Cambridge University Hospitals

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Together
Safe
Kind
Excellent

Quality Account 2024/25

Quality care at the heart of the CUH strategy

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Part 1 - Introduction

Statement from the Chief Executive

Delivering high quality care and services underpins all that we do, especially in these challenging times. Thanks to the support of our patients and their carers, and the dedication of our staff and partners during 2024/25, we have built strong foundations for the future.

The NHS is no stranger to overcoming challenges and the past year was no exception. It is important for us to be open and honest when things are not right.

In February 2025 we announced an external retrospective clinical review into the practice of an orthopaedic surgeon who specialises in paediatric surgery. This followed the conclusion of an initial external review which identified that the outcomes of treatment provided to some patients were below the standard we would expect.

We are very sorry that this has happened, and we have apologised unreservedly to our patients and their families. We have put in place a dedicated Patient and Family Liaison Team who will be the primary point of contact for patients and their families for the duration of the external clinical review. While we anticipate that the process of reviewing all the patients will take at least a year, we will be contacting patients and families during this time once the review of their care is complete to inform them of the outcome and to confirm whether further clinical assessment and treatment are needed.

We have also commissioned an independent investigation into whether there were opportunities to have identified and addressed these issues sooner. This independent investigation is due to be completed by the end of July 2025 and we will publish and implement the findings.

Quality starts with the patient's first contact with Cambridge University Hospitals (CUH) and remains our priority. This includes quality of access, convenience, care, diagnosis and treatment. I am pleased to report that we have taken steps during the past year, including addressing additional pressures on services during winter, that have helped us to reduce waiting lists and improve patient experience.

The Cambridge Movement Surgical Hub, which opened last year, has made a major contribution to the progress made in reducing our waiting lists for elective care. We are also providing diagnostic tests more quickly, efficiently and closer to people's homes thanks to our two new community diagnostic centres (CDCs).

We expanded our award-winning Virtual Wards, which enable patients to be safely looked after at home, saving 7,900 bed days for the hospital last year across 32 specialties. Our additional new discharge lounge also helped free up beds for patients coming into the hospital during winter.

We continue to modernise our outpatient services, finding new ways of delivering services that provide more flexibility for patients and free up clinic appointments.

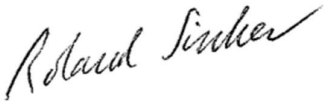
We also started to look at how we will deliver urgent and emergency care in future, working with our partners across the healthcare system, to ensure these services are future fit for a rapidly increasing local population. This included launching a programme of engagement with our community of staff, patients and partners.

Looking to the future, our new cancer and children's hospitals provide exciting opportunities to provide new and innovative ways of delivering cancer care and integrated children's mental and physical health care. Embedded research institutes at both new hospitals will enable cutting-edge research that readily informs clinical practice. This will enable us to bring to bear the new insights we are gaining into genetics, advanced detection and diagnosis, and disease management to transform outcomes for patients.

Our staff continue to be at the forefront of embedding quality into everything we do. Their lived experience helps to identify both issues and resolutions. We rely on them to undertake training and development, feedback on how well we are doing and suggest improvements.

There are undoubtedly challenging times ahead, but our goal continues to be delivering safe, kind and excellent patient care.

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



Roland Sinker
Chief Executive

1.1 About us and the service we provide

Cambridge University Hospitals (CUH) is an internationally renowned healthcare organisation. Part of the NHS, we deliver expert care for patients while our vibrant teaching community equips and empowers the healthcare leaders of tomorrow.

CUH – Addenbrooke's and the Rosie – is a community of over thirteen thousand people who are passionate about improving people's lives. We provide services as a local hospital for people in Cambridge, South and East Cambridgeshire, and as a specialist hospital for a much wider population. As an academic medical centre, we work across 75 medical and surgical specialties, with corporate and support teams – and health, care, academic and industry partners – to deliver care, learning and research.

Each of these three strands is equally important: caring for patients who are sick today while training the skilled staff who will care for patients in the future and researching the next generation of advances to clinical practice. Each strand also supports the other two strands: conducting research attracts staff wanting to broaden their skills and enables our patients to benefit from better care sooner; and providing care enables innovative clinical treatments to get into practice sooner.

Our location in Cambridge, as part of an innovation ecosystem, unlocks huge opportunity to go further. As the largest centre of health science and medical research in Europe, we aspire to continue developing the cross-industry partnerships that further improve outcomes for patients while powering economic growth.

The care CUH provides:

- Emergency, medical and surgical care for a local population of half a million people in Cambridge, South and East Cambridgeshire; and is a member of the Integrated Care Board serving a million people across Cambridgeshire and Peterborough.
- Specialist services for a regional population of six million people across the East of England.
- National services in organ transplantation, cancer, neurosciences, paediatrics, genetics and rare or complex conditions.

Learning – CUH is a teaching hospital for:

- Medical students from the University of Cambridge.
- Undergraduate students and apprentices in areas including Nursing, Midwifery, Pharmacy and Allied Health Professions, from a number of partner Higher Education providers.
- Apprentices in non-clinical roles including estates, engineering, maintenance, plumbing, customer service, administration, and data.

Research – CUH is:

- Part of the National Institute for Health and Care Research (NIHR) through the Cambridge Biomedical Research Centre (BRC).

- A member of Cambridge University Health Partners (CUHP), one of eight Academic Health Science Centres.
- A partner with the University of Cambridge and a thriving ecosystem of life sciences and technology industry on and beyond the Cambridge Biomedical Campus (CBC).

1.2 Trust Strategy

The Strategy Triangle

Strategy for maintaining high quality care

In 2022 the Trust published a three-year strategy which articulated our vision to deliver a healthier life for everyone through care, learning and research. We seek to achieve this as a Trust, as a core provider within a wider health and care system, as part of a dynamic biomedical campus and through our role locally, regionally, nationally and internationally.

Our three core strategic pillars - Improving patient care, supporting our staff, and building for the future – remain fundamental to our approach, but we have focused this year particularly on the changes we need to make across the Trust to continue to provide the best care for our patients and to keep improving services. This has included our 'Small things, big difference' campaign, engaging directly with staff to encourage suggestions, focused on the key themes of: Quality, productivity and flow; Culture, leadership and inclusion; and New Models of Care. Many ideas have already been implemented, such as increased re-use, recycling or repair of equipment and generation of energy from waste, improving patient flow, and modernising outpatient services, and we will continue to develop and put these ideas into practise in the days, weeks and months ahead.

Our 'New Models of Care' work engages directly with regional partners and teams across the East of England to define and implement a future model of care based on wider transformation of clinical services. This work spans activities such as segmenting patient cohorts to tailor care more effectively and developing a series of enabling activities through the Cambridge South Care Partnership, which CUH hosts, to drive and support the integrated care agenda to manage more patients' needs in primary care.

We have also progressed significantly with our two new hospital developments, Cambridge Children's Hospital and the Cancer Research Hospital.
Cambridge Children's Hospital (CCH) will be a 35,000sqm specialist children's facility for the East of England (EoE), currently the only region without a specialist children's hospital, and the first hospital truly designed to bring mental and physical health care together for children and young people. The hospital project is a partnership between CUH, Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), and the University of Cambridge (UoC). It will house a UoC research institute focusing on preventing childhood illness and early intervention across mental and physical healthcare.
The Outline Business Case was signed off by the Chief Secretary to the Treasury and the Secretary of State for Health and Social Care in August 2024, and work is underway to develop the Full Business Case (FBC) ready for submission to Government in 2026. The FBC will set out how Cambridge Children's will operate and connect with the whole EoE region, ensuring children are treated as close to home wherever possible. Subject to final FBC approval, it is hoped construction of the new hospital will commence in 2027.
The hospital is being co-designed with the help of children, young people, families and healthcare professionals across the region to ensure the new facilities will meet the needs of patients, families and staff. The fundraising campaign for the new hospital has passed the halfway mark and the project remains on track to meet its £100m philanthropy target.
Also designed in partnership with our patients and staff, Cambridge Cancer Research Hospital (CCRH) will bring together clinical and research expertise in a new NHS hospital that houses three University of Cambridge research institutes. We are collaborating with industry partners, harnessing all disciplines, to create new diagnostics and treatments to detect the earliest signs of cancer and deliver personalised, precision medicine. Any innovations developed within this new facility will directly support NHS care, to be rolled-out across the UK.
CCRH is part of the Government's New Hospital Programme, has an approved Outline Business Case, full planning permission, and a contractor on board (Laing O'Rourke), who will begin the main construction of CCRH in 2026, subject to approval of our Full Business Case. CCRH opening is planned for 2029.

The Trust has also begun work on an Acute Care Strategy to develop a long-term plan for acute healthcare services on the Cambridge Biomedical Campus and surrounding communities. This builds on the Addenbrookes 3 Strategy and Programme Business Case that was approved by the Board in 2021. Through this work we will both seek to improve services today at CUH and across the local system as well as build a future-focused, sustainable, equitable, and digitally and technologically enhanced acute clinical model for the future in the face of significant anticipated population growth.

Progress on delivering our strategic objectives is overseen by our Management Executive, with regular reports to the Trust Board with a formal strategy update. In addition, we

undertake detailed horizon scanning alongside discussions at senior management and Board meetings on strategic and operational priorities. The output of these are used to monitor our strategy as we move forward to ensure that we are well-positioned to adapt and respond to new challenges as they emerge.

1.3 Quality Programme

Providing high quality care to our patients is at the heart of our trust strategy. We are committed to continuously improving our services to provide safe care, the best possible outcomes for our patients and an overall positive experience for all, including our staff. Quality is also at the core of our Nursing, Midwifery and AHP strategy, with a commitment to *'embed fully the accreditation programme, encouraging ownership of data at Ward and department level so teams can see how well they are doing and run their own quality improvement projects'*.

As part of this strategy, the Quality Programme has been developed to support the delivery of high-quality care every day, quality assurance to monitor this, and support continual improvement.

The 'Good Quality Care, Every day in Our Hospitals' programme was launched in spring 2024 and consists of 3 key pillars - Care Quality Assurance, Safety Culture and Statutory & Regulatory compliance. Within each of these key pillars, there are detailed plans and improvement projects underway. In our 'Care quality assurance' pillar, we are working on the following 4 objectives:

- Improving first impressions of the organisation with a programme called "Our Place".
- Ensuring educational excellence by supporting staff to have the competence and confidence in their roles,
- A focus on good quality care with a harm free care programme led by the Divisional Heads of Nursing.
- Implementing consistent standards through ward accreditation.

The programme has a strong emphasis on staff engagement, provision of exceptional patient care, and continuous improvement, while celebrating areas of excellence.

Quality Programme – The journey so far

Self-assessment:

In 2023-24, a self-assessment against the Care Quality Commission (CQC) inspection framework was carried out in core services that had not recently been inspected by the CQC. This consisted of two phases, a desk- top self-assessment and a 'fresh eyes' external observation. The peer review findings identified a number of areas of focus and a quality improvement programme of work was designed to facilitate improvement.

Improved oversight:

To support this programme of work the Quality & Regulatory oversight Group, (QROG), chaired by the Chief Nurse, was established reporting into Quality Committee via Management Executive. The purpose of the group is to provide oversight of the programme and monitor the progress and effectiveness of agreed interventions.

Accreditation:

In early 2024, a revised ward accreditation scheme was introduced. Between April and October 2024, all forty-one adult inpatient wards were accredited, marking a significant milestone in the programme and establishing a benchmark across the Trust. To date, thirty-three wards have been awarded bronze and eight silver, though no ward has yet met all essential criteria.

The accreditation process consolidates key measures of nursing and clinical care into a single overarching framework, enabling a comprehensive assessment of care quality on the ward. A review of the data obtained through this process has highlighted several areas of excellence and demonstrated the benefits of external system collaboration, with colleagues from across the ICS participating in some accreditation visits again to give us a 'fresh eyes' review.

The review also again identified several areas requiring improvement and key themes, including gaps in set standards, effective communication between managers and ward staff, and learning from patient feedback with missed opportunities to hear the patient/relative's voice.

Next steps for the programme:

To achieve nursing and midwifery excellence and meet the Trust's quality objectives of providing 'good quality care every day,' the following steps are central:

- **Identify, source, and implement digital solutions** to enable the collection and triangulation of quality data and audits. This will release time to care, enhance overall efficiency, and support data standardisation, providing transparency and ward-to-board oversight.
- **Celebrate areas of excellence and support staff recognition initiatives** while identifying areas for improvement. Promoting joy at work and recognising staff contributions are key components.
- **Implement improvement huddles**: Conduct improvement huddles to embed a continuous improvement culture. These use visual management tools like whiteboards to display vital outcome measures and encourage staff and patients to identify opportunities for improvement. Championing a multi-disciplinary approach teams discuss and prioritise these opportunities, using improvement tools and techniques to resolve issues and enhance patient journeys and staff working environments.
- **Consider 'Pathway to Excellence' accreditation**: Investigate the internationally recognised Pathway to Excellence programme to further support and recognise nursing and midwifery excellence.

External Accreditation

Accreditation by independent organisations demonstrates the Trust meets or exceeds required quality standards and provides assurance key services are effective. The Trust policy for management of external visits outlines how the Trust monitor oversight of visits from external agencies or statutory bodies. Key findings or performance during inspections or accreditation visits are highlighted through a regular report to the Clinical Effectiveness Group. We are improving how we monitor accreditation, possible risks to meeting the required quality standards, and how we prioritise actions to maintain existing accreditations or gain new accreditation.

In some cases, accreditation is a regulatory requirement, in others, accreditation is not mandated but demonstrates a service has a commitment to maintaining good standards of care, and positively benchmarking against their peers.

Cambridge University Hospitals is routinely visited by over 40 external bodies, including the Medicines and Healthcare products Regulatory Agency (MHRA), United Kingdom Accreditation Service (UKAS), National Health Service England (NHSE), and the Human Tissue Authority (HTA).

In the period 2024/5, the Trust has performed well in several accreditation visits.
There were five accreditation visits before the mid-year point, including UKAS accreditations for Haematology & Oncology Diagnostic Services (HODS) (ISO 15189:2022), Histopathology (Sept 24 UKAS accreditation re-instated), Tissue Typing, and Blood Sciences.

In September 2024, Sterile Services retained accreditation to ISO13485:2016, the Cancer Directorate maintained the existing Healthcare intelligence and quality improvement services, CHKS International Accreditation Programme for Radiology /Oncology (ISO9001), and accreditation in the Quality Standard for Imaging (formerly ISAS) for diagnostic imaging was retained.

CUH revalidated against the new Stage 7 standard EMRAM (Electronic Medical Record Adoption Model), the highest rating of the Healthcare Information and Management Systems Society (HIMSS) international digital maturity and adoption model for healthcare. A rigorous assessment took place at CUH on Wednesday 25 September 2024. As part of the assessment, HIMSS inspectors observed clinical staff from various hospital areas including inpatient wards, ED, outpatient clinics, and pharmacy using the Trust's Epic electronic patient record and analytics, to demonstrate how digital use is embedded within their clinical and operational practice for everyday patient care. Inspectors also heard from patients about how technology - notably the Trust's 'My Chart' patient portal - is involving, engaging and supporting them in their care and treatment. My Chart provides patients with secure access to parts of their hospital health record (such as appointment details, test results, follow-up letters) and the ability to communicate directly with their clinical teams. The Trust has been revalidated to HIMMS Stage 7.

CUH has also received Level 2 accreditation from Global Antimicrobial Stewardship Accreditation Scheme (GAMSAS), in recognition of its work in Antimicrobial Stewardship across the Trust. The team achieved 32/33 expected criteria.

The most significant risks to retaining existing accreditation standards currently are related to staffing shortages, expertise and capacity in relation to areas such as radio pharmacy, radiation protection services and nuclear medicine.

Martha's Rule

In the last year, the Secretary of State for Health and Social Care and NHS England committed to implement 'Martha's rule'; to ensure the concerns of patient's, relatives and staff are listened to and acted upon. CUH has been selected as a pilot site for the national implementation of Martha's rule. Martha's rule has three components:

- All staff in NHS trusts must have 24/7 access to a rapid review from a critical care outreach team, who they can contact should they have concerns about a patient.
- All patients, their families, carers, and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via mechanisms advertised around the hospital, and more widely if they are worried about the patient's condition.
- The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist trusts. Maternity and Emergency Departments are excluded from the initial pilot.

At CUH, the first two elements are addressed by "Call for Concern". Using our existing Rapid Response Team, we can now provide an alternative means of escalation to patients, relatives and carers in the event that they feel their concerns have not been adequately addressed by ward teams. Calls are made to a dedicated phone number and answered 24hrs a day. If the concerns are related to an acutely deteriorating patient, they will be assessed by the Rapid Response team (who have Critical Care competencies) and appropriate actions taken. This service has been available to all children, young people and adult inpatients in the Trust since October 2024. A number of calls have been made and, in some cases, have led to changes in medical management and even Critical Care admission.

Any staff members in these ward areas can follow the same process if they have a patient who is deteriorating but feel their concerns aren't being heard. This work sits alongside the existing escalation systems for deteriorating patients in routine practice such as NEWS, MEOWS and PEWS.

The third element, also known as 'Patient Wellness Questions', is the process of asking every day how patients are feeling. The responses to the questions generate a score and a high score leads to medical review and increased frequency of observations. This has been positively received by patients and staff during trials, and we will be rolling out to all inpatient areas over the next few months.

Martha's rule is named after 13-year-old Martha Mills, who tragically died of sepsis during her hospital stay in London, despite her parents expressing serious concern about their daughter's condition. Work has been going on since April 2024 to roll out this service nationally, and pilot sites have made significant moves toward implementation. We have implemented all three components of Martha's Rule across most of the Trust.

1.4 Activity in 2024/25

In the 2024/25 year, the Trust had an increase in total admissions of 5.65% compared to the prior year. This reflects a combination of investment in new capacity in 2024/25 at the Trust, as well as the impact of industrial action in the 2023/24 comparator year.

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

The increase in day cases (+8.16%) and elective in-patients (+12.96%) reflects the Trust's continued focus on access to case despite the challenges caused by high occupancy and increasing demand.

- The Trust has significantly increased the number of patients being treated in a virtual ward environment. This alternative pathway helps us to reduce bed occupancy and ensure space is available to support elective recovery.

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

Table 1: Activity Comparison 2023/24 vs. 2024/25

	2023/24	2024/25	Change Apr-Mar 23/24 to Apr-Mar 24/25
	Apr - Mar	Apr - Mar	(%)
A&E attendances* (excluding MIU) Type 1 & Type 3 activity only	143,977	150,374	4.44%
Visits to outpatients	873,563	954,560	9.27%
Births	5,501	5,307	-3.53%
Day cases	142,185	153,793	8.16%
Total inpatients	**50,340**	**51,476**	**0.54%**
− *elective*	12,897	14,568	12.96%
− *emergency > 85 years old*	6,539	6,228	-4.76%
− *emergency < 85 years old*	33,692	32,843	-2.42%
− *maternity*	6,791	6,601	-2.80%
Total	**1,225,145**	**1,324,274**	**8.09%**

Total Admissions (IP / DC / Births)	**207,605**	**219,340**	**5.65%**

Virtual Ward Admissions	**1,263**	**2,021**	**60.0%**

1.5 Data and terms used in this report

Unless stated otherwise, the data presented in this report is the latest available on 31 March 2025.

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

Part 2 - Priorities for improvement & statements of assurance from the Board

2.1 Reviewing performance against 2024/25 priorities for improvement

Safe

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

Priority 1: Falls Risk Assessments

What did we measure?	Our target	How did we do?	
		2023/24	2024/25
Compliance with falls risk assessment & documentation within 12 hours of admission	≥90%	85.9%	96.2%

Why was this a priority?

Patient falls remains one of the highest occurring categories of reported incidents in the Trust. Improving compliance with falls risk assessment helps to identify the appropriate falls prevention care each patient requires.

What was our target?

The target was to achieve compliance of ≥90% with the falls risk assessment and its documentation, overall, for inpatient wards, by March 2025.

How did we measure and monitor our performance?

The falls risk assessment is recorded in the electronic patient record (Epic) and compliance is measured via the Trust 'CHEQS' system. The numerator being the number of falls risk assessments undertaken within 12 hours of admission, and the denominator is all admissions with a length of stay greater than 24 hours.

How and where was progress reported?

Compliance tracking is shared monthly with the Board via the monthly Trust Integrated report, and with Divisions via falls data analysis report. Compliance is also shared bi-monthly via a patient safety report with the Falls Quality Steering Group, the Patient Safety Group, and the Quality Committee.

Did we achieve our intended target?

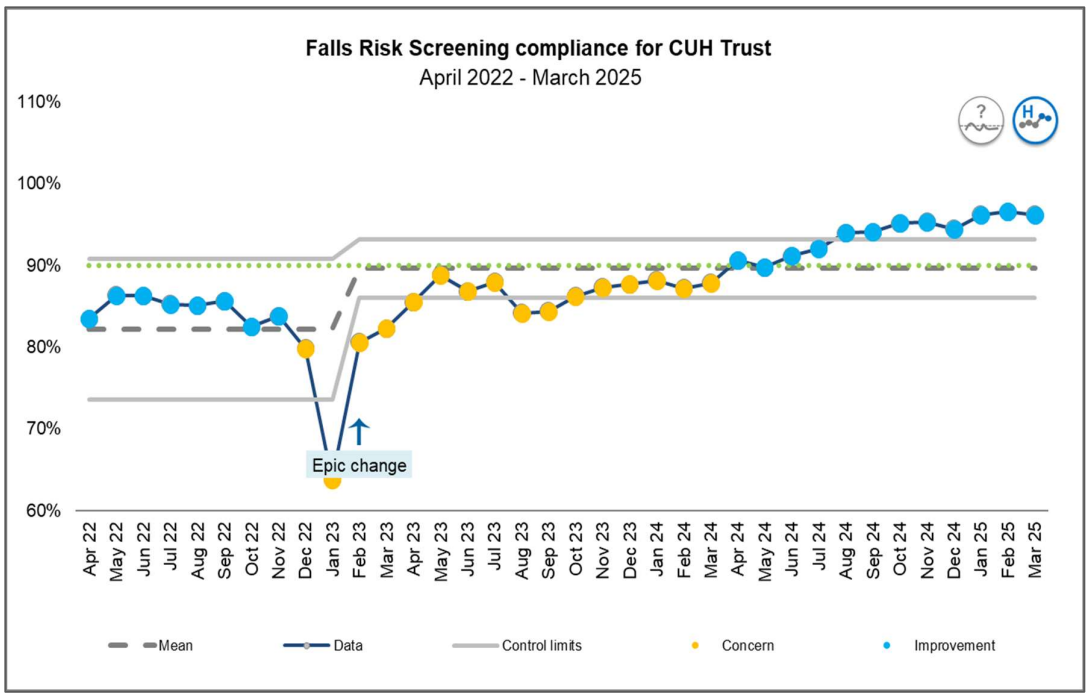
We met our target consistently. The compliance target has been achieved for the last ten months (June 2024 – March 2025).

Our key achievements against this priority:

There has been a continued statistically significant upwards shift since April 2024 – March 2025 (last twelve months).

Our results:

The statistical process control shows the performance through the monitoring period. A data issue occurred in Jan 2023, and therefore a temporary artefact in the data. This data point is removed from the calculation, showing a tighter controlled performance range since April 2023.



Priority 2: Prevention of hospital acquired pressure ulcers

What did we measure?	Our target	How did we do?	
		Baseline	2024/25
Hospital acquired category 2+ pressure ulcers per 1000 bed days	≤0.395 Per 1,000 bed days	0.79 per 1,000 bed days	0.67 per 1,000 bed days

Why was this a priority?

The incidence of hospital-acquired pressure ulcers (HAPUs) has increased in our Trust since July 2022. A quality improvement program of work commenced in July 2023 to reduce the incidence of HAPUs of categories higher than one i.e. category 2, 3, 4, un-stageable, suspected deep tissues injury, and mucosal.

What was our target?

Our target was to reduce the rate of HAPUs per 1,000 bed days from 1.08 to a rate of 0.395 (50% reduction) by March 2025, with an interim target of 25% reduction (rate 0.592) by July 2024, in all inpatient areas.

How did we measure and monitor our performance?

The incidence rate of HAPUs category 2 or above was measured per 1,000 bed days, to normalise for activity. The numerator being HAPUs of category 2, 3, 4, un-stageable, mucosal, and suspected deep tissue injury and the denominator being all admissions with a length of stay greater than 24 hours.

How and where was progress reported?

The rate of incidence is shared monthly with the Board via the monthly Trust Integrated report, and with Divisions via a Tissue injury data analysis report. The rate of incidence is also shared bi-monthly via a patient safety report with the Tissue viability Quality Steering Group, the Patient Safety Group, and the Quality Committee.

Did we achieve our intended target?

Unfortunately, we did not meet the target overall. The lowest rate we have reached in the monitoring period is 0.64 HAPUs per 1,000 bed days in February 2024 and latest rate is 0.73 March 2025.

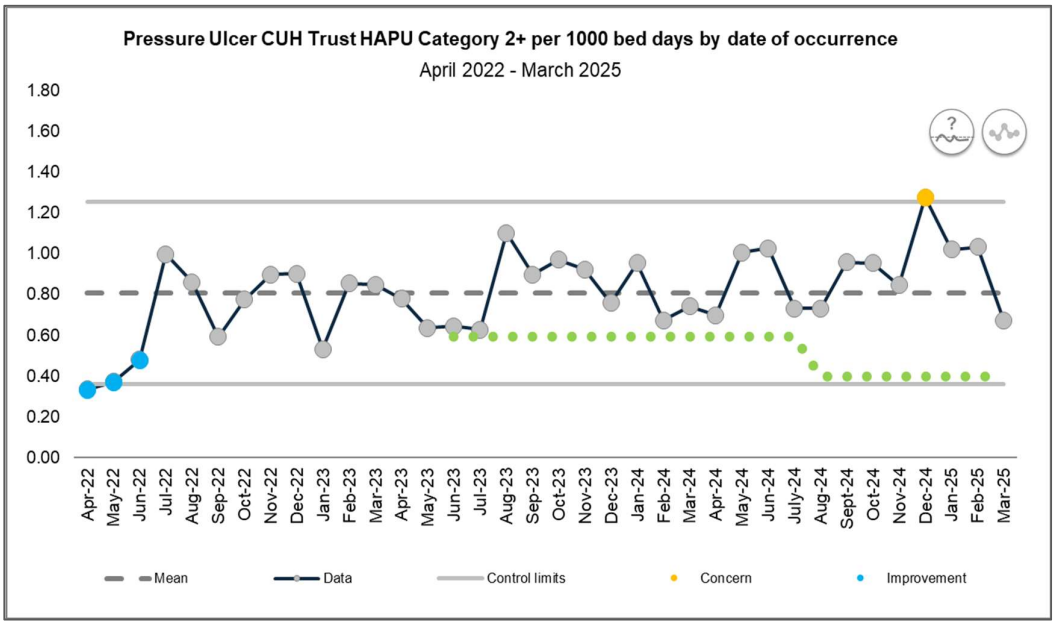
Our key achievements against this priority:

We have successfully introduced a better sliding sheet product into all clinical areas, which has been embraced by the nursing community and usage of this piece of equipment for repositioning has improved. We have also reviewed (and removed where appropriate) all foam mattresses within the hospital and set up more resilient processes to ensure we have effective mattresses in place for all patients. We have seen some improvements in HAPU incidence in some areas, for example HAPUs: associated with devices - respiratory masks and nasogastric tubes; HAPUs located on the sacrum, ischial tuberosity, knees, nose, and shoulder. We have seen good engagement with nursing colleagues across all the pilot wards involved in the pressure ulcer reduction improvement

program including sharing of best practice and development of improvement skills.

Our results:

The rate of HAPUs per 1,000 bed days is currently in normal variance. We will continue to work to achieve our target.



Priority 3: Nutrition Screening

What did we measure?	Our target	How did we do?	
		2023/24	2024/25
Nutrition screening compliance for admitted patients	≥90%	77%	91%

Why was this a priority?

Ensuring patients in our care have the appropriate risk assessments on admission means that we can identify concerns/risk early and put in an appropriate care plan. Adequate nutrition during periods of illness is integral to wound healing and recovery.

In 2022, this area was highlighted as a CQC 'Should do' for medical care, and in addition to addressing the shortfall, we identified an opportunity to shine a light on the importance of good nutrition.

What was our target?

To ensure >90% of patients aged >1 year, (admitted as inpatients for >24 hours) must have a nutrition score documented within 24 hours of admission. (This excluded maternity admissions).

How did we measure and monitor our performance?

The percentage of completed assessments are expressed as a percentage of the expected assessments and monitored locally through nursing quality metrics for each division.

How and where was progress reported?

Each division reviews their overall performance with quality metrics, and discussion regarding improvement occurs via the Trust's Nutrition Steering group and Nurses and AHP sub-groups. Executive Quality and Performance meetings discuss key measures and progress.

Did we achieve our intended target?

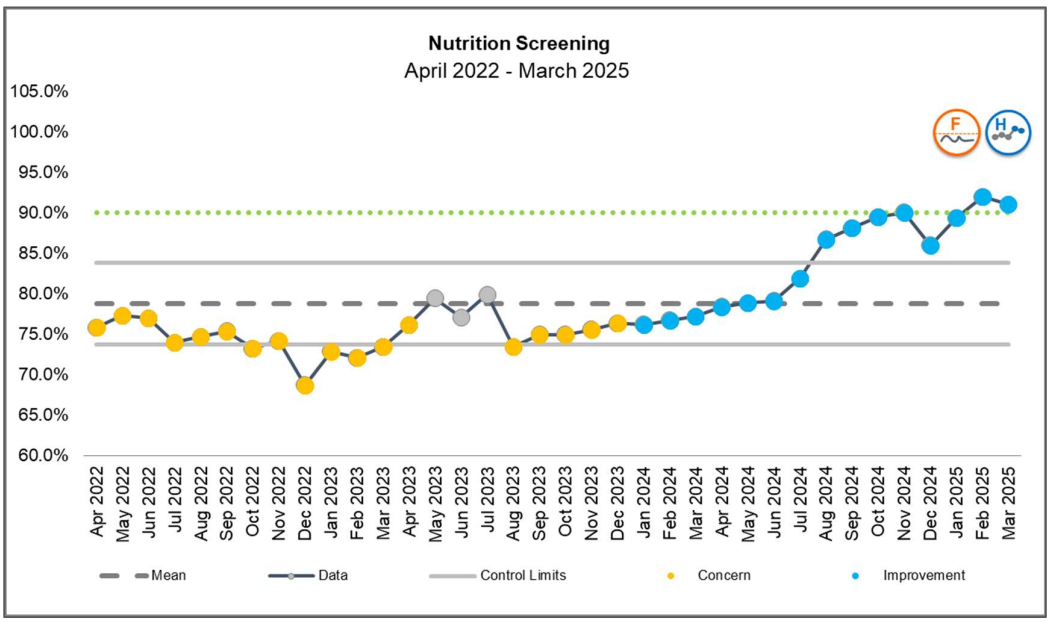
There is a continually improving picture, and we have met our target overall periodically, although we have yet to see this consistently across all divisions and to sustain this over time to ensure the improvement is embedded.

Our key achievements against this priority:

We improved on our 2023/24 position where an average compliance was 76.5%.

Our results:

Improvement has facilitated identification of the risk of malnutrition for our patients, to support effective recovery and/or care planning. We will carry his over to 2025/26 where our focus will be around robust care planning to ensure patients are provided with person-centred care plans.



Priority 4: Post-partum haemorrhage

What did we measure?	Our target	How did we do?	
		2023/24	2024/25
Post-partum haemorrhage (PPH) >1500mls	≤3.3%	4.6% (Annual average)	4.1% (Annual average)

Why was this a priority?

The care quality commission inspected maternity services in 2023, and recommended the Trust improve on the rate of PPH. The maternity improvement plan incorporated this target and devised a work plan, which was medically led.

What was our target?

Equivalent or less than 3.3% of women in our care experience a post-partum haemorrhage >1500mls (singleton births between 37-42 weeks, having a vaginal birth). Our targets are in line with benchmarking against our peers.

How did we measure and monitor our performance?

The detail of the process for measuring blood loss in theatre was modified to align methodology with peers. A baseline rate for ongoing improvement required establishment prior to monitoring improvement and ongoing benchmarking. The number of people experiencing post-partum haemorrhage are expressed as a percentage of the overall births in the month.

How and where was progress reported?

Progress was reported through the maternity improvement oversight board, including midwifery and quality leads from the system and region, with oversight from the Trust Quality Committee.

Did we achieve our intended target?

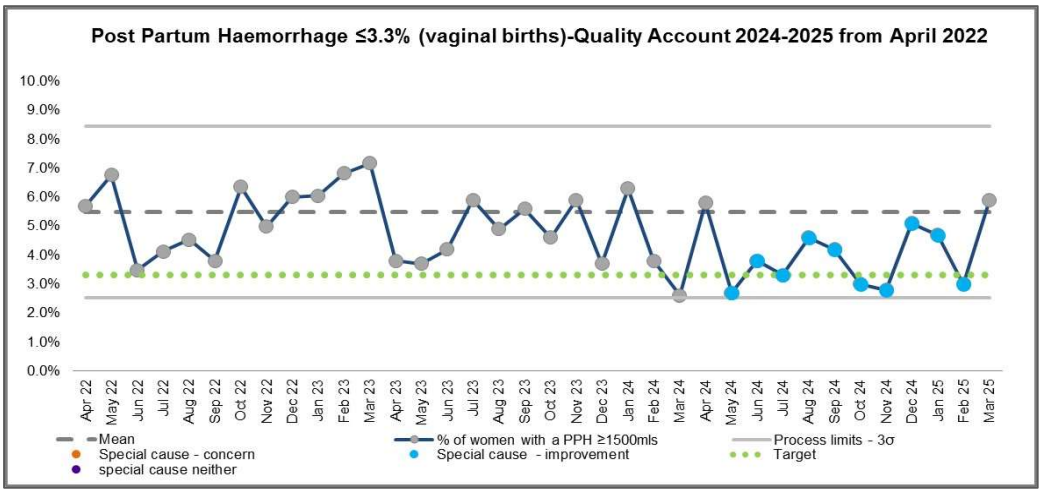
We did not sustainably meet our intended target, although have seen a reduction in post-partum haemorrhage in this cohort of patients. Work and monitoring of progress continues.

Our key achievements against this priority:

Although we have not sustainably met our target, work remains ongoing. The campaign to embed the ‘ROBUST’ protocol to support timely recognition, administration of drugs, and uterine massage along with changes to new doctor’s induction has supported improvements. Two new ‘YouTube’ videos were launched as part of staff education to support embedding of ROBUST. The PPH and massive obstetric haemorrhage (MOH) protocol were updated with revised monitoring arrangements are being embedded to ensure improvement is maintained.

Our results:

Long term data suggests an overall trend in the reduction of the incidence of post-partum haemorrhage of 1500mls of above for vaginal births.



Priority 5: Patient Safety National Training

What did we measure?	Our target	How did we do?	
		2023/24	2024/25
PSIRF Level 2 Training Compliance	90%	36% (year -end)	92% (year-end)

Why was this a priority?

Training in the 'Patient Safety Incident Response Framework' (PSIRF) was a new requirement under the NHS Patient Safety Strategy and contract. This parameter was chosen to support the Trust's transition to the framework on 1 January 2024, to ensure staff were adequately trained on the requirements of the framework.

What was our target?

The target was to reach ≥90% compliance by the end of March 2025.

How did we measure and monitor our performance?

The compliance was collected digitally via our central educational database (DOT). The numerator being the total number of staff who completed PSIRF training level 2. The denominator being the total number of staff required to undertake the training (band 7 clinical and non-clinical staff).

How and where was progress reported?

Compliance is shared with the Trust Board via the monthly Trust Integrated report, and bi-monthly via the Quality Committee. Compliance is shared with Divisions via the bimonthly Patient safety report to the Patient Safety group.

Did we achieve our intended target?

The target overall for the Trust was reached in October 2024 at 91.4%.

Our key achievements against this priority:

The Trust overall requirement was to ensure over 2500 staff completed this training, which has been met –a significant number of hours were dedicated by the teams to ensure this mandatory training was completed.

Our results:

	Staff Count	Compliant	Non-Compliant	% Compliance
Trust Overall	2590	2392	198	92%
Division A	251	241	10	96%
Division B	909	853	56	94%
Division C	178	163	15	92%
Division D	282	250	32	89%
Division E	300	257	43	86%
Corporate	521	496	25	95%

Effective/Responsive

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

Priority 6: Cancelled elective operations

What did we measure?	Our target	How did we do?	
		2023/24	2024/25
Percentage of elective operations cancelled at last minute for non-clinical reasons.	<1%	1.6% (Annual average)	1.3 % (Annual average)

Why was this a priority?

Our aspiration in 2024/25 was that with the opening of ring-fenced elective capacity in the Cambridge Movement Surgical Hub that the volume of orthopaedic surgery cancellations due to competing demands of trauma cases would reduce. Also, that the additional beds in haematology oncology would reduce bed capacity related cancellations across the Oncology bed pool.

What was our target?

Less than 1% of elective operations would be cancelled at the last minute for non-clinical reasons.

How did we measure and monitor our performance?

The proportion of cancellations for non-clinical reasons on the day of admission is expressed as a % of total elective admissions. Validated performance is reported monthly. A dashboard for cancelled operations allows granular trends by specialty and cancellation reason to be interrogated.

How and where was progress reported?

Progress was reported as part of the Trust's Integrated Performance Report and updates provided to our Quality Committee.

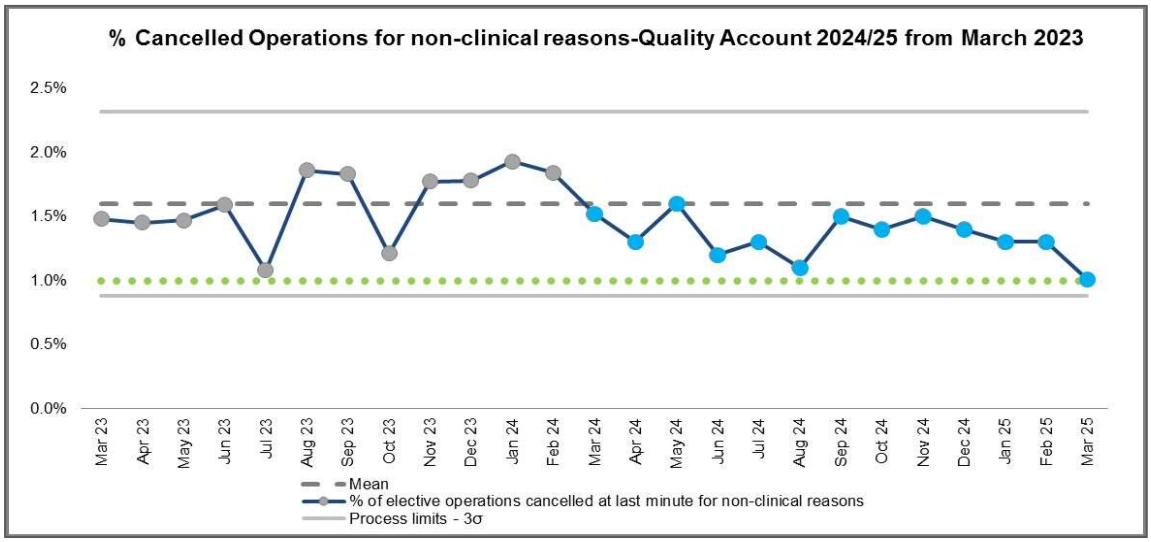
Did we achieve our intended target?

The target of <1% of elective surgeries cancelled for non-clinical reasons was not achieved, but steady improvement was made in-year from a mean performance of 1.6% in 2023/24 to consistently between 1.0-1.6% in 2024/25.

Our key achievements against this priority:

- Total non-clinical cancellations on the day of admission have reduced by 9% in 2024/25.
- Bed related cancellations were 26% of the total in 2023/24 and the proportion has reduced to 15% in 2024/25.
- Orthopaedic cancellations due to bed pressures and lack of operating time have reduced by 24% in 2024/25.
- Bed related cancellations across the oncology bed pool have reduced by 33% in 2024/25.

Our results



Priority 7: Same day emergency care

What did we measure?	Our target	How did we do?	
		2023/24	2024/25
Same day emergency care (SDEC)	30.0%	25.7% (Annual average)	25.5% (Annual average)

Why was this a priority?

Same Day Emergency Care (SDEC) aims to provide emergency patients with the right service on a timely basis. This improves patient experience and supports a reduction in crowding in the emergency department. Existing metric in 2023/24. We did not reach target in 2023/24 and therefore maintained the quality priority. However, the method of calculation has been modified, and therefore is not directly comparable to the 2023/24 cycle.

What was our target?

Our target for 2024/25 was that 30% of patients who attend the emergency department would be seen in an SDEC area. This includes patients attending our medical and surgical assessment areas and emergency hot clinics.

How did we measure and monitor our performance?

SDEC performance was monitored through the integrated flow board (chaired by Deputy Chief Operating Officer, DCOO). Oversight was also maintained through Divisional Quality & Performance meetings.

How and where was progress reported?

Progress was reported to the Non-Elective Flow Board (chaired by the Chief Operating Officer) and the Trust's Performance Committee and the Trust Board on a monthly basis.

Did we achieve our intended target?

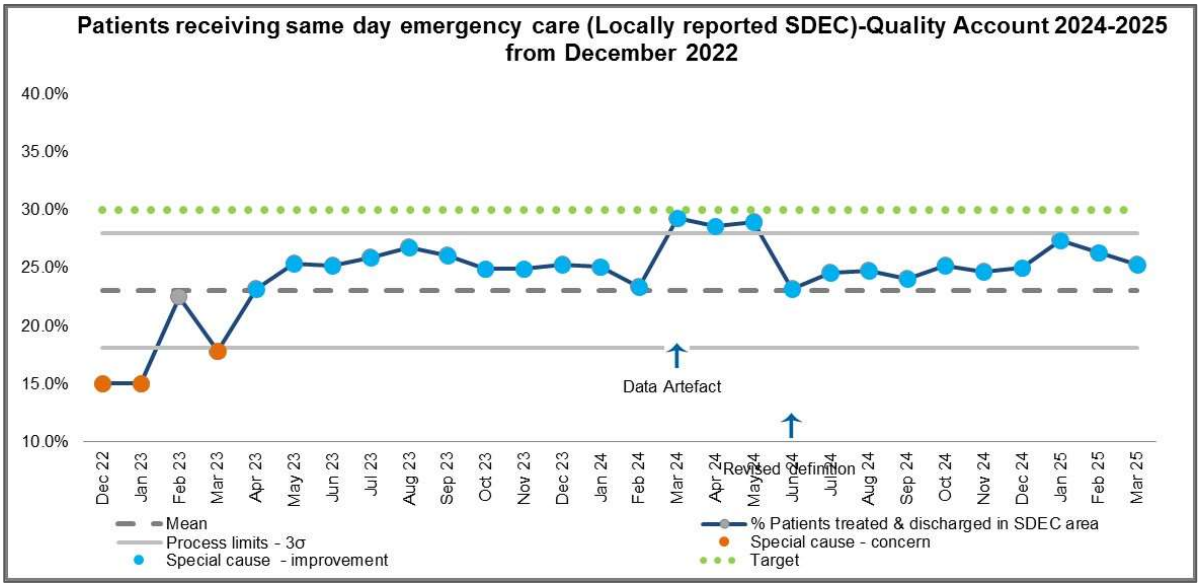
The Trust achieved a maximum average 29% SDEC activity for 2024/25 financial year with a range between 23 - 29%. While this fell short of the 30% target, it represented some improvement from the performance in the previous year. Key challenges to delivery of this quality indicator included high bed occupancy levels, beds closed to infection, and limited community capacity. As flow was affected, there were subsequent delays in flow of patients from SDEC to the wards.

Our key achievements against this priority:

The Trust has consistently delivered over 24% SDEC performance every month. This was despite a 5% year-on-year increase in urgent and emergency care attendances.

Our results

It should be noted that a change in recording occurred in year in October 2024 and means that year-on-year performance for this measure is not comparable.



Priority 8: A&E Standard Type 1

What did we measure?	Our target	How did we do?	
		2023/24	2024/25
Compliance with 4-Hour A&E standard (Type 1)	66%	47%	51%

Why was this a priority?

The 4-Hour A&E standard (Type 1) focuses on identifying and treating the sickest patients quickly, improving bed management and reducing waiting times. It aims to minimise delays in care, ensuring patients are admitted, transferred, or discharged promptly to reduce the risk of increased mortality and illness.

What was our target?

Our target for 2024/25 was that 66% of patients who attended the emergency department would be admitted, transferred or discharged within four hours.

How did we measure and monitor our performance?

4-Hour A&E performance was monitored through the Trust's daily operational data and NHS England monthly situation reports. Oversight was also maintained through Divisional Quality & Performance meetings.

How and where was progress reported?

Progress was reported to the Trust's Performance Committee and the Board on a monthly basis.

Did we achieve our intended target?

The Trust achieved an annual average of 51% compliance with the 4-hour A&E standard (type 1). The benchmarking data for February 2025 shows CUH ranked 65th out of 118 trusts, placing it near the top of the third quartile nationally. The Trust's performance against the 4-hour standard has remained resilient, given a 5% increase in urgent and emergency care attendances and significant challenges from bed closures due to infections.

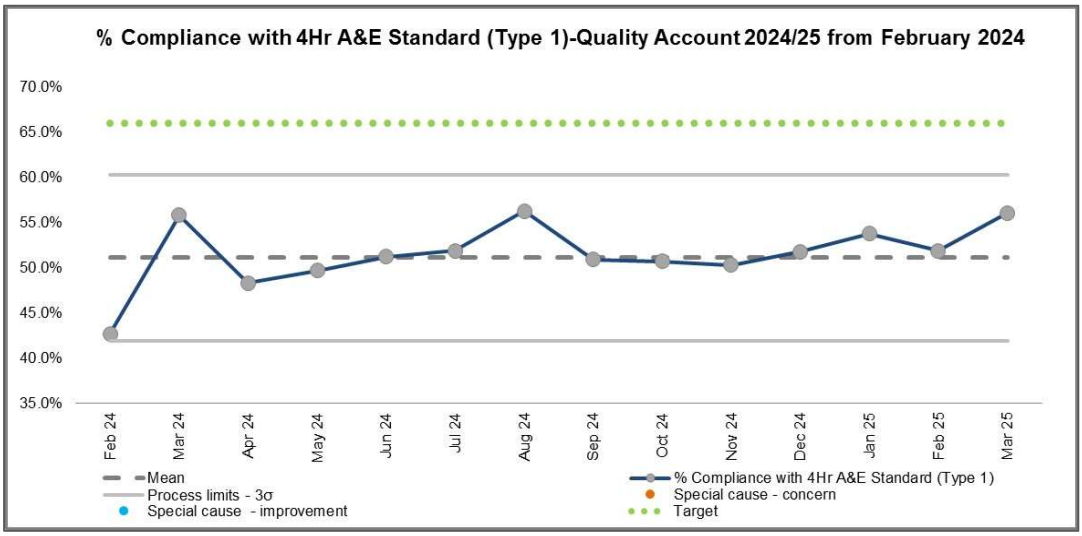
Our key achievements & results against this priority:

An improvement of nearly 5% has been achieved between 2023/24 and 2024/25. This has been realised through an improved pre-noon discharge position, better use of assessment areas and some stability with weekend discharges as well as consistent management and monitoring of 4 hr performance at daily performance meetings and regular dissemination of the 4hr messaging.

Our results

In reviewing the previously reported figure for 2023/24 compliance with the 4-hour A&E standard, it has come to our attention that the figure of 65% was inaccurately presented as reflecting only type 1 A&E performance. In fact, this figure encompassed the overall 4-hour A&E performance, including all types of

A&E attendances. After careful verification, we have adjusted the figure to accurately represent the type 1 A&E performance, which stands at 46.5%. We apologise for any confusion caused by this reporting error and have now updated the figures to reflect the correct performance.



Priority 9: Cancelled Obstetric Clinics/Theatres

What did we measure?	Our target	How did we do?	
		2023/24	2024/25
Number of lists (clinic/theatre) cancelled in maternity services to facilitate senior medical cover in month.	0%	New Measure	0%

Why was this a priority?
To have the on-call rota covered by the recommended level of junior doctor to avoid consultants having to act in the role to cover the on-call commitment.

What was our target?
Our goal was to achieve no cancelled clinics due to medical cover absences.

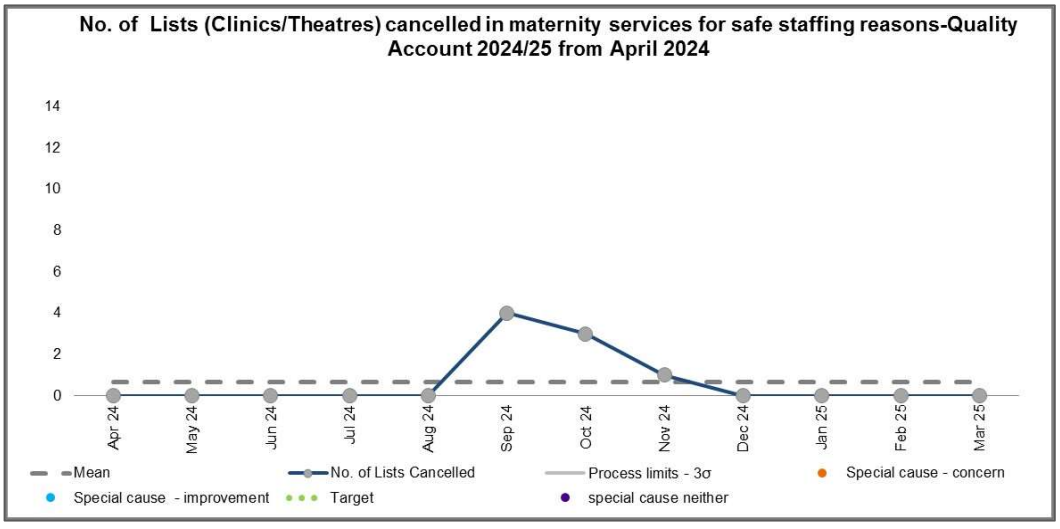
How did we measure and monitor our performance?
Recorded how often consultants needed to act down and how many elective sessions were cancelled due to this.

How and where was progress reported?
This was reported via the divisional Maternity Improvement Board, Maternity Improvement Oversight Board and divisional executive meetings.

Did we achieve our intended target?
Yes. September to November 2024 proved to be challenging due to recruiting into new posts at that time. As new members of staff started work with the Trust, we were able to continue, successfully, with all elective work.

Our key achievements against this priority:
To fill the junior doctor vacancies and increase establishment. The on-call rota was covered to a safe level and elective work continued.

Our results



Patient Experience/Caring

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

Priority 10: Complaints

What did we measure?	Our target	How did we do?	
		2023/24	2024/25
Responses to service user complaints are within agreed time frames	80%	47% (Annual average)	57% (Annual average)

Why was this a priority?

Although there is no national or NHS standard for complaint response times, it was identified as a priority as part of the internal improvement process to ensure timely responses to patients, carers relatives who have raised issues.

In 2024, there was ongoing work to reduce a backlog of complaints with increasing complexity, to restore appropriate response times.

What was our target?

A stretch target of 80% of complaints responded to within agreed timeframes, with an interim target of 66%.

How did we measure and monitor our performance?

Using our system to pull data on dates when complaints cases were opened and closed. This was monitored locally in the complaint's teams in weekly reporting and more widely through the established Trust governance process.

How and where was progress reported?

Progress reported to monthly divisional quality meetings, bi-monthly corporate performance and the Patient Experience Group.

Did we achieve our intended target?

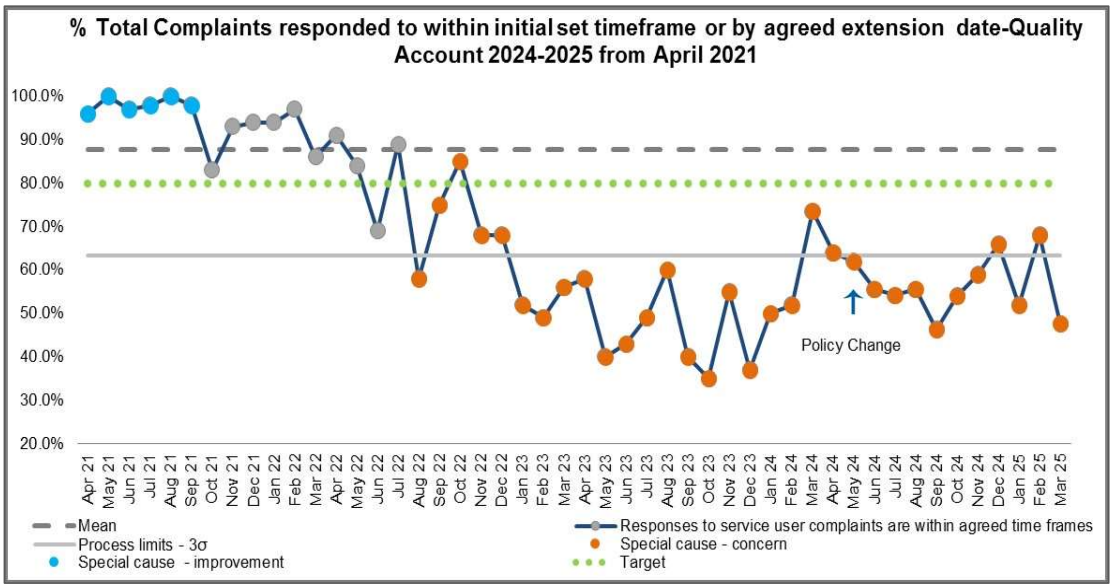
A steady improvement in progress achieved the 66% target by December 24.

The 80% target was not sustainably achieved yet – although the number of complaints received in December 2024 was higher than normal variance, indicating increasing numbers of complaints are being processed.

Our key achievements against this priority:

Improvement in response rate and good divisional engagement with the improvement approach, and the team continue to work towards stretch target of 80%.

Our Results:



Staff Experience/Well-led

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

The experience of staff who are involved in an error or near miss and the sense of psychological safety staff have, are two possible contributing factors to the following metric.

The overall staff experience and how engaged they feel is important for a culture of high performance and impacts our ability to attract and retain qualified nurses all of which impact on our continual drive to deliver safe and high-quality care.

Priority 11: Raising concerns

What did we measure?	Our target	How did we do?	
		2023/24	2024/25
Morale Indicator: I feel secure about raising concerns about unsafe clinical practice.	78%	70.4%	73.6%

Why was this a priority?

The organisation had reduced scores for this important indicator since 2021 and are below target. Patient safety is a priority and supported by a culture of speaking up and responding positively to concerns. The Trust had experienced high staff turnover and was on a journey to improving and reaching target.

What was our target?

The target for the measure "I feel secure about raising concerns regarding unsafe clinical practice within the organisation'' remained at 78% which was not achieved last year.

How did we measure and monitor our performance?

Our performance is measured through staff survey responses on an annual basis.

How and where was progress reported?

The staff survey results are shared at Divisional Boards and corporate directorates and included in the CUH's Integrated Reporting process.

Did we achieve our intended target?

The target of 78% was not met in relation to raising concerns regarding unsafe clinical practice last year. We have achieved an increase in 2024/5, which is the highest for the last three years (2021 was 75.9%, the highest point for the last 5 years) and is above Picker Average of 70% for 2024 national staff survey.

Our key achievements against this priority:

Just Culture principles remain and are supported through the management of patient safety incidents. Just and Learning Culture development work is being reinstated, including in support of PSIRF and workforce culture outcomes.

A number of pastoral support initiatives and interventions provide opportunities for staff to share and raise concerns and suggestions for improvements. In addition, the work of our 'Freedom to Speak up Guardian' is likely to assist in building confidence including through increased attendance and at staff events, inductions, training and development sessions and meetings.

There has also been consideration for groups of staff that historically have found speaking up more challenging. There has been regular attendance at staff network meetings and events and internationally recruited staff welcome gatherings. Proactively seeking to recruit a diverse of 'listeners' is happening with an aim to have a group that reflects the diversity of our workforce.

2.2 External reviews into orthopaedic surgeon

In reporting on our performance in 2024/25, it is important to acknowledge the reviews that we have commissioned relating to the practice of a consultant orthopaedic surgeon who specialises in paediatric surgery.

In February 2025, the Trust announced that it would be carrying out a retrospective external review into the practice of an orthopaedic surgeon who specialises in paediatric surgery. This followed the conclusion of an initial external review, received in January 2025, which identified that the outcomes of treatment provided to nine patients were below the standard the Trust would expect, and that they and their families were entitled to expect from us.
We would like to reiterate how sorry we are that this has happened and apologise unreservedly to our patients and their families.

The external clinical review of the surgeon's practice is being undertaken by a panel of expert clinicians and chaired by Andrew Kennedy KC. The expert clinical panel will review the care of almost 700 patients who have undergone planned surgical procedures during the time the surgeon has been employed by CUH. The Trust is committed to doing this in a thorough, open and transparent way.

The Trust has contacted patients and families to confirm that they are in scope of this review and to outline the support we will provide to them as the review progresses. We have put in place a dedicated Patient and Family Liaison Team who will be the primary point of contact for patients and their families for the duration of the review.

We anticipate that the process of reviewing all the patients will take at least a year and we will be contacting patients and families during this time once the review of their care is complete to inform them of the outcome and to confirm whether further clinical assessment and treatment are needed.
While the individual surgeon specialises in paediatric surgery, it is normal practice for all orthopaedic consultants to carry out emergency orthopaedic procedures on both adults

and paediatric patients. Therefore, as part of this retrospective external clinical review, the expert clinical panel will also review an initial 100 adults and paediatric orthopaedic trauma cases to determine whether there are any concerns about the emergency treatment provided by this surgeon.

In addition, the Trust has commissioned Verita to undertake an independent investigation into what was known when and whether there were opportunities to have identified these issues sooner. This includes investigating whether an external clinical review in 2016 was acted upon appropriately and, if not, why. This independent investigation is due to be completed by the end of July 2025 and we will publish and implement the findings.

A dedicated governance structure has been put in place to oversee this issue, with regular reporting to the Board of Directors and the Quality Committee. External stakeholders, including representatives of NHS England, the Care Quality Commission and Healthwatch, are represented on the Oversight Board.

2.3 Priorities for quality improvement for 2025/26

The priorities for improvement for 2025/26 were selected after consideration of existing Trust and national priorities, performance against 2024/25 priorities, and benchmarking data. The priorities have been agreed by the Trust's Board of Directors and Council of Governors and reflect areas for improvement that align to the delivery of high quality, effective, safe and patient centred care. The priorities are aligned to the five key questions posed by our regulator, the Care Quality Commission - namely Safe, Effective, Caring, Responsive and Well-Led.

Safe

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

Patient Safety Improvement 2025/26

The organisation remains committed to promoting harm free care. For the 2025/26 year, the Trusts 'Care Quality Plan' sets out the areas for improvement in addition to ongoing improvement in maternity care provision.

The measures we will use in 2025/26 will be:

Measure	Definitions	Baseline	Target	Rationale
Hospital Acquired Pressure Ulcers (HAPU)	Rate of Hospital acquired category 2+ pressure ulcers per 1000 bed days	0.79 per 1,000 bed days	≤0.395 per 1,000 bed days	The target reduction in the rate of HAPUs was not met as planned in the previous year, measurement continues to reflect our harm free care improvement projects.
Nutrition screening compliance for admitted patients	Percentage of nutrition screening assessment carried out within 24 hours of an inpatient admissions.	76%	≥90%	The target compliance not consistently met in previous year; measure will be continued from last year.
Maternity Triage Midwife	Percentage of birthing people reviewed by a midwife (for initial triage) within 15 minutes of arrival	71% (Dec 24)	85%	Existing improvement work-stream in maternity services
Maternity Triage Obstetrician	Percentage of birthing people reviewed by obstetrician within the required timeframe based on initial midwives' review.	82% (Dec 24)	85%	Existing improvement work-stream in maternity services

Effective/Responsive

Our aim is to consistently deliver high quality care that is effective, accessible, & patient centred.

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

The measures we will use in 2025/26 will be:

Measure	Definitions	Baseline	Target	Rationale
Bed Occupancy (consultant –led beds)	General and acute consultant led bed occupancy - number of adult beds occupied as the proportion of total adult beds open	88%	93%	Aim to improve the organisations bed utilisation with by reducing length of stay.
Same day emergency care (SDEC)	The percentage of patients attending the hospital as an emergency patient who are treated and discharged on the same day or within 12 hours if the admissions is overnight)	22% (Av 2023-24) 25% (Av 2024-25)	30.0%	Existing metric in 2023/24. We did not reach target in 2023/24. SDEC helps to reduce crowding in the Emergency Department and reduces the demand for in-patient capacity The method of calculation has been modified, and therefore is not directly comparable to the 2023/24 cycle.
Waiting Times for first outpatient appointment	% patients waiting 18 weeks or less for first appointment.	63.8%	64.0%	The NHS Elective care providers' commitments and operational planning guidance was published in January 2025. Key expectations are to increase the proportion of patients waiting less than 18 weeks for elective treatment to the target of 65% nationally by March 2026.Reducing waits helps to achieve this target.
Number of patients who spend >12 hours in the Emergency Department (A&E)	% of patients who spend >12 hours in ED (Type 1)	12%	TBC	Aim to reduce time spent in emergency department
Smoking Cessation – Number of Inpatient referrals for acute admissions (excl. elective and Maternity)	Number of IP referrals for acute admissions seen by smoking cessation team	438 (Annual 2024-5)	N/A	EDI / Health Inequality measure. This is a key measure around preventative care, supporting system-wide strategic priorities. Our overall aim is to increase the reach of our program by widening referrals to the service in the first instance."
Smoking cessation – Number of 28-day follow-up confirmed quits (quarterly)	Smoking Quit rates across inpatient referrals for acute admissions (excluding Maternity)	18 % (Annual Quit Rate 24-25)	20% (Annual Quit rate 25-26)	Supporting Community Health initiatives: Overall aim is to increase the reach of the program by widening referrals to the service.

Patient Experience/Caring

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

The measures we will use in 2025/26 will be:

Measure	Definitions	Baseline	Target	Rationale
Responses to service user complaints are within agreed time frames	Responses to service user complaints are within 30, 45 or 60 working days depending upon complexity	57% (Annual average 2024/5)	80%	Metric carried over from last year as the target was not yet met.
Dementia Care - Completion of "What's Important for Me" for all admitted patients with a known diagnosis of dementia.	Number of admitted patients with 'WIM' completed /Total number of admissions with a diagnosis of dementia	28% (Annual average 2024/25)	50%	We admit a high percentage of elderly patients. The measure was chosen to ensure meaningful understanding of patient needs at an individual level for those diagnosed with dementia.

Staff Experience/Well-led

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

A measure that indicates how staff feel about the organisation's safety culture was chosen. Safe organisations engage staff in the safety agenda, and they feel secure raising concerns. Our staff experience impacts on our continual drive to deliver safe and high-quality care.

The measures we will use in 2025/26 will be:

Measure	Definitions	Target	Rationale
Morale Indicator: I feel secure about raising concerns about unsafe clinical practice.	National Staff Survey Theme: Safety Culture.	78%	Workforce pressures and impact upon staff.

External reviews into the orthopaedic surgeon employed at CUH

In addition to the above indicators, a key priority for the Trust during 2025/26 will be to continue to manage the response to the external reviews relating to the orthopaedic surgeon in an open, transparent and robust way and in accordance with the following priorities:
Prioritise the identification of all harm, with an immediate focus on time critical addressable harm.

- Work with patients and their relatives as partners.
- Seek and maintain external, independent clinical leadership to conduct the next stage of the comprehensive external clinical review.
- Be open and transparent with patients, the public and staff.
- Act immediately upon any and all learning as the reviews progress.

We will continue to focus on doing the right thing for patients and families and we will continue to provide regular updates to all those affected.
We will publish and implement the findings from Verita's independent investigation into missed opportunities.
Alongside this, we will take forward work, commissioned by the Trust Quality Committee, to examine the approach taken by the Trust when clinical concerns are raised, to confirm the process for when reviews are undertaken, and to identify when they may be potential indicators of issues in other services.

2.4 Statements of assurance from the Board

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

The Board of Directors

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

Scrutiny of the information contained within these indicators and its implication as regards patient safety, clinical outcomes and patient experience takes place at the Quality Committee.
The Board of Directors reviews the Trust's integrated quality, performance, finance and workforce reports each month. Reviews of data quality, and the accuracy, validity and completeness of Trust performance information, fall within the remit of the Audit Committee, which is informed by the reviews of internal and external audit and internal management assurances.

Review of our services

During 2024/25 Cambridge University Hospitals NHS Foundation Trust provided and/or sub-contracted 105 relevant health services.
The Cambridge University Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in all 105 of these relevant health services.
The income generated by the relevant health services reviewed in 2024/25 represents 99.15% of the total income generated from the provision of relevant health services by the Cambridge University Hospitals NHS Foundation Trust for 2024/25.

Participation in national clinical audits and national confidential enquiries

During 2024/25, a total of 80 national clinical audits and 3 national confidential enquiries covered relevant health services that Cambridge University Hospitals NHS Foundation Trust provides.

During that period Cambridge University Hospitals NHS Foundation Trust participated in 100% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Cambridge University Hospitals NHS Foundation Trust was eligible to participate in during 2024/25 are listed in *Appendix B*.

Table 2: Participation in national confidential enquiries

National confidential enquiry title	Participation
Blood sodium	Participated
End of Life Care	Participating
Rehabilitation following critical illness	Participating

Learning from audit

National audits

The reports of at least 80 national clinical audits were reviewed by the provider in 2024/2 and Cambridge University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see *Appendix B* for list of national clinical audit reports, outcomes and action plans).

Local audits

The reports of 366 local clinical audits were reviewed by the provider in 2024/25 and Cambridge University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. In addition, *Appendix C* provides examples of local clinical audit report outcomes and action plans.

Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Cambridge University Hospitals NHS Foundation Trust in 2024/25 that were recruited during that period to participate in research approved by a research ethics committee are 24,300.
Figures given are compiled by the Clinical Research Network and cover all research studies conducted at CUH that are on the National Portfolio.

Use of the CQUIN payment framework

Cambridge University Hospitals NHS Foundation Trust income in 2024/25 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework as the CQUIN scheme was paused by NHS England.

The link between CQUIN programmes and the Trust's remuneration is expected to remain under review with NHSE and has the potential to impact on payment arrangements in future years.

Prior to the Covid-19 pandemic a proportion of an NHS provider's income would have been conditional upon the CQUIN programme's objectives being achieved.

Care Quality Commission registration and compliance

Cambridge University Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and is currently registered with no conditions attached.
The Care Quality Commission has not taken enforcement action against Cambridge University Hospitals NHS Foundation Trust during 2024/25.
Cambridge University Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Data quality

Data quality refers to assurance of the information about patients recorded by the Trust on computerised systems. The Trust follows national guidelines about how these data are collected and stored, and we undertake regular audits to make sure that data held on the system is accurate and that we are compliant with what is expected.
CUH submits records to the secondary uses service (SUS) for inclusion in the hospital episode statistics (HES). We also share data with partners as appropriate, for example Integrated Care Boards (ICBs). These data are used to plan and review the healthcare needs of the area.
Cambridge University Hospitals submitted 2,177,773 records during the reporting period, April 2024 – March 2025, to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- Which included the patient's valid NHS number was:
  99.8% for admitted patient care;
  99.7% for outpatient care; and
  98.9% for accident and emergency care.

- Which included the patient's valid General Medical Practice Code was:
  100% for admitted patient care;
  99.2% for outpatient care; and
  97.6% for accident and emergency care.

Information governance toolkit attainment levels

All NHS organisations are required to comply with the 'Information Governance Toolkit'. This covers standards on data protection, confidentiality, information security, clinical information and corporate information.
The Cambridge University Hospital Data Security & Protection Toolkit submission for 2023/24 was 'approaching standards'. The DSPT assessment for 2024/25 is not due until the end of June 2025. The Trust is currently working through the requirements and gathering evidence ready for the submission at the end of June. The Trust is aiming to meet all standards but, at the time of publishing the annual Quality Account, cannot confirm that all standards have been met.

Clinical coding

Cambridge University Hospitals undertake the following actions to improve data quality:

- Develop data quality dashboards and provide missing/invalid item reports for many of the national returns so that front line staff may see where improvements are possible.
- Scheduled deep dives into divisional, mandated returns.
- Audit documented clinic outcomes against evidence within the electronic patient record (Epic) to provide process assurance.
- Administrative and ward clerk lunch and learn sessions held virtually throughout the period designed to highlight data issues and improve compliance.
- e-Hospital Clinical Liaison team working across all inpatient areas to improve adherence to Trust clinical workflows and ensure that the technology deployed is fit for purpose.
- Continuous review / improvement of Epic workflows to enable staff to work efficiently and effectively thereby improving data quality.
- EPR / IT training strategy progressing well, and all classroom session content and tip sheets reviewed. Post training at-the-elbow support now offered and a series of eLearning tutorials are available.
- The Data Governance, Reporting and Stewardship Oversight Group reinforces processes relating to data collection, curation and storage across the Trust. The group works with divisional management and operational teams to ensure that data quality processes are embedded and to promote a culture of continuous improvement in order to improve the quality of our national returns.
- The Referral to Treatment (RTT) pathways forum runs as a quarterly event to reinforce the development and learning for front line staff. The forum focuses on education around new or enhanced Epic functionality, data analytics resulting from audit deep dives and examples of existing good practice.
- Personalisation discussions help clinicians set up their own preferences in Epic. This helps clinicians to navigate the system appropriately and understand the importance of data quality.
- Workflows in Epic are built to guide the user to complete workflows appropriately. Errors or omissions are flagged with warning and stop signs used to aid correction.

Learning from Deaths

In March 2017, the National Quality Board introduced new guidance for NHS providers on how they should learn from the deaths of people in their care.
CUH launched its new policy and procedures in October 2017 in line with NHSI timeframes. The learning from deaths policy within CUH is supported by the Trust Learning from Deaths Oversight Committee and reports to the Quality Committee bi-monthly via the Patient Safety Report and monthly to the Board via the Trust integrated report.
The data shown below reflects the mandated KPIs for reporting via the Quality Account. These numbers have been provided using the Trust's mortality case reviews, including Structured Judgement Reviews (SJR) and Perinatal Mortality Review tool (PMRT) methodologies.

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

During the period April 2024 to March 2025, 1687 CUH patients died. This comprised the following number of deaths, which occurred in each quarter of that reporting period: 410 in the first quarter; 399 in the second quarter; 448 in the third quarter and 427 in the fourth quarter.

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

All inpatient deaths are subject to a proportionate case record review by the Medical Examiner's Office.

During the period April 2024 to March 2025, 312 of the 1687 deaths outlined in 27.1 were subject to a more detailed mortality case review of the case record. 242 underwent a structured judgement review and 70 went via alternative processes (Perinatal mortality review tool, Initial rapid review, Complaint or MBRRACE)

Of the 312, the number of deaths in each quarter for which mortality case review was undertaken: 78 in the first quarter; 72 in the second quarter; 89 in the third quarter and 73 in the fourth quarter.

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

Of the 242 deaths that underwent a structured judgement review during the period April 2024 to March 2025, 13 were judged to be more likely than not to have included problems in the care provided to the patient (scores 1-3 in 2024/25). A score of 1-3 comments upon the presence of problems in care, not the impact of these problems upon the death of the patient.

In relation to each quarter, this consisted of: 6, representing 1.5% for the first quarter for all deaths; 3 representing 0.8% for the second quarter; 4 representing 0.9% for the third quarter and 0 representing 0% for the fourth quarter.

There were nine incidents relating to unexpected/potentially avoidable deaths of which had further investigations.

Date investigation commissioned	Title	Date investigation commissioned
19/03/2024	Deteriorating patient	PSII
16/04/2024	Patient aspiration	Thematic analysis
21/05/2024	INC1669 – Missed opportunity to diagnose cardiac disease	Multi-professional Roundtable Review
16/07/2024	INC6683 – Missed diagnosis of lupus (SLE)	Multi-professional Roundtable Review
16/08/2024	INC10468 - Cardiac arrest	AAR
04/12/2024	INC18309 - Unexpected complication	IRR
12/11/2024	INC16466 – delayed diagnosis	IRR
03/12/2024	INC16676 – Paediatric cardiac arrest	PSII
04/03/2025	INC19447 – Deteriorating patient – exacerbation of COPD	PSII

(27.4/27.5) A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3 (scores 1-3 in 2024/2025

SJR Thematic Review:

A review of SJR's which highlighted problems in care (scores 1-3) within the last year has identified key areas for learning and improvement:

- Patient flow and capacity in the Emergency Department. There were several SJRs that highlighted delayed ambulance off-loads, and patients having long-waits in the department. This led to delays in patients accessing medical review as well as delays in initiating treatments and investigations. In most cases, the standard of clinical care was judged to be high, despite the pressures faced within the service due to the high volume of patients.
- Medical handover. Communication between teams and the handover of important clinical information was highlighted as an issue. Examples included the handover of important medication information by pharmacy to the medical team. Continuity of care was also an issue with patients being reviewed by multiple doctors, leading to key clinical information not being handed over and a lack of holistic overview in a patient's care.
- Implementation of nursing care. Certain aspects of nursing care were highlighted as problems in care. This included potential missed opportunities to access and management the patient's risk of falling, and gaps in the management of patient's pressure areas and skin integrity. Learning from these case reviews were fed into the respective quality improvement work streams. There was also an example of poor care relating to the management of a patient's feeding tube which may have resulted in harm. The learning from this case was taken forward by the Nutrition Steering Group.
- End of Life Care (EOLC). A common theme in SJRs are delays in recognising that patients are at the end of life. This results in delays in the patient being

moved onto an EOLC pathway, and the potential for receiving unnecessary interventions that are not in the patient's best interests. Learning from these SJRs was presented at the Trust's inaugural EOLC conference.

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

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

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

Fifty four case record reviews completed after 01 April 2024 related to deaths which took place before the start of the reporting period, from the previous financial year 2023 – 2024.

2.5 Reporting against core indicators

The Trust's performance against the core indicators is described in Appendix A. These are updated based on data available from NHS Digital.

Part 3 - Other information

3.1 Performance against indicators and performance thresholds

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

Table 3: National targets – 2024/25 performance

Indicator for disclosure		Target 2024/25	CUH performance 2024/25
Referral To Treatment (RTT)	Percentage compliance with maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	92%	Apr – March 25 59%
A&E target	Maximum waiting time of four hours from arrival to admission/ transfer/ discharge	66%	April – March 25 57.4% *CUH not including MIU. (Type 1 & Type 3 activity only)*
All cancers - 62-day wait for first treatment from:	Urgent GP referral for suspected cancer	85%	With reallocations Apr- Mar 25 72.8%
	NHS Cancer Screening Service referral	90%	With reallocations Apr- Mar 25 73.8%
	62d Combined	85%	With reallocations Apr- Mar 25 73.2%
Infection Prevention and Control	Clostridium difficile – variance from plan	<=134 cases (HOHA and COHA).	Apr – March 25 *164 is currently correct as per the UKHSA DCS (mandatory surveillance)*
Summary Hospital-level Mortality Indicator (SHMI)	See Appendix A		
Diagnostic waiting times	Maximum 6-week wait for diagnostic procedures	1%	April – March 25 28.7%
Patient Safety	Venous thromboembolism (VTE) risk assessment	See Appendix A	

Duty of Candour

When a patient has been involved in a notifiable safety incident, staff have a duty to inform the patient, relatives, and/or carers as appropriate. A notifiable safety incident is defined as any incident that is unintended or unexpected; occurring during the provision of regulated care; and in the reasonable opinion of a healthcare professional, already has, or might, result in death, severe, or moderate harm to the person receiving care. CUH has a clear policy that outlines this process and ensures organisational compliance with this regulation. Previous requirements (NHS contract and CQC standards) required stages 1

and 2 to be completed within 10 working days; this specific timeframe is no longer a requirement; our Trust standard now is within a reasonable timeframe.
Compliance with Duty of Candour stage 1 requires that an appropriately senior clinician informs the patient about the incident, explains the impact and consequences for the patient, apologises, and informs the patient that the incident will be investigated, and finally, all these elements are captured in a formal letter from the clinical team to the patient (or relative/carer).

Stage 2 pertains to ensuring that once the investigation is completed the Trust will share the findings of their investigation with the patient/relative/carer, should the latter so wish. Duty of candour is delivered by the relevant clinical teams and is recorded in the patient's medical record and in Datix; compliance is monitored from Datix and reported by the divisional governance teams and corporate patient safety team. Compliance data is shared monthly with the Board via the monthly Trust Integrated report, with Divisions via metrics in their Divisional Board meetings (Accountability Framework report), and with the Quality Committee via the Patient Safety Group's bi-monthly Patient Safety Report.

In 2024/25 our compliance with Duty of Candour, stage one is 89% (244/275), and stage two is 96% (267/278). The outstanding actions are in progress with oversight through performance reporting to the Trust Board.

Just Culture

Our Trust is committed to the principles of the NHS Just culture guide to ensure the fair, open, and transparent treatment of staff who are involved in patient safety incidents. Our Trust recognises the significant impact being involved in a patient safety incident can have on staff and the value of ensuring we have a restorative culture.

We are committed to continue building on our strong foundations of the just culture principles already embedded in our review of patient safety incidents. Our commitment and manifesto are detailed in our Patient Safety and Incident Response Framework (PSIRF) Policy.

Equality Diversity and Inclusion (EDI)

EDI remain central to our commitment of delivering high-quality, person-centred care. In this year's Quality Account, we continue to prioritise actions that promote fair access to services, reduce health inequalities and foster an inclusive environment for both patients and staff.

We are actively engaging with diverse communities to better understand their needs and experiences, ensuring their voices shape the services we provide. By working in partnership with local groups and stakeholders, we aim to build trust, improve outcomes, and deliver care that is respectful, responsive, and equitable for all.

Table 4: Staff Survey Results

What did we measure?	How did we do?		
	2022/23	2023/24	2024/25
KF27 % reporting most recent experience of harassment, bullying or abuse (Higher scores are better)	43.4%	48.0%	50.1%
Relate to - Workforce Race Equality Standard:			
KF21 / Q15 (percentage believing that Trust provides equal opportunities for career progression or promotion) (Higher scores are better)	56.8%	57.5%	59.5%
KF26 presented as 2 separate questions: (percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months) (Q14b)	11.4%	12.2%	9.3%
(percentage of staff experiencing harassment, bullying or abuse at work from other colleagues in last 12 months) (14c)	20.5%	21.6%	20.0%

KF27: A Trust internal communications campaign was created and rolled-out signalling expectations around behaviour when accessing services and possible consequences of abuse to staff. The messaging encourages staff to report experience of harassment, bullying or abuse. Whilst there is an improvement in reporting since 22/23 the issue of harassment, bullying and abuse remains an issue across the NHS, including for CUH. Further work is taking place within CUH to further reduce experiences and prevent where possible.

KF21: We are pleased to see improvement whilst recognising that cultural and behavioural changes take time. Improvement interventions continue centred around the WRES and WDES action plans.
Over 100 diverse interview panellists with lived experience of minority groups continue to support recruitment to posts for band 8a and above from shortlisting through to interview. A further career conversations event took place in May building on the success of one held in October 2023. This was designed and delivered by Culture, Leadership and Learning team in collaboration with REACH network members. In feedback for the May 2024 session, 95% of respondents rated their conversation as 5/5, saying that they felt listened to, supported and empowered, feeling the mentors were informative and able to offer a different perspective.

KF26: During 2024/25 CUH signed the NHS Sexual Safety Charter with significant work happening to implement. Work continued to deliver on the principles of our Just & Learning culture declaration including through implementation of the National Patient Safety Strategy, where a key focus is on how staff behave towards each other i.e. in a fair, respectful, proportionate and consistent way across the organisation – in particular in response to when things have gone wrong. The learning from the Just & Learning Culture masterclasses delivered has been translated into the development programmes offered across middle management levels to provide awareness and skills to embed a just and

learning culture into local teams, together with the creation of an e-learning package for all staff. This work is complementary with other work streams focused on embedding just culture principles into Trust processes and practices.

Table 5: Harassment & bullying comparator information

	Comparator Information	2022	2023	2024
Qu.	Description	n = 6493	n = 4895	n = 7015
q14a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	76.2%	75.7%	77.9%
q14b	Not experienced harassment, bullying or abuse from managers	88.6%	87.8%	90.7%
q14c	Not experienced harassment, bullying or abuse from other colleagues	79.5%	78.4%	80.0%
q14d	Last experience of harassment/bullying/abuse reported	41.7%	48.0%	50.1%
q15	Organisation acts fairly: career progression	56.8%	57.5%	59.5%

3.2 Improving patient care, patient experience and supporting our staff

Improving Patient Experience

The results of the 2023 adult inpatient survey for CUH were published in August 2024. The results are based on the responses of 488 patients (response rate of 42%) and show an overall experience score of 8.1 out of 10.
The results were very positive in relation to the following areas:

- 98% of patients had trust and confidence in their doctor.
- 98% said they were treated with kindness and compassion.
- 98% of patients said they were treated with respect and dignity.
- 98% said nurses answered questions in a way they could understand.
- 99% of patients said all staff helped when they needed attention.

The survey has also highlighted some areas for further focus:

- Noise at night having an impact on sleep.
- Information provided to patients while on our waiting list.

The results for National Children's (CYP) patient experience survey 2024 were published Jan 2025.
The sample period was taken between March to May 2024, and the response rate was 29%, (compared to 22% for similar organisations). CUH scored statistically significantly better than the Picker average for 15 questions, none were significantly worse and 53 showed no statistical difference.
Excellent feedback was received in relation to the following areas:
98% of parents felt their child was looked after in hospital.
98% of parents/carers were treated with dignity and respect by staff.
93% of parents rated their child's experience in hospital as 7/10 or more.

The lowest scores relate to being prevented from sleeping, being able to get food outside of mealtimes and parents feeling there was enough choice of hospital food for their child.

The results of surveys are routinely discussed through the Trust's Patient Experience Group, where oversight of improvement work is provided through multi-disciplinary membership.

Freedom to Speak Up

In line with the recommendations of the Freedom to Speak Up review undertaken by Sir Robert Francis; the Trust has had a Freedom to Speak up Guardian (FTSUG) in post since December 2016. The post holder reports to the Director of Corporate Affairs in their role as Lead Executive for Speaking Up and is supported by a growing network of local listeners throughout the organisation. In addition, there is a named Non-Executive Director for Speaking Up that the FTSUG can access for support where necessary.
The role of the FTSUG is primarily to support workers when they have a concern that they do not feel able to raise through local channels. The FTSUG offers a safe and confidential service to explore concerns, signpost toward solutions, and in some cases confidentially take forward the concern raised on behalf of an individual or group to ensure that it is heard and acted upon. It is also expected that the FTSUG will raise the profile of Speaking-Up

across the organisation with a view to achieving a culture where Speaking-Up is considered "Business as Usual" as per the National Guardian's Office (NGO) expectations. To support this the FTSUG presents to managers as a subject matter expert in the Essentials for Management and Leadership Excellence programme which began in late 2024 to further embed the principles of listening to workers that wish to raise a concern locally and taking appropriate action.

In the financial year 2024/25, colleagues raised 295 concerns with the FTSUG compared to 269 the previous year. The main themes of concerns raised during 2024/25 using the categories prescribed by the NGO were 'worker safety and wellbeing' and 'inappropriate attitudes and behaviours. Concerns can often be categorised within more than one category and experiencing difficulties at work commonly impacts worker wellbeing which accounts for the high number of concerns in this category. The staff group accounting for the greatest proportion of concerns raised were registered nursing and midwifery staff, with administrative and clerical staff followed by additional clinical support services (commonly healthcare support workers) also coming forward.

The FTSUG continues to raise awareness of the value of speaking up to workers and of listening and taking action for managers.

Improving rota gaps for NHS Doctors and Dentists in training

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

With effect from 01 April 2024, the inclusion of 'rolled-up holiday pay' into locum rates for temporary workers (those undertaking additional shifts via our internal locum bank) will once again be lawful. The Trust plans to implement this across 2025. This has been welcomed by the Local Negotiating Committee (LNC) and resident doctors Forum (JDF) and it is hoped that the prompter payment of this entitlement will improve the engagement of our resident doctors.

An agreement to the national pay deal with uplifts to pay across resident doctors in November 2024 has meant an end to a lengthy period of industrial action and improvement to working relations with resident doctors.

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

There is no consistent pattern in relation to grade and speciality of these non-training grade vacancies. As such vacancies arise, the Medical Staffing team work with individual clinical teams to agree a timely recruitment process, changes to work schedules, and innovative ways to make such posts more attractive such as support for a Post graduate certificate (PG Cert) and other postgraduate qualifications.

Many successful applicants for non-training grade vacancies are recruited from overseas however the impact of the EU exit and requirements for visas significantly increases the length of time it takes from recruitment to commencement, however the number of applications received from non-UK applicants for many of our resident doctor posts has increased considerably over the past year.

3.3 Feedback on the quality report and quality account

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

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

Or email: cuh.trustsecretariat@nhs.net.

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

Annex 1: Statement by stakeholders

Governors' statement on the quality account 2024/25

Through the Council of Governors and the quarterly update meetings held between the Non-Executive Directors and the Council of Governors, assurance has been provided around the Trust's response to key challenges faced over the past 12 months and the confidence with which the Non-Executive Directors feel the Trust is positioned to deal with the challenging year ahead.

The Council of Governors were disappointed to hear that concerns had been raised regarding the standard of care provided by an orthopaedic surgeon specialising in paediatric surgery. With the external review identifying that the outcomes of treatment provided to nine children fell below the standard the Trust expects, the Council of Governors will continue to seek assurance that the Trust has adequate internal mechanisms for identifying potentially similar incidents of poor clinical practice.

We recognise that the Trust has taken steps to address the initial findings and has been transparent with the public and the families of those affected. The Council of Governors is keen to ensure that appropriate steps are in place to ensure that the resources required to support patients and their families affected by this incident does not have a detrimental impact on other services across the Trust.

Some positive progress in the management of the PALS and Complaints backlog has been made over the past 18 months, though more needs to be done. This remains a key area for the Trust to seek feedback from patients around their experiences within the Trust. It will be imperative that resources remain available for those teams to continue to listen to patients and families when concerns are raised and to ensure that action is taken to address those concerns in a timely manner.

The results of the 2024 annual staff survey were largely positive, with a 17% increase in staff completing the survey. Across a number of key metrics, the Trust has shown significant improvement and benchmarks well when compared with peer Trusts.

As in previous years, we would hope to see the Trust take on board the views raised by staff through the survey, particularly from those who have experienced bullying and harassment in the workplace. The Council of Governors will seek assurances that the Workforce and Education Committee are monitoring the implementation of the action plan. Additionally, we will continue to seek the views of our staff governors to ensure that the work being implemented strategically is resonating with staff members.

Throughout 2024-25, there has been focus on monitoring key performance metrics. Of particular note was the Trust's performance against the 4-hour A&E wait standard, ambulance hand over times and referral to treatment (RTT) targets.

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

The last year has seen a number of key members of the Board moving on from the Trust, having held pivotal roles in providing scrutiny of the quality of clinical care provided within the Trust.

As Lead Governor, I would like to note my thanks on behalf of the Council of Governors to Professor Sharon Peacock, who served as a Non-Executive Director for 9 years and was previously the Chair of the Quality Committee. Sharon's term as a Non-Executive Director came to an end on 31 March 2025.

Additionally, Professor Ian Jacobs, Non-Executive Director, left the Trust in February 2024 to take up the role of Trust Chair at Barts Health NHS Trust. Ian was the CUH Maternity Champion and was a passionate advocate for matters relating to the safety and quality of maternity services in CUH.

We welcome John Crompton and Philippa Hird as non-executive directors replacing Sharon Peacock and Ian Jacobs. John is vice chair of Marshall of Cambridge and is experienced in commercial matters and public finance. Philippa Hird is Chair of the NHS Pay Review Body and Chair and Pro Chancellor of the University of Manchester. She brings expertise in major change and transformation, which will be of great value as the NHS changes in response to increasing demand.

In December 2024, Dr Mike More stepped down from his role as Trust Chair, having held the role for seven years. Mike was a constant presence at the hospital, always willing to discuss concerns with patients and staff and worked to resolve them. He won the respect of the board, staff, patients and the local community, by being approachable, open and honest and being able to speak to anyone, regardless of their position. He was committed to the Trust and committed to our governance model. He valued what governors brought to the trust and made time to listen to what we had to offer.

As the Trust enters a period of stricter financial controls, with a reduced workforce, it will be important to ensure that the new Trust Chair is able to oversee and hold the Executive to account for the delivery of the key financial, performance and productivity targets that have been set out in this document and the national operational plan.

There is recognition that the challenging conditions outlined in the 2025/26 operational planning guidance and the requirement to reduce the overall head count across support functions, may have a detrimental impact on quality of care and also staff morale, if the processes to implement those changes are not managed in a way that is in line with the values of the Trust.

Cambridgeshire & Peterborough Integrated Care Board (ICB) statement for inclusion in the 2024/25 quality account

Cambridgeshire & Peterborough Integrated Care Board
Stakeholder Feedback – Cambridge University Hospitals Foundation Trust (CUHFT) Quality Account 2024/25

Cambridgeshire and Peterborough Integrated Care Board (the ICB) has reviewed the Quality Account produced by Cambridge University Hospital Foundation Trust (CUHFT) for 2024/25.

CUHFT have produced a well written report outlining the progress and current position against the 2024/25 priorities and those identified for 2025/26.

The Trust had 10 priorities for improvement in 2024/25, and the report provides supportive data and detail around these priority targets, with evidence of progress and improvements. For example, improvement in the Falls Risk Assessment and Nutrition Screening metrics demonstrate the effectiveness of focused clinical initiatives with measurable impact. Areas identified for further improvements for 2025/26 are included.

The continued challenge with pressure ulcer prevention despite targeted interventions suggests either systemic complexity or inconsistent implementation of best practices that may affect patient outcomes. It is positive to see improvement work for reducing pressure injuries and transparency in identifying that further work is required and will be an area of focus for the Trust in 2025/26.

It is positive to see the Trust continuing to focus on nutrition screening during 2025/26 and how this will be progressed in relation to patient centred care plans. A recommendation is for this to be aligned to a food first approach and not increased utilisation of oral nutritional supplements.

The scope and execution of the Quality Programme, including revised ward accreditation and quality assurance structures, is comprehensive. However, more narrative on the medical leadership's role in driving these improvements would strengthen the message.

The 2022 three-year Strategy for maintaining high quality, focus for this year was introducing the campaign "small things, big difference" which has allowed direct engagement with staff for suggestions that have been implemented which is commended. The "good quality care, every day in our hospitals" programme launched in 2024 which supports strengthening continuous improvement, staff engagement and exceptional care. An overview of the improvements and outcomes for patients from this programme would be welcomed in the future.

The Account includes a detailed narrative of the external orthopaedic review, acknowledging potential harm, outlining governance, and engaging patients and families transparently, demonstrating candour and leadership. The Trust is commended for the dedicated team introduced to engage and support patients and families during the review. Whilst the review has highlighted reputational and legal risks, the full implications for clinical governance and medical oversight structures will require ongoing scrutiny throughout 2025/26.

CUH was selected as a pilot site for Martha's rule elements addressed by the "Call for Concern" as an alternative escalation for patients, relatives and carers. The service commenced in October 2024 with a dedicated phone number. I am pleased to note that the Trust has implemented all three components of Martha's Rule across most of the Trust.

Following transfer to the Patient Safety Incident Response Framework (PSIRF) the Trust has started to embed the new processes, using a variety of patient safety investigating tools to identify learning. Further training has been provided to support staff across the whole organisation to understand and support the new way of working. The Trust PSIRF plan for the coming year have been agreed by the ICB and the ICB are looking forward to supporting the Trust along this journey.
The Trust has successfully achieved Level 2 accreditation from the Global Antimicrobial Stewardship Accreditation Scheme (GAMSAS).
The measures which are being taken forward to support effectiveness and responsiveness in relation to minimising delays to a patient's journey and support health promotion, do not include anything related to medicines or medicines reconciliation. This is an opportunity for the Trust in relation to wider implementation of the Discharge Medicine Service which the Trust is not implementing to the level of other similar Trusts and has been shown to reduce readmission rates and where patients are readmitted reduce bed days. This may be an area the Trust would like to consider next year.
The Trust has shown strong engagement with the digital transformation through Epic and MyChart platforms. This is validated by HIMSS Stage 7 revalidation, which is an important achievement with a positive impact on both patients and clinicians.
The account includes good reporting on Learning from Deaths. There is evidence of sampling of a proportion of deaths for detailed reviews and investigation into causes of deaths and care provided. There is evidence of shared learning to implement actions and improve quality of care.
The Trust's Infection, Prevention & Control (IPC) team have been fully engaged with the system IPC Board and contributed significantly to the collaboration work and outcomes seen across the system. The account lacks information or detail of the Trust IPC initiatives. They have some of the highest rates of HCAI in the East of England but have not added any information regarding actions to improve this or any IPC audit information pertaining to this, this should be a focus for the Trust in 2025/26.
Maternity and Neonatal services have continued to be a priority for the Trust over the last year. The Trust has continued with the Maternity Improvement Board, which the ICB are members of. This focus will continue next year.
The maternity departments have worked extremely hard to evidence work in relation to the Saving Babies Lives Care Bundle (SBLCB) which enabled them to successfully report compliance against all ten of the safety actions within the Maternity Incentive Scheme (MIS). This is a significant amount of work, and the ICB congratulate the whole team on their success.
CUHFT notes in the report that research is one of the three pillars of their operation as an academic medical centre, and that this will continue in the planned new cancer and children's hospitals with embedded research institutes to inform clinical practice.
During 2024/25, CUHFT participated in 100% of all relevant national clinical audits (80) and confidential enquiries (3). This is commended; however, the report lacks detailed information on participation in research studies. The Trust could consider elaborating on consultant engagement and medical audit contributions, particularly for peer learning and feedback mechanisms (e.g., structured judgement reviews, PSIRF application in clinical teams).

The ICB would like to thank all staff working for Cambridge University Hospitals for their dedication, professionalism, hard work and commitment to patient care throughout the year.
Overall Cambridgeshire and Peterborough ICB agree the CUHFT Quality Account is a true representation of quality during 2024/25.

Carol Anderson
Chief Nursing Officer

Cambridgeshire & Peterborough ICB

18th June 2025

Cambridgeshire County Council Adults and Health Committee statement for inclusion in the 2024/25 quality account

Due to the timing of the local elections this year the Adults and Health Committee will not be submitting comments on the 2024/25 Quality Account.

Richenda Greenhill
Cambridgeshire County Council
13th June 2025

Healthwatch Cambridgeshire and Peterborough statement for inclusion in the 2024/25 quality account

Healthwatch Response to CUH Quality Account 2024/2025

Healthwatch Cambridgeshire and Peterborough welcomes the opportunity to comment on the draft Quality Account for Cambridge University Hospitals NHS Trust – 2024-2025.

We are encouraged by your ongoing commitment to improving access to care, including the development of the Cambridge Surgical Movement Hub. Despite ongoing pressures such as high bed occupancy and increasing demand, it is positive to note your progress in expanding day case and elective inpatient activity, particularly as people continue to tell us about concerns around waiting times.

It is also reassuring to hear of the increase in numbers of people being treated in virtual wards which have the potential to support with issues around high occupancy and elective recovery. We are pleased to hear of the implementation of these initiatives to improve patient flow.

As coordinators of the Adult Social Care Partnership Boards, Healthwatch Cambridgeshire and Peterborough facilitates the involvement of people with lived experience in shaping local health and care services. The Learning Disability Partnership Board has raised concerns regarding poorer health outcomes for people with learning disabilities and autism. Some of our Independent Members additionally contribute to a dedicated Health Sub-Group. We are pleased to see continued efforts to address these inequalities, particularly through the ongoing funding of the Learning Disability Lead role for Children and Young People. This role is critical in improving care pathways, staff training, and support for vulnerable young people attending both outpatient and inpatient settings.

Patient Experience

We are pleased to note that CUH has improved its overall accessibility score. We look forward to hearing of progress being made in terms of performance in keeping patients informed about length of waiting times in particular for initial consultation, also improvements in discussing further care following leaving the Treatment Centre and acting on feedback heard through patient surveys. It is also reassuring to hear that you are focusing on improving effective demographic patient monitoring. This is vital in addressing health inequalities and identifying what key issues are.

Healthwatch Cambridgeshire and Peterborough has engaged with local people to understand their concerns and identify where our collective focus should be. A clear priority that has emerged is the need for better communication around referral to treatment and for patient experiences to be routinely reported to support service improvement.

To support this, we invite Cambridge University Hospitals NHS Trust to share our Referral to Treatment feedback form with patients currently on waiting lists or have been through the process. This will enable us to gather independent feedback into patient experiences. We will regularly report this feedback to the Trust to help inform decision-making and drive improvements in patient care. Share your experience of referrals from Adult Social Care, GP, Community Clinic, Hospital to any other service providing your treatment | Healthwatch Cambridgeshire

Thank you once again for your ongoing commitment to improving patient care. We look forward to continuing our collaborative partnership to ensure patient voices are heard and that services are shaped by meaningful, actionable feedback.

Caroline Tyrrell-Jones
Head of Operations
Healthwatch Cambridgeshire and Peterborough
16th June 2025

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

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.
NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the quality report.
In preparing the Quality report, directors are required to take steps to satisfy themselves that:

- the content of the Quality report meets the requirements set out in *supporting guidance "Detailed requirements for quality reports 2020".*
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
- Board minutes and papers for the period April 2024 to March 2025
- papers relating to quality reported to the Board over the period April 2024 to March 2025
- feedback from commissioners dated 18th June 2025
- feedback from governors 20th June 2025
- feedback from the CCC Adults and Health Committee dated 13th June 2025
- feedback from the local Healthwatch organisation dated 16th June 2025
- feedback from overview and scrutiny committee (Trust Management Executive) 26th June 2025
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, (pending publication).
- the 2023/24 national patient survey (National inpatient survey) dated August 2024
- the 2023/24 national staff survey, published March 2025.
- CQC inspection report dated 4th of September 2023
- the quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- the performance information reported in the Quality report is reliable and accurate.

- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice.
- the data underpinning the measures of performance reported in the Quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the Quality report.

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

By order of the board

Chairman	**Chief Executive**
26 June 2025	26 June 2025

Appendix A: National Quality Indicators – 2024/25 performance

The indicators are outlined in National Quality Account guidance for reporting, although this process is in transition and the expectation is that the NHS oversight framework measures may influence the future reporting process, and as such national level data may not be published in 2024 for the following data sets. Where available at the time of Quality Account publication, these are included below.

Ref	Indicator	CUH performance 2021/22	CUH performance 2022/23	CUH performance 2023/4	National average	Best performer among Trusts	Worst performer among Trusts	Trust statement
12	(a) The value and banding of the summary hospital-level mortality indicator ('SHMI') for the Trust for the reporting period; and	SHMI by provider (all non-specialist acute providers) for all admissions in Nov 2021 to Oct 2022 – 0.9695/ 96.95 Band: 2 (published 9 March 2023)	SHMI by provider (all non-specialist acute providers) for all admissions in Nov 2022 to Oct 2023 – 0.9743/ 97.43 Band: 2 (published 14 March 2024)	SHMI by provider (all non-specialist acute providers) for all admissions in Nov 2023 to Oct 2024 – 0.98/ 98.0 Band: 2 (published 13 March 2025)	Reported by NHS Digital			CUH considers that this data is as described for the following reasons: ○ The Trust has a robust process for clinical coding and review of mortality data so is confident that the data is accurate. See further notes below*
	*In 2023 CUH engaged in a pilot study to submit Same Day Emergency Care (SDEC) data to the Emergency Care Data Set (ECDS), rather than the Admitted Patient Care Dataset (APC). As SHMI is calculated using APC data, this had a potential impact on SHMI values. Trusts with SDEC activity removed from the SHMI have generally seen an increase in the SHMI value. This is due to the observed number of deaths remaining approximately the same, as the mortality rate for this cohort is very low, and secondly, the expected number of deaths decreased because a large number of spells are removed (all of which would have had a small risk of mortality contributing to the expected number of deaths). Work was ongoing to understand the recording of SDEC activity and the impact and this is described in the NHS digital data descriptor.							

	(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.	01 Dec 21-30 Nov 22 45%	01 Dec 22-30 Nov 23 55%	01 Dec 23-30 Nov 24 60%	Reported by NHS Digital			
18	During the reporting period, the Trust's patient reported outcome measures scores for:		For hip and knee replacement surgery the Trusts usually reports on the **Adjusted Average Health gain score**, which is in the CUH performance column, however this does not have details of the highest and lowest performers readily available, so has also included the **adjusted health gain** score to enable a comparison, although **these are not the figures normally published.** PROMs data was collected on varicose vein and groin hernia procedures in England, however following on from the NHS England Consultation on PROMs, collection of these procedures ceased on 1 October 2017. Historical data will be unaffected. **National Best and Worst performer data is not available for these PROMs.*					
	(i) groin hernia surgery	-	-		0.089 (to Sep.17)	*	*	Not measured - collection of data on this procedure ceased on 1 October 2017 (see comments above).
	(ii) varicose vein surgery				-8.45 (to Sep.17)			Not measured - collection of data on this procedure ceased on 1 October 2017 (see comments above).
	(iii) hip replacement surgery	No data available *Case mix-adjusted figures not calculated where there are fewer than 30 modelled records*	16 modelled records (insufficient data)	60 modelled records Oxford hip score Adjusted health gain: 22.506 (Not an outlier)	22.574	Not reported	Not reported	N/A Ref: NHS Digital
		No data available	9 modelled records					N/A

	(iv) knee replacement surgery	*Case mix-adjusted figures not calculated where there are fewer than 30 modelled records.*	(insufficient data)	68 modelled records Oxford knee score Adjusted health gain: 15.208 (Not an outlier)	16.887	Not reported	Not reported	
19	The percentage of patients aged:		Re-admitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.					NHS Digital has not published an update of this data since 2012; therefore, we have not included this data in our Quality Account. The data provided is local data reflecting 30-day readmissions (the national standard has not been 28 days for some time).
	(i) 0 to 15 and				Comparison not provided nationally			
	(ii) 16 or over							
20	The Trust's responsiveness to the personal needs of its patients during the reporting period.	No Data available	No Data available	No Data available	No Data available	No Data available	No Data available	*An NHS Trust's responsiveness to patient needs during a reporting period was measured by Indicator 4.2 within the NHS Outcomes Framework 2021 (NHS OF), as reflected in the National Inpatient Survey. The indicator value is derived from the average score of five specific questions from the survey that focus on responsiveness to personal needs. This is no longer reported.* ***Source: NHS Digital***
21	The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to	74.6%	Not published	77% of staff reported they would be satisfied with the standard of care at CUH if a friend or relative needed treatment – higher than the	Not published	Not published	Not published	Source: 2024 NHS Staff Survey, published March 2025. Maintaining the focus on quality and safety, and the implementation of the Trust PSIRF and Just culture, and leadership development programmes, which are intended to positively impact on staff engagement,

	their family or friends.			national average of 66%				inclusion, culture, leadership and staff wellbeing.
23	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	Q1: 95.1% Q2: 95.4% Q3: 95.5% Q4: 95.4% (Internal Data, >age 16)	Suspended 2022/2023 2023/2024	Latest 2024/5 Data: Q1: >94% Q2: >95% Q3: >96% Q4: Pending publication (>age 16)	2024/2025 Q1: 89.4% Q2: 89.9: % Q3: 90.6% Q4: Pending publication (>age 16)	Not published	Not published	CUH considers that this data is as described for the following reasons: ○ The Trust has a carried out a deep dive of the VTE risk assessment data reporting algorithms in 2022-2023. Source: NHS Digital
24	The rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	Available at gov.uk	Available at gov.uk	Available at gov.uk	Not available	Available at gov.uk	Available at gov.uk	Publication of data is expected in October 2025
25	The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	Number NRLS incidents reported: 19,430 Rate of reporting (per1000 bed days):45 Rate resulted in severe harm or death: 0.65 (126 incidents	*Not published	*Not published	*Not available	Available at NHS Digital	Available at NHS Digital	The Trust transitioned reporting systems in line with NHSE guidance to LFPSE. The Trust is monitoring internally if this has negatively impacted incident reporting culture *NHSE have currently paused the publishing of this data while future publications are reviewed in line with the introduction of LFPSE, (Learning from Patient Safety Events).

	NHS England » Monthly data on patient safety incident reports	based on NRLS data Apr 2022 to Mar 2023						

Appendix B: HQIP National Clinical Audits

Table 1: List of national clinical audit programmes where the Trust participated

Audit Title	What is the audit about?	Case Participation %
British Association of Urological Surgeons (BAUS): Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices (I-DUNC)	The purpose of this retrospective audit is to assess national practices for the diagnostic evaluation of patients with suspected Upper tract urothelial cancer (UTUC) and the impact of diagnostic ureteroscopy on the outcomes of Radical nephroureterectomy (RNU).	Participated
British Association of Urological Surgeons (BAUS): Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	This project ensures care delivered to patients on the bladder cancer pathway meets national standards.	Participated
British Association of Urological Surgeons (BAUS): Penile Fracture Audit (SNAP)	All patients undergoing a surgical repair for a suspected confirmed penile fracture between 1 April and 31 March 2024 (*data collection period may be extended to 2 years)*	Participated
Breast and Cosmetic Implant Registry (BCIR)	This registry captures all details of breast implant procedures completed in England, Scotland and Northern Ireland by both the NHS and private providers.	Participated
British Hernia Society Registry	The British Hernia Society provides leadership with regard to hernia surgery and collects routinely data on hernia surgery.	Participated
Case Mix Programme (CMP) – Intensive Care National Audit and Research Centre - (ICNARC)	The aim of this audit is to improve resuscitation care and patient outcomes for the UK and Ireland. This project runs in three parts focusing on the intensive care unit (ICU), critical care unit and rapid response unit.	Participated
Cleft Registry and Audit Network Database (CRANE)	A peer registry collecting data on all children born with a cleft lip or cleft pallet.	Participated
Elective surgery (National Patient Reported Outcomes Measures Programme (PROMS).	The audit looks at the change in patients' self-reported health status for hip and knee replacement surgery – continuous data collection. CUH reviews hips and knees only.	Participated
Epilepsy 12 - The national clinical audit of health care for children and young people with suspected epileptic seizures	Epilepsy 12 provides insight into the diagnosis and care of children and young people with epilepsy, and the organisation of paediatric epilepsy services in England and Wales.	Participated

Audit Title	What is the audit about?	Case Participation %
Falls and Fragility Fractures Audit Programme (FFFAP): Fracture Liaison Service Database	FFFAP is a national audit run by the Royal College of Physicians designed to audit the care that patients with fragility fractures and inpatients falls receive in hospital and to facilitate quality improvement initiatives – continuous data collection. It is the clinically led web-based national audit of secondary fracture prevention in England and Wales.	Participated
Falls and Fragility Fractures Audit Programme (FFFAP): National Audit of Inpatient Falls	FFFAP is a national audit run by the Royal College of Physicians designed to audit the care that patients with fragility fractures and inpatients falls receive in hospital and to facilitate quality improvement initiatives – continuous data collection focusing on patients over 60 who sustain an inpatient fall causing a fracture to the hip or thigh.	Participated
Falls and Fragility Fractures Audit Programme (FFFAP): Hip Fracture Database	FFFAP is a national audit run by the Royal College of Physicians designed to audit the care that patients with fragility fractures and inpatients falls receive in hospital and to facilitate quality improvement initiatives – continuous data collection focusing on hip fracture care and secondary prevention.	Participated
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE): Maternal morbidity confidential enquiry	Selected topic based serious maternal morbidity cases - as sample is identified each year.	Participated
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE): Maternal mortality confidential enquiries	All maternal deaths during pregnancy and up to one year after the end of pregnancy regardless of how the pregnancy ended.	Participated
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE): Maternal mortality surveillance	All maternal deaths during pregnancy and up to one year after the end of pregnancy regardless of how the pregnancy ended.	Participated
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE): Perinatal mortality and serious morbidity confidential enquiry	Selected topic based perinatal deaths and serious perinatal morbidity cases - a sample is identified each alternate year.	Participated
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE): Perinatal Mortality Surveillance	All perinatal deaths regardless of location of care and location of death.	Participated

Audit Title	What is the audit about?	Case Participation %
National Cancer Audit Collaborating Centre (NATCAN): National Audit of Metastatic Breast Cancer (NAoME)	This audit aims to report on all patients diagnosed with metastatic breast cancer (MBC; also known as secondary, advanced or stage 4 breast cancer) in NHS hospitals in England and Wales.	Participated
National Cancer Audit Collaborating Centre (NATCAN): National Audit of Primary Breast Cancer (NAoPri)	This audit provides insight on all patients newly diagnosed with primary breast cancer (stages 0 to 3) in NHS hospitals in England and Wales.	Participated
National Cancer Audit Collaborating Centre (NATCAN): National Bowel Cancer Audit (NBOCA)	This audit collects data on colorectal (large bowel) cancer which is the second most common cause of death from cancer in England and Wales.	Participated
National Cancer Audit Collaborating Centre (NATCAN): National Kidney Cancer Audit (NKCA)	This audit looks at diagnosis and treatment, and how patients are managed for kidney cancer in the cancer pathway.	Participated
National Cancer Audit Collaborating Centre (NATCAN): National Lung Cancer Audit (NLCA)	This audit reviews cancer services provided in both England and Wales to understand patterns in patient outcomes to improve the quality of care for those diagnosed with lung cancer.	Participated
National Cancer Audit Collaborating Centre (NATCAN): National Non-Hodgkin Lymphoma Audit (NNHLA)	This audit aims to provide continuous improvement in England and Wales for all patients diagnosed with Non-Hodgkin Lymphoma.	Participated
National Cancer Audit Collaborating Centre (NATCAN): National Oesophago-gastric Cancer Audit (NOGCA)	This audit provides the Trust with the most up-to-date information on the care and outcomes of patients diagnosed with Oesophago-Gastric (OG) cancer or oesophageal high-grade dysplasia in England and Wales.	Participated
National Cancer Audit Collaborating Centre (NATCAN): National ovarian cancer audit (NOCA)	This audit focuses on information obtained regarding diagnosis, treatment and surgery for this with ovarian cancer in England and Wales.	Participated
National Cancer Audit Collaborating Centre (NATCAN): National Pancreatic Cancer Audit (NPaCA)	This audit utilises information from databases across England and Wales, to compare patient outcomes and revealing where shortfalls need to be addressed.	Participated
National Cancer Audit Collaborating Centre (NATCAN): National Prostate Cancer Audit (NPCA)	The aim of the NPCA is to assess the process of care and its outcomes in men diagnosed with prostate cancer in England and Wales. The NPCA aims to contribute to changes in clinical practice in England and Wales that will save lives and improve quality of life.	Participated

Audit Title	What is the audit about?	Case Participation %
LeDeR learning from lives and deaths of people with a learning disability and autistic people *(previously known as Learning Disability Mortality Review Programme)*	The aim of this programme is to review deaths of people with learning disability and autism, to use lessons learnt to make improvements to service provision.	Participated
National Adult Diabetes Audit (NDA): National Diabetes Core Audit (NDCA)	The core NDA audit focuses on data recorded about all people of all ages with diagnosed diabetes in England and Wales.	Participated
National Adult Diabetes Audit (NDA): National Diabetes Foot Care Audit (NDFA)	The National Diabetes Foot Care Audit (NDFA) enables all diabetes foot care services to measure their performance against NICE clinical guidelines and peer units, and to monitor adverse outcomes for people with diabetes who develop diabetic foot disease – continuous data collection.	Participated
National Adult Diabetes Audit (NDA): National Diabetes Inpatient Safety Audit (NDISA)	This audit measures the frequency of avoidable diabetic harms.	Participated
National Adult Diabetes Audit (NDA): National Pregnancy in Diabetes Adult (NPID)	This audit supports clinical teams to deliver better care and outcomes for women with diabetes who become pregnant.	Participated
National Adult Diabetes Audit (NDA): Transition (Adolescents and Young Adults) and Young Type 2 Audit	The NDA and NPDA datasets are being linked to identify key findings and recommendations the support the care of young people with diabetes. This will support them to be tracked during the transition from paediatric diabetes services to adult diabetes services. The audit measures against the National Service Framework and NICE Clinical Guidelines and Quality Standards.	Participated
National Adult Diabetes Audit (NDA): National Gestational Diabetes Audit	This audit supports women with a diagnosis of GDM during pregnancy; this parameter does not include pre-existing diabetes.	Participated
National Respiratory Audit Programme (NRAP): Children and Young People's Asthma Secondary Care	This audit aims to collect information on all people admitted to hospital paediatric services with asthma attacks – continuous data collection.	Participated
National Respiratory Audit Programme (NRAP): Adult Asthma Secondary Care	This audit aims to collect information on all people admitted to hospital adult services with asthma attacks – continuous data collection.	Participated
National Respiratory Audit Programme (NRAP): COPD Secondary Care	This audit aims to collect information on all people admitted to hospital with COPD exacerbations – continuous data collection.	Participated
National Audit of Cardiac Rehabilitation (NACR)	NACR combines data from cardiac rehabilitation programmes across the UK to improve patient outcomes.	Participated

Audit Title	What is the audit about?	Case Participation %
National Audit of Care at the End of Life (NACEL)	The National Audit of Care at the End of Life (NACEL) focuses on the quality and outcomes of care experienced by those in their last admission in acute, community and mental health hospitals throughout England and Wales.	Participated
National Audit of Dementia (NAD)	The audit examines assessments, discharge planning and aspects of care received by people with dementia.	Participated
National Cardiac Arrest Audit (NCAA)	The purpose of this audit is to monitor the incidence of, and outcome from, in-hospital cardiac arrest in the UK.	Participated
National Cardiac Audit Programme (NCAP): National Heart Failure Audit (NHFA)	This audit collects data on the characteristics of patients admitted to hospital with acute or sub-acute heart failure and describes their in-hospital investigation and care, the treatment given, the discharge planning and follow up which is offered.	Participated
National Cardiac Audit Programme (NCAP): National Audit of Cardiac Rhythm Management (NACRM)	This audit collects information about all implanted cardiac devices and all patients receiving interventional procedures for management of cardiac rhythm disorders in the UK.	Participated
National Cardiac Audit Programme (NCAP): Myocardial Ischaemia National Audit Project (MINAP)	This audit examines the quality of management of heart attacks (myocardial infarction) in hospitals in England and Wales.	Participated
National Cardiac Audit Programme (NCAP): National audit of Mitral Valve Leaflet Repairs (MVLR)	NHS England have commissioned Percutaneous mitral valve leaflet repair for primary degenerative mitral regurgitation in adults.	Participated
National Cardiac Audit Programme (NCAP): UK Transcatheter Aortic Valve Implantation (TAVI) registry	TAVI (transcatheter aortic valve implantation) provides a less invasive alternative to cardiac surgery and avoids the requirement for cardiopulmonary bypass. The project aims to capture detailed information on how TAVI is used to treat patients with severe aortic stenosis and significant comorbidities; improving the care of patients and benchmarking TAVI units to learn best practice.	Participated
National Cardiac Audit Programme (NCAP): Left Atrial Appendage Occlusion (LAOO) registry	The aim of the audit is to collect clinical and outcome data on structural heart intervention services carried out in the UK.	Participated
National Cardiac Audit Programme (NCAP): Patient Foramen Ovale Closure (PFOC) registry	Percutaneous patent foramen closure (PFOC) is performed in hospitals under anaesthetic using x-ray guidance and usually takes less than one hour. The aim of the audit is to collect clinical and outcome data on structural heart intervention services carried out in the UK.	Participated

Audit Title	What is the audit about?	Case Participation %
National Cardiac Audit Programme (NCAP): Transcatheter Mitral and Tricuspid Valve TMTV Registry	This registry collects data on all transcatheter interventions on the mitral and tricuspid valve carried out in NHS hospitals and some private sector hospitals in England.	Participated
National Child Mortality Database (NCMD)	This audit gathers information on all children who die in England to improve and save children's lives.	Participated
National Comparative Audit of Blood Transfusion: 2024 Audit of Blood Transfusion against NICE Quality Standard 138	To assess Trust compliance with national standards for NICE quality standards for blood Transfusion and benchmark against other participating Trusts.	Participated
National Comparative Audit of Blood Transfusion: National Comparative Audit of Bedside Transfusion Practice	The objective of the programme is to provide evidence blood is being ordered and used appropriately, administered safely, to highlight where practice is deviating from guidelines to the possible detriment of patient care.	Participated
National Early Inflammatory Arthritis Audit (NEIAA)	The overall aim of the audit is to improve the quality of care provided by specialist rheumatology services in the management of early inflammatory arthritis - continuous data collection.	Participated
National Emergency Laparotomy Audit (NELA)	NELA aims to look at structure process and outcomes measures for the quality of care received by patients undergoing emergency laparotomy – continuous data collection.	Participated
National Joint Registry (NJR)	The clinical audit covers joint replacements during the previous calendar year and outcomes including survivorship, mortality and length of stay – continuous data collection.	Participated
National Maternity and Perinatal Audit (NMPA)	The National Maternity and Perinatal Audit (NMPA) is a large-scale audit of the NHS maternity services across England, Scotland and Wales. The audit aims to evaluate a range of care processes and outcomes in order to identify good practice and areas for improvement in the care of women and babies looked after by NHS maternity services.	Participated
National Neonatal Audit Programme (NNAP)	This audit assesses whether babies admitted to neonatal units receive consistent, high-quality care and identifies areas for quality improvement.	Participated
National Ophthalmology Database (NOD) Audit: Age-related Macular Degeneration Audit	Age-related Macular Degeneration (AMD) is a common condition that is caused by damage to the macular region of the eye. The AMD audit aims to provide benchmarks that can enable patients, providers, and commissioners to compare clinical outcomes and key process at different sites to improve the quality of care.	Participated

Audit Title	What is the audit about?	Case Participation %
National Ophthalmology Database (NOD) Audit: Cataract Audit	The National Ophthalmology Database (NOD) was established under the auspices of the Royal College of Ophthalmologists (RCOphth) in 2010 to collate pseudonymised data collected as a by-product of routine clinical care using electronic medical record (EMR) systems for the purposes of national audit, research and establishing meaningful measures for revalidation.	Participated
National Paediatric Diabetes Audit (NPDA)	This audit measures health outcomes and experiences of children with diabetes in England and Wales.	Participated
National Perinatal Mortality Review Tool (PMRT)	This tool has been developed and established to provide a national standardised Perinatal Mortality Review Tool (PMRT).	Participated
National Vascular Registry (NVR)	The audit addresses the outcome of surgery for patients who underwent two types of vascular procedures. The first is an elective repair of abdominal aortic aneurysms (AAA). The second is a carotid endarterectomy (CEA) – continuous data collection.	Participated
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry	Integrated data reporting for patients who attend hospital with return of spontaneous circulation (ROSC) and are brought to hospital by the EEAST ambulance service.	Participated
Paediatric Intensive Care (PICANet)	PICANet aims to support the improvement of paediatric intensive care provision throughout the UK by providing detailed information on paediatric intensive care activity and outcomes.	Participated
Perioperative Quality Improvement Programme (PQIP)	This Quality Improvement Programme (QIP) measures complications, mortality and patient reported outcome from major non-cardiac surgery.	Participated
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Non-melanoma skin cancers	The QOMS Non-Melanoma Skin Cancer (NMSC) registry focuses on squamous cell and basal cell carcinomas (SCC and BCC).	Participated
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oncology & Reconstruction	This project aims ensure effectiveness of care provided based upon appropriate metrics were key to the continued successful development of surgical care in the NHS.	Participated
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oral and Dentoalveolar Surgery	Dento-alveolar surgery is the surgical treatment of disorders of the teeth and their supporting hard and soft tissues. It covers a range of procedures, such as removing complicated impacted wisdom teeth or surgery after mouth trauma.	Participated
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Orthognathic Surgery	This project aims to review the outcomes of Orthognathic Surgery which is a branch of surgery to correct misaligned jaws.	Participated

Audit Title	What is the audit about?	Case Participation %
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Trauma	This project aims to review the outcomes of Orthognathic Surgery which is a branch of surgery to correct trauma in the mouth, jaw, face and neck.	Participated
UK Renal Registry: National Acute Kidney Injury Audit	The aim of this audit is to reduce the risk and burden of acute kidney injury.	Participated
UK Renal Registry: Chronic Kidney Disease Audit	The Registry contains analyses of data submitted relating to direct clinical care and laboratory permit analysis with the purpose to improve the quality of care for renal patients.	Participated
Royal College of Emergency Medicine (RCEM) Emergency Medicine QIPs: Adolescent Mental Health	This QIP aims to support Adolescents/Young adult patients are defined as being between the ages of 12 and 25 years attending the emergency department for urgent mental health support.	Participated
Royal College of Emergency Medicine (RCEM) Emergency Medicine QIPs: Care of Older People	To assess and improve the quality of care given to older and frail patients on key conditions which affect outcomes primarily in older people, and define a broad range of standards with the aim of improving holistic medical and nursing care in ED.	Participated
Royal College of Emergency Medicine (RCEM) Emergency Medicine QIPs: Time critical medications	Time Critical scheduled medications are those where early or delayed administration of maintenance doses of greater than 30 minutes before or after the scheduled dose may cause harm or result in substantial sub-optimal therapy or pharmacological effect.	Participated
Sentinel Stroke National Audit Programme (SSNAP)	The audit collects information about care provided to stroke patients in the first three days of hospital - continuous data collection.	Participated
Serious Hazards of Transfusion UK National Haemovigilance Scheme (SHOT)	SHOT is the UK's independent, professionally led haemovigilance scheme. Since 1996 SHOT has been collecting and analysing anonymised information on adverse events and reactions in blood transfusion from all healthcare organisations that are involved in the transfusion of blood and blood components in the United Kingdom. Where risks and problems are identified, SHOT produces recommendations to improve patient safety.	Participated
Society for Acute Medicine Benchmarking Audit (SAMBA)	The Society for Acute Medicine (SAM) Benchmarking Audit (SAMBA) is a national benchmark audit of acute medical care. The aim of SAMBA is to describe the severity of illness of acute medical patients presenting to Acute Medicine, the speed of their assessment, their pathway and progress at seven days after admission and to provide a comparison for each participating unit with the national average (or 'benchmark').	Participated
National Major Trauma Registry (previously known as TARN)	National Major Trauma Registry is working towards improving emergency health care systems by collating and analysing trauma care.	Participated

Audit Title	What is the audit about?	Case Participation %
UK Cystic Fibrosis Registry	The audit aims to examine both life expectancy and quality of life for children and adults with Cystic Fibrosis.	Participated

For registries that had a case ascertainment threshold in 2024/25, CUH participated and met the threshold for all national audits as required.

Table 2: National clinical audit results summary & actions

Title	Outcome
National Ophthalmology Database (NOD) Audit Programme: 2024 Cataract Surgery report PRN11148	The NOD audit programme has two audit it reports upon: Cataract Surgery and Age-related Macular Degeneration (AMD) services for the UK. Key Audit Standards Std 1: Case ascertainment - Compliance achieved: 94.3% (No national standard). Std 2: Risk-adjusted posterior capsule rupture rate - Compliance achieved: 0.5% (No national standard – national peers achieved 1.1%). CUH has been identified as a positive outlier regarding this standard. Std 3: Risk-adjusted Visual Acuity Loss - Compliance achieved: N/A – no operations (No national standard – national peers achieved 0.9%). **Key learning from this audit showed:** Std 2 showed that we are a positive national outlier amongst our peers. Std 1 & 2 showed minimal changes to the previous report with std 1 reducing from 98.2% to 94.3% and std 2 increased by 0.1%. **Actions:** Achieving better than national average. No current concerns requiring action plan. Continue to monitor to ensure no decreasing trend; within normal parameters.
National Vascular Registry (NVR): 2023 Report PRN11147	The NVR audit measures the quality of care for patients who undergo vascular surgery in NHS hospitals. Key Audit Standards Std 1: Case Ascertainment [Abdominal Aortic Aneurysm] - Compliance achieved: >85% (National standard >85% – national peers achieved 90%). Std 2: Risk-adjusted post-operative in-hospital mortality rate [Abdominal Aortic Aneurysm] - Compliance achieved: 0.5% (No national standard – national peers achieved 1.4%). Std 3: Case ascertainment all eligible patients [Carotid Endarterectomy] - Compliance achieved: >85% – (National standard >85% – national peers achieved 92%). Std 4: Risk-adjusted 30-day mortality and stroke rate [Carotid Endarterectomy] - Compliance achieved: 0.9% (No national standard – national peers achieved 2.2%). Std 5: Crude median time from symptom to surgery [Carotid Endarterectomy] - Compliance achieved: 2.3% (national peers achieved 2.2%). Std 6: Lower limb angioplasty case ascertainment - Compliance achieved: >70% (National standard >85% – national peers achieved 54%).

Title	Outcome
	Std 7: Lower limb angioplasty Risk-adjusted post-operative in-hospital mortality rate - Compliance achieved: 1.2% (National peers achieved 1.9%). Std 8: Lower Limb Bypass Case Ascertainment - Compliance achieved: >85% (National standard >85% – national peers achieved 89%). Std 9: Lower limb bypass Risk-adjusted post-operative in-hospital mortality rate - Compliance achieved: 1.2% (National peers achieved 3%). Std 10: Major Lower Limb Amputation Case Ascertainment - Compliance achieved: >85% (National standard >85% – national peers achieved 88%). Std 11: Major Amputation Risk-adjusted in-hospital mortality rate within 30 days - Compliance achieved: 7.7% (National peers achieved 6.5%). **Key learning from this audit showed:** All standards are within expected range showing no concerns in current data. Several standard shows cased where CUH achieves better against its peers such as Stds 2, 4, 7 and 9. All case ascertainment (submissions of required data) where achieved and met the appropriate threshold. **Actions:** Meeting national standards or achieving better than national average.
Maternal, Newborn and Infant Clinical Outcome Review Programme: 2023 report PRN12144	This programme investigates women, and their babies deceased during or after childbirth, and investigates women and their babies survive serious illness during pregnancy or after childbirth. Key Audit Standards Std 1: Stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) - Compliance achieved: 6.49 (National peers achieved 5.19). Std 2: Stabilised and risk-adjusted extended perinatal mortality rate, excluding congenital anomalies (per 1,000 births) – Compliance achieved: 4.81 (No national standard or national aggregate). **Key learning from this audit showed:** The current standards do not discuss in the report if any data differences are caused by the Rosie hospital being a tertiary centre which also accepts cases throughout the region.
National Cancer Audit Collaborating Centre (NATCAN): National Oesophago-Gastric Cancer Audit (NOGCA): 2024 report PRN11112	The NOGCA audit reviews all adult patients diagnosed with either invasive epithelial cancer of the oesophagus, gastro-oesophageal junction (GOJ) or stomach cancers. Key Audit Standards Std 1: Case Ascertainment (%). All eligible patients - Compliance achieved: >85-100% (No national standard – national peers achieved 86.7%). Std 2: Adjusted proportion of patients diagnosed after an emergency admission adjusted for age, sex, deprivation, site of cancer and presence of comorbidities - Compliance achieved: 17.2% (National peers achieved 13.1%). Std 3: Risk-adjusted 90-day post-operative mortality rate - Compliance achieved: 1.2% (No national standard – national peers achieved 2.9%). Std 4: Crude proportion of patients with stage 0-3 cancer with curative treatment plan - Compliance achieved: 61.2% (No national standard – national peers achieved 58.4%). **Key learning from this audit showed:** CUH continues to meet the case ascertainment requirements. Std 3 has continued to improve by 0.5% and still in advance of our peers. **Actions:**

Title	Outcome
	Std 4 has shown both a local and national drop in compliance but is still within the expected range; this will be monitored to ensure there are no negative concerns regarding this trend.
National Audit of Care at the End of Life (NACEL): 2022 report PRN8831	NACEL reports on the care of those dying in hospital. Key Audit Standards Std 1: The proportion of deaths where it was recognised that the patient may die imminently – Compliance achieved: 88% (No national standard – national peers achieved 87.1%). Std 2: The proportion of patients with documented evidence of individualised care plan addressing their end-of-life care needs – Compliance achieved: 77% (No national standard – national peers achieved 73.4%). Std 3: Is the face-to-face specialist palliative care service (doctor and/or nurse) available 8 hours a day, 7 days a week) Compliance achieved: Yes - 8 hours a day, 7 days a week (No national standard – national peers achieved 59.7%). **Key learning from this audit showed:** This report showed that CUH remains above national peers in lieu of a national standard. No concerns identified. **Actions:** To continue to monitor results to ensure no deviation or decline in care provided.

Appendix C: Local audits

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

Title	Outcome
Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) PRN12054	**Audit Standards** Standard 1: 100% of patients have been considered for a ReSPECT conversation within 72 hours of admission (excluding day case, obstetric and patients less than 18 years old). Standard 2: Section 2a: 100% of ReSPECT forms have relevant information including diagnosis completed. Standard 3: Section 4: 100% of ReSPECT forms have either; CPR attempts recommended, or CPR attempts NOT recommended recorded. Standard 4: Section 5: 100% of ReSPECT forms state whether the patient has capacity to participate in making the decisions or not. Standard 5: Section 5: 100% of ReSPECT forms that state the patient does NOT have mental capacity to make a decision, have an appropriate explanation of why they lack capacity. Standard 6: Section 6a: 100% of ReSPECT forms in those 18 years old or above have option A, B or D selected. Standard 7 Section 6b: If option D has been selected, 100% of ReSPECT forms state there was a concern that a discussion would cause the patient physical or psychological harm, or the patient lacked capacity, and it was impractical or inappropriate to contact those relevant family members/friends. Standard 8: Section 6c: 100% of ReSPECT forms have names and roles of those who participated in the section 6b discussion recorded. Standard 9: Section 7: 100% of ReSPECT forms state the designation, name and date of the clinician completing the form. Standard 10: Section 7: 100% of ReSPECT forms completed by a doctor who is not a consultant or less than an ST3 has the senior responsible clinician documented. Standard 11: Section 9: 100% of ReSPECT forms where section 9 has been completed includes a review date, designation of the clinician, their name and senior clinician if appropriate. Standard 12: 100% of Nursing Staff should be familiar with ReSPECT recommendations within their clinical area. **Key learning from this audit showed:** This report looks at the ReSPECT documentation of each patient from approximately 11 ward areas per audit cycle. The results are measured against the ReSPECT audit standards and are presented for each patient specialty in a table format. If necessary, specific feedback is given. Specialties not achieving 100% for

Title	Outcome
	any of the 11 standards are asked to refer to the audit standards for guidance or to please contact Resuscitation Services. Some of the larger specialities audited have overall compliancy of >90%, but overall compliancy has dropped and should be improved to >90%. **Actions:** • Resuscitation services to continue to educate and reiterate on ReSPECT conversations in Basic Life Support teaching for both Medics and Nurses. • Continue to develop programme involving specialist nurses to complete ReSPECT form where appropriate. • Resuscitation services to assist Ward Accreditation process by providing Standard 1 compliancy for each ward area when required, therefore encouraging ward areas to strive to improve. • Further education for areas with low compliancy. • Contacting medical staff when notes reviewing a 2222 call where a ReSPECT documentation has not been completed within the 72hrs. **Implementation of actions** ReSPECT conversations within 72 hours of admission has been implemented and also added to local e-learning. Other actions are currently in progress.
Routine Checking of resuscitation equipment Cycle Four of Four 2023/2024 PRN12177	**Audit Standards** Standard 1: Items on the equipment MyKitCheck template were present on the trolley/box/PaNDR every day of the month audited, and where documented missing, were replaced before next check. Standard 2: Items on the trolley/box/ PaNDR were within their use by date every day of the month audited, and where documented expired were replaced before next check. Standard 3: All areas performed daily checks and completed on MyKitCheck for the month audited. Standard 4: All areas performed weekly checks of the resuscitation trolley/box/ PaNDR contents and completed on MyKitCheck for the month audited. **Key learning from this audit showed:** Standard 1 and 2 for cycle 4 23/24 is >82%. Overall, the Trust achieves 95% and 96% on Standard 1 and 2, respectively. MyKitCheck has been a valuable tool in alerting for missing/ expired items. Standard 3 and 4 have remained very low in compliance in comparison to two previous audit years. Overall, equipment audit compliance in the Trust for 2023/2024 is 46% which is below the recommended 83%. **Actions:** • Resuscitation officers allocated to each clinical area to continue to support. with equipment audits and spot checks to monitor matching compliance on MyKitCheck and actual equipment in-situ. • Resuscitation Services to ensure contact person/ manager on MyKitCheck system is registered to action/ chase alerts on expired/ missing items and authorise missed checks on resuscitation carriers. • Resuscitation services to review implications of looking at missed daily checks and missed weekly checks separately, as opposed to MyKitCheck generated

Title	Outcome
	data which merged them into “overdue check missed” category. Aligning with MyKitCheck will speed up generating report and produce data timely. • Resuscitation services to recommend and encourage daily huddles to include checking of resuscitation equipment. • Resuscitation services to update standard operating procedure around enabling/disabling equipment and update end users (e.g. community midwives). **Implementation of actions** 1. Audit standards were proposed at the resuscitation group meeting and changes agreed. 2. Community midwives were informed of updates required to community resuscitation boxes. 3. Random spot checks continue in clinical areas not achieving >82% compliance (on-going action). • Daily huddles continue to include resuscitation equipment checks via Mykitcheck.
Documentation of – ‘Prep, stop, block’ for peripheral nerve blocks. **PRN12191**	**Audit Standard** 100% of patients receiving peripheral nerve block should have ‘Prep, stop and block’ performed. **Key learning from this audit showed:** Results show that we perform the safety checks prior to performing nerve block 96% of the times. **Actions:** Improve on documentation of these safety checks and aim for 100% performance of the Prep stop block prior to performing block. **Implementation of actions** 1. In theatre sessions and presentation of the audit and delivered a session of importance of, how to perform and document Prep Stop Block, at the audit meeting for anaesthetists and ODPs. Re-audit cycle planned.
VTE prophylaxis in UGI patients **PRN12207**	**Audit Standards** 1. The Trust’s VTE risk assessments on EPIC must be used. 2. The VTE risk assessment must be undertaken, on admission or by the first consultant review, by a doctor (with the exception of designated areas that have an agreed local policy for nurse-led assessment). 3. The admitting clinician is responsible for ensuring that the relevant VTE risk assessment has been completed at initial patient clerking and that thromboembolism prophylaxis has been considered. 4. The medical team is responsible for ensuring that: • VTE risk assessments are reviewed at admission or by the point of consultant review and if the clinical condition changes. • Appropriate thromboembolism prophylaxis has been prescribed. • Consideration is given to whether it is clinically indicated that the patient needs to continue thromboembolism prophylaxis on discharge. • Patients identified as having a risk of developing venous thromboembolism should be commenced on prophylaxis at 18:00 each day. • Patients identified as having thrombosis risk present and no bleeding risk should be prescribed prophylactic dose dalteparin to be given subcutaneously once a day (at 1800).

Title	Outcome
	Key learning from this audit showed: • Comprehensive audit/ review of UGI Team of current practice. Education of new juniors regarding importance of VTE assessment/ prescribing and pitfalls that may occur in this process in day-to-day clinical practice. •Smartphrases being 'automatically' selected without checking the drug chart orders each time (to ensure prescribed/ not withheld). •Two of three new PE/ DVT diagnosis may have been preventable if VTE prescribing/administration as per Trust Guidelines, had been adhered to MAR automatic 'hold' when patients transferred between ward areas (even though drug has already been prescribed), requiring 'manual' unholding of medication. **Actions:** • Complete VTE assessments on initial review. • Check orders before selecting VTE smart phrase on ward rounds. • Check if pLMWH is prescribed appropriately daily (check not been held, check appropriate for weight and renal function). **Implementation of actions** 1. Results presented to new junior doctors and added to induction email. • Re-audit cycle planned.
An audit of CT head imaging requests for suspected physical abuse in children under the age of one year (CT-805) PRN11599	**Audit Standards** 1. Imaging should always include skeletal survey and CT head scan in children under the age of one year old (target 100%). 2. Where CT head was not undertaken, we will review the notes for documentation from a senior clinician, explaining why this was not performed. **Key learning from this audit showed:** 93% of infants undergoing skeletal survey for suspected physical abuse are undergoing CT head (or MRI) – this represents 5 patients in 6 years not undergoing appropriate neuroimaging. 87% of those undergoing CT head locally, do so within one day of admission. 62% of those infants not undergoing CT head have appropriate documentation from a senior decision maker. **Actions:** 1. Continue to ensure high compliance with RCR/RCPCH guidance. 2. Continue to perform expedient CT head image acquisition. 3. Ensure appropriate documentation where CT head not performed against guidelines. **Implementation of actions** 1. High compliance report communicated to paediatric safeguarding lead in September 2024. 2. CT head imaging reminders provided in May 2024 audit meeting. 3. Documentation discussion undertaken with paediatric safeguarding in September 2024.
Multi-centre Audit of Contrast Dose and Renal Injury After Interventional radiology procedures	**Audit Standards** The Royal College of Radiology (RCR) guideline does not give recommendations on the amount of contrast that should be used per procedure or patient but rather acknowledges that the aforementioned risk factors should be accounted for by measuring an eGFR value for each non-emergency patient within 3 months.

Title	Outcome
(ACORN) Study (IR-806) PRN11636	Patients with a concurrent illness or with known chronic kidney disease (CKD) will need a measurement within the previous 7 days to be compared against their baseline. By considering these eGFR values the RCR recommends weighing out the potential risk of acute kidney injury (AKI) against the potential benefits of performing the procedure. They do also list strategies to prevent AKI such as expanding ECF volume with IV fluids, temporarily stopping ACE inhibitors and Angiotensin receptor blockers in patients with CKD and involving the nephrology team from early on. Specific to this study the RCR also advises that the dose of contrast medium should be minimised and should consider patients' weight. The aim of this audit is to assess the incidence of post-procedure AKI in patients who underwent specific IR procedures (using KDIGO criteria). All patients undergoing non-emergency angiographic procedures have had baseline creatinine blood tests within the recommended timeframe set by the Royal College of Radiology. **Key learning from this audit showed:** 100% of elective patients had baseline creatine blood tests within 3 months (or within 7 days for patients with CKD). 95% of patients undergoing angiographic procedures did not develop AKI post-procedure. This data will be analysed by the national ACORN audit to determine if there is a link between contrast and CI-AKI in interventional radiological procedures. **Actions:** Review ACORN audit results and take action accordingly**.** **Implementation of actions** • Audit shows full compliance with RCR recommendation of baseline creatinine. • Within 3 months for non-emergency procedures using intravenous contrast for patients without CKD Within 7 days for non-emergency procedures using intravenous contrast for patients without CKD
Use of local Safety Standards in Invasive Procedures (LOCSSIP) in Neuro Interventional Radiology (IR-801) PRN11753	**LOCSSIP Standards for Neuro Interventional Radiology** 1. 100% of lists with invasive procedures have a team brief completed. 2. 100% WHO Sign in compliance. 3. 100% Surgical pause compliance. 4. 100% Sign out compliance. 5. 100% of lists have a debrief completed. 6. Augmented debrief completed (where required) and shared with team. **Key learning from this audit showed:** Standard 5: 100% compliant with the debrief comments being shared with the team. Standard 3: 89% compliance for surgical pause. All other standards were above 96%. **Actions:** Shared learning to improve the areas of non-compliance. Re-audit in 1 year.
Compliance with the Trust Potassium Policy 2023 -24	**Audit standards**

Title	Outcome
PRN11822	1. 100% of concentrated potassium ampoules supplied from Central Pharmacy (CP) are to critical care areas, defined by the Trust Potassium Policy as being allowed to keep as stock. 2. 100% of concentrated potassium ampoules supplied from CP follow an appropriately completed and signed CD order. 3. 100% of concentrated potassium ampoules supplied from CP are accurately recorded in the CP CD register. 4. 100% of concentrated potassium ampoules received by critical care areas, defined by the Trust Potassium Policy as being allowed to keep as stock, from CP are recorded appropriately in the CD register of the critical care area. 5. 100% of order forms for issues of concentrated potassium from Central Pharmacy have 'Accepted for delivery'* signature details completed as per CD policy. 6. 100% of concentrated potassium issued from IPP is supplied following CD requirements. **Key learning from this audit showed:** There were administration issues around filing of the order slips rather than compliance with the potassium policy. This is being addressed. 100% compliance was found for all applicable standards. **Actions:** It was recommended and agreed that is more practical not to remove the order slips from the books; to keep them in the order book, rather than file them since the order books are kept only in CP. Update departmental SOPs DIS004 and DIS032, to detail new agreed process. Also include detail that completed potassium order books will be retained in Central Pharmacy for two years from the date of their last entry. Re audit as per 3-year schedule. **Implementation of actions** As per recommendation update SOPs: DIS004 and DIS032. Include detail that completed Potassium order books will be retained in Central Pharmacy for two years from the date of their last entry.
Re-audit of inclusion of relevant data items for loop excision and cervical biopsy reports PRN12058	**Audit Standards** • All reports must include the relevant data set items for loop excisions and cervical biopsies as below: • Specimen type [Loop excision reports: Yes; Cervical biopsy reports: Yes] • Number of pieces [Loop excision reports: Yes; Cervical biopsy reports: Yes] • Dimensions of pieces in 3 planes [Loop excision reports: Yes; Cervical biopsy reports: Yes (1 dimension only)] • Presence and completeness of cervical os [Loop excision reports: Yes; Cervical biopsy reports: No] • Description of any lesion seen naked eye [Loop excision reports: Yes; Cervical biopsy reports: No] • Method of trimming/inking, for example serially sliced in blocks [Loop excision reports: Yes; Cervical biopsy reports: No] • Other histological features if present, for example tuboendometrioid metaplasia, endometriosis, microglandular hyperplasia [Loop excision reports: Yes; Cervical biopsy reports: Yes]

Title	Outcome
	• Correlation with cytology (less than 1 grade difference) [Loop excision reports: Yes; Cervical biopsy reports: Yes] • Comment if case should be discussed at MDT [Loop excision reports: Yes; Cervical biopsy reports: Yes] • Diagnosis [Loop excision reports: Yes; Cervical biopsy reports: Yes] • SNOMED CT/SNOMED code [Loop excision reports: Yes; Cervical biopsy reports: Yes] • Number of slices examined [Loop excision reports: Yes; Cervical biopsy reports: Number of additional levels examined] • Presence or absence of TZ [Loop excision reports: Yes; Cervical biopsy reports: Yes] • Presence or absence of HPV-related changes [Loop excision reports: Yes; Cervical biopsy reports: Yes] • Presence or absence of CIN [Loop excision reports: Yes; Cervical biopsy reports: Yes] • Grades of CIN when present [Loop excision reports: Yes; Cervical biopsy reports: Yes] • Presence or absence of crypt involvement by CIN [Loop excision reports: Yes; Cervical biopsy reports: Yes] • Presence or absence of CGIN [Loop excision reports: Yes; Cervical biopsy reports: Yes] • Presence or absence of SMILE [Loop excision reports: Yes; Cervical biopsy reports: Yes] • Completeness of excision at ectocervical margin [Loop excision reports: Yes; Cervical biopsy reports: No] • Completeness of excision at endocervical margin [Loop excision reports: Yes; Cervical biopsy reports: No] • Completeness of excision at deep lateral margin [Loop excision reports: Yes; Cervical biopsy reports: No] • Presence or absence of invasion [Loop excision reports: Yes. If invasion present, then use RCPath data set for cervical neoplasia in loop excisions; Cervical biopsy reports: Yes] • Results of p16 or other immuno performed [Loop excision reports: Yes; Cervical biopsy reports: Yes] **Key learning from this audit showed:** Results showed that uptake of the use of the malignant reporting proformas has been limited (used in one out of four malignant specimens in this audit). **Actions:** • Remind Consultants and registrars reporting cervical pathology of the existence of the proformas (for biopsies and LLETZ specimens) for reporting malignant cervical specimens and encourage their use. • Malignant proformas will be renamed to ensure consistency with benign counterparts (‘CERVICALBIOPSYMALIGNANT’ and CERVICALLETZMALIGNANT’) Remind Consultants and registrars reporting cervical pathology specimens of the need to state “not applicable” in the reporting proforma when necessary, rather than delete sections of the proforma which are not necessarily applicable to the specific specimen). • Introduction of electronic macroscopic description proforma for processing LLETZ specimens.

Title	Outcome
	Implementation of actions 1. Pathologists reminded at weekly team meeting and via email regarding malignant cervical specimens. 2. Appropriate staff reminded via email and also verbally at the weekly gynaecology pathology meeting attended by all Consultants to ensure 'not applicable' is added to the reporting proforma. 3. Macroscopic description proforma has been written. Currently awaiting relevant individuals to be given access on EPIC. • Renaming of proformas completed.
Auditing the Use of Local Safety Standards in Invasive Procedures in the Cambridge Breast Unit **PRN12304**	**Audit standards:** • 100% of cases with image guided invasive procedures have a team brief completed. • 100% of cases with image guided invasive procedures have a Who Sign In completed. • 100% of cases with image guided invasive procedures have a 'WHO Sign-Out' completed. • Augmented debrief is completed when needed and shared within the team. **Key learning from this audit showed:** The Trust has developed Local Safety Standard in Invasive Procedures (LocSSIP). To ensure accurate documentation and optimise patient safety for patients undergoing image-guided interventional procedures all safety checks and procedures should be followed and recorded. The main objective of this project is to analyse the compliance within the Breast Imaging Department of completing the pre-procedure checks and adhering to the LocSSIP policy. This will improve patient care and clinical practice. It will also identify areas for improvement within the team. Std 4: - Augmented debrief completed (when needed) and shared with the team - met 100% compliance. The department is not reaching 100% compliance for any other aspect of the LocSSIP policy. In Ultrasound procedures there is 0% compliance. Team feedback has suggested it was not clear as to which checks needed to be completed and what procedures this applied to. **Actions:** Reminders to all staff to ensure that all members of the team in both X-ray and Ultrasound are aware they need to complete the checklist to improve our practice and compliance to 100% and meet the expected target. This reminder will be included in the next department staff meeting as well as a reminder email being sent out with guidance on how to complete these checks and which procedures this applies to. This will be re-audited in three months' time after the team are more aware of the policy to confirm improvement, after this the audit will be repeated annually to ensure improvement and compliance. The findings of this audit will be discussed with the Imaging Clinical Lead regarding the low compliance rates and how to improve this. **Implementation of actions** Overall compliance has increased from 35.1% to 85.4%. Compliance for X-ray guided procedures is now 100% which meets the expected standard. Ultrasound

Title	Outcome
	compliance has improved from 0% to 60% compliance which is an improvement. Further reminders have been sent to colleagues to remind them when these checks need to be performed.
Ward Storage and Security of Medicines Q1 (May 2024) 2024/2025 PRN12323	**Audit Standards** **Standard 1:** Is every drug cupboard, fridge and trolley lockable? **Standard 2:** Is every drug cupboard, fridge and trolley locked? **Standard 3:** If the main medicines storage is in a locked room, is it locked? **Standard 4:** Are the drug trolley(s) or white metal boxes secured to the wall? **Standard 5:** Are all medicines securely stored within drug cupboards, fridges and trolleys? **Standard 6:** Are all boxes of IV fluids stored off the floor and within secure rooms or cupboard(s). **Standard 7:** Are the keys held by an authorised member of staff? **Standard 8:** If the unit is not open 24 hours a day - are there appropriate arrangements for storage of keys? **Standard 9:** Does the clinical area have a current max/min thermometer in use within ALL medicine fridges? **Standard 10:** Is there an up-to-date written record of daily fridge temperature monitoring for ALL fridges? (**Standard 11:** Has the fridge temperature remained within range? 2-8 degrees (last 28 days) **Standard 12:** If the fridge has gone out of the range above - has any action taken been recorded on the record sheet? **Standard 13**: Does the clinical area have a current room temperature thermometer in use within ALL drug storage rooms and the IV fluid storage area (if separate storage)? **Standard 14**: Is there an up to date written record of drug storage room and IV fluid storage area temperature monitoring? (last 28 days) **Standard 15:** Has the maximum room temperature remained within range? **Key learning from this audit showed:** Storage and Security of Medicines – TRUST WIDE - standards 1, 7,8,9,10,11 and 13 met 100% compliance. Storage and Security of Medicines – Division A -: standards 1,2,4,5,6,7,8,9,10,11,13 and 14 - met 100% compliance. Storage and Security of Medicines – Division B -: standards 1, 4, 6, 7, 9, 10, 12, 13 and 14 met 100% compliance. Storage and Security of Medicines – Division C -: Standards 1,3,7,8,9,10 and 13 met 100% compliance. Storage and Security of Medicines – Division D -: Standards 1,3,6,7,8,9,10,13 and 14 - met 100% compliance.

Title	Outcome
	Storage and Security of Medicines – Division E -: Standards 1,3,7,8,9,10,11,12,13,& 14 and 15 - met 100% compliance. Storage and Security of Medicines – R&D/Corporate -: Standards 4,5,6,7 and 8 - met 100% compliance. **Actions:** 1. Ensure all medicines storage in the Trust is lockable ongoing action per quarter. 2. Provide Calibrated Min/Max Thermometers in R&D area. 3. Share findings from audit with ward managers, Target areas with storage reviews. 4. Share results of audit with Lead Pharmacists. **Implementation of actions** 1. Reported broken locks to Estates team & scope replacement secure storage where necessary. 2. Annual roll out of new calibrated thermometers undertaken April/May 2024. 3. Targeted storage reviews on D7, C7, G6, N2, N3. 4. Findings disseminated.
Audit of adequacy of LLETZ procedure provided by Colposcopy clinic at Addenbrookes Hospital PRN12602	**Audit Standards:** 1. The positive predictive value of a colposcopic diagnosis should be at least 65% for a high-grade lesion (CIN2 or worse). 2. Of all biopsies taken (directed and excisional) more than 90% should be suitable for histological interpretation. 3. When excision is used, at least 80% of cases should have the specimen removed as a single sample. 4. Adequacy of depth of LLETZ >/= 95%. **Key learning from this audit showed:** • Positive predictive value of colposcopic diagnosis was 89%for a high-grade lesion (CIN 2 or worse) which was higher than recommended standards. Of all histological samples 90% samples were suitable for histological interpretation - at par with national recommended standards. • Adequate LLETZ depth was achieved in 68% cases which is lower than recommended national standards. **Actions:** 1. Adequacy of LLETZ depth >/= 95%. Not compliant at 68%. **Implementation of actions** Repeat audit to review change and improvement. Re-audit cycle planned.

Discharge Audit – Hepato-pancreatic-biliary (HPB) Surgery PRN12227	**Audit Standard** The discharge summary and final sign-off rate to be 100%. **Key learning from this audit showed:** Discharge summary rate has improved to a close 100%. Second audit cycle illustrated the recommendations from the 1st cycle made a significant impact on the discharge summary rates. **Actions:** Nil recommendations from Cycle 2. However, it's important to ensure the quality of the discharge summaries is standardised and remains high. As discharge summaries are often subjective to the individual writing them, it is crucial to standardize them while allowing for necessary patient-specific changes to occur during the editing process. The EPIC system offers an advantage in this regard, as it allows the use of pre-made templates or smart phrases for healthcare professionals in the department. We can create smart phrases specific to certain conditions within the HPB department, complete with appropriate follow-ups, outpatient appointments, and necessary investigations. This approach not only increases efficiency but also reduces the time required to write summaries, resulting in quicker patient discharges from the hospital. **Implementation of actions** None.
Impact of peri-operative HbA1c optimisation on post-operative outcomes after Vitreoretinal surgery in CUH PRN11595	**Audit Standards** 1. Surgical teams should identify people with suboptimal diabetes management (HbA1c >69mmol/mol,8.5%) and refer to a specialist team for preoperative planning and optimisation (Page 9, Guideline for Perioperative Care for People with Diabetes Mellitus Undergoing Elective and Emergency Surgery March 2021) 2. The adequacy of diabetes control should be assessed again at the time of listing for surgery, ideally with a recorded HbA1c < 69 mmol.mol-1 in the previous three months. If it is ≥ 69 mmol.mol-1, elective surgery should be delayed while control is improved. (Page 3, Peri-operative management of the surgical patient with diabetes September 2015) 3. HbA1c >69mmol/mol implies poor diabetic control. Patients having routine elective surgery should be referred back to the community. Clinically urgent cases should be discussed with an anaesthetist and referred to the diabetic outreach team for optimisation. (Page 28, Preoperative assessment (POA) clinics: Standard operating procedures January 2019) 4. P1a – Emergency – operation needed within 24 hours, P1b – Urgent – operation needed within 72 hours, P2 – Surgery that can be deferred for up to 4 weeks, P3 – Surgery that can be delayed for up to 3 months, P4 – Surgery that can be delayed for more than 3 months (Operation priority score) **Key learning from this audit showed:** The concern in patients with poorly controlled diabetes is the potential for surgical complications and poorer outcomes including infection, postoperative inflammation and delayed wound healing. There is not much data on ophthalmic surgical outcomes in people with inadequately controlled diabetes. The rate of post-operative complications was not higher in patients who were not referred for HbA1c optimisation compared to those who were. • Only 70% of cases with HbA1c ≥69 undergoing elective eye surgery were referred for Anaesthetic POA.

	• Only 47% of cases with HbA1c ≥69 undergoing elective eye surgery were referred back to the community. • Only 27% of cases with BM >12 for 2 consecutive readings on the day of surgery were started on VRIII. • Only 55% of cases met timeframes suggested by the operation priority score. **Actions:** 1. Vitreoretinal surgeons must routinely check with diabetic patients during appointments that they are being regularly reviewed by their GP/ Diabetes Specialist Nurse. 2. Department of Anaesthesia must consider assigning an Anaesthetist in-charge of pre-operative assessments for Ophthalmology. 3. Anaesthetists must start VRIII for diabetics with CBG >12 mmol/l on 2 consecutive readings on the day of surgery according to trust guidelines. 4. CUH Diabetes Specialist Nurses must consider reviewing clinically urgent patients with HbA1c ≥69 undergoing elective eye surgery instead of referring them back to the community. 5. Vitreoretinal Specialist Nurses must ensure that diabetics with HbA1c ≥69 undergoing elective eye surgery are referred for Anaesthetic POA or discussed with the list anaesthetist. 6. Vitreoretinal Specialist Nurses to consider looking into the 20 cases that were referred to GP/ DSN to see if they were seen by GP/ DSN and if any changes were made to medications. 7. Vitreoretinal Specialist Nurses to consider a future audit on post-operative outcomes for patients specifically with advanced diabetic eye disease and poorly controlled HbA1c. **Implementation of Actions:** 1. Vitreoretinal surgeons must routinely check with diabetic patients during appointments that they are being regularly reviewed by their GP/ Diabetes Specialist Nurse. 2. A review of all diabetic patients referred to POA anaesthetist in 2024 thus far has shown no inconsistencies in regard to the management and advice provided for these patients. CL and CD of anaesthetics both been made aware of opthalmology concerns and can liaise further with them. 3. No evidence found that this process was not happening – 100% compliance. 4. & 5. Feedback from specialist nurse: In order for the diabetes educator team to review these patients it would require a service commissioned by ophthalmology. It is unlikely that we would improve HBA1c in a short time frame as this is a long-term marker. Support from that person's usual diabetes care provider would enable them to improve daily glucose levels in the short term. Patients often prefer support from their usual provider and are happier being seen in their local area rather than travelling into Cambridge. In a short time frame, we are likely to only see minimal impact and ideally the operative team should make a risk-based decision. Whilst in hospital the person can have VRIII, and the diabetes outreach team can be involved. 6. Vitreoretinal Specialist Nurses provided a list of patients to review medications. • Re-audit cycle planned.
Emmeline Centre standard operating procedures for appointments are carried out and recorded appropriately PRN11596	**Standards from NICE TA566 and other guidelines:** https://www.tandfonline.com/doi/full/10.1080/14670100.2023.2197344 https://www.nice.org.uk/guidance/ta566 https://www.hcpc-uk.org/registration/meeting-our-standards/information-on-record-keeping/ https://www.rcslt.org/-/media/Project/RCSLT/rcslt-guidance-to-help-members-adhere-to-hcpc-standards.pdf **Key learning from this audit showed:**

	•Significant improvement in most domains compared to previous cycle. Sustained good performance in completing flowsheets, use of Epic templates and other documentation. •New item of aided thresholds shows good results which is one of the department's key measures. **Actions:** 1. Findings disseminated at staff meeting 15/2/24. 2. Revise standards for next cycle. 3. Plan to re-audit in 2025. **Implementation of actions** 1. Policy is being reviewed at the rehabilitation committee. 2. Standards to be reviewed at cycle 5 audit.
Clinical audit on World Health Organization surgical safety checklist: A prospective trial PRN11964	The WHO safety checklist is mandated across the country. All members of the oral maxillofacial surgery and orthodontics department (doctors, dental nurses, nurses, HCAs and booking team) involved in the delivery of patient care within clinic 8 are expected to adhere to the principles embodied in the LocSSIP policy. The Five Steps to Safer Surgery involve: briefing, sign-in, timeout, sign-out and debriefing. All the patients having treatment should have documented WHO safety checklist completed. **Key learning from this audit showed:** Our Department Clinic 8, Oral and Maxillofacial Surgery (OMFS) has a Local Safety Standards for Invasive Procedures (LocSSIPs) based on National Safety Standards for Invasive Procedures (NatSSIPs). The reason for undertaking this project is to spread awareness of our LocSSIPs policy and by doing this to decrease errors and adverse events and increase teamwork and communication in surgery. A high percentage of patients treated for minor oral surgery in clinic 8 had WHO safety checklists (Sign in and Sign out) recorded. - The role of recording 'Timeout' is not clearly in our policy- making it difficult for clinicians to understand when and how to record. **Actions:** • Promote increased awareness of current LocSSIP. Discuss in departmental meetings and teaching sessions importance of recording WHO checklists and decide what is mandatory to be recorded. • WHO checklists available: sign in, sign out, surgical procedure pause, team brief, timeout. • Review our LocSSIPs policy regarding recording 'time out'. • Re-audit. **Implementation of actions** • Discussed in Oral and Maxillofacial departmental meetings and teaching sessions importance of recording WHO checklists and agreed what is mandatory to be recorded.
CNST Maternity Incentive Scheme SA6 - Saving Babies Lives care bundle	**Audit Standards** 1. All pregnant women should be advised to take 10mcg vitamin D daily during pregnancy at the booking appointment. (90%). 2. All pregnant women should be advised to take 400mcg folic acid until 12 weeks

version 3: Audit of vitamin D and folic acid advice at the booking appointment PRN12077	of pregnancy at the booking appointment. (90%). 3. All pregnant women with a BMI of 30 or more at the booking appointment should be advised to take 5mg of folic acid until 12 weeks of pregnancy. (90%) **Key learning from this audit showed:** Standard 2: All pregnant women should be advised to take 400mcg folic acid until 12 weeks of pregnancy at the booking appointment, currently at 100% compliance. Standard 1, 2: Compliance with advice to take vitamin D and folic acid in pregnancy has fallen. Standards 3: Women with raised BMI are not consistently given advice on folic acid supplementation. **Actions:** • Findings from the audit to be relayed to midwives undertaking booking appointments. • Smartphrases often referred to letters being sent to GPs and patients regarding advice for higher dose folic acid but there was no evidence of the letters being sent. Recommend a review of smartphrases. • Explore options for improving documentation via Epic, including use of the episode checklist as this was noted to be an effective way of documenting discussions when it was used. **Implementation of actions** 1. Updated community matrons and request reminder in community bulletin for midwives undertaking community bookings. Presented at June 2024 directorate quality governance and perinatal business meeting.
CNST SA6 – Saving Babies Lives care bundle version 3: Audit on the information provided about and the management of Reduced Fetal Movements PRN12240	**Audit Standards** 1. All women booked for antenatal care by Rosie community midwives will receive information on reduced fetal movements by 28 weeks of pregnancy. SBL intervention: 3.1 (95% local target) 2. All women who attend with reduced fetal movements from 28+0 will have a computerised CTG using Dawes-Redman analysis. SBL intervention/process indicator 3.2 / 3a (95% LMNS target). 3. All women attending with reduced fetal movements where an ultrasound scan is indicated are offered a scan within three working days (as per local guideline). (100% local target). 4. All women who have recurrent RFM or who report no FMs during the cCTG are offered an ultrasound scan within one working day. (Recurrent RFM is defined as 2nd episode within 28 working days where there has not been a growth USS within the last 14 days.) SBL intervention/process indicator 3.2 / 3b (50% LMNS target). 5. There is evidence of the Reduced Fetal Movements section within the Triage Navigator on Epic being completed for all women attending with reduced fetal movements. (95% local target). **Key learning from this audit showed:** • 100% of women presenting with reduced fetal movements had a computerised CTG. 22.5% of notes reviewed used the new Epic reduced fetal movements assessment within the Triage Navigator to record the encounter, which is a marked improvement from the previous audit. 50% of all women with RRFM were scanned within 1 working day, which meets the target.

	• 82.5% of women had evidence of being provided with an information leaflet on reduced fetal movements by 28 weeks of pregnancy, which is a drop in compliance from the previous audit. **Actions:** In order to demonstrate compliance with standard 1, it was helpful when community midwives used the 202316WEEK Epic smartphrase at the 16-week appointment, as this meant that all women were given written information on reduced fetal movements and links to further information including the Tommy's leaflet and RCOG website. There was significant variation in the use of this. A reminder will be sent to all community midwives about using this smartphrase via the community matron bulletins. The Reduced Fetal Movements assessment section within the Triage Navigator was introduced in March 2023 and despite further education following the previous audit, compliance with use by staff in Clinic 23 remains low (standard 6). The findings of this audit will be shared with the Clinic 23 team and feedback on issues with use will be sought. **Implementation of actions** 1. Findings disseminated at governance and Perinatal business meeting. 2. Reduced fetal movement patient information leaflet added in booking packs. 3. The reduced fetal movement smartphrase on epic has been updated and this has been circulated through the matron's bulletin. Clinic 23 has been updated with the findings and supported to use the reduced fetal movements navigator.
ATAIN: Term admissions to NICU of babies born to women with a pregnancy complicated by diabetes – did antenatal and intrapartum care meet required standards? PRN12259	**Audit Standards** 1. All women with Type I and Type II Diabetes should have at the first appointment with the diabetes in pregnancy team an HbA1c, Urine ACR, Urea and Electrolytes and an assessment of thyroid axis. 2. All women with Type I and Type II Diabetes should be advised to take aspirin 150mg from 12-36 weeks gestation. 3. All women with Type I and Type II Diabetes should have a repeat HbA1c at 24+0-30+0 weeks of pregnancy and be offered extra care if the result falls in the amber or red category. 4. All women with Type I and Type II Diabetes should have urea and electrolytes repeated at 28 weeks. 5. Women with Type I diabetes should have an additional uterine artery Doppler scan between 18+0 and 23+6 weeks. 6. All women with diabetes in pregnancy should have four weekly scans from 28 weeks of pregnancy. 7. All women with diabetes in pregnancy should have four weekly MDT appointments from 28 weeks – 36 weeks (obstetric and diabetes teams). 8. All women with diabetes in pregnancy should be seen by a member of the diabetes in pregnancy team during any antenatal admission. 9. All women with diabetes in pregnancy should had an individualised birth plan clearly presented in her EPIC record. 10. All women with diabetes in pregnancy should have a variable rate intravenous

	insulin infusion (VRIII – formerly sliding scale) prescribed if capillary blood glucose is >8.0mmol/l on two consecutive occasions during labour, the blood glucose level is <5.0mmol/l and the woman is unable to take hypoglycaemic treatment or the treatment is not working, or there are urinary ketones of 2+ or more. 11. All women with pregnancy complicated by diabetes should have capillary blood glucose monitoring recorded hourly during active labour/prior to elective caesarean section in Epic. 12. Whilst an in-patient all blood glucose levels should be recorded in Epic and all diabetes medications should be prescribed in Epic even if the woman is self-caring. **Key learning from this audit showed:** The aim of the audit was to ensure women are receiving recommended care in the antenatal and intrapartum periods. Results indicate that care is, provided in line with recommendations. However, some elements of care could be improved. Antenatal and intrapartum care provided for women with pregnancies complicated by diabetes is of a high standard. All standards met 100% compliance apart from standard 7. Women whose pregnancies are complicated by diabetes do not always get the chance to meet with the obstetric team as the intervals recommended. Blood glucose monitoring of women during labour is not always carried out as regularly as required. Std 7 - did not meet 100% compliance. **Actions:** This report has demonstrated that antenatal and intrapartum care provided to women with pregnancies complicated by diabetes is generally of a high standard and is in line with guidance. There is room for improvement in terms of access to the obstetric team for antenatal appointments as well as blood glucose monitoring of women during labour. **Implementation of actions** • Women continue to be triaged prior to appointments to ensure a full MDT review is completed. • Education provided to midwives facilitating intrapartum care and blood glucose monitoring takes place hourly during labour.
Obstetric Ultrasound Capacity Deep Dive PRN12374	**Audit Standards** 1. 100% of women booked for a pregnancy episode at the Rosie received dating and anomaly ultrasound scans within the recommended time frame. 2. 100% of women who did not attend (DNA) their ultrasound scan were followed up. 3. 100% of women who required an interpreter had translation services used at their ultrasound scan appointments. 4. 100% of women who attend maternity triage have prompt access to ultrasound scanning if required. **Key learning from this audit showed:** • Physical room capacity for additional activity is very limited. • Although the audit shows compliance against the standards above, the available workforce remains a challenge with recruitment and retention. **Actions:**

	• Work regionally on consistency of pay for certain staff in this service to improve recruitment and retention. • Working group looking at a reconfiguration of space. **Implementation of actions** Audit findings shared SQOG via LMNS.
Compliance with Perinatal Post-mortem Consent Requirements within the Rosie Hospital. PRN12269	**Audit Standards** 1. 100% of consent forms completed fully in Section 1: Your decisions about a post-mortem examination. 2. 100% of consent forms completed fully in Section 2: Tissue samples. 3. 100% of consent forms completed fully in Section 3: Genetic testing. 4. 100% of consent forms completed fully in Section 4: Keeping tissue samples for training professionals and for research. 5. 100% of consent forms completed fully in Section 5: Any other requests or concerns. 6. 100% of consent forms completed fully in Section 6: Parental consent. 7. 100% of consent forms completed fully in Section 7: Consent taker's statements. 8. 100% of consent forms with changing your mind time period clear. **Key learning from this audit showed:** Record keeping overall was to a good standard with excellent completion of the following sections: 'Keeping tissue samples for training professionals and for research', 'Any other requests or concerns' and 'Consent taker's statements. No further concerns were identified. **Actions:** - A record of staff who are considered compliant with consent seeking training to be kept and certificates issued. -The SOP (ID101516 Perinatal post-mortem consent taking, training and competency for obstetric and midwifery staff) is to be updated to clarify the period of time specified to allow withdrawal of consent. **Implementation of actions** • Obstetric staff within the Rosie who were considered compliant with consent seeking training) were documented and a certificate issued for individual portfolios. Refresher training to be scheduled every 3 years. • ID101516 Perinatal post-mortem consent taking, training and competency for obstetric and midwifery staff published on Merlin 07/08/24. Also reviewed 'Guidance for Health Professionals – Completing the consent form'.
Improving Timeliness of Discharge Summaries: Evaluating and Enhancing Compliance with 24-Hour GP Notification Targets PRN12428	**Audit Standards** 1. Standard: Discharge summaries should be sent to the GP within 24 hours of patient discharge, in accordance with NHS standards and local trust policies. 2. Standard: Regular audits should be conducted to monitor compliance with the 24-hour discharge summary completion target, with the goal of achieving and maintaining at least 90% compliance. 3. Standard: Ensuring timely discharge summaries supports safe transitions of care from hospital to primary care. **Key learning from this audit showed:** **1.** Approximately a 15% increase in meeting requirements. **2.** No further transfers without discharge summaries. **3.** Weekend ED to clinic pathway is now clear and all patients have discharge summaries. **4.** EPIC upgrades expected to improve compliance.

	5. Some patient discharges missed on day cases. **Actions:** • Daily reminder email. • Train staff to avoid accidental admissions when cancelling surgeries. • CNS to complete discharge summaries or alert doctors if needed. • Theatre SpR to confirm discharge summaries are completed and signed off post-list. • Follow up on progress of meeting target. **Implementation of actions** All actions have been completed and embedded as of September 2024.
Saving Babies Lives (v3) Element 6: Management of Pre-existing Diabetes in Pregnancy PRN12586	• **Audit Standards** 95% of women with Type 1 diabetes should use real time continuous glucose monitoring (CGM) during pregnancy. • 80% of women with pre-gestational diabetes (type 1 and 2) have an HbA1C undertaken at the start of the third trimester (between 24+0 and 30+0 weeks). • 100% of women whose third trimester result it over 48mmol/L should be offered increased surveillance (including additional diabetes nurse/dietetic support, more frequent face to face review and input from their named, specialist Consultant to plan ongoing care and timing of birth decisions). **Key learning from this audit showed:** Good evidence that woman with pre-gestational diabetes are receiving recommended care All standards were fully compliant. **Actions:** 1. The report was disseminated to Division E. **Implementation of actions** No action plan required as fully compliant across both recommended interventions. The team continue to be committed to providing care in line with the recommendations from Saving Babies Lives version 3.
Saving Babies Lives care bundle version 3: Audit of vitamin D and folic acid advice at the booking appointment. PRN12607	**Audit Standards** 1. All pregnant women should be advised to take 10mcg vitamin D daily during pregnancy at the booking appointment. 2. All pregnant women should be advised to take 400mcg folic acid until 12 weeks of pregnancy at the booking appointment. 3. All pregnant women with a BMI of 30 or more at the booking appointment should be advised to take 5mg of folic acid until 12 weeks of pregnancy. 4. A booking MSU must still be sent for all women at risk of preterm birth. **Key learning from this audit showed:** • Compliance with the advice to take 5mg of folic acid until 12 weeks of pregnancy has shown consistent improvement. • Compliance with advice to take vitamin D and folic acid in pregnancy is under target and has remained static since the last quarterly review. • Compliance with the advice to take 400mcg of folic acid until 12 weeks of pregnancy has fallen and is under target. • Compliance with MSU recommendation for women with higher risk of preterm birth is significantly below target. **Actions:** 1. Findings from the audit should be relayed to midwives undertaking booking appointments. As there are some team booking smart phrases that specifically lacked discussion on vitamin D, the auditor recommends this is discussed at a community meeting so that this can be reviewed locally. A general review of smartphrases, especially the booking smart phrases is needed as most used

	were out of date and did not include sufficient information and discussion around folic acid and vitamin D supplementation. 2. Midwives carrying out booking appointments should consider use of the pregnancy checklist to record antenatal discussions, including discussions at booking about folic acid and vitamin D. This can be a useful tool to track discussions and compliance with the standards. 3. Community staff and those carrying out bookings should be reminded of this new standard and that sending off MSU's at booking is still recommended for those with pre-term risk factors. **Implementation of actions** • Information sent to midwives managing the community newsletter. • Discussed MSU guidance with community matron - shared learning over previous year. • Training programme updates commencing Dec 2024. Jan 2025: Risk assessments included in IST commenced Dec 2024. Teams with high noncompliance informed via email.
Compliance with the Maternity Incentive Scheme Safety Action 10. This is demonstrated by reporting qualifying incident cases to MNSI and to NHS Resolution **PRN12631**	**Audit Standards** 1. All cases were reported to MNSI via the electronic portal. 2. All cases were reported to NHS Resolution via the Claims Reporting Wizard, once MNSI have confirmed they are progressing an investigation. 3. All final reports received were shared with the Early notification Team within 30 days of receipt 4. All families have received information on the role of MNSI and the Early notification Scheme 5. All cases have had duty of candour discharged in line with regulation 20 of the Health and Social Care Act 2008. **Key learning from this audit showed:** Relatively high percentage of operation note plans including weight bearing instructions. High percentage of those with weight bearing restrictions provided with quantification allowing for clear instruction for the ward and therapy teams. **Actions:** • Improve departmental knowledge of the guidelines Provide resources to encourage appropriate use of the guidelines. • Additional audit cycle following implementation of recommendations to review departmental compliance. • Ensure to document weight bearing status post operatively using clear unambiguous language: - Non weight bearing - Limited weight bearing - Unrestricted weight bearing. • If limiting patients weight bearing, ensure to document: - Clinical justification for limitation - Quantification of limitation - Timescale for limitation. **Implementation of actions** • No action plan is required due to the full achieved compliance. To conclude, there is an appropriate level of adherence to the standard assessed in this audit.
Administration of Analgesia to	**Audit Standards** 1. Pain assessment should include the use of a validated pain assessment tool.

Paediatric Sickle Cell Anaemia (SCA) Patients Attending ED/transfers with a Painful Crisis or complications including pain PRN12760	2. Pain assessed on arrival to ED/Ward. 3. Analgesia should be administered to a child presenting to ED/transfer into general ward in a painful crisis within 30 minutes. 4. Children should be monitored every 30 minutes until satisfactory pain relief has been achieved. **Key learning from this audit showed:** • This audit aimed to evaluate how well Addenbrooke's Hospital Paediatric ED is managing pain in children with SCA. • In the cases where pain assessed was documented, pain control was administered within 30 minutes. • Not all patients had pain assessment scores documented on arrival to ED/wards. • Patient's pain scores were not reassessed within 30 minutes. **Actions:** 1. All children with sickle cell disorders should have a pain score assessment when presenting to EDs or on transfers from LHT's. ALERTS on Epic notes. Teaching on all paediatric areas including paediatric ED. 2. Clearer documentation of assessment / previous analgesia given at home or in Local Hospital is required. 3. Increase awareness in Paediatric ED and wards to ensure pain assessment is completed as part of initial and ongoing assessment. 4. This audit should be replicated in all the LHT's who receive urgent patients with sickle crises. **Implementation of actions** All actions have been completed and integrated as of January 2025.

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

ATAIN (Avoiding Term Admissions into Neonatal units)

A program designed to improve care and reduce avoidable admissions of full-term babies to neonatal units. A central aim is to avoid unnecessary separation between mothers and babies.

BAME (BME)

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

CBC (Cambridge Biomedical Campus)

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

HAPU (Hospital acquired pressure ulcer)

A localized lesion or injury to the underlying tissue (wound) while the patient is an in-patient in hospital.

ICB (Integrated Care Board)

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

C.difficile

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

CHKS (Provider of healthcare intelligence and quality improvement services)

CHKS accreditation provides credible and independent recognition of your commitment to quality improvement for your patients, Board and external regulators.

CQC (Care Quality Commission)

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

CQUIN (Commissioning for Quality and Innovation) indicators

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

CUH

Cambridge University Hospitals NHS Foundation Trust

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

CYP
Children & Young People

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

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.

DSPT (Data Protection & Security Toolkit)

The Data Security and Protection Toolkit is an online self-assessment tool that allows organisations to measure their performance.

EDI

Equality, Diversity & Inclusion

EOLC (End of Life Care)

End of life care provides support for individuals approaching the end of their life, aiming to help them live as well as possible and die with dignity. It involves managing physical symptoms, offering emotional and spiritual support, and addressing practical needs.

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

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

GDE (Global Digital Exemplar)

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

HIMSS (Healthcare Information and Management Systems Society)

The Healthcare Information and Management Systems Society is an American not-for-profit organization dedicated to improving health care in quality, safety, cost-effectiveness and access through the best use of information technology and management systems.

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

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

ICS (Integrated Care System)

ICSs are partnerships between NHS organizations, local authorities, and other local entities to improve health and care services across a specific geographic area.

IPC
Infection prevention and control
KPI
Key performance Indicator – a measure of performance or improvement

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

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

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

MHRA (Medicines for Human Use Regulatory Authority

The Medicines and Healthcare products Regulatory Agency regulates medicines, medical devices and blood components for transfusion in the UK.

MRSA (Methicillin-Resistant Staphylococcus Aureus)
MRSA is a type of bacterial infection that is resistant to a number of widely used antibiotics. This means it can be more difficult to treat than other bacterial infections.

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

NCEPOD (National Confidential Enquiry into Patient Outcome and Death)
The National Confidential Enquiry into Patient Outcome and Death reviews clinical practice and identifies potentially remediable factors in practice. NCEPOD's purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the

public by reviewing the management of patients, by undertaking confidential surveys and research, by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities.

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

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

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

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

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

PALS
Patient advice liaison service

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

PEWS
Paediatric Early Warning Score

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

RCA (Root cause analysis)
A systematic process for identifying “root causes” of problems or events and an approach for responding to them.

ReSPECT

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

RTT
Referral to treatment

SDEC (Same day Emergency Care)

A service within the NHS where patients who would otherwise be admitted to hospital for emergency care are assessed, diagnosed, and treated on the same day. This aims to reduce hospital waiting times and unnecessary admissions, benefiting both patients and the healthcare system.

UKHSA
United Kingdom Health Security Agency – (formerly public health laboratory service).

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

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