Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 10 May 2023

Agenda item	9.4
Title	Finance report
Sponsoring executive director	Mike Keech, Chief Finance Officer
Author(s)	As above
Purpose	To update the Board on financial performance in 2022/23 M12
Previously considered by	Performance Committee, 3 May 2023

Executive Summary

The report provides details of financial performance during 2022/23 Month 12 and in the year to date. A summary is set out in the Chief Finance Officer's message on pages 3-5 of the report.

Related Trust objectives	All Trust objectives
Risk and Assurance	The report provides assurance on financial performance during Month 12.
Related Assurance Framework Entries	BAF ref: 011
Legal / Regulatory / Equality, Diversity & Dignity implications?	n/a
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	n/a

Action required by the Board of Directors
The Board is asked to note the finance report for 2022/23 Month 12 (March 2023).

Contents

Trust actual surplus / (deficit)

(£1.2m)	*Actual (adjusted)**
(£1.3m)	*Plan (adjusted)**
£0.1m	*Actual YTD (adjusted)**
£0.0m	*Plan YTD (adjusted)**

Covid-19 expenditure and system Covid-19 funding

£1.1m	*Covid actual in month*
£1.8m	*Covid plan in month*
£1.9m	*Covid funding in month*
£21.3m	*Covid actual YTD*
£22.2m	*Covid plan YTD*
£22.3m	*Covid funding YTD*

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

Net current assets

(£81.7m)	*Actual*
(£74.2m)	*Plan*

Debtor days

19	*This month*
22	*Previous month*

Payables performance (YTD) **

Actual	85.5%	*Value*
Plan	86.8%	*Quantity*

Cash and EBITDA

Cash

£226.4m	*Actual*
£159.2m	*Plan*

EBITDA

£38.1m	*Actual YTD*
£42.5m	*Plan YTD*

Capital expenditure

£13.2m	*Capital - actual spend in month*
£67.1m	*Capital - actual spend YTD*
£66.5m	*Capital – plan YTD*

Elective Recovery Fund (ERF)

ERF values based on CUH fair share. NHSE/I have now confirmed that this income will not be subject to clawback.

£5.0m	*ERF forecast actual in month*
£5.0m	*ERF plan in month*
£26.7m	*ERF forecast actual YTD*
£29.7m	*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.

Month 12 Financial Performance

- **The Month 12 year end position is a £0.1m surplus for performance management purposes**. This performance, subject to audit, is in line with the Trust financial plan for 22/23.
- After accounting for the impact of national adjustments for the proposed additional 22/23 pay award and additional NHS pension contributions and funding, the following points should be noted:
    - Income favourable variance of £58.3m. This position is driven by additional clinical income of £16.8m from in year service developments and growth in pass-through drugs and devices and in year R&D pass-through grant income and consortium grossing-up income of £40.6m. This income is matched against associated expenditure in year. Other income receipts relating to the redevelopment of the Cambridge Biomedical Campus, education and training and national PPE funding are partially offset by a shortfall in the recognition of fire prevention works income and associated expenditure of £5.6m.
    - Pay favourable variance of £0.4m. This position is driven by slippage on planned investments offset by premium pay rates due to a higher level of absenteeism and vacancy.
    - Non pay adverse variance of £54.7m. This position is driven by the offsetting expenditure associated with the favourable income performance outlined above. Please refer to the non-pay analysis later in the report.
- Whilst the Trust is operating in line with its plan, within this position the delays in investment in additional operational capacity are further contributing to productivity shortfalls, as discussed below.

Productivity

- The Trust underlying performance (excluding non-recurrent and pass-through expenditure) is broadly in line with its expenditure plan at month 12 but continues to perform below its planned levels of productivity.
- At month 12 the under performance in clinical activity can be valued at £11.9m. A shortfall of £25.0m from planned care services is due to operational pressures and limitations, including as a result of staffing vacancies. In year the Trust remains protected from this shortfall through the block funding arrangement but this represents a significant performance challenge to be addressed in advance of the new year.
- There has been an estimated increase in expenditure levels of £20-22m associated with operational delivery/capacity.
- Overall, with the reduction in productivity and additional capacity investments in year, we are performing at a c.£32-34m gap from pre-Covid-19 levels.
- Non recurrent efficiency savings delivered in the year will also add to the longer term cost management target for the Trust.

Covid-19 Expenditure

- The Trust received £22.3m of funding and incurred £21.3m of Covid-19 associated expenditure, reflecting the reduction in monthly expenditure in 22/23.
- Whilst the number of Covid-19 patients in the hospital fluctuates from month to month, the amount of Covid-19 spend incurred to date is a reflection of the pressures services are facing, to cope with higher than usual demand, together with the need to maintain a safe operating environment.

Elective Recovery Fund (ERF)

- The Trust has recognised Elective Recovery Fund (ERF) income of £26.7m in the financial year.
- NHSE/I have provided confirmation that the planned ERF values will be funded in full for 22/23 without the risk of clawback.

Productivity and Efficiency Programme (PEP, previously CIP)

- The Trust successfully delivered an efficiency requirement of £12.4m in H2 21/22 and £17.2m in total across 21/22.
- For 22/23 the efficiency requirement was £62.0m and it was planned that this be delivered via Covid cost reductions (£22.4m), Efficiency & transformation (£32.7m) and Productivity & growth (£6.9m).
- The final position for 22/23 reports broadly in line with plan, with efficiencies of £62.1m achieved.
- Of the total efficiency, £47.6m were forecast to be recurrent. The plan includes £11.0m of non-recurrent savings that funded 2022/23 system support requirements.
- Recurrent achievement is below plan by £4.3m at £43.3m. This has been mitigated by non-recurrent delivery of efficiencies placing an additional requirement on the delivery of recurrent savings in 23/24. Pay efficiencies are ahead of plan by £1.3m. Within this, recurrent initiatives are £3.9m adverse to plan and non-recurrent schemes are £5.2m ahead of plan. For non-pay efficiencies, initiatives are £0.4m favourable to plan, reporting achievement of £24.2m against plan of £23.8m. Note that values are subject to rounding.
- Income efficiencies are reporting adverse to plan by £1.6m driven by a shortfall in non-recurrent scheme delivery. This measure includes the non-recurrent campus development project income receipt of £4.2m.
- The Trust will continue to track the performance of existing schemes and review those which have failed to deliver or have been delayed this year, in 23/24.

Cash and Capital Position

- The Trust received an initial system capital allocation for the year of £32.2m for its core capital requirements. In addition to this, we received further funding for the Children's Hospital (£3.7m), Cancer Hospital (£7.5m) Movement Surgical Hub (£14.9m), additional theatre equipment (£4.1m) and Endoscopy equipment (£1.0m). Together with capital contributions from ACT, the Trust's capital budget for the year now totals £66.5m.
- The Trust has invested £67.1m in it's capital programme in 2022/23 - £0.5m above the planned figure of £66.5m.
- The Trust's cash position remains strong due to the timing of payments for major capital projects and against a prudent plan. The 13 week cash flow forecast does not identify any need for additional revenue cash support in the foreseeable future.

FY23/24 Financial Plan

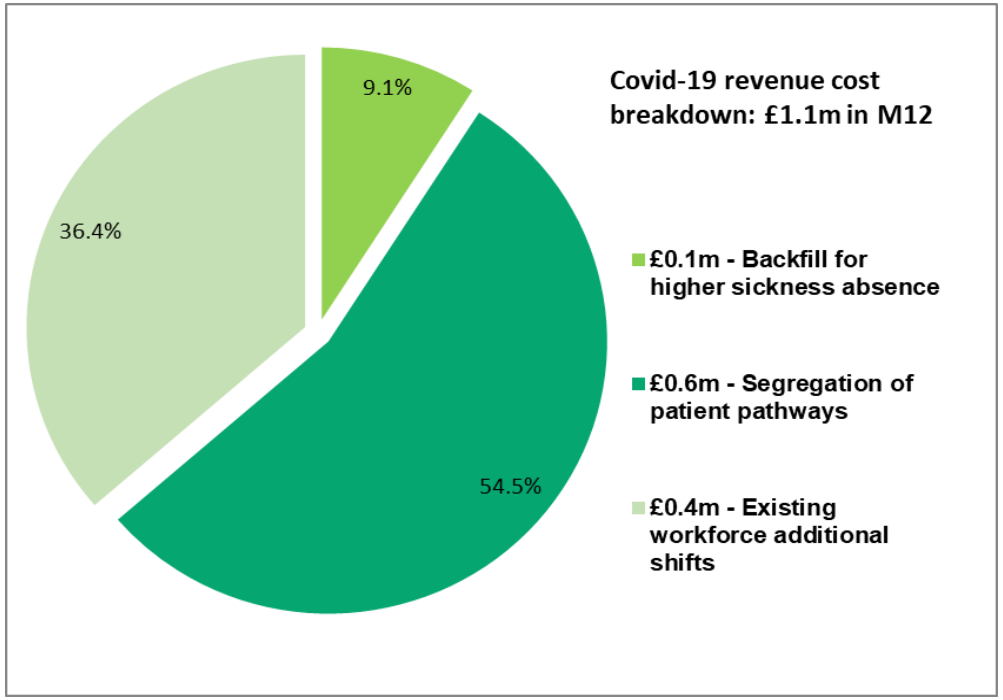
- An updated financial plan for 2023/24 is due to be submitted in early May where the Trust is proposing to present a break-even position.
- The information that has been shared to date on the financial settlement and through the guidance indicates that 2023/24 will be a significantly challenging year.
- To achieve this position the Trust will need to focus on productivity improvements, allowing more activity to be delivered within the current physical capacity and the current cost base. This, in the context of operational and workforce pressures, will be challenging, but it will increasingly need to be a focus of the organisation.

Month 12 performance against plan

	In Month						Year to Date					
£ Millions	**Budget**	**Actual**	**Variance**	**National pension adj 6.3%**	**Pay award adjustments**	**Variance (exc. Covid, pension and pay adjs)**	**Budget**	**Actual**	**Variance**	**National pension adj 6.3%**	**Pay award adjustments**	**Variance (exc. Covid, pension and pay adjs)**
Clinical Income - exc. D&D*	68.7	120.8	52.1	26.8	21.9	3.4	838.5	912.0	73.5	26.8	33.4	13.4
Clinical Income - D&D*	13.5	14.3	0.8			0.8	161.9	165.3	3.4			3.4
ERF income	5.0	2.0	(3.0)			(3.0)	29.7	26.8	(3.0)			(3.0)
Devolved Income	15.1	48.6	33.5			33.5	183.7	228.2	44.6			44.6
Covid - Income top-up & outside envelope	1.8	1.9	0.1				21.6	22.3	0.7			
Total Income	**104.1**	**187.7**	**83.6**	**26.8**	**21.9**	**34.8**	**1,235.4**	**1,354.6**	**119.2**	**26.8**	**33.4**	**58.3**
Pay	56.8	109.4	(52.7)	26.8	21.9	(4.1)	656.0	715.2	(59.1)	26.8	32.8	0.4
Drugs	14.5	13.8	0.6			0.6	173.0	183.4	(10.5)			(10.5)
Non Pay	28.8	61.9	(33.1)		0.1	(33.0)	341.3	396.7	(55.4)		0.7	(54.7)
Covid - Pay	1.2	1.1	0.1				14.8	14.7	0.1			
Covid - Drugs	0.0	0.0	0.0				0.4	0.2	0.1			
Covid - Non pay	0.6	0.0	0.6				7.4	6.4	1.1			
Operating Expenditure	**101.8**	**186.3**	**(84.5)**	**26.8**	**21.9**	**(36.5)**	**1,192.9**	**1,316.6**	**(123.7)**	**26.8**	**33.4**	**(64.8)**
EBITDA	**2.3**	**1.4**	**(0.9)**	**0.0**	**0.0**	**(1.7)**	**42.5**	**38.1**	**(4.5)**	**0.0**	**0.0**	**(6.5)**
Depreciation, Amortisation & Financing	3.5	3.1	0.5			0.5	42.5	39.2	3.3			3.3
Reported gross Surplus / (Deficit)	**(1.3)**	**(1.7)**	**(0.4)**	**0.0**	**0.0**	**(1.2)**	**0.0**	**(1.2)**	**(1.2)**	**0.0**	**0.0**	**(3.2)**
Add back technical adjustments:												
Capital donations/grants net I&E impact	0.0	0.1	0.1			0.1	0.0	1.2	1.2			1.2
Net benefit of PPE consumables transactions	0.0	0.0	0.0			0.0	0.0	0.1	0.1			0.1
Surplus / (Deficit) NHS financial performance basis	**(1.3)**	**(1.6)**	**(0.3)**	**0.0**	**0.0**	**(1.1)**	**0.0**	**0.1**	**0.1**	**0.0**	**0.0**	**(1.9)**

Please note that the values reported in the above table and throughout the report are subject to rounding.

Summary financial position



Key messages:

The Trust has recorded £1.1m of Covid expenditure in month 12, bringing the total year to date for 22/23 to £21.3m. This represents a £1.3m favourable variance against the plan of £22.6m.

The main areas of Covid investment in Month 12 are:

- Segregation of patient pathways £0.6m
- Existing workforce covering additional shifts £0.4m
- Backfill for higher sickness absence £0.1m

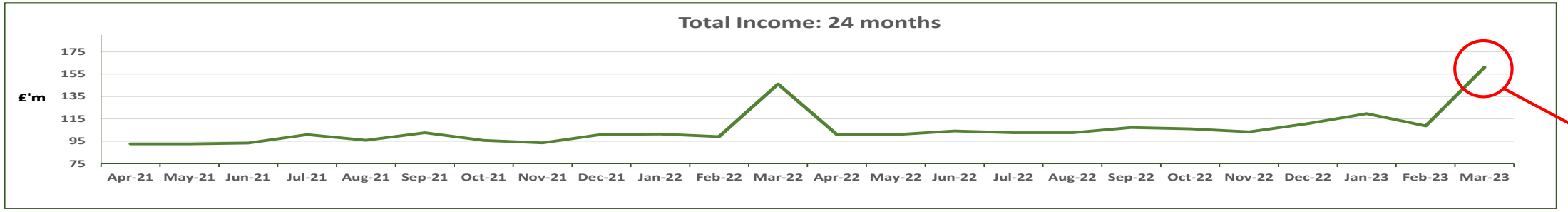
Total expenditure for 21/22 was £45.5m which averaged £3.8m per month. The Trust's plan for 22/23 included a reduction in funding for Covid-19 of £22.4m due to the financial impact of the pandemic reducing.

Expenditure in month 12 is £1.1m, which is a reduction on the year to date average.

Division (£m's)	Apr & May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Corporate	£1.4	£0.6	£0.6	£0.2	£0.2	£0.6	£0.4	£0.3	(£0.1)	£0.3	(£0.2)
Division A	£0.7	£0.4	£0.4	£0.3	£0.3	£0.3	£0.3	£0.2	£0.3	£0.2	£0.2
Division B	£0.9	£0.4	£0.3	£0.3	£0.4	£0.4	£0.4	£0.5	£0.6	£0.4	£0.5
Division C	£0.7	£0.3	£0.4	£0.4	£0.4	£0.4	£0.5	£0.3	£0.4	£0.4	£0.4
Division D	£0.5	£0.3	£0.3	£0.1	£0.2	£0.1	£0.1	£0.2	£0.1	£0.2	£0.1
Division E	£0.4	£0.1	£0.2	£0.2	£0.2	£0.2	£0.0	£0.0	£0.0	£0.0	£0.0
Total	**£4.5**	**£2.2**	**£2.2**	**£1.6**	**£1.6**	**£2.0**	**£1.7**	**£1.5**	**£1.3**	**£1.5**	**£1.1**

Elective Activity Recovery Period

Covid-19 expenditure overview



£'m	In Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Elective admissions	12.0	11.9	(0.1)	144.2	134.6	(9.6)
Non-elective admissions	15.2	15.8	0.6	182.7	185.5	2.8
Outpatients	10.4	10.2	(0.2)	125.1	109.7	(15.4)
A&E	2.0	3.3	1.3	24.5	34.7	10.3
High-cost drugs income from commissioners	13.5	14.3	0.8	161.9	165.3	3.4
Other Clinical Income	29.0	30.9	1.9	362.0	387.3	25.3
Covid - Income top-up & outside envelope	1.8	1.9	0.1	21.6	22.3	0.7
ERF	5.0	2.0	(3.0)	29.7	26.8	(3.0)
Pay award adjustments	0.0	21.9	21.9	0.0	33.4	33.4
National pension adjustment	0.0	26.8	26.8	0.0	26.8	26.8
Total Clinical Income	**89.0**	**139.1**	**50.1**	**1,051.7**	**1,126.4**	**74.7**
Devolved Income	15.1	48.6	33.5	183.7	228.2	44.6
Total Trust Income	**104.1**	**187.7**	**83.6**	**1,235.4**	**1,354.6**	**119.2**

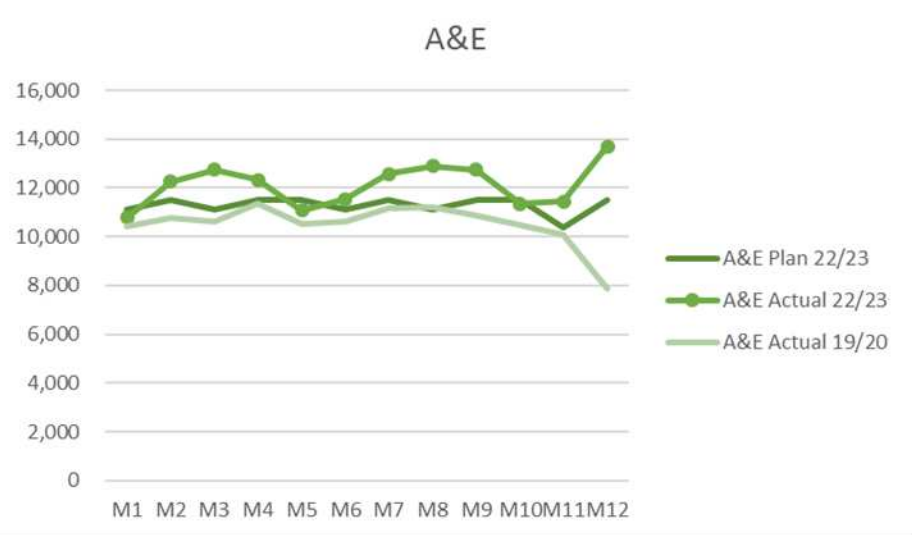
Note: The March 2023 figures include additional funding from NHSE/I for the non-consolidated pay award (£21.1m), the impact of R&D consortium arrangements accounted for in M12 (£13.6m), apprenticeship funding (£2.4m) and national PPE funding (£2.2m). All of which included matched expenditure in M12.

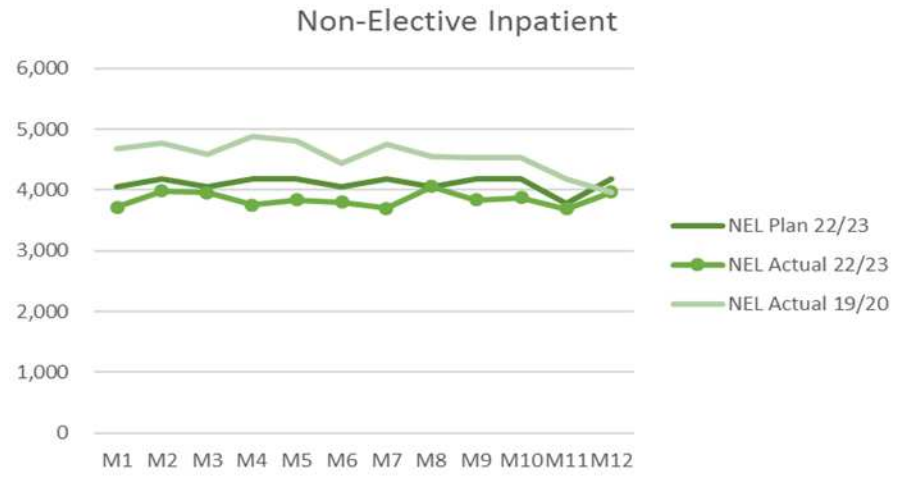
Key messages:

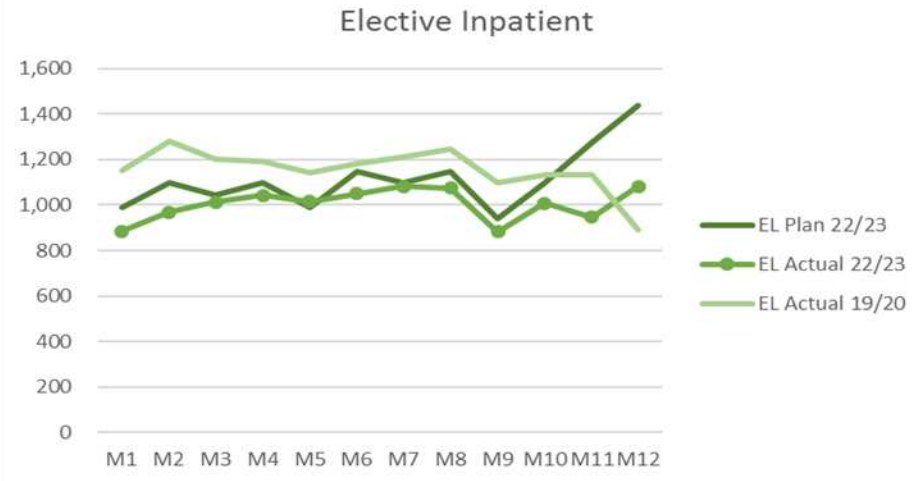
- The values included in the table for elective, non elective, outpatients and A&E income are based upon regular reporting methods (PbR view) and align to NHS E reporting categories.
- As the Trust's clinical income is predominantly paid through block contracts a block top-up is included within other clinical income. The total clinical income includes income earnt from NHS and devolved administration commissioners and NHS arms length bodies.
- The overall income recognised each month can fluctuate for a number of reasons including patient case-mix or commissioner pricing challenges.
- Year to date there is a favourable variance of £3.4m relating to high-cost drugs pass-through expenditure, which includes an under performance by the Car-T service along with the Cancer Drugs Fund, which are both fully offset by over-performance for other high cost drugs. The pay award adjustment category reports £12.3m of additional pay award funding that was provided in month 6 to cover the additional costs of the national pay settlements for Consultants, Agenda for Change staff and Very Senior Managers. A further £21.1m is included in the M12 position to reflect the additional non-consolidated pay award.
- Devolved income has a favourable variance of £44.6m year to date. This is driven by the following additional income at month 12, all of which is wholly offset by corresponding expenditure; R&D consortium grossing-up income and pass-through grant income of £40.0m, £4.2m receipts relating to the redevelopment of the biomedical campus, £4.2m of Education and training income, apprenticeship funding of £2.4m and national PPE funding of £2.2m. This is partially offset by a shortfall in income recognition which is attributable to fire prevention works expenditure being lower than planned by £5.6m.

Clinical and other income

Clinical Income - Activity information (A&E, DC, NEL and EL)

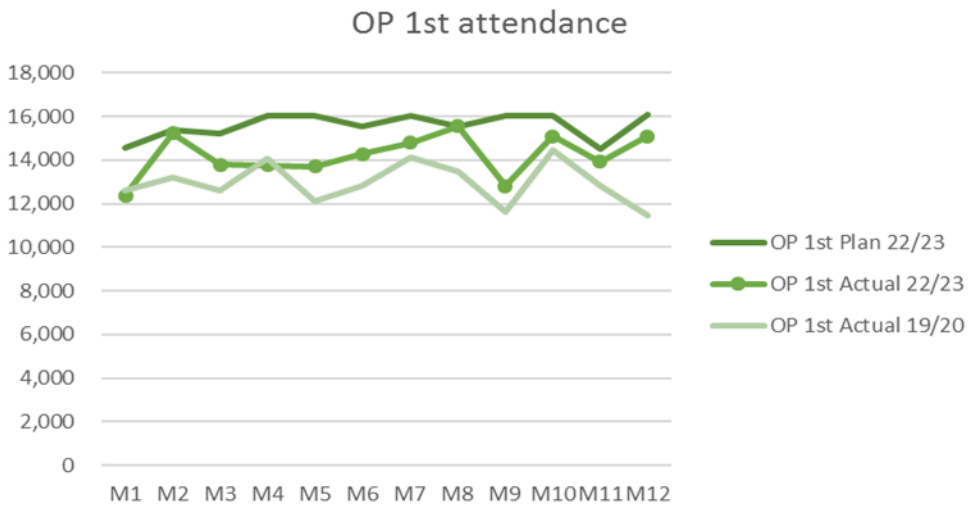


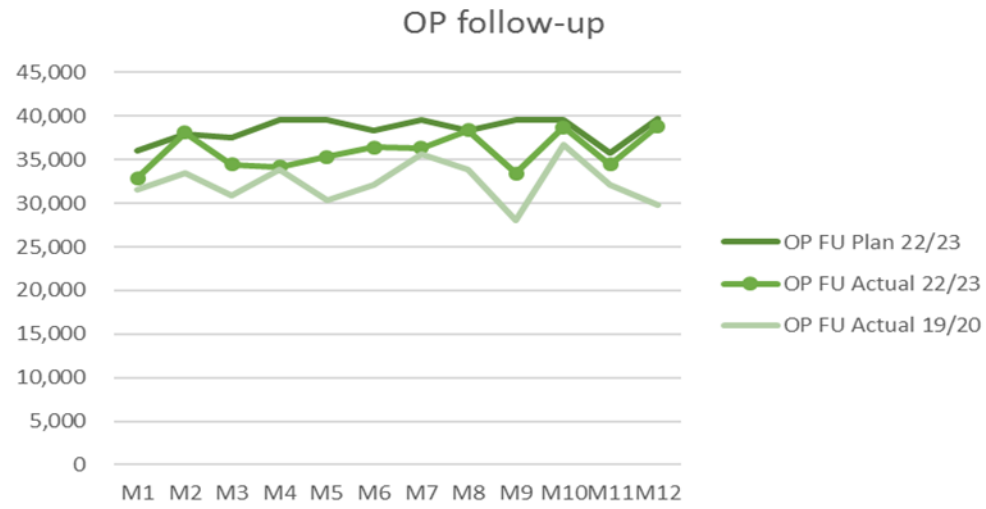


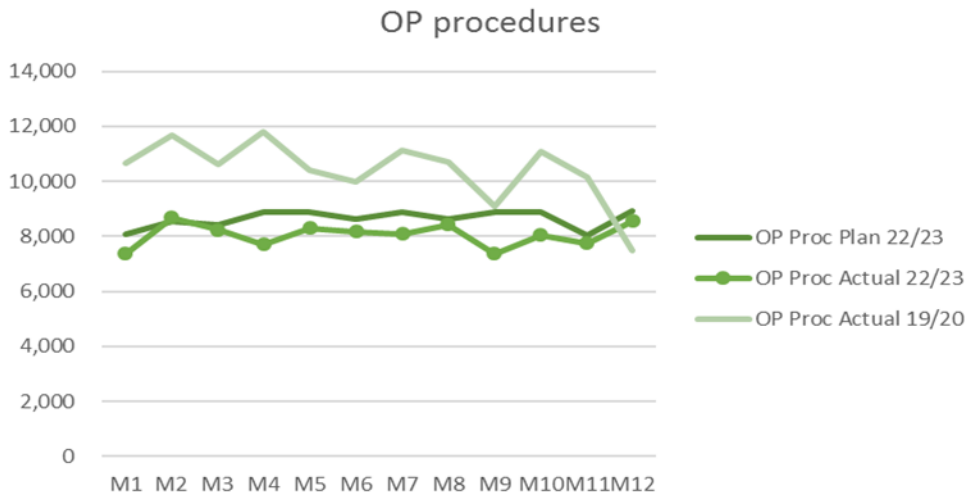


Clinical and other income (continued)

Clinical Income - Activity information (OP FA, FUP and Procedure)







Key messages:

- Strong performance is reported in A&E in month 12, particularly type 5 attendances. Year to date, A&E is 7.4% above plan and in month 18.9% above plan.
- Non elective spells are below plan both in month and against 19/20 actuals. Year to date, NEL are 6.3% below plan and in month 5.3%.
- Elective spells performed well in month 12 against prior months, yet reported below plan. This is due to the phasing of the plan increasing considerably in the final quarter owing to planned capacity works. Year to date, EL is 9.8% below plan and in month 24.7%.
- Day cases performed at 6.4% below plan in month 12 but report in line with plan for the year to date.
- Outpatient first attendances are below plan yet above 19/20 levels. Year to date, OP 1st is 8.9% below plan, and in month 6.1%.
- Outpatient follow-up attendances are marginally below plan in month 12, yet above 19/20 levels. Year to date, OP FUP reports at 6.5% below plan, and in month 2.1%.
- Outpatient procedures are lower than plan in month 12 and overall below 19/20 levels. Year to date, OP proc. are 6.8% below plan and in month 4.2%.

Clinical Income – Elective Recovery Fund (ERF)

	FY22/23 ERF Initial Plan (£'m)												22/23 FY
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Total
ERF PLAN %	2.8%	2.8%	2.8%	5.5%	5.5%	5.5%	8.3%	8.3%	8.3%	16.7%	16.7%	16.8%	100.0%
ERF PLAN £m's	**0.8**	**0.8**	**0.8**	**1.6**	**1.6**	**1.6**	**2.5**	**2.5**	**2.5**	**5.0**	**5.0**	**5.0**	**29.7**

ERF:

- The Trust has now received confirmation from NHSE/I that the full year planned ERF will be funded in full without the risk of claw-back.
- The Trust has recognised £26.7m of ERF in the current year against the plan of £29.7m.
- The tables on the right are the initial regionally published ERF performance percentages of current year priced volume weighted activity against the equivalent 19/20 values, for months 1 to 3 (published October 2022). No further national data has been published.

	CUH Provider		
	M1	M2	M3
Day Case	97%	110%	98%
Elec spell	85%	80%	95%
OP 1st att	103%	110%	105%
OP proc	87%	90%	93%
Overall	**92%**	**95%**	**96%**

	QUE System Level		
	M1	M2	M3
Day Case	91%	106%	93%
Elec spell	100%	102%	104%
OP 1st att	99%	100%	97%
OP proc	89%	97%	93%
Overall	**95%**	**100%**	**96%**

Please note: M4-12 national data not yet available

Clinical and other income (continued)

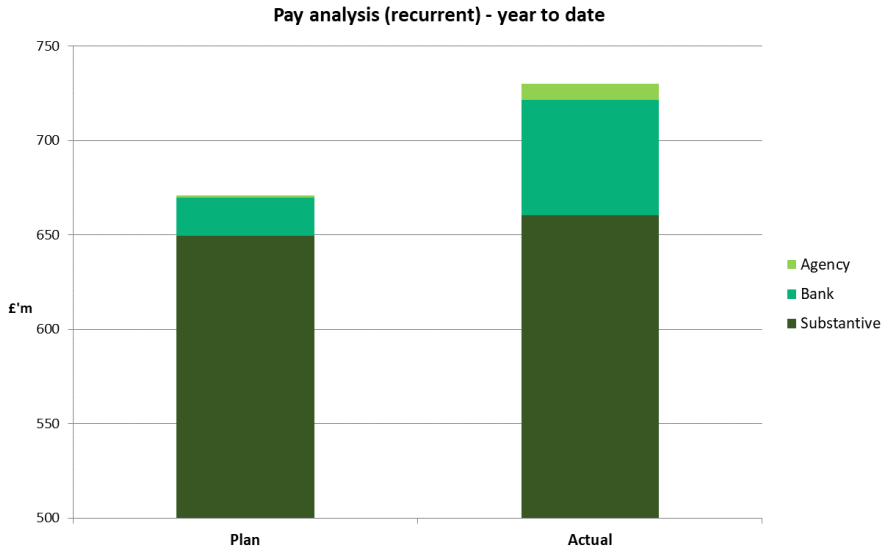
Key messages:

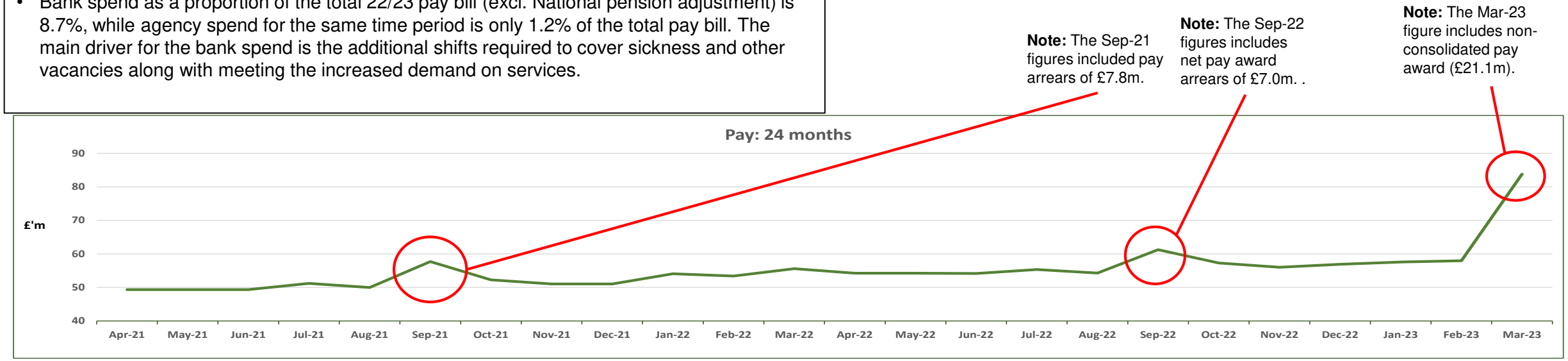
- At the end of month 12, the Trust is reporting a £58.9m year to date adverse position on pay with a £52.6m adverse position in month. The year to date position includes £26.8m of National pensions adjustments and £32.7m of national pay award arrears including £21.1m relating to the recent non-consolidated pay offer . This expenditure is funded by additional clinical income.

- Excluding the pay award the key driver for the underlying favourable position is slippage on planned investments across a number of areas, predominantly critical care beds which remain closed due to staff vacancies. Overall there is Trust-wide slippage in Medical and Nursing staffing against the 22/23 sustainability agenda. This has resulted in increased Bank and Agency spend being incurred at premium rates.

- The Trust continues to take actions to restore and maintain services in a Covid safe environment and has invested £14.7m of Covid pay related spend in the financial year to date.

- Bank spend as a proportion of the total 22/23 pay bill (excl. National pension adjustment) is 8.7%, while agency spend for the same time period is only 1.2% of the total pay bill. The main driver for the bank spend is the additional shifts required to cover sickness and other vacancies along with meeting the increased demand on services.





Note: For comparability purposes the chart reports average values for months 1 & 2, in line with external reporting requirements month 1 values are not reported in isolation. Additional central NHS pension contributions are excluded from March '22 and March '23 totals.

Pay expenditure – trend and year to date

£ Millions	In Month						Year to Date					
	Budget	Actual	Variance	National pension adj 6.3%	Pay awards adjustment	Variance (exc. Pay adjs)	Budget	Actual	Variance	National pension adj 6.3%	Pay awards adjustment	Variance (exc. Pay adjs)
Non-Covid:												
Administrative & Clerical	8.3	17.4	(9.1)	4.9	5.8	1.5	99.3	107.7	(8.3)	4.9	7.6	4.2
Allied Healthcare Professionals	3.4	6.7	(3.3)	1.6	1.8	0.1	39.6	41.7	(2.1)	1.6	2.5	2.0
Clinical Scientists & Technicians	5.5	9.0	(3.5)	2.7	3.1	2.3	64.0	63.1	0.9	2.7	4.2	7.8
Medical and Dental Staff	18.9	36.6	(17.7)	8.8	0.2	(8.7)	222.3	233.5	(11.2)	8.8	2.7	0.3
Nursing	20.6	36.5	(15.9)	8.8	10.9	3.8	240.8	250.3	(9.5)	8.8	15.3	14.5
Other Pay Costs	1.2	3.2	(1.9)	0.0	0.0	(1.9)	15.2	18.9	(3.6)	0.0	0.3	(3.3)
Efficiency savings	(1.2)	0.0	(1.2)	0.0	0.0	(1.2)	(25.1)	0.0	(25.1)	0.0	0.0	(25.1)
Subtotal for Non-Covid	**56.8**	**109.4**	**(52.7)**	**26.8**	**21.9**	**(4.0)**	**656.2**	**715.2**	**(59.0)**	**26.8**	**32.7**	**0.5**
Covid:												
Administrative & Clerical	0.2	0.2	0.0			0.0	2.3	2.0	0.3			0.3
Allied Healthcare Professionals	0.1	0.1	0.0			0.0	1.0	0.6	0.3			0.3
Clinical Scientists & Technicians	0.0	0.0	(0.0)			(0.0)	0.3	0.3	0.0			0.0
Medical and Dental Staff	0.3	0.2	0.1			0.1	3.7	2.9	0.7			0.7
Nursing	0.6	0.6	0.0			0.0	6.8	8.1	(1.2)			(1.2)
Other Pay Costs	0.1	0.1	(0.0)			(0.0)	0.7	0.7	(0.0)			(0.0)
Subtotal for Covid	**1.2**	**1.1**	**0.1**	**0.0**	**0.0**	**0.1**	**14.8**	**14.7**	**0.1**	**0.0**		**0.1**
Total Pay Cost	**58.0**	**110.6**	**(52.6)**	**26.8**	**21.9**	**(3.9)**	**670.9**	**729.9**	**(58.9)**	**26.8**	**32.7**	**0.5**

Key messages:

- Pay expenditure for Non-Covid , excluding the 6.3% pension uplift and Pay awards adjustments, has a favourable variance of £0.4m.
- Covid expenditure reports broadly in line with plan year for the financial year.

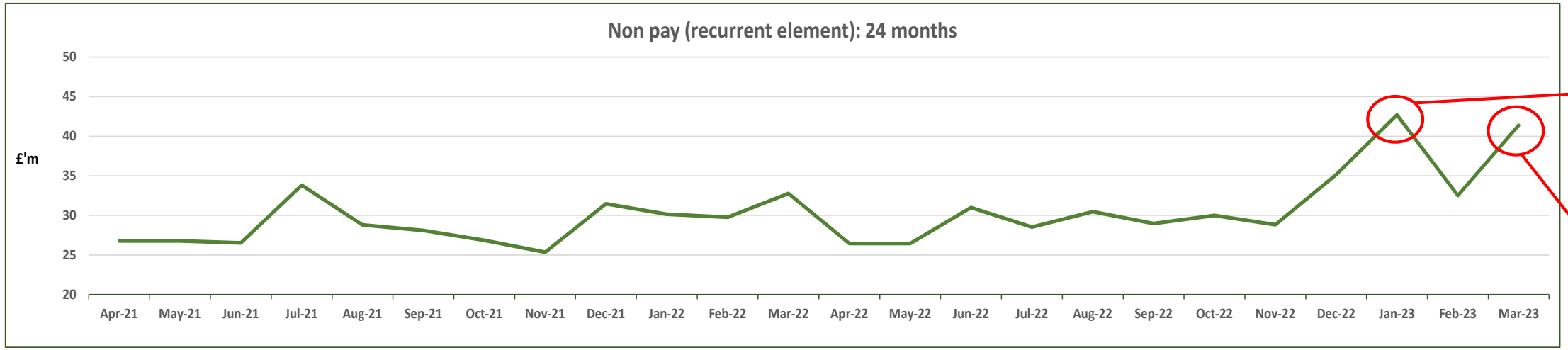
Pay expenditure (continued)

	In Month						Year to Date					
£ Millions	Budget	Actual	Variance	National pension adj 6.3%	Pay awards adjustment	Variance (exc. Pay Award)	Budget	Actual	Variance	National pension adj 6.3%	Pay awards adjustment	Variance (exc. Pay Award)
Non-Covid:												
Agency	0.0	0.8	(0.8)	0.0		(0.8)	0.3	6.7	(6.5)	0.0		(6.5)
Bank	1.3	7.8	(6.5)	0.0	0.1	(6.4)	16.4	54.8	(38.5)	0.0	1.0	(37.5)
Contracted	0.2	0.9	(0.7)	0.0		(0.7)	2.6	4.6	(2.0)	0.0		(2.0)
Substantive	55.2	99.9	(44.7)	26.8	21.8	3.9	636.9	649.1	(12.1)	26.8	31.7	46.3
Subtotal for Non-Covid	**56.8**	**109.4**	**(52.7)**	**26.8**	**21.9**	**(4.0)**	**656.2**	**715.2**	**(59.0)**	**26.8**	**32.7**	**0.4**
Covid:												
Agency	0.1	0.2	(0.1)	0.0		(0.1)	0.8	1.6	(0.8)			(0.8)
Bank	0.3	0.3	0.0	0.0		0.0	4.0	6.3	(2.3)			(2.3)
Contracted	0.0	0.0	(0.0)	0.0		(0.0)	0.0	0.0	(0.0)			(0.0)
Substantive	0.8	0.6	0.2	0.0		0.2	10.0	6.8	3.2			3.2
Subtotal for Covid	**1.2**	**1.1**	**0.1**	**0.0**	**0.0**	**0.1**	**14.8**	**14.7**	**0.1**	**0.0**	**0.0**	**0.1**
Total Pay Cost	**58.0**	**110.6**	**(52.6)**	**26.8**	**21.9**	**(3.9)**	**670.9**	**729.9**	**(58.9)**	**26.8**	**32.7**	**0.5**

Key messages:

- After adjusting for the National pension adjustment (£26.8m) and Pay awards adjustment non-Covid substantive and contracted staff expenditure is £44.3m favourable to budget. The Trust has incurred offsetting Bank and Agency expenditure which are adverse to budget by £37.5m and £6.5m respectively producing a £0.4m favourable variance for the financial year.
- The in month adverse variance of £4.0m related to industrial action and annual leave related costs, both of which are non-recurrent cost pressures.
- Whilst the overall full year pay plan figures align to the Trust wide-view, the plan for Bank and Agency was understated. NHSE are aware of this position and are taking it into account for performance management purposes.

Pay expenditure (continued)



Note: For comparability purposes the chart reports average values for months 1 & 2, in line with external reporting requirements month 1 values are not reported in isolation.

Note: M10 increase driven by £10.1m technical adjustment to a key IT contract

Note: The following non-recurrent / pass-through items have led to the March 2023 increase; R&D consortium grossing up and pass-through expenditure (£29.8m), National PPE (£2.2m) and Notional apprenticeship fund (£2.4m)

Key messages:

- At the end of month 12, the Trust's non pay position is £64.8m adverse to plan (including Covid costs) with an in month adverse movement of £31.9m.
- The in month adverse movement was primarily driven by non-recurrent items including £29.8m of R&D consortium grossing up and pass-through expenditure, £2.2m of centrally procured PPE and £2.4m of notional apprenticeship fund. These items of expenditure are all fully offset by matching income.
- The year to date adverse variance of £64.8m adverse movements includes non-recurrent items listed above plus a £10.1m technical adjustment to the accounting treatment of a key IT contract, £7.2m impairment of receivables and £5.9m of miscellaneous expenditure including £2.9m of staff related provisions. Cost pressures are partially offset by lower than planned fire prevention works expenditure of £5.7m.
- Overall Drugs expenditure is £10.5m adverse to plan. The adverse variances are funded by commissioners and are largely driven by neurology and clinical immunology drugs, with the balance spread across a range of service areas and pass-through drugs and devices. Some offset has been provided by less Car-T patients than planned across the year.
- At month 12 there is a year-end variance of £1.2m versus the plan.

£millions	In Month Budget	In Month Actual	In Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance
Non Covid:						
Drugs	14.5	13.8	0.6	173.0	183.4	(10.5)
Supplies and Services	17.1	11.9	5.1	203.0	196.1	6.9
Misc Other Operating expenses	0.3	(1.6)	1.9	1.2	7.1	(5.9)
Premises	4.6	7.3	(2.7)	55.4	61.5	(6.1)
Clinical Negligence	2.0	2.0	0.0	24.3	24.3	0.0
Other non pay costs (including CIP)	4.7	5.8	(1.1)	56.4	42.5	13.9
Total Recurrent	***43.2***	***39.3***	***3.8***	***513.3***	***515.0***	***(1.7)***
Other non pay costs	0.2	0.3	(0.0)	2.9	2.7	0.2
Receivables impairment net of reversals	(0.2)	1.8	(1.9)	(2.0)	7.2	(9.2)
R&D NIHR grants		16.2	(16.2)		27.0	(27.0)
R&D consortium grossing-up		13.6	(13.6)		13.6	(13.6)
Technical IT contract adjustment		0.0	0.0		10.1	(10.1)
Centrally procured PPE		2.2	(2.2)		2.2	(2.2)
Notional Apprenticeship fund		2.4	(2.4)		2.4	(2.4)
Total Non-recurrent	***0.1***	***36.4***	***(36.3)***	***0.9***	***65.1***	***(64.3)***
Subtotal for non-covid	***43.2***	***75.7***	***(32.5)***	***514.1***	***580.1***	***(66.0)***
Covid:						
Drugs	0.0	0.0	0.0	0.4	0.2	0.1
Supplies and Services	0.2	0.4	(0.2)	3.1	3.5	(0.4)
Misc Other Operating expenses	0.0	0.0	0.0	0.5	0.4	0.2
Premises	0.1	(0.0)	0.1	0.8	0.4	0.3
Clinical Negligence	0.0	0.0	0.0	0.0	0.0	0.0
Other non pay costs (including CIP)	0.2	(0.4)	0.6	3.0	2.1	1.0
Subtotal for covid	***0.6***	***0.0***	***0.6***	***7.8***	***6.6***	***1.2***
Total Non Pay	**43.8**	**75.7**	**(31.9)**	**521.9**	**586.7**	**(64.8)**

Non pay expenditure (continued)

£'m	M2 YTD		M3		M4		M5		M6		M7		M8		M9		M10		M11		M12		YTD		Forecast	
	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual
Total Pay Efficiencies	1.8	2.5	1.5	1.7	3.8	4.0	2.4	2.7	2.3	3.1	2.2	1.9	1.8	1.8	1.6	1.5	2.5	2.4	2.1	2.1	2.4	2.1	24.5	25.7	24.5	25.7
Total Non-pay Efficiencies	3.4	3.0	1.7	1.7	2.1	1.6	2.6	2.2	1.5	1.8	2.2	2.3	2.3	2.5	2.4	2.6	1.9	1.8	2.3	2.5	1.4	2.0	23.8	24.2	23.8	24.2
Total Income Efficiencies	5.6	5.6	0.8	0.8	0.8	0.7	0.8	0.8	0.8	(0.3)	0.8	1.0	0.8	0.6	0.8	0.7	0.8	1.0	0.8	0.6	0.8	0.6	13.7	12.1	13.7	12.1
Total Efficiencies - 2022/23	**10.8**	**11.1**	**4.0**	**4.2**	**6.7**	**6.3**	**5.7**	**5.7**	**4.6**	**4.6**	**5.2**	**5.2**	**4.9**	**4.9**	**4.9**	**4.9**	**5.2**	**5.2**	**5.2**	**5.2**	**4.6**	**4.7**	**62.0**	**62.1**	**62.0**	**62.1**

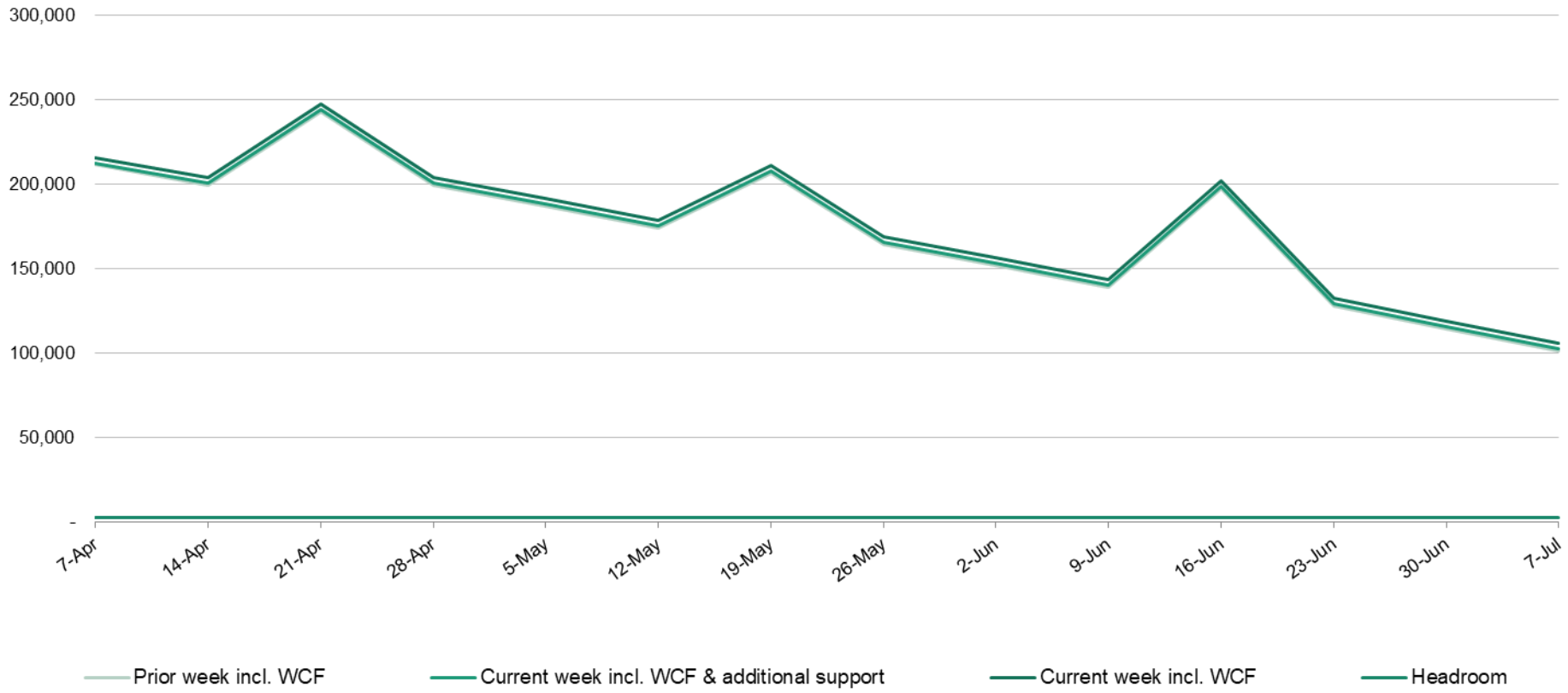
Key messages:

- The Trust has delivered £62.1m of efficiencies in line with plan; £43.3m are recurrent and £18.7m non-recurrent including £11.0m of non-recurrent savings that met the 2022/23 System support requirements.
- Recurrent achievement reported is below plan by £4.3m at £43.3m. This has been mitigated by non-recurrent delivery of efficiencies placing an additional requirement on recurrent savings delivery in 23/24.
- Pay efficiencies report ahead of plan by £1.3m. Within this, recurrent initiatives are (£3.9m) adverse to plan and non-recurrent schemes are £5.2m ahead of plan.
- For non-pay efficiencies, initiatives are £0.4m favourable to plan, reporting achievement of £24.2m against plan of £23.8m. Note that values are subject to rounding.
- Income efficiencies are reporting adverse to plan by (£1.6m) driven by a shortfall in non-recurrent scheme delivery. This measure includes the non-recurrent campus development project income receipt of £4.2m.
- The Trust will continue to track the performance of existing schemes and review those which have failed to deliver or have been delayed this year, in 23/24.
- Please see appendices for detailed efficiency plan schedules.

	YTD Plan			YTD Actual Delivery			YTD Variance		
£m	Recurrent	Non-recurrent	Total	Recurrent	Non-recurrent	Total	Recurrent	Non-recurrent	Total
Pay	23.8	0.7	24.5	19.8	5.9	25.7	(3.9)	5.2	1.3
Non-pay	23.2	0.6	23.8	22.6	1.6	24.2	(0.6)	1.0	0.4
Income	0.6	13.1	13.7	0.9	11.2	12.1	0.3	(1.9)	(1.6)
	47.6	**14.4**	**62.0**	**43.3**	**18.7**	**62.1**	**(4.3)**	**4.3**	**0.1**

	Full Year Plan			Forecast Full Year Delivery			Variance		
£m	Recurrent	Non-recurrent	Total	Recurrent	Non-recurrent	Total	Recurrent	Non-recurrent	Total
Pay	23.8	0.7	24.5	19.8	5.9	25.7	(3.9)	5.2	1.3
Non-pay	23.2	0.6	23.8	22.6	1.6	24.2	(0.6)	1.0	0.4
Income	0.6	13.1	13.7	0.9	11.2	12.1	0.3	(1.9)	(1.6)
	47.6	**14.4**	**62.0**	**43.3**	**18.7**	**62.1**	**(4.3)**	**4.3**	**0.1**

CUH 13 week rolling cash flow forecast (£000)



Key messages:

- The forecast suggests that there is no requirement for additional revenue cash support within this 13 week period.

Appendices

Month 12 capital expenditure position

Year to Date (Month 12)			
Programme	Budget £m	Actuals £m	Variance £m
Cambridge Movement Surgical Hub (CMSH)	13.9	13.9	-
Theatre equipment & infrastructure	5.1	5.1	-
P&Q ward modifications	2.5	2.5	-
Existing Estate/HV	9.2	9.2	-
Cancer Research Hospital (CCRH)	5.5	5.5	-
Thrombectomy	5.9	5.3	0.6
Medical Equipment Replacement	4.5	6.8	-2.3
Children's Hospital (CCH)	5.9	5.9	-
Nuclear Medicine	3	2.9	0.1
Community Diagnostic Hub/Centre (CDC)	2.5	2.6	-0.1
eHospital/Legacy IT Systems	3	3	-
Other Developments/PFI	5.6	4.5	1.1
Programme Total	**66.5**	**67.1**	**-0.5**

Forecast		
Budget £m	Expenditure £m	Variance £m
13.9	13.9	-
5.1	5.1	-
2.5	2.5	-
9.2	9.2	-
5.5	5.5	-
5.9	5.3	0.6
4.5	6.8	-2.3
5.9	5.9	-
3	2.9	0.1
2.5	2.6	-0.1
3	3	-
5.6	4.5	1.1
66.5	**67.1**	**-0.5**

Key Issues/Notes Year to Date

£67.1m has been invested this year, compared to a budget of £66.5m. The larger areas of spend this year have been:

- Cambridge Movement Surgical Hub - £13.9m
- Cambridge Children's Hospital (CCH) - £5.9m
- Cambridge Cancer Research Hospital (CCRH) - £5.5m
- Thrombectomy - £5.3m
- Theatre Equipment & Infrastructure - £5.1m
- Nuclear Medicine refurbishment - £2.9m
- Community Diagnostic Centre (CDC) equipment - £2.6m
- P&Q ward modifications - £2.5m

Spend in M12 at £13.2m was the highest monthly spend all year (~20% of annual spend). Across the year there was an overspend of £0.5m, which equates to 0.8% of the budget. Against budget there was some slippage on the Thrombectomy & NCCU refurb projects, and a number of CAB mid-year approvals were not realised and will be rolled forwards to 23/24. Offsetting those underspends was an overspend on the replacement of Medical Equipment.

Key Issues/Notes Forecast

The capital programme for 23/24 was delivered in line with budget. Adjustments to 23/24's budget will be made to account for the need to complete the CMSH, Thrombectomy and Nuclear Medicine projects, which will all finish in the next financial year.

CAB will review and approve the budget for 23/24 at its April meeting and we will report performance against that in future Board reports.

Capital expenditure by programme

Balance sheet

	M12 Actual £m
Non-current assets	
Intangible assets	19.8
Property, plant and equipment	538.9
Total non-current assets	**558.7**
Current assets	
Inventories	13.4
Trade and other receivables	68.4
Cash and cash equivalents	226.4
Total current assets	**308.2**
Current liabilities	
Trade and other payables	(265.4)
Borrowings	(13.8)
Provisions	(18.8)
Other liabilities	(91.9)
Total current liabilities	**(389.9)**
Total assets less current liabilities	**477.0**
Non-current liabilities	
Borrowings	(114.1)
Provisions	(4.0)
Total non-current liabilities	**(118.1)**
Total assets employed	**358.9**
Taxpayers' equity	
Public dividend capital	616.0
Revaluation reserve	47.0
Income and expenditure reserve	(304.1)
Total taxpayers' and others' equity	**358.9**

Balance sheet commentary at month 12

- The balance sheet shows total assets employed of £358.9m.
- Non-current liabilities at month 12 are £118.1m, of which £114.1m represents capital borrowing (including PFI and IFRS 16).
- Cash balances remain strong at month 12.
- The balance sheet includes £23.3m of resource to support the completion of the remedial fire safety works expected to be deployed over the coming years.
- International Financial Reporting Standard 16 (IFRS 16) changes the way in which leases are accounted and applies to the NHS from 1 April 2022. The impact on the Trust's balance sheet is that an additional £51m of non-current assets are recognised as at 1 April 2022, with a corresponding liability split £4m current liabilities and £38m non-current liabilities. The remaining impact has been taken to the income and expenditure reserve, totalling £9m.

Trust balance sheet

Board of Directors

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NHS Foundation Trust

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Report to the Board of Directors: 10 May 2023

Agenda item	10
Title	Nursing and midwifery establishment review
Sponsoring executive director	Lorraine Szeremeta, Chief Nurse
Author(s)	Amanda Small, Deputy Chief Nurse Emma Glover, Head of finance: Division D Christopher Gray, Lead nurse for safe staffing
Purpose	To provide an overview of nurse staffing capacity and compliance with the National Institute for Clinical Excellence (NICE) safe staffing and National Quality Board (NQB) standards.
Previously considered by	Nursing, Midwifery and Allied Health professional Committee, April 2023 Management Executive, 20 April 2023

Executive summary

This report provides assurance that arrangements are in place to review the Trust's nursing and midwifery establishments in line with regulatory requirements. It details the outcome of the annual establishment review for the period from April 2022 to February 2023 based on the configuration of wards/units and clinical pathways that are currently in place to ensure that there is an operating and staffing model for the period ahead which is clinically, operationally and financially sustainable. The paper provides the position against which current staffing levels are assessed and has made reference to areas where additional capacity has been approved and the staffing establishment required to ensure safe staffing levels.

In order to maintain patient safety and the safest staffing levels, staff continue to be moved between areas as necessary on a shift-by-shift basis, recruiting to the identified establishments that have been identified by this review will lead to a reduction in the requirement to redeploy nursing staff.

Related Trust objectives	Improving patient care; Supporting our staff
Risk and Assurance	The paper provides assurance on the arrangements in place for reviewing nursing and midwifery establishments.
Related Assurance Framework Entries	BAF ref: 007
Legal / Regulatory / Equality, Diversity & Dignity implications?	NHS England & CQC letter to NHSFT CEOs (31.3.14) NHS Improvement Letter – 22 April 2016 NHS Improvement letter re: CHPPD – 29 June 2018 NHS Improvement – Developing workforce safeguards October 2018
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	Yes

Action required by the Board of Directors

The Board is asked to note:

- That the annual establishment review process for nurse staffing has been undertaken in line with our agreed methodology.
- The resulting nursing establishments for the current configuration of wards and departments across the hospitals resulting in a recommended increase of 9.52 WTE RNs (net) and a decrease of 0.24 WTE HCSWs (net) following the SNCT and professional review.
- A number of new clinical areas were opened within the last financial year and a number are planned to open in 2023/24, and the same methodology used for establishment reviews has been applied to these areas to inform the safe staffing levels required.
- Ongoing discussions regarding investment will take place at Management Executive and the Investment Committee.
- A full midwifery workforce review was undertaken using the Birthrate Plus® methodology between January and March 2022 and the findings were presented to the Board of Directors in November 2022. This resulted in a recommended increase of 9.16 WTE Midwives for which financial approval will be sought through divisional budget setting for 2023/24.

10 May 2023

Board of Directors
Annual nursing and midwifery establishment review
Lorraine Szeremeta, Chief Nurse

1. Purpose

1.1 The purpose of this paper is to provide the Board of Directors with an overview of registered nurse staffing capacity and compliance with the National Institute for Clinical Excellence (NICE) safe staffing and National Quality Board (NQB) standards. It is a requirement that every executive board receives an annual establishment report with a further review on a biannual basis (National Quality Board, 2016).

1.2 In October 2018, NHS Improvement (NHSI) published the 'Developing Workforce Safeguards' guidance. This defined how trusts' compliance with the 'triangulated approach' to safer staffing outlined within the NQB standards would be assessed. This triangulated approach combines evidence-based tools (e.g. Safer Nursing Care Tool (SNCT), professional judgement and outcomes. By implementing the document's recommendations, together with strong and effective governance, boards can be assured that workforce decisions will promote patient safety and compliance with regulatory standards.

1.3 The report provides cumulative oversight of care hours per patient day (CHPPD) over the past 12 months. It also provides a comparison to peer organisations for the same time period.

2. National and local nursing and midwifery staffing context

2.1 Delivering sustainable, long-term growth in the nursing workforce is vital to ensuring that the health and social system has the right workforce in the right numbers to support high quality and safe care. As part of its manifesto pledges, the government committed in 2019 to growing the nursing workforce by 50,000 by March 2024.

2.2 The 50,000 Nurses Programme is overseen by a programme board chaired by the Minister of State for Health. It includes senior membership from the Department of Health and Social Care, NHS England (NHSE), Health Education England (HEE) and HM Treasury. The programme is split into three work streams:

1) Domestic recruitment including:
    - preregistration students
    - degree nurse apprentices
    - conversions from nursing associates and assistant practitioners to registered nurses (RN's)
    - nurse return to practice

2) International recruitment.

3) Retention of existing staff and reducing the leaver rate.

2.3 The most recently published data on NHS digital (November 2022), suggests that the programme is on target to deliver an additional 50,000 nurses by March 2024 with 10,362 more nurses working in the NHS compared to last year and 38,300 more nurses now compared to September 2019.

2.4 Within the East of England, the target was to increase the nursing workforce in the NHS and primary care by over 5,000 between September 2019 and March 2024. Progress to date shows that the region has 30,589 nurses in employment in November 2022 compared with 28,654 in September 2019. This is an increase of 1,935 nurses.

2.5 The increase in nurses in employment has been due in part to the large number of international nurses that have been deployed with over 20,000 international nurses being supported with employment nationally over the past 12 months. Additionally, over 153 refugees who are registered nurses overseas have been able to continue their nursing careers in the NHS. In 2023 it is planned to welcome an additional cohort of 75 refugees across the United Kingdom (UK).

2.6 CUH have supported the arrival of 301 international nurses over the last 12 months. In addition, CUH were proud to be one of first NHS trusts supporting the refugee project with 6 individuals employed within the trust. 4 of these nurses have achieved registration with the Nursing and Midwifery Council (NMC) and 2 are in the process of completing their exams.

2.7 It has been recognised that there are a number of healthcare support workers in the NHS, who are registered nurses overseas but have not obtained the English language requirements for UK NMC registration. NHSE have provided funding alongside HEE to support over 2,035 to obtain the required levels of English language qualifications with the plan to provide funding to support an additional 383 individuals to achieve this in 2023.

2.8 In response to the national shortage of RNs, CUH continues to have success in recruiting to its Nursing Apprenticeship programme with 304 apprentices on the programme currently. The Trust is also supporting 9 apprentice Nursing Associates.

2.9 Whilst there is relative certainty about the numbers within the recruitment pipeline, there is significant uncertainty related to retention of the existing workforce. The last 2 years have been some of the most challenging in the history of the NHS, and many staff have been placed under sustained and severe pressure. While a wide range of measures to support staff were put in place during the pandemic, some staff will reassess their longer-term careers in light of the challenges they have faced, or reassess their lifestyle and decide that a career in the NHS is no longer for them.

2.10 The Chief Nursing officer and National Director for People wrote to all NHS organisations in July 2022 outlining NHSE's expectations of organisations in relation to retaining the Nursing and Midwifery workforce. Within this letter, two important principles which will support the retention of nurses and midwives was outlined:

1) Targeted intervention for different career stages: early career, experience at work and later career.

2) Bundles of high-impact actions are more effective than single actions.

2.11 All organisations were asked to prioritise the delivery of five high impact actions, these being:

1) Complete the nursing and midwifery retention self-assessment tool to identify the biggest gaps against globally evidenced best practice and the people promise areas and implement a retention improvement action plan. CUH have completed this self-assessment and submitted this and the associated action plan to the integrated care board (ICB). Progress with the action plan is being monitored through the Nursing, Midwifery and Allied Health professionals steering group which reports to the Nursing, Midwifery and Allied Health Professionals advisory committee (NMAAC).

2) Implement the National Preceptorship Framework. CUH are updating the existing preceptorship programme to ensure it aligns to this framework.

3) Implement legacy mentoring schemes to support late career nurses and midwives to extend their NHS career whilst supporting early career nurses and midwives. CUH are working with the ICB to develop this scheme within the Cambridge and Peterborough Integrated Care System.

4) Encourage staff to attend national pension seminars and access information on pensions and flexible retirement options and encourage trusts to ensure the availability of flexible retirement options. These seminars are publicised widely within the trust.

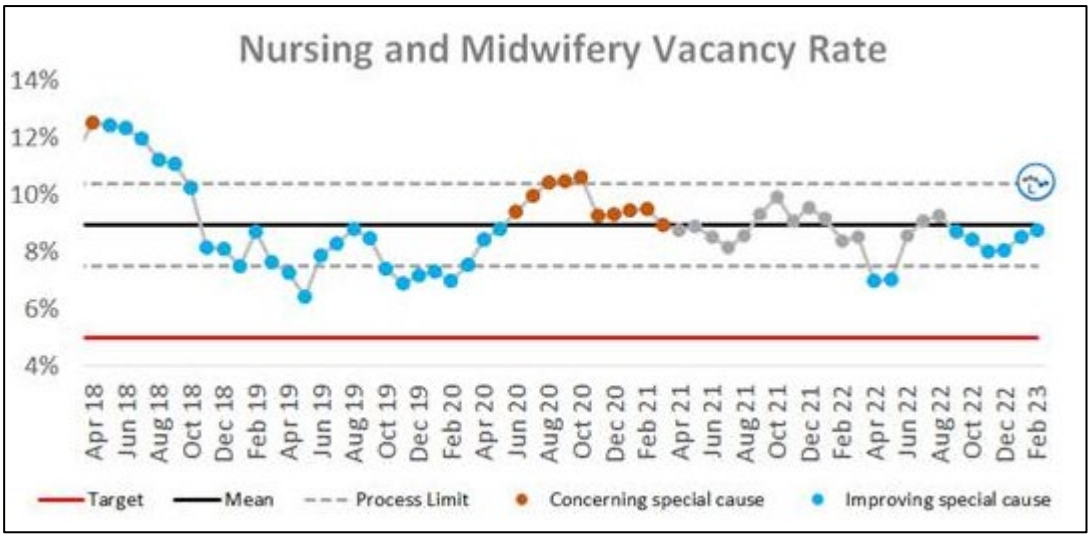
5) Develop a menopause policy / guidance or add to existing policies and action plan or amend your policies and take action to ensure availability of menopause support. Other relevant policies could include flexible working, health and wellbeing and equality diversity and inclusion. The national guidance on menopause is in development.

2.12 All of the above actions are incorporated within the CUH retention strategy.

3. Nursing and midwifery vacancy

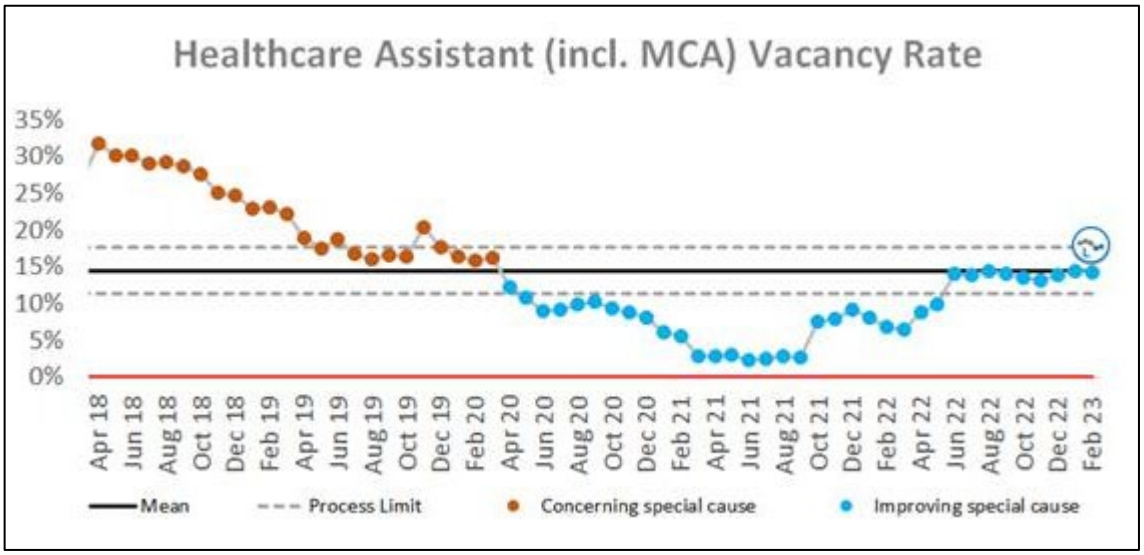
3.1 The last year has remained challenging for the Nursing workforce with high vacancy rates despite a strong recruitment pipeline. Conversely, the registered midwife (RM) vacancy rate has been a decreasing trend from 13.0% at its highest (July 2022) to 1.11% in February 2023. Figure 1 shows the CUH trend in nursing and midwifery vacancy rates over the past four years. The registered nurse (RN) vacancy rate over the past year increased from 6.9% in April 2022 to 9.3% in February 2023. The vacancy rate for registered sick children nurses has also been an increasing trend with a vacancy rate of 17.4% in April 2022 compared to a vacancy position of 19.4% in February 2023.

Figure 1: Nursing and midwifery vacancy rates



3.2 CUH has experienced an increasing trend in the Health Care Support Worker (HCSW) vacancy rate over the last twelve months with a vacancy rate of 8.8% at the beginning of the financial year (April 2022) compared to a vacancy rate of 14.3% in February 2023. This is due in part to the reduction in the number of applications received for HCSW roles over the last six months coupled with a high turnover rate of 17.9%. There is currently an ongoing project to review the application of the national agenda for change profiles for HCSW's job descriptions within the trust which may have an impact upon the band of a HCSW within CUH. This coupled with targeted actions to support HCSW's in practice and define career development opportunities should lead to improvements in retention of this workforce. Figure 2 illustrates the trend in vacancy rate for HCSWs over the past four years.

Figure 2: Health care support worker vacancy rates



4. Redeployment of staff to maintain safe staffing levels

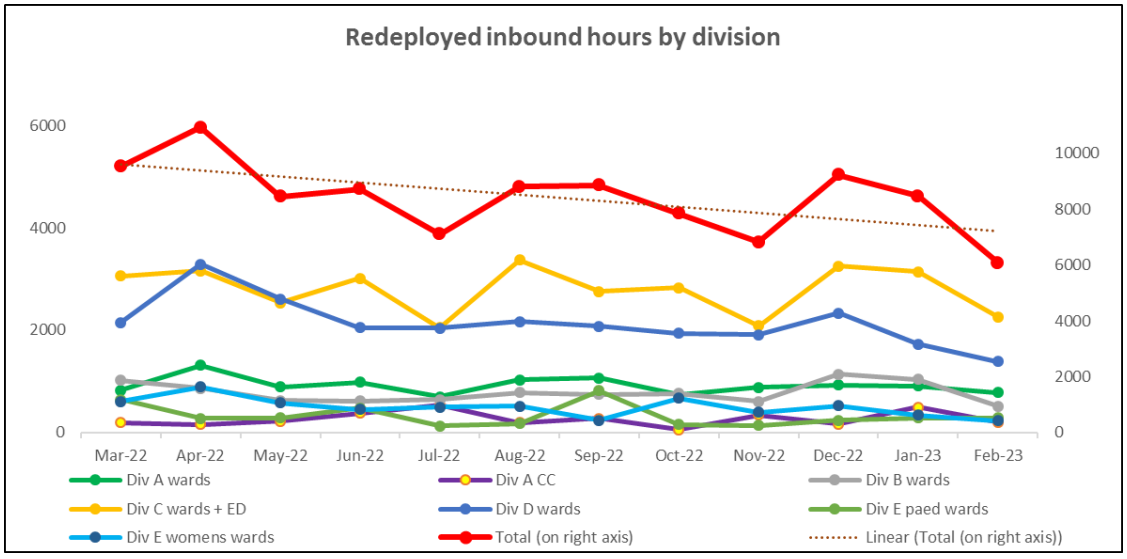
4.1 Over the last six months it has been necessary to open additional contingency areas to manage the increased activity within the trust. In total, there are four additional contingency areas that have been opened regularly when demand requires. These contingency areas do not have an established team.

4.2 In order to support safe nurse staffing levels and to maintain patient safety across the trust, nursing staff have frequently been redeployed from their usual clinical area to alternative clinical areas where safe staffing levels are compromised and to ensure safe staffing levels are in place in contingency areas. This has been managed in two ways, initially nursing staff are moved on a shift-by-shift basis by the divisional bleep holder to achieve the safest staffing levels across the division. Additionally, the senior nurse of the day reviews all nurse and midwifery staffing levels at the site safety meeting which occurs three times a day. Further staff deployment across the trust takes place at the site safety meeting to achieve the safest staffing levels across the entire trust including the contingency areas.

4.3 The operational pool established during the COVID 19 pandemic to reduce the number of substantive staff that are required to move to another ward area on a shift-by-shift basis has continued to be utilised. Both RNs and HCSWs can book into an operational pool shift via the bank office in the knowledge that they will be deployed to any area in the trust to work. The deployment of the operational pool staff is facilitated by the senior nurse of the day and operational matron at the site safety meetings this includes, where appropriate deployment into maternity services.

4.4 While the operational pool does reduce the number of substantive staff that are required to move to an alternative area to work, there are still high numbers of substantive staff being redeployed on a shift-by-shift basis as illustrated in Figure 3. However, the number of redeployed hours has reduced over the last 12 months.

Figure 3: Number of redeployed working hours per month



4.5 Over the past year, the senior nursing team have met as frequently as required, ranging from daily to twice weekly, to ensure that there was oversight of staffing, safety, quality concerns and patient flow. Escalation of decision making that compromised recognised staffing ratios was provided to the management executive and the operational site team as necessary. The board of directors has also been updated as part of the monthly safe staffing report.

5. Establishment Setting Process

5.1 Nursing workload and the ability to provide good care is influenced by many variables. No establishment setting tool can incorporate all factors. Therefore, combining the use of an evidence-based tool together with application of professional judgement and patient outcomes is required (NQB 2016, Shelford Group 2010, NICE 2014).

5.2 Data acquired from using the evidence-based tool is triangulated with the professional judgement of senior nurses to determine the right level and skill mix of nursing staff for each clinical ward area. Nurse sensitive indicators are used as part of the review to inform the establishment setting process.

5.3 At CUH the Safer Nursing Care Tool (SNCT) is used as the evidence base to guide nursing establishment reviews. The majority of adult wards utilise the SNCT and the paediatric wards utilise the Children's and Young People SNCT (C&YP SNCT) methodology. Following an NHS Improvement review of establishment setting in December 2018, refreshed training on use of the SNCT and a policy in relation to establishment reviews has taken place.

5.4 In response to feedback received in relation to previous establishment reviews, the following areas in addition to inpatient wards and critical care areas have been included in this year's establishment review:

- Theatre teams
- Endoscopy
- Rapid response team
- Cambridge eye unit
- Major trauma co-ordinators
- Emergency department including Paediatric ED and Clinic 5
- Discharge lounge
- Dialysis units
- Infusion centre
- Paediatric and Neonatal critical care transport service

5.5 It should be noted that the SNCT is not appropriate for all clinical areas. In these cases, professional judgement together with society or joint advisory guidelines are used as methodologies for nursing establishment setting.

5.6 Check and challenge meetings were held with ward sisters/charge nurses, Matrons, Deputy and Heads of Nursing, the Deputy Chief Nurse, the lead nurse for safe staffing finance and workforce leads to ensure professional scrutiny was applied to decision making as per the establishment setting process.

6. Establishment review outcome

6.1 The establishment review process has demonstrated that the current process for setting safe nurse staffing establishments is working well. As such only minor changes have been recommended as part of this review following SNCT data collection, professional judgement review and divisional check and challenge meetings which were held between November 2022 and January 2023. These changes are summarised at Appendix 1.

Registered Nursing establishment

6.2 Following the establishment review process it is recommended that an overall increase of 9.52 WTE RN's is required compared to the 2022/23 establishment.

6.3 The main areas where an increase in RN's has been recommended is:

- Paediatric Emergency Department – Increase of 2.5 WTE as the department has seen an increase in activity from 23,649 attendances (2021/22) to 31,363 attendances (2022/23).

- Ward F4 – Increase of 2.75 WTE due to the establishment that was agreed last year being based on 2 months as a red ward and 10 months DME model however after reconfiguration the ward was an acute ward and was overspent on staffing in 22/23. Therefore the proposed establishment is already within the run rate and is required to provide safe staffing to this patient group.

- Ward C10 - Professional judgement recommends an increase of 1 RN on a late shift due to increased activity in afternoons (cell infusion, blood product replacement and electrolyte replacements).

- Ward D5 - Increase of 1 RN per shift. Last 3 SNCT reviews have demonstrated increased acuity. D5 is a specialist regional transplant unit resulting in a higher number of acutely unwell patients from throughout the region which increases average acuity above a 'typical' acute medical ward. Additionally, there have been a high number of incidents raised in this area due to staffing concerns.

- Discharge lounge - increase of 0.51WTE RN due to the lounge now being open 7 days per week which has not been reflected in establishment previously.

- Paediatric Day Unit - Increase of 1.67 WTE RN due to the requirement to run 2 additional general anaesthetic lists per week.

6.4 While there have been a number of clinical areas where an increase in establishment has been recommended, the impact of this has been offset due to the number of areas where a decrease in establishment has been recommended following SNCT and professional judgement review.

6.5 The SNCT tool has suggested a slight increase in establishment on C9 however when applying professional judgement, it was felt that the current staffing levels are safe however it was noted that the skill mix on the ward is a concern. It was therefore felt that an increase in the ratio of band 6 nurses to enable 1 band 6 to be rostered per shift would support safe staffing.

6.6 The RN establishment within the dialysis units has been aligned to national guidance of a 1:4 nurse to patient ratio. This has meant a reduction in establishment in the Cambridge dialysis centre where previously the unit had a nurse to patient ratio of 1:3 and an increase in the satellite dialysis units where previously the units had a nurse to patient ratio of 1:5.

Health Care Support Worker Establishment

6.7 Following the establishment review process it is recommended that an overall decrease of 0.24 WTE HCSW's is required compared to the 2022/23 establishment.

6.8 The majority of HCSW efficiencies have been realised within the HCSW establishment identified for specialling requirements, this reduction has been based on reviewing the average specialling requirements for each area and converting a proportion of the specialling budget into ward establishments.

6.9 The rationale for including specialling within the ward establishment is that safety concerns have been raised on some wards due to a high number of patients who require specialling and the inability to fill temporary shifts. The biggest impact has been seen on Wards A4, A5 and J2. Moving the specialling budget into the HCSW establishment in these areas will enable posts to be recruited to substantively thus providing a consistent, safe level of staffing to provide care for these patients.

Additional Investment Committee approved increase in establishments

6.10 In addition to the establishment review recommendations, there has been additional investment in establishment budgets for which approval has already been sought by divisions and agreed through investment committee. This was outside of the establishment review process. The main investments have been:

- Endoscopy – Increase of 2.03 WTE RN in line with the additional capacity investment case.
- Major trauma co-ordinators – Increase by 4 WTE RN in line with previously approved investment case.
- Cambridge infusion centre – Increase by 0.56 WTE RN in line with MS chairs investment case.
- Charles Wolfson Ward – Increase by 2.25 WTE RN due to movement of patient pathway from C3 and PICU in line with divisional investment case.

New developments

6.11 A number of new clinical areas have been approved for opening in 2023/2024 including Ward P2, Ward Q2, Ward U2, Ward U3 and the 40 bedded acute ward including theatres and recovery. In addition wards EAU3 and T2 were opened within this financial year and were funded via COVID funding. The same methodology used for establishment reviews has been applied to these areas to inform the safe staffing levels required and this information has been included within the approved business cases.

Investment Committee approval

6.12 The proposed establishments following the full review in addition to the establishments required for the new developments and previously agreed investment cases was presented to Investment Committee in April 2023. Subsequent discussion is to be taken by Management Executive regarding the investment requested.

Critical care unit

6.14 Following the first phase of the pandemic, the Trust agreed to increase the critical care bed capacity from 46 beds to 59 beds. In order to comply with the guidelines for the provision of intensive care services (GPICS) standards, a 36.26 WTE increase in the RN establishment was required resulting in a total budgeted establishment of 259.61 WTE RNs. Whilst a high number of registered nurses have been recruited since this increase in establishment, Critical care has also seen an increase in the number of leavers which has resulted in a current vacancy rate of 13.4%.

6.15 This vacancy position coupled with an increased unavailability of staff due to sickness had led to GPICS breaches on a shift-by-shift basis. The decision was taken by the divisional leadership team, Chief Nurse, Medical Director and Chief Operating Officer to reduce the critical care bed capacity to 52 beds at the beginning of the financial year to maintain GPICS compliance whilst recruitment was ongoing to the vacant positions. Management Executive have oversight of these breaches and the mitigation that has been put in place to maintain patient safety. The Board of Directors has also been updated as part of the monthly safe staffing report.

6.16 A number of recruitment and retention initiatives have been put in place to attract and retain critical care skilled staff. This includes increasing the band 6 establishment, recruiting into a clinical academic position and targeted in country, international recruitment. These initiatives have enabled the re-opening of two level 2 beds from the end of March (5 beds remain closed at this point).

Neonatal Staffing

6.17 The British Association of Perinatal Medicine (BAPM) sets the standards for neonatal nurse staffing levels. The nursing establishment is activity adjusted using the BAPM neonatal clinical reference group nursing workforce calculator. The BAPM standard is that a Neonatal Intensive Care Unit (NICU) nurse establishment should be set for 90% activity. 80% of the nursing workforce should be RN and 70% of the total RN workforce should be qualified in specialty nurses (QIS) and hold a university accredited neonatal qualification.

6.18 The NICU is funded for 12 intensive therapy unit (ITU - level 3) cots, 16 high dependency unit (HDU – level 2) cots and 12 special care baby unit (SCBU) cots. The BAPM standards for nurse staffing suggests an establishment required to achieve BAPM standards is 171.08 WTE for 100% occupancy, 157.5 WTE for 90% occupancy, 139.36 WTE for 80% occupancy.

6.19 Recurrent 'Bridge the Gap' funding has been awarded to CUH from NHSE via the operation delivery network (ODN) which has supported an increase in the nursing establishment to 157.5 WTE which is the required establishment for 90% occupancy.

6.20 A recruitment and retention plan is in place to address the vacant positions and includes trainee Advanced Neonatal Nurse Practitioners (ANNPs) within the workforce plan. Once recruitment is achieved, neonatal nurse staffing will meet the BAPM nursing workforce calculator, and BAPM standard of 90% occupancy. To mitigate any staffing shortages, a risk assessment of each ITU nursing care allocation is undertaken to maintain compliance with BAPM one to one care for sick neonates.

Maternity staffing

6.21 The vision for maternity services across England is "for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances" (Better births 2016).

6.22 Maternity teams must have sufficient and appropriate staffing capacity and capability to ensure safe, high quality and cost-effective care for women and their babies at all times. The National Quality Board improvement resource for maternity services (2018) outlined the requirement for organisations to use systematic evidence-based workforce planning tools, to be cross checked with professional judgement and benchmarked with peers.

6.23 Birthrate plus® is the only national tool available for calculating midwifery staffing levels which has been endorsed by the National Institute for Health and Care Excellence (NICE). The tool considers the midwife-to-birth ratio and the mother's and baby's acuity and complexity for women throughout pregnancy, labour and the post-natal period, in both hospital and community settings. It is recommended that a birth rate plus review is conducted every 3 years.

6.24 CUH last undertook a birth rate plus review in January to March 2022 with the final report presented to the executive board in November 2022. The review recommended an increase of 9.16 WTE midwives. Due to the level of midwifery vacancy in 2022/23, the funded establishment in 2022/23 remained unchanged however the increase in establishment required to meet the Birthrate plus recommended establishment, is included in the budget setting for 2023/4. A business case will be submitted for approval within Division before being presented to Investment committee.

7. Care Hours per Patient Day (CHPPD)

7.1 CHPPD is the total number of hours worked on the roster (clinical staff), divided by the bed state captured at 23.59 each day. For the purposes of reporting, this is aggregated into a monthly position. It gives a single comparable figure that can represent both staffing levels and patient requirements. CHPPD can be used as a comparison between wards in a trust and also nationally to benchmark. It differentiates registered nurses/ midwives from HCSWs to ensure skill mix can be well described and that the nurse-to-patient ratio is visible.

7.2 The CHPPD data, along with Care Costs per Patient Day (CCPPD), are available on the Model Hospital to enable benchmarking. CHPPD trends had increased in the last financial year which was a reflection of the demands on staffing higher level care areas during the pandemic however over the last six months this has reduced. CHPPD total for nursing and midwifery (including HCSWs) demonstrates that since April 2022, the CHPPD for CUH has ranged from 8.1 – 8.4 which is aligned to the national median of between 7.9 – 8.2 CHPPD. However when comparing to our peer organisations (Shelford), the CUH CHPPD is below the Shelford median of between 9.2 – 9.9 CHPPD (CUH 8.1-8.4).

8. Nursing and Midwifery red flags

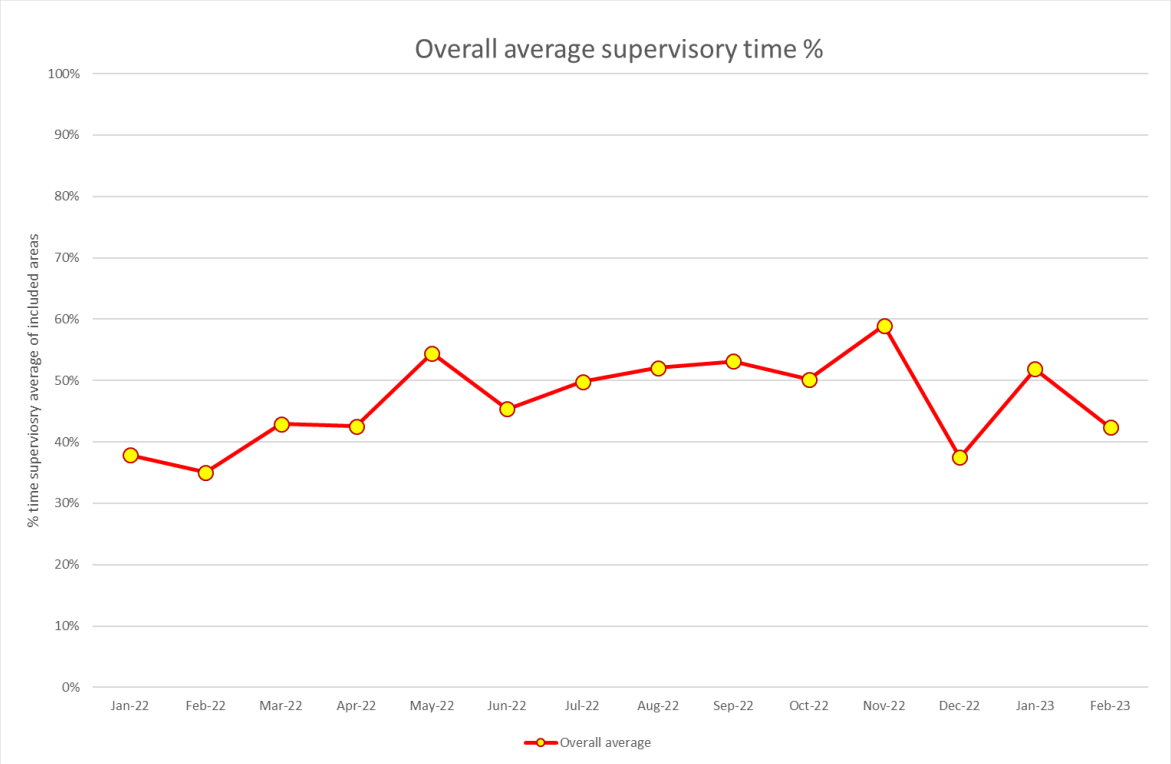
8.1 A staffing red flag event is a warning sign that something may be wrong with nursing or midwifery staffing. If a staffing red flag event occurs, the registered nurse or midwife in charge of the service should be notified and necessary action taken to resolve the situation.

8.2 Staffing red flags are reported monthly to the board of directors through the safe staffing paper. With the exception of November and December 2022, there has been a decreasing trend in nursing red flags throughout the financial year. Conversely, there has been an increase in the number of maternity red flags reported in the last 3 months. This is reflective of the high levels of activity and difficulty in maintaining flow within maternity services.

9. Supervisory sister/charge nurse time

9.1 The Trust supports the ward Senior Sister/Charge Nurse to be in a supervisory capacity to enable delivery of high-quality care and positive patient experience. Figure 4 below shows that the supervisory time has been affected by the staffing challenges over the last 12 months with supervisory time ranging from 35% to 60%. This will have impacted upon the capacity for senior sisters and charge nurses to be able to focus on quality improvement within their areas.

Figure 4: Percentage of senior sister/ charge nurse supervisory time



10. Recommendations

10.1 The Board of Directors is asked to note that:

- That the annual establishment review process for nurse staffing has been undertaken in line with our agreed methodology.
- The resulting nursing establishments for the current configuration of wards and departments across the hospitals resulting in a recommended increase of 9.52 WTE RNs (net) and a decrease of 0.24 WTE HCSWs (net) following the SNCT and professional review.
- A number of new clinical areas were opened within the last financial year and a number are planned to open in 2023/24, and the same methodology used for establishment reviews has been applied to these areas to inform the safe staffing levels required.
- Ongoing discussions regarding investment will take place at Management Executive and the Investment Committee.
- A full midwifery workforce review was undertaken using the Birthrate Plus® methodology between January and March 2022 and the findings were presented to the Board of Directors in November 2022. This resulted in a recommended increase of 9.16 WTE Midwives for which financial approval will be sought through divisional budget setting for 2023/24.

Appendix 1: Proposed changes following establishment review by unit

Division	Unit	Difference compared to 22-23 establishment	Narrative/rationale
Division A	M4	Decrease HCSW specialling budget by 2 WTE	Majority of specialling can be covered within current establishment.
Division A	Theatres: Unit 1 (SNCT n/a)	Increase HCSW by 0.77WTE	High volume /low complexity cases - adding in Theatre Support Worker for these cases to clean between cases/ act as runners to increase efficiency of theatre lists
Division A	Theatres: Unit 3 (SNCT n/a)	Increase RN by 2.05WTE Increase HCSW by 0.34WTE	1 RN Monday to Friday to operate laser in addition to theatre team. Additional 1 RN and 1 Theatre Support Worker per week for flap surgery.
Division A	Theatres: Extra ODP's (SNCT n/a)	Decrease ODP by 0.41WTE	Additional ODP's to cover services outside of theatres (IVF, PDU, MRI, Endoscopy & CT paeds, thrombectomy and ABR) requires 3.52 WTE ODP rather than budgeted 3.93 WTE
Division A	Theatres: ATC (SNCT n/a)	Increase HCSW by 0.79WTE	High volume /low complexity cases - adding in Theatre Support Worker for these cases 2 days per week on a long day to clean between cases/ act as runners to increase efficiency of theatre lists
Division A	Theatres: Rosie (SNCT n/a)	Increase RN by 3.54WTE	1 additional RN on nights each day. 1 additional RN on weekend long day for safety (band 6) due to remote site, activity (elective sections) and junior skill mix.
Division A	Theatres: Neuro (SNCT n/a)	Increase RN by 0.70WTE Increase HCSW by 0.70WTE	Commencing funded theatre list on Saturday for neurosurgery.
Division A	Theatres: Neuro anaesthetics (SNCT n/a)	Increase RN by 0.37WTE	Commencing funded theatre list on Saturday for neurosurgery.
Division A	Theatres: CEU (SNCT n/a)	Decrease ODP by 0.34WTE	1 ODP not required on a Monday and Thursday list
Division A	Theatres: Ely (SNCT n/a)	Increase RN by 1WTE	1 8a matron to drive productivity

Division	Unit	Difference compared to 22-23 establishment	Narrative/rationale
Division A	Theatres: Paeds recovery 2 (SNCT n/a)	Decrease RN by 1WTE Increase HCSW by 0.06WTE	Staffing for satellite areas and MRI. Remove Saturday staffing.
Division A	Theatres: Paeds recovery 3 (SNCT n/a)	Decrease RN by 2.69WTE Decrease HCSW by 1.14WTE	Due to reconfiguration, budget no longer required
Division A	Theatres: OIR temp (SNCT n/a)	Decrease RN by 2.46WTE Decrease HCSW by 4.31WTE	Due to reconfiguration, budget no longer required
Division B	C10	Increase RN by 1.79WTE	Professional judgement recommends increase of 1 RN on late shift due to increased activity in afternoons (cell infusion, blood product replacement and electrolyte replacements).
Division C	C4	Decrease HCSW specialling budget by 4.35 WTE	Majority of specialling can be covered within current establishment.
Division C	D5	Increase RN by 5.5WTE	Increase of 1 RN per shift. Last 3 SNCT reviews have demonstrated increased acuity. D5 is a specialist regional transplant unit resulting in a higher number of acutely unwell patients from throughout the region which increases average acuity above a 'typical' acute medical ward. Additionally, high number of incidents raised in this area due to staffing concerns.
Division C	EAU4	Decrease HCSW specialling budget by 1.41 WTE	Proportion of specialling can be covered within current establishment.
Division C	EAU5	Decrease HCSW specialling budget by 3.57 WTE	Majority of specialling can be covered within current establishment.
Division C	N2	Decrease RN by 2.75 WTE	Decreased to bring more in line with SNCT calculation however acknowledging that SNCT does not take into account configuration of side rooms.
Division C	N3	Decrease HCSW by 2.75 WTE	Reduced by 1 HCSW on day shift.
Division C	Dialysis unit: Hinchingbrooke (SNCT n/a)	Increase RN by 1.18WTE Increase HCSW by 1.18WTE	Ratio's reviewed across all dialysis units to reach a 1:4 ratio in line with national guidance.

Division	Unit	Difference compared to 22-23 establishment	Narrative/rationale
Division C	Dialysis unit: Cambridge (SNCT n/a)	Decrease RN by 5.5WTE Increase HCSW by 3.04WTE	Ratio's reviewed across all dialysis units to reach a 1:4 ratio in line with national guidance.
Division C	Dialysis unit: Kings Lynn (SNCT n/a)	Increase RN by 0.46WTE Increase HCSW by 1.54WTE	Ratio's reviewed across all dialysis units to reach a 1:4 ratio in line with national guidance.
Division C	Paediatric Emergency Department	Increase RN by 2.55WTE	Increased activity in paediatric ED from 23,649 attendances (2021/22) to 31,363 attendances (2022/23).
Division D	J2	Increase HCSW by 11.01 WTE Decrease specialling budget by 11.76 WTE	Safety concerns raised on this ward due to high number of patients who require specialling and inability to fill temporary shifts therefore moved specialling budget into roster
Division D	F4	Increase RN by 2.75 WTE Increase HCSW by 0.86 WTE	Budgeted last year on 2 months red ward and 10 months at DME model however after reconfiguration the ward is an acute ward and was overspent on staffing in 22/23.
Division D	G3	Increase HCSW by 2.75WTE Decrease specialling budget by 3.62WTE	Additional 1 HCSW required on night shift. Proportion of specialling covered within establishment.
Division D	A4	Increase HCSW by 9.44 WTE Decrease specialling budget by 4.5WTE	Safety concerns raised on this ward due to high number of patients who require specialling and inability to fill temporary shifts therefore moved some specialling budget into roster
Division D	A5	Increase HCSW by 11.01WTE Decrease specialling budget by 10.72WTE	Safety concerns raised on this ward due to high number of patients who require specialling and inability to fill temporary shifts therefore moved some specialling budget into roster (provides 2 HCSW per shift for specialling)
Division D	Lewin	Increase HCSW by 0.96WTE	Conversion of a late HCSW shift to a long night to increase safety and support at night.
Division D	R2	Increase RN by 2.75WTE	Hyper acute bay includes 8 beds, stroke guidance states that these patients should be 2:1. SNCT does not take into

Division	Unit	Difference compared to 22-23 establishment	Narrative/rationale
			consideration the hyper acute beds. Increase of 1 RN on night shift to 4 RN's to ensure hyper acute bay can be safely staffed.
Division D	M5	Decrease HCSW specialling budget by 1WTE	Proportion of specialling can be covered within current establishment.
Division E	D2	Decrease RN by 0.36WTE Increase HCSW by 2.24WTE	Due to dependency at night, 1 HCSW has been added to each night shift. This ward cares for a number of challenging patients with mental health needs, eating disorders, behavioural issues etc. and the HCSW's are pivotal in managing these challenging patients.
Division E	F3 (SNCT n/a)	Decrease RN by 1.56WTE Decrease HCSW by 0.78WTE	Additional staff had been previously included in roster for specific theatre cases however these are not deemed necessary.
Division E	PANDR service	Decrease RN by 0.47WTE	Commissioned service with associated income into trust. Staffing aligned to commissioned numbers.
Division E	C2	Increase HCSW by 3.48WTE	2 additional beds are to be opened in line with the BMT funding resulting in 19 beds in total. Current staffing only has 1 HCSW per shift therefore an additional 1HCSW has been added to an early and late to provide care to patients (2 HCSW's per day shift)
Division E	Paediatric day unit	Increase RN by 1.67 WTE Increase HCSW by 1.50 WTE	Additional staffing are required for the 2 per week approved additional general anaesthetic lists

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
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Kind
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Report to the Board of Directors: 10 May 2023

Agenda item	11
Title	Annual Staff Survey results 2022
Sponsoring executive director	David Wherrett, Director of Workforce
Author(s)	Gillian Booth, Senior Leadership and OD Facilitator
Purpose	To receive the survey results.
Previously considered by	Workforce and Education Committee, 29 March 2023

Executive Summary

The attached slide pack summarises the findings of the 2022 National Staff survey.

Related Trust objectives	Supporting our staff
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 Board of Directors

The Board is asked to note and discuss the findings of the Annual Staff Survey 2022.

NHS National Staff Survey 2022

Summary for Board

Prepared by Dulani Liyanage & Gillie Booth, March 2023

Reference: Picker draft management report December 2022
National Report, Staff Survey Co-ordination Centre, March

NHS
Cambridge University Hospitals
NHS Foundation Trust

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CUH Workforce Commitments

We are ambitious for our people, we focus on and invest in the following commitments

Good Work

We strive to ensure that working here is a good experience - *with a positive impact on our health, safety and well-being*

Resourced

We invest to ensure that we are well staffed to deliver safe and high quality care - *with vacancy rates of 5% or less across all staff groups*

Ambition

We enable professional and personal growth - *developing our people is vital to individual and organisational success*

Inclusion

We seek to drive out inequality - *we are stronger as an organisation which values difference and inclusion*

Relationships

We value compassionate appreciative and productive working relationships - *we will listen to each other, reflect and learn*

January 2023

Response Rate

The National Staff Survey was open for staff to complete from October to November 2022. A total of 4895 substantive staff responded giving us a decrease of 15% from last year and a total of 43%. For the first time bank staff were included in the survey. To allow for separate reporting bank staff completed a slightly abridged version with questions more pertinent to their experience. 260 bank staff responded giving a response rate of 20%. In line with last year's results there were approximately 1200 free text comments.

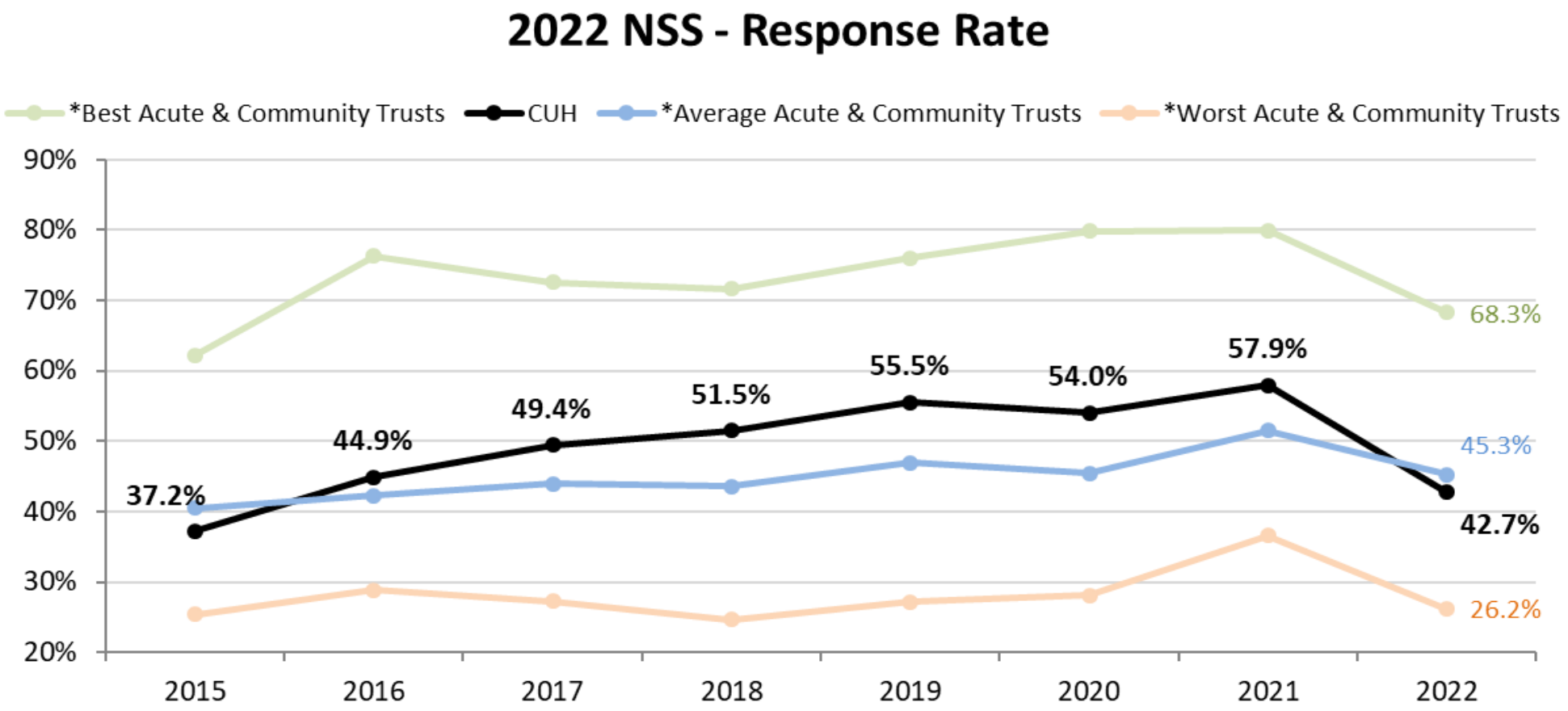
Division	2022 Response Rate	2021 Response Rate	Change on Last Year
Division A	37.4%	53.0%	-15.6% ↓
Division B	48.0%	59.1%	-11.1% ↓
Division C	38.1%	55.6%	-17.5% ↓
Division D	40.2%	53.0%	-12.8% ↓
Division E	34.3%	51.9%	-17.6% ↓
Corporate	53.5%	72.8%	-19.3% ↓
R&D	49.2%	69.7%	-20.5% ↓
Trust	**42.7%**	**57.9%**	**-15.2% ↓**

Staff Group	2022 Response Rate	2021 Response Rate	Change on Last Year	Bank
Add Prof Scientific	53.8%	61.2%	-7.4% ↓	23.1%
Additional Clinical Services	41.3%	54.3%	-13.0% ↓	19.1%
Administrative and Clerical	56.0%	74.0%	-18.0% ↓	23.6%
Allied Health Professionals	45.4%	57.3%	-11.9% ↓	26.1%
Estates and Ancillary	28.5%	52.5%	-24.0% ↓	14.7%
Healthcare Scientists	62.3%	66.0%	-3.7% ↓	12.5%
Medical and Dental	25.5%	38.7%	-13.2% ↓	*
Nursing and Midwifery	38.9%	56.6%	-17.7% ↓	18.1%
Trust	**42.7%**	**57.9%**	**-15.2% ↓**	**20.0%**

- Corporate and R&D have the highest response rate and equally the most significant decline in response rate since 2021.
- Every Division experienced a decline in response rate with Division B experiencing the least.
- Estates & Ancillary staff group had the most significant decline in response rate and Healthcare Scientists the least with only a small margin of decline at 4%.
- Significant declines amongst Admin & Clerical and Nursing & Midwifery staff groups are also to be noted.

Response Rate

Historic CUH & National Data

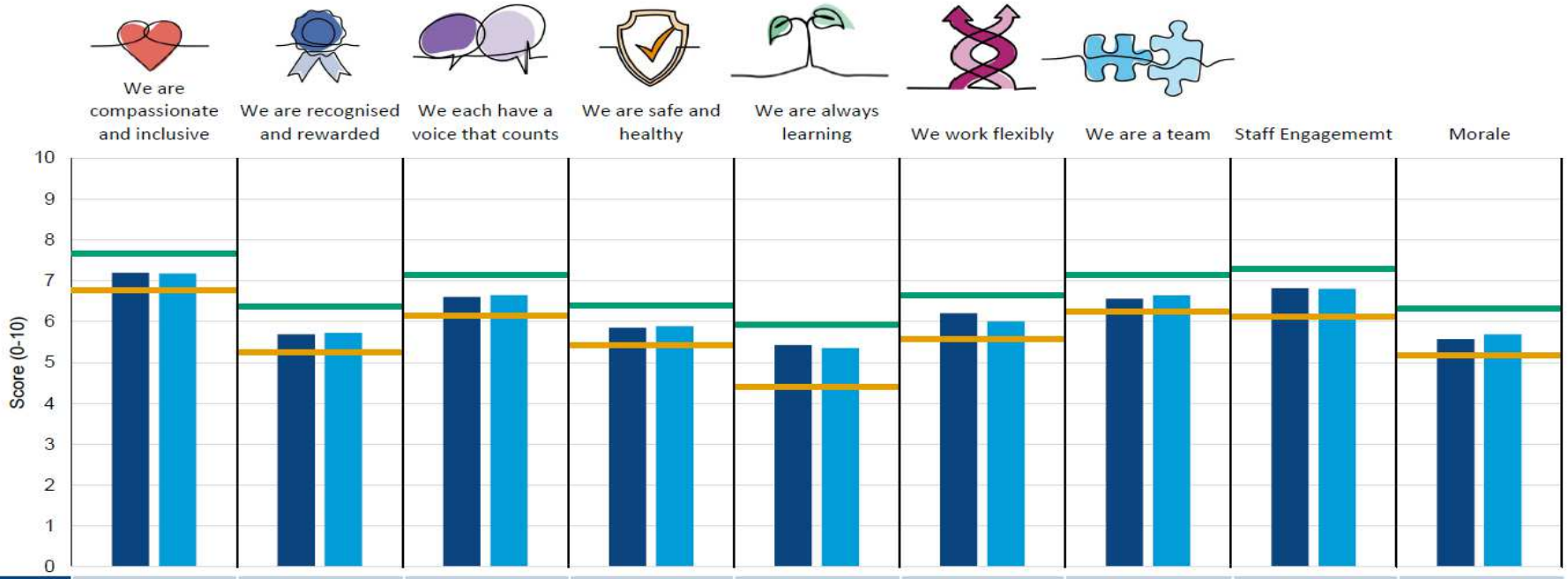


NHS People promise and theme results

People Promise Elements and Themes: Overview

Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score.**



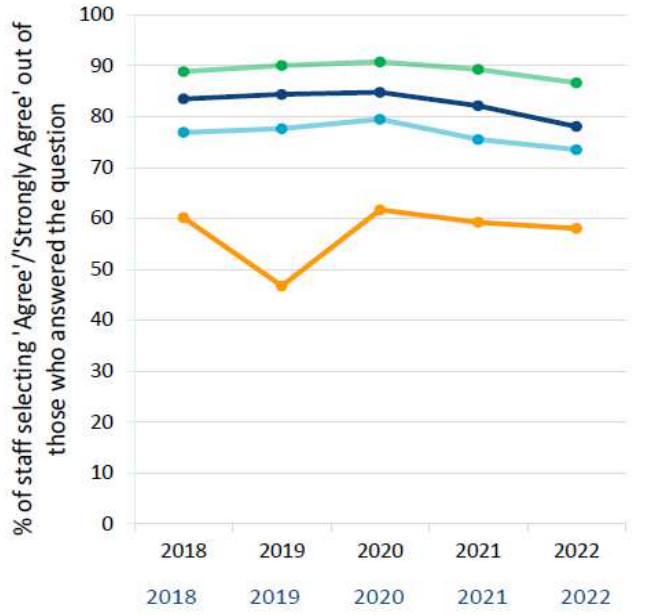
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	7.2	5.7	6.6	5.8	5.4	6.2	6.6	6.8	5.6
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	4879	4891	4860	4872	4696	4886	4881	4890	4889

National Benchmarking: Advocacy

People Promise elements and theme results – Staff engagement: Advocacy

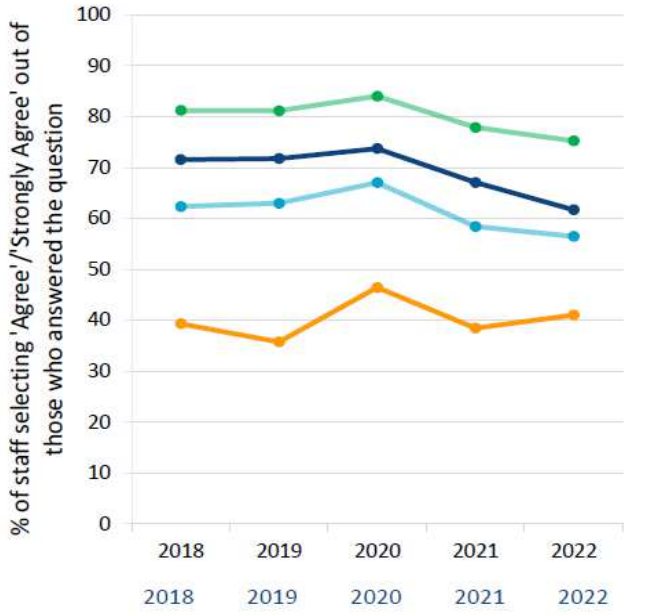
Survey Coordination Centre

Q23a Care of patients / service users is my organisation's top priority.



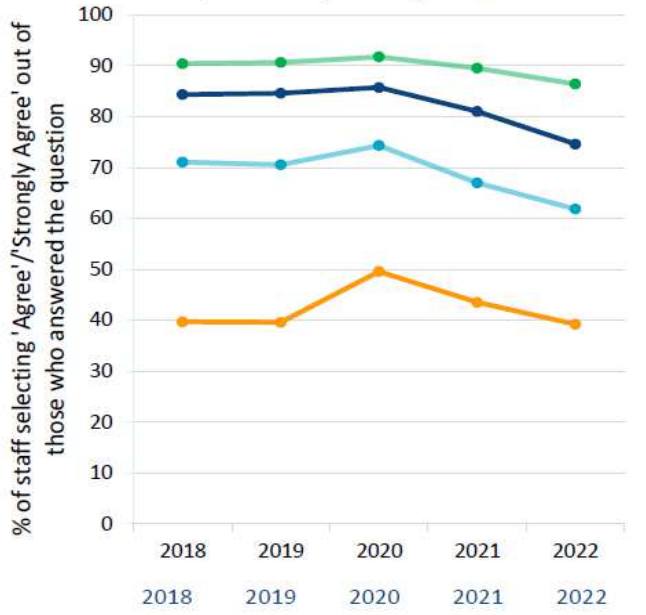
	2018	2019	2020	2021	2022
Your org	83.5%	84.4%	84.8%	82.1%	78.1%
Best	88.8%	90.0%	90.8%	89.3%	86.6%
Average	76.9%	77.6%	79.5%	75.5%	73.5%
Worst	60.1%	46.7%	61.7%	59.2%	58.0%
Responses	4902	5552	5644	6165	4861

Q23c I would recommend my organisation as a place to work.



	2018	2019	2020	2021	2022
Your org	71.5%	71.8%	73.7%	67.1%	61.7%
Best	81.2%	81.2%	84.0%	77.9%	75.2%
Average	62.3%	63.0%	67.1%	58.4%	56.5%
Worst	39.3%	35.7%	46.5%	38.5%	41.0%
Responses	4894	5549	5643	6166	4862

Q23d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.



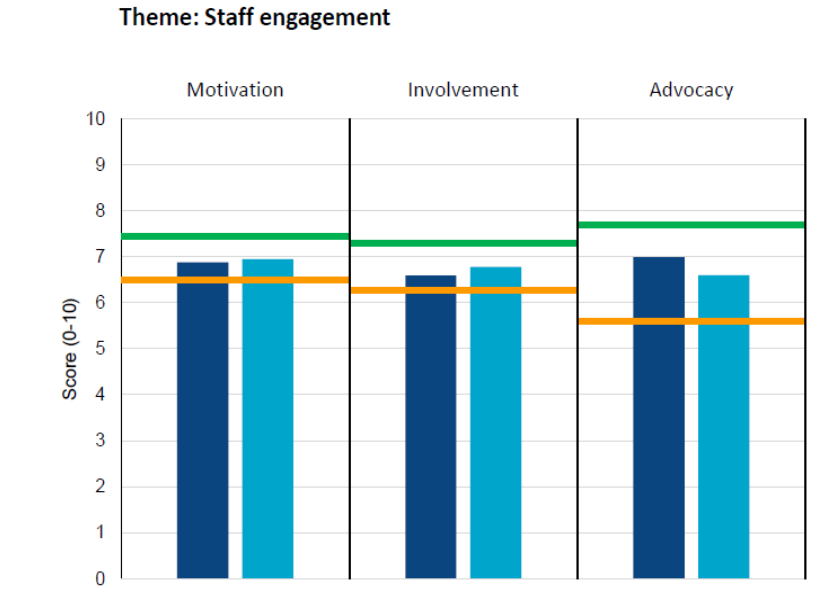
	2018	2019	2020	2021	2022
Your org	84.4%	84.6%	85.7%	81.0%	74.6%
Best	90.4%	90.6%	91.8%	89.5%	86.4%
Average	71.1%	70.6%	74.3%	67.0%	61.9%
Worst	39.7%	39.6%	49.6%	43.5%	39.2%
Responses	4871	5548	5647	6166	4868

Staff Engagement Score in detail

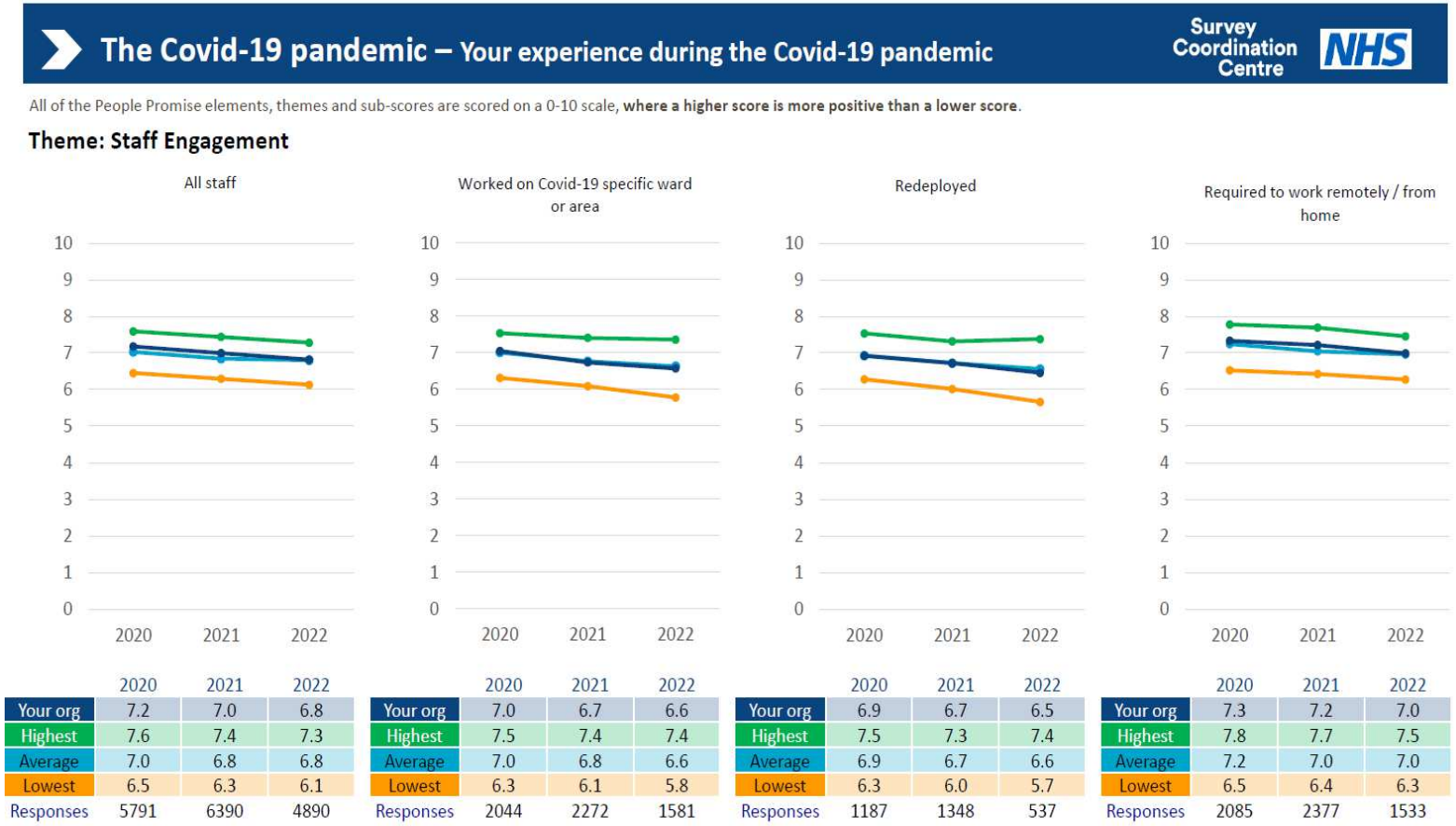
The nine questions below contribute to the overall staff engagement score. The detail below demonstrates the most significant change being the decrease in our advocacy and motivation scores.

Survey Questions	Response Rate						Bank	Engagement Score					
	2018	2019	2020	2021	2022	Change		2018	2019	2020	2021	2022	Change
Often/always look forward to going to work	64%	64%	60%	54%	52%	-2%	63%	6.8	6.8	6.6	6.3	6.2	-0.1
Often/always enthusiastic about my job	78%	77%	73%	67%	64%	-3%	77%	7.7	7.6	7.4	7.1	7.0	-0.1
Time often/always passes quickly when I am working	76%	77%	76%	73%	71%	-2%	77%	7.7	7.7	7.7	7.5	7.4	-0.1
Opportunities to show initiative frequently in my role	74%	75%	72%	72%	71%	-1%	66%	7.1	7.2	6.9	7.1	7.1	0.0
Able to make suggestions to improve the work of my team/dept	76%	75%	72%	69%	68%	-1%	55%	7.2	7.1	7.0	6.9	6.8	-0.1
Care of patients/service users is organisation's top priority	83%	84%	85%	82%	78%	-4%	80%	7.7	7.8	7.7	7.6	7.4	-0.2
Would recommend organisation as place to work	71%	72%	74%	67%	62%	-5%	69%	7.0	7.0	7.2	6.8	6.4	-0.4
If friend/relative needed treatment would be happy with standard of care provided by organisation	84%	84%	86%	81%	75%	-6%	74%	7.7	7.8	7.9	7.6	7.2	-0.4

National Benchmarking: Staff Engagement & Covid classifications



	Motivation	Involvement	Advocacy
Your org	6.9	6.6	7.0
Best	7.4	7.3	7.7
Average	7.0	6.8	6.6
Worst	6.5	6.3	5.6
Responses	4831	4889	4870



	All staff			Worked on Covid-19 specific ward or area			Redeployed			Required to work remotely / from home		
	2020	2021	2022	2020	2021	2022	2020	2021	2022	2020	2021	2022
Your org	7.2	7.0	6.8	7.0	6.7	6.6	6.9	6.7	6.5	7.3	7.2	7.0
Highest	7.6	7.4	7.3	7.5	7.4	7.4	7.5	7.3	7.4	7.8	7.7	7.5
Average	7.0	6.8	6.8	7.0	6.8	6.6	6.9	6.7	6.6	7.2	7.0	7.0
Lowest	6.5	6.3	6.1	6.3	6.1	5.8	6.3	6.0	5.7	6.5	6.4	6.3
Responses	5791	6390	4890	2044	2272	1581	1187	1348	537	2085	2377	1533

Despite a decline in staff engagement score it is important to note when looking at results by ***where*** people are working it is evident that those working remotely/from home continue to have more positive results a position which is echoed throughout all nine themes with the exception of **we are learning** .

Shelford Group – Staff Engagement Scores

Pos	Trust	2014
1	GST	3.96
2	Newcastle	3.90
3	Birmingham	3.87
4	UCLH	3.87
5	Oxford	3.82
6	Sheffield	3.81
7	Kings	3.79
8	Imperial	3.77
9	Manchester	3.76
10	**CUH**	**3.70**

Pos	Trust	2015
1	GST	4.04
2	Birmingham	3.90
3	Newcastle	3.89
4	Manchester	3.88
5	UCLH	3.85
6	**CUH**	**3.83**
7	Kings	3.81
8	Oxford	3.76
9	Sheffield	3.74
10	Imperial	3.74

Pos	Trust	2016
1	GST	4.03
2	Newcastle	3.97
3	Birmingham	3.90
4	UCLH	3.89
5	**CUH**	**3.88**
6	Oxford	3.87
7	Manchester	3.84
8	Sheffield	3.82
9	Imperial	3.80
10	Kings	3.74

Pos	Trust	2017
1	GST	3.99
2	Newcastle	3.91
3	Birmingham	3.88
4	UCLH	3.88
5	**CUH**	**3.84**
6	Imperial	3.84
7	Sheffield	3.83
8	Manchester	3.78
9	Oxford	3.78
10	Kings	3.72

Pos	Trust	2018
1	GST	7.4
2	Newcastle	7.3
3	**CUH**	**7.2**
4	UCLH	7.2
5	Manchester	7.1
6	Birmingham	7.0
7	Imperial	7.0
8	Sheffield	7.0
9	Oxford	6.9
10	Kings	6.8

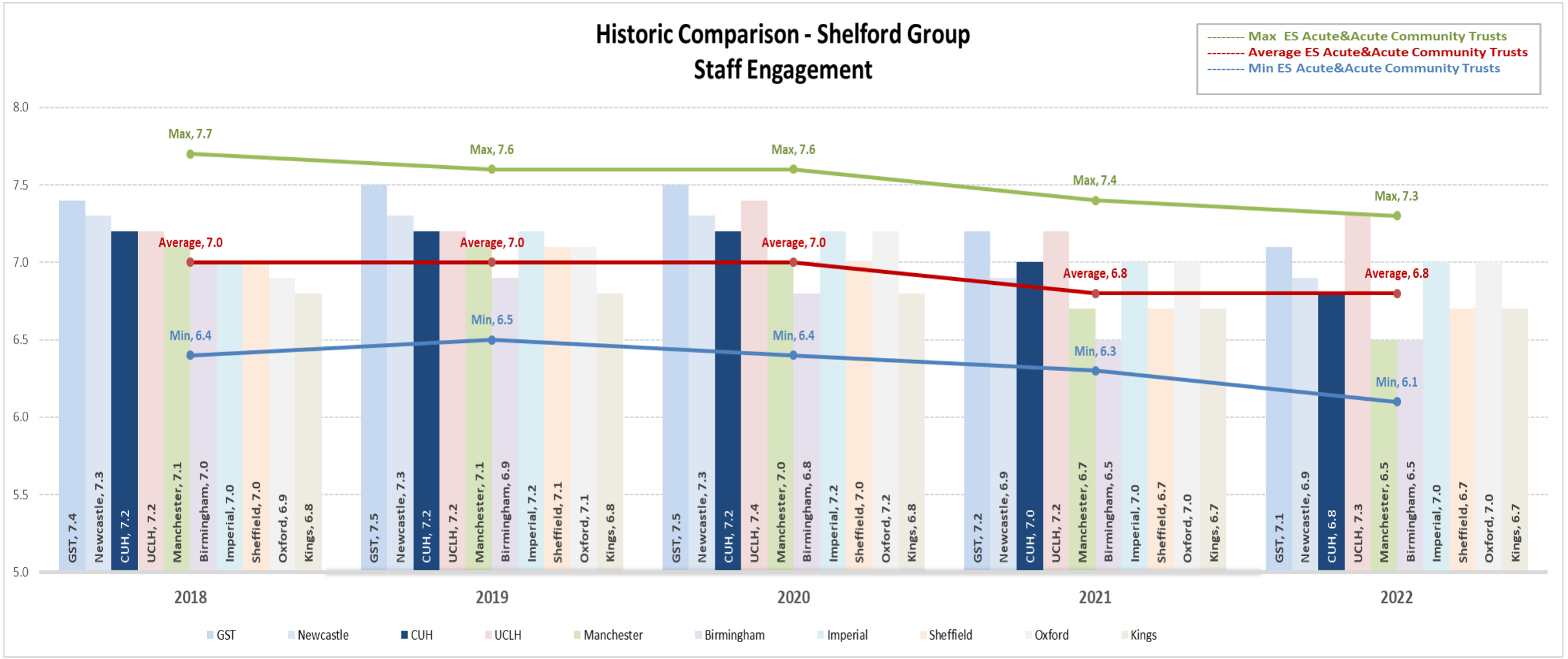
Pos	Trust	2019
1	GST	7.5
2	Newcastle	7.3
3	**CUH**	**7.2**
4	Imperial	7.2
5	UCLH	7.2
6	Oxford	7.1
7	Manchester	7.1
8	Sheffield	7.1
9	Birmingham	6.9
10	Kings	6.8

Pos	Trust	2020
1	GST	7.5
2	UCLH	7.4
3	Newcastle	7.3
4	**CUH**	**7.2**
5	Imperial	7.2
6	Oxford	7.2
7	Manchester	7.0
8	Sheffield	7.0
9	Birmingham	6.8
10	Kings	6.8

Pos	Trust	2021
1	GST	7.2
2	UCLH	7.2
3	Oxford	7.0
4	**CUH**	**7.0**
5	Imperial	7.0
6	Newcastle	6.9
7	Sheffield	6.7
8	Kings	6.7
9	Manchester	6.7
10	Birmingham	6.5

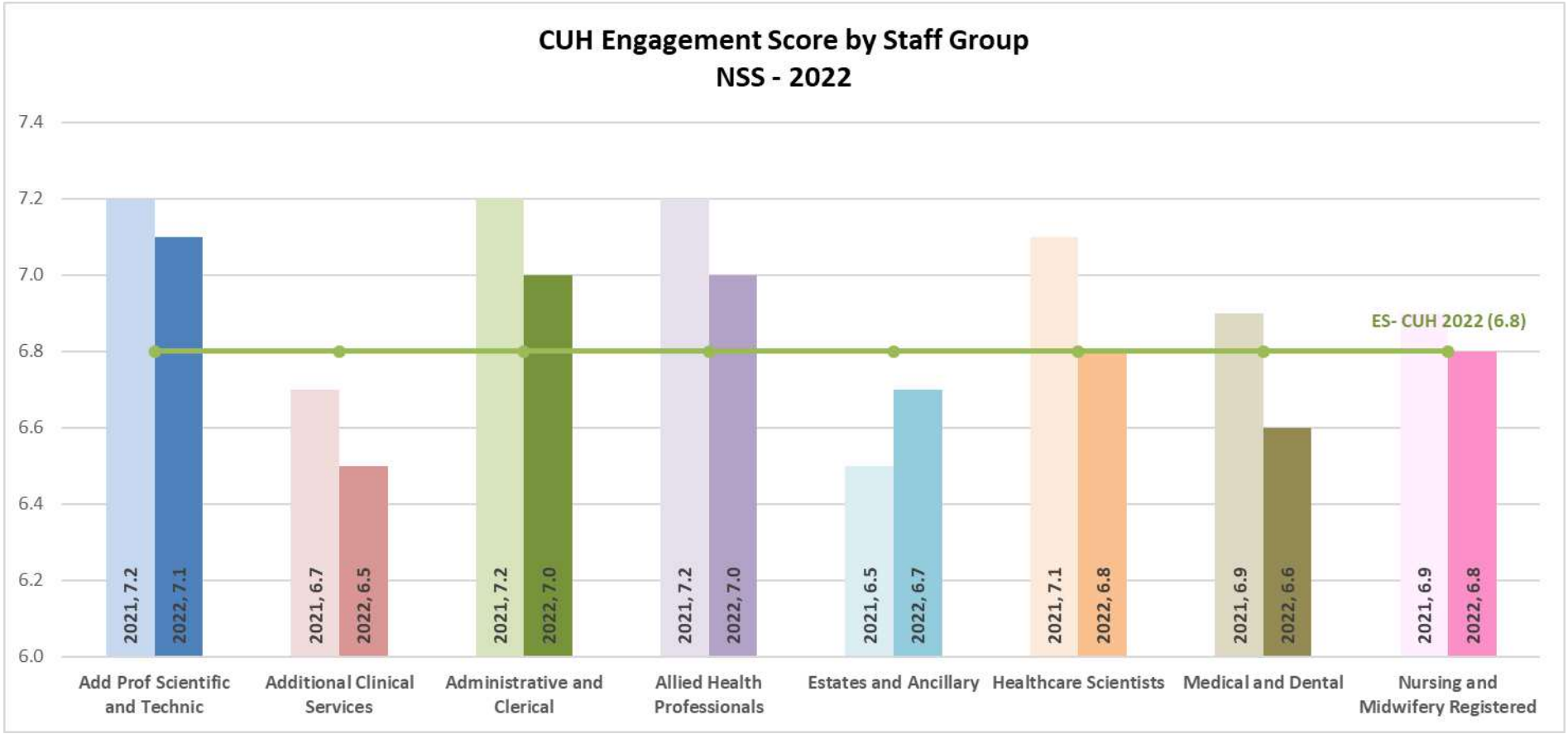
Pos	Trust	2022
1	UCLH	7.3
2	GST	7.1
3	Imperial	7.0
4	Oxford	7.0
5	Newcastle	6.9
6	**CUH**	**6.8**
7	Sheffield	6.7
8	Kings	6.7
9	Manchester	6.5
10	Birmingham	6.5

Shelford Group – Staff Engagement Scores



Historic comparison

CUH Staff Engagement Score by Staff Group 2021 - 2022



East of England

All East of England - ranked in order of staff "agreeing" or "strongly agreeing" they would recommend it as a place to work

Trust	2019	2020	2021	2022	Change 2021 to 2022	Change 2019 to 2022
Milton Keynes University Hospital NHS Foundation Trust	67%	74%	69%	68%	-1%	1%
Cambridge University Hospitals NHS Foundation Trust	72%	74%	67%	62%	-5%	-10%
West Suffolk NHS Foundation Trust	77%	74%	64%	60%	-4%	-17%
James Paget University Hospitals NHS Foundation Trust	68%	72%	65%	59%	-6%	-9%
Bedfordshire Hospitals NHS Foundation Trust		65%	59%	55%	-3%	
East and North Hertfordshire NHS Trust	58%	62%	57%	53%	-4%	-6%
West Hertfordshire Teaching Hospitals NHS Trust	60%	59%	55%	51%	-4%	-8%
East Suffolk and North Essex NHS Foundation Trust	57%	61%	54%	51%	-3%	-6%
North West Anglia NHS Foundation Trust	60%	63%	52%	46%	-6%	-14%
The Queen Elizabeth Hospital King's Lynn NHS Foundation T	51%	57%	46%	44%	-2%	-7%
The Princess Alexandra Hospital NHS Trust	58%	54%	45%	43%	-2%	-15%
Mid and South Essex NHS Foundation Trust		58%	47%	42%	-5%	
Norfolk and Norwich University Hospitals NHS Foundation T	62%	62%	48%	41%	-7%	-21%

CUH Workforce Commitments

We are ambitious for our people, we focus on and invest in the following commitments

Good Work

We strive to ensure that working here is a good experience - *with a positive impact on our health, safety and well-being*

Resourced

We invest to ensure that we are well staffed to deliver safe and high quality care - *with vacancy rates of 5% or less across all staff groups*

Ambition

We enable professional and personal growth - *developing our people is vital to individual and organisational success*

Inclusion

We seek to drive out inequality - *we are stronger as an organisation which values difference and inclusion*

Relationships

We value compassionate appreciative and productive working relationships - *we will listen to each other, reflect and learn*

January 2023

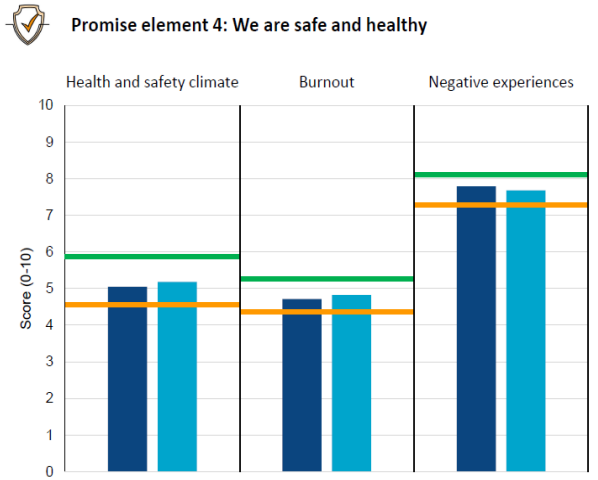
Staff Survey Workforce Race Equality Standards

Workforce Race Equality Questions		2020 CUH	2021 CUH	2022 CUH	Change 2021/22
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	23%	23%	24%	1%
	BME	26%	24%	24%	0%
Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months	White	12%	10%	11%	1%
	BME	12%	10%	11%	1%
Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months	White	19%	17%	19%	2%
	BME	24%	22%	23%	1%
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	62%	61%	61%	0%
	BME	50%	48%	47%	-1%
In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	7%	7%	8%	1%
	BME	16%	17%	19%	2%

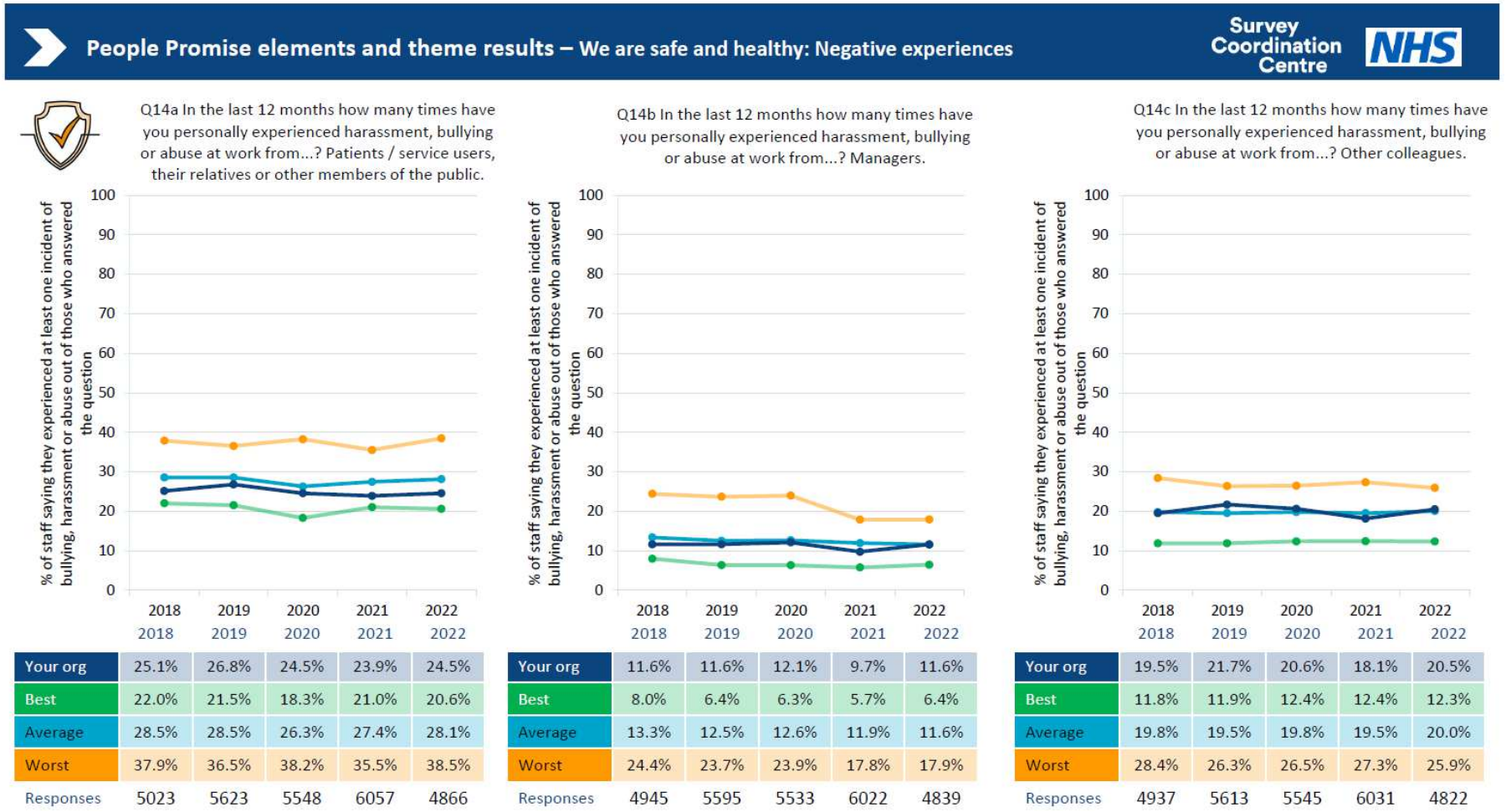
Staff Survey Workforce Disability Equality Standard

Workforce Disability Equality Standard (WDES)	Disabled: 1,088 responses Non Disabled: 3,750 responses	2020	2021	2022	Change 2021/22
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Disabled	26.6%	29.9%	30.5%	0.6%
	Non Disabled	23.2%	21.6%	22.0%	0.4%
Percentage of staff experiencing harassment, bullying or abuse from manager in last 12 months	Disabled	19.8%	15.7%	19.0%	3.3%
	Non Disabled	10.2%	8.2%	9.3%	1.1%
Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months	Disabled	26.8%	26.0%	28.6%	2.6%
	Non Disabled	19.3%	15.9%	18.3%	2.4%
Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	Disabled	54.4%	48.5%	45.2%	-3.3%
	Non Disabled	44.1%	44.2%	40.5%	-3.7%
Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	Disabled	54.0%	52.6%	53.6%	1.0%
	Non Disabled	60.7%	59.1%	57.8%	-1.3%
Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Disabled	28.0%	27.9%	31.0%	3.1%
	Non Disabled	20.5%	19.6%	20.9%	1.3%
Percentage of staff satisfied with the extent to which their organisation values their work	Disabled	44.3%	35.4%	34.4%	-1.0%
	Non Disabled	52.3%	48.0%	45.9%	-2.1%
Percentage of disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work	Disabled CUH	77.8%	75.9%	71.1%	-4.8%
Staff engagement score (0-10)	Disabled	6.8	6.6	6.4	-0.2
	Non Disabled	7.3	7.1	7.0	-0.1

Harassment, bullying or abuse:



	Health and safety climate	Burnout	Negative experiences
Your org	5.0	4.7	7.8
Best	5.9	5.3	8.1
Average	5.2	4.8	7.7
Worst	4.6	4.4	7.3
Responses	4890	4881	4880



	2018	2019	2020	2021	2022
Your org	25.1%	26.8%	24.5%	23.9%	24.5%
Best	22.0%	21.5%	18.3%	21.0%	20.6%
Average	28.5%	28.5%	26.3%	27.4%	28.1%
Worst	37.9%	36.5%	38.2%	35.5%	38.5%
Responses	5023	5623	5548	6057	4866

	2018	2019	2020	2021	2022
Your org	11.6%	11.6%	12.1%	9.7%	11.6%
Best	8.0%	6.4%	6.3%	5.7%	6.4%
Average	13.3%	12.5%	12.6%	11.9%	11.6%
Worst	24.4%	23.7%	23.9%	17.8%	17.9%
Responses	4945	5595	5533	6022	4839

	2018	2019	2020	2021	2022
Your org	19.5%	21.7%	20.6%	18.1%	20.5%
Best	11.8%	11.9%	12.4%	12.4%	12.3%
Average	19.8%	19.5%	19.8%	19.5%	20.0%
Worst	28.4%	26.3%	26.5%	27.3%	25.9%
Responses	4937	5613	5545	6031	4822

National Benchmarking: Relationships/ We are safe and healthy

Free text comments summary of themes

Over 1200 free text comments were supplied by staff proving an in depth perspective on the range of factors impacting on staff experience and hospital life currently. Most frequently mentioned and contributing factors were issues surrounding staffing and the cost of living. This then in turn impacting on wellbeing, workload, stress and work life balance.

Many staff started their comments with I am proud to work here **however…** or I like it here **but…** and many comments indicating that poor work life balance is getting in the way of job fulfillment. It is evident the magnitude and multitude of external factors that are outside of staff control are significantly impacting on experience and wellbeing such as; as travel, the cost of living and accommodation issues resulting in staff seeking employment elsewhere or changing professions entirely to manage these circumstances.

Poor working relationships, once again play a key role in the commentary whilst other aspects, appreciation, facilities and car parking also increased in volume.

The fatigue and wellbeing of staff is easy to hear in the narrative along with as mentioned a decline in work life balance for many. It is however pleasing to see there remains a sense of pride from many in the narrative and that despite these circumstances so many still offer their voice through the survey and contribute their ideas for improvement.

"Good opportunities within the department for having a flexible working pattern making the days varied. A significant under staffing within the admin team is having a great impact on clinical."

"We need a higher enhanced pay out of hours, local hospitals receive more than us. e.g Bury and Ipswich. Cambridge is an expensive place to live and we get no help which is why our department is now 50% down on staff. "

valued, listened to, and supported in my work in CUH. I feel confident to raise issues and concerns and where possible, we strive to make improvements. However there are areas where we are simply 'stuck' and cannot seem to make beneficial changes. The organisation just feels too big to move / be agile in implementing changes that could

What we do well

We work flexibly

CUH scored **above average** in relation to this theme, specifically in relation to the scores for the organisation being committed to supporting the balance of work and home life, opportunities for flexible working patterns and being able to approach immediate manager about flexible working.

We are always learning

CUH scored **above average** for the scores relating to development, specifically in relation to opportunities to develop knowledge and skills, career progression and challenging work.

Compassionate culture

Despite a small decrease from the previous year CUH still remain **above average** for the sub-section of compassionate culture which includes the questions relating to advocacy and patient care being a priority for the organisation as well as acting on patient concerns.

Our line managers

Responses in relation to questions about line managers continue to score consistently well and on the whole maintained consistency from 2021 to 2022, a position which has held throughout the pandemic. Specifically they were above average in relation to approaching managers to talk about flexible working and managers taking an interest in staff health and wellbeing.

In summary

The results for CUH see a significant shift in position in relation to the nine people promise themes. Unfortunately moving from an above average position for every theme in 2021 to now being in line with the average position for six of the themes and below average for the theme of **safe and healthy** and **morale**. The only exception being a slightly above average score for the theme of **we work flexibly**.

This year saw a significant drop in response rate from 58% to 43% which for the first time in many years puts us below the national average. Nationally there was a decline in the take up of the survey of around 6%.

Our engagement score has seen a steady decline since the start of the pandemic and this continues, now dropping below 7 (out of 10) to 6.8, again in line with the National average. Whilst we still remain above average in relation to the specific questions relating to advocacy (within the engagement theme) it is important to note an almost 6% decrease in recommending the organisation as a place to work, now at 61.7% although remaining above the average of 56.5%.

We continue to see a deterioration in the experience of BME staff in relation to harassment, bullying and abuse from managers, patients or colleagues and a significant 10% gap continues in relation to discrimination between white and BME and White (Other) staff.

In line with an emerging pattern of more positive results for those staff working remotely we note above average scores for staff feeling able to approach their line manager to talk about flexible working and above average scores for flexible working patterns although staff commentary highlights repeatedly the difficulties staff have being able to achieve the balance of work/home life.

CUH Workforce Commitments

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Good Work

We strive to ensure that working here is a good experience - *with a positive impact on our health, safety and well-being*

Resourced

We invest to ensure that we are well staffed to deliver safe and high quality care - *with vacancy rates of 5% or less across all staff groups*

Ambition

We enable professional and personal growth - *developing our people is vital to individual and organisational success*

Inclusion

We seek to drive out inequality - *we are stronger as an organisation which values difference and inclusion*

Relationships

We value compassionate appreciative and productive working relationships - *we will listen to each other, reflect and learn*

January 2023

Board of Directors

NHS
Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 10 May 2023

Agenda item	12
Title	Our Action 50 Green Plan (Phase 1: 2022-2024) annual progress report
Sponsoring executive director	Carin Charlton, Director of Capital, Estates and Facilities Management and Board Level Net Zero Lead
Author(s)	Rachel Northfield, Head of Corporate Support and Sustainability Richard Hales, Energy and Sustainability Manager Carin Charlton, Director of Capital, Estates and Facilities Management and Board Level Net Zero Lead
Purpose	To present the first annual progress report on the delivery of CUH's *Our Action 50 Green Plan: (Phase 1 2022-2024).*
Previously considered by	Management Executive, 4 May 2023

Executive Summary

- CUH's Green Plan governance arrangements require an annual progress report to be made to the CUH Board of Directors.
- The CUH Action 50 Green Plan (A50GP) was adopted in April 2022 with the objectives (by the end of 2024) of:
  - i.) cutting direct carbon emissions by 10% (from 2019/20 baseline), and
  - ii.) embedding re-use, repair, remanufacture and optimal value recycling within all decision-making across the organisation.
- The nature of environmental sustainability and carbon reduction means that the Plan's 50 actions are wide ranging across physical infrastructure, organisational processes, and behavioural responses. To meet the NHS carbon reduction targets (50% by 2032 and net-zero by 2040/45) requires a strategic transformation in decision-making as to what, how and how much CUH consumes.
- With monitoring needing to be provided across the full breadth and depth of the organisation, a balanced scorecard (BSC) approach has been adopted.

- The 50 actions have therefore been assigned to, and reported under, the relevant BSC perspectives (defined as stakeholder, learning and growth, internal process, and financial).
- Overall progress in Year 1 has been good. In terms of the accurately quantifiable direct carbon emissions, an 8% reduction has been achieved against the 2019/20 baseline (target= 10%). In the all-important areas of recognition, participation and involvement progress has also been strong.
- Twenty-seven of the actions are already delivering materially beneficial outcomes in line with their objectives, nine actions are developing according to their planned direction and fourteen require further reconsideration and review in relation to delivery.
- The BSC 'connected strategy map' has proved a useful tool for shaping and flexing progress over time.

Related Trust objectives	Improving patient Care, Supporting our staff, Building for the future
Risk and Assurance	Key risks are included on the BAF and the Corporate Risk Register (CR59) and local risk register (1612 – Summertime Overheating of Trust Premises; 672 – Energy and Sustainability Carbon Commitment; 1549 – Waste management; 1565 – Surface Water Flooding)
Related Assurance Framework Entries	BAF ref: 005 and 015
How does this report affect Sustainability?	Report centres on sustainability in relation to delivery of Net Zero Carbon and requirements of the NHS standard contract.
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	n/a

Action required by the Board of Directors

The Board is asked to:

- Note the content of this first annual monitoring report of the CUH Green Plan.
- Note the thought given to meaningful reporting of progress against the CUH Green Plan, proposing a hybrid approach of both quantitative and qualitative measures.
- Note the proposed framework setting the foundation of reporting utilising the principles of the Kapland and Norton Balanced Score card framework, and the associated strategy mapping undertaken.
- Note in addition to the delivery highlights in the body of the paper, the detailed assessment of each of the 50 actions categorised by domain, and core delivery element.
- Note the achievement of an 8% reduction in direct emissions against a 10% reduction target by 2024.
- Comment on the proposed approach to develop a sustainable and flexible framework for reporting on the Green Plan progress.

10 May 2023

Board of Directors
Cambridge University Hospitals – 2022-23 Annual Progress Report on Our Action 50 Green Plan (Phase 1, 2022-24)
Carin Charlton – Director of Capital, Estates and Facilities Management

1. Purpose of this report

The purpose of this paper is the first formal annual monitoring report which aims to provide:

1.1 An update on the delivery progress of all the 50 actions laid out in CUH's Our Action 50 Green Plan (Phase 1: 2022-24) – adopted by the Board of Directors at their meeting on 13 April 2022.

1.2 An assessment of how the strategic objectives, measures, and assumptions are playing out in terms of the effectiveness of their cause-and-effect relationships in resetting CUH's trajectory from high-carbon/high-waste linear consumption to net-zero/zero waste circular consumption.

1.3 CUH progress in a structured manner and format that facilitates the long-term transformational nature of the Green Plan as it develops and establishes itself as an essential driver of CUH's consumption-based activity.

2. Background

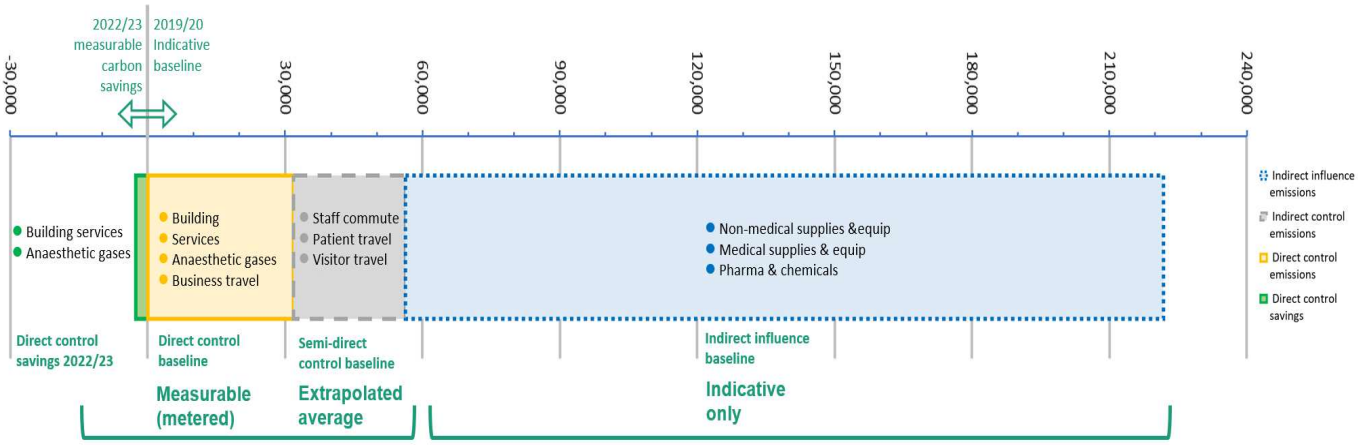
2.1 Appendix 1 sets out the CUH Objectives, timeline and principles that under that underpin the CUH Action50 Green Plan (A50GP). The A50GP emphasises that if the 50 actions are going to both begin and set-up the exceptionally challenging journey of halving the Trust's carbon emissions by 2032 and then move on to achieve 'net-zero' by 2040/45, system transformation is required. Minor adjustments or incremental efficiency improvements will only marginally slow the inevitable acceleration of climate chaos and ecological breakdown.

2.2 Business-as-usual in the form of a take-make-use-dispose 'linear economy' approach to consumption is no longer a viable option to sustain health, wellbeing and the "together: safe, kind, and excellent" (T:SKE) delivery of CUH's public service provision and requires a paradigm shift to one of a 'circular economy'.

2.3 Monitoring the A50GP therefore becomes not simply a matter of checking in on, and correcting as necessary, an ordered set of financial and non-financial measures, but also one of establishing the linkages between the measures so we can articulate, support and flexibly correct as required.

2.4 To this end we have adopted the well-established Balanced Scorecard approach as not only a means of performance measurement, but also a strategic management system and communication tool to take the plan forward. Because system transformation is at the heart of all the measures included in our Green Plan, cause and effect between these measures becomes as important as ticking each of them off as completed

2.5 The image below, gives a visual representation of the CUH carbon footprint based on the 2019/20 baseline, broken down by those direct control emissions; those that we have some control over and the remainder which we can influence only indirectly. Appendix 2 sets out the challenges associated with measuring carbon.



3. A hybrid approach – balancing quantitative and qualitative

3.1 The CUH A50GP is based on transforming from a linear economy which is a high-carbon/high-waste operation to a circular economy which is a net-zero/zero-waste operation, and the 50 actions are difficult to accurately and clearly assess in terms of progress.

3.2 As we move beyond a framework where the sustainability gains are frequently short-lived and pared back to 'fit where they touch' to one that is designed for optimal environmental benefit/return – we pay attention to the inherent value of material carbon or waste reduction and focus on 'additionality', maximising the scale required for net-zero/zero-waste.

3.3 CUH through its Green Plan, recognises that this can only be achieved with actions that urgently develop the relevance, learning, processes and costing logic that are aligned with the reality of a climate emergency, species extinction and ecological breakdown. Conventional short-term 'win-win' thinking is still, of course, a valuable outcome, but frequently fails to reflect the realities of the crisis which requires lifecycle thinking and recognising intergenerational returns; connecting today's spend with the costs of tomorrow's climate chaos and that every stakeholder needs to become a responsible NZ/ZW-oriented consumer.

3.4 These essential considerations mean that the objective of NZ/ZW requires a very rounded approach to our Green Plan performance monitoring and progress management - One in which performance is viewed in terms of corporate transformation. The challenge of this requirement is further compounded by the difficulty in transparently attaching accurate saved or avoided values to actions in terms of both cost (£) and carbon (tCO_{2e}).

3.5 These are problems for both carbon and waste reduction monitoring that relate to:

- conversion (the emission factors associated with goods and activities),
- attribution (assigning specific responsibility by organisation/individual and location), and

- additionality (are these things that would have happened anyway, i.e., did not need to be planned for).

3.6 There are both qualitative and quantitative measures associated with our A50GP and a focus on just carbon is problematic purely focusing on carbon reduction measurements. The accurate reporting of corporate performance towards net-zero/zero-waste for us therefore becomes a hybrid of numbers and narrative from the ground-up as both leading and lagging performance indicators. The nature of performance will also evolve as learning, financial management, operational procedures, and stakeholder responses step into and become integrated elements of the transformation.

3.7 We are very clear about the activities that create the main sources of human-made carbon emissions (and waste), and the actions required to counteract them. What is far less assured, and often little more than indicative, is the necessary level of granularity to accurately record baselines and the impact of local mitigation actions. There is a very real danger that striving for accurate measurement becomes a drag on performance as many action outcomes would have to be individually calculated, assessed, and reported locally with matching methodologies, then carefully aggregated and vetted to prevent double-counting and misplaced assumptions.

3.8 What really matters now is engaged leadership across divisions and departments. Leadership that is critically reviewing progress against the rapid transformation from high-carbon/high-waste business-as-usual to a new normal built around net-zero/zero-waste.

3.9 CUH's 50 Green Plan actions comprise the first step, in a 20-year journey, to do this. To prevent a crisis becoming an irreversible catastrophe by taking out the carbon emissions and unsustainable extraction of natural resources. It is essential we set off in the right direction.

3.10 It is therefore essential that the A50GP and its implementation is matched with a suitable monitoring and progress management system.

4. The Balanced Scorecard

4.1 As introduced above, almost all 'sustainability' actions to date have been driven and underwritten by the over-riding financial priority of immediate revenue savings with short-term paybacks on investment. Without the integration of longer-term lifecycle thinking, heavily revised processes and clearly allocated responsibility, with the capacity and capability to match, then the trajectory to climate chaos and subsequent ecological breakdown remains locked in.

4.2 The approach and principles we have built into our A50GP embrace a clear sense of balance: reframing decision-making with reference to the incorporation of full lifecycle thinking, with an active devolving of responsibility, and the vital importance of re-shaping spending to prevent the extreme budgetary pressures that will impact the running of our hospitals if the worst of climate chaos is not avoided.

4.3 The 50 actions within our Green Plan text have been presented in the plan itself to illustrate how they specifically contribute to tackling the shared climate emergency through four action sets that immediately start, and go on to sustain cuts to direct and indirect carbon emissions. For monitoring and progress assessment purposes, however, reporting against the systemic change of business as usual through reframing decision-making is more important than marking off actions as completed.

4.4 To this end we have adopted the tried and tested 'Balanced Scorecard' methodology (Kaplan and Norton, 1992[1]; Niven, 2002[2]) with its aim of assuring strategic programme integration (in our case, the transition to net-zero/zero-waste consumption) via reporting that not only assesses progress, but also acts as an effective management system for fully achieving programme objectives and targets.

4.5 The four conventional Balanced Scorecard (BSC) perspectives have been adopted: 1. Stakeholder, 2. Learning and growth, 3. Internal process, and 4. Financial. They all fit well against the A50GP format in terms of both coverage and outcomes, i.e., the core premises of the BSC are:

1. the importance of understanding the impact on, and relevance to, our staff, patients, visitors and partners of tackling the climate emergency; this needs to include the existing perceived levels of responsibility, decision-making and the values attached. This is a society-wide global crisis – everybody is involved: sustainability is for everyone (the '**stakeholder**' perspective – where the learning and growth, and amended processes develop into new and permanent change through all the players involved);

2. that existing knowledge and understanding must be iteratively checked and developed against the reality the of where we are now and where we need to be (the '**learning and growth**' perspective – the roots of change);

3. the established ways of working determined by our professional rules and regulations need to be recognised and worked with – aligning the A50GP objectives and principles with formally adopted T:SKE processes that are probably at best only partially sighted on the implications of today's climate emergency and the imperative of net-zero (the '**internal process**' perspective – the main body of formal organisational change);

4. the financial assumptions tied to how we have conventionally shaped business investment cases and procurement choices must be challenged in ways that ensure spending today does, at minimum, not exacerbate or accelerate the unfolding environmental crisis (the '**financial**' perspective – the cost benefits that grow and grow over time).

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[1] Kaplan R.S. and Norton D.P., 1992, *The Balanced Scorecard – Measures that Drive Performance*, Harvard Business Review (Jan-Feb)

[2] Niven P.R., 2002, *Balanced Scorecard Step–by–Step: Maximizing Performance and Maintaining Results*, John Wiley and Sons

4.6 The Balanced Scorecard provides more than just additional measures from additional perspectives on the performance of individual actions. Within a Balanced Scorecard, the setting of critical success factors and critical measurements under each perspective allows for the 'mapping' of the A50GP strategy and the system transformation that lies at its heart. This is a dynamic building process that maximises the transformation performance process over the extended timeline to 2045. By introducing a Balanced Scorecard at the very start of implementation, the long-term delivery of the CUH Green Plan (over ten years and beyond) should not be allowed to lose its way.

4.7 Appendix 3 shows the articulation of the CUH Green Plan monitoring approach in BSC format along with the 'strategy map' that shows the connections or relationships between the A50GP strategic objectives – the critical success factors.

4.8 This is crucial, because NHS suppliers, CUH and the communities we serve all come together in a highly complex system. The relationships between the innumerable moving parts mean they do not do this according to a blueprint. Instead, the interactions are pressed into the stable patterns that deliver the best outcomes possible for our patients with capability, capacity, policy, procedure, collaboration and, of course, spending. The current stable pattern is both high-carbon and high-waste and to transform this into a new stable pattern, that is both net-zero and zero-waste, will require real and permanent change to each of these perspectives and how they relate to each other.

4.9 The Balanced Scorecard (BSC) therefore offers more than a measure of performance from several perspectives – it also provides a means of managing the progress and implementation of the required transformation across the four key organisational perspectives. This review paper uses BSC as:

- a strategic management tool – aligning Phase 1 actions with the strategy behind them;

- a powerful communication tool for A50GP understanding and progress;

- a way of linking A50GP actions/measures together in chains of cause-and-effect relationships that allows for dynamic monitoring, managing and validation as the Green Plan programme progresses;

- a means of establishing real balance between a.) financial and non-financial indicators, b.) pure utility value at the point of consumption and full asset lifecycle value; c.) internal and external (e.g. community, ICS, supply-chain) aspects of delivery, and; d.) lagging and leading indicators of performance.

5. Are we on target to reduce CUH's directly controllable carbon emissions by 10% by the end of 2024?

5.1 Within the NHS carbon footprint the bulk of emissions (75% for CUH) are embedded in the goods, materials and services purchased, can only be very roughly calculated and are best considered as signposts to high carbon categories of products. Another 10% of CUH's estimated carbon footprint is tied to personal staff, patient, and visitor transport with no accurate way to calculating the mileages by mode. The remaining 15% of emissions CUH has direct control and most immediate responsibility. These fall under three key categories: building services, anaesthetic gases, and business travel.

5.2 Calculated savings from 2022/23:

Energy efficiency programme are

- 33 tCO_{2e} for electricity and
- 328 tCO_{2e} for gas.

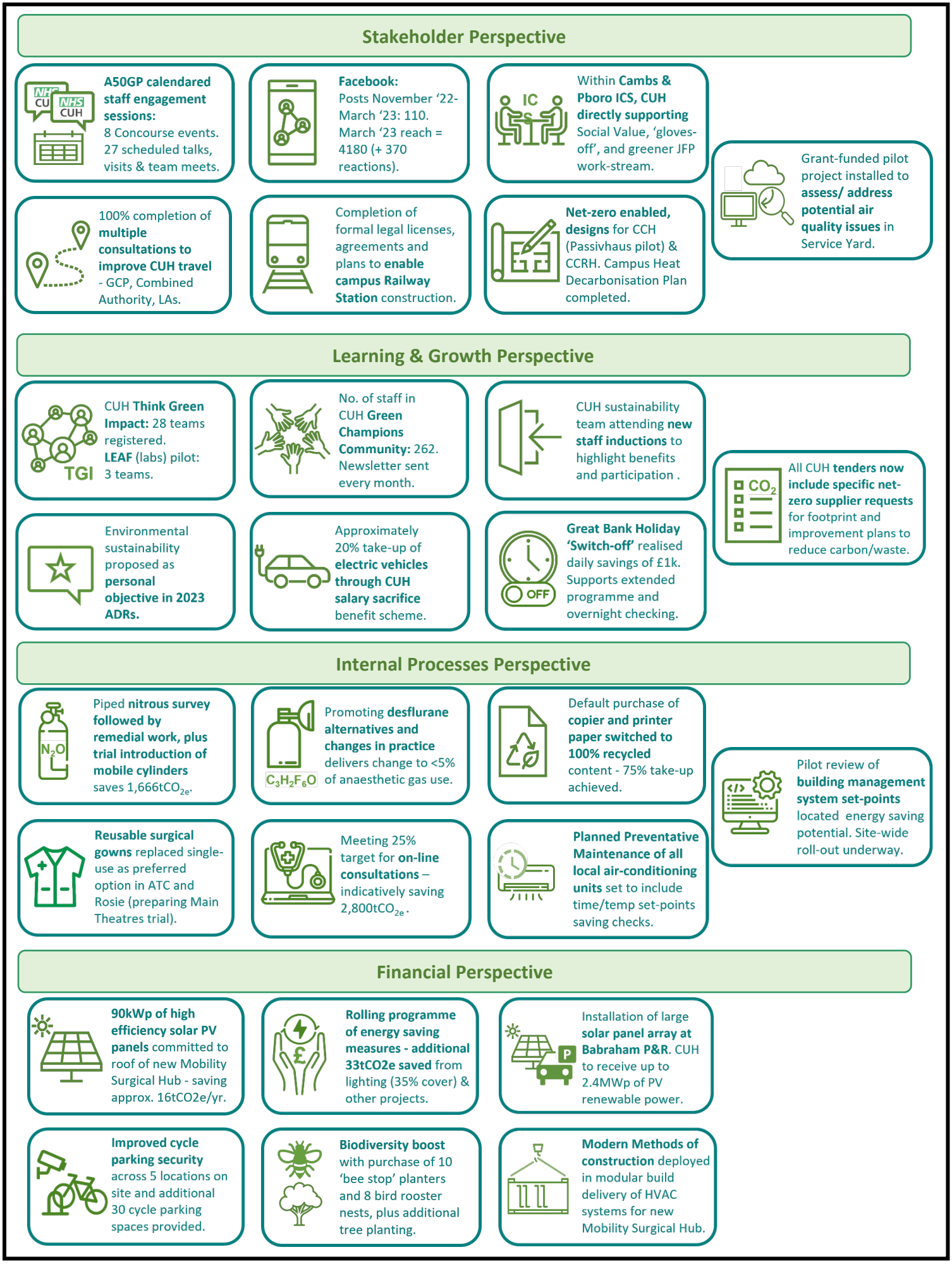
Anaesthetic/analgesic gas savings are

- 2,208 tCO_{2e}.

5.3 Together these comprise **8%** of the 2019/20 direct emissions baseline (the target by the end of 2024 is **10%**).

6. Progress Highlights

The image below summarises key progress highlights across our first year Green Plan implementation plan, with substantive detail set out in Appendix 4.



7. Challenges

7.1 It is good to celebrate progress made on so many fronts, we do however have a challenging journey ahead. The extreme pressure staff are working under on an ongoing basis is very real and a barrier to delivering capacity and capability within our workforce to drive through the actions of our Green Plan, to devolve responsibility as close to where carbon is consumed. There are however over 260 Green Champions and 28 teams registered on the Think Green Impact behaviour change programme. A number of initiatives are led by clinicians and others outside of Capital, Estates & Facilities, and the more can create opportunity and space for people to make a local change that can have scalable benefit, the closer we get to becoming responsible consumers carefully thinking about the carbon we consume.

7.2 It is great that Environmental sustainability is proposed as a personal objective in the 2023 ADR process, and the more we can create a policy environment that support environmental sustainability, the easier we make it for people to do the right thing. Our staff have given their views and believe that environmental sustainability should be a particular area of focused action for CUH.

8. Summary

8.1 As we come to the end of the first year of the A50GP, we can reflect on progress on a number of fronts, whilst recognising the challenges of delivering a step change in CUH's approach to reducing its impact on the environment, the impact of irreversible climate change on our ability to deliver healthcare and the health inequalities resulting from climate change.

8.2 This paper has sought to capture the detailed thinking about how we capture and report on progress against the initial 50 actions in our A50GP, whilst recognising carbon is difficult to calculate and can be a distraction from actual delivery. This paper seeks to propose a hybrid approach to monitoring and utilising a well-established performance framework as the basis of this work.

9. Recommendations

9.1 The Board of Directors are asked to:

- Note the content of this first annual monitoring report of the CUH Green Plan.
- Note the thought given to meaningful reporting of progress against the CUH Green Plan, proposing a hybrid approach of both quantitative and qualitative measures.
- Note the proposed framework setting the foundation of reporting utilising the principles of the Kapland and Norton Balanced Score card framework, and the associated strategy mapping undertaken.
- Note in addition to the delivery highlights in the body of the paper, the detailed assessment of each of the 50 actions categorised by domain, and core delivery element.
- Note the achievement of an 8% reduction in direct emissions against a 10% reduction target by 2024.
- Comment on the proposed approach to develop a sustainable and flexible framework for reporting on the Green Plan progress.

Appendix 1: Core CUH Green Plan objectives, principles and timeline

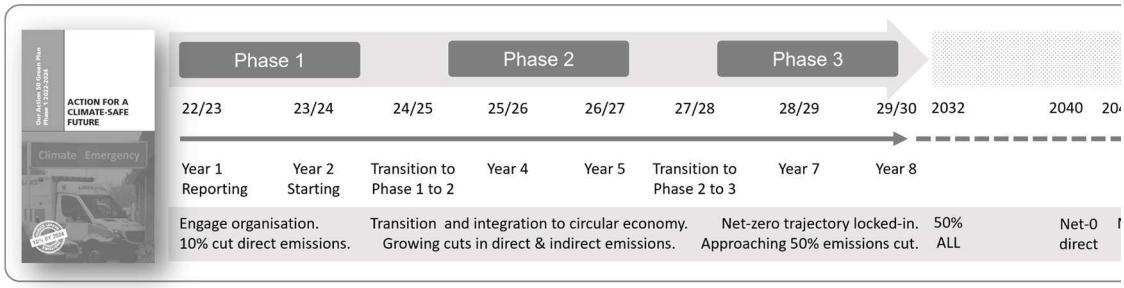
Box 1: Core CUH Green Plan objectives, principles and timeline

To implement the CUH Green Plan we need to bring a highly transformative approach to bear in all business decisions and transactions. It can however, at least initially, be difficult to recall the necessary objectives and approaches of this transformation. The following is offered as the core elements to hold in mind (as detailed in the CUH A50GP)

Objectives: by 2024 to have:

1. **reduced carbon emissions by 10% (and then 50% by 2032, with net-zero by 2040)** from: i.) the heating and powering of all CUH premises, ii.) all miles travelled on CUH business (from a 2019/20 baseline). High impact anaesthetic gases are also included here but with a target to fully negate these by the end of 2024.

Timeline:



Principles: by the end of 2024 the aim is for organisational decision-making to be explicitly embracing the following principles:

1. **Life-cycle thinking (LCT):** the carbon, pollution and resource loss impacts of all aspects of consumption are to be expressly taken account of in an integrated (circular economy) manner during the supply, use and disposal of all goods, materials and equipment (replacing the dominance of decision-making based upon cost and utility alone).
2. **Devolved responsibility:** the essential locus of life-cycle thinking should reside with those at the point of consumption – these local teams understand most clearly what, how and how much they are consuming and are best placed to understand and bring forward adjustments based upon LCT that also ensures they maintain T:SKE delivery.

Appendix 2: Monitoring the quantitative and qualitative aspects of the CUH carbon footprint

1. Quantitative aspects (directly controllable emissions)

1.1 There is an internationally recognised methodology for calculating an organisation's carbon footprint (known as the Greenhouse Gas Protocol). This divides the business footprint into three categories referred to as 'scopes', for CUH:

Scope 1: direct emissions from sources that the Trust owns or directly controls. These include emissions from: natural gas burnt in our boiler and incineration plant to generate heat; fuel oil burnt as a backup to gas; petrol or diesel burnt in our lease cars; and, certain anaesthetic/analgesic gases such as desflurane, nitrous oxide and Entonox.

Scope 2: indirect emissions (i.e. released elsewhere but caused by CUH's consumption needs) from the remote generation of mains grid electricity and then cabled into the site.

Scope 3: indirect emissions embedded in all the goods, materials, equipment, water, food, pharmaceuticals, staff travel in their own cars, and waste management. These can be thought of as all the Scope 1 and Scope 2 emissions which everyone else emits on our behalf to ensure the hospital campus runs effectively.

1.2 There are two other categories that fall outside of these three, but over which CUH has important control and influence:

Out of scope emissions: for CUH these are patient and visitor travel miles.

Avoided emissions: these arise from our capability and capacity to reuse, repair, return for remanufacture, or separate for recycling at end of life any of the goods, materials, and equipment CUH purchases. By doing this the organisation slows down the flow of these items that need to be made from scratch again in the supply chain and thereby 'avoid' the emissions that would have been produced. Purchasing goods with these emission avoiding characteristics is something CUH can control and is therefore one of the organisation's most important means of reducing Scope 3 emissions.

1.3 Scope 1, Scope 2 and a small sub-set of Scope 3 emissions can be calculated in a relatively accurate way as there is normally some form of metering involved (e.g., gas, electricity and water meters, vehicle mileometers, and anaesthetic gas volume recording). These are largely the emissions that the NHS describes as those within its direct control (the NHS Carbon Footprint) and for which the 2040 net-zero target has been set, the remainder (the majority of emissions) are only within indirect control or influence (the NHS Carbon Footprint Plus) and hence have an extended net-zero target date of 2045.

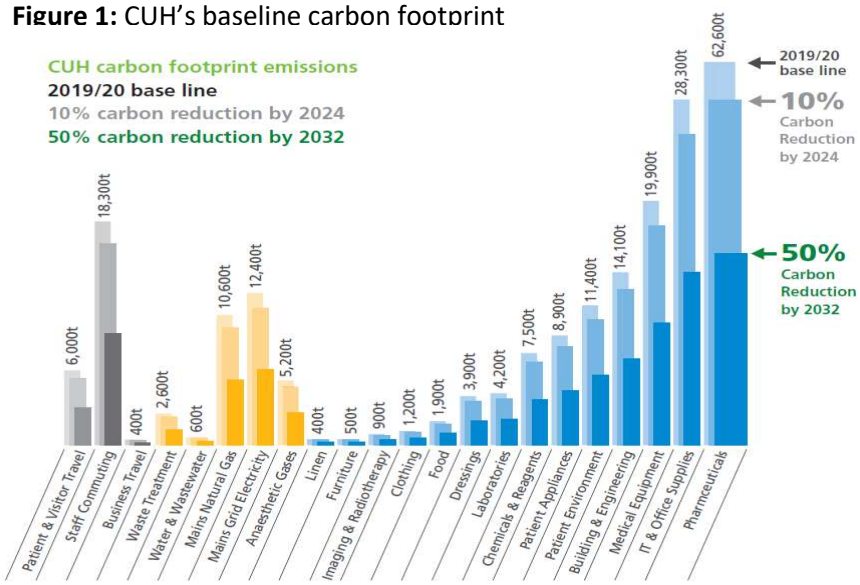
1.4 The A50GP has set an immediate quantitative target of a 10% reduction in directly controllable and quantifiable carbon equivalent emissions by the end of 2024.

2. Qualitative aspects (indirectly controllable emissions)

2.1 As Figure 1 (below) shows, the majority (approximately 75%) of CUH's emissions fall into the Scope 3 category. The carbon footprint of these goods, materials, equipment, etc., are subject to multiple supply chain variables which are an aggregate of all the direct emissions of each organisation in the chain that adds to their marketable value.

2.2 CUH purchases tens of thousands of different types of products. It is wholly impractical to try and calculate the carbon footprint of each product, therefore the variables are aggregated into a single emissions factor for a type of product (known in procurement terms as its 'e-class') and applied against pounds (£) spent for that class. These are illustrated in the centre to right-hand-side categories in Figure 1 – from linen to pharmaceuticals. It is essential to understand that, because each e-class contains thousands of possible product types, the single aggregate emissions factor is a wholly approximate and purely indicative figure. It is only suitable for identifying 'hot-spots' of emissions. It is also crucial to appreciate that actions to reduce these emissions cannot, in any way, be expected to be reflected in the aggregate 'top-down' e-class figures. The success of actions designed to reduce, or avoid, Scope 3 emissions must be determined using a 'ground-up' methodology for the specific item in question.

Figure 1: CUH's baseline carbon footprint



2.3 The consumption and disposal chain impacts of actions to avoid emissions through reducing waste via reuse, repair, remanufacturing, and recycling (towards a circular economy) are also often similarly hard to attribute, quantify, and verify. The systems currently in place for recording are crudely tied to cost (such as units purchased or waste collection rates) and gross weights (such as kilograms of dry-mixed recycling). An accurate understanding and calculation of the 'circularity factor' of goods, materials and equipment is presently as rare and difficult to find as accurate Scope 3 carbon emission factors.

2.4 This does not undermine the imperative of material actions to reduce carbon footprints, or steps to improve the circularity of waste arising, but does frequently undermine the metrics recording the respective levels of achievement. CUH is a large, complex, and multifunctional organisation. It has centralised support systems for energy, water, waste, and business travel which allows these direct emissions to be quantified with some accuracy. But assessing the numeric value of indirect embedded carbon emissions and circularity is generally impractical/unviable. We can evidence a change in the right direction but quantified magnitude to assess real change on the ground is currently beyond reach.

2.5 Consequently, no short-term target has been set for the majority Scope 3 emissions (plus the out-of-scope patient and visitor travel emissions) – the emissions over which CUH has only indirect control/influence. Looking forward, they are part of an intermediate (and potentially quantifiable in the longer-term) target to cut all emissions by 50% by the end of 2032. In the short-term of our A50GP (Phase 1) the crucial measures are qualitative – raising the relevance of lifecycle thinking to advance net-zero/zero-waste consumption as an essential element of decision-making; raising capacity and capability with appropriate learning and guidance content for all; and adjusting internal processes as a consequence.

Appendix 3: Balanced Score Card and Strategy Map

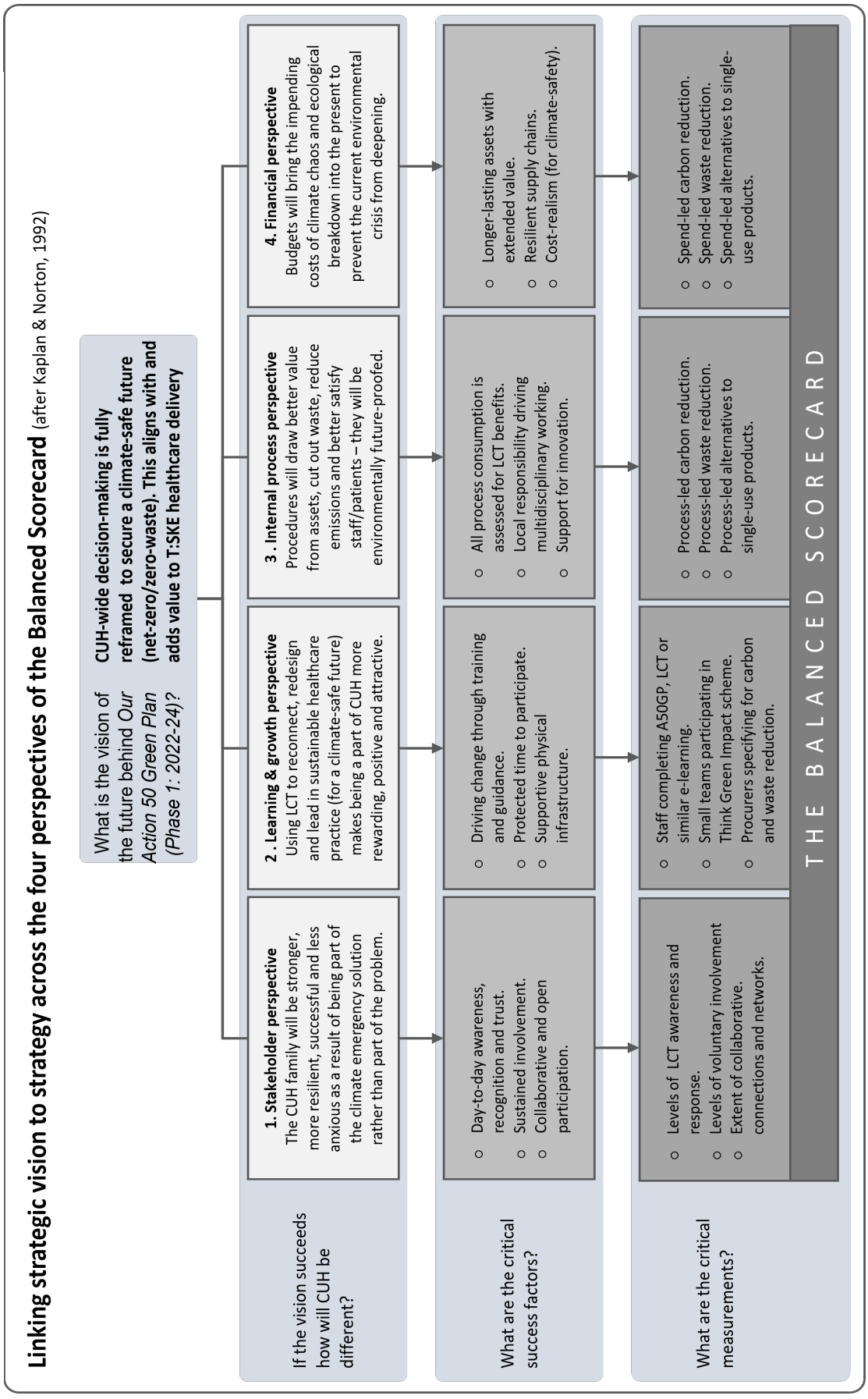


Figure 2: the balanced scorecard developed to monitor the progress of the CUH *Our Action 50 Green Plan (Phase 1: 2022-24)*

Figure 3: A50GP - layout of balanced scorecard 'strategy map' elements
(prior to establishing 'live' interconnections/interrelationships between the boxed strategic objectives (critical success factors)

Appendix 4: Summary delivery highlights & Detailed BSC

1. Summary Delivery Highlights

Stakeholder perspective: Is lifecycle thinking (LCT) becoming relevant as an impact in decision-making for all players?

1.1 Overall, the openings for LCT and its relevance within CUH have moved forward over the past 12 months and, to a degree, become more normalised via regular and consistent engagement activity, a sustained advance in new major infrastructure projects and the extending of external channels to try and broaden the lifecycle view.

1.2 However, LCT has yet to break through into the mainstream in terms of delivering the wave of change most urgently needed. It remains rare as an explicit point of reference and checkpoint for most stakeholders. The business-as-usual factors of utility and cost at the point of consumption continue to dominate. Turning this around in Year 2 will require a concerted push through the learning and development perspective together with determined leadership promotion to release net-zero/zero-waste LCT from the confines of existing reductionist linear economy practices.

1.3 This initial period of constraint and challenge to LCT is to be expected. Only strong committed leadership can break it down across its individual, team and material factors.

Learning and growth perspective: Is the organisation developing its LCT capability and capacity at a rate appropriate to the emergency circumstances? Is it helping staff come to terms with what LCT is and how to exercise it across all levels of decision-making?

1.4 It is important to remember that success from the learning and growth perspective is the root to success in the other three. Overall, delivery to date has established a growing voluntary space for staff to develop their understanding of what LCT is, its relevance for a climate-safe future, and assemble the working knowledge to create room for it in their decision-making. This has come through expansion of the Think Green Impact programme, Green Champions' Community, the re-introduction of the new starters and new managers induction/orientation live programme, and the opportunity to establish environmental sustainability objectives within the formal Annual Development Review process.

1.5 The introduction of compulsory tender assessment criteria in procurement exercises has been the strongest regulated aspect of change. It has been taken up firmly and with a sense of leadership. Year 2 will need to see this normalised for all those constructing tender specifications and taken through into contract management in teams and departments across the Trust.

1.6 As with the stakeholder impacts, learning and growth for LCT-shaped decision-making comes up against deep-set resistance from individual social and material factors (re. Figure 5). Existing and developing actions will need to have embraced a response to all these factors. In Year 2 these responses will form the backbone of a training and learning programme to be constructed and rolled out for both internal and external use. The importance of allowing some protected learning and development time for all staff to engage with LCT and the net-zero/zero-waste challenge is also of great significance to the effectiveness of CUH's A50GP delivery.

Internal Process perspective: Is the organisation's way of working being adjusted to incorporate LCT into all its functions and delivery mechanisms?

1.7 Year 1 has seen strong progress in developing clinical procedural change. Historically this has been difficult but the launch of the Green Plan itself and the raft of engagement and communications work covered under the two previous perspectives has created new openings – especially as regards anaesthetic gases, and reusable surgical gowns. Traction here is now creating new opportunities (e.g. reusable venous tourniquets and laboratory consumables).

1.8 Embedding procedural updates to minimise carbon and waste as standard practice in all process reviews across the Trust is a core Year 2 objective. There are major opportunities to be brought forward in drinks cups, printer paper and business travel which can reach and influence all corners of the organisation.

1.9 The foundation for this change could be set on establishing a Trust policy position in response to the three questions raised in point 7.6 above:

- All CUH activities will seek to minimise energy consumption.
- All CUH activities will prioritise reusable items over single-use when it is safe to do so.
- All CUH activities will seek to find the highest value recycling route for items that must be thrown away.

Financial perspective: Are the climate-safety, resource longevity and resilience benefits of LCT activity being recognised, accounted for, and extended into all aspects of business case preparation and purchasing?

1.10 Upgrading physical infrastructure on campus to both improve energy efficiency and facilitate more active travel are both tried and tested means of lowering the CUH carbon-footprint. Both have clear approaches and will continue to be strongly sustained.

1.11 Matching these more conventional steps with investment in longer term returns has been starting to drive change in Year 1 and will be the crucial testing ground in Year 2. There are four key projects in this vein that will challenge conventional spending parameters in one way or another to actively contribute to a climate-safe future: EV charging points, on-site re-use/repair/recycling space, anaesthetic gas scavenging and containment, and renewable energy power purchase agreements.

1.12 Alongside these individual projects, the new CUH Heat Decarbonisation Plan will begin to raise similar issues in terms of the Addenbrooke's 3 master-planning process.

2. Progress against the 50 actions in the A50GP in the format of the Balanced Score Card

1. The Stakeholder perspective (12 Green Plan actions measuring & indicating change)					
Vision of success: The CUH family will be stronger, more resilient, successful and less anxious as a result of being part of the climate emergency solution rather than part of the problem. Critical success factors: ① Day-to-day awareness, recognition and trust. ② Sustained involvement. ③ Collaborative and open participation. Critical measurements: ① Levels of LCT awareness and response. ② Levels of voluntary involvement. ③ Extent of collaborative connections and networks.					
Progress key:	✓	Progress delivered	→	Progress developing	△ Under review

● **Three actions tied to engagement** of stakeholders for which strong participation and take-up rates will indicate that they are developing space and relevance for LCT.	
EN1:	**Green Plan patient and staff focus groups.**
→	Focus groups reviewing A50GP year 1 are being scheduled.
EN2:	**Day-in-the-life carbon-finding tool.**
△	The concept of a day-in-the-life carbon-finding tool is being reshaped into both an interactive graphic and associated app to demonstrate how CUH will be when running with 50% less carbon and a circular economy approach to consumption (by 2032) – LCT will be embedded in this ambition.
EN7:	**Calendar of event/promotions.**
✓	Full calendar of events/promotions strongly delivered – monthly foci with concerted period of comms activity: whole week promotions completed for A50GP, TGI, Energy and Transport.
RR1:	**Reduce clinical plastics/PPE/curtain waste**
✓	Switch to reusable surgical gowns in Rosie and ATC, trial to start in Main Theatres. Recycling of clinical curtains under renewed linen contract. Seeking approvals for re-usable venous tourniquet. 'Gloves-off' campaign in development. Top-ten clinical reusables project with UCLH/USH Trusts.
LO3:	**Tree-planting and biodiversity**
→	T2 garden complete, containerised bee-friendly units ready to roll-out.

● **Four actions tied to major infrastructure process** that are at a point in their development which actively provides LCT opportunities.	
EN6:	**Clean Air Hospital Framework.**
△	The Clean Air Hospital Framework is an extensive planning tool in itself and has, to date, proved too ambitious to develop beyond an initial overview assessment. It is likely that we will select specific clean air related actions and focus on delivering these: currently, an air quality monitoring and managing pilot has just begun for the Service Yard area.
BS8:	**Towards net-zero new build and refurbishment.**
✓	CUH has been an early adopter of the NHS Net Zero Building Standard – this has been used to successfully engage design-related stakeholders for CCH, CCRH and the new Movement Surgical Hub: the designs for all three are now well progresses as regards low-carbon delivery and net-zero enablement. New Heat Decarbonisation Plan will be integral to A3 transition.
TT6:	**Cambridge South Station.**
✓	Very positive impact for sustainable travel secured through completion of a series of formal legal licenses, agreements and plans, with pre-enablement works on site underway.
TT7:	**Sustainable travel routes.**
✓	100% completion of multiple consultations as they have come forward from public sector partnership bodies for development of more sustainable travel routes to site, e.g. GCP's "Making Connections" and other Combined Authority and County Council local transport plans.

● **Three actions where external partner** connections provide conduits in and out of the organisation for the external wider context of LCT and Trust environmental sustainability activity.	
LA4:	**Net-zero/zero-waste anchor institutions.**
→	The 'anchor institution' methodology is still under-developed – we continue to push out strongly with A50GP external local connections to raise net-zero LCT relevance with academic and public sector organisations. Need to develop stronger links for community and third sector benefits.
LA5:	**Cambridgeshire and Peterborough ICS Green Planning.**
✓	CUH is actively represented on the C&P ICS Green Plan Programme Board and within the EoE Regional Greener NHS Team. Current projects: 'gloves off' campaign; NHS Net Zero Supplier Roadmap), Judge Business School carbon accounting, sustainability clinical fellow recruitment.
AE1:	**Exercise extended producer responsibility (EPR).**
△	EPR provides a real opportunity to connect net-zero LCT relevance with CUH suppliers. To date this has been well exercised via the net-zero/social value requirements in tender exercises (RE. AE2). This is not tied to EPR regulations for which there is limited direct advice on how to exercise from the stance of a healthcare consumer.

2. The Learning & Growth perspective (10 Green Plan actions measuring & indicating change)					
Vision of success: Using LCT to reconnect, redesign and lead in sustainable healthcare practice (for a climate-safe future) makes being a part of CUH more rewarding, positive & attractive. Critical success factors: ① Driving change through training and guidance. ② Protected time to participate. ③ Supportive physical infrastructure. Critical measurements: ① Staff completing A50GP, LCT or similar e-learning. ② Small teams participating in Think Green Impact. ③ Procurers specifying for carbon & waste reduction.					
Progress key:	✓	Progress delivered	→	Progress developing	△ Under review

● **Two actions tied to the provision and completion of dedicated training modules.**	
EN3:	**Carbon literacy training.**
△	No CUH specific training as yet: complexity of pitch and relevance. Current guidance comes through 'champion' comms, induction/ADRs, TGI and Connect. Currently sign-posting staff to national ELfH content which has an introductory level plus another more relevant to management functions.
EN4:	**Net zero / zero waste e-learning module.**
→	Specific 'how-to' guide on implementing A50GP in development. Generic corporate content with bolt-on of bespoke local specialty/function aspects (to trial with Oncology and laboratories).

● **Two actions with outcomes arising from participation within networks and programmes..**	
EN8:	**Formalise Think Green Champions Network.**
✓	Over 200 members, monthly newsletters. Champions 'Plus' group established for more active members to collaborate on specific projects and opportunities.
BS8:	**Think Green Impact for small teams.**
✓	2022 programme concluded with 6 high-performing teams. Relaunched with upgraded platform as rolling programme in February – 26 teams have joined.

● **Four actions tied to the inclusion of specific promotion, guidance and subsequent responses.**	
LA1:	**New Starter/new manager net-zero/zero waste inductions.**
✓	Providing sustainability 'stall' for re-established CUH new starter induction sessions (every other Monday). Have provided input and support to participation in restarting of New Managers Orientation and existing managers development programmes.
LA2:	**Net-zero/zero waste progress in mgt. level Annual Development Reviews.**
✓	Content submitted for all staff to set an environmental sustainability objective/commitment as part of their ADR process in 2023.
BS6:	**Out of hours lights and equipment switch off check.**
✓	Security providing weekly reports of lights left on out-of-hours in non-24/7 areas, following up with Medirest cleaning service and local occupants to resolve. Great Bank Holiday Switch-off promotion over Easter weekend. New IT Sustainability Working Group (from March 23).
TT8:	**Promote salary sacrifice ultra-low/zero emission vehicles.**
✓	Promoted via contract lease-hire Advantage scheme in-line with Greener NHS guidance but not fully following direction to make EV/ULEV only option. Strong EV take-up of approx. 20%.

● **Two actions with outcomes tied to supply chain and pathways.**	
AE2:	**Supplier specifications to include net-zero/zero-waste.**
✓	Over 25 tenders developed to include 10% assessment weighing for net-zero/zero-waste contract commitments in terms of collaborative baselining for both carbon and waste with subsequent provision of an improvement implementation plan. The essential step now is to ensure this is carried through into contract management by the respective local management teams.
LO4:	**Off/In-setting by materially supporting ill-health prevention.**
△	Opportunities to work through the wider community carbon and waste reduction benefits from LCT in care pathways (from prevention to recovery) are present at the newly interconnected ICS level (e.g. heart failure and radiology pathways). There should be genuine carbon 'in-setting' options for CUH to materially contribute to out of scope community support (i.e. not within the usual operational/budget boundaries of acute secondary care) in pursuit of net-zero/zero-waste for disease prevention, treatment and recovery programmes (referred to as in-setting as it directly relates to CUH's core healthcare delivery function). However, currently there is only limited resource to co-ordinate and operationalise this potentially very strong and beneficial area of environmental sustainability activity (covering, for example, ill-health prevention measures tied to diet, air quality, active travel and domestic energy).

3. The Internal Process perspective (14 Green Plan actions measuring & indicating change)					
Vision of success: Procedures will draw better value from assets, cut out waste, reduce emissions and better satisfy staff/patients – they will be environmentally future-proofed. Critical success factors: ① All process consumption is assessed for LCT benefits. ② Local responsibility driving multidisciplinary working. ③ Support for innovation. Critical measurements: ① Process-led carbon reduction. ② Process-led waste reduction. ③ Process-led alternatives to single-use products.					
Progress key:	✓	Progress delivered	→	Progress developing	△ Under review

● **One actions tied to all internal processes.**	
EN5:	**Net-zero/zero-waste reference in all policies/procedures.**
△	Very high level policy to date: CUH corporate strategy (*Our Strategy – CUH Together 2025)*, Addenbrooke's 3 policy position commitments (net-zero carbon and high sustainability), and the A50GP itself. No mechanism yet developed for inclusion in operational level policy and procedure.

● **Four actions tied to clinical processes.**	
CP2:	**Changes in clinical practice to reduce desflurane use.**
✓	Clinical teams and leadership achieved <5% of volatile anaesthetic gas use. CUH now committed to no longer purchasing desflurane: savings equate to 252 tCO_{2e} in 2022/23.
CP3:	**Changes in clinical practice to minimise nitrous releases.**
✓	Strong MDT switching from high-waste N_2O piped network to mobile cylinders in ATC and Rosie theatres and currently under trial in Main Theatres: towards objective of all theatres accessing N_2O via mobile cylinders only. Savings (with leak remedials) of 1,666 tCO_{2e} in 2022/23
CP5:	**Alternatives to metered-dose inhalers (MDIs).**
△	Data on usage gathered from Pharmacy. Struggling to establish clinically led MDT to progress options on switch from high-carbon MDIs to DPIs and responsible disposal (Primary care lead).
RR3:	**Re-usable sharps bins.**
→	LCA option review underway against on-site incineration (initial focus on single use instruments).

● **Six actions tied to building services and management processes.**	
BS4:	**Automated energy set-points for building services.**
✓	Trial process delivered important material savings by resolving unnecessary 24/7 setting. Roll-out now underway across all BMS automated control HVAC units – with occupancy consultation. Trial to raise IT server room temp set-points successful and now being rolled out Trust-wide.
BS5:	**Manual energy set-points for building services.**
✓	Checks on locally/manually set air-conditioning schedules and temperatures now put in PPMs.
CP1:	**Negate any nitrous oxide waste in distribution**
✓	New leak-detection device used to check piped network. Subsequent remedial work significantly reduced losses. Savings: Pure N_2O >1,500 tCO_{2e}, Entonox 290t CO_{2e}. Re. action CP3: for objective to switch to mobile cylinders for pure N_2O so piped network can be decommissioned.
PI2:	**Switch to recycled paper and reducing consumption.**
✓	Trial of marginally lower cost 100% recycled paper in copiers/printers successful. Now set as default purchase and currently 75% by volume switch. Comms campaign planned on 22m sheets/annum printer paper usage.
PI3:	**Swapping out of single-use cups.**
△	Data gathered. Reusable hot drinks cup being trialled by patient catering. Switch from plastic to paper proposed for catering trolleys. Initial focus to drive down 2m polystyrene cup usage (driven back up by COVID). Promotions run in reusables for retail outlets.
PI5:	**Net zero/zero waste input to catering and cleaning.**
△	Reviewing food waste reduction in patient catering process. Contract tender postponed.

● **Three actions tied to travel and transport processes**	
TT3:	**Travel expenses for net-zero.**
→	Revised travel expenses policy drafted to prioritise low carbon options for CUH business travel.
TT4:	**Lease car policy to ensure CUH vehicles are ultra-low/zero emissions.**
→	Retender process for lease car provision is underway. This will include flexible requirement for EVs/ULEVs. Interim capacity for EV charging is being secured through planning for temporary car parks for the CCRH development (re. TT1).
AE3:	**Telemedicine to reduce patient travel.**
✓	Meeting Greener NHS target of 25% of all patient consultations. Potentially reducing patient travel by the same proportion – indicatively 2,800t CO_{2e}/annum saving over 2019/20.

4. The Financial perspective (14 Green Plan actions measuring & indicating change)						
Vision of success: Budgets will bring the impending costs of climate chaos and ecological breakdown into the present to prevent the current environmental crisis from deepening. Critical success factors: ① Longer-lasting assets with extended value. ② Resilient supply chains. ③ Cost-realism (for climate-safety). Critical measurements: ① Spend-led carbon reduction. ② Spend-led waste reduction. ③ Spend-led alternatives to single-use products.						
Progress key:	✓	Progress delivered	→	Progress developing	?	Progress uncertain

● **Three actions tied to renewable energy provision.**	
BS3:	**On-site photovoltaic solar panels (50% increase)**
✓	Current 100kWp will increase to 186kWp with opening of new Movement Surgical Hub in 2023/24 (saving in the region of 16 tCO_{2e}/annum).
PI1:	**Power purchase from Babraham P&R solar array.**
✓	Installation underway, PPA close to sign-off, switch-on due Spring 24 (saving 440 tCO_{2e}/annum).
PI4:	**Corporate renewable energy power purchase agreements (CPPAs).**
?	Additionality driven CPPAs hinge on long-term contracts, Treasury rules are currently an obstacle to this for public sector. NHSE reviewing this and options for national contract. Opening options for a commercial large-scale private-wire project currently being taken forward for CUH.

● **Three actions tied to travel and transport infrastructure provision.**	
TT1:	**Electric vehicle charging.**
→	Interim capacity being secured through temp car parks for the CCRH development. Longer term provision is anticipated to be provided in Car Park 6 (requiring networked power and car park redesign). Principal staff provision expected to be via Babraham P&R from Spring '24.
TT2:	**Switch existing vehicle fleet to ultra low/zero emissions.**
→	Retender process for lease car provision is underway. This will include flexible requirement to switch existing vehicles to EVs/ULEVs. Interim capacity for EV charging is being secured through planning for temporary car parks for the CCRH development (re. TT1 and TT4).
TT5:	**Cycle Parking.**
✓	30 new spaces provided alongside GCP project to improve security (CCTV and lighting). Additional capacity (70 spaces) installed for U2/3, plus extra capacity (20) reserved for T2 when temporary generator removed. Currently specifying 20 secure cycle lockers option.

● **Five actions tied to building services infrastructure provision.**	
BS1:	**Backlog maintenance carbon reduction options.**
?	Progress constantly made in terms of energy efficiency upgrades but very limited on decarbonisation of heating due to constraints (capacity and distribution) of existing HV network.
BS2:	**LED lighting upgrades.**
✓	Strong delivery through Salix revolving fund, capital programme & maintenance replacements. Permanent savings of 17 tCO_{2e}/annum - approximately 35% of site now upgraded to high-efficiency and high quality LED lighting.
BS7:	**Deployment of dedicated energy saving fund.**
✓	The Trust's Salix-backed revolving energy saving-fund continues to deliver significant and permanent reductions in carbon emissions and energy costs through building services upgrades. Permanent savings of 16 tCO_{2e}/annum (excluding lighting – re. action BS2).
CP4:	**Anaesthetic Gas Scavenging and containment.**
✓	Trial Entonox mobile destruction unit currently in use in The Rosie. Specification for a centralised unit is being developed. Nitrous and desflurane containment in theatres should become negligible.
RR2:	**Allocate space to support reuse/recycling.**
?	Space to hold unwanted furniture (plus other large non-clinical items) remains limited/awkward. Currently reviewing options for a dedicated repair and storage in Level 1 of the K Block.

● **Three actions tied to new build construction projects.**	
AE4:	**Modern methods of construction (MMC).**
✓	Integral and written in to the designs for Movement Surgical Hub, Cambridge Cancer Research Hospital and Cambridge Childrens' Hospital.
LO1:	**Incinerator ash recycling for concrete manufacturer (supplementary cementitious material)**
?	Limited industry traction to pursue CUH ash as an SCM to date. Reviewing option for Imperial College London material research study.
LO2:	**Carbon storage via building materials: timber construction.**
?	Little or no direct take-up in new build/major refurbishment projects due to potential fire-risk (HSE 2010). New guidance from Structural Timber Association to be reviewed.

Board of Directors

Cambridge University Hospitals
NHS Foundation Trust

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Report to the Board of Directors: 10 May 2023

Agenda item	13
Title	Research and Development
Sponsoring executive director	Ashley Shaw, Medical Director
Author(s)	John Bradley, R&D Director
Purpose	To provide an update on Research and Development activity
Previously considered by	Management Executive, 4 May 2023

Executive Summary

This report from the Research Board of Cambridge University Hospitals NHS Foundation Trust provides the Board of Directors with a summary of issues relating to strategy, governance, performance and outputs.

Related Trust objectives	Improving patient care Building for the future
Risk and Assurance	The report is the main source of assurance on governance issues relating to Research and Development.
Related Assurance Framework Entries	BAF ref: 012
Legal / Regulatory / Equality, Diversity & Dignity implications?	There are no new legal/regulatory/ equality and diversity/dignity implications.
How does this report affect Sustainability?	n/a

Does this report reference the Trust's values of “Together: safe, kind and excellent”?	n/a

Action required by the Board of Directors

The Board is asked to receive the report.

Cambridge University Hospitals NHS Foundation Trust

10 May 2023

Board of Directors

Research and Development

John Bradley, Director of R&D

1. Clinical Trials

1.1 The National Institute for Health and Care Research (NIHR) Clinical Trials Unit Standing Advisory Committee congratulated the Cambridge Clinical Trials Unit on its activity during 2021-2022, and has maintained funding at its current level for 2023. This is against the background of the 'Reset' process, launched in March 2022, to help recover the UK's capacity to deliver clinical research in the context of the challenges facing the NHS due to the pandemic. While activity for academic research supported by the Clinical Trials Unit is recovering, commercial contract research is not recovering at the same rate as non-commercial, and sponsors have been asked to expedite the setup and delivery of commercial contract studies.

2. NIHR Cambridge Biomedical Research Centre and Clinical Research Facility

2.1 NIHR have arranged to visit the NIHR Cambridge Biomedical Research Centre and NIHR Clinical Research Facility on 20 June 2023.

2.2 The International Scientific Advisory Board will be reviewing the re-designated Biomedical Research Centre on Thursday 25 and Friday 26 April 2024.

3. NIHR BioResource

3.1 Cambridge University Hospitals hosts the NIHR BioResource, one of four key infrastructures supporting population level genomic projects in the Life Science Industrial Strategy.

3.2 The NIHR BioResource has entered into a contract with Oxford Nanopore to undertake long read sequencing on patients recruited to the BioResource, including those with rare diseases and eating disorders, and volunteers recruited to the Genes and Cognition BioResource.

3.3 Plans are advanced for the national launch of D-CYPHR, the Children's and Young People's BioResource in June 2023.

4. Health Data Research

Secure Data Environment for Research and Development

4.1 The Outline Business Case for an East of England Sub-National Secure Data Environment for Research and Development (SNSDE for R&D) was submitted at the end of March 2023, with Cambridge University Hospitals as the lead accountable organisation. This seeks to develop a minimal viable product with an initial focus on cardiovascular disease, reflecting the health and care priorities of Integrated Care Systems across the East of England.

Bloodcounts

4.2 The Bloodcounts project, sponsored and led by Cambridge University Hospitals and the University of Cambridge, builds on work undertaken using the EpiCov database that used machine learning to demonstrate that a signal could be derived from population-scale full blood count data corresponding to the SARS-CoV-2 outbreak in Cambridgeshire. Bloodcounts aims to develop Artificial Intelligence (AI) and machine learning-based models, which use data from full blood count tests for disease detection. The full blood count is the world's most common medical test and is performed one million times annually at Cambridge University Hospitals. Bloodcounts is a partnership with University College London Hospitals (UCLH) and NHS Blood and Transplant (NHSBT) and an international BloodCounts! Consortium, which links leading academic hospitals (University Medical Center Amsterdam; KU Leuven, Belgium; SingHealth, Singapore; MRC The Gambia, among others) with industry partners in nine countries

5. Cambridge led Covid-19 clinical trials

5.1 **PROTECT-V** (PROphylaxis for vulnerable paTiEnts at risk of Covid-19 infecTion) – Chief Investigator Rona Smith is evaluating the use of agents to prevent Covid-19 in vulnerable patients, including kidney patients on dialysis or receiving immunosuppression for a renal transplant. The study is a ‘platform trial’, which allows new drugs to be added.

5.2 The first drug to be evaluated is niclosamide, a drug used to treat intestinal worms, which has shown activity against SARS-CoV-2 in the laboratory and is being delivered as a nasal spray. Sotrovimab, a fully humanised neutralising monoclonal antibody directed against the spike protein of SARS-CoV-2 was added in 2022.

5.3 1,653 patients were randomsied in the niclosamide arm of the study, and follow up has been completed and data analysis is underway. The results will be presented as a late breaking clinical trial presentation at the European Renal Association meeting in Milan in June. Recruitment to the sotrovimab arm is ongoing.

6. Recommendations

6.1 The Board of Directors is asked to receive the report.

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

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Report to Board of Directors: 10 May 2023

Agenda item	14
Title	Learning from Deaths Quarterly Report
Sponsoring executive director	Ashley Shaw, Medical Director
Author[s]	Amanda Cox, Deputy Medical Director Chris Edgley, Patient Safety Lead
Purpose	To receive the quarterly report
Previously considered by	Management Executive, 4 May 2023

Executive Summary

Between January 2023 and March 2023 [Q4], there were 496 deaths; of these 48 [10%] were in the Emergency Department, the remainder were inpatient deaths.

- 20% [100/496] met the criteria for a Structured Judgement Review [SJR] during Q4.
- 3% [3/100] of the SJRs completed within Q4 identified significant problems in care [scores 1-3].

Between January 2023 and March 2023, there were three serious incidents in relation to an unexpected/potentially avoidable death reported to the commissioners. There have been no Prevention of Future Deaths ordered between January 2023 and March 2023.

On a quarterly basis, representatives from across the system are invited to join the Learning from Deaths Committee. This includes CPFT, CCG, East of England Ambulance Trust, Royal Papworth and the Senior Coroner for Cambridgeshire and Peterborough with the focus on developing reliable and robust pathways to share learning both within and across organisational boundaries.

Related Trust objectives	Improving patient care
Risk and Assurance	The report provides assurance on the arrangements in place to ensure learning from deaths.
Related Assurance Framework Entries	n/a
Legal implications/Regulatory requirements	n/a
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of “Together: safe, kind and excellent”?	n/a

Action required by the Board of Directors
The Board is asked to receive the learning from deaths report for 2022/23 Q4.

Cambridge University Hospitals NHS Foundation Trust

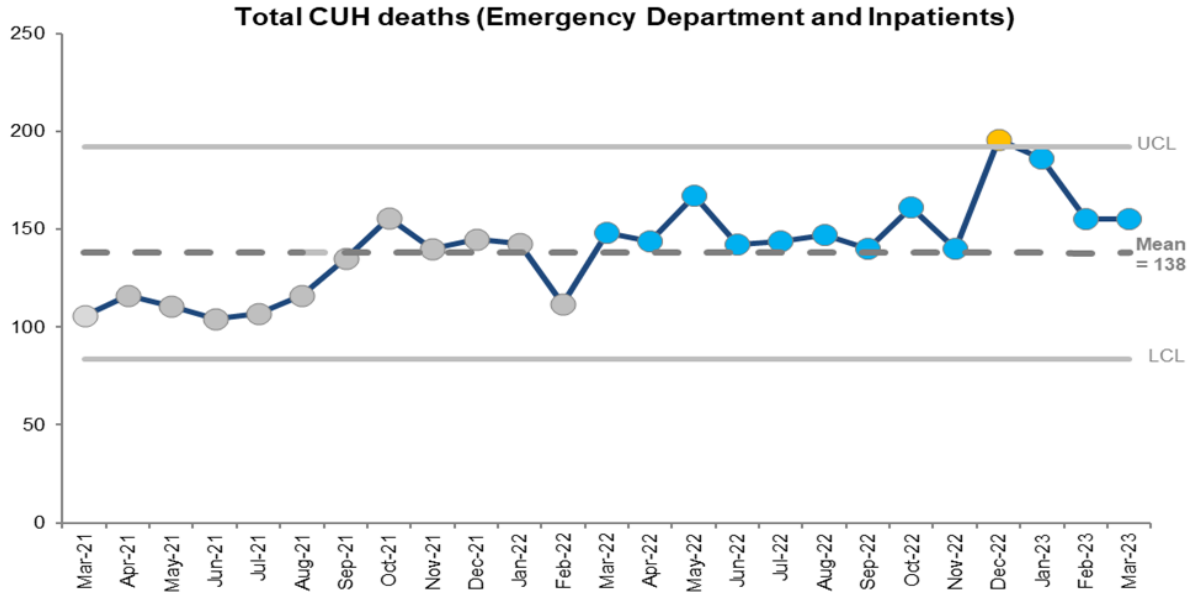
10 May 2023

Board of Directors
Learning from Deaths Quarterly Report

1. Number of deaths in quarter

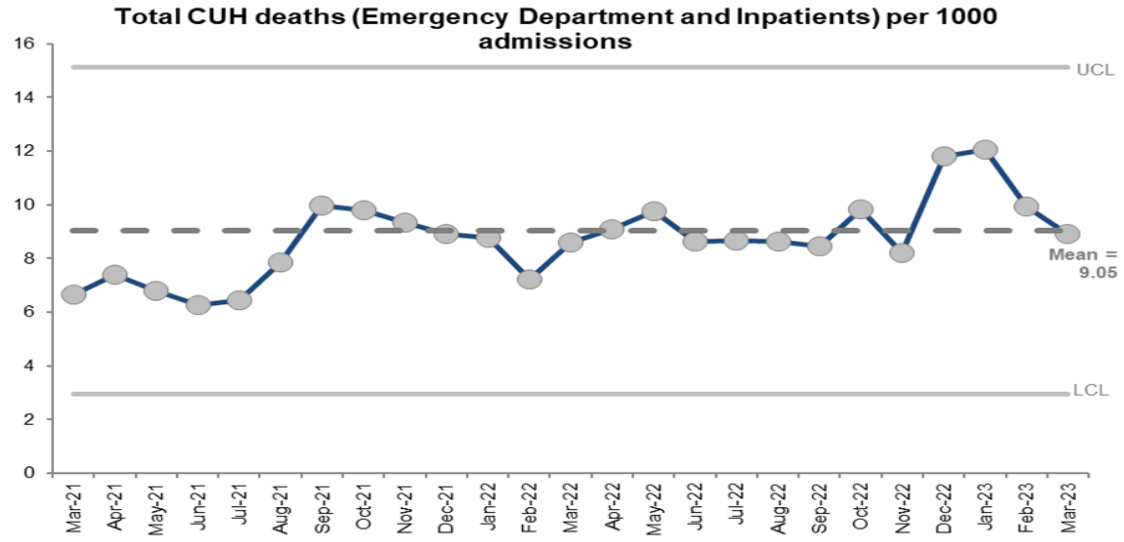
There were 496 deaths between January 2023 and March 2023 [Q4] [Emergency Department [ED] and inpatients], of which 20% [100/496] were in the ED and 80% [396/496] were inpatient deaths.

Graph 1 shows total CUH deaths [inpatients and ED] that have been recorded on Epic from March 2021 to March 2023. The data is within normal variation range.

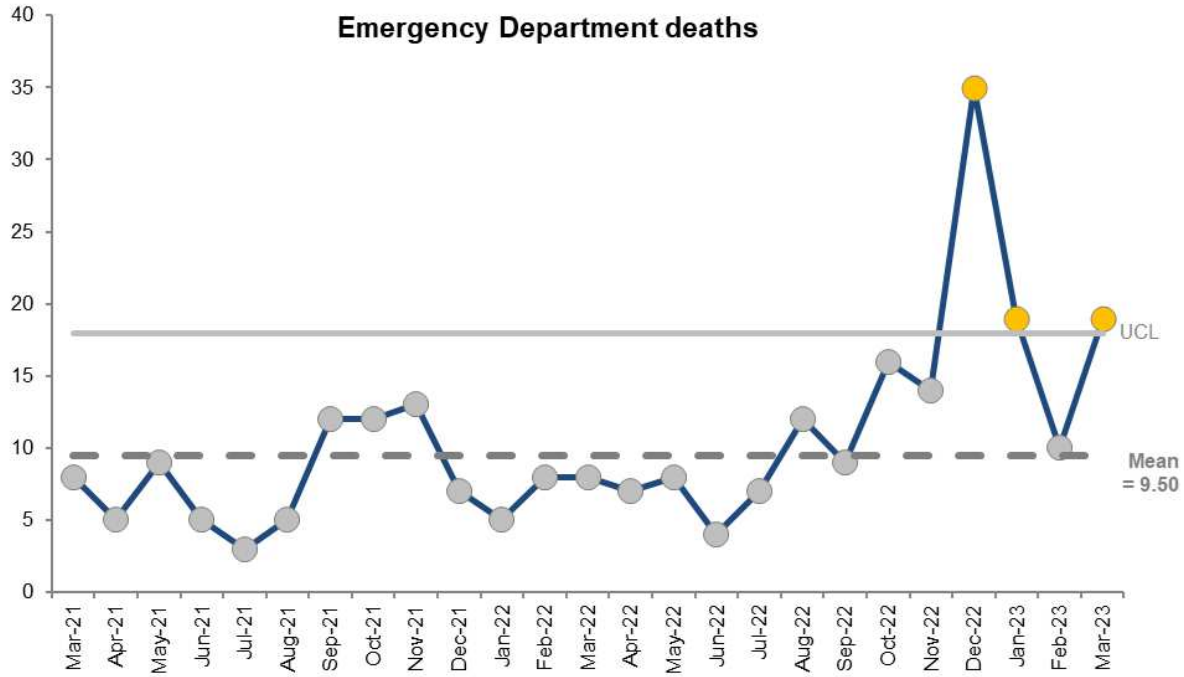


***Please note: outlying data points are highlighted in yellow, and shifts and trends in the data are in blue.*

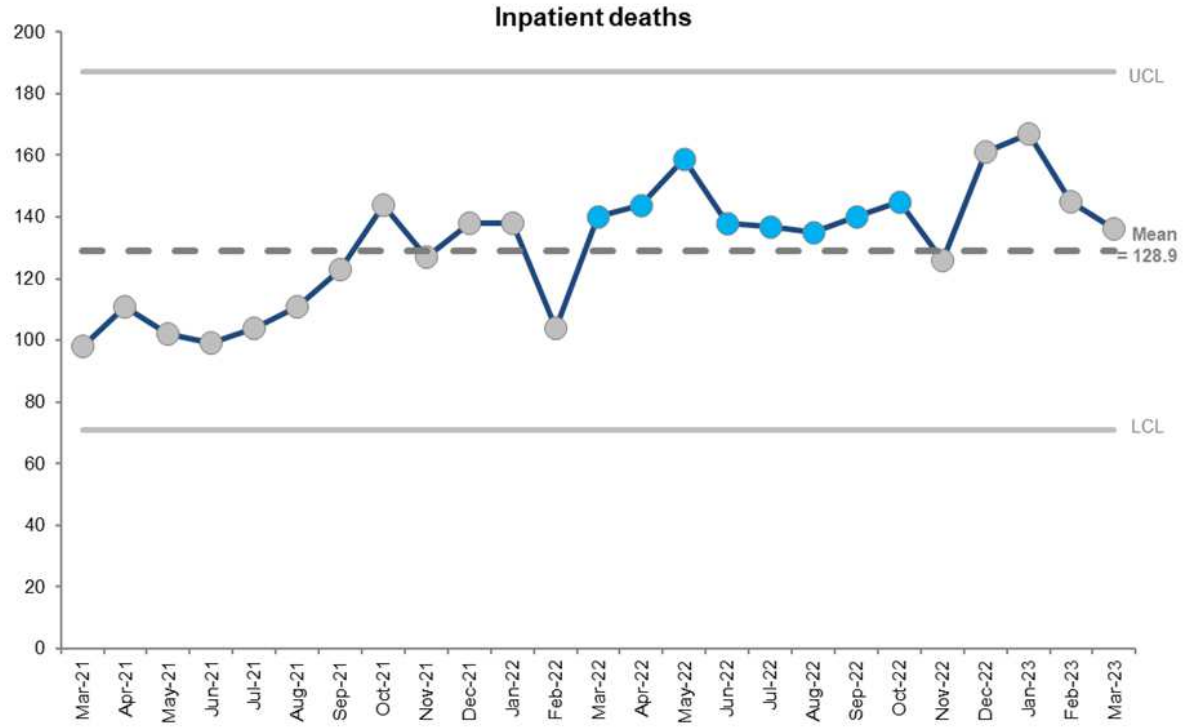
Graph 2 demonstrates total CUH deaths per 1,000 admissions that have been recorded on Epic from March 2021 to March 2023.



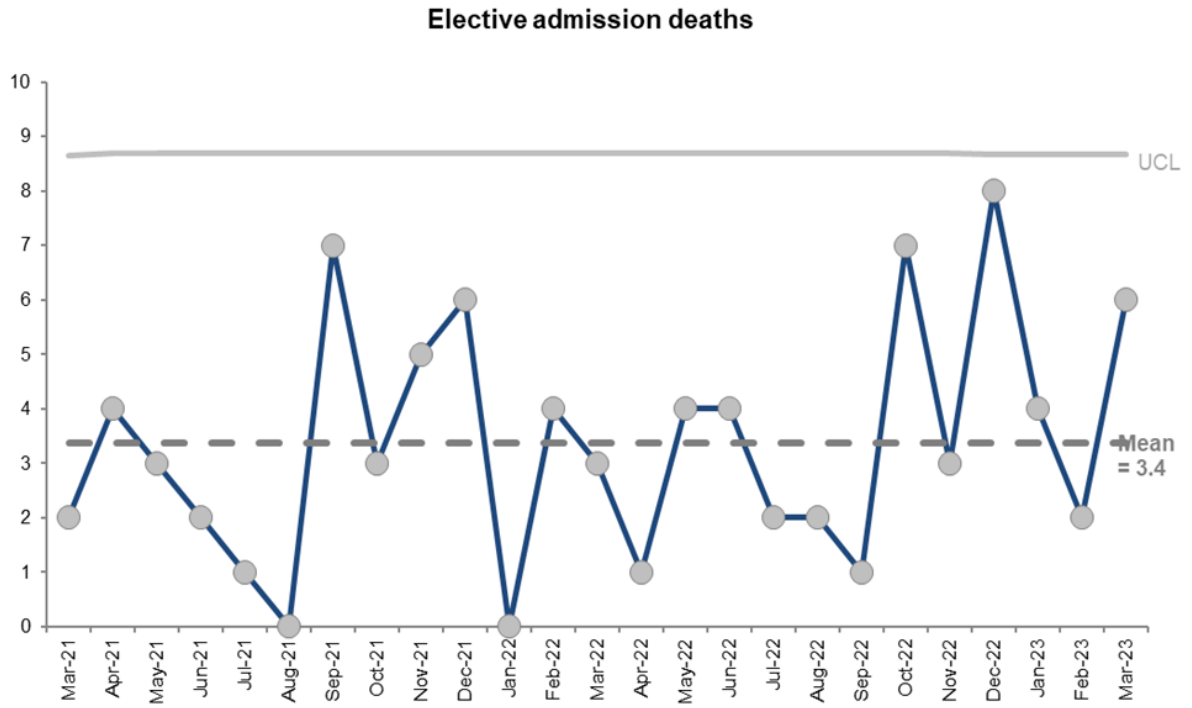
Graph 3 shows Emergency Department deaths only, from March 2021 to March 2023.



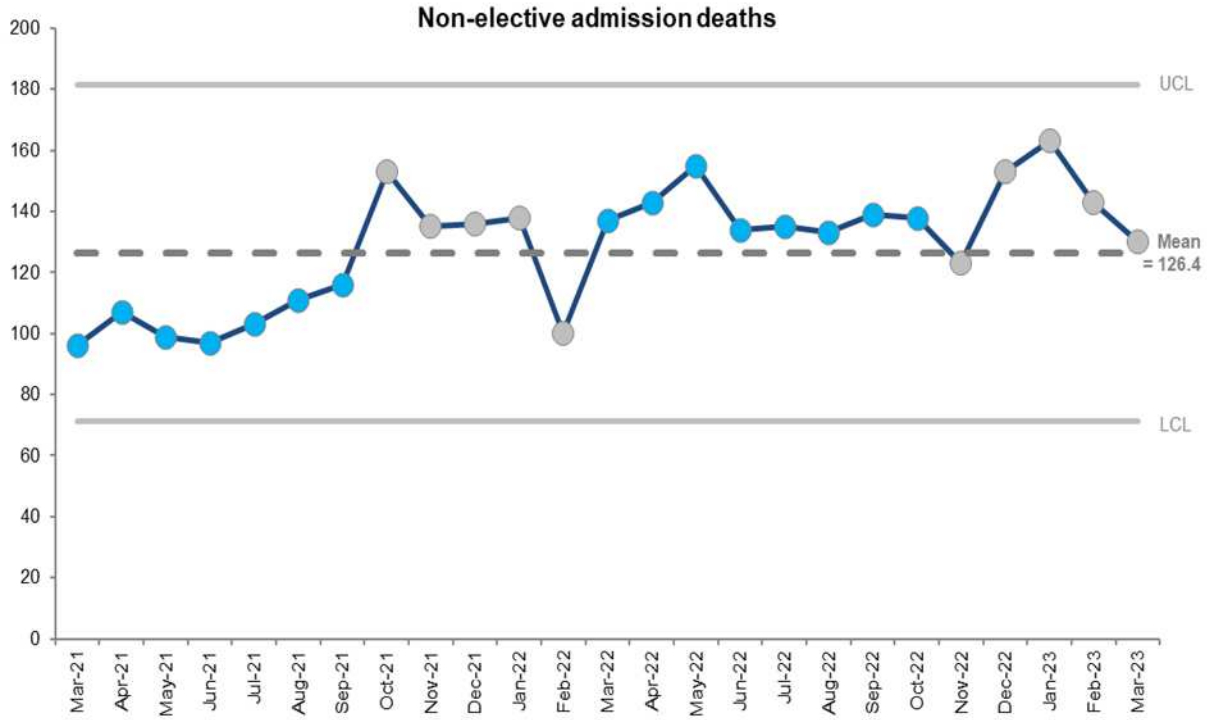
Graph 4 shows inpatient deaths only, from March 2021 to March 2023. There is currently normal variation in the number of inpatient deaths.



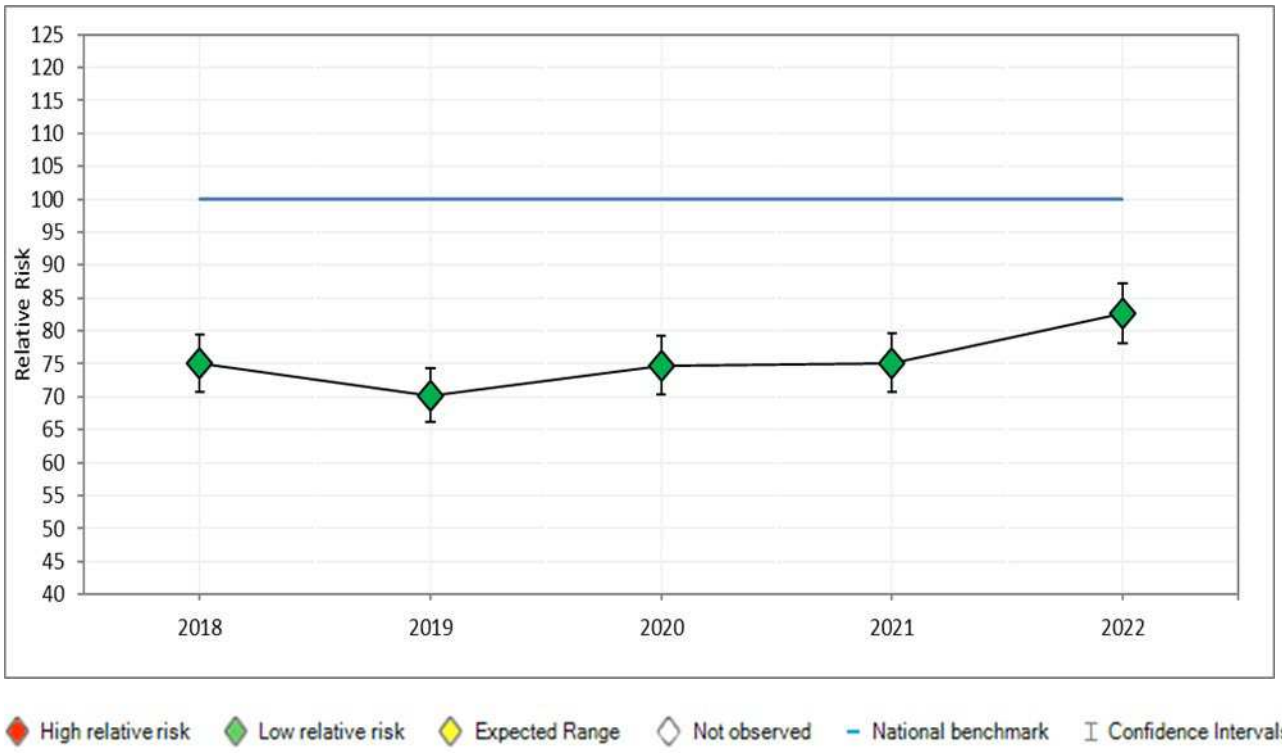
Graph 4a shows inpatient elective admission deaths only, from March 2021 to March 2023. There is currently normal variation in the number of inpatient elective admission deaths.



Graph 4b shows inpatient deaths in a non-elective admission from March 2021 to March 2023 and it is currently within normal variation.



Graph 5 displays the latest Hospital Standardised Mortality Ratio [HSMR] figures by month from January 2018 to December 2022.



2. Mortality case review process – Structure Judgement Review [SJR]

The table below shows a summary of learning from deaths key performance indicators [KPIs] in Q4 of 2022-2023 financial year

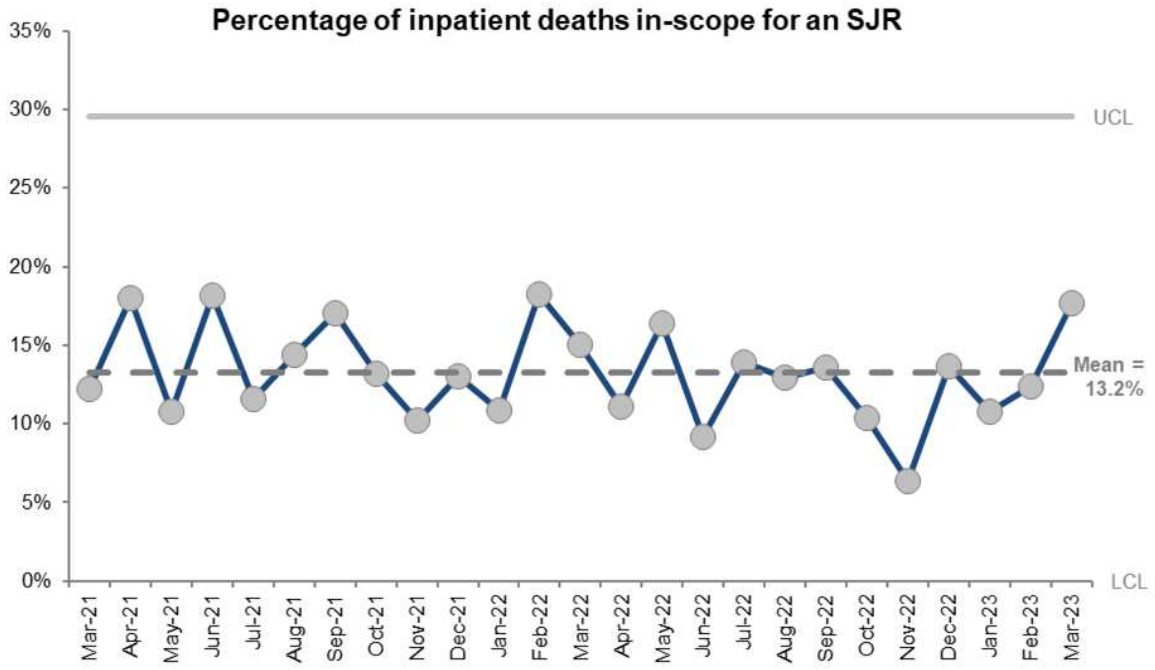
KPI	No. of deaths in month	No. of deaths in-scope	Compliance with SJRs		Problems in Care Identified [score 1-3]	Serious Incidents triggered by SJRs	% of problems in care (by deaths 'in scope')		% of all deaths with problems in care (by total deaths in month)		SJRs triggered by family / carers	PFD issued to CUH
			Number received	Number due			Month	Quarter	Month	Quarter		
Jan-23	186	36	51% 19 37		1	2	5% 1 19	7% 3 45	0.5% 1 186	3 496	0	0
Feb-23	155	28	52% 14 27		0	0	0% 0 14		0.0% 0 155		0	0
Mar-23	155	36	33% 12 36		2	2	17% 2 12		1.3% 2 155		0	0

3. Structured judgement review [SJR] compliance

3.1. Deaths in-scope

Between January 2023 and March 2023, 20% [100] of patient deaths met the in-scope criteria for a structured judgement review.

Graph 6 shows the percentage of *inpatient* deaths that are in-scope for an SJR over time from March 2021 to March 2023. There is currently normal variation.



Of the 100 in-scope deaths identified in Q4, 45% of SJRs [45/100] have been completed to date. The compliance figures for each division are shown in the table below.

KPI	SJR + PMRT compliance by timeframes	A	B	C	D	E
Jan-23	51% [19/37]	40% [2/5]	33% [2/6]	78% [14/18]	20% [1/5]	0% [0/3]
Feb-23	52% [14/27)	50% [2/4]	50% [1/2]	75% [9/12]	100% [1/1]	0% [1/7]
Mar-22	33% [12/36]	0% [0/3]	0% [0/1]	53% [10/19]	40% [2/5]	0% [0/8]

N.B The updated Learning from death policy sets a SJR completion compliance threshold of 75%.

4. Serious Incidents [SIs] following Structured Judgement Review [SJR]

4.1. SI investigations commissioned between January 2023 – March 2023

There have been three SIs commissioned in relation to an unexpected death between January to March 2023.

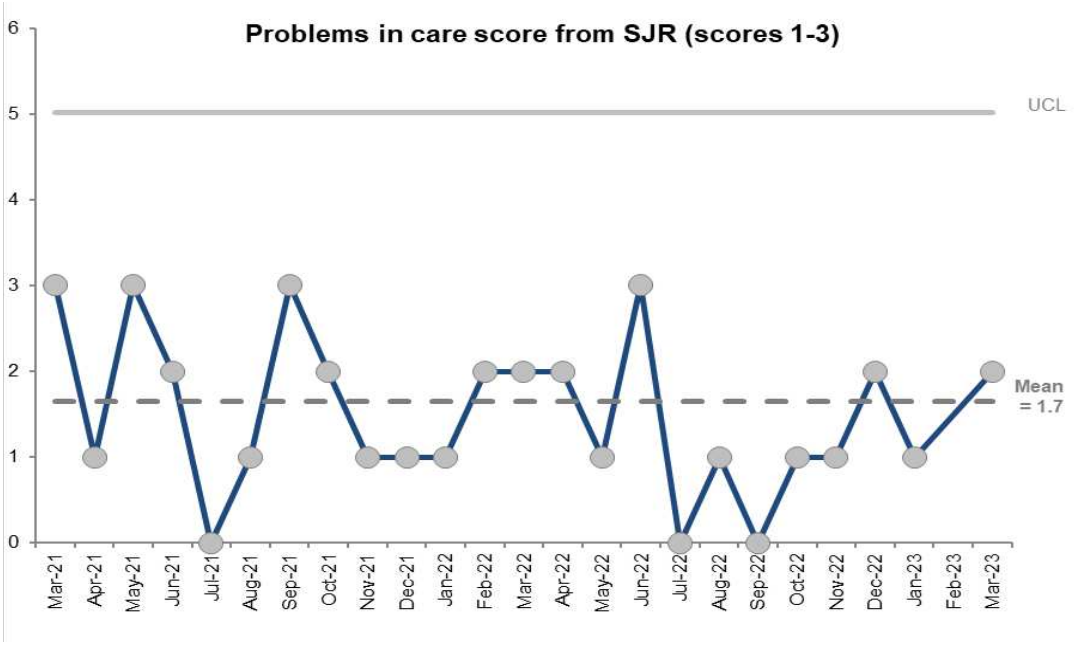
4.2. Structured Judgement Review problems in care scores

Three SJRs have highlighted less than satisfactory care between January 2023 and March 2023. All three SJRs are being investigated as Serious Incidents. These SJRs will be shared with the Coroner for information following completion of the Serious Incident Investigation.

The percentage of deaths with problems in care [scores1-3] identified through the SJR process, from January 2023 - March 2023 is 3% [3/100]. The distribution of these scores are shown in the table below:

	Poor quality of care [1]	Less than satisfactory [2]	Room for improvement [3]	Room for improvement [4]	Room for improvement [5]	Good practice [6]
	Multiple aspects of clinical &/or organisational care that were well below what you consider acceptable.	*Several aspects of clinical &/or organisational care that were well below what you consider acceptable*	*Aspects of both clinical and organisational care that could have been better.*	*Aspects of organisational care that could have been better and may have had an impact on the patient's outcome.*	*Aspects of clinical care that could have been better but not likely to have had an impact on the outcome.*	*A standard that you consider acceptable.*
Jan-23	0	0	1	0	3	14
Feb-23	0	0	0	1	4	7
Mar-23	0	1	1	2	2	4

Graph 7 shows the number of SJRs with problems in care score of 1-3 from March 2021 to March 2023. There is currently normal variation.



5. Structured judgement reviews triggered by family/carers

There were no SJRs initiated by family/carers concerns between January 2023 and March 2023.

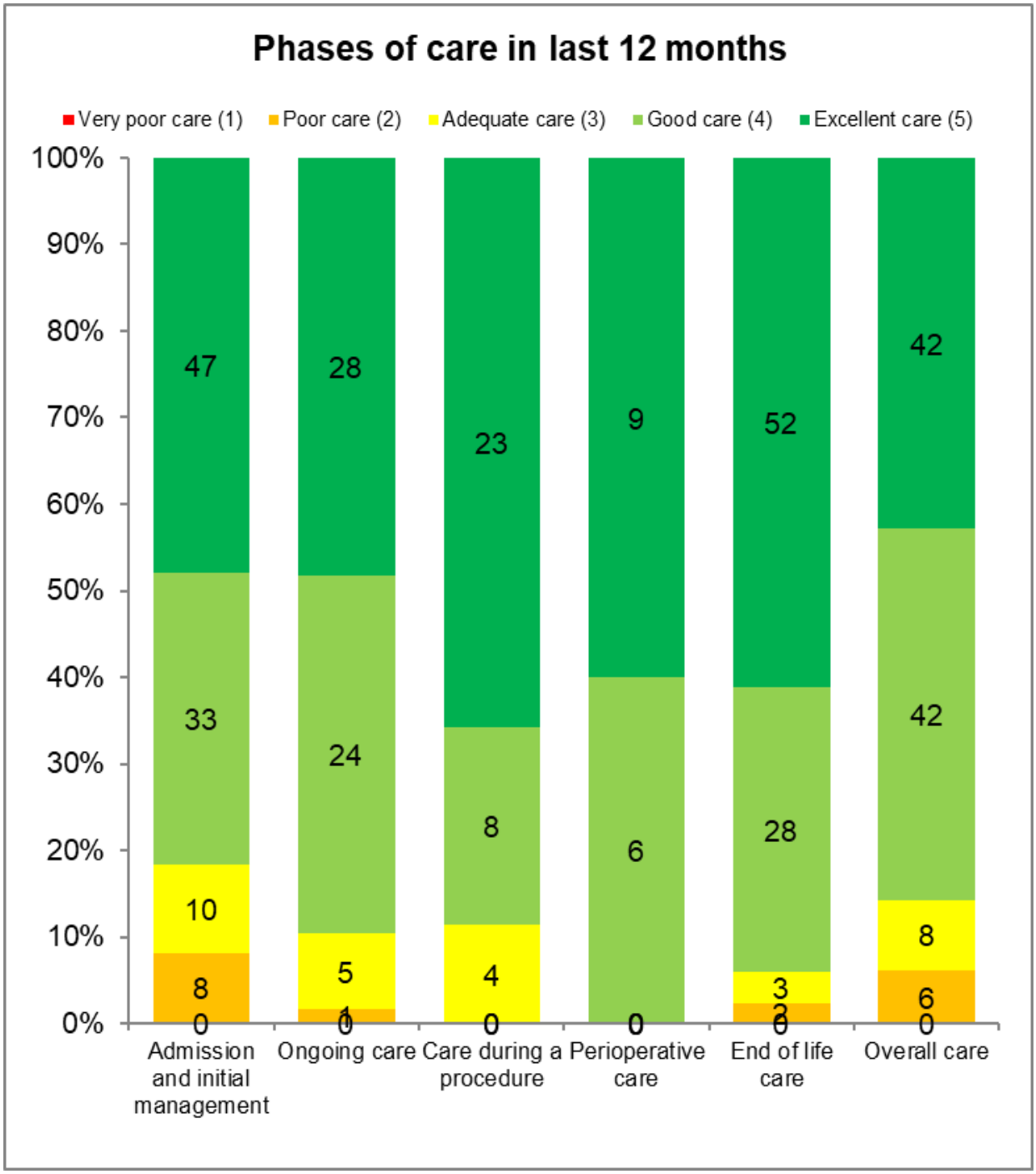
6. Prevention of future death reports issued to Cambridge University Hospitals

There have been no Prevent Future Death reports issued to CUH in this quarter.

7. Learning

7.1. Learning from phases of care

Scores allocated to each of the phases of care are displayed in the graph below for all completed SJRs between April 2022 to March 2023:



N.B. Poor care does not automatically indicate the problems in care score allocated.

8. Learning from deaths improvement plan

The Quality Improvement Plan for the last financial year came to its end in Q4 [2021-2022], with some actions still outstanding. The QI plan is currently under review by the Mortality Improvement Group.