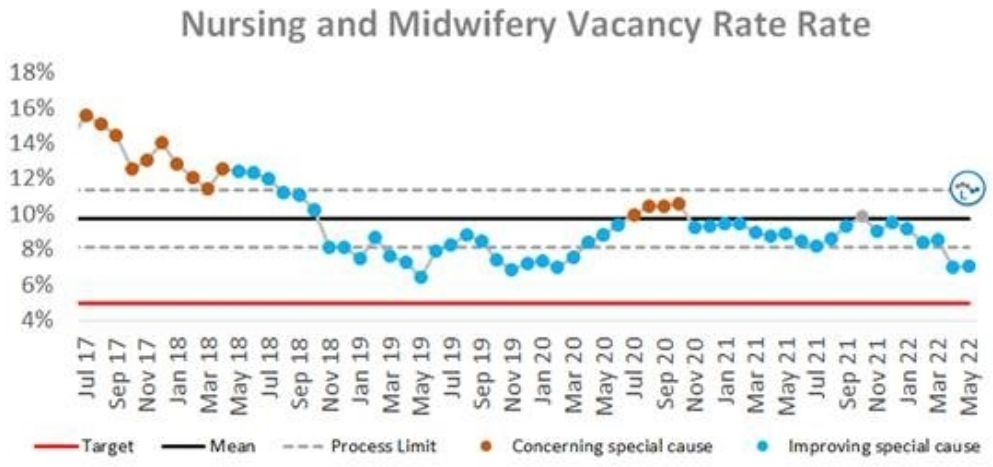
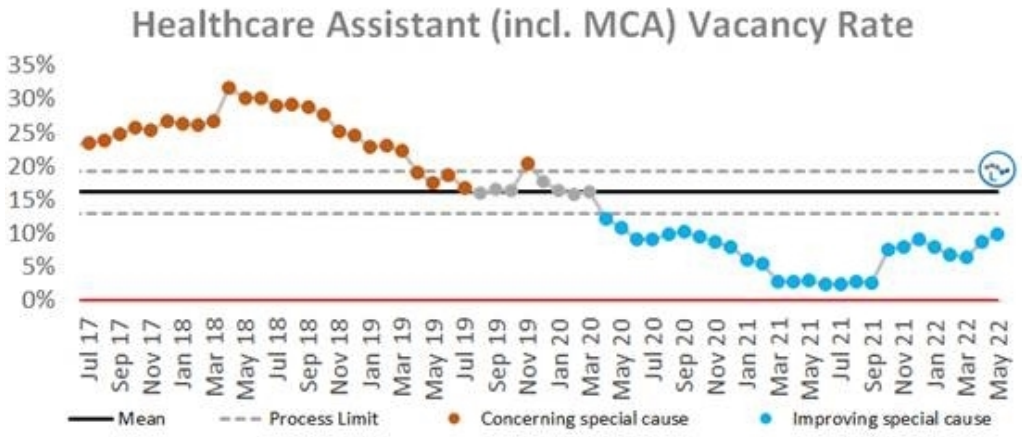
Combined Nursing and Midwifery Staffing Position Vacancy Rates

Graph 1. Nursing and midwifery vacancy rates



Graph 2. Healthcare Assistant vacancy rates



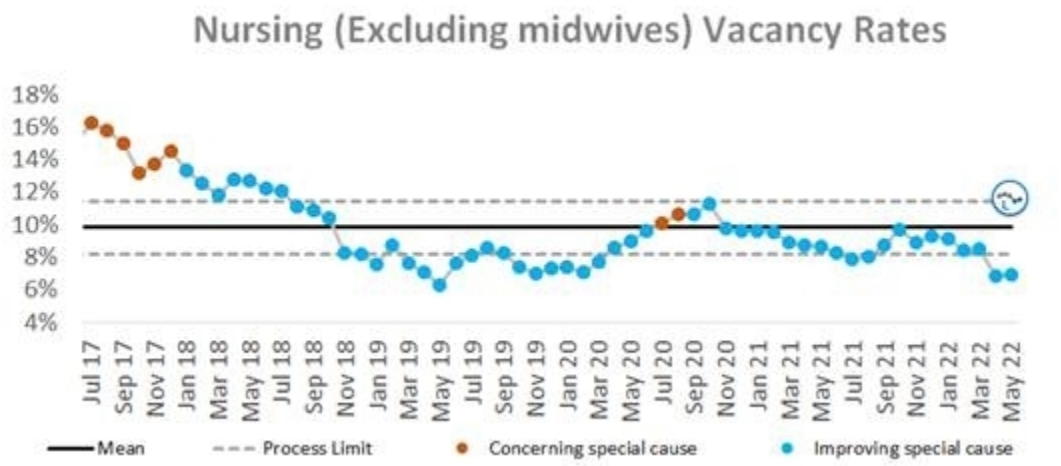
Vacancy position

The combined vacancy rate for Registered Nurses (RNs) and Registered Midwives (RMs) has remained static in May at 7.0%. Conversely, the vacancy rate for Health care support workers (HCSWs) (including Maternity Care Assistants (MCAs) has increased to 9.9% compared to 8.8% in April. When broken down further into Nursing and Midwifery specific vacancies, the MCA workforce vacancy rate is 13.2% which has increased from 11.3% in April and the HCSW vacancy rate (excl MCA) has also increased significantly to 10.5% from 8.8% in April.

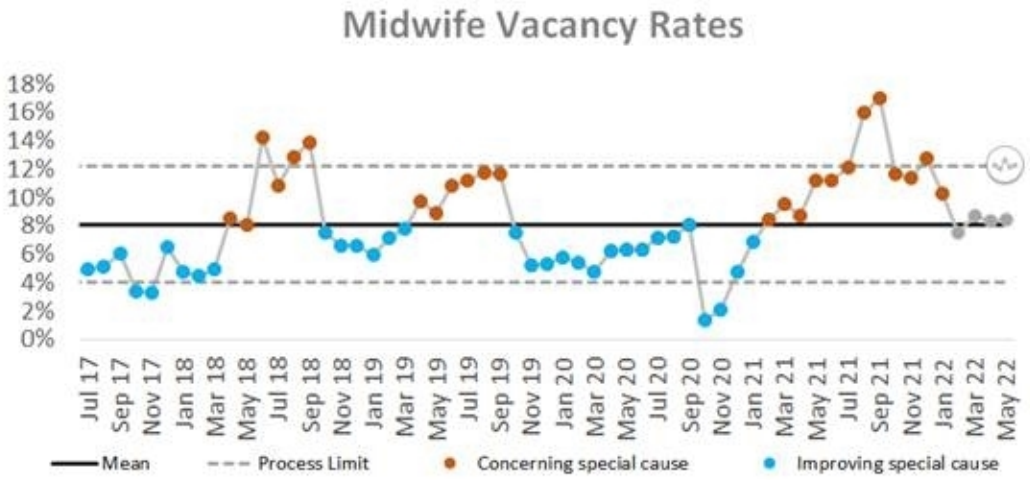
The HCSW (including MCAs) turnover rate remains high at 19.7% (18.6% April). The main reason for HCSWs leaving remains voluntary resignation – relocation (32.6%) and the next highest reason is voluntary resignation – work life balance (21.6%). The leavers destination is unknown for the majority of HCSWs (46.2%), 15.2% of HCSWs are leaving to take up employment in other NHS organisations and 16.1% 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

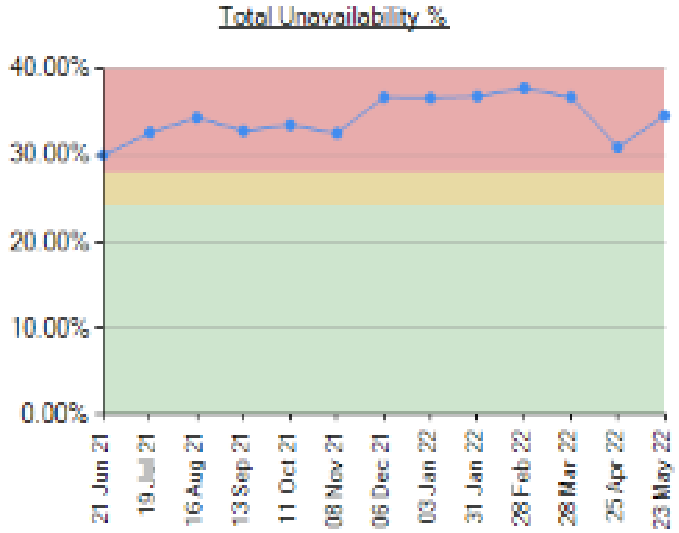
The vacancy rate for Registered Nurses working in adult areas remains static at 6.9%. The vacancy rate for registered children's nurses has decreased slightly to 16.5% compared with 17.4% in April.

The vacancy rate for Registered Midwifes has remained relatively static in May at 8.5% compared with 8.4% in April. It should be noted that the ledger is currently based on 19/20 establishments and has not been updated to reflect the additional approved investment in workforce. Work has now been undertaken as reported at the last Board of Directors meeting to align the workforce ESR and financial ledger. The actual vacancy position for midwifery is 14.7%

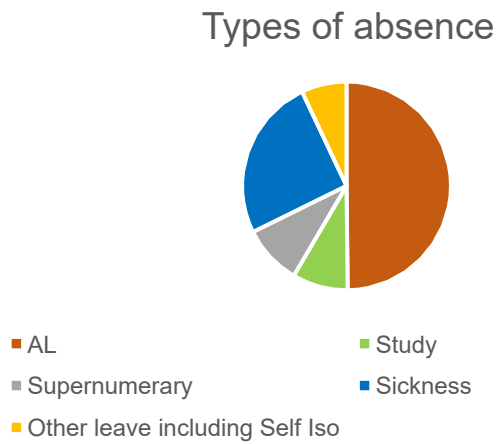
The turnover rate in May remains high at 14.4% for RNs in adult areas (13.9% in April), 20.4% for Registered children's nurses (19.3% in April) and 18.6% for RMs (19.2% in March). The main reason for leaving is voluntary resignation – relocation for RNs (46.6%). The main reason for RMs leaving is voluntary resignation – work life balance (24.4%). The Leavers destination data demonstrates that 32.9% of RNs and 35.5% of RMs are leaving to take up employment in other NHS organisations. 28.9% of RMs are leaving for no employment compared with 7.5% of RNs.

Unavailability for Registered Nurses Midwives and Health Care Support Workers

Graph 5. Unavailability of staff



Graph 6. Types of absence



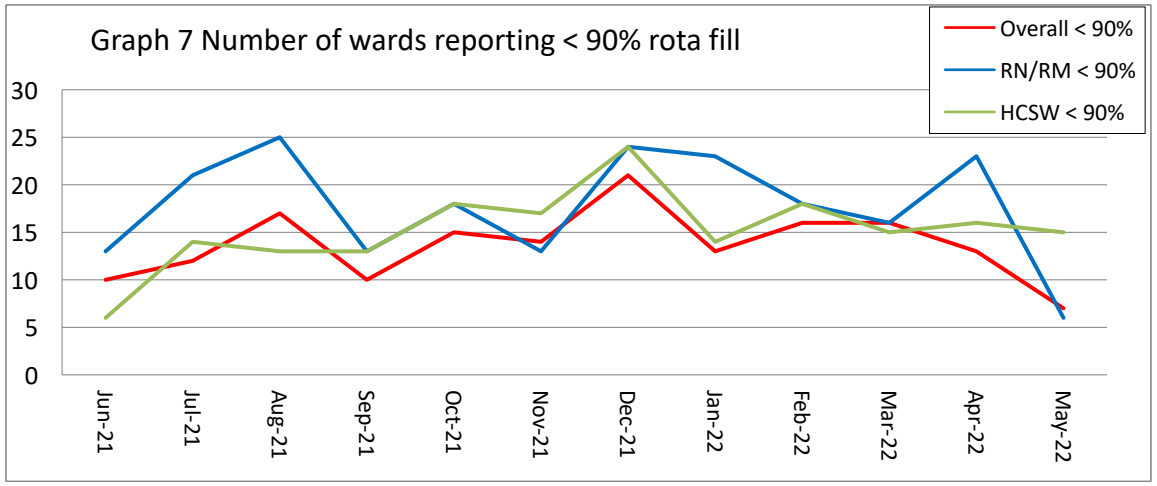
Unavailability of staff

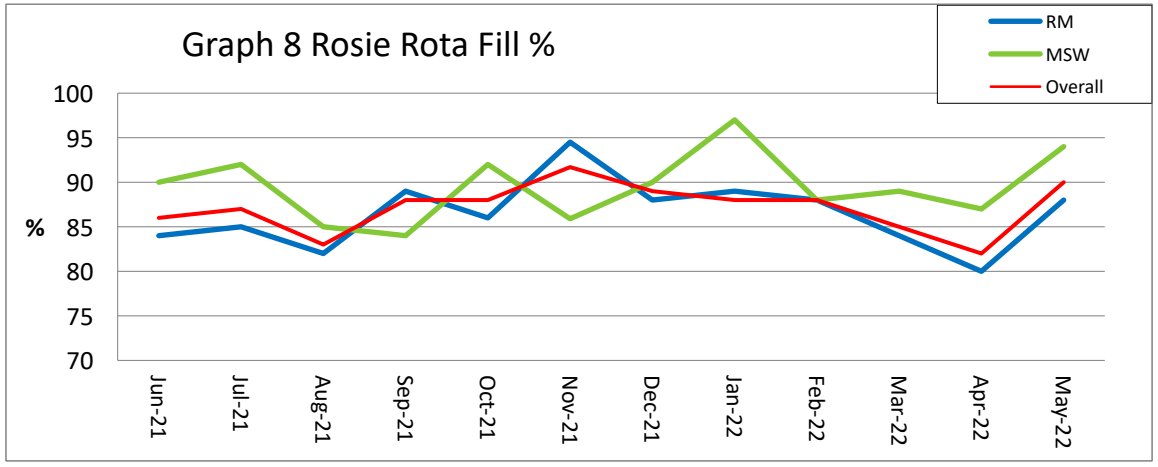
Unavailability relates to periods of time where an employee has been given leave from their regular duties. This might be due to circumstances such as annual leave, sick leave, study leave, self isolation, carers leave etc.

The total unavailability of the workforce working time in May has increased slightly to 31% compared to 27% in April. Graph 5 illustrates this trend however it should be noted that data point for 23rd May relates to the beginning of the May roster and will change as rosters are updated.

Graph 6 illustrates the percentage breakdown of the type of unavailability. The majority of unavailability (15.6%) 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 May sickness absence has increased slightly to 7.9% compared with 6.7% in April. Additionally, 2.2% of working time was unavailable due to other leave including medical self isolation which is comparable to April (2.1%), 2.7% was due to study leave and 2.9% 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, this has been a decreasing trend with 7 clinical areas in May 13 reporting overall fill rates of <90% compared to 13 in April. The number of areas reporting <90% rota fill for registered (RN/RM) fill rates has decreased to 6 compared to 23 in April. The number of areas reporting <90% rota fill for HCSWs has remained relatively static at 15 clinical areas.

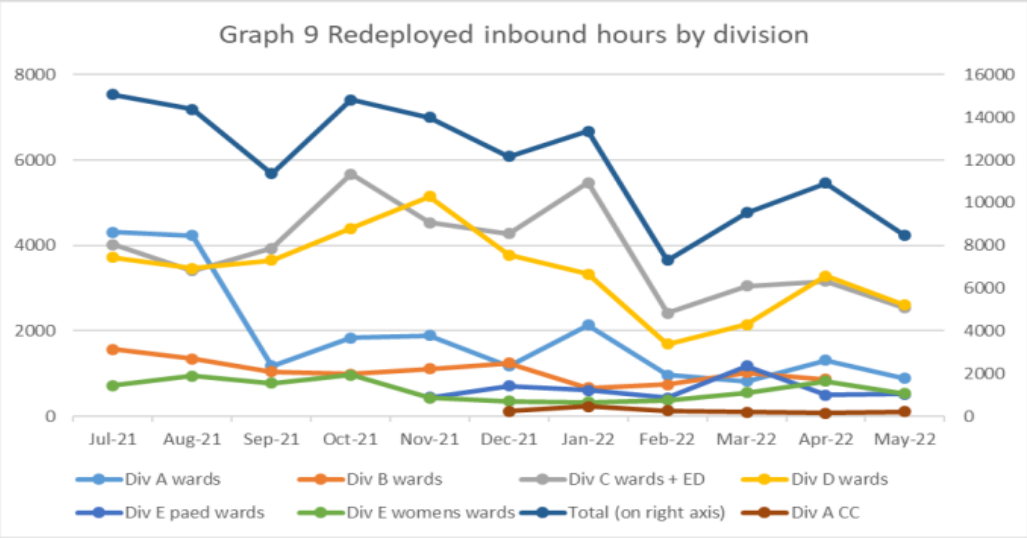
3 divisions (A, C and E) reported rota fill rates of <90% in May. The highest reporter this month was division E with 5 areas across paediatrics and maternity reporting fill rates of <90%. Appendix 1, details the exception reports for all areas reporting fill rates of <90%.

Across the critical care units in May, there has been a significant decrease in the number of occasions that 1 critical care nurse has needed to care for more than 1 level 3 patient (34 occasions compared to 183 in April). Additionally there have been 81 occasions where there has been no side room co-ordinator (166 in April). This is due in part to the decision taken by the divisional leadership team, Chief Nurse, Medical Director and Chief Operating Officer to maintain critical care bed capacity at 52 beds rather than 59 beds whilst recruitment is ongoing to the vacant positions. Any concerns with regards to critical care staffing are escalated through silver command. 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.

Midwifery & MSW fill rate

Graph 8 illustrates that the overall fill rate for maternity has increased in May at 90% compared to 82% in April. The lowest fill rates have been seen on Sara Ward and the delivery unit.

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.

There has been a decrease in May in the number of substantive staff redeployed. In May, an average 282 working hours were redeployed per day compared with 352 hours in April. This equates to 24 long day or night shifts per day. The majority of redeployments are within division (94.7% compared to 5.33% 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.

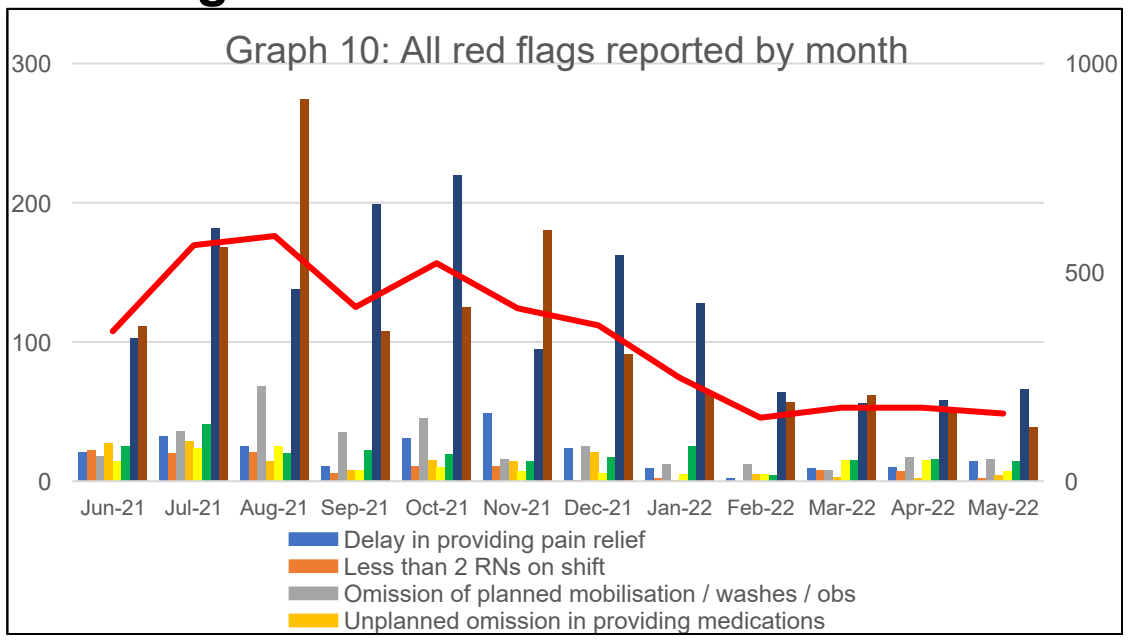
Nursing Pipeline

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 15.78% which is significantly 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.

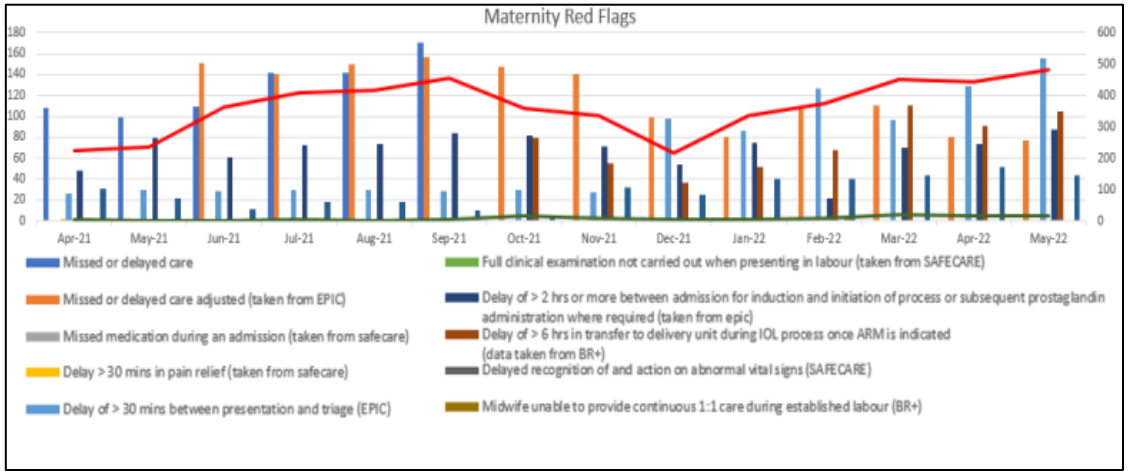
Appendix 3 provides detail on the forecasted position in relation to the number of Paediatric band 5 RN and HCSW vacancies up to March 2023. Numbers are based on those interviewed and offered positions in addition to planned campaigns. The current forecast demonstrates a year end band 5 Paediatric RN vacancy position of 35.2% and a band 2 HCSW position of 0.6%.

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

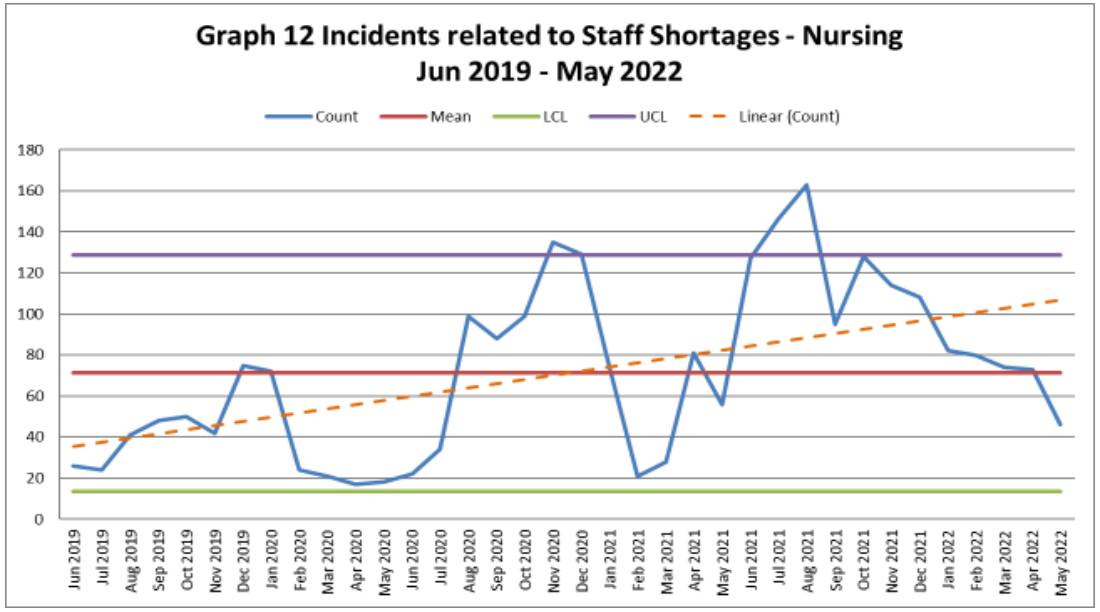
A staffing red flag event is a warning sign that something may be wrong with nursing or midwifery staffing. If a staffing red flag event occurs, the registered nurse or midwife in charge of the service should be notified and necessary action taken to resolve the situation.

Nursing red flags

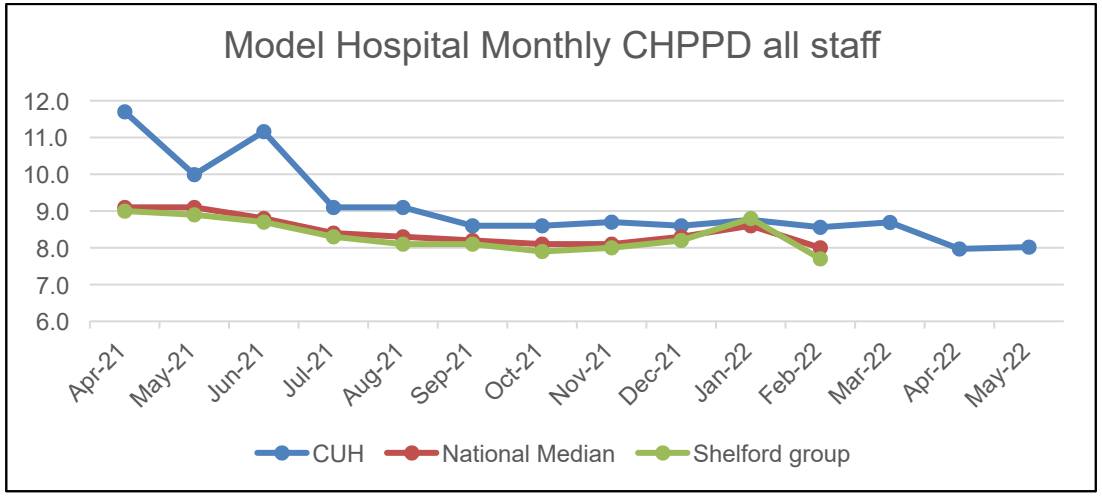
Graph 10 illustrates that the number of red flags reported in May has reduced slightly to 162 compared with 176 in April. The highest number of red flags reported in May was in relation to unmet required nursing skills (66 compared with 58 in April). An additional 39 red flags were reported for an unmet 1:1 specialling requirement compared with 51 in April. A trust wide improvement project focusing on specialling is being developed to review specialling across the organisation.

Maternity red flags

The number of maternity red flags reported in May increased to 483 from 442 in April. Graph 11 illustrates the red flags that have been reported. 15% of these red flags were due to missed or delayed care and 21.7% were due to 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.



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 46 incidents reported relating to nurse staffing in May compared with 73 in April. The number of incidents reported relating to staff shortages has been a downward trend since October 2021.

Division D and Division E reported the most incidents related to staffing levels in May. Division D reported 13 incidences across the division and Division E reported 15 incidences across the division with no specific area having a higher number of incidences than others. Safety continues to be monitored through the daily safe staffing meetings and the senior nursing huddles.

Care hours per patient day (CHPPD)

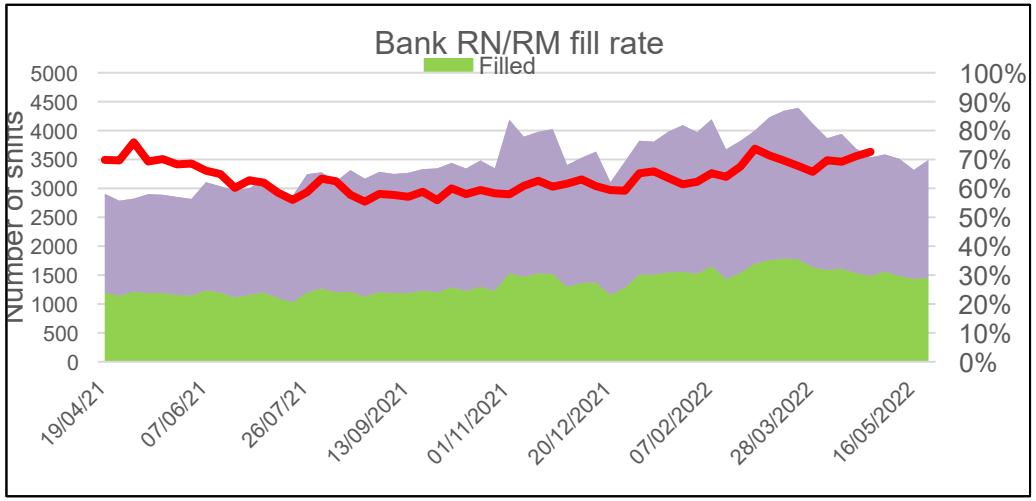
Care hours per patient day (CHPPD) is the total number of hours worked on the roster (clinical staff including AHPs) divided by the bed state captured at 23.59 each day. NHS Improvement began collecting care hours per patient day formally in May 2016 as part of the Carter Programme. All Trusts are required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

CUH CHPPD recorded for May has remained static at 8. This trend can be seen in graph 13. Unfortunately, the national average and Shelford group data has not yet been published for March to May thus we are unable to benchmark against our peers.

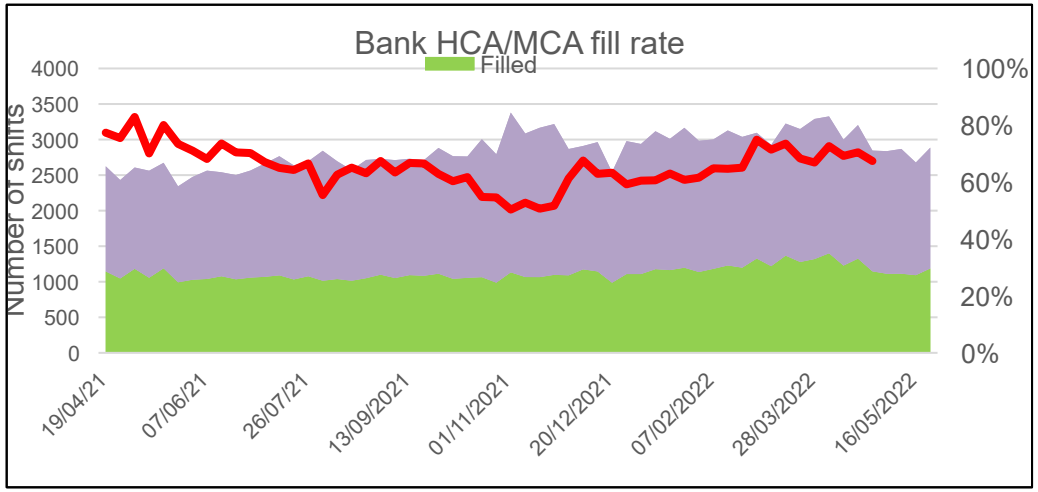
In maternity, from 1 April 2021, the total number of patients now includes babies in addition to transitional care areas and mothers who are registered as a patient. CHPPD for the delivery unit in May was 13.79 compared to 10.91 in April.

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 1992 shifts per week requested and an average bank fill rate of 74%.

The number of requests for Health care support workers and Maternity support workers remains high with an average of 1126 shifts per week requested and an average bank fill rate of 66%.

In addition to bank workers we have the equivalent of 50.93 WTE agency workers working across the divisions to support staffing challenges in the short term. This accounts for 10% of the total Nursing filled shifts. Of the total proportion of shifts filled through temporary staffing 10% have been filled via agency workers compared with 90% 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	% fill registered	% fill care staff	Overall filled %	CHPPD	Analysis of gaps	Impact on Quality / outcomes	Actions in place
M4	89%	105%	94%	5.23	4.64 WTE Band 5. 7 Wte waiting PIN. 2.80 Maternity leave and 1 LTS. 31% unavailability. 7 WTE Band 2 vacancy	9 red flags. 4 unmet pain relief. 1 unmet nursing skills. 1 less than 2 RN shift. 139 unused contracted hours. Low supervisory time. Quality Metrics: Red for Medication scanning, Blood product scanning, M & H, Pressure ulcer assessment. Day 3 covid screen. Amber for catheter documentation, Day 5 covid, falls, IV access and nutrition screening. 2 Incidents low harm related to banging toe and Pressure ulcer. 1 Pals case 1 complaints.	Daily Divsional escalation and mitigation. Site safety escalation and weekly staffing reviews. Scoping HCSW retention project. Pipeline in RN's good. Relaint on overseas nursing. Matron focus on staffing and patient safety.
NCCU	91%	78%	88%	22.08	26.19 Band 5 WTE vacancies with piepline in 9.55 WTE vacancies. 3 currently waiting PIN. High levels of Trauma and level 3 activity over May.	No Pals 1 Complaint. 4 incidents Low / minor harm. 82% medication scanning. All other metrics green for May 22	Daily Divisional escalation and mitigation. Site safety escalation and weekly staffing reviews. Scoping HCSW retention project. Pipeline in RN's good. Reliant on overseas nursing. Matron focus on staffing and patient safety.
Division C	% fill registered	% fill care staff	Overall filled %		**Analysis of gaps**	**Impact on Quality / outcomes**	**Actions in place**
T2 (P and Q)	98%	78%	87%	5.44	102 unfilled HCSW gaps for May. High unavailability in week 1 of rota due to sickness and annual leave. 278 hours of redeployed HCSW time to P/Q from other divisional wards. 99 hours of redeployed HCSW time from P/Q to Other divisional wards. Some unused hours but mainly NAP/TNA staff.	2 red flags raised for omission of planned mobilisation/washes/observations. Supervisory sister time-16.9%. Quality metrics red for BCMA medication scanning and amber for pain score. Total incidents: P2- total 7, all no harm ; Q2- total 13, 12 no harm, 1 low/minor harm.	Daily divisional mitigation; site safety escalation; weekly prospective staffing reporting and mitigation; divisional recruitment and retention strategy. Matron quality focus. Daily matron validation of patients requiring specialling and vulnerable patients.
Division E	% fill registered	% fill care staff	Overall filled %		**Analysis of gaps**	**Impact on Quality / outcomes**	**Actions in place**
PICU	74%	102%	79%	26.17	Current shortfall of 15 WTE RN vacancy, 14.6 WTE pipeline in. 6 RN awaiting dates to commence. O.8 WTE RN pipeline out Increased oversea nurses with experience.	Increased level 3 acuity in may Refusal of regional patients due to staffing levels. , PaNDR service commenced 24 hour cover, no change to NQM or patient experience feedback. LTV starts and sleep starting to be admitted.	High vacancy, recruitment ongoing -national and Overseas recruitment/ PIC/HDU course continue to develop skill mix. Bank enhancements rate 3.
Delivery Unit	86%	87%	86%	13.79	Vacancy rate and sickness rate of 10% for this area	1:1 care in labour at risk and supernumary status of the coordinator	Support for staff returning from LTS
Rosie Birth Centre	92%	82%	89%	15.98	24.9% parenting unavailbility for unregistered staff in this area	support for midwives for birth buddy's in addition to PN support with infant feeding	ongoing recruitment to this area and redeployment from community, x1 mat leave MSW due back June
Sara Ward	78%	76%	77%	4.14	13.4% sickness for registered staff and 18.6% for unregistered, x1 RM on maternity leave	inadequate cover affects flow for IOL and and overall timeliness of observations/interventions	Support for staff returning from LTS, substantive matron now in post and ward manager recruited
Neonatal ICU	90%	66%	88%	12.45	Current shortfall of 21.9 WTE RN vacancy, 13.8 WTE pipeline at RNQIS/Non QIS	Closure of NICU to ODN and refusal of regional patients due to staffing levels. No change to NQM or patient experience feedback.	Bank enhancements at tier . 3High vacancy in RN QIS group which is below 70% standard-currently 58%. Increase in LTS and maternity leave. Recruitment ongoing -national and Overseas recruitment. NICU ITU course continues to develop skill mix. Use of agency to support QIS. Over recruited to band 5 RN staff group. Good progress franchising NICU course in house with LSB university to commence Jan 2023. Community and education team supporting senior cover.

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
Apr-22	7					25	32	15	14	**1584**	**1768**	**10.41%**	**184.12**
May-22	8			17		20	45	25	7	**1597**	**1768**	**9.67%**	**171**
Jun-22	4			2		21	27	20	3	**1601**	**1768**	**9.45%**	**167**
Jul-22	7					31	38	22	14	**1603**	**1768**	**9.33%**	**165**
Aug-22	5				2	40	47	20	9	**1621**	**1768**	**8.31%**	**147**
Sep-22	7	25	3		1		36	28	27	**1602**	**1768**	**9.39%**	**166**
Oct-22	5	18	12				35	22	20	**1595**	**1768**	**9.79%**	**173**
Nov-22	5						5	18	14	**1568**	**1806**	**13.18%**	**238**
Dec-22	10					24	34	18	15	**1569**	**1806**	**13.12%**	**237**
Jan-23	8			32		24	64	18	15	**1600**	**1806**	**11.41%**	**206**
Feb-23	6					24	30	18	15	**1597**	**1875**	**14.82%**	**277.8**
Mar-23	5	5	5				15	18	15	**1579**	**1875**	**15.78%**	**295.8**
TOTAL	77	48	20	51	3	209	408	242	168	**1579**	**1874.8**	**15.78%**	**295.8**

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	1	1	1	182.42	284.41	35.86%	101.99	0
Jul-22	3				1	4	4	1	181.42	284.41	36.21%	102.99	0
Aug-22	3				1	4	3	2	180.31	284.41	36.60%	104.10	0.89
Sep-22				4	1	5	2	3	180.31	284.41	36.60%	104.10	3
Oct-22		7	11		1	19	5	2	192.31	284.41	32.38%	92.10	14
Nov-22			2		1	3	1	2	192.31	284.41	32.38%	92.10	2
Dec-22	1		2		1	4	5	1	190.31	284.41	33.09%	94.10	-1
Jan-23			1		1	2	6	1	185.31	284.41	34.84%	99.10	-4
Feb-23	2				1	3	2	1	185.31	284.41	34.84%	99.10	1
Mar-23	2				1	3	3	1	184.31	284.41	35.20%	100.10	0
TOTAL	13	7	16	4	15	55	41.11	18	184.31	284.41	35.20%	100.10	13.89

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	25	12	37	20	825	970	15.0%	145
Jul-22	30		30	20	835	970	13.9%	135
Aug-22	30		20	15	840	970	13.4%	130
Sep-22	30		30	20	850	970	12.4%	120
Oct-22	30	37.5	67.5	20	898	970	7.5%	73
Nov-22	30		30	20	908	1,018	10.9%	111
Dec-22	35		35	15	928	1,018	8.9%	91
Jan-23	30		30	20	938	1,018	7.9%	81
Feb-23	30		30	15	953	1,018	6.5%	66
Mar-23	35	40	75	15	1,013	1,018	0.6%	6
TOTAL	337	89.5	416.5	217	1,013	1,018	0.6%	6

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 13 July 2022

Agenda item	10
Title	Annual nursing and midwifery establishment review
Sponsoring executive director	Lorraine Szeremeta, Chief Nurse
Author(s)	Amanda Small, Deputy Chief Nurse Sarah Raper, Project Lead: E-rostering/Nurse Safe staffing Emma Glover, Head of finance: Division D
Purpose	To provide an overview of nurse staffing capacity and compliance with the National Institute for Clinical Excellence (NICE) safe staffing and National Quality Board (NQB) standards.
Previously considered by	Management Executive, 7 July 2022

Executive summary

This report provides assurance that arrangements are in place to review the Trust's nursing and midwifery establishments in line with regulatory requirements. It details the outcome of the annual establishment review for the period from April 2021 to February 2022 based on the configuration of wards/units and clinical pathways that are currently in place to ensure that there is an operating and staffing model for the period ahead which is clinically, operationally and financially sustainable. The configuration of clinical services within the trust have been subject to significant change over the past 12 months as a result of the Covid-19 pandemic and at this time, ward areas are still subject to ongoing reconfiguration dependent on service need, capacity constraints and infection control requirements. The paper provides the position against which current staffing levels are assessed and has made reference to areas where ongoing reconfiguration is expected. This has impacted upon the ability to realise the staffing efficiencies that could be achieved if additional Covid capacity was not expected to be required. In order to maintain patient safety and the safest staffing levels, staff continue to be moved between areas as necessary on a shift-by-shift basis, recruiting to the

identified establishments that have been identified by this review will lead to a reduction in the requirement to redeploy nursing staff.

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

Action required by the Board of Directors

The Board of Directors is asked to note:

- That the annual establishment review process for nurse staffing has been undertaken in line with our agreed methodology.
- The resulting nursing establishments for the current configuration of wards and departments across the hospitals.
- The impact that the ongoing reconfiguration of wards and pathway changes in the trust has had upon the ability to realise other potential staffing efficiencies resulting in a recommended decrease 1.04 WTE RNs (net) and a decrease of 3.22 WTE HCSWs (net) following the SNCT and professional review.
- That a further piece of work has been requested by the Investment Committee to be undertaken related to configuration of the wards and the need to consider the operational model we currently use in the Trust, balanced with how we staff these models to ensure optimum efficiencies on wards.
- The proposed ward establishments were supported by Investment Committee with two exceptions (C8 and Daphne ward) which have been taken into consideration in the final proposed establishment.
- The review of the Emergency Department nursing workforce has been professionally approved by the Chief Nurse with the recommendation that we move to a revised establishment. This proposal has also been supported financially for 2022/23. As noted above, the Investment Committee has requested a review of the operating model that we currently use at the Trust, including in respect of the emergency pathway. Staffing requirements will kept under review in line with normal practice and may change following the outcome of this exercise.

- A full midwifery workforce review is currently being undertaken using the Birthrate Plus® methodology and the findings will be presented to the Board of Directors when complete.

Cambridge University Hospitals NHS Foundation Trust

13 July 2022

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

1. Purpose

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

1.2 In October 2018, NHS Improvement (NHSI) published the 'Developing Workforce Safeguards' guidance. This 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 The report provides cumulative oversight of care hours per patient day (CHPPD) over the past 12 months. It also provides a comparison to peer organisations for the same time period.

2. National and local nursing and midwifery staffing context

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

2.2 The 50,000 Nurses Programme is overseen by a programme board chaired by the Minister of State for Health. It includes senior membership from the Department of Health and Social Care, NHS England/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 An update report published by the government in March 2022, suggests that the programme is currently on target to deliver at least an additional 50,000 nurses by March 2024 as 328,065 nurses were in employment in November 2021 compared with 300,904 in September 2021. This is an increase of 27,162 nurses.

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 high number of students that have enrolled on pre-registration Nursing and Midwifery programmes in 2019/20 will impact positively on the ability to reach the 50,000 target however it is acknowledged that it is not known at this stage, how many will complete their courses and go on to be employed by an NHS provider.

2.5 While 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 21 months 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 Within the East of England, the target was to increase the nursing workforce in the NHS and primary care by over 5,000 between September 2019 and March 2024. Progress to date shows that the region has exceeded the projected growth with 31,516 nurses in employment in November 2021 compared with 28,654 in September 2019. This is an increase of 2,862 nurses (10.0%).

2.7 The East of England target for increasing undergraduate nursing numbers was 22% from the 2019 baseline. This was achieved with an increase across the East of England of 25.9%.

2.8 East of England provider workforce returns indicated that a total of 3,308 overseas nurses were required to meet the needs of organisations by March

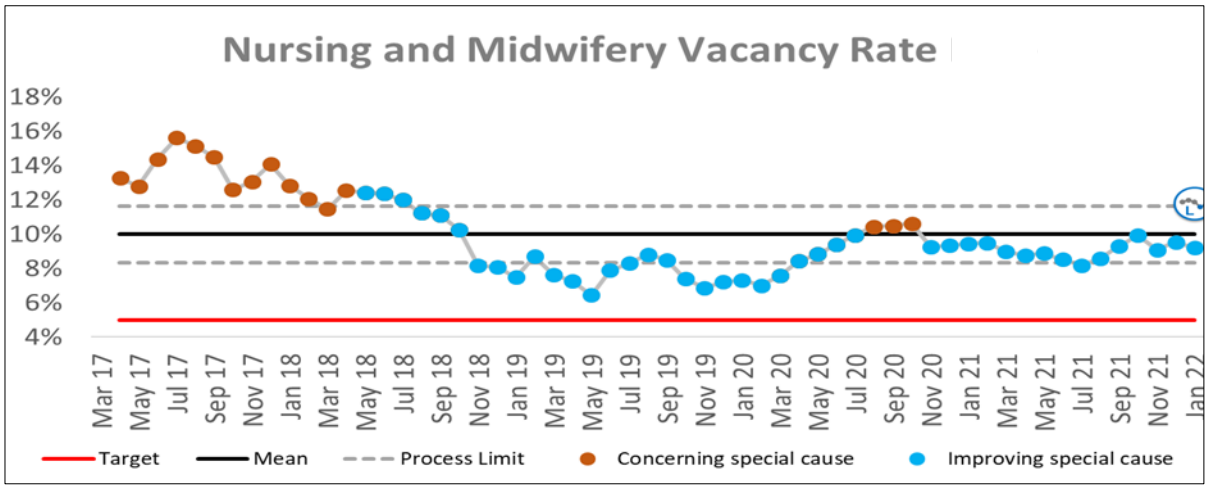
2022. NHSEI have supported organisations by allowing bids for funding to support overseas nurses in practice. This has resulted in 2520 International nurses arriving in the East of England at 31st December 2021. It is expected that the region will be slightly below the planned target however CUH have exceeded the organisational commitment with 433 International nurses arriving (December 21) against a target of 392. Additionally, on average 30 International Nurses are planned to arrive each month.

2.9 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. Nursing and midwifery vacancy

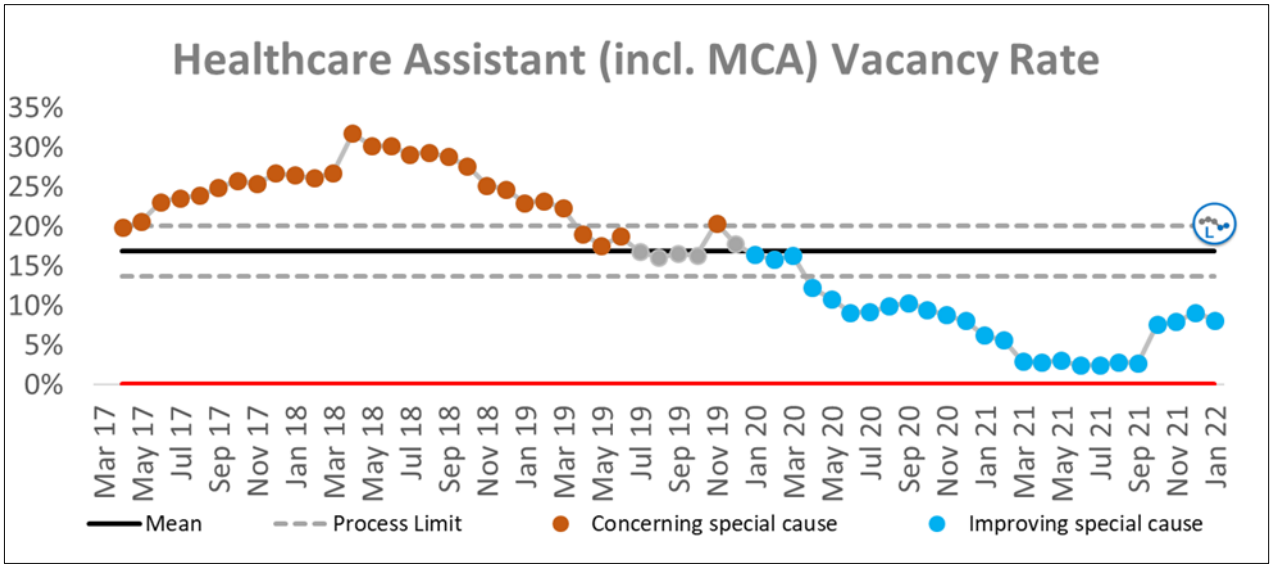
3.1 The last year has remained challenging for both the Nursing and Midwifery workforce with increasing vacancy rates and high unavailability due to staff sickness, isolation due to COVID and the requirement for pregnant staff to not work clinically from 28 weeks. Figure 1 shows the CUH trend in nursing and midwifery vacancy rates over the past four years. The RN vacancy rate over the past year has been relatively static, ranging from 8.6% to 9.3%. The RM vacancy rate has ranged from 8.5% to 15.4%.

Figure 1. Nursing and midwifery vacancy rates



3.2 The East of England set a target for a Healthcare Support Worker (HCSW) vacancy rate of 0% by March 2022. Unfortunately, this has not been achieved within the region. Despite a vacancy rate of 2.8% at the beginning of the financial year, CUH have experienced an increase in the HCSW vacancy rate with a vacancy rate at January 2022 of 8.1%. Figure 2 illustrates the trend in vacancy rate for HCSWs over the past four years.

Figure 2. Health care support worker vacancy rates



4. Staff redeployment during COVID-19 pandemic

4.1 The need to be responsive to the different phases of the pandemic throughout 2021/22 has continued to require rapid staff deployment and redeployment at CUH for both short term redeployment and longer-term redeployment.

4.2 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.

4.3 Long term redeployment of Nursing staff has been required to open additional capacity including redeployment to support the critical care surge and more recently, the requirement to open additional red COVID capacity. The impact of social distancing and COVID outbreaks has also led to the requirement to open additional capacity including a transit ward to relieve the capacity constraints within the Emergency department. These areas have been unstaffed and have therefore required staff to be redeployed from across divisions to be able to safely staff these areas.

4.4 An operational pool was established to reduce the number of substantive staff that are required to move to another ward area on a shift-by-shift basis. Both Registered Nurses (RN's) and Health Care Support Workers (HCSW's) 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.

4.5 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.

4.6 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 and safety. Escalation of decision making that compromised recognised staffing ratios was provided to Management Executive and Silver command as necessary. The Board of Directors has also been updated as part of the monthly safe staffing report.

4.7 It is expected that staff movement and deployment will continue to be necessary as we respond to the recovery phase of the pandemic and ongoing reconfiguration of clinical areas. However, every effort is being made to minimise staff movements where possible.

5. Establishment Setting Process

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

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

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

5.4 The SNCT is not appropriate for all clinical areas. In these cases, professional judgement together with society or joint advisory guidelines are used as methodologies for nursing establishment setting.

5.5 The establishment setting review process for 2021/22 has continued to be impacted by the Covid-19 pandemic. The frequent reconfiguration of wards to care for mixed specialities (L5: haematology and Vascular, C8: Orthopaedic and Neurosurgery), creation of additional red COVID capacity and closure of A3 for a period of time has affected the collection of three full datasets of SNCT scoring

which informs establishment reviews. In some cases, it has been necessary to use the previous years' establishment data alongside professional judgement and patient outcomes to inform the position on 2021/22 establishments.

5.6 The workforce requirement for 1:1 patient supervision (specialling) has not been included in all funded nursing establishments previously. The requirement for these additional shifts fluctuates and therefore matching an establishment can be challenging thus requiring additional support through bank shifts. It is recognised that a large number of ward areas have specialling requirements as part of their core workload. This has been taken into account in this year's SNCT review and proposed establishments.

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

6. Establishment review outcome - summary

6.1 Figure 3 below summarises the resulting nursing establishments following divisional review and check and challenge meetings held in January and February 2022. An account of each unit SNCT together with current agreed establishments is available on request.

6.2 Day units and off-site units are reviewed in accordance with the SNCT methodology and the review does not indicate any change in establishment from current levels.

6.3 Endoscopy staffing was reviewed using professional judgement and joint advisory guidelines. No changes in establishment was indicated at this time.

6.4 Outpatients has changed significantly due to the Covid-19 pandemic resulting in a reduction of face-to-face appointments and capacity within the outpatient department. No changes to establishment levels are proposed at this time but a full review of outpatients staffing is to be undertaken.

Figure 3: Proposed changes following establishment review by unit

Division	Unit	Difference compared to H2 21-22 establishment	Narrative/rationale
Division A	M4	Decrease HCSW specialling budget by 4 WTE	Majority of specialling can be covered within current establishment.
Division A	C7	Decrease HCSW specialling budget by 3.19WTE	Current 5.2WTE HCSW budget for specialling, SNCT suggest 1.95WTE specialling requirement therefore reduced by 3.19WTE.
Division A	C8	Increase RN by 4.55 WTE Increase HCSW by 6.04 WTE	Current establishment is based on 33 beds. Plan to move to full orthopaedic ward (37beds) from April 22. Acuity scoring (SNCT) shows current staffing below calculation within tool.
Division B	J3H	Decrease RN by 16.18 WTE Decrease HCSW by 2.56 WTE	Due to reconfiguration, ward no longer open, 6 haematology beds opened on L5. Benefit nets off pressure on J3 RED ward (Division C).

Division	Unit	Difference compared to H2 21-22 establishment	Narrative/rationale
Division B	D9	Decrease RN by 2.75 WTE Increase HCSW by 0.96 WTE	Removed 1 RN off nights and removed the HCSW twilight shift. Increased by 1 HCSW on night shifts due to dependency of patients.
Division B	C10	Increase RN 0.69 WTE Decrease HCSW 0.69 WTE	Transferred specialling to RN's from HCSW's as this patient group are high acuity and require specialist skills due to chemotherapy and carte treatment.
Division C	C6	Increase HCSW by 2.36 WTE	Last 2 SNCT data collections have shown higher acuity and whilst SNCT suggests an increase in RN's, professional judgement applied and staffing deemed safe. High specialling requirement therefore 2.36WTE HCSW included within establishment.
Division C	F5/G5 transplant unit	Decrease HCSW by 0.67 WTE	Removed HCSW specialling budget as minimal specialling requirement which can be covered within existing establishment.
Division C	EAU4	Decrease RN by 4.19 WTE	Removed 1 RN off long day and twilight in line with SNCT calculation.
Division C	N2	Decrease HCSW by 5.5 WTE	Reduced 1 HCSW on Long day and night shifts in line with SNCT calculation.
Division C	N3	Decrease RN by 3.59 WTE Decrease HCSW by 0.53 WTE	Removed Specialling budget as can be covered within establishment, reduced by 1 RN on long day and moved to 100% long days.
Division C	J3 (Red)	Increase RN by 12.97 WTE Increase HCSW by 8.97 WTE	Additional capacity opened as red COVID ward, whilst timeframe that the ward will be opened is unknown (modelling has assumed 12-month period). J3 haem establishment utilised here and increase due to gap in establishment due to increased bed base.
Division D	J2	Increase RN by 0.96 WTE Increase HCSW by 2.75 WTE	Acuity scoring (SNCT) shows current staffing below tool. Reduced 1 RN early shift and increase 1 RN long day. Increased 1 HCSW at night.
Division D	K3	Decrease RN by 0.84 WTE Decrease HCSW by 0.84 WTE	Moved to 100% long days which has resulted in a reduction in establishment.
Division D	D7	Decrease HCSW by 1.48 WTE	Removed HCSW specialling budget as specialling requirement can be covered within establishment.
Division D	F4 red (Apr – May)	Increase 5.5 WTE RN Increase 2.75 WTE HCSW	SNCT collection is not accurate reflection due to configuration of wards in relation to COVID and low occupancy. Modelled on 2 months red due to COVID activity and 10 months at DIV C DME model. Staffing requirements reflect acuity of red ward.
Division D	F4 DME (June – Mar)	Increase RN by 2.75 WTE Decrease HCSW by 0.96 WTE	SNCT collection is not accurate reflection due to configuration of wards in relation to COVID and low occupancy. Modelled on 2 months red and 10 months at DIV C DME model. F4 original rota set below standard for DME resulting in nurse/patient ratios of 1:9 therefore realigned to reflect Nurse/patient ratio of 1:7
Division D	A4	Decrease HCSW by 4.5 WTE	Specialling budget reduced to align with average specialling requirement.
Division D	L5	Increase RN by 2.75 WTE Increase HCSW by 2.75 WTE Increase by 1 WTE ward manager	Due to reconfiguration, 2 separate divisional rosters in place for bed base (6 haematology beds staffed by Division B staff, 26 beds staffed by division D). In order to maintain nurse/patient ratio of 1:4.3, requires 1 additional RN and HCSW per shift. Reconfiguration is recommended to enable more efficient rota.
Division D	A5	Decrease RN by 2.75 WTE	Reduce by 1 RN on long day shifts.

6.5 The proposed establishments were presented to Investment Committee in April 2022, all were supported with the exception of C8 due to the high cost per bed associated with staffing an additional 4 beds (37 beds in total). An additional challenge meeting was convened and both the proposed RN and HCSW establishments were reviewed.

6.6 It was not possible to reduce the proposed RN establishment as a reduction of 1 RN per shift, would result in stretched Nurse/patient ratio's that would not be sufficient to provide safe specialised patient care for the acuity of patients however it has been possible to reduce the HCSW by 1 WTE on a day shift. This is a reduction of 2.76 WTE HCSW's from the proposed establishment above resulting in a final proposed increased in establishment for C8 of 3.28WTE HCSW's and 4.55WTE RN's.

Registered Nursing establishment

6.7 The SNCT and professional judgement review recommends an overall reduction in the registered nursing establishment of 5.78 WTE RNs (net) compared to the current H2 establishment.

6.8 The current configuration of COVID red capacity has impacted upon the overall establishment reductions which could have been realised as 12.97 WTE RNs are required to staff a COVID red ward for this financial year (J3 within division C). It is also expected that F4 will continue to be needed as red capacity for a 2-month period (April and May 2022), this will require an additional 5.5 WTE RN's and 2.75 WTE HCSW's above the modelled DME ward establishment due to acuity of this patient group.

6.9 The SNCT tool has suggested a slight increase in RN establishment on C9, C6 and the Lewin ward however professional judgement has been applied and it was felt that as there are good support structures in place from other professionals i.e., Clinical Nurse Specialists and Allied Health Professionals that no increase in establishment was required.

6.10 C8 current establishment is based on 33 beds however the planned configuration is to move to a full orthopaedic ward (37beds) from April 22. In order to maintain the nurse/patient ratio with this increase in beds, an additional 4.55 WTE RN is required.

Health Care Support Worker Establishment

6.11 The SNCT and professional review recommends an overall decrease in the HCSW establishment of 3.22 WTE HCSWs (net) compared to the current establishment.

6.12 The current configuration of COVID red capacity has impacted upon the overall establishment increase as 8.97 WTE HCSWs are required to staff a COVID red ward for this financial year (J3 within division C). It is also expected that F4 will continue to be needed as red capacity for a 2-month period (April and May 2022), this will require an additional 2.75 WTE HCSW's above the modelled DME ward establishment due to acuity of this patient group.

6.13 The majority of HCSW efficiencies have been realised within the HCSW establishment identified for specialling requirements, this reduction has been based on reviewing the average specialling requirements for each area.

6.14 5.5WTE HCSW has been reduced on ward N2 to reflect the requirements calculated within SNCT however C8 requires an increase of 3.28WTE in HCSWs due to the planned increase in orthopaedic beds and SNCT suggesting that current staffing is below the safe staffing required for the acuity and dependency of this patient group.

Additional investment in ward budgets

6.15 In addition to the SNCT recommendations, figure 4 below details further investment in ward establishment budgets for which approval was sought through investment committee.

Figure 4: Additional investment

Division	Unit	Difference compared to H2 21-22 establishment	Narrative/rationale
Division A	SAU	Increase RN by 4.74WTE	SAU establishment has increased by 1 RN per shift in line with previously approved divisional investment committee case
Division E	Daphne	Increase RN by 1.13 WTE Increase HCSW by 0.60 WTE	Previously increased establishment template by 1 RN on weekdays and 1 HCSW twilight shift, been running a cost pressure within division. This increase is to manage the activity associated with reconfiguration of the gynaecology pathway away from the Emergency Department with direct referrals to Daphne ward.

6.16 Investment committee supported the investment of 4.74WTE RN for SAU in addition to the SNCT recommendations. It was felt that there was no evidence to support the investment in Daphne ward establishments.

7. Critical care units and Emergency Department

7.1 Following the first phase of the pandemic, the Trust agreed to increase the critical care bed capacity from 46 beds to 59 beds. This required an increase in WTE establishment of 36.26 registered nurses and 14 HCSWs in order to comply with guidelines for the provision of intensive care services (GPICS) standards (2020/21 financial year). Whilst 97 registered nurses have been recruited since this increase in establishment, Critical care has also seen an increase in the number of leavers (73 RN's) which has resulted in an 11% vacancy rate. This coupled with increased unavailability of staff due to sickness and COVID isolation has led to GPICS breaches on a shift-by-shift basis. Management Executive and Silver command had 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.

7.2 Recently the decision has been taken by the divisional leadership team, Chief Nurse, Medical Director and Chief Operating Officer to reduce the critical care

bed capacity to 52 beds to maintain GPICS compliance whilst recruitment is ongoing to the vacant positions.

7.3 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 calculation demonstrates a shortfall of 10 WTE RNs to achieve compliance based on BAPM occupancy of 90%. Recurrent funding has been awarded from NHSE via the operation delivery network (ODN) to recruit to these posts. A recruitment 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.

7.4 The Emergency Department has seen considerable changes to layout and pathways in response to the pandemic which have impacted on the nursing workforce. Nationally, new standards have been identified for Type 1 Emergency Departments related to staffing, of which shortfalls have been identified for the ED and existing nurse staffing models. A full review using these guidelines has recently been undertaken which has resulted in a requirement to increase the registered nurse workforce by 17.7 WTE, this has been financially supported. It should be noted that previously, there has been no evidence-based tool available to support staffing decisions within the Emergency Department (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.

8. Maternity staffing

8.1 A full midwifery workforce review is currently being undertaken using the Birthrate Plus® methodology. The findings and recommendations from this review should be available to present to the Board of Directors in July 2022.

8.2 A full overview of maternity staffing was presented to the Board in April 2021 to provide assurance in relation to compliance with the Clinical Negligence Scheme for Trusts (CNST) standards. CNST reporting was paused in December 2021 and is due to recommence in April 2022. CUH will continue to report on the midwifery workforce and establishment in line with structure outlined by CNST.

9. Care Hours per Patient Day (CHPPD)

9.1 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.

9.2 The CHPPD data, along with Care Costs per Patient Day (CCPPD), are available on the Model Hospital to enable benchmarking. CHPPD trends had increased at the beginning of the 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 September 2021 we are comparable to our peer organisations (Shelford) with an average CUH CHPPD of 8.6 compared to an average of 8 in Shelford organisations.

9.3 CUH have contacted NHSEI to benchmark our nurse/patient ratios against other Shelford organisations and are awaiting receipt of the benchmarking data.

10. Nursing and Midwifery red flags

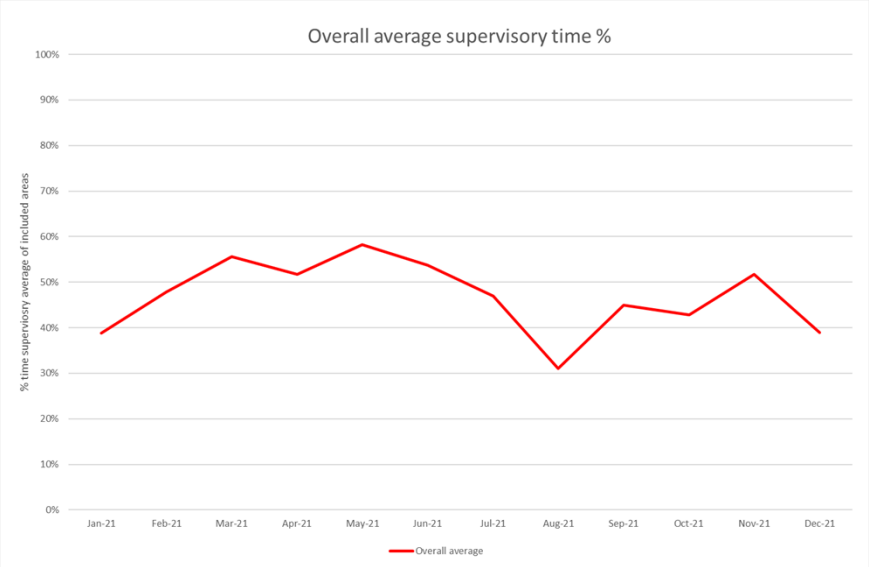
10.1 A staffing red flag event is a warning sign that something may be wrong with nursing or midwifery staffing. If a staffing red flag event occurs, the registered nurse or midwife in charge of the service should be notified and necessary action taken to resolve the situation.

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

11. Supervisory sister/charge nurse time

11.1 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 12 months. It is anticipated that Senior Sister/Charge Nurse supervisory time will improve as the Trust recovers its staffing position during the recovery phase of the pandemic.

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



12. Recommendations

12.1 The Board of Directors is asked to note:

- That the annual establishment review process for nurse staffing has been undertaken in line with our agreed methodology.
- The resulting nursing establishments for the current configuration of wards and departments across the hospitals.
- The impact that the ongoing reconfiguration of wards and pathway changes in the trust has had upon the ability to realise other potential staffing efficiencies resulting in a recommended decrease 1.04 WTE RNs (net) and a decrease of 3.22 WTE HCSWs (net) following the SNCT and professional review.
- That a further piece of work has been requested by the Investment Committee to be undertaken related to configuration of the wards and the need to consider the operational model we currently use in the Trust, balanced with how we staff these models to ensure optimum efficiencies on wards.
- The proposed ward establishments were supported by Investment Committee with two exceptions (C8 and Daphne ward) which have been taken into consideration in the final proposed establishment.
- The review of the Emergency Department nursing workforce has been professionally approved by the Chief Nurse with the recommendation that we move to a revised establishment. This proposal has also been supported financially for 2022/23. As noted above, the Investment Committee has requested a review of the operating model that we currently use at the Trust, including in respect of the emergency pathway. Staffing requirements will kept under review in line with normal practice and may change following the outcome of this exercise.
- A full midwifery workforce review is currently being undertaken using the Birthrate Plus® methodology and the findings will be presented to the Board of Directors when complete.

NHS
Cambridge University Hospitals
NHS Foundation Trust

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Report to the Board of Directors: 13 July 2022

Agenda item	11
Title	CUH Together 2025 – Our Strategy
Sponsoring executive director	Claire Stoneham, Director of Strategy and Major Projects
Author(s)	Dan Northam Jones, Director of Strategy
Purpose	To approve the CUH Strategy Refresh.
Previously considered by	Management Executive, 7 July 2022

Executive Summary

Over the past 10 months we have engaged staff, patients and partners to inform a refresh of the CUH Strategy. This paper summarises the activities completed; presents our finished document; and outlines the communications and engagement activities planned to support the launch and embed the strategy across CUH.

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?	Yes
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:

- Receive and approve the revised CUH Strategy.
- Note the launch and implementation plan.

Cambridge University Hospitals NHS Foundation Trust

13 July 2022

Board of Directors
CUH Together 2025 – Our Strategy
Claire Stoneham, Director of Strategy and Major Projects

1. Introduction

1.1. After more than two years of intense pressure due to Covid, we have undertaken a refresh of the CUH Strategy looking forward to 2025.

2. Developing the Strategy

2.1. Over the last year we have undertaken various activities to shape our strategy:

- Engaging more than two hundred and fifty staff through After Action Reviews on Covid; six open-invite engagement sessions; sessions with our BAME, Purple and LGBT+ staff networks; a meeting with staff side representatives (NMC, Unite, Unison); sessions with professional groups through the hospital (healthcare scientists, AHPs, senior sisters, Clinical Directors and Speciality Leads) and some clinical teams; and submissions to an email inbox;
- Engaging with patients through After Action Reviews on Covid and a session with Healthwatch;
- Hosting Board Seminars and Away Day sessions on national policy, anchor institutions, integrated care and the South Integrated Care Partnership (ICP), health inequalities, financial strategy, digital strategy and specialised services;
- Reviewing and incorporating a wide range of other strategic work currently underway including surge capacity, workforce commitments, operational and financial planning for 2022/23 and the next five years, the green plan, development of our new hospital builds, the East of England Specialised Provider Collaborative, the South Place and much else; and
- Engaging with partners through 1:1 interviews and focus groups with NHS partners across Cambridgeshire and Peterborough, CUHP and the South ICP Board.

2.2. We have reviewed previous CUH strategies, and other hospitals' recently published strategies particularly among Shelford Group peers. While much of what we commit to continues long-standing priorities at CUH and mirrors what others are doing now, we are seeking to situate our strategy distinctively in 2022

and looking forward to 2025; and specifically at CUH rather than any other teaching hospital.

2.3. We have worked with lead Executive Directors and their teams to develop detailed content; and with the Communications team on the style of the document and wider materials.

2.4. The Strategy is presented in PDF format at Appendix 1.

2.5. In line with CUH and NHS accessibility standards the content will also be published online on the CUH website.

3. Communications, launch and dissemination

3.1. We are producing other materials to accompany the launch, particularly to support staff to make connections between their work each day and the Trust-wide strategy:

- **Leaflet**. We are producing a fold-out leaflet summarising the strategy and will give this to every member of staff. This was a significant success at the last strategy refresh, and copies of the leaflet are still found across the hospital on notice boards. This will also be used to support staff appraisals over the summer, asking staff to consider how their work supports the strategy;
- **Videos**. We have worked with a production company to create a series of short videos outlining the strategy: an overarching summary, with three supporting videos for each theme (Improving Patient Care, Supporting Our Staff, Building for the Future). The videos feature more than thirty staff and partners and will be premiered at the 08:27 next week;
- **Internal communications**. We are launching the Strategy at next week's 08:27, with Roland hosting a panel discussion of a diverse range of staff members who feature in the video. We will send an all-staff email and include in the rest of next week's email bulletins;
- **External communications**. We are working on a media campaign with the communications team; and
- **Partners**. We will send Strategy materials to a long list of health and care, academic and industry partners.

3.2. As always, we welcome other suggestions on how to maximise the reach of the CUH Strategy.

4. Next steps

4.1. We are currently working with Divisions and Corporate teams to accelerate planning to build capacity for implementing the strategy, particularly to ensure that clinical and operational teams have time to prioritise this important work alongside urgent pressures.

4.2. We are also producing an implementation plan, with quantified objectives and trajectories, to support Performance Committee to scrutinise our delivery of these goals over the coming years.

4.3. We will continue to report qualitatively on implementation of the strategy to the Board of Directors.

5. Action required by the Board of Directors

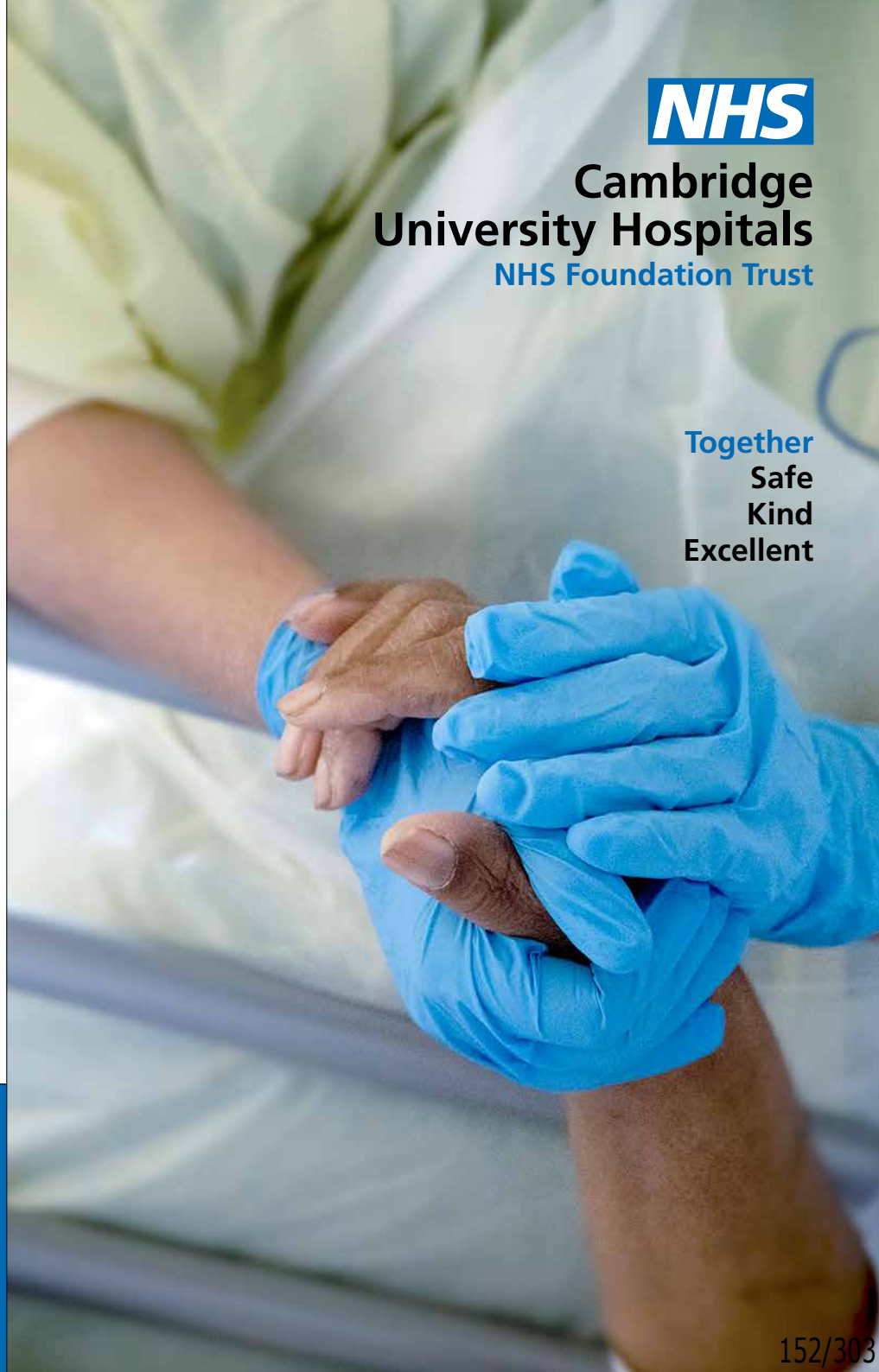
5.1. The Board of Directors is asked to:

- Receive and approve the revised CUH Strategy.
- Note the launch and implementation plan.

CUH Together
Our Strategy

Our strategy for a healthier life for everyone through care, learning and research

CUH Together 2025



Contents

Foreword

CUH is about people: the patients we care for, the staff who deliver that care, the community we serve and the partners we work with across our health and care system. Throughout the pandemic our colleagues went to extraordinary lengths to serve our patients and each other, living our values: Together – Safe, Kind, Excellent.

Our people delivered outstanding care to patients with Covid in uncertain and dangerous circumstances; continued to provide 24/7 emergency care and as much planned care as possible; and led world-leading research that developed the treatments that are enabling society to return to a new normal.

In November 2021 it was our privilege to award the Covid Star to our colleagues and members of the wider CUH community as a lasting token of gratitude for their contribution during the pandemic.

Looking further back, our previous strategy led to some significant achievements:

- A hugely improved 'Good' rating from the Care Quality Commission
- Deepening relationships with health and care partners locally and regionally
- Continued expansion of the Cambridge Biomedical Campus (CBC) with industry and academic partners
- Cambridge Children's and Cancer Research hospitals in development with support from the Government

Looking forward, we have progressed this strategy alongside colleagues, patients and partners – and we are excited about the next phase of our journey together. We set out an ambitious agenda for care, learning and research for the next three years, articulating the next phase of long-standing priorities as we come out of the pandemic, such as:

- Tackling a huge backlog and long waits for planned care
- Providing emergency care to a growing and ageing population
- Building a culture of continuously improving outcomes, experience, value and equity
- Conducting world-leading research with academic and industry partners
- Ensuring we are sufficiently staffed, and that all our staff feel equally valued and can thrive

We also set out opportunities to realise our potential over the next three years:

- Working more closely with primary, community and social care partners, and using technology, to help patients to stay well at home
- Working more closely with other hospitals in our region to increase local access to specialised services
- Tackling inequalities in access to, experience of, and outcomes from our services between different patient groups
- Delivering major new hospital builds on the CBC: Cambridge Children's and Cancer Research hospitals
- Reducing our carbon emissions on the way to NHS net zero to tackle the climate emergency

We look forward to working with colleagues, patients and partners to deliver this ambitious strategy over the next three years.

Mike More
Chair

Roland Sinker
Chief Executive

Introduction

Who we are?

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

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

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

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

Care – CUH provides:

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

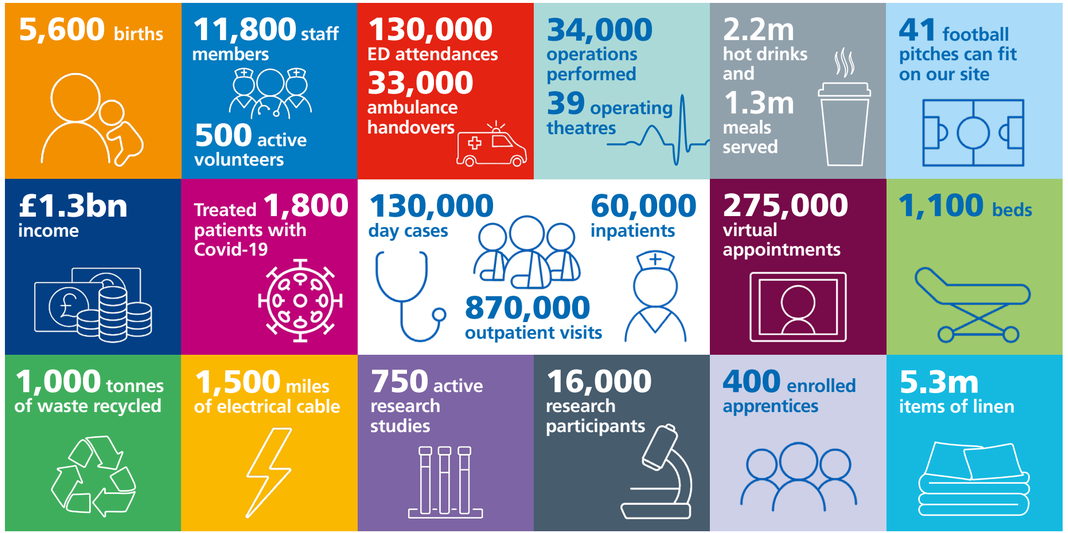
Learning – CUH is a teaching hospital for:

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

Research – CUH is:

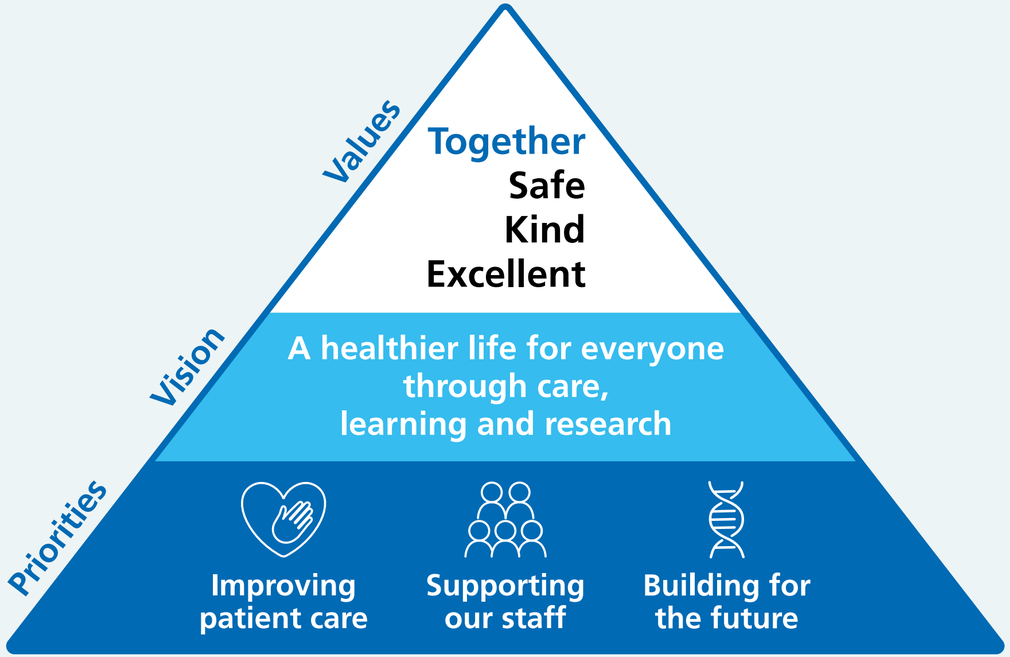
- Part of the National Institute for Health and Care Research (NIHR) through the Cambridge Biomedical Research Centre (BRC)
- A member of Cambridge University Health Partners (CUHP), one of eight Academic Health Science Centres
- A partner with the University of Cambridge and a thriving ecosystem of life sciences and technology industry on and beyond the Cambridge Biomedical Campus (CBC)

A year at CUH in numbers



2021/22

The Strategy Triangle



Our commitments in summary

Improving patient care	Supporting our staff	Building for the future
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
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
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
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
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

Our strategic priorities

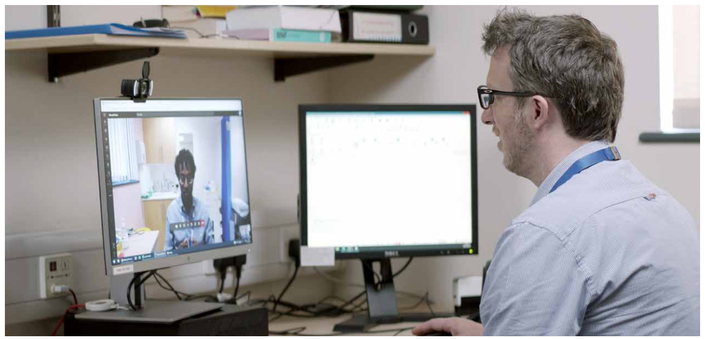
Improving patient care

Integrated care: We will work with NHS, other public sector and voluntary sector organisations to improve the health of our local population

We are proud to be part of a diverse system of health and care partners dedicated to serving our local population in the South of Cambridgeshire: GPs, community NHS teams, social care workers, public health professionals, care providers, local government, patient groups and many voluntary sector organisations.

We want all our patients to live long and healthy lives. Good health helps people to thrive at home, at work and in their community. However, our population is ageing and living for longer in poor health. Health and care services should work together to help patients stay well and spot early signs of ill health, and hospitals like CUH have a responsibility to work with others to address the wider determinants of ill health: poverty, loneliness, debt, poor housing, health risk factors such as smoking and obesity, as well as long-term health conditions. By working in this way, the NHS can support patients to thrive in their normal life, rather than simply restoring people to health when they are sick.

Each year, one out of one hundred and fifty people in our local population has an emergency admission to hospital for a potentially avoidable exacerbation of a long-term condition such as asthma. Additionally, many outpatient appointments currently performed at the hospital could be undertaken closer to home, as part of an integrated team in the community. By improving the health and well-being of our population we reduce the need for unplanned hospital care, which means we can care for more patients requiring treatment that can only be provided in a hospital.



By 2025 we want to:

- Improve the health of our local population by integrating pathways across primary, community, secondary and social care alongside the voluntary sector and local government
- Reduce unnecessary hospitalisations by supporting more patients at home during a health crisis, and enabling patients in hospital to return home as soon as they are able
- Increase the value of every pound spent to maximise the health and well-being of our population, with an increasing share of resources used to support patients outside the hospital
- Deepen trust and relationships with partners in other organisations so that we work together with energy and purpose to achieve our shared outcomes for those we serve

We will achieve this by:

- Hosting the South Place partnership of health and social care providers, local government, voluntary sector organisations and partners that will enable us to work even closer to make collective decisions, co-designed with patients, and use a shared budget to improve population health and health outcomes, share learning, expertise and resources and commission services to provide better integrated local services
- Supporting the South Place to nurture 'integrated neighbourhoods' that add more of our staff to single teams based around local Primary Care Networks and use data to target services where they are needed most
- Supporting the South Place to lead key operational priorities at the interface of secondary, primary, community, voluntary and social care such as admission avoidance and hospital discharge
- Implementing a change programme within CUH to ensure all of our services focus on proactively improving the health of our population and making the best use of collective resources, alongside treating patients who are currently in the hospital
- Embedding integrated care through other elements of our strategy, including our new builds and digital transformation

Emergency care: When patients come to the hospital in an emergency we will treat them, and help them to return home, quickly

Acute health emergencies are extremely frightening for patients and their loved ones. Quick access to highly trained clinical teams and the right equipment can be the difference between life and death, and gives patients the best chance of recovery.

Major trauma is the leading cause of death for people under 40, and CUH is the Major Trauma Centre for the East of England, providing surgery, critical care, inpatient, rehabilitation and discharge services to some of the sickest patients in our region.

We are seeing the highest ever activity in our Emergency Department (ED) from our growing and ageing population, increasingly including those with multiple long-term conditions. Patients requiring admissions are waiting much longer because we have fewer beds available, which also leads to crowding and delays in offloading ambulances. Patients who wait the longest are often experiencing a mental health crisis, and we have many frequent attenders with very complex needs.

In this context we are working closely with other partners in the urgent care pathway to improve services.

By 2025 we want to:

- Reduce the proportion of patients needing to access emergency care, particularly at hospital
- Reduce crowding in the ED to ensure patients are treated, and staff are able to work, in a calm environment
- Reduce journey times through the ED to ensure patients move on to the most appropriate setting as quickly as possible
- Reduce waiting times for patients requiring admission to leave the ED and reach an appropriate inpatient bed
- Reduce excess length-of-stay for emergency admissions to ensure patients return home as soon as they are able
- Reduce ambulance handover delays to ensure the next acutely unwell patients in the community get quick access to expert clinical care
- Reduce avoidable harm in emergency pathways and increase the quality, safety and patient experience in these services
- Ensure equitable access to high quality emergency care for all patients

We will achieve this by:

- Working more closely with primary, community and social care partners to improve population health and reduce the need for unplanned hospital care
- Streaming more patients away from the ED through different channels such as urgent community response, video appointments and NHS 111; and to quieter times of day by expanding same-day emergency care (SDEC) and bookable appointments
- Improving flow by embedding a front door frailty model to support patients most at risk, reclaiming assessment units, and maximising use of SDEC
- Modelling admissions and discharges by speciality and ward to optimise bed capacity planning
- Creating more capacity within the ED through use of temporary structures, repurposing adjacent capacity within the hospital and implementing plans rapidly to increase flow including by reverse boarding
- Improving inpatient flow and creating additional community capacity with partners in primary, community and social care

Planned care: When patients need planned care we will see them as quickly and efficiently as possible

Quick access to planned outpatient, diagnostic and surgical care gives patients the best chance to recover from ill-health. During the pandemic waiting times for these treatments increased considerably as our capacity to treat patients was reduced. Many of our patients travel significant distances for specialised treatments that can only be provided at CUH within our region or across the country, and so ensuring we have enough capacity to treat patients as soon as possible is of paramount importance.

Advances in clinical practice, new technology and different ways of working with partners mean our services are continuously evolving to deliver the best care for patients. Over the coming years this will mean working differently to ensure we can treat as many patients as efficiently and effectively as possible, increasing capacity and productivity by helping frontline teams to identify and implement improvements to care.

Access to planned hospital care is lower among the most deprived patients, which contributes significantly to stark inequalities in life expectancy and healthy life expectancy within our local population and across the East of England. We want everyone to have equitable access to our services and recognise our responsibility to work alongside patients and partners to achieve this.

By 2025 we want to:

- Increase resilience of elective capacity to withstand future Covid surges, winter pressures and other shocks
- Achieve outstanding outcomes and experience for patients, and best-in-class productivity and efficiency across all our pathways, informed by national Getting It Right First Time (GIRFT) best practice standards
- Reduce inequalities in access, outcomes and experience within our population
- Achieve national ambitions on access to care including first, follow-up and virtual outpatients plus enhanced advice and guidance, 52-78-104-week waiters, 28-day faster diagnosis standard, and 31-day decision to treatment for cancer patients

We will achieve this by:

- Increasing surgical capacity through use of new P2 and Q2 facilities on the Cambridge Biomedical Campus (CBC) as an elective surgical centre, and off-site diagnostic capacity including mobile scanners in the community
- Changing the setting of care, such as conducting more activity in primary care, off-site capacity or at smaller or independent sector hospitals; and the channel of care, such as through virtual appointments
- Using digital technology to raise productivity through remote monitoring, voice recognition and asynchronous communication through MyChart and Secure Chat
- Ensuring patients can return home more quickly and live more independently by promoting rehabilitation, utilising remote technology-enabled care, creating virtual wards and integrated pathways across organisations
- Changing pathways to reduce unnecessary referrals, such as through integration of specialist services into primary care, use of shared decision-making and advice and guidance
- Maintaining transparent clinical prioritisation processes to ensure the sickest patients are treated first and that harm to patients while waiting is minimised
- Reviewing data on access rates and waiting times between different patient groups and acting decisively where inequalities are identified

Health inequalities: We will tackle disparity in health outcomes, access to care and experience between patient groups

Every patient is a unique and equally valued individual. We recognise and value the diversity of all our patients and strive for every patient to have equitable access to our services so that they can live healthier and more fulfilled lives. Age, disability, gender reassignment, race, religion or belief, sex, and sexual orientation have a significant impact on people's health; and, despite our aspirations for equity, significant and long-standing disparities in the actual experience of patients in our communities and in hospital remain, and in some cases are growing.

Deprivation and geography also play a significant role in excess mortality and morbidity of our population, with the poorest areas having higher rates of health risk factors, fewer GPs and lower rates of access to planned care. For example, the life expectancy of traveller communities is approximately 10 to 12 years less than non-traveller populations.

Tackling these inequalities is a growing priority across the NHS, with the Government's focus on 'levelling up' across the country; the NHS's 'Core20PLUS5' framework targeting the most deprived fifth of the population and the five biggest disease areas to address inequalities (maternity, severe mental illness, respiratory, cancer and hypertension); increasing focus on racial disparities including through the formation of the NHS Race & Health Observatory and many other initiatives. We are committed to playing our role, and working with others, to ensure every patient receives the safe, kind and excellent care that we aspire to. We achieve this directly through our clinical services, and indirectly as an 'anchor institution' that employs people, purchases goods and services, owns assets, advocates for causes and works with partners.

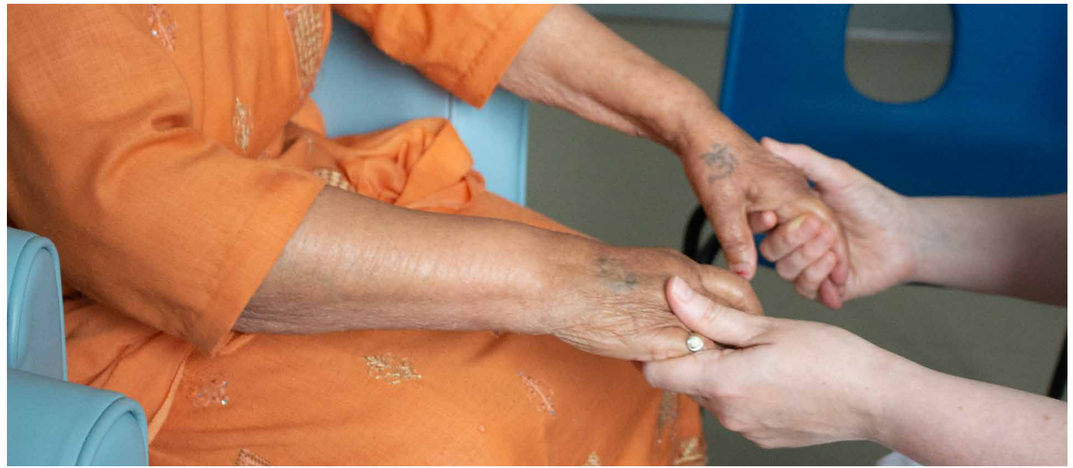
Other commitments in the strategy also present opportunities to tackle inequalities for patients, inequalities for staff, targeting care to the neediest patients, improving air quality and many others.

By 2025 we want to:

- Reduce the gap in avoidable mortality and morbidity between different population groups in our local and regional population
- Reduce the gap in access to and experience of care at CUH between different population groups
- Maximise the positive impact of our core activities to address the wider determinants of health as an 'anchor institution'

We will achieve this by:

- Increasing data completeness and using data to identify and understand disparities in outcomes, access and experience, including using the Equality Delivery System Tool (EDS2) to assess our performance
- Collaborating with staff and partners with lived experience to improve our services including through staff networks, partners in our ICS, Healthwatch and other patient engagement groups
- Playing our role in the five Core20PLUS5 priorities
- Identifying opportunities to address inequalities at each stage of planned care pathways, and working with partners to improve models of care to address these inequalities locally
- Maximising the wider impacts of our core activities to improve the health of our population as an employer, partner, asset-holder and purchaser
- Working with a range of organisations to build inclusive leadership capability



Quality, safety and improvement:
We will continuously improve the quality, safety and experience of all our services

As one of our values, safety is a core priority at CUH. Hospitals provide care for people at a time when they are vulnerable and many clinical interventions carry risk.

During the pandemic protecting patients from a highly infectious virus was one of our overriding priorities, and CUH had among the best outcomes for Covid patients, and the lowest rates of in-hospital transmission, in the NHS. We also introduced innovative ways of working to sustain the quality and safety of services during ongoing and unprecedented disruption, but the increase in waiting times across our pathways brings many challenges for quality and safety.

We strive to create a culture accompanied by robust processes that sustainably and continuously improve the quality of services that we provide, investing in improvement capability in leaders and teams, listening to patients and staff, identifying and learning from errors, and sharing good practice.

By 2025 we want to:

- Continue providing consistently high-quality care to all patients in line with our values, plus CQC and other professional standards
- Continue to learn from safety incidents and promote a process of transparency and learning
- Embed a culture of sustainable continuous improvement where staff are empowered and equipped to lead change
- Create a just culture environment for learning
- Achieve a CQC rating of Outstanding

We will achieve this by:

- Embedding accreditation, safety huddles and quality board reports in all wards and departments
- Implementing the new NHS Patient Safety Strategy including the Patient Safety Incident Response Framework and Patient Safety Partners
- Managing corporate quality processes such as harm reviews, clinical prioritisation and surgical prioritisation groups to prioritise care for patients in greatest need
- Implementing Digital Consent to support a consistent and safe consenting process
- Actively seeking feedback from patients and their loved ones through our Patient Engagement Group, survey data, Patient Advice and Liaison Service (PALS) and other engagement channels
- Refreshing the CUH Mental Health Strategy in line with ICS plans
- Creating psychological safety, encouraging reporting of incidents and errors without fear with a focus on learning and improvement
- Evolving the 'Learning from Deaths' process to identify further improvements to quality and safety
- Embedding After Actions Reviews as an approach to learning
- Investing in leadership training for clinical and non-clinical staff
- Training staff in improvement techniques, supported by the Institute for Healthcare Improvement (IHI)
- Delivering improvement projects across the hospital, supported by the improvement team, or by teams utilising those techniques directly
- Building capacity in divisions to give staff the time, resources and skills required to focus on improvement
- Celebrating and sharing best practice improvements