Contents

1. The Quality Account ................................................................. 4
  1.1 Statement on quality from the Chief Executive ......................... 4
  1.2 Introduction ........................................................................... 6
  1.3 Priorities for improvement in 2014/15 and beyond ..................... 7
  1.4 Statements of assurance ....................................................... 12
  1.5 Independent assurance report ................................................ 23
  1.6 Reviewing performance against last year’s priorities for improvement .... 26
  1.7 Reviewing and setting local and national indicators and targets .......... 33
  1.8 Feedback on the quality report and accounts .............................. 34
  1.9 Annex 1: Statement of directors’ responsibilities in respect of the quality report .................................................. 35
  1.10 Annex 2: Statements by stakeholders ......................................... 37
  1.11 Annex 3: Our 2014/15 priorities in detail .................................... 43
  1.14 Annex 6: CQUINs 2013/14 performance .................................... 55
  1.15 Annex 7: National Targets - 2013/14 performance ..................... 59
  1.16 Annex 8: Glossary of terms used in quality report ..................... 60
1. The Quality Account

1.1 Statement on quality from the Chief Executive

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

On becoming Chief Executive at Cambridge University Hospitals, I promised that quality would be my top priority. I have spent the last year making that pledge a reality.

The starting point, was putting the infrastructure in place to make sure that quality, in all its dimensions, drives our decision-making and transformation agenda within the Trust. So, under the leadership of our Medical Director and with the support of a dedicated group from the ward to the board, we wrote our Quality Strategy. This strategy sets out our ambition, and all other plans and strategies across the Trust are its enablers. The Quality Strategy was endorsed by the board and launched across the Trust with a series of high-profile events.

Next, we need to hard-wire that strategy into the Trust. We appointed a Quality Director to stimulate and drive change. We established a series of challenging measures against which we will rigorously monitor our progress. We are challenging and changing the objectives of every single staff member to make sure quality is at the heart of what we all do, day in and day out.

The challenge for the coming year is to further improve our structures and systems to help us constantly and consistently improve the care we give.

There are five drivers of our quality strategy. We strive to:

- Improve the experiences of our patients through person-centred care
- Improve our staff experience through treating staff as partners
- Improve safety through harm-free care
- Improve our reliability through delay-free care
- Provide clinically effective care

Fundamentally, all this change is about the effectiveness of the interaction between a clinician and a patient. Are we listening, are we caring, are we able to make the right choices about the best care, and then effectively and efficiently deliver that care? Does the way this complex and often unwieldy organisation goes about its business, make it easy for a nurse or a doctor, health care assistant or any other health care professional to do the right thing?

We start, of course, in a strong place. We stand above most of the Shelford group (a group of 10 leading Teaching Hospitals) in measures of harm free care. Our death rates are lower than you would normally expect in a hospital of our size, nature and complexity. Our performance on many levels such as the incidence of *Clostridium difficile* infection (CDI) is now strong. We are world-leaders in many clinical areas, and we have committed and professional staff who go above and beyond because they care passionately about quality and the people they provide care to.
One of the things I didn’t want to change when I became Chief Executive was the statement of our values – Kind, Safe and Excellent - because they are so strongly embedded into the culture of this place. We strive to be kind, safe and excellent – simple and effective words, but the lesson of Francis was to take none of these things for granted. So, under the leadership of the Chief Nurse, we have launched a major listening exercise to re-affirm our values, and focus on the care we show to both our patients and to our staff. This programme of events with patients and staff will help us reinforce our positive values, and drive out negative values and methods.

CUH has many challenges to manage, and will face many more in the years to come. Creating the space for quality to be front and centre of everything we do is hard, and will require us to make some tough decisions.

I want therefore to give every single member of staff permission to put quality front and centre, and to be at the heart of everything we do. By doing so we will ensure that the patients come first – the patient first… and always. It is what I expect of myself, and I expect nothing less from all the staff here at CUH.

Dr Keith McNeil
Chief Executive
22 May 2014
1.2 Introduction

Cambridge University Hospitals in context

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

In October 2014 our largest ever investment in improving healthcare quality, eHospital will go live. This will change the way we deliver patient care by using the latest and best information systems. It will make the right thing the easy thing to do.

Our aim is to provide quality healthcare and a first-class service through collaboration with research, academic and healthcare colleagues and engagement with the community, families, carers and patients.

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

For an explanation of terms please see the glossary set out in annex 8.

2013/14 Activity

During 2013/14 we treated more patients than ever before; the following table sets out key activity numbers.

Table 21

Patients treated: comparison of 2012/13 and 2013/14

<table>
<thead>
<tr>
<th></th>
<th>For year 2012/13</th>
<th>For year 2013/14</th>
<th>Increase or decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>• no of visits to outpatients</td>
<td>528,707</td>
<td>574,998</td>
<td>↑8.8%</td>
</tr>
<tr>
<td>• births</td>
<td>5,785</td>
<td>5,749</td>
<td>↓0.6%</td>
</tr>
<tr>
<td>• day cases</td>
<td>109,296</td>
<td>115,176</td>
<td>↑5.4%</td>
</tr>
<tr>
<td>• total inpatients admissions</td>
<td>70,402</td>
<td>73,069</td>
<td>↑3.8%</td>
</tr>
<tr>
<td>• A&amp;E attendances</td>
<td>98,695</td>
<td>102,709</td>
<td>↑4.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>812,885</strong></td>
<td><strong>871,701</strong></td>
<td><strong>↑7.2%</strong></td>
</tr>
</tbody>
</table>

The increase in the total number of patients seen has and will continue to challenge us in terms of having sufficient beds and staff to deliver the quality of care we aspire to provide. We have robust systems and processes to
manage peaks in demand, but recognise these will be put to the test in the coming 12 months.

**Working together to monitor quality**

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

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

During the year, we have continued to work with our commissioners, GPs, Cambridgeshire and Suffolk Healthwatch, and with Cambridgeshire Overview and Scrutiny Committee. Trust representatives regularly attend and participate in meetings on subjects important to the community’s health in all the relevant fora. Our chair has met with the leadership of the Overview and Scrutiny Committee, with the chair and CEO of Cambridgeshire Healthwatch, and the CEO of Healthwatch Suffolk, to discuss a variety of issues at first hand. Concern about the number of patients whose discharge is delayed awaiting social or health care provision in the community had continued this year, and integrated care remains a priority.

During 2014/15 we took on the leadership of the Discharge Planning Team which assesses the long term care needs of patients in hospital. This team comprised of staff from Cambridgeshire County Council and Cambridgeshire Community Services NHS has significantly reduced the delays for patients in hospital beds awaiting assessment. We are also working with Cambridgeshire Council and NHS Cambridgeshire and Peterborough Clinical Commissioning Group to implement ‘Discharge2Assess’ in 2014/15 which will see patients assessed for their long term care needs outside of hospital, which should improve the clinical outcomes and independence of older people.

**Never Events**

Introduced by the Department of Health, a ‘never event’ is defined as serious, largely preventable incidents that should never happen if the right measures are in place. As with all serious incidents these events need prompt reporting and a detailed investigation. During this reporting time 2013/14, the Trust had one never event; as a consequence a detailed action plan has been enacted. A second never event occurred involving a CUH patient being treated in the private sector, this never event being the responsibility of the private provider. CUH was fully involved in the investigation and the subsequent actions taken to minimise recurrence.

**1.3 Priorities for improvement in 2014/15 and beyond**

**Our vision and priorities**

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

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

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

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

Achieving our quality vision to be one of the best academic healthcare organisations in the world is something that will require leadership, staff engagement and a willingness to innovate. A key part of this strategy will be the establishment of a quality and safety academic unit at CUH.

We want to measure up against the best nationally, and aim to be in the upper decile for all key performance indicators used by our regulators. Going beyond that, we will start to set our standards and measure our performance using Global Comparators. By 2018 we will have submitted CUH for an external assessment through, for example, Joint Commissioning International (JCI) or an equivalent detailed assessment programme. We will work to gain membership of Dr Foster global comparators, seeking to benchmark our performance against other leading medical institutions and looking beyond national boundaries to international standards of leading clinical practice.

**How will we measure our success?**

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

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

Priorities and targets

Person Centred

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

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

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

In 2014/15 our priorities and targets are as follows:

Over 90% of patients who respond to our inpatient surveys answer questions as ‘yes,’ ‘met expectations’ or ‘above expectations’.

Over 90% of patients who respond to our outpatient surveys answer questions as ‘strongly agree’ or ‘agree’.

To improve our 2013/14 friends and family test score by 10%.

The number of formal patient complaints received should be less than 0.1% of patient contacts.

A detailed explanation of each measure is included in annex 3
Investment in our staff is investment for the future: allowing for turnover, over two thirds of the people who will deliver our services in 2018 are working here already. Recruiting the new third will involve a national and international recruitment programme. Individual patients and their families rely upon staff working in teams to provide high quality care. We are committed to developing all our staff, listening to and learning from their experiences, and investing in the leaders of today and tomorrow as described in the Berwick Report. CUH will make an explicit commitment to provide education and training opportunities for all staff which will include specific training in quality. An engaged, motivated and well-trained workforce is key to providing high quality care. We will continue to be an organisation that our staff are proud to work for and would recommend to their families and friends.

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

**In 2014/15 our priorities and targets are as follows:**

- Reduce staff turnover rate by 10%
- Ensure over 90% of staff have an annual appraisal
- Improve participation in the internal staff engagement survey to 55%
- Reduce sickness absence rates by 5%
- Implement the staff Friends and Family Test in line with national guidance

A detailed explanation of each measure is included in annex 3

Patients rightly expect CUH to be a safe place and that the healthcare we provide will help them. We must protect our patients from unintentional harm whilst they are in our care. This includes hospital-acquired infections, medication errors, surgical infections, pressure ulcers and other unintended injuries resulting from, or contributed to by clinical care (including the absence of indicated treatment or best practice). In addition, we aim to provide an appropriate, clean and safe environment for all patients at all times.
In 2014/15 our priorities and targets are as follows:

Care, as measured by the monthly ‘safety thermometer’ audit should be 98% harm-free

Less than 0.2% of patient contacts should result in an incident report where patient harm is recorded

We will strive for no avoidable infections. There will be zero hospital acquired MRSA bacteraemia and the number of cases of hospital-acquired *Clostridium difficile* will be less than the agreed ceiling of 61

A detailed explanation of each measure is included in annex 3

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

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

In 2014/15 our priorities and targets are as follows:

95% of patients who attend our Emergency Department are seen within four hours.

90% of our patients who require admission will be admitted within 18 weeks of GP referral.

85% will be patients are treated within 62 days of their GP urgent cancer referral

The number of operations cancelled on or after the day of admission will be less than 1%.

A detailed explanation of each measure is included in annex 3

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

In 2014/15 our priorities and targets are as follows:

We will have an aggregate Hospital Standardised Mortality Ratio (HSMR) of less than 90.

For 2014/15 our patient-related outcome measures (PROMS) results will show an improvement on those of 2012/13 and be above the national average.

At least 85% of patients aged 75 and over admitted as emergencies will be screened for frailty using the clinical frailty score (CFS) within 72 hours of admission.

A detailed explanation of each measure is included in annex 3

1.4 Statements of assurance

The board of directors

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

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

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

Review of services

During 2013/14 CUH provided and/or sub-contracted 113 relevant health services.

CUH has reviewed all the data available to them on the quality of care in all 113 of these relevant health services.

The income generated by the NHS services reviewed in 2013/14 represented 99% of the total income generated from the provision of relevant health services by CUH for 2013/14.
Participation in clinical research

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

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

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

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

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

The number of patients receiving relevant health services provided by or subcontracted by CUH in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 13,919.

Education and training

One strand of our tripartite mission is our activities in the field of education and training, which supports excellence in the care which our staff provide for patients. We work closely with the University of Cambridge to train the next generation of doctors. The Postgraduate Medical Centre (PGMC) continues to deliver the Health Education East of England Learning Development Agreement (LDA). The PGMC delivers medical education to a very high standard as evidenced by the last East of England Multiprofessional Deanery report to the Trust. In addition the centre has a high fidelity Medical Simulation Centre which has a regional and national reputation.

New initiatives in 2013 included the formal opening of the Evelyn Cambridge Surgical Training Centre by the vice-chancellor of the University of Cambridge. The Evelyn Cambridge Surgical Training Centre is a state-of-the-art facility providing advanced education to health professionals. The Centre is fully operational and delivering courses. An on-site surgical training room has been established. The 'drop in’ facility allows doctors in training 24-hour access to practice their surgical techniques.

The Education Quality Assurance Framework demonstrates the provision of excellent multi professional student and continuing professional development at CUH as evidenced by the robust processes in place, evaluations of programmes, and student and staff feedback.
The Trust is committed to the training and development of over 600 pre-registration students including nurses, midwives, radiographers, physiotherapists, dieticians, occupational therapists, operating department practitioners and healthcare scientists whilst on clinical placements at CUH, to ensure they meet the needs of the future workforce and patient care.

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

Continuing education for staff in bands two to nine is managed via a plan agreed with Health Education East of England and supports the provision of safe and effective patient care, the development of new and existing services and developing leadership capability across all staff. It is delivered by Higher Education Institutions and the Trust. Many speciality programmes are well regarded and delivered by Trust experts using blended learning and simulation approaches.

**Participation in national confidential enquiries**

During 2013/14 two national confidential enquiries covered NHS services that CUH provides. CUH participated in both of these.

**Table 22**

<table>
<thead>
<tr>
<th>Confidential enquiry title</th>
<th>Numbers to submit</th>
<th>Numbers submitted (100% unless otherwise stated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Surgical Clinical Outcome Review programme – National Confidential Enquiry into patient outcome and death</td>
<td>Subarachnoid haemorrhage</td>
<td>31 cases submitted, 21 of which were selected for detailed review</td>
</tr>
<tr>
<td></td>
<td>Alcohol Related Liver Disease</td>
<td>30 cases submitted, 2 of which were selected for detailed review</td>
</tr>
<tr>
<td></td>
<td>Death following lower limb amputation</td>
<td>11 cases submitted, 6 of which were selected for detailed review</td>
</tr>
<tr>
<td>Maternal, Infant &amp; Newborn Clinical Outcome Review Programme (MBRRACE-UK)</td>
<td>all deaths that fit criteria</td>
<td>43</td>
</tr>
</tbody>
</table>

**Participation in clinical audits**

During 2013/14, 42 national clinical audits covered NHS services that CUH provides. CUH participated in all of these.
<table>
<thead>
<tr>
<th>Audit title</th>
<th>Numbers to submit</th>
<th>Numbers submitted (100% unless otherwise stated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head &amp; Neck Oncology (DAHNO)</td>
<td>All newly diagnosed patients</td>
<td>181</td>
</tr>
<tr>
<td>Lung Cancer (NLCA)</td>
<td>All newly diagnosed patients</td>
<td>233</td>
</tr>
<tr>
<td>Diabetes (Adult) (ANDA)</td>
<td>All inpatients</td>
<td>3067</td>
</tr>
<tr>
<td>National Audit of Seizure Management in Hospital (ASH 2)</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion: Information &amp; Consent</td>
<td>24 Adult patients over a 12 week period</td>
<td>Data collection/ submission ongoing</td>
</tr>
<tr>
<td>Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)</td>
<td>All MINAP patients</td>
<td>152</td>
</tr>
<tr>
<td>Cardiac Arrhythmia (HRM)</td>
<td>All Cardiac. Arrhythmia. Patients</td>
<td>112</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD) (RCP)</td>
<td>All COPD patients</td>
<td>Postponed to 2014</td>
</tr>
<tr>
<td>National Diabetes Inpatient Audit (NADIA)</td>
<td>All diabetic inpatients</td>
<td>113</td>
</tr>
<tr>
<td>Emergency Use of Oxygen (BTS)</td>
<td>All inpatients using oxygen</td>
<td>104</td>
</tr>
<tr>
<td>Heart Failure (NICOR)</td>
<td>All heart failure patients</td>
<td>179</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease (IBD) (RCP) (Adult)</td>
<td>All UKIBD patients</td>
<td>30</td>
</tr>
<tr>
<td>Moderate or Severe Asthma in Children (care provided in emergency departments) (College of Emergency Medicine)</td>
<td>50 from the 16/09/13 to the 31/03/13</td>
<td>40 (80%)</td>
</tr>
<tr>
<td>Paracetamol Overdose (care provided in emergency departments) (College of Emergency Medicine)</td>
<td>50 from the 16 September 2013 to 31 March 2014</td>
<td>40 (80%)</td>
</tr>
<tr>
<td>Renal Replacement Therapy (Renal Registry)</td>
<td>All Renal patients</td>
<td>4016</td>
</tr>
<tr>
<td>Rheumatoid &amp; Early Inflammatory Arthritis</td>
<td>All REI patients seen in 2014</td>
<td>1 Org + clinical ongoing</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP) - includes SINAP (Royal College of Physicians)</td>
<td>1 Organisational questionnaire and 171 patients</td>
<td>1 Organisational questionnaire and 168 patients (98%)</td>
</tr>
<tr>
<td>Severe Sepsis &amp; Shock (College of Emergency Medicine)</td>
<td>50 from the 16/09/13 to the 31/03/13</td>
<td>40 (80%)</td>
</tr>
<tr>
<td>Audit Category</td>
<td>Description</td>
<td>Number/Percentage</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td><strong>Severe Trauma (TARN) (audit in 3 sections)</strong></td>
<td>All TARN patients (2319 patient records submitted for all 3 sections)</td>
<td>2518 (109%)</td>
</tr>
<tr>
<td><strong>HQIP National Audit - National Joint Registry (NJR)</strong></td>
<td>All Hip, knee, ankle, elbow and shoulder joint replacements</td>
<td>602</td>
</tr>
<tr>
<td><strong>HQIP National Emergency Laparotomy Audit (NELA)</strong></td>
<td>All patients over the age of 18 years, having a general surgical emergency laparotomy</td>
<td>23 so far</td>
</tr>
<tr>
<td><strong>HQIP National Audits - Bowel cancer</strong></td>
<td>All patients diagnosed with colorectal and rectal cancer</td>
<td>227</td>
</tr>
<tr>
<td><strong>HQIP: National Prostate Cancer Audit (NPCA)</strong></td>
<td>All patients diagnosed with Prostate cancer</td>
<td>Audit just started</td>
</tr>
<tr>
<td><strong>National Oesophago-gastric cancer Audit</strong></td>
<td>All patients diagnosed with invasive epithelial cancer of the oesophagus, gastro-oesophageal junction (GOJ) or stomach</td>
<td>145</td>
</tr>
<tr>
<td><strong>National Vascular Registry</strong></td>
<td>All patients who have repair of Abdominal Aortic Aneurysms, carotid endarterectomy (among stroke patients), and interventions for peripheral arterial disease</td>
<td>AA - 540, Open procedure - 115, Endo vascular Aneurysm Repair (EVAR) - 425</td>
</tr>
<tr>
<td><strong>Audit of management of patients in Neuro Critical Care (NCCU) (NHSBT)</strong></td>
<td>All applicable NCCU patients</td>
<td>24</td>
</tr>
<tr>
<td><strong>National Cardiac Arrest Audit 13/14</strong></td>
<td>Individuals receiving chest compressions and/or defibrillation and attended by the hospital-based resuscitation team (or equivalent) in response to the 2222 call.</td>
<td>113</td>
</tr>
<tr>
<td><strong>ICNARC Case Mix Programme 13/14</strong></td>
<td>Data is collected on every patient admitted to the John Farman Intensive Care Unit.</td>
<td>1210</td>
</tr>
<tr>
<td><strong>National Pregnancy in Diabetes Audit (NPID)</strong></td>
<td>Deliveries to Aug 14</td>
<td>38</td>
</tr>
<tr>
<td><strong>Diabetes (Paediatric) (PNDA)</strong></td>
<td>All under 24's - approx 250</td>
<td>281</td>
</tr>
<tr>
<td>Audit/Programme</td>
<td>Description</td>
<td>Total</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Epilepsy 12 Audit (Childhood Epilepsy) (RCPCH)</td>
<td>Children aged 1 month to 15 years Data collection to start Jan 2013 (1st EEG 1 Feb13 to Oct 13.</td>
<td>20</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease (IBD) (RCP) (Paediatric)</td>
<td>50</td>
<td>6</td>
</tr>
<tr>
<td>NHSBT Comparative audit of Use of Anti-D</td>
<td>26 patients</td>
<td>26</td>
</tr>
<tr>
<td>Neonatal Intensive &amp; Special Care (NNAP) (RCPCH)</td>
<td>January to December 2013 patients</td>
<td>990</td>
</tr>
<tr>
<td>Paediatric asthma (BTS)</td>
<td>All children over 1 year of age admitted with wheezing/acute asthma into a paediatric unit and under paediatric care during the audit period (calendar month of November for national audit period).</td>
<td>10</td>
</tr>
<tr>
<td>Paediatric intensive care (PICANet)</td>
<td>All children admitted to PICU</td>
<td>558</td>
</tr>
<tr>
<td>BTS Paediatric Bronchiectasis 2013</td>
<td>all patients seen in clinic Oct and Nov 13</td>
<td>5</td>
</tr>
<tr>
<td>Child Health Programme (RCPCH) Epilepsy</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA) (ICNARC)</td>
<td>all patients between 01.04.2013 and 31.03.2014</td>
<td>37</td>
</tr>
<tr>
<td>Management of patients in Neuro Critical Care Units</td>
<td>No exact patient sample requested</td>
<td>24</td>
</tr>
<tr>
<td>National Comparative Audit of the use of blood components in Neurocritical Care Units in the United Kingdom.</td>
<td></td>
<td>24</td>
</tr>
</tbody>
</table>

The reports of 28 national clinical audits were reviewed by the Trust in 2013/14 and CUH has taken a number of actions to improve the quality of healthcare provided. Examples include:

**Chronic Obstructive Pulmonary Disease (COPD):**
All COPD patients are now being referred for Pulmonary rehabilitation. COPD patients now being offered inhaled and oral therapies in accordance with National guidelines.
Clear documentation and processes now in place on how this group of patients can access stand-by therapies if they are not on repeat prescriptions.

**National Dementia Audit:**
In consultation with the Older People’s Mental Health Commissioners, a Standardised Assessment policy for patients over 75 years of age has been implemented and is now being used as practice guidance in the Trust.
A ‘Dementia awareness’ course has now been introduced and was incorporated in the Trust’s new clinical staff induction programmes with effect from August 2013. ‘This is me’ inpatient proforma has been implemented and has enabled collection of information about patients with dementia which is now being used during their period in admission.

**Myocardial Ischaemia National Project (MINAP):**

The proportion of patients with non ST elevation myocardial infarction (nSTEMI) at discharge who were seen by a cardiologist was reported as much worse than expected in the 2012 report and it was noted that while such patients could be in any part of the hospital with other conditions, they may not have been brought to the attention of the Cardiology department. Altered MINAP data collection sheets in the 2013 audit enabled the Cardiologists to identify nSTEMI patients who are in other areas and report on them. The MINAP report for 2014/15 is expected to show a confirmation of this new change in Cardiology coverage of MINAP patients.

**National Diabetes Inpatient Audit:**

A Diabetic Foot Referral Pathway has now been launched and is in use in the Trust, enabling nearly half of the diabetic specific admissions, previously noted as having foot disease, to be referred directly to the Foot Specialist Team and avoid loss of limbs associated with the condition. There has been marked improvement in the provision of diabetes multidisciplinary team allocation to inpatient diabetes care which had been noted in a previous audit.

**National Oesophago-gastric cancer Audit 2013**

All patients considered for curative treatment undergo an EUS (if oesophageal or upper junctional tumour) or a staging laparoscopy (if gastric or lower junctional tumour). All patients with oesophageal SCC considered for curative treatment are discussed with both a clinical oncologist who specialises in the treatment of Upper GI Cancers as well as a surgeon, to discuss the most appropriate treatment approach. As surgical mortality continues to fall, increased focus goes into optimising efficacy of surgery (lymph node yield and proportion of patients with positive longitudinal margins) and complication rates. These are monitored prospectively by surgeons.

**HQIP National Audits - Bowel cancer 2013**

There is a poorer outcome associated with emergency colorectal cancer admission. Addenbrooke’s have arrangements for caring for the elderly, high risk patient presenting acutely. Pathways are in place that provide pre-operative resuscitation, adequate theatre access, post-operative critical care, and early colorectal team involvement, including full radiological support and facilities for colonic stenting, these improve post-operative survival. Laparoscopic surgery is now considered in all suitable cases. Laparoscopic colorectal surgery has clear advantages for selected patients in terms of length of stay and possibly outcome measures. In line with the current NICE guidance, suitable patients are offered the opportunity for a laparoscopic resection.
Local audits of recurrence and resection margins after AP resection have been carried out. All our outcomes are within the expected ranges or are better than average.

Renal Transplantation (NHSBT UK Transplant Registry)

There are more specialist nurses providing an increase in public education which has resulted in an increase in organ donation.

The reports of 379 local clinical audits were reviewed by the Trust in 2013/14; and CUH has taken a number of actions to improve the quality of healthcare provided. Examples include:

- An audit of bone health assessment in Clinic 1a resulted in the preparation and distribution of lifestyle advice to patients on how to minimise osteoporosis and fracture risk. Using an algorithm that was put in place at the start of this year, all patients aged 50 years and above who are managed in this clinic now have annual checks and management of their Vitamin D levels, ALPs, FRAX & bone function.

- A new Plasmodium Falciparum Malaria Care pathway was introduced in 2013 which now enables Haematology labs, upon identification of positive malaria films from GP patients, to alert the Infectious Diseases Teams for fast track intervention and treatment.

- Hospital guidelines for Acute Coronary Syndrome were reviewed and they now have treatment options for ACS patients presented with acute bleeding. Furthermore, the guidelines now clarify the criteria for moderate to high risk group patients.

- A DEXA Scanning audit enabled triaging of routine GP DEXA requests and flagging of these directly to Radiology for immediate attention. This exercise has now spread to all oncology and breast cancer patients, as needed.

- Oral and Maxillofacial Service (OMFS) has implemented changes since the original audit was completed in 2012, these included staff education, more regular review of inpatient drug charts (ideally daily during ward round), and more thorough induction for junior staff.

Use of the CQUIN payment framework

The CQUIN framework is a national framework for locally agreed quality improvement schemes. 2.5% of CUH income in 2013/14 was conditional upon achieving the CQUINs agreed with NHS Cambridgeshire for the provision of NHS services. The potential CQUIN income available if the Trust had met all its targets across all commissioners’ contracts was £11,021,485. CUH received CQUIN in 2013/14 of £10,634,225. The corresponding CQUIN value for 2012/13 was £11.4m, with the Trust achieving £10.3m.

Full details of each CQUIN and the performance achieved during the year are set out in annex 6.
Care Quality Commission registration and compliance

The Trust was required to register with the Care Quality Commission (CQC) in April 2010. The Trust continues to be registered without any compliance conditions.

During 2013/14 the Trust received one unannounced visit from the CQC as part of a themed national inspection programme reviewing the quality of care provided to support people living with dementia. The Trust was found to be compliant with Outcome 4: care and welfare of service users, Outcome 6: co-operating with other providers and Outcome 16: assessing & monitoring the quality of service provision. There were no compliance or improvement actions issued following this visit. The Trust has no outstanding actions following any previous CQC visit.

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

In October 2013, the CQC replaced their quality and risk profile (QRP) with the intelligent monitoring report (IRP). This report contains key performance indicators which the CQC use in order to determine the level of risk that patients may not be receiving ‘safe, effective and high quality care’. The March 2014 report, the second of the new style reports issued by the CQC, placed CUH in band 6, which represents the lowest level of risk.

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

Data quality

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

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

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

We also share data with partners as appropriate, for example clinical commissioning groups (CCGs). This data are used to plan and review the healthcare needs of the area.

Part of data quality is the use of the NHS Number. This is the only national unique identifier which is a strictly safe way of sharing information about a patient with other clinicians and healthcare staff, especially across organisational boundaries. It is therefore essential that the data quality work within CUH incorporates this number.

CUH submitted records during 2013/14 to the Secondary Uses Service for inclusion in the hospital episode statistics which are included in the latest
published data. The percentage of records in the published data which included the patient’s valid NHS number was 99.5% for admitted patient care, 99.6% for outpatient care, and 96.4% for accident and emergency care. The percentage of records in the published data which included the patients’ valid general practitioner registration code was 100% for admitted patient care, 100% for outpatient care and 99.9% for accident and emergency care.

The following tables show this, and additional information.

**Table 24**
Information governance – clinical information assurance

<table>
<thead>
<tr>
<th>Data Quality Results</th>
<th>All SHAs</th>
<th>EOE SHA</th>
<th>Addenbrooke’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted Patient Care</td>
<td>95.9</td>
<td>94.2</td>
<td>98.5</td>
</tr>
<tr>
<td>Outpatients</td>
<td>95.6</td>
<td>94.6</td>
<td>93.5</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>97.0</td>
<td>98.1</td>
<td>97.9</td>
</tr>
<tr>
<td>Births</td>
<td>93.6</td>
<td>96.8</td>
<td>99.8</td>
</tr>
<tr>
<td>Delivery Events</td>
<td>95.8</td>
<td>98.7</td>
<td>99.8</td>
</tr>
<tr>
<td>Other Birth Events</td>
<td>96.5</td>
<td>92.2</td>
<td>98.4</td>
</tr>
<tr>
<td>Other Delivery Events</td>
<td>96.6</td>
<td>96.8</td>
<td>99.1</td>
</tr>
<tr>
<td>Maternity Data Quality Score</td>
<td>0.994</td>
<td>1.001</td>
<td>0.994</td>
</tr>
<tr>
<td>Adult Critical Care</td>
<td>98.3</td>
<td>99.5</td>
<td>99.9</td>
</tr>
<tr>
<td>Paediatric Critical Care</td>
<td>99.2</td>
<td>99.5</td>
<td>99.8</td>
</tr>
<tr>
<td>Neonatal Critical Care</td>
<td>98.9</td>
<td>99.8</td>
<td>99.8</td>
</tr>
</tbody>
</table>

**Table 25**
Data quality report

<table>
<thead>
<tr>
<th>Data Quality Results</th>
<th>All SHAs</th>
<th>EOE SHA</th>
<th>Addenbrooke’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered GP Practice:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admitted Patient Care</td>
<td>99.9</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Outpatients</td>
<td>99.9</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>99.1</td>
<td>99.9</td>
<td>99.9</td>
</tr>
<tr>
<td>NHS Number:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admitted Patient Care</td>
<td>99.1</td>
<td>99.7</td>
<td>99.5</td>
</tr>
<tr>
<td>Outpatients</td>
<td>99.3</td>
<td>99.0</td>
<td>99.6</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>95.8</td>
<td>98.5</td>
<td>96.7</td>
</tr>
</tbody>
</table>

Information Source: NHS Information Centre – data quality dashboards
Based on SUS April–December 13/14 data at the month 9 inclusion date.

**Information governance toolkit attainment levels**

All NHS organisations are required to comply with the ‘Information Governance Toolkit’, this covers standards on data protection, confidentiality, information security, clinical information and corporate information. Acute trusts are assessed against 45 requirements and can achieve a level score of between 0-3. All trusts must reach a ‘level 2’ in all requirements, which is then assessed as a satisfactory score.

The CUHFT Information Governance Assessment Report overall score for 2013/14 was 84% (113 out of 135) achieving a level 2 or 3 against all requirements and was graded a satisfactory green rating.
A&E clinical coding
CUH was not subject to the Payment by Results clinical coding audit during 2013/14 by the Audit Commission
1.5 Independent assurance report

Independent auditor’s report to the council of governors of Cambridge University Hospitals Foundation Trust

We have been engaged by the council of governors of Cambridge University Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of CUH’s Quality Report for the year ended 31 March 2014 (the ‘Quality Report’) and certain performance indicators contained therein.

Scope and subject matter
The indicators for the year ended 31 March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:
- Cases of *Clostridium difficile* diarrhoea (‘C. diff’) in patients aged 2 years or over, that are attributed to the Trust; and
- Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer.
- We refer to these national priority indicators collectively as the ‘indicators’.

Respective responsibilities of the directors and auditors
The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:
- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the specified information sources; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

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

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:
- Board minutes for the period April 2013 to May 2014;
- Papers relating to Quality reported to the Board over the period April 2013 to May 2014;
- Feedback from the Commissioners dated May 2014;
- Feedback from local Healthwatch organisations dated May 2014;
- The Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2013/14;
The 2013 national patient survey;
• The 2013 national staff survey;
• Care Quality Commission QRP/intelligent monitoring reports 2013/14; and
• The 2013/14 Head of Internal Audit’s annual opinion over the Trust’s control environment

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

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

This report, including the conclusion, has been prepared solely for the council of governors of Cambridge University Hospitals NHS Foundation Trust as a body, to assist the council of governors in reporting Cambridge University Hospitals NHS Foundation Trust’s quality agenda, performance and activities.

We permit the disclosure of this report within the Annual Report for the year ended 31 March 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Cambridge University Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed
We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included:
• Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
• Making enquiries of management
• Testing key management controls
• Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
• Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report
• Reading the documents

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.
The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

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

**Conclusion**

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual.

KPMG LLP, Statutory Auditor

Chartered Accountants
Botanic House
100 Hills Road
Cambridge
CB2 1AR

22 May 2014
1.6 Reviewing performance against last year’s priorities for improvement

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

One: Improving safety and reducing harm – harm-free care

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

Safety Thermometer

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

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

Our aim was that care, as measured by the monthly audit should be 97% harm-free.

Did we achieve our aim in 2013/14?

Yes - we achieved an aggregate 97% harm free care. The rate excluding old harm (where the patient had the harm prior to coming under our care) has been greater than 98.3% over the year.

Harm rates

The hospital has in place a well developed incident reporting process which requires staff to report incidents, irrespective of whether harm occurred. We recognise that the system does rely on identifying that an event which is reportable has taken place, and reporting it, however around 10,000 patient-
related incidents were reported in 2013. A high reporting rate is viewed as an indication of a positive safety culture. We measured the rate of harm as a percentage of patient contacts each month. Patient contacts are the number of inpatients admitted, outpatient, day case and Emergency Department attendances.

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

**Did we achieve our aim in 2013/14?**
Yes – aggregate for the year was 0.15%, the monthly harm rate being between 0.13% and 0.18%. In 2013/14 a total of 10,638 patient safety incidents were reported. The actual number of incidents reported each month where some degree of harm was reported ranged between 89 and 127.

**Minimising Infection**
We committed to reduce the number of all avoidable infections and the harm they cause and in particular to keep the number of patients who acquire *C. difficile* or a MRSA bacteraemia in hospital to a minimum. By reducing the numbers of affected patients to a minimum, we reduced the need for a prolonged length of stay, surgery or admission to an intensive care unit as a result of the infection. During 2013/14 we focussed on environmental cleaning standards, isolation, antibiotic prescribing, hand hygiene and staff education as part of the programme to help reduce and prevent healthcare associated infections. In 2014/15 we will continue to ensure judicious antibiotic prescribing through regular audits, monthly performance reports and engagement with eHospital.

Our aim was to minimise the number of avoidable hospital acquired infections and to meet our contractual ceilings for these infections during 2013/14. The ceiling for hospital acquired MRSA bacteraemia was zero and 39 for hospital-acquired *Clostridium difficile* cases.

**Did we achieve our aims in 2013/14?**
MRSA- No- In 2013/14 there were four MRSA blood stream infections, two of which were in the same patient and although this was a decrease from the six infections identified in 2012/13, our aim was to have zero

As with the previous year, those patients who developed a MRSA bacteraemia (infection in the blood) were very sick and had multiple and complex problems. However we are determined to understand how this infection can be prevented so the care of each patient was reviewed in great detail to ensure all standards of care were adhered to and any lessons identified.

The challenge for the future is to prevent patients with MRSA colonisation (i.e. MRSA on the skin) of the skin developing a bacteraemia when they have severe underlying medical conditions, poor skin, or require the insertion of intravascular lines and other devices as part of their treatment. Ensuring there is prompt identification of colonisation by regular screening of long stay patients and the completion of decolonisation regimens will continue to be an area of focus.
We committed to reduce the number of avoidable infections and the harm they cause and in particular to keep the number of patients who acquire C. difficile or MRSA in hospital to a minimum. By reducing the numbers of affected patients to a minimum, we reduced the need for a prolonged length of stay, surgery, admission to an intensive care unit, or causing serious harm. During 2013/14 we focussed on cleaning standards, antibiotic prescribing and staff education as part of the programme to help reduce and prevent healthcare associated infections. In 2014/15 we will continue to ensure judicious antibiotic prescribing through regular audits, monthly performance reports and engagement with eHospital.

Our aim was to minimise the number of avoidable hospital acquired infections and to meet our contractual ceilings for these infections during 2013/14. The ceiling for hospital acquired MRSA bacteraemia was zero and for hospital-acquired Clostridium difficile cases was 39.

C. Difficile - No – In 2013/14 there were 50 cases of C. Difficile infection. Whilst we ended the year above our ceiling of 39 cases, this was 2 above our best ever annual position of 48 cases (2011/12) and is significantly better than our last end year position of 73 cases (2012/13). A proportion of these infections were classified as ‘unavoidable’ in that all appropriate measures to prevent the infection had been completed.
Two: Improving the reliability of care – delay-free care

Our goal was that care delivered by the hospital would be reliable and timely, measured by the following indicators.

**Outpatient appointments**

In excess of 500,000 outpatient attendances occur each year and we believe that patients should expect to be seen at the time agreed, while recognising this is not always possible as some patients will require longer consultations than others.

Our aim was that 80% of patients are seen within 30 minutes of their stated outpatient appointment time.

**Did we achieve our aims in 2013/14?**

Yes – 82% of patients attending outpatient clinics were seen within 30 minutes.

**Emergency Department waiting time**

In excess of 102,000 patients attended the emergency department at Addenbrooke’s in 2013/14. There is a nationally mandated target to see 95% of patients within four hours.

Our aim was to meet this target each quarter.

**Did we achieve our aims in 2013/14?**

No – we met the target in the first two quarters of the year, but not the last two, the yearly average was 94.7%. There has been considerable increases in demand for the Emergency Department compared to the previous year:

- Ambulance arrivals for 2013/14 up by 9.8%
- Admissions via the emergency department were up 7.6% (2,415 patients)
- Attendances for 2013/14 up by 4.1%(4,014 patients)
In the last quarter we would have needed to treat 232 more patients across quarter 4 within 4 hours to have reached 95%. We have looked at the total time spent in the department for patients who exceeded 4 hours in quarter 4, and we can conclude that had we been able to reduce the patient pathway by 11 min 42 seconds for the 232 patients, we would have achieved 95% in even the most challenging quarter of the year. When described in this context, delivering the standard is achievable in 2014/15.

**Admission within 18 weeks of GP referral**

We recognise the importance for patients to be admitted in a timely manner following referral by their GP.

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

**Did we achieve our aims in 2013/14?**

We achieved this standard at Trust level for 10 of the 12 months of the year, the aggregate score being 93%. For the two months in which we did not meet the target our performance was 89.6% and 89.7% respectively.

**Cancelled operations**

Once a date is set for an operation, we will do our best to ensure that date is kept to, while recognising there will be occasions when emergencies impact on routine operating.

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

**Did we achieve our aims in 2013/14?**

No – We just missed our target, the aggregate score for the year was 1.02%. Towards the end of the year inpatient bed capacity has become an issue and to address this we have a Capacity Workstream as part of our Transformation Programme. This Workstream is aiming to provide alternatives to admission, to reduce length of stay and improve the pre-operative assessment of older patients.

**Delayed Transfers of care (DTOC)**

With Cambridgeshire Commissioning Group and Cambridge County Council we aspire to reach a level of zero delayed transfers of care. Our aim was that bed days lost to assessment each week was less than 10.

**Did we achieve our aims in 2013/14?** No – We never achieved the aim of less than 20 of our beds occupied by DTOC patients on any of the weeks of the year. Throughout the year we averaged 56 beds occupied by DTOC patients, reducing only to 51 beds in the final quarter.

Whilst we only achieved the aim of less than 10 bed days lost to assessment each week on 6 weeks of the year, our performance in assessment has improved significantly. In the first three quarters of the year an average of 47 bed days were lost to assessment each week, reducing to 25 bed days per week in the last quarter.
Three: Improving the experience of our patients – person-centred care

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

Inpatient Experience
We surveyed patients each month using a 24-point questionnaire to seek views of the care received. The questions covered topics that include infection control, cleanliness, privacy, safety, nursing and medical care received, being informed and involved in the care provided, and food.

Our aim was that 95% of patients who respond to the surveys answer questions as ‘yes,’ ‘met expectations’ or ‘above expectations’.

Did we achieve our aims in 2013/14? No – We just missed this target by 0.1%, the aggregate score for the year being 94.9%. This year we surveyed patients after they had been discharged in comparison to other hospitals in the UK who surveyed prior to discharge. This is thought to be a contributing factor to a lower score. In the coming year we will adopt the survey method used by the majority of hospital and survey all our patients prior to their leaving the hospital. However we know that our discharge process can be a source of patient dissatisfaction and therefore we will continue to undertake a quarterly post discharge survey.

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

Our aim is that 95% of patients who respond to the surveys answer questions as ‘strongly agree’ or ‘agree’.

Did we achieve our aims in 2013/14?
Yes – Outpatient surveys were undertaken in July 2013 and February 2014 with just over 20,000 questionnaires returned each time. The results of the July 2013 survey gave a score of 96.3%, with the February 2014 survey recording 95.1%.

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

Our aim was to improve our score to 75 or achieve at least a 10 point increase on our 2012/13 score

Did we achieve our aims in 2013/14?
No we achieved a score of 51.7. However a large number of work streams, led by clinical teams, senior nurses, and transformation leads have been undertaken this year to improve the patient experience. There has been a
The Quality Account 2013/14

Cambridge University Hospitals NHS Foundation Trust

Focus on improving discharge, as this is the area of the Trust’s own larger survey where patients report relatively low levels of satisfaction. It is likely that the Trust’s Friends and Family score is driven in part by this area of the patient experience. The Chief Nurse has convened a multidisciplinary task and finish group to focus on improving the discharge process and it is hoped that this work will lead to improvements in the Friends and Family score. In addition, the Trust is adopting a new methodology for the collection of the Friends and Family score, using iPads’ on the day of discharge, rather than writing to patients within 48 hours of discharge, therefore bringing the Trust’s methodology in line with the majority of other Trusts in the country. We are aiming for a 10% increase in our score in 2014/15.

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

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

Did/will we achieve our aims in 2013/14?
Yes – The monthly rate as a percentage of patient contacts ranged between 0.04% and 0.07%. In 2013/14 a total of 465 formal complaints were received. The actual number of complaints reported each month ranged between 25 and 48.

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

Re-admission rate
This measures the number of patients who are readmitted to the hospital within 30 days of being discharged as an inpatient, excluding those being treated for cancer or who are under the care of an obstetrician.

Our aim was to keep avoidable readmissions below 10%.

Did we achieve our aims in 2013/14?
Due to a previous audit programme not being re-commissioned by the CCG it is not possible to report fully regarding this metric. However information is available as part of national indicators relating to all re-admissions, not just avoidable ones. The latest information available for CUH (2011/12) as set out in Annex 5, identified a re-admission rate within 28 days of discharge for patients aged 15 or over of 10.64%. This compares with the national average of 11.45%..

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

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

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

Patient related outcome measures (PROMS)
These are nationally mandated and provide a patient perspective of the effectiveness of the care they received, in simple terms the health gain or loss following the procedure. They cover surgery undertaken in respect of hips and knees, groin hernia and varicose veins. The information is collated nationally and therefore data for 2011/12 is only recently been made available.

Our aim was that for 2014/15 our results show an improvement on those of 2011/12 and are above the national average.

Did we achieve for 2013/14?
Yes – The information so far available in 2013/14 identifies an improvement on 2011/12 and the results are above the national average in three out of the four measures. The Trust did not undertake enough varicose vein procedures to submit data.

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

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

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

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

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

CQUINs

The CQUIN framework is a national framework for locally agreed quality improvement schemes. 2.5% of CUH income in 2013/14 was conditional upon achieving the CQUINS agreed with NHS Cambridgeshire for the provision of NHS services. The potential CQUIN income available if the Trust had met all its targets across all commissioners’ contracts was £11,021,485. CUH received CQUIN in 2013/14 of £10,634,225. The corresponding CQUIN value for 2012/13 was £11.4m, with the Trust achieving £10.3m.

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

National targets

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

Full details of each National Target and the performance achieved during the year is set out in annex 7.

1.8 Feedback on the quality report and accounts

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

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

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

This document is also available on request in other languages, large print and audio format – please phone 01223 274468.
1.9 **Annex 1: Statement of directors’ responsibilities in respect of the quality report**

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

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

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

- the content of the quality account meets the requirements set out in the ‘NHS Foundation Trust Annual Reporting Manual’ 2013/14
- the content of the quality account is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2013 to March 2014
  - papers relating to quality reported to the board over the period April 2013 to March 2014
  - feedback from commissioners dated 15/04/2014
  - feedback from governors dated 02/05/2014
  - feedback from local Healthwatch organisations dated 12/05/2014
  - the Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 08/05/2014
  - latest national patient survey dated 08/04/2014
  - latest national staff survey dated 26/02/2014
  - the head of internal audit’s annual opinion over the Trust’s control environment dated 14/05/2014
  - CQC quality and risk profiles dated 04/04/2013, 07/06/2013, 04/07/2013 and 07/08/2013.
  - CQC intelligent monitoring reports dated 21/10/2013 and 11/03/2014.
  - the quality account presents a balanced picture of the NHS foundation trust’s performance over the period covered
  - the performance information reported in the quality account is reliable and accurate
  - there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice the data underpinning the measures of performance reported in the quality account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the quality account has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality account.
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board:

Dr Keith McNeil
Chief Executive
22 May 2014

Jane Ramsey
Chair
22 May 2014
Annex 2: Statements by stakeholders

Governors’ statement on the quality account 2012/13
The Council of Governors values the opportunity which governors have to be involved in the development of the trust’s quality priorities, and to comment on the quality account for 2013/14.

During this year, as well as scrutinising the new integrated report on Quality, Finance and Performance, Governors were involved in the development of the Trust’s Quality Strategy and welcomed its launch in January 2014, with five key priorities underpinning everything which the Trust does for the community.

Governors were pleased that the Trust achieved some of its quality account aims for 2013/14, but disappointed that aims for improvement in a number of areas which are important to patients and the public were not met. Governors welcomed the improved openness and transparency of the trust’s reporting on quality in the new integrated report. Following the introduction of the integrated report Governors have actively monitored performance against the Quality Account on a monthly basis. As in previous years, governors and directors will have the opportunity to discuss together the trust’s quality performance at the quality and public engagement governor/director working group. We will continue to monitor the trust’s progress towards the aims which it has set itself, and offer necessary but constructive challenge if we consider that this is not progressing as planned.

Governors welcome the quality priorities which the trust has set out for the coming year, 2014/15, based on the aims of the Quality Strategy and on five key priorities: person-centred care; improving staff engagement (staff as partners); harm-free care; delay-free care and providing clinically effective care. Governors look forward to improved quality performance to report to the public in the next Quality Account.
Statement from Cambridgeshire and Peterborough Clinical Commissioning Group

Statement for inclusion in 2013/14 Quality Account for CUH
May 2014

Cambridgeshire and Peterborough Clinical Commissioning Group (the CCG) has reviewed the Quality Account produced by Cambridge University Hospitals NHS Foundation Trust (CUH) for 2013/14.

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

These visits included a review of End of Life care, one of the key priorities for improvement for the CCG. The CCG identified areas of good practice including the Bereavement Care follow up service, the Breathless Intervention System, and the work of the Palliative Care team. Some areas of improvement were also identified including ensuring appropriate staff are available for decision making at all times.

CUH is monitored by both the Care Quality Commission and Monitor, the independent regulator of NHS Foundation Trusts. The Trust is compliant with all Care Quality Commission requirements. However, it has been in significant breach of its Monitor authorisation throughout 2013/14 due to breaching of treatment targets in certain areas. The CCG has been working with CUH to drive improvements and continues to monitor how the Trust is addressing the required improvements in capacity and capability.

CUH has developed a valuable Quality Strategy aimed at ensuring the Trust provides person-centred care. The priorities for 2014/15 in the CUH Quality Account emphasise the key elements of the Quality Strategy which, in addition to being person centred, aim to promote clinically effective care, improve harm free care, reduce delays and focus on staff engagement. The CCG particularly commends the new priority covering the use of a clinical frailty score for older patients, which is in line with our focus on improving services for older people.

The CCG stated in last year’s Quality Account that CUH needed to reflect on why none of the targets set for the 2012/13 priorities were achieved and to ensure the learning is embedded into its quality delivery programme in 2013/14. CUH’s performance against its quality priorities set for 2013/14 has improved, with seven out of twelve achieved in full and positive actions taken for Infection Control. However, the results from the Friends and Family test, where patients are asked if they would recommend the Trust to their friends and family, have not shown significant improvement.

The CCG also has concerns about delayed transfers of care and how the Trust is working with partners in the health economy to reduce these delays. We would like to see a continued focus in this area as part of the work on delay-free care set out in the CUH Quality Account. In addition, further work is
needed to address other concerns with the discharge process as highlighted by feedback from patents, including waiting for medicine and communication issues between staff.

Many of CUH’s priorities have been carried forward from 2013/14. In some cases the targets for improvement are the same as or less than those for 2013/14, but the CCG would expect to see improved performance going forward. In particular, the CCG expect CUH to focus on the target of a minimum score of 75 for the Friends and Family test for 2014/15. The CCG would also like to see details of more targeted patient surveys to help address areas of concern highlighted by feedback and through other initiatives. There is minimal detail on how the Trust involves patients in change and improvement, and the CCG will look for an increase in these initiatives in 2014/15.

The statement of the Chief Executive highlights a strong performance in reducing healthcare-acquired infections during 2013/14. However, the CCG has stressed to the Trust that although progress have been made, this work needs to continue to maintain improvement. Changes to practice include communication strategies, a robust scrutiny panel with increased medical input and achievement of a detailed action plan for improvement. The Trust had four cases of MRSA bacteraemia during the year compared with six in 2012/13. However, there is a zero tolerance for MRSA and the CCG commend the CUH priority to achieve this in 2014/15. The number of C Difficile cases has also fallen and the CCG look to CUH to continue this reduction. We expect the Trust to reduce the number of cases of C Difficile in 2014/15 to less than the number of cases recorded in 2013/14.

The statement of the Chief Executive acknowledges the importance of the staff in the work of the Trust, and this is emphasised in the Francis Report, particularly in relation to safe staffing. However, detail of workforce planning, and capability and skill mix required to achieve the priorities for improvement are not set out in the Quality Account. Similarly, intelligence from the staff survey and any areas for improvement are not included.

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

The CUH Quality Account is presented in an understandable and consistent format. The priorities for the Trust are set out clearly, with rationale for inclusion for the 14/15 goals. The report includes all the nationally mandated sections. However, a list of services and specialties provided by the Trust is not given or signposted. The CCG has reviewed the data presented in the Quality Account and this appears to be in line with other data published.
Statement by Cambridgeshire County Council adults wellbeing health overview and scrutiny committee (AWHOSC)

Delayed discharge and discharge planning
In response to an increase in the level of delayed discharge, particularly from Addenbrooke’s, during the winter of 2011/12, the AWHOSC conducted a major review of delayed discharge and discharge planning during 2012/13. The OSC obtained evidence from management and operational staff at Addenbrooke’s, other NHS providers, NHS commissioners, and the County Council, and made recommendations to all these agencies in May 2013. Recommendations to CUHFT related to stronger interagency working, more streamlined assessment and discharge planning processes, improved internal and external communication, and improved communication with patients. The AWHOSC considered CUHFT’s response in July 2013, and a progress report in March 2014.

The AWHOSC welcomes the priority CUHFT has given over the past year to reducing delays, which included a focused transformation programme in collaboration with other agencies. We welcome the improvements that have been made to the assessment process, discharge pathway and documentation; and the specific initiatives CUHFT has undertaken, such as improved matching of patients to where there is community based capacity; and geriatrician advice to GPs to help avoid admission, which have contributed to reductions in delays during 2013/14.

We welcome the aim of having all patients aged 75 and over admitted as emergencies having a CFS screen performed within 72 hours of admission.

We strongly encourage CUHFT, working with partner agencies to maintain its focus on this issue, as despite these improvements, the 2013/14 aims in relation to delayed transfers of care were not achieved. We also note that CUHFT identifies the patient experience of discharge as an area requiring improvement, and that work is therefore being undertaken to improve the discharge process.

Priorities for improvement in 2014/15 and beyond
We support the priorities set out in the Quality Account, and encourage CUHFT to maintain a strong focus on those areas where it has not met its targets, particularly hospital acquired infections; Emergency Department waiting times; cancer 62 day waits; 18-week waits, and patient experience.

22nd May 2014
Statement from Cambridgeshire Healthwatch

The Trust has delivered a generally high level of care in the past year and where inspections or information has suggested otherwise, they have taken prompt action. As a world leader in many fields the Trust is to be commended for its outstanding performance in various specialism’s. The Trust has worked with Healthwatch Cambridgeshire, welcoming us and responding to any concerns. We support the quality indicators chosen for 14/15.

We welcome the priority the Trust has given to patient experience. In future Quality Accounts Healthwatch Cambridgeshire would like to see more analysis of the trends and learning taken from both PALS and complaints data. During the year we have been made aware of a number of closures of the Rosie maternity service and reported poor experience of discharge from hospital. Healthwatch Cambridgeshire looks forward to seeing progress in these areas in the coming year.

Healthwatch Cambridgeshire is watching developments around the Clinical Commissioning Group older people’s and community services procurement. As one of the bidders, whether successful or not, the resultant changes will have a significant impact upon people’s health care experiences as well as the Trust’s business model. We hope to see all the partners in the system working closely to ensure that changes have positives impacts for people using health services.
Healthwatch Suffolk response to Cambridge University Hospitals NHS Foundation Trust (CUHFT) Quality Account 2013/14

The Quality Account of the CUHFT is a well presented document which is readable and accessible to the general public, we note that the report is available in a variety of other languages as well as large print and audio formats. The Trust has five key priorities centred on the person. Healthwatch Suffolk also welcomes the Trust’s use of the reporting of potential harm in that it requires incidents to be reported even when there is no harm. The Trust has achieved many of its measurable aims and improved their performance in the others, while not achieving their targets which were quite ambitious in several areas.

The Trust had a disappointing score in the friends and family test of 52, while their target was to achieve 75, they have identified the area which they believe contributed to the score being lower than they wished and are focussing efforts on improving the satisfaction of patients.

The Trust has achieved a good performance in the HSMR rate with an average for the year of 90. The Trust takes part in a large number of clinical audits, as might be expected given its size and extent of the complex care it provides, however these are published in a table, which due to its length may be less accessible than the remainder of the report. The Trust had only one ‘never event’ reported and this is low for a Trust of this size and complexity it would have been helpful had they chosen to discuss it in the quality audit.

The Trust has set out its priorities for the coming year, these are clear and are based on national as well as local patient and staff surveys and other feedback. The priorities are realistic and achievable. The priorities are supported by a clearly set out range of measures. The Trust publishes a comprehensive five year quality strategy, which is available from their web site.

The CUHFT is a large teaching hospital as well as being the local district general for its catchment area. Many complex treatments are carried out for patients from across the Anglia region, and the Trust has a good reputation which it clearly intends to reinforce. Healthwatch Suffolk looks forward to seeing the Trust achieve its goals for the coming year and will work with the Trust in helping it achieving those goals.
1.11 **Annex 3: Our 2014/15 priorities in detail**

**Person Centred**

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

This will be measured through:

**Inpatient experience:** We survey patients each month using a 24-point questionnaire to seek views of the care received. The questions cover topics that include infection control, cleanliness, privacy, safety, nursing and medical care received, being informed and involved in the care provided, and food. Our aim is that over 90% of patients who respond to the surveys answer questions as ‘yes,’ ‘met expectations’ or ‘above expectations’.

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

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

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

Our aim is to improve our score by 10%

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

Our aim is that the number of formal complaints received should be less than 0.1% of patient contacts.
Staff as Partners
A fully engaged, skilled, trained and competent workforce delivering care of the highest quality. An organisation that is well-led at all levels.

This will be measured through:

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

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

**Staff appraisal:** All staff who work for the Trust should have an annual appraisal meeting with their manager to discuss objectives, performance and any other issues relating to their employment.

Our aim is to ensure that over 90% of staff have an annual appraisal.

**Staff engagement:** The Trust undertakes its own internal staff engagement survey.

Our aim is to improve staff participation to 55%.

**Sickness absence:** This is measured using the number of days lost to sickness as a percentage of the contracted working hours of all Trust staff and is split by profession and department.

Our aim is to reduce the Trust’s overall sickness absence rate by 5%.

**Staff Friends and Family test:** One of the key elements of the national Friends and Family programme is to ask staff their views regarding the care delivered at the hospital in which they work. In simple terms is its good enough for them or their family. This test will be introduced in 2013/14 and the target at this stage is to ensure its smooth introduction.

Our aim is to implement the test in line with national guidance in 2013/14.

Harm Free
Patients will suffer no avoidable harm.

**This will be measured through:**

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

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

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

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

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

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

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

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

This will be measured through:

**Emergency department waiting time:** In excess of 102,000 patients attended the emergency department at Addenbrooke’s in 2013/14. There is a nationally mandated target to see 95% of patients within four hours.

Our aim is to meet this target each quarter.

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

Our aim is that 90% of our patients who require admission will be admitted within an 18-week timeframe.
Treatment within 62 days of an urgent cancer referral: We recognise the importance for patients of being treated in a timely manner following urgent referral by their GP where cancer is suspected.

Our aim is that 85% of patients are treated within 62 days of referral.

Cancelled operations: Once a date is set for an operation, we will do our best to ensure that date is kept to, while recognising there will be occasions when emergencies impact on routine operating.

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

Clinically Effective

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

This will be measured through:

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

Our aim is have an aggregate hospital HSMR of less than 90.

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

Our aim is that for 2014/15 our results show an improvement on those of 2012/13 and are above the national average.

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

We are committed to deliver a streamlined service to support robust cross interface integration and propose the development of a specialist SAFE team (Specialist Advice for Frail Elderly) to provide integrated support to all frail elderly irrespective of presenting complaint and location within the Trust. This will allow patients to be supported along their whole pathway from the point of admission through to discharge and integrate with community services.
A key element of their admission is that they undergo a proper screening using the clinical frail score tool within their first 72 hours in hospital to identify their treatment requirements.

Our aim is that at least 85% of patients aged 75 and over, admitted as emergencies will have a CFS screen performed within 72 hours of admission.
### 1.12 Annex 4: National quality indicators – 2013/14 performance

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2012/13 (or previous reporting period to latest available)</th>
<th>2013/14 (or latest reporting period available)</th>
<th>CUHFT considers that this data is as described for the following reasons…</th>
<th>CUHFT intends to take/has taken the following actions to improve this proportion/ score/rate/number, and so the quality of its services, by…</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary Hospital-Level Mortality Indicator (SHMI)</strong></td>
<td>83.6, placing the Trust in Band 3 indicating better than expected mortality</td>
<td>85.6 from July 2012 to June 2013 placing the Trust in Band 3</td>
<td>The Trust has a robust process for clinical coding and review of mortality data so is confident that the data is accurate.</td>
<td>The Trust reviews SHMI data and always looks at how it can be reduced further.</td>
</tr>
<tr>
<td><strong>Note 100 = average performance</strong></td>
<td>16 Trusts were similarly placed in Band 3</td>
<td>17 Trusts were in Band 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>% of patient deaths with palliative care code</strong></td>
<td>17.6%</td>
<td>14.2%</td>
<td>The Trust has a robust process for clinical coding and review of mortality data so is confident that the data is accurate.</td>
<td>The Trust percentage is better than the national average so no further action is being taken at present.</td>
</tr>
<tr>
<td></td>
<td>The national average is 18.4%</td>
<td>The national average is 20.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PROMS relating to:</strong></td>
<td>April 2011 to March 2012</td>
<td>April 2012 to March 2013</td>
<td>The Trust has processes in place to ensure that relevant patients are given questionnaires to complete. However it has no control over their completion and</td>
<td>The use of PROMS data within the Trust is reviewed and reported in the Integrated Report to the Quality Committee each month. Where our data is applicable, the Trust is better than the national average in the latest</td>
</tr>
<tr>
<td>Indicator</td>
<td>2012/13 (or previous reporting period to latest available)</td>
<td>2013/14 (or latest reporting period available)</td>
<td>CUHFT considers that this data is as described for the following reasons…</td>
<td>CUHFT intends to take/has taken the following actions to improve this proportion/ score/rate/number, and so the quality of its services, by…</td>
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<td>-----------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Groin hernia surgery</td>
<td>Trust 0.095</td>
<td>Trust 0.106</td>
<td>return.</td>
<td>return.</td>
</tr>
<tr>
<td></td>
<td>Ave 0.087</td>
<td>Ave 0.085</td>
<td></td>
<td>reporting period.</td>
</tr>
<tr>
<td>Varicose vein surgery</td>
<td>Trust N/A</td>
<td>Trust N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ave 0.094</td>
<td>Ave 0.093</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip replacement surgery</td>
<td>Trust 0.451</td>
<td>Primary – Trust 0.460</td>
<td></td>
<td>The Trust has a robust process for clinical coding so is confident that the data is accurate.</td>
</tr>
<tr>
<td></td>
<td>Ave 0.416</td>
<td>Trust N/A</td>
<td></td>
<td>The Trust rates for 0-14 and 15 plus ages re-admissions show some improvement on last year and are both better than the national average.</td>
</tr>
<tr>
<td>Knee replacement surgery</td>
<td>Trust 0.299</td>
<td>Primary – Trust 0.323</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Ave 0.302</td>
<td>Trust N/A</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Ave 0.319</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readmission within 28 days of discharge (i)</td>
<td>Trust rate was 9.27% for 2010/11 placing the Trust in</td>
<td>Trust rate was 8.36% for 2011/12 placing the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>aged 0-14</td>
<td>band W (within national average expected variation).</td>
<td>Trust in band B1, meaning significantly better than the national average</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Trust has a robust process for clinical coding so is confident that the data is accurate.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Indicator

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2012/13 (or previous reporting period to latest available)</th>
<th>2013/14 (or latest reporting period available)</th>
<th>CUHFT considers that this data is as described for the following reasons...</th>
<th>CUHFT intends to take/has taken the following actions to improve this proportion/ score/rate/number, and so the quality of its services, by...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission within 28 days of discharge (ii) aged 15 or over</td>
<td>Trust rate was 10.70% for 2010/11 placing the Trust in Band B1</td>
<td>Trust rate was 10.64% for 2011/12 placing the Trust in Band B1</td>
<td>the 99.8% interval.</td>
<td>The Trust looks at how it can be reduced further.</td>
</tr>
<tr>
<td></td>
<td>National average rate was 10.15%</td>
<td>National average was 10.01%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>National average rate was 11.42%</td>
<td>National average was 11.45%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsiveness to inpatients' personal needs</td>
<td>Trust score was 70.8 in 2011/12</td>
<td>Trust score was 70.5 for 2012/13</td>
<td>Undertaken independently as part of the annual national inpatient survey.</td>
<td>The Trust has experienced unprecedented levels of activity in the last 12 months which has, at times, proved challenging. We continue to use feedback from surveys and complaints to address areas of performance which fall short of our standards.</td>
</tr>
<tr>
<td></td>
<td>National average was 67.4</td>
<td>National average was 68.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% risk assessed for VTE</td>
<td>Trust achieved 98.7% in Q2 2013/14</td>
<td>Trust achieved 98.8% in Q3 2013/14</td>
<td>The Trust has a robust process assessing VTE risk assessment of patients and this is also part of the monthly Safety Thermometer audit.</td>
<td>The Trust remains vigilant to ensure that this performance is sustained. It is monitored by the Trusts VTE Committee.</td>
</tr>
</tbody>
</table>
### Cases of *C. difficile* infection per 100,000 bed days

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2012/13 (or previous reporting period to latest available)</th>
<th>2013/14 (or latest reporting period available)</th>
<th>CUHFT considers that this data is as described for the following reasons…</th>
<th>CUHFT intends to take/has taken the following actions to improve this proportion/ score/rate/number, and so the quality of its services, by…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Trust average was 95.7%</td>
<td>Acute Trust average was 95.8%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust rate was 15.2 in 2011/12 (48 cases)</td>
<td>Trust rate was 23.5 in 2012/13 (73 cases)</td>
<td>Difficult to define why rate of infection has increased since mid 2012. The lack of capacity (and consequent impact on deep cleaning programme and time to isolation) and increasing acuity of attendance is likely to be a significant factor.</td>
<td>AC. <em>difficile</em> task force meet weekly. A number of wide ranging actions involving both the Trust and wider health economy have been instituted or are nearing completion. A number of visits and external reviews have been commissioned to learn from others.</td>
<td></td>
</tr>
</tbody>
</table>

### Patient safety incidents

#### (i) Number

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2012/13 (or previous reporting period to latest available)</th>
<th>2013/14 (or latest reporting period available)</th>
<th>CUHFT considers that this data is as described for the following reasons…</th>
<th>CUHFT intends to take/has taken the following actions to improve this proportion/ score/rate/number, and so the quality of its services, by…</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Trust number for April 2012 to September 2012 was 5,913</td>
<td>(i) Trust number for October 2012 to March 2013 was 5,955</td>
<td>Data is submitted to the National Reporting and Learning System in accordance with national reporting requirements.</td>
<td>The Trust has a positive reporting culture. Reducing harm to patients is a one of the key elements of our quality account and quality strategy.</td>
<td></td>
</tr>
</tbody>
</table>

#### (ii) Rate per 100 admissions

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2012/13 (or previous reporting period to latest available)</th>
<th>2013/14 (or latest reporting period available)</th>
<th>CUHFT considers that this data is as described for the following reasons…</th>
<th>CUHFT intends to take/has taken the following actions to improve this proportion/ score/rate/number, and so the quality of its services, by…</th>
</tr>
</thead>
<tbody>
<tr>
<td>(ii) Rate was 9.03</td>
<td>(ii) Rate was 9.09</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### (iii) Number and percentage resulting in severe harm/death

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2012/13 (or previous reporting period to latest available)</th>
<th>2013/14 (or latest reporting period available)</th>
<th>CUHFT considers that this data is as described for the following reasons…</th>
<th>CUHFT intends to take/has taken the following actions to improve this proportion/ score/rate/number, and so the quality of its services, by…</th>
</tr>
</thead>
<tbody>
<tr>
<td>(iii) 17 resulted in severe harm/death, 0.29% of incidents</td>
<td>(iii) 21 resulted in severe harm/death, 0.35% of incidents</td>
<td>Note: these figures relate to incidents reported via the Trust incident reporting system which relies on the reporter identifying that an incident has occurred</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Friends and Family

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2012/13 (or previous reporting period to latest available)</th>
<th>2013/14 (or latest reporting period available)</th>
<th>CUHFT considers that this data is as described for the following reasons…</th>
<th>CUHFT intends to take/has taken the following actions to improve this proportion/ score/rate/number, and so the quality of its services, by…</th>
</tr>
</thead>
<tbody>
<tr>
<td>78% in 2012 survey, placing</td>
<td>83% in 2013 survey,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undertaken independently</td>
<td>Already in the top 20% and looks to at</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>2012/13 (or previous reporting period to latest available)</td>
<td>2013/14 (or latest reporting period available)</td>
<td>CUHFT considers that this data is as described for the following reasons…</td>
<td>CUHFT intends to take/has taken the following actions to improve this proportion/ score/rate/number, and so the quality of its services, by…</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td>------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Test – Staff</td>
<td>Trust in best 20% of trusts</td>
<td>placing Trust in best 20% of trusts</td>
<td>as part of the annual national staff survey.</td>
<td>least sustain this position.</td>
</tr>
<tr>
<td>% of staff recommending the trust to family or friends</td>
<td>Acute trust average65%</td>
<td>Acute trust average64%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends and Family Test – Patient (not statutory)</td>
<td>Inpatient Net Promoter Score for March 2014 is 49.4. This is based on 785 responses and the score is an increase from 45.1 in February. The score for the overall 2013/14 financial year is 51.7.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## 1.13 Annex 5: Quality Account indicators 2013/14 performance

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

#### AS AT END MARCH 2014

<table>
<thead>
<tr>
<th>HARM FREE CARE</th>
<th>Improving safety and reducing harm</th>
<th>PERSON CENTRED CARE</th>
<th>Improving the experience of our patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How we measure this</strong></td>
<td><strong>Our target</strong></td>
<td><strong>How are we doing?</strong></td>
<td><strong>How are we doing?</strong></td>
</tr>
<tr>
<td>Care Delivered Harm Free (Safety Thermometer)</td>
<td>97%</td>
<td>Last month (comparison to last month)</td>
<td>Year to date</td>
</tr>
<tr>
<td></td>
<td></td>
<td>98.6%</td>
<td>Better</td>
</tr>
<tr>
<td>Harm Rates (as reported on incidents)</td>
<td>Less than 0.2%</td>
<td>Last month (comparison to last month)</td>
<td>Year to date</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimise Infection - MRSA</td>
<td>0</td>
<td>Last month (comparison to last month)</td>
<td>Year to date</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimise Infection - Clostridium Difficile</td>
<td>39</td>
<td>Last month (comparison to last month)</td>
<td>Year to date</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### DELAY FREE CARE
Improving the reliability of care

<table>
<thead>
<tr>
<th>How we measure this</th>
<th>Our target</th>
<th>How are we doing?</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Last month</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(comparison to last month)</td>
<td></td>
</tr>
<tr>
<td>Outpatient Appointments within 30 minutes</td>
<td>80%</td>
<td>83.8%</td>
<td>Worse</td>
</tr>
<tr>
<td>Emergency Department waiting time (four-hour Target)</td>
<td>95%</td>
<td>91.7%</td>
<td>Worse</td>
</tr>
<tr>
<td>Admission within 18 weeks of GP referral</td>
<td>90%</td>
<td>93.0%</td>
<td>Better</td>
</tr>
<tr>
<td>Cancelled Operations</td>
<td>Less than 1%</td>
<td>1.52%</td>
<td>Worse</td>
</tr>
<tr>
<td>Delayed Transfers of Care (bed days lost to assessment each week)</td>
<td>Less than 10</td>
<td>24.5</td>
<td>Worse</td>
</tr>
</tbody>
</table>

### CLINICALLY EFFECTIVE CARE
Improving the effectiveness of care

<table>
<thead>
<tr>
<th>How we measure this</th>
<th>Our target</th>
<th>How are we doing?</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-admission rate (includes avoidable re-admissions)</td>
<td>Less than 12.95%</td>
<td>14.68</td>
<td>Worse</td>
</tr>
<tr>
<td>Hospital Standardised Mortality Ratio (HSMR)</td>
<td>Less than 90</td>
<td>68.1 (January test month available)</td>
<td>Worse</td>
</tr>
<tr>
<td>Patient Related Outcome (above national average or not)</td>
<td>Hip</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Knees</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hernia</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Varicose Veins</td>
<td>No data available - low procedure numbers</td>
<td></td>
</tr>
</tbody>
</table>
## 1.14 Annex 6: CQUINs 2013/14 performance

<table>
<thead>
<tr>
<th>Goal Number</th>
<th>CQUIN</th>
<th>% Indicator weighting</th>
<th>Indicator description</th>
<th>Q1 target</th>
<th>Quarter 1 actual</th>
<th>Q2 target</th>
<th>Quarter 2 actual</th>
<th>Q3 target</th>
<th>Quarter 3 actual</th>
<th>Q4 target</th>
<th>Quarter 4 actual</th>
<th>Year end Target</th>
<th>2015/16 Final Indicator weighted</th>
<th>CQUIN Value (€)</th>
<th>CQUIN Value (€)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phased Expansion</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>50%</td>
<td>Deliver the nationally agreed roll-out plan to the national timetable. (Maturity by end of October 2013 and additional services (TPRS) by end March 2014)</td>
<td>Roll out: September 2013 (Maturity by October 2013)</td>
<td>October 2013</td>
<td>Roll out: September 2013 (Maturity by October 2013)</td>
<td>Roll out: September 2013 (Maturity by October 2013)</td>
<td>100%</td>
<td>February 2014</td>
<td>No additional nationally mandated services defined</td>
<td>Roll out site implemented</td>
<td>March 2014</td>
<td>£165,222</td>
<td>£165,222</td>
<td></td>
</tr>
<tr>
<td><strong>Increased response rate</strong></td>
<td></td>
<td>40%</td>
<td>Increasing response rate in acute inpatient and A&amp;E areas. Achieve in top 50% which also improves on Q2 rate.</td>
<td>Increasing response rate in acute inpatient and A&amp;E areas. Achieve in top 50% which also improves on Q2 rate.</td>
<td>March 2014</td>
<td>Increasing response rate in acute inpatient and A&amp;E areas. Achieve in top 50% which also improves on Q2 rate.</td>
<td>Increasing response rate in acute inpatient and A&amp;E areas. Achieve in top 50% which also improves on Q2 rate.</td>
<td>100%</td>
<td>April 2014</td>
<td>No additional nationally mandated services defined</td>
<td>Increasing response rate in acute inpatient and A&amp;E areas. Achieve in top 50% which also improves on Q2 rate.</td>
<td>April 2014</td>
<td>£220,435</td>
<td>£220,435</td>
<td></td>
</tr>
<tr>
<td><strong>Staff, Friends and Family Test</strong></td>
<td></td>
<td>20%</td>
<td>Improved performance on the adult friends and Family test compared to 2012/13, remain in top quartile</td>
<td>Improved performance on the adult friends and Family test compared to 2012/13, remain in top quartile</td>
<td>February 2014</td>
<td>Improved performance on the adult friends and Family test compared to 2012/13, remain in top quartile</td>
<td>Improved performance on the adult friends and Family test compared to 2012/13, remain in top quartile</td>
<td>100%</td>
<td>January 2014</td>
<td>No additional nationally mandated services defined</td>
<td>Improved performance on the adult friends and Family test compared to 2012/13, remain in top quartile</td>
<td>January 2014</td>
<td>£165,222</td>
<td>£165,222</td>
<td></td>
</tr>
<tr>
<td><strong>Pressure Ulcers</strong></td>
<td></td>
<td>100%</td>
<td>Number of patients recorded as having a category 2-4 pressure ulcer as measured using the NHS Safety Thermometer. CQUIN focuses on all Pus in the data collection with aim to reduce 2012/13 prevalence rate (baseline by 50%)</td>
<td>Number of patients recorded as having a category 2-4 pressure ulcer as measured using the NHS Safety Thermometer. CQUIN focuses on all Pus in the data collection with aim to reduce 2012/13 prevalence rate (baseline by 50%)</td>
<td>December 2013</td>
<td>Number of patients recorded as having a category 2-4 pressure ulcer as measured using the NHS Safety Thermometer. CQUIN focuses on all Pus in the data collection with aim to reduce 2012/13 prevalence rate (baseline by 50%)</td>
<td>Number of patients recorded as having a category 2-4 pressure ulcer as measured using the NHS Safety Thermometer. CQUIN focuses on all Pus in the data collection with aim to reduce 2012/13 prevalence rate (baseline by 50%)</td>
<td>100%</td>
<td>November 2013</td>
<td>No additional nationally mandated services defined</td>
<td>Number of patients recorded as having a category 2-4 pressure ulcer as measured using the NHS Safety Thermometer. CQUIN focuses on all Pus in the data collection with aim to reduce 2012/13 prevalence rate (baseline by 50%)</td>
<td>November 2013</td>
<td>£501,074</td>
<td>£501,074</td>
<td></td>
</tr>
<tr>
<td><strong>Find, Assess, Investigate and Refer</strong></td>
<td></td>
<td>60%</td>
<td>% of emergency admissions aged 75 who have been asked five dementia case finding questions</td>
<td>% of emergency admissions aged 75 who have been asked five dementia case finding questions</td>
<td>September 2013</td>
<td>% of emergency admissions aged 75 who have been asked five dementia case finding questions</td>
<td>% of emergency admissions aged 75 who have been asked five dementia case finding questions</td>
<td>100%</td>
<td>August 2013</td>
<td>No additional nationally mandated services defined</td>
<td>% of emergency admissions aged 75 who have been asked five dementia case finding questions</td>
<td>August 2013</td>
<td>£310,645</td>
<td>£310,645</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Leadership</strong></td>
<td></td>
<td>20%</td>
<td>Accredited clinician for dementia and appropriate training for staff</td>
<td>Accredited clinician for dementia and appropriate training for staff</td>
<td>September 2013</td>
<td>Accredited clinician for dementia and appropriate training for staff</td>
<td>Accredited clinician for dementia and appropriate training for staff</td>
<td>100%</td>
<td>August 2013</td>
<td>No additional nationally mandated services defined</td>
<td>Accredited clinician for dementia and appropriate training for staff</td>
<td>August 2013</td>
<td>£110,215</td>
<td>£110,215</td>
<td></td>
</tr>
<tr>
<td><strong>Supporting Carers</strong></td>
<td></td>
<td>20%</td>
<td>Monthly audit of cases of patients admitted with dementia during their stay. Results reported to the Board</td>
<td>Monthly audit of cases of patients admitted with dementia during their stay. Results reported to the Board</td>
<td>September 2013</td>
<td>Monthly audit of cases of patients admitted with dementia during their stay. Results reported to the Board</td>
<td>Monthly audit of cases of patients admitted with dementia during their stay. Results reported to the Board</td>
<td>100%</td>
<td>August 2013</td>
<td>No additional nationally mandated services defined</td>
<td>Monthly audit of cases of patients admitted with dementia during their stay. Results reported to the Board</td>
<td>August 2013</td>
<td>£110,215</td>
<td>£110,215</td>
<td></td>
</tr>
<tr>
<td>National 4</td>
<td>VTE Risk Assessment</td>
<td>25%</td>
<td>% of adult inpatients who have had a VTE risk assessment on admission to hospital</td>
<td>Apr - 31.5% May - 30.8% June - 39.0% July - 40.8% Aug - 39.7% Sep - 56.7% Oct - 58.7% Nov - 58.1% Dec - 58.7% Jan - 56.5% Feb - 55.3% Mar - 57.3% Apr - 50.2%</td>
<td>£137,769</td>
<td>£137,769</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>National 4</td>
<td>VTE Root Cause Analysis</td>
<td>75%</td>
<td>The number of root cause analyses carried out on cases of hospital associated thrombosis</td>
<td>Apr: 100% May: 100% June: 100% July: 100% Aug: 100% Sep: 100% Oct: 93% Nov: 90% Dec: 93% Jan: 97% Feb: 100% Mar: 93% Apr: 93%</td>
<td>£142,206</td>
<td>£142,206</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National 4</td>
<td>Clinical Dashboard for Specialised Services</td>
<td>100%</td>
<td>To embed and demonstrate routine use of specialised services clinical dashboards</td>
<td>100%</td>
<td>£0</td>
<td>£0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National 4</td>
<td>Highly specialised services clinical outcome collaborative audit workshop and provider report</td>
<td>100%</td>
<td>Full participation of providers highly specialised services in the collaborative audit workshop</td>
<td>100%</td>
<td>£403,001</td>
<td>£403,001</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: The table shows the progress and achievement of different initiatives and their corresponding targets and achievements for the year 2013/14. The table includes details of VTE risk assessment, VTE root cause analysis, clinical dashboard, and highly specialised services clinical outcome collaborative audit workshop and provider report.
### Frail Elderly Identified at point of admission

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Details</th>
<th>Screening tool</th>
<th>Tool in place</th>
<th>April 2013</th>
<th>October 2013</th>
<th>Jan-Mar 2014</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Average Q4</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>1 July 13</th>
<th>4 July 13</th>
<th>£310,797</th>
<th>£310,797</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>All patients aged 75+ yrs and over admitted as emergencies to be screened for frailty using the clinical frailty score CFS within 72hrs of admission</td>
<td>CAMSCREEN point of care tool to assess frailty</td>
<td>Tool in place 1/10 July - 31/7 Aug - 30/9 Sept - 30/11 Dec - 31/1 Q1- 1/3 Q2</td>
<td>April 2013</td>
<td>October 2013</td>
<td>Jan-Mar 2014</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Average Q4</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>1 July 13</td>
<td>4 July 13</td>
<td>£310,797</td>
<td>£310,797</td>
</tr>
</tbody>
</table>

### Frail Elderly under the care of a Geriatrician/DME Team

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Details</th>
<th>Screening tool</th>
<th>Tool in place</th>
<th>April 2013</th>
<th>October 2013</th>
<th>Jan-Mar 2014</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Average Q4</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>1 July 13</th>
<th>4 July 13</th>
<th>£771,057</th>
<th>£771,057</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>All frail elderly patients admitted to the Trust are to be managed under the care of a senior member of the DME team</td>
<td>CAMSCREEN point of care tool to assess frailty</td>
<td>Tool in place 1/10 July - 31/7 Aug - 30/9 Sept - 30/11 Dec - 31/1 Q1- 1/3 Q2</td>
<td>April 2013</td>
<td>October 2013</td>
<td>Jan-Mar 2014</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Average Q4</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>1 July 13</td>
<td>4 July 13</td>
<td>£771,057</td>
<td>£771,057</td>
</tr>
</tbody>
</table>

### Improved Communication to Carers/Relatives

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Details</th>
<th>Screening tool</th>
<th>Tool in place</th>
<th>April 2013</th>
<th>October 2013</th>
<th>Jan-Mar 2014</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Average Q4</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>1 July 13</th>
<th>4 July 13</th>
<th>£310,797</th>
<th>£310,797</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>All patients admitted aged 65+ yrs and over whose carers or relatives have been contacted during their admission</td>
<td>CAMSCREEN point of care tool to assess frailty</td>
<td>Tool in place 1/10 July - 31/7 Aug - 30/9 Sept - 30/11 Dec - 31/1 Q1- 1/3 Q2</td>
<td>April 2013</td>
<td>October 2013</td>
<td>Jan-Mar 2014</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Average Q4</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>1 July 13</td>
<td>4 July 13</td>
<td>£310,797</td>
<td>£310,797</td>
</tr>
</tbody>
</table>

### Orthogeriatric Assessment

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Details</th>
<th>Screening tool</th>
<th>Tool in place</th>
<th>April 2013</th>
<th>October 2013</th>
<th>Jan-Mar 2014</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Average Q4</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>1 July 13</th>
<th>4 July 13</th>
<th>£310,797</th>
<th>£310,797</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>Orthogeriatric patients aged over 65+ yrs and eligible to be assessed by a consultant orthogeriatrician (G7) within 72hrs of admission</td>
<td>CAMSCREEN point of care tool to assess frailty</td>
<td>Tool in place 1/10 July - 31/7 Aug - 30/9 Sept - 30/11 Dec - 31/1 Q1- 1/3 Q2</td>
<td>April 2013</td>
<td>October 2013</td>
<td>Jan-Mar 2014</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Average Q4</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>1 July 13</td>
<td>4 July 13</td>
<td>£310,797</td>
<td>£310,797</td>
</tr>
</tbody>
</table>

### Enhanced discharge summary

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Details</th>
<th>Screening tool</th>
<th>Tool in place</th>
<th>April 2013</th>
<th>October 2013</th>
<th>Jan-Mar 2014</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Average Q4</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>1 July 13</th>
<th>4 July 13</th>
<th>£310,797</th>
<th>£310,797</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>Enhanced discharge summary for frail elderly patients 75+ yrs and over that supports development of community management plan</td>
<td>CAMSCREEN point of care tool to assess frailty</td>
<td>Tool in place 1/10 July - 31/7 Aug - 30/9 Sept - 30/11 Dec - 31/1 Q1- 1/3 Q2</td>
<td>April 2013</td>
<td>October 2013</td>
<td>Jan-Mar 2014</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Average Q4</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>1 July 13</td>
<td>4 July 13</td>
<td>£310,797</td>
<td>£310,797</td>
</tr>
</tbody>
</table>

### Heart Failure Patients with a Personalised Management Plan

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Details</th>
<th>Screening tool</th>
<th>Tool in place</th>
<th>April 2013</th>
<th>October 2013</th>
<th>Jan-Mar 2014</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Average Q4</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>1 July 13</th>
<th>4 July 13</th>
<th>£310,797</th>
<th>£310,797</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>% of heart failure patients given a personalised management plan shared with the patient, their GP and the care team</td>
<td>CAMSCREEN point of care tool to assess frailty</td>
<td>Tool in place 1/10 July - 31/7 Aug - 30/9 Sept - 30/11 Dec - 31/1 Q1- 1/3 Q2</td>
<td>April 2013</td>
<td>October 2013</td>
<td>Jan-Mar 2014</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Average Q4</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>1 July 13</td>
<td>4 July 13</td>
<td>£310,797</td>
<td>£310,797</td>
</tr>
</tbody>
</table>

### Designated DME Specialist Staff

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Details</th>
<th>Screening tool</th>
<th>Tool in place</th>
<th>April 2013</th>
<th>October 2013</th>
<th>Jan-Mar 2014</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Average Q4</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>1 July 13</th>
<th>4 July 13</th>
<th>£310,797</th>
<th>£310,797</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>Specialist DME staff to be contactable by GPs, district nurses, or community nurses in order to support earlier and more robust discharge arrangements</td>
<td>CAMSCREEN point of care tool to assess frailty</td>
<td>Tool in place 1/10 July - 31/7 Aug - 30/9 Sept - 30/11 Dec - 31/1 Q1- 1/3 Q2</td>
<td>April 2013</td>
<td>October 2013</td>
<td>Jan-Mar 2014</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Average Q4</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>1 July 13</td>
<td>4 July 13</td>
<td>£310,797</td>
<td>£310,797</td>
</tr>
<tr>
<td>LOCAL 7 Neuro</td>
<td>Neurosurgical Shunt Surgery</td>
<td>100%</td>
<td>Reduce to 10% or less the number of new shunts requiring revisions within 30 days of insertion due to infection</td>
<td>Apr - 16% May - 6% June - 5% Q1 - 3%</td>
<td>July - 3% Aug - 3% Sept - 0% Q2 - 0%</td>
<td>Oct - 0% Nov - 0% Dec - 0% Q2 - 0%</td>
<td>Jan - 0% Feb - 0% Mar - 0%</td>
<td>20% of £ per Quarter providing Q4 &lt;10%</td>
<td>£342,441</td>
<td>£542,441</td>
<td>2013/14</td>
<td>£17,001,495</td>
<td>£18,034,225</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOCAL 8 Nuclear</td>
<td>Bone Marrow Transplant donor acquisition measures</td>
<td>25% per element</td>
<td>Scheme of 4 elements to gain better understanding and improvement on processes to identify unrelated donors</td>
<td>Only report as defined</td>
<td>Only report as defined</td>
<td>Only report as defined</td>
<td>Data in files</td>
<td>Only report as defined</td>
<td>Only report as defined</td>
<td>Only report as defined</td>
<td>Only report as defined</td>
<td>Only report as defined</td>
<td>25% of £ for each Only report</td>
<td>£342,441</td>
<td>£542,441</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOCAL 9 Haemat</td>
<td>Haemophilia - Haemtrack monitoring</td>
<td>100%</td>
<td>Increase the number of severe and moderate haemophilia A and B patients who have clotting factor data provided on Haemtrack</td>
<td>Qualify quarterly progress report</td>
<td>Qualify quarterly progress report</td>
<td>Qualify quarterly progress report</td>
<td>Performance at 33.5%</td>
<td>Performance at 73.7%</td>
<td>50%</td>
<td>Final performance 77.7% annum 2013-14</td>
<td>25% for each Only milestone providing Q4 50% target met</td>
<td>£342,441</td>
<td>£542,441</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOCAL 10 NICU</td>
<td>Neonatal Intensive Care</td>
<td>Timely administration of total parenteral nutrition</td>
<td>100%</td>
<td>% of babies &lt;36+4 weeks gestation and &lt;1000g birthweight who start TPN by day 2 of life (excluding babies who have undergone surgery)</td>
<td>Submit dataset rationale, action plan</td>
<td>Baseline from 2012/13: 71%</td>
<td>Submit quarterly action plan update</td>
<td>July - 100% Aug - 100% Sept - 100% Q2 - 100% Q3 - 100% Q4 - 100%</td>
<td>YTD Avg = 96.2%</td>
<td>Submit quarterly action plan update</td>
<td>Oct - 100% Nov - 100% Dec - 100% Q1 - 100% Q2 - 100%</td>
<td>YTD Avg = 97.7%</td>
<td>25% for each Only milestone providing Q4 50% target met</td>
<td>£342,441</td>
<td>£542,441</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LOCAL 11 NICU</td>
<td>Renal transplant cold ischaemic time</td>
<td>100%</td>
<td>To reduce cold ischaemic time for all first recipient kidney transplants DDD donors under 18hrs DCD donors under 12hrs</td>
<td>Activity report; working group action plan</td>
<td>Activity report; working group action plan</td>
<td>Activity report; working group action plan</td>
<td>YTD performance 59% (02/10/13)</td>
<td>YTD performance 72% (07/10/13) before accounting for any unplanned re-transplants or exclusions for non-compliance criteria</td>
<td>25% Activity Information and final report</td>
<td>Final YTD performance: 89% Performance below target, but qualifies for 50% payment</td>
<td>25% for each Only milestone providing Q4 50% target met if not met &lt;40% = 0 80% - 89% = 50% of £</td>
<td>£342,441</td>
<td>£521,721</td>
<td>£11,001,495</td>
<td>£18,034,225</td>
<td>2013/14</td>
<td>£17,001,495</td>
</tr>
</tbody>
</table>
## Annex 7: National Targets - 2013/14 performance

### 2013/14 National & PCT Targets

<table>
<thead>
<tr>
<th>Target Description</th>
<th>2012-13 Actual</th>
<th>Current Month</th>
<th>2013/14 Financial Year</th>
<th>2013/14 Target</th>
<th>Key Driver</th>
<th>Data up to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of MRSA Bacteraemias</td>
<td>5</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>Monitor &amp; Contract Penalties</td>
<td>Mar-14</td>
</tr>
<tr>
<td>Clostridium difficile infection in the 2 and over age group</td>
<td>73</td>
<td>5</td>
<td>50</td>
<td>39</td>
<td>Monitor &amp; Contract Penalties</td>
<td>Mar-14</td>
</tr>
<tr>
<td>A&amp;E - % of Patients who have waited less than 4 hours</td>
<td>94.0%</td>
<td>91.7%</td>
<td>94.4%</td>
<td>95%</td>
<td>Monitor &amp; Contract Penalties</td>
<td>Mar-14</td>
</tr>
<tr>
<td>Cancer 2-week wait from urgent referral to first seen</td>
<td>94.7%</td>
<td>96.9%</td>
<td>96.9%</td>
<td>93%</td>
<td>Monitor &amp; Contract Penalties</td>
<td>Feb-14</td>
</tr>
<tr>
<td>Cancer 31-day wait for first treatment from diagnosis</td>
<td>96.6%</td>
<td>97.6%</td>
<td>97.5%</td>
<td>96%</td>
<td>Monitor &amp; Contract Penalties</td>
<td>Feb-14</td>
</tr>
<tr>
<td>Cancer 31-day wait for subsequent treatment - Anti-cancer drugs</td>
<td>99.8%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>98%</td>
<td>Monitor &amp; Contract Penalties</td>
<td>Feb-14</td>
</tr>
<tr>
<td>Cancer 31-day wait for subsequent treatment - Surgery</td>
<td>95.1%</td>
<td>98.2%</td>
<td>95.4%</td>
<td>94%</td>
<td>Monitor &amp; Contract Penalties</td>
<td>Feb-14</td>
</tr>
<tr>
<td>Cancer 31-day wait for subsequent treatment - Radiotherapy</td>
<td>96.1%</td>
<td>98.6%</td>
<td>96.5%</td>
<td>94%</td>
<td>Monitor &amp; Contract Penalties</td>
<td>Feb-14</td>
</tr>
<tr>
<td>Cancer 62-day wait for first treatment from Standard urgent referral (85.0% with reallocations)</td>
<td>80.7%</td>
<td>83.2%</td>
<td>84.8%</td>
<td>85%</td>
<td>Monitor &amp; Contract Penalties</td>
<td>Feb-14</td>
</tr>
<tr>
<td>Cancer 02-day wait for first treatment from Screening service urgent</td>
<td>95.4%</td>
<td>86.0%</td>
<td>91.4%</td>
<td>90%</td>
<td>Monitor &amp; Contract Penalties</td>
<td>Feb-14</td>
</tr>
<tr>
<td>18 weeks from GP referral to hospital treatment - admitted patients</td>
<td>87.9%</td>
<td>93.0%</td>
<td>93.0%</td>
<td>90%</td>
<td>Monitor &amp; Contract Penalties</td>
<td>Mar-14</td>
</tr>
<tr>
<td>18 weeks from GP referral to hospital treatment - non-admitted patients</td>
<td>97.3%</td>
<td>97.4%</td>
<td>97.7%</td>
<td>95%</td>
<td>Monitor &amp; Contract Penalties</td>
<td>Mar-14</td>
</tr>
<tr>
<td>18 weeks from GP referral to hospital treatment - Incomplete</td>
<td>95.1%</td>
<td>97.6%</td>
<td>97.5%</td>
<td>92%</td>
<td>Monitor &amp; Contract Penalties</td>
<td>Mar-14</td>
</tr>
</tbody>
</table>

**Key:**
- Red: Adverse to absolute target or a deterioration in performance from 12/13 year
- Orange: Adverse to target, but an improvement from 12/13 year
- Green: Favourable to target
1.16 Annex 8: Glossary of terms used in quality report

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

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

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

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

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

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

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

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

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

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

MRSA (meticillin-resistant staphylococcus aureus)
MRSA is a type of bacterial infection that is resistant to a number of widely used antibiotics. This means it can be more difficult to treat than other bacterial infections. The full name of MRSA is meticillin-resistant staphylococcus aureus. You may have heard it called a superbug.

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

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

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

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

PROMS
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.

Terms of authorisation
The framework that sets out what we are required to and how we operate as a Foundation Trust.