Council of Governors

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There will be a meeting of the Council of Governors on Wednesday 21 September 2022 at 17.00 in Rooms 8 and 9, Deakin Centre, Addenbrooke's Hospital (*with an opportunity to join remotely for those unable to attend in person*)

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

AGENDA

General Business			Purpose
17.00	**1.***	**Welcome and apologies for absence** Including confirmation of any changes to the composition of the Council of Governors since the previous meeting of the Council	For note
	2.	**Declarations of interest** Copies of the Register of Governors' interests are available from the Trust Secretariat	For note
17.05	**3.***	**Minutes of the previous meeting** To approve the minutes of the meeting held on 29 June 2022	For approval
	4.*	**Council of Governors action tracker and matters arising not covered by other items on the agenda**	For review
17.10	**5.***	**Presentation from the External Auditor** To receive the annual report of the Trust's External Auditor	For receipt
17.25	**6.***	**Chair's Report** To receive the report of the Trust Chair	For receipt

17.35	**7.***	**Chief Executive's Report (including Integrated Performance Report)** To receive the report of the Chief Executive	For receipt
18.10	**8.***	**Governors' Reports** **8.1 Lead Governor** To receive the report of the Lead Governor **8.2 Membership Engagement Strategy Implementation Group** To receive the report of the Membership Engagement Strategy Implementation Group	For receipt
Items for information			**Purpose**
18.25	**9.**	**Any other business** Items of any other business to be identified to the Secretary in advance of the meeting	For note
	10.	**Date of the next meeting** Monday 19 December 2022 at 17.00 (details to be confirmed).	
18.30	**11.**	**Close of meeting**	

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Report to the Council of Governors: 21 September 2022

Agenda item	1
Title	Changes to the Council of Governors since the previous meeting
Sponsoring executive director	Ian Walker, Director of Corporate Affairs
Author(s)	As above
Purpose	To note changes to the composition of the Council of Governors.
Previously considered by	n/a

Executive Summary

Since the previous meeting of the Council of Governors in June 2022, there have been the following changes to the Council of Governors:

1. Ruth Greene (Patient Governor), Melissa Lee (Public Governor) and Howard Sherriff (Patient Governor) were re-elected to the Council of Governors in the 2022 election, and their new three-year terms commenced on 1 July 2022.

2. Mahad Nur was elected as a Staff Governor in the 2022 election, as his first three-year term commenced on 1 July 2022.

3. Bill Davidson (former Staff Governor) was not re-elected to the Council of Governors in the 2022 election and left the Council on 30 June 2022.

4. Under the recent NHS reforms, Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) ceased to exist from 1 July 2022. The CCG's nomination of Jessica Bawden as a Partnership Governor therefore ended on 30 June 2022.

5. At the Council of Governors' meeting on 29 June 2022, it was reported that Dr Rachael Cubberley had been appointed to replace Dr Annette Thomas-Gregory with immediate effect as the Partnership Governor representing Anglia Ruskin University.

6. Cambridgeshire County Council reconfirmed in July 2022 the appointment of Cllr Gerri Bird as their Partnership Governor.

7. Professor John Clarkson has temporarily stood down from the Council of Governors as a University of Cambridge Partnership Governor with effect from 1 September 2022 for a period of 12 months, while he undertakes a sabbatical from his University role. The University of Cambridge has appointed Dame Carol Black as a Partnership Governor until 31 August 2023.

Related Trust objectives	All Trust objectives
Risk and Assurance	n/a
Related Assurance Framework Entries	n/a
Legal / Regulatory / Equality, Diversity & Dignity implications?	The composition of the Council is defined by the Trust Constitution.
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 Council of Governors

The Council of Governors is asked to note the changes to the composition of the Council since the previous meeting.

Composition of the Council of Governors as at 1 September 2022

Public (7)		Patient (8)		Staff (4)		Partnership (10)		
Samira Addo	1st term (2024)	Brian Arney	1st term (2023)	Mahad Nur	1st term (2025)	Peter St George-Hyslop	University of Cambridge	2nd term (Jun 2024)
John Lee Allen	1st term (2024)	Ruth Greene	3rd term (2025)	Polly Rushton-Ray	1st term (2023)	Karen Woodey	Campus Research Organisations	1st term (Jan 2024)
Jane Biddle	2nd term (2023)	Julia Loudon	3rd term (2024)	Gill Shelton	1st term (2024)	Rachael Cubberley	Anglia Ruskin University	1st term (Jun 2025)
David Dean	2nd term (2023)	David Noble	1st term (2024)	William Watson	1st term (2024)	Gerri Bird	Cambridgeshire County Council	2nd term (Jun 2023)
Gemma Downham	1st term (2024)	Colin Roberts	2nd term (2023)	[redacted]		Carol Black	University of Cambridge	1st term (Aug 2023)
Melissa Lee	2nd term (2025)	Howard Sherriff	2nd term (2025)			Mairead Healy	Cambridge City Council	2nd term (May 2023)
Carina Tyrrell	1st term (2023)	Neil Stutchbury	2nd term (2023)			Stephen Webb	Royal Papworth NHS Foundation Trust	1st term (Oct 2023)
[redacted]		Adele White	2nd term (2024)			Stephen Legood	Cambridgeshire and Peterborough NHS Foundation Trust	3rd term (Feb 2024)
						[Vacancy]	[Public health – Cambridgeshire County Council]	-
						-	[nomination of the former Cambridgeshire and Peterborough CCG]	-

The figure in ( ) refers to the end of the current term of office.

1. Terms of service

1.1 All governors are eligible to serve up to nine years in office. The nine years is calculated cumulatively.

1.2 Elected governors may serve single terms of up to three years. Elected governors who are elected for part terms are eligible to serve up to a maximum of nine years, therefore may only be eligible for a reduced length of service in a final term.

1.3 The Council of Governors cannot extend appointments beyond the nine year maximum limit or (for elected governors) individual terms beyond three years.

1.4 The Trust and individual nominating organisations will agree a review cycle which will normally be a maximum of three years between reviews.

1.5 Governors may only hold one governor role at a time, therefore may not be a governor at another trust while being a CUH governor.

2. Vacancy procedure (elected governors)

2.1 In the event of a vacancy arising outside of the normal election cycle, the vacancy will be filled at the next scheduled election unless the number of vacancies will result in one or more of following occurring:

a) The Council of Governors will not be quorate.

b) The number of vacancies in the Public, Patient or Staff Constituency is greater than 50% of the places in the relevant constituency.

2.2 In the event of a) or b) applying, the following will be implemented:

a) Candidates from the last scheduled election who secured at least 10% of the overall number of ballots in the relevant constituency may be co-opted to the Council of Governors until the next scheduled election.

b) In the event of the number of vacancies exceeding the number of potential or actual co-options, and there is greater than six months until the next scheduled election, a by-election will be convened for all current vacancies. The six months shall be calculated from the date of issuing of the formal notice of election. The successful candidates in the election will be elected for the remaining components of the departing governors' terms.

3. Vacancy procedure (partnership governors)

3.1 In the event of a vacancy arising for a partnership governor, the Trust will contact the nominating organisation and seek a new nomination.

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Minutes of the meeting of the Council of Governors held on Wednesday 29 June 2022 at 17.00 via videoconference

Member	Position	Present	Apologies
Dr M More	Trust Chair	X	
Dr S Addo	Public Governor	X	
Dr J Allen	Public Governor	X	
Mr B Arney	Patient Governor	X	
Ms J Bawden	Partnership Governor (Cambridgeshire and Peterborough Clinical Commissioning Group)	X	
Dr J Biddle	Public Governor		X
Cllr G Bird	Partnership Governor (Cambridgeshire County Council)		X
Prof J Clarkson	Partnership Governor (University of Cambridge)	X	
Dr R Cubberley	Partnership Governor (Anglia Ruskin University)	X	
Mr B Davidson	Staff Governor	X	
Mr D Dean	Public Governor	X	
Ms G Downham	Public Governor	X	
Miss R Greene	Patient Governor	X	
Cllr M Healy	Partnership Governor (Cambridge City Council)		X
Ms M Lee	Public Governor	X	
Mr S Legood	Partnership Governor (Cambridgeshire & Peterborough NHS Foundation Trust)	X	
Dr J Loudon	Patient Governor	X	
Mr D Noble	Patient Governor		X
Dr C Roberts	Patient Governor	X	
Ms P Rushton-Ray	Staff Governor	X	
Ms G Shelton	Staff Governor		X
Dr H Sherriff	Patient Governor	X	
Prof P St George Hyslop	Partnership Governor (University of Cambridge)	X	
Dr N Stutchbury	Patient Governor and Lead Governor	X	
Dr C Tyrrell	Public Governor		X
Dr W Watson	Staff Governor		X
Mrs A White	Patient Governor	X	

Dr S Webb	Partnership Governor (Cambridgeshire and Peterborough NHS Foundation Trust)		X
Ms K Woodey	Partnership Governors (Campus Research and Funding Organisations)		X
In attendance			
Ms N Ayton	Chief Operating Officer		
Dr A Doherty	Non-Executive Director		
Prof I Jacobs	Non-Executive Director		
Prof P Maxwell	Regius Professor of Physic		
Mr N Nur	Staff Governor designate		
Prof S Peacock	Non-Executive Director		
Dr A Shaw	Medical Director		
Mr I Walker	Director of Corporate Affairs		
Mr M Whelan	Deputy Trust Secretary		

09/22 Apologies for absence

Apologies for absence received from governors are recorded in the attendance summary.

Apologies were also recorded from Daniel Abrams, Adrian Chamberlain, Ali Layne-Smith and Rohan Sivanandan (Non-Executive Directors) and Roland Sinker (Chief Executive).

The Chair summarised the recent changes to the composition of the Council of Governors:

1. Annette Thomas-Gregory had stepped down as the Anglia Ruskin University (ARU) Partnership Governor with effect from 9 June 2022. Dr Rachael Cubberley, Deputy Head of the School of Allied Health – Clinical Sciences, had been nominated as her replacement and had taken up the role on 29 June 2022. Annette was thanked for her service to the Council of Governors and Rachael was welcomed to her first meeting.
2. Following discussions between the Trust Chair and Cambridgeshire County Council, the County Council had confirmed that it would not be making a nomination to the vacant public health Partnership Governor role. The position would be reviewed by the Trust Constitution Committee at its next meeting.
3. Ruth Greene, Melissa Lee and Howard Sherriff had been re-elected to the Council of Governors in the 2022 elections, with new terms starting on 1 July 2022.
4. Bill Davidson had not been re-elected to the Council of Governors in the 2022 elections and would therefore leave the Council of Governors on 30 June 2022. Mahad Nur had been elected as a Staff Governor and would commence his three-year term of office on 1 July 2022. Bill was thanked for his service to the Council of

Governors and Mahad was welcomed to the meeting which he would be observing ahead of taking up his role.

5. Under the NHS reforms, Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) would cease to exist from 1 July 2022. The CCG's nomination of Jessica Bawden as a Partnership Governor would therefore end at this point. Discussions were currently taking place regarding the potential to agree an alternative nominating organisation. Jessica was thanked for her service to the Council of Governors.
6. Cambridge City Council had confirmed on 26 May 2022 the re-appointment of Cllr Mairead Healy as a Partnership Governor.

The Chair also congratulated Martin Whelan, Deputy Trust Secretary, on his appointed to a role at the Cambridgeshire and Peterborough Integrated Care Board. Martin would be leaving the Trust in early September and was thanked for his support to the Council of Governors over many years.

10/22 Declarations of Interest

No additional interests or changes to previously declared interests were reported.

11/22 Minutes of the Council of Governors

The minutes of the Council of Governors' meeting held in public on 23 March 2022 were approved as an accurate record.

12/22 Action Tracker

Received and noted: the action tracker.

13/22 Chair's Report

Mike More, Trust Chair, reported.

Noted:

1. Jonathan Nicholls, a former Partnership Governor representing the University of Cambridge between 2007 and 2016, had died in March 2022 following an accident. The Chair and Julia Loudon, former Lead Governor, had written to his family on behalf of the Trust and would be attending the forthcoming Memorial Service.

Agreed:

1. To note the report of the Trust Chair.

14/22 Chief Executive's Report (including Integrated Performance Report)

Nicola Ayton, Chief Operating Officer, and Ashley Shaw, Medical Director, reported in the absence of the Chief Executive.

Noted

1. The gradual reduction in the number of Covid-19 positive inpatients in recent months had supported an increase in elective activity.
2. The number of patients waiting over two years for treatment had reduced significantly and the Trust was on track to eliminate 104-week waits over the next few weeks.
3. However, more recently the number of Covid-19 positive inpatients had begun to increase again. The cases were primarily patients admitted for reasons other than Covid-19. Additional Covid-19 capacity had been created which was impacting adversely on the broader operational management of the Trust. Staff absence was also increasing.
4. Due to the increasing number of Covid-19 cases, mandatory wearing of face masks had been reintroduced in clinical areas with effect from 27 June 2022.
5. The number of medically fit patients awaiting domiciliary care was rising.
6. While the Trust was continually seeking to balance of a number of competing risks, and despite the challenges faced by the organisation, there remained a strong commitment to building for the future. Additional bed capacity was planned to become available over the next 12 months, which would provide resilience to the Trust's operational position. Maintaining the momentum with new developments was a key element of engaging positively with staff.
7. The new system governance arrangements would formally commence on 1 July 2022. The Trust was actively working at an Integrated Care Board and Integrated Care Partnership level.
8. The CQC had conducted an unannounced visit on 21 March 2022, as part of a wider system review of urgent and emergency care. The review team had identified a number of examples of excellent care as well as some areas for improvement, none of which were surprises to the Trust. The CQC rating for the safe domain for urgent and emergency care had been reduced to 'requires improvement', in line with the Trust's own self-assessment.

Prior to inviting questions from Governors, the Chair highlighted that the Board recognised the depth and breadth of challenges faced by the Trust in an ongoing pandemic environment. The Chair emphasised the importance of the role of the Council of Governors in monitoring and responding to the mood of the community and the wider public.

The Chair invited the Lead Governor to introduce the questions from Governors:

1. *At the recent Addenbrooke's 3 Committee, Governors learned more about the plans to move Clinic 9 to an offsite location to free up space for emergency patients, but this is unlikely to happen until next year. In the meantime, what plans do the Board have for managing winter pressures and reduce ambulance waits outside A&E?*

Governors were advised that, as part of the overall improvement programme, the Trust was seeking to reorganise processes to maximise efficiency.

The proposed changes to Clinic 9 would increase the capacity for same day emergency care, which would reduce the likelihood of patients requiring admission. Governors noted that the changes would not be in place ahead of the forthcoming winter.

The Winter Steering Group, which would co-ordinate and lead the response to the forthcoming winter, had been established.

2. *Governors noted the reference to the accommodation challenges in the report of the Chief Executive, and sought further information on the response of the Trust to the challenges. Clarification was also requested whether there was a mechanism for property owners, to advertise accommodation including spare rooms as part of the response to the challenges.*

It was acknowledged that the Trust needed to enhance the accommodation support infrastructure provided to staff. Governors recognised that these challenges had been exacerbated by the rising cost of living.

As part of an enhanced support offer, a number of options were being explored including improving the visibility of accommodation offers and the potential development of a dedicated accommodation office.

Governors commented that there was a risk that the goodwill enjoyed by the Trust from the wider public could decrease over time. The meeting acknowledged that the CQC report findings could potentially negatively impact on the reputation of the Trust. Specifically in relation to the Emergency Department, Governors observed that capacity challenges pre-dated Covid-19 (ED). Assurance was provided that addressing the ED challenges was a key priority.

3. *The CEO's report mentions the good progress being made with the implementation of virtual wards. Based on experience so far, and considering the ambition to expand this service from the current 35 beds to 134 by Oct 22 and 294 by Oct 23, what questions are the NEDs asking (and will continue to ask) to assure themselves that this initiative represents a comprehensive and safe service?*

The Chair of Quality Committee reported that the discussions at the Quality Committee to date had focused on the potential patient experience implications of virtual wards.

The following points were noted:

Progress to date

- An operational group chaired by the Director of Improvement and Transformation was in place to oversee the overarching governance. Members included senior leaders from across the organisation and system to ensure rapid and effective decision making.
- Design working groups consisting of clinicians and senior members of the relevant departments, e.g. pharmacy leads, were developing the clinical pathways and supporting infrastructure. This included having robust referral inclusion and exclusion criteria, structured patient reviews and a clear escalation process should the patient require an immediate or urgent review, including an emergency.
- There was a feedback loop between the design working groups and the operational group to ensure that all processes and ways of working gained approval from the latter.

Current plans

- The virtual ward clinical director would be in post from the beginning of July 2022 and the dates for the lead nurse and operations manager starting were currently being agreed; all were currently working in other roles within the Trust.

- Activity in the virtual ward would initially start small to enable clinical teams to test the clinical model and supporting infrastructure to ensure it worked as planned and delivered a safe and robust service for patients. Before going live with the service, mock patients and previous patients, who were now well, would be involved in testing the processes. This approach would enable rapid learning in relation to what worked and where processes needed to be adapted before being implemented on a larger scale.

How safety is being assured

- Management within the virtual ward was being designed to replicate the standard of care on an inpatient ward as far as practicable. For example, pharmacy processes were being designed to rapidly respond to changes in patient medication requirements.
- To further ensure quality and safety of the service, the virtual ward would be underpinned by robust clinical governance. To facilitate this, along with leading the day-to-day running of the service, a virtual ward clinical director, lead nurse and operations manager had been appointed. They would ensure all medical, nursing and operational ways of working and processes met all relevant Trust and professional safety standards and protocols. All appropriate risk assessments would be undertaken, as with any service development.
- A supporting workforce plan was being developed to ensure appropriately skilled and experienced staff were seconded or recruited to deliver a safe and effective service.
- Patients and their carers would input to both the design and implementation of the virtual ward service, to ensure it was safe from a patient's perspective and that patients had a positive experience.

In response, Governors highlighted the benefits of co-production with patients, and questioned whether this had been considered for the development of virtual wards. Confirmation was provided that Healthwatch were involved, although the work was currently at an early stage.

Governors noted that the Trust had a number of long established virtual clinical pathways.

4. *The Trust has worked hard over recent months to assess compliance with the Ockenden Assessment Criteria, and work on this continues. Given the ongoing challenges to staffing in*

midwifery services, how are the NEDs assuring themselves that the care provided for mothers and babies at CUH will never be at risk of the failings identified at some other Trusts, most recently reported at Nottingham?

It was highlighted that quality and safety in Maternity Services was a standing agenda item on every Quality Committee agenda. Actions on improvement plans, Clinical Negligence Scheme for Trusts (CNST) compliance, operational performance and safety metrics were discussed here in full.

It was also highlighted that maternity quality metrics were reported to Board of Directors via the Integrated Performance Report.

Governors noted that Ian Jacobs had been appointed as the Non-Executive Director Maternity Safety Champion, and had planned monthly walk arounds and safety meetings with the teams in all areas of perinatal services, together with a range of informal interactions.

Governors acknowledged that the problems experienced at other centres had been primarily as a result of culture and behavioural issues.

Governors also recognised that there was a national maternity staffing crisis, which was impacting all centres.

The commitment and dedication of maternity staff was emphasised.

5. *Please could we have an update on rest areas for staff; specifically in the geographical outskirts of the hospital building. For example at the Eye Unit, there is only a small staff rest room which is insufficient for the number of staff using it, so some staff just sit on the bottom of a stairwell for their lunch break. This is obviously not ideal for staff or patients.*

In response, assurance was provided that the Trust was actively seeking to improve on-site amenities for staff.

The following points were noted:

- 7 additional outside seating areas had been installed around the site.
- The site was quite constrained at the bus station end of the hospital, and very close to a main site artery road, so it was unlikely that there would be a significant improvement possible in this area, but this would be reviewed again.

- Work would continue to identify areas, where possible, and in the meantime, staff should be encouraged to utilise the additional spaces, and not sit in stairwells.
- There was no longer social distancing in place, so the food court spaces were less constrained (compared to 2 metres social distancing). Seating in the concourse would return after the flooring replacement works were complete.
- Work was ongoing in local amenities with new furniture, and equipment.
- It was recognised that local staff rooms in many areas were small. Staff should be encouraged to stagger breaks to make best use of the space – unfortunately this was a constraint and there was no immediate remedy given the pressure on clinical space.

6. *One of my wife's colleagues recently attended an appointment for an operation at Addenbrooke's. Her husband drove her from Milton Keynes and she was installed safely in a ward awaiting her operation. She had nothing to eat or drink as she was going to have a general anaesthetic. At 1pm the surgeon visited her profusely apologising because he had had to cancel the operation. The theatre was available and correctly staffed; the problem was no bed for her to go to for the overnight stay that was required post the operation. Her husband had to drive back from MK to collect her and now she awaits another appointment without knowing when that might be. This is obviously a poor patient experience, and I would hope that it is an exceptional situation not happening often. However, I would like to know: does Addenbrooke's track the number of operations cancelled on the day and does it know how many of these are cancelled because of bed capacity? Are these numbers worsening as a result of growing pressures on the hospital? There is some data on p21 of the IR, but it isn't clear how "short notice" these cancellations are. What assurances can NEDs give that everything possible is being done to avoid cancelling operations on the day?*

It was recognised that cancellation of appointments and procedures was disruptive and upsetting for patients, and assurance was provided that cancellations were minimised. Governors noted that due to the operational position of the organisation, there was always the possibility that short notice cancellations may be required.

Between March and May 2022 an average of 63 operations were cancelled on the day due to bed pressures. This was lower than the average of 73 per month over the 2021/22 financial year but higher than the average of 35 per month in the same months before Covid-19 (March to May 2019). In June 2022 to date (1-23 June), there were

28 cancellations, suggesting that June would finish at a lower level than recent months.

While the direction of travel was positive, the Trust's aim was never to cancel operations on the day due to bed pressures as it was recognised that these had a significant impact on patients, many of whom had been waiting a long time for their procedure.

Agreed:
1. To note the report of the Chief Executive.

15/22 Governors' Reports

a) Lead Governor

Neil Stutchbury, Lead Governor, reported.

Noted:
1. The Governors' Nomination and Remuneration Committee had recently considered the re-appointment of the Trust Chair. The process followed was detailed in item 16/22.
2. The Cambridgeshire and Peterborough Integrated Care Board had organised a meeting for foundation trust governors on 26 October 2022.
3. Governors had discussed the potential return to face-to-face meetings. While there was enthusiasm for returning to face to face meetings where possible, Governors had expressed some caution on the grounds of safety and inclusion. Further consideration was planned ahead of a final decision.

b) Governor Strategy Group

Neil Stutchbury, Lead Governor, reported.

Noted:
1. The report author had been incorrectly recorded in the paper and should state Neil Stutchbury as the author.
2. Confirmation was provided that the roll-out of the refreshed Trust strategy was planned following the Board of Directors' meeting on 13 July 2022.

Agreed:
1. To note the Governors' reports.

16/22 Re-appointment of the Trust Chair

Neil Stutchbury, Lead Governor, reported.

Noted:

1. The report outlined the process followed by the Council of Governors in considering whether to re-appoint Dr Mike More as the Trust Chair.

The Lead Governor invited the Director of Corporate Affairs to comment on the process followed. Assurance was provided that the governance process followed had been robust and transparent.

Agreed:

1. To note the Council's decision to re-appoint Dr Mike More as Trust Chair from 10 April 2023 to 11 September 2025.
2. To note the Council's decision to amend the Trust Constitution allow a Chair, in exceptional circumstances, to serve on the Board of Directors for a cumulative maximum period of 12 years.
3. To note the details of the exceptional circumstances identified by governors in reaching this decision.
4. To note the process followed in reaching the decision to re-appoint the Chair.

17/22 Any other business

There was no other business.

18/22 Date of the next meeting

The next meeting of the Council of Governors was scheduled for Wednesday 21 September 2022 at 17.00.

Meeting closed: 18.30

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Council of Governors: Action Tracker

Minute	Action	Lead	Target date	Status	RAG rating
There are no outstanding actions					

Council of Governors

Cambridge University Hospitals NHS Foundation Trust

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Report to the Council of Governors: 21 September 2022

Agenda item	5
Title	External Auditor's Annual Report
Sponsoring director	Ian Walker, Director of Corporate Affairs
Author(s)	As above
Purpose	To receive the annual report.
Previously considered by	n/a

Executive Summary

The appointment and re-appointment of the External Auditor is a matter reserved to the Council of Governors. The current external audit provider (Mazars) will attend the meeting on 21 September 2022 to present the Auditor's Annual Report which summarises the work they have undertaken and their findings as the External Auditor for the Trust for the year ended 31 March 2022.

The final Annual Report and Accounts for 2021/22 are available on the Trust website at the following link, and will be formally presented at the Annual Public Meeting on 28 September 2022:

https://www.cuh.nhs.uk/documents/1327/Annual_report__2021-22_Complete_final_version.pdf

Related Trust objectives	All Trust objectives
Risk and Assurance	n/a
Related Assurance Framework Entries	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 Council of Governors

The Council is asked to note the report.

Auditor's Annual Report

Cambridge University Hospital NHS Foundation Trust – year ended 31 March 2022

30 June 2022

mazars

Contents

01

Section 01:

Introduction

1. Introduction

Purpose of the Auditor's Annual Report

Our Auditor's Annual Report (AAR) summarises the work we have undertaken as the auditor for Cambridge University Hospital NHS Foundation Trust ('the Trust') for the year ended 31 March 2022. Although this report is addressed to the Trust, it is designed to be read by a wider audience including members of the public and other external stakeholders.

Our responsibilities are defined by the Local Audit and Accountability Act 2014 and the Code of Audit Practice ('the Code') issued by the National Audit Office ('the NAO'). The remaining sections of the AAR outline how we have discharged these responsibilities and the findings from our work. These are summarised below.

Opinion on the financial statements
We issued our audit report on 22 June 2022. Our opinion on the financial statements was unqualified.

Wider reporting responsibilities
In line with group audit instructions issued by the NAO, on 23 June 2022 we reported that the Trust's consolidation schedules were consistent with the audited financial statements.

Value for Money arrangements
In our audit report issued we reported that we had completed our work on the Trust's arrangements to secure economy, efficiency and effectiveness in its use of resources and had not identified significant weaknesses in those arrangements. Section 3 provides our commentary on the Trust's arrangements.

02

Section 02:

Audit of the financial statements

2. Audit of the financial statements

The scope of our audit and the results of our opinion

Our audit was conducted in accordance with the requirements of the Code, and International Standards on Auditing (ISAs).

The purpose of our audit is to provide reasonable assurance to users that the financial statements are free from material error. We do this by expressing an opinion on whether the statements are prepared, in all material respects, in line with the financial reporting framework applicable to the Trust and whether they give a true and fair view of the Trust's financial position as at 31 March 2022 and of its financial performance for the year then ended. Our audit report, issued on 22 June 2022 gave an unqualified opinion on the financial statements for the year ended 31 March 2022.

03

Section 03:

Our work on Value for Money arrangements

3. VFM arrangements – Overall summary

Approach to Value for Money arrangements work

We are required to consider whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The NAO issues guidance to auditors that underpins the work we are required to carry out and sets out the reporting criteria that we are required to consider. The reporting criteria are:

- **Financial sustainability** - How the Trust plans and manages its resources to ensure it can continue to deliver its services
- **Governance** - How the Trust ensures that it makes informed decisions and properly manages its risks
- **Improving economy, efficiency and effectiveness** - How the Trust uses information about its costs and performance to improve the way it manages and delivers its services

Our work is carried out in three main phases.

Phase 1 - Planning and risk assessment

At the planning stage of the audit, we undertake work so we can understand the arrangements that the Trust has in place under each of the reporting criteria; as part of this work we may identify risks of significant weaknesses in those arrangements.

We obtain our understanding or arrangements for each of the specified reporting criteria using a variety of information sources which may include:

- NAO guidance and supporting information
- Information from internal and external sources including regulators
- Knowledge from previous audits and other audit work undertaken in the year
- Interviews and discussions with staff and directors

Although we describe this work as planning work, we keep our understanding of arrangements under review and update our risk assessment throughout the audit to reflect emerging issues that may suggest there are further risks of significant weaknesses.

Phase 2 - Additional risk-based procedures and evaluation

Where we identify risks of significant weaknesses in arrangements, we design a programme of work to enable us to decide whether there are actual significant weaknesses in arrangements. We use our professional judgement and have regard to guidance issued by the NAO in determining the extent to which an identified weakness is significant.

Phase 3 - Reporting the outcomes of our work and our recommendations

We are required to provide a summary of the work we have undertaken and the judgments we have reached against each of the specified reporting criteria in this Auditor's Annual Report. We do this as part of our Commentary on VFM arrangements which we set out for each criteria later in this section.

We also make recommendations where we identify weaknesses in arrangements or other matters that require attention from the Trust. We refer to two distinct types of recommendation through the remainder of this report:

- **Recommendations arising from significant weaknesses in arrangements**

  We make these recommendations for improvement where we have identified a significant weakness in the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Where such significant weaknesses in arrangements are identified, we report these (and our associated recommendations) at any point during the course of the audit.

- **Other recommendations**

  We make other recommendations when we identify areas for potential improvement or weaknesses in arrangements which we do not consider to be significant but which still require action to be taken

The table on the following page summarises the outcomes of our work against each reporting criteria, including whether we have identified any significant weaknesses in arrangements or made other recommendations.

3. VFM arrangements – Overall summary

Overall summary by reporting criteria

Reporting criteria	2020/21 Actual significant weaknesses identified?	2021/22 Commentary page reference	2021/22 Identified risks of significant weakness?	2021/22 Actual significant weaknesses identified?	2021/22 Other recommendations made?
Financial sustainability	No	10	No	No	No
Governance	No	13	No	No	No
Improving economy, efficiency and effectiveness	No	16	No	No	No

3. VFM arrangements – Financial Sustainability

Overall commentary on the Financial Sustainability reporting criteria

Significant weakness in 2020/21	Nil
Significant weaknesses identified in 2021/22	Nil.

Background to the NHS financing regime in 2021/22

Following the onset of the Covid-19 pandemic in March 2020, the original NHS Planning Guidance 2020/21 was suspended and a new financial regime was implemented. For the second half of the 2020/21 year (October 2020 to March 2021) there was a move to "system envelopes", with funding allocations covering most NHS activity made at the system level, including resources to meet the additional costs of the Covid-19 pandemic. The 2021/22 financial year was also split into two halves, with a different funding regime in each. However, the regimes were largely a continuation of those introduced in 2020/21 in response to COVID-19, where system envelopes and block payment arrangements remained in place.

The 2021/22 H1 (April 2021 to September 2021) envelopes comprised of adjusted CCG allocations, system top-up and COVID-19 fixed allocation, based on the H2 2020/21 envelopes, adjusted for known pressures and policy priorities. The 2021/22 H1 NHS guidance also confirmed that block payment arrangements would remain in place for relationships between NHS commissioners and NHS providers. The guidance for H2 (October 2021 to March 2022) confirmed that the arrangements would stay broadly consistent with a continuation of the H1 framework. The 2021/22 H2 "system envelopes" contained adjusted CCG allocations, system top-up and COVID-19 fixed allocation, based on the H1 2021/22 envelopes adjusted for additional known pressures, such as the impact of pay awards, and increased efficiency requirements.

Over the course of the year and into 2022/23, the focus of the funding regime has shifted from responding to the immediate challenges caused by COVID-19 to supporting recovery in the healthcare system. This has facilitated the need for collaborative working between commissioners and providers, as local systems were expected to work together to deliver a balanced position in 2021/22, with additional funding available for those systems exceeding target activity levels through the Elective Recovery Fund. The planning guidance for 2022/23 supports the transition back to local agreement of contracts, and requires systems to achieve a break even position each year. This will necessitate further collaboration through the planning process, as individual organisations work together to achieve system-level outcomes.

The Trust's financial planning and monitoring arrangements

At the start of the financial year, funding allocations were only known for the first half of 2021/22 (H1). However, the Trust was keen to understand the full extent of financial pressures it faced and therefore, developed plans to cover the full twelve month period of revenue expenditure for 2021/22, based on a number of assumptions on H2 funding. In April 2021, the Trust developed an initial plan for 2021/22 based on a forecast breakeven position. The financial pressure for the Cambridgeshire and Peterborough Sustainability and Transformation Plan (STP) (as it was referred to then) for H1 was reported as £18.4m before mitigations. The Trust agreed a plan to achieve break even for 2021/22.

3. VFM arrangements - Financial Sustainability

Overall commentary on the Financial Sustainability reporting criteria

The Trust's financial planning and monitoring arrangements (continued)

We reviewed the assumptions underpinning the updated plan, the reports prepared for the Board and the minutes of relevant meetings where the updated financial plan was considered. We confirmed the assumptions made by management appeared reasonable, the reports were clear and concise and adequate scrutiny by the Board was evident at the approval meeting.

For 2021/22 the Trust achieved a surplus of £0.1m (surplus £0.1m – 2020/21) before technical accounting adjustments of £14.7m. We have considered the arrangements in place in respect of budget management as part of the Governance criteria on page 12.

During the year the Trust reported its financial position to the Performance Committee and then subsequently to the Board. We reviewed a sample of reports presented for 2021/22, which contain evidence of a clear summary of the Trust's performance, detailing any variances and providing adequate explanation of the causes. The reports also provided an updated forecast to the end of the financial year.

The Trust's arrangements for the identification, management and monitoring of funding gaps and savings

Throughout 2021/22 the Trust continued to work with the Cambridgeshire and Peterborough Integrated Care System (C&PICS) and C&P CCG to mitigate its financial risks and support the wider ICS financial performance and position. Internal reporting to the Performance Committee demonstrate that the Trust has a range of arrangements in place to monitor and manage funding including a close focus on the impact of Covid-19 on productivity (and associated income), progress in earning Elective Recovery Fund income and progress against its Productivity and Efficiency Programme (PEP), previously CIP.

During 2021/22 the Trust targeted the delivery of it's PEP across the following three main areas:

1. Efficiency and productivity savings, i.e. schemes that will help to reduce the current cost base or by growing the margin on other income generation schemes.
2. COVID 19 cost reductions
3. Delivering increased ERF income/cost margin

The Trust also focused on close monitoring and management of its cash position.

Overall responsibilities for financial governance

We have reviewed the Trust's overall governance framework, including Trust Board and Committee Reports, the Annual Governance Statement, and Annual Report and Accounts to confirm the Trust Board has arrangements to meet its responsibility to make the best use of financial resources and deliver the services people need, to standards of safety and quality which are agreed nationally.

We have reviewed reports and minutes of the Performance Committee, confirming there is oversight on divisional and corporate performance, quality of services and financial governance on behalf of the Board. We have reviewed the reports and minutes of the Investment Committee, confirming there is oversight on capital, specific investment decisions and commercial activities. We have reviewed reports and minutes of the Audit Committee, confirming there is oversight on the Trust's internal control and risk management arrangements.

3. VFM arrangements - Financial Sustainability

Overall commentary on the Financial Sustainability reporting criteria

Overall responsibilities for financial governance (continued)

The Trust's business is segmented into Divisions with dedicated finance, clinical and management teams. These Divisions regularly review their services to identify risks and cost pressures. These are considered through Divisional level Performance Review Meetings as well as Executive level oversight forums. Business cases are taken through the Trust's approval processes for new investments which include a dedicated Investment Committee and the Performance Committee and Board of Directors as required. External support in the form of specialist advisory is also contracted from time to time to help the Trust to identify areas where it is either under-investing or over-investing in services in order to bridge the funding gap.

Continued development, support and performance management of Directorates remains critical to delivering good financial (and operational) performance going forward.

The Trust's arrangements and approach to 2022/23 financial planning

We reviewed the Trust's 2022/23 financial plan submitted to NHSE/I in April 2022 and the supporting Board paper. We have discussed these with management and in our view, the Trust's arrangements are adequate.

For 2022/23 the NHS has reverted to contracting arrangements instead of the current block payments system introduced to simplify arrangements during the pandemic. The financial plan submitted in April 2022 showed an I&E deficit of £33.4m, within the overall C&PICS deficit of £76.3m. Like all other NHS providers, the Trust identified inflation and the ongoing impact of Covid-19 as two of the main drivers of cost pressure at £17.6m and £15.8m respectively. The April plan also included ERF of £30m and targeted efficiency improvements of around £52m which was in line with the thresholds set out in the planning guidance. Although specific areas of planned saving had not been firmed up it was expected that the risks could be managed non-recurrently through cost control and reserves.

In respect of capital, in common with the rest of the NHS, the Trust has found the capital funding outlook for 2022/23 to be considerably tougher than 2021/22, with a reduction in it's share of the C&PICS funds to £32.2m from £42.7m the previous year. In May, the Trust had identified that in-year demand for capital exceeded the funding available by £19.7m. The Trust's Capital Advisory Board is making some initial prioritisation decisions to allow certain key schemes to continue to progress.

NHSE/I required that all 2022/23 plans be resubmitted by 20 June 2022 and offered ICSs additional funding to help broker breakeven positions in local plans. Nationally an additional £1.5bn was provided with C&PICS offered £29.8m, with the Trust's share as £11.9m. The Trust worked with its ICS colleagues and internally to update its planning and the Trust's resubmitted plan shows a break even target for 2022/23. The final plan shows that the efficiency improvement target for the year has increased to £62m, with £47.6m expected to be recurrent (£46.3m in the original plan).

The creation of the statutory ICS from July 2022, along with the introduction of new financial/contracting arrangements, will lead to the need for, and opportunity to, develop more medium-term financial and operational plans. The Trust will continue to work with the ICS, to shape new management arrangements and deliver improved service configurations in the coming years. The Trust is expected to respond to national requirements whilst endeavouring to work with patients and the public to deliver good services within available resources.

Overall, we are satisfied that there are no indications of a significant weakness in arrangements under the Financial Sustainability criteria.

3. VFM arrangements – Governance

Overall commentary on the Governance reporting criteria

Significant weakness in 2020/21	Nil
Significant weaknesses identified in 2021/22	Nil.

The Trust's risk management and monitoring arrangements

The Trust has a comprehensive risk management system in place which is embedded into the governance structure of the organisation. The processes are supported by the Trust-wide Risk Management Framework and the Trust leadership plays a key role in implementing and monitoring the risk management process.

Ultimate responsibility sits with the Board of Directors and its assurance committees, including the Audit Committee which has a specific remit to oversee the system of internal controls in place to manage risks, including in relation to fraud. The Board tracks the principal risks to the achievement of its strategic objectives through the Board Assurance Framework which it, and its sub-committees, review on a regular basis. More operational risks are overseen through review of the Corporate Risk Register (CRR).

An independent Non-Executive Director chairs the Audit Committee. At Executive level, the Chief Executive chairs a monthly Risk Oversight Committee meeting which is attended by all members of the Management Executive. The Accountability Framework describes the relationship between the Board, the Management Executive and the Clinical Divisions in terms of reviewing performance and monitoring and assessing risk.

At an operational level, responsibility rests with each Divisional Director, supported by the Associate Director of Operations and Head of Nursing, for clinical divisions; and with each Executive Director for the corporate directorates. Divisional 'red-rated' risks are reviewed at divisional Performance Meetings with members of the Executive Team.

We have reviewed minutes of Board meetings and confirmed detailed discussion and challenge has taken place on high level risks. The risks are clearly linked to the Strategic Objective of the Trust and are cross-referred to the Board Assurance Framework, providing a thread from operational to strategic risk management. The minutes include an action tracker allowing for timely monitoring of risks. This is supported by a schedule of CRR discussions at Risk Oversight Committee .

In order to provide assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud, the Trust has appointed internal auditors and local counter fraud specialists. Work plans are agreed with management at the start of the financial year and reviewed by Audit Committee prior to final approval.

We have reviewed the Internal Audit Plans for 2021/22 and 2022/23. Progress reports are presented to each Audit Committee meeting including follow up reporting of recommendations not fully implemented by agreed due dates. This allows the Committee to effectively hold management to account on behalf of the Board. Attendance at Audit Committees throughout the period confirms the significance placed on internal audit findings. Members of the committee actively request management attendance at committees to discuss findings from internal audit reports.

3. VFM arrangements – Governance

Overall commentary on the Governance reporting criteria

The Trust's arrangements for budget setting and budgetary control

Directorate Budgets are an end point in the Financial Planning process which is a bottom-up process built on Directorate submissions. Financial Planning assumptions (reflecting the agreed Budget Setting Methodology) are built into the Business Planning Pack. This process is undertaken as part of the wider business planning process for the Trust. This ensures that the wider plans are fully triangulated.

The Financial Plan is developed to reflect the best available information and assumptions including funding growth, inflation costs, cost pressures, activity levels, efficiency plans and service priorities. The process itself is run by the Trust finance team working closely with divisional teams and the wider C&PICS. Plans are reviewed in the Management Executive meeting in the first instance and then with the Non-Executive Directors through the Performance Committee and Board Meetings.

Monthly budget and financial monitoring reports are produced both at Directorate and Corporate level.

Finance Managers work with Directorate Teams and Budget Holders to ensure that budget variances are explained and appropriate corrective action taken, or concerns escalated where corrective action will not cover the entire variance. Directorates produce monthly Performance Committee which explains the key aspects of their financial position. Through the Trust's Performance Committee, unsatisfactory performance is raised with Directorates such that appropriate corrective action is taken.

As set out in the previous section the financial position is reported to Trust Board each meeting and includes sufficient detail to allow for effective review and challenge at the senior leadership level. We have reviewed Board minutes and supporting papers to confirm this.

The Trust's decision making arrangements and control framework

The Trust has an established governance structure in place which is set out within its Annual Governance Statement. This is supported by the Trust's Constitution and scheme of delegation. Executive Directors have clear responsibilities linked to their roles and the Board Committee structure in place at the Trust allows for effective oversight of the Trust's operations and activity.

Clinical divisions and corporate directorates regularly review their services and key risks. Performance data covering workforce, quality and safety, operational delivery and access standards are reviewed by Divisional Boards and at monthly Performance Review meetings with the Executive Team. Actions are assigned to correct performance and address issues as required. There is a clear Executive committee structure with exception reporting to the Management Executive.

The following Board assurance committees are in place to provide oversight and assurance to the Board of Directors: Audit, Performance, Quality and Workforce and Education. Board and committee minutes demonstrate effective challenge. In recognition of the significant capital works that will take place at the Trust in the coming years, a Hospital Redevelopment Committee for 'Addenbrookes 3' was set up during 2020/21. This committee has both executive and non-executive members.

The Trust promotes a culture of openness and challenge to support good decision making and early identification of concerns. There is a well-established Freedom to Speak Up service and a range of mechanisms for raising concern.

In line with NHSE guidance, the Trust's standard policy requires all staff to declare interests, including offers of gifts and hospitality. The Trust maintains and promotes the completion of a register of Interests that also encompasses declarations of hospitality and gifts. This is monitored to ensure appropriate behaviours are being maintained. Directors are subject to annual fit and proper person declarations.

3. VFM arrangements – Governance

Overall commentary on the Governance reporting criteria

The Trust's decision making arrangements and control framework (continued)

Lead Executive Directors have responsibility for tracking compliance with legislative and regulatory requirements and reporting to the Management Executive and the Board of Directors accordingly.

The Trust has a full suite of governance arrangements in place. These are set out in the Trust's Annual Report and Annual Governance Statement. We reviewed these documents as part of our audit and confirmed they were consistent with our understanding of the Trust's arrangements, in place and operating. This includes arrangements such as registers of interests being maintained and published and the Board completing an annual review and self certification of its compliance with the conditions of the NHS provider licence.

The Trust regularly reviews its financial governance framework to ensure that it meets the needs of the organisation whilst providing good financial governance.

Overall, we are satisfied that there are no indications of a significant weakness in arrangements under the Governance criteria.

3. VFM arrangements – Improving Economy, Efficiency and Effectiveness

Overall commentary on the Improving Economy, Efficiency and Effectiveness reporting criteria

Significant weakness in 2020/21	Nil
Significant weaknesses identified in 2021/22	Nil.

The Trust's arrangements for assessing performance and evaluating service delivery

Arrangements are in place to review services against relevant performance and quality metrics through the clinical service, directorate and divisional structures. Monthly Performance Review meetings take place between each Clinical Division and the Executive Team, with issues escalated as required to the Management Executive. As well as internal performance data, evidence on performance is provided through patient surveys and feedback, internal and external audits, external accreditation and inspection visits, etc.

Performance information is presented to the Performance Committee on a regular basis. In 2021/22 the Performance Committee has received a wide range of performance related reports. The Committee has continued to pay particular focus to the impact of the COVID-19 pandemic on performance and has also focused its attention on changes arising from the formation of the statutory ICS on 1 July 2022 including the impact of the Trust's role as host of the South Integrated Care Partnership. We have reviewed the performance information provided to the Committee and can confirm that the Committee effectively holds managers to account where performance improvements are required.

The Trust continues to work closely with the Institute for Health Improvement on embedding a culture of sustainable continuous improvement. Key areas of focus include implementing an improvement methodology for the implementation of virtual wards and building improvement capability and capacity across our its 11,000 staff.

The Trust continues at pace with plans for two new hospitals, the Cambridge Children's Hospital (in partnership with Cambridgeshire & Peterborough NHS Foundation Trust and the University of Cambridge) and the Cambridge Cancer Research Hospital (in partnership with the University of Cambridge), both of which will create state-of the art facilities from which the Trust plans to provide patient care and cutting edge research. These two schemes are included within the 'New Hospitals Programme' (within the 13 first wave schemes) and both include plans to secure significant amounts of external (non-NHS) funding, thereby increasing the value obtained by the Trust. These partnership projects are separate from the 'Addenbrookes 3' project, being undertaken by the Trust. Separately to these major projects, the Trust is developing plans to expand this capacity further to support its recovery planning.

The Trust's arrangements for effective partnership working

Partnership working is wholly embraced at the Trust, given its location on the Cambridge Biomedical Campus. The Trust is working with Cambridge University Health Partners (CUHP) and other partners to support the next phase of the development for the Campus through a new company and engagement with partners across Greater Cambridgeshire and Peterborough and on a strategy for improving use of date across the partnership.

The Trust is engaged with partner organisations in the local health and care system in discussing quality and risk issues impacting on patients, in particular through the work of the Cambridgeshire and Peterborough Integrated Care System, which serves a population of 1 million people with a health and social care spend of over £1.5 billion.

3. VFM arrangements – Improving Economy, Efficiency and Effectiveness

Overall commentary on the Improving Economy, Efficiency and Effectiveness reporting criteria

The Trust's arrangements for effective partnership working (continued)

The Trust continues to work with six other trusts across the East of England, and the NHSE/I East of England teams, to develop a Specialised Provider Collaborative.

Given the focus on system wide solutions the Trust has increasingly had to work with partner organisations across the Cambridgeshire & Peterborough System to deliver a sustainable financial position for the wider area in addition to overseeing the Trust's financial sustainability.

The Trust's arrangements for commissioning services

The Trust follows normal procurement policies and processes, overseen by professionals in this area. There will be a robust specification and a process to ensure that the selected option/ supplier gives best value for money. Use of legally compliant Framework Agreements with agreed discounts to purchase goods and services. The Scheme of Delegation sets out the various levels for approval of expenditure. The lead manager, who is responsible for ensuring that the procured service is delivered. Post Project Evaluations are required in some cases.

Overall, we are satisfied that there are no indications of a significant weakness in arrangements under the improving economy, efficiency and effectiveness criteria.

04

Section 04:

Other reporting responsibilities and our fees

4. Other reporting responsibilities and our fees

Matters we report by exception

The Local Audit and Accountability Act 2014 provide auditors with specific powers where matters come to our attention that, in their judgement, require specific reporting action to be taken. Auditors have the power to:

- issue a report in the public interest;
- make a referral to the Secretary of State; and
- make a written recommendation to the Trust which must be responded to publicly.

We have not exercised any of these statutory reporting powers.

Annual Governance Statement

We are also required to report if, in our opinion, the governance statement does not comply with relevant guidance or is inconsistent with our knowledge and understanding of the Trust. We did not identify any matters to report in this regard.

Reporting to the NAO in respect of consolidation data

The NAO, as group auditor, requires us to report to them whether consolidation data that the Trust has submitted is consistent with the audited financial statements. We have concluded and reported that the consolidation data is consistent with the audited financial statements.

Fees for work as the Trust's auditor

We reported our proposed fee for the delivery of our work under the Code of Audit Practice (£93,770 plus VAT) in our Audit Strategy Memorandum presented to the Audit Committee. In our Audit Completion Report we highlighted areas of additional work and confirm the final fees we have agreed with the Chief Financial Officer.

	2020/21 Final fee (£)	2021/22 Proposed Fee (£)	2021/22 Final fee (£)
Initial agreed fee	59,000	93,770	93,770
Increase to base from change in scope of NAO Code	8,850	-	-
Additional fees arising from additional work: - IFRS 16 preparation - Sensyne transaction - Year end deployment of funds - New provisions - WGA sampled	-	TBC	11,500
Total	67,850	TBC	105,270

Fees for other work

We confirm that we have not undertaken any non-audit services for the Trust in the year.

Suresh Patel, Partner

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Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Council of Governors: 21 September 2022

Agenda item	6
Title	Chair's Report
Sponsoring director	Mike More, Trust Chair
Author(s)	As above
Purpose	To receive the Chair's 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
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 Council of Governors

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

Cambridge University Hospitals NHS Foundation Trust

21 September 2022

Council of Governors
Chair's Report
Mike More, Trust Chair

1. Introduction

1.1 We were all deeply saddened by the death of Her Majesty Queen Elizabeth II on 8 September 2022. We had the pleasure of welcoming The Queen to our hospitals on a number of occasions and she was with us to celebrate some of the most important moments in our history – opening Addenbrooke's Hospital in 1962 and returning to the Cambridge Biomedical Campus in 2013 to open the new Rosie Hospital. We will remember with great fondness her long-lasting contributions to this country. Arrangements have been put in place to support staff and patients to pay their respects and offer their condolences. Significant work is also being undertaken to re-plan clinical activity for the day of the state funeral and bank holiday.

1.2 Liz Truss was appointed Prime Minister on 6 September 2022. By the time the Council meets, we can expect that the Prime Minister will already have made some announcements on how the Government will tackle the sharp escalation in energy prices, which is a major driver in the cost of living crisis. The challenges facing the new Prime Minister are immense.

1.3 The challenges facing the NHS and Social Care systems are well known and well documented. They have preoccupied us as a Board over recent years and months. As many have remarked, the pressures on the system over the summer are of a magnitude consistent with a "normal" winter and with baseline metrics in terms of waiting lists which are still recovering from the Covid pandemic. Part of the challenge for the NHS is that even if it is a major national priority it will be one among many, and resolution of the challenges will not be short term.

1.4 Government announcements about the cost of living crisis will be important for everyone, especially for lower and middle income groups. That means important for most of our staff. Also important is the work we are doing in the short, medium and longer term to support our teams. In that context the response of colleagues to the newly introduced Annual Awards has been very positive and welcome.

2. Addenbrooke's Charitable Trust (ACT)

2.1 As an independent charity, the principal purpose of ACT is to support CUH in its delivery of care to patients of Addenbrooke's and the Rosie Hospitals and in the wider communities.

2.2 The Trustees of ACT include two NHS Link Trustees. One of these roles is held by Dr Hugo Ford, Divisional Director for Division D and Consultant Oncologist. The other role was held by Dr Mike Knapton until he stood down as a CUH Non-Executive Director in March 2022. Subject to the agreement of the ACT Board, it is proposed – and the CUH Board is asked to endorse – Dr Annette Doherty, CUH Non-Executive Director, assuming the second NHS Link Trustee role.

2.3 On behalf of the CUH Board, I would like to reiterate our thanks to the trustees and staff of ACT, and all their supporters, for all that they do to support the work of our hospitals.

3. Diary

3.1 My diary has contained a number of meetings and discussions, both remotely and physically, and both within and outside the hospital, over the past two months including some visits to clinical areas.

CUH
Performance Committee
Audit Committee
Quality Committee
Addenbrooke's 3 Committee
Children's Board
Medicine for Members: Cambridge Global Health
'You Made A Difference' Awards
New Governor Inductions
Council of Governors Strategy Group

3.2 The Integrated Care Board (ICB) arrangements are now up and running. As CUH we will be giving a lot of attention to the South Integrated Care Partnership which will be the vehicle for connecting acute and primary/community provision in the south of the county.

The following related meetings have been held:

- ICP/Health and Wellbeing Board Meeting

3.3 Other meetings attended during this period include:

- NHS Confederation Chairs Meeting
- NHS Providers Networking Meeting
- Wes Streeting, Shadow Secretary of State for Health and Social Care

4. Recommendation

4.1 The Council of Governors is asked to note the contents of the report.

Cambridge University Hospitals NHS Foundation Trust

Together
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Excellent

Report to the Council of Governors: 21 September 2022

Agenda item	7
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

The Chief Executive's report is divided into two parts. Part A provides a review of the five areas of operational performance. Part B focuses on the Trust strategy and other CUH priorities and objectives.

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.
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 Council of Governors
The Council is asked to note the contents of the report.

Cambridge University Hospitals NHS Foundation Trust

21 September 2022

Council of Governors
Chief Executive's Report
Roland Sinker, Chief Executive

1. Introduction / Background

1.1 The Chief Executive's report provides an overview of the five areas of operational performance. The report also focuses on the three parts of the Trust strategy: improving patient care, supporting staff and building for the future, and other CUH priorities and objectives. Further detail on the Trust's operational performance can be found within the Integrated Performance Report.

1.2 The health and care system nationally, regionally and locally is under pressure, with challenges ahead in terms of waiting times, demand for services, uncertainty around Covid and other conditions including flu; and staffing pressures. As an update on one indicator, as at 9 September 2022 the Trust was caring for 23 patients with Covid including three in critical care.

1.3 In this context the Trust is advanced in planning to mobilise for the fourth time since February 2020. This involves applying the five lessons from our response to Covid 19 over the last two and a half years and includes: clarity around objectives for the next 12 months; supporting and empowering staff and aligning teams around Task Forces in areas from capacity delivery, to cost of living, to patient flow; identifying areas to de-prioritise for now; assurance and challenge through our governance processes; and resourcing. This planning process will conclude during September 2022.

1.4 The Trust continues to work on the 15 programmes in the refreshed strategy of looking after patients, supporting staff and building for the future (set out in section 7). Timings for delivery of some elements of the strategy will change as the mobilisation plan above is finalised - some programmes taking longer; others being accelerated.

1.5 During the autumn the Trust is considering options for a Governance Review, in line with best practice corporate governance.

Part A

2. The five areas of operational performance

2.1 Quality

Areas of challenge

Staffing

2.2 The availability of nurses remains a challenge with specific areas of concern around critical care units, including the paediatric intensive care unit and the neonatal intensive care unit.

2.3 Vacancies within midwifery remains a concern with a current vacancy rate of 13%. However a full establishment of midwives is projected from October 2022.

2.4 The impact of staffing levels on safety continues to be monitored via the incident reporting system and divisional governance. Key themes are monitored via the existing governance safety routes.

Complaints and Patient Advice and Liaison Service (PALS)

2.5 The Complaints and PALS teams remain under extreme pressure with increased complexity of contacts and high sickness and vacancy rates resulting in longer waits for responses. An external review has been undertaken and an improvement plan has been developed.

Never Events

2.6 Overall the Trust has recently reported an increasing number of Never Events. This provides evidence of a strong reporting culture, and reflects the ongoing work around improving together and 'just culture'. The Patient Safety Team are however monitoring this going forward.

Waits for care

2.7 As set out in section 3 the Trust continues to review waits for care, including waits in the emergency department and for elective care.

Areas of Success

2.8 The Trauma Audit & Research Network (TARN) have reported that Cambridge University Hospital (CUH) is a positive outlier in trauma outcomes.

Compliance visits

2.9 Radiology is accredited by the United Kingdom Accreditation Service (UKAS) and underwent a surveillance visit on the 7 and 8 June 2022. Subject to resolution of some areas of non-compliance the initial assessment recommended that accreditation be maintained.

2.10 Clinical engineering has accreditation with UKAS for undertaking preventative plan maintenance of anaesthetic and ventilators and the management of medical devices. This accreditation is still in development and CUH is one of only four hospitals currently accredited.

2.11 The HTA inspection report under the main theatres Human Application License (Cardiovascular vessels, Ophthalmology, Plastics & Orthopaedics) was received in July 2022. A corrective and preventative action plan has been provided to the HTA and all actions should be completed by October 2022.

3. Access to Care

3.1 CUH continues to make good progress in terms of elective care, and is performing relatively well in access for cancer care. The Trust is very focussed on areas of concern in the emergency pathway, including long waits in the emergency department, flow within the hospital, and discharge of patients.

3.2 In July 2022 the Trust saw significant pressures on our emergency pathways, similar to other trusts within the region and nationally. Overall 14.0% of patients attending ED waited for 12hrs or more within the department and 14.4% of patients arriving by ambulance waited for more than 60mins for handover. These have both improved during August, with 12hr waits reducing to 12.4% of attendances and ambulance delays reducing significantly to 4.3%. Throughout this period our focus continues to be to streamline our emergency pathways where possible and delivering our elective recovery programme. Work is ongoing in relation to both physical capacity and out of hospital capacity to ensure the Trust is as well placed as it can be for them winter period.

3.3 **Emergency Department (ED).** Overall ED attendances were 11,673 in July 2022, which is 294 (2.6%) higher than July 2019. This equates to a rise in average daily attendances from 367 to 3377 over the same period. 1,636 patients had an ED journey time in excess of 12 hours, compared to 1 in July 2019. This represents 14% of all attendances and compares to regional and national levels of 9%.

3.4 **Referral to Treatment (RTT).** The total RTT waiting list size increased by 1,506 in July 2022 to 58,203. Our Month 3 planning submission had forecast growth to 55,160 so we are currently 5.5% higher than plan. Compared to pre-pandemic the waiting list has grown by 71%.

3.5 **Delayed discharges**. For July 2022 the Trust is reporting 6.8%, which is another consecutive increase of 0.4% from the previous month. There has been a larger increase in the number of overall lost bed days in comparison to previous months, but due to the overall monthly occupied bed state, the impact of DTOC % is lower. Within the 6.8%, 71% were attributable to Cambridgeshire and Peterborough CCG, and the remainder across a further seven CCG's.

3.6 **Cancer.** In July 2022 two week wait suspected cancer referral demand had reached 124% compared to the baseline period in 2019. The number of patients waiting over 62 days was currently 134, with 61% of the breaches relating to CUH only pathways.

3.7 **Operations.** Elective theatre activity in July 2022 delivered an improved 87 % of the July 2019 baseline. Taking account of the loss of the A Block theatres from our capacity, this would bring the performance up to 98%.

3.8 **Diagnostics.** Total diagnostic activity in July 2022 delivered to 108.9% of the July 2019 baseline. Scheduled activity delivered 108% of baseline. Total activity was up by 1.4% and scheduled activity by 4% compared to the prior month. The total waiting list size reduced by 219 to 15,117. The volume of patients waiting over 6 weeks reduced by 336 this month.

3.9 **Outpatients.** Outpatients delivered 97.7% of its new patient pre-Covid baseline, a reduction of 2,380 attendances. Robust recovery plans are being developed for the biggest areas of concern.

4. Finance – Month 4

4.1 The Month 4 year to date position is a £3.9m surplus. The overall full year plan is to deliver a break-even financial position.

4.2 The following points should be noted in respect of the Trust's Month 4 financial performance:

- The Month 4 year to date surplus includes £4m of income receipts relating to a specific one-off transaction in Month 2. The surplus in the year to date is offset in later months leading to a full year planned breakeven position.

- The Trust is currently delivering on its planned reduction in Covid related expenditure with year to date costs of £8.8m. This remains an area of risk for the Trust and the health system due to volatility of Covid rates in the community. Costs relating to Covid will remain under review.

- The Trust has recognised Elective Recovery Fund (ERF) income of £4.1m year to date in line with plan. This funding remains at risk as the final process for qualifying for and calculating the value of ERF has not yet been published at the time of this report.

4.3 The Trust has received an initial system capital allocation for the year of £32.2m for its core capital requirements. In addition to this, we expect to receive further funding for the Children's Hospital (£3.7m), Cancer Hospital (£7.5m) and Orthopaedic Theatre Scheme (14.9m) and additional funding for theatre equipment (£5.1m). Together with capital contributions from ACT, this would provide a total capital programme of at least £65.9m for the year.

4.4 The Trust has invested £7.6m of capital at Month 4, £5.3m below the planned figure of £12.9m. The Trust expects to recover this under performance by year-end and achieve the forecast plan of £65.9m of capital expenditure.

<u>2022/23 CUH Financial Plan</u>

4.5 The Trust plan for 2022/23 is to deliver a break-even position for the year.

4.6 It should be noted that the following key areas of risk still remain and have been included as part of the overall plan submission, to be monitored in year:

1) Inflation pressures above the (revised) funded level
2) Covid costs exceeding budgeted levels (e.g. due to an increase in Covid rates)
3) Non receipt of forecast ERF income.

4.7 The Trust is continuing to review and mitigate these risks, alongside Cambridgeshire and Peterborough ICS colleagues on an ongoing basis.

4.8 The Trust continues work on a 5 year financial plan linked to the refreshed strategy; and to deliver the Cost Improvement Plan set out in section 6.

5. Workforce

5.1 The Trust has set out five workforce ambitions, committing to focus and invest in the following areas; Good Work, Resourcing, Ambition, Inclusion and Relationships. Given the challenges and pressures of the last two years, this five part strategy will look at the additional staff support mechanisms required across the Trust in the medium to long term. The CUH Annual Awards process continues to progress well with over 1000 nominations being considered.

Good Work

5.2 The Trust have set out an ambition plan, focussed on six initial priority areas under the Good Work agenda where progress has already been made.

The focus areas are:

- Accommodation
- Travel and transport – commuting to and from work
- Nourishment and hydration
- Spaces
- Hybrid working
- Market forces – cost of living and working in Cambridge

5.3 The lack of availability and affordability of accommodation for staff continues to be concerning, limiting our ability to recruit overseas and we are seeing “relocation” as the main reason cited for those leaving the trust. An accommodation support officer is now in post and we are already seeing the benefits of this role. The Trust also progressing a number of initiatives to secure additional accommodation stock, including the conversion of office space to flats (in the onside residences).

5.4 There has been significant investment in travel support with the introduction of subsided onsite parking costs, funded park and ride travel and other public transport subsidies.

5.5 The national increase in the cost of living is concerning for staff and we have seen an increase in the number of individuals accessing support. In response we are refreshing our financial support and benefits pages with information, advice and signposting for staff experiencing financial hardship.

Resourcing

5.6 38 nurses, three midwives and 39 healthcare support workers all new to CUH joined the Trust in July 2022 and we have 133 nurses waiting to commence work. The Trust will be undertaking a recruitment campaign in the Philippines at the beginning of October 2022 with the aim of recruiting a further 100 nurses for this financial year. We continue to work on increasing the accommodation stock available to staff and are delighted with the positive impact the new accommodation support officer is having; feedback has been incredibly positive regarding this new service.

5.7 In June 2022 CUH recommenced a programme of face to face recruitment events, including attendance at the Cambridge Country show and a weekend Healthcare support worker one stop shop (where applicants can find out about the role, be interviewed and offered a job in one day). Whilst the resourcing teams have run events remotely throughout the pandemic it has been fantastic to work directly with people and, when onsite, introduce them to our campus. Further events are planned for October and December, working in collaboration with Royal Papworth Hospital (RPH).

5.8 Retention remains a key focus with increased attrition seen across all staff groups. A full review of the reasons for attrition has been undertaken and a strategy is being developed with representative of different staff groups.

Ambition

5.9 CUH has developed a Talent Management Strategy and toolkit to help teams identify talent (diverse skills and capabilities) available, to meet current and future service delivery.

Inclusion

5.10 The new programme lead for anti-racism commenced in July 2022; this is a new role that will closely with the EDI team and staff networks, as well as system partners, to progress our work on anti-racism.

5.11 On 8 July 2022 the Trust marked EID with a small edible for staff. This is part of a wider initiative to raise awareness and celebrate a wider range of religious festivals, events and celebrations important to our colleagues. Our next event is a Diwali celebration in October 2022 where colleagues will be invited to attend a lunchtime event onsite.

5.12 The Trust Stonewall action plan has been developed and launched, very much led by the LGBT staff network. A number of actions, including workforce policy changes and amendments to recruitment processes have already been completed.

Relationships

5.13 In July 2022 the Trust was delighted to host a staff BBQ on the campus and invite our RPH colleagues. The BBQ, as well as clement weather, allowed staff from both hospitals to sit and enjoy a meal together.

The shortlist has been announced for the CUH annual awards and we look forward to welcoming guests to the awards event in September, held in Kings College.

6. Improvement and Transformation

6.1 The Trust continues to work with its improvement partner, the Institute for Healthcare Improvement (IHI), on embedding a culture of sustainable continuous improvement.

6.2 In relation to the Trusts work with the IHI on building improvement capability and capacity across our 11,000 staff, wave two of the improvement coach programme commenced on 22 June 2022, with 38 participants, including a number of applicants from system partners (two from Royal Papworth Hospital and a further two from the South Integrated Care Partnership). Applications for wave two of the improvement programme for teams closed on 15 August 2022, with applications sought from teams wanting to focus on what makes a good day for them, or deteriorating patients.

6.3 The Significant improvement work is ongoing in Urgent and Emergency Care, Outpatients and Virtual Wards. As one example, in Virtual Wards:

Virtual ward (VW)

- Design of the virtual ward pathway and supporting infrastructure is being completed at pace. This will be tested from October 2022, initially with small numbers of patients, to ensure that the model is reliable and safe. Through rapid cycle testing, the emphasis will be on early learning and adaptation, before larger scale implementation of the model. The aim is to achieve an average occupancy of 30 patients per day during October – November 2022, increasing to an average occupancy of 60 patients per day from December 2022.

- There will be a core VW team dedicated to managing patients through frequent contact, remote monitoring and visits. The VW team will be supported by the relevant specialist team's input when necessary.

- A workforce plan has been developed and recruitment is underway, with the aim of staff being in place by October 2022.

- Effective communication with our system partners and working together to design safe, effective pathways is crucial, to ensure there are robust handover processes in place.

6.4 The improvement and transformation team continues to work with colleagues from across the organisation, to ensure that productivity and efficiency schemes for 2022/23 are identified to meet an overall requirement of £62m, which will deliver an end-of-year break-even position. As at 11 August 2022, there remains an unidentified gap in supporting schemes of £26k and work is ongoing to ensure that this gap is further reduced, along with increasing the number of schemes that are recurrent.

PART B

7. Strategy update

Strategy refresh

7.1 After ten months of engagement with staff, patients and partners, the Trust launched its refreshed strategy in July 2022, reaffirming our three core priorities and outlining 15 commitments aligned to these priorities which will provide our focus for the next three years.

7.2 The core priorities and associated commitments are:

- Improving patient care: integrated care; emergency care; planned care; health inequalities; quality, safety and improvement;
- Supporting our staff: resourcing; ambition; good work; inclusion; relationships;
- Building for the future: specialised services; research and life sciences; new hospitals and the estate; climate change; digital.

7.3 The communication and engagement plan across the Trust and with partners is now underway, supported by a range of materials including videos and documents which are available on the strategy pages of the CUH website.

7.4 Progress on many of these commitments are reported elsewhere in this update paper; further elements are included below. A detailed plan, focusing on delivery over the next five years, is being developed. Some areas of update include the following:

Improving patient care

Integrated Care

7.5 The Trust continues to work with partners across our 'place', in the South of Cambridgeshire, to improve care for patients in and outside of hospital. Work is ongoing to identify opportunities to increase the value we get from every pound invested in our community, social and health care system, to help people to stay healthy and well at home for longer, to address demand for elective care and reduce waiting times, to improve the growing health inequalities, to provide safe and high quality emergency care, and to return our system to financial balance.

7.6 We have established a new Joint Strategic Board for the South Place, co-chaired across CUH, primary care and local government, to oversee the next phase of work. This will include the next stage of developing integrated neighbourhoods rooted in primary care and continued integration of clinical pathways between primary and secondary care.

7.7 As host organisation for the South ICP, the Trust has recently supported reforms in how the South ICP operates and makes decisions. These reforms responded to issues raised through an independent listening exercise undertaken across all partners in the South ICP. It will provide a focus on delivering across four areas – service redesign, finances and commissioning, urgent and emergency care and organisational development. Delivery boards are being established in each of these areas to provide a means for partner organisations to come together and deliver projects.

7.8 NHSE has formally acknowledged the Cambridgeshire and Peterborough Integrated Care System's final operational plan for 2022/23 which focuses on elective care, cancer care, emergency care and system resilience, mental health and learning disability, finance and workforce. NHSE has accepted the plan being developed in the context of a changing external environment as a result of Covid and the impact of wider economic factors on the cost of delivery, and has noted key elements of the submission that require ongoing review and follow-up actions.

Health inequalities

7.9 The Trust has formed a Steering Group for improving equality, diversity and inclusion across our staff and patients, which is a core element of our new strategy. Over the coming months the group will assess our current performance in these areas, identify opportunities to do more over the coming years, and secure the skilled resources needed to seize these opportunities.

Supporting our staff

7.10 The Trust has implemented a wide programme of work focusing on wellbeing and support of our staff. Detailed information has been covered in Section 5 of this report.

Building for the future

New hospitals and the estate

7.11 The focus of Addenbrooke's 3 remains on the delivery of projects within phases one and two of our four phase programme. An important element of Addenbrooke's 3 is incorporating the views of patients and carers into the design of our future hospitals and the services within them. Healthwatch has recently completed a piece of work to capture experiences from patients who have had an urgent attendance or admission. This piece of work has provided valuable feedback that is being used to inform how services can be improved both now, within our current facilities, and in the future development of the acute hospital.

7.12 Phase one is focused on addressing our highest risk areas. The Trust, as a core part of its strategy, has invested in its physical estate to create additional capacity and address specific risks relating to operating in an old estate, including in respect of fire safety and statutory compliance. This has included the addition of 115 beds (across three surge units), all of which are expected to be available for use in the 2022/23 financial year. In addition, over the last 12-18 months, the Trust has been developing its plans for elective recovery. This has centred on the development of three additional theatres, utilising the available bed capacity in the 40-bedded surge unit, to create a ring-fenced surgical facility for elective orthopaedics. The remaining 75 beds (across two units) create long-term additional ward capacity (as opposed to Covid surge capacity) to support operational pressures, for example medically fit patients awaiting discharge, and decant capacity to allow statutory works to be undertaken. Final timings for delivery of U-block are currently being worked through.

7.13 Phase two (up to 2025) covers development of the Cambridge Cancer Research Hospital (CCRH) and Cambridge Children's Hospital (CCH).

7.14 The CCRH project team has been supplemented with a full time New Hospitals Programme (NHP) 'Delivery Partner'. This demonstrates the UK Government's ongoing commitment to support CUH in its delivery of the CCRH.The project team are producing the Outline Business Case (OBC) for submission in autumn 2022. The project has received approval to seek a construction partner and a number of design reviews have been held recently with key stakeholders to begin that process. The construction partner will support us throughout the remainder of the design, and then take responsibility for construction of the new hospital which will be a seven-storey 26,000m^2 facility at the heart of the Cambridge Biomedical Campus, next to Addenbrooke's Hospital.

7.15 Cambridge Children's Hospital (CCH) is also working towards submitting its OBC to regulators in autumn 2022. The Trust is continuing to work closely with the national NHP team to secure its position in an early cohort of the programme. The project's fundraising campaign has maintained its good progress.

Specialised Services

7.16 The Trust is working with six other trusts across the East of England, and the NHSE East of England team, to support the Specialised Provider Collaborative (EoE SPC).

7.17 Over the last three months, the EoE SPC has identified some key opportunities through conversations with stakeholders across the region, including clinical leads. From the long list of opportunities identified, we have now created a draft set of priorities for 2022/23, based on our vision and objectives.

7.18 The CEOs of the EoE SPC members met in July 2022, and confirmed our overarching priorities, as well as agreeing the need for further engagement across the region and to refine our governance structure. The EoE SPC members jointly responded to the Advisory Committee on Resource Allocation's (ACRA) proposed methodology to set target allocations for specialised services.

7.19 Going forward, we will confirm our priorities for 2022/23 and further develop the objectives and scope of these areas of work with relevant leads. We will also continue engagement across the region, and particularly to work with ICBs as they prepare to take on specialised commissioning responsibilities from April 2023.

Research and life sciences

7.20 The Trust continues to work with industry partners in life sciences to explore opportunities to enhance our world-leading infrastructure to serve patients and power growth. We have participated in a range of events with local, regional and national partners to promote the next stage of development for the Cambridge Biomedical Campus and wider life sciences ecosystem.

7.21 The Trust also continues to work with a range of partners on the Biomedical Research Centre, the Clinical Research Facilities and the regional Clinical Research Network.

Sustainability

7.22 Our new Trust Strategy affirms our commitment to tackle the climate emergency, with the first phase of a new ten-year programme of focused CUH activity in the form of 'Our Action 50 Green Plan (Phase 1: 2022-24)'. Organisational engagement with this comprehensive plan is well underway: over 200 staff have joined the Green Champions network, 25 teams have signed up to the Think Green Impact programme and a reach of almost 4,000 has been achieved on CUH Facebook. This will be stepped up further in November with a strong profile-raising campaign as part of a rolling 'drumbeat' for staff, patient and partner involvement.

7.23 Several of the Green Plan's direct carbon saving and waste reduction actions are already delivering real results, of particular note: work on cutting piped nitrous oxide losses has already provided approximately half of the 2024 target for direct carbon-equivalent emissions; the construction programme for the Babraham Park and Ride solar panel array has begun and, by this time next year, should be reducing the Trust's electricity carbon footprint by 400t per annum; and the default purchase option for all A4 copier and printer paper has now switched to 100% recycled content.

7.24 Progress continues to be made on the Genomics service:

<u>Genomic Laboratory Hub (GLH) operating model</u>

- The latest operational plan has been agreed by CUH, University Hospitals Leicester and Nottingham University Hospital and shared with NHSE following the latest assurance visits.

- Workforce recruitment remains a challenge with often very few, or no, eligible applicants for the advertised roles.

Delivering a high quality testing service

- A data quality improvement plan for the East GLH is in progress. Plans to reduce turnaround times include increased automation, increased staffing in all areas of the lab, and implementation of EPIC Beaker genomics module as our LIMS.

- The GLH is unable to process whole genome sequencing requests or perform interpretation and reporting at the pace required for activity forecast. A recovery action plan was currently under review at GLH.

8. Recommendation

8.1 The Council of Governors is asked to note the contents of the report.

Cambridge University Hospitals
NHS Foundation Trust

Integrated Report

Quality, Performance, Finance and Workforce to end July 2022

Chief Finance Officer
Chief Nurse
Chief Operating Officer
Director of Workforce

Report compiled: 31 Aug 2022

Key

Cambridge University Hospitals NHS Foundation Trust

Key

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 achieve and fail at random

Owner(s): Ewen Cameron, Ashley Shaw, Ed Smith, Lorraine Szeremeta, David Wherrett

Quality Account Measures

NHS
Cambridge University Hospitals
NHS Foundation Trust

2022/23 Performance Framework

2022/23 Quality Account Measures

Domain	Indicator	Data to	Target	May 22 Previous Month-1	Jun 22 Previous Month	Jul 22 Current status	Trend	FYtD	Baseline	LTM
Safe	Average % compliance with individual elements of NEWS2 escalation policy	Jun-22	85%	61%	60%	N/A	▪	60%	50.0%	51.3%
	% of patients over 65 years of age who have a lying and standing blood pressure completed within 48 hours of admission	Jun-22	50%	16.2%	16.7%	N/A	▪	15.1%	13.4%	15.1%
	% of patients who have a VTE risk assessent undertaken within 14 hours of admission	Apr-22	95%	N/A	N/A	N/A	▪	N/A	N/A	N/A
	Average % compliance with blood cultures within 60 minutes of Sepsis diagnosis	Apr-22	95%	N/A	N/A	N/A	▪	N/A	70.0%	N/A
Patient Experience / Caring	Healthcare Inequality: Percentage of patients in calendar month where ethnicity data is **not recorded** on EPIC CheQs demographics report (Ethnicity Summary by Patient)	Jul-22	7%	12.7%	12.6%	13.3%	⇩	12.7%	14.0%	12.3%
	Publication of actions and improvements undertaken as a result of feedback received from patients and their representatives	Jul-22	100%	8.3%	8.3%	8.3%	⇔	8.3%	0.0%	8.3%
Effective / Responsive	% of Early Morning Discharges (07:00-12:00)	Jul-22	20%	16.3%	15.2%	15.6%	⇧	16.0%	15.3%	15.6%
	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. 80% (of weekday rate) **Additional Filters Simple Discharges, G&A etc**	Jul-22	80%	78.7%	72.4%	68.0%	⇩	73.6%	74.0%	76.3%
	Same day emergency care (SDEC)	Jul-22	30%	21.3%	19.3%	N/A	▪	20.5%	22.0%	20.8%
	Quarterly			Dec 21	Mar 22	Jun 22				
	SSNAP Domain 2: % of patients admitted to a stroke unit within 4 hours of clock start time (Team centred)	Jun-22	55%	N/A	N/A	25.9%	▪	25.9%	29.2%	25.9%
Staff Experience / Well-led	Retention of band 5 nurses (quarterly)	Jun-22	88.5%	N/A	N/A	N/A	▪	N/A	87.0%	N/A
	Annual			2016	2017	2018				
	I feel secure about raising concerns re unsafe clinical practice within the organisation		78.0%	75.0%	73.0%	74.0%	⇧		75.0%	

SAFE: Sepsis data continues to be worked on by the Sepsis team. We have recruited a new group of auditors to retrospectively gather and analyse data in lieu of a sepsis lead for the Trust
[this post is still being recruited into]

Quality Summary Indicators

NHS Cambridge University Hospitals NHS Foundation Trust

2022/23 Performance Framework

Performance Framework - Quality Indicators				May 22	Jun 22	Jul 22				
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)	Jul-22	0	1	0	0	⇔	1	4	3
	E.Coli Bacteraemias (Total Cases)	Jul-22	50% over 3 years	41	29	34	⇩	135	384	398
	C. difficile Infection (hospital onset and COHA* avoidable)	Jul-22	TBC	11	16	11	⇧	50	123	132
	Hand Hygiene Compliance	Jul-22	TBC	97.8%	97.4%	96.6%	⇩	97.4%	97.5%	97.5%
Clinical Effectiveness	% of NICE Technology Appraisals on Trust formulary within three months. ('last month')	Jul-22	100%	88.9%	25.0%	57.1%	⇧	53.1%	33.8%	43.2%
	% of external visits where expected deadline was met (cumulative for current financial year)	Jul-22	80%	57.1%	N/A	100.0%	⇩	50.0%	46.7%	46.3%
	80% of NICE guidance relevant to CUH is returned by clinical teams within total deadline of 32 days.	Jul-22	-	50.0%	56.3%	80.0%	⇧	54.8%	17.2%	44.2%
	No national audit negative outlier alert triggered	Jul-22	0	0	0	0	⇔	0	-	0
	85% of national audit's to achieve a status of better, same or met against standards over the audit year	Jul-22	85%	N/A	50.0%	40.0%	⇩	-	84.6%	68.8%
Nursing Quality Metrics	Blood Administration Patient Scanning	Jul-22	90%	99.3%	99.9%	99.6%	⇩	99.6%	99.1%	99.5%
	Care Plan Notes	Jul-22	90%	96.8%	96.9%	96.6%	⇩	96.7%	95.8%	95.9%
	Care Plan Presence	Jul-22	90%	99.9%	99.8%	99.9%	⇧	99.9%	99.6%	99.7%
	Falls Risk Assessment	Data reported in slides								
	Moving & Handling	Jul-22	90%	58.9%	65.9%	64.0%	⇩	62.1%	63.1%	62.0%
	Nurse Rounding	Jul-22	90%	97.2%	97.3%	97.3%	⇩	97.2%	96.6%	96.7%
	Nutrition Screening	Jul-22	90%	99.6%	99.5%	99.6%	⇧	99.5%	99.6%	99.5%
	Pain Score	Jul-22	90%	77.3%	77.0%	73.9%	⇩	76.0%	77.1%	75.2%
	Pressure Ulcer Screening	Data reported in slides								
	EWS									
	MEOWS Score Recording	Jul-22	90%	61.6%	56.1%	52.8%	⇩	58.0%	64.0%	60.7%
	PEWS Score Recording	Jul-22	90%	86.1%	86.1%	85.2%	⇩	86.0%	86.6%	86.2%
	NEWS Score Recording	Jul-22	90%	76.5%	76.0%	72.4%	⇩	74.6%	74.2%	73.7%
	VIP									
	VIP Score Recording (1 per day)	Jul-22	90%	89.7%	91.2%	88.1%	⇩	89.4%	91.2%	90.0%
	PIP Score Recording (1 per day)	Jul-22	90%	99.3%	99.3%	99.3%	⇩	99.3%	99.2%	99.3%
Patient Experience	Mixed sex accommodation breaches	Jun-20	0	-	-	-	▪	0	0	0
	Number of overdue complaints	Jul-22	0	5	14	4	⇩	25	29	49
	Re-opened complaints (non PHSO)	Jul-22	N/A	3	5	3	⇩	12	74	65
	Re-opened complaints (PHSO)	Jul-22	N/A	0	0	0	⇩	0	4	1
				May 22	Jun 22	Jul 22				
	Number of medium/high level complaints	Jul-22	N/A	24	27	21	⇩	89		257

Operational Performance

Cambridge University Hospitals NHS Foundation Trust

Operational Performance

POD	Performance Standards	SPC	Target	Target due by	Internal Target	In Month Actual	Actual
Urgent & Emergency Care More information on page 15	Ambulance handovers <15mins		65%	Immediate		22%	
	Ambulance handovers <30mins		95%	Immediate		66%	
	Ambulance handovers > 60mins	L	0	Immediate		328	
	12hr waits in ED (type 1)	H	2%	Immediate	8%	14%	
Cancer More information on pages 17,18	Cancer patients < 62 days	L	85%	Immediate		67%	
	28 day faster diagnosis standard		75%	Immediate	81.1%	75.4%	
	31 day decision to first treatment	L	96%	Immediate		88%	
Outpatient Transformation More information on page 21	Advice and Guidance Requests		16%	Mar-23	12%	10%	
	Patients moved / discharged to PIFU	H	5%	Mar-23	2.8%	2.4%	
Diagnostics More information on page 19	Patients waiting > 6 weeks	L	5%	Mar-24		41%	
RTT Waiting List More information on page 16	RTT Patients waiting > 78 weeks	L	0	Mar-23	248	373	
	RTT Patients waiting > 104 weeks	L	0	Jul-22	-	8	

Productivity and Efficiency	SPC	In Month Actual	Actual
Non-elective LoS (days, excl 0 LoS)	H	9.14	
Long stay patients (>21 LoS)	L	5.4	
Elective LoS (days, excl 0 LoS)		5.4	
Discharges before noon	H	16%	
Theatre sessions used		1482	
In session theatre utilisation	H	83%	
Virtual Outpatient Attendances	L	22%	

	Jul-22	Jun-22	% change	Feb-20	% change
Outpatients - New	29,138	29,104	↑0%	28,700	↑2%
Diagnostics - Total WL	15,117	15,558	↓3%	8,708	↑74%
RTT Pathways - Total WL	58,203	56,697	↑3%	34,097	↑71%
Cancer (62d pathway) >62d	156	157	↓1%	56	↑179%

Surgical Prioritisation - WL	Jul-22	Jun-22	% change
P2 (4 weeks) Including planned	2077	1978	↑5%
P3 (3 months)	5262	5026	↑5%
P4	3580	3589	↓0%

Key / notes

Bar charts show data over the past 12 months, current month is highlighted depending on performance: green = meeting national standard, amber = meeting internal plan, red = not meeting standard or plan

SPC variances calculated from rolling previous 12 months

Author(s): James Hennessey

Owner(s): Nicola Ayton

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Acute Priorities Delivery

NHS
Cambridge University Hospitals
NHS Foundation Trust

2022/23 Performance Framework

Elective Inpatient Activity

88%	In Month Actual
92%	In Month Plan
84%	YTD Actual
79%	YTD Plan

Elective Daycase Activity

110%	In Month Actual
108%	In Month Plan
107%	YTD Actual
103%	YTD Plan

Emergency Admissions

82%	In Month Actual
97%	In Month Plan
82%	YTD Actual
93%	YTD Plan

New Outpatient Activity

101%	In Month Actual
105%	In Month Plan
100%	YTD Actual
99%	YTD Plan

Follow Up Outpatient Activity

105%	In Month Actual
127%	In Month Plan
110%	YTD Actual
122%	YTD Plan

Diagnostic activity (national planning submission)

122%	In Month Actual
139%	In Month Plan
111%	YTD Actual
122%	YTD Plan

RTT Clockstops (All)

91%	In Month Actual
107%	In Month Plan
91%	YTD Actual
101%	YTD Plan

RTT Clockstops (Admitted)

88%	In Month Actual
94%	In Month Plan
82%	YTD Actual
86%	YTD Plan

RTT Clockstops (Non admitted)

91%	In Month Actual
111%	In Month Plan
94%	YTD Actual
105%	YTD Plan

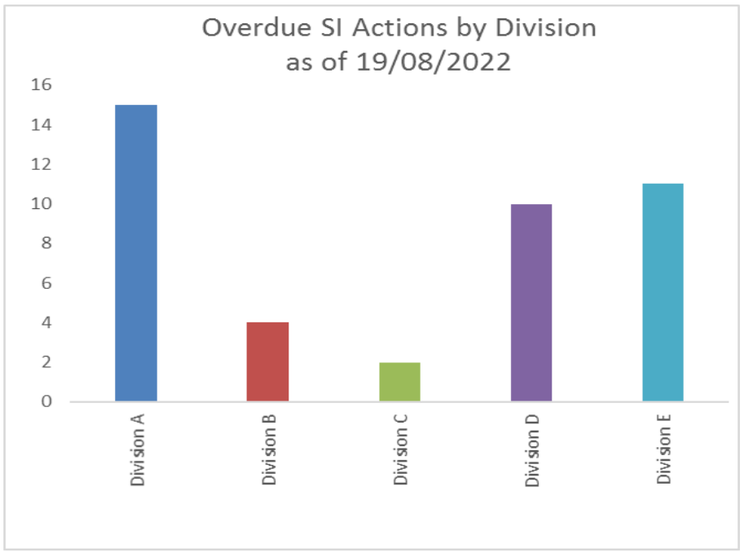
Serious Incidents

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	May 18 - July 22	month	-	1484	1411			-	The number of patient safety incidents is within normal variance.
Percentage of moderate and above patient safety incidents	Nov 19 - July 22	month	2%	32.0%	1.5%				There is currently normal variance in the percentage of moderate and above patient safety incidents.
All Serious Incidents	July 18 - July 22	month	-	5	5			-	5 Serious Incidents were declared with the CCG in July 2022, which is within normal variance for the trust.
Serious Incidents submitted to CCG within 60 working days (or agreed extension)	Jun 18 - July 22	month	100%	75%	63%				3 Serious Incidents were due to the CCG in July 2022, 2 of which were submitted within the 60 day target.

Ref		STEIS SI Sub categories	Actual Impact	Div.	Ward / Dept.
SLR142100	Category 3 HAPU	Pressure ulcer meeting	Severe / Major	Division D	Ward L5
SLR143458	Unstageble HAPU	Pressure ulcer meeting	Severe / Major	Division C	Ward G4
SLR143785	Patient Fall (P2)	Slips/trips/falls	Death / Catastrophic	Division C	Ward P2
SLR144393	Neurosurgery treatment delay	Treatment delay	Severe / Major	Division D	Theatres - Neurosurgery
SLR145391	Never Event - Bilateral Eye	Surgical/invasive procedure incident	No Harm	Division D	Clinic 14



The number of patient safety incidents remains in normal variance. Moderate harm incidents have risen above 2% target but this is not statistically significant. Based on the 60 day target 3 Serious incident investigations were due to the CCG, 2 of these were submitted within 60 days, the 3rd was submitted 2 days late. The Patient Safety Improvement team continues to investigations for all serious incidents relating to HAPUs and patient falls or when the Divisional team are unable to allocate an investigator. 5 SI investigations were commissioned at SIERP and SI Action plan closures continue to be supported by the monthly SIERP Action Assurance Meeting and collaboration with the CCG.

Author(s): Clare Miller

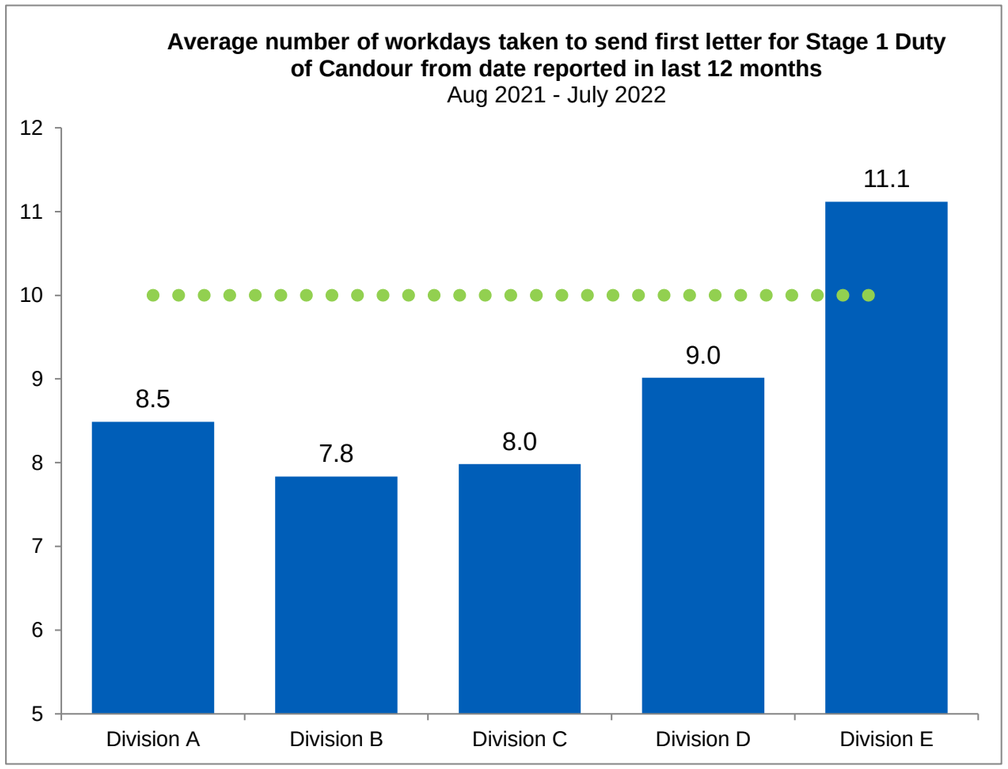
Owner(s): Oyejumoke Okubadejo

Duty of Candour

NHS 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 19 - Jul 22	month	100%	78%	69%		-		The system may achieve or fail the target subject to random variation.
Duty of Candour Stage 2 within 10 working days**	Jun 19 - Jul 22	month	100%	73%	69%		-		The system may achieve or fail the target subject to random variation.



Executive Summary

Trust wide stage 1* DOC is compliant at 96% for all confirmed cases of moderate harm or above in July 2022. 78% of DOC Stage 1 was completed within the required timeframe of 10 working days in July 2022. The average number of days taken to send a first letter for stage 1 DOC in July 2022 was 5 working days.

Trust wide stage 2** DOC is compliant at 100% for all completed investigations into moderate or above harm in July 2022 and 73% DOC Stage 2 were completed within 10 working days.

All incidents of moderate harm and above have DOC undertaken. Compliance with the relevant timeframes for DoC is monitored and escalated at SIERP on a Division by Division basis.

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.

Falls

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	Aug 19 - Jul 22	month	-	179	144		-	-	There were a total of 179 falls (inpatient, outpatient and day case) in July 2022. The Trust remains within normal variance however has shown an continuous increasing trend over the last 3 years
Inpatient falls per 1000 bed days	Aug 19 - Jul 22	month	-	4.99	4,51			-	There were 160 inpatient falls in July 2022. The Trust remains within normal variance and has remained fairly static in the rate of falls per 1000 bed days over the last 3 years.
Moderate and above inpatient falls per 1000 bed days	Aug 19 - Jul 22	month	-	0.20	0.09			-	There were 7 falls categorised as Moderate or above harm in July 2022. The level of harm is classed according to injury and not lapses in care.
Falls risk screening compliance within 12 hours of admission	Aug 19 - Jul 22	month	90.00%	85.10%	86.00%				Completion of Falls risk screening within 12 hours of admission remains below the 90% target.
Falls KPI; patients 65 and over have a Lying and Standing Blood Pressure (LSBP) completed within 48hrs of admission	Aug 19 - Jul 22	month	90.00%	14.90%	10.90%				Since April 2021 compliance has shown a small increasing trend
Falls KPI: patients 65 and over who have a cognitive impairment have an appropriate care plan in place	Aug19 - Jul 22	month	90.00%	19.80%	15.10%				Since April 2021 compliance has shown a small increasing trend
Falls KPI: patients 65 and over requiring the use of a walking aid have access to one for their sole use	Aug19 - Jul 22	month	90.00%	67.30%	77.40%				Compliance has started to show a downward trend. An issue with interpretation of the question has been identified along with a supply issue of align frames. Both of these issues are currently under review.

Executive Summary

After a reduction in falls in May and June, July saw an increase in the number of falls with the highest numbers since January 2022. The Trust had substantial capacity issues in July which may have contributed to the rise in the number of falls. The Lead Falls Prevention Specialist will continue to monitor

The Falls Risk Screening tool has been reviewed and suggested changes have been identified and an EPIC change request has been submitted. It has been given a priority 1 status as it is an action that has resulted from an SI and an inquest.

Compliance with the Lying and standing blood pressure and confusion care planning KPI remains low. The Divisions and Falls Advocates have been asked to identify what they see as the challenges to completing these KPIs and any initiatives to improve compliance

.

The Falls Advocates have started to produce ward level reports on KPI compliance and their plans for improvement. These reports will be used to collate challenges and initiatives for further development. Wards that are having particular challenges will be supported by the Lead Falls Prevention Specialist

The Falls QI plan is under continuous review to identify and prioritise further improvement plans

Hospital Acquired Pressure Ulcers (HAPUs)

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	Feb 18 - Jul 22	month	-	46	22	H	SP	-	The total number of HAPUs shows a steep increase for July outside of the normal variance, this has added to the mean increase and the upper trend continues.
To increase reporting of category 1 HAPU to achieve an upward trajectory in reporting by March 2022	Feb 18 - Jul 22	month	-	14	11		-	-	KPI 2021-2022- to increase early reporting of category 1 HAPU to prompt early prevention. Category 1 HAPUs remain within normal variance. New KPIS's will be incorporated in the forthcoming QI Plans
Category 2, 3, 4, Suspected Deep Tissue Injury and Unstageable HAPUs by date of occurrence	Feb 18 - Jul 22	month	-	33	11	H	SP	-	Category 2 and above HAPU are outside of the upper limit of normal variance for July increasing the upward trajectory.
Pressure Ulcer screening risk assessment compliance	Feb 18 - Jul 22	month	90%	78%	80%		-	F	PU screening risk assessment compliance remains below the target of 90%. A QI plan is in progress to implement ward based training to increase compliance, focussing on assessment areas.
KPI downward trend of category 2, 3, 4, Suspected Deep Tissue Injury and Unstageable HAPUs by March 2022	Apr 19 - Jul 22	month	9	33	10	H	SP	F	KPI 2021-2022 - to decrease number of category 2 and above HAPU as a result of early reporting of category 1. Reporting for category 2 and above HAPU has increased for July increasing the upper trajectory, this KPI was not achieved. New KPIS's will be incorporated in the forthcoming QI Plans

Exec Summary

There has been a steep increase in HAPU incidents for July, which has increased the mean and has exceeded the upper trajectory.
The mean for category 2 and above HAPU's continues to increase and has exceeded the upper trajectory for July.
There has been a slow mean increase in suspected deep tissue injuries and Unstageable HAPU's over the past 3 years and during July this exceeded the upper control limit.
The new TVN Lead is currently analysing data to inform the improvement plans for Pressure Ulcer Prevention. A thematic review of outstanding SI's is in progress and will also inform the QI Plan.

HAPU incidents; Category 1 = 12, Category 2 = 16, Category 3 = 1, Category 4 = 0, SDTI = 15, Unstageable = 2

Author(s): Jane Parker

Owner(s): Oyejumoke Okubadejo

Sepsis

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									
All elements of the Sepsis Six Bundle delivered in 60 mins from time patient triggers Sepsis (NEWS 5>) - Emergency Department	Jun-22	Monthly	95%	53%	55%		-	?	Compliance with Sepsis 6 delivered within 60 Mins is at 53%. Elements of the sepsis 6 bundle that have impacted on the overall compliance this month is Antibiotic administration within an hour of t5riggering sepsis (67%) and Blood Cultures (80%)
Antibiotics administered with 60 mins from time patient triggers Sepsis (NEWS 5>) - Emergency Department	Jun-22	Monthly	95%	67%	71%		-	?	Average door to needle time was 73 mins for Jun 22 , the same as May 22 . 4 audits impacted on this average time because door to needle time in those particular audits exceeded 60-120 Mins. The average time between patient triggering sepsis (NEWS 2 5>) and prescription of antibiotics was 20 mins. In 60% of audits the time between the patient triggering sepsis and antibiotics being prescribed was under 30 mins. One audit exceeded 60 mins. The average time between antibiotic prescription and administration was 21 mins, in 53% of the audits antibiotics were administered within 30 Mins of being prescribed. The average prescription and administration time of antibiotics together was 51 mins.
All elements of the Sepsis Six Bundle delivered in 60 mins from time patient triggers Sepsis (NEWS 5>)- Inpatient wards	Feb-22	Monthly	95%	#N/A	22%		-	F	Please note that there will be no inpatient data until the new clinical lead for inpatient sepsis is appointed.
Antibiotics administered with 60 mins form time patient triggers Sepsis (NEWS 5>) - Inpatient wards	Feb-22	Monthly	95%		65%		-	F	
Antibiotics administered within 60 mins of patient being diagnosed with Sepsis - Emergency Department	Jun-22	Monthly	95%	100%	90%		-	?	The average prescription and administration time of antibiotics together was 51 mins an Improvement on May 22.
Antibiotics administered within 60 mins of patient being diagnosed with Sepsis - Inpatient wards	Feb-22	Monthly	95%		69%		-	F	There will be no inpatient data until Sept/Oct 22 due the sepsis inpatient lead not starting until sept 22

Executive Summary:

Inpatient Sepsis data is currently being pulled and analysed by a new team of sepsis auditors, due to the continued difficulty in recruiting a sepsis lead for the Trust.

The overall compliance of the sepsis 6 bundle being delivered in 60 mins is dependant on all elements of the bundle being compliant within 60 mins, therefore one or two elements can impact on the overall compliance. Please see breakdown table above with the elements highlighted in yellow and each elements compliance within 60 mins.

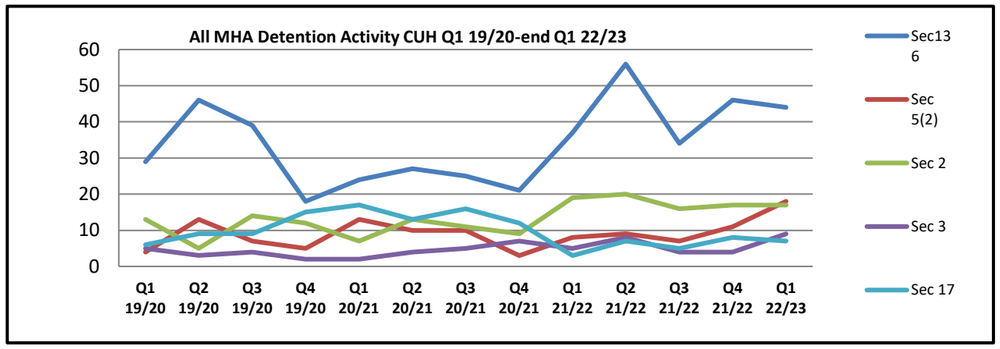
Themes from the data are:

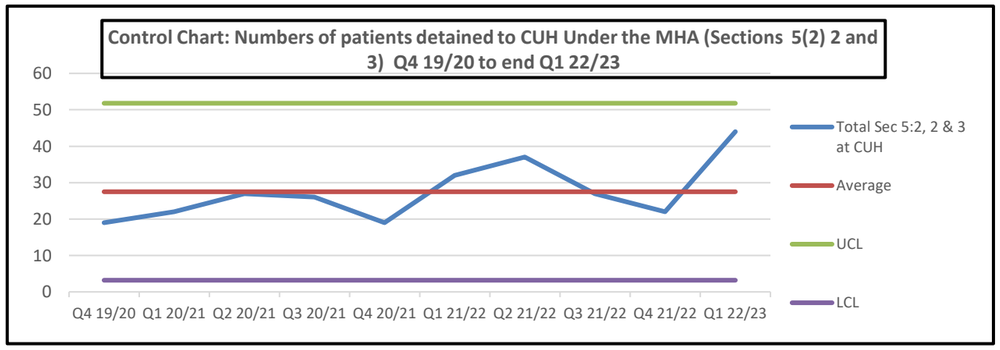
Delay in observations
Delay in cubicle allocation in ED
Delay in prescription of antibiotics despite early escalation

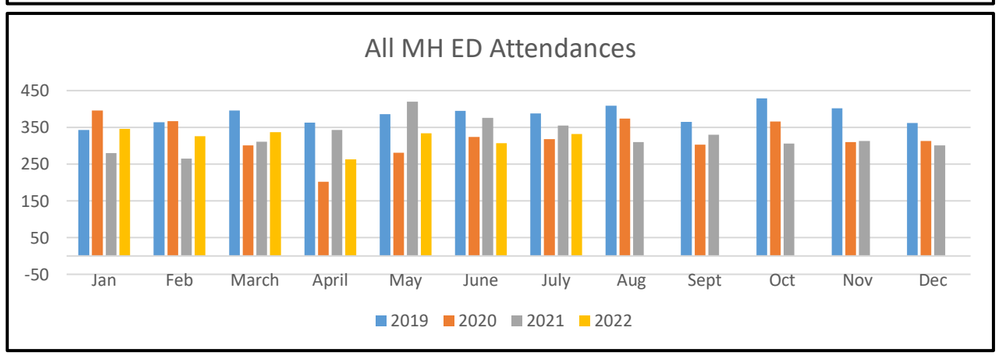
Mental Health - Q1 2022/23

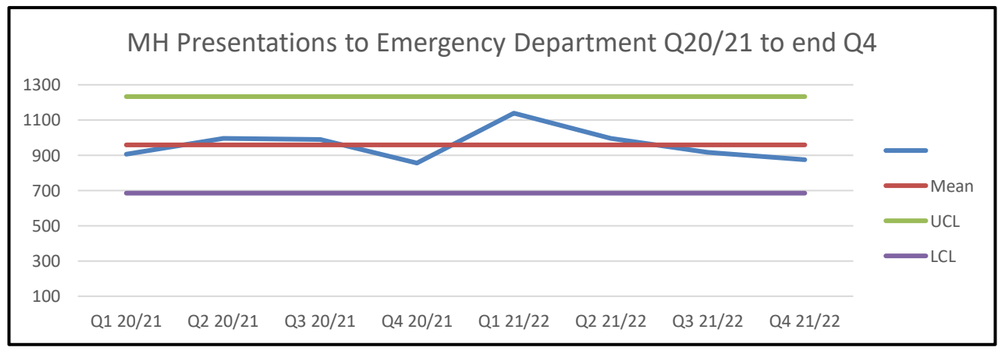
Cambridge University Hospitals NHS Foundation Trust

Mental Health









Narrative

- The numbers of inpatients detained under the Mental Health Act has increased slightly in Q1 22/23. Specifically there were 18 patients detained under Sec 5(2) (Doctors emergency holding power) over 11 in Q4 21/22 and 9 patients detained on Section 3 over 4 in Q4 21/22. It is too early to say if this represents an upward trend at this point .
- The numbers of patients brought to CUH on Sec 136 has stabilised over Q1. The mean number of patients detained on Sec 136 per quarter since Q1 2019/20 is 34.3. In Q1 22/23 there were 44 . This will be monitored
- The total number of mental health presentations in the period January to July 2022 (1913) is 14% lower than for the same period 2019 (pre-pandemic) , 2.5% higher than 2020 and 4% lower than the same period last year
- The number of people presenting to ED (332) at CUH with a mental health need in July 2022 shows a 8% increase from June 2022 (307).
- The number of adults presenting in July (299) increased by 11% compared to June 22. Q2 historically sees an increase in Mental health presentation therefore this is in line with yearly trends. 11% of those attending were admitted to CUH.
- From Jan-July 2022 there has been a 23.% decrease in the number of Adults who presented at ED for mental health reasons who were admitted to CUH (240) in comparison to the same period a year ago (312).
- There was a 19.5% decrease in CAMH patients presenting in ED from June (41) to July (33). 48.5% of those who presented were subsequently admitted to CUH. This is the highest conversion rate since July 2021 (51.3%).
- For CAMH aged patients, the number of those admitted has reduced from 126 patients between Jan-July 2021 to 101 in same period 2022, a 19.8% decrease.
- Although the numbers of those eligible for CAMH services presenting at ED is very much smaller than for adults, the conversion rate to admission is significantly higher.

Ongoing work:

- The mental health team have been allocated substantive funding for both the Mental health lead (currently out to advert) and the Mental health specialist nurse posts (due to commence in October). Currently a gap in service provision whilst recruitment process is completed.
- Work has been undertaken to revise both the ligature point policy and the anti ligature assessment tool at CUH. Assessments have been completed in the 7 areas that have the highest mental health activity in the hospital. These assessments will need to be repeated annually as per policy or if the areas concerned have any environmental changes before then. Action plans to mitigate some of the issues raised are now in place,
- Interface meetings between mental health and CUH for both adult and younger peoples services continue. The plan now is to invite other agencies to the meeting such as Centre 33 who provide support for younger people with mental health needs in the county.

Author(s): Claire Ward

Owner(s): Lorraine Szeremeta

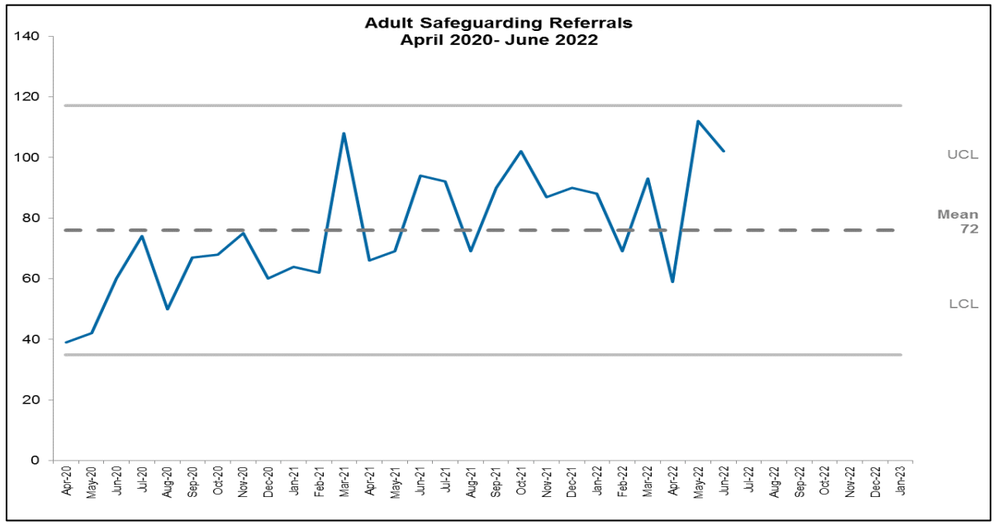
Safeguarding

Cambridge University Hospitals NHS Foundation Trust

Safety and Quality

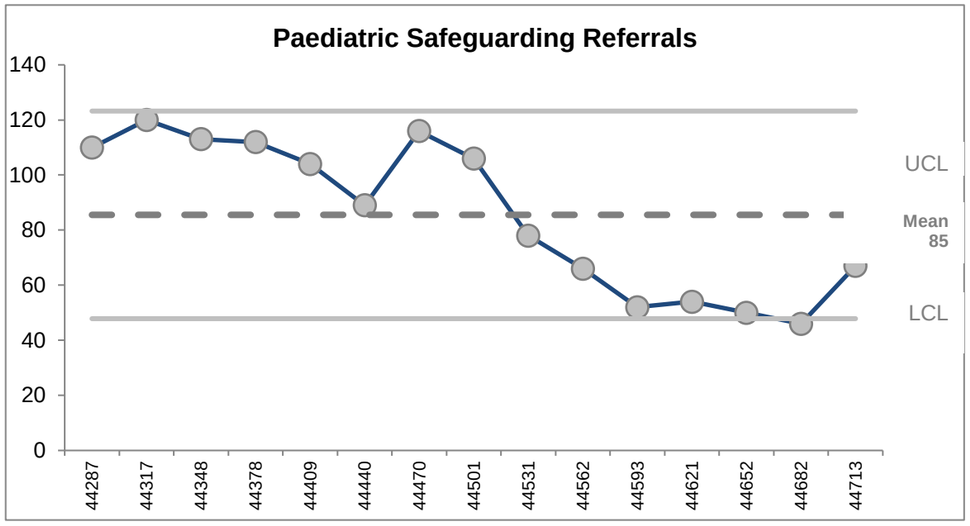
Adult Safeguarding

19% increase in referrals in Q1 22/23 compared to the same time period in 21/22. A total of 273 referrals were made to the Adult Safeguarding Team this quarter compared to 250 in Q4 21/22 (this figure does not include DOLs requests). 49% of the referrals received were safeguarding enquiries and of these 37% were forwarded to the relevant Local Authority for further investigation. The largest number of referrals relate to concerns of neglect or acts of omission (31%). 18% of referrals related to domestic abuse concerns which is comparable to Q4 21/22.



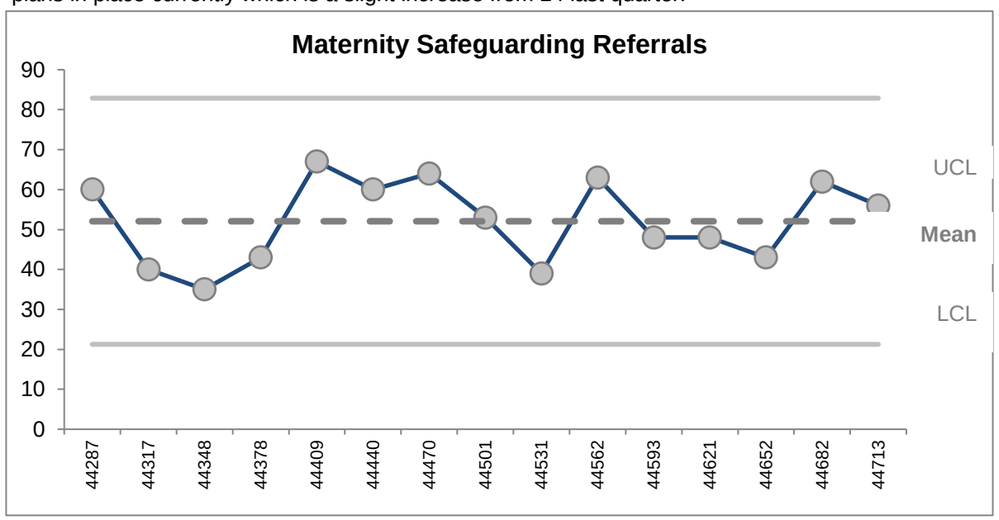
Children's Safeguarding

There has been a slight decrease (4%) in the number of referrals to the children's safeguarding team this quarter in comparison to Q4. Mental Health concerns continue to be the consistent theme dominating Children's social care referrals, these peaked in May with 29 referrals which coincides with the school half term holiday period. During Q1, there has been a decrease of 9.6% of patients (186) who did not attend their appointments compared to Q4. Overall this is a positive trend for CUH and Division E and can perhaps be attributed to the work being done around capturing, reviewing and managing DNA'S. There are 2 local authority investigations ongoing related to staff members.



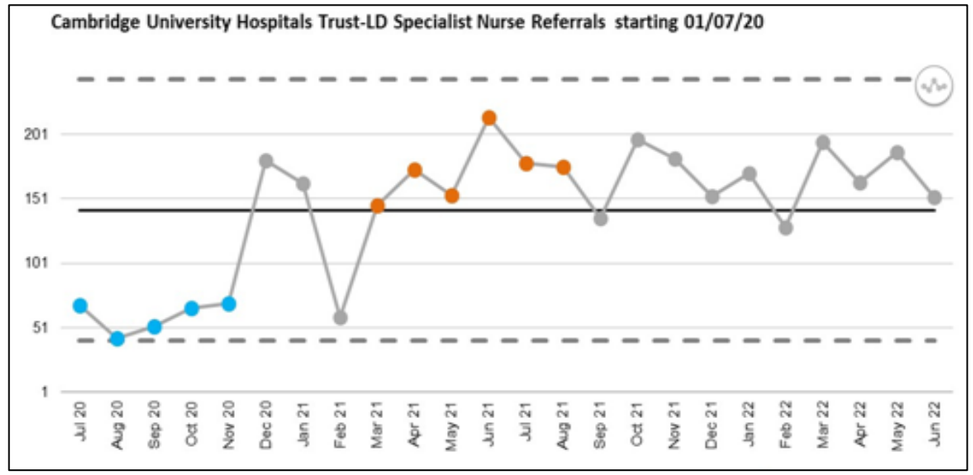
Maternity safeguarding

The number of referrals to the maternity safeguarding team has ranged between 43 and 62 referrals per month. The greatest reason for onward referral to children's services is due to domestic abuse of the mother, this has been a continuing trend over the last 12 months. There are 18 unborn babies with child protection plans in place currently which is a slight increase from 14 last quarter.



Learning disabilities

The number of referrals to the learning disability specialist nurse has increased year on year. During Q1 there have been 503 referrals to the learning disability specialist nurse which is a 2% from Q4 21/22 but an 8% decrease when comparing against Q1 2021. The learning disability nurse is working in close partnership with the Learning disability partnership and local services.



Author(s): Amanda Small

Owner(s): Lorraine Szeremeta

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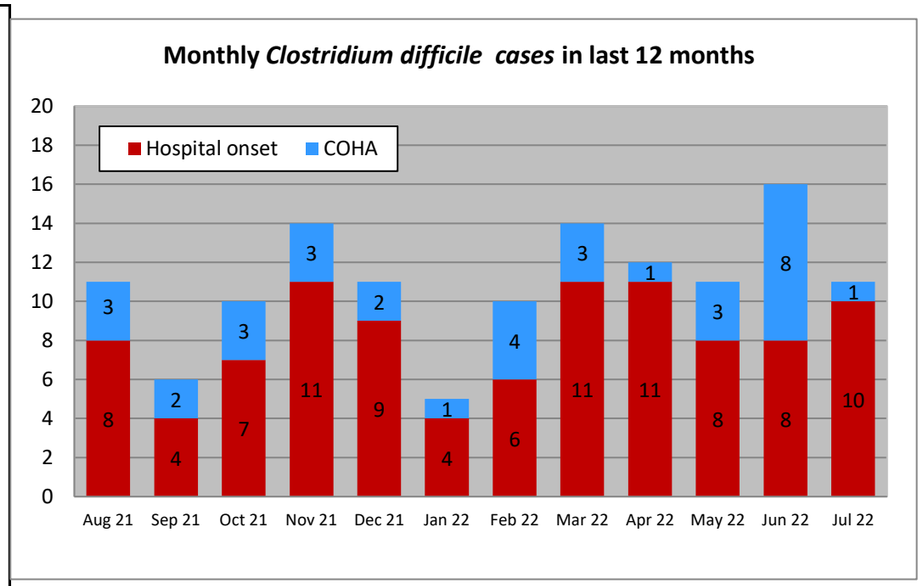
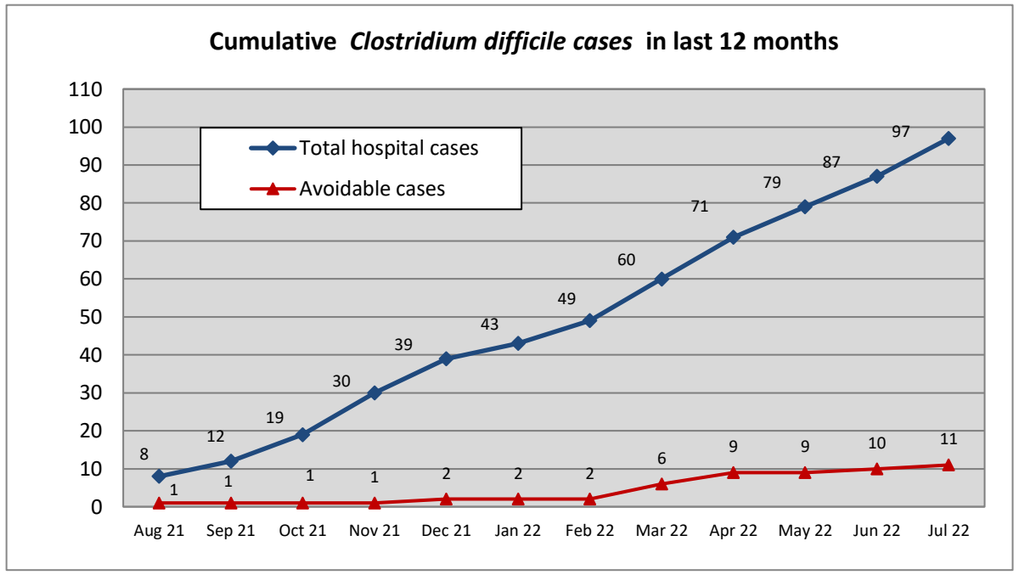
Infection Control

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 2022/23 is zero avoidable hospital acquired cases.

• No cases of hospital onset MRSA bacteraemia in July 2022
• 1 case (unavoidable) hospital onset MRSA bacteraemia year to date

C. difficile ceiling for 2022/23 is 110 cases for both hospital onset and COHA*.

▪ 10 cases of hospital onset *C difficile* and 1 case of COHA in July 2022.
• 37 hospital onset cases and 13 COHA case year to date. 44 cases unavoidable, 5 avoidable and 1 pending.

MRSA and C difficile key performance indicators

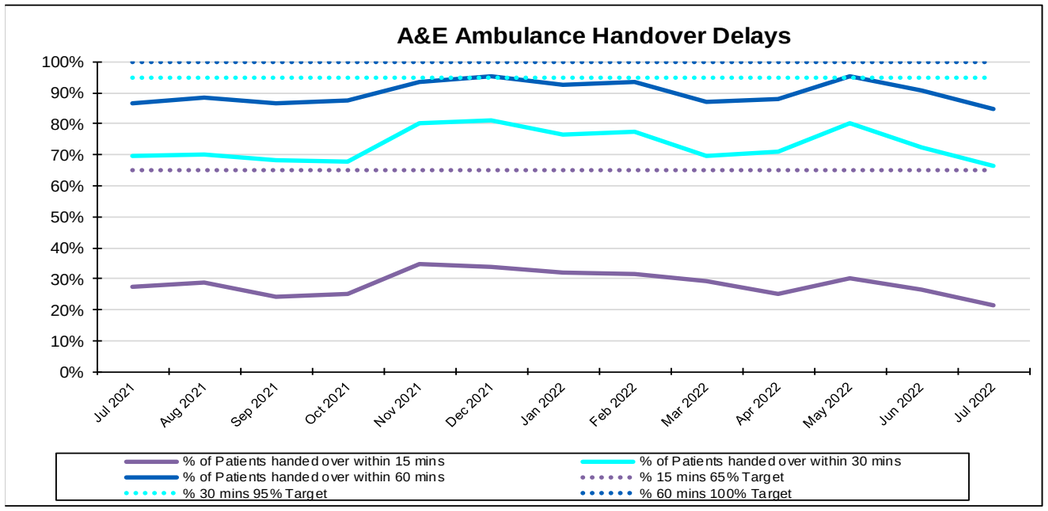
▪ Compliance with the MRSA care bundle (decolonisation) was 78.1% in July 2022 (91.2% in June 2022).
▪ The latest MRSA bacteraemia rate comparative data (12 months to June 2022) put the Trust 7th out of 10 in the Shelford Group of teaching hospitals.

▪ Compliance with the *C. difficile* care bundle was 90.9% in July 2022 (91.7% in June 2022).
▪ The latest *C. difficile* rate comparative data (12 months to June 2022) put the Trust 7th out of 10 in the Shelford Group of teaching hospitals.

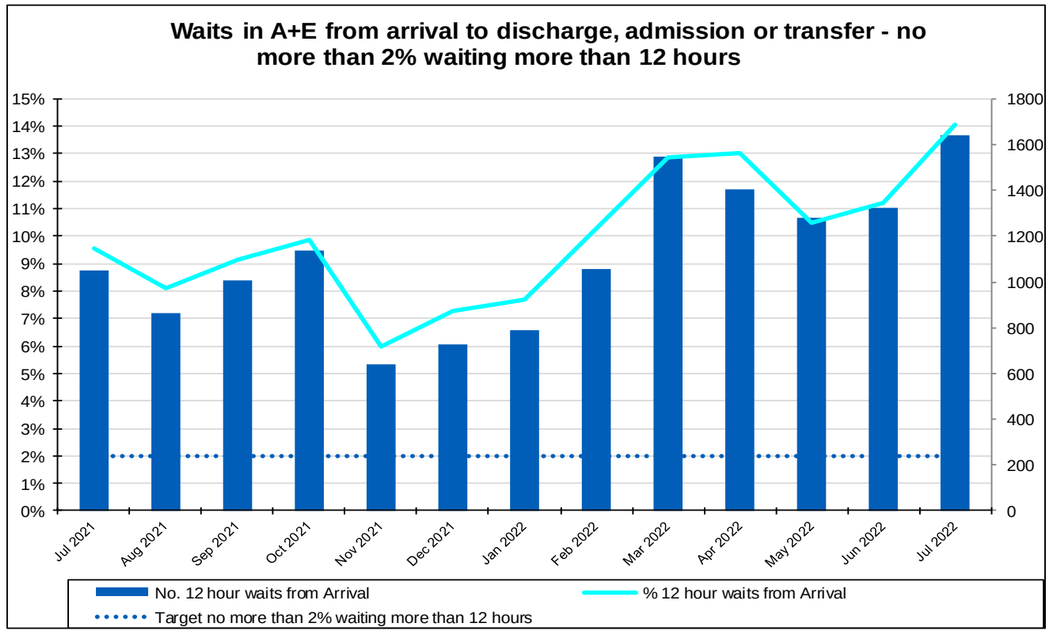
Amb. Handovers & 12 Hr Waits From

Cambridge University Hospitals NHS Foundation Trust

Operational Performance



	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
No. of Patients not handed over within 30 mins	544	697	646	485	624	780	434
No. of Patients not handed over within 60 mins	159	300	265	113	212	328	98



Demand:
- ED attendances in July were 11,673. This is 294 (2.6%) higher than July 2019. This is equivalent to an increase from 367 to 377 attendances per day.
- Paediatric attendances showed the greatest proportional rise, increasing by 18.7% (+403) from July 2019.
- 1,636 patients had an ED journey time in excess of 12 hours compared to 1 in July 2019. This represents 14.0% of all attendances and compares to regional and national levels of 9.0%

Streaming: To mitigate the increase in demand the ED has a dedicated clinician based at the front door and the ambulance bay to identify patients suitable for streaming to alternative locations:
- 743 patients were streamed from ED to our medical assessment units on wards N2 and EAU4 and a further 377 patients to our Surgical Assessment Unit.
- 3,746 patients were streamed to the Urgent Treatment Centre (UTC), of which 1,791 patients were seen by a GP or ECP.

Ambulance handovers: In July 2022 we saw 2,178 conveyances to CUH which was a decrease of 22.9%, (-647) compared to July 2019. Of these:
- 21.6% of handovers were clear within 15mins vs. 60.6% in July 2019
- 66.3% of handovers were clear within 30mins vs. 95.4% in July 2019
- 85.6% of handovers were clear within 60mins vs. 99.4% in July 2019.

Actions being undertaken by the Emergency Department:
The new UEC Programme Board met for the first time in July to coordinate the recovery of our UEC position. Action plans have been developed by the Board's sub-groups to deliver improvements to the emergency pathway across both system partners and the Trust. This group will report progress to the Trust's Management Executive team on a monthly basis and link with the wider system through the South Alliance Resilience Group. These actions include developing the urgent community response prior to ED attendances, realising efficiency opportunities in the department including implementing the ED coordination hub and improving streaming, the expansion and utilisation of SDEC pathways, realising length of stay efficiencies and increasing simple and complex discharges.

Author(s): Linda Clarke Owner(s): Nicola Ayton

Fit Testing compliance for substantive staff

Cambridge University Hospitals NHS Foundation Trust

Fit Testing compliance for substantive staff

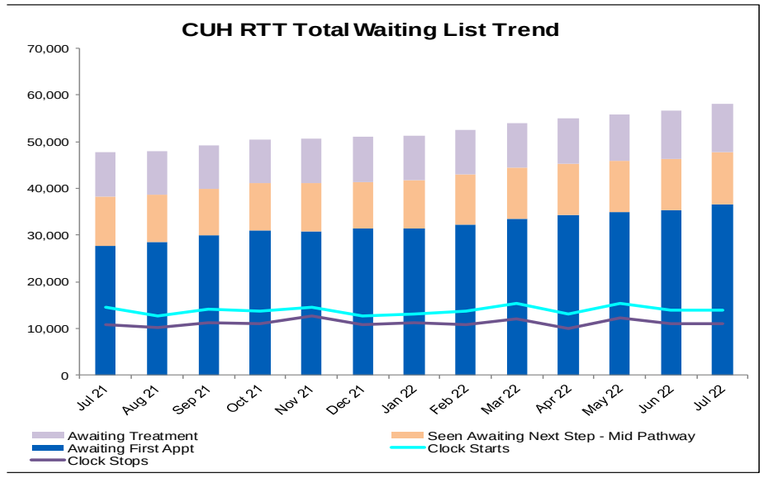
Division	Corporate			Division A			Division B			Division C			Division D			Division E			Total		
Staff Group	No. Staff requiring testing	Total protected staff	% Total staff protected	No. Staff requiring testing	Total protected staff	% Total staff protected	No. Staff requiring testing	Total protected staff	% Total staff protected	No. Staff requiring testing	Total protected staff	% Total staff protected	No. Staff requiring testing	Total protected staff	% Total staff protected	No. Staff requiring testing	Total protected staff	% Total staff protected	No. Staff requiring testing	Total protected staff	% Total staff protected
Add Prof Scientific and Technical (Pharmacists only)	6	4	67%	-	-	-	125	86	69%	1	1	100%	-	-	-	-	-	-	**132**	**91**	**69%**
Additional Clinical Services	9	7	78%	179	119	66%	68	51	75%	97	77	79%	68	44	65%	57	38	67%	**478**	**336**	**70%**
Allied Health Professionals	-	-	-	53	21	40%	116	80	69%	1	0	0%	-	-	-	-	-	-	**170**	**101**	**59%**
Estates and Ancillary (Porters and Securuty Personnel only)	54	54	100%	5	2	40%	1	1	100%	-	-	-	-	-	-	-	-	-	**61**	**57**	**93%**
Medical and Dental	-	-	-	127	67	53%	78	54	69%	166	120	72%	99	59	60%	128	90	70%	**598**	**390**	**65%**
Nursing and Midwifery Registered	-	-	-	515	364	71%	25	18	72%	226	182	81%	138	105	76%	274	224	82%	**1178**	**893**	**76%**
Total	**69**	**65**	**94%**	**879**	**573**	**65%**	**413**	**290**	**70%**	**491**	**380**	**77%**	**305**	**208**	**68%**	**459**	**352**	**77%**	**2617**	**1868**	**71%**

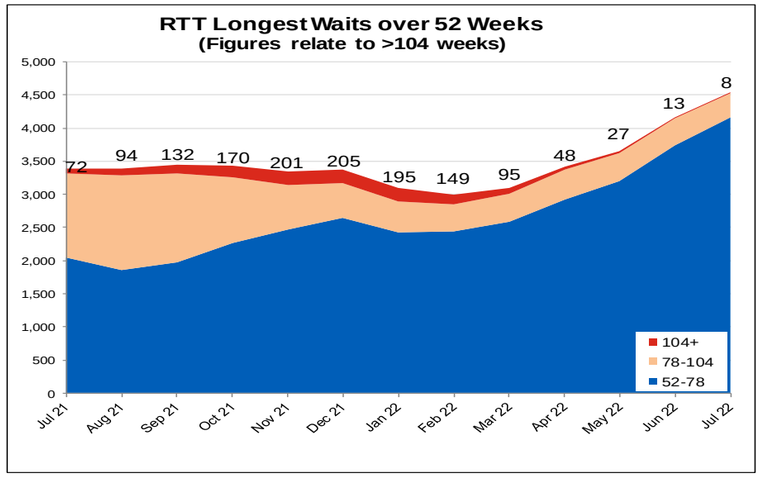
The data displayed is at 19/07/22. This data reflects the current escalation areas requiring staff to wear FFP3 protection. This data set does not include Medirest, student Nurses, AHP students or trainee doctors. Conversations on fit testing compliance with the leads for the external entities take place on a regular basis. These leads provide assurance on compliance and maintain fit test compliance records. Fit test compliance for Bank and Agency staff working in 'red' areas is checked at the start of each shift and those not tested to a mask in stock are offered fit testing and/or provided with a hood.
Staff are required to be mask fit tested every two years with many staff due to be retested . This may be reflected in the reduction in compliance percentages

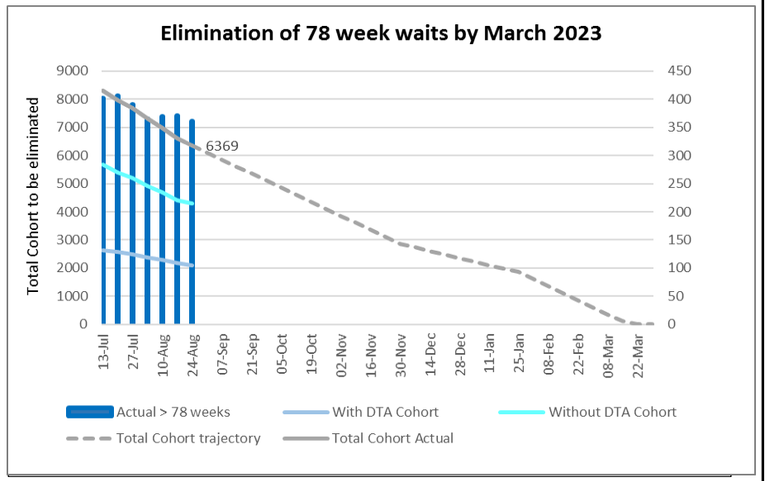
Referral To Treatment - (RTT)

Cambridge University Hospitals NHS Foundation Trust

National Targets







The Operational Planning requirements 2022/23 for the Referral to Treatment (RTT) waiting list require us to:-

- eliminate waits over 104 weeks by 1st July 2022 and maintain this position throughout 2022/23 (except where patients choose to wait longer)
- eliminate waits over 78 weeks by April 2023

The total waiting list size grew by 1,506 in July to 58,203. Our Month 3 planning submission had forecast growth to 55,160 so we are now 5.5% higher than plan.
Compared to pre-pandemic the waiting list has grown by 71%.
The number of patients joining the RTT waiting list (clock starts) were 3.7% lower than last month, but 6.8% higher than July 2019. We had forecast continued referral growth of 2.3% above 2019 baseline so this higher level of demand will be driving the waiting list up. Clock starts (referrals) represented 24% of the total waiting list size in the month. Patients waiting to commence their first pathway step accounted for 63% of the total.

The number of RTT treatments (stops) delivered in July were 6% lower than June and represented 90.5% compared to July 2019. Non-admitted stops were 91.4% of baseline, but were 8% lower than last month. Admitted stops rose to 87.7% of baseline and were higher then the previous month. Total treatments were 16% below our submitted planning levels overall. Lower than planned outpatient attendances is the biggest driver of this variance in planned RTT clock stops. With the rise in demand, and lower treatments, the clearance time for the RTT waiting list (how long it would take to clear if no further patients were added) increased to 22.4 weeks.

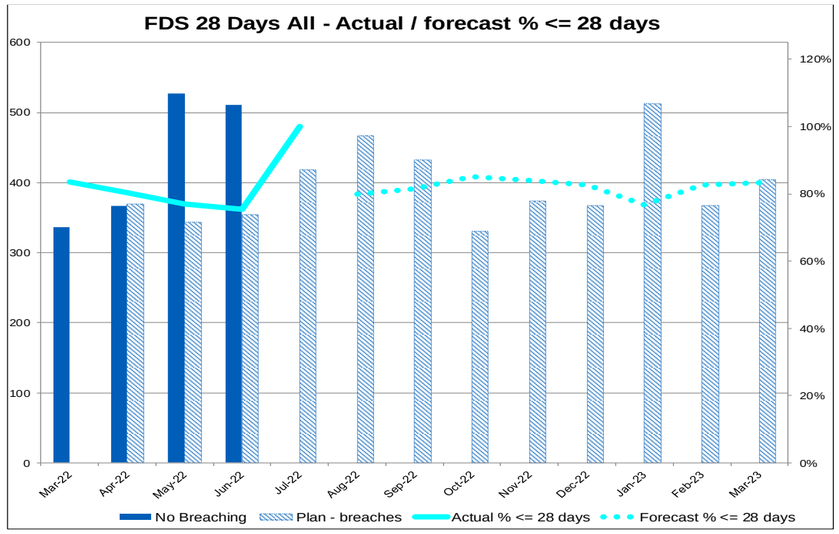
The 92nd percentile total waiting time increased to 51 weeks. The delays are still lengthening in the non-admitted stage of the pathway which has risen to 47 weeks.
The volume of patients waiting over 52 weeks continued to rise up to 4,537. This was a 9% growth and compares to the last reported National figures of a 7% growth. The growth in month was driven by OMFS (20%) Rheumatology (15%) and Ophthalmology, ENT and Cardiology all representing 13%. 745 patients in total were treated who had waited over a year but this did not keep pace with the higher rate of patients reaching 52 weeks. OMFS will be commencing Insourcing from September with the aim of delivering 900 units of activity to support long wait reduction. Mutual aid opportunities within Rheumatology and Cardiology continue to be a focus of the ICS but no specific actions to support activity have commenced as yet. ENT is a challenge across the ICS and a deep dive discussion was held at the ICS Planned Care Board with a review with the National GIRFT team planned for the end of September. The non-admitted pathway and the role of the community provider needs to be the focus of the ENT work system wide.
The volume of patients waiting over 78 weeks is continuing to decrease currently, down to 373 from 417. Divisions are working with a step down plan to reduce maximum waits by 2 weeks per month through to year end and the current rate of reduction of the total cohort is meeting the trajectory to deliver the requirement to eliminate 78 week waits by April 2023. The Trust has been placed in Tier 2 for Regional oversight of our progress with the 78 week requirement. Waits over 104 weeks reduced to 8 by end of July and we forecast to have 8 at the end of August and 2 at the end of September. The outstanding cases are either patient choice or for complex/clinical reasons. NHSE are currently reviewing the rules regarding patient choice.

Nationally the RTT waiting list continues to rise, reaching 6.7 million in June 2022 with a 45.7 week 92nd percentile wait and 5.3% of patients waiting over 52 weeks. CUH has7.3% over 52 weeks which is now 4th highest of the 14 Acute Trusts in EoE. At 13.1% over 52 weeks, Norfolk and Norwich remains the greatest challenge in the Region for long waiting patients. We remain third highest amongst the Shelford Group with Birmingham the most challenged with 20.2% over 52 weeks.

Cancer

National Targets

Cancer Standards 22/23	Target	Qtr 1 - 21/22	Qtr 2 - 21/22	Qtr 3 - 21/22	Qtr 4 - 21/22	Apr-22	May-22	Jun-22	Qtr 1 - 22/23
2Wk Wait (93%)	93%	93.0%	94.9%	81.8%	78.9%	74.9%	88.1%	86.1%	83.3%
2wk Wait SBR (93%)	93%	84.4%	92.4%	43.9%	35.5%	23.0%	73.8%	69.6%	55.1%
31 Day FDT (96%)	96%	92.9%	91.7%	91.0%	94.3%	93.8%	90.8%	88.5%	91.0%
31 Day Subs (Anti Cancer) (98%)	98%	98.8%	99.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
31 Day Subs (Radiotherapy) (94%)	94%	94.9%	99.1%	98.3%	93.7%	75.1%	89.6%	90.1%	85.1%
31 Day Subs (Surgery) (94%)	94%	87.5%	85.1%	83.0%	89.0%	82.9%	83.7%	82.1%	82.9%
31 Day - Combined	**96%**				**94.2%**	**87.0%**	**90.8%**	**89.9%**	**89.3%**
FDS 2WW (75%)	75%	83.8%	81.1%	85.3%	81.3%	81.2%	77.7%	75.4%	78.0%
FDS Breast (75%)	75%	99.5%	97.6%	98.0%	94.6%	93.3%	98.3%	98.2%	96.6%
FDS Screen (75%)	75%	65.8%	72.9%	65.7%	64.5%	64.6%	61.3%	67.8%	64.6%
FDS - Combined	**75%**				**80.6%**	**80.3%**	**77.0%**	**75.4%**	**77.4%**
62 Day from Urgent Referral with reallocations (85%)	85%	**75.4%**	**75.1%**	**73.2%**	**73.0%**	**77.4%**	**74.7%**	**67.3%**	**71.0%**
62 Day from Screening Referral with reallocations (90%)	90%	**68.6%**	**55.0%**	**68.9%**	**61.4%**	**59.5%**	**47.5%**	**54.1%**	**50.6%**
62 Day from Consultant Upgrade with reallocations (50% - CCG)	50%	65.8%	60.0%	51.2%	74.2%	85.7%	33.3%	53.3%	47.6%
62 Day Reallocations - Combined	85%				**67.7%**	**75.7%**	**70.8%**	**65.4%**	**70.7%**



The latest nationally reported Cancer waiting times performance is for June 2022.
The Cancer Waiting Time standards are currently out for consultation Nationally with a view to being consolidated into three combined standards: Faster Diagnosis within 28 days; Referral to Treatment within 62 days; and Decision to Treat to Treatment within 31 days. The combined standard performance is reflected in the table above in preparation for this.

Breast remained 44% of the 2WW breaches in June although this was a further reduction on the prior month. An increased number of breaches were seen in Skin, and patient choice breaches increased to 48% in the month. The breaches that were due to capacity reflected an average wait of 18 days for patients rather than within 2 weeks. The National performance was lower in June for both 2ww and 2ww SBR at 77.7%% and 66.1% respectively.

Our combined performance on the Faster Diagnosis standard within 28 days remains ahead of target at 75.4% although performance did decline again in June . National average is 70.3% for FDS.

The 62 day Urgent standard performance dropped in June to 67.3%. This was still ahead of performance Nationally of 58.9%. There were 49.5 accountable breaches of which 38 were CUH only pathways. 22 of these delays were provider initiated delays, within which 9 sighted histology turnaround delays, 5 other diagnostic delays, 5 surgical delays and 3 outpatient delays. 19.5 were due to late referrals of which 11 were treated within 24 days of transfer. Breaches spanned 10 cancer sites, with the highest volumes by site being Urology with 16.5, Gynaeoncology 10, Head and Neck 7.5 and Lower GI 7. The 62 day screening standard incurred 7.5 breaches this month, all bar one was in Breast. Performance was 54.1% compared to higher National performance at 67.1%.

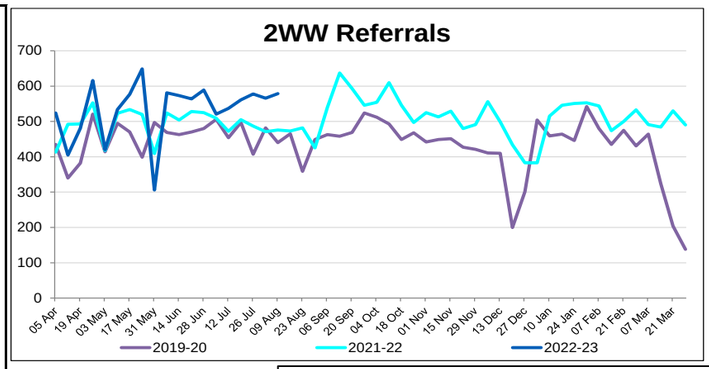
The 31 day FDT standard deteriorated in June down to 88.5%, and was below National at 91.8%. The subsequent surgery standard also dropped to 82.1% but was above National of 80.5%. Elective capacity accounted for 75% of those exceeding 31 days, the highest being Urology, Breast and Lower GI with 10, 6 and 6 breaches due to surgical capacity respectively. The impact of the CT replacement in Radiotherapy is still pulling down the subsequent radiotherapy performance but there was improvement up to 90.1%. Performance in this areas is likely to be more challenging due to increased staffing gaps in the peak holiday season impacting the mitigation plan.

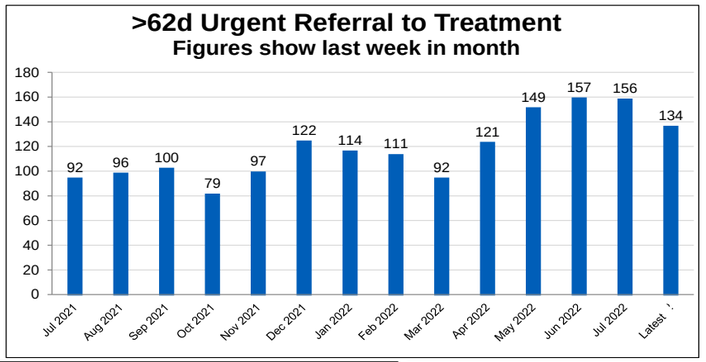
30 pathways waited >104 days for treatment in June. 19 were shared pathways referred between day 58 and 219, with the highest volume form a single Trust being NWAFT with seven. Eleven CUH pathways exceeded 104 days across eight different cancer sites. The RCAs have been reviewed by the MDT Lead Clinicians and the Cancer Lead Clinician for the Trust., three remain outstanding. One case from May was referred to the Trust Harm review panel for discussion as harm was indicated. The assessment was upheld, and the RCA is being shared with the quality leads of the referring Trust where the delays occurred.

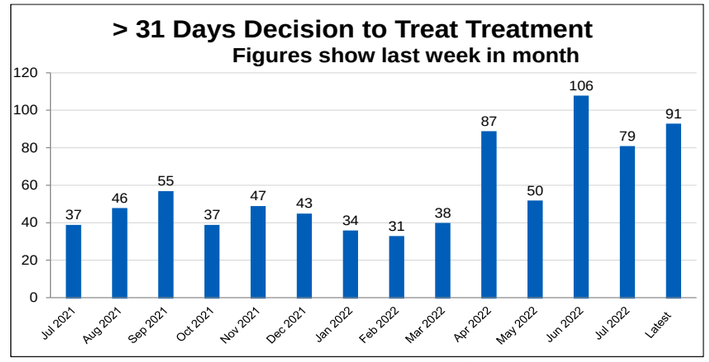
Cancer

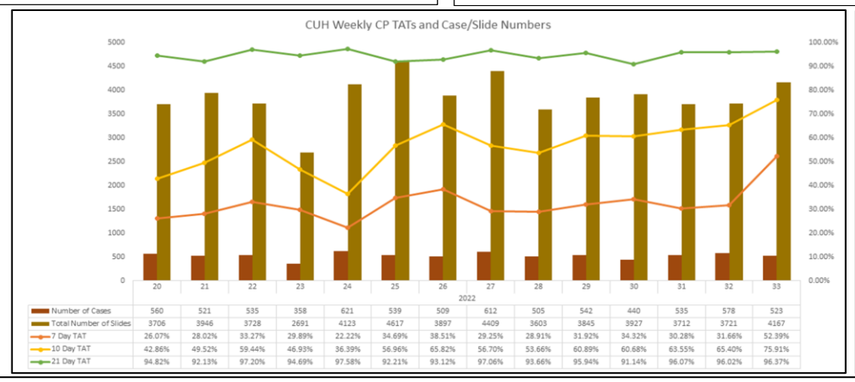
Cambridge University Hospitals NHS Foundation Trust

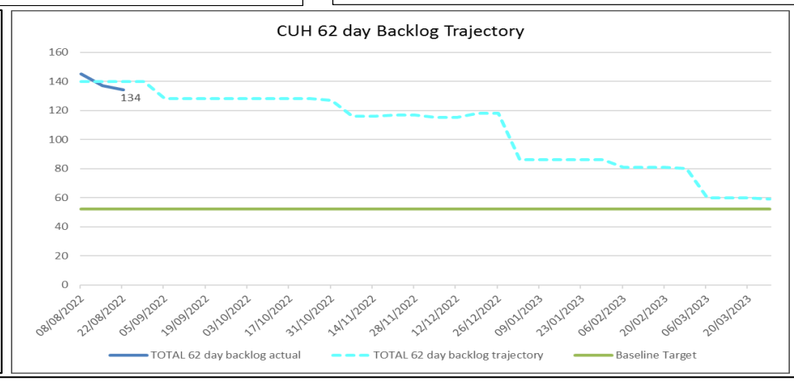
National Targets











Current position

Over the past four weeks 2WW suspected cancer referral demand has reached 124% compared to the same baseline period in 2019. Lower GI continue to see exceptional demand over the past month with 56% higher 2ww referrals than in the same period in the baseline year. Skin is seeing a 35% higher referral demand. Lower GI have largely managed to continue to offer capacity within 2 weeks through delaying other lower priority groups. As we approach the end of August Dermatology are offering 2ww appointments within 2 weeks again, however the Plastic Surgery cohort within the Skin service are reporting a weekly shortfall of 19 slots with significant ongoing delays to appointments. 2ww breaches will exceed 500 in July and August due to the impact of Skin and a deterioration in Breast. A further ICS meeting regarding Skin and Dermatology services is due to be held on 31st August.

We reported last month that trajectories for the recovery of 62 day backlog were required to be completed by the end of August 2022. This followed recognition Nationally that 10.3% of cancer patients waiting were over 62 days, and that in the EoE this was 12.2%. A requirement to be no more than 6.4% waiting past day 62 by March 2023 was outlined by NHS England. CUH is achieving 5.7% in our latest data, however we recognise that with 134 patients waiting over 62 days we are still far from recovering the baseline performance of 52 that we achieved before the pandemic. Our Lead Cancer Manager led a deep dive into the backlog position by cancer site capturing all the multiple delays along the pathway that were exceeding the best practice internal standards, not just the dominant delay. This analysis has been triangulated with the actions being undertaken in our Cancer Improvement plan to forecast when the planned actions will impact on a reduction in patients waiting over 62 days. The trajectory above has two notable step changes in December and March when pathology estimate a sustained improvement in turnaround times linked to recruitment. It should however be noted that in the most recent week that turnaround within 7 days saw a significant improvement to 52% which was supported by high uptake in additional hours and a reduction in hours lost to sickness. The 62 day backlog has been on an improving trend for the past three weeks. 61% of the breaches are CUH only pathways, of which Lower GI 30%, Urology 20% and Skin 17%.

The number of patients waiting over 31 days for treatment has increased since last month up to 91. Delays have increased in Prostate, Breast, HPB and Gynaeoncology. Delays for Radiotherapy are impacting the Breast and Prostate deterioration and these are being re-validated. Without these the position would remain stable with last month. Robotic prostatectomy mutual aid discussions are in progress as this will not only support the backlog for prostate surgery but also support the pressure on Robotic theatre capacity for Kidney patients. HPB have been asked to determine if they require mutual aid as the improvement seen last month has not continued. Skin surgical capacity remains a risk due to the high demand but one-stop see and treat pilots have commenced and new locations for surgery at Newmarket have been confirmed

Author(s): Linda Clarke

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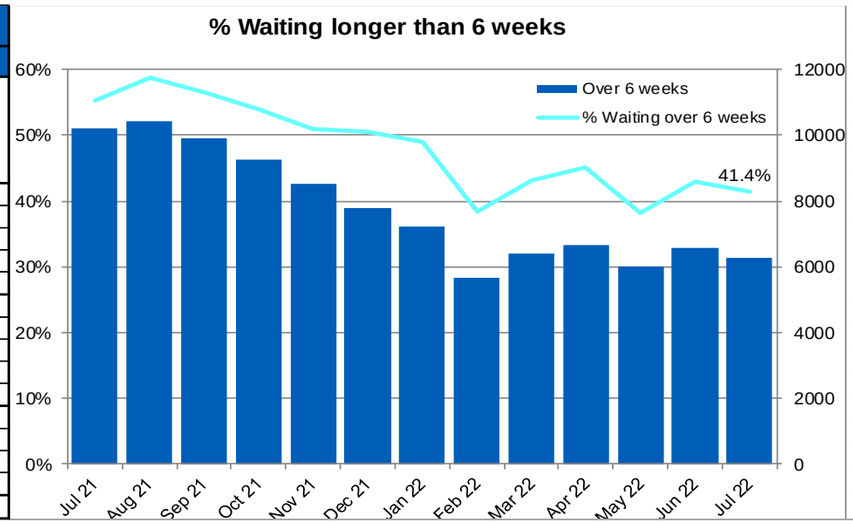
Diagnostics

Cambridge University Hospitals NHS Foundation Trust

Operational Performance

Change from previous month:		Jul-22								
		Waiting List					Scheduled Activity		Total Activity	
Deteriorated / Improved		Total Waiting List	Variance from Feb 2020		%> 6 weeks	Mean wait in weeks	Scheduled Activity	Variance from Jul-19 Baseline	Total Activity	Variance from Jul-19 Baseline
Imaging	Magnetic Resonance Imaging	3223	1962	64%	47.4%	8	2588	114.0%	2978	113.6%
	Computed Tomography	2323	1038	124%	53.2%	13	3017	119.9%	6011	122.1%
	Non-obstetric ultrasound	4061	1876	116%	39.9%	6	3105	97.2%	3723	94.3%
	Barium Enema	64	31	106%	23.4%	4	40	162.3%	42	170.4%
	DEXA Scan	856	648	32%	23.4%	4	622	123.2%	622	120.4%
Physiological Measurement	Audiology	713	338	111%	48.5%	7	400	87.4%	400	87.4%
	Echocardiography	1842	967	90%	59.0%	11	1455	109.9%	1855	110.6%
	Neurophysiology	189	269	-30%	1.6%	2	196	70.4%	207	70.8%
	Respiratory physiology	61	24	154%	72.1%	13	21	115.0%	23	114.5%
	Urodynamics	227	93	144%	55.5%	9	72	101.1%	72	101.1%
Endoscopy	Colonoscopy	622	539	15%	0.3%	2	532	144.2%	538	140.3%
	Flexi sigmoidoscopy	128	106	21%	0.8%	2	86	129.0%	110	111.6%
	Cystoscopy	190	236	-19%	15.8%	4	362	85.8%	374	84.5%
	Gastroscopy	618	581	6%	2.8%	3	547	96.3%	598	93.0%
Total Diagnostic Waiting List		**15117**	**8708**	**74%**	**41.4%**	**8**	**13043**	**108.0%**	**17553**	**108.9%**



The Planning guidance for 2022/23 requires Systems to increase diagnostic activity to a minimum of 120% of pre-pandemic levels . This would include community diagnostic activity as well as that delivered in the Acute hospital setting. Recovery of 6ww performance is required to be <5% by March 2025. Four of the diagnostic modalities are now achieving <5%.

Total diagnostic activity in July delivered to 108.9% of July 2019 baseline. Scheduled activity only, which addresses our waiting list, delivered 108% of baseline. Total activity was up by 1.4% and scheduled activity by 4% compared to the prior month. The total waiting list size reduced by 219 to 15,117, and the volume of patients waiting over 6 weeks reduced by 336 this month so the > 6 weeks performance improved to 41.4%. The Mean waiting time was stable at 8 weeks. Nationally published data for June 2022 shows National performance of 27.5%. From a Regional perspective of the 14 Acute Trusts in EoE, CUH were 4th from bottom with Kings Lynn, West Suffolk and E&N Herts with a slower recovery rate.

Imaging is 70% of the diagnostic waiting list. Imaging activity overall achieved above baseline levels for total activity and scheduled activity at 111% and 110% respectively. The Imaging waiting list overall reduced by just 16, with progress made in all modalities bar Ultrasound where the increase was 472.

- **CT** were tracking well against their recovery trajectory of September until the very end of July. Demand is running ~10% above plan through August, activity is running 12% below plan. 65% of the activity shortfall is from CUH staffed capacity due to staffing pressures. The additional mobile CT for the ICS based at NWAFT may now not be available full time until October. NWAFT have a CT replacement planned so the ICS Diagnostic Board is determining the impact, and the allocation of the resource . This together with a day of Independent Sector capacity per week will determine the extent of slippage on CT recovery. CUH CT is now the second slowest to recover 6ww performance in the Region behind West Suffolk.
- **MRI** started to see an improving waiting list from mid July and remain ahead of trajectory by ~400. Neither core capacity nor the Hinchingbrooke mobile capacity are delivering to plan currently however. Options to mitigate a further MRI replacement at CUH in Q3 continue to be explored and a solution to this is required to deliver the Jan 2023 recovery plan. A mobile unit has been identified but a site for it to be located is required. CUH MRI % recovery is now third worst in the Region behind E&N Herts and Kings Lynn.
- **Dexa** have been achieving high core capacity and have maintained access to community capacity at the required volume per month. The total waiting list size looks to be achieving baseline by the end of August and the 6 week wait volume is forecast to reduce to 140. A focus on treating in turn will be needed to meet the Trajectory for recovery in October 2022.
- **Ultrasound** started to see a reducing waiting list from mid August, but remain ~450 off trajectory and that trajectory did not have a recovery date within 22/23. Over the past four weeks demand has continued 237 above forecast and activity has been 87 below, mainly due to core capacity. This is despite an expectation that demand would be reducing with the extra community capacity in place for direct access referrals. Additional community locations were still being progressed within the ICS so this model needs to be more effective to support recovery. CUH is ranked 10/14 for ultrasound recovery across the Region.

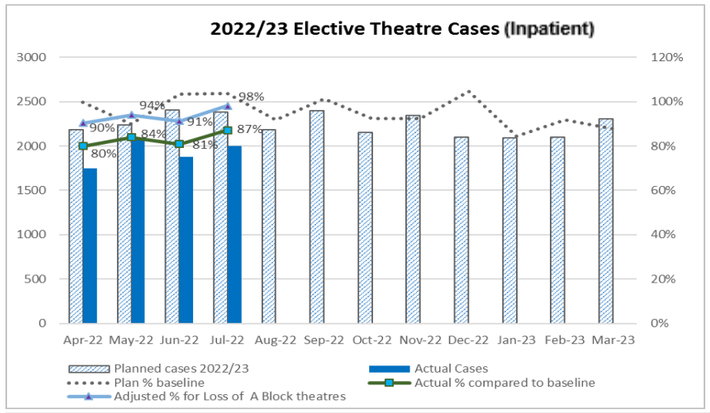
Physiological measurement saw a waiting list reduction of 349 in July, of which 425 was in Echocardiography, with increases seen in Audiology and Neurophysiology. Activity across the group was above 100% of baseline. Echocardiography is now 12% % of the total diagnostic waiting list and has the lowest recovery performance at 59% for the large diagnostic modalities. Echo remain on track with the recovery trajectory but as this extends beyond Q4 they continue to explore all options. We are ranked 9/14 for recovery across the EoE with Bedford and Norfolk & Norwich still with >80% waiting more than 6 weeks. Audiology have sought the support of the Diagnostic Taskforce to pursue locum appointments to help with their recovery trajectory.

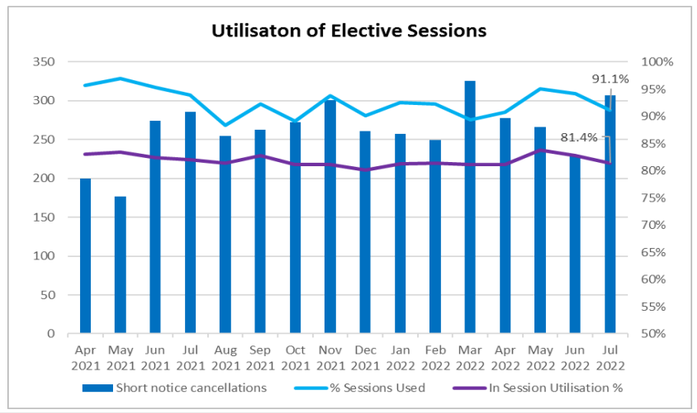
Endoscopy achieved 3.2% for > 6 weeks in July. Waiting lists did increase by 146 which is likely the impact of the high 2ww demand for Lower GI. Only cystoscopy remains with a long wait issue to address despite now having an overall waiting list lower than baseline . The imbalance between Urology and Gynaecology cystoscopy needs further action.

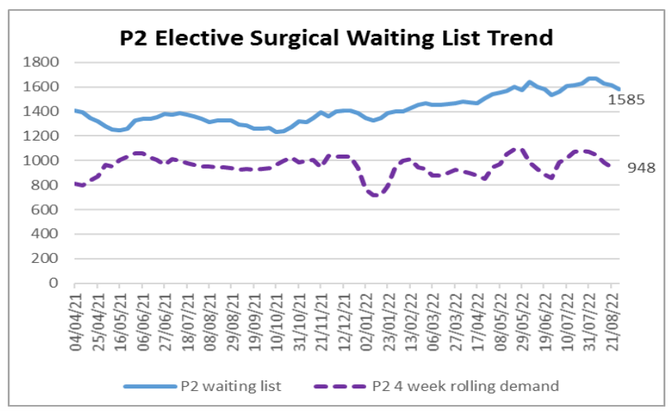
Operations

Cambridge University Hospitals NHS Foundation Trust

Operational Performance







Elective theatre activity in July delivered an improved 87% of the July 2019 baseline. Taking account of the loss of the A Block theatres from our capacity, this would bring the performance up to 98%.

- Our plan for July 2022 was to deliver 104% of baseline so we fell short by 383 operations. Productivity dipped again in July, achieving 91.1 % of sessions used against the standard of 95%, with in-session utilisation dropping to 81.4%.
- Short notice cancellations in elective sessions increased in July and were the second highest in the past year. At 307 cases , they equated to 548 hours of theatre time. 11% were directly attributable to COVID due to either staff or patients testing positive, 21% were cancellations for other clinical reasons. 16% were due to bed availability, 14% were short notice cancellations by patients, and 11 % due to staff unavailability. The impact was again highest across Ophthalmology with 45 cancellations, followed by Urology (42) . As Ophthalmology have a high volume of clinical and patient initiated cancellations they are looking at an HCA role to support additional patient contacts ahead of the day of admission.
- Ely continued to see in-session utilisation of over 80% but it had dropped to 81.4% . Sessions used dropped significantly in July to 64.2%. Lack of surgical cover was the reason for underutilisation. 20 of the 38 unused sessions were for Pain Management for the Treatment room. The Right Procedure Right Place initiative is now being taken forward as part of the Surgery Programme Board to broaden the procedures that can be undertaken in this environment.
- The Cambridge Eye Unit dropped to 87.8% sessions used due to surgeon leave and sickness. In-session utilisation did improve to 78.5% although remains well below the required standard. The HVLC cataract lists achieved 8 cases in July but barriers remain to stepping this up to nine then ten in accordance with the investment case in nurse staffing.
- The weekend elective activity in July was only 22 elective cases. Willingness from staff to support more weekend sessions is still not forthcoming. A business case from Division D to support Neurosurgical weekend elective lists has been agreed to proceed to recruitment.

The number of P2 patients (inpatients) awaiting surgery has reduced from last month to 1,585, but this will have been supported by a drop in the rolling four weekly demand through August. The volume waiting over 4 weeks has increased by 27 over the past month to 901. Orthopaedics, Neurosurgery, Ophthalmology, Urology and Paediatric Surgery are the services with the highest volumes overdue. Orthopaedics will get higher session allocation from September in line with job planning adjustments and some of their P2 cases can now be undertaken in the Ely Treatment room with the new guidance for hand surgery.

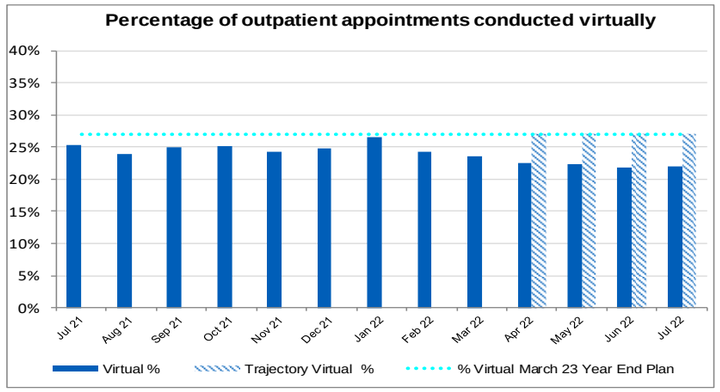
The Surgery Programme Board meets fortnightly with clinical engagement from across the HVLC specialties and monitor improvements against the GIRFT recommendations:

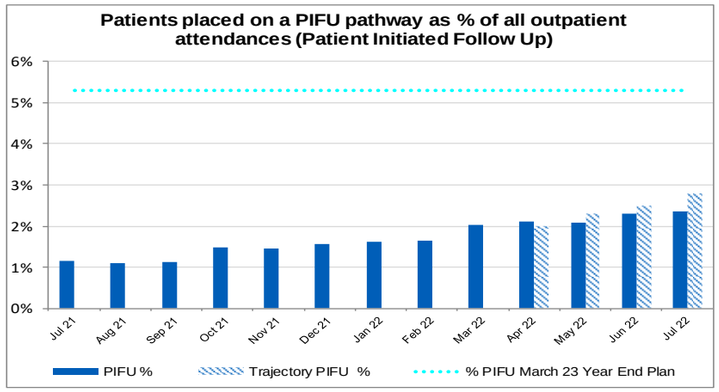
- **Ely DSU:** OMFS have been focusing on utilisation and have delivered 90.8% in their 6 sessions in August.
  Plastic surgery have also shown improvement up to 85% across their 12 sessions in August. Urology still aim to increase sessions timetabled for Ely and equipment is still awaited to support that further, they are consistently delivering over 85% utilisation in their Ely sessions over the past 3 months,
- **Gynaecology:** Use of new technology to support an expansion in minimally invasive hysterectomy being introduced. Metrics being tracked relative to efficiency, productivity and patient outcomes.
- **Orthopaedics:** Dedicated HVLC lists for 4x Ortho joints on a list, 3 dates booked 19th, 22nd, and 29th September
- **ENT:** We have trialled dedicated theatre lists to HVLC casemix using Associate specialist we have demonstrated delivery of the required cases per list and day case rates for GIRFT. The competing priorities of cancer and longest wait patients that are not the HVLC casemix is limiting the opportunity to do this with regularity.
- **General Surgery:** Dedicated HVLC lists for General Surgery, both HPB and UGI agreed to start with DC Lap Chole. Joint 78 week eradication plan and shared CAS to begin in September
  RFAs moving to Radiology to free up Theatre Capacity, awaiting confirmation from Anaesthetics, meeting to agree pathway 9th September

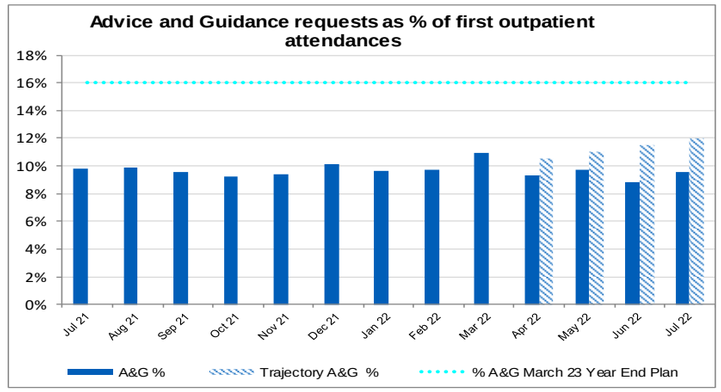
Outpatients

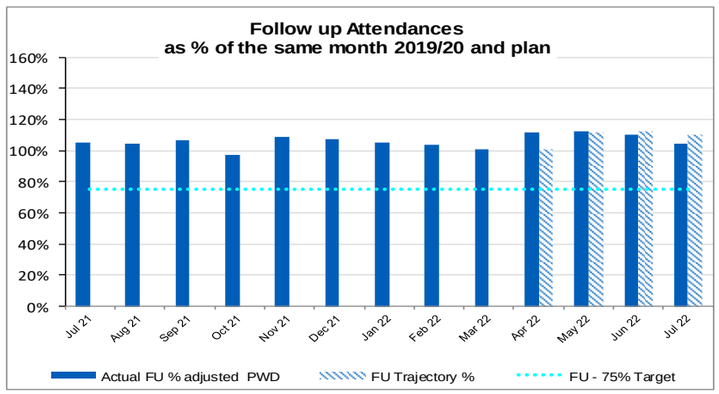
Cambridge University Hospitals NHS Foundation Trust

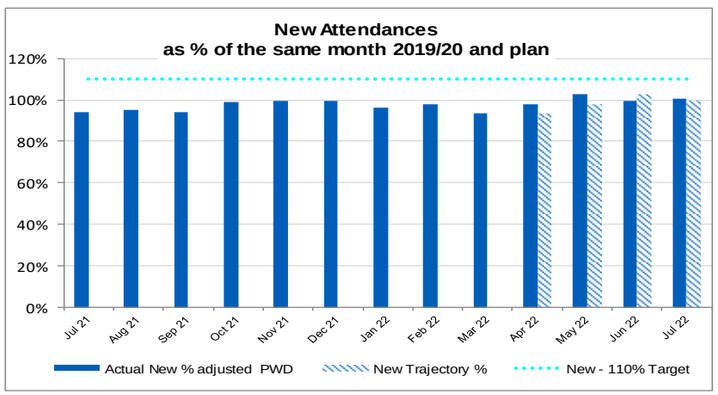
Operational Performance











Outpatients delivered just 97.7% of its new patient pre-Covid baseline, a reduction of 2380 attendances. Areas of biggest concern are Rheumatology, Gynaecology and Pain. There is a robust recovery plan for Rheumatology, and working alongside the Improvement Team, other areas are also developing recovery plans.

Follow-up performance against baseline was 108.5% in July, down from 110.6%, which is a positive reduction. There is a requirement from NHS England to deliver less follow-up appointments and therefore a downward trajectory is positive unlike new appointments. Areas of specific concern include Gynaecology, Midwifery Service, Endocrinology and some of the Paediatric services. Reducing follow-ups for paediatrics is a complex discussion, but all services have been asked to consider what options they have. A number of services have indicated they would be keen to implement "patient not present" consultations but we are waiting for a national guidance on how these should be recorded.

We continue to perform well with PIFU, we achieved 2.3% in July. There are opportunities for this to continue to increase and the Improvement Team are continuing to work with services to maximise this. A meeting was recently held with Norfolk and Norwich who were one of the NHS England pilot sites as part of the Personalised Outpatient Program, and this provided lots of context and considerations that we can follow up with. We continue to have a very low conversion rate at around 7%.

The Trust position continues to exceed 16% in Advice and Guidance?. Our external reporting for outpatient attendances includes Diagnostic Imaging activity. This is recorded as new activity, adversely affecting the perceived A&G % performance. We are continuing to work with the ICS and national teams on how to resolve this difference to reflect equity.

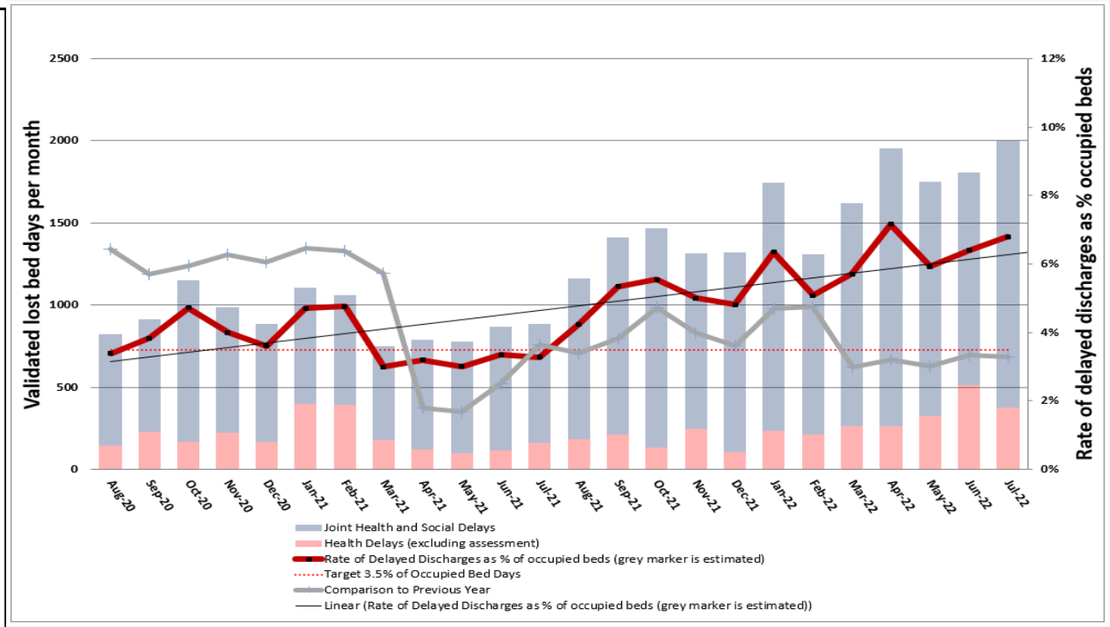
Author(s): Andi Thornton

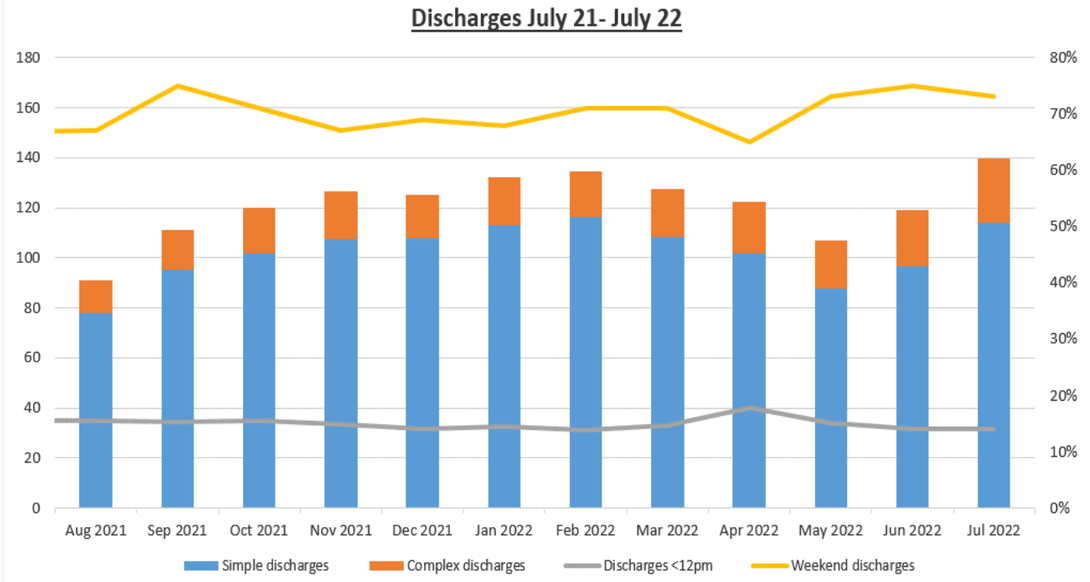
Owner(s): Nicola Ayton

Delayed Discharges

Cambridge University Hospitals NHS Foundation Trust

Operational Performance





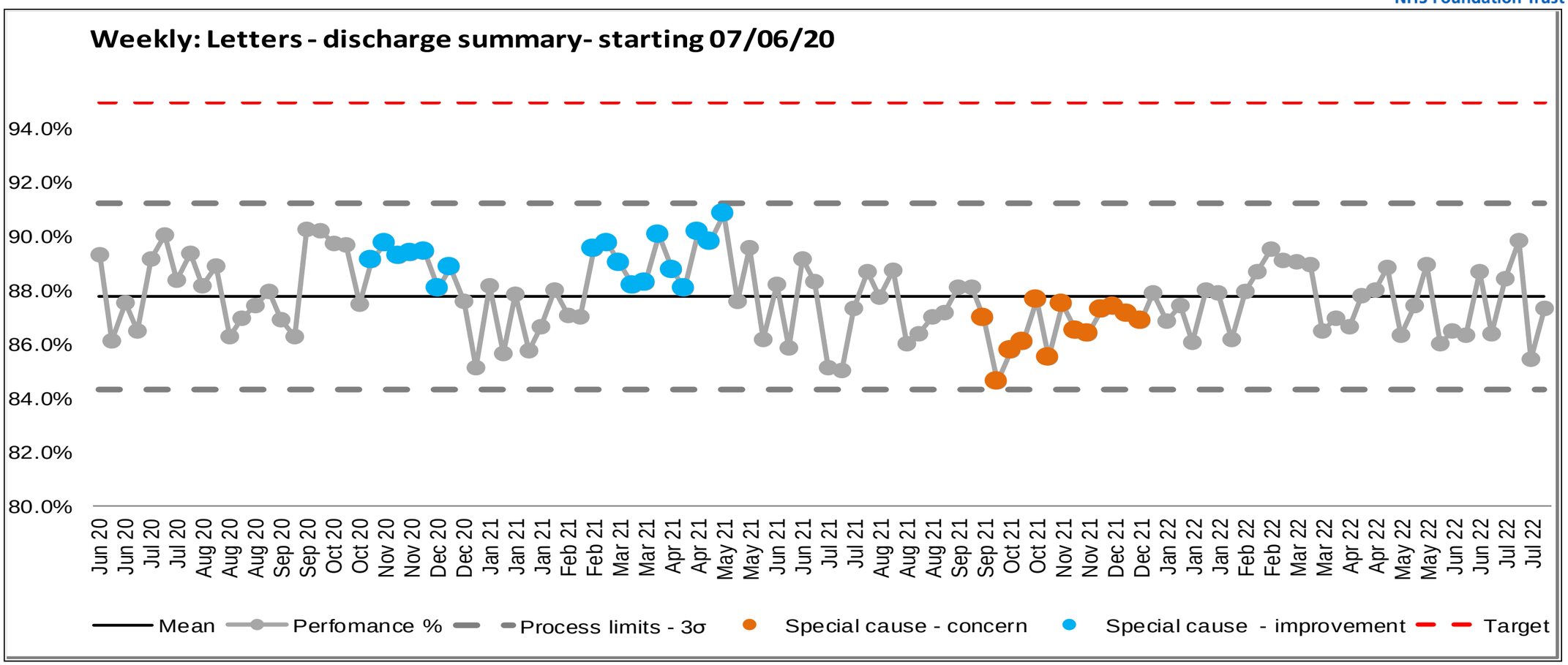
The Hospital Discharge Service Requirements guidance was updated on March 31st 2022. For this June data, you will see above 2 graphs.
The graph on the left looks at the overall lost bed days for the month, spanning back over the previous 12 months (similar to the previous integrated performance reports). The graph on the right looks at average number of complex and simple discharges per day, with average weekend discharges (% from week day discharges) and average discharges before noon (for the month).
For July 2022, we are reporting 6.8%, which is another consecutive increase of 0.4% from the previous month. There has been a larger increase in the number of overall lost bed days in comparison to previous months, but due to the overall monthly occupied bed state, the impact of DTOC % is lower. Within the 6.8%, 71% were attributable to Cambridgeshire and Peterborough CCG, and the remainder across a further 7 CCG's. *Please note that we have referred to delays per CCG instead of Local Authority.*
In relation to lost bed days for Cambridgeshire and Peterborough overall for July (1420) this has been an increase from June (1297).
For out of county patients, we continue to see a sustained elevated number of CCGs that our patients are from and waiting care provision however we have seen a decrease in overall lost bed days which have increased to similar numbers to May (601), now reporting at 580 for July, from June at 455 lost bed days.
For the total delays (local and 'out of area') within June for Care Homes were 41% equating to 820 lost bed days for this counting period; domiciliary care (inclusive of Pathway 1 and Pathway 3) at 27.2% of the total lost bed days for the month, at 544. This is an increase from June, where we reported 440 lost bed days due to domiciliary care.
For community bedded intermediate care (inclusive of waits for national specialist rehabilitation units), the overall lost bed days is currently at 324, a slight increase since June (293 lost bed days reported).

The national hospital discharge funding ceased in March 2022 and there has been a noticeable increase in delays for patients awaiting care provision post discharge. It is unlikely that there will be a significant consistent step change in the reduction of lost bed days per month until there is further system development of 'discharge to assess' pathways.

Discharge Summaries

Cambridge University Hospitals NHS Foundation Trust

Operational Performance



Discharge summaries

The importance of discharge summaries has been raised repeatedly with clinical staff of all grades and is included at induction.

The ongoing performance of each clinical team can be readily seen through an Epic report available to all staff

The clinical leaders have been repeatedly challenged over performance in their areas of responsibility at CD/ DD meetings and within Divisional Performance meetings

Author(s): James Boyd

Owner(s): Ashley Shaw

Patient Experience - Friends & Family Test (FFT)

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	Jul 20 - Jul 22	Month	-	94.0%	95.8%		-	-	For July, there was a 1% decline in the Good score from 95.3% in June to 94.0%. This is the second month in a row with a 1% decline in the score. The Poor score increased 0.7%. The number of responses decreased by 100 and this the lowest number of FFT collected so far this year, well below FFT responses of 850-950 pre pandemic. **FOR JUL: there were 342 FFT responses collected from approx. 4,457 patients.**
FFT Inpatient poor experience score	Jul 20 - Jul 22	Month	-	2.7%	1.5%		-	-	
FFT Outpatients good experience score	Apr 20 - Jul 22	Month	-	93.1%	95.3%	L	SP	-	For July, the Good score decreased by 1% from 94.1% in June and is the second month in a row with a 1% decline in the score. The Poor score had a slight increase compared to June which has triggered the SPC High icon. Very few comment cards are being collected in paediatric clinics so this data is mainly adult. **FOR JUL: there were 1,718 FFT responses collected from approx. 11,850 patients. See comment below regarding # of SMS.**
FFT Outpatients poor experience score	Apr 20 - Jun 22	Month	-	2.7%	2.2%		-	-	
FFT Day Case good experience score	Apr 20 - Jul 22	Month	-	95.0%	96.8%	L	SP	-	For July, there was a 1% decrease in the Good score and the Poor score remained the same compared to June. This is the same pattern as IP and OP data with the second month in a row the Good score decreased again by 1%. **FOR JUL: there were 393 FFT responses collected from approx. 2,010 patients. See comment below regarding # of SMS.**
FFT Day Case poor experience score	Apr 20 - Jul 22	Month	-	2.0%	1.6%		-	-	
FFT Emergency Department good experience score	Apr 20 - Jul 22	Month	-	70.0%	85.7%	L	SP	-	For July the Good score decreased again and is now 70.0%, which is 2% lower compared to June (and 10% lower compared to Apr). The Poor score decreased by 2%. Paeds FFT; 1% increase in Good score/ 74.1% and 2.5% decrease in Poor score 13.0%. Adult FFT; 5.5% decrease in Good and is now 65.0% (April score was 75.7%) / 1% increase in Poor score and is now 21.0%. **FOR JUL: there were 502 FFT responses collected from approx. 3,359 patients**. The SPC icon shows special cause variations: low is a concern and high is a concern with both having more than 7 consecutive months below/above the mean.
FFT Emergency Department poor experience score	Apr 20 - Jul 22	Month	-	17.0%	8.7%	H	SP	-	
FFT Maternity (all FFT data from 4 touchpoints) good experience score	Jul 20 - Jul 22	Month	-	95.0%	95.4%		-	-	**FOR JUL:** Antenatal had 8 FFT responses; 100% Good score. Birth had 66 FFT responses out of 438 patients; 97% Good score / 1.5% Poor score, both a small change from June. Postnatal had 112 FFT responses, the majority from LM (60 FFT with 95.0% Good / 1.7% Poor), Birth Unit with 31 FFT with 87.1% Good and DU & COU 100% Good. 1 FFT 100% Good from Post Community. **JUL** overall Good score decreased by 2.5% and Poor score remained the same compared to June.
FFT Maternity (all FFT data from 4 touchpoints) poor experience score	Jul 20 - Jul 22	Month	-	1.0%	1.7%		-	-	

FFT data starts from April 2020 for day case, ED and OP FFT (SMS used to collect FFT), and inpatient and maternity FFT data starts with July 2020 due to Covid-19 restrictions on collecting FFT data. For NHSE FFT submission, wards still not collecting FFT are not being included in submission. In June 14 wards did not collect any FFT data and could be due to rise in the number of Covid patients/red wards.

Overall FFT, the scores slightly declined in July, as they did in June, with ED having the largest negative change in scores. Maternity scores declined as well, and the number of birth FFT responses continue to remain very low from the delivery unit. They had 28 FFT responses from 360 patients. However this is an improvement from the number of FFT in June.

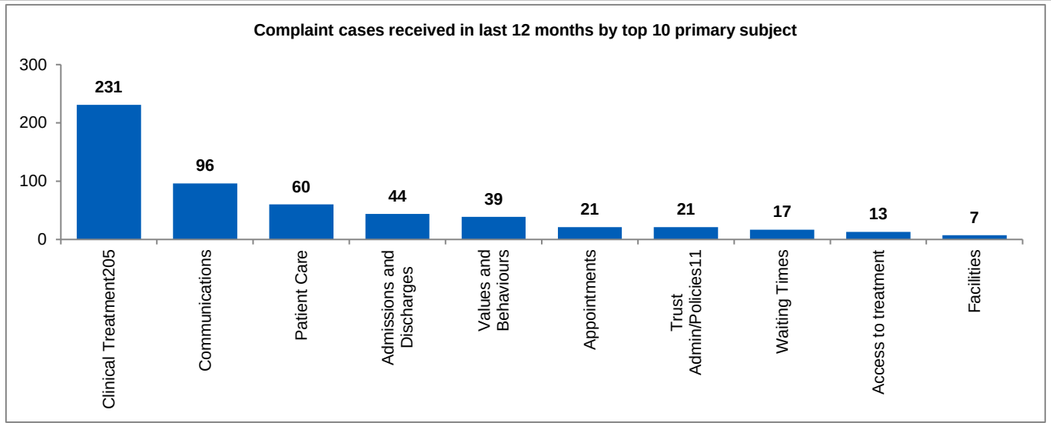
Please note starting 1 June, the Trust has reduced the number of SMS being sent to adult patients. Instead of sending a text message to every adult patient that attend an OP/DU appointment, or presented to A&E, the Trust now sends a fixed number of SMS daily,.

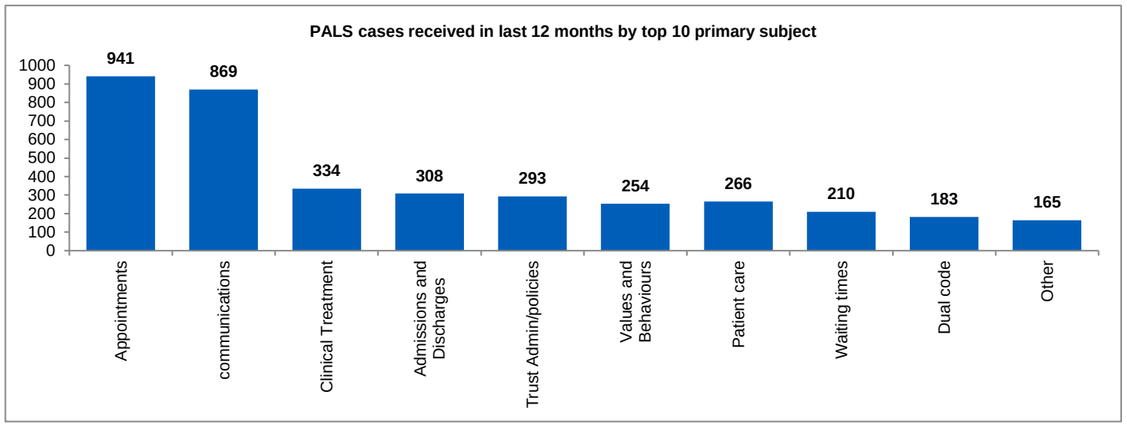
PALS and Complaints Cases

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	Jul 19 - Jul 22	month	-	85	50		-	-	The number of complaints received between July 2019 - July 2022 is higher than normal variance.
% acknowledged within 3 days	Jul 19 - Jul 22	month	95%	92%	94%		-	?	78 out of 85 complaints received in July were acknowledged within 3 working days.
% responded to within initial set timeframe (30, 45 or 60 working days)	Jul 19 - Jul 22	month	50%	13%	32%		-	?	4546omplaints were responded to in July 22, 6 of the 46 met the initial time frame of either 30.45 or 60 days.
Total complaints responded to within initial set timeframe or by agreed extension date	Jul 19 - Jul 22	month	80%	89%	92%		SP	?	41 out of 46 complaints responded to in July were within the initial set time frame or within an agreed extension date.
% complaints received graded 4 to 5	Jul 19 - Jul 22	month	-	26%	35%		-	-	There were 19 complaints graded 4 severity, and 3 graded 5. These cover a number of specialties and will be subject to detailed investigations.
Compliments received	Jul 19 - Jul 22	month	-	15	37		-	-	There were 15 compliments logged for July 22. This number is lower due to admin shortages.





PHSO - There were no cases accepted by the PHSO for investigation in July 2022. **Completed actions** During July 2022, a total of 12 actions were registered and allocated to the appropriate staff members. These actions were as a result of all complaints closed between 1 and 30 June 2022. Four of these actions were as a result of grade 1 and 2 complaints and the other eight actions were as a result of grade 3, 4 and 5 complaints. A total of six of these actions have already been completed within their allocated timescales. There are currently six actions yet to be completed, however, these are still within the allocated timeframes. Taking this into consideration, 100% of the actions registered in July 2022, have been completed in time.

Author(s): Sue Bennison

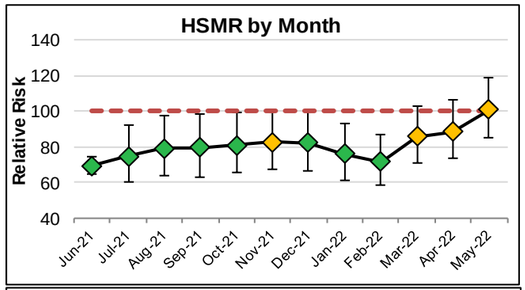
Owner(s): Oyejumoke Okubadejo

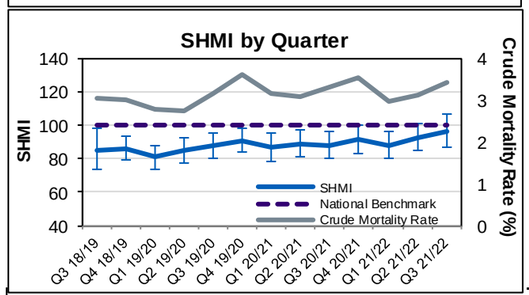
Learning from Deaths

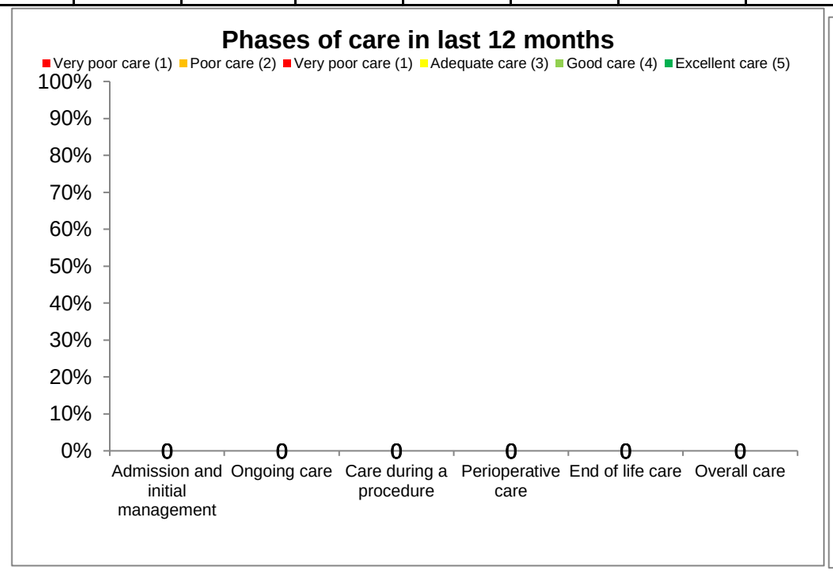
Cambridge University Hospitals NHS Foundation Trust

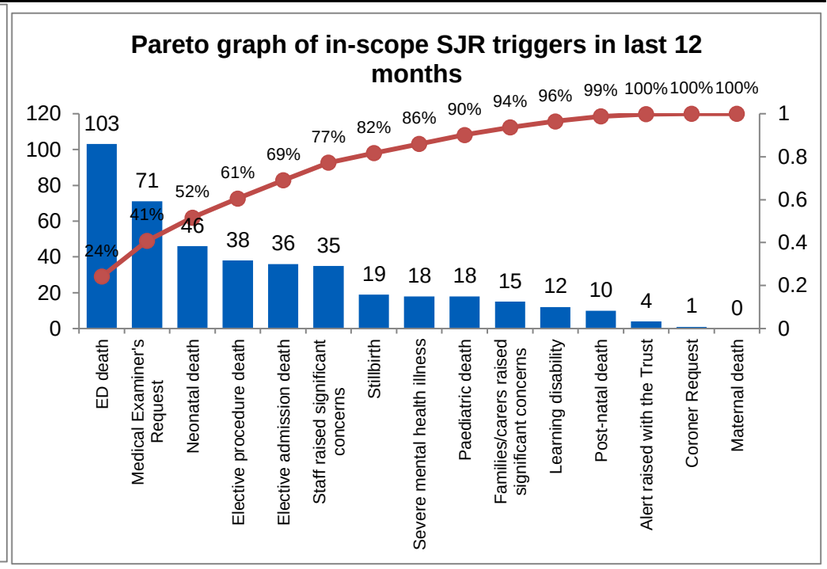
Mortality

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
Emergency Department and Inpatient deaths per 1000 admissions	Apr 18 - Jul 22	month	-	8.65	8.34		-	-	There were 144 deaths in June 2022 (Emergency Department (ED) and inpatients), of which 7 were in the ED and 137 were inpatient deaths. There is normal variance in the number of deaths per 1000 admissions.
% of Emergency Department and Inpatient deaths in-scope for a Structured Judgement Review (SJR)	Feb 18 - Jul 22	month	-	19%	19%		-	-	In July 2022, 23 SJRs were commissioned and 4 PMRTs were commissioned
Unexpected / potentially avoidable death Serious Incidents commissioned with the CCG	Feb 18 - Jul 22	month	-	2	0.76		-	-	There was 1 unexpected/potentially avoidable deaths serious incident investigations commissioned in July 2022.









Executive Summary

HSMR - The rolling 12 month June 2021 to May 2022) HSMR for CUH is 81.28, this is 5th lowest within the London and ATHOL peer group. The rolling 12 month HSMR for the Shelford Peer group is 94.55.
SHMI - The Summary Hospital-level Mortality Indicator (SHMI) for CUH in the latest period, December 2020 to November 2021 is 91.78.
Alert - There are 0 alerts for review within the HSMR and SHMI dataset this month.

Author(s): Richard Smith

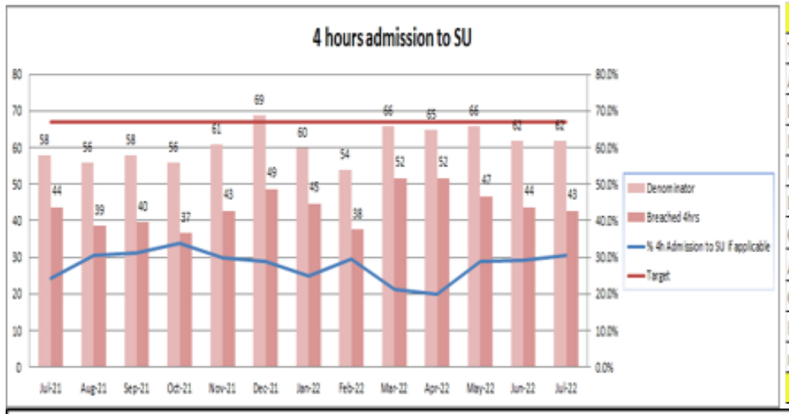
Owner(s): Dr Sue Broster

Together-Safe | Kind | Excellent

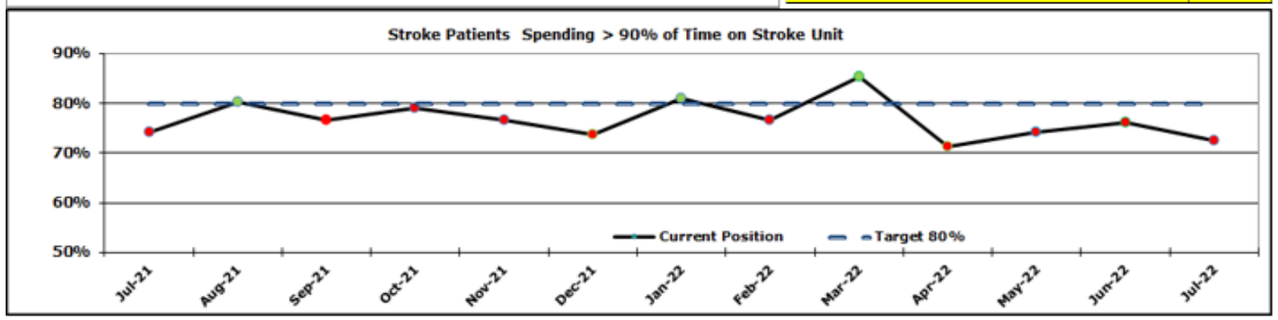
Stroke Care

Cambridge University Hospitals NHS Foundation Trust

Stroke Measures



Themes	Count of MRN
Trust Bed Capacity	18
Aw senior medical review	7
Delayed referral to Stroke Team	4
Not referred on arrival	3
Patient seen on back of ambulance, ED busy	3
Difficult diagnosis. MRI confirmd new stroke	2
CT department busy	2
Appropriately placed in acute medical ward	1
CT clear, MRI confirmed stroke	1
Inpatient stroke. Delay to referral	1
multiple thrombolysis calls, aW senior doctor review	1
Grand Total	43



Breach reasons for not achieving 90% IP stay on Stroke ward 2021/22 and Monthly Stroke position

Month	Stroke Bed Capacity * No outliers *	Trust Bed Capacity * Outliers *	Suspected COVID-19 patient	Covid 19 - Stroke ward closed	Delayed transfer of care (DTOC)	Operational decision - pt moved off the unit to accommodate an acute stroke	Delay in medical review in ED	Clinical - Appropriate pathway for patient	Difficult presentation	Not referred to Stroke Team	Delayed diagnosis	Clinician's decision to place pt on different ward	Unclear presentation	Difficult diagnosis/Complex patient	Failure to request stroke bed	Resource capacity	Number of breaches	Month Position (Target 80%)
Jul-21		9					1			1			3			1	15	74.1%
Aug-21		4					2	2		1			2				11	80.4%
Sep-21		5						4		1			3	1		1	15	76.6%
Oct-21		5					1	3		1	2					1	13	79.0%
Nov-21		5	1					1		1	2		3	1		1	15	76.6%
Dec-21		11						4		2			1			2	20	73.7%
Jan-22		2						1		3	1		1			4	12	81.0%
Feb-22		7	1				1	1		1			2	1			14	76.7%
Mar-22		6	1				1						2				10	85.3%
Apr-22		8					2	3					4			2	19	71.2%
May-22	3	1					4			1			5	3		1	18	73.1%
Jun-22	3	1					1	2					7	1		1	16	76.1%
Jul-22	6	5						2		1			1	1		3	19	72.5%
Summary	12	69	3	0	0	0	13	28	0	13	5	0	34	8	0	17	197	

90% target (80% Patients spending 90% IP stay on Stroke ward) was not achieved for July = **72.5%**

'Trust Bed Capacity' (6) was the main factor contributing to breaches last month, with a total of 19 cases in July 2022.

4hrs adm to SU (67%) target compliance was not achieved in July = **30.6%**

Key Actions

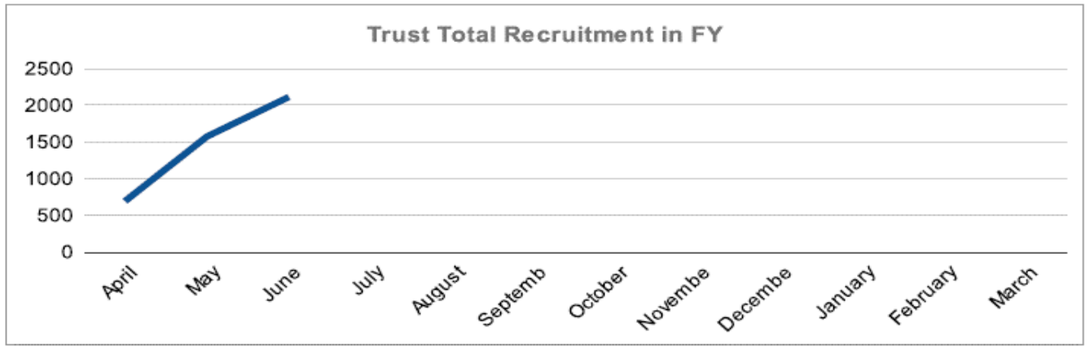
- On 3rd December 2019 the Stroke team received approval from the interim COO to ring-fence one male and one female bed on R2. This is enabling rapid admission in less than 4 hours. The Acute Stroke unit continues to see and host a high number of outliers. Due to Trust challenges with bed capacity the service is unable to ring-fence a bed at all times. Instead it is negotiated on a daily basis according to the needs of the service and the Trust.
- **As of August 2021 the service has been in discussion with the Operations directorate about formally re-introducing the ring-fencing of beds**.
- The Mixed-sex HASU bay on R2 has opened week commencing 02/05/22. Performance will be closely monitored, to date there has been 1 breach of SSA policy.
- National SSNAP data shows Trust performance from Jan - Mar 22 at Level B.
- There were an increasing number of stroke patients not referred to the stroke bleep on arrival resulting in a delay to stroke unit admissions and treatment. This has been escalated to the ED Matron and ED medical staff, reminding the need for rapid stroke referral.
- Stroke is trialling an MRI in Stroke triage process. This will use existing Stroke/TIA slots that are not currently being utilised.
- The new Red/Amber/Green Stroke SOP has been finalised with agreed pathways for these patients. The operational team are working to ensure optimal Stroke care for patients on all pathways, cohorting of patients where possible and timely step-down/transfer back to Stroke wards when possible.
- Stroke Taskforce meetings remain in place, plus weekly review with root cause analysis undertaken for all breaches, with actions taken forward appropriately.
- The stroke bleep team continue to see over 200 referrals in ED a month, many of those are stroke mimics or TIAs. TIA patients are increasingly treated and discharged from ED with clinic follow up. Many stroke mimics are also discharged rapidly by stroke team from ED. For every stroke patient seen, we see three patients who present with stroke mimic.
- The TIA service are planning to resume their ambulatory service in Clinic 5 as it has

Author(s): Charles Smith, Jane Fenner Owner(s): Nicola Ayton

Clinical Studies

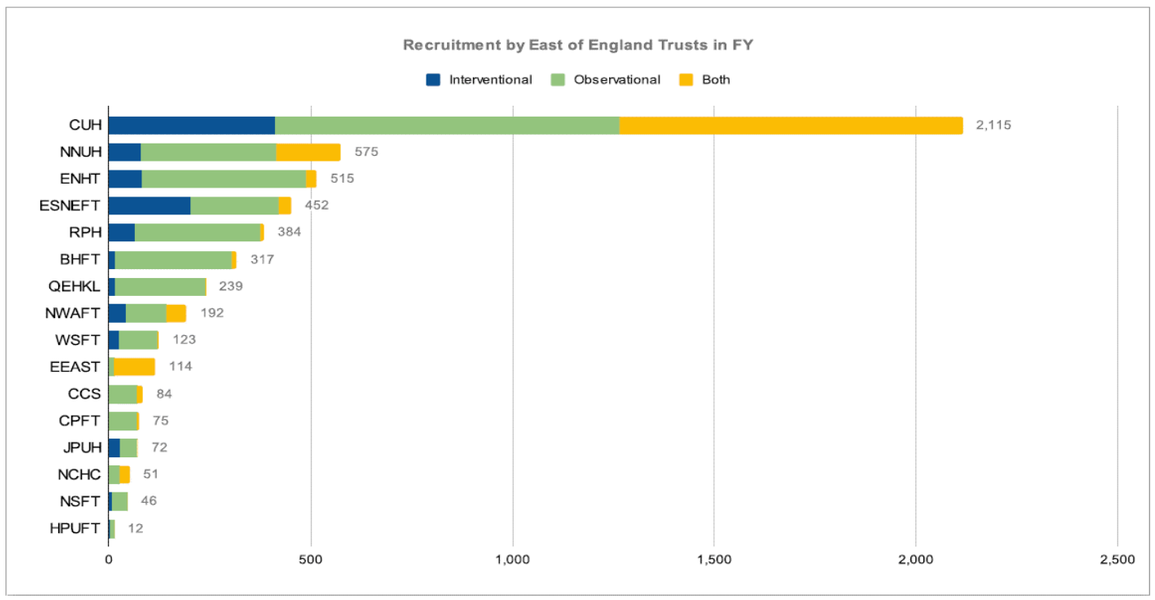
Cambridge University Hospitals NHS Foundation Trust

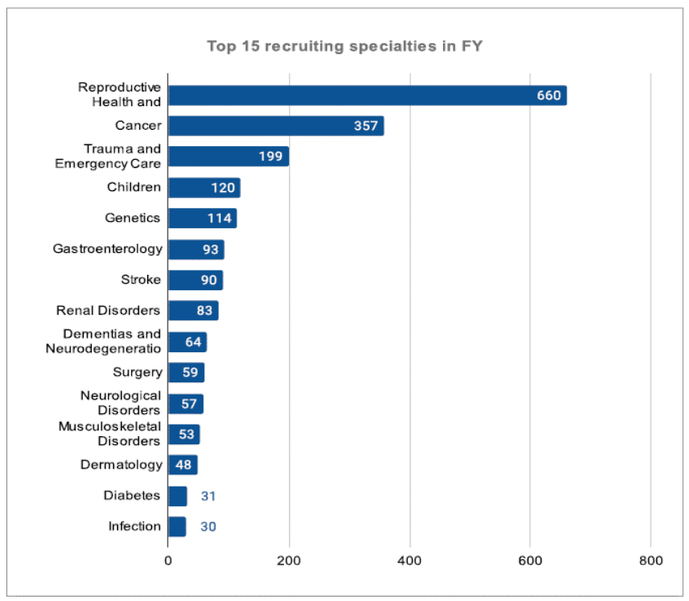
Clinical Studies Measures



Total Recruitment at end of June - FY 2022-23
2,115

Recruiting Studies at end of June for FY 2022-23			
Open	185	Non Commercial	161
Closed	3	Commercial	27
Suspended	0		
Total	**188**		





Situation as at end of March 2022

* Total recruitment in the financial year to date: 2,115
* CUH accounted for 39% of total recruitment by Eastern Trusts in the financial year to date. Interventional only studies accounted for just under 20% of the total, while Observational only studies accounted for just over 40% of the total. The remaining 40% were both Interventional and Observational .
* Recruitment to the Reproductive Health speciality accounted for 31% of all recruitment (660). Second was Cancer (357). All of the other individual specialities accounted for less than 10% of the total recruitment.
* There were 188 recruiting studies, of which 27 were Commercial, and 161 Non-Commercial.

Note: Figures were compiled by the Clinical Research Network and cover all research studies conducted at CUH that are on the national portfolio.

Maternity Dashboard

Cambridge University Hospitals NHS Foundation Trust

Maternity Measures

East of England Regional Perinatal Quality Oversight Group
Highlight Report (v15)

LMNS: Cambridgeshire and Peterborough

Reporting period: July 2022

Overall System RAG: (Please refer to key next slide)

CQC DOMAINS						
Maternity unit	CUHFT (date of last inspection : Jan 2017) Not in Maternity Safety Support Programme					
C-caring R-responsive E-effective W-well-led S-safe	S	E	C	R	W	Action Plan Status: To commence Progressing Completed
Rating (last inspection)						Action plan status:

KPI (see slide 4 for detail)	Measurement / Target		Trust Rate (current reporting period)
Please see exemplar v8 for full detail			CUH
Preterm birth rate	≤26+6 weeks	≤6% annual rolling rate	0.57%
	≤36+6 weeks		9.18%
Massive Obstetric Haemorrhage ≥ 1500 mls	Vaginal birth	2.5%	2.95%
	Caesarean	4.3%	0.98%
Term admissions to NNU (all levels)		<6%	3.85%
3rd & 4th degree tear	SVD (unassisted)	Unassisted 2.8%	3.27%
	Instrumental (assisted)	Assisted 6.8%	9.43%
Right place of birth (born outside a tertiary centre)		Number of births = 0	0
Smoking at time of delivery		≤6%	8.25%
Percentage of women placed on CoC pathway		≥35% (March 21)	21.7% (Jun 22)
Percentage of women on CoC pathway :BAME / areas of deprivation)	BAME	≥75%	13% (Jun 22)
	Area of deprivation		10.3% (Jun 22)

Proportion of midwives who agree or strongly agree on whether they would recommend their trust as a place	Proportion of speciality trainees in Obs and Gynae responding with excellent or good on how they would rate the quality of clinical supervision out of hours
To work (entire division): 71% (2020)	92.5% (2021)
To receive treatment (entire division): 85% (2020)	

Total Births	Total Bookings	1:1 Care in Labour
446	568	100%

KEY: CQC DOMAINS	MW to birth ratio		MW Minimum Safe Staffing		Obstetric Cover on Delivery Unit		Vacancy rate		LW co-ordinator supernumerary (%)
	BR+ Recommendation	Actual	Planned Cover	Actual Cover	Hours of consultant presence	Gaps in Rotas	Midwife no's WTE	%age of total staff	
Outstanding									
Good									
Requires Improvement	1:23.0	1:27.0	100 %	78%	81	None due to acting down	30	14%	63%
Inadequate									

Incident Reporting					LMNS confirmation of SI oversight (evidenced through governance & safety meetings) Yes ☐ No ☐									
	Datix		Incidents Graded as Moderate and Above	Maternity Serious Incidents	Maternity Never Events	Coroner Reg 28	HSIB Cases (new)	Still Births			HIE cases (grade 2 or 3)	Neonatal deaths		Maternal Mortality	
	Unactioned	Open > 30 days						All	Term	Intrapartum		Early	Late	Direct	Indirect
CUH	0	48	1	0	0	0	0	2	1	0	0	1	0	0	0

Maternity Dashboard

NHS
Cambridge University Hospitals
NHS Foundation Trust

Maternity Measures

Assessed compliance with10 Steps-to-Safety – Year 4 – (inc. reasons for non compliance, mitigation and actions)

	Please identify unit	CUH
1	Perinatal review tool	
2	MSDS	Compliance with the minimum CQIM requirements due to data quality ratings. Mitigation required for out of area non compliance and current CO monitoring booking process.
3	ATAIN	
4	Medical Workforce	
5	Midwifery Workforce	Delivery Unit Supernumerary coordinator status consistently low. This month is 41% compliance due to current vacancy rate and sickness.
6	SBLCB V2	NHS digital involved in reviewing out of area data inclusion in AN CQIMs (CO monitoring). Fetal monitoring mandatory annual competency assessment 83% compliance.
7	Patient Feedback	
8	Multi-professional training	Additional faculty for NLS required. Did not meet trajectory for 80% compliance with PROMPT training by end of June 2022 due to current vacancy and sickness rate. Amended trajectory for 90% by November 2022.
9	Safety Champions	
10	Early notification scheme (HSIB)	

Key	
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

Evidence of SBLCB V2 Compliance – (inc. reasons for non compliance, mitigation and actions)

	Please identify unit	CUH
1	Reducing smoking	Compliance thresholds met for in area women. Discussions with NHS digital to exclude out of area women and submit manual audit for compliance.
2	Fetal Growth Restriction	
3	Reduced Fetal Movements	
4	Fetal monitoring during labour	Mandatory CTG study day in place. Mandatory competency assessment in place. Compliance not yet >85%.
5	Reducing pre-term birth	Fetal fibronectin machines training planned process being implemented for quantitative pre term assessment.

Assessment against Ockenden Immediate and Essential Action (IEA) – (inc. reasons for non compliance, mitigation and actions)

Please identify unit	CUH
Audit of **consultant led labour ward rounds** twice daily	Consultant posts investment received and being appointed into.
Audit of **Named Consultant** lead for complex pregnancies	Audit Cycle 2 currently underway.
Audit of **risk assessment** at each antenatal visit	
Lead **CTG Midwife and Obstetrician** in post	
Non Exec and Exec Director identified for Perinatal Safety	
Multidisciplinary training – PrOMPT, CTG, Obstetric Emergencies (90% of Staff)	Trajectory in place.
Plan in place to meet **birth rate plus** standard (please include target date for compliance)	
Flowing accurate data to **MSDS**	NHS digital involved in reviewing out of area inclusion in antenatal based out of area data. Plan to submit to all fields within MSDS by September 2022.
Maternity SIs shared with trust Board	

Maternity Dashboard

NHS
Cambridge University Hospitals
NHS Foundation Trust

Maternity Measures

Maternity unit:	CUH: All
1. Freedom to speak up / Whistle blowing themes and HSIB / NHSR / CQC or other organisation with a concern or request for action made directly with Trust	**None**
	CUH: Top 3
2. Themes from Datix (to include top 3 reported incidents/ frequently occurring)	• Communication including EPIC, handovers and MDT working • Maternity clinical pph • Environmental issues excessive heat for patients and medication
3. Themes from Maternity Serious Incidents (Sis) and findings of review of all cases eligible for referral to HSIB	• No maternity serious incidents or HSIB reports received
4. Themes arising from Perinatal Mortality Review Tool (review of perinatal deaths using the real time data monitoring tool)	• No care issues from this month's review
5. Themes / main areas from complaints	• Clinical Treatment • Patient Care • Communication • Infant Feeding Support • Delays in Induction of Labour
6. Listening to women / Service User Voice Feedback (sources, engagement / activities undertaken)	• Written language agreements service user co production meeting held following publication of the re birth report. • Neonatal listening event held • Changes being explored to booking process
7. Evidence of co-production	• Written information agreements on language use. • Planned informed choice and consent policy development meetings
8. Listening to staff (eg activities undertaken, surveys and actions taken as a result) Staff feedback from frontline champions and walk-abouts	• Safety champion meeting held with NED ward: • Theme: ward temperatures • Theme: medical and midwifery workforce
9. Embedding learning (changes made as a result of incidents / activities / shared learning/ national reports)	• Cross border working groups continue re: communication / documentation • Maternity safety improvement group now includes fetal monitoring and birth within an hour of transfer on SPC. • PPH working group – targeted education re: primary oxytocic use. • Neonatal resuscitation QI

Maternity Dashboard

NHS Cambridge University Hospitals NHS Foundation Trust

Maternity Measures

Workforce

Sources / References	KPI	Goal	Target	Measure	Data Source	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Actions taken for Red/Amber results
Source - EPIC	Births (Benchmarked to 5716 per annum)	For information	N/A	Births per month	Rosie KPI's	431	455	421	469	434	446	
Antenatal Care NICE quality standard [QS22]	Health and social care assessment <GA 12+6/40	> 90%	< 85%	Booking Appointments	EPIC	76.89%	73.05%	71.40%	69.90%	70.64%	73.24%	Bookings working group in place across Division. Booking data currently includes all transfers of care at later gestations which would automatically not meet the KPI as transferred after 12+6.
Source - CHEQS	Booking Appointments	For Information	N/A	Booking Appointments	EPIC	582	720	654	615	664	568	Threshold changed in November 2021 - now includes all women who book (approximately 85% of total figure will go on to have a livebirth within the maternity service).
Source - EPIC	Vaginal Birth (Unassisted)	For Information	N/A	SVD's in all birth settings	Rosie KPI's	52.43%	51.42%	49.16%	48.82%	54.60%	51.12%	Plans to reintroduce 36 week clinic in Rosie Birth Centre for all women
Source - EPIC	Home Birth	For Information	N/A	Planned home births (BBA is excluded)	Rosie KPI's	2.08%	1.53%	1.42%	1.7%	1.84%	1.34%	
Source - EPIC	Rosie Birth Centre Birth	For Information	N/A	Births on the Rosie Birth Centre	Rosie KPI's	16.93%	14.5%	11.87%	14.92%	17.1%	15%	Transfers from the RBC all appropriate. Plans to reintroduce 36 week clinic in Rosie Birth Centre for all women
Source - EPIC	Induction of Labour	For Information		Women induced for birth	Rosie KPI's	30.16%	31.61%	31.80%	31.87%	30%	29.80%	
Source - EPIC	Delay in commencement of Induction	0%	<10%	Percentage of Inductions where Induction commencement was postponed	Red Flags							Data to be reported from September 2022
Source - EPIC	Delay in continuation of Induction	0%	<10%	Percentage of Induction continuation was delayed for more than 6 hours	Red Flags							Data to be reported from October 2022
Source - EPIC	Assisted vaginal birth (Instrumental)	For Information	N/A	Instrumental Del rate	Rosie KPI's	10.67%	10.32%	9.02%	11.94%	10.6%	12.55%	
Source - EPIC	CS rate (planned & unplanned)	For Information	N/A	C/S rate overall	Rosie KPIs	36.89%	38.24%	41.80%	39.23%	34.80%	36.32%	RAG rating removed as per NHSE&I recommendation. Robson group caesarean section differentiation being implemented within MSDS dataset to better review outcome data as LSCS is a process measure.
Source - EPIC	Women in RG*1 having a caesarean section with no previous births: nullip spontaneous labour)	For information	10%	Relative contribution of the Robson group to the overall C/S Rate	Rosie KPIs							Report being built - expected deployment October 2022
Source - EPIC	Women in RG*2 having a caesarean section with no previous births: nullip induced labour, nullip pre-labour LSCS	20-35%	20-35%,	Relative contribution of the Robson group to the overall C/S Rate	Rosie KPIs							Report being built - expected deployment October 2022
Source - EPIC	Ratio of women in RG1 to RG2	Ratio of >2:1	N/A	Ratio of group 1 to 2 should be 2:1 or higher	Rosie KPIs							Report being built - expected deployment October 2022
Source - EPIC	Women in RG*5. Multips with 1 or 2+ previous C/S	50-60%	50-60%	Relative contribution of the Robson group to the overall C/S Rate	Rosie KPIs							Report being built - expected deployment October 2022
Source - EPIC	Women in RG1, RG2, RG5 combined contribution to the overall C/S rate.	66%	60-70%,	Relative contribution of the Robson group to the overall C/S Rate	Rosie KPIs							Report being built - expected deployment October 2022
Source - EPIC	Smoking at delivery - Number of women smoking at the time of delivery	≤ 6%	Green = ≤ 6%, Amber = 6.1% - 7.9 %, Red = ≥8	% of women Identified as smoking at the time of delivery	Rosie KPI's	5.89%	6.95%	3.37%	5.02%	3.95%	8.25%	on investigation the KPI definition looks at all social history relating to smoking – report being amended to only look at time of delivery smoking status.
Workforce												
	Midwife/birth ratio (actual)**	1:24	1.28	Total permanent and bank clinical midwife WTE*/Births (rolling 12 month average)	Finance	1:27	1:26.2	1:27.2	1:25.4	1:27.2	1:28.2	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	1:24	1:23.4	1:23.4	1:23.4	1:23.3	1:23.3	Midwife/birth ratio based on the BR+ methodology
Source - CHEQS	Staff sickness as a whole	< 3.5%	> 5%	ESR Workforce Data	CHEQs	6.87%	7.22%	7.59%	7.63%	7.69%		This is reported 1 month behind from CHEQ's. Sickness absences related to S.A.D (stress anxiety and depression) is increasing. PMA support available and bid in place for funds to psychological support. Priority project for senior leadership team.
Source - CHEQs	Education & Training - mandatory training - overall compliance (obstetrics and gynaecology)	>92% YTD	<75% YTD	Total Obstetric and Gynaecology Staff (all staff groups) compliant with mandatory training	CHEQs	87.50%	87.80%	87.50%	87.50%	86.40%		This is reported 2 months behind.
Source - PD	Education and Training - Training Compliance for all staff groups: **Prompt**	≥90% YTD	≤85% YTD	Total multidisciplinary obstetric staff compliant with annual Prompt training	PD	57.05%	58.84%	61.28%	60.91%	61.00%	65.56%	Training recommenced in February 2022. Unable to meet trajectory for 80% compliance by end of June 2022 due to current vacancy and sickness rate. Amended trajectory in line with CNST requirements for 90% compliance by November 2022.
Source - PD	Education and Training - Training Compliance for all staff groups: **NBLS**	>90% YTD	<85% YTD	Total multidisciplinary staff compliant with annual NBLS training	Resus Services					55.00%		Midwifery staff 50% compliance, NICU medical 39% compliant, NICU nursing 71% compliant. Reporting comenced June 2022.
Source - K2	Education and Training - Training Compliance for all staff groups: **K2**	≥90% YTD	≤85% YTD	Total multidisciplinary obstetric staff passed CTG competence threshold of 80%.	PD	76.12%	79.85%	81.00%	83.39%	83.39%	84.62%	Breakdown presented at governance, non compliance relates to both midwifery and obstetric staff. Follow up process in place. HR drafting process for redeployment of non compliant staff in line with Ockenden requirements.
Source - CHEQS	Education & Training - mandatory training - **midwifery compliance**.	>92% YTD	<75% YTD	Proportion of midwifery compliance with mandatory training	CHEQs	89.4%	89.7%	89.2%	89.5%	89.20%		This is reported 1 month behind from CHEQ's. Trust cancellation of training until end of January 2022 - e learning compliance mitigation plans in place to increase compliance.

Maternity Dashboard

NHS Cambridge University Hospitals NHS Foundation Trust

Maternity Measures

Maternity Morbidity												
Source - QSIS	Eclampsia	0	> 1		Risk Report	0	0	0	0	0	0	
	Maternal Sepsis					TBC	TBC	TBC	TBC	TBC	TBC	Benchmark to be allocated from dashboard review ETA September 2022.
Source - QSIS	ITU Admissions in Obstetrics	1	> 2		Risk Report	1	2	0	1	1	0	
Source - QSIS	PPH≥ 1500 mls	< 3%	> 4%		CHEQS	7.31%	4.21%	5.70%	6.77%	3.48%	4.13%	Normal variation. 9 cases over 2000mls. 3 of these cases were instrumental births (assisted birth) 3 caesarean sections, 1 placenta accreta. The consutlant was present at 6 cases out of the 9 cases. No admissions to ITU
Source - QSIS	3rd/ 4th degree tear **rate vaginal birth**	<5%	>6%		Risk Report	2.21%	1.81%	2.05%	2.48%	2.83%	3.90%	
Source - QSIS	Direct Maternal Death	0	>1		Risk Report	0	0	0	0	0	0	
Risk												
Source - QSIS	Total number of SI's	0	>1	Serious Incidents	Datix	0	0	0	1	0	1	
Source - QSIS	Information Governance	0	>1		Datix	*0*	*0*	*0*	*0*	*0*	*1*	community midwife diary lost
Source - QSIS	Clinical	0	>1		Datix	*0*	*0*	*0*	*1*	*0*	*0*	
Source - QSIS	Never Events	0	>1	DATIX	Datix	0	0	0	0	0	0	
Neonatal Morbidality												
Source - EPIC	Shoulder Dystocia per vaginal births	< 1.5%	> 2.5%		Risk Report	3.32%	3.24%	4.52%	3.90%	3.19%	2.46%	
Source - EPIC	Still Births per 1000 Births			3.33/1000 (Mbrrace 2021)	Risk report	0.86/1000	0.21/1000	1.26/1000	0.42/1000	0.43/1000	0.88/1000	
Source - EPIC	Stillbirths - number ≥ 22 weeks	0	6	MBBRACE	Risk report	2.00	1.00	3.00	2.00	1.00	2.00	
Source - EPIC	Number of birth injuries	0	> 1		Risk Report	0	0	0	1	0	0	
Source - EPIC	Number of term babies who required therapeutic cooling	0	> 1		Risk Report	0	0	0	0	0	0	
Source - EPIC	Baby born with a low cord gas < 7.1	<2%	> 3%		Risk Report	0.46%	1.09%	0.47%	0.42%	1.15%	1.57%	
Source - EPIC	Term admissions to NICU	<6.5	>6.5	NHSE/I	Risk Report	6.49%	6.57%	4.27%	4.90%	5.52%	3.85%	
Quality												
Source - Rosie Divert Folder	Number of times Rosie Maternity Unit Diverted	0	> 1	All ward diverts included	Rosie Diverts	4	3	4	7	1	4	1 woman referred elsewhere for assessment. 0 births elsewhere.
Source - Rosie Divert Folder	Total number of hours on divert	For information	N/A		Rosie Diverts	61	>88	190	148	23	103	
Source - EPIC	1-1 Care in Labour	>95%	<90%	Exlcuding BBA's	Rosie KPI's	98.83%	98.65%	100%	98.69%	100%	100%	
Source - EPIC	Breast feeding Initiated at birth	> 80%	< 70%	Breastfeeding	Rosie KPI's	83.01%	79.59%	82.89%	81.22%	84.33%	79.4%	
Source - EPIC	VTE	>95%	< 95%		CHEQs	99.59%	99.32%	99.9%	99.96%	99.74%	96.64%	

Finance

Cambridge University Hospitals NHS Foundation Trust

Financial Performance

Trust performance summary - Key indicators

Trust actual surplus / (deficit)

(£0.1m)	*Actual (adjusted)**
(£0.1m)	*Plan (adjusted)**
£3.9m	*Actual YTD (adjusted)**
£3.9m	*Plan YTD (adjusted)**

Covid-19 expenditure and system Covid-19 funding

£2.2m	*Covid actual in month*
£1.9m	*Covid plan in month*
£1.8m	*Covid funding in month*
£8.8m	*Covid actual YTD*
£8.1m	*Covid plan YTD*
£7.4m	*Covid funding YTD*

Net current assets/(liabilities), debtor days and payables performance

Net current assets

(£55.2m)	*Actual*
(£55.4m)	*Plan*

Debtor days

16	*This month*
15	*Previous month*

Payables performance (YTD) **

Actual	83.1%	*Value*
Plan	88.6%	*Quantity*

Cash and EBITDA

Cash

£200.3m	*Actual*
£166.0m	*Plan*

EBITDA

£18.0m	*Actual YTD*
£18.1m	*Plan YTD*

Capital expenditure

£3.0m	*Capital - actual spend in month*
£7.6m	*Capital - actual spend YTD*
£12.9m	*Capital – plan YTD*

Elective Recovery Fund (ERF)

ERF values based on CUH fair share but not yet confirmed and may be subject to change

£1.6m	*ERF forecast actual in month*
£1.6m	*ERF plan in month*
£4.1m	*ERF forecast actual YTD*
£4.1m	*ERF plan YTD*

Legend *£ in million* — *In month* — *YTD*

* On a control total basis, excluding the effects of impairments and donated assets
** Payables performance YTD relates to the Better Payment Practice Code target to pay suppliers within due date or 30 days of receipt of a valid invoice.

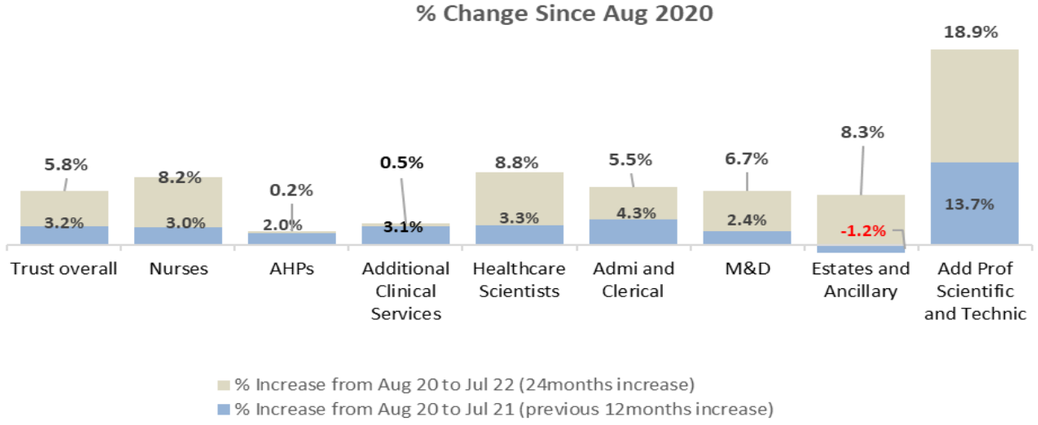
Staff in Post

Cambridge University Hospitals NHS Foundation Trust

Workforce: Staff in Post

12 Month Growth by Staff Group

Staff Group	Headcount		Headcount 12 Month growth	FTE		FTE 12 Month growth	
	Aug-21	Jul-22		Aug-21	Jul-22		
Add Prof Scientific and Technic*	232	248	6.9%	214	227	12	5.8%
Additional Clinical Services	1,972	1,932	-2.0%	1,813	1,777	-36	-2.0%
Administrative and Clerical	2,368	2,390	0.9%	2,160	2,191	31	1.5%
Allied Health Professionals*	732	717	-2.0%	646	632	-14	-2.2%
Estates and Ancillary	337	368	9.2%	328	356	28	8.7%
Healthcare Scientists	613	643	4.9%	573	604	31	5.3%
Medical and Dental	1,625	1,660	2.2%	1,533	1,568	35	2.3%
Nursing and Midwifery Registered	3,631	3,802	4.7%	3,327	3,498	171	5.1%
Total	**11,510**	**11,760**	**2.2%**	**10,594**	**10,853**	**259**	2.4%



Admin & Medical Breakdown

Staff Group	Aug-21	Jul-22	FTE 12 Month growth	
Administrative and Clerical	2,160	2,191	31	1.5%
of which staff within Clinical Division	1,062	1,081	18	1.7%
of which Band 4 and below	760	754	-7	-0.9%
of which Band 5-7	215	235	20	9.5%
of which Band 8A	41	46	5	12.6%
of which Band 8B	6	7	1	17.9%
of which Band 8C and above	40	38	-2	-4.5%
of which staff within Corporate Areas	875	871	-3	-0.4%
of which Band 4 and below	245	240	-5	-1.9%
of which Band 5-7	411	410	-1	-0.2%
of which Band 8A	77	84	7	8.6%
of which Band 8B	55	51	-4	-6.7%
of which Band 8C and above	87	86	-1	-1.1%
of which staff within R&D	223	239	17	7.4%
Medical and Dental	1,533	1,568	35	2.3%
of which Doctors in Training	631	641	11	1.7%
of which Career grade doctors	226	235	9	4.1%
of which Consultants	676	691	15	2.2%

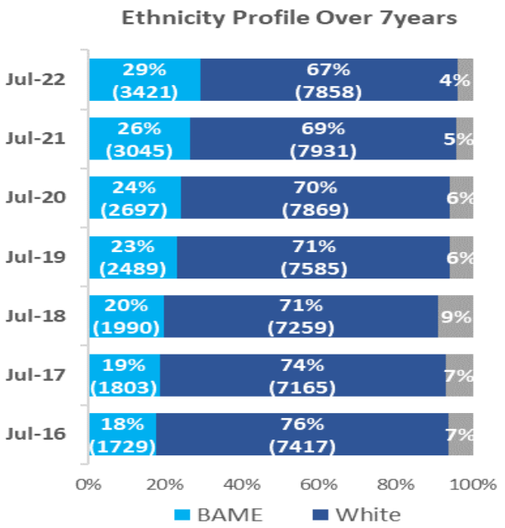
What the information tells us: Overall the Trust saw a 2.4% growth in its substantive workforce over the past 12 months and 5.8% over the past 24 months. Growth over the past 24 months is lowest within the Allied Health Professionals at 0.2% and highest within Add Prof Scientific and Technic at 18.9%. Growth over the past 12 months is lowest within Additional clinical services and highest within Estates.

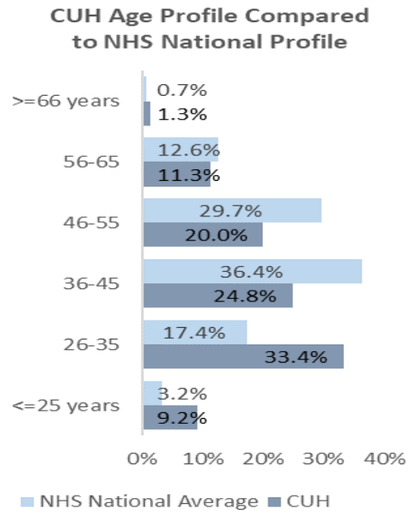
*Operating Department Practitioner roles were regroup from Add Prof Scientific and Technic to Allied Health Professionals on ESR from June 21 . This change has been updated for historical data set to allow for accurate comparison

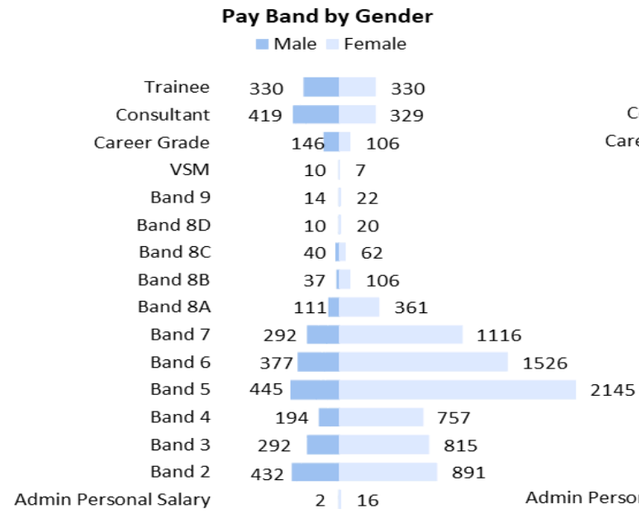
Equality Diversity and Inclusion (EDI)

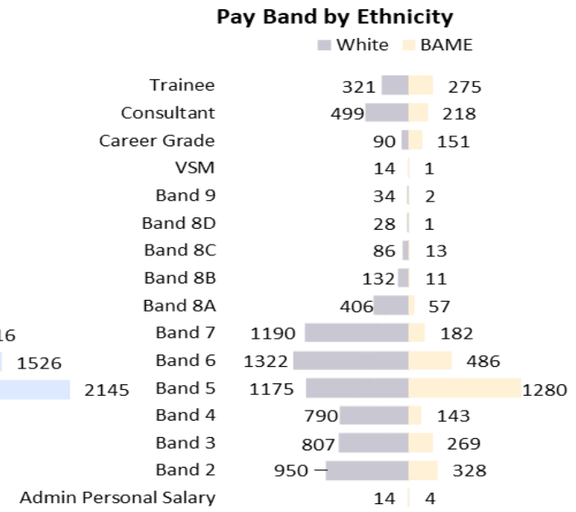
Cambridge University Hospitals NHS Foundation Trust

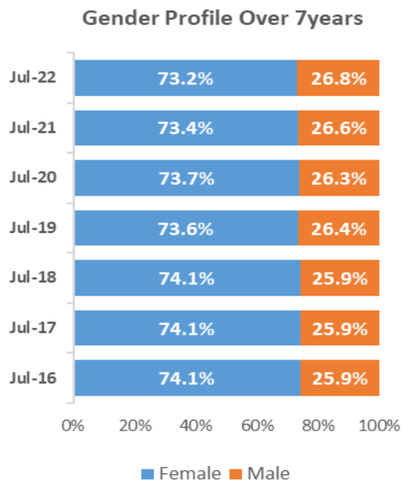
Workforce: Equality Diversity and Inclusion (EDI)

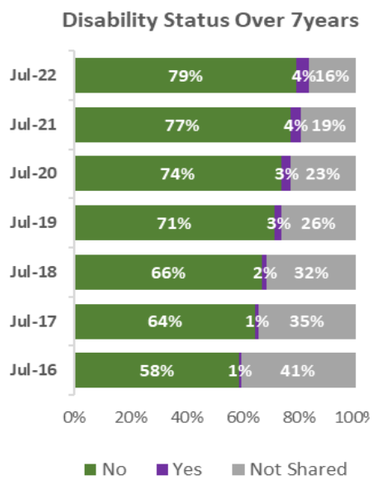


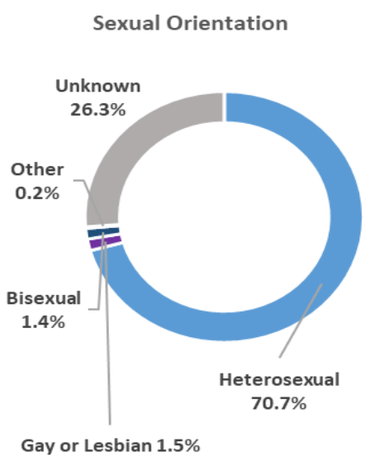












What the information tells us:

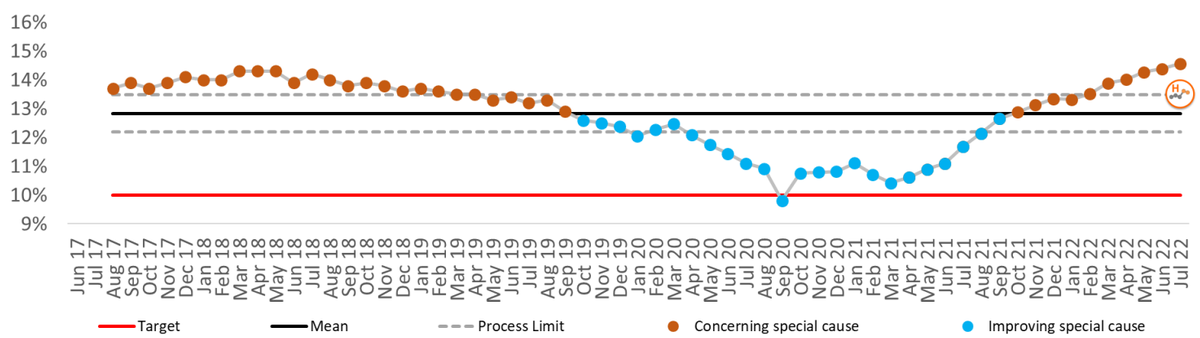
- CUH has a younger workforce compared to NHS national average. The majority of our staff are aged 26-45 which accounts for 58% of our total workforce.
- The percentage of BAME workforce increased significantly by 11% over the 7 year period and currently make up 29% of CUH substantive workforce.
- The percentage of male staff increased by 0.9% to 27% over the past seven years.
- The percentage of staff recording a disability increased by 3% to 4% over the seven year period. However, there are still significant gaps between the data recorded about our staff on ESR compared with the information staff share about themselves when completing the National Staff Survey.
- There remains a high proportion of staff who have, for a variety of reasons, not shared their sexual orientation.

Staff Turnover

Cambridge University Hospitals NHS Foundation Trust

Workforce: Staff Turnover

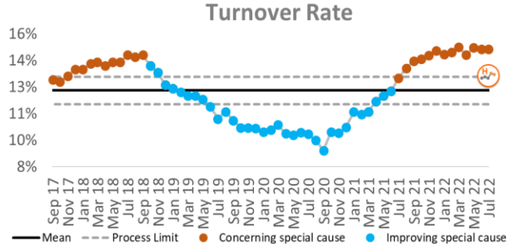
Turnover Rates - All Staff



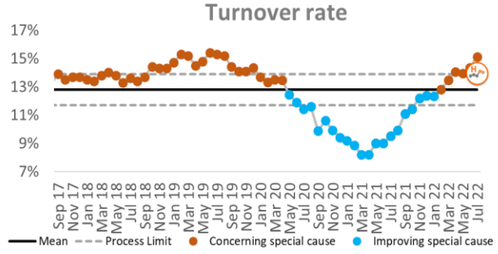
Background Information: Turnover describes the rate that employees leave an establishment. Staff turnover is calculated by the number of leavers from the Trust over the previous twelve months as a percentage of the total number of employed staff at a given time. (exclude all fixed term contracts including junior doctor).

What the information tells us: The Trust's turnover has been steadily increasing over the past nine months and currently at 14.6%. It's highest rate for 3 years, pre-pandemic, with an increase of 1.3% over the past three years. Nursing and Midwifery staff group have the highest increase of 3.5% to 14.6%, followed by Additional clinical services with an increase of 1.8% to 19.6%. Within the staff group, Additional clinical services have the highest turnover rate at 19.6% followed by Admin staff at 15.1%.

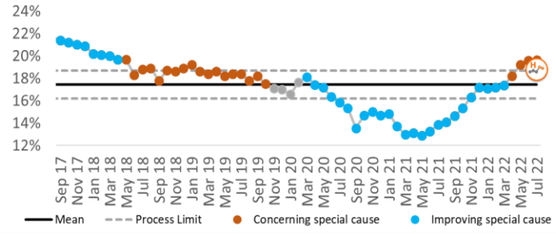
Nursing and Midwifery Turnover Rate



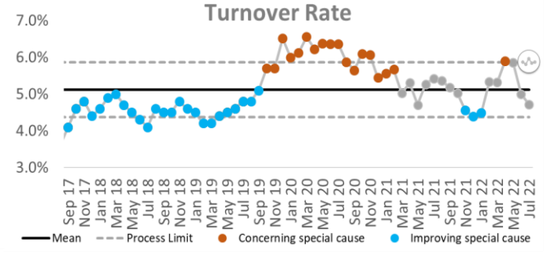
Administrative and Clerical Turnover rate



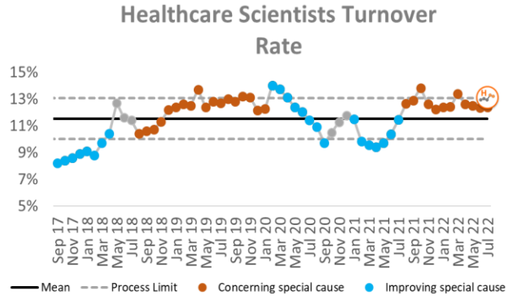
Additional Clinical Services Turnover Rate



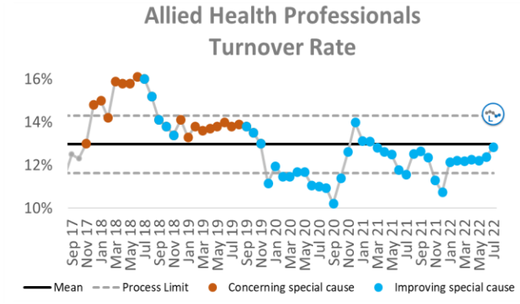
Medical and dental Turnover Rate



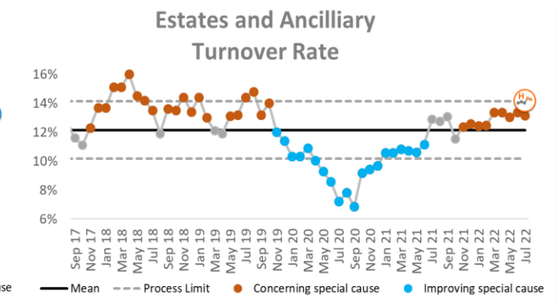
Healthcare Scientists Turnover Rate



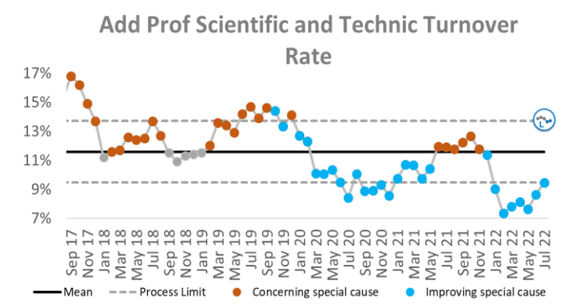
Allied Health Professionals Turnover Rate



Estates and Ancilliary Turnover Rate



Add Prof Scientific and Technic Turnover Rate

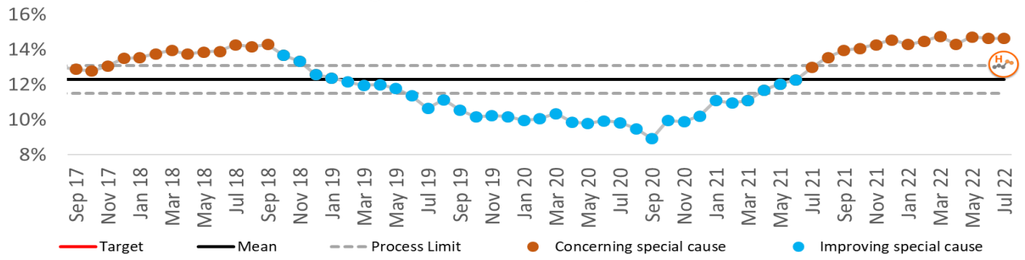


Turnover for Nursing & Midwifery Staff Group (Registered & Non-Registered)

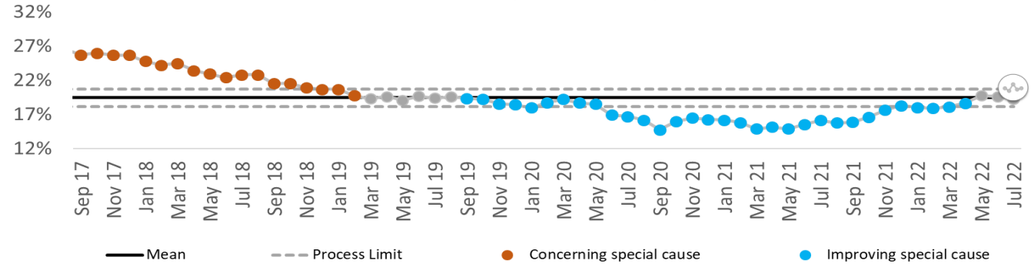
NHS Cambridge University Hospitals NHS Foundation Trust

Workforce: Turnover rate for Nursing & Midwifery Staff Group

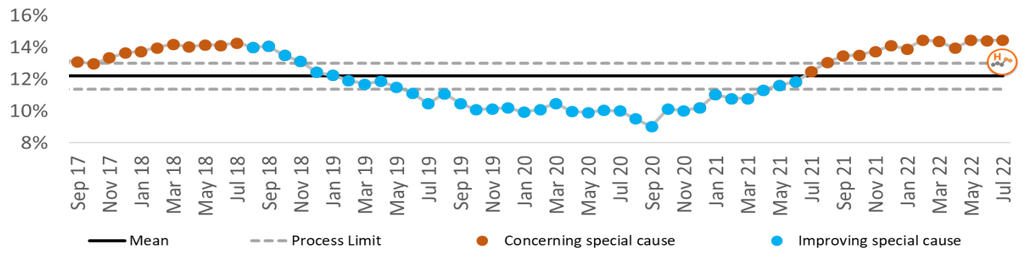
Nursing and Midwifery Turnover Rate



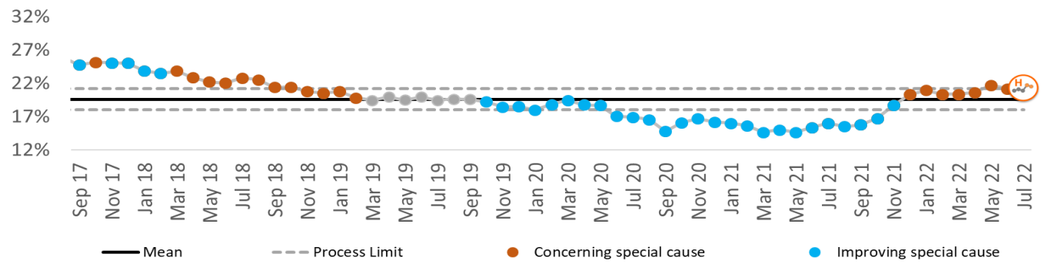
Healthcare Assistant (incl. MCA) Turnover Rate



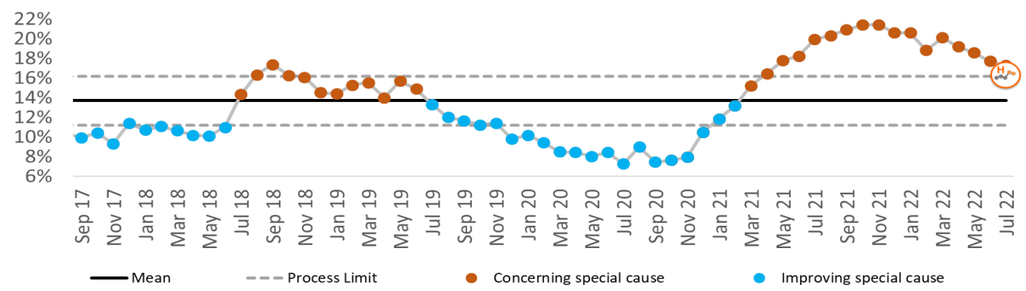
Nursing (Excluding midwives) Turnover Rates



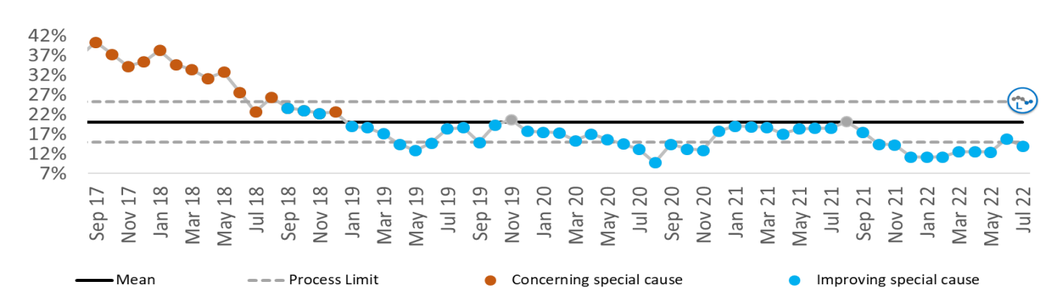
Healthcare Assistant (excl. MCA) Turnover Rate



Midwife Turnover Rates



Maternity Care Assistants (MCA) Turnover rates



Author(s): Tosin Okufuwa, Amanda Coulier Owner(s): David Wherrett

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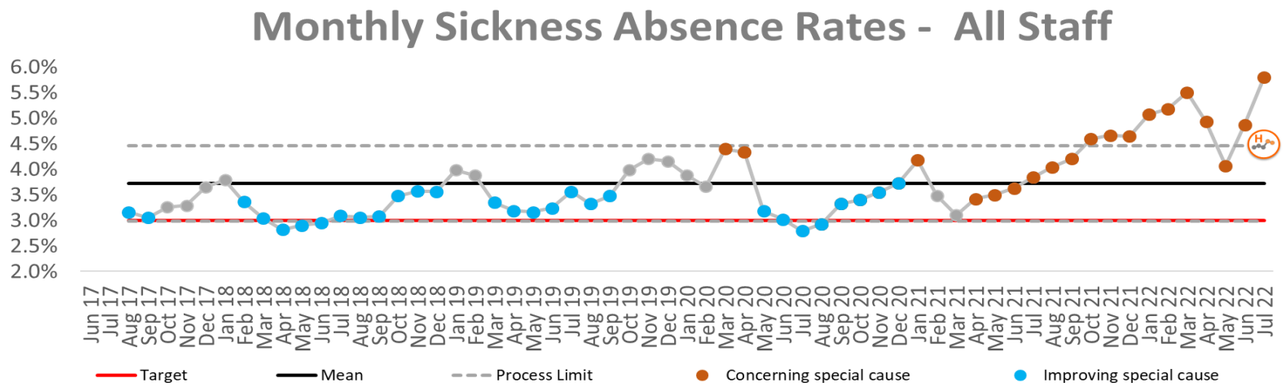
Sickness Absence

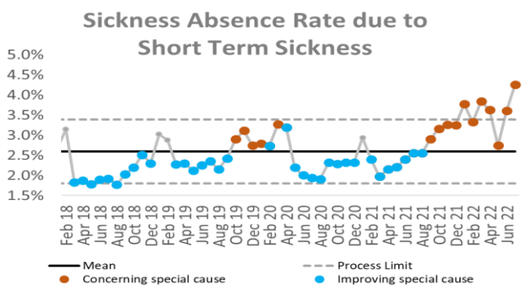
Cambridge University Hospitals NHS Foundation Trust

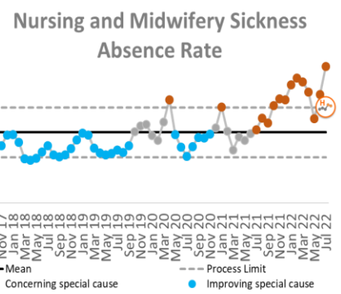
Workforce: Sickness Absence

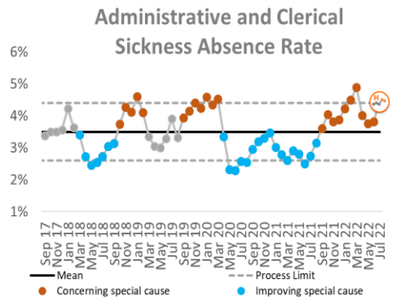


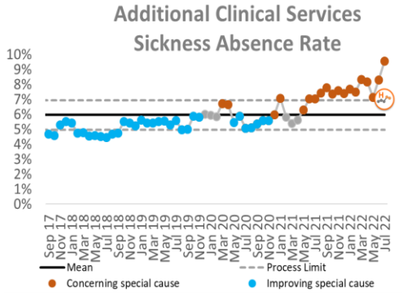
Background Information: Sickness Absence is a monthly metric and is calculated as the percentage of FTE days missed in the organisation due to sickness during the reporting month.

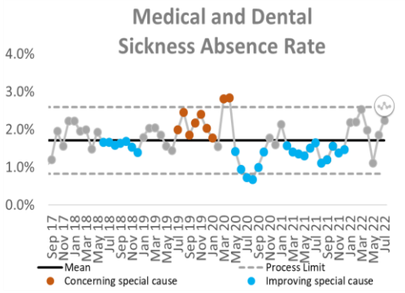
What the information tells us: The overall Monthly Sickness Absence is above average at 5.8%. This is higher than previous month, June 2022 (4.8%) and higher than same period previous year, July 2021 (3.8%). Sickness absence rate due to short term illness is higher at 4.3% compared to long term sickness at 1.6%. Additional Clinical Services have the highest sickness absence rate at 9.6% followed by Estates at 7.6%.

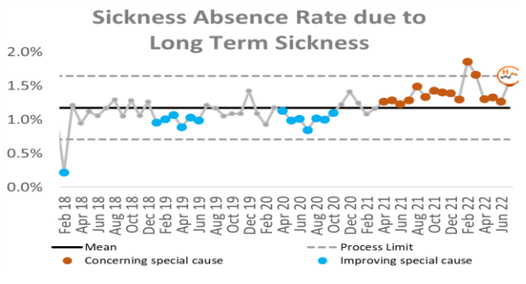


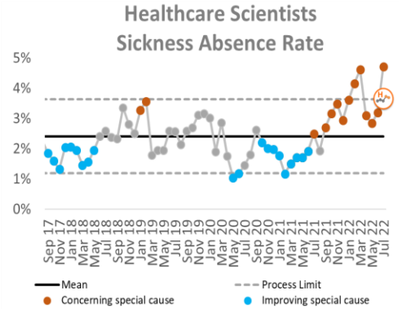


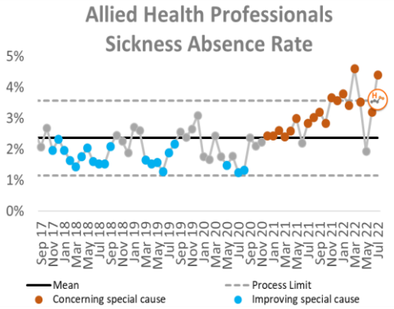


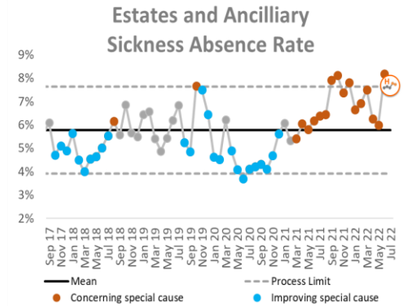


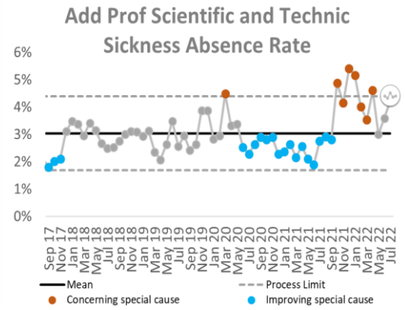












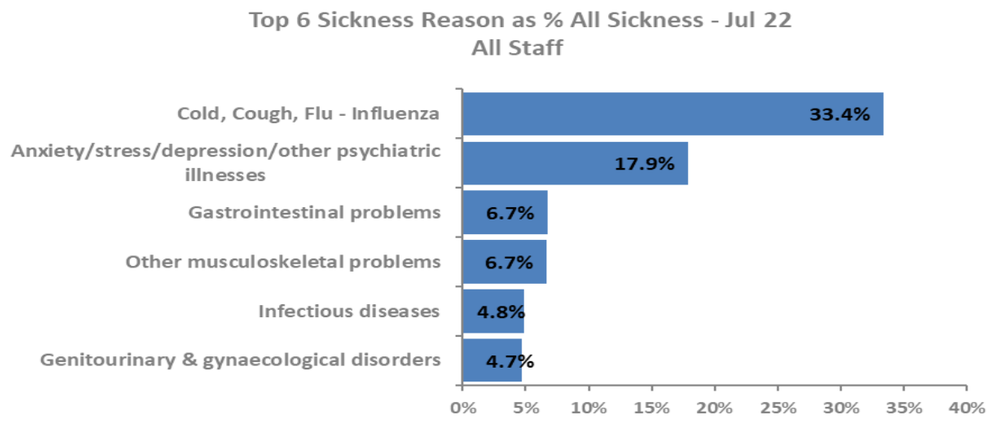
Author(s): Tosin Okufuwa, Amanda Wood

Owner(s): David Wherrett

Top Six Sickness Absence Reason

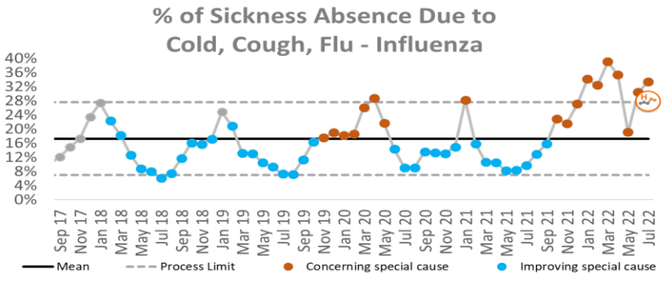
Cambridge University Hospitals NHS Foundation Trust

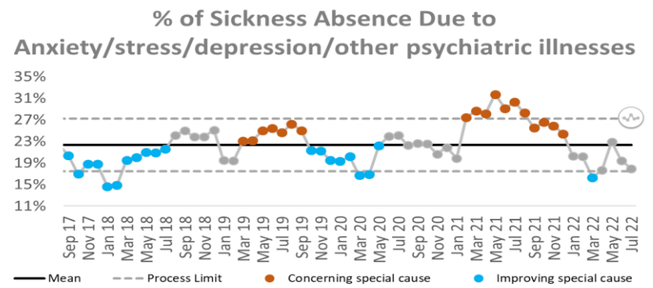
Workforce: Top Six Sickness Absence

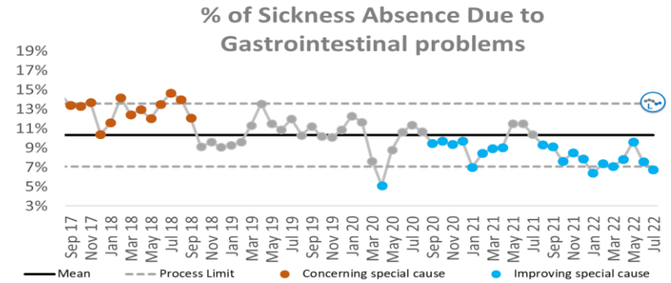


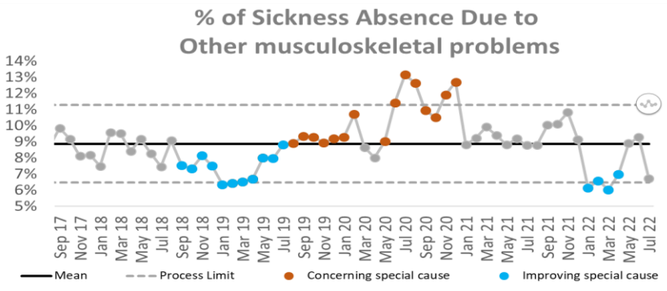
Background Information: Sickness Absence reason is provided as a percentage of all FTE days missed due to sickness during the reporting month.

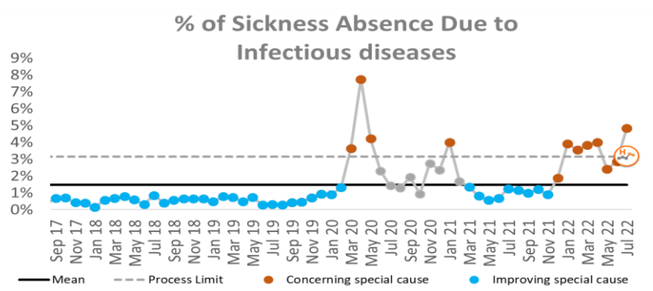
What the information tells us: The highest reason for sickness absence is influenza related sickness which saw an increase of 3% from previous month to 33.4%. Potential Covid-19 related sickness absence (this includes chest & respiratory problems, influenza related sickness and infectious diseases) accounts for 41.3% of all sickness absence in Jul 2022, compared to 35.8% from the previous month.

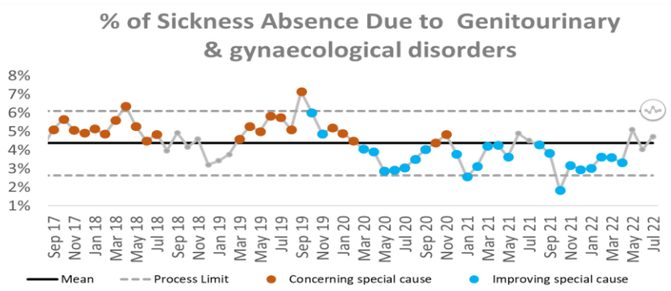












Author(s):Tosin Okufuwa, Amanda Wood

Owner(s): David Wherrett

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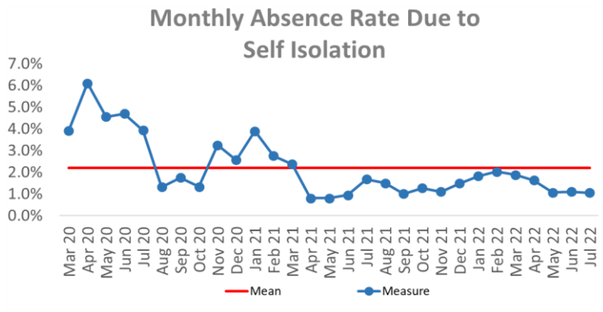
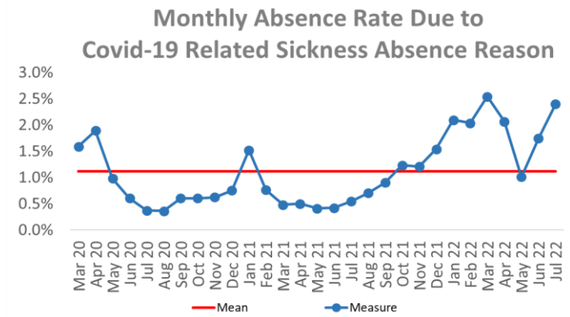
Covid-19 Related Absence

Cambridge University Hospitals NHS Foundation Trust

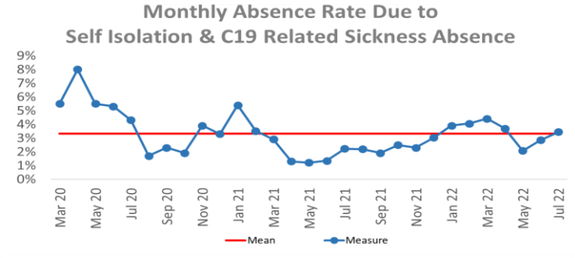
Workorce: Covid-19 Related Absence

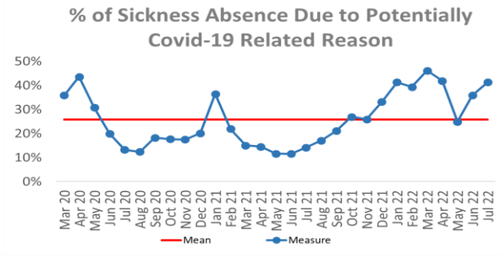


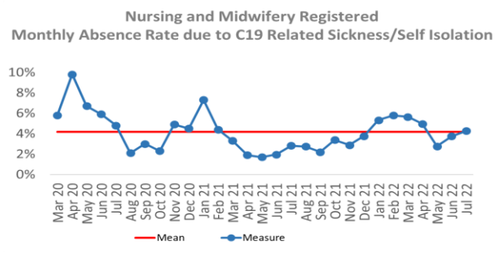


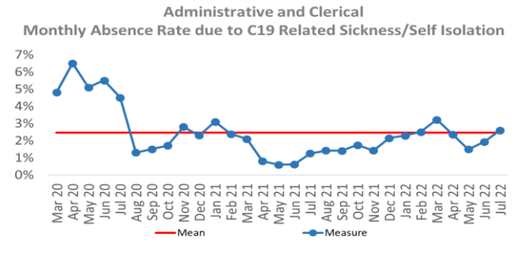
Background Information: Monthly absence figures due to Covid-19 are presented. This provides monthly absence information relating to FTE lost due to Self Isolation and potentially Covid-19 Related Sickness Absence (this includes chest & respiratory problems, influenza related sickness and infectious diseases).

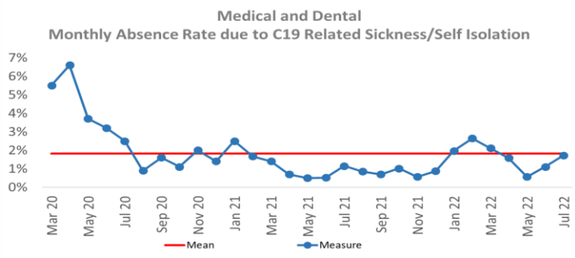
What the information tells us: The Trust's monthly absence rate due to Self Isolation remained at 1%. Monthly absence rate due to potential Covid-19 related sickness is 1.7% in Jul 2022. Overall, absence rates due to Covid-19 related sickness and self isolation increased by 0.6% from the previous month to 3.4%.

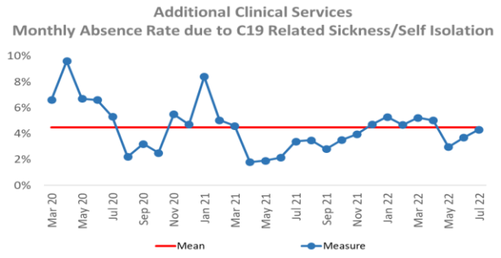


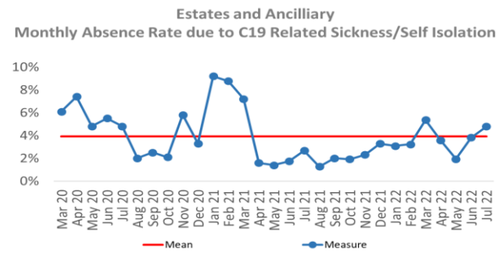


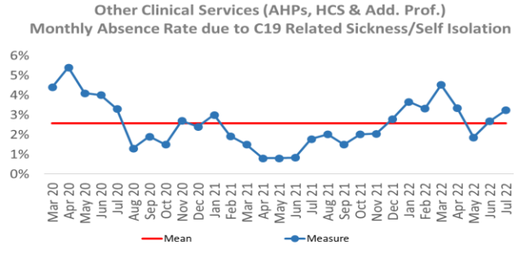












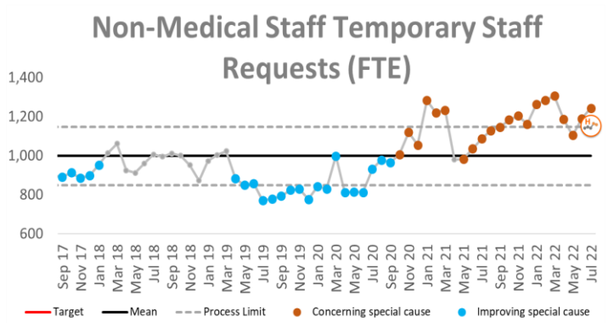
Author(s): Tosin Okufuwa, Amanda Wood

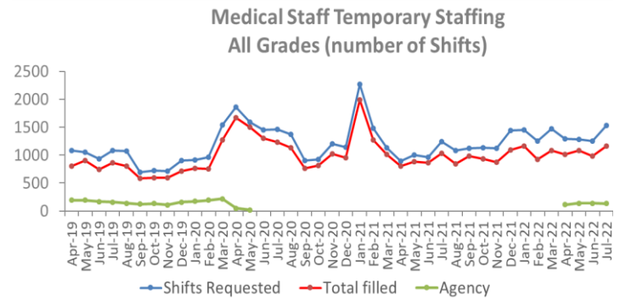
Owner(s): David Wherrett

Temporary Staffing

Cambridge University Hospitals NHS Foundation Trust

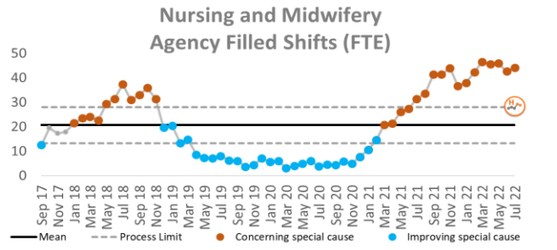
Workforce: Temporary Staffing

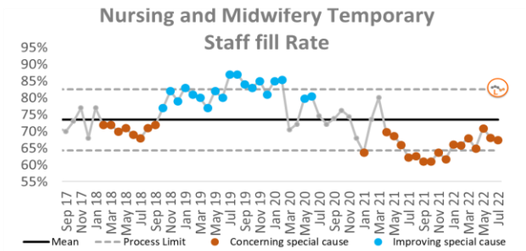


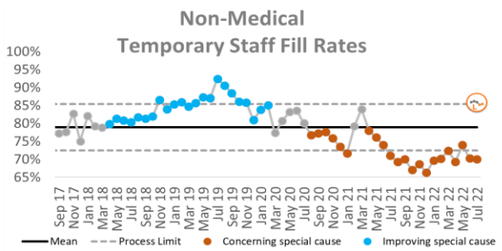


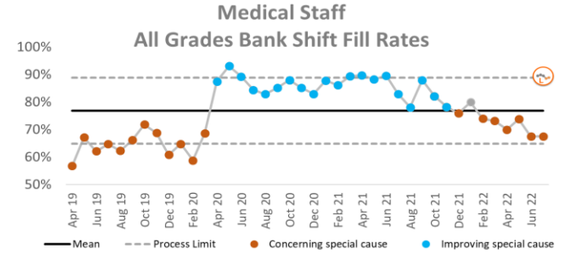
Background Information: The Trust works to ensure that temporary vacancies are filled with workers from staff bank in order to minimise agency usage, ensure value for money and to ensure the expertise and consistency of staffing.

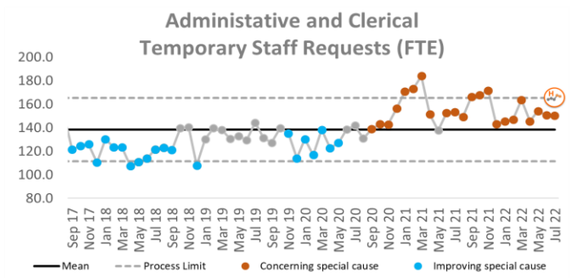
What the information tells us: Demand for non-medical temporary staff increased by 4.5% from the previous month to 1242.6 WTE. Top three reasons for request includes vacancy (47%), sickness (18%) and increased workload (15%). Nursing and midwifery agency usage slightly increased by 1.52 WTE from the previous month to 44.1 WTE. This accounts for 7.8% of the total nursing filled shifts. Overall, fill rate remained the same from previous month at 70% despite an increase in demand

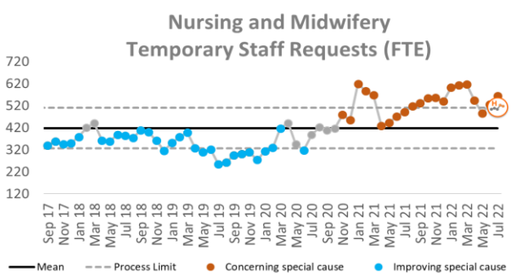


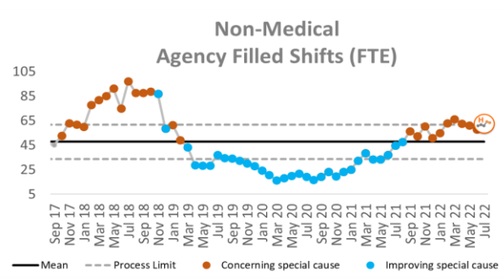


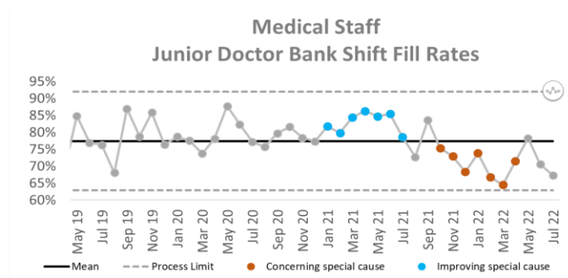










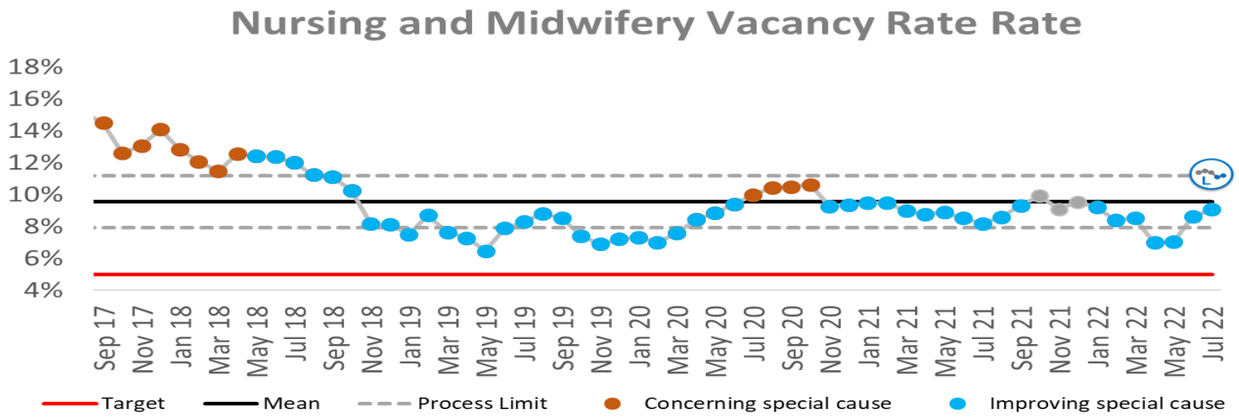


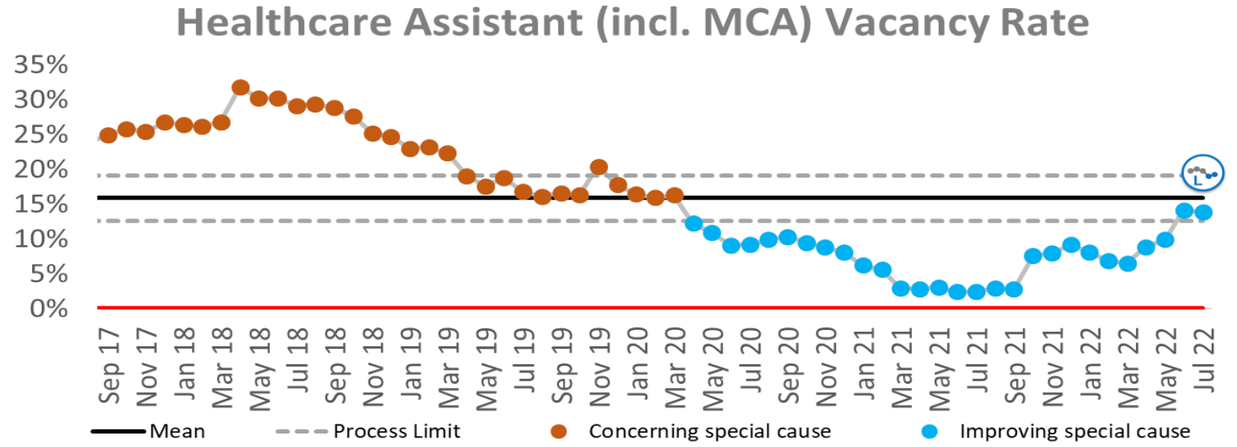
*Please note that temporary Medical staffing data was not available at the time of reporting and hence not updated

ESR Vacancy Rate

Cambridge University Hospitals NHS Foundation Trust

Workforce: ESR Vacancy Rate





Background Information: Vacancy rate provides vacancy information based on established post within an organisation. The figure below relates to ESR data for clinical areas only and includes pay band 2-4 for HCA and 5-7 for Nurses.

What the information tells us: The vacancy rate for both Healthcare Assistants and Nurses remained below the average rate at 13.8% and 9.1% respectively. However, the vacancy rate for both staff groups are above the target rate of 5% for Nurses and 0% for HCA.

*Please note ESR reported data has replaced self reported vacancy data for this report. The establishment is based on the ledger and may not reflect all Covid related increases. Work is ongoing to review both reports and further changes to this report will follow. **Nurses preparing for their OSCE exams were previously included in the data as filled HCA posts but are now included as filled Nursing posts instead.

Author(s): Tosin Okufuwa, Amanda Wood

Owner(s): David Wherrett

C19 - Individual Health Risk Assessment & Annual Leave Update

Cambridge University Hospitals NHS Foundation Trust

Workforce: C19 - Risk Assessment & Annual Leave Update

Percentage of Annual Leave (AL) Taken – June 22 Breakdown

	Staff Group	Total Entitlement (Hrs)	Total AL Taken (Hrs)	*% AL Taken	% of staff with Entitlement recorded on Healthroster
Annual Leave taken by Staff Group	Add Prof Scientific and Technic	49,456	13,432	27.2%	95%
	Additional Clinical Services	369,801	117,809	31.9%	97%
	Administrative and Clerical	478,245	136,268	28.5%	95%
	Allied Health Professionals	144,752	44,543	30.8%	99%
	Estates and Ancillary	79,013	25,724	32.6%	98%
	Healthcare Scientists	136,399	38,874	28.5%	97%
	Medical and Dental	143,036	29,905	20.9%	38%
	Nursing and Midwifery Registered	764,510	245,006	32.0%	97%
	Trust	**2,165,212**	**651,560**	30.1%	88%
Annual Leave taken by Division	*Division*				
	Corporate	301,159	86219	29%	95%
	Division A	408,714	129425	32%	87%
	Division B	598,300	184292	31%	93%
	Division C	274,997	77984	28%	81%
	Division D	262,887	79100	30%	86%
	Division E	227,043	69569	31%	84%
	R&D	92110	24971	27%	92%

* Greater than 27% | Less than 20% | Between 20% and 27%

What the information tells us: The Trust's annual leave usage is 90% of the expected usage after fourth month of the financial year. Overall usage is 30% compared to the expected 33%. The highest rate of use of annual leave is within Estates followed by Nursing and Midwifery staff at 33% and 32% respectively.

Mandatory Training by Division and Staff Group

Cambridge University Hospitals NHS Foundation Trust

Workforce: Mandatory Training

Background Information: Statutory and Mandatory training are essential for the safe and efficient delivery of the organisation services They are designed to reduce organisational risks and comply with local or national policies and government guidelines. Training can be undertaken on-line or by attending a class based session.

Induction >94% <80% Between 79% and 94%

Mandatory Training Competency (as defined by Skills for Health) Greater than 89% Less than 75% Between 74% and 89%

	Induction: Non-Medical Corporate Induction	Induction: Non-Medical Local Induction	Induction: Medical Corporate Induction	Induction: Medical Local Induction	Conflict Resolution	Equality, Diversity and Human Rights	Fire Safety	Health, Safety and Welfare	Infection Control	Information Governance including GDPR and Cyber Security	Moving & Handling	Resuscitation	Safeguarding Adults	Safeguarding Adult Lvl 2	Safeguarding Children Lvl 1	Safeguarding Children Lvl 2	Safeguarding Children Lvl 3	Prevent Level Three (WRAP)	Total Compliance
Frequency					3 yrs	3 yrs	2 yrs/1yr	3yrs	2 yrs	1 yr	2 yrs/1yrs	2 yrs/1yrs	3 yrs	3 yrs	3 yrs	3 yrs	3 yrs/1yr	3 yrs	
Delivery Method	cl	f2f	cl/	f2f	cl/e/	cl/e/	cl/e/	cl/e/	cl/e/	cl/e/	cl/e/	cl/el	cl/e/	cl/el	cl/el	cl/el	cl/el	cl	
Staff Requiring Competency	1,119	1,119	549	549	10,635	10,635	10,769	10,635	10,635	10,635	10,766	7,185	10,635	7,600	10,635	7,612	1,712	1,380	
Compliance by Division																			
Division A	(13)93.2%	(24)87.4%	(22)83.7%	(22)83.7%	(70)96.5%	(73)96.4%	(341)83.3%	(83)95.9%	(99)95.1%	(213)89.5%	(326)84.1%	(394)78.2%	(100)95.0%	(222)88.0%	(76)96.2%	(197)89.4%	(71)65.4%	(12)92.4%	90.5%
Division B	(26)91.1%	(49)83.2%	(11)85.9%	(13)83.3%	(76)97.2%	(78)97.2%	(238)91.4%	(73)97.3%	(125)95.4%	(232)91.6%	(358)87.1%	(293)79.4%	(101)96.3%	(192)88.8%	(82)97.0%	(174)89.9%	(25)80.6%	(14)89.1%	93.0%
Division C	(22)88.0%	(29)84.2%	(30)80.6%	(16)89.7%	(61)95.9%	(66)95.5%	(244)83.9%	(80)94.6%	(98)93.4%	(213)85.6%	(326)78.5%	(336)75.7%	(96)93.5%	(153)89.0%	(77)94.8%	(147)89.5%	(58)75.3%	(24)89.8%	88.9%
Division D	(7)94.5%	(33)74.0%	(20)78.5%	(18)80.6%	(48)96.5%	(55)96.0%	(209)85.1%	(63)95.5%	(99)92.9%	(185)86.7%	(304)78.3%	(335)71.1%	(76)94.5%	(129)89.1%	(58)95.8%	(119)89.9%	(17)86.5%	(14)88.8%	89.3%
Division E	(8)93.4%	(21)82.8%	(16)79.2%	(8)89.6%	(40)96.7%	(43)96.5%	(199)83.9%	(45)96.3%	(65)94.7%	(119)90.3%	(319)74.3%	(236)78.4%	(79)93.5%	(138)87.4%	(48)96.1%	(110)90.0%	(252)74.6%	(81)88.7%	88.9%
Corporate	(24)84.0%	(28)81.3%	(2)77.8%	(2)77.8%	(41)96.9%	(47)96.5%	(92)93.2%	(47)96.5%	(59)95.6%	(127)90.6%	(83)93.8%	(36)78.2%	(64)95.2%	(24)86.0%	(52)96.1%	(21)87.9%	(7)56.3%	(3)80.0%	94.1%
R & D	(1)98.1%	(5)90.7%			(7)98.4%	(5)98.9%	(16)96.3%	(7)98.4%	(16)96.3%	(22)95.0%	(40)90.9%	(18)88.8%	(10)97.7%	(13)93.1%	(8)98.2%	(12)93.6%	(1)85.7%	(1)75.0%	96.0%
Breakdown of Medical staff compliance																			
Consultant			(8)86.0%	(13)77.2%	(16)97.8%	(17)97.6%	(32)95.5%	(17)97.6%	(25)96.5%	(61)91.4%	(34)95.2%	(142)80.3%	(20)97.2%	(46)93.6%	(13)98.2%	(42)94.1%	(34)84.2%	(14)92.6%	94.1%
Non Consultant			(94)80.9%	(67)86.4%	(121)85.6%	(129)84.7%	(170)79.8%	(151)82.1%	(175)79.2%	(296)64.8%	(214)74.6%	(437)49.1%	(176)79.1%	(196)76.9%	(153)81.8%	(195)77.1%	(77)56.7%	(52)65.6%	76.4%
Compliance by Staff group																			
Add Prof Scientific and Technic	(0)100.0%	(0)100.0%			(4)98.3%	(3)98.7%	(8)96.6%	(4)98.3%	(12)94.8%	(23)90.0%	(17)92.7%	(8)75.0%	(7)97.0%	(19)90.5%	(6)97.4%	(19)90.5%	(0)100.0%	(0)100.0%	94.9%
Additional Clinical Services	(37)83.7%	(49)78.4%			(43)97.4%	(46)97.2%	(295)82.8%	(39)97.7%	(61)96.3%	(153)90.8%	(392)77.2%	(366)72.8%	(55)96.7%	(216)85.7%	(38)97.7%	(186)87.7%	(46)68.7%	(8)90.8%	89.9%
Administrative and Clerical	(20)91.2%	(44)80.7%			(66)97.0%	(77)96.5%	(78)96.5%	(80)96.4%	(98)95.6%	(185)91.6%	(114)94.8%	(8)60.0%	(110)95.0%	(16)86.1%	(89)96.0%	(17)85.5%	(4)42.9%	(2)71.4%	95.1%
Allied Health Professionals	(4)94.8%	(8)89.6%			(10)98.4%	(8)98.8%	(85)86.9%	(7)98.9%	(20)96.9%	(38)94.1%	(143)78.0%	(102)84.2%	(11)98.3%	(39)94.0%	(10)98.4%	(36)94.4%	(16)72.9%	(6)89.5%	93.2%
Estates and Ancillary	(16)73.3%	(4)93.3%			(9)97.4%	(9)97.4%	(27)92.1%	(10)97.1%	(14)95.9%	(36)89.4%	(8)97.6%	(8)97.6%	(13)96.2%	(13)96.2%	(11)96.8%				95.1%
Healthcare Scientists	(3)95.1%	(13)78.7%			(15)97.5%	(19)96.9%	(22)96.4%	(18)97.0%	(21)96.6%	(35)94.3%	(56)90.8%	(20)83.2%	(18)97.0%	(27)84.5%	(14)97.7%	(26)85.1%	(1)94.1%	(2)88.2%	94.9%
Medical and Dental			(102)81.4%	(80)85.4%	(137)91.2%	(146)90.6%	(202)87.0%	(168)89.2%	(200)87.1%	(357)77.0%	(248)84.0%	(579)63.3%	(196)87.4%	(242)84.5%	(166)89.3%	(237)84.9%	(111)71.8%	(66)80.6%	84.2%
Nursing and Midwifery Registered	(21)95.3%	(71)84.2%			(59)98.3%	(59)98.3%	(622)82.0%	(72)97.9%	(135)96.0%	(284)91.6%	(778)77.5%	(565)83.6%	(116)96.6%	(312)90.8%	(67)98.0%	(259)92.4%	(253)76.7%	(65)92.5%	91.4%
Trust Total	(101)91.0%	(189)83.1%	(102)81.4%	(80)85.4%	(343)96.8%	(367)96.5%	(1339)87.6%	(398)96.3%	(561)94.7%	(1111)89.6%	(1756)83.7%	(1648)77.1%	(526)95.1%	(871)88.5%	(401)96.2%	(780)89.8%	(431)74.8%	(149)89.2%	91.06%

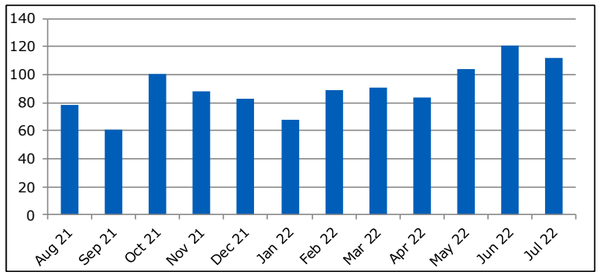
Author(s): Tosin Okufuwa, Amanda Coulier Owner(s): David Wherrett

Health and Safety Incidents

Cambridge University Hospitals NHS Foundation Trust

Health and Safety

No. of health and safety incidents affecting staff:

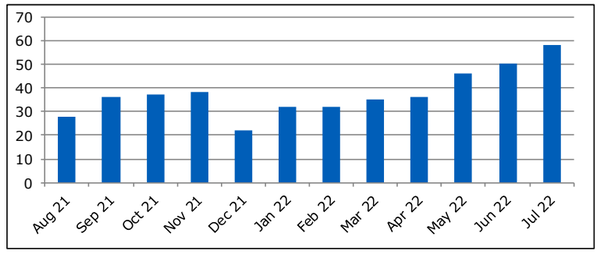


	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Total
Accident	21	8	15	8	12	17	16	21	16	15	14	20	**183**
Blood/bodily fluid exposure (dirty sharps/splashes)	19	11	30	26	12	15	17	18	17	16	19	20	**220**
Environmental Issues	6	4	7	13	4	1	5	4	10	4	7	20	**85**
Moving and Handling	3	5	1	3	7	5	3	4	3	3	5	2	**44**
Sharps (clean sharps/incorrect disposal & use)	3	3	2	3	3	2	7	3	6	8	4	8	**52**
Slips, Trips, Falls	4	9	8	12	9	4	6	8	7	8	7	3	**85**
Violence & Aggression	20	19	32	23	34	22	32	29	23	45	61	36	**376**
Work-related ill-health	2	2	5	0	2	2	3	4	2	5	4	3	**34**
Total	**78**	**61**	**100**	**88**	**83**	**68**	**89**	**91**	**84**	**104**	**121**	**112**	**1079**

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

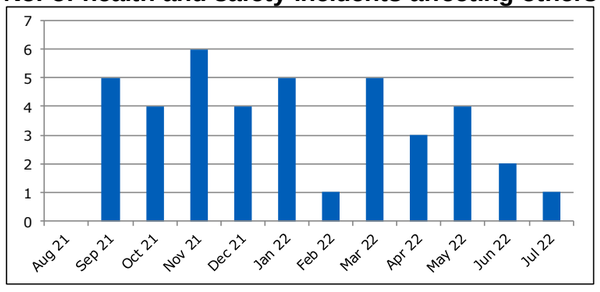
	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Total
No. of health & safety incidents	78	61	100	88	83	68	89	91	84	104	121	112	**1079**
Staff incident rate per month/year	0.7	0.6	0.9	0.8	0.8	0.6	0.8	0.8	0.8	1.0	1.1	1.0	**9.9**

No. of health and safety incidents affecting patients:



	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Total
Accident	16	18	17	13	7	11	11	17	19	25	20	19	**193**
Blood/bodily fluid exposure (dirty sharps/splashes)	1	2	2	0	3	0	1	4	2	1	1	1	**18**
Environmental Issues	4	3	3	4	4	0	4	3	2	1	4	12	**44**
Equipment / Device - Non Medical	1	0	2	2	0	1	2	1	0	1	1	2	**13**
Moving and Handling	0	1	2	0	0	3	1	1	0	0	5	2	**15**
Sharps (clean sharps/incorrect disposal & use)	0	5	2	3	3	3	2	1	0	0	3	2	**24**
Violence & Aggression	6	7	9	16	5	14	11	8	13	18	16	20	**143**
Total	**28**	**36**	**37**	**38**	**22**	**32**	**32**	**35**	**36**	**46**	**50**	**58**	**450**

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



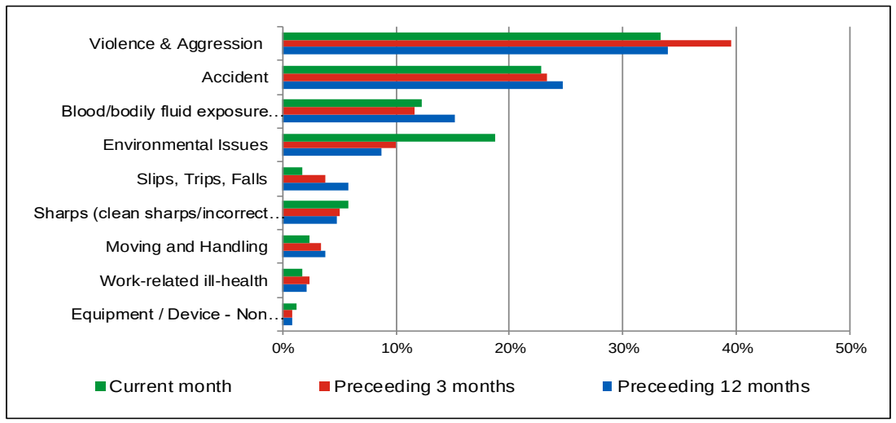
	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Total
Accident	0	3	2	1	1	1	0	0	0	2	1	0	**11**
Environmental Issues	0	1	0	0	1	3	0	1	0	2	0	0	**8**
Slips, Trips, Falls	0	0	0	3	1	0	0	1	0	0	1	0	**6**
Violence & Aggression	0	1	2	2	1	1	1	3	3	0	0	1	**15**
Total	**0**	**5**	**4**	**6**	**4**	**5**	**1**	**5**	**3**	**4**	**2**	**1**	**40**

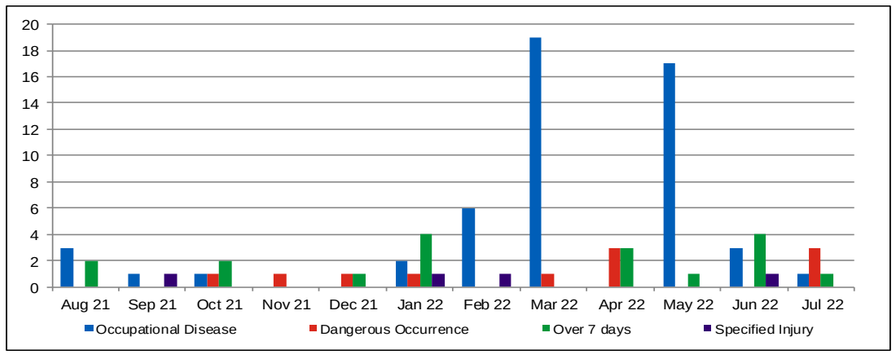
Health and Safety Incidents

Cambridge University Hospitals NHS Foundation Trust

Health and Safety

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:	**1569**	**312**	**220**	**480**	**284**	**145**	**50**	**78**
Accident	**387**	86	70	93	62	40	8	28
Blood/bodily fluid exposure (dirty sharps/splashes)	**238**	71	38	50	45	28	5	1
Environmental Issues	**137**	26	28	13	22	25	7	16
Equipment / Device - Non Medical	**13**	3	1	4	5	0	0	0
Moving and Handling	**59**	11	14	9	15	3	2	5
Sharps (clean sharps/incorrect disposal & use)	**76**	31	11	12	4	12	5	1
Slips, Trips, Falls	**91**	21	22	15	6	10	7	10
Violence & Aggression	**534**	52	29	282	120	25	11	15
Work-related ill-health	**34**	11	7	2	5	2	5	2





A total of 1,569 health and safety incidents were reported in the previous 12 months.

792 (50%) incidents resulted in harm. The highest reporting categories were violence and aggression (34%), accidents (25%) and blood/bodily fluid exposure (15%).

1,079 (69%) of incidents affected staff, 450 (29%) affected patients and 40 (3%) affected others i.e. contractors and members of the public.

The highest reported incident categories for staff were: violence and aggression (35%), blood/bodily fluid exposure (20%) and accidents (17%).

The highest reported incident categories for patients were: accidents (43%), violence & aggression (32%) and environmental issues (10%).

The highest reported incident categories for others were: violence and aggression (38%), accidents (28%) and environmental issues (20%).

Staff incident rate is 9.9 per 100 members of staff (by headcount) over a rolling 12 month period.

The highest reporting division was division C with 480 incidents. Of these, 59% related to violence & aggression.

In the last 12 months, the highest reported RIDDOR category was occupational disease (62%). 29% of RIDDOR incidents were reported to the HSE within the appropriate timescale. In July 2022, 5 incidents were reported to the HSE:

Over 7 day injury (1)

- The Injured Person (IP) was undertaking a drug round. The drug trolley lid was opened and extended backwards to 45 degrees past the vertical. The IP noticed that a chair was in the way. The IP went to move the chair and, in doing so, the drug trolley lid suddenly closed making contact with the IPs left shoulder/neck.

Occupational disease (1)

- Covid-19: 1 member of staff tested positive for Covid-19 and there is reasonable evidence to suggest that a work-related exposure is the likely cause of the disease. To note, the high number reported in March and May partially reflects prevalence at the time but also the practicalities of the cases being assessed such that they are not all from those months.

Dangerous occurrence (3)

- A patient presented in the Emergency Department with a self-diagnosis of Monkeypox. This did not trigger the Trusts Monkeypox pathway and therefore not all appropriate control measures were followed.
- The IP sustained an injury whilst using a suture needle during a procedure. The patient was Hep B Positive.
- A package was received in goods in. When moving the package the bottom of the box failed and a bottle filled with approximately 500ml of Formamide fell to the floor. The bottle leaked the full contents onto the floor.

Author(s): Helen Murphy

Owner(s):

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Cambridge University Hospitals
NHS Foundation Trust

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Report to the Council of Governors: 21 September 2022

Agenda item	8.1
Title	Report of the Lead Governor
Sponsoring executive director	n/a
Author(s)	Neil Stutchbury, Governor
Purpose	To receive the report of the Lead Governor
Previously considered by	n/a

Executive Summary

This report summarises the activities of the Lead Governor since the previous meeting of the Council of Governors.

Related Trust objectives	n/a
Risk and Assurance	n/a
Related Assurance Framework Entries	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 Council of Governors

The Council is asked to note the report of the lead Governor.

Cambridge University Hospitals NHS Foundation Trust

21 September 2022

Council of Governors
Report from the Lead Governor
Neil Stutchbury

1. Recent Governor meetings

This has been a relatively quiet period for governors due to the summer holiday period. Since the last Council of Governors' meeting, there has been one Strategy Group meeting and one quarterly meeting with Non-Executive Directors (NEDs), neither of which unfortunately the Lead Governor was able to attend.

1.1 A **Governor Strategy** meeting was held on 18 July. We received an update on the strategy work, which was presented to the Board at its July meeting and watched a video to support communicating it to staff. The group also discussed some of the opportunities and challenges of working in an integrated care system, which included examples of where integrated working is already delivering benefits. The group also discussed ways in which the team can work with members of the public and patients to co-produce ways of working in an integrated care model.

1.2 Governors met the NEDs at the **quarterly Governor/NED** meeting on 20 July and sought assurance on a range of issues, including the follow-up actions from the Care Quality Commission (CQC) visit, monitoring patient safety, use of patient data and the Integrated Care System/Integrated Care Partnership (ICS/ICP).

2. Upcoming Governor meetings

2.1 The Governor Strategy Group scheduled for 12 September was postponed.

2.2 The next Council of Governors' meeting is on 21 September. Governors have been discussing when would be prudent to go back to face-to-face meetings and it has been agreed to hold this meeting on the hospital site, with a site tour beforehand and a social event afterwards.

2.3 The next Governor Forum is on 28 September.

2.4 There is a Cambridgeshire and Peterborough Lead Governors' meeting on 29 September at which we will prepare for the meeting of all governors with the Chair of the Integrated Care Board (see below). The next quarterly meeting with the NEDs is on 2 November.

2.5 The next quarterly meeting with NEDs is on 2 November.

3. Other Governor activities

3.1 Other than individual induction training, there has been no formal joint training for governors since the start of the pandemic, despite several efforts by the Secretariat to identify a suitable date. We have therefore decided to allocate the next Governor Seminar slot on 20 October for a two-hour training session, facilitated by an external consultant. Training will be focused on practical skills in effective questioning and holding NEDs to account. The planned session on patient experience and Healthwatch will be deferred to a subsequent Seminar slot.

4. Recommendation

4.1 The Council of Governors is asked to note the activities over the past three months.

Cambridge University Hospitals
NHS Foundation Trust

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Report to the Council of Governors: 21 September 2022

Agenda item	8.2
Title	Membership Engagement Strategy Implementation Group
Sponsoring executive director	Ian Walker, Director of Corporate Affairs
Author(s)	Namoo Boodoo, Membership Manager
Purpose	To provide a summary of the meeting held on 19 July 2022.
Previously considered by	n/a

Executive Summary

This paper provides a summary of the meeting of the group held on 19 July 2022.

Related Trust objectives	All
Risk and Assurance	n/a
Related Assurance Framework Entries	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 Council of Governors

The Council is asked to receive and note the report.

Cambridge University Hospitals NHS Foundation Trust

21 September 2022

Council of Governors
Membership Engagement Strategy Implementation Group

1.1 At its meeting on 19 July 2022, the Group received an update on the progress in implementing the Membership Engagement Strategy and reviewed and endorsed a draft version of a new 'Membership Hub' website page.

1.2 There was a discussion on further ways of reaching out to the wider community, including young people. It was agreed that members of the Group would provide further input to the Membership Manager via email.

1.3 The Group agreed that an item should be re-instated on Medicine for Members agendas to provide an opportunity to briefly talk about the roles of Governors and members.

1.4 The script for a new film about membership would be shared with the Group for comments.

1.5 It was agreed that, for sustainability purposes, any printed material being sent to members should be aligned with election correspondence if this was possible. The focus should remain on moving towards electronic-only correspondence with members.

1.6 It was agreed that a more detailed update on implementing the Membership Engagement Strategy would be provided to the Council of Governors in December 2022.