a system of sustainable continuous QI and that it is far reaching and understood by all, and also to actively celebrate improvements within and external to the Trust, capturing videos of staff involved in QI projects, holding celebration events, including our annual staff awards.

Our programme seeks to promote a culture of being open and honest when things have not worked as predicted, by following the Model for Improvement and will use our collective learning to further improve the experience and outcomes for our patients and staff, aiming to actively capture lessons learnt and ensure that widespread dissemination of learning is in place.

Improving patient care and supporting our staff

Seven day hospital services

Between the dates November 2017 – March 2020 the Trust was mandated to complete twice-yearly audits against a set of clinical standards for seven day services:

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

In the last audit in November 2019 the Trust assessed itself as being compliant (>90%) against standards 5 and 6, but non-compliant against standards 2 (83%) and 8 (89%), primarily due to issues with documentation where consultants may have seen patients but not recorded their attendance on ward rounds in clinical notes.

During the first wave of COVID in March 2020, these standards were relaxed by NHSE/I and have not been reinstituted since. However the Trust continues to monitor progress against related metrics including weekend discharges as part of our set of quality metrics, and non-elective mortality rates.

Monitoring of the seven-day standards will resume, led by the Office of the Medical Director with support from the clinical audit function, when we are instructed to do so by the national team.

Freedom to Speak up

In line with the recommendations of the Freedom to Speak Up review undertaken by Sir Robert Francis, the Trust has had a Freedom to Speak Up Guardian in post since December 2016. The Guardian reports to the Director of Corporate Affairs and is supported by a network of local listeners across the organisation. There is a link Non-Executive Director for Freedom to Speak Up.

The Freedom to Speak Up service offers a confidential service to all employees and workers to ensure their concerns are heard and acted upon. The Freedom to Speak Up Guardian works with staff and leaders across the Trust to ensure continued promotion and embedding of an open and listening organisational culture. Additional training sessions have been run during the year for local listeners.

In the financial year 2022/23, 111 colleagues raised concerns with the Freedom to Speak Up service. This compared to 88 cases in 2021/22.

The main themes of concerns raised in 2022/23 related to inappropriate attitudes and behaviours, in addition to worker safety and/or wellbeing. The staff groups accounting for the greatest proportion of concerns raised were Nursing & Midwifery and Administrative & Clerical staff. Themes and trends in concerns raised continue to be monitored through the bi-annual reports to the Board of Directors.

The 2022 National Staff Survey shows that the Trust remains at or above the national average in respect of the questions relating to raising concerns. Nevertheless, further work is required to address differences in the results across staff groups and protected characteristics.

The Freedom to Speak Up Guardian continues to engage with national, regional and local networks in order to promote awareness and learning about the importance of speaking up.

Improving rota gaps for NHS Doctors and Dentists in training

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

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

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

In response to feedback from Junior Medical Staff and Consultants and in conjunction with a reduction in our internal locum fill rate from circa 80% to circa 60-65%, in spring 2022 an extensive benchmarking exercise was undertaken with appropriate peers. Revised rates were introduced with effect from 01 October 2022. Subsequent feedback has been positive and early data suggests that the internal fill rates have recovered.

Many successful applicants for non-training grade vacancies are recruited from overseas however the impact of the EU exit and requirements for visas significantly increases the length of time it takes from recruitment to commencement and post Covid and the EU exit, number of applicants applying for posts from the EU and across the world have reduced.

Priorities for quality improvement in 2023/24

The priorities for improvement for 2023/24 were selected after consideration of existing trust and national priorities, performance against 2022-23 priorities, and benchmarking data.

The priorities have been agreed by the Trust's Board of Directors and Council of Governors, and reflect areas for improvement that align to the delivery of high quality, effective, safe and patient centred care. The priorities are aligned to the five key questions posed by our regulator, the Care Quality Commission - namely Safe, Effective, Caring, Responsive and Well-Led.

Objectives and measures for 2023/24

Safe

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

Patient Safety Improvement 2023/24

The organisation remains committed to promoting harm free care, The Trusts Patient Safety Improvement work sets out the patient safety improvement oversight for the Trust, as part of its commitment to a culture of continuous improvement. For the 2023/24 year, the trust will focus on improving safety and performance as well as on the roll out and implementation of the new national Patient Safety Incident Response Framework (PSIRF).

The measures we will use in 2023/24 will be:

Measure	Definitions	Baseline	Target	Rationale
Falls KPI; % Compliance with Falls risk assessment and documentation	Numerator: A falls risk assessment is carried out within 12 hours of admissions Denominator: All admissions with length of stay of greater than 24 hours	83% (Mar 22-Feb 23)	≥90%	Patient falls remain a key driver of reported incidents in the Trust. A previous measure was 'lying and standing blood pressure' which will still be monitored- however blood pressure recording alone (or lack of) is not the leading cause of incidents related to falls.
Pressure Ulcers KPI; % Compliance with Pressure Ulcer Risk Assessment Tool and documentation	Numerator: A pressure ulcer risk assessment is carried out within 6 hours of admission Denominator: All admissions for patients aged 18+ with length of stay greater than 24 hours.	77% (Apr 22-Mar 23)	≥90%	Pressure ulcers are identified in the Trust top 3 incident types. There is a CQUIN in place this year.
Total MDT Obstetric staff passed foetal surveillance training and PROMPT emergencies training.	YTD Total multidisciplinary obstetric staff passed CTG competence threshold.	PROMPT - 71%, FS 72% (Mar 23)	≥90%	**New:** CNST requirement and part of maternity improvement plan following recommendations of the Ockenden Inquiry final report.

Effective/Responsive

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

In order for us to have a clear focus on ensuring that we will minimise delays to patients' journeys, we will continue to focus on the following priorities to help us best understand where we have effective and responsive systems in place, and also to identify where we need to continue to improve.

The measures we will use in 2023/24 will be:

Measure	Definitions	Target	Rationale
Early discharges	% of patients who are discharged from the Trust between 7am-12pm, as a proportion of all discharges. Excludes time spent in the discharge lounge and 0 LoS patients.	20.0%	Existing metric has not reached target and A&E performance continues to be impacted. Early discharges are vital to deliver capacity early in the day. This metric supports outflow from the ED.
Weekend discharges *(Calculated as the average daily discharges on Sat/Sun divided into the average daily discharges Mon-Fri).*	Percentage of in-patient discharges on a Saturday and Sunday compared to the rest of the week (Excludes day cases).	80.0% (of weekday rate)	Existing metric. Weekend discharges help to smooth capacity over the week and avoid bottlenecks on Mondays. Changes to previous measures: • Limit to adults only (16+) • Limit to simple discharges • Limit to G&A wards • Exclude 0 LoS & exclude deaths.
Same day emergency care (SDEC)	The percentage of urgent and emergency patients who are treated and discharged on the same day or within 12 hours if the admissions is overnight.	30.0%	Existing metric target not achieved. SDEC helps to reduce crowding in the Emergency Department and reduces the demand for in-patient capacity
SSNAP Domain 2: % of patients admitted to a stroke unit within 4 hours of clock start time (Team centred)	SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator Royal College of Physicians - Sentinel Stroke National Audit	55%	Benchmarking. Existing measure: key stroke unit indicator Royal College of Physicians - Sentinel Stroke National Audit Programme (SSNAP). 55% target to mirror national average.

Measure	Definitions	Target	Rationale
	Programme (SSNAP) Quarterly data		
Percentage of admissions >65 years old and admitted for ≥48 hours with dementia/delirium or cognitive impairment with a care plan in place.	Numerator: Number of care plans in place on EPIC Denominator: Total number of admissions over 65 where patient is admitted for ≥48 hours and recognized with dementia, delirium of cognitive impairment.	50%	One in four beds in hospitals at any one time are occupied by patients with dementia. Dementia Care plans are being developed in EPIC at CUH, planned for March 2023. Falls QI work is in progress which links with understanding risk of falls. This also fits with the healthcare inequality work streams focusing on the high percentage of elderly healthcare service users, focus on mental health in additional to physical health and care plans support the onward journey into the community for these patients and their carers to support improved outcomes.

Patient Experience/Caring

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

The measures we will use in 2023/24 will be:

Measure	Definitions	Baseline	Target	Rationale
Healthcare Inequality	Percentage of patients in calendar month where ethnicity data is NOT recorded on EPIC	11% (March 2023)	7%	Existing measure to support preparation of a health inequalities strategy, and focus on better identifying inequalities by understanding of our own population demographics. This demographic could be used as a surrogate for completion of other demographic data points in EPIC, our electronic patient record.

Staff Experience/Well-led

Our aim is to further improve our staff's overall experience at work through strong engagement and feedback including through appraisal. With our culture of quality improvement, leadership and engagement our staff become more confident in speaking up and our overall ability to retain staff improves.

A measure that indicates how staff feel about the organisation is how well their appraisal helps them improve how well they do their job. The focus on how the organisation treats staff who are involved in an error or near miss is measured through how secure they feel in raising concerns. Our staff experience and support is reflected in our ability to attract and retain qualified nurses all of which impact on our continual drive to deliver safe and high quality care.

The measures we will use in 2023/24 will be:

Measure	Definitions	Baseline	Target	Rationale
Morale Indicator: I feel secure about raising concerns about unsafe clinical practice.	National Staff Survey 2022 Theme: Safety Culture.	75%	78%	Workforce pressures and impact upon staff.
Vacancy rate for band 5 nurses	% Vacancy Rate for Band 5 nursing staff	12%	5%	Meeting staffing challenges targets, this aligns with existing workforce targets for improvement.

Statements of assurance from the board

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

The Board of directors

The priorities and targets in our quality account were identified following a process which included the Board of Directors, clinical directors and senior managers of the Trust, and have been incorporated into the key performance indicators reported regularly to the Board of Directors as part of the performance monitoring of the Trust's corporate objectives, and which are produced within the Trust's data quality policy, framework and standards.
Scrutiny of the information contained within these indicators and its implication as regards patient safety, clinical outcomes and patient experience takes place at the Quality Committee. The Board of Directors reviews the Trust's integrated quality, performance, finance and workforce reports each month. Reviews of data quality, and the accuracy, validity and completeness of Trust performance information, fall within the remit of the audit committee, which is informed by the reviews of internal and external audit and internal management assurances.

Review of our services

During 2022/2023 Cambridge University Hospitals NHS Foundation Trust provided and/or sub-contracted 109 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 109 of these relevant health services.

The income generated by the relevant health services reviewed in 2022/23 represents 99.04% of the total income generated from the provision of relevant health services by the Cambridge University Hospitals NHS Foundation Trust for 2022/23.

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Cambridge University Hospitals NHS Foundation Trust in 2022/23 that were recruited during that period to participate in research approved by a research ethics committee was 21,781.

Participation in national clinical audits and national confidential enquiries

During 2022/23 54 national clinical audits and 5 national confidential enquiries covered relevant health services that Cambridge University Hospitals NHS Foundation Trust provides.
During that period Cambridge University Hospitals NHS Foundation Trust participated in 100% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.
The national clinical audits and national confidential enquiries that Cambridge University Hospitals NHS Foundation Trust was eligible to participate in during 2022/23 are listed in *Appendix B*.

The national clinical audits and national confidential enquiries that Cambridge University Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2022/23, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table: List of eligible and participated in national clinical audit programmes

Audit Title	What is the audit about?	Case Participation
Breast and Cosmetic Implant Registry (BCIR)	This registry captures all details of breast implant procedures completed in England, Scotland and Northern Ireland by both the NHS and private providers.	Participated
British Thoracic Society (BTS): Adult Respiratory Support Audit	This registry captures all details of breast implant procedures completed in England, Scotland and Northern Ireland by both the NHS and private providers.	Participated
Case Mix Programme (CMP) – Intensive Care National Audit and Research Centre - *(ICNARC)*	The aim of this audit is to improve resuscitation care and patient outcomes for the UK and Ireland.	Participated
Cleft Registry and Audit Network Database (CRANE)	A peer registry collecting data on all children born with a cleft lip or cleft pallet.	Participated
Elective surgery (National Patient Reported Outcomes Measures Programme (PROMS)).	The audit looks at the change in patients' self-reported health status for hip and knee replacement surgery – continuous data collection. CUH reviews Hips and Knees only.	Participated
Epilepsy 12 - The national clinical audit of health care for children and young people with suspected epileptic seizures	Epilepsy12 provides insight into the diagnosis and care of children and young people with epilepsy, and the organisation of paediatric epilepsy services in England and Wales.	Participated
Falls and Fragility Fractures Audit Programme (FFFAP): Fracture Liaison Service Database	FFFAP is a national audit run by the Royal College of Physicians designed to audit the care that patients with fragility fractures and inpatients falls receive in hospital and to facilitate quality improvement initiatives – continuous data collection. The clinically-led web-based national audit of secondary fracture prevention in England and Wales.	Participated
Falls and Fragility Fractures Audit Programme (FFFAP): National Audit of Inpatient Falls	FFFAP is a national audit run by the Royal College of Physicians designed to audit the care that patients with fragility fractures and inpatients falls receive in hospital and to facilitate quality improvement initiatives – continuous data collection focusing on patients over 60 who sustain an inpatient fall causing a fracture to the hip or thigh.	Participated
Falls and Fragility Fractures Audit Programme (FFFAP):	FFFAP is a national audit run by the Royal College of Physicians designed to audit the care that patients with fragility fractures and inpatients falls receive in hospital and to facilitate quality improvement initiatives – continuous data collection focusing on hip fracture care and secondary prevention.	Participated
Gastro-intestinal Cancer Audit Programme: National Bowel Cancer Audit (NBOCAP)	Colorectal (large bowel) cancer is the second most common cause of death from cancer in England and Wales.	Participated

Audit Title	What is the audit about?	Case Participation
Gastro-intestinal Cancer Audit Programme: National Oesophago-gastric Cancer (NOGCA)	This audit provides us with the most up-to-date information on the care and outcomes of patients diagnosed with Oesophago-Gastric (OG) cancer or oesophageal high grade dysplasia.	Participated
LeDeR - learning from lives and deaths of people with a learning disability and autistic people (previously known as Learning Disability Mortality Review Programme)	The aim of this programme is to review deaths of people with learning disability and autism, to use lessons learnt to make improvements to service provision.	Participated
National Adult Diabetes Audit (NDA): National Diabetes Core Audit (NDCA)	The core NDA audit focuses on data recorded about all people of all ages with diagnosed diabetes in England and Wales.	Participated
National Adult Diabetes Audit (NDA): National Diabetes Foot care Audit (NDFA)	The National Diabetes Foot care Audit (NDFA) enables all diabetes foot care services to measure their performance against NICE clinical guidelines and peer units, and to monitor adverse outcomes for people with diabetes who develop diabetic foot disease – continuous data collection.	Participated
National Adult Diabetes Audit (NDA): National Diabetes Inpatient Safety Audit (NDISA)	This audit measures the frequency of avoidable diabetic harm	Participated
National Adult Diabetes Audit (NDA): National Pregnancy in Diabetes Adult (NPID)	This audit supports clinical teams to deliver better care and outcomes for women with diabetes who become pregnant.	Participated
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Paediatric Asthma Secondary Care	This audit aims to collect information on all people admitted to hospital paediatric services with asthma attacks – continuous data collection.	Participated
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) – Adult Asthma Secondary Care	This audit aims to collect information on all people admitted to hospital adult services with asthma attacks – continuous data collection.	Participated
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) – Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	This audit aims to collect information on all people admitted to hospital with COPD exacerbations – continuous data collection.	Participated
National Audit of Breast Cancer in Older People (NABCOP)	The audit looks at whether or not older women with breast cancer have different outcomes than younger women, and if there are differences between breast cancer teams in the patterns of care delivered to older women.	Participated

Audit Title	What is the audit about?	Case Participation
National Audit of Cardiac Rehabilitation (NACR)	NACR combines data from cardiac rehabilitation programmes across the UK to improve patient outcomes.	Participated
National Audit of Care at the End of Life (NACEL)	The National Audit of Care at the End of Life (NACEL) focuses on the quality and outcomes of care experienced by those in their last admission in acute, community and mental health hospitals throughout England and Wales.	Participated
National Audit of Dementia (NAD)	The audit examines assessments, discharge planning and aspects of care received by people with dementia.	Participated
National Cardiac Arrest Audit (NCAA) – Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK	The purpose of this audit is to monitor the incidence of, and outcome from, in-hospital cardiac arrest in the UK.	Participated
National Cardiac Audit Programme (NCAP) - managed by the National Institute for Cardiovascular Outcomes Research (NICOR): Myocardial Ischaemia National Audit Project (MINAP)	This audit examines the quality of management of heart attacks (myocardial infarction) in hospitals in England and Wales.	Participated
National Cardiac Audit Programme (NCAP) - managed by the National Institute for Cardiovascular Outcomes Research (NICOR): National Audit of Cardiac Rhythm Management (NACRM)	This audit collects information about all implanted cardiac devices and all patients receiving interventional procedures for management of cardiac rhythm disorders in the UK.	Participated
National Cardiac Audit Programme (NCAP) - managed by the National Institute for Cardiovascular Outcomes Research (NICOR): National Audit of Percutaneous Coronary Interventions (NAPCI)	Percutaneous coronary intervention (PCI) is used to treat patients with narrowed or blocked arteries that supply the heart muscle with blood; this audit allows clinicians to assess key aspects of the patterns and quality of their care when performing PCI.	Participated
National Cardiac Audit Programme (NCAP) - managed by the National Institute for Cardiovascular Outcomes Research (NICOR): National Heart Failure Audit (NHFA)	This audit collects data on the characteristics of patients admitted to hospital with acute or sub-acute heart failure and describes their in-hospital investigation and care, the treatment given, the discharge planning and follow up which is offered.	Participated
National Child Mortality Database (NCMD)	This audit gathers information on all children who die in England to improve and save children's lives.	Participated

Audit Title	What is the audit about?	Case Participation
National Early Inflammatory Arthritis Audit (NEIAA)	The overall aim of the audit is to improve the care quality of care provided by specialist rheumatology services in the management of early inflammatory arthritis - continuous data collection.	Participated
National Emergency Laparotomy Audit (NELA)	NELA aims to look at structure process and outcomes measures for the quality of care received by patients undergoing emergency laparotomy – continuous data collection.	Participated
National Joint Registry (NJR)	The clinical audit covers joint replacements during the previous calendar year and outcomes including survivorship, mortality and length of stay – continuous data collection.	Participated
National Lung cancer (NLCA)	This audit was set up in response to the NHS Cancer Plan to monitor the introduction and effectiveness of cancer services.	Participated
National Maternity and Perinatal Audit (NMPA)	The National Maternity and Perinatal Audit (NMPA) is a large scale audit of the NHS maternity services across England, Scotland and Wales. The audit aims to evaluate a range of care processes and outcomes in order to identify good practice and areas for improvement in the care of women and babies looked after by NHS maternity services.	Participated
National Neonatal Audit Programme – Neonatal Intensive and Special Care (NNAP)	This audit assesses whether babies admitted to neonatal units receive consistent, high quality care and identifies areas for quality improvement.	Participated
National Ophthalmology Audit Database (NOD)	The project aims to collect and analyse a standardised set of nationally agreed cataract surgery data set, from all centres providing this service.	Participated
National Paediatric Diabetes Audit (NPDA)	This audit measures health outcomes and experiences of children with diabetes in England and Wales.	Participated
National Perinatal Mortality Review Tool (PMRT)	This tool has been developed and established to provide a national standardised Perinatal Mortality Review Tool (PMRT).	Participated
National Prostate Cancer Audit (NPCA)	The audit covers organisational elements of the service and whether key diagnostic, staging and therapeutic facilities are available on site for each provider of prostate cancer services.	Participated
National Vascular Registry (NVR)	The audit addresses the outcome of surgery for patients who underwent two types of vascular procedures. The first is an elective repair of abdominal aortic aneurysms (AAA). The second is a carotid endarterectomies (CEA) – continuous data collection.	Participated

Audit Title	What is the audit about?	Case Participation
Neurosurgery National Audit Programme (NNAP)	The aim of this programme is to engage units in a comprehensive audit programme that reflects the full spectrum of elective and emergency neurosurgical activity, and to provide a consistent and meaningful approach to reporting on national clinical audit and outcomes data.	Participated
Out-of-Hospital Cardiac Arrest Outcomes: Cardiac Arrest Outcomes Data for patients who attend hospital with a Return of spontaneous circulation (ROSC)	Integrated data reporting for patients who attend hospital with return of spontaneous circulation (ROSC) and are brought to hospital by the EEAST ambulance service.	Participated
Paediatric Intensive Care (PICANet)	PICANet aims to support the improvement of paediatric intensive care provision throughout the UK by providing detailed information on paediatric intensive care activity and outcomes.	Participated
Perioperative Quality Improvement Programme (PQIP)	This Quality Improvement Programme (QIP) measures complications, mortality and patient reported outcome from major non-cardiac surgery.	Participated
Renal Audits: National Acute Kidney Injury Audit	The aim of this audit is to reduce the risk and burden of acute kidney injury.	Participated
Renal Audits: UK Renal Registry Chronic Kidney Disease Audit	The Registry contains analyses of data submitted relating to direct clinical care and laboratory permit analysis with the purpose to improve the quality of care for renal patients.	Participated
Royal College of Emergency Medicine (RCEM) Consultant Sign off (CSO)	This quality improvement programme (QIP) aims to specify particular high-risk patient groups who should be reviewed by a consultant in Emergency Medicine before they are discharged from the Emergency Department.	Participated
Royal College of Emergency Medicine (RCEM) Infection Prevention and Control	This QIP aims to improve patient safety and quality of care as well as workspace safety by collecting data to track change.	Participated
Royal College of Emergency Medicine (RCEM) Pain in children (care in emergency departments)	This QIP aims to improve patient care by reducing pain and suffering, in a timely and effective manner through sufficient measurement to track change.	Participated
Sentinel Stroke National Audit Programme (SSNAP)	The audit collects information about care provided to stroke patients in the first three days of hospital - continuous data collection.	Participated
The British Association of Urological Surgeons (BAUS): Muscle Invasive Bladder Cancer Audit	This audit collects data on the management and outcomes of patients diagnosed with muscle invasive bladder at transurethral resection of the bladder and variations in pathways and treatments received in the UK.	Participated

Audit Title	What is the audit about?	Case Participation
Trauma Audit and Research Network (TARN)	TARN is working towards improving emergency health care systems by collating and analysing trauma care – continuous data collection.	Participated
UK Cystic Fibrosis Registry	The audit aims to examine both life expectancy and quality of life for children and adults with Cystic Fibrosis – continuous data collection.	Participated
UK Parkinson's Audit	This audit measures practice against evidence based standards and patient feedback in a continuous cycle of improvement.	Participated

For registries that had a case ascertainment threshold in 2022- 2023, CUH participated and met the threshold for all national audits as required.

Table: Participation in national confidential enquiries

National confidential enquiry title	Participation (percentage)
Endometriosis	On-going
Community Acquired Pneumonia	64%
Crohn's Disease	67%
Transition from child to adult health services	88%
Testicular torsion	On-going

Learning from audit

National audits

The reports of 4 national clinical audits were reviewed by the provider in 2022/23 and Cambridge University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see Appendix B. for list of national clinical audit reports, outcomes and action plans).

Local audits

The reports of 237 local clinical audits were reviewed by the provider in 2022/23 and Cambridge University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Appendix C provides examples of local clinical audit report outcomes and action plans.

Use of the CQUIN payment framework

The Commissioning for Quality and Innovation (CQUIN) programme is a national framework for locally agreed quality improvement schemes. Prior to the Covid-19 pandemic a proportion of a provider's income would have been conditional upon the CQUIN programme being achieved.

The CQUIN programme re-started in 2022-23, following suspension in 2021/22 due to the impact of Covid-19. However, a proportion of Cambridge University Hospitals NHS Foundation Trust income in 2022/23 was not conditional on achieving quality improvement and innovation goals agreed between Cambridge University Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. The link between CQUIN programmes and the Trust's remuneration is expected to remain under review with NHSE/I and has the potential to impact on payment arrangements in future years.

Further information is available at cuh.trustsecretariat@nhs.net

Care Quality Commission registration and compliance

Cambridge University Hospitals NHS Foundation Trust (CUH) is required to register with the Care Quality Commission and is currently registered with no conditions attached.
The Care Quality Commission has not taken enforcement action against CUH during 2022/23.
Cambridge University Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The Trust's CQC rating remains consistent with an overall rating of Good. The full table of ratings from the last full inspection (October 2018) is available below, however an inspection of Urgent and Emergency Care and Medical care was carried out in March 2022. Medical care was not rated again in 2022, although Urgent & emergency care was rated as 'required improvement in the 'safe' domain, which impacted the overall rating for urgent & emergency to 'Requires Improvement'.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	*Requires Improvement	Good	Outstanding	Requires improvement	Outstanding	*Requires Improvement
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Good	Outstanding	Outstanding	Requires improvement	Good	Good
Maternity and gynaecology	Good	Good	Good	Requires improvement	Good	Good
Services for children and young people	Good	Good	Good	Requires improvement	Good	Good
End of life care	Good	Good	Outstanding	Good	Outstanding	Outstanding
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Overall	Good	Good	Outstanding	Requires improvement	Outstanding	**Good**

Data quality

Data quality refers to assurance of the information about patients recorded by the Trust on computerised systems.
The Trust follows national guidelines about how these data are collected and stored, and we undertake regular audits to make sure that data held on the system is accurate and that we are compliant with what is expected.
CUH submits records to the secondary uses service (SUS) for inclusion in the hospital episode statistics (HES). We also share data with partners as appropriate, for example integrated care boards (ICBs). These data are used to plan and review the healthcare needs of the area.

Cambridge University Hospitals submitted 1,941,120 records during the reporting period, April 2022 – March 2023, 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:

  99.8% for admitted patient care
  99.7% for outpatient care and
  98.7% for accident and emergency care.

- Which included the patient's valid General Medical Practice Code was:

  100% for admitted patient care;
  100% for outpatient care; and
  97.2% for accident and emergency care.

Information governance toolkit attainment levels

All NHS organisations are required to comply with the 'Information Governance Toolkit'. This covers standards on data protection, confidentiality, information security, clinical information and corporate information.
The Cambridge University Hospital Data Security & Protection Toolkit submission for 2021/22 was 'approaching standards'. The DSPT assessment for 2022/23 is not due until the end of June 2023. The Trust is currently working through the requirements and gathering evidence ready for the submission at the end of June. The Trust is aiming to meet all standards but, at the time of publishing the Quality Accounts, cannot confirm that all standards have been met.

Clinical coding

Cambridge University Hospitals was not subject to the Payment by Results clinical coding audit during 2022/23 by the Audit Commission.
Cambridge University Hospitals undertake the following actions to improve data quality:

- Develop data quality dashboards and provide missing/invalid item reports for many of the national returns so that front line staff may see where improvements are possible.
- Timetable deep dives into divisional mandated returns to validate and improve data quality.
- Audit documented clinic outcomes against evidence within Epic to provide process assurance.
- Administrative and Ward Clerk lunch and learn sessions held virtually throughout the period designed to highlight data issues and improve compliance.
- E-Hospital Clinical Liaison team working across all inpatient areas to improve adherence to trust clinical workflows and ensure that the technology deployed is fit for purpose.
- Continuous review / improvement of Epic workflows to enable staff to work efficiently and effectively thereby improving data quality. The RTT DQ team run bi-annual review sessions in addition to a weekly focus on shared learning to ensure consistency in workflow
- EPR / IT training strategy progressing well and all classroom session content and tip sheets reviewed. Post training at-the-elbow support now offered and a series of eLearning tutorials are available.
- The Data Governance, Reporting and Stewardship Oversight Group reinforces processes relating to data collection, curation and storage across the Trust. The Group works with Divisional management and operational teams to ensure that data

quality process are embedded to promote a culture of continuous improvement and improve the quality of our national returns.

- The RTT forum runs as a quarterly event to reinforce the development and learning of front line staff. The forum focuses on education around new or enhanced Epic functionality, data analytics resulting from audit deep dives and examples of existing good practice.
- The in-house course on Practical Data Analysis was suspended during COVID and we are working to get the content into an eLearning package. This course teaches practical skills to help staff better use the data available to them, encouraging data review and promoting good data quality.
- Personalisation discussions help clinicians set up their own preferences in Epic. This helps clinicians to navigate the system appropriately and understand the importance of data quality.
- Workflows in Epic are built to guide the user to complete workflows appropriately. Errors or omissions are flagged with warning and stop signs used to aid correction.

Learning from Deaths

In March 2017, the National Quality Board introduced new guidance for NHS providers on how they should learn from the deaths of people in their care.
CUH launched its new policy and procedures in October 2017 in line with NHSI timeframes. The Learning from deaths policy within CUH is supported by the Trust Learning from Deaths Oversight Committee and reports to the Quality Committee bi-monthly via the Patient Safety Report and monthly to the Board via the Trust Integrated Report.
The data shown below reflects the mandated KPIs for reporting via the Quality Account. These numbers have been estimated using the Structured Judgement Review tool methodology for the required case review process (as recommended by the Royal College of Physicians).

(27.1) The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.

During April 2022 to March 2023 1877 of CUH patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 453 in the first quarter; 431 in the second quarter; 497 in the third quarter, and 496 in the fourth quarter.

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

By March 2023, 358 case record reviews and 15 Serious Incident investigations have been carried out in relation to 1877 of the deaths included in item 27.1.

In 358 cases a death was subjected to both a case record review and/or an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 74 in the first quarter; 86 in the second quarter; 98 in the third quarter, and 100 in the fourth quarter.

(27.3) An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have included problems in the care provided to

the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.

13 deaths, representing 0.7% of the patient deaths during the reporting period, are judged to be more likely than not to have included problems in the care provided to the patient.

In relation to each quarter, this consisted of: 5 representing 1.1% for the first quarter; 2 representing 0.4% for the second quarter; 4 representing 0.8% for the third quarter. 2 representing 0.4% for the fourth quarter. These numbers have been estimated using the Structured Judgement Review Tool (scores 1-3 in 2022/23).

(27.4/27.5) A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3 (scores 1-3 in 2021/22)

SJR Thematic Review:

A review of a sample of SJR's (with scores 1-3) within the last year revealed a number of common themes. These have often included aspects that highlight areas for development and good practice.

Admission and initial management:

A recurring theme in the SJR that highlighted problems in care was delays in recognition of illness and initiating of treatment of patients' presenting to the Emergency Department This includes the frequency of observations, documentation and time to review as well as delays in accessing specialist review and accessing required investigations. These issues are symptomatic of the pressures on the service as a result of the volume of patients arriving in the department. There was evidence that when patients were reviewed the level of assessment and initiation of treatment was of a good standard. The learning from these SJRs have been fed into the ongoing quality improvement work of the Urgent and Emergency Care Taskforce

End of Life Care (EOLC):

Analysis of the data suggested that appropriate decisions were made in relation to the patient and EOLC. There was evidence of patient wishes being respected, appropriate ceilings of care being met and communication occurring with the affected families. However, there were instances of delays in discussion around EOLC as well as the clarification of patient's resuscitation status. These findings have fed into a wider piece of work by the Trust to look at supporting end of life/respect discussions.

For the Serious Incident Investigations that have been undertaken, some key actions have included:

- The use of continuous physiological monitoring to help prioritise those most at risk in the Emergency Department.
- Dedicated space for front door review for urgent review of patients by clinicians.
- Review of weekend staffing levels and expectation of ward coverage on medicine take
- Creation of an 'abnormal results' track board on Epic.
- C02 monitoring to be available on all resuscitation trolleys on tracheostomy designated wards.
- Imaging reconsidering the threshold for radiology alerts for positive imaging findings.

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

Currently, the clinical governance structures within CUH provide the correct structure to create actions and escalate concerns from learning from deaths. The various Quality Improvement plans and working groups are responsive to learning gathered through mortality, patient safety, and compliance.

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

17 case record reviews and 4 investigations completed after 01 April 2022 which related to deaths which took place before the start of the reporting period, from the previous financial year.

Duty of Candour

When a patient has been involved in a notifiable safety incident, staff have a duty to inform the patient, relatives, and/or carers as appropriate. A notifiable safety incident is defined as any incident that is unintended or unexpected; occurring during the provision of regulated care; and in the reasonable opinion of a healthcare professional, already has, or might, result in death, severe, or moderate harm to the person receiving care. Internally, CUH has a clear policy that outlines this process and ensures organisational compliance with this regulation. Previous requirements (NHS contract and CQC standards) required stages 1 and 2 to be completed within 10 days; this specific timeframe is no longer a requirement. The trust standard now is within a reasonable timeframe.
Compliance with Duty of Candour stage 1 requires that an appropriately senior clinician informs the patient about the incident, explains the impact and consequences for the patient, apologises, and informs the patient that the incident will be investigated, and finally, all these elements are captured in a formal letter from the clinical team to the patient (or relative/carer). Stage 2 pertains to ensuring that once the investigation is completed the Trust will share the findings of their investigation with the patient/relative/carer, should they so wish.
Duty of candour is delivered by the relevant clinical teams and is recorded in the patient's medical record and in Datix; compliance is monitored from Datix and reported by the divisional governance teams and corporate patient safety team. Compliance data is shared monthly with the Board via the Trust Integrated report, with Divisions via metrics in their Divisional board meetings, and with the Quality Committee via the Patient Safety Group's bi-monthly Patient Safety Report.

In 2022/23 our compliance with Duty of Candour stage one is 89%, and stage two is 84%.

Staff Survey Results

What did we measure?	How did we do?		
	2020/21	2021/22	2022/2023
KF27 % reporting most recent experience of harassment , bullying or abuse (Higher scores are better)	46.4%	45.3%	43.4%
Relate to - Workforce Race Equality Standard:			
KF21 / Q15 (percentage believing that Trust provides equal opportunities for career progression or promotion) (Higher scores are better)	59.3%	57.6%	56.8%
KF26 presented as 2 separate questions: (percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months) (Q14b)	12.1%	9.9%	11.4%
(percentage of staff experiencing harassment, bullying or abuse at work from other colleagues in last 12 months) (14c)	20.6%	18.2%	20.5%

Please note: KF21 Q. Trust provides equal opportunities for career progression or promotion. The methodology of calculation has been changed this year. So historic data (2020/21) has been adjusted accordingly.

KF27: The process of reporting experience of harassment, bullying or abuse continues to be promoted and encouraged. This remains an issue across the NHS, including for CUH. A key priority of the WRES Action plan is the protection of staff from racial harassment and abuse from patients, public and colleagues.

KF21: It is recognised that cultural and behavioural changes will take time to embed. Actions in place to address equal opportunities for career progression or promotion are within both our WRES Action Plan and WDES action plans to debias the recruitment process by implementing the NHS East of England No More Tick Boxes guide for inclusive recruitment using evidence based practice and ensuring adjustments at the recruitment stage are in place.

This is building on the work of the diverse interview panellist role. Over 56 diverse interview panellists with lived experience of minority groups that have been recruited and trained for all recruitment to posts for band 8a and above from shortlisting through to interview;

Over 250 leaders have attended our programme with Above Difference Ltd of Inclusive Leadership with Cultural Intelligence (CQ) so far consisting of 16 masterclasses and 10 action planning workshops to equip leaders to be intentionally inclusive and better able to lead diverse teams. This programme gives leaders the CQ framework tool to understand, different cultural value preferences; how these cultural value preferences such as high or low power distance cultures, collectivist or individualist; directive/expressive communication styles, will play out in the workplace including at recruitment, in an interview, who will feel able to apply and their role; or at an appraisal when discussing development. The 4 trained in house CQ facilitators will work with Head EDI and Above Difference to embed learning into practice and other leadership development.

The Trust's Talent Management lead has been appointed and developed a talent toolkit to support career conversations that are inclusive. The Talent lead is also one of the 4 trained CQ facilitators who will embed cultural intelligence in the toolkit CQ and support embedding in leadership development.

Work is also ongoing to ensure training and development opportunities are accessible to all and widely communicated. Two successful career development webinars for black and minority ethnic clinical staff were arranged with the regional RCN Learning representative , REACH staff network and EDI team to share information of career opportunities available, access to funding for development from the Clinical education lead; application and interview advice and sharing career journeys from staff stories.

KF26: Work is progressing to embed principles of a Just and Learning Culture at CUH through an integrated project built around the new National Patient Safety Strategy, where a key focus is on how staff behave towards each other i.e. in a fair, respectful, proportionate and consistent way across the organisation – in particular in response to when things have gone wrong but equally a just culture will support continuous improvement and a reduction in incivility and bullying. The implementation of this Trust wide project will increase understanding of the value of a just and learning culture, embed just and learning culture into practice and grow a just and learning community across the workforce.

Table to Show Harassment & Bullying theme

	2020	2021	2022
CUH	8.1	7.9	7.8
Average Acute Trust	8.1	7.7	7.7
Best Acute Trust	8.7	8.1	8.1
Worst Acute Trust	7.2	7.3	7.3

NSS is aligned with people promises from year 2021 and there is no Harassment & Bulling Theme. But those questions come under "we are safe and healthy" - Negative Experiences (sub group).

Table to show comparator information

	Comparator Information	2020	2021	2022
Qu.	**Description**	***n* = 5884**	***n* = 6493**	***n*= 4895**
q14a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	76.2%	76.6%	76.2%
q14b	Not experienced harassment, bullying or abuse from managers	87.9%	90.1%	88.6%
q14c	Not experienced harassment, bullying or abuse from other colleagues	79.4%	81.8%	79.5%
q14d	Last experience of harassment/bullying/abuse reported	46.4%	45.3%	41.7%
q15	Organisation acts fairly: career progression	59.4%	57.6%	56.8%

Reporting against core indicators

The Trust's performance against the core indicators is described at *Appendix A*.

Part 3 - Other information

Reviewing performance against 2022/23 priorities for improvement

Safe

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

What did we measure?	Our target	How did we do?	
		2021/22	2022/23
Compliance with National Early Warning Score Escalation Protocol for Adults.	85%	53%	77%

Why was this a priority?

This is a key element of deteriorating patient improvement work stream to ensure sustainability and effectiveness of escalation. Ensuring that patients are escalated appropriately when deterioration occurs is important to maintain patient safety. Nationally, the NEWS2 score is used to guide appropriate and effective escalation. Compliance with this is important to ensure escalation happens as required in a timely manner.

What was our target?

Target last year was that over 85% of the notes audited must meet the quality mark.

How did we measure and monitor our performance?

Retrospective audits and real time audits were used to analyse instances of patients who had deteriorated within the organisation. A standardised audit proforma was updated this year to include more detailed information to guide improvement.

How and where was progress reported?

Progress was reported within corporate governance structures related to the deteriorating patient, patient safety assurance group, and as part of the integrated performance report.

Did we achieve our intended target?

The Trust has not achieved the quality mark target of over 85% in 2022/23.

Our key achievements against this priority:

During the year, there has been a gradual improvement towards the quality target. Improvements were also seen in individual metrics of the audit such as: escalation to a senior registrar, nurse in charge review, and referral to the rapid response team.

What did we measure?	Our target	How did we do?	
		2021/2022	2022/23
Falls KPI; patients 65 and over have a Lying and Standing Blood Pressure (LSBP) completed within 48hrs of admission	50%	13.4%	15.8%

Why was this a priority?

In 2019/20 the baseline measure was 6%, supporting he case for falls prevention improvement work. This is a key element of the patient falls improvement work stream to support the reduction of falls. This improvement work stream supports the implementation of best practice in the identification and management of falls risk factors and reduce the risk of falls for inpatients. This metric is related to the identification of postural hypotension as part of a multifactorial assessment as recommended by the NICE guidance (CG161) for falls prevention in older adults during a hospital stay.

What was our target?

The target for 2022/23 was 50% or more, compliance with completion of a lying and standing blood pressure (for the detection of postural hypotension) in inpatients over 65 years of age.

How did we measure and monitor our performance?

Performance is being measured and monitored via the Falls Quality Improvement dashboard.

How and where was progress reported?

Progress was reported within corporate and divisional governance structures related to patient falls, patient safety assurance group, and as part of the integrated performance report.

Did we achieve our intended target?

The Trust has not achieved the quality mark target of over 50% in 2022/23.

Our key achievements against this priority:

As of August 2022, all wards now have a falls champion whose role is to focus on this specific goal.

A prompt to complete the lying and standing blood pressure has been added to the new falls risk screening (live 17.01.2023).

A lying and standing blood pressure e-learning pack has been devised and available from December 2022.

Lying and standing blood pressure requirement has been added to the newly updated Qualified Practitioner orientation programme (recommended in January 2023) and is now part of the Heath Care Support Workers induction training (CSSIP)

What did we measure?	Our target	How did we do?	
		2021/22	2022/23
Venous thromboembolism (VTE) Risk Assessment Compliance	≥95%	93.7%	95.5% (March 2023)

Why was this a priority?

Venous thromboembolism (deep vein thrombosis or pulmonary embolism) is a common diagnosis in hospitalised patients and in acute patients presenting to the hospital and untreated PE has a mortality of 25%. This metric reflects effective identification of patients at risk of developing a VTE, enabling appropriate preventive management to reduce the risk of VTE occurrence. Risk assessment compliance is a key quality requirement in the NICE (CG158), British Thoracic Society guidance, and NHS standard contract 2022/23.

What was our target?

The compliance target was 95% or higher.

How did we measure and monitor our performance?

The data is generated from patient records in Epic and reported via the internal CHEQS database.

How and where was progress reported?

Progress was reported within corporate and divisional governance structures, patient safety assurance group, clinical effectiveness group, and as part of the integrated performance report.

Did we achieve our intended target?

The Trust met the compliance level that was set at the beginning of the year.

Our key achievements against this priority:

The Trust has re-established the central VTE group and assigned a new Chair to the group and strengthened divisional representation. The e-hospital team is working with divisional teams to ensure the compliance data on CHEQS accurately reflects compliance.

The Neurosurgical speciality has led an effective quality improvement programme of work across acute neurosurgical wards to improve compliance in 2022.

What did we measure?	Our target	How did we do?	
		Baseline in 2021/2022	2022/23
Sepsis Six Bundle - Blood Cultures within 60 minutes	95%	70%	89%*

**inpatient data in 2022/2023 was 91%, data in the emergency department was 87%, therefore an average has been reported.*

Why was this a priority?

This is a key element of the sepsis improvement work stream to ensure sustainability and effectiveness implementation of the sepsis six bundle. Compliance with the sepsis 6 bundle is a NICE quality standard (QS161).

What was our target?

The compliance target was 95% or higher.

How did we measure and monitor our performance?

Compliance is measured by retrospective audits

How and where was progress reported?

Progress is reported within the Sepsis Action Group, Patient Safety and Assurance Group, and the trust Integrated Report.

Did we achieve our intended target?

The Trust has not achieved the quality target of 95% or higher in 2022/23, although some improvement has been demonstrated.

Our key achievements against this priority:

A new medical sepsis lead has been appointed in 2022 following a gap in this role.

Effective/Responsive

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

What did we measure?	Our target	How did we do?	
		2021/22	2022/23*
Early discharges (07:00 – 12:00)	20.0%	N/A	16.2%

**In 2021-2022 this measure reported between midnight to 12pm. This was adjusted to 7am to 12pm for 2022/2023 monitoring onward, with a baseline of 15.3%*

Why was this a priority?

Earlier discharges create capacity in the morning when the organisation needs it. They support flow out of ED and provide capacity for elective patient placement to the appropriate specialty.

What was our target?

The target for 2022/23 was that 20% of in-patients should be discharged before 12pm. This excludes zero length of stay patients and time spent in the discharge lounge.

How did we measure and monitor our performance?

Performance was monitored through Quality Performance meetings as well as at UEC Taskforce meetings chaired by the Trust's Chief Operating Officer (COO). The COO also monitored and shared data at ward level with senior staff across divisions to identify areas of opportunity to increase early morning discharges. The Trust's internal systems also allowed real-time reporting of progress.

How and where was progress reported?

Progress against early morning discharges was reported to the UEC Taskforce as noted above. It was also reported to the Trust's Performance Committee and the Board on a monthly basis.

Did we achieve our intended target?

The Trust achieved 16.2% during 2022/23 (YTD) and therefore did not achieve its intended target of 20%. We did achieve periods of improved performance in certain months of the year however, reaching a peak of 17.9% in September. This performance was driven by the introduction of elements of the 'North Bristol model' which promotes reverse boarding to in-patient wards beginning early in the morning and continuing throughout the day. We will continue to employ the approach during 2023/24, alongside other interventions, and monitor the impact on performance.

Our key achievements against this priority:

During 2022/23 infection levels were a significant challenge, particularly during Q3 when COVID and flu increased substantially. Our key achievement in this context was the introduction of elements of the North Bristol model which encourages wards to increase discharges early in the day and shares the risk of overcrowding across the Emergency Department and wards. We also increased the usage of the discharge lounge by 18% compared to last year which supports early discharge. We will continue with these initiatives during 2023/24 and work with our Improvement and Transformation team to introduce further interventions to drive a sustainable increase in early discharge performance.

What did we measure?	Our target	How did we do?	
		2021/22	2022/23
Weekend discharges	80.0% (of weekday rate)	68.4 %	75.8%

Why was this a priority?

An increase in weekend discharges provides capacity to the Trust at the start of the week when non-elective demand is highest and our elective programme for the week commences.

What was our target?

The target for 2022/23 was 80%. This excludes 0 Length of Stay (LoS) and elective day case patients.

How did we measure and monitor our performance?

Weekend discharges were measured through Quality Performance meetings. As with early discharges, the Trust's internal systems allowed real-time reporting of progress.

How and where was progress reported?

Progress was reported to Quality Performance meetings as noted above, and the Trust's Performance Committee and the Board on a monthly basis.

Did we achieve our intended target?

The Trust achieved 75.8% in the 2022/23 year to date, an improvement on 2021/22 performance but short of the target of 80%.

Our key achievements against this priority:

The Trust saw a significant increase in weekend discharges year-on-year from 68.4% in 2021/22 to 75.8% in 2022/23. Although this did not reach our intended target of 80.0%, this represents our best performance since 2015. Specific programmes of work targeting complex discharges were introduced during 2022/23, coordinated by the integrated care system, supported this increase in performance.

What did we measure?	Our target	How did we do?	
		2021/22	2022/23
Same day emergency care (SDEC)	30.0%	21.9%	19.6%

Why was this a priority?

Same Day Emergency Care (SDEC) aims to provide emergency patients with the right service on a timely basis. This improves patient experience and supports a reduction in crowding in the emergency department.

What was our target?

Our target for 2022/23 was that 30% of patients who attend the emergency department would be seen in an SDEC area. This includes patients attending our medical and surgical assessment areas and emergency hot clinics.

How did we measure and monitor our performance?

SDEC performance was measured through the UEC Taskforce which was chaired by the Trust COO. It was also intensively reviewed and monitored on a fortnightly basis by the dedicated SDEC and Specialty Assessment group chaired by the Divisional Director of Division C.

How and where was progress reported?

Progress was reported to the UEC Taskforce, as noted above, and the Trust's Performance Committee and the Board on a monthly basis.

Did we achieve our intended target?

The Trust achieved 19.6% SDEC activity during the 2022/23 YTD. This was a decrease compared to 21.9% in the prior year and short of the target of 30%. Key issues included the significant increase in bed occupancy which introduced delays to outflow from SDEC areas to admitted areas, particularly from the medical and surgical assessment areas where a large proportion require onward admission.

Our key achievements against this priority:

In November we relaunched the Medical Assessment Unit, expanding its capacity and increasing the number of high turnover spaces available. This produced an immediate increase in SDEC to 24.0% for the month, a very significant rise compared to 16% in the previous month. A new process to record SDEC activity in real time was introduced in March 2023, which will improve the Trust's live visibility and management of SDEC data going forwards.

What did we measure?	Our target	How did we do?	
		2021/2022	2022/23
SSNAP Domain 2: % of patients admitted to a stroke unit within 4 hours of clock start time (Team centred)	30.0%	29.2%	Av. 27%

Why was this a priority?

Addenbrookes stroke unit service as a comprehensive stroke centre for the East of England. Adults presenting at an A&E department with suspected stroke are admitted to a specialist acute stroke unit within 4 hours of arrival. Specialist acute stroke units are associated with improved patient safety due to better outcomes, such as reduced disability and mortality, because of the range of specialist treatments they provide. Admission to these units should be within 4 hours of arrival at A&E, so that treatment can begin as quickly as possible, and to help prevent complications. Previous National Clinical audits show the Trust as an outlier benchmarking poorly against other Trusts, with a national average of 55%.

What was our target?

The 4 hours admissions to Stroke Unit target (Team centred) for 2022/23 was to maintain 30% of patients being admitted within 4 hours.

How did we measure and monitor our performance?

Performance was monitored through quality performance meetings, as well as at Operational Taskforce meetings chaired by the Trust's Chief Operating Officer (COO). Stroke is also discussed at the Trust Medical Care Board attended by multidisciplinary staff.

How and where was progress reported?

Progress against % of patients admitted to a stroke unit within 4 hours of clock start time was reported to the Operational Taskforce as noted above. It is also reported to the Board on a monthly basis.

Did we achieve our intended target?

The Trust achieved an average 27% of patients admitted to a stroke unit within 4 hours of clock start time during the 12 monthly performance reports between April 2022 and March 3. The range during the monthly reporting figures was 18.3% to 38.5%. The overall average (n=12) was a decrease compared to 30% in the prior year. Trust bed capacity and a high number of outliers placed on the stroke ward were the main factors contributing to a decreased performance.

Looking forward we hope to improve performance by improving flow via nurse led discharges, collaboration with Royal Papworth Hospital and consider utilisation of space for rehabilitation patients versus acute stroke patients.

In addition the 4 hour standard in accident and emergency has been re-implemented at CUH, and therefore it is anticipated that this may also promote improvement, providing capacity (beds) are available.

Our key achievements against this priority:

The Mixed-sex HASU bay on Stroke Ward (R2) has opened in May 2022 to support with the prompt placement of stroke patients from the Emergency Department.

The Stroke team received approval from the Chief Operating Officer to ring-fence one male and one female bed on R2. This is enabling rapid admission in less than 4 hours. The Acute Stroke unit continues to see and host a high number of outliers. Due to Trust challenges with bed capacity the service is unable to ring-fence a bed at all times. Instead it is negotiated on a daily basis according to the needs of the service and the Trust.

Patient Experience/Caring

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

What did we measure?	Our target	How did we do?	
		2021/2022 Baseline	2022/23
Healthcare Inequality: Percentage of patients in calendar month where ethnicity data is not recorded on EPIC	7%	14%	11%

Why was this a priority?

Effective demographic patient monitoring is a requirement for the NHS as part of the Equality Act 2010. The collection of ethnicity data is crucial to increasing understanding of the inequalities faced by different ethnic groups in order to improve the planning and delivery of services for those who identify as an ethnic minority and to ensure that the services and pathways are appropriate to improve patient outcomes and experiences.

Cambridge University Hospitals is fully committed to ensuring a safe, kind and excellent environment for everyone receiving care from us and an important part of this is our commitment to tackling inequality of opportunity in the provision of the services we provide.

Due to changes in how appointments have been facilitated and offered during the pandemic, the Trust had noticed a decline in demographic data collection especially ethnicity which was impacting on the ability for the Trust to fully understand the population we serve.

What was our target?

The target for 22/23 was to improve the percentage of records where ethnicity demographic data was collected for our patients and service users by reducing the 'not recorded on EPIC' results from the original baseline of 14% to 7%.

How did we measure and monitor our performance?

We improved the Trust existing Patients and service user demographic data collection dashboard to be able to reflect data captured at a ward/clinic level rather than at Division. This gave us the ability to focus on specific areas including individual clinics and departments for improvement rather than a trust wide approach.

This data is now available for all Divisional Managers to review to identify trends and opportunities.

There is evidence to suggest that self-reporting is the most effective way of asking about an individual's ethnic identity, particularly due to potential issues of stereotyping. My Chart, which is the electronic patient portal at Addenbrooke's and The Rosie hospitals allows patients to securely access parts of their health record held within the hospitals' Epic electronic patient record system. From November 2022, the demographic data

section which includes ethnicity recording was made mandatory enabling them to self-populate and improve data collection at source.

It is too early to see the impact that self-reporting through My Chart will have on the data collection however there has been a steady improvement across the year to around 11.5%, this rose to 13% in November and December and decreased back to 11.2% in January.

How and where was progress reported?

Progress was reported to the Equality, Diversity and Inclusion operational group which was established in April 2022. The purpose of the group was to develop, implement and deliver a trust wide work plan to ensure that national, contractual and legislation requirements relating to equality, diversity and inclusion for our patients, service users and visitors were met under the Equality Act 2010

A quarterly report was shared at the Trust Executive chaired Equality, Diversity and Dignity Committee.

Did we achieve our intended target?

The Trust reduced the record gap to 10.8% of patients in the overall year not having ethnicity recorded on the Trust EPIC report during 2022/23, although we did not achieve our intended target to reduce to 7%.

Although there has been a significant increase in face to face appointments, virtual consultations continue and we know this is where there is difficulty in data capturing during the consultation.

Due to the improvements in the dashboard we have been able to identify areas where focused work is required to train and support staff to feel confident in being able to ask and collect and the data. This work will continue through 2023/24 working with the integrated Care board on joint communication and engagement strategies to promote the importance of data capture and how the NHS use personal data to improve services.

Our key achievements against this priority:

The establishment of the Equality, Diversity and Inclusion Group in May 2022 which focuses on patients, service users and visitors. Members of the group are from staff from across the trust delivering or responsible for services impacting on the EDI agenda. A draft work plan has been created identifying priorities of work, including data collection and analysis.

Self reporting mandatory demographic collection in My Chart which went live in November 2022.

What did we measure?	Our target	How did we do?	
		Baseline	2022/23
Publication of actions and improvements undertaken as a result of feedback received from patients and their representatives. (1 Report per month)	100%	New Measure	100%

Why was this a priority?

Patients and their representatives can provide feedback about the services they have received via surveys, complaints, PALS and focus groups. They may also work with staff to develop and improve services via engagement routes such as patient participation groups embedded in services, or through engagement activities relating to major developments. It is vital that the outcomes of these feedback routes and engagement

processes are available in the public domain in order to restore confidence in services where there has been a shortfall identified; indicate that the Trust is willing to listen and take action as a result of feedback; and to encourage others to speak up or get involved. Publication of actions and improvements undertaken as a result of feedback is also relevant to the 2020 report by Sir Robert Francis 'Shifting the Mind-set': this report addressed the importance of hospitals sharing learning from complaints in order to increase confidence in the public that they will be heard and action taken if they complain.

What was our target?

We aimed to publish at least one report per month on the CUH website.

How did we measure and monitor our performance?

The Head of Patient Experience ensured that the reports were published on the website and provided confirmation via the Trust's monthly tracking of Quality Account measures

How and where was progress reported?

The measures were reported monthly to The Board via the Integrated Performance Report

Did we achieve our intended target?

All reports or case studies were published on the CUH website every month.

Our key achievements against this priority:

The target was met. In addition, the section of the CUH website where the reports are published Let Us Know Your Views was reorganised to improve the presentation, and the area of the website Acting on Feedback is clearly visible so that website users can easily navigate to the reports and case studies at cuh.nhs.uk/contact-us/let-us-know-your-views/acting-on-feedback

Staff Experience/Well-led

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

What did we measure?	Our target	How did we do?	
		2021/22	2022/23
I feel secure about raising concerns regarding unsafe clinical practice within the organisation.	78%	76%	71%
Vacancy rate for band 5 nurses *The Trust has made an amendment to this metric. Previously 'Retention of band 5 nurses'. The Vacancy Rate figure is considered to be more stable and a better indicator of the availability of suitably qualified staff.*	5%	Q4 11.74%	Q1 = 7.04% Q2 = 7.38% Q3 = 8.43% Q4 = 9.40%

Why was this a priority?

The measure reflects staff perception of the organisation including Just Culture and specifically that staff feel psychological safe enough to raise patient safety concerns.

This also reflects the level of staffing impacting directly on service safety and quality.

What was our target?

The target for the measure "I feel secure about raising concerns regarding unsafe clinical practice within the organisation'' was increased to 78%, which was not achieved, and a decrease in this score is an area of concern.

A 5% vacancy rate for band 5 nursing is a long term target for CUH.

How did we measure and monitor our performance?

Our performance is measured through staff survey responses on an annual basis and the band 5 vacancy rate is measured monthly. Safe staffing levels are monitored on a shift by shift basis through the three times a day site safety meeting. This meeting enables concerns regarding safety to be raised in real time and a mitigation to be put in place to maintain safety and quality such as the redeployment of staff from one clinical area to another or through the allocation of bank operational staff.

How and where was progress reported?

The staff survey results are shared at divisional boards and corporate directorates and included in the CUH's Integrated Reporting process. Band 5 vacancy rates are reported to Divisional Boards, the Quality Committee and Trust Board on a monthly basis. Incidents related to staffing are reported to Management Executive on a weekly basis and board on a monthly basis.

Did we achieve our intended target?

The target of 78% was not met in relation to raising concerns regarding unsafe clinical practice.

The nurse recruitment and retention position is recovering since the pandemic however there are have been budget increases relating to ward configuration, clinical quality and acuity, and service increases increasing our demand for nurses. Instability with cost of living increases and high employment has continued to impact on retention. The Trust has funding to support international recruitment, pastoral support and maximises apprenticeship opportunities.

Our key achievements against this priority:

To support nurse retention, funding has been secured to enable pastoral and career support and retention has been identified as a workforce strategic priority, with a particular focus on our programme 'good work'. The Trust has internal targets for accommodation to support international nurses. An oversight group focusing on retention to understand how we can better retain staff at CUH is in place. A lead nurse for safer staffing is undertaking a project to consider if we can improve work/life balance through rostering in a different way.

Performance against indicators and performance thresholds

The Trust's performance against the required indicators (limited to those that were included in the Single Oversight Framework for 2019/20) is described below:

National targets – 2022/23 performance

Indicator for disclosure		Target 2022/23	CUH performance 2022/23
Referral To Treatment (RTT)	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	Apr – Mar 23 59%
A&E target	Maximum waiting time of four hours from arrival to admission/ transfer/ discharge	CUH suspended from reporting '4hr standard' whilst part of National pilot for new Access Standards during 2022/23. This standard is will be monitored again from May 2023 onwards.	
All cancers - 62-day wait for first treatment from:	Urgent GP referral for suspected cancer	85%	With reallocations Apr – Mar 23 70.6%
	NHS Cancer Screening Service referral	90%	With reallocations Apr – Mar 23 55.5%
Infection Prevention and Control	Clostridium difficile – variance from plan	≤110 cases (hospital onset and COHA: community onset healthcare associated)	April – Mar 23 129 cases in total (94 hospital + 35 COHA reported cases)
Summary Hospital-level Mortality Indicator (SHMI)	See Appendix A		
Diagnostic waiting times	Maximum 6-week wait for diagnostic procedures	1%	Apr – Mar 23 41.%
Patient Safety	Venous thromboembolism (VTE) risk assessment	See Appendix A	

Feedback on the quality report and quality account

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

Director for Corporate Affairs

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

Or email: cuh.trustsecretariat@nhs.net.

This document is also available on request in other languages, large print and audio format – please phone 01223 274648.

Annex 1: Statement by stakeholders

Governors' statement on the quality account 2022/23

The last three years have been incredibly challenging for the Trust on a number of fronts.

The opportunity for Governors to observe the Board sub-committees has provided first-hand insight into the discussions that support the Trust's quality, performance and workforce agendas is helpful and provides a degree of transparency to the decision making and operational challenges the Trust faces.

Through the Council of Governors, and the Governor – NED quarterly meetings, the governors are able to gain assurance from the Non-Executive Directors about the Trust's response to key challenges.

A number of areas have been of particular focus to governors over the last year, as follows:

It is important to highlight the impact that the periods of industrial action from members of the Royal College of Nursing and the British Medical Association has had during the last few months. To date, staff have worked diligently in order to ensure that the hospital was able to run safely and effectively. Through discussions at the Council of Governors, the Workforce and Education Committee and the Quality Committee, the Governors have been able to seek assurance around the decision making and prioritisation of risk in the lead up to industrial action.

Given that there appears to be limited progress so far in the pay negotiations across a portion of the workforce, the Council of Governors considers it essential for the Trust to have a plan of action to be able to manage a sustained period of industrial action that may go on well into 2023-24.

The results of the 2022 annual staff survey show a decline in the response rate for staff and some deterioration against a number of the key metrics. Recognising the decline across the national results as a whole, there were some worrying results locally within CUH. Of particular concern was the increase in the number of staff reporting instances of bullying and harassment and the experiences of our workforce from ethnic minority backgrounds and with disabilities. This has been a regular topic of discussion for governors following staff survey results over the last few years, and it is disappointing to see that efforts to improve the situation appear to be having limited impact.

We hope to see the Trust take on board the views raised by staff through the survey, and will seek assurances that the Workforce and Education Committee are monitoring the implementation of the action plan. Additionally, we will continue to seek the views of our staff governors to ensure that the work being implemented strategically is resonating with staff members. It is clear that the high the cost of living in Cambridge continues to be a factor that impacts on our ability to effectively recruit and retain staff across the hospital.

Performance and Quality Metrics

Throughout 2022-23 there has been focus on monitoring key performance metrics. Of particular note was the Trust's performance in ambulance handover times, which from January 2023 onward have been among the best in the region. Throughout 2023-24 we are hoping to see improvements against the key metrics outlined in this document and progress in implementing the use of technology through the virtual wards to help manage the capacity constraints. However, governors continue to seek assurance that patient flow is managed as well as possible, and are concerned that early discharges continue to miss the target set.

As the Trust returns to reporting on the 4 hour target in 2023-24, it will be imperative to ensure that the Trust is able to adhere to the national performance target. Given that the Trust had been part of a national pilot to move away from a time based target, the Council of Governors are keen to be assured that the Trust is able to deliver high quality care, whilst ensuring that patients are seen in a timely manner.

There are also concerns around the management of PALS and Complaints cases. Over the past few years there has been a steady increase in the number of open cases. Through the various mechanisms available, the Council of Governors will continue to seek assurance that the experience of patients within CUH is a positive one and that the learning from complaints is captured and embedded.

Neil Stutchbury, Lead Governor CUH FT
30th May 2023

Cambridgeshire & Peterborough Integrated Care Board (ICB) statement for inclusion in the 2022/23 quality account

Cambridgeshire and Peterborough Integrated Care Board (the ICB) has reviewed the Quality Account produced by Cambridge University Hospital Foundation Trust (CUHFT) for 2022/23.

CUHFT are commended for an excellent quality account report. The accounts demonstrate that CUHFT have a depth of understanding in relation to their risks, areas for improvement and have a plan to focus on next year. Their culture for staffing, leadership and improving care is evident throughout the report.

CUHFT continued to have challenges during 2022/23 with activity levels in both emergency and planned care remaining higher than average throughout the year. The focus of this year has been returning services to normal levels of activity as well as responding to fluctuations in covid levels.

There have been numerous achievements throughout the year. The Trust has achieved the faster diagnostic standard; achieved 100% of electives against plan and exceeded the total diagnostics against plan by 103%. The implementation of virtual wards has resulted in a positive impact on patient experience, hospital bed capacity and flow.

CUHFT has a good process in place for learning from deaths including a selection of deaths put forward for structured judgement reviews. They have also embedded learning from feedback with themes being utilised for improvement and introduction of the ward accreditation programme consolidates the nursing quality improvement framework. The development of a framework for fundamentals of care is in progress which shows a desire to keep patients safe.

There has clearly been extensive and impressive clinical audit activity across a wide range of services with 100% participation, as well as involvement in five national enquiries, and excellent outlines of the proposed responsive actions based on the findings of clinical audits.

During the year a new Head of Safeguarding was appointed. Safeguarding Children levels 1 and 2 training has being consistently above 90% with Safeguarding Adults level 1 training achieving 90% compliance in the final months of the year. However, there is no reference to compliance of safeguarding level 3 training for both children and adults, without this training there is a potential risk that staff might not be well equipped to deal with safeguarding concerns in order to safeguard or prevent further harm of children or adults at risk.

From a patient safety perspective, staffing challenges have resulted in the Trust not achieving their target of reporting and managing the serious incidents process from identification to action plan completion. Significant numbers of extensions to report deadline dates have been requested throughout the year. The Trust has continued with "Focus Fridays", their internal quality assurance visits across all departments and wards, which the ICB quality team have attended. Integrated Care Board led quality assurance visits were also conducted to provide external oversight and triangulation.

During the year, the Trust has commenced the preparation for implementation of the Patient Safety Incident Response Framework (PSIRF). They have regularly attended the community of practice and facilitated workshops to support the preparation work and are on track to transition to the new framework during 2023.

The Trust participated in the national pilot recording individual patient ED journey times rather than reporting against the 4-hour target. Cessation of the pilot is due in 2023 and the Trust will revert back to reporting the 4-hour target.

It will be good to see the Trust achieve the targets in relation to their Patient Safety Improvement Plan. Particularly continuing the progress with compliance against the falls key performance indicators relating to the completion of lying and standing blood pressure and the Sepsis Six Bundle.

The Trust are undertaking further work to ensure performance targets are met. There is potential risk of non-achievement of these targets as a result of the prolonged industrial action which may impact on Cancer Standards, Referral to Treatment thresholds, early and weekend discharge, all of which could impact on patient safety and quality. The ICB will continue to support the Trust to ensure these priorities are monitored and plans for improvement in place.

Staff satisfaction has also declined year on year which could potentially impact the Trust's ability to deliver the improvements, however the ICB note the Trust are undertaking significant work to support the health and wellbeing of their staff.

The ICB would like to thank all the staff at CUHFT for their continued efforts and high-quality care offered to patients.

Overall Cambridgeshire and Peterborough ICB agree the CUHFT Quality Account is a true representation of quality during 2022/23.

Carol Anderson
Chief Nurse
Cambridgeshire & Peterborough Integrated Care Board (ICB)

22nd May 2023

Cambridgeshire County Council Adults and Health Committee statement for inclusion in the 2022/23 quality account

The Adults and Health Committee received the draft Quality Account for Cambridge University Hospital NHS Foundation Trust (CUHFT) on 24th April 2023. A Task and Finish Group comprising the members appointed to the CUHFT Quarterly Liaison Group was established to consider the draft in the committee's scrutiny capacity and to respond within the required timeframe. Councillors were grateful for early sight of the report, although the inclusion of provisional or incomplete data did make analysis of performance over time difficult.

In is important to recognise the challenging context in which the Trust was operating during 2022/23. Staff faced a continuing backlog in referrals arising from the pandemic and additional winter pressures against a background of industrial action across multiple parts of the NHS. We fully acknowledge the real and cumulative impact this had on staff across the Trust and on the patients and families they were caring for.

The Committee was pleased to welcome the Trust's chief executive to a scrutiny session on 5th October 2022 to provide an update on issues and developments at CUHFT as at September 2022. Councillors raised a wide variety of issues reflecting their local knowledge and topics raised with them by residents, and this discussion is summarised in the minutes of the meeting (minute 133 refers). Waiting times and staff well-being were both highlighted by the Committee during that meeting as areas of concern. Data in relation to performance against national targets in 2022/23 was still being finalised in the draft report we received, but the provisional figures were significantly below national expectations in relation to the maximum 18 week wait from point of referral to treatment (RTT) and for referrals from NHS cancer screening services. We understand the complexity of factors behind these delays and welcome the focus on improving patient flow given the high importance which the public attaches to waiting times. We would also advocate a focus on 'waiting well,' given that waiting times are likely to be longer than we would all wish for some time to come. We welcome the collaboration between Adult Social Care and CUHFT to co-ordinate the safe and timely discharge patients. This includes referrals to Adult Social Care for longer term care and support being triaged, assessed and sent to our Brokerage team within 4 hours of receiving the referral. Brokerage have also been successful in discharging people home with care and support within 24 hours and to care homes within 48 hours.

Information shared informally about support now being provided to staff is encouraging, but staff survey reporting of experiences of harassment, bullying and abuse make clear that there is still much to be done. Staff are the Trust's most valuable asset, including those recruited locally, from the national talent pool and from overseas. We welcome the recognition of the importance of staff retention, and would encourage the inclusion of qualitative data around staff morale in future reports. Figures and narrative around the number of staff raising concerns with the Freedom to Speak Up service were not available in the draft we received, but we hope to see this included in the published report. We would also welcome the inclusion of the results of the friends and family test and information about the Patient Advice and Liaison Service (PALS).

Addressing health inequalities is a key priority for all parts of the health service and its partners, including local government. In recognition of the importance of preventative measures in the new integrated care approach we feel there is an opportunity for Addenbrookes to be a champion for active travel for its workforce. We would encourage liaison on this and on the Trust's wider work to address health inequalities with the Director of Public Health. We also

look forward to seeing quantified and qualitative outcomes of the strategic review of equality, diversity and inclusion planned for 2023, and would encourage an active relationship with the Public Health team on this. Looking ahead, the Committee would welcome more information in future reporting around the role of preventative services in improving individual and community health and quality of life and easing the demand for acute care.

The Adults and Health Committee considered a report from the ICS on Virtual Wards at its meeting on 9 March 2023, and notes with interest that this has released around 460 bed days for CUHFT since October 2022. However, we did express some concern about the potential impact on carers and family members, particularly where the interests of the patient and carer diverged. We also felt there could be implications for the identification of potential safeguarding issues and felt it was important to give proper weight to these considerations. A summary of the discussion is available in the minutes of the meeting on 9 March 2023 (minute 170 refers).
It was striking to note from the Quality Account that at any one time an average of one in four hospital beds is occupied by a patient with dementia. It will be important to put systems in place to recognise the needs of those who require hospital care but may not be able to advocate this for themselves.
The Adults and Health Committee welcomes the willingness of the Trust's chief executive and senior leadership team to engage with the health scrutiny process through both formal public meetings and informal contacts. We look forward to maintaining this constructive relationship during the coming year and beyond.

Richenda Greenhill
Democratic Services Officer
Cambridgeshire County Council's Adults and Health Committee

22nd May 2023

Healthwatch Cambridgeshire and Peterborough statement for inclusion in the 2022/23 quality account

No statement received by the Trust.

Annex 2: Statement of directors' responsibilities for the quality report

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

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

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

- the content of the Quality report meets the requirements set out in *supporting guidance "Detailed requirements for quality reports 2020".*
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2022 to March 2023
    - papers relating to quality reported to the board over the period April 2022 to March 2023
    - feedback from commissioners dated 22nd of May 2023
    - feedback from governors 30th May 2023
    - feedback from the local Healthwatch organisation - Not received
    - feedback from overview and scrutiny committee (Management Executive) dated 01st of June 2023
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, (pending publication).
    - the 2020/21 national patient survey (latest published – National inpatient survey) dated Dec 2022
    - the 2021/22 national staff survey March 2023
    - CQC inspection report dated 24th of June 2022
- the quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- the performance information reported in the Quality report is reliable and accurate.
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice.
- the data underpinning the measures of performance reported in the Quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the Quality report.
- The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality report.

Appendix A: National Quality Indicators – 2022/23 performance

Ref	Indicator	CUH performance 2019/20	CUH performance 2020/21	CUH performance 2021/22	National average	Best performer among trusts	Worst performer among trusts	Trust statement
12	(a) The value and banding of the summary hospital-level mortality indicator ('SHMI') for the Trust for the reporting period; and	SHMI by provider (all non-specialist acute providers) for all admissions in Nov 2019 to Oct 2020 – 0.8842/ 88.42 Band: 3	SHMI by provider (all non-specialist acute providers) for all admissions in Nov 2020 to Oct 2021 – 0.9368/ 93.68 Band: 2* *(Values for are based on incomplete data and should therefore be interpreted with caution)	SHMI by provider (all non-specialist acute providers) for all admissions in Nov 2021 to Oct 2022 – 0.9695/ 96.95 Band: 2 (published 9 March 2023)	Reported by NHS Digital			CUH considers that this data is as described for the following reasons: ○ The Trust has a robust process for clinical coding and review of mortality data so is confident that the data is accurate. See further notes below* CUH intends to continue /has taken the following actions to improve this indicator, and so the quality of its services, by: ○ The Trust outlined last year that the SHMI is not designed for covid-19 pandemic data (which is excluded) and the statistical modelling used to calculate the SHMI may not be as robust if such activity were included. Activity that is being coded as COVID-19, and therefore excluded, is monitored in the contextual indicator 'Percentage of provider spells with COVID-19 coding' which is part of the NHS Digital publication.
	*CUH is engaged in a pilot study to submit Same Day Emergency Care (SDEC) data to the Emergency Care Data Set (ECDS), rather than the Admitted Patient Care Dataset (APC). As SHMI is calculated using APC data, this has a potential impact on SHMI values. Trusts with SDEC activity removed from the SHMI have generally seen an increase in the SHMI value. This is due to the observed number of deaths remaining approximately the same, as the mortality rate for this cohort is very low, and secondly, the expected number of deaths decreased because a							

Ref	Indicator	CUH performance 2019/20	CUH performance 2020/21	CUH performance 2021/22	National average	Best performer among trusts	Worst performer among trusts	Trust statement
	large number of spells are removed (all of which would have had a small risk of mortality contributing to the expected number of deaths). Work is ongoing to understand the recording of SDEC activity and the impact.							
	(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.	01 Dec 19-30 Nov 20 44%	01 Dec 20 – 30 Nov 21 45%	01 Dec 21-30 Nov 22 45%	Reported by NHS Digital			CUH intends to continue with the following actions to improve this indicator, and so the quality of its services , by: ○ The Trust will continue working to improve the accuracy of clinical documentation and in turn clinical coding, so that we continue to learn and improve our services. ○ Use of newly established internal mortality dashboards to provide early warning of changes, monitor trends and do deep dives by Diagnosis Group ○ EPR documentation highlighting Palliative Care team input continues to be monitored and used to inform Palliative care clinical coding as per locally agreed Policy.
18	During the reporting period, the Trust's patient reported		For hip and knee replacement surgery the Trusts usually reports on the **Adjusted Average Health gain score**, which is in the CUH performance column, however this does not have details of the highest and lowest performers readily available, so has also included the **adjusted health gain** score to enable a comparison, although **these are not the figures normally published.**					

Ref	Indicator	CUH performance 2019/20	CUH performance 2020/21	CUH performance 2021/22	National average	Best performer among trusts	Worst performer among trusts	Trust statement
	outcome measures scores for:		PROMs data was collected on varicose vein and groin hernia procedures in England, however following on from the NHS England Consultation on PROMs, collection of these procedures ceased on 1 October 2017. Historical data will be unaffected. **National Best and Worst performer data is not available for these PROMs.*					
	(i) groin hernia surgery	-	-		0.089 (to Sep.17)	*	*	Not measured - collection of data on this procedure ceased on 1 October 2017 (see comments above).
	(ii) varicose vein surgery				-8.45 (to Sep.17)	*	*	Not measured - collection of data on this procedure ceased on 1 October 2017 (see comments above).
	(iii) hip replacement surgery and	22.845 (April 19- March 20 data - published Feb 21 - Primary) 23.176 (Total)	No data available *Case mix-adjusted figures not calculated where there are fewer than 30 modelled records.*	Not published in 2022/2023	Not published in 2022/2023	Not published in 2022/2023	Not published in 2022/2023	○ N/A
	(iv) knee replacement surgery	16.519 (April 19- March 20 data - published Feb 21) 16.520 (Total)	No data available *Case mix-adjusted figures not calculated where there are fewer than 30 modelled records.*	Not published in 2022/2023	Not published in 2022/2023	Not published in 2022/2023	Not published in 2022/2023	○ N/A

Ref	Indicator	CUH performance 2019/20	CUH performance 2020/21	CUH performance 2021/22	National average	Best performer among trusts	Worst performer among trusts	Trust statement
19	The percentage of patients aged:		re-admitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.					NHS Digital has not published an update of this data since 2012; therefore we have not included this data in our 2020/21 Quality Account. The data provided is local data reflecting 30 day readmissions (the national standard has not been 28 days for some time).
	(i) 0 to 15 and	6.5%	6.4% (Apr 21-Mar 22		Comparison not provided nationally			
	(ii) 16 or over	14.8%	13.2% (Apr 21-Mar 22)					
20	The Trust's responsive - ness to the personal needs of its patients during the reporting period.	70.8% *(Hospital stay: 01/07/2019 to 31/07/2019; Survey collected 01/08/2019 to 31/01/2020*	77.5% *(Hospital stay: 01/11/2020 to 30/11/2020; Survey collected 01/01/2021 to 31/05/2021*)	No Data available	No Data available	No Data available	No Data available	CUH considers that this data is as described for the following reasons: Supported by Inpatient Survey ***Note: As of the 2020-21 survey, changes have been made to the wording of the 5 questions, as well as the corresponding scoring regime, which underpin the indicator. As a result, 2020-21 results are not comparable with those of previous years.***
21	The percentage of staff employed by, or under contract to, the Trust during the reporting period who	85.7%	81%	74.6%	61.9%	86.4%	39.2%	CUH considers that this data is as described for the following reasons: ○ CUH performed in the top 15 best performing non specialist trusts against this statement. ○ This is above the national average.

Ref	Indicator	CUH performance 2019/20	CUH performance 2020/21	CUH performance 2021/22	National average	Best performer among trusts	Worst performer among trusts	Trust statement
	would recommend the Trust as a provider of care to their family or friends.							CUH intends to continue with the following actions to improve this indicator, and so the quality of its services, by: ○ Maintaining the focus on quality and safety, and the implementation of the Trust organisational development programme, which is intended to positively impact on staff engagement, inclusion, culture, leadership and staff wellbeing.
23	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	Q1: 94.9% Q2: 95.0% Q3: 95.5% Q4: 93.1%	Q1: 94.0% Q2: 93.9% Q3: 93.2% Q4: 93.6% (Internal Data)	Q1: 95.1% Q2: 95.4% Q3: 95.5% Q4: 95.4% (Internal Data, >age 16)	The National VTE data collection and publication is suspended.	N/A	N/A	CUH considers that this data is as described for the following reasons: ○ The Trust has a carried out a deep dive of the VTE risk assessment data algorithms in 2022-2023. CUH intends to take the following actions to improve this percentage, and so the quality of its services: ○ The Trust will continue working to improve the accuracy and depth of coding ○ The Trust VTE group will continue to monitor VTE risk assessment across the Trust

Ref	Indicator	CUH performance 2019/20	CUH performance 2020/21	CUH performance 2021/22	National average	Best performer among trusts	Worst performer among trusts	Trust statement
								and identify areas where improvement is required.
24	The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	21.9 (April 19 – March 20) Total number of CDT was 73 in 2019/20	16.5 (April 20 – March 21) Total number of CDT was 47 in 2020/21	Available at gov.uk	Not available	Available at gov.uk	Available at gov.uk	CUH considers that this data is as described for the following reasons: Coding for C.Difficile hospital onset cases is reliable within CUH.
25	The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient	Number incidents reported: 8,684 Rate of reporting: 52.76 Rate resulted in severe harm or death: 0.22 (37 incidents) based on NRLS data Oct	Number incidents reported: 17,057 Rate of reporting: 60 Rate resulted in severe harm or death: 0.47% (80 incidents) based on NRLS data Apr	Number incidents reported:19,430 Rate of reporting(per1000 bed days):45 Rate resulted in severe harm or death: 0.65 (126 incidents	Not available	Available at NHS Digital	Available at NHS Digital	CUH considers that this data is as described for the following reasons: ○ The reporting of patient safety incidents is within normal variance. There is a statistically significant decrease in the number of reported incidents graded as severe harm and death in the last 7 months (Sept 22- March 23). For all incidents graded moderate harm, severe harm, or death/catastrophic there is normal variance; however the trust has been above the internal threshold of 2% for

Ref	Indicator	CUH performance 2019/20	CUH performance 2020/21	CUH performance 2021/22	National average	Best performer among trusts	Worst performer among trusts	Trust statement
	safety incidents that resulted in severe harm or death. NHS England » Monthly data on patient safety incident reports	19 to March 2020	20 to March 2021	based on NRLS data Apr 22 to Mar 2023				the last 8 months (Aug 22-Mar 23) CUH intends to continue with the following actions to improve this indicator, and so the quality of its services , by: ○ CUH continues to ensure that incident reporting within the organisation is a central part of the culture of safety. Organisational teams are encouraged to report incidents that cause harm and near misses to ensure the ability of risk assessment and learning.

Appendix B: HQIP National Clinical Audits

Audit Title
Breast and Cosmetic Implant Registry (BCIR)
British Thoracic Society (BTS): Adult Respiratory Support Audit
Case Mix Programme (CMP) – Intensive Care National Audit and Research Centre - *(ICNARC)*
Cleft Registry and Audit Network Database (CRANE)
Elective surgery (National Patient Reported Outcomes Measures Programme (PROMS).
Epilepsy 12 - The national clinical audit of health care for children and young people with suspected epileptic seizures
Falls and Fragility Fractures Audit Programme (FFFAP): Fracture Liaison Service Database
Falls and Fragility Fractures Audit Programme (FFFAP): National Audit of Inpatient Falls
Falls and Fragility Fractures Audit Programme (FFFAP): National Hip Fracture Database
Gastro-intestinal Cancer Audit Programme: National Bowel Cancer Audit (NBOCAP)
Gastro-intestinal Cancer Audit Programme: National Oesophago-gastric Cancer (NOGCA)
LeDeR - learning from lives and deaths of people with a learning disability and autistic people (previously known as Learning Disability Mortality Review Programme)
National Adult Diabetes Audit (NDA): National Diabetes Core Audit (NDCA)
National Adult Diabetes Audit (NDA): National Diabetes Foot care Audit (NDFA)
National Adult Diabetes Audit (NDA): National Diabetes Inpatient Safety Audit (NDISA)
National Adult Diabetes Audit (NDA): National Pregnancy in Diabetes Adult (NPID)
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Paediatric Asthma Secondary Care
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) – Adult Asthma Secondary Care
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) – Chronic Obstructive Pulmonary Disease (COPD) Secondary Care
National Audit of Breast Cancer in Older People (NABCOP)
National Audit of Cardiac Rehabilitation (NACR)
National Audit of Care at the End of Life (NACEL)
National Audit of Dementia (NAD)
National Cardiac Arrest Audit (NCAA) – Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK
National Cardiac Audit Programme (NCAP) - managed by the National Institute for Cardiovascular Outcomes Research (NICOR): Myocardial Ischaemia National Audit Project (MINAP)
National Cardiac Audit Programme (NCAP) - managed by the National Institute for Cardiovascular Outcomes Research (NICOR): National Audit of Cardiac Rhythm Management (NACRM)
National Cardiac Audit Programme (NCAP) - managed by the National Institute for Cardiovascular Outcomes Research (NICOR): National Audit of Percutaneous Coronary Interventions (NAPCI)

Audit Title
National Cardiac Audit Programme (NCAP) - managed by the National Institute for Cardiovascular Outcomes Research (NICOR): National Heart Failure Audit (NHFA)
National Child Mortality Database (NCMD)
National Early Inflammatory Arthritis Audit (NEIAA)
National Emergency Laparotomy Audit (NELA)
National Joint Registry (NJR)
National Lung cancer (NLCA)
National Maternity and Perinatal Audit (NMPA)
National Neonatal Audit Programme – Neonatal Intensive and Special Care (NNAP)
National Ophthalmology Audit Database (NOD)
National Paediatric Diabetes Audit (NPDA)
National Perinatal Mortality Review Tool (NPEU)
National Prostate Cancer Audit (NPCA)
National Vascular Registry (NVR)
Neurosurgery National Audit Programme (NNAP)
Out-of-Hospital Cardiac Arrest Outcomes: Cardiac Arrest Outcomes Data for patients who attend hospital with a Return of spontaneous circulation (ROSC)
Paediatric Intensive Care (PICANet)
Perioperative Quality Improvement Programme (PQIP)
Renal Audits: National Acute Kidney Injury Audit
Renal Audits: UK Renal Registry Chronic Kidney Disease Audit
Royal College of Emergency Medicine (RCEM) Cycle Consultant Sign off
Royal College of Emergency Medicine (RCEM) Infection Prevention and Control
Royal College of Emergency Medicine (RCEM) Pain in children (care in emergency departments)
Sentinel Stroke National Audit Programme (SSNAP)
The British Association of Urological Surgeons (BAUS): Muscle Invasive Bladder Cancer Audit
Trauma Audit and Research Network (TARN)
UK Cystic Fibrosis Registry
UK Parkinson's Audit

Appendix C: Local audits

Please note that in the below examples of local audit carried out, the learning and recommendations to improve practice and outcomes.
The standard has been abbreviated to std (i.e. std 1) and project registration number has been abbreviated to PRN.

Title	Outcome
HQIP National Early Inflammatory Arthritis Audit (NEIAA) 2021/22 (Formerly NCAREIA) PRN9618	**Key learning from this audit showed:** CUH engage with BSR who run HQIP nationally to understand our data better on a rolling fashion, and thus review performance regularly rather than once a year at report publishing. By making it a standing agenda item at clinical governance, we ensure it remains a priority for iterative review and performance improvement. Current provisional data indicates CUH are no longer an outlier for QS2 (i.e. the proportion of patients with suspected synovitis assessed with a rheumatology service within 3 weeks) for the period April 1st and October 2022, provided by the BSR NEIAA Quarterly report. Currently the statistic provided them for QS2 is 68.4% which meets our action plan target (of the national average of 42%), but this is subject to change across a while year for which the audit cycle runs for (April 2022- April 2023) rather than periods within the whole year. Outlier for proportion of patients with suspected synovitis assessed within a rheumatology service within 3 weeks, (01/4/21 - 31/3/22 year 4); - 14%. **Actions:** 1. Improve ring-fencing of existing early inflammatory arthritis codes. 2. Improve triage. 3. Improve clinical availability. 4. Review performance. **Implementation of Actions:** 1. Better ring-fencing of existing early inflammatory arthritis code from other urgent referrals not related to EIA. 2. Improved triage: improved the quality of referrals from GPs by amending the referral template to include a mandatory free text section describing the clinical presentation. 3. There is now improved clinical availability (new patient EIA) as Covid restrictions have lifted on appointments. 4. Performance is continually reviewed at quarterly clinical governance meeting.
Rolling audit of intrapartum foetal monitoring PRN6771	**Key learning from this audit showed:** Standards were drawn from the Trust guidance which is based on NICE 'Intrapartum Care: care of healthy women and their babies during childbirth. Three standards improved compared to the previous audit, All other standards have either remained at the same level of compliance or declined, showing limited improvements. Educational input will be beneficial for intermittent and continuous fetal monitoring to raise awareness of the standards required. **Actions identified:** 1. Updates to training content 2. Epic change request and build for hourly assessment of foetal monitoring.

Title	Outcome
	Implementation of Actions: **Work continues under the maternity improvement programme to improve numbers of trained staff.** 1. A champion education roadshow on monitoring was undertaken. 2. Hourly assessment of foetal monitoring build completed, and is live on EPIC, with staff training ongoing.
Cerebrospinal fluid (CSF) drainage system monitoring of best practice guidelines PRN9389	**Key learning from this audit showed:** Overall, the results show that the standards of care are adhered to and documentation maintained appropriately. Drainage bag fill volumes were recorded at not more than 75% fill volume in 35 care episodes. In the remaining 15 episodes, bags were not changed at the fill volume limit as patients were either in the process of transfer to theatre for shunt insertion (hence bags clamped closed) or clamped closed prior to removal. This is a change in practice, implemented following the 2015 audit. The wound management guideline was updated in April 2022 to reflect changes in best practice. **Actions:** Ensure each nurse receives education on CSF Drainage Management as part of their induction within the first month of clinical placement; and completes a CSF competency pack. Further training is incorporated into the annual neurosciences mandatory refresher. All new medical staff are trained during their induction by relevant medical team. (Included on Supernumerary programme for new registrants within neuroscience) Mandatory training on Management of EVD to all new to neuroscience qualified nursing and medical staff induction training respectively via the Neuro Foundation Course. Continuously delivered twice yearly.
An audit of the ward based management of non-traumatic subarachnoid haemorrhage (SAH) PRN9785	**Key learning from this audit showed:** • Commencing dalteparin following aneurysm definitive treatment. • Prompt prescribing of nimodipine on admission. • Blood tests taken within 24 hours of admission. • Prescribing of antiplatelet agents following endovascular coiling. • Venous thromboembolism (VTE) assessment on admission requires completion. • Blood glucose needs to be checked on admission. • Daily urea & electrolytes (U&E's) to be collected beyond the first day of admission. • Volume status assessment must be completed. **Actions:** Education for medical and nursing staff involved in caring for non-traumatic SAH patients will take place, with the following format: • A teaching session on the ward-based management of SAH is delivered to the junior doctors in neurosurgery, to consolidate their knowledge and explain the practical aspects of implementing the treatment policy. • A visual aid in the form of a brief poster is created for ward areas, to serve as a prompt and reminder for the nursing staff on specific tasks to complete for this patient group. **Implementation of Actions:** Visual aids (posters) with key reminders have been generated and distributed.
New-born Hearing Screening Key	**Key learning from this audit showed:** We achieved 100% compliance.

Title	Outcome
performance indicators (KPI) NH2 PRN9791	Future plans for Auditory Brainstem Response (ABR) testing onsite at Addenbrooke's to be carried out in the newly-renovated room in the Emmeline Centre is now on hold, as the room is still not electrically isolated. The interim plan was to move back to Fulbourn Health Centre for ABRs from June 2022. Also, referral numbers from NHSP were relatively low for this quarter, which is likely to have made the targets easier to achieve in this instance. **Actions:** We recommended that the report was circulated to the key local NHSP Stakeholders to make them aware that KPI NH2 was met for this quarter. We also recommend that KPI NH2 continues to be monitored on a quarterly basis so that any actions required can be implemented as soon as possible. Dissemination of final report and key learning points This report is circulated to Key NHSP Stake holders via email.
To assess the rates of utilization of the HEEADSSS (mental health) assessment for children and young people presenting to Addenbrooke's Emergency Department (ED). PRN9822	**Key learning from this audit showed:** A significant improvement in psychosocial assessment usage in ED: almost 10-fold increase. All but one children presenting with a mental health issue had a psychosocial assessment completed and documented clearly. An aspirational standard that every child obtains a psychosocial assessment was not met. However, given how busy clinicians are this is unlikely to be met and it is only an aspirational RCEM standard. Psychosocial assessment rates in Addenbrooke's Emergency Department are now above national psychosocial assessment rates. **Actions:** Ongoing teaching sessions to improve psychosocial assessment rates further and repeat audit in 2 years. **Implementation of Actions:** Ongoing teaching of both ED and Paediatric doctors as they rotate has commenced and a re-audit is planned for 2024.
ToRcH-UK Audit comparing outcomes of decompensated liver patients managed with or without the admission liver care bundle across the country. PRN9888	**Key learning from this audit showed:** This is a large-scale multi-centre study with data submitted from all NHS regions with multiple data points encompassing patient care across each admission. Admissions are predominately for patients with established diagnoses of preventable liver disease. It is vital that focus is placed on preventing liver disease and its complications via public health strategies targeting alcohol and obesity combined with effective early detection programs. This is an important key message. We demonstrate that variables which determine inpatient mortality for patients with decompensated cirrhosis are relatively fixed at time of admission to hospital. Again, highlighting the importance of early intervention of decompensated events even from primary care. Whilst there have been some improvements in inpatient care since the first Lancet Commission report, this has not correlated with increased inpatient survival. Lower Consultant Gastroenterologist/Hepatologist numbers at non-specialist centres are associated with increased mortality. **Actions:** In conclusion, we demonstrate that variables which determine inpatient mortality for patients with decompensated cirrhosis are relatively fixed at time of admission to hospital. Whilst there have been some improvements in inpatient care since the first

Title	Outcome
	Lancet Commission report, this has not correlated with increased inpatient survival. 3 Lower Consultant Gastroenterologist/Hepatologist numbers at non-specialist centres are associated with increased mortality. Developing the workforce to support this cohort in the inpatient and outpatient environment is imperative. Admissions are predominately for patients with established diagnoses of preventable liver disease. It is vital that focus is placed on preventing liver disease and its complications via public health strategies targeting alcohol and obesity combined with effective early detection programs. This approach will likely have greater impact on UK morbidity and mortality from decompensated cirrhosis than specific inpatient interventions. **Implementation of Actions:** ToRcH -UK (Trainee Collaborative for Research and Audit in Hepatology UK) is a committee made of registrars from hepatology and gastroenterology specialty with the view to address questions related to liver disease and improve outcomes of patients with liver disease. For that purpose, the first project was set to look at the care that patients with decompensated liver disease received during their admission in the hospital.
Grid or No Grid? Horizontal Beam Lateral (HBL) Hip Imaging PRN9907	**Key learning from this audit showed:** 94% of patients under 90kg attending for HBL hip imaging in the Inpatients X-ray department were imaged using a no grid technique. Data indicates a reduction in radiation dose for HBL hip imaging of patients under 90kg in the Inpatients X-ray department since the initial audit. 14% of radiographs were excluded at the first stage of analysis for unacceptable artefact and incomplete anatomical field of view. 2.3% of radiographs were deemed unacceptable at the second stage of analysis due to under exposure. **Actions:** Continue to use air gap technique for HBL hip imaging of patients under 90kg, exceptions at radiographer discretion. Relay learning points/improvements to radiographers regarding unacceptable artefact and incomplete anatomical field of view. **Implementation of Actions:** 1. Continue to use air gap technique for HBL hip imaging of patients under 90kg, exceptions at radiographer discretion was relayed to the inpatients x-ray department. The team disseminated the report via email and team meetings. This also included a poster sharing improvements and learning points.
Assessing the Quality of Paediatric Vancomycin Prescribing and Monitoring PRN9922	**Key learning from this audit showed:** • Excellent performance on prescribing frequency, creatinine monitoring, and appropriate dose/frequency adjustments being made. • Improvement on correct first dose prescribing compared to first cycle audit. • Still room for improvement for correct first dose prescribing. • Lower rates of therapeutic drug levels than in previous cycle, despite better prescribing and monitoring. • Poor urine analysis rates. **Actions:** 1. Dissemination of findings and discussion with paediatric gastroenterology, microbiology and pharmacy in a weekly teaching slot.

Title	Outcome
	2. Ensure new starters/prescribers are familiar with Prescribing Monographs and advise them to use this over the BNFc. 3. Recirculate Vancomycin Prescribing Monograph at 6 monthly intervals. 4. Discuss review of the Vancomycin Prescribing Monograph within presentation – may require higher doses to achieve better therapeutic levels, improve efficacy and reduce resistance. **Implementation of Actions:** 1. Ensure new starters/prescribers are familiar with Prescribing Monographs and advise them to use this over the BNFc. 2. Recirculate Vancomycin Prescribing Monograph at 6 monthly intervals. 3. Potential review of the Vancomycin Prescribing Monograph – may require higher doses to achieve better therapeutic levels, improve efficacy and reduce resistance.
Audit of treatment targets and de-escalation in the management of diabetes in older people PRN9986	**Key learning from this audit showed:** • General agreement and enthusiasm for appropriate de-escalation of diabetes management in frail elderly patients. • Clear evidence based and consensus based guidelines published to guide appropriate target setting. • Challenges in consistent recording of frailty scores and target HbA1c • Challenge to appropriately escalate and deescalate treatment in hospital, which does not reflect oral intake or activity or function at home. **Actions**: • Documentation of frailty scores by parent teams but also by DOT educators/doctors in review. • Documentation of target HbA1c based on frailty when reviewing patients • Development of Epic smart-phrase (table of frailty scores with target HbA1c and de-escalation threshold) to make access to guidelines easy. • Ongoing discussion with DOT about how to optimise their review, conscious of limiting additional work for DOT and making notes as simple and accessible as possible. • Education to nurses on DME wards re: looming hypoglycaemia with encouragement that patients can be referred to DOT even when CBGs look "good", which might encourage appropriate de-escalation of Rx. • Ultimately, education for GPs/PNs to review HbA1c target and treatment in context of frailty. **Implementation of Actions:** 1. Documentation of frailty scores by parent teams. To be completed on consultant review and/or by EIT. 2. Consideration of frailty & HbA1c in DOT review. To be completed by Diabetes Outreach Team; in progress. 3. Development of Epic smart phrase (table of frailty scores with target HbA1c and de-escalation thresholds). In progress.
The examination and management of paediatric ophthalmology patients in Optometrist led clinics	**Key learning from this audit showed:** The current service evaluation has highlighted that optometrists are currently able to assess a wide range of paediatric ophthalmology patients within their clinic. Optometrists working within these clinics are carrying out a range of different types of refraction suggesting the optometrists are flexible in carrying out the most suitable refraction type for the individual patients. Optometrists were found to prescribe the full spectacle prescription in 109 (95.6%) of patients who were given a

Title	Outcome
PRN10000	prescription. This indicates optometrists at CUH are already following similar practice in prescribing the full prescription where possible. During this audit period 87 patients (77.7% of the follow up patients) had not had a refraction or a fundus check in the last 12 months. This indicates many patients are having regular enough follow up appointments. 37 patients (24%) did not have a fundus check as part of their optometrist clinic appointment and had not had a fundus check for at least 12 months. This shows an inconsistency in how frequently the fundus is being checked in these clinics. There is a variation between time frames for follow up appointments ordered. **Actions:** 1. A clinical guideline for the management and assessment of patients in the paediatric optometry clinics was implemented to encourage consistency and maintain standards of care amongst different clinicians. This guideline included : • Guidance on the type of refraction to carry out. • When to perform a fundus check. • Spectacle prescribing recommendations. • Recommended follow up intervals. Additional clinical capacity needs to be generated in order to improve the number of patients receiving their refraction and fundus checks on time. This may include the development of cycloplegic only clinics and training appropriate non-optometric staff in cycloplegic refraction. Staffing levels have prevented adequate implementation of planned training. Re-audit will be undertaken in 2023 to assess implementation.
Paediatric Early Warning Score (PEWS) and Safety Huddle Audit and Recognition, escalation and management of deteriorating patient. PRN10047	**Key learning from this audit showed: Staff report a good awareness of the need to escalate concerns** • Staff report they are aware of the escalation process for deteriorating children, and 88.6% of staff state they have received training on PEWS. • Overall concern that there appears to be an overall drop in compliance and feel this is reflective of the need for a reinvigorated education programme for PEWS and deteriorating patients. **Implementation of Actions:** 1. Local policy guideline has been edited to reflect changes to bleep system and neurosurgical escalation process. (Approved in October 2022). 2. Message of the week has been rolled out for education updates and huddles for paediatric staff. 3. Online DOT module has been generated and added to the yearly updates for Paediatric nursing staff. Compliance will be monitored via DOT. 4. Safety huddle documentation has not been utilised effectively. This has been reworked to include information for matron board rounds/accreditation and NIC/HCA checklists. This has been trialled on wards and implemented form September 2022. Amendments are being taken through the deteriorating patient group for Paediatrics.
Testing for Lynch Syndrome (LS) in women with	**Key learning from this audit showed:** 86.5% of women with new endometrial cancer were tested for Lynch syndrome in accordance with NICE diagnostic guidance DG42. All women with abnormal

Title	Outcome
endometrial cancer PRN10081	immunohistochemistry were screened with hypermethylation testing. All pathology reports were clear on actions required. There remains room for improvements in coverage of Lynch syndrome testing in women with new endometrial cancer. Women's MMR status could be more consistently recorded in their notes. **Actions:** • The LS testing pathway is not currently deliverable with the current resources. • Despite high levels of engagement from healthcare professionals, and the introduction of Cancer MDT Lynch Leads, the LS testing pathway is still not delivering successfully, and unlikely to deliver without change. • Working with the GMSA, the Cancer Alliance and the National we propose to establish CUH as a regional multi-disciplinary hub for LS by focusing on key areas requiring improvement. • Additional funding will be required to improve the service. • A working group needs to be established. • A LS specific database should be developed, and overseen by an administrator. • EPIC changes need to be implemented to support appropriate documentation of LS status. **Implementation of Actions:** 1. The gynae staging form has been amended to reflect lynch syndrome status, action complete as of June 2022. 2. Prototype of LS database in development and in use as of September 2022.
Antenatal & New-born (ANNB) Annual Screening Audit PRN10092	**Key learning from this audit showed:** This audit has demonstrated that the antenatal and new-born screening programmes meet the majority of the standards at the acceptable threshold or better. (Although there was no cases to audit from the selected sample for ID2; ST4a/b; NH2). The avoidable repeat rate has been closely monitored this past year and was removed from the risk register due to an improved performance. The screening team are constantly seeking improvements to this standard and ensure this is discussed and training given at the midwives mandatory training update sessions. The avoidable repeat rate for the new-born bloodspot screening met the standard in this sample. **Implementation of Actions:** 1. Since the audit was undertaken; the trisomy screening form (blue form for combined/QUAD test) for the Fetal Anomaly Screening Programme is now being undertaken alongside the screening discussion at the booking appointment for the women who book local to Cambridge. This was an action from the programme board to ensure women are being offered an informed choice and to also ensure that women are aware of what they are opting to be screened for and that form is being filled in correctly with the woman and the midwife. 2. Regular monitoring since the audit was undertaken to prevent avoidable repeat rate has been at 1.3% for two consecutive quarters (October 2021- March 2022) reassuring; Added to Gap Analysis for 2022-23; audit planned, local governance aware.

Title	Outcome
Audit of Communication Aid Service East of England (CASEE) referrals between March 2016 and March 2021 to understand reasons why people were discharged without a final prescription of powered Augmentative and Alternative Communication (AAC) after being accepted at referral and whether these relate back to the standards acceptance criteria PRN10103	**Key learning from this audit showed:** ○ 14 additional reasons categorised to add to NHSE criteria reasons. ○ Some people found to not meet NHSE criteria after being accepted at triage. ○ Large proportion of people not prescribed final equipment due to being unwell or dying during the episode of care – however these people often had equipment. ○ Lack of paper-based AAC in place is biggest factor after illness. ○ Differences between reasons for discharging people without powered AAC depending on caseload type and diagnosis. **Actions in progress** • To have these 14 additional reasons plus 7 criteria reasons available at triage to provide support for asking for further information before accepting referrals. • To ask team members to use these 15 reasons to categorise reason for discharge. • To add into our training programmes for referrers. • To use this information to liaise with commissioners and local services with regard to alternative funding sources. • To deep dive into some cases with high numbers of reasons or with specific reason codes e.g. support, communication partner directed referral. • To explore by diagnosis further to help with advice to referrers and patients with certain diagnoses.
National sustainable respiratory care audit - British Thoracic Society (BTS) PRN10334	**Key learning from this audit showed:** A representative snapshot of inhaler usage in patients recently admitted to hospital during the COVID pandemic. • Despite the pandemic, two thirds of patients had had their inhaler technique checked within the last 12 months by a healthcare professional • 75% of patients would be willing to switch to an inhaler with a lower carbon-footprint. • 95% patients are prescribed an pMDI inhaler • 63% of patients prescribed pMDI inhalers do not know when their inhaler need replacing • Only 20% of patients were aware of how to recycle inhalers correctly **Implementation of Actions:** CUH are fully compliant with Cambridgeshire and Peterborough ICS Asthma and COPD pathways. The asthma pathway version includes a response to IIF and greener prescribing. The COPD pathway is older, and does not include this information and is expected to be updated in 2022/23. **Recommendations:** 1. Expansion of CUH formulary to include devices with a lower carbon footprint. 2. Patient education on the greenhouse gas emission of different types of inhaler. 3. Availability of devices to check inspiratory force and effectiveness of DPI technique. 4. Patient education on assessing the need for salbutamol PMDI replacement. 5. Patient education on recycling of inhalers.

Title	Outcome
	Proforma specific recommendations: 1. Questions regarding each type of inhaler should be expanded to include each individual inhaler used, e.g. different questions for salbutamol and combination pMDIs. 2. Questions regarding a preference on spacer cleaning are ambiguous. 3. A specific option for a clinically appropriate inhaler mismatch should be made available, e.g. the discontinuation of a LAMA when using an ipratropium nebuliser.
Documentation of tourniquet use in orthopaedic surgery - are we BOAST compliant? PRN10135	**Key learning from this audit showed:** • Creation and dissemination of the smart phrase increased awareness and improved compliance records against guidance. • Currently not meeting100% compliance – further intervention needed. • Collection of data has highlighted that contrary to guidance, in some cases, padding is not being used with the tourniquet. • In some cases, it appears there is no rationale for choice of tourniquet pressure and that in some cases tourniquet pressure used was higher than recommended by guidance. **Actions:** • We recommend that all surgeons operating with a tourniquet use the BOAST Tourniquet smart phrase in EPIC to ensure documentation is compliant with the new BOAST guidance. This was a significant factor contributing to improvement in documentation in the second cycle. • We recommend a poster in the orthopaedic offices reminding surgeons to use this smart phrase. **Implementation of Actions:** 1. The poster and results of the audit have been disseminated at the May 2022 divisional governance meeting. Based on discussions, a re-audit is due in July 2023. A junior doctor in the Orthopaedic team will undertake documentation of tourniquet use in surgery.
An Audit to Assess the Quality of Discharge Documentation and Information Transferred to Primary Care for Patients Discharged from CUH through the 'Fast Track' Pathway PRN10150	**Key learning from this audit showed:** • Evidence of prognosis communicated by discharge letter. • Excellent provision and safe prescribing of syringe pumps. • Change of GP on discharge, a barrier to verbal handover of patients – this is more critical in those patients who are in their last days of life. • Patient discharged with medication (anticipatory or in a syringe pump) without local documents to facilitate ongoing doses (note that District Nurses may administer against the discharge letter for up to 48 hours). **Recommendations** • Staff education regarding which patient cohort requires injectable anticipatory medicines on discharge and the process involved for each staff group. • With reduced numbers of patients being appropriately discharged with injectable anticipatory medicines (or syringe pumps), support to the community nursing staff (District Nurses and Nursing Home Nurses) should be provided. This may include provision of a community administration chart – reflecting the discharge letter and TTO medication supplied from CUH. • Pre-registration with new GP surgery before discharge to allow for handover of patient.

Title	Outcome
	Implementation of Actions: 1. A new Guideline completed and shared with End of Life Committee. Fed back to ICS partners. Not able to facilitate from a CUH Discharge Planning point of view – to remain as part of active review; given numbers of patients changing GP.
Clinical Audit on Critical Time Standards for Hyperacute Stroke Care - Measuring against 3 of the 4 National Targets PRN10200	**Key learning from this audit showed:** • Overall National Stroke Service Model standards generally met over the period studied. • Statistically significant improvements in door-to-1 std responder and door-to consultant time. Non-statistically significant improvements in door-to-CT scanner and door-to-thrombolysis time. • Door-to-CT scanner time still not reaching the National Stroke Service model ideal standard. • Door-to-thrombolysis time also not reaching National Stroke Service model ideal standard. • Delivery of thrombectomy service is key. 1. **Recommendations** Reduce the door-to-CT scanner time as a priority, to subsequently reduce the door-to-thrombolysis time. 2. Assess patient in the ambulance, get patient's consent, and transfer them straight to the CT scanner to reduce the time needed to obtain a bed in ED before getting to the CT scanner. 3. Instate a stroke-preferred CT scanner + In essence, a CT scanner for general use until a stroke alert comes in, in which case the CT scanner opens for stroke and only stroke until the patient is cleared. 4. Remove CT (P). 5. Thrombolysis directly after CT head, after which CT (A). 6. Expand and improve thrombectomy service, next phase of a regional mechanical thrombectomy service for patients presenting with acute ischaemic stroke to Trusts across the East of England in progress. **Implementation of Actions:** The results of audit and recommendations have been presented to stroke department, the final details of the action plan is in place generated from recommendations which has informed the action plan.
Opiate Safety Audit PRN10252	**Key learning from this audit showed:** This audit was a re-audit assessing the safety of high dose opioid prescribing at CUH; additional standards were included. Stds 1-9 & 11-12 all achieved 100% compliance. 1. No patients were commenced on non-formulary medication while in hospital. 2. No opioid naïve patients were commenced on fentanyl patches, this is an improvement from the previous audit, indicating that the measures put in place after the last audit have been successful. 3. No patients on high strength opioids were administered naloxone, indicating that the patients were not on unsafe doses of opioids. 4. Comparing the results of this audit with the previous in the general population there was an increase in the prescribing of morphine first line as well as adhering to the oxycodone policy when prescribing oxycodone. Additionally, there was an increase in the correct calculation of the breakthrough dose in the general population.

Title	Outcome
	Key concerns were that although the breakthrough dose was generally better calculated compared to the previous audit, this was not reflected in the high dose opioid population. Correct breakthrough doses were generally not calculated, in particularly for the morphine population. This could potentially increase the number of episodes of uncontrolled pain the patient's experiences. Additionally, many patients were not co-prescribed naloxone in the morphine population. A memo is to be drafted and emailed to the medicine and pharmacy team reminding of prescribing guidelines at CUH. Additional concerns were issues with documentation of opioid dose review and documentation of analgesia plans sent to the GP. The EPIC team will be asked to create a smart text, creating an organised uniform review template. Additionally, a discussion with the pain team will be initiated to create a plan to improve communications with the GP. Std 10. Patients administered naloxone whilst on opioid therapy - Compliance: 0% Std 13. Opioid naïve patients prescribed fentanyl patches as a new therapy for treatment of acute uncontrolled pain - Compliance: 0% **Recommendations** 1. Improve prescribing of supportive therapies. Consider creating an EPIC order set when prescribing Morphine, Oxycodone, Fentanyl or Buprenorphine which includes first line anti-emetic and laxative. 2. Improve documentation recording suitability of opioids. Consider creating an EPIC smart text which will create a uniform template for recording opioid reviews. 3. Improve documentation within discharge letters regarding opioids. Discuss with Pain Team plan for how to improve discharge communication with regard to opioids. 4. Improve prescribing of supportive therapies and correct breakthrough doses. Email memo send round medicine and pharmacy staff reminding of CUH guidelines regarding prescribing of supportive therapies and how to calculate breakthrough doses. **Implementation of Actions:** Epic order, smart text, liaison with pain team and staff memo all currently in progress.
The fifth audit cycle of adherence to "The intravenous fluid therapy in children and young people in hospital" NICE QS131- prescribing, administering and monitoring. PRN10255	**Key learning from this audit showed:** • Standards 7 and 8 relating to the implementation of National Patient Safety Alert recommendations regarding hospital-acquired hyponatraemia, achieved 100% adherence. Patient safety has remained paramount, as there were no IV fluid-induced hyponatraemia incidences within the trust since the previous audit of 2020. There was an improvement in standards 3, 4 and 6 relating to input/output monitoring and measurement of serum sodium levels. • Standards relating to the trust guideline, 'IV fluid therapy in children and young adults' did not achieve 100% adherence. Adherence to standards 2 and 5 were poor, which related to daily body weight measurement and blood glucose monitoring during IV fluid administration. **Actions:** 1. Update of the trust 'Information on Paediatric Pharmacy for New Doctors' sheet, including the frequency of monitoring parameters and need for documentation. 2.Discussion of the findings of this audit took place at a monthly paediatric pharmacist meeting.

Title	Outcome
	3. Email paediatric medical team and senior nurses to feedback audit results. Discuss findings of this audit at a paediatric MDT meeting. 4. EPIC team to look into the feasibility of creating an order set. for IV fluid prescribing which includes the ordering of daily weights, input/output, electrolytes and blood sugar to prompt nursing staff and medical review Re-audit against the Trusts IV fluid therapy in children and young people guideline.
An audit of practice and imaging quality of CT colonography performed at Cambridge University Hospitals PRN10260	**Key learning from this audit showed:** • 23 new cancers identified in a two year period as well as many more potentially pre-malignant polyps. • Scan quality has been stable 2019-2021. • Same day staging CT for C5a lesions exceeds minimum RCR/BSGAR standard. • Additional acquisition rate suggests radiographers have confidence in evaluation images and re-scanning where appropriate. • Proportion of diagnostic scans does not meet the minimum RCR/BSGAR standard, however we use the minimum BCSP dataset for both screening and symptomatic patients and do not stratify “target lesions” for detection in individual patients. **Recommendations** Review of bowel prep protocol and patient information provided. 1. Determine radiographer confidence in evaluating colonic distension and contacting a CTC reporter. Consider increasing allocated scanning time. Provide further radiographer training in identifying C5a lesions whilst on table.
Re-audit of Sickle Pain management during VOC admission in CUH and audit of home patient pain management PRN10300	**Key learning from this audit showed:** • In general, personalised pain and emergency department management protocols were available and well-followed for all patients presenting to CUH with an acute sickle cell pain episode in 2021 (1.1.1). • Opioid boluses, patient-controlled analgesia and additional medications including NSAIDs and paracetamol were readily offered where indicated (1.1.8, 1.1.13, 1.1.9 and 1.1.14). • There were clear documentation of History & Examination findings and previous analgesia use before admission to aid diagnoses and management (1.1.6 and 1.1.7). • A key area requiring improvement is in addressing the psychological and social needs of patients presenting with acute sickle cell pain episode (1.1.2). Currently, improvements are needed in patient pain education and use of self-help strategies (1.1.22). • In the telephone interviews with the 52 patients registered with CUH, only 6 were aware of the WHO pain ladder and use their home supply of analgesia effectively. There has been suboptimal performance in ensuring patients receive timely analgesia on presentation (within 30 minutes) and regular monitoring (1.1.4 and 1.1.12). **Improvements in response to the findings:** 1. Produce Patient Information Material on pain management (In progress). 2. Appointed a psychologist). 3. Appointed physiotherapist 4. Update Pain Summary Accordion Report on Epic (Complete). 5. Offer multidisciplinary pain education (Once staff appointed and familiar with task and material produced). 6. Start offering targeted follow up for patients admitted with VOC and offer outpatient sessions - Currently in progress. .

Appendix D: Glossary of terms and abbreviations used in this report

BAME (BME)

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

CBC (Cambridge Biomedical Campus)

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

ICB (Integrated Care Board)

ICB's bring together NHS providers, local authorities and other health and care services that are organised into geographical areas in which people and organisations are working together to develop plans to transform and sustain the delivery of health and care services. ICB's are responsible for planning and buying local NHS services, such as the care people receive at hospital and in the community, as well as ensuring that providers deliver the best possible care and treatment for patients. Services at CUH are commissioned by Cambridgeshire and Peterborough ICB.

C.difficile

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

CQC (Care Quality Commission)

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

CQUIN (Commissioning for Quality and Innovation) indicators

The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

CUH

Cambridge University Hospitals NHS Foundation Trust

CUHP (Cambridge University Health Partners)

An academic health science centre that brings together the University of Cambridge, Cambridge University Hospitals NHS Foundation Trust, Papworth Hospital NHS Foundation Trust and Cambridge and Peterborough NHS Foundation Trust.

DTOC (Delayed transfer of care)

Medically fit patients who cannot be discharged from hospital until there are arrangements in place for their continuing care and support.

EPIC

Electronic patient Information record - The Epic software based system used for eHospital.

FTSUG (Freedom to Speak Up Guardian)

The Freedom to Speak Up Guardians are members of Trust staff appointed to help protect patient safety and the quality of care, improve the experience of workers and promote learning and improvement.

GDE (Global Digital Exemplar)

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

HQIP

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

Human Factors

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

KPI

Key performance Indicator – a measure of performance or improvement

MBRRACE

MBRRACE-UK is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to continue the national programme of work investigating maternal deaths, stillbirths and infant deaths, including the Confidential Enquiry into Maternal Deaths (CEMD). The programme of work is now called the Maternal, New-born and Infant Clinical Outcome Review Programme (MNI-CORP).

The aim of the MBRRACE-UK programme is to provide robust information to support the delivery of safe, equitable, high quality, patient-centred maternal, new-born and infant health service.

MDT (Multidisciplinary Team)

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

MRSA (Methicillin-Resistant Staphylococcus Aureus)

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

National Quality Indicators

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

NCEPOD (National Confidential Enquiry into Patient Outcome and Death)

The National Confidential Enquiry into Patient Outcome and Death reviews clinical practice and identifies potentially remediable factors in practice. NCEPOD's purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research, by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities.

'Never event'

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

NHSBT (NHS Blood and Transplant)

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

NHSE (NHS England)

NHS England responsible for overseeing the budget, planning, delivery and day-to-day operation of the commissioning side of the NHS in England as set out in the Health and Social Care Act 2012. NHS Improvement became part of NHSE and is responsible for overseeing Foundation Trusts and NHS Trusts, as well as independent providers that provide NHS-funded care.

NICE (National Institute for Health and Care Excellence)

The National Institute for Health and Care Excellence (NICE) is an executive non-departmental public body of the Department of Health in the United Kingdom, which publishes guidelines in four areas:

- the use of health technologies within the NHS (such as the use of new and existing medicines, treatments and procedures)
- clinical practice (guidance on the appropriate treatment and care of people with specific diseases and conditions)
- guidance for public sector workers on health promotion and ill-health avoidance
- guidance for social care services and users

Palliative care/End of Life Care

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

PEWS

Paediatric Early Warning Score

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.

Datix QSiS -Quality and Safety Information System)

Datix (QSiS) is a bespoke electronic risk management system, based on the Datix software & used by the majority of NHS Trusts in the UK. The system is made up of a number of modules, including safety incident reporting, risk register, complaints, claims, and has reporting features.

RCA (Root cause analysis)

A systematic process for identifying "root causes" of problems or events and an approach for responding to them.

ReSPECT

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

RTT

Referral to treatment

WRES (NHS Workforce Race Equality Standard)

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

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