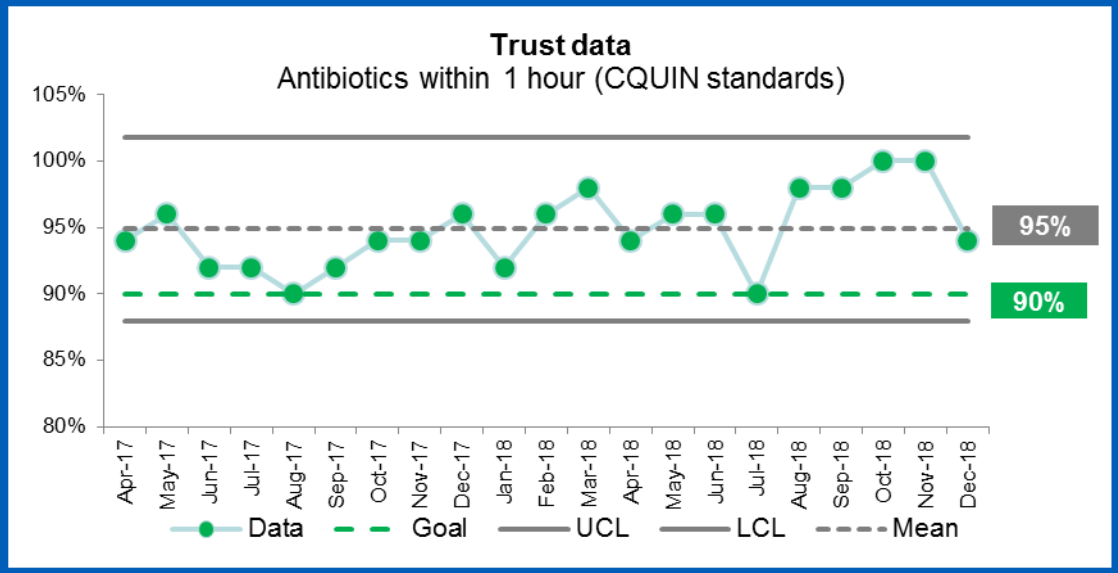
NHS
Cambridge University Hospitals
NHS Foundation Trust

Quality Account Update

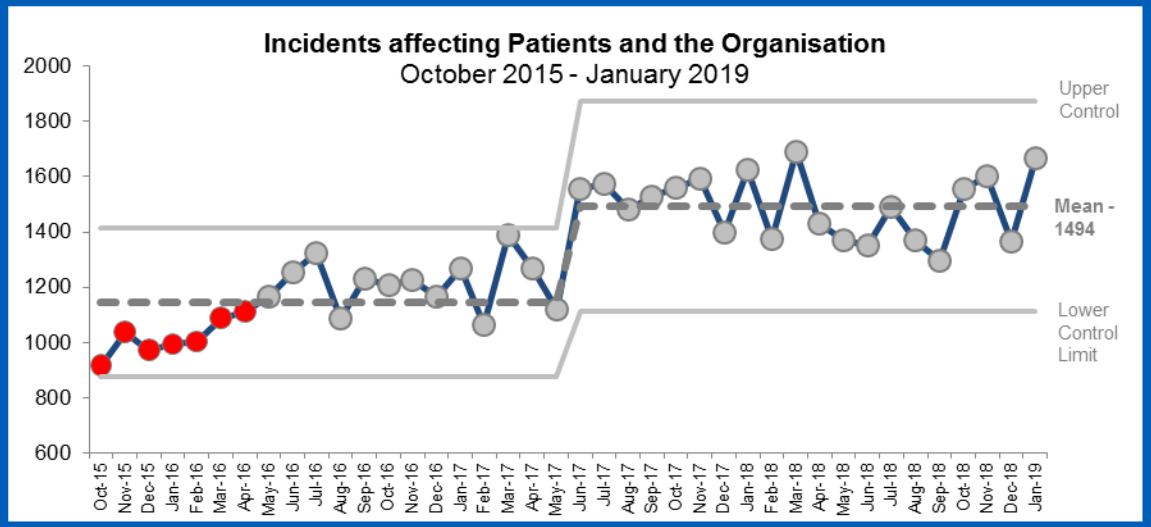
Our performance against 2018/19 Quality Priorities in Safe Domain

What did we measure?	Our target	How did we do?	
		2017/18	2018/19
Trust-Wide Compliance with Sepsis 6 care bundle (ED and inpatient wards)	≥90%	Sepsis 6 bundle: ED Patients 63% (Inpatient wards baseline in was 20%)	Sepsis 6 bundle: ED Patients 62% (Inpatient wards baseline was 52%)



Our performance against 2018/19 Quality Priorities in Safe Domain

What did we measure?	Our target	How did we do?	
		2017/18	2018/19
Average reported patient safety incident rate per 1,000 bed days	5% increase on baseline (45.24)	43.09 incidents per 1,000 bed days (6,979 incidents) Q1 and Q2 2017/18 NRLS data	42.22 incidents per 1,000 bed days Q1 & Q2 2018-19 (NRLS data)



Our performance against 2018/19 Quality Priorities in Safe Domain

What did we measure?	Our target	How did we do?	
		2017/18	2018/19
National Safety Standards for Invasive Procedures (NatSSIPs) % of named leads appointed	100%	0	100%
% of clinical areas (main theatres) using new audit observational tool to measure effective compliance with WHO checklist, by trained auditors	>50% in main theatres	0	50%

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

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

Our performance against 2018/19 Quality Priorities in Effective/Responsive Domain

What did we measure?	Our target	How did we do?	
		2017/18	2018/19
Number of Discharges before midday	20%	15.3%	13.0%

Our key achievements against this priority:

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

Our performance against 2018/19 Quality Priorities in Effective/Responsive Domain

What did we measure?	Our target	How did we do?	
		2017/18	2018/19
Patients that remain in an acute Trust bed for 7 days or more	10% reduction	453 patients	472 patients

Our key achievements against this priority:

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

Our performance against 2018/29 Quality Priorities in Effective/Responsive Domain

What did we measure?	Our target	How did we do?	
		2017/18	2018/19
Accuracy of Clinically Fit Dates (CFDs)	40%	35%	31%

Our key achievements against this priority:

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

Our performance against 2018/19 Quality Priorities in Caring Domain

What did we measure?	Our target	How did we do?	
		2017/18	2018/19
Percentage of complaints out of the annual total received which receive a response within 30 working days or by the date agreed with the complainant.	85%	87%	78%*

Our key achievements against this priority:

Over the course of 2018/19, the volume of complaints received has increased. The staffing in the complaints team was also increased mid-year and focus was maintained meeting the timeframes for responding to complaints, but the increase in volume has meant that performance against the responding timeframes overall has not improved.

A new complaint complexity/severity grading system with associated variation in initial responding timeframes (30, 45 or 60 working days) was introduced in January 2019 in order to better reflect investigation and response timeframes and manage complainants' expectations in a more realistic way. We want to ensure that we improve and therefore we will continue to make timely responses to patients' complaints a quality priority for the Quality Account for 2019/20.

Our performance against 2018/19 Quality Priorities in Caring Domain

What did we measure?	Our target	How did we do?	
		2017/18	2018/19
Introduction of MyChart	My Chart available to all adult specialties by 2019	0%	100%

Our key achievements against this priority:
Over 2000 patient activated to use MyChart.

Our performance against 2018/19 Quality Priorities in Caring Domain

What did we measure?	Our target	How did we do?	
		2017/18	2018/19
Compliance with 'ReSPECT' programme across adult inpatient specialities	Rolled out across all adult inpatient specialities by March 2019	N/A	100% (Fully implemented across all adult inpatient specialities)

Our key achievements against this priority:

ReSPECT introduced across all inpatient areas.

No inappropriate resuscitation attempts as a consequence of the introduction of ReSPECT.

No complaints from ambulance clinicians/GP practices/Nursing homes/hospices about the transition to ReSPECT.

Our performance against 2018/19 Quality Priorities in Well-Led Domain

What did we measure?	Our target	How did we do?	
		2017/18	2018/19
KF 1: Staff recommendation of the organisation as a place to work or receive treatment.	2% improvement against previous year	73%	75%
KF 29: % of staff reporting errors, near misses or incidents witnessed in the last month.	2% improvement against previous year	91%	91%
KF 31: Staff confidence and security in reporting unsafe clinical practice.	2% improvement against previous year	68%	68%

Our key achievements against this priority:
During 2018/19 we deployed our Continuous Professional Development for our staff which will continue into 2019/20. Clear links to the refreshed CUH strategy have been made to strengthen the leadership and to improve staff experience.

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

Priorities for 2019/20 against Safe Domain

Measure	Definitions	Baseline	Target	Rationale
After Action Review (AAR) first wave of trainers complete training.	All first wave trainers successfully completed AAR training by 31 March 2020.	0	>95%	This is a key element of the Just Culture work stream which forms part of the Trust current Patient Safety Improvement Plan (2018-2020).The Just Culture work steam will be launched in January 2019.
Internal Root Cause Analysis (RCA) investigations to meet the quality standards (of >90%) by March 2020.	>90% internal RCA investigations meet the quality standard of (>90%) as defined by the quality measurement tool.	9%	>90%	Key element of the Strengthening of the RCA investigations work stream which is part of the Trust current Patient Safety Improvement Plan (2018-2020).
Compliance with the National Early Warning Score Escalation protocol for adults.	>90% of patients received appropriate clinical response to triggering deterioration in line with national standards (NEWS 2).	5%	>90%	Key element of the deteriorating patient work stream which is part of the Patient Safety Improvement Plan (2018-2020).

Priorities for 2019/20 against Effective Domain

Measure	Definitions	Baseline	Target	Rationale
Patients that remain in an acute Trust bed for 21 days or more	Number of patients that remain in an acute Trust bed for 21 days or more. The national definition applies; with the main criteria being; acute patients only, 18+only. Excludes regular day & night attenders, day cases and zero length of stay (LoS) admissions.	186	116	The stranded patient metric from 2018/19 has been updated to 'super-stranded' (21 +LoS) in line with national priorities. The Trust has been set a target to reduce the number of beds lost to long stay patients by 25% from a baseline of 186 in 2017/18. This reduction indicates more effective and efficient patient pathways, improves patient experience (as they are more likely to be being cared for in an appropriate environment) and creates much need capacity.
Occupancy rate at midnight	The number of G&A patients occupying trust beds at midnight divided by the number of G&A beds available. Definitions in the KH03 national return apply; the main exclusions are patients under obstetrics and critical care.	93.3%	92%	Lower occupancy levels support the appropriate placement of patients and enhance the operational efficiency of the hospital by ensuring that it can meet both elective and emergency demand. The baseline is the average occupancy rate from January-December 2018. 92% is the commissioned level agreed with NHSE/I based on anticipated growth levels for 19/20. There are no plans to increase our bed base in 19/20, therefore maintaining a flat line occupancy level will be a significant challenge especially if demand grows.

Priorities for 2019/20 against Responsive Domain

Measure	Definitions	Baseline	Target	Rationale
Accuracy of Clinically Fit Dates (CFDs) This excludes DTOC patients.	% of CFDs which accurately predict the date of patients' discharges (excludes DTOC patients).	31.2%	40%	The Trust uses CFDs to predict patients' likely date of discharge. The accuracy of CFDs is important as it enables the Trust to better manage patient flow and on-time discharges. This aligns with both the Quality Strategy and Plan. We propose to keep this measure increasing the target to 40%. Achievement of this metric will require on-going support from the office of the Medical Director, since the accuracy of CFDs depends upon robust clinical input and oversight.
% of early discharges	The percentage of patients who are discharged from the Trust before midday, as a proportion of all discharges. This excludes zero length of stay patients and time spent in the discharge lounge.	12.3%	20%	Earlier discharges create capacity in the morning when the organisation needs it. They create flow out of ED and support the correct placement of patients in the right specialty.

Priorities for 2019/20 against Caring Domain

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

Priorities for 2019/20 against Well Led Domain

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

Thank You

Any questions?