Board of Directors

Cambridge University Hospitals
NHS Foundation Trust

Together
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Kind
Excellent

There will be a meeting of the Board of Directors in public on Wednesday 9 November 2022 at 11.00

This meeting will be held by videoconference.
Members of the public wishing to attend the virtual meeting should contact the Trust Secretariat for further details (see further information on the Trust website)

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

AGENDA

General business			Purpose
11.00	**1**	**Welcome and apologies for absence**	For note
	2	**Declarations of interest** To receive any declarations of interest from Board members in relation to items on the agenda and to note any changes to their register of interest entries A full list of interests is available from the Director of Corporate Affairs on request	For note
	3*	**Minutes of the previous Board meeting** 3.1 To approve the Minutes of the Board meeting held in public on 12 October 2022 3.2 To approve the Minutes of the Annual Public Meeting held on 28 September 2022	For approval
	4*	**Board action tracker and matters arising not covered by other items on the agenda**	For review
11.05	**5**	**Staff story** To hear a staff story	For receipt

11.20	**6***	**Chair's report** To receive the report of the Chair	For receipt
11.25	**7***	**Report from the Council of Governors** To receive the report of the Lead Governor	For receipt
11.30	**8***	**Chief Executive's report** To receive the report of the Chief Executive	For receipt
Performance, strategy and assurance			**Purpose**
11.40	**9***	**Performance reports** *The items in this section will be discussed with reference to the Integrated Report and other specific reports* 9.1* Finance 9.2 Improvement 9.3 Access standards 9.4 Workforce 9.5* Quality (including nurse staffing report)	For receipt
12.15	**10***	**Biannual nursing and midwifery establishment update** To receive the report of the Chief Nurse	For receipt
12.20	**11***	**Reading the Signals, Maternity and Neonatal Services in East Kent** To receive the report of the Chief Nurse	For receipt
12.35	**12***	**Strategy update** To receive the report of the Interim Director of Strategy and Major Projects	For receipt
12.40	**13***	**Workforce Race Equality and Workforce Disability Equality Schemes** To receive the reports of the Director of Workforce	For receipt
12.55	**14***	**Education, learning, training and development** To receive the report of the Director of Workforce	For receipt
13.05	**15***	**Learning from deaths** To receive the report of the Medical Director	For receipt
13.10	**16***	**Board Assurance Framework and Corporate Risk Register** To receive the report of the Director of Corporate Affairs and Chief Nurse	For receipt

Items for information/approval – not scheduled for discussion unless notified in advance			
13.15	**17***	**Risk Management Strategy and Policy** To receive the report of the Chief Nurse	For approval
	18*	**Board assurance committees – Chairs' reports** 18.1 Workforce and Education Committee: 20 September 2022 18.2 Addenbrooke's 3 Committee: 28 September 2022 18.3 Performance Committee: 2 November 2022 18.4 Quality Committee: 2 November 2022	For receipt
Other items			**Purpose**
	19	**Any other business**	
13.20	**20**	**Questions from members of the public**	
	21	**Date of next meeting** The next meeting of the Board of Directors will be held on Wednesday 19 January 2023 at 11.00.	For note
	22	**Resolution** That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (NHS Act 2006 as amended by the Health and Social Care Act 2012).	
13.30	**23**	**Close**	

NHS
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Minutes of the meeting of the Board of Directors held in public on Wednesday 12 October 2022 at 11.00 via videoconference

Member	Position	Present	Apologies
Dr M More	Trust Chair	X	
Mr D Abrams	Non-Executive Director	X	
Dr E Cameron	Director of Improvement and Transformation	X	
Ms N Ayton	Chief Operating Officer	X	
Mr A Chamberlain	Non-Executive Director		X
Dr A Doherty	Non-Executive Director	X	
Prof I Jacobs	Non-Executive Director	X	
Mr M Keech	Chief Finance Officer	X	
Mr N Kirby	Interim Director of Strategy and Major Projects	X	
Ms A Layne-Smith	Non-Executive Director	X	
Prof P Maxwell	Non-Executive Director	X	
Prof S Peacock	Non-Executive Director		X
Dr A Shaw	Medical Director	X	
Mr R Sinker	Chief Executive	X	
Mr R Sivanandan	Non-Executive Director	X	
Ms L Szeremeta	Chief Nurse	X	
Mr I Walker	Director of Corporate Affairs *	X	
Mr D Wherrett	Director of Workforce	X	

** Non-voting member*

In attendance	Position
Ms M Abbot	Deputy Divisional Head of Nursing, Division B (Item 85/22 only)
Ms S Goodwin	Breast Cancer Nurse Specialist (Item 85/22 only)
Dr J MacDougall	Guardian of Safe Working (Item 92/22 only)
Dr C Ramus	Junior Doctors' Forum Co-Chair (Item 92/22 only)
Dr N Stutchbury	Lead Governor
Ms C Collick	Secretariat Officer (minutes)

81/22 Welcome and apologies for absence

The Chair welcomed everyone to the meeting and noted that, following the death of Her Majesty Queen Elizabeth II, and in line with NHS England guidance, the Board meeting in public which had been due to take place on 14 September 2022 had been postponed. This meeting was being held

in place of the September 2022 meeting. The Board would meet again in public in November 2022.

Apologies for absence are recorded in the attendance summary.

82/22 Declarations of interest

Standing declarations of interest of Board members were noted.

83/22 Minutes of the previous meeting

The minutes of the Board of Directors' meeting held in public on 13 July 2022 were approved as a true and accurate record.

84/22 Board action tracker and matters arising not covered under other agenda items

Received and noted: the action tracker.

85/22 Patient story

Lorraine Szeremeta, Chief Nurse, Marie Abbott, Deputy Divisional Head of Nursing (Division B), and Sian Goodwin, Breast Cancer Nurse Specialist, introduced the patient story. The video told the story of Debbie, a staff member, who been diagnosed with breast cancer and undergone treatment at Addenbrooke's Hospital.

Following the presentation of the patient story, the following points were made in discussion:

1. It was noted that Debbie had contacted the Chief Executive and the Chief Nurse to highlight her concerns regarding aspects of the operation of the Day Surgery Unit and infection control arrangements due to changes made during the pandemic. As a result, a review of the Unit had been conducted and a number of actions had been taken to improve the environment and address the concerns raised, including in relation to crowding and cleanliness.
2. A number of the pandemic-related restrictions highlighted in the story, including patients being unable to be accompanied to appointments, had since been relaxed.
3. As part of quality assurance and to improve patient experience, matrons regularly visited clinical areas and reviewed patient feedback, including Friends and Family Test scores.

Agreed:
1. To thank Debbie for having shared her story.
2. To note the patient story.

86/22 Chair's report

Mike More, Chair, presented the report. There were no specific items to which the Chair drew the attention of Board members.

Received and noted: the report of the Chair.

87/22 Report from the Council of Governors

Neil Stutchbury, Lead Governor, presented the report.

Noted:
1. The Lead Governor had attended a meeting of regional Lead Governors on 29 September 2022. The aim of these meetings was to discuss issues of common interest and share best practice. The meeting had included a discussion of working arrangements between Boards of Directors and Councils of Governors and the Lead Governor commented on what he regarded as the positive and open relationship between the CUH Board and Council.
2. A meeting of the Lead Governors of North West Anglia NHS Foundation Trust, Cambridge and Peterborough NHS Foundation Trust, Royal Papworth Hospital NHS Foundation Trust and CUH had taken place on 5 October 2022. This had included preparation for a forthcoming meeting of all governors with the Chair of the Cambridgeshire and Peterborough Integrated Care Board (ICB).

Agreed:
1. To note the activities of the Council of Governors.

88/22 Chief Executive's report

Roland Sinker, Chief Executive, presented the report.

Noted:
1. The health and care system nationally, regionally and locally remained under extreme pressure. The NHS continued to experience significant staffing pressures and increased demand for services.
2. The Trust was planning to mobilise for the fourth time since February 2020 in order to manage the forthcoming winter. This would include applying the lessons learnt from the pandemic to the Winter Plan and ensuring it was appropriately resourced and governed.
3. It was planned to undertake a governance review in the coming months to ensure that appropriate arrangements remained in place for the

effective governance of the Trust. This would also include producing an updated self-assessment of compliance against the domains of the Care Quality Commission's inspection framework.
4. Work continued on the implementation of the refreshed Trust strategy through 15 programmes of work to improve patient care, support staff and build for the future. The timeline for the implementation plan was being reviewed and prioritised alongside the Winter Plan.

The following points were made in discussion:

1. Board members recognised the major challenges faced by the health and care system and the complex range of factors that would impact on delivery during the winter period. The Chief Executive acknowledged how challenging the circumstances were but felt that the Trust remained as well placed as it could be to face these pressures.

Agreed:
1. To note the contents of the report.

89/22 Performance reports

Quality (including nurse staffing report)

Lorraine Szeremeta, Chief Nurse, and Ashley Shaw, Medical Director, presented the update.

Noted:
1. At its meeting in September 2022, the Quality Committee had discussed the pressures faced by the organisation and how these were being reflected in quality metrics.
2. There had been a recent increase in hospital-acquired pressure ulcers. Thematic reviews had identified issues with the assessment of patients at risk of skin damage related to training of new nurses. Action had been taken to revert to pre-Covid orientation and training levels for nurses new to the organisation.
3. Pressures on the Patient Advice and Liaison Service (PALS) remained a concern. Complaints continued to increase and the service had needed to reduce opening hours to deal with the backlog.
4. Staffing remained a challenge with the availability of nurses a concern, particularly in critical care units, including the paediatric intensive care unit and the neonatal intensive care unit. This continued to result in breaches of intensive case staffing ratio standards.
5. Staffing challenges had resulted in increased use of agency staff. Staff were moved on a daily basis to maintain the safest possible position.
6. There had been a number of maternity service diverts due to staffing and capacity challenges.
7. In May 2022, the Hospital Standardised Mortality Ratio (HSMR) had increased to over 100. However, the number of deaths within the organisation and the rate of deaths per 100,000 patients had not

changed. The data had been reviewed in detail with Dr Foster and the increase appeared likely to have been due to patient mix and coding issues. Figures for June 2022 had returned to within normal variance.

8. An increase in Covid-19 infection rates had been seen within the community and among Trust inpatients. It was noted that Covid-19 positive inpatients were generally not significantly unwell due to Covid-19 and the vast majority were in hospital for other conditions.
9. The Trust had changed its approach to cohorting of Covid-19 patients to make greater use of side rooms and bays rather than dedicated Covid wards. This reflected the assessment of the balance of risks and the safety benefits of patients remaining with the relevant specialty medical and nursing teams.
10. The rollout of the staff vaccination programmes for flu and Covid-19 had commenced.
11. The Trust had received positive feedback on the outcomes for the bone marrow transplantation service. The first-year successful outcome rate for use of CAR T-cell therapy was 76%, compared with a national average of 59%.
12. An amber national alert had been issued regarding a shortage of red blood cells. This would impact on elective surgery priority three and four patients with a 20% or greater likelihood of requiring blood during their procedures. The national shortage was not anticipated to affect cancer, urgent and life-saving operations.

Workforce

David Wherrett, Director of Workforce, presented the update.

Noted:

1. UNISON and the Royal College of Nursing were balloting members on potential industrial action. Planning would be undertaken to minimise any impact on patient care.
2. The Trust had set out five workforce ambitions: Good Work, Resourcing, Ambition, Inclusion and Relationships. Six initial priority areas under the Good Work agenda were highlighted as:
    - Accommodation
    - Travel and transport
    - Nourishment and hydration
    - Spaces
    - Hybrid working
    - Market focus – cost of living and working in Cambridge
3. Administrative staffing levels were showing some improvement. However, the Trust continued to face challenges to recruit at the required pace to maintain the pipeline.
4. The lack of availability and affordability of accommodation for staff continued to be a significant concern, limiting the Trust's current ability to recruit overseas. Work to secure additional accommodation continued.
5. National cost of living pressures were also a major concern. There had been an increase in the number of staff seeking and accessing support.

The Trust had updated its signposting to sources of financial support and staff benefits to help staff experiencing financial hardship. In total, around 10% of staff had withdrawn from the pension scheme, with a high number citing affordability as a reason.

Access standards

Nicola Ayton, Chief Operating Officer, presented the update.

Noted:

1. August 2022 data demonstrated good progress in reducing the number of long-waiting elective patients, with a target to eliminate over-78 weeks by the end of March 2023. Cardiology, Rheumatology and ENT require additional support to meet the target, including from other trusts locally and regionally.
2. In August 2022 new outpatient activity was 108% of the pre-Covid baseline.
3. Overall performance against cancer waiting time standards continued to be favourable in comparison to regional and national peers. Skin cancer diagnosis and treatment was a particular area of focus, with increases in the number of patients on the dermatology two-week wait pathway being seen nationally.
4. Significant pressures on the non-elective inpatient bed base continued, affecting the ability to provide timely, accessible and safe emergency care.
5. Core metrics for Urgent and Emergency Care (UEC) showed a significant improvement in August 2022 compared with July 2022. The number of ambulances waiting over 60 minutes had reduced to 4%, compared to the regional average of 16% and the national average of 11%. 12-hour waits in the Emergency Department were 13% in August 2022, down on July 2022 but above the regional average of 11% and the national average of 8%.
6. UEC performance had, however, deteriorated in September and early October 2022.
7. A Winter Plan had been developed, the implementation of which would be overseen by the Trust's Winter Taskforce. The Plan incorporated a range of workstreams including on additional capacity (on-site and outside of the hospital), patient flow, staffing, infection prevention and control, cost of living, and communications and engagement.

Improvement and transformation

Ewen Cameron, Director of Improvement and Transformation, presented the update.

Noted:

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

2. Wave two of the improvement coaching programme had begun with 38 participants, including a number of applicants from system partners (including two from Royal Papworth Hospital and two from the South Integrated Care Partnership).
3. Wave two of the improvement programme for teams had commenced on 30 September 2022, with 19 teams participating. 16 teams were focused on improvement projects related to 'a good day at work' with the remaining three teams working on projects linked to deteriorating patients.
4. Work continued on the roll-out of virtual wards. Due to recruitment challenges and the associated risks, the original go-live date had been delayed by a week. The aim was to achieve an average occupancy of 30 patients per day during October and November 2022, increasing to an average occupancy of 60 patients per day from December 2022.

Finance

Mike Keech, Chief Finance Officer, presented the update.

Noted:
1. The year-to-date position at month 5 was a £3.4m surplus. The full-year plan was based on achieving a breakeven position.
2. The Cambridgeshire and Peterborough system remained on plan in the year to date.
3. The position varied across NHS provider organisations, with a number of trusts being impacted by significant rises in energy prices.
4. The Trust had recognised Elective Recovery Fund (ERF) income of £5.7m in the year-to-date, in line with plan. The Trust's expectation was that NHS England would support ERF funding for the first half of the year but this had not yet formally been confirmed.
5. The Trust had received an initial system capital allocation for the year of £32.2m for core capital requirements. In addition, further funding was expected for the Children's Hospital (£3.7m), Cancer Hospital (£7.5m), Orthopaedic Theatres (£14.9m) and theatre equipment (£5.1m). Together with capital contributions from Addenbrooke's Charitable Trust, this would provide a total capital programme of at least £65.9m for the year. The Trust had invested £10.0m of capital at Month 5, which was £9.5m below plan. However, this position was expected to be recovered by year end.

Agreed:
1. To note the Integrated Performance Report for August 2022.
2. To note the finance report for 2022/23 Month 5.
3. To note the nurse safe staffing report for August 2022.

90/22 Research and development

Ashley Shaw, Medical Director, presented the report.

Noted:

1. The Trust and the University of Cambridge had undergone a statutory Good Clinical Practice (GCP) inspection by the Medicines and Healthcare products Regulatory Agency (MHRA) between 1 and 5 November 2021 as non-commercial sponsors of clinical trials. A response to the findings, none of which were critical, was sent to the MHRA in June 2022 including identification of corrective and preventative actions. These were reviewed by the GCP Inspectorate and considered acceptable, and the inspection was closed on 22 June 2022.
2. The proposal for re-designation and funding of the National Institute for Health Research (NIHR) Cambridge BRC, was submitted in October 2020. The Trust had been notified of the outcome, which was currently embargoed, and was planning accordingly.

The following points were raised in the discussion:

1. In response to a question, the Medical Director noted that there were a range of research facilities on the campus, supporting a large number of active clinical trials. Royal Papworth had recently completed the Heart and Lung Research Institute, working in partnership with the University of Cambridge.

Agreed:

1. To receive and note the contents of the report.

91/22 Learning from deaths

Ashley Shaw, Medical Director, presented the report.

Noted:

1. As noted earlier in the meeting, the Hospital Standardised Mortality Ratio (HSMR) had increased to over 100 in May 2022. However, the number of deaths within the organisation and the rate of deaths per 100,000 patients had not changed. The ratio had since returned to within normal variance.

Agreed:

1. To note the learning from deaths report for 2022/23 Q1.

92/22 Guardian of Safe Working quarterly report

Ashley Shaw, Medical Director, Jane MacDougall, Guardian of Safe Working, and Milly Ramus, Junior Doctors' Forum (JDF) Co-Chair, presented the report.

Noted:

1. Significant progress had been made on weekend working issues. 11 non-compliant rotas were noted in the 2021/22 report and only three now remained, in the Emergency Department, PICU (Paediatric Intensive Care Unit) and NICU (Neonatal Intensive Care Unit). These were rotas where trainees were working more than the recommended maximum of one in three weekends. Significant investment in additional posts in the Emergency Department and PICU had been agreed and recruitment was in progress.
2. Gaps in rotas continued to be a major concern, both internally and nationally. The difficulty in filling posts was noted, with the implications for working hours, patient safety and training. The rate of sickness had also caused rota gaps.
3. The Junior Doctors' Forum, chaired by a trainee doctor, continued to meet virtually each month. Senior managers were invited to join and attended to listen to trainees' concerns.

The following points were made in discussion:

1. The impact of the pandemic on training for junior doctors was discussed. While there had been concerns that doctors in certain specialities would not have gained as much experience as colleagues who had been in training prior to the pandemic, this was not felt to generally be the case.
2. The number of staff who were off work with Covid-19 continued to impact on rotas. It was anticipated that a recent increase in locum pay rates should have a positive impact in helping to fill some rota gaps. The Medical Director explained that the junior doctor rota in the Emergency Department was currently five individuals short, despite two recruitment efforts. This had been discussed at the recent meeting of the Junior Doctors' Forum and suggestions to make these posts more desirable would be acted on. Separately, a review of bank rates for junior doctors had taken place, with bank rates now matching the regional average.

Agreed:

1. To receive and discuss the 2022/23 Q1 report to the Board from the Guardian of Safe Working.

93/22 Board Assurance Framework and Corporate Risk Register

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

Noted:

1. There were currently 13 risks on the Board Assurance Framework (BAF), unchanged from the previous version received by the Board, with nine of the 13 risks rated red. This reflected the significant risks faced by the organisation in relation to capacity, patient flow, waiting times, staffing and staff wellbeing, and estates compliance.
2. Work was underway to update the BAF to reflect the refreshed CUH strategy. Consideration was being given to the addition of two new risks

on environmental sustainability and the overarching strategy for equality, diversity and inclusion.
3. The process of introducing forward risk trajectories into the BAF had commenced for some of the risks, with others to follow. It was hoped that the addition of risk trajectories would help to further discussion on the adequacy of actions to mitigate risk relative to the Board's risk appetite.
4. The risks on the Corporate Risk Register (CRR) were reviewed on a monthly basis by the Risk Oversight Committee and the relevant Board assurance committee.

The following points were made in discussion:

1. It would be helpful to give further consideration to scenario planning and horizon scanning activities, and how these linked in to the Trust's risk management framework.

Agreed:
1. To approve the current versions of the Board Assurance Framework and the Corporate Risk Register.

94/22 Medical and nursing revalidation

Ashley Shaw, Medical Director, and Lorraine Szeremeta, Chief Nurse, presented the reports.

Agreed:
1. To receive the report on medical revalidation which would be shared, along with the annual audit, with the higher level responsible officer at NHS England (East) Region.
2. To approve the designated body statement of compliance, Section 7, confirming that the organisation, as a designated body, was in compliance with the regulations.
3. To receive the annual report on nursing and midwifery revalidation and to note that there were no issues requiring escalation.

95/22 Board assurance committees – Chairs' reports

Received: the following Chairs reports:

- Performance Committee: 6 October 2022

The Board also received the Health and Safety Annual Report 2021/22 which had been discussed by the Quality Committee at its meeting on 6 July 2022.

96/22 Any other business

There was no other business.

97/22 Questions from members of the public

The Government is considering reviving the 'Discharge to Assess' scheme for 'medically fit' patients to be transferred to care homes. Is this feasible for CUH when most care homes struggle to find enough staff to care for their own residents?

The Chief Operating Officer responded.

'Discharge to Assess' had remained as a constant deliverable in the national hospital discharge policy since the first publication at the beginning of the pandemic. For patients with the most complex needs, workforce capacity with care homes could be a factor in delays in sourcing a placement. However, generally speaking, this was not a concern raised by responsible commissioners and brokers for the majority of the Trust's patients who required care home placement following their hospital admission.

Over a period of four months, CUH discharged 499 patients (registered under the Cambridgeshire and Peterborough ICB) to care homes, of which 294 were returning to their care home. Patients returning to their care home had an average delay of 0.8 days from clinically fit to discharge date. Of the remaining 205 patients, 35% were discharged via an NHS funded pathway, 39% via a social care pathway and 26% were classed as self-funders.

There had been an increase in delays since the national hospital discharge funding ceased earlier in the year, as patients who did not meet the criteria for an NHS-funded pathway required a review to determine whether they met the threshold for social care funding or whether they were deemed as 'self-funders'. If there was any progression at a national or a local level for either pooled funding or national funding for hospital discharge, CUH would expect to see a fairly quick improvement in lost bed days associated with self-funders and social care pathways.

The Chief Executive's report refers, under 'Workforce Focus', to issues of 'food and hydration'. Will he please explain?

The Director of Workforce responded.

The need to have an even greater focus on how staff are supported had been recognised. This included providing facilities for food and for staff to stay hydrated at work. This would be addressed in the 'good work' strategic model, focusing on supporting staff in having a good work experience.

Nearly 30 private providers of training for those on apprenticeship schemes have recently been rated 'inadequate' and all but one have all been banned for two years from taking on new starters. Not all of these serve NHS apprenticeship schemes, but many do. Can you assure us that CUH apprentices have all their training provided by NHS entities and that no private 'training' companies are used.

The Director of Workforce responded.

CUH worked with a range of specialist training providers including Universities, Further Education Colleges and some private training providers. The CUH apprenticeship team procured all apprenticeship standards via the Salisbury NHS ITT Frameworks, of which the vast majority had been commissioned via Health Education England.

Every provider of apprenticeship training needed to be on the Register of Approved Training Providers (RoATP), have an Ofsted rating of Good or above and be able to evidence a history of quality provision and a high level of outcomes for apprentices.

If a provider of apprenticeship training received an inadequate Ofsted outcome, they were removed from the Salisbury frameworks.

98/22 Date of next meeting

The next meeting of the Board of Directors would be held on Wednesday 9 November 2022 at 11.00.

99/22 Resolution

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

Meeting closed: 13.16

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Cambridge University Hospitals NHS Foundation Trust

Annual Public Meeting

Held on Wednesday 28 September 2022 at 17.00 via videoconference

Member	Position	Present	Apologies
Dr M More	Trust Chair	X	
Mr D Abrams	Non-Executive Director	X	
Ms N Ayton	Chief Operating Officer		X
Dr E Cameron	Director of Improvement and Transformation	X	
Mr A Chamberlain	Non-Executive Director	X	
Dr A Doherty	Non-Executive Director	X	
Mr M Keech	Chief Finance Officer	X	
Mr N Kirby	Interim Director of Strategy and Major Projects	X	
Ms A Layne-Smith	Non-Executive Director	X	
Prof P Maxwell	Non-Executive Director		X
Prof S Peacock	Non-Executive Director	X	
Prof I Jacobs	Non-Executive Director	X	
Dr A Shaw	Medical Director		X
Mr R Sinker	Chief Executive	X	
Mr R Sivanandan	Non-Executive Director	X	
Ms L Szeremeta	Chief Nurse		X
Mr I Walker *	Director of Corporate Affairs	X	
Mr D Wherrett	Director of Workforce	X	

** Non-voting member*

In attendance	Position
Mr J Davies	Deputy Medical Director
Ms A Small	Deputy Chief Nurse
Dr N Stutchbury	Lead Governor

Members of the Council of Governors, staff and the public also attended virtually.

1. Welcome and introduction

Dr Mike More, Trust Chair, welcomed everyone to the meeting and thanked patients, staff and partners for their support over the past year.

The Chair thanked the Trust membership and the wider community for their continued support for the Trust during what had been another challenging year.

The Annual Report and Accounts for 2021/22 were received. These had been approved by the Board of Directors in June 2022 and laid in Parliament. The Annual Report and Accounts were available on the Trust website.

2. Lead Governor's report

Dr Neil Stutchbury, Lead Governor, presented his report on the activities of the Council of Governors over the past year, highlighting the following points:

- The continued focus of Governors on key areas of concern including access to services and staff experience and wellbeing.
- Ongoing open dialogue and interaction between the Governors and Non-Executive Directors.
- The extension of the Trust Chair's tenure until 2025.
- The strategic focus on the Integrated Care System, new hospital developments and the recovery from the pandemic waves.

The Lead Governor concluded by acknowledging the significant pressure faced by the Trust, praised the staff and leadership of the organisation and encouraged members of the public to get involved further with the hospitals.

3. Chief Executive's report

Roland Sinker, Chief Executive, gave a presentation highlighting key developments over the past year and key issues for the period ahead.

The Chief Executive expressed his thanks to patients, communities, staff and partners.

The presentation began with the story of Derek, a 46 year old father of three who suffered a deep leg infection. Facing amputation, a series of antibiotics were successfully administered as an alternative. After a long stay in hospital, with care for multiple teams, Derek was discharged and returned home for a successful recovery.

Some of the key achievements of the past year included service developments aimed at improving patient outcomes and reducing the length of hospital stays, such as the use of robotic surgery; the award of the Covid Star to all staff and a number of partners in gratitude and recognition for everything they did as part of the pandemic response; and continued progress on sustainability and the Trust's Green Plan.

However, the Trust continued to face a number of significant challenges, including urgent and emergency care waiting times, waiting lists for elective care and staffing pressures.

The Board had recently approved a refreshed Trust Strategy for the next three years and a video summarising the key elements of the strategy was shown. The Chief Executive outlined how the strategy was designed to achieve the three key commitments to improve patient care, support staff and build for the future.

4. Questions

The following questions were either pre-submitted or raised during the meeting by those present, and Board members responded accordingly.

1. The wellbeing of staff is a concern, including a lack of changing facilities, appropriate provision of food on a 24-hour basis and space for staff to eat.

The Chair invited the Director of Workforce and the Director of Capital, Estates and Facilities Management to respond to the question.

The Director of Workforce explained that the Board was focused on improving facilities for staff, which was a key element of the CUH Workforce strategy. It was acknowledged that the Trust estate varied from new buildings to old and out-dated environments, which did result in differences in facilities between areas. The process of listening to staff continued, including tracking and acting on staff survey results.

The Director of Capital, Estates and Facilities Management explained that work with the Management Staff Forum to improve facilities continued. 78 local area surveys had taken place, resulting in new programmes of work including additional seating, water boilers and microwaves. Although the Trust was constrained by available space, plans were in place to provide more centralised facilities for staff breaks.

2. The Emergency Department is too small for the size of the population – what is the future vision for capacity going forward and are governors and members involved in these conversations?

The Chair confirmed that timely access to urgent and emergency care, including through the Emergency Department, was a key issue for the Board. It was acknowledged that the facilities had not kept pace with the growth in the local population.

The Chair invited the Interim Director of Strategy and Major Projects to respond.

It was explained that the Addenbrooke's 3 hospital redevelopment programme was active, exploring both short-term and longer-term capacity requirements, through various phases:

- Immediate (phase one) – this contained a number of funded streams which was due to deliver 120 additional beds and three orthopaedic

theatres within the next 12 months. Additionally, a business case to expand Emergency Department capacity was under review.
- The proposals for the Cambridge Cancer Research Hospital and the Cambridge Children's Hospital.
- Longer-term planning for a new acute hospital on the Campus.

The Lead Governor explained that governors observed the Addenbrooke's 3 Committee and discussed development plans at regular meetings of the Governor Strategy Group.

3. Why should fundraising activities focus on financing major pieces of medical equipment such as MRI scanners and surgical robots at a time when more rudimentary improvements are needed?

The Chair invited the Chief Executive to respond.

The Chief Executive expressed his gratitude to the Addenbrooke's Charitable Trust for their fundraising support, which covered a wide range of areas including the new hospitals, investing in equipment and research, and staff wellbeing and recognition. This was able to supplement the Trust's own capital programme, which had increased over the past two years.

4. What is the timeframe for the build of the Cambridge Cancer Research Hospital and the Cambridge Children's Hospital?

The Chair invited the Interim Director of Strategy and Major Projects to respond.

It was noted that the Cambridge Cancer Research Hospital Outline Business Case was under development and due to be submitted later in 2022. Subject to national approval, the Full Business Case was due for submission in autumn 2023. If full approval was granted, the build would commence in early 2024 with a target completion date of mid-2027. The Cambridge Children's Hospital Outline Business Case was due for submission in December 2022.

5. With the building of the Children's and new Cancer hospitals on site, why has provision for parking, particularly disabled parking, not been factored into the planning?

The Chair invited the Director of Capital, Estates and Facilities Management to respond.

It was explained that planning permission for the Cambridge Children's Hospital had been granted and included parking, disabled parking and drop-off space outside the hospital. The Cancer Research Hospital planning application would be submitted in due course and would also include provision for parking, disabled parking and drop-off spaces.

6. **It was suggested that, on leaving the hospital, patients' records should include information on the cost of their care.**

   The Chair invited the Chief Finance Officer to respond.

   It was acknowledged that this was a complex issue. At present it would be complicated and time consuming to implement such a model. The Trust's focus was therefore while seeking to achieve the best value for taxpayers' money.

7. **There are often comments in the media that solely putting more cash into the NHS is not the answer to overcoming delivery problems. Within the current NHS framework, will you ever meet patient need and aspirations or is a new funding, operational and organisational model required with a clearer definition of what can be delivered?**

   The Chair invited the Chief Finance Officer to respond.

   The recently refreshed strategy set out the Trust's ambitions, including developing the workforce plan and working with the wider health and care system to further develop integrated care partnerships, which would help to develop a more joined-up model of care for patients.

8. **The issue of secure cycle parking was raised, noting several reports of bike theft from the Trust bike stores.**

   The Chair invited the Director of Capital, Estates and Facilities Management to liaise directly with the County Councillor who had raised the issue.

9. **Does the Integrated Care Board (ICB) have input from the ambulance service and NHS 111?**

   The Chair confirmed that the East of England ambulance service was represented on the Cambridgeshire and Peterborough ICB, as well as the other ICBs within the East of England region. The Chief Executive added that, although NHS 111 did not have a formal seat on the ICB, they were fully involved in discussions on the care provided to patients.

10. **Are rare diseases covered in the CUH strategy?**

    The Chair invited the Interim Director of Strategy and Major Projects to respond.

    It was noted that the provision of services to patients with rare diseases was integral to the Trust's role as a specialist service provider across the region. The Lead Governor noted that he was not aware of any patient advocacy group established for rare diseases. A number of patient representation groups were in place at CUH (e.g. for Cancer and Irritable Bowel Syndrome) and forming a

similar group for rare diseases could be an option. This would be discussed further with colleagues.

11. What will help with recruitment apart from the obvious of higher pay, e.g. housing, public transport, changing visa restrictions, etc?

The Chair invited the Director of Workforce to respond.

It was explained that opportunities for training and development were major recruitment drivers, with positive feedback received on opportunities at the Trust. Such feedback helped to drive reputational value, further supporting recruitment. Other factors included the affordability of accommodation and good transport links, and these were active parts of the Trust's recruitment and retention strategy.

12. What conversations is CUH having with the Combined Authority Skills Committee regarding their long-term plans for ensuring adults wanting to switch careers are able to do so, for example establishing new lifelong learning colleges as called for by the House of Commons Education Select Committee?

The Chair invited the Director of Workforce to respond.

It was noted that meetings were taking place to review partnership working. The Trust's role as a provider of education and supporter of careers was very important, with a strong focus on expanding apprenticeship programmes.

13. Regarding ongoing staff shortages, what conversations has CUH been having with local planning authorities, the Mayor and Combined Authority and the County Council to identify and secure new sites for key workers?

The Chair invited the Director of Capital, Estates and Facilities Management to respond.

It was noted that during 2020 a detailed piece of research was commissioned which highlighted the affordability challenges faced by staff. The local authority view was that a blend of affordable housing offers were required to meet needs. The Trust continued to explore models with developers and work with the Cambridge Biomedical Campus partners to develop proposals.

14. **“The Greater Cambridge Executive Board "notes” the conclusion of updated Cambridge Biomedical Campus Transport Needs Review, that ‘even with all the planned transport interventions for the site, there will still be a surplus 4k+ daily journeys over the 'sustainable' target’. What is the plan? Has CUH had conversations with the Cambridge Connect Light Rail project proposals which has a single light rail line from Cambourne-Cambridge-The Railway Station-Addenbrooke’s-Haverhill?**

The Chair invited the Director of Capital, Estates and Facilities Management to respond.

It was explained that engagement on all fronts with public transport schemes continued to be highly important. All consultations were responded to by the Trust and representations were frequently made. A combined Travel and Transport Group was active on the Cambridge Biomedical Campus.

The Chair thanked everyone for attending the meeting and for their continued support for the hospitals.

Meeting closed: 18.32

NHS
Cambridge University Hospitals
NHS Foundation Trust

Board of Directors (Part 1): Action Tracker

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

Key to RAG rating:

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

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

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Report to the Board of Directors: 9 November 2022

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

Executive Summary

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

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

Action required by the Board of Directors

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

Cambridge University Hospitals NHS Foundation Trust

9 November 2022

Board of Directors
Chair's Report
Mike More, Trust Chair

1. Introduction

1.1 We have three Board meetings in public in quick succession in October, November and January, the meeting last month being additional. As a result, this meeting follows shortly after our last and this report is accordingly relatively light.

1.2 This is not though to say not much has happened. A lot is happening to gear up our approach to managing the operation of the hospital with a Winter Plan and a supporting governance machinery designed to optimise our performance in very challenging circumstances. The governance machinery is designed to get a secure handle on the supportive medium-term themes which enable good performance, and I am glad to see the arrangements we have put in place to learn from the way we managed Covid.

1.3 Anxiety about the cost of living is prevalent across many millions of people and across many businesses. These are additional pressures on top of the long-term fatigue and concerns which arose from Covid. The outcome is a worry about our ability to retain colleagues, especially in the lower paid grades. This is my number one concern and the Board will be keen to confirm that we are doing all we can to support our teams, without whom we are nothing. This, of course, is not a unique CUH problem and everyone will be aware of the prospect of industrial action in the NHS.

1.4 We have to work on a resumption of relative stability in government in coming months and this will be important as we continue to pursue plans for the Cancer and Children's Hospitals. We are also working within the Integrated Care Board (ICB) to ensure that there is a clear and commonly agreed pathway towards integrated health and care arrangements in the south of the county, in which we are a leading player.

1.5 To celebrate 256 years since Addenbrooke's Hospital opened, St Catharine's College gifted the Trust a birthday cake baked by their college chefs. The hospital's founder John Addenbrooke was a former student, Fellow and Bursar at St Catharine's College. Joined by several CUH colleagues, I had the pleasure of accepting the cake from a small group of medical fellows from the college.

2. ‘You Made A Difference’ Awards/Staff Awards

2.1 I was pleased to attend a ‘You Made A Difference’ award event on 2 November. 142 individual nominations were received and I would like to personally congratulate the winners Sandra Kent, Kate Baldwin and Danuta Fabiszczuzak.

2.2 I would also like express our thanks and gratitude to the Addenbrooke’s Charitable Trust (ACT) and the Alborada Trust for sponsoring these awards so generously, which enables us to recognise so many of our Trust colleagues.

3. Diary

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

CUH
Performance Committee
Audit Committee
End of Life Committee
‘You Made A Difference’ Awards
Consultant Development Programme
Launch and closing events for ‘Black History Month’
Meeting with the undergraduate teaching leads to discuss our approach to undergraduate teaching

3.2 Other meetings attended during this period include:

NHS Confederation Chairs meeting
ICB – Health and Wellbeing Board
Cambridge Biomedical Campus (CBC) Local Liaison Group Meeting
Cambridge University Health Partners (CUHP)/CBC Masterplanning
Meeting with local officials to discuss the CBC Local Plan submissions
Chair/CEO meeting to discuss the new integrated arrangements

4. Recommendation

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

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

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Report to the Board of Directors: 9 November 2022

Agenda item	7
Title	Report from the Lead Governor
Sponsoring executive director	n/a
Author(s)	Neil Stutchbury, Lead Governor of the Council of Governors
Purpose	To summarise the activities of the Council of Governors, highlight matters of concern and note successes.
Previously considered by	n/a

Executive Summary

The report summarises the activities of the Council of Governors.

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

Action required by the Board of Directors

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

Cambridge University Hospitals NHS Foundation Trust

9 November 2022

Board of Directors
Report from the Council of Governors
Neil Stutchbury, Lead Governor

1. Recent Governor meetings

1.1 On 26 October 2022 a number of CUH governors, together with governors from Cambridgeshire and Peterborough NHS Foundation Trust, North West Anglia NHS Foundation Trust and Royal Papworth Hospital NHS Foundation Trust, attended a workshop to discuss the Cambridgeshire and Peterborough Integrated Care System (ICS).

1.2 John O'Brien, Chair of the Integrated Care Board (ICB), provided the background to the ICS, its structure and the strategic context; described the concept of system, place and neighbourhoods; commented on how accountability and relationships are intended to work; and identified some immediate challenges.

1.3 In groups, governors discussed questions relating to:

- How governors could best fulfil their role in relation to the wider Cambridgeshire and Peterborough ICS.
- What practical next steps could help to achieve this.
- How to balance immediate challenges (e.g. urgent and emergency care) with the longer-term focus on wider health and well-being, combating inequalities and prevention.

1.4 During the final plenary session, governors summarised the key points raised during group discussions. For each question, these were:

- In each Trust, governors will continue to focus on their statutory responsibilities of holding the Non-Executive Directors (NEDs) to account for the performance of the Board. In order to best support the ICS, governors need ongoing information on the structure, objectives, accountabilities, how primary care relationships will be managed, and the patient/community engagement strategy of the ICS.

- It might be useful to establish a cross-Council of Governors (CoG) group of governors who act as a conduit between the ICS and each Council of Governors. This could enable a consistent source of questions on which to seek assurance on ICS topics from each Trust's NEDs. John O'Brien noted that ICB NEDs may want to have joint,

informal sessions with foundation trust NEDs as part of the overall network.

- Governors were obviously concerned about how focus could be kept on medium/long-term ICS objectives given the current challenges, and how progress against these objectives would be measured. John O'Brien confirmed that a long-term dashboard was still under discussion but offered that business intelligence and real-time data would be used to inform best decision-making.

1.5 It was agreed that future briefings on ICS progress, and maintaining cross-trust governor communication, would be helpful in finding ways to continue to engage with other Councils of Governors and influence the future of the ICS. Lead Governors would continue to be the initial contacts between the ICS and their Councils of Governors.

1.6 Governors met the NEDs at the **quarterly Governor/NED** meeting on 2 November and sought assurance on a range of issues, including radiology reporting times, emergency department waits, hospital-acquired pressure ulcers, delivery of the digital strategy and the embedding of the ICS/ICB arrangements.

2. Upcoming Governor meetings

2.1 The next Governor Strategy Group meeting is scheduled for 15 November. A meeting of the Membership Engagement Strategy Implementation Group is also scheduled for that day.

2.2 A Governor Seminar is scheduled for 8 December.

2.3 The next Council of Governors' meeting is scheduled for 19 December.

3. Other Governor activities

3.1 As noted in the previous report, the Governor Seminar slot on 20 October was used to provide a two-hour training session for governors, facilitated by an external consultant. The training was well attended and well received, and focused on effective questioning and holding NEDs to account.

4. Recommendation

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

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

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Report to the Board of Directors: 9 November 2022

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

Executive Summary

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

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

Action required by the Board of Directors
The Board is asked to note the contents of the report.

Cambridge University Hospitals NHS Foundation Trust

9 November 2022

Board of Directors
Chief Executive's Report
Roland Sinker, Chief Executive

1. Introduction/background

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

1.2 The health and care system nationally, regionally and locally remains under pressure, with challenges ahead in terms of waiting times, demand for services, uncertainty around Covid-19 and other conditions including flu, and staffing pressures. As an update on one indicator, as at 3 November 2022, the Trust was caring for 50 inpatients with Covid-19, with none in critical care. Current modelling of conditions including Covid-19, flu and RSV does not indicate the very significant increases or 'waves' experienced in the previous periods of the Covid-19 pandemic; but the collective impact is anticipated to be significant, and the Trust is planning accordingly.

1.3 Across the five areas of operational performance the Trust faces particular challenges in waits in the Emergency Department, although we continue to achieve relatively strong performance on ambulance handover times. We are also experiencing challenges in staffing levels (with an impact to some elements of care provision), and we are closely engaging with staff around their wellbeing. Alongside these areas of challenge the Trust sees relatively strong performance in terms of outcomes, access for cancer care, elective activity, financial delivery and improvement / transformation in a number of services.

1.4 In this context the Trust has mobilised for the fourth time since February 2020. This involves applying the lessons from our previous responses to Covid-19 and includes development of a Winter Plan. A Winter Taskforce has been established; including Task and Finish Groups aligned to the following five pillars:

- Maximising and expanding capacity including e.g. working in partnership on capacity with Royal Papworth Hospital
- Safety and efficiency including e.g. a balanced approach to infection control
- Communication and engagement including e.g. supporting partners outside of the Trust, and listening to in-hospital teams on areas for improvement'
- Supporting staff including e.g. ongoing recruitment, support for wellbeing, recognition and cost of living pressures'
- New models for winter including e.g. maintaining vital elective activity and core enabling services.

1.5 Work continues on the three domains of the Trust strategy: improving patient care; supporting staff; and building for the future. There is particular focus on integrating with our partners in the 'southern place'; pushing forward with the Outline Business Cases for the Children's and Cancer Hospitals; and developing our strategies around digital, sustainability, specialised services and inclusion.

Part A

2. The five areas of operational performance

2.1 Quality

Areas of challenge

Staffing

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

Capacity

2.3 Capacity remains a significant quality and safety risk and the Emergency Department continues to see high activity resulting in long waits. There have been two significant long waits (in excess of 60 hours) and a full review is being undertaken to identify learning. In both incidents there was no harm to the patients.

Blood products

2.4 A national amber alert has been issued from NHSBT relating to a shortage of red cell products. An Incident Management Team (IMT) has been established, led by the Medical Director's office. The Trust has

reduced red cell usage and established several new pathways to mitigate this risk going forward.

Complaints and Patient Advice and Liaison Service (PALS)

2.5 Both services remain under extreme pressure with increased complexity of contacts and high sickness rates coupled with vacancies, resulting in longer waits for responses. An external review of the service commissioned by the Chief Nurse to look at processes has been completed and an improvement plan is being developed in co-production with the team and external project support. Additional temporary staffing and reduced opening hours is also underway. Divisional processes are currently being reviewed to ensure clear oversight of complaints to reduced response times.

Areas of Success

2.6 The outcomes for allogeneic Bone Marrow Transplant (BMT) and CAR-T cell therapies in hematological malignancy have been published and shows that the Trust has outcomes significantly better than the national average.

2.7 A new clinical sepsis lead has been appointed and will commence in post on 1 November 2022.

Regulatory and Compliance visits

2.8 The CQC State of Care report was published on 21 October 2022. The report highlights a number of key concerns nationally and the Trust are reviewing the recommendations.

2.9 A national report on learning disability is expected from the CQC during November 2022.

2.10 All maternity units will be inspected by the CQC in early 2023. To support preparation of this the regional team will be conducting a peer review for the Trust using CQC methodology during November 2022.

3. Access to Care

The Trust continues to implement the four part operational strategy, aligned to the Winter Taskforces referred to in Section 1. In particular the focus is on waits for emergency or urgent care, looking at improvements in the core of the hospital, the Emergency Department and appropriate discharge of patients. This focus sits alongside maintaining and

improving access to cancer and elective care, where performance is relatively strong.

3.1 **Emergency Department (ED).** Overall ED attendances were 10,948 in September 2022, which is 322 (3.0%) higher than September 2019. This equates to a rise in average daily attendances from 354 to 365 over the same period. 1,452 patients had an ED journey time in excess of 12 hours, compared to 45 in September 2019. This represents 13.2% of all attendances.

3.2 **Referral to Treatment (RTT).** The total RTT waiting list size increased by only 212 in September 2022 to 59,960. The Month 6 planning submission had forecast growth to 53,629 so we are currently 12% higher than plan. Compared to pre-pandemic the waiting list has grown by 76%.

3.3 **Delayed discharges**. For August 2022 the Trust is reporting 6%, which is a decrease of 0.6% from the previous month. Within the 6%, 64% were attributable to Cambridgeshire and Peterborough ICB, and the remainder across a further eight ICB's.

3.4 **Cancer.** The volume of 2 week wait patients seen in August 2022 was 21% higher than in August 2019, the baseline year. 2 week wait breaches increased to 506 in August 2022 leading to performance of 78.8%. 72% were capacity related.

3.5 **Operations.** Elective theatre activity in September 2022 compared to 2019 baseline achieved 90%. Taking account of the loss of the A Block theatres from Trust capacity, this would bring the performance above baseline at 101% for the second consecutive month.

3.6 **Diagnostics.** Total diagnostic activity in September 2022 delivered to 110% of the September 2019 baseline. The total waiting list size reduced by 205 to 13,881, and the volume of patients waiting over 6 weeks decreased by 365 this month.

3.7 **Outpatients.** In September 2022 outpatients delivered 99.6% new activity against baseline which has been adjusted for working days per month.

4. Finance – Month 6

4.1 The Month 6 year to date position is a £2.4m surplus and the Trust remains on target with our plan to deliver a break-even year-end financial position. Significant capital investment has continued in year in line with our plan supporting the creation of additional physical capacity for

services. Planning has commenced for what is anticipated to be a very challenging financial year in 2023/24.
This is in the context of significant levels of uncertainty over budgetary pressure on the NHS due to the current political and economic environment.

4.2 The following points should be noted in respect of the Trust's Month 6 financial performance:

- The Month 6 year to date surplus includes £4m of income receipts relating to a specific one-off transaction in Month 2. The surplus in the year to date is offset in later months leading to a full year planned breakeven position.

- The Trust is currently delivering on its planned reduction in Covid related expenditure with year to date costs of £12m. This remains an area of risk for the Trust and the health system due to volatility of Covid rates in the community. Costs relating to Covid will remain under review.

- The Trust has recognised Elective Recovery Fund (ERF) income of £7.3m year to date in line with plan. The Trust's expectation is that NHSE/I will support ERF funding for the 22/23 financial year but this has not yet formally been confirmed. This funding will, therefore, remain at risk until the final process for qualifying for and calculating the value of ERF has been published.

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

4.4 The Trust has invested £15.0m of capital at Month 5, £11.0m below the planned figure of £26.0m. The Trust expects to recover this under performance by year-end and achieve the forecast plan of £65.9m of capital expenditure.

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

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

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

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

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

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

5. Workforce

5.1 The Trust has set out five workforce ambitions, committing to focus and invest in the following areas; Good Work, Resourcing, Ambition, Inclusion and Relationships. Given the challenges and pressures of the last two years, this five part strategy will look at the additional staff support mechanisms required across the Trust in the medium to long term. In addition the workforce winter plan has been developed to set out areas of focus that require delivery in the coming months.

Good Work

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

The focus areas are:

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

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

approved to support a number of additional initiatives around nourishment and hydration and also rest space.

Resourcing

5.4 During October 40 nurses, and 21 midwives joined the Trust. We were also delighted to welcome 83 new Healthcare support workers (HCSW) during September and October 22. The Trust recently undertook a recruitment campaign in the Philippines where 74 offers of employment were made to experienced nurses.

5.5 In October the trust undertook a joint weekend recruitment event with Royal Papworth Hospital (RPH). Over 250 people attended and, undertaking same day interviews, we were able offer 29 HCSW posts. RPH had similar success so a great outcome for the campus.

5.6 A system wide event which we participated in (a recruitment bus, touring the region) was also well attended and resulted in 24 offers made, mainly for administrative posts.

5.7 Retention remains a key focus with increased attrition seen across all staff groups. A full review of the reasons for attrition has been undertaken and a strategy has been developed and shared both internally and with the wider system retention collaborative.

Ambition

5.8 CUH has expanded its “Admin Academy” offer to include a new enhanced induction for administrative staff. The aim of academy is to support skills enhancement and careers development for those in admin roles who are so vital to the successful running of services.

Inclusion

5.9 The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) 2022 data set has been submitted and corresponding actions plans developed. A broader inclusion strategy to include staff and patients is in development; and a process to appoint a single lead and refresh our governance is underway.

5.10 Black History Month ran during October 2022 with an incredible programme of events, including guest speakers, panel debate, workshops and social events. A Diwali celebration was held for all staff on 24 October with local faith leaders also in attendance.

5.11 In October the newly titled REACH (Race Equality and Cultural Heritage) staff network, formally the BAME (Black, Asian and Minority Ethnic) network, was launched. Members of the network do an incredible amount of work, not least delivering incredible events such Black History Month, mentioned above.

Relationships

5.12 A review of the first CUH Annual Awards process has been undertaken with a view to building on the success of 2022 to launch the 2023 process early in the New Year.

5.13 Leadership Support Circles continue to run and review well and the New Year will see the leadership offer expanded through the introduction of line management support and a senior leadership alumni programme.

6. Improvement and Transformation

Building Capability

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

6.2 On 12 and 13 October 2022, senior IHI colleagues undertook an annual site visit, meeting with a wide range of Trust staff, including those undertaking improvement projects, as well as with the Board of Directors and Management Executive. A summary report, including supporting recommendations, will be discussed by Management Executive. The Trust is at a pivot point, considering how to accelerate the current programme around improvement, including alignment with strategic priorities, additional training, alignment with a wide range of improvement activities and focus on system and hospital opportunities.

6.3 In relation to the Trust's work with the IHI on building improvement capability and capacity across our 11,500 staff, wave two of the improvement coach programme concluded on 20 October 2022, with 37 new coaches progressing to graduation. Wave two of the improvement programme for teams is underway, with 19 teams participating in the first face-to-face workshop held in October 2022.

Urgent and emergency care

6.4 The improvement and transformation team has supported, or continues to support, a number of initiatives aimed to reduce patient length of stay

in the Emergency Department (ED) and/or to stream patients to more appropriate care settings.

Outpatients

6.5 The improvement and transformation team continues to support colleagues with the Trust's outpatients programme, focusing on 2022/23 priorities and operational planning guidance objectives. Examples of the improvement projects supported include nurse led virtual clinics in gastroenterology, use of electronic referral systems in ophthalmology and waiting list and clinic template reviews in gynaecology. Other improvement projects are being scoped within colorectal dietetics, oncology, nephrology and cardiology.

Virtual wards

6.6 The virtual ward programme went live with its first patient on 31 October 2022; initial patient numbers will be low with, typically, low acuity. All elements of the supporting infrastructure have been planned, tested and implemented, with a core team now in place to run a 24/7 service. Appropriate pathways and escalations have been agreed to safely care for patients out of hospital. Using an improvement approach, early learning and adaptation will inform larger-scale implementation.

Productivity and efficiency

6.7 The improvement and transformation team continues to work with colleagues from across the organisation, to ensure that productivity and efficiency schemes for 2022/23 are identified to meet an overall requirement of £62m, which will deliver an end-of-year break-even position. As at end month 6, the Trust is £8k ahead of target, with a forecast year-end over-achievement of £16k; however, this is contingent on delivery of the divisional activity plans at agreed budget levels and securing ERF (elective recovery fund) funding in full. The Trust continues work on a 5 year financial plan linked to the refreshed strategy; and to deliver the Cost Improvement Plan.

PART B

7. Strategy update

NHS England Operating Framework

7.1 NHS England published its new operating framework in October 2022, setting out how it will work to best empower and support local system partners to deliver on their responsibilities following the establishment of Integrated Care Systems on a statutory footing earlier in the year. The

framework outlines the medium-term priorities/long term aims for NHSE, and the accountabilities and responsibilities of the different organisations in the NHS.

7.2 As part of this transformation, NHS England, Health Education England and NHS Digital are due to merge on 1 April 2023, to create a 'new' NHS England, putting workforce, data, digital and technology at the heart of their plans to transform the NHS.

7.3 The organisation's stated focus will be on setting direction, allocating resources, ensuring accountability, supporting and developing people, mobilizing expert networks, enabling improvement, delivering services, and driving transformation. Aligned to this, they have set out five transformational priorities for the next 3-5 years:

- Stop avoidable illness and intervene early;
- Shift to digital and community;
- Share the best;
- Strengthen the hands of the people they serve;
- Support local partners.

7.4 The document reflects a move towards engagement and co-production with system leaders, based on more collaborative behaviours underlying the new statutory duties on NHS England and system partners, but without being too prescriptive about local arrangements for providers at System Oversight Framework level 3 (SOF3) or below. CUH is at SOF2 and will remain mostly accountable through the Board and Council of Governors, with additional oversight from ICB and not the NHS national or regional teams who are committed to support ICBs to deliver their plans and give systems the agency and autonomy, as well as practical support, to identify the best way to deliver agreed priorities in their local context.

<u>Strategy engagement and implementation</u>

7.5 Following the launch of the Trust's refreshed strategy in July 2022, the focus is now on its implementation through engagement with colleagues. A key area of focus is to support managers to set aligned strategies and plans for their local teams that will enable teams and individuals to understand and explore how the strategy applies to them and to recognise how they contribute to its delivery.

7.6 Work is also underway to develop a five-year strategy implementation plan to quantify key commitments in the strategy and consider their impact on the Trust's activity, capacity, income, expenditure, waiting lists, waiting times etc.

7.7 Progress on many of the 15 commitments outlined in the strategy are reported elsewhere in this update paper; further elements are included below.

Improving patient care

Integrated Care

7.8 The Trust continues to work with partners across the Cambridgeshire South Partnership (working across East Cambridgeshire, South Cambridgeshire and Cambridge City) to improve care for people in and outside of hospital. Within Cambridgeshire South, the focus over the coming year remains on co-developing new approaches (and aligning resources) to:

- Support people to receive urgent and emergency care within their own home or primary care practice;
- Support people to receive care that would usually be provided in an Emergency Department or hospital ward in their own home, or return home as soon as possible after a hospital stay;
- Identify people who would benefit most from more proactive and personalised care, delivered by neighbourhood-based inter-disciplinary care teams;
- Test innovative models of care, learning from local experience and national / international evidence;
- Put in place a practical plan to ensure our general practices are supported and sustainable;
- Integrate and streamline aspects of patient discharge processes to improve patient and carer experience.

7.9 Conversations with the Integrated Care Board continue to determine what responsibility and resource will be devolved to South Place to support local integration work.

7.10 Within CUH, a Clinical Lead for Integrated Care has been identified who will work internally and across partner organisations to promote clinical engagement, establish clinical priorities and develop the processes required to support integration of clinical pathways.

7.11 The Primary Care Liaison Service hosted an event to share information with general practice colleagues about the development of the medical GP liaison service and how primary care can access this service. We plan to host similar events to share information and build cross-setting relationships and understanding every 6-8 weeks.

Health Inequalities, Equality, Diversity and Inclusion

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

Supporting our staff

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

Building for the future

New hospitals and the estate

7.14 The focus of Addenbrooke's 3 remains primarily on the delivery of projects within phases one (addressing our highest risk issues) and phase two (the new cancer and children's hospitals) of our four-phase programme.

7.15 Phase one has successfully delivered four compelling business cases which now have full approval to proceed. Once implemented they will deliver: an additional 115 beds (across three surge units) by 2023; a ring-fenced surgical facility for elective orthopaedics by 2023; a new facility for our Histopathology laboratory by 2024; and over £5m of investment to support expansion of the Emergency Department together with an associated increase in staff and the relocation of orthotics as an enabler for the expansion. The next challenge is to build a business case providing costed options to address improving capacity, managing growth whilst delivering efficiencies in our Genomics Service which is under pressure to manage current demand and predicted growth.

7.16 The key focus of the Cambridge Cancer Research Hospital (CCRH) project team over the summer has been on finalising the Outline Business Case (OBC), together with associated letters of support from our commissioners and partners, ready for submission to our regulators in October 2022, with expected approval in spring 2023. In parallel, the project has commenced working on the next, more detailed phase of designing the new hospital, working with stakeholders from across CUH and the University of Cambridge, as well as our design and development team and the New Hospitals Programme (NHP), to ensure the CCRH

designs respond fully to the needs of our staff and patients. More broadly, communication and engagement continue to be of the highest importance to the project, with activities ranging from sessions with our Staff Reference Group and Patient Advisory Group, an MP briefing event in June 2022, and the first meeting of our Global Advisory Board in October 2022, taking place. This is paramount to ensuring that stakeholders are kept informed about and have confidence in the CCRH project as it progresses, and that they have maximum opportunity to be involved.

7.17 Cambridge Children's Hospital (CCH) is also working towards submitting its OBC to regulators before the end of 2022. The Trust is continuing to work closely with the NHP team to secure its position in an early cohort of the programme. The project's fundraising campaign has seen excellent progress, with some major steps towards its target over the summer. The design of the building is progressing well too; user engagement sessions for the next phase of the design started in September.

Specialised Services

7.18 The Trust is in advanced planning for the necessary resourcing and infrastructure to deliver the next phase of major capital development on the site.

7.19 Since September 202, the EoE SPC has continued to progress our priorities including working with clinical leads, networks and the NHSE regional team to move forward opportunities for transformation e.g. developing proposals to address regional gaps in specialist dentistry and severe asthma.

7.20 The EoE SPC is also working with Integrated Care Boards (ICBs) and NHSE EoE to prepare for the delegation of specialised commissioning in March 2023. We facilitated a meeting with ICB specialised commissioning leads in early September to discuss how we can work more closely together. We also responded, both as CUH and as part of the EoE SPC, to an NHSE commission for transformation opportunities in specialised services.

7.21 Going forward, we are seeking to make further progress against the priorities we have identified, particularly where there are opportunities to produce tangible benefits in the short- to mid-term. We will also continue our engagement activities across the region, and to support our activities through evolving our governance and resourcing models over time. These steps are due to be confirmed with EoE SPC CEOs during the month.

Research and life sciences

7.22 The National Institute for Health and Care Research (NIHR) has awarded £86 million to the NIHR Cambridge Biomedical Research Centre (BRC), a partnership between CUH and the University of Cambridge, to continue its ground-breaking research, translating new scientific insights into state-of-the-art diagnostics and treatments to transform healthcare. This bidding round implemented a £100m cap on BRC awards, with Cambridge retaining its status as one of the largest centres, and is the fourth round of funding for the NIHR Cambridge BRC and one of 20 such awards granted to leading NHS and University partnerships across the country.

Climate change

7.23 The Trust has successfully bid into the Public Sector Low Carbon Skills Fund to develop a technical heat decarbonisation plan for the CUH Hills Road Campus, a key step towards a low-carbon heating future for the Trust.

7.24 The Trust continues to work with partners on the Cambridge Biomedical Campus and beyond on options for sustainable development including transport, housing, callous development and greater contribution to Cambridge and the Eastern region.

8. Recommendation

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

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 9 November 2022

Agenda item	9
Title	Integrated Report
Sponsoring executive director	Chief Operating Officer, Chief Nurse, Medical Director, Director of Workforce, Chief Finance Officer
Author(s)	As above
Purpose	To update the Trust Board on performance during September 2022.
Previously considered by	Performance Committee, 2 November 2022

Executive Summary
The Integrated Performance Report provides details of performance to the end of September 2022 across quality, access standards, workforce and finance. It provides a breakdown where applicable of performance by clinical division and corporate directorate and summarises key actions being taken to recover or improve performance in these areas.

Related Trust objectives	All objectives
Risk and Assurance	The report provides assurance on performance during Month 6.
Related Assurance Framework Entries	BAF ref: 001, 002, 004, 007, 011
Legal implications/Regulatory requirements	n/a
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of “Together: safe, kind and excellent”?	n/a

Action required by the Board of Directors
The Board is asked to note the Integrated Performance Report for September 2022.




Cambridge University Hospitals
NHS Foundation Trust





Integrated Report

Quality, Performance, Finance and Workforce to end Sep 2022

Chief Finance Officer
Chief Nurse
Chief Operating Officer
Director of Workforce

Report compiled: 31 Oct 2022

Key

Cambridge University Hospitals NHS Foundation Trust

Key

Key

Data variation indicators


Normal variance - all points within control limits


Negative special cause variation above the mean


Negative special cause variation below the mean


Positive special cause variation above the mean


Positive special cause variation below the mean

Rule trigger indicators

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

Target status indicators


Target has been and statistically is consistently likely to be achieved


Target failed and statistically will consistently not be achieved


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

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

Quality Account Measures

NHS
Cambridge University Hospitals
NHS Foundation Trust

2022/23 Performance Framework

2022/23 Quality Account Measures

Domain	Indicator	Data to	Target	Jul 22 Previous Month-1	Aug 22 Previous Month	Sep 22 Current status	Trend	FYtD	Baseline	LTM
Safe	Average % compliance with individual elements of NEWS2 escalation policy	Sep-22	85%	57%	49%	43%	⇩	55%	50.0%	54.3%
	% of patients over 65 years of age who have a lying and standing blood pressure completed within 48 hours of admission	Sep-22	50%	14.9%	15.8%	16.1%	⇧	15.3%	13.4%	15.3%
	% of patients who have a VTE risk assessent undertaken within 14 hours of admission	Apr-22	95%	N/A	N/A	N/A	▪	N/A	N/A	N/A
	Average % compliance with blood cultures within 60 minutes of Sepsis diagnosis	Sep-22	95%	80%	80%	100%	⇧	83%	70.0%	82.8%
Patient Experience / Caring	Healthcare Inequality: Percentage of patients in calendar month where ethnicity data is **not recorded** on EPIC CheQs demographics report (Ethnicity Summary by Patient)	Sep-22	7%	12.4%	12.7%	13.4%	⇩	12.4%	14.0%	12.2%
	Publication of actions and improvements undertaken as a result of feedback received from patients and their representatives	Sep-22	100%	8.3%	8.3%	8.3%	⇔	8.3%	0.0%	8.3%
Effective / Responsive	% of Early Morning Discharges (07:00-12:00)	Sep-22	20%	15.6%	16.0%	17.9%	⇧	16.3%	15.3%	15.9%
	Percentage of in-patient discharges on a Saturday and Sunday compared to the rest of the week (calculated as the average daily discharges on Sat/Sun divided into the average daily discharges Mon-Fri). Excludes day cases. 80% (of weekday rate) **Additional Filters Simple Discharges, G&A etc**	Sep-22	80%	68.0%	78.4%	89.8%	⇧	76.9%	74.0%	77.1%
	Same day emergency care (SDEC)	Sep-22	30%	16.8%	16.6%	14.9%	⇩	18.2%	22.0%	19.8%
	Quarterly			Mar 22	Jun 22	Sep 22				
	SSNAP Domain 2: % of patients admitted to a stroke unit within 4 hours of clock start time (Team centred)	Sep-22	55%	N/A	25.9%	29.2%	⇩	27.5%	29.2%	27.5%
Staff Experience / Well-led	Retention of band 5 nurses (quarterly)	Jun-22	88.5%	N/A	N/A	N/A	▪	N/A	87.0%	N/A
	Annual			2016	2017	2018				
	I feel secure about raising concerns re unsafe clinical practice within the organisation		78.0%	75.0%	73.0%	74.0%	⇧		75.0%	

Quality Summary Indicators

NHS
Cambridge University Hospitals
NHS Foundation Trust

2022/23 Performance Framework

Performance Framework - Quality Indicators				Jul 22	Aug 22	Sep 22				
Domain	**Indicator**	**Data to**	**Target**	**Previous Month-1**	**Previous Month**	**Current status**	**Trend**	**FYtD**	**Previous FYR**	**LTM**
Infection Control	MRSA Bacteraemia (avoidable hospital onset cases)	Sep-22	0	0	0	1	⇩	2	4	4
	E.Coli Bacteraemias (Total Cases)	Sep-22	50% over 3 years	34	29	33	⇩	197	384	394
	C. difficile Infection (hospital onset and COHA* avoidable)	Sep-22	TBC	11	20	8	⇧	78	123	143
	Hand Hygiene Compliance	Sep-22	TBC	96.6%	97.0%	96.4%	⇩	97.1%	97.5%	97.4%
Clinical Effectiveness	% of NICE Technology Appraisals on Trust formulary within three months. ('last month')	Sep-22	100%	57.1%	50.0%	71.4%	⇧	55.8%	33.8%	42.3%
	% of external visits where expected deadline was met (cumulative for current financial year)	Sep-22	80%	100.0%	N/A	0.0%	⇩	46.2%	46.7%	45.9%
	80% of NICE guidance relevant to CUH is returned by clinical teams within total deadline of 32 days.	Sep-22	-	80.0%	57.1%	20.0%	⇩	52.7%	17.2%	44.7%
	No national audit negative outlier alert triggered	Sep-22	0	0	0	0	⇔	0	-	0
	85% of national audit's to achieve a status of better, same or met against standards over the audit year	Sep-22	85%	40.0%	80.0%	N/A	⇧	-	84.6%	70.0%
Nursing Quality Metrics	Blood Administration Patient Scanning	Sep-22	90%	99.6%	99.0%	99.7%	⇧	99.5%	99.1%	99.6%
	Care Plan Notes	Sep-22	90%	96.6%	96.9%	96.6%	⇩	96.7%	95.8%	96.1%
	Care Plan Presence	Sep-22	90%	99.9%	100.0%	99.9%	⇩	99.9%	99.6%	99.8%
	Falls Risk Assessment	Data reported in slides								
	Moving & Handling	Sep-22	90%	64.0%	63.9%	58.7%	⇩	61.8%	63.1%	62.2%
	Nurse Rounding	Sep-22	90%	97.3%	97.6%	97.5%	⇩	97.3%	96.6%	96.7%
	Nutrition Screening	Sep-22	90%	99.6%	99.4%	99.5%	⇧	99.5%	99.6%	99.5%
	Pain Score	Sep-22	90%	73.9%	74.7%	75.3%	⇧	75.7%	77.1%	75.0%
	Pressure Ulcer Screening	Data reported in slides								
	EWS									
	MEOWS Score Recording	Sep-22	90%	54.4%	59.9%	61.3%	⇧	59.3%	64.0%	60.2%
	PEWS Score Recording	Sep-22	90%	85.2%	85.5%	85.3%	⇩	85.8%	86.6%	86.0%
	NEWS Score Recording	Sep-22	90%	72.4%	74.8%	74.3%	⇩	74.6%	74.2%	73.6%
	VIP									
	VIP Score Recording (1 per day)	Sep-22	90%	88.0%	86.5%	88.0%	⇧	88.7%	91.2%	89.2%
	PIP Score Recording (1 per day)	Sep-22	90%	99.3%	98.9%	99.1%	⇧	99.2%	99.2%	99.2%
Patient Experience	Mixed sex accommodation breaches	Jun-20	0	-	-	-	▪	0	0	0
	Number of overdue complaints	Sep-22	0	4	18	2	⇩	45	29	68
	Re-opened complaints (non PHSO)	Sep-22	N/A	3	1	0	⇩	13	74	53
	Re-opened complaints (PHSO)	Sep-22	N/A	0	0	0	⇩	0	4	1
				Jul 22	Aug 22	Sep 22				
	Number of medium/high level complaints	Sep-22	N/A	21	17	17	⇩	123		236

Operational Performance

Cambridge University Hospitals NHS Foundation Trust

Operational Performance

POD	Performance Standards	SPC	Target	Target due by	Internal Target	In Month Actual	Actual
Urgent & Emergency Care More information on page 15	Ambulance handovers <15mins		65%	Immediate		37%	
	Ambulance handovers <30mins		95%	Immediate		80%	
	Ambulance handovers > 60mins	L	0	Immediate		172	
	12hr waits in ED (type 1)	H	2%	Immediate	5%	13%	
Cancer More information on pages 17,18	Cancer patients < 62 days	L	85%	Immediate		72%	
	28 day faster diagnosis standard		75%	Immediate	81.4%	79.3%	
	31 day decision to first treatment	L	96%	Immediate		90%	
Outpatient Transformation More information on page 21	Advice and Guidance Requests		16%	Mar-23	13%	9%	
	Patients moved / discharged to PIFU	H	5%	Mar-23	3.4%	2.4%	
Diagnostics More information on page 19	Patients waiting > 6 weeks	L	5%	Mar-24		43%	
RTT Waiting List More information on page 16	RTT Patients waiting > 78 weeks	L	0	Mar-23	183	365	
	RTT Patients waiting > 104 weeks	L	0	Jul-22	-	5	

Productivity and Efficiency	SPC	In Month Actual	Actual
Non-elective LoS (days, excl 0 LoS)	H	9.14	
Long stay patients (>21 LoS)	L	5.4	
Elective LoS (days, excl 0 LoS)		5.4	
Discharges before noon	H	18%	
Theatre sessions used		1384	
In session theatre utilisation	H	83%	
Virtual Outpatient Attendances	L	21%	

	Sep-22	Aug-22	% change	Feb-20	% change
Outpatients - New	30,303	30,079	↑1%	28,700	↑6%
Diagnostics - Total WL	13,878	14,336	↓3%	8,708	↑59%
RTT Pathways - Total WL	59,960	59,748	↑0%	34,097	↑76%
Cancer (62d pathway) >62d	136	132	↑3%	56	↑143%

Surgical Prioritisation - WL	Sep-22	Aug-22	% change
P2 (4 weeks) Including planned	2014	1945	↑4%
P3 (3 months)	5289	5273	↑0%
P4	3480	3525	↓1%

Key / notes

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

SPC variances calculated from rolling previous 12 months

Author(s): James Hennessey

Owner(s): Nicola Ayton

Acute Priorities Delivery

NHS
Cambridge University Hospitals
NHS Foundation Trust

2022/23 Performance Framework

Elective Inpatient Activity

79%	In Month Actual
84%	In Month Plan
85%	YTD Actual
80%	YTD Plan

Elective Daycase Activity

20%	In Month Actual
109%	In Month Plan
20%	YTD Actual
102%	YTD Plan

Emergency Admissions

78%	In Month Actual
89%	In Month Plan
80%	YTD Actual
91%	YTD Plan

New Outpatient Activity

100%	In Month Actual
96%	In Month Plan
101%	YTD Actual
99%	YTD Plan

Follow Up Outpatient Activity

107%	In Month Actual
116%	In Month Plan
109%	YTD Actual
121%	YTD Plan

Diagnostic activity (national planning submission)

55%	In Month Actual
116%	In Month Plan
58%	YTD Actual
120%	YTD Plan

RTT Clockstops (All)

92%	In Month Actual
101%	In Month Plan
91%	YTD Actual
101%	YTD Plan

RTT Clockstops (Admitted)

85%	In Month Actual
93%	In Month Plan
83%	YTD Actual
86%	YTD Plan

RTT Clockstops (Non admitted)

94%	In Month Actual
104%	In Month Plan
94%	YTD Actual
105%	YTD Plan

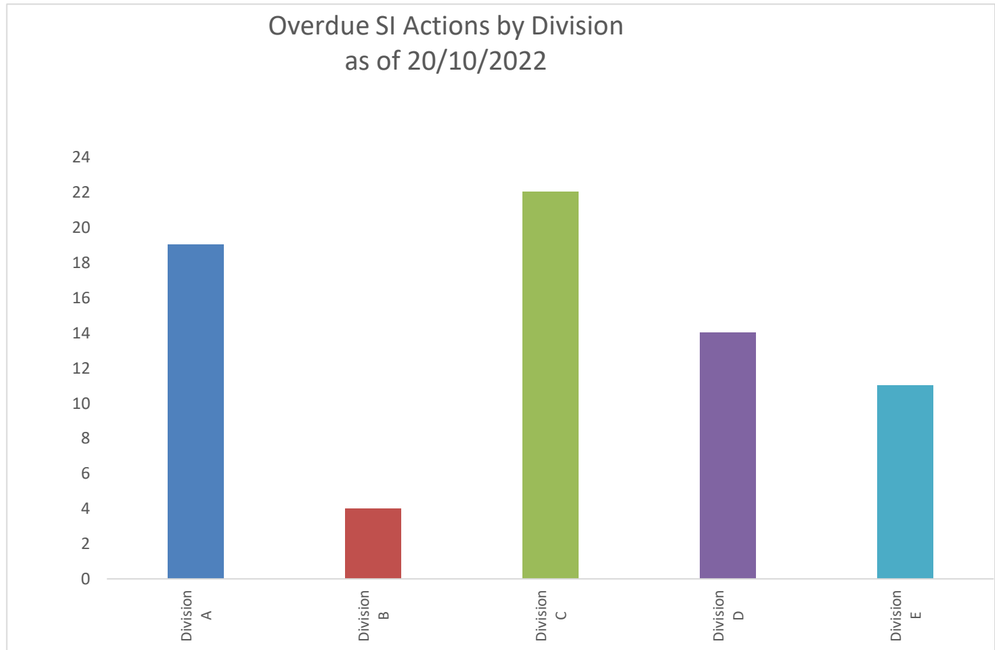
Serious Incidents

Cambridge University Hospitals NHS Foundation Trust

Safety and Quality

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
Patient Safety Incidents	Oct 19- Sep 22	month	-	1516	1439			-	The number of patient safety incidents is within normal variance.
Percentage of moderate and above patient safety incidents	Oct 19- Sep 22	month	2%	2.8%	2.0%				There is currently normal variance in the percentage of moderate and above patient safety incidents.
All Serious Incidents	Oct 19 - Sep 22	month	-	6	5			-	6 Serious Incidents were declared with the CCG in Sep 2022, which is within normal variance for the trust.
Serious Incidents submitted to CCG within 60 working days (or agreed extension)	Oct 19 - Sep 22	month	100%	67%					3 Serious Incidents were due to the CCG in Sep 2022, 2 of which were submitted within the 60 day target.

Ref	SI Title	STEIS SI Sub categories	Actual Impact	Division	Ward / Department
SLR146648	Paediatric neurosurgery death	Treatment delay	Death / Catastrophic	Division E	Ward D2
SLR147042	Patient fall (ward C6	Slips/trips/falls	Severe / Major	Division C	Ward C6
SLR147854	Paediatric renal stones	Treatment delay	Moderate	Division E	Recovery - Paediatric
SLR148195	Delay in radiology report impacting oncological management of a patient	Treatment delay	Severe / Major	Division B	MRI / CT
SLR148468	HAPU ICU	Pressure ulcer meeting	Severe / Major	Division A	ICU (D3)
SLR149033	Oesophageal obstruction	Pending review	Severe / Major	Division A	Ward C7



Author(s): Clare Miller

Owner(s): Oyejumoke Okubadejo

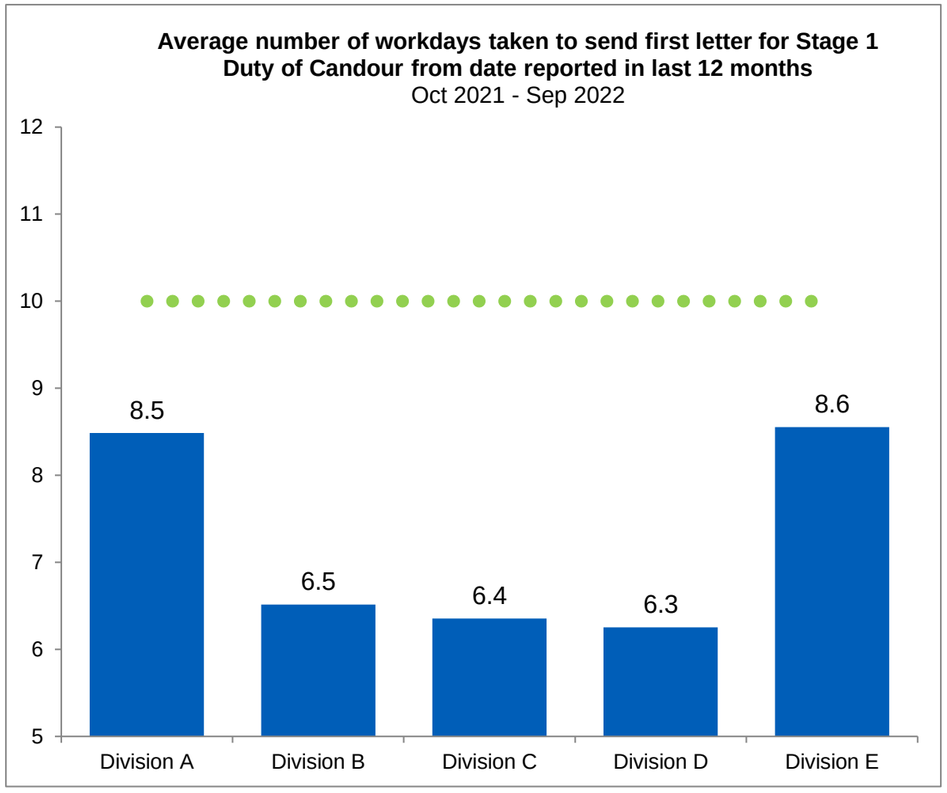
Together-Safe | Kind | Excellent

Duty of Candour

NHS Cambridge University Hospitals NHS Foundation Trust

Safety and Quality

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
Duty of Candour Stage 1 within 10 working days*	Aug 19 - Sep 22	month	100%	68%	70%		-		The system may achieve or fail the target subject to random variation.
Duty of Candour Stage 2 within 10 working days**	Aug 19 - Sep 22	month	100%	85%	69%		-		The system may achieve or fail the target subject to random variation.



Executive Summary

Trust wide stage 1* DOC is compliant at 95% for all confirmed cases of moderate harm or above in September 2022. 68% of DOC Stage 1 was completed within the required timeframe of 10 working days in September 2022. The average number of days taken to send a first letter for stage 1 DOC in September 2022 was 7 working days.

Trust wide stage 2** DOC is compliant at 100% for all completed investigations into moderate or above harm in September 2022 and 85% DOC Stage 2 were completed within 10 working days.

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

Indicator definitions:
*Stage 1 is notifying the patient (or family) of the incident and sending of stage 1 letter, within 10 working days from date level of harm confirmed at SIERP or HAPU validation.
**Stage 2 is sharing of the relevant investigation findings (where the patient has requested this response), within 10 working days of the completion of the investigation report.

Falls

Safety and Quality

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
All patient falls by date of occurrence	Oct 19 - Sep 22	month	-	193	143		-	-	There were a total of 193falls (inpatient, outpatient and day case) in September 2022. This was a single point of statistical significance with the Trust breeching the upper control limit.
Inpatient falls per 1000 bed days	Oct 19 - Sep 22	month	-	5.51	4.52			-	The Trust remains within normal variance.
Moderate and above inpatient falls per 1000 bed days	Oct 19 - Sep 22	month	-	0.32	0.09			-	There were 11 falls categorised as Moderate or above harm in September 2022. The level of harm is classed according to injury and not lapses in care. This was a single point of statistical significance with the Trust breeching the upper control limit.
Falls risk screening compliance within 12 hours of admission	Aug 19 - Aug 22	month	90.00%	85..60%	87.30%				Completion of Falls risk screening within 12 hours of admission remains below the 90% target.
Falls KPI; patients 65 and over have a Lying and Standing Blood Pressure (LSBP) completed within 48hrs of admission	Aug 19 - Aug 22	month	90.00%	16.10%	11.00%				Lying and standing blood pressure continues to be an area of focus for improvement efforts due to continued low compliance.
Falls KPI: patients 65 and over who have a cognitive impairment have an appropriate care plan in place	Aug 19 - Aug 22	month	90.00%	22.60%	15.10%				Improvement work is ongoing to address continued low compliance in care planning for patients with a cognitive impairment
Falls KPI: patients 65 and over requiring the use of a walking aid have access to one for their sole use	Aug 19 - Aug 22	month	90.00%	69.70%	77.40%				An issue with understanding of this question has been identified in the inpatient area, which is now being reviewed to ensure compliance is accurately reflected in this metric

Executive Summary

Trust capacity remains an important factor in the number of falls across the Trust. When this is stratified by falls per 1000 bed days, data is well within normal variance.

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

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

Work is underway to make changes the Falls Risk Screening that were identified as part of investigations and thematic analysis

An EPIC change request for the development and implementation of CUH specific confusion care plans has been completed and given a priority 1 status as this is an action from SI's and inquests.

A quality improvement project on ward D7 will commence in November 2022. The project will look at the use of 1:1 care for patient identified as being at risk of falls or have fallen on the ward. Part of the project will look at the relevance and impact of 1:1 care on reducing the risk of falls.

Hospital Acquired Pressure Ulcers (HAPUs)

Cambridge University Hospitals NHS Foundation Trust

Safety and Quality

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
All HAPUs by date of occurrence	Feb 18 - Sep 22	month	-	35	23		-	-	The total numbers of HAPU's for Aug and September is lower than July, however the mean trajectory remains on an upward slope.
To increase reporting of category 1 HAPU to achieve an upward trajectory in reporting by March 2022	Feb 18 - Sep 22	month	-	17	11		-	-	KPI 2021-2022- to increase early reporting of category 1 HAPU to prompt early prevention. Category 1 HAPUs remain within normal variance. The KPI's will remain the same.
Category 2, 3, 4, Suspected Deep Tissue Injury and Unstageable HAPUs by date of occurrence	Feb 18 - Sep 22	month	-	18	11		-	-	Category 2 and above HAPU's are within the upper control limit for September, however the mean trajectory remains on an upward slope.
Pressure Ulcer screening risk assessment compliance	Feb 18 - Sep 22	month	90%	80%	80%		-	F	PU screening risk assessment compliance remains below the target of 90%. A QI plan was presented and discussed at NMAAC.
KPI downward trend of category 2, 3, 4, Suspected Deep Tissue Injury and Unstageable HAPUs by March 2022	Apr 19 - Sep 22	month	9	18	11	H	S7	F	KPI 2021-2022 - to decrease number of category 2 and above HAPU as a result of early reporting of category 1. Reporting for category 2 and above HAPU's remain on an upper trajectory, this KPI was not achieved. The KPIS's will remain and be incorporated in the forthcoming QI Plan.

Exec Summary

HAPU's remain on an upper trajectory, however incidents were lower than the previous 2 months.
A new band 6 TVN has been appointed within the Corporate TVN team and will commence post in Dec 2022/Jan 2023.
The November Tissue Viability Champions Study Day will focus on pressure ulcer prevention for Stop the Pressure Ulcer Day.

HAPU incidents; Category 1 = 17, Category 2 = 9, Category 3 = 0, Category 4 = 0, SDTI = 7, Unstageable = 2

A thematic review is currently being undertaken, of all serious incidents relating to HAPU's. A quality improvement plan is in development as a result of findings from review.

Sepsis

Cambridge University Hospitals NHS Foundation Trust

Safety and Quality

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
Trust internal data									
All elements of the Sepsis Six Bundle delivered in 60 mins from time patient triggers Sepsis (NEWS 5>) - Emergency Department	Sep-22	Monthly	95%	67%	55%		-		Compliance with Sepsis 6 delivered within 60 Mins has improved since June 22. Elements of the sepsis 6 bundle that have impacted on the overall compliance this month is Antibiotic administration within an hour of triggering sepsis (73%) and IV fluids (80%).
Antibiotics administered with 60 mins from time patient triggers Sepsis (NEWS 5>) - Emergency Department	Sep-22	Monthly	95%	73%	72%		-	-	Average door to needle time was 70 mins and has been improving since July 22 ,8 audits impacted on this average time because door to needle time in those particular audits exceeded 60 Mins. The average time between patient triggering sepsis (NEWS 2 5>) and prescription of antibiotics was 25 mins. In 86% of audits the time between the patient triggering sepsis and antibiotics being prescribed was under 30 mins. The average time between antibiotic prescription and administration was 32 mins, in 53% of the audits antibiotics were administered within 30 Mins of being prescribed. The average prescription and administration time of antibiotics together was 57 mins. Prolonged stay in ambulance bay likely contributed, Long stay in the ambulance bay in PAT space for over 6 hours
All elements of the Sepsis Six Bundle delivered in 60 mins from time patient triggers Sepsis (NEWS 5>)- Inpatient wards	Jul-22	Monthly	95%	80%	23%		SP	-	Due to a change in data collection, inpatient data for August and September has not yet been analysed, awaiting submission from Junior Dr's This will be retrospectively completed, a regular collection and analysis schedule is being formalised.
Antibiotics administered with 60 mins form time patient triggers Sepsis (NEWS 5>) - Inpatient wards	Jul-22	Monthly	95%	100%	67%		S7	-	Due to a change in data collection, inpatient data for August and September has not yet been analysed, awaiting submission from Junior Dr's This will be retrospectively completed, a regular collection and analysis schedule is being formalised.
Antibiotics administered within 60 mins of patient being diagnosed with Sepsis - Emergency Department	Sep-22	Monthly	95%	100%	91%		-		
Antibiotics administered within 60 mins of patient being diagnosed with Sepsis - Inpatient wards	Jul-22	Monthly	95%	100%	70%		SP	-	Due to a change in data collection, inpatient data for August and September has not yet been analysed, awaiting submission from Junior Dr's This will be retrospectively completed, a regular collection and analysis schedule is being formalised.

Executive Summary:

Inpatient Sepsis data is currently being collated and analysed by a new team of sepsis auditors, a new sepsis lead has been appointed and will start in Nov 22.

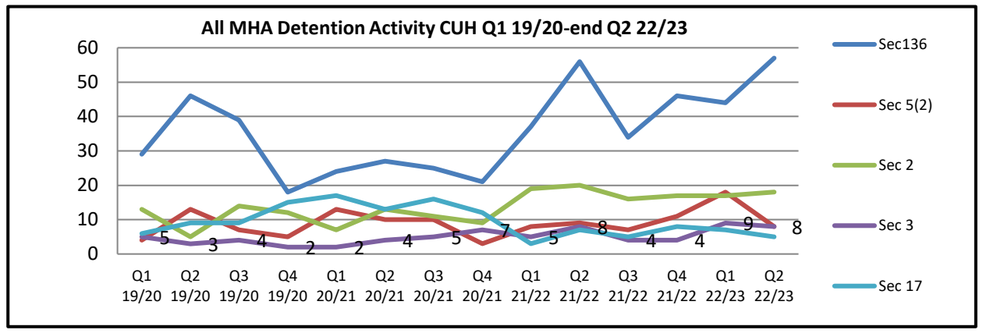
Increased efforts are being made to ensure that gaps in data spanning back to April 2022 are retrospectively analysed there is now data for May, June, July 22. awaiting April and May 22 and September 22 is currently being collected.

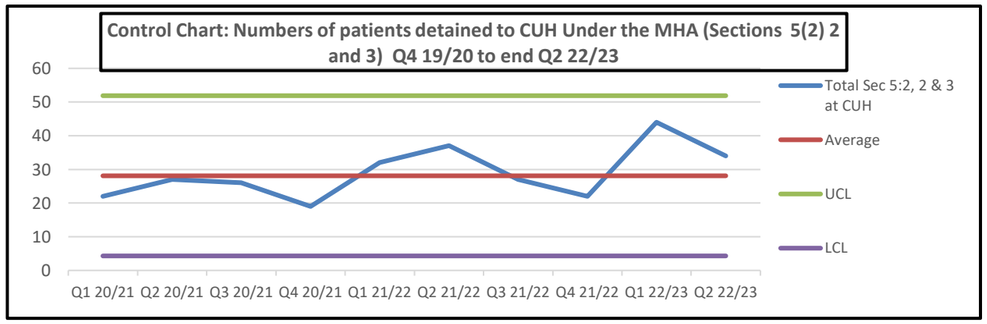
The overall compliance of the sepsis 6 bundle being delivered in 60 mins is dependant on all elements of the bundle being compliant within 60 mins, therefore one or two elements can impact on the overall compliance. Please see breakdown table above with the elements highlighted in yellow and each elements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

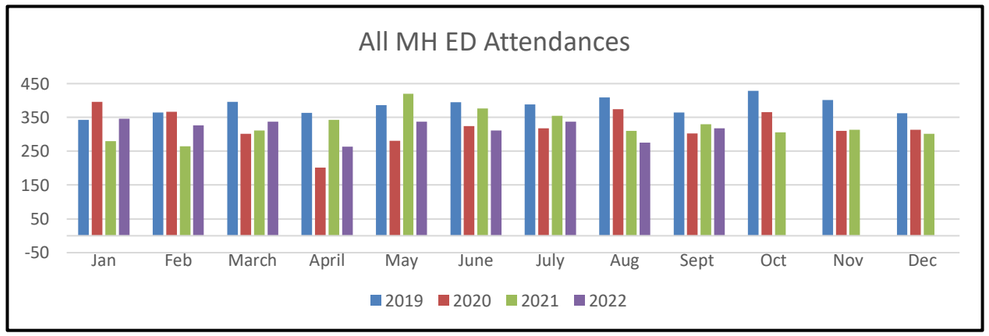
Mental Health - Q1 2022/23

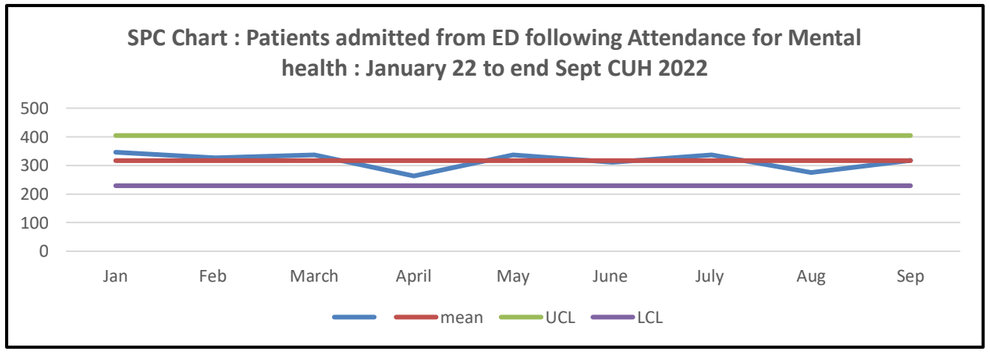
Cambridge University Hospitals NHS Foundation Trust

Mental Health









Narrative

- The numbers of inpatients detained under the Mental Health Act has levelled out in Q2 22/23 following a slight increase in Q1. That increase was largely accounted for by an increased use of Section 5(2) emergency Doctors Holding Power. There were 18 5(2) detentions in Q1 and 8 in Q2.
- The numbers of patients brought to CUH on Sec 136 (place of safety) has increased in Q2. The mean number of patients detained on Sec 136 per quarter since Q1 2019/20 is 35.4. In Q2 22/23 the number of 136's was 57. There is historically an increase in use of Sec 136 in Q2 and this will be monitored. However it is becoming apparent that the use of Sec 136 is gradually returning to pre-pandemic levels. CUH was used as a place of safety when the 136 suite was full on 26 occasions in Q2 compared with 19 occasions in Q1. This likely relates to an overall increase in the use of Sec 136 by the police.
- The cumulative number of mental health presentations to ED in the period January to end September 2022 (2850) is 16.4% lower than for the same period 2019 (pre-pandemic), 0.5% lower than 2020 and 4.9% lower than the same period last year, however, the number of individuals presenting to ED (318) at CUH with a mental health need in September 2022 shows an 15.6% increase from August 2022 (275).
- The number of *adults* presenting to ED in September (271) represents an 8.4% increase on August '22 .
- The cumulative no of patients presenting at ED for mental health reasons who were subsequently admitted to CUH in the period Jan-Sept 2022 shows a 14.7% decrease (325) in comparison to the same period 21/22 (381).
- Compared with August '22, (25), there was an 88% Increase in CAMH aged patients presenting in ED in September (47). 44.7% of those who presented in September were subsequently admitted to CUH (21).
- For CAMH aged patients, the cumulative number of those admitted to a CUH bed from ED has reduced from 147 patients between Jan-Sept 2021 to 133 in same period 2022, a 9.5% decrease.
- Although the numbers of those eligible for CAMH services presenting at ED is very much smaller than for adults, the conversion rate to admission is significantly higher.

Ongoing work:

- The mental health team have been allocated substantive funding for both the Mental health lead (recruitment in process, expected to commence in post February 2023) and the Mental health specialist nurse posts. One commenced in post in October and 1 due to commence in November. Currently a gap in service provision whilst recruitment process is completed.
- Work has been undertaken to revise both the ligature point policy and the anti ligature assessment tool at CUH. Assessments have been completed in the 7 areas that have the highest mental health activity in the hospital. These assessments will need to be repeated annually as per policy or if the areas concerned have any environmental changes before then. Action plans to mitigate some of the issues raised are now in place.

Author(s): Claire Ward

Owner(s): Lorraine Szeremeta

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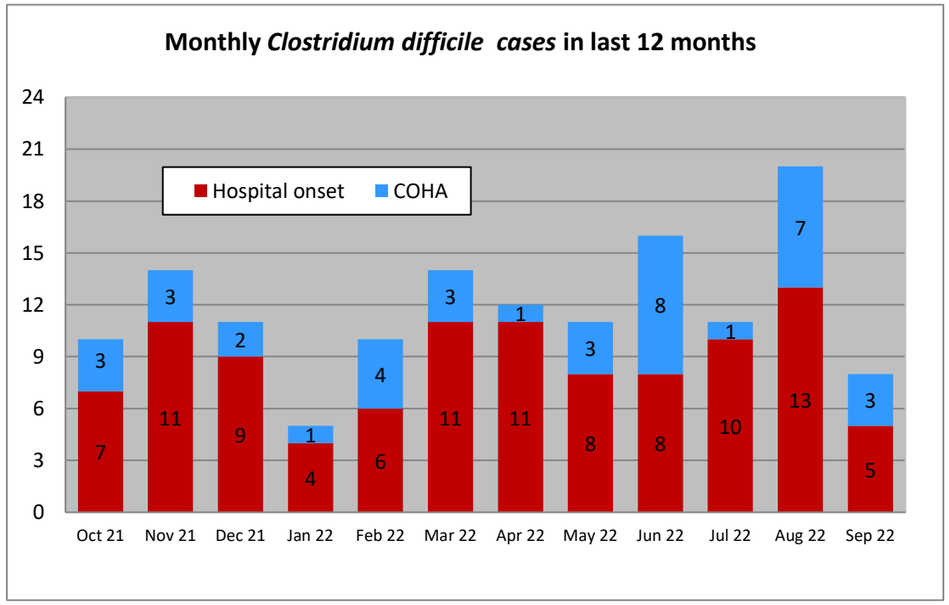
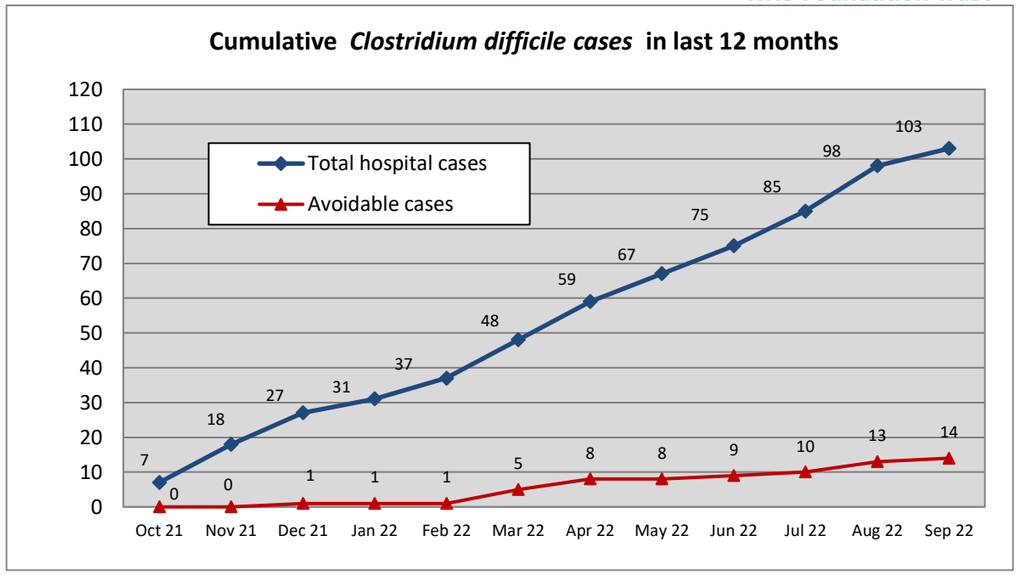
Infection Control

Cambridge University Hospitals NHS Foundation Trust



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



CUH trend analysis

MRSA bacteraemia ceiling for 2022/23 is zero avoidable hospital acquired cases.

- 1 avoidable case of hospital onset MRSA bacteraemia in September 2022
- 2 cases (1 avoidable & 1 unavoidable) hospital onset MRSA bacteraemia year to date

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

- 5 cases of hospital onset *C difficile* and 3 cases of COHA in September 2022.
- 55 hospital onset cases and 23 COHA case year to date. 65 cases unavoidable, 9 avoidable and 4 pending.

MRSA and C difficile key performance indicators

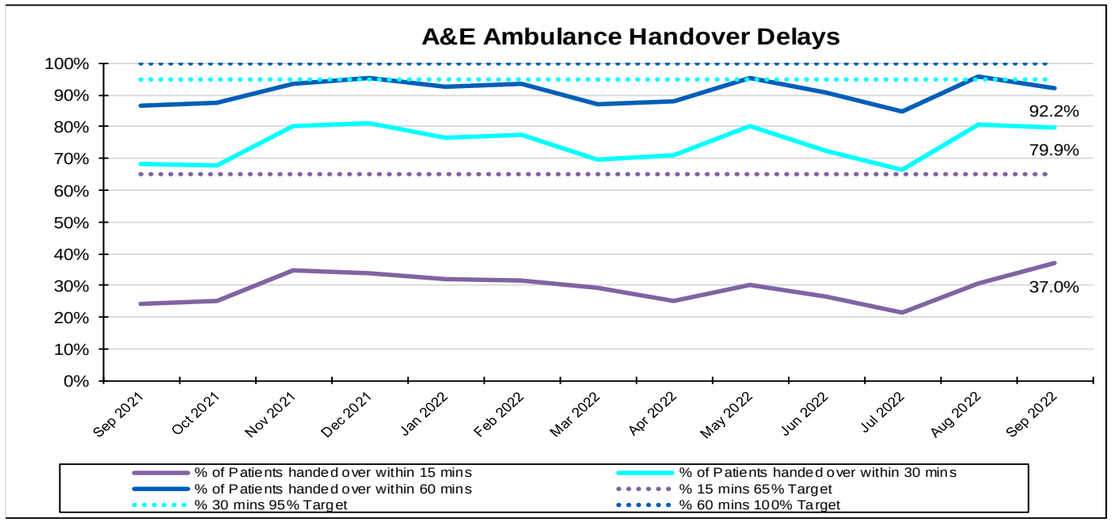
- Compliance with the MRSA care bundle (decolonisation) was 89.4% in September 2022 (83.7% in August 2022).
- The latest MRSA bacteraemia rate comparative data (12 months to August 2022) put the Trust 4th out of 10 in the Shelford Group of teaching hospitals.

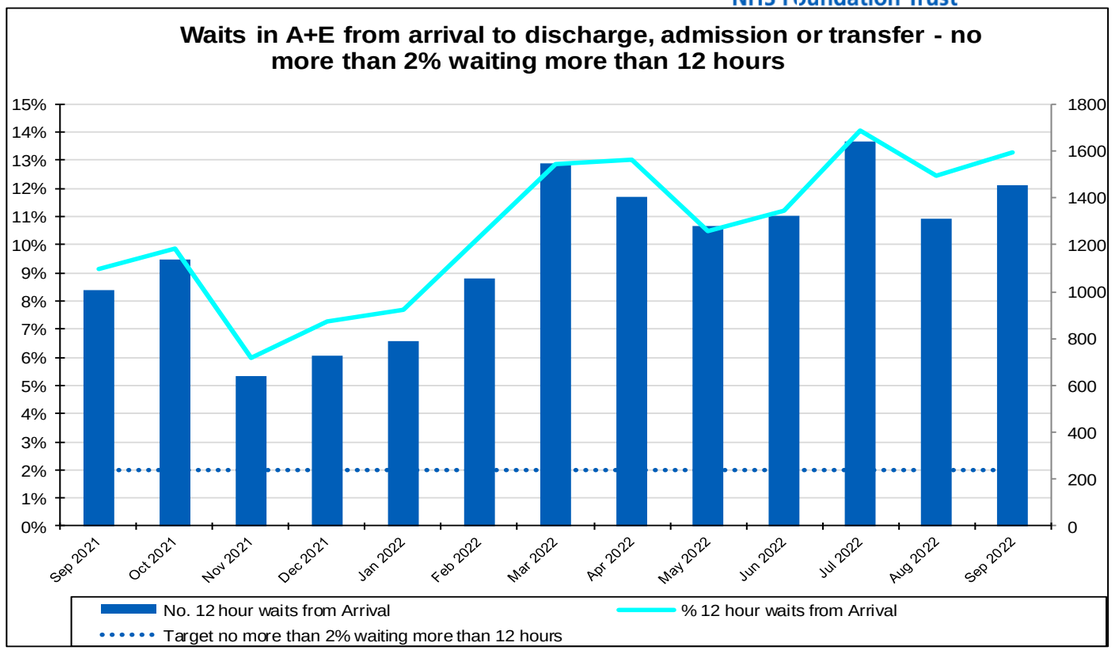
- Compliance with the *C. difficile* care bundle was 90.5% in September 2022 (86.7% in August 2022).
- The latest *C. difficile* rate comparative data (12 months to August 2022) put the Trust 9th out of 10 in the Shelford Group of teaching hospitals.

Amb. Handovers & 12 Hr Waits From

Cambridge University Hospitals NHS Foundation Trust

Operational Performance





	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
No. of Patients not handed over within 30 mins	697	646	485	624	780	434	443
No. of Patients not handed over within 60 mins	300	265	113	212	328	98	172

Demand:
- ED attendances in September were 10,948. This is 322 (3.0%) higher than September 2019. This is equivalent to an increase from 354 to 365 attendances per day.
- Paediatric attendances showed the greatest proportional rise, increasing by 9.0% (+184) from September 2019.
- 1,452 patients had an ED journey time in excess of 12 hours compared to 45 in September 2019. This represents 13.2% of all attendances.

Streaming: To mitigate the increase in demand the ED has a dedicated clinician based at the front door and the ambulance bay to identify patients suitable for streaming to alternative locations:
- 634 patients were streamed from ED to our medical assessment units on wards N2 and EAU4 and a further 391 patients to our Surgical Assessment Unit.
- 3,544 patients were streamed to the Urgent Treatment Centre (UTC), of which 1,702 patients were seen by a GP or ECP.

Ambulance handovers: In September 2022 we saw 2,200 conveyances to CUH which was a decrease of 18.5%, (-501) compared to September 2019. Of these:
- 37.0% of handovers were clear within 15mins vs. 58.1% in September 2019
- 79.9% of handovers were clear within 30mins vs. 95.0% in September 2019
- 92.2% of handovers were clear within 60mins vs. 99.0% in September 2019.

Actions being undertaken by the Emergency Department:
The new UEC Programme Board led by the COO continues to coordinate the recovery of our UEC position. At the last meeting in early October there was a focus on the immediate actions we could take to improve our position and a programme of work was initiated to run over four weeks from 24th October. The aim of this work is to improve outflow from the ED by increasing reverse boarding, use of the discharge lounge and early discharges. Another key initiative was the introduction of the expanded medical assessment unit (MAU) which went live from 19th October. This provides the Trust with additional capacity to quickly flow Medicine patients from the department for assessment, reducing crowding in the department and improving patient experience. We are also preparing for the opening of the Frailty Unit at the beginning of November which will support the admission avoidance of frail elderly patients and release triage space in ED.

Fit Testing compliance for substantive staff

NHS Cambridge University Hospitals NHS Foundation Trust

Fit Testing compliance for substantive staff

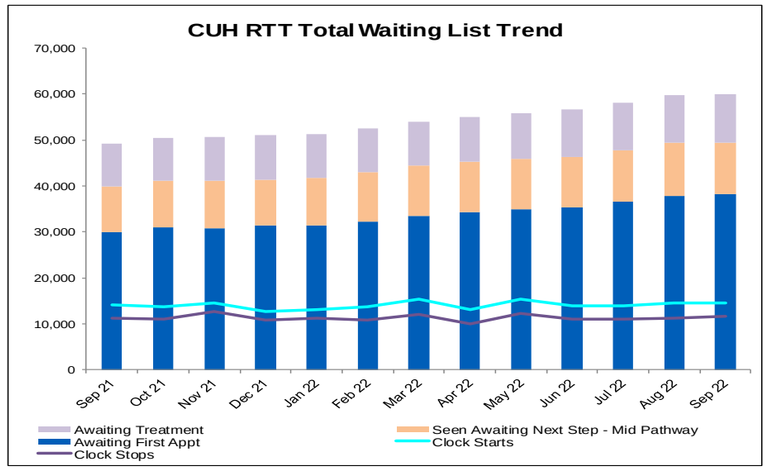
Division	Corporate			Division A			Division B			Division C			Division D			Division E			Total		
Staff Group	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected
Add Prof Scientific and Technical (Pharmacists only)	6	4	67%	-	-	-	130	86	66%	1	1	100%	-	-	-	-	-	-	137	91	66%
Additional Clinical Services	10	7	70%	171	107	63%	60	33	55%	97	69	71%	68	44	65%	63	32	51%	469	292	62%
Allied Health Professionals	-	-	-	52	19	37%	116	54	47%	1	0	0%	-	-	-	1	1	100%	170	74	44%
Estates and Ancillary (Porters and Securuty Personnel only)	53	53	100%	4	1	25%	-	-	-	-	-	-	-	-	-	-	-	-	58	54	93%
Medical and Dental	-	-	-	88	45	51%	51	33	65%	158	110	70%	73	40	55%	90	60	67%	460	288	63%
Nursing and Midwifery Registered	-	-	-	498	316	63%	24	9	38%	220	154	70%	145	105	72%	260	179	69%	1147	763	67%
Total	**69**	**64**	**93%**	**813**	**488**	**60%**	**381**	**215**	**56%**	**477**	**334**	**70%**	**286**	**189**	**66%**	**414**	**272**	**66%**	2441	1562	64%

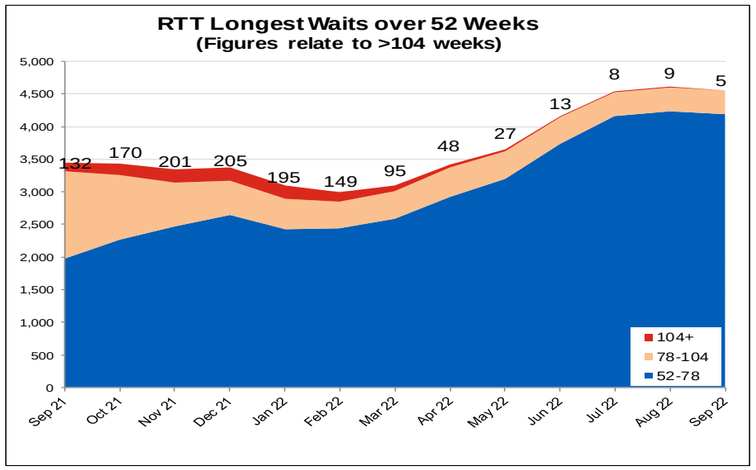
The data displayed is at 11/10/22. This data reflects the current escalation areas requiring staff to wear FFP3 protection. This data set does not include Medirest, student Nurses, AHP students or trainee doctors. Conversations on fit testing compliance with the leads for the external entities take place on a regular basis. These leads provide assurance on compliance and maintain fit test compliance records. Fit test compliance for Bank and Agency staff working in 'red' areas is checked at the start of each shift and those not tested to a mask in stock are offered fit testing and/or provided with a hood. Security and Access agency staff are not deployed to 'red' areas inline with local policy.

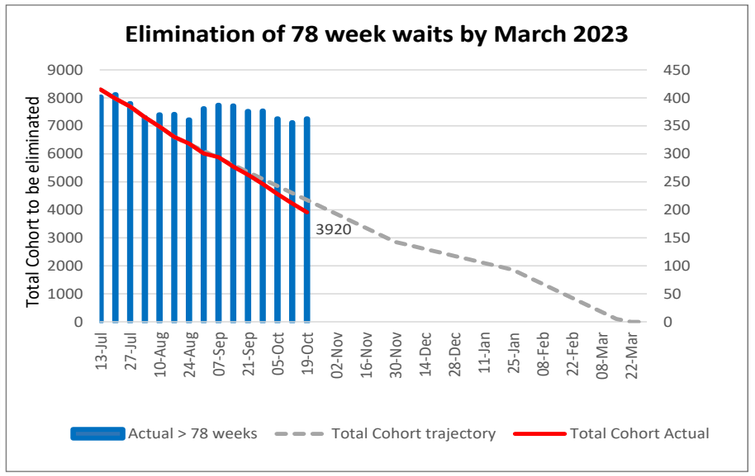
Referral To Treatment - (RTT)

Cambridge University Hospitals NHS Foundation Trust

National Targets







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

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

The total waiting list size grew by only 212 in September to 59,960. Our Month 6 planning submission had forecast growth to 53,629 so we are now 12% higher than plan.
Compared to pre-pandemic the waiting list has grown by 76%.

The number of patients joining the RTT waiting list (clock starts) were 4% higher than last month, and 12.5% higher than September 2019. We had forecast continued referral growth of 2.3% above 2019 baseline and cumulatively year to date we are now 5% above planned levels. This significantly higher level of demand will be driving the waiting list up. Clock starts (referrals) represented 24% of the total waiting list size in the month. Patients waiting to commence their first pathway step accounted for 64% of the total. The highest demand growth was seen in ENT, Gastroenterology, Colorectal and Ophthalmology which were 36% of the total.

The number of RTT treatments (stops) delivered in September were 7% higher than the prior month and represented 96.5% compared to September 2019. Non-admitted stops were 98.9% of baseline, and admitted stops were 88.7% of baseline. Total treatments were 9% below our submitted plan for September, but we would not have planned for the additional Bank Holiday which will have had a -5% impact on activity. The number of validations was higher than planned which supported reduced growth in the total waiting list. The clearance time for the RTT waiting list (how long it would take to clear if no further patients were added) reduced to 21 weeks given the higher treatments and lower growth in the waiting list this month.

The 92nd percentile total waiting time remained at 51 weeks.
The volume of patients waiting over 52 weeks reduced by 1% for the first month in 7 months to 4,554. The last reported National figures show a 3% growth. 1112 patients in total were treated who had waited over a year which was 9.6% of treatments. The specialties with the highest volumes over 52 weeks remain OMFS, ENT, Cardiology and Rheumatology and 82% of these are non-admitted pathways. Insourcing has commenced for OMFS, and ICS Mutual Aid support for Rheumatology and Cardiology will give some activity increases from November. Mutual Aid support via the Regional and National process has been requested for Thyroid surgery within ENT.

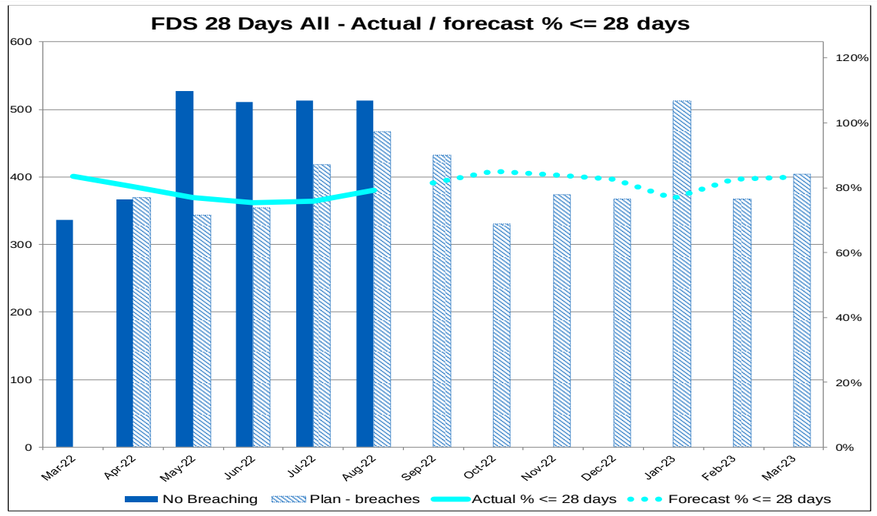
The volume of patients waiting over 78 weeks reduced to 365. Divisions are working with a step down plan to reduce maximum waits by 2 weeks per month through to year end. The current rate of reduction of the total cohort is 438 ahead of trajectory to deliver the requirement to eliminate 78 week waits by April 2023. We are also tracking twelve individual specialty trajectories for our Tier 2 recovery monitoring meeting. Waits over 104 weeks were reduced to five at the end of September, and we currently forecast one complex case at the end of October. None have been capacity breaches. NHSE have issued new National guidance relating to patient choice. We currently have one patient choice breach forecast for November which pre-dates the new guidance.

Nationally the RTT waiting list continues to rise, reaching 7 million in August 2022 with 5.5% of patients waiting over 52 weeks. CUH had 7.7% over 52 weeks which was joint 2nd highest of the 14 Acute Trusts in EoE. At 13.2% over 52 weeks, Norfolk and Norwich remains the greatest challenge in the Region for long waiting patients. We remain third highest amongst the Shelford Group with Birmingham the most challenged with 20% over 52 weeks.

Cancer

National Targets

Cancer Standards 22/23	Target	Qtr 1 - 21/22	Qtr 2 - 21/22	Qtr 3 - 21/22	Qtr 4 - 21/22	Qtr 1 - 22/23	Jul-22	Aug-22
2Wk Wait (93%)	93%	93.0%	94.9%	81.8%	78.9%	83.3%	75.3%	78.8%
2wk Wait SBR (93%)	93%	84.4%	92.4%	43.9%	35.5%	55.1%	66.7%	31.0%
31 Day FDT (96%)	96%	92.9%	91.7%	91.0%	94.3%	91.0%	91.4%	89.6%
31 Day Subs (Anti Cancer) (98%)	98%	98.8%	99.7%	100.0%	100.0%	100.0%	100.0%	98.9%
31 Day Subs (Radiotherapy) (94%)	94%	94.9%	99.1%	98.3%	93.7%	85.1%	95.0%	89.3%
31 Day Subs (Surgery) (94%)	94%	87.5%	85.1%	83.0%	89.0%	82.9%	68.8%	73.1%
31 Day - Combined	**96%**				**94.2%**	**89.3%**	**91.7%**	**88.7%**
FDS 2WW (75%)	75%	83.8%	81.1%	85.3%	81.3%	78.0%	77.1%	79.8%
FDS Breast (75%)	75%	99.5%	97.6%	98.0%	94.6%	96.6%	97.7%	98.2%
FDS Screen (75%)	75%	65.8%	72.9%	65.7%	64.5%	64.6%	57.8%	68.4%
FDS - Combined	**75%**				**80.6%**	**77.4%**	**75.9%**	**79.3%**
62 Day from Urgent Referral with reallocations (85%)	85%	**75.4%**	**75.1%**	**73.2%**	**73.0%**	**70.4%**	**71.7%**	**72.0%**
62 Day from Screening Referral with reallocations (90%)	90%	**68.6%**	**55.0%**	**68.9%**	**61.4%**	**54.7%**	**57.1%**	**52.3%**
62 Day from Consultant Upgrade with reallocations (50% - CCG)	50%	65.8%	60.0%	51.2%	74.2%	60.0%	50.0%	100.0%
62 Day Reallocations - Combined	85%				**67.7%**	**70.7%**	**69.0%**	**68.9%**



The latest nationally reported Cancer waiting times performance is for August 2022.

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

The volume of 2ww patients seen in August 2022 was 21% higher than in August 2019, the baseline year. 2ww breaches increased to 506 in August leading to performance of 78.8%. 72% were capacity related. Breast 2ww were 55% of the breaches, with Skin breach volumes improving from July but still representing 26%. The breaches that were due to capacity reflected an average wait of 18 days for Breast but much longer at 33 days for Skin. The National 2WW performance was lower at 75.6%. For symptomatic breast referrals our performance was well below National at 31% compared to 70.9%, with the service clinically prioritising the suspected cancer referrals.

Our combined performance on the Faster Diagnosis standard within 28 days remains ahead of target at 79.3%. National average is 69.5% for FDS.

The 62 day Urgent standard performance improved in August to 72%. This remained ahead of performance Nationally of 61.9%. There were 48.5 accountable breaches of which 34 were CUH only pathways. 21 of these delays were provider initiated delays, within which 14 were in the diagnostic phase and 6 surgical delays. 11.5 were due to late referrals of which 6,5 were treated within 24 days of transfer. Complex pathways requiring multiple diagnostic tests were high this month with 11.5 breaches. Breaches spanned 11 cancer sites, with the highest volumes by site being Urology with 11.5, then Lung, Gynaecology and Head and Neck all with 6.5. The 62 day screening standard incurred 13 breaches this month, between Breast and Lower GI. Performance was 52.3% compared to higher National performance at 68.5%. 50% were due to patient choice predominantly in Lower GI.

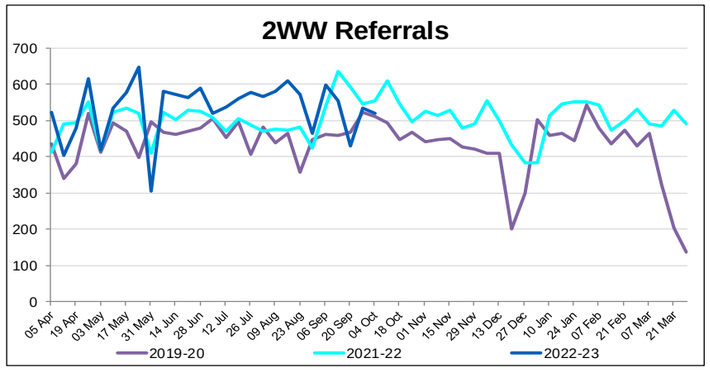
The 31 day FDT standard deteriorated in August to 89.6%, and remained below National at 92.1%. The subsequent surgery standard improved to 73.1% against National of 80.3%. Elective capacity accounted for 93% of those exceeding 31 days, and Urology capacity specifically accounted for 35% of the breaches. The subsequent radiotherapy performance also fell back below standard in August to 89.3% due to capacity. The CT replacement coupled with workforce gaps leads to a reliance on additional hours which were not sufficient in the peak the holiday month to mitigate.

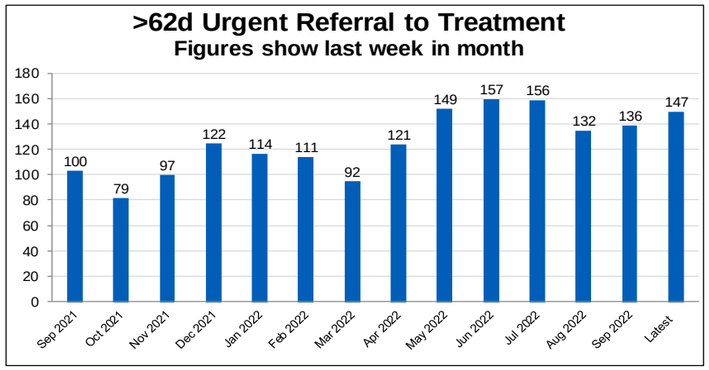
21 pathways waited >104 days for treatment in August. 14 were shared pathways referred between day 20 and 243, with the highest volume from a single Trust being NWAFT with six. Seven CUH pathways exceeded 104 days across HPB, Urology, Lung, Haematology Lower GI. Complex diagnostic delays were the reasons. The RCAs have been reviewed by the MDT Lead Clinicians and the Cancer Lead Clinician for the Trust. and to date harm has been classified as 'no harm' or 'low harm' with three reviews outstanding.

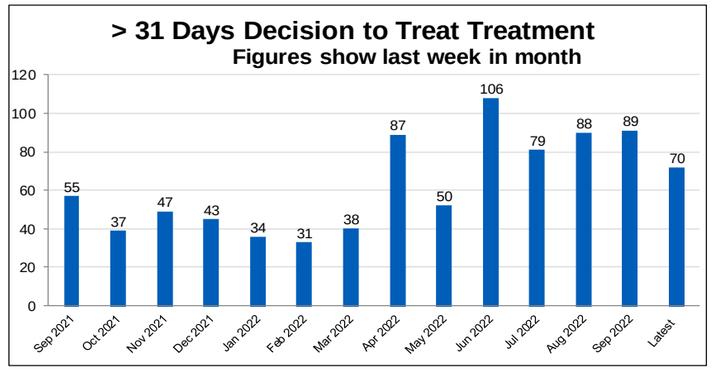
Cancer

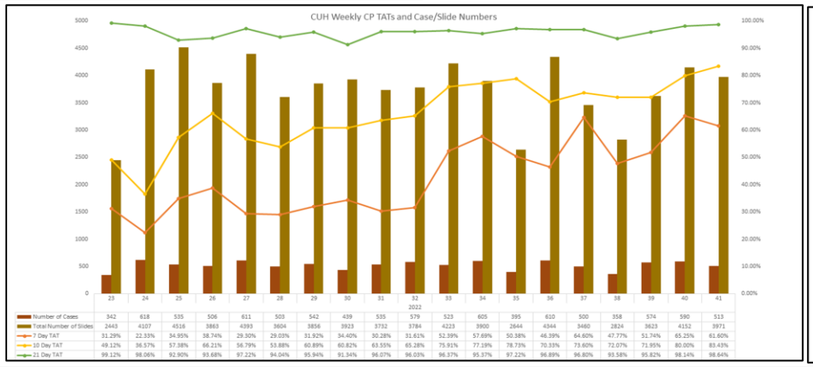
Cambridge University Hospitals NHS Foundation Trust

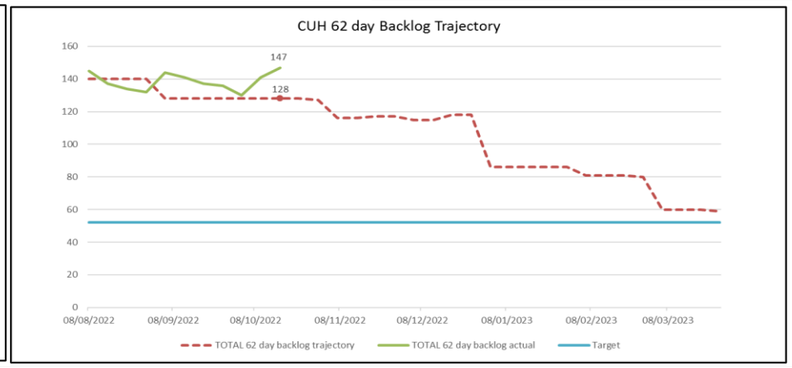
National Targets











Current position

Over the past four weeks 2WW suspected cancer referral demand dipped to 117% compared to the same baseline period in 2019, but this does include the impact of the additional Bank Holiday. 2ww breaches are expected to exceed 600 in both September and October with Breast accounting for 50% of these and Skin (Plastics) ~30%. Average waits for those exceeding 2 weeks have reached 24 days for Breast and 32 days for Skin. The last remaining post to recruit for the Breast service expansion commences on 15th November and this will facilitate an increase in capacity of 69 slots per week. This should support recovery back to 14 days by the end of the calendar year. Prior to this final role commencing, we are offering mutual aid to NWAFT Breast service for four weeks by providing diagnostic ultrasound capacity as they have a significant shortfall in this capacity in their Breast pathway and NWAFT are in Tier 2 for oversight of their cancer recovery.
Plastics surgery have introduced locum medical support to cover gaps in workforce from 14th October. This role provides an additional 18 slots for 2ww per week, plus excision capacity. Patients are being brought forward into this capacity and the backlog has reduced by 20% so far.

We are monitoring the number of patients waiting longer than 62 days from referral to treatment against our recovery trajectory submitted to the Cancer Alliance. The backlog > 62 days has increased to 147 and is 19 behind trajectory. Representing 7.1% of the total cancer waiting list over 62 days, this is still the best performing in the EoE Region. The highest variances from plan are in Urology and Skin. 54% of the 62 day backlog are CUH only pathways, of which Skin are 32%, Lower GI 19% and Urology 16%. Of the Inter Trust backlog, 57% is Urology, and these represent 75% of the total Urology backlog.
We have continued to see improvement in histology , with >60% turnaround within 7 days on the past 2 weeks data.

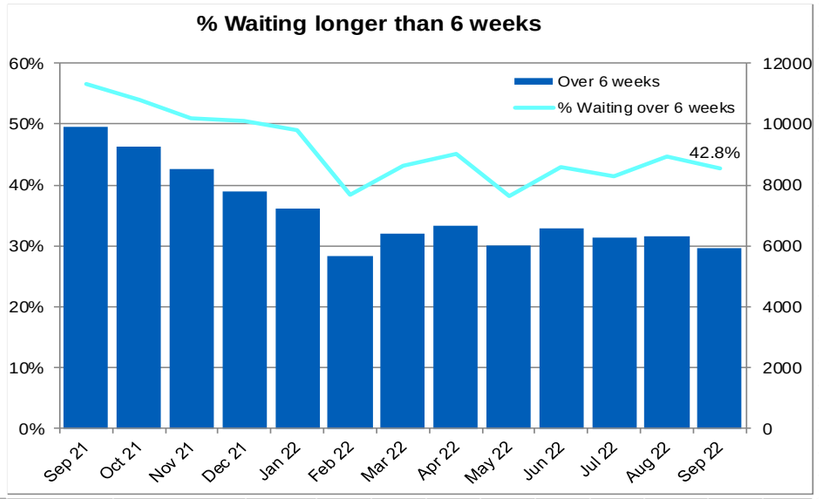
The number of patients waiting over 31 days for treatment has reduced to 70 from 89 last month. 60% are booked for treatment. Skin account for 27% of the delays across both Dermatology and Plastics. Breast are 26% of the delays, of which half are due to surgical capacity. It is expected that additional use of the Independent sector could support capacity over the next month. 17% are in Urology but these are predominantly now for Kidney procedures with the prostate backlog having reduced by 75% in the past month. Medical workforce gaps in Urology are impacting on the service. HPB continue with delays to surgery but this is on an improving trend.

Diagnostics

Cambridge University Hospitals NHS Foundation Trust

Operational Performance

Change from previous month:		Sep-22								
Deteriorated / Improved		Waiting List					Scheduled Activity		Total Activity	
		Total Waiting List	Variance from Feb 2020		%> 6 weeks	Mean wait in weeks	Scheduled Activity	Variance from Sep-19 Baseline	Total Activity	Variance from Sep-19 Baseline
Imaging	Magnetic Resonance Imaging	3007	1962	53%	46.7%	8	2657	111.9%	3070	113.3%
	Computed Tomography	2024	1038	95%	45.2%	9	2875	114.9%	5977	118.4%
	Non-obstetric ultrasound	3675	1876	96%	51.4%	7	3657	109.4%	4354	103.6%
	Barium Enema	45	31	45%	22.2%	3	42	161.5%	46	176.9%
	DEXA Scan	553	648	-15%	10.3%	4	605	117.5%	605	114.2%
Physiological Measurement	Audiology	734	338	117%	48.8%	6	470	123.4%	470	123.4%
	Echocardiography	1955	967	102%	56.6%	10	1221	103.0%	1603	109.0%
	Neurophysiology	172	269	-36%	6.4%	3	220	67.3%	231	69.0%
	Respiratory physiology	46	24	92%	45.7%	9	30	115.4%	32	123.1%
	Urodynamics	234	93	152%	57.7%	9	37	63.8%	37	63.8%
Endoscopy	Colonoscopy	569	539	6%	0.2%	2	460	103.4%	469	103.1%
	Flexi sigmoidoscopy	122	106	15%	0.0%	2	73	110.6%	89	98.9%
	Cystoscopy	169	236	-28%	8.9%	3	380	94.3%	391	93.8%
	Gastroscopy	576	581	-1%	2.6%	3	578	105.1%	628	99.7%
Total Diagnostic Waiting List		**13881**	**8708**	**59%**	**42.8%**	**7**	**13305**	**109.0%**	**18002**	**109.9%**



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

Total diagnostic activity in September delivered to 110% of September 2019 baseline. Scheduled activity only, which addresses our waiting list, also delivered to 109% this month. The total waiting list size reduced by 205 to 13,881, and the volume of patients waiting over 6 weeks decreased by 365 this month so the > 6 weeks performance improved to 42.8%. The Mean waiting time reduced to 7 weeks. Nationally published data for July 2022 shows National performance of 27.9%. From a Regional perspective of the 14 Acute Trusts in EoE, CUH were ranked 12th of 14 with Kings Lynn and E&N Herts having a slower recovery rate.

Imaging activity overall achieved above baseline levels for total activity and scheduled activity at 112%. The Imaging waiting list overall reduced by 367, with progress made in all bar MRI.

- **CT** reduced their long waits over 6 weeks by 214 in month leading to a 7.2% improvement in performance. The total waiting list reduction, whilst still improving, has slipped a further ~750 behind trajectory since the start of September. 17% of this variance is explained by higher demand, but 83% is due to lower activity than forecast. At this rate baseline would not be recovered until end of January. CUH will have access to the CT mobile based at NWAFT for 3 weeks in November. Cardiac CT represents 20% of the total CT waiting list and it has been identified that a change in clinical practice could support a 20% increase in productivity of the existing CT Cardiac capacity which is being taken forward with Cardiology. CUH CT is ranked 13/14 for recovery of 6ww performance in the Region with only East & North Herts further behind.
- **MRI** saw a slight increase in waiting list by 57 in September but reduced the longest waits > 6 weeks by 200 leading to a 7% improvement in performance. In the last 2 weeks progress against trajectory for January has slowed due to higher demand and underachievement of activity via the ICS mobile scanner based at Hinchingbrooke. Better utilisation of this capacity will be a focus. The next MRI replacement has been delayed until Feb 2023. CUH MRI % recovery ranks 12/14 in the Region with E&N Herts and Kings Lynn behind.
- **Dexa** have recovered their total waiting list to baseline levels, and now have just 57 patients > 6 weeks to recover their long wait performance which improved by 2.2% in month.
- **Ultrasound** have demonstrated an improving waiting list since mid August, and reduced by 196 in September. If the rate of reduction continued it could recover to baseline in six months. The volume waiting over 6 weeks did reduce by 41 but in percentage terms increased by 1.5%. The overall reduction is being delivered through redirection of GP Direct Access demand to Community Ultrasound services which is administratively challenging for CUH. There remains underutilised capacity within the community and the ICS is targeting high referring GP practices to alter their referral patterns at source direct to community for appropriate scans. Ultrasound recovery is challenging across the EoE with only 2 providers recovering at a slower rate than CUH.

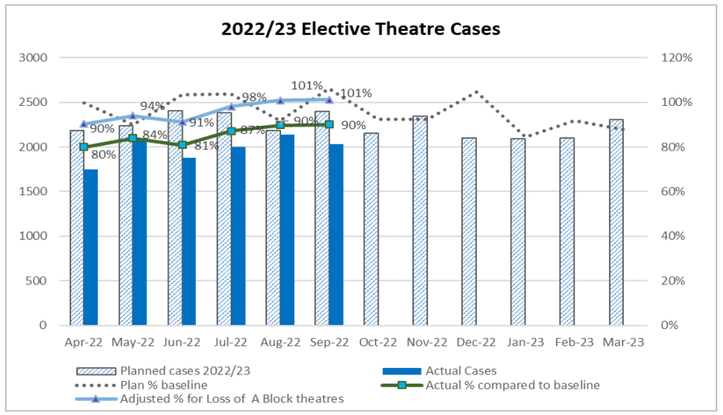
Physiological measurement saw a waiting list increase of 255 in September of which 212 was in Echocardiography. Activity across the group was 105% of baseline. Activity in Echocardiography was lower than planned in September due to ongoing equipment faults. This has now been resolved in the short term with loan machines, and new replacement machines are being ordered as part of the capital programme. Bank staffing at enhanced rates are being continued beyond September whilst the Phased workforce plan is implemented. Recruitment to Phase 1 has been unsuccessful, and Phase 2 will commence this month. We are ranked 7/14 for recovery across the EoE with two Trusts still having over 70% of patient waiting over 6 weeks.

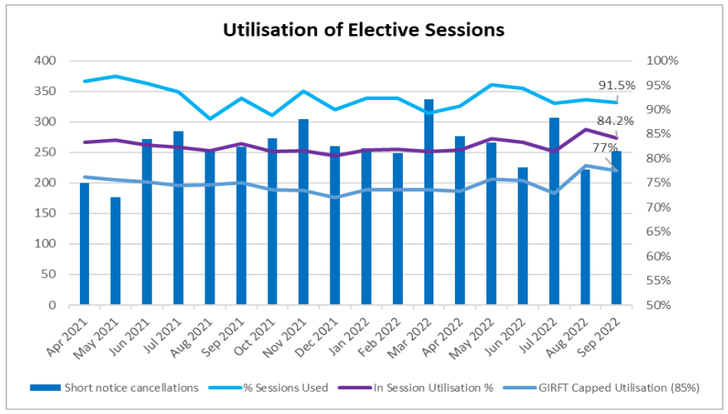
Endoscopy Only cystoscopy remains with a long wait issue to address despite now having an overall waiting list lower than baseline . The volume over 6 weeks has halved to 15, and we are performing well compared to Trusts in the Region, ranking 4/13 for Cystoscopy recovery. Endoscopy recovery in the North of the ICS is much more challenged and our Clinical Director supporting the wider System on Endoscopy delivery.

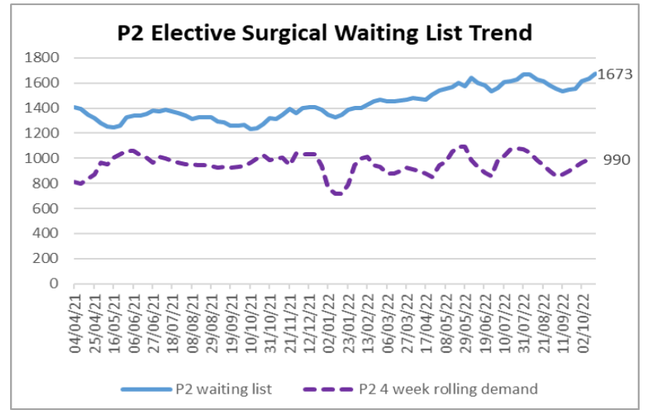
Operations

Cambridge University Hospitals NHS Foundation Trust

Operational Performance







Elective theatre activity in September compared to 2019 baseline achieved 90%. Taking account of the loss of the A Block theatres from our capacity, this would bring the performance above baseline at 101% for the second consecutive month.

- Our plan for September 2022 was to deliver 106% of baseline so we fell short by 362 operations. The additional bank holiday will have impacted the ability to deliver to plan.
- Productivity in September was 91.5% of sessions used against our aim of 95%. 15/90 unused sessions were on the Bank Holiday. 43% of those remaining unused were at Ely. The Surgical Prioritisation Group has asked that Surgery Programme Board review and realign the Ely schedule to provide capacity to other specialties based on underuse.
- In-session utilisation dropped to 84.2% against our aim of 90%. Against the GIRFT Capped Utilisation metric our performance was 77% in September which is 1% down on last month.
- Short notice cancellations in elective sessions increased in September. At 252 cases , they equated to 494 hours of theatre time. 30% of cancellations were for clinical reasons. A further 9% were due to boiler failure at Ely DSU which impacted for 2 days. Bed capacity was the third highest reason with 8%.
- Ely in-session utilisation was flat in September at 84.7%, and very low on the GIRFT Capped Utilisation measure at 65%.
- The Cambridge Eye Unit dropped to 82.4% sessions used due to surgeon availability. In-session utilisation was flat at 77.3% and Capped utilisation is 66%.
- The weekend elective activity shows only three cases undertaken.

The number of P2 patients awaiting surgery has increased by 7.5% from last month to 1,673. The four week rolling demand is also up by 6%. The volume waiting over 4 weeks has increased by 42 over the past month to 932.

The Surgery Programme Board meets fortnightly with clinical engagement from across the HVLC specialties and monitor improvements against the GIRFT recommendations.
Recent activity includes reviews of best practice nationally, regionally, and within in the ICS for Day Case rates and Pre-assessment solutions:

- Visit to Ortho surgical hubs in Northumbria and now Exeter to improve existing elective pathways, focussed on pre-habilitation and optimisation to aid post-op recovery and reduce length of stay. Other initiatives include protecting operating time and reducing cancellations on the day.
- Visits to West Suffolk, Peterborough, and Hinchingbrooke in early October established CUH as an outlier for conducting all pre-assessment face-to-face. Immediate actions taken to facilitate appropriate cohorts to undergo telephone assessments.
- Day Surgery Units with better 'day case rate' performance were also identified as having a better staffing ratio at key points of the day, particularly on receipt of patients back from recovery and into the early evening. Findings raised with senior nursing and review of nursing establishments to accommodate Day Case, 23hr, and contingency space underway. New National Core requirements have been issued by the National Per-operative Care Programme for Pre-assessment.
- Specific focus on placing Day Case first on the list has seen an impact on HVLC procedures such as Lap Choles, where CUH was previously 2nd worst performing Trust (28%) in March 2022, latest Model Hospital data (Jul 2022) has CUH top of Quartile 1 at 56%, with the national median at 72%. Local data shows rapid improvement following GIRFT visit and Programme Board creation. Rolling 4 week average now at 70% for Lap Choles.

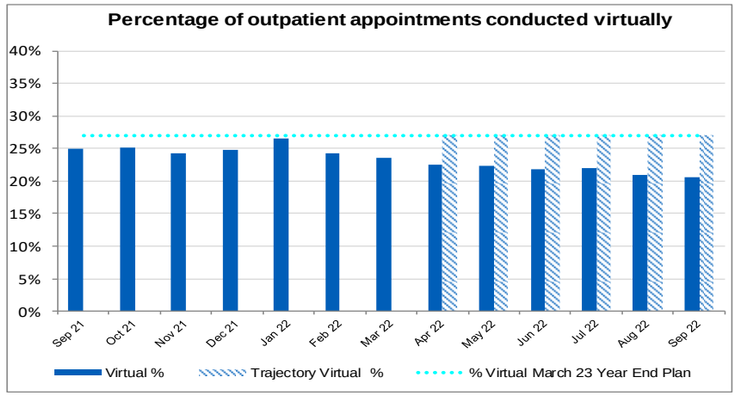
Recent challenges to the elective surgical activity include increased staff shortages with sickness, and bed capacity due to use of L2DSU for emergency surgical contingency

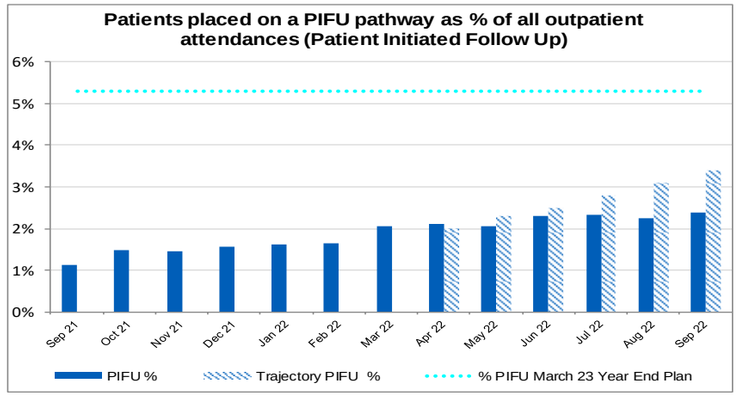
- Start times and turnarounds had marked improvement in September, these have suffered in early October with limited patient flow affecting ability to move into and out of recovery.

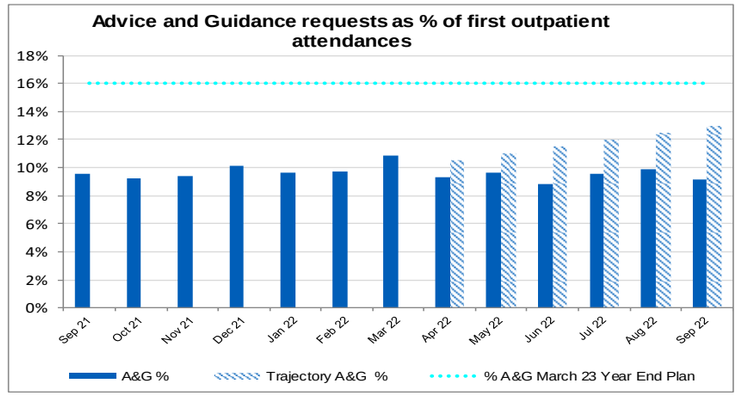
Outpatients

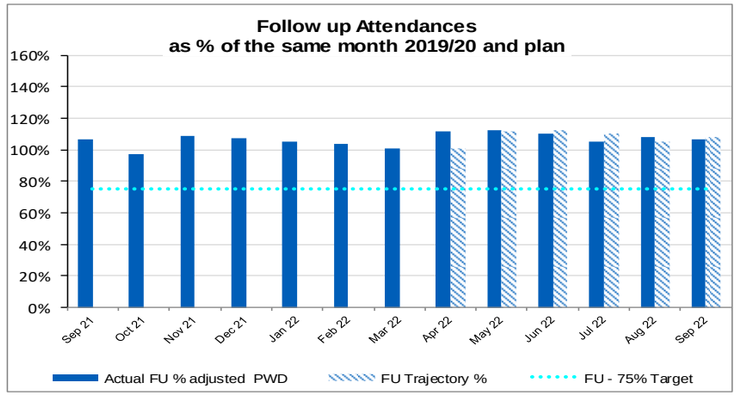
Cambridge University Hospitals NHS Foundation Trust

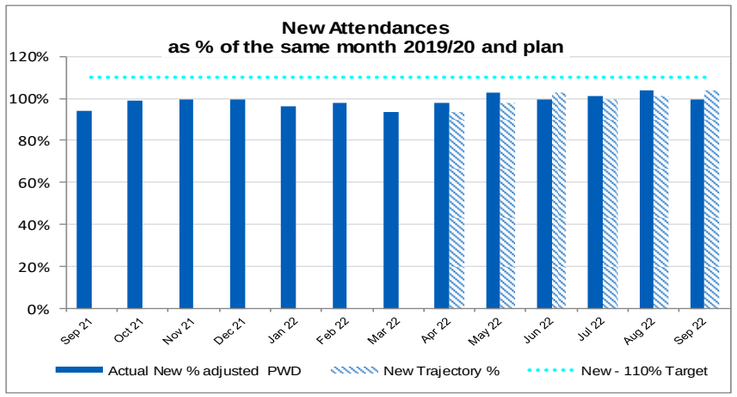
Operational Performance











In September outpatients delivered 99.6% new activity against baseline which has been adjusted for working days per month. This is down on the previous two months and is something that will form part of the agenda for the next Outpatient Improvement Board meeting. It is essential that we continue to perform above 100% to reduce the backlog and have set ourselves a target of 110%. Follow-up numbers continue to perform above baseline at 106.5%, this figure is also adjusted for working days per month. We continue to be a long way from the targeted 75%. Change ideas being tested to achieve this include 'patient not present' reviews, e.g. within Rheumatology; pathway redesign to reduce follow ups e.g. Endometriosis; and analysis of different types of follow ups, e.g. in Oncology, to determine which follow ups require procedures/treatment and where true opportunity lies for reduction.

PIFU numbers have increased slightly to 2.4%, with approximately 500 orders being placed per month. There are some larger services which have yet to take good advantage of the process. Specific work is being supported by the Improvement Team in Cardiology, Endocrinology and Diabetic Medicine to try to improve usage.

Advice & Guidance requests remain low against both trajectory and target. Discussions are ongoing with the system around how we can increase usage to reduce inappropriate referrals. The numbers are predominantly driven by GP requests and therefore difficult to manage internally. Work is however also needed to ensure that we are triaging appropriately.

Virtual consultations continue to fall which is disappointing considering how well we performed last year. Again we are looking at ways to improve this by approaching services with low use of virtual clinics to see whether their patient cohort is appropriate to be seen virtually. We are also exploring options around Patient Not Present consultations where a number of services have expressed an interest.

Author(s): Andi Thornton

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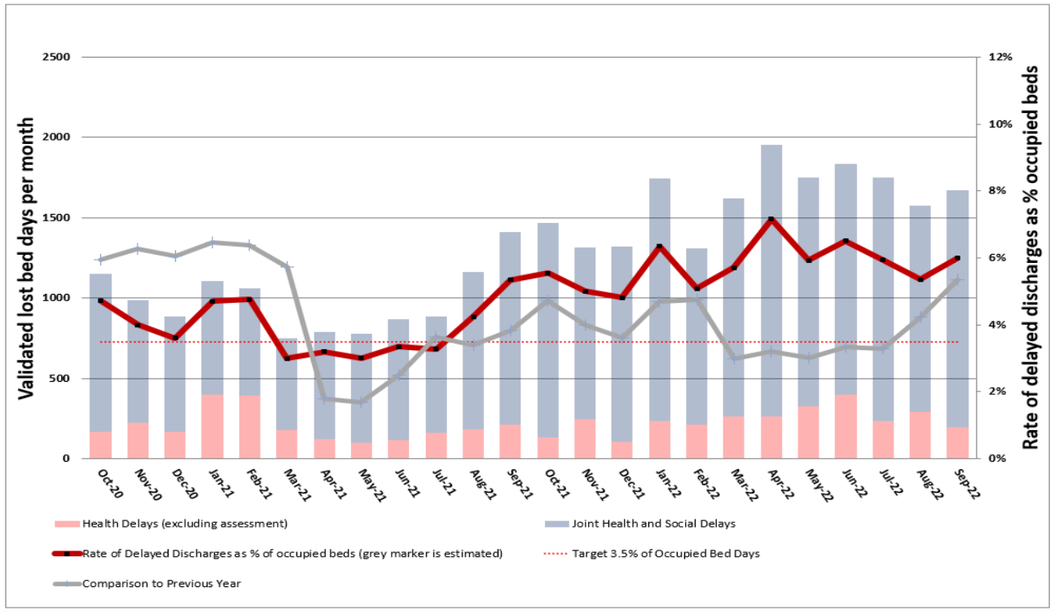
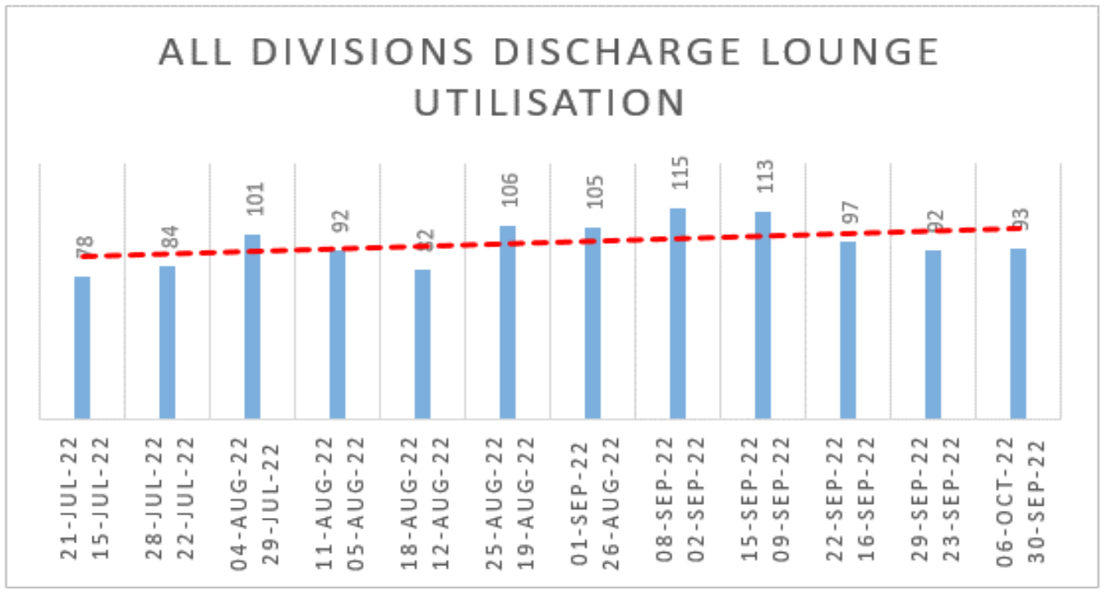
Delayed Discharges

Cambridge University Hospitals NHS Foundation Trust

Operational Performance





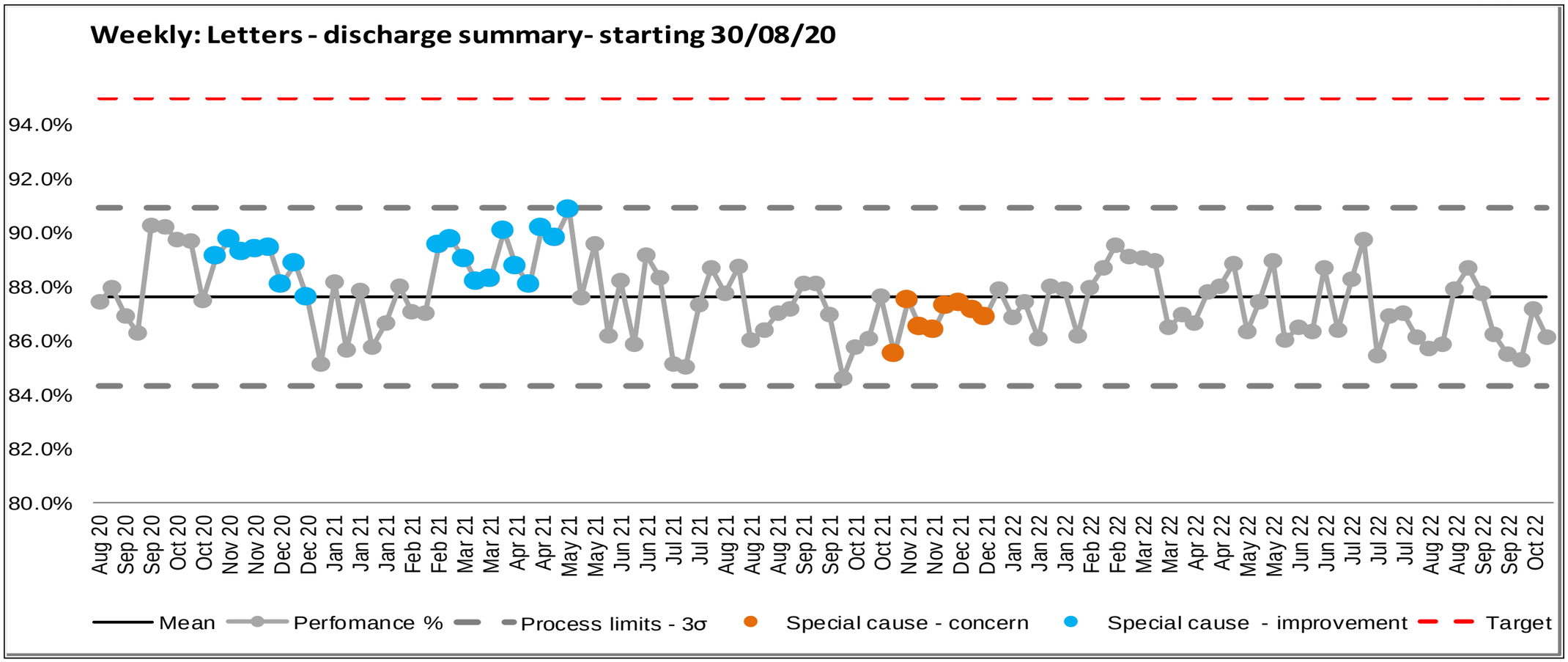
The Hospital Discharge Service Requirements guidance was last updated on September 2022. For this September data, you will see above 2 graphs.
The graph on the left looks at the overall lost bed days for the month, spanning back over the previous 12 months (similar to the previous integrated performance reports). The graph on the right looks at average number of complex and simple discharges per day, with average weekend discharges (% from week day discharges) and average discharges before noon (for the month).
For August 2022, we are reporting 6%, which is an increase of 0.6% from the previous reporting month (an increase of 100 lost bed days).
Within the 6%, 64% were attributable to Cambridgeshire and Peterborough ICB, and the remainder across a further 8 ICB's. *Please note that we have referred to delays per CCG instead of Local Authority.*
In relation to lost bed days for Cambridgeshire and Peterborough overall for September (1074) this has been an increase in overall lost bed days from August (958) which equates to a 12% increase in the last month.
For out of county patients, we continue to see a sustained elevated number of ICBs that our patients are from and waiting care provision with the overall lost bed days associated for out of area ICBs at 600. There has not been any significant changes over the last month
For the total delays (local and 'out of area') within August for Care Homes were 49% equating to 831 lost bed days for this counting period (a 26% increase from August); domiciliary care (inclusive of Pathway 1 and Pathway 3) at 26% of the total lost bed days for the month, at 441, a 12.5% decrease from August.
For community bedded intermediate care (inclusive of waits for national specialist rehabilitation units), the overall lost bed days is currently at 171, a decrease of 40% over the last couple of months

The national hospital discharge funding ceased in March 2022 and there has been a noticeable increase in delays for patients awaiting care provision post discharge, and an increase in lost bed days associated with patients self-funding their care post discharge. Potential solutions are currently being explored ahead of Winter to support patients and/or relatives with sourcing their own care.

Discharge Summaries

Cambridge University Hospitals NHS Foundation Trust

Operational Performance



Discharge summaries

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

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

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

Author(s): James Boyd

Owner(s): Ashley Shaw

Patient Experience - Friends & Family Test (FFT)

Cambridge University Hospitals NHS Foundation Trust

Patient Experience

The good experience and poor experience indicators omit neutral responses.

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
FFT Inpatient good experience score	Jul 20 - Sep 22	Month	-	95.6%	95.8%		-	-	For September, the Good score remained about the same as August at 95.7%. However the Poor score increased to 2.0% and is a 1% increase from August. The number of responses in September was slightly lower compared to August, and continues to be well below FFT responses of 850-950 pre pandemic. **FOR SEP: there were 411 FFT responses collected from approx. 4,198 patients.**
FFT Inpatient poor experience score	Jul 20 - Sep 22	Month	-	2.0%	1.5%		-	-	
FFT Outpatients good experience score	Apr 20 - Sep 22	Month	-	93.6%	95.2%	L	SP	-	For September, the Good score remained the same as August and is 93.6%. The Poor score increased to 3.3% and is the highest score since last year. There was 0 FFT data collected from paediatric clinics so the FFT scores are only from adult clinics. **FOR SEP: there were 5,133 FFT responses collected from approx. 29,671 patients. See comment below regarding # of SMS.**
FFT Outpatients poor experience score	Apr 20 - Sep 22	Month	-	3.3%	2.2%	H	SP	-	
FFT Day Case good experience score	Apr 20 - Sep 22	Month	-	94.6%	96.7%	L	SP	-	For September, the Good score decreased by 1% compared to August and is 94.5%. The Poor score slightly increased compared to August and is 2.6%, this highest score this year. **FOR SEP: there were 1065 FFT responses collected from approx. 4,275 patients. See comment below regarding # of SMS.**
FFT Day Case poor experience score	Apr 20 - Sep 22	Month	-	2.6%	1.7%		-	-	
FFT Emergency Department good experience score	Apr 20 - Sep 22	Month	-	75.4%	85.1%	L	SP	-	For September the Good score decreased by 4% compared to August and is 75.4%. While the score decreased, it is still better than May, June and July scores. The Poor score increased by 3% compared to August and is 15.7%. The increase & decrease in scores are from both Adult & Paeds. Paeds FFT compared to Aug; 4.5% decrease in Good score/ 4% increase in Poor score. Adult FFT compared to Aug; 2% decrease in Good score / 1.5% increase in Poor score. **FOR SEP: there were 909 FFT responses collected from approx. 5,315 patients**. The SPC icon shows special cause variations: low is a concern and high is a concern with both having more than 7 consecutive months below/above the mean.
FFT Emergency Department poor experience score	Apr 20 - Sep 22	Month	-	15.7%	9.1%	H	SP	-	
FFT Maternity (all FFT data from 4 touchpoints) good experience score	Jul 20 - Sep 22	Month	-	88.0%	95.0%		SP	-	**FOR SEP:** Antenatal had 5 FFT responses; 40% Good score / 20% Poor. Birth had 54 FFT responses out of 470 patients; 94.4% Good score / 1.8% Poor score, no change from Aug. Postnatal had 49 FFT responses, the majority from Birth Unit (21 FFT with 76.2% Good /9.5% Poor), DU had 11 FFT with 100% Good, LM had 13 FFT with 84.6% Good, and COU 100% Good from 4 responses. 0 Post Community. **SEP** overall Good score decreased by 3% compared to Aug, and is the lowest for the year. The Poor score increased by 1.5% compared to Aug, and is the highest for the year.
FFT Maternity (all FFT data from 4 touchpoints) poor experience score	Jul 20 - Sep 22	Month	-	3.7%	1.8%	L	-	-	

FFT data starts from April 2020 for day case, ED and OP FFT (SMS used to collect FFT), and inpatient and maternity FFT data starts with July 2020 due to Covid-19 restrictions on collecting FFT data. For NHSE FFT submission, wards still not collecting FFT are not being included in submission. In August 12 wards did not collect any FFT data.

Overall FFT in September, the Good scores remained about the same for inpatient and outpatient. The Good scores declined for day case (1% decline from Aug), ED (4% decline from Aug) and maternity (3% compared to Aug). The Poor scores increased for all areas, with day case increasing by only .5% and ED increasing by 3%.

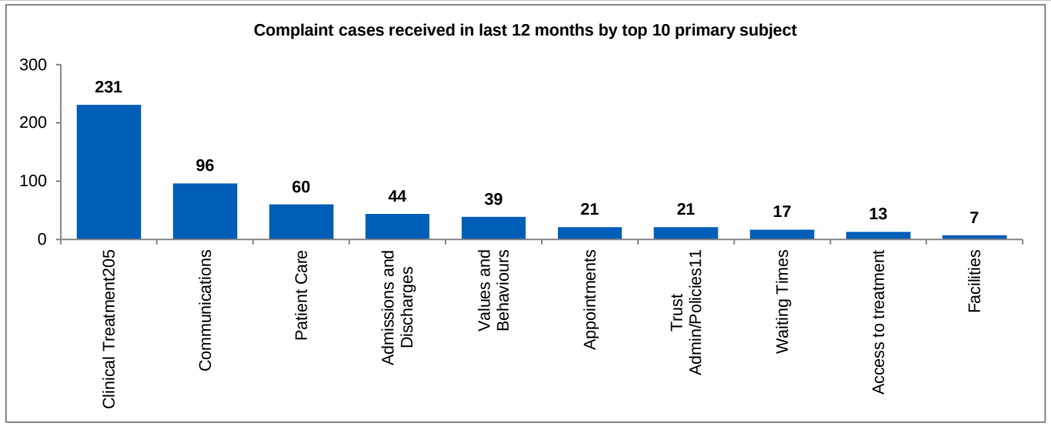
Please note starting 1 June, the Trust has reduced the number of SMS being sent to adult patients. Instead of sending a text message to every adult patient that attend an OP/DU appointment, or presented to A&E, the Trust now sends a fixed number of SMS daily. The number of SMS sent in September increased.

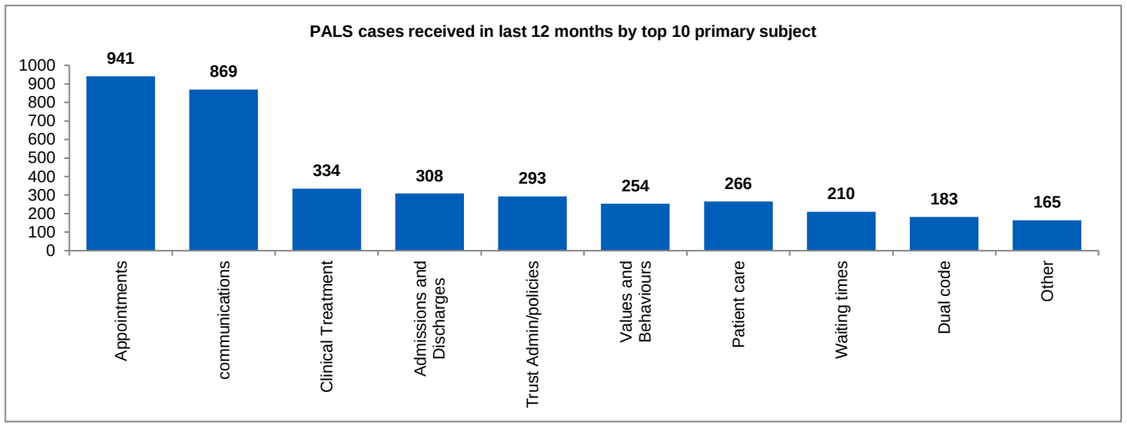
PALS and Complaints Cases

Cambridge University Hospitals NHS Foundation Trust

Safety and Quality

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
Complaints received	Sep 19 -Sep 22	month	-	81	50		-	-	The number of complaints received between Sep 2019 - Sep 2022 is higher than normal variance.
% acknowledged within 3 days	Sep 19 - Sep 22	month	95%	77%	94%		-		62 out of 81 complaints received in September were acknowledged within 3 working days.
% responded to within initial set timeframe (30, 45 or 60 working days)	Sep 19 - Sep 22	month	50%	20%	32%		-		20 Complaints were responded to in September, 4 of the 20 met the initial time frame of either 30.45 or 60 days.
Total complaints responded to within initial set timeframe or by agreed extension date	Sep 19 - Sep 22	month	80%	75%	92%		SP		15 out of 20 complaints responded to in September were within the initial set time frame or within an agreed extension date.
% complaints received graded 4 to 5	Sep 19 - Sep 22	month	-	27%	35%		-	-	There were 19 complaints graded 4 severity, and 3 graded 5. These cover a number of specialties and will be subject to detailed investigations.
Compliments received	Sep 19 - Sep 22	month	-		37		-	-	Compliment numbers have not been added due to administrative staff shortages





PHSO - There were no cases accepted by the PHSO for investigation in September 2022. **Completed actions** Due to current workload actions have not been reported this month.

Author(s): Sue Bennison

Owner(s): Oyejumoke Okubadejo

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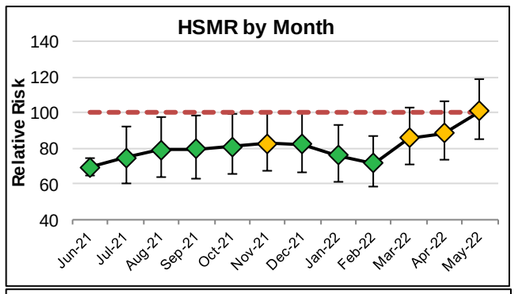
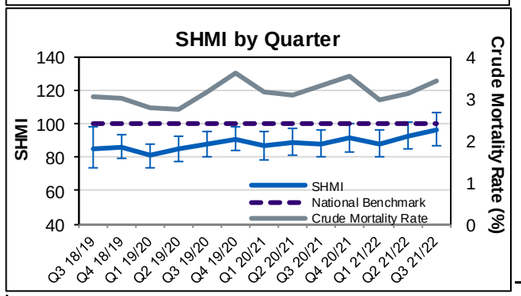
Learning from Deaths

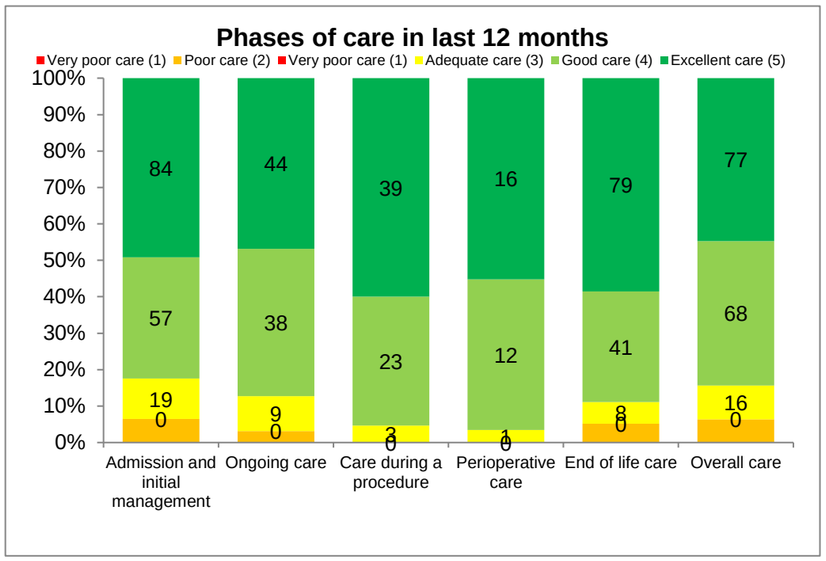
Cambridge University Hospitals NHS Foundation Trust

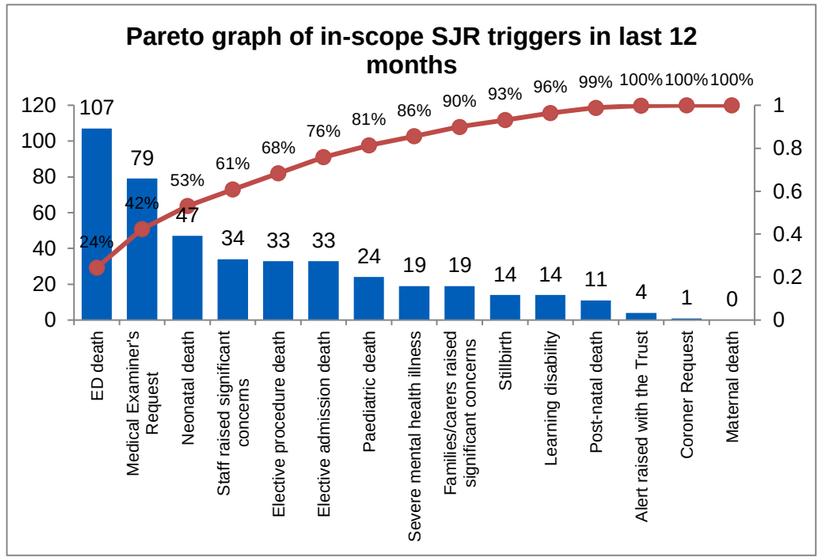
Mortality

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
Emergency Department and Inpatient deaths per 1000 admissions	Apr 18 - Sep 22	month	-	8.44	8.35	H	S7	-	There were 140 deaths in September 2022 (Emergency Department (ED) and inpatients), of which 9 were in the ED and 131 were inpatient deaths. There is normal variance in the number of deaths per 1000 admissions.
% of Emergency Department and Inpatient deaths in-scope for a Structured Judgement Review (SJR)	Feb 18 - Sep 22	month	-	20%	19%		-	-	In September 2022, 25 SJRs were commissioned and 3 PMRTs were commissioned
Unexpected / potentially avoidable death Serious Incidents commissioned with the CCG	Feb 18 - Sep 22	month	-	0	0.71		-	-	There were no unexpected/potentially avoidable death serious incident investigations commissioned in September 2022.









Executive Summary

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

Author(s): Richard Smith

Owner(s): Dr Sue Broster

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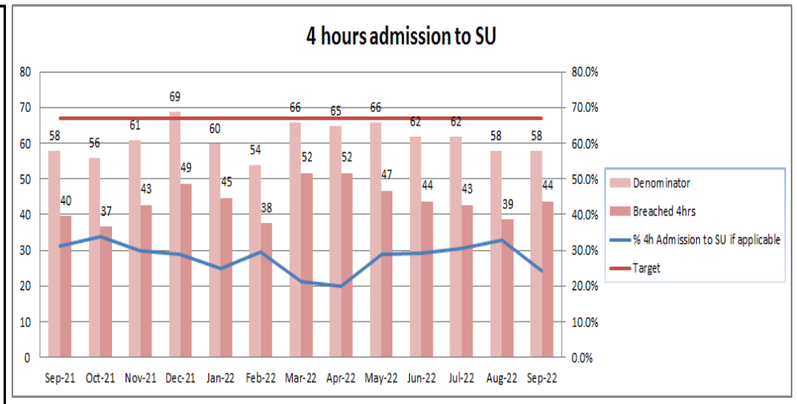
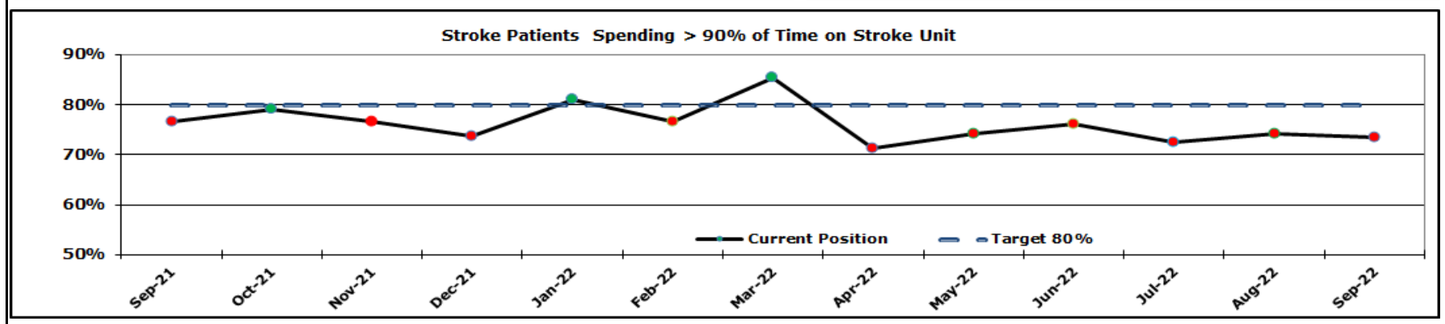
Stroke Care

Cambridge University Hospitals NHS Foundation Trust

Stroke Measures



Themes	Count of MRN
CT capacity issue	1
Delay in senior medical review	4
Late referral to stroke	4
Palliative patient	1
Patient not referred to stroke	5
Trust Bed Capacity	26
Unclear presentation	2
Total	44



Breach reasons 2021/2022 and Monthly Stroke position

Month	Stroke Bed Capacity * No outliers *	Trust Bed Capacity * Outliers *	Suspected COVID-19 patient	COVID-19 - Stroke ward closed	Operational decision - patient moved off the unit to accommodate an acute stroke	Delay in medical review in ED	Delay in referral to Stroke Team	Clinical - Appropriate pathway for patient	Difficult presentation	Not referred to stroke team	Delayed diagnosis	Clinician's decision to place patient on different ward	Unclear presentation	Difficult diagnosis / Complex patient	Failure to request stroke bed	Resource capacity	Number of breaches	Month Position (Target 80%)
Sep-21		5						4		1			3	1		1	15	76.6%
Oct-21		5				1		3		1	2					1	13	79.0%
Nov-21		5	1					1		1	2		3	1		1	15	76.6%
Dec-21		11						4		2			1			2	20	73.7%
Jan-22		2						1		3	1		1			4	12	81.0%
Feb-22		7	1			1		1		1			2	1			14	76.7%
Mar-22		6	1			1							2				10	85.3%
Apr-22		8				2		3					4			2	19	71.2%
May-22	3	1				4				1			4	3		2	18	73.1%
Jun-22	3	1				1		1					7			1	14	75.0%
Jul-22	6	5				1		2					1	1		3	19	72.5%
Aug-22	2	10						2					1			1	16	68.0%
Sep-22		11					1						5				17	73.4%
Summary	14	77	3	0	0	11	1	22	0	10	5	0	34	7	0	18	202	

90% target (80% Patients spending 90% IP stay on Stroke ward) was not achieved for September = **73.4%**

'Trust Bed Capacity' (11) was the main factor contributing to breaches last month, with a total of 17 cases in September 2022.

4hrs adm to SU (67%) target compliance was not achieved in September = **24.1%**

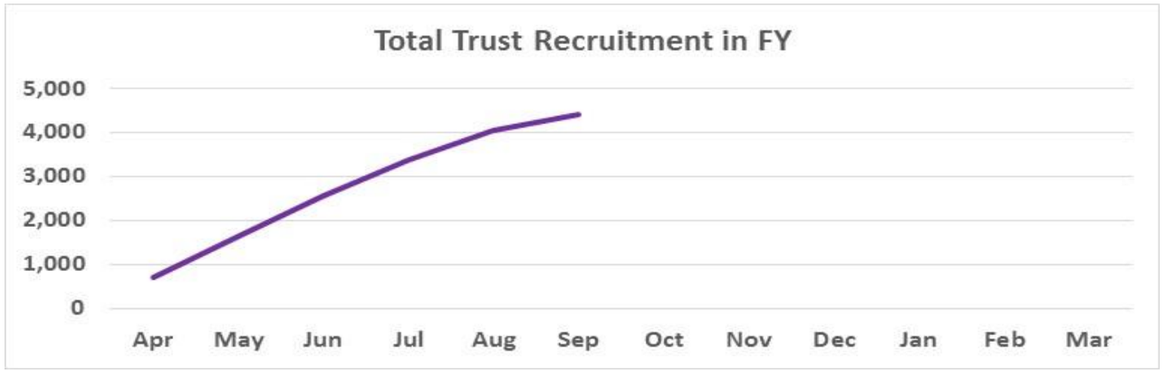
Key Actions

- On 3rd December 2019 the Stroke team received approval from the interim COO to ring-fence one male and one female bed on R2. This is enabling rapid admission in less than 4 hours. The Acute Stroke unit continues to see and host a high number of outliers. Due to Trust challenges with bed capacity the service is unable to ring-fence a bed at all times. Instead it is negotiated on a daily basis according to the needs of the service and the Trust.
- The Mixed-sex HASU bay on R2 has opened week commencing 02/05/22. Performance will be closely monitored, to date there has been 3 breaches of SSA policy.
- National SSNAP data shows Trust performance from Apr - Jun 22 at Level B.
- Stroke Taskforce meetings remain in place, plus weekly review with root cause analysis undertaken for all breaches, with actions taken forward appropriately.
- The stroke bleep team continue to see over 200 referrals in ED a month, many of those are stroke mimics or TIAs. TIA patients are increasingly treated and discharged from ED with clinic follow up. Many stroke mimics are also discharged rapidly by stroke team from ED. For every stroke patient seen, we see three patients who present with stroke mimic.

Clinical Studies

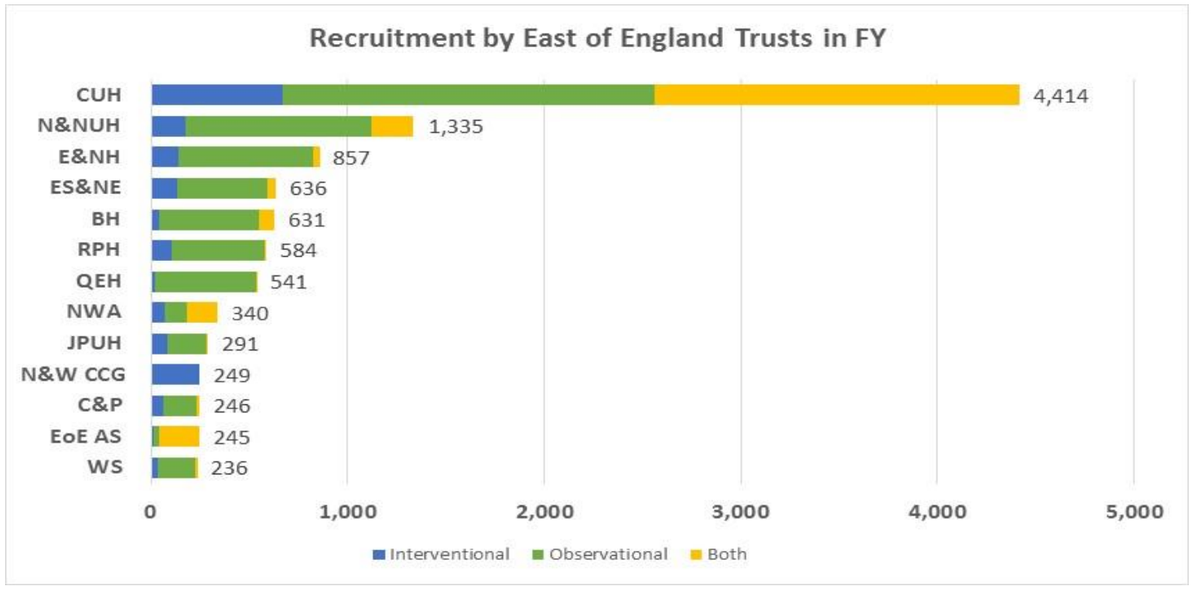
Cambridge University Hospitals NHS Foundation Trust

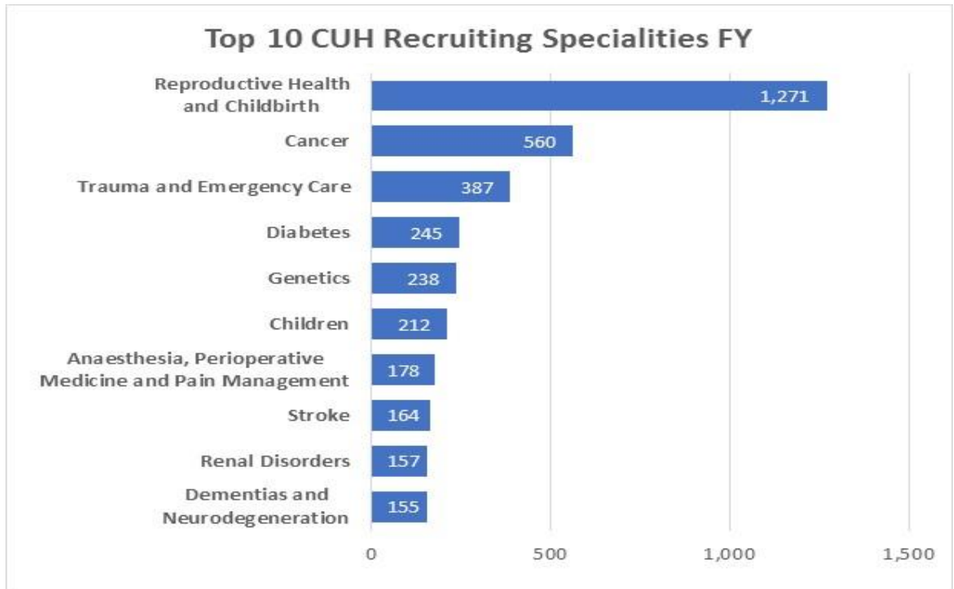
Clinical Studies Measures



Total Recruitment at end of Sept - FY 2022-23
4,414

Recruiting Studies at end of Sept for FY 2022-23			
Open	191	Non Commercial	185
Closed	15	Commercial	24
Suspended	3		
Total	209		





Situation as at end of September 2022

* Total recruitment in the financial year to date: 4,114
* CUH accounted for 35% of total recruitment by Eastern Trusts in the financial year to date. Interventional only studies accounted for 15% of the total, while Observational only studies accounted for 43% of the total. The remaining 42% were both Interventional and Observational .
* Recruitment to the Reproductive Health speciality accounted for 29% of all recruitment (1,271). Second was Cancer (560). All of the other individual specialities accounted for less than 10% of the total recruitment.
* There were 209 recruiting studies, of which 24 were Commercial, and 185 Non-Commercial.

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

Maternity Dashboard

Cambridge University Hospitals NHS Foundation Trust

Maternity Measures

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

LMNS: Cambridgeshire and Peterborough | **Reporting period: September 2022**

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

CQC DOMAINS

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

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

Total Births	Total Bookings	1:1 Care in Labour
476	550	99.8%

KPI (see slide 4 for detail)	Measurement / Target		Trust Rate (current reporting period)
Please see exemplar v8 for full detail			CUH
Preterm birth rate	≤26+6 weeks	≤6% annual rolling rate	0.64%
	≤36+6 weeks		7.83%
Massive Obstetric Haemorrhage ≥ 1500 mls	Vaginal birth	2.5%	2.24%
	Caesarean	4.3%	2.47%
Term admissions to NNU (all levels)		<6%	4.2%
3rd & 4th degree tear	SVD (unassisted)	Unassisted 2.8%	1.94%
	Instrumental (assisted)	Assisted 6.8%	0.24%
Right place of birth (born outside a tertiary centre)		Number of births = 0	0
Smoking at time of delivery		≤6%	3.82%
Percentage of women placed on CoC pathway		≥35% (March 21)	TBC
Percentage of women on CoC pathway :BAME / areas of deprivation)	BAME	≥75%	BAME TBC
	Area of deprivation		AOD TBC

KEY: CQC DOMAINS	MW to birth ratio		MW Minimum Safe Staffing		Obstetric Cover on Delivery Unit		Vacancy rate		LW co-ordinator supernumerary (%)
	BR+ Recommendation	Actual	Planned Cover	Actual Cover	Hours of consultant presence	Gaps in Rotas	Midwife no's	%age of total staff	
Outstanding Good Requires Improvement Inadequate	1.24.1	1.23.3	100	83%	81	None due to acting down	18.71	8%	60%

	Incident Reporting					LMNS confirmation of SI oversight (evidenced through governance & safety meetings) Yes ☐ No ☐										
	Datix		Incidents Graded as Moderate and Above	Maternity Serious Incidents	Maternity Never Events	Coroner Rota 28	HSIB Cases (new)	Still Births			HIE cases (grade 2 or 3)	Neonatal deaths		Maternal Mortality	
	Unactioned	Open > 30 days						All	Term	Intrapartum		Early	Late	Direct	Indirect
CUH	0	245	1	0	0	0	0	0	0	0	0	1	0	0	0

Maternity Dashboard

NHS
Cambridge University Hospitals
NHS Foundation Trust

Maternity Measures

Assessed compliance With 10 Steps-to-Safety – Year 4 – (inc. reasons for non compliance, mitigation and actions)

	Please identify unit	CUH
1	Perinatal review tool	
2	MSDS	Will require submission of manual audit to exclude out of area and transfers of care for BMI KPI.
3	ATAIN	
4	Medical Workforce	
5	Midwifery Workforce	Delivery Unit Supernumerary coordinator status consistently low., requires non compliance with the standard to be declared. (Anticipated improvement in October with new standard publication)
6	SBLCB V2	Awaiting confirmation from NHS digital that we can submit a valid exemption for split booking process relating to CO monitoring KPI figure.
7	Patient Feedback	
8	Multi-professional training	Additional faculty for NLS required. Did not meet trajectory for 80% compliance with PROMPT training by end of June 2022 due to current vacancy and sickness rate. Amended trajectory for 90% by end of November 2022.
9	Safety Champions	
10	Early notification scheme (HSIB)	

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

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

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

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

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

Maternity Dashboard

NHS
Cambridge University Hospitals
NHS Foundation Trust

Maternity Measures

Maternity unit:	CUH: All
1. Freedom to speak up / Whistle blowing themes and HSIB / NHSR / CQC or other organisation with a concern or request for action made directly with Trust	• 3 X FTSU escalations following awareness campaign of FTSU guardian role within the organisation. • Concerns regarding safe staffing levels and general concerns for how the service can support NQM entering the profession.
	CUH: Top 3
2. Themes from Datix (to include top 3 reported incidents/ frequently occurring)	• Neonatal and maternity clinical concerns - postpartum haemorrhage • Implementation of care and delays in care • Staffing
3. Themes from Maternity Serious Incidents (Sis) and findings of review of all cases eligible for referral to HSIB	• Serious Incident themes MEOWS outside of maternity and referral to Obstetric team from ED • HSIB case report back from May 2022 1 safety recommendation clinical assessment regarding SROM management
4. Themes arising from Perinatal Mortality Review Tool (review of perinatal deaths using the real time data monitoring tool)	• Lack of postnatal emotional support following loss of baby
5. Themes / main areas from complaints	• Communication • Clinical Treatment • Appointments
6. Listening to women / Service User Voice Feedback (sources, engagement / activities undertaken)	• Communications guide work in progress • Launch of informed choice and consent policy co-production work • Orientation to early pregnancy matron role and plans for EPU improvements
7. Evidence of co-production	• Launch of informed choice and consent policy co-production work
8. Listening to staff (eg activities undertaken, surveys and actions taken as a result) Staff feedback from frontline champions and walk-abouts	• In relation to FTSU escalations – local and wider staff forums planned • In relation to FTSU escalations - Workforce position and trajectory has been shared with all staff via huddles and email. • MDT staff meeting • Preceptorship / international midwives orientation and support
9. Embedding learning (changes made as a result of incidents / activities / shared learning/ national reports)	• Fetal Surveillance discussions with DU coordinator team • Changes to the PROM guideline in response to an HSIB recommendation – and added to safety huddles. • Telemetry monitoring removed from use following safety alert (retained in pool room) and ongoing IMT.

Maternity Dashboard

Cambridge University Hospitals NHS Foundation Trust

Maternity Measures

Sources / References	KPI	Goal	Target	Measure	Data Source	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	SPC	Narrative and Actions taken for Red/Amber/Special cause concerning trend results
Activity													
National Maternity Dashboard	Births	For information	N/A	Births per month	Rosie KPI's	421	469	434	446	464	476		
Antenatal Care ICS contracted booking KPI	Health and social care assessment <GA 12+6/40	> 90%	>=90% <90% and >=80% <80%	Booking Appointments	Epic	71.40%	69.90%	70.64%	73.24%	75.69%	75.45%		This metric is compliant however requires an Epic build to amend the reporting to exclude transfers of care >12 weeks gestation. Build in next top 5, awaiting completion. .
National Maternity Dashboard	Booking Appointments	For Information	N/A	Booking Appointments	Epic	654	615	664	568	551	550		
Source - EPIC	Vaginal Birth (Unassisted)	For Information	N/A	SVD's in all birth settings	Rosie KPI's	49.16%	48.82%	54.60%	51.12%	59.05%	52.31%		
Source - EPIC	Home Birth	For Information	N/A	Planned home births (BBA is excluded)	Rosie KPI's	1.42%	1.7%	1.84%	1.34%	1.29%	0.84%		
Source - EPIC	Rosie Birth Centre Birth	For Information	N/A	Births on the Rosie Birth Centre	Rosie KPI's	11.87%	14.92%	17.1%	15%	15.52%	16.38%		
Source - EPIC	Rosie Birth Centre transfers	For information	N/A	Women admitted to RBC and subsequently transferred for birth	Rosie KPIs					p			
Source - EPIC	Induction of Labour	For Information	N/A	Women induced for birth	Rosie KPI's	31.80%	31.87%	30%	29.80%	26.50%	30.00%		
NICE - Red Flag	Delay in commencement of Induction	0%	<10%	Percentage of Inductions where Induction commencement was postponed >2 hours	Red Flags	40.00%	53.00%	36%	36.00%	32.60%	32.28%		New metric. Women delayed in initiation of IOL once arrived on the antenatal ward / DU. IOL coordinator post increased. Affected by redeployment.
NICE - Red Flag	Delay in continuation of Induction	0%	<10%	Percentage of Induction continuation was delayed for more than 6 hours	Red Flags					13.81%	16.40%		New metric. Affected by vacancy, redeployment and capacity. 2 further IOL coordinators in post.
SBLCBV2	Indication for IOL (SBLCBV2)	NA	NA	Percentage of IOL where reduced fetal movements is the only indication before 39 weeks	IOL Team								Data to be reported from November 2022
Source - EPIC	Indication for IOL	100%	≥95%	Percentage of IOL with a valid indication as per guidance.	IOL Team								Data to be reported from November 2022
Source - EPIC	Birth assisted by instrument (forceps or ventouse) (Instrumental)	For Information	N/A	Instrumental birth rate	Rosie KPI's	9.02%	11.94%	10.6%	12.55%	12.93%	10.5%		
Source - EPIC	CS rate (planned & unplanned)	For Information	N/A	C/S rate overall	Rosie KPIs	41.80%	39.23%	34.80%	36.32%	35.78%	37.18%		
CQIM / CNST	Women in RG*1 having a caesarean section with no previous births: nullip spontaneous labour)	For information	10%	Relative contribution of the Robson group to the overall C/S Rate	Rosie KPIs	8.5%	9.2%	8.6%	14.2%	9.6%	11.9%		
CQIM / CNST	Women in RG*2 having a caesarean section with no previous births: nullip induced labour, nullip pre-labour LSCS	For Information	For Information	Relative contribution of the Robson group to the overall C/S Rate	Rosie KPIs	31.3%	26.1%	25.8%	27.2%	18.1%	28.2%		
CQIM / CNST	Ratio of women in RG1 to RG2	Ratio of >2:1	N/A	Ratio of group 1 to 2 should be 2:1 or higher	Rosie KPIs	0.27	0.35	0.33	0.52	0.53	0.42		
CQIM / CNST	Women in RG*5. Multips with 1 or 2+ previous C/S	For Information	For Information	Relative contribution of the Robson group to the overall C/S Rate	Rosie KPIs	25.6%	23.4%	31.1%	23.5%	32.5%	23.2%		
CQIM / CNST	Women in RG1, RG2, RG5 combined contribution to the overall C/S rate.	66%	60-70%,	Relative contribution of the Robson group to the overall C/S Rate	Rosie KPIs	65.4%	58.7%	65.5%	64.9%	60.2%	63.3%		
Source - Rosie Divert Folder	Divert Status - incidence	0	> 1	Incidence of divert for the perinatal service	Rosie Diverts	4	7	1	4	4	6		2 women transferred to another provider organisation for assessment, 1 woman gave birth in another provider organisation. 4 x staffing and capacity, 1 x staffing only, 1 x capacity only.
Source - Rosie Divert Folder	Total number of hours on divert	For information	N/A		Rosie Diverts	190	148	23	103	100	86.00		
Source - Rosie Divert Folder	Admissions during divert status	For information	N/A		CHEQs								Report awaited from CHEQs - report request submitted.
Source - Rosie Divert Folder	Number of women giving birth in another provider organisation due to divert status	For information	N/A		Rosie KPIs	0	6	0	0	1	1		No adverse outcome

Maternity Dashboard

NHS Cambridge University Hospitals NHS Foundation Trust

Maternity Measures

Workforce													
Birth Rate Plus	Midwife/birth ratio (actual)**	1:24	1.28	Total permanent and bank clinical midwife WTE*/Births (rolling 12 month average)	Finance	1:27.2	1:25.4	1:27.2	1:28.2	1:28.2	1:28.3		Clinical midwife WTE as per BR+ = clinical midwives, midwife sonographers, post natal B3 and nursery nurses. For actual ratio, calculation includes all permanent WTE plus bank WTE in month.
Birth Rate Plus	Midwife/birth ratio (funded)**	For information	1.24.1	Total clinical midwife funded WTE*/Births (rolling 12 month average)	Finance	1:23.4	1:23.4	1:23.3	1:23.3	1:23.3	1:23.3		Midwife/birth ratio based on the BR+ methodology
Safer Chilbrith / CNST	Supernumerary Delivery Unit Coordinator	100%	≥95%	Percentage compliance with Delivery Unit coordinator remaining supernumerary (no caseload of their own during a shift)	Red Flags / BR+	72%	67%	41%	63%	70%	60%		From 11th October the CNST maternity incentive scheme has changed the definiton of supernumerary labour ward coordinator to only include provision of 1:1 labour or high risk care.
Source - CHEQS	Staff sickness as a whole	< 3.5%	> 5%	ESR Workforce Data	CHEQs	7.59%	7.63%	7.69%	7.95%	7.72%			This is reported 1 month behind from CHEQ's. Sickness most significant in Delivery Unit. Clinical psychology support in place. Most common reason for sickness includes stress, anxiety and depression.
Core Competency Framework	Education & Training - mandatory training - overall compliance (obstetrics and gynaecology)	>92% YTD	<75% YTD	Total Obstetric and Gynaecology Staff (all staff groups) compliant with mandatory training	CHEQs	87.50%	87.50%	86.40%	86.50%	87.30%			This is reported 2 months behind from CHEQs. Consistent decline in mandatory training now a special cause concerning trend. Includes Basic life support, moving and handling and fire.
CNST	Education and Training - Training Compliance for all staff groups: **Prompt**	≥90% YTD	≤85% YTD	Total multidisciplinary obstetric staff compliant with annual Prompt training	PD	61.28%	60.91%	61.00%	65.56%	75.77%	TBC		
CNST	Education and Training - Training Compliance for all staff groups: **NBLS**	≥90% YTD	<85% YTD	Total multidisciplinary staff compliant with annual NBLS training	Resus Services			55.00%		58.00%	60%		NBLS remains low complaiance - mainly due to medical staff training and midwifery staff training. Bank sourced for trajectory confirmation by November 2022.
CNST	Education and Training - Training Compliance for all staff groups: **K2**	≥90% YTD	≤85% YTD	Total multidisciplinary staff passed CTG competence threshold of 80%.	PD	81.00%	83.39%	83.39%	84.62%	80.00%	77.78%		Trajectory in place to achieve 90% by November 2022. Plans made re: GP trainees competency requirements.
CNST	Education and Training - Training Compliance for all Staff Groups - **Fetal Surveillance Study Day**	>90% YTD	<85% YTD	Total multidisciplinary staff compliant with annual fetal surveillance study day attendance.	PD								To be reported from November 2022
Core competency Framework	Education & Training - mandatory training - **midwifery compliance**.	>92% YTD	<75% YTD	Proportion of midwifery compliance with mandatory training, inclusive of mandated e-learning and mandated face to face sessions.	CHEQs	89.2%	89.5%	89.20%	84.50%	85.70%			Affected by redeployment. Systems for booking into training and monitoring compliance reviewed.
Maternal Morbidity													
CQC KLOE	Puerperal Sepsis	For information	N/A	Incidence of puerperal sepsis within 42 days of birth	CHEQs						0.64%		New metric from September 2022
Source - CHEQs	ITU Admissions in Obstetrics	For information	N/A	Total number of pregnant / postnatal women admitted to the intensive care unit	CHEQs	0	1	1	0	1	0		
NMPA	Massive Obstetric Haemorrhage ≥ 1500 mls - vaginal birth	≤2.5%	>2.5	Percentage of women with a PPH >1500mls (singleton births between 37+0-42+6) having a vaginal birth	Rosie KPIs	2.08%	6.62%	2.48%	2.95%	3.16%	2.24%		
NMPA	Massive Obstetric Haemorrhage ≥ 1500 mls - caesarean birth	≤4.3%	>4.3%	Percentage of women with a PPH >1500mls (singleton births between 37+0-42+6) having a caesarean section	Rosie KPIs	1.82%	6.67%	3.45%	0.98%	0.73%	2.47%		
NMPA	3rd/ 4th degree tear rate	≤3.5	>5%	Percentage of women with a vaginal birth having a 3rd or 4th degree tear (spontaneous and assisted by instrument) singleton baby in cephalic position between 37+0 and 42+6.	Rosie KPIs	2.05%	2.48%	2.83%	3.90%	4.06%	2.01%		
CQC KLOE	Maternal readmission rate	For information	N/A	Percentage of women readmitted to maternity service within 42 days of birth.	Rosie KPIs	2.62%	2.35%	1.38%	1.80%	2.59%	1.05%		
MBRRACE	Peripartum Hysterectomy	For information	N/A	Incidence of peripartum hysterectomy	QSIS								To be reported from November 2022.
MBRRACE	Direct Maternal Death	0	≥1		QSIS	0	0	0	0	0	0		
Governance													
Source - QSIS	Total number of Serious Incidents (SIs)	0	≥1	Serious Incidents	QSIS	0	1	0	1	1	0		
Source - QSIS	Never Events	0	>1	DATIX	QSIS	0	0	0	0	0	0		

Maternity Dashboard

Cambridge University Hospitals NHS Foundation Trust

Maternity Measures

Neonatal Morbidity													
MBRRACE / PMRT	Still Births per 1000 Births	3.33/1000 (Mbrrace 2021)		Incidence per 1000 births	CHEQs	1.26/1000	0.42/1000	0.43/1000	0.88/1000	0/1000	0.42/1000		
MBRRACE / PMRT	Stillbirths - number ≥ 22 weeks	<3	≥6	MBBRACE	CHEQs	3	2	1	2	0	2		
Epic	Number of birth injuries	0	> 1	Percentage of babies born with a birth related injury	CHEQs	0	1	0	0	0	0		
NMPA	Babies born with an Apgar <7 at 5 minutes of age	For information	N/A	Percentage of babies born who have an Apgar score <7 at 5 minutes of age	Rosie KPIs	1.66%	2.35%	1.38%	1.57%	3.02%	0.84%		0 babies required cooling.
CQC KLOE	Incidence of neonatal readmission	For information	N/A	Percentage of babies readmitted within 42 days of birth	Rosie KPIs	4.28%	3.84%	3.92%	3.81%	3.02%	3.15%		New metric.
SBLCBV2	Babies born at <3rd centile at >37+6	For information	N/A	Incidence	CHEQs								CHEQs report request submitted - report awaited.
	Term Admission to NICU Rate	<6%	N/A	Rate	CHEQs						4.20%		
ATAIN / CNST	Expected Term Admissions to NICU	For information	N/A	Inclusive of congenital abnormality and tertiary referral babies with planned term admission to NICU	Badgernet / CHEQs								New metric expected in November 2022
ATAIN / CNST	Unexpected Term Admissions to NICU	For Information	N/A	Incidence of term admissions to NICU that were unplanned prior to birth	Badgernet / CHEQs								New Metric expected in November 2022.
Quality													
CNST	1-1 Care in Labour	>95%	<90%	Percentage of women receiving 1:1 care in labour (excluding BBAs)	Rosie KPI's	100%	98.69%	100%	100%	99.56%	99.80%		
CQIM	Babies with a first feed of breastmilk	> 80%	< 70%	Breastfeeding	Rosie KPI's	82.89%	81.22%	84.33%	79.4%	84.07%	82.55%		
CNST / SBLCBV2 / PHE	SATOD (Smoking at Time of Delivery)	< 6%	Green = < 6%, Amber = 6.1% - 7.9 %, Red = >8	% of women Identified as smoking at the time of delivery	Rosie KPIs	3.37%	5.02%	3.95%	8.25%	5.97%	3.82%		Report has been amended and now reflecting correct figures.
CNST / SBLCBV2 / CQIM	CO Monitoring at booking	≥95%	≥=95% <95% and >=84% <85%	Compliance with recording CO Monitoring reading at booking appointment (excluding out of area)	Smoking Report				89.97%	92.74%	91.95%		Action plan in place to increase to 95% target threshold. Meets CNST requirement of 80%.
CNST / SBLCBV2 / CQIM	CO Monitoring at 36 weeks	>95%	>=95% <95% and >=84% <85%	Compliance with recording CO Monitoring reading at 36 week appointment (excluding out of area)	Smoking Report				72.81%	85.61%	84.56%		Action plan in place to increase to 95% target threshold. Meets CNST requirement of 80%.
Source - Epic	VTE Assessment - PN	>95%	≤95%	Percentage of women with a valid PN VTE risk assessment completed following birth.	CHEQs								CHEQs report request submitted - report awaited (September 2022).
Source - EPIC	VTE Assessment - AN	>95%	≤ 95%	Percentage of women with a valid VTE risk assessment completed on admission to hospital	CHEQs								CHEQs report request submitted - report awaited (September 2022).

Finance

Cambridge University Hospitals NHS Foundation Trust

Financial Performance

Trust performance summary - Key indicators

Trust actual surplus / (deficit)

(£0.9m)	*Actual (adjusted)**
(£1.0m)	*Plan (adjusted)**
£2.4m	*Actual YTD (adjusted)**
£2.4m	*Plan YTD (adjusted)**

Covid-19 expenditure and system Covid-19 funding

£1.6m	*Covid actual in month*
£1.8m	*Covid plan in month*
£1.9m	*Covid funding in month*
£12.0m	*Covid actual YTD*
£11.6m	*Covid plan YTD*
£11.0m	*Covid funding YTD*

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

Net current assets

(£57.5m)	
(£54.7m)	

Debtor days

23	*This month*
21	*Previous month*

Payables performance (YTD) **

Actual	88.6%	*Value*
Plan	90.7%	*Quantity*

Cash and EBITDA

Cash

£176.1m	*Actual*
£166.7m	*Plan*

EBITDA

£22.1m	*Actual YTD*
£23.7m	*Plan YTD*

Capital expenditure

£4.9m	*Capital - actual spend in month*
£15.0m	*Capital - actual spend YTD*
£26.0m	*Capital – plan YTD*

Elective Recovery Fund (ERF)

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

£1.6m	*ERF forecast actual in month*
£1.6m	*ERF plan in month*
£7.3m	*ERF forecast actual YTD*
£7.3m	*ERF plan YTD*

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

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

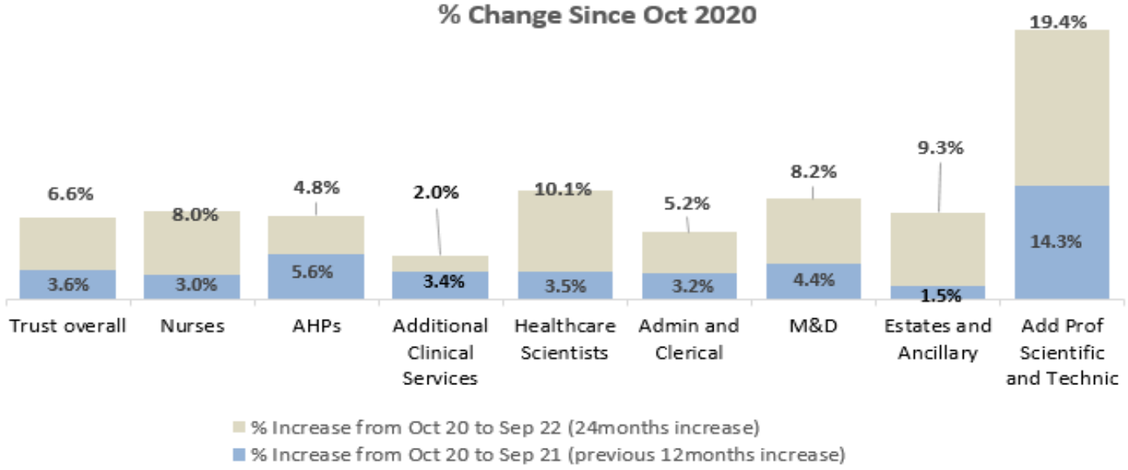
Staff in Post

NHS
Cambridge University Hospitals
NHS Foundation Trust

Workforce: Staff in Post

12 Month Growth by Staff Group

Staff Group	Headcount		Headcount 12 Month growth	FTE		FTE 12 Month growth	
	Oct-21	Sep-22		Oct-21	Sep-22		
Add Prof Scientific and Technic*	236	247	4.7%	217	224	7	3.1%
Additional Clinical Services	1,964	1,928	-1.8%	1,809	1,776	-33	-1.8%
Administrative and Clerical	2,371	2,390	0.8%	2,163	2,195	33	1.5%
Allied Health Professionals*	741	736	-0.7%	658	650	-8	-1.2%
Estates and Ancillary	366	365	-0.3%	355	353	-2	-0.7%
Healthcare Scientists	623	659	5.8%	583	618	36	6.1%
Medical and Dental	1,642	1,701	3.6%	1,553	1,609	56	3.6%
Nursing and Midwifery Registered	3,695	3,811	3.1%	3,389	3,507	118	3.5%
Total	**11,638**	**11,837**	**1.7%**	**10,727**	**10,933**	**206**	1.9%



Admin & Medical Breakdown

Staff Group	Oct-21	Sep-22	FTE 12 Month growth	
Administrative and Clerical	2,163	2,195	33	1.5%
of which staff within Clinical Division	1,065	1,079	14	1.3%
of which Band 4 and below	759	750	-9	-1.2%
of which Band 5-7	218	236	18	8.4%
of which Band 8A	40	45	4	11.1%
of which Band 8B	7	7	0	4.2%
of which Band 8C and above	40	40	0	-0.5%
Areas	879	885	5	0.6%
of which Band 4 and below	249	245	-4	-1.5%
of which Band 5-7	413	420	6	1.6%
of which Band 8A	73	86	13	17.8%
of which Band 8B	56	50	-6	-11.4%
of which Band 8C and above	88	84	-4	-4.6%
of which staff within R&D	219	232	13	6.1%
Medical and Dental	1,553	1,609	56	3.6%
of which Doctors in Training	643	669	26	4.1%
of which Career grade doctors	230	234	3	1.3%
of which Consultants	680	706	27	3.9%

What the information tells us:

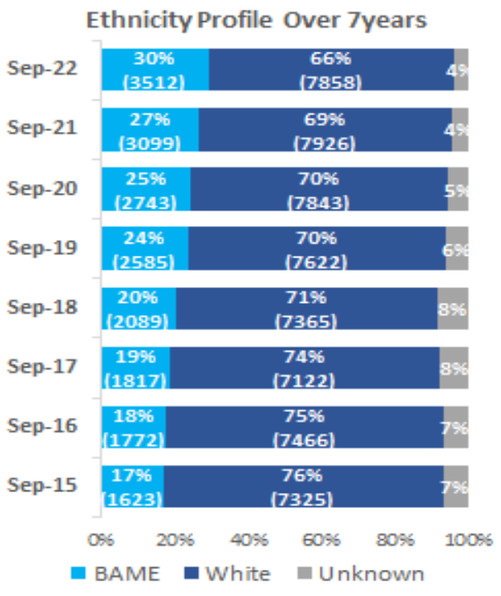
Overall the Trust saw a 1.9% growth in its substantive workforce over the past 12 months and 6.6% over the past 24 months. Growth over the past 24 months is lowest within Additional Clinical Services at 2% and highest within Add Prof Scientific and Technic at 19.4%. Growth over the past 12 months is lowest within Additional Clinical Services and highest within Healthcare Scientists.

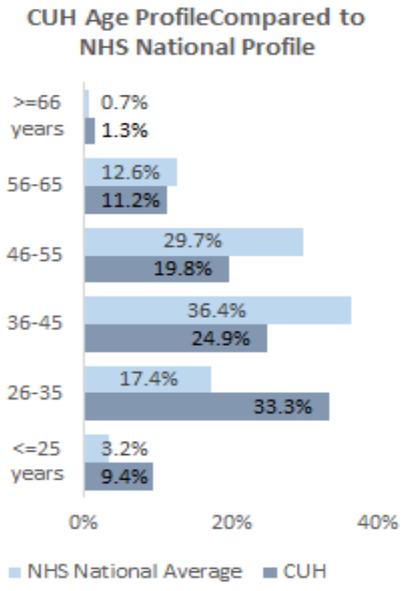
*Operating Department Practitioner roles were regroup from Add Prof Scientific and Technic to Allied Health Professionals on ESR from June 21 . This change has been updated for historical data set to allow for accurate comparison

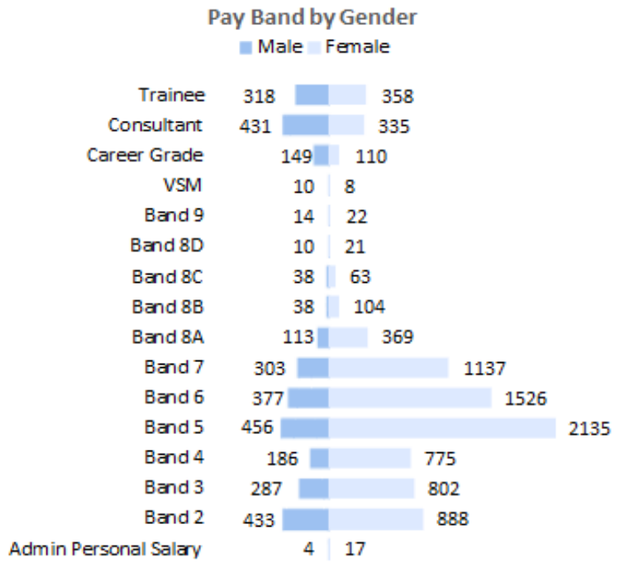
Equality Diversity and Inclusion (EDI)

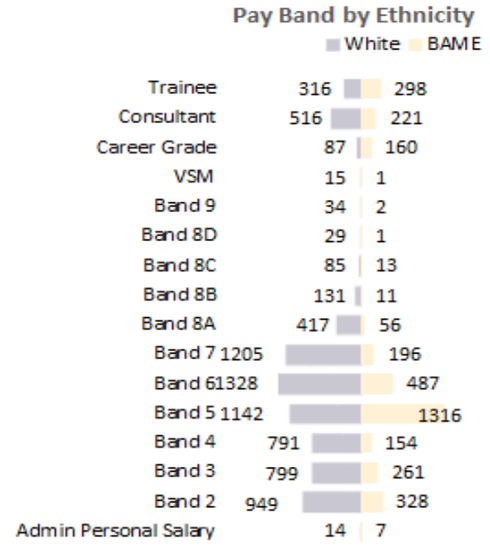
Cambridge University Hospitals NHS Foundation Trust

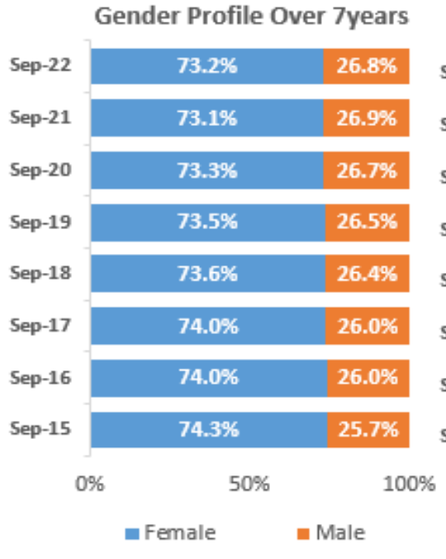
Workforce: Equality Diversity and Inclusion (EDI)

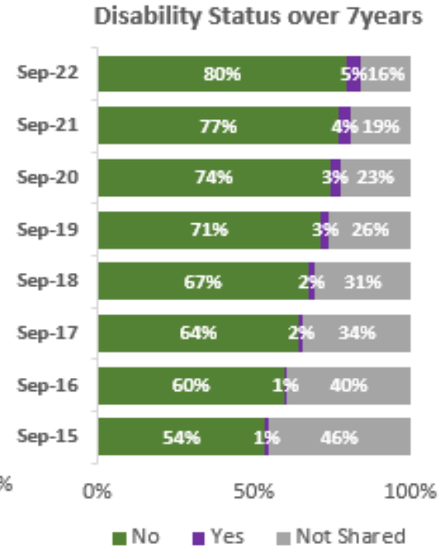


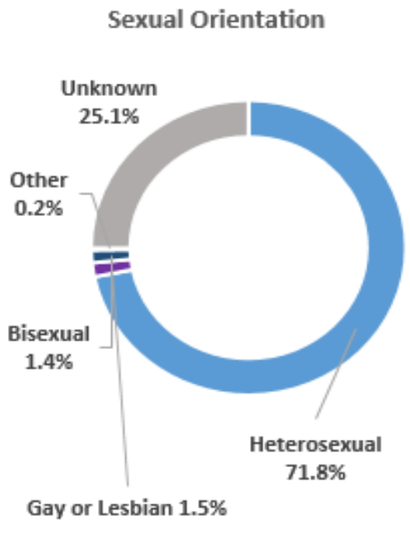












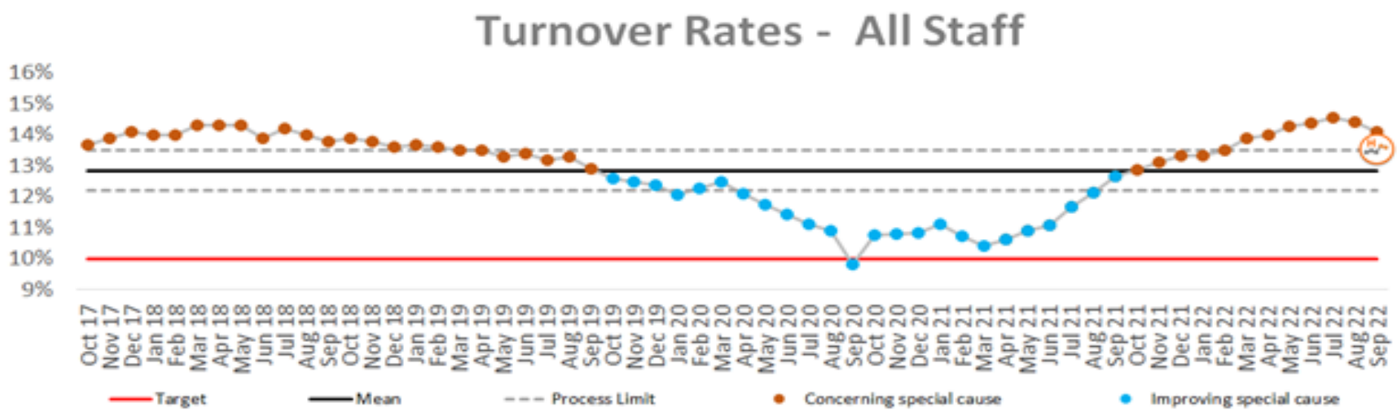
What the information tells us:

- CUH has a younger workforce compared to NHS national average. The majority of our staff are aged 26-45 which accounts for 58% of our total workforce.
- The percentage of BAME workforce increased significantly by 13% over the 7 year period and currently make up 30% of CUH substantive workforce.
- The percentage of male staff increased by 1% to 27% over the past seven years.
- The percentage of staff recording a disability increased by 4% to 5% over the seven year period. However, there are still significant gaps between the data recorded about our staff on ESR compared with the information staff share about themselves when completing the National Staff Survey.
- There remains a high proportion of staff who have, for a variety of reasons, not shared their sexual orientation.

Staff Turnover

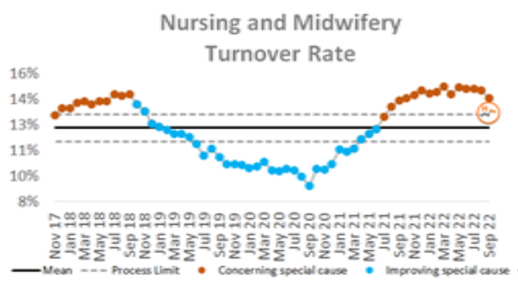
Cambridge University Hospitals NHS Foundation Trust

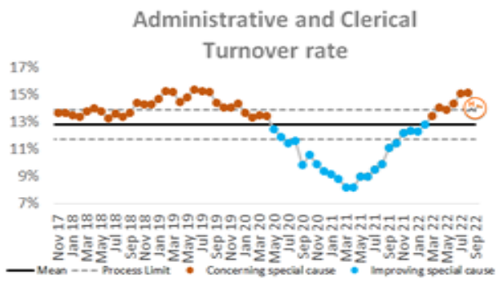
Workforce: Staff Turnover

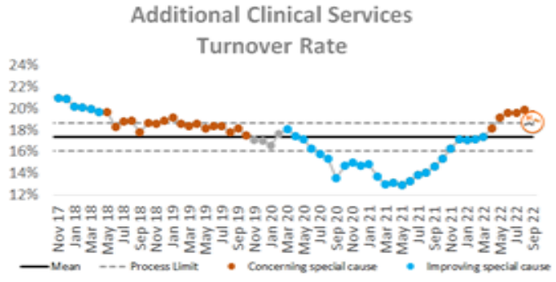


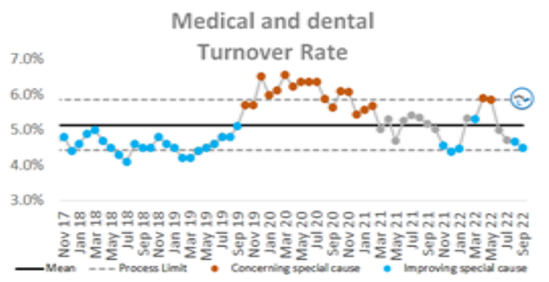
Background Information: Turnover describes the rate that employees leave an establishment. Staff turnover is calculated by the number of leavers from the Trust over the previous twelve months as a percentage of the total number of employed staff at a given time. (exclude all fixed term contracts including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

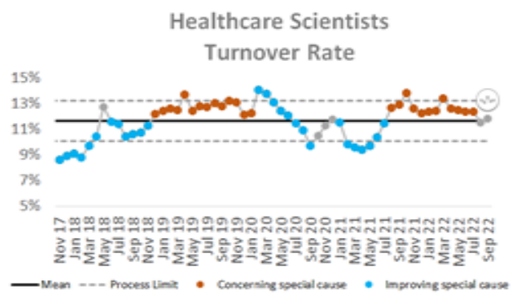
What the information tells us:
The Trust's turnover has been steadily increasing over the past eighteen months and is currently at 14.1%. For the last two months the turnover rate has decreased from the previous month, but is still higher than pre-pandemic rates, with an increase of 1.5% over the past three years. Nursing and Midwifery staff group have the highest increase of 3.9% to 14.1% in the last three years, followed by Additional Clinical Services with an increase of 2% to 19.5%. Within the staff groups, Additional Clinical Services have the highest turnover rate at 19.9% followed by Estates and Ancillary staff at 14.6%.

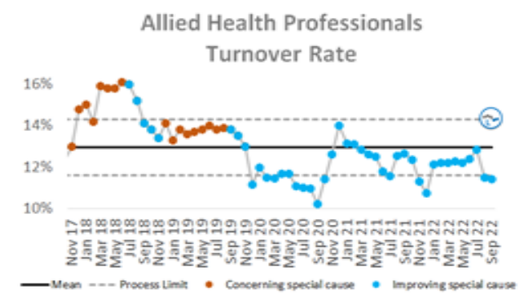


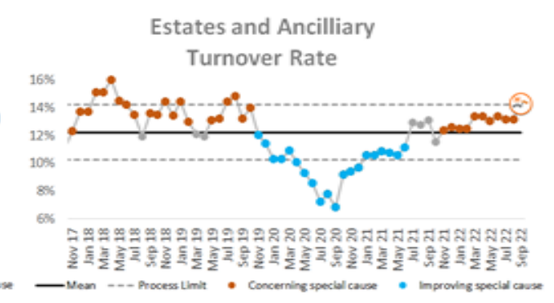


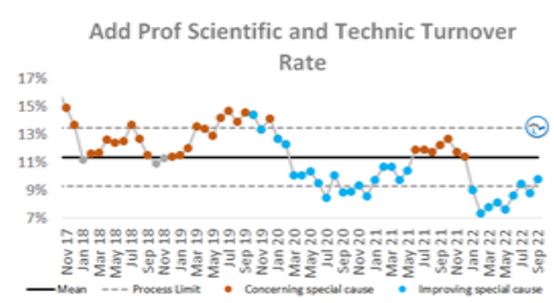












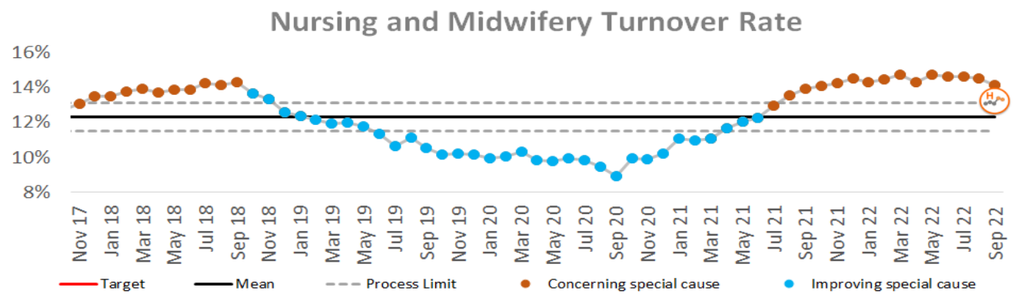
Author(s):Tosin Okufuwa, Amanda Wood

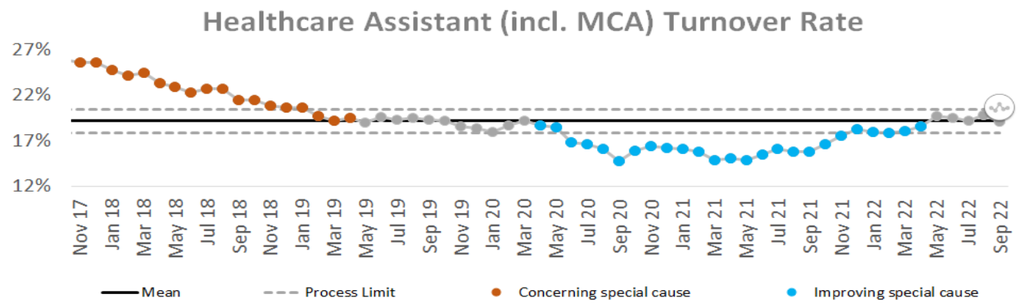
Owner(s): David Wherrett

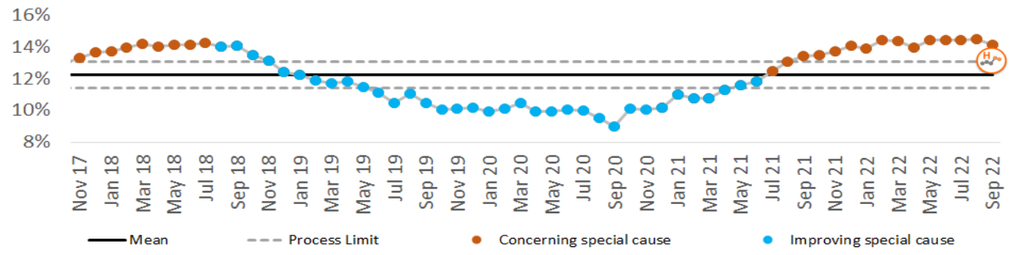
Turnover for Nursing & Midwifery Staff Group (Registered & Non-Registered)

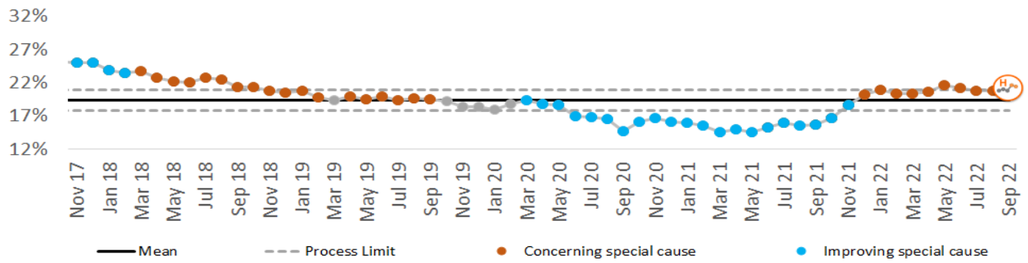
NHS Cambridge University Hospitals NHS Foundation Trust

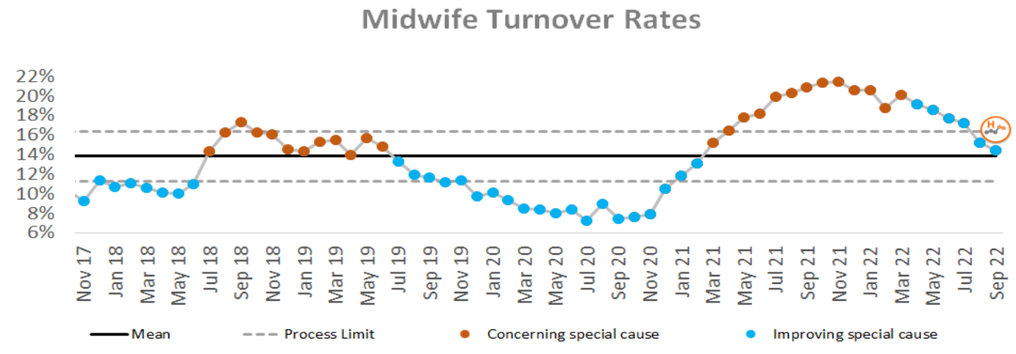
Workforce: Turnover rate for Nursing & Midwifery Staff Group

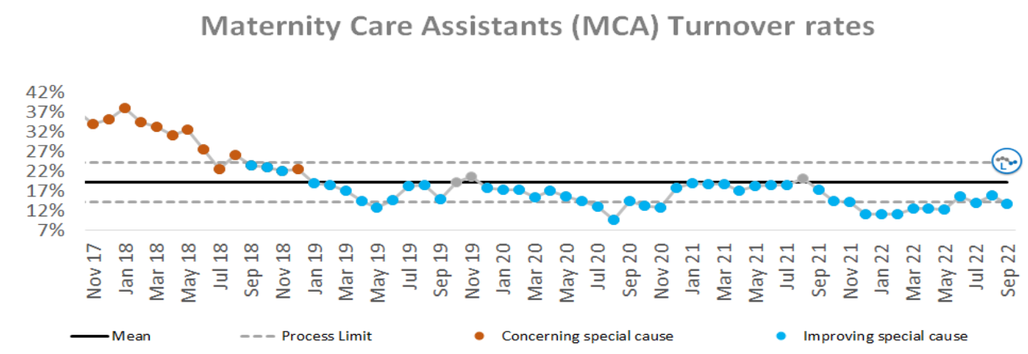












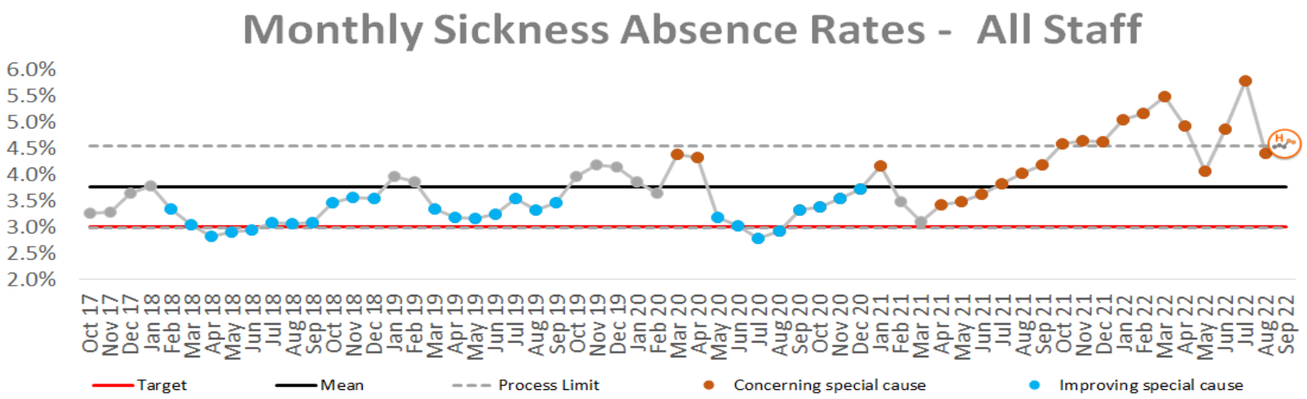
Author(s): Tosin Okufuwa, Amanda Coulier Owner(s): David Wherrett

Together-Safe | Kind | Excellent

Sickness Absence

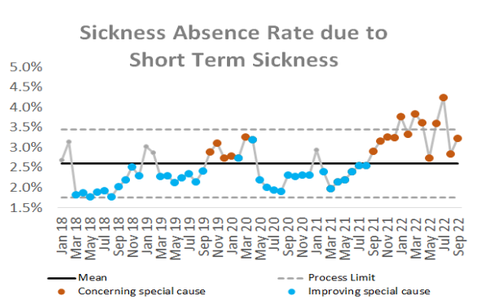
Cambridge University Hospitals NHS Foundation Trust

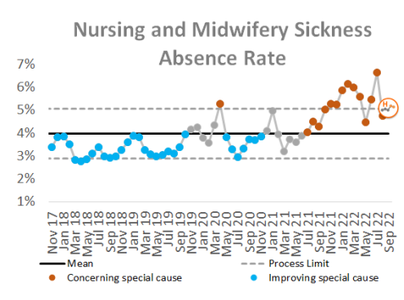
Workforce: Sickness Absence

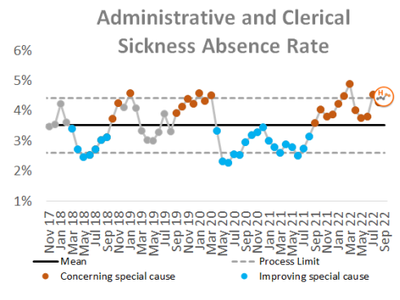


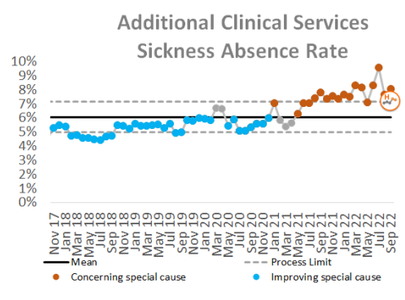
Background Information: Sickness Absence is a monthly metric and is calculated as the percentage of FTE days missed in the organisation due to sickness during the reporting month.

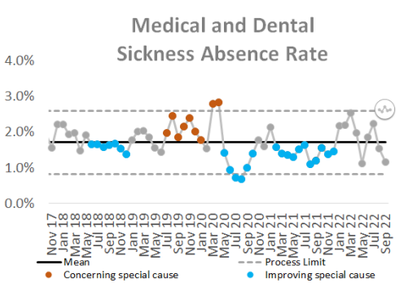
What the information tells us: The overall Monthly Sickness Absence is above average at 4.5%. This is slightly higher than last month, August 2022 (4.4%) and also slightly higher than the same period previous year, September 2021 (4.2%). Sickness absence rate due to short term illness is higher at 3.2% compared to long term sickness at 1%. Additional Clinical Services have the highest sickness absence rate at 8.05% followed by Estates at 5.6%.

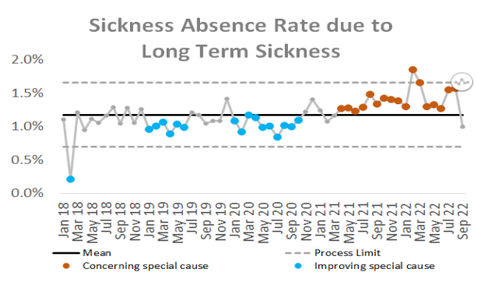


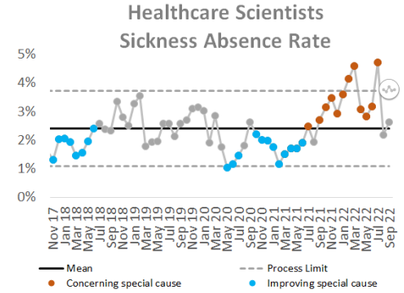


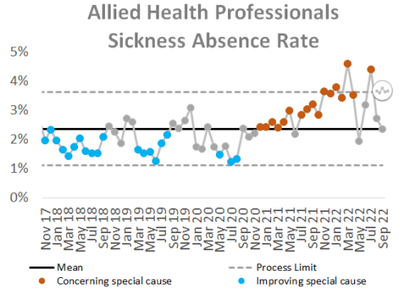


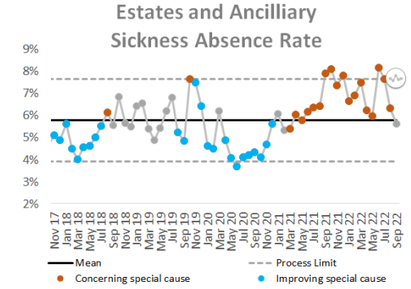


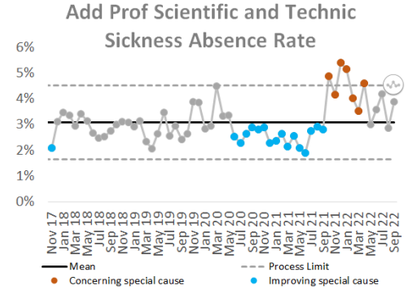












Author(s): Tosin Okufuwa, Amanda Wood

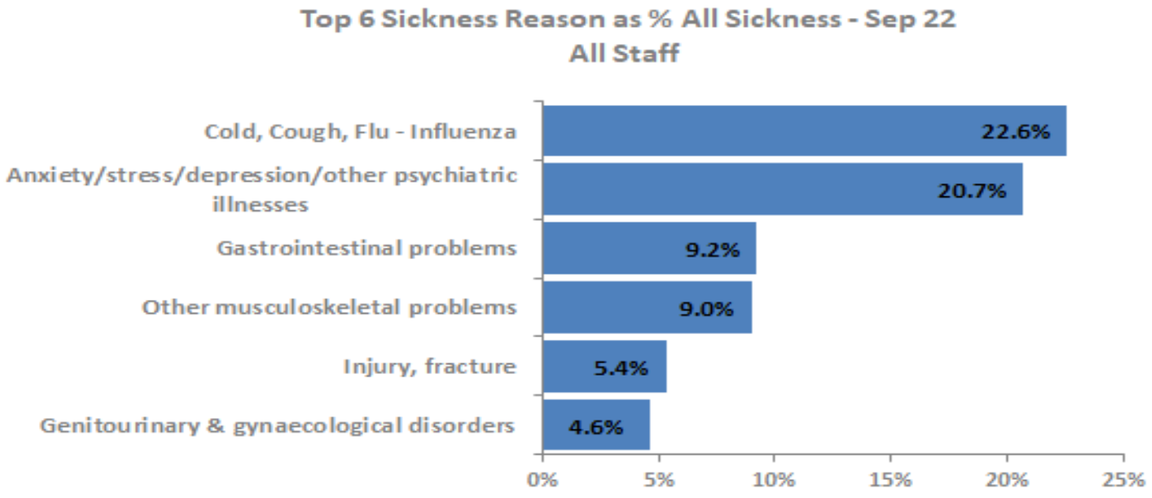
Owner(s): David Wherrett

Together-Safe | Kind | Excellent

Top Six Sickness Absence Reason

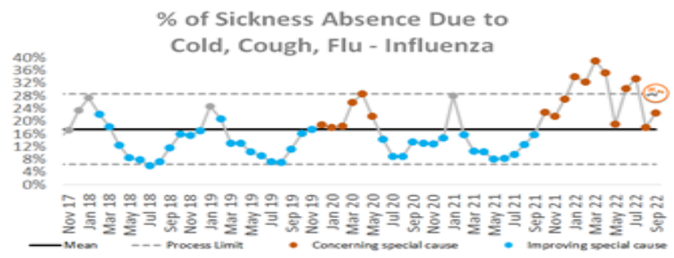
NHS Cambridge University Hospitals NHS Foundation Trust

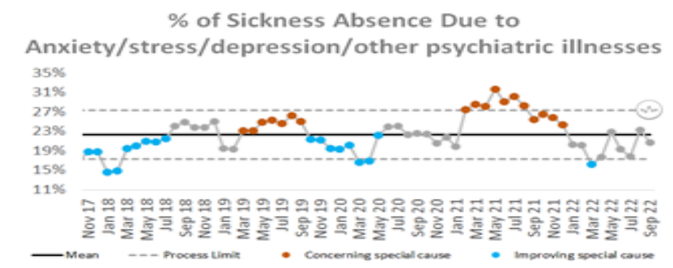
Workforce: Top Six Sickness Absence

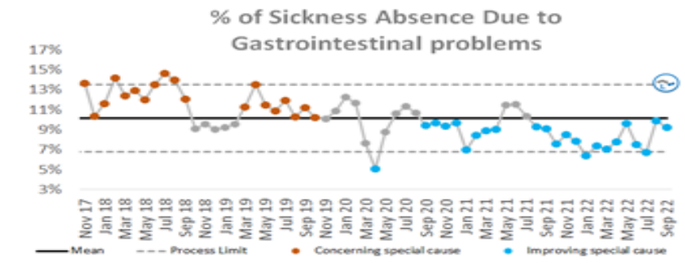


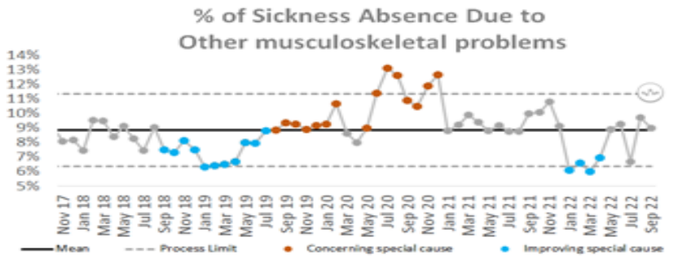
Background Information:Sickness Absence reason is provided as a percentage of all FTE days missed due to sickness during the reporting month.

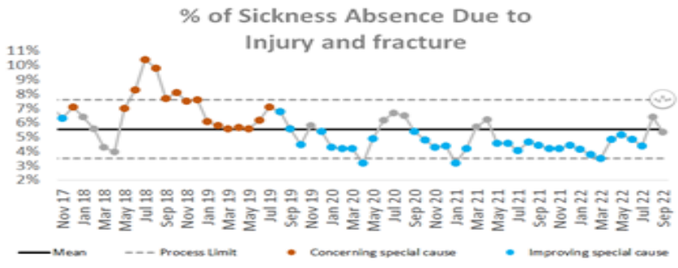
What the information tells us: The highest reason for sickness absence is influenza-related sickness, which saw an increase of 4.5% from the previous month to 22.6%, and has again overtaken anxiety/stress/depression/other psychiatric illnesses as the top sickness reason. Potential Covid-19 related sickness absence (this includes chest & respiratory problems, influenza related sickness and infectious diseases) accounts for 26.5% of all sickness absence in September 2022, compared to 23% from the previous month.

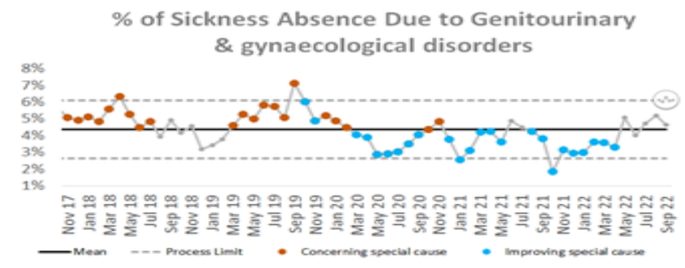












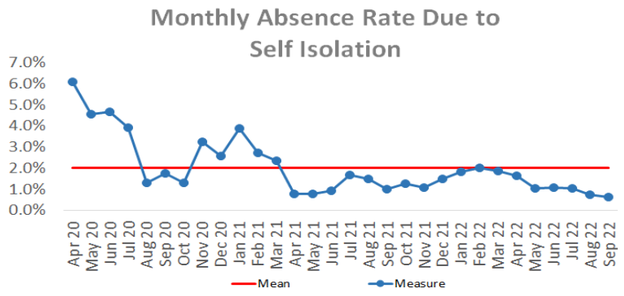
Author(s):Tosin Okufuwa, Amanda Wood

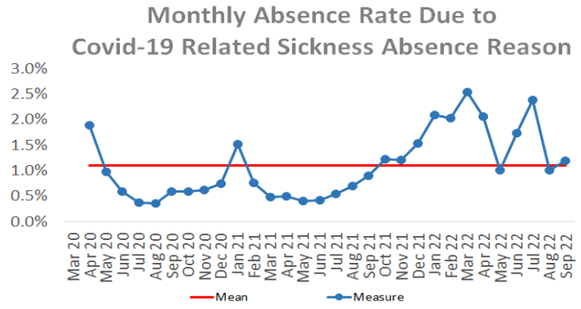
Owner(s): David Wherrett

Covid-19 Related Absence

Cambridge University Hospitals NHS Foundation Trust

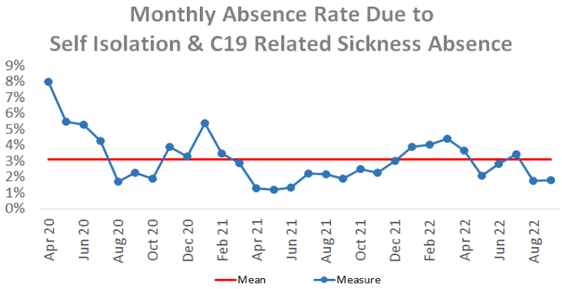
Workorce: Covid-19 Related Absence

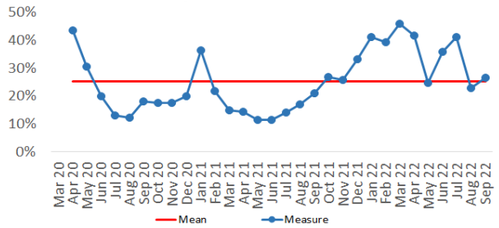


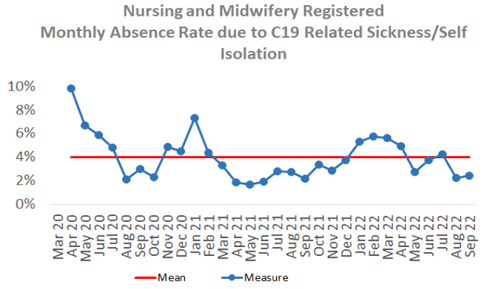


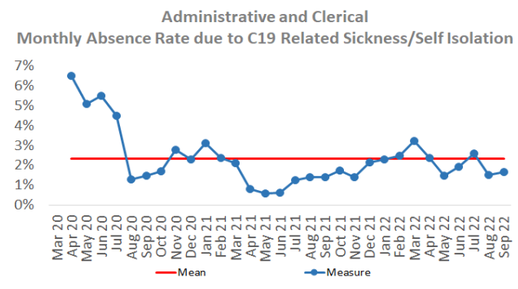
Background Information:Monthly absence figures due to Covid-19 are presented. This provides monthly absence information relating to FTE lost due to Self Isolation and potentially Covid-19 Related Sickness Absence (this includes chest & respiratory problems, influenza related sickness and infectious diseases).

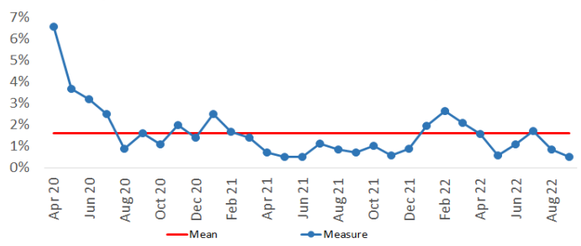
What the information tells us: The Trust's monthly absence rate due to Self Isolation has decreased to 0.6%. Monthly absence rate due to potential Covid-19 related sickness has increased to 1.2% in September 2022. Overall, absence rates due to Covid-19 related sickness and self isolation increased slightly to 1.83%.

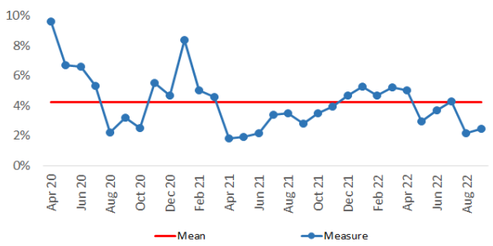


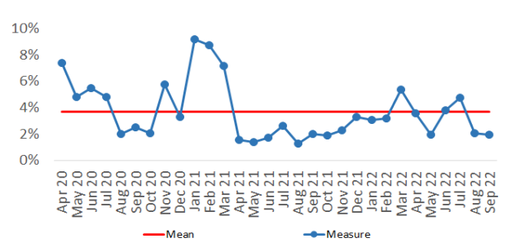


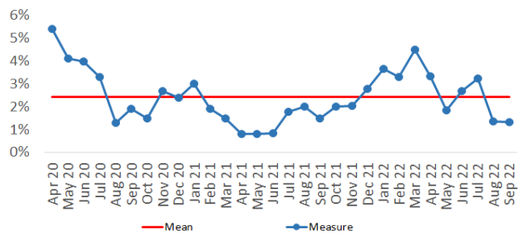












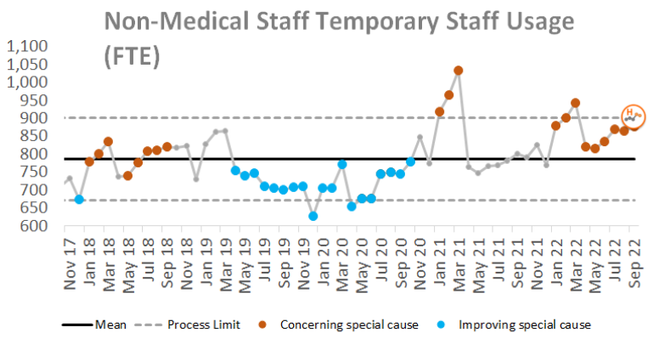
Author(s): Tosin Okufuwa, Amanda Wood

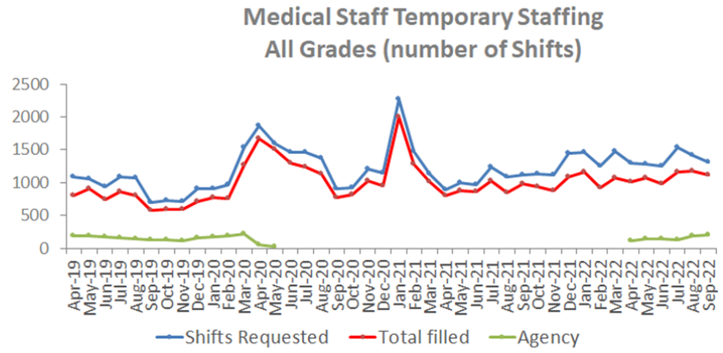
Owner(s): David Wherrett

Temporary Staffing

Cambridge University Hospitals NHS Foundation Trust

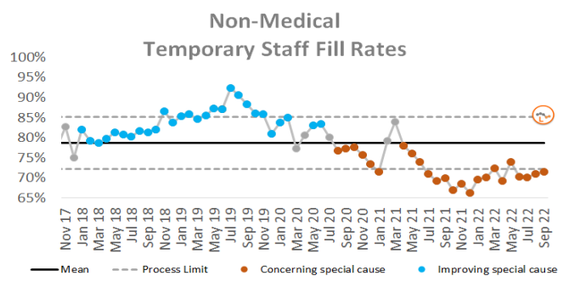
Workforce: Temporary Staffing

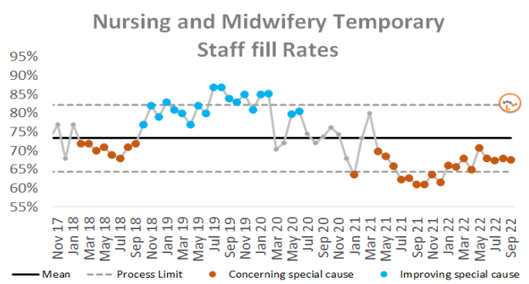


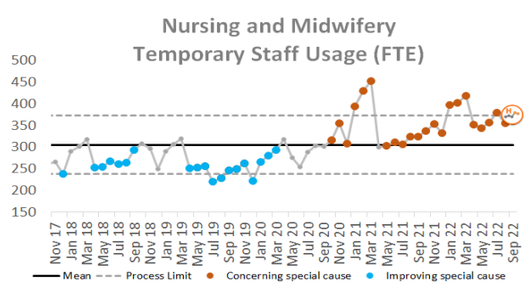


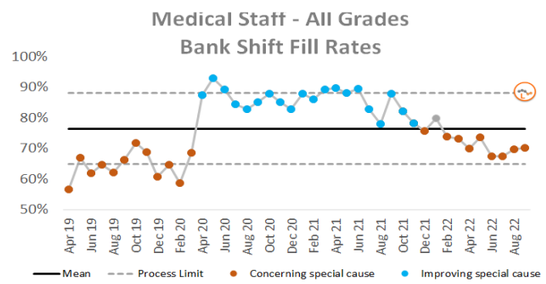
Background Information: The Trust works to ensure that temporary vacancies are filled with workers from staff bank in order to minimise agency usage, ensure value for money and to ensure the expertise and consistency of staffing.

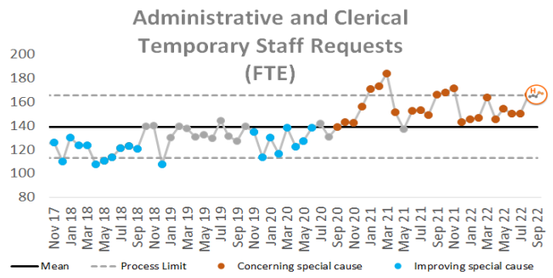
What the information tells us: Demand for non-medical temporary staff increased by 0.9% from the previous month to 1,228 WTE. Top three reasons for request includes vacancy (51%), increased workload (16%) and sickness (14%). Nursing and midwifery agency usage decreased by 1.5 WTE from the previous month to 37.3 WTE. This accounts for 10% of the total nursing filled shifts. Overall, fill rate has remained the same as last month at 71%.

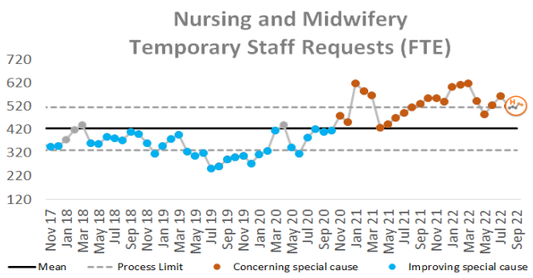


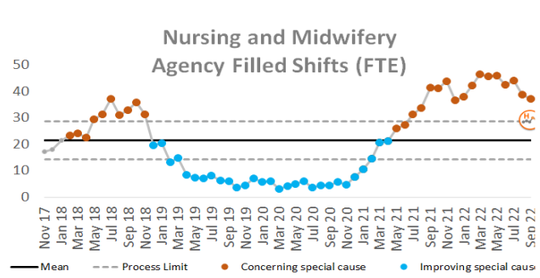


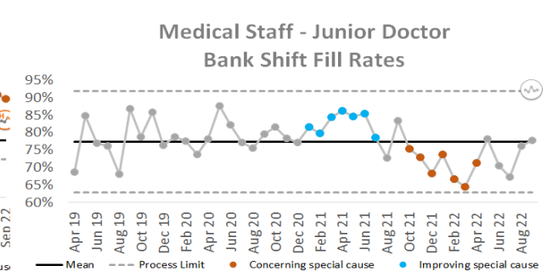










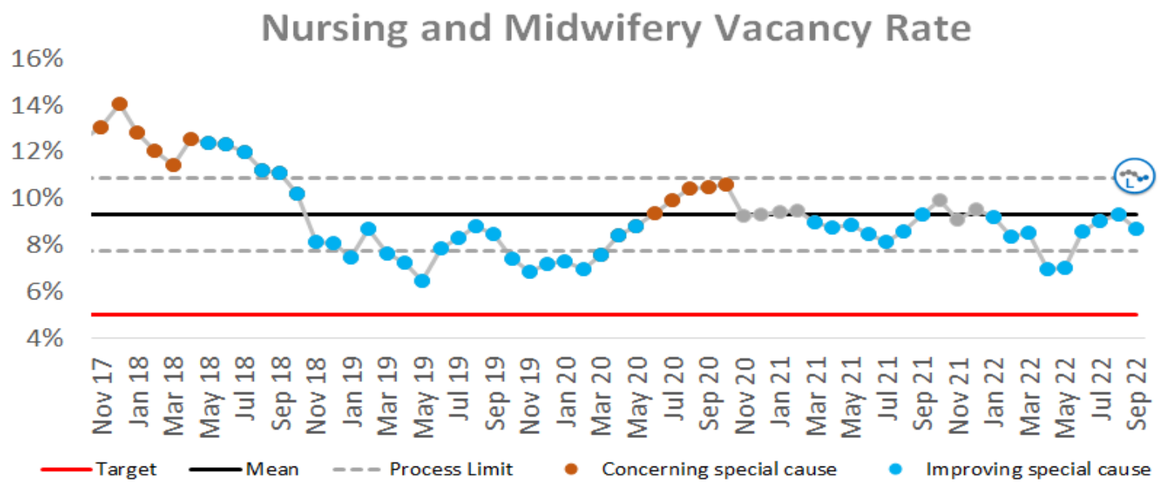


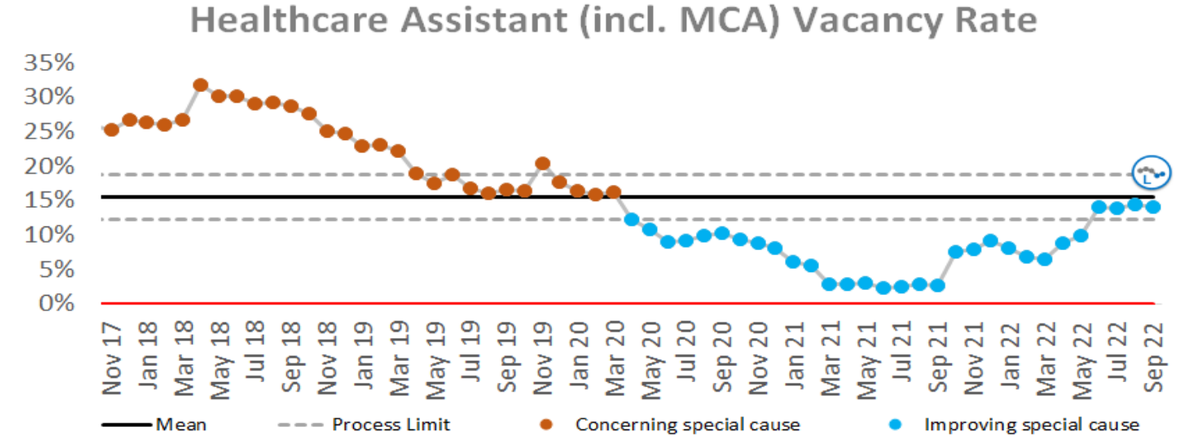
*Please note that temporary Medical staffing data was not available at the time of reporting and hence not updated

ESR Vacancy Rate

Cambridge University Hospitals NHS Foundation Trust

Workforce: ESR Vacancy Rate





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

What the information tells us: The vacancy rate for both Healthcare Assistants and Nursing and Midwifery remained below the average rate at 14.1% and 8.7% respectively. However, the vacancy rate for both staff groups are above the target rate of 5% for Nurses and 0% for HCAs.

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

Author(s): Tosin Okufuwa, Amanda Wood

Owner(s): David Wherrett

Annual Leave Update

Cambridge University Hospitals NHS Foundation Trust

Workforce: C19 - Risk Assessment & Annual Leave Update

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

	Staff Group	Total Entitlement (Hrs)	Total AL Taken (Hrs)	*% AL Taken	% of staff with Entitlement recorded on Healthroster
Annual Leave taken by Staff Group	Add Prof Scientific and Technic	49,935	24,192	48.4%	96%
	Additional Clinical Services	367,037	182,152	49.6%	97%
	Administrative and Clerical	478,442	223,257	46.7%	96%
	Allied Health Professionals	146,978	71,625	48.7%	100%
	Estates and Ancillary	77,886	41,277	53.0%	98%
	Healthcare Scientists	139,656	66,441	47.6%	97%
	Medical and Dental	140,399	44,268	31.5%	37%
	Nursing and Midwifery Registered	764,970	373,400	48.8%	98%
	Trust	**2,165,303**	**1,026,612**	47.4%	89%
Annual Leave taken by Division	*Division*				
	Corporate	300,030	144,252	48%	95%
	Division A	410,581	193,102	47%	87%
	Division B	597,897	288,928	48%	94%
	Division C	273,312	123,005	45%	81%
	Division D	260,173	125,195	48%	85%
	Division E	229,413	110,429	48%	84%
	R&D	93,897	41,701	44%	95%

* Greater than 40% | Less than 30% | Between 30% and 40%

What the information tells us: The Trust's annual leave usage is 95% of the expected usage after the sixth month of the financial year. Overall usage is 47.4% compared to the expected 50%. The highest rate of use of annual leave is within the Estates and Ancillary staff group, followed by Additional Clinical Services staff at 53% and 49.6% respectively.

Medical staffing percentages are lower due to a range of local recording practices in place. Other staff groups use the Trusts e-rostering system.

Mandatory Training by Division and Staff Group

Cambridge University Hospitals NHS Foundation Trust

Workforce: Mandatory Training

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

		Induction				Mandatory Training Competency (as defined by Skills for Health)														
		Non-Medical		Medical																
		Corporate Induction	Local Induction	Corporate Induction	Local Induction	Conflict Resolution	Equality, Diversity and Human Rights	Fire Safety	Health, Safety and Welfare	Infection Control	Information Governance including GDPR and Cyber Security	Moving & Handling	Resuscitation	Safeguarding Adults	Safeguarding Adult Lvl 2	Safeguarding Children Lvl 1	Safeguarding Children Lvl 2	Safeguarding Children Lvl 3	Prevent Level Three (WRAP)	Total Compliance
Frequency						3 yrs	3 yrs	2 yrs/1yr	3yrs	2 yrs	1 yr	2 yrs/1yrs	2 yrs/1yrs	3 yrs	3 yrs	3 yrs	3 yrs	3 yrs/1yr	3 yrs	
Delivery Method		cl	f2f	cl/	f2f	cl/e/	cl/e/	cl/e/	cl/e/	cl/e/	cl/e/	cl/e/	cl/el	cl/e/	cl/el	cl/el	cl/el	cl/el	cl	
Staff Requiring Competency		1,058	1,058	177	177	10,272	10,272	10,434	10,272	10,272	10,272	10,433	7,132	10,272	7,563	10,272	7,575	1,693	1,343	
Compliance by Division	Compliance by Division																			
	Division A	(16)90.9%	(19)89.1%	(9)82.7%	(11)78.8%	(49)97.5%	(51)97.4%	(302)84.9%	(55)97.2%	(72)96.3%	(175)91.0%	(268)86.6%	(390)78.7%	(69)96.5%	(197)89.4%	(51)97.4%	(168)91.0%	(68)67.8%	(13)92.0%	91.8%
	Division B	(15)94.1%	(35)86.2%	(5)84.4%	(7)78.1%	(58)97.9%	(60)97.8%	(227)91.7%	(56)97.9%	(119)95.6%	(204)92.4%	(353)87.1%	(349)75.4%	(85)96.8%	(185)89.3%	(60)97.8%	(179)89.7%	(24)80.0%	(12)90.0%	93.2%
	Division C	(23)88.0%	(31)83.9%	(5)85.3%	(5)85.3%	(44)96.8%	(48)96.5%	(226)83.8%	(57)95.8%	(81)94.1%	(148)89.1%	(266)80.9%	(311)77.2%	(71)94.8%	(150)89.2%	(49)96.4%	(137)90.1%	(60)75.1%	(23)90.5%	90.0%
	Division D	(8)92.7%	(21)80.9%	(7)81.1%	(7)81.1%	(39)97.0%	(46)96.5%	(189)85.8%	(50)96.2%	(79)94.0%	(153)88.3%	(260)80.4%	(299)73.6%	(61)95.3%	(118)89.7%	(50)96.2%	(98)91.5%	(23)81.7%	(20)84.0%	90.3%
	Division E	(6)95.1%	(20)83.6%	(4)78.9%	(5)73.7%	(29)97.5%	(32)97.3%	(174)85.5%	(34)97.1%	(46)96.1%	(103)91.3%	(282)76.5%	(247)76.9%	(59)95.0%	(102)90.5%	(35)97.0%	(81)92.5%	(222)77.1%	(59)91.2%	90.3%
	Corporate	(23)84.9%	(29)80.9%	(0)100.0%	(0)100.0%	(35)97.4%	(45)96.7%	(76)94.4%	(43)96.8%	(51)96.2%	(106)92.1%	(79)94.1%	(31)81.1%	(53)96.1%	(17)89.8%	(46)96.6%	(17)89.9%	(6)64.7%	(3)81.3%	94.9%
	R & D	(1)98.1%	(4)92.6%			(6)98.6%	(7)98.4%	(14)96.7%	(7)98.4%	(10)97.7%	(24)94.4%	(39)90.9%	(18)88.6%	(11)97.4%	(10)94.6%	(9)97.9%	(10)94.6%	(3)62.5%	(1)80.0%	96.1%
	Breakdown of Medical staff compliance																			
	Consultant			(8)81.8%	(11)75.0%	(19)97.4%	(22)97.0%	(33)95.4%	(27)96.3%	(31)95.7%	(72)90.1%	(34)95.3%	(187)74.7%	(25)96.6%	(50)93.2%	(17)97.7%	(44)94.0%	(30)86.2%	(16)91.7%	93.2%
	Non Consultant			(22)83.5%	(24)82.0%	(79)83.7%	(73)84.9%	(111)77.1%	(87)82.0%	(115)76.2%	(188)61.2%	(136)71.9%	(472)38.8%	(100)79.3%	(176)76.9%	(84)82.6%	(172)77.6%	(61)58.2%	(27)77.5%	73.2%
Compliance by Staff Group	Compliance by Staff group																			
	Add Prof Scientific and Technic	(0)100.0%	(1)95.8%			(6)97.4%	(5)97.8%	(6)97.4%	(5)97.8%	(8)96.5%	(15)93.4%	(12)94.8%	(8)74.2%	(7)96.9%	(19)90.5%	(7)96.9%	(21)89.5%	(0)100.0%	(0)100.0%	95.3%
	Additional Clinical Services	(36)83.7%	(36)83.7%			(32)98.1%	(37)97.8%	(272)84.2%	(33)98.0%	(54)96.8%	(131)92.2%	(341)80.2%	(311)76.9%	(56)96.6%	(202)86.8%	(38)97.7%	(172)88.7%	(47)67.6%	(7)91.5%	91.1%
	Administrative and Clerical	(17)92.2%	(40)81.7%			(52)97.6%	(63)97.1%	(82)96.3%	(64)97.1%	(91)95.8%	(162)92.6%	(102)95.3%	(8)61.9%	(88)96.0%	(13)88.3%	(72)96.7%	(13)88.5%	(4)42.9%	(1)85.7%	95.7%
	Allied Health Professionals	(3)95.1%	(11)82.0%			(7)98.9%	(7)98.9%	(76)88.4%	(7)98.9%	(21)96.7%	(36)94.4%	(161)75.5%	(150)77.0%	(12)98.1%	(33)94.9%	(8)98.8%	(31)95.2%	(17)71.7%	(5)91.4%	92.7%
	Estates and Ancillary	(14)77.4%	(4)93.5%			(5)98.5%	(5)98.5%	(17)95.1%	(6)98.2%	(7)98.0%	(30)91.2%	(4)98.8%	(4)98.8%	(6)98.2%	(6)98.2%	(5)98.5%				96.8%
	Healthcare Scientists	(2)95.6%	(7)84.4%			(10)98.4%	(10)98.4%	(23)96.3%	(10)98.4%	(19)96.9%	(36)94.1%	(46)92.5%	(18)84.5%	(12)98.0%	(33)81.6%	(10)98.4%	(31)82.7%	(2)87.5%	(2)87.5%	95.6%
	Medical and Dental			(30)83.1%	(35)80.2%	(98)91.9%	(95)92.1%	(144)88.1%	(114)90.6%	(146)87.9%	(260)78.5%	(170)85.9%	(659)56.3%	(125)89.7%	(226)84.9%	(101)91.6%	(216)85.6%	(91)74.9%	(43)86.3%	84.5%
	Nursing and Midwifery Registered	(20)95.3%	(60)85.9%			(50)98.5%	(67)98.0%	(588)83.0%	(63)98.1%	(112)96.7%	(243)92.8%	(711)79.5%	(491)85.8%	(103)96.9%	(253)92.6%	(59)98.3%	(206)93.9%	(245)77.7%	(73)91.6%	92.3%
	Trust Total	(92)91.3%	(159)85.0%	(30)83.1%	(35)80.2%	(260)97.5%	(289)97.2%	(1208)88.4%	(302)97.1%	(458)95.5%	(913)91.1%	(1547)85.2%	(1645)76.9%	(409)96.0%	(779)89.7%	(300)97.1%	(690)90.9%	(406)76.0%	(131)90.2%	92.0%

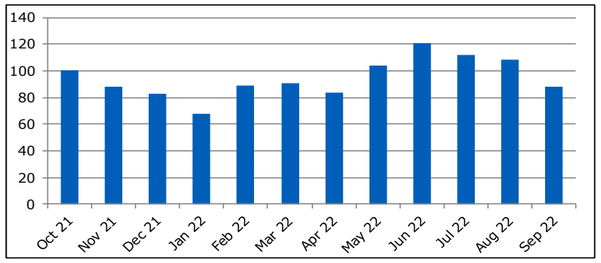
Author(s): Tosin Okufuwa, Amanda Coulier Owner(s): David Wherrett

Health and Safety Incidents

Cambridge University Hospitals NHS Foundation Trust

Health and Safety

No. of health and safety incidents affecting staff:

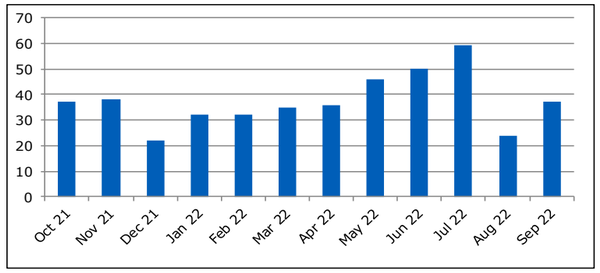


	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Total
Accident	15	8	12	17	16	21	16	15	14	20	15	18	**187**
Blood/bodily fluid exposure (dirty sharps/splashes)	30	26	12	15	17	18	17	16	19	20	17	13	**220**
Environmental Issues	7	13	4	1	5	4	10	4	7	20	17	1	**93**
Moving and Handling	1	3	7	5	3	4	3	3	5	2	4	7	**47**
Sharps (clean sharps/incorrect disposal & use)	2	3	3	2	7	3	6	8	4	8	10	5	**61**
Slips, Trips, Falls	8	12	9	4	6	8	7	8	7	3	5	10	**87**
Violence & Aggression	32	23	34	22	32	29	23	45	61	36	36	34	**407**
Work-related ill-health	5	0	2	2	3	4	2	5	4	3	4	0	**34**
Total	**100**	**88**	**83**	**68**	**89**	**91**	**84**	**104**	**121**	**112**	**108**	**88**	**1136**

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

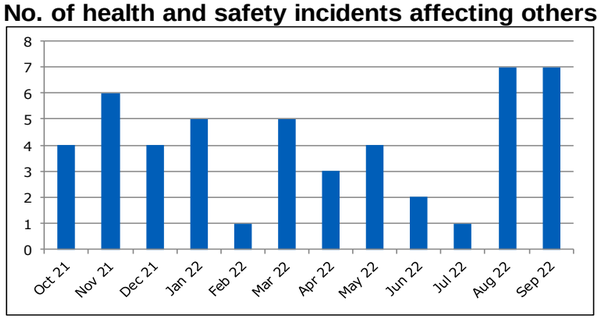
	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Total
No. of health & safety incidents	100	88	83	68	89	91	84	104	121	112	108	88	**1136**
Staff incident rate per month/year	0.9	0.8	0.8	0.6	0.8	0.8	0.8	1.0	1.1	1.0	1.0	0.8	**10.5**

No. of health and safety incidents affecting patients:



	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Total
Accident	17	13	7	11	11	17	19	25	20	20	8	13	**181**
Blood/bodily fluid exposure (dirty sharps/splashes)	2	0	3	0	1	4	2	1	1	1	1	3	**19**
Environmental Issues	3	4	4	0	4	3	2	1	4	12	2	0	**39**
Equipment / Device - Non Medical	2	2	0	1	2	1	0	1	1	2	1	0	**13**
Moving and Handling	2	0	0	3	1	1	0	0	5	2	2	1	**17**
Sharps (clean sharps/incorrect disposal & use)	2	3	3	3	2	1	0	0	3	2	2	2	**23**
Violence & Aggression	9	16	5	14	11	8	13	18	16	20	8	18	**156**
Total	**37**	**38**	**22**	**32**	**32**	**35**	**36**	**46**	**50**	**59**	**24**	**37**	**448**

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



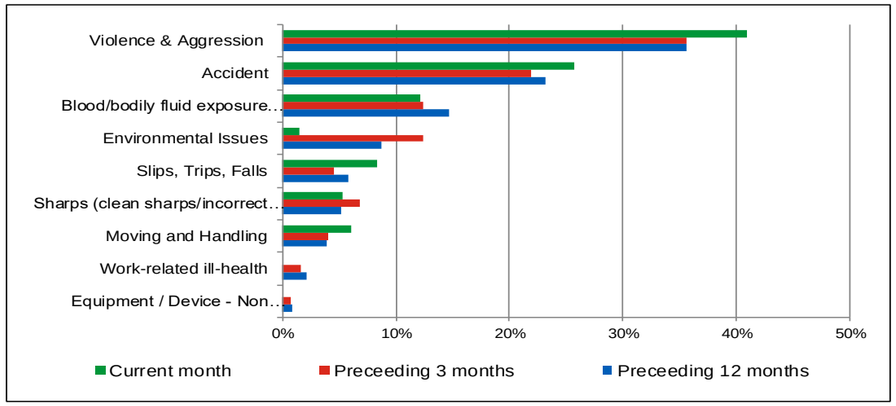
	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Total
Accident	2	1	1	1	0	0	0	2	1	0	0	3	**11**
Environmental Issues	0	0	1	3	0	1	0	2	0	0	2	1	**10**
Sharps (clean sharps/incorrect disposal & use)	0	0	0	0	0	0	0	0	0	0	1	0	**1**
Slips, Trips, Falls	0	3	1	0	0	1	0	0	1	0	1	1	**8**
Violence & Aggression	2	2	1	1	1	3	3	0	0	1	3	2	**19**
Total	**4**	**6**	**4**	**5**	**1**	**5**	**3**	**4**	**2**	**1**	**7**	**7**	**49**

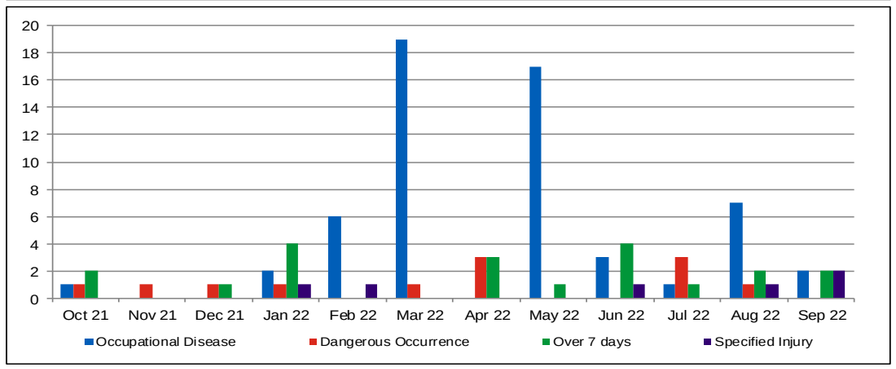
Health and Safety Incidents

NHS Cambridge University Hospitals NHS Foundation Trust

Health and Safety

No. of health and safety incidents reported by division:	Trustwide	Division A	Division B	Division C	Division D	Division E	Corporate	Estates
No. of health and safety incidents reported in a rolling 12 month period:	**1633**	**318**	**242**	**474**	**307**	**154**	**49**	**89**
Accident	**379**	88	72	87	60	33	6	33
Blood/bodily fluid exposure (dirty sharps/splashes)	**239**	67	43	44	46	32	6	1
Environmental Issues	**142**	24	34	11	22	28	7	16
Equipment / Device - Non Medical	**13**	3	1	5	4	0	0	0
Moving and Handling	**64**	9	16	10	16	4	2	7
Sharps (clean sharps/incorrect disposal & use)	**85**	36	11	12	7	11	6	2
Slips, Trips, Falls	**95**	24	19	15	7	10	7	13
Violence & Aggression	**582**	58	39	287	139	34	10	15
Work-related ill-health	**34**	9	7	3	6	2	5	2





A total of 1,633 health and safety incidents were reported in the previous 12 months.

792 (48%) incidents resulted in harm. The highest reporting categories were violence and aggression (36%), accidents (23%) and blood/bodily fluid exposure (15%).

1,136 (70%) of incidents affected staff, 448 (27%) affected patients and 49 (3%) affected others i.e. contractors and members of the public.

The highest reported incident categories for staff were: violence and aggression (36%), blood/bodily fluid exposure (19%) and accidents (16%).

The highest reported incident categories for patients were: accidents (40%), violence & aggression (35%) and environmental issues (9%).

The highest reported incident categories for others were: violence and aggression (39%), accidents (22%) and environmental issues (20%).

Staff incident rate is 10.5 per 100 members of staff (by headcount) over a rolling 12 month period.

The highest reporting division was division C with 474 incidents. Of these, 61% related to violence & aggression.

In the last 12 months, the highest reported RIDDOR category was occupational disease (60%). 40% of RIDDOR incidents were reported to the HSE within the appropriate timescale. In September 2022, 6 incidents were reported to the HSE:

Over 7 day injury (2)

- The Injured Person (IP) was investigating a leaking urinal. The IP went to remove a panel that was part of an Integrated Plumbing System (IPS) to investigate the enclosed pipe work and in doing so cut their finger.
- A metal foot stool was placed behind the IP without the IP being made aware. On turning, the IP kicked the stool and fell to the theatre floor. The IP bruised their left ankle and experienced swelling and pain.

Occupational disease (2)

- Covid-19: 2 members of staff tested positive for Covid-19 and there is reasonable evidence to suggest that a work-related exposure is the likely cause of the disease. To note, the high number reported in March and May partially reflects prevalence at the time but also the practicalities of the cases being assessed such that they are not all from those months.

Specified injury (2)

- The IP entered the staff kitchen and slipped on a patch of water that had accumulated on the floor. The IP sustained a fracture to their wrist.
- The IP tripped over some plastic pipework and fell to the floor. The plastic pipework had been left on the floor following works undertaken by an external contractor. The IP sustained multiple fractures below the right shoulder.

Author(s): Helen Murphy

Owner(s):

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 9 November 2022

Agenda item	9.1
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 M6
Previously considered by	Performance Committee, 2 November 2022

Executive Summary

The report provides details of financial performance during 2022/23 Month 6 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 6.
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 6.

Contents

Trust actual surplus / (deficit)

(£0.9m)	*Actual (adjusted)**
(£1.0m)	*Plan (adjusted)**
£2.4m	*Actual YTD (adjusted)**
£2.4m	*Plan YTD (adjusted)**

Covid-19 expenditure and system Covid-19 funding

£1.6m	*Covid actual in month*
£1.8m	*Covid plan in month*
£1.9m	*Covid funding in month*
£12.0m	*Covid actual YTD*
£11.6m	*Covid plan YTD*
£11.0m	*Covid funding YTD*

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

Net current assets

(£57.5m)	*Actual*
(£54.7m)	*Plan*

Debtor days

23	*This month*
21	*Previous month*

Payables performance (YTD) **

Actual	88.6%	*Value*
Plan	90.7%	*Quantity*

Cash and EBITDA

Cash

£176.1m	*Actual*
£166.7m	*Plan*

EBITDA

£22.1m	*Actual YTD*
£23.7m	*Plan YTD*

Capital expenditure

£4.9m	*Capital - actual spend in month*
£15.0m	*Capital - actual spend YTD*
£26.0m	*Capital – plan YTD*

Elective Recovery Fund (ERF)

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

£1.6m	*ERF forecast actual in month*
£1.6m	*ERF plan in month*
£7.3m	*ERF forecast actual YTD*
£7.3m	*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 6 Financial Performance

- **The month 6 year to date position is a £2.4m surplus for performance management purposes**. This is in line with the Trust financial plan.
- The month 6 surplus is due to the phasing of £4m of income receipts relating to the redevelopment of the Cambridge Biomedical Campus which were received in the first quarter of 22/23 (in line with plan). This surplus is offset in later months leading to a full year planned breakeven position.
- The year to date position includes pass-through drugs and devices income and expenditure over performance of £5.2m and fire prevention works income and expenditure underperformance of £4.3m (as the phasing of works are not aligning to the plan).
- The pay expenditure position is £3.2m adverse to plan year to date due to the September payment of the national pay award arrears of £7.0m for which the Trust was funded in full from a nationally mandated uplift to NHS Commissioner block payments. The underlying favourable variance is largely due to slippage on planned investments including the investment in a higher proportion of level 2/3 beds in critical care.
- 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 is operating broadly in line with its expenditure plan at month 6 year to date but continues to perform below its planned levels of productivity.
- At month 6 the under performance in clinical activity can be valued at £21.0m with £18.6m of this from planned care services 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 £10-12m associated with operational delivery/capacity.
- Overall, with the reduction in productivity and additional capacity investments in year, we are performing at a c.£29-31m 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 has incurred £12.0m of Covid-19 associated expenditure year to date which is £0.4m above the plan.
- The Trust has received £11.0m of funding to support the Covid-19 expenditure.
- 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 £7.3m year to date in line with plan and based on a fair share allocation. For the full year the Trust has planned to receive £29.7m of ERF funding. This funding remains at risk as the final process for qualifying for and calculating the value of ERF has not yet been published at the time of this report.
- However, please note that some assurance has now been provided that the planned ERF will be funded in full for 22/23. Further detail on this risk is included in this report.

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 is £62.0m and this will be delivered via the following themes:-

  - *Covid cost reductions* *£22.4m*
  - *Efficiency & transformation* *£32.7m*
  - *Productivity & growth* *£6.9m*

- At month 6 our cumulative position is in line with plan, with efficiencies of £31.8m achieved.
- Pay efficiencies are currently ahead of plan by £2.1m. Within this, recurrent initiatives are (£1.7m) adverse to plan and non-recurrent schemes are £3.8m ahead.
- For non-pay efficiencies, initiatives are (£0.8m) adverse to plan, reporting achievement of £10.3m against plan of £11.1m. Recurrent schemes are (£1.1m) adverse to plan with non-recurrent schemes £0.3m favourable to plan.
- Income efficiencies are reporting adverse to plan by (£1.3m) driven by a shortfall in non-recurrent scheme delivery. This measure includes the planned non-recurrent campus development project income receipt of £4m.
- Total efficiencies of £64.1m have been identified against £62.0m target, of which £41.5m are identified as recurrent. This represents 87.1% of the recurrent £47.6m plan.
- The Trust continues to target efficiencies to bridge the £6.1m gap versus the £47.6m recurrent target and to mitigate any scheme slippage in advance of the new financial year.

Cash and Capital Position

- The Trust has received an initial system capital allocation for the year of £32.2m for its core capital requirements. In addition to this, we expect to receive further funding for the Children's Hospital (£3.7m), Cancer Hospital (£7.5m) and orthopaedic theatre scheme (£14.9m) and additional theatre equipment (£5.1m). Together with capital contributions from ACT, this would provide a total capital programme of £65.9m for the year.
- The Trust has invested £15.0m in it's capital programme so far - £11.0m below the planned figure of £26.0m. The year-end forecast however, remains in line with the plan of £65.9m of capital expenditure in year.
- The Trust's cash position remains strong and the 13 week cash flow forecast does not identify any need for additional revenue cash support in the foreseeable future.

FY22/23 Financial Plan

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

  1) Inflation pressures above the (revised) funded level
  2) Covid-19 costs exceeding budgeted levels (e.g. due to an increase in Covid rates)
  3) Non receipt of forecast ERF income

- The following point should also be noted in respect of the 22/23 financial plan:

  1) The plan retains CUH support to our ICS of £11m to ensure that all ICS organisations can deliver break-even financial performance.

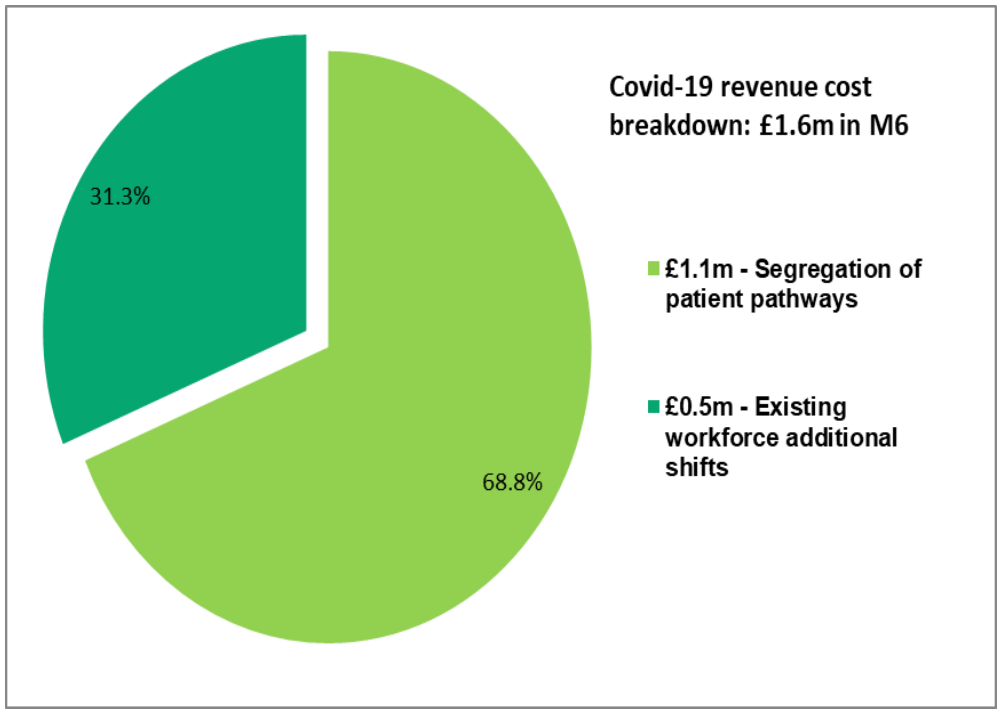
- **In addition to those risks highlighted above, going into 23/24, the Trust is also carrying the following risks due to in year performance:**

  1) Productivity levels performing below plan carrying forward a productivity gap to 23/24 posing a financial risk if the current block funding financial framework is changed
  2) Under delivery of recurrent efficiencies carrying forward a recurrent cost pressure to 23/24

Month 6 performance against plan

£ Millions	In Month Budget	In Month Actual	In Month Variance	In Month Variance (Exc. Covid)	Year to Date Budget	Year to Date Actual	Year to Date Variance	Year to Date Variance (Exc. Covid)	Full Year Budget
Clinical Income - exc. D&D*	69.9	75.3	5.4	5.4	422.9	426.9	4.0	4.0	858.9
Clinical Income - D&D*	13.5	14.3	0.8	0.8	81.0	86.1	5.2	5.2	161.9
Covid - Income top-up & outside envelope	1.8	1.9	0.1		10.8	11.0	0.2		21.6
ERF income	1.6	1.6			5.7	5.7	0.0	0.0	29.7
Devolved Income	14.8	14.2	(0.6)	(0.6)	93.5	88.6	(4.8)	(4.8)	163.3
Total Income	**101.6**	**107.2**	**5.6**	**5.6**	**613.8**	**618.4**	**4.6**	**4.3**	**1,235.4**
Pay	54.2	60.1	(5.9)	(5.9)	322.1	325.3	(3.2)	(3.2)	656.4
Drugs	14.4	15.8	(1.4)	(1.4)	86.5	90.7	(4.2)	(4.2)	173.0
Non Pay	28.5	28.6	(0.1)	(0.1)	169.7	168.3	1.5	1.5	341.3
Covid - Pay	1.4	1.2	0.2		7.6	8.2	(0.7)		14.4
Covid - Drugs	0.0	0.0	0.0		0.2	0.1	0.1		0.4
Covid - Non pay	0.6	0.4	0.2		4.1	3.7	0.4		7.4
Operating Expenditure	**99.1**	**106.1**	**(7.0)**	**(7.4)**	**590.1**	**596.3**	**(6.2)**	**(6.0)**	**1,192.9**
EBITDA	**2.5**	**1.1**	**(1.4)**	**(1.8)**	**23.7**	**22.1**	**(1.6)**	**(1.7)**	**42.5**
Depreciation, Amortisation & Financing	3.5	2.5	1.1	1.1	21.3	20.2	1.1	1.1	42.5
Reported gross Surplus / (Deficit)	**(1.0)**	**(1.3)**	**(0.3)**	**(0.7)**	**2.4**	**1.9**	**(0.5)**	**(0.6)**	**0.0**
Add back technical adjustments:									
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital donations/grants net I&E impact	0.0	0.4	0.4	0.4	0.0	0.5	0.5	0.5	0.0
Net benefit of PPE consumables transactions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit) NHS financial performance basis	**(1.0)**	**(0.9)**	**0.1**	**(0.3)**	**2.4**	**2.4**	**0.0**	**(0.0)**	**0.0**

Summary financial position



Key messages:

The Trust has recorded £1.6m of Covid expenditure in month 6, bringing the total year to date for 22/23 to £12.0m. This represents a £0.4m adverse variance against the plan of £11.6m.

The main areas of Covid investment in Month 6 are:

- Segregation of patient pathways £1.1m
- Existing workforce covering additional shifts £0.5m

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

Expenditure seen in month 6 reflects a reduction against the first 4 months of the financial year and is in line with month 5. Average monthly spend remains at £2.0m.

The Trust plans to maintain the current reduction in Covid-19 expenditure. This is based on operational planning which aims to manage Covid cases efficiently during times of prevalence and work in line with national guidance.

Division (£m's)	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr & May-22	Jun-22	Jul-22	Aug-22	Sep-22
Corporate	£1.1	£1.5	£1.3	£1.5	£1.3	(£1.0)	£1.4	£0.6	£0.6	£0.2	£0.2
Division A	£1.3	£1.5	£1.2	£1.7	£1.2	£1.1	£0.7	£0.4	£0.4	£0.3	£0.3
Division B	£0.5	£0.1	£0.4	£0.3	£0.5	£0.5	£0.9	£0.4	£0.3	£0.3	£0.4
Division C	£0.5	£0.3	£0.5	£0.6	£0.5	£0.5	£0.7	£0.3	£0.4	£0.4	£0.4
Division D	£0.3	£0.2	£0.2	£0.2	£0.1	£0.2	£0.5	£0.3	£0.3	£0.1	£0.2
Division E	£0.2	£0.1	£0.1	£0.2	£0.2	£0.3	£0.4	£0.1	£0.2	£0.2	£0.2
Total	**£3.9**	**£3.8**	**£3.7**	**£4.5**	**£3.9**	**£1.5**	**£4.5**	**£2.2**	**£2.2**	**£1.6**	**£1.6**

Elective Activity Recovery Period

Covid-19 expenditure overview

Full Year Plan – key messages

£'m	M1&2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	22/23
Operating income from patient care activities	175.6	87.8	88.0	88.0	88.0	89.3	89.3	89.4	90.2	90.2	90.2	**1,065.7**
Other operating income	31.8	13.7	13.7	13.7	13.6	13.8	13.8	13.9	14.0	13.9	13.9	**169.8**
Total operating income	**207.4**	**101.5**	**101.7**	**101.7**	**101.6**	**103.1**	**103.1**	**103.2**	**104.1**	**104.0**	**104.1**	**1,235.4**
Employee expenses	(109.3)	(54.5)	(54.9)	(55.3)	(55.6)	(56.1)	(56.4)	(56.5)	(57.0)	(57.2)	(58.0)	**(670.8)**
Operating expenses excluding employee expenses	(92.4)	(45.9)	(45.9)	(46.0)	(46.2)	(46.3)	(46.3)	(46.1)	(46.3)	(46.1)	(46.5)	**(554.0)**
Operating Surplus/(Deficit)	**5.6**	**1.0**	**0.8**	**0.4**	**(0.1)**	**0.7**	**0.4**	**0.6**	**0.8**	**0.7**	**(0.4)**	**10.6**
Finance expense	(1.2)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	**(7.2)**
PDC dividends payable/refundable	(0.6)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	**(3.4)**
Net finance costs	(1.8)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	**(10.6)**
Surplus/(Deficit) - NHS financial performance basis for the year to date	**3.9**	**0.1**	**(0.1)**	**(0.5)**	**(1.0)**	**(0.2)**	**(0.5)**	**(0.3)**	**(0.0)**	**(0.2)**	**(1.3)**	**0.0**
Add back technical adjustments:												
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Capital donations/grants net I&E impact	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Net benefit of PPE consumables transactions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Reported gross surplus/(deficit)	**3.9**	**0.1**	**(0.1)**	**(0.5)**	**(1.0)**	**(0.2)**	**(0.5)**	**(0.3)**	**(0.0)**	**(0.2)**	**(1.3)**	**0.0**

Key messages:

- The Trust plan delivers a 22/23 break-even position on an NHS financial performance basis.
- It assumes that the Trust will receive £29.7m of ERF income however, this remains at risk as the final guidance for the payment mechanism has not yet been published.
- The Trust has supported the C&P ICS position by non-recurrently returning £11.0m of income.
- Productivity and Efficiency schemes totalling £62.0m are included within the overall plan. £51.0m is driven by the national efficiency expectation with a further £11.0m required to support the system financial position.

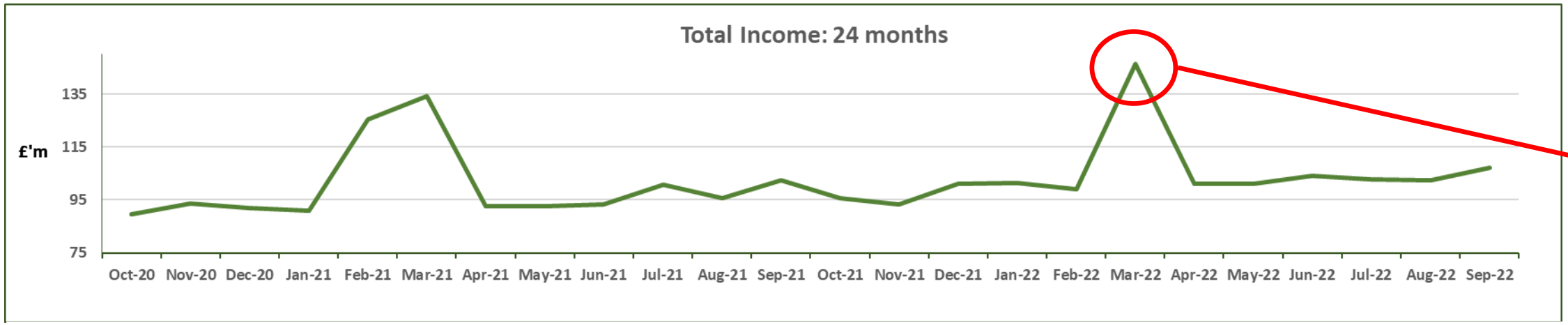
£'m	M6 YTD Plan	M6 YTD Actual	Variance	Key Variances
Operating income from patient care activities	527.3	536.5	9.2	Income over performance is largely driven by the national pay award funding of £7.0m received in month 6. Lower pass through drug recharges driven by Car-T (£3.6m) and Cancer Drugs Fund (£2.1m) are offset by over achievement in other high-cost drugs leading to a net reported over performance in this area of £5.2m.
Other operating income	86.5	81.9	(4.6)	Shortfall in income recognition is attributable to fire prevention works expenditure being lower than planned by (£4.3m).
Total income	**613.8**	**618.4**	**4.6**	
Employee expenses	(329.7)	(333.5)	(3.9)	Overspend is largely driven by the national pay award of £7.0m paid in month 6. Corresponding income over performance is reported above. This is partially offset by slippage on planned investments across a number of areas, predominantly seven critical care beds which remain largely closed due to staff vacancies. Overall there is Trust-wide slippage in Medical Staffing against the 22/23 sustainability agenda. This has resulted in increased Bank and Agency spend incurred at premium rates.
Operating expenses excluding employee expenses	(276.4)	(278.7)	(2.3)	Trust wide increase in annual leave and debt provisions to reflect financial position as at H1.
Operating surplus / (deficit)	**7.7**	**6.1**	**(1.6)**	
Finance costs				
Finance income	0.0	1.1	1.1	Due to the significant increase in bank interest rates nationally, a year to date alignment of finance income has been completed in month 6, reporting £1.1m bank interest received year to date. A full year forecast of this measure is expected to achieve income of c.£2.5-3.5m.
Finance expense	(3.6)	(3.6)	0.0	
PDC dividends payable/refundable	(1.7)	(1.7)	0.0	
Net Finance costs	**(5.3)**	**(4.2)**	**1.1**	
Reported gross surplus/(deficit)	**2.4**	**1.9**	**(0.5)**	
Add back technical adjustments:				
Impairments (AME)	0.0	0.0	0.0	
Capital donations/grants net I&E impact	0.0	0.5	0.5	
Net benefit of PPE consumables transactions	0.0	0.0	0.0	
Surplus/(Deficit) - NHS financial performance basis for the year to date	**2.4**	**2.4**	**0.0**	**Net position is in line with plan year to date**

**D&D = Drugs & devices*

Key messages:

- Year to date performance on an NHS financial performance basis shows a surplus of £2.4m.
- This is due to the phasing of income associated with the development of the Cambridge Biomedical Campus and the Trust is forecasting to be back to breakeven by the end of the financial year.

Plan performance FY22/23 (continued)



£'m	In Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Elective admissions	12.0	11.2	(0.8)	72.1	65.0	(7.1)
Non-elective admissions	15.2	14.4	(0.9)	91.4	87.1	(4.2)
Outpatients	10.4	8.5	(2.0)	62.5	51.0	(11.5)
A&E	2.0	4.1	2.1	12.2	14.0	1.8
High-cost drugs income from commissioners	13.5	14.3	0.8	81.0	86.1	5.2
Other NHS Clinical Income	30.2	37.2	7.0	183.1	208.1	25.0
Covid - Income top-up & outside envelope	1.8	1.9	0.1	10.8	11.0	0.2
ERF	1.6	1.6	0.0	7.3	7.3	0.0
Total Clinical Income	**86.8**	**93.0**	**6.2**	**520.3**	**529.7**	**9.4**
Devolved Income	14.8	14.2	(0.6)	93.5	88.6	(4.8)
Total Trust Income	**101.6**	**107.2**	**5.6**	**613.8**	**618.4**	**4.6**

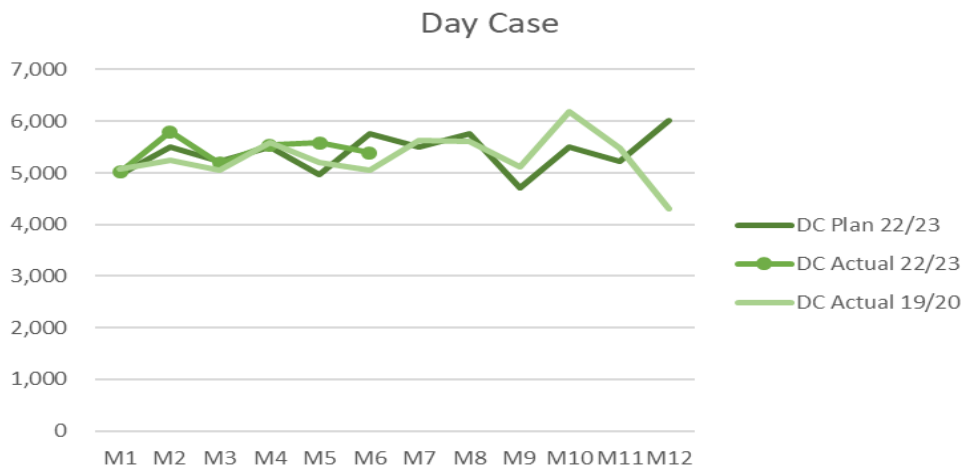
Note: The March 2022 figures include additional funding from NHSE/I for the extra 6% NHS pension contribution (£24.6m), The impact of R&D projects accounted for in M12 (£10.9m), apprenticeship funding (£2.4m), national PPE funding (£2.8m) and an NIHR R&D grant (£11.0m). All of which included matched expenditure in M12.

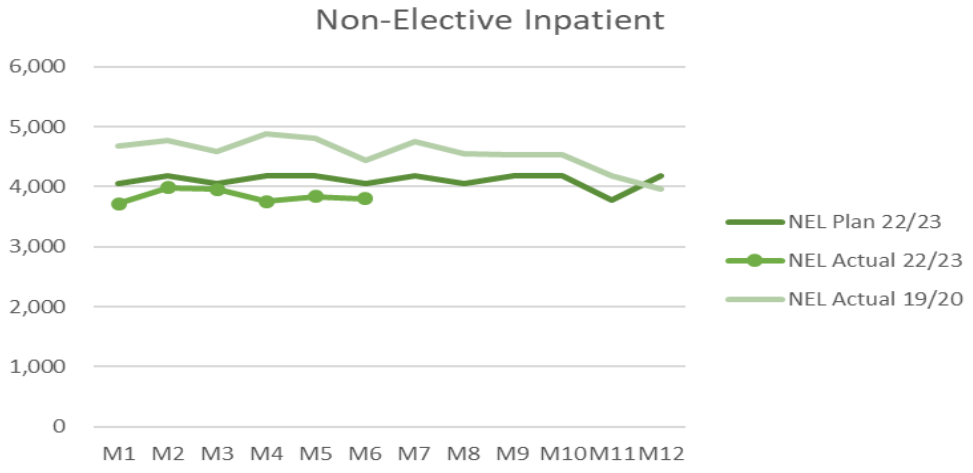
Key messages:

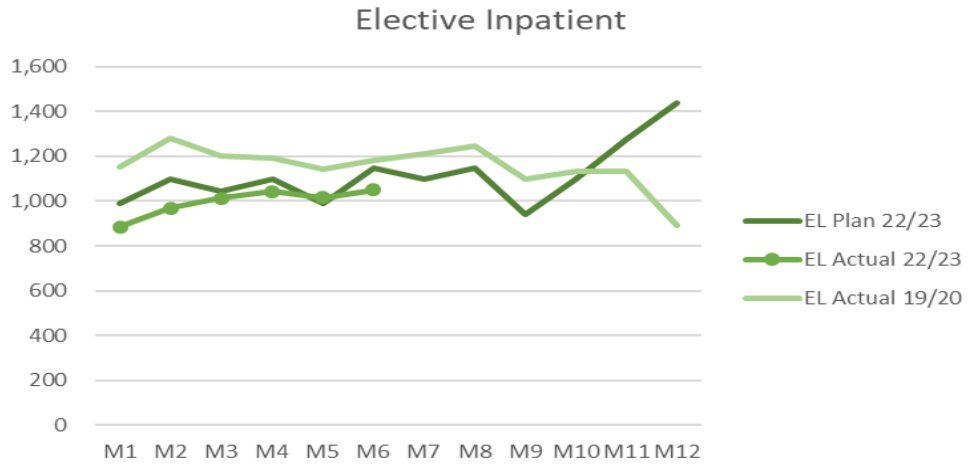
- The values included in the table for elective, non elective, outpatients and A&E income are as per regular reporting methods (PbR view). As the Trust's clinical income is predominantly through block contracts a block top-up is included within other clinical income.
- The total clinical income includes income earnt from NHS and devolved administration commissioners and NHS arms length bodies. The headings reported above align to NHS E/I reporting categories.
- Year to date there is a favourable variance of £5.2m 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 Other NHS Clinical Income category includes £7.0m of additional pay award funding – this was provided to cover the additional costs of the national pay settlements for Consultants, Agenda for Change staff and Very Senior Managers.
- The overall income recognised each month can fluctuate for a number of reasons including patient case-mix or commissioner pricing challenges.
- Devolved income is reporting an adverse variance of £4.8m year to date. This is largely driven by fire prevention works expenditure being lower than plan (£4.3m).

Clinical and other income

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

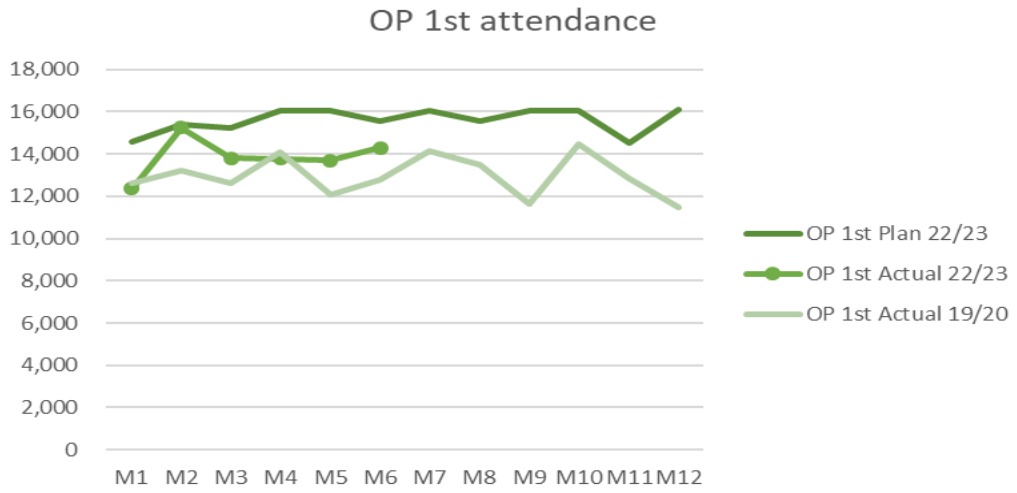


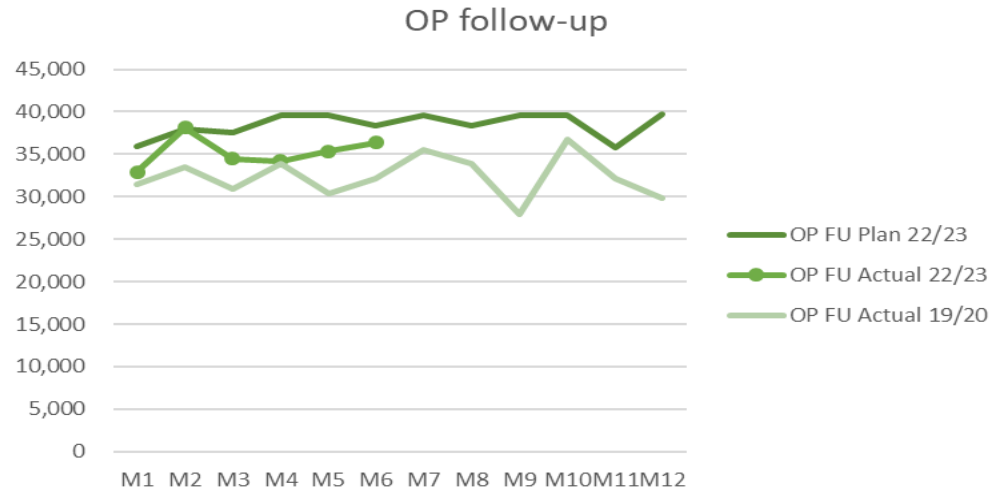


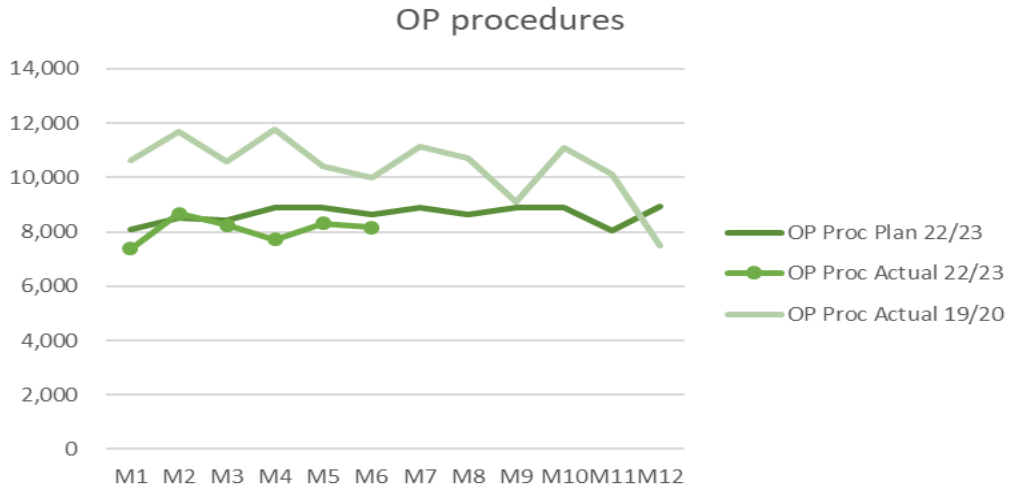


Clinical and other income (continued)

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







Key messages:

- A&E attendances are forecast to recover at month 6 after a lower than planned performance last month. Year to date A&E reports 5.2% above plan and in month 10%.
- Non elective spells continue to remain below plan and 19/20 actuals. Year to date, NEL is 6.6% below plan and in month 6.1%.
- Elective spells are close to previous 22/23 levels at month 6, and continue to be below 19/20 levels. It is notable that the phasing of the plan increases from month 6, due to planned capacity works. Year to date, EL is 6.2% below plan and in month 8.6%.
- Day cases are lower than plan at month 6 but remain above 19/20 actuals. Year to date, DC is 1.8% above plan, however in month is below plan by 6.5%.
- Outpatient first attendances remain considerably below plan. Year to date, OP FA are 10.4% below plan and in month 8.1%.
- Outpatient follow-up attendances also remain considerably below plan. Year to date, OP FUP are 7.7% below plan and in month 5.2%.
- Outpatient procedures continue to report both below both plan and considerably below 19/20 levels. Year to date, OP proc are 5.8% below plan and in month 5.3%.

Clinical Income – Elective Recovery Fund 1 (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**

Please note:- due to rounding the M1-6 plan figures add to £7.3m.

ERF:

- Planned ERF in months 1 to 3 is £0.8m per month, increasing to £1.6m for months 4 to 6, totaling £7.4m (phased plan in table above).
- **The trust has now received verbal assurance from NHSE/I that the H1 ERF will be awarded in full at 50% of the full year plan value, and further, that H2 will not be subject to clawback.**
- NHSE and other organisations have now enacted the above and paid 50% in full at month 6.
- 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).
- Final written confirmation of the change to the ERF payment process is expected in advance of next months report.
- Due to the complexity of the CUH portfolio of NHS Commissioners we will be seeking formal clarification from them that they will be funding ERF in line with our agreed plans and the NHSE/I update.
- A further update will be provided at month 7.

	CUH Provider Level		
	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: M4-6 national data not yet available

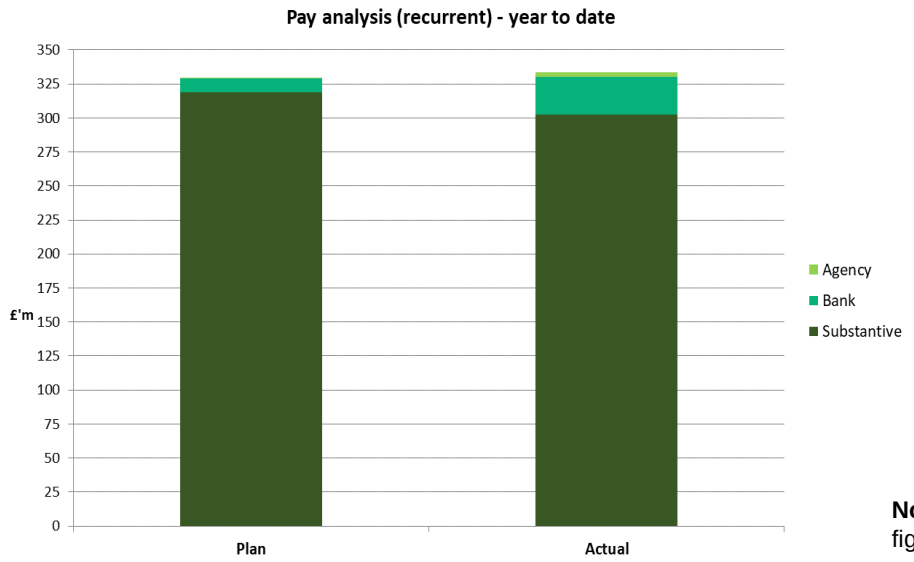
Key messages:

- At the end of month 6, the Trust is reporting a £3.8m adverse position on pay with a £5.7m adverse position in month. The in month position is driven by c£7.0m of national pay award arrears for Consultants, Agenda for Change staff over and above the 2% levels accrued in month 5. 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 seven critical care beds which remain closed due to staff vacancies. Overall there is Trust-wide slippage in Medical Staffing against the 22/23 sustainability agenda. This has resulted in increased Bank and Agency spend incurred at premium rates. Pay slippage is partially offset by pressures on Covid pay expenditure (£0.7m).

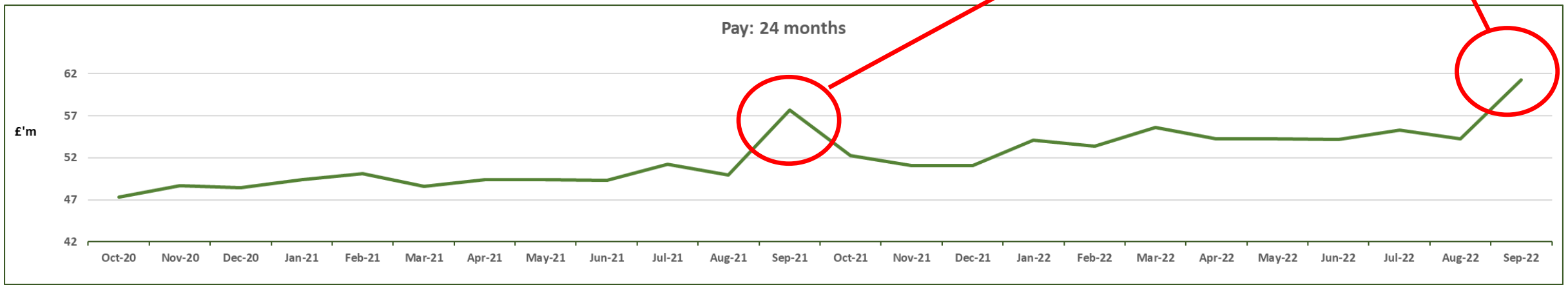
- The Trust continues to take actions to restore and maintain services in a Covid safe environment and has invested £8.2m of Covid pay related spend in H1 22/23.

- Bank spend as a proportion of the total 22/23 pay bill is 8.2%, while agency spend for the same time period is only 1.1% 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: The Sep-21 figures included estimated pay arrears of £7.8m.

Note: The Sep-22 figures includes net pay award arrears of £7.0m. .



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.

Pay expenditure – trend and year to date

	In Month			Year to Date		
£ Millions	Budget	Actual	Variance	Budget	Actual	Variance
Non Covid:						
Administrative & Clerical	8.3	9.0	(0.7)	49.5	48.4	1.2
Allied Healthcare Professionals	3.3	3.3	(0.1)	19.6	18.5	1.1
Clinical Scientists & Technicians	5.3	5.3	0.0	31.4	29.3	2.2
Medical and Dental Staff	18.5	18.9	(0.4)	110.3	106.0	4.3
Nursing	19.8	21.7	(1.9)	119.0	114.9	4.0
Other Pay Costs	1.3	1.8	(0.6)	7.9	8.3	(0.5)
Efficiency savings	(2.2)	(0.0)	(2.2)	(15.5)	0.0	(15.5)
Subtotal for non-covid	**54.2**	**60.1**	**(5.8)**	**322.2**	**325.3**	**(3.2)**
Covid:						
Administrative & Clerical	0.2	0.2	0.1	1.2	1.1	0.0
Allied Healthcare Professionals	0.1	0.1	0.0	0.5	0.4	0.2
Clinical Scientists & Technicians	0.0	0.1	(0.0)	0.2	0.1	0.1
Medical and Dental Staff	0.3	0.3	0.1	1.9	1.6	0.2
Nursing	0.7	0.6	0.0	3.5	4.7	(1.2)
Other Pay Costs	0.1	0.0	0.0	0.3	0.3	(0.0)
Subtotal for covid	**1.4**	**1.2**	**0.2**	**7.6**	**8.2**	**(0.7)**
Total Pay Cost	**55.6**	**61.3**	**(5.7)**	**329.7**	**333.5**	**(3.8)**

Key messages:

- Non Covid pay expenditure reports an adverse variance of £3.2m year to date.
- Covid expenditure is £0.7m adverse to plan. This is driven by higher usage of bank and agency nursing staffing than planned.

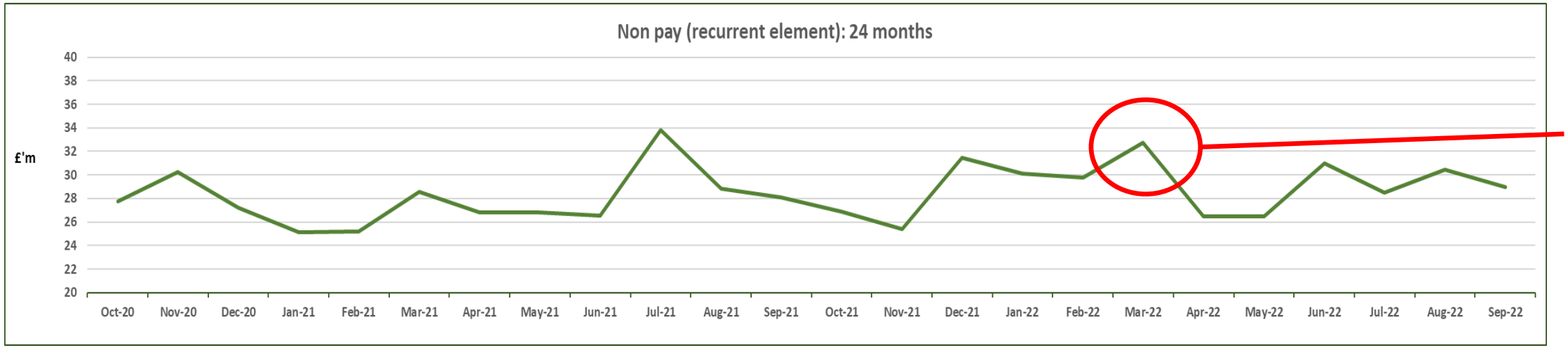
Pay expenditure (continued)

	In Month			Year to Date		
	Budget	Actual	Variance	Budget	Actual	Variance
£ Millions						
Non Covid:						
Agency	0.0	0.4	(0.4)	0.1	2.7	(2.6)
Bank	1.3	4.6	(3.3)	8.1	23.0	(14.8)
Contracted	0.2	0.2	0.0	1.3	1.8	(0.5)
Substantive	52.7	54.8	(2.1)	312.6	297.9	14.7
Subtotal for non-covid	**54.2**	**60.1**	**(5.8)**	**322.2**	**325.3**	**(3.2)**
Covid:						
Agency	0.1	0.1	(0.0)	0.5	0.9	(0.4)
Bank	0.4	0.3	0.0	2.0	4.5	(2.5)
Contracted	0.0	0.0	(0.0)	0.0	0.0	(0.0)
Substantive	0.9	0.8	0.2	5.1	2.8	2.2
Subtotal for covid	**1.4**	**1.2**	**0.2**	**7.6**	**8.2**	**(0.7)**
Total Pay Cost	**55.6**	**61.3**	**(5.7)**	**329.7**	**333.5**	**(3.8)**

Key messages:

- Substantive and Contracted staff expenditure is £14.2m below budget in the year to date however the Trust has incurred offsetting Bank and Agency expenditure which are adverse to budget by £14.8m and £2.6m respectively.
- Whilst the overall full year pay plan figures align to the Trust wide-view, the plan for Bank and Agency is understated. NHSE/I 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.

Key messages:

- At the end of month 6, the Trust's non pay position is £2.3m adverse to plan (including Covid costs) with an in month adverse movement of £1.3m.
- The in month adverse movement was primarily driven by drugs expenditure that was £1.4m over budget and an increase in the level of debt provision (Receivables Impairment) of £0.5m offset by lower than planned expenditure for Clinical Supplies which included the Trust inflation funding reserves.
- The year to date adverse variance of £2.3m includes adverse movements of £4.2m for Drugs, £2.9m impairment of receivables, £1.9m untaken annual leave provisions, £1.1m of premises costs offset by fire prevention works expenditure being lower than planned (£4.3m) and lower than planned expenditure on Clinical supplies (£9.4m).
- Overall Drugs expenditure is £4.2m 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 a reduction in volume of Car-T in the year to date, totalling at £3.6m as at month 6. Costs historically fluctuate from month to month so this area of expenditure will be monitored closely over the remainder of the financial year.
- Covid non-pay expenditure reports consistently with prior month, bringing year to date expenditure £0.5m favourable to budget.

Note: The following non-recurrent items have been adjusted out of the March 2022 figure presented; Impairment-AME (£15.8m), R&D grossing-up (£10.9m), R&D NIHR grant (£11.0m), National PPE (£2.8m), Notional apprenticeship fund (£2.4m) and Loss on disposal (£0.5m)

Non pay expenditure

	In Month			Year to Date		
£millions	**Budget**	**Actual**	**Variance**	**Budget**	**Actual**	**Variance**
Non Covid:						
Drugs	14.4	15.8	(1.4)	86.5	90.7	(4.2)
Clinical Supplies	17.0	16.3	0.7	101.3	91.9	9.4
Misc Other Operating expenses	0.1	0.6	(0.5)	(0.1)	5.8	(5.9)
Premises	4.6	4.5	0.1	27.7	28.9	(1.1)
Clinical Negligence	2.0	2.0	0.0	12.2	12.2	0.0
Other non pay costs (including CIP)	4.6	4.5	0.1	28.1	25.5	2.6
Total Recurrent	***42.8***	***43.8***	***(1.0)***	***255.7***	***255.0***	***0.7***
Other non pay costs	0.2	0.2	0.1	1.4	1.1	0.4
Receivables impairment net of reversals	(0.2)	0.4	(0.5)	(1.0)	2.9	(3.9)
Total Non-recurrent	***0.1***	***0.6***	***(0.5)***	***0.4***	***4.0***	***(3.5)***
Subtotal for non-covid	***42.9***	***44.4***	***(1.5)***	***256.1***	***259.0***	***(2.8)***
Covid:						
Drugs	0.0	0.0	0.0	0.2	0.1	0.1
Clinical Supplies	0.2	0.2	0.0	1.8	1.4	0.4
Misc Other Operating expenses	0.0	0.0	0.0	0.3	0.2	0.1
Premises	0.1	0.1	0.0	0.4	0.3	0.0
Clinical Negligence	0.0	0.0	0.0	0.0	0.0	0.0
Other non pay costs (including CIP)	0.2	0.1	0.1	1.7	1.7	(0.0)
Subtotal for covid	***0.6***	***0.4***	***0.2***	***4.3***	***3.8***	***0.5***
Total Non Pay	**43.5**	**44.8**	**(1.3)**	**260.4**	**262.8**	**(2.3)**

Key messages:

- The non pay position shows a £2.3m adverse year to date variance at M6. The key drivers for this position are described on the earlier page.
- Please note that the negative year to date budget on Misc Other Operating expenses is driven by planned slippage on non pay expenditure.
- The negative budget for Receivables impairment net of reversals relates to a budgeted reduction in the level of Aged Debt. Changes in this metric are reported each quarter.

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		1.8		1.6		2.5		2.1		2.4		11.8	13.9	24.5	27.0
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		2.4		1.9		2.3		1.4		11.1	10.3	23.8	21.7
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		0.8		0.8		0.8		0.8		0.8		8.9	7.6	13.7	13.4
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**	**0.0**	**4.9**	**0.0**	**4.9**	**0.0**	**5.2**	**0.0**	**5.2**	**0.0**	**4.6**	**0.0**	**31.8**	**31.8**	**62.0**	**62.0**

Key messages:

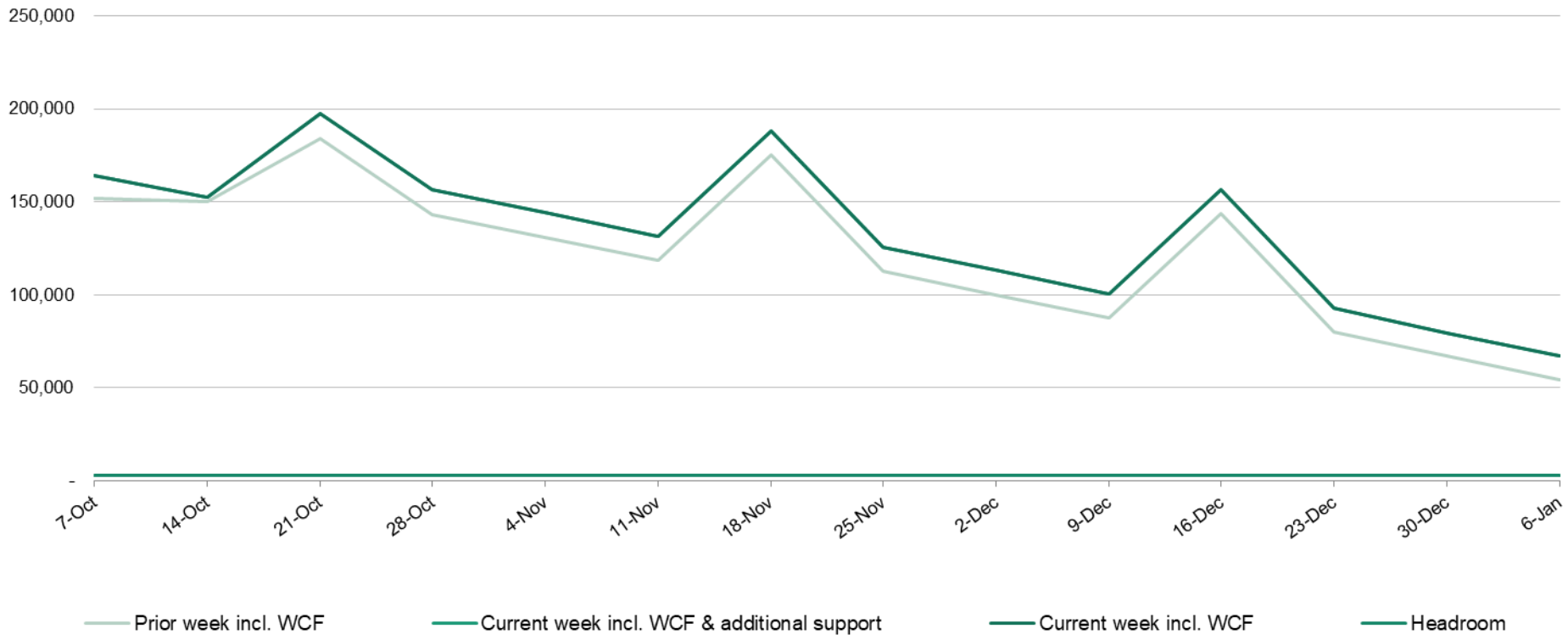
- The Trust has identified £62.0m efficiencies in line with the plan; £41.4m are forecast to be recurrent. The plan includes £11.0m of non-recurrent savings that were required to fund the £11.0m non-recurrent support to the system position in 22/23.
- At month 6, the cumulative position reports in line with plan, with efficiencies of £31.8m achieved.
- Pay efficiencies are currently ahead of plan by £2.1m. Within this, recurrent initiatives are (£1.7m) adverse to plan and non-recurrent schemes are £3.8m ahead of plan.
- For non-pay efficiencies, initiatives are (£0.8m) adverse to plan, reporting achievement of £10.3m against plan of £11.1m.
- Income efficiencies are reporting adverse to plan by (£1.3m) driven by a shortfall in non-recurrent scheme delivery. This measure includes the non-recurrent campus development project income receipt of £4m.
- The latest full year efficiency forecast identifies full delivery of the plan however there is a significant estimated shortfall in recurrent savings of £6.1m. This is mainly attributed to Trust-wide and cross-divisional schemes.
- The Trust will continue to review existing schemes alongside the development plans across 22/23 with the clear objective to increase the proportion of schemes that will deliver recurrent benefits into 23/24.
- Please see the appendix for the detailed efficiency plan.

	YTD Plan			YTD Actual Delivery			YTD Variance		
£m	Recurrent	Non-recurrent	Total	Recurrent	Non-recurrent	Total	Recurrent	Non-recurrent	Total
Pay	11.5	0.4	11.8	9.8	4.2	13.9	(1.7)	3.8	2.1
Non-pay	10.7	0.4	11.1	9.6	0.7	10.3	(1.1)	0.3	(0.8)
Income	0.3	8.5	8.9	0.1	7.5	7.6	(0.2)	(1.0)	(1.3)
	22.5	**9.4**	**31.8**	**19.4**	**12.4**	**31.8**	**(3.0)**	**3.1**	**0.0**

	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	20.9	6.1	27.0	(2.9)	5.4	2.5
Non-pay	23.2	0.6	23.8	20.4	1.3	21.7	(2.8)	0.7	(2.1)
Income	0.6	13.1	13.7	0.2	13.2	13.4	(0.4)	0.1	(0.4)
	47.6	**14.4**	**62.0**	**41.5**	**20.5**	**62.0**	**(6.1)**	**6.1**	**0.0**

Efficiency Plan & Delivery

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 6 capital expenditure position

Year to Date (Month 6)				Forecast		
	Budget £m	Actuals £m	Variance £m	Budget £m	Expenditure £m	Variance £m
Programme						
Orthopaedic theatres	5.4	2.3	3.1	14.9	14.9	-
Theatre equipment & infrastructure	1.7	-	1.7	5.1	5.1	-
P&Q ward modifications	0.8	-	0.8	2.5	2.5	-
Existing Estate/HV	4.2	2.0	2.3	12.2	12.0	0.3
Cancer Research Hospital (CCRH)	2.7	1.2	1.5	5.3	5.3	-
Thrombectomy	2.9	3.5	(0.6)	5.9	5.9	-
Medical Equipment Replacement	1.4	0.9	0.5	4.1	4.1	-
Children's Hospital (CCH)	2.3	1.3	0.9	5.9	5.9	-
Nuclear Medicine	1.5	2.3	(0.8)	3.0	2.8	0.2
e Hospital/Legacy Systems	1.5	0.1	1.4	3.0	3.6	(0.5)
Other Developments/PFI	1.6	1.5	0.1	4.0	4.0	-
Programme Total	**26.0**	**15.0**	**11.0**	**65.9**	**65.9**	**-**

Key Issues/Notes Year to Date

£15.0m has been invested YTD, against a budget of £26.0m. The larger areas of spend this year have been:

- Thrombectomy - £3.5m
- Nuclear Medicine refurbishment - £2.3m
- Orthopaedic theatres - £2.3m
- Children's Hospital (CCH) - £1.3m
- Cancer Hospital (CCRH) - £1.2m

Spend is behind budget across most areas of the capital plan, but all are the result of slippages in project spend rather than cancellations.

Key Issues/Notes Forecast

Our forecast for 22/23 is in line with the budget of £65.9m, however the budgeted slippage of £7.7m has now been fully covered by projects being delayed to future years. It is therefore imperative that we deliver the current projects in line with their current forecasts.
There are risks around the delivery of the larger Estates projects and plans are being put in place to manage and mitigate any further slippage.
We have a contingency budget of £0.6m for mid-year CAB approvals and so far have approved £0.1m of this.

Capital expenditure by programme

Balance sheet

	M6 Actual £m
Non-current assets	
Intangible assets	24.2
Property, plant and equipment	475.0
Total non-current assets	**499.2**
Current assets	
Inventories	11.8
Trade and other receivables	74.9
Cash and cash equivalents	176.1
Total current assets	**262.8**
Current liabilities	
Trade and other payables	(199.3)
Borrowings	(8.9)
Provisions	(6.5)
Other liabilities	(105.6)
Total current liabilities	**(320.3)**
Total assets less current liabilities	**441.7**
Non-current liabilities	
Borrowings	(117.3)
Provisions	(13.1)
Total non-current liabilities	**(130.4)**
Total assets employed	**311.3**
Taxpayers' equity	
Public dividend capital	583.3
Revaluation reserve	37.5
Income and expenditure reserve	(309.5)
Total taxpayers' and others' equity	**311.3**

Balance sheet commentary at month 6

- The balance sheet shows total assets employed of £311.3m.
- Non-current liabilities at month 6 are £130.4m, of which £117.3m represents capital borrowing (including PFI and IFRS 16).
- Cash balances remain strong at month 6.
- The balance sheet includes £27.9m 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 £40m of non-current assets are recognised as at 1 April 2022, with a corresponding liability split £5m current liabilities and £35m non-current liabilities. The overall impact on net assets employed is therefore nil.

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 9 November 2022

Agenda item	9.5
Title	Nurse safe staffing
Sponsoring executive director	Lorraine Szeremeta, Chief Nurse
Author(s)	Amanda Small, Interim Deputy Chief Nurse Sarah Raper, Roster Support Lead Annesley Donald, Deputy Director of Workforce
Purpose	To provide the Board with the monthly nurse safe staffing report.
Previously considered by	Management Executive, 4 November 2022

Executive Summary

The nursing and midwifery safe staffing report for September 2022 is attached. Page 2 of the report includes an Executive Summary.

Related Trust objectives	Improving patient care, Supporting our staff
Risk and Assurance	Insufficient nursing and midwifery staffing levels
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”?	n/a

Action required by the Board of Directors

The Board is asked to receive and note the nurse safe staffing report for September 2022.

Monthly Nurse Safe Staffing

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Sponsoring executive director: Lorraine Szeremeta, Chief Nurse

Amanda Small, Deputy Chief Nurse

Sarah Raper, Project Lead Nurse safe staffing

Board of Directors: 9 November 2022

Executive Summary

This slide set provides an overview of the Nursing and Midwifery staffing position for September 2022.

The vacancy position has decreased slightly in September for Registered Nurses (RN's) at 8.5% compared to 9.1% in August, Registered children's nurses (RSCN) at 22.8% compared with 24.4% in August, Registered Midwifes (RM's) at 11.79% compared to 12.35% in August and maternity care assistants (MCA's) at 13.2 % from 20.2% in August. Conversely the vacancy position for Health Care Support Workers (HCSW's) has remained static at 14.1%. It should be noted that in addition to the funded clinical areas, 4 contingency areas have been regularly open which require an additional 48WTE RN's and 37 WTE HCSW's to staff safely. These figures are not reflected in the funded establishment and therefore vacancy rates.

Turnover rate remains high at 14.1% for RN's, 14.4% for RM's, 17.6% for RSCN's and 19.1% for HCSW's. The main reason for leaving for RN's, HCSW's and RSCN's is voluntary resignation – relocation whereas for RM's it is cited as being due to Voluntary resignation – work/life balance.

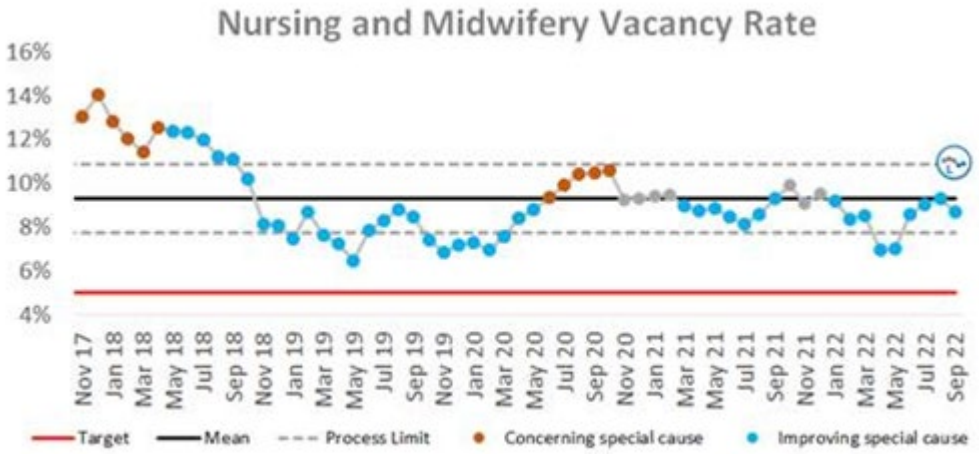
The planned versus actual staffing report demonstrates that 9 clinical areas reported <90% rota fill in September. The overall fill rate for maternity has increased slightly to 87% compared to 86% in August. The total unavailability in September has remained relatively static at 31.7% compared with 31.1% in August. The majority of unavailability (14.6%) is due to planned annual leave, sickness absence has increased to 9.3% from 7.7% in August. Additionally, 1.5% of working time was unavailable due to other leave which is comparable to August (1.6%), 3.7% was due to study leave and 2.6% was due to supernumerary time.

In order to mitigate staffing risks, the number of requests for bank workers remains high with an average of 2198 shifts per week requested for registered staff and 1999 shifts requested for Health care support workers and Maternity support workers per week with an average bank fill rate of 70% for registered staff and 62.5% for Health Care Support workers. In addition, the equivalent of 38.8WTE agency workers are working across the divisions. Despite this, redeployment of nurses and midwives has remained necessary due to staff unavailability, with an average of 286 working hours being redeployed each day of which 96.5% of the redeployed hours have been within division.

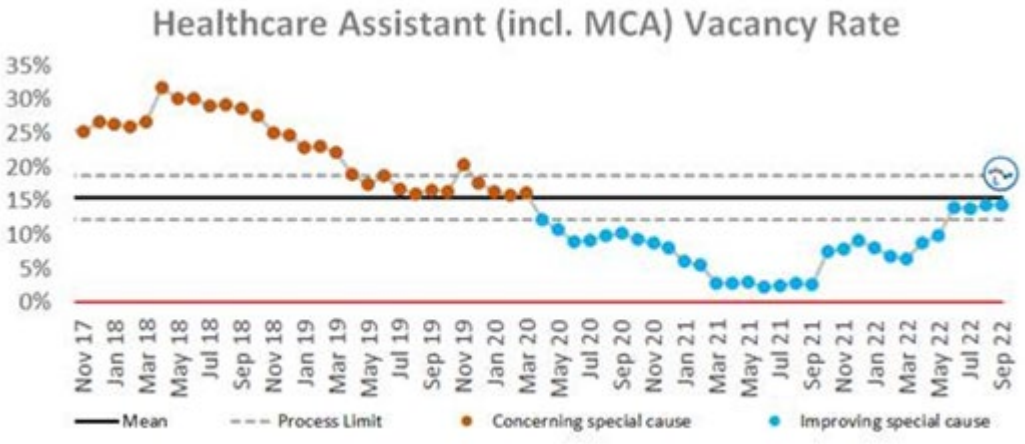
There has been an increase in the number of occasions that 1 critical care nurse has needed to care for more than 1 level 3 patient in September (34 occasions compared to 13 in August). Additionally there have been 103 occasions where there has been no side room co-ordinator (71 in August). Any concerns with regards to critical care staffing are escalated through the senior nurse of the day. Staffing has been supported through the use of temporary workers (agency and bank), bank enhancements and registered staff (non critical care trained) are redeployed from the operational pool and clinical areas on a shift by shift basis. Critical care bed capacity remains at 52 beds rather than 59 beds whilst recruitment is ongoing to the vacant positions however it has been necessary to open an additional bed at times to support capacity.

Combined Nursing and Midwifery Staffing Position Vacancy Rates

Graph 1. Nursing and midwifery vacancy rates



Graph 2. Healthcare Assistant vacancy rates



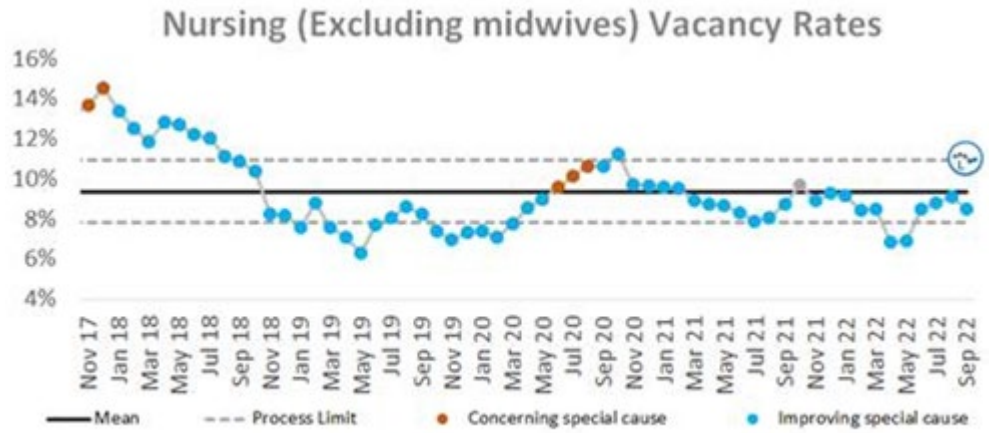
Vacancy position

The combined vacancy rate for Registered Nurses (RN's) and Registered Midwives (RM's) has decreased slightly in September to 8.7% from 9.3% in August. The vacancy rate for Health care support workers (HCSW's) (including Maternity Care Assistants (MCA's) has remained static at 14.4%. When broken down further into Nursing and Midwifery specific vacancies, the MCA workforce vacancy rate has reduced significantly from 20.2% in August to 13.2% and the HCSW vacancy rate (excl MCA) has remained static at 14.1%.

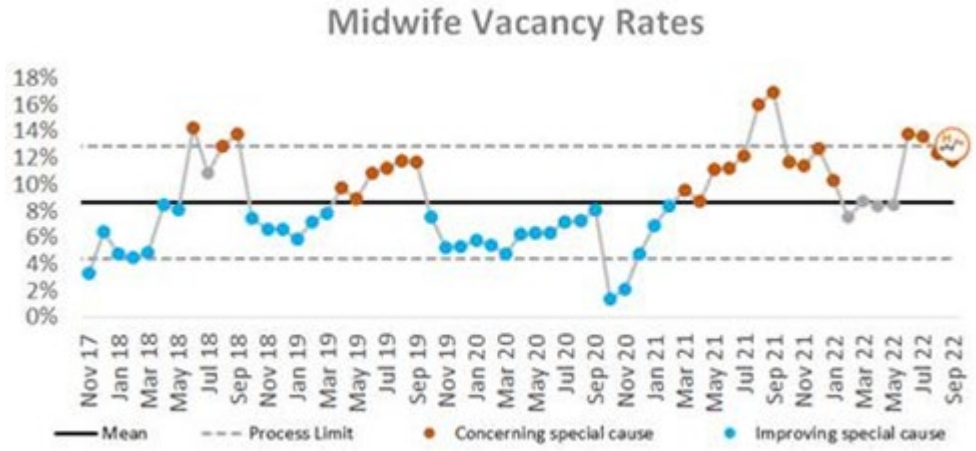
The HCSW (including MCA's) turnover rate remains high at 19.1% (19.8% August). The main reason for HCSWs leaving remains voluntary resignation – relocation (29.9%) and the next highest reason is voluntary resignation – work life balance (23.4%) . The leavers destination is unknown for the majority of HCSWs (48.9%), 15.2% of HCSW's are leaving to take up employment in other NHS organisations and 15.2% are leaving for no employment.

Staffing Position Vacancy Rates for Registered Nurses and Registered Midwives

Graph 3. Registered Nurse vacancy rates



Graph 4. Registered Midwife vacancy rates



Vacancy position

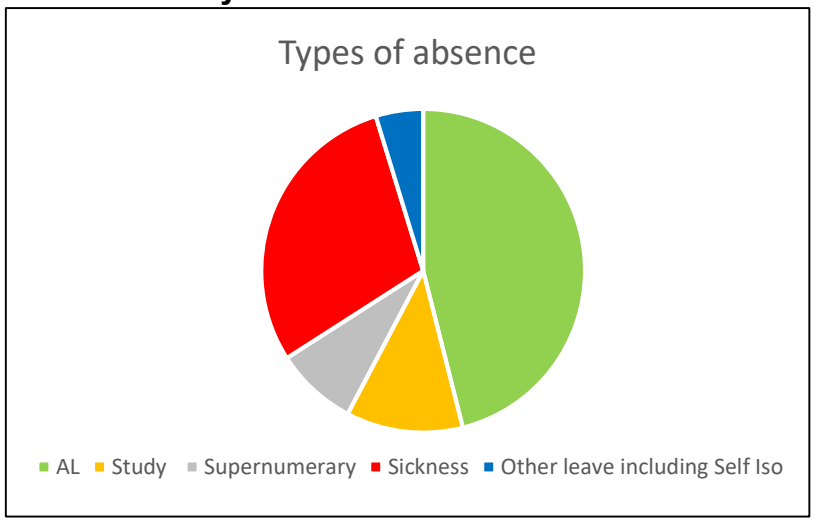
The vacancy rate for Registered Nurses working in adult areas has decreased slightly to 8.5% compared to 9.1% in August. The vacancy rate for registered children's nurses has also decreased to 22.8% compared with 24.4% in August.

The vacancy rate for Registered Midwifes illustrated a sharp increase in Graph 4 in June however this was due to the work that had been undertaken to align the workforce Electronic Staff Record (ESR) and financial ledger to reflect the additional approved investment in maternity workforce. The actual vacancy rate had remained static for a number of months. Over the last 3 months, there has been a decreasing trend in the vacancy rate from 13.0% in July to 11.79% in September.

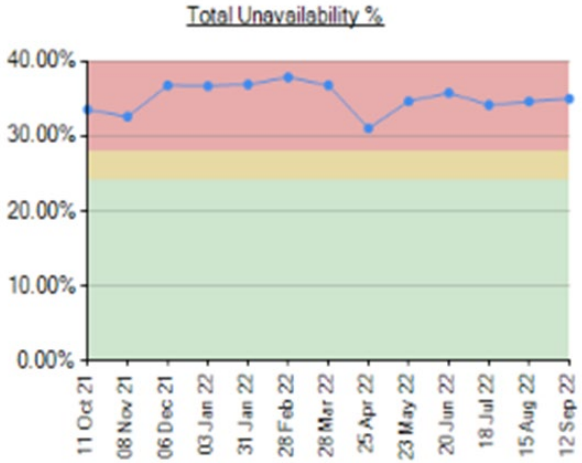
The turnover rate in September remains high at 14.1% for RNs in adult areas which is comparable to August (14.5%), 17.6% for Registered children's nurses (17.7% in August) and 14.4% for RMs (15.3% in August). The main reason for leaving is voluntary resignation – relocation for RNs (50%). The main reason for RMs leaving is voluntary resignation – work life balance (26.5%). The leavers destination data demonstrates that 32.3% of RNs and 35.3% of RMs are leaving to take up employment in other NHS organisations. 26.5% of RMs are leaving for no employment compared with 7.3% of RNs.

Unavailability for Registered Nurses, Midwives and Health Care Support Workers

Graph 5. Unavailability of staff



Graph 6. Types of absence



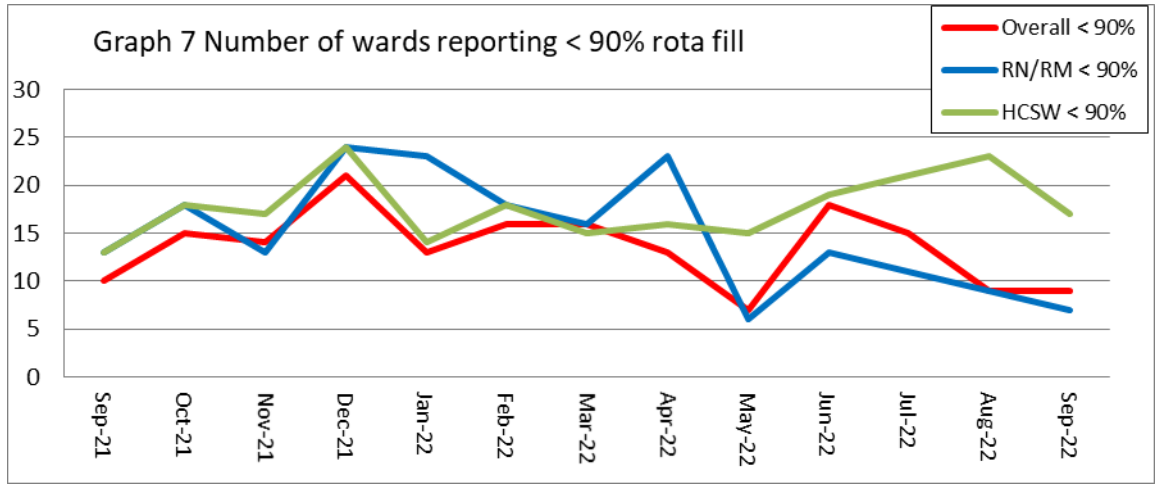
Unavailability of staff

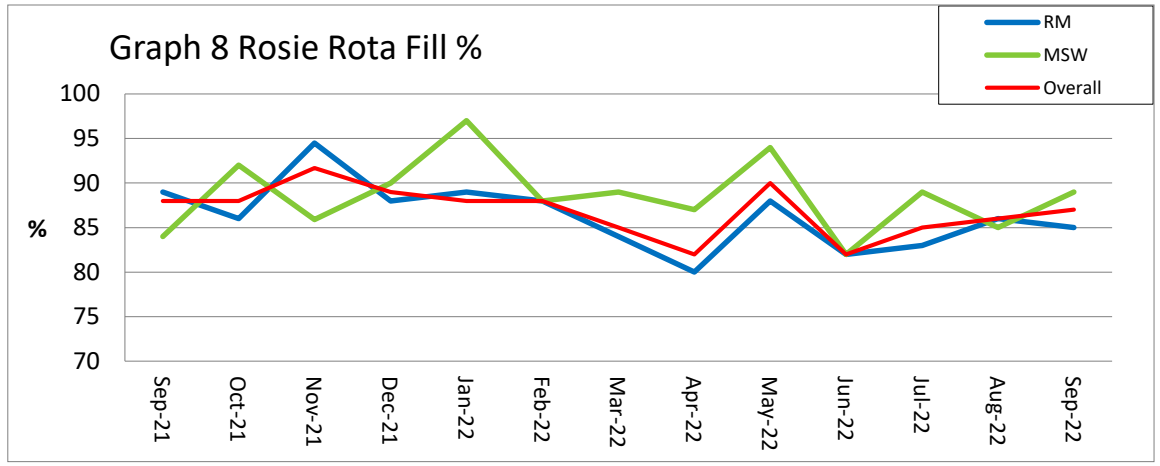
Unavailability relates to periods of time where an employee has been given leave from their regular duties. This might be due to circumstances such as annual leave, sick leave, study leave, self isolation, carers leave etc.

The total unavailability of the workforce working time in September has remained relatively static at 31.7% compared with 31.1% in August as illustrated in Graph 5.

Graph 6 illustrates the percentage breakdown of the type of unavailability. The majority of unavailability (14.6%) was due to planned annual leave which would have been accounted for in the department rosters however there was a high percentage of unplanned leave that would have impacted upon fill rates within the rosters. In September, sickness absence has increased to 9.3% from 7.7% in August. Additionally, 1.5% of working time was unavailable due to other leave which is comparable to August (1.6%), 3.7% was due to study leave and 2.6% was due to supernumerary time.

Planned versus actual staffing





Planned versus actual staffing

Graph 7 illustrates trend data for all wards reporting < 90% rota fill. The number of areas reporting <90% rota fill for registered RN/RM has been a decreasing trend over the last 3 months with 7 areas in September reporting <90% fill rates compared to 9 in August. There has also been a reduction in the number of areas reporting <90% rota fill for HCSWs in September with 17 clinical areas reporting HCSW fill rates of <90% compared with 23 in August. Conversely, the number of ward areas reporting overall fill rates of <90% in September has remained static at 9.

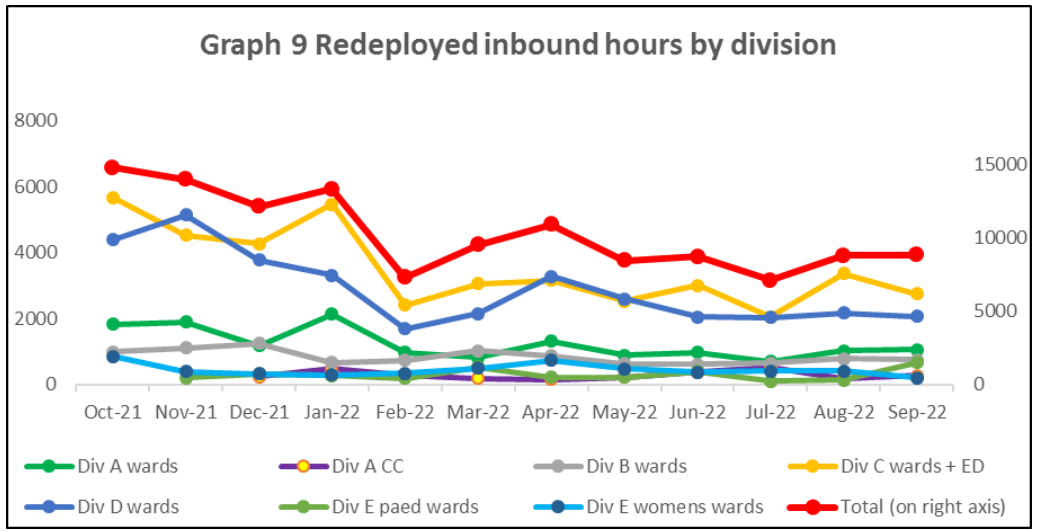
Division E reported 6 areas across paediatrics and maternity with overall fill rates of <90%. The only other division to report overall fill rates of <90% was division A with 1 area. Appendix 1, details the exception reports for all areas reporting fill rates of <90%.

There has been an increase in the number of occasions that 1 critical care nurse has needed to care for more than 1 level 3 patient in September (34 occasions compared to 13 in August). Additionally there have been 103 occasions where there has been no side room co-ordinator (71 in August). Any concerns with regards to critical care staffing are escalated through the senior nurse of the day. Staffing has been supported through the use of temporary workers (agency and bank), bank enhancements and registered staff (non critical care trained) are redeployed from the operational pool and clinical areas on a shift by shift basis. Critical care bed capacity remains at 52 beds rather than 59 beds whilst recruitment is ongoing to the vacant positions however it has been necessary to open an additional bed at times to support capacity.

Midwifery & MSW fill rate

Graph 8 illustrates that the overall fill rate for maternity has increased slightly to 87% compared to 86% in August. The lowest fill rates have been seen in the Rosie birth centre (74%).

Staff deployment



Staff deployment

Graph 9 illustrates the movement of staff across wards to support safe staffing to ensure patient safety. This includes staff who are moved on an ad hoc basis (shift by shift) and shows which division they are deployed to.

The number of substantive staff redeployed in September has increased slightly with an average of 286 working hours being redeployed per day compared with 284 hours in August. This equates to 25 long day or night shifts per day. The majority of redeployments are within division (96.5% compared to 3.5% of staff who are deployed outside of their division). Staffing is also being supported by the operational pool whereby bank staff book a bank shift on the understanding that they will work anywhere in the trust where support is required.

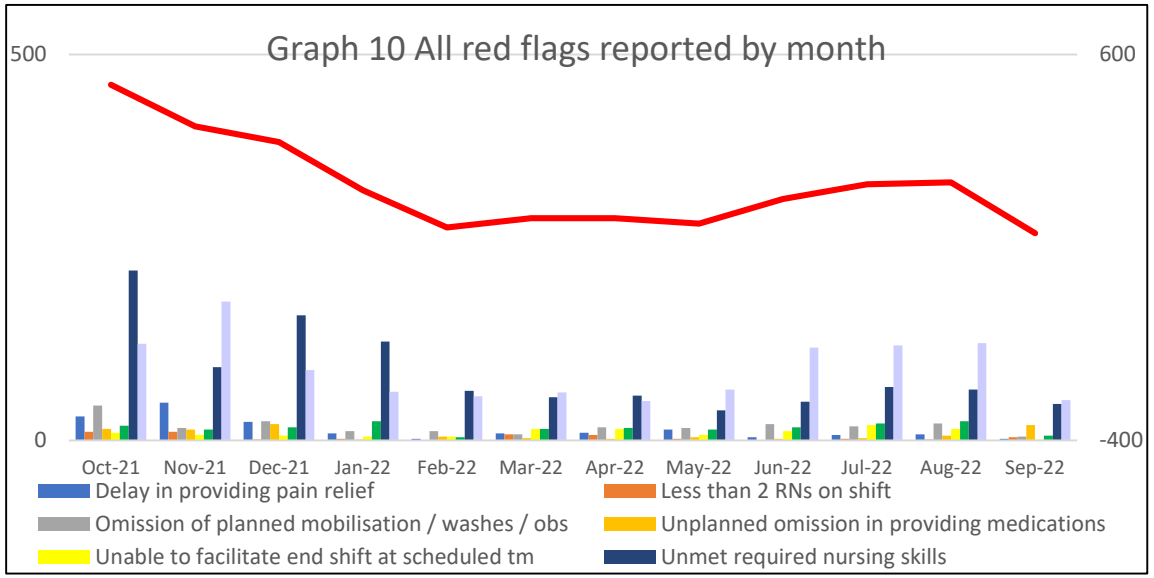
Nursing Pipeline

Appendix 2 provides detail on the forecasted position in relation to the number of adult RN vacancies based on FTE and includes UK experienced, UK newly qualified, apprenticeship route, EU and international recruits up to March 2023. The current forecast demonstrates a year end band 5 RN vacancy position of 7.62% which is slightly above the target of 5%. This is due in part to the reliance on international recruitment and the challenges with accommodation which has impacted upon the numbers of staff that can be deployed each month. A detailed recruitment plan is being collated for all Nursing recruitment pipelines to outline what can realistically be achieved, the blockers that may prevent this and the mitigations that can be put in place to address these.

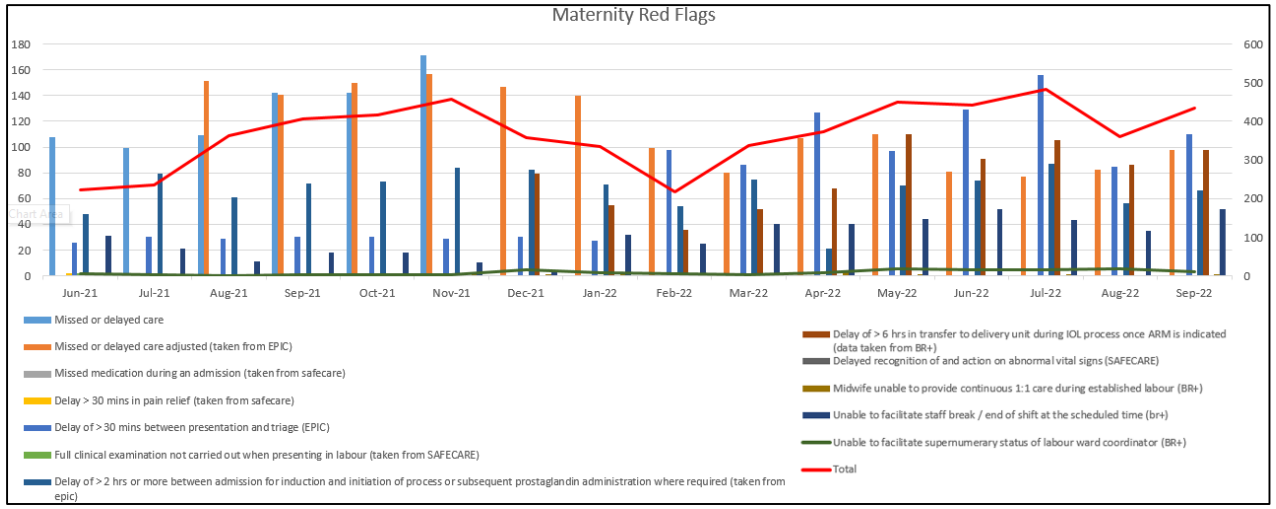
Appendix 3 provides detail on the forecasted position in relation to the number of Paediatric band 5 RN and HCSW vacancies up to March 2023. Numbers are based on those interviewed and offered positions in addition to planned campaigns. The current forecast demonstrates a year end band 5 Paediatric RN vacancy position of 14.43% and a band 2 HCSW position of -3.3%.

Whilst the recruitment pipeline is positive with multiple pipelines including apprenticeship routes, domestic and international recruitment, the predicted numbers are only achievable if the appropriate infrastructure is in place to support.

Red flags



Graph 11: Maternity Red Flags



Red Flags

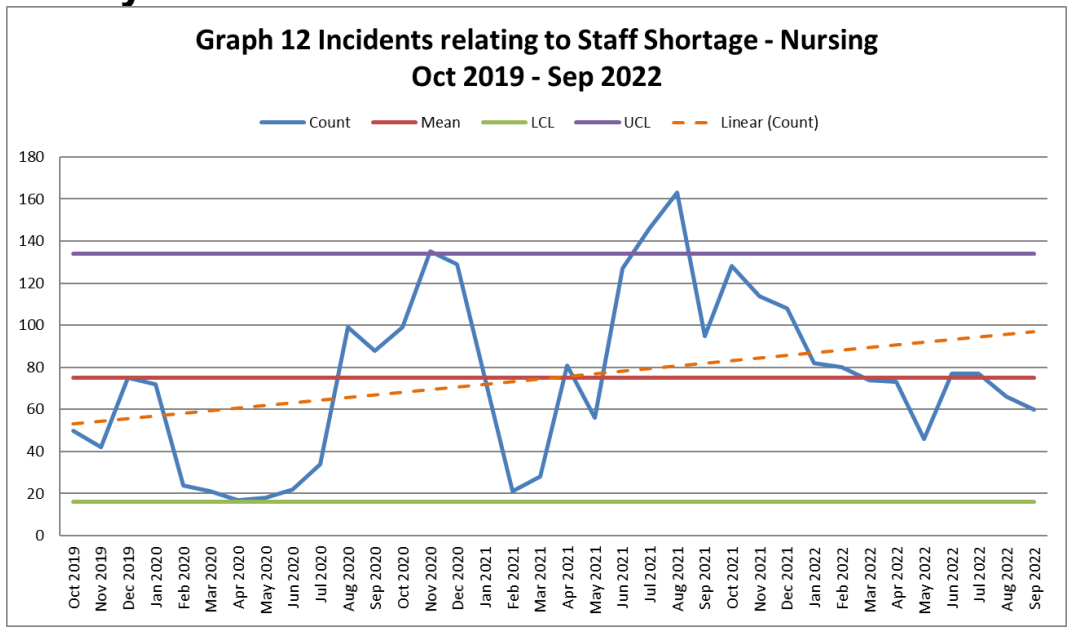
A staffing red flag event is a warning sign that something may be wrong with nursing or midwifery staffing. If a staffing red flag event occurs, the registered nurse or midwife in charge of the service should be notified and necessary action taken to resolve the situation.

Nursing red flags

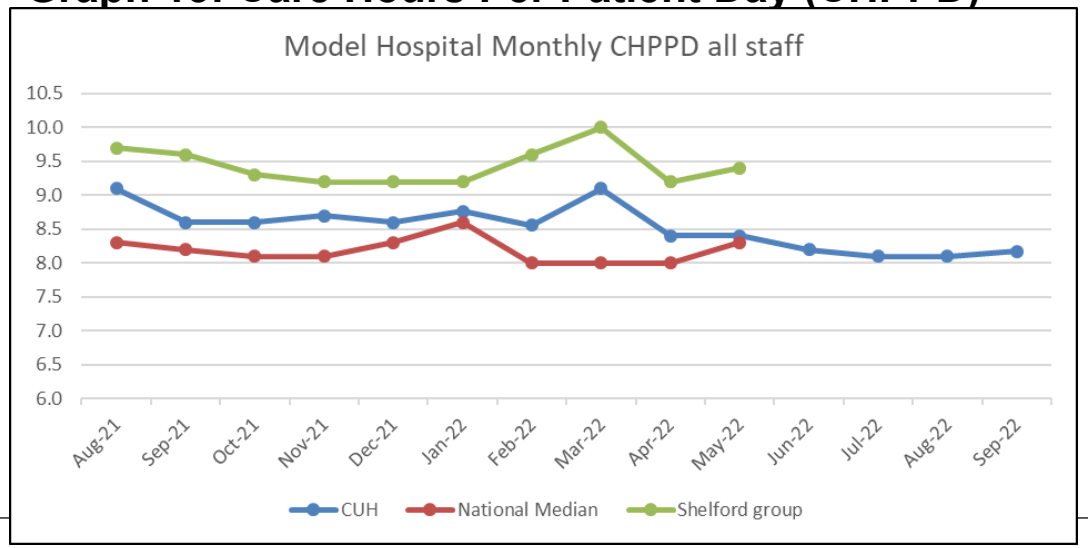
Graph 10 illustrates that the number of red flags reported in September has decreased from 269 to 137. The highest number of red flags reported in September was in relation to an unmet 1:1 specialling requirement (52 compared with 126 in August). A trust wide improvement project focusing on specialling is being developed to review specialling across the organisation. Additionally, 47 red flags were reported in relation to an unmet required nursing skills compared with 66 in August.

Maternity red flags

The number of maternity red flags reported in September has increased to 575 compared with 388 in August. Graph 11 illustrates the red flags that have been reported. 34.1% of these red flags were due to a delay of >30mins between presentation and triage, 19.3% of these red flags were due to missed or delayed care and 18.6% were due to a delay of >6hrs in transfer to delivery unit in induction of labour process. This is reflective of the high levels of activity and difficulty in maintaining flow.



Graph 13: Care Hours Per Patient Day (CHPPD)



Incidents reported relating to staff shortages

Graph 12 illustrates the trend in Safety Learning Reports (SLRs) completed in relation to nurse staffing. There were 60 incidents reported relating to nurse staffing in September which has decreased from the number reported in August (66).

The majority of the incidents related to staffing levels in September were reported by division D (27). Within Division D, the majority of staffing incidents were reported on Ward D7 (10). Safety continues to be monitored through the site safety meetings.

Care hours per patient day (CHPPD)

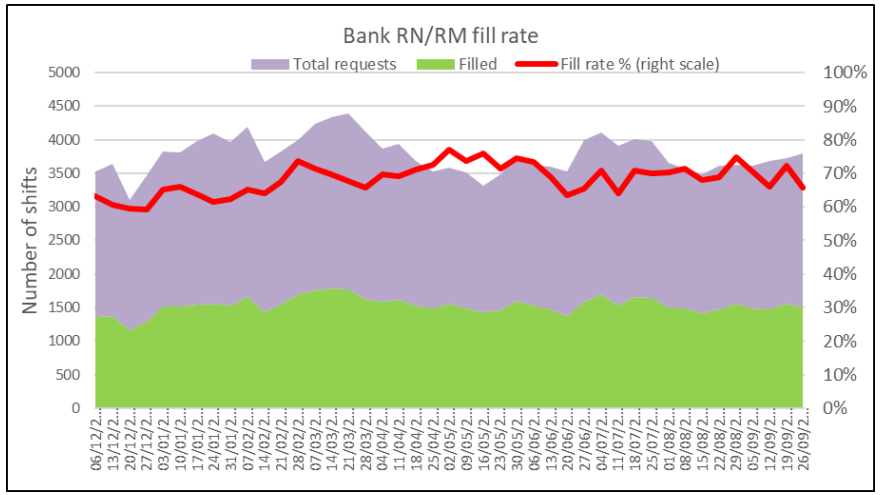
Care hours per patient day (CHPPD) is the total number of hours worked on the roster (clinical staff including AHPs) divided by the bed state captured at 23.59 each day. NHS Improvement began collecting care hours per patient day formally in May 2016 as part of the Carter Programme. All Trusts are required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

CUH CHPPD recorded for September has remained static at 8.1 which is comparable to the national median of 8.3 however is lower than other Shelford hospitals (9.4).

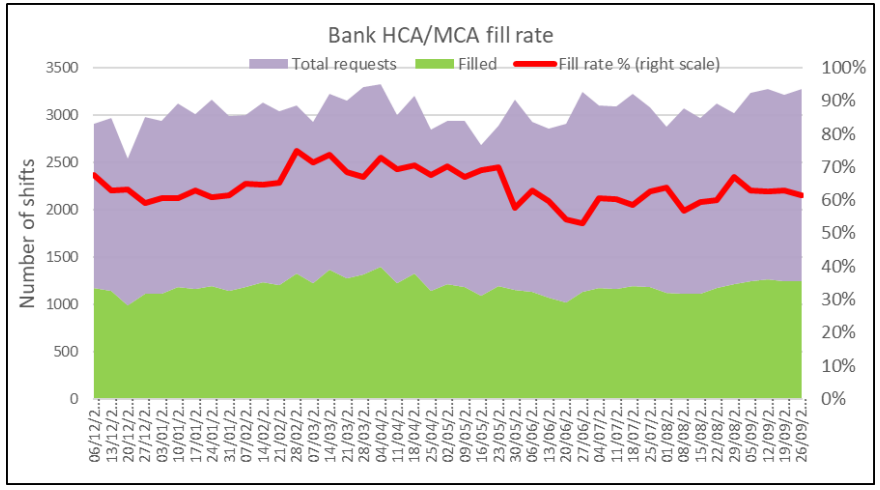
In maternity, from 1 April 2021, the total number of patients now includes babies in addition to transitional care areas and mothers who are registered as a patient. CHPPD for the delivery unit in September was 12.24 which is slightly lower than August (13.33).

Bank Fill Rate and Agency Usage

Graph 14 Registered RN/RM Bank fill rate per week



Graph 15 HCSW/MSW bank fill rate per week



Bank fill rate

The Trust's Staff Bank continues to support the clinical areas with achieving safe staffing levels. Graph 14 and 15 illustrate the trends in bank shift fill rate per week. Overall we have seen an increase in bank shift requests for registered staff over the last 6 months to mitigate those areas who have less than a rota fill of 90%. The number of requests for registered staff is an average of 2198 shifts per week requested and an average bank fill rate of 70%.

The number of requests for Health care support workers and Maternity support workers remains high with an average of 1999 shifts per week requested and an average bank fill rate of 62.5%.

In addition to bank workers we have the equivalent of 38.8 WTE agency workers working across the divisions to support staffing challenges in the short term. This accounts for 11% of the total Nursing filled shifts. Of the total proportion of shifts filled through temporary staffing 5% have been filled via agency workers compared with 95% filled via bank workers.

Short term pay enhancements for bank shifts have been put in place in areas where we are looking to encourage a higher uptake of shifts. These bank enhancements are reviewed regularly (at least on a 6 weekly basis) through the weekly bank enhancement meeting and are for fixed periods of time.

Appendix 1: Exception report by Division – Division A and E

Division A	% fill registered	% fill care staff	Overall filled %	CHPPD	Analysis of gaps	Impact on Quality / outcomes	Actions in place
L4	89%	104%	94%	6.21	High sickness mainly Band 7 (later half of month) and some band sickness. A/L on roster analyser retrospective looks just over threshold but unclear what this was at roster sign off. Band 5 RNs a/w Pin so working as HCAs. Otherwise RN vacancy appears reasonable	Risk of delays to patients care, transfering patients from recovery and poor patient experience. Risk to staff morale and wellbeing.	Review daily at 8:15 and then after site safety at 4:15 with Matron OTD- staff are redepolyed then to balance out numbers Appears max x1 RN down after mitigation on each shift though band 7 available on early shifts. Support from M4 Band 7 and Matron
Division E	% fill	% fill care staff	Overall filled %	**CHPPD**	**Analysis of gaps**	**Impact on Quality / outcomes**	**Actions in place**
C2	88%	95%	89%	10.55	Current shortfall of 15 WTE RN vacancy and 2.84 HCSW, 9 RN awaiting PINor pipeline. 1 WTE pipeline out. This is inclusive of staffing for the 2 extra beds that are not open which equates to 5WTE.	no impact on NQM ,patient experience feedback. Impact on staff wellbeing as reported by senior team. Skill concerns due to chemotherapy competence.	Currently utilising agency nurses with paediatric training. Three times review a day of occupancy and staffing. Support from CPFand PD , CPF supported to be supernumary to support new starters. Rate 3 for all staff. New starters commencing in October and November.
PICU	70%	96%	73%	26.40	Current shortfall of 23.98 WTE RN vacancy and 4.5 HCSW/practioner, 9.5 WTE pipeline in. 1.4 WTE pipeline out.	increased pressure on QIS staff to support junior team. Positive patient experience feedback. Challenges with practice development due to PICU course and sickness.Development days continue. Psychological support for team maintained with plan to increase psychology in PICU.	Three times review a day of occupancy and staffing. Rate 3 for all staff. Support from unit when possible. Plan for support from the ODN to support repatriation
Delivery Unit	87%	73%	83%	12.24	overall vacancy rate 32 wte improving from october to 18.75 wte with new starters. Fill rate decreasing as staff not picking up as much bank. Agency continues in this area, decrease to long line.	Impact to acheieving 1:1 care in labour and supernumary status of the coordinator as a safety metric and CNST standard is put at risk.	Action plan shared at governance around SN status of coordinator. Vacancy factor will improve due to intact of new starters. SN time for the new starters willend middle November when should really see impact on the rostered staffing numbers.
Lady Mary	83%	91%	87%	4.28	sickness absence increasing in this area at 11.7% also affected by vacancy factor	Ability to discharge and complete observations, giving IVI AB on time and other medications is disrupted.	New starter in October will make a difference to roster, in addition to IR being placed in this area
Rosie Birth Centre	70%	89%	74%	10.17	Sickness in this area 85 which has an impact on small team. Template has now increased to 3 midwives per shift. CoC teams are support with a shift however cannot cover all shifts. Also don't roster new starters to this area as small team and not the level of support available.	Have been required to temporerily close the RBC to enable staff to be redeployed to other areas or if not enough staff to safely cover the area.	Looking at possible staff that could be redeployed to this area from other areas as new starters wont be placed on RBC
Sara Ward	85%	85%	85%	4.50	Low sickness in this area but vacancy factor remains. There have been a number of IR that are placed in this area however encountering problems with CTG interpretation which has meant that there has needed to be an increase to SN time	IOL are delayed and this is captured within our red flags. General care can also be delayed due to gaps on roster	There has been an increase to the IOL team to support IOL pathway and prevent delays. New way of introducing IR to the area is planned for november/dec for all IR's

Appendix 2: Adult RN Recruitment pipeline

Adult band 5 RN position based on predictions and established FTE														
Month	UK based exp. applicants	Anglia Ruskin NQ (60% of graduates)	Other NQ	NAP	Return to Practice	Overseas	Total New Starters	Leavers FTE	Promotions and transfer out of scope- retained by the trust	Staff in post FTE	ESR Establishment FTE	Vacancy rate based on established FTE	No. of vacancies based on established FTE	Starter leaver variance
Apr-22	7					25	32	15	14	**1584**	**1768**	**10.41%**	**184.12**	**17**
May-22	8			17		20	45	25	7	**1597**	**1768**	**9.67%**	**171**	**20**
Jun-22	1					23	24	14.4	13	**1594**	**1768**	**9.86%**	**174.4**	**9.6**
Jul-22	6			9		29	44	24	14	**1600**	**1768**	**9.52%**	**168.4**	**20**
Aug-22	5.2		0.45			23	29	22.6	4	**1591**	**1699**	**6.33%**	**107.47**	**6.05**
Sep-22	3	1		0		22	26	18	14	**1585**	**1699**	**6.68%**	**113.47**	**8**
Oct-22	8	9				15	32	22	20	**1575**	**1699**	**7.27%**	**123.47**	**10**
Nov-22	3	8				11	22	18	14	**1565**	**1699**	**7.86%**	**133.47**	**4**
Dec-22	2					15	17	18	15	**1549**	**1699**	**8.80%**	**149.47**	**-1**
Jan-23	8			32		10	50	18	15	**1566**	**1699**	**7.80%**	**132.47**	**32**
Feb-23	6					24	30	18	15	**1563**	**1699**	**7.97%**	**135.47**	**12**
Mar-23	5	5	5			24	39	18	15	**1569**	**1699**	**7.62%**	**129.47**	**21**
TOTAL	62	23	5	58	0	241	390	231	160	**1569**	**1698.95**	**7.62%**	**129.47**	**158.65**

Appendix 3: Paediatric RN and Band 2 HCSW Recruitment pipeline

Paediatric band 5 RN position based on predictions and established FTE													
Month	UK based exp. applicants	Anglia Ruskin NQ	Other NQ	NAP	Overseas	Total New Starters FTE	Leavers FTE (based on leavers in the last 12 months)	Promotions and transfer out of scope- retained by the trust	Staff in post FTE	ESR Establishment FTE	Vacancy rate based on established FTE	No. of vacancies based on established FTE	Starter leaver variance
Apr-22	2					2	1	2	187.42	284.41	34.10%	96.99	1
May-22					5	5	8	1	183.42	284.41	35.51%	100.99	-3
Jun-22	1				0	1		1	183.42	284.41	35.51%	100.99	1
Jul-22	1		1		1	3	2	1	183.42	284.41	35.51%	100.99	1
Aug-22			1		3	4	2	2	170.89	213.73	20.04%	42.84	2.47
Sep-22	1		1		0	2	2	1	170	213.73	20.51%	43.84	0
Oct-22	2	8	11		4	25	5	2	188	213.73	12.09%	25.84	20
Nov-22	1	8	2		1	12	5	3	192	213.73	10.22%	21.84	7
Dec-22	1				1	2	6	1	187	213.73	12.56%	26.84	-4
Jan-23			1		1	2	4	1	184	213.73	13.96%	29.84	-2
Feb-23	2				1	3	2	1	184	213.73	13.96%	29.84	1
Mar-23	2				1	3	3	1	183	213.73	14.43%	30.84	0
TOTAL	**13**	**16**	**17**	**0**	**18**	**64**	**39.53**	**17**	**182.89**	**213.73**	**14.43%**	**30.84**	**24.47**

Band 2 HCSW position based on predictions and established FTE								
Month	UK based applicants	Apprenticeship (direct entry)	Total New Starters FTE	Leavers FTE	Staff in post FTE	ESR Establishment FTE	Vacancy rate based on established FTE	No. of vacancies based on established FTE
Apr-22	15		15	16	812	947	14.3%	135
May-22	17		17	21	808	970	16.7%	162
Jun-22	27.8		27.8	13	823	970	15.2%	148
Jul-22	21		21	16	828	970	14.7%	143
Aug-22	18	8	26	2	745	855	12.9%	110
Sep-22	17	4	21	11	755	855	11.7%	100
Oct-22	28	37.5	65.5	20	800	855	6.4%	55
Nov-22	28		28	20	808	855	5.5%	47
Dec-22	25		25	15	818	855	4.3%	37
Jan-23	25		25	20	823	855	3.7%	32
Feb-23	25		25	15	833	855	2.5%	22
Mar-23	25	40	65	15	883	855	-3.3%	-28
TOTAL	**271.8**	**89.5**	**361.3**	**184**	**883**	**855**	**-3.3%**	**-28**

Board of Directors

Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 9 November 2022

Agenda item	10
Title	Biannual nursing and midwifery establishment update
Sponsoring executive director	Lorraine Szeremeta, Chief Nurse
Author(s)	Amanda Small, Deputy Chief Nurse Meg Wilkinson, Director of Midwifery
Purpose	To provide an overview of nurse and midwifery staffing capacity and compliance with the National Institute for Clinical Excellence (NICE) safe staffing, National Quality Board (NQB) standards and Clinical Negligence Scheme for Trusts (CNST) standards.
Previously considered by	Management Executive, 3 November 2022

Executive summary

This report provides an overview of registered nurse and midwifery staffing capacity and provides assurance of compliance with the National Institute for Clinical Excellence (NICE) safe staffing, National Quality Board (NQB) standards and Clinical Negligence Scheme for Trusts (CNST) standards. It is a requirement that every board of directors receives an annual establishment report with a further review on a biannual basis (National Quality Board, 2016).

This paper meets the requirements of the biannual update, providing an overview of safe staffing in relation to the approved budgeted establishment and cumulative oversight of care hours per patient day (CHPPD) over the past six months.

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 safe staffing.
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 high vacancy rates for Registered Nurses (RNs), Registered Midwives (RMs) and Health Care Support Workers (HCSWs) remain despite a strong recruitment pipeline.
- An additional 48 WTE RNs and 37 WTE HCSWs are required above the budgeted establishment to safely staff the identified contingency areas.
- Redeployment of both RNs and HCSWs will continue to be necessary over the winter period in response to increased demand on services.
- CUH Care Hours Per Patient Day (CHPPD) is aligned to the national median; however, when comparing to Shelford peers, the CUH CHPPD is below the Shelford median of between 9.2–10 CHPPD (CUH 8.1-8.4).
- There has been an increase in unavailability with sickness absence increasing from 6.8% to 9% and annual leave increasing from 13.5% to 17.5%. There is a focused project led by the lead for safer staffing to understand the drivers for unavailability and develop associated actions to decrease unavailability.
- A review of the neonatal staffing requirements has been undertaken in line with the British Association of Perinatal Medicine (BAPM) standards.
- In line with guidance, a Birthrate Plus® review has been undertaken in maternity, with recommendations made regarding future establishments.
- The action plan to achieve 100% compliance with 1-1 care in labour and supernumerary status of the labour ward co-ordinator.

Cambridge University Hospitals NHS Foundation Trust

9 November 2022

Board of Directors
Biannual nursing and midwifery establishment update
Lorraine Szeremeta, Chief Nurse
Amanda Small, Deputy Chief Nurse
Meg Wilkinson Director of Midwifery

1. Purpose

1.1 The purpose of this paper is to provide the Board of Directors with an overview of registered nurse and midwifery staffing capacity and compliance with the National Institute for Clinical Excellence (NICE) safe staffing, National Quality Board (NQB) standards and Clinical Negligence Scheme for Trusts (CNST) standards. It is a requirement that every board of directors 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 outlined 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 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. 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. The establishment review process was undertaken at the end of the last financial year and the board approved the recommended establishments in July 2022.

1.4 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. The most recent Birthrate Plus® review was undertaken at CUH from January to March 2022.

1.5 This report provides an overview of safe staffing in relation to the approved budgeted establishment and cumulative oversight of care hours per patient day (CHPPD) over the past six months. It also provides a comparison to peer organisations for the same time period.

2. National 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/Improvement (NHSEI), 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
    - nurse return to practice

2) International recruitment.

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

2.3 According to figures released by NHS England in October 2022, there are currently more than 46,828 nursing, midwifery, and health visiting vacancies in the NHS in England alone. Whilst nursing vacancies are still high within the NHS, there are 9,100 more nurses compared to last year and over 29,000 more nurses working in the NHS now compared to September 2019.

2.4 The increase in nurses in employment has been due in part to the large number of international nurses that have been deployed. It is also anticipated that the increase in students that have enrolled on pre-registration Nursing and Midwifery programmes since the pandemic will impact positively on the ability to reach the 50,000 target with applications having increased by more than a quarter, from 40,770 to 52,150 since 2019.

2.5 Whilst there is relative certainty about the numbers of people who are commencing pre-registration courses or travelling to the UK to work, 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.

2.6 The Chief Nursing officer and National Director for People wrote to all NHS organisations in July outlining NHS England'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.

2.7 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.

2) Implement the National Preceptorship Framework. CUH are awaiting publication of this framework and will review and update 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. The guidance on implementation of legacy mentors was due to be published in September 2022 but has been delayed.

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.

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.

2.8 All of the above actions will be incorporated into the CUH retention strategy.

2.9 NHSEI have supported organisations with funding to support overseas nurses in practice. CUH have supported the arrival of 151 international nurses since April 2022.

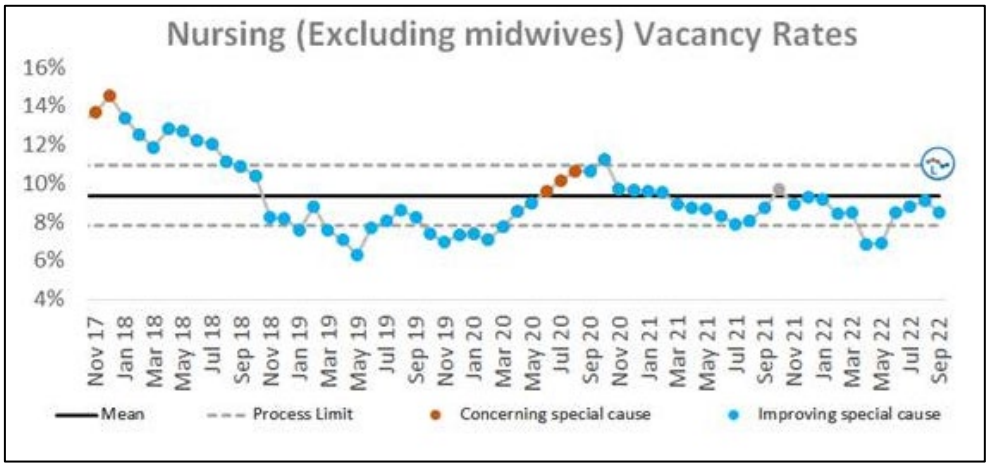
2.10 In response to the national shortage of registered Nurses (RNs), CUH continues to have success in recruiting to its Nursing Apprenticeship programme with 277 apprentices on the programme currently. The Trust is also supporting 23 apprentice Nursing Associates.

3. Nurse staffing

Nursing vacancy position

3.1 The last six months has remained challenging for the nursing workforce with high vacancy rates despite a strong recruitment pipeline. Figure 1 shows the CUH trend in nursing vacancy rates over the past four years. The RN vacancy rate over the past six months has been relatively static, ranging from 6.9% to 9.1%. The sharp increase demonstrated in July 2022 is attributed to the electronic staff record (ESR) and financial ledger being updated with the approved investment following the establishment review.

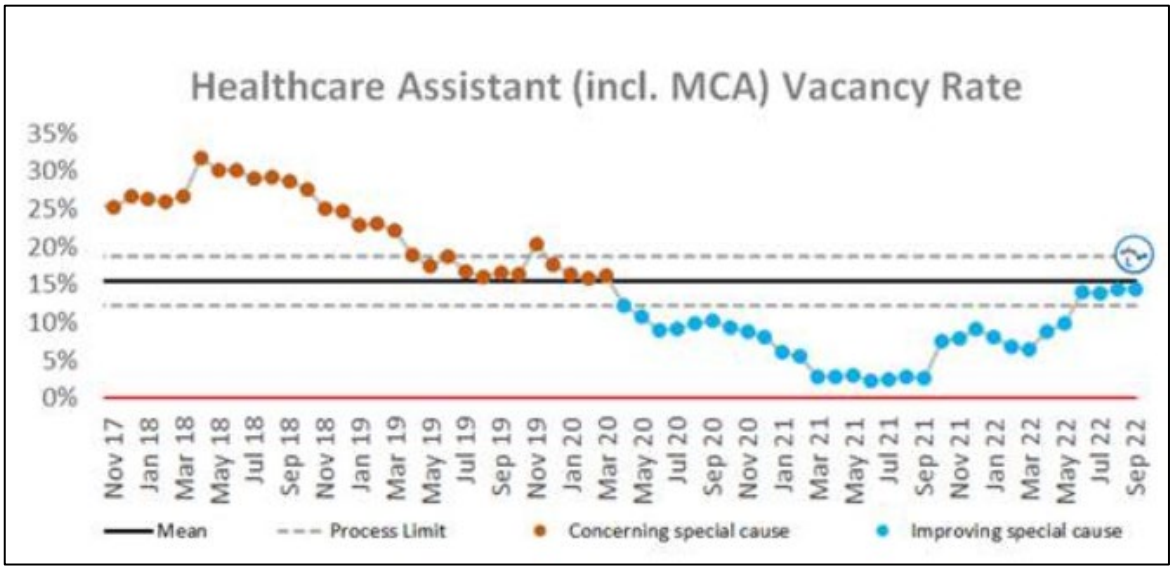
Figure 1. Registered Nurse vacancy rates



3.2 The vacancy rate for registered sick children nurses has been an increasing trend over the last six months with a vacancy rate of 17.4% in April 2022 compared to a vacancy position of 22.8% in September 2022.

3.3 The East of England had set a target for a Healthcare Support Worker (HCSW) vacancy rate of 0% by March 2022. Unfortunately, this was not achieved within the region. CUH has experienced an increasing trend in the HCSW vacancy rate over the last six months with a vacancy rate of 8.8% at the beginning of the financial year (April 2022) compared to a vacancy rate of 14.1% in September 2022. 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 19.1%. Figure 2 illustrates the trend in vacancy rate for HCSWs over the past four years.

Figure 2. Health care support worker vacancy rates



3.4 It should be noted that the vacancy position reported is based upon the approved budgeted establishment for the clinical areas. 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.

3.5 When all contingency areas are open, an additional 48 WTE RNs and 37 WTE HCSWs are required above the budgeted establishment to safely staff these areas. As these contingency areas do not have an established team, it has been necessary to redeploy staff from other areas and utilise temporary staff to ensure safe staffing levels.

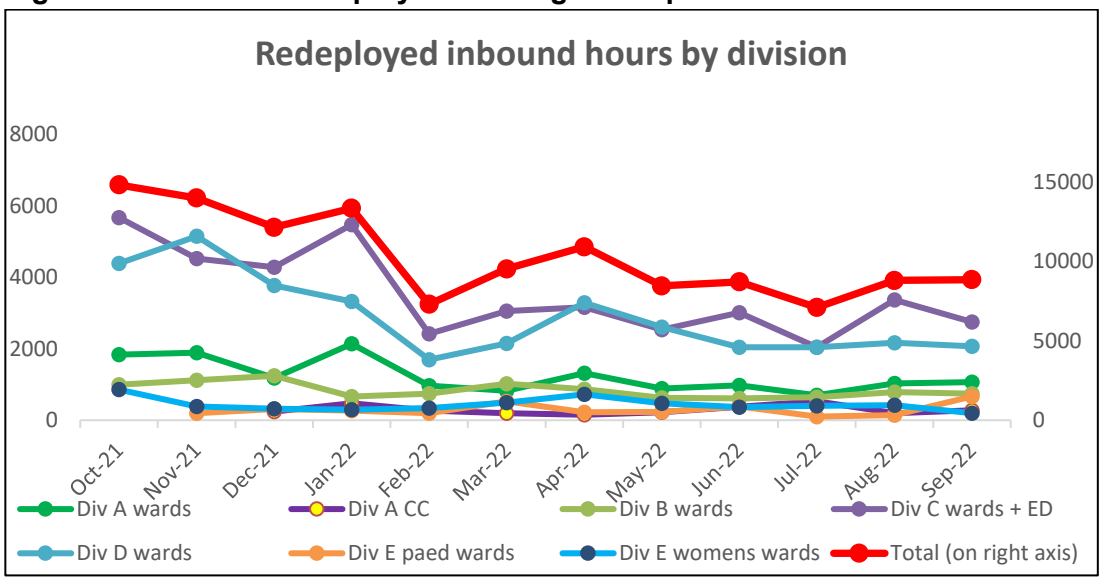
4. Redeployment of staff to maintain safe staffing levels

4.1 In order to support safe nurse staffing 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. 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. 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.

4.2 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 where the areas who require staffing support are identified, this includes, where appropriate into maternity services.

4.3 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 as demonstrated, the number of redeployed hours has reduced over the last 12 months.

Figure 3. Number of redeployed working hours per month



4.4 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 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.

4.5 It is expected that staff movement and deployment will continue to be necessary over the winter period as we respond to the increased demand on services and are required to staff additional capacity. However, every effort is being made to minimise staff movements where possible.

5. Care Hours per Patient Day (CHPPD)

5.1 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.

5.2 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 8 – 8.3 CHPPD. However when comparing to our peer organisations (Shelford), the CUH CHPPD is below the Shelford median of between 9.2 – 10 CHPPD (CUH 8.1-8.4).

5.3 The lead for safer staffing is working with colleagues across comparable organisations to benchmark data and understand the reasons for the differences in this CHPPD. Any findings will be presented in the annual staffing establishment review.

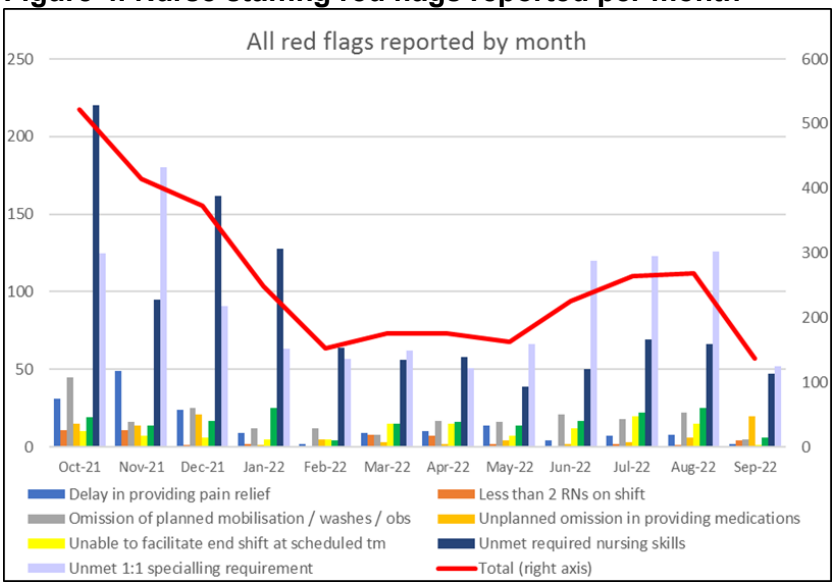
6. Nursing red flags

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

6.2 Staffing red flags are reported monthly to the board of directors through the safe staffing paper. There had been a decreasing trend in the nursing red flags reported in the last financial year however as illustrated in figure 4 below, over the summer period, the number of nursing red flags increased from 162 reported in May 2022 to 269 reported in August 2022. This can be triangulated to an increase in unavailability of staff in the same time period with sickness absence increasing from 6.8% to 9% and annual leave increasing from 13.5% to 17.5%. The lead for safer staffing and E rostering lead have been working on a project with NHSIE to understand the drivers for this increased unavailability and are working with the senior nursing team to put actions in place to address this where we are able to.

6.3 The most frequently raised red flag is in relation to an unmet 1:1 specialling requirement. A trust wide improvement project focusing on specialling had been in place before the pandemic however was paused during this time frame. This is now being reconvened to review specialling across the organisation.

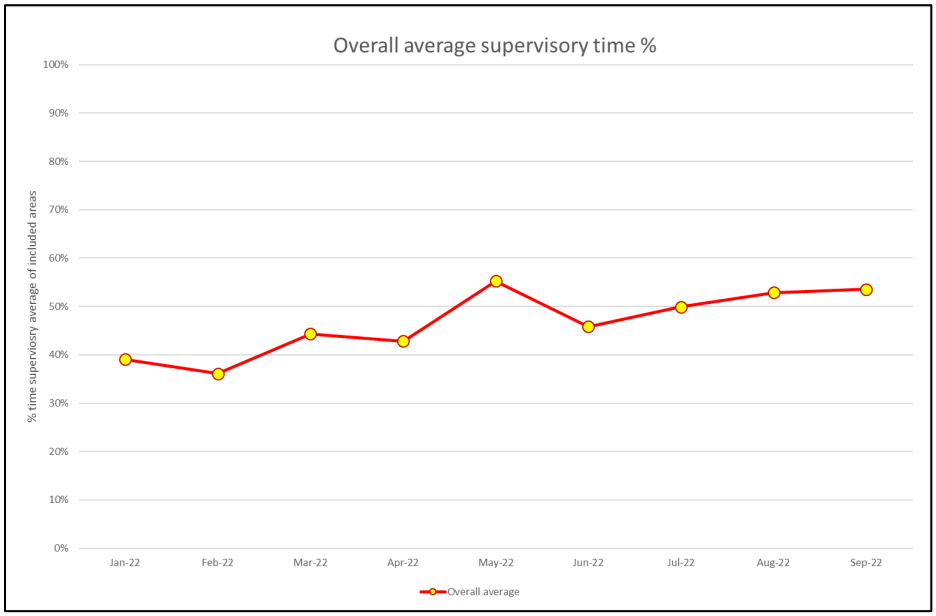
Figure 4. Nurse staffing red flags reported per month



7. Supervisory sister/charge nurse time

7.1 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 5 below shows that the supervisory time has been affected by the staffing challenges over the last 6 months however there has been a gradual increase in the overall percentage of supervisory time. It is anticipated that Senior Sister/Charge Nurse supervisory time will improve in line with a decrease in vacancy rates and unavailability.

Figure 5. Percentage of senior sister/ charge nurse supervisory time



8. Critical care units

8.1 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 17% (September 2022).

8.2 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.

8.3 The 7 beds remain closed at this point however 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.

9. Emergency Department

9.1 Nationally, new standards were identified for Type 1 Emergency Departments (ED) related to staffing, of which shortfalls were identified for the nurse staffing models in the CUH ED. As part of the annual establishment review, a 17.7 WTE increase of the RN establishment was approved resulting in a total RN establishment of 147 WTE.

9.2 Although the ED has a strong recruitment pipeline with 47.22 WTE RNs offered positions and awaiting to commence employment, the current staff in post position illustrates a vacancy rate of 34%. Due to this vacancy and an increased unavailability of staff, it has been necessary to utilise temporary staff (bank and agency) to support safe staffing levels. On a daily basis, it has also been necessary to redeploy staff from the operational pool and from across the trust to ED to mitigate the risks associated with the gaps in staffing.

9.3 It should be noted that previously, there has been no evidence-based tool available to support staffing decisions within the ED however in September 2021, the Shelford group launched the ED SNCT. The tool is similar to the SNCT utilised within inpatient wards in as much as it considers the acuity and dependency of patients whilst also taking into consideration annual attendance activity. Data is collected utilising the ED SNCT tool twice per year however three sets of data are required to ensure a trend in data can be identified to be considered for staffing establishment reviews. Therefore, CUH will have SNCT data available to inform ED staffing establishments from next financial year.

10. Neonatal staffing

10.1 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.

10.2 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 are calculated on the following:

- ITU 6.75 WTE per cot, as CUH have 12 ITU cots this is a staffing requirement of 81.0 WTE

- HDU 3.8 WTE per cot, as CUH have 16 HDU cots this is a staffing requirement of 60.8 WTE

- SCBU 2.44 WTE per cot, as CUH have 12 SCBU cots this is a staffing requirement of 29.28 WTE

Based on these calculations, the NICU 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.

10.3 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 150.95 WTE.

10.4 The required establishment for 90% occupancy is 157.5 WTE. For 90% activity, the target QIS will be 99.05 WTE RN. Based on the 2022 establishment and BAPM workforce calculator the current shortfall to achieve compliance on a BAPM occupancy of 90% is 10.62 WTE RN. A recruitment and retention plan is in place to address this shortfall 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.

11. Maternity staffing

11.1 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).

11.2 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.

11.3 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.

11.4 CUH last undertook a birth rate plus review in 2019 and this was repeated January to March 2022. The final report was published in August 2022. The detailed report can be found at Appendix 1.

11.5 The review recommends an increase on current funded establishment of 10.06 WTE midwives. Areas requiring the largest uplift are in triage/clinic 23 and the post-natal ward.

11.6 In line with midwifery staffing recommendations from the Ockenden report the trust board is required to provide evidence of funded establishment being compliant with the outcomes of BirthRate plus.

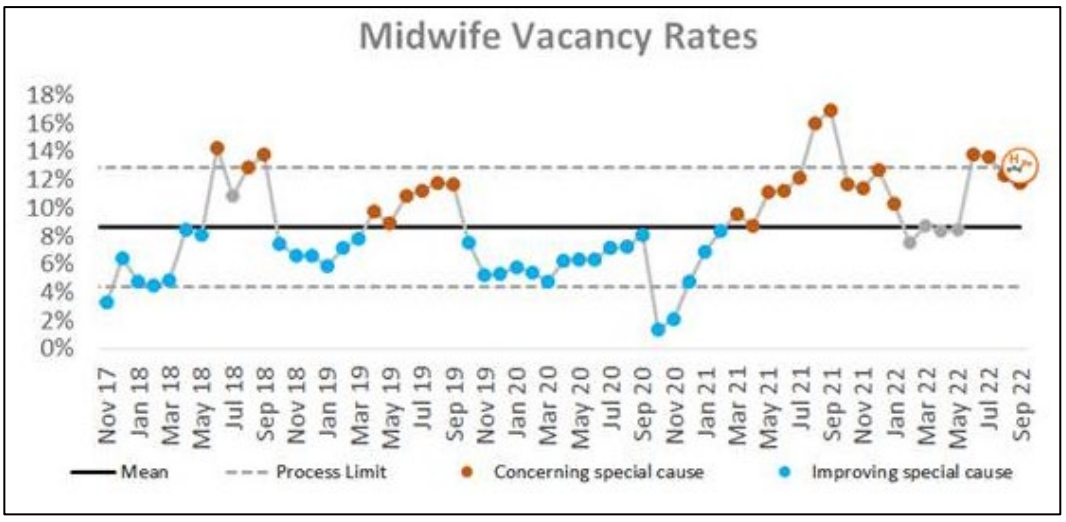
11.7 The recommendation from the divisional triumvirate and finance lead is that due to the current level of midwifery vacancy that the funded establishment in year remains unchanged but that the proposal to meet the Birthrate plus recommended establishment is included in the budget setting for 2023/4. A business case will be submitted for approval within Division before being presented to Investment committee.

11.8 In order to maintain safety in the areas identified as requiring the highest level of increase, a review of rotas and staff allocation is being undertaken alongside recommendations from a workforce deep dive conducted by the regional team, which explores alternative staffing models. This will be overseen by the Director of Midwifery.

12. Maternity vacancy position

12.1 The last six months has remained challenging for the maternity workforce with high vacancy rates coupled with a high turnover of staff (14.6%). Figure 6 below illustrates the trend in midwifery vacancy rates over the past four years. The Registered Midwife (RM) vacancy rate for the last six months has ranged from 8.5% to 14.7%. The increase in vacancy rates demonstrated in figure 6 below from July onwards is attributed to the work that had been undertaken to align the workforce Electronic Staff Record (ESR) and financial ledger to reflect the additional approved investment in the maternity workforce.

Figure 6. Registered Midwife vacancy rate



12.2 A cohort of newly qualified midwives (23 WTE) commenced in post in October 2022. It is anticipated that a reduction in the midwifery vacancy rate to approximately 10% will be achieved with these new starters. Additional work is ongoing with local institutes of higher education to secure two student cohorts per year to ensure even spread within pipeline plans for new starters.

13. Midwifery red flag

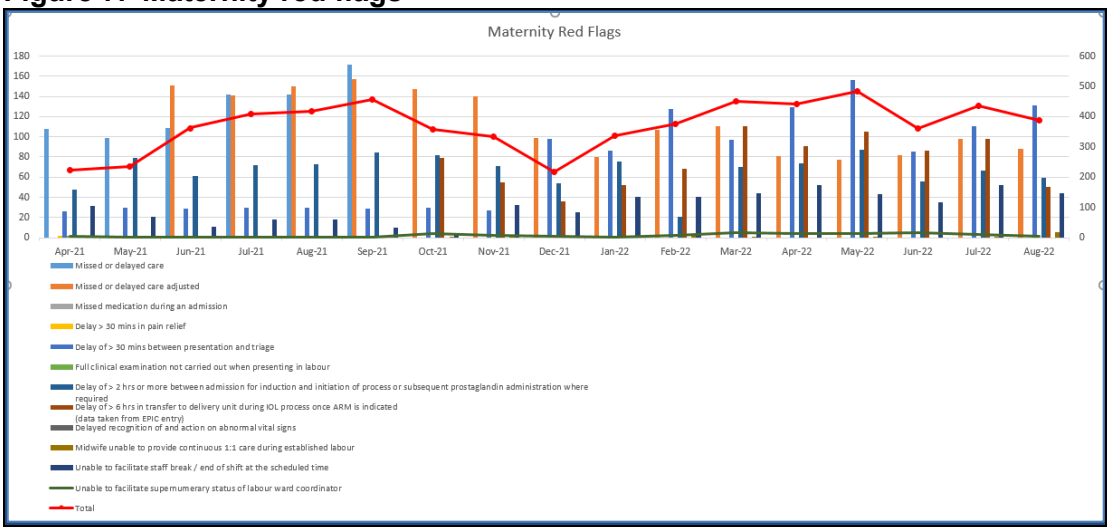
13.1 The BirthRate Plus® acuity app is a ward acuity tool used to proactively assess the clinical needs of the women on the ward and match them against the staff available. Data is

captured six times a day within the intrapartum areas and four times on ward based areas as a minimum. Management actions may include internal redeployment to support workload and escalation to the manager of the day for senior support.

13.2 A red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwifery bleep holder should be notified and are responsible for determining whether midwifery staffing is the cause, and the required action that is needed. Any unresolved flags should be escalated and management/mitigation put in place to ensure patient safety.

13.3 Figure 7 demonstrates the trend data for red flag reporting at the Rosie. The most frequently reported maternity red flags were a delay of >30 mins between presentation and triage and a delay of >6hrs in transfer to the delivery unit during the induction of labour process. This is reflective of the high levels of activity and difficulty in maintaining flow within maternity services. Staffing red flags are reported monthly to the board of directors through the safe staffing paper.

Figure 7. Maternity red flags



13.4 Based on the trend data above the service anticipate a fall in the number of unresolved red flags by December 2022 due to the reduction in vacancy rate following the large in-take of band 5 Midwives in October. To note, these Midwives will require a year long preceptorship programme.

14. Planned verses actual maternity staffing levels

14.1 Figure 8 demonstrates the planned verses actual maternity staffing levels for the last 6 months (fill rates). The fill rates are reported monthly to the Board of Directors in the safe staffing paper and the Head of midwifery provides an exception report when fill rates are less than 90% in any area.

Figure 8. Planned verses actual maternity staffing levels

Month	Planned staffing	Actual staffing
April 2022	100%	78.75%
May 2022	100%	85%
June 2022	100%	79.25%
July 2022	100%	78%
August 2022	100%	83%
September 2022	100%	85%

15. Midwife to Birth Ratio

15.1 The national average of midwife to birth ratio is 1:25 (dependent on unit acuity). The Rosie Hospital maternity services are currently at a funded establishment to support 1:24. The average midwife to birth ratio in the Rosie has been 1:27.8 over the last 6 months due to the current vacancy and number of births as illustrated in figure 9.

Figure 9. Maternity dashboard highlighting funded verses actual midwife to birth ratio

Sources / References	KPI	Goal	Target	Measure	Data Source	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Birth Rate Plus	Midwife/birth ratio (actual)**	1:24	1.28	Total permanent and bank clinical midwife WTE*/Births (rolling 12 month average)	Finance	1:27:5	1:26:1	1:26	1:27:3	1:27.5	1:27	1:26.2	1:27.2	1:25.4	1:27.2	1:28.2	1:28.2
Birth Rate Plus	Midwife/birth ratio (funded)**	1.24.1	N/A	Total clinical midwife funded WTE*/Births (rolling 12 month average)	Finance	1:23:3	1:23:4	1:23:7	1:23:6	1:23:8	1:24	1:23.4	1:23.4	1:23.4	1:23.3	1:23.3	1:23.3

16. Supernumerary Status of the Delivery Unit Co-ordinator

16.1 CUH use the Birthrate Plus® acuity tool to monitor and report compliance with 1:1 care in labour and supernumerary status of the labour ward co-ordinator.

16.2 The delivery unit co-ordinator should remain, at all times supernumerary, with no caseload of their own, to provide the helicopter view of the unit. As a low risk area the birth centre is not required to have a supernumerary coordinator but does have a designated midwife in charge who is responsible for oversight of the ward.

16.3 Figure 10 highlights the output from the Birthrate Plus® acuity tool in the two intrapartum areas (Delivery unit and Rosie Birth Centre). The confidence factors related to the flags for the supernumerary status of the delivery unit co-ordinator and

the percentage of time of 1-1 care in labour is maintained relates to the number of times the tool is used. To be 100% compliant the tool is required to be used as a minimum six times in 24 hours. A confidence factor range of 80%-100% is needed to ensure reliable data capture and reporting. Figure 10 below demonstrates the range of confidence factor at CUH of between 67% - 82%. This shows that further embedding of this process is required.

Figure 10. Compliance with 1-1 care in labour and supernumerary status of the delivery unit co-ordinator.

Month	Intrapartum area	Confidence factor	Percentage of time supernumerary status of labour ward coordinator maintained	Percentage of time 1:1 care in labour maintained	Mitigation
January 2022	Delivery Unit	73.12%	96%	99.78%	Redeployment of staff, management team working clinically consideration to divert. On call Midwifery Manager on-call for escalation and senior support out of hours.
February 2022	Delivery Unit	69.05%	73%	98.83%	As above
March 2022	Delivery Unit	66%	64%	98.65%	As above
April 2022	Delivery Unit	71.11%	72%	100%	
May 2022	Delivery unit	67.2%	67%	98.69%	
June 2022	Delivery Unit	82.78%	41%	100%	Initiation of action for SN status of the LW co-ordinator
July 2022	Delivery Unit	70.43%	63%	100%	
August 2022	Delivery unit	72.04%	70%	99.56%	Consideration of suspension of non-essential services such as birth Afterthoughts service.

16.4 From January to August 2022 compliance with 1:1 care in labour was reported between 98 and 100% compliance through the tool. Mitigation when 1:1 care cannot be achieved is though the escalation to divert policy and internal redeployment of staff to ensure areas and staffing levels are safe utilising the role of the operational bleep holder and Manager of the day where required.

16.5 June 2022 showed the poorest reported compliance with supernumerary status of the coordinator. In accordance with CNST guidance an action plan has been devised to address the issues which are largely based around our vacancy factor and sickness absence.

16.6 NHS resolution published revised technical guidance relating to the CNST safety action 5 on 11th October with a redefined definition of supernumerary status of the labour ward co-ordinator. Further clarification on the evidential requirements is awaited. The action plan in appendix 2 details progress against these recommendations and actions to consistently achieve supernumerary status of the delivery co-ordinator and provision of 1-1 care in labour.

17. Recommendations

17.1 The Board of Directors is asked to note:

- That high vacancy rates for Registered Nurses (RNs), Registered Midwives (RMs) and Health Care Support Workers (HCSWs) remain despite a strong recruitment pipeline.
- An additional 48 WTE RNs and 37 WTE HCSWs are required above the budgeted establishment to safely staff the identified contingency areas.
- Redeployment of both RNs and HCSWs will continue to be necessary over the winter period in response to increased demand on services.
- CUH Care Hours Per Patient Day (CHPPD) is aligned to the national median; however, when comparing to Shelford peers, the CUH CHPPD is below the Shelford median of between 9.2–10 CHPPD (CUH 8.1-8.4).
- There has been an increase in unavailability with sickness absence increasing from 6.8% to 9% and annual leave increasing from 13.5% to 17.5%. There is a focused project led by the lead for safer staffing to understand the drivers for unavailability and develop associated actions to decrease unavailability.
- A review of the neonatal staffing requirements has been undertaken in line with the British Association of Perinatal Medicine (BAPM) standards.
- In line with guidance, a Birthrate Plus® review has been undertaken in maternity, with recommendations made regarding future establishments.
- The action plan to achieve 100% compliance with 1-1 care in labour and supernumerary status of the labour ward co-ordinator.

Appendix 1

ROSIE HOSPITAL CAMBRIDGE

UNIVERSITY HOSPITALS

NHS FOUNDATION TRUST

MIDWIFERY WORKFORCE REPORT

AUGUST 2022

birthrateplus® | Safe Staffing for Maternity Services

Contents

Birthrate Plus ®: THE SYSTEM

Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published.

It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

The RCM strongly recommends using Birthrate Plus® (BR+) to undertake a systematic assessment of workforce requirements, since BR+ is the only recognised national tool for calculating midwifery staffing levels. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour (as per recommendation 1.1.3).

Birthrate Plus® has been used in maternity units ranging from stand-alone community/midwife units through to regional referral centres, and from units that undertake 10 births p.a. through to those that have more than 8000 births. In addition, it caters for the various models of providing care, such as traditional, community-based teams and continuity caseload teams. It is responsive to local factors such as demographics of the population; socio-economic needs; rurality issues; complexity of associated neo-natal services, etc. The methodology remains responsive to changes in government policies on maternity services and clinical practices. Birthrate Plus® is the most widely used system for classifying women and babies according to their needs and using clinical outcome data to calculate the numbers of midwives required to provide intrapartum and postpartum care.

An individual service will produce a casemix based on clinical indicators of the wellbeing of the mother and infant throughout labour and delivery. Each of the indicators has a weighted score designed to reflect the different processes of labour and delivery and the degree to deviations from obstetric normality. Five different categories are created - the lower the score the more normal are the processes of labour and delivery.

Other categories classify women admitted to the delivery suite for other reasons than for labour and delivery.

Together with the casemix, the number of midwife hours per patient/client category based upon the well-established standard of one midwife to one woman throughout labour, plus extra midwife time needed for complicated Categories III, IV & V, calculates the clinical staffing for the annual number of women delivered.

Included in the workforce assessment is the staffing required for antenatal inpatient and outpatient services, ante and postnatal care of women and babies in community birthing in either the local hospital or neighbouring ones.

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the midwifery management and specialist roles required to manage maternity services. Adjustment of clinical staffing between midwives and competent & qualified support staff is included.

The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of the local % for annual, sick & study leave allowance and for travel in community**.**

Factors affecting Maternity Services for inclusion within the Birthrate Plus® Study

The Governance agenda, which includes evidence-based guidelines, on-going monitoring, audit of clinical practices and clinical training programmes, will have an impact upon the required midwifery input; plus, other key health policies. Birthrate Plus® allows for inclusion of the requisite resources to undertake such activities.

Increasingly, with having alongside midwife units where women remain for a short postnatal stay before being transferred home, the maternity wards provide care to postnatal women and/or babies who are more complex cases. Transitional care is often given on the ward rather than in neonatal units, safeguarding needs require significant input which put higher demand on the workload.

Shorter postnatal stays before transfer home requires sufficient midwifery input to ensure that the mothers are prepared for coping at home. It is well known that if adequate skilled resources are provided during this postnatal period, then such problems as postnatal depression or inability to breast-feed can be reduced or avoided.

Community based care is expanding with the emphasis being placed on ‘normal/low risk/need care being provided in community by midwives and midwifery support roles. Women and babies are often being seen more in a clinic environment with less contacts at home. However, reduced antenatal admissions and shorter postnatal stays result in an increase in community care. Midwives undertake the Newborn and Physical Examination (NIPE) instead of paediatricians, either in hospital or at home.

Cross border activity can have an impact on community resources in two ways. Some women may receive antenatal and/or postnatal care from community staff in the local area but give birth in another Trust. This activity counts as extra to the workload as not in the birth numbers. They have been termed as "imported" cross border cases. Equally, there ae women who birth in a particular hospital but from out of area so are ‘exported’ to their local community service. Adjustments are made to midwifery establishments to accommodate the community flows. Should more local women choose to birth at the local hospital in the future adjustments will need to be made to workforce to provide the ante natal and intrapartum care.

The NICE guideline on Antenatal Care recommends that all women be ‘booked’ by 10 weeks’ gestation, consequently more women are meeting their midwife earlier than previously happened. This early visit requires midwifery assessment/advice, but the pregnancy may end as a fetal loss, so the total number of postnatal women is less than antenatal.

Discussion of Data

1. Rosie Hospital is part of Cambridge University Hospitals NHS Foundation Trust and provides maternity services at Rosie Hospital and the local community.

2. Allowances of 22% uplift for annual, sick and study leave, and 15% community travel are included in the staffing figures.

3. Annual Activity is based on 2021/22 and total births of 5571 allocated as below.

Delivery Unit Births	4653
Rosie Birth Centre	818
Home Births	100
Total Births	**5571**

Annual Activity Table 1

4. The Birthrate Plus® staffing is based on the activity and methodology rather than on where women may be seen and/or which midwives provide the care.

5. The 2018 casemix was reassessed using the Maternity Dashboard and a sample of births in 2021 which shows in an increase in the acuity of mothers and babies

2021/22	Cat I	Cat II	Cat III	Cat IV	Cat V
% D/S Casemix	0.4	4.8	17.4	36.8	40.6
	22.6%			77.4%	
2018 DS Casemix	*31.2%*			*68.8%*	
% Generic Casemix *(DU & RBC births)*	4.0	12.5	14.2	32.8	36.5
	30.7%			69.3%	
2018 Generic Casemix	*44.6%*			*55.4%*	

Casemix Table 2

6. The generic casemix indicates that 69.3% of women are in the 2 higher categories IV and V and in 2018 was 55.4% - an increase of 13.9% and mainly in category V. Whilst most maternity units are showing an increase in the acuity, the average for England is 60% based on 70 maternity units with the range is from 51% to 79%. The casemix is unique to each service as reflects the clinical and social needs of women, local demographics, clinical decision making and adherence to national guidelines. Appendix 1 provides a description of the 5 categories.

7. There will be a correlation between the casemix, and maternity stats recorded on the dashboard especially in relation to Induction rates, delivery method, post-delivery problems, obstetric and medical conditions.

8. Table 3 shows the additional intrapartum activity in the delivery suite

	Annual Total
Antenatal cases	730
P/N readmissions	130
Non-viable pregnancies	26
Escorted transfers	112

Additional Intrapartum Activity Table 3

9. Table 4 shows Rosie Birth Centre activity

	Annual Total
Births	818
Transfers to Delivery Unit	654
Triage cases	320
PN women from DU	457

Birth Centre activity Table 4

10. As with all maternity units, there are women who commence their intrapartum episode in the Birth Centre but require transfer to delivery unit for clinical reasons (n=654).

11. An average of 30 women transfer to the postnatal ward for maternal or baby clinical reasons. This commonly occurs in all birth centres although sometimes, it's due to lack of capacity for women to remain in the birth centre until ready for discharge home.

12. Rosie Birth centre see 320 women per annum with labour queries who may not deliver on this occasion and be discharged home.

13. An estimate of 457 women are transferred from DU to RBC rather than go to Lady Mary Ward.

14. Table 5 shows the annual core activity on Sarah Ward and Lady Mary Ward.

	Annual Total
Antenatal admissions	890
Inductions of Labour	2312
Postnatal women	4196
P/N readmissions	64
Extra care babies	515
NIPE, BCGs and Tongue Ties	

Maternity Wards activity Table 5

15. Inductions of labour are based on the annual number of doses (2312) administered, so will be less women. The staffing is allocated to the clinical area where the induction commences.

16. Often the antenatal activity taking place in hospital is reflective of the higher % in Categories IV & V, as women with medical/obstetric problems, low birth weight &/or preterm infants require more frequent hospital based care. The annual activity indicates 890 admission episodes to the ward excluding inductions and elective sections.

17. The ‘extra care babies’ of 515 are those that have a postnatal stay longer than 72hrs. The increase in babies that require frequent monitoring is covered in the casemix as more hours are allocated to women in the higher categories IV and V.

18. Staffing is included for babies to have their NIPE carried out by a midwife. NIPE for home births is routinely included.

19. The staffing for Clinic 23 (Maternity Assessment Unit) and Clinic 22 as the day unit are combined and provides a 24 service for the triage activity.

20. Outpatient Clinic services are based on services and on session times and numbers of staff required to cover these, rather than on a dependency classification and average hours. Professional judgement from the senior midwives is a valid method to apply when assessing the length of clinic sessions and numbers of staff required. The configuration of outpatients’ clinics is unique to each maternity service.

21. Table 6 provides a summary of the community population receiving maternity care from Rosie Hospital Cambridge.

	Annual Total
Home Births	100
Community Exports (Out of Area cases who birth In Rosie)	2093
Community A/N &/or P/N Imports	49
Community Cases (AN &/or PN care – hospital births)	3427
Attrition Cases *(pregnancy loss or move out of area)*	1073

Community Activity Table 6

22. The community annual total includes 49 women who birth in neighbouring units and receive ante and or postnatal care, from (community imports).

23. There are 2093 women who birth in Rosie and receive their community care from their home Trust (community exports). There has always been significantly more export activity than import due to having specialist services.

24. Additional staffing for significant safeguarding cases is included in the community staffing.

25. The Birthrate Plus staffing is based on the activity and methodology rather than on where women may be seen and/or which midwives provide the care.

26. At the request of the senior management team using professional judgement, core staffing has been included for the Ante Natal Ward and Birth Centre to maintain required numbers per shift due to the clinical pressures of these areas.

27. The total clinical wte will contain the contribution from Band 3 and 4 Midwifery Support Staff in hospital and community postnatal services.

28. Most maternity units work with a minimum of 90/10% skill mix split of the clinical total wte, although this is a local decision by the Senior Midwifery Team.

Breakdown of Birthrate Plus Staffing based on 22% Uplift

Delivery Unit • Births • Non-birthing activity	70.13wte RMs
Rosie Birth Centre • Births • Transfers to DS • Triage Cases • Postnatal Women from DU • VBAC Clinics	18.50wte RMs
Sarah Ward • Antenatal Admissions • Ward Attenders • Inductions	20.30wte RMs
Lady Mary Ward • Postnatal women • Postnatal Re-admissions • NIPEs • BCGs • Extra Care Babies	48.42wte RMs & MSWs
Outpatients Services • Obstetric Clinics • Fetal Medicine • Pregnancy Diabetes Service	14.72wte RMs
Clinics 22 and 23	18.69wte RMs
Community Services: • Home Births • Community Cases • Community Bookings Only • Additional Safeguarding	40.30wte RMs & MSWs
Total Clinical WTE	**231.06wte**

Birthrate Plus Staffing (22%) Table 7

Current Clinical Funded Bands 3 – 7

29. Comparisons were made with the current funded establishment as per table 8 below. The table indicates that there are 195.23 clinical midwives including a contribution of 9.56wte from the specialist midwives. There are 25.50wte Band 3/4s providing postnatal care on Lady Mary Ward, in Rosie Birth centre and the community.

RMs & RNs Bands 5-7	Contribution from Specialist roles	B3 MSWs	Total Clinical wte
185.67	9.56	25.50	220.73

Current Funded Establishment Table 8

30. In addition, there is a requirement for other support staff on the delivery unit, in Outpatients and on the Maternity Wards, usually Band 2s. The wte is calculated based on numbers per shift and not on a clinical dependency method.

Comparison of Clinical Staffing

Current Funded Establishment bands 3 – 7	Birthrate Plus recommended establishment bands 3 - 7	Variance Bands 3 - 7
220.73	231.06	-10.33

Comparison of Clinical Staffing Table 9

31. There are 220.73 bands 3 - 7, and Birthrate Plus recommends wte indicating a deficit of 10.33wte.

Clinical Specialist Midwives

32. The % of clinical time provided by specialist midwives included in the workforce calculations is a local decision although there is a commonly applied rationale within the methodology and generally accepted by Directors and Heads of Midwifery. Of the total specialist midwives, 9.56wte have been included in the clinical wte and the remaining is within the additional roles as explained below.

Non-Clinical Midwifery Roles

33. The total clinical establishment as produced from Birthrate Plus® is **231.06wte** and this excludes the management and the non-clinical element of the specialist midwifery roles needed to provide maternity services, as summarised below.

- Director of Midwifery, Deputy Director of Midwifery, Matrons/managers with additional hours for team leaders to participate in strategic planning & wider Trust business
- Antenatal Screening
- Diabetes
- Bereavement Midwife
- Fetal Surveillance
- Infant Feeding
- Practice Development
- Care for Vulnerable Adults
- Quality and Safety
- Digital Lead
- PMA

As an example, applying 12% to the Birthrate Plus clinical wte provides additional staff of **27.73wte** for the above roles with it being a local decision as to which posts are required and appropriate hours allocated.

Note: To apply a % to the clinical total ensures there is no duplication of midwifery roles and 12% is appropriate for a tertiary service.

Current Funded Additional wte	Birthrate Plus wte (12%)	Variance
28.00	27.73	0.27

Comparison of additional Specialist and Management wte Table 10

Summary of Results

Rosie Hospital Cambridge	Current Funded wte	Birthrate Plus wte	Variance wte
Clinical Bands 3 - 7	220.73	231.06	-10.33
Additional specialist and management roles	28.00	27.73	0.27
Total Clinical, Specialist and Management wte	**248.73**	**258.79**	**-10.06**

Total Clinical, Specialist and Management wte Table 11

34. The results indicate an overall deficit of 10.06wte RMs as the current contribution from postnatal MSWs in hospital and community is 12%.

35. Note: The sonography service is provided by 9.45 wte RMs who have no clinical midwifery function so are excluded from the Birthrate Plus results and in the comparison with current funded establishment. They remain in the midwifery budget as providing an additional service.

Using ratios of births/cases to midwife wte for projecting staffing establishments

36. Table 12 shows the overall ratio for the breakdown and combined services. The ratio is calculated by dividing total hospital and home births by the total clinical wte which will include the contribution from specialist midwives as described in point 32.

37. The ratios below are based on the Birthrate Plus® dataset, national standards with the methodology and local factors, such as % uplift for annual, sick & study leave, local factors due to size of service, case mix of women birthing in hospital, provision of outpatient/day unit services and total number of women having community care irrespective of place of birth.

38. The overall ratios of 24.1 births to 1wte for Rosie Hospital and equates to the often-cited ratios 28 or 29.5 births to 1 wte, but they are not directly comparable for the above local factors. Workforce assessments in the past 3 years have shown that the 'nationally cited' ratios may not be appropriate to use for comparison, mainly due to increase in acuity of mothers and babies and subsequent care required. These factors have changed the overall and, indeed, individual ratios. Therefore, it is advisable to use own ratios calculated from a detailed assessment for workforce planning purposes.

39. To calculate for staffing based on increase in activity, it is advisable to apply ratios of births/cases to midwife wte, as this will consider an increase or decrease in all areas and not just the intrapartum care of women. There will be changes in community, hospital outpatient and inpatient services if the annual number of women giving birth alters.

40. Once the clinical 'midwifery' establishment has been calculated using the ratios, a skill mix % can be applied to the total clinical wte to work out what of the total clinical 'midwifery' wte can be suitably qualified support staff, namely MSWs Band 3 or Nursery Nurses.

41. In addition, 12% is added to include the non-clinical roles as these are outside of the skill mix adjustment as above. However, the addition of other support staff (usually Band 2s MCAs) that do not contribute to the clinical establishment will be necessary.

42. Calculating staffing changes using a ratio to meet increase in births assumes that there will be an increase in activity across ALL models of care and areas including homebirths.

43. If there is an increase or decrease in activity, then the appropriate ratio can be applied depending on the level of care provided to the women. For example, if the women just have ante and postnatal community care as birth in neighbouring units, it is only necessary to estimate the increase in community staffing so the ratio of 96.5 cases to 1 wte is the correct ratio to apply. To use overall ratio of 1: 24.1 will overestimate the staffing as this covers all ante, intra and postnatal care.

ACTIVITY	RATIO
Delivery Unit Births (all hospital inpatient and outpatient care)	27.0 births to 1wte
Birth Centre Births	44.2 births to 1 wte
All hospital births (all hospital inpatient and outpatient care)	28.7 births to 1 wte
Home births	34.6 births to 1 wte
Community Care (AN and PN care only)	96.5 cases to 1 wte
Community care including attrition and safeguarding	91.5 cases to 1 wte
Overall Ratio	**24.1 births to 1wte**

Ratios of births/cases to midwife wte Table 12

Appendix 1

Method for Classifying Birthrate Plus® Categories by Scoring Clinical Factors in the Process and Outcome of Labour and Delivery

There are five [5] categories for mothers who have given birth during their time in the delivery suite [Categories I – V)

CATEGORY I **Score = 6**

This is the most normal and healthy outcome possible. A woman is defined as Category I [*lowest level of dependency*] if:
The woman's pregnancy is of 37 weeks' gestation or more, she is in labour for 8 hours or less; she achieves a normal delivery with an intact perineum; her baby has an Apgar score of 8+; and weighs more than 2.5kg; and she does not require or receive any further treatment and/or monitoring

CATEGORY II **Score = 7 – 9**

This is also a normal outcome, very similar to Category I, but usually with the perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention. However, if more than one of these events happens, then the mother and baby outcome would be in Category III.

CATEGORY III **Score = 10 – 13**

Moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries will fall into this category, as may continuous fetal monitoring. Women having an instrumental delivery with an epidural, and/or syntocinon may become a Category IV.

CATEGORY IV **Score = 14 –18**

More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal delivery will also be Category IV, as will those having a straightforward instrumental delivery.

CATEGORY V **Score = 19 *or more***

This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth, or multiple pregnancy, as well as unexpected intensive care needs post-delivery. Some women who require emergency anaesthetic for retained placenta or suture of third degree tear may be in this category.

Appendix 2 CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

Risk Reduction Action Plan – 100% compliance with of labour Ward Co-ordinator supernumerary (SN) status and provision of 1:1 care in labour.

Authors: Claire Garratt, Amanda Rowley, Tora Clark-Ward

Key for categorisation of Status	
Complete / Closed	**Blue**
On Track	**Green**
Behind schedule /On Going	**Amber**
Delayed /Overdue	**Red**
Not started/ New action	**Grey**

Action Plan – 5.8.22

Ref	Recommendation	Action/s	Owner	Deadline	Evidence required	Status	Comment
1	Plan DU Rota's to ensure x2 band 7's on duty per shift with one identified on health roster as the SN labour ward Co-ordinator	Recruit into current vacancy to ensure establishment to support 2 x Band 7's per shift. Advertise for interim positions to backfill current mat leave	TCW	December 2022	Reduction in vacancy factor for DU Coordinators. Health roster evidencing x 2 band 7 per shift		21/08/2022: Currently 1.14 WTE vacancy against establishment of 11.86 WTE with 1.9WTE on mat leave. Rotas planned for 2 RM where possible. Second band 7 in the unit is SN as operational bleep holder for maternity services.

2.	Improve vacancy factor to <5% though effective implementation of the maternity recruitment plan	Ensure rolling adverts for qualified and support staff. Implement Bi-annual F2F and virtual recruitment days. Support of international recruitment campaign. Support inclusive recruitment processes. Offer a variety of intake methods including degree and apprenticeship pathways, RTP and conversion course.	AR	March 2023	Vacancy factor of <5% evidence through monthly governance reporting.		21/08/22: The monthly workforce data captures the pipeline trajectory that will show when improvements should take place with SN status. This is monitored through directorate and divisional governance.
3	Ensure escalation to divert policy contains with clear table of actions for 984 bleep holder to ensure provision of SN status of DU Co-ordinator and 1;1 labour care provision	Review current divert policy and identify any additional actions needed and include in a specific action card to enable SN status of the Co-ordinator to be achieved	CG	November 2022	Revised Escalation to divert policy published on Merlin. Audit to confirm escalation in line with escalation to divert policy. Improved compliance with standard achieved as evidenced through monthly reporting		21/08. In progress. Action card to be added as an appendix. Plan for policy to be signed off at PPG and PBM meetings in October 2022

4	Clearly define the definition of loss of SN status to ensure consistent interpretation and reporting	Request further clarification of definition on SN status from NHSR. Raise at monthly DU Co-cordinators meeting to encourage consistent reporting.	AR	December 2022	Updated guidance from NHSR included within Escalation to divert policy and communicated to DU Co-coordinators. Data reported within BR+ acuity tool with evidence of monthly reporting through governance meetings.		21/08/22: Email received from NHSR confirming that SN status definition will be reviewed and any updated guidance will be shared in the coming weeks. Discussed at DU coordinators meeting to improve consistency of reporting. Data captured through red flag reporting and shared through governance and maternity highlight report.
5	Review of themes and trends of staffing unavailability through sickness to identify actions to support safe staffing provision.	Identify actions within staffing retention action plan and monitor response/ success to actions taken through clearly defined KPI's. Introduce a PMA retention project / stay interviews to identify themes around staff well-being where further action is needed as part of retention action plan.	AR	December 2022	Output from Clinical Psychology support Programme demonstrates improved attendance and a reduction in sickness related absence Monthly reporting demonstrates reduction in sickness rates to <4%		

6	Improve the confidence factor and consistency in reporting of supernumerary status of labour ward Co-ordinator through BR+ acuity tool	Capture on Birth rate (BR+) acuity application 6 times in 24 hours. Meet with DU coordinators to discuss method of capture and importance of capturing narrative and actions taken in response to loss of SN status	CG/TCW	September 2022	Consistently achieve >85% confidence factor in monthly reporting statistics.		21/08/22: Confidence factor of reporting improving. DU Co-ordinators reminded of the importance of capturing the narrative around start of loss of status and resuming status through BR+ and 984 diary.
7	Ensure identification of incidents potentially related to loss of SN status to ensure themes are reviewed and mitigation identified.	Any Incident potentially related to SN status should be taken to weekly rapid review meeting for MDT oversight and to identify learning and further mitigation needed	CB	October 2022	Minutes and actions from rapid review meeting. Any necessary actions identified should be added to this action plan. Improved consistency in 100% compliance with labour ward Co-ordinator supernumerary status		
8	24-hour midwifery manager of the day/ on call to enable escalation from the DU Co-ordinator / 984 bleep holder to ensure senior support and oversight of escalation and actions taken.	Maternity senior leadership team availability and time called out captured to evidence appropriate escalation and actions taken	CG	November 2022	Audit of compliance with escalation as per the escalation to divert policy and the loss of SN status action card within.		

9	Review recommendations following the planned NHSE Full workforce review on 23rd August 2022	Review recommendations regarding workforce models to identify changes that could support best use of Midwifery resource to best support safe staffing and 100% compliance with DU Co-ordinator SN Status	AR	October	Identification of actions included and monitored through recruitment and retention action plan for maternity services		Visit scheduled for Tuesday 23rd August. Sara ward and lady Mary identified as areas of focus. Review and guidance of current call provision also requested.
10	Scope ideas for introduction of a staffing escalation plan to support safe staffing during peaks in demand / poor rota fill to ensure safety.	Working with HR and staff side reps to review current on-call payments / options in keeping with agenda for change for consideration. .	CG	December 2022	Prepare business case / proposal for presentation to Divisional Forum for consideration that would enable a tiered approach to escalation through inclusion of band 7 / 6's on a tier 1 escalation rota to support safe staffing / manage peaks in demand		

Board of Directors

Cambridge University Hospitals
NHS Foundation Trust

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Report to the Board of Directors: 9 November 2022

Agenda item	12
Title	Reading the Signals, Maternity and Neonatal Services in East Kent
Sponsoring executive director	Lorraine Szeremeta, Chief Nurse
Author(s)	Meg Wilkinson, Director of Midwifery Claire Garratt, Head of Midwifery Hannah Missfelder Lobos, Clinical Director Kanwalraj Moar, Divisional Director
Purpose	To provide the key findings of the report and assurance on the work already in progress at CUH through the Maternity Improvement Plan.
Previously considered by	Management Executive, 3 November 2022

Executive summary

Dr Bill Kirkup published in October 2022 the report of his independent investigation on '*Reading the Signals, Maternity and Neonatal Services in East Kent*'.

This paper sets out the key findings of the Kirkup report and describes how these will be incorporated into the Trust's existing Maternity Improvement Plan which already includes the CUH response to recommendations, national standards, guidance and regulatory requirements resulting from a range of sources including the 2015 Kirkup report on Morecambe Bay, the two (2020 and 2022) Ockenden reports relating to Shrewsbury and Telford Hospitals and the national Maternity Self-assessment Tool.

Related Trust objectives	Improving patient care, Supporting our staff
Risk and Assurance	The report provides an overview on the 4 areas for action outlined within the Kirkup report on East Kent and identifies the action being taken to review the findings and ensure learning is fully reflected in the Trust's existing Maternity Improvement plan.
Related Assurance Framework Entries	BAF ref: 001, 007
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"?	Yes

Action required by the Board of Directors

The Board is asked to note:

- The publication, findings and four key actions of the Kirkup independent investigation of Maternity and Neonatal Services in East Kent.
- How the issues identified are already reflected in the CUH Maternity Improvement Plan.
- That a CUH gap analysis of the Kirkup report is currently being undertaken to identify any additional actions which need to be added to the Maternity Improvement Plan.
- That assurance on Maternity Services will continue to be provided to the Board via the Quality Committee and the Board-level Executive and Non-Executive Perinatal Safety Champions.

Cambridge University Hospitals NHS Foundation Trust

9 November 2022

Board of Directors
Reading the Signals, Maternity and Neonatal Services in East Kent
Director of Midwifery, Meg Wilkinson; Divisional Director, Kanwalraj Moar;
Head of Midwifery, Amanda Rowley; Head of Midwifery designate, Claire Garratt

Introduction

1.1 Dr Bill Kirkup's report 'Reading the Signals, Maternity and Neonatal Services in East Kent' was published on 19 October 2022. The full report can be found at: *Reading the signals: maternity and neonatal services in East Kent, the report of the independent investigation (print ready) (publishing.service.gov.uk)*

1.2 The report examined maternity services in two hospitals in East Kent and found that:

- Had care been given to the nationally recognised standards the **outcome could have been different** in 97 (48%) of the 202 cases assessed (2009 –2020) and the outcome could have been different in 45 (69%) of the 65 baby deaths.

- There were at least eight opportunities where problems could have been acknowledged and tackled effectively.

- The harm was not restricted to physical damage but the **disturbing effects of repeated lack of compassion and kindness**.

1.3 The report acknowledges that NHS maternity services have had scrutiny over several years and reports with numerous recommendations that have not necessarily worked. The recommendations of this report are limited to four key action areas.

2. Key action areas

2.1 For each of the key action areas, the sections below summarise the key issues identified in the investigation, the future state expected by the investigation panel and some of the relevant elements of CUH's current Maternity Improvement Plan.

Key action area 1: Monitoring safe performance – finding signals among noise

2.2 The following issues were identified:

- No reliable early warning mechanism in place to monitor safety in real-time and failure to identify relevant signals in relation to perinatal outcomes.
- No meaningful, reliable, risk adjusted, timely outcome measures.
- Maternity outcome data provided false reassurance with variation concealed by league table positioning and spurious rankings.

2.3 The future state that is expected is:

- Identification of early warning signs where action can be taken before problems and behaviours become embedded.
- Regulators can identify units that are outliers. All parties can have a conversation based on relevant shared information.
- Measures are meaningful, risk adjustable and presented in a way that is relevant.
- A national task force to be established to driver the introduction of valid maternity and neonatal outcome measures for mandatory national use.

2.4 The CUH Maternity Improvement Plan includes related actions within the governance workstream that cover escalation and accountability and clinical governance and leadership. The Trust awaits further information on the planned national taskforce.

Key action area 2: Standards of clinical behaviour – technical care is not enough

2.5 The following issues were identified:

- Failure to listen directly to women negatively affected patient safety.
- Staff did not always act professionally or show empathy.
- Openness and honesty was not always evident –institutional defensiveness, blame shifting, and punishment was inherent.

- Stubborn and entrenched poor behaviour across all clinical groups was normalised and tolerated, Senior role models influenced all staff. When issues were highlighted, they were dismissed, challenged or ignored.

2.6 The future state that is expected is:

- Compassionate care should be re-established and re-emphasised. Listening to women must be re-established and mastered.
- Every interaction should be based on kindness and respect, achieved by the attitudes and behaviours of clinicians.
- Professional behaviour and compassionate care should be embedded into training and continuing professional development.
- Staff should acknowledge and accept the authority of those in clinical leadership roles.
- They must have time and skills to carry them out.
- Reasonable and proportionate sanctions are required for employers and regulators to address poor behaviours

2.7 The CUH Maternity Improvement Plan includes a culture workstream. Current actions taken from Kirkup (2015) and the first and final Ockenden reports (2020 and 2022) that address this recommendation have a target completion date of March 2023.

Key Action Area 3: Flawed team working – pulling in different directions

2.8 The following issues were identified:

- Dysfunctional team working with poor relationships between and within professional working groups.
- Toxic and stressful working environments.
- Arguments occurring in front of women and families.
- Different staff groups seen as defenders and inflictors of medicalised care.
- Clinicians in training felt isolated, exposed, vulnerable and worked unsupervised in complex situations beyond their experience.
  A stronger basis for team working in maternity and neonatal services is needed based on an integrated service and workforce with common goals and shared understanding.

2.9 The future state that is expected is:

- A stronger basis for team working in maternity and neonatal services. Increased opportunities for teams to train together over and above the use of emergency drill training to increase understanding of individual roles and responsibilities.

- Re-evaluation of the changed patterns of working and training for junior doctors (unintended consequences of fragmentation of work and support given)

2.10 This is addressed within the CUH Maternity Improvement Plan actions and the Maternity Clinical Negligence Scheme for Trusts (CNST) year 4 safety action 8. The CUH maternity Service service is on track to meet the evidential requirements for this standard by December 2022.

Key Action 4: Organisational behaviour – looking good while doing badly

2.11 The following issues were identified:

- Reputation management was prioritised to the detriment of being open and straightforward with families, regulators and others.
- Concerns were dismissed and complaints were managed rather than seen as a source of feedback and learning.
- Too much effort spent seeking to challenge and undermine scrutiny.
- Pattern of hiring and firing of senior teams. Ethos of heroic leadership followed by high levels of criticism.

2.12 The future state that is expected is:

- The need for openness, honesty, disclosure and learning must outweigh any perceived benefit of denial.
- Introduction of legislation to oblige public bodies and officials to make of their dealings with families.
- Responses to families must be based on compassion and kindness as well as openness and honesty.
- Review of the regulatory approach to failing organisations by NHS England to include the provision of support to trusts in difficulty and incentives for organisations to ask for help.
- Identification of problems should be seen as a sign of readiness to learn.

2.13 Appreciative enquiry training and human factors training is captured within the CUH Maternity Improvement Plan as actions related to clinical governance and leadership.

3. CUH Maternity Improvement Plan

3.1 The Trust's Maternity Improvement Plan currently encompasses all identified improvement actions from existing and planned internal improvement work streams: Workforce, Culture and Governance (including external and peer reviews). Table 1 below highlights progress with the ongoing actions in the Maternity Improvement Plan.

Table 1: Progress against CUH Maternity Improvement Plan

Action Plan	Total Number of Actions Identified	Total Progress Against Identified Actions
Ockenden 1	76	**July** 63% (48/76) **September** 66% (50/76)
Ockenden 2 (Final Report)	58	**July** 7% (4/58) **September** 10% (6/58)
Kirkup	35	**July** 23%(8/35) **September** 34% (12/35)
Maternity Self Assessment	36	**July** 19% (7/36) **September** 22% (8/36)
Workforce ***New Sep 22***	20	**September** 5% (1/20)
Governance ***New Sep 22***	72	**September** 31% (22/72)
Culture ***New Sep 22***	7	**September** 0% (0/7)
Maternity Quality Improvement Plan **(In Entirety)**	304	**July** 31% (67/214) **September** 33% (99/304)

3.2 Some of the key successes in implementing the CUH Maternity Improvement Plan to date have been as follows:

- Operational policy development and publication for the postnatal ward.
- Launch of a monthly safety and quality bulletin.
- Cross-divisional agreement of national requirements for theatre and recovery nurses working in maternity high dependency areas.
- Equality and equity gap analysis completed in line with the LMNS Equity and Equality plan.
- Regular all staff listening events, including raising awareness of the CUH Freedom to Speak Up service and visits by the Freedom to Speak Up Guardian.
- Progress on reducing vacancies and improving retention of staff.
- Appointment of a full-time Professional Midwifery Advocate (PMA) starting in December 2022.
- Active engagement of the Executive and Non-Executive Director Board-level Perinatal Safety Champions.

3.3 Some of the key challenges in implementing the CUH Maternity Improvement Plan, as discussed at the Board's Quality Committee, are as follows:

- Pressures resulting from ongoing staffing shortages.
- Pastoral and clinical support of newly-qualified staff.

- The ongoing need for service diverts.

4. Governance

4.1 Progress against the CUH Maternity Improvement Plan is monitored and reviewed through service and divisional governance meetings. Updates are provided bimonthly to each meeting of the Board's Quality Committee. In addition, there are regular Safety Champion meetings involving the Board-level Perinatal Safety Champions.

5. Next steps

5.1 The CUH Maternity Service is currently undertaking a detailed gap analysis of the Kirkup findings using a multi-disciplinary approach, and any gaps identified which are not covered in the current Maternity Improvement Plan will be incorporated into the relevant workstreams within the Plan.

5.2 Any new required actions will be agreed through the local governance structure and monitored through the Maternity Services directorate and divisional governance structure.

5.3 The conclusions of the gap analysis and any resulting additional actions will be reported to the Perinatal Safety Champions and the Quality Committee.

6. Recommendations

6.1 The Board of Directors is asked to:

- The publication, findings and four key actions of the Kirkup independent investigation of Maternity and Neonatal Services in East Kent.
- How the issues identified are already reflected in the CUH Maternity Improvement Plan.
- That a CUH gap analysis of the Kirkup report is currently being undertaken to identify any additional actions which need to be added to the Maternity Improvement Plan.
- That assurance on Maternity Services will continue to be provided to the Board via the Quality Committee and the Board-level Executive and Non-Executive Perinatal Safety Champions.

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

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Report to the Board of Directors: 9 November 2022

Agenda item	12
Title	Strategy update
Sponsoring executive director	Nick Kirby, Interim Director of Strategy and Major Projects
Author(s)	Dan Northam Jones, Director of Strategy Denise Franks, Assistant Director of Planning and Development Matthew Zunder, Strategy Adviser
Purpose	To update the Board on implementation of the Trust Strategy agreed in July 2022
Previously considered by	Management Executive, 3 November 2022

Executive Summary

In July 2022, the Trust agreed a new Strategy: CUH Together 2025. This report presents the four-monthly strategy report, now aligned to the new 15 commitments in the new strategy. This update covers activities undertaken during July to October 2022 and outlining plans for November 2022 to February 2023.

Alongside this we are currently undertaking a comprehensive communication, engagement and implementation plan details of which are found in an additional section at the end of this document.

Related Trust objectives	All
Risk and Assurance	The Trust strategy is a key tool for addressing the major risks facing the Trust.
Related Assurance Framework Entries	All
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”?	Yes

Action required by the Board of Directors

The Board of Directors is asked to note progress made in recent months in delivering our strategy, and commitments for the coming months.

Improving patient care

Progress from July to October 2022	Key areas of focus for November 2022 to February 2023
Integrated Care: We will work with NHS, other public sector and voluntary sector organisations to improve the health of our local population	
• Launched a Discharge Hub with partners to help patients out of hospital and home as quickly as possible. • Continued work with primary care, community services, social care and the voluntary sector to develop Integrated Neighbourhood Teams to treat more patients at or close to home. • Formed a Joint Strategic Board (JSB) to oversee decision-making across the South Place, co-chaired across CUH, the County Council and Primary Care. • Shaped our Integrated Care Board's (ICB) Accountable Business Unit Development Programme. • Worked with Healthwatch to involve a diverse range of patients in co-production work as Health Champions.	• Deliver Winter Plan alongside system partners. • Implement short term interventions to support Primary Care throughout winter. • Prototype integrated pathway models with primary care and identify how this could expand to include other partners • Recruit a substantive Managing Director for South Place. • Continue to engage with the ICB and other ABUs to define common objectives. • Increase patient, process, clinical and population engagement in partnership with Healthwatch
Emergency Care: When patients come to the hospital in an emergency we will treat them, and help them to return home, quickly	
• Delivered additional Same Day Emergency Care (SDEC) and assessment capacity with ~40% of patients now seen outside the main Emergency Department (ED). • Implemented five-stage escalation process to decompress ED, including opening contingency areas and increasing patient numbers on wards. • Launched our first Virtual Ward with 30 patients. • Formed cross system group to coordinate capacity across partners over winter through the Southern Alliance Resilience Group (SARG). • Formed Winter Task Force to coordinate activities within the hospital including quality and safety, additional capacity, seven-day	• Expand the list of referral options for GPs, Ambulance Service and NHS 111 to stream more patients to SDEC and away from ED. • Increase referrals to the Urgent Community Response team. • Create a frailty unit on G2 to cohort frail and elderly patients to streamline discharge. • Implement pathways to discharge patients for assessment in the community at or near home rather than in the hospital. • Complete improvement work focused on flow including criteria to reside, simple discharges, time of discharge and reducing weekend variation. • Expand the Virtual Ward to accommodate 60 patients. • Collaborate with other Trusts to improve discharge capacity and free up space in emergency care for unwell patients.

working, support for patients on the cost of living and winter modelling.	• Review Full Capacity Protocol and make enhancements to align with changes to Ambulance Cohorting protocols. • Reduce Ambulance Handover delays >60 mins to nil by 31 December 2022 in line with national guidance.
Planned Care: When patients need planned care we will see them as quickly and efficiently as possible	
Outpatients • Achieved pre-pandemic levels of activity. • Reviewed 2019/20 benchmarking data and identified opportunities for further productivity improvements. • Further increased Patient-Initiated Follow-Up (PIFU), continuing an upward trend. • Recovered Advice and Guidance position to above the 16% target.	*Outpatients* • Prioritise new-patient first appointments, particularly for patients who have been waiting more than 78 weeks. • Maximise clinical engagement with further opportunities to increase the use of PIFU.
Surgery • Increased in-session utilisation by 5% through regular meetings with theatre teams and booking coordinators. • Initiated a late start report, shared daily with all stakeholders, in perioperative care. • Improved High Volume Low Complexity (HVLC) day case rates. • Used Model Hospital data to drive innovation and monitor impact. • Commenced reconfiguration of P2 and Q2 as an elective orthopaedic centre.	*Surgery* • Use telephone and digital solutions to increase pre-operative assessment capacity, enable more elective operations and reduce length of stay. • Develop further the 23-hour pathways via L2 Day Surgery Unit (DSU). • Increase the volume of activity undertaken at Ely DSU. • Improve overall discharge rates by reducing conversion to inpatient and facilitating expedited discharge. • Streamline surgical flow and support colleagues in Surgical Assessment Units with contingency patient moves to maximise capacity.
Diagnostics • Recovered Endoscopy and Bone Density Scan (DEXA) backlogs to pre-Covid baseline. Performed above plan for MRI activity.	*Diagnostics* • Recover backlogs of CT by early 2023, MRI by Dec 2022 and Echo by Jan 2023.

• Successfully recruited to medical and non-medical posts, including up-skilling staff through training courses. • Completed Consultant productivity review to identify efficiencies. • Received loan of Echo machines to cover whilst faulty machines are being replaced. • Submitted business case for Ely/Wisbech Community Diagnostic Centre (CDC) in partnership with Cambridgeshire Community Services (CCS).	• Support additional actions to recover Ultrasound and improve accuracy of Echo tracking. • Work with the independent sector to maximise their capacity. • Collaborate with ICB and North West Anglia Foundation Trust (NWAFT) to ensure patients are able to access diagnostics regardless of location. • Develop approach to diagnostics in virtual wards. • Commence implementation of approved CDC model at Ely and Wisbech. Respond to feedback and progress implementation on additional CDC business cases if approved.
Health Inequalities: We will tackle disparity in health outcomes, access to care and experience between patient groups	
• Launched Strategy Group to set out strategy for staff and patient Equality, Diversity and Inclusion (EDI) and health inequalities, and reviewed learning from other organisations including other Shelford Group peers. • Commenced recruitment for an Interim Director of EDI. • Implemented a health inequalities Operations Group to meet regularly. • Supported ICS to create tobacco dependency/smoking cessation programme and cardiovascular risk programme. • Developed new ways for engagement and data gathering to collect accurate patient demographics and feedback.	• Support the development of the National Core20Plus5 scheme to reduce health inequalities. • Ensure that patients across the region are equally able to access services from the NHS Genomic Medicine Service Alliance (GMSA). • Embed EDI and health inequalities priorities across all aspects of work of at CUH, with the Interim Director providing advice and guidance. • Continue to improve our approach to engagement and data gathering to collect accurate patient demographics and feedback. • Increase the number of Equality Impact Assessments completed and track usage to target improvements.
Quality, Safety and Improvement: We will continuously improve the quality, safety and experience of all our services	
• Developed a quality improvement plan to support harm-free care from a review of pressure ulcers and falls. • Reduced the number of patients waiting over 78 weeks for treatment. • Awarded first full ward accreditation status.	• Implement a digital consent platform to deliver best practice consent for patients. • Introduce leads within specialities to promote harm-free care focusing on venous thromboembolism. • Reduce the need for blood transfusions through early identification, investigation and better treatment of anaemia.

• Recruited lead for Patient Safety Incident Response Framework (PSIRF). • Implemented new leadership programme for matrons and sisters/charge nurses. • Welcomed the Institute for Healthcare Improvement (IHI) for an annual visit, including a Board development session and work with Management Executive. • Concluded Wave Two of the Improvement Coach Programme and commenced the Improvement Programme for Teams.	• Reduce delays on reporting of x-rays and scans to increase patient safety. • Develop implementation plan for PSIRF. • Agree and progress the supporting next steps following the IHI visit. • Commence Wave Two of the Leading for Improvement Programme.

Supporting our staff

Progress from July to October 2022	Key areas of focus for November to February 2023
Resourcing: We will invest to ensure that we are well staffed to deliver safe and high quality care	
• Initiated centralised administration process. • Recruited 285 international nurses. • Developed new job description, person specification and recruitment advertisement templates. • Introduced rapid upload to Staff Bank. • Participated in ICS/NHS England e-rostering improvement programme.	• Develop a draft workforce plan for 2023/24. • Fully implement the centralised administration process. • Complete the Band 2 Health Care Support Worker (HCSW) review. • Establish an Immunity Screening Questionnaire (ISQ) Clearance taskforce to provide health clearance for staff.
Ambition: We will invest in education, learning, development and new ways of working	
• Completed Phase 2 delivery of the Divisional Leaders Programme and commenced initial planning for Phase 3. • Flexible working focus group re-commenced as part of Good Work Programme. • New centralised recruitment for administrative posts to ensure offer of flexible working a key feature.	• Introduce new iteration of Senior Leaders Programme (SLP) and initiate SLP alumni programme of development • Develop Operational Manager Development Programme, aligned to divisional leaders programme and SLP. • Develop New Line Manager Programme.
Good Work: We will strive to ensure that working at CUH will positively impact our health, safety and well-being	
• Developed six strands of the Good Work Programme, defining deliverables in the short, medium and long term. • Recruited wellbeing programme lead and facilitators. • Secured investment for recruitment of Occupational Health mental health nurse and staff support chaplain. • Developed proposal for Trauma Risk Management (TRiM) service, working with Addenbrooke's Charitable Trust (ACT) to secure funding. • Delivered pension information sessions.	• Complete launch of Wagestream financial wellbeing platform and fully develop financial wellbeing strategy. • Return on-site residences to support staff accommodation. • Secure continued investment (2023/24) for priority areas in the Good Work programme. • Induct wellbeing facilitators and recruit wellbeing champions. • Set up TRiM including recruitment, training and Quality Surveillance Information System (QSIS). • Complete annual flu and Covid-19 booster programme.

• Commenced annual flu and Covid-19 booster vaccination programmes. • Completed Trust-wide launch of Workplace Adjustment programme for staff requiring specific measures to support and manage their health condition at work.	
Inclusion: We will seek to drive out inequality, recognising that we are stronger when we value difference and inclusion	
• Refreshed Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) action plans. • Delivered Black History Month Programme. • Commenced recruitment for an Interim Director of EDI.	• Further develop staff network groups, supported by introduction of new selection process and honorarium payments for network leads.
Relationships: We will foster compassionate and enabling working relationships	
• Held inaugural annual CUH awards event.	• Review learning from 2022 calendar of events. • Development of recognition events calendar for 2023.

Building for the future

Progress from July to October 2022	Key areas of focus for November to February 2023
Specialised Services: We will work with hospitals across the East of England to provide high quality specialised care for more patients closer to home	
• Identified long list of opportunities for service transformation and prioritisation framework to assess these. • Met with the NHSE regional and Specialised Commissioning teams, and with ICBs, to identify shared priorities. • Convened a meeting with CEOs of Trust members of the East of England Specialised Provider Collaborative (EoESPC). • Engaged with key stakeholders across the region to test and refine our priorities, including clinical networks, Cancer Alliances, and acute trusts beyond the EoE SPC • Coordinated joint response from EoE SPC partners to the Advisory Committee on Resource Allocation's (ACRA) draft methodology for specialised commissioning. • Responded to NHSE regional team's commission on the joint planning and strategic development of specialised services • Reviewed best practice on provider collaboration from other regions and incorporated into the EoE SPC's work.	• Agree scope, objectives and resourcing for priority transformation projects, and begin to progress these with the aim of delivering tangible benefits in the next year • Work with ICBs and NHSE to prepare for delegation of specialised commissioning and influence the national agenda. • Start formalising the EoE SPC's governance to coordinate the next phase of work. • Explore the EoE SPC's role in supporting research and life sciences across the region, in discussion with external partners such as Universities and Health Education England.
Research and Life Sciences: We will conduct world-leading research that improves care and drives economic growth	
• Approved the Nursing and Midwifery & Allied Health Professional Research Strategy. • Completed and closed an inspection on Good Clinical Practice by the Medicines and Healthcare product Regulatory Agency (MHRA), undertaking corrective and preventative actions based on recommendations.	• Launch the NIHR Young People's BioResource to increase engagement of children and young people in clinical research. • Continue to support the development of the internationally leading Patient-Led Research Hub in Cambridge. • Continue to support national COVID-19 studies including CNS-COVID, HEAL-COVID and PROTECT-V.

• Achieved re-designation and funding of the National Institute for Health and Research (NIHR) Cambridge Clinical Research Facility and Cambridge Biomedical Research Centre.	
New Hospitals and the Estate: We will maintain a safe estate and invest in new facilities to improve care for patients locally, regionally and nationally	
Cambridge Children's Hospital (CCH) • Progressed the Outline Business Case (OBC) to near completion other that the financial model which is still in development. • Engaged local and regional commissioners on key information with OBC. • Agreed mental and physical health integration structure between CUH and Cambridgeshire and Peterborough Foundation Trust (CPFT). • Initiated Royal Institute of British Architects plan of work Stage 3.	*Cambridge Children's Hospital (CCH)* • Finalise the OBC Financial model • Secure letters of support from commissioners. • Gain Trust approval of OBC and submit to the national New Hospitals Programme. • Continue Royal Institute of British Architects plan of work Stage 3.
Cambridge Cancer Research Hospital (CCRH) • Complete and submit the Outline Business Case. • Updated CCRH revenue model. • Secure letters of support from commissioners. • Initiate Royal Institute of British Architects plan of work Stage 3. • Continue to engage stakeholders at all levels on the design of the CCRH.	*Cambridge Cancer Research Hospital (CCRH)* • Procure the Public Sector Construction Partner who should ultimately build the CCRH (this is subject to cost and approval from His Majesties Treasury and the Department of Health and Social Care • Respond to queries from NHS assurers on the Outline Business case. • Complete Royal Institute of British Architects plan of work Stage 3. • Begin work on the Full Business Case
Addenbrookes 3 • Worked with cancer and children's hospitals project teams to ensure consistent assumptions on demand and activity. • Continued development of communications plan including an active programme of engagement with local Members of Parliament. • Continued input into Community Diagnostic Centres (CDCs).	*Addenbrookes 3* • Continue to support the case for children's and cancer hospitals to be included in cohort 2 of NHP. • Work with partners within the ICB to develop CDCs including models of care.

• Completed proposal to New Hospitals Programme (NHP) to be in Cohort 2 of the national programme.	• Begin planning for impact and opportunities of Phase 2 projects on the CUH campus. • Begin scoping out phase 3 projects, such as neurosciences.
Phase 1 • Gained approval and funding to build a regional elective orthopaedic facility. • Received approval for an off-site Orthotics and Prosthetics Service allowing for expansion of ED into vacated space. • Extended Histopathology lease and secured CUH Board approval to move to new accommodation. • Drafted two business cases to address ED capacity challenges.	*Phase 1* • Recruit to 56 bedded regional surge centre unit. • Build theatres and recruit to orthopaedic facility to manage elective backlog. • Develop implementation plan for histopathology move and consider co-location of other diagnostic capacity. • Procure an Orthotics and Prosthetics service including accommodation. • Refurbish Clinic 9 to expand ED. • Execute medium term strategy for UEC and ED physical capacity infrastructure.
Estates • Continued investment in four-year fire safety remedial works programme. Developed technical evaluations of fire safety issues. • Continued backlog maintenance programme as per capital allocation. • Proceeded with the delivery or work-up of 32 capital projects and commenced 5 key capacity schemes which are on target for completion. • Developed approach to purging risks on risk register associated with infrastructure and services.	*Estates* • Continue the fire safety remedial works programme. Continue the fire detection programme of works. • Continue backlog maintenance investment programme, capital and capacity schemes. • Refresh backlog maintenance forward plan as part of planning for 2023/24. • Refresh risks on risk registers. • Collaborate with ICS partners through the ICS estates group.
Climate Change: We will tackle the climate emergency and enhance environmental sustainability	

• Bid successfully into national Low Carbon Skills Fund, to develop a technical Heat Decarbonisation Plan for the CUH Hills Road campus. • Commenced Babraham Park and Ride solar energy project. • Reviewed energy purchase strategy. • Secured commitment from Passivhaus Institut to support the Cambridge Children's Hospital low energy objectives. • Switched to energy saving thermostatic radiator valves in clinical engineering. • Maintained major reduction in nitrous oxide consumption. • Revised clinical anaesthetic practice to secure significant reduction in use of desflurane. • Continued to support the behaviour change programme: Think Green Impact. • Completed first phase of improved security measures for cycle parking.	• Launch first phase of CUH Action50 Green Plan and supporting governance. • Finalise the legal agreements with Network Rail in relation to Cambridge South Station. • Undertake the heat decarbonisation plan. • Continue LED light upgrade as part of rolling programme. • Continue work on the outcomes of the major consultation to radically transform access into Cambridge and Greater Cambridge area.
Digital: We will use technology and data to improve care	
• Implemented Trust-wide Modal Fluency Direct Voice Recognition. • Supported implementation of Virtual Wards through Epic builds and other technological interventions. • Extended implementation of MS Teams and NHS.net mail capability throughout the Trust. • Developed MyChart appointments functionality further to facilitate staff flu and Covid vaccinations.	• Complete Epic upgrade. • Cease printing appointment letters for patients with MyChart. • Update Epic to facilitate work with East of England Genomics Laboratory Hub. • Integrate Digital Pathology and Medcurrent iRefer decision support solution for Radiology with Epic. • Implement shared care record through collaboration with the ICB.

Implementing the Strategy

Progress from July to October 2022	Key areas of focus for November to February 2023
Communication: Communicate the Strategy to CUH staff, patients and partners	
• Created new pages on the CUH website. • Recorded Strategy videos accessible via YouTube, Facebook and the CUH website. • Launched a Comms campaign across the staff Facebook page, email bulletin and on payslips. • Printed 12,000 leaflets to handout to every member of staff and commenced distribution. • Embedded new resources in medical and corporate inductions. • Led sessions with professions and staff networks.	• Complete distribution of leaflets to all staff. • Launch a wipe-clean strategy triangle that can be completed by teams to develop and share team strategic objectives. • Continue to increase engagement on digital and social media channels.
Capability: Build strategic awareness and capability among senior leaders at CUH	
• Delivered seminars at team meetings, training and leadership development sessions to relate the Strategy to team and individual objectives. • Updated the recruitment job description template to include references to Strategy. • Updated the Appraisal process including links to the new Strategy.	• Continue with programme of seminars and training.
Capacity: Recruit additional posts in Divisions, Operations and Strategy teams to support implementation	
• Agreed capital funding to support divisional and corporate operations teams to implement Major Projects and the Strategy. • Completed recruitment campaign for these posts.	• Induct new joiners and commence work on divisional and corporate priorities. • Create network to support the roles cross-divisionally.
Planning: Develop an implementation plan for the Strategy, with quantified goals and synthesis across schemes	
• Developed a 5-year implementation plan covering demand, activity, capacity and productivity.	• Developed a 5-year implementation plan covering demand, activity, capacity and productivity.

• Assessed the impact of strategic initiatives on these using national and local modelling tools.	• Assessed the impact of strategic initiatives on these using national and local modelling tools.

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Report to the Board of Directors: 9 November 2022

Agenda item	13.1
Title	Annual Workforce Race Equality Standard (WRES) report for 2022
Sponsoring executive director	David Wherrett, Director of Workforce
Author(s)	Monica Jacot, Head of Equality Diversity & Inclusion Erica Chisanga, Race Equality Project Lead
Purpose	To receive the 2022 report and action plan.
Previously considered by	Workforce and Education Committee, 20 September 2022

Executive Summary

The paper provides:

- The Trust's 2022 Workforce Race Equality Standard (WRES) data set and the CUH race disparity ratio benchmarked position as advised by NHS England WRES team
- A summary of action taken for protecting, supporting, and engaging with our Black Asian and minority ethnic colleagues post COVID-19.
- A refreshed WRES action plan co-created with our staff network to address systemic racism, aligned to Cambridge and Peterborough ICS and implementing the East of England Regional anti-racism strategy launched on 1 July 2021
- Note that the WRES position set out in this paper sits alongside the Trust's overarching commitment to workforce inclusion across a range of protected characteristics.

Related Trust objectives	Improving patient care, Supporting our staff
Risk and Assurance	The report provides assurance on progress against the WRES.
Related Assurance Framework Entries	BAF ref: 008
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 and discuss the latest WRES dataset.
- Note and discuss the proposed refreshed WRES actions.
- Note and discuss the employer commitment to implementing the East of England Ant-racism strategy, tackling racism and discrimination to be an anti-racist organisation.
- Ensure their personal information on ESR is updated, including on ethnicity.
- Consider personal actions and commitment to progress race equality and inclusion at CUH as part of the broader inclusion agenda.

Cambridge University Hospitals NHS Foundation Trust

9 November 2022

Board of Directors

Annual Workforce Race Equality Standard (WRES) 2022 data report and priorities for action to be an antiracist organisation

David Wherrett, Director of Workforce

1. Introduction / Background

This paper provides the Committee with the 2022 WRES data set for CUH that has been submitted in August 2022, together with a summary of action taken in the past year and proposed refreshed WRES action plan.

The WRES was introduced in April 2015 as the NHS England WRES briefing for boards states that NHS workforce race equality delivers better care, outcomes and performance. Research and evidence such as that from Prof Michael West and Prof Jeremy Dawson has found that less favourable treatment of Black and minority ethnic (BME) staff in the NHS, through poorer experience or opportunities, has significant impact on the efficient and effective running of the NHS and adversely impacts the quality of care received by patients. West and Dawson assert "*The greater the proportion of staff from a Black or minority ethnic background who report experiencing discrimination at work in the previous 12 months, the lower the levels of patient satisfaction. The experience of BME staff is a very good barometer of the climate of respect and care for all within NHS Trusts*"

The Committee is reminded that, in its simplest form, the WRES offers NHS organisations the framework to understand their workforce race equality performance, including the degree of BME staff representation at senior management and board level. The WRES indicators highlight differences between the experience and treatment of white staff and BME staff in their organisations. The WRES is intended to help all NHS organisations to focus on where they are right now on this agenda, where they need to be, and how they can get there.

The CUH WRES strategy is informed by a number of recent publications and wider actions:

- The National WRES team NHS England in February 2021 published the WRES 2020 Data analysis report which suggests priorities for

action and, in May 2021, wrote to all Trusts advising them for the first time of their Race Disparity Ratio and benchmarked their relative likelihood of BME and white staff progressing to lower, middle and upper tiers of Agenda for Change bandings based on 2020 data. The National WRES team has also set out Model Employer leadership targets for the NHS; an ambition for all posts across the NHS to have 19% BME staff representation, including at senior leadership and Board level by 2028. CUH's model employer senior leadership Board target is 25%.

- Since its engagement with *Cambridge and Peterborough Ethnic Minority Development programme* to support career development of ethnic minority staff across the STP in March 2021; *Our People Plan Operational Guidance for 2021/22 and;* East of England *Making Anti-racism a Reality*, CUH has appointed a WRES Project Lead and put in place various initiatives which are referenced in this report.
- In September 2022 the Trust committed to the UNISON Eastern Antiracism Charter. This outlines various pledges under the themes of Leadership, Process and Audit.
- In May 2022 NHS England WRES team published The WRES report 2021 analysing all national data submitted in 2021 across the NHS.

In presenting this report, it should be highlighted that all leaders and all members of the workforce have a responsibility and a role to play, and are accountable for tackling racism and discrimination and promoting inclusion.

A note on language: there has, and continues to be, much local and national debate regarding the terminology best employed to respectfully and accurately make reference to ethnicity. For a number of years the trust has actively used the term Black, Asian and Minority Ethnic (BAME), supported by the staff network who adopted the same term for their network title as members wished to specifically reference colleagues of Asian ethnicity. In December 2021 the government announced that it would no longer be using the terms BAME and Black and Minority Ethnic (BME), stating that such terminology emphasises certain ethnic minority groups and excludes others. They now use the term ethnic groups or ethnic minority groups. They have also actively decided that they will not use capitalisation for ethnic groups unless the group's name includes a geographical place.

Both NHS England and WRES material use the term Black and Minority Ethnic (BME). Following recent internal discussion it has been agreed that for the purposes of this report and future documentation we will use this terminology, so as to align to NHS England and WRES reporting material. It

has also been agreed with internal partners that we will capitalise ethnic groups which include a geographical place and also the term Black when used to refer to ethnicity.

Please note that the staff network, formally known as the BAME Network relaunched as the REACH Network in October 2022, which stands for Race Equality and Cultural Heritage.

2. 2022 WRES data set

The WRES indicators for the Trust's 8th WRES data report to NHS England were submitted August 2022. In summary the Trust has:

- Improved in 6 of the 9 indicators in the last year
- Deteriorated in 3 indicators.

The results for each indicator are set out below.

2.1 WRES indicator 1: Staff in post by pay band, as at 31 March 2021

- 11,799 staff were in post as at 31 March 2022 of which 28.03% (3306) are Black, Asian & Minority Ethnic groups. An increase of 2.2% on 2021 data.
- This is greater than the 17.6% of the local Cambridge City population and the 7. 5% of the Cambridgeshire County (ONS 2011).
- 67.8% (8008) were from white ethnic groups.
- 4% (484) Ethnicity was "Not known/Not given". This proportion on ESR continues to reduce year on year from 4.7% and 5.7% in 2021 and 2020 respectively. The EDI and Workforce Information teams continue to encourage staff to update their personal data including information on all protected characteristics on ESR.
- Our current position for numbers in Agenda for Change pay bands 8a (c. £48k) and above has improved since 31 March 2021. Appendix 1 shows the Trust wide position and the staff profile by pay band for each Division. Our target in our WRES plan remains at 25% (1 in 4) staff from BME backgrounds at all levels of the organisation.
- Progress has been made in mobility from 2021 to 2022 between bands 5-6 and 6-7 with an increase in band 6 from 22.9% 2021 to 24.7% and band 7 from 11.9% to 12.7%. This increasing trend is not yet seen in mobility between bands 7-8.
- With regards the medical staff data position as at 31 March , it should be noted that for Consultant posts the average postholder will stay in post for 20-30 plus years and, therefore, it is proposed that a useful additional exercise will be to analyse the number of consultant

appointments in the past 5 years by ethnic group, presenting a greater understanding of more recent activity.

Action for 2022/23

- The Trust will undertake an ethnicity pay gap audit in order to inform actions to further address inequality.

2.2 WRES Indicator 2: Relative likelihood of being appointed after shortlisting, 1 April 2021 to 31 March 2022

- White candidates are 1.74 x more likely than BME to be appointed after shortlisting (worse than previous year 1.48 x). This may have been further exacerbated by a reduced level of overseas recruitment in this period (due to COVID related travel restrictions and, latterly, accommodation shortages).
- This indicator differs between non-medical and medical recruitment as follows:
  Non-medical: White candidates 1.77x more likely than BME candidates to be appointed. Worse than 1.45 on 2021 data
  Medical: White candidates 1.85 x more likely than BME candidates to be appointed. Negligible difference on 2021 data.

Action in 2021/22

- One of the initiatives put in place to seek to debias the recruitment process is the inclusion of Diversity Inclusion Panellists (DIP) when recruiting leadership roles of band 8a and above. The Trust now has 55 DIPs in post and intends to move to the inclusion of DIPs in all recruitment processes by 2028.

Actions for 2022/23

- CUH is taking part in the East of England regional project to take further steps to de-bias all recruitment processes by piloting and implement the De-biasing Recruitment toolkit that has been commissioned and developed for the Region by Research fellow and diversity expert Roger Kline from Middlesex University Business school (author of *The Snowy White Peaks of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England.*
- The CUH WRES Project Lead is supporting leaders in each division to implement recommendations to debias recruitment as set out in the No More Tick Boxes Report (2021).

2.3 WRES indicator 3: Relative likelihood of entering formal disciplinary investigation, 1 April 2021 to 31 March 2022

- BME Staff are 0.54 x less likely than white staff to enter a formal disciplinary process – (Improvement on last year BME1.67 x more likely).
- **Non-Medical formal disciplinary cases**: 40 (White = 31; BME = 8 ; Unknown = 1)
  Medical cases: 6 (white 5; BME 0 UK =1)
- Since September 2019 Cultural Ambassadors (CA) involved in pre-disciplinary investigation action reviews. The Trust has now 17 CAs of which 3 are Medical staff

In 2022 this is a reassuring result and encourages extending the use of the CA role in formal employee relations processes.

Actions in 2021/22

- A second cohort of 6 Cultural Ambassadors (CA), including 3 medical staff, were recruited and trained through the RCN national CA programme in December 2021. The three medical Cultural Ambassadors are now involved in medical disciplinary processes when allegations are made against BME medical staff. They join the 17 CAs are in place to assist Employee Relations team to seek to debias the disciplinary investigation process when any allegation is made against a Black Asian or minority ethnic member of staff.
- Audits of Employee Relations cases have been presented by the Head of Employee Relations at the WRES implementation group.
- To equip leaders with the capability and confidence in leading and working with culturally diverse teams and develop Cultural intelligence (CQ™) we have partnered with Above Difference Ltd to deliver *Leading inclusively with CQ*™ 1 day masterclasses; 6 cohorts of 20 places have been delivered between April 2021 and March 2022 targeted at senior clinical leaders, with a further 10 masterclasses commissioned July to December 2022. In November 2021, to ensure sustainability of the programme, the Head of EDI and EDI project manager in November 2021 attended the five day CQ train the trainer Above Difference Facilitator programme and are now qualified CQ™ facilitators.

Action for 2022/23

- Continued investment in Cultural Intelligence (CQ)™ for inclusive leadership masterclasses to improve leaders' cultural intelligence, knowledge and understanding when leading diverse teams to help

leaders be aware of potential cultural barriers and misunderstandings in the workplace.

- This investment will be coupled with ensuing there are additional key performance indicators as well as the WRES metrics to measure the impact of the CQ for Inclusive leadership programme and objective setting for participants with action learning sets

2.4 WRES indicator 4: Relative likelihood of accessing non-mandatory training, 1 April 2021 and 31 March 2022

- White staff are 0.8 x less likely than BME staff to access non-mandatory training and CPD.
- As stated in previous board reports, it should be noted that not all non-mandatory training/CPD is recorded on the Learning management system (DOT).

Actions for 2022/23

- Developing line manager's Cultural intelligence (see above) will be important to help address this and ensuring all Workforce policies and processes are aligned with the overall ambition.

WRES indicators 5 – 8: Staff survey scores 2021

	Workforce Race Equality Questions		2020 CUH	2021 CUH	Change 2020/21
Indicator 5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	23%	23%	0%
		BME	26%	24%	-2%
Indicator 6	Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months	White	12%	10%	-2%
		BME	12%	10%	-2%
	Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months	White	19%	17%	-2%
		BME	24%	22%	-2%
Indicator 7	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	62%	61%	-1%
		BME	50%	48%	-2%
Indicator 8	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	7%	7%	0%
		BME	16%	17%	1%

Across CUH there has been some demonstrable improvement in indicators 5 and 6 but a deterioration in indicators 7 and 8.

2.5 WRES indicator 5: **Percentage of staff experiencing harassment, bullying and abuse from patients, relatives or the public in the last 12 months**

- 24% of BME staff experienced harassment in the last 12 months. Although better than the 2020 result of 26%, the percentage is still high.
- Our BME staff are 2% more likely than white staff to have experienced harassment and bullying from patients, relatives and public.

Actions in 2021/22

- The CUH Violence and Aggression Management Procedure has been reviewed and the categories for reporting racism and other categories refreshed to make it simpler.

Action for 2022/23

- As part of the regional Anti-racism Strategy launched 1 July 2021 zero tolerance of harassment and abuse with consistent messaging will be developed by December 2022 so that staff feel supported and have clarity on what mechanisms are in place to support their actions. Tackling racial harassment and abuse from patients and the public is a national, regional and local priority for action. A Zero tolerance approach will be clearly defined; racism will not be ignored and something will be done. It will be challenged and action taken as set out in the NHSI Civility and Respect Toolkit Pyramid of responses (Appendix 3). This will be embedded in the organisation through various interventions.
- As part of the regional Anti-racism Strategy agreed in July 2021, we will continue to work across the Cambridge and Peterborough system aiming to agree consistent messaging to the public, develop agreements with local police to ensure action is taken, staff feel safe and supported and that staff know how to and feel safe to report.
- Revision of “Protecting our staff against traumatic incidents policy” and “Bullying, harassment and incivility action plan”.

2.6 WRES Indicator 6: **Percentage of staff experiencing harassment, bullying and abuse from staff.**

- 22% of BME staff experienced harassment and bullying from compared to 17% of white staff completing the survey.

Action in 2021/22

- A range of anti-racism resources, videos, e-learning and webinars are available on the staff portals.
- Partnered with external organisation, BRAP, to deliver pilot workshop for teams in April 2022

Action for 2022/2023

- BRAP to deliver corporate master classes *Be Curious about Race* to equip leaders to be confident talking about race and be accountable for tackling racism in the workplace. This investment will be coupled with ensuing there are key performance indicators in addition to the WRES metrics, to measure the impact of the programme, with objective setting and agreed actions for leaders with action learning sets

2.7 WRES Indicator 7: Percentage of staff believing that the organisation provides equal opportunities for career progression

- 48% of BME staff believe there are equal opportunities for career progression or promotion at CUH compared to 61% of white respondents.
- The gap in experience between BME and white has reduced by 2% from a 15.5% difference in 2021.

Action in 2021/22

- As referenced in last year's Annual WRES report, Cambridge and Peterborough ethnic minority development programme has been developed by EDI leads, BME staff network chairs and alumni of locally delivered NHS Stepping up and Ready Now programme. Alumni BME Staff at CUH who attended these programmes attended mentoring training programme in 2021 and have taken on mentorship roles through Mentornet hosted by the East of England Leadership Academy and with uptake across the ICS.
- The Trust has appointed a Talent Lead to support talent management, learning and development with creation of a talent pools, advertising of stretch assignments and secondment opportunities
- In March 2022 Division E organised a career development webinar for BME staff with guest speakers. A repeat webinar being delivered in October for all BME staff. This work has been highlighted in the RCN Journal.

Actions 2022/2023

- Regularly audit recruitment processes and demonstrate transparency in vacancy advertising and selection methods.
- Develop career mentoring scheme to support BME colleagues career progression
- Partnering with the Tropical Health and Education Trust (THET) and Cambridge Global Health Partners (CGHP) as one of the means by which we will develop an inclusive and anti-racist culture.

2.8 WRES Indicator 8: Percentage of staff experiencing discrimination at work from manager or team

- 17% of BME staff reported they had experienced discrimination compared to 7% white staff
- This is worse compared to the previous year; 1% more BME staff have experienced discrimination and the gap between in experience between BME staff and white staff continues to widen.

Action in 2021/22

- The EDI team, Cultural ambassadors, staff network chairs and members, Trade Union colleagues and Freedom to Speak up Guardian (FGSG) work in collaboration to support colleagues to address issues of discrimination. Increasing the ethnic diversity of FTSUG listeners is important. The FTSG has attended the BME staff network to recruit listeners from the BME community.

Actions 2022/2023

- Cultural intelligence Master Classes for inclusive leadership rolled out to leaders across the organisation
- EDI and WRES Project Lead to co-ordinate corporate master classes *Be Curious about Race* to be delivered by BRAP.
- Promote quarterly attendance of the FTSUG at the BME Network meetings to update on trends of complaints/reports

2.9 WRES indicator 9: BME board representation as at 31st March 2022

- Since 2021 there has been an increase in BME board membership to two Non-Executive Directors
- There is one very senior manager (VSM) of a BME background
- Our Model Employer target that the national WRES team have set us is that BME Board membership should match the proportion of BME staff in post i.e. 1 in 4.

Actions 2022/2023

- Continue to work with skilled and experienced recruitment agencies to source potential candidates from diverse backgrounds when vacancies arise
- BME staff network leads to be invited to attend Board meetings
- Grow the capability of our own staff for talent management and succession planning.

3. Race Disparity Ratio

The national WRES team wrote to all Trusts in May 2022 to set out a new measure, our Race Disparity Ratio which has been calculated using our WRES 2021 data submission. This indicator has been used to benchmark Trusts across the country.

Definition: Race Disparity Ratio is the difference in proportion of BME staff at various Agenda for Change bands in a Trust compared to proportion of White staff at those bands. It is presented at three tiers;

- bands 5 and below ('lower')
- bands 6 and 7 ('middle')
- bands 8a and above ('upper')

Data sources and assumptions: The correlation to demographic profile and mix has not been considered in this calculation. This is on the basis that once recruited into an organisation, progression/promotion chances should be equally accessible to everyone. The lower the score the better. For CUH the published position is:

Non Clinical

- bands 5 and below ('lower') = 0.85 (22nd percentile nationally)
- bands 6 and 7 ('middle') = 1.75 (57th percentile nationally)
- bands 8a and above ('upper') = 1.49 (38th percentile nationally)

Clinical

- bands 5 and below ('lower') =2.53 (80th percentile nationally)
- bands 6 and 7 ('middle') = 1.78 (61st percentile nationally)
- bands 8a and above ('upper') = 4.51 (78th percentile nationally)

Cambridge University Hospitals NHS Foundation Trust
East of England

Summary for the 2020/21 reporting year RGT

Indicator number and description			Trust	East of England	National	Percentile rank*
Indicator 1: BME representation in the workforce by pay band						
	BME representation in the workforce overall		25.9%	23.9%	22.4%	
Pay band at which BME under-representation first occurs	Non-clinical	Band 4 and under	Proportional	Band 3	Band 3	
		Band 5 and over	Band 8A	Band 9	Band 8B	
	Clinical	Band 4 and under	Band 4	Band 3	Band 3	
		Band 5 and over	Band 6	Band 6	Band 6	
	Medical		Consultant	Consultant	Consultant	
Race disparity ratios	Non-clinical	Lower to middle	0.85	0.88	0.91	22%
		Middle to upper	1.75	1.07	1.39	57%
		Lower to upper	1.49	0.95	1.27	38%
	Clinical	Lower to middle	2.53	1.95	1.59	80%
		Middle to upper	1.78	1.38	1.36	61%
		Lower to upper	4.51	2.68	2.16	78%

*Ranks the trust from 0% (best in the country) to 100% (worst in the country on each indicator

Note: Awaiting report for submissions made for 2022

4. Key BME Staff Network activity in the past 12 months

The WRES implementation group, including the BME staff network has met at a minimum every month to ensure the WRES action plan has traction and engagement. Activities include:

- BME Network Chairs have been meeting with senior executives every 4-6 weeks to bring ideas together which will inform the strategy on antiracism
- Diverse Interview Panel members recruited by the previous Chair of the BME Staff network, Erica Chisanga, have been active in recruiting to posts for band 8a positions and above and all senior appointments including Divisional and Clinical Directors, Executive and Non-Executive Directors.
- Cultural Ambassadors have been informally mentoring BME staff as well as being involved in disciplinary pre action reviews to seek to eliminate cultural bias and ensure fair people management processes as part of a just and learning culture

Additional Key actions in WRES action plan in past 12 months

- Anti-racism introductory session hosted by BRAP April 2022. This is part of a suite of development programmes to align the organisation with the Antiracism Charter
- Bi- Monthly bespoke training has been held for DIP in order to grow the pool of DIPs and roll out their involvement in recruitment and selection at all bands in the organisation by 2028
- Two Webinars to raise awareness on learning opportunities and different strategies for career development for BME Nurses and Midwives hosted in March and October 2022.

- Allyship resources have been curated on the staff portal to educate staff on allyship skills.
- Cultural Intelligence (CQ) training to support leaders in developing their cultural competence and confidence in leading diverse teams delivered by Above Difference Team. These have been opened up to leaders at various levels in the organisation.
- Divisional engagement continues through the sharing of divisional WRES data and divisional WRES action planning and supporting with remedial actions.

5. Priorities for action for refreshed WRES action plan for a CUH anti-racism strategy

Our priorities for refreshing our WRES action plan with our BME staff network and leaders will continue to be informed by our WRES data and will also require focus on the following:

1. The Cambridge University Hospital NHS Trust East of England report has informed our proposed focus on the following three key areas:

    - Leadership and management
    - Talent and Career progression
    - Tackling racial harassment and abuse from patients and the public and staff

2. The *People Plan Operational Guidance 2021/22* sets out clear priorities for action to address inequalities and the development of WRES improvement plans under the strategic theme *Belonging in the NHS are:*

    - Enabling diverse staff to have a voice during the pandemic and continuing to support their development
    - Developing an inclusive and compassionate culture and addressing inequalities
    - Ensuring staff networks are able to influence and be prominent in decision making
    - Accelerating delivery of Model Employer leadership goals (WRES indicator 1)
    - Eliminating disciplinary ethnicity gap (WRES indicator 3)
    - Overhaul de-biasing recruitment and promotion processes

3. National WRES priorities for action are set out in

https://www.england.nhs.uk/wp-content/uploads/2021/02/Workforce-Race- Equality-Standard-2020-report.pdf

4. CUH Model Employer goals have been set for us by NHS England WRES team which are for 1 in 4 of all posts at all leadership positions by 2028 to be from Black, Asian and minority ethnic staff.

The Workforce and Education Committee, 20 September 2022, asked that further consideration be given to how the impact of actions, particularly training such as BRAP and Cultural Intelligence, is measured and reported. It was requested that, prior to action being taken, it is clearly articulated what the intended outcome is and how this will be measured, i.e. is it making a positive difference?

It was also recommended that further consideration be given to getting greater knowledge and real insight from those with a lived experience about how it feels to work at CUH. Also, to seek views from those with a lived experience as to what would really make a difference; are we focusing on the right areas and the right actions?

This feedback has been taken to the REACH network and also the WRES action group for consideration and action.

The success of our WRES action plan and our participation in the implementation of the regional anti-racism strategy will require all colleagues to be supportive and inclusive in their behaviour. We require all leaders to be accountable and responsible for creating an inclusive culture where racism and discrimination is not tolerated and action is taken to address racial harassment, micro-aggressions and incivility. Measures and targets to meet our Model Employer goals and with what are described as 'accountability nudges' by Roger Kline will be incorporated in our anti-racism strategy. We will continue to inform educate and support colleagues and leaders to be accountable. Our aim is to shift the current culture and improve the experience of work and opportunity for Black, Asian, minority, ethnic staff.

6. Next steps / future reports

6.1 The Board is asked to note that:

- The CUH WRES data has been submitted to NHS England in August 2022.
- Once approved by the Board, this report and accompanying action plan will be published on the Trust's website.

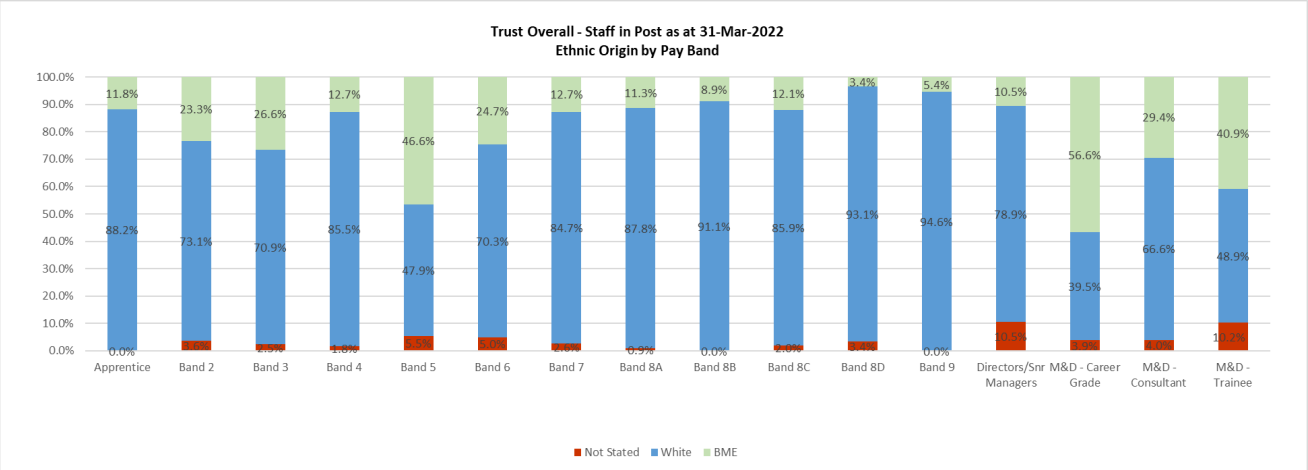
7. Recommendations

7.1 The Board of Directors is asked to:

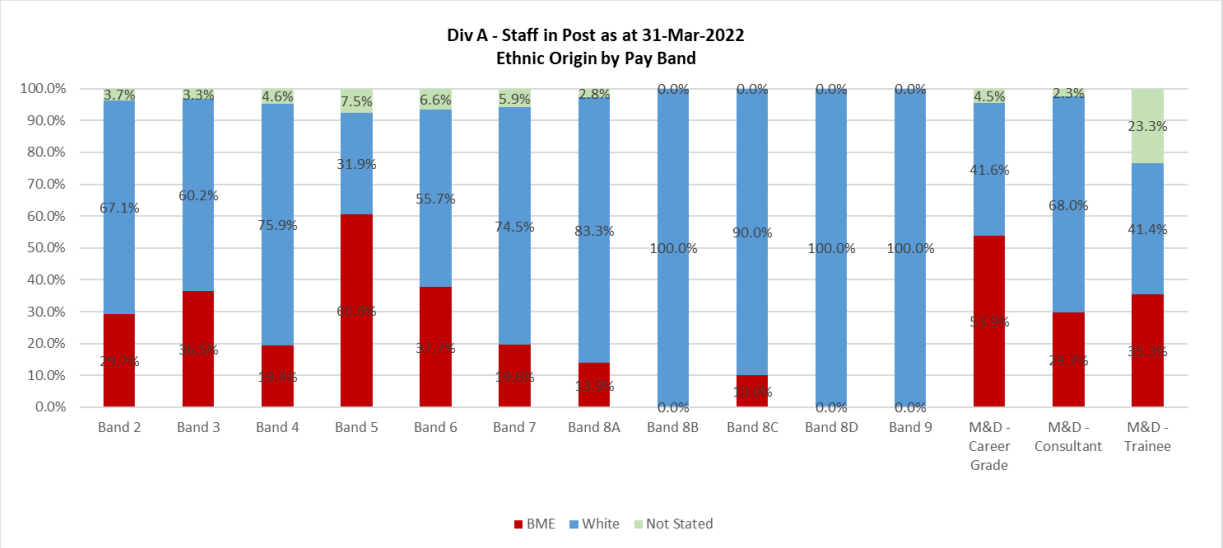
- Note and discuss the latest WRES dataset.
- Note and discuss the proposed refreshed WRES actions.
- Note and discuss the employer commitment to implementing the East of England Ant-racism strategy, tackling racism and discrimination to be an anti-racist organisation.
- Ensure their personal information on ESR is updated, including on ethnicity.
- Consider personal actions and commitment to progress race equality and inclusion at CUH as part of the broader inclusion agenda.

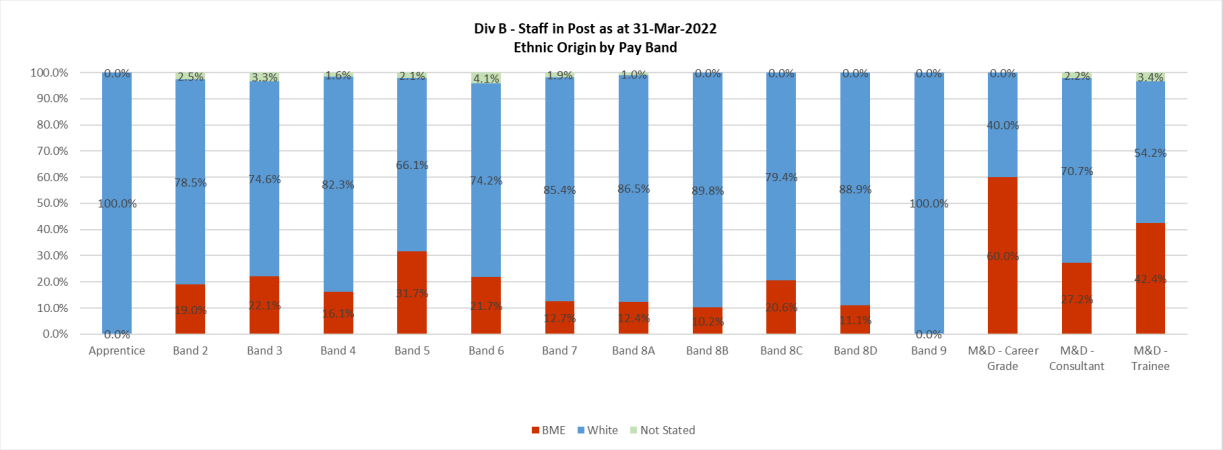
Appendix 1: Trust profile of staff in post as at 31 March 2022 by ethnicity, pay band and division

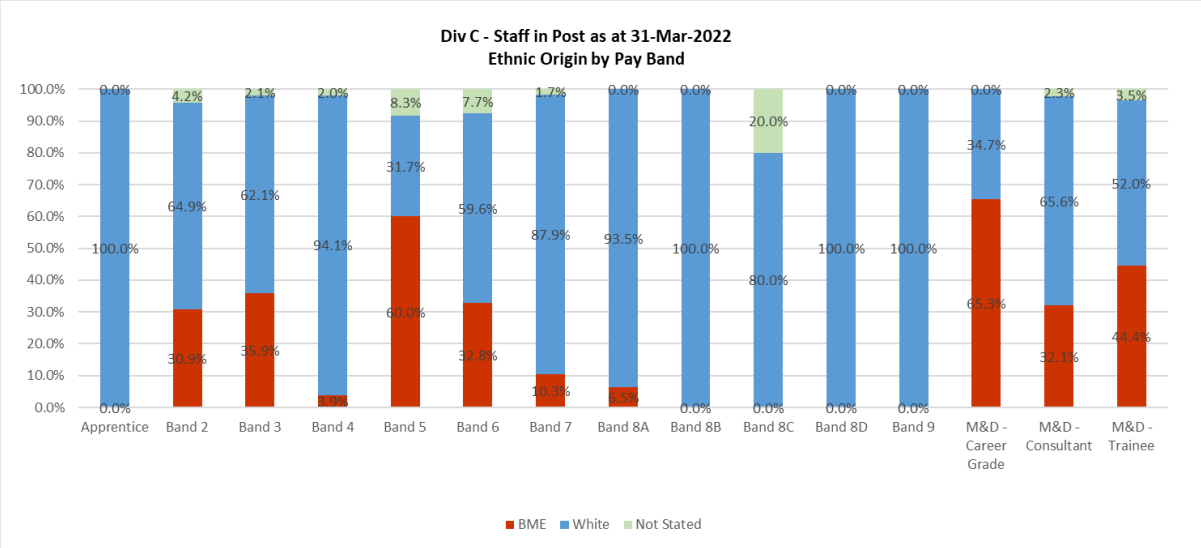
CUH Staff by pay Band and Ethnicity Trust wide and by division
As at 31st March 2022

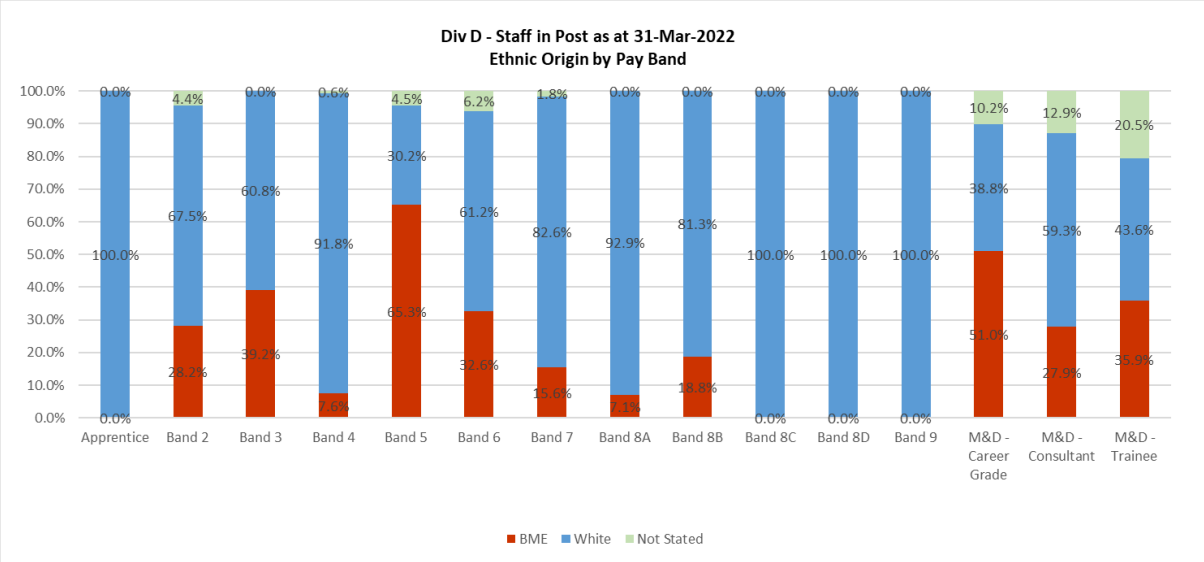


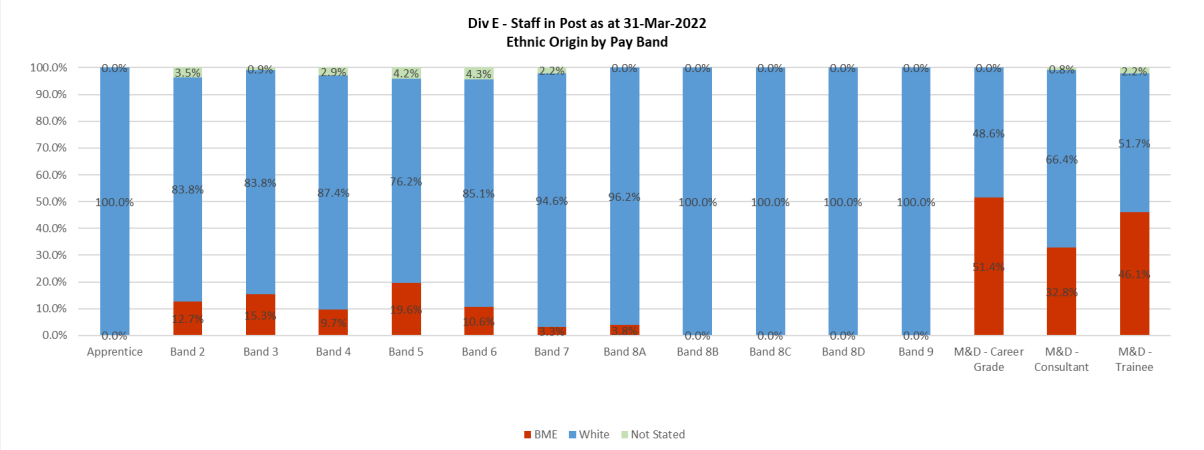
Trust Overall							
	HC			% of HC			Total HC
Pay band	White	BME	Not Stated	White	BME	Not Stated	
Apprentice	15	2	0	88.2%	11.8%	0.0%	17
Band 2	1020	325	50	73.1%	23.3%	3.6%	1395
Band 3	806	303	28	70.9%	26.6%	2.5%	1137
Band 4	796	118	17	85.5%	12.7%	1.8%	931
Band 5	1219	1184	140	47.9%	46.6%	5.5%	2543
Band 6	1344	472	95	70.3%	24.7%	5.0%	1911
Band 7	1176	176	36	84.7%	12.7%	2.6%	1388
Band 8A	404	52	4	87.8%	11.3%	0.9%	460
Band 8B	133	13	0	91.1%	8.9%	0.0%	146
Band 8C	85	12	2	85.9%	12.1%	2.0%	99
Band 8D	27	1	1	93.1%	3.4%	3.4%	29
Band 9	35	2	0	94.6%	5.4%	0.0%	37
Directors/Snr Manager	15	2	2	78.9%	10.5%	10.5%	19
M&D - Career Grade	14	16	1	39.5%	56.6%	3.9%	258
M&D - Consultant	502	222	30	66.6%	29.4%	4.0%	754
M&D - Trainee	418	406	78	48.9%	40.9%	10.2%	675
Grand Total	**8009**	**3306**	**484**	**67.9%**	**28.0%**	**4.1%**	**11799**


Div A - Staff in Post as at 31-Mar-2022
Ethnic Origin by Pay Band
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
3.7%
67.1%
3.3%
60.2%
4.6%
75.9%
7.5%
31.9%
6.6%
55.7%
5.9%
74.5%
2.8%
83.3%
0.0%
100.0%
0.0%
90.0%
0.0%
100.0%
0.0%
100.0%
4.5%
41.6%
2.3%
68.0%
23.3%
41.4%
Band 2
Band 3
Band 4
Band 5
Band 6
Band 7
Band 8A
Band 8B
Band 8C
Band 8D
Band 9
M&D - Career Grade
M&D - Consultant
M&D - Trainee
BME
White
Not Stated


Div B - Staff in Post as at 31-Mar-2022
Ethnic Origin by Pay Band
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
0.0%
100.0%
2.5%
78.5%
3.3%
74.6%
1.6%
82.3%
2.1%
66.1%
4.1%
74.2%
1.9%
85.4%
1.0%
86.5%
0.0%
89.8%
0.0%
79.4%
0.0%
88.9%
0.0%
100.0%
0.0%
40.0%
2.2%
70.7%
3.4%
54.2%
Apprentice
Band 2
Band 3
Band 4
Band 5
Band 6
Band 7
Band 8A
Band 8B
Band 8C
Band 8D
Band 9
M&D - Career Grade
M&D - Consultant
M&D - Trainee
BME
White
Not Stated


Div C - Staff in Post as at 31-Mar-2022
Ethnic Origin by Pay Band
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
0.0%
100.0%
4.2%
64.9%
30.9%
2.1%
62.1%
35.9%
2.0%
94.1%
3.9%
8.3%
31.7%
60.0%
7.7%
59.6%
32.8%
1.7%
87.9%
10.3%
0.0%
93.5%
6.5%
0.0%
100.0%
0.0%
20.0%
80.0%
0.0%
100.0%
0.0%
0.0%
100.0%
0.0%
0.0%
34.7%
65.3%
2.3%
65.6%
32.1%
3.5%
52.0%
44.4%
Apprentice
Band 2
Band 3
Band 4
Band 5
Band 6
Band 7
Band 8A
Band 8B
Band 8C
Band 8D
Band 9
M&D - Career Grade
M&D - Consultant
M&D - Trainee
BME
White
Not Stated


Div D - Staff in Post as at 31-Mar-2022
Ethnic Origin by Pay Band
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
0.0%
100.0%
4.4%
67.5%
28.2%
0.0%
60.8%
39.2%
0.6%
91.8%
7.6%
4.5%
30.2%
65.3%
6.2%
61.2%
32.6%
1.8%
82.6%
15.6%
0.0%
92.9%
7.1%
0.0%
81.3%
18.8%
0.0%
100.0%
0.0%
0.0%
100.0%
0.0%
0.0%
100.0%
0.0%
10.2%
38.8%
51.0%
12.9%
59.3%
27.9%
20.5%
43.6%
35.9%
Apprentice
Band 2
Band 3
Band 4
Band 5
Band 6
Band 7
Band 8A
Band 8B
Band 8C
Band 8D
Band 9
M&D - Career Grade
M&D - Consultant
M&D - Trainee
BME
White
Not Stated


Div E - Staff in Post as at 31-Mar-2022
Ethnic Origin by Pay Band
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
0.0%
100.0%
3.5%
83.8%
12.7%
0.9%
83.8%
15.3%
2.9%
87.4%
9.7%
4.2%
76.2%
19.6%
4.3%
85.1%
10.6%
2.2%
94.6%
3.3%
0.0%
96.2%
3.8%
0.0%
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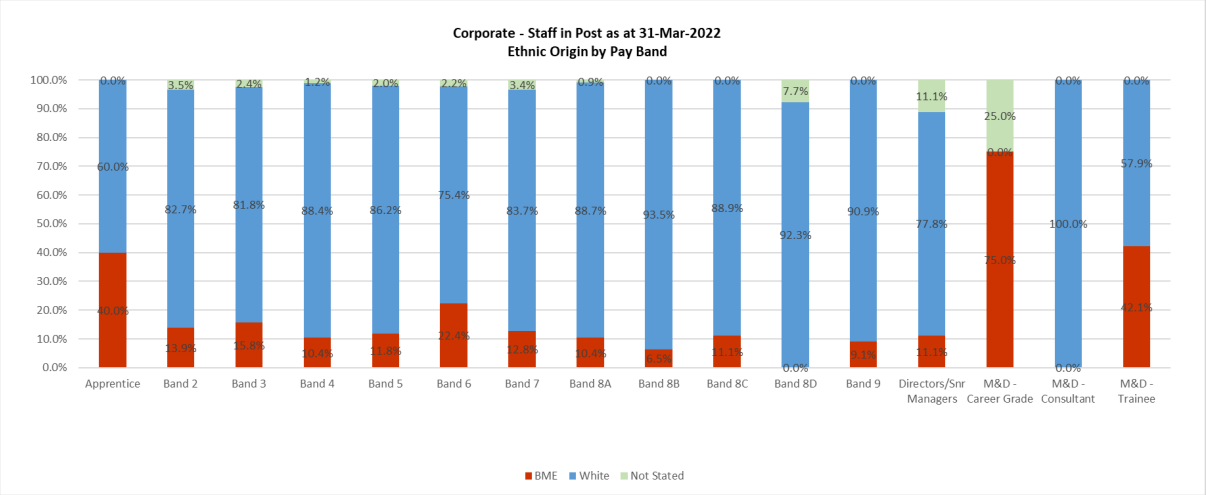
0.0%
48.6%
51.4%
0.8%
66.4%
32.8%
2.2%
51.7%
46.1%
Apprentice
Band 2
Band 3
Band 4
Band 5
Band 6
Band 7
Band 8A
Band 8B
Band 8C
Band 8D
Band 9
M&D - Career Grade
M&D - Consultant
M&D - Trainee
BME
White
Not Stated


Corporate - Staff in Post as at 31-Mar-2022
Ethnic Origin by Pay Band
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
0.0% 60.0% 40.0%
3.5% 82.7% 13.9%
2.4% 81.8% 15.8%
1.2% 88.4% 10.4%
2.0% 86.2% 11.8%
2.2% 75.4% 22.4%
3.4% 83.7% 12.8%
0.9% 88.7% 10.4%
0.0% 93.5% 6.5%
0.0% 88.9% 11.1%
7.7% 92.3% 0.0%
0.0% 90.9% 9.1%
11.1% 77.8% 11.1%
25.0% 0.0% 75.0%
0.0% 100.0% 0.0%
0.0% 57.9% 42.1%
Apprentice
Band 2
Band 3
Band 4
Band 5
Band 6
Band 7
Band 8A
Band 8B
Band 8C
Band 8D
Band 9
Directors/Snr Managers
M&D - Career Grade
M&D - Consultant
M&D - Trainee
BME
White
Not Stated

Appendix 2:

Proposed WRES Action Plan 2022/23

The key areas for focus for the WRES action plan for 2022/23 are:

1. Inclusive leadership and management
    I. Proportionate representation in senior roles and decision making
    II. Educating our leaders and supporting their commitment to antiracism
2. Equitable and inclusive talent management and clinical career progression
3. Protection of staff from Racial harassment and abuse from patients/public and colleagues

Priority 1 Leadership and management: i. Proportionate representation in senior roles and decision making

Objective	Current position	Action	Time scale	Lead
To meet model employer target of 1 in 4 proportionate representation of BME employees at all levels of the organisation	Under representation at senior level with majority of BME staff working at Band 6 and below (28%) As at 31 March Board 2 NEDS are BME	1. Audit of: • commitment to advertise all acting up and secondment opportunities across the organisation. • distribution of who is applying for senior roles and outcomes • Commitment to DIP involvement in all Band 8a+ leadership recruitment processes 2. .De-bias recruitment processes from attraction to implement NHS England No Tick Boxes recruitment guide 2.2 DIP involvement extended recruitment to Band 7 leadership roles 3. Implementation of exit interviews for "early in career" leavers to identify and address race disparities 4. Implementation of ethnicity pay gap report 5. Drill down Trust WRES data by division and corporate function. • Use Divisional WRES dashboard staff KPIs for each division and corporate sharing with Divisions and identify hot spots for focused action.	1.November 22 2.1 December 22 2.2 March 23 3. March 23 4. March 23 5. March 23	1. Head of Resourcing 2. Head of Resourcing 3. Assoc. Director of Workforce 4. Assoc. Director of Workforce 5. Assoc. Director of Workforce
Ensure our staff network is supported to thrive and is part of decision making processes	Networks well established but attendance/member-ship relatively low	1. Support BME Staff Network to thrive and relaunch as REACH network 2. Implementation of agreed processes for reasonable release time and back fill for network activity 3. Establishment of payment process of honorarium for co-chairs of network 4. Ensure staff network leads are involved in decision making and are invited to board meetings 5. Promote REACH Network representation at Divisional meetings, and report to WRES implementation group MSF and Board	1. October 22 2. September 22 3. April 23 4. April 23 5. April 23	1. Head of EDI 2. Director of HR 3. Director of HR 4. Director of Workforce 5. Head of EDI

Priority 1 Leadership and management ii. Educating our leaders and supporting their commitment to antiracism

Objective	Current position	Action	Time scale	Lead
Develop leaders' capability to lead inclusively with CQ™ Cultural Intelligence	Small number of masterclasses delivered. Reviewed very well.	1. Leading Inclusively with CQ™ phase 2 : 10 cohorts of masterclasses July – November 2022, embedded into leadership and line manager programmes 2. CQ™ session for Board members 3. Review our people management processes with a CQ™ and an antiracist lens	1. March 23 2. March 23 3. March 23	1. Head of EDI 2. Head of EDI 3. Associate Director of Workforce
Support our leaders to understand racism, it's impact and their role in accelerating change Learn about allyship and become antiracists	Reverse mentorship scheme in place at Board level. BRAP masterclass pilot undertaken. Further development work in progress	1. Recruit second cohort to Reverse mentoring scheme expansion for Board and senior divisional leaders triumvirate 2. *Be Curious About Race* masterclasses with BRAP for leaders and line manager programmes to equip leaders to be confident talking about race and be accountable for tackling racism in the workplace	1. December 23 2. February 23	1. Head of EDI 2. WRES Project Lead

Priority 2 Talent and Career Development

Objective	Current position	Action	Time scale	Lead
To address the under representation of BME staff in senior clinical roles by respective Divisions	2020/2021-25.9% of staff from BME Background. The race disparity ratio was at 4.51	1. Include cross cultural understanding in nurse, midwife and AHP induction and career development work: in Qualified Practitioner and HCSW programmes	1. December 22	1. Head of Education
		2. Promote and facilitate access to educational funding opportunities using Cultural Intelligence CQ™ and monitor applications for FLAG funding by protected characteristics to establish gaps	2. December 22	2. Head of Education & Associate Director Workforce
		3. Advertise and promote positive action programmes such as Stepping up and Ready Now	3. October 22	3. Interim Associate Director of Leadership and OD
		4. Introduce career mentoring scheme for BME staff ,training BME staff in senior roles to be career mentors	4. December 22	4. WRES Project Lead
		5. Promote Talent Toolkit and career maps with deliberate reference to international work experience	5. January 23	5. Talent Lead
		6. Celebrate staff role models	6. November 23	6. WRES Project Lead
		7. Partner with Tropical Health and Education Trust (THET) and CGHP as development opportunities for diaspora staff	7. March 23	7. Head of Cambridge Global Health Partnerships

Priority 3 Protection of staff from racial harassment and abuse from patients, public and colleagues

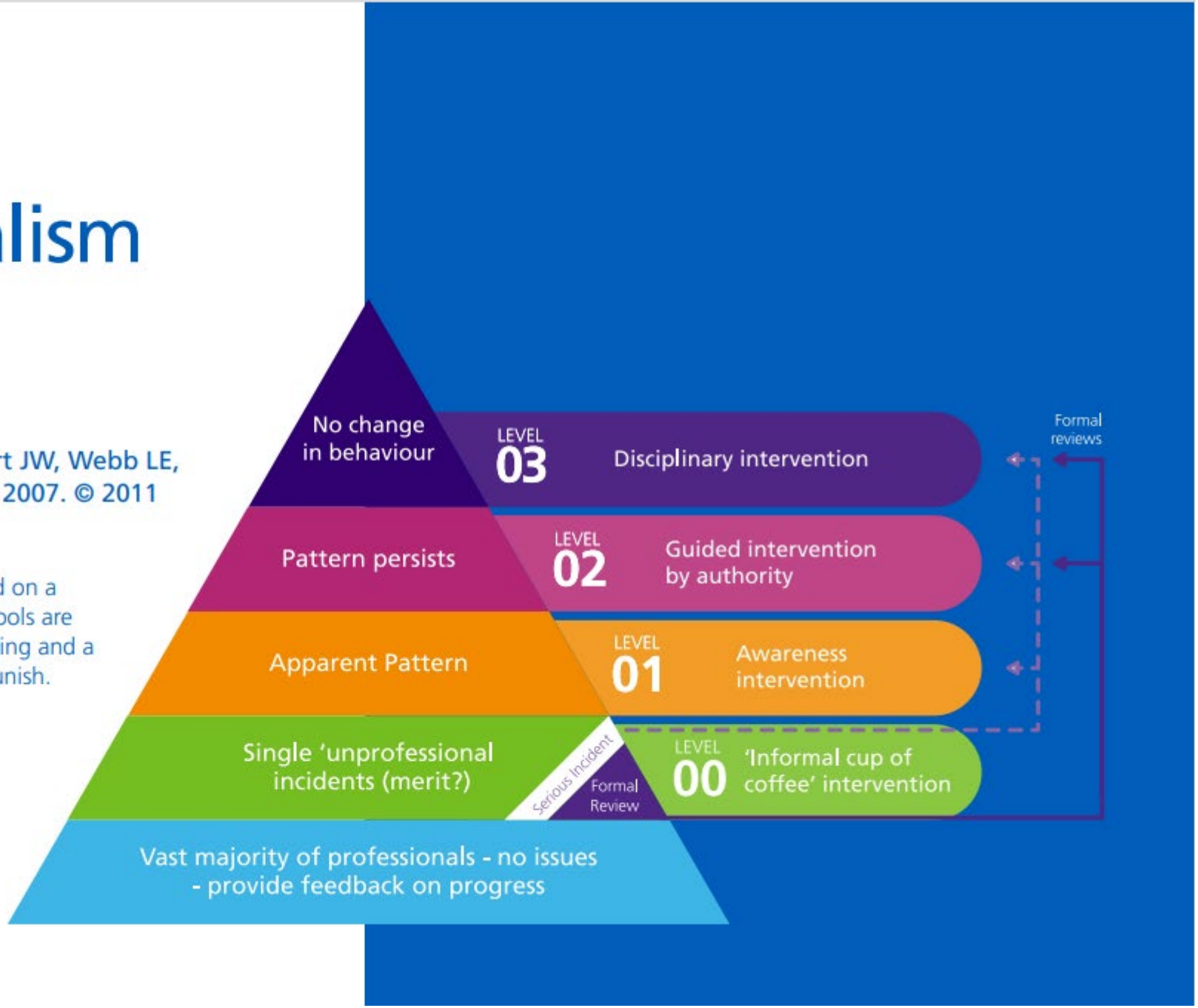
Objective	Current position	Action	Time scale	Lead
To reduce percentage experiencing harassment abuse from patients and provide support to staff with mechanisms to raise concerns	WRES Indicator 5 1% BME 1% more likely than white colleagues experiencing racial harassment and abuse from patients and public. 24% BME Staff Vs 23% White Staff (White other category are more likely than White British to report abuse WRES indicator 6 BME staff are 5% more likely than white staff to have experienced harassment and abuse from colleagues	1. Joint work across ICS to promote Zero tolerance campaign through ICS task force 2. CEO message to our staff at corporate induction i.e. Trust will take action against Patients/Public 3. Launch of “Kindness and respect” campaign. 4. Revision of “Protecting our staff against traumatic incidents policy” & “Bullying, harassment and incivility action plan” with staff network 5. Sign up to the Halo Collective to prevent hair discrimination 6. Provide signposting to culturally competent counselling services for staff experiencing racism	1. December 22 2. October 22 3. December 22 4. December 22 5. December 22 6. March 23	1. To be confirmed 2. Associate Director of Workforce 3. Communications Team 4. Director of Workforce 5. Head of EDI 6. Associate Director of Workforce
Create psychologically safe environments and support our staff to speak up when they experience racism and take swift action		1. Escalation of serious concerns, including hate crimes, to police or via legal processes. 2. Increase diversity of FTSUG listeners 3. Promote and signpost staff experiencing discrimination and harassment to sources of support including Cultural Ambassadors and REACH network	1. October 22 2. December 22 3. January 23	1. Head of Trust Security 2. FTSUG 3. Associate Director of Workforce

Figure 1:

Promoting professionalism pyramid

Adapted from Hickson GB, Pichert JW, Webb LE, Gabbe, SG. Acad Med November 2007. © 2011 Vanderbilt University

The approaches in this toolkit are based on a supportive and corrective stance. The tools are intended to bring about an understanding and a change behaviour, not to blame and punish.



Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 9 November 2022

Agenda item	13.2
Title	Workforce Disability Equality Standard (WDES) annual report 2022
Sponsoring executive director	David Wherrett, Director of Workforce
Author(s)	Monica Jacot, Head of Equality Diversity and Inclusion Elisse Grint, EDI Project Manager
Purpose	To receive the WDES progress report and action plan.
Previously considered by	Workforce and Education Committee, 20 September 2022

Executive Summary

This paper sets out the latest annual Workforce Disability Equality Standard (WDES) metrics and report for CUH.

In summary, the Trust has improved on 3 of the ten WDES metrics since 2021 (metrics 1, 2 and 6). Metric 4 comprises four component parts, two of which have improved. There has been a worsening in the position for metrics 3, 5, 7, 8, 9 and 10.

The report provides an update on each of the areas of the WDES action plan, and requests action from the Board in a number of areas to progress disability equality and inclusion at CUH.

Related Trust objectives	Improving patient care, Supporting our staff
Risk and Assurance	Mandated in the NHS contract and considered by the CQC
Related Assurance Framework Entries	BAF ref: 008
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 and discuss the WDES metrics, changes from 2021 and the engagement of staff with disabilities, health conditions and neuro-differences.
- Note that the WDES position set out in this paper sits alongside the Trust’s overarching commitment to workforce inclusion across a range of protected characteristics.
- Agree the updated action plan and this report for publication on the CUH website.
- Align this work with other Trust priorities to ensure everything we do contributes to a fairer and more inclusive place to work for all staff, taking best practice from priorities such as: current race equality discussions; the Trust’s approach to bullying, harassment and violence in the workplace; recruitment and resourcing; just and learning culture.
- Ensure their personal information on ESR is updated, including disability status.
- Consider personal actions and commitment to progress disability equality and inclusion at CUH as part of the broader inclusion agenda.

Cambridge University Hospitals NHS Foundation Trust

9 November 2022

Board of Directors
Workforce Disability Equality Standard annual report 2022
David Wherrett, Director of Workforce

1. Introduction

1.1 This paper sets out the latest annual Workforce Disability Equality Standard (WDES) metrics and report for CUH, now in its fourth year. While progress has been made in some areas, the results highlight the continued disparity of experience for our staff with disabilities, health conditions and neurodifferences compared to those without, with these gaps in experience increasing in many cases. Appendix 1 provides background and context to the WDES.

1.2 The WDES is a key part of the CUH workforce commitment to inclusion: we will strive to drive out inequality, recognising we are stronger as an organisation which values difference and inclusion.

1.3 A note on language: the term 'disabled staff' is used throughout this report to refer to anyone with a disability, long term health condition or neurodifference that is protected under the Equality Act 2010. This is in line with the language used throughout WDES, and based on self-reporting through ESR or the National Staff Survey. It should be noted that many of these staff will not consider themselves 'disabled' and caution should be used in applying this term to individuals. 'Non-disabled' is used throughout the report to refer to anyone who does not have a disability, long term health condition or neurodifference, according to their ESR or National Staff Survey response.

2. WDES Metrics for 2022

2.1 There are ten metrics within the WDES that highlight and examine the inequalities between disabled and non-disabled staff. Appendix 2 shows full WDES metrics on a slide deck.

2.2 In summary, there is an improvement in the position against 3 of the ten metrics since 2021:

- Metric 1: percentage of disabled staff compared with overall workforce
- Metric 2: relative likelihood of being appointed from shortlisting. Non-disabled and disabled applicants are equally as likely to be appointed after shortlisting
- Metric 6: percentage of staff saying they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties (very slight improvement).

2.3 Metric 4, regarding bullying, harassment or abuse from patients and service users, managers and other colleagues, comprises four component parts, two of which have improved.

2.4 There has been a worsening in the position for 6 of the ten metrics

- Metric 3: relative likelihood of entering the formal capability process. Disabled staff are 6.5 times more likely to enter the formal capability procedure than non-disabled staff.
- Metric 5: percentage of staff believing that the Trust provides equal opportunities for career progression or promotion
- Metric 7: percentage of staff saying they are satisfied with the extent to which their organisation values their work
- Metric 8: percentage of staff saying their employer has made adequate adjustments to enable them to carry out their role
- Metric 9a: staff engagement score
- Metric 10: difference between the Board voting membership and its overall workforce.

2.5 The Trust has and continues to take action to ensure the voices of disabled staff are heard and acted upon in the organisation. (Staff engagement, Metric 9b: Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?). The following areas of staff engagement are highlighted:

- The CUH Purple Network has been active since December 2019, currently under the leadership of Glynn Rolland and Nonte Mfefa. The Purple Network is for staff with any visible or invisible disability, physical or mental health condition or neurodifference, as well as anyone with an interest in equality and inclusion in this area.
- The network works alongside its executive sponsor, Ewen Cameron, Executive Director of Improvement and Transformation. Ewen provides a direct link between the network and the Board.
- Members of the Purple Network are invited to attend the WDES Implementation Group, and the committee are invited to attend the Equality, Diversity and Dignity Steering Committee.
- The WDES action plan was originally co-produced with members of the Purple Network, and the network continues to shape priorities and work streams. The network benefits from a number of passionate and committed individuals who are generous with their time and are involved in various projects over and above their usual role in the Trust. The most recent WDES metrics have been shared with and discussed at Purple Network meetings during the spring of 2022.
- The Purple Network is often used as a consultative mechanism, with members asked to share their views on a number of significant areas, including the refresh of the CUH strategy and development of the Cancer Research Hospital.

- The Trust also has an Open Minds network (previously called Time to Change) chaired by Abbie Jarvis and Chris Folkard, which campaigns specifically against mental health stigma and for mental health awareness. Staff from the Open Minds Network are actively involved in the Trust's health and wellbeing plans.
- The Purple Network have launched 'disability champions', with the aim of providing a specific point of contact and shared lived experience for individuals living with particular health conditions or disabilities, as well as being able to improve awareness and raise systemic issues. Disability champions have been involved in supporting communications around particular awareness days and weeks that relate to the relevant health condition or disability.
- Members of the network have been instrumental in shaping a number of the areas included below in section 3.
- Ongoing work focusing on neurodiversity has seen more than 40 staff involved in focus groups, 1:1 discussions or sharing their experiences and ideas via email and sharing staff stories to co-create a Neurodiversity Guide hub now on our public website.
- The Trust is a member of PurpleSpace, a professional development organisation for disability network leaders. Members of the network have access to the resources and materials available through the Purple Space website hub. There is opportunity to attend their 'Networkology' workshops, already attended by a number of network members.
- A number of disabled staff are 'Freedom to Speak Up Listeners', offering support to staff who want to raise concerns about work and don't feel able to speak to or access other sources of support. Disabled staff are also represented among our trade union stewards and workplace representatives.
- Plans for additional cohorts of reverse mentors are underway, which will include members of the Purple Network mentoring senior leaders.

3. WDES Action Plan progress

The WDES action plan 2019-22 agreed by the Board in November 2019 and subsequently in November 2020 and November 2021 has been updated for 2022 and is provided in Appendix 3.

3.1 **Improve staff sharing of disability/health condition at commencement of employment and during their career at CUH**:

- The latest workforce information data shows that 4.2% (498) of staff have recorded that they have a disability on ESR, with 0.2% (29) actively stating they prefer not to say and 17.4% (2,052) unknown. This is an improvement from 3.4% with a recorded disability in March 2021, and 20.4% unknown. 20.5% of CUH respondents to the 2021 NHS staff have identified as having a long-term condition or illness – up from 17% in 2020.

- Reminders continue to be shared through communication channels for staff to update their equality information on ESR, with links to FAQs about why this information is collected and what happens to it.
- The Board have been asked to ensure their own ESR profiles are up to date; seven members (39%) of the Board are yet to complete this information and currently have 'unknown' currently recorded against their disability status on ESR. Board members are requested to update their disability status and other equality information on ESR to role model this to the organisation.
- A number of staff stories from disabled staff continue to be developed and shared, helping to create a culture where disability and difference is celebrated and is openly discussed.

3.2 **Improve recruitment of disabled staff to CUH and reduce gap between disabled and non-disabled staff with regards appointment from shortlisting**:

- Non-disabled staff are now 1.01 times more likely to be appointed from shortlisting than disabled staff – this is considered to demonstrate no adverse effect.
- The Recruitment Services team continue to aim to ensure that imagery and communications and promotional materials is representative of disabled staff. Information about EDI including staff networks and the Purple Passport are included on the careers microsite.
- All adverts now include wording about welcoming applications from a wide range of people, and invitation to interview letters specifically mention the offer of reasonable adjustments to enable candidates to perform at their best at interview.

3.3 **Review management of sickness and performance management processes**

- The Head of Employee Relations is committed to improving not just the data but also the experience of staff being supported through the performance management process, as well as other HR processes. Discussions have taken place with the Purple Network and with individuals who were invited to share their experiences, with their feedback having prompted changes to the processes and scripts used within Employee Relations. The standard template letters are also being reviewed to ensure a compassionate and inclusive approach.

3.4 **Improve culture, understanding and empathy so disabled staff feel supported to tackle bullying, harassment and abuse:**

- Bullying, harassment and abuse are not unique to CUH but rather evident across the whole NHS, and this is consistently higher for individuals with certain protected characteristics. CUH continually

strives to be a fairer and more inclusive organisation where all staff feel valued and where there is a culture of belonging and empathy.

- This work is multifaceted and does not sit solely within the WDES, although work specifically on disability awareness and confidence contributes to overall culture change and aligns to work being undertaken by the Security Lead, Chief Nurse and Workforce teams as well as the excellent work many teams and individuals are doing.
- Where staff raise concerns via the Purple Network or directly to the EDI team, they are supported and action taken to address those concerns. This is often undertaken in collaboration with the Employee Relations team, Freedom to Speak Up guardian and Occupational Health teams.

3.5 **Improve disability awareness, confidence and ensure inclusive communication:**

- Following discussion with the Purple Network and WDES Implementation Group, two further pilot disability awareness sessions were held in July 2022. Members of the Purple Network volunteered to attend both in order to help evaluate which is most suitable to take forward.
- The new neurodiversity guide and resources, co-produced with more than 40 staff, were launched in Neurodiversity Celebration Week in March 2022, including a 08:27 panel discussion with four neurodivergent members of staff. A communications plan is being developed to continue momentum and build on this throughout the rest of the year.
- Key stakeholders from across the Trust have taken part in a 'discovery workshop' with neurodiversity specialists Lexxic, who have developed a roadmap to support CUH in becoming more neuro-inclusive. This will inform the WDES action plan to ensure neurodiversity is included throughout. A neurodiversity working group consisting workforce representatives and neurodivergent colleagues has been set up to meet with Lexxic every 6 weeks to ensure traction of neurodiversity action plan
- The Communications team and EDI team continue to work to curate additional stories of disabled and neurodiverse staff as part of My CUH Story and other work streams.

3.6 **Improve accessibility of training**:

- Discussions are ongoing with the DOT team and education teams to ensure that staff have the option to request and are fully supported with any reasonable adjustments that they might need to attend training that is bookable through DOT.

3.7 **Develop processes that improve access and implementation of recommended adjustments to support employment at CUH:**

- The Occupational Health team are leading on the development of the new Workplace Adjustments Service, which went live with a soft launch in June 2022. This provides a centralised budget and process for workplace adjustments to be requested and actioned promptly. Adjustments that involve, for example, changes to working patterns or hours, will remain the responsibility of the line manager.
- The Purple Passport continues to be a useful tool to support an open conversation to create a shared understanding about any health conditions, disabilities or neurodifferences and the support an individual requires to enable them to perform well.

3.8 **Address accessibility of buildings and the campus environment:**

- External audits either by *AccessAble* (formally called *Disabled Go*) or another provider on behalf of Estates and facilities to go out to tender when possible to do so.

3.9 **Launch disability/lived experience network**:

- The Purple Network continues to provide a safe space for disabled staff and to act as a mechanism to ensure disabled staff voices are heard and acted upon across CUH. Members of the Purple Network have been directly involved in shaping and influencing many of the work streams mentioned so far.
- The network continues to work with Ewen Cameron, Executive Director of Improvement and Transformation, as their executive sponsor. Thank you to Ewen for his commitment to the network and to inclusion for our disabled staff, for amplifying the voices of disabled staff to the Board and Management Executive, and to continuing to develop his own understanding of the lived experience of disability.

4. WDES key priorities for 2022/23

4.1 Continue to support the Purple Network to grow and develop, with active involvement in the WDES action plan alongside the network's own priorities, with the support of Ewen Cameron as executive sponsor.

4.2 Promote and embed the new Workplace Adjustments Service and ensure this is well communicated, with regular review points to learn and improve.

4.3 Develop a disability awareness training proposal with a robust evaluation strategy including measures of performance and measures of effectiveness. Training will be targeted at areas that would benefit most.

4.4 Continue to develop resources and staff stories focused on neurodiversity, improving the organisational understanding of neurodiversity and the

strengths and talents that neurodivergent people bring to their teams.

4.5 Use the roadmap and implement the action plan generated by neurodiversity specialists Lexxic with Workforce leads and neurodivergent colleagues towards becoming a neuro-inclusive organisation.

4.6 Work alongside the Employee Relations team to review sickness and performance management processes, in collaboration with the Purple Network.

4.7 Encourage disabled staff to become Diversity and Inclusion Panellists and reverse mentors.

4.8 Continue to share staff stories, talk openly about and increase understanding of disability, health conditions and neurodifferences to develop a culture where staff feel comfortable and confident to share their personal experiences, including recording this on ESR.

4.9 Continue to support and influence the anti-bullying, harassment and abuse action plan.

4.10 Review Disability Confident membership and identify outstanding actions to achieve Level 3 Leader status.

4.11 Review the 2019-22 action plan during 2022 and co-produce a refreshed action plan with the Purple Network.

The Workforce and Education Committee, 20 September 2022, asked that further consideration be given to how the impact of actions, particularly training interventions, is measured and reported. It was requested that, prior to action being taken, it is clearly articulated what the intended outcome is and how this will be measured, i.e. will this make a positive difference?

It was also recommended that further consideration be given to getting greater knowledge and real insight from those with a lived experience about how it feels to work at CUH. Also, to seek views from those with a lived experience what would really make a difference; are we focusing on the right areas and the right actions? A piece of work will be undertaken using qualitative and quantitative data to understand perceptions and feelings of disabled and non-disabled staff relating to Metrics 4-9.

This feedback has been taken to the Purple network and also the WDES action group for consideration and action.

5. Next steps / Future reports

5.1 The Board is asked to note that:

- The CUH WDES 2022 dataset and accompanying narrative has been submitted to NHS England in August 2022.
- Once approved by the Board, this report and accompanying action plan will be published on the Trust's website.

6. Recommendations

6.1 The Board is asked to:

- Note and discuss the WDES metrics, changes from 2021 and the engagement of staff with disabilities, health conditions and neuro-differences.
- Note that the WDES position set out in this paper sits alongside the Trust's overarching commitment to workforce inclusion across a range of protected characteristics.
- Agree the updated action plan and this report for publication on the CUH website.
- Align this work with other Trust priorities to ensure everything we do contributes to a fairer and more inclusive place to work for all staff, taking best practice from priorities such as: current race equality discussions; the Trust's approach to bullying, harassment and violence in the workplace; recruitment and resourcing; just and learning culture.
- Ensure their personal information on ESR is updated, including disability status.
- Consider personal actions and commitment to progress disability equality and inclusion at CUH as part of the broader inclusion agenda.

Appendix 1

Background and context to the Workforce Disability Equality Standard; definitions, language and underpinning principles

1 The WDES was introduced in the NHS as an evidence-based tool to compare the workplace and career experiences of disabled and non-disabled staff, leading to robust action, monitoring and evaluation to support positive change and a more inclusive environment for disabled people working and applying to the NHS.

2 At a national level, the evidence clearly highlights that many disabled staff continue to experience inequality in the workplace when compared to their non-disabled colleagues. This provides the first year on year analysis of progress for disabled staff.

3 Under the Equality Act 2010, a person is 'disabled' if they have a physical or mental impairment that has a 'substantial' and 'long term' negative impact on their ability to do normal daily activities.

- 'Substantial' means more than minor or trivial, for example taking longer to complete a daily task.
- Long term means lasting or expected to last 12 months or more.

4 This definition covers a broad range of conditions, impairments or disabilities, visible and invisible, including but not exclusive to: heart disease, musculoskeletal conditions, lung or respiratory conditions, stroke, mental health conditions, sensory impairments, progressive and fluctuating conditions, auto-immune conditions, developmental or learning disabilities, HIV, cancer, some injuries and neurodiversity.

5 Nationally, data from the Office for National Statistics in September 2018 tells us that 22% of the working age population has a disability, the vast majority of whom do not use a wheelchair or any other visible aid. 83% of people acquire their disability, impairment or condition in adulthood, which for many will be during their working lives.

6 It is estimated that by 2030, 40% of the working age population in the UK will have at least one chronic health condition or disability; this does not currently include the effects of long Covid.

7 Many people who are 'disabled' under the Equality Act do not consider themselves to be disabled or may use other language to describe themselves. This report refers to 'disabled staff' or 'staff with disabilities, health conditions and neurodifferences' as shorthand, while recognising that this may not be how people talk about themselves.

8 Our disabled staff work in a broad range of roles across the Trust, at all levels of seniority and across all staff groups.

9 Questions about disability or health conditions are asked differently at various stages of the employee journey:

a) When applying for a role at CUH through NHS Jobs, candidates are asked the following question:

‘Under the Equality Act 2010 the definition of disability is if you have a physical or mental impairment that has a 'substantial' and 'long-term' adverse effect on your ability to carry out normal day to day activities. Further information regarding the definition of disability can be found at: www.gov.uk/definition-of-disability-under-equality-act-2010. Reasonable adjustments will be made available should you be invited to interview.
According to the definition of disability do you consider yourself to have a disability?’
Candidates can select from ‘Yes’, ‘No’ or ‘I do not wish to disclose whether or not I have a disability'.

b) On the MyESR portal, staff navigate to the ‘Disability Information’ section under ‘Personal Information’, where they can search through categories to add a disability or health condition at any stage of their employment.

c) In the NHS Staff Survey, the question is posed as follows:
‘Do you have any physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more?’
Staff can select from ‘Yes’ or ‘No’.

10 Underpinning principles: The WDES is underpinned by the social model of disability, the ethos of ‘Nothing About Us Without Us’ and the concept of ‘Disability as an Asset’, which is advocated by Disabled people and disability rights organisations.

- The social model of disability recognises that Disabled people face a range of societal barriers, including buildings and estates, limited job and career opportunities, working environment and attitudinal challenges from colleagues and the public. It is these barriers, rather than an individual’s impairment or long-term condition, which create disability.

- The ethos of ‘Nothing About Us Without Us’ means that any actions or decisions that affect Disabled people should be informed by the views of Disabled people. It is therefore vital that our Disabled staff are involved with the WDES and have co-produced the action plan, through the CUH Purple Network.

- The concept of ‘Disability as an Asset’ refers to the benefits of employing Disabled staff and the positive impact that disability inclusion can have in the workplace. We are striving to create a culture where people can speak openly and positively about disability, bringing their lived experience into work. Disabled staff are visible and feel supported.

Appendix 2:

WDES Metrics(2022)

Monica Jacot, Head of EDI

September 2022

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
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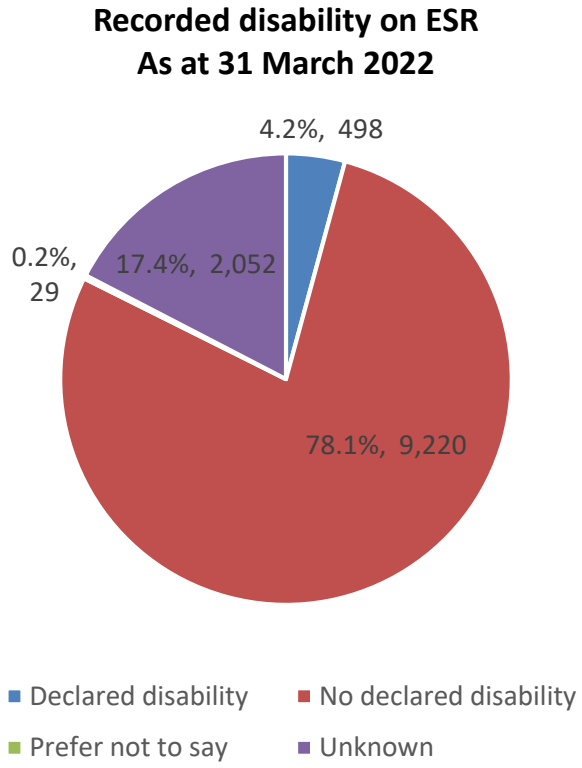
Metric 1

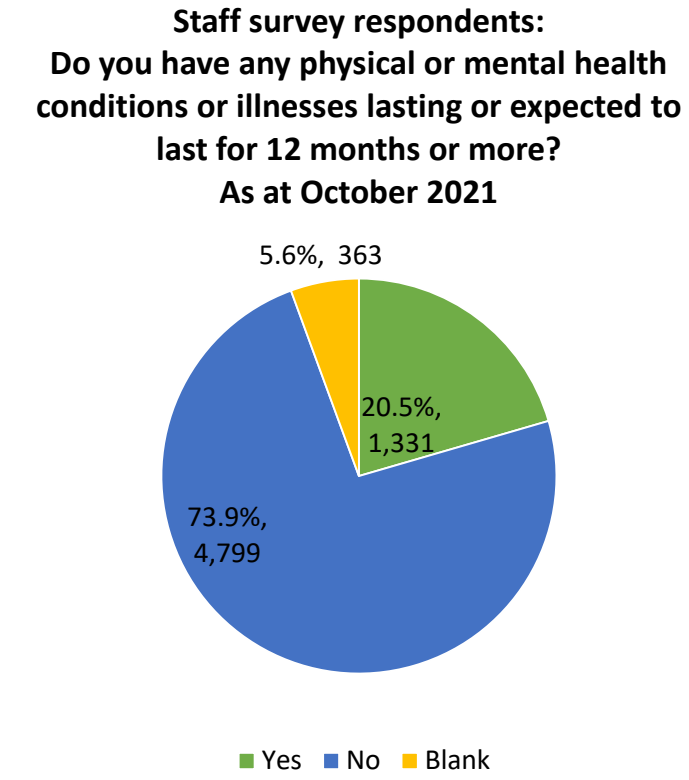
% of disabled staff compared with % in overall workforce



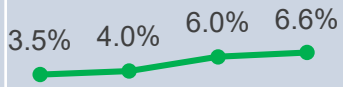
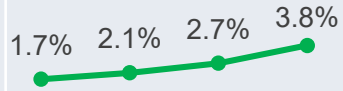
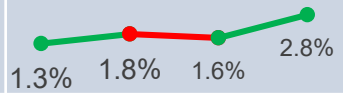
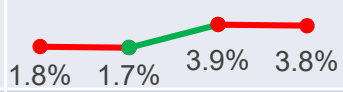
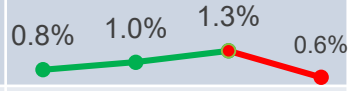
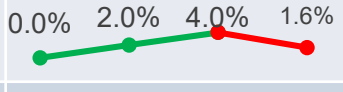
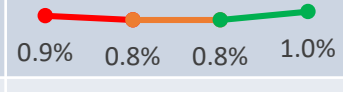
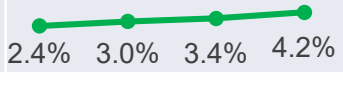
4.2% of staff have recorded a disability on ESR – an increase from 3.4% in 2021

0.2% prefer not to answer

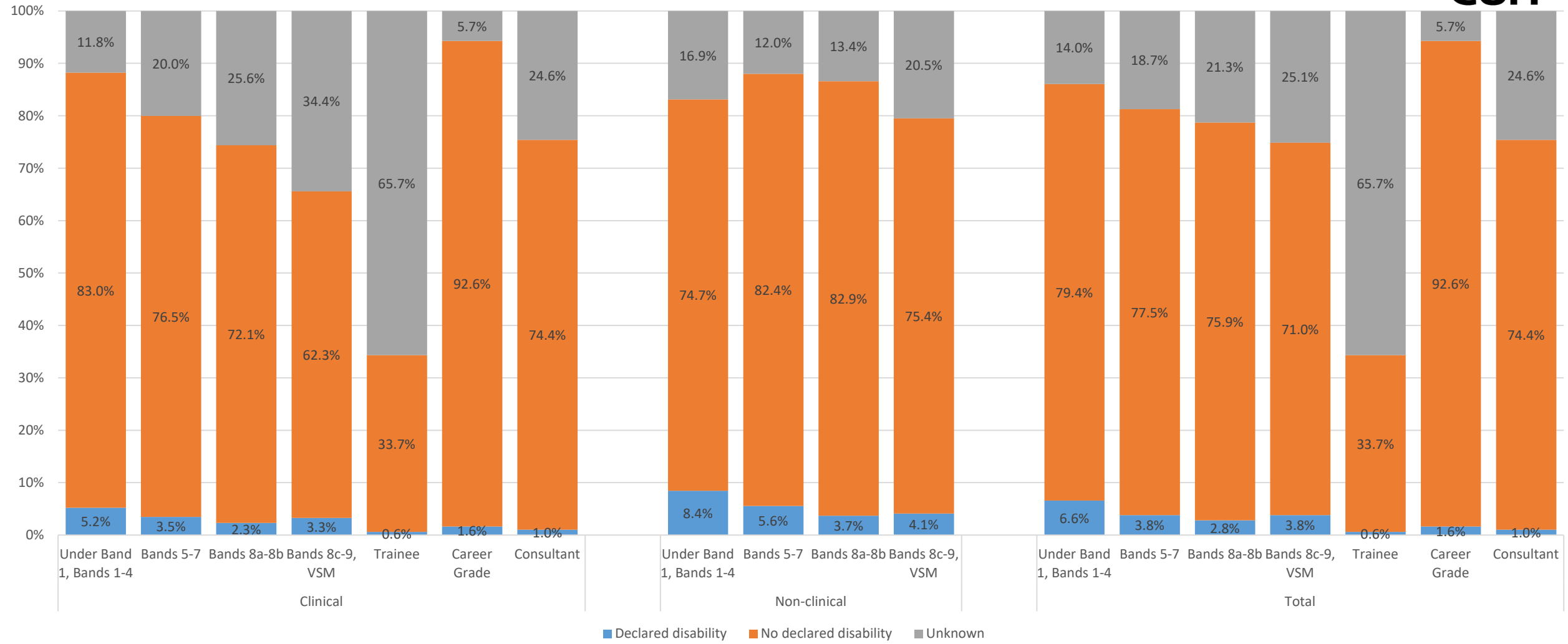
17.4% unknown (blank) – down from 20.4% in 2021



20.5% of respondents have a long-term condition or illness – up from 17% in 2020

Staff who have recorded a disability	2019	2020	2021	2022	Change 2021-22	Trend
Cluster 1: Under Band 1, Bands 1-4	3.5%	4.0%	6.0%	6.6%	+0.6%	
Cluster 2: Bands 5-7	1.7%	2.1%	2.7%	3.8%	+1.1%	
Cluster 3: Bands 8a-8b	1.3%	1.8%	1.6%	2.8%	+1.2%	
Cluster 4: Bands 8c-9 & VSM	1.8%	1.7%	3.9%	3.8%	-0.1%	
Trainee	0.8%	1.0%	1.3%	0.6%	-0.7%	
Career grade	0.0%	2.0%	4.0%	1.6%	-2.4%	
Consultant	0.9%	0.8%	0.8%	1.0%	+0.2%	
Overall	**2.4%**	**3.0%**	**3.4%**	**4.2%**	**+0.8%**	

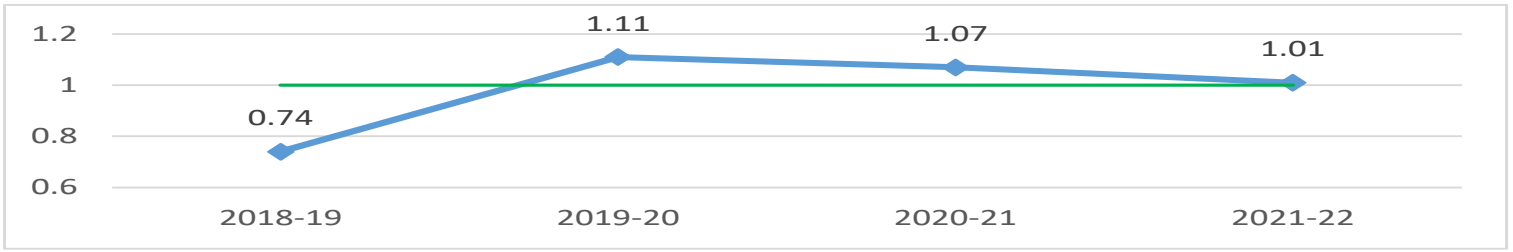
% of disabled staff compared with % in overall workforce
Clinical, non-clinical and total by payband clusters
As at 31 March 2022



Metric 2

Relative likelihood of non-disabled staff compared with disabled staff being appointed from shortlisting across all posts

	2018-19	2019-20	2020-21	2021-22	Change
Medical				0.56	
Non-medical				0.96	
Overall	0.74	1.11	1.07	1.01	



In 2021-22, non-disabled staff were 1.01 times **more likely** to be appointed from shortlisting than disabled staff.

7.1% of shortlisted applicants and 6.5% of successful applicants recorded that they have a disability.

NB: 6 medical shortlisted applicants recorded a disability, 5 of whom were appointed.

Metric 3

Relative likelihood of disabled staff compared with non-disabled staff entering the formal capability process

(Two year rolling average)

	2017-19	2018-20	2019-21	2020-22	Change
Medical				0 cases	
Non-medical				5.87	
Overall	6.03	4.75	4.01	6.58	tbc

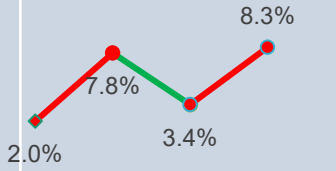
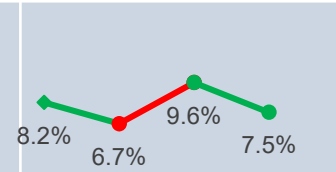
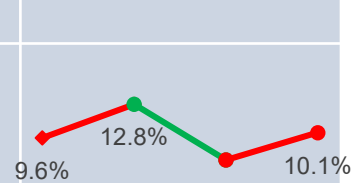
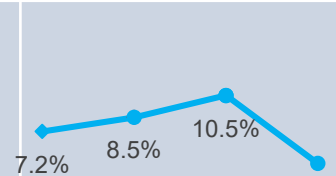
In 2020-22, disabled staff were 6.58 times **more likely** than non-disabled staff to be entered into the performance management process.

NB: this is calculated from 48 cases where 11 staff had recorded a disability.

Metric 4

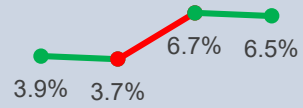
a) % of disabled staff compare to non-disabled staff experiencing harassment, bullying or abuse from: i) patients/service users; ii) managers; iii) other colleagues

b) % of disabled staff saying last time they experienced harassment, bullying or abuse at work, they or a colleague reported it

		2018	2019	2020	2021	Change 2020-21	Gap in experience 2021 | trend
% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Staff with a LTC or illness	26.6%	33.2%	26.5%	29.9%	+3.3%	8.3% 
	Staff without a LTC or illness	24.6%	25.4%	23.1%	21.6%	-1.6%	
% of staff experiencing harassment, bullying or abuse from manager in last 12 months	Staff with a LTC or illness	18.8%	17.2%	19.8%	15.7%	-4.1%	7.5% 
	Staff without a LTC or illness	10.6%	10.5%	10.2%	8.2%	-2.0%	
% of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months	Staff with a LTC or illness	27.8%	32.6%	26.8%	26.0%	-0.8%	10.1% 
	Staff without a LTC or illness	18.2%	19.8%	19.3%	15.9%	-3.4%	
% of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	Staff with a LTC or illness	50.0%	53.4%	54.6%	48.5%	-5.9%	4.3% 
	Staff without a LTC or illness	42.8%	44.9%	44.1%	44.2%	+0.1%	

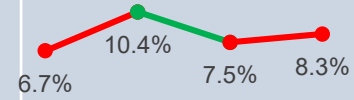
Metric 5

% of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion

		2018	2019	2020	2021	Change 2020-21	Gap in experience 2021 | trend	
% of staff who believe that their organisation provides equal opportunities for career progression or promotion	Staff with a LTC or illness	79.9%	82.1%	79.5%				
	Staff without a LTC or illness	83.8%	85.8%	86.8%				
	Staff with a LTC or illness	*The calculation methodology for this question changed in 2021. 2020 data has been adjusted to allow for comparison*		54.0%	52.6%	-1.4%	6.5%	
	Staff without a LTC or illness			60.7%	59.1%	-1.6%		

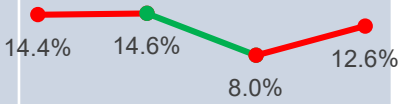
Metric 6

% of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

		2018	2019	2020	2021	Change 2020-21	Gap in experience 2021 | trend	
% of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Staff with a LTC or illness	25.9%	28.8%	28.0%	27.9%	-0.1%	8.3%	
	Staff without a LTC or illness	19.2%	18.4%	20.5%	19.6%	-0.9%		

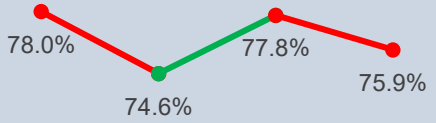
Metric 7

% of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work

		2018	2019	2020	2021	Change 2020-21	Gap in experience 2021 | trend
% of staff satisfied with the extent to which their organisation values their work	Staff with a LTC or illness	40.1%	40.0%	44.3%	35.4%	-8.9%	12.6% 
	Staff without a LTC or illness	54.5%	54.6%	52.3%	48.0%	-4.3%	

Metric 8

% of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work

	2018	2019	2020	2021	Change	Trend
% of staff with a LTC or illness saying that their employer has made adequate adjustment(s) to enable them to carry out their work	78.0%	74.6%	77.8%	75.9%	-1.9%	

Metric 9a

Staff engagement score for disabled staff, compared to non-disabled staff

		2018	2019	2020	2021	Change 2020-21	Gap in experience 2021 | trend	
Staff engagement score (0-10)	Staff with a LTC or illness	6.9	6.9	6.8	6.6	-0.2	0.0	
	Staff without a LTC or illness	7.3	7.3	7.3	7.1	-0.2		

Organisation engagement score: 7.0 (-0.2)

Metric 10

% difference between the organisation's Board voting membership and its overall workforce:

i) By voting members of the Board

ii) By Executive membership of the Board

		2019	2020	2021	2022	Change 2021-22
Voting membership of the Board	Recorded disability	0.0%	0.0%	6.3%	0.0%	-6.3%
	No recorded disability	33.3%	41.2%	75.0%	64.7%	-10.3%
	Unknown	66.7%	58.8%	18.8%	35.3%	+16.5%
Executive membership of the Board	Recorded disability	0.0%	0.0%	0.0%	0.0%	----
	No recorded disability	50.0%	54.5%	87.5%	80.0%	-7.5%
	Unknown	50.0%	45.5%	12.5%	20.0%	+7.5%
Overall workforce	Recorded disability	2.4%	3.0%	3.4%	4.2%	+0.8%
	No recorded disability	69.8%	73.4%	75.9%	78.1%	+2.1%
	Unknown	27.8%	23.6%	20.6%	17.6%	-3.0%

None of the current Board have recorded a disability.

Percentage difference between the overall Board membership, executive membership and voting membership and the overall workforce is therefore -4.2%

Appendix 3: Refreshed WDES Action Plan 2022- 2024

Priority area : Reasonable adjustments 1/2

Objective	Gap to address	Actions	Owner	Timescale
Improve staff sharing of disability/health condition at commencement of employment and during their career at CUH	WDES metric1 4.2% (498) staff recorded disability on ESR, compared with 20.5% (1,331) of staff survey respondents is low	Campaign to promote benefits of sharing disability status on ESR Senior Leaders role model and share their status on ESR Communication campaign - when and how to use *My ESR* for recording	Head of EDI Associate Director of Workforce Associate Director of Workforce	December 2022 December 2022 December 2022
Ensure staff with a disability LTC or illness have reasonable adjustments in place	WRES indicator 8: 75.9 % of CUH staff with a LTC or illness say that their employer has made adequate adjustment(s) to enable them to carry out their work	Fully launch, promote & embed the new centralised Workplace Adjustments Service that was launched in June 2022 and ensure this is well communicated. Launch campaign to promote Purple Passport	Occupational Health Head of EDI	December 2022 December 2022

Priority area : Reasonable adjustments 2/2

Objective	Gap to address	Actions	Owner	Timescale
Ensure staff with a disability LTC or illness have reasonable adjustments in place (Cont)	WDES indicator 8: 75.9 % of CUH staff with a LTC or illness say that their employer has made adequate adjustment(s) to enable them to carry out their work	Accessibility of training: • improve accessibility and adjustments for training and development opportunities • Provide access to hearing loops and other relevant equipment LMS DOT booking registration schedules record adjustments needed for delegates	Learning and Development Head of DOT	March 2023 March 2023
Ensure workplace premises are accessible		Accessibility audit of premises commissioned and improvement action plan developed Signpost and provide support to disabled staff with applications for Blue Badge with briefing sessions	Estates and Facilities Estates and Facilities With Purple Network	March 2023 March 2023

Priority area : Career progression

Objective	Gap to address	Actions	Owner	Timescale
Improve recruitment of Disabled staff to CUH and reduce gap between Disabled and non-disabled staff	WDES metric 2 Non-disabled staff 1.1 times more likely to be appointed from shortlisting than Disabled staff Less likely to be in senior roles WDES Metric 5 52.6% of disabled staff who believe that their organisation provides equal opportunities for career progression or promotion	Review Recruitment processes and communications to include proactive offer of support and adjustments at interview, and importance of sharing personal characteristic information De-biasing the recruitment process, particularly through a disability and neurodiversity lens, to include a review of the information available on the Careers microsite and communications.	Head of Resourcing Head of Resourcing	March 2023 March 2023
Improve accessibility of training and development	Metric 5 above	Accessibility of training: improve accessibility and adjustments for training and development opportunities	Head of Learning and Development	March 2023

Priority area: Creating a supportive inclusive culture

Objective	Gap to address	Actions	Owner	Timescale
Rollout of new disability awareness training		Develop a disability awareness training proposal with a robust evaluation strategy including measures of performance and measures of effectiveness. Training to targeted at areas who would benefit most	Head of EDI team with Purple Network	March 2023
Review sickness and performance management processes	Metric 6 27.9% staff with LTC disability cp 19% non disabled, who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Review sickness Management process including implementation of NHS Employers guidance on Disability leave Review performance management processes and undertake Equality Impact Assessment	Interim Head of Employee relations with Purple Network Interim Head of Employee relations with Purple Network	March 2023 March 2023

Priority area: Creating a supportive inclusive culture

Objective	Gap to address	Actions	Owner	Timescale
Support Purple Network to thrive	All WDES metrics Metric 9a Staff engagement score Disabled staff is 6.6 which is lower then non-disabled staff 7.1 Trust Staff engagement score is 7 (0-10)	Celebrate Disability History month	The Purple Network	December- annually
		Support Purple network, Open Mind Network and Neurodiversity staff group to thrive and be a voice for disabled staff, to shape WDES action plan and involved in decision making. Refresh committee role descriptions and terms of reference	Head of EDI team with Purple Network	Ongoing
		Implement time off arrangements facilities for network chairs and secretaries	Head of EDI team with Purple Network	September 2022
		Introduce Honorarium for network co-chairs	Head of EDI team with Purple Network	March 2023
		Embed governance arrangements of staff network	Head of EDI team with Purple Network	September 2022

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

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Report to the Board of Directors: 9 November 2022

Agenda item	14
Title	Report on multi-professional Education, Learning, Development and Training
Sponsoring executive director	David Wherrett, Director of Workforce
Author(s)	Sanjay Ojha, Post Graduate Medical Director Gary Parlett, Head of Education: Nursing, Midwifery and Allied Health Professionals Karen Clarke, Associate Director of Workforce
Purpose	To provide the Board of Directors with an update on education, learning, training and development across CUH
Previously considered by	Management Executive, 3 November 2022

Executive Summary

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

Related Trust objectives	Improving patient care, Supporting our staff
Risk and Assurance	Inadequately trained staff Inability to recruit and retain staff Inability to develop shortage skills and staff
Related Assurance Framework Entries	Health Education England, Quality framework for education
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

9 November 2022

Board of Directors

Report on Multi-professional Education, Learning, Development and Training

David Wherrett, Director of Workforce

1. Introduction/Background

1.1 This paper provides an update on multi-professional education, learning and development at CUH; its purpose is to provide information about a number of key developments, against the Trust's priorities, since the last report to the Board in July 2022.

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

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

This report focusses on three themes 1, 2 and 6

Dr Sanjay Ojha will attend the Trust board meeting as the new Director for Post-Graduate Medical Education. Dr Ojha will describe his role, ambition and challenges for PGME, focussing on the of the PGME sections of this report.

The July Board report included for the first-time information regarding undergraduate medical education at CUH provided by Dr Ruchi Sinnatamby, Clinical Sub Dean for CUH. Dr Sinnatamby had planned to attend the November board but she has had to delay until March, 2023 where she will provide a focus on undergraduate medical education.

2. Review of the Trust's multi-professional education, learning and development strategy

The Trust's Multi-professional Education, Learning and Development group (MPELDG) met on 1 October, 2022. It welcomed Dr Rushi Sinnatamby as a

new member of the group and Sub Dean for CUH and Dr Sanjay Ojha, Director for Post-Graduate Medical Education replacing Arun Gupta.

The group undertook a review of the Trust's multi-professional education, learning and development strategy. It was agreed that the strategy should retain its current eight themes as they continue to provide a good framework to articulate and shape the multi-professional education, learning and development at CUH over the coming years. Using this structure the group will ensure that the specific areas of work aligns with the trust's overall strategy and the Cambridge & Peterborough's System priorities. Further drafts of the strategy will be developed and consulted upon with key stakeholders.

3. Theme 1: Good learning experience for all students/learners

3.1 CUH provides a range of formal learning experiences for a range of staff including undergraduate and postgraduate students who spend time with the Trust as part of formal education/rotation programmes. This element of strategy sets out our ambition to consistently seek to improve the experience of the 'learner' and provide an excellent leaning experience, specifically for those who come to CUH as part of a formal training programme

HEE Provider Self-Assessment (SA) return

CUH completed the annual HEE Provider Self-Assessment return; for the first time this is now multi-professional to include all professional registered professions. The SA is a process by which organisations carry out their own quality evaluation against a set of HEE standards. The Trust is awaiting feedback on the self-assessment.

3.2 Post Graduate Medical Education

3.2.1 GMC Trainee Survey

The trust has received the results of the GMC survey 2022, with the 660 doctors in training at CUH invited to complete the survey. The General Medical Council (GMC) national training survey is an annual survey to better understand the quality of medical education and training in the UK from the experience of the learner - the survey asks all doctors in training for their views about the training they are receiving.

The GMC use red and green colour coding to highlight results that are significantly above or below the average to help identify areas for investigation. Positive (green) outliers represent scores in upper quartile nationally. Negative (red) outliers represent scores in the lowest quartile nationally.

A comparison between the 2022 to the 2021 data showed a positive trend in the number of red outliers, down from 70 red outliers in 2019, to 37 in 2021 and 29 in 2022. The majority of these outliers are in the domains of: workload (5), regional teaching (4), rota design (3) and adequate experience (3). The

specialties with three or more red outliers are Obstetrics and Gynecology (5) Ophthalmology (3).

There was a reduction in the number of green outliers (positive indicators), to 23 in 2022, compared to 29 in 2021. The majority of the green outliers are in the domains of: local teaching (4), clinical supervision out of hours (3) and facilities (3). Specialties with 4 or more green outliers are: Neurology (7), Emergency Medicine (5).

Comparison with Shelford Group Rankings: CUH ranked fifth (out of 10) for overall satisfaction, up from 6th place in 2021. The Trust ranked 5th for the number of red outliers, and 10th (worst) for the number of green outliers.

The attached paper (Appendix 1) provides a summary of the results.

Actions: The survey findings have been disseminated via Faculty Groups/Education Committee, with focused information gathering from service/education leads for departments with any red flags. The Medical Director and Director of Medical Education will be meeting with department specialty leads with more than 1 red flag to identify root causes and establish action plans.

3.2.2 SuppoRTT (Supported Return to Training) and LTFT (less than full time training)

The SuppoRTT and LTFT Champion continues to offer monthly virtual drop in sessions for these trainees. Training courses have been delivered including ones on well-being, resilience and procedural skills. Feedback from the attendees has been positive. We have been awarded funding from the SUPPORTT innovation fund to run these courses again next year. We are also pleased to have also been awarded funding to run a new course for surgical trainees as there were no specific SUPPORTT courses currently for this group of trainees. We are hoping to work with the regional Surgical Training Programme Directors to set this course up.

3.3. Non-medical pre-registration student placements

3.3.1 Pre-registration student placement experience

Students undertaking clinical placements within nursing and midwifery clinical areas have been invited to complete a newly developed online placement evaluation survey at the end of their clinical placement. The tool is designed to assess a number of areas including overall placement experience, learning culture and the quality of education provided whilst within the organisation. The placement evaluation survey captures both numerical data and narrative responses which are then analysed by the Clinical Education Team.

Early data from nursing and midwifery students indicates high levels of satisfaction with placements across the organisation with over 84% reporting that their experience of the learning culture across the organisation is either positive (39.8%) or highly positive (44.6%).
Positive themes emerging from narrative survey responses include: opportunities to work across the multidisciplinary team; high levels of support provided by nursing staff; opportunities to access a wide range of learning opportunities.

Areas for development are focused on the following themes; challenges of having to complete academic tasks whilst undertaking placement; busyness of clinical areas thus reducing time for bedside teaching and adjusting to working shifts.

Going forward, the non-medical placement evaluation survey will be used for all non-medical students undertaking placements across the organisation in order to capture ongoing trends in relation to non-medical placement satisfaction.

The outcomes from the evaluation tool will be reported to the Workforce and Education Committee and included in CUH Board reports and form the basis of improvement plans for each professional group.

3.3.2 Students nurses applying for Band 5 professional positions at CUH

Traditional undergraduate programmes

CUH is keen to ensure that students undertake placements at CUH go on to take up roles with us or with system partners. Student tracking undertaken by HEIs is weak, with very limited data on employment patterns and first destination on graduation.

From trust data, for the last cohort (September) of ARU and UEA adult branch nursing students (undertaking traditional undergraduate programmes) 11 of the 33 students chose to work at CUH. For the Children's nursing branch, 16 students undertook a final placement at CUH with 8 (50%) choosing to work at CUH. (It should be noted that changes to Health Education England Commissioning in 2017 and removal of student bursaries resulted in lower numbers of student nurses being recruited by universities in that year and graduating in this year. In response to national campaigns to increase nursing numbers, CUH has provided a higher number of student placements over the past 2 years.).

In response to the COVID-19 pandemic, universities moved programmes to online delivery. This resulted in a high proportion of students moving back to their home addresses across the UK returning only to undertake clinical placements and mandatory skills lectures. Choosing to live at their usual home address avoided students having to pay year-long accommodation costs. Students are therefore only seeking accommodation when they are undertaking

placements, the cost of which is reimbursed. However, it is understood that the resultant impact of this on our workforce is that many students then go on to commence employment close to their usual home address which is often much less costly than living in the Cambridge locality.
The introduction of a £5,000 Government grant to assist student nurses with living costs from September 2020 onwards has however seen an increase in the number of student nurses on programme but the impact of this from a workforce perspective will not be evident until September 2023.

In early 2023 there will be a review of the numbers of students that have undertaken placements at CUH and how many then go on to work CUH or with our system partners. This work will be undertaken in collaboration with university partners and system colleagues. We are keen to understand the factors that influence choice of employer at the end of training programmes to ascertain if there are further actions CUH can take to attract and retain.

CUH Nursing Apprentices to Registered Nurse programme

The number of CUH staff undertaking the BSc Nursing degree amounted to 120 between April, 2018 to November 2022; 108 successfully completed their programmes, 10 are on intermit (break in studies); the majority have joined later cohorts. Two apprentices left. The current conversation from apprentice to registered nurse for those that completed during this period is 90%.

4. Theme 2: Sustainable continuous professional development and multi-disciplinary learning

4.1 Non-Medical Qualified Practitioner Orientation (QPO) Programme

The QPO programme is undertaken by all newly recruited Registered Nursing and Midwifery and Operating department practitioner colleagues during their first week of employment with the Trust.

This six day programme plays a key role in the orientation of new colleagues thus facilitating a comprehensive introduction to the organisation. A broad range of speakers from across the organisation deliver sessions on the progamme.

A recent review of the QPO programme has recently been undertaken which identified a need to offer a more comprehensive programme which covers a broader range of subject areas including fundamentals of care which include nutrition and end of life care. The review process involved seeking feedback from staff who had undertaken the programme along with feedback from practice development colleagues and specialist teams across the organisation.

The revised QPO programme will be evaluated on a continuous basis; findings will be reported to Nursing and Midwifery Allied Health Professionals Advisory Committee and Workforce and Education Committee.

4.2 Support for welcoming and developing international nurse recruits

International Nurse/Midwife Recruitment

This is on trajectory with 256 international nurses joining CUH since January 2022. A summary of international arrivals to date for 2022 against targets is outlined below:

International Nurses	
2022 Overall Target	**Year-to-date arrivals for Jan – October 2022**
285	256 (This includes 6 nurses who joined CUH from the Lebanon as part of the NHSE/I 'Refugee Nurse Project)'.

International Midwives	
Total arrivals since January 2022	**Overall target for 2022**
15	27

4.3 Support for Internationally Recruited Nurses, Midwives and AHPs

The Clinical Education Team continue to provide a high level of support to internationally recruited nurses and midwives. This support is provided from the point of arrival, throughout the teaching programme which prepares colleagues for the examination in order to register with the Nursing and Midwifery Council and after registration. In order to further enhance the support provided to overseas colleagues, the Clinical Education Team have recently appointed an Integration and Pastoral Care Coach. This role will play a pivotal role with integration in UK healthcare practice and provide practical support with matters such as housing and integration into the local community.

5. Theme 6: Modern fit for purpose education facilities and resources

5.1 Simulation Centre

The board has been informed in previous papers about the collaboration with GigXR a Californian Tech company to develop immersive, extended reality training tools. Co-production of Mixed Reality scenarios with holographic patients are nearly complete. The first product is due to launch in late autumn.

The Centre has enrolled in an HEE six-week Virtual Reality pilot for doctors in training. The Centre will receive five headsets and some resources to help explore their potential usefulness in an educational context.

5.2 The Cambridge Digital Health and Surgical Training Centre

CUH has entered into a leasehold agreement with Marshalls for the 'Digital Health and Surgical Training Centre' to be relocated to "The Cambridge Quorum", Barnwell Road, Cambridge. The lease is for the lower and ground floors of the Quorum. Funding has been secured for the surgical training Centre, located on the ground floor, with funding still to be secured for the Digital Health Centre on the first floor. The Digital Health Centre will include an Extended Reality (XR) Hub, which will have immersive learning technologies including virtual reality (VR), augmented reality (AR) and mixed reality (MR). These technologies extend reality by adding to or simulating the real world through digital materials that learners can interact with. The first floor will also have seminar rooms and a simulation suite. An initial design has been prepared, and we are awaiting a costing for the work.

The design of the surgical training centre has been signed off by the team, and it is expected that the refurbishment of the space will be completed around the end of April 2023.

6. Recommendations

6.1 The Board is asked to receive the report.

Appendix 1:

2022 GMC Survey Results

Cambridge University Hospitals NHS Foundation Trust

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Context – Impact of covid on training:

- Loss of educational opportunities – “craft” specialities especially (Surgery; Anaesthetics; Procedure-intensive)
- Reduced outpatient training - limited clinic space
- Change in outpatient training – transition from face-to-face consultations to remote consultations.
- Increased workload
- Increased risk of Trainee / Trainer Burnout

GMC survey - Indicators for trainees

Questions are based around distinct themes, or, ‘indicators’, which are as follows:

- Overall Satisfaction
- Clinical Supervision
- Clinical Supervision OOH
- Reporting systems
- Workload
- Teamwork
- Handover
- Educational governance
- Educational supervision
- Supportive environment
- Induction
- Adequate experience
- Curriculum coverage
- Feedback
- Local teaching
- Regional Teaching
- Study Leave
- Rota design

GMC survey - Indicators for trainers

Questions are based around distinct themes, or, ‘indicators’, which are as follows:

- Supportive environment
- Support for trainers
- Curriculum coverage
- Time for training
- Resources for trainers
- Trainer development
- Rota design
- Educational governance
- Handover
- Work load
- Overall satisfaction
- Burnout

Additional question areas (not indicators in the reporting tool)

- Working Less Than Full Time
- Undergraduate teaching responsibilities

National Findings:

- >67,000 doctors in training and trainers completed the survey.
  - 76% of trainees
  - 34% of trainers

- 75% Trainees rate workplace training as good / very good
- 87% Trainees describe clinical supervision as good / very good
- 90% Trainers enjoy this role.

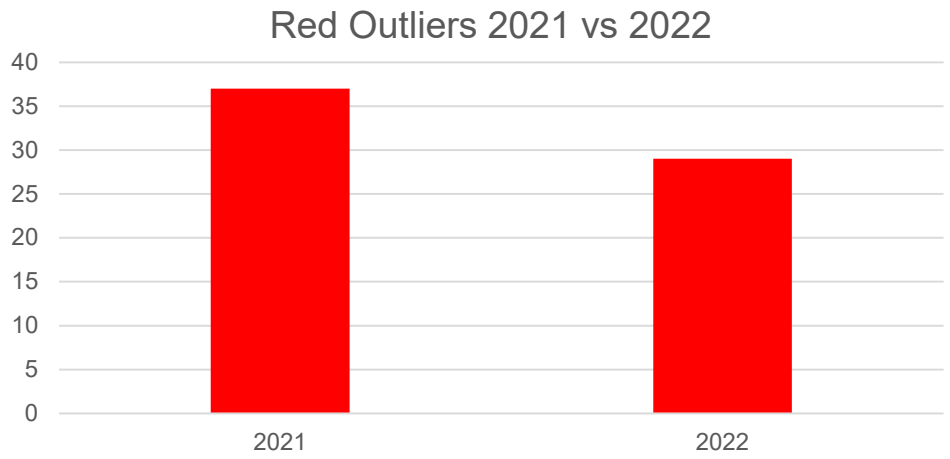
National Findings:

- >45% Trainees describe intensity of work as heavy or very heavy
- 63% Trainees at moderate – high risk of burnout
- 52% Trainers at moderate – high risk of burnout
- 55% Trainers unable to use all time allocated for the purpose of training (conflicting workload pressures).
- 23% Trainers have not had an Educational Appraisal in the last 12 months.

CUH report 2022

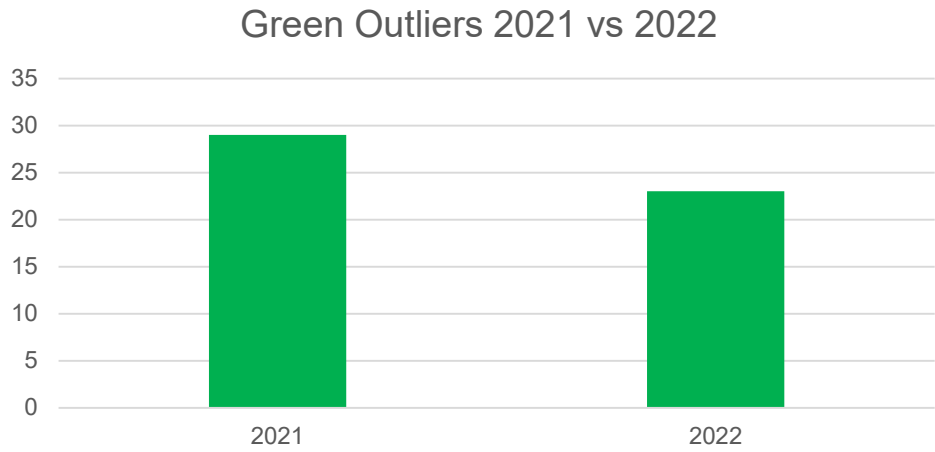
2022 Results

- Total Number of Green Outliers: 23
- Total Number or Red Outliers: 29



2021 Results

- Total Number of Green Outliers: 29
- Total Number or Red Outliers: 37



2022 GMC Survey results CUH – Red Flags by domain

Overall Satisfaction	1
Clinical Supervision	1
Clinical Supervision out of hours	
Reporting systems	1
Work Load	5
Teamwork	2
Handover	2
Supportive environment	2
Induction	
Adequate Experience	3

Curriculum Coverage	
Educational Governance	1
Educational Supervision	1
Feedback	
Local Teaching	2
Regional Teaching	4
Study Leave	1
Rota Design	3
Facilities	

Shelford Group – Overall Satisfaction

Rank	Trust	Score	2021 Rank	Movement
1st	University College London Hospitals NHS Foundation Trust	82.76	1st	No Change
2nd	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	80.55	3rd	Up 1
3rd	Imperial College Healthcare NHS Trust	80.07	5th	Up 2
4th	Guy's and St Thomas' NHS Foundation Trust	79.14	4th	No Change
5th	Cambridge University Hospitals NHS Foundation Trust	77.33	6th	Up 1
6th	Oxford University Hospitals NHS Foundation Trust	76.56	2nd	Down 4
7th	King's College Hospital NHS Foundation Trust	75.75	8th	Up 1
8th	Manchester University NHS Foundation Trust	74.81	9th	Up 1
9th	Sheffield Teaching Hospitals NHS Foundation Trust	73.97	7th	Down 2
10th	University Hospitals Birmingham NHS Foundation Trust	72.51	10th	No Change

Cambridge and Peterborough ICS & Shelford Group – Overall Satisfaction

Rank	Trust	Score	2021 Rank	Movement
1st	Cambridgeshire Community Services NHS Trust	87.00	3rd	Up 2
2nd	Cambridgeshire and Peterborough NHS Foundation Trust	82.87	2nd	Up 1
3rd	University College London Hospitals NHS Foundation Trust	82.76	4th	Down 1
4th	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	80.55	6th	Up 1
5th	Imperial College Healthcare NHS Trust	80.07	8th	Up 3
6th	Guy's and St Thomas' NHS Foundation Trust	79.14	7th	Up 1
7th	Cambridge University Hospitals NHS Foundation Trust	77.33	9th	Up 2
8th	Oxford University Hospitals NHS Foundation Trust	76.56	5th	Down 3
9th	King's College Hospital NHS Foundation Trust	75.75	12th	Up 3
10th	Manchester University NHS Foundation Trust	74.81	13th	Up 3
11th	North West Anglia NHS Foundation Trust	74.63	11th	No Change
12th	Sheffield Teaching Hospitals NHS Foundation Trust	73.97	10th	Down 2
13th	Royal Papworth Hospital NHS Foundation Trust	73.63	1st	Down 12
14th	University Hospitals Birmingham NHS Foundation Trust	72.51	14th	No Change

Summary

1. Falling number of red flags - most frequent indicator across departments is workload.

2. Falling number of green flags – despite reputation of trust as a very strong educational provider.

3. Overall satisfaction minimally changed over last 12 months.

Plan - strategic:

- Provision of effective simulation facilities to replace missed training opportunities.
- Development of Digital Health and Surgical Training Centre
- Targeted use of HEE Covid-19 Training recovery funds to deliver educational opportunities, with priority to prevent extensions to training.
- Development of Telemedicine Training room.
- Identify trainees (and trainers) at risk of burnout
  - Wellbeing support
  - Risk correlated with workload – align with workforce planning strategy.

Board of Directors

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Report to Board of Directors: 9 November 2022

Agenda item	15
Title	Learning from Deaths Quarterly Report
Sponsoring executive director	Ashley Shaw, Medical Director
Author[s]	Amanda Cox, Deputy Medical Director Freya Durrant, Head of Patient Safety Reena Jeyakumar, Quality Improvement Data Analyst
Purpose	To receive the quarterly report.
Previously considered by	Management Executive, 3 November 2022

Executive Summary

Between July 2022 – September 2022 [Q2], there were 431 deaths; of these 28 [6%] were in the Emergency Department, the remainder were inpatient deaths.

- 20% [86/431] met the criteria for a Structured Judgement Review [SJR] during Q2.
- 2% [2/86] of the SJRs completed within Q2 identified significant problems in care [scores 1-3].

Between July 2022 and September 2022, there have been no deaths identified through the structured judgement review process that have been investigated as Serious Incidents.

There have been no Prevention of Future Deaths ordered between July and September 2022.

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 Q2.

Cambridge University Hospitals NHS Foundation Trust

9 November 2022

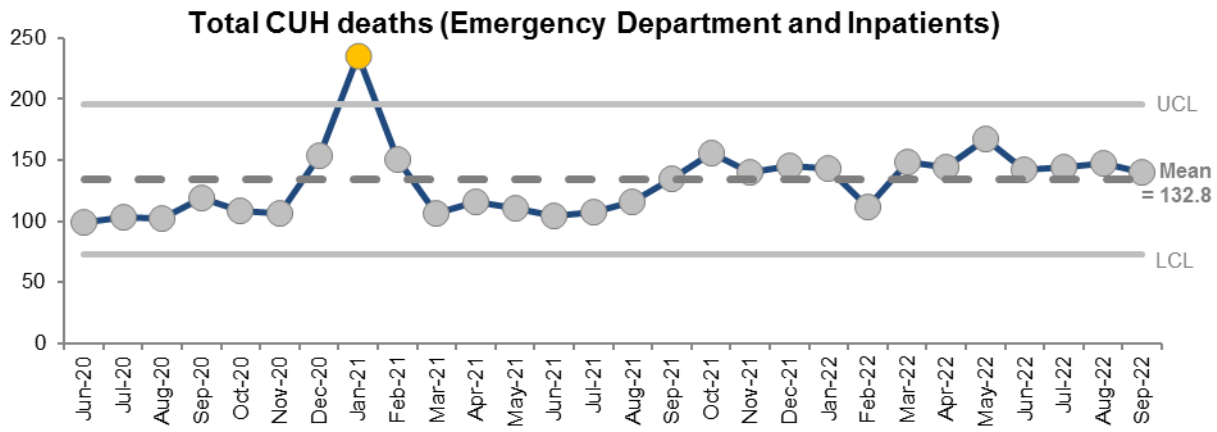
Board of Directors

Learning from Deaths Quarterly Report

1. Number of deaths in Quarter

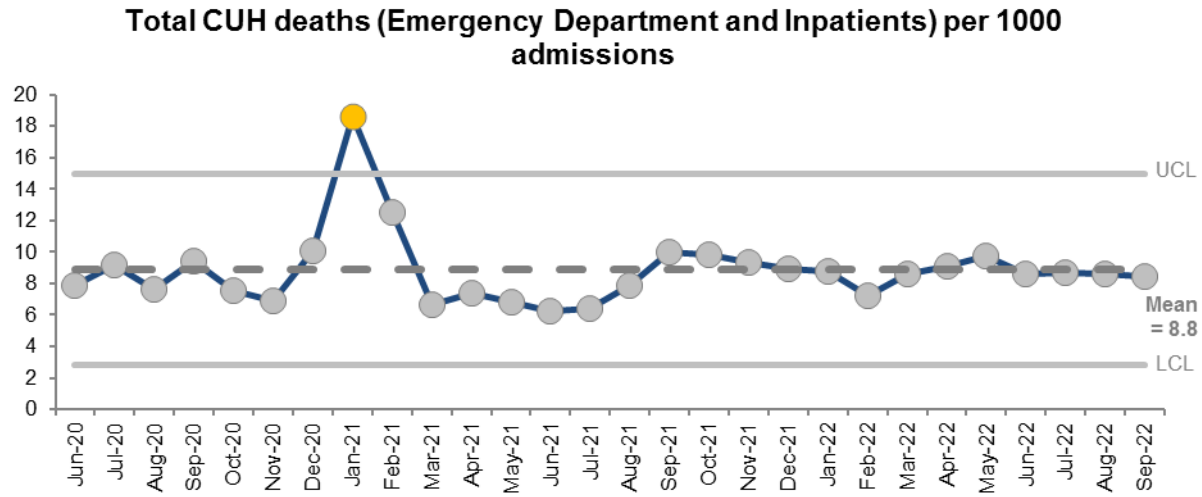
There were 431 deaths between July 2022 and September 2022 [Q2] [Emergency Department [ED] and inpatients], of which 6% [28/431] were in the ED and 94% [403/431] were inpatient deaths.

Graph 1 shows total CUH deaths [inpatients and ED] that have been recorded on Epic from June 2020 to September 2022. Apart from a single data point increase in the total number of deaths in January 2021, the data is within normal variation range.

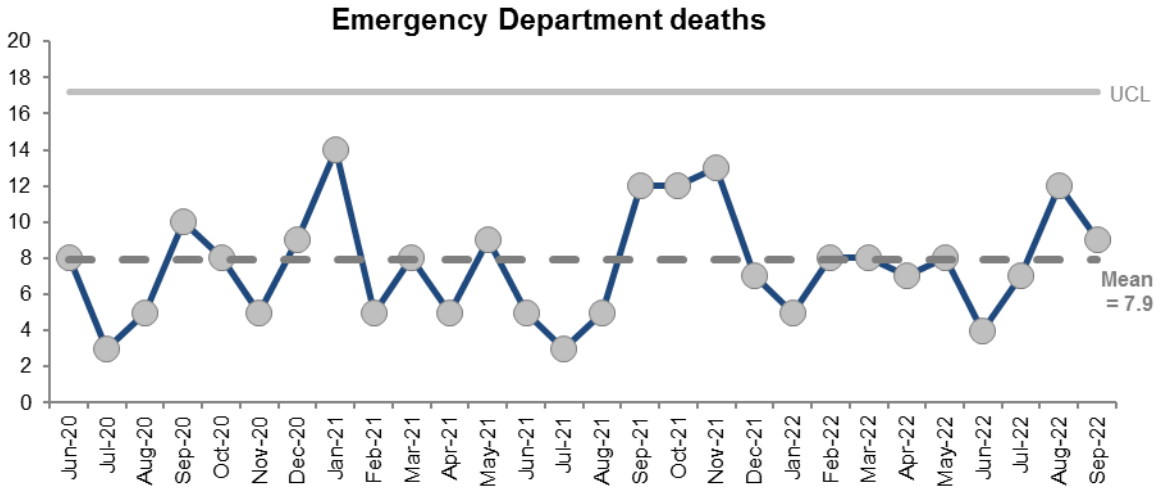


***Please note: outlying data points are highlighted in yellow, and shifts and trends in the data are in blue.*

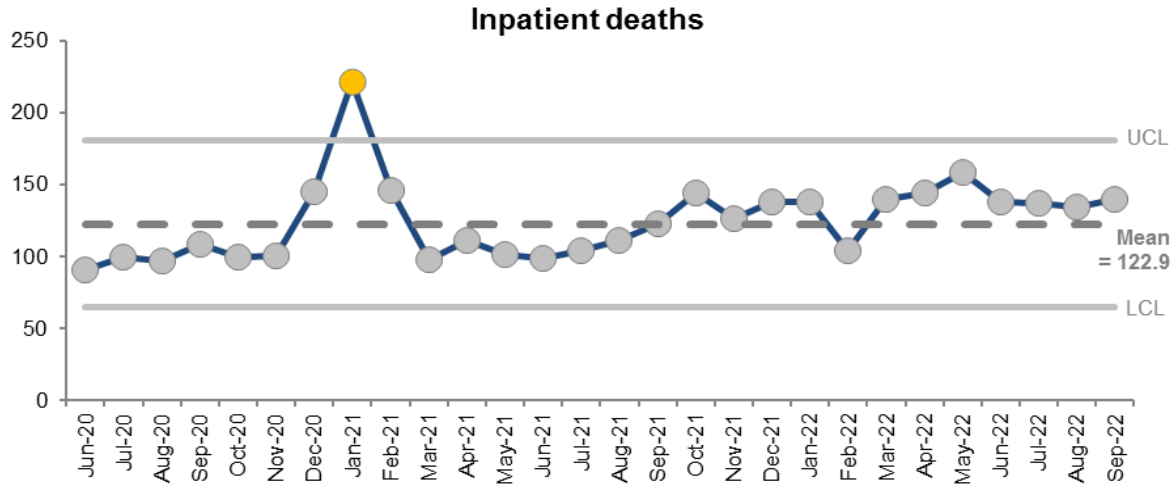
Graph 2 demonstrates total CUH deaths per 1,000 admissions that have been recorded on Epic from June 2020 to September 2022. Apart from a single data point increase in the total number of deaths in January 2021, there is currently normal variation.



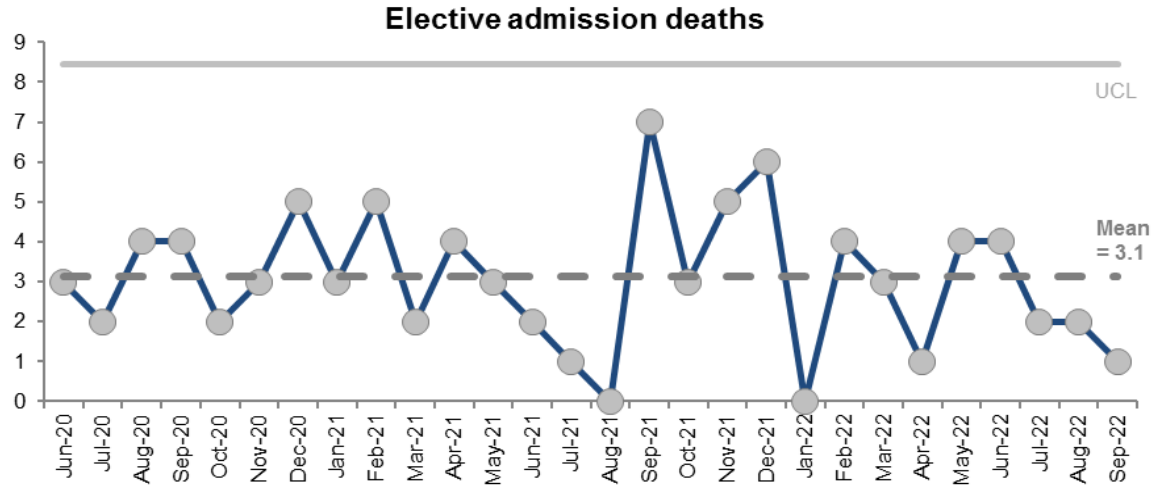
Graph 3 shows Emergency Department deaths only, from June 2020 to September 2022. There is currently normal variation in the number of Emergency Department deaths.



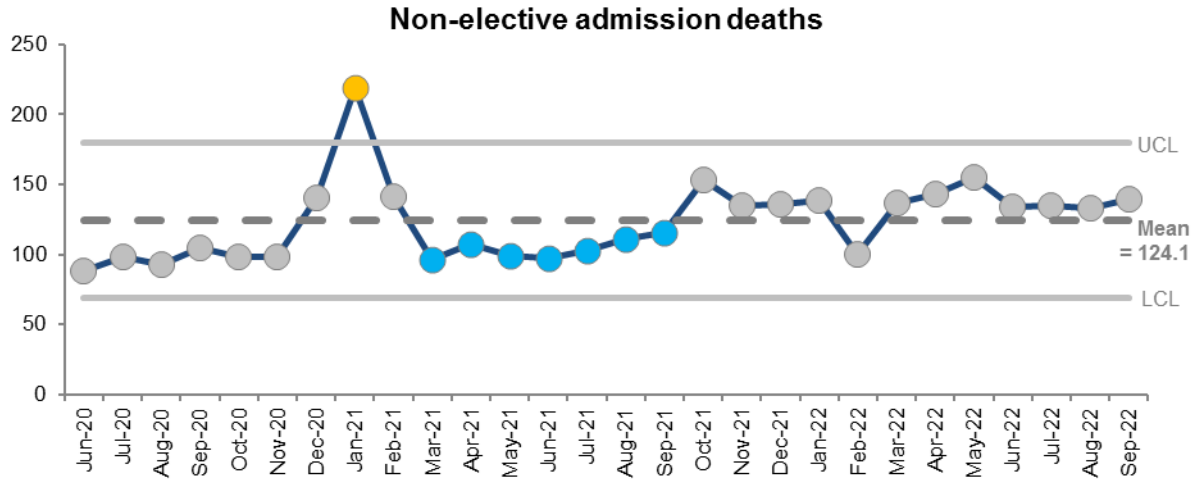
Graph 4 shows inpatient deaths only, from June 2020 to September 2022. Aside from a single significant increase [single data point] in January 2021, there is currently normal variation in the number of Inpatient deaths.



Graph 4a shows inpatient elective admission deaths only from June 2020 to September 2022 which is within normal variation.

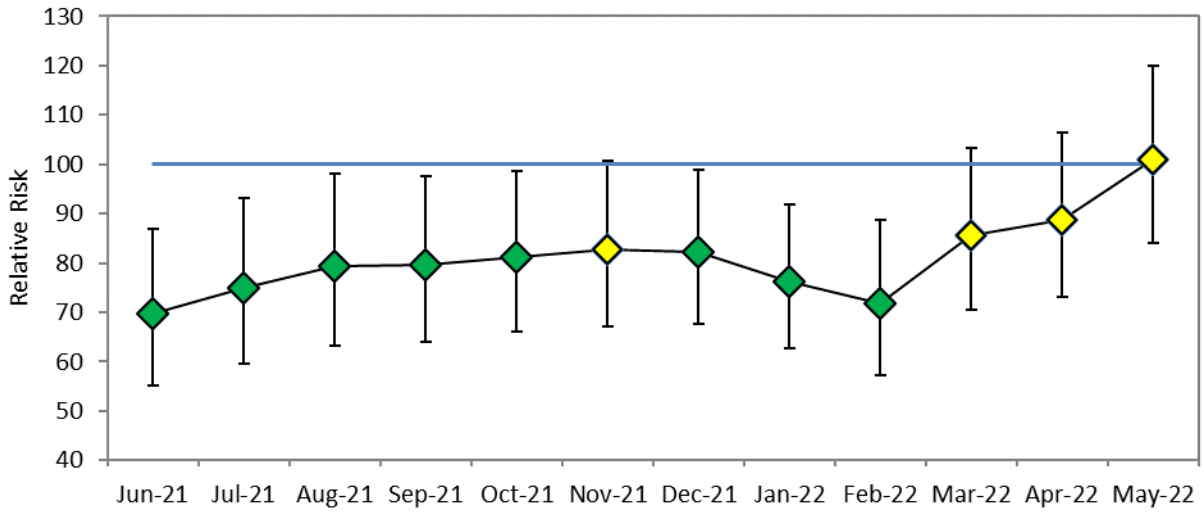


Graph 4b shows inpatient deaths in a non-elective admission from June 2020 to September 2022. Aside from a single significant increase [single data point] in January 2021, there is currently normal variation in the number of non-elective admission deaths.



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

Graph 5 shows the latest Hospital Standardised Mortality Ratio [HSMR] by financial year from June 2021 to May 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 Q2 of 2022-2023 financial year

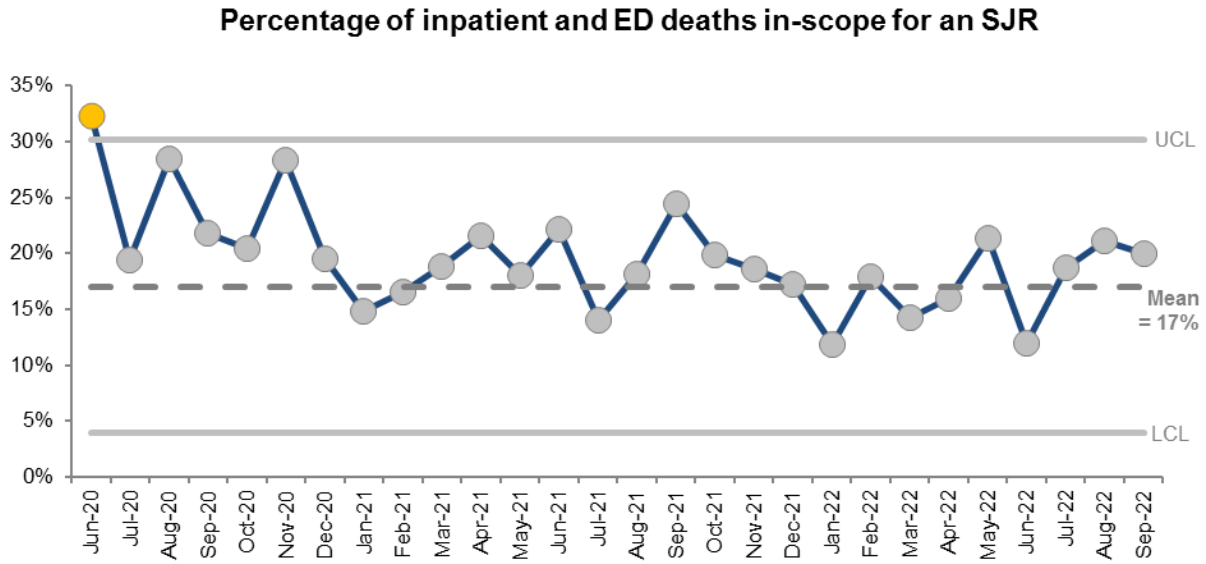
KPI	No. of deaths in month	No. of deaths in-scope	Compliance with SJRs		Problems in Care Identified [score 1-3]	Serious Incidents triggered by SJRs	% of problems in care (by deaths 'in scope')		% of all deaths with problems in care (by total deaths in month)		SJRs triggered by family / carers	SJR training compliance	PFD issued to CUH
			Number received	Number due			Month	Quarter	Month	Quarter			
Jul-22	144	27	52% 14 27		1	1	7% 1 14	5% 2 43	0.7% 1 144	0% 2 431	3	86% 12 14	0
Aug-22	147	31	48% 15 31		1	0	7% 1 15		0.7% 1 147		2	87% 13 15	0
Sep-22	140	28	50% 14 28		0	0	0% 0 14		0.0% 0 140		2	64% 9 14	0

3. Structured judgement review [SJR] compliance

3.1. Deaths in-scope

Between July 2022 and September 2022, 86 [20%] of patient deaths met the in-scope criteria for a structured judgement review.

Graph 6 shows the percentage of *both* inpatient and Emergency Department deaths that are in-scope for an SJR over time from June 2020 to September 2022. There is currently normal variation.

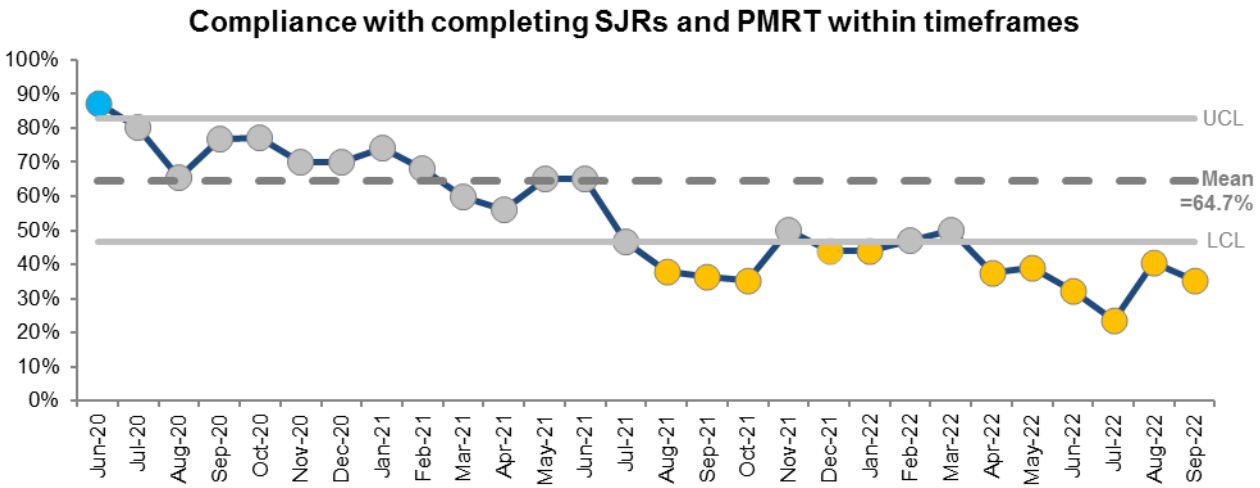


Of the 86 in-scope deaths identified in Q2, 50% of SJRs [43/86] have been completed to date. The compliance figures for each division are shown in the table below.

KPI	SJR + PMRT compliance by timeframes	A	B	C	D	E
Jul-22	51% [14/27]	43% [3/7]	None	90% [9/10]	33% [1/3]	14% [1/7]
Aug-22	48% [15/31]	0% [1/2]	0% [0/1]	93% [13/14]	20% [1/5]	0% [0/9]
Sep-22	50% [14/28]	0% [0/3]	0% [0/1]	69% [9/13]	20% [1/5]	0% [0/6]

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

Graph 7 shows the percentage of SJRs that were completed within their timeframe [25 working days for SJR and 85 working days for PMRT] between June 2020 to September 2022. Statistically we can expect between 45% and 82% of reviews to be completed within their timeframes:



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

4.1. SI investigations commissioned between July 2022 – September 2022

There have been no SI commissioned in relation to an unexpected death between July to September 2022.

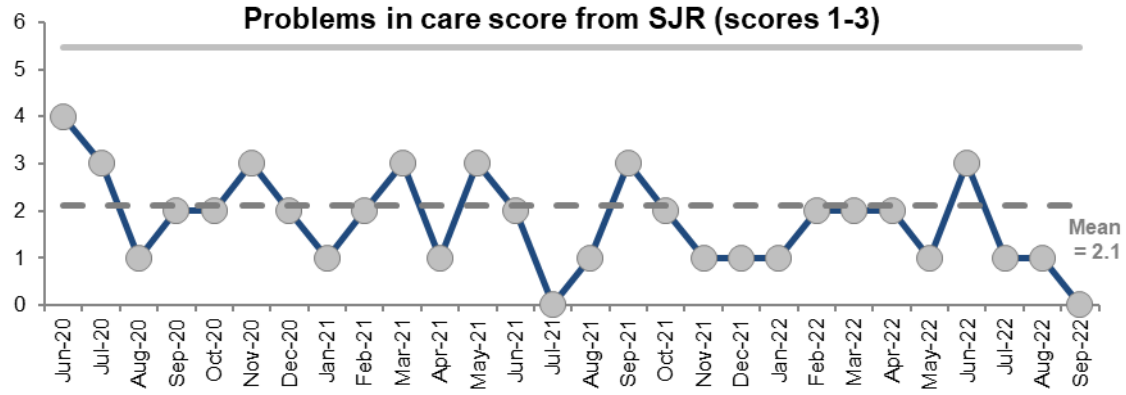
4.2. Structure Judgement Review problems in care scores

One SJR was highlighted as less than satisfactory care in August 2022. This SJR was reviewed by the Deputy Medical Director and it was determined that the highlighted problems in care did not lead to the patient's outcome. Therefore, the SJR was shared with the Coroner for information after being sent through the serious incident executive review panel for approval. Furthermore, learning was generated following thorough discussion of the SJR in the ED mortality and morbidity meeting.

The percentage of deaths with problems in care [scores1-3] identified through the SJR process, from July 2022 - September 2022 is 2% [2/86]. 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.*
July-22	0	1	0	0	0	6
Aug-22	0	1	0	1	6	7
Sep-22	0	0	0	0	4	6

Graph 8 shows the number of SJRs scored 1-3 between June 2020 to September 2022. There is currently normal variation.

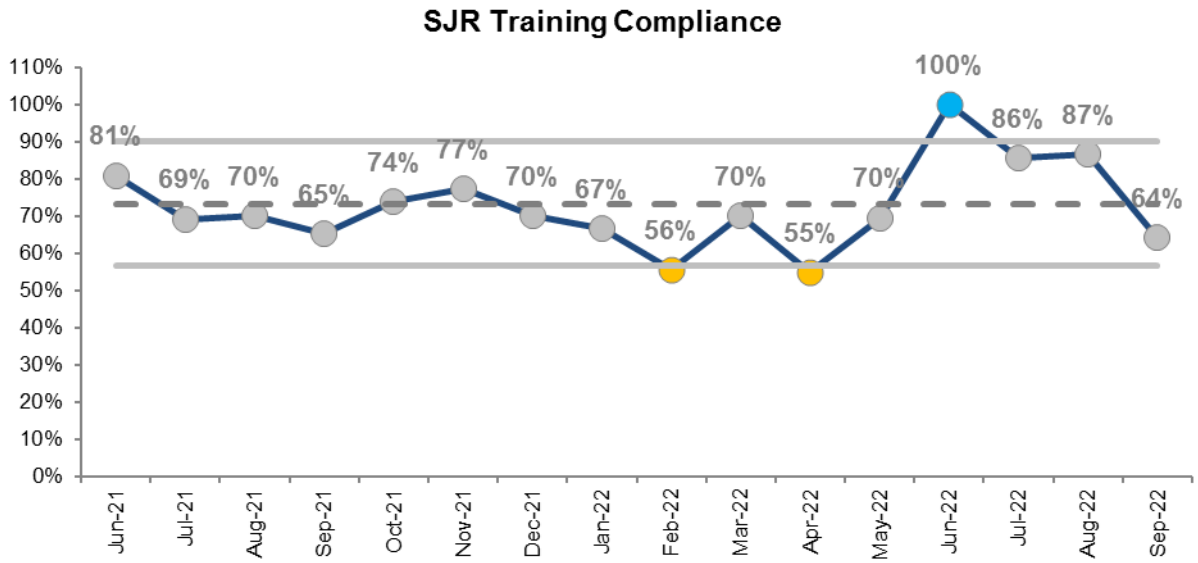


5. Structured judgement reviews triggered by family/carers

One SJR which is currently awaiting completion was initiated by family/carers concerns between July 2022 and September 2022.

6. Consultant training compliance

Of the SJRs completed for patients who died between June 2020 – September 2022, an average of 77% of SJRs were reviewed by a consultant who had completed the SJR training.



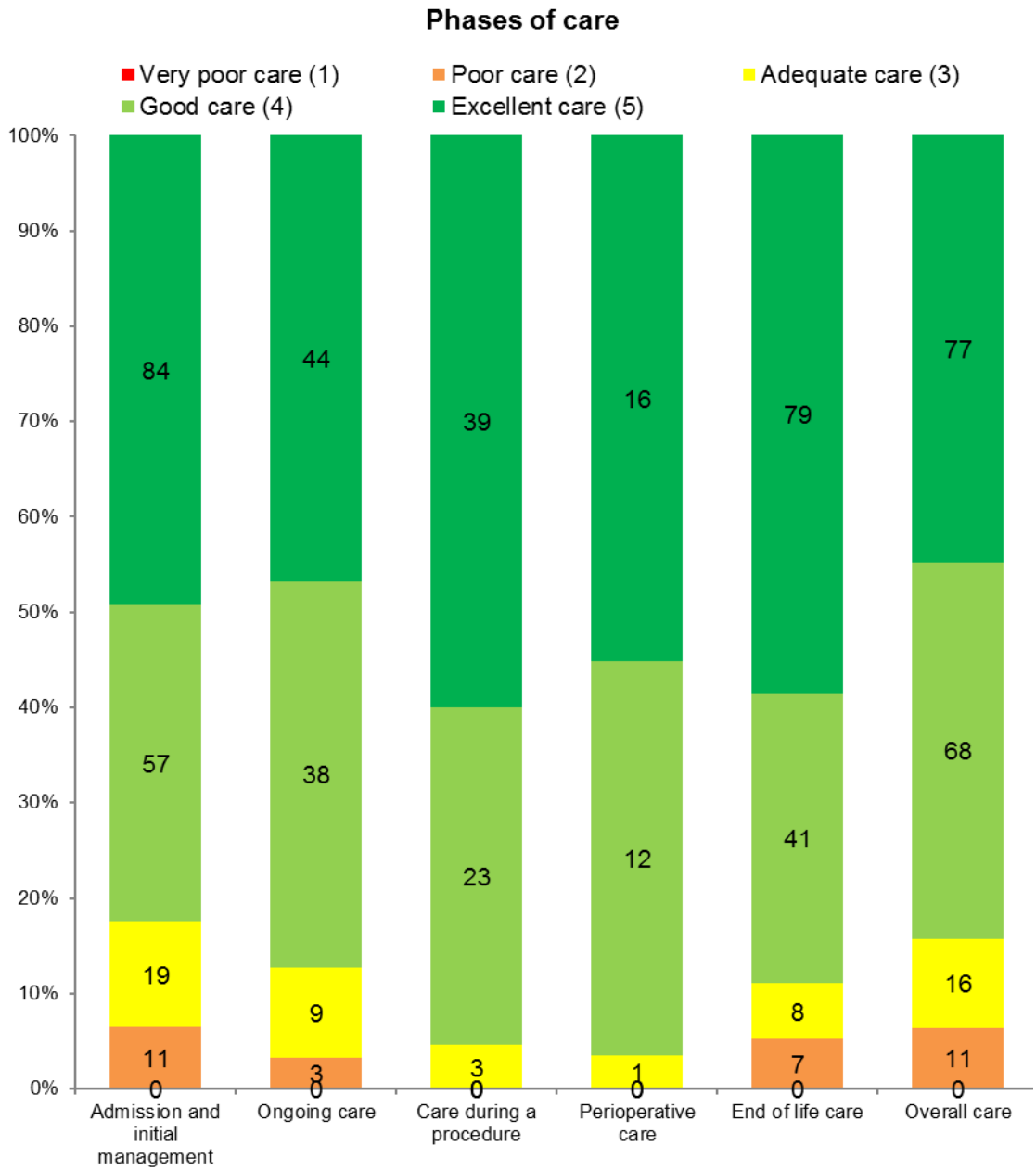
7. Prevention of future death reports issued to Cambridge University Hospitals

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

8. Learning

8.1. 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 October 2021 to September 2022:



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

9. Learning from deaths improvement plan

9.1 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 will be continued to be reviewed by the Mortality Improvement Group.

Board of Directors

NHS
Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 9 November 2022

Agenda item	16
Title	Board Assurance Framework and Corporate Risk Register
Sponsoring executive director	Ian Walker, Director of Corporate Affairs Lorraine Szeremeta, Chief Nurse
Author(s)	Jumoke Okubadejo, Director of Clinical Quality; Elke Pieper, Head of Risk and Patient Outcomes; Ian Walker, Director of Corporate Affairs
Purpose	To receive the latest versions of the BAF and CRR.
Previously considered by	Risk Oversight Committee, 27 October 2022

Executive Summary

The Board Assurance Framework (BAF) and the Corporate Risk Register (CRR) are refreshed on a monthly basis through discussion with the Executive Director leads for each risk and presented to the Risk Oversight Committee for review. The risks are assigned to Board assurance committees for oversight and they are also received by the Board four times a year (most recently in October 2022).

This paper provides the Board with the latest version of the BAF which contains 14 principal risks to the achievement of the Trust's strategic objectives. 10 of these risks are currently rated at 15 or above.

The paper also provides a summary of the current CRR risks, as reviewed by the Risk Oversight Committee on 27 October 2022.

Related Trust objectives	All objectives
Risk and Assurance	The report sets out the principal risks to achievement of the Trust's strategic objectives.
Related Assurance Framework Entries	All BAF entries.
Legal implications/Regulatory requirements	The BAF is a key document which informs the Annual Governance Statement.
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	n/a

Action required by the Board of Directors

The Board is asked to receive and approve the current versions of the Board Assurance Framework and the Corporate Risk Register.

Cambridge University Hospitals NHS Foundation Trust

9 November 2022

Board of Directors
Board Assurance Framework and Corporate Risk Register
Ian Walker, Director of Corporate Affairs
Lorraine Szeremeta, Chief Nurse

1. Introduction

1.1 The Board Assurance Framework (BAF) provides a structure and process which enables the Board of Directors to focus on the principal risks which might compromise the achievement of the Trust's strategic objectives. The BAF identifies the key controls which are in place to manage and mitigate those risks and the sources of assurance available to the Board regarding the effectiveness of the controls. The BAF is received by the Board four times a year (most recently in October 2022 - the September 2022 version).

1.2 The Board also receives a report four times a year on the Corporate Risk Register (CRR) to provide additional assurance that key operational risks are being effectively managed.

1.3 Board assurance committees review both the BAF and the CRR risks assigned to them at each meeting. The BAF and CRR are refreshed on a monthly basis in discussion with the lead Executive for each risk and then reviewed by the Risk Oversight Committee.

2. Board Assurance Framework

2.1 The October 2022 version of the BAF is attached at Appendix 1. It incorporates updates from monthly reviews undertaken since the last report to the Board in October 2022. These have been reviewed by the respective Board assurance committees.

2.2 There are currently 14 risks on the BAF, one more than in the previous version received by the Board.

2.3 A detailed log of monthly amendments and updates to the BAF as reviewed by the Risk Oversight Committee is available to Board members on request. There have been a number of updates to controls and assurances and to actions to address gaps in controls and assurance over the past month.

2.4 Work is continuing to update the BAF to reflect the refresh of the CUH strategy which was agreed by the Board of Directors in July 2022. In addition to the review of a number of the current risks, it is planned to include two new risks – one on tackling the climate emergency and enhancing environmental sustainability; and one on the overarching strategy for equality, diversity and inclusion.

2.5 Alongside the above, work is proceeding on developing medium-term trajectories for each of the BAF risks, indicating how the level of risk is expected to change over time in response to the implementation of actions within the Trust's control and/or or anticipated external developments. While this is not an exact science, and the way this is considered might need to differ between risks given the varying nature of the BAF risks, it is intended to be a positive development which will support the Board in tracking risk profiles over time and assessing risk trajectories against the Trust's risk appetite.

2.6 For this month, two further trajectories have been included. Trajectories are now therefore shown for the following risks: BAF 001, 002, 003, 007, 011 and 013. Further trajectories will be developed as other risks are refreshed.

2.7 In terms of key amendments to individual BAF risks during this period, the following are highlighted:

- BAF risk 009: the risk has been reviewed in line with the refreshed CUH strategy and focused on the development of the Cancer Research and Children's Hospitals. Reflecting the increased economic uncertainty, including the impact of high rates of inflation, and funding uncertainties, the current risk score has been increased from 12 to 16. Gaps in control have been updated.

- BAF risk 010: the risk has been reviewed and redrafted to focus on the Integrated Care System and the South Place Integrated Care Partnership, with Specialised Services now added as a separate risk on the BAF (014) to align with the refresh of the Trust Strategy. The current risk score has been retained at 12, although this is subject to further review.

- BAF risk 014: this is a new risk focusing on specialised services, created from dividing the current risk 010 which now focuses on ICB and South Place. The current risk score is 12.

2.8 Of the 14 current BAF risks, 10 are 'Red' rated at 20, 16 or 15 as follows:

- Capacity and patient flow (20)
- Fire safety (20)
- Estates backlog maintenance and statutory compliance (20)
- Staffing availability (20)
- Effective prioritisation of patients in greatest clinical need (16)
- Equality and diversity (16)
- Financial sustainability (16)
- Staff health and wellbeing (16)
- Prioritisation of IT resources (16)
- New hospitals development (16)

2.9 The Trust's risk scoring matrix is appended to the BAF for reference.

2.10 The table below summarises the mapping of the BAF risks to the Trust's strategic commitments (as appended to the BAF).

Table 1: Strategic commitments and associated BAF risks

Strategic objective	Associated BAF risks
A1	010
A2	001
A3	001, 002
A4	004
A5	002, 004
B1	007
B2	007
B3	013
B4	008
B5	013
C1	010, 014
C2	012
C3	005, 006, 009
C4	-
C5	003

3. Corporate Risk Register

3.1 The risks on the CRR are reviewed on an ongoing basis by the Risk Oversight Committee and the relevant Board assurance committees.

3.2 The current CRR is summarised at Appendix 1. There are currently 35 risks on the CRR.

4. Recommendations

4.1 The Board of Directors is asked to receive and approve the current versions of the Board Assurance Framework and the Corporate Risk Register.

Appendix 1: Corporate Risk Register summary, October 2022

CRR Ref	Title	CQC Domain	Executive Director	Assurance Committee	Inherent rating (C x L)	Current rating (C x L)	Target rating (C x L)	Aug-22	Sep-22	Oct-22
CR05a	Insufficient urgent and emergency capacity to meet patients' needs	Responsive	Chief Operating Officer	Performance	4x5=20 (Red)	4x5=20 (Red)	3x4=12 (Amber)	Same	Same	Same
CR05c	Insufficient outpatient capacity to meet patients' needs	Responsive	Chief Operating Officer	Performance	4x5=20 (Red)	4x5=20 (Red)	3x4=12 (Amber)	Same	Same	Same
CR05d	Insufficient diagnostic capacity to meet patients' needs	Responsive	Chief Operating Officer	Performance	4x5=20 (Red)	4x5=20 (Red)	4x2=8 (Amber)	Same	Same	Same
CR05e	Insufficient surgery capacity to meet patients' needs	Responsive	Chief Operating Officer	Performance	4x5=20 (Red)	4x5=20 (Red)	3x4=12 (Amber)	Same	Same	Same
CR29	Imaging reporting backlog	Responsive	Chief Operating Officer	Performance	4x5=20 (Red)	4x5=20 (Red)	4x1=4 (Yellow)	Same	Same	Same
CR42a	Compliance with Fire Safety Regulations – Trust-wide buildings	Safe	Director of Capital, Estates and Facilities Management	Board	5x5=25 (Red)	5x4=20 (Red)	5x3=15 (Red)	Same	Same	Same
CR42b	Compliance with Fire Safety Regulations in A Block	Safe	Director of Capital, Estates and Facilities Management	Board	5x5=25 (Red)	5x4=20 (Red)	3x3=9 (Amber)	Same	Same	Same
CR42c	Fire safety systems in the ATC	Safe	Director of Capital, Estates and Facilities Management	Board	5x5=25 (Red)	5x4=20 (Red)	5x2=10 (Amber)	Same	Same	Same

CR42d	Fire Alarm – operation of fire system evacuation key switches	Safe	Director of Capital, Estates and Facilities Management	Board	5x5=25 (Red)	5x4=20 (Red)	5x2=10 (Amber)	Same	Same	Same
CR43a	Insufficient staffing on adult wards	Safe	Chief Nurse	Quality	4x5=20 (Red)	4x5=20 (Red)	3x3=9 (Amber)	Same	Same	Same
CR04b	Medical device repairs and planned preventative maintenance	Safe	Medical Director	Quality	4x5=20 (Red)	4x5=20 (Red)	4 x 2 = 8 (Amber)	Same	Same	Same
CR50	Failure to deliver digital requirements due to staffing levels in e-Hospital department	Responsive	Director of Improvement and Transformation	Performance	5x5=25 (Red)	4x5=20 (Red)	3x2=6 (Yellow)	Same	Same	Same
CR54	Attracting and retaining staff due to increasing cost of living	Safe	Director of Workforce	Workforce	4x5=20 (Red)	4x5=20 (Red)	4x4=16 (Red)		NEW	Same
CR43b	Medical and midwifery staffing in maternity services	Safe	Chief Nurse	Quality	4x5=20 (Red)	4x5=20 (Red)	2x3=6 (Yellow)		NEW	Same
CR08	**Capacity to deal with winter pressures**	**Responsive**	**Chief Operating Officer**	**Performance**	**4x5=20 (Red)**	**4x5=20 (Red)**	**4x2=8 (Amber)**			**NEW**
CR04a	Replacement of unsupported/aging/unsuitable medical equipment	Safe	Medical Director	Performance	5x5=25 (Red)	4x4=16 (Red)	4x3=12 (Amber)	Same	Same	Same
CR07	Failure to reduce incidence of Healthcare Acquired Infections	Safe	Medical Director	Quality	5x5=25 (Red)	4x4=16 (Red)	4x2=8 (Amber)	Same	Same	Same
CR41	Pathways for patients with mental health conditions	Responsive	Chief Nurse	Quality	4x4=16 (Red)	4x4=16 (Red)	4x1=4 (Yellow)	Same	Same	Same
CR46	Expiry of LMB Building Lease housing Histopathology services	Well-led	Director of Strategy and Major Projects	Performance	4x5=20 (Red)	4x4=16 (Red)	4x1=4 (Yellow)	Same	Same	Same
CR55	Radiopharmacy services manufacturing licence	Safe	Medical Director	Quality	4x5=20 (Red)	4x4=16 (Red)	3x2=6 (Yellow)		NEW	Same
CR52	Potential short-term supply issues	Safe	Chief Finance Officer/ Medical Director	Quality	5x4=20 (Red)	4x4=16 (Red)	4x3=12 (Amber)	Same	Same	Same

CR05f	Insufficient capacity within maternity services	Safe	Chief Nurse	Quality	4x5=20 (Red)	4x4=16 (Red)	4x3=12 (Amber)			NEW
CR45	Failure to meet patients' equality and diversity needs	Well-led	Chief Nurse	Quality	4x4=16 (Red)	4x4=16 (Red)	3x2=6 (Yellow)	Same	Same	Same
CR03	Risk of water borne infection	Safe	Director of Capital, Estates and Facilities Management	Quality	5x5=25 (Red)	5x3=15 (Red)	5x2=10 (Amber)	Same	Same	Same
CR10	Capacity and resilience of the High Voltage Electrical Infrastructure	Safe	Director of Capital, Estates and Facilities Management	Performance	5x4=20 (Red)	5x3=15 (Red)	5x2=10 (Amber)	Same	Same	Same
CR38	Deteriorating Patient and Sepsis	Safe	Chief Nurse	Quality	5x4=20 (Red)	5x3=15 (Red)	5x1=5 (Yellow)	Same	Same	Same
CR24	Compliance with critical ventilation requirements	Safe	Director of Capital, Estates and Facilities Management	Performance	4x4=16 (Red)	4x3=12 (Amber)	4x2=8 (Amber)	Same	Same	Same
CR44	Meeting blood transfusion regulations	Safe	Medical Director	Quality	4x4=16 (Red)	4x3=12 (Amber)	3x2=6 (Yellow)	Same	Same	Same
CR49	RAAC panel failure	Responsive	Chief Operating Officer	Performance	5x3=15 (Red)	4x3=12 (Amber)	3x3=9 (Amber)	Same	Same	Same
CR17	Maintaining a suitably skilled workforce	Well-led	Director of Workforce	Workforce	3x5=15 (Red)	3x4=12 (Amber)	3x2=6 (Yellow)	Same	Same	Same
CR20	Expansion of the Cambridge Biomedical Campus impacting access to and from the Campus due to inadequate local transport	Safe	Director of Capital, Estates and Facilities Management	Performance	4x4=16 (Red)	4x3=12 (Amber)	3x2=6 (Yellow)	Same	Same	Same
CR23b	Performance of FM contract in the Addenbrooke's Treatment Centre (ATC)	Responsive	Director of Capital, Estates and	Performance	4x3=12 (Amber)	4x3=12 (Amber)	4x2=8 (Amber)	Same	Same	Same

			Facilities Management							
CR23c	Delivery of services under the PFI Project Agreement	Responsive	Director of Capital, Estates and Facilities Management	Performance	4x3=12 (Amber)	4x3=12 (Amber)	3x3=9 (Amber)	Same	Same	Same
CR32	Cyber security protection	Safe	Director of Improvement and Transformation	Audit	5x3=15 (Red)	5x2=10 (Amber)	4x1=4 (Yellow)	Same	Same	Same
CR25	Compliance with the Accessible Information Standard	Safe	Chief Nurse	Quality	4x5=20 (Red)	3x3=9 (Amber)	3x2=6 (Yellow)	Reduced	Same	Same

Cambridge University Hospitals
NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust
Board Assurance Framework: October 2022
Board Assurance Framework overview – ranked by current risk rating

Risk ref.	Current risk score	Risk description	Lead Executive	Board monitoring committee
001	20	Due to physical capacity constraints and sub-optimal patient flow, the Trust is not able to deliver timely and responsive urgent and emergency care services, sustainably restore services to pre-Covid levels and reduce waiting lists, while at the same time managing future Covid surges and providing decant capacity to address fire safety and backlog maintenance, which adversely impacts on patient outcomes and experience.	Chief Operating Officer	Performance and Quality
005	20	A failure to address life safety estate infrastructure systems and statutory compliance priorities caused by a backlog of works, insufficient capital funding commitment and decant capacity impacts on patient and staff safety, continuity of clinical service delivery, regulatory compliance and reputation.	Director of Capital, Estates & Facilities Mgt	Performance
006	20	A failure to address fire safety statutory compliance priorities caused by insufficient capital funding and decant capacity impacts on patient and staff safety and continuity of clinical service delivery.	Director of Capital, Estates & Facilities Mgt	Board of Directors
007	20	There is a risk that the Trust does not have sufficient staff with appropriate skills to deliver its plans now and in the future which results in poorer outcomes for patients and poorer experience for patients and staff.	Director of Workforce	Workforce and Education
002	16	Due to the ongoing impact of delays resulting from the Covid-19 pandemic, there is a risk that the Trust is not able to effectively identify and diagnose those patients in greatest clinical need which could result in harm, poorer outcomes and worse experience for patients.	Chief Nurse and Medical Director	Quality
011	16	There is a risk that the Trust, as part of the Cambridgeshire and Peterborough ICS, is unable to deliver the scale of financial improvement required in order to achieve a breakeven or better financial performance within the funding allocation that has been set for the next three years, leading to regulatory action and/or impacting on the ability of the Trust to invest in its strategic priorities and provide high quality services for patients.	Chief Finance Officer	Performance
008	16	The Trust does not develop and implement effective actions to achieve greater equality and diversity in the CUH workforce and therefore does not realise the benefits of being a truly diverse and inclusive organisation from a workforce perspective, which impacts adversely on staff wellbeing and the quality of patient care.	Director of Workforce	Workforce and Education
013	16	There is a risk that we fail to maintain and improve the physical and mental health and wellbeing of our workforce, particularly in the context of the effects of the Covid-19 pandemic, which impacts adversely on individual members of staff and our ability to provide safe patient care now and in the future.	Director of Workforce	Workforce and Education
003	16	The Trust does not prioritise and deploy to best effect the limited resources available for IT investment to support staff to deliver improved patient care and experience.	Director of Improvement and Transformation	Audit
009	16	New hospitals proposals are not developed, approved and/or built in a timely way resulting in the need to maintain poor quality facilities for an extended period of time and a failure to realise the clinical, operational and wider benefits.	Interim Director of Strategy and Major Projects	Addenbrooke's 3/ Board of Directors
004	12	The Trust does not have a common framework across all areas within which we can consistently measure, track and improve standards of care, including patient experience and outcomes and provide assurance.	Chief Nurse and Medical Director	Quality
010	12	The Trust does not work effectively with partners across the Cambridgeshire and Peterborough Integrated Care System (ICS) and the South Place resulting in a failure to sustain and improve services for local patients and regulatory intervention and/or the recurrence of a financial deficit.	Interim Director of Strategy and Major Projects	Board of Directors
014	12	The Trust does not work effectively with regional partners (particularly regarding specialised services) resulting in a failure to sustain and improve services for regional patients and regulatory intervention and/or the recurrence of a financial deficit.	Interim Director of Strategy and Major Projects	Board of Directors
012	9	The Trust and our industry and research partners – convened through Cambridge University Health Partners (CUHP) – fail to capitalise on opportunities to improve care for more patients now, generate new treatments for tomorrow and power economic growth in life sciences in Cambridge and across the region.	Interim Director of Strategy and Major Projects	Board of Directors

BAF risk	001	Due to physical capacity constraints and sub-optimal patient flow, the Trust is not able to deliver timely and responsive urgent and emergency care services, sustainably restore services to pre-Covid levels and reduce waiting lists, while at the same time managing future Covid surges and providing decant capacity to address fire safety and backlog maintenance, which adversely impacts on patient outcomes and experience.

Current risk rating: 20

Strategic objective	A2, A3
Latest review date	October 2022

Lead Executive	Chief Operating Officer
Board monitoring committee	Performance, Quality

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	4	5	20
Current (Oct 22)	4	5	20

Change since last month: ⟺

Related BAF and Corporate Risk Register entries

ID	Score	Summary risk description
BAF 002	20	Effective prioritisation of patients
BAF 005/006	20	Estates backlog/fire safety compliance
BAF 007	20	Meeting workforce demand
CR43	20	Staffing on adult inpatient wards
CR05a, c-e	20	Capacity
CR08	20	Winter pressures

Key controls
What are we already doing to manage the risk?

1. Operational strategy 22/23 agreed by ME and Board.
2. CUH Winter Plan 22/23 agreed by ME.
3. Winter 22/23 Taskforce established (supported by task & finish groups).
4. Cohorting and configuration plan informed by modelling work and data-driven approach to optimise use of capacity in line with clinical need.
5. Covid Infection Prevention and Control guidance in place and reviewed regularly, based on assessment of the balance of risk between Covid transmission and treatment capacity.
6. Regional surge centre – use of Ward T2 (and P2/Q2 until September 2022) to provide additional capacity.
7. 56-bed unit approved in November 2021 and under construction.
8. Business case for 3 modular theatres approved in July 2022, planning permission granted in August 2022 and now under construction.
9. Pathway and other changes to create additional UEC capacity – use of EAU3 as discharge lounge, EAU4 as assessment area & G2 as frailty unit.
10. Development of expanded virtual ward offering to create additional acute capacity.
11. Use of independent sector and other off-site physical capacity, including surgical capacity at Ely.

Assurances on controls
How do we gain assurance that the controls are working?

1. Reporting to Management Executive (ME) via Winter Taskforce, Urgent and Emergency Care (UEC) Programme Board and Capacity Oversight Group.
2. Reporting to Performance and Quality Committees and Board of Directors on implementation of Winter Plan and delivery of capacity and flow programmes/ objectives.
3. Ongoing review of metrics including capacity as a percentage of pre-Covid baseline.
4. Virtual ward programme governed through Division C governance arrangements.
5. System reporting to Health Gold, System Leaders and ICS Board.
6. ICS and regional oversight through System Resilience Group and System Oversight and Assurance Group (SOAG).

12. Whole system focus on recovery and demand management via South ICP; continue to evolve UEC model within CUH including ED front door. 13. Identification of 15 step down beds in the community for Winter 22/23. 14. Ongoing programme of Executive meetings with specialties.	

Gaps in control	Gaps in assurance	Actions to address gaps in controls and assurances	Due date
C1. Implementation of Winter Plan and further development and delivery of individual workstreams via task and finish groups.		C1. Management Executive lead for each task and finish group driving development and delivery of priorities, with reporting to Management Executive and Performance Committee.	Ongoing
C2. Use of additional on-site physical capacity: C2a: 56-bed unit – including decision on balance between use for additional capacity and decant space to support fire safety and other essential works.		C2a: Construction in progress. Staffing plans in development. Agreement to be taken on balance of use between additional capacity and decant space. Opening scheduled for June 2023 (delayed from previous date of November 2022).	June 2023
C2b: Use of 40-bed unit for elective surgical capacity.		C2b: Theatre construction works and recruitment underway with scheduled opening date of August 2023.	August 2023
C2c: 3 currently closed neurosurgery theatres in A Block.		C2c: Available following fire improvement works to A Block.	September 2023
C2d: ED Urgent Treatment Centre (UTC) expansion scheme.		C2d: Business case approved in October 2022.	March 2024
C3: System working to respond to growth in both elective and non-elective demand.		C3. ICB Winter Plan developed with system partners and being implemented, overseen by Unplanned Care Board and South System Resilience Group. Focus on Virtual Wards; 2-hour urgent community response model; work with primary care; and transfer of care hub for winter 2022/23.	Ongoing

Risk score	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
	20	20	20	20	20	20	20	20	20	20	20	20	20

BAF 001: Risk trajectory

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Oct 22)	4x5=20	
September 2023	4x4=16	Opening of 56-bed unit (U-Block) and elective orthopaedic facility (P2/Q2 and 3 theatres) backed by workforce model.
September 2024	4x3=12	Re-opening of 3 A Block theatres and additional ED UTC capacity backed by workforce model.

BAF risk	002	**Due to the ongoing impact of delays resulting from the Covid-19 pandemic, there is a risk that the Trust is not able to effectively identify and diagnose those patients in greatest clinical need which could result in harm, poorer outcomes and worse experience for patients.**

Current risk rating: 16

Strategic objective	A3, A5
Latest review date	October 2022

Lead Executive	Chief Nurse and Medical Director
Board monitoring committee	Quality

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	5	3	15
Current (Oct 22)	**4**	**4**	**16**

Change since last month

⟺

Related BAF and Corporate Risk Register entries		
ID	**Score**	**Summary risk description**
BAF 001	20	Capacity and patient flow

Key controls
What are we already doing to manage the risk?

1. Maximisation of capacity across theatres, outpatients and diagnostics – see BAF risk 001 - within constraints of responding to Covid-19 waves.
2. Review of balance between Covid/non-Covid and emergency/ elective activity, informed by data, ethical input and professional judgement.
3. All surgical specialties undertaking at least weekly clinical prioritisation reviews in line with national and Royal College guidance, feeding into decisions by Surgical Prioritisation Group.
4. Waiting list harm review process to minimise risk to patient safety.
5. Review of complaints and incidents and potential/actual harm at SIERP.
6. Messaging to patients and public on what to expect while waiting and who to contact with concerns, including letters to long-waiting patients.

Assurances on controls
How do we gain assurance that the controls are working?

1. Comparative data monitored by NHSE/I against other centres.
2. Review of harm review process by Management Executive in March/April 2021 and Quality Committee in May 2021, with external legal input.
3. Ongoing assurance role for Quality Committee on harm review process.
4. Outcomes data monitored through Board and Quality Committee.
5. Waiting lists monitored against trajectory.
6. Established monitoring of patient feedback and experience.
7. Robust oversight of delivery of actions through relevant taskforce boards.
8. Close monitoring of incident reporting (including no harm/near miss) overseen by SIERP, Patient Safety Group and through IPR to Board – including capturing learning to improve processes.

Gaps in control	Gaps in assurance
C1. Insufficient physical/staffing capacity to reduce waiting lists by increasing diagnostic/treatment volumes. C2. Patients not presenting to GPs during pandemic. C3. Maintaining effective contact with patients on waiting lists.	

Actions to address gaps in controls and assurances	Due date
C1. See BAF risks 001 and 007.	See 001 and 007
C2. Emphasising national/local messaging via website/social media on importance of continuing to access NHS services.	Ongoing
C3. Implementation of validation letter and survey; writing to long-waiting patients; information on CUH website and to GPs.	Ongoing

Risk score	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun22	Jul 22	Aug 22	Sep 22	Oct 22
	16	16	16	16	16	16	16	16	16	16	16	16	16

BAF 002: Risk trajectory

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Oct 22)	**4x4=16**	
March 2024	**4x3=12**	Ability to manage and prioritise will remain compromised until elective waiting list reduces significantly, which will be facilitated by a cumulative increase in capacity from opening of 56-bed unit (U-Block), elective orthopaedic facility (P2/Q2 and 3 theatres), re-opening of 3 A Block theatres and additional ED UTC capacity.

BAF risk	003	There is a risk that the Trust does not invest in, prioritise and deploy IT resources effectively to support achievement of the Trust's strategic priorities.

Current risk rating: 16

Strategic objective	C5
Latest review date	October 2022

Lead Executive	Director of Improvement and Transformation
Board monitoring committee	Audit

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	4	3	12
Current (Oct 22)	4	4	16

Change since last month
⟺

Related BAF and Corporate Risk Register entries		
ID	Score	Summary risk description
BAF 011	16	Financial sustainability
CR50	16	eHospital team staffing

Key controls
What are we already doing to manage the risk?

Investment

1. Commodity IT services through Telefonica Tech.
2. 6-12 monthly cycle for deploying additional infrastructure and new Epic versions/EPR work programme.
3. Workforce to ensure the application, data and infrastructure environments are reliable secure, sustainable and resilient, and compliant with regulatory requirements through delivering a robust infrastructure and application lifecycle management

Prioritisation

4. Digital Strategy approved by Board of Directors; prioritisation through divisions/Digital Prioritisation Board to ensure alignment with strategy (under development) with cases for change supported by robust benefit cases.

Deployment

5. Telefonica Tech transformation programme.
6. Implementation plan for Digital Strategy in development.
7. Digital Board to monitor delivery against the strategy (under development).

Assurances on controls
How do we gain assurance that the controls are working?

Investment

1. Review of monthly performance reports and annual review of Telefonica Tech service by eHospital SMT Board and Digital Board; Internal Audit programme reviewed by Audit Committee. Regular reports to Performance Committee.
2. Implementation programmes including operational support to undertake upgrade work. Planned upgrade in November 2022 and then the move to Epic Hyperdrive.
3. Monthly review at eHospital SMT. Regular reports to Performance Committee and Digital Board.

Prioritisation

4. Regular reports to Digital Board, Management Executive and Performance Committee.

Deployment

5. Transformation Benefits plans reviewed by eHospital SMT Board and Digital Board. Internal audit of transformation programme benefits realisation.
6. Reports to Performance Committee on Digital Strategy implementation.
7. New Digital Board to monitor delivery against the strategy with oversight of benefits realisation (in development).

Gaps in control	Gaps in assurance
Investment C1. Sufficient staffing to enable/align with digital aspirations. **Prioritisation** C2. Robust Trust-wide prioritisation process for digital change requirements aiming to maximise the benefits derived from the Trust's digital resources. C3. Establishment of methodology for the definition of benefits of IT investments. **Deployment** C4. New Digital Board to be put in place. C5. Implementation plan for Digital Strategy. C6. Establishment of IT investment benefits tracking approach.	

Actions to address gaps in controls and assurances	Due date
Investment C1a. Investment Committee proposal in preparation. C1b. Recruitment and retention plan to be revised and implemented (complete recruitment by June 2023). **Prioritisation** C2. New prioritisation process for Epic change requests, Telefonica Tech bespoke requests and non-Epic software deployment; strengthened Digital Board; benchmarking of prioritisation process with Johns Hopkins. C3. Develop, agree and embed benefits definition methodology as part of business case process. **Deployment** C4. Implementation of new Digital Board assuring Digital Strategy implementation plan. C5. Development of Digital Strategy implementation plan. C6. Develop, agree and embed benefits tracking approach.	 December 2022 December 2023 January 2023 January 2023 January 2023 January 2023 March 2023

Risk score	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun22	Jul 22	Aug 22	Sep 22	Oct 22
	12	12	12	12	16	16	16	16	16	16	16		
Risk redefined												16	16

BAF 003: Risk trajectory

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Oct 22)	4x4=16	
June 2023	4x3=12	Successful implementation of new IT prioritisation and benefits process and associated governance.
March 2024	4x2=8	Funding of additional staffing and successful implementation of recruitment and retention plan.

BAF risk	004	The Trust does not have a common framework across all areas within which we can consistently measure, track and improve standards of care, including patient experience and outcomes and provide assurance.

Current risk rating: 12

Strategic objective	A4, A5
Latest review date	October 2022

Lead Executive	Chief Nurse and Medical Director
Board monitoring committee	Quality

Risk rating	Impact	Likelihood	Total
Initial (Jun 19)	4	3	12
Current (Oct 22)	**4**	**3**	**12**

Change since last month

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Related BAF and Corporate Risk Register entries

ID	Score	Summary risk description
CR 06	9	Medication errors
CR 07a/07b	12	Infection prevention and control
CR 38	15	Deteriorating patients and Sepsis

Key controls
What are we already doing to manage the risk?

1. Trust strategic programme on Ward Accreditation is being developed with an education plan behind it.
2. Fundamentals of Care and accreditation committee is led by Head of Nursing for Assurance and Quality team, reporting into NMAAC.
3. Management Executive support for approach to ward accreditation.
4. Clinical policies and guidelines group leading adoption of Marsden manual.
5. Package of education being developed for fundamentals of care.
6. Education for development of Matrons is being developed.
7. Matron quality rounds being standardised & digitalised so data is transparent.
8. Value management boards for wards. Divisions and corporately are being developed to highlight improvement work across the Trust.
9. Transformation team are linking in with value management initiative.

Assurances on controls
How do we gain assurance that the controls are working?

1. Reporting to Patient Experience, Clinical Effectiveness and Patient Safety Groups.
2. Divisional quality meetings and monthly Performance Review meetings.
3. Reporting to Quality Committee and Board of Directors via IPR.
4. Outcome of CQC inspections and review of CQC outlier reports.
5. CQC peer review programme and Matron Quality Rounds.
6. Findings of reviews commissioned by the Trust.
7. First draft of ward accreditation metrics developed.
8. Clinical Fridays, twilight shifts and Executive visits.
9. Clinical audit programme.
10. Feedback from patients and staff.

Gaps in control	Gaps in assurance
C1. No systematic approach to overview of standards across all wards/clinical areas. C2. Insufficient staff engagement and ownership in improving practice standards. C3. Resources to take forward fundamentals of care.	

Actions to address gaps in controls and assurances	Due date
C1a. Development of ward accreditation programme – Division B-E audits being evaluated and piloting in Division A.	July 2022
C1b. Full roll-out of ward accreditation programme.	September 2022
C2. Development of a model of shared governance.	Ongoing
C3. Fundamentals of care standards launched across the organisation.	Ongoing

Risk score	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
	12	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**

BAF risk	005	**A failure to address life safety estate infrastructure systems and statutory compliance priorities caused by a backlog of works, insufficient capital funding commitment and decant capacity impacts on patient and staff safety, continuity of clinical service delivery, regulatory compliance and reputation.**

Current risk rating: 20

Strategic objective	C3
Latest review date	October 2022

Lead Executive	Director of Capital, Estates and Facilities Management
Board monitoring committee	Performance

Risk rating	Impact	Likelihood	Total
Initial (Sep 17)	5	4	20
Current (Oct 22)	5	4	20

Change since last month

Related BAF and Corporate Risk Register entries

ID	Score	Summary risk description
BAF 001	20	Capacity and patient flow
BAF 006	20	Fire safety compliance
CR 03	15	Water quality
CR 07a/07b	12	Infection control
CR 10	15	Electrical infrastructure resilience
CR 23b	12	FM contract performance in the ATC
CR 24	12	Ventilation requirements
CR42a	20	Safety Risk and non-compliance with the Fire Safety Regulation – Trust-wide buildings
CR 42b	20	Non-compliance with fire safety regulation in A block
CR42c	20	Failure of fire safety systems in the ATC
CR42d	20	Fire Alarm risks – operation of fire system evacuation key switches

Key controls

What are we already doing to manage the risk?

1. Policies, procedures and protocols in place to support management of building and engineering maintenance and direct future life safety infrastructure systems and compliance works.
2. Skilled maintenance and engineering staff.
3. Authorising engineers and appointed persons in place for each HTM discipline and training matrix established identifying key competency requirements. Training and refresher programme in place.
4. HTM subgroups to the CEFM Health and Safety Group established with quarterly reporting.
5. Up to date condition survey, in 2019, refreshed and reviewed annually.
6. Condition survey forms basis of backlog register and annual priorities.
7. Capital allocated via Capital Advisory Board (CAB).

Assurances on controls

How do we gain assurance that the controls are working?

1. Critical infrastructure and life safety systems register with risk rated entries presented annually to CAB, and reports to Board of Directors.
2. Spend on life safety systems reviewed by CAB.
3. QSIS reports of failures/incidents.
4. Health and safety related items from Divisional quality managers at Health and Safety Committee.
5. Infection Prevention and Control reports on infections associated with water quality.
6. Training records.
7. Compliance reporting to FMHSG.

8. Comprehensive maintenance agreements in place for key infrastructure. 9. Facilities Management Health and Safety Group (FMHSG). 10. Review of Risk register entries and QSIS incident reports at quarterly governance meetings. 11. Reports to Management Executive following quality incidents. 12. 24/7 Shift Technical Managers on duty, along with on-call engineering rota. 13. Annual external Authorising Engineer reports. 14. Bids to STP capital resulted in allocation of £19.2m for decant capacity in 2018. Regional surge centre (£49.2m) superseded £19.2m scheme. To be fully operational from June 2022. Part of the additional capacity (1 ward only) will be used as fire safety and critical infrastructure decant. 15. Capital allocation to continue with fire alarm upgrade project. 16. Ring-fenced revenue allocation over a number of financial years dedicated to fire compartmentation works. 17. Work continues to support development of the Cambridge Cancer Research Hospital with government funding announced in October 2020. 18. Work continues to support development of the Cambridge Children's Hospital as part of STP wave 4 allocation – now incorporated into New Hospitals Programme. 19. Forward planning work underway as part of Estates Masterplan works and emerging development control plan.	

Gaps in control	Gaps in assurance
C1. Capital allocation does not meet the high risks (£45.9m) and £6.5m approved to date of the requested £9.495m for 2022/23. C2. Work continues to improve overall governance, data quality and pace of the statutory compliance groups, using Premises Assurance Model. C3. Not all failures can result in replacement and proactive replacement is not always possible.	A1. Not all infrastructure failures are reported, as staff respond to emergencies and deal with these as they arise.

Actions to address gaps in controls and assurances	Due date
C1. Risks associated with critical infrastructure and life safety systems to be considered as part of all organisational risks, including operational capacity. Full funding allocation via CAB for 2022/23 pending.	Ongoing
C2 and A1. Targeted work continues to improve the governance, supported by external authorising engineers and an increase in Appointed Persons and Competent Persons. Overall compliance is independently assessed and reported to CEFM Health and Safety Group.	Ongoing
C3. As part of forward planning in 2022/23, incorporate high risk systems for replacement during the ward fire safety works which are programmed as part of Stage 2 accelerated works.	Ongoing

Risk score	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
	20	20	20	20	20	20	20	20	20	20	20	20	20

BAF risk	006	A failure to address fire safety statutory compliance priorities caused by insufficient capital funding and decant capacity impacts on patient and staff safety and continuity of clinical service delivery.

Current risk rating: 20

Strategic objective	C3
Latest review date	October 2022

Lead Executive	Director of Capital, Estates and Facilities Management
Board monitoring committee	Board of Directors

Risk rating	Impact	Likelihood	Total
Initial (Dec 17)	5	4	20
Current (Oct 22)	5	4	20

Change since last month
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Related BAF and Corporate Risk Register entries		
ID	**Score**	**Summary risk description**
BAF 001	20	Capacity and patient flow
BAF 005	20	Life safety critical infrastructure systems
CR42a	20	Safety Risk and non-compliance with the Fire Safety Regulation – Trust-wide buildings
CR 42b	20	Non-compliance with fire safety regulation in A block
CR42c	20	Failure of fire safety systems in the ATC
CR42d	20	Fire Alarm risks – operation of fire system evacuation key switches

Key controls

What are we already doing to manage the risk?

1. Fire policy, protocols and risk assessments in place for all areas.
2. Authorising engineer for Fire is appointed and Fire Safety Team and Fire Response Team in place.
3. Skilled fire managers and fire advisers appointed.
4. HTM subgroup to the CEFM Health and Safety Group established with bi-monthly reporting.
5. Fire alarm upgrade continues as part of a multi-year programme.
6. Evacuation strategy and plan and equipment in place, including two fire evacuation lifts in A Block and installation of evacuation aids.
7. Fire safety awareness training in place – predominantly e-learning during Covid.
8. Ring-fenced revenue allocation for fire safety remedial works in place, administered via Capital Advisory Board (CAB) from 2021/22.
9. Approach to remedial works agreed by Board of Directors.
10. Opportunity for investment in fire risks as they arise, funded through CAB, if the ring-fenced revenue allocation cannot cover the costs.
11. Decant capacity now being delivered as part of Regional Surge Centre – works commenced in September 2020 with first phase completed in June

Assurances on controls

How do we gain assurance that the controls are working?

1. Review of Trust plans by Cambridgeshire Fire and Rescue Service (CFRS) - regular meetings continue to take place and future meetings are scheduled. CFRS planned audit programme to inspect the CUH premises re-commenced in summer 2021.
2. Quarterly reports to the Board of Directors to provide updates and assurance on plans.
3. Authorising Engineer audit report and Trust action plan reviewed by Audit Committee in February 2021.
4. Work to develop capacity plans – see BAF 001. Vacancies within fire safety team being addressed as soon as possible.
5. Multi-year ring-fenced fund to continue fire safety remedial works.

2021 and 56 beds due for delivery in late 2022 (see BAF risk 005). 12. Accelerated Stage 2 works scheme developed as a further step to compliance ahead of full decant. Accelerated Stage 2 works due to commence in April 2020 were paused due to Covid-19 but then restarted, with Ward D8 works completed in September 2020. Ward C2 accelerated stage 2 works completed in January 2022. 13. Authorised Engineer (AE) for Fire report on the A-block fire safety risks have been discussed at ROC with associated elements risk rated. Project tendered and approved by Board to commence in June 2022 with a target operational date of September 2023.	

Gaps in control	Gaps in assurance
C1. Detailed and definitive long-term fire safety improvement plan agreed with CFRS and progress monitored on a six-monthly basis, but does not show a definitive end date. C2. Large proportion of fire risk assessments are past their review dates. C3. AE report highlighted lack of local ownership for fire safety. C4. Fire training needs analysis to be refreshed and fire training in line with HTM paused due to Covid-19, with additional e-learning established but a reduction in face-to-face evacuation training. C5. Fire alarm evacuation key switches may not operate correctly or provide coverage to all areas. C6. Although vacancies reinstated, insufficient qualified staff to undertake the volume of work until fully recruited to. C7. Fire safety risks and operational challenge risks to be considered to develop a credible fire safety forward plan. Fire Safety Manager vacancy.	A1. Forward plan for Stage 2 works is contingent on decant capacity being made available. The Stage 2 forward programme has a predicted closure date of 2027, although it remains untested given Stage 2 works as part of the decant capacity do not commence until 2022/23.

Actions to address gaps in controls and assurances	Due date
C1. Being developed as part of ME discussions about capacity, fire safety and operational challenges. C2. Recruitment to vacancies in fire team. C3. Forms part of action plan. C4. Forms part of action plan. On-line training to be developed to improve mechanism for evidencing knowledge acquisition and develop a blend of face-to-face and e-learning. C5. Fire alarm system programming to bring the Trust in line with HTM 05-03 Part B cause and effect recommendations has been brought forward. Re-programming of the key switch operation and areas covered is currently being undertaken. Detailed strategy developed to address the risks over an 18 month period. C6. Prioritisation of duties and tasks. C7. As per C1. Interim support mobilised to support fire safety competent advice. Substantive appointment to head of fire safety made, postholder commenced on 4 April 2022. A1. As per C1.	C1. Ongoing – CFRS updated regularly. C2.-C6. Ongoing and incremental, with priority on fire alarm works over culture work. C7. See C1. A1. See C1.

Risk score	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
	20	20	20	20	20	20	20	20	20	20	20	20	20

BAF risk	007	There is a risk that the Trust does not have sufficient staff with appropriate skills to deliver its plans now and in the future which results in poorer outcomes for patients and poorer experience for patients and staff.

Current risk rating: 20

Strategic objective	B1, B2
Latest review date	October 2022

Lead Executive	Director of Workforce
Board monitoring committee	Workforce and Education

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	4	4	16
Current (Oct 22)	4	5	20

Change since last month

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Related BAF and Corporate Risk Register entries

ID	Score	Summary risk description
BAF 001	20	Capacity and patient flow
CR43	20	Insufficient staffing on adult inpatient wards
CR54	20	Cost of living

Key controls

What are we already doing to manage the risk?

Recruitment

1. Multi-source recruitment pipeline for nursing and medical recruitment, including apprenticeships, local, national and international supply.
2. Comprehensive calendar of recruitment - CUH and part of wider system.
3. Daily review and programme of redeployment of staff to maintain safety.
4. Identification of staffing requirements and review of staffing ratios and ways of working in response to capacity pressures.
5. Use of Bank enhancements and agency with governance and scrutiny.
6. Board approval in November 2021 to commence recruitment for 56-bed unit and in July 2022 for recruitment for 40-bed unit.
7. Changes to recruitment plan to attract candidates to roles traditionally recruited locally, in context of relatively high local employment levels.
8. Investment at scale in new registered nursing supply route: Graduate Nurse Apprenticeships.
9. Outline plan for the Trust to become an anchor institution for learning.
10. Collaboration on international recruitment of nurses and midwives with east of England partners.
11. Development of new roles such as Nursing Associate role (first recruitment wave completed).

Retention

1. Use of data analysis to identify reasons for attrition in order to develop response plan.
2. Development of retention plan focusing on five workforce priorities.
3. Benchmarking with regional and national trusts to review recruitment and retention premium (RRP) payments and put in place where required.

Assurances on controls

How do we gain assurance that the controls are working?

1. Daily site safety meetings to evaluate staff levels and mitigate against shortfalls.
2. Weekly pay review meetings to consider bank fill rates vs enhanced payments.
3. Monthly nursing/midwifery safe staffing report to Board of Directors, including tracking of progress against nursing pipeline through safe staffing Board report from Chief Nurse.
4. Monthly data in Integrated Performance Report on turnover, vacancies, bank/agency fill rates/etc. reviewed by Performance Committee and Board.
5. Staff Survey (annual and quarterly FFT) recommender scores.
6. Quarterly reporting to Board by Guardian of Safe Working for junior doctors.
7. Workforce and Education Committee oversight (quarterly).
8. NHSE/I Oversight and Support Meetings.
9. Establishment in July 2022 of new weekly retention and recruitment taskforce chaired by Director of Workforce.
10. Data analysis in place to track impact of interventions on retention.

4. Enhanced wellbeing and good work programme, supported by ACT. 5. Partnership working on real living wage, transport and accommodation.	

Gaps in control	Gaps in assurance	Actions to address gaps in controls and assurances	Due date
C1. Potential national visa processing delays due to prioritisation of Ukrainian refugees.		C1a. Broaden pipeline to reduce dependency on any one recruitment stream. Bringing forward pipeline in accordance with quarantine regulations. Work with international agencies to increase pipeline of "ready now" nurses. C1b. Continue to submit visa applications as early as possible.	C1 – March 2023 aim to achieve overall 5% vacancy rate
C2a.Very limited hospital-provided accommodation impacting on numbers of new international recruits we can start. C2b. Shortage of affordable accommodation in Cambridge impacting on employee attraction and retention.		C2a. Working with partners on sourcing affordable, accessible accommodation including conversion of on-site space. Use of additional accommodation at Waterbeach. C2b. Raising issue of scope for funded high cost of living allowance for Cambridge.	C2a. March 2023 C2b. Ongoing
C3. Continued high levels of staff unavailability due to levels of sickness absence.		C3a. Prospective review of rosters and daily review of staffing. C3b. Increasing enhancements to support operations pool fill.	C3. Ongoing
C4. Workforce plans for 40/56 bed units identified and recruitment commenced but not complete.		C4a. Strong pipelines in place and targeted campaigns continue (6 month lead time). C4b. Working with system partners.	C4. Ongoing
C5. National shortage of training places in specific professions.		C5a. Introduction of AHP apprenticeship roles. C5b. Work regionally and nationally to identify options to increase training places within C&P system, including apprenticeships across nursing, admin and AHPs.	C5. Ongoing
C6. Increasing vacancy rates for admin and clerical roles.		C6. Large A&C advertising campaign, centralisation of admin recruitment process and flexible working drive.	C6. March 2023

Risk score	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
	20	20	20	20	20	20	20	20	20	20	20	20	20

BAF 007: Risk trajectory

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Oct 22)	4x5=20	
March 2023	4x4=16	Achievement of overall 5% vacancy rate by March 2023.
March 2024	4x3=12	Maintain overall 5% vacancy rate and secure positive position on retention and work availability through work on accommodation, cost of living, etc.

BAF risk	008	The Trust does not develop and implement effective actions to achieve greater equality and diversity in the CUH workforce and therefore does not realise the benefits of being a truly diverse and inclusive organisation from a workforce perspective, which impacts adversely on staff wellbeing and the quality of patient care.

Current risk rating: 16

Strategic objective	B4
Latest review date	October 2022

Lead Executive	Director of Workforce
Board monitoring committee	Workforce and Education

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	4	3	12
Current (Oct 22)	4	4	16

Change since last month
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Related BAF and Corporate Risk Register entries		
ID	Score	Summary risk description
CR45	12	Failure to meet patients' equality and diversity needs

Key controls

What are we already doing to manage the risk?

1. The explicit inclusion of workforce diversity and inclusion in the Trust strategy and core objectives.
2. A Non-Executive director appointment with a portfolio that includes EDI.
3. Establishment of staff networks aligned to EDI minority groups, with board level sponsorship and active promotion of meetings/events.
4. Driving of the WRES and WDES agenda, including establishing an oversight at board level of ambitious action plans and audit or progress.
5. Sign up to and active participation in regional (East of England) Anti-Racism Strategy.
6. Introduction of operational interventions:
    - Diversity leads participating in senior appointment processes and decision making – successful campaign for Diversity Panellists
    - Cultural ambassadors introduced to disciplinary processes
    - Introduction of formal triage process prior to ER investigations
7. Established and Board level Reverse Mentoring Programme.
8. Response to Covid-19 global pandemic: BAME staff health taskforce and monitoring vaccination uptake among BAME staff.
9. Roll out of individual health risk assessment with high level of completion, with reference to ethnicity.
10. Monitoring of Gender Pay gap.
11. Exploration of wider groups to support EDI agenda, e.g. Women's Network and Inter-Faith Group.

Assurances on controls

How do we gain assurance that the controls are working?

1. Annual staff survey results, specifically the experiences of and engagement of minority groups.
2. Quarterly Staff FFT results including local questions and breakdown by protected characteristics.
3. Monitoring by Equality, Diversity and Dignity Steering Group.
4. Oversight by Workforce and Education Committee.
5. WRES and WDES implementation groups established to establish and ensure delivery of WRES and WDES action plans.
6. Annual diversity updates to Board (most recently WRES in September 2021and WDES in November 2021).
7. Biannual reporting to the Board of Directors on Freedom to Speak Up.
8. CQC Well-led internal assessment in 2018/19.
9. Freedom to Speak Up index – CUH 2nd highest in Shelford Group.
10. Monitoring of BAME individual health staff risk assessments undertaken.
11. Equality Impact Assessment tool introduced to decision making in the Covid-19 command structure.
12. Annual report on Gender Pay Gap.
13. Challenge from East of England Anti-Racism Group.

Gaps in control	Gaps in assurance
C1. Issues regarding equality highlighted in WRES metrics 2022 and staff survey, including as they relate to BAME and disabled staff – significant deterioration in staff survey results relating to ethnicity and disability. C2. Poor representation of BAME colleagues at senior level (Band 6 and above). C3. Trust does not have an overarching equality, diversity and inclusion strategy.	

Actions to address gaps in controls and assurances	Due date
C1a. Implementation of staff survey action plan including action plans on bullying, WRES (informed by Anti-Racism Strategy) and WDES (including new 10-year BME staff targets from NHSE/I). Review and strengthening of action plan in response to 2021 survey results. C1b. HRD stakeholder in regional EDI programme. C1c. Commissioning of support from external stakeholders ('brap' and 'Above Difference'). C2. Review of recruitment practice and implementation of regional and national action plans. C3. Group convened under Chief Executive's leadership to develop plans for a CUH EDI strategy, including use of external support.	Ongoing Date to be confirmed Ongoing

Risk score	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
	16	16	16	16	16	16	16	16	16	16	16	16	16

BAF risk	009	New hospitals proposals are not developed, approved and/or built in a timely way resulting in the need to maintain poor quality facilities for an extended period of time and a failure to realise the clinical, operational and wider benefits.

Current risk rating: 16

Strategic objective	C3
Latest review date	October 2022

Lead Executive	Director of Strategy and Major Projects
Board monitoring committee	Addenbrooke's 3/ Board of Directors

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	3	4	12
Current (Oct 22)	4	4	16

Change since last month

Related BAF and Corporate Risk Register entries		
ID	**Score**	**Summary risk description**
CR05a-e	16-20	Insufficient capacity for patient needs
CR20	8	Access to/from the campus due to inadequate local transport
BAF 005	20	Estates backlog
BAF 006	20	Fire safety
BAF 010	12	Effective ICS working
BAF 012	9	Impact of Trust and industry/research partners

Key controls

What are we already doing to manage the risk?

1. Joint Strategic Board (JSB) and underpinning governance including Joint Delivery Board (JDB) and workstreams in place for Cambridge Children's Hospital (CCH) and for Cambridge Cancer Research Hospital (CCRH).
2. Regular reporting to ME and Addenbrooke's 3 Board committee in place.
3. Monthly progress meetings with NHSE/I (regional & national) and DHSC and regular engagement with New Hospitals Programme (NHP).
4. CCRH Outline Business Case (OBC) approved by CUH Board in October 2022 and CCH OBC due for Board approval in November 2022.
5. CCRH part of the first wave of the Government's NHP. CCH now included in NHP although programme phase not yet known – further work underway with NHP to 'twin' the projects or agree another suitable route for CCH to proceed with national funding to current timetable.
6. All projects and their business cases underpinned by core objectives such as being an active partner within our ICS and region; transforming models of care; digital enablement; accelerating research benefits locally, regionally and nationally.
7. Fundraising campaigns in place for CCH and CCRH. Cornerstone gift secured for CCH. Work underway on commercial strategies.

Assurances on controls

How do we gain assurance that the controls are working?

1. Monthly reporting on progress to JDBs and six weekly to JSBs. Progress reported and areas for escalation raised and resolved.
2. Addenbrooke's 3 programme work plan actively monitored in working group meeting and progress reported at Addenbrooke's 3 Board committee.
3. Addenbrooke's 3 Board committee overseeing progress and providing input to the overarching Addenbrooke's 3 programme and strategy.
4. Performance Committee review/sign off and Board sign off of business cases ahead of submission to regulators and proactive engagement with commissioners to determine final content and approval process.
5. The PBC options describe the phases of development of the CUH campus over the next 10-15 years.
6. Aspects of the business cases are shared with NHSE and DHSC on a regular basis for comment and input, to increase familiarity with our plans ahead of formal sign off.

8. Patient and public engagement plans in place for both CCRH and CCH. 9. Addenbrooke's 3 Programme Business Case (PBC) submitted in May 2021.	

Gaps in control	Gaps in assurance	Actions to address gaps in controls and assurances	Due date
C1. Impact of high rates of inflation on development costs for new hospitals.		C1. Ongoing discussions with NHP team on funding issues.	Ongoing
C2. University of Cambridge require enhanced decision making rights across CCH and CCRH in order to demonstrate sufficient control over programme risks.		C2. New governance model to be developed between University of Cambridge and NHS partners for CCH and CCRH, to augment the current landlord-tenant model beyond OBC submission.	January 2023
C3. CCH and CCRH programmes require strengthened governance and capabilities, including project management, in phases following OBC.		C3. New Programme Director role to be established with complete oversight of both CCH and CCRH programmes; new Construction Director roles to be appointed in both programmes; new governance arrangements to be established to ensure governance arrangements of overall programme workstreams are robust, as set out in OBC management case.	March 2023
C4. Phasing of CCH within NHP and scope/funding gap issues to be resolved.		C4. Costs versus benefits of any scope increase for CCH to be described within the OBC. Ongoing discussions with NHP team.	December 2022
C5. There is no allocated funding before 2025 for any further Addenbrooke's 3 projects, resulting in an impact on the ability of CUH to address the ED estates constraints and the critical infrastructure issues (see BAF risk 005).		C5. PBC for Addenbrooke's 3 describes phased plans for CUH campus for short (next 18 months), medium (2021–2025) and longer term (2025+). Work to identify potential estates redevelopment/upgrade opportunities arising from delivery of CCRH and CCH.	Ongoing

Risk score	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
	12	12	12	12	12	12	12	12	12	12	12	12	16

BAF risk	010	The Trust does not work effectively with partners across the Cambridgeshire and Peterborough Integrated Care System (ICS) and the South Place resulting in a failure to sustain and improve services for local patients and regulatory intervention and/or the recurrence of a financial deficit.

Current risk rating: 12

Strategic objective	A1
Latest review date	October 2022

Lead Executive	Interim Director of Strategy and Major Projects
Board monitoring committee	Board of Directors

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	*Risk reframed in Oct 22*		
Current (Oct 22)	4	3	12

Change since last month: ⟺

Related BAF and Corporate Risk Register entries		
ID	**Score**	**Summary risk description**
BAF 009	16	New hospitals development proposals
BAF 011	16	Financial sustainability

Key controls
What are we already doing to manage the risk?

1. Setting Integrated Care as a major priority in the Trust's refreshed Strategy.
2. Participating in ICS/Integrated Care Board (ICB) working groups and processes.
3. Hosting Cambridgeshire South Integrated Care Partnership (South Place); agreeing 'Framework for Integrated Care' as a vision and roadmap; co-chairing the ICP Joint Strategic Board to set direction; investing in a skilled team at CUH to undertake work with partners; investing in patient engagement through Healthwatch.
4. Leading urgent and emergency care (UEC) and discharge transformation programmes; developing pathway transformation between primary and secondary care; developing integrated teams in primary care.

Assurances on controls
How do we gain assurance that the controls are working?

1. Regular communication with ICS/ICB Executive to shape programmes of work and escalate issues.
2. Regular updates to Management Executive from the South Place Joint Strategic Board and bimonthly reporting to the Board of Directors.
3. Feedback and intelligence from Executive Team participation in, and leadership of some, system-wide groups.

Gaps in control	Gaps in assurance
C1. Arrangements not yet confirmed regarding the devolution of resource and accountability from the ICB to the South Place. C2. Not all providers are investing sufficiently to design and implement integrated models of care.	

Actions to address gaps in controls and assurances	Due date
C1. Executive engagement with ICB/other providers to achieve clear and ambitious devolution of contracts and resource. C2. Use Cambridgeshire South ICP boards to identify shared transformation priorities and pilot new approaches. Develop a repeatable process to identify, grow and spread these.	September 2023 December 2023

C3. Tight financial positions at CUH and at the ICB lead to short-term, ad-hoc, at-risk funding for work that requires sustained support. C4. Clinical transformation in CUH and with partners is crowded out by urgent pressures to sustain current services.		C3. Develop a methodology to quantify shared risk / reward / benefits for collaborative projects and evolve CUH's investment approach to support this. C4. Allocate clinical lead for Integrated Care within CUH and use backfill arrangements to facilitate clinical engagement.	March 2024 December 2022 and ongoing

Risk score	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
	12	12	12	12	12	12	12	12	12	12	12	12	12

BAF risk	011	**There is a risk that the Trust, as part of the Cambridgeshire and Peterborough ICS, is unable to deliver the scale of financial improvement required in order to achieve a breakeven or better financial performance within the funding allocation that has been set for the next three years, leading to regulatory action and/or impacting on the ability of the Trust to invest in its strategic priorities and provide high quality services for patients.**

Current risk rating: 16

Strategic objective	All
Latest review date	October 2022

Lead Executive	Chief Finance Officer
Board monitoring committee	Performance Committee

Risk rating	**Impact**	**Likelihood**	**Total**
Initial (Dec 20)	*Risk reframed in Dec 20*		
Current (Oct 22)	**4**	**4**	**16**

Change since last month
⟺

Related BAF and Corporate Risk Register entries		
ID	**Score**	**Summary risk description**
BAF 001	20	Capacity to restore services
BAF 003	12	Deployment of IT resources
BAF 010	12	Effective ICS working

Key controls
What are we already doing to manage the risk?

Financial planning and strategy

1. Development of financial plan for the 2022/23 financial year, underpinned by credible assumptions and realistic productivity and efficiency assumptions. Approved by Board in June 2022.
2. Financial input into development of system financial plans for Integrated Care Board (ICB) and oversight through Financial Planning and Performance Group (FPPG) within the ICB governance. Break even 2022/23 financial plan for ICB approved by Integrated Care Partnership (ICP) governing body and supported by regulators.
3. Oversight of the development of plans for the South Place.
4. Improvement and Transformation team oversight of Trust's improvement and transformation programme. Regular review of schemes and scheme identification against targets through divisional performance meetings.
5. Active engagement and involvement in national work to inform the development and design of the funding regime for the NHS, both directly and through the Shelford Group and NHS Providers.

Financial control:

6. Controls in place via Investment Committee to ensure appropriate governance and financial control on expenditure decisions (including Covid-related investments), including mechanism to ensure cases are appropriately prioritised through investment decision process/framework.

Assurances on controls
How do we gain assurance that the controls are working?

1. Oversight of financial plan delivery through Management Executive, Performance Committee and Board of Directors.
2. Updates on ICB system plans and financial performance to Performance Committee and Board.
3. Oversight of South Place planning through Performance Committee, Audit Committee and Board of Directors.
4. Monitoring of improvement programme through Divisional Performance Meetings, Improving Together Steering Group, Performance Committee and Board of Directors.
5. Updates on NHS financial regime provided to Management Executive, Performance Committee and Board of Directors.
6. Key financial controls reviewed on an annual basis by the Trust's internal auditors. Assurance over the design and effectiveness of financial controls provided by the Trust's Audit Committee. Investment decisions reported to Management Executive on a monthly basis.
7. Monthly financial performance reporting through divisional performance meetings, Management Executive, Performance Committee and Board.
8. Key financial controls reviewed on an annual basis by the Trust's internal auditors. Assurance over the design and effectiveness of financial controls provided by the Trust's Audit Committee.

7. Regular reviews of the Trust's financial performance through the monthly internal and external financial reporting cycle, including regular assessments of the Trust's underlying financial position and the use of forecasting tools to identify financial risks and mitigations 8. Effective design and implementation of key financial controls to ensure expenditure is reasonable, justifiable and represents value for money. Key controls - financial system controls, vacancy control procedures, segregation of duties, and procurement/contract management processes.	

Gaps in control	Gaps in assurance	Actions to address gaps in controls and assurances	Due date
C1. Macroeconomic environment, including supply constraints, inflation and pressure on public sector finances, as well as prevalence of Covid, may lead to additional financial pressure above funded levels or reduction in funding available to Trust. Ability to control these largely outside Trust's direct control.		C1. Ongoing monitoring of risks and impact on the Trust and ICB financial plan.	Ongoing
C2. Planning guidance for the 2023/24 financial year is not yet available, and there remains significant uncertainty about the funding available for the NHS beyond the 2022/23 financial year. As a result, the Trust does not have a detailed financial plan and operating budget for the 2023/24 financial year.		C2. Develop and agree (through Management Executive, Performance Committee and Board) the financial plan and budget for the 2023/24 financial year.	February 2023
C3. Lack of a long-term financial strategy and plan to secure a sustainable financial future for the Trust as part of the ICB.		C3. Agreement of financial strategy and long-term plan through Management Executive, Performance Committee and Board.	November 2022
C4. Limited control over the financial and operational performance of other organisations in the ICB which may impact the Trust's financial performance (e.g. the value of Elective Recovery Funding received by the Trust).		C4. Ongoing monitoring of risks through FPPG, with reporting to Performance Committee.	Ongoing

Risk score	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 21
	16	16	16	16	16	16	16	16	16	16	16	16	16

BAF 011: Risk trajectory

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Oct 22)	4x4=16	
April 2023	4x3=12	Delivery of a 2022/23 financial position in line with plan. Development and agreement of a financially-sustainable plan and budget for the 2023/24 financial year.
November 2023	4x3=12	Delivery of the 2023/24 financial plan as at month 6, and a clear and agreed longer-term financial plan (2-3 years) which delivers a financially-sustainable financial performance for the Trust and the ICB.

BAF risk	012	The Trust and our industry and research partners – convened through Cambridge University Health Partners (CUHP) – fail to capitalise on opportunities to improve care for more patients now, generate new treatments for tomorrow and power economic growth in life sciences in Cambridge and across the region.

Current risk rating: 9

Strategic objective	C2
Latest review date	October 2022

Lead Executive	Director of Strategy and Major Projects
Board monitoring committee	Board of Directors

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	3	3	9
Current (Oct 22)	3	3	9

Change since last month: ⟺

Related BAF and Corporate Risk Register entries		
ID	**Score**	**Summary risk description**
BAF 009	16	New hospitals development proposals

Key controls
What are we already doing to manage the risk?

1. CBC Strategy Group is undertaking public consultation on a vision for 2050, setting out how the Biomedical Campus can bring together the right set of research, education, healthcare delivery and industry partners; and what opportunities and requirements this generates for transport and other infrastructure, people and skills. CUH taking a leading role in community engagement. Particular issues raised by our neighbours are being actively addressed – further work required to address concerns.
2. Through CBC Strategy Group we are supporting the further development of the Campus expansion proposals, including improving the existing Campus and work on masterplanning. CUH masterplanning work to be aligned.
3. CUH is a founding member of CBC Ltd spanning key current occupants of the CBC to drive forward implementation of the Vision.
4. Material on the Cambridge offer in the next stage of the pandemic being produced, following workshops to gather and articulate Cambridge's distinctive assets nationally and globally.
5. Specific work on how the CBC can support the ICS, in particular elective recovery and diagnostics; and wider priorities including economic growth and levelling up.
6. Continuing to develop world-class research infrastructure at the Cambridge Biomedical Research Centre and Clinical Research Facility. Digital strategy for CUH includes opportunities to enhance and maximise

Assurances on controls
How do we gain assurance that the controls are working?

1. Regular updates to Board of Directors on CUHP, CBC and life sciences, most recently in April 2021.
2. Board Committee established for Addenbrooke's 3 programme to increase Non-Executive scrutiny, including of how we are working with and contributing to our campus and other partners. Significant discussion on CUHP and CUH masterplan took place in March 2022.
3. Strategy refresh considering partnerships as a major plank, including how we build capacity and capability internally to work as effective partners.
4. Involving partners in key CUH governance groups, particularly on major projects.
5. Executives participating in CBC Ltd working group on Campus development proposals and appropriate ICS and regional NHS groups.
6. Regular engagement with Government and other national bodies to assess how Cambridge is perceived. Cambridge Life Sciences Council now established, with first meeting in May 2022, chaired by David Prior.
7. External input and expertise from NHS, academic and industry partners to provide independent advice and challenge.

the wider benefits of this key resource for research. Very positive Research Excellence Framework (REF) outcome for University of Cambridge. 7. Supporting engagement between the Eastern Genomics Laboratory Hub and Illumina to address capacity challenges, broaden joint research projects and embed genomics fully within our programme of new hospital builds. 8. Broadening partnerships with industry and the University, including extending work with the Institute for Manufacturing (IfM) to RPH, CPFT, AZ, GSK, primary care and other NHS trusts across the East of England. Discussions to begin on broadening IfM type partnership to other areas of the University of Cambridge. 9. Work ongoing with other trusts across the East of England on the specialist provider collaborative, focused on improving access to specialist care within the region, including in paediatrics and cancer.	

Gaps in control	Gaps in assurance	Actions to address gaps in controls and assurances	Due date
C1. National work to promote Cambridge's distinct contribution to the Covid response. C2. Buy-in and commitment from all partners to make the most of our collective opportunities, working through differences in priorities as they arise.		C1a. Involving Campus partners in regional and national media. C1b. Implementation of the Cambridge offer currently being planned. C2a. Maximise in-kind contributions, including from CUH, to complement CUHP core team. Enhanced core budget agreed. C2b. CUH strategy refresh includes strong focus on capacity and capability to invest in new partnerships. C2c. Further work on a clear 'manifesto' for Cambridge Life Sciences being undertaken, drawing in thought leaders from across the Campus. C2d. Further work with University of Cambridge to extend partnerships to new areas.	Ongoing Ongoing Completed Completed Ongoing Ongoing

Risk score	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
	9	9	9	9	9	9	9	9	9	9	9	9	9

BAF risk	013	There is a risk that we fail to maintain and improve the physical and mental health and wellbeing of our workforce, particularly in the context of the effects of the Covid-19 pandemic, which impacts adversely on individual members of staff and our ability to provide safe patient care now and in the future.

Current risk rating: 16

Strategic objective	B3, B5
Latest review date	October 2022

Lead Executive	Director of Workforce
Board monitoring committee	Workforce and Education

Risk rating	Impact	Likelihood	Total
Initial (Apr 21)	4	4	16
Current (Oct 22)	**4**	**4**	**16**

Change since last month

⟺

Related BAF and Corporate Risk Register entries

ID	Score	Summary risk description
BAF 007	20	Meeting workforce demand
CR54	20	Cost of living

Key controls

What are we already doing to manage the risk?

1. Staff Wellbeing Strategy in development.
2. Occupational Health offer with a range of services in place including health pre-employment support, health surveillance programme and management referral pathways.
3. Staff psychological wellbeing and support offer, collaborating with system partners (inc. CPFT), and complemented by Chaplaincy offer. Introduction of multidisciplinary ZIP team bringing together professions from across the Trust.
4. Covid-19 health risk assessment (Version 7) process in place, comprehensive Covid-19 in-house test and trace system and on-site vaccination programme. Range of measures to maintain a Covid secure environment under regular review.
5. Annual flu vaccination and Covid-19 booster vaccination programmes confirmed for autumn 2022 and being delivered.
6. Established equality, diversity and inclusion networks and events promoting health and wellbeing.
7. Public health offer (lifestyle health checks, support and advice – smoking cessation, weight management).
8. 24/7 employee assistance programme (Health Assured) offering practical advice, counselling and support.
9. Support offer for redeployees returning to substantive areas of work and leadership support circle facilitation Trust-wide.
10. Developing a model of 'Good Work' with six priority areas including a programme of support for staff wellbeing, cost of living assistance

Assurances on controls

How do we gain assurance that the controls are working?

1. Management Executive oversight on key programmes of work via taskforce reporting and reporting on specific issues.
2. Reporting to Workforce and Education Committee.
3. Reporting to Health and Safety and Infection Prevention and Control Committees; and Covid-19 Secure Taskforce.
4. Safe Effective Quality Occupational Health Services (SEQOHS) independent accreditation.
5. Assurance update on staff Covid-19 vaccination to Quality Committee in May 2021 with subsequent updates, including on ethnic group breakdown.
6. National and local staff survey evidence on staff health and wellbeing and collation of learning from staff stories.
7. Reporting to Regional People Board via the Regional Health Safety and Wellbeing Group.
8. Chief Executive-led working group on 'Good Work' reporting to Management Executive.

(including on transport costs) and staff amenities. Initial transport cost support measures announced on 23 May 2022, including car parking subsidy and free Park and Ride bus travel.	

Gaps in control	Gaps in assurance	Actions to address gaps in controls and assurances	Due date
C1. Emerging impact of Long Covid and potential emergence of new variants - uncertain impact on CUH staff health and wellbeing.		C1. Situational awareness, call-back service and monitoring.	Ongoing
C2. Ability to meet increasing demand for staff psychological health support.		C2. Plans to grow psychological support programme following May 2021 investment case approval.	Ongoing
C3. Inadequate provision of staff rest spaces and other amenities.		C3. Management Executive has received and reviewed costed options, and Capital Advisory Board has allocated funding for initial schemes to be progressed. Initial schemes being implemented and further ones developed.	Ongoing
C4. Further work required on measures to support staff with cost of living pressures.		C4. Development of further plans through 'Good Work' Group.	Ongoing

Risk score	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
	16	16	16	16	16	16	16	16	16	16	16	16	16

BAF 013: Risk trajectory

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Oct 22)	4x4=16	
March 2023	4x4=16	Avoid further increase in risk though range of interventions including psychological support, staff recognition and cost of living support.
March 2024	4x3=12	Reduced sickness absence; improved staff engagement and wellbeing scores as measured through national staff survey.

BAF risk	014	The Trust does not work effectively with regional partners (particularly regarding specialised services) resulting in a failure to sustain and improve services for regional patients and regulatory intervention and/or the recurrence of a financial deficit.

Current risk rating: 12

Strategic objective	C1
Latest review date	October 2022

Lead Executive	Interim Director of Strategy and Major Projects
Board monitoring committee	Board of Directors

Risk rating	Impact	Likelihood	Total
Initial (Oct 22)	4	3	13
Current (Oct 22)	**4**	**3**	**12**

Change since last month
New

Related BAF and Corporate Risk Register entries		
ID	**Score**	**Summary risk description**
BAF 009	16	New hospitals development proposals
BAF 011	16	Financial sustainability
BAF 012	9	Impact of Trust and industry/research partners

Key controls
What are we already doing to manage the risk?

1. Setting Specialised Services as a major priority in the Trust's refreshed Strategy.
2. Working with other trusts in the region through the East of England Specialised Provider Collaborative (East of England SPC), including quarterly CEO meetings.
3. Engaging with key stakeholders (NHS England Specialised Commissioning, ICBs, providers, networks) to prioritise opportunities for specialised services.
4. Influencing NHS England on specialised commissioning developments by participating in / leading Shelford Group forums on specialised services.

Assurances on controls
How do we gain assurance that the controls are working?

1. Regular EoE SPC meetings to continue to progress agenda.
2. Regular updates to Management Executive and Board of Directors.
3. Feedback and intelligence from Executive Team participation in, and leadership of some, national and regional groups.

Gaps in control	Gaps in assurance
C1. ICBs and regional commissioning teams do not engage with providers on changes to specialised services (e.g. lack of representation in key governance forums). C2. EoE SPC partners do not co-invest/commit to changes to services and the collaborative becomes unviable. C3. Tight budgets at CUH/other providers leads to short-term, ad-hoc, at-risk funding for work requiring sustained support. C4. Clinical transformation in CUH and with partners is crowded out by urgent pressures to sustain current services.	

Actions to address gaps in controls and assurances	Due date
C1. Continue engaging with ICB leads and NHS England regional team to secure participation in governance forums. C2 and C3. Obtain support from CEOs to co-resource the collaborative and expand over time; continue investment from CUH. C4. Agree shared priorities across providers in EoE SPC, as well as internal discussions within CUH, and begin to show impact through progressing identified transformation initiatives.	January 2023 September 2023 March 2023

Risk score	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
	12	12	12	12	12	12	12	12	12	12	12	12	12

Annex 1: Trust risk scoring matrix and grading

	Likelihood				
Impact	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
Catastrophic 5	5	10	15	20	25
Major 4	4	8	12	16	20
Moderate 3	3	6	9	12	15
Minor 2	2	4	6	8	10
Negligible 1	1	2	3	4	5

Risk Assessment	Grading
15 – 25	**Extreme**
8 – 12	**High**
4 – 6	**Medium**
1 – 3	**Low**

Annex 2: Trust strategic commitments, July 2022

	A	B	C
	Improving patient care	**Supporting our staff**	**Building for the future**
1	**Integrated care:** We will work with NHS, other public sector and voluntary sector organisations to improve the health of our local population	**Resourcing:** We will invest to ensure that we are well staffed to deliver safe and high quality care	**Specialised services:** We will work with hospitals across the East of England to provide high quality specialised care for more patients closer to home
2	**Emergency care:** When patients come to the hospital in an emergency we will treat them, and help them to return home, quickly	**Ambition:** We will invest in education, learning, development and new ways of working	**Research and life sciences:** We will conduct world-leading research that improves care and drives economic growth
3	**Planned care:** When patients need planned care we will see them as quickly and efficiently as possible	**Good work:** We will strive to ensure that working at CUH will positively impact our health, safety and well-being	**New hospitals and the estate:** We will maintain a safe estate and invest in new facilities to improve care for patients locally, regionally, and nationally
4	**Health inequalities:** We will tackle disparity in health outcomes, access to care and experience between patient groups	**Inclusion:** We will seek to drive out inequality, recognising that we are stronger when we value difference and inclusion	**Climate change:** We will tackle the climate emergency and enhance environmental sustainability
5	**Quality, safety and improvement:** We will continuously improve the quality, safety and experience of all our services	**Relationships:** We will foster compassionate and enabling working relationships	**Digital:** We will use technology and data to improve care

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 9 November 2022

Agenda item	17
Title	Risk Management Strategy and Policy
Sponsoring executive director	Lorraine Szeremeta, Chief Nurse
Author(s)	Jumoke Okubadejo, Director of Clinical Quality
Purpose	To review and approve the revised Risk Management Strategy and Policy.
Previously considered by	Risk Oversight Committee, 6 October 2022

Executive Summary

The Risk Management Strategy and Policy has been reviewed by the Risk Oversight Committee in line with its annual review cycle. Minor amendments have been made to ensure that the policy remains current and these were agreed by the Risk Oversight Committee at its meeting on 6 October 2022. The risk matrix now attached percentage ranges to the likelihood domain, as agreed by the Risk Oversight Committee.

The risk appetite statement, which forms part of the strategy and policy, has been reviewed as part of this process. No changes are proposed to the underlying risk appetite of the Trust.

Related Trust objectives	All Trust objectives
Risk and Assurance	The Trust strategy and policy sets out the framework for the management of risk by the Trust.
Related Assurance Framework Entries	All
Legal / Regulatory / Equality, Diversity & Dignity implications?	Compliance with the 'Well-Led' domain/CQC fundamental standards; Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
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 approve the revised Risk Management Strategy and Policy.

Strategy and policy

Risk management strategy and policy 2022/23

Key messages

- All staff must ensure that they identify all clinical and non-clinical risks to the delivery of safe, effective and high quality services.
- All staff must ensure that risks are assessed as soon as is reasonably practicable, identifying controls to mitigate negative impacts.
- When risks are identified and cannot be controlled effectively, risk leads are responsible for ensuring that they are escalated through the risk governance structure.
- Staff who manage risks on the risk register on behalf of the organisation must ensure that they receive training that is appropriate to their level of accountability and responsibility.

Summary

Cambridge University Hospitals NHS Foundation Trust's (the Trust) board recognises that the provision of healthcare and the activities associated with the treatment and care of patients, employment of staff, maintenance of premises and managing finances by their nature incur risks.

This document sets out the Trust's roles and responsibilities, accountability and systems and processes to enable robust risks management.

1 Scope

Trust-wide: Risk management activities applies equally to all staff and individuals employed by the Trust including; contractors, volunteers, students, locum, agencies and staff employed with honorary contracts.

2 Purpose

The document sets out strategic direction for risk management as it is both a statutory requirement and an important element of informed management decision-making at all levels of the organisation.

2.1 Strategy statement

The purpose of the risk management strategy is to provide the overarching principles, framework and processes to support managers and staff in the management of risk by ensuring that the Trust is able to deliver its objectives by

identifying and managing risks, enhancing opportunities and creating an environment that adds value to on-going operational activities.

The Trust is therefore committed to:

- Adopting best practice in the identification, evaluation and cost effective control of risks to ensure that they are reduced to an acceptable level or eliminated as far as is reasonably practical.
- Maximising opportunities to achieve the Trust's objectives and deliver core services provisions.

The Trust acknowledges that risks will always exist and never be fully eliminated and accepts responsibility for the residual risks when the risks have been reduced to an acceptable level or eliminated as far as is reasonably practical.

The Trust's strategic aim is to make the effective risk management an integral part of the Trust's governance, which is underpinned by clear responsibility and accountability arrangements throughout the organisational structure of the Trust.

These arrangements are set out in the following documents:

- Standing orders of the Board of Directors
- Standing financial instructions
- Standing financial instructions: Scheme of delegation of authority from the board of directors
- Accountability framework.

The Trust has adopted a holistic approach to risk management incorporating both clinical and non-clinical operational risks as well as risks to the strategic objectives. It has a board assurance framework in place to monitor risks to the strategic objectives and an electronic risk register called QSiS for operational risks, including the corporate risk register.

2.2 Policy statement

The board of directors is committed to the active management of operational risk, providing better care and a safer environment for patients, staff and other stakeholders. The aim is to achieve this without compromising flexibility, innovation and best practice in the delivery of patient care and treatment and service delivery and development.

The board assurance framework supports the management of risks to delivery of the Trust's strategic objectives, providing visibility of these risks to the management executive and the board.

The purpose of the risk management policy is to identify the proactive systems used by the Trust to effectively identify and manage its risks with the aim of protecting patients, staff and members of the public as well as its assets.

The Trust accepts its corporate responsibility to provide the highest standards of patient care and staff safety and as such, the process of risk management is viewed as an essential component in maintaining and improving standards in the Trust.

The objective of the policy is to ensure that the Trust has an effective system for identifying and managing risks with the aim of:

- Achieving its objectives
- Protecting patients, staff and members of the public
- Protecting its assets.

3 Introduction

The Trust recognises that healthcare provision and the activities associated with caring for patients, employing staff, operating premises and managing finances all involve risk. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks and responding to them.

Risk management is the responsibility of all staff and managers at all levels, and they are expected to take an active lead to ensure that risk management is a fundamental part of their operational area.

The Trust encourages an open and just culture that requires all Trust employees, contractors and third parties working within the Trust to operate within the systems and structures outlined herein, identifying, articulating, managing and escalating any risks where required.

Risk management is both a statutory requirement and also an integral part of good governance. It is a fundamental part of the total approach to quality, corporate and clinical governance and is essential to the Trust's ability to discharge its functions as a partner in the local health and social care community, as a provider of health services to the public and an employer of significant numbers of staff. It is expected that all risk management activities in the Trust will follow the process described in this document.
The Trust has adopted an integrated approach to the overall management of risk, irrespective of whether the risks are clinical, strategic, operational, environmental or financial.

4 Framework

This section describes the broad framework for the management of risk. Operational instructions for risk management, health and safety risk assessments, investigation of incidents and learning from incidents and central

alerts systems management are detailed in separate procedural documents (see section 16). The framework below explains the process for how risk is managed by the Trust:

Figure 1: Risk management process:

Figure 2: Operational governance framework
CUH Risk Management Strategy & Policy Operational Governance Framework 2020 (ii): *Adapted from Operational Risk Management Framework (Soneri Bank) 2017*

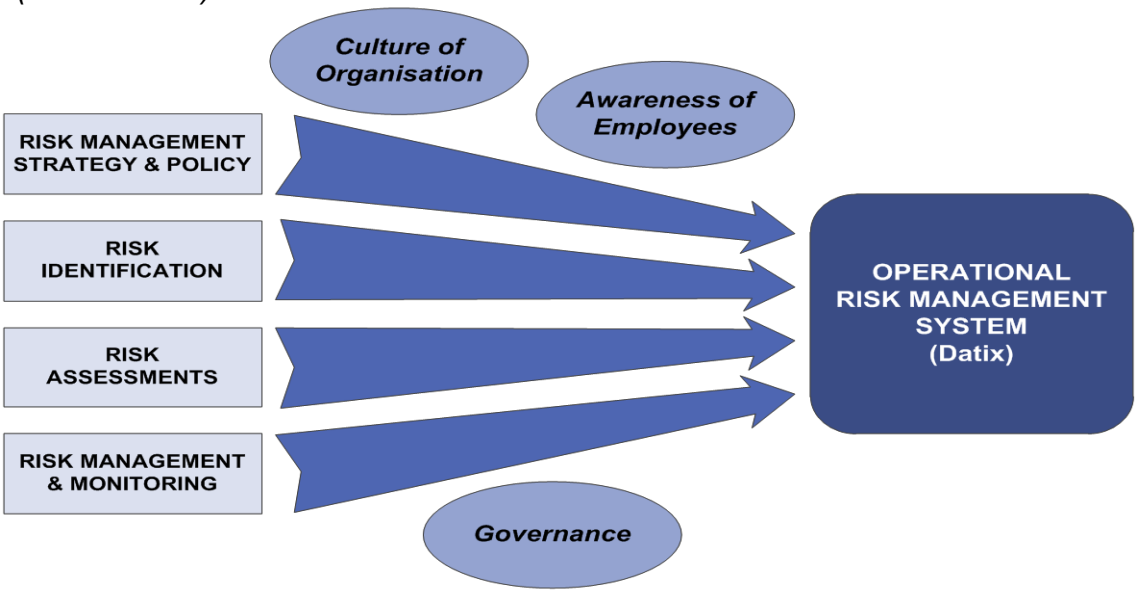
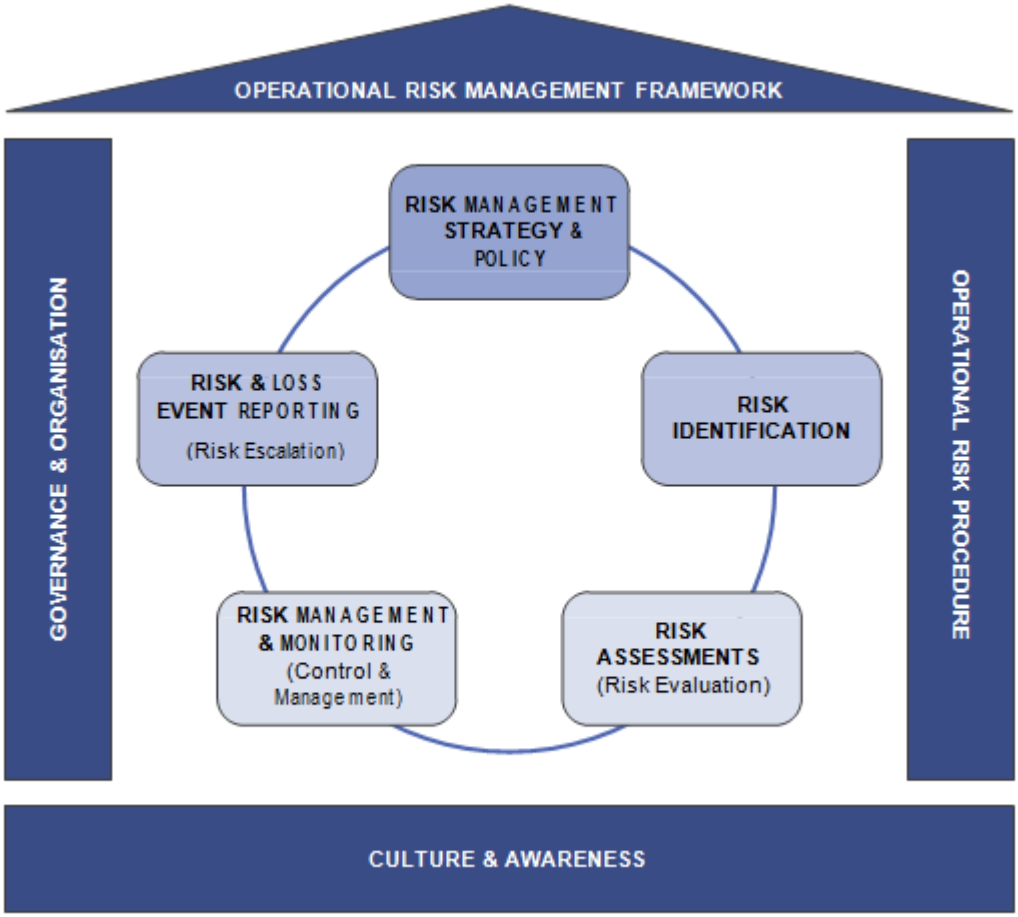


Figure 3: Governance framework 2022:



5 Assurance framework

Assurance of achievement, weaknesses in delivery and key risks to the delivery of Trust objectives are reported through the assurance committees of the board. The Trust assurance committees receive reports to inform them of all significant risk exposures, material changes to risks and progress with milestones.

The Trust assurance committees are responsible for providing assurance on the management of corporate risks to the board of directors and are identified in appendix 2 and 3 of the accountability framework.

6 Risk appetite statement

Risk appetite is defined as the amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time. The Trust's risk appetite statement shows the level of risk that the board has agreed to take with regards to quality/ outcomes, compliance/ regulation, innovation, reputation, financial/ value for money and commercial. The risk appetite statement expresses the

organisation's agreed level of risk it is collectively willing to accept and provides guidance to the organisations on how much risk should/ could be taken in the pursuit of operational or strategic delivery.

Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, consideration should be given to take further action to reduce the risk or to accept, after careful consideration, a higher risk tolerance.

The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk (see appendix 2 for statement and appendix 3 for the supporting risk matrix).

The Trust will review annually its risk appetite statement, updating these where appropriate. This includes the setting of risk tolerances at the different levels of the organisation, thresholds for escalation and authority to act, and evaluating the organisational capacity to handle risk. The periodic review and arising actions will be informed by an assessment of risk maturity, which in turn enables the board to determine the organisational capacity to control risk. The risk appetite review will consider:

- Risk leadership
- People
- Risk strategy and policy
- Partnerships
- Risk management process
- Risk handling
- Outcomes.

7 Risk management process

The Trust adopts a structured approach to risk management. Risks are identified, assessed, controlled and monitored, and where appropriate, escalated or de-escalated through the governance mechanisms of the Trust.

- Board committees are involved in the Trust's governance of risk. These are underpinned by divisional and corporate committees that provide the oversight for specific aspects of the operational or strategic delivery and are set out in the accountability framework and the good practice guide - quality governance in action (see section 16). A risk management governance structure is in place and explained on the Trust intranet.

7.1 Sources of risk

Risks for inclusion on the operational risk register may be identified from a number of sources including operational service delivery, audits, incidents/ near-misses, inspections, health and safety risk assessments, complaints and enforcement action.

Risks to the Trust's strategic objectives are identified through the annual review of the Trust strategic objectives and are included in the board assurance framework.

7.2 Risk management procedure

This risk management strategy and policy document is underpinned by a comprehensive risk management handbook which describes the process for effectively identifying, assessing, evaluating and monitoring risks. The document is held on the Trust's document management system.

The Trust's risk management cycle ensures that risks are identified, assessed, controlled, monitored, closed or accepted. When necessary, gaps in controls are escalated. These main stages are carried out through:

- Clarifying objectives
- Identifying risks to the objectives
- Assess and score the risk
- Identify controls and their effectiveness
- Identify and record actions to mitigate the risk
- Regularly review and monitor the risk, with accepting residual risks or closing risks when at target level
- Escalation and de-escalation of risks.

These processes are explained in the risk management handbook and e-learning is provided to risk leads and risk owners.

The operational risks are managed and monitored by the divisional senior leadership utilising the electronic risk register on QSIS.

Each division, directorate and specialty discusses their risk register, actions, and any required escalation through the accountability and quality governance framework.

7.3 Risk matrix

The Trust has adopted the risk matrix published by the National Patient Safety Agency to ensure that risks rated in the organisation fall broadly in line with other organisations. This also improves consistency of risk ratings within the organisation (see appendix 1).

7.4 Training and support

Support for staff involved in risk management - to support the successful implementation and embedding of the risk management strategy, policy and risk procedure the Trust has the following support in place for staff with a responsibility in risk management:

- All relevant staff are required to complete e-learning to access the Trust's risk module on QSiS.
- Risk owners are required to complete e-learning to enable them to articulate and manage risks on the risk register
- Risk leads are required to complete e-learning to enable them to support risk owners, monitor risk management in their area of responsibility and escalate gaps in controls
- Staff also have access to comprehensive guidance on the Trust intranet and advice by the risk team.

Board training – the Trust board will receive training every **two years**, to ensure that the requirements for understanding and discharging duties in relation to risk management at board level is reviewed and refreshed, thereby maintaining compliance with nationally agreed policy and practice.

Attendance/ participation records are co-ordinated centrally on the Trust's learning management system.

The Trust's management executive ensures monitoring arrangements are in place to review the overall effectiveness of the delivery of risk management training for board members and senior managers. Where such monitoring identifies deficiencies, recommendations will be agreed and an action plan developed and changes implemented accordingly.

7.5 Corporate risk register and board assurance framework

Risk management by the board is underpinned by a number of interlocking systems of control. The management executive risk oversight committee provides oversight, challenge and support to the divisions to manage their risks.

They review risk principally through the following three related mechanisms:

- **The board assurance framework (BAF)** sets out the strategic objectives of the Trust, identifies risks in relation to each strategic objective along with the controls in place and assurances available on their operation. The BAF is used to drive the board agenda.
- **The corporate risk register (CRR)** is the operational risk register including significant risks and actions plans where divisions cannot implement sufficient controls or they require executive oversight due to their Trust-wide nature or potentially high impact on the organisation

- **The annual governance statement** is signed by the chief executive as the accountable officer and sets out the organisational approach to internal control. This is produced at the year-end (following regular reviews of the internal control environment during the year) and scrutinised as part of the annual accounts process and brought to the board with the accounts.

The above is reported regularly to the board for assurance and with escalation of relevant significant risks where required. The quality and audit committees provide assurance on the robustness of risk management and support the board.

In addition, the risk management processes are currently reviewed annually by internal audit for external assurance.

The Trust risk management activities are a part of its overall commitment to effective clinical governance and patient safety. The risk management approach is underpinned by additional Trust policies supported by ongoing training including:

- All policies and procedures associated with healthcare acquired infections
- Business continuity planning policy
- Management of concerns and complaints policy
- Health and safety policy
- Health and safety risk assessments procedure
- Information governance and information security policy
- Management of incidents and serious incidents requiring investigation policy
- Management of safety alerts issued by the central alert system (CAS) policy and procedure
- Risk management handbook
- Safeguarding policies and procedures (adult and child)
- Perinatal services risk management strategy
- Violence and aggression management policy.

The Trust's systems of internal control are based on its on-going risk management programme that aims to:

- Identify principal risks to the achievement of goals set out in the annual plan
- Evaluate the nature and extent of risks

- Manage all risks effectively, efficiently and economically
- Enable the completion of the annual governance statement.

8 Horizon scanning

Horizon scanning focuses on identifying, evaluating and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the organisation.

Horizon scanning helps identify positive areas for the Trust to develop its business and services and provides a steer toward taking opportunities where these arise. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

By implementing formal mechanisms to horizon scan, the Trust will be better able to respond to changes or emerging issues in a planned, structured and co-ordinated way. Issues identified through horizon scanning should link into and inform the business planning process. As an approach it should consider ongoing risks to services.

The outputs from horizon scanning should be reviewed and used in the development of the Trust's strategic priorities, policy objectives and development. The scope of horizon scanning covers, but is not limited to:

- Legislation
- Government white papers
- Government consultations
- Socio-economic trends
- Trends in public attitude towards health
- International developments
- NHS England and NHS Improvement publications
- Local demographics
- Seeking stakeholders views
- Risk assessments.

All staff have a responsibility to bring potential issues identified in their areas which may impact on the Trust delivering on its objectives to the attention of their managers.

Board members have the responsibility to horizon scan and formally communicate matters in the appropriate form relating to their area of responsibility. The management executive undertakes regular horizon scanning with the support of the Strategy team.

9 Delivering the strategy

Executive directors, senior management teams and departmental/operational managers within the Trust will:

- Take into account the Trust's quality priorities and strategic objectives when managing risks
- Promote awareness and understanding of the benefits of proactive risk management, therefore developing a positive risk culture
- Manage risks through their own clinical/ speciality, departmental, directorate, divisional structure in line with this document
- Provide opportunities for training and ongoing support to ensure that staff are aware of the Trust's risk management processes and systems.

The Trust will:

- Ensure corporate ownership and accountability throughout the organisation for risk management
- Promote and support the development and implementation of risk management through annual review of this document
- Monitor the up-take of training in risk management
- Review and up-date the risk management strategy and policy and resources underpinning this document to ensure that they remain in line with best practice.

10 Roles and responsibilities

10.1 Chief executive

The chief executive is the accountable officer for Cambridge University Hospitals NHS Foundation Trust and is accountable for ensuring that the Trust can discharge its legal duty for all aspects of risk. As accountable officer, the chief executive has overall responsibility for maintaining a sound system of internal control, as described in the annual governance statement.

Operationally, the chief executive has designated responsibility for implementation as outlined below. The chief executive chairs the management executive risk oversight committee. The management executive, as the group responsible for the corporate risk register, decides which risks require recording and managing corporately or should be included on the board assurance framework.

10.2 Executive directors

Executive directors are accountable to the chief executive and the board of directors for the maintenance of effective systems of internal control within their areas of responsibility. Executive directors are responsible for reporting on controls and assurances of the highest risks to the Trust objectives through the board assurance framework and corporate risk register and other identified significant risks.

Each director is responsible for risk management leadership including the implementation of and compliance with current Trust policies, and for ensuring sufficient resources have been allocated to undertake effective risk management.

Executive directors are responsible for ensuring that the risks for which they are the executive leads on the corporate risk register and board assurance framework are reviewed on a monthly basis and that action plans for risk mitigations are implemented in a timely manner as agreed.

Leading by example, executive directors are fundamental in establishing and sustaining an environment of openness on risk management within their directorates.

10.3 Non-executive directors

Non-executive directors have responsibility for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (clinical and non-clinical) that support achievement of the organisation's policy. In particular, members of the audit committee will review the adequacy of the risk management policy, and receive regular monitoring information against the management of risks judged as significant within the board assurance framework and corporate risk register and provide assurance to the board of directors on the effectiveness of systems within the Trust designed to manage risk.

10.4 Chief nurse

The chief nurse is responsible for the executive leadership of risk management and the implementation of the processes and procedures set out in this policy. The chief nurse supports the executive and non-executive directors in carrying out their responsibilities for risk management and takes the lead, on behalf of the board of directors, for maintaining the corporate risk register that defines the principal risks to achieving the Trust's operational delivery together with associated controls, sources of assurance and action plans. The chief nurse works closely with the director of clinical quality in all matters relating to organisational governance and risk.

10.5 Director of corporate affairs

The director of corporate affairs is the corporate governance lead for the organisation. The director of corporate affairs supports the executive and non-executive directors in carrying out their responsibilities for risk management and takes the lead, on behalf of the board of directors, for maintaining the board assurance framework that defines the principal risks to achieving the Trust's strategic objectives together with associated controls, sources of assurance and action plans. The director of corporate affairs also advises the board in relation to the decision-making regarding the Trust's annual risk appetite statement and on the Trust's annual governance statement. The director of corporate affairs works closely with the chief nurse and the director of clinical quality in all matters relating to organisational governance and risk.

10.6 Director of clinical quality

The director of clinical quality is the quality governance lead for the Trust and is responsible for the Trust's risk management strategy and policy. The director of clinical quality is accountable to the chief nurse and is responsible for promoting and ensuring the implementation of Trust-wide systems and processes to enable the Trust to meet its requirements in relation to risk, up to and including the corporate risk register. The director of clinical quality works closely with the director of corporate affairs and appropriate others, in all matters relating to organisational governance and risk.

The director of clinical quality has a responsibility to ensure the delivery of appropriate training to Trust staff that enables the correct identification, analysis and scoring of risk, together with maintaining the Trust's electronic integrated system for risk management.

10.7 Head of risk and patient outcomes

The head of risk and patient outcomes is accountable to the director of clinical quality. The post holder is responsible for:

- Promoting and supporting the implementation of Trust-wide systems of risk management (including an electronic risk register)
- Administering the Trust's corporate risk register on behalf of the director of clinical quality and the management executive
- Reviewing annually the risk management strategy and policy and all underlying processes
- Providing support and training to staff on matters associated with risk management
- Providing assurance regarding data quality standards within the quality governance framework and to the assurance committees.

10.8 Risk management team

The risk management team are responsible for:

- Provide a database for managing risks for the organisation
- Monitor the quality of new risks in line with agreed key performance indicators (KPIs) and processes as set out in this document
- Provide training and be an expert resource to all staff involved in risk management
- Support and manage the corporate risk register on behalf of the Trust board
- Provide assurance to the management executive - risk oversight committee, performance, quality, workforce and audit committees (as appropriate) on risk management across the organisation.

10.9 Divisional senior leadership

Divisional directors are responsible for:

- Ensuring that appropriate and effective risk management processes are in place in their designated area and scope of responsibility
- Implementing and monitoring any control measures identified
- Ensuring risks are captured on the electronic risk register
- Ensuring that gaps in controls are escalated where all reasonably practicable actions have been taken and the risk is not sufficiently controlled
- Ensuring that local groups review risk registers on a regular basis to consider and plan actions being taken.

They are accountable for:

- Ensuring that clinical risks, health and safety risks, emergency planning and business continuity risks, relevant project and operational risks are identified and managed
- Ensuring that risks are reviewed by an appropriate divisional group as part of performance monitoring, actions are taken to mitigate risks
- Ensuring appropriate escalation of risks from services or directorates to divisional level within the defined tolerances and processes as set out in the risk management handbook.

10.10 Senior managers and senior staff

Senior managers take the lead on risk management in their services and are expected to:

- Identify risks to the safety, effectiveness and quality of services, finance, delivery of objectives and reputation
- Oversee and support the risk owners and risk leads in the carrying out their duties with regards to risk management
- Ensure that assurance and oversight of risk management in their area is managed through the governance framework.

10.11 Head of health and safety

The head of health and safety is accountable to the director of workforce and is responsible for promoting and supporting the implementation of Trust-wide systems for health and safety.

The head of health and safety is responsible for:

- Developing an effective health and safety management system that is compliant with statutory requirements
- Supporting the implementation of the Trust's health and safety policies and procedures
- Providing competent advice and support to staff on health and safety matters
- Monitoring corporate health and safety risks and escalating any concerns or significant delays.

10.12 Divisional quality manager/ trust risk and corporate quality manager

The divisional quality manager or Trust risk and corporate quality manager is responsible for:

- Ensure divisional ownership and accountability throughout the organisation for risk management
- Coordinating reporting of relevant risk registers to the appropriate divisional committees
- Liaising with and support risk leads in the division to ensure that each directorate/ specialty or department reviews their risks
- Ensuring that there is clarity of who is responsible for creating and reporting risks registered within directorate/ specialty or department below the divisional level
- Identifying new risk leads and notifying any changes to risk leads to the team managing the database holding the electronic risk register
- Addressing non-compliance with the Trust's risk management strategy and policy

- Managing and monitoring any escalation of gaps in controls or assurance on behalf of their division
- Ensuring that the list of risk leads and any changes to risk owners is reflected on the electronic risk register and the risk team is informed of changes to risk leads
- Ensuring the list of contacts for committees within the division is correct and any updates are sent to the team managing the database holding the electronic risk register.

10.13 All employees (permanent, temporary, contract)

All Trust employees including permanent temporary or contract have a duty and a responsibility to be 'safety aware' and co-operate in the identification and minimisation of risks.

Staff are responsible for:

Ensuring they are familiar with significant local hazards and know and use safe systems of work. If staff identify hazards or risks in the workplace they are responsible for taking immediate action to reduce the risk (for example wiping up a spillage, warning others or removing and reporting a piece of equipment identified as not working properly).

All Trust employees have a responsibility to identify risk, to report these to their line managers and where applicable to ensure that appropriate controls are being implemented to manage these risks.

11 Equality impact assessment

As part of the development of this strategy and policy its impact on equality has been reviewed. The purpose of the assessment is to minimise and, if possible, remove any disproportionate impact on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detrimental effects were identified.

12 Implementation and dissemination

This strategy and policy document is available to all staff via the Trust's document management system (Merlin) and intranet site.

Internally: Notification of this document will be included in an all staff email bulletin, as well as through the Trust's other communication routes.

Externally: The reviewed policy will be sent to the Trust's main commissioners and is freely available on request to Trust stakeholders.

13 Review

This strategy and policy will be reviewed annually.

14 Monitoring compliance with and the effectiveness of this document

The Trust will seek assurance that risk management activities and systems are being appropriately identified, articulated and managed through ongoing monitoring at the patient safety and assurance group and the risk oversight committee. The Trust seeks further assurance through a range of external sources including reviews by internal and external audit and Care Quality Commission inspections.

A monitoring dashboard has been developed to facilitate the monitoring of the key elements of this strategy and this is reviewed regularly at the patient safety and assurance group. The dashboard will be subject to annual review in support of the ongoing monitoring process by the director of clinical quality.

15 References

NHS England – Risk Management, Policy and Process Guide (2015).
National Patient Safety Agency - A risk matrix for risk managers (2008).

16 Associated documents

- All policies and procedures associated with healthcare acquired infections
- Business continuity planning policy
- Risk management handbook
- Risk management Connect pages
- Health and safety policy
- Health and safety risk assessments procedure
- Management of concerns and complaints policy
- Good practice guide - Quality governance in action
- Information governance and information security policy
- Management of incidents and serious incidents requiring investigation policy
- Management of safety alerts issued by the central alert system (CAS) policy and procedure
- Managing employee performance procedure
- Perinatal services risk management strategy

- Safeguarding policies and procedures (adult and child)
- Violence and aggression management policy

Equality and diversity statement

This document complies with the Cambridge University Hospitals NHS Foundation Trust service equality and diversity statement.

Disclaimer

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Document management

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Appendix 1: CUH's risk matrix (based on National patient safety agency's risk matrix)

Table 1: Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table, then work along the columns in the same row to find the severity that best fits the risk. The consequence will be a number from 1 to 5, which is the number given at the top of the severity column. The consequence score may be determined by taking more than one domain into account. If the consequence score is different for the domains, e.g. 5 in one domain and 3 in another, an average can be calculated to reach a consensus across the domains (average of 4).

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/ key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract/ payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2: Likelihood score (L)

In the second step, the probability of the risk occurring is estimated and then used to determine the likelihood score using the table below:

Description	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
Likelihood (How often might it /does it occur)	Likelihood of the risk occurring is less than 5%.	Likelihood of the risk occurring is between 5 and 20%.	Likelihood of the risk occurring is between 21 and 79%.	Likelihood of the risk occurring is between 80 and 95%.	Likelihood of the risk occurring is between 96 100%.
Probability	0-4%	5-20%	21-79%	80-95%%	96-100%

Table 3: Risk scoring = Consequence x Likelihood (C x L)

Calculate the risk score of the risk by multiplying the consequence score by the likelihood score:
Consequence score (C) x Likelihood score (L) = risk score.

	Consequence score				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
5 - Almost certain (96-100%)	5	10	15	20	25
4 - Likely (80-95%)	4	8	12	16	20
3 - Possible (21-79%)	3	6	9	12	15
2 - Unlikely (5-20%)	2	4	6	8	10
1 - Rare (0-4%)	1	2	3	4	5

Risks Grading

In some cases it may be useful to categorise risks by risk grade and colour, which are shown below:

Risk Assessment	Grading
Red 15 – 25	Significant
Amber 8 – 12	High
Yellow 4 – 6	Medium
Green 1 – 3	Low

Appendix 2: Risk appetite statement[1] (November 2022)

The Trust recognises that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, staff, the local community and strategic partners. The below statements describe the Board of Director's risk appetite in relation to the primary risk groupings as set by the Good Governance Institute (2012) . This statement will guide the Board of Directors in its decision making in relation to the implementation of the Trust's strategy (CUH Together), associated plans and other matters impacting on the well-being of patients and staff. This statement will be kept under regular review by the Risk Oversight Committee.

Quality/ outcomes
The Board will be cautious in its approach to taking risks related to patient and staff safety, patient experience or clinical outcomes. Its tolerance for risk taking will be limited to decisions where the potential for adverse consequent effects on patient and staff safety, experience or outcomes are medium to low and the potential for mitigating actions are strong, supported by robust governance systems and practices. (**Risk appetite moderate**)

Compliance/ regulatory
The Board has a cautious risk appetite related to compliance and regulatory issues, including health and safety. It will make every effort to meet regulator expectations and comply with laws, regulations and standards that regulators have set, unless there is strong evidence or argument to challenge them. The Board is willing to take opportunities where positive gains can be anticipated and are within the regulatory environment. (**Risk appetite moderate**)

Innovation
The Board will actively seek opportunities for innovation, strategic transformation and developing effective external relationships and alliances, depending on the nature of the innovation being proposed. It will seek innovation that supports quality, patient safety and operational effectiveness. This means that it will support the adoption of innovative solutions that have been tried and tested elsewhere, which challenge current working practices and involve systems/technology developments as enablers of operational delivery. Other innovations will be limited to only essential developments and with decision- making held by senior management. (**Risk appetite significant**)

Reputation
The Board has a cautious approach to risks that will affect the Trust's reputation. Decisions with the potential to expose the Trust to additional scrutiny of its reputation will be considered carefully and progressed only with strong mitigations and careful management of any potential repercussions.
(**Risk appetite moderate**)

[1] *Bullivant J & Corbett-Nolan A (2012) Risk Appetite for NHS Organisations: A matrix to support better risk sensitivity in decision taking accessed from http://www.good-governance.org.uk/risk-appetite-for-nhs-organisations-a-matrix-to- support-better-risk-sensitivity-in-decision-taking/ on 26 April 2019.*

Financial/ Value for Money
The Board will adopt a cautious approach to financial risk and is prepared to accept the possibility of some limited financial loss. Value for money is still the primary concern but the Board is willing to consider other benefits or constraints. Resources will be generally restricted to existing commitments. (**Risk appetite moderate**)

Commercial
The Board has an open approach to commercial risk. It will support risk opportunities in business areas and markets where the potential to have significant commercial strength over its competitors is identified, and/or wishes to secure continuity to the benefits and outcomes for the Trust's patients and the wider community it operates in. (**Risk appetite high**)

Appendix 3: Risk appetite matrix

Risk Appetite for NHS Organisations
A matrix to support better risk sensitivity in decision taking

Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012

Good Governance Institute

Risk levels ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

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Appendix 4: Definitions

Assurance is the means by which the organisation, board of directors, Trust senior leadership, manager, or clinical lead know that the controls designed to manage/ mitigate risks are effective and being properly implemented. Assurance can be defined as positive or negative, and internal or external. External assurance is generally considered of greater value due to its objective source.

Board Assurance Framework (BAF) – The Assurance Framework provides the Trust with a simple but comprehensive method for the effective and focused management of the principal risks to meeting their objectives. It also provides a structure for the evidence to support the Chief Executive's Annual Governance Statement.

Consequence (impact) is the level of harm that has, or may be suffered and is measured at the Trust on a scale of 1 to 5.

Controls are actions, arrangements and/or systems that are intended to minimise the likelihood or severity of a risk. An effective control will always reduce the probability of a risk occurring. If this is not the case, then the control is ineffective and needs to be reconsidered. Controls are intended to improve resilience.

Gap in control indicates that further work needs to be undertaken to ensure that the control is fully functional or effective. Until the development and implementation of controls have been completed, they are recorded in gaps in control. A negative assurance (a poor internal audit report for example) highlights gaps in control.

Internal control is the process effected by the board of directors designed to provide reasonable assurance that the Trust's objectives will be met with regards to: (1) Effectiveness and efficiency of operations; (2) Reliability of financial reporting and (3) Compliance with applicable laws and regulations.

Likelihood is measured by the frequency of exposure to the hazard or the probability of an event occurring on a scale of 1 to 5.

Risk is the likelihood (probability) that an event with adverse consequences or impact (hazards) will occur in a specific time period, or as a result of a specific situation. This event may cause harm to patients, visitors, staff, property, or have an impact on the Trust reputation, corporate objectives, stakeholders or assets.

Risks differ from their hazard in that the former is the calculated probability of the event occurring whilst the consequences or impact measure the effect of the risk

being realised as a hazard. Put simply, hazards represent risks that have been realised.

Risk appetite - at the organisational level, is the amount of risk exposure, or potential adverse impact from an event, that the organisation is willing to accept/ retain. Once the risk appetite threshold has been breached, risk management treatments and business controls are implemented to bring the exposure level back within the accepted range. The risk appetite may vary according to risk type.

Risk management is the systematic identification, assessment, treatment, monitoring and communication of risks. This process is followed by the application of current or planned resources to effectively control, monitor and minimise the overall likelihood (and in some instances, impact) of the identified risk.

Risk owner manage risks on behalf of the organisation and most likely is the person who enters the risk onto the risk module on Datix for the first time. The corporate risk register is owned by the executive directors of the management executive – risk oversight committee and the board assurance framework is owned by the Trust board of directors.

Risk lead: Role-based risk leads are responsible for risk oversight within divisions and corporate directorates.

Risk register is a management tool that allows the Trust to understand its comprehensive risk profile. It is simply a repository of risk information linking risks and controls for the whole organisation.

Strategic risks are those risks that can adversely affect the achievement of the Trust's corporate objectives and are identified, assessed and monitored by the board assurance framework.

Appendix 5: Risk management policy monitoring dashboard

Minimum requirement to be monitored	Method of monitoring e.g. audit	Responsible individual	Frequency of Monitoring	Responsible individual/group/committee (including timescales) for:		
				Review of results	Development of action plan	Monitoring of action plan and implementation
Identification and management of risk: *Board Assurance Framework Review*	Process Review	Director of corporate affairs	Annually	Audit Committee	Director of corporate affairs	Board of Directors (BoD)
Chief Executive report to the Board of Directors re significant risks	Review	Director of corporate affairs	Monthly	BoD	Director of clinical quality	BoD
Corporate Risk Register	Review	Director of clinical quality	Monthly	Executive Risk Committee/ Assurance Committees	Executive Risk Committee/ Assurance Committees	BoD

Minimum requirement to be monitored	Method of monitoring eg audit	Responsible individual	Frequency of Monitoring	Responsible individual/group/committee (including timescales) for:		
				Review of results	**Development of action plan**	**Monitoring of action plan and implementation**
Managing risks locally: *Local management of risk*	Divisional performance reports	Divisional directors	Monthly	Monthly executive performance reviews	Divisional directors	Management executive (ME)/BoD
Training : *Risk management training for risk owners and role-based risk leads*	Annual report	Director of clinical quality	Annual	Workforce and Education Committee	Director of clinical quality	ME/BoD
Assurance committees: *Reporting arrangements into the assurance committees and to the board*	Self-assessment	Director of corporate affairs	Annual	BoD	Director of corporate affairs	BoD

Cambridge University Hospitals NHS Foundation Trust

CHAIR'S KEY ISSUES REPORT

ISSUES FOR REFERRAL / ESCALATION

ORIGINATING BOARD / COMMITTEE:	Workforce and Education Committee	**DATE OF MEETING:**	20 September 2022
CHAIR:	Rohan Sivanandan	**LEAD EXECUTIVE DIRECTOR:**	Director of Workforce
RECEIVING BOARD / COMMITTEE:	Board of Directors, 9 November 2022		

AGENDA ITEM	DETAILS OF ISSUE:	FOR APPROVAL / ESCALATION / ALERT/ ASSURANCE / INFORMATION?	CORPORATE RISK REGISTER / BAF REFERENCE	PAPER ATTACHED (Y/N)
5.	**Workforce Race Equality Standards (WRES) Board report** 1. The paper provided the 2022 WRES data set for CUH that had been submitted in August 2022, together with a summary of actions taken in the past year and the proposed refreshed WRES action plan. 2. The committee noted that progress had been made in six of the nine WRES indicators, work to improve each indicator continued. 3. Key areas for improvement and focus in the WRES action plan had been identified as: • Inclusive leadership and management; ensuring that there is proportionate representation in senior roles and decision making, bringing diversity into meetings by involving staff network chairs, educating leaders and supporting commitments to anti-racism. • Equitable and inclusive talent management, including clinical career progression; several engagement meetings have taken place since July and will continue, with several barriers regarding clinical progression already identified.	Information/ Assurance	BAF 008	N

	• Protection of staff from racial abuse from patients and public; working together as a system to share information on racial abuse, sending a clear message to the public that harassment and abuse is not tolerated.			
6.	**Workforce Disability Equality Standards Board report** 1. The report sets out the latest annual Workforce Disability Equality Standard (WDES) metrics. 2. The Trust had improved on three of the 10 WDES metrics since 2021. 3. Metrics 1, 2 and 6 had shown an improvement. Metric 4 comprises of four components, two of which have improved. 4. Key areas for improvement and focus in the WDES action plan had been identified as; • Continued support to the Purple Network, with active involvement in the WDES action plan. • Promote and adjust the new Workplace Adjustment Service, ensuring this is communicated and regular review points are in place. • Continued development of resources and staff stories focusing on neurodiversity and improving organisational understanding of neurodiversity. • Encourage disabled staff to become Diversity and Inclusion Panellists and reverse mentors. • Improve recruitment of disabled staff to CUH, reducing the gap between disabled and non-disabled staff. • Improve staff sharing of disability/health conditions at commencement of employment and during their career at CUH. Overall, on the WDES and WRES reports the Committee noted the training and other specific interventions in place in the work to date and in the plans. They suggested a clearer articulation of what the	Information/ Assurance	BAF 008	N

	objectives of the training (and other interventions) is in any case, and a clearer 'wrap around' of other things that should be in place to achieve the objective. Training in itself is insufficient to deliver the hoped-for change.			
7.	**GMC Survey** 1. The GMC National Training Survey (NTS) takes place annually to gather feedback from Postgraduate Doctors in Training and Trainers, in relation to training and posts and programmes. 2. The impact of Covid-19 had been recognised, with changes in outpatient training (from face-face to remote consultations) and an increased workload noted. 3. The committee noted the need for structured protected time for training and noted that conversations to protect this time were underway. 4. Overall, the Trust had made improvements on negative outliers raised in 2021 survey. 5. Workload had been noted as the largest negative indicator. 6. Local teaching and clinical supervision out of hours were the best positive indicators. 7. Overall satisfaction had shown minimal change since the 2021 survey.	Information/ Assurance		N
8. **8.1**	**Director of Workforce report** 1. The Trusts workforce ambitions remained wellbeing, resourced, ambition, inclusion and relationships. 2. In addition, a focus on 'Good Work' will be incorporated. This ambition will focus on 6 areas: travel and transport, accommodation, space, nourishment/hydration, hybrid working and market focus.	Information/ Assurance	BAF 008, 013	N

	Wellbeing 1. Flu vaccination clinics were due to begin at the end of September. 2. Covid-19 boosters will also become available, staff will be able to book an appointment via MyChart. 3. The vaccination programmes will run until the 23 December 2022. Resourced 1. The availability of affordable accommodation locally continued to have a significant effect on the Trust's ability to recruit and retain staff. Longer term plans continue to be explored. Relationships 1. The new CUH Annual Awards programme had begun, helping to recognise and celebrate members of the CUH 'family', both teams and individuals, against several nomination categories.			
8.2	Workforce Winter Plan 1. The committee recognised that NHS services were under considerable pressure at present and that this would be further compounded during winter months. High demands due to seasonal illnesses, increased acuity, the effects of the increased cost of living, increasing fuel prices and the impact of Covid-19 recovery will all intensify the pressure further this winter. 2. The committee received an update on plans for the winter, this included resourcing support; workforce planning aligned to winter hospital configuration, staff availability and rostering, support to reduce short term sickness and flexible working offers. 3. Good work and wellbeing would also play a part in supporting staff over the winter. Vaccinations are available, access to affordable food, immediate access to emergency food and non-food supplies and financial wellbeing support would all play a part in additional support for staff.			

9.	**Board Assurance Framework (BAF) and Corporate Risk Register**. 1. The committee received and noted the current version of the Board Assurance Framework and Corporate Risk Register.	Information/ Assurance		N

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CHAIR'S KEY ISSUES REPORT

ISSUES FOR REFERRAL / ESCALATION

ORIGINATING BOARD / COMMITTEE:	Addenbrooke's 3 Committee	**DATE OF MEETING:**	28 September 2022
CHAIR:	Dr Annette Doherty	**LEAD EXECUTIVE DIRECTOR:**	Director of Strategy and Major Projects
RECEIVING BOARD / COMMITTEE:	Board of Directors, 9 November 2022		

AGENDA ITEM	DETAILS OF ISSUE:	FOR APPROVAL / ESCALATION / ALERT/ ASSURANCE / INFORMATION?	CORPORATE RISK REGISTER / BAF REFERENCE	PAPER ATTACHED (Y/N)
5.	**Cambridge Research developments** 5.1 Professor Richard Gilbertson gave a presentation on current cancer research developments. The emphasis on the early diagnosis of cancer and the resulting increase in the chance of cure was highlighted. 5.2 Projects working with industry were outlined including the development of artificial intelligence to look at data holistically for each patient's benefit and the ambition to create a virtual institute for brain cancer patients making precision medicine available to all patients with brain cancer. 5.3 The committee discussed the benefits of research groups being co-located on one site, the importance of establishing links between researchers and industry, and the need to engage with national programmes. The committee was impressed with the transformational agenda and new clinical operating model planned in the new hospital.		BAF 009, 012	N

6.	**ICP future plan** 6.1 The committee discussed the current position with the ICP. There had been a pause in the pace of devolution of resource and accountability to the new Accountable Business Units (ABU). This would be the focus of a meeting with Chairs and CEOs across the system on 18 October. 6.2 Progress in developing the Southern Place ABU was noted, with an emphasis on integrating care to improve patient access and outcomes over the winter period. 6.3 The committee discussed opportunities to improve across the system in pre-diagnosis, post-treatment, and care in the community. 6.4 The importance of maintaining links between the north and south places was discussed	Information/ Assurance	BAF 010	N
7.	**Communications and engagement** 7.1 The committee was updated on the work done to support the Addenbrooke's 3 programme including stakeholder engagement for the Cambridge Cancer Research (CCRH) and Cambridge Children's (CCH) hospitals; the newly developed stakeholder strategy and the creative health programme being led by the CUH Arts team. 7.2 Committee members felt that the change in direction of the communication strategy, especially towards a more stakeholder led communication strategy emphasising input from patients, the community and governors was welcome.	Information/ Assurance	BAF 009	N
8.	**Project delivery update** 8.1 The committee received updates regarding the current major projects which the Trust is developing: • Histopathology move to 100 Discovery drive had been approved and was moving into implementation stage with the extension of the current lease • Orthopaedic theatres and 40 beds scheme was on track for completion in summer 2023	Information/ Assurance	BAF 009	N

	• Emergency department expansion and re-development of Clinic 9 to go to October Performance Committee meeting • U block (56 beds) had been approved and on track to open in summer 2023 • Final outline business cases (OBC) for CCRH and CCH would be submitted in October and December respectively. The process for confirming commissioner support has been successfully established through the CCRH OBC sign off process and is being undertaken for CCH in advance of the December 2022 submission.			
9.	**Review of Board Assurance Framework Risks and Corporate Risk Register** 9.1 The committee received and noted the current version of the Board Assurance Framework. 9.2 Currently there are no corporate risks allocated to this committee.	Information/ Assurance	BAF 001, 006, 009	N

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CHAIR'S KEY ISSUES REPORT

ISSUES FOR REFERRAL / ESCALATION

ORIGINATING BOARD / COMMITTEE:	Quality Committee	**DATE OF MEETING:**	2 November 2022
CHAIR:	Sharon Peacock	**LEAD EXECUTIVE DIRECTOR:**	Chief Nurse / Medical Director
RECEIVING BOARD / COMMITTEE:	Board of Directors, 9 November 2022		

AGENDA ITEM	DETAILS OF ISSUE:	FOR APPROVAL / ESCALATION / ALERT/ ASSURANCE / INFORMATION?	CORPORATE RISK REGISTER / BAF REFERENCE	PAPER ATTACHED (Y/N)
5.	**Clinical Audit** 1. The organisation met the national and regulatory requirements during quarter one. 2. Successful implementation of key processes and procedures to support improvements to the organisation were noted. 3. Improved data of NICE implementation adjusted our compliance figures from 67% to 80%, this is an increase of 13% for quarter one 2022.	Information/ Assurance		N
6. 6.1	**Lead Executives' Report and Patient Safety and Experience Overview** <u>Lead Executives' Report</u> 1. The Chief Nurse and Medical Director presented the report to the committee.	Information/ Assurance	BAF 001/002	N

6.2	2. The outcomes for allogeneic Bone Marrow Transplant (BMT) and CAR-T cell therapies in haematological malignancy had been published. CUH were found to have outcomes significantly better than the national average. 3. A new clinical sepsis lead had been appointed, due to commence in post on 1 November 2022. 4. The numbers of Covid cases were now declining. 5. Roll out of the staff vaccination programme for Flu and Covid-19 boosters had commenced. 6. Capacity and flow through the Emergency Department remained a significant concern for the Trust and the Committee discussed the clinical impact of long waits. 7. There is a national amber alert from NHS Blood Transfusion in relation to a shortage of red cell products. Elective surgery priority three and four patients that have a >20% likelihood of requiring red cells had been postponed. Red cell usage had been reduced and several new pathways established to mitigate this risk. 8. The committee also discussed the Complaints and Patent Advice and Liaison Service, Hospital Acquired Pressure Ulcers, maternity staffing and diverts and nurse staffing levels. <u>Patient Safety and Experience Overview and Quality Account update</u> 1. The report covered the period up until the end of July 2022. 2. Normal variance in the amount of patient safety incidents had been reported. 3. Falls and Hospital Acquired Thrombosis (HAT) remained in normal variance. 4. The number of complaints received between September 2019 – September 2022 was higher than normal variance,			

7.	**Patient Safety Incident Response Framework** 1. The NHS Patient Safety Strategy, published in 2019, subsequently updated in February 2021 outlines key changes to the NHS approach to safety. 2. Two main foundations of safety culture and safety system, with three main objectives of insight, involvement, and improvement were noted. 3. A Patient Safety Incident Response Framework (PSIRF) would be introduced and embedded. This framework was published in August 2022 with a requirement for organisations to implement over a 12 month period. 4. Communication and work with all stakeholders to embed the new practice continued.	Information/ Assurance	BAF 004	N
8.	**Maternity** 1. The committee noted a Serious Incident Report and a Healthcare Safety Investigation Branch outcome report. 2. The Maternity Quality Improvement plan (which incorporates Ockenden) was noted. 3. A paper on the Kirkup report would go to Board the following week. 4. The number of maternity diverts was discussed, assurance was provided that no adverse outcomes or incidents for mothers or babies had occurred as a result of being diverted. 5. The significant ongoing staffing pressures were discussed.	Information/ Assurance	BAF 001, 007 CRR 43b, 05f	N
9.	**End of Life Annual Report** 1. During 2021/2022 there had been continued focus in the delivery of high quality, timely, effective and individualised services for patients requiring end of life care at the Trust. 2. This year the focus had been on developing a systems strategy, working closely with the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG). The aim has been to build on the	Information/ Assurance		N

	learning from Covid-19 and consolidate this in the Palliative and End of Life Care Strategy. 3. As part of the part of the team that helps deliver the Bereavement Care Follow-Up service, the chaplaincy team continued to deliver pastoral, spiritual and religious care for patients and staff five days a week, and provide an out of hour's on-call service. 4. Discharge planning remained a focus and collaboration with our local system partners continued, meeting regularly as part of a system operational group which focuses on discharge pathways, including End of Life discharges.			
10.	**Review of the Quality Committee Terms of Reference** 1. The Quality Committee reviewed the Terms of Reference and agreed some proposed amendments for Board approval.	Information/ Assurance		N
11.	**Board Assurance Framework (BAF) and Corporate Risk Register (CRR)** 1. The committee received and discussed the current version of the Board Assurance Framework and Corporate Risk Register. It was noted that risks relating to maternity services staffing and capacity had been added to the CRR.	Information/ Assurance	CRR 43b, 05f	N