NHS
Cambridge University Hospitals
NHS Foundation Trust

There will be a meeting of the Board of Directors in public on Wednesday 8 July 2020 at 11.00

Due to the COVID-19 pandemic, this meeting will be held by videoconference. Members of the public wishing to attend the virtual meeting should contact the Trust Secretariat for further details (see further information on the Trust website)

(*) = paper enclosed
(+) = to follow

AGENDA

General business			**Purpose**
11.00	**1**	**Welcome and apologies for absence**	For note
	2	**Declarations of interest** To receive any declarations of interest from Board members in relation to items on the agenda and to note any changes to their register of interest entries A full list of interests is available from the Director of Corporate Affairs on request	For note
	3*	**Minutes of the previous Board meeting** To approve the Minutes of the Part 1 Board meeting held on 13 May 2020	For approval
	4*	**Board action tracker and matters arising not covered by other items on the agenda**	For review
11.05	**5**	**Patient story** To hear a patient story	For receipt
11.20	**6***	**Chair's report** To receive the report of the Chair	For receipt
11.25	**7***	**Report from the Council of Governors** To receive the report of the Lead Governor	For receipt
11.30	**8***	**Chief Executive's report** To receive the report of the Chief Executive	For receipt
Quality, access standards, workforce and finance			**Purpose**
11.40	**9***	**The items in this section will be discussed with reference to the Integrated Report and other specific reports**	
	9.1	**Quality** To receive the report of the Chief Nurse and Medical Director	For receipt
	9.2	**Access standards** To receive the report of the Chief Operating Officer	For receipt

	9.3*	**Workforce (including nurse safe staffing)** To receive the reports of the Director of Workforce and the Chief Nurse	For receipt
	9.4*	**Financial performance** To receive the report of the Chief Finance Officer	For receipt
	9.5	**Improvement** To receive the report of the Director of Improvement and Transformation	For receipt
12.10	**10***	**Nursing reconfiguration establishments** To receive the report of the Chief Nurse	For receipt
Governance and assurance			**Purpose**
12.15	**11***	**Refreshing our Strategy in response to Covid-19** To receive the report of the Director of Strategy and Major Projects	For receipt
12.30	**12***	**WRES and supporting BAME staff** To receive the report of the Director of Workforce	For receipt
12.45	**13***	**Education, learning, development and training** To receive the report of the Director of Workforce	For receipt
12.55	**14***	**Guardian of Safe Working annual report** To receive the report of the Medical Director	For receipt
13.05	**15***	**Freedom to Speak Up Guardian six-monthly report** To receive the report of the Director of Corporate Affairs	For receipt
13.15	**16***	**Research and development** To receive the report of the Medical Director	For receipt
13.25	**17***	**Board assurance committees – Chairs' reports** 17.1 Quality Committee: 1 July 2020 • Safeguarding annual report 17.2 Performance Committee: 1 July 2020 17.3 Audit Committee: 17 June 2020	For receipt
Other items			**Purpose**
	18	**Any other business**	
	19	**Questions from members of the public**	
	20	**Date of next meeting** The next meeting of the Board of Directors will be held on Wednesday 9 September 2020 at 11.00.	For note

	21	**Resolution** That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (NHS Act 2006 as amended by the Health and Social Care Act 2012).	
13.30	**22**	**Close**	

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Minutes of the Part 1 meeting of the Board of Directors held on Wednesday 13 May 2020 at 11.00 via videoconference

Member	Position	Present	Apologies
Dr M More	Trust Chair	X	
Mr D Abrams	Non-Executive Director	X	
Ms N Ayton	Chief Operating Officer	X	
Dr E Cameron	Director of Improvement and Transformation	X	
Mr A Chamberlain	Non-Executive Director	X	
Dr A Doherty	Non-Executive Director	X	
Dr M Knapton	Non-Executive Director	X	
Prof P Maxwell	Non-Executive Director		X
Ms M Monie	Director of Major Projects and Specific Incident Projects	X	
Mr D Northam Jones	Director of Strategy and Incident Management Support	X	
Ms D Olulode	Non-Executive Director	X	
Ms S Pointer	Non-Executive Director	X	
Mr P Scott	Chief Finance Officer	X	
Dr A Shaw	Medical Director	X	
Mr R Sinker	Chief Executive	X	
Ms L Szeremeta	Chief Nurse	X	
Mr I Walker	Director of Corporate Affairs *	X	
Mr D Wherrett	Director of Workforce	X	

** Non-voting member*

In attendance	Position
Mr M Whelan	Deputy Trust Secretary
Mr G Burgess	Assistant Trust Secretary (minutes)

41/20 Welcome and apologies for absence

Apologies were received from Patrick Maxwell.

Nicola Ayton was welcomed to her first Part 1 meeting of the Board of Directors in her capacity as Chief Operating Officer. Dan Northam Jones and Marianne Monie were also welcomed to the meeting in their interim roles covering the Strategy and Major Projects portfolio.

While the meeting was not being recorded or live streamed, the agenda and papers had been made available to the public on the Trust website. A summary of the meeting and responses to questions submitted by members of the public would also be published on the Trust website. The minutes of the meeting would also be publicly available in due course.

The Trust would continue to review its approach to Part 1 Board meetings during the period in which social distancing restrictions were in place.

42/20 Declarations of interest

Standing declarations of interest of Board members were noted.

43/20 Minutes of the previous meeting

The minutes of the Board of Directors' meeting held in public on 11 March 2020 were approved as a true and accurate record.

44/20 Board action tracker and matters arising not covered under other agenda items

Received and noted: the action tracker.

45/20 Patient stories

Lorraine Szeremeta, Chief Nurse, introduced two patient stories.

Noted:

1. The Board of Directors received a story about the experiences of an inpatient being treated at the Trust prior to, and during, the COVID-19 outbreak.
2. While the patient and his family were incredibly grateful for the compassion and honesty, as well as expert knowledge, that the clinical teams provided, concern was raised around communication on the wards. Not all staff introduced themselves or made the patient feel welcome and aspects of the care provided were unsatisfactory. Some of the COVID-19 processes on the wards had also appeared confusing and inconsistent.

Noted:

1. The Board of Directors received a story about a couple, married for 73 years, who had both been admitted with COVID-19.
2. The family received daily calls to update them on progress and both patients were successfully discharged after a two week stay and remain together.
3. This couple's story was overwhelmingly positive and they, and their families, wanted to thank the staff for the dedicated and professional care provided.

The following points were raised in discussion:

1. Verbal communication remained vitally importable for keeping both patients and their families informed about the care being provided.
2. The importance of all wards being consistent in their approach to patient communication and staff introductions was highlighted. The Trust had implemented a yellow 'Hello my name is…' badge to aid this process.
3. At the start of the pandemic, staff were required to work in very different ways and new COVID-19 processes were still in implementation stage. While some initial challenges were to be expected, the Trust was working closely with Matrons and Ward Sisters to get their feedback and share learning.
4. Going forward the Trust would increasingly be treating both COVID and non-COVID patients. This would bring new challenges and anxieties for staff and the importance of putting appropriate support mechanisms in place was highlighted. In response it was noted that minimising hospital acquired COVID-19 and maintaining appropriate segregation was a key element of the Trust's strategy. Each patient placement would need careful consideration and input from a wide range of staff. Work was ongoing to standardise patient placement processes.

5. The importance of establishing effective relationships and communication between staff and patients was highlighted. Frequently moving staff or patients between different areas of the hospital could affect this. In response it was noted that, as a result of COVID-19, there had been an increase in staff redeployment. While this had been unavoidable, it was acknowledged that this had had an impact on relationships and retention. Limiting, where possible, the movement of staff to different areas of the Trust remained a core element of the Trust's retention strategy.
6. COVID-19 patients tended to have a longer length of stay than other patient groups and were likely to feel more isolated. This could add to levels of anxiety and the importance of amending care and communication styles accordingly was noted.

46/20 Chair's report

Mike More, Trust Chair, presented the report.

Noted:
1. The Chair paid tribute to all staff for their extraordinary skill and expertise, their care and compassion and their mutual support for each other over the past few weeks. The wider Management Executive team, senior leaders and external colleagues were also thanked for their leadership during this very challenging period.

Agreed:
1. To note the report.

47/20 Integrated Performance Report

Received and noted: the report.

48/20 Finance report

Paul Scott, Chief Finance Officer, presented the report.

Noted:
1. While costs associated with the COVID-19 response had impacted the financial position in March 2020, the Trust had delivered its 2019/20 financial plan.
2. The Trust had achieved its Cost Improvement Programme (CIP) in full.
3. Taking account of technical adjustments, the Trust's published accounts would show a deficit of £37m for 2019/20.

The following points were raised in discussion:

1. The importance of achieving the 2019/20 financial plan should not be underestimated and was key to retaining the Trust's financial credibility.
2. A new operating model for CIP was currently being developed.
3. The importance of measuring the Trust's effective use of resources during the pre and post COVID-19 period was highlighted. With an anticipated reduction of 100 beds due to segregation measures, it would be important to monitor the impact on throughput and productivity going forward.
4. The need to maintain an appropriate balance between efficiency and resilience was emphasised. An understanding of this nationally and regionally would be key.

5. Many trusts had experienced a much higher number of COVID-19 inpatient cases than CUH. The importance of learning from their experiences was highlighted.
6. The Board of Directors expressed its thanks to the finance and transformation teams and staff across the organisation on the achievement of the 2019/20 financial plan.

49/20 Nurse safe staffing

Lorraine Szeremeta, Chief Nurse, presented the report.

Noted:

1. The report provided a summary of the nursing and midwifery staffing response during the first phase of the COVID-19 pandemic, focusing mainly on critical care.
2. While the Trust's critical care surge plan had been based on a critical care nurse to patient ratio of 1:6 at maximum surge, the actual ratio of critical care nurses to patients had not exceeded 1:2. had been anticipated for the maximum surge plan the Trust had not exceeded 1:2. Including Category A and Category B staff, a bedside ratio of at least 1:1 had been maintained at all times.
3. Over 600 staff had been trained to provide additional critical care support.
4. The Red Flag reported on C7 was being reviewed by the Head of Nursing.
5. The registered nurse vacancy rate for April 2020 was 6.89%.

The following points were made in discussion:

1. Over 600 staff had received two days' training on the critical care environment and then undertaken 'shadow' shifts. They were trained to provide additional support where required and were not expected to be experts in critical care. In the event of any future surges, the importance of refamiliarising these staff with the critical care environment and building their confidence was highlighted.
2. The number of retired staff that had returned to the Trust through the formal East of England process had been low. In total five medical and two non-medical staff had returned.
3. Third year medical students coming into paid employment had provided vital support during this time. Over 100 trainees had also come to work at the Trust. The longer-term impact of this was, however, not yet known.
4. The current spotlight on the NHS and challenges in the wider employment market could result in the number of trainees increasing. Perceived job security in the NHS compared to the private sector could also help. It was noted that since 19 April 2020 over 250 new staff had joined the Trust and the UK staff pipeline remained healthy.
5. The impact of COVID-19 on staff attrition was not yet known but could be significant for the NHS. The Trust's Occupational Health team was currently reviewing options for additional mental health and wellbeing support for staff. Over recruiting during this period should also be considered.
6. As CUH exited this wave of the COVID-19 pandemic, staff would remember how they had been supported by their employer. While the Trust was receiving positive feedback from staff, the importance of continuing to review the staff offer was noted.
7. Going forward there may be an impact on the number and availability of volunteers. This would need to be monitored carefully.

Agreed:

1. To note the safe staffing report for April 2020.

2. To note the critical care staffing model during the COVID-19 surge.
3. To note that the registered nurse vacancy rate for April 2020 was 6.89%.
4. To note that that the healthcare support worker vacancy rate for April 2020 was 18.10%.
5. To note that the Care Hours Per Patient Day for April 2020 was 23.13.

50/20 Chief Executive's report: COVID-19 update

Roland Sinker, Chief Executive, presented the report.

Noted:

1. The Trust's primary objectives were to maximise the number of lives saved and minimise suffering of both those infected with COVID-19 and other patients, and to maintain staff safety and welfare.
2. Work was ongoing to embed testing processes for both patients and staff.
3. At the peak, the Trust had around 135 COVID-19 positive inpatients.
4. There were currently 19 COVID-19 positive patients in critical care and 66 in other areas of the hospital.
5. The length of stay for COVID-19 patients was high.
6. On average, the Trust was recording three new COVID-19 inpatients per day.
7. Emergency Department (ED) attendances had decreased from around 11,000 in March 2019 to 7,860 in March 2020.
8. Outpatient face-to-face appointments had reduced significantly. There had been a large increase in remote, particularly telephone, consultations. The importance of capturing the benefits of these new ways of working was highlighted.
9. While emergency surgery had continued, the majority of elective surgery had been postponed as theatre staff were released to support COVID-19 care. Work was now underway to recommence elective activity.
10. A range of COVID-19 activity modelling had been undertaken and the Trust had planned on the basis of a requirement of 325 general beds for COVID-19 patients and an additional 135 critical care beds. Fortunately the peak was significantly below this level, despite some regional transfers in from other hospitals.
11. The Trust has established 12 executive-led taskforces. Highlights and key issues from each of the taskforces were appended to the report.
12. Governance processes and command structures had been reviewed and adapted in light of COVID-19. Work was now underway to re-start key elements of the governance structure, while learning from the past eight weeks and adapting for the issues the Trust may face in the period ahead.
13. The Risk Oversight Committee (ROC) had continued to meet monthly with a focus on the Corporate Risk Register (CRR) and Board Assurance Framework (BAF) risks significantly impacted by the COVID-19 response. The Trust's risk appetite statement had also been reviewed.
14. A COVID-19 communications strategy had been agreed by Management Executive which included mechanisms for communicating with patients, the public, staff, external stakeholders and the media.
15. A key focus for the Trust would be looking at how to restart services safely and as quickly as possible for non-COVID patients.
16. A refresh of the Trust's strategy was currently being undertaken.

The following points were made in discussion:

1. At the start of the COVID-19 pandemic, a clear command structure had been put in place. The Clinical Commissioning Group (CCG) had coordinated the system response. A Gold Health Command structure had been established across the system had been working very effectively with all partners. The importance of reverting to the statutory provider and commissioner model to

ensure rapid and clear decision making was highlighted. The need to capture the lessons learnt from this period, and to re-establish effective links between primary and secondary care, was also noted.

2. While the number of COVID-19 cases at CUH had been below the anticipated peak, many other hospitals across the country had been severely affected. The forward modelling had identified three potential scenarios – continued low COVID-19 numbers, repeated manageable peaks and troughs, or an uncontrolled peak that exceeded the first.
3. The potential impact of university students retuning to Cambridge was highlighted.
4. Emergency Department (ED) activity was starting to increase and was likely to increase further as people started to feel more comfortable about attending the hospital again. This would increase pressure on staff and reduce the number of available beds across the Trust.
5. The numbers of staff self-isolating and off sick were continuing to reduce.
6. The Trust was currently testing 300 to 400 staff per day. To date, 2,626 members of staff had been tested and 90 (3.4%) had been COVID-19 positive.
7. An increase in presentations of mental health related conditions and other issues related to COVID-19 survivorship was anticipated. The importance of a health needs assessment being undertaken was highlighted. In response it was noted that the Trust was working closely with Cambridgeshire and Peterborough NHS Foundation Trust to progress this.
8. 51 staff cases of COVID-19 had been reported to the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).
9. While there had been no CUH staff deaths related to COVID-19, four NHS staff from other healthcare organisations had died at the Trust.
10. Risk assessment processes for Black, Asian and Minority Ethnic (BAME) staff were being reviewed.
11. While COVID-19 had resulted in a backlog in diagnostics and elective surgery, it was too early to determine the full impact of these delays on patients. The Sustainability taskforce would be taking this forward and further information would be brought to the next meeting of the Board of Directors.
12. The importance of developing performance metrics linked to the ongoing recovery and sustainability work was highlighted. Being able to measure success over the next 12-18 month period would be key.

Agreed:

1. To note the contents of the report.

51/20 Board Assurance Framework (BAF) and Corporate Risk Register (CRR)

Ian Walker, Director of Corporate Affairs, presented the report.

Noted:

1. The Risk Oversight Committee had agreed in March 2020 that the usual monthly process of updating the CRR and BAF should be suspended, with the risks 'accepted' at their current level, but subject to light touch oversight by ROC each month until normal arrangements could be reinstated.
2. The Trust's risk appetite and risk tolerance was reviewed by ROC at its meeting on 23 April 2020 in the light of COVID-19. The review concluded that while there were no strong grounds for proposing a change in the overall risk appetite, the Trust's tolerance for risk was likely to be higher.
3. As part of the Trust's COVID-19 response, an overarching COVID-19 risk had been added to the Corporate Risk Register (CR34).

4. The Head of Risk and Clinical Audit had worked closely with the Incident Management Team to create the COVID-19 risk register, which would be reviewed by taskforce leads monthly prior to presentation to ROC.
5. Detailed risks to the delivery of the taskforce's priorities were included in the taskforce reporting to Management Executive.
6. The BAF would be refreshed following the current Strategy refresh exercise.

The following points were made in discussion:

1. At its meeting on 14 May 2020, Management Executive would discuss reinstating governance processes which had been suspended during the initial phase of the response to the pandemic, including risk management processes.
2. It was questioned whether the IT resilience risk had increased over the period as a result of the increase in home working and requirements for video conferencing/consultations. In response, it was noted that the bandwidth of the Trust's network had been increased and additional servers and remote working licences had been purchased in order to mitigate the risk. This issue had been discussed at the Performance Committee meeting on 6 May 2020.

Agreed:
1. To note the update on the approach to risk management.
2. To note and endorse the review of the Trust's risk appetite statement.
3. To note the new overarching CRR risk on the COVID-19 response (Appendix 3 of the report) and the summary of the COVID-19 risk register (Appendix 4 of the report).
4. To receive the current (February 2020) version of the BAF (Appendix 5 of the report) and note material issues identified by the Risk Oversight Committee at its April 2020 meeting.
5. To note plans to refresh the BAF following the current strategy refresh exercise.

52/20 Learning from Deaths Quarterly Performance Report: April 2020

Ashley Shaw, Medical Director, presented the report.

Noted:
1. The majority of data included in the report related to the pre-COVID period.
2. The Hospital Standardised Mortality Ratio (HSMR) remained stable.
3. The report had been discussed at the Quality Committee meeting on 6 May 2020.
4. Structured Judgement Review (SJR) compliance remained stable.
5. A regional Learning from COVID Deaths Committee had been established.

The following points were made in discussion:

1. While COVID-19 mortality rates were currently low at CUH, this could be linked to the traditionally low HMSR. When comparing COVID mortality rates across different trusts, there would be a need to look at a wide range of contributory factors such as patient demographics, staffing and equipment.
2. The importance of regular updates to the Board of Directors and Board assurance committees on survivorship, learning from others and staff safety was noted.

53/20 Board Assurance Committees – Chair's Reports

Quality Committee: 6 May 2020

Received and noted: the report.

Performance Committee: 6 May 2020

Received and noted: the report.

Remuneration and Nomination Committee: 6 May 2020

Received and noted: the oral update.

54/20 Any other business

There was no other business.

55/20 Questions from members of the public

The following questions were submitted. Written responses would be published on the Trust website.

1. *In the papers for the meeting of 13 May 2020 we noted the following:*

   <u>Chair's Report 2.4:</u>
   'co-operation with the independent sector has been an important aspect of our strategy…'

   We assumed that this referred only to strategy during the Covid emergency but it was then followed by:

   <u>CEO Report Slides under 'Elective Activity':</u>
   - *Phase 1: 'some activity moved to the independent sector' and, specifically: '101 surgeries in April'*
   - *Phase 2: 'plans to maximise (our italics) utilisation [of the independent sector] being developed'*

   We can understand resorting to the private sector in times of emergency but will the Board please define the scope of 'maximisation' in this context and confirm that use of private healthcare providers will remain a last resort during post-COVID need and that there is no intention for it to become a default option?

   In these Board papers the use and meaning of the word 'private' seems to have been replaced by 'independent'. Is this now CUH policy when referring to 'for profit' organisations?

2. *In very small print in the Integrated Report p.19, following notes on phone and video consultation, there are the following:*

   'Developing a new outpatient service' and 'This is great opportunity to redesign outpatients in line with NHS long-term plan ambitions'

What are those 'long term ambitions' and can we be assured that CUH remains firmly committed to face-to-face outpatient consultations with its own senior NHS clinicians and held on CUH premises?

3. *Has CUH received, or managed so far to source, all the PPE that they need? Are they now reliant on centralised procurement outsourced to the private sector? And is that now providing all that is required?*

4. *Please can you explain how day care treatment will be re-started for those patients who have had their treatment cancelled or postponed until further notice, such as various cancer treatments , and day surgery's or treatment for serious conditions i.e. Heart or Lung issues and when this will happen and is there a date for it to commence.*

   Also what on-going contact is being made with patients whose condition could or possibly will deteriorate during the delay, which is in some cases is already three months or more to reassure them as not only do they have the worry of their illness but of covid19.

   Which makes it extremely stressful?

56/20 Date of next meeting

The next Part 1 meeting of the Board of Directors would be held on Wednesday 8 July 2020 at 11.00.

Meeting closed: 12.40

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Board of Directors (Part 1): Action Tracker/Decision Log

Minute Ref	Action	Executive lead	Target date / date on which Board will be informed	Action Status	RAG rating
No outstanding actions					

Key to RAG rating:

1. Red rating: for actions where the date for completion has passed and no action has been taken.
2. Amber rating: for actions started but not complete, actions where the date for completion is in the future, or recurrent actions.
3. Green rating: for actions which have been completed. Green rated actions will be removed from the action tracker following the next meeting, and transferred to the register of completed actions, available from the Assistant Trust Secretary.

Cambridge University Hospitals NHS Foundation Trust

Report to the Board of Directors: 8 July 2020

Agenda item	6
Title	Chair's report
Sponsoring executive director	Mike More, Trust Chair
Author(s)	As above
Purpose	To receive and note the contents of the report.
Previously considered by	n/a

Executive Summary

This paper contains an update on a number of issues pertinent to the work of the Chair.

Related Trust objectives	All Trust objectives.
Risk and Assurance	n/a
Related Assurance Framework Entries	n/a
Legal / Regulatory / Equality, Diversity & Dignity implications?	n/a
How does this report affect environmental Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	n/a

Action required by the Board of Directors

The Board is asked to note the contents of this report.

Cambridge University Hospitals NHS Foundation Trust

8 July 2020

Board of Directors
Chair's report
Mike More

1. Introduction

1.1 This report covers the period since the May 2020 Board meeting.

1.2 All of the comments in my last report remain valid and reports elsewhere on the agenda cover the issues and the complexities of the situation. Once again, it is right for the Board to register our thanks and appreciation for all that colleagues have done and do throughout the Trust, and supported by volunteers, communities and families outside.

2. Update

2.1 It is normal in emergency crises for there to be phases to the event. Usually there is a brief, intense, period of dealing with the immediate manifestation of the crisis, then a recovery phase as you, for example, re-accommodate people who have lost homes in a flood and put systems back; then a period of learning and a return to normal. Most crisis events follow this pattern and most phases are relatively short. There are cases where an emergency has profound societal effects, perhaps the best example being the events in the US in 2001. There are cases where the events need policy solutions to prevent their recurrence.

2.2 This pandemic is more complex. We recognised at the beginning that it was going to be long, not short, and put governance mechanisms in place accordingly. This pandemic does have phases but they are more like the currents and cross currents in the sea, where lots of things are going on at once rather than a straight linear path.

2.3 At the time of writing, we have seen a continuous run over a few weeks of low numbers of presentations of patients suffering from Covid-19 and low numbers of such patients with need for intensive care. The peak was in April, and was lower than our reasonable worst case modelling forced us to prepare for. Which is good. And generally in the East of England, the Covid "R-rate" has been comparatively low and the presentation of the disease flatter than in some other parts of the country.

2.4 However, the virus has not gone away and we are seeing some areas of the country having to talk about specific measures in their area in order to defend against community infection. We are also seeing nervousness and anxiety in many places across the world, about whether measures to emerge out of lockdown have been taken too quickly, with attendant resurgence of the disease. While progress is being made in understanding the disease and in identifying therapeutic treatment, there remains considerable uncertainty about the development of a successful vaccine. Even if such be found, it will not provide a solution in the short term. Will we be faced with an autumn peak? We don't know. Will it be as severe as that already experienced? Most think unlikely but we don't know. If we were, how would we experience that

alongside the period when flu and other respiratory and winter conditions are likely to be more prevalent?

2.5 We are also increasingly recognising that returning services which had been stood down or reduced in the first phase of the pandemic is itself very complex and harder to do. The difficulty arises partly from having to do so while still living with Covid. It arises from the pent-up demand and unmet need, as patients withdrew from treatment. It arises from the very significant challenges in dealing with the backlog of patients who had had treatment deferred in the early stages of the disease and the risk of their deterioration. And it arises from the productivity problems associated from preventing cross-infection between Covid and non-Covid patients.

2.6 For some time, and with significant current focus, the Executive team and the Board are giving a huge amount of attention to this problem. We are aware of the concerns of patients and their families; we are aware of the concerns of clinicians who are anxious to ensure a sustainable return of these important services. I am conscious that Divisional Directors and their teams are working hard, with the Medical Director, the Chief Nurse and the Chief Operating Officer, sometimes with very difficult judgements to make. Many significant changes will be necessary to get the balance right and I recognise that many of these changes are of an order of magnitude different to some of these which we have made before. In addition to the need for specialty-by-specialty conversations about how to optimise services, the Executive Team is also giving a lot of time and thought to how best we organise ourselves to achieve the best possible outcomes.

2.7 The Non-Executive Directors are playing their part by adjusting the agendas of the Board assurance sub-committees so as the proper focus is placed on the appropriate target outcomes and management of hospital operations (Performance Committee); the metrics and risk management to do with patient safety and quality (Quality Committee); the support around use of digital information inside and outside the hospital (Performance and Audit Committees); and the support of the right and optimising workforce strategies (Workforce and Education Committee.) I am confident that the committees will play this role with the appropriate balance of support for our leadership teams in what is a very difficult task and ensuring we achieve the best possible outcomes for patients.

3. Diary

3.1 Since my last report, and in common with many people across the country, I have continued to take part in many meetings virtually. These have included a series of meetings and discussions around the Cambridgeshire and Peterborough STP; meetings with MPs and NHSE/I at regional level; meetings with other colleagues nationally; and many meetings with Executive and Clinical Leaders in the Trust. In addition, there has been a range of useful discussions with the Council of Governors, Cambridge University Health Partners (CUHP) and the University of Cambridge, and campus partners. I have been pleased physically to meet and thank a number of colleagues across the Trust as they have made their contribution to our mission of providing excellent care.

4. Recommendation

4.1 The Board of Directors is asked to note the contents of this report.

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Cambridge University Hospitals NHS Foundation Trust

Report to the Board of Directors: 8 July 2020

Agenda item	8
Title	Report from the Council of Governors
Sponsoring executive director	n/a
Author(s)	Julia Loudon, Lead Governor of the Council of Governors
Purpose	To summarise the activities of the Council of Governors, highlight matters of concern and note successes.
Previously considered by	n/a

Executive Summary

The report summarises the activities of the Council of Governors.

Related Trust objectives	All
Risk and Assurance	n/a
Related Assurance Framework Entries	n/a
Legal / Regulatory / Equality, Diversity & Dignity implications?	n/a
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	n/a

Action required by the Board

The Board is asked to note the activities of the Council of Governors.

Cambridge University Hospitals NHS Foundation Trust

8 July 2020

Board of Directors
Report from the Council of Governors
Julia Loudon, Lead Governor of the Council of Governors

1. Recent and upcoming Governor meetings

1.1 Since the introduction of lockdown in March 2020, all governor meetings have been held remotely by teleconference or Zoom. These have generally been well-attended by governors, NEDs and Executive Directors and have worked as well as possible under the circumstances.

1.2 The quarterly NED/Governor meeting was held by teleconference on 1 April 2020 where topics discussed included:

- Discussion of key Covid-19 related questions raised by governors.
- An update from each of the Board Sub-Committee Chairs on the areas of focus for the Performance, Quality, Workforce and Audit Committees, covering both standard operational activities as well as the impact of the Covid-19 effort on operations, performance, staff, quality of care and financial considerations.

1.3 The quarterly director/governor working groups were combined into a single meeting and held by Zoom on 3 June 2020. Topics discussed included:

- A finance update, including year-end performance and planning for 2020/21. Governors are appreciative of the strong leadership that Paul Scott has brought to both the Finance department at CUH and the STP and wish him well when he moves to his new Chief Executive role.
- An IT update, including the expansion of Electronic Patient Record capabilities to support Covid-19 initiatives.
- A progress report on Major Projects including the Cambridge Children's Hospital, the Cambridge Cancer Research Hospital, Addenbrooke's 3 and proposals for surge capacity to be located on the Cambridge Biomedical Campus.
- An update on Workforce workstreams, including how Covid-19 will impact the workforce strategy themes over the next 12-18 months and beyond. As part of this a Covid-19 survey has been distributed throughout the Trust and the collated results will help shape future working arrangements at CUH. It was noted that recruitment has continued, with high interest in HCA roles, perhaps reflecting the appreciation given to NHS staff by the public.

1.4 The Governor Strategy Group met with Mike More and the Strategy team on 2 June 2020. The Group was updated on the strategy refresh work being conducted with the Board to take account of the future implications of the pandemic, including the learnings that can be taken from the operational changes that were implemented rapidly in order to be able to cope with Covid-19. An update on the Trust Strategy will be brought to the broader governor meetings in due course.

1.5 In addition to the formal governor meetings, the Chair and Chief Executive provided two governor Covid-19 briefings by teleconference/Zoom. The briefings, which were welcomed and well-received, provided governors with:

- Updates on the status and management of Covid-19 patients within the Trust.
- Activities being undertaken across the range of Covid-19 workstreams.
- Reassurance that the Board was already considering support, activities and strategic changes that will be required to manage patient treatment going forward to effectively manage both Covid and non-Covid patients.

1.6 The Board sub-committee meetings have continued to schedule (via Zoom), with governor observers. Agendas have been shaped to focus on priority topics, both Covid and non-Covid related, to ensure that all aspects of Trust governance continue.

1.7 The majority of the range of other Trust committees attended by governors has been cancelled during the pandemic. One exception is the Joint Drugs and Therapeutics Committee, which has continued to meet on a monthly basis (most participants connecting remotely) to deal with the high number of new policies and procedures needed to manage medicine supply during the Covid-19 pandemic. The committee has considered changes to treatment plans, extension of medicine expiry dates (where necessary and possible), provision of medicines to partners supporting the work of the Trust outside the main hospitals (e.g. work being undertaken by the Nuffield and Spire Hospitals).

1.8 The next quarterly NED/governor meeting is scheduled for 1 July 2020. At the meeting governors will seek the NEDs' perspectives on:

- Process for the re-introduction of routine services.
- How they can help assure that beneficial changes made in the Trust's operational practices in order to manage the Covid pandemic are retained and built on as the Trust plans for the future.

1.9 The next Director/Governor Working Group meetings are scheduled for 2 September 2020.

2. Other Governor activities

2.1 The proposal raised at the March 2020 Council of Governors meeting - that (i) the 2020 Governor elections due to take place in May 2020 be postponed due to the focus on coronavirus until such elections could reasonably be held, up to a maximum of 1 year, and (ii) for continuity purposes, that the tenure of the Lead Governor be extended until governor elections can be scheduled, up to a maximum of 1 year - was formally approved at the April 2020 Board meeting.

2.2 On 10 June 2020 I attended the quarterly *Regional Meeting of Lead Governors*. This group involves Lead Governors from trusts across Bedfordshire, Hertfordshire, Cambridgeshire and Peterborough, Norfolk & Suffolk and Essex, and discusses topics of common interest. This meeting was held via Microsoft Teams and proved to be an effective way to involve Lead Governors from right across the region (14 trusts participated). Topics discussed included:

- How the different trusts were managing governor communications and governor meetings. In general, trusts were making strong efforts to maintain governor involvement and continue to run meetings remotely. Those trusts who involve governors in the Board sub-committees were continuing to do this during the period.
- How governors can continue to hold the NEDs to account during this period.
- Disruption to planned Governor elections as a result of Covid-19 and how each Trust was handling this.
- New governor training.

2.3 The annual NHS Providers Governors conference, normally held in London in May, has been postponed until November. In the meantime, NHS Providers has scheduled a 'virtual' governor workshop for several dates. Julia Loudon and David Dean will attend the 30 July session.

3. Recommendations

3.1 The Board of Directors is asked to note the activities of the Council of Governors.

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Report to the Board of Directors: 8 July 2020

Agenda item	8
Title	Chief Executive's report
Sponsoring executive director	Roland Sinker, Chief Executive
Author(s)	As above
Purpose	To receive and note the contents of the report.
Previously considered by	n/a

Executive Summary

This month's Chief Executive's report is intended to provide assurance to the Board of Directors on the Trust's approach to the COVID-19 pandemic, in terms of a summary of core performance, phases 1 and 2 of the Trust's response and planning for sustainability over the next 18 months and beyond.

The update should be seen alongside regular updates to Board members from the Trust Chair who has provided non-executive oversight and input into the bi-weekly Management Executive meetings which are accountable for the Trust response. The Board assurance committees, particularly Quality and Performance, have also had the opportunity to discuss the Trust response in greater detail over recent weeks.

Related Trust objectives	All Trust objectives
Risk and Assurance	A number of items within the report relate to risk and assurance.
Related Assurance Framework Entries	A number of items covered within the report relate to Board Assurance Framework entries.
Regulatory / Equality, Diversity & Dignity implications?	n/a
does this report affect environmental Sustainability?	n/a
his report reference the Trust's values of "Together: safe, kind and excellent"?	n/a

Action required by the Board of Directors

The Board is asked to note the contents of the report.

Cambridge University Hospitals NHS Foundation Trust

8 July 2020

Board of Directors
Chief Executive's report
Roland Sinker

1. Introduction

1.1 The Chief Executive's report is evolving. Part A provides the Board of Directors with a Board update on the five domains of operational performance, not just data we would traditionally report on. Part B of the report articulates the Trust's planned approach for the next 18 months.

PART A

2. Operational areas in summary

2.1 Quality

2.1.1 The Trust remains focused on working with patients and staff to improve quality. During the past month, a number of areas of the quality agenda have been raised to Management Executive for discussion and action. A summary of these are presented below.

2.2 Management of non-Covid-19 activity

2.2.1 The number of patients who are waiting to be seen for assessment, diagnostics or treatment has increased in the past months as the Trust has focused its resources on managing the care of patients with suspected or confirmed Covid-19 diagnoses, as well as patients attending the hospital through our emergency pathways. As we now re-open our elective care pathways it is clear that a significant number of actions are required to prioritise care for our patient populations. Work is underway which focuses on three key areas:

- Ensuring that patients are risk assessed to ensure that those at greatest need of services are prioritised in the coming weeks and months, and that we have sufficient resource available to support our clinical teams in achieving this.
- That capacity is maximised to ensure that as many patients as possible are seen and treated, while ensuring appropriate infection control measures are in place
- That there are robust communication pathways in place that support our staff in managing patient expectations during this unique time as well as clear guidance as to how we keep our patients and their families informed in respect of their care pathways.

2.3 Sepsis/deteriorating patients

2.3.1 This safety improvement workstream is being reenergised, with quality improvement support to assist our teams in delivering care for our patients in accordance with national and international best practice standards.

2.4 Quality metrics

2.4.1 As part of business as usual and the restart of usual governance processes, the quality metrics which feature in the monthly Executive Divisional Performance meeting templates have been reviewed. This will enhance the rigour of challenge within the Trust, ensuring that the key aspects of care delivery are being provided to the expected high standard, with any areas of shortfall challenged and support offered to improve quality where required.

2.5 Patient testing

2.5.1 A combination of near patient testing with SAMBA machines and high volume testing through Public Health England has been developed which enables rapid identification of Covid positive patients. All patients are retested following seven days as an inpatient and prior to discharge to any residential care setting. We have also introduced antibody testing for patients in CUH.

2.6 Staff testing

2.6.1 Working with the University of Cambridge, we have developed capacity to test 300 symptomatic and asymptomatic staff members each day. This has enabled us to identify positive staff members quickly, minimise outbreaks and improve infection control measures across the Trust. We have commenced antibody testing in staff groups.

2.7 Personal Protective Equipment (PPE)

2.7.1 From the outset it has been a key priority to ensure there has been adequate PPE for all staff groups within the hospital. This has required continued and constant engagement with regional and national procurement and leadership teams to maintain the flow of PPE that meets the needs of staff at CUH. An extensive governance framework has been developed to fully capture current and evolving risks as well provide assurance to the Board around key areas including, but not limited, to fit testing, differential use of PPE across surgical settings and the introduction of face masks in all areas of the hospitals.

3. Performance

3.1 Emergency Department (ED)

3.1.1 Attendances in the Emergency Department decreased from 10,788 in May 2019 to 7,505 in May 2020. This is equivalent to a fall in average daily attendances from 348 to 242. Despite this reduction, the recent trend of attendances continues to show a week-on-week increase during June. Emergency admissions have also risen and now stand at 93% of baseline levels as at week ending 21 June 2020.

3.2 Referral to Treatment (RTT)

3.2.1 Since the onset of the Covid pandemic, the number of patients joining the RTT waiting list has reduced significantly. However, the most recent data for June shows referrals are up to 60% of the pre-Covid baseline. The total waiting list size is no longer reducing as had been seen for the previous three months. Non-essential elective activity in the Trust has also been reduced, and treatments in May remained at just 47% of the average volume. Our sustainability taskforces are working on phased plans to recover the pre-Covid activity levels while continuing to keep patients and staff safe with the required infection prevention and control measures (see later in the report).

3.3 Delayed Transfers of Care (DTOC)

3.3.1 From April the Trust received a directive to stop national reporting of DTOC for three months. This has temporarily been replaced with a daily discharge situation report. The Trust has agreed to continue to internally record DTOC with the same principles as pre-Covid to enable comparative measure of data throughout this period. We are anticipating an update from NHS England and NHS Improvement over the coming weeks.

3.4 Impact of Covid-19 on Cancer

3.4.1 There has been a national focus to encourage patients to present as normal with health concerns. In response the Trust has seen the volume of two week wait suspected cancer referrals rising again and are now back to 80% of the normal referral volume.

3.4.2 The total number of patients being monitored against the 62 days standard has been fairly stable over the past four weeks indicating that we are managing to progress the pathways to meet the rising referral demand. The number of patients waiting for treatment longer than 31 days has continued to reduce over the last month.

3.4.3 The increase for treatment delays continues to be most significant in Urology surgery for both Prostate and Kidney cancer. These cases are undergoing risk stratification and are being presented weekly to the Surgery Prioritisation Panel where they are clinically assessed. An options appraisal to consider how to recommend Robotic Prostatectomy is being considered and the Cancer Alliance has commenced further discussion on the concept of Surgical Hubs for the region. Additional elective theatre capacity at CUH will be dependent on the de-escalation of PPE requirements and physical capacity. The Sustainability taskforces are looking to greatly increase this (see later in the report).

3.5 Operations

3.5.1 Surgical activity continues to be one of the greatest challenges resulting from the Covid pandemic. Non-elective/emergency theatre activity has been stable since mid-May at 79% of previous volumes, utilising a greater proportion of theatre sessions due to the required infection control measures. Elective operating has reached 31% of pre-Covid volumes, 42% of which we are delivering with the support of the independent sector national NHS contract. This is an ongoing requirement throughout 2020/21. The CUH elective activity

alone is only at 18% of pre-Covid levels. The greatest barrier to increasing activity remains the requirements for PPE.

3.6 Diagnostics

3.6.1 Scheduled diagnostic activity in May started to show small signs of recovery but remained significantly reduced. Looking forward in June there is greater progress, with Imaging forecasting to deliver 50% of pre-Covid activity levels. The consequence of the reduced activity is that diagnostic waiting lists continue to increase.

3.7 Outpatients

3.7.1 Access to Outpatients continued to be restricted through May with urgent referrals only available through the Advice and Guidance route within the national NHS England referral service. Routine referral pathways began a phased opening from 15 June and in most recent weeks referrals are at 60% of pre-Covid levels. The Trust is now delivering 75% of pre-Covid attendances. We are maintaining 50% of outpatient attendances on a virtual baiss. The primary concern in Outpatients is physical capacity. A significant amount of footfall has been lost due to social distancing requirements and in addition a number of clinics have been repurposed for other services during the crisis.

4. Finance

4.1 **The year to date position is on plan and breakeven.** Due to Covid-19 the financial framework for the NHS has been reset until at least the end of July 2020 with baseline and Covid costs fully reimbursed by a top up process. Some form of this is expected to be in place for the remainder of the financial year. We are, therefore, expecting to remain in a breakeven position for the 2020/21 financial year.

4.2 **Capital funding is still being finalised**, however we expect to deploy capital of at least £28m in 2020/21. Year to date we have spent £1m.

5. Staff

5.1 Vacancy rate

5.1.1 The Healthcare Support Worker vacancy rate for June was 16.74%. The Registered Nurse vacancy rate for June was 6.57%.

5.2 Covid-related staff absence

5.2.1 Both the number of staff self-isolating and the number of Covid-related sickness absence recorded continues to decrease and remains below the average for the Covid-19 period. As of 20 June 2020, 521 staff are self-isolating which is below the average of 607 for the last four months. Covid-related sickness absence currently accounts for 17% of the total sickness absence recorded within the Trust. This is a decrease from a 33% peak recorded during March. Overall, 7% of staff are absent from work due to Covid-related sickness or self-isolation.

5.3 Equality, Diversity and Inclusion

5.3.1 It is now well known that Covid-19 disproportionately affects individuals from a Black, Asian and Minority Ethnic (BAME) background. In response the Trust has established a BAME Staff Health Taskforce, a multidisciplinary group, which is focusing on three priority areas:

- Communication and engagement
- Risk assessment and management of workplace health
- Data intelligence gathering and monitoring

5.3.2 A revised staff risk assessment has launched to include ethnicity, alongside intelligence gathering on sickness, staff testing and staff profiles of those working in clinical areas.

5.3.3 Virtual BAME staff network wellbeing meetings have been taking place regularly for BAME staff to share their experiences of working during this time and to ensure we remain responsive and able to provide support.

5.3.4 The Trust has a dedicated area on the CUH Staff Portal for all information related to supporting our BAME staff members. There is a range of resources and further reading for all staff on how to be an ally to our BAME colleagues at CUH and to the broader Black Lives Matter movement.

5.3.5 Other staff networks including The Purple Network, LGBT+ staff, "It's Not Just You" staff mental health support are meeting virtually.

5.4 Staff engagement update

5.4.1 A short staff survey was launched on 18 May. The response rate to the survey was 34% (3,700 staff). The purpose was to understand staff experience of the Covid-19 pandemic, including safety, health and wellbeing and how supported staff have felt during this time. The survey has been analysed by ethnicity as well as other protected characteristics under the Equality Act 2010, to better understand the experience of different groups working across the Trust during the Covid-19 response.

5.4.2 Results from the survey highlight positive views regarding providing the best possible patient care, escalating concerns, communication and team work. Opportunities for improvement centre on working from home, supporting staff health and wellbeing and valuing contributions. The data highlights the difference in experience for BAME compared with White staff, and those who are disabled compared with non-disabled. The results also point to a variance in feeling secure to raise concerns across a number of categories, for example, staff group, division and pay band.

5.4.3 The results are being used as part of the wider CUH Reflects listening piece with a view that the information can inform and leverage the necessary changes required as the Trust moves forward. Further details of the survey results are appended to the separate paper on the agenda relating to the refresh of the Trust strategy.

5.5 Employee support

5.5.1 A wide range of employee support was quickly established during phase 1 of the pandemic. This included a comprehensive Trust-wide employee health and wellbeing package, a joint provision delivered by CUH and Cambridgeshire and Peterborough NHS Foundation Trust. Our employee offer also included the creation of 'The Sanctuary' and the provision of emergency accommodation, taxis and free/reduced rate food.

6. Improvement and transformation

6.1 A key strand of the Trust's strategy refresh is to embed a culture of sustainable continuous improvement across our 11,000 staff, in order to improve patient outcomes, patient and staff experience and value. By doing so, this will contribute to the sustainability of the Cambridgeshire and Peterborough healthcare system. In light of the Covid-19 pandemic, the improvement and transformation team are supporting colleagues from across the Trust in relation to the taskforces, in particular urgent and emergency care, outpatients and surgery and critical care. A crucial part of this work is to ensure that we keep our patients and staff as safe as possible, as well as improving outcomes, experience and value.

6.2 As part of the Trust's CUH Reflects exercise in May 2020, to reflect and learn from the Covid-19 crisis, the improvement and transformation team undertook a learning together exercise with staff to understand what contributed to the successful implementation of the supporting changes in relation to the pandemic. The key factors from this exercise will be factored, as appropriate, into our ongoing improvement work moving forward.

PART B

7. Strategy Update (this is covered in more detail in agenda item 'Refreshing our Strategy in response to Covid-19').

7.1 Context

7.1.1 At the outset of the Covid major incident, the Management Executive and the Board of Directors agreed a clear Trust strategy for the first phase of the response. The primary objectives were to maximise the number of lives saved and provide care to both Covid and non-Covid patients, while maintaining the safety and welfare of staff. These two primary objectives have guided all aspects of our response. With the support of the Trust's taskforces, this has worked well.

7.1.2 While our long-term strategy remains firmly in place, a plan has been developed to provide a clear focus and set of priorities to guide us through the uncertainties of the next 18 months. This plan takes account of staff feedback from the recent Covid Staff Survey, our CUH Reflects exercise and the refreshed activity model.

7.2 Strategy refresh

7.2.1 In response to the Covid-19 pandemic and to facilitate the move towards recovery and 'business as usual', we have been refreshing our strategy and

modelling demand and activity for the next few months. Our 18 month plan has three priorities:

- Improving patient care
- Supporting our staff
- Building for the future

7.3 The Trust's nine key objectives for the next 18 months

Improving patient care

1. Safely restore all the services we provide both as a local hospital and a specialist teaching hospital for the East of England, and prioritise those patients with greatest clinical need in reducing waiting lists.
2. Work with our partners to maximise our capacity to treat both Covid and non-Covid patients in hospital and in the community, enabled by technology.
3. Provide consistently high standards of patient care and experience in and outside the hospital using agreed clinical standards and protocols, embedding a culture of sustainable continuous improvement, and maintaining a safe environment.

Supporting our staff

4. Ensure that we have sufficient numbers of appropriately skilled and trained staff to deliver our plans now and in the future.
5. Provide a comprehensive package of support to keep our staff safe, engaged, healthy and able do their jobs to the best of their abilities.
6. Develop further actions to achieve greater equality and diversity in the CUH family across all the protected characteristics.

Building for the future

7. Develop and secure national support for the next major stages of the business cases for the Cambridge Children's Hospital and Addenbrooke's 3.
8. Develop an Integrated Care System across Cambridgeshire and Peterborough that improves our population's health, outcomes and experience within the available resources.
9. Play a leading role with partners on the Cambridge Biomedical Campus in the national Covid-19 research effort and powering economic growth through life sciences.

7.4 Improving patient care

7.4.1 CUH is maximising capacity to provide the highest quality services to patients with and without Covid. We have created Covid and non-Covid areas within our hospitals including ring-fenced Green Addenbrooke's Treatment Centre (ATC) elective and non-elective surgery capacity, and flexible and dynamic capacity for Red and Amber activity. A Covid Configuration Bed Plan was implemented in June and a further reconfiguration of beds is planned for the autumn to prepare for winter pressures. A framework has been developed to clinically prioritise service delivery 'switch on'; and an improvement programme is being implemented to maximise theatre utilisation on site and in the independent sector.

7.4.2 The Trust is collaborating with health and care partners across Cambridgeshire and Peterborough to provide the right care to the right patients in the right place at the right time, using technology wherever possible to increase access for patients and productivity for staff:

- We have provided support to nursing homes, e.g. for testing.
- We are participating in the system's Phase 3 recovery groups, e.g. Recovery Oversight Group, Recovery Taskforce Groups, Joint Clinical Group.
- Our Outpatient Sustainability Taskforce includes multi-agency system partners; more work is planned with Primary Care Networks to deliver a sustainable integrated outpatient model.
- We have developed a new Clinical Assessment Service and introduced Advice and Guidance for all specialties.
- We are reconfiguring our Urgent and Emergency Care pathways to direct demand pre-hospital, stream patients to the right place at the right time, and improve patient flow.
- We have successfully implemented telephone clinics for outpatients (45% for new patients and 61% for follow-ups).

7.4.3 Plans for a Regional Surge Centre are being developed to provide specialist Covid-19 services across the East of England and lead a regional critical care network for the sickest patients.

7.4.4 As a Trust we are ensuring patient safety in and outside the hospital through consistent deployment and embedding of agreed clinical standards and protocols. Rapid Equality Impact Assessments have been introduced and there is a continued focus on embedding the fundamentals of care through consistent deployment of agreed clinical protocols.

7.4.5 We are embedding a culture of sustainable continuous improvement, to improve patient outcomes, patient and staff experience and value, contributing to the sustainability of the Cambridgeshire and Peterborough healthcare system.

7.5 Supporting our staff

7.5.1 Please see section 5 earlier in the report.

7.6 Building for the future

7.6.1 CUH is working with patients to design and build three new hospitals, and maintain a fit for purpose estate, to improve outcomes locally and regionally, and enhance the research and life sciences ecosystem in Cambridge. Work on the development of Addenbrooke's 3 has recommenced, with strong engagement with our clinical teams to design services fit for the coming decades, and with regional and national teams to expedite the business case process. The Cambridge Children's Strategic Outline Case has been approved, and we are commencing work on the Outline Business Case.

7.6.2 We are working to develop an Integrated Care System, jointly accountable with partners across health and care for improving our population's health and wellbeing, outcomes and experience by making the best use of our collective resources. The system strategy has been updated to focus on tackling health and health care inequalities; the South Provider Alliance is coordinating a range

of work to recover and restart services; and the Trust has identified the need to rearticulate the vision to become an ICS by April 2021, in line with the national Long Term Plan ambitions.

7.6.3 CUH continues to work with partners to enhance the Cambridge Biomedical Campus's contribution to the life sciences sector, developing new forms of disease prevention, detection and treatment and powering economic growth regionally, nationally and internationally. We are engaged in research programmes to improve outcomes for Covid patients or prevent transmission of the disease; and we have hugely expanded Covid testing capacity and reduced turnaround times, including through joint work with AstraZeneca and the University of Cambridge.

7.6.4 CUH continues to collaborate with Royal Papworth Hospital to maximise benefits for patients, including improvements in patient pathways and associated clinical support services, as well as leading the regional critical care network across the East of England.

7.7 Taskforces and Business as Usual

7.7.1 In order to deliver these priorities and objectives we have, over the last three months, established a number of taskforces to respond to particular challenges and risks, including around the re-introduction and management of sustainable clinical services. Now, as we finalise our Phase 2 response to Covid and plan for the third phase of recovery and business as usual, we have focused on eight taskforces, with associated workstreams. These eight taskforces, each led by an Executive Director with senior colleagues, are:

- Surgery and Critical Care
- Outpatients and Diagnostics
- Primary and Community Care
- Cohorting and Configuration
- Urgent and Emergency Care
- COVID Secure Environment
- Respiratory Protective Equipment
- Testing

7.7.2 Business as Usual priorities across all departments for the next 12-18 months are committed to providing a safe, effective and high quality environment for the delivery of healthcare.

7.8 STP Recovery Plan

7.8.1 CUH, along with all system partners, contributed to the STP Covid-19 Recovery Plan submission on 18 June 2020, ahead of a national focus meeting on 24 June 2020. This is the latest iteration of the work STPs have already done as part of their ongoing work on recovery and transformation. The Recovery Plan spans the period between August 2020 and March 2021 and focuses on refining the local and regional understanding of capacity, constraints and options to bridge gaps between supply and demand, covering Phase 2 (stepping up non-Covid urgent services) and Phase 3 of our recovery programme.

8. Other areas

8.1 21 applications across the range of Health Data Research (HDR) UK activities were submitted for the HDR UK Team of the Year Award in June 2020. This award celebrates collaborative endeavours by groups of researchers, innovators and technologists working together within the HDR UK. The Trust is delighted that the overall winner of the HDRUK Team of the Year Award went to John Bradley and the Rare Diseases Sprint Exemplar Project Team.

8.2 The Trust is underway with the recruitment process for the new Chief Finance Office and the Cambridgeshire and Peterborough STP Executive Director.

9. Recommendation

9.1 The Board of Directors is asked to note the contents of the report.

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Cambridge University Hospitals NHS Foundation Trust

Report to the Board of Directors: 8 July 2020

Agenda item	9
Title	Integrated Report
Sponsoring executive director	Chief Operating Officer, Chief Nurse, Medical Director, Director of Workforce, Chief Finance Officer
Author(s)	As above
Purpose	To update the Trust Board on performance during May 2020.
Previously considered by	Performance Committee, 1 July 2020

Executive Summary

The Integrated Report provides details of performance to the end of May 2020 across quality, access standards, workforce and finance. It provides a breakdown where applicable of performance by clinical division and corporate directorate and summarises key actions being taken to recover or improve performance in these areas.

Related Trust objectives	All objectives
Risk and Assurance	The report provides assurance on performance during Month 2.
Related Assurance Framework Entries	BAF ref: 001, 002, 004, 010
Legal implications/Regulatory requirements	n/a
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	n/a

Action required by the Board of Directors

The Board is asked to note the Integrated Report for May 2020.

NHS
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Integrated Report

Quality, Performance, Finance and Workforce

to end May 2020

Chief Financial Officer
Chief Nurse
Chief Operating Officer
Director of Workforce
Medical Director

Report compiled: 30/06/2020

Contents

NHS
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Overall reporting

Key

Data variation indicators

Normal variance - all points within control limits

Negative special cause variation above the mean

Negative special cause variation below the mean

Positive special cause variation above the mean

Positive special cause variation below the mean

Rule trigger indicators

SP	One or more data points outside the control limits
R7	Run of 7 consecutive points; H = increasing, L = decreasing
S7	shift of 7 consecutive points above or below the mean; H = above, L = below

Target status indicators

Target has been and statistically is consistently likely to be achieved

Target failed and statistically will consistently not be achieved

Target falls within control limits and will acheieve and fail at random

Owner(s): Nicola Ayton, Paul Scott, Ashley Shaw, Lorraine Szeremeta, David Wherrett

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Quality Account Measures

NHS Cambridge University Hospitals NHS Foundation Trust

2019/20 Performance Framework

2020/21 Quality Account Measures

Domain	Indicator	Data to	Target	Mar 20 Previous Month-1	Apr 20 Previous Month	May 20 Current status	Trend	FYtD	Baseline	LTM
Safe	>80% of patients are escalated in accordance with the NEWS2 escalation policy in order to meet the quality standard of 90%	May-20	80%	N/A	N/A	0%	▪	0%	0.0%	0%
	>90% of agreed areas complete an observational audit within 12 months from April 2020	Apr-20	90%	N/A	N/A	N/A	▪	N/A	25.0%	N/A
	>90% of Serious Incidents actions meet the quality standard of (>90%)	May-20	90%	N/A	N/A	N/A	▪	N/A	0.0%	N/A
Effective / Responsive	% of early discharges **(existing metric)**	May-20	30%	15.3%	15.6%	14.9%	⇩	15.2%	15.3%	14.7%
	Percentage of in-patient discharges on a Saturday and Sunday compared to the rest of the week (calculated as the average daily discharges on Sat/Sun divided into the average daily discharges Mon-Fri). Excludes day cases.	May-20	80%	53.5%	67.5%	69.3%	⇧	68.5%	68.9%	56.2%
	Same day emergency care (SDEC)	May-20	92%	N/A	N/A	N/A	▪	N/A	19.6%	N/A
Patient Experience / Caring	>90% of actions are completed within the agreed date (Actions from Complaints graded 3 or above)	Mar-20	90%	73.0%	N/A	N/A	▪	N/A	0.0%	73.0%
	>90% of areas (Adult inpatient wards excluding Rosie) access their MES data on a monthly basis	Apr-20	80%	N/A	N/A	N/A	▪	N/A	35%	N/A
				Mar 20	Apr 20	May 20				
	Total complaints responded to within initial set timeframe or by agreed extension date **(existing metric)**	May-20	90%	97.4%	96.8%	100.0%	⇧	97.7%	80.0%	83.7%
				Mar 20	Apr 20	May 20				
Staff Experience / Well-led	Nursing and Midwifery vacancy rate for band 5 nurses **(existing metric)**	May-20	6.6%	6.4%	5.4%	6.7%	⇩	0.0%	6.5%	5.8%
				2016	2017	2018				
	I feel secure about raising concerns re unsafe clinical practice within the organisation. **(existing metric)**		76.0%	75.0%	73.0%	74.0%	⇧		74.0%	
	People saying ' my appraisal helped me to improve how I do my job' **(existing metric)**		28.0%	22.0%	24.0%	26.0%	⇧		26.0%	

The Deteriorating Patient and Sepsis workstreams have recommenced in June to ensure robust support is in place for clinical teams to meet the required standards for NEWS2 compliance. It is expected that performance will improve in the coming months.

Quality Summary Indicators

NHS Cambridge University Hospitals NHS Foundation Trust

2019/20 Performance Framework

2019/20 Performance Framework - Quality Indicators				Mar 20	Apr 20	May 20				
Domain	Indicator	Data to	Target	Previous Month-1	Previous Month	Current status	Trend	FYtD	Previous FYR	LTM
Infection Control	MRSA Bacteraemia (avoidable hospital onset cases)	May-20	0	1	0	0	⇔	0	3	2
	E.Coli Bacteraemias (Total Cases)	May-20	50%over 3 years	34	19	27	⇩	46	406	391
	C. difficile Infection (hospital onset and COHA* avoidable)	May-20	TBC	8	4	3	⇧	7	N/A	N/A
	Hand Hygiene Compliance	May-20	TBC	97.70%	97.98%	97.17%	⇩	97.6%	96.4%	96.5%
Clinical Effectiveness	% of NICE Technology Appraisals on Trust formulary within three months. ('last month')	May-20	100%	44.4%	50.0%	14.3%	⇩	30.8%	38.6%	35.9%
	% of relevant NICE recommendations recorded as met in the returned baseline assessment. ('last month')	May-20	85%	0.0%	0.0%	-	▪	0.0%	77.3%	75.2%
	% of NICE quality standards where the gap analysis was returned in line with the NICE policy. ('last month')	May-20	100%	N/A	N/A	N/A	⇔	-	28.6%	28.6%
	% of data submitted to national clinical audits (rolling YTD) Target is 100% at FYR end	May-20	100%	N/A	N/A	N/A	⇔	-	-	-
	% of national clinical audits with an action plan in place at 12 weeks post publication (last month)	May-20	100%	50.0%	0.0%	N/A	⇧	0.0%	24.6%	21.4%
	% of national clinical audits with completed recommendations (last month)	May-20	100%	60.0%	28.6%	N/A	⇧	28.6%	75.0%	70.4%
	% of external reviews where action plan was either overdue or no date for completion was provided	May-20	10%	73.7%	40.0%	42.9%	⇧	41.7%	39.5%	43.6%
Nursing Quality Metrics	Blood Administration Patient Scanning	May-20	90%	99.2%	98.9%	99.5%	⇧	99.3%	99.3%	99.4%
	Care Plan Notes	May-20	90%	96.3%	97.0%	96.9%	⇩	96.9%	95.2%	95.4%
	Care Plan Presence	May-20	90%	98.9%	99.7%	99.7%	⇩	99.7%	98.2%	98.5%
	Falls Risk Assessment	Data reported in slides								
	Moving & Handling	May-20	90%	77.4%	73.6%	77.6%	⇧	75.8%	76.4%	76.2%
	Nurse Rounding	May-20	90%	99.7%	99.7%	99.9%	⇧	99.8%	99.7%	99.7%
	Nutrition Screening	May-20	90%	78.8%	76.8%	82.5%	⇧	80.1%	80.1%	79.9%
	Pain Score	May-20	90%	88.6%	87.3%	88.4%	⇧	87.9%	88.1%	88.3%
	Pressure Ulcer Screening	Data reported in slides								
	EWS									
	MEOWS Score Recording	May-20	90%	72.6%	75.5%	71.1%	⇩	73.2%	94.8%	92.0%
	PEWS Score Recording	May-20	90%	97.0%	98.2%	98.3%	⇧	98.3%	97.7%	97.7%
	NEWS Score Recording	May-20	90%	96.7%	94.9%	96.1%	⇧	95.6%	96.7%	96.7%
	VIP									
	VIP Score Recording (1 per day)	May-20	90%	93.1%	95.1%	95.2%	⇧	95.2%	93.3%	93.5%
	PIP Score Recording (1 per day)	May-20	90%	91.1%	93.1%	90.5%	⇩	91.8%	87.5%	87.3%
Patient Experience	Mixed sex accommodation breaches	May-20	0	0	0	0	⇩	0	16	14
	Number of overdue complaints	May-20	0	2	1	0	⇩	1	109	103
	Re-opened complaints (non PHSO)	May-20	N/A	11	4	4	⇩	8	103	99
	Re-opened complaints (PHSO)	May-20	N/A	0	0	0	⇩	0	4	4
				Mar 20	Apr 20	May 20				
	Number of medium/high level complaints	May-20	N/A	11	12	7	⇩	19		169

Operational Performance

NHS Cambridge University Hospitals NHS Foundation Trust

2019/20 Performance Framework

Taskforce	Indicator	Data range	Period	Previous period	Current period	Baseline (mean Apr19-Feb20)	performance to baseline (#)	% var to baseline (activity shown as %	Variance	Special causes	Comments
Cohorting and Configuration	Long stay patients (>21 LoS)	07/04/19 - 14/06/20	Week ending	112	111	171	-60	-35%	L	SP	Long stay patients are currently 35% below baseline levels at 111.
	Discharge lounge usage	07/04/19 - 14/06/20	Week ending	15	20	87	-67	-77%	L	SP	Discharge lounge usage is 77% below baseline levels. It should be noted that the discharge lounge now has a maximum occupancy of 5 (compared to 13 in the baseline period) due to social distancing requirements, which reduces its capacity.
	Discharges before noon	07/04/19 - 14/06/20	Week ending	11%	12%	15%	-3%	-	L	S7	Discharges before noon are 12%, which is lower than baseline levels of 15%.
	Weekend discharge rate	07/04/19 - 14/06/20	Week ending	67%	66%	68%	-1%	-		-	The weekend discharge rate is flat compared to baseline.
Urgent and Emergency Care	Non-elective admissions	07/04/19 - 14/06/20	Week ending	770	722	907	-185	80%	L	SP	Non-elective admissions have reduced by 48 week-on-week and are at 80% of baseline levels.
	Admissions via ED (excluding Rosie)	07/04/19 - 14/06/20	Week ending	514	592	757	-165	78%	L	SP	Admissions via ED have increased by 78 week-on-week are at 78% of baseline levels.
	ED attendances	07/04/19 - 14/06/20	Week ending	1747	1753	2459	-706	71%	L	SP	ED attendances are flat week-on-week and are now 71% of baseline.
	12hr waits in ED	26/05/19 - 14/06/20	Week ending	2	0	44	-44	100%	L	S7	There were no 12hr waits in ED in the most recent week compared to 14 per week in the baseline period.
	Time to initial medical assessment (mins)	07/04/19 - 14/06/20	Week ending	45	44	89	-45	-51%	L	S7	The average time to initial medical assessment was 44 mins, 45 mins lower than baseline levels of 89 mins.
	Streamed to UTC	07/04/19 - 14/06/20	Week ending	181	182	205	-23	-11%	L	S7	182 patients were streamed to the Urgent Treatment Centre in the most recent week, compared to 205 in the baseline period.
	ED conversion rate	07/04/19 - 14/06/20	Week ending	29%	34%	31%	3%	-		-	The ED conversion rate increased to 34% from baseline levels of 31%.
Critical Care and Elective activity	Elective admissions	07/04/19 - 14/06/20	Week ending	1687	1861	2793	-932	67%	L	SP	Elective admissions increased by 174 week-on-week but are still only 67% of baseline. 42% of elective activity is currently taking place in the independent sector.
	Average theatre turnaround time (mins)	07/04/19 - 14/06/20	Week ending	62	65	18	47	258%	H	SP	Theatre turnaround time was 65 mins, 18 mins higher than baseline. PPE requirements have contributed to this increase.
	Theatre sessions used	07/04/19 - 14/06/20	Week ending	162	180	317	-137	-43%	L	SP	Theatre sessions increased by 18 week-on-week but are still 43% below baseline.
	Total operations performed	07/04/19 - 14/06/20	Week ending	238	249	765	-516	33%	L	SP	Operations performed were at 33% of baseline.

Operational Performance

NHS Cambridge University Hospitals NHS Foundation Trust

2019/20 Performance Framework

Taskforce	Indicator	Data range	Period	Previous period	Current period	Baseline (mean Apr19-Feb20)	performance to baseline (#)	performance to baseline (%)	Variance	Special causes	Comments
Diagnostics	Diagnostic waiting list	07/04/19 - 14/06/20	Week ending	12209	12609	8555	4054	47%	H	SP	The diagnostic waiting list increased by 400 patients week-on-week and is now 47% higher than baseline.
	Diagnostic activity	07/04/19 - 14/06/20	Week ending	1134	1324	3413	-2089	39%	L	SP	Diagnostic activity increased by 190 week-on-week but remains low, at 39% of baseline levels.
	Patients waiting >6 weeks for diagnostic	07/04/19 - 14/06/20	Week ending	8221	8439	75	8364	11152%	H	SP	Diagnostic breaches are now 8,439 compared to baseline levels of 75.
Outpatients	Attendance levels	07/04/19 - 14/06/20	Week ending	7456	7395	9393	-1998	79%	L	S7	Outpatient attendances reached 79% of baseline levels.
	Attendance via phone/video	07/04/19 - 14/06/20	Week ending	5338	5151	244	4907	2011%	H	SP	70% of outpatients appointments are now conducted via phone or video.
	Referral levels	07/04/19 - 14/06/20	Week ending	2246	2571	4509	-1938	57%	L	SP	Referral levels increased by 325 week-on-week, equivalent to 57% of baseline.

			Week on week movement				actuals compared to baseline				
Taskforce	Indicator	Actuals (last 7 days)	Previous week (8-14 days ago)	Var (#)	Var (%)	↑↓	Pre-COVID weekly baseline (Apr 19 - Feb 20)	Var to baseline (#)	% var to baseline (activity shown as % delivery of baseline)	↑↓	Comments
Cross cutting	Cancer 2WW referrals**	389	375	14	4%	N/A	468	-79	83%	N/A	2-week wait referrals for cancer are now at 83% of baseline levels.
	Cancer >31 day waits	74	81	-7	-9%	↓	TBC	-	-	-	Cancer >31 day waits decreased by 7 week-on-week.
	Cancer >62 day waits	186	217	-31	-14%	↓	66	120	182%	↑	Cancer >62 day waits decreased by 31 week-on-week but are 120 above baseline levels of 66.
	Patients waiting 28 days for diagnosis	360	397	-37	-9.3%	↓	203	157	77%	↑	360 patients waited more than 28 days for diagnosis. This is a 77% increase on baseline weekly levels of 203.
RTT	52 weeks waits on RTT pathway (unvalidated)	157	124	33	27.0%	↑	1	156	15600%	↑	Patients waiting >52 weeks on an RTT pathway increased to 157 compared to an average of 1 patient per week in the baseline period.

Serious Incidents

NHS Cambridge University Hospitals NHS Foundation Trust

Safety and Quality

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
Patient Safety Incidents	Jun 17 - May 20	month	-	1043	1357		-	-	There is currently normal variance in the number of incidents affecting patients.
Percentage of moderate and above patient safety incidents	Jan 19 - May 20	month	2%	1.7%	1.4%		-		The number or moderate harm or greater incidents has returned to normal variance in month following an increase during April.
All Serious Incidents	Jun 17 - May 20	month	-	4	6		-	-	There is currently normal variance in the number of serious incidents commissioned with the CCG. In May 2020 there were 4 serious incidents commissioned, details of which can be found in the table below.
Serious Incidents submitted to CCG within 60 working days	Jun 17 - May 20	month	100%	11%	51%		-		There is currently normal variance in the number of SIs being submitted to the CCG within 60 working days and compliance of submitting 100% of SI reports is not improving, however, this does not account for the agreed CCG dates that have been adjusted.

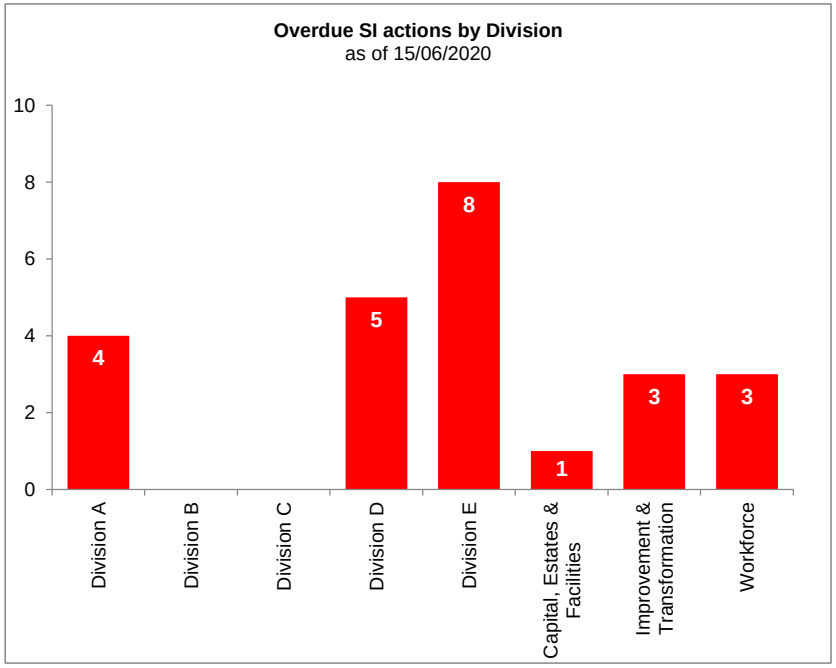
Ref	STEIS SI Sub-category	Actual Impact	Div.	Ward / Dept.
SLR90576	Surgical/invasive procedure	Severe / Major	C	Ward C5
SLR92336	Treatment delay	Moderate	C	ED - Adult
SLR91419	Slips/trips/falls	Severe / Major	D	Ward D7
SLR90586	Maternity/Obstetric incident	No harm	E	Community Maternity

Executive Summary

A total of 1043 patient safety incidents (SLR) occurred in May 2020.

The actual impact was graded as; 85% (887) were graded as no harm, 13% (135) as low harm, 1.4% (15) as moderate harm, 0.2% (2) major harm, 0.1% (1) graded as death.

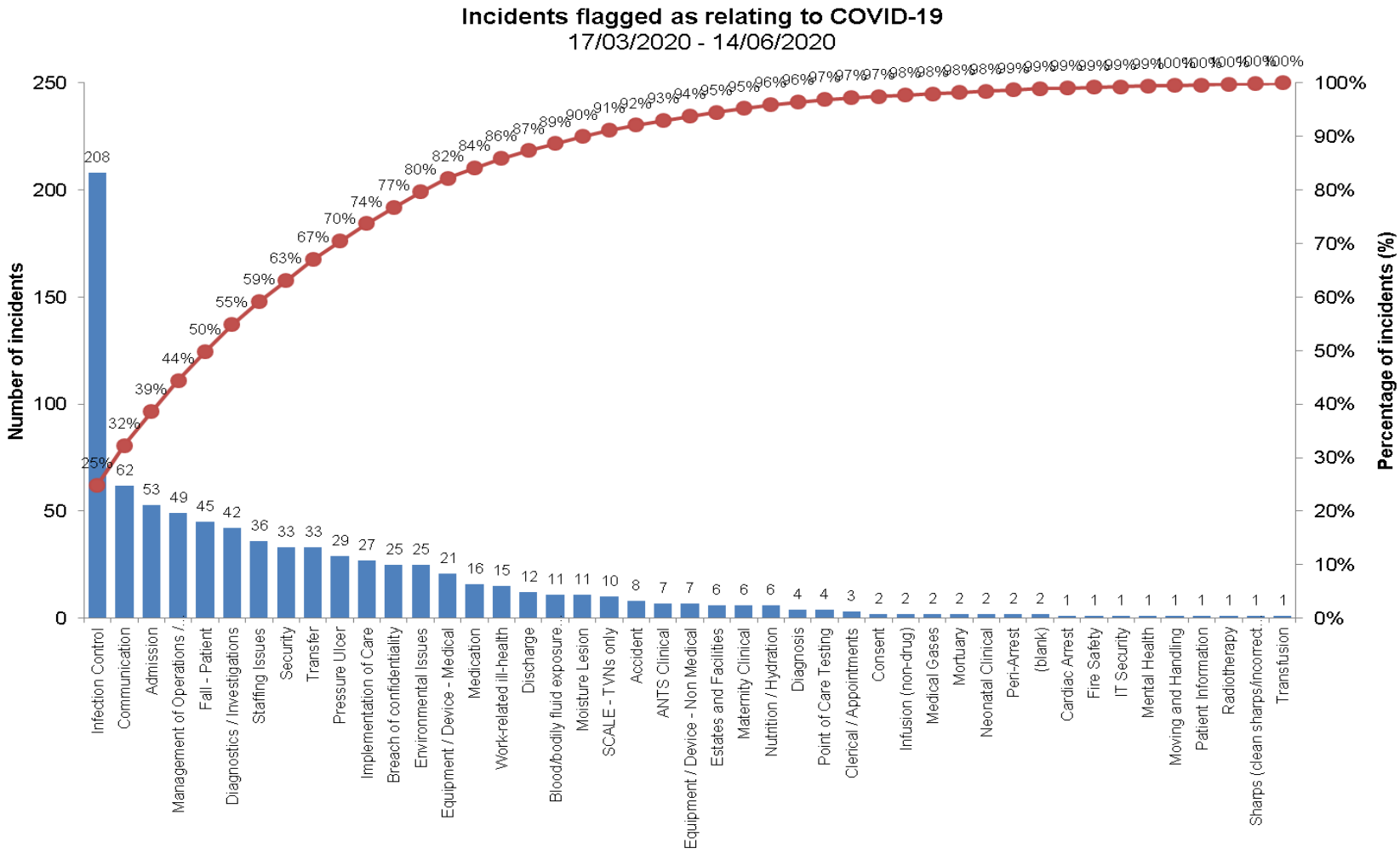
During the COVID-19 pandemic, in conjunction with the CCG, a number of SI investigations are currently paused, thereby resulting in lower compliance with the 60 day standard. The metric above does not account for this agreed activity to be paused, hence the low percentage completion. The Patient Safety Team continues to work with the relevant investigation leads to support completion of investigation as soon as is practically possible and there is a plan in place to complete the investigations, with approximate submission dates.. All families and patient's have been informed on the progress on their investigation.



COVID-19 Incident Analysis
(Past Harm and Anticipation and Preparedness)

NHS
Cambridge University Hospitals
NHS Foundation Trust

Safety and Quality



COVID-19 Incident Analysis
(Past Harm and Anticipation and Preparedness)

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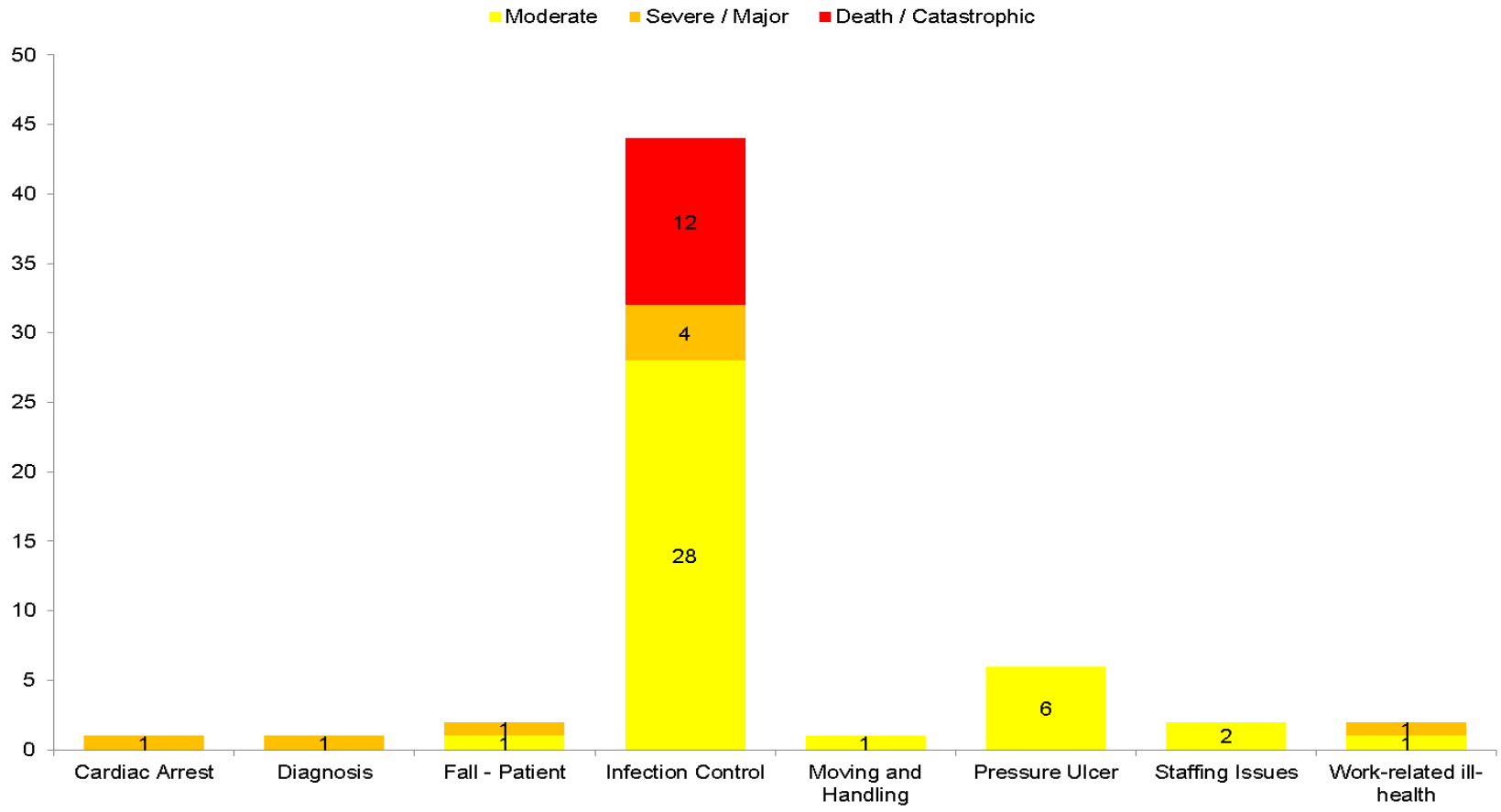
Safety and Quality

Moderate or above harm incidents flagged as relating to COVID-19 by category and actual impact
17/03/2020 - 14/06/2020



Author(s): Patient Safety Improvement Owner(s): Giles Thorpe

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COVID-19 Incident Analysis
(Past Harm and Anticipation and Preparedness)

NHS Cambridge University Hospitals NHS Foundation Trust

Safety and Quality

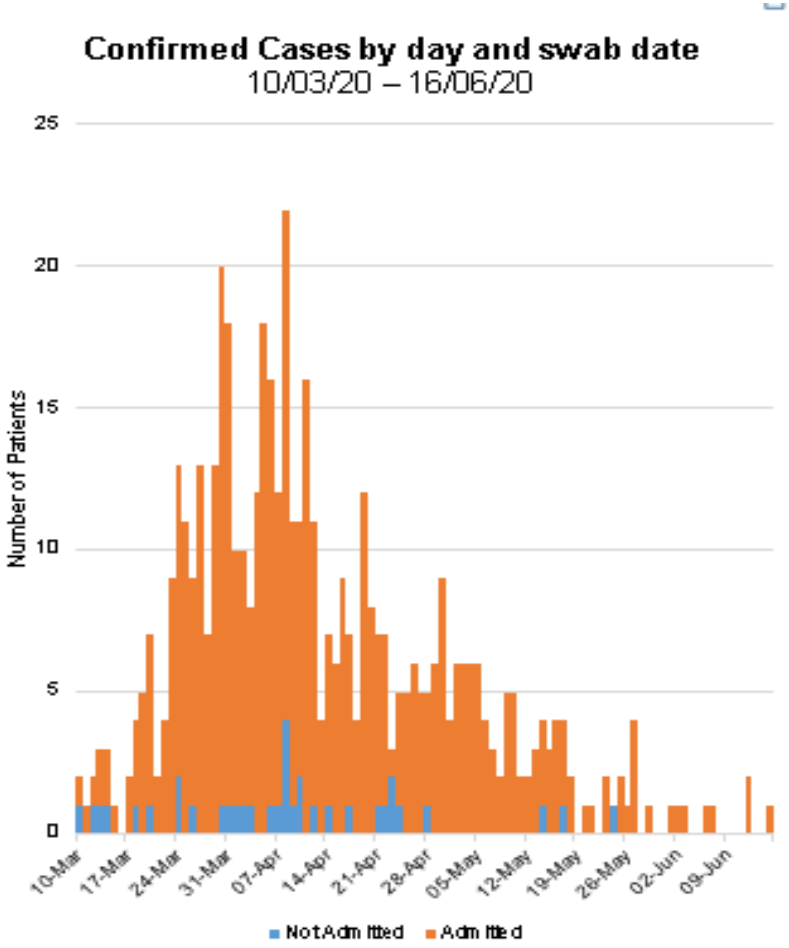
Categories	No Harm	Low / Minor	Mod	Severe / Major	Death / Catast.
Division A					
Infection Control	30	3	8	1	3
Pressure Ulcer	3	8	6		
Management of Operations / Procedures	5	7			
Division B					
Infection Control	26	1	2		
Breach of confidentiality	21				
Diagnostics / Investigations	17	1			
Division C					
Infection Control	55	9	15	3	6
Admission	37	1			
Fall - Patient	23	2	1		
Division D					
Infection Control	18	3	3		3
Management of Operations / Procedures	22	4			
Fall - Patient	8	2		1	
Division E					
Infection Control	14				
Implementation of Care	8	1			
Communication	8				

Sub-categories	No Harm	Low / Minor	Mod	Severe / Major	Death / Catast.
Division A					
Hospital Attributed COVID19	2		8	1	3
Non-compliance with infection control standards/policy	13				
Lack of PPE	8	3			
Division B					
Administration		1			
Appointment Recording Error	1				
Booking In Error	6				
Division C					
Hospital Attributed COVID19	6	8	12	3	6
More than 60 minutes for Ambulance Handover	19				
Non-compliance with infection control standards/policy	18	1			
Division D					
RTT 52 week breach	21	4			
Hospital Attributed COVID19	4	2	3		3
Inappropriate Admission	5				
Division E					
Communication Failure across Team(s)	7				
RTT 52 week breach	7				
Non adherence to PPE guidance	6				

COVID-19 Incident Analysis
(Past Harm and Anticipation and Preparedness)

NHS
Cambridge University Hospitals
NHS Foundation Trust

Safety and Quality



Patients discharged from ED/N2 (n=49)*
*Further 7 patients swabbed only in outpatient settings

Age, mean (range) median (IQR)	66 (0-98) 70 (55-82)
Paediatric (age <18 yrs)	14 (3%)
Male gender (%)	282 (60%)
Female gender (%)	191 (40%)
Ethnicity – White	346 (73%)
Ethnicity – Black, Asian and minority ethnic	35 (7%)
Ethnicity – missing/not stated	92 (19%)
LOS* (days), mean (range) median (IQR)	10.2 (0.3-62.6) 7.0 (2.4-14.8)

All Admissions (n=473)
*(n=198 discharged pts, not including readmissions, with community acquired infections); LOS = Length of stay, IQR = interquartile range

Age, mean (range) median (IQR)	47 (22-88) 45 (32-57)
Male gender (%)	31 (63%)
Female gender (%)	18 (37%)
Readmissions	21 (43%)

COVID-19 Incident Analysis
(Past Harm and Anticipation and Preparedness)

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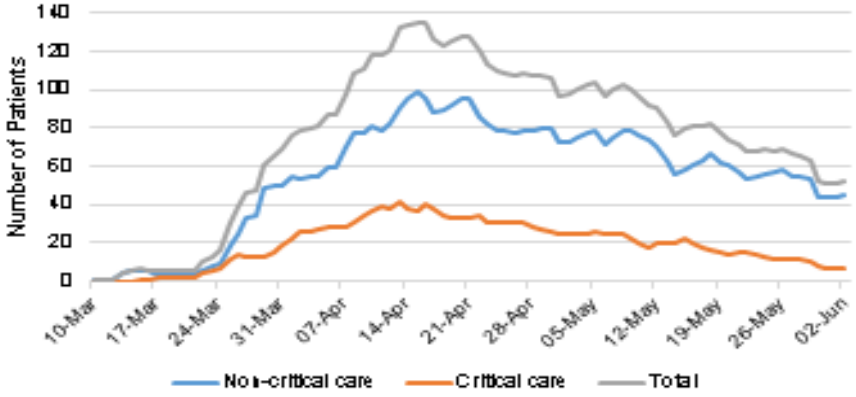
NHS Foundation Trust

Safety and Quality

Bed Occupancy of all cases by day and critical care status
10/03/20 – 16/06/20



Fatalities (n=107 since COVID swab)

Age (mean, range) (median, IQR)	77 (0-97) 80 (73-87)
Gender (male)	73 (62%)
Gender (female)	44 (38%)
Ethnicity – White	89 (76%)
Ethnicity – Black, Asian, minority ethnic	4 (3%)
Ethnicity – missing/not stated	24 (21%)
LOS* (days), mean (range) median (IQR)	9.6 (0.2-29.7) 8.7 (4.1-14.1)
Critical care admission	27 (23%)

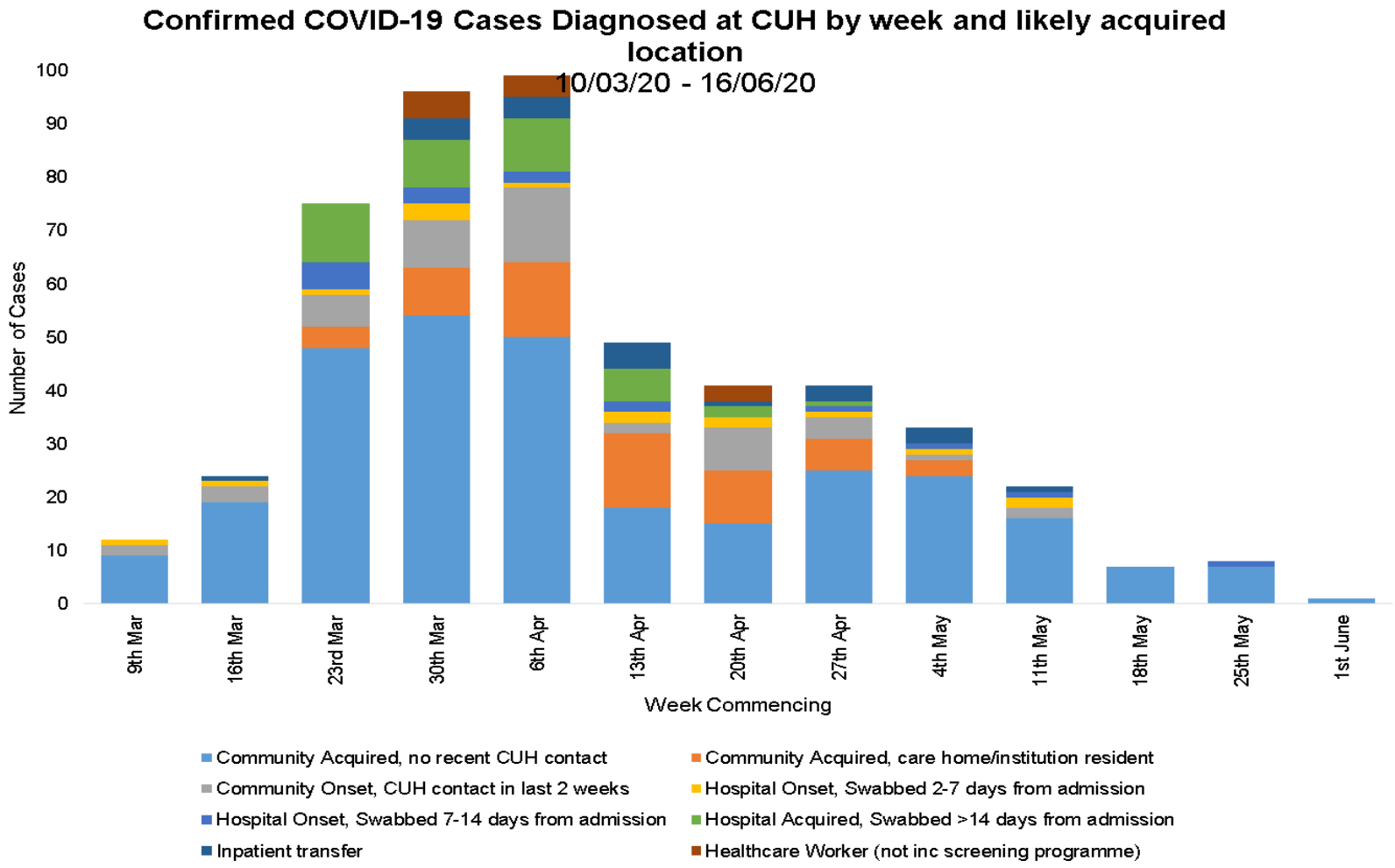
Admissions requiring critical care (n=91)
*(n=75 community acquired cases, excluding transfers from other hospitals); **(n=84 cases discharged or transferred from critical care, or deceased); ***(n=34 cases discharged from hospital)

Age (yrs)	Mean, (range) median (IQR)	56 (0-82) 60 (48-69)
Gender	Male	65 (71%)
	Female	26 (29%)
Ethnicity	White	52 (57%)
	Black, Asian and minority ethnic	12 (13%)
	missing/not stated	27 (30%)
Inpatient transfers		13 (14%)
LOS (days)	Pre-ICU (mean, range) median (IQR)*	2.7 (0.0-34.0) 0.5 (0.2-1.8)
	On ICU (mean, range) median (IQR)**	16.7 (0.3-68.6) 13.1 (5.3-25.1)
	Post-ICU (mean, range) median (IQR)***	7.4 (0-31.8) 4.9 (3.7-9.0)
Current Status	Discharged to ward	10 (11%)
	Deceased	27 (30%)
	Inpatient on ICU	6 (7%)
	Transferred	11 (12%)
	Discharged from hospital	37 (41%)

COVID-19 Incident Analysis
(Past Harm and Anticipation and Preparedness)

NHS
Cambridge University Hospitals
NHS Foundation Trust

Safety and Quality

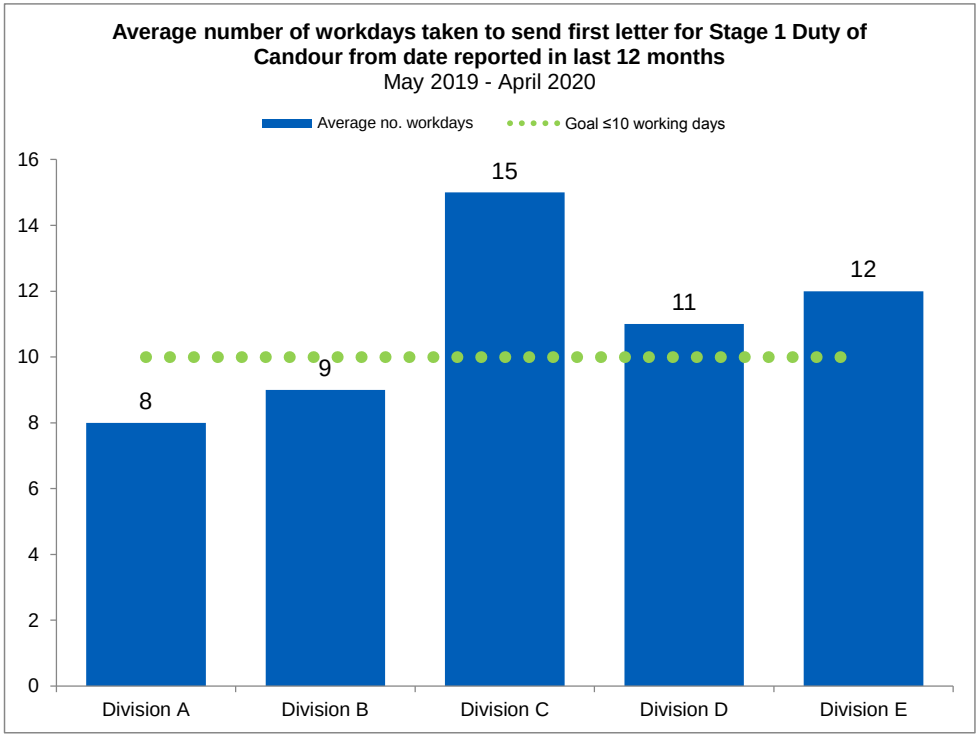


Duty of Candour

Cambridge University Hospitals NHS Foundation Trust

Safety and Quality

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
Duty of Candour Stage 1 within 10 working days*	Jun 17 - May 20	month	100%	70%	61%		-		The system may achieve or fail the target subject to random variation.
Duty of Candour Stage 2 within 10 working days**	Jun 17 - May 20	month	100%	85%	64%		-		The system may achieve or fail the target subject to random variation.



Executive Summary

Trust wide stage 1* DOC is compliant at 90% for all confirmed cases of moderate harm or above in May 2020. 70% of DOC Stage 1 were completed within 10 working days in May 2020. The average number of days taken to send a first letter for stage 1 DOC in May 2020 was 8 working days.

Trust wide stage 2** DOC is compliant at 85% for all completed investigations into moderate or above harm in May 2020 and 85% DOC Stage 2 were completed within 10 working days.

During the COVID-19 period and the new incident investigation commissioning process, the statutory principles of DOC remain unchanged. All incidents of moderate harm and above will have DOC undertaken. Revised DOC template letters have been created to support this process.

Indicator definitions

*Stage 1 is notifying the patient (or family) of the incident and sending of stage 1 letter, within 10 working days from date level of harm confirmed at SIERP or HAPU validation.

**Stage 2 is sharing of the relevant investigation findings (where the patient has requested this response), within 10 working days of the completion of the investigation report.

Recovery of position

It is recognised that the operational pressures placed upon the Trust during the COVID-19 pandemic led to a deterioration in the Trust's internal compliance target, although this has recovered in month from April 2020. Weekly SIERP meetings maintain oversight of Trust performance, offering support where required to Divisions.

Falls

NHS Cambridge University Hospitals NHS Foundation Trust

Safety and Quality

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
All patient falls by date of occurrence	Jun 17 - May 20	month	-	95	138		-	-	There were a total of 95 falls (inpatient, outpatient and day case) in May 2020.
Inpatient falls per 1000 bed days	Jun 17 - May 20	month	-	3.75	4.08		-	-	The rate of falls per 1000 bed days reamins within normal variance
Moderate and above inpatient falls per 1000 bed days	Jun 17 - May 20	month	-	0.13	0.07		-	-	There were 3 inpatient falls categorised as moderate harm and above in May 2020.
Falls risk assessment compliance within 12 hours of admission	Jun 17 - May 20	month	90%	90%	82%		S7		Statistically, there has been a significant improvement (shift) in the falls risk assessment compliance. The system however may achieve or fail the target subject to random variation.
5% reduction threshold of inpatient falls per 1000 bed days by March 2020	Apr 19 - Mar 20	month	3.60	5.62	4.39	-	-		We failed to meet the target of ≤3.60 in 2019/20. The Falls Steering Group are to consider a new KPI for 2020/21

Executive Summary

The system failed the target of 5% reduction in inpatient falls per 1000 beddays. There has been an 11% increase of inpatient falls between April 2019 – March 2020 compared to last year. The average rate of inpatient falls per 1000 bed days between April 2018 – March 2019 was 3.79 compared to 4.22 between April 2019 – March 2020.

The KPI for 2020-2021 will be proposed and approved at the next Falls Steering Group and Patient Safety Group.

A plan is being developed to embed the completion of Lying and Standing Blood Pressures per the Royal College of Physicians guidance following the National Inpatient Falls Audit and last years CQIUN.

The plan for implementation of new updated Falls Alarms is under way and further work has commenced to strengthen the educational and training resources to support ward staff in following best practice in terms of falls prevention.

The Falls Quality Improvement Programme is under review, with new QI metrics and methodology being developed.

An in depth review of falls in April and May has commenced to identify system and process gaps, which will inform the QI programme, working closely with clinical teams.

Pressure Ulcers

NHS Cambridge University Hospitals NHS Foundation Trust

Safety and Quality

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
All HAPUs by date of occurrence	Jun 17 - May 20	month	-	20	19		-	-	The number of falls in months were within normal variance
Category 1 HAPUs by date of occurrence	Jun 17 - May 20	month	-	9	9		-	-	The rate of Category 1 HAPUs remains within normal variance
Category 2, 3, 4, Suspected Deep Tissue Injury and Unstageable HAPUs by date of occurrence	Jun 17 - May 20	month	-	8	10		-	-	There were 6 x Category 2 HAPUs and 2 x unstageable/Suspected Deep Tissue Injuries in May 2020. There were no Category 3 or Category 4 HAPUs in April 2020.
Pressure Ulcer screening risk assessment compliance	Jun 17 - May 20	month	90%	83%	77%		SP		Although there has been a statistically significant increase in the PU screening risk assessment compliance in the last 18 months (shift), the system is expected to consistently fail the target. Statistically, the upper control limit is 80%.
25% reduction threshold of category 2, 3, 4, Suspected Deep Tissue Injury and Unstageable HAPUs by March 2020	Apr 19 - Mar 20	month	9	4	6	-	-		We met our target of a 25% reduction threshold (≤9 HAPUs per month) in 2019/20. The Pressure Ulcer Steering Group are to consider a new KPI for 2020/21

Executive Summary

The trust has met the year end KPI of a 25% reduction in HAPU category 2 and above by achieving an actual reduction of 52.4%. KPI's for 2020-2021 are due to be set at the Steering Group meeting this month and the Quality Improvement plan will be updated to incorporate learning from recent gap analysis investigations.

There is currently normal variance between April 2019 and May 2020 for all reported HAPU, pressure ulcers present on admission and medial device related HAPU. Category 1 HAPUs are within normal variance. Category 2-4 HAPUs are within normal variance, with one exceptional point above normal in category 3 and above in April 2020.

SCALE (Skin changes at life's end) reports are validated by the Lead TVN only and are within normal variance though there was an increase in March/ April with increased covid related skin failure being reported.

HAPU affecting the heels continues to be the highest reported body location, the “heels off” project is ongoing, though has been challenging to monitor during the reconfiguration of the trust bed plan due to Covid.
DME, critical care and Orthopaedics remain the areas where most pressure ulcers occur. Quality improvement plans are ongoing in these areas and will be reviewed at the Steering group.

There have been 7 reported staff related HAPU due to PPE, a care guide and referral pathway is in place for this staff group, additionally there is an awareness campaign planned for later this month..

Sepsis

NHS Cambridge University Hospitals NHS Foundation Trust

Safety and Quality

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
Trust internal data									
Sepsis Six Bundle in 1 hour - Emergency Department*								-	Our system will not hit our target of completing the sepsis six bundle within 1 hour ≥95%. There has been a statistically significant decrease in the compliance of the bundle in the last 12 months between January 2019 - December 2019. Data is unavailable for January, February, March and April 2020.
Antibiotics within 1 hour - Emergency Department*								-	Our system will not reliably hit our target of completing the sepsis six bundle within 1 hour ≥95%. Data is unavailable for January, February, March and April 2020.
Sepsis Six Bundle in 1 hour - Inpatient wards**								-	Medical Director's office agreed data to be changed from monthly to quarterly as of April 2019. The average compliance for Sepsis Six Bundle within 1 hour achieved between April 2018 - March 2019 was 53%. Data is unavailable for quarter 4.
Antibiotics within 1 hour - Inpatient wards**								-	Medical Director's office agreed data to be changed from monthly to quarterly as of April 2019. The average compliance for Antibiotics within 1 hour achieved between April 2018 - March 2019 was 89%. Data is unavailable for quarter 4.
Antibiotics within 1 hour as per contract agreement - Emergency Department***								-	This is quarterly data for the contract agreement which began in April 2019 – this is not the Trust's internal data. Quarter 3 and quarter 4 data is unavailable.
Antibiotics within 1 hour as per contract agreement - Inpatient wards***								-	This is quarterly data for the contract agreement which began in April 2019 – this is not the Trust's internal data. Quarter 4 data is unavailable.

Executive Summary

Data from January 2020 to May 2020 is not available for any of the metrics due to sepsis data collection being curtailed due to Covid 19. No Serious Incidents have been declared in relation to sub optimal care of the patient with sepsis. The QI plan in relation to Sepsis has been placed into 'hibernation' for the period of COVID-19 due to reassignment of staff and resource however, the education delivered to those upskilling in preparation for working in ED included sepsis recognition and management.

In order to support audits being undertaken staff who are currently shielding will be requested to undertake the audits remotely, so that a better picture of compliance with the Sepsis 6 can be undertaken. This work is currently being scoped and discussions will be had with the Office of the Medical Director to determine next steps, so that the Board are provided with assurance.

Infection Control

NHS
Cambridge University Hospitals
NHS Foundation Trust

Infection Control

Hygiene Code

The infection prevention & control code of practice of the Health & Social Care Act 2008

Criterion 1 Have systems to manage and monitor the prevention and control of infection.

Criterion 2 Provide and maintain a clean environment

Criterion 3 Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance

Criterion 4 Provide accurate information on infections to service users and their visitors in a timely fashion

Criterion 5 Ensure that people with an infection are identified promptly and receive appropriate treatment to reduce the risk of transmission

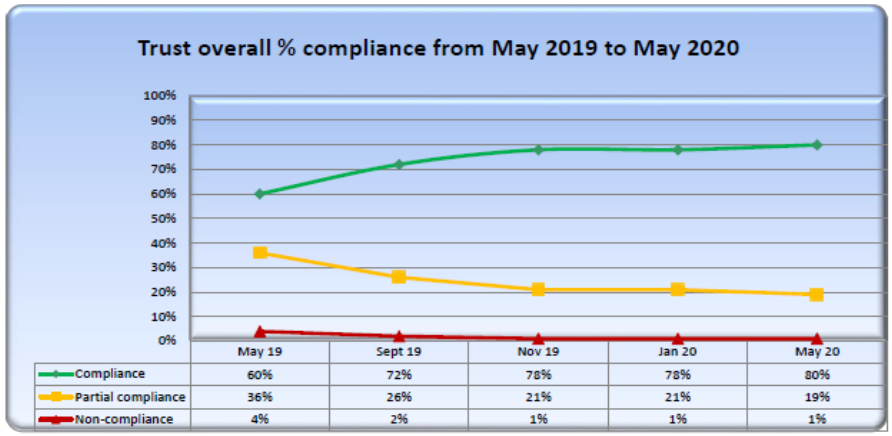
Criterion 6 Ensure that all are fully involved in the process of preventing and controlling infection.

Criterion 7 Provide adequate isolation facilities

Criterion 8 Access to adequate laboratory support

Criterion 9 Have and adhere to infection prevention & control policies

Criterion 10 Ensure that staff are free of and protected from exposure to infections that can be caught at work and that they are educated in the prevention and control of infection associated with the provision of health and social care.



	May 19	Sept 19	Nov 19	Jan 20	May 20
Compliance	60%	72%	78%	78%	80%
Partial compliance	36%	26%	21%	21%	19%
Non-compliance	4%	2%	1%	1%	1%

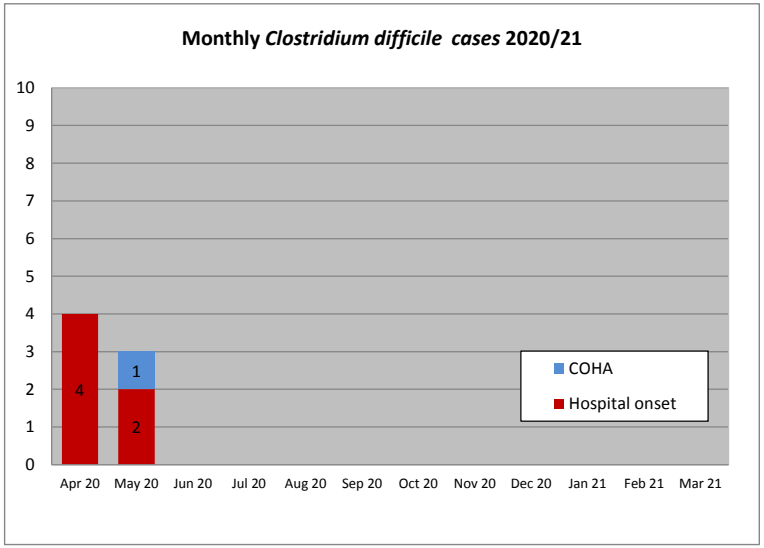
Concerns and actions

As demonstrated in the chart above compliance has slightly improved (2%) since January 2020 mainly due to decontamination policy updated. The key areas of partial or non-compliance for each criterion are:

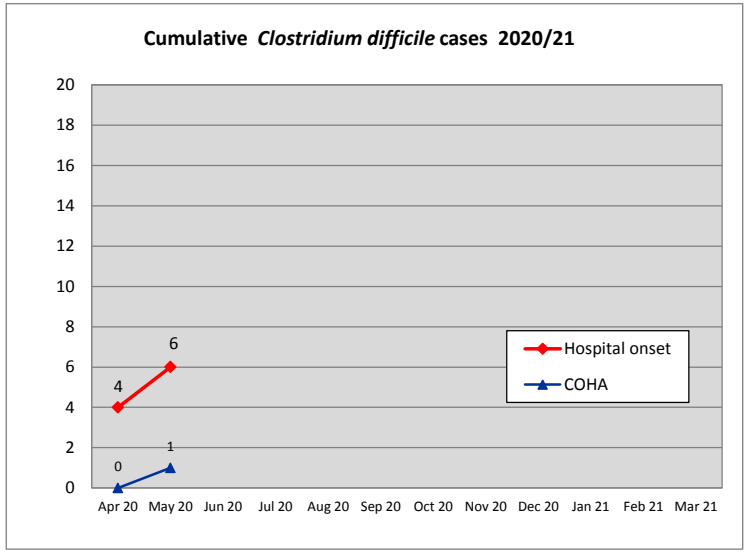
Criterion 1 and 2 governance reporting issues, poor condition of estate impacting on cleaning, need to increase knowledge and practice regarding cleaning and tagging of equipment. Ward/environmental visits walkabouts will continue to monitor and address these issues.
Criterion 3 strategy document due for review.
Criterion 4 antimicrobial teaching and dissemination of local data.
Criterion 6 need assurance regarding infection control competences.
Criterion 7 lack of adequate isolation facilities.
Criterion 9 non-compliance due to some aspects of infection control not currently covered in specific policies.
Criterion 10 gaps in availability of immunisation records and screening of new starters.

Infection Control

NHS Cambridge University Hospitals NHS Foundation Trust



* COHA - community onset healthcare associated = cases that occur in the community when the patient has been an inpatient in the Trust reporting the case in the previous four weeks



CUH trend analysis

MRSA bacteraemia ceiling for 2020/21 is zero avoidable hospital acquired cases.
- 0 case of hospital onset MRSA bacteraemia in May 2020.
- 0 case of hospital onset MRSA bacteraemia year to date.

C. difficile ceiling for 2019/20 was no more than 95 hospital onset and COHA* avoidable cases. No guidance has been issued for 2020/21.
- 2 cases of hospital onset and 1 case of COHA *C difficile* in May 2020. Internal reviews will be carried out and any learning pionts fed back to the clinical and nursing teams.
- 6 cases of hospital onset and 1 case of COHA *C difficile* year to date.

MRSA and C difficile key performance indicators

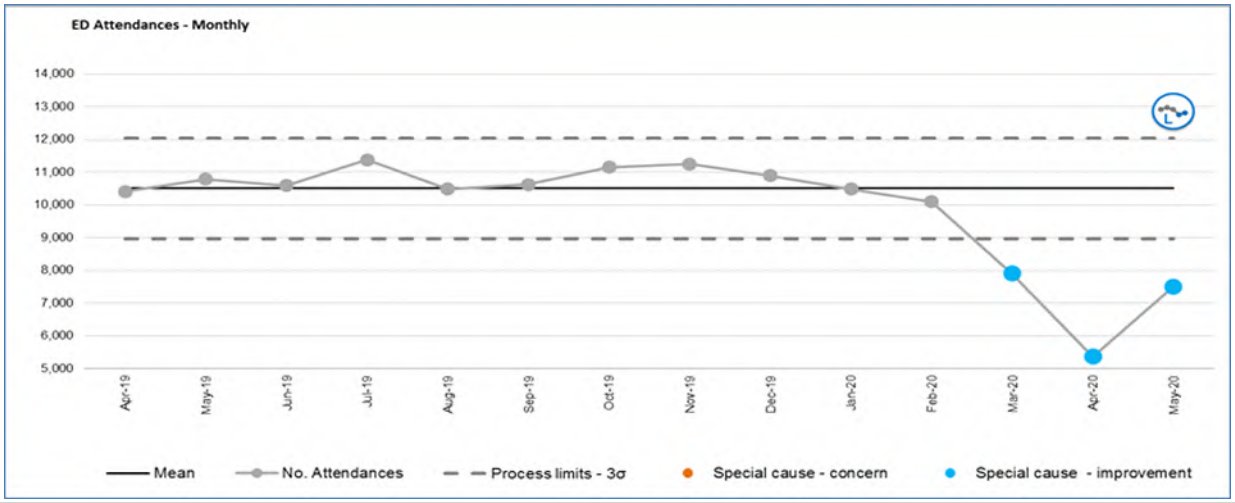
- Compliance with the MRSA care bundle (decolonisation) was 83.2% in May (99.1% in April).

- The latest MRSA bacteraemia rate comparative data (12 months to April 2020) put the Trust 4th out of 10 in the Shelford Group of teaching hospitals.

- The latest *C. difficile* rate comparative data (12 months to April 2020) put the Trust 10th out of 10 in the Shelford Group of teaching hospitals.

Emergency Department

National Targets



Emergency Department attendances in May 2020 and June 2020
Attendances to the CUH Emergency Department decreased from 10,788 in May 2019 to 7,505 in May 2020. This is equivalent to a fall in average daily attendances from 348 (May 2019) to 242 (May 2020).
There was one patient with a total ED length of stay over 12 hours in May 2020 who was awaiting an amber monitored bed to become available overnight. A bed was identified but required fogging before it could be utilised. No patient waited more than 12 hours for admission from decision to admit.

During May:
- The average time to initial medical assessment was 46 minutes compared to 1hr 39mins in May 2019
- The conversion rate was 31.4% for admitted patients compared to 31.8% in May 2019
- 702 patients (9.4% of attendances) were streamed to the Urgent Treatment Centre compared to 1,032 (9.6% of attendances) in May 2019

The Trust continues to work within the UEC access standards as part of the national pilot. The Emergency Department has processes in place to track performance against these standards and agree actions to improve through regular performance meetings.
For the June month to date (1st-21st June) average daily attendances were 257. This compares to an average of 352 daily attendances by the same point in the moth in June 2019. Despite this reduction, the recent trend of attendances continues to show a week-on-week increase during June. Emergency admissions have also risen and now stand at 93% of baseline levels as at w/e 21st June.

During June one patient had a total ED length of stay in the department over 12 hours. This was due to a delay in secure transport to transfer the patient to Fulbourn mental health hospital.

Internal ED department changes

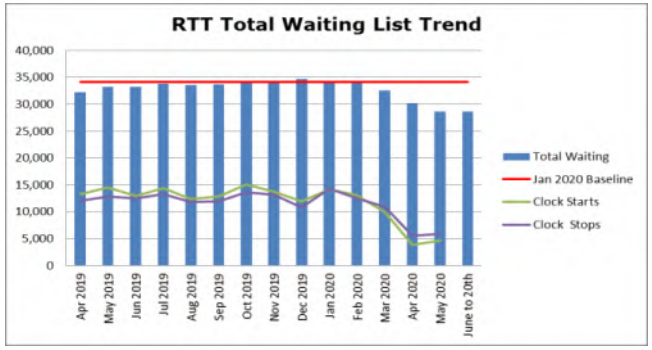
- We have altered our infection control screening questions at entry to the ED to reflect the changing community prevalence of COVID-19 and the fact that other infectious agents such as norovoirus, CDI and CPE will present on occasions to the ED
- Area A (Majors area) has been re-designated as amber space to provide an enhanced ability to shield patients. This also allows us to place patients more efficiently beyond the ED since they haven't been exposed to open red areas
- A request has gone to the Estates team that sets out our priorities for better infection control measures within the department. This includes installing walls/screens to provide better segregation amongst patients.

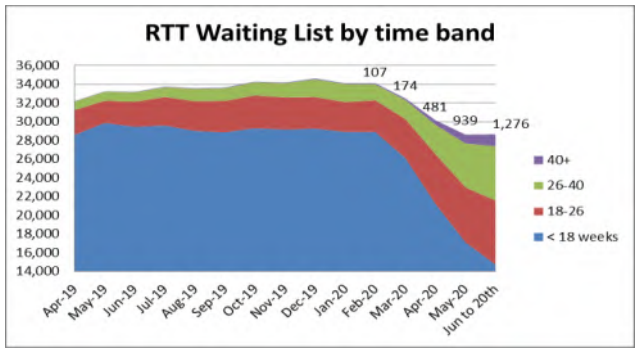
Emergency Pathway reconfiguration

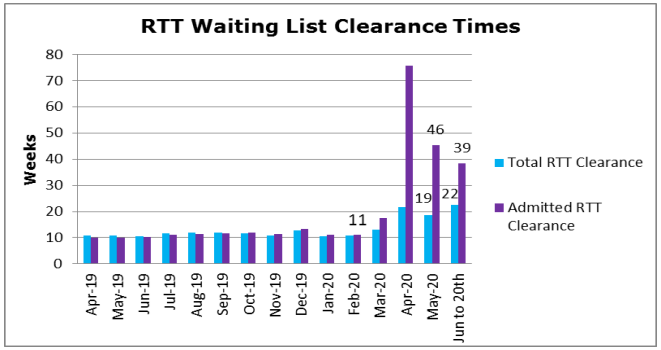
Work is continuing on the emergency pathway reconfiguration and weekly meetings have been set up for each work stream to discuss progress with the overarching Sustainability taskforce. General themes/work streams include:
- Setting up a Urgent Treatment Unit (UTU)
- Improving the streaming processes upon arrival to the ED
- Reducing the length of stay within the ED
- Directing demand to other providers such as the Minor Injury Units or 111
- Reviewing Surgical, Medical and Woman and Children's emergency pathways
- Enhancing discharge processes.

RTT

National Targets







Comments

Since the onset of the COVID pandemic the number of patients joining the RTT waiting list (clock starts) has reduced significantly, and in May clock starts equated to 35% of the average monthly volume in 2019/20. This was however a slight increase on April and we would forecast that June overall will be up to ~45% of pre-COVID levels. The most recent week up to 21st June shows referral are up to 60% of pre-COVID baseline. The Total waiting list size is no longer reducing as we had seen for the past 3 months.

Non-essential elective activity in the Trust has also been curtailed, and treatments in May remained at just 47% of the average volume. Within this, the number of admitted treatments that could be delivered has been most affected but there was an increase in May to 703 compared to 426 in April. This is still only 25% of the average volume, with June forecasting to be ~33%. The consequence is that those patients who were already on a pathway awaiting treatment are now waiting longer. Only 59.8% of patients are waiting below 18 weeks. In total the 92nd percentile waiting time has now increased to 35 weeks from 22 weeks at the end of February. Admitted patients have risen to 43 weeks and non-admitted to 30. The volume of patients waiting over 40 weeks has increased from 107 at the end of February to 1276 as at 20th June. 79% of these are awaiting admitted treatment. Ophthalmology (222) Orthopaedics (199) and ENT(146) having the highest at specialty level.

There were 65 patients still waiting over 52 weeks at the end of May, harm reviews have been undertaken on all and no harm has been identified. National data published for April showed an increase in 52 week waits up to 11,042 from 3,097. We are forecasting a deterioration to 190 at the end of June with available capacity still being allocated on the basis of clinical priority.

Clearance times

Clearance times provide a means for assessing the relative size of a waiting list, and are calculated by comparing the number of patients waiting, with a typical week's RTT activity. Clearance times are expressed as the number of weeks it would notionally take to treat the entire waiting list if no further patients were added to the list and treatments continue to be delivered at the current rate. The pre-covid clearance time for CUH was 11 weeks.

In May we only delivered 45% of the volume of total RTT treatments we averaged throughout 2019/20. To clear our RTT waiting list at this rate would take 19 weeks if no further patients were added to the list. For the cohort awaiting admitted treatment, we have seen an increasing number of treatments in May but the rate would still equate to a clearance time of 46 weeks for the admitted waiting list with no further patients added. June would reflect an reduction to 39 weeks. If we can get to 50% by the end of July the admitted clearance time would reduce to 26 weeks.

However, this analysis varies greatly as you review Specialty level. Ophthalmology who have the highest volume of longest waiting patients of all specialties were only able to treat 22% of their usual admitted volumes in May, and this would give a clearance time of 18 months. Their pre-COVD clearance time was 14 weeks. With the growth in the waiting list , Ophthalmology would now have to deliver 120% of pre-COVID admitted activity to return to a 14 week clearance time.

Our sustainability taskforces are working on phased plans to recover pre-COVID activity levels whilst continuing to keep patients and staff safe with the required infection prevention and control measures.

Cancer

National Targets

Cancer Standards 20/21	Target	19-20 Q1	19-20 Q2	19-20 Q3	19-20 Q4	Apr-20
2Wk Wait (93%)	93%	93.1%	91.5%	93.1%	94.9%	90.8%
2wk Wait SBR (93%)	93%	93.1%	93.5%	93.4%	95.2%	94.4%
31 Day FDT (96%)	96%	96.7%	96.4%	98.3%	94.5%	95.2%
31 Day Subs (Anti Cancer) (98%)	98%	99.7%	100.0%	99.7%	99.8%	98.7%
31 Day Subs (Radiotherapy) (94%)	94%	97.4%	97.1%	98.2%	96.5%	99.0%
31 Day Subs (Surgery) (94%)	94%	95.5%	94.8%	97.0%	94.2%	75.7%
FDS 2WW (70%)	70%					79.0%
FDS Breast (70%)	70%					90.0%
FDS Screen (70%)	70%					79.4%
62 Day from Urgent Referral with reallocations (85%)	85%	**84.3%**	**85.0%**	**86.2%**	**84.6%**	**86.3%**
62 Day from Screening Referral with reallocations (90%)	90%	**79.4%**	**80.0%**	**88.1%**	**70.2%**	**75.0%**
62 Day from Consultant Upgrade with reallocations (50% - CCG)	50%	80.0%	90.9%	66.7%	83.8%	100.0%

To April 2020 by site

To April 2020	62 Day from Urgent Referral		62 Day from Screening Referral		31 Day FDT		31 Day Subs (Surgery)		2Wk Wait		2WW FDS		>104 day
	Breaches	%	Breaches	%	Breaches	%	Breaches	%	Breaches	%	Breaches	%	Breaches
Breast	1	96%		100%		100%		100%	7	100%		100%	1
Children's						100%		100%	1				
Lung	2	64%				100%		100%		67%	1	67%	
Upper GI	0.5	83%			1	95%	1	75%	1	100%		100%	1
Lower GI	7	44%	4	20%	2	92%	4		19		1		3
Skin	2	91%			5	84%	2	80%	19	87%	2	87%	
Gynaecological	3.5	63%	0.5	67%	1	96%		100%	5	100%		100%	2
Urological	2.5	86%			1	97%	1	50%	9	36%	7	36%	1
Head & Neck	2.5	72%				100%	1		2	67%	1	67%	
Sarcomas	0.5	67%				100%							
Other Haem Malignancies	1	83%				100%			1	50%	2	50%	1
Other suspected cancers	1				1					79%			
FDSUnknown	0		0		0		0		0		118	79%	

The last Nationally reported Cancer waiting times performance is for April 2020.

COVID started to impact Cancer performance in April but this did vary against the specific targets. Cancer performance is not measured until the end of a patient pathway when each stage has concluded. Further detail of the impact of COVID delays on cancer pathways can be found on page 19

2ww performance dropped to 90.8%. We saw 727 patients for a 2ww appointment in April, 41% of the usual monthly volume. Only 6 of the 66 patients who were seen beyond 2 weeks were referred prior to lockdown.

This is the first month that the new Faster Diagnosis Standard has been reportable, and the indicative 70% target was achieved.

We also achieved the 62 day Urgent standard in April. Overall we treated 77% of the usual volume of patients on 62 day pathways. Of those who did breach the standard, 61% had targets prior to lockdown The impact of COVID has not yet fully manifested on the performance against this longest cancer pathway standard.

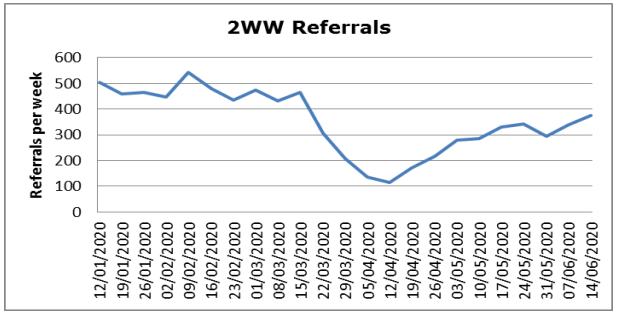
The 31 day FDT standard was only marginally missed in April, but the Subsequent Surgery standard dropped to 75.7%. We did treat 73% of the usual volume against all 31 day standards, but only 43% for the subsequent surgery standard. All 31 day pathways that exceeded the standard had targets after lockdown.

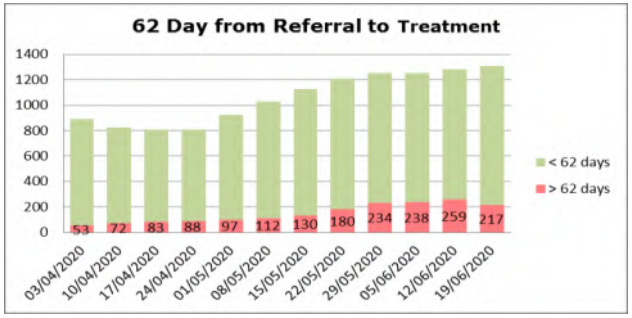
There were 9 >104 day breaches in April. These patients clearly started their pathways well ahead of the COVID pandemic. No harm was identified on these pathways. Going forward an interim harm review will be undertaken as a patient reaches 104 days, before they are treated, given the potential that the volume of pathways exceeding this threshold will increase due to COVID delays.

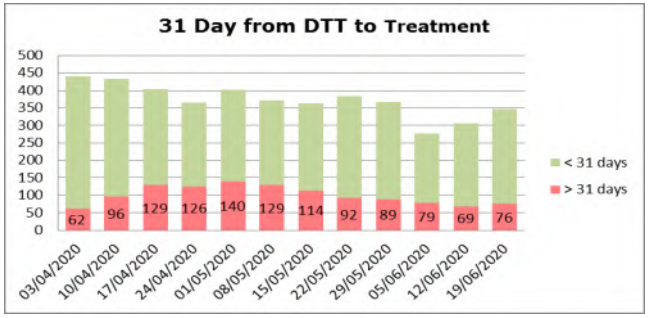
Cancer

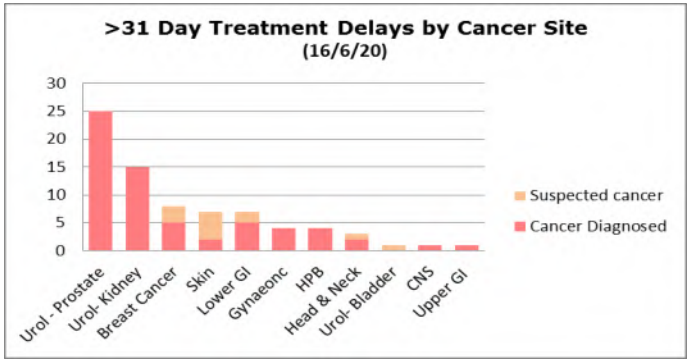
NHS Cambridge University Hospitals NHS Foundation Trust

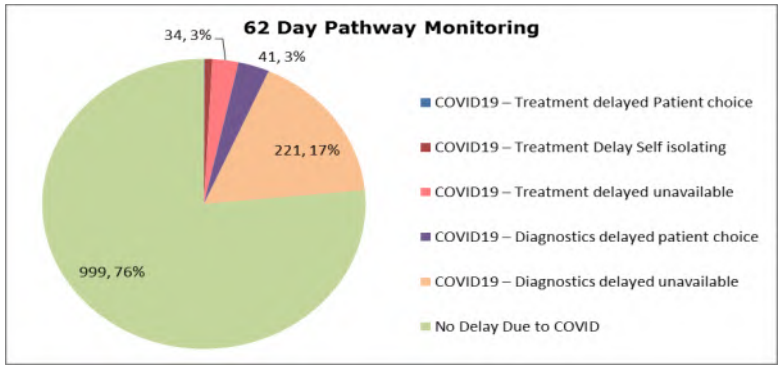
National Targets











Impact of COVID - 19

There has been a national focus to encourage patients to present as normal with health concerns. In response we have seen the volume of 2WW suspected cancer referrals rising again, and in the last complete week they were back to 80% of the normal referral volume. The total number of patients being monitored against the 62 day standard s has been fairly stable through the past 4 weeks indicating that we are managing to progress pathways to meet the rising referral demand.

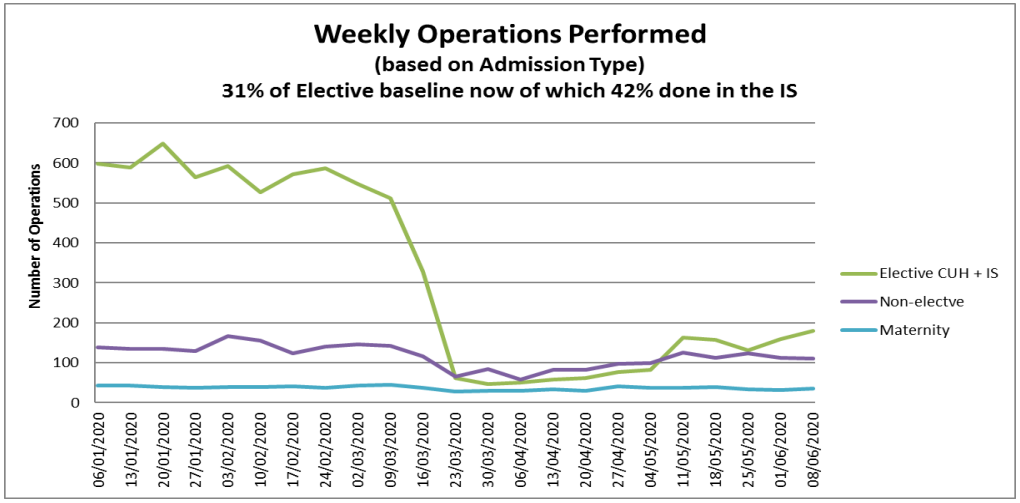
Within the total volume we are seeing the number of patients waiting >62 days decrease, but at 217 it remains very high compared to a pre-covid average of 63 . 69% of these are for Lower GI. We monitor the volume of patients experiencing a delay to their 62 day pathway whilst they continue to wait. Encouragingly , 75% of those waiting are now experiencing no delay associated directly with COVID19. 17% (221) are experiencing delay due to diagnostics not being available, but this is down from 431 last month . Of these 48% are for Lower GI due to the suspension of Endoscopy procedures, but colonoscopy restarted from 8th June and the backlog is reducing. The Endoscopy environment was also the location for cystoscopy services and they now represent a further 39% of the diagnostic delays for Urology bladder investigations. Some of this activity has now commenced using the Independent sector , and the on-site Endoscopy facilities. will support cystoscopy to recommence from 29th June. There remains a shortfall compared to pre-covid activity levels which need to be addressed to enable the backlog to be sufficiently reduced. These same diagnostic delays are reflected in the number of patients waiting over 28 days for diagnosis which has increased t o 397 from a baseline of 180.

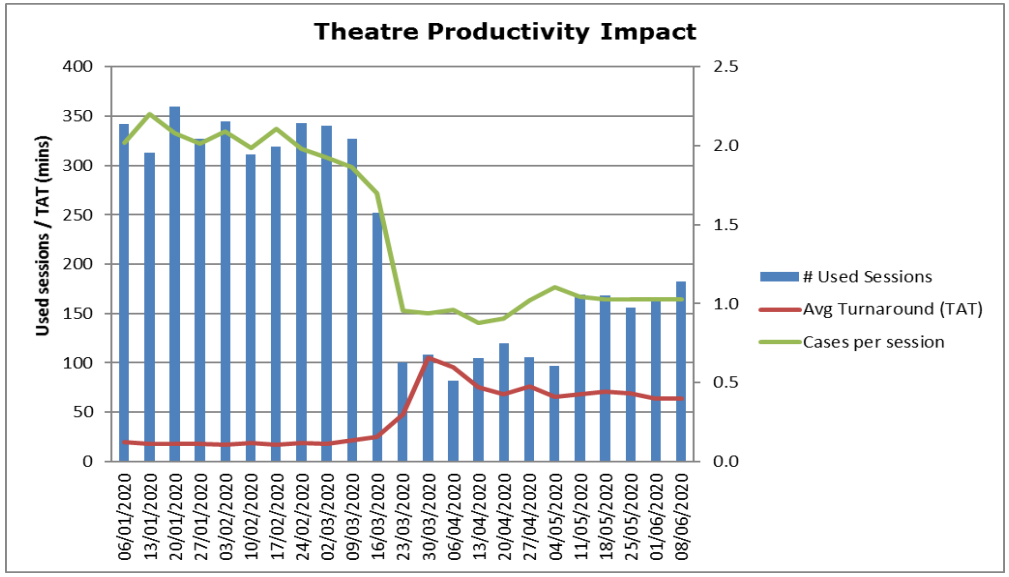
The number of patients waiting treatment > 31 days has continued to reduce over the last month but mainly due to continued im provement in Skin . The increase for treatment delays continues to be most significant in Urology surgery for both Prostate and for Kidney cancer, where 39 cases are awaiting surgery over 31 days. These cases are undergoing risk stratification and are being presented weekly to th e Surgery Prioritisation panel where they are clinically being assessed as primarily a P3/P4 category with a delay of up to or over 3 months. As some reach this maximum their priority will be reassessed. An options appraisal to consider how to recommence Robotic Prostatectomy is being considered by the Divisional Directors at the Surgical prioritisation panel this w eek. The Cancer Alliance has commenced further discussions on the concept of Surgical Hubs for the Region. Additional elective theatre capacity at CUH will be dependent on the de-escalation of PPE requirements.

Operations

Cambridge University Hospitals NHS Foundation Trust

Operational Performance





Surgical activity continues to be one of the greatest challenges resulting from the COVID pandemic.
Non-elective/emergency theatre activity saw a reduction from the commencement of lockdown, but has continued to be stable since mid May at 79% of previous volumes, utilising a greater proportion of theatre sessions due to the required Infection Control measures.

Elective operating has reached 31% of pre-covid volumes, 42% of which we are delivering with the support of the Independent Sector National NHS contract. We have highlighted this as an ongoing requirement throughout 20/21. The CUH elective activity alone is only at 18% of pre-COVID levels. The greatest barrier to increasing activity remains the requirements for PPE. Were these able to be de-escalated for 'Green' theatre activity a further three elective operating tables could be supported daily. This could then deliver 50% of surgical activity. The staffing models are being reviewed to ascertain how further increases could be achieved. Extended working to 7 days per week for elective surgery is being modelled and has been costed for the Phase 3 Regional Plan submission.

The number of theatre sessions currently running has increased to 55% from 50% last month. Average turnaround time between cases has not yet reduced and the number of cases performed per half day session is still at one. This also reflects that the casemix of elective operations being undertaken at CUH are the more complex major surgery with the highest clinical priority.

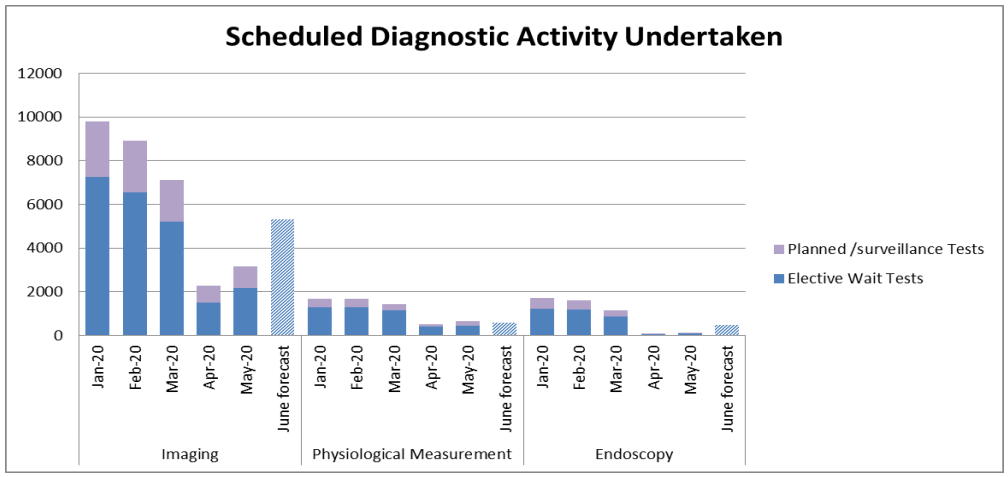
The admitted surgical waiting list has now increased by 17%, ~1300 cases. In line with Royal College guidelines, the allocation of elective theatre resource is overseen by a weekly Surgical Prioritisation Panel based on the clinical risk assessment of the cases waiting. This is now captured in EPIC and over 4000 (50%) of the entire surgical waiting list has now been prioritised. This has highlighted that 6% of cases are currently waiting longer than the ideal, and allocations are adjusted to attempt to rectify that. This is particularly challenging for those cohorts that are not suitable to be considered for the Independent Sector. From the start of July a greater number of cases who were deemed able to wait up to three months (P3) will reflect greater pressures on available capacity. To address health inequalities, the concept of surgical hubs has been discussed within the Cancer Alliance, but, as yet, specific enquiries to seek capacity from other providers have not leveraged any solutions.

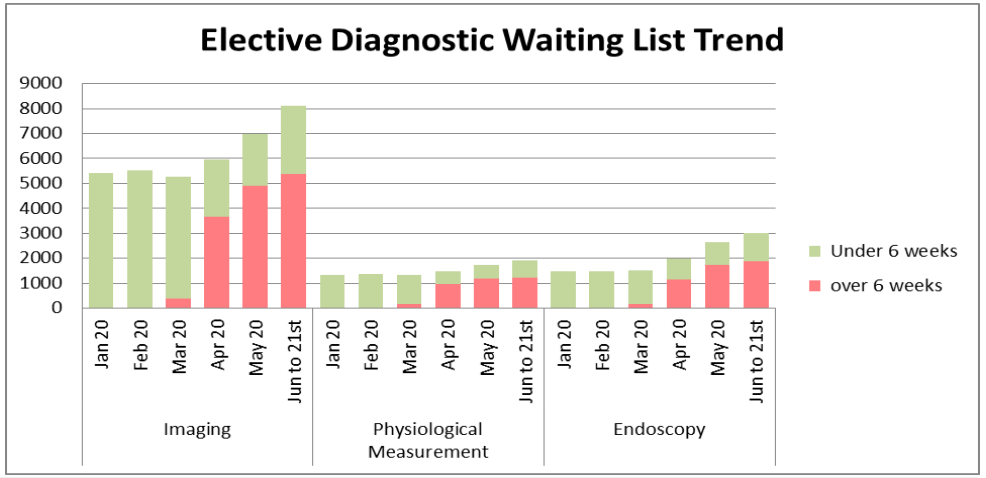
Management Executive will be reviewing the Infection Control requirements this week based on the latest evidence and guidance available.

Diagnostics

Cambridge University Hospitals NHS Foundation Trust

Operational Performance





Diagnostic activity is grouped into three cohorts for National Reporting:

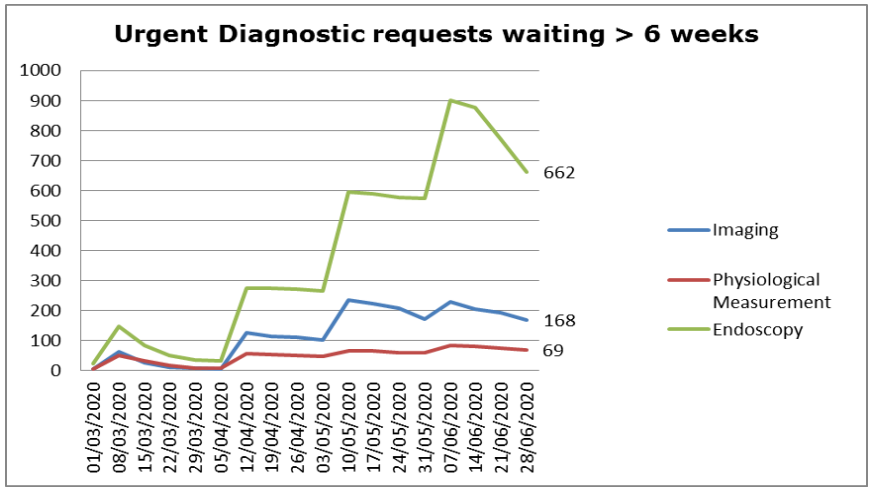
- **Imaging** which includes MRI, CT, Ultrasound and Dexa.
- **Physiological measurement** which includes Neurophysiology, Urodynamics, Echocardiography and Respiratory physiology.
- **Endoscopy** which includes Gastroscopy, Colonoscopy, Flexible sigmoidoscopy and Cystoscopy.

Scheduled diagnostic activity in May started to show small signs of recovery but remained significantly reduced. Looking forward in June there is greater progress, with Imaging forecasting to deliver 50% of pre-covid activity levels; Physiological measurement 47%; and Endoscopy 27%, up from only 10% in May having recommenced services in June.

The consequence of the reduced activity is that diagnostic waiting lists continuing to increase. Imaging are now reporting a 54% increase in waiting list size; Physiological measurement is 42%; and Endoscopy is 96% higher. Collectively the diagnostic waiting list has now increased by over 4800 in the last 3 months. The number of patients waiting beyond six weeks at the end of May, was 8269 (68.5%) up from 831 at the end of March. The median weeks wait is 11 weeks compared to 5 at the end of March.

We are now seeing an improvement in the number of clinically urgent diagnostics waiting, being driven largely by colonoscopy where activity recommenced on 8th June. All bar 20 patients referred on a 2ww have now been dated for this service. Cystoscopy has also commenced in the Independent Sector and will restart sessions at CUH with effect from 29th June.

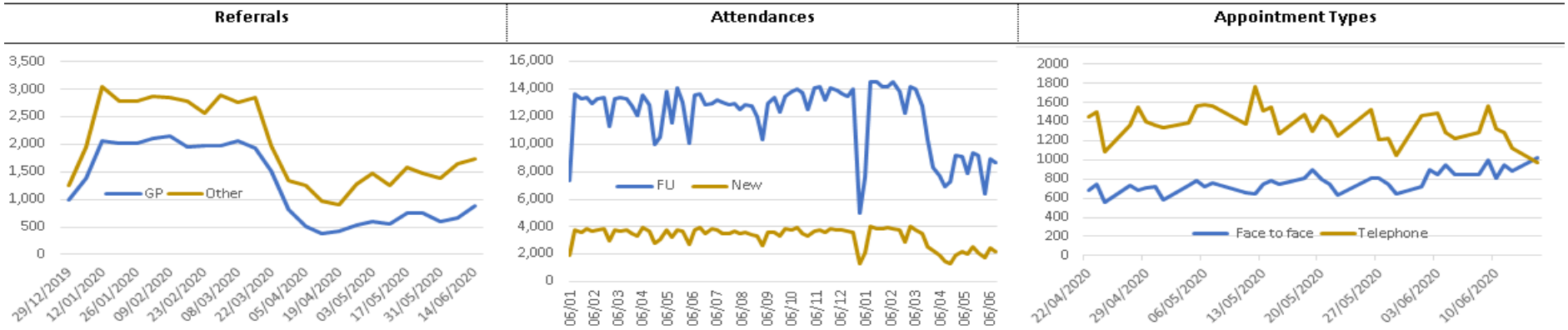
Increasing diagnostics is a priority for the entire STP to support both Primary Care and our hospital requirements. Options for community diagnostic hubs are being actively scoped and these are vital if non face to face consultation methods are going to be embedded for the long term. Any impending changes to the social distancing rules will also open up some opportunity for increased capacity.



Outpatients

NHS Cambridge University Hospitals NHS Foundation Trust

Operational Performance



Access to Outpatients continued to be restricted through May with urgent referrals only available through the advice and guidance within the national NHS E referral service. Routine referral pathways began a phased opening form 15th June, and in the most recent week referrals are at 60% of pre-COVID levels. We are now delivering 75% of pre-COVID attendances, with a slight shift between face-to-face and virtual appointments,. This is somewhat expected as we start to invite those patients who are urgent on site and who could not be dealt with remotely. We are still maintaining 50% of attendances as virtual . The enabling of video appointments continues ot be rolled out, and we have now held over 1000 consultations, the largest number across the eastern region.

The New Outpatient waiting list has reduced in line with the drop in referrals , but the median wait for patients has increased from 10 to 15 weeks. The number of follow up appointments overdue has risen from 20,000 to 28,000. These are a priority for the risk stratification process which has now been built into EPIC.

Much of the month of May was spent preparing to safely increase footfall in outpatients. Risk assessments and infection control assessments have taken place in all clinics to determine the safe number of patients that can be in a particular clinic at any one time. Individual clinical services have been asked to complete a request form to reopen services, which is then matched against the safe number of patients, and approved or adjusted accordingly. We continue to estimate that under the current 2 m guidelines approximately 60% of physical capacity has been lost, and while we are increasing the number of remote appointments, they are not necessarily freeing up space as we have no separate facilities for clinicians to hold telephone/video consultations. This means that in a number of cases the consultant continues to carry out these appointments within the clinic environment.

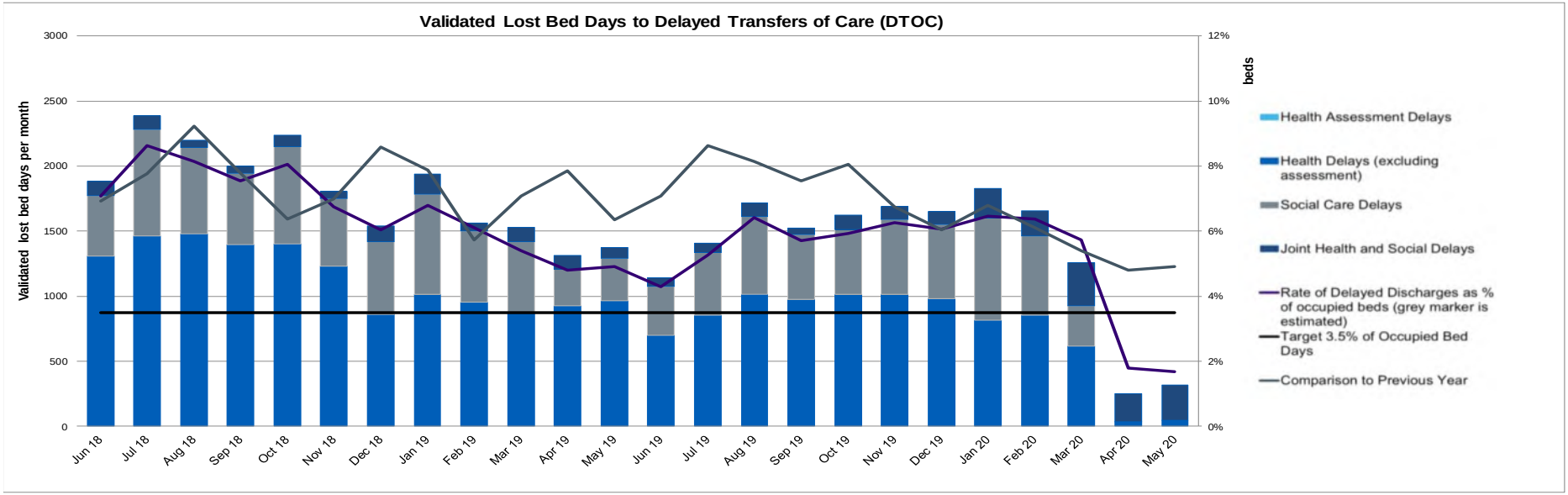
In line with guidance, patients and staff who enter outpatients are provided with masks, We are continuing to manage the number of people entering outpatients by ensuring that where appropriate, minimal numbers of relatives or friends attend appointments with patients. We have closed the travel claims desk in favour of providing forms for patients to complete, and for them to get paid directly, to avoid handling cash and the queues that often occurred. We continue to work with pharmacy to explore different ways of delivering drugs to outpatients, including home deliveries via courier. We are also hoping to introduce a system which will enable patients to wait in their car until such time as we call them to the clinic via SMS to again minimise people waiting. Solution to a community based phlebotomy service continue s to be scoped as this has been identified by Primary Care and our hospital clinicians as vital to support the shift the virtual consultations.

Primary concern in outpatients is physical capacity. As mentioned above, we have lost a significant amount due to social distancing requirements, but in addition, clinics such as clinic 5, 9, 33 and 43 have been repurposed for other services during the crisis, and there is no indication as to when that space will be released back to outpatients. In addition, our ability to be able to communicate effectively with patients due to the restrictions placed upon us by the heat sealed appointment slips is also a challenge as we are unable to give patients proper guidance with regards to what to expect in the new Covid-19 safe environment.

Delayed Transfers of Care

NHS Cambridge University Hospitals NHS Foundation Trust

Operational Performance



The Hospital Discharge Service Requirements directive was issued to NHS and Local Authority organisations on the 19th March. Changes included the immediate extension of hospital discharge team operating hours, which are now 8am-8pm 7 days a week. For the purpose of this reporting period, May 2020, partner organisations were continuing to mirror their operating hours according to the directive.

From April, we received a directive to stop national reporting of Delayed Transfer of Care for 3 months. This has been temporarily replaced with a daily discharge sitrep.

We have agreed to continue to internally record 'delayed transfer of care' with the same principles as pre-Covid, to enable comparative measure of data throughout this period of time. We are anticipating to receive an update from NHSE/I over coming weeks which may further direct us in longer term reporting measures.

For May 2020, we continued to sustain a substantial reduction in DToC's, reporting 1.69%, in comparison to 4.91% in May 2019. Whilst DToC's are a similar level to the previous month, April, there was an increase in the monthly lost bed days, rising from 250 in April, to 318 this month.

Within the 1.69%, 72.6% were attributable to Cambridgeshire and Peterborough CCG, and the remainder across a further 5 CCG's. *Please note that we have referred to delays per CCG instead of Local Authority as with previous months, due to the implementation of the all discharges that now require a new or adjusted care provision throughout this Covid period will be funded by the NHS.*

Overall the majority of delays within the total for May were for Care Homes (76.52%), equating to 243 lost bed beds for this counting period. Whilst we have recognised capacity issues for specific types of bed based care, such as dementia care placements, a proportion of delays within May potentially arose from changing guidance Re: swabbing and discharge to care homes.

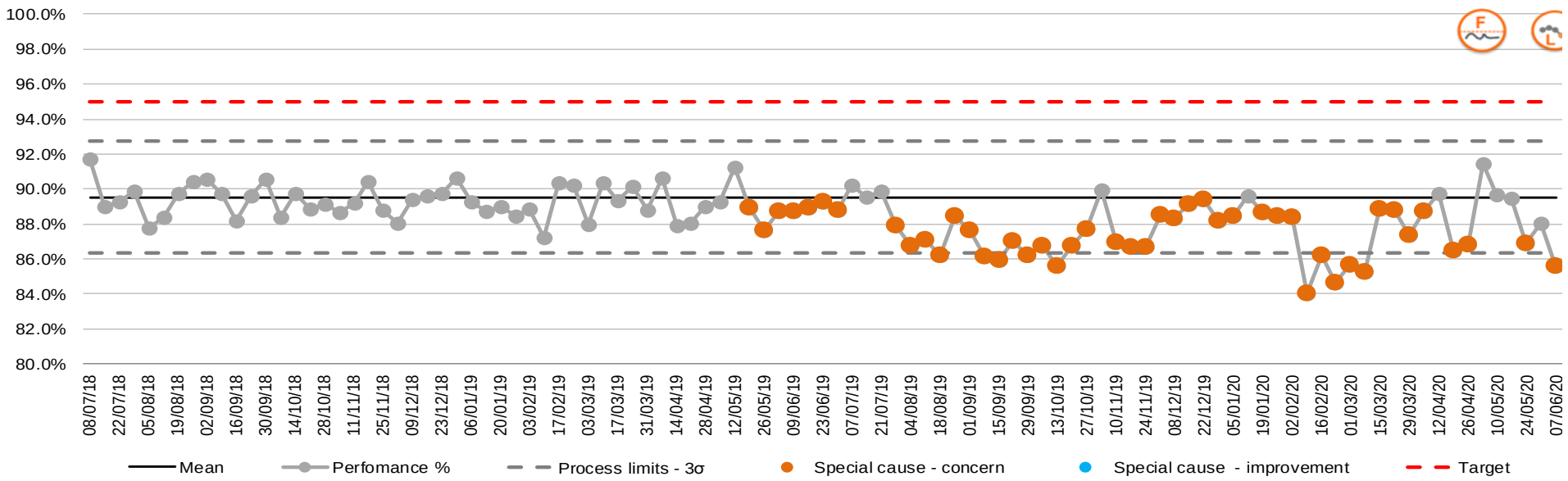
As part of a local system, Cambridgeshire and Peterborough CCG, CPFT, Cambridgeshire and Peterborough County Councils, are continuing to work together to look at the longer term plan for discharge pathways, working on the rapid pathway changes that were implemented at the end of March to ensure a continuation of flow from the acute hospitals, whilst ensuring that patients are safely discharged with the emphasis of a 'home first' approach.

Discharge Summaries

Cambridge University Hospitals NHS Foundation Trust

Operational Performance

Weekly: Letters-discharge summary- starting 01/01/17



Current processes mean that we will never achieve the 95% target for this measure without making an intervention. Statistical ly our upper achievement limit is 93.6%..

Discharge summaries

Escalated through Divisional Performance meetings, CD/ DD/ MD meeting and Junior Doctor forum during November 2019

Alerting mechanism within Epic now implemented to notify consultants of patient discharged without a summary.

New development underway to make it more obvious to clinicians when summaries are incomplete was deployed on 18 January 2017.

Additional indicators to highlight if a summary has been sent were deployed on 6 April 2017.

Patient Experience

NHS Cambridge University Hospitals NHS Foundation Trust

Patient Experience

The good experience and poor experience indicators omit neutral responses.

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
FFT Inpatient good experience score	Apr 17 - May 20	Month	-	97.2%	95.0%		-	-	For May, there were 2659 eligible inpatients and data are from 179 patients due to Covid-19 surveying declined.
FFT Inpatient poor experience score	Apr 17 - May 20	Month	-	1.6%	2.0%		-	-	
FFT Outpatients good experience score	Apr 17 - May 20	Month	-	95.6%	93.7%		S7	-	For May, there were 22,924 eligible outpatients and data are from 6025 patients. The number of outpatient appointments declined due to Covid-19.
FFT Outpatients poor experience score	Apr 17 - May 20	Month	-	1.8%	2.3%		-	-	
FFT Day Case good experience score	Apr 17 - May 20	Month	-	97.2%	97.4%		-	-	For May, there were 1,693 eligible day case patients and data are from 362 patients. The number of day case appointments declined due to Covid-19.
FFT Day Case poor experience score	Apr 17 - May 20	Month	-	1.6%	1.1%		-	-	
FFT Emergency Department good experience score	Apr 17 - May 20	Month	-	94.2%	92.4%		-	-	For May, there were 3697 eligible ED patients and data are from 1038 patients. The Poor Experience score is under 4.5% (below the Mean) for the second consecutive month.
FFT Emergency Department poor experience score	Apr 17 - May 20	Month	-	3.1%	3.8%		-	-	
FFT Maternity (antenatal, birth and postnatal) good experience score	Apr 17 - May 20	Month	-	100.0%	94.0%	-	SP	-	The April FFT Maternity score was a special concern due to 5 responses collected. May score has returned to within control limits, regardless of 7 responses.
FFT Maternity (antenatal, birth and postnatal) poor experience score	Apr 17 - May 20	Month	-	0.0%	1.7%	-	S7	-	

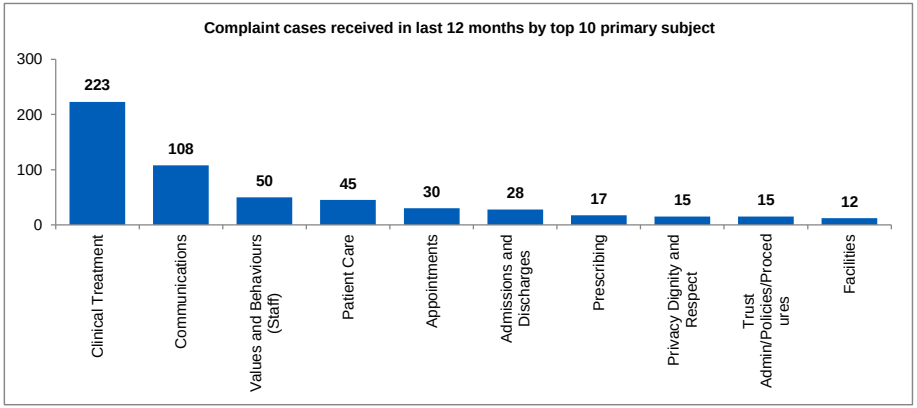
Maternity FFT data for May 2020 is from 7 patients. This is due to the Covid-19 impact on collecting patient feedback. NHS England suggested to suspended FFT reporting on 31st March due to Covid-19 however various locations collected some FFT. SMS surveying for adults in Outpatients, Emergency Department and Day Case has continued.

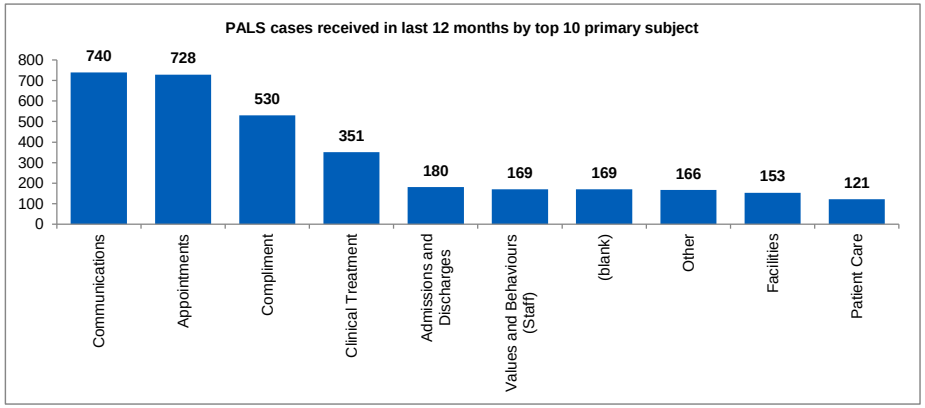
PALS and Complaints Cases

Cambridge University Hospitals NHS Foundation Trust

Safety and Quality

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
Complaints received	Jun 17 - May 20	month	-	25	54	L	SP	-	There was a statistically significant decrease (shift and single point) in the number of complaints received between November 2019 - May 2020.
% acknowledged within 3 days	Jun 17 - May 20	month	95%	96%	93%		-	?	The system may achieve or fail the target of ≥95% subject to random variation.
% responded to within initial set timeframe (30, 45 or 60 working days)	Jun 17 - May 20	month	50%	25%	37%		-	?	The system may achieve or fail the target of ≥50% subject to random variation. The figure in the current period is lower due to the complaints team supporting the helpline and there have also been delays in receiving responses from clinical areas due to the impact of COVID-19
Total complaints responded to within initial set timeframe or by agreed extension date	Jun 17 - May 20	month	80%	100%	74%	H	SP	?	In the last 5 months, there has been a statistically significant increase (single points) in the percentage of complaints responsed to within the initial set timeframe or agreed extension. The system however may continue to achieve or fail the target of ≥80% subject to random variation.
% complaints received graded 4 to 5	Dec 18 - May 20	month	-	24%	28%		-	-	There were 6 complaints graded Level 4 in May 2020, these cover a number of specialties and will be subject to detailed investigations.
Compliments received	Jun 17 - May 20	month	-	27	37		-	-	Compliments received via PALS remains within normal variation; however, this figure does not represent the number of compliments received directly in patient areas, or via the MES system.





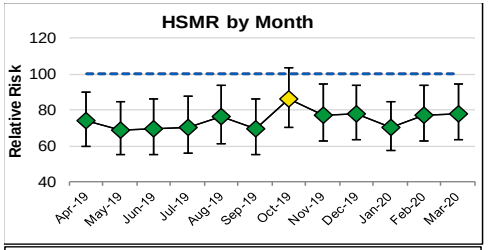
The PHSO have recommenced receiving complaint investigations following a period of suspension due to COVID-19. Furthermore, national guidance on complaints timescales has also recommenced; therefore, this target will be monitored for comparative performance. In addition to their normal case work, the PALS and Complaints Team are currently running a Helpline from 8.00am - 8.00pm Mon-Fri to address a variety of COVID-19 issues incuding cancelled surgery / appointments, visiting restrictions, signposting for bereavment issues and delivering messages, photographs, food and discharge clothing to patients whose family are unable to visit.

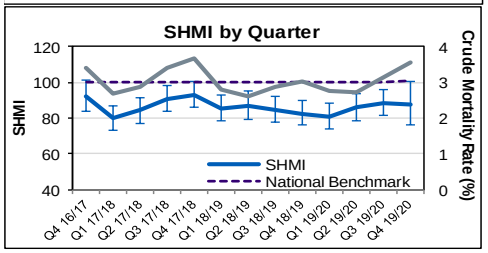
Learning from Deaths

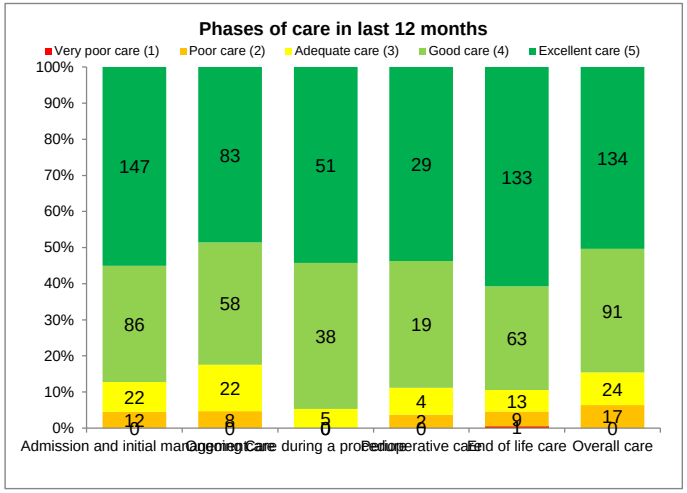
Cambridge University Hospitals NHS Foundation Trust

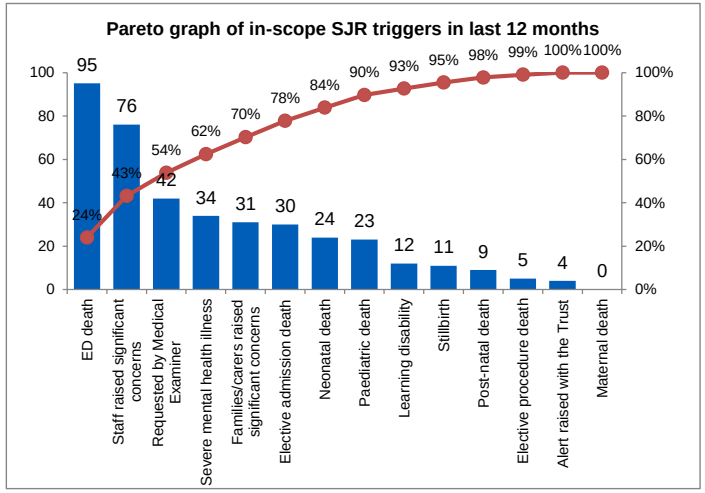
Mortality

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
Emergency Department and Inpatient deaths per 1000 admissions	Apr 18 - May 20	month	-	11.86	7.87		SP	-	There were 133 deaths in May 2020 (Emergency Department (ED) and inpatients), of which 7 were in the ED and 126 were inpatient deaths. There was a statistically significant increase (single point) in the number of deaths per 1000 admissions in both April 2020 and May 2020.
% of Emergency Department and Inpatient deaths in-scope for a Structured Judgement Review (SJR)	Oct 17 - May 20	month	-	22%	18%		S7	-	In May 2020, 29 SJRs were commissioned. 20 (69%) have been completed at time of reporting. There was one SJR which identified deaths associated with a problem in care. These will be taken to SIERP for consideration of further investigation.
Unexpected / potentially avoidable death Serious Incidents commissioned with the CCG	Oct 17 - May 20	month	-	1	0.88		-	-	There was one unexpected/potentially avoidable death serious incident investigations commissioned in May 2020. See page 7 for further information.









Executive Summary

HSMR - The rolling 12 month (April 2019 to March 2020) HSMR for CUH is 74.46 this is 3rd lowest within the London and ATHOL peer group. The rolling 12 month HSMR for the Shelford Peer group is 90.13.
SHMI - The Summary Hospital-level Mortality Indicator (SHMI) for CUH in the latest period, February 2019 to January 2020 is 85.77.
Alert - There are 0 alerts for review within the HSMR and SHMI dataset this month.

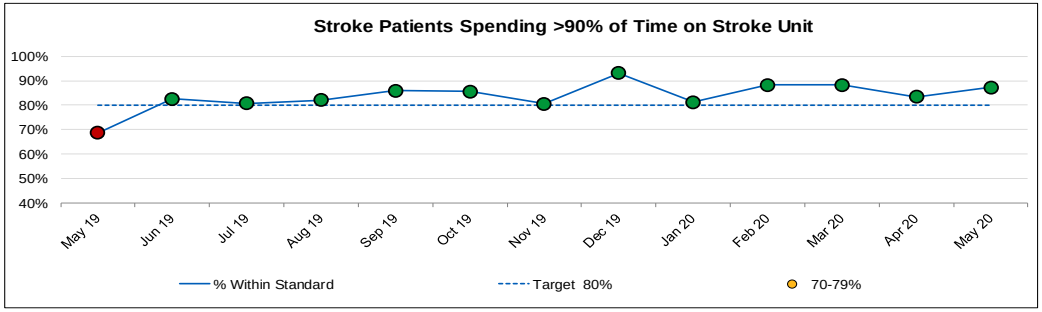
Stroke Care

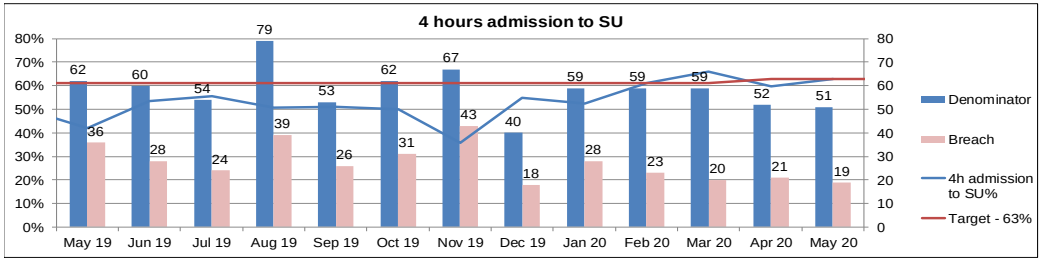
Cambridge University Hospitals NHS Foundation Trust

Stroke Measures

Breach reasons 2019 and Monthly Stroke position

Month	Stroke Bed Capacity * No outliers *	Trust Bed Capacity * Outliers *	Suspected COVID-19 patient	Delayed transfer of care (DTOC)	Operational decision - patient moved off accommodate an acute stroke	Delay in medical review in ED	Clinical - Appropriate pathway for patient	Difficult presentation	Medical SpR did not request stroke bed/ team	Delayed diagnosis	Clinician's decision to place patient on d	Unclear presentation	Difficult diagnosis	Failure to request stroke bed	Resource capacity	Number of breaches	Month Position (Target 80%)
May 19		3					2		3			2	6		5	21	68.7%
Jun 19	1	5					1					3	1			11	82.5%
Jul 19	1	4					2					1	2		1	11	80.7%
Aug 19	1	4				1	4	2				3				15	82.1%
Sep 19							4			1		2	1			8	86.0%
Oct 19	1	2					1		2	2			1		1	10	85.3%
Nov 19		7					2						2		2	13	80.6%
Dec 19		2							1							3	93.0%
Jan 20		6				1	1		2			2				12	81.3%
Feb 20		1							3			2	1			7	88.3%
Mar 20		1									1	2	3			7	88.3%
Apr 20			2				1		1	1			4			9	83.3%
May 20		1						1				1	4			7	87.3%
Summary	4	36	2	0	0	2	18	3	12	4	1	18	25	0	9	134	





Achieved for May = **87.3%**

4hrs adm to SU (63%) target compliance was achieved for May= **63%**

'Difficult diagnosis' (4) was the main factor contributing to breaches last month, with a total of 7 cases in May 2020.

Key Actions

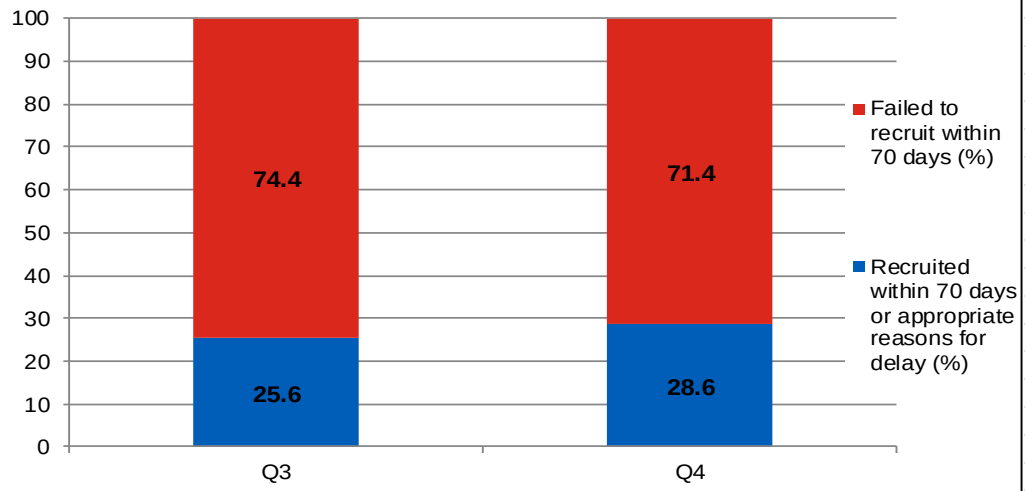
- During the COVID 19 pandemic we have created red and green stroke pathways and introduced training and support to wards C7 and D6, who will receive the 'red' and 'amber' stroke patients respectively.
- Working with community partners to plan and address capacity requirements for Stroke patients in relation to COVID19.
- National SSNAP data shows Trust performance from Oct-Dec19 maintained at **Level .**
- As from the 1st June Stroke registrars will be covering the front door with the stroke bleep nurse. Registrar time: 08:00 – 17:00. Out of hours covered by stroke bleep nurse with Neurology registrar for complex thrombectomy and thrombolysis patients. Complex patients alongside multiple stroke calls can lead to resource capacity issues. Stroke clinical research nurses back fill stroke bleep nurse 09:00- 18:00 where possible. On-call stroke bleep nurse set up to support D6 and C7 with complex stroke patients out of hours.
- On 3rd December 2019 the Stroke team received approval from the interim COO to ring-fence one male and one female bed on R2. This is enabling rapid admission in less than 4 hours. The Acute Stroke unit hosts a high number of outliers, but is working closely with the Op's centre to protect two Stroke beds. Awaiting Covid swab results having an impact on four hour admission to SU.
- Ward improvement work with support from the transformation team is on pause, but rapid discharge from front door continues. These workstreams are expected to resume virtually in June 2020.
- Repatriation of WSH stroke patients within 24-48 hours as per SOP continues. The CUH team continue to liaise with other DGH's to improve the repatriation process of patients to other local hospitals. The West Suffolk Stroke Pathway proved itself by LOS reduction for those repatriated to WSH from 27 days to 2.78 days.
- Stroke Taskforce meetings remain in place, plus weekly review with root cause analysis undertaken for all breaches, with actions taken forward appropriately.
- Stroke follow up phone clinic at one week commenced led by bleep / research team to look at unmet need during the present crisis. This has been successful and is to be audited for potential long-term implementation.

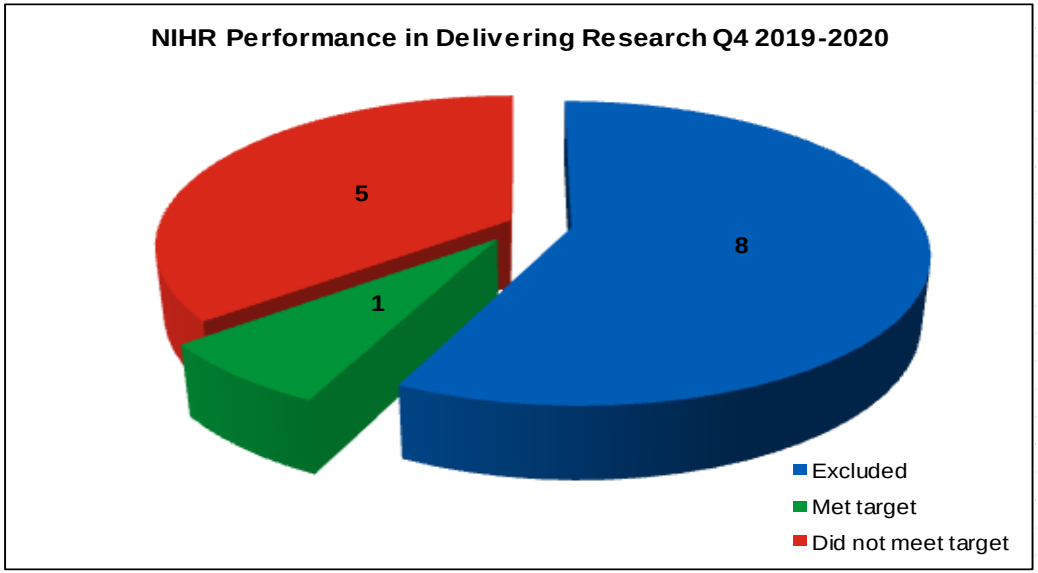
Reason for not meeting 4hrs in April 2020	Total
Complex patient, stroke not major issue	2
Delay to transfer to R2 by ED	1
Delay/No referral Stroke bleep	8
Infection control reasons	1
Patient unwell	1
Stroke Nurse Capacity	2
Trust Bed Capacity - outliers on SU	4
Grand Total	19

Clinical Studies

Cambridge University Hospitals NHS Foundation Trust

Clinical Studies Measures





Situation as at 31/03/2020 reported to the NIHR
[quarterly update only]
While the National Institute for Health Research (NIHR) has now abolished the time and target initiative (70 days from the date we received the document pack from the Sponsor to the date the 1st patient was recruited), we continue to report on our performance against it for consistency. Only studies which are approved by HRA are included in the report, but it will include studies which are CUH site selected but not yet open.
The performance in delivery target for commercial studies remains unchanged, and is for trials closed to recruitment in the preceding 12 months and whether they met their target recruitment in the agreed timeframe.

70 days (Initiating):
Data on 100 non-commercial and commercial clinical trials was submitted this quarter.
Of all analysed trials, 28.6% (8/28) met the target, which is a slight increase in performance from the previous three quarters. We did anticipate this improvement, as we have been working with the governance team to improve targets.
81 studies did not meet the target, but appropriate reasons have been given for 61 of them, which will exclude them from the analysis.
11 studies are still able to meet the target and are excluded from the analysis.

Delivering to target:
Data was submitted on 14 commercial trials this quarter.
With 8 studies not having an agreed target, 6 trials have been analysed, giving a performance of 16.7% (1/6).
This is up from Q3's performance of 12.5% (1/8).
Of the trials not meeting the recruitment target, 60% (3/5) were withdrawn by the Sponsor before having the opportunity to meet the recruitment number/range agreed.

Actions in progress
While our performance in initiating research studies is no longer matched against the 70-day target, the NIHR are focusing on measurement, reporting and improvement, with an emphasis on transparency. We therefore will continue to supply information on times taken to set up studies and recruit, to aid their high level analysis of recruitment issues and developing trends, while focusing on resolving any issues internally where possible.
There continues to be inherent tension in the system, whereby funders set arbitrary start dates without proper appreciation of the Trust's processes of due diligence. This causes problems with studies being submitted to HRA for review, as fundamental issues need resolving prior to study commencement.

Maternity Dashboard

NHS Cambridge University Hospitals NHS Foundation Trust

Maternity Measures

Rosie Maternity Dashboard May 20								
Sources / References	KPI	30/04/2020	Red Flag	Measure	Data Source	Apr-20	May-20	Actions taken for Red/Amber results
	Activity							
Source - EPIC	Births (Benchmarked to 5716 per annum)	< 476	> 520	Births per month	Rosie KPI's	402	424	
Antenatal Care NICE quality standard [QS22]	Health and social care assessment <GA 12+6/40	> 90%	< 85%	Booking Appointments	EPIC	95%	92%	
Source - EPIC	Normal Birth	> 55%	< 55%	SVD's in all birth settings	Rosie KPI's	59%	59%	
Source - EPIC	Home Birth	> 2%	< 1%	Planned home births (BBA is excluded)	Rosie KPI's	2%	4%	
Source - EPIC	MLBU Birth	> 22%	< 20%	MLBU births	Rosie KPI's	19%	20%	We are reviewing our admissions to RBC to encourage more eligible pregnancies to use the facilities. We are also looking at our reasons for transfer to DU and subsequent care and outcomes as part of this.
Source - EPIC	Induction of Labour	< 24%	> 29%	Women induced for delivery	Rosie KPI's	26%	30%	
Source - EPIC	Ventouse & Forceps	<10-15%	<5%>20%	Instrumental Del rate	Rosie KPI's	14%	13%	
Source - EPIC	National CS rate (planned & unscheduled)	< 25%	> 28%	C/S rate overall	Rosie KPI's	27%	28%	Our rates are consistent and our perinatal outcomes are not outlying so potentially this rate is right for our population. Population factors – we have a higher than average number of women who are older mothers who have a higher rate of caesarean section. We are a tertiary unit. LSCS rate reflective of our acuity
Source - EPIC	Smoking at delivery Number of women smoking at the time of delivery	< 10%	> 11%	% of women Identified as smoking at the time of delivery	Rosie KPI's	6%	8%	
	Workforce							
	Midwife/birth ratio (actual)**	01:24	06:43	Total permanent and bank clinical midwife WTE*/Births (rolling 12 month average)	Finance	01:23.5	01:24.3	Clinical midwife WTE as per BR+ = clinical midwives, midwife sonographers, post natal B3 and nursery nurses. For actual ratio, calculation includes all permanent WTE plus bank WTE in month.
	Midwife/birth ratio (funded)**	1.24.1	N/A	Total clinical midwife funded WTE*/Births (rolling 12 month average)	Finance	1:23.2	1:24:9	Midwife/birth ratio has been restated from April 19 based on the BR+ methodology and targets updated. Previous ratio was based on total clinical and non-clinical midwife posts excl midwife sonographers.
Source - CHEQS	Staff sickness as a whole	< 3.5%	> 5%	ESR Workforce Data	CHEQs	4.24%	4.31%	This is reported 1 month behind from CHEQ's
Source - CHEQS	Education & Training - attendance at mandatory training (midwives)	>92% YTD	<75% YTD	Training database	CHEQs	96%	96%	This is reported 1 month behind from CHEQ's

Maternity Dashboard

NHS Cambridge University Hospitals NHS Foundation Trust

Maternity Measures

	Maternity Morbidity							
Source - QSIS	Eclampsia	0	> 1		Risk Report	0	0	
Source - QSIS	ITU Admissions in Obstetrics	1	> 2		Risk Report	0	0	
Source - QSIS	PPH≥ 1500 mls	< 3%	> 4%	NMPA	CHEQS	4.73%	4.71%	PPH working group have identifed instrumentals in the delivery room improvement work - standardised care to be the same as theatre started
Source - QSIS	3rd/ 4th degree tear rate vaginal birth	< 5%	> 7%		Risk Report	2.38%	3.36%	
Source - QSIS	Maternal Death	0	>1		Risk Report	0	0	
	Risk							
Source - QSIS	Total number of SI's	0	>1	Serious Incidents	Datix	0	1	safeguarding case
Source - QSIS	Information Governance	0	>1		Datix	0	0	
Source - QSIS	Clinical	0	>1		Datix	0	1	
Source - QSIS	Never Events	0	>1	DATIX	Datix	0	0	
	Neonatal Morbidality							
Source - EPIC	Shoulder Dystocia per vaginal births	< 1.5%	> 2.5%		Risk Report	1.23%	0.99%	No themes following review
Source - EPIC	Still Births per 1000 Births			3.87/1000 (Mbrrace)	Risk report	1.6/1000	0.42/1000	
	Stillbirths - number ≥ 24 weeks	0	≥ 2	MBBRACE	Risk report	4	1	
Source - EPIC	Number of birth injuries	0	> 1	Injuries to neonate during delivery	Risk Report	0	0	
Source - EPIC	Number of term babies who required therapeutic cooling	0	> 1		Risk Report	0	0	
Source - EPIC	Baby born with a low cord gas < 7.1	<2%	> 3%		Risk Report	0.49%	0.42%	
Source - EPIC	Term admissions to NICU	<6.5	>6.5	Percentage of all live births	Risk Report	5.72%	5.91%	ATAIN work on going . priorities being reviewed low temp in first hour work
	Quality							
	Number of times Rosie Maternity Unit Diverted	0	> 1	All ward diverts included	Rosie Diverts	0	0	
Source - EPIC	1-1 Care in Labour	>95%	<90%	Exlcuding BBA's	Rosie KPI's	100%	100%	
Source - EPIC	Breast feeding Initiated at birth	> 80%	< 70%	Breastfeeding	Rosie KPI's	85%	83%	
Source - EPIC	VTE	>95%	< 95%		CHEQs	100%	100%	

Maternity Dashboard

NHS
Cambridge University Hospitals
NHS Foundation Trust

Maternity Measures

Maternity Safety Highlight Report

Trust: Cambridge University Hospitals | Date: May 2020

10 Steps-to-safety		
1	Perinatal review tool	
2	MSDS	
3	ATAIN	
4	Medical Workforce	
5	Midwifery Workforce	
6	SBLCB	
7	Patient Feedback	
8	Multi-professional training	
9	Safety Champions	
10	Early notification scheme	

SBLCB V2		
1	Reducing smoking	
2	Fetal Growth Restriction	
3	Reduced Fetal Movements	
4	Fetal monitoring during labour	
5	Reducing pre-term birth	

Outliers – Red flags	National Rate	Trust Rate
Still births	3.87/1000	1.6/1000
Maternal Sepsis NMPA	3.87/1000	xxxx/1000
PPH >1500mls	4%	4.01%
Term admissions to NICU	5%	5.91%

Number of	
Serious Incidents	Unactioned DATIX
2	9

Continuity of carer

Compliance	0%	
LMS target	15% (March 2020)	
Progress against action plan	• Team 1 planned Launch 4th May (currently under review due to COVID-19 and related workforce shortage) • Revised trajectory devised for 12 teams which will achieve 49% compliance by march 2021. • Current pandemic likely to delay roll out.	

Key		Colour codes for RAG
Complete	The Trust has completed the activity with the specified timeframe – No support is required	
On Track	The Trust is currently on track to deliver within specified timeframe – No support is required	
At Risk	The Trust is currently at risk of not being deliver within specified timeframe – Some support is required	
Will not be met	The Trust will currently not deliver within specified timeframe – Support is required	

Finance

Financial Performance

Trust actual and 'True-up' funding received

0.0 Act ost

10.3 'True-up' in month

0.0 Act ost

18.5 'True-up' YTD

Net current ass ets/(liabilities)

Net current liabilities

(370.2) act ost

Debtor days

34 This month

9 Previous month

Covid-19 spend M2 and YTD

(8.4) Act ost

(15.0) Act ost

Cash and EBITDA

Cash

84.9 act ost

3.3 plan

EBITDA

2.8 act ost

3.0 plan

Legend
£ in million
In month
YTD

Author(s): Marcus Rashford

Owner(s): Paul Scott

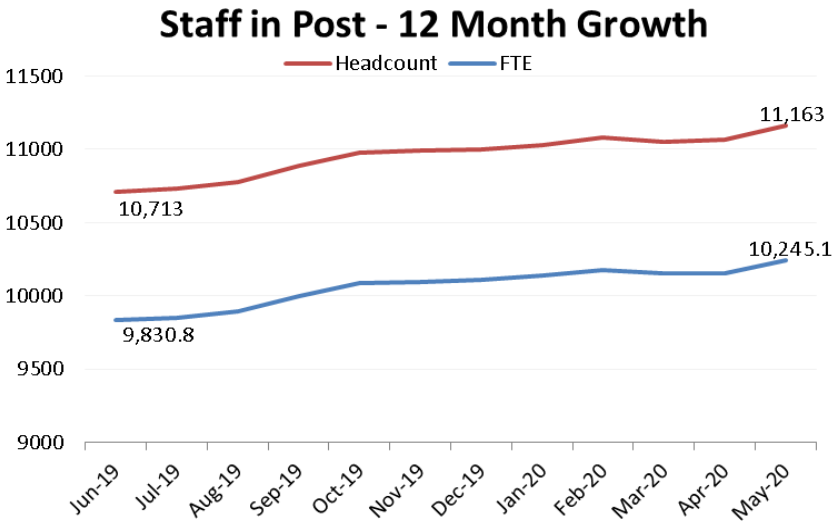
Staff in Post

Cambridge University Hospitals NHS Foundation Trust

Workforce: Staff as Partners

12 Month Growth by Staff Group

Staff Group	Jun-19	May-20	FTE 12 Month growth	
Add Prof Scientific and Technic	250	271	21	8.4%
Additional Clinical Services	1,655	1,772	117	7.1%
Administrative and Clerical	1,977	2,059	82	4.2%
Allied Health Professionals	501	541	41	8.1%
Estates and Ancillary	291	316	25	8.7%
Healthcare Scientists	533	553	20	3.7%
Medical and Dental	1,369	1,463	94	6.9%
Nursing and Midwifery Registered	3,255	3,269	14	0.4%
Total	**9,831**	**10,245**	**414**	**4.2%**



Admin & Medical Breakdown

Staff Group	Jun-19	May-20	FTE 12 Month growth	
Administrative and Clerical	1,977	2,059	82	4.2%
of which staff within Clinical Division	1,009	1,026	17	1.7%
of which Band 4 and below	740	746	6	0.8%
of which Band 5-7	184	195	11	5.7%
of which Band 8A	38	40	2	5.8%
of which Band 8B	4	3	-1	-23.8%
of which Band 8C and above	43	42	-1	-2.2%
of which staff within Corporate Areas	783	824	42	5.3%
of which Band 4 and below	217	233	16	7.6%
of which Band 5-7	373	389	16	4.2%
of which Band 8A	70	75	5	7.3%
of which Band 8B	49	51	2	3.6%
of which Band 8C and above	73	76	3	3.8%
of which staff within R&D	185	209	23	12.7%
Medical and Dental	1,369	1,463	94	6.9%
of which Doctors in Training	557	612	55	9.9%
of which Career grade doctors	205	207	2	1.0%
of which Consultants	607	644	37	6.1%

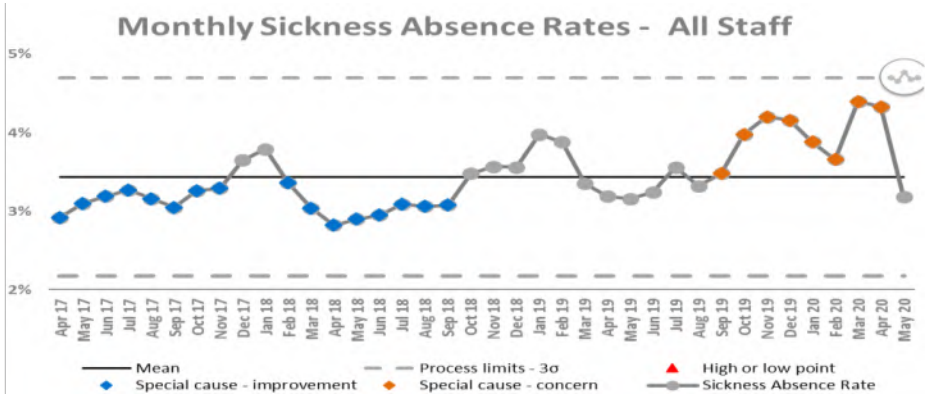
What the information tells us: Overall the Trust saw a 4.2% growth in its substantive workforce over the past 12 months.

Sickness Absence

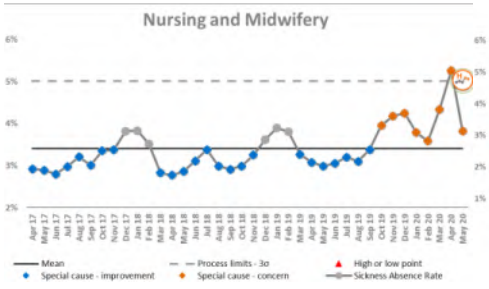
NHS
Cambridge University Hospitals
NHS Foundation Trust

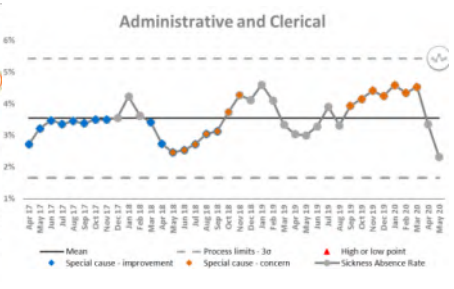
Workforce: Staff as Partners

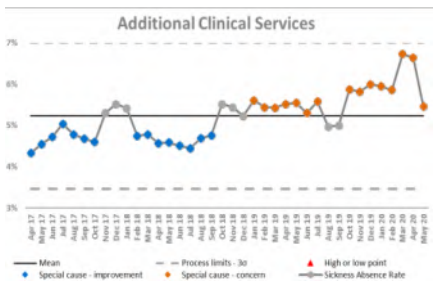
Background Information: Sickness Absence is a monthly metric and is calculated as the percentage of FTE days missed in the organisation due to sickness during the reporting month.

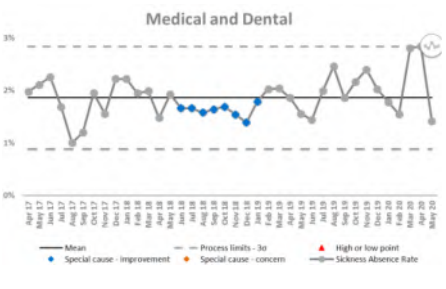


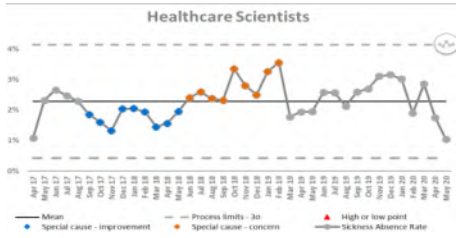
What the information tells us: Monthly Sickness Absence Rate has dropped below average for the first time in nine months. There is a significant decrease from the previous month by 1.2% to 3.18%. Potential Covid-19 related sickness absence (this includes chest & respiratory problems, flu and infectious diseases) has also fallen by 13% from the previous month. While sickness absence rates for both Nursing & Midwifery and Additional clinical services staff groups have dropped from the previous month, they remain in an area of concern.

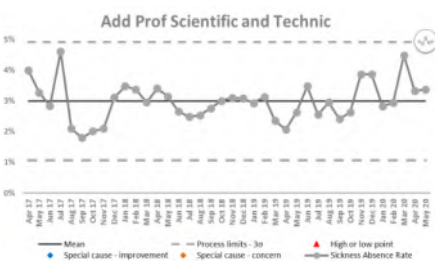










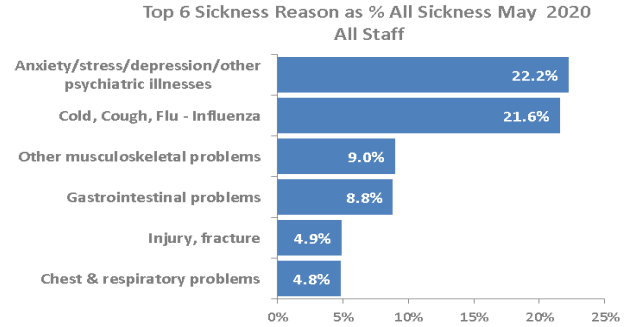


Sickness Information

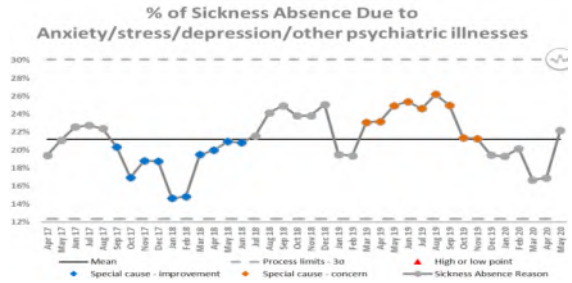
NHS
Cambridge University Hospitals
NHS Foundation Trust

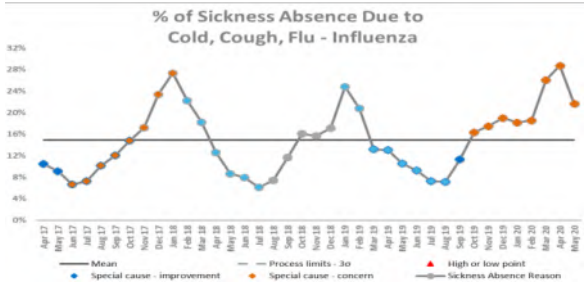
Workforce: Staff as Partners

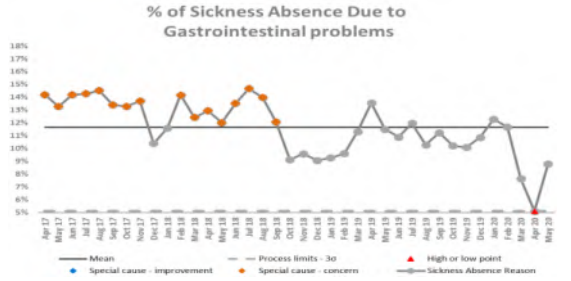
Background Information: Sickness Absence reason is provided as as a percentage of all FTE days missed due to sickness during the reporting month.

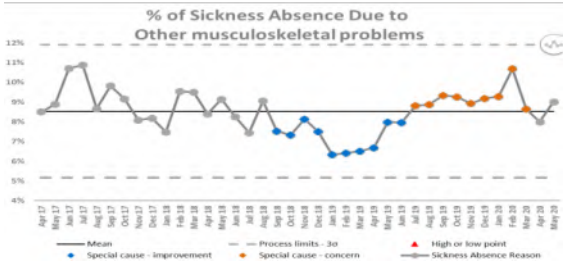


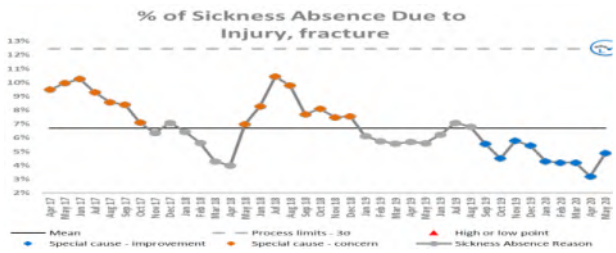
What the information tells us: The percentage of Influenza related sickness has significantly decreased from the previous month and has dropped to the second highest absence reason, below, mental health related sickness. It accounts for 21.6% of all sickness absence in May 2020, compare to 28.7% in the previous month.

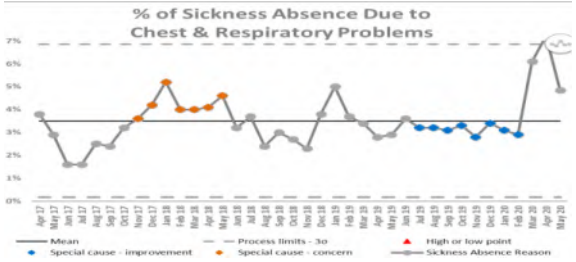










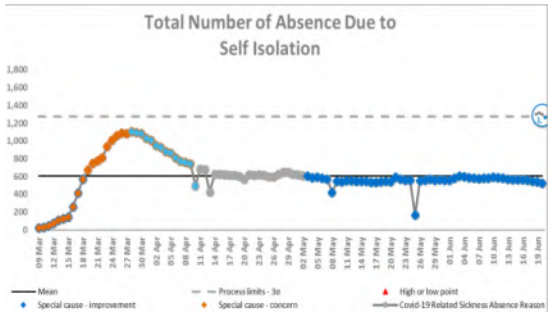


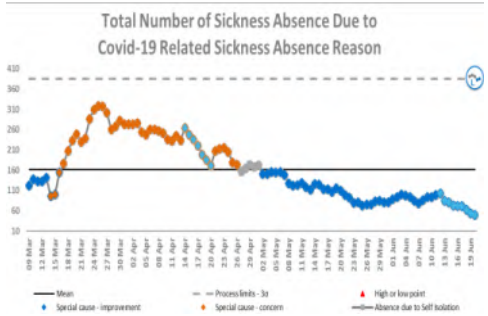
Covid-19 related Absence

Cambridge University Hospitals NHS Foundation Trust

Workforce: Staff as Partners

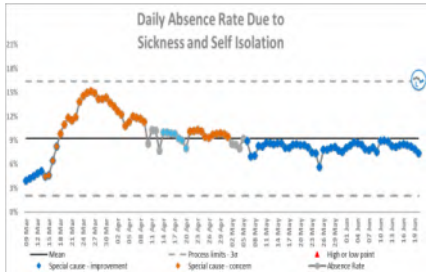
Background Information: Daily absences figures due to Covid-19 are presented. This only provides daily information relating to the number of staff recorded as being absent from work rather than the equivalent FTE days lost which is used in calculating monthly sickness absence rate.

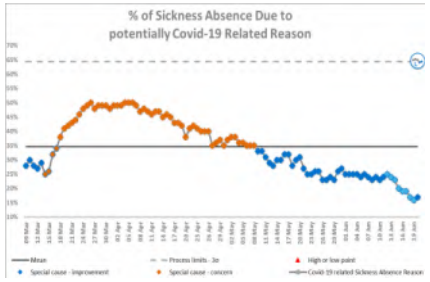


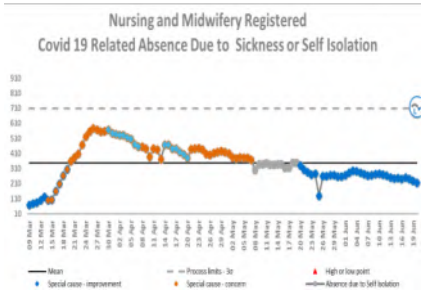


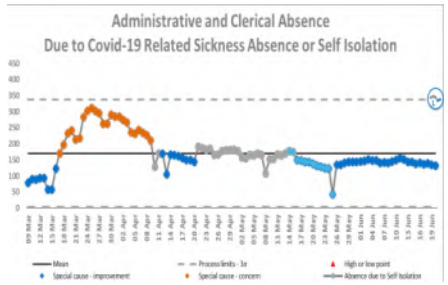
What the information tells us:

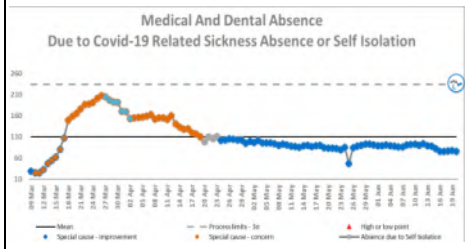
Both the total number of staff self-Isolating and the number of Covid-19 related sickness absence recorded continues to decrease and remains below the average for the Covid-19 period. As of 20th June 521 staff are self isolating, which is below the average of 607 for the last four months. Covid-19 related sickness absence currently accounts for 17% of the total sickness absence recorded within the Trust. This is down by 33% from the highest recorded in March. Overall, 7% of staff are absent from work due to Covid-19 related sickness or self-isolation.

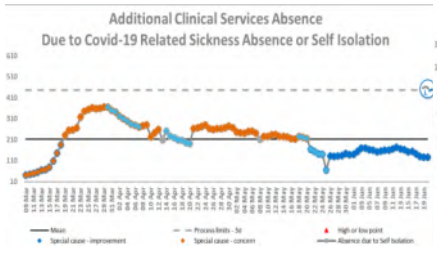


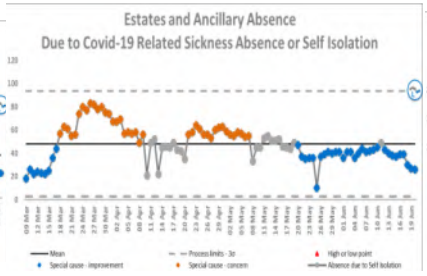


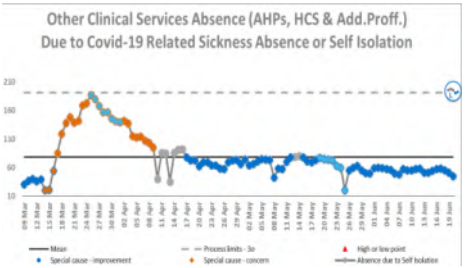










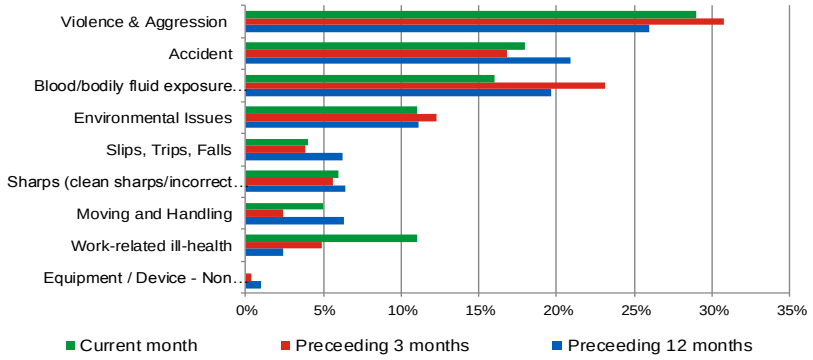


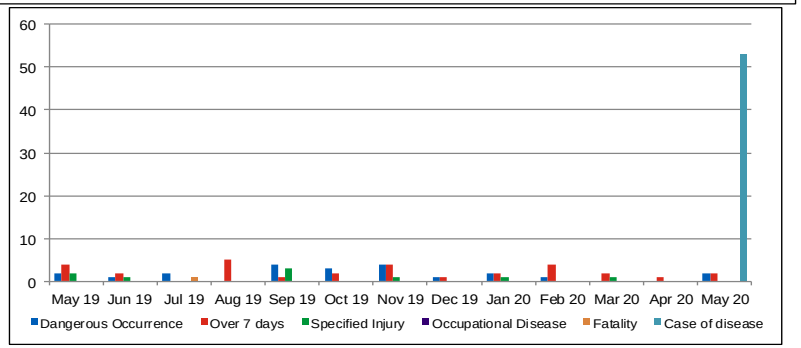
Health and Safety Incidents

Cambridge University Hospitals NHS Foundation Trust

Health and Saftey

No. of health and safety incidents reported by division:	Trustwide	Division A	Division B	Division C	Division D	Division E	Corporate	Estates
No. of health and safety incidents reported in a rolling 12 month period:	**1432**	**287**	**283**	**393**	**189**	**163**	**46**	**71**
Accident	**299**	56	72	70	41	25	11	24
Blood/bodily fluid exposure (dirty sharps/splashes)	**282**	77	66	59	24	42	10	4
Environmental Issues	**159**	34	40	17	20	34	6	8
Equipment / Device - Non Medical	**14**	2	1	4	4	2	1	0
Moving and Handling	**91**	17	29	19	14	5	1	6
Sharps (clean sharps/incorrect disposal & use)	**92**	31	14	14	9	18	4	2
Slips, Trips, Falls	**89**	19	15	11	10	13	8	13
Violence & Aggression	**372**	39	39	192	63	22	4	13
Work-related ill-health	**34**	12	7	7	4	2	1	1





A total of 1,432 health and safety incidents were reported in the previous 12 months.

643 (45%) incidents resulted in harm. The highest reporting categories were violence and aggression (26%), accidents (21%) and blood/bodily fluid exposure (20%).

75% (1,081) of incidents affected staff, 20% (278) affected patients and 5% (73) affected others ie visitors, contractors and members of the public.

The highest reported incident categories for staff were: blood/bodily fluid exposure (25%), violence and aggression (23%) an d accidents (18%).

The highest reported incident categories for patients were: violence and aggression (35%), accidents (31%) and environmental issues (17%).

The highest reported incident categories for others were: accidents (33%), violence and aggression (27%) and slips, trips an d falls (22%).

Staff incident rate is 9.8 per 100 members of staff (by headcount) over a rolling 12 month period.

The highest reporting division was division C with 393 incidents. Of these, 49% related to violence & aggression.

In the last 12 months, the highest reported RIDDOR category was case of disease (covid -19 non-fatal) (50%). 51% of incidents were reported to the HSE within the appropriate timescale. In May 2020, 57 RIDDORs were reported:

Case of Disease (53)
- Staff who have tested positive for Covid-19 where there is reasonable evidence to suggest that a work-related exposure is the likely cause of the disease.

Dangerous Occurrence (2)
- A CAS alert was published stating that Tiger Eye protective goggles should not be used. It is likely that AGPs were conducted whilst wearing this product, causing a potential work-related exposure to covid-19.
- The Injured Person (IP) sustained a small nick on their finger with a scalpel. The patient was hep C positive.

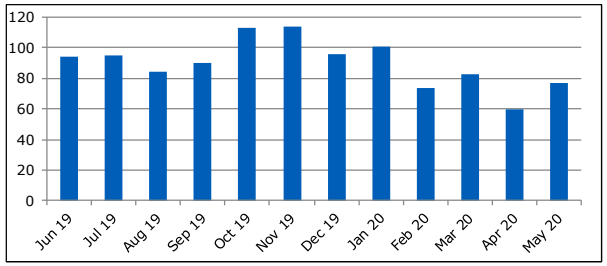
Over 7 Day Injury (2)
- A box was used to keep a door open which the IP tripped over whilst moving across the room. The IP was off work/on light duties for over 7 consecutive days .
- The IP was trying to reach a theatre set on the top shelf and strained their shoulder. The IP was unable to carry out their normal duties for over 7 consecutive days .

Health and Safety Incidents

NHS Cambridge University Hospitals NHS Foundation Trust

Health and Saftey

No. of health and safety incidents affecting staff:

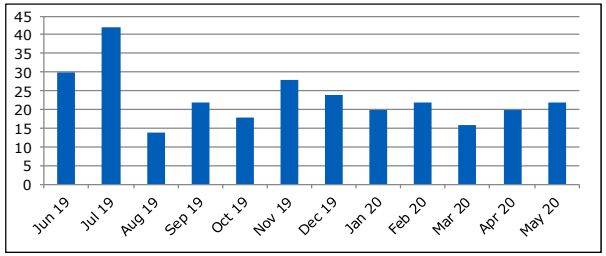


	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Total
Accident	8	17	19	20	22	26	17	18	13	12	8	10	**190**
Blood/bodily fluid exposure (dirty sharps/splashes)	23	26	16	17	21	28	30	23	23	26	21	14	**268**
Environmental Issues	7	11	8	7	13	7	6	9	10	12	5	8	**103**
Moving and Handling	18	6	7	8	16	5	5	5	5	2	0	5	**82**
Sharps (clean sharps/incorrect disposal & use)	6	8	4	6	10	6	9	10	2	7	3	6	**77**
Slips, Trips, Falls	8	3	7	8	10	13	3	8	2	4	3	4	**73**
Violence & Aggression	23	19	20	21	19	27	25	27	17	18	19	19	**254**
Work-related ill-health	1	5	3	3	2	2	1	1	2	2	1	11	**34**
Total	**94**	**95**	**84**	**90**	**113**	**114**	**96**	**101**	**74**	**83**	**60**	**77**	**1081**

Staff incident rate per 100 members of staff (by headcount):

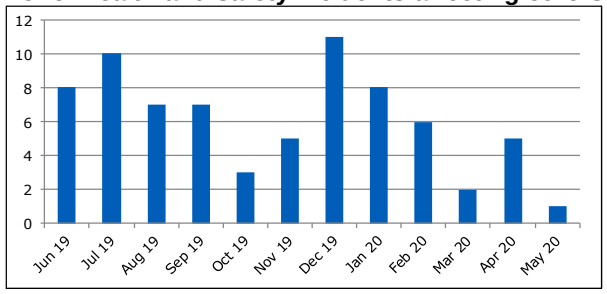
	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Total
No. of health & safety incidents	94	95	84	90	113	114	96	101	74	83	60	77	**1081**
Staff incident rate per month/year	0.9	0.9	0.8	0.8	1.0	1.0	0.9	0.9	0.7	0.8	0.5	0.7	**9.8**

No. of health and safety incidents affecting patients:



	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Total
Accident	11	10	7	9	6	13	6	4	5	2	4	8	**85**
Blood/bodily fluid exposure (dirty sharps/splashes)	1	2	0	0	0	1	1	2	1	2	1	2	**13**
Environmental Issues	2	15	3	2	3	1	5	3	6	5	0	2	**47**
Equipment / Device - Non Medical	1	2	0	1	1	1	3	0	4	1	0	0	**14**
Moving and Handling	0	0	0	0	0	3	2	2	2	0	0	0	**9**
Sharps (clean sharps/incorrect disposal & use)	4	1	0	0	2	2	1	1	1	0	0	0	**12**
Violence & Aggression	11	12	4	10	6	7	6	8	3	6	15	10	**98**
Total	**30**	**42**	**14**	**22**	**18**	**28**	**24**	**20**	**22**	**16**	**20**	**22**	**278**

No. of health and safety incidents affecting others ie visitors, contractors and members of the public:



	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Total
Accident	2	2	3	0	1	0	6	3	3	0	4	0	**24**
Blood/bodily fluid exposure (dirty sharps/splashes)	0	0	0	0	0	0	0	0	1	0	0	0	**1**
Environmental Issues	1	3	1	0	0	0	0	1	0	2	0	1	**9**
Sharps (clean sharps/incorrect disposal & use)	1	2	0	0	0	0	0	0	0	0	0	0	**3**
Slips, Trips, Falls	0	0	1	5	1	4	2	1	2	0	0	0	**16**
Violence & Aggression	4	3	2	2	1	1	3	3	0	0	1	0	**20**
Total	**8**	**10**	**7**	**7**	**3**	**5**	**11**	**8**	**6**	**2**	**5**	**1**	**73**

NHS
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Cambridge University Hospitals NHS Foundation Trust

Report to the Board of Directors: 8 July 2020

Agenda item	9.3
Title	Nurse Safe Staffing
Sponsoring executive director	Lorraine Szeremeta, Chief Nurse
Author(s)	Maura Screaton, Deputy Chief Nurse Sarah Raper, Roster Support Lead Annesley Donald, Deputy Director of Workforce
Purpose	To provide the Board with the monthly Nurse Safe Staffing Exception Report.
Previously considered by	Management Executive, 25 June 2020

Executive Summary

The paper sets out the regular nursing and midwifery retrospective staffing report for May 2020 and provides an update on current nurse vacancy levels, including areas of challenge or concern and actions in place.

Related Trust objectives	Improving patient journeys Strengthening the organisation
Risk and Assurance	Insufficient nursing and midwifery staffing levels
Related Assurance Framework Entries	BAF ref: 004
Legal / Regulatory / Equality, Diversity & Dignity implications?	NHS England & CQC letter to NHSFT CEOs (31.3.14) NHS Improvement Letter – 22 April 2016. NHS Improvement letter re: CHPPD – 29 June 2018 NHS Improvement – Developing workforce safeguards October 2018
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	Yes

Action required by the Board of Directors:

The Board is asked to note:

- The safe staffing report for May 2020.
- The Registered Nurse vacancy rate for May 2020 was 6.57%.
- Registered children's nurse vacancy rate for May 2020 was 16.9%.
- Care Hours Per Patient Day (CHPPD) for May 2020 was 16.09.

Cambridge University Hospitals NHS Foundation Trust

8 July 2020

Board of Directors
Monthly Nurse Safe Staffing
Lorraine Szeremeta, Chief Nurse

1. Executive Summary

1.1 The Chief Nurse's Office and Heads of Nursing continue to work together to ensure our wards and departments are safely staffed at Cambridge University Hospitals (CUH). Working closely with divisional and workforce colleagues we continue to look for opportunity for efficiencies within the workforce while also monitoring any impact on safety and quality of care.

2. Purpose

2.1 The purpose of this paper is to present the Board of Directors with an overview of nurse staffing capacity for the month of May 2020 in line with the National Institute for Clinical Excellence (NICE) safe staffing and National Quality Board (NQB) standards.

2.2 The report gives an overview of nurse staffing for May 2020 including actual versus planned hours worked, temporary staffing usage, reports of NICE red flag staffing issues as well as details of care hours per patient day (CHPPD).

3. Background – National and Local Context

3.1 Since April 2014 all hospitals have been required to publish information about the number of nursing and midwifery staff working on each ward, together with the percentage of shifts meeting safe staffing guidelines. This was in response to the Francis report which called for greater openness and transparency in the health service.

3.2 The Carter report (2016) identified that one of the obstacles to eliminating unwarranted variation in the deployment of nursing and healthcare support workers has been the absence of a single means of recording and reporting how staff are deployed. Care hours per patient day (CHPPD), is the total number of hours worked on the roster (clinical staff), divided by the bed state captured at 23.59 each day. For the purposes of reporting, this is aggregated into a monthly position. CHPPD is now the principal measure of nursing, midwifery and health care support worker deployment and from September 2018, CUH publish data on CHPPD on My NHS and NHS Choices. Data from all hospitals are stored on the model hospital dashboard which allows comparison against peers to be made.

3.3 October 2018 saw the publication of 'Developing Workforce Safeguards' by NHS improvement. Trusts compliance with safer staffing, from April 2019, will be assessed with a triangulated approach which combines evidence based tools (e.g. SNCT), professional judgement and outcomes. By implementing the documents recommendations together with strong and effective governance, boards can be assured that workforce decisions will promote patient safety and compliance with regulatory standards.

3.4 In response to the COVID-19 pandemic, the Nursing and Midwifery Council (NMC) worked with Health Education England (HEE) to enable 2nd and 3rd year students to undertake paid clinical placements throughout the NHS. It was recognised that during the pandemic, students would not be supernumerary and would work within the workforce whilst also being provided with learning opportunities.

3.5 One hundred student nurses and 30 student midwifes undertook placements in the trust during this time. These students have been able to complete their placement hours and achieve their competencies which enables them to progress with their academic programmes as planned. There have been a number of students who were unable to take up the option of a paid placement for a variety of reasons or have not completed the expected clinical hours. HEI's are working with these individuals to identify how this time can be made up however it should be noted that some individuals may need to delay the completion of their programme which will have an impact upon the recruitment pipeline.

3.6 All first year students will not have completed the required number of clinical placement hours however HEI's are working with practice partners and the NMC to identify how these hours can be made up over the reminder of their programme through extended placements in year 2 and 3 to ensure that they complete their programme and register as planned.

3.7 All student nurses and midwives who are studying at Anglia Ruskin University have been offered a post within the Cambridge and Peterborough STP upon completion of their programme. These students have been invited to express an interest for their preferred employing organisation. This has resulted in 13 adult nursing students, 9 paediatric students and 16 midwifery students expressing an interest to work at Cambridge University Hospitals.

3.8 It is expected that there will also be additional adult students from nationwide universities that apply to work here but at this time, recruitment is still in progress.

3.9 The HCSW vacancy rate for May was 16.74%. The current RN vacancy rate for May was 6.57%, which is similar to April, (5.44%).

3.10 The self-reported Band 5 vacancy rate in paediatrics for registered children's nurses (RCN) for May was 16.9% (across all paediatric areas). Turnover for all bands Paediatric Nursing and Midwifery Registered remains is 12.8%, compared with the Trust average position for nursing of 9.8%. A paediatric nursing retention & recruitment strategy has been developed & being monitored via workforce experience committee and nursing midwifery and AHP advisory group, as cross divisional.

4. Actual and planned staffing report for May 2020

4.1 Appendix 1 gives an overview of the planned versus actual coverage in hours for the calendar months of May 2020. To ensure that the Board is given sight of the staffing within all areas the planned versus actual staffing hours are included within the relevant divisional table.

4.2 Throughout the data monitoring period, for wards with an overall rota fill of <90%, or where the trained nursing rota was <90%, or the ward had been a concern to the Divisional Head of Nursing; an individual written summary is reported.

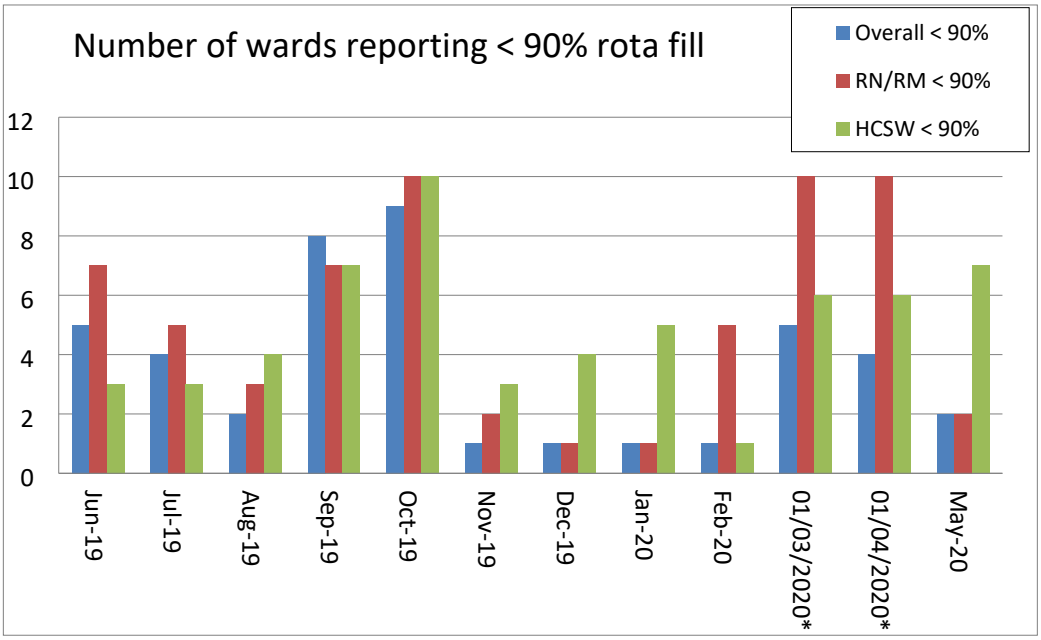
4.3 The overall daytime fill rate for registered nurses for May was 95.6% (April 94.2%). The overall day time fill rate for registered midwives for May was 95.7%, (April 93.4%).

4.4 Night shift RN fill rate for May was 95.6%, (April 89.9%). Night shift RM fill rate was 95.7% in May, (April 90.4%).

4.5 Exception reports for fill rates in excess < 90% is explained in Appendix 2. Two ward areas reported fill rates of <90% in May 2020.

Trend data is included in charts below.

Chart 1: Ward rota fill rates



4.6 *Adult Critical Care Units*

Critical Care continued to be in surge phase during May. Staffing was in accordance and compliant with speciality guidance for critical care during COVID pandemic.

4.7 PICU & NICU

The daytime RN fill rate for PICU in May was 100%, (April 100.3 %) & the night time fill rate was 100%, (April 104.6%). NICU daytime fill rate was 100% in May and 99.6% at night.

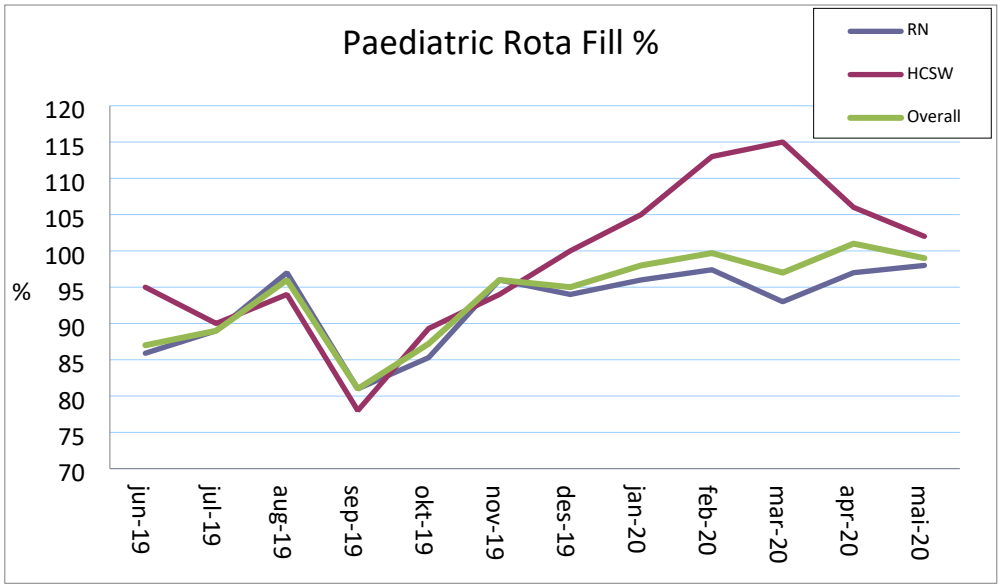
4.8 *Emergency Department (ED)*

Adult ED had an overall RN fill rate for May of 93.9%, (April 93.0%).

Paediatric ED day time fill rate in May was 97.9%, (April 91.3%). All shifts were covered by a registered children's nurse. Night time fill rate for May was 110.6% (April 93.6%)

4.9 Charts 2 shows the trend in fill rates across paediatric ward areas. The overall fill rate on paediatric wards was 99% in May. It must be noted that the occupancy on paediatric wards was low in May.

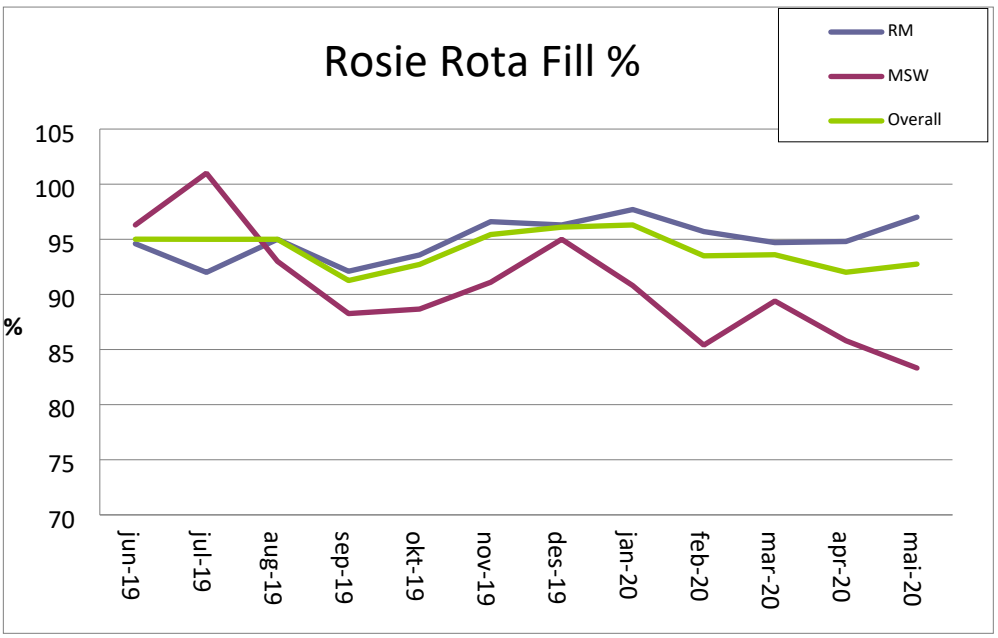
Chart 2: Paediatric ward % fill rates



5. Maternity

5.1 Chart 3 shows the trend in % fill rate for the Rosie according to current establishment. RM fill rate was 97.01% in May, April 94.75%.

Chart 3: Maternity - Rosie % fill rate



Source: CUH MAPS data

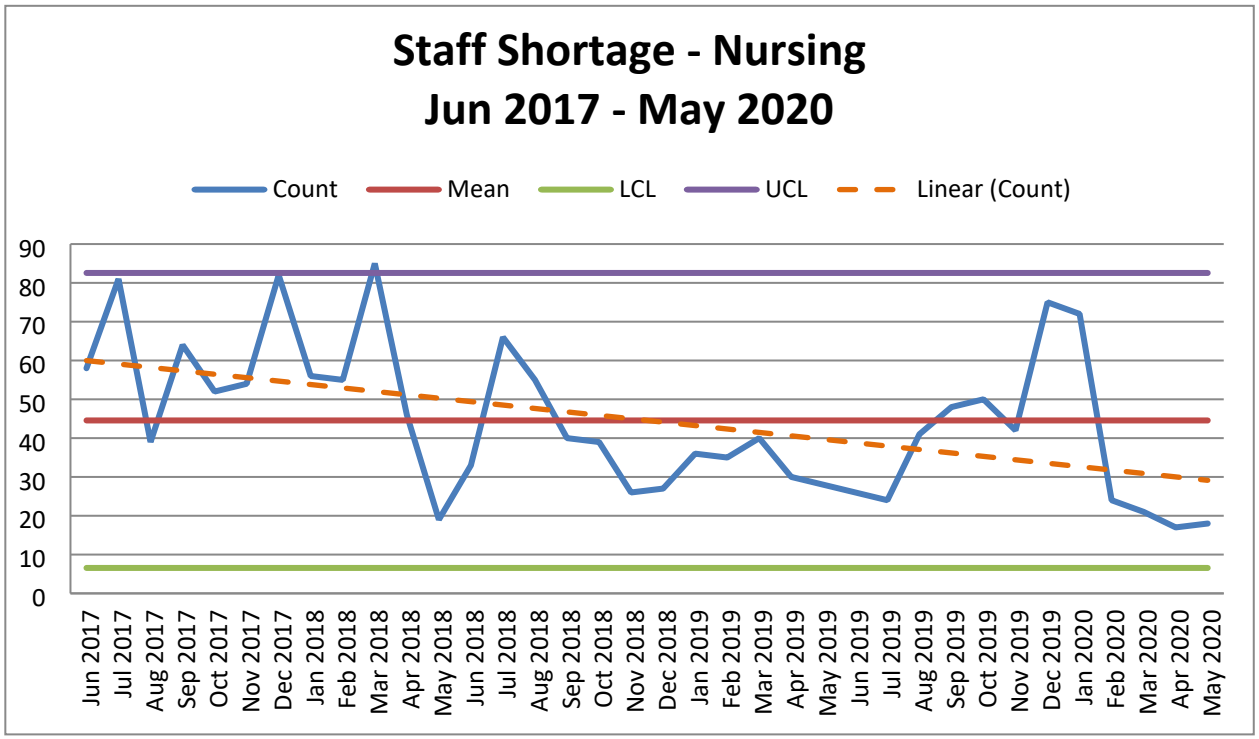
6. Operational exceptions

6.1 It must be noted that the ward reconfigurations as part of the COVID recovery is in progress. The nursing workforce implications are being overseen and tracked by the nursing reconfiguration taskforce.

7. Safety and risk

7.1 The trend in Safety Learning Reports (SLRs) completed in relation to nurse staffing is shown in chart 4 below. The number of SLRs reported relating to nurse staffing has remained low for May. This is likely to be as a result of reduced bed occupancy. There were no direct patient harm incidents as a result of staff shortage incidents.

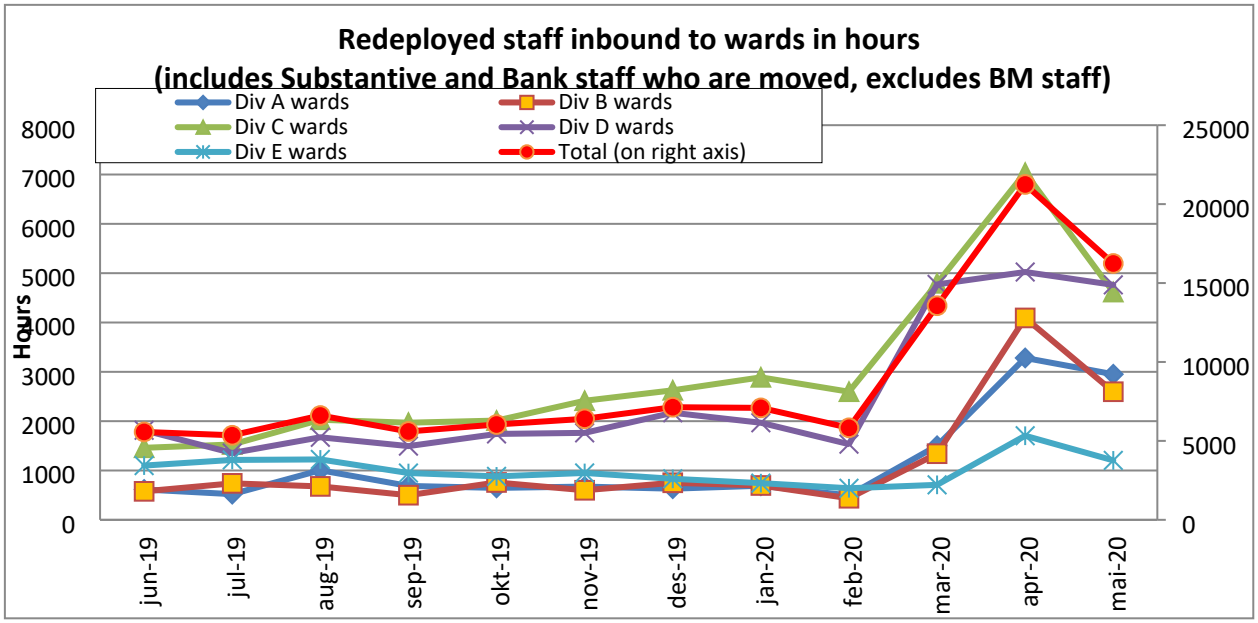
Chart 4: Incidents reported relating to nurse staffing



7.2 A daily escalation plan is used in line with the Safer Staffing Policy to mitigate wards with inadequate fill rates or training needs, and to ensure support is directed on a shift by shift basis as required in line with patient acuity and activity demands.

7.3 Movement of staff across wards to support safe staffing can be seen in Chart 5. It shows that 16,293 nursing hours were reallocated in the month of May. This is a decrease from April. It is recognised that movement of staff across wards will continue to happen due to the ward reconfiguration required as part of COVID recovery. Support structures are in place to ensure staff wellbeing is being considered as part of this reconfiguration.

Chart 5: Redeployment of staff to other ward areas



8. Red flags

8.1 A staffing red flag event is a warning sign that something may be wrong with nursing or midwifery staffing. If a staffing red flag event occurs, the registered nurse or midwife in charge of the service should be notified and necessary action taken to resolve the situation. In May there was just 1 red flag raised in relation to midwifery staffing and none for adult or paediatric nursing.

9. Care Hours per Patient Day (CHPPD) and Cost per Care Hours (CPCH)

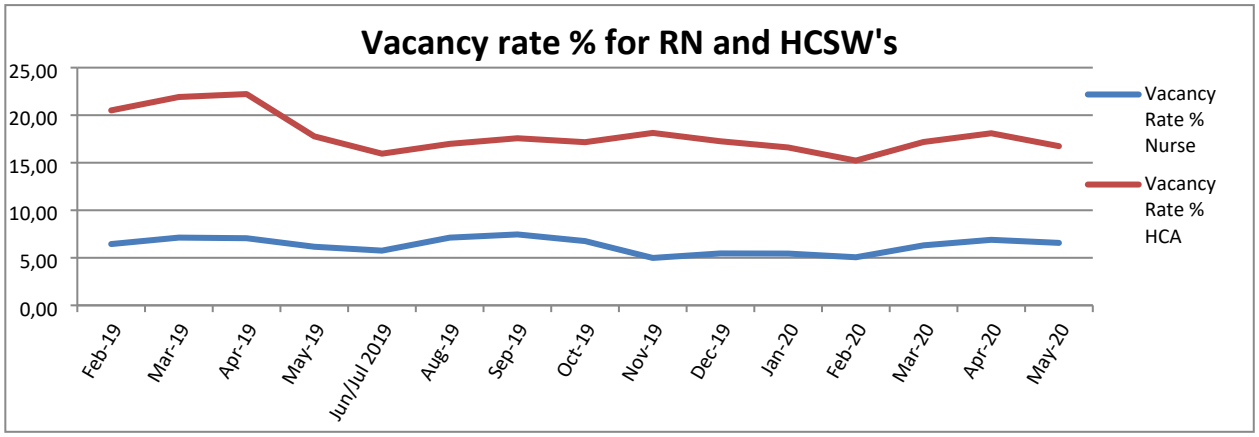
9.1 Care hours per patient day (CHPPD), is the total number of hours worked on the roster (clinical staff), divided by the bed state captured at 23.59 each day. NHS Improvement began collecting care hours per patient day formally in May 2016 as part of the Carter Programme. All trusts are required to report this figure externally.

9.2 The overall CHPPD for the month of May was 16.09. This is higher than pre COVID data. This can be explained by the reduction in number of in patients on wards in May. Data to compare to Shelford CHPPD is not yet available post COVID.

10. Forecast of nurse staffing position

10.1 Chart 6 shows the nurse vacancy rate for both RNs and HCSWs. The vacancy rate for RNs (bands 5, 6, 7) is 6.57% and the HCSW (bands 2,3,4) vacancy rate is 16.74% (from the unit reported Vacancy data). The vacancy data is self-reported from divisions against their establishment. All overseas nurses are currently working as RN's under the NMC's temporary registration, therefore the perceived vacancy rate is the same as the actual.

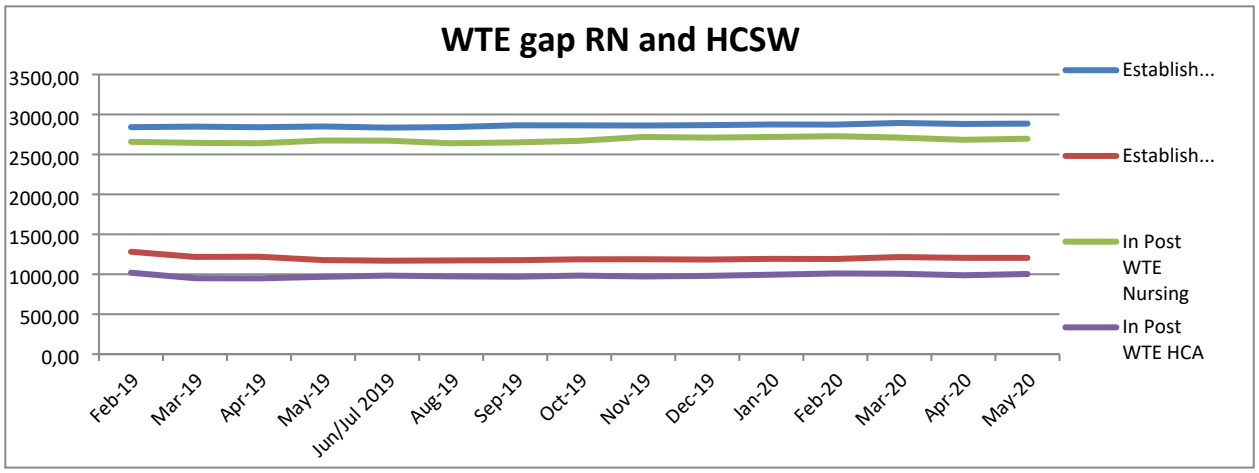
Chart 6: Vacancy rate % for RN and HCSWs



10.2 Chart 7 shows the WTE gap yet to be filled for both RNs and HCSWs. There are 189 Band 5 Nurses in the pipeline (those who have been made offers) - 98 international and 91 (external candidates only) from the UK.

10.3 The self-reported Band 5 vacancy rate in paediatrics for registered children's nurses(RCN) for May was 16.9% (across all paediatric areas). Turnover for all bands Paediatric Nursing and Midwifery Registered remains is 12.8%, compared with the Trust average position for nursing of 9.8%. A paediatric nursing retention & recruitment strategy has been developed & being monitored via workforce experience committee & nursing midwifery & AHP advisory group, as cross divisional.

Chart 7: WTE Gap RN and HCSW



10.4 The current vacancy rate for Healthcare Support Workers is currently 16.8%.

10.5 Appendix 3 provides detail on the forecasted position in relation to the number of RN and HCSW vacancies based on FTE and includes UK experience, UK newly qualified, apprenticeship route, EU and international recruits up to March 2021. Numbers based on those interviewed and offered positions in addition to planned campaigns.

11. Bank Fill Rate and Agency Usage

11.1 The Trust's Staff Bank continues to support the clinical areas with achieving safe staffing levels. In May, the total number of requests for RN Bank shifts was 7,013 this is a decrease of 2,870 shifts (5 week month) with an average fill rate of 81.6% (5,717 shifts filled with 1,296 unfilled) – see Chart 8. The total number of requests for HCSW Bank shifts has decreased to 5,304 with an average fill rate of 76.1% (4,024 shifts filled with 1280 unfilled) – see Chart 9.

Chart 8: RN Bank shift fill

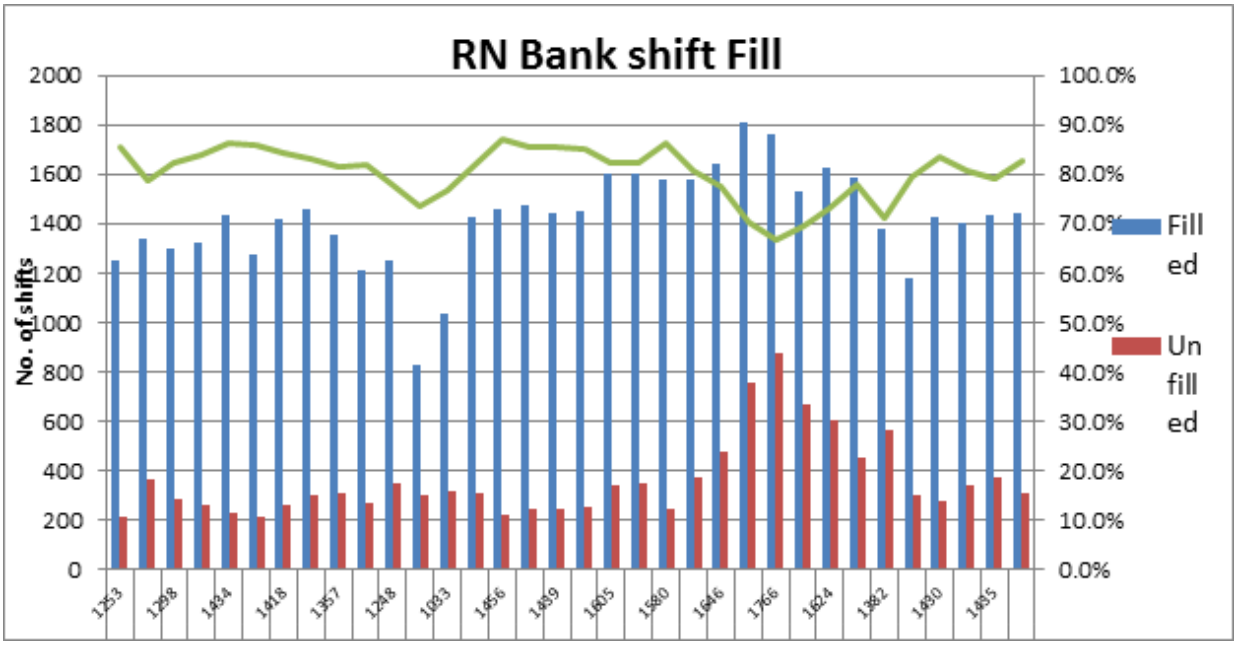
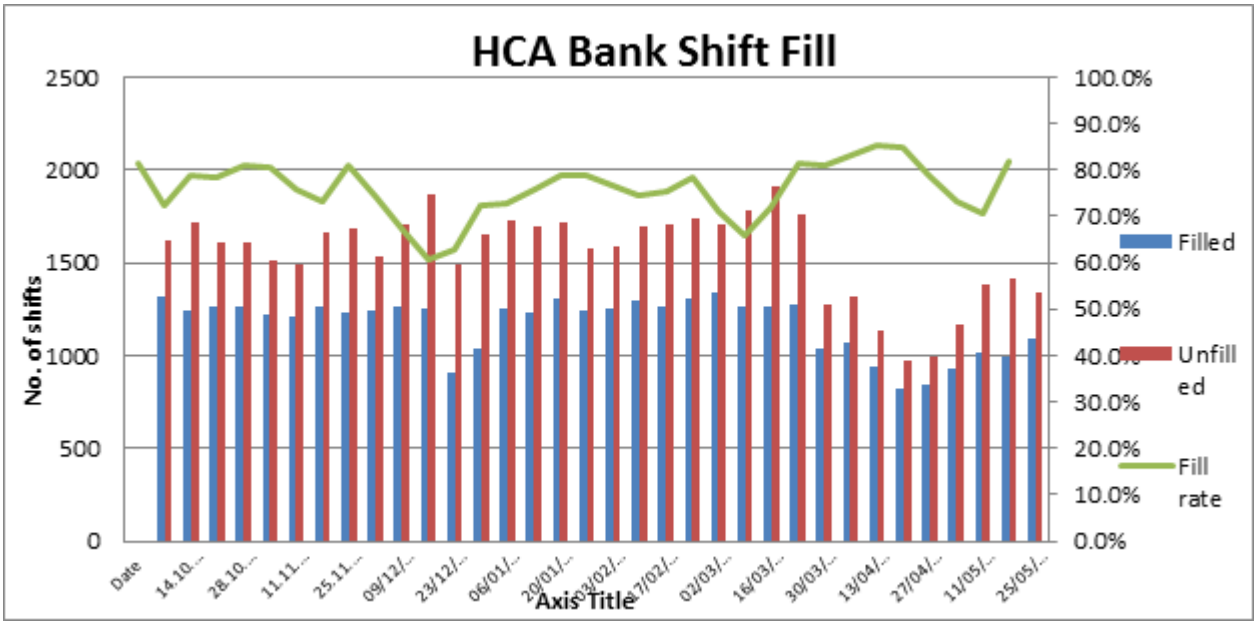


Chart 9: HCA Bank shift fill



12. Recommendations

12.1 The Board of Directors is asked to note:

- The safe staffing report for May 2020.
- The Registered Nurse vacancy rate for May 2020 was 6.57%.
- Registered children's nurse vacancy rate for May 2020 was 16.9%.
- Care Hours Per Patient Day (CHPPD) for May 2020 was 16.09.

Appendix 1: Actual and Planned Staffing Report (May 2020)

The data used within this report is pulled retrospectively from our Healthroster, and includes the % of hours (registered nurse and care staff) that were filled against the planned (baseline) number of hours for the calendar month. This data set is the same as our national submission to UNIFY.

Please note, areas with > 100% fill is due to additional hours filled to care for patients who require 1:1 supervision (specialling). Greater than 100% does not mean that all planned hours were filled, just that once totalled the actual hours planned and unplanned are greater than simple planned hours.

Division A		Day		Night		May-20		
	Main Speciality	Day - Average fill rate RN / RM (%)	Day- Average fill rate care staff (%)	Night - average fill rate RN / RM (%)	Night - average fill rate care staff (%)	RN/RM average fill rate	Care staff average fill rate	Total % hours filled (registered and care staff)
C8*	Trauma and Orthopaedics	99.6%	87.3%	99.0%	90.8%	99%	88%	96%
D8	Trauma and Orthopaedics	100.0%	163.0%	95.9%	79.9%	98%	138%	111%
L2 overnight stay	23 hour Stay Day Surgery	105.2%	99.4%	97.3%	97.3%	103%	99%	102%
L4	Colorectal Surgery	99.6%	132.2%	100.0%	113.9%	100%	123%	108%
M4	Gastroenterology	95.0%	105.9%	92.8%	108.0%	94%	107%	98%
IDA	Intermediate Critical care Unit	93.3%	97.6%	93.1%	90.2%	93%	94%	93%
J3 ICU*	Critical Care	95.2%	98.3%	96.3%	91.8%	96%	95%	96%
JOHN FARMAN ICU	Critical Care	90.4%	112.8%	95.8%	104.4%	93%	109%	94%
NCCU	Neuro Critical Care	91.3%	140.8%	93.2%	135.5%	92%	138%	96%
OIR	Overnight Intensive Recovery	#DIV/0!	#DIV/0!	100.0%	93.3%	100%	93%	99%
	Overall divisional fill	**94%**	**115%**	**95%**	**106%**	**94%**	**111%**	**97%**

Division B		Day		Night		May-20		
	Main Speciality	Day - Average fill rate RN / RM (%)	Day- Average fill rate care staff (%)	Night - average fill rate RN / RM (%)	Night - average fill rate care staff (%)	RN/RM average fill rate	Care staff average fill rate	Total % hours filled (registered and care staff)
C10	Haematology	100.0%	99.5%	98.9%	99.3%	100%	99%	100%
C9	Teenage Cancer Trust	98.2%	155.6%	100.0%	153.7%	99%	155%	117%
D6 HAEM	Haematology	94.5%	100.0%	100.0%	98.0%	97%	98%	97%
D9	Oncology	100.0%	89.6%	99.8%	108.1%	100%	97%	99%
	Overall divisional fill %	**99%**	**104%**	**100%**	**112%**	**99%**	**108%**	**102%**

Division C		Day		Night		May-20		
	Main Speciality	Day - Average fill rate RN / RM (%)	Day- Average fill rate care staff (%)	Night - average fill rate RN / RM (%)	Night - average fill rate care staff (%)	RN/RM average fill rate	Care staff average fill rate	Total % hours filled (registered and care staff)
C4	Geriatric Short Stay Medicine	99.5%	118.5%	100.0%	125.7%	100%	122%	109%
C5	Nephrology	96.1%	91.2%	95.2%	98.2%	96%	94%	95%
C6 was J3*	Geriatric Medicine	93.6%	97.2%	91.6%	91.9%	93%	95%	93%
C7 is J2*	General Medicine	100.0%	116.8%	97.5%	107.3%	99%	112%	103%
D10	Infectious Diseases	100.0%	119.0%	97.3%	124.1%	99%	122%	105%
D5	Hepatology	93.8%	95.8%	96.1%	111.9%	95%	102%	98%
EAU 4	Medical Decisions Unit	99.0%	117.9%	98.7%	118.1%	99%	118%	105%
F4 was C6*	Geriatric Medicine	90.3%	91.4%	97.2%	97.6%	93%	94%	93%
F5	Transplant and HDU	99.3%		97.6%		98%		98%
F6	Hepatobilary	97.9%	100.6%	98.3%	93.4%	98%	97%	98%
G3	Geriatric Medicine	100.0%	99.7%	98.9%	115.6%	100%	105%	102%
G4	Geriatric Medicine	99.0%	93.4%	97.2%	108.9%	98%	99%	99%
G5	Transplant and HDU	98.8%	92.0%	99.2%	93.5%	99%	93%	97%
G6	Geriatric Medicine	100.0%	115.3%	100.0%	141.8%	100%	124%	110%
MSEU	Medical Emergency Short Stay Unit	92.7%	133.8%	89.9%	170.0%	91%	148%	109%
N2	Infectious Diseases	89.4%	87.1%	84.7%	91.3%	87%	89%	88%
N3	Respiratory Medicine	97.7%	94.5%	95.9%	102.5%	97%	97%	97%
	Overall divisional fill %	96.4%	**101.5%**	**94.9%**	**108.0%**	**96%**	**104%**	**99%**

Division D		Day		Night		May-20		
	Main Speciality	Day - Average fill rate RN / RM (%)	Day- Average fill rate care staff (%)	Night - average fill rate RN / RM (%)	Night - average fill rate care staff (%)	RN/RM average fill rate	Care staff average fill rate	Total % hours filled (registered and care staff)
A3	DoSA	100.0%	91.2%	100.0%	127.3%	100%	100%	100%
A4	Neurology	95.0%	165.1%	98.8%	146.8%	96%	156%	118%
A5	Neurosurgery / oncology	96.4%	170.1%	95.4%	171.9%	96%	171%	125%
D6 Neuro	Neurology	88.1%	155.1%	85.8%	194.6%	87%	168%	106%
D7	Diabetes and General Medicine	92.5%	123.7%	95.1%	98.2%	94%	111%	100%
J2	Neuro Rehabilitation	99.6%	103.6%	96.8%	105.2%	98%	104%	101%
K3	Cardiology	98.0%	115.5%	100.0%	104.9%	99%	110%	103%
K3 CCU	CCU	99.0%	139.1%	100.0%		99%	125%	105%
L5	Vascular Surgery	99.5%	129.5%	100.0%	141.7%	100%	135%	112%
LEWIN	Stroke Rehabilitation	93.8%	132.8%	100.0%	166.4%	96%	145%	116%
M5	ENT & Ophthalmology	94.6%	123.5%	99.1%	172.3%	96%	144%	114%
R2	Acute Stroke Unit	96.7%	162.6%	100.0%	109.7%	98%	136%	111%
	Overall divisional fill %	**95.6%**	**137.2%**	**97.0%**	**138.1%**	**96%**	**138%**	**111%**

Maternity		Day		Night		May-20		
	Main Speciality	Day - Average fill rate RN / RM (%)	Day- Average fill rate care staff (%)	Night - average fill rate RN / RM (%)	Night - average fill rate care staff (%)	RN/RM average fill rate	Care staff average fill rate	Total % hours filled (registered and care staff)
Daphne	Gynaecology incl. Oncology	92.8%	76.9%	100.0%	63.6%	96%	73%	88%
Delivery Unit	Obstetrics	100.0%	74.9%	100.0%	77.1%	100%	76%	94%
Lady Mary Ward	Obstetrics	94.7%	86.8%	98.3%	92.4%	96%	89%	93%
RBC	Obstetrics	90.2%	101.4%	93.9%	96.8%	92%	99%	93%
Sara	Obstetrics (antenatal)	95.1%	85.9%	95.1%	93.7%	95%	88%	93%
	Overall divisional fill %	**96%**	**83%**	**98%**	**85%**	97%	84%	93%

Childrens		Day		Night		May-20		
	Main Speciality	Day - Average fill rate RN / RM (%)	Day- Average fill rate care staff (%)	Night - average fill rate RN / RM (%)	Night - average fill rate care staff (%)	RN/RM average fill rate	Care staff average fill rate	Total % hours filled (registered and care staff)
C2	Paediatric Oncology	97.7%	96.1%	100.0%	56.5%	98%	80%	96%
C3	Paediatric medicine & surgery (babies)	100.0%	167.6%	97.3%	100.0%	99%	155%	107%
Charles Wolfson Ward	Mother and Babies	99.1%	90.7%	85.0%	96.5%	93%	93%	93%
D2	Paediatric medicine & surgery	95.1%	100.5%	97.6%	100.0%	96%	100%	97%
F3	Paediatric DoSA + Cont			100.0%	100.0%	100%	117%	104%
PICU	Paediatric Critical Care	100.0%	94.7%	100.0%	100.0%	100%	96%	100%
Neonatal Unit	Neonatal Critical Care	100.0%	96.6%	99.5%	87.5%	100%	93%	99%
	Overall divisional fill %	99%	107%	98%	92%	98%	102%	99%

Emergency Department		Day		Night		May-20		
	Main Speciality	Day - Average fill rate RN / RM (%)	Day- Average fill rate care staff (%)	Night - average fill rate RN / RM (%)	Night - average fill rate care staff (%)	RN/RM average fill rate	Care staff average fill rate	Total % hours filled (registered and care staff)
CDU	Clinical Decisions Unit	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		
EAU3 Assessment	Assessment	100.0%	76.5%			100%	77%	92%
ED Adult	ED	93.9%	85.2%	97.9%	93.5%	96%	89%	94%
ENP	ED	105.0%				105%		105%
Paed ED	ED	**97.9%**	98.4%	98.6%		98%	99%	98%
	Overall divisional fill %	**96%**	**86%**	**98%**	**94%**	**97%**	**89%**	**95%**

Appendix 2: Staffing Exception report January 2020

Throughout the data monitoring period, wards with an overall rota fill of <90% or where the trained nursing rota was <90%, or the ward had been a concern to the Head of Nursing for any other reason, an individual written summary is reported. A written summary for ward areas with a > 90% fill rate is also reported below. The nursing KPIs are analysed and used to inform the report.

May-20						Report from the Divisional Head of Nursing		
Division	**C**	**Speciality**	**% fill registered**	**% fill care staff**	**Overall filled %**	**Analysis of gaps**	**Impact on Quality / outcomes**	**Actions in place**
N2			87%	89%	88%	2 staff on maternity leave. Covid 19 = 5 staff shielding for the month and 6 staff requiring periods of self isolation. 1 HCA on unauthorised leave (DNA) for the whole month. Ward established to a 'summer' establishment model at this time. Due to Covid, the ward was changed to an acute assessment area with triage direct from the ED/ambulance service. Patient acuity was much higher and the staffing was increased significantly to cope with this.	Hand hygiene - missed for May although the ward was continuously visited by many ID/IC and senior staff to check on PPE and practice. NQM - were improved in all areas from the previosu month. Some safety checks were missed - these have been addressed with the team.Incidents - 1 Grade 2 HAPU on 12th May recorded, investigated and learning disseminated	Staffing was reviewed regularly by the divisional senior nurse team to ensure safe staffing based on the acuity of patients which was variable. ED staff allocated to the front assessment area of N2 to support safe triage of unwell patients. Increased training and education to support new infection control guidance. Staff temporarily deployed from PD team and advanced clinical practitioners based there to assess patients quickly. Staff with acute nursing skills were also moved to support the roster. Staff were reminded of the ward safety and quality metric results. PPE action taken as a priority on the day and escalated through the divisional bronxe command structure.
Division	**D**	**Speciality**	**% fill registered**	**% fill care staff**	**Overall filled %**	**Analysis of gaps**		**Actions in place**
D6			87%	167%	106%	Reduced bed numbers as an amber ward, Actual V required shows increased staffing.	None	Day to day movement of staff made using professional judgement
Division	**E**	**Speciality**	**% fill registered**	**% fill care staff**	**Overall filled %**	**Analysis of gaps**	**Impact on Quality / outcomes**	**Actions in place**
Daphne			96%	73%	88%	Daphne seeing a lower number of patients due to postponement of elective procedures during COVID. Less staff needed due to less patients. Appropriate redeployment of staff to support other wards in the Trust.	Suffient staffing maintained to support safe care.	N/A

SCN = Senior Clinical Nurse *FFT = Friends and Family Test* *ST = Safety Thermometer* *NQMs = Nursing Quality Metrics* *NMC = Nursing and Midwifery Council*

ONP = Overseas Nurses Programme *WTE = Whole Time Equivalent*

Appendix 3: Nurse staffing data

Adult band 5 RN position based on predictions and established FTE											
Month	UK based exp. applicants	Anglia Ruskin NQ (60% of graduates)	Other NQ	NAP	Overseas	Total New Starters FTE	Leavers FTE	Staff in post FTE	ESR Establishment FTE	Vacancy rate based on established FTE	No. of vacancies based on established FTE
Apr-20	8					8	7.36	1539	1659.49	7.29%	120.96
May-20	5					5	12.7	1517	1659.49	8.57%	142.26
Jun-20	3	1				4	8	1500	1659.49	9.60%	159.26
Jul-20	5					5	12	1480	1659.49	10.80%	179.26
Aug-20	6				15	21	21.75	1466	1659.49	11.63%	193.01
Sep-20	5				15	20	19	1454	1659.49	12.35%	205.01
Oct-20	3	11	8		15	37	9	1469	1659.49	11.45%	190.01
Nov-20	5				15	21	12	1465	1659.49	11.69%	194.01
Dec-20	5				15	20	14.34	1458	1659.49	12.13%	201.35
Jan-21	5				20	25	10	1460	1679.49	13.06%	219.35
Feb-21	5				25	30	17.04	1460	1679.49	13.06%	219.39
Mar-21	5	7	10	12	25	59.68	22.3	1484	1659.49	10.55%	175.01
TOTAL	**60**	**19**	**18**	**12**	**145**	**256**	**165.49**	**1484**	**1659.49**	**10.55%**	**175.01**

Paediatric band 5 RN position based on predictions and established FTE												
Month	UK based exp. applicants	Anglia Ruskin NQ	Other NQ	Overseas	Conversion	Total New Starters FTE	Leavers FTE (based on leavers in the last 12 months)	Staff in post FTE	ESR Establishment FTE	Vacancy rate based on established FTE	No. of vacancies based on established FTE	Starter leaver variance
Apr-20	1		1			2	0	196.21	236.45	17.02%	40.24	2
May-20	0					0	2	192.41	236.45	18.63%	44.04	-1.8
Jun-20	2					2	3	189.41	236.45	19.89%	47.04	-1
Jul-20	2					2	3	186.41	236.45	21.16%	50.04	-1
Aug-20	2			4		6	3	186.93	236.45	20.94%	49.52	2.52
Sep-20						0	2	181.01	236.45	23.45%	55.44	-1.92
Oct-20		12	12		5	24	4	197.01	236.45	16.68%	39.44	20
Nov-20						0	3	192.01	236.45	18.79%	44.44	-3
Dec-20	1		1			2	3	190.21	236.45	19.56%	46.24	-0.8
Jan-21						0	2	187.21	236.45	20.82%	49.24	-2
Feb-21	2					2	4	183.41	236.45	22.43%	53.04	-1.8
Mar-21	2					2	3	180.41	236.45	23.70%	56.04	-1
TOTAL	**12**	**12**	**14**	**4**		**42**	**32**	**180.41**	**236.45**	**23.70%**	**56.04**	**10.2**

Band 2 HCSW position based on predictions and established FTE with additional capacity added in										
Month	UK based applicants	Apprenticeship (direct entry)	Associate	Total New Starters FTE	Leavers FTE	Staff in post FTE	ESR Establishment FTE	Vacancy rate based on established FTE	No. of vacancies based on established FTE	Starter leaver variance
Apr-20	9			9	8	733	861	14.9%	128	1
May-20	15	12		27	12	748	861	13.1%	113	15
Jun-20	8	27		35	17	766	861	11.0%	95	18
Jul-20	8	20		28	15	779	861	9.5%	82	13
Aug-20	8	20		28	14	792	861	7.9%	68	14
Sep-20	8			8	10	791	861	8.1%	70	-2
Oct-20	8			8	14	784	861	8.9%	77	-6
Nov-20	8			8	5	788	861	8.5%	73	4
Dec-20	8		12	20	10	798	861	7.3%	63	10
Jan-21	8			8	9	797	881	9.5%	84	-1
Feb-21	8			8	11	793	881	9.9%	87	-3
Mar-21	8			8	17	784	861	8.9%	76	-9
TOTAL	**104**	**79**	**12**	**195**	**143**	**784**	**861**	**8.9%**	**76**	**52**

Cambridge University Hospitals NHS Foundation Trust

Report to the Board of Directors: 8 July 2020

Agenda item	9.4
Title	Finance report
Sponsoring executive director	Paul Scott, Chief Finance Officer
Author(s)	Ed Smith, Interim Director of Finance
Purpose	To update the Board on financial performance in 2020/21 M2.
Previously considered by	Performance Committee, 1 July 2020

Executive Summary

The report provides details of financial performance during 2020/21 Month 2 and in the year to date. A summary is set out in the Chief Finance Officer's message on page 3 of the report.

Related Trust objectives	Strengthening the organisation
Risk and Assurance	The report provides assurance on financial performance during Month 2.
Related Assurance Framework Entries	BAF ref: 010, 011
Legal / Regulatory / Equality, Diversity & Dignity implications?	n/a
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	n/a

Action required by the Board of Directors

The Board is asked to note the finance report for May 2020 (2020/21 Month 2).

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NHS
Cambridge
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NHS Foundation Trust

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Trust performance summary - Key indicators

Cambridge University Hospitals NHS Foundation Trust

Trust actual and 'True-up' received

0.0	*Actual*
10.3	*'True-up' in month*
0.0	*Actual*
18.5	*'True-up' YTD*

Net current assets/(liabilities) and debtor days

Net current liabilities

(370.2)	*actual*
Not Available	*plan*

Debtor days

34	*This month*
9	*Previous month*

Covid-19 spend M2 and YTD

(8.4)	*Revenue actual*
(15.0)	*Revenue actual*
(1.9)	*Capital- actual spend*

Cash and EBITDA

Cash

84.9	*actual*
3.3	*plan*

EBITDA

2.8	*actual*
3.0	*plan*

Legend

£ in million

In month

YTD

CFO message

Cambridge University Hospitals NHS Foundation Trust

Month 2 financial performance

- **The Trust's financial position at the end of Month 2 and YTD is Breakeven.**
- The underlying Covid-19 financial impact in Month 2 is **£25.4m** – This is chiefly driven by direct Covid-19 expenditure and changes in productivity and service delivery to manage the Covid-19 crisis, with Clinical Income, on a payment by activity basis, being adversely impacted by £18.1m in month (refer to page 5 for a further breakdown)
- The Trust incurred £8.4m of revenue Covid-19 expenditure in M2. This consists of £3.7m of pay and £4.7m of non-pay spend.
- In order to achieve a Breakeven position the Trust received 'top-up' funding of £5.9m and 'true-up' funding of £10.3m, totalling £16.2m in month.
- The 'true-up' payment covers the loss of Clinical and Other Income sources and in M2 is the result of the following main drivers:
  - A reduction in Clinical Income of c.£3m
  - Increased risk to Other Income streams (such a private and overseas patients, for example) of c.£1.0m
  - Significant uncertainty over R&D income of c.£3m and how this will be recognised over the course of M1 to M4
  - Covid-19 related in month spend of £8.4m, offset by underspends in non Covid-19 related pay and non-pay

  (Refer to page 7 for a detailed summary of the components of the 'true-up' payment)

The new financial regime for M1-M4 of FY20/21

- Based on the budget setting process undertaken Jan-March 2020, the CUH FY20/21 planned deficit was £73.8m.
- As a result of Covid-19, NHSE/I have introduced an amended financial framework for NHS Providers for the initial period of: 01 April to 31 July 2020 (i.e. M1-M4).
- It is expected that this framework will be extended to cover: 01 August 2020 to 31 March 2021 (i.e. M05-M12) but no further details have been confirmed.
- This sets a new budget for the Trust (based on the M08 to M10 FY19/20 run rate uplifted for inflation) with 'top-up' funding of £5.9m/month aiming to deliver a breakeven position and the ability to charge 'true-up' funding for the net costs of Covid-19 and to bring the Trust to breakeven.
- The Trust has now adopted this as an interim budget to support performance management - divisional and corporate budgets have been allocated at a cost centre and account code level across the Trust in line with this.

CFO message

Cambridge University Hospitals NHS Foundation Trust

CIP delivery

- CIP plans have been suspended for the duration of M1 to M4, as per national guidance to NHS providers.

Cash and Capital position

- In response to Covid-19, trusts are receiving funding for core contracted NHS Commissioners on a block basis one month in advance. This significantly improves CUH's cash position and results in a forecast cash balance well in excess of the minimum cash balance required for the foreseeable future. No further revenue cash support should therefore be required during this 13 week period. We do, however, continue to await final confirmation of capital funding allocations for 2020/21 and it is not yet clear when Covid-19 capital expenditure will be reimbursed.

Cambridge University Hospitals NHS Foundation Trust

Trust underlying Covid-19 financial impact

	M1	M2	YTD	
	£m	£m	£m	Covid-19 Financial Pressure
	21.1	18.1	39.2	Compromised Clinical Income
	-5.4	-5.1	-10.5	Expenditure underspend – Reduced service delivery
1	**15.7**	**13.0**	**28.7**	**Productivity Reduction**
	6.6	8.4	15.0	Covid-19 revenue costs
2	**6.6**	**8.4**	**15.0**	**Covid-19 – Incremental Costs**
	2.1	3.0	5.1	R&D income at risk
	1.9	1.0	2.9	Other compromised income
3	**4.0**	**4.0**	**8.0**	**Other compromised Income**
	26.3	**25.4**	**51.7**	**Full adverse impact of Covid-19**
	£m	£m	£m	Mitigations
	-18.1	-15.0	-33.1	Clinical income through block payments
	-8.3	-10.3	-18.6	'True-up' payment
	0.0	**0.0**	**0.0**	**Breakeven positon**

This table sets out the adverse impact of Covid-19 on the Trust's finances and the mitigating mechanisms currently in place.

The underlying performance is driven by three factors:

1) **Productivity Reduction**
Compromised clinical income offset to an extent by service delivery related underspends in pay and non-pay

2) **Covid-19 – Incremental Costs**
Covid-19 direct expenditure and incremental Covid-19 related increases in our usual cost base

3) **Net other compromised income**
R&D income deferral of NIHR contract and non NHS paying patient income

YTD the underlying financial pressure from Covid-19 stands at £51.7m

Please note: At this stage we are not analysing the total cost of Covid-19 service provision.

CFO message - summary financials

NHS Cambridge University Hospitals NHS Foundation Trust

(£'m)	In month					YTD				
	Budget	Actual	Covid	Variance	Variance - covid	Budget	Actual	Covid	Variance	Variance - covid
Clinical Income - exc. D&D*	53.8	51.3	0.0	(2.5)	(2.5)	107.6	103.1	0.0	(4.5)	(4.5)
Clinical Income - D&D*	11.9	11.3	0.0	(0.6)	(0.6)	23.8	22.1	0.0	(1.7)	(1.7)
Devolved Income	20.1	26.2	10.3	6.1	(4.2)	40.2	50.5	18.6	10.3	(8.3)
Total Income	**85.8**	**88.9**	**10.3**	**3.1**	**(7.2)**	**171.6**	**175.8**	**18.6**	**4.2**	**(14.4)**
Pay	45.6	48.2	3.8	(2.6)	1.2	91.2	96.5	6.3	(5.3)	1.0
Drugs	11.3	10.5	0.0	0.8	0.8	22.6	21.4	0.1	1.2	1.3
Non Pay	25.9	27.4	4.5	(1.5)	3.1	51.8	52.3	8.6	(0.5)	8.1
Operating Expenditure	**82.8**	**86.1**	**8.4**	**(3.3)**	**5.1**	**165.6**	**170.1**	**15.0**	**(4.5)**	**10.4**
EBITDA	**3.0**	**2.8**		**(0.2)**	**(2.1)**	**6.0**	**5.7**		**(0.3)**	**(4.0)**
Depreciation, Amortisation & Financing	3.0	2.8	0.0	0.2	0.2	6.0	5.7	0.0	0.3	0.3
Deficit	**0.0**	**0.0**		**0.0**	**(1.9)**	**0.0**	**0.0**		**0.0**	**(3.7)**

Table 1 - CUH Financial Position in month at Month 2

**D&D = Drugs & devices*

Covid-19 'true-up' Payment

NHS
Cambridge University Hospitals
NHS Foundation Trust

Covid-19 'true-up' payment of £10.3m key drivers in M2

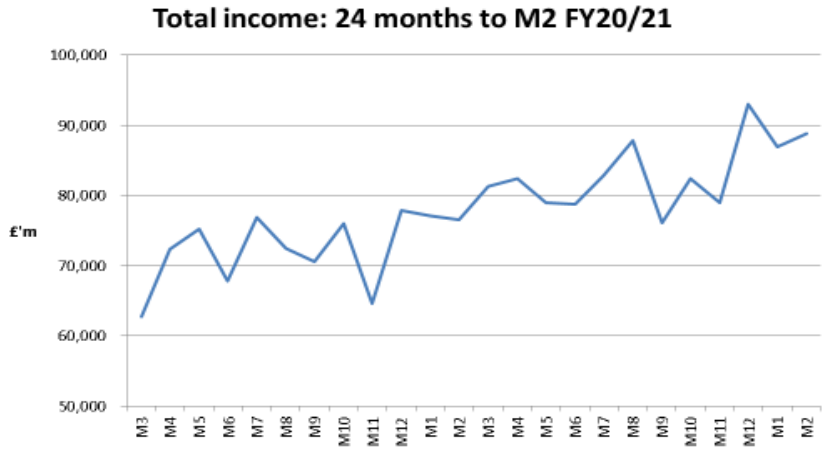
M1	M2	YTD	Narrative
£m	£m	£m	
-3.0	-3.0	-6.0	NHS Clinical Income: Non-contracted activity not billable to Commissioners or recovered via top-up mechanism
-2.1	-1.1	-3.2	Other non NHS Clinical Income: Lower private patient and Injury Cost Recovery Scheme
-2.1	-3.1	-5.2	R&D - income deferral of NIHR contract (£2.4m in month)
-7.2	**-7.2**	**-14.4**	**Overall income position variance**
-6.6	-8.4	-15	Covid-19 – Revenue costs
5.4	5.1	10.5	Expenditure underspend (pay & non-pay) – Reduced service delivery
0.2	0.2	0.4	Finance cost - Favourable variance on PDC
-8.3	**-10.3**	**-18.6**	**'True-up' payment**

This table summarises the main components behind the YTD 'True-up' payment, which brings the Trust's in month positions and YTD position to break-even. Note that there is considerable uncertainty at this stage over how much Other Income is at risk, as this will only begin to crystallise over the course of the coming months.

Clinical and Other income in M2

NHS Cambridge University Hospitals NHS Foundation Trust

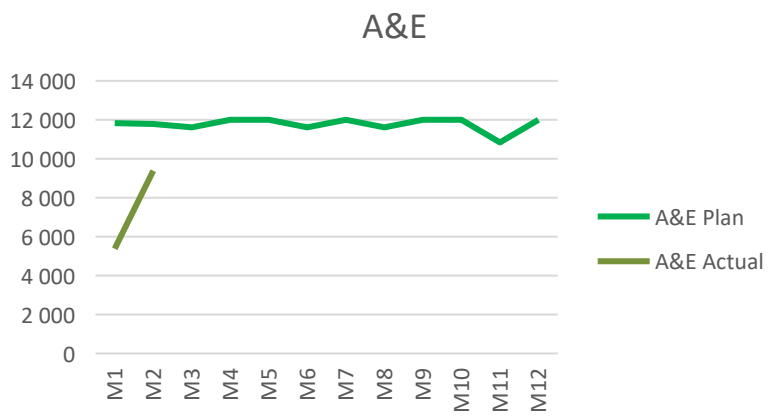
- At the end of month 2, the Trust's YTD overall income position is £4.2m greater than plan. Clinical income is £6.1m less than plan, with devolved income £10.3m above plan.
- Note that in M2, as was the case at M1, the Trust applied a 'true up' payment in order to achieve the expected breakeven position. The 'true-up' for M2 was £10.3m (£18.6m YTD).
- It is important to recognise that the negative variances are offset by the block contract agreements that have been put in place for months 1-4.

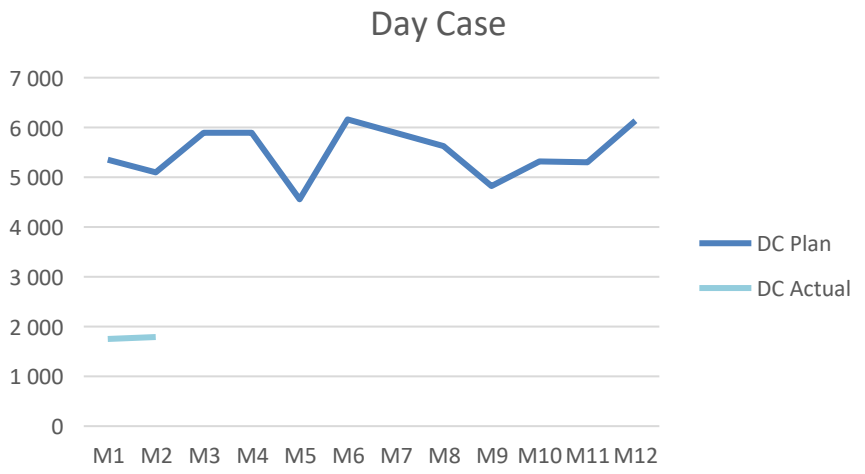


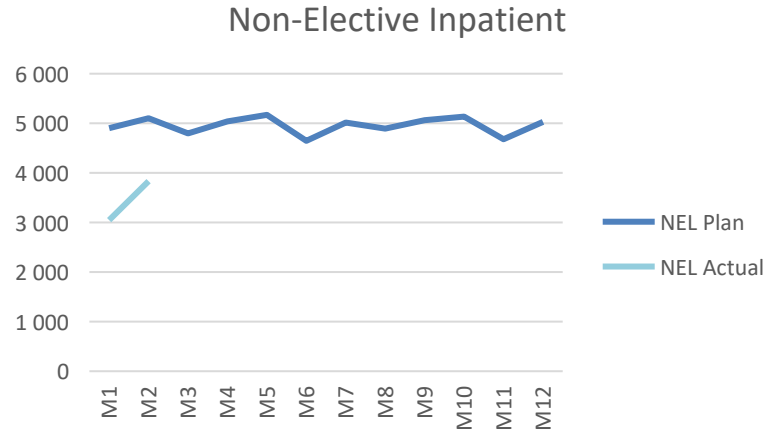
£'m	M2 In month Plan	Actual	Var	YTD Year to Date Plan	Actual	Var
Admitted Patient Care	27.80	15.15	-12.65	55.49	29.03	-26.46
Outpatient	10.43	6.32	-4.11	20.52	12.13	-8.40
Accident and Emergency	2.10	1.58	-0.52	4.13	2.57	-1.46
Other Activity	25.37	39.61	14.24	51.24	81.48	30.24
Total Clinical Income	**65.70**	**62.76**	**-3.04**	**131.40**	**125.30**	**6.10**
Devolved Income	20.10	26.14	6.04	40.20	50.50	10.30
Total Trust Income	**85.80**	**88.90**	**3.10**	**171.60**	**175.80**	**4.20**

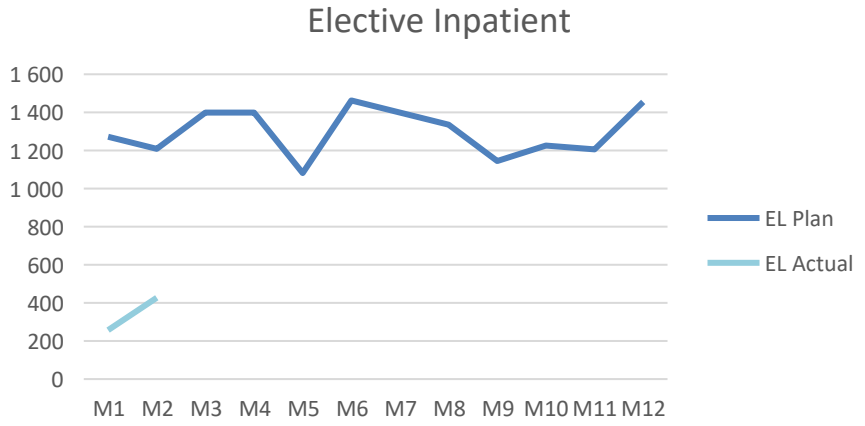
NHS Cambridge University Hospitals NHS Foundation Trust

Clinical Income - Activity Information









The above graphs show the adverse impact of Covid-19 on the Trust's billable activity; however, there is some evidence in M2 of activity starting to approach previously planned levels. This is most evident in A&E.

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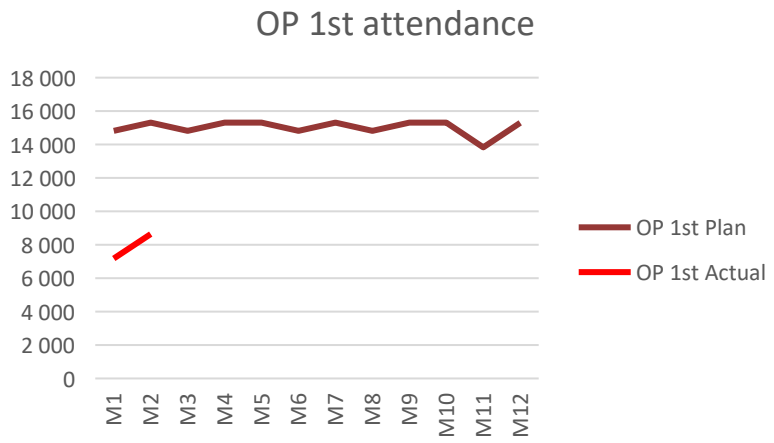
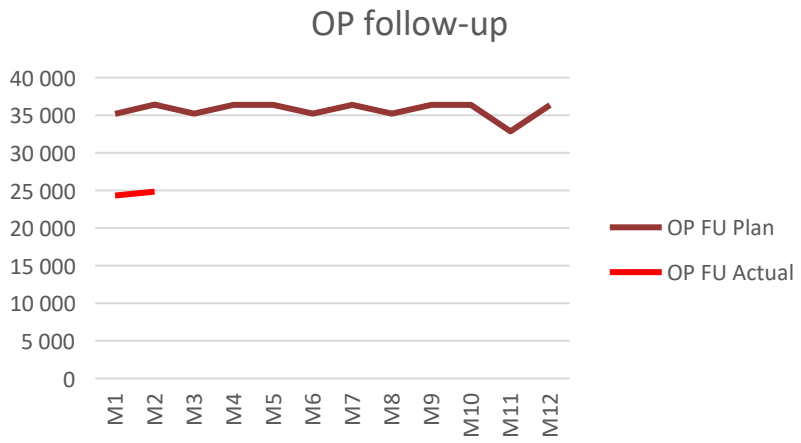
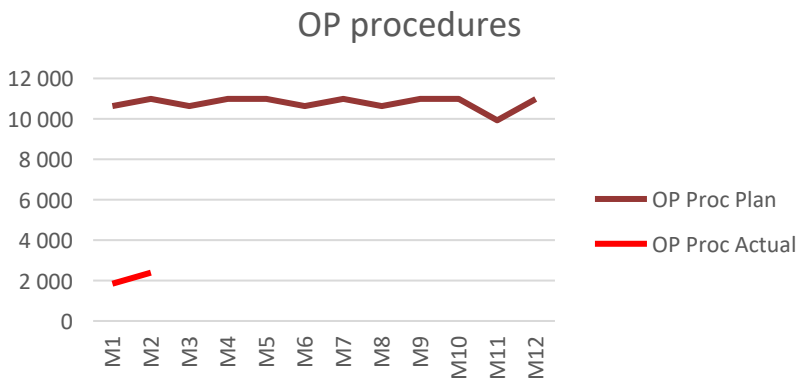
Clinical Income - Activity Information (cont.)





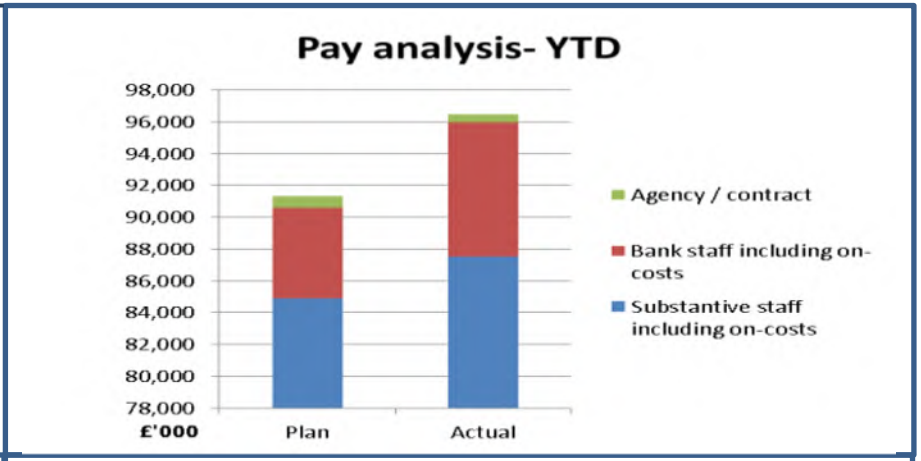


The adverse impact of Covid-19 YTD is also clearly visible in Outpatients. The above analysis includes both face-to-face and remote activity.

Pay expenditure in M2

NHS Cambridge University Hospitals NHS Foundation Trust

- At the end of month 2, the Trust's YTD pay position is £5.2m adverse to budget.
- This is mainly due to overspends year to date in Bank spend.
- Of the £5.2m overspend, the Trust has reported £6.3m of Covid related pay expenditure, which nets to an underlying favourable pay variance of £1.1m
- Refer overleaf of an additional analysis of the Covid element in pay expenditure.



Pay costs by Staff Group

	In Month			Year to Date		
£ Millions	Budget	Actual	Variance	Budget	Actual	Variance
Administrative & Clerical	6.86	7.44	(0.58)	13.72	14.85	(1.13)
Allied Healthcare Professionals	2.55	2.54	0.01	5.02	5.09	(0.07)
Clinical Scientists & Technicians	4.22	4.11	0.11	8.31	8.22	0.09
Medical and Dental Staff	14.78	15.88	(1.10)	29.55	32.86	(3.31)
Nursing	16.17	17.11	(0.94)	32.54	33.31	(0.77)
Other Pay Costs	1.05	1.08	(0.03)	2.10	2.13	(0.03)
TOTAL PAY	**45.62**	**48.15**	**(2.53)**	**91.25**	**96.47**	**(5.22)**

Pay expenditure YTD (Continued)

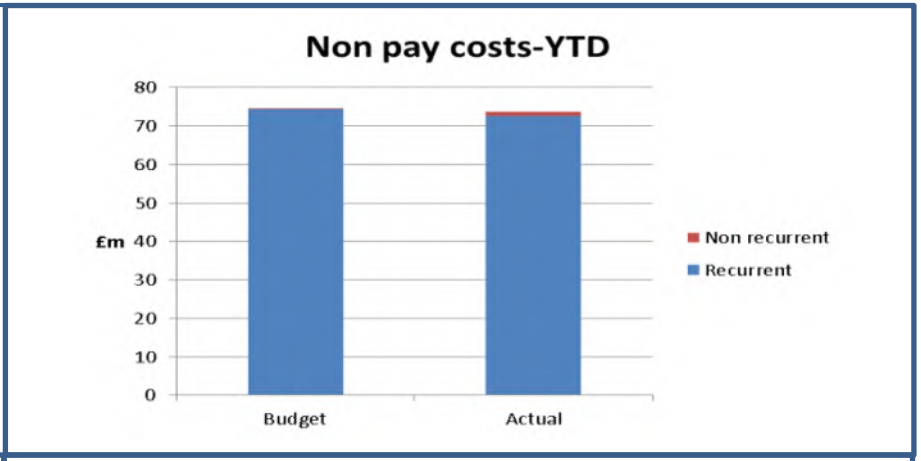
Cambridge University Hospitals NHS Foundation Trust

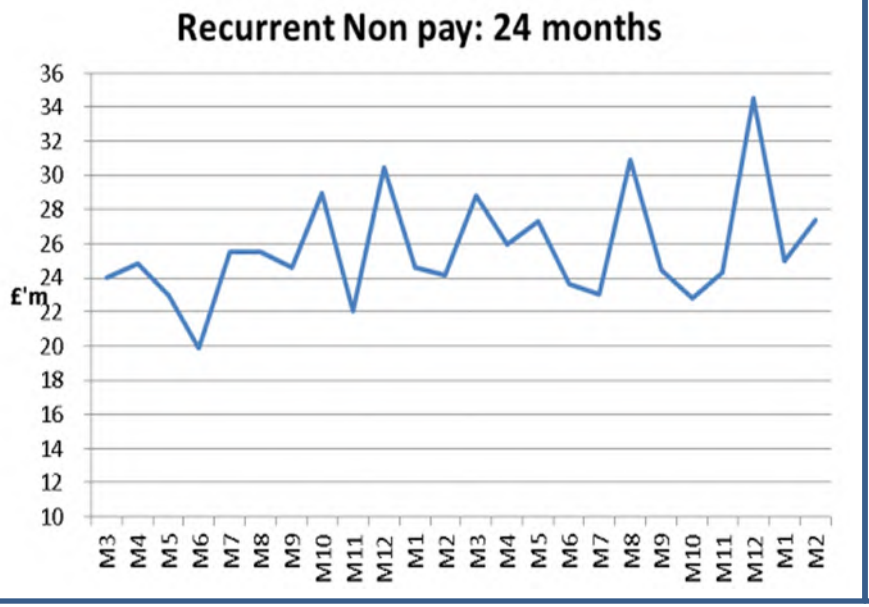
Pay Covid Costs	In Month			Year to Date		
£ Millions	Budget	Actual	Variance	Budget	Actual	Variance
Agency	0.00	0.02	(0.02)	0.00	0.11	(0.11)
Bank	0.00	1.77	(1.77)	0.00	3.20	(3.20)
Contracted	0.00	0.26	(0.26)	0.00	0.39	(0.39)
Substantive	0.00	1.78	(1.78)	0.00	2.61	(2.61)
TOTAL PAY	**0.00**	**3.83**	**(3.83)**	**0.00**	**6.31**	**(6.31)**

Pay Costs (Exc Covid)	In Month			Year to Date		
£ Millions	Budget	Actual	Variance	Budget	Actual	Variance
Agency	0.33	0.12	0.21	0.66	0.37	0.29
Bank	2.85	2.79	0.06	5.70	5.26	0.44
Contracted	0.22	0.22	(0.00)	0.44	0.45	(0.01)
Substantive	42.22	41.17	1.05	84.45	84.07	0.38
TOTAL PAY	**45.62**	**44.31**	**1.31**	**91.25**	**90.15**	**1.10**

Non-Pay expenditure in M2

- At the end of month 2, the Trust's non-pay position is £0.9m favourable to plan (including Covid costs)
- When excluding Covid related non-pay spend, the underlying favourable variance becomes £9.5m YTD
- This is mainly driven by underspends in Drugs, Clinical Supplies and Other non pay costs.
- Refer overleaf for additional analysis on the Covid element of non-pay expenditure.





Non Pay costs

Non Pay costs (Inc Covid)

£millions	In month Budget	In month Actual	In month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance
Drugs	11.3	10.5	0.7	22.5	21.4	1.1
Clinical Supplies	11.5	9.1	2.4	23.0	19.4	3.6
Misc Other Operating expenses	6.5	8.7	(2.2)	13.3	15.8	(2.5)
Premises	4.0	4.5	(0.5)	8.0	9.0	(1.1)
Clinical Negligence	1.6	1.7	(0.1)	3.2	3.4	(0.2)
Other non pay costs (including (	2.2	2.4	(0.1)	4.5	3.6	0.8
Total Recurrent	37.0	36.8	0.2	74.4	72.7	1.8
eHospital	0.0	0.0	0.0	0.0	0.0	0.0
Other non pay costs	0.1	1.0	(0.9)	0.1	1.0	(0.9)
NR System support	0.0	0.0	0.0	0.0		0.0
Total Non-recurrent	0.1	1.0	(0.9)	0.1	1.0	(0.9)
Total Non Pay	37.2	37.9	(0.7)	74.5	73.7	0.9

Non Pay expenditure in M2 (Continued)

NHS Cambridge University Hospitals NHS Foundation Trust

Non pay Covid Costs						
	In month			Year to Date		
£millions	Budget	Actual	Variance	Budget	Actual	Variance
Drugs	0.0	0.0	(0.0)	0.0	0.1	(0.1)
Clinical Supplies	0.0	0.8	(0.8)	0.0	2.7	(2.7)
Misc Other Operating expenses	0.0	3.3	(3.3)	0.0	5.0	(5.0)
Premises	0.0	0.3	(0.3)	0.0	0.8	(0.8)
Clinical Negligence	0.0	0.0	0.0	0.0	0.0	0.0
Other non pay costs (including CIP)	0.0	0.1	(0.1)	0.0	(0.0)	0.0
Total Covid Non pay	0.0	4.6	(4.6)	0.0	8.7	(8.7)

Non Pay (Excluding Covid)						
	In month			Year to Date		
£millions	Budget	Actual	Variance	Budget	Actual	Variance
Drugs	11.3	10.5	0.8	22.5	21.3	1.2
Clinical Supplies	11.5	8.3	3.2	23.0	16.7	6.3
Misc Other Operating expenses	6.5	5.4	1.1	13.3	10.7	2.5
Premises	4.0	4.1	(0.1)	8.0	8.2	(0.2)
Clinical Negligence	1.6	1.7	(0.1)	3.2	3.4	(0.2)
Other non pay costs (including CIP)	2.2	2.2	(0.0)	4.5	3.7	0.8
Total Recurrent	37.0	32.3	4.8	74.4	64.0	10.4
eHospital	0.0	0.0	0.0	0.0	0.0	0.0
Other non pay costs	0.1	1.0	(0.9)	0.1	1.0	(0.9)
NR System support	0.0	0.0	0.0	0.0		0.0
Total Non-recurrent	0.1	1.0	(0.9)	0.1	1.0	(0.9)
Total Non Pay	37.2	33.3	3.9	74.5	65.0	9.5

Cash flow and creditor payment days

Weighed average creditor payment days				
M10	M11	M12	M1	M2
50	55	42	38	37

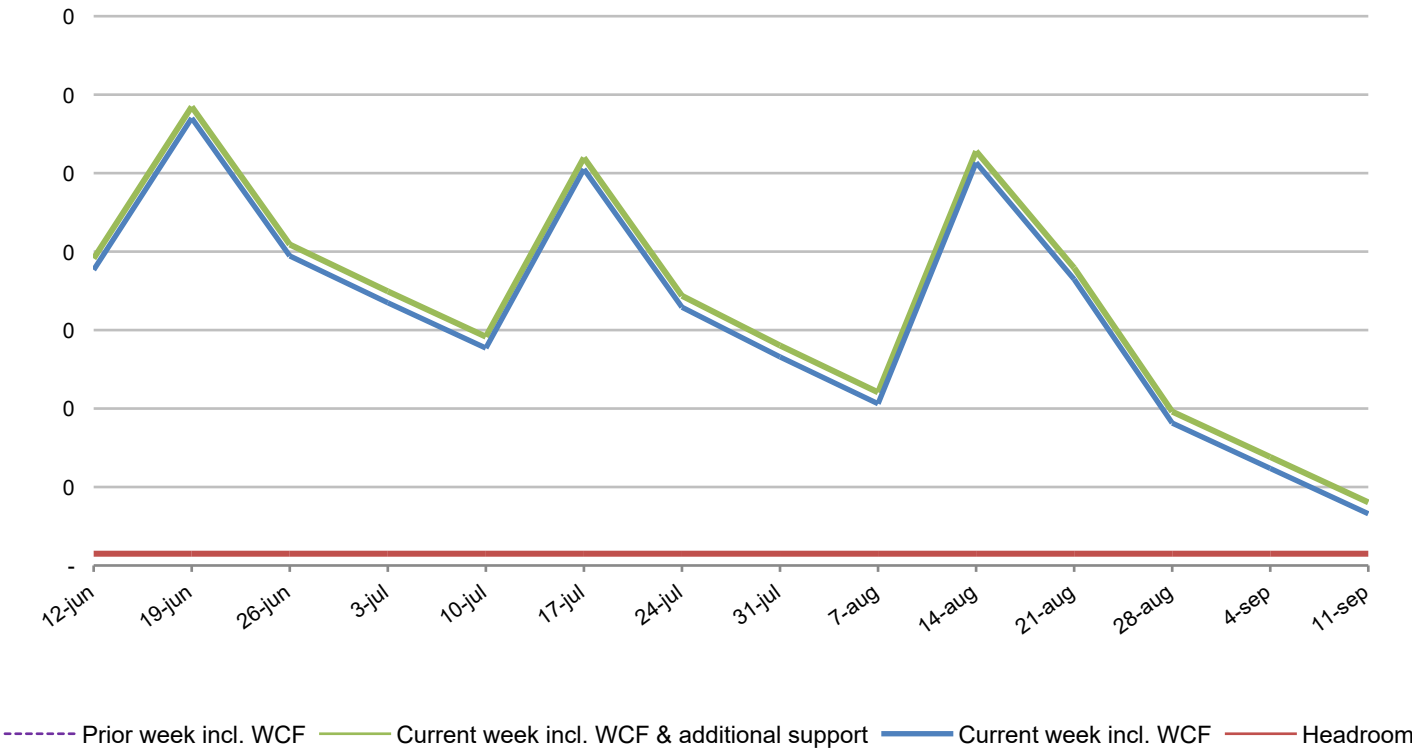


Chart 2 – CUH 13 week rolling cash flow forecast (£000)

In response to Covid-19, trusts are being paid on a block contract basis one month in advance. This significantly improves CUH's cash position and results in a forecast cash balance well in excess of the minimum cash balance required for the foreseeable future. No further revenue cash support should therefore be required during this 13 week period. Some uncertainty remains around the speed of deployment of capital funding and around the timing of reimbursement of Covid-19 capital expenditure, but these are unlikely to have a significant adverse impact over this 13 week timeframe.

Capital expenditure by programme

NHS Cambridge University Hospitals NHS Foundation Trust

M2 position

Interim Capital Budget

	Year to Date (M2)		
	Budget £m	Actuals £m	Variance £m
Programme			
Estates	0.7	0.7	0.0
e Hospital/Legacy Systems	0.1	0.1	0.0
Medical Equipment Replacement	0.1	0.1	0.0
G2	0.0	0.0	0.0
Addenbrooke's 3	0.0	0.0	0.0
Other Developments	0.2	0.2	0.0
Unallocated/Emergencies	0.0	0.0	0.0
Programme Total	1.1	1.1	0.0

	Forecast		
	Budget £m	Expenditure £m	Variance £m
Estates	5.4	5.4	0.0
e Hospital/Legacy Systems	1.6	1.6	0.0
Medical Equipment Replacement	1.3	1.3	0.0
G2	4.4	4.4	0.0
Addenbrooke's 3	5.0	5.0	0.0
Other Developments	6.4	6.4	0.0
Unallocated/Emergencies	4.1	4.1	0.0
	28.4	28.4	0.0

	Capital Commitments 2020/21	
	Planned Budget £m	Committed £m
Estates	5.4	0.9
e Hospital/Legacy Systems	1.6	0.5
Medical Equipment Replacement	1.3	0.7
G2	4.4	0.1
Addenbrooke's 3	5.0	0.1
Other Developments	6.4	1.4
Unallocated/Emergencies	4.1	0.0
	28.4	3.7

Key Issues/Notes Year to Date

- Initial capital budget based on confirmed funding available and pending final agreement of STP allocations.
- COVID-19 expenditure currently excluded as funded separately by NHSI/E

Key Issues/Notes Forecast

- Budget now includes £4.8m for the Children's Hospital scheme.

Capital Commitments 2019/20

- 2020/21 committed expenditure reflects contractual commitments (unavoidable) against this year's budget,

including actual spending YTD.

NHS Cambridge University Hospitals NHS Foundation Trust

Balance Sheet at M2

	Actual £million
Non-current assets	
Intangible assets	28.2
Property, plant and equipment	341.8
Total non-current assets	370.0
Current assets	
Inventories	12.6
Trade and other receivables	89.6
Cash and cash equivalents	84.9
Total current assets	187.1
Current liabilities	
Trade and other payables	(108.2)
Borrowings	(350.8)
Provisions	(2.3)
Other liabilities	(96.1)
Total current liabilities	(557.4)
Total assets less current liabilities	(0.3)
Non-current liabilities	
Borrowings	(102.0)
Provisions	(3.2)
Total non-current liabilities	(105.2)
Total assets employed	(105.5)
Taxpayers' equity	
Public dividend capital	139.8
Revaluation reserve	37.4
Income and expenditure reserve	(282.7)
Total taxpayers' and others' equity	(105.5)

Balance sheet commentary at M2

- The balance sheet is showing net liabilities of £105.5m
- Non-current liabilities stand at £102m for borrowings, and £3.2m for provisions
- Note the change between non current and current liabilities since year end FY19/20, which anticipates the agreed re-financing of the Balance Sheet
- This re-financing exercise is expected to happen in late September 2020 and will return the Trust to positive net assets.
- In the meantime, cash remains strong despite creditor payments being accelerated to support the private sector during COVID-19.

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Cambridge University Hospitals NHS Foundation Trust

Report to the Board of Directors: 8 July 2020

Agenda item	10
Title	Nursing reconfiguration establishments
Sponsoring executive director	Lorraine Szeremeta, Chief Nurse
Author(s)	Maura Screaton, Deputy Chief Nurse Sarah Raper, Roster Support Lead Amanda Coulier Associate Director of Workforce
Purpose	To provide an update on the nursing reconfiguration establishment work.
Previously considered by	Management Executive, 25 June 2020

Executive Summary

This paper provides details of the nursing establishments to support the Trust's ward reconfiguration plan. It also outlines the steps being taken to ensure effective staff redeployment and measures to support staff with this process.

Related Trust objectives	Improving patient journeys Strengthening the organisation
Risk and Assurance	Insufficient nursing and midwifery staffing levels
Related Assurance Framework Entries	BAF ref: 004
Legal / Regulatory / Equality, Diversity & Dignity implications?	NHS England & CQC letter to NHSFT CEOs (31.3.14) NHS Improvement Letter – 22 April 2016. NHS Improvement letter re: CHPPD – 29 June 2018 NHS Improvement – Developing workforce safeguards October 2018
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	Yes

Action required by the Board of Directors

The Board is asked to note the:

- Establishment of a nursing reconfiguration oversight taskforce.
- Nursing establishments proposed for the new ward reconfigurations.
- Overall WTE registered and unregistered nurses to meet the new reconfiguration.
- Next steps to ensure successful implementation of staff migration and adequate skill mix.
- Risks associated with staff movement to enable the ward reconfiguration plan will be tracked by using key indicators.

Cambridge University Hospitals NHS Foundation Trust

8 July 2020

Board of Directors
Lorraine Szeremeta, Chief Nurse

1. Executive Summary

1.1 The Chief Nurse's Office and Heads of Nursing continue to work together to ensure our wards and departments are safely staffed at Cambridge University Hospitals (CUH). Working closely with divisional and workforce colleagues we continue to look for opportunity for efficiencies within the workforce while also monitoring any impact on safety and quality of care.

1.2 This paper provides detail in respect to the nursing establishments to support the ward reconfiguration plan. It also outlines the steps being taken to ensure staff redeployment and measures to support staff with this process.

2. Purpose

2.1 The purpose of this paper is to provide an update on the nursing taskforce work to support the agreed ward reconfiguration plan.

3. Background

3.1 The nursing establishments to support the ward reconfigurations are set according to the principles and methodology for setting and reviewing Nursing and Midwifery establishment and skill mix. This is the usual governance arrangement to ensure transparency and that evidence-based tools (safer nursing care tool), professional judgement and scrutiny is applied throughout the process.

3.2 It is recognised that bed usage and patient pathways will need to flex over the next 12-18 months as the number of patients presenting with Covid-19 potentially fluctuates between plateau and surge phases, while maintaining essential and elective activity.

3.3 A taskforce has been established to oversee the nursing reconfiguration workstream. Membership includes Heads of Nursing and Education, Head of Workforce and Staffside representation. The group is chaired by the deputy chief nurses and reports to the Nursing, Midwifery and Allied Health Professionals Advisory Committee.

4. Reconfigured nursing establishments

4.1 Safe, sustainable and productive nursing and midwifery staffing establishment setting requires a systematic approach to be adopted using an evidence-informed decision support tool triangulated with professional judgement and comparison with relevant peers, NQB 2016.

4.2 The Safer Nursing Care Tool, SNCT, which has been endorsed by NICE, is an evidence based tool used at CUH. The review or resetting of establishments is dependent on the collection of three sets of SNCT scoring data (20 days for each set) at defined time points throughout the year. Data to inform establishment reviews for 2020/21 budget setting were collected in February, June and November 2019. This date was used as a basis for setting the establishments for the reconfigured wards. In addition to this

clinical judgement and patient outcomes to indicate if a change to this baseline staffing is required. Check and challenge meetings were held with Deputy Chief Nurse, ward Sisters/Charge Nurses, Matrons, Heads of Nursing for each division.

4.3 Appendix 1 details the proposed nursing establishments for the reconfigured wards. It also details the reasons for proposed increases. Changes to the ways of working as a result of Covid-19 have led to increases in some areas, e.g. increase in assessment areas and infection control considerations.

4.4 The impact of Covid-19 has required a significant change to all clinical areas within the emergency department. This has resulted in the relocation of some existing areas and the addition of new areas. In line with these changes nurse staffing levels have been reviewed and it has been recognised that an uplift of registered nurses.

4.5 The registered nurse requirement for reconfiguration is 21.62 WTE less than current establishment and for HCSW is 14.71 less than current establishment. Appendix 2 provides the details.

4.6 The Trust continues to support the role of the supervisory sister in all areas.

4.7 The planned care hours per patient day (CHPPD) for the reconfigured establishments is 8.06 which is in line with Shelford Group benchmarking.

5. Implementation and redeployment of staff

5.1 The nursing reconfiguration taskforce is now focusing on the implementation of the reconfigured establishments. There are four sub workstreams which have leads identified within each division. These sub workstreams include communication, rostering, teaching and training and staff support/welfare.

5.2 Key to staff redeployment will be ensuring that staff with the right skills are in the right place to care for patients. A training needs analysis has identified skills gaps. These are being addressed through an education and competency programme supported by the clinical education and practise development teams.

5.3 All workstreams are being supported by Workforce Information and Heads of Workforce to ensure staff are being supported in transitioning between teams.

5.4 A number of listening events have been set up for staff supported by workforce leads to understand and support concerns.

5.5 In conjunction with Staffside and the Organisational Development team, the workstreams will set and work to consistent guiding principles to ensure fairness and equity and staff support.

5.6 It is recognised that this implementation and redeployment of staff is time critical to ensure the Trust operational reconfiguration plan remains on track. However, it should be appreciated that this will be a stressful time for teams and individuals which will require support and resource.

5.7 A number of key indicators will be tracked throughout the reconfiguration to ensure safety for patients and staff. These indicators will include staffing red flags, retention of staff, staff morale sought through local listening events freedom to speak up guardian and staff side representative feedback. Patient safety will be tracked through incident reporting, nursing metrics and patient feedback.

6. Recommendations

6.1 The Board of Directors is asked to note the:

- Establishment of a nursing reconfiguration oversight taskforce.
- Nursing establishments proposed for the new ward reconfigurations.
- Overall WTE registered and unregistered nurses to meet the new reconfiguration.
- Next steps to ensure successful implementation of staff migration and adequate skill mix.
- Risks associated with staff movement to enable the ward reconfiguration plan will be tracked by using key indicators.

Appendix 1

Average last 3 SNCT speciality results; adjusted for beds			5.59							
Proposed SNCT staffing RN	Proposed SNCT staffing HCA	WTE RN	WTE HCA	RN:Pt ratio	Supervisory Band 7	Total WTE RN	Total WTE HCA	CHPPD	Proposed Use (Colour depending on covid activity & specialty) Ward	Comments from Challenge meeting
5	3	30.75	16.77	4.6	1	31.75	16.77	6.55	Elective Surgery Patients	PJ due to Environment, new and multiple specialities. Matched to Level 4 staffing. B7 Specialism nurse for HPB to move to ward
4	2			8.0					Professional judgement	
5	3	30.75	16.77	4.6	1	31.75	16.77	6.55	Elective Surgery Patients	
4	2			8.0					Professional judgement	PJ due to Environment, new and multiple specialities. Matched to Level 4 staffing
5	3	30.75	16.77	4.6	1	31.75	16.77	6.55	Non-Elective Surgery Patients	
4	3			8.0					Professional judgement	PJ due to Environment, new and multiple specialities. Matched to Level 5 staffing
5	3	30.75	16.77	4.6	1	31.75	16.77	6.55	Non-Elective Surgery Patients	PJ due to Environment, new and multiple specialities. Matched to Level 5 staffing. Ward manager yet
4	3			8.0					Professional judgement	to be agreed
3	2	16.77	8.39	5.6	0.8	17.57	8.39	7.14	Gynae/Gynae Onc / Breast	
2	1			7.0						
7	3	39.13	16.77	3.9	1	40.13	16.77	7.95	Cardiology	7 Amber siderooms. CCU 2 SR Red CPAP. Requesting 1x RN runner each day shift. Narrative
6	2			5.2					Professional judgement	required to understand this role
4	2	39.13	27.95	3.1	1	40.13	27.95	13.44	Amber Medical Admissions for Covid Pathway	Winter modelling amended to Amber/Red ED Assessment unit staffing, includes Cardiac monitors.
3	2			3.1					Professional judgement	ED triage nurse 24/7 making it 7D and 5N RN
4	3	39.13	16.77	3.6	1	40.13	16.77	9.86	Respiratory	?? NIV/trache can be nurses in cohort bay B? Currently acute NIV nursed in SR, staffing BTS
3	2			3.6					Professional judgement	guidelines 1:2 ratio. Scenario 2 PPE. Will alert if trache/NIV in SR increasing (max 9)
4	3	18.45	11.18	5.8	1	19.45	11.18	6.22	Major Trauma Rehab	
3	1			7.0						Reflecting current staffing
4	2	16.77	5.59	2.0	1	17.77	5.59	5.94	Post Anaesthetic Care Unit (PACU) and 23 Hour Stays	Staffing to be confirmed
3	2			2.0					Professional judgement	
4	3	25.16	16.77	5.4	1	26.16	16.77	6.84	Diabetes	
4	2			6.8					Professional judgement	
4	2	19.57	8.39	4.5	1	20.57	8.39	6.84	Renal	
3	1			6.0						
4	2	19.57	11.18	4.8	1	20.57	11.18	7.13	Hepatology	
3	1			6.3					Professional judgement	
3		22.36	0.00	1.3	1	23.36	0.00	19.71	Transplant	
3				1.3						
5	3	30.75	13.98	4.1	1	31.75	13.98	6.80	Transplant	
5	2			7.3					Professional judgement	Holding at current staffing; impacted by high SNCT level ward attenders
4	2	27.95	16.77	4.5	1	28.95	16.77	7.30	overflow surgery	
4	2			6.8					Professional judgement only	
4	3	25.16	16.77	5.4	1	26.16	16.77	6.84	DME	The bay nursing work undertaken previously identified improved outcomes for patients and reduced
4	2			6.8					Professional Judgement	specialling need within DME

4	27.95	19.57	4.8	1	28.95	19.57	7.22	DME	Removed from Acute Care Hub model. The bay nursing work undertaken as above improved
3			7.3					**Professional judgement**	outcomes for patients and reduced specialling need within DME. 4 monitored beds in 2 bays
2	25.16	16.77	4.6	1	26.16	16.77	8.03	Renal - day time work hours higher ratio	
2			5.8						
3	25.16	22.36	6.0	1	26.16	22.36	6.98	DME	Consider placement of nurses station to improve cohorting in more spaced/reduced visibility
2			7.5					**Professional judgement**	environment. Increased HCA as with DME specialing reduction.
2	25.16	16.77	5.2	1	26.16	16.77	7.70	DME	C6 26 beds at Amber, 24 beds at Red. Staffing model reflects current staffing. Consideration to 3+3
2			6.5					**Professional judgement**	at night ; this amended to 4+2 to avoid a greater than 1:8 RN to patient ratio at night if 26 beds
2	22.36	11.18	3.8	1	23.36	11.18	9.86	Neuro/Stroke/Neurosurgery/Gastro	
1			3.8					**Numbers increased for trache bay**	PJ requiring 1+1 per bay for trachy safety (on avearge 2 pt) Scenario 2 for PPE
2	19.57	11.18	3.3	1	20.57	11.18	10.42	Diabetes	At green 31 beds 6+4, 4+3 Amber 13 beds PPE scenario 1. D7 and G3 B7ward manager
1			4.3					**Professional judgement**	exchange
2.6	30.75	16.77	4.7	1	31.75	16.77	6.35	Gastro moving from M4	
2			8.3					**Professional Judgement**	Ward manager from M4 moved. PJ due to observation/monitoring speciality patient load.
2	16.77	11.18	6.3	1	17.77	11.18	6.48	Amber Surgical Admissions Ward	
2			6.3						Taking patients moved from SAU whilst awaiting swab results
								DECANT Ward (fire safety works)	
1	13.98	5.59	2.7	1	14.98	5.59	10.78	Oncology	
1			4.0						
2	16.77	11.18	4.3	1	17.77	11.18	9.48	Oncology	
1			4.3						
1	19.57	5.59	3.3	1	20.57	5.59	8.53	Haematology - Haem guidelines 1:3 RN	
1			4.3						13 beds, as SR are single bed only
1	22.36	5.59	2.8	0.8	23.16	5.59	11.20	Respiratory Acute NIV	Red Acute NIV requiring 1:2 staffing for SR. Red Oncology. Staffing on 2 x SR Acute NIV. Will
1			2.8					Red Oncology	need to increase staffing as required if increased side room usage for NIV/trache
2	15.37	8.39	0.0	0.5	15.87	8.39		Paediatric Emergency Department - current staffing used	
1			0.0						Currently for Paed EAU staffing - no changes proposed
4	40.53	22.36	3.7	1	41.53	22.36	10.66	Green Medical Admissions/Short Stay	Work ongoing for nursing model, 24/7 ED assessment pathway. Narrative required for NMAC. Night
3			3.5					**Professional Judgement**	is 7.5 as 7 nights and 1 twilight
8	157.45	74.07	2.9	6	163.45	74.07	11.67	ED, front door, resus, Amb bay areas a-d-UTC **and N2**	
9									**N2 staffing counted in both ED paper that went through NMAAC and on the N2 line here.**
4									Work ongoing for nursing model, 24/7 ED assessment pathway. Narrative required for NMAC. Night
8			3.0					**Approved through NMAAC**	is 7.5 as 7 nights and 1 twilight
4	30.75	19.57	4.3	1	31.75	19.57	8.53	Red Medicine	Red Medicine - note increased risk on ongoing delirium due to minimal windows if patients have
3			5.2						increased LoS.
2	19.57	8.39	3.5	1	20.57	8.39	8.80	Stroke	
1			4.7					**Professional Judgement**	Hyperacute stroke unit. Stroke guidelines 80:20 ratio
3	20.96	15.37	5.8	1	21.96	15.37	6.16	Stroke/Rehab	
2			8.7					**Professional Judgement**	Staffing on early 5+3, on late 4+4
173	1481	664			1524	664	8.48		

Appendix 2

	Current WTE Establishment		Required WTE for Reconfig		Reconfiguration Excess /Deficit (-) WTE						
Division / Unit	Reg	Unreg	Reg	Unreg	Reg	Unreg					
A Totals	**200.22**	**100.33**	**192.72**	**97.33**	**7.50**	**3.01**	With J3 closed and Ely, CEU closed				
C7 surgery			19.94	11.18	-19.94	-11.18					
C8	29.96	16.13	17.77	11.18	12.19	4.95					
D8	32.48	17.90	0.00	0.00	32.48	17.90					
F6 HPB			28.95	16.77	-28.95	-16.77					
J3	0.00	0.00			0.00	0.00	not yet open	reconfig demand WTE		16.77	5.59
L2 Day Surgery	33.37	17.30	17.25	10.68	16.12	6.62					
L4 Colorectal	29.94	15.57	31.75	16.77	-1.81	-1.20					
M4 Gastro	36.83	17.90	31.75	16.77	5.09	1.13					
SAU	0.00	0.00	22.96	8.39	-22.96	-8.39					
A3 - MTW	0.00	0.00	22.36	5.59	-22.36	-5.59					
Ely DU	24.64	12.53			24.64	12.53	closed	reconfig demand WTE tba			
CEU	13.00	3.00			13.00	3.00	closed	reconfig demand WTE tba			
B Totals	**82.14**	**39.01**	**76.55**	**36.51**	**5.59**	**2.50**					
C10 Haematology	22.09	6.41	20.57	5.59	1.53	0.82					
C9 Teenage Cancer	6.40	6.40	14.98	5.59	-8.58	0.81					
CUH Nuffield	0.00	0.00	23.24	14.15	-23.24	-14.15					
D6 Haematology	17.10	3.60	0.00	0.00	17.10	3.60					
D9 Oncology	36.55	22.60	17.77	11.18	18.78	11.42					
C Totals	**563.31**	**284.37**	**620.40**	**320.04**	**-57.09**	**-35.67**					
C4 FAME	29.29	22.50	28.95	19.57	0.34	2.94					
C5 Renal	33.90	19.25	26.16	16.77	7.75	2.48					
C6	23.57	19.50	26.16	16.77	-2.59	2.73					
D10 Inf Med	14.36	5.50	23.16	5.59	-8.80	-0.09					
D5 Hepatology	29.03	14.12	26.16	22.36	2.88	-8.24					
F4	20.94	8.39	20.57	8.39	0.38	0.01					
F5 Transplant HDU (see below for G5)	0.00	0.00	23.36	0.00	-23.36	0.00					
G2 Infusion Sv (+OPAT)	13.47	4.90	8.36	2.80	5.11	2.10					
G3 DME	24.05	16.75	26.16	16.77	-2.11	-0.02					
G4 DME	23.69	16.75	20.57	11.18	3.13	5.57					
G5 Transplant	56.27	14.32	31.75	13.98	24.53	0.35					
G6 DME	23.69	16.75	26.16	16.77	-2.47	-0.02					
EAU 4	31.95	16.75	42.09	22.36	-10.14	-5.61					
EAU 5	32.07	16.51	31.75	19.57	0.33	-3.06					
N2	23.69	19.50	40.13	27.95	-16.44	-8.45	both ED and N2 have the triage nurse in numbers, need to confirm where sitting				
N3 Respiratory	37.53	16.87	40.13	16.77	-2.60	0.10					
ED paeds	15.37	8.39	15.37	8.39	0.00	0.00					
ED Adult	130.44	47.62	163.45	74.07	-33.01	-26.45	both ED and N2 have the triage nurse in numbers, need to confirm where sitting				

D Totals	297.83	156.75	288.88	156.89	8.95	-0.14
A3 preassessment	11.44	7.28	2.56	2.56	8.88	4.72
A4	28.30	17.18	28.95	19.57	-0.65	-2.39
A5	28.30	13.64	28.95	19.57	-0.65	-5.93
J2	21.24	11.85	28.95	16.77	-7.71	-4.92
D6	19.44	10.31	23.36	11.18	-3.92	-0.87
D7	30.71	19.86	20.57	11.18	10.15	8.68
K2 CHC	10.12	3.79	9.40	2.00	0.72	1.79
K3 Cardiology	38.50	14.12	40.13	16.77	-1.63	-2.65
L5 Vascular	33.23	17.79	31.75	16.77	1.49	1.02
M5 ENT Oral MF	34.23	17.11	31.75	16.77	2.49	0.34
R2	20.26	8.26	20.57	8.39	-0.30	-0.13
Stroke & Rehab	22.06	15.56	21.96	15.37	0.10	0.19
Overall Totals	**1143.50**	**580.46**	**1178.55**	**610.76**		
					RN WTE	HCA WTE
Overall current establishment WTE of ward based nurses v Reconfiguration WTE establishment demand; including ED and Critical care uplifts from establishment changes					**-35.05**	**-30.30**
				Excluding ED	-2.04	-3.85

Cambridge University Hospitals NHS Foundation Trust

Report to the Board of Directors: 8 July 2020

Agenda item	11
Title	Refreshing our Strategy in response to Covid-19
Sponsoring director	Claire Stoneham, Director of Strategy and Major Projects Ian Walker, Director of Corporate Affairs
Author(s)	Dan Northam Jones, Director of Strategy Ed Smith, Director of Finance Ali Bailey, Director of Communications Denise Franks, Assistant Director of Planning
Purpose	To receive the outcomes of the strategy refresh
Previously considered by	Management Executive, 2 July 2020

Executive Summary

Over the last two months we have been conducting a rapid refresh of our Trust Strategy. This has included input from the Management Executive, the Board of Directors, the Governors' Strategy Group and the CUH Reflects staff reflection exercise. This paper sets out:

- The context in which we are working, based on our modelling work, the listening exercise conducted with staff and our current operational plan.
- Proposed objectives for the next 18 months, with key focus areas of work within these.
- How we propose to deliver these objectives through Taskforces on cross-cutting work and all of our teams aligning their work.
- How we propose to govern and report on this ambitious programme of work to ensure that the Board can provide oversight and receive assurance.
- A summary of key issues emerging from the strategy refresh.

Related Trust objectives	All
Risk and Assurance	Key risks to the delivery of the objectives will be set out in a revised version of the Board Assurance Framework.
Related Assurance Framework Entries	All
Legal implications/Regulatory requirements	n/a
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	Yes

Action required by the Board of Directors

The Board is asked to:

- Endorse the strategy refresh exercise.
- Agree the revised objectives for the next 18 months.
- Note the proposed approach to delivering and reporting on the strategy and objectives.

Cambridge University Hospitals NHS Foundation Trust

8 July 2020

CUH Board of Directors
Refreshing our Strategy in response to COVID-19

1. Introduction

1.1 Over the last two months we have been conducting a rapid refresh of our Trust Strategy. This has included input from the Management Executive, the Board of Directors, the Governors' Strategy Group and the CUH Reflects staff reflection exercise.

1.2 This paper sets out:

1. The context in which we are working, based on our modelling work, a listening exercise conducted with staff and our current operational plan.
2. Proposed objectives for the next 18 months, with key focus areas of work within these.
3. How we propose to deliver these objectives through Taskforces on cross-cutting work and all of our teams aligning their work.
4. How we propose to govern and report on this ambitious programme of work to ensure that the Board can provide oversight and receive assurance.
5. A summary of key issues emerging from the strategy refresh.

2. Our context

Covid modelling

2.1 From the outset of the Covid critical incident, we have convened an expert modelling group, drawing on expertise from our infectious diseases team with support from the corporate finance, strategy, improvement and workforce teams, and external input from the Institute for Manufacturing at the University of Cambridge.

2.2 The modelling group has identified a series of assumptions to underpin the next period:

- <10% of CUH catchment population infected during first wave.
- UK government policy aimed at partially lifting lockdown while maintaining R0</=1.
- If unsuccessful/break-through, doubling time will be prolonged compared with the first wave.
- UK government policy aimed at suppressing break-through/s with further lockdown/s.
- UK government policy calibrated at national level and may be compromised by error/incomplete adherence.

2.3 These generate three broad demand scenarios with consequent bed requirements:

- Suppressed: sporadic cases, similar levels to early in epidemic, controlled by social distancing and enhanced testing/quarantine, assume 0-3 admissions/day as per 10-Mar to 17-Mar (requiring 20 General Internal Medicine (GIM) and 10 Critical Care (CC) beds).
- Intermittent lock-down: peak height less than or equal to first wave as per 18-Mar-present, periodicity likely longer (requiring 100 GIM and 30 CC beds).
- Second wave: incompletely suppressed as per the first wave (requiring 275 GIM and 70 CC beds).

2.4 The modelling team expect the most likely scenario to be repeated transitions between the first and second scenario, with a second wave as a downside scenario.

CUH Reflects

2.5 Given the pressure that staff have faced over the last four months, we launched phase 1 of 'CUH Reflects' in May 2020. The aim is for individuals, teams and the Trust to come together to reflect and learn from the extreme circumstances of a pandemic before many of the details were forgotten, identifying common issues and priorities for improvement over the next period. Feedback was gathered through three channels over a short period of time:

- A survey sent to all staff (18 May – 1 June, n=3,616).
- Seven open questions circulated by email in our daily bulletin (18 May – 7 June, n=222).
- A series of improvement conversations held with staff involved in improvement projects (May, n=30).

2.6 The biggest single theme was enhanced team working during this period: multidisciplinary teams working together towards a common goal; strengthened relationships across the Trust and within teams; and opportunities for wider collaboration.

2.7 Four other themes emerged:

- Making our working lives easier: flexible working arrangements; access to park on site for free, accommodation, hot food and drink; and space to take a break, relax and recharge.
- Recognition of our work/commitment: thanks and appreciation – from leadership, local management and the public; small acts of kindness (donations and gifts); a clear sense of thought from the trust about doing what is possible to support staff.
- Clear and consistent communications and leadership: a clear purpose and direction set from senior management; consistent and clear communication, support and policy at local management level; local level empowerment and a strong clinical voice.
- Keeping us all safe: PPE and protocols; Covid secure environment; reduced footfall.

2.8 Appendix 1 provides more details of the findings of CUH Reflects.

2.9 As well as informing our strategy refresh now, CUH Reflects will continue over the coming period to ensure that we keep engaging effectively with our staff.

Operational Planning

2.10 As part of the STP's 'Phase 3' response to COVID-19 recovery (covering the period August 2020 to March 2021), the Trust and other system providers undertook an early assessment of the implications of returning to pre-COVID-19 patient treatment levels, whilst continuing to operate in a COVID-19 environment, to help inform planning and resource discussions between the Department of Health and Social Care and HM Treasury.

2.11 CUH's assessment was driven by operational proposals from both the clinical divisions and Taskforces and identified the following key areas of impact on resources:

- Loss of productivity to meet infection prevention and control (IPC) and social distancing requirements. For example, theatre capacity is estimated to reduce by 30% due to the needs to meet IPC standards and the impact of this on case turnaround times.

- Loss of productivity through increased sickness rates and the need for staff to self-isolate / shield.
- Reduced available inpatient bed base to facilitate the management of COVID patients, i.e. beds have had to be removed for social distancing and for staff doffing / donning facilities.
- The COVID bed base has to be run at low occupancy levels to facilitate:
    - The closure of beds to manage IPC.
    - Same sex accommodation (SSA) compliance.
    - Maintaining availability across all stages of COVID inpatient capacity, i.e. green, amber and red wards.

2.12 In order to address these pressures and return the Trust to pre-COVID service levels, there is an estimated additional capital financial investment required of £109.4m and revenue investments with a full year impact of £126.9m (13% increase in cost base). This investment would support:

- Additional inpatient general bed capacity, to part offset the reduction in available beds and the increased demand for COVID inpatient beds. (Most of this additional bed capacity would come through the proposed Regional Surge Centre.)
- Additional critical care beds.
- Theatre capacity.
- Emergency Department capacity to meet IPC and social distancing requirements and the separation of query COVID-19 patients.
- PPE requirements.
- Workforce requirements: initial forecasts signal a significant increase in workforce requirements (over 1,100 medical, nursing and other staff).
- Diagnostic capacity increases, particularly Radiology and Endoscopy.
- Outpatient reconfiguration.

2.13 The Trust's approach to managing the crisis has led to the fast tracking of operational transformation, particularly in outpatients and a significant expansion of offsite working for support services. The implications of this on the future operating model and finances of the Trust have not yet been fully assessed but remain in development.

3. Our strategy and objectives

3.1 In the context outlined above, we have spent the last month developing our strategy in response. This is based on the following three goals:

- Improving patient care
- Supporting our staff
- Building for the future

3.2 Within each of these goals, we have identified key objectives for the next 18 months, each with a series of focus areas underway to deliver them:

Theme	Objective	Focus Areas	
Improving patient care	Safely restore all the services we provide both as a local hospital and a specialist teaching hospital for the East of England, and prioritise those patients with greatest clinical need in reducing waiting lists.	• Outpatients • Diagnostics • Surgery • Beds	• Patient testing • Covid secure environment • Clinical leadership
	Work with our partners to maximise our capacity to treat both Covid and non-Covid patients in hospital and in the community, enabled by technology.	• Regional Surge Centre • Independent sector • Critical care • Emergency Department	• Mobile CT unit • Care homes • Primary Care • South Alliance
	Provide consistently high standards of patient care and experience in and outside the hospital using agreed clinical standards and protocols, embedding a culture of sustainable continuous improvement, and maintaining a safe environment.	• Patient and public involvement • Fundamentals of care • Improvement • Deteriorating patients	• Clinical governance risk • Ward accreditation • Building safety • Covid secure environment
Supporting our staff	Ensure that we have sufficient numbers of appropriately skilled and trained staff to deliver our plans now and in the future.	• Recruitment • Retention	• Training • Education
	Provide a comprehensive package of support to keep our staff safe, engaged, healthy and able do their jobs to the best of their abilities.	• Communications and engagement • Culture and values • PPE and RPE • Flexible working	• Psychological support • Health, safety and risk assessment • Staff offer • Staff testing
	Develop further actions to achieve greater equality and diversity in the CUH family across all the protected characteristics.	• Recognising inequality • WRES and WDES • Equality in leadership • Just and learning culture	• Recruitment practice • Staff networks • Events
Building for the future	Develop and secure national support for the next major stages of the business cases for the Cambridge Children's Hospital and Addenbrooke's 3.	• Addenbrooke's 3 • Cancer Research Hospital	• Cambridge Children's • Emergency Hospital
	Develop an Integrated Care System across Cambridgeshire and Peterborough that improves our population's health, outcomes and experience within the available resources.	• System recovery planning • ICS leadership • Health inequalities	• Financial settlement • Digital transformation
	Play a leading role with partners on the Cambridge Biomedical Campus in the national Covid-19 research effort and powering economic growth through life sciences.	• Covid and other research • Royal Papworth • Digital	• Open for business • Life sciences • Anchor institution

4. Delivering our strategy

4.1 Since the start of the Covid critical incident we have worked across the organisation in a flexible way to ensure we bring the right people together to address emerging issues at a rapid pace. We established Taskforces to pursue work on cross-cutting, goal-specific, time-limited pieces of work that our normal structures would have struggled to support: such as trebling our critical care capacity in three weeks, or coordinating our cohorting our patients into red, amber and green areas of the hospital.

4.2 Over the coming 18 months we will need to continue working in this flexible way in a smaller number of areas, and reflect that the work of our core teams (such as workforce, communications, improvement and nursing) is also a central element of delivering our strategy. As such our current plan to deliver the strategy involves:

- Four Taskforces focused on the sustainability of our clinical services during this period (urgent and emergency care; primary and community care; surgery and critical care; diagnostics and outpatients). We expect these to continue for some time given the scale of the challenge ahead.

- Three Taskforces focussed on cross-cutting enablers (respiratory protective equipment, Covid secure environment and testing). We expect these to draw to a close over the coming months, and that other issues will emerge in their place.

- A major programme of work on cohorting and configuration to be put in place by September 2020 recognising the scale of the challenge to prioritise services and maximise capacity on and off the Campus, including principles and a processes for managing competing demands.

- Our substantive Teams aligning behind delivering this plan – including workforce, estates, nursing, medical, improvement, digital, communications, operations, finance, and strategy and major projects.

4.3 Appendix 2 contains the latest updates from the current set of Taskforces, a number of which have now been closed.

5. Governance and reporting

5.1 Our progress in delivering the revised objectives, for which individual Executive Directors will be accountable, will be overseen by the Management Executive, in turn reporting to Board assurance committees and the Board of Directors.

5.2 The revised meeting arrangements for the Management Executive, which were put in place to manage the first phase of the pandemic, have now been reviewed and revised for the next phase. Going forward it is proposed that Management Executive will review progress against the objectives on a fortnightly, rolling basis. This will feed into a progress report which will be presented to the Board of Directors every two months at the Part 1 Board meeting.

5.3 In addition, the sustainability taskforces will report and escalate issues directly to the Management Executive on a regular basis.

5.4 In relation to risk, the Risk Oversight Committee will continue to review the Board Assurance Framework (BAF) and the Corporate Risk Register on a monthly basis and provide assurance to the relevant Board sub-committees that the risks are being managed and mitigated. Once the revised Trust objectives have been approved, the BAF will be refreshed over the next two months to ensure that it reflects the principal risks to the

achievement of the objectives. An update will be provided to the Board in September 2020.

6. Key issues emerging from the strategy refresh

6.1 It is hard to overplay the scale of the delivery challenge inherent in realising the ambitious strategy objectives we have set out – they deliberately cover a broad waterfront, and the Board is well sighted on the context of the challenges we are facing recovering from Covid. Equally, we will want to continue to challenge ourselves to remain focused on a small number of key areas where we really want to drive progress.

6.2 While setting the right objectives is of course important in its own right, the real power of this work will come from enabling us to harness the joint endeavours of all of our corporate teams, clinical leaders and workforce in emerging stronger from the Covid pandemic. There is more therefore we need to do to develop the communications narrative to the organisation in line with the strategy so that everyone can see their role to play.

6.3 We have also had to think carefully about how best to use our limited resource in the organisation to support the very significant volume of cross-cutting, urgent and critical work covered by the strategy. The Divisional Directors and their teams have provided valuable, creative and energetic clinical leadership. We have settled on taskforces to lead the sustainability work for the next phase, but it will be important to ensure they have sufficient support from across our corporate teams and the wider organisation, and that they interface effectively with the five divisions. We will want in all this to ensure that the lack of bureaucracy and pace that was a feature of our initial response is retained.

7. Recommendations

7.1 The Board of Directors is asked to:

- Endorse the strategy refresh exercise.
- Agree the revised objectives for the next 18 months.
- Note the proposed approach to delivering and reporting on the strategy and objectives.

NHS
Cambridge University Hospitals
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Appendix 1

CUH Reflects

Outcomes of phase 1

June 2020

Introduction

We launched phase 1 of CUH reflects in May 2020 to understand the experience of our staff in the extreme circumstances of a pandemic.

The aim of the exercise was for individuals, teams and the Trust to come together to reflect and learn from this crisis before many of the details were forgotten.

Feedback form phase 1 was gathered via three channels over a short period of time;

1. Staff survey (18 May – 01 June, n=3,616)
2. Seven open questions (18 May – 07 June, n=222)
3. Improvement conversations (May, n=30)

CUH Reflects will help us;

- Understand what our staff have and are experiencing
- Help us to focus on priority areas for improvement
- Identify and support common issues, for example on health and wellbeing issues
- Plan and implement changes at pace

Staff survey

Response rates

NHS Cambridge University Hospitals NHS Foundation Trust

The breakdown of the response rates are shown in the tables below.

Division	Number of Completed Surveys	Response Rate
Division A	625	31.9%
Division B	969	34.1%
Division C	478	30.4%
Division D	394	30.3%
Division E	404	31.4%
R&D	133	40.4%
Corporate	609	45.4%
Trust Total	**3,616**	**33.8%**

Staff Group	Number of Completed Surveys	Response Rate
Add Prof Scientific and Technic	95	33.0%
Additional Clinical Services	563	30.3%
Administrative and Clerical	1,074	49.2%
Allied Health Professionals	197	34.3%
Estates and Ancillary	75	23.8%
Healthcare Scientists	200	35.3%
Medical and Dental	316	21.1%
Nursing and Midwifery Registered	1,096	32.0%
Trust Total	**3,616**	**33.8%**

Number of Responses

The survey asked staff for Ethnicity, Age and Pay Band. The number of completed surveys and response rates are shown below

Ethnicity	Number of Completed Surveys	Response Rate
BAME	730	28.4%
White	2,866	38.3%

Pay Band	Number of Completed Surveys	Response Rate
Band 1-4	1,046	33.3%
Bands 5-7	1,881	34.9%
Bands 8+	339	49.3%
Medical - Consultants	177	26.4%
Medical - Non Consultants	115	13.9%

Age Band	Number of Completed Surveys	Response Rate
16-20	42	25.1%
21-30	814	27.8%
31-40	886	30.8%
41-50	890	36.7%
51-65	933	42.6%
66+	39	32.2%

Trust results – part 1

NHS
Cambridge University Hospitals
NHS Foundation Trust

The table below shows the % staff responding positively to each survey question (e.g. Agree or Strongly Agree)

Survey Questions	Overall (n=3,616)
	%
1. I have confidence in the leadership team's decisions for the organisation at this time.	74%
2. Communication on COVID-19 has been helpful in understanding what resources are available to me (e.g., safety & well-being guidance, access to support, work from home practices).	86%
3. Communication has provided me with the information I need to continue to work safely in my role.	75%
4. Communication across teams has been effective during this critical period.	59%
5. I have the equipment (Personal Protective Equipment (PPE), Masks, Gloves, Gowns, Aprons, Sanitiser, etc.) I need to keep myself safe.	73%
6. I feel confident if I needed Covid19 individual staff health risk assessment I would be able to access one.	86%
7. I know who I should escalate concerns to about my health and safety.	89%
8. I have been able to balance working with taking care of myself.	69%
9. I have been able to maintain a positive outlook on my ability to contribute during this time.	70%
10. I have been supported to work from home.	65%
11. My team has been working well together to support each other during this time.	82%
12. I feel confident I can keep myself healthy while doing my job.	68%
13. I feel secure to raise concerns/speak up when there are things that I see that concern me.	75%
14. I feel confident the organisation is providing the best possible care for its patients including those with Covid19.	86%
15. I feel confident the organisation is providing the best possible care for its staff, including those with Covid19.	70%

Trust results – part 2

Cambridge University Hospitals NHS Foundation Trust

The table below shows the % staff responding 'yes'

Survey Questions	Overall (n=3,616) %
16. Are you in a role that has direct clinical contact with patients or in an area of the trust where care is delivered?	63%
17. If yes have you worked in a red / COVID19 areas?	49%
18. Have you undertaken a COVID19 risk assessment?	69%
19. If you have undertaken a risk assessment, have adjustments to work activities based on the outcome of the risk assessment been implemented?	77%

The table below shows the % staff selecting each available option

20. What additional equipment would you need to make you feel safer at work?	Overall (n=3,616)
Masks	60%
Other	40%
Sanitiser	33%
PPE	31%
Gowns	28%
Gloves	15%
Aprons	9%

21. I have worked at home during this period.	Overall (n=3,616)
1 - Occasionally	20%
2 - Most of the time	19%
3 - Not at all	48%
4 - I'd like to but it is not possible	10%
5 - I'd like to and it is possible but it hasn't happened	3%

Ethnicity headline results

NHS
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Some survey questions have highlighted some disparities between the experiences of our BAME and white staff, specifically:

- 64% of BAME staff feel confident the organisation is providing the best possible care for its staff compared with 71% white staff
- 56% of BAME staff feel they have been supported to work from home compared with 67% of white staff
- 69% of BAME staff feel secure to raise concerns/speak up compared with 77% of white staff
- 79% of BAME staff feel they have been able to maintain a positive outlook on their ability to contribute during this time compared with 68% of white staff

We are interested in understanding that despite the difference in the experience of BAME staff in the first three scores above they continue to maintain a significantly more positive outlook on their ability to contribute compared to white staff

It is encouraging to note that there is no difference between white and BAME staff in teams working well to support each other, both groups at 82% and in feeling confident the organization is providing the best possible care for its patients including those with Covid 19, both groups at 86%

Results by ethnicity

NHS
Cambridge University Hospitals
NHS Foundation Trust

The table below shows the % staff responding positively to each survey question (e.g. Agree or Strongly Agree)

Survey Questions	Overall (n=3,616)	BAME (n=730)		White (n=2,866)	
	%	%	+/- Overall	%	+/- Overall
1. I have confidence in the leadership team's decisions for the organisation at this time.	74%	69%	-5%	76%	+2%
2. Communication on COVID-19 has been helpful in understanding what resources are available to me (e.g., safety & well-being guidance, access to support, work from home practices).	86%	84%	-2%	87%	+1%
3. Communication has provided me with the information I need to continue to work safely in my role.	75%	75%	0%	76%	+1%
4. Communication across teams has been effective during this critical period.	59%	64%	+5%	58%	-1%
5. I have the equipment (Personal Protective Equipment (PPE), Masks, Gloves, Gowns, Aprons, Sanitiser, etc.) I need to keep myself safe.	73%	73%	0%	74%	+1%
6. I feel confident if I needed Covid19 individual staff health risk assessment I would be able to access one.	86%	85%	-1%	86%	0%
7. I know who I should escalate concerns to about my health and safety.	89%	87%	-2%	90%	+1%
8. I have been able to balance working with taking care of myself.	69%	75%	+6%	69%	0%
9. I have been able to maintain a positive outlook on my ability to contribute during this time.	70%	79%	+9%	68%	-2%
10. I have been supported to work from home. *	65%	56%	-9%	67%	+2%
11. My team has been working well together to support each other during this time.	82%	82%	0%	82%	0%
12. I feel confident I can keep myself healthy while doing my job.	68%	65%	-3%	69%	+1%
13. I feel secure to raise concerns/speak up when there are things that I see that concern me.	75%	69%	-6%	77%	+2%
14. I feel confident the organisation is providing the best possible care for its patients including those with Covid19.	86%	86%	0%	86%	0%
15. I feel confident the organisation is providing the best possible care for its staff, including those with Covid19. *	70%	64%	-6%	71%	+1%

* Questions 10 and 15 have been broken down further on the following page

Results by ethnicity – further breakdowns

Cambridge University Hospitals NHS Foundation Trust

10. I have been supported to work from home

The disparity in responses to this question between white and BAME staff is fairly low in Admin staff but larger in Healthcare Scientists and AHPs. There is also a higher disparity within the lower pay bands.

Staff Group	Overall (n=3,616)	BAME (n=730)		White (n=2,866)	
	%	%	+/-	%	+/-
All Staff	65%	56%	-9%	67%	+2%
Add Prof Sci & Tec	71%	64%	-7%	73%	+2%
Add Clinical Services	49%	46%	-3%	49%	0%
Admin and Clerical	71%	69%	-2%	72%	+1%
AHPs	71%	60%	-11%	76%	+5%
Estates and Ancillary	38%	0%	-38%	43%	+5%
Healthcare Scientists	72%	48%	-24%	77%	+5%
Medical and Dental	65%	55%	-10%	67%	+2%
Nursing & Midwifery	52%	48%	-4%	53%	+1%

Pay Band	Overall (n=3,616)	BAME (n=730)		White (n=2,866)	
	%	%	+/-	%	+/-
All Staff	65%	56%	-9%	67%	+2%
Band 1-4	58%	46%	-12%	60%	+2%
Bands 5-7	67%	56%	-11%	69%	+2%
Bands 8+	74%	86%	+12%	73%	-1%
Medical - Cons	67%	61%	-6%	69%	+2%
Medical - Non Cons	55%	53%	-2%	58%	+3%

15. I feel confident the organisation is providing the best possible care for its staff, including those with Covid19

The disparity in responses to this question between white and BAME staff is low within medical staff and pay bands 1-4 and higher among healthcare scientists, admin staff, nurses and bands 5 and above.

Staff Group	Overall (n=3,616)	BAME (n=730)		White (n=2,866)	
	%	%	+/-	%	+/-
All Staff	70%	64%	-6%	71%	+1%
Add Prof Sci & Tec	74%	88%	+14%	71%	-3%
Add Clinical Services	67%	73%	+6%	65%	-2%
Admin and Clerical	78%	67%	-11%	80%	+2%
AHPs	74%	72%	-2%	76%	+2%
Estates and Ancillary	53%	43%	-10%	54%	+1%
Healthcare Scientists	73%	55%	-18%	77%	+4%
Medical and Dental	61%	61%	0%	63%	+2%
Nursing & Midwifery	65%	61%	-4%	67%	+2%

Pay Band	Overall (n=3,616)	BAME (n=730)		White (n=2,866)	
	%	%	+/-	%	+/-
All Staff	70%	64%	-6%	71%	+1%
Band 1-4	70%	70%	0%	70%	0%
Bands 5-7	70%	64%	-6%	72%	+2%
Bands 8+	81%	71%	-10%	83%	+2%
Medical - Cons	67%	66%	-1%	69%	+2%
Medical - Non Cons	56%	57%	+1%	54%	-2%

n = number of responses

Division Results – Part 1

NHS
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Survey Questions	Overall (n=3,616)	Div A (n=625)		Div B (n=969)		Div C (n=478)		Div D (n=394)		Div E (n=404)		R&D (n=133)		Corporate (n=609)	
	%	%	+/- Overall	%	+/- Overall	%	+/- Overall	%	+/- Overall	%	+/- Overall	%	+/- Overall	%	+/- Overall
1. I have confidence in the leadership team's decisions for the organisation at this time.	74%	63%	-11%	74%	0%	66%	-8%	74%	0%	79%	+5%	88%	+14%	83%	+9%
2. Communication on COVID-19 has been helpful in understanding what resources are available to me (e.g., safety & well-being guidance, access to support, work from home practices).	86%	79%	-7%	87%	+1%	81%	-5%	86%	0%	93%	+7%	93%	+7%	90%	+4%
3. Communication has provided me with the information I need to continue to work safely in my role.	75%	66%	-9%	73%	-2%	72%	-3%	75%	0%	81%	+6%	81%	+6%	83%	+8%
4. Communication across teams has been effective during this critical period.	59%	51%	-8%	58%	-1%	57%	-2%	57%	-2%	66%	+7%	67%	+8%	63%	+4%
5. I have the equipment (Personal Protective Equipment (PPE), Masks, Gloves, Gowns, Aprons, Sanitiser, etc.) I need to keep myself safe.	73%	70%	-3%	73%	0%	72%	-1%	71%	-2%	87%	+14%	76%	+3%	68%	-5%
6. I feel confident if I needed Covid19 individual staff health risk assessment I would be able to access one.	86%	84%	-2%	86%	0%	87%	+1%	87%	+1%	88%	+2%	84%	-2%	86%	0%
7. I know who I should escalate concerns to about my health and safety.	89%	88%	-1%	89%	0%	90%	+1%	87%	-2%	92%	+3%	91%	+2%	90%	+1%
8. I have been able to balance working with taking care of myself.	69%	67%	-2%	68%	-1%	69%	0%	67%	-2%	78%	+9%	76%	+7%	69%	0%

Division Results – Part 2

NHS
Cambridge University Hospitals
NHS Foundation Trust

Survey Questions	Overall (n=3,616)	Div A (n=625)		Div B (n=969)		Div C (n=478)		Div D (n=394)		Div E (n=404)		R&D (n=133)		Corporate (n=609)	
	%	%	+/- Overall	%	+/- Overall	%	+/- Overall	%	+/- Overall	%	+/- Overall	%	+/- Overall	%	+/- Overall
9. I have been able to maintain a positive outlook on my ability to contribute during this time.	70%	65%	-5%	69%	-1%	71%	+1%	69%	-1%	73%	+3%	70%	0%	72%	+2%
10. I have been supported to work from home.	65%	38%	-27%	67%	+2%	50%	-15%	63%	-2%	71%	+6%	78%	+13%	74%	+9%
11. My team has been working well together to support each other during this time.	82%	76%	-6%	81%	-1%	83%	+1%	79%	-3%	88%	+6%	91%	+9%	84%	+2%
12. I feel confident I can keep myself healthy while doing my job.	68%	60%	-8%	68%	0%	63%	-5%	66%	-2%	75%	+7%	80%	+12%	73%	+5%
13. I feel secure to raise concerns/speak up when there are things that I see that concern me.	75%	68%	-7%	77%	+2%	69%	-6%	74%	-1%	81%	+6%	85%	+10%	77%	+2%
14. I feel confident the organisation is providing the best possible care for its patients including those with Covid19.	86%	83%	-3%	84%	-2%	81%	-5%	83%	-3%	93%	+7%	90%	+4%	91%	+5%
15. I feel confident the organisation is providing the best possible care for its staff, including those with Covid19.	70%	58%	-12%	71%	+1%	64%	-6%	68%	-2%	78%	+8%	79%	+9%	77%	+7%

Staff survey

Cambridge University Hospitals NHS Foundation Trust

The Covid-19 survey has provided a wealth of information for the organisation to respond to and highlights the benefits and opportunities inherent of having a highly engaged workforce. A full pack of the results is available. Specific results which require attention and careful consideration:

- The difference regarding staff feeling secure to raise concerns across many indicators, i.e. ethnicity, pay band, staff group and Division
- There was a statistically significant difference found in 10 of the questions between white and BAME staff
- The opportunity to understand the experience of staff groups and target responses accordingly especially in relation to working from home and staying healthy
- Responding to variances in understanding regarding health, safety and escalating concerns
- Full consideration is being given to the 2,951 free text comments received these are currently being analysed, themed and aligned to Divisional/Corporate Teams

Our seven questions

We asked staff seven questions

1. What made the biggest difference for you and your team to help you through the outbreak?
2. If we had to do it all again, what would you want to do differently? What would you want the Trust to do differently?
3. How has the last ten weeks affected your relationships at work?
4. How have your feelings about your job changed?
5. What are you most proud of?
6. What one thing should we keep as the COVID-19 legacy at CUH?
7. What have we stopped that we should never bring back?

The 222 responses to these questions were themed. The following slides show the 12 themes that were most frequently raised by our staff in responding to these questions. The percentage shows the percentage of responses relating to the theme, for each question.

Common themes

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Statements	What made the difference?	What could we have done differently?	How has this affected your relationships at work?	How has this changed how you feel	What are you most proud of?	What should we keep as a legacy	What should we continue to stop?
Team work: “We’ve come together in and across teams to make a difference and we want to continue to develop great team work. We need everyone in the team to feel connected and valued.”	**22%**	2%	**45%**	14%	**55%**	13%	2%
Staff support: “Small things really matter and we have loved the free parking, meals, gifts sent to wards and the sanctuary at the Frank Lee.”	17%	5%	3%	15%	0	14%	**51%**
Communication and leadership: “Clear communication from the leadership of the Trust makes a big difference and we want more relevant information regularly from channels we can read or watch anywhere.”	16%	13%	3%	4%	6%	12%	0
Flexible working: “Support and trust us to work flexibly and remotely when we can. It works and we feel valued if you support our work-life balance.”	11%	7%	8%	11%	2%	**17%**	8%

Common themes

NHS
Cambridge University Hospitals
NHS Foundation Trust

Statements	What made the difference?	What could we have done differently?	How has this affected your relationships at work?	How has this changed how you feel about your job?	What are you most proud of?	What should we keep as a legacy	What should we continue to stop?
Planning / preparation: "We didn't feel as prepared for this as we should/could have been as a Trust and system. We want to understand the bronze/silver/gold command decision structure and we want consistency in how change is implemented."	1%	**18%**	0	5%	1%	3%	0
Health and safety: "We are anxious and exhausted. We want to know that our health, safety and wellbeing as CUH staff needs is of paramount importance and we want to see action which supports that."	3%	17%	13%	15%	4%	6%	2%
Staffing/rotas: "The pace at which changes were made to rotas and people were redeployed was unsettling and could have been handled better."	0	9%	1%	2%	0	3%	2%
Kindness and recognition: "We need to continue to be more kind, be proud of what we've achieved and show more appreciation to staff for what they do."	3%	3%	10%	**23%**	4%	13%	2%

Common themes

NHS
Cambridge University Hospitals
NHS Foundation Trust

Statements	What made the difference?	What could we have done differently?	How has this affected your relationships at work?	How has this changed how you feel about your job?	What are you most proud of?	What should we keep as a legacy	What should we continue to stop?
Giving our best: “We feel proud when we find out what we’re capable of and show resilience during tough times to do the very best for patients.”	0	0	0	0	20%	1%	0
Footfall: “Please continue to reduce all unnecessary visits to the site including outpatient appointments that could be held remotely and people visiting to use the shops on the concourse.”	0	12%	0	0	0	7%	21%
IT: “We need good IT systems that support new ways of working.”	7%	7%	7%	1%	0	2%	0%
Bureaucracy: “Less bureaucracy please: we want to be helped to change faster and we like pace. We particularly see some face-to-face meetings as a waste of time.”	3%	2%	0	2%	0	5%	10%
Common goal: “We like to have a clear sense of purpose and a single aim that unites us all”	6%	0	0	6%	0	1%	0

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Improvement conversations

What contributed to the successful implementation of the supporting changes in relation to Covid-19?

What we heard:

- A single unifying aim and an inspiring purpose: “The sense of ‘we’re all in this together’ and people helping each other out across the Trust”
- Multi-disciplinary team (MDT) working, from clinical and non-clinical areas, as well as from system partners: “Increased interaction between front and back office teams, some real positives in how prepared many people have been to just pitch in with what’s needed”
- Breaking down hierarchies and working across team, divisional and organisational boundaries: “Hierarchies have become less relevant and people have felt on more of an equal footing, because their work is valued in a different way through this.’
- Strengthened and supported clinical leadership: “Felt a hands off approach from operations helped expedite changes - no waiting for agreement on clinical decisions/proposals through traditional levels of review.”

What contributed to the successful implementation of the supporting changes in relation to Covid-19?

What we heard:

- Learning as we go along and the use of rapid tests of change, with subsequent adaptation, adoption, or abandonment: “Reviewed meeting outputs and effectiveness on regular basis and adapted on weekly basis.”
- Facilitating rapid decision making, with delegated authority: “Increased scope to view whole Trust and feed into the current Command Structure. Delegated authority from Gold Command to make decisions in response to staffing needs of the Trust”
- Streamlined governance, with reduced bureaucracy: “Improved governance – fixed agenda which is under regular review, formal record of escalations and actions collated, actions reviewed regularly.”
- Compassionate leadership: “Observing the senior management team discussions and how they reached decisions really demonstrated to me how they role model the trust values:”

What contributed to the successful implementation of the supporting changes in relation to Covid-19?

What we heard:

- Clear communications from the Trust's leadership, utilising a variety of platforms: "'Daily communications from the centre on everything of note – be kept well informed re headline facts, also video meetings."
- Embedding remote and flexible working, by developing appropriate policies to support staff to stay connected with one another, whilst working differently: "Working from home 1 -2 days per week could become the new normal to help work/life balance."
- The value of an improvement mind-set and approach as we progress this learning: "Although no formal procedure was in place the methodology mirrored PDSA principles and whenever issues were identified they were rectified and the new process tested'
- The necessity of involving patients in reshaping services to bolster patient confidence and trust: "Weekly follow up clinic for patients discharged to understand what the stroke team could do to improve support for patients."

Conclusions

What appears to matter most to our staff during the COVID-19 period?

Cambridge University Hospitals NHS Foundation Trust

- Team work:
  - Multidisciplinary teams working together towards a common goal
  - Strengthened relationships across the Trust and within teams
  - Opportunities for wider collaboration
- Making our working lives easier:
  - Flexible working arrangements
  - Access to park on site for free, accommodation, hot food and drinks
  - A space to take a break, relax and recharge
- Recognition of our work / commitment:
  - Thanks and appreciation – from leadership,local management and the public
  - Small acts of kindness (donations and gifts)
  - A clear sense of thought from the trust about doing what is possible to support staff
- Clear and consistent communications and leadership:
  - A clear purpose / direction set from senior management
  - Consistent and clear communication, support and policy at local management level
  - Local level empowerment and a strong clinical voice
- Keeping us all safe
  - PPE and protocols
  - Covid secure environment
  - Reduced footfall

Cambridge University Hospitals
NHS Foundation Trust

Appendix 2

Taskforce Update Report COVID-19

Board of Directors
8 July 2020

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- Management
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- COVID Secure Environment
- Regional Surge Capacity
- Supply Chain
- PPE
- RPE

Purpose of the report

- This report highlights progress against the Taskforces set up to support CUH's response to the COVID-19 pandemic for the period 5 June to 1 July 2020.
- This report includes:
    i. An executive summary highlighting key areas for consideration and discussion
    ii. A summary of the COVID-19 Risk Register as aligned to the taskforces
    iii. Progress reports on each of the key taskforces
- The taskforces are areas of work that CUH has identified that will enable us to contribute to delivering our strategy and vision throughout this pandemic and into the future.
- Each taskforce is outlined in further detail including aims and objectives, timelines, key decisions made and due to be made, including financial impacts.
- The report is presented for information and context and should be viewed as a basis for ongoing engagement with the Board, staff, STP partners and our patients. The Board is not being asked to make any specific decisions at this time.
- This is the final edition of this report in this format. A new version will be submitted to the Board in due course.

Summary

The following key themes have been identified over the last month:

- **Sustainability**: we have made significant progress in restarting services that were paused because of the Covid critical incident. Significant challenges remain givenbed losses and lower theatre productivity due to infection prevention and control measures, and higher rates of staff absence. We are working with STP partners and NHSE/I to increase bed, theatre and staff capacity; redesigning pathways to serve more patients closer to home and through virtual appointments; and reconfiguring the hospital to maximise capacity;
- **Testing**: our collaboration with the University and industry partners continues to expand capacity for patient and staff testing. Staff testing shows very low levels of antibodies, indicating that infection prevention and PPE have been effective;
- **Respiratory Protective Equipment**: our clinicians are developing effective processes to prioritise use of FFP3 masks in line with PHE, HSE and College guidance; and
- **COVID secure environment**: we have made a range of physical modifications to public space, office space and clinical areas within the hospital, as well as reflecting national guidance in our working policies, to protect patients and staff.

Over the last month we have closed some Taskforces that have completed their objectives or are conducting the same activities through business-as-usual teams: staffing, management, external links, supply chain, regional surge centre and PPE. Our refreshed strategy will reflect these changes.

COVID-19 Risk Register Summary

(reflects position as at June 2020 Risk Oversight Committee meeting and does not yet include new taskforces established or closed in the past month)

Ref.	Title	CQC Domain	Executive Director Lead	Assurance Committee	Inherent rating (cXML)	Current rating (CxL)	Target rating (CxL)	21 May 2020	04 June 2020	18 June 2020
CR34	**Management of Coronavirus - COVID-19**	**Safe**	**Chief Operating Officer**	**Quality**	4x5=20 (Red)	5x4=15 (Red)	3x4=12 (Amber)	Decreased	Same	Decreased
TF01	Taskforce 01: Staffing	Safe	**Director of Workforce**	**Workforce**	5x5=25 (Red)	4x3=12 (Amber)	3x4=12 (Amber)	Same	Same	Same
TF04	Taskforce 04: Supply chain	Responsive	**Chief Financial Officer**	**Performance**	4x4=16 (Red)	3x4=12 (Amber)	3x3=9 (Amber)	Same	Same	Same
TF05	Taskforce 05: Management	Safe	**Director of Strategy**	**Performance**	4x5=20 (Red)	4x4=16 (Red)	3x4=12 (Amber)	Same	Same	Same
TF06	Taskforce 06: Testing	Safe	**Medical Director**	**Quality**	4x5=20 (Red)	4x3=12 (Amber)	4x2=8 (Amber)	Decreased	Same	Same
TF07	Taskforce 07: Communications and engagement	Responsive	**Director of Corporate Affairs**	**Quality**	4x4=16 (Red)	3x4=12 (Amber)	3x3=9 (Amber)	Same	Same	Same
TF08	Taskforce 08: Personal Protective Equipment	Safe	**Chief Nurse**	**Quality**	4x5=20 (Red)	3x4=12 (Amber)	3x3=9 (Amber)	Same	Same	Same
TF09	Taskforce 09: External Links	Well-led	**Director of Improvement and Transformation**	**Performance**	4x5=20 (Red)	5x3=15 (Red)	5x2=10 (Amber)	Same	Same	Same
TF12	**Taskforce 12: Sustainability**	**Well-led**	**Chief Nurse**	**Performance**	**4x5=20 (Red)**	**4x5=20 (Red)**	**3x3=9 (Amber)**			**NEW**
TF14	Taskforce 14: RPE Insufficient or insecure supply of respiratory protective equipment	Safe	**Chief Nurse**	**Quality**	**5x4=20 (Red)**	**5x4=20 (Red)**	**5x3=15 (Red)**		**NEW**	Same

Taskforce – Staffing (1/2)

Executive Leads: David Wherrett, Director of Workforce and Lorraine Szeremeta, Chief Nurse

Scope: to protect our staff and maximise our capacity and availability to deliver emergency care.

Rapid deployment	Redeployment	Staff health and wellbeing	Staff welfare	Workforce planning
• Rapid recruitment and supply enhancement • Participation in national return to work programmes	• Training and retraining • Homeworking • Remuneration	• Staff COVID-19 testing • Health risk assessment • Health guidance, advice and psychological support	• Accommodation • Staff sanctuary space • Food and refreshments • Childcare and transport	• Short term • Medium term • Long term

What are we trying to do?	How does this help?	Who is working on this?	When are things happening?	What decisions have already been made? Are there financial implications?	What decisions are due to be made? Are there financial implications?
Rapid deployment	Ensure CUH have the right people with the right skills to enable maintenance of the recruitment pipeline over time and meet the needs of patients in the short and long term.	Projects leads in place	Ongoing recruitment medium/long term pipeline	• Process to support RPH signed system-wide MOU. • Continued international recruitment campaigns.	• Workforce plans for taskforces 01/07/20. • Confirmation of winter workforce plans.
Redeployment	Ensure that CUH utilise the skills in our existing workforce and the right staff the meet the needs of patients.	Projects leads in place	Staff pool live Ongoing training for redeployment	Clinical, non clinical and project staff pools established. Plans to repatriate those temporarily redeployed.	Adoption of new roles (including apprenticeships) and support for creating greater agility in workforce to meet any future surges.
Staff health and wellbeing	Support staff to remain healthy and well, physically and psychologically. A healthy workforce is essential to providing good patient care.	Projects leads in place	Ongoing activity staff testing and track and trace	Large scale staff testing and serology screening in place. V5 of risk assessment to be undertaken by all staff.	Long term re-establishment of Occupation Health Services.

Taskforce – Staffing (2/2)

Executive Leads: David Wherrett, Director of Workforce and Lorraine Szeremeta, Chief Nurse

Scope: to protect our staff and maximise our capacity and availability to deliver emergency care.

Rapid deployment	Redeployment	Staff health and wellbeing	Staff welfare	Workforce planning
• Rapid recruitment and supply enhancement • Participation in national return to work programmes	• Training and retraining • Homeworking • Remuneration	• Staff COVID-19 testing • Health risk assessment • Health guidance, advice and psychological support	• Accommodation • Staff sanctuary space • Food and refreshments • Childcare and transport	• Short term • Medium term • Long term

What are we trying to do?	How does this help?	Who is working on this?	When are things happening?	What decisions have already been made? Are there financial implications?	What decisions are due to be made? Are there financial implications?
Welfare	Ensure that staff are supported to be able to attend work and stay well and to ensure CUH have right staff present to meet patient needs.	Projects leads in place	Offer on accommodation, food, childcare support, transport live.	Changes to funded offers for food, transport and accommodation. Hardship fund and You Made a Difference awards launched in June 2020.	Exit strategy for removing offers in due course.
Workforce planning	Maintain a clear overview of our staffing pipeline, including as it relates to turnover, and the various supply routes. This provides immediate plans for cover and remuneration and longer term view.	Projects leads in place	Internal working group established which feeds into daily site safety meetings.	Pay decisions to be taken via usual processes. Staffing requirements for surge hospital plan.	Workforce planning for Taskforces to be completed by 1 July 2020. Children's hospital and Addenbrooke's 3 are business as usual.

Taskforce - Cohorting and Configuration

Executive Leads: Nicola Ayton - Chief Operating Officer

Scope: To cohort COVID19 and non-COVID19 patients.

Capacity	Bed Plan	Nursing and Medical Model	Pathway and Algorithm
Full reconfiguration and maximisation of hospital capacity and pathways in line with modelled peak	Development of hospital Plan for Positive and Negative COVID cohorts including critical care	Medical staffing and rostering to provide in line with modelled peak	• Model route for positive and negative COVID patients aligned to peak demand • Ensure containment arrangements for COVID patients

What are we trying to do?	How does this help?	Who is working on this?	When are things happening?	What decisions have already been made? Are there financial implications?	What decisions are due to be made? Are there financial implications?
Cohorting and configuration	Agile configuration of the hospital to allow for infection control and appropriate management of patients creating a safe environment for patients. Creation of maximum COVID response to include up to 450 Red COVID patients, and 150+ critical care beds. Creation of ring-fenced Green elective and non-elective surgery capacity.	Various	Phase 1 – Complete Phase 2 – July 2020 Phase 3 – Autumn 2020	• Cohorting and configuration plan developed and implemented for Phase 1. • Placing patients guidance implemented and scale down plan being enacted.	• Ongoing implementation of reverse surge plan to enable stepping up of non-Covid-19 services. • Proposal for dedicated regional COVID-19 sites submitted to NHS England for approval.
Fire Safety Works	Close Ward D8 to enable the estates team to commence the Fire Safety Works. This will allow the Fire Safety programme to proceed.	Cohorting and Configuration Group	Close Ward – 26/6 Cleaning and Decommission – 30/6 Handover to E&F -1/7	• Ward has been selected as next ward to have works completed. • Programme has been through the required financial gateways.	When the ward returns to clinical use which team will use the space this creates (D8 will go back to MSK).

Taskforce – Urgent and Emergency Care (1/3)

Executive Lead: Nicola Ayton - Chief Operating Officer

Scope: Implement a sustainable clinical and operating model for the next 18 months throughout the peaks and troughs of the outbreak to maximise the survivorship of patients and protect our staff. Maintain flexibility for Covid capacity, prioritise patients based on risk, deliver through new channels (remote, independent sector, primary care).

Directing demand | **Streaming** | **Urgent Treatment Unit** | **ED Flow** | **Discharge pathway** | **Medical pathway** | **Surgical pathway** | **Women's and Children's pathway**

What are we trying to do?	How does this help?	Who is working on this?	When are things happening?	What decisions have already been made? Are there financial implications?	What decisions are due to be made? Are there financial implications?
Directing Demand	To reduce the need to attend the ED by enabling 111, primary care, ambulance and community services access to most appropriate care setting within CUH and the wider system. Enhance clinical validation before decision to send to Emergency Department. Reduces attenders and helping to divert patients to existing services in community across the region.	Projects leads in place	Ongoing	• Meeting scheduled with CCG to finalise supporting metrics for 111 streaming pilot. • Agreed who can undertake the urgent care coordinator role for the pilot. • Contacted East of England Ambulance Service in relation to updating the local Directory of Services. (MiDOS).	• Agree data submission dispensations with CCG. • Finalise supporting metrics for 111 streaming pilot. • Communicate pilot to ED. • Agree communications for patients. • Sign off policy for streaming to 111/primary care. • Finalise start date for pilot.
Streaming patients to the right place at the right time	Ensure that patients attending the ED, who require urgent and emergency care can be assessed and streamed to access the right treatment, in the most appropriate place and at the right time. Quickly gets patients to an appropriate setting based on level of acuity and patient requirements.	Projects leads in place	Ongoing	Process terminology document produced.	• Streaming pilot for 111 to be undertaken, see workstream 1 (Directing Demand) for details.

Taskforce – Urgent and Emergency Care (2/3)

What are we trying to do?	How does this help?	Who is working on this?	When are things happening?	What decisions have already been made? Are there financial implications?	What decisions are due to be made? Are there financial implications?
Establish Urgent Treatment Unit (UTU)	Strengthen the urgent ambulatory offer by co-locating the assessment of minor injuries, major ambulant, Same Day Emergency Care and Out of Hours GP patients. Relocate ambulant patients from ED.	Projects leads in place	Ongoing	• Continued discussion with medical, surgical and ED teams. • Draft list of facilities needed. • Analysis and discussion of data on modelling for patient activity, specific requirement for blood testing and imaging. Infection control walk around to assist in establishing capacity planned 24/6.	• Progress discussion on space requirements and what patients cohort. • Review imaging & blood data to determine activity volumes ranges/ transfers to Radiology. • Collate list of equipment needed.
Patient flow within and from Emergency Department	To review/establish pathways that ensure patients, who have been assessed and had their treatment initiated, within the ED can flow efficiently and effectively to other assessment or admissions areas. Aim to transfer patients within 2 hours. Reduce primary clerking, remove secondary clerking in ED to reduce time patient spends in ED that adds no value.	Projects leads in place	Ongoing	• Analysis of ED activity data for example e.g. number of ambulance arrivals, number of patients admitted, discharged and admitted patients (speciality breakdown).	• Complete analysis of activity data to inform ED process review. • Review policy and portering model for patient transfers. • Medical Assessment Unit start date 06/07/20.
Enhancing discharge pathways	Improve and maintain the reduction in the number of patients classified as Delayed Transfers of Care. Establish pathways into out-of-hospital support solutions as an alternative to admitting patients for review. .	Projects leads in place	Ongoing	• Start regular workstream meetings with stakeholders. • Map out process for proactive management of patients with early warning flag Plan for reintroduction of Long Length of Stay Reviews with Division D.	• Implement processes agreed last week. • Seek input with Heads of Nursing. • Discuss medicines optimisation on targeted wards with Pharmacy.

Taskforce – Urgent and Emergency Care (3/3)

What are we trying to do?	How does this help?	Who is working on this?	When are things happening?	What decisions have already been made? Are there financial implications?	What decisions are due to be made? Are there financial implications?
Medical pathway	Develop medical pathways for the assessment of infectious and non-infectious patients through the establishment of separate medical assessment areas to minimise the time medical patients spend in ED. Supports treat and discharge approach.	Projects leads in place	Ongoing	• Draft standard operating procedures being finalised for two wards. • Drafted patient flow process. • Monitored beds requirement confirmed.	• Confirm Point of Care availability for N2. • Agree equipment requirements for admissions units.
Surgical pathway	To develop surgical pathways that can accommodate both infectious and non-infectious patients through the establishment of a surgical assessment area with the aims of preventing attendance to the ED or minimising the time surgical patients spend in the ED should they self-present. Supports 'treat and discharge' and avoids admissions and helps to segregates red/green patients.	Projects leads in place	Ongoing	• Move to Cambridge Eye Unit completed on 22/06. • Medical cover in place. • Standard operating procedure sent to Silver Command for information.	• Meeting lead for surgical pathways to determine patient pathways suitable for Surgical Assessment Unit or Same Day Emergency Care. Obtain speciality level activity data for surgical patients admitted or discharged from ED.
Women's and Children's pathway	Develop pathways for the assessment of infectious and non-infectious patients through the establishment of separate assessment areas with the aim avoiding attendance to the and minimising time patients spend in ED, if they self-present. Supports 'treat and discharge' and avoids admissions and helps to segregates red/green patients.	Projects leads in place	Ongoing	• Paediatrics ambulatory pathway list drawn up. • Flow: children from ED front door to Clinic 9, reduce ED crowding. • Gynaecology pathway established. Patients attend by GP or self-referral.	• Review of space requirements for Paediatrics. • Explore whether Gynaecology patients can come via ambulance directly to clinic 24 if criteria met.

Taskforce – Outpatients and Diagnostics

Executive Lead: Nicola Ayton - Chief Operating Officer

Scope: Restart outpatients and diagnostics services whilst keeping the innovative ways of working developed as a response to the crisis. Establishing prioritisation framework to enable CUH to meet clinical need and regulatory requirements.

Diagnostics	Outpatients
12,600 patients on waiting list, capacity currently 40% of baseline.	Loss of 4 clinics to emergency/COVID activity. Wholesale move to remote consultation.

What are we trying to do?	How does this help?	Who is working on this?	When are things happening?	What decisions have already been made? Are there financial implications?	What decisions are due to be made? Are there financial implications?
Formation of Taskforce	Overcome obstacles encountered by individual work streams and provide cross divisional oversight. To minimise delay, allow for equity and reporting both internally and for external regulators.	Projects leads in place	Ongoing	• Taskforce group established. • Reset of process to turn services back on – sessions being held with specialities in June. • Outpatients environment guidance.	There is a need to increase community diagnostic capacity, this has local and national support but will have significant financial implications.
Diagnostics	Provide capacity to meet demand for diagnostics, clinical need and regulatory targets.	Projects leads in place	Ongoing	• Re-opening GI endoscopy • Reopened Saffron Walden for some services. • Off-site CT scanner to be located at Sawston.	• Location and scope of community diagnostic hubs. • Agree offsite solution for phlebotomy. • Consider 1m social distancing in waiting areas.
Outpatients	Provide capacity to meet demand and embed new ways of working to match clinical need and free up space on site.	Projects leads in place	Ongoing	New Clinical Advice Service (CAS) model established. Specialties open for routine referral for advice and guidance. Opened up to attendances (77% of pre COVID, 70% via telephone).	Location for virtual clinics (call-centre) to be established. Assessment and decision on redeployment of capacity released by virtual clinics to be made.

Taskforce – Surgery and Critical Care (1/2)

Executive Lead: Nicola Ayton - Chief Operating Officer

Scope: The successful and safe restart of core elective activity. Efficient and productive use of theatres for both urgent and elective surgery and effective use of critical care capacity. Reviewing processes and flow, working toward the overarching aim of achieving pre-COVID activity levels.

Surgery and Critical Care	Critical Care	Independent Sector Provision	Surgery	Endoscopy	Surgical Assessment Unit

What are we trying to do?	How does this help?	Who is working on this?	When are things happening?	What decisions have already been made? Are there financial implications?	What decisions are due to be made? Are there financial implications?
Surgery and Critical Care	Re-establish urgent and routine surgery in an agile way whilst encouraging the evaluation of new models of care where appropriate. To establish and embed a transparent decision-making process for clinical prioritisation based on clinical need and regulatory requirements. To embed a culture of continuous improvement that supports a way of working that creates joy in work for our staff.	Projects leads in place	Ongoing	Establishing 5 workstreams to deliver our aims.	
Critical Care	Enable capacity to incorporate COVID surge; future-proof and develop suitable critical care capacity for non-COVID patients; and improve post-operative care in the perioperative setting.	Projects leads in place	Ongoing	Expanding critical care capacity in the Post Anaesthetic Care Unit (PACU) by 6x rising to 12x.	Recruitment required.
Independent Sector Provision	Efficiently utilise the ISP to support the Trust getting back to pre-COVID activity levels.	Projects leads in place	Ongoing	Standardised processes with the independent sector providing surgery.	Proposal to maximise independent sector capacity until March 2021.

Taskforce – Surgery and Critical Care (2/2)

Executive Lead: Nicola Ayton - Chief Operating Officer

Scope: The successful and safe restart of core elective activity. Efficient and productive use of theatres for both urgent and elective surgery and effective use of critical care capacity. Reviewing processes and flow, working toward the overarching aim of achieving pre-COVID activity levels.

Surgery and Critical Care	Critical Care	Independent Sector Provision	Surgery	Endoscopy	Surgical Assessment Unit

What are we trying to do?	How does this help?	Who is working on this?	When are things happening?	What decisions have already been made? Are there financial implications?	What decisions are due to be made? Are there financial implications?
Surgery	To re-establish pre-COVID activity levels	Project leads In place	Ongoing	• 4 stage process to return to pre-Covid levels as per Royal College Surgery (RCS) guidance. • Prioritisation aligned with national P1 and P2 categories. • Repurposing of Addenbrookes Treatment Centre (ATC) to increase elective surgery. • Commit to improving joy in work for staff.	• PPE feedback due to Management Executive late June. • Establish improvement champions in theatres. • Reviewing most suitable use of Ely Day Surgery Unit.
Endoscopy	To resume diagnostic endoscopy services, retaining high quality, safe standards, and to reshape pre-procedure pathway in line with British Society of Gastroenterology (BSG) guidance.	Project leads In place	Ongoing	• Successfully restarted colonoscopy and increased list number. • Successfully restarted Endoscopy (ODGS) procedures. • Repatriated all procedures from Cambridge Clinical Research Centre.	• Restarting cystoscopy on 29th June 2020. • Recruitment more endoscopy nurses.
Surgical Assessment Unit	To establish a Surgical Assessment Unit to efficiently manage patient flow away from the Emergency Department.	Project leads In place	Ongoing	• Move complete to Cambridge Eye Unit 22.06.2020. • Medical cover in place.	• Standard operating procedure sent to Silver Command for information.

Taskforce – Primary and Community Care

Executive Lead: Nicola Ayton - Chief Operating Officer

Scope: The focus of the Primary and Community Care Taskforce is to identify and initiate new ways of working between defined specialities and Primary Care Networks (PCNs), by building relationships and developing new ways of working. There is scope to manage demand and work in a way which is better for patients and more viable for the system in the short and long term. While the taskforce is focusing on rapid change, this work is in line with the broader aims of the STP Operational Plan, to "join up out of hospital care, building on strong primary care to improve the quality of care for patients; outcomes for the local population; and value for the taxpayer."

Geriatrics	Heart Failure	Respiratory	Diabetes	Dermatology	Neurology

What are we trying to do?	How does this help?	Who is working on this?	When are things happening?	What decisions have already been made? Are there financial implications?	What decisions are due to be made? Are there financial implications?
Primary and Community Care	Create effective links and ways of working with the South Provider Alliance in order to deliver care out of hospital, where appropriate. Enabling CUH to meet clinical need, particularly for patients with long term conditions, and regulatory requirements.	Projects leads in place	Ongoing	• Initial workshops and co-design session with PCNs, South Alliance and CUH. • Specialty areas selected for new models: diabetes, heart failure, geriatrics, respiratory and dermatology, neurology. All areas have now had at least one scoping session leading to defined next steps. • Focus on virtual Multidisciplinary team models and use of MyChart in short term. MyChart is the patient facing aspect of the CUH patient record system, EPIC.	• Baselining and determining specific quantifiable and qualitative outcomes for each workstream. • Scoping of additional investment (e.g. for licences, portable diagnostic or IT equipment) • Regular review of individual specialty approaches to assess if meeting need for patients, PCNs, CUH and other partners.

Taskforce – Management

Executive Lead: Dan Northam Jones - Director of Strategy

Scope: To provide consistent and effective management of the Covid 19 critical incident and ensure effective governance and reporting.

Supporting the command structure	Allocating staff to meet priority project needs	Setting strategy and supporting planning
Ensure that Gold and Silver Command are able to make and implement timely and effective decisions.	Ensure that project work from Gold, Silver and Taskforces is sufficiently resourced to deliver.	Ensure that Gold, Silver and Taskforces are informing, and informed by, our overall strategy.

What are we trying to do?	How does this help?	Who is working on this?	When are things happening?	What decisions have already been made? Are there financial implications?	What decisions are due to be made? Are there financial implications?
Command Structure Support	Make timely and efficient decisions and document these appropriately This enables timely resolution of emerging problems supported by good governance.	CUH Incident Management Support Unit. (IMSU).	Support underway and working well. Handbook of protocols being drafted for future surges.	Streamline Silver and Gold support processes and staffing to release more staff to support sustainability work, while maintaining EPRR requirements.	Ongoing review of Silver and Gold functions
Reporting	Inform ME and the Board of what is happening and escalate issues from Taskforces. This enables timely resolution of emerging problems supported by good governance.	Taskforce Executive leads; IMSU	Monthly reports for ME/BoD and Risk Oversight Committee (ROC).	Regular updates to ME/Board Strategy refresh proposes changes	Future reporting structure given strategy refresh
Resource Pool	Identify and redeploy Trust staff and others whose normal job has ceased. Enables new project work on COVID-19 to be staffed appropriately and quickly.	Resource Pool	Daily allocation of requests; fortnightly update calls.	65+ requests allocated; members now formally hosted by own teams	Future model for resourcing Taskforces
Model	Forecast COVID-19 and non-COVID-19 demand, and capacity to meet this various demand scenarios. This informs planning and use of resources within the Trust and across the region.	Modelling Group; Institute for Manufacturing	Fortnightly meetings; weekly meeting of Sustainability sub-group; monthly update at ME.	Model extended to cover non-COVID-19 patients and wider set of resources, and inform recovery planning.	Future development of IfM's Arena model and links with other CUH models.
Strategic Support	Align Taskforce work with our agreed strategy and plan to ensure consistency of approach and common assumptions.	IMSU	In line with other Taskforce requirements.	To pool corporate team resources to support this.	How to best resource a cross cutting agile strategy function

1. A gold–silver–bronze command structure is a command hierarchy used for major operations by the emergency services of the United Kingdom.

Taskforce – Testing (1/2)

Executive Lead: Ashley Shaw - Medical Director

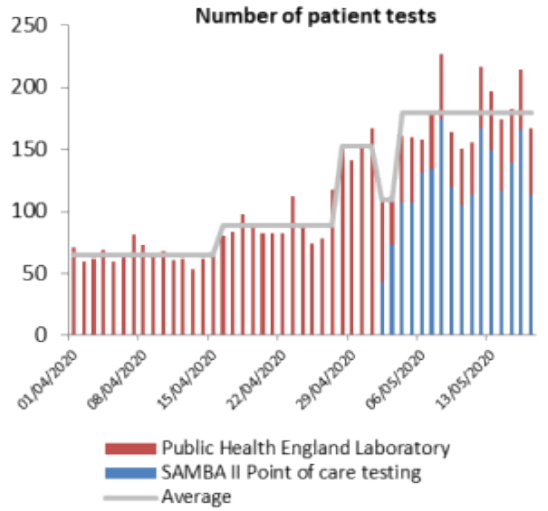
Scope: To maximise COVID -19 testing capacity and capability for patients and staff across the Trust.

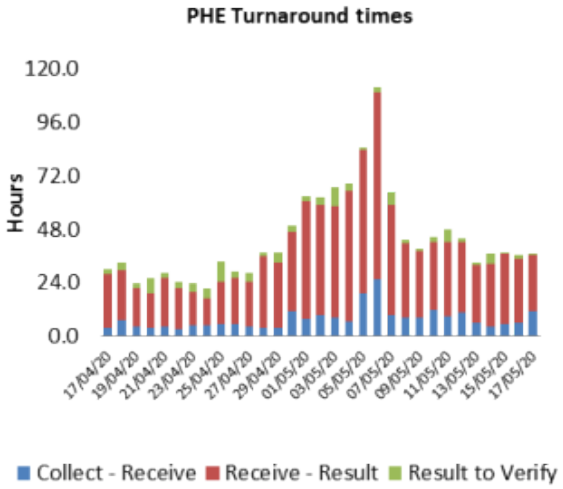
Patients	Staff	Laboratory Capacity	Testing Capability
• To quickly and accurately confirm COVID-19 status of patients. • To support decision making on cohorting and containment and limit the spread of the disease within the hospital.	• To provide testing to onsite staff to limit the spread of COVID-19 and protect the workforce. • To allow staff to return to work as soon as is safe to do so. • To provide assurance to staff that PPE measures are working.	• Expand laboratory capacity to support predicted demand. • Repurpose Pathology capacity as needed. • Seek additional external capacity.	• Introduce new processes to maximise the number of tests processed in the shortest possible time. • Use modelling to quantify the peak testing capacity required to meet patient and staff testing needs in line with national policy.

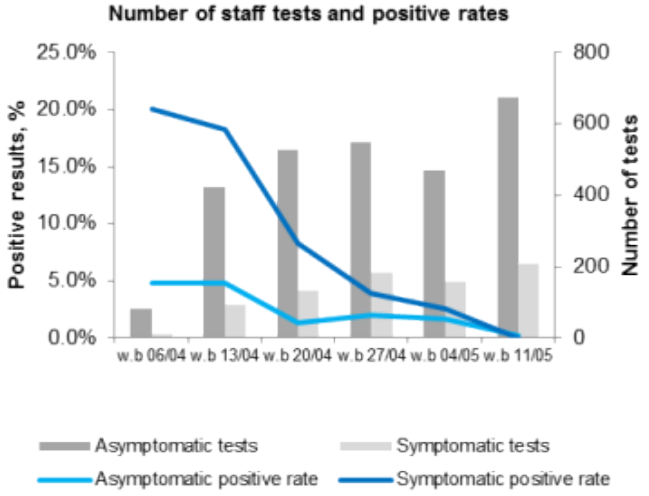
What are we trying to do?	How does this help?	Who is working on this?	When are things happening?	What decisions have already been made? Are there financial implications?	What decisions are due to be made? Are there financial implications?
Patient antigen testing	Increasing testing capacity and capability prioritising query COVID-19 areas. This ensures patients are diagnosed and provided with the most relevant and appropriate medical care.	Microbiology; Virology; Point of Care team and Public Health England (PHE).	Commenced.	Standard Operating Procedure published for patient testing. Non-elective, high risk patients and those requiring urgent decisions tested using SAMBA II Point Of Care tests. Elective care and patients discharged to care settings tested using Public Health England tests	Development of pre-admission and diagnostic swabbing service.
Staff antigen testing	Providing testing to staff working in high risk areas. Provides assurance that infection containment procedures are effective and provides assurance for those staff isolating at home.	Occupational Health; PHE; Microbiology; Research and Development; Virology.	Commenced with over 3,500 staff tested to date.	Two streams of staff testing are in place with phased schedules: a) symptomatic staff or those with a symptomatic household member; b) asymptomatic screening programme. Capacity has increased to allow 300 tests per day.	Longer term strategy and operational plans for staff testing, including sustainability of laboratory capacity.

Taskforce – Testing (2/2)

What are we trying to do?		How does this help?	Who is working on this?	When are things happening?	What decisions have already been made? Are there financial implications?	What decisions are due to be made? Are there financial implications?
Laboratory and Testing Capability	Developing further testing capability through research and innovation and streamlining existing processes.	This will increase throughput, reduce turnaround times and remove backlog as well as develop new tests for people who may have had the virus.	Research and Development, Pathology and PHE.	Ongoing	Antibody testing now available with capacity for 200 tests per day and 24-48 hours turnaround time. Public Health England have put in a number of measures to increase antigen testing capacity and return turnaround times to ~24 hours.	How to use results of antibody test and strategy for who and when to test. Develop understanding of regional demand and capacity for patient testing and implications for 3, 6, 12 months







Taskforce – External Links (1/2)

Executive Leads: Roland Sinker - Chief Executive, Mike More - Chairman , Ewen Cameron - Director of Improvement and Transformation

Scope : Triage offers of support and providing national escalation where required.

University of Cambridge	Cambridge Biomedical Campus	Sustainability and Transformation Partnership (STP) and region.	National
Resource sharing including Personal Protective Equipment (PPE) accommodation, equipment and staff.	• Medical research • Medical trials • Genomics	Optimising treatment of system and regional patients.	Liaise with key stakeholders including local MPs and councillors, NHS England and national government where appropriate for escalation.

What are we trying to do?	How does this help?	Who is working on this?	When are things happening?	What decisions have already been made? Are there financial implications?	What decisions are due to be made? Are there financial implications?
University of Cambridge	Continue our partnership and strong collaboration across key areas including research and testing capability and capacity and the brokerage of shared assets, equipment and resources locally.	Management Executive and Chief Executive	Ongoing	We are seeking to maximize our shared skills and common ambitions across the research and life sciences arena.	
Cambridge Biomedical Campus	Continue to work closely with our campus partners such as Royal Papworth Hospital (RPH) as we look to support the development of a regional surge centre.	Chief Executive	Ongoing	Every part of the system has a different lived experience – care homes, mental health providers and critical care, However, we are working well together.	
STP and Region	• CCG has taken a strong lead in managing the local health and care system response to the COVID-19 pandemic and immediate tactical action to support our recovery plans. • We are working hard with the region to align objectives and share our expertise for example via the critical care network and the 'Super Surge' response.	Cambridgeshire and Peterborough CCG NHS England Regional Team	Ongoing	CUH has supported the installation of an Epic care link in Brookfield Care Home and the Prince of Wales Hospital in Ely – enabling patient data to be shared directly across different care settings. Testing all patients COVID-19 status prior to discharge back into the community to ensure partners can care for patients effectively.	

Taskforce – External Links (2/2)

Executive Leads: Roland Sinker - Chief Executive, Mike More - Chairman and Ewen Cameron - Director of Improvement and Transformation					
Scope : Triage offers of support and providing national escalation where required.					
University of Cambridge		**Cambridge Biomedical Campus**		**Sustainability and Transformation Partnership (STP) and region.**	**National**
Resource sharing including Personal Protective Equipment (PPE) accommodation, equipment and staff.		• Medical research • Medical trials • Genomics		Optimising treatment of system and regional patients.	Liaise with key stakeholders including local MPs and councillors, NHS England and national government where appropriate for escalation.
What are we trying to do?	**How does this help?**	**Who is working on this?**	**When are things happening?**	**What decisions have already been made?** Are there financial implications?	**What decisions are due to be made?** Are there financial implications?
National	We are working with key stakeholders to share and communicate our experiences and stories as a front line NHS service in a meaningful way influencing and shaping the national agenda particularly on critical care and the testing and research.	Management Executive and Chief Executive	Ongoing	To be advised	To be advised

Taskforce – COVID Secure Environment (1/2)

Executive Leads: Carin Charlton – Director of Capital, Estates and Facilities

Scope : Maximise the safety of staff and patients by introducing appropriate sustainable (workplace, waiting and communal areas) measures to reduce the risk of transmission of COVID 19 in line with government guidance and HSE regulations.

Risk Assessment | **Messaging** | **Food Court and Concourse** | **Clinical environment** | **Entrances and circulation spaces** | **Offices** | **Other workplaces** | **Face coverings/ infection control**

What are we trying to do?	How does this help?	Who is working on this?	When are things happening?	What decisions have already been made? Are there financial implications?	What decisions are due to be made? Are there financial implications?
Risk Assessment and Messaging	• Ensure corporate risk assessment undertaken in line with legal requirement. • Local risk assessment process in place to enable local managers to manage a secure Covid-19 environment. • Alignment with appropriate clinical group re patient messaging.	Project leads in place	Ongoing weekly project meetings	• Corporate risk assessment completed and issued. Accepted as candidate risk at ROC 25/6. • Local risk assessment template issued. • Guidance document issued. • Initial checklist issued. • Printed resources available.	Unknown cost implication of Covid secure workplace at local level. Work in progress regarding facemasks and secure environment. Restriction of use of amenity facilities. Messaging re staff adherence.
Food court and Concourse	• Reinforce social distancing measures. • Proportionate measures to be considered as footfall increases.	Project leads in place	Ongoing weekly project meetings	• Occupier-led social distancing measures. • Reinforcement of existing measures and further strengthening.	Restriction of use of amenity facilities.
Entrances and Circulation Spaces	• To ensure a consistent approach to entrances for public and staff and traffic flow to minimise contact. • Appropriate signage and signposting.	Project leads in place	Ongoing weekly project meetings	• Security presence at main entrances, issuing face masks, challenge compliance. • Final signage agreed.	Consider sustainable model for face masks at entrances – by end July move to BAU.

Taskforce – COVID Secure Environment (2/2)

Executive Leads: Carin Charlton – Director of Capital, Estates and Facilities

Scope : Maximise the safety of staff and patients through introducing appropriate sustainable (workplace, waiting and communal areas) measures to reduce the risk of transmission of COVID 19 in line with government guidance and HSE regulations.

Risk Assessment | **Messaging** | **Food Court and Concourse** | **Clinical environment** | **Entrances and circulation spaces** | **Offices** | **Other workplaces** | **Face coverings/ infection control**

What are we trying to do?	How does this help?	Who is working on this?	When are things happening?	What decisions have already been made? Are there financial implications?	What decisions are due to be made? Are there financial implications?
The clinical environment (waiting and reception)	• To ensure screens at receptions and waiting room furniture suitably arranged. • Link with sustainability taskforce to ensure capacity is not exceeded.	Project leads in place	Ongoing - weekly project meetings	Screens at receptions (cost implication) and social distancing in waiting areas – significant work on social distancing in clinic areas.	Impact on ward staff areas.
Offices	• To provide clear principles of safe working environment and to establish enhanced cleaning requirements for working environment.	Project leads in place	Ongoing - weekly project meetings	As per risk assessment stream.	Review risk assessment submission compliance.
Other workplaces	• To provide clear principles of safe working environment adapted for different work spaces.	Project leads in place	Ongoing - weekly project meetings	As per risk assessment stream.	Review risk assessment submission compliance.
Face coverings and general infection control	• To ensure alignment with PPE bronze regarding face coverings. • To ensure alignment with Infection Control Bronze work programme.	Project leads in place	Ongoing - weekly project meetings	Mask wearing in public and non-public facing areas across the trust implemented.	Comply with any updated national guidance.

Taskforce – Regional Surge Capacity (1/2)

Executive Leads: Nicola Ayton - Chief Operating Officer, Carin Charlton – Director of Capital, Estates and Facilities.

Scope: Build additional temporary accommodation for patients on Cambridge Biomedical Campus to serve as part of the Regional Surge Centre response led by NHS England (East of England Regional Leadership Team).

Design and Build	Finance	Clinical	Technology	Non clinical services
• Planning and construction. • Equipment, hardware and consumables. • National and regional engagement.	• Legal, regulatory and financial.	• Clinical model and pathways. • Workforce.	• Technology infrastructure. • Application management.	• Operating model. • Non clinical services. • Equipment and consumables.

What are we trying to do?	How does this help?	Who is working on this?	When are things happening?	What decisions have already been made? Are there financial implications?	What decisions are due to be made? Are there financial implications?
CUH team has continued to press nationally in support of our regional surge bid. The date for a decision is pending, however, CUH/RPH will restart limited work on a week by week basis to create a Full Business Case which recognises the need to move at pace, in advance of a National decision on funding.					
Design and Build	Deliver a facility that optimises services to patients in recovery and rehabilitation and improves staff safety as well. Meet immediate and long term needs for model of care that secures Care Quality Commission licence and complies with best practice guidance and regulations relating to the built environment.	Director of Capital, Estates and Facilities.	Business Case for patient facility submitted on 01/05/20.	• To conduct a feasibility study for site. • Regional approval given to proceed with development of business case for 180 beds.	• Review of business case governance process to be completed by CUH and RPH.
Finance	Secure funding sources and finances in a way that enables CUH to manage financial costs, benefits, assumptions, implications and risks effectively.	Director of Finance	Financial case set out in the business case.	• Weekly cash flow to enable restart of design and build, clinical modelling before National funding decision.	
Clinical	Develop a clinical model, diagnostic requirements infection prevention and control, patient care pathways, patient discharge/transfer and repatriation pathways.	Director of Improvement	Preparation of draft clinical model.	• Restart work on clinical model ready for design stage.	• Approval of clinical and operating models.

Taskforce – Regional Surge Capacity (2/2)

Executive Leads: Nicola Ayton - Chief Operating Officer, Carin Charlton – Director of Capital, Estates and Facilities.

Scope: Build additional temporary accommodation for patients on Cambridge Biomedical Campus to serve as part of the Regional Surge Centre response led by NHS England (East of England Regional Leadership Team).

Design and Build	Finance	Clinical	Technology	Non clinical services
• Planning and construction • Equipment, hardware and consumables. • National and regional engagement.	Legal, regulatory and financial.	• Clinical model and pathways. • Workforce.	• Technology infrastructure. • Application management.	• Operating model. • Non clinical services. • Equipment and consumables.

What are we trying to do?	How does this help?	Who is working on this?	When are things happening?	What decisions have already been made? Are there financial implications?	What decisions are due to be made? Are there financial implications?
CUH team has continued to press nationally in support of our regional surge bid. The date for a decision is pending, however, CUH/RPH will restart limited work on a week by week basis to create a Full Business Case which recognises the need to move at pace, in advance of a National decision on funding					
Technology	Ensure technical architecture, infrastructure and applications for clinical model that delivers a facility that provides a suitable care and work environment for patients and staff.	Director of Improvement	Workstream due to commence.		
Non clinical Services	Develop operating model for each of the non-clinical services to support the operation of the facility including staffing model, managing support services, equipment and consumables soft facilities management operational. This will enable CUH to deliver an operational facility that provides a suitable care and work environment for patients and staff	Director of Capital, Estates and Facilities	Workstream due to commence.	• The operation of the facility is to be incorporated as part of the overall service delivery approach to the rest of the hospital. • Financial assumptions made in the revenue costings around non-clinical services.	The scope of non-clinical services and leads for each service.

Taskforce – Supply Chain

Executive Leads: Paul Scott - Chief Financial Officer		
Scope: To ensure sufficient supply to meet demand for essential equipment.		
PPE	**Ventilation Consumables**	**BAU**
Ensure there is a fit for purpose, real time tracking system to meet the project peak and sustain flow.	Develop the supply chain resilience including innovative and novel approaches.	Service non Covid-19 demand in timely manner.

	What are we trying to do?	How does this help?	Who is working on this?	When are things happening?	What decisions have already been made? Are there financial implications?	What decisions are due to be made? Are there financial implications?
Live stock dashboard	Single source of truth for Covid-19 requirements, stock and orders which helps alleviates staff anxiety over supply chain resilience and allows early action.		Nominated Project Lead	In place iterative improvements	Daily reporting structure agreed and in place.	
PPE Distribution Process	Appropriate distribution process for pandemic related product ensuring the right stock in the right place and the right time.		Nominated Project Lead	Pull system in place – reviewed weekly	Decision made to progress to push and pull service.	Push and pull service in place and working successfully.
Procurement channels for PPE	Establish alternate direct procurement channels for COVID19 related consumables to provide resilience alongside government supply. Reduces risk of product shortages.		Nominated Project Lead	Daily	Processes in place for donations local manufacturing and direct procurement.	Direct procurement channels require approval from NHS England/Innovation.
Team resilience	Build a resilient, 24/7 team to handle the increased load with 24/7 replenishment		Nominated Project Lead	In place	24/7 internal PPE supply service is in place.	Additional layer of resilience resources.

Taskforce – PPE

Executive Leads: Paul Scott - Chief Financial Officer and Lorraine Szeremeta - Chief Nurse					
Scope: To protect our staff by providing adequate and appropriate personal protective equipment					
Protocols and Policy		**Staff Training**	**Distribution**	**Supply**	
PHE guidance			Challenges of national supply chain impacting PHE advice	All aspects of PPE	
What are we trying to do?	**How does this help?**	**Who is working on this?**	**When are things happening?**	**What decisions have already been made ?** Are there financial implications?	**What decisions are due to be made?** Are there financial implications?
Protocol and Policy	Develop protocols in line with national guidance to protect staff from transmission of COVID-19.	Dedicated project leads in place	Changing rapidly as new Public Health England (PHE) guidance.	• Working in line with PHE guidance – reviewing PPE practice in some areas (see also RPE Taskforce) . • As services restart reviewing guidance • Outpatients attendees to wear face masks.	
Staff training	Ensure staff are trained adequately to use PPE to protect protective staff from transmission of COVID-19.	Dedicated project leads in place	Extensive training package designed and PPE champions employed.	• New guidance printed • Training programmes in place. • Rolling audit of PPE practice implemented. Messages delivered following audit results and education given as part of audit .	
Supply	Ensure adequate supplies of all PPE including sterile theatre gowns and help to protect our staff from transmission of COVID-19 and allow maintenance and or expansion of urgent operating capacity	Project Team nominated	Hub for Donations established and links with manufacturing Mutual aid across the system in place.	National procurement leading changes to supply chain. Sourcing of alternative supplies of theatre gowns and reusable RPE (masks and hoods).	Feasibility of safely maintaining current surgical capacity in CUH and by Independent Sector.

Taskforce – Respiratory Protective Equipment (RPE)

Executive Leads: Lorraine Szeremeta - Chief Nurse, Ian Walker - Director of Corporate Affairs

Scope : A dedicated Respiratory Protective Equipment (RPE) Taskforce has been established, the purpose of which is to maximise the safety of staff through sourcing, prioritisation and use of appropriate RPE protection in line with PHE guidance and HSE regulations.

Appropriate use and prioritisation | **Supply** | **Fit Testing** | **Communications and Engagement** | **Governance**

What are we trying to do?	How does this help?	Who is working on this?	When are things happening?	What decisions have already been made? Are there financial implications?	What decisions are due to be made? Are there financial implications?
Appropriate use and prioritisation	To review use of FFP3 masks within CUH scenarios against PHE guidance and identify circumstances where there are safe alternatives.	Deputy Medical Directors, Deputy Chief Nurse	Discussions held with clinical teams, summary being prepared for ME.	Review completed and being taken through governance processes. Further engagement activities being taken.	Decisions to be taken on any changes in Trust RPE scenarios in accordance with PHE guidance and local risk assessment.
Supply	To secure greater certainty and sustainability of RPE supplies.	Chief Finance Officer, Director of Procurement	Ongoing work with national and regional teams.	Procurement of reusable masks and hoods where available. Exploring non-supply chain sources.	Reviewing approach to allocation of different types of mask across the Trust.
Fit Testing	To ensure there is a robust and comprehensive fit testing programme in place for all staff required to use RPE in accordance with HSE regulations.	Deputy Chief Nurse, Head of Health and Safety	Ongoing	Fit testing programme resumed. Dashboard developed to provide insight fail rates by area, person and align supply.	Ongoing oversight of fit testing programme and resource requirements, especially to manage multiples changes in types of masks being received.

Cambridge University Hospitals NHS Foundation Trust

Report to the Board of Directors: 8 July 2020

Agenda item	12
Title	Workforce Race Equality Standard (WRES) and supporting BAME staff
Sponsoring executive director	David Wherrett, Director of Workforce
Author(s)	Monica Jacot, Equality Diversity and Inclusion Lead
Purpose	To receive the WRES 2020 data and an update on supporting and engaging BAME staff.
Previously considered by	Management Executive, 2 July 2020

Executive Summary

The report sets out the Trust's WRES dataset for 2020 submission. It also provides a summary of actions taken for protecting, supporting and engaging with our BAME colleagues during COVID-19; and the proposed actions required to re-invigorate our WRES action plan (co-produced with our BAME staff network) to address systemic racism and discrimination and make further progress in being an actively anti-racist organisation.

Related Trust objectives	Strengthening the organisation
Risk and Assurance	BAF ref: 005
Related Assurance Framework Entries	Implementing NHS Workforce Race Equality Standard WRES
Legal / Regulatory / Equality, Diversity & Dignity implications?	Equality Act 2010 and NHS Workforce Race Equality Standard
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	Yes

Action required by the Board of Directors

The Board is asked to:

- Note the latest WRES 2020 data.
- Note the summary of actions taken so far for protecting, supporting and engaging with our BAME colleagues during COVID-19.
- Endorse the need to reinvigorate our WRES action plan to address systemic racism and discrimination and make further progress in being an actively anti-racist organisation.

Cambridge University Hospitals NHS Foundation Trust

8 July 2020

Board of Directors
Workforce Race Equality Standard (WRES) and supporting BAME staff
Monica Jacot, Equality Diversity and Inclusion Lead

1. Introduction/Background

1.1 This paper provides the Board with the WRES dataset for 2020 together with a summary of action taken in protecting, supporting and engaging with our BAME colleagues during COVID-19 and a call to action to take steps to being an actively anti-racist organisation in the light of our WRES data.

1.2 COVID-19 has highlighted the health inequalities experienced by BAME communities. NHS England and Public Health England (PHE) have highlighted the disproportionate effects of the COVID-19 infection in the Black, Asian and Minority Ethnic (BAME) population, including among health and social care workers. This report highlights that people of Bangladeshi ethnicity have around twice the risk of death when compared to people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10-50% higher risk of death when compared to White British. The Intensive Care National Audit and Research Centre report (ICNARC) published on 22 May found that Black and Asian patients were over represented among those critically ill with confirmed COVID-19 receiving advanced respiratory support. The report found that 15.2% and 9.7% of critically ill patients were from Asian and Black Ethnic groups respectively. The Public Health England report 'Beyond the data: Understanding the Impact of COVID-19 on BAME groups' heard deep dismay anger, loss and fear from stakeholders about the emerging data and realities of BAME groups being harder hit by the COVID-19 pandemic than others, exacerbating inequalities. The pandemic has exposed and exacerbated longstanding inequalities affecting BAME communities in the UK. The report states racism and discrimination experienced by communities and more specifically by BAME key workers as a root cause affecting health.

1.3 On 19 May, a joint letter was sent to all CEOs from NHS England's Chief People Officer Prerana Issar and Baroness Dido Harding stating that WRES and WDES data collection was resuming (having previously advised the Trust that this was being paused in March in the early part of the COVID-19 pandemic) and to ask trusts to review their COVID-19 command and governance structures to ensure diverse representation in leadership decision making.

1.4 This paper, besides sharing the latest WRES data, sets out the ways we have been providing support and engaging with our BAME colleagues during this time of COVID-19 and in the aftermath of the unlawful killing of George Floyd, the Black Lives Matter protests and the discussion in the media which have brought up difficult upsetting emotions for colleagues. This time requires a renewed call to action for a reinvigorated WRES action plan co-produced with the BAME network that reflects a more activist approach in order for CUH to take steps to become an active anti-racist organisation in tackling racism and discrimination.

2. WRES data set for 2020 submission

The WRES indicators for the Trust's 6th WRES data report to NHS England will be submitted between July and August 2020. In summary the Trust has improved in 6 out of the 9 indicators in the last year: 1, 2, 4, 7, 8 and 9. The results are set out below.

2.1 WRES indicator 1:
Staff in post by pay band as at 31 March 2020 (see Appendix 1)

2.1.1 24% of our staff in post are BAME an increase of 2% on last year. 5.7% of staff have not declared their ethnicity which is a 1.3% improvement on the 7% figure last year. 57% of BAME staff are in pay Bands 1-5. We have seen an increase in BAME representation at levels above Band 5. 20% of BAME staff are in Bands 5-7. 22% of Band 6 staff are BAME, 10% of Band 7 post holders are BAME.

2.1.2 Our current position for numbers in pay Bands 8a and above has improved further since 31 March 2019 since our last WRES data submission; we now have one band 8d, 3 additional band 8cs and 7 more band 8as to 45 up from 38 last year; in addition one BAME Divisional director and our newest NED is BAME. Appendix 1 shows the Trust wide position and the staff profile by pay band for each Division. Our target in our WRES plan is for 1 in 5 staff BAME at all levels in the organisation.

2.2 WRES indicator 2
Relative likelihood of appointment after shortlisting

2.2.1 The total numbers of staff recruited to medical and non-medical roles from 1 April 2019 to 31 March 2020 show that White candidates are 0.92 x BAME candidates to be appointed after shortlisting.

2.2.2 The total number of white candidates shortlisted was 4350 and the total number of white candidates appointed was 1040
A total of 1885 BAME candidates were shortlisted of which 483 BAME candidates were appointed
Relative likelihood of appointment after shortlisting is as follows
White = 1040/4350 = 0.24
BAME = 483/1885 = 0.26
Relative likelihood is therefore: 0.24/0.26 = 0.92

2.2.3 There is a difference, however, if we compare Non-Medical recruitment with medical recruitment. For non-medical recruitment the ratio is white 0.23/ BAME 0.26 = 0.88. This may be accounted for due to the high level of international recruitment.
For medical recruitment, white candidates are 2.16 x more likely than BAME candidates to be appointed after shortlisting.

2.2.4 We will continue to work to ensure a diversity representative, as nominated by the BAME staff network, is a member of all interview panels. The Chair of the BAME staff network has recruited diverse champions to be part of interview panels. The BAME Network has also organised interview and job application preparation workshops for BAME staff.

2.3 WRES indicator 3
Relative likelihood of entering formal disciplinary investigation

2.3.1 Between 1 April 2019 and 31 March 2020, BAME staff were 1.5 x more likely than White staff to enter a formal disciplinary process. This is disappointing. A worse position than in the past two years. A further audit will be done and a deep dive to assess why this is the case, despite the introduction of the role of the cultural ambassador in September 2019.

2.3.2 If we break the data down non-medical cases shows that BAME were 1.8 x more likely than White staff to enter formal disciplinary investigation. However for medical staff this is reversed BAME medical staff are 0.17 x likely compared to White medical staff.

2.4 WRES indicator 4
Relative likelihood of accessing non-mandatory training

2.4.1 Between 1 April 2019 to 31 March 2020 White staff are 0.96 x BAME staff in accessing non-mandatory training. According to information recorded on DOT Learning Management system there was no difference between BAME and White staff accessing non-mandatory training.

2.4.2 It is important to note that not all non-mandatory training/CPD is recorded on DOT. The WRES implementation group has carried out a deep dive exercise in this metric. The Funded Learning Advisory Group (FLAG) agrees applications for funding for training and CPD for: nurses, allied health professionals and scientific health professionals and all other non-medical staff. Further analysis has been undertaken to monitor the number of applications for training made to the recently formed FLAG by ethnic group and other protected characteristics and the number of successful applicants approved by the group. Promotion of this funding application process needs to be advertised and promoted more periodically. This also raises questions of how staff know, apply or ask to get approval from their manager to access non-mandatory training/CPD. Cultural barriers may inhibit staff from some cultures applying. Developing line manager's Cultural intelligence (CQ) will be important to address this.

2.4.3 Separate data will be made available about the positon for leadership development programmes that have been a focus of investment at CUH in recent years.

2.5 WRES indicator 5 – 8 Staff survey scores 2019
(See also Appendix 2 to compare CUH with Trust average)

Workforce Race Equality Standard (WRES)		2018 CUH	2019 CUH	Change	2019 Average Acute Trust
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	24.0%	26.3%	2.3%	28.2%
	BME	28.0%	27.4%	-0.6%	29.9%
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	24.3%	26.0%	1.7%	25.8%
	BME	26.9%	27.7%	0.8%	28.8%
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	87.0%	88.1%	1.1%	86.7%
	BME	69.5%	76.4%	6.9%	74.4%
Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months	White	7.9%	6.4%	-1.5%	6.0%
	BME	17.0%	14.5%	-2.5%	13.8%

2.5.1 As reported to the Board in March, WRES Indicators 5 and 6 in 2019, there has been no improvement for white or BAME staff. There has been an increase in both White staff (26%) and BAME staff (27%) experiencing harassment, bullying or abuse from patients (indicator 5); this is greater for staff identifying as *White other* (7% more) and *white Irish*, (8% more) than *White British* staff. This also reflects the national picture that has been highlighted in the 2019 national data analysis report. In the past three years, the proportion of both BAME and white staff in the NHS experiencing harassment, bullying or abuse from patients, relatives or the public has been increasing.

2.5.2 For WRES Indicator 6, the percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months has got worse: 26% white and 27% BAME have experienced this (2% more white and just under 1% more BAME than in 2018). The Trust has developed and is implementing a comprehensive action plan to address anti-bullying, harassment and incivility and this work will continue.

2.6 WRES indicator 7
Percentage of staff believing the Trust has equal opportunities for career progression or promotion

Our CUH WRES 2019 score for Indicator 7 is 2% better than the average acute Trust. In 2019 6.9% more BAME staff believed there were equal opportunities for career progression than in 2018 and 1% more white staff believed so. The gap between BAME and white staff has closed from a 17.5% difference in 2018 to a 11.7% difference in 2019.

2.7 WRES indicator 8
Percentage experiencing discrimination

Our CUH WRES score for this indicator has improved for both BAME and White staff: 2.5% fewer BAME staff and 1.5% fewer White staff have experienced discrimination and the gap between White and BAME staff experiencing discrimination has reduced from a 9.1 % difference in 2018 to a 8.1% difference in 2019 which is marginally 0.3% worse than the average acute trust.

2.8 WRES indicator 9

2.8.1 We now have one board member who is BAME, an improvement on nil in the last 2 years.

2.8.2 In summary, we are delighted to see improvement in 6 of the 9 mandated WRES indicators. These results will be discussed at the next WRES implementation group on 15 July to inform review of the WRES action plan. Although elements of the WRES action plan have been paused such as Reverse mentoring for some colleagues since the last Board report in March, our focus since March has been to engage, protect, and support BAME colleagues which this paper sets out

3. Protecting, supporting and engaging with our BAME staff during COVID-19 and beyond

3.1 Weekly BAME WebEx meetings

3.1.1 Since 4 May, Erica Chisanga, chair of our BAME network, along with Monica Jacot, equality, diversity and inclusion lead, have arranged weekly WebEx check-in BAME staff wellbeing meetings to hear of staff experiences during COVID-19, listen to their concerns, enquire about access to PPE, check understanding of risk assessment process, experiences of working from home, feedback actions of BAME staff health taskforce, signpost to sources of support. These meetings have been advertised and communicated in a number of ways; including by email invitation sent to all 2,600 colleagues whose ethnicity is recorded as BAME on ESR inviting them to the meetings, communication via COVID-19 bulletin, COVID-19 staff portal and advertised via social media channels, Twitter and Facebook groups. Members of the executive team, including the Director of Workforce and the Chief Nurse, have been invited and have joined some of these meetings to take the time to listen, learn and answer questions from colleagues. Notes and action points from the meetings are made and published on the COVID-19 staff portal.

3.1.2 One of the first outcomes of these WebEx meetings with members of the executive was the creation of the BAME health Task Force. Another was that staff requested that a Q1 staff survey be carried out to be analysed by ethnicity and other protected characteristics to compare experiences during this time of the pandemic.

3.1.3 The meetings have sign-posted colleagues to sources of support including explaining the role of the Freedom to Speak up Guardian and listeners who also link in with the EDI lead and Chair of the BAME staff network to share intelligence.

3.1.4 These WebEx meetings chaired by Erica, besides supporting staff to feel informed and safe during COVID-19 are also exploring how to support colleagues experiencing racism and listening to their experiences and discuss actions required. These meetings now take place on Wednesdays at 1pm and our CEO and BAME network executive sponsor Roland Sinker joined the session on 24 June along with 28 colleagues to talk to staff, take time to answer questions and hear staff views on suggested actions we as an organisation need to take to address racism.

3.2 BAME staff health task force

3.2.1 The BAME Staff Health Taskforce has met weekly since 7 May and co-produced a risk assessment with BAME colleagues. It is chaired by Giles Wright, Associate Director Workforce, Health and Wellbeing. The multi-disciplinary group includes infectious disease specialists, the Trust's medical director and workforce director as executive sponsors and Chair of the BAME staff network and other BAME staff representatives and EDI lead. Issues raised from the WebEx sessions are also feedback to the task force. The task force action plan has focussed on three areas:

- Review of the Risk Assessment
- Communication and engagement
- Data intelligence gathering.

3.2.2 In partnership with the BAME staff health network the Trust has developed a review of the Trust's Individual Risk Assessment (version 5) to include the findings from the emerging evidence in BAME staff risks. This was published on 21 May shortly after the publication on 19 May of the national risk assessment framework guidance from the Faculty of Occupational Medicine. Feedback from BAME colleagues through this taskforce has been positive.

3.2.3 The Director of Workforce wrote in May to all CUH colleagues who have identified themselves as a member of the BAME community outlining our response and areas of work that have been taking place and attaching a link to this new risk assessment. This letter has also been made available on the COVID portal page: Impact of COVID-19 for colleagues from the BAME community. Line managers and HR colleagues were also sent briefing.

3.3 Individual Risk Assessments

3.3.1 All staff have been asked to complete their Individual Risk Assessment using version 5 with their line manager and upload that they have completed the assessment on their Health roster record.

3.3.2 In the first instance colleagues and their line managers have been asked to familiarise themselves with this tool. It is intended that all staff review the latest version, with particular focus on those staff with additional risk factors which may potentially lead them to a heightened level of risk (orange or yellow in the tool). This includes BAME staff, staff over the age of 55, who have pre-existing health conditions or a combination of these. The percentage completion rate of risk assessments is closely monitored by Workforce Silver command as we move to be 100% compliant. Trust CEOs have received a letter dated 24 June from NHS England executives Risk assessments for at-risk staff groups: Letter from Prerana Issar, Dr Nikki Kanani and Amanda Pritchard requiring trusts to publish completion rates.

3.4 CUH Reflects: data informing the WRES / BAME action plans

3.4.1 As Prompted by the discussions at the BAME staff health task force, the Trust undertook an all staff survey (18 May – 1 June). Some of the survey questions have highlighted disparities between the experiences of our BAME and white staff, specifically:

- 64% of BAME staff feel confident the organisation is providing the best possible care for its staff compared with 71% white staff
- 56% of BAME staff feel they have been supported to work from home compared with 67% of white staff
- 69% of BAME staff feel secure to raise concerns/speak up compared with 77% of white staff

3.4.2 It is highlighted that 79% of BAME staff feel they have been able to maintain a positive outlook on their ability to contribute during this time compared with 68% of white staff.

3.5 External engagement events for BAME staff networks

3.5.1 In May, Monica, Erica and David Wherrett attended a large virtual national meeting for senior leaders, Chairs of BAME staff networks and EDI leads arranged by the NHS Chief People officer Prerana Issar where she announced 5 key principles that are crucial for all trusts to support BAME staff networks.

- Every trust to have a thriving BAME staff network
- BAME staff networks are not a single BAME staff conscience for an organisation but will work to increase understanding to make things fairer for all
- BAME staff networks will support organisations at Board level to help make recruitment fairer, support talent management and career progression for BAME staff
- All BAME staff networks to have executive non BAME sponsor
- Being a BAME network member should be a badge of honour and not bring a fear of reprisal

3.5.2 Our BAME staff network has been pivotal in driving real change both prior to and during this period of COVID-19, as set out in this paper including a coproduced Risk assessments, holding the trust to account and will continue to be coproducing with leaders, revisions of our Workforce Race Equality Standard (WRES) action plan. Our BAME staff network has an executive sponsor the CEO and the members of the Executive team are actively supportive but our staff network needs to be supported at all levels of leadership in the organisation for it to grow and thrive.

3.5.3 The EDI lead and Chair of BAME staff network are working with Director of Communications and Communications Team to develop BAME network engagement plan using social media for example face book live and virtual meeting applications Zoom to support communication to support the network.

3.6 Black Lives Matters and supporting BAME colleagues

3.6.1 The unlawful killing of George Floyd and the outrage that this has sparked around the wave of Black Live Matters campaign and ensuing discussion in the media has been the subject of recent BAME network WebEx meetings. This has stirred up painful emotions; dealing with racism, the covert and subtle micro-aggressions experienced by colleagues is emotionally tiring and draining for BAME colleagues. As Roland Sinker mentioned in his CEO bulletin on 5 June https://cuhstaffportal.co.uk/2020/06/05/message-from-ceo-friday-05-june-2020/

'*Black Lives Matter is as much about the systems that support and propagate structural discrimination and racism as it is about specific acts of racism. We have much more to do to tackle the underlying causes of structural inequality and the lack of diversity at the most senior levels of this organisation.*"

3.6.2 Roland has also discussed his reflections at a 8:27 Facebook live session with senior leaders and at the BAME staff WebEx meeting that this time is critical for a renewed energy and activism at CUH against racism.

3.6.3 Key to supporting BAME colleagues is the importance of ally ship on the part of white colleagues to step up to be active anti-racists, help deconstruct structural racism that exists, challenge bystander culture and racism in all its forms and in supporting our BAME staff network to thrive. Essential components for being a good ally are; education, listening with humility, seeking to understand without being quick to deny experiences or emotions felt, amplifying voices of BAME colleagues, having an understanding of white privilege, and acting to challenge racism.

3.6.4 The EDI lead's article on allyship with helpful resources, books, video clips and useful external guides has been published on the COVID-19 portal, in the Leadership and OD bulletin, EDI newsletter, recommended in the latest CEO bulletin, with allyship tips published on CUH equality Twitter feed.

4. WRES action plan revisions – a call to action

4.1 The WRES data and the Q1 staff survey results, listening to staff experiences and dialogue show there is still much to do to improve the culture and to move up a gear for CUH to become an activist anti-racist organisation. Proposed actions discussed at the BAME WebEx meetings with the latest WRES data will be explored further and discussed at the next WRES implementation group scheduled to take place on 15 July which meets for the first time virtually since COVID-19.

4.1.1 Actions proposed include

- Virtual CQ Cultural Intelligence for Inclusive leadership workshops that will be piloted in one division for roll out across the Trust to ensure leaders are culturally intelligent and confident in cross cultural discussions with colleagues
- Training for colleagues on skills and actions required of allyship and equipping leaders, line managers and colleagues with the skills and confidence to tackle racism which is rooted in learning from our CUH BAME staff stories and personal experiences of racism. Key component of allyship training will be to also include understanding of racial identity development (Helms Model) to move colleagues from "being colour blind" to active anti-racist
- Tackling racial harassment by patients/service users and the public is required with new vigour and clear corporate messaging that it will not be tolerated
- Reinvigorating our Antibullying and harassment action plan
- Supporting our BAME staff network to enable it to grow and thrive and meeting the five principles as already outlined
- Ensuring BAME representation involvement in decision making and in command and governance structures
- Engaging with BAME staff to create staff stories to share and learn
- The EDI lead and BAME network Chair and other network representatives will continue to collaborate with Divisional Heads of

Workforce and divisional management teams sharing divisional WRES data for divisional action planning
- Engaging with our BAME staff network to coproduce a revised WRES action plan to equip the organisation to be an active anti-racist organisation

4.1.2 As Roger Kline asserts in his recent article "After the speeches: what now for NHS staff race discrimination?" June 2020

'*Boards and teams must prioritise psychological safety so they become inclusive… Boards must understand that whilst improved BAME representation is crucial, the benefits are limited without inclusive behaviours and culturally sensitive psychological support….*

'Boards and leaders must model inclusive behaviours they expect of others with consequences if they do not. The focus of NHS work around race equality must change. Remorselessly challenging racism must go hand in hand with supporting those who want to eliminate discrimination, question their own privilege and be allies'

5. Next steps/future reports

5.1 The WRES dataset will be submitted to NHS England by 31 August 2020. A refreshed WRES action plan will be presented to the Board in September/October 2020.

6. Recommendations

6.1 The Board of Directors is asked to:

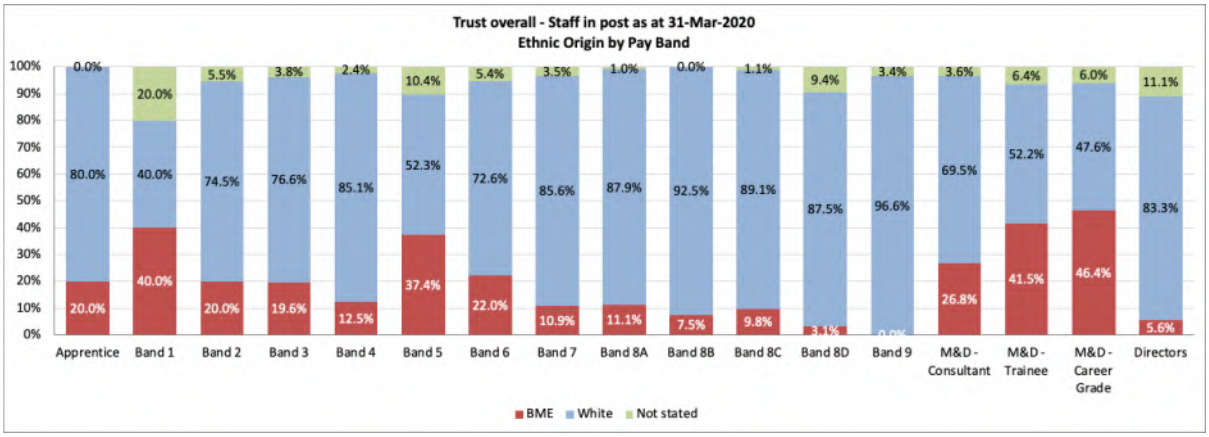
- Note the latest WRES 2020 data.
- Note the summary of actions taken so far for protecting, supporting and engaging with our BAME colleagues during COVID-19.
- Endorse the need to reinvigorate our WRES action plan to address systemic racism and discrimination and make further progress in being an actively anti-racist organisation.

7. Appendices

Appendix 1: WRES indicator 1 Staff in post by ethnicity by pay band by Trust and by Division as at 31 March 2020
Appendix 2: WRES metrics 5-8 CUH compared to national average

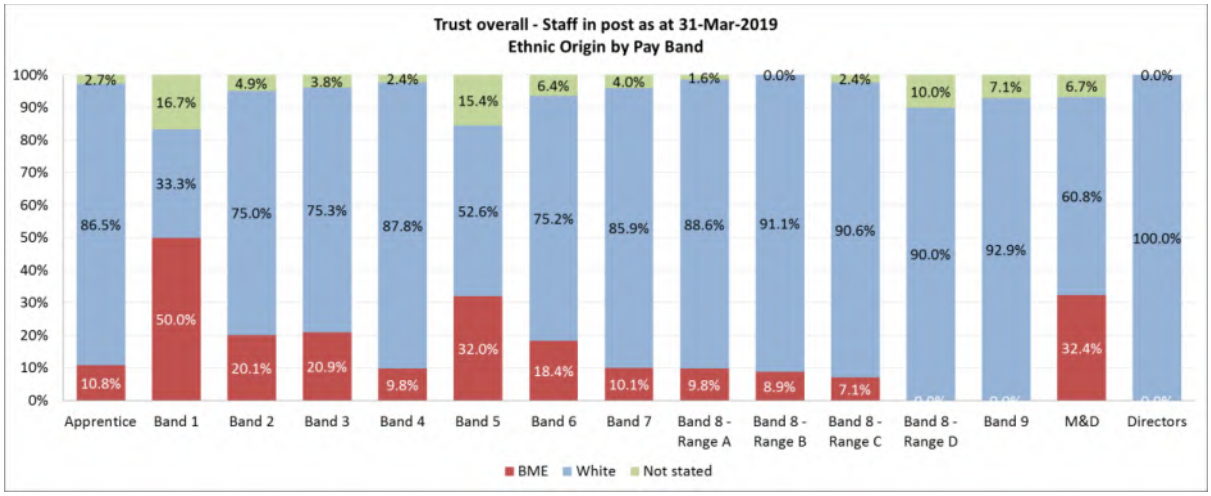
Appendix 1

WRES indicator 1 Staff in post by ethnicity by pay band by Trust and by Division as at 31 March 2020



Trust overall							
Excludes TPP, Bank, Honorary, Agency, ACT staff							
	HC			% of HC			Total HC
Staff Group	White	BME	Not stated	White	BME	Not stated	
Apprentice	24	6	0	80.0%	20.0%	0.0%	30
Band 1	2	2	1	40.0%	40.0%	20.0%	5
Band 2	1,018	274	75	74.5%	20.0%	5.5%	1,367
Band 3	725	186	36	76.6%	19.6%	3.8%	947
Band 4	709	104	20	85.1%	12.5%	2.4%	833
Band 5	1,342	960	266	52.3%	37.4%	10.4%	2,568
Band 6	1,311	398	98	72.6%	22.0%	5.4%	1,807
Band 7	1,089	139	44	85.6%	10.9%	3.5%	1,272
Band 8A	355	45	4	87.9%	11.1%	1.0%	404
Band 8B	123	10	0	92.5%	7.5%	0.0%	133
Band 8C	82	9	1	89.1%	9.8%	1.1%	92
Band 8D	28	1	3	87.5%	3.1%	9.4%	32
Band 9	28	0	1	96.6%	0.0%	3.4%	29
M&D - Consultant	461	178	24	69.5%	26.8%	3.6%	663
M&D - Trainee	312	248	38	52.2%	41.5%	6.4%	598
M&D - Career Grade	120	117	15	47.6%	46.4%	6.0%	252
Directors	15	1	2	83.3%	5.6%	11.1%	18
Grand Total	**7,744**	**2,678**	**628**	**70.1%**	**24.2%**	**5.7%**	**11,050**

Trust staff in post by ethnicity as at 31 March 2019

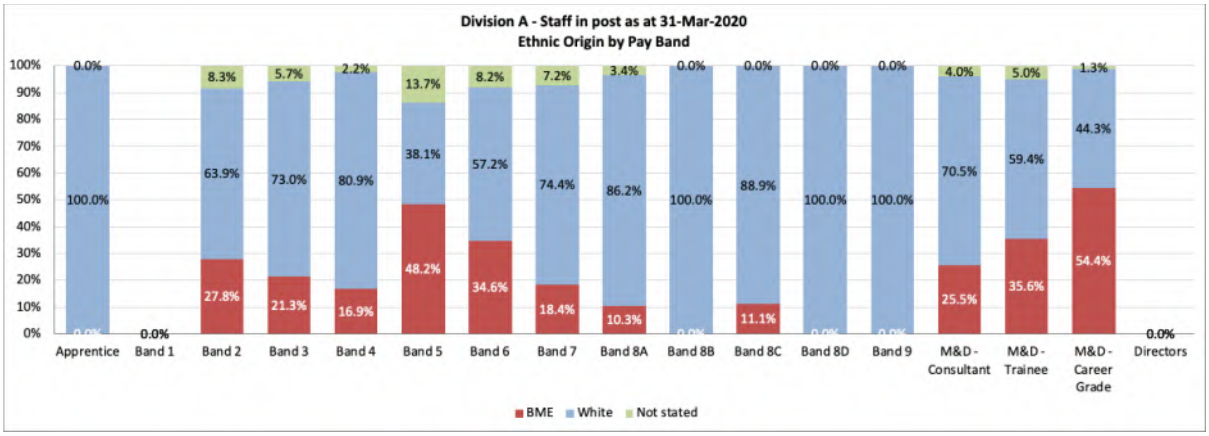


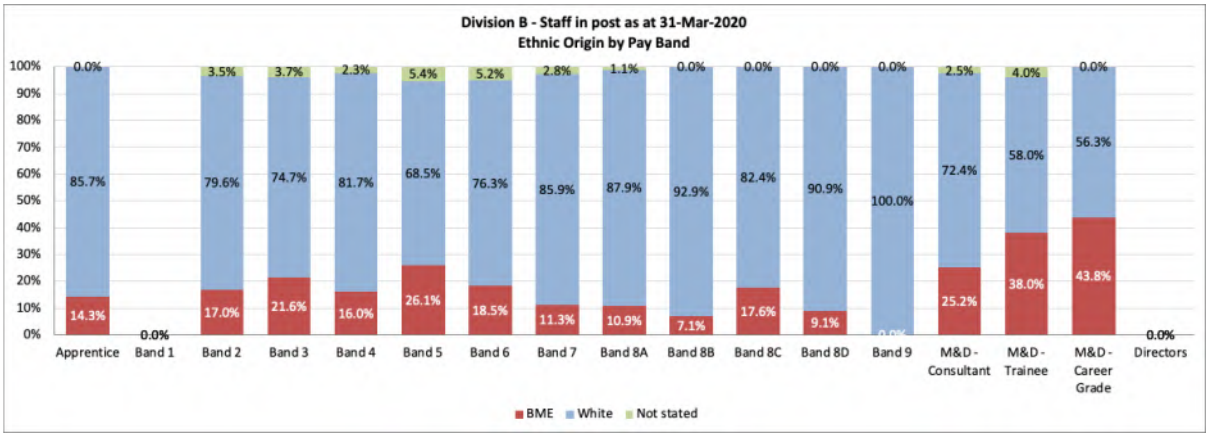
Trust overall as at 31 March 2019

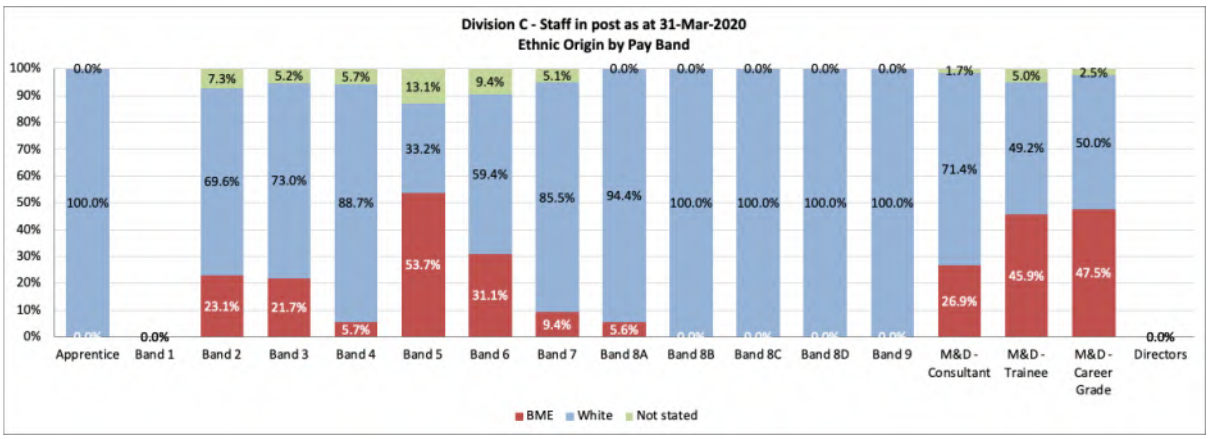
Excludes TPP, Bank, Honorary, Agency, ACT staff

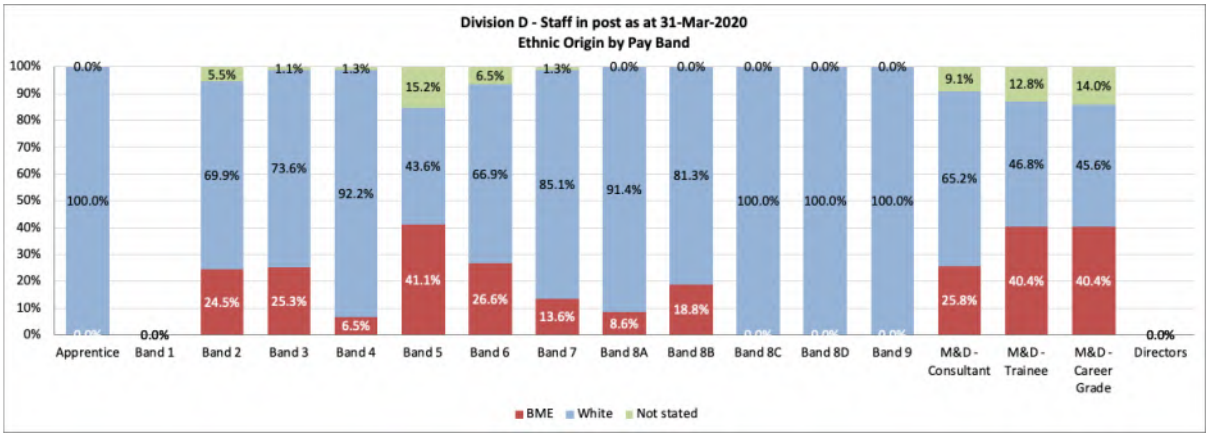
	HC			% of HC			Total HC
Staff Group	**White**	**BME**	**Not stated**	**White**	**BME**	**Not stated**	
Apprentice	32	4	1	86.5%	10.8%	2.7%	37
Band 1	2	3	1	33.3%	50.0%	16.7%	6
Band 2	1,009	271	66	75.0%	20.1%	4.9%	1,346
Band 3	752	209	38	75.3%	20.9%	3.8%	999
Band 4	692	77	19	87.8%	9.8%	2.4%	788
Band 5	1,286	781	377	52.6%	32.0%	15.4%	2,444
Band 6	1,288	315	110	75.2%	18.4%	6.4%	1,713
Band 7	1,026	120	48	85.9%	10.1%	4.0%	1,194
Band 8 - Range A	343	38	6	88.6%	9.8%	1.6%	387
Band 8 - Range B	113	11		91.1%	8.9%	0.0%	124
Band 8 - Range C	77	6	2	90.6%	7.1%	2.4%	85
Band 8 - Range D	27		3	90.0%	0.0%	10.0%	30
Band 9	26		2	92.9%	0.0%	7.1%	28
M&D	876	467	97	60.8%	32.4%	6.7%	1,440
Directors	16			100.0%	0.0%	0.0%	16
Grand Total	**7,562**	**2,302**	**773**	**71.1%**	**21.6%**	**7.3%**	**10,637**

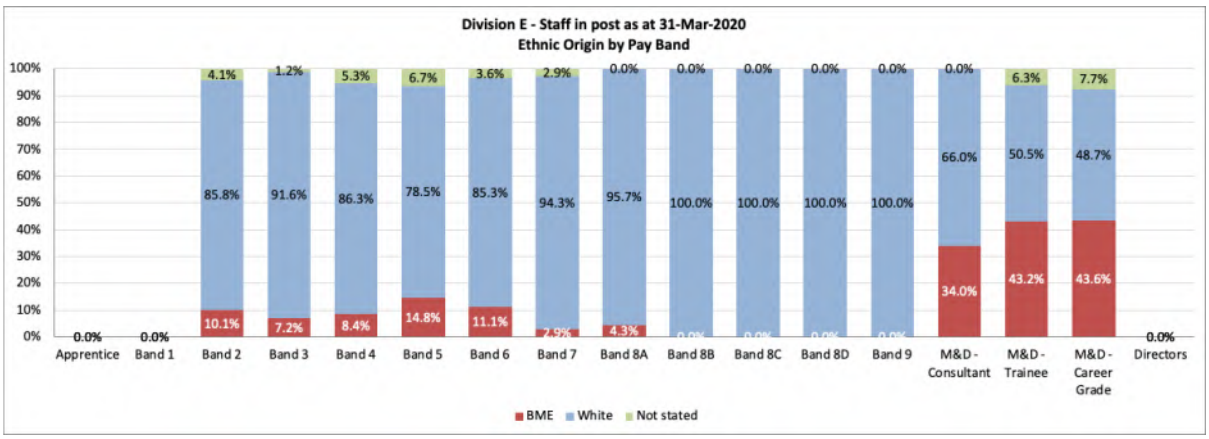
Staff in post by ethnicity by Division as at 31 March 2020

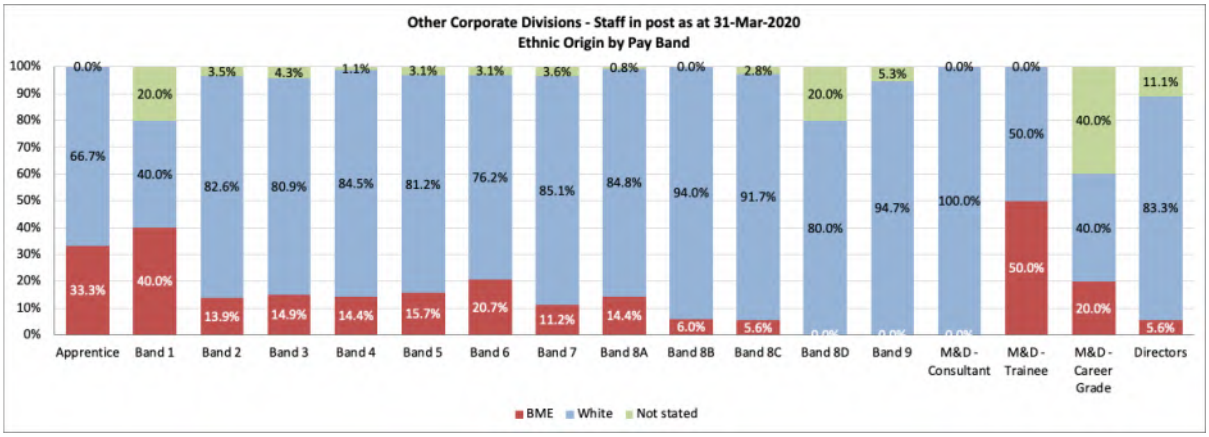







Division D - Staff in post as at 31-Mar-2020
Ethnic Origin by Pay Band
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
0.0% 100.0%
0.0% 0.0%
5.5% 69.9% 24.5%
1.1% 73.6% 25.3%
1.3% 92.2% 6.5%
15.2% 43.6% 41.1%
6.5% 66.9% 26.6%
1.3% 85.1% 13.6%
0.0% 91.4% 8.6%
0.0% 81.3% 18.8%
0.0% 100.0%
0.0% 100.0%
0.0% 100.0%
9.1% 65.2% 25.8%
12.8% 46.8% 40.4%
14.0% 45.6% 40.4%
0.0%
Apprentice
Band 1
Band 2
Band 3
Band 4
Band 5
Band 6
Band 7
Band 8A
Band 8B
Band 8C
Band 8D
Band 9
M&D - Consultant
M&D - Trainee
M&D - Career Grade
Directors
BME
White
Not stated


Division E - Staff in post as at 31-Mar-2020
Ethnic Origin by Pay Band
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
0.0% 0.0%
0.0% 0.0%
4.1% 85.8% 10.1%
1.2% 91.6% 7.2%
5.3% 86.3% 8.4%
6.7% 78.5% 14.8%
3.6% 85.3% 11.1%
2.9% 94.3%
0.0% 95.7% 4.3%
0.0% 100.0%
0.0% 100.0%
0.0% 100.0%
0.0% 100.0%
0.0% 66.0% 34.0%
6.3% 50.5% 43.2%
7.7% 48.7% 43.6%
0.0%
Apprentice
Band 1
Band 2
Band 3
Band 4
Band 5
Band 6
Band 7
Band 8A
Band 8B
Band 8C
Band 8D
Band 9
M&D - Consultant
M&D - Trainee
M&D - Career Grade
Directors
BME
White
Not stated


Other Corporate Divisions - Staff in post as at 31-Mar-2020
Ethnic Origin by Pay Band
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
0.0% 66.7% 33.3%
20.0% 40.0% 40.0%
3.5% 82.6% 13.9%
4.3% 80.9% 14.9%
1.1% 84.5% 14.4%
3.1% 81.2% 15.7%
3.1% 76.2% 20.7%
3.6% 85.1% 11.2%
0.8% 84.8% 14.4%
0.0% 94.0% 6.0%
2.8% 91.7% 5.6%
20.0% 80.0%
5.3% 94.7%
0.0% 100.0%
0.0% 50.0% 50.0%
40.0% 40.0% 20.0%
11.1% 83.3% 5.6%
Apprentice
Band 1
Band 2
Band 3
Band 4
Band 5
Band 6
Band 7
Band 8A
Band 8B
Band 8C
Band 8D
Band 9
M&D - Consultant
M&D - Trainee
M&D - Career Grade
Directors
BME
White
Not stated

Appendix 2
WRES Indicators 5-8 Trust scores 2017, 2018 and 2019

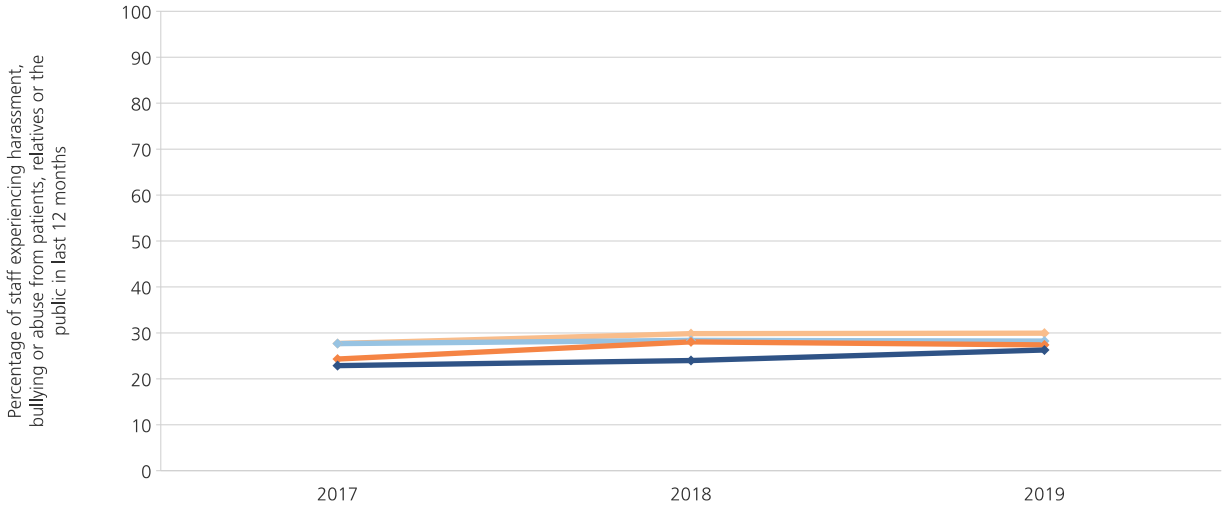
WRES indicator 5

Percentage of Staff experiencing harassment, bullying and abuse from patients, relatives or the public

Survey Coordination Centre

2019 NHS Staff Survey Results > WRES > Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

NHS England



	2017	2018	2019
White: Your org	22.9%	24.0%	26.3%
BME: Your org	24.3%	28.0%	27.4%
White: Average	27.7%	28.4%	28.2%
BME: Average	27.7%	29.8%	29.9%
White: Responses	3,540	3,726	4,115
BME: Responses	728	1,084	1,249

Average calculated as the median for the benchmark group

165

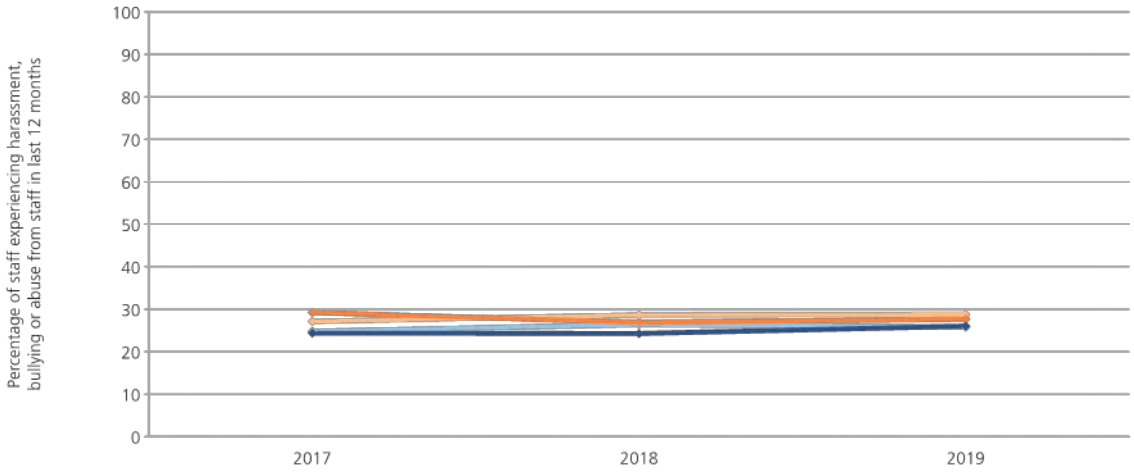
WRES indicator 6

Percentage of staff experiencing harassment, bullying or abuse from colleagues

Survey Coordination Centre

2019 NHS Staff Survey Results > WRES > Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

NHS England



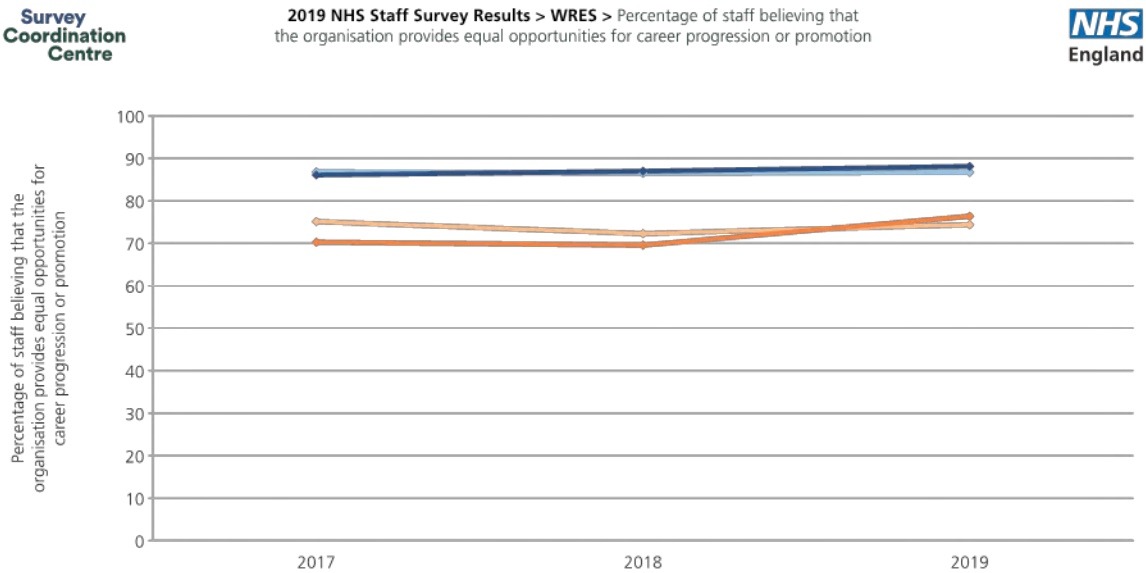
	2017	2018	2019
White: Your org	24.4%	24.3%	26.0%
BME: Your org	29.2%	26.9%	27.7%
White: Average	24.8%	26.4%	25.8%
BME: Average	27.1%	28.6%	28.8%
White: Responses	3,519	3,695	4,119
BME: Responses	715	1,068	1,249

Average calculated as the median for the benchmark group

166

WRES indicator 7

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion



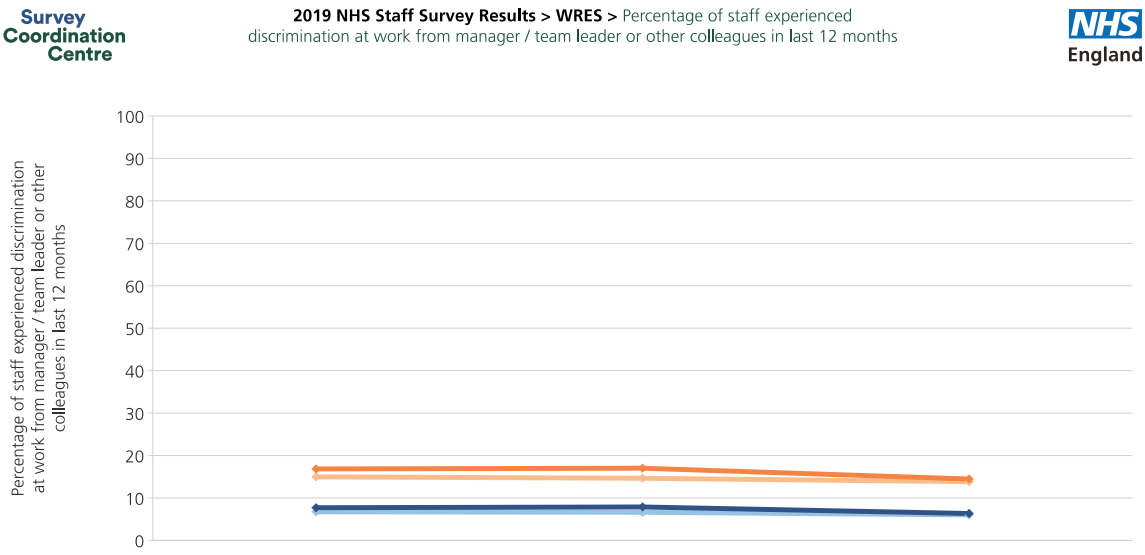
	2017	2018	2019
White: Your org	86.1%	87.0%	88.1%
BME: Your org	70.3%	69.5%	76.4%
White: Average	86.8%	86.5%	86.7%
BME: Average	75.1%	72.3%	74.4%
White: Responses	2,646	2,657	2,967
BME: Responses	491	729	842

Average calculated as the median for the benchmark group

167

CUH WRES in 2019 score is 2% better than average acute trust. In 2019 6.9% more BME staff believed there was equal opportunities for career progression than in 2018 and 1% more white staff believed so. The gap between BME and white staff has closed from 17.5% difference in 2018 to a 11.7% difference in 2019

WRES indicator 8
Percentage of staff experiencing discrimination in the last 12 months



	2017	2018	2019
White: Your org	7.7%	7.9%	6.4%
BME: Your org	16.8%	17.0%	14.5%
White: Average	6.7%	6.6%	6.0%
BME: Average	15.0%	14.6%	13.8%
White: Responses	3,547	3,700	4,123
BME: Responses	713	1,052	1,244

Average calculated as the median for the benchmark group

168

CUH WRES score for this indicator has improved for both BME and White staff: 2.5% fewer BME staff and 1.5% fewer White staff have experienced discrimination and the gap between White and BME staff experiencing discrimination has reduced from a 9.1 % difference in 2018 to a 8.1% difference in 2019 which is marginally 0.3% worse than the average acute Trust.

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Cambridge University Hospitals NHS Foundation Trust

Report to the Board of Directors: 8 July 2020

Agenda item	13
Title	Report on Multi-professional Education, Learning, Development and Training
Sponsoring Executive Director	David Wherrett
Author(s)	Arun Gupta, Director of Post Graduate Medical Education; Amanda Small, Head of Education: Nursing, Midwifery and Allied Health Professionals; Karen Clarke, Associate Director of Workforce
Purpose	To provide an update on education, learning, training and development relating to COVID-19.
Previously considered by	Management Executive, 2 July 2020

Executive Summary

This paper provides an update on multi-professional education, learning and development activity. The content of this paper sets out progress since the last Board report aligned to themes set out in the Trust's Multi-professional Education, Learning and Development Strategy.

Related Trust objectives	Improving patient journeys; Strengthening the organisation
Risk and Assurance	To provide assurance on progress against the strategy.
Related Assurance Framework Entries	Health Education England, Quality framework for education
Legal / Regulatory / Equality, Diversity & Dignity implications?	In order to maintain professional registration staff need to undertake continuous professional development. There are a number of regulatory requirements relating to staff training requirements.
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	Yes

Action required by the Board of Directors

The Board is asked to note the update on education, learning, training and development relating to COVID-19.

Cambridge University Hospitals NHS Foundation Trust

8 July 2020

Board of Directors
Report from the Multi-professional Education, Learning, Development and Training group
Dr Arun Gupta, Amanda Small, Karen Clarke

1. Introduction/Background

1.1 This paper provides an update on multi-professional education, learning and development; its purpose is to provide information about a number of key developments since the last report in March, 2020.

1.2 The eight themes of the Trust's multi-professional education, learning and development strategy and work plan are:

Theme 1: Good learning experience for all students/learners
Theme 2: Sustainable Continuous Professional Development (CPD) and multi-disciplinary learning
Theme 3: Maximise the opportunities of the Apprenticeship Levy
Theme 4: Great leadership and management development
Theme 5: Innovation leading to new roles and routes to training and employment
Theme 6: Modern fit for purpose education facilities and resources
Theme 7: Opportunity to learn and develop speciality skills in a high-quality environment
Theme 8: Strong partnership working with education providers

1.3 This report provides information to the board on the significant and on-going impact of COVID 19 on all aspects of the Trust's education and training strategy and work plan.

1.4 In accordance with the schedule for reporting key themes, the July report would ordinarily focus on:

- Theme 2: Provision of an annual update on CPD investment in training and equality reporting
- Theme 3: Maximise the opportunities of the Apprenticeship Levy
- Theme 4: Great leadership and management development

1.5 These items will be carried forward to the November 2020 Board report.

2. Impact of COVID-19 on education and training delivery

This section of the report seeks to outline the broad impact of the COVID-19 period on education learning and development at CUH. It sets out the positon by main staff group.

2.1 Postgraduate Medical Education

2.1.1 In response to the COVID-19 pandemic, virtually of the 96 rotas covering circa CUH 650 trainees were rewritten to focus on CUH's role in the pandemic. As a result all specialist training was halted. This represented a significant effort from medical staffing and a major impact on the lives of our junior doctors. The response of all training grades to the crisis has

been extremely impressive, rising to the challenge at this difficult and very stressful time. The impact on their training will be assessed in the coming months. All non-essential PGMC face to face courses have been cancelled/postponed up until 31 August 2020, with this date being reviewed in early July.

2.2 In addition the Board is asked to note the following:

2.2.1 GMC Trainee Survey – 2020

The GMC has postponed this year's national training survey, which was due to launch on 24 March. They are monitoring the COVID-19 situation and hope to run the survey later in the year.

2.2.2 Foundation Training

Graduating medical students have been offered the opportunity to commence in an F1 post early to support the pandemic response (normal start date August). This group of doctors are called FiY1s, and 38 have started at the Trust on 4 May for a 4 month period. Although, the FiY1s will require additional support, they will undertake these new roles safely and without detriment to their short and long-term wellbeing. These new doctors will be overseen by Medical staffing and the PGMC.

2.2.3 August Rotations

HEE put forward a proposal that for this year the August rotation for Junior doctors in the East of England be staggered over the summer in an attempt to minimise the effect of COVID. However, it was considered that staggering rotation dates this year would cause more disruption to the clinical service, professional and domestic arrangements of trainees, and administrative staff. The staggering of rotations in August and October next year is being considered.

2.2.4 Simulation Centre

The Simulation Centre team responded magnificently to the challenge of COVID-19 by delivering essential training to the CUH health professionals. At the beginning of the COVID-19 pandemic, the Simulation team supported the delivery of training sessions covering: donning/doffing of PPE, intubation equipment, intubating COVID-19 positive patients and theatre specific scenarios. Over 150 medical and non-medical staff attended these sessions. Videos were made of the training delivered which attracted 10,000+ views on YouTube.

2.2.5 On-line Learning

HEE has procured an online platform to continue the delivery of the teaching programmes. The Panopto/Bridge platform has the capability to deliver and record lectures online as well as share lecture and research materials. There is a need for content to be created, which will require time from the already very busy clinicians.

2.3 Non-Medical training undertaken during the COVID-19 pandemic

2.3.1 Non-medical Pre-registration placements

At the beginning of the COVID-19 pandemic, our partner universities made the difficult decision to remove their direct entry students from clinical practice and moved to on line delivery for the academic content of the programmes. Our apprenticeship programmes continued with on line delivery and clinical hours undertaken in the apprentices' home ward.

2.3.2 It was recognised that due to the pandemic, it may not be possible to maintain the supernumerary status of students. In response to this, the Nursing and Midwifery Council (NMC) and the Health and Care Professions Council (HCPC) worked with Health Education England (HEE) to enable students to undertake paid clinical placements throughout the NHS, enabling the students to achieve their clinical hours while working as part of the NHS workforce.

2.3.3 The following table details the number of students who are in the process of undertaking or are due to commence on placement in a paid capacity within CUH.

Student profession	**Number undertaking placement**
Adult Nurse	40
Paediatric Nurse	25
Midwife	19
Physiotherapist	13
Therapeutic Radiographers	5
Dietician	1

2.3.4 The majority of these students have been those in their final year of study. Our partner HEIs have raised some concern that Nursing and Midwifery students in their second year of study will have a shortfall of clinical placement hours to remain on target for completion of their programme on time which has an impact upon our workforce pipeline. We are working with our partner HEIs, the STP and HEE to identify a plan to address the deficit in placement hours to bring the students back on track for completion of their study at the planned time. The plan for CUH is that this student group will undertake a paid clinical placement from the end of June through until the end of August. From September onwards, supernumerary placements will recommence as per the planned timetable.

2.3.5 NMC temporary register

The NMC invited all overseas trained nurses that are currently living in the UK, have passed all stages of the NMC process except their OSCE to join the temporary NMC register. CUH had 17 overseas nurses who were booked to undertake their OSCEs in April 2020 who were invited to join this register. Of these 16 opted to join the register and are now working as band 5 nurses within the Trust. The NMC is currently considering how the transition to the permanent register might work for overseas trained nurses and further guidance will follow on this in due course.

2.3.6 During the COVID-19 pandemic, a number of training programmes were developed in collaboration with specialist practice development nurses, the clinical education team and subject matter experts. It should be noted that these sessions were developed and delivered at pace and scale, those delivering the training responded quickly to the changing needs of our workforce and with flexibility to deliver this training in a short time period. Furthermore, thanks should be extended to our wider workforce that has been flexible and adaptable in releasing staff to attend these sessions. The table below illustrates the programmes that were delivered and the number of staff who were trained in these areas.

Staff Training	Critical Care (CC) Skills for redeployees	546
	Adult ward skills	413
	Respiratory Management	696
	ED Course	19
	Proning (Includes CC numbers as included in course)	556
	CSSIP rapid deployment (for non-clinical staff willing to work in a clinical support role)	35
	Total	**2265**

2.3.7 In addition to the face to face programmes, competency based training was delivered in clinical areas for a number of clinical skills including Dialysis and Tracheostomy care.

2.3.8 CUH has worked collaboratively with The Royal Papworth Hospital (RPH) to develop a 1 day induction programme for CUH staff who are deployed to work in critical care at RPH.

2.4 Training required for recovery phase

2.4.1 In line with the reconfiguration of wards and departments that is currently being undertaken, a skills gap analysis has been carried out to ensure that staff working in each area have the identified skills required to care for patients safely. This analysis has enabled training to be targeted to specific areas and needs. The training that has been identified includes speciality care (neuro, gastro, respiratory care etc.), tracheostomy care, TPN administration and cardiac monitoring.

2.4.2 The education team within CUH are working collaboratively with the education team at Royal Papworth Hospital (RPH) to design a rehabilitation education programme and a Neuro/trauma study day to prepare RPH staff to care for this group of patients when they are transferred to RPH for specialist care. Additionally, members of the critical care team at RPH will be attending the CUH 'Transferring critical care patients' training day and the critical care foundation programme.

2.5 Non-medical Continuing Professional Development

2.5.1 The COVID-19 pandemic has impacted upon our workforce being able to complete CPD activities as planned. A number of programmes commissioned from partner HEIs that required face to face delivery were paused during the pandemic with others moving to online delivery. These programmes are due to recommence imminently as our partner HEIs move the majority of their programmes to on line delivery. There is a risk that this will impact upon individuals being able to evidence that they have completed the required number of CPD hours to revalidate/re-register however we are working with professional leads to ensure that development needs are met and to prepare a plan for utilising CPD funds moving forwards.

2.6 Apprenticeship training

2.6.1 COVID-19 has created some unprecedented logistical issues for apprenticeships across the UK, not least in the healthcare economy. However, the Work Opportunities team has not allowed this to detrimentally affect CUH apprentices. The team has ensured that all apprentices whether working on site, self-isolating or shielding are able to continue to study.

2.6.2 The team is also working closely with the Education and Skills Funding Agency (ESFA), HEE, Colleges and our HEIs to ensure that exams and End Point Assessment are still being facilitated to enable those on nursing apprenticeships to progress to next stages of their development.

2.6.3 COVID-19 impact does mean that learning will take the form of distance delivery via a range of electronic/virtual methods, which will continue into 2021. As a result we might find some apprentices struggle or progress slowly; we will need to be mindful of the additional support these apprentices will require.

2.6.4 The team has had to quickly learn and embrace the use of communications technology in the last few months and has identified many opportunities and teaching possibilities to develop the apprenticeship workforce. There is also work underway with schools and colleges to consider creative ways to engage with schools and colleges to provide career events and retain our range of work opportunities and shadowing schemes.

2.7 Trust wide leadership and organisational development training

- All training and development has been postponed during the COVID-19 pandemic with plans to review the current position in line with social distancing and government regulations
- Reinstatement of programmes will be reviewed in light of guidance and Trust capacity to support in the short and medium term; in the meantime working with colleagues across CUH consideration is being given to how we embrace technology enabled learning.

2.8 Corporate Induction

2.8.1 Non-medical Corporate Induction

This was moved to a virtual induction programme in April and further work is underway to improve and develop content to enhance the experience as we anticipate this may have to remain virtual for the next 12 months.

2.8.2 Medical corporate induction

The Medical and Dental Corporate Induction programme for August will also be moving to a virtual induction programme and preparations for this are underway. EPIC training will be provided in two parts; there will be an e-learning demo for new starters to access remotely followed by a shorter practical session. Local induction preparations are also underway and departments have been asked to develop material that can be delivered and accessed remotely along with face to face sessions in smaller groups to allow for social distancing.

3. Technology Enabled Learning (TEL) Project Group

3.1 A group met in June 2020 to consider how CUH fully embraces technology enabled learning. There is currently a range of good practice in place however COVID-19 has required all functions to consider how they advance their capability to different ways of delivering education and training in the short term as well as

working through longer term approaches. The first meeting of the group identified:

- The need to understand current IT plans including infrastructure, technology, devices and access to current platforms for learning
- Increasing knowledge of the vast range of other platforms and tools including those used by partner organisations (Cambridge University, Judge Business School)
- Enhancing the skills of those in education and training roles and supporting staff and student to embrace different ways of learning

The TEL group consists of representative from PGME, Nursing, Workforce and IT.

4. Impact of COVID-19 on the delivery of mandatory training

4.1 A decision was taken in March to suspend all mandatory training; this was supported by HEE who issued a communication that this was permitted during the pandemic.

4.2 The April mandatory training report shows that compliance was high at 94.6%; we will clearly see a reduction in compliance during 2020-21.

4.3 The subject matter experts for resuscitation, moving & handling and fire have made arrangements to re-commence this training; divisions have also stated that they would wish this training to recommence where they are able to release staff to attend. E-learning across all mandatory and essential for role training remains completely accessible and staff are encouraged to complete this if they have capacity to do so.

5. Appraisals in 2020 as a result of COVID-19

5.1 Non-Medical Staff

5.1.1 The CUH appraisal cycle that runs between March and July each year was paused in March due to COVID-19 for non-medical appraisals. The Management Executive has agreed a different approach for staff this year; the current CUH appraisal process will be set aside and instead the discussion will take the form of a reflective conversation; with an emphasis on being supportive and constructive focused on staff well-being, staff experience and development (what next). This will include learning and reflection from the COVID-19 period.

5.1.2 This has been communicated across CUH; divisions and directorates can decide when they wish to commence these conversations depending upon their capacity. A nominal end date for completion has been set at 30 November 2020; this will be flexed if it is necessary to do so.

5.1.3 Divisional Directors, Clinical Directors and Specialty Leads are included in the process above, in relation to their Medical managerial responsibilities.

5.2 Medical Staff

5.2.1 Medical appraisals for the purposes of GMC revalidation were suspended in March 2020 by the NHS Medical Director. In addition the GMC confirmed that the requirement to revalidate is deferred by one year. However, the GMC is encouraging Designated Bodies (employers) to restart these where possible. Medical Appraisal is required to sit out with the medical line manager hierarchy and while it is expected that any medical appraisals

which are undertaken will include reflection on the challenges of the COVID-19 crisis, these conversations will by necessity not be with the individuals Line Manager.

5.2.2 The Medical Director's office will be continuing to encourage medical line managers to participate supportive conversations as outlined in the process above for non-medical members of CUH, with particular emphasis on staff well-being and staff experience.

6. Conclusions

6.1 The report highlights:

- The response of all staff to this situation including those in training roles, particularly doctors in training and other students who have chosen to work in clinical areas during the COVID-19 period. and the response of staff to undertake this.
- The impact of COVID-19 on apprenticeship and leadership programmes. The establishment of a CUH Technology Enabled Learning (TEL) Project Group to consider immediate and longer term approaches to education, training and development.
- The changes to pausing of mandatory training and the phased recommencement of this from late June 2020. The implementation of a new appraisal for 2020 that focuses on staff well-being, staff experience, development and reflection from the COVID-19 period.
- That while the positon is constantly under review, and that we hope to be able to return to some level of normality in our educational provision in the autumn, there are a number of variables which will continue to make this challenging.

7. Recommendation

7.1 The Board of Directors is asked to note the update on education, learning, training and development relating to COVID-19.

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Report to the Board of Directors: 8 July 2020

Agenda item	14
Title	Annual Report on Safe Working Hours: Doctors and Dentists in Training
Sponsoring executive director	Dr Ashley Shaw, Medical Director
Author(s)	Dr Jane MacDougall, Guardian of Safe Working
Purpose	To receive the report on safeguarding working hours.
Previously considered by	Management Executive, 29 June 2020

Executive Summary

This is the third annual report, based on a national template, to the Board of Directors by the Guardian of Safe Working. This role was introduced to support the implementation and maintenance of the 2016 national contract for Doctors in Training and provides an independent oversight of their working hours. The process of exception reporting provides data on their working hours and can be used to record safety concerns related to these and rota gaps. In addition it can identify missed training opportunities. Reporting to the Board of Directors is a stipulated requirement of this role and this report reflects the financial year 2019/20. The Trust has 646 doctors in training who have all transferred to the 2016 Terms and Conditions of Service.

Related Trust objectives	Improving patient journeys Strengthening the organisation
Risk and Assurance	Assurance involves the development of key performance indicators, benchmarking, peer review and audit.
Related Assurance Framework Entries	n/a
Legal / Regulatory / Equality, Diversity & Dignity implications?	Safeguards around doctors' hours are outlined in national terms and conditions. These stipulate that the Guardian of Safe Working Hours "shall report no less than once every quarter to the Board".
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	Yes.

Action required by the Board of Directors

The Board is asked to note this third annual (2019/20) report from the Guardian of Safe Working and is asked to provide their continuing support for measures to improve trainee welfare and morale and thus recruitment and retention.

Cambridge University Hospitals NHS Foundation Trust

8 July 2020

Board of Directors
Annual Report on Safe Working Hours: Doctors and Dentists in Training
Dr Jane MacDougall, Guardian of Safe Working

Key messages

- Levels of exception reporting were similar to last year until they reduced just prior to the end of the reporting period with the onset of the Covid-19 pandemic and subsequent lockdown with re-deployment of staff. There is a consistent cyclical variation with more reports submitted in August (as new doctors start work) and over the winter (winter pressures and staff vacancies).

- Under reporting is still a significant concern both here and nationally. Once again, few exception reports (ERs) have been submitted for missed training opportunities. Trainees report regularly missing training or overworking in the annual GMC trainee survey and this discrepancy merits further investigation. A re-audit of the process of exception reporting suggests that a few clinical & educational supervisors are neither engaged with the process, nor recognise its value in providing data that can be used to effect change. Further work with this group is important, as well as wider recognition of associated cultural issues.

- The 2019 amendments to the Terms and Conditions of Service (TCS) for junior doctors (2016) require changes to 60 of the 96 rotas in CUHFT. The new TCS advises that trainees should work no more often than 1:3 weekends. CUHFT has a number of rotas (n=11, mostly A&E and intensive care) which require trainees to work more than 1:3 weekends. Exemptions can be applied if there is agreement from trainees involved, the JDF & the GOSW; these have been agreed but will need annual review. Medical Staffing are developing plans to make these rotas compliant but this will not be achievable within the required timeframe. Solutions will require more healthcare staff and changes in working patterns.

- Exception reporting prior to the pandemic suggested that working hours last year were mostly compliant and safe across the Trust. There do appear to be some extra hours worked on a variety of different rotas, with a few areas with persistent problems. Uncertainty around the covid-19 pandemic does complicate plans to redesign rotas that will comply with the new TCS (2019) as well as retaining flexibility for Covid ward cover. This however, does provide the Trust with an opportunity to develop new better rotas that address training as well as service issues. Continuing surveillance will be important to ensure trainee and patient welfare.

- Gaps in rotas continue to be a major concern (both here and nationally) - even if posts are created they often cannot be filled and this has implications for working hours, patient safety and training.

- Attendance at the Junior Doctors' forum continues to improve this year and has facilitated discussion between junior doctors and senior management. This has the potential to improve the wider hospital environment and culture.

- Trust Board engagement continues to be more positive than most other Trusts in the East of England (benchmarking via the Regional GOSW network).

1. Introduction

1.1 The process of exception reporting provides data on the working hours of doctors in training and can also identify missed training opportunities. This provides an additional mechanism to record safety concerns related to working hours and rota gaps. Reporting to the Board of Directors is a stipulated requirement of this role and this report reflects the position at completion of the third year since the implementation of the new 2016 Terms and Conditions of Service.

1.2 Please note that the detailed data below relates only to doctors directly overseen by the Guardian of Safe Working for Cambridge University Hospitals NHS Foundation Trust.

2. Board reporting

High level data

Number of doctors / dentists in training (total):	646
Number of doctors / dentists in training on 2016 TCS (total):	646
Number of doctors / dentists on local contracts (Clinical Fellows):	163
Total junior doctor/ dentist establishment:	809

With effect from August 2018, the ability to exception report was rolled out to all junior doctors, including non-consultant non-training grade doctors.

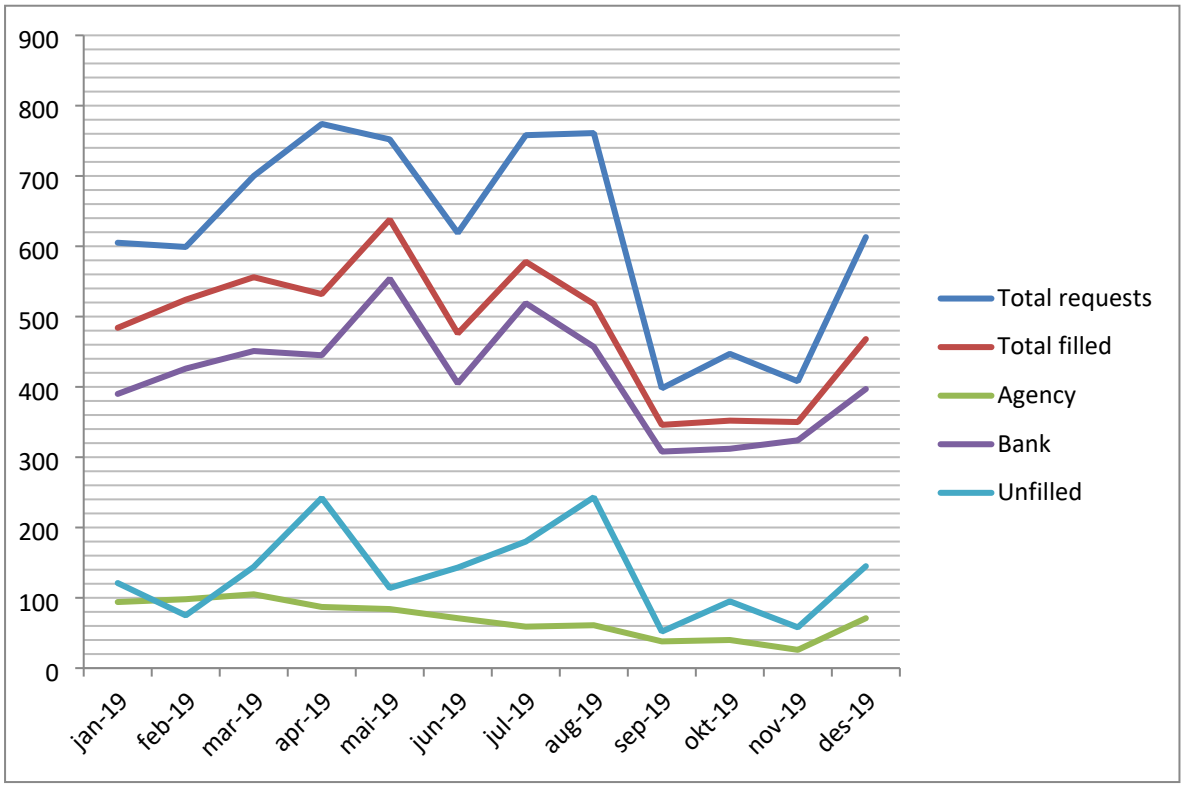
Amount of time available in job plan for Guardian to do the role:	2 PAs / 8 hours per week
Admin support provided to the Guardian:	1 WTE
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

3. Annual data summary

3.1 The Trust's Junior Doctor locum usage over the financial year 2019/2020 is as follows (note data missing Feb & March 2020 due to the Covid-19 pandemic):

Month	Total requests	Total filled	Agency	Bank	Unfilled	Fill rate
Apr-19	774	532	87	445	242	69%
May-19	752	638	84	554	114	85%
Jun-19	619	476	71	405	143	77%
Jul-19	758	578	59	519	180	76%
Aug-19	761	518	61	457	243	68%
Sep-19	398	346	38	308	52	87%
Oct-19	447	352	40	312	95	79%

Nov-19	408	350	26	324	58	86%
Dec-19	613	468	71	397	145	76%
Jan-20	686	540	89	451	146	79%
Feb-20						
Mar-20						



4. Issues arising

4.1 Exception reporting

- Levels of exception reporting were similar to last year until they dropped just prior to the end of the reporting period with the onset of the covid-19 pandemic and subsequent lockdown with re-deployment of staff. There is a consistent cyclical variation with more reports submitted in August (as new doctors start work) and over the winter (winter pressures and staff vacancies). Rota design to mitigate this would be helpful.

- Under reporting is still a significant concern both here and nationally. Once again, few exception reports (ERs) have been submitted for missed training opportunities. Reasons that trainees do not submit ERs but do report regularly missing training or overworking in the annual GMC trainee survey are unclear and merit further investigation. Previous trainee surveys suggested that reasons for not reporting included lack of anonymity, a dislike of more paperwork, nothing obvious changing as a result of their reports and a perception that submitting an ER would be perceived negatively by their clinical supervisors. Our annual audit of

the exception reporting process suggests that a few clinical and educational supervisors are neither engaged with the process, nor recognise its value in providing data that can be used to effect change.

4.2 Areas of concern

Perioperative Care (Anaesthesia/ICU/NCCU)

4.2.1 All three areas are very hard to recruit to and rely on international recruitment. The vacancies are a mixture of unfilled training posts and local Clinical Fellow posts that we have been unable to recruit to. Where there are vacancies in local posts these have an impact on the ability of the trainees to comply with hours regulations and can affect access to training opportunities.

Obstetrics & Gynaecology

4.2.2 Several exception reports received and a work schedule review identified a failure to include the handover period in hours worked. New handover process agreed but failed to address issue.

Renal Medicine

4.2.3 A number of exception reports were submitted related to rota gaps.

Hepato-biliary

4.2.4 Persistent exception reports received from this service from FY1-2s.

Diabetes and Endocrine

4.2.5 Multiple ERs submitted by a variety of trainees related to high patient workloads and rota gaps in addition to underlying challenges related to acute medical rotas.

4.3 Immediate safety concerns

4.3.1 Immediate safety concerns were mostly related to illness and short term rota gaps, where it had not been possible to secure appropriate locum cover. This is a particular problem in general medical rotas. Clinical teams do seem to be aware in advance of the shifts and as far as we are aware there have been no obvious adverse patient consequences related to any reported immediate safety concerns.

4.4 Recruitment and retention – particularly international recruitment

4.4.1 Further to last year's report recruitment and retention of junior staff has continued to improve. However, filling rota gaps does remain challenging.

4.5 Implementation of the 2019 amendments to the Terms and Conditions of Service for Junior Doctors (2016)

4.5.1 Prior to the pandemic plans were being made to accommodate the (2019) amendments to the Terms and Conditions of Service (TCS) for junior doctors (2016) which requires changes in 60/96 rotas in CUHFT. Work on this was deferred with the onset of the pandemic but will need to be completed by August 2020 alongside the development of interim rotas to support the resumption of normal activity in parallel with maintaining Covid-19 ward cover.

The new TCS also advises that trainees should not work at a frequency of greater than 1:3 weekends. Exemptions can be applied for clinical reasons if there is agreement from trainees involved, the JDF and the GOSW. CUHFT had a number of rotas (n=11, mostly A & E and intensive care) which required trainees to work more than 1 in 3 weekends.

5. Actions taken to resolve issues

5.1 Exception reporting process

5.1.1 The guardian administrator has worked with medical staffing to ensure that problems with logging in to Allocate are addressed. The software has improved with further updates expected.

5.1.2 We have worked with educational and clinical supervisors to demonstrate the benefits to patient care of exception reporting (ES updates, quarterly newsletter and attendance at induction). A plan to repeat the questionnaire about the ER process to trainees has been deferred because of the Covid pandemic, but will be arranged later this year.

5.2 Areas of concern

Perioperative Care (Anaesthesia/ICU/NCCU)

5.2.1 Work by Medical Staffing and the Specialty Leads to develop a perioperative care recruitment strategy aimed at improving recruitment does appear to have been successful with good candidates applying during the recent recruitment round.

Obstetrics & Gynaecology

5.2.2 Currently running Covid rotas – new rota agreed for August 2020. Review planned after this.

Renal Medicine

5.2.3 Support being provided to improve recruitment to rota gaps.

Hepato-biliary

5.2.4 Sixth registrar post approved by manpower committee. 1:3 weekend rota planned from October when this post should be filled.

Diabetes & endocrine

5.2.5 Discussion continuing around organisation of acute medical rotas, further complicated by the Covid-19 pandemic. There is an opportunity to re-think rotas as teams move from Covid rotas; it is likely that hybrid rotas will persist for some time. This has implications for training and trainee welfare which requires further consideration.

5.3 Immediate safety concerns

5.3.1 We continue to emphasise the importance of trainees escalating short term rota gaps at the time they occur to clinical leads so that gaps can be filled and patient safety ensured – if necessary by senior doctors "acting down". We are continuing to discuss rota arrangements in medicine.

5.4 Recruitment and retention

5.4.1 It is widely acknowledged that there is an under supply of UK trained doctors and nurses to fill all existing vacancies across the NHS and the reasons for this are multi-faceted and complex. The Trust has a range of ever evolving initiatives to improve both recruitment and retention, these include opportunities for training, career development, practical assistance with accommodation, recruitment and retention premia. Medical Staffing continue to work with areas experiencing specific issues.

5.5 Implementation of the 2019 amendments to the Terms and Conditions of Service for Junior Doctors (2016)

5.5.1 Uncertainty around the covid-19 pandemic does complicate plans to redesign rotas that will comply with the TCS for junior doctors. Continuing surveillance will be important to ensure trainee and patient welfare.

5.5.2 Exemptions had been agreed to the amendment that advises that trainees should not work more than 1:3 weekends but this will need annual review. A plan has been developed to reduce weekend working which will involve various interventions including more staff and a change in working patterns. It will not be achieved by August 2020.

6. Summary

6.1 In general working hours for doctors and dentists in training are compliant and safe across CUHFT. Staffing levels are generally adequate to provide good quality care. However there are areas with persistent problems and rota gaps. The exception reporting process has been useful in highlighting departments and rotas where there are issues; it also provides data that can be used to drive change – extra posts or reallocation of tasks to other professional groups. It should be noted that the process has not been cost neutral.

6.2 There are continuing concerns over rota gaps on a variety of rotas which are difficult to recruit into, with implications for working hours, workload and patient safety combined with a reduction in training opportunities. The Trust Board has recognized these risks and the importance of improving trainee welfare (cf NHSI Eight high impact actions to improve the working environment for junior doctors) in order to attract and retain staff.

6.3 The 2019 amendments to the TCS have provided additional challenge this year which has necessitated a redesign of the majority of CUHFT rotas. There is continuing concern as to how rotas can accommodate the recommendation for trainees to work no more than 1:3 weekends. Although exemptions have been agreed these should be considered as temporary while permanent solutions are found.

6.4 Finally, the Covid pandemic, which developed towards the end of the year covered by this report, has provided more challenge, with medical staffing working very hard to develop new Covid rotas which are compliant with the TCS. There is an opportunity to re-think rotas as teams move from these Covid rotas; it is likely, however, that hybrid rotas will persist for some time. Managing trainee expectations will be important.

7. Conclusion

7.1 Staffing levels in CUHFT are generally adequate to provide good quality patient care but there are some areas with persistent problems and rota gaps. The Board is asked to note that the 2019 amendments to the 2016 TCS for junior doctors in combination with the need to design new Covid rotas is challenging and is likely to impact on training and trainee welfare.

8. Recommendation

8.1 The Board of Directors is asked to note this third annual (2019/20) report from the Guardian of Safe Working and is asked to provide their continuing support for measures to improve trainee welfare and morale and thus recruitment and retention.

9. Appendices

Appendix I: Glossary of terms and abbreviations

Appendix I: Glossary of terms and abbreviations

F1	Foundation Doctor Year 1
F2	Foundation Doctor Year 2
StR	Specialty Registrar
SpR	Specialist Registrar
ACAS	Advisory, Conciliation and Arbitration Service
CCT	Certificate of Completion of Training
COGPED	Committee of General Practice Education Directors
CQC	Care Quality Commission
DME	Director of Medical Education
FPP	Flexible pay premium / premia
GDC	General Dental Council
GMC	General Medical Council
GP	General Practitioner
HEE	Health Education England
JLNC	Joint Local Negotiating Committee
LTFT	Less than Full Time
NHSI	NHS Improvement
NIHR	National Institute for Health Research
OOP	Out Of Programme
OOPC	Out Of Programme (Career Break)
OOPE	Out Of Programme (Experience)
OOPR	Out Of Programme (Research)
OOPT	Out Of Programme (Training)
PIDA	Public Interest Disclosure Act 1998
SDM	Senior decision maker
SID	Senior independent director
TCS	Terms and Conditions of Service
WTR	The Working Time Regulations 1998 (as amended)

Acting down	Acting down is where a doctor is requested by their employer to cover the duties of a more junior colleague within their contracted working hours, although it may extend to covering the duties of a more junior colleague during unplanned additional hours. This definition does not apply, however, where the doctor undertakes duties as part of their normal workload which a more junior doctor might be competent to undertake; nor does it apply where a doctor agrees to undertake locum work at a more junior level.
Allocated Leave	Allocated leave is residual leave which is allocated to an individual doctor after requests for leave have been accommodated as best as possible.
Caring responsibilities	Significant responsibilities to care for another person, whether solely or as part of a group (for example of family members). This may include but is not limited to acting as a carer for a child or an ill or disabled family member.

Director of Medical Education (DME)	The DME is a member of consultant medical staff and an employee of the employer / host organisation who leads on the delivery of postgraduate medical and dental education in the Local Education Provider (LEP), ensuring that doctors receive a high quality educational experience and that GMC/GDC standards are met, together with the strategic direction of the organisation and Health Education England (HEE). The DME is responsible for delivering the educational contract between the LEP/ lead provider (LP) and HEE local team. For the purposes of these terms and conditions, where reference is made to the DME, the responsibilities described may be discharged by a nominated deputy to the DME.
Doctor	Wherever 'doctor' is used in these terms and conditions, it is intended to mean a doctor or dentist in an approved postgraduate training programme under the auspices of HEE.
Doctor or dentist in training	A doctor or dentist in postgraduate medical or dental education undertaking a post of employment or a series of posts of employment in hospital, general practice and/or other settings.
Educational review	An educational review is a formative process which enables doctors to receive feedback on their performance and to reflect on issues that they have encountered. Doctors will be able to raise concerns relating to curriculum delivery and patient safety. This will include regular discussions about the work schedule.
Educational supervisor	A named individual who is selected and appropriately trained to be responsible for supporting, guiding and monitoring the progress of a named trainee for a specified period of time. The educational supervisor may be in a different department, and occasionally in a different organisation, to the trainee. Every trainee should have a named educational supervisor and the trainee should be informed of the name of the educational supervisor in writing. This definition also covers approved clinical supervisors in GP practice placements.
Employer	The organisation by which the employee is employed and which holds the contract of employment.
Episodes of work	Periods of continuous work within an on call period separated by periods of rest.
Exception reporting	Mechanism used by doctors to inform the employer when their day- to-day work varies significantly and/or regularly from the agreed work schedule. Primarily these variations will be differences in total hours of work, pattern of hours worked, in the educational opportunities and support available to the doctor.
Form B	Form B is a GMC document which approves a training post at a specific point in time. It provides an outline of the educational and service activities and the expected learning outcomes from the post.

Guardian of safe working hours	A senior appointment made jointly by the employer / host organisation and junior doctors, who ensures that issues of compliance with safe working hours are addressed by the doctor and/or employer/host organisation, as appropriate and provides assurance to the Board of the employing organisation that doctors' working hours are safe.
Host organisation	An organisation where a doctor is deployed to work in a post for a fixed period of time under a lead employer arrangement. The employer can also be, but is usually not, the host organisation.
Integrated clinical academic pathway	Integrated clinical academic pathway combines both clinical and academic components within one training programme (for example, those defined under the auspices of the National Institute for Health Research (NIHR)).
Lead employer	An organisation that issues and holds the contract of employment throughout a doctor's training programme, during which the doctor may be deployed into one or more host organisations.
Long shift	For the purposes of these TCS, a long shift is any shift that exceeds 10 hours in duration.
On-call	A doctor is on-call when they are required by the employer to be available to return to work or to give advice by telephone but are not normally expected to be working on site for the whole period. A doctor carrying an 'on-call' bleep whilst already present at their place of work as part of their scheduled duties does not meet the definition of on-call working.
On-call period	An on-call period is the time that the doctor is required to be on call (as defined above) by their employer.
Period of grace	6 months of continued employment after a doctor has successfully completed their specialist training. Periods of grace are not applicable to GP trainees.
Placement	For the purposes of these TCS, a placement is a setting into which a doctor is placed to work for a fixed period of time in a post or posts in order to acquire the skills and competencies relevant to the training curriculum, as described in the work schedule.
Post	For the purposes of these TCS, a post has approval by the GMC/HEE for the purposes of postgraduate medical and dental education. Each approved post is located within an employer or host organisation.
Professional leave	Professional leave is leave in relation to professional work.

Professional work	Professional work is work done outside of the requirements of the curriculum and/or the employer/host organisation for professional bodies such as Royal Colleges, Faculties or the GMC/GDC. Non-trade union activities undertaken by for a recognised trade union, for example work on an Ethics Committee would count as professional work, however trade union duties and activities are covered through recognition agreements.
Public holiday	Holidays recognised by the NHS in England. Currently, these are: New Year's Day; Easter Friday (otherwise also known as Good Friday); Easter Monday; the two May bank holidays; the August bank holiday; Christmas Day and Boxing Day.
The regulator	General Medical Council or (for dental programmes) other relevant body.
Resident on-call	A doctor who is resident on-call is required to be present on site and available to work for the whole on-call period, but will not be expected to be working during that time unless called upon to do so.
Rota	The working pattern of an individual doctor or group of doctors.
Rota cycle	The number of weeks' activity set out in a rota, from which the average hours of a doctor's work and the distribution of those hours are calculated.
Rotation	A rotation is a series of placements made by the HEE local office into posts with one or more employers or host organisations. These can be at one or more locations.
Senior independent director	Non-executive director appointed by the board of directors to whom concerns regarding the performance of the guardian of safe working hours can be escalated where they are not properly resolved through the usual channels.
Shift	The period which the employer schedules the doctor to be at the work place performing their duties, excluding any on-call duty periods.
Special leave	Special leave for any circumstances will be defined by the employer's local policy.
Study leave	Study leave is leave that allows time, inside or outside of the workplace, for formal learning that meets the requirements of the curriculum and personalised training objectives. This will include regional educational events where the time is protected.

Training programme	Training programmes and training posts are approved by the GMC or (for dental programmes) HEE. Learning environments and posts used for training are recommended for approval by HEE for the purpose of postgraduate medical/dental education. Time spent in those posts/environments allows the doctor to acquire and demonstrate the competencies to progress through the training pathway for their chosen specialty (including general practice) and to acquire a Certificate of Completion of Training (CCT).
Work schedule	A work schedule is a document that sets out the intended learning outcomes (mapped to the educational curriculum), the scheduled duties of the doctor, time for quality improvement, research and patient safety activities, periods of formal study (other than study leave), and the number and distribution of hours for which the doctor is contracted.
Work schedule review	A work schedule review is a formal process by which changes to the work schedule may be suggested and/or agreed. A work schedule review can be triggered by one or more exception reports, or by a request from either the doctor or the employer. A work schedule review should consider safe working, working hours, educational concerns and/or issues relating to service delivery.
WTR reference period	Reference period as defined in the Working Time Regulations 1998 (as amended), currently 26 weeks.

Cambridge University Hospitals NHS Foundation Trust

Report to the Board of Directors: 8 July 2020

Agenda item	15
Title	Freedom to Speak Up Guardian report
Sponsoring executive director	Ian Walker, Director of Corporate Affairs
Author(s)	Denise Hollinger, Freedom to Speak Up Guardian
Purpose	To inform the Board of progress on the Speaking Up service.
Previously considered by	Management Executive, 2 July 2020

Executive Summary

This report provides the Board with a six-monthly update from the Freedom to Speak Up Guardian covering the period to March 2020. The usual reporting period has been supplemented by information for April to June 2020 to highlight the impact of the Covid-19 pandemic in relation to raising concerns.

Related Trust objectives	Improving patient journeys; Working with our communities; Strengthening the organisation
Risk and Assurance	The report provides assurance on the steps being taken to promote an open and transparent speaking up culture.
Related Assurance Framework Entries	BAF 004, 005
Legal / Regulatory / Equality, Diversity & Dignity implications?	Compliance with Department of Health and CQC guidance on Freedom to Speak Up.
How does this report affect Sustainability?	n/a
Do this report reference the Trust's values of "Together: safe, kind and excellent"?	The Trust's Safe value: "I never walk past; I always speak up"

Action required by the Board of Directors

The Board is asked to receive and discuss the report from the Trust's Freedom to Speak Up Guardian.

Cambridge University Hospitals NHS Foundation Trust

8 July 2020

Board of Directors
Freedom to Speak Up Guardian report
Denise Hollinger

1. Background

1.1 The creation of the Freedom to Speak Up Guardian (FTSUG) role was one of the recommendations of Sir Robert Francis' Freedom to Speak Up review following the Mid Staffordshire Public Inquiry.

1.2 The Trust's Freedom to Speak Up Guardian, Denise Hollinger, took up post in December 2016. This report provides the Board with the latest six-monthly update on activities and progress since the previous report to the Board of Directors in January 2020. It also focuses specifically on how the raising concerns service has been used during the first phase of the Covid-19 pandemic from March to June 2020.

1.3 The Director of Corporate Affairs is the Executive lead for speaking up and Shirley Pointer is the link Non-Executive Director for Freedom to Speak Up.

2. Progress to date

2.1 The Trust's speaking up service continued to engage with a wide range of staff across the organisation in the six months to March 2020, through divisional/departmental/team meetings, staff governors, Staffside meetings, study days and open forums to raise awareness of the service and to hear their views on the speaking up culture at CUH. The importance of speaking up and raising concerns is also emphasised to all new staff as part of the Director's session on the corporate induction programme and at junior doctor's induction sessions.

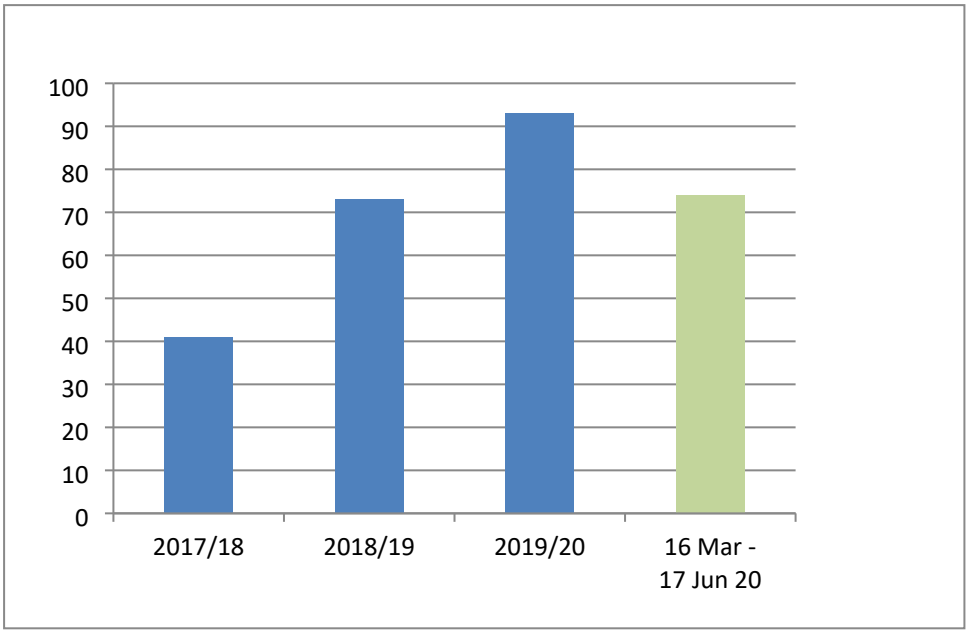
2.2 The CUH FTSUG has attended all of the annual National Guardian's Office (NGO) conferences and is a member of the East of England regional FTSUG Network which meets on a quarterly basis.

2.3 More recently, a number of the above activities have not been possible due to the Covid-19 restrictions on face-to-face meetings and alternative ways of engaging with staff are being explored.

3. Concerns raised, October 2019 – March 2020

3.1 In the six month period from October 2019 to March 2020, 60 members of staff contacted the FTSUG and local listeners to raise concerns. (11 of these were in the second half of March 2020 – see below.) This compares with 33 members of staff raising concerns between April and September 2019. Chart 1 below and Table 1a at Appendix A demonstrates a positive upward trend, with the number of staff raising concerns increasing year-on-year as awareness of, and confidence in, the service increases.

Chart 1: Number of staff contacts to CUH Speaking Up service



3.2 Of the 60 staff members contacting the service in the October 2019 to March 2020 period, the highest numbers by staff group were Nurses and Midwives (24) and Administrative and Clerical staff (16). These have historically been the largest staff groups accessing the service and above average as a proportion of the size of the total workforce group (see Table 1a).

3.3 The main themes of concerns raised in the past six months remain Trust policy/procedure in practice (31%), behaviour/relationships (27%) and management support (20%). In the latest six month period, 17% of concerns raised were patient-related. This is broadly in line with the national average and the Shelford Group average (see Tables 1d and 1e).

3.4 The Trust policy/procedure in practice category predominantly relates to concerns about the application of Trust policies and procedures by line managers, particularly in relation to workforce policies and procedures (e.g. recruitment, sickness absence, disciplinary and dignity at work procedures). There continues to be a close working relationship between the Speaking Up service and Workforce directorate colleagues. Individuals are signposted to the right person and always encouraged to use existing processes where applicable. Where concerns are raised by members of staff which potentially indicate wider practice concerns, this provides an opportunity to review the need for additional guidance and training for managers.

3.5 A more detailed breakdown of the latest six months' data is provided at Appendix A.

4. Concerns raised during the Covid-19 pandemic, mid-March to mid-June 2020

4.1 The three-month period from mid-March to mid-June 2020 has seen a sharp increase in concerns raised with the service in response to the Covid-19 pandemic (see Chart 1 above). Between 16 March and 17 June 2020, the service received

74 contacts – a monthly average of 25 contacts, compared with a monthly average of 10 contacts during the second half of 2019/20. Within this, the peak of concerns was seen during April 2020 but numbers remain above pre-COVID levels.

4.2 The majority of concerns during this period were raised directly with the Freedom to Speak Up Guardian or via the Raising Concerns mailbox. A smaller number were picked up by the Freedom to Speak Up Guardian from posts on the CUH Staff Facebook page which has been an active staff forum during the pandemic.

4.3 Unsurprisingly, the main themes of concerns raised during the Covid pandemic align with feedback from the recent CUH Reflects exercise. Of the 74 contacts during this period, over half (42) have related to staff health and well-being while around a quarter (19) have related to attitude and behaviours and workforce policy and procedure issues. Five concerns have related to patient safety.

4.4 The staff health and well-being concerns break down further as follows:

- Personal protective equipment (14)
- Social distancing (14)
- Staff support, homeworking and individual health and safety (14)

4.5 During this three-month period, the staff groups accounting for the greatest proportion of the concerns raised were Nursing and Midwifery (39%) and Administrative and Clerical (24%), in line with the experience of the previous six months.

4.6 The Speaking Up service has maintained a consistent and responsive presence throughout the pandemic to date to support staff and has continued to escalate and signpost concerns for resolution/action in a timely way. This responsiveness has been valued by staff raising concerns. However, local listeners have been less able to support the service given operational and clinical pressures.

4.7 There has been an increased communications and publicity campaign during this period. Regular messaging has been included in the daily Covid-19 bulletins encouraging staff to raise any concerns they might have through the various channels available. The CUH Staff Facebook page has helped gauge the mood across the organisation and offered the opportunity to pick up on emerging concerns at an early stage.

4.8 Despite operational and clinical pressures, many colleagues – in particular the PPE and Covid Secure Environment taskforces, the Chief Nurse's Office, Infection Control and Occupational Health – have been extremely supportive in responding to staff concerns and incorporating learning from these experiences into revised guidance.

4.9 A short staff survey was undertaken in the second half of May 2020 to understand staff experience during the Covid-19 pandemic. It received a response rate of 34% (approximately 3,700 staff) and included the following question:

"*I feel secure to raise concerns/speak up when there are things that I see that concern me.*"

4.10 Details of the survey responses can be found in Table 1f at Appendix A. Key points are as follows:

- Overall, 75% of respondents said that they feel secure to raise concerns/speak up. (This compares with a figure of 76% in the 2019 national staff survey, although the national staff survey question relates specifically to unsafe clinical practice.)

- The figure is 69% for BAME respondents and 70% for respondents with a disability.

- By staff group, a significantly lower proportion of medical staff and estates and ancillary staff report feeling secure to raise concerns/speak up (67% and 68% respectively).

- By division, a significantly lower proportion of staff in Divisions A and C report staff report feeling secure to raise concerns/speak up (68% and 69% respectively). In contrast, Division E and R&D had responses in excess of 80%.

4.11 There is a clear message from this staff survey (which is consistent with previous surveys) that more work needs to be done to encourage estates staff, medical staff, BAME staff and staff with disabilities to speak up. These are ongoing areas of focus.

4.12 In particular, previous reports have described how the Freedom to Speak Up Guardian is working with the Trust's Equality, Diversion and Inclusion (EDI) lead and with the BAME and Purple Network leads to better understand the reasons for the survey findings and to help create a better listening and empowering environment within which all colleagues feel able to speak up (see also Section 5).

5. National developments and CUH position

5.1 During April and May 2020, the National Guardian's Office (NGO) undertook two pulse surveys to gauge the level of speaking up activity and how well supported Guardians felt. Respondents reported a 34% increase in activity in May (21% in April) and 83% reported that worker safety and wellbeing was the biggest concern, with the largest categories relating to PPE and social distancing. The national picture also shows an increase in workers being encouraged to speak up and an increase in guardians/listeners being diverted to other duties.

5.2 During this period, the NGO has also been concerned to ensure that all BAME staff, in particular, have psychologically safe channels to speak up. This is alongside the NGO and NHS Workforce Race Equality Standard team working collaboratively to improve the experience of BAME staff across the NHS.

5.3 At CUH, the Speaking Up service has seen very few contacts citing concerns about the impact of Covid-19 on BAME workers. To date, we are unable to provide accurate data on the proportion of staff from BAME backgrounds who have accessed the service due to a low response rate to the demographics questionnaire introduced for those accessing the service. However, working closely with the Trust's EDI lead and the Chair of the BAME staff network, we will seek to create an environment in which staff become more aware of the Speaking Up service and feel comfortable to provide this information. In addition, we will

be offering opportunities for staff to join small bespoke sessions, not only to ask questions and give their opinions, but to build links with others in similar circumstances.

6. Local support for the FTSUG

6.1 Our local listeners' scheme has now been operational for over two years and there are 50 trained listeners across different areas of the Trust. There has been a particular focus on recruiting staff from lower pay bands (< Band 6) from one listener in the first cohort to 19 listeners in the current group, and from BAME backgrounds, although the latter remains a challenge. This continues to be discussed with the BAME Staff Network.

6.2 The latest cohort of a further 10 members of staff, including two Medical and Dental colleagues (one from a BAME background) are in the early stages of their training, which has been delayed by the Covid-19 pandemic. Work is continuing to address remaining gaps in listener coverage across divisions, as well as running virtual training sessions for listeners.

7. Raising Concerns (Whistleblowing) procedure

7.1 The review of the Trust's Raising Concerns (Whistleblowing) procedure was presented to the Board of Directors meeting in March 2020. The updated procedure was approved and has been published.

8. Governance

8.1 In line with national recommendations, the Board of Directors has previously agreed to receive a six-monthly report on Freedom to Speak Up.

9. Recommendations

9.1 The Board of Directors is asked to receive and discuss the six-monthly report from the Trust's Freedom to Speak Up Guardian.

Appendix A: Analysis of Freedom to Speak Up concerns raised

A1. Tables 1a and 1b below provide a breakdown of the concerns raised by occupational group and theme respectively. Note: some concerns cover more than one theme, i.e. in this period (October 2019 – March 2020) 60 individuals raised concerns across 88 themes. Table 1c shows the breakdown by division. The latest comparative data from the National Guardian's Office is for the quarter October–December 2019. The average number of concerns raised in that period is 21 compared with 28 for CUH.

Table 1a: Concerns raised with the CUH Speaking Up service by occupational group

October 2019 – March 2020			**2019/20 (April – March)**		**2018/19 (April – March)**		**2017/18 (April – March)**	
Occupational group	**Number**	**% of group workforce** (CHEQS Mar 2020)	**Number**	**% of group workforce** (CHEQS Mar 2020)	**Number**	**% of group workforce** (CHEQS Apr 2019)	**Number**	**% of group workforce** (CHEQS Apr 2018)
Admin & Clerical	16	0.7	27	1.2	29	1.3	15	0.7
Nursing & Midwifery	24	0.7	35	1.0	22	0.6	13	0.4
Health Care Assistant	4	0.2	7	0.4	8	0.5	3	0.2
Ancillary & Technical	1	0.3	3	1.0	2	0.7	3	1.0
Add Prof, Tech and Scientific and H/C Sci	4	0.4	6	0.7	4	1.4	2	0.8
Medical & Dental	3	0.2	4	0.3	3	0.2	2	0.2
Allied Health Professionals	6	1.0	9	1.5	1	0.2	0	0
Other	2		2	-	4		3	
TOTAL	**60**	**0.5**	**93**	**0.8**	**73**	**0.7**	**41**	**0.4**

Table 1b: Concerns raised with the CUH Speaking Up service by theme

October 2019 – March 2020			**2019/20**		**2018/19**		**2017/18**	
Concern theme	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Behaviour/attitude	24	27	43	29	27	28	23	43
Trust procedure/ practice	27	31	38	26	32	33	14	26
Management support	18	20	32	22	23	23	7	13
Patient related	15	17	24	16	12	12	8	15
Capacity/workload /training	4	5	9	6	4	4	2	4
TOTAL	**88**	**100**	**146**	**99**	**98**	**100**	**54**	**100**

A.2 Table 1a also shows the number of staff within each occupational group raising concerns as a percentage of the total workforce for that occupational group. In the October 2019 – March 2020 period, the following points stand out:

- Compared to the Trust average, staff in the Admin & Clerical, Nursing & Midwifery and Allied Health Professionals are more likely to raise concerns.
- Compared to the Trust average, staff in the Medical and Dental, Healthcare Assistant and Ancillary and Technical groups are much less likely to raise concerns.
- The main themes of concerns relate to Trust procedure/practice and behaviour/attitude (Table 1b).
- Staff in divisions A and B and Corporate departments are accessing the Speaking Up service more than average (see Table 1c).

A.3 Work continues to seek to better understand the drivers of these differences. There are likely to be a number of factors at play including awareness of the FTSU service, access to other channels for raising concerns and varying levels of staff engagement across occupational groups.

Table 1c: Concerns raised with the CUH Speaking Up service by division, October 2019 - March 2020

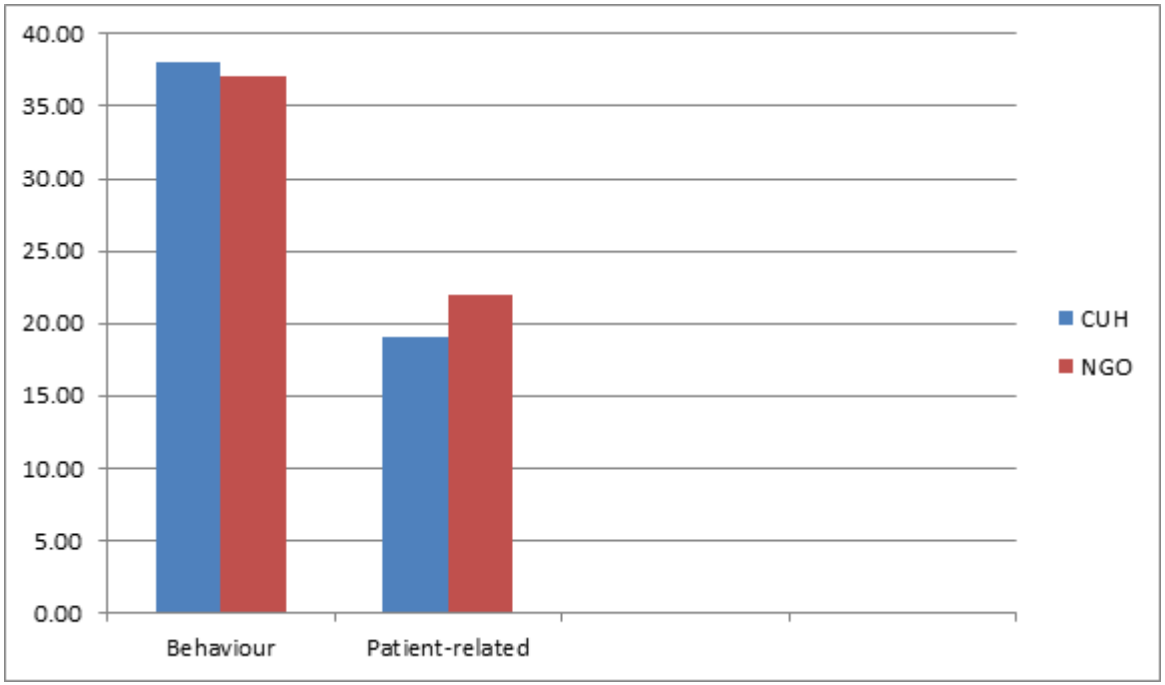
Job Role	Patient related	Behaviour/ relationship	Trust proc in practice	Mgmt support	Capacity workload training	Total	Total Themes	Total workforce	% Total of workforce
A	1	*4*	*7*	*4*	0	13	16	2013	0.6
B	5	*9*	*7*	*9*	1	20	31	2907	0.7
C	2	*5*	*1*	*0*	0	6	8	1611	0.4
D	3	*2*	*6*	*1*	1	7	13	1369	0.5
E	0	*1*	*1*	*0*	1	3	3	1356	0.2
Corp	2	*3*	*4*	*3*	1	8	13	1339	0.6
R&D	2	*0*	*0*	*0*	0	2	2	455	0.4
Other/ External	0	*0*	*1*	*1*	0	1	2		
Grand Total	15	*24*	*27*	*18*	4	60	88	11050	0.5

A.4 Comparisons between CUH data, National Guardian's Office data and Shelford Group comparisons are provided at Tables 1d and 1e. Nationally there is a wide disparity between the number of cases and resources allocated to speaking up services in trusts which makes direct comparisons difficult.

Table 1d: Shelford Group FTSU comparisons

Trust	FTSU index %	WTE guardians	Number of champions/ ambassadors end Mar 2020	Q1 2019/2020 total cases	Q1 2019/2020 Patient care/safety cases	Q1 2019/2020 B&H cases	Q2 2019/2020 total cases	Q2 2019/2020 Patient care/safety cases	Q2 2019/2020 B&H cases	Q3 2019/2020 total cases	Q3 2019/2020 Patient care/safety cases	Q3 2019/2020 B&H cases
CUHFT	81	0.6	50	20	4	11	13	5	8	28	8	16
GSTT	82	1.0 + 1.0 (bus sup)	100	49	3	8	53	5	12	52	7	13
Imperial	77	No data	No data	17	0	6	20	4	5	No data sent to NGO		
King's	75	No data	No data	34	10	4	31	5	2	28	3	8
Manchester	78	No data	No data	26	4	11	11	2	5	13	4	8
Newcastle	81	No data	No data	26	2	23	22	0	16	14	4	5
Oxford	77	0.6	2	33	10	14	53	17	22	30	9	10
Sheffield	79	No data	No data	3	0	2	9	6	3	9	2	5
UCL	78	No data	No data	27	1	1	33	0	6	28	3	1
UHB	75	No data	No data	7	3	6	16	5	8	14	5	12
Total				**242**	**37**	**86**	**261**	**49**	**87**	**216**	**45**	**78**
Average				**24**	**4**	**9**	**26**	**5**	**9**	**24**	**5**	**9**

Table 1e: % comparison of CUH themes (October - December 2019) with NGO data for the same period



A.5 Across this six month period, 83% of staff raising concerns were female and 17% were male. This is not in line with the gender split of the CUH workforce (73% female/27% male). It has not been possible to accurately report the % of our staff raising concerns who are from a BAME background. A more formal system of reporting has been introduced, sending a demographics questionnaire and feedback form to all staff who have contacted the service. To date, only 10% returns have been received. It is likely that this low return is due to the work pressures of the Covid-19 pandemic period.

A.6 Of the 60 concerns raised with the FTSUG in this six month period to March 2020, one case remains open due to ongoing investigations.

A.7 10 staff members have accessed the local listeners in this period and a small number of concerns have been picked up from the Staff Facebook page.

A.8 17% of concerns have been raised via the Trust's Raising Concerns dedicated email address. The biggest number relate to line manager behaviours either in relation to the individual or their ability to manage (e.g. sickness absence, planning, decision-making). Others have expressed concern about patient care and safety. More recent concerns in the period relate to PPE and one has led to investigations involving Counter Fraud and is under the disciplinary procedure.

A.9 Staff also continue to raise issues and concerns within their local teams and the vast majority of these are managed and resolved successfully at local level.

A.10 A confidential case log is held by the FTSUG and shared with the Director of Corporate Affairs. This also includes any concerns raised through other organisations such as the Care Quality Commission.

A11. The Covid-19 staff survey undertaken in the second half of May 2020 included a question on raising concerns. The survey response rate was 34% and the results for the raising concerns question are set out below.

Table 1f (i): Excerpt from Staff Survey Q1 2020 (Covid-19): Raising Concerns question, ethnicity and pay banding

Q13	Overall response %	BAME staff	White staff	Disabled staff	Non-disabled staff	Bands 1-4	5-7	8+	Med Consultant`	Med Non Consultant
I feel secure to raise concerns/speak up when there are things that I see that concern me	75	69	77	70	76	73	75	89	77	59

Table 1f (ii): Excerpt from Staff Survey Q1 2020 (Covid-19): Raising Concerns question, staff groups

Q13	Overall response %	Add Prof Sc and Tech	Additional Clinical Services	Admin and Clerical	AHPs	Estates and Ancillary	Health Care Scientists	Medical and Dental	Nursing and Midwifery
I feel secure to raise concerns/speak up when there are things that I see that concern me	75	80	71	78	80	68	76	67	74

Table 1f (iii): Excerpt from Staff Survey Q1 2020 (Covid-19): Raising Concerns question, divisions

Q13	Overall response %	Division A	Division B	Division C	Division D	Division E	R&D	Corporate
I feel secure to raise concerns/speak up when there are things that I see that concern me	75	68	77	69	74	81	85	77

Cambridge University Hospitals NHS Foundation Trust

Report to the Board of Directors: 8 July 2020

Agenda item	16
Title	Research and Development
Sponsoring executive director	Ashley Shaw, Medical Director
Author(s)	John Bradley, R&D Director
Purpose	To provide an update on Research and Development activity
Previously considered by	Management Executive, 29 June 2020

Executive Summary
This report from the Research Board of Cambridge University Hospitals NHS Foundation Trust provides the Board of Directors with a summary of issues relating to strategy, governance, performance and outputs.

Related Trust objectives	All Trust objectives
Risk and Assurance	The report is the main source of assurance on governance issues relating to Research and Development.
Related Assurance Framework Entries	n/a
Legal / Regulatory / Equality, Diversity & Dignity implications?	None identified.
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	n/a

Action required by the Board of Directors
The Board is asked to receive and discuss the report.

Cambridge University Hospitals NHS Foundation Trust

8 July 2020

Board of Directors
Research and Development
Ashley Shaw, Medical Director

1. Academic Health Science Centre (AHSC)

1.1 Following an interview on 25 February 2020, Cambridge University Health Partners, a partnership between Cambridge and Peterborough NHS Foundation Trust, Cambridge University Hospitals NHS Foundation Trust, Royal Papworth Hospital NHS Foundation Trust and the University of Cambridge has been re-designated as an Academic Health Science Centre.

1.2 The designation recognises excellence in patient care, research and health education across the partnership. The feedback recognised the volume, breadth, and quality of the research to be excellent across a range of fields, and that the partnership's track record in translating scientific advances into patient benefit was very strong. It was also recognised that the capacity and plans to contribute to economic growth through partnerships with commercial life science organisations were strong, demonstrating the potential economic benefits of the AHSC through working with multiple commercial partners.

2. Health Data Research (HDR) UK team of the year 2020

2.1 The team involved in the Cambridge University Hospitals led Rare Diseases Sprint Exemplar Innovation Project has been awarded the HDR UK 2020 team of the year. The team established under the umbrella of the NIHR BioResource included five NHS trusts (Cambridge University Hospitals, Leeds Teaching Hospitals, Newcastle Hospitals, Royal Liverpool and Broadgreen University Hospitals and Royal Papworth Hospital), Cambridge University Health Partners and the Eastern Academic Health Science Network, Privitar, AIMES and Microsoft, the National Disease Registries at Public Health England, Microsoft and the Wellcome Sanger Institute. In just ten months, the Rare Diseases Sprint Exemplar Innovation Project developed a secure cloud research platform to transform the understanding of rare genetic disorders and help to drive improvements in diagnosis, as well as acting as a proof of principle for use in other diseases.

2.2 The success was down to the willingness of world leading private and public sector organisations to work with patients to improve health and build what may be a world first - cloud integration of longitudinal healthcare data, research and lifestyle data, and genomics. The project is now providing the basis for development of 'Gut Reaction', the Health Data Research Hub for Inflammatory Bowel Disease (IBD) led by Cambridge University Hospitals, and other research and development projects

involving integration of data and new technologies including a high-profile Covid-19 study.

3. NIHR BioResource

3.1 The results of the NIHR BioResource programme of whole genome sequencing of NHS patients with rare diseases have been published in the journal Nature https://www.nature.com/articles/s41586-020-2434-2#Sec21. The programme delivered whole-genome sequencing as a diagnostic test providing proof of principle for its use in patient care; a world first in modernising clinical genomics.

3.2 In the study the entire genomes of almost 10,000 NHS patients who had a rare disease were sequenced to find the genetic cause of their condition. Many new genetic variants that cause rare diseases, and many new genetic diseases, were identified. The integrated analysis and diagnostic systems developed mean that a patient's clinical genetic report can be made available within weeks, compared to many months previously.

3.3 In one study from the programme, published in the same issue of Nature, researchers examined 886 patients with primary immunodeficiency, a condition that affects the ability of the immune system to fight infections, and identified four novel associated genes.

4. COVID-19 pandemic

4.1 The COVID-19 pandemic has had a major impact on research activity, with many existing studies being paused because of feasibility or safety concerns, and many new COVID-19 related studies being set up. A COVID-19 Clinical Research Oversight Group has been established with representation from Cambridge University Hospitals NHS Foundation Trust, Cambridge and Peterborough NHS Foundation Trust, Royal Papworth Hospital NHS Foundation Trust, the University of Cambridge and Public Health England, initially meeting twice weekly.

4.2 Over the past three months, 750 existing research studies have been paused, and 28 new COVID19 research studies have been opened. 3,541 participants have been recruited to COVID19 research studies, of which 191 entered interventional studies. This far exceeds our normal level of research activity and reflects a remarkable collaboration between clinical and research staff within the hospital and across the campus, many of whom have been willing to take on or be redeployed into new research roles. As a result all patients with COVID-19 have been given the opportunity to participate in research.

4.3 Activity has included:

Interventional studies

4.4 In addition to participating in national clinical trials, including the RECOVERY trial led by Oxford University, Cambridge University Hospitals is leading the TACTIC-R trial (a mulTi-Arm Therapeutic study in pre-ICu patients admitted with Covid-19 – Repurposed Drugs).

4.5 **TACTIC-R** aims to test the ability of drugs that are licensed for use in conditions caused by immune inflammation, and where the safety profile is known. This builds on the hypothesis that for seriously ill patients the severe phase of the infection typically occurs around 8-14 days into the illness. At this point replication of the virus may be on the decline, and the severity of the symptoms may be due to an excessive inflammatory response driven by the patient's immune system.

4.6 The first medications have been chosen by a national consortium of clinicians and clinician-scientists led by Cambridge and who all have expertise in the treatment of immune-mediated disease. These are Raviluzimab, a humanised monoclonal antibody complement inhibitor (see above), and Baricitinib, a drug that inhibits an enzyme (janus kinase) involved in inflammatory pathways and used for the treatment of rheumatoid arthritis. We have entered into collaborative partnerships with the pharma companies providing these drugs who have also been included in the design of the platform. TACTIC-R is a national platform, which commenced on 8 May 2020. Although we have seen a fall in patient numbers, 18 patients have been recruited across four sites in the first six weeks.

Testing for COVID-19

4.7 Rapid and effective testing for SARS-CoV-2 is essential for the effective triage and management of patients admitted to hospital, and for the screening of healthcare workers to provide appropriate occupational health advice and prevent nosocomial spread of the virus. Nucleic acid testing is the optimal approach, but central laboratory testing introduces significant delays.

Point of care testing

4.8 We compared a point of care nucleic acid amplification based platform SAMBA (simple amplification based assay) II for diagnosis of COVID-19 against the standard laboratory based test, and undertook an implementation study[1]. Point of care testing with SAMBA II performed as well as standard laboratory RT-PCR for specificity and sensitivity, and a shorter time (2.6 hours versus 26.4 hours) to result both in trial and 'live' settings, which was associated with faster time to triage from the ED, release of isolation rooms, secure patient movement with expedited access to hospital investigations and procedures, and safer discharge to care homes and into the community.

[1] Collier et al. Rapid point of care nucleic acid testing for SARS-CoV-2 in hospitalised patients: a clinical trial and implementation study. https://www.medrxiv.org/content/10.1101/2020.05.31.20114520v1

Healthcare worker screening

4.9 To undertake rapid healthcare worker screening at scale we replicated the standard PHE RT-PCR in a research laboratory, and over a three week period in April 2020 screened 1,032 asymptomatic healthcare workers at Cambridge University Hospitals. 3% of health care workers tested positive for SARS-CoV-2. 15% of symptomatic healthcare workers also tested positive. Clusters of healthcare worker infection were discovered on two wards, and whole viral genome sequencing showed that the majority of healthcare workers had the dominant lineage B•1[2]. Over 4,000 healthcare workers have now been screened and corresponding with a decline in patient admissions with COVID-19, the proportion of asymptomatic and symptomatic HCW testing positive from both groups rapidly declined over the following four weeks to at or near-zero. These data demonstrate how infection prevention and control measures including staff testing may help prevent hospitals from becoming independent 'hubs' of SARS-CoV-2 transmission.

4.10 Healthcare workers testing positive for SARS-CoV-2 are invited to join the NIHR COVID-19 BioResource (see below), providing an important cohort of asymptomatic or mildly symptomatic individuals for in depth study of the immune response to SARS-CoV-2 and its genetic basis.

4.11 These studies have received considerable attention in the national media, and contributed to parliamentary and DHSC briefings[3,4,5].

NIHR COVID BioResource

4.12 The COVID-19 cohort of the NIHR BioResource offers patients and staff the opportunity to participate in research by providing biological samples and health data that allow us to better understand the disease and its impact. A key question is why some people have few or no symptoms, whereas for others the disease is severe or fatal. Over 250 patients and healthcare workers across the spectrum of COVID-19 disease (asymptomatic through to patients requiring ventilator support in intensive care), and controls with non-COVID-19 infections have been recruited. Detailed analysis of their immune response is underway, and distinct patterns are emerging that can act as predictors of disease outcome, and inform therapeutic targets for experimental medicine trials. An example of this analysis of complement components in the plasma of patients with COVID-19. The complement pathway involves a group of proteins, which act to amplify and escalate inflammatory

[2] Rivett et al. Screening of Healthcare Workers for SARS-CoV-2 Highlights the Role of Asymptomatic Carriage in COVID-19 Transmission. Elife. 2020 May 11;9:e58728. doi: 10.7554/eLife.58728. Online ahead of print.

[3] House of Commons Library. Briefing Paper. Number CBP 8897, 19 May 2020. Coronavirus: Testing for Covid-19.

[4] Jones et al. Effective control of SARS-CoV-2 transmission between healthcare workers during a period of diminished community prevalence of COVID-19. 2020. https://elifesciences.org/articles/59391

[5] Department of Health and Social Care. Coronavirus (COVID-19) Scaling up our testing programmes. Published 04 April 2020

processes. We have observed distinct patterns of complement activation that might drive severe COVID-19 lung disease. This hypothesis will be tested in the TACTIC trial (see above), which involves testing a direct complement inhibitor in patients with COVID-19.

4.13 As part of a national initiative the NIHR BioResource, in partnership with Genomics England and GenOMICC , is recruiting trios of children/young adults who require admission to hospital with COVID-19, and their parents, to understand if there are genetic factors that makes some younger people more likely to become sick.

5. Recommendation

5.1 The Board of Directors is asked to receive and discuss the report.

NHS
Cambridge University Hospitals
NHS Foundation Trust

CHAIR'S KEY ISSUES REPORT

ISSUES FOR REFERRAL / ESCALATION

ORIGINATING BOARD / COMMITTEE:	Quality Committee	**DATE OF MEETING:**	1 July 2020
CHAIR:	Mike Knapton	**LEAD EXECUTIVE DIRECTOR:**	Chief Nurse / Medical Director
RECEIVING BOARD / COMMITTEE:	Board of Directors, 8 July 2020		

AGENDA ITEM	DETAILS OF ISSUE:	FOR APPROVAL / ESCALATION / ALERT/ ASSURANCE / INFORMATION?	CORPORATE RISK REGISTER / BAF REFERENCE	PAPER ATTACHED (Y/N)
5.	**COVID-19 Safety and Experience Report** 1. The committee received a report presented by the Deputy Chief Nurse regarding the patient safety and experience related Covid-19. The report also updated the committee on a broader range of quality metrics. The committee discussed the importance of restoring and maintaining visibility of the wider suite of performance metrics. The committee also discussed the importance of achieving an appropriate balance between responding to the pandemic and providing care to a broader range of patients. 2. The committee noted that the Serious Incident (SI) process continued to be suspended, however assurance was provided that investigative activity and implementation of learning actions continued. 3. The committee was advised that compliance with duty of candour requirements was continuing to return to pre-COVID 19 levels. 4. The committee noted that hospital acquired pressure ulcers had significantly reduced. However, assurance was provided that focus would remain on the issue. 5. The Deputy Medical Director updated the committee on learning from deaths. It was noted that there was delay in the reporting of mortality data of three months, therefore the impact of COVID-19 had yet to be reflected in the national mortality metrics. The committee was advised that the Trust was continuing to undertake structured judgement reviews (SJRs) of deaths in the Trust.	Information/ Assurance	C34	N

	6. The committee welcomed the focused work, which was being undertaken with the intention of improving VTE assessment compliance. 7. Assurance was provided that the Trust had responded appropriately to all COVID-19 related safety alerts. 8. The committee welcomed that the Trust had achieved 100% compliance with the complaints performance metrics during the reporting period. The Deputy Chief Nurse highlighted that complaints and other correspondence regarding patient care and experience were increasing again. The committee thanked the PALS and Complaints team for their flexibility and support to the Trust during the pandemic. 9. It was noted that the friends and family test had been suspended nationally, but that the Trust had decided to continue with the use of the SMS system for data collection of friends and family data during the COVID-19 pandemic. 10. The committee received assurance that PPE arrangements were being kept under close review, which included monitoring of compliance with the PHE guidelines. 11. The Medical Director updated the committee on the implementation and delivery of antibody testing for staff. The committee were advised that, where possible, staff who agreed to be tested, with their consent would be enrolled on research trails. 12. The committee was advised that while compliance the deteriorating patient metrics, including NEWS2 standards, had temporarily dropped, no patients to date had been reported as coming to harm. Assurance was provided that compliance was improving.			
6.	**Quality implications of Covid-19** 1. The Chair introduced the item and invited the committee to highlight any further areas of potential concern related to the quality implications of COVID-19. 2. The committee discussed the approach of the Trust to maintaining staff social distancing. 3. The committee noted that visiting restrictions remained in place but were being kept constant review. 4. The committee agreed on the importance of achieving an appropriate balance between responding to COVID patients, and providing care to all patients.	Information/ Assurance	CR34	

	5. The committee discussed the overall approach to clinical stratification and prioritisation, including the role of the taskforces. 6. The Chair updated the committee, on the recent meeting of Quality Committee Chairs from across the Cambridgeshire and Peterborough system. It was noted that further meetings were planned.			
7.	**Annual Safeguarding report** 1. The committee received the Annual Safeguarding report for review. 2. The committee discussed the key points in the report and agreed to keep a number of areas of concern under review.	Information/ Assurance	CR34	
8.	**Infection prevention and control board assurance framework** 1. The committee received a report regarding the infection prevention and control board assurance framework. 2. The committee noted that the Trust had undertaken a gap analysis against the standards and that a detailed action plan had been developed. 3. The committee received assurance that the Trust followed Public Health England guidance in respect of cleaning all areas of the Trust. 4. The committee agreed to receive an update on the progress against the action plan in November 2020.	Information/ Assurance	CR34	
9.	**Board Assurance Framework and Corporate Risk Register** 1. The Director of Corporate Affairs and the Chief Nurse updated the committee on the Board Assurance Framework and the Corporate Risk Register. 2. The committee noted that while some of the risk review processes had been temporarily amended during the COVID-19 that the Risk Oversight Committee had continued to meet. The committee was advised that the previous risk review arrangements were currently being reintroduced. 3. The committee was advised that the Board Assurance Framework risks were currently being refreshed and an update would be provided to the Board of Directors in September 2020.	Information/ Assurance	n/a	

Cambridge University Hospitals NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust

Report to the Board of Directors: 8 July 2020

Agenda item	17.1
Title	Safeguarding Annual Report 2019/20
Sponsoring executive director	Lorraine Szeremeta, Chief Nurse
Author(s)	As above
Purpose	To note safeguarding annual report for 2019/20
Previously considered by	Quality Committee, 1 July 2020

Executive Summary

The Safeguarding Annual Report for 2019/20 is attached. It was received and endorsed by the Quality Committee at its meeting on 1 July 2020.

Related Trust objectives	Improving patient journeys; Strengthening the organisation
Risk and Assurance	The paper provides assurance on arrangements in place in relation to safeguarding.
Related Assurance Framework Entries	n/a
Legal / Regulatory / Equality, Diversity & Dignity implications?	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13 Section 11 Children's Act 2004 Care Act (2015) Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009) Counter terrorism and Security Bill 2015 (Health Element: PREVENT) Care Quality Commission (Registration) Regulations 2009: Regulation 18
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent	Yes

Actions required by the Board of Directors

The Board is asked to receive the Safeguarding annual report for 2019/20.

Cambridge University Hospitals NHS Foundation Trust

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1.0 Introduction

This report gives an oversight of the safeguarding agenda at CUHFT over the past year, and aims to provide assurance that the Trust continues to fulfil its legislated safeguarding responsibilities through robust processes, delivered in line with the Trust values.

2.0 Executive Summary

The safeguarding team are responsible for children's (including the unborn baby), adults, and women at risk of abuse in maternity services, safeguarding. They oversee guidelines and policies ensuring they reflect changes to national policy. Joint working continues with partner agencies to develop and promote safe systems and practise for all groups in challenging and ever changing landscapes.

3.0 Strategic Context

3.1 Strategic Safeguarding Aims

In line with the Trust values and priorities the safeguarding team aims are:

1. Improving patient journeys by making safeguarding personal.
2. Working with our partner agencies e.g. social care, CQC, and local safeguarding boards to ensure we are constantly seeking ways to improve how we work together to ensure best outcomes for all those who use or come into contact with our services.
3. Strengthening the organisation by ensuring education and training is delivered to all staff is constantly reviewed in line with National policy.
4. Contributing nationally and internationally by sharing expertise through addressing safeguarding conferences and publishing work and experiences.
5. Contributing to initiatives to reduce health inequalities and improve health outcomes for people with socially complex lives.

3.2 National Agenda

The Wood Report (2019) identified that the traditional structure of the original Local Safeguarding Children's Boards no longer encompassed the spectrum of risk for children, and recommended their remit be redefined to incorporate the evolving risks of Female Genital Mutilation; gang culture; trafficking, and online, criminal and sexual exploitation posed by some community areas. In Cambridgeshire, the Cambridge and Peterborough Local Safeguarding Board has been restructured to comply with this recommendation, and is now known as the Safeguarding Children's Partnership Board (SCB). 2019-2020 has seen the implementation of the redefined Boards.

Sir Michael Marmot published a follow up Report to the initial report in 2010, into the extent of Health Inequalities in England, in February 2020 (Marmot, M et al (2020) Health equity in England: The Marmot Review, 10 years on. London: The Health Foundation). The report highlights that very little progress has been made in this area in the intervening decade between the 2 reports, and points at political and social factors as prime causes. A raft of recommendations for Health concludes a chapter of the Report, which should be adopted by health providers:

- Areas performing well have adopted a 'whole system approach' with integrated health and social care
- Promoting social and health equality is positively considered and inbuilt into organisational policy
- Organisations use evidence-based interventions and delivery systems.

Public Health England (PHE) agree, with a stated aim 'to protect and improve the nation's health and reduce health inequalities' by "integrating the reduction of inequalities into everything we do"

The Homelessness Reduction Act (2017) came into force in Quarter 4 of this year, and recognises the devastating effects of homelessness on health and family life. The legislation places a statutory obligation on professionals working in public services to refer homeless people to a Local Authority of their choice. Referral is consent-based, using a set pro-forma. Housing is more likely to be arranged if the person has a link to the referral area, but people are being advised not to opt for areas where they may be targeted for abuse. There is already a mandatory responsibility to house homeless women who are pregnant, but this may be to temporary accommodation only.

The Liberty Protection safeguards (LPS) passed into law in May 2019. This will provide new legislation to replace the Deprivation of Liberty Safeguards (DOLS) with a new system that will work better with existing care planning and allow people to faster access to protections.

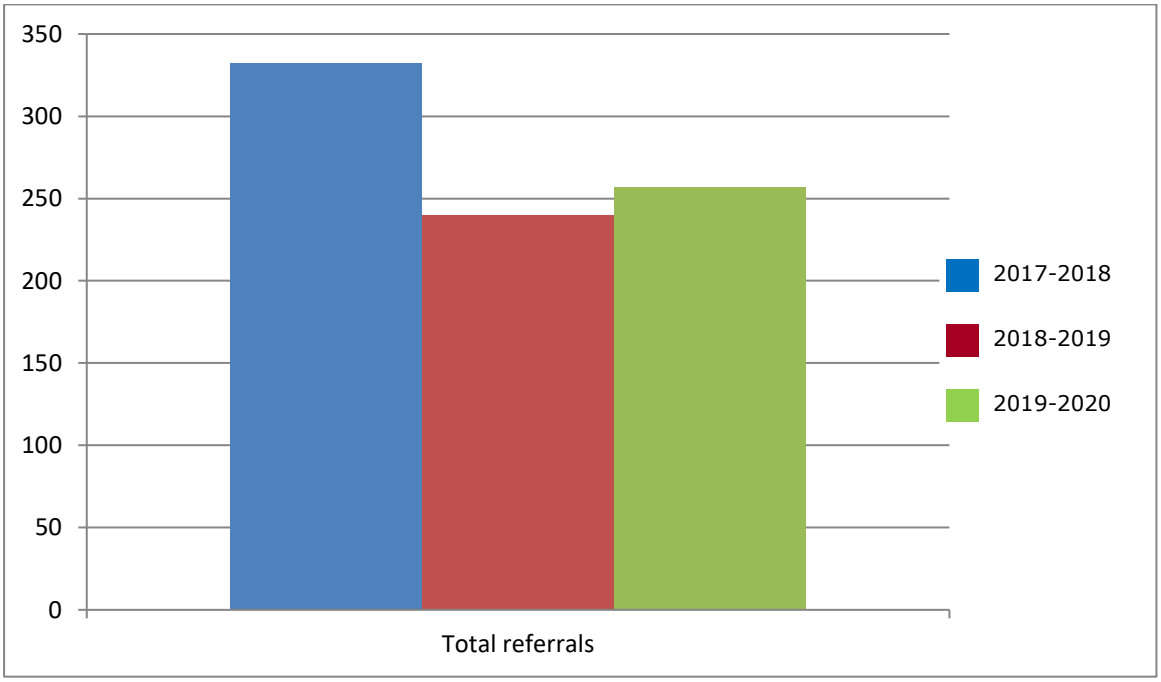
The Intercollegiate document (2019) provides a clear framework for safeguarding children which identifies the competencies required for all healthcare staff who may be involved in their care. Levels 1-3 relate to different occupational groups, while level 4 and 5 are related to specific roles namely safeguarding professionals. The trust ensures that all staff remain compliant within these national guidelines.

4.0 Maternity & Women's Services

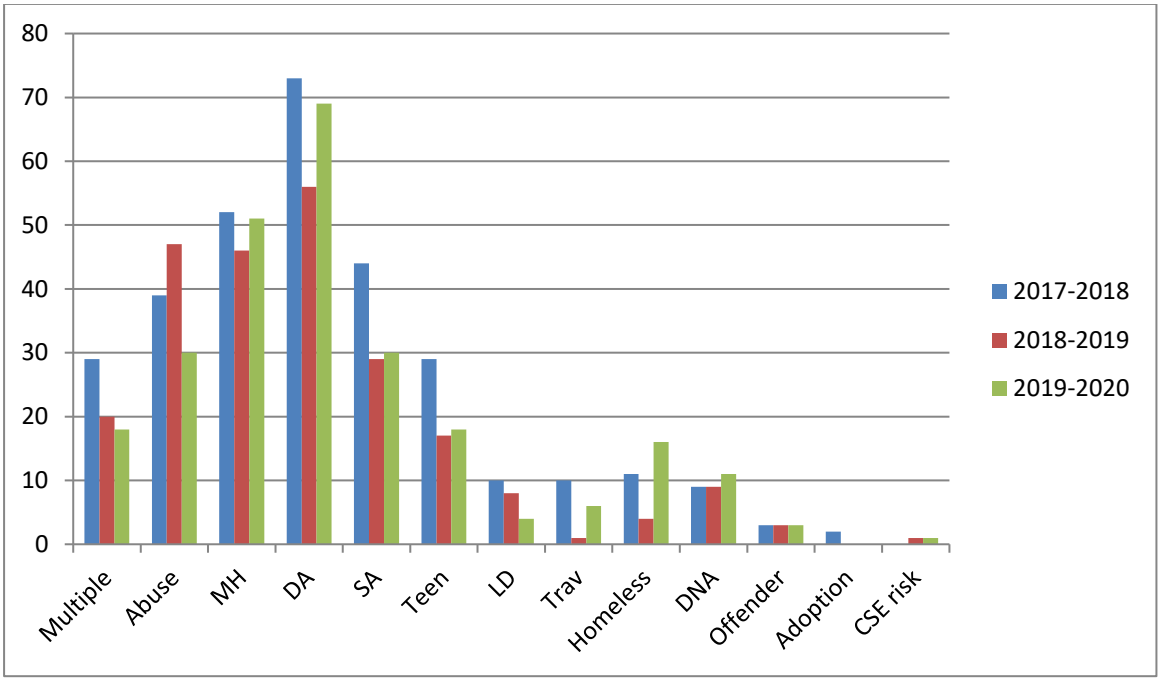
4.1 Activity

Referrals from Maternity Services to Children's Social Care (2017-2020)

Referrals to Children's Social Care from maternity, totals:



Referrals to Children's Social Care from maternity, totals by indication:



Key:

MH:	Mental health (either parent)
DA:	Domestic Abuse
SA:	Substance Abuse
LD:	Learning Disability
Trav:	Traveller
DNA:	Did Not Attend
CSE:	Child Sexual Exploitation

Analysis of data:

Overall, the total number of referrals annually remains similar for the Safeguarding Team in maternity. It should be remembered that the team also manage a rolling monthly caseload of approximately 120-150 maternity cases where there has not been a referral to social care.

There continues to be an increase in referrals for support with accommodation, since Homelessness Reduction Act (2017).

The data demonstrates that the most common indicators for referral to social care are consistently:

- Domestic Abuse (see later sections)
- Perinatal Mental Health: Despite the pathway of care and support for women experiencing PMH issues, the number of social care referrals remains high. However, this can be attributed to better recognition of mental ill health in pregnancy following staff training, and increased disclosure by women.
- History of child abuse: Where there has been previous social care involvement, a referral will always be sent to social care in respect of an unborn baby, as per Rosie safeguarding policy, so a high number for this element is usual

- Parental Substance Misuse: Noted that although the number of referrals remains constant, the profile of the substance used has changed. The most common substances are the recreational drugs of cocaine, cannabis and alcohol, with heroin and polydrug use being exceptional

Did not attend appointments (DNA) in Maternity Services (2019-2020)

There were 11 referrals to social care this year for non-attendance for maternity care.

Evidence from Confidential Enquiries into maternal and fetal deaths (MBRACE 2015-2017) highlights the risks of poor pregnancy outcomes where care is missed. In a safeguarding context, missed care is often underpinned by an abusive relationship, poor mental health, substance use or unaddressed poverty. The Rosie Hospital has a DNA policy to guide staff, and monitor attendance for care; a 3rd DNA is the trigger to commence safeguarding measures.

However, it is important to reflect that care is voluntary, and women may opt to decline recommended care.

4.2 Female Genital Mutilation (FGM)

Abiding by the CUH policy, all women are asked about FGM at maternity booking appointment, regardless of ethnicity, and the response documented. Women who disclose a history of undergoing FGM are asked about the family history of FGM and familial attitudes towards the FGM are assessed. Women are informed of the illegality of FGM, and also asked about their intentions regarding FGM if the baby is a girl.

Where there is a perceived risk to the child, a referral to Children's Social Care is sent. Although there were 9 cases disclosed this year, there were no concerns the parents would perpetrate FGM of their child, and hence there were no referrals this year.

The Named Midwife for Safeguarding is the Trust Lead with responsibility for contributing to quarterly national audit data and FGM monitoring; cases from other specialties will be notified to this postholder, in order to submit as full a dataset as possible to the Clinical Audit Platform. However, data is disregarded for any area submitting fewer than 6 cases per quarter; CUH regularly falls into this category, and is therefore classified as a low prevalence area.

In order to ensure ongoing monitoring of female children in families where there is a history of FGM, Maternity staff contribute to the FGM-RIS system linked to the NHS 'Spine'. A tab is completed to the NHS record, to alert Health professionals to any FGM risk.

4.3 Service Delivery

Key Achievements
The latter part of quarter 4 was affected by the restrictions due to the Covid-19 pandemic, which will be discussed fully in Q1 of 2020-2021 when the full impact can be assessed.

Despite these challenges, Rosie Safeguarding has maintained focus on the families identified as at risk, and striven to achieve safe outcomes for mothers and babies.

Areas of Focus in the Coming Year	Key Milestones / Targets
▪ Compliance with SCPB and CCG priorities of the 'lived experience of the child'; domestic abuse; contextual safeguarding; multi agency working; effectiveness of prevention and early intervention at reducing current and future risks to children and meeting their needs.	Evidenced through safeguarding dataset
▪ Maintenance of core business in changing times (Covid and post Covid-19)	Families continue to receive support and multiagency plans are enabled
▪ Service review	Implementation of review recommendations
▪ Reinstatement of routine safeguarding supervision	All safeguarding and Juno Team midwives will attend monthly supervision and caseload review
▪ Chaperone Policy: Sign off revised Chaperone policy; CUH compliance with this; multidisciplinary addendum to policy regarding virtual clinics during immediate pandemic era and for future such outbreaks	Sign off planned for 29/6/20 6 monthly Audit cycle
▪ Update of IT hardware	Able to easily take part in multiagency online meetings

5.0 Safeguarding Children

5.1 Activity

Number of Child Social Care Referrals 2019/20

2017/18	2018/19	2019/20
948	953	852

The number of social care referrals has remained steady as in the two previous years. There is a slight decline in the number this year (10%) and the possible reason for this is that social care have refined the criteria for the referral process when using the Effective Support for Children and their Families (previously known as the threshold document).

Staff continue to share concerns to social care using the communications navigator on Epic. Staff send the document electronically to any social care department in the UK. However, it was identified in August 2019 that there was an issue when sending them to Cambridgeshire social care. Due to human error,

when social care changed the email address, it was discovered that up to 536 referrals did not reach their destination. Working closely with social care we were able to ascertain that the worst cases of child abuse/neglect had been safety netted with phone calls, emails and discharge summaries. We looked at every single referral. Social care followed up the ones that may have been missed and there were no reports of any vulnerable child or family not receiving the help they required. As a result of this we completed an audit of the referrals. This enabled the team to be able to address issues of the quality of referrals and issues with consent. We were able to provide more education to staff based on these issues to make sure the referral process was more robust for the future.

Of the 852 referrals, 716 were completed by the Paediatric Emergency Department, 101 were made by the adult emergency department where there concerns with regards to parental mental health, substance misuse or domestic abuse thus demonstrating the "Think Family" approach. These concerns are all highlighted when staff are completing the safeguarding assessment as part of the attendance to ED or admission to the wards.

A large majority of these referrals (361) were concerns regarding adolescent mental health, compared to the 206 from 2018/19. A large proportion 232 (64%) were admitted to the wards for review by the Child Adolescent Mental health team. Many other children were assessed by the team in ED and discharged with a follow plan in the community. Similarly there was a significant amount of referrals due to parental mental health (146) where they were assessed by the First Response Service (FRS) at triage or admitted for a mental health assessment.

Neglect in children was one of the Children's Partnerships priorities with extra training aimed at agencies to identify early signs of neglect that can impact on the future development of a child. In 2018/19 there were 49 children identified and this has remained steady at 51 for 2019/20. Further education using adapted tools like the Graded Care Profile to assess neglect is used widely by community services. This was identified in the Section 11 audit and could be adapted for use in CUH to ensure the most vulnerable are identified early.

Please refer to Appendix 1 for detailed statistics relating to:

- Number of child social care referrals (by quarter).
- Number of child social care referrals (by category).
- Child protection conference invitations.
- Child mental health/social care referrals (by quarter).
- Child Death Overview Panel requests.
- DNA - children (by quarter).

5.2 DNA of Children (under 18s)

2017/18	2018/19	2019/20
6,118	6,484	6,666

Over the past year, it has been demonstrated that the total number of DNAs for children was 6,666 and those with a safeguarding alert was 932 (13.9%) This has seen an increase in overall DNAs with a safeguarding alert compared to last year (828). Each division received a monthly breakdown of their specific DNAs with a safeguarding alert and are tasked with providing assurance that those DNA's have been followed up by the relevant team to enable further appointments or liaison

with the GP or partner agency. This assurance was fed back by most divisions to the safeguarding team and the Joint Safeguarding Committee.

In other areas of the country, there has been a drive to rename DNAs as "was not brought" as this does put the onus of the responsibility on the child to attend appointments but highlights that it is the overall responsibility of the parent/guardian to ensure children are brought to appointments for medical treatment. This is a project that the safeguarding team would like to work on over the next year.

5.3 Child Sexual Exploitation (CSE)

No cases of CSE reported in maternity. Although there were 3 teenage pregnancies to mothers under the age of 16 years (1 x 14 and 2 x 15 years), there were no features of CSE and the fathers were of similar age.

The LSCB exploitation checklist is part of the Epic safeguarding checklist build. Intelligence shared by partner agencies is used to create an Epic alert to notify staff that the child or young person is vulnerable to exploitation. The check list is also integrated into Children's social care referral form to assist staff in assessing the level of risk when suspecting CSE is a risk. There were four referrals for suspected CSE over the year from Paediatrics.

5.4 Service Delivery

Key Achievements
In current times the different ways of working and maintaining links with partner agencies. We have embraced different technological challenges to ensure that strategy meetings about concerns around children and families have taken place. This has seen an increase of workload where often there have been multi-agency meetings three times a day to ensure that a child protection plan has been put in place. This has been challenging but successful and has further enhanced the relationship with key members of the social care team. For example – the vulnerable child teleconference which takes place weekly to identify vulnerable children and to meet their needs. This has built up valuable links with senior social workers, CPFT and the CCG. ▪ The challenges of the missed referrals and we way worked together to ensure that no child suffered from significant harm. ▪ The Informal audit completed which highlighted issues with the quality of referrals and the issue of consent which led to a more robust quality of referral. ▪ Thematic review - A new method of collating information for Safegaurding Practice Reviews (formerly Serious Case review) which enabled the team to look at three deaths from suicide and draw on local knowledge and research in to complex mental health in adolescents.

Areas of Focus in the Coming Year	Key Milestones / Targets
Compliance with partnership board priorities of the lived experience of the child; domestic abuse, contextual safeguarding; multi-agency working;	Will be reflected in SI reporting and safeguarding team statistics.

effectiveness of prevention and early intervention at reducing current and future risks to children and meeting their needs. In light of the COVID-19 when we have successfully left lock down to look at the safeguarding presented during this period to identify trends of concerns. For example mental health, domestic violence, non-accidental injuries in order to learn from these admissions and how to plan for future pandemics using health promotion and prevention	To be agreed.

5.4 Impact on Patient Care

Case Study

In the media there has been lots of attention given to County Lines. There have been many cases that have presented to ED. On this occasion a young person from out of the area travelled by train during lockdown and was targeted in an attack. He had injuries that were compatible with stabbing injuries. This young man was 15 and was heavily involved in county lines and was known to social care. He was reported missing by his mother.
A strategy meeting was convened and attended virtually. There were 29 agencies on the teleconference as he was known to many professionals. He was placed into protective custody as fear of reprisals. This case spanned over four local authorities ensuring that communication was paramount to ensure that the other members of family remained safe.

Feedback from the senior practitioner "Can I also say thanks for yours and your teams support and amazing multi-agency working which made our job so much easier".

Patient / User Feedback

Feedback from a mother whose child was being investigated for non-accidental injuries.

"We would like to thank you for everything you have done for X and ourselves during the hardest time of our lives. We will never forget how friendly and supportive you have been given the circumstances. We are hoping for the best outcome that X can return to us."

At the end of each training session we hand out cards asking the question "What does Safeguarding mean to me?"

"Breaking down barriers"

"Helpful refresher of what to watch out for. Delivered passionately and professionally. Essential and helpful"

5.5 Independent Inquiry into Child Sexual Abuse (IICSA)

IICSA was scheduled to conclude in 2020, but due to problems in governance of the inquiry, and the expansion of its remit, the timescale has been extended. CUH has not been asked for any contribution. The timetable of hearings is monitored by the Named Midwife for Safeguarding and the CCG, in case there is a likelihood of a request for information. At present, this is unlikely.

5.6 Mental Health

Referrals to Children and adolescent mental health (CAMH) and Social Care

2017/18	2018/19	2019/20
236	206	361

Mental health presentations have dramatically risen in the past year. These children are cared for initially in the Emergency department before being transferred to the ward. On several occasions there have been a group of young people that have attended with mental health problems repeatedly which has been challenging. Social care and CAMHS invited health to take part in a series of meetings called Network + where we would meet as a large multi-agency group to look at the young person and their needs to prevent repeated admissions. This was very productive and enabled the team to create ED management plans to safeguard the young person.

A new initiative called to Time to Talk was rolled out across the ED and Paediatric division, which was aimed at talking to young people about their mental health and how to address these issues.

6.0 Safeguarding Adults

Six Key Principles

Empowerment:	People being supported and encouraged to make their own decisions and informed consent.
Prevention:	It is better to take action before harm occurs.
Proportionality:	The least intrusive response appropriate to the risk presented.
Protection:	Support and representation for those in greatest need.
Partnership:	Local solutions through services working with their Communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
Accountability:	Accountability and transparency in safeguarding practice.

6.1 Activity

2017/18	2018/19	2019/20
375	421	395

There has been a slight reduction in referrals in 2019/20 compared with referrals in 2018/19. The safeguarding team did report an unusual increase in activity during 2018 this was thought to be a result of the introduction on an electronic referral pathway and may explain the reduction in referrals in 19/20

The Emergency Department (ED) are responsible for 30% (115) of referrals received in the last year this is in keeping with previous years as safeguarding concerns are often identified as the patient arrives in the ED This does not include referrals made by the ED to an Independent Domestic Violence Advisor(IDVA) service, referrals to IDVA are often for patients who have no care and/or support needs and would not require a referral to social care The Adult Safeguarding team have made 11 referrals to IDVA in the last year and will support the patient to liaise with the IDVA and other agencies with their consent.

The largest number of referral(35%) forwarded to the Local Authority for further safeguarding investigations relate to neglect , this presents the same pattern as in 2016/17 and 2018/19 although the numbers are lower this year and there has been an increase in referrals for Domestic Abuse .
We have received a small number of enquires in relation to Human Trafficking and Modern Slavery that have not progressed to safeguarding referrals and are not captured in the data for this year. We intend to review this to ensure we capture all enquires to the team in addition to referrals.
76 % of all referrals requiring a community safeguarding investigation were directed to Cambridgeshire Adult Social Care.

The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so if it believes an adult is experiencing or at risk of abuse or neglect .Safeguarding concerns relating to the care and treatment received by patients during an in-patient admission or out-patient visit are investigated by the ward or department responsible for their care supported by the safeguarding team This is monitored by Cambridgeshire Local Authority who have responsibility for ensuring the investigation is completed and agreeing appropriate actions with the Trust

A total of 25 concerns have been raised this year after initial fact finding 18 cases did not proceed to an investigation as the facts established that no abuse or neglect had taken place. 1 case was identified as a serious incident (SI) and investigated and managed under this pathway. The police led on 2 investigations, the cases were closed, and no further action was required by the Trust.
We were required to complete section 42 investigation in 4 cases resulting in 3 cases being closed with no evidence of abuse or neglect, the investigations may have identified additional learning with agreed actions to be implemented at ward level.

The outcome of 1 safeguarding investigation concluded that the Trust had failed to recognise the limits of decisions covered by The Mental Capacity Act 2005 (MCA) This resulted in agreement to commission a learning event to provide bespoke training for identified staff groups unfortunately due to the current pandemic the event due to take place on April 1st was postponed .We are currently exploring alternative ways of delivering this training taking into consideration the current restrictions

A total of 301 requests for Urgent Deprivation of Liberty Safeguards (DoLs) authorisations were made by this year this is a reduction of 16% from 2018/19 and in line with the numbers for 2017/18.
Authorisations for patients who live in Cambridgeshire continues to remain the highest, as is to be expected and reflects our patient population.

Currently the safeguarding team do not collect data on enquiries to the team for requests of support, advice, and information. For example, we receive a number of calls to advise on the MCA; we plan to include this information in future reporting to help to identify gaps in knowledge and training needs.

During 2019/20 The Adult Safeguarding Team have contributed to 7 Multi Agency Adult Safeguarding Reviews (SAR) and 2 Domestic Homicide Reviews (DHR) including submission of chronologies and Independent Management Reviews (IMR)
The reviews are at varying stages of completion, when the final reports are signed off learning will be reported via the Joint Safeguarding Committee

Please refer to Appendix 2 for detailed statistics relating to:

- Number of adult safeguarding referrals by ward /dept
- Number of adult safeguarding referrals by vulnerability
- Referrals by type of Abuse
- Referrals by Division
- Internal Safeguarding Referrals by type
- Deprivation of liberty safeguarding authorisations 2019/20
- Deprivation of liberty by local authority (number by month).
- Deprivation of liberty referrals (according to vulnerability by month).

6.2 Mental Capacity Act / Deprivation of Liberty Safeguards

2017/18	2018/19	2019/20
304	360	301

The legislative framework of the Mental Capacity Act 2005 occupies a central role in the pathways and practices of acute hospital care, and efforts continue at CUH to embed capacity assessment and the Best Interests process into all aspects of care and treatment. MCA and DOLS training is include Adult Safeguarding training at Trust Induction for identified staff groups and this is supplemented by bespoke training delivered to many staff groups across the Trust. Our electronic patient record allows us to record assessments and report on them collectively. We also monitor the care and treatment given to those who are unable to provide consent through our DoLS referrals.

The Mental Capacity (Amendment) Act 2019 received the Royal Assent on 16th May 2019. The purpose of the Act is to abolish the Deprivation of Liberty Safeguards (DoLS) and to replace them with a completely new system, the Liberty Protection Safeguards (LPS). This system will apply to England and Wales only. The new Act also broadens the scope to treat people, and deprive them of their liberty, in a medical emergency, without gaining prior authorisation.

The target date for implementation was spring 2020. Prior to this, a revised Code of Practice was expected to be published, to guide us in the implementation of this new legislation. The lockdown caused by the Coronavirus pandemic has

further affected planning; the government is considering a new implementation timetable for LPS. It is anticipated new timescales will be announced soon. All stakeholder have been asked not to prioritise any LPS implementation.

6.3 Prevent

The NHS needs to ensure that staff can identify early signs of an individual being drawn into radicalisation and to be confident in referring individuals to their organisational safeguarding lead or the police. There are two training packages available to CUH staff dependent on their role, and we are required to collect data to assure training compliance.

The aim of the data collection is to demonstrate how all NHS commissioned providers are delivering the key elements of the Duty. These include identified Prevent Leads, delivery of awareness training, the level of referrals made and the engagement with relevant partnership forums that coordinate the Prevent Strategy at local and regional level.

All NHS Trusts and Foundation Trusts are required to submit Prevent data to NHS England using the Strategic Data Collection Service (SDCS) portal provided by NHS Digital.

From April 2019 the collection of Prevent training data became a contractual matter and measured against contractual requirements.

6.4 Domestic Abuse

Victims of domestic abuse who have care and support needs are referred with their consent to the relevant Local Authority Safeguarding team. Many patients who are in an abusive relationship and are seeking support do not have care and support needs and can receive advice and support from the Independent Domestic Advice (IDVA) service. Cambridgeshire IDVA service will offer support to patients during an in-patient stay and can provide on-going support in the community Patients who reside outside of Cambridge can be referred to an appropriate IDVA service in their area.

Maternity:

Victims of domestic abuse who have care and support needs are referred with their consent to the relevant Local Authority Safeguarding team. Many patients who are in an abusive relationship and are seeking support do not have care and support needs and can receive advice and support from the Independent Domestic Advice (IDVA) service. Cambridgeshire IDVA service will offer support to patients during an in-patient stay and can provide on-going support in the community Patients who reside outside of Cambridge can be referred to an appropriate IDVA service in their area.

2019-2020 has been a challenging period for addressing the high incidence of domestic abuse within maternity services. Approx. 78% of the Specialist Midwife for Domestic abuse and Substance Misuse caseloaded families are experiencing domestic abuse, each month.

During this period 29 referrals were sent to the IDVA, the majority of which were offered support by the Trust IDVA service.

There were 69 referrals to Cambridge Children's Social Care for domestic abuse during this period. Though this appears a high number this is due to maternity staff recognising domestic abuse and women disclosing abuse in pregnancy, and there is evidence of seasonal variation (e.g. an increase in disclosures in January and September).

Training remained a priority with targeted training for domestic abuse for community midwives held in July 2019 and ad-hoc training with staff as and when needed.

The Specialist Midwife works within a multi-agency approach to supporting women, working closely with the Trust IDVA, For Baby's Sake team, Cambridge Social Care and Women's Aid.

Women at high risk of domestic abuse receive continuity of care by the Specialist Midwife in the antenatal and postnatal period. The Specialist Midwife also provides an overview of all women experiencing domestic abuse, offering support and guidance for community midwives.

In March 2020 COVID-19 presented new challenges and created additional considerations and barriers for safe enquiry and effective safety planning. The following strategies were implemented:

- The Specialist Midwife held a training session with clinic 21 and Sonographers due to the changed antenatal pathway and the new opportunities to ask all women about domestic abuse without the partner present. An on-line training session is planned for Q1 of 2020.
- Enhanced Multi-agency approach with Specialist Midwife for Domestic Abuse, Trust IDVA, Women's Aid, For Baby's Sake and Cambridge Social services sharing information for high risk current cases by including all professionals on emails. This included close liaison with Women's Aid regarding Refuge availability.
- 'Code Word Strategy' commenced at The Rosie in partnership with Women's Aid, allowing women to call in and attend clinic 23 if needing a safe space due to domestic abuse. 100+ posters were put around all areas to inform women of the code word and additional training given by Specialist Midwife for midwives involved.

6.5 Service Delivery

Key Achievements
• Increased investment in the CUH Adult Safeguarding team, appointment of Adult Safeguarding Specialist Nurse • Inclusion of Learning Disability Specialist Nurse to the Safeguarding Team • Improvement to Safeguarding Referral pathways and triage of referrals • Joint MCA teaching delivered to Anglia Ruskin Students in conjunction with Speech and Language Therapy Team • Development of face to face training at Clinical Support staff Induction programme (CSSIP) • Increased ward support and review of DoLs assessments • Improvements to referral data reporting

Areas of Focus in the Coming Year	Key Milestones / Targets
Identify longer term changes to multi - agency referral pathways and working arrangements due to COVID 19	Discussion with external agencies to agree changes
Review of Trust training, considering current face to face (COVID 19) training restrictions.	Implementation of training programme
Development of MCA/ DoLs/LPS advisory group to lead on implementation and review of procedures, and documentation.	Group members identified TOR agreed
Bespoke MCA learning event, cascade and implemented training.	Evidence of increased knowledge, and quality of assessments.

6.6 Impact on Patient Care

Case Study

The safeguarding team were contacted by a consultant in an outpatient clinic who was concerned that a patient and their family may be victims of modern slavery/human trafficking. We met with the patient with an interpreter, the patient and family gave an account of their living and work arrangements; there were no concerns about the nature of the patient's physical injury.

The patient disclosed their concerns about on-going financial hardship as the severity of the injury preventing the patient from working. The patient did not know how to register with a GP and where to go for advice and support.
We identified concerns about the private transport arrangements the patient had made for travel to hospital appointments and possible financial exploitation.

At a follow up appointment with the agreement of the patient we were able liaise with a specialist team who confirmed the working arrangements were legitimate and agreed to contact the patient and provide on-going support.

The patient was able to access alternative transport arrangement to attend further appointments.

Patient / User Feedback

Training Feedback

I have never understood DoLS now the penny has finally dropped – thank you.

Very engaging speaker – would like to have more time for discussion.

The session is very informative and made it easier to understand. It made me more confident to complete appropriate forms for patients, this will also help me teach my colleagues.

Multi-Agency Feedback

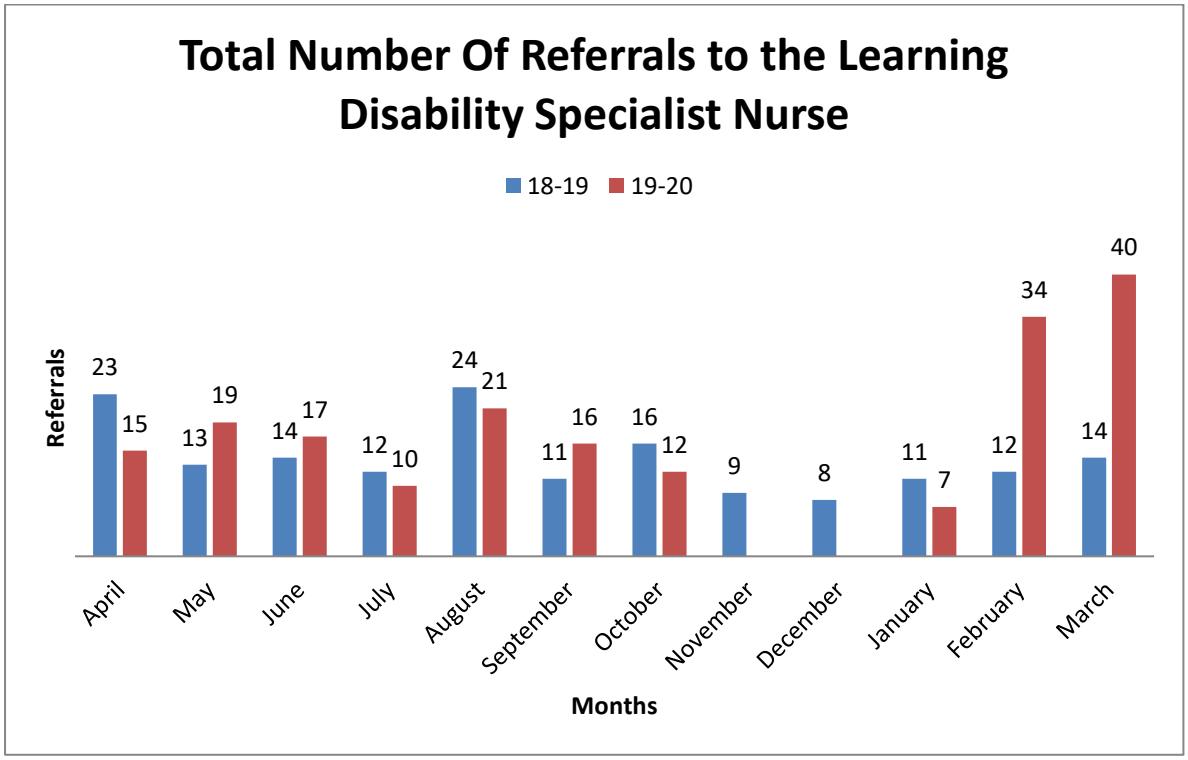
Thank you for taking the time to look into this and providing a written response.

Your assistance was really helpful, I will pass on your contact details to my colleagues for future concerns.

7.0 Learning Disability

Evidence indicates that people with learning disability have an increased burden of multi morbidity (Cooper et al 2015). In addition to this, many find that they have difficulty accessing and using health services: some hospital systems and processes can be particularly challenging for patients with learning disabilities.

7.1 Activity



The referrals to the Learning Disability Specialist Nurse increase by approximately 14% from 167 2018/19 to 191 2019/20 this does not include approximately 3 months November- January where the post was vacant, support was provided by the adult safeguarding lead however data was not collected over this period.

Please refer to appendix 3 for statistics relation to:

- Average age of the person referred
- Average length of stay
- Evidence of Reasonable adjustments implemented by staff
- Learning Disability Specialist role

7.2 The Trust Learning Disability Strategy

The Learning Disability 3 year strategy recognises that people with learning Disability and Autism will often require adjustments to their care and treatment pathways in order to: support access (in adherence to the Equality Act 2010); improve the patient experience and improve health outcomes.

The Strategy was developed during 2017/18. It was ratified at the Equality, Diversity and Dignity Steering Committee in June 2018. Following this the Learning Disability and Autism Working Group was reconvened in September 2018. This group meets every 8 weeks. The group aims to: implement and review the objectives set out in the LD and Autism strategy; improve and build on collaborative working between the Trust, patients with learning disability, local authority partners, families and carers; support and monitor progress against regional and national improvement programmes that relate to the care of learning disability (adult) patients in acute hospital Trusts. The Working Group currently reports to the Equality, Diversity and Dignity Steering Committee. The new Learning Disability Specialist Nurse will review the Trust Strategy and Terms of Reference for the working group for 2020/21.

Themes from the strategy during the year:

7.2.1 Improving Patient journeys

Outpatient Matron and her team have developed an action plan from the NHSI improvement standards and made improvements to the patient experience by:

- Decluttering the walls to provide a calmer environment for people with learning Disability/Autism
- Carried out training to the staff in the department about making reasonable adjustments
- The accessibility email address is encouraged and used by patients/carers to identify requirements prior to attending
- Responded to feedback and provided learning opportunities to staff
- There are still some Information technology issues to be overcome in relation to pulling off information onto the daily Department Appointment Report (DAR) which can identify people in advance of appointments.
- Reasonable adjustment appointment letters to be included as part of the discussion with Accessible working Group
- Home visits/ video consultations for individual cases to be discussed as part of the NHS 5year plan

The outpatient Department was also awarded The Carers Tick Award For Health' by Caring Together The Carer Friendly Tick Award – Health is designed to provide organisations with an emphasis on local and relevant standards which young carers, young adult carers and adult carers feel are necessary to ensure they are easily identified and properly supported when they are involved with a health setting. These standards can then be built on to work towards any national model of best practice such as Triangle of Care and NHS England's quality markers.

7.2.2 Learning Disability Improvement Standards for NHS Trusts 2018

There are four standards that trusts need to meet (3 relevant to acute Trusts); meeting these identifies Trusts as delivering high quality services for people with learning disabilities, Autism, or both. These standards are supplemented by improvement measures or actions that trusts are expected to take to make sure they meet the

standards and deliver the outcomes that people with learning disabilities, autism or both and their families expect and deserve.

The three standards for acute trusts concern:

1. Respecting and protecting rights
2. Inclusion and engagement
3. Workforce

Trusts are expected to publish their performance against these standards in their annual quality accounts: to demonstrate to the population they serve how they measure quality of services and whether quality is improving.

The 2019 reports showed compliance in most areas. Areas which identified improvement organisationally were around access around waiting list data and reporting.

The reporting highlighted good compliance with engagement relating to views of people with learning disabilities and their carers. However, areas for improvement include further engagement with Trust board sub-committees.

7.2.3 Learning Disability Mortality Review (LeDeR) Programme

2017/18 saw the launch of the Learning Disability Mortality Review (LeDeR) Programme provided by Bristol University and funded by NHS England.

There are a few key activities related to the programme:

- Acts as a central point for the notification of deaths of people with learning disabilities.
- Supports local areas to review the deaths of people with learning disabilities, identify learning and take forward lessons learnt into service improvements.
- Collates and shares anonymised information so that common themes, learning points and recommendations can be identified and taken forward.

Any death in the Trust concerning a patient with a learning disability is notified to Bristol as required under the LeDeR programme. Under the Trust's mortality programme, patients with a learning disability receive a Structured Judgement Review with oversight provided by the Learning from Deaths Oversight Committee.

The LeDeR programme commenced across Cambridgeshire and Peterborough on 01 May 2017. A total of 40 deaths at CUH have been notified to the LeDeR programme between May 2017 – April 2020. 13 in scope deaths reported between May 2019-April 2020 Cambridgeshire and Peterborough CCG have a key role in supporting local areas to review deaths of people with learning disability, however difficulties remain both locally and nationally in allocating and undertaking reviews of deaths. A local reviewer has been appointed to Cambridgeshire and Peterborough CCG and is due to commence role shortly. There is a local recovery programme in place and NHS England has allocated an additional £5m to support local areas to speed up allocation and reduce the backlog of reviews. The North East Commissioning Support Unit have been allocated 47 backlog reviews to date 14 have been completed. CUH has received 11 information requests the last quarter however, we still have issues with our information sharing process due to the level of security between the different organisational systems.

The NHSI report 2019 showed LeDeR embedded within the organisation.

7.2.4 Strengthening the Organisation

During the year there has been a change in learning Disability Specialist nurse with the post being vacant between October- January. With the NHSI improvement Standards part of this focus is on the workforce. Currently adults with Learning Disability and Autism are supported by one Specialist Learning Disability Nurse FTE across the organisation. The Learning Disability Standards requires review of specialist staffing support within the workforce for meeting the needs of Adults, Children/ transition with Learning disability OR Autism across the organisation.

Learning Disability and Autism level 1 induction training is offered to all new staff Qualified practitioner orientation (QPO) and Clinical Support Staff Induction Programme (CISSIP) programme (Nursing/allied professionals/Midwives and Healthcare Assistance) across the organisation (New medical staff not routinely part of level 1 training). Level 2 training (Full Day) offered to all staff available to register via DOT. Learning Disability/ Autism awareness also has allocated time within the Be Disability Confident training available to all staff via DOT. Bespoke training is offered across the organisation by request.

CUH Training Numbers for 2019/20

Training	Participant Numbers
QPO	419
Cissip	358
Be Disability Confident (3 courses)	31
Full day Learning Disability/Autism Awareness March and October sessions	28
Total staff trained	836

The NHSI report 2019 highlighted that:

- 77% of staff say they receive up to date training covering learning Disability/Autism.
- 75% said they knew how to contact the learning Disability Specialist Nurse.
- 21% said the trust programme invites people with learning Disabilities to contribute to staff training. The induction training has been reviewed and includes videos of people with learning disabilities. The level 2 training always invites people with learning Disabilities and carer/family representatives. Mandatory training will be coming which will include training resources.

7.3 Service Delivery

Areas of focus in the coming year	Key milestones/targets
Review of the Learning Disability Strategy and terms of reference for the working Group	August 2020
Development of patient feedback in alternative formats	As restructuring happens with Covid
Review/Promotion of representation on sub committees/ council	As restructuring happens with Covid

Process for sharing information for LeDeR reviews	August 2020
Adherence to Reasonable adjusted pathways as the Trust restructures with the Covid 19 pandemic	Ongoing
Review of learning Disability specialist and Autism Specialist workforce across the organisation (NHSI)	As restructuring happens with Covid
Review of waiting list procedures	As restructuring happens with Covid

7.4 Impact on Patient Care

Case Study
A patient with severe learning Disability, Autism, Epilepsy and who communicated distress through behaviours attended ED following seizures and decreased respiration. The patient lived outside of Cambridgeshire in a residential care home and the provider manager spoke about concern that there was limited. Engagement/involvement from family and possible financial abuse. The patient's mother had arrived at the hospital. There was some concern from the provider that the mother had expressed views about DNACPR which the provider had found upsetting. The staff at CUH carried out appropriate capacity assessments and made best interest decisions in consultation with mother which were no different from clinically indicated and escalated treatment to ITU. Advice to ITU was to continue to consult with family but due to needing to establish some factors, if they were concerned at all about consultations then advice from IMCA may need to be sort. Learning Disability Specialist Nurse role was able to gather information from provider manager, Safeguarding team social care team from out of area. No concern was raised in relation to health decisions and the financial situation would be addressed separately in the community. Advice was provided to staff also in relation to liaising with the family, information within the hospital passport, advice about risk when moving into a ward area in relation to treatment and behaviour strategies. The patient's rights were adhered to in the hospital and the admission had a positive outcome to health and they were successfully discharged.

Patient/User Feedback
Voiceability Speak out council have been working on a few initiatives with CUH over the last year. CUH have joined the National Safe Place Scheme. A safe place helps people if they feel scared or at risk while they are out and about in the community and need support right away. Voiceability attended community events with National Mencap Campaign "Treat me well" and informed the Learning Disability Nurse Karen Thomson what people were

saying. This feeds into the workstream.

Secret shopper feedback from Voicability speak out council High support needs group- October 2019 (Learning Disability Specialist Nurse Post vacant during this period). This has been sent to Head of Patient Experience for action.

191206 HSN Addenbrookes tour

Collection of feedback to be develop further with Patient Engagement & Surveys Project Manager to support surveys in accessible formats.

NHSI report highlighted that:

79% were happy with the care they received from the trust 78% said they received high quality care.
94% felt they were treated with respect.
63% said staff read Hospital passports (60% said they had Hospital Passports).
46% said they had seen a learning Disability Nurse 43% were happy with the support.

8.0 Governance & Accountability

Safeguarding Team

Executive Lead:
Lorraine Szeremeta, Chief Nurse

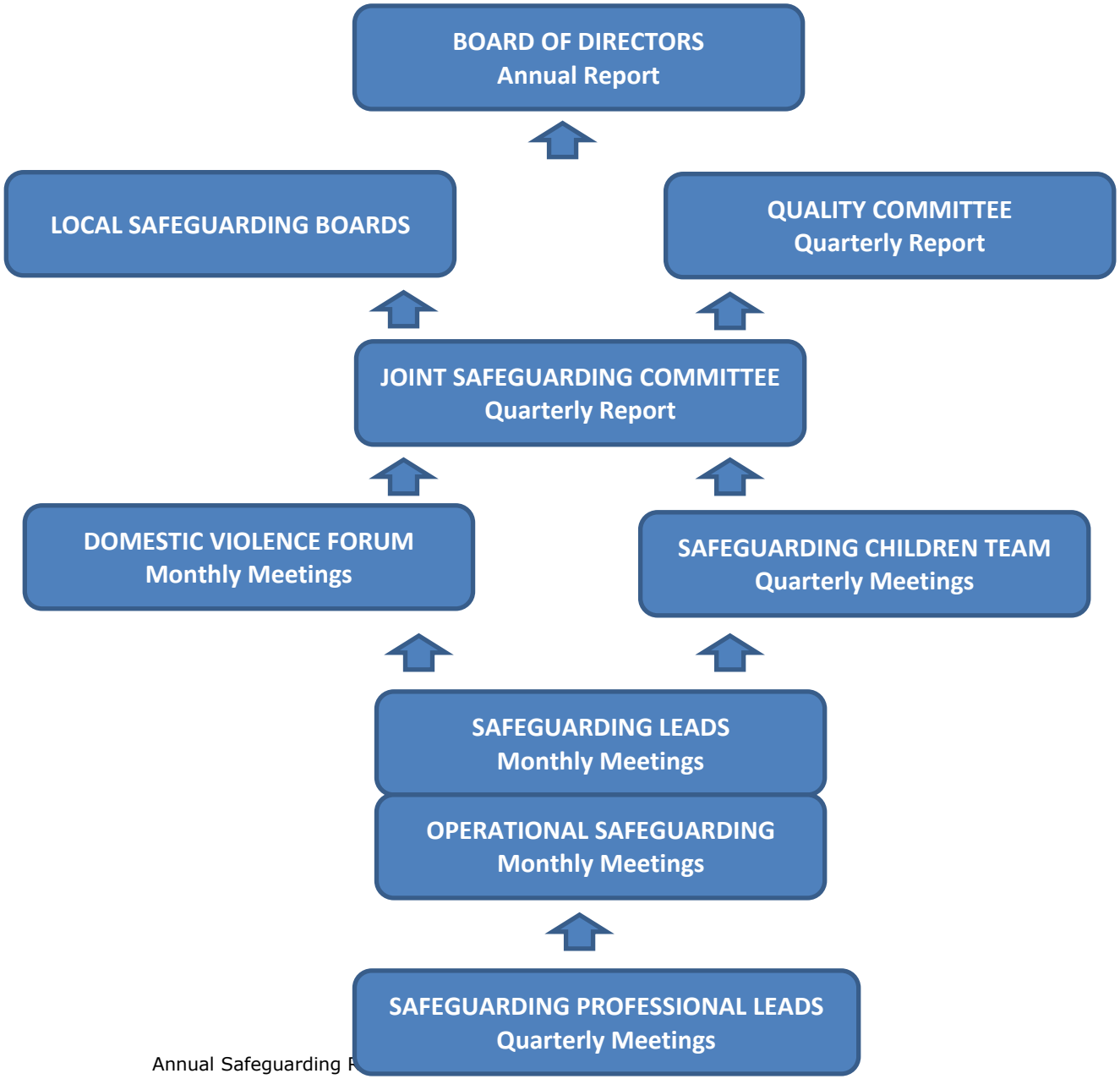
Operational Lead:
Maura Screaton, Deputy Chief Nurse

Adult Safeguarding Leads:
Tracy Brown (Named adult safeguarding lead)
Dr Liam Brennan (named doctor)

Children Safeguarding Leads:
Diane Coughlin, Kim Turner, Dr Lucy Preston (named doctor)

Maternity Safeguarding Leads:
Toni Van Voorst, Joanna Bellamy

Workforce Safeguarding Lead:
Richard Lewis



9.0 Working & Learning Together

9.1 Contribution to Groups

The safeguarding teams contribute to a number of internal and external forums, ensuring our safeguarding expertise is informing agenda and contributing to decision making:

External forums
▪ Acute Trust Named Nurse Forum ▪ ADASS Eastern Region Adult Safeguarding Network ▪ Adult Safeguarding Operational and Best Practice Group ▪ Cambridgeshire and Peterborough Safeguarding Adults Board ▪ Child Death Overview Panel CDOP ▪ Delivery Group, Cambridgeshire and Peterborough Safeguarding Adults Board ▪ Health, Training and Quality Subgroups of SAB ▪ LeDeR reviewers CCG meeting ▪ LeDer Steering Group, Cambridgeshire and Peterborough Safeguarding Adults Board ▪ LSCB Business meeting ▪ LSCB Delivery Group meeting ▪ LSCB Health Safeguarding Group ▪ LSCB Serious Case Review subgroup ▪ MCA Management and Practice Group, Cambridge County Council ▪ NHS East of England Adult Safeguarding Forum ▪ Quality and Effectiveness Group, Cambridgeshire and Peterborough Safeguarding Adults Board ▪ Safeguarding Adult Review Panel and Sub-Group Meetings – Cambridgeshire & Peterborough SAB ▪ SCB Business meeting ▪ SCB Delivery Group Meeting ▪ SCB Health Safeguarding Group ▪ SCB Serious Case Review Sub-Group ▪ Staff safeguarding supervision(monthly) maternity services ▪ The East of England Regional Safeguarding Forum ▪ Unborn Baby Panel (monthly) ▪ Voiceability Speak Out Council ▪ Vulnerable child group

Internal forums
▪ Accessible Information Standards Working Group ▪ Adult Learning Disability and Autism Forum ▪ Carers Strategy Group ▪ Clinical Nurse Specialist Group ▪ Discharge Assurance Panel and Steering Group ▪ Domestic Abuse Forum ▪ Education and Training- Subject Matter Expert Forum ▪ Equality, Diversity and Dignity Steering Committee ▪ Harm free Care Panel ▪ Joint Safeguarding Committee (quarterly) ▪ Learning from Deaths Oversight committee ▪ Learning from Deaths Oversight Committee

- Monthly multiagency maternity meeting
- Paediatric Clinical Governance Meeting
- Paediatric Gastro-enter ology psycho-social meeting.
- Paediatric Morbidity and Mortality Meeting (PICU)
- Paediatric Peer Review
- Paediatric Rheumatology Psycho-social meeting.
- Paediatric/Emergency Department Link meeting.
- PICU Clinical Governance Meeting
- Psychosocial meeting for the Paediatric Neurology team
- Psychosocial meeting for the Paediatric Respiratory Team
- Restrictive Interventions Steering Group

9.2 Child protection information sharing (CP-IS)

Child Protection-Information Sharing scheme applies to all children and young people, and pregnant women (unborn baby). The rationale for the scheme, set up in 2016, was to safeguard the most vulnerable children by mitigating the risk of the family fleeing to a different location where they were unknown to services. Where an unborn, child or young person is the subject of a Child Protection Plan or in Local Authority Care, a 'tab' is added to their record on the NHS Spine. Responsibility for the national database remains with the Local Authority who must update any changes within 24 hours of implementation. All NHS Trusts offering unscheduled care settings were obliged to embed a system which could dovetail with the LA IT to access this information instantly, should such a child present.

The current system at CUH still retains one manual step in the process, with a fully automated service dependent on epic upgrade.

In practice, any child or young person, or pregnant women attending CUH and where there is a safeguarding issue, is alerted to the Named Midwife via an allocated inbox on epic. There are between 110-170 alerts a week, and cases are assessed to ensure appropriate follow up.

9.3 Serious Case Reviews (SCR) / Safeguarding Adult Reviews (SAR) / Domestic Homicide Reviews (DHR)

Serious Case Reviews involving CUHFT in 2019/20.

Domain SCR/SAR	Immediate Learning	Publication Date	Recommendations for CUH
SCR	2	Not yet confirmed	Awaited
DHR		Submnitted March 2020	Process in place to ensure when wards are advised to make a referral, this is followed up by the Audit Safeguarding Team – recommendation completed

CUH have contributed to reviews, alongside the safeguarding team providing support to the ward teams and to safeguarding partners during the course of enquiries.

Embedding the Learning from SCR/SAR and Casework

There are two ongoing safegaurding practice reviews ongoing. The first commenced in April 2019 (from a case in December 2018). The second commenced in January 2020 and is called a thematic review. Chronologies have yet to be submitted at the time of the report.

9.4 Recruitment – Standards for Checking

The Recruitment team undertake all relevant pre-engagement checks to ensure NHS safe recruitment practices are adhered to at all times.

The reference checking process requires that all successful applicants recruited externally are subjected to a reference checking process which requires references from previous employers covering the last consecutive three years and those recruited internally require a reference from their current line manager. Each referee is asked – "Are you aware of any recent/outstanding allegations that were made against the applicant that relate to safeguarding issues/or referrals (including any referrals to the Disclosure and Barring Service (DBS))?" If concerns are disclosed, the Recruitment team proactively investigate the raised concerns and take action as considered necessary, which may result in the withdrawal of a conditional offer of employment.

A DBS check is systematically completed for all those applicants who are appointed to roles which have patient contact. The barred list is checked for roles involving both adults and/or children. DBS certificates that contain any information regarding cautions or convictions are assessed by the Employee Relations Team, to establish whether there is any potential risk to both the Trust and patients in employing the applicant in question, in which case actions are taken to mitigate any perceived risks.

The Trust's recruitment due diligence checking requirements are in accordance with NHS safe recruitment practice guidelines.

9.5 Audit

There is an audit programme aligned to safeguarding assurance.

Title	Time Frame	Strategic Links	Assurance Group	RAG
Planned Audit To identify the quality of referrals Following on from the missed referrals	6 months	Karena Fraser	Paediatric Link meeting. Paediatric Clinical Governance	TBC
National NHS benchmarking of the Learning Disability and Autism Standards	3 months Completed Nov-Feb 2019/20	Tracy Brown	Learning Disability and Autism Forum/Joint Safeguarding Committee	

10 Safeguarding Training

Safeguarding training is a priority for the Trust. It is a mandatory requirement that all staff undertake safeguarding awareness training when they start in the organisation, and a detailed training need analysis identifies groups of staff that are required to undertake more in-depth training which is aligned to their role.

To comply with the recommendations from the Intercollegiate Document (2014) areas where 16-17 year olds receive their care and treatment, the designated senior staff are required to complete level 3 training. These senior staff are then used as a resource for junior staff to signpost them to enhanced advice and support. The majority of this cohort is also mapped to require WRAP 3.

Compliance with safeguarding training for end year (2019/20)

Safeguarding Training Compliance Rates (Divisional %)

Division / Department	Safeguarding Adults	Safeguarding Children L1	Safeguarding Children L 2	Safeguarding Children L3	Safeguarding Adults L2
Division A	(50) 97.3%	(48) 97.4%	(104) 93.8%	(23) 86.7%	(104) 93.8%
Division B	(40) 98.5%	(37) 98.6%	(74) 95.5%	(14) 90.8%	(71) 95.7%
Division C	(58) 96.0%	(56) 96.1%	(75) 94.6%	(43) 83.3%	(68) 95.1%
Division D	(37) 97.0%	(43) 96.6%	(59) 94.5%	(25) 81.2%	(53) 95.1%
Division E	(45) 96.3%	(38) 96.9%	(62) 94.4%	(72) 92.9%	(75) 93.2%
Chief Executive Officer	(10) 86.5%	(10) 86.5%	(0) 100.0%	(0) 100.0%	(0) 100.0%
Chief Financial Officer	(2) 98.9%	(3) 98.4%	N/A	N/A	N/A
Chief Information Officer	(0) 100.0%	(0) 100.0%	(0) 100.0%	N/A	(0) 100.0%
Chief Nurse	(1) 99.1%	(3) 97.2%	(3) 95.5%	(2) 83.3%	(3) 95.5%
Chief Operating Officer	(2) 96.9%	(1) 98.5%	(1) 96.0%	(1) 0.0%	(1) 96.0%
Director of Improvement & Transformation	(0) 100.0%	(0) 100.0%	N/A	N/A	N/A
Director of Strategy & Major Projects	(0) 100.0%	(0) 100.0%	N/A	N/A	N/A
Estates & Facilities	(6) 98.4%	(4) 98.9%	N/A	N/A	N/A
Medical Director	(3) 90.3%	(2) 93.5%	(2) 75.0%	N/A	(2) 75.0%
Director of Workforce	(6) 96.5%	(6) 96.5%	(2) 95.5%	N/A	(0) 100.0%
NIHR R & D Operational	(6) 98.3%	(5) 98.5%	(7) 95.1%	(1) 66.7%	(6) 95.8%
Research Grants Directorate	(3) 95.6%	(3) 95.6%	(2) 95.7%	(0) 100.0%	(2) 95.7%
	(269) 97.3%	**(259) 97.4%**	**(391) 94.6%**	**(181) 89.6%**	**(385) 94.7%**

Safeguarding Training Compliance Rates (Staff Group %)

Staff Group	Safeguarding Adults	Safeguarding Children Lvl 1	Safeguarding Children Lvl 2	Safeguarding Children Lvl 3	Safeguarding Adults Lvl 2
Add Prof Scientific and Technic	(3) 98.9%	(5) 98.2%	(8) 96.2%	(1) 66.7%	(5) 97.6%
Additional Clinical Services	(20) 98.8%	(14) 99.2%	(87) 94.1%	(5) 97.0%	(98) 93.3%
Administrative and Clerical	(43) 97.9%	(38) 98.2%	(12) 90.6%	(3) 66.7%	(11) 91.2%
Allied Health Professionals	(7) 98.7%	(9) 98.4%	(20) 96.4%	(8) 88.2%	(15) 97.3%
Estates and Ancillary	(3) 99.0%	(4) 98.6%	N/A	N/A	N/A
Healthcare Scientists	(7) 98.7%	(5) 99.1%	(8) 94.7%	(0) 100.0%	(10) 93.4%
Medical and Dental	(150) 88.8%	(152) 88.7%	(202) 85.5%	(71) 79.6%	(201) 85.6%
Nursing and Midwifery Registered	(36) 98.9%	(32) 99.0%	(54) 98.4%	(93) 91.8%	(45) 98.7%
Total	**(269) 97.3%**	**(259) 97.4%**	**(391) 94.6%**	**(181) 89.6%**	**(385) 94.7%**

The Trust continues in its endeavours of ensuring the highest possible levels of safeguarding training, thereby ensuring that safeguarding issues are rigorously identified and effectively addressed.

11 Regulatory Bodies

11.1 Care Quality Commission (CQC)

Regulation 13 – Safeguarding service users from abuse and improper treatment

The intention of this regulation is to safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005.

To meet the requirements of this regulation, providers must have a zero tolerance approach to abuse, unlawful discrimination and restraint. This includes:

- neglect
- subjecting people to degrading treatment
- unnecessary or disproportionate restraint
- deprivation of liberty.

In October 2018 the CQC inspected four services at CUH. The inspection team reported that staff were aware of processes and standard procedures to keep people safe from abuse, and received training to assess, recognise and report abuse. They did however recommend that the Trust should ensure medical staff attendance at mental capacity act (MCA) and Deprivation of Liberty Safeguards (DoLS) training is improved to meet the trust target.

11.2 SCPB / Section 11

The Trust continues to be a member of the local safeguarding boards (LSCB/LSAB). The boards seek how to test effectiveness of multiagency arrangements and find ways of improving children's and adults journeys in key local priority areas, including "getting child protection right".

The safeguarding teams continue to work proactively with the LSCB and LSAB to take forward health responses and input to these important agenda items e.g. revision of the domestic abuse policy.

As part of the section 11 audit organisations that provide services to children are asked by LSCB to self-assess the extent to which they meet the standards set out in section 11 of the Children's Act, 2004. The Trust last completed a Section 11 audit in February 2020 and CUH are awaiting all actions and recommendations.

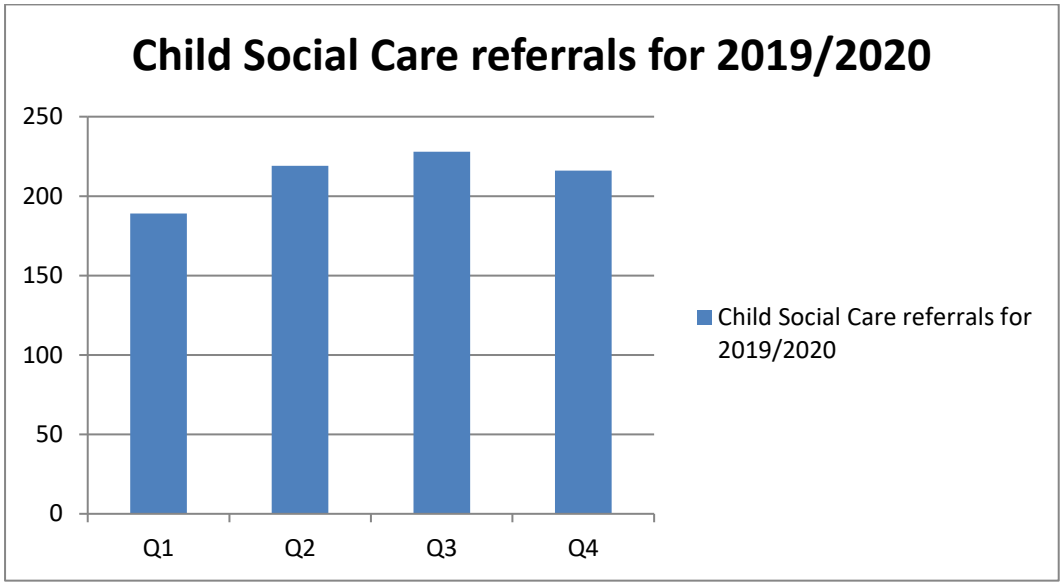
12 Recommendations

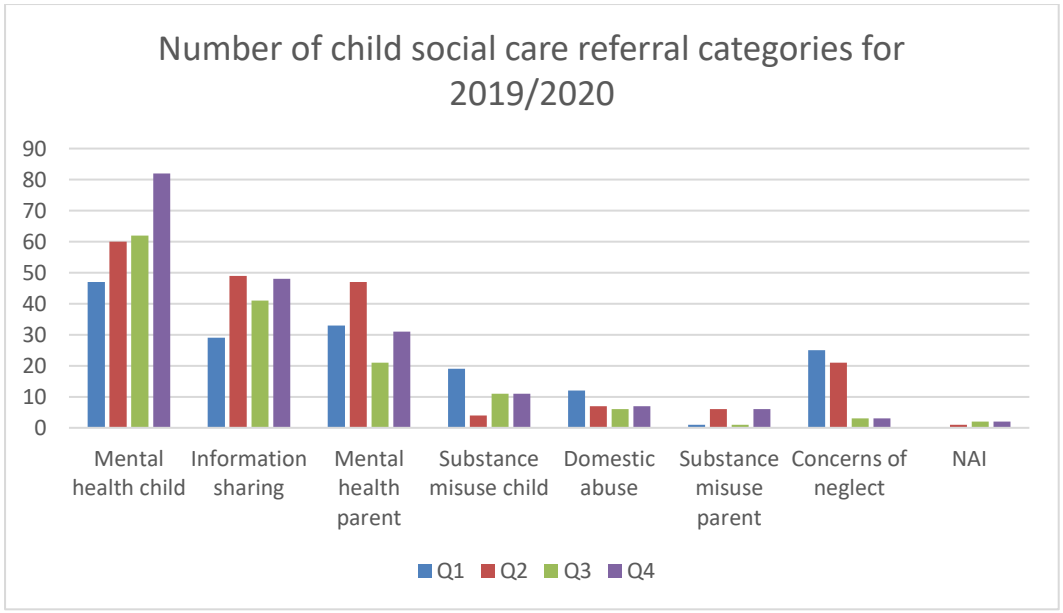
Whilst the annual report provides many examples of the positive and inspiring progress, the safeguarding team are constantly seeking ways to improve how they work together to ensure best outcomes for all those who use our services and that they are at all times protected from abuse.

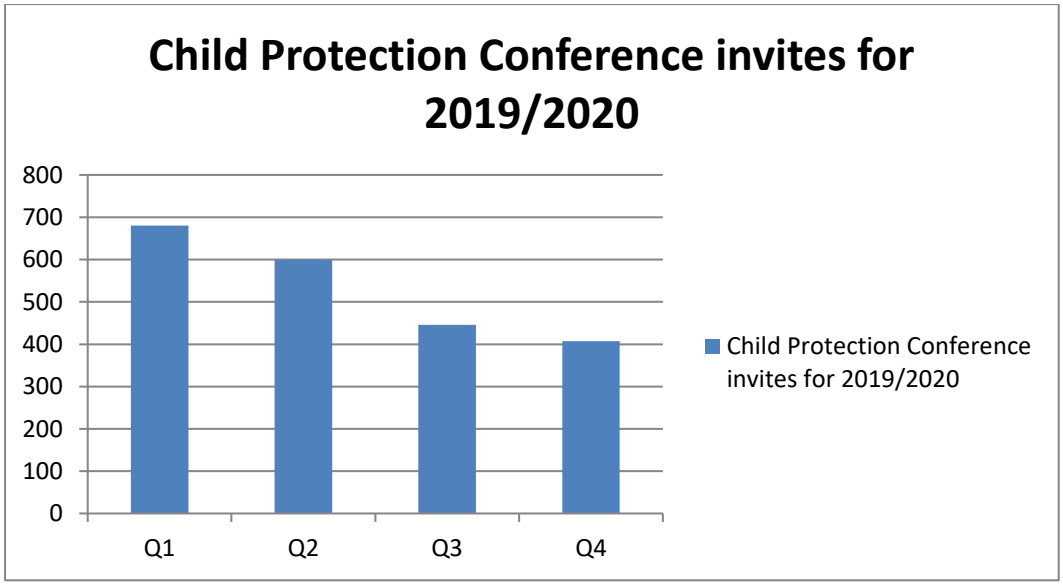
The team in 2020/21 recommends the following areas of work to progress:

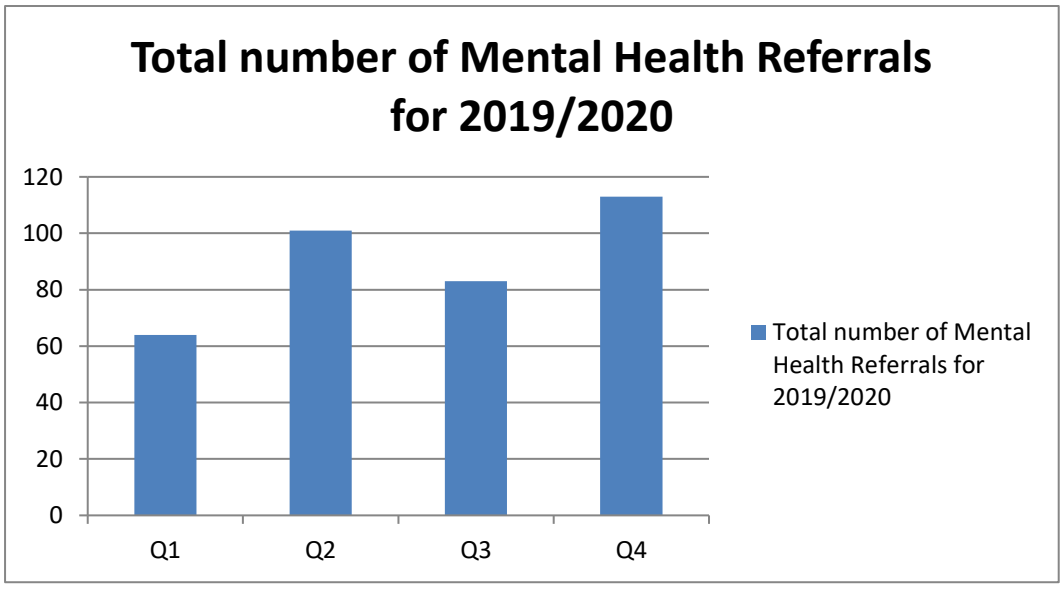
- Ensure systems and processes are in place at CUH to enable effective working in the light of changes to ways of working as a result of the pandemic.
- Review of maternity services safeguarding team.
- Focus on improving staff knowledge and documentation in relation to mental capacity assessment.
- Refresh learning disabilities strategy.
- Proactive review of audit data to understand the safeguarding impact of the pandemic on children, adults and maternity services.

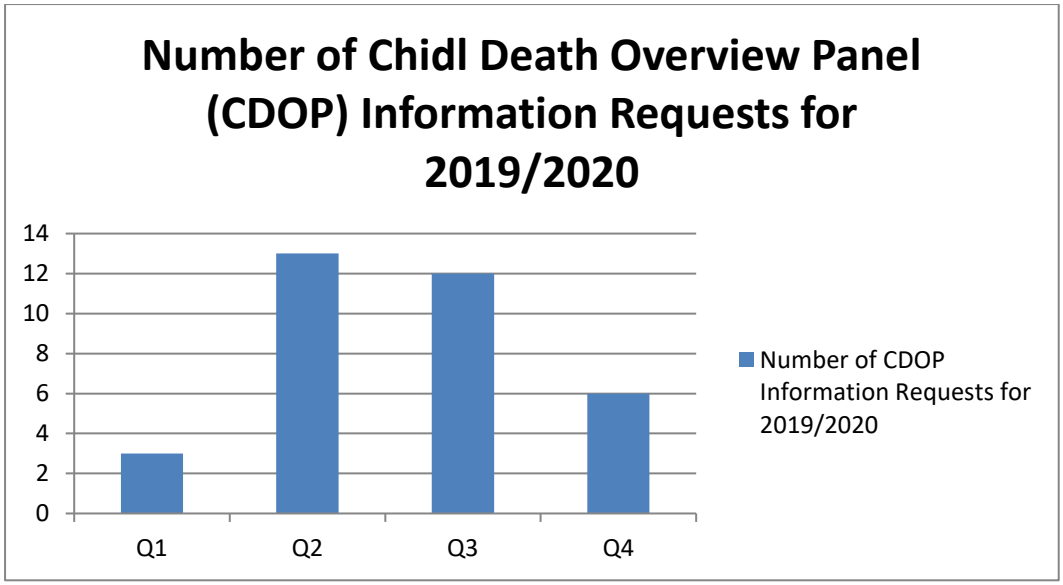
Appendix 1 – Safeguarding Children Activity Data

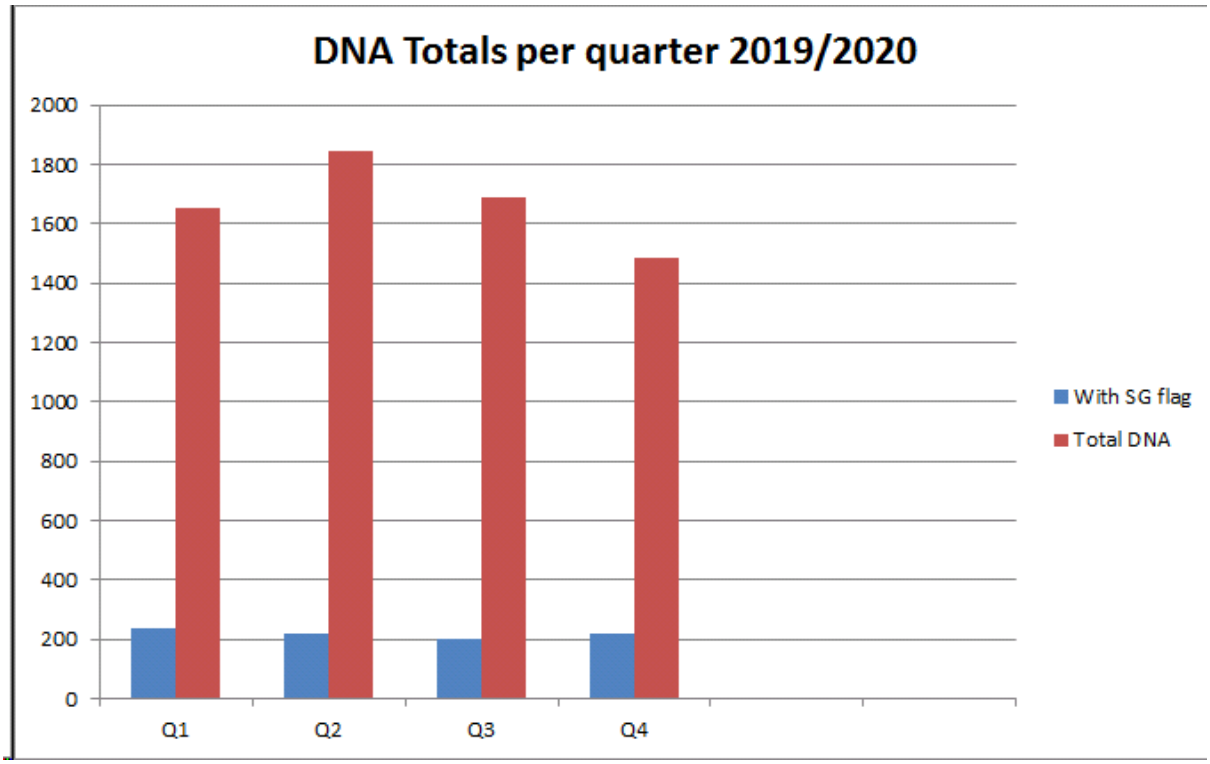


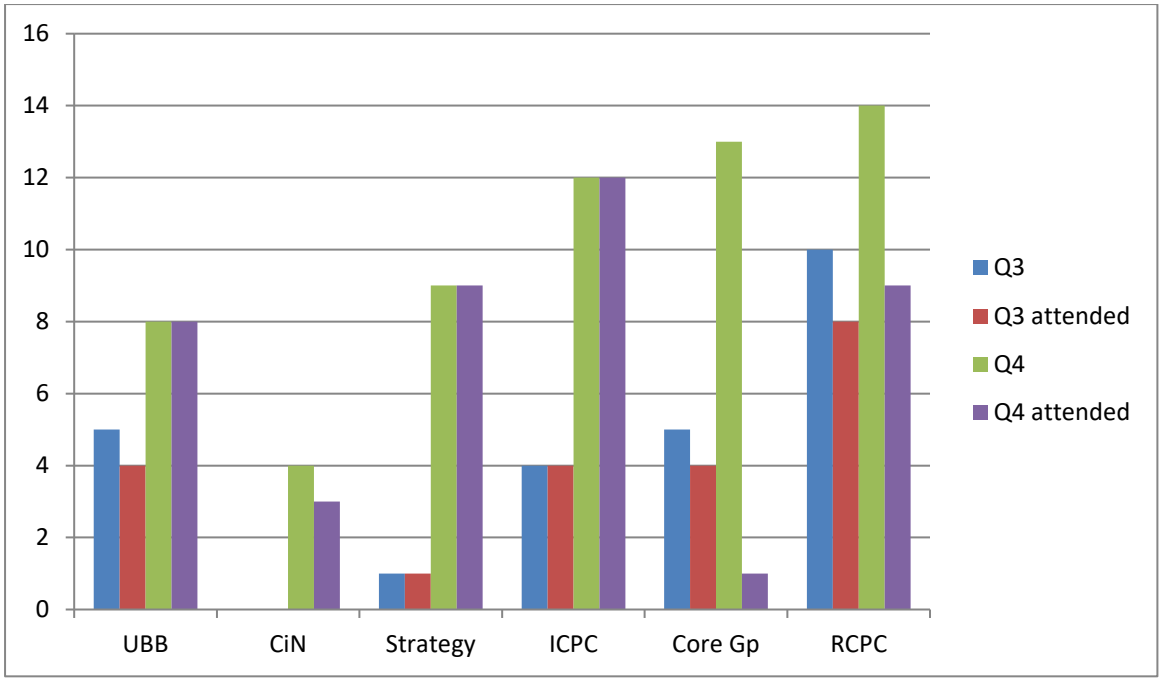



Child Protection Conference invites for 2019/2020
800
700
600
500
400
300
200
100
0
Q1
Q2
Q3
Q4
Child Protection Conference invites for 2019/2020


Total number of Mental Health Referrals for 2019/2020
120
100
80
60
40
20
0
Q1
Q2
Q3
Q4
Total number of Mental Health Referrals for 2019/2020


Number of Chidl Death Overview Panel (CDOP) Information Requests for 2019/2020
14
12
10
8
6
4
2
0
Q1
Q2
Q3
Q4
Number of CDOP Information Requests for 2019/2020


DNA Totals per quarter 2019/2020
2000
1800
1600
1400
1200
1000
800
600
400
200
0
Q1
Q2
Q3
Q4
With SG flag
Total DNA



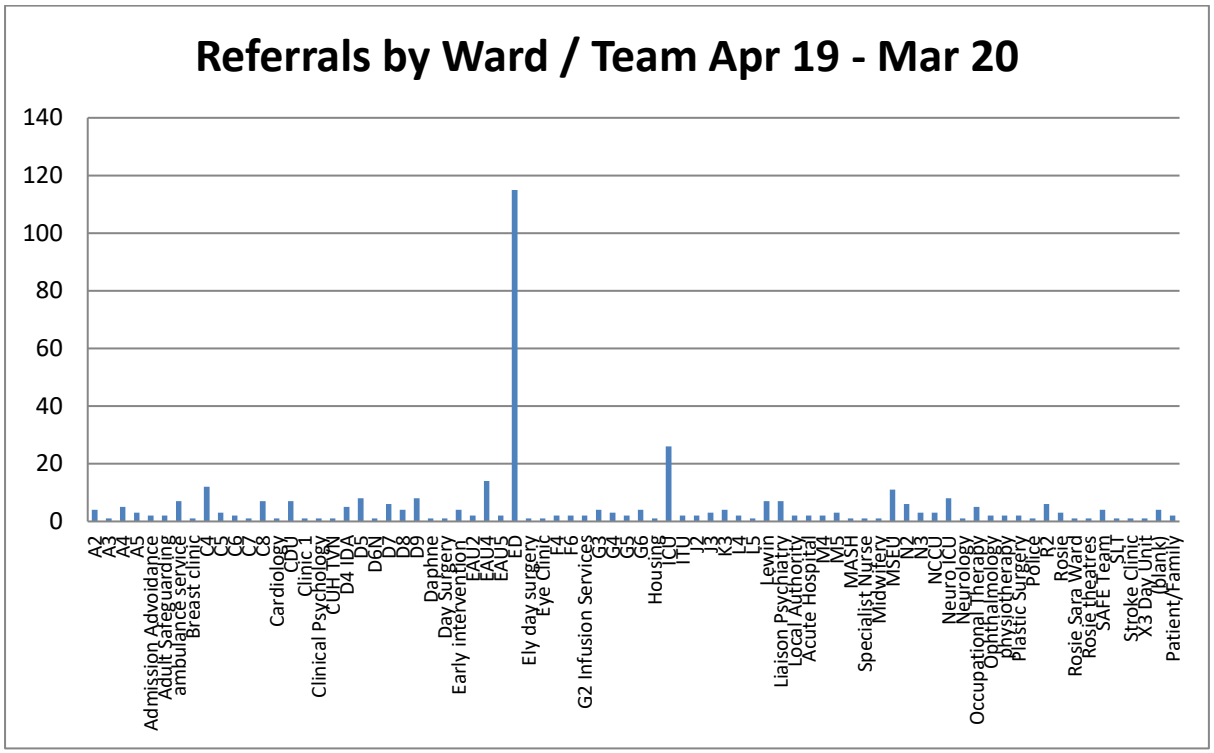
Maternity multiagency meetings, invited and attended Q3/Q4 2019-20

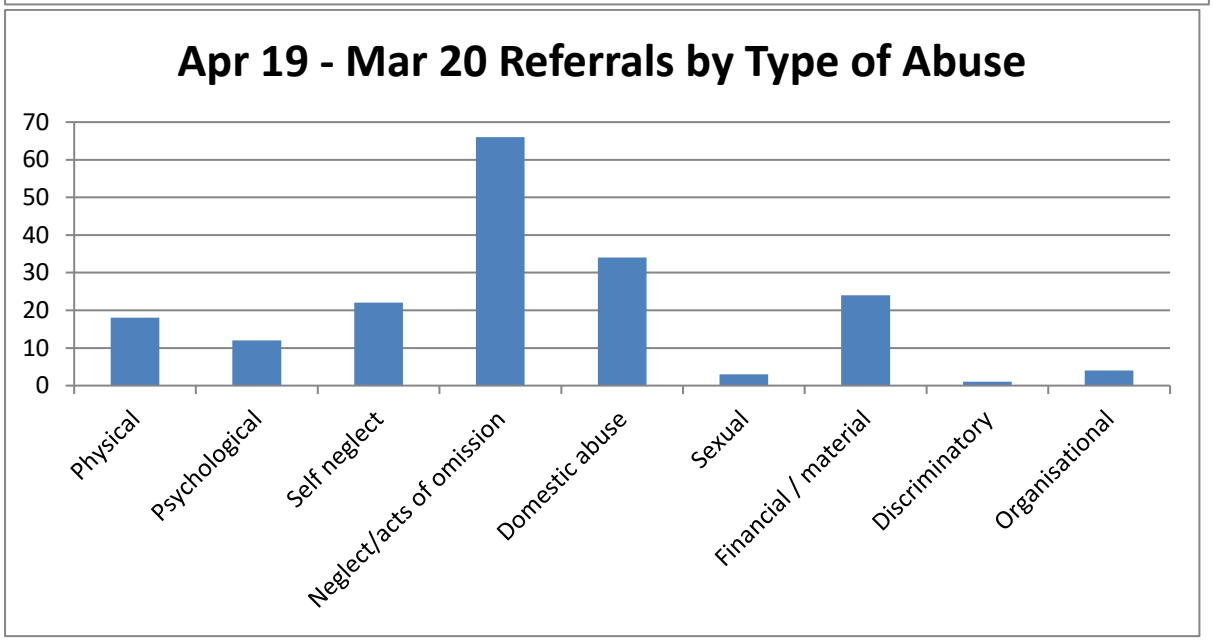
Key: UBB: Unborn baby Panel; CiN; Child in Need; ICPC: Initial Child Protection Conference; RCPC: Review Child Protection Conference.

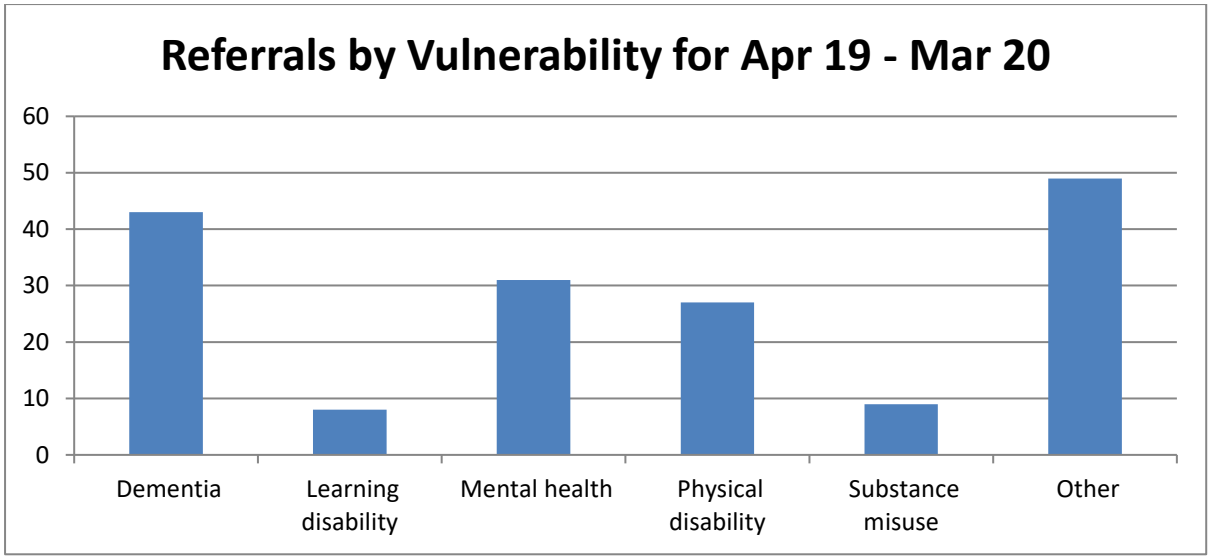
Analysis of data:

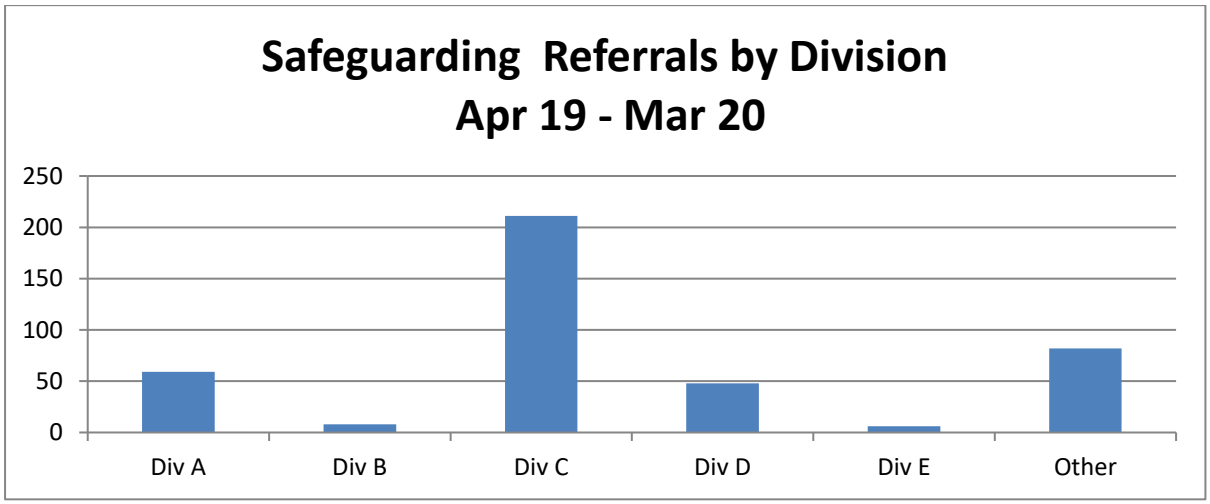
This is incomplete data comprising of Q's 3 and 4 only; data collection was commenced to monitor the maternity safeguarding contribution to multiagency working. Child in Need meetings and Core Groups need not be attended by safeguarding personnel, and are often undertaken by community midwives. RCPC attendance is lower, as many families have been discharged from midwifery care by this time; in 2 cases the family lived out of area. There is excellent attendance at UBB, Strategy meetings and ICPC. Where attendance is not possible, a Report on behalf of CUH was sent in every case.

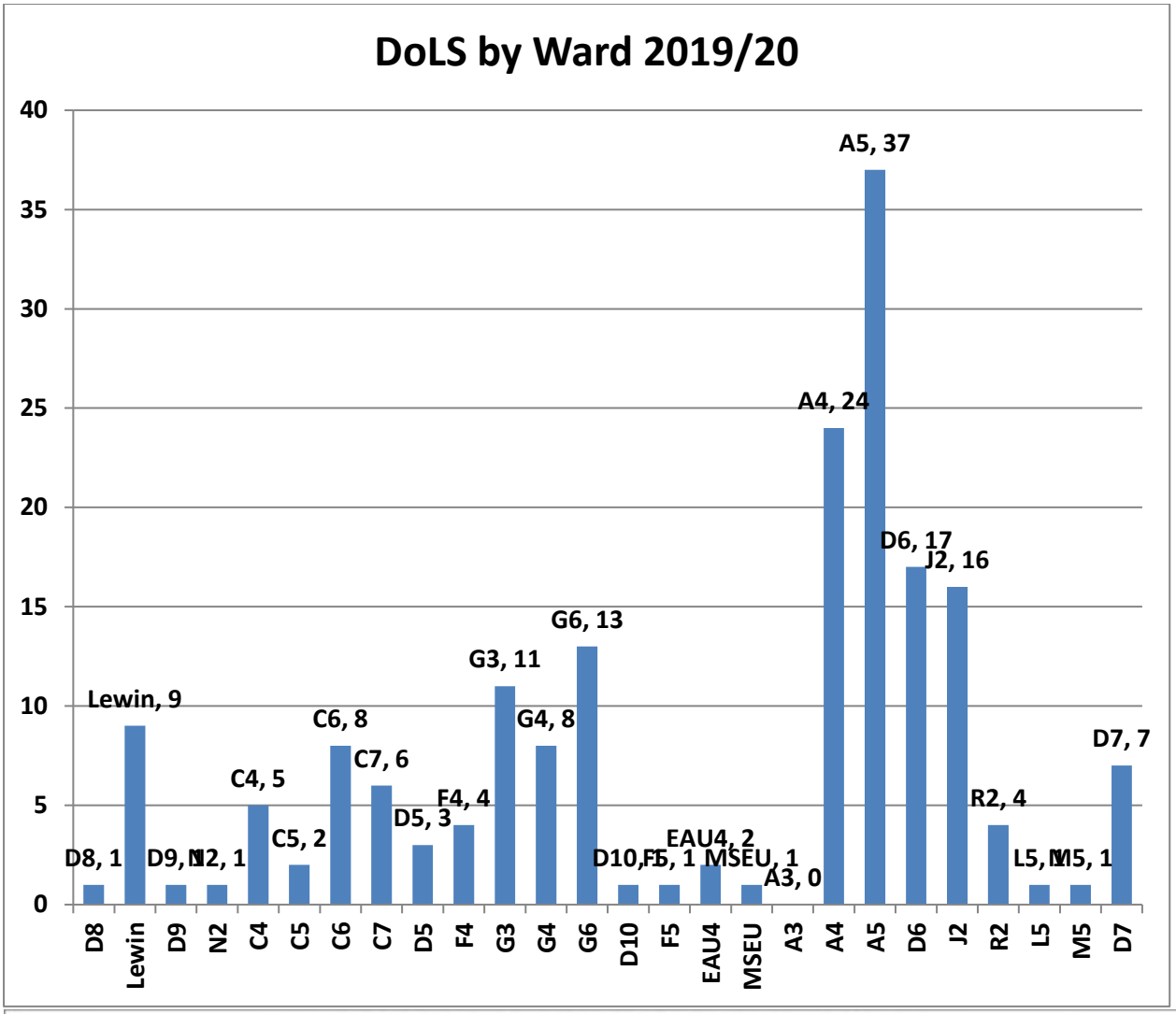
Appendix 2 – Safeguarding Adults Activity Data

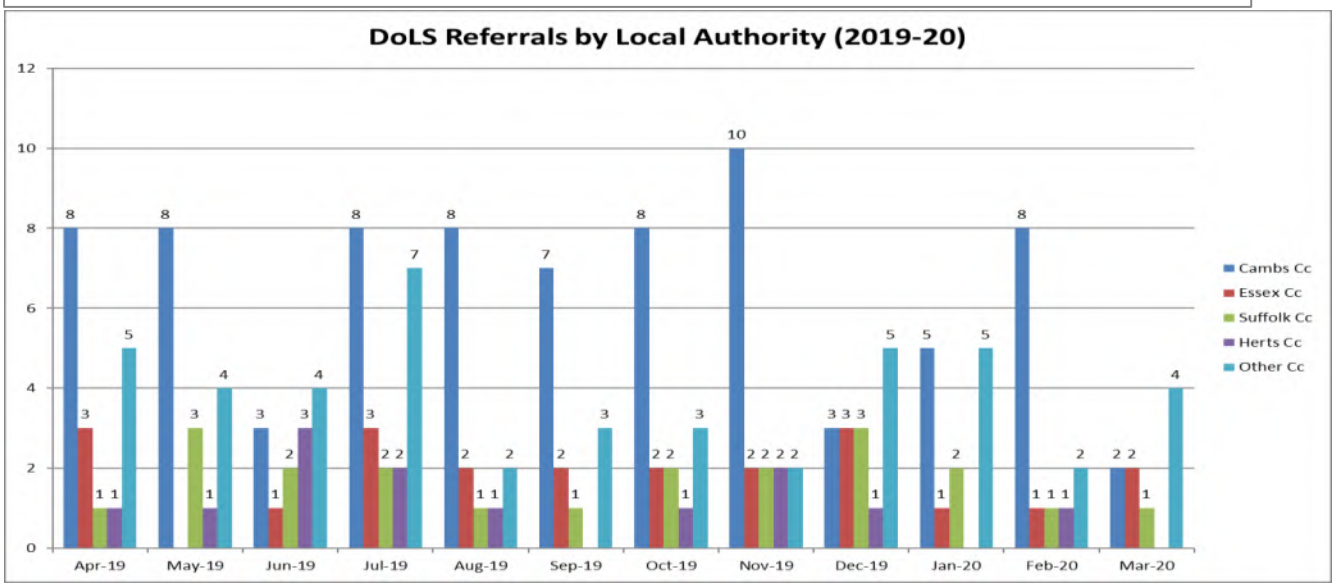


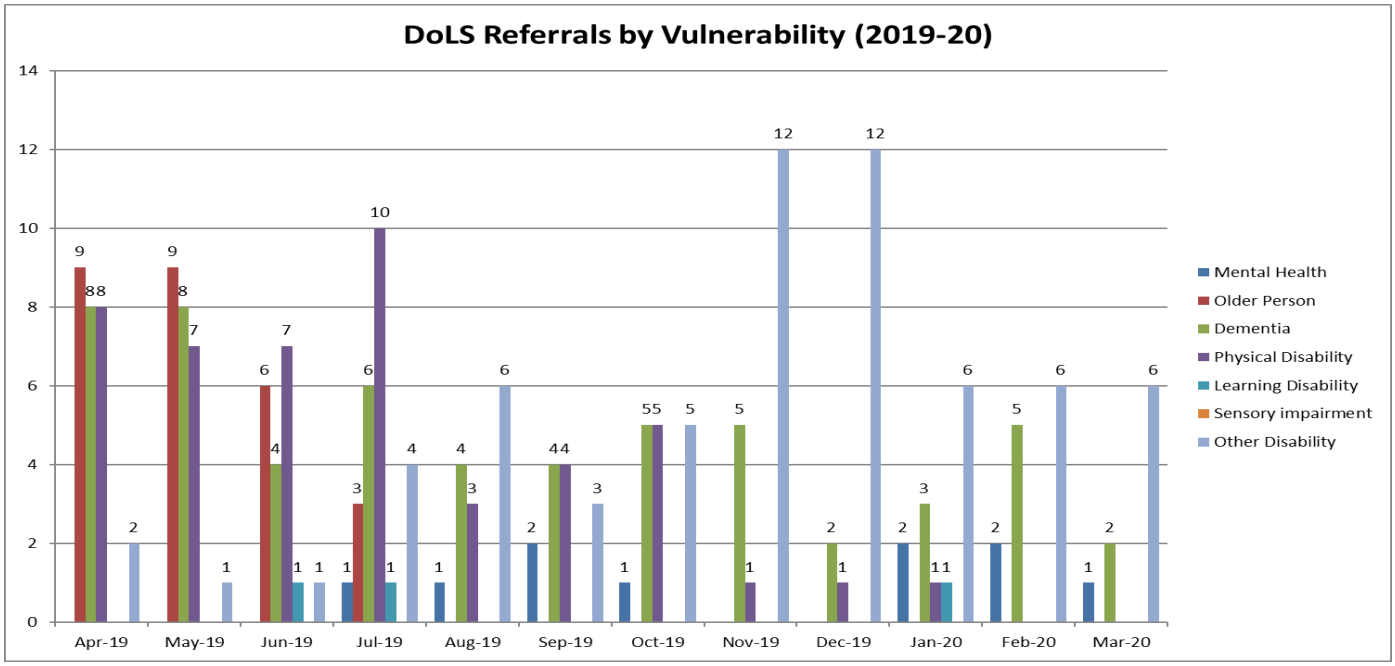



Referrals by Vulnerability for Apr 19 - Mar 20
60
50
40
30
20
10
0
Dementia
Learning disability
Mental health
Physical disability
Substance misuse
Other


Safeguarding Referrals by Division
Apr 19 - Mar 20
250
200
150
100
50
0
Div A
Div B
Div C
Div D
Div E
Other

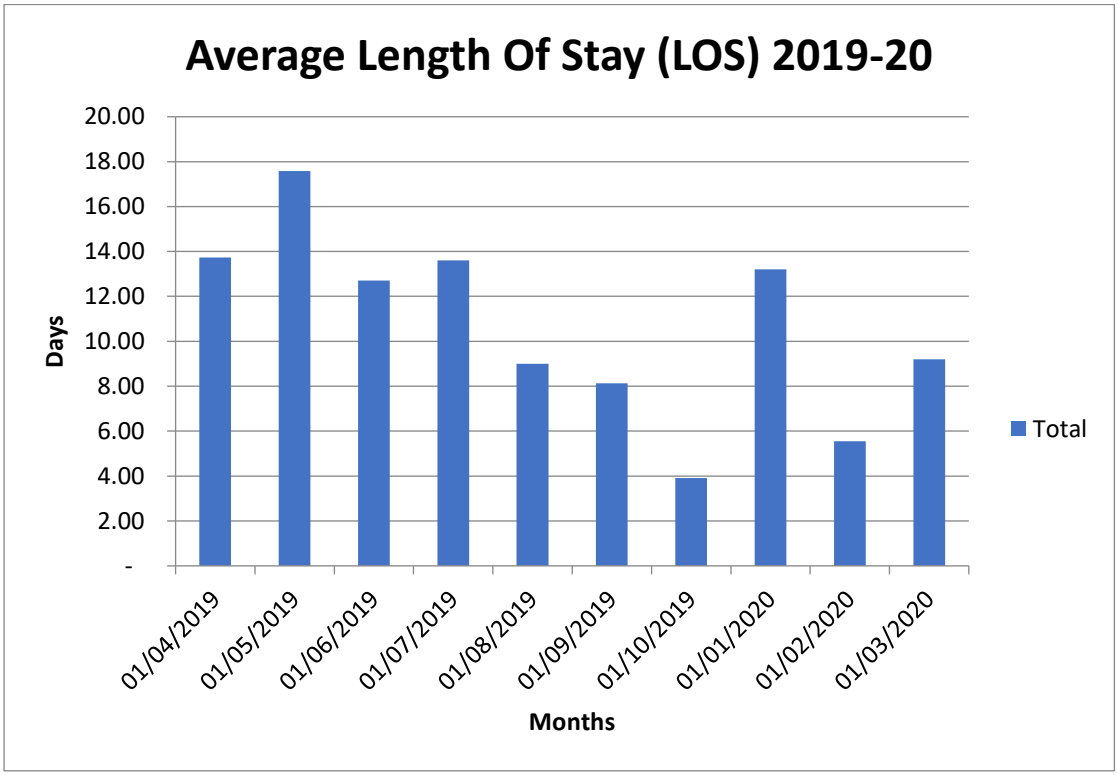

DoLS by Ward 2019/20
40
35
30
25
20
15
10
5
0
D8, 1
Lewin, 9
D9, 1
N2, 1
C4, 5
C5, 2
C6, 8
C7, 6
D5, 3
F4, 4
G3, 11
G4, 8
G6, 13
D10, 1
F5, 1
EAU4, 2
MSEU, 1
A3, 0
A4, 24
A5, 37
D6, 17
J2, 16
R2, 4
L5, 1
M5, 1
D7, 7
D8
Lewin
D9
N2
C4
C5
C6
C7
D5
F4
G3
G4
G6
D10
F5
EAU4
MSEU
A3
A4
A5
D6
J2
R2
L5
M5
D7


DoLS Referrals by Local Authority (2019-20)
12
10
8
6
4
2
0
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Cambs Cc
Essex Cc
Suffolk Cc
Herts Cc
Other Cc

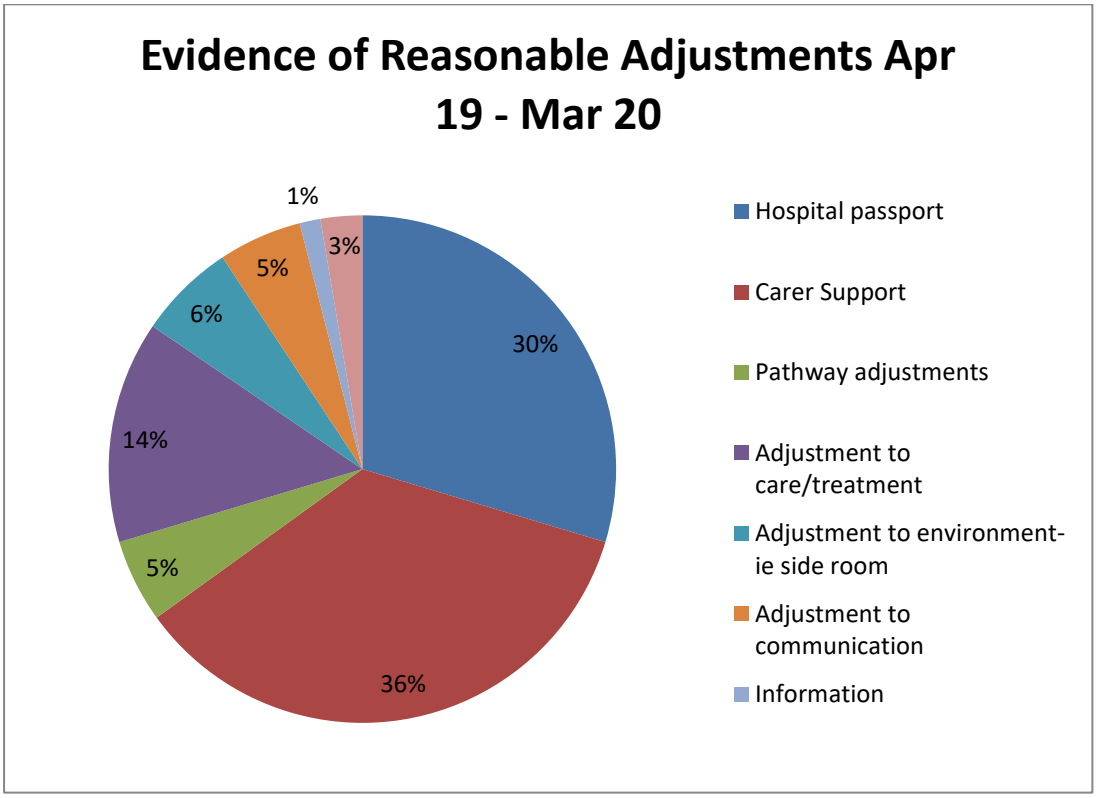

DoLS Referrals by Vulnerability (2019-20)
14
12
10
8
6
4
2
0
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Mental Health
Older Person
Dementia
Physical Disability
Learning Disability
Sensory impairment
Other Disability

Appendix 3 –Adults with Learning Disability and Autism Activity Data

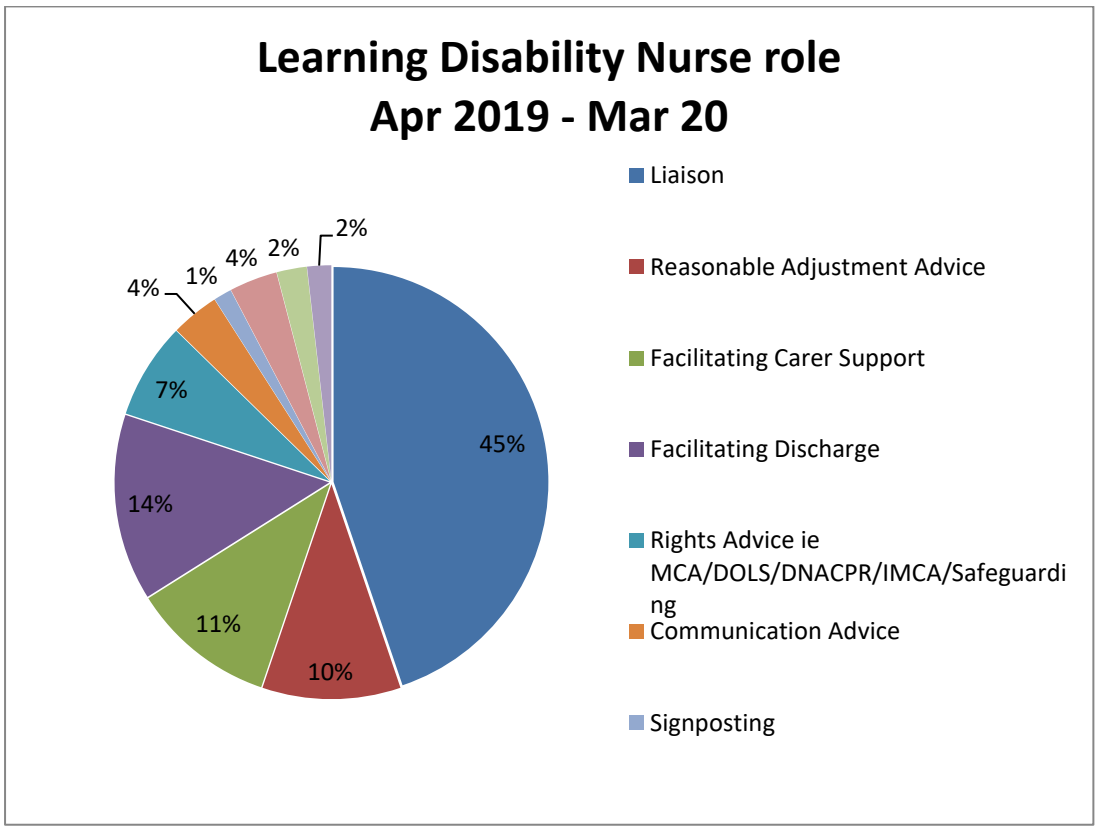
Average Length of Stay for people with Learning Disability and Autism 2019/20



Evidence of Reasonable adjustments offered by staff 2019/20



Role of the Learning Disability Specialist Nurse



Cambridge University Hospitals NHS Foundation Trust

CHAIR'S KEY ISSUES REPORT

ISSUES FOR REFERRAL / ESCALATION

ORIGINATING BOARD / COMMITTEE:	Performance Committee	**DATE OF MEETING:**	1 July 2020
CHAIR:	Adrian Chamberlain	**LEAD EXECUTIVE DIRECTOR:**	COO, CFO, MD
RECEIVING BOARD / COMMITTEE:	Board of Directors, 8 July 2020		

AGENDA ITEM	DETAILS OF ISSUE:	FOR APPROVAL / ESCALATION / ALERT/ ASSURANCE / INFORMATION?	CORPORATE RISK REGISTER / BAF REFERENCE	PAPER ATTACHED (Y/N)
5	**Operational Performance** **<u>Integrated Performance Report</u>** 1. The committee received the Integrated Performance Report for month 2. 2. The committee was advised that the operational performance metrics and targets which had operated prior to the COVID-19 pandemic were currently of more limited value. It was noted that while new performance metrics were being developed, in the interim the majority of the key metrics were based on measuring current performance against the pre-COVID 19 performance. 3. The committee discussed the extent to which the Trust was delivering activity in comparison to pre-COVID 19 levels. It was noted that in some areas the Trust was operating at significantly lower levels of activity due to the impact of COVID-19. 4. The committee welcomed the resumption of endoscopy activity, and acknowledged the complexity which had been overcome to restart this area of activity. 5. The committee received an update on the current levels of outpatient activity and the extent to which this activity was being delivered remotely. 6. The committee acknowledged the current constraints faced by the Trust, but expressed concern regarding the potential impact on patient outcomes and experience due to increased waiting times. It was agreed that the Trust	For information	BAF 002	n/a

	would need to operate collaboratively across the health and social care system to address these challenges. 7. The committee received an update on the number of patients treated for the effects of the COVID-19 by the Trust. 8. The Medical Director updated the committee on staff antibody testing. The committee noted that the Trust was currently delivering 200 staff antibody tests per day. 9. The committee discussed the importance of reaching an appropriate balance in treating COVID-19 and non COVID-19 patients, while protecting staff safety. <u>Workforce</u> 1. The committee received the quarterly update on workforce performance from the Director of Workforce. 2. The committee discussed the likely range of future additional workforce requirements, which would be required to support major projects and the response to COVID-19. The discussion acknowledged that the ability of the Trust to recruit staff may be challenging due to the competitiveness of the employment market. 3. The committee agreed that the Trust and the wider health system may need to further consider developing different roles, or evolving existing roles.			
6	**Finance** **<u>COVID-19 phase 3 recovery</u>** 1. The committee received a jointly produced report from the Chief Operating Officer and Chief Finance Officer regarding the Trust's planning for the recovery phase of the response to COVID-19. 2. The committee discussed the challenges that the Trust was currently facing and was likely to continue to face due to the impact of COVID-19. 3. The committee also reviewed and supported in principle a business case to increase critical care capacity within the Trust, subject to further details being worked up and brought back to the committee.	For information	BAF 010	n/a

	Month 2 Position 1. The committee noted that the Trust had reported a break even position for month 2 of the financial year. However, it was noted that the current financial framework was masking underlying challenges to the financial sustainability of the Trust. 2. The committee noted that COVID-19 had resulted in a significant reduction in the productivity of the Trust, which had a consequential financial impact. 3. The committee noted that the financial framework for the remainder of the 2020/21 financial year was expected to be announced prior to the end of July 2020. Capital 1. The committee noted the update on the capital programme.			
8.	**Infrastructure Update** 1. The Director of Capital, Estates and Facilities Management verbally updated the committee on the current position on key estates issues. 2. The committee welcomed the continued support of Addenbrooke's Charitable Trust (ACT) in enhancing the estate of the Trust.	For information	n/a	n/a
9.	**Board Assurance Framework and Corporate Risk Register** 1. The committee received a report from the Director of Corporate Affairs which outlined the approach taken by the Trust during the Covid-19 pandemic to risk management, and the transition back to business as usual risk management arrangements.	For information	n/a	n/a

NHS
Cambridge University Hospitals
NHS Foundation Trust

CHAIR'S KEY ISSUES REPORT

ISSUES FOR REFERRAL/ESCALATION

ORIGINATING BOARD/ COMMITTEE:	Audit Committee	**DATE OF MEETING:**	17 June 2020
CHAIR:	Daniel Abrams	**LEAD EXECUTIVE DIRECTOR:**	Chief Finance Officer
RECEIVING BOARD/ COMMITTEE:	Board of Directors: 8 July 2020		

AGENDA ITEM	DETAILS OF ISSUE:	FOR APPROVAL / ESCALATION / ALERT/ ASSURANCE / INFORMATION?	CORPORATE RISK REGISTER / BAF REFERENCE	PAPER ATTACHED (Y/N)
5.	**Counter Fraud Annual Report** The committee received the Counter Fraud Annual Report. The committee noted that there had been an increase in the number of referrals to the Local Counter Fraud Specialist during the reporting period. Assurance was provided to the committee that the Local Counter Fraud Specialist had and would continue to work closely with the Trust to revise working protocols to respond to specific issues as they arose. The committee were advised that the annual self-assessment to the NHS Counter Fraud Authority had been submitted ahead of the deadline of 31 May 2020. The committee sought clarification from the Local Counter Fraud Specialist regarding potential areas for future improvement. The committee requested continued focus on the development of financial KPIs to monitor the impact of counter fraud activities within the Trust, and how the Trust compared with similar trusts.	Information	n/a	n/a
6.	**Internal Audit Annual Report** The committee received the annual report of the Internal Auditors. The committee welcomed the positive Head of Internal Audit Opinion, and the continued progress made by the Trust over the past 12 months.	Information	n/a	n/a

	The committee noted that the flexibility within the Internal Audit Plan, had allowed audit resources to be reallocated during the financial year to support the preparations for the CQC inspection. The Internal Auditors advised that that the 2020/21 audit plan was currently being finalised and would be presented to the next meeting of the committee (15 July 2020).			
7.	**Pension Tax – Accounting Treatment** The committee received an update on the accounting treatment for pension tax liabilities. The committee noted that the Trust had received confirmation of the accounting treatment arrangements from regulators for the financial year 2019/20, but that uncertainty remained regarding the arrangements for the current and future financial years. The committee received assurance that the Trust would continue to lobby key stakeholders to minimise the additional administrative requirements on other individual providers.			
8.	**External Audit** The committee received the draft audit clearance report. The External Auditors presented the draft audit opinion including the value for money judgement. In reaching the proposed opinions, the External Auditors highlighted the significant progress made by the Trust over the last 12 months, but also the continued uncertainty regarding the financial framework in which the Trust operates. The committee noted that due to COVID-19 the Trust had received a qualified opinion on inventory, due to the auditors not being able to assess the inventory levels on site due to movement restriction.	Information	n/a	n/a

	The committee noted that the remainder of the audit opinion was true and fair, with the exception of value for money which received an 'except' for opinion. The 'except' for opinion was primarily due to the scale of the Trust deficit and the current absence of a financial plan for 2020/21 which would return the Trust to a break even position. It was also recognised that this was made difficult to achieve in the current year given the move to block contracts and the uncertainty for the remainder of the year after July 2020. The committee congratulated the Chief Finance Officer and his team for the excellent performance in achieving the control total for 2019/20.			
9.	**Annual Report and Accounts** The committee received assurance that the Annual Report and Accounts had been reviewed by the External Auditors, to ensure that all required disclosures were included. The committee reviewed the Annual Report and Accounts and agreed, subject to any further comments following the meeting, to recommend submission to the Board of Directors for approval.	Information	n/a	n/a
10.	**Risk Management** The committee received an update on the risk management arrangements, and specifically the Board Assurance Framework and Corporate Risk Register. The committee noted that while the Risk Oversight Committee had continued to meet during the COVID-19, the risk review processes had been temporarily amended. The committee were advised that the normal risk review processes, were in the process of restarting. The committee were advised that the Board Assurance Framework was in the process of being refreshed and the updated BAf would be presented to the September 2020 meeting of the Board of Directors.	Information	n/a	n/a

	The committee agreed to review the IT resilience risks at the next meeting of the committee.			
11.	**Long term financial plan** The Chief Finance Officer provided a verbal update on the long-term financial plan. The committee welcomed the significant progress made to date in seeking to achieve a sustainable financial outcome for the Trust.			