Board of Directors

Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

There will be a meeting of the Board of Directors in public on Wednesday 12 October 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** To approve the Minutes of the Board meeting held in public on 13 July 2022	For approval
	4*	**Board action tracker and matters arising not covered by other items on the agenda**	For review
11.05	**5**	**Patient story** To hear a patient story	For receipt

11.20	**6***	**Chair's report** To receive the report of the Chair	For receipt
11.25	**7***	**Report from the Council of Governors** To receive the report of the Lead Governor	For receipt
11.30	**8***	**Chief Executive's report** To receive the report of the Chief Executive	For receipt
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* Quality (including nurse staffing report) 9.2 Workforce 9.3 Access standards 9.4 Improvement 9.5* Finance	For receipt
12.20	**10***	**Research and development** To receive the report of the Medical Director	For receipt
12.30	**11***	**Learning from deaths** To receive the report of the Medical Director	For receipt
13.40	**12***	**Guardian of Safe Working quarterly report** To receive the report of the Medical Director	For receipt
12.50	**13***	**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			
12.55	**14***	**Medical and nursing revalidation** To receive the reports of the Medical Director and Chief Nurse	For receipt
	15*	**Board assurance committees – Chairs' reports** 15.1* Performance Committee: 6 October 2022 15.2* Quality Committee • Health and safety annual report	For receipt

Other items			Purpose
	16	**Any other business**	
13.00	**17**	**Questions from members of the public**	
	18	**Date of next meeting** The next meeting of the Board of Directors will be held on Wednesday 9 November 2022 at 11.00.	For note
	19	**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).	
13.15	**20**	**Close**	

NHS
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Minutes of the meeting of the Board of Directors held in public on Wednesday 13 July 2022 at 11.00 via videoconference

Member	Position	Present	Apologies
Dr M More	Trust Chair	X	
Mr D Abrams	Non-Executive Director	X	
Ms N Ayton	Chief Operating Officer	X	
Dr E Cameron	Director of Improvement and Transformation	X	
Mr A Chamberlain	Non-Executive Director	X	
Dr A Doherty	Non-Executive Director		X
Prof I Jacobs	Non-Executive Director	X	
Mr M Keech	Chief Finance Officer	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 C Stoneham	Director of Strategy and Major Projects	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 K Clarke	Associate Director of Workforce (Item 73/22 only)
Mr C Gray	Matron, Orthopaedics (Item 66/22 only)
Dr A Gupta	Director of Postgraduate Medical Education (Item 73/22 only)
Mr N Kirby	Interim Director of Strategy and Major Projects designate
Dr J MacDougall	Guardian of Safe Working (Item 74/22 only)
Mr D Northam Jones	Director of Strategy (Item 72/22 only)
Mr G Parlett	Head of Non-Medical Education (Item 73/22 only)
Dr M Ramus	Interim Junior Doctors' Forum (JDF) Lead (Item 74/22 only)
Dr T Rock	JDF Chair (Item 74/22 only)
Ms L Shirland	Speciality Support Nurse, Trauma and Orthopaedics (Item 66/22 only)
Dr N Stutchbury	Lead Governor
Ms F Taylor	Freedom to Speak Up Guardian (Item 75/22 only)
Mr M Whelan	Deputy Trust Secretary (minutes)

62/22 Welcome and apologies for absence

The Chair welcomed everyone to the meeting and extended a particular welcome to Nick Kirby who would be joining the Trust as Interim Director of Strategy and Major Projects during August 2022 for the period while Claire Stoneham was on maternity leave.

Apologies for absence are recorded in the attendance summary.

63/22 Declarations of interest

Standing declarations of interest of Board members were noted.

64/22 Minutes of the previous meeting

The minutes of the Board of Directors' meeting held in public on 11 May 2022 were approved as a true and accurate record.

65/22 Board action tracker and matters arising not covered under other agenda items

Received and noted: the action tracker.

66/22 Patient story

Lorraine Szeremeta, Chief Nurse, Lizzie Shirland, Speciality Support Nurse for Trauma and Orthopaedics, and Chris Gray, Matron for Orthopaedics, introduced the patient story. This told the story of Derrick, who was initially treated for Sepsis at Addenbrooke's Hospital following transfer from his local hospital where he had surgery following a car accident. He then underwent nine operations at Addenbrooke's to save his legs, before being discharged to continue his recovery and rehabilitation.

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

1. Despite use of technology to keep in touch, maintaining family contact during a long inpatient stay had been challenging due to visiting restrictions as a result of the pandemic.
2. The pandemic had also delayed the delivery of education programmes for families, impacting on recovery times.
3. It was noted that procedures to fit external fixator frames were generally undertaken on a semi-planned basis, with a waiting time of around one week. The frames were designed to be used for up to two years.
4. The fitting of the frames needed to be accompanied by significant pain management support.

5. In response to a question about the resourcing of the team, it was noted that dedicated physiotherapy support would be helpful.

Agreed:
1. To thank Derrick for having shared his story.
2. To note the patient story.

67/22 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.

68/22 Report from the Council of Governors

Neil Stutchbury, Lead Governor, presented the report.

Noted:
1. The decision taken by the Council of Governors on 17 May 2022 to re-appoint Mike More as Trust Chair until September 2025. The process followed and the rationale for the decision were set out in a paper received by the Council of Governors at its meeting held in public on 29 June 2022 and available on the Trust website.
2. It was hoped to hold the next meeting of the Council of Governors as a face-to-face meeting on the hospital site.
3. A draft Addendum to 'Your statutory duties' had been published by NHS England for consultation. The draft proposed a number of changes to the role of governors to reflect the development of Integrated Care Systems (ICSs).
4. Ruth Greene, Patient Governor, had made a generous donation for the provision of a new all-electric patient courtesy bus (the Green-e Get Around) to help transport patients around the site. This had been launched on 5 July 2022.

Board members expressed their thanks and gratitude to Ruth Greene for her donation.

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

69/22 Chief Executive's report

Roland Sinker, Chief Executive, presented the report.

Noted:

1. As of 13 July 2022, there were 132 Covid-19 positive inpatients in general and adult beds, with a further five in critical care. A significant majority of these patients were primarily being treated for conditions other than Covid-19.
2. In relation to staff recruitment, retention and wellbeing, the shortage of affordable accommodation locally and the rising cost of living pressures posed significant concerns.
3. Despite the operational and workforce pressures, the Trust was well placed to build for the future.

The following points were made in discussion:

1. Work was being undertaken on the reasons for a significant increase in the number of patients being referred on two-week pathways.
2. Board members acknowledged the prolonged period of significant pressure on the Trust and the potential impact on organisational resilience.

Agreed:

1. To note the contents of the report.

70/22 Performance reports

Improvement and transformation

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

Noted:

1. Good progress was being made on building improvement capability and the Investment Committee had approved the next stage of the improvement programme.
2. Colleagues from Royal Papworth Hospital NHS Foundation Trust and the South Integrated Care Partnership (ICP) would be joining the next improvement coach programme. Other improvement training had been delivered to matrons, Band 6s and Consultants.
3. The process of identifying cost improvement programme (CIP) schemes was ongoing.

Finance

Mike Keech, Chief Finance Officer, presented the update.

Noted:

1. Significant uncertainty remained about the financial planning process for 2023/24 and beyond.
2. A core capital programme of £66m plus £11m for fire-compliance works had been secured for the current financial year.

3. At the end of month two, the Trust had reported a surplus of £3.9m. The full-year plan was based on achieving a breakeven position.
4. The month one and two positions assumed full receipt of £1.7m of elective recovery funding. Clarification as to how the scheme would operate was awaited.

Quality (including nurse staffing report)

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

Noted:

1. The Care Quality Commission (CQC) had undertaken an unannounced inspection of the Trust's urgent and emergency care (UEC) pathway in March 2022, as part of a Cambridgeshire and Peterborough system-wide UEC inspection. The CQC team had reviewed the safe, responsive and well-led domains. While the inspection had highlighted many positive aspects, a number of 'must do's' and 'should do's' had been identified and action plans had been developed to address these.
2. Nursing and midwifery vacancy reporting was now fully aligned with the financial ledger. Critical care and paediatrics continued to be particular hotspots.
3. The latest in-month Hospital Standardised Mortality Ratio (HSMR) was 60, with a rolling year-to-date figure of 72. There were no issues for escalation.
4. Discussions were ongoing on the most effective operational model for treating Covid-positive patients in the period ahead.

Workforce

David Wherrett, Director of Workforce, presented the update.

Noted:

1. The number of healthcare assistants in post had reduced.
2. Nursing turnover was now at the highest level in three years.
3. Currently around 500 employees were absent for Covid-19 related reasons.
4. As well as presenting a major recruitment challenge, availability of affordable local accommodation was a significant factor in staff choosing to leave the organisation. A programme of work was being undertaken on accommodation and an Accommodation Officer had been appointed to support staff with accommodation issues.
5. Around 1,200 nominations had been received across the Trust Staff Annual Awards categories.

Access standards

Nicola Ayton, Chief Operating Officer, presented the update.

Noted:

1. Urgent and emergency care performance had improved in May 2022 compared with April 2022.
2. 12.4% of Emergency Department patients had breached the 12-hour standard in April 2022, compared with 10.4% in May 2022.
3. Ambulance handover delays had fallen between April 2022 and May 2022 and were significantly lower than the regional average.
4. However, these urgent and emergency care performance improvements had not been sustained into June 2022. A refreshed plan for addressing the performance challenges was being implemented.
5. Elective activity was generally above plan across the hospital.
6. Good progress continued to be made in reducing the number patients waiting in excess of 104 weeks for elective treatment. The Trust was projecting that only six patients would exceed this threshold by the end of July 2022.
7. Endoscopy had fully recovered its waiting list to pre-pandemic levels. Good progress was continuing to be made across other diagnostic services.
8. As part of the refreshed operational strategy, the Trust was seeking to appropriately maximise the number of day case procedures.

Following the presentation of the performance reports, the following points were made in discussion:

1. Non-Executive Directors noted that other trusts tended to perform more strongly in relation to the number of patients discharged prior to midday, and sought clarification on the constraints which were preventing the Trust from improving in this area. In response, it was highlighted that there was a range of factors which collectively contributed to this position. It was also recognised that the current configuration of the hospitals due to Covid-19 complicated the situation.
2. Timely provision of UEC treatment was a key issue identified in the CQC report. In response to a question about what the CQC would regard as “timely”, it was indicated that the CQC did not provide a specific measure. Nonetheless, Non-Executive Directors emphasised the importance of having an internal view of what could be regarded as timely.
3. The Chief Executive invited the Medical Director to comment on current infection control arrangements and the impact of Covid-19 on operational flow. While the majority of inpatients with Covid-19 were primarily being treated for other conditions, Covid-19 had the potential to delay the recovery of patients, as well as significantly restricting the ability of the Trust to discharge patients to care homes.
4. Board members acknowledged that reducing vacancies would positively impact on turnover, and this remained the aspiration of the Trust despite the significant challenges associated with accommodation and cost of living.

Agreed:

1. To note the Integrated Performance Report for May 2022.
2. To note the finance report for May 2022.
3. To note the nurse safe staffing report for May 2022.

71/22 Nursing and midwifery establishment review

Lorraine Szeremeta, Chief Nurse, presented the report.

Noted:

1. The Trust was required to review and report on nursing and midwifery establishment annually to the Board of Directors.
2. The report had been reviewed by Management Executive and the Investment Committee.
3. The proposals had been developed using the Safer Nursing Care Tool and were broadly neutral.
4. The Birthrate Plus® review of midwifery staffing had been completed recently and the recommendations were being reviewed.

The following points were raised in discussion:

1. A separate report would be presented for consideration once the Birthrate Plus® review had been completed.

Agreed:

1. To note that the annual establishment review process for nurse staffing has been undertaken in line with the Trust's agreed methodology.
2. To note the resulting nursing establishments for the current configuration of wards and departments across the hospitals.
3. To note the impact that the ongoing reconfiguration of wards and pathway changes in the Trust was having on the ability to realise other potential staffing efficiencies, resulting in a recommended decrease of 1.04 Whole Time Equivalent (WTE) Registered Nurses (net) and a decrease of 3.22 WTE Health Care Support Workers (net) following the SNCT and professional review.
4. To note that a further piece of work had been requested by the Investment Committee related to the configuration of wards and the need to consider the operational model currently used in the Trust, balanced with how best to staff these models to ensure optimum efficiencies on wards.
5. To note that the proposed ward establishments were supported by Investment Committee with two exceptions (C8 and Daphne ward) which had been taken into consideration in the final proposed establishment.
6. To note that the review of the Emergency Department nursing workforce had been professionally approved by the Chief Nurse with the recommendation of move to a revised establishment. This proposal has also been supported financially for 2022/23. As noted above, the Investment Committee had requested a review of the operating model

currently used by the Trust, including in respect of the emergency pathway. Staffing requirements would be kept under review in line with normal practice and may change following the outcome of this exercise.
7. To note a full midwifery workforce review was currently being undertaken using the Birthrate Plus® methodology and the findings would be presented to the Board of Directors when complete.

72/22 CUH Together 2025 – Our Strategy

Claire Stoneham, Director of Strategy and Major Projects, and Dan Northam Jones, Director of Strategy, presented the report.

Noted:
1. The Trust's strategy had been refreshed with input from a wide range of stakeholders, including staff, patients, partners, Board members and Governors.
2. Subject to the approval of the Board, the strategy was scheduled to be launched on 19 July 2022 with a supporting communications and engagement programme.

Agreed:
1. To receive and approve the revised CUH Strategy.
2. To note the launch and implementation plan.

73/22 Education, learning, training and development

David Wherrett, Director of Workforce, supported by Karen Clarke (Associate Director of Workforce), Arun Gupta (Director of Postgraduate Medical Education) and Gary Parlett (Head of Non-Medical Education), presented the report.

Noted:
1. The Trust was currently fully utilising its apprenticeship levy allocation. In excess of 85% of nursing apprentices remained with the Trust following completion of their training. Extension of the apprenticeship scheme to allied health professions (AHPs) and scientists was planned.
2. The Trust was supporting 25 fully-funded Health Education England science apprenticeships.
3. Support for functional skills development had been strengthened and was regularly promoted to staff.
4. The Trust's Work Experience Programmes had been paused for the past two years due to the pandemic but had recently resumed.
5. Continuing Professional Development funding applications continued to increase.
6. The Trust was seeking to enhance support for international staff, including securing educators from different countries. An Integration Post had been created to support international staff.

7. The Director of Postgraduate Education would be leaving the role prior to the next report to the Board of Directors.
8. The planning for the August 2022 changeover of junior doctor was on track. Outputs from the F2 annual review were largely positive.
9. Results from the latest General Medical Council (GMC) survey were awaited.
10. Good progress continued to be made with the development of the Digital Health Centre.

The following points were made in discussion:

1. Board members recognised apprenticeships as a key element of the future workforce strategy of the Trust. It was, however, acknowledged that for some of the smaller AHP roles, a system-wide approach might be more beneficial.
2. Clarification was requested on the approach of training partners to the delivery of learning. It was noted that the majority of partners had adopted a hybrid model.
3. It was recognised that the Trust's ability to release staff for training remained a significant issue, including the cost of providing backfill.
4. Board members acknowledged the range of opportunities to expand access to training through use of technology.
5. Working collaboratively with partners in the provision of training allowed for a broader experience to be provided to trainees.

Agreed:
1. To receive the report.

74/22 Guardian of Safe Working quarterly and annual reports

Jane MacDougall, Guardian of Safe Working, presented the report supported by Tom Rock (Junior Doctor Forum Chair) and Milly Ramus (Interim JDF Lead).

Noted:
1. Concerns remained about under reporting.

The following introductory comments were made by the JDF Chair:

1. The continued support of the Guardian and Medical Staffing in addressing issues as they arose was welcomed.
2. A mechanism to allow anonymous reporting of concerns had been introduced.
3. Good progress had been made in resolving the remaining rota compliance issues.

The following points were made in discussion:

1. Clarification was requested on the reference to “one in two rotas”. In response it was highlighted that this referred to rotas where juniors doctors were expected to work one in two weekends, rather than the one in three weekends included in the 2018 Junior Doctor contract. It was also noted that exact working patterns in terms of hours varied between specialities.
2. Tom Rock was thanked for his period as Chair of the JDF.
3. Comments were invited from the Guardian and JDF representatives as to whether there were any additional actions which the Trust could implement to improve the reporting of concerns and exceptions. In response, the continued focus on delivery of Clinical and Education Supervisor training was highlighted as a key priority. The possibility of Trust leaders supporting junior doctor inductions in August 2022 was suggested. It was also noted that the junior doctor locum rates paid by the Trust had been identified as an area of concern in the recent survey of junior doctors.

Agreed:
1. To note the Q4 2021/2022 report from the Guardian of Safe Working.
2. To note the fifth annual (2021/22) report from the Guardian of Safe Working.

75/22 Freedom to Speak Up six-monthly report

Ian Walker, Director of Corporate Affairs, and Francesca Taylor, Freedom to Speak Up Guardian, presented the report.

Noted:
1. During the reporting period, the highest number of concerns came from nurses, with a low number from medical and dental staff.
2. 25% of the concerns raised related to the theme of management support. Behavioural and relationship related issues were consistent themes.
3. Despite the availability of some benchmarking data, it was difficult to compare different organisations.
4. The latest annual Staff Survey results continued to indicate that staff with protected characteristics were less likely to raise concerns and have confidence that concerns would be addressed.

Agreed:
1. To receive the six-monthly report from the Trust’s Freedom to Speak Up Guardian.

76/22 Board assurance committees – Chairs’ reports

Received: the following Chairs reports:

- Workforce and Education Committee: 22 June 2022

- Quality Committee: 6 July 2022 (including the Safeguarding annual report)
- Performance Committee: 6 July 2022
- Remuneration and Nomination Committee: 6 July 2022

77/22 Any other business

There was no other business.

78/22 Questions from members of the public

The following questions were asked by members of the public and responded to by Executive Directors.

When will ED be replaced and rehoused in premises fit for purpose?

The present ED was opened when the population of the city was 70,000. It has now doubled. This ignores users from outside Cambridge.

Please do something radical to improve ED for both patients and staff.

The Chair indicated that as the person who had submitted the question was not present, the following answer would supplied in writing and included in the minutes:

The Trust is aware that the emergency department estate was not designed for current demand and that this places significant pressure on staff and the services for patients – points that were again reinforced in the recent CQC inspection.

Longer term, the strategy as articulated within the Addenbrooke's 3 Programme Business Case is to build a new acute hospital on the Hospital Expansion Land that would be fit for purpose, but this is dependent on capital availability.

Most immediately, the Trust has been working on a five phase plan to make modifications to the current ED to improve the environment where possible.

Alongside this, the Trust has recently initiated a new major project to develop an Urgent and Emergency Care strategy that would bridge from the current plan through to the acute hospital in 10-15 years' time. This work is expected to use an analytical approach to understand future demand and to provide options for how available physical space could be best matched to the optimum patient pathway, including repurposing of areas adjacent to the ED or that will be vacated over these timeframes (e.g. by the completion of the cancer and children's hospitals).

The Trust's Director of Workforce was quoted in the Cambridge Independent on 11 of May stating:

"[Housing] is a problem and currently we have no solution to it,"
See *https://www.cambridgeindependent.co.uk/news/lack-of-housing-for-cambridge-hospital-staff-never-been-mor-9253901/*

Given the higher-than-expected increases in population for Cambridge and South Cambridgeshire, please could The Board state what conversations they have had with The Combined Authority for Cambridgeshire & Peterborough regarding future transport plans (mindful of the very low staff awareness rate I found when I was a cardiac ward patient at Addenbrooke's & Papworth in December 2021), including but not limited to light rail, and what conversations Directors have had with the Greater Cambridge Planning Service on identifying potential sites to build new accommodation blocks for new staff at proposed transport hubs proposed by both the Greater Cambridge Partnership and the Combined Authority.

Furthermore, I urge directors to significantly improve the publicity of the Combined Authority's consultation on their local transport plan (See https://yourltcp.co.uk/) including ensuring the Combined Authority puts up posters on staff notice boards and at bus stops across the Cambridge Biomedical Campus - as your staff told me that bus timetables do not match the hospital shift changes.

The Chair indicated that as the person who had submitted the question was not present, the following answer would supplied in writing and included in the minutes:

CUH commissioned a detailed analysis of the housing needs of our workforce in 2020. This research, grounded in a staff survey, was undertaken by Savills, and has been used to articulate to key stakeholders with an interest in housing delivery, the urgent need for housing tenure types to meet the affordability challenges of our workforce. Given the cost of living crisis, these pressures continue to grow.

The organisation has been engaged in detailed discussions with housing and planning officers, Councillors and with a range of developers across the Greater Cambridge area to explore opportunities. However, there is a widely acknowledged challenge in the Greater Cambridge area of delivering housing that is affordable, for working people on low to medium incomes. This applies to both public and private sector workers. The existing approach to allocation of affordable housing does not give enough priority to our essential health workers. There has been limited success in securing legal agreements which will provide some affordable housing prioritised for our workforce (for instance through Local Lettings Plans on schemes close to the hospital). These should ensure our workers qualify for priority allocation of homes. However, our position remains of the need

to work with all parties to develop new forms of housing tenure targeting specifically working people on low to medium incomes, supplemented by the delivery of some form of key worker housing close to the hospital, potentially on the proposed CBC expansion land.

It is strongly believed that other major growth locations across the wider Greater Cambridge area would provide a great opportunity for new models of housing delivery, targeting key workers, if more innovative approaches to allocating affordable housing could be adopted.

Transport:

1. CUH travel and transport team are actively involved with the CPCA transport consultation for the Local Transport and Connectivity Plan (LTCP) and support the approach which the CPCA are taking.
2. CUH have been part of a stakeholder group consulted on the shaping and launch of the consultation, along with university partners and local transport representatives, has attended public briefing sessions, and has facilitated representatives from the CPCA team presenting at the Campus Travel and Transport Group meeting.
3. CUH is part of the Cambridge Ahead Transport sub group – where the CPCA also have a seat at the table, and presentations given with updates on the development of the plan.
4. CUH is conscious of the miss-match for some shifts with public transport offerings and is in contact on a regular basis with bus operators and the CPCA bus team to look to see where, if there is appropriate demand, these can be altered.
5. CUH continues to work closely with the CPCA, Network Rail and GCP in relation to infrastructure schemes which will deliver improved access to the CBC, including all GCP schemes within Cambridgeshire, Cambridge South Station and East / West Rail link / Bus service provision and support for the vision and objectives proposed in the new CPCA LTCP.
6. CUH will be responding to the consultation, which closes on 4 August. The response is in preparation.
7. As for notices on staff notice boards – pre-COVID the CPCA would have roadshows in the hospital as required. It will be reviewed how we can give greater visibility to staff on the various consultations.

The Chair's report (1.4) states that CUH is 'engaging very strongly with philanthropic funders for Children's and Cancer [hospitals]' and the CEO reports (7.10) a 'significant individual gift'. Such funding often comes with strings – with personal or corporate requirements for changes in design/provision/emphasis etc. How is CUH ensuring that the buildings are immutably what they plan and what is needed, and that no donor can deflect that provision?

The Director of Strategy and Major Projects responded.

The philanthropic campaigns for Children's and Cancer are being led by CUDAR (Cambridge University Development and Alumni Relations) and

well-established NHS charities (ACT and Head to Toe), with appropriate governance structures in place. There are approved policies and processes in place for the acceptance of gifts, including thorough due diligence, gift agreements and naming committees, to ensure consistency and the delivery of the overall programme goals. The principles of fairness and consistency are fundamental to how we interact with all of our funders, and any policy decision would need to be endorsed by all parties through the combined Joint Strategic Boards.

You say (CEO 5.9) that you are instituting e-rostering 'focussing on how staff are effectively deployed' while the Integrated Report records that 23% of those off sick are suffering from stress. For staff any electronic system will only be acceptable if *their* needs, as well as the institution's, are part of the input. Does the e-roster allow and take primary account of stated individual staff preferences for location, hours, responsibilities etc?

The Director of Workforce responded.

Good rostering has a win-win for staff and the team and the trust. Making rostering request, clarity on the individuals competencies, being notified early of shift patterns and good allocation of skills to establish good safe rotas and good team working is a key aspect of our rostering work.

Can the CEO please enlarge and explain his statement on Inclusion (5.14)? As we know this is an area of great concern for all of us but I am unable to understand what is proposed, how it will help and what the 'workplace adjustments' might be.

Inclusion. To improve the access and implementation of recommended reasonable adjustments for staff, a new service has been launched centralising 'workplace adjustments' across the Trust. This will be led by OH and aligns well with the Purple Passport already in place across the organisation. Work to align around inclusion for patients, staff and our population continues

The Director of Workforce responded.

This specific development covered in this statement is to ensure that where a disabled staff has a requirement for an adjustment, perhaps a new chair or other piece of kit then we can secure this without unnecessary delay. Our experiences in the past, as heard through staff networks, has been that we can take some time to work out the budgetary issues and we want to minimise any delay in allowing our colleagues to undertake their roles to best effect.

The COO recently reassured us that virtual wards would be introduced gradually and be closely monitored yet the CEO *still* refers (6.4) to a ward of 134 *within two months* and then 294 by Oct 2023. You have appointed a dedicated clinical director, lead nurse and manager but this still looks as though it is driven by Govt/NHSE requirements rather than by considered CUH planning and clinical effectiveness and safety. Are you in control and are you able to slow down or cut back the roll-out in response to your monitoring?

The Director of Improvement and Transformation responded.

The Trust is in control of the exact speed of roll out which will be dependent on clinical factors. The actual scale of virtual wards is not yet clear.

The Chair of the Performance Committee also provided assurance that the extension of virtual wards would be closely monitored.

79/22 Date of next meeting

The next meeting of the Board of Directors in public would be held on Wednesday 14 September 2022 at 11.00. [*Following the death of Her Majesty Queen Elizabeth II, and guidance on the period of national mourning, this meeting was subsequently postponed until Wednesday 12 October 2022.*]

80/22 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: 13.44

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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: 12 October 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

12 October 2022

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

1. Introduction

1.1 Summer has clearly concluded and we are in autumn, hurtling towards winter. As has been remarked many times before, though, we have been facing a winter-like scenario in hospital and wider health and care services throughout the summer. As is well known nationally, and as is shown in papers throughout this Board agenda, we will face very significant challenges over the coming months.

2. 'You Made A Difference' Awards/Staff Awards

2.1 I was pleased to attend a 'You Made A Difference' award event on 28 September 2022. 138 individual nominations and 52 team nominations were received and I would like to personally congratulate the winners Emma Nash, Ally Perkins, Louise Boden, Alin–Ionut Salcianu, Carmen Jimenez and Clinic 21.

2.2 The first staff Annual Awards took place at King's College in September. I was unable to be present but am told it was hugely enjoyed by everyone and it is great to see this introduced into our normal fabric for acknowledging and celebrating our fantastic teams.

2.3 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. Cambridge Children's Hospital Gala Dinner

3.1 I wish publicly to thank Ginny Robinson and her team, and all the Regional Ambassadors, for the hugely successful Gala Event in September at Trinity College on behalf of the Cambridge Children's Hospital. This was very successful in raising money for the project and is an important part of our regional engagement.

4. Diary

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

CUH
Performance Committee
Addenbrooke's 3 Committee
'You Made A Difference' Awards
New Governor Inductions
Council of Governors
REACH Network Launch
Volunteer/ long service awards
Consultants Development Programme
Visit of Amanda Pritchard and Sue Hill to the Genomics Service
Visit of Daniel Zeichner MP to the Emergency Department

4.2 Other meetings attended during this period include:

RAaFT - Paediatric Palliative Care Service Launch Event
University of Cambridge - The Vice-Chancellor's Farewell Reception
CBC Local Liaison Group Meeting
Meeting with local officials to discuss the CBC Local Plan submissions

5. Arun Gupta

5.1 I want to thank Arun for all he has personally done over recent years to promote Postgraduate Education within the Trust. He has presented regularly to the Board and I am sure that the whole Board will join me in thanking him and wishing him well.

6. Annette Doherty

6.1 On behalf of the Board, I would like to congratulate Annette Doherty, Non-Executive Director, on her election as President-elect of the Royal Society of Chemistry. Annette will take up her role as President in July 2024.

7. Recommendation

7.1 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: 12 October 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

12 October 2022

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

1. Recent Governor meetings

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

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

1.3 A **Council of Governors** meeting was held on 21 September. It was hoped for this to be our first face-to-face meeting since pre-pandemic, together with a tour and social event. In the event the Lead Governor had tested positive for Covid-19 (and he wasn't the only one), so it was decided at the last minute to conduct it remotely. We will aim to make the December 2022 Council of Governors' meeting face-to-face. Governors asked questions relating to the delays in completing U Block, preparedness for a flu epidemic in the winter, effectiveness of improvement projects and the annual audit report. Questions on the proposed congestion charge in Cambridge and the time taken to vet volunteers will be responded to in writing.

1.4 The Lead Governor gave a presentation to the **Annual Public Meeting** on 28 September, where he summarised some of the activities governors had been engaged in and the main areas we have scrutinised over the past 12 months.

1.5 A **Regional Lead Governors** meeting was held on 29 September. One of the aims of this group is to support each other and share best practice. It was clear that whereas CUH and Mid and South Essex FTs, for example, had boards who were very supportive of the contribution governors make, this is not the case in every trust. Some trust governors have great difficulties in being allowed to do their job properly, due in part to poor relationships with

their board. There was also wide variation in the degree with which trust governors had already connected with their Integrated Care Boards.

2. Upcoming Governor meetings

2.1 There is 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 on 5 October at which we will prepare for the meeting of all governors with the Chair of the Cambridgeshire and Peterborough ICB (see below).

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

2.3 The next Governor Strategy Group meeting is scheduled for 15 November.

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

3. Other Governor activities

3.1 There has been no training for governors for a couple of years now despite several efforts by the Secretariat to identify a date. Instead, we have decided to allocate the next Governor Seminar slot on 20 October for a shortened two-hour training session, facilitated by an external consultant. Training will be focused on practical skills in effective questioning and holding NEDs to account. The planned session on patient experience and Healthwatch will be deferred to a later seminar slot.

3.2 The regional lead governors of trusts in the South Integrated Care Partnership have organized a meeting for all governors with the Chair of the Integrated Care Board, John O'Brien, on 26 October. Initially it was hoped to be face-to-face, but it will now be virtual. This follows a similar meeting we had in 2019 with Mike More, Interim ICS Chair at the time.

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: 12 October 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

12 October 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 is 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 6 October 2022 the Trust was caring for 102 inpatients with Covid-19 including 4 in critical care.

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

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

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

Part A

2. The five areas of operational performance

2.1 Quality

Areas of challenge

Staffing

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

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

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

Complaints and Patient Advice and Liaison Service (PALS)

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

Never Events

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

Waits for care

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

Areas of Success

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

Compliance visits

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

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

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

3. Access to Care

3.1 **Emergency Department (ED).** Overall ED attendances were 10,562 in August 2022, which is 72 (0.7%) higher than August 2019. This equates to a rise in average daily attendances from 338 to 341 over the same period. 1,325 patients had an ED journey time in excess of 12 hours, compared to 28 in August 2019. This represents 12.4% of all attendances and compares to regional levels of 9% and national levels of 8%.

3.2 **Referral to Treatment (RTT).** The total RTT waiting list size increased by 1,545 in August 2022 to 59,748. Our Month 4 planning submission had forecast growth to 54,129 so we are currently 10% higher than plan. Compared to pre-pandemic the waiting list has grown by 75%.

3.3 **Delayed discharges**. For August 2022 the Trust is reporting 5.4%, which is a decrease of 0.5% from the previous month. Within the 5.4%, 61% were attributable to Cambridgeshire and Peterborough ICB, and the remainder across a further seven ICB's.

3.4 **Cancer.** In August 2022 two week wait suspected cancer referral demand had reached 129% compared to the baseline period in 2019.

3.5 **Operations.** Elective theatre activity in August 2022 comparative to the 2019 baseline was the best month year to date, achieving 90%. Taking account of the loss of the A Block theatres from our capacity, this would bring the performance above baseline at 101%.

3.6 **Diagnostics.** Total diagnostic activity in August 2022 delivered to 107.2% of the August 2019 baseline. Scheduled activity delivered 107.5% of baseline.

3.7 **Outpatients.** In August 2022 Outpatients delivered 108% new activity against the baseline. This is a good achievement, especially considering August is often disrupted due to holiday season.

4. Finance – Month 4

4.1 The Month 5 year to date position is a £3.4m surplus. The overall full year plan is to deliver a break-even financial position.

4.1 The following points should be noted in respect of the Trust's Month 5 financial performance:

- The Month 5 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 £10.4m. 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 £5.7m year to date in line with plan. The Trust's expectation is that NHSE/I will support ERF funding for the first half of the 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.

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

4.3 The Trust has invested £10.0m of capital at Month 5, £9.5m below the planned figure of £19.5m. The Trust expects to recover this under performance by year-end and achieve the forecast plan of £65.9m of capital expenditure.

2022/23 CUH Financial Plan

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

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

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

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

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

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

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

Resourcing

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

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

Further events are planned for October and December, working in collaboration with Royal Papworth Hospital (RPH).

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

Ambition

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

Inclusion

5.10 The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) 2022 data set has been submitted and corresponding actions plans developed. These will be presented at the November trust board meeting.

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

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

Relationships

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

On 22 September the trust hosted its first CUH staff award event, held at King's College, Cambridge. The evening was the culmination of a 9 month programme of recognition for the fabulous contribution made by colleagues throughout the organisation. It is intended for the awards programme to be an annual event.

6. Improvement and Transformation

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

6.2 In relation to the Trust's work with the IHI on building improvement capability and capacity across our 11,500 staff, wave two of the improvement coach programme commenced on 22 June 2022, with 38 participants, including a number of applicants from system partners (two from Royal Papworth Hospital and a further two from the South Integrated Care Partnership).

6.3 Wave two of the improvement programme for teams commenced on 30 September 2022, with 19 teams participating. 16 teams are focused on improvement projects related to topics that will help to make a good day at work and the remaining three teams are focused on projects linked to deteriorating patients.

6.4 Wave two of the leading for improvement programme will commence on 31 January 2023 and in conjunction with members of Management Executive it will be determined which senior leaders undertake this wave.

6.5 Significant improvement work is ongoing in urgent and emergency care (UEC), outpatients and virtual wards, which is highlighted as one example below.

Virtual wards

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

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

- A workforce plan has been developed and recruitment is underway, with the aim of staff being in place during October 2022 to avoid delay in implementation.

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

1.6 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 5, year-to-date delivery has been achieved and £63.05m of schemes overall have been identified; however, work is ongoing to increase the number of divisional / corporate schemes that will deliver recurrent, rather than single year, savings.

PART B

7. Strategy update

Strategy refresh

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

7.2 The core priorities and associated commitments are:

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

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

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

Improving patient care

Integrated Care

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

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

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

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

Health inequalities

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

Supporting our staff

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

Building for the future

New hospitals and the estate

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

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

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

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

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

Specialised Services

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

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

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

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

Research and life sciences

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

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

Sustainability

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

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

7.24 Progress continues to be made on the Genomics service:

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

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

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

Delivering a high quality testing service

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

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

8. Recommendation

8.1 The 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: 12 October 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 August 2022.
Previously considered by	Performance Committee, 6 October 2022

Executive Summary
The Integrated Performance Report provides details of performance to the end of August 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 2.
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 August 2022.




Cambridge University Hospitals
NHS Foundation Trust





Integrated Report

Quality, Performance, Finance and Workforce to end Aug 2022

Chief Finance Officer
Chief Nurse
Chief Operating Officer
Director of Workforce

Report compiled: 30 Sep 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	Jun 22 Previous Month-1	Jul 22 Previous Month	Aug 22 Current status	Trend	FYtD	Baseline	LTM
Safe	Average % compliance with individual elements of NEWS2 escalation policy	Aug-22	85%	60%	57%	49%	⇩	57%	50.0%	53.6%
	% of patients over 65 years of age who have a lying and standing blood pressure completed within 48 hours of admission	Aug-22	50%	16.7%	14.9%	15.8%	⇧	15.2%	13.4%	15.2%
	% 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	Aug-22	95%	71%	80%	80%	⇔	77%	70.0%	77.0%
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)	Aug-22	7%	12.3%	12.8%	13.3%	⇩	12.6%	14.0%	12.3%
	Publication of actions and improvements undertaken as a result of feedback received from patients and their representatives	Jul-22	100%	8.3%	8.3%	N/A	▪	8.3%	0.0%	8.3%
Effective / Responsive	% of Early Morning Discharges (07:00-12:00)	Aug-22	20%	15.2%	15.6%	16.0%	⇧	16.0%	15.3%	15.7%
	Percentage of in-patient discharges on a Saturday and Sunday compared to the rest of the week (calculated as the average daily discharges on Sat/Sun divided into the average daily discharges Mon-Fri). Excludes day cases. 80% (of weekday rate) **Additional Filters Simple Discharges, G&A etc**	Aug-22	80%	72.4%	68.0%	78.4%	⇧	74.5%	74.0%	76.7%
	Same day emergency care (SDEC)	Aug-22	30%	19.3%	16.8%	16.6%	⇩	18.8%	22.0%	20.2%
	Quarterly			Dec 21	Mar 22	Jun 22				
	SSNAP Domain 2: % of patients admitted to a stroke unit within 4 hours of clock start time (Team centred)	Jun-22	55%	N/A	N/A	25.9%	▪	25.9%	29.2%	25.9%
Staff Experience / Well-led	Retention of band 5 nurses (quarterly)	Jun-22	88.5%	N/A	N/A	N/A	▪	N/A	87.0%	N/A
	Annual			2016	2017	2018				
	I feel secure about raising concerns re unsafe clinical practice within the organisation		78.0%	75.0%	73.0%	74.0%	⇧		75.0%	

SAFE – Sepsis data continues to be collated an analysed by a new team of auditors, who are working on the backlog of data from March 22

Quality Summary Indicators

NHS
Cambridge University Hospitals
NHS Foundation Trust

2022/23 Performance Framework

Performance Framework - Quality Indicators				Jun 22	Jul 22	Aug 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)	Aug-22	0	0	0	0	⇔	1	4	3
	E.Coli Bacteraemias (Total Cases)	Aug-22	50% over 3 years	29	34	29	⇧	164	384	391
	C. difficile Infection (hospital onset and COHA* avoidable)	Aug-22	TBC	16	11	20	⇩	70	123	141
	Hand Hygiene Compliance	Aug-22	TBC	97.4%	96.6%	97.0%	⇧	97.3%	97.5%	97.5%
Clinical Effectiveness	% of NICE Technology Appraisals on Trust formulary within three months. ('last month')	Aug-22	100%	25.0%	57.1%	50.0%	⇩	52.8%	33.8%	41.8%
	% of external visits where expected deadline was met (cumulative for current financial year)	Aug-22	80%	N/A	100.0%	N/A	⇧	50.0%	46.7%	47.4%
	80% of NICE guidance relevant to CUH is returned by clinical teams within total deadline of 32 days.	Aug-22	-	56.3%	80.0%	57.1%	⇩	55.1%	17.2%	46.7%
	No national audit negative outlier alert triggered	Aug-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	Aug-22	85%	50.0%	40.0%	80.0%	⇧	-	84.6%	69.8%
Nursing Quality Metrics	Blood Administration Patient Scanning	Aug-22	90%	99.9%	99.6%	99.0%	⇩	99.5%	99.1%	99.5%
	Care Plan Notes	Aug-22	90%	96.9%	96.6%	96.9%	⇧	96.7%	95.8%	96.0%
	Care Plan Presence	Aug-22	90%	99.8%	99.9%	100.0%	⇧	99.9%	99.6%	99.8%
	Falls Risk Assessment	Data reported in slides								
	Moving & Handling	Aug-22	90%	65.9%	64.0%	63.9%	⇩	62.5%	63.1%	62.3%
	Nurse Rounding	Aug-22	90%	97.3%	97.3%	97.6%	⇧	97.3%	96.6%	96.7%
	Nutrition Screening	Aug-22	90%	99.5%	99.6%	99.4%	⇩	99.5%	99.6%	99.5%
	Pain Score	Aug-22	90%	77.0%	73.9%	74.7%	⇧	75.8%	77.1%	75.0%
	Pressure Ulcer Screening	Data reported in slides								
	EWS									
	MEOWS Score Recording	Aug-22	90%	56.4%	54.1%	59.9%	⇧	58.7%	64.0%	60.4%
	PEWS Score Recording	Aug-22	90%	86.1%	85.2%	85.5%	⇧	85.9%	86.6%	86.1%
	NEWS Score Recording	Aug-22	90%	76.0%	72.4%	74.8%	⇧	74.6%	74.2%	73.6%
	VIP									
	VIP Score Recording (1 per day)	Aug-22	90%	91.3%	87.9%	87.1%	⇩	89.0%	91.2%	89.5%
	PIP Score Recording (1 per day)	Aug-22	90%	99.3%	99.3%	98.9%	⇩	99.2%	99.2%	99.2%
Patient Experience	Mixed sex accommodation breaches	Jun-20	0	-	-	-	▪	0	0	0
	Number of overdue complaints	Aug-22	0	14	4	18	⇩	43	29	67
	Re-opened complaints (non PHSO)	Aug-22	N/A	5	3	1	⇩	13	74	60
	Re-opened complaints (PHSO)	Aug-22	N/A	0	0	0	⇩	0	4	1
				Jun 22	Jul 22	Aug 22				
	Number of medium/high level complaints	Aug-22	N/A	27	21	17	⇩	105		248

Author(s): Various

Owner(s): Oyejumoke Okubadejo

Operational Performance

NHS
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		31%	
	Ambulance handovers <30mins		95%	Immediate		81%	
	Ambulance handovers > 60mins	L	0	Immediate		98	
	12hr waits in ED (type 1)	H	2%	Immediate	7%	12%	
Cancer More information on pages 17,18	Cancer patients < 62 days	L	85%	Immediate		72%	
	28 day faster diagnosis standard		75%	Immediate	79.9%	75.9%	
	31 day decision to first treatment	L	96%	Immediate		91%	
Outpatient Transformation More information on page 21	Advice and Guidance Requests		16%	Mar-23	13%	10%	
	Patients moved / discharged to PIFU	H	5%	Mar-23	3.1%	2.3%	
Diagnostics More information on page 19	Patients waiting > 6 weeks	L	5%	Mar-24		45%	
RTT Waiting List More information on page 16	RTT Patients waiting > 78 weeks	L	0	Mar-23	213	373	
	RTT Patients waiting > 104 weeks	L	0	Jul-22	-	9	

Productivity and Efficiency	SPC	In Month Actual	Actual
Non-elective LoS (days, excl 0 LoS)	H	9.14	
Long stay patients (>21 LoS)	L	5.4	
Elective LoS (days, excl 0 LoS)		5.4	
Discharges before noon	H	16%	
Theatre sessions used		1559	
In session theatre utilisation	H	83%	
Virtual Outpatient Attendances	L	21%	

	Aug-22	Jul-22	% change	Feb-20	% change
Outpatients - New	30,021	29,146	↑3%	28,700	↑5%
Diagnostics - Total WL	14,082	15,384	↓8%	8,708	↑62%
RTT Pathways - Total WL	59,748	58,203	↑3%	34,097	↑75%
Cancer (62d pathway) >62d	132	156	↓15%	56	↑136%

Surgical Prioritisation - WL	Aug-22	Jul-22	% change
P2 (4 weeks) Including planned	1945	2077	↓6%
P3 (3 months)	5273	5262	↑0%
P4	3525	3580	↓2%

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

88%	In Month Actual
79%	In Month Plan
85%	YTD Actual
79%	YTD Plan

Elective Daycase Activity

18%	In Month Actual
92%	In Month Plan
20%	YTD Actual
101%	YTD Plan

Emergency Admissions

74%	In Month Actual
88%	In Month Plan
80%	YTD Actual
91%	YTD Plan

New Outpatient Activity

104%	In Month Actual
105%	In Month Plan
101%	YTD Actual
100%	YTD Plan

Follow Up Outpatient Activity

108%	In Month Actual
125%	In Month Plan
109%	YTD Actual
123%	YTD Plan

Diagnostic activity (national planning submission)

57%	In Month Actual
116%	In Month Plan
59%	YTD Actual
120%	YTD Plan

RTT Clockstops (All)

91%	In Month Actual
103%	In Month Plan
91%	YTD Actual
101%	YTD Plan

RTT Clockstops (Admitted)

87%	In Month Actual
82%	In Month Plan
83%	YTD Actual
85%	YTD Plan

RTT Clockstops (Non admitted)

92%	In Month Actual
109%	In Month Plan
94%	YTD Actual
106%	YTD Plan

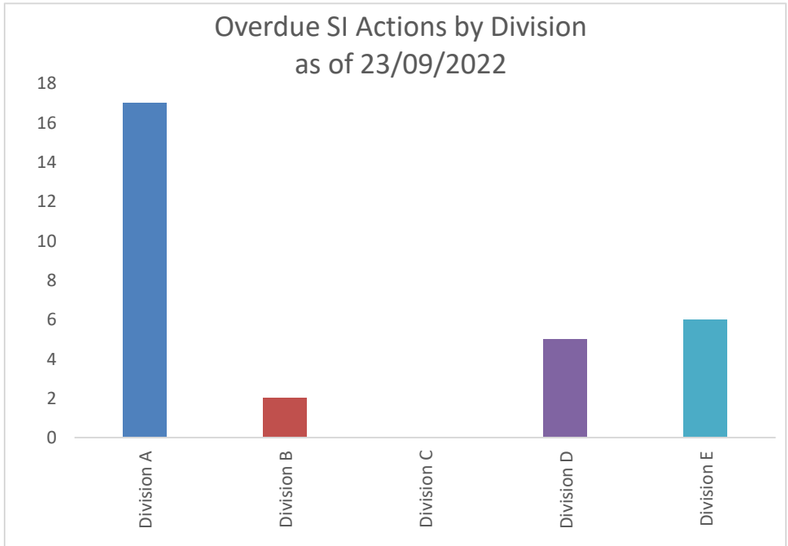
Serious Incidents

Cambridge University Hospitals NHS Foundation Trust

Safety and Quality

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
Patient Safety Incidents	May 18 - Aug 22	month	-	1495	1411			-	The number of patient safety incidents is within normal variance.
Percentage of moderate and above patient safety incidents	Nov 19 - Aug 22	month	2%	2.8%	1.5%				There is currently normal variance in the percentage of moderate and above patient safety incidents.
All Serious Incidents	July 18 - Aug 22	month	-	10	5			-	10 Serious Incidents were declared with the CCG in Aug 2022, which is within normal variance for the trust.
Serious Incidents submitted to CCG within 60 working days (or agreed extension)	Jun 18 - Aug 22	month	100%	80%	63%				10 Serious Incidents were due to the CCG in Aug 2022, 8 of which were submitted within the 60 day target.

Ref		STEIS SI Sub categories	Actual Impact	Div.	Ward / Dept.
SLR145108	Fall on Ward J3	Slips/trips/falls	Death	Division C	J3
SLR144612	Unexpected death of a patient-	Sub-optimal care of the deteriorating patient	Severe	Division D	M5
SLR144981	Unexpected patient death-	Sub-optimal care of the deteriorating patient	Severe	Division C	F6
SLR143966	Category 3 HAPU	HAPU	Severe	Division D	G3
SLR144643	PU ward D7	HAPU	Severe	Division D	D7
SLR144011	Glaucoma Delay	Diagnostic Delay	Severe	Division D	Neuro Mgmt
SLR142664	PU ward G2	HAPU	Severe	Division C	G2
SLR145254	Deteriorating patient (ED)	Sub-optimal care of the deteriorating patient	Death	Division C	ED
SLR146293	Unstageable PU Ward G4	HAPU	Severe	Division C	G4
SLR145397	Retained Guidewire	Retained foreign object post-procedure	No Harm	Division B	Ultrasound

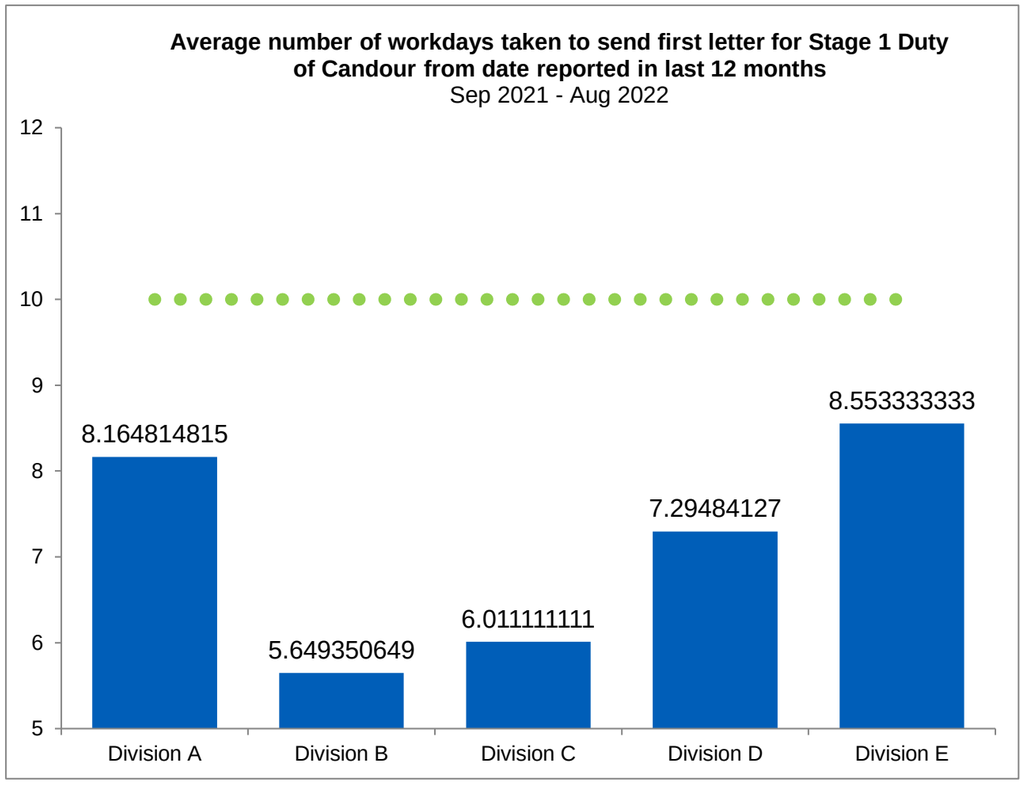


Duty of Candour

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*	Jul 19 - Aug 22	month	100%	90%	70%		-		The system may achieve or fail the target subject to random variation.
Duty of Candour Stage 2 within 10 working days**	Jul 19 - Aug 22	month	100%	67%	68%		-		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 August 2022. 90% of DOC Stage 1 was completed within the required timeframe of 10 working days in August 2022. The average number of days taken to send a first letter for stage 1 DOC in August 2022 was 4 working days.

Trust wide stage 2** DOC is compliant at 100% for all completed investigations into moderate or above harm in August 2022 and 67% DOC Stage 2 were completed within 10 working days.

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

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

Falls

Cambridge University Hospitals NHS Foundation Trust

Safety and Quality

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
All patient falls by date of occurrence	Aug 19 - Aug 22	month	-	166	144		-	-	There were a total of 166 falls (inpatient, outpatient and day case) in August 2022. The Trust remains within normal variance.
Inpatient falls per 1000 bed days	Aug 19 - Aug 22	month	-	4.99	4,51			-	The Trust remains within normal variance.
Moderate and above inpatient falls per 1000 bed days	Aug 19 - Aug 22	month	-	0.20	0.09			-	There were 6 falls categorised as Moderate or above harm in August 2022. The level of harm is classed according to injury and not lapses in care.
Falls risk screening compliance within 12 hours of admission	Aug 19 - Aug 22	month	90.00%	85.10%	86.00%				Completion of Falls risk screening within 12 hours of admission remains below the 90% target.
Falls KPI; patients 65 and over have a Lying and Standing Blood Pressure (LSBP) completed within 48hrs of admission	Aug 19 - Aug 22	month	90.00%	15.80%	10.90%				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%	23.20%	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%	68.00%	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

Author(s): Debbie Quartermaine

Owner(s): Oyejumoke Okubadejo

Hospital Acquired Pressure Ulcers (HAPUs)

NHS Cambridge University Hospitals NHS Foundation Trust

Safety and Quality

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
All HAPUs by date of occurrence	Feb 18 - Aug 22	month	-	38	22		-	-	The total numbers of HAPU's for Aug is lower than July, however it still remains above the upper control limit.
To increase reporting of category 1 HAPU to achieve an upward trajectory in reporting by March 2022	Feb 18 - Aug 22	month	-	10	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 - Aug 22	month	-	28	11	H	SP	-	Category 2 and above HAPU remain above the upper control limit increasing the upward trajectory.
Pressure Ulcer screening risk assessment compliance	Feb 18 - Aug 22	month	90%	80%	80%		-	F	PU screening risk assessment compliance remains below the target of 90%. A QI plan will be presented at NMAAC in October and a 1 yr fixed term band 6 TVN post is being advertised for ED to focus on all aspects pressure ulcer prevention.
KPI downward trend of category 2, 3, 4, Suspected Deep Tissue Injury and Unstageable HAPUs by March 2022	Apr 19 - Aug 22	month	9	28	10	H	SP	F	KPI 2021-2022 - to decrease number of category 2 and above HAPU as a result of early reporting of category 1. Reporting for category 2 and above HAPU remain above the 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 above the upper control limit in August although are lower than July..

A 1 year fixed term band 6 TVN post is being advertised to support ED on all aspects of pressure ulcer prevention. This will help identify patients being admitted with existing pressure ulcers being mistaken as HAPU's and those "at risk" patients from developing HAPU's, thus improving risk assessment screening compliance and incident rates.

HAPU incidents; Category 1 = 10, Category 2 = 19, Category 3 = 0, Category 4 = 0, SDTI = 6, Unstageable = 3

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	Aug-22	Monthly	95%	47%	55%		-	?	Compliance with Sepsis 6 delivered within 60 Mins has dropped to 47% from 53% in July. Elements of the sepsis 6 bundle that have impacted on the overall compliance this month is Antibiotic administration within an hour of triggering sepsis (67%) and Blood Cultures (80%) and monitoring (67%). Possible delay in escalation and review . Prolonged stay in ambulance bay likely contributed, Patient in PAT space would likely be contributing factor
Antibiotics administered with 60 mins from time patient triggers Sepsis (NEWS 5>) - Emergency Department	Aug-22	Monthly	95%	67%	72%		-	?	Average door to needle time was 82 mins for Aug 22 , a 20 mins decrease on July . 5 audits impacted on this average time because door to needle time in those particular audits exceeded 100 Mins. The average time between patient triggering sepsis (NEWS 2 5>) and prescription of antibiotics was 30 mins. In 73% 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 27 mins, in 66% of the audits antibiotics were administered within 30 Mins of being prescribed. The average prescription and administration time of antibiotics together was 29 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%	26%	H	SP	F	Due to a change in data collection, inpatient data for August has not yet been analysed. This will be retrospectively completed once a regular collection and analysis schedule has been formalised.
Antibiotics administered with 60 mins form time patient triggers Sepsis (NEWS 5>) - Inpatient wards	Jul-22	Monthly	95%	100%	67%		-	F	Due to a change in data collection, inpatient data for August has not yet been analysed. This will be retrospectively completed once a regular collection and analysis schedule has been formalised.
Antibiotics administered within 60 mins of patient being diagnosed with Sepsis - Emergency Department	Aug-22	Monthly	95%	87%	90%		-	?	
Antibiotics administered within 60 mins of patient being diagnosed with Sepsis - Inpatient wards	Jul-22	Monthly	95%	100%	71%		SP	F	Due to a change in data collection, inpatient data for August has not yet been analysed. This will be retrospectively completed once a regular collection and analysis schedule has been formalised.

Executive Summary:

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

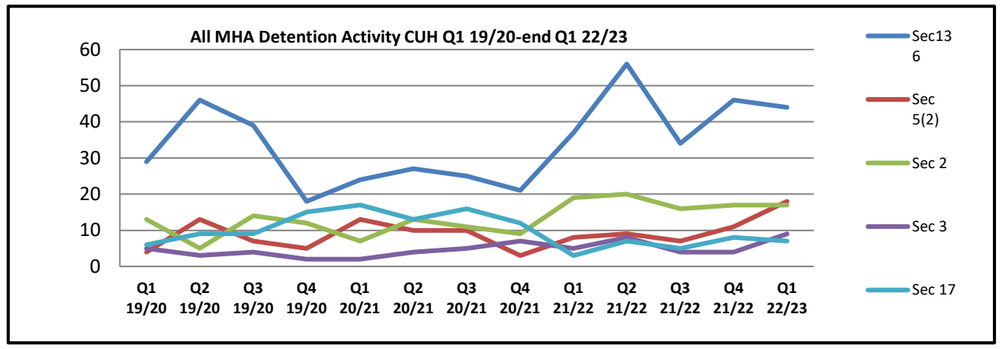
Efforts are being made to ensure that gaps in data spanning back to April 2022 are retrospectively analysed.

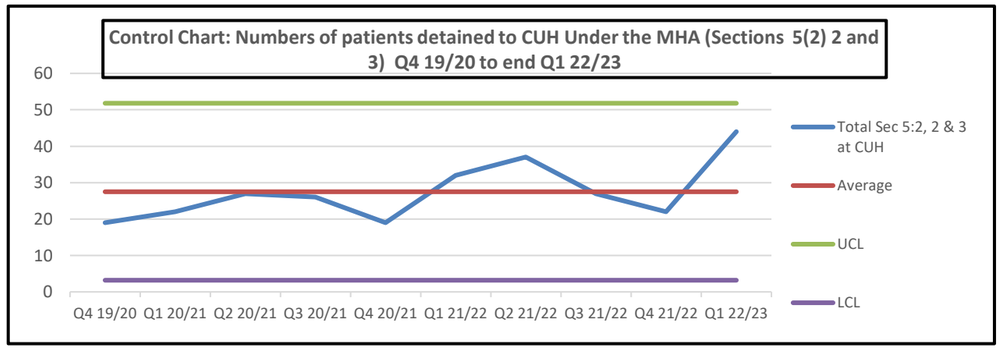
The overall compliance of the sepsis 6 bundle being delivered in 60 mins is dependant on all elements of the bundle being compliant within 60 mins, therefore one or two elements can impact on the overall compliance. Please see breakdown table above with the elements highlighted in yellow and each elements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

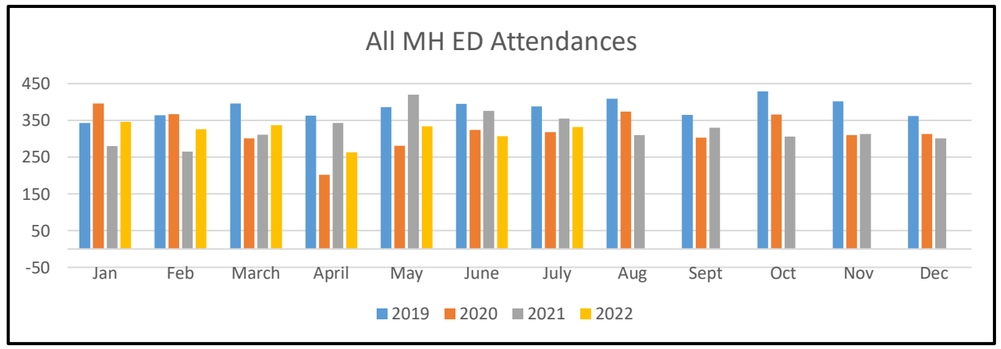
Mental Health - Q1 2022/23

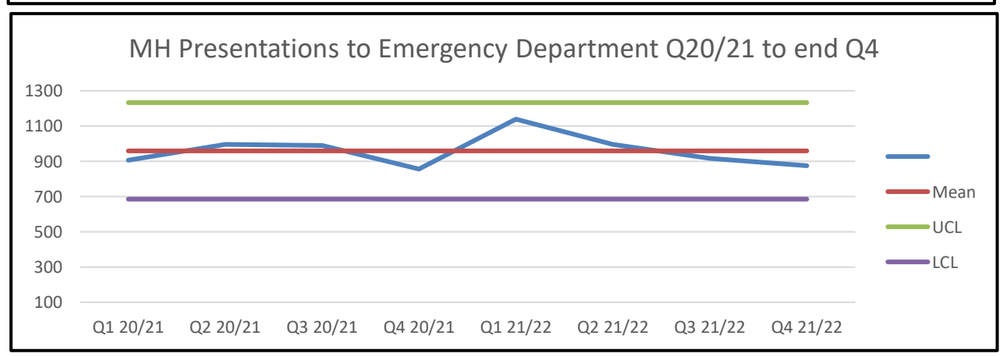
Cambridge University Hospitals NHS Foundation Trust

Mental Health









Narrative

- The numbers of inpatients detained under the Mental Health Act has increased slightly in Q1 22/23. Specifically there were 18 patients detained under Sec 5(2) (Doctors emergency holding power) over 11 in Q4 21/22 and 9 patients detained on Section 3 over 4 in Q4 21/22. It is too early to say if this represents an upward trend at this point . Figures for Q2 will be presented in the next report
- The numbers of patients brought to CUH on Sec 136 has stabilised over Q1. The mean number of patients detained on Sec 136 per quarter since Q1 2019/20 is 34.3. In Q1 22/23 there were 44 . This will be monitored
- The total number of mental health presentations in the period January to August 2022 (2530) is 16.9% lower than for the same period 2019 (pre-pandemic) , 1.3% lower than 2020 and 4.9% lower than the same period last year
- The number of individuals presenting to ED (273) at CUH with a mental health need in August 2022 shows an 18% decrease from July 2022 (337).
- The number of adults presenting in August (248) decreased by 18% compared to July 22. 14.5% of those attending were admitted to CUH.
- From Jan-Aug 2022 there has been a 20.5.% decrease in the number of Adults who presented at ED for mental health reasons who were admitted to CUH (276) in comparison to the same period a year ago (347).
- There was an 18.3% decrease in CAMH patients presenting in ED from July (34) to August (25). 40% of those who presented in August were subsequently admitted to CUH.
- For CAMH aged patients, the number of those admitted has reduced from 136 patients between Jan-Aug 2021 to 111 in same period 2022, an 18.3% decrease.
- Although the numbers of those eligible for CAMH services presenting at ED is very much smaller than for adults, the conversion rate to admission is significantly higher.

Ongoing work:

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

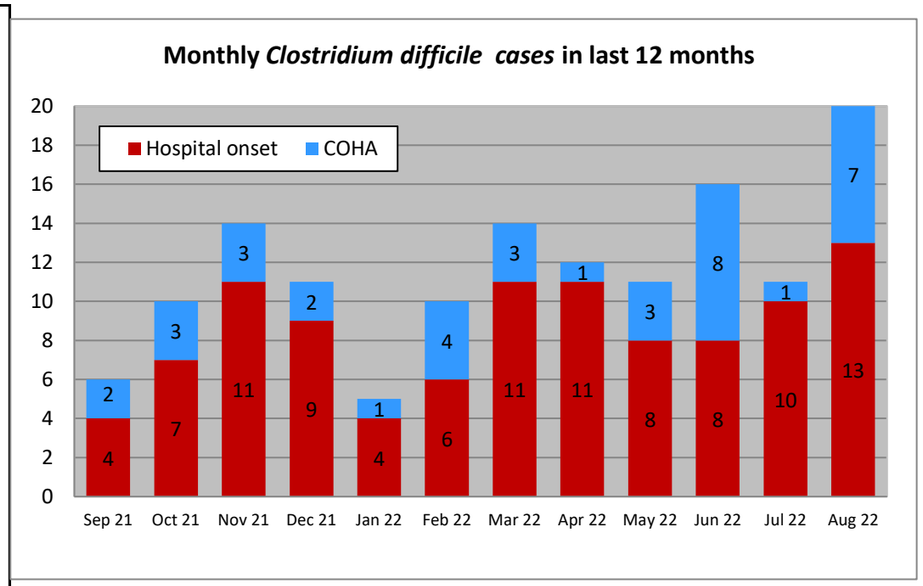
Author(s): Claire Ward

Owner(s): Lorraine Szeremeta

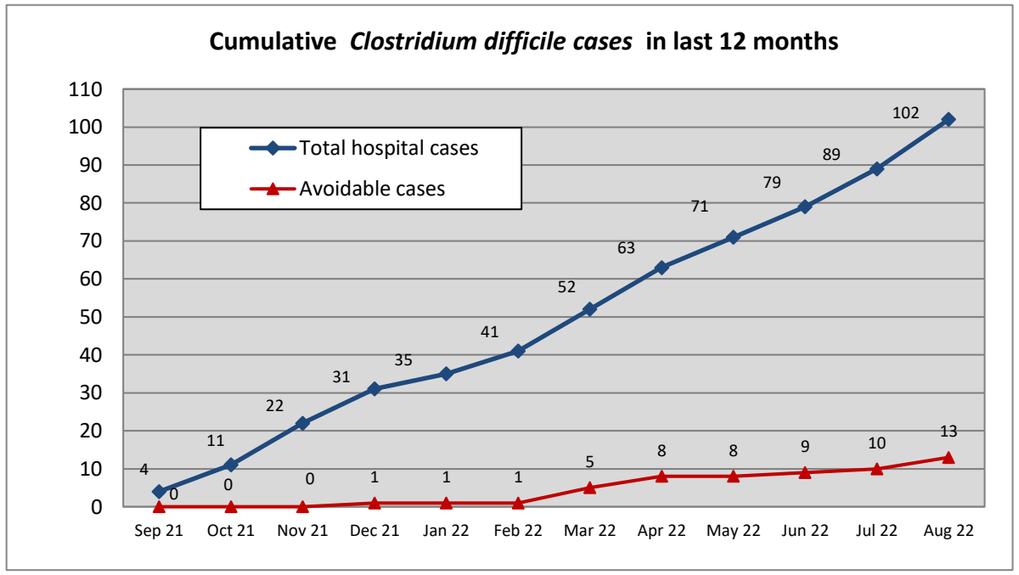
Together-Safe | Kind | Excellent

Infection Control

Cambridge University Hospitals NHS Foundation Trust



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



CUH trend analysis

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

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

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

- 13 cases of hospital onset *C difficile* and 7 cases of COHA in August 2022.
- 50 hospital onset cases and 20 COHA case year to date. 58 cases unavoidable, 8 avoidable and 4 pending.

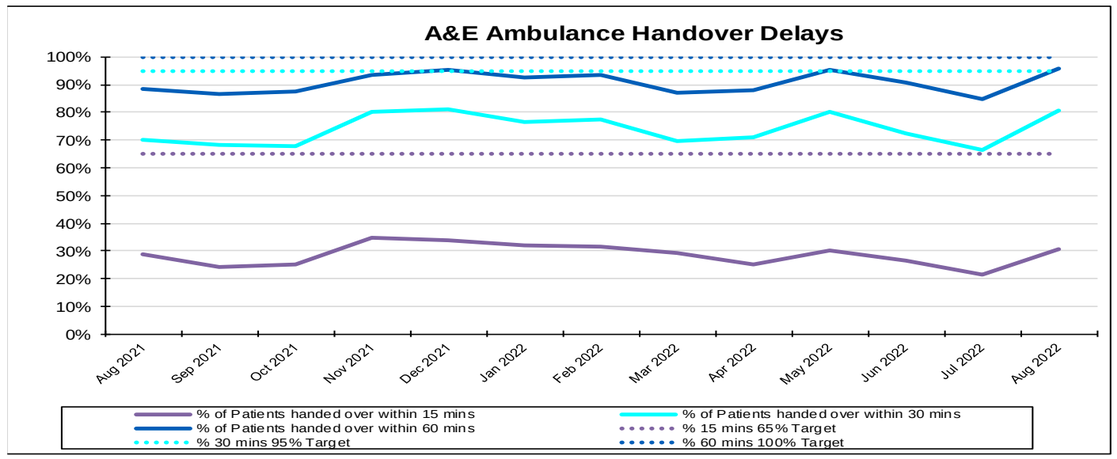
MRSA and C difficile key performance indicators

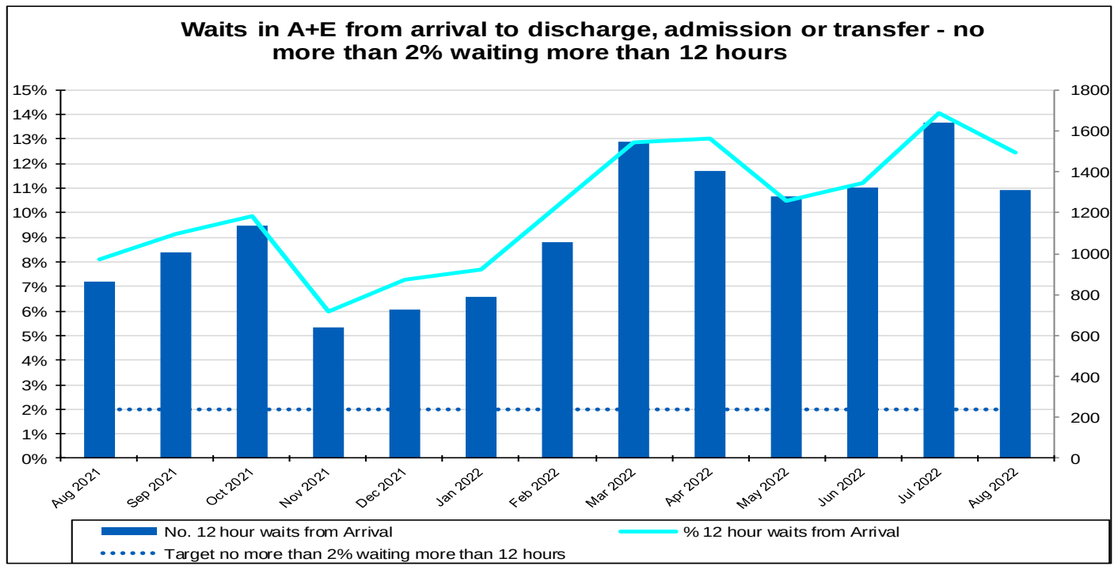
- Compliance with the MRSA care bundle (decolonisation) was 83.7% in August 2022 (78.1% in July 2022).
- The latest MRSA bacteraemia rate comparative data (12 months to July 2022) put the Trust 5th out of 10 in the Shelford Group of teaching hospitals.
- Compliance with the *C. difficile* care bundle was 86.7% in August 2022 (90.9% in July 2022).
- The latest *C. difficile* rate comparative data (12 months to July 2022) put the Trust 7th out of 10 in the Shelford Group of teaching hospitals.

Amb. Handovers & 12 Hr Waits From

Cambridge University Hospitals NHS Foundation Trust

Operational Performance





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

Demand:
- ED attendances in August were 10,562. This is 72 (0.7%) higher than August 2019. This is equivalent to an increase from 338 to 341 attendances per day
- Paediatric attendances showed the greatest proportional rise, increasing by 8.9% (+139) from August 2019
- 1,325 patients had an ED journey time in excess of 12 hours compared to 28 in August 2019. This represents 12.4% of all attendances and compares to regional levels of 9% and national levels of 8%.

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:
- 526 patients were streamed from ED to our medical assessment units on wards N2 and EAU4 and a further 398 patients to our Surgical Assessment Unit
- 3,401 patients were streamed to the Urgent Treatment Centre (UTC), of which 1,642 patients were seen by a GP or ECP.

Ambulance handovers: In August 2022 we saw 2,257 conveyances to CUH which was a decrease of 22.7%, (-661) compared to August 2019. Of these:
- 32% of handovers were clear within 15mins vs. 62% in August 2019
- 82% of handovers were clear within 30mins vs. 96% in August 2019
- 96% of handovers were clear within 60mins vs. 100% in August 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. Action plans have been developed by the Board's sub-groups to deliver improvements to the emergency pathway across both system partners and the Trust. This group reports progress to the Trust's Management Executive team on a monthly basis and link with the wider system through the South Alliance Resilience Group. These actions include developing the urgent community response prior to ED attendances, realising efficiency opportunities in the department, the expansion and utilisation of SDEC pathways, realising length of stay efficiencies and increasing simple discharges. External funding has been granted for the delivery of a frailty unit to support admissions avoidance of frail elderly patients and additional triage space in ED.

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

Fit Testing compliance for substantive staff

Cambridge University Hospitals NHS Foundation Trust

Fit Testing compliance for substantive staff

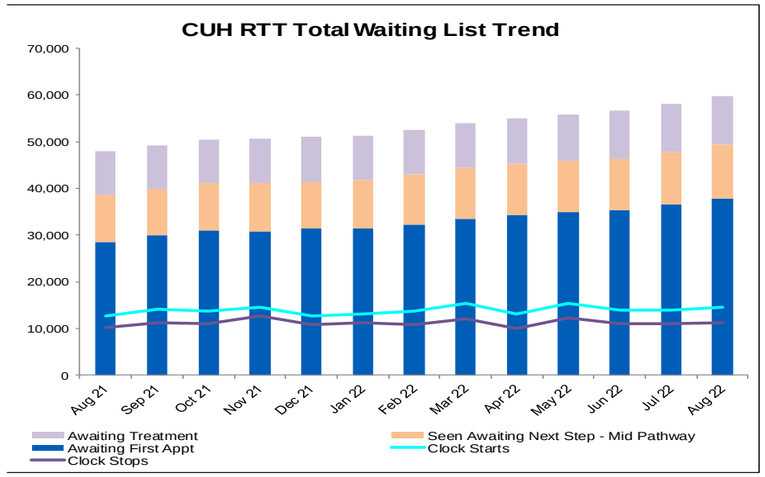
Division	Corporate			Division A			Division B			Division C			Division D			Division E			Total		
Staff Group	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total 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	No. 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%	176	114	65%	63	39	62%	99	70	71%	69	45	65%	60	33	55%	477	308	65%
Allied Health Professionals	-	-	-	51	20	39%	116	59	51%	1	0	0%	-	-	-	1	1	100%	169	80	47%
Estates and Ancillary (Porters and Securuty Personnel only)	52	52	100%	4	1	25%	1	0	0%	-	-	-	-	-	-	-	-	-	58	53	91%
Medical and Dental	-	-	-	105	55	52%	58	34	59%	128	94	73%	79	41	52%	94	66	70%	464	290	63%
Nursing and Midwifery Registered	-	-	-	506	328	65%	24	10	42%	215	152	71%	146	106	73%	266	189	71%	1157	785	68%
Total	**68**	**63**	**93%**	**842**	**518**	**62%**	**392**	**228**	**58%**	**444**	**317**	**71%**	**294**	**192**	**65%**	**421**	**289**	**69%**	2462	1607	65%

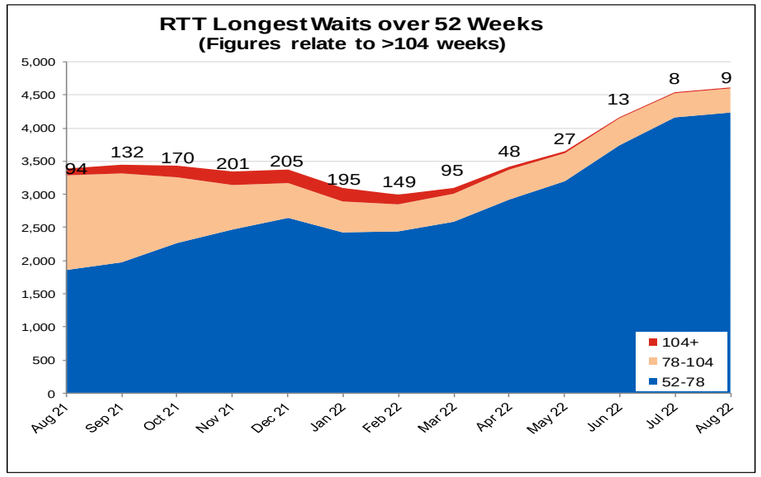
The data displayed is at 13/09/22. This data reflects the current escalation areas requiring staff to wear FFP3 protection. This data set does not include Medirest, student Nurses, AHP students or trainee doctors. Conversations on fit testing compliance with the leads for the external entities take place 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.

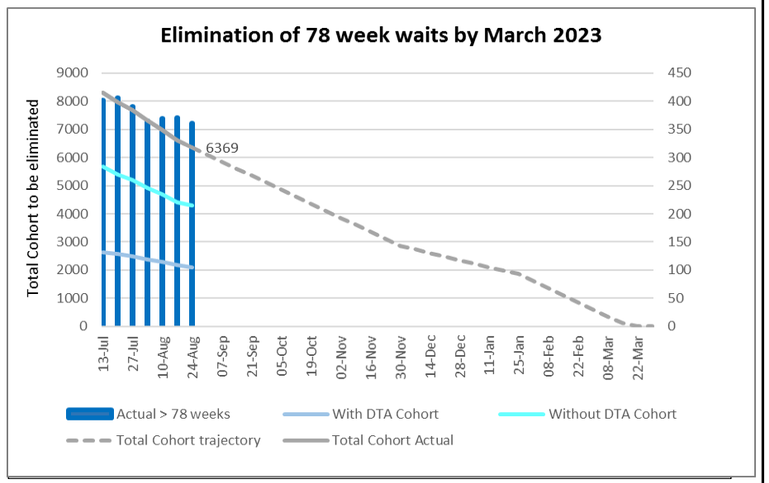
Referral To Treatment - (RTT)

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 1,545 in August to 59,748. Our Month 4 planning submission had forecast growth to 54,129 so we are now 10% higher than plan. Compared to pre-pandemic the waiting list has grown by 75%.

The number of patients joining the RTT waiting list (clock starts) were 1% lower than last month, but 12% higher than August 2019. We had forecast continued referral growth of 2.3% above 2019 baseline so 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 63% of the total. The highest demand was seen in Dermatology, and Gastroenterology and Colorectal which were 35% of the total growth.

The number of RTT treatments (stops) delivered in August were 1.5% lower than the prior month and represented 91% compared to August 2019. Non-admitted stops were 92.2% of baseline, but admitted stops were 87.1% of baseline. Total treatments were 11% below our submitted planning levels overall but the admitted treatments were above plan. Lower than planned outpatient attendances is the biggest driver of this variance in planned RTT clock stops. With the rise in demand, and lower treatments, the clearance time for the RTT waiting list (how long it would take to clear if no further patients were added) increased to 23 weeks.

The 92nd percentile total waiting time remained at 51 weeks.
The volume of patients waiting over 52 weeks continued to rise up to 4,610 and this is a concern across the Region. This slowed in August to a 2% growth compared to 9% last month. The last reported National figures show a 6% growth. In month this was driven by Ophthalmology (26%), Oral Surgery (18%), Cardiology (14%). 874 patients in total were treated who had waited over a year which was 7.8% of treatments. OMFS will be commencing Insourcing on the last weekend of September to support long wait reduction. Mutual aid opportunities within Rheumatology and Cardiology have made progress with some support from NWAFT and RPH agreed. The system ENT GIRFT review meeting agreed that a review of the community provision was the priority for the work system wide.

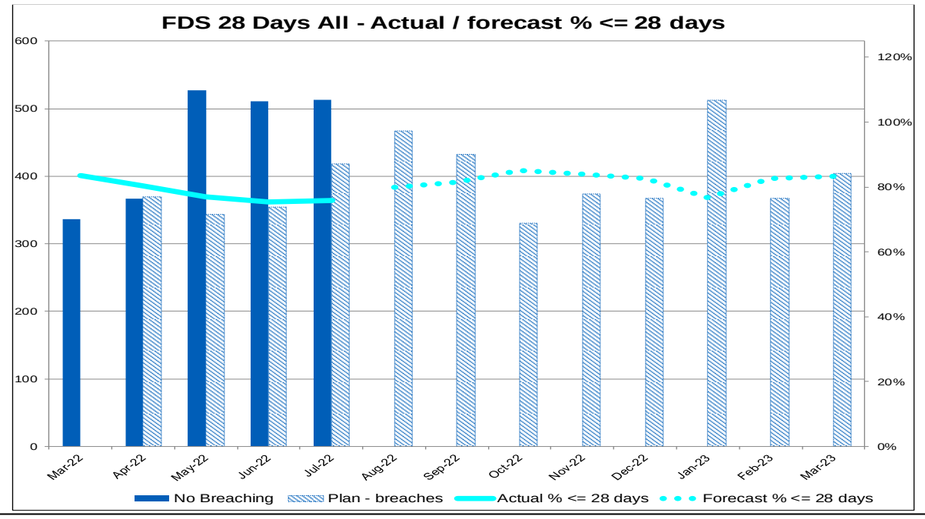
The volume of patients waiting over 78 weeks has plateaued at 373. Divisions are working with a step down plan to reduce maximum waits by 2 weeks per month through to year end. The current rate of reduction of the total cohort is 180 ahead of trajectory to deliver the requirement to eliminate 78 week waits by April 2023. We are also tracking twelve individual specialty trajectories for our Tier 2 recovery monitoring meeting. Waits over 104 weeks were nine at the end of August, and we currently forecast five at the end of September and zero for October. The outstanding cases are either patient choice or for complex/clinical reasons. None have been capacity breaches.

Nationally the RTT waiting list continues to rise, reaching 6.8 million in July 2022 with a 45.9 week 92nd percentile wait and 5.5% of patients waiting over 52 weeks. CUH has 7.8% over 52 weeks which is now 2nd highest of the 14 Acute Trusts in EoE. At 13.6% over 52 weeks, Norfolk and Norwich remains the greatest challenge in the Region for long waiting patients. We remain third highest amongst the Shelford

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
2Wk Wait (93%)	93%	93.0%	94.9%	81.8%	78.9%	83.3%	75.3%
2wk Wait SBR (93%)	93%	84.4%	92.4%	43.9%	35.5%	55.1%	66.7%
31 Day FDT (96%)	96%	92.9%	91.7%	91.0%	94.3%	91.0%	91.4%
31 Day Subs (Anti Cancer) (98%)	98%	98.8%	99.7%	100.0%	100.0%	100.0%	100.0%
31 Day Subs (Radiotherapy) (94%)	94%	94.9%	99.1%	98.3%	93.7%	85.1%	95.0%
31 Day Subs (Surgery) (94%)	94%	87.5%	85.1%	83.0%	89.0%	82.9%	68.8%
31 Day - Combined	**96%**				**94.2%**	**89.3%**	**91.7%**
FDS 2WW (75%)	75%	83.8%	81.1%	85.3%	81.3%	78.0%	77.1%
FDS Breast (75%)	75%	99.5%	97.6%	98.0%	94.6%	96.6%	97.7%
FDS Screen (75%)	75%	65.8%	72.9%	65.7%	64.5%	64.6%	57.8%
FDS - Combined	**75%**				**80.6%**	**77.4%**	**75.9%**
62 Day from Urgent Referral with reallocations (85%)	85%	**75.4%**	**75.1%**	**73.2%**	**73.0%**	**71.2%**	**71.7%**
62 Day from Screening Referral with reallocations (90%)	90%	**68.6%**	**55.0%**	**68.9%**	**61.4%**	**53.7%**	**57.1%**
62 Day from Consultant Upgrade with reallocations (50% - CCG)	50%	65.8%	60.0%	51.2%	74.2%	48.1%	50.0%
62 Day Reallocations - Combined	85%				**67.7%**	**70.7%**	**69.0%**



The latest nationally reported Cancer waiting times performance is for July 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.

2ww breaches increased to 516 in July leading to performance of 75.3%. 72% were capacity related with Skin breaches in particular increasing with the pressure of demand. Overall Skin accounted for 58% of breaches and Breast 26%. The breaches that were due to capacity reflected an average wait of 19 days for Skin and 17 days for Breast. The National performance was marginally higher in July for both 2ww and 2ww SBR at 77.8%% and 68.5% respectively.

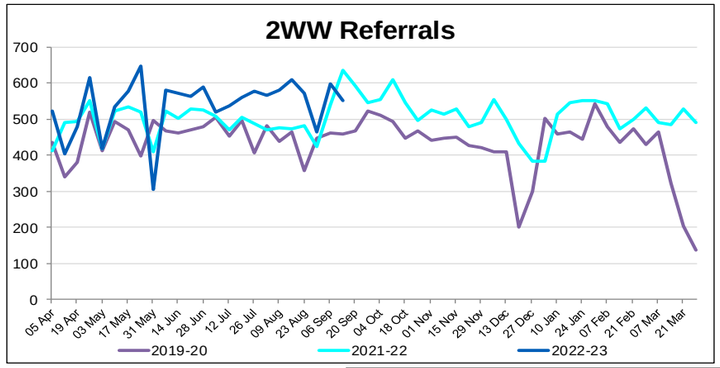
Our combined performance on the Faster Diagnosis standard within 28 days remains ahead of target at 75.9%. National average is 71.1% for FDS.
The 62 day Urgent standard performance improved in July to 71.7%. This remained ahead of performance Nationally of 61.6%. There were 61.5 accountable breaches of which 40 were CUH only pathways. 23 of these delays were provider initiated delays, within which 11 sighted histology turnaround delays and 4 surgical delays. 17 were due to late referrals of which 9 were treated within 24 days of transfer. Breaches spanned 12 cancer sites, with the highest volumes by site being Urology with 16, Lower GI 10 and Lung 7.5 . The 62 day screening standard incurred 14 breaches this month, between Breast and Lower GI. Performance was 57.1% compared to higher National performance at 70.2%. 29% were due to patient choice but there was no other dominant theme.

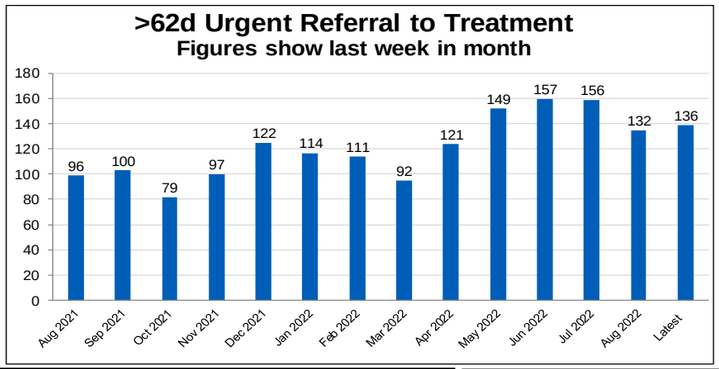
The 31 day FDT standard improved in July to 91.4%, but remained below National at 92.9%. The subsequent surgery standard however dropped further to 68.8% against National of 82.1%. Elective capacity accounted for 85% of those exceeding 31 days, the highest being Urology and Lower GI with 6 each breaches due to surgical capacity respectively. The subsequent radiotherapy performance was recovered this month to 95%.

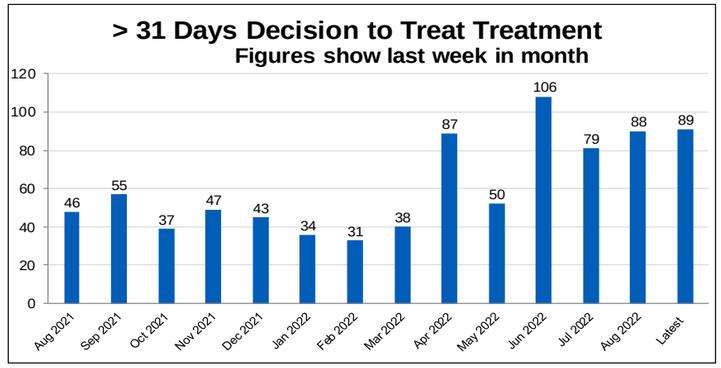
28 pathways waited >104 days for treatment in July. 20 were shared pathways referred between day 48 and 202, with the highest volume from a single Trust being QEH Kings Lynn with five, but Bedford, NWAFT and WSH all had four. Eight CUH pathways exceeded 104 days across Gynaeoncology, Urology, Skin and Lower GI. Histology delays coupled with patient initiated delays were the reasons. The RCAs have been reviewed by the MDT Lead Clinicians and the Cancer Lead Clinician for the Trust. Harm has been classified as 'no harm' or 'low harm' on all pathways.

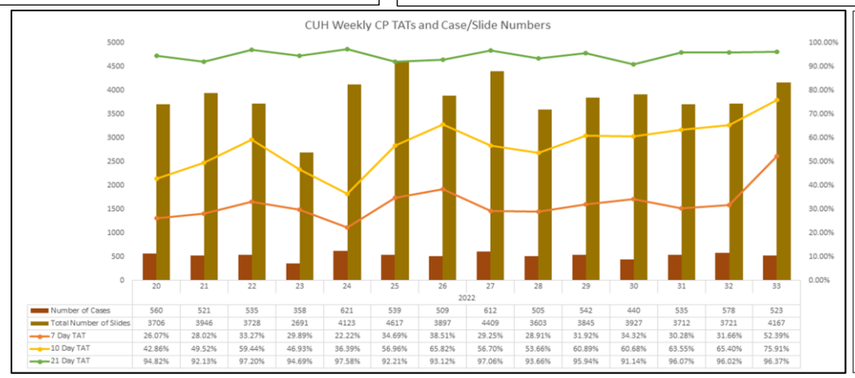
Cancer

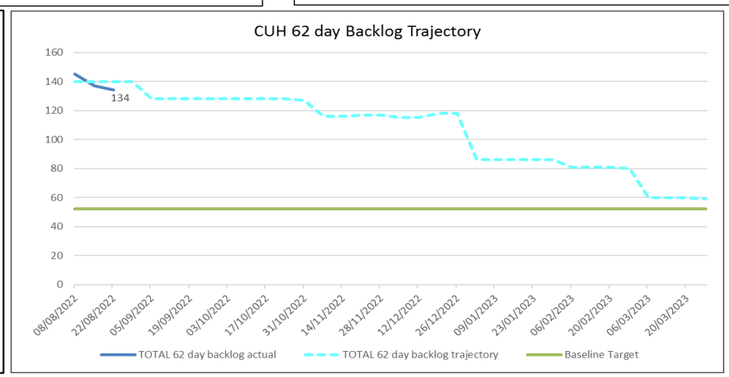
National Targets











Current position

Over the past four weeks 2WW suspected cancer referral demand has reached 129% compared to the same baseline period in 2019. Lower GI and Skin are both seeing a >50% increase in 2ww referrals. Lower GI continue to predominantly offer capacity within 2 weeks through delaying other lower priority groups. Breast and Skin (Plastics) are both booking beyond 14 days and 2ww breaches will exceed 500 in July and August and be over 600 in September. Plastics surgery are introducing some locum medical support to cover gaps in workforce in October, and Breast continue to implement their increased substantive resourcing.

We reported last month that trajectories for the recovery of 62 day backlog were required to be completed by the end of August 2022. This followed recognition Nationally that 10.3% of cancer patients waiting were over 62 days, and that in the EoE this was 12.2%. A requirement to be no more than 6.4% waiting past day 62 by March 2023 was outlined by NHS England. In our most recent week CUh is achieving 6.3% , and have 136 patients waiting over 62 days. this is eight higher than our trajectory. The highest variance is in Urology where we are eleven over trajectory. It should however be noted that we have been seeing an improvement in histology , getting back up to ~50% turnaround within 7 days rather than 30% which had been the trend. 53% of the breaches are CUH only pathways, of which Skin are 30%, Urology 19% and Lower GI 18%.

The number of patients waiting over 31 days for treatment has remained flat at 89. Skin account for 27% of the delays, 96% of these are still suspected. A further 25% of the delays are associated with Radiotherapy and Brachytherapy, impacting on Breast and Prostate pathways. HPB and Kidney are seeing delays to surgery as a reason for exceeding 31 days. 65% of those awaiting treatment have their treatment date scheduled.

Author(s): Linda Clarke

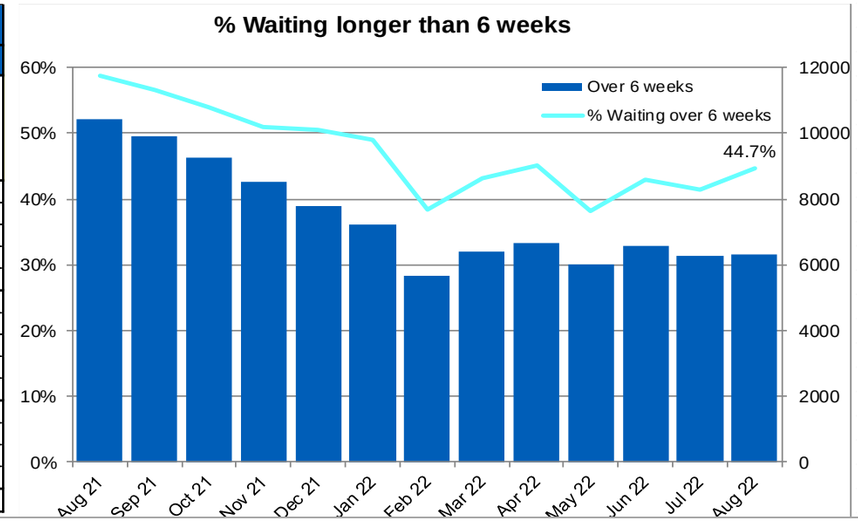
Owner(s): Nicola Ayton

Diagnostics

Cambridge University Hospitals NHS Foundation Trust

Operational Performance

Change from previous month:		Aug-22								
		Waiting List					Scheduled Activity		Total Activity	
Deteriorated / Improved		Total Waiting List	Variance from Feb 2020		%> 6 weeks	Mean wait in weeks	Scheduled Activity	Variance from Aug-19 Baseline	Total Activity	Variance from Aug-19 Baseline
Imaging	Magnetic Resonance Imaging	2950	1962	50%	54.4%	9	2670	114.3%	3106	114.5%
	Computed Tomography	2155	1038	108%	52.3%	11	2849	113.4%	5955	113.8%
	Non-obstetric ultrasound	3871	1876	106%	49.8%	7	3531	114.0%	4205	106.9%
	Barium Enema	56	31	81%	16.1%	4	34	101.2%	39	116.1%
	DEXA Scan	639	648	-1%	12.5%	4	661	133.1%	661	131.7%
Physiological Measurement	Audiology	719	338	113%	52.2%	8	390	79.7%	390	79.7%
	Echocardiography	1743	967	80%	54.7%	11	1177	85.8%	1592	90.7%
	Neurophysiology	171	269	-36%	5.3%	3	221	88.8%	232	90.2%
	Respiratory physiology	54	24	125%	64.8%	12	29	131.5%	29	125.5%
	Urodynamics	199	93	114%	64.3%	9	64	84.7%	65	86.0%
Endoscopy	Colonoscopy	635	539	18%	0.0%	2	477	116.2%	497	117.2%
	Flexi sigmoidoscopy	130	106	23%	0.0%	2	87	109.0%	103	86.0%
	Cystoscopy	175	236	-26%	18.9%	5	380	90.0%	396	87.9%
	Gastroscopy	589	581	1%	2.7%	3	568	90.9%	648	90.9%
Total Diagnostic Waiting List		**14086**	**8708**	**62%**	**44.7%**	**8**	**13138**	**107.5%**	**17918**	**107.2%**



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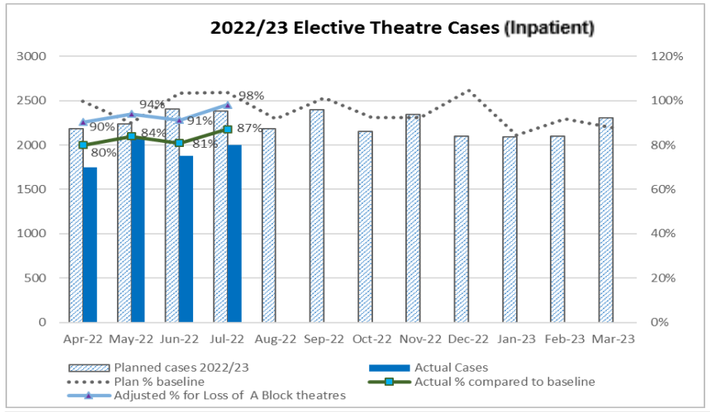
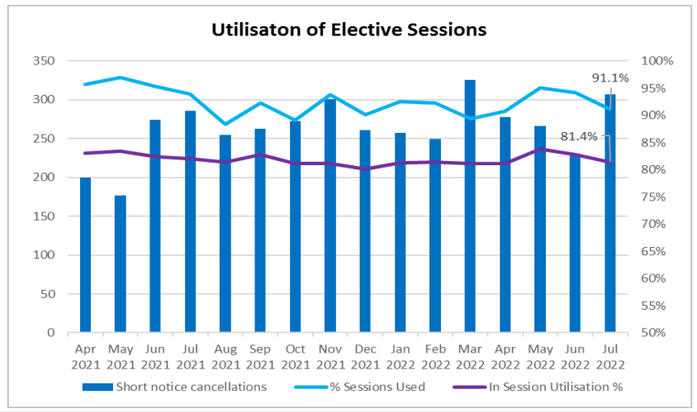
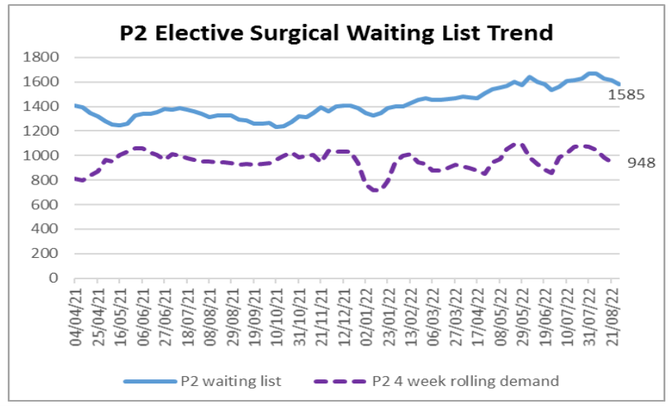
Operations

Cambridge University Hospitals NHS Foundation Trust

Operational Performance







Elective theatre activity in August comparative to 2019 baseline was the best month year to date, achieving 90%. Taking account of the loss of the A Block theatres from our capacity, this would bring the performance above baseline at 101%.

- Our plan for August 2022 was to deliver 92% of baseline so we fell short by 50 operations.
- Productivity improved in August, achieving 92 % of sessions used against our aim of 95%, with in-session utilisation improving to 85.9% against our aim of 90%.
- The National GIRFT Programme is having a significant focus on Theatre Utilisation and they measure Capped Utilisation which excludes turnaround time and any overrun. The expectation is to deliver 85%, and our performance against this measure was 78% in August which is on an improving trend and the highest achieved in the past 18 months.
- Short notice cancellations in elective sessions reduced in August. At 222 cases , they equated to 383 hours of theatre time and were the lowest since April 2021. This will have aided the improved productivity.
- Ely continued to see in-session utilisation improving to 84.8%, but still looks very low on the Capped Utilisation measure at 65%. GIRFT are considering additional theatre metrics, one of which may take account of staff breaks required within sessions. CUH sessions are mostly all day lists, and in a remote small facility such as Ely there are less resources on site to backfill breaks to ensure continuity. Trusts that run many half day sessions would not have the impact of this in their reporting. Sessions used dropped to below 70% at Ely in August as teams prioritised cover for the main site with the impact of leave. It was higher than August 2021
- The Cambridge Eye Unit dropped to 87.5% sessions used due to surgeon leave. In-session utilisation also dropped to 77.4% and Capped utilisation is 66%. The HVLC cataract lists are aiming to step up to 9 with three consultants supporting this next stage of improvement.
- The weekend elective activity in August was slightly higher at 30 elective cases mostly in Ophthalmology and ENT.

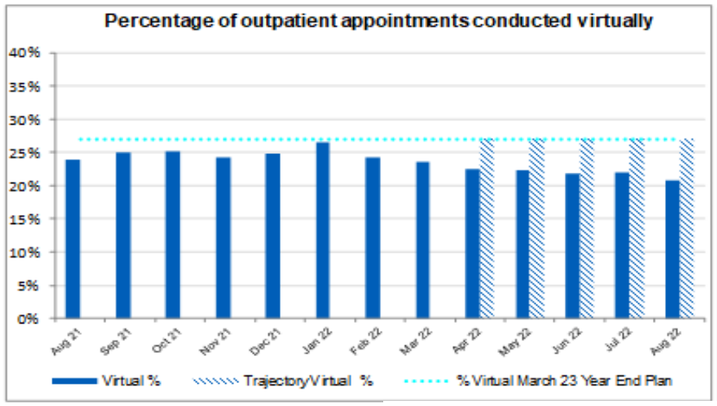
The number of P2 patients (inpatients) awaiting surgery has reduced from last month to 1,556, but this will have been supported by a drop in the rolling four weekly demand through August. The volume waiting over 4 weeks has reduced by 11 over the past month to 890.
The Surgery Programme Board meets fortnightly with clinical engagement from across the HVLC specialties and monitor improvements against the GIRFT recommendations.
We have had a National GIRFT gateway review meeting in ENT across the ICS in September. The agreed focus for ENT across the ICS was to review the community ENT service provision.

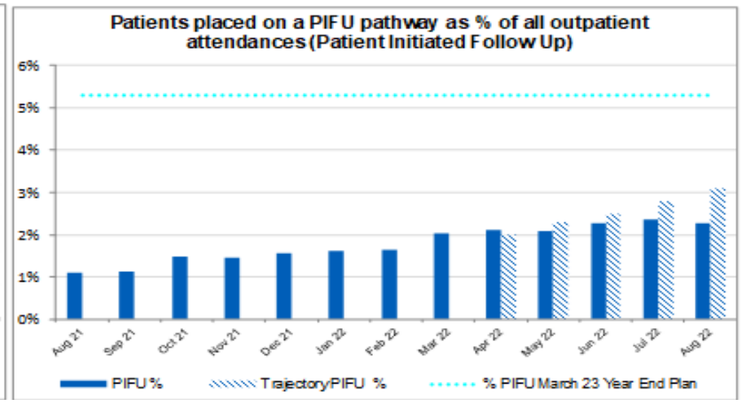
- A further GIRFT review meeting with the National Lead Professor Tim Briggs is being scheduled for December. He will be keen to see progress with "moving the dial" on the key GIRFT metrics in the HVLC specialties. These are a focus of our Surgery Programme Board.
- Orthopaedics will be of particular interest for this meeting given the supported capital investment in the Orthopaedic Elective Theatres. Professor Andrew McCaskie is providing leadership to the Orthopaedics GIRFT improvements. Development over the last 8 weeks include:-
    - Specific HVLC leads in place for subspecialties of hip and knee, and Clinical Director for Anaesthesia leading the anaesthetic process review.
    - Four primary joints on a list now established for a minimum of 1 list per week. Eight surgeons supporting. Initial observations suggest an associated decrease in LOS.
    - Day case uni-knee being developed across ICS
    - Visit to Northumbria complete with visits to South West planned for October. Enthusiasm form CUH stakeholders. Evidence of what can be achieved with limited bed numbers.

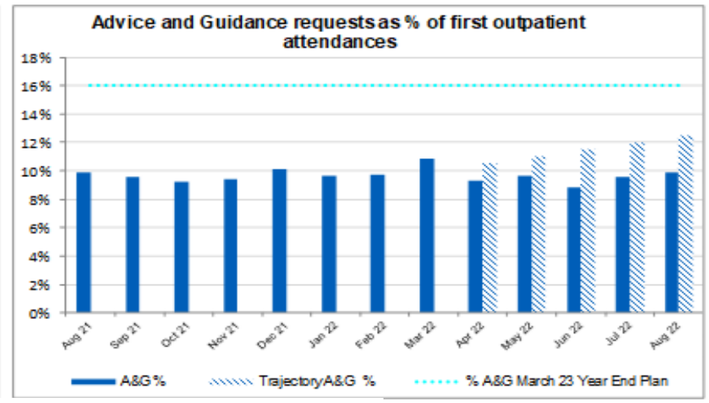
Outpatients

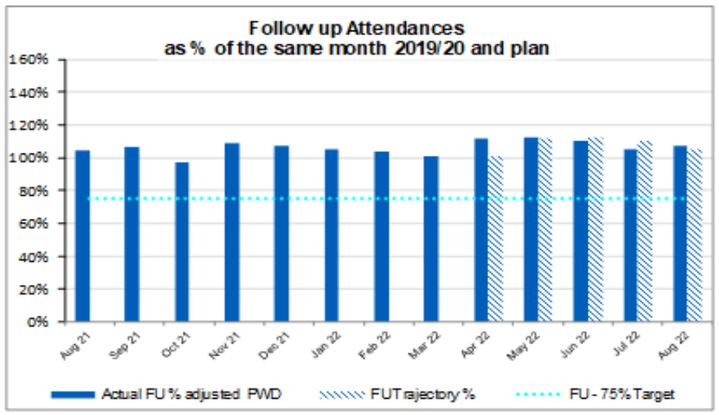
Cambridge University Hospitals NHS Foundation Trust

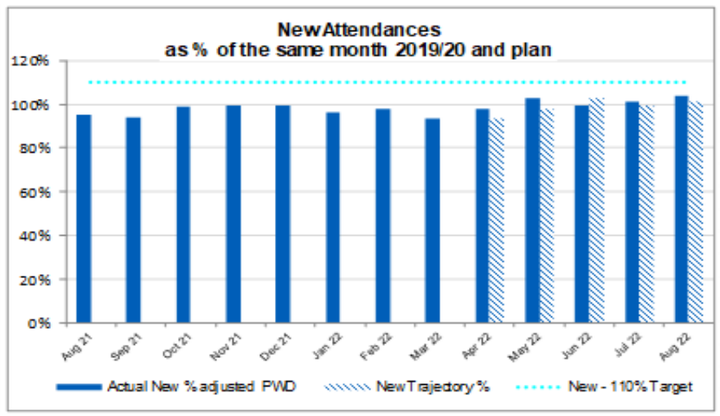
Operational Performance











In August outpatients delivered 108% new activity against baseline, 103% adjusted for working days per month. This is a good achievement, especially considering August is often disrupted due to holiday season. However, follow-up numbers continue to perform above baseline and trajectory at 112% and 107% adjusted. Target is to achieve 110% against baseline for new appointments and a reduction of 75% against baseline for follow-ups.

PIFU numbers have somewhat flatlined over recent months at 2.3%. 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 and 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.

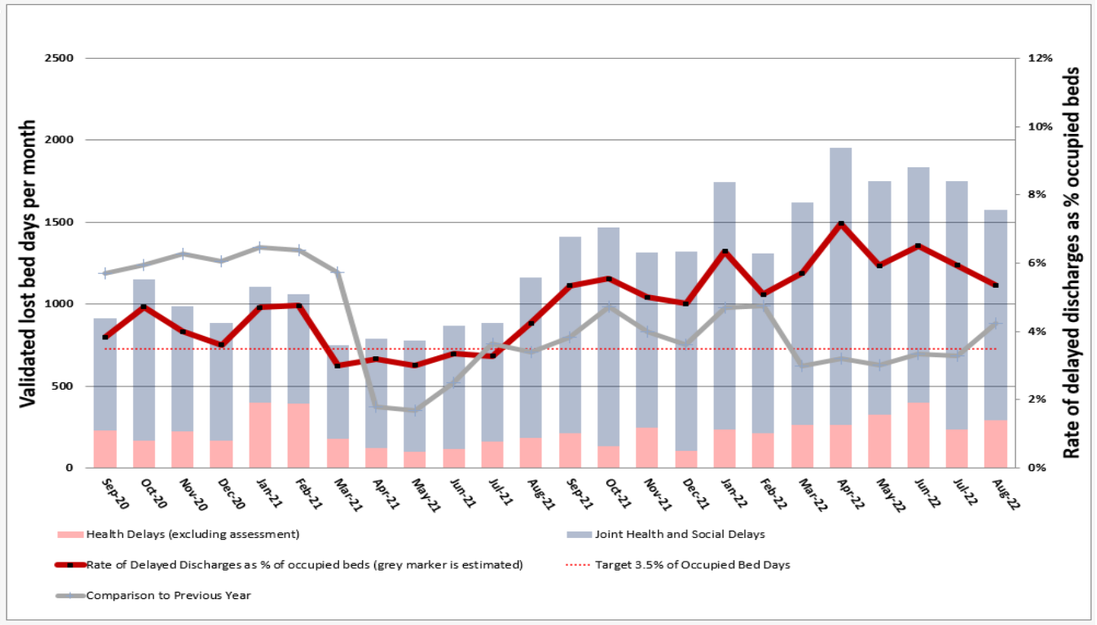
Author(s): Andi Thornton

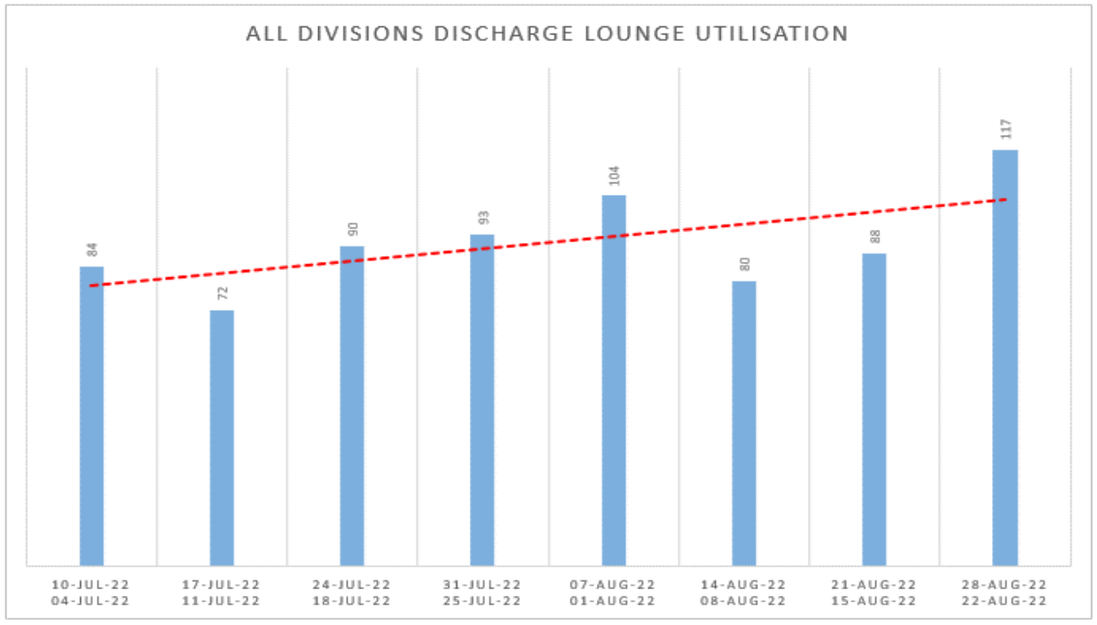
Owner(s): Nicola Ayton

Delayed Discharges

Cambridge University Hospitals NHS Foundation Trust

Operational Performance





The Hospital Discharge Service Requirements guidance was updated on March 31st 2022. For this August 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).

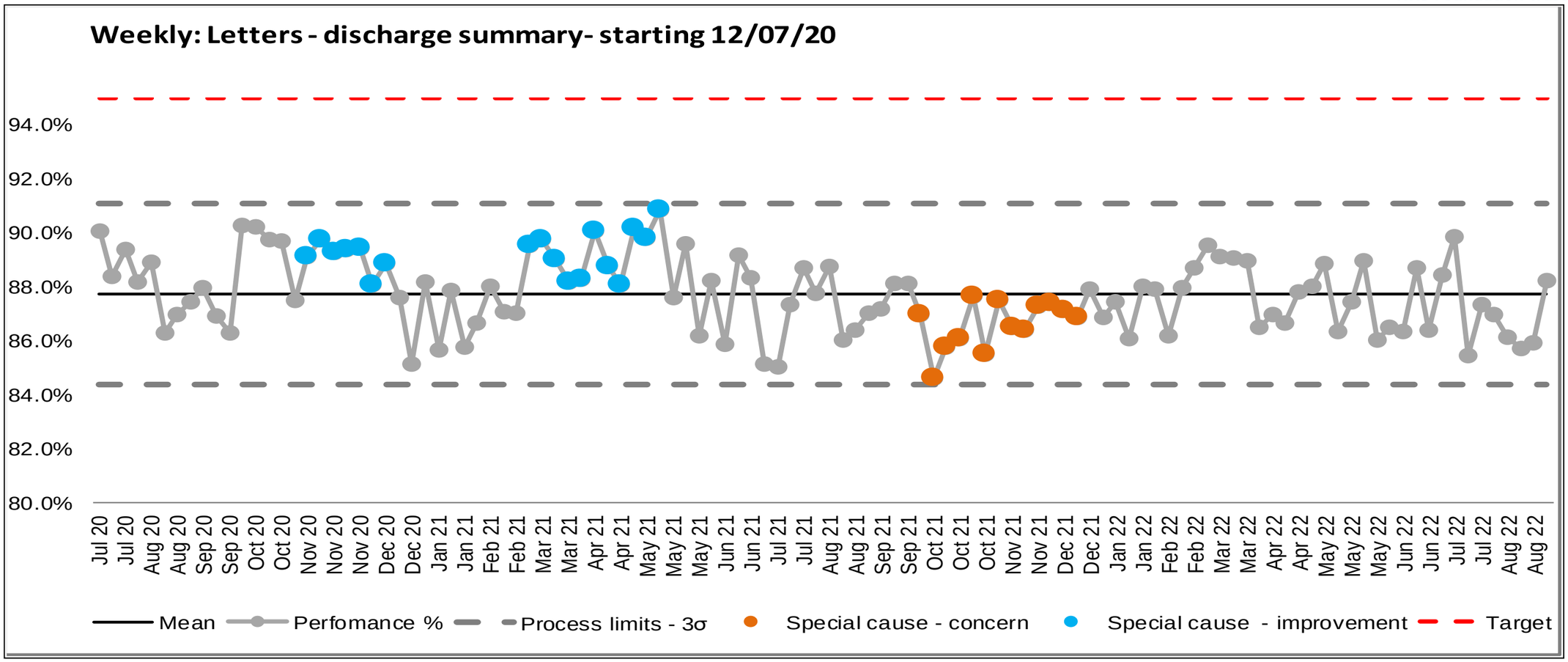
For August 2022, we are reporting 5.4%, which is a decrease of 0.5% from the previous reporting month approximately 178 lost bed days.
Within the 5.4%, 61% were attributable to Cambridgeshire and Peterborough ICB, and the remainder across a further 7 ICB's. *Please note that we have referred to delays per CCG instead of Local Authority.*
In relation to lost bed days for Cambridgeshire and Peterborough overall for August (958) this has been a small decrease from July (-158) and around 25% decrease over the last two months.
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 615. There has not been any significant changes over the last couple of months
For the total delays (local and 'out of area') within August for Care Homes were 41% equating to 652 lost bed days for this counting period (a 17% decrease from July); domiciliary care (inclusive of Pathway 1 and Pathway 3) at 32% of the total lost bed days for the month, at 504, approx. 10% decrease from July.
For community bedded intermediate care (inclusive of waits for national specialist rehabilitation units), the overall lost bed days is currently at 288, a slight increase since April (233 lost bed days reported).
The national hospital discharge funding ceased in March 2022 and there has been a noticeable increase in delays for patients awaiting care provision post discharge, 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.

Author(s): Emily Hall
Owner(s): Nicola Ayton

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 - Aug 22	Month	-	96.1%	95.8%		-	-	For August, there was a 2% improvement in the Good score from 94% in July to 96%. This is now close to May of 96.6%, the strongest Good score for the year. The Poor score decreased by 2%, from 2.7% in July to 0.8%. This is the best Poor score so far this year. The number of responses in August improved slightly compared to July but remains well below FFT responses of 850-950 pre pandemic. **FOR AUG: there were 486 FFT responses collected from approx. 4,323 patients.**
FFT Inpatient poor experience score	Jul 20 - Aug 22	Month	-	0.8%	1.5%		-	-	
FFT Outpatients good experience score	Apr 20 - Aug 22	Month	-	94.0%	95.3%	L	SP	-	For August, the Good score improved by 1% from 93% in Jul. The Poor score remained about the same . Very few comment cards are being collected in paediatric clinics so this data is mainly adult. **FOR AUG: there were 2,773 FFT responses collected from approx. 18,593 patients. See comment below regarding # of SMS.**
FFT Outpatients poor experience score	Apr 20 - Aug 22	Month	-	2.6%	2.2%		-	-	
FFT Day Case good experience score	Apr 20 - Aug 22	Month	-	95.5%	96.8%	L	S7	-	For August, there was very little change with both the Good score and Poor score. The Good score improved by 0.5% from 95% in July and the Poor score remained the same compared to July. **FOR AUG: there were 590 FFT responses collected from approx. 2,694 patients. See comment below regarding # of SMS.**
FFT Day Case poor experience score	Apr 20 - Aug 22	Month	-	2.1%	1.6%		-	-	
FFT Emergency Department good experience score	Apr 20 - Aug 22	Month	-	79.2%	85.5%	L	S7	-	For August the Good score finally improved and the 9% increase means August is about equal to April score of 79.6%. The Poor score also improved by 4.5% and is about 2% better than April score of 14.2%. The improved scores are from both Adult & Paeds. Paeds FFT; 12.5% increase in Good score/ 86.6% and 7% decrease in Poor score/ 6%. Adult FFT; 10% increase in Good/ 75% and 5% decrease in Poor score/ 16.2%. **FOR AUG: there were 606 FFT responses collected from approx. 3,145 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 - Aug 22	Month	-	12.5%	8.9%	H	S7	-	
FFT Maternity (all FFT data from 4 touchpoints) good experience score	Jul 20 - Aug 22	Month	-	91.1%	95.3%		-	-	**FOR AUG:** Antenatal had 8 FFT responses; 100% Good score. Birth had 53 FFT responses out of 451 patients; 94.3% Good score / 1.9% Poor score, both a small negative change from July. Postnatal had 129 FFT responses, the majority from LM (87 FFT with 88.5% Good /3.4% Poor), Birth Unit with 23 FFT with 87% Good, DU 6 FFT with 83.3% Good, and COU 100% Good from 13 responses. 0 Post Community. **AUG** overall Good score decreased by 4% compared to July, and is a 7% decrease from June. The Poor score increased by 1% compared to July.
FFT Maternity (all FFT data from 4 touchpoints) poor experience score	Jul 20 - Aug 22	Month	-	2.1%	1.7%		-	-	

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

Overall FFT in August, the Good scores improved, except for Maternity. Both ED adult and paediatric FFT Good scores had significant improvement of 10-12%. Some Poor scores decreased in August with Impatient score a 2% improvement and ED a 4.5% improvement. Maternity scores declined for both Birth scores and Postnatal scores, compared to July.

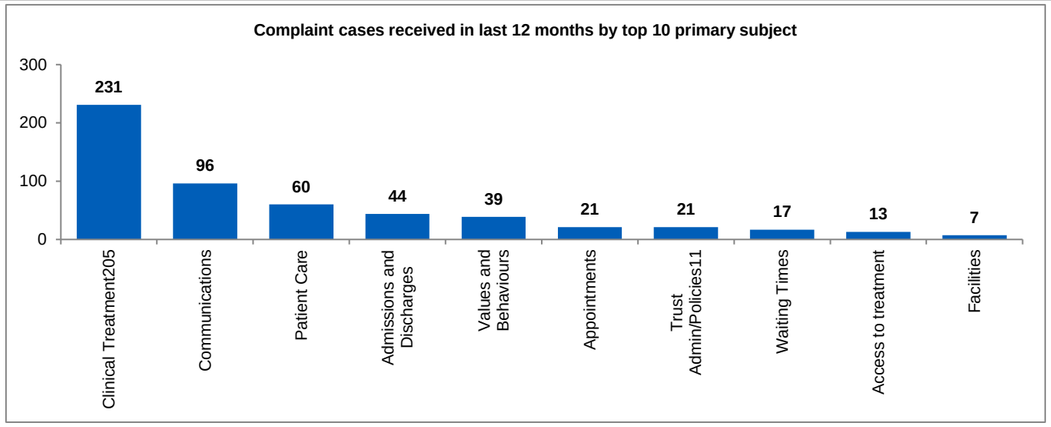
Please note starting 1 June, the Trust has reduced the number of SMS being sent to adult patients. Instead of sending a text message to every adult patient that attend an OP/DU appointment, or presented to A&E, the Trust now sends a fixed number of SMS daily,.

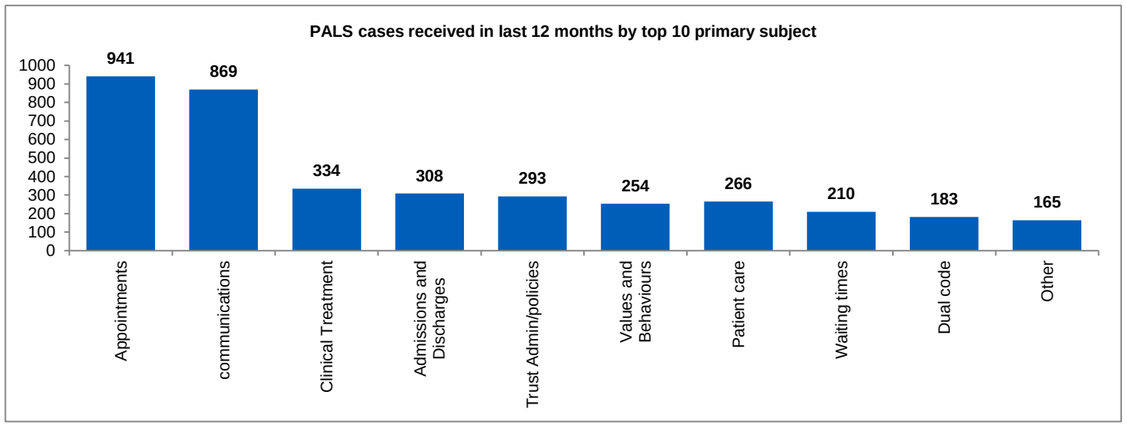
PALS and Complaints Cases

Cambridge University Hospitals NHS Foundation Trust

Safety and Quality

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
Complaints received	Aug 19 -Aug 22	month	-	73	50		-	-	The number of complaints received between Aug 2019 - Aug 2022 is higher than normal variance.
% acknowledged within 3 days	Aug 19 - Aug 22	month	95%	93%	94%		-		68 out of 73 complaints received in August were acknowledged within 3 working days.
% responded to within initial set timeframe (30, 45 or 60 working days)	Aug 19 - Aug 22	month	50%	12%	32%		-		43 Complaints were responded to in August, 5 of the 43 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	Aug 19 - Aug 22	month	80%	58%	92%		SP		25 out of 43 complaints responded to in August were within the initial set time frame or within an agreed extension date.
% complaints received graded 4 to 5	Aug 19 - Aug 22	month	-	24%	35%		-	-	There were 16 complaints graded 4 severity, and 1 graded 5. These cover a number of specialties and will be subject to detailed investigations.
Compliments received	Aug 19 - Aug 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 August 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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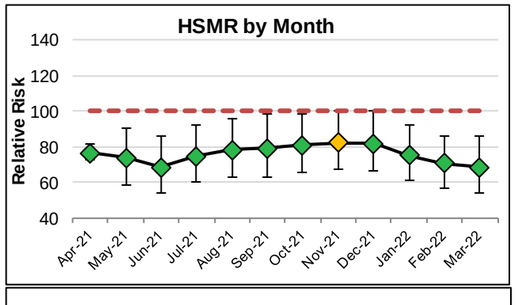
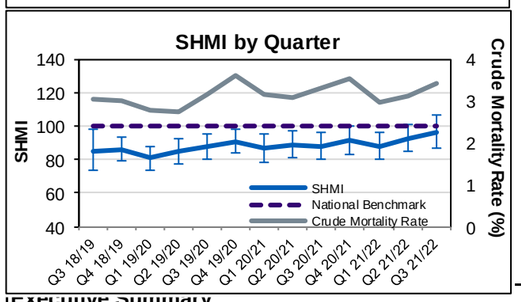
Learning from Deaths

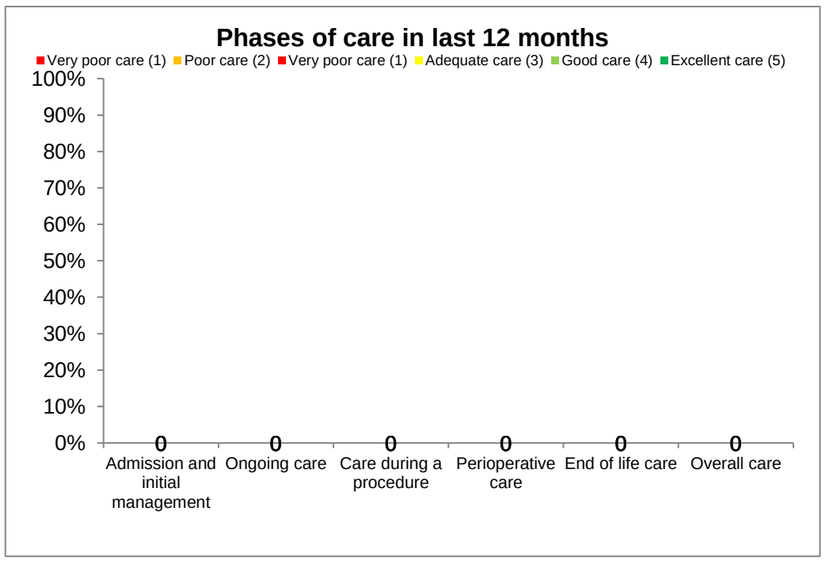
Cambridge University Hospitals NHS Foundation Trust

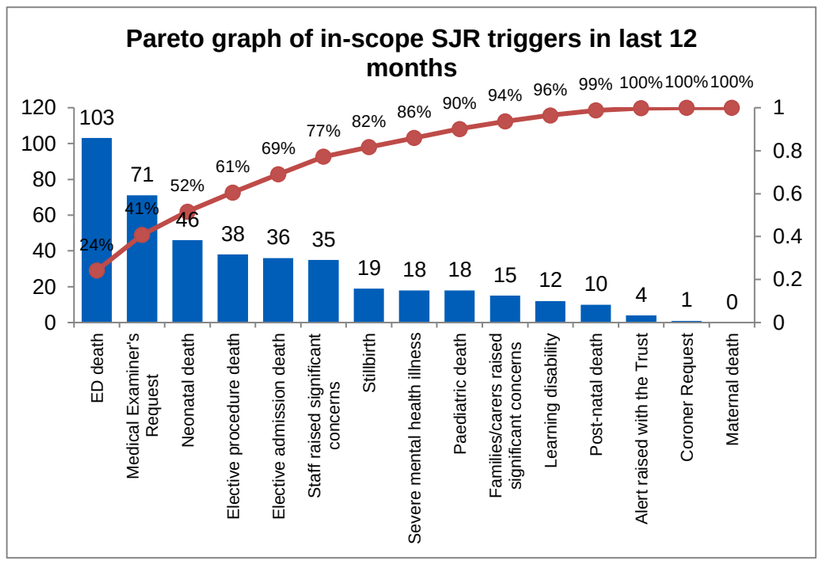
Mortality

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
Emergency Department and Inpatient deaths per 1000 admissions	Apr 18 - Aug 22	month	-	8.63	8.35		-	-	There were 147 deaths in August 2022 (Emergency Department (ED) and inpatients), of which 12 were in the ED and 135 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 - Aug 22	month	-	22%	19%		-	-	In August 2022, 27 SJRs were commissioned and 2 PMRTs were commissioned
Unexpected / potentially avoidable death Serious Incidents commissioned with the CCG	Feb 18 - Aug 22	month	-	0	0.73		-	-	There were no unexpected/potentially avoidable death serious incident investigations commissioned in August 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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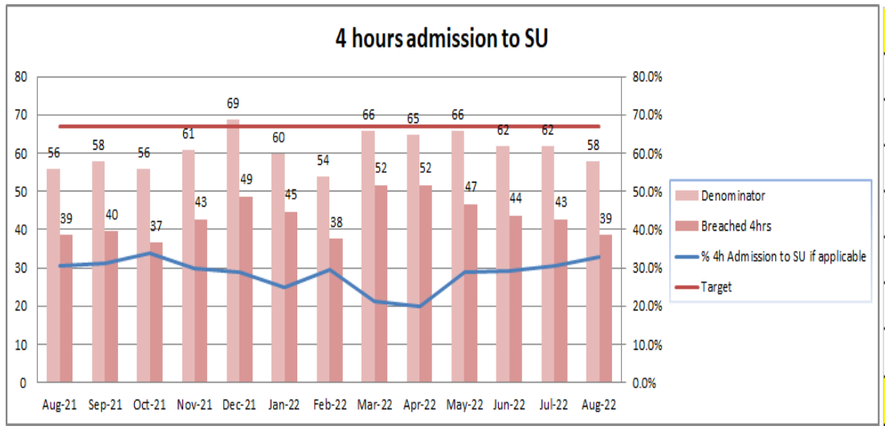
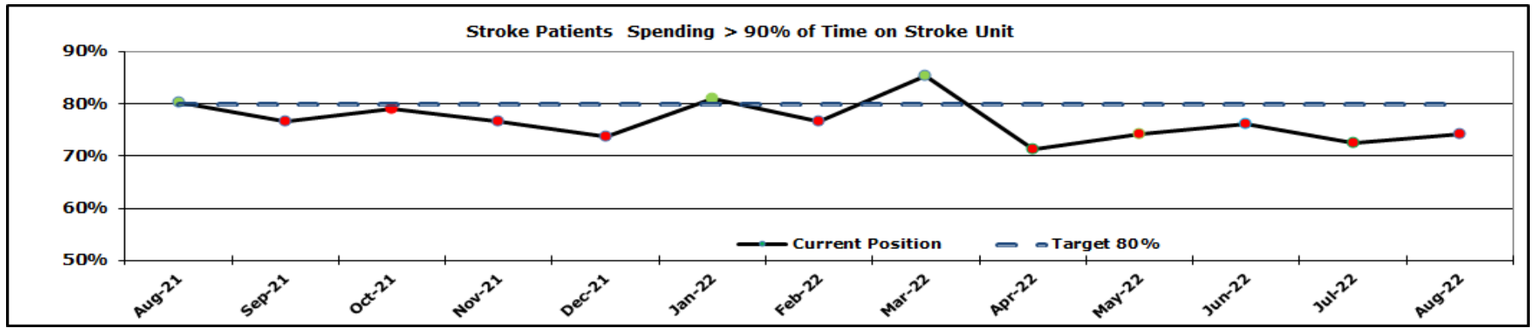
Stroke Care

Cambridge University Hospitals NHS Foundation Trust

Stroke Measures



Themes	Count of MRN
Awaiting senior review	4
delayed diagnosis - MRI confirmed stroke	1
Late referral to Stroke Team	3
Not referred on arrival	2
Trust Bed Capacity	24
Unclear presentation	1
Stroke Bed Capacity	4
Grand Total	39



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

Month	Stroke Bed Capacity * No outliers *	Trust Bed Capacity * Outliers *	Suspected COVID-19 patient	Covid 19 - Stroke ward closed	Delayed transfer of care (DTOC)	Operational decision - pt moved off the unit to accommodate an acute stroke	Delay in medical review in ED	Clinical - Appropriate pathway for patient	Difficult presentation	Not referred to Stroke Team	Delayed diagnosis	Clinician's decision to place pt on different ward	Unclear presentation	Difficult diagnosis/Complex patient	Failure to request stroke bed	Resource capacity	Number of breaches	Month Position (Target 80%)
Aug-21		4					2	2		1			2				11	80.4%
Sep-21		5						4		1			3	1		1	15	76.6%
Oct-21		5					1	3		1	2					1	13	79.0%
Nov-21		5	1					1		1	2		3	1		1	15	76.6%
Dec-21		11						4		2			1			2	20	73.7%
Jan-22		2						1		3	1		1			4	12	81.0%
Feb-22		7	1				1	1		1			2	1			14	76.7%
Mar-22		6	1				1						2				10	85.3%
Apr-22		8					2	3					4			2	19	71.2%
May-22	3	1					4			1			5	3		1	18	73.1%
Jun-22	3	1					1	2					7	1		1	16	76.1%
Jul-22	6	5						2		1			1	1		3	19	72.5%
Aug-22	2	11						2					1			1	17	74.2%
Summary	14	71	3	0	0	0	12	25	0	12	5	0	32	8	0	17	199	

90% target (80% Patients spending 90% IP stay on Stroke ward) was not achieved for August = **74.2%**

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

4hrs adm to SU (67%) target compliance was not achieved in August = **32.8%**

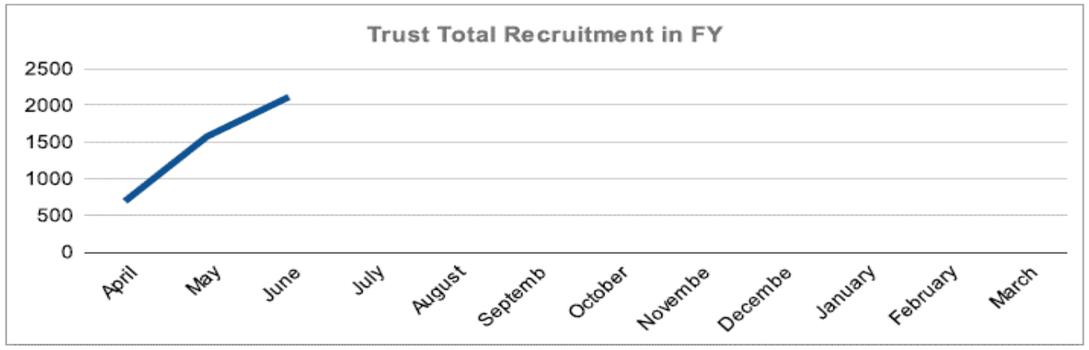
Key Actions

- 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

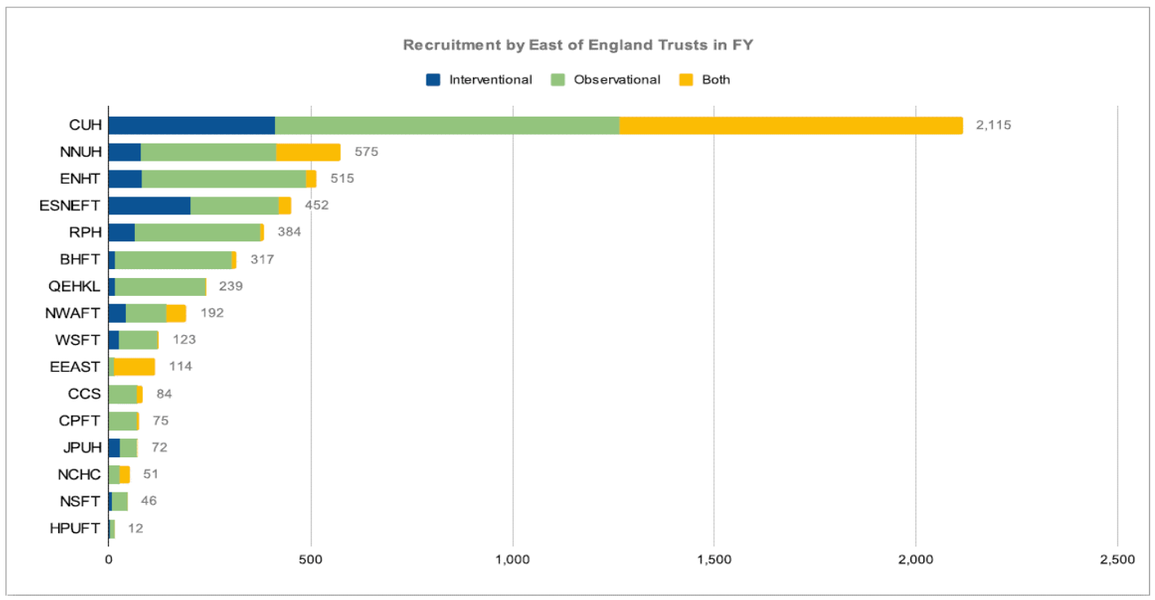
Cambridge University Hospitals NHS Foundation Trust

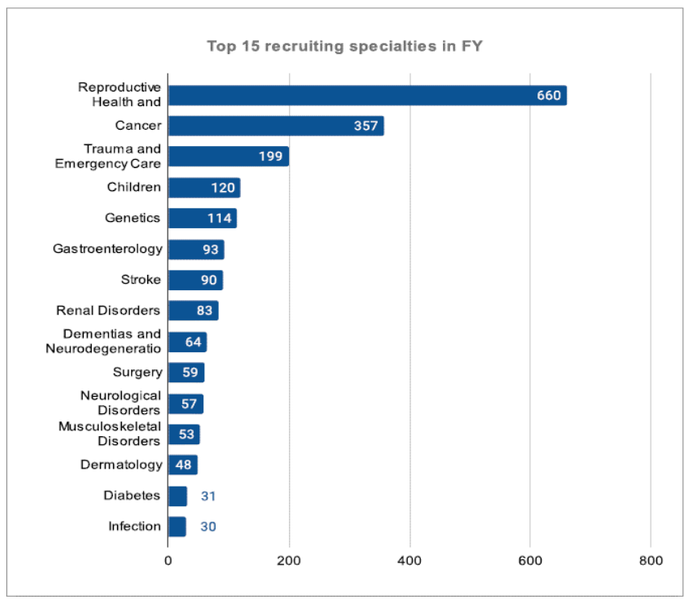
Clinical Studies Measures



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

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





Situation as at end of March 2022

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

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

Maternity Dashboard

Cambridge University Hospitals NHS Foundation Trust

Maternity Measures

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

LMNS: Cambridgeshire and Peterborough | **Reporting period: August 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
464	551	99.56%

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	0.62%
	≤36+6 weeks		8%
Massive Obstetric Haemorrhage ≥ 1500 mls	Vaginal birth	2.5%	3.16%
	Caesarean	4.3%	0.73
Term admissions to NNU (all levels)		<6%	6.46%
3rd & 4th degree tear	SVD (unassisted)	Unassisted 2.8%	4.46%
	Instrumental (assisted)	Assisted 6.8%	5.26%
Right place of birth (born outside a tertiary centre)		Number of births = 0	
Smoking at time of delivery		≤6%	5.97%
Percentage of women placed on CoC pathway		≥35% (March 21)	23%
Percentage of women on CoC pathway :BAME / areas of deprivation)	BAME	≥75%	14% (July)
	Area of deprivation		11% (July)

KEY: CQC DOMAINS	MW to birth ratio		MW Minimum Safe Staffing		Obstetric Cover on Delivery Unit		Vacancy rate		LW co-ordinator supernumerary (%)
	BR+ Recommendation	Actual	Planned Cover	Actual Cover	Hours of consultant presence	Gaps in Rotas	Midwife no's WTE	%age of total staff	
Outstanding									
Good									
Requires Improvement	1:23.03	1:28.2	100%	83%	81	None due to acting down	30.4W TE	15.8%	70%
Inadequate									

Incident Reporting			LMNS confirmation of SI oversight (evidenced through governance & safety meetings) Yes ☐ No ☐													
	Datix		Incidents Graded as Moderate and Above	Maternity Serious Incidents	Maternity Never Events	Coroner Reg 28	HSIB Cases (new)	Still Births			HIE cases (grade 2 or 3)	Neonatal deaths		Maternal Mortality	
	Unactioned	Open > 30 days						All	Term	Intrapartum		Early	Late	Direct	Indirect
CUH	0	96	1	1	0	0	0	0	0	0	0	1	1	0	0

Maternity Dashboard

NHS
Cambridge University Hospitals
NHS Foundation Trust

Maternity Measures

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

	Please identify unit	CUH
1	Perinatal review tool	
2	MSDS	Projected pass of 9 out of 11 CQIMs for July MSDS data. 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.
6	SBLCB V2	NHS digital involved in reviewing out of area data inclusion in AN CQIMs (CO monitoring). Manual audit being completed. Fetal monitoring mandatory annual competency assessment 80% compliance.
7	Patient Feedback	
8	Multi-professional training	Additional faculty for NLS required. Did not meet trajectory for 80% compliance with PROMPT training by end of June 2022 due to current vacancy and sickness rate. Amended trajectory for 90% by 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	Compliance thresholds met for in area women. Discussions with NHS digital to exclude out of area women and submit manual audit for compliance.
2	Fetal Growth Restriction	
3	Reduced Fetal Movements	
4	Fetal monitoring during labour	Mandatory CTG study day in place. Mandatory competency assessment in place. Compliance not yet >85%.
5	Reducing pre-term birth	Fetal fibronectin machines training planned process being implemented for quantitative pre term assessment.

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

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

Maternity Dashboard

Cambridge University Hospitals NHS Foundation Trust

Maternity Measures

Maternity unit:	CUH: All
1. Freedom to speak up / Whistle blowing themes and HSIB / NHSR / CQC or other organisation with a concern or request for action made directly with Trust	• None received in August 2022
	CUH: Top 3
2. Themes from Datix (to include top 3 reported incidents/ frequently occurring)	• Communication including electronic patient record system, handovers and MDT working • Maternity clinical PPH • Staffing medical and midwifery
3. Themes from Maternity Serious Incidents (Sis) and findings of review of all cases eligible for referral to HSIB	• 1 HSIB reports received 1 safety recommendation to ensure that mothers experiencing SROM are offered assessment and immediate or expectant management, with information about the risks and benefits of each provided to support informed decision making.
4. Themes arising from Perinatal Mortality Review Tool (review of perinatal deaths using the real time data monitoring tool)	• No care issues from this month's review
5. Themes / main areas from complaints	• Clinical Treatment • Communication • Patient not listened to • Delays / failure to follow up
6. Listening to women / Service User Voice Feedback (sources, engagement / activities undertaken)	• Language / Communication guide work based on the re birth report recommendations. • Informed choice and consent project planned imminently • RMNVP catch ups and service user voice escalations addressed
7. Evidence of co-production	• Language / Communication guide work based on the re birth report recommendations.
8. Listening to staff (eg activities undertaken, surveys and actions taken as a result) Staff feedback from frontline champions and walk-abouts	• IPC at ward level
9. Embedding learning (changes made as a result of incidents / activities / shared learning/ national reports)	• PPH working group – targeted education re: primary oxytocic use. • World Safety Day PPH management and BCMA • New safety and quality newsletter launched and embedded.

Maternity Dashboard

NHS Cambridge University Hospitals NHS Foundation Trust

Maternity Measures

Sources / References	KPI	Goal	Target	Measure	Data Source	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	SPC	Narrative and Actions taken for Red/Amber/ Special Cause concerning trend results
Activity													
National Maternity Dashboar	Births	For information	N/A	Births per month	Rosie KPI's	455	421	469	434	446	464		Goal / target removed, for information only
Antenatal Care ICS Contracted Booking KPI	Health and social care assessment <GA 12+6/40	> 90%	< 85%	Booking Appointments	Epic	73.05%	71.40%	69.90%	70.64%	73.24%	75.69%		Working with informatics team to remove women who transfer care after 12+6 weeks as these are currently included in the KPI
National Maternity Dashboar	Booking Appointments	For Information	N/A	Booking Appointments	Epic	720	654	615	664	568	551		Goal / target removed, for information only
Source - EPIC	Vaginal Birth (Unassisted)	For Information	N/A	SVD's in all birth settings	Rosie KPI's	51.42%	49.16%	48.82%	54.60%	51.12%	59.05%		Goal / target removed, for information only
Source - EPIC	Home Birth	For Information	N/A	Planned home births (BBA is excluded)	Rosie KPI's	1.53%	1.42%	1.7%	1.84%	1.34%	1.29%		Goal / target removed, for information only
Source - EPIC	Rosie Birth Centre Birth	For Information	N/A	Births on the Rosie Birth Centre	Rosie KPI's	14.5%	11.87%	14.92%	17.1%	15%	15.52%		Goal / target removed, for information only
Source - EPIC	Induction of Labour	For Information	N/A	Women induced for birth	Rosie KPI's	31.61%	31.80%	31.87%	30%	29.80%	26.50%		Goal / target removed, for information only
NICE - Red Flag	Delay in commencement of Induction	0%	<10%	Percentage of Inductions where Induction commencement was postponed	Red Flags	41.00%	40.00%	53.00%	36%	36.00%	32.60%		New KPI introduced in September 2022. Normal variation, includes all women who were admitted and then had a ≥ 2 hour wait to commence their IOL
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%		New KPI introduced in September 2022.. Includes allwomen who were delayed for ≥ 6 hours for subsequent prostaglandin administration or transfer to delivery unit for membrane rupture during the IOL process.
Source - EPIC	Assisted vaginal birth (Instrumental)	For Information	N/A	Instrumental Del rate	Rosie KPI's	10.32%	9.02%	11.94%	10.6%	12.55%	12.93%		Goal / target removed, for information only
Source - EPIC	CS rate (planned & unplanned)	For Information	N/A	C/S rate overall	Rosie KPIs	38.24%	41.80%	39.23%	34.80%	36.32%	35.78%		Goal / target removed, for information only
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								To be reported from October 2022
CQIM / CNST	Women in RG*2 having a caesarean section with no previous births: nullip induced labour, nullip pre-labour LSCS	20-35%	20-35%,	Relative contribution of the Robson group to the overall C/S Rate	Rosie KPIs								To be reported from October 2022
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								To be reported from October 2022
CQIM / CNST	Women in RG*5. Multips with 1 or 2+ previous C/S	50-60%	50-60%	Relative contribution of the Robson group to the overall C/S Rate	Rosie KPIs								To be reported from October 2022
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								To be reported from October 2022
Source - Rosie Divert Folder	Divert Status - incidence	0	> 1	Incidence of divert for the perinatal service	Rosie Diverts	3	4	7	1	4	4		2 women transferred to another provider organisation for assessment, 1 woman gave birth in another provider organisation. 2 x staffing and capacity, 1 x staffing only, 1 x NICU capacity.
Source - Rosie Divert Folder	Total number of hours on divert	For information	N/A	Hours of divert	Rosie Diverts	>88	190	148	23	103	100		

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	1:26.2	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	1:23.4	1:23.4	1:23.4	1:23.3	1:23.3	1:23.3		
Source - CHEQS	Staff sickness as a whole	< 3.5%	> 5%	ESR Workforce Data	CHEQs	7.22%	7.59%	7.63%	7.69%	7.82%			Special cause variation concerning trend
Source - CHEQs	Education & Training - mandatory training - overall compliance (obstetrics and gynaecology)	>92% YTD	<75% YTD	Total Obstetric and Gynaecology Staff (all staff groups) compliant with mandatory training	CHEQs	87.80%	87.50%	87.50%	86.40%				Special cause variation concerning trend
Source - PD	Education and Training - Training Compliance for all staff groups: **Prompt**	≥90% YTD	≤85% YTD	Total multidisciplinary obstetric staff compliant with annual Prompt training	PD	58.84%	61.28%	60.91%	61.00%	65.56%	75.77%		Increased in line with trajectory to meet 90% by end of November 2022.
Source - PD	Education and Training - Training Compliance for all staff groups: **NBLS**	>90% YTD	<85% YTD	Total multidisciplinary staff compliant with annual NBLS training	Resus Services				55.00%	55.00%	58%		NBLS remains low complaince - mainly due to medical staff training and midwifery staff training.
Source - K2	Education and Training - Training Compliance for all staff groups: **K2**	≥90% YTD	≤85% YTD	Total multidisciplinary obstetric staff passed CTG competence threshold of 80%.	PD	79.85%	81.00%	83.39%	83.39%	84.62%	80.00%		Reviewing GP trainee requirements.
Source - CHEQS	Education & Training - mandatory training - **midwifery compliance**.	>92% YTD	<75% YTD	Proportion of midwifery compliance with mandatory training	CHEQs	89.7%	89.2%	89.5%	89.20%	90.20%			
Maternity Morbidity													
Source - QSIS	Eclampsia	0	> 1		Risk Report	0	0	0	0	0	0		
	Maternal Sepsis					TBC	TBC	TBC	TBC	TBC	TBC		
Source - QSIS	ITU Admissions in Obstetrics	1	> 2		Risk Report	2	0	1	1	0	1		
Source - QSIS	PPH≥ 1500 mls	< 3%	> 4%		CHEQS	4.21%	5.70%	6.77%	3.48%	4.13%	4.31%		on review all 12 cases of 2000mls managed appropriately 3 acreta cases one transfer to Papworth ITU 4 assisted deliveries consultant presence at all
Source - QSIS	3rd/ 4th degree tear **rate vaginal birth**	<3.5%	>5%		Risk Report	1.81%	2.05%	2.48%	2.83%	3.90%	4.06%		Benchmark amended in line with NMPA from August 2022, backdated RAG prior to this for one annum . Audit underway.
Source - QSIS	Direct Maternal Death	0	>1		Risk Report	0	0	0	0	0	0		
Risk													
Source - QSIS	Total number of SI's	0	>1	Serious Incidents	Datix	0	0	1	0	1	1		transfer to Papworth ITU following significant intra-thoracic bleeding secondary to misplacement of right sided central line
Source - QSIS	Information Governance	0	>1		Datix	*0*	*0*	*0*	*0*	*1*	*0*		
Source - QSIS	Clinical	0	>1		Datix	*0*	*0*	*1*	*0*	*0*	*1*		
Source - QSIS	Never Events	0	>1	DATIX	Datix	0	0	0	0	0	0		

Maternity Dashboard

Cambridge University Hospitals NHS Foundation Trust

Maternity Measures

Neonatal Morbidity													
Source - EPIC	Shoulder Dystocia per vaginal births	< 1.5%	> 2.5%		Risk Report	3.24%	4.52%	3.90%	3.19%	2.46%	2.70%		normal variation no admissions to NICU
Source - EPIC	Still Births per 1000 Births			3.33/1000 (Mbrrace 2021)	Risk report	0.21/1000	1.26/1000	0.42/1000	0.43/1000	0.88/1000	0/1000		
Source - EPIC	Stillbirths - number ≥ 22 weeks	0	6	MBBRACE	Risk report	1.00	3.00	2.00	1.00	2.00	0.00		
Source - EPIC	Number of birth injuries	0	> 1		Risk Report	0	0	1	0	0	0		
Source - EPIC	Number of term babies who required therapeutic cooling	0	> 1		Risk Report	0	0	0	0	0	0		
Source - EPIC	Baby born with a low cord gas < 7.1	<2%	> 3%		Risk Report	1.09%	0.47%	0.42%	1.15%	1.57%	1.07%		
Source - EPIC	Term admissions to NICU	<6.5	>6.5	NHSE/I	Risk Report	6.57%	4.27%	4.90%	5.52%	3.85%	6.68%		close monitoring continues monthly there were 31 babies admitted after 37+0 weeks - 4 were expected admissions 27 unexpected admissions (5.81%)
Quality													
Source - EPIC	1-1 Care in Labour	>95%	<90%	Exlcuding BBA's	Rosie KPI's	98.65%	100%	98.69%	100%	100%	99.56%		
Source - EPIC	Breast feeding Initiated at birth	> 80%	< 70%	Breastfeeding	Rosie KPI's	79.59%	82.89%	81.22%	84.33%	79.4%	84.07%		
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	6.95%	3.37%	5.02%	3.95%	8.25%	5.97%		
Source - EPIC	VTE	>95%	< 95%		CHEQs	99.32%	99.9%	99.96%	99.74%	96.64%	99.82%		

Finance

Cambridge University Hospitals NHS Foundation Trust

Financial Performance

Trust performance summary - Key indicators

Trust actual surplus / (deficit)

(£0.5m)	*Actual (adjusted)**
(£0.5m)	*Plan (adjusted)**
£3.4m	*Actual YTD (adjusted)**
£3.4m	*Plan YTD (adjusted)**

Covid-19 expenditure and system Covid-19 funding

£1.6m	*Covid actual in month*
£1.8m	*Covid plan in month*
£1.8m	*Covid funding in month*
£10.4m	*Covid actual YTD*
£9.9m	*Covid plan YTD*
£9.2m	*Covid funding YTD*

Net current assets, debtor days and payables performance

Net current assets

(£53.7m)	
(£54.8m)	

Debtor days

21	*This month*
16	*Previous month*

Payables performance (YTD) **

Actual	85.9%	*Value*
Plan	88.4%	*Quantity*

Cash and EBITDA

Cash

£183.0m	*Actual*
£166.6m	*Plan*

EBITDA

£20.9m	*Actual YTD*
£21.1m	*Plan YTD*

Capital expenditure

£2.4m	*Capital - actual spend in month*
£10.0m	*Capital - actual spend YTD*
£19.5m	*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*
£5.7m	*ERF forecast actual YTD*
£5.7m	*ERF plan YTD*

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

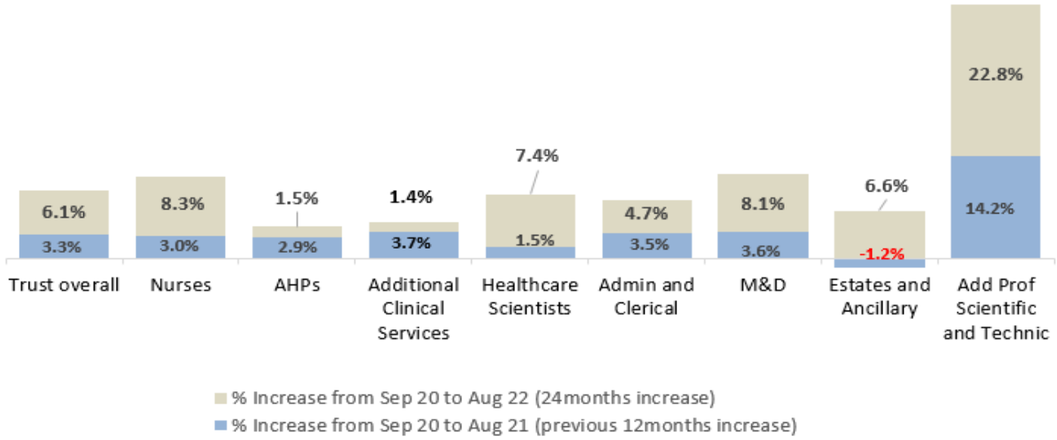
* On a control total basis, excluding the effects of impairments and donated assets
** Payables performance YTD relates to the Better Payment Practice Code target to pay suppliers within due date or 30 days of receipt of a valid invoice.

Staff in Post

Cambridge University Hospitals NHS Foundation Trust

12 Month Growth by Staff Group

Staff Group	Headcount Sep-21	Headcount Aug-22	Headcount 12 Month growth	FTE Sep-21	FTE Aug-22	FTE 12 Month growth
Add Prof Scientific and Technic*	233	253	8.6%	214	230	16 7.4%
Additional Clinical Services	1,955	1,923	-1.6%	1,799	1,772	-27 -1.5%
Administrative and Clerical	2,362	2,380	0.8%	2,154	2,186	32 1.5%
Allied Health Professionals*	739	724	-2.0%	655	637	-18 -2.7%
Estates and Ancillary	337	366	8.6%	327	354	26 8.0%
Healthcare Scientists	622	646	3.9%	581	606	25 4.4%
Medical and Dental	1,641	1,691	3.0%	1,553	1,599	46 3.0%
Nursing and Midwifery Registered	3,649	3,805	4.3%	3,345	3,498	153 4.6%
Total	**11,538**	**11,788**	**2.2%**	**10,628**	**10,883**	**255** 2.4%



Admin & Medical Breakdown

Staff Group	Sep-21	Aug-22	FTE 12 Month growth
Administrative and Clerical	2,154	2,186	32 1.5%
of which staff within Clinical Division	1,062	1,074	12 1.1%
of which Band 4 and below	756	749	-7 -1.0%
of which Band 5-7	218	233	16 7.2%
of which Band 8A	40	45	4 10.9%
of which Band 8B	7	7	0 4.2%
of which Band 8C and above	40	39	-1 -3.0%
Areas	874	879	4 0.5%
of which Band 4 and below	249	244	-5 -2.1%
of which Band 5-7	410	412	2 0.5%
of which Band 8A	72	86	14 18.9%
of which Band 8B	56	51	-5 -9.6%
of which Band 8C and above	86	86	0 -0.4%
of which staff within R&D	218	234	16 7.2%
Medical and Dental	1,553	1,599	46 3.0%
of which Doctors in Training	645	651	6 0.9%
of which Career grade doctors	228	243	15 6.8%
of which Consultants	679	704	25 3.7%

What the information tells us:

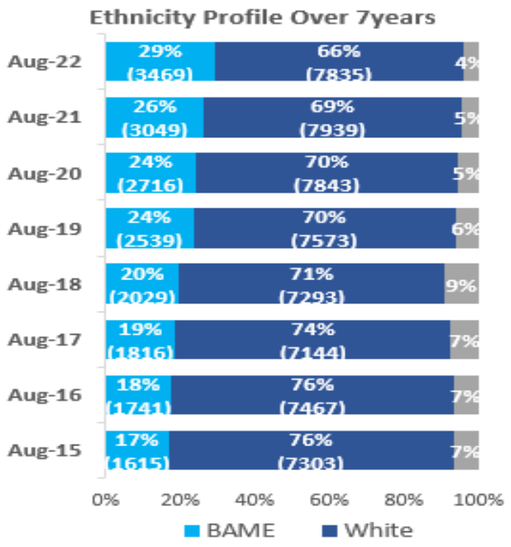
Overall the Trust saw a 2.4% growth in its substantive workforce over the past 12 months and 6.1% over the past 24 months. Growth over the past 24 months is lowest within Additional Clinical Services at 1.4% and highest within Add Prof Scientific and Technic at 22.8%. Growth over the past 12 months is lowest within Allied Health Professionals and highest within Estates and Ancillary.

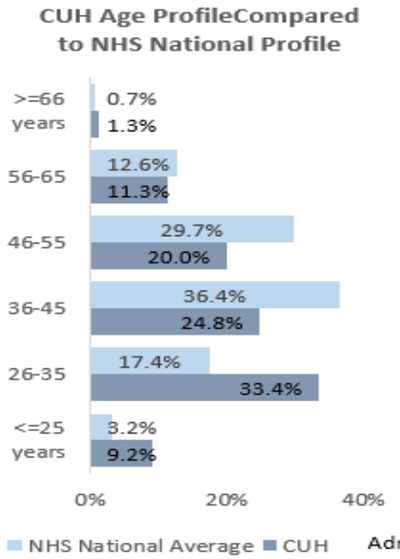
*Operating Department Practitioner roles were regroup from Add Prof Scientific and Technic to Allied Health Professionals on ESR from June 21 . This change has been updated for historical data set to allow for accurate comparison

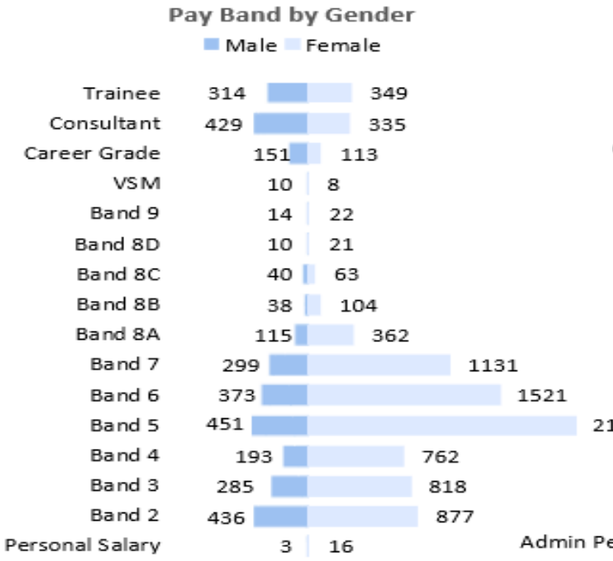
Equality Diversity and Inclusion (EDI)

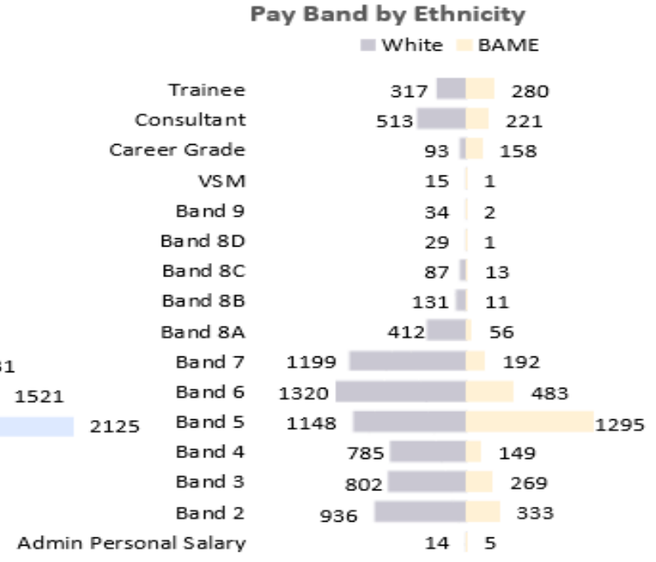
Cambridge University Hospitals NHS Foundation Trust

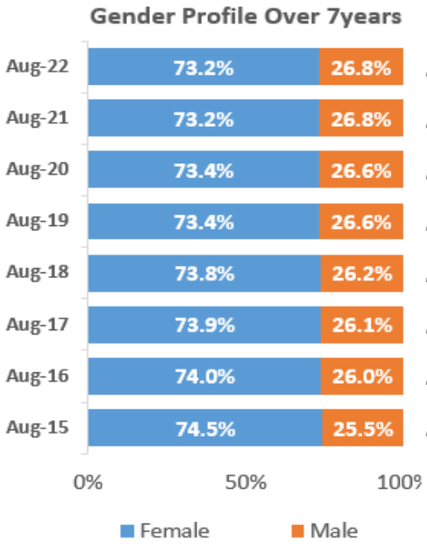
Workforce: Equality Diversity and Inclusion (EDI)

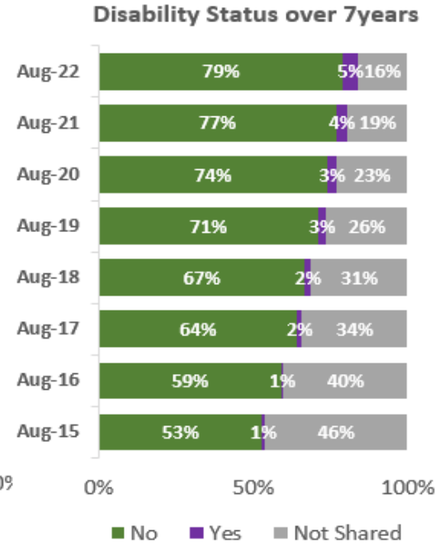


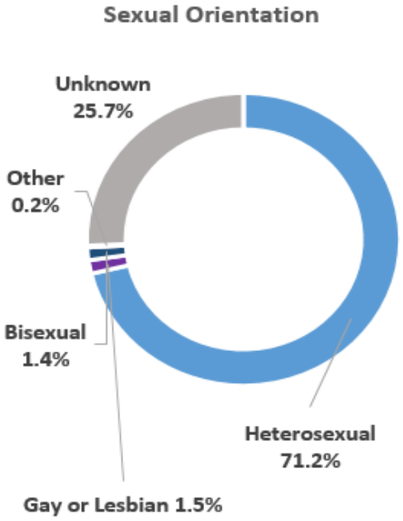












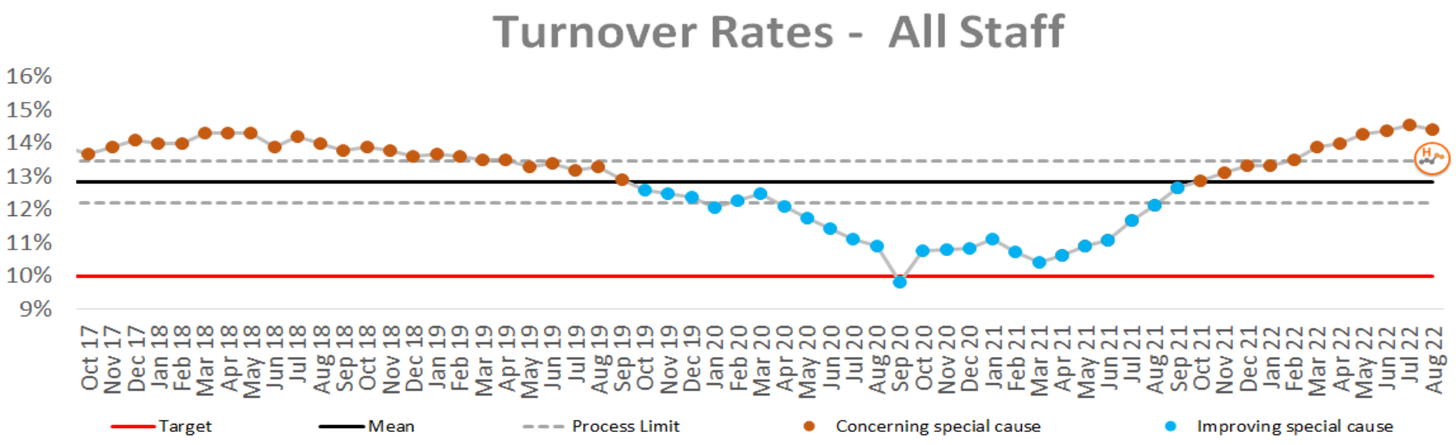
What the information tells us:

- 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 12.5% over the 7 year period and currently make up 29% of CUH substantive workforce.
- The percentage of male staff increased by 1.3% 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

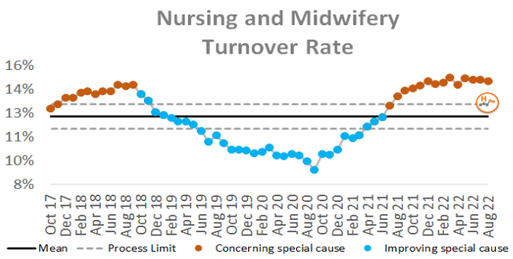
Workforce: Staff Turnover

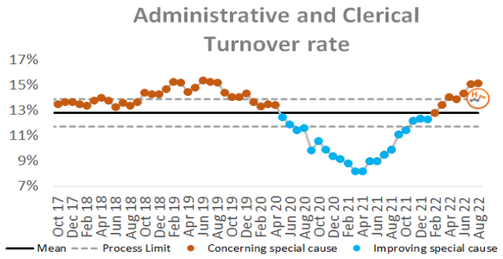


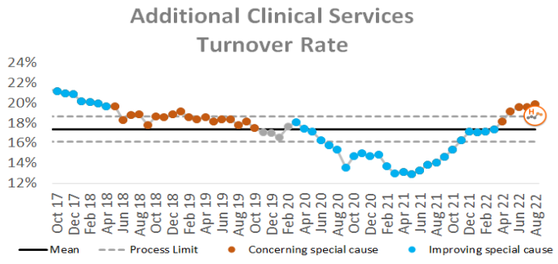
Background Information: Turnover describes the rate that employees leave an establishment. Staff turnover is calculated by the number of leavers from the Trust over the previous twelve months as a percentage of the total number of employed staff at a given time. (exclude all fixed term contracts including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

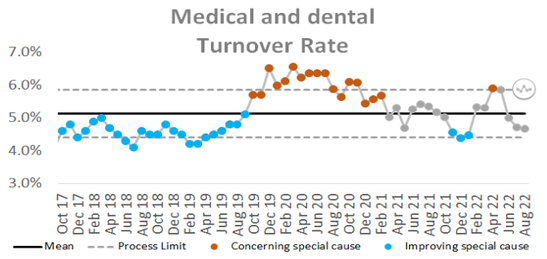
What the information tells us:

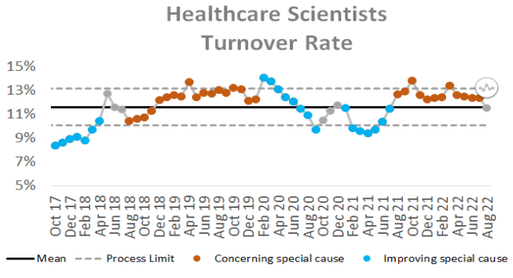
The Trust's turnover has been steadily increasing over the past nine months and currently at 14.4%. This is slightly lower than last month, but still higher than pre-pandemic rates, with an increase of 1.11% over the past three years. Nursing and Midwifery staff group have the highest increase of 3.4% to 14.5%, followed by Additional Clinical Services with an increase of 2.09% to 19.9%. Within the staff groups, Additional Clinical Services have the highest turnover rate at 19.9% followed by Admin staff at 15.2%.

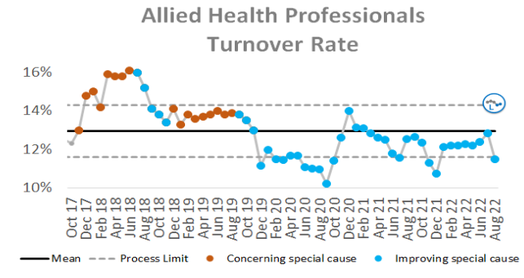


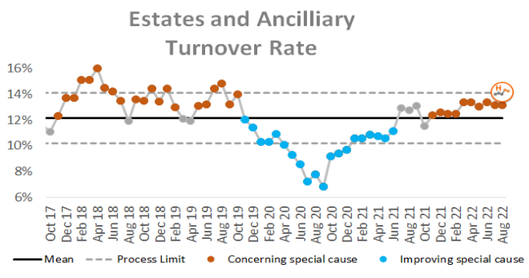


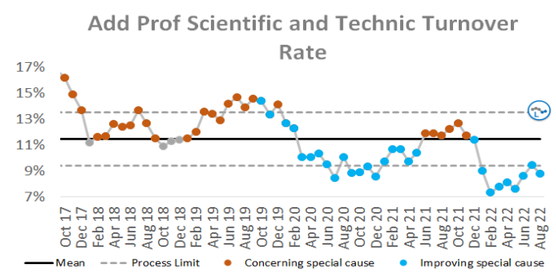










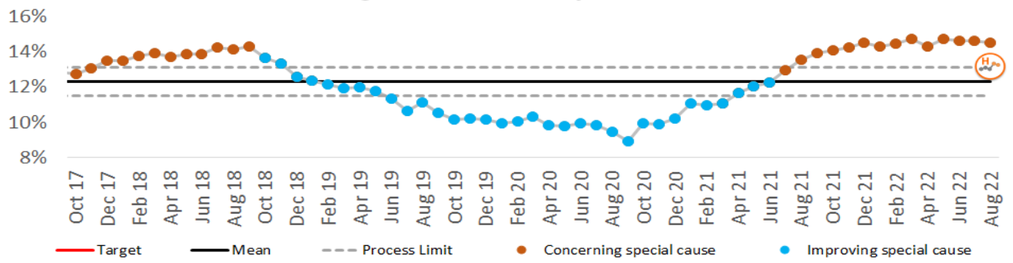


Turnover for Nursing & Midwifery Staff Group (Registered & Non-Registered)

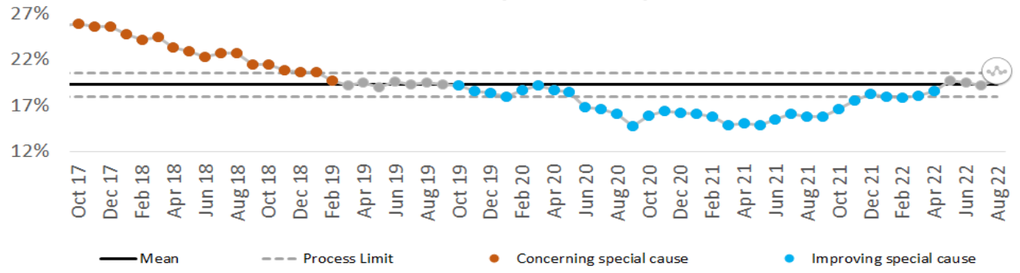
NHS Cambridge University Hospitals NHS Foundation Trust

Workforce: Turnover rate for Nursing & Midwifery Staff Group

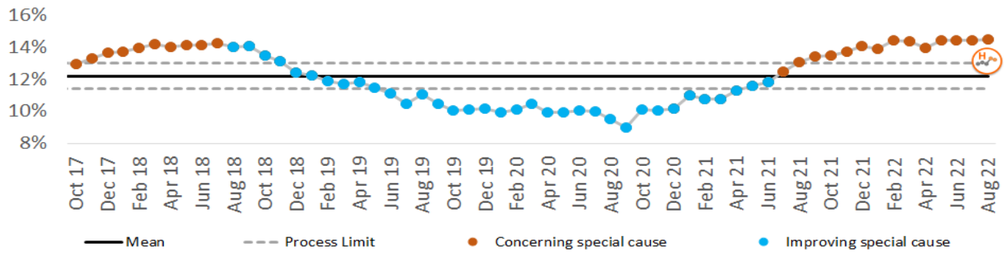
Nursing and Midwifery Turnover Rate



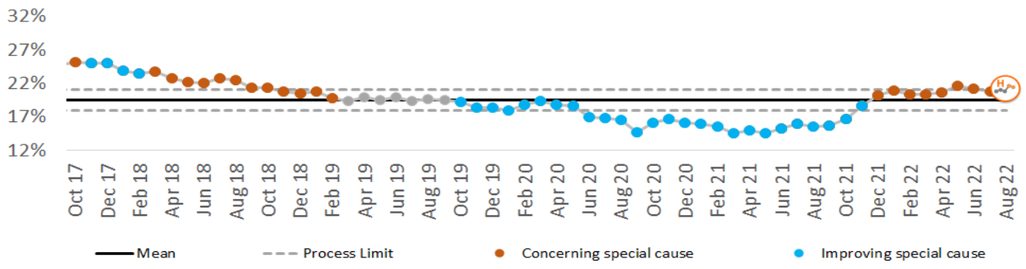
Healthcare Assistant (incl. MCA) Turnover Rate



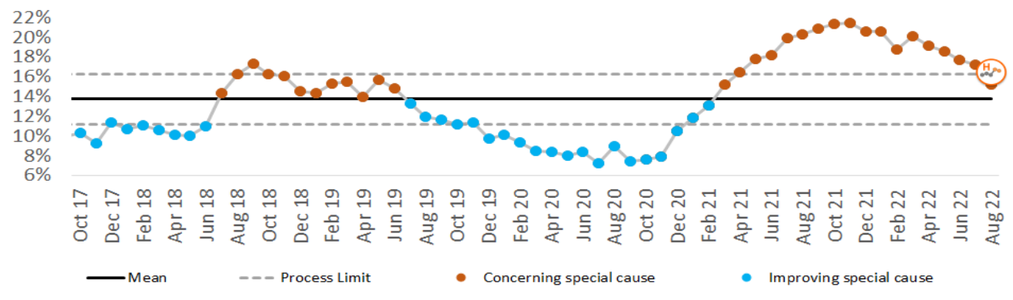
Nursing (Excluding midwives) Turnover Rates



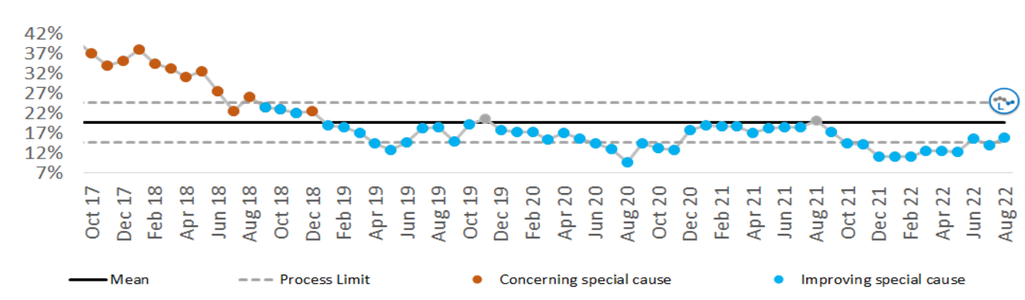
Healthcare Assistant (excl. MCA) Turnover Rate



Midwife Turnover Rates



Maternity Care Assistants (MCA) Turnover rates

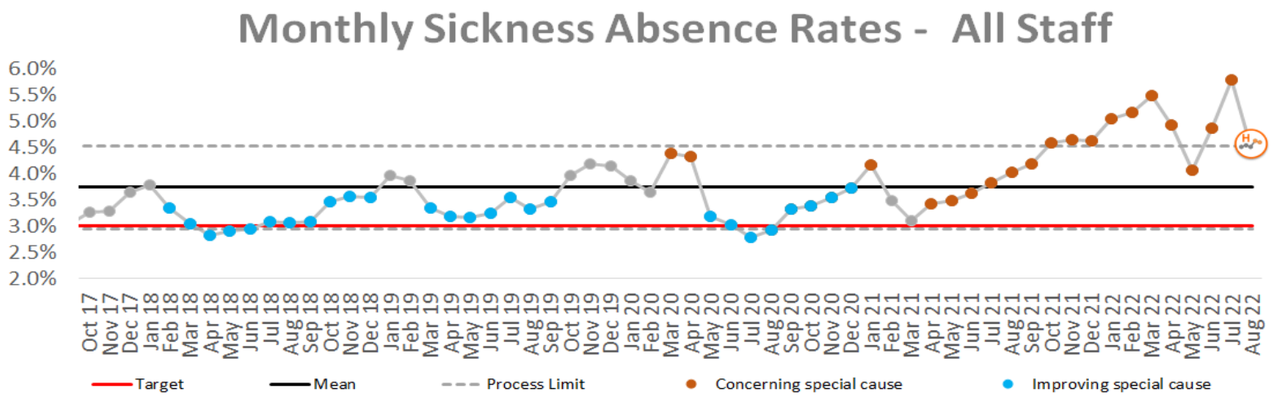


Author(s): Tosin Okufuwa, Amanda Coulier Owner(s): David Wherrett

Sickness Absence

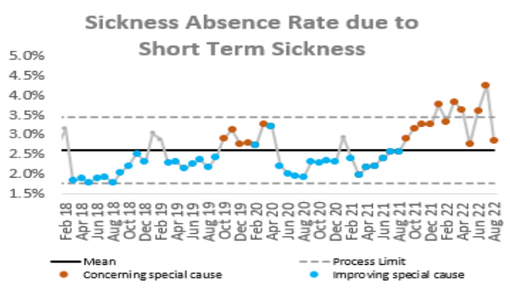
Cambridge University Hospitals NHS Foundation Trust

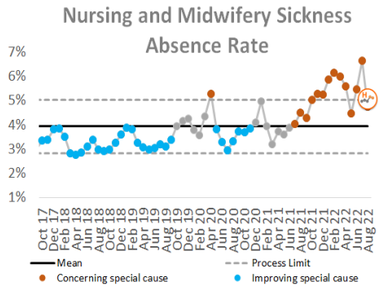
Workforce: Sickness Absence

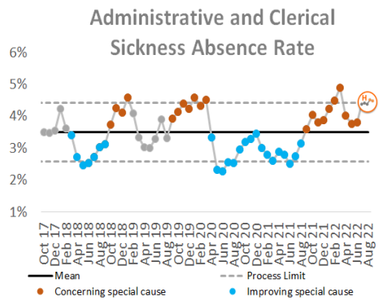


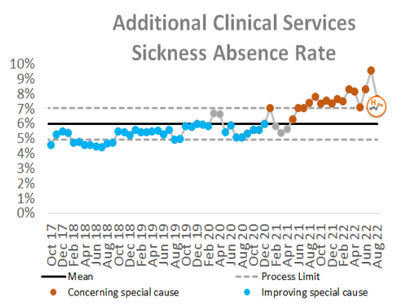
Background Information: Sickness Absence is a monthly metric and is calculated as the percentage of FTE days missed in the organisation due to sickness during the reporting month.

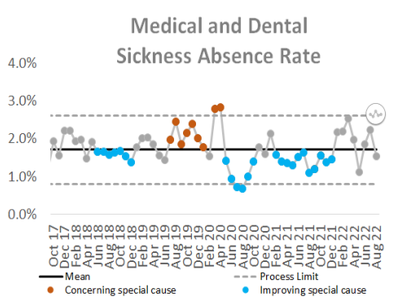
What the information tells us: The overall Monthly Sickness Absence is above average at 4.4%. This is lower than previous month, July 2022 (5.8%) and higher than same period previous year, August 2021 (4.04%). Sickness absence rate due to short term illness is higher at 2.8% compared to long term sickness at 1.6%. Additional Clinical Services have the highest sickness absence rate at 7.7% followed by Estates at 6.3%.

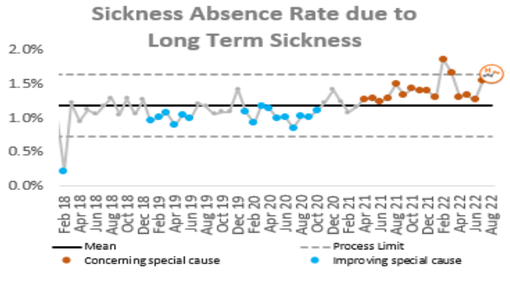


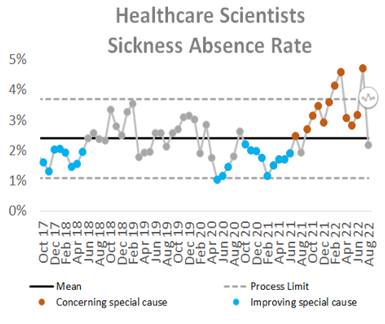


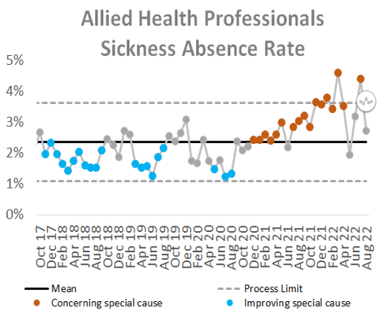


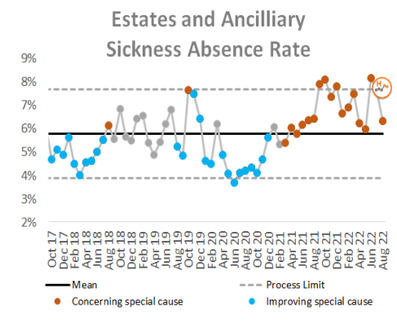


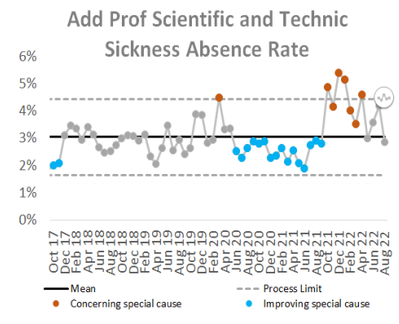












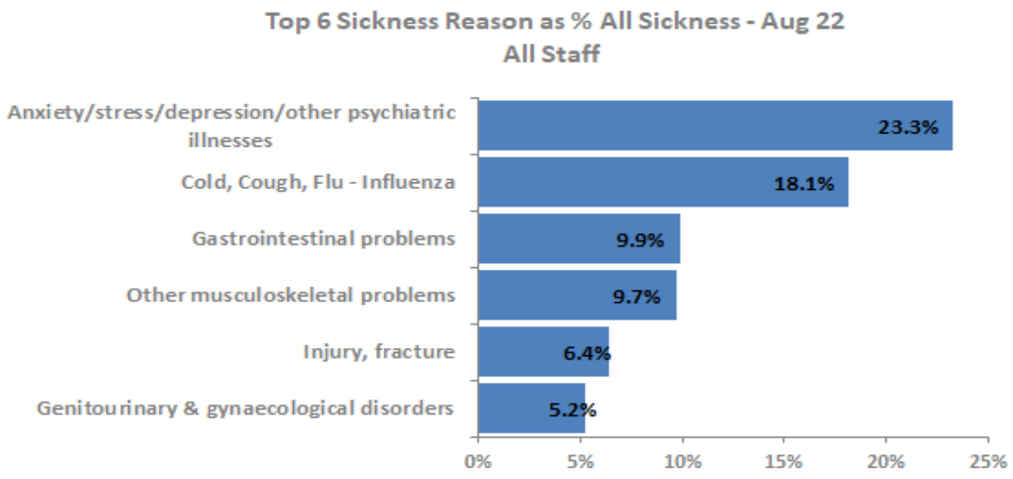
Author(s): Tosin Okufuwa, Amanda Wood

Owner(s): David Wherrett

Top Six Sickness Absence Reason

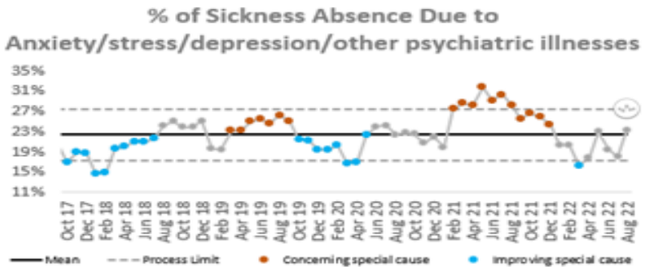
Cambridge University Hospitals NHS Foundation Trust

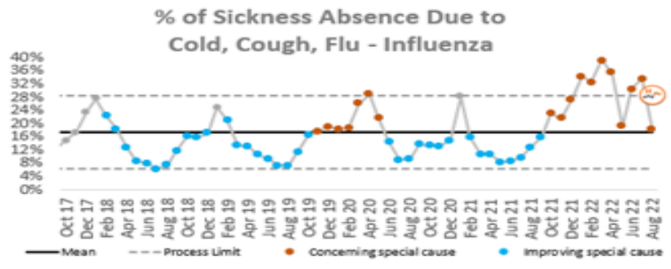
Workforce: Top Six Sickness Absence

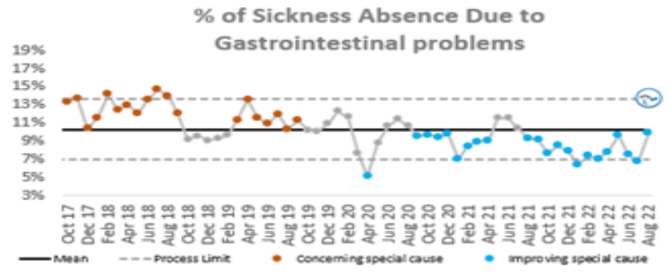


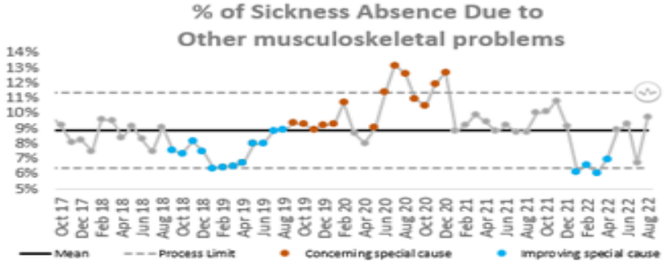
Background Information: Sickness Absence reason is provided as a percentage of all FTE days missed due to sickness during the reporting month.

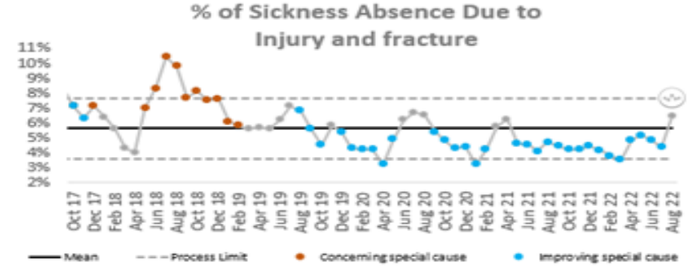
What the information tells us: The highest reason for sickness absence is anxiety/stress/depression/other psychiatric illnesses, which saw an increase of 5% from the previous month to 23.3%, and has now overtaken influenza-related sickness as the top sickness reason. Potential Covid-19 related sickness absence (this includes chest & respiratory problems, influenza related sickness and infectious diseases) accounts for 23.0% of all sickness absence in August 2022, compared to 41.3% from the previous month.

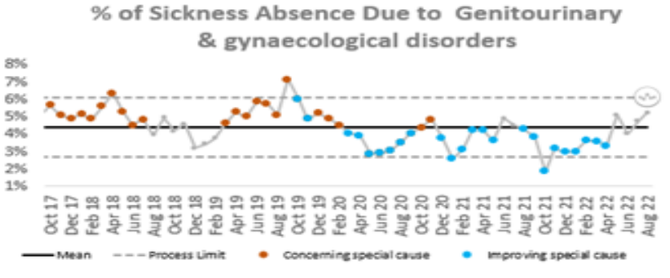












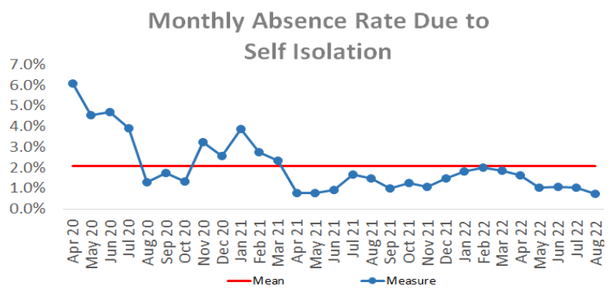
Author(s):Tosin Okufuwa, Amanda Wood

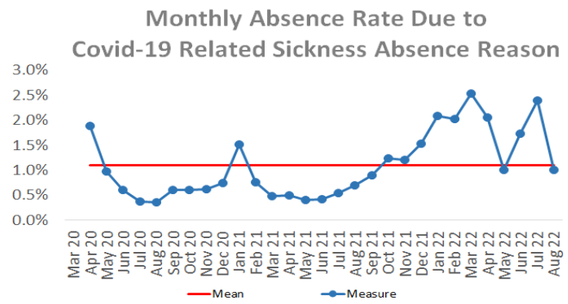
Owner(s): David Wherrett

Covid-19 Related Absence

Cambridge University Hospitals NHS Foundation Trust

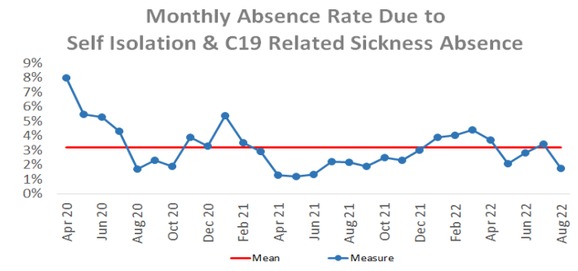
Workforce: Covid-19 Related Absence

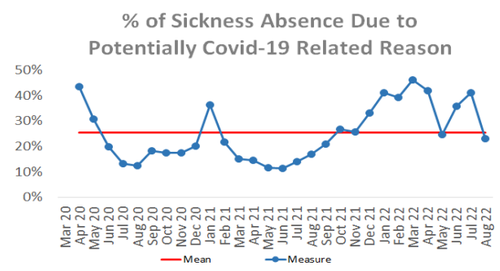


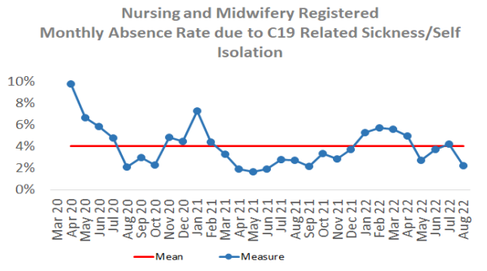


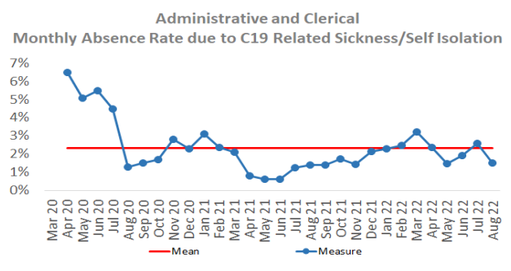
Background Information: Monthly absence figures due to Covid-19 are presented. This provides monthly absence information relating to FTE lost due to Self Isolation and potentially Covid-19 Related Sickness Absence (this includes chest & respiratory problems, influenza related sickness and infectious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

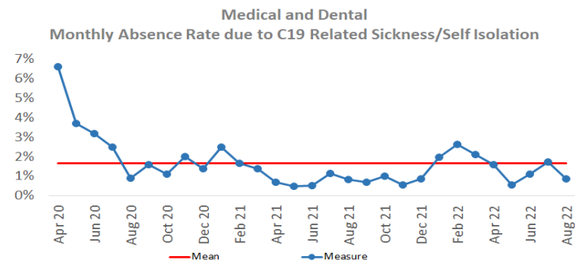
What the information tells us: The Trust's monthly absence rate due to Self Isolation has decreased to 0.7%. Monthly absence rate due to potential Covid-19 related sickness has also decreased to 1% in August 2022. Overall, absence rates due to Covid-19 related sickness and self isolation decreased by 1.7% from the previous month to 1.8%.

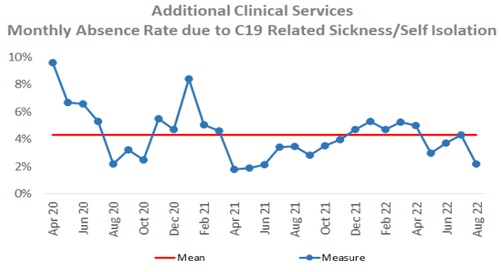


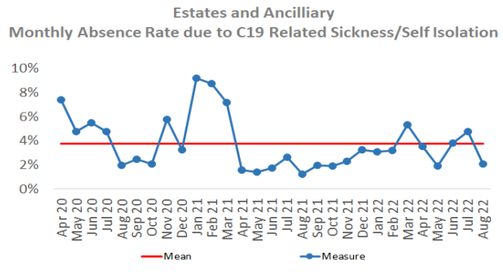


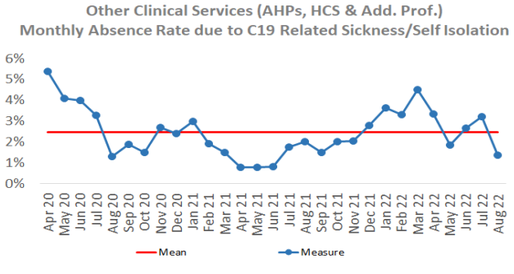












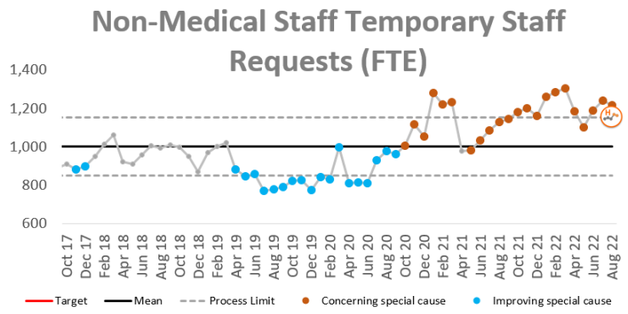
Author(s): Tosin Okufuwa, Amanda Wood

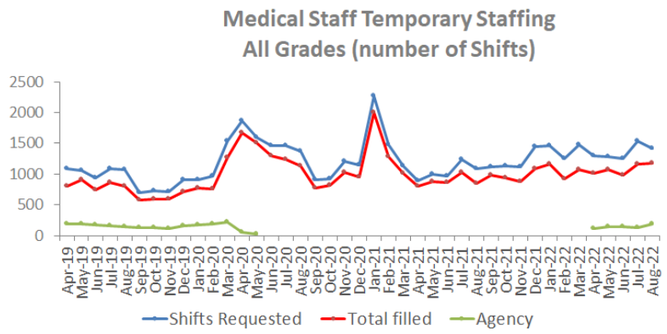
Owner(s): David Wherrett

Temporary Staffing

Cambridge University Hospitals NHS Foundation Trust

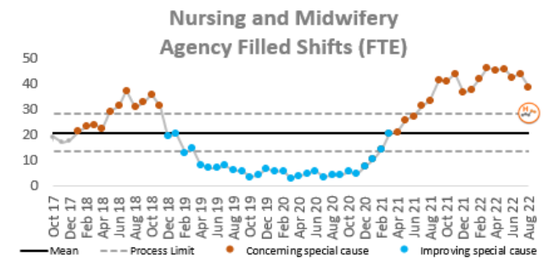
Workforce: Temporary Staffing

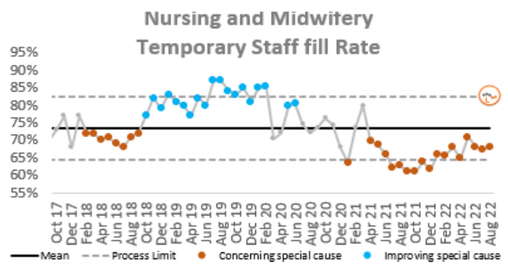


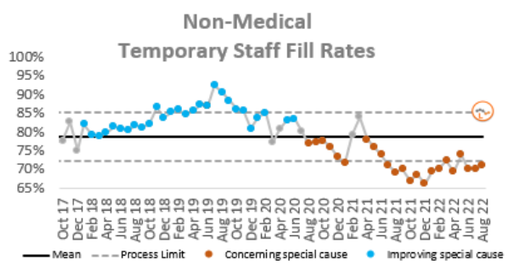


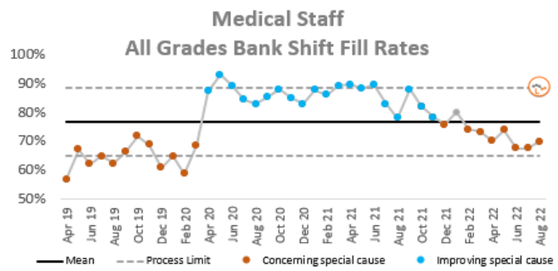
Background Information: The Trust works to ensure that temporary vacancies are filled with workers from staff bank in order to minimise agency usage, ensure value for money and to ensure the expertise and consistency of staffing.

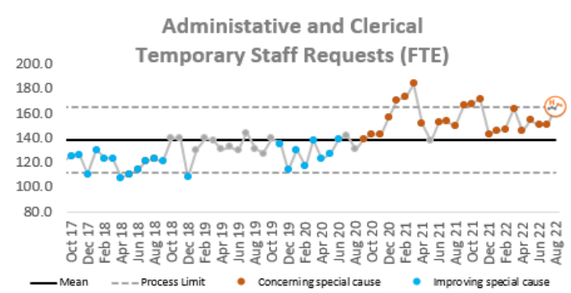
What the information tells us: Demand for non-medical temporary staff decreased by 2% from the previous month to 1,217 WTE. Top three reasons for request includes vacancy (52%), increased workload (16%) and sickness (14%). Nursing and midwifery agency usage decreased by 5.3 WTE from the previous month to 38.8 WTE. This accounts for 11% of the total nursing filled shifts. Overall, fill rate has increased slightly from previous month to 71% due to a decrease in demand.

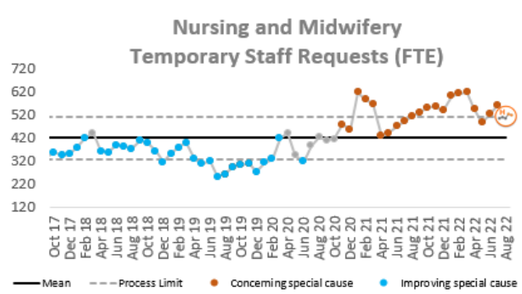


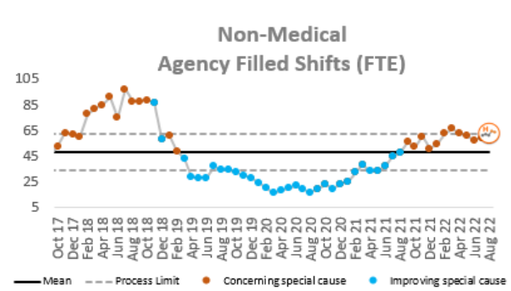


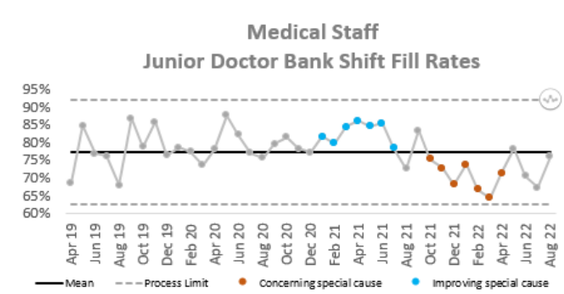












*Please note that temporary Medical staffing data was not available at the time of reporting and hence not updated

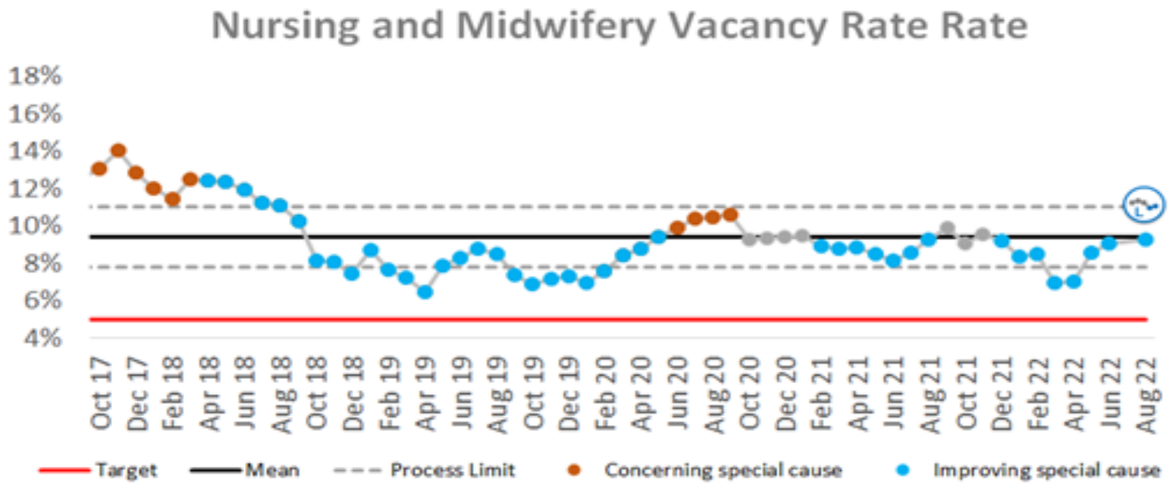
Author(s): Tosin Okufuwa, Amanda Wood

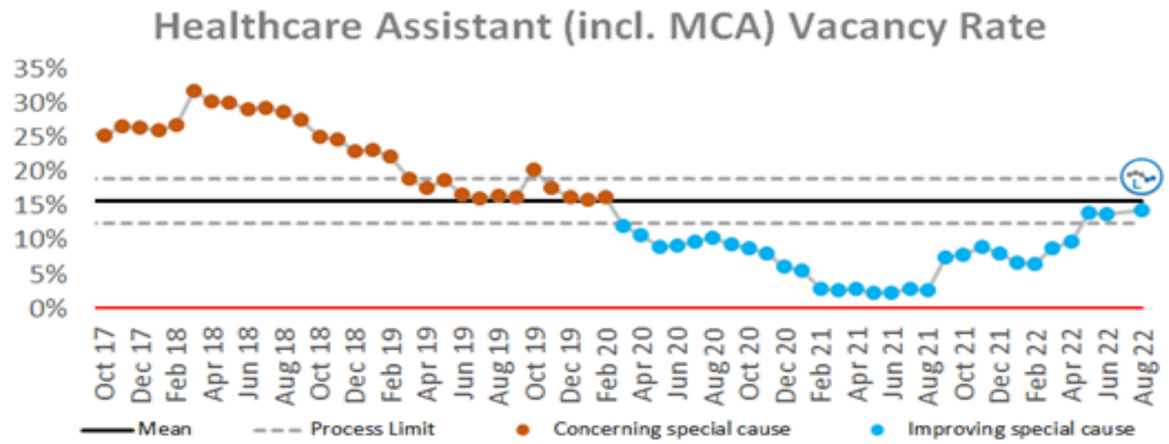
Owner(s): David Wherrett

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 14.4% and 9.3% respectively. However, the vacancy rate for both staff groups are above the target rate of 5% for Nurses and 0% for HCA.

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

Annual Leave Update

Cambridge University Hospitals NHS Foundation Trust

Workforce: C19 - Risk Assessment & Annual Leave Update

Percentage of Annual Leave (AL) Taken - Aug 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	51,488	20,594	40.0%	96%
	Additional Clinical Services	367,775	151,128	41.1%	97%
	Administrative and Clerical	478,158	184,488	38.6%	96%
	Allied Health Professionals	145,388	59,582	41.0%	99%
	Estates and Ancillary	78,538	34,522	44.0%	99%
	Healthcare Scientists	136,377	54,544	40.0%	95%
	Medical and Dental	140,255	37,971	27.1%	32%
	Nursing and Midwifery Registered	763,339	308,465	40.4%	97%
	Trust	**2,161,318**	**851,295**	39.4%	88%
Annual Leave taken by Division	*Division*				
	Corporate	300,588	119,044	40%	94%
	Division A	411,263	162,999	40%	86%
	Division B	594,674	240,109	40%	92%
	Division C	274,209	101,117	37%	80%
	Division D	259,776	102,664	40%	83%
	Division E	226,251	89,966	40%	82%
	R&D	94,559	35,396	37%	93%

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

What the information tells us: The Trust's annual leave usage is 95% of the expected usage after the fifth month of the financial year. Overall usage is 39.4% compared to the expected 42%. The highest rate of use of annual leave is within the Estates and Ancillary staff group, followed by Additional Clinical Services staff at 44% and 41.1% respectively.

Mandatory Training by Division and Staff Group

Cambridge University Hospitals NHS Foundation Trust

Workforce: Mandatory Training

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

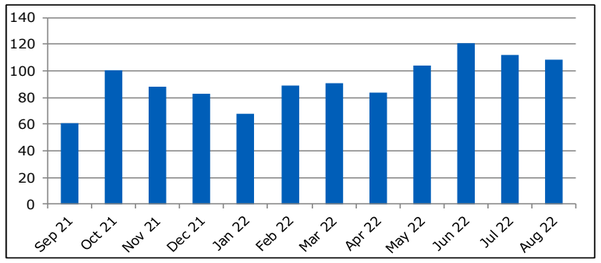
		Induction (Greater than 94% / Less than 80% / Between 79% and 94%)				Mandatory Training Competency (as defined by Skills for Health) (Greater than 89% / Less than 75% / Between 74% and 89%)														
		Non-Medical		Medical																
		Corporate Induction	Local Induction	Corporate Induction	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		1,111	1,108	290	287	10,377	10,377	10,520	10,377	10,377	10,377	10,517	6,946	10,377	7,364	10,377	7,376	1,678	1,352	
Compliance by Division																				
Compliance by Division	Division A	(18)90.8%	(21)89.3%	(13)80.3%	(13)79.7%	(60)97.0%	(61)96.9%	(302)84.9%	(69)96.5%	(81)95.9%	(191)90.3%	(297)85.2%	(347)80.3%	(84)95.7%	(201)88.8%	(65)96.7%	(175)90.3%	(62)70.0%	(11)93.2%	91.4%
	Division B	(20)92.9%	(46)83.6%	(7)85.7%	(10)79.6%	(70)97.4%	(72)97.3%	(231)91.6%	(68)97.5%	(120)95.6%	(208)92.3%	(360)86.9%	(316)77.3%	(94)96.5%	(181)89.3%	(75)97.2%	(169)90.0%	(26)80.2%	(14)89.3%	93.1%
	Division C	(24)87.4%	(27)85.7%	(10)82.8%	(7)87.9%	(39)97.2%	(48)96.5%	(209)85.3%	(55)96.0%	(78)94.4%	(159)88.5%	(280)80.4%	(276)78.7%	(71)94.9%	(127)90.3%	(52)96.2%	(113)91.4%	(43)80.2%	(20)90.8%	90.6%
	Division D	(9)92.2%	(22)80.9%	(11)80.0%	(11)80.0%	(46)96.6%	(51)96.2%	(195)85.6%	(56)95.8%	(80)94.0%	(162)87.9%	(278)79.5%	(281)74.8%	(70)94.8%	(117)89.7%	(54)96.0%	(99)91.3%	(18)85.6%	(15)87.9%	90.2%
	Division E	(9)92.8%	(25)80.0%	(14)75.9%	(4)93.0%	(37)96.9%	(34)97.2%	(173)85.8%	(39)96.8%	(54)95.5%	(111)90.8%	(298)75.6%	(252)76.6%	(70)94.2%	(123)88.6%	(46)96.2%	(103)90.5%	(222)77.2%	(72)89.7%	89.6%
	Corporate	(24)83.9%	(28)81.2%	(1)66.7%	(1)66.7%	(40)97.0%	(50)96.2%	(82)93.9%	(49)96.3%	(59)95.6%	(118)91.1%	(78)94.1%	(30)80.6%	(61)95.4%	(16)90.0%	(50)96.2%	(14)91.4%	(7)61.1%	(3)82.4%	94.4%
	R & D	(1)98.2%	(5)90.7%			(6)98.6%	(6)98.6%	(14)96.8%	(7)98.4%	(11)97.5%	(22)94.9%	(35)91.9%	(14)91.2%	(12)97.2%	(11)94.1%	(11)97.5%	(10)94.6%	(1)85.7%	(0)100.0%	96.3%
	Breakdown of Medical staff compliance																			
	Consultant			(10)82.1%	(14)74.5%	(23)96.8%	(24)96.7%	(35)95.2%	(26)96.4%	(31)95.7%	(69)90.4%	(33)95.4%	(170)76.6%	(27)96.3%	(48)93.4%	(18)97.5%	(45)93.8%	(27)87.4%	(14)92.6%	93.3%
	Non Consultant			(46)80.3%	(32)86.2%	(95)83.6%	(92)84.1%	(128)77.9%	(108)81.3%	(133)77.0%	(218)62.3%	(160)72.4%	(347)41.3%	(129)77.7%	(141)75.7%	(112)80.7%	(143)75.6%	(47)64.1%	(34)69.9%	74.4%
	Compliance by Staff group																			
Compliance by Staff Group	Add Prof Scientific and Technic	(0)100.0%	(0)100.0%			(5)97.8%	(4)98.3%	(7)97.0%	(4)98.3%	(9)96.1%	(24)89.6%	(16)93.1%	(7)78.8%	(8)96.5%	(22)89.3%	(8)96.5%	(21)89.8%	(0)100.0%	(0)100.0%	94.7%
	Additional Clinical Services	(41)81.7%	(40)82.1%			(39)97.7%	(46)97.2%	(279)83.8%	(43)97.4%	(66)96.0%	(156)90.6%	(397)76.9%	(352)73.9%	(63)96.2%	(218)85.6%	(46)97.2%	(180)88.1%	(42)71.0%	(8)90.5%	90.0%
	Administrative and Clerical	(19)91.5%	(38)82.9%			(60)97.3%	(70)96.8%	(72)96.7%	(74)96.6%	(94)95.7%	(166)92.4%	(112)94.9%	(8)57.9%	(97)95.6%	(14)87.6%	(81)96.3%	(14)87.8%	(4)42.9%	(1)85.7%	95.5%
	Allied Health Professionals	(4)94.7%	(11)85.1%			(12)98.1%	(11)98.3%	(78)88.1%	(11)98.3%	(15)97.7%	(29)95.5%	(156)76.1%	(132)79.5%	(15)97.7%	(36)94.4%	(11)98.3%	(35)94.6%	(18)70.5%	(5)91.5%	92.8%
	Estates and Ancillary	(15)74.6%	(4)93.1%			(8)97.6%	(8)97.6%	(24)92.9%	(8)97.6%	(15)95.6%	(37)89.1%	(5)98.5%	(5)98.5%	(11)96.7%	(11)96.7%	(9)97.3%				95.4%
	Healthcare Scientists	(2)96.6%	(12)79.3%			(9)98.5%	(13)97.9%	(20)96.7%	(12)98.0%	(18)97.1%	(33)94.6%	(46)92.5%	(17)85.5%	(13)97.9%	(26)85.0%	(10)98.4%	(24)86.1%	(1)93.8%	(1)93.8%	95.8%
	Medical and Dental			(56)80.7%	(46)84.0%	(118)90.9%	(116)91.1%	(163)87.5%	(134)89.7%	(164)87.4%	(287)77.9%	(193)85.2%	(517)60.8%	(156)88.0%	(189)85.5%	(130)90.0%	(188)85.7%	(74)78.6%	(48)84.2%	84.7%
	Nursing and Midwifery Registere	(24)94.7%	(69)84.8%			(47)98.6%	(54)98.4%	(563)83.8%	(57)98.3%	(102)97.0%	(239)93.0%	(701)79.8%	(483)86.1%	(99)97.1%	(271)92.0%	(58)98.3%	(221)93.5%	(240)78.2%	(72)91.8%	92.5%
	Trust Total	(105)90.5%	(174)84.3%	(56)80.7%	(46)84.0%	(298)97.1%	(322)96.9%	(1206)88.5%	(343)96.7%	(483)95.3%	(971)90.6%	(1626)84.5%	(1516)78.2%	(462)95.5%	(776)89.5%	(353)96.6%	(683)90.7%	(379)77.4%	(135)90.0%	91.80%

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

Health and Safety Incidents

Cambridge University Hospitals NHS Foundation Trust

No. of health and safety incidents affecting staff:

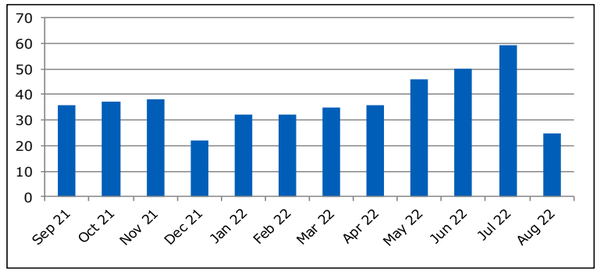


	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Total
Accident	8	15	8	12	17	16	21	16	15	14	20	16	**178**
Blood/bodily fluid exposure (dirty sharps/splashes)	11	30	26	12	15	17	18	17	16	19	20	18	**219**
Environmental Issues	4	7	13	4	1	5	4	10	4	7	20	17	**96**
Moving and Handling	5	1	3	7	5	3	4	3	3	5	2	4	**45**
Sharps (clean sharps/incorrect disposal & use)	3	2	3	3	2	7	3	6	8	4	8	10	**59**
Slips, Trips, Falls	9	8	12	9	4	6	8	7	8	7	3	4	**85**
Violence & Aggression	19	32	23	34	22	32	29	23	45	61	36	35	**391**
Work-related ill-health	2	5	0	2	2	3	4	2	5	4	3	4	**36**
Total	**61**	**100**	**88**	**83**	**68**	**89**	**91**	**84**	**104**	**121**	**112**	**108**	**1109**

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

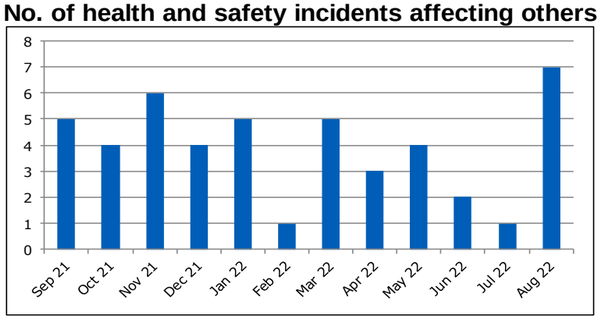
	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Total
No. of health & safety incidents	61	100	88	83	68	89	91	84	104	121	112	108	**1109**
Staff incident rate per month/year	0.6	0.9	0.8	0.8	0.6	0.8	0.8	0.8	1.0	1.1	1.0	1.0	**10.2**

No. of health and safety incidents affecting patients:



	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Total
Accident	18	17	13	7	11	11	17	19	25	20	20	9	**187**
Blood/bodily fluid exposure (dirty sharps/splashes)	2	2	0	3	0	1	4	2	1	1	1	1	**18**
Environmental Issues	3	3	4	4	0	4	3	2	1	4	12	2	**42**
Equipment / Device - Non Medical	0	2	2	0	1	2	1	0	1	1	2	1	**13**
Moving and Handling	1	2	0	0	3	1	1	0	0	5	2	2	**17**
Sharps (clean sharps/incorrect disposal & use)	5	2	3	3	3	2	1	0	0	3	2	2	**26**
Violence & Aggression	7	9	16	5	14	11	8	13	18	16	20	8	**145**
Total	**36**	**37**	**38**	**22**	**32**	**32**	**35**	**36**	**46**	**50**	**59**	**25**	**448**

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



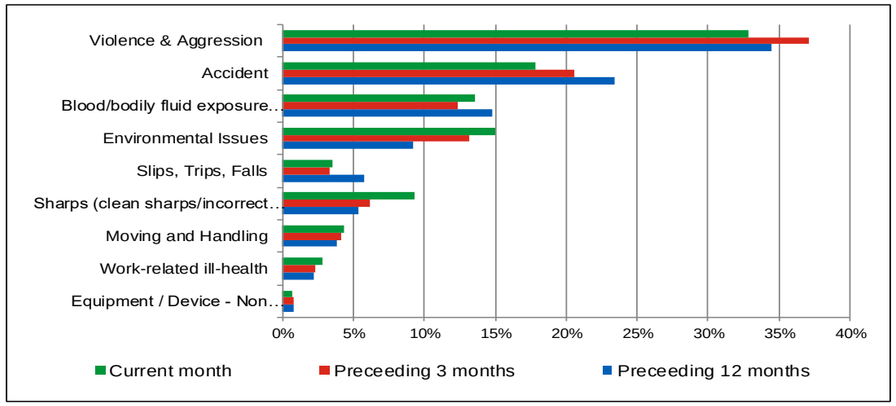
	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Total
Accident	3	2	1	1	1	0	0	0	2	1	0	0	**11**
Environmental Issues	1	0	0	1	3	0	1	0	2	0	0	2	**10**
Sharps (clean sharps/incorrect disposal & use)	0	0	0	0	0	0	0	0	0	0	0	1	**1**
Slips, Trips, Falls	0	0	3	1	0	0	1	0	0	1	0	1	**7**
Violence & Aggression	1	2	2	1	1	1	3	3	0	0	1	3	**18**
Total	**5**	**4**	**6**	**4**	**5**	**1**	**5**	**3**	**4**	**2**	**1**	**7**	**47**

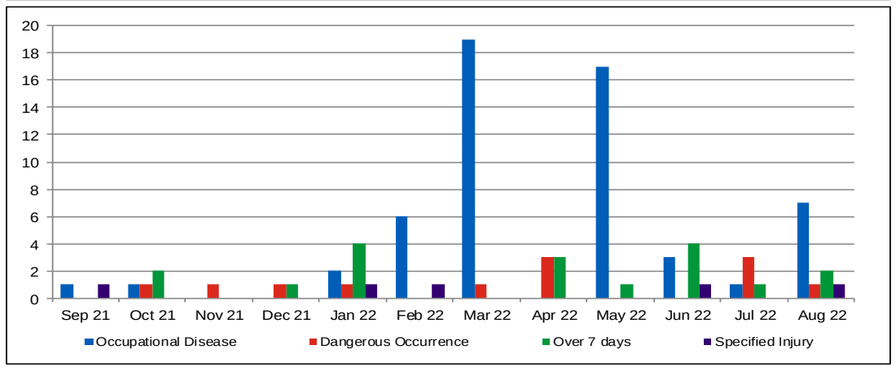
Health and Safety Incidents

Cambridge University Hospitals NHS Foundation Trust

Health and Safety

No. of health and safety incidents reported by division:	Trustwide	Division A	Division B	Division C	Division D	Division E	Corporate	Estates
No. of health and safety incidents reported in a rolling 12 month period:	**1604**	**317**	**234**	**479**	**293**	**154**	**49**	**78**
Accident	**376**	86	68	92	59	35	8	28
Blood/bodily fluid exposure (dirty sharps/splashes)	**237**	70	40	47	44	31	4	1
Environmental Issues	**148**	28	35	13	22	28	7	15
Equipment / Device - Non Medical	**13**	3	1	5	4	0	0	0
Moving and Handling	**62**	11	15	11	14	4	2	5
Sharps (clean sharps/incorrect disposal & use)	**86**	34	13	13	6	12	6	2
Slips, Trips, Falls	**92**	21	21	16	7	10	7	10
Violence & Aggression	**554**	54	33	279	131	32	10	15
Work-related ill-health	**36**	10	8	3	6	2	5	2





A total of 1,604 health and safety incidents were reported in the previous 12 months.

793 (49%) incidents resulted in harm. The highest reporting categories were violence and aggression (35%), accidents (23%) and blood/bodily fluid exposure (15%).

1,109 (69%) of incidents affected staff, 448 (28%) affected patients and 47 (3%) affected others ie contractors and members of the public.

The highest reported incident categories for staff were: violence and aggression (35%), blood/bodily fluid exposure (20%) and accidents (16%).

The highest reported incident categories for patients were: accidents (42%), violence & aggression (32%) and environmental issues (9%).

The highest reported incident categories for others were: violence and aggression (38%), accidents (23%) and environmental issues (21%).

Staff incident rate is 10.2 per 100 members of staff (by headcount) over a rolling 12 month period.

The highest reporting division was division C with 479 incidents. Of these, 59% related to violence & aggression.

In the last 12 months, the highest reported RIDDOR category was occupational disease (62%). 37% of RIDDOR incidents were reported to the HSE within the appropriate timescale. In August 2022, 11 incidents were reported to the HSE:

Over 7 day injury (2)
- The Injured Person (IP) was transferring a patient on a trolley. The IP slipped on a patch of water in the corridor. Whilst trying to get up from the initial fall, the IP slipped again.
- The IP bent down to pick up oxygen/air pipes from a ventilator and struck their forehead and eye socket against the metal door of the ventilator. The IP sustained a laceration to their eyebrow and symptoms of concussion.

Occupational disease (7)
- Covid-19: 7 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.

Dangerous occurrence (1)
- A patient had been scratching themselves and drawn blood. The patient then scratched the IP and also drew blood. The patient was Hep B/C positive.

Specified injury (1)
- The IP went into a side room to assess a patient. On exiting, the IP slipped on a wet floor and sustained an avulsion fracture of right 5th metacarpal bone. The floor had been wet due to being cleaned whilst the IP had been in the side room.

Author(s): Helen Murphy

Owner(s):

Together-Safe | Kind | Excellent

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

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Safe
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Excellent

Report to the Board of Directors: 12 October 2022

Agenda item	9.1
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, 6 October 2022

Executive Summary

The nursing and midwifery safe staffing report for August 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 August 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: 12 October 2022

Executive Summary

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

The vacancy position has increased slightly in August for Registered Nurses (RNs) at 9.1% compared to 8.8% in July, registered children's nurses (RSCN) at 24.4% compared with 23.5% in July, maternity care assistants (MCAs) to 20.2% from 15.4% in July and Health Care Support Workers (HCSWs) at 14.1% compared to 13.8% in July. Conversely, there has been a slight decrease in the vacancy position for Registered Midwifes (RMs) at 12.35% compared to 13% in July.

Turnover rate remains high at 14.5% for RNs, 15.3% for RMs, 17.7% for RSCNs and 19.8% for HCSWs. The main reason for leaving for RN's, HCSWs and RSCNs is voluntary resignation – relocation whereas for RMs it is cited as being due to Voluntary resignation – work/life balance.

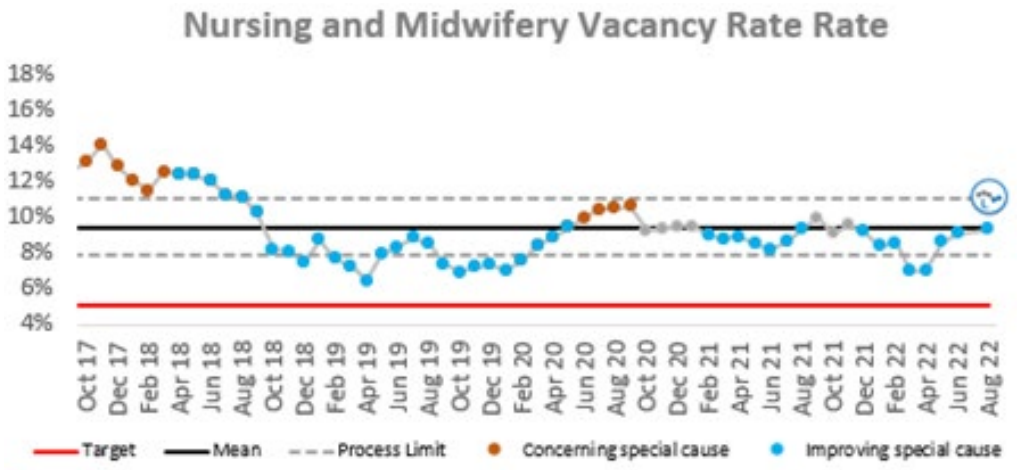
The planned versus actual staffing report demonstrates that 9 clinical areas reported <90% rota fill in August. The overall fill rate for maternity has increased slightly to 86% in August compared to 85% in July. The total unavailability in August has remained relatively static at 31.1% compared with 30.9% in July. The majority of unavailability (17.5%) is due to planned annual leave, sickness absence has decreased slightly to 7.7% from 9.0% in July. Additionally, 1.6% of working time was unavailable due to other leave including medical self isolation which is comparable to July (1.8%), 2.4% was due to study leave and 1.9% was due to supernumerary time.

In order to mitigate staffing risks, the number of requests for bank workers remains high with an average of 2111 shifts per week requested for registered staff and 1883 shifts requested for Health care support workers and Maternity support workers per week with an average bank fill rate of 68.8% for registered staff and 59.9% for Health Care Support workers. In addition, the equivalent of 50.93 WTE 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 284 working hours being redeployed each day of which 96.9% of the redeployed hours have been within division.

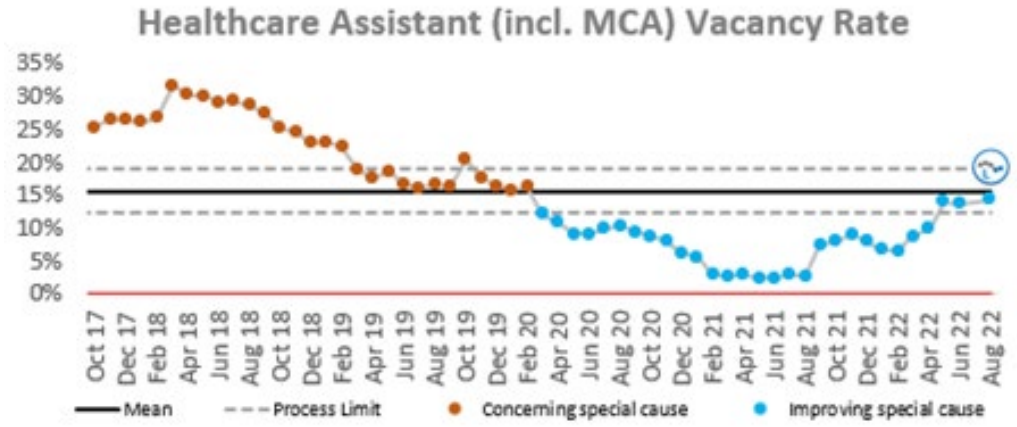
There has been a significant decrease in the number of occasions that 1 critical care nurse has needed to care for more than 1 level 3 patient (13 occasions compared to 45 in July). Additionally there have been 71 occasions where there has been no side room co-ordinator (147 in July). Any concerns with 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.

Combined Nursing and Midwifery Staffing Position Vacancy Rates

Graph 1. Nursing and midwifery vacancy rates



Graph 2. Healthcare Assistant vacancy rates



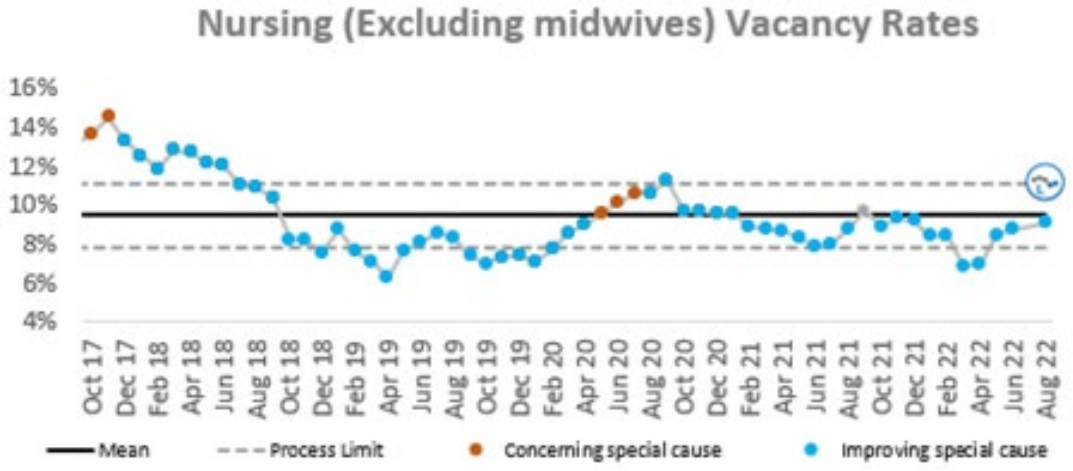
Vacancy position

The combined vacancy rate for Registered Nurses (RNs) and Registered Midwives (RMs) has remained relatively static in August at 9.3% compared to 9.1% in July. The vacancy rate for Health care support workers (HCSWs) (including Maternity Care Assistants (MCAs) has increased slightly to 14.4% from 13.9% in July. When broken down further into Nursing and Midwifery specific vacancies, the MCA workforce vacancy rate has increased to 20.2% from 15.4% in July and the HCSW vacancy rate (excl MCA) is 14.1% compared to 13.8% in July.

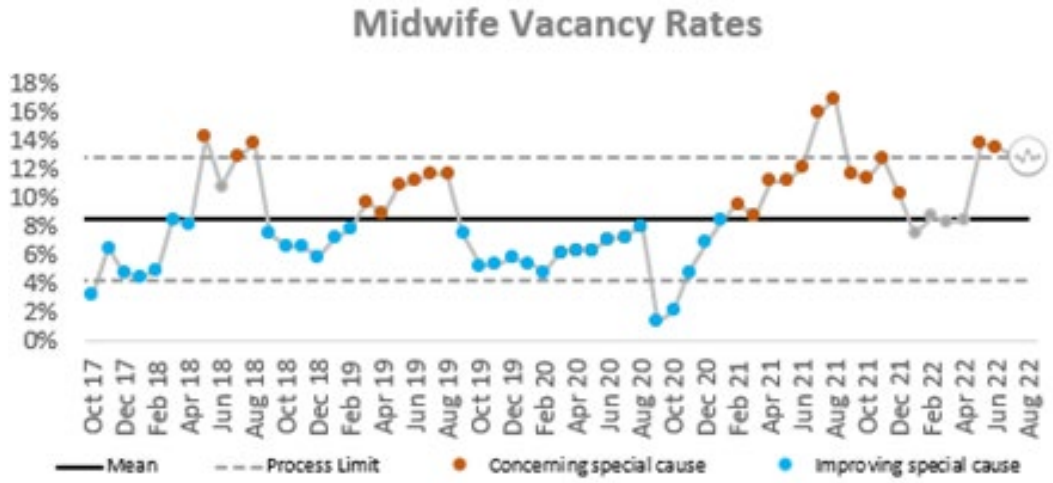
The HCSW (including MCAs) turnover rate remains high at 19.8% (19.2% July). The main reason for HCSWs leaving remains voluntary resignation – relocation (30.4%) and the next highest reason is voluntary resignation – work life balance (22.8%) . The leavers destination is unknown for the majority of HCSWs (47.7%), 15.2% of HCSWs 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

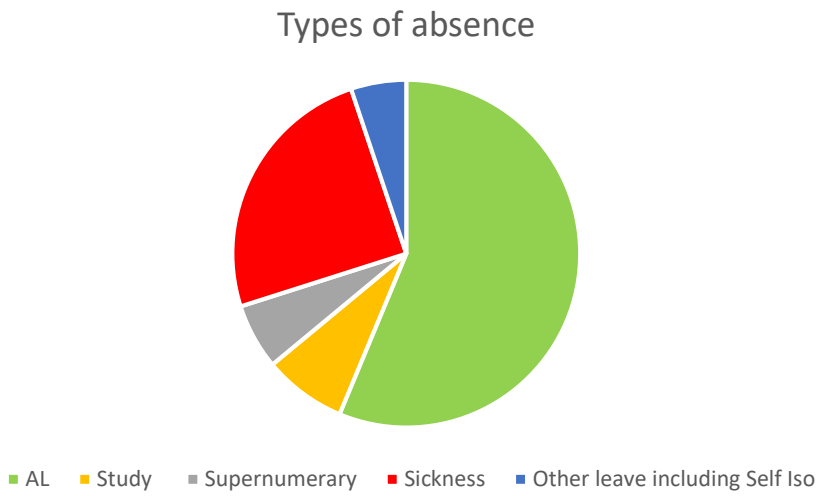
The vacancy rate for Registered Nurses working in adult areas has increased slightly to 9.1% compared to 8.8% in July. The vacancy rate for registered children's nurses has increased slightly to 24.4% compared with 23.5% in July.

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 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. In August, there has been a slight decrease to 12.35% compared to 13.0% in July.

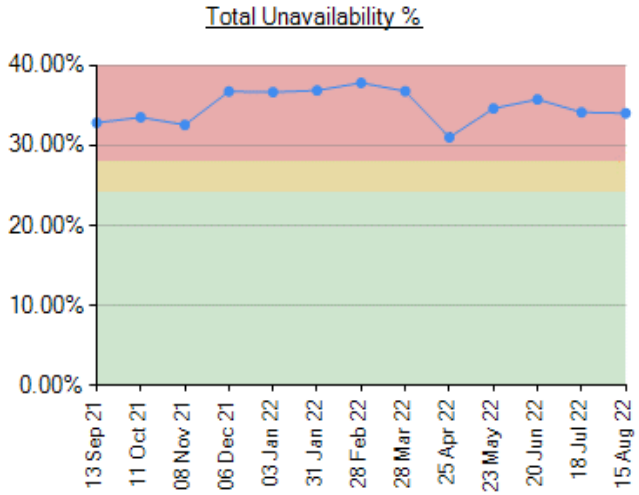
The turnover rate in August remains high at 14.5% for RNs in adult areas which is comparable to July (14.5%), 17.7% for Registered children's nurses (19.1% in July) and 15.3% for RMs (17.3% in July). The main reason for leaving is voluntary resignation – relocation for RNs (48.1%). The main reason for RMs leaving is voluntary resignation – work life balance (25%). The leavers destination data demonstrates that 33.1% of RNs and 36.1% of RMs are leaving to take up employment in other NHS organisations. 25% of RMs are leaving for no employment compared with 7.0% of RNs.

Unavailability for Registered Nurses, Midwives and Health Care Support Workers

Graph 5. Unavailability of staff



Graph 6. Types of absence



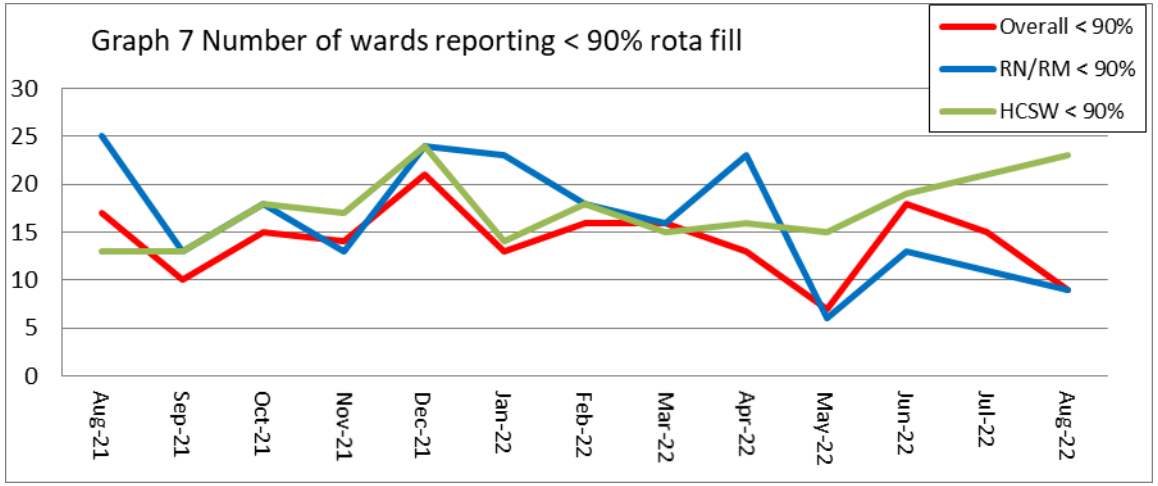
Unavailability of staff

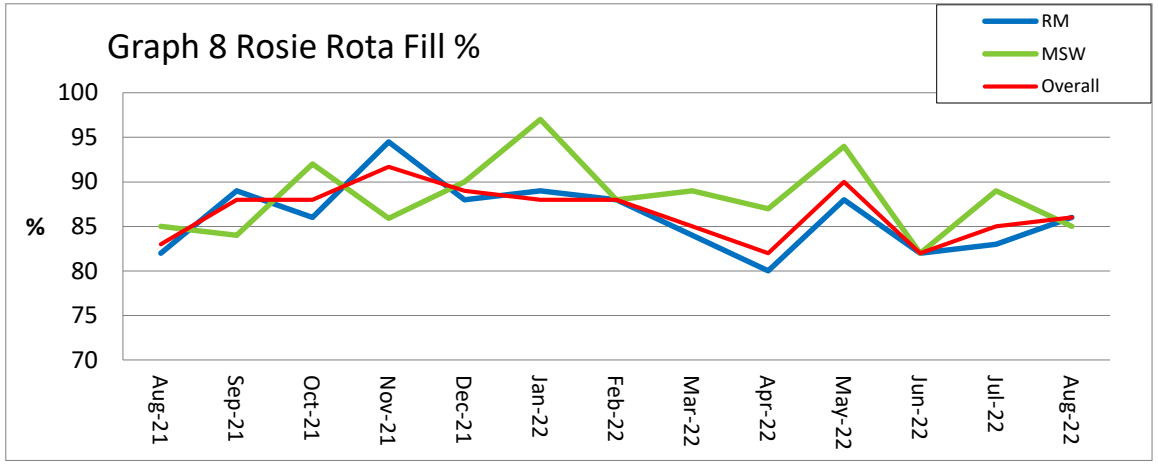
Unavailability relates to periods of time where an employee has been given leave from their regular duties. This might be due to circumstances such as annual leave, sick leave, study leave, self isolation, carers leave etc.

The total unavailability of the workforce working time in August has remained relatively static at 31.1% compared with 30.9% in July as illustrated in Graph 5.

Graph 6 illustrates the percentage breakdown of the type of unavailability. The majority of unavailability (17.5%) 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 August sickness absence has decreased slightly to 7.7% compared with 9.0% in July. Additionally, 1.6% of working time was unavailable due to other leave including medical self isolation which is comparable to July (1.8%), 2.4% was due to study leave and 1.9% 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 had been a decreasing trend over the last 3 months with 9 ward areas reporting overall fill rates of <90% in August compared to 15 in July. The number of areas reporting <90% rota fill for registered (RN/RM) fill rates has decreased slightly to 9 compared to 11 in July. Conversely, the number of areas reporting <90% rota fill for HCSWs is an increasing trend with 23 clinical areas reporting HCSW fill rates of <90% in August compared to 21 in July.

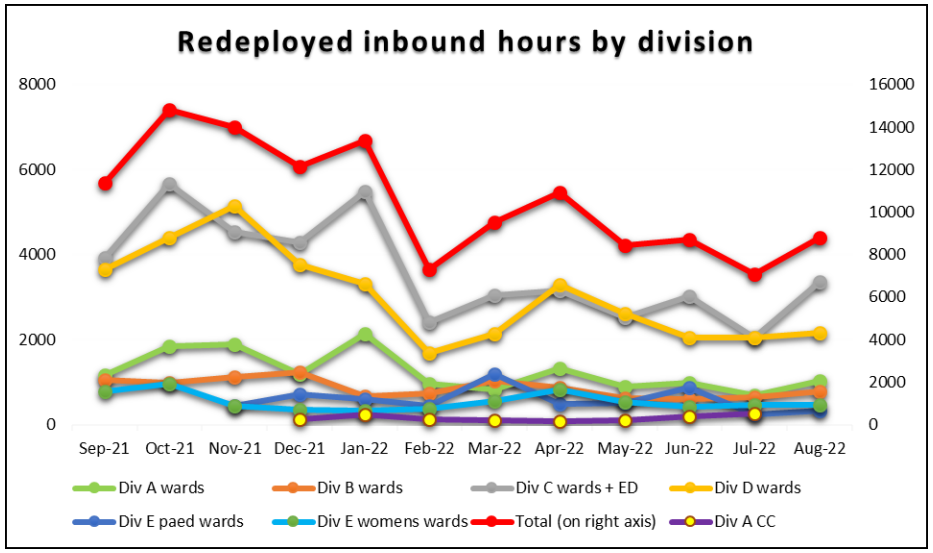
Division E were the only division to report overall rota fill rates of <90% in August with 8 areas across paediatrics and maternity reporting fill rates of <90%. Appendix 1, details the exception reports for all areas reporting fill rates of <90%.

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 (13 occasions compared to 45 in July). Additionally there have been 71 occasions where there has been no side room co-ordinator (147 in July). 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.

Midwifery & MSW fill rate

Graph 8 illustrates that the overall fill rate for maternity has increased slightly to 86% compared to 85% in July. The lowest fill rates have been seen in the Rosie birth centre (77%).

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 August has increased with an average of 284 working hours being redeployed per day compared with 237 hours in July. This equates to 24 long day or night shifts per day. The majority of redeployments are within division (96.9% compared to 3.1% 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.

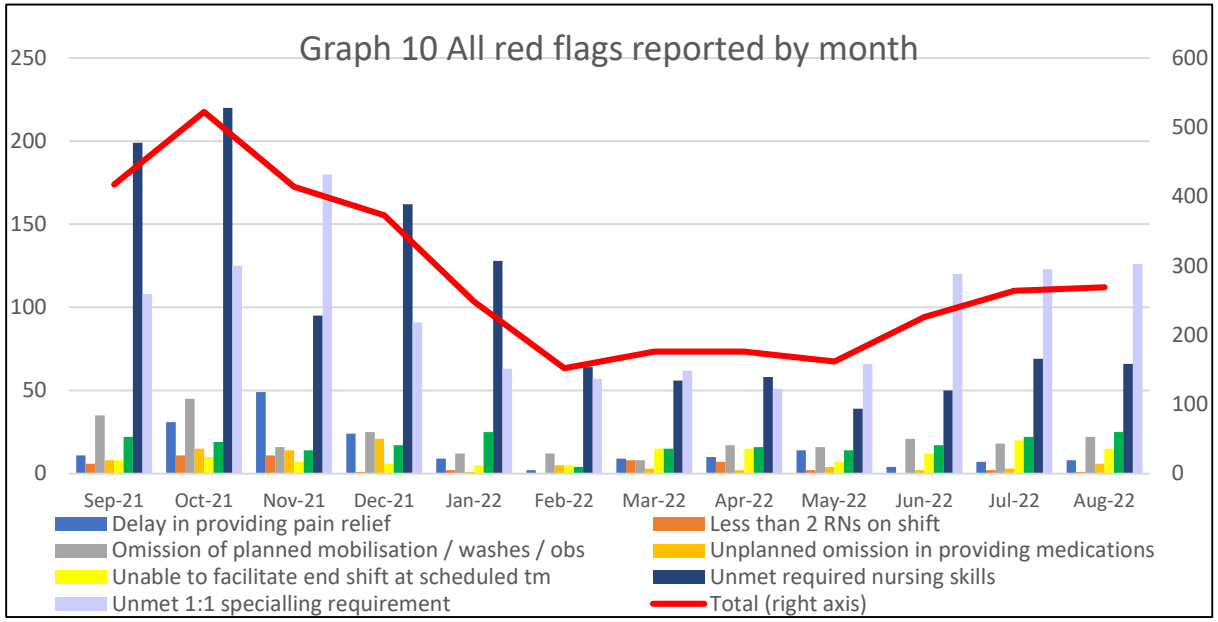
Nursing Pipeline

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 13.45% 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.

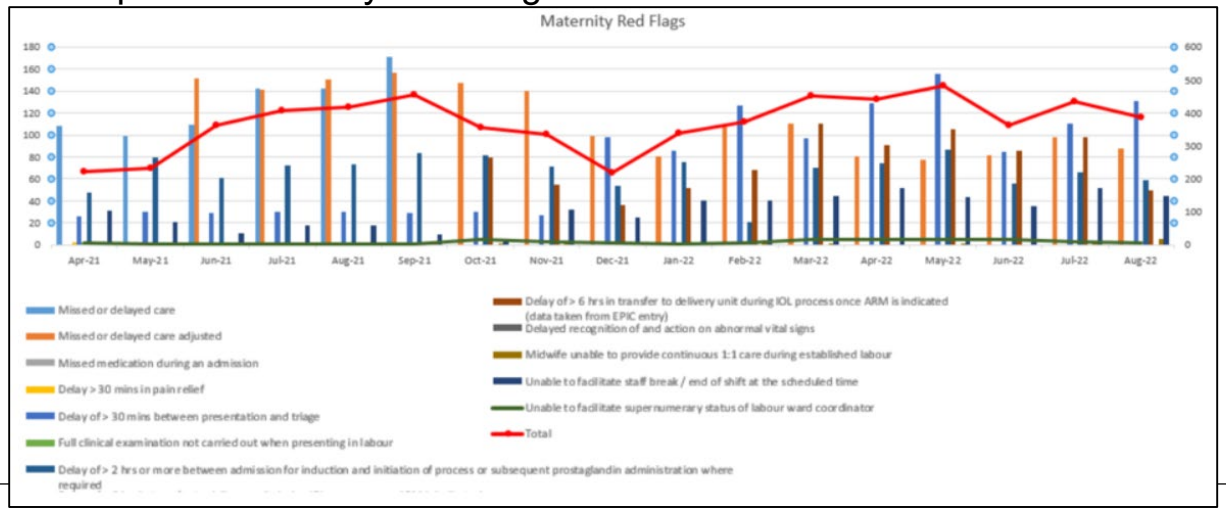
Appendix 3 provides detail on the forecasted position in relation to the number of Paediatric band 5 RN and HCSW vacancies up to March 2023. Numbers are based on those interviewed and offered positions in addition to planned campaigns. The current forecast demonstrates a year end band 5 Paediatric RN vacancy position of 29.02% and a band 2 HCSW position of 3.4%.

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.

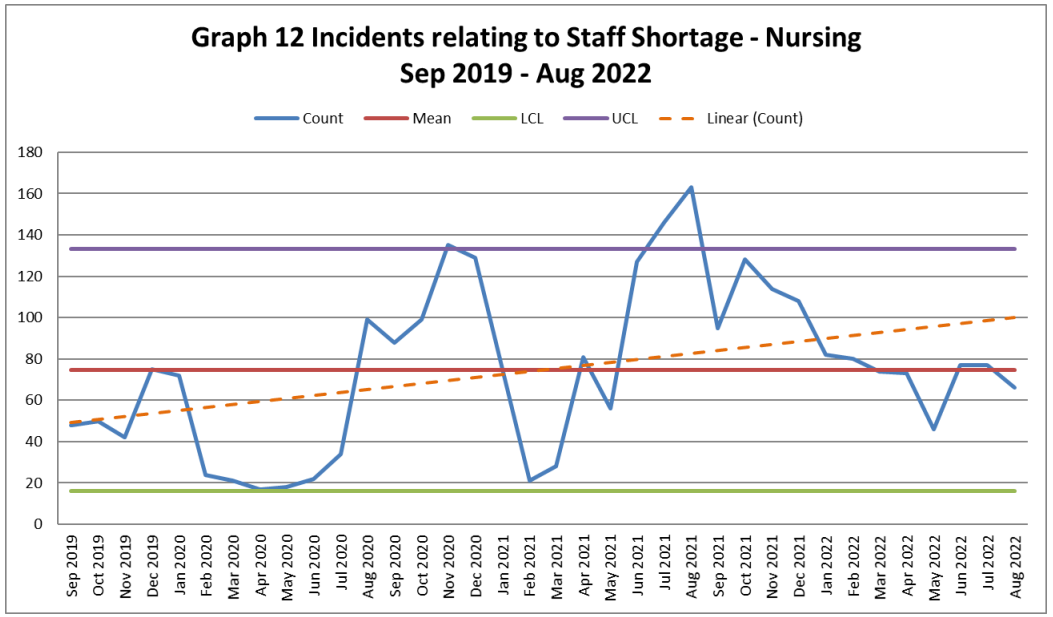
Nursing red flags

Graph 10 illustrates that the number of red flags reported in August has remained relatively static at 269 compared with 265 in July. The highest number of red flags reported in August was in relation to an unmet 1:1 specialling requirement (126 compared with 123 in July). A trust wide improvement project focusing on specialling is being developed to review specialling across the organisation. Additionally, 66 red flags were reported in relation to an unmet required nursing skills compared with 69 in July.

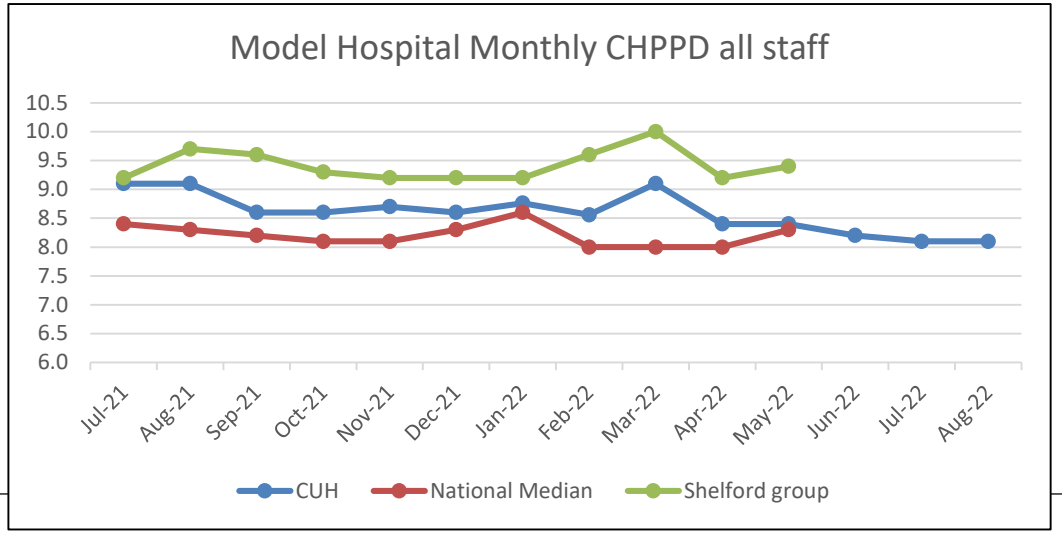
Maternity red flags

The number of maternity red flags reported in August has decreased to 388 compared with 435 in July. Graph 11 illustrates the red flags that have been reported. 33.8% of these red flags were due to a delay of >30mins between presentation and triage, 22.7% of these red flags were due to missed or delayed care and 20.5% were due to a delay of >2hrs or more between admission for induction and initiation of the process. This is reflective of the high levels of activity and difficulty in maintaining flow.

Safety and Risk



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 66 incidents reported relating to nurse staffing in August which has decreased from the number reported in July (77).

The majority of the incidents related to staffing levels in August were reported by division C (25) and division D (25). Within Division C, Ward N3 reported the most incidents (5), the remaining incidents were reported evenly across the division. Within Division D, the majority of staffing incidents were reported on Ward D7 (17). Safety continues to be monitored through the site safety meetings.

Care hours per patient day (CHPPD)

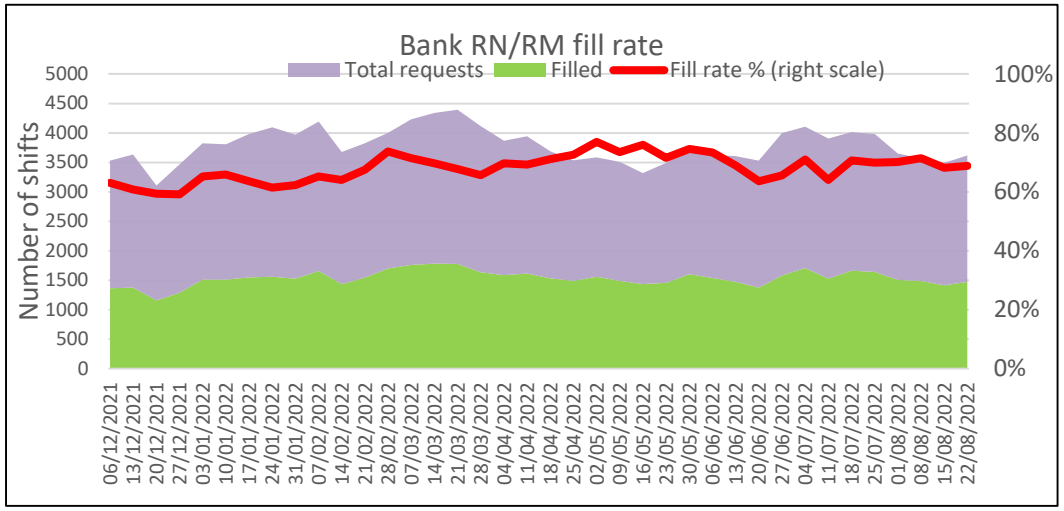
Care hours per patient day (CHPPD) is the total number of hours worked on the roster (clinical staff including AHPs) divided by the bed state captured at 23.59 each day. NHS Improvement began collecting care hours per patient day formally in May 2016 as part of the Carter Programme. All Trusts are required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

CUH CHPPD recorded for August 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).

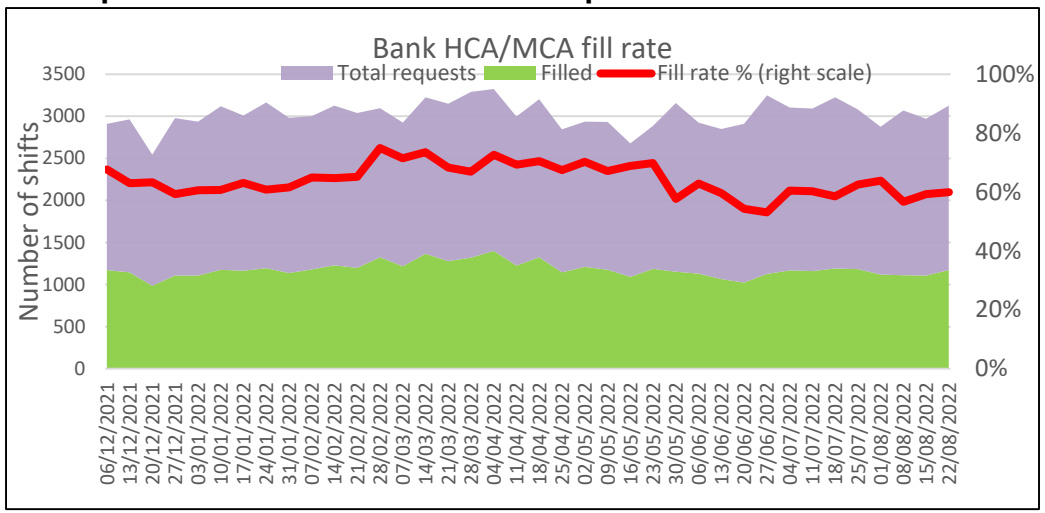
In maternity, from 1 April 2021, the total number of patients now includes babies in addition to transitional care areas and mothers who are registered as a patient. CHPPD for the delivery unit in August was 13.33 which is slightly lower than July (14.41).

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 2111 shifts per week requested and an average bank fill rate of 68.8%.

The number of requests for Health care support workers and Maternity support workers remains high with an average of 1883 shifts per week requested and an average bank fill rate of 59.9%.

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 E

Division E	% fill registered	% fill care staff	Overall filled %	CHPPD	Analysis of gaps	Impact on Quality / outcomes	Actions in place
C2	86%	78%	86%	9.78	Current shortfall of 15 WTE RN vacancy and 2.84 HCSW, 9 RN WTE pipeline in. 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 CPF , senior sister and CPF within roster. Rate 3 for all staff. New starters commencing from September.
D2	88%	132%	97%	10.65	Current shortfall of 10 WTE RN vacancy and 3 HCSW, 6 RN WTE and 3 HCSW pipeline in. 1.6 WTE pipeline out.	Reduced occupancy , no impact on NQM ,patient experience feedback.	Currently utilising agency nurses with paediatric training. Three times review a day of occupancy and staffing. Support from CPF and senior sister rostered Rate 3 for all staff.
PICU	74%	95%	77%	28.89	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.
Neonatal ICU	82%	51%	79%	11.92	Current shortfall of 30.8 WTE RN vacancy, 15.8 WTE pipeline in. 2.6 WTE pipeline out. Inclusive of bridging the gap extra posts.	Increased pressure on QIS staff to support junior team, no change to NQM .Positive patient experience feedback.	Three times review a day of occupancy and staffing. Rate 3 for all staff. Support from unit when possible. Non clinical rostered posts inclusive in roster. Loss of MoD and at times 1 NIC.
Delivery Unit	88%	74%	84%	13.33	shortfall of 26.98 wte across the whole service, large number are on DU further compromised by sickness rates in this area of 7.5%	delay to continuation of IOL and risk of loss of SN stat and 1:1 care in labour which is a CNST standard and a safety risk	26 WTE's joining from early october. These will be rostered throughout the rosie. They are junior staff requiring support and SN period
Lady Mary	84%	84%	84%	4.49	Overall vacancy rate also effecting this area	Effects service user experience, trends of complaints around support with BF. Also have delays with giving AB to neonates due to skill mix and availability of second checker	New starters to area will improve vacancy rate however will need support and SN period
Rosie Birth Centre	74%	87%	77%	11.79	Overall vacancy rate effecting this areas, further compromised with maternity leavers sickness overall 13.8% at the start of august with improves to 0.8% by the end of august. Small team which is effected by spikes in sickness absence	Ability to keep the area open when staffing is compromised across the whole service. This effects womens choice around place of birth and places women in a high risk environment when they don't need to be which could cause further intervention	CoC team members rotating onto the rota to provide extra support. Template has gone up to 3 per shift from 2
Sara Ward	86%	78%	83%	4.82	vacancy rate across the whole service with gaps in this area further compromised by sickness at 9.5% in this area at the beginning of august. This improves to 3.7% by middle of august	Delay to starting IOL, delay with MEOWS compliance and poor patient experience	2 IR midwives working within the area as SN awaiting their PIN and 3 further joining the area in September. There are also have new starters joining in October that will be allocated to the ward

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	**1602**	**1768**	**9.41%**	**166.35**	**6.05**
Sep-22	3	10				24	37	28	27	**1584**	**1768**	**10.43%**	**184.35**	**9**
Oct-22	7	18	12			19	56	22	20	**1598**	**1773**	**9.89%**	**175.35**	**34**
Nov-22	5					30	35	18	14	**1601**	**1812**	**11.65%**	**211.05**	**17**
Dec-22	10					30	40	18	15	**1608**	**1812**	**11.26%**	**204.05**	**22**
Jan-23	8			32		10	50	18	15	**1625**	**1812**	**10.32%**	**187.05**	**32**
Feb-23	6					24	30	18	15	**1622**	**1812**	**10.49%**	**190.05**	**12**
Mar-23	5	5	5			24	39	18	15	**1628**	**1881**	**13.45%**	**252.85**	**21**
TOTAL	71	33	17	58	0	281	461	241	173	**1628**	**1880.5**	**13.45%**	**252.85**	**219.65**

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	183.89	284.41	35.34%	100.52	2.47
Sep-22	3			4	0	7	2	3	185.89	284.41	34.64%	98.52	5
Oct-22	2	8	11		1	22	5	2	200.89	284.41	29.37%	83.52	17
Nov-22		9	2		1	12	1	2	209.89	284.41	26.20%	74.52	11
Dec-22	1		2		1	4	5	1	207.89	284.41	26.91%	76.52	-1
Jan-23			1		1	2	6	1	202.89	284.41	28.66%	81.52	-4
Feb-23	2				1	3	2	1	202.89	284.41	28.66%	81.52	1
Mar-23	2				1	3	3	1	201.89	284.41	29.02%	82.52	0
TOTAL	**14**	**17**	**18**	**4**	**15**	**68**	**36.53**	**18**	**201.89**	**284.41**	**29.02%**	**82.52**	**31.47**

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	854	970	12.0%	117
Sep-22	28		28	20	862	970	11.2%	109
Oct-22	25	37.5	62.5	20	904	970	6.8%	66
Nov-22	25		25	20	909	970	6.3%	61
Dec-22	25		25	15	919	970	5.3%	51
Jan-23	25		25	20	924	970	4.8%	46
Feb-23	25		25	15	934	970	3.7%	36
Mar-23	25	40	65	15	984	1,018	3.4%	34
TOTAL	**276.8**	**85.5**	**362.3**	**193**	**984**	**1,018**	**3.4%**	**34**

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

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Report to the Board of Directors: 12 October 2022

Agenda item	9.5
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 M5
Previously considered by	Performance Committee, 6 October 2022

Executive Summary

The report provides details of financial performance during 2022/23 Month 5 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 5.
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 5.

Contents

Trust actual surplus / (deficit)

(£0.5m)	*Actual (adjusted)**
(£0.5m)	*Plan (adjusted)**
£3.4m	*Actual YTD (adjusted)**
£3.4m	*Plan YTD (adjusted)**

Covid-19 expenditure and system Covid-19 funding

£1.6m	*Covid actual in month*
£1.8m	*Covid plan in month*
£1.8m	*Covid funding in month*
£10.4m	*Covid actual YTD*
£9.9m	*Covid plan YTD*
£9.2m	*Covid funding YTD*

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

Net current assets

(£53.7m)	*Actual*
(£54.8m)	*Plan*

Debtor days

21	*This month*
16	*Previous month*

Payables performance (YTD) **

Actual	85.9%	*Value*
Plan	88.4%	*Quantity*

Cash and EBITDA

Cash

£183.0m	*Actual*
£166.6m	*Plan*

EBITDA

£20.9m	*Actual YTD*
£21.1m	*Plan YTD*

Capital expenditure

£2.4m	*Capital - actual spend in month*
£10.0m	*Capital - actual spend YTD*
£19.5m	*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*
£5.7m	*ERF forecast actual YTD*
£5.7m	*ERF plan YTD*

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

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

Trust performance summary - Key indicators

Month 5 Financial Performance

- **The month 5 year to date position is a £3.4m surplus for performance management purposes**. This is in line with the Trust financial plan.
- The month 5 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 £4.4m and fire prevention works income and expenditure underperformance of £3.8m (with the phasing of works not aligning to the plan position).
- The pay expenditure position is £1.9m favourable to plan year to date 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 in line with its expenditure plan at month 5 year to date but continues to perform below its planned levels of productivity.
- At month 5 the under performance in clinical activity can be valued at £19.4m with £15.7m of this from planned care services due to operational pressures and limitations, chiefly 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 £8-10m associated with operational delivery/capacity.
- Overall, with the reduction in productivity and additional capacity investments in year, we are performing at c.£27-29m 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 £10.4m of Covid-19 associated expenditure in the YTD, which is £0.5m above the plan.
- The Trust has received £9.2m 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 £5.7m year to date based on a fair share allocation. 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.
- For the full year the Trust has planned to receive £29.7m of ERF funding. 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 5 our cumulative position shows efficiencies reporting broadly on target at £27.3m year to date, versus plan of £27.3m.
- Pay efficiencies are currently reporting ahead of plan by £1.3m within this recurrent initiatives are (£2.0m) adverse to plan and non-recurrent schemes are £3.3m ahead of plan.
- For non-pay efficiencies, initiatives are adverse to plan by (£1.1m), largely being driven by a shortfall in recurrent schemes.
- Income efficiencies report broadly in line with plan, at £7.9m to month 5. This includes the planned non-recurrent campus development project income receipt of £4m.
- Efficiencies of £63.0m have been identified against target, of which £41.6m are identified as recurrent. This represents 66% of the total £62.0m plan.
- The Trust continues to look for efficiencies to bridge the recurrent £9.4m gap versus the c.£51m target and to mitigate any scheme slippage.

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 £10.0m in it's capital programme so far - £9.5m below the planned figure of £19.5m. The year-end forecast 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:

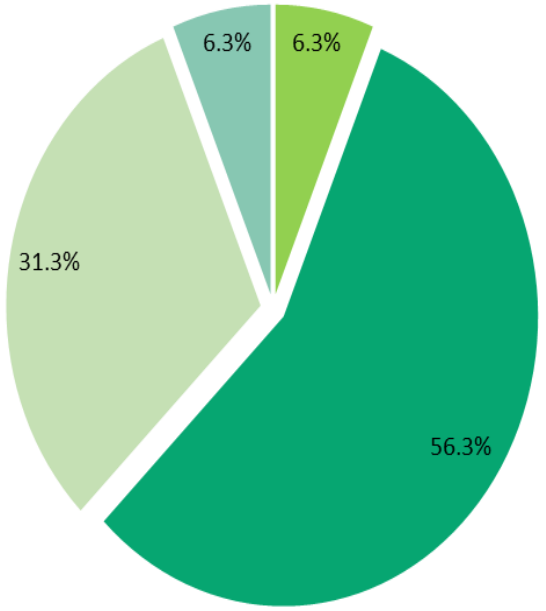
    1) The plan retains CUH support to our ICS of £11m to ensure that all ICS organisations can deliver break-even financial performance.

- Budgets have been aligned to the final 20 June 2022 plan and form the basis of the financial analysis produced within this report.

Month 5 performance against plan

	In Month				Year to Date				Full Year
£ Millions	**Budget**	**Actual**	**Variance**	**Variance (Exc. Covid)**	**Budget**	**Actual**	**Variance**	**Variance (Exc. Covid)**	**Budget**
Clinical Income - exc. D&D*	69.9	69.6	(0.4)	(0.4)	351.4	350.0	(1.4)	(1.4)	858.9
Clinical Income - D&D*	13.5	15.1	1.6	1.6	67.5	71.9	4.4	4.4	161.9
Covid - Income top-up & outside envelope	1.8	1.8	0.0		9.0	9.2	0.2		21.6
ERF income	1.6	1.6			5.7	5.7	0.0	0.0	29.7
Devolved Income	14.8	14.5	(0.4)	(0.4)	78.7	74.4	(4.2)	(4.2)	163.3
Total Income	**101.7**	**102.6**	**0.9**	**0.9**	**512.2**	**511.1**	**(1.0)**	**(1.2)**	**1,235.4**
Pay	54.1	53.1	1.0	1.0	267.9	265.3	2.6	2.6	656.4
Drugs	14.4	14.9	(0.5)	(0.5)	72.1	74.9	(2.8)	(2.8)	173.0
Non Pay	28.3	30.1	(1.8)	(1.8)	141.2	139.7	1.5	1.5	341.3
Covid - Pay	1.2	1.2	(0.0)		6.2	7.0	(0.8)		14.4
Covid - Drugs	0.0	0.0	0.0		0.2	0.1	0.0		0.4
Covid - Non pay	0.6	0.4	0.2		3.5	3.2	0.3		7.4
Operating Expenditure	**98.6**	**99.7**	**(1.0)**	**(1.2)**	**491.1**	**490.2**	**0.8**	**1.4**	**1,192.9**
EBITDA	**3.0**	**2.9**	**(0.1)**	**(0.3)**	**21.1**	**20.9**	**(0.2)**	**0.1**	**42.5**
Depreciation, Amortisation & Financing	3.5	3.5	0.0	0.0	17.7	17.7	0.0	0.0	42.5
Reported gross Surplus / (Deficit)	**(0.5)**	**(0.6)**	**(0.1)**	**(0.3)**	**3.4**	**3.2**	**(0.2)**	**0.2**	**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	0.1	0.1	0.1	0.0	0.2	0.2	0.2	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	**(0.5)**	**(0.5)**	**(0.0)**	**(0.2)**	**3.4**	**3.4**	**(0.0)**	**0.3**	**0.0**

Summary financial position



Covid-19 revenue cost breakdown: £1.6m in M5

- £0.1m - Backfill for higher sickness absence
- £0.9m - Segregation of patient pathways
- £0.5m - Existing workforce additional shifts
- £0.1m - Miscellaneous others

Key messages:

The Trust has recorded £1.6m of Covid expenditure in month 5, bringing the total year to date for 22/23 to £10.4m. This represents a £0.5m adverse variance against the plan of £9.9m.

The main areas of Covid investment in Month 5 are:

• Segregation of patient pathways	£0.9m
• Existing workforce covering additional shifts	£0.5m
• Backfill for higher sickness absence	£0.1m
• Miscellaneous expenditure	£0.1m

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 5 reflects a reduction against the first 4 months of the financial year, bringing the average monthly spend to £2.0m; a reduction of £0.2m per month.
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)	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr & May-22	Jun-22	Jul-22	Aug-22
Corporate	£0.7	£1.1	£1.5	£1.3	£1.5	£1.3	(£1.0)	£1.4	£0.6	£0.6	£0.2
Division A	£1.0	£1.3	£1.5	£1.2	£1.7	£1.2	£1.1	£0.7	£0.4	£0.4	£0.3
Division B	£0.4	£0.5	£0.1	£0.4	£0.3	£0.5	£0.5	£0.9	£0.4	£0.3	£0.3
Division C	£0.5	£0.5	£0.3	£0.5	£0.6	£0.5	£0.5	£0.7	£0.3	£0.4	£0.4
Division D	£0.5	£0.3	£0.2	£0.2	£0.2	£0.1	£0.2	£0.5	£0.3	£0.3	£0.1
Division E	£0.2	£0.2	£0.1	£0.1	£0.2	£0.2	£0.3	£0.4	£0.1	£0.2	£0.2
Total	**£3.4**	**£3.9**	**£3.8**	**£3.7**	**£4.5**	**£3.9**	**£1.5**	**£4.5**	**£2.2**	**£2.2**	**£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.

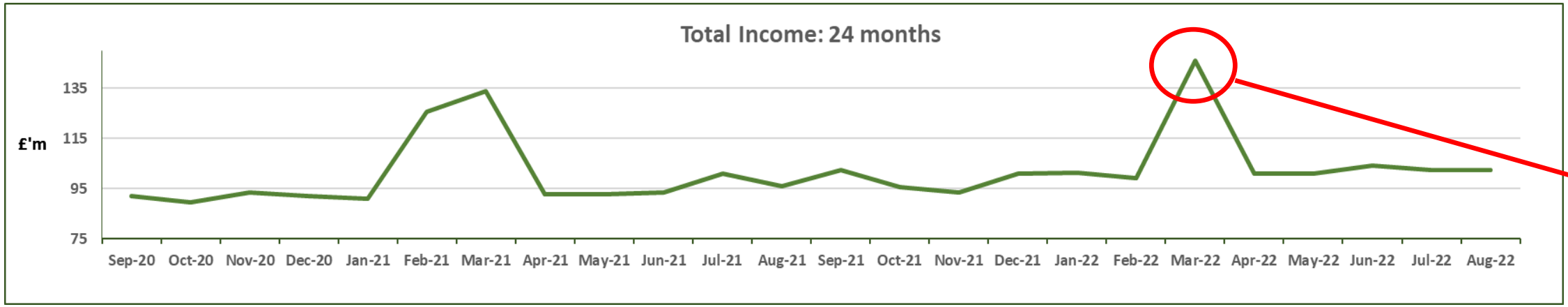
£'m	M5 YTD Plan	M5 YTD Actual	Variance	Key Variances
Operating income from patient care activities	439.3	442.5	3.1	Lower pass through drug recharges driven by Car-T (£3.4m) are offset by over achievement in other high-cost drugs leading to a net reported over performance in this area of £4.4m. Adverse activity levels across the divisions further reduces over performance to a reported level of £3.1m year to date.
Other operating income	72.9	68.7	(4.2)	Shortfall in income recognition is largely driven by Fire prevention works expenditure being lower than planned by (£3.8m). Additionally, lower activity/cost recharges are reported in Estates of (£0.7m) relating to rechargeable energy usage. Increases are expected in future months as activity recovers and prices are updated for inflation.
Total income	**512.2**	**511.1**	**(1.0)**	**Total income is behind plan year to date**
Employee expenses	(274.1)	(272.3)	1.8	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. It is notable that pay slippage is offset by pressure on Covid pay expenditure of (£0.8m).
Operating expenses excluding employee expenses	(230.3)	(231.2)	(1.0)	Cost pressures in timing of expenditure relating to pass through income across the divisions, along with unachieved CIPs drive the adverse variance. Global supply chain issues and inflationary pressures drive cost increases. It is notable that cost pressures have been offset by fire prevention works being lower than planned (£3.8m) and slippage on GLH incestment due to late NHS E approval of funding (£1.5m).
Operating surplus / (deficit)	**7.8**	**7.6**	**(0.2)**	**Operating position is broadly in line with plan**
Finance costs				
Finance expense	(3.0)	(3.0)	0.0	
PDC dividends payable/refundable	(1.4)	(1.4)	0.0	
Net Finance costs	**(4.4)**	**(4.4)**	**0.0**	
Reported gross surplus/(deficit)	**3.4**	**3.2**	**(0.2)**	**Performance is broadly in line with plan**
Add back technical adjustments:				
Impairments (AME)	0.0	0.0	0.0	
Capital donations/grants net I&E impact	0.0	0.2	0.2	
Net benefit of PPE consumables transactions	0.0	0.0	0.0	
Surplus/(Deficit) - NHS financial performance basis for the year to date	**3.4**	**3.4**	**(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 £3.4m.
- 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	11.6	(0.4)	60.1	53.9	(6.2)
Non-elective admissions	15.2	14.2	(1.1)	76.1	72.8	(3.4)
Outpatients	10.4	8.3	(2.1)	52.1	42.6	(9.5)
A&E	2.0	0.8	(1.2)	10.2	9.9	(0.3)
High-cost drugs income from commissioners	13.5	15.1	1.6	67.5	71.9	4.4
Other NHS Clinical Income	30.2	34.6	4.4	152.8	170.9	18.0
Covid - Income top-up & outside envelope	1.8	1.8	0.0	9.0	9.2	0.2
ERF	1.6	1.6	0.0	5.7	5.7	0.0
Total Clinical Income	**86.8**	**88.1**	**1.3**	**433.5**	**436.7**	**3.2**
Devolved Income	14.8	14.5	(0.4)	78.7	74.4	(4.2)
Total Trust Income	**101.7**	**102.6**	**0.9**	**512.2**	**511.1**	**(1.0)**

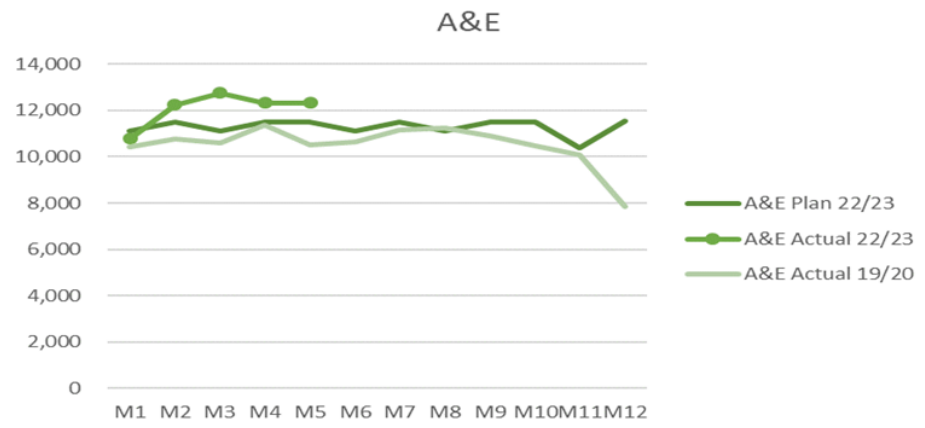
Key messages:

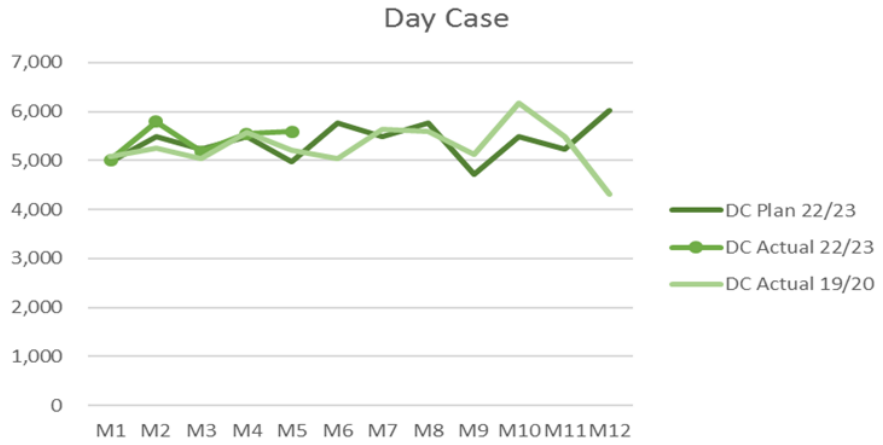
- The values included in the table for elective, non elective, outpatients and A&E income are as per regular reporting methods (PbR view). As the Trust's clinical income is predominantly through block contracts a block top-up is included within other clinical income.
- The total clinical income includes 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 £4.4m relating to high-cost drugs pass-through expenditure, which includes an under-performance by the Car-T service offset by over-performance for other high cost drugs. 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 £4.2m year to date. This is largely driven by fire prevention works expenditure being lower than plan (£3.8m). Additionally, lower activity/cost recharges are reported in Estates (£0.7m) relating to rechargeable energy usage. Increases are expected in future months as the impact of wider inflationary pressures become visible.

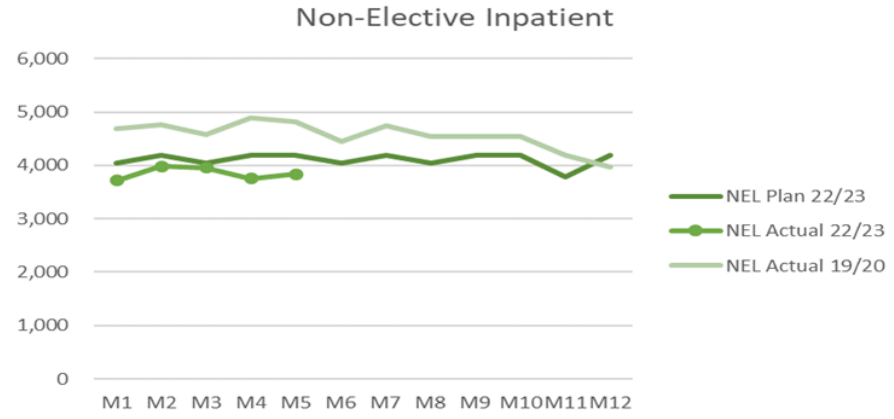
Note: The March 2022 figures include additional funding from NHSE/I for the extra 6% NHS pension contribution (£24.6m), The impact of R&D projects accounted for in M12 (£10.9m), apprenticeship funding (£2.4m), national PPE funding (£2.8m) and an NIHR R&D grant (£11.0m). All of which included matched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

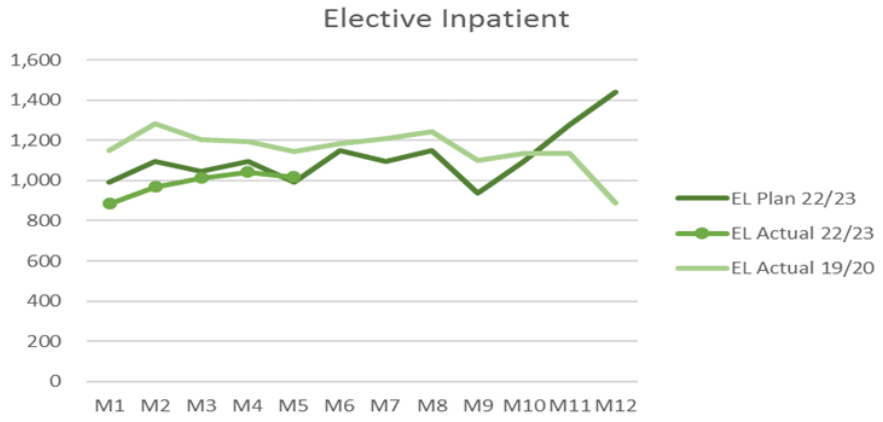
Clinical and other income

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







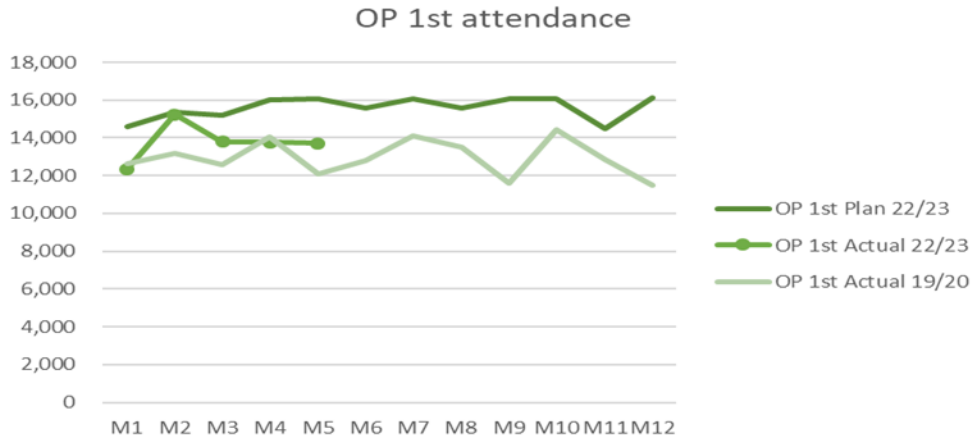


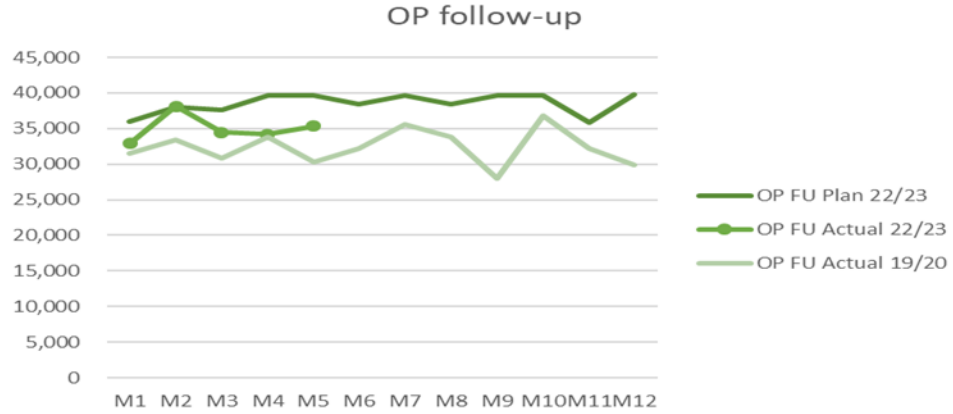
Key messages:

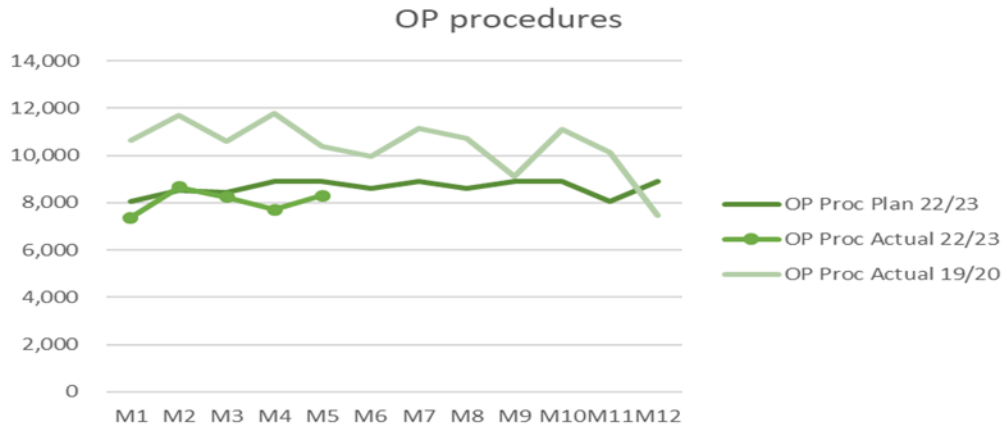
- A&E attendances are higher than both plan and 19/20 actuals at month 5, similar to previous months. Non elective spells continue to remain below plan and 19/20 actuals.
- Elective spells are close to plan at month 5, however, it is notable that the phasing of the plan increases from H2.
- Day cases are above both plan and 19/20 actuals.

Clinical and other income (continued)

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







Key messages:

- Outpatient attendances (first and follow-up) have continued at similar levels from month 3 onwards, but remain considerably below plan.
- Outpatient procedures continue to report both below both plan and 19/20 levels.
- Financial over performance relates to cost & volume drugs at month 5. High cost drugs are over performing by £9.9m but this is offset by an under performance on CAR-T drugs of £5.5m and in other areas of £1.2m.

	Income (£m)
Plan – Clinical Income	433.5
Actuals	436.7
Variance	3.2
Explanation for variance:	
Variable cost & volume of drugs	4.4
Other variable NHS clinical income	(1.2)

Please note – tables may not cross-cast due to rounding

Clinical and other income (continued)

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 M1-5 plan figures add to £5.7m.

ERF:

- Planned ERF in months 1 to 3 is £0.8m per month, increasing to £1.6m for months 4 and 5, totaling £5.7m (phased plan in table above).
- Using Trust operational performance year to date could lead to the following ERF funding being proposed:
  1) **21/22 H1 ERF methodology** – Against this methodology the Trust is over achieving against the adjusted baseline by 3%, which would lead to £1.6m ERF funding.
  2) **21/22 H2 ERF methodology -** Against this methodology the Trust is under achieving. Estimates indicate a performance of 81% in month 1, 87% in month 2 and 81% in month 3.
  3) **22/23 potential ERF methodology 1** – Draft national ERF data, at system level, for months 1 & 2 was released on 9th August. The ICB has raised queries with the national team to understand the data and the outputs.
  4) **22/23 potential ERF methodology 2** - national acknowledgement that Covid-19 levels so far in H1 exceeded the planned low Covid-19 scenario. Early intelligence would suggest this may lead to 50% FYE ERF levels being reimbursement (£14.9m) for months 1 to 6.

	ERF H1 21/22 Methodology			
	Activity			£
	19/20 YTD M5	22/23 YTD M5	%	22/23 YTD M5
EL	4,916	4,942	101%	£125,618
DC	32,027	32,711	102%	£474,415
OP	235,310	241,467	103%	£1,049,249
	272,253	**279,120**	**103%**	**£1,649,282**

	ERF H2 21/22 Methodology				
	M1	M2	M3	M4	M5
Adm	75%	79%	76%	84%	-
Non-Adm	90%	99%	90%	90%	-
Total	**81%**	**87%**	**81%**	**87%**	

Please note: M5 national data not yet available

Clinical Income – Elective Recovery Fund 2 (ERF)

ERF notes:

- ERF final guidance and methodology have not yet been published. The ERF tool for 22/23 has not yet been released.
- Draft ERF data, at system level, for months 1 & 2 were released on 9th August. These were data tables only without backing or methodology.
- Both the system and CUH have asked for formal methodology and a number of clarifying points.
- Proposed baseline adjustments (2,970 EL / £12.5m) have been accepted; however this is not transparent in the month 1 & 2 data.
- The tables on the right are the initial nationally published ERF performance percentages of current year priced volume weighted activity against the equivalent 19/20 values, for months 1 & 2.
- The figures for months 3 and 4 at CUH are estimates only based upon current draft data.
- Outpatient follow up performance is capped at 85% of baseline value regardless of performance.
- The overall figures for each month indicate an under performance for ERF.
- Given the uncertainty above, and current underperformance, up to £5.7m of ERF income at month 5 year to date may be at risk, however, potential methodology 1 for H1 may deliver over performance and it remains expected that nationally cover will be provided for H1 performance to ensure a fair share of planned ERF income is paid.

22/23 potential ERF methodology 1 – Provider & System

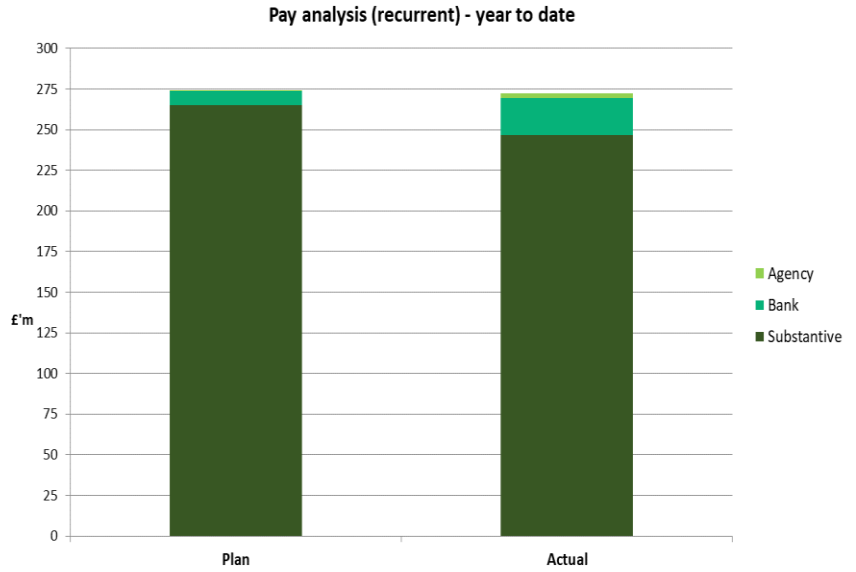
	CUH Provider			
	M1	**M2**	**M3**	**M4**
Day Case	96%	113%	101%	106%
Elec spell	90%	77%	96%	96%
OP 1st att	102%	109%	105%	105%
OP proc	88%	93%	94%	94%
Overall	**94%**	**95%**	**98%**	**98%**

	QUE System Level			
	M1	**M2**	**M3**	**M4**
Day Case	91%	106%		
Elec spell	95%	97%		
OP 1st att	99%	100%		
OP proc	89%	97%		
Overall	**94%**	**99%**		

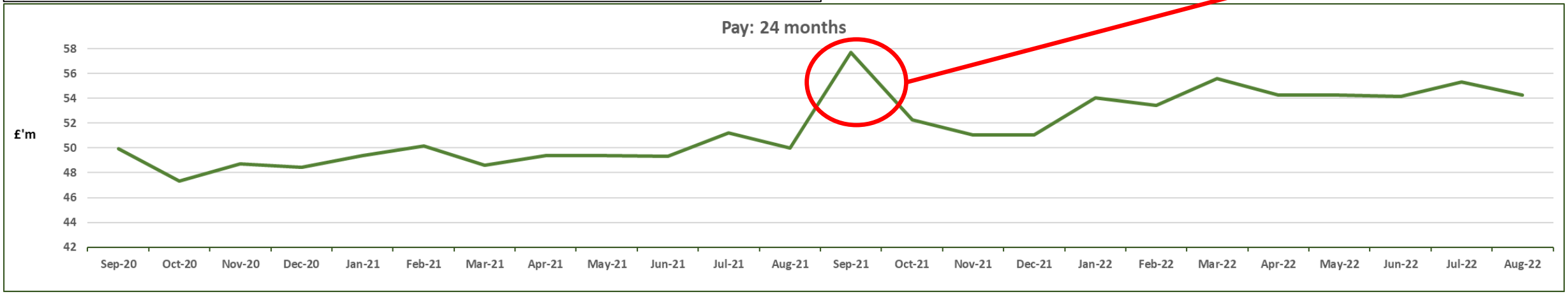
Please note: M3-5 national data not yet available

Key messages:

- At the end of month 5, the Trust is reporting a £1.9m favourable position on pay with a £1.0m favourable position in month.
- The key driver for the 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 (£0.8m).
- The Trust continues to take actions to restore and maintain services in a Covid safe environment and has invested £7.0m of Covid pay related spend in the first five months of 22/23.
- Bank spend as a proportion of the total 22/23 pay bill is 8.3%, 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 to meet the increased demand on services.
- The national pay award has been accrued at £4.6m year to date to month 5. This value represents 2.0% in line with national guidance. The nationally approved pay award value will be reflected in the month 6 position when the majority of staff will receive their pay arrears.



Note: The Sep-21 figures included estimated pay arrears of £7.8m.



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

£ Millions	In Month			Year to Date		
	Budget	Actual	Variance	Budget	Actual	Variance
Non Covid:						
Administrative & Clerical	8.3	7.8	0.5	41.3	39.4	1.9
Allied Healthcare Professionals	3.3	3.1	0.2	16.3	15.1	1.2
Clinical Scientists & Technicians	5.3	4.8	0.5	26.1	24.0	2.1
Medical and Dental Staff	18.5	17.6	0.9	91.8	87.0	4.7
Nursing	19.9	18.4	1.5	99.2	93.3	5.9
Other Pay Costs	1.3	1.3	(0.1)	6.6	6.5	0.1
Efficiency savings	(2.4)	(0.0)	(2.4)	(13.3)	0.0	(13.3)
Subtotal for non-covid	**54.1**	**53.1**	**1.0**	**268.0**	**265.3**	**2.7**
Covid:						
Administrative & Clerical	0.2	0.2	0.0	0.9	0.9	(0.0)
Allied Healthcare Professionals	0.1	0.0	0.0	0.5	0.3	0.1
Clinical Scientists & Technicians	0.0	0.0	0.0	0.1	0.0	0.1
Medical and Dental Staff	0.3	0.3	0.0	1.6	1.4	0.2
Nursing	0.5	0.7	(0.1)	2.8	4.0	(1.2)
Other Pay Costs	0.1	0.0	0.0	0.3	0.3	(0.0)
Subtotal for covid	**1.2**	**1.2**	**(0.0)**	**6.2**	**7.0**	**(0.8)**
Total Pay Cost	**55.3**	**54.3**	**1.0**	**274.1**	**272.3**	**1.9**

Key messages:

- Non Covid pay expenditure has a favourable variance of £2.7m year to date. This variance is driven by slippage on planned investments.
- Covid expenditure is £0.8m adverse to plan. This is driven by higher usage of bank and agency nursing staffing than planned.

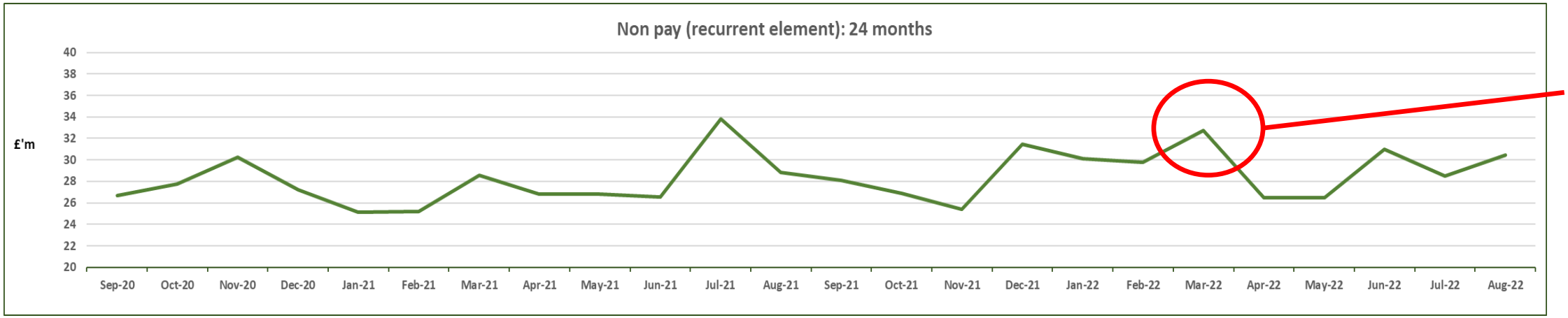
Pay expenditure (continued)

	In Month			Year to Date		
	Budget	Actual	Variance	Budget	Actual	Variance
£ Millions						
Non Covid:						
Agency	0.0	0.5	(0.5)	0.1	2.2	(2.1)
Bank	1.3	3.8	(2.4)	6.8	18.4	(11.5)
Contracted	0.2	0.3	(0.1)	1.1	1.6	(0.5)
Substantive	52.6	48.5	4.1	259.9	243.1	16.8
Subtotal for non-covid	**54.1**	**53.1**	**1.0**	**268.0**	**265.3**	**2.7**
Covid:						
Agency	0.1	0.1	(0.0)	0.4	0.8	(0.4)
Bank	0.3	0.5	(0.1)	1.6	4.1	(2.5)
Contracted	0.0	0.0	(0.0)	0.0	0.0	(0.0)
Substantive	0.8	0.6	0.2	4.1	2.1	2.1
Subtotal for covid	**1.2**	**1.2**	**(0.0)**	**6.2**	**7.0**	**(0.8)**
Total Pay Cost	**55.3**	**54.3**	**1.0**	**274.1**	**272.3**	**1.9**

Key messages:

- Bank expenditure is adverse to budget by £11.5m and Agency by £2.1m. Whilst the overall full year pay plan figures align to the Trust wide-view, a plan correction is required for Bank and Agency. Discussions are to be held with NHS E.
- Prior year spend on non-Covid Bank averaged at £4.2m per month, with the same period year to date reporting a decrease in expenditure of £2.6m.
- In 21/22, non-Covid Agency spend averaged at £0.3m per month. We are reporting additional cost pressures of £0.6m in 22/23 versus prior year.

Pay expenditure (continued)



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

Note: 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)

Key messages:

- At the end of month 5, the Trust's non pay position is £1.0m adverse to plan (including Covid costs) with an in month adverse movement of £2.1m.
- The in month adverse movement was driven by a non-recurrent provision to recognise untaken annual leave at month 5 (£1.9m) and additional premises costs recognised in month (£0.5m) offset by slippage of planned investments expenditure.
- The year to date adverse variance of £1.0m includes £3.3m impairment of receivables, £1.9m untaken annual leave provisions, £1.3m of premises costs offset by fire prevention works expenditure being lower than planned (£3.8m) and slippage on GLH investment due to late NHS E approval of funding (£1.5m).
- Overall Drugs expenditure is £2.8m adverse to plan. The adverse variances are funded by commissioners and are largely driven by multiple sclerosis (£1.2m) and LSD (£0.9m), 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 £2.4m as at month 5. Costs historically fluctuate from month to month so this area of expenditure will be monitored closely over the remainder of the financial year.
- Lower Covid non-pay expenditure is reported in the month, and year to date this measure is reporting £0.3m favourable to budget.

	In Month			Year to Date		
£millions	**Budget**	**Actual**	**Variance**	**Budget**	**Actual**	**Variance**
Non Covid:						
Drugs	14.4	14.9	(0.5)	72.1	74.9	(2.8)
Clinical Supplies	16.8	16.3	0.5	84.3	75.6	8.7
Misc Other Operating expenses	0.1	2.4	(2.4)	(0.2)	5.2	(5.4)
Premises	4.6	5.6	(0.9)	23.1	24.4	(1.3)
Clinical Negligence	2.0	2.0	0.0	10.1	10.1	0.0
Other non pay costs (including CIP)	4.7	3.7	1.0	23.5	21.0	2.5
Total Recurrent	***42.6***	***44.9***	***(2.3)***	***212.9***	***211.2***	***1.7***
Other non pay costs	0.2	0.1	0.1	1.2	0.9	0.3
Receivables impairment net of reversals	(0.2)	(0.0)	(0.1)	(0.8)	2.5	(3.3)
Total Non-recurrent	***0.1***	***0.1***	***(0.0)***	***0.4***	***3.4***	***(3.0)***
Subtotal for non-covid	***42.7***	***45.0***	***(2.3)***	***213.3***	***214.6***	***(1.3)***
Covid:						
Drugs	0.0	0.0	0.0	0.2	0.1	0.0
Clinical Supplies	0.2	0.2	0.1	1.5	1.2	0.3
Misc Other Operating expenses	0.0	0.0	0.0	0.2	0.2	0.0
Premises	0.1	0.1	(0.0)	0.3	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	1.4	1.6	(0.2)
Subtotal for covid	***0.6***	***0.4***	***0.2***	***3.7***	***3.4***	***0.3***
Total Non Pay	**43.3**	**45.4**	**(2.1)**	**216.9**	**217.9**	**(1.0)**

Key messages:

- The non pay position shows a £1.0m adverse year to date variance at M5. 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. It is planned to report changes in this metric each quarter.

Non pay expenditure (continued)

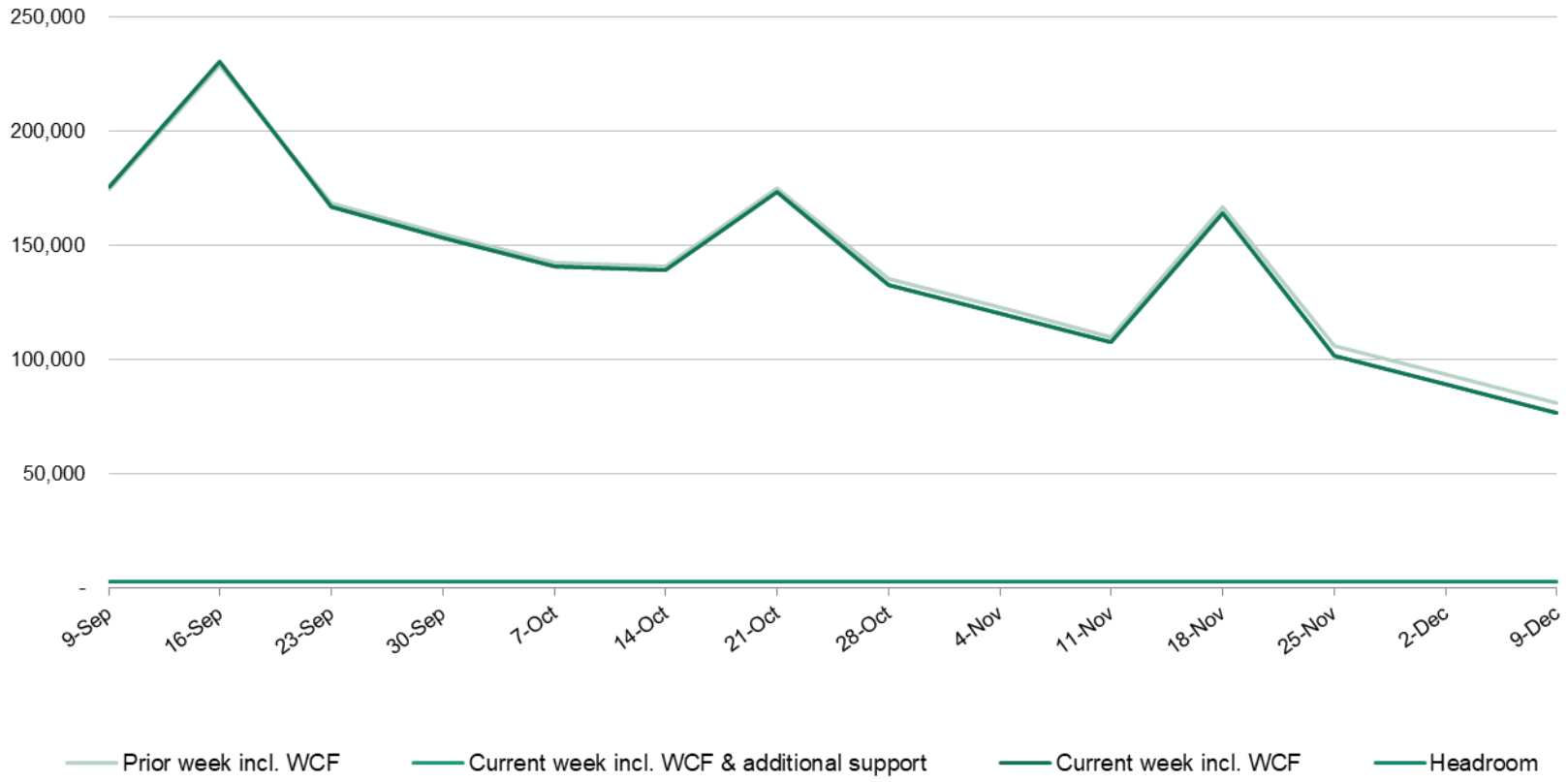
£'m	M2 YTD		M3		M4		M5		M6		M7		M8		M9		M10		M11		M12		YTD		Forecast	
	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual
Total Pay Efficiencies	1.8	2.5	1.5	1.7	3.8	4.0	2.4	2.7	2.3		2.2		1.8		1.6		2.5		2.1		2.4		9.6	10.9	24.5	25.6
Total Non-pay Efficiencies	3.4	3.0	1.7	1.7	2.1	1.6	2.6	2.2	1.5		2.2		2.3		2.4		1.9		2.3		1.4		9.6	8.5	23.8	23.0
Total Income Efficiencies	5.6	5.6	0.8	0.8	0.8	0.7	0.8	0.8	0.8		0.8		0.8		0.8		0.8		0.8		0.8		8.0	7.9	13.7	13.5
Total Efficiencies - 2022/23	**10.8**	**11.1**	**4.0**	**4.2**	**6.7**	**6.3**	**5.7**	**5.7**	**4.6**	**0.0**	**5.2**	**0.0**	**4.9**	**0.0**	**4.9**	**0.0**	**5.2**	**0.0**	**5.2**	**0.0**	**4.6**	**0.0**	**27.3**	**27.3**	**62.0**	**62.0**

	YTD Plan			YTD Actual Delivery			YTD Variance			Full Year Plan			Forecast Full Year Delivery			Variance		
£m	Recurrent	Non-recurrent	Total	Recurrent	Non-recurrent	Total	Recurrent	Non-recurrent	Total	Recurrent	Non-recurrent	Total	Recurrent	Non-recurrent	Total	Recurrent	Non-recurrent	Total
Pay	9.3	0.3	9.6	7.3	3.6	10.9	(2.0)	3.3	1.3	23.8	0.7	24.5	19.5	6.1	25.6	(4.3)	5.4	1.1
Non-pay	9.2	0.4	9.6	8.3	0.2	8.5	(0.9)	(0.2)	(1.1)	23.2	0.6	23.8	20.2	2.8	23.0	(3.0)	2.2	(0.8)
Income	0.3	7.8	8.0	0.1	7.8	7.9	(0.1)	(0.0)	(0.2)	0.6	13.1	13.7	0.4	13.1	13.5	(0.3)	(0.0)	(0.3)
	18.7	**8.5**	**27.3**	**15.7**	**11.6**	**27.3**	**(3.0)**	**3.0**	**0.0**	**47.6**	**14.4**	**62.0**	**40.1**	**21.9**	**62.0**	**(7.5)**	**7.5**	**0.0**

Key messages:

- The Trust has identified £62.0m efficiencies in line with the plan. £40.1m are as recurrent, representing 65% of the total plan..
- At month 5 our cumulative position shows efficiencies totalling £27.3m in line with the plan of £27.3m.
- Pay efficiencies are currently ahead of plan by £1.3m within this recurrent initiatives are (£2.0m) adverse to plan and non-recurrent schemes are £3.3m ahead of plan.
- For non-pay efficiencies, initiatives are adverse to plan by (£1.1m), largely being driven by a shortfall in recurrent schemes.
- Income efficiencies are broadly in line with plan, at £7.9m to month 5. This includes the planned 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 £7.5m. 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.

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 5 capital expenditure position

Year to Date (Month 5)				Forecast		
	Budget £m	Actuals £m	Variance £m	Budget £m	Expenditure £m	Variance £m
Programme						
Orthopaedic theatres	3.8	1.3	2.5	14.9	14.9	-
Theatre equipment & infrastructure	1.1	-	1.1	5.1	5.1	-
P&Q ward modifications	0.6	-	0.6	2.5	2.5	-
Existing Estate/HV	3.0	2.8	0.2	12.2	13.6	(1.3)
Cancer Research Hospital	2.3	0.7	1.6	7.5	7.5	-
Thrombectomy	2.4	1.5	1.0	5.9	5.9	-
Medical Equipment Replacement	1.0	0.0	1.0	4.1	4.1	-
Children's Hospital (CCRH)	1.7	1.2	0.5	3.7	3.4	0.3
Nuclear Medicine	1.3	1.1	0.1	3.0	3.0	-
e Hospital/Legacy Systems	1.0	0.1	1.0	3.0	2.1	1.0
Other Developments/PFI	1.3	1.4	(0.1)	4.0	3.9	-
Programme Total	**19.5**	**10.0**	**9.5**	**65.9**	**65.9**	**-**

Key Issues/Notes Year to Date

£10.0m has been invested YTD, against a budget of £19.5m. The larger areas of spend this year have been:

- Thrombectomy - £1.5m
- Orthopaedic theatres - £1.3m
- Children's Hospital - £1.2m
- Nuclear Medicine refurbishment - £1.1m
- Cancer Hospital - £0.7m

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

We continue to forecast to spend in line with the budget figure of £65.9m.

We have a contingency budget of £0.6m for any emergencies which may arise from equipment failure; and are budgeting slippage of projects to keep within the £65.9m total. We will review and manage slippage as the year progresses and make amendments as appropriate. the continued under-spend is of concern and will be managed through actions allocated at CAB.

Capital expenditure by programme

Balance sheet

	M5 Actual £m
Non-current assets	
Intangible assets	24.2
Property, plant and equipment	472.6
Total non-current assets	**496.8**
Current assets	
Inventories	11.8
Trade and other receivables	67.4
Cash and cash equivalents	183.0
Total current assets	**262.2**
Current liabilities	
Trade and other payables	(200.2)
Borrowings	(8.8)
Provisions	(6.5)
Other liabilities	(100.4)
Total current liabilities	**(315.9)**
Total assets less current liabilities	**443.1**
Non-current liabilities	
Borrowings	(117.4)
Provisions	(13.1)
Total non-current liabilities	**(130.5)**
Total assets employed	**312.6**
Taxpayers' equity	
Public dividend capital	583.3
Revaluation reserve	37.5
Income and expenditure reserve	(308.2)
Total taxpayers' and others' equity	**312.6**

Balance sheet commentary at month 5

- The balance sheet shows total assets employed of £312.6m.
- Non-current liabilities at month 5 are £130.5m, of which £117.4m represents capital borrowing (including PFI and IFRS 16).
- Cash balances remain strong at month 5.
- The balance sheet includes £28.4m 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.

Trust balance sheet

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Cambridge University Hospitals NHS Foundation Trust

Report to the Board of Directors: 12 October 2022

Agenda item	10
Title	Research and Development
Sponsoring executive director	Ashley Shaw, Medical Director
Author(s)	John Bradley, R&D Director
Purpose	To provide an update on Research and Development activity
Previously considered by	Management Executive, 1 September 2022

Executive Summary

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

Related Trust objectives	Improving patient care; Building for the future
Risk and Assurance	The report is the main source of assurance on governance issues relating to Research and Development.
Related Assurance Framework Entries	BAF ref: 012
Legal / Regulatory / Equality, Diversity & Dignity implications?	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 and discuss the report.

Cambridge University Hospitals NHS Foundation Trust

12 October 2022

Board of Directors
Research and Development
John Bradley, Director of R&D

1. MHRA inspection

1.1 Cambridge University Hospitals NHS Foundation Trust and University of Cambridge underwent 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. This was a joint inspection of the shared sponsor systems of both the University of Cambridge and Cambridge University Hospitals. The inspection was hosted by the Cambridge Clinical Trials Unit (CCTU). An inspection report was received in May 2022 and a response to the findings, none of which were critical, was sent to MHRA in June 2022. Corrective and preventative actions were provided in response to the findings in the inspection report. These were reviewed by the GCP Inspectorate and considered acceptable, and the inspection was closed on 22 June 2022.

2. NIHR Cambridge Biomedical Research Centre (BRC)

2.1 The proposal for re-designation and funding of the National Institute for Health Research (NIHR) Cambridge BRC, led by Professor Miles Parkes, was submitted in October 2020, and a team from Cambridge University Hospitals and the University of Cambridge attended for interview on 8 April 2022. CUH has been notified of the outcome and is planning accordingly. The outcome is currently embargoed externally.

3. Health Data Research (HDR) UK – Data Research Hub

3.1 The **Gut Reaction HDR UK Data Research Hub** has collated data from multiple sources on patients recruited to the NIHR Inflammatory Bowel Diseases BioResource. Data from electronic health records at NHS trusts is being combined with research, including genomic data. Gut Reaction is currently funded by UK Research and Innovation (UKRI) through the Industrial Strategy Challenge Fund, and sustainability beyond the UKRI award has been achieved through a combination of industry, charitable and academic funding.

3.2 A submission by Gut Reaction "Gut Reaction patient and public involvement: a partnership to deliver positive change." has been selected as a finalist for The Innovate Awards (Welcome (innovatehealthcareawards.co.uk)) in the category

'Excellence in Patient and Public Involvement in Transformation and Innovation Award'.

4. NIHR Young People's BioResource

4.1 The NIHR BioResource is a recallable resource of around 250,000 volunteers from the general population, and patients with rare and common diseases. Participants provide information about their health and lifestyle, together with biological samples, including DNA, and consent for access to their health records and to be contacted about clinical research studies according to their phenotype and/or genotype.

4.2 The NHS Long Term Plan calls for paediatrics to encompass people aged 0-25 years, a period when many adult chronic diseases are likely to originate. The NIHR BioResource currently includes around 13,000 participants in this age range, across the general population and disease cohorts.

4.3 The NIHR Young People's BioResource will bring these together, and build cohorts with antenatal, common (e.g. mental health), chronic (e.g. Inflammatory Bowel Disease) and rare diseases. Recruitment of 11-15 year old pupils has started via schools in partnership with NIHR Birmingham and Great Ormond Street Hospital BRCs, and the Anna Freud National Centre (AFC; https://www.annafreud.org/) for Children and Families. AFC hosts the 25,000 strong Schools in Mind network, which works with the public to develop communication strategies, and providing resources and training in research to school leaders, teachers, parents and carers, children and young people, and academics.

4.4 A formal launch of the NIHR Young People's BioResource is planned for spring 2023.

5. Patient Led Research Hub

5.1 The Cambridge Patient Led Research Hub (PLRH) is part of the Cambridge Clinical Trials Unit and provides a unique resource that works in partnership with charities and patient groups to deliver clinical studies based on patients' own research questions.

5.2 A recently adopted study aims to help with the diagnosis of ring chromosome 20 syndrome. Ring chromosome 20 syndrome (r(20)) is an ultra-rare and under-diagnosed condition associated with hard-to-treat epilepsy, learning and behavioural difficulties. Many people with r(20) wait years for their diagnosis because the ring formation is difficult to detect using standard genetic assessments. To address this issue, the PLRH is working with Ring 20 Research and Support UK and Illumina to learn more about how the ring chromosome forms, and hopefully lead the way to better diagnostic tools.

6. Covid-19

6.1 All studies paused during the pandemic have now been reviewed, and where appropriate restarted.

6.2 **Ongoing Cambridge led COVID-19 clinical trials include:**
HEAL-COVID (HElping to Alleviate the Longer-term consequences of Covid-19), Chief Investigator (CI) Charlotte Summers, is evaluating the effect of existing drugs on the long term effects of Covid-19 following discharge from hospital. HEAL-COVID has recruited over 1000 participants from over 100 NHS trusts.

6.3 **PROTECT-V** (PROphylaxis for vulnerable paTiEnts at risk of Covid-19 infecTion), CI Rona Smith, is evaluating the use of agents to prevent Covid-19 in vulnerable patients, including kidney patients on dialysis or patients receiving immunosuppression. The study is a 'platform trial', which allows new drugs to be added. The first drug to be evaluated is niclosamide, a drug used to treat intestinal worms, which has shown activity against SARS-CoV-2 in the laboratory and is being delivered as a nasal spray. Sotrovimab a monoclonal antibody with neutralising activity against the spike protein of SARS-CoV-2 was added in August 2022. PROTECT-V has recruited over 1,300 participants from 34 sites.

7. Recommendation

7.1 The Board of Directors is asked to receive and discuss the report.

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

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Report to Board of Directors: 12 October 2022

Agenda item	11
Title	Learning from deaths
Sponsoring executive director	Ashley Shaw, Medical Director
Authors	Amanda Cox, Deputy Medical Director Freya Durrant, Head of Patient Safety
Purpose	To receive the quarterly report.
Previously considered by	Management Executive, 8 September 2022

Executive Summary

Between April 2022 – June 2022 [Q1], there were 453 deaths; of these 19 [4%] were in the Emergency Department, the remainder were inpatient deaths.

- 69 [15%] met the criteria for a Structured Judgement Review [SJR].
- 6% [4/69] SJRs completed to date identified significant problems in care [scores 1-3].

Between April 2022 and June 2022 there have been two deaths identified through the structured judgement review process that have been investigated as a Serious Incidents.

There have been no Prevention of Future Deaths ordered between April and June 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 Q1.

Cambridge University Hospitals NHS Foundation Trust

12 October 2022

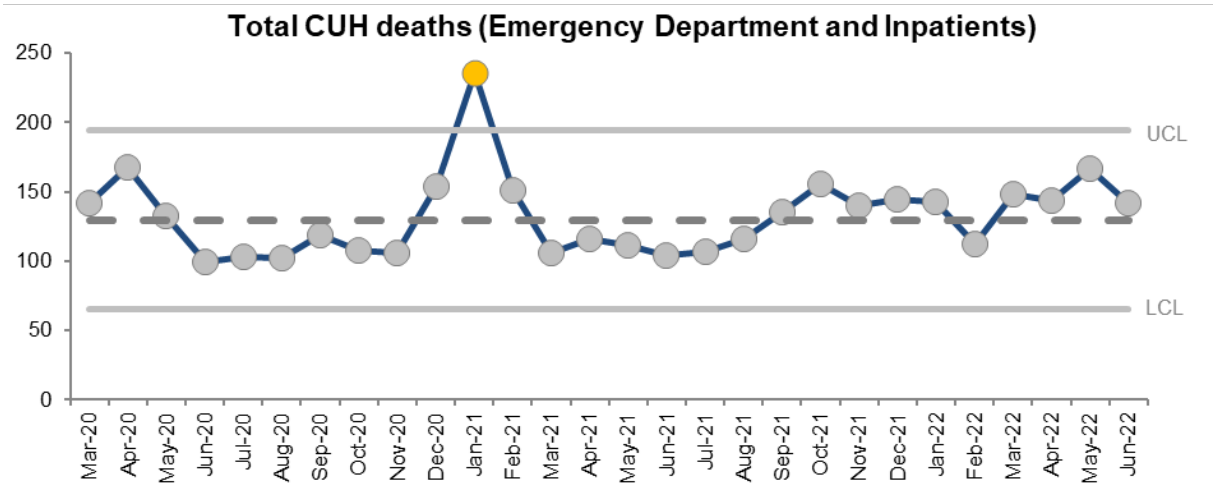
Board of Directors

Learning from Deaths Quarterly Report

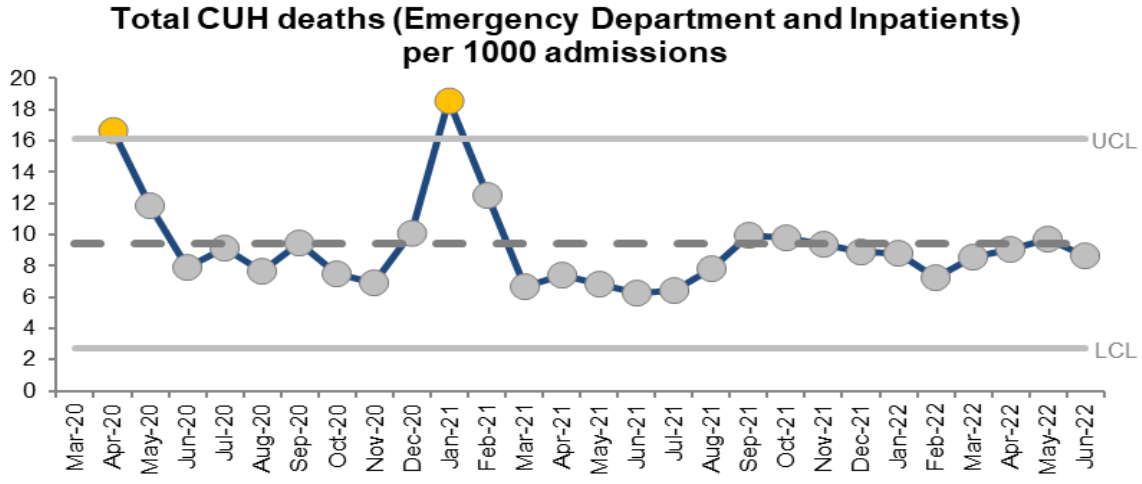
1. Number of deaths in Quarter

There were 434 deaths between April 2022 and June 2022 [Q1] [Emergency Department [ED] and inpatients], of which 4% [19/453] were in the ED and 96% [434/453] were inpatient deaths. The data in the graphs below show deaths that have been recorded on Epic since March 2020.

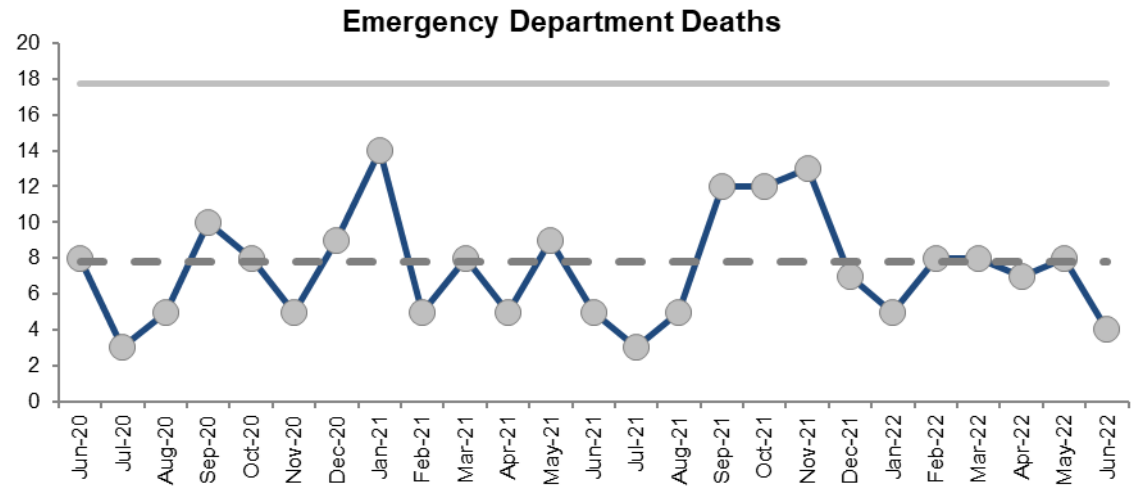
Graph 1 shows total CUH deaths from March 2020 to June 2022. There was a statistically significant increase [single point] in January 2021. This may in part be attributable to the COVID-19 pandemic and the context of the operational demand of the hospital. Triangulation and scrutiny of other data sources did not suggest any other concern in relation to patient safety, or quality, for this single point increase and has now returned to within normal variance.



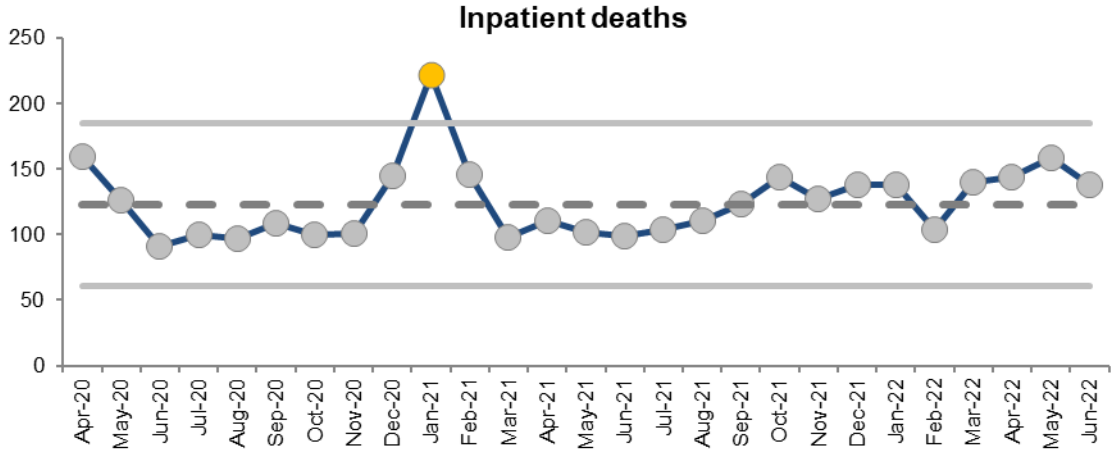
In **Graph 2**, there were statistically significant increases [single points] in the total number of deaths at CUH per 1000 admissions in April 2020 and January 2021.



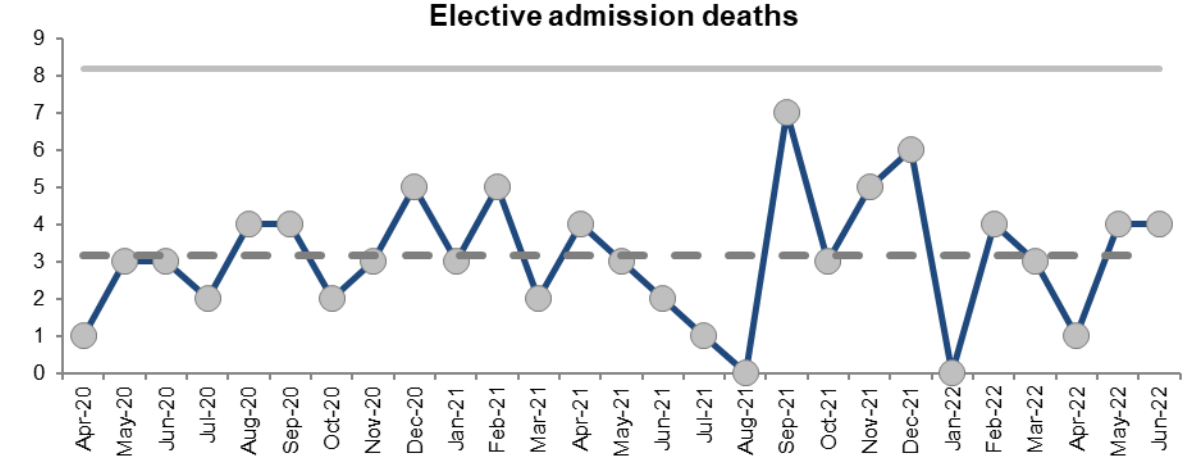
Graph 3 shows Emergency Department deaths only, from June 2020 to June 2022. There is currently normal variation in the number of Emergency Department deaths.



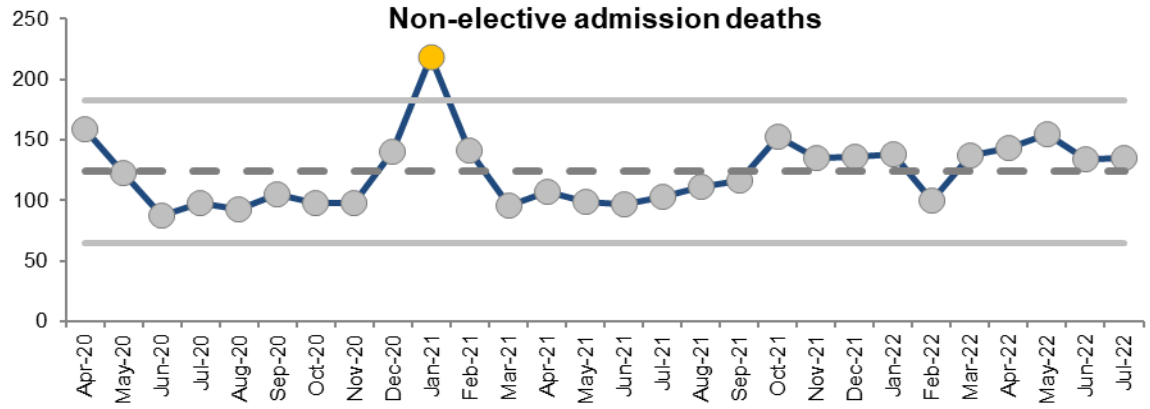
Graph 4 shows inpatient deaths only, from April 2020 to June 2022. There has been a statistically significant increase [single point] in January 2021. There is currently normal variation in the number of Inpatient deaths.



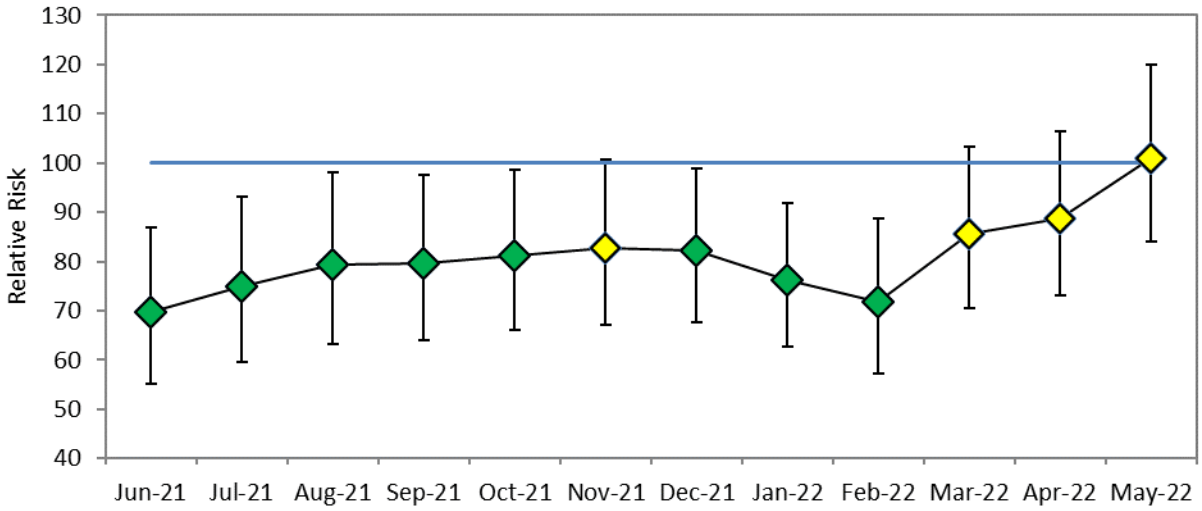
Graph 4a shows inpatient elective admission deaths only. From April 2020 to June 2022 there is normal variation.



Graph 4b shows inpatient deaths in a non-elective admission from April 2020 to July 2022 and it is currently within normal variation, apart from January 2021.



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 the 2022-2023 financial year

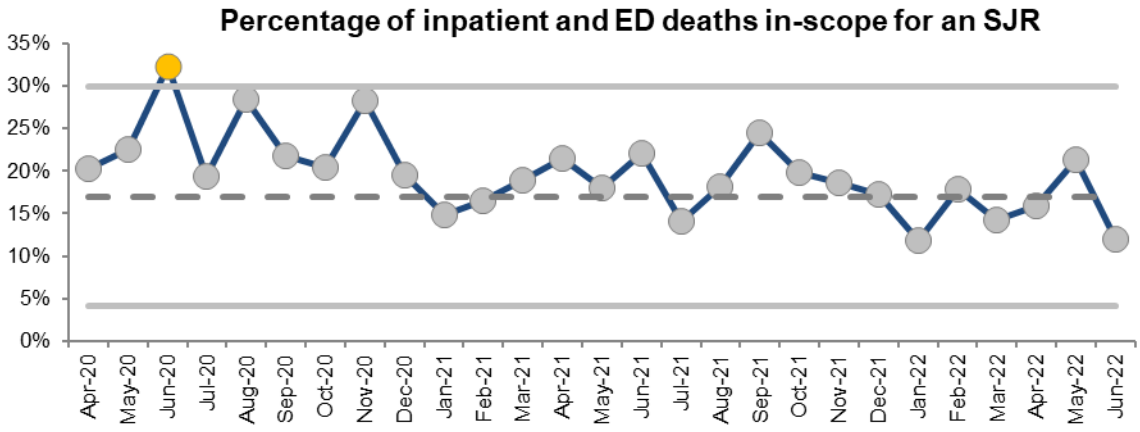
KPI	No. of deaths in month	No. of deaths in-scope	Compliance with SJRs		Problems in Care Identified [score 1-3]	Serious Incidents triggered by SJRs	% of problems in care (by deaths 'in scope')		% of all deaths with problems in care (by total deaths in month)		SJRs triggered by family / carers	SJR training compliance	PFD issued to CUH
			Number received	Number due			Month	Quarter	Month	Quarter			
Apr-22	144	23	83% 19 23		2	2	11% 2 19	9% 4 45	1.4% 2 144	1% 4 453	2	58% 11 19	0
May-22	167	34	53% 18 34		1	1	6% 1 18		0.6% 1 167		1	89% 16 18	0
Jun-22	142	17	47% 8 17		1	1	13% 1 8		0.7% 1 142		2	113% 9 8	0

3. Structured judgement review [SJR] compliance

3.1. Deaths in-scope

Between April 2022 and June 2022, 74 [16%] of patient deaths met the in-scope criteria for a structured judgement review.

Graph 6 shows the percentage of CUH deaths which were in-scope for an SJR since April 2020. On average, 17% of deaths are in-scope for an SJR.

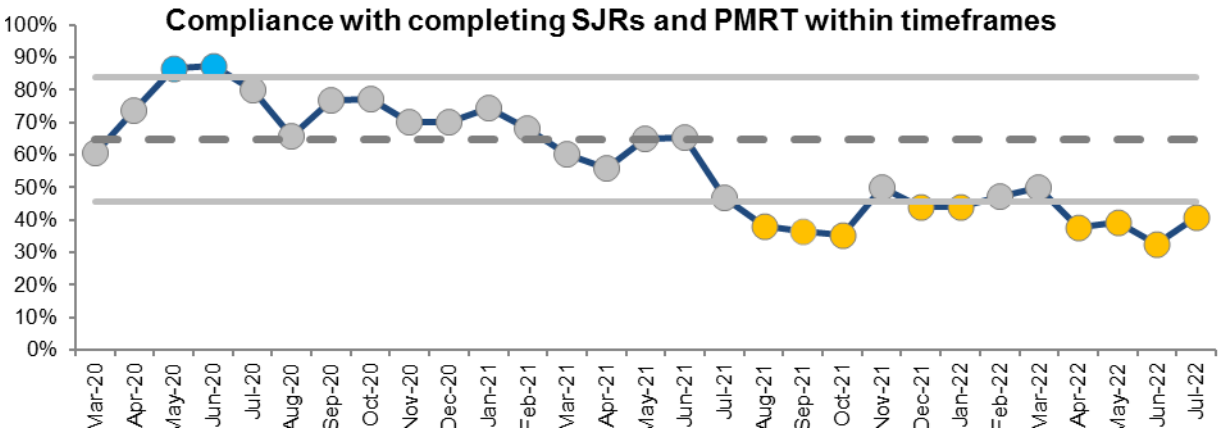


For Q4, of the 74 in-scope deaths, 45 SJRs have been completed to date. Therefore, compliance with completion of SJR for patients who died in Q4, April 2022 to June 2022, is currently 60% [45/74]. The compliance by the thresholds for completion and by divisions are shown in the table below.

KPI	SJR + PMRT compliance by timeframes	A	B	C	D	E
Jul-21	87% [13/15]	67% [2/3]	N/A [0/0]	100% [6/6]	100% [1/1]	80% [4/5]
Aug-21	95% [20/21]	100% [2/2]	N/A [0/0]	100% [11/11]	100% [2/2]	83% [3/5]
Sep-21	76% [25/33]	50% [2/4]	0% [0/3]	83% [16/18]	100% [2/2]	75% [3/4]
Oct-21	74% [23/31]	N/A [0/0]	0% [0/2]	86% [12/14]	100% [7/7]	60% [3/5]
Nov-21	85% [22/26]	100% [1/1]	100% [2/2]	88% [15/17]	N/A [0/0]	100% [3/3]
Dec-21	80% [20/25]	67% [2/3]	N/A [0/0]	90% [9/10]	100% [1/1]	88% [7/8]
Jan-22	88% [15/17]	100% [1/1]	N/A [0/0]	77% [10/13]	N/A [0/0]	60% [3/5]
Feb-22	90% [18/20]	50% [1/2]	0% [0/1]	86% [12/14]	N/A [0/0]	80% [4/5]
Mar-22	79% [19/24]	50% [2/4]	0% [0/1]	100% [9/9]	75% [3/4]	56% [5/9]
Apr-22	83% [19/23]	0% [0/2]	0% [0/1]	100% [12/12]	100% [2/2]	N/A
May-22	53% [18/34]	33% [1/3]	0% [0/2]	88% [14/16]	0% [0/2]	8% [1/12]
Jun-22	47% [8/17]	50% [1/2]	N/A	90% [9/10]	25% [1/4]	0% [0/7]

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 as of January 2020]. Statistically we can expect between 40% and 88% of reviews to be completed within their timeframes:



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

4.1. SI investigations commissioned between April 2022 – June 2022

There has been two Serious Incident [SI] investigations commissioned by the Trust's SI Executive Review Panel following an SJR between April 2022 and June 2022. One investigation was focused upon a delayed CT scan, and the other upon a delay in drug administration.

Both investigations have concluded, and actions have been generated to prevent future occurrence. These reports have been managed through the serious incident process, which ensures effective dissemination and engagement in learning.

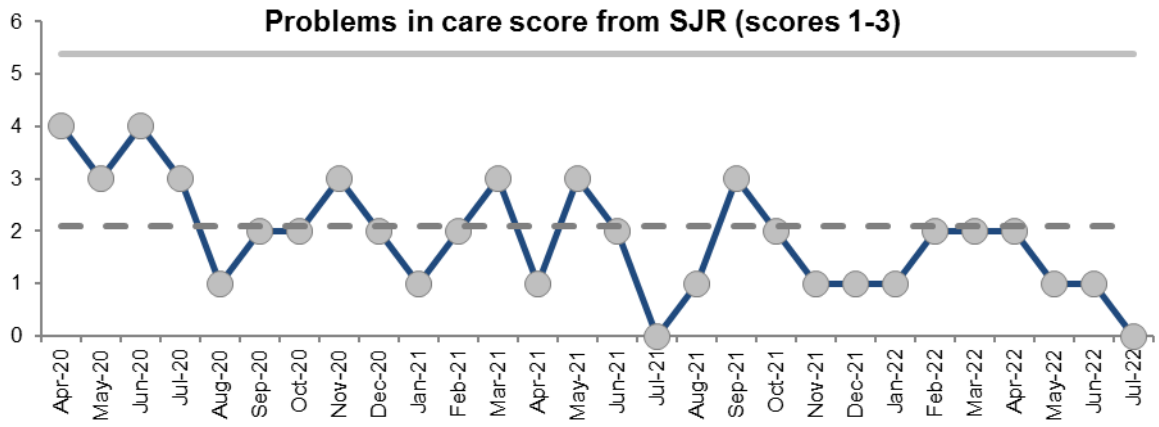
4.2. Structure Judgement Review problems in care scores

The percentage of deaths with problems in care identified through the SJR process, from April 2022 - June 2022 is 10% [4/41]. 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.*
Apr-22	0	1	1	0	5	8
May-22	0	0	1	1	7	9
Jun-22	0	1	0	0	0	0

All 4 deaths that scored 1-3 [death with problems in care score] were further investigated via the Serious Incident Executive Review Panel [SIERP] process.

Graph 8 shows the number of SJRs scored 1-3. There is currently normal variation in the number of SJRs scored 1-3:

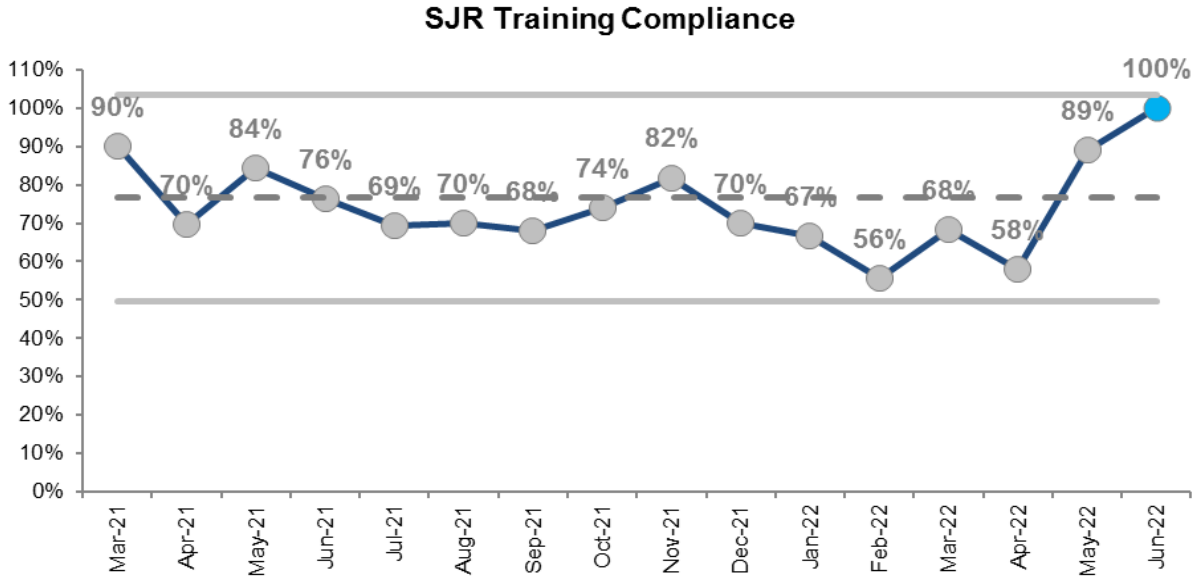


5. Structured judgement reviews triggered by family/carers

Two SJRs were initiated by family or carers concerns between April 2022 and June 2022. No problems in care were identified. One has been completed thus far, and no problems in care were identified.

6. Consultant training compliance

Of the SJRs completed for patients who died March 2021 – June 2022, an average of 77% of SJRs were reviewed by a consultant who had completed the SJR training.



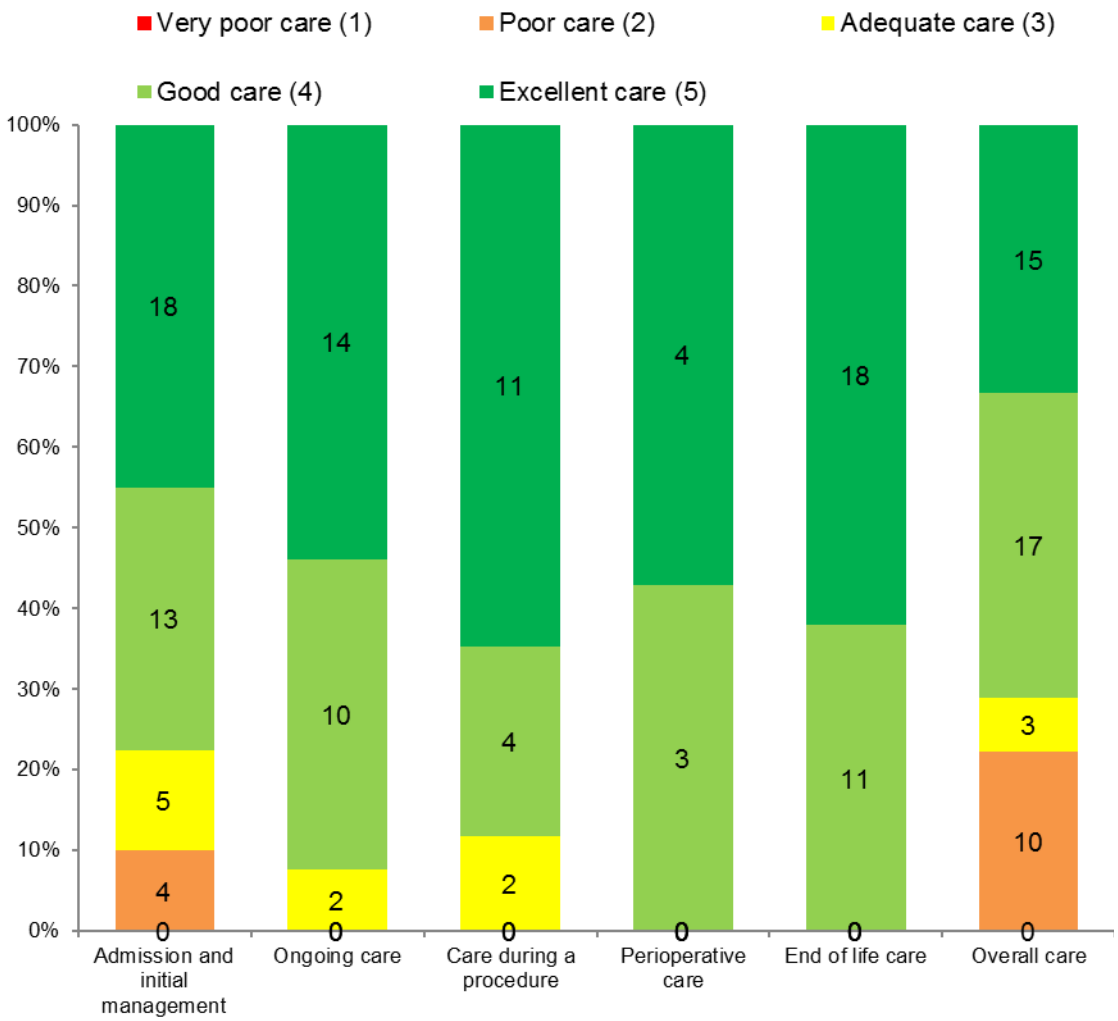
7. Prevention of future death reports issued to Cambridge University Hospitals

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 April 2022 to June 2022:



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

9. Learning from deaths improvement plan:

The Quality Improvement Plan for the last financial year came to its end in Q4, with some actions still outstanding. The QI plan will be continued to be reviewed by the Mortality Improvement Group.

Board of Directors

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Report to the Board of Directors: 12 October 2022

Agenda item	12
Title	Quarterly Report on Safe Working Hours: Doctors and Dentists in Training (2022/23 Q1)
Sponsoring executive director	Dr Ashley Shaw, Medical Director
Author(s)	Dr Jane MacDougall, Guardian of Safe Working
Purpose	To receive the report on safeguarding working hours.
Previously considered by	Management Executive, 8 September 2022

Executive Summary

This is the first quarterly report for the year 2022/23, based on a national template, to the Board of Directors by the Guardian of Safe Working. This role supports the implementation and maintenance of the 2016 national contract for Doctors in Training and provides an independent oversight of their working hours. The process of exception reporting provides data on their working hours and can be used to record safety concerns related to these and rota gaps. In addition, it can identify missed training opportunities. Reporting to the Board of Directors is a stipulated requirement of this role and this report reflects the position at 30 June 2022. The Trust has 660 doctors in training who have all transferred to the 2016 Terms and Conditions of Service.

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

Action required by the Board of Directors

The Board is asked to receive and discuss the 2022/23 Q1 report to the Board from the Guardian of Safe Working

Cambridge University Hospitals NHS Foundation Trust

12 October 2022

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

1. Introduction

The annual Guardian of Safe Working (GoSW) report for 2021/22 described the pattern of exception reporting during and after the Covid-19 pandemic. Last year the number of exception reports increased to pre-pandemic levels, and in Q4 exceeded these. There was evidence of the previously noted cyclical variation with more reports submitted in August and September (as new doctors start work) and over the winter (winter pressures and staff vacancies). Overall working hours were considered safe on most rotas despite all the service pressures. However, areas of concern included under reporting, loss of training, rota gaps and excessive weekend working on some rotas. Surveys also suggested that some clinical and educational supervisors were not engaged with, nor supportive of the process of exception reporting. Areas of good practice were identified and included the Junior Doctors' Forum (JDF) and Board of Directors engagement.

The Q1 report describes the Trust's position from April-June 2022. The number of Exception Reports (ERs) submitted (n = 207) is the same as for Q4 2021-22 (n=209) and increased compared to Q1 last year (n= 127). Most rotas are compliant with the Terms and Conditions of Service (TCS).

There has been significant progress on the weekend working issue; out of the original 11 non-compliant rotas only 3 (A&E, PICU (Paediatric Intensive Care Unit), NICU (Neonatal Intensive Care Unit)) rotas remain where trainees are working more than the recommended maximum of 1:3 weekends. Significant investment in extra posts in A & E and PICU has been agreed and recruitment is in progress. Medical Staffing are hopeful that there will only be one rota still working > 1:3 weekends by February 2022 (NICU).

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

There is a continuing need to engage clinical and educational supervisors to support trainees when they exception report. Doctors who are tired may make poor clinical decisions. ER data can be used to drive change and improvements in rotas and working hours and thus improve patient care.

The JDF (chaired by a trainee) continues to meet virtually every month with senior management joining to listen to trainee concerns. The JDF chairs are invited to attend Board of Directors' meetings and provide direct feedback to the Board. The Regional GOSW network (chaired by the CUH GOSW) still meets

virtually every two months. Benchmarking from this group provides reassurance that Trust Board engagement here continues to be more positive than some other Trusts in the East of England (EoE).

2. Actions required by Board

The Board of Directors is asked to receive and discuss the 2022/23 Q1 report to the Board from the Guardian of Safe Working.

High level data

Number of doctors / dentists in training (total):	660	
Number of doctors / dentists in training on 2016 TCS (total):	660	
Number of doctors / dentists on local contracts (Clinical Fellows):	235	
Total junior doctor/ dentist establishment:		895
Reference period of report		Q1 2022/23
Total number of exception reports received		207
Number relating to immediate patient safety issues		1
Number relating to hours of working		188
Number relating to pattern of work		11
Number relating to educational opportunities		7
Number relating to service support available to the doctor		1
Total number work schedule reviews	2	
Total value of fines levied		£0
Amount of time available in job plan for Guardian to do the role:		2 PAs/8hrs/week
Admin support provided to the Guardian:		1 WTE
Amount of job-planned time for educational supervisors:		0.125 PAs per trainee

3. Exception Reports

Total number of exception reports received per month within this quarter:

	Immediate safety concerns (ISC)	**Total hours of work**	**Pattern of Work**	**Service support available**	**Educational opportunities**	**TOTAL**
MONTH 1 (April)	0	38	2	0	2	42
MONTH 2 (May)	0	88	5	1	4	98
MONTH 3 (June)	1	62	4	0	1	67
QUARTER	**1**	**188**	**11**	**1**	**7**	**207**

Note: An immediate safety concern report is NOT an additional report but is identified within a report submitted for any other reason and therefore is not counted in the total column (there were 207 reports of which 1 had ISC).

3.1 Commentary

The number of exception reports has increased and is now higher than in 2020 and 2021. Exception reports were received from a broad range of specialities including General Surgery, Transplant, Haematology, Oncology, Neurology, Obstetrics & Gynaecology and Paediatrics. There were very few ERs from General and Acute Medicine this quarter possibly reflecting the re-organisation of these rotas last year.

3.2 Trends in Exception Reporting

Levels of exception reporting in Q1 (n=207) were the same as those in Q4 2021 (n=209) and higher than those in Q1 2020-2021 (n=127). They are also higher than levels in Q1 2019 pre covid (n=107). Reporting of missed educational opportunities and service support issues remains low. The number of immediate safety concerns is lower than the last quarter.

3.3 Resolutions

Total number of exception reports per month within this quarter resulting in:

	TOIL granted	**Payment for additional hours**	**Work schedule reviews**	**No action**	**TOTAL**
MONTH 1 (April)	2	54	2	36	80
MONTH 2 (May)	0	63	0	0	40
MONTH 3 (June)	0	51	0	14	58
QUARTER 1	**2**	**174**	**2**	**36**	**214**

3.4 Commentary

Most trainees who submit exception reports are asking for payment for extra hours worked rather than time off in lieu (TOIL) which is the preferred option to improve their wellbeing. This is primarily because the reasons for reporting are rota gaps or a high workload and therefore additional TOIL would only compound the problem.

The discrepancies in totals in this table reflect the timings of ER submission and sign off.

4. Work schedule reviews

Month	Specialty/ Department & Grade	Details of work schedule review
August 2021	A & E/ ED rotas	Review to reduce weekend working – previously > 1: 3 weekends. The Trust agreed to fund 15 new medical posts and recruitment is in progress to fill these and a new rota has been designed
August 2021	Transplant	Review to assess weekend working > 1:3 weekends
January	Paediatrics (Higher)	Review to enable inclusion of extra training time into work schedules (as per TCS)
August 2021	PICU	Review to reduce weekend working – Agreement to fund extra posts – recruitment in progress
August 2021	NICU	Review continues to reduce weekend working. Limited solutions currently

4.1 Commentary

There are currently two active work schedule reviews (Paediatrics and NICU - both left over from previous quarters). Many rotas were re-designed during the covid pandemic. Medicine and surgery rotas were particularly problematic and were reviewed in the light of service and training need. There is now only one rota (NICU) that is not able to reduce weekend working to 1:3 or less as per the new TCS (2019). Subject to recruitment into recently funded new posts the ED rotas and those in PICU and transplant will be compliant shortly as documented elsewhere in this report.

5. Detail of immediate safety concerns and actions proposed and/or taken

Department	Safety concern raised	Action(s) proposed and/or taken
06/06 Neurology Middle Rota	Less than 2 hours sleep on a non-resident on call (NROC) rota – due to multiple referrals overnight	Discussed with Clinical supervisor Wider issue over NROC rotas and whether these need conversion to resident on call rotas

6. Fines

Fines levied against departments this quarter:

Department	Detail	Total value of fine levied
Total fines levied	Nil	£0

	TOTAL
Balance at end of last quarter	**£5881.3**
Fines incurred this quarter	**£0**
Cumulative total	**£5881.3**
Total paid to trainees (£)	**£0**
Total spent (£)	**£0**
Balance at end of this quarter	**£5881.3**

7. Junior Doctor Forum and junior doctor engagement

The JDF was held monthly on Zoom. The virtual platform is working reasonably well, with senior management and others (Medical Director, Director of Medical Education, LTFT (less than full-time training) lead, Medical Staffing lead and team, Workforce Lead and Freedom to Speak up Guardian) joining for the second half of the meeting. Issues discussed included the rotas in A&E and weekend working, rota gaps and the loss of training opportunities particularly in the craft specialities. Annual leave (the importance of taking this), induction and the new epic messaging app, car parking and the use of Health Education England (HEE) funding for Trust rest facilities were also discussed. The importance of exception reporting was emphasised and is encouraged.

8. Doctors and dentists in training not on 2016 Terms and Conditions of Service (TCS)

Non-consultant, non-training grade doctors are able to exception report alongside their trainee colleagues using the same system and processes. So far we have not received many exception reports from this staff group.

9. Assurance processes

The following assurance processes have been put in place to provide assurance on the Guardian role and the appropriate implementation of the new junior doctors' contract:

- Development of key performance indicators for example establishment and sustainability of JDF and response times to exception reports.
- Benchmarking via the Regional and National Guardians' networks
- Peer review – ask other trusts/Guardians to review our processes in 2020/21.
- Audit of exception reporting process (annual).
- Requesting trainee feedback – a survey of juniors

A Non-Executive Director, Annette Doherty, provides support for the Guardian role.

KPIs: JDF sustained currently. Response times for ERs were assessed in our annual audit (January each year). 77 ERs were submitted in January 2022 – 24 (31%) were resolved within 7 days with 69% not having been returned from clinical or educational supervisors within 7 days. This compares to 55% in 2021 and 38% in 2020. We believe that this standard is challenging and unrealistic and note that other Trusts in the region agree. 58/77 ERs (75%) were closed. 39 ERs (51%) were raised by trainees within 7 days of occurrence with 38 being raised outside of 7 days.

Benchmarking takes place regionally and nationally via the GOSW who is chair of Regional GOSW network and arranges minuted meetings of the regional network every two months and attends national meetings on alternate months.
A peer review has been requested from another hospital in the Shelford group.

A survey of trainees' views of exception reporting was distributed by the JDF in Q4 2020-21 (please see summary in Q4 report). This echoes the regional trainee survey (2021) which identified problems accessing the reporting system, lack of awareness of how & when to submit reports, a negative culture around reporting with variable support from supervisors, difficulties in accessing TOIL and delays in receiving compensation. A HEE-EOE project team has developed an induction package and resources for supervisors that has been distributed to all new starters since August 2021. This has now been recognised nationally.

10. Key issues and summary

Levels of exception reporting decreased during the covid pandemic with the subsequent lockdown, cancellation of many NHS activities and the redeployment of staff and was consistent across the EOE region and nationally. Last year levels of reporting reverted to pre-covid levels and have now exceeded these. The number of immediate safety concerns has reduced this quarter. Despite the loss of training opportunities, trainees rarely submit educational ERs. Rota gaps continue to be problematic; this has implications for working hours and patient safety.

Covid-19 affected interpretation of exception reporting data for the past two years. Under reporting continues to be a concern here and nationally and does not necessarily reflect the (anonymous) General Medical Council (GMC) trainee survey. Exception reporting of "immediate safety concerns" is considered in parallel with incident reporting by outside bodies including the Care Quality Commission (CQC).

The revised TCS (2019) advised that trainees should not work more frequently than 1:3 weekends. Exemptions can be applied if there is a clearly identified clinical reason agreed by the relevant clinical director for that rota and deemed appropriate by the GOSW. Such rotas should be co-produced and must be

approved by the affected doctors, agreed via the JDF, and reviewed annually. CUHFT had a number of rotas (n=11, mostly A&E and intensive care) which required trainees to work more than 1 in 3 weekends. Exemptions were agreed in September 2019. Solutions include more healthcare staff, re-allocation of roles and changes in working patterns, most of which have major financial implications. Several rotas were resolved (n=6) last year. Of the remaining five, four are largely sorted with NICU remaining unresolved. At the time of writing, the Trust has committed significant funding to new medical posts in A&E and PICU and recruitment to these posts is in progress and rotas have been rewritten.

Concerns were previously expressed that some individuals would require an extension to their training due to the impact of the covid pandemic particularly for the craft specialities but this does not appear to have been necessary. However, some are anxious that trainees are completing their training with inadequate experience. Hospitals are under pressure to address the backlog of patient care and there continues to be a risk that training will not be prioritised.

We are keen to ensure that clinical and educational supervisors and trainees remain engaged with the process of exception reporting and recognise its value in providing data that can be used to effect change. We are continuing to work on this by attending educational supervisor meetings and induction, whether in person or on line.

The Junior Doctors Forum (JDF) has the potential to identify, discuss and jointly address, with the Medical Director, Medical Staffing, the Guardian and the Postgraduate Medical Education Centre, rota and training issues as they arise. Improving the working conditions and morale of junior doctors is important as it will aid recruitment and retention, reducing rota gaps and will thus improve patient safety. NHS England awarded the Trust £55k for the JDF to use; this has been used to improve rest facilities across the Trust for trainees and clinical fellows. Currently monthly meetings of the JDF continue to be held remotely with variable attendance.

Exception reporting suggests that working hours remained mostly compliant in Q1 and patient safety has not been compromised. There are extra hours worked on some rotas and continuing problems with rota gaps that cannot be filled with locums. Concerns now are focused on the backlog of patient care post pandemic recovery and how best to ensure training (including catch up training) alongside service posts within the amended (2019) 2016 Terms and Conditions for Service.

11. Appendices

Appendix 1: Glossary of terms and abbreviations
Appendix 2: Graphs of Exception Reporting data

Appendix 1: Glossary of Terms and Abbreviations

F1	Foundation Doctor Year 1
F2	Foundation Doctor Year 2
StR	Specialty Registrar
SpR	Specialist Registrar
ACAS	Advisory, Conciliation and Arbitration Service
ARCP	Annual review competency progression
CCT	Certificate of Completion of Training
COGPED	Committee of General Practice Education Directors
CQC	Care Quality Commission
DME	Director of Medical Education
FPP	Flexible pay premium / premia
GDC	General Dental Council
GMC	General Medical Council
GP	General Practitioner
HEE	Health Education England
JLNC	Joint Local Negotiating Committee
LTFT	Less than Full Time
NHSI	NHS Improvement
NIHR	National Institute for Health Research
OOP	Out Of Programme
OOPC	Out Of Programme (Career Break)
OOPE	Out Of Programme (Experience)
OOPR	Out Of Programme (Research)
OOPT	Out Of Programme (Training)
PIDA	Public Interest Disclosure Act 1998
SDM	Senior decision maker
SID	Senior independent director
TCS	Terms and Conditions of Service
WPBA	Workplace based assessment
WTR	The Working Time Regulations 1998 (as amended)

Director of Medical Education (DME)	The DME is a member of consultant medical staff and an employee of the employer / host organisation who leads on the delivery of postgraduate medical and dental education in the Local Education Provider (LEP), ensuring that doctors receive a high quality educational experience and that GMC/GDC standards are met, together with the strategic direction of the organisation and Health Education England (HEE). The DME is responsible for delivering the educational contract between the LEP/ lead provider (LP) and HEE local team. For the purposes of these terms and conditions, where reference is made to the DME, the responsibilities described may be discharged by a nominated deputy to the DME.
Doctor or dentist in training	A doctor or dentist in postgraduate medical or dental education undertaking a post of employment or a series of posts of employment in hospital, general practice and/or other settings.
Educational review	An educational review is a formative process which enables doctors to receive feedback on their performance and to reflect on issues that they have encountered. Doctors will be able to raise concerns relating to curriculum delivery and patient safety. This will include regular discussions about the work schedule.

Educational supervisor	A named individual who is selected and appropriately trained to be responsible for supporting, guiding and monitoring the progress of a named trainee for a specified period of time. The educational supervisor may be in a different department, and occasionally in a different organisation, to the trainee. Every trainee should have a named educational supervisor and the trainee should be informed of the name of the educational supervisor in writing. This definition also covers approved clinical supervisors in GP practice placements.
Episodes of work	Periods of continuous work within an on call period separated by periods of rest.
Exception reporting	Mechanism used by doctors to inform the employer when their day-to-day work varies significantly and/or regularly from the agreed work schedule. Primarily these variations will be differences in total hours of work, pattern of hours worked, in the educational opportunities and support available to the doctor.
Guardian of safe working hours	A senior appointment made jointly by the employer / host organisation and junior doctors, who ensures that issues of compliance with safe working hours are addressed by the doctor and/or employer/host organisation, as appropriate and provides assurance to the Board of the employing organisation that doctors' working hours are safe.
On-call	A doctor is on-call when they are required by the employer to be available to return to work or to give advice by telephone but are not normally expected to be working on site for the whole period. A doctor carrying an 'on-call' bleep whilst already present at their place of work as part of their scheduled duties does not meet the definition of on-call working.
On-call period	An on-call period is the time that the doctor is required to be on call (as defined above) by their employer.
Placement	For the purposes of these TCS, a placement is a setting into which a doctor is placed to work for a fixed period of time in a post or posts in order to acquire the skills and competencies relevant to the training curriculum, as described in the work schedule.
Post	For the purposes of these TCS, a post has approval by the GMC/HEE for the purposes of postgraduate medical and dental education. Each approved post is located within an employer or host organisation.
Rota	The working pattern of an individual doctor or group of doctors.
Rota cycle	The number of weeks' activity set out in a rota, from which the average hours of a doctor's work and the distribution of those hours are calculated.
Rotation	A rotation is a series of placements made by the HEE local office into posts with one or more employers or host organisations. These can be at one or more locations.

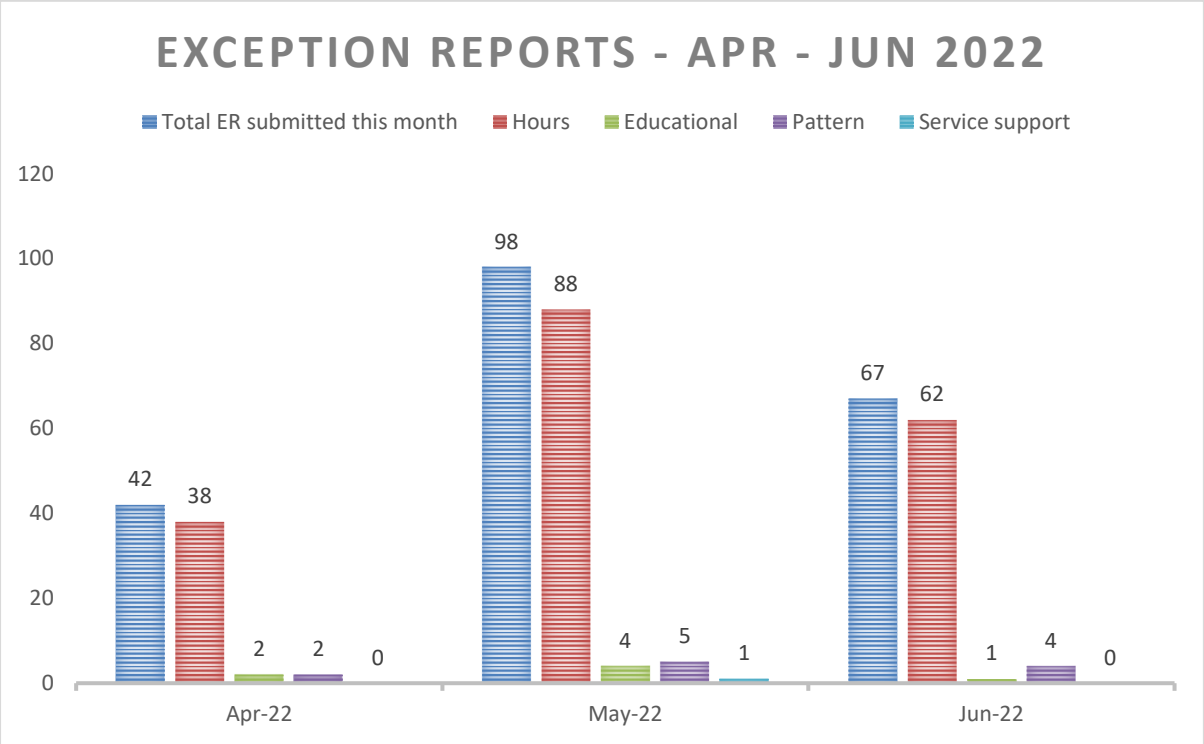
Senior independent director	Non-executive director appointed by the board of directors to whom concerns regarding the performance of the guardian of safe working hours can be escalated where they are not properly resolved through the usual channels.
Shift	The period which the employer schedules the doctor to be at the work place performing their duties, excluding any on-call duty periods.
Training programme	Training programmes and training posts are approved by the GMC or (for dental programmes) HEE. Learning environments and posts used for training are recommended for approval by HEE for the purpose of postgraduate medical/dental education. Time spent in those posts/environments allows the doctor to acquire and demonstrate the competencies to progress through the training pathway for their chosen specialty (including general practice) and to acquire a Certificate of Completion of Training (CCT).
Work schedule	A work schedule is a document that sets out the intended learning outcomes (mapped to the educational curriculum), the scheduled duties of the doctor, time for quality improvement, research and patient safety activities, periods of formal study (other than study leave), and the number and distribution of hours for which the doctor is contracted.
Work schedule review	A work schedule review is a formal process by which changes to the work schedule may be suggested and/or agreed. A work schedule review can be triggered by one or more exception reports, or by a request from either the doctor or the employer. A work schedule review should consider safe working, working hours, educational concerns and/or issues relating to service delivery.
WTR reference period	Reference period as defined in the Working Time Regulations 1998 (as amended), currently 26 weeks.

Appendix 2

Exception report data

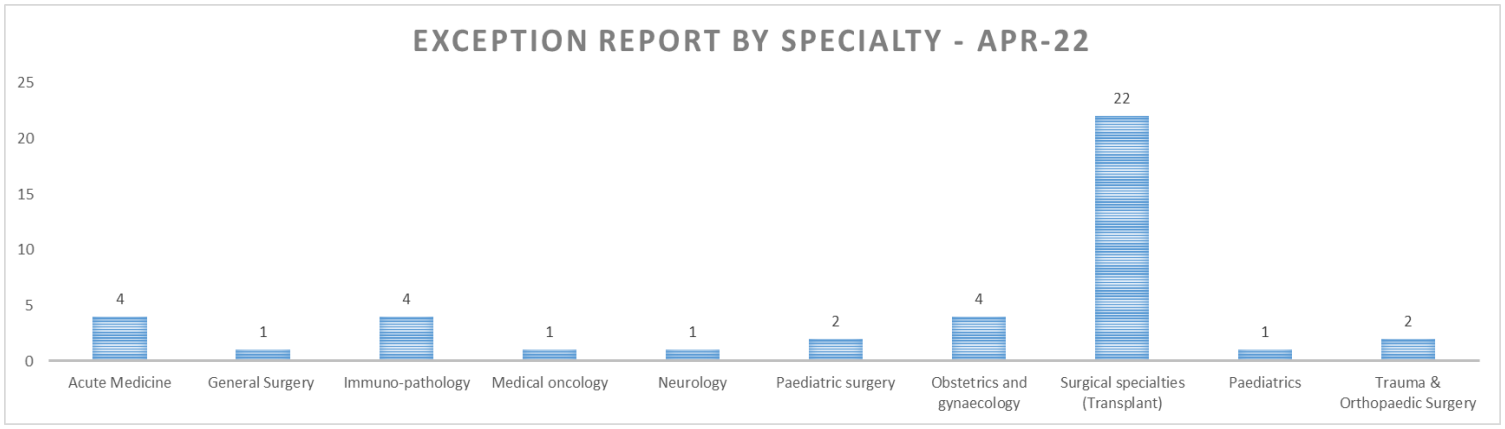
April - June 2022

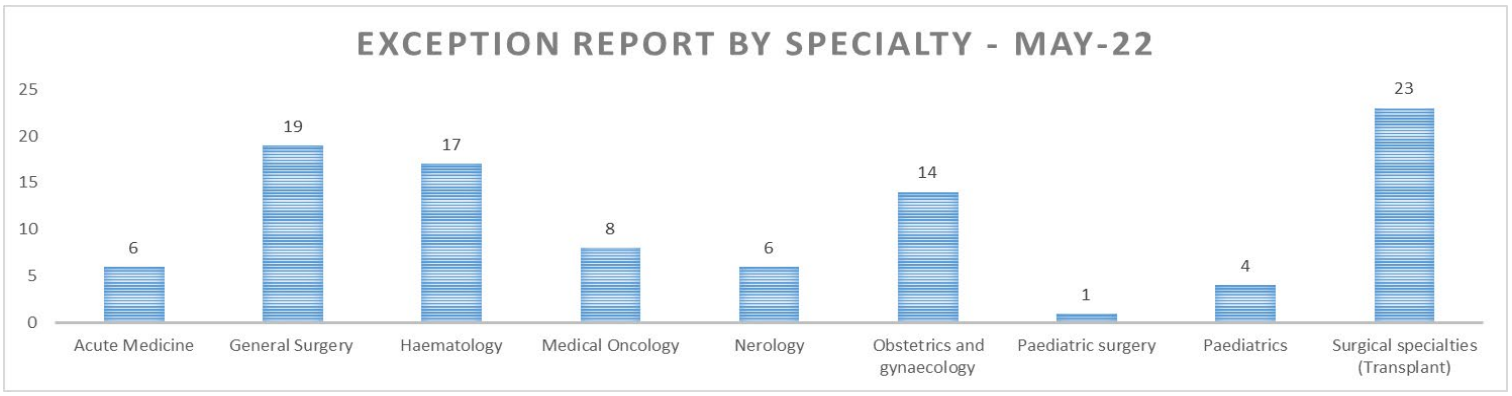
Overview:

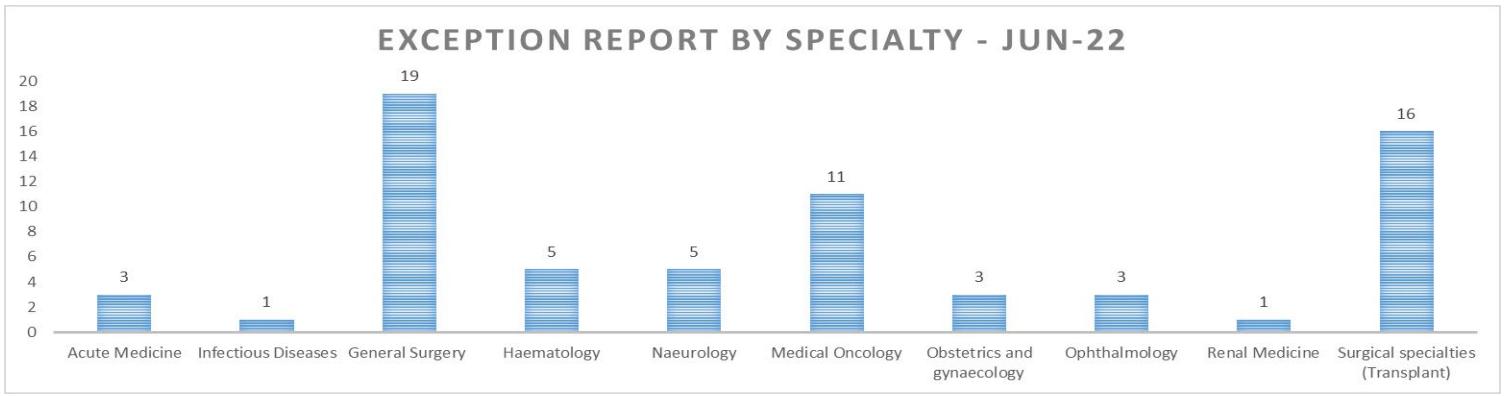


- 207 exceptions reported for Apr– Jun 2022
- 188 hours related which includes overtime and additional hours
- 7 related to educational or missed training opportunities
- 11 pattern related where work differs to established rota/ work schedule
- 1 service support related

Specialty breakdown:

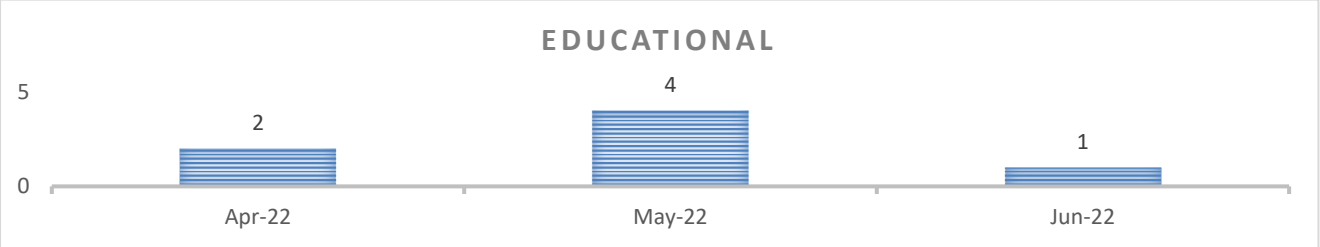






Category breakdown:

Educational:

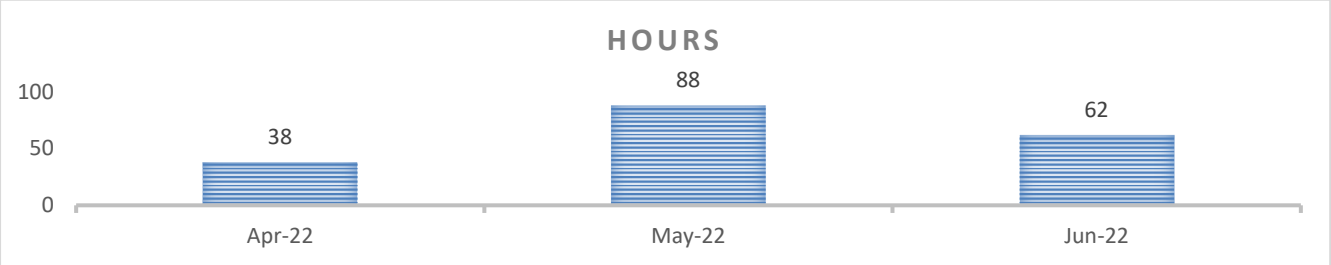


A total of 7 exceptions have been received in regards to education or missed training opportunities.

Obstetrics and gynaecology – 5
Paediatrics – 1
Acute Medicine – 2

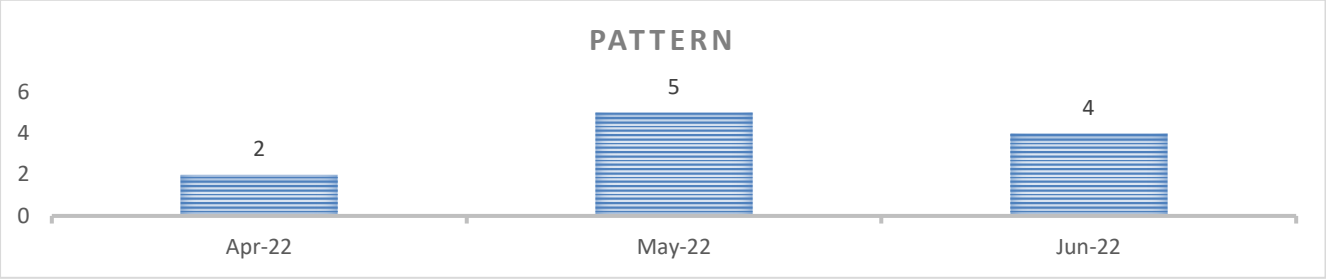
Reasons include missing teaching or training due to staff shortages/ busy departments.

Hours:



A total of 188 exceptions have been received in regards to education or missed training opportunities.

Pattern:

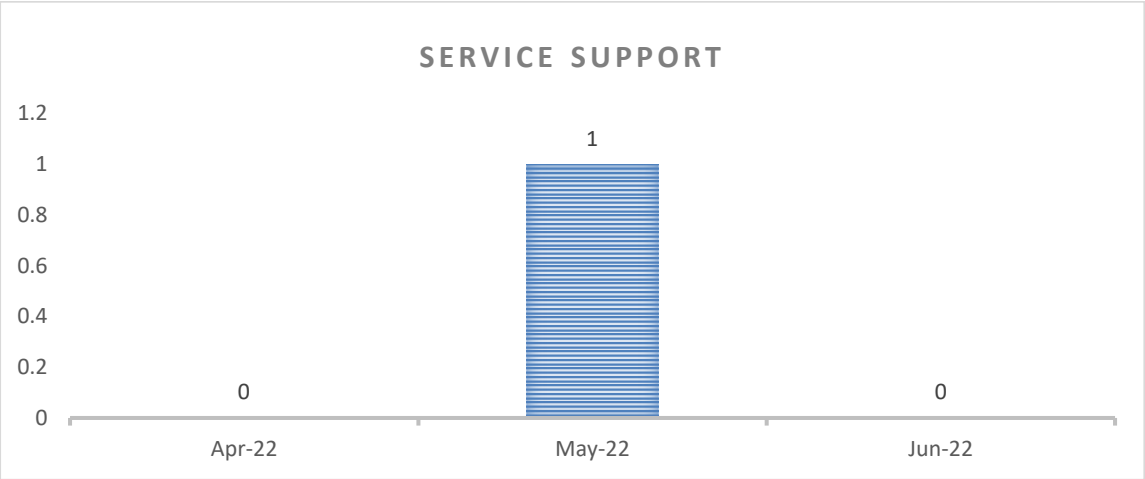


A total of 11 exceptions have been received in regards to pattern of working.

Transplant – 4
Medical Oncology – 4
Neurology – 3

Reasons include working during NROC/ missed continuous rest/ overtime.

Service Support:



A total of 1 exceptions have been received in regards to service support.

Board of Directors

NHS
Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 12 October 2022

Agenda item	13
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, 6 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 May 2022).

This paper provides the Board with the latest version of the BAF which contains 13 principal risks to the achievement of the Trust's strategic objectives. Nine 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 in early 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

12 October 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 May 2022).

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 September 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 May 2022. These have been reviewed by the respective Board assurance committees.

2.2 There are currently 13 risks on the BAF, unchanged from 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 five months.

2.4 Work is currently being undertaken 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, consideration is also being given to the addition of 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, initial trajectories have been included for the following risks: BAF 001, 002, 003 and 007. Comments are invited on the approach, and 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 001 (capacity and patient flow): the risk has been updated to reflect the Winter Plan and associated governance, the development of the ED urgent and emergency care expansion business case, and the revised dates for opening of additional capacity (P and U Blocks).

- Risk 002 (identification and diagnosis of patients in greatest clinical need): the risk description has been reviewed and updated to more clearly distinguish between BAF risk 001 (the ability to reduce waiting lists for treatment) and 002 (the ability to identify and diagnose those patients in greatest clinical need).

- BAF risk 003 (prioritisation of digital resources): the risk has been redefined to align with the strategic commitment on Digital in the refreshed CUH Strategy.

- Risk 007 (recruitment and retention): the gaps in control have been updated to more explicitly set out the issue of the shortage of affordable accommodation and the high cost of living in Cambridge.

- Risk 011 (financial sustainability): the controls, assurances on controls, gaps in control and associated actions have been reviewed

and redrafted to place a greater focus on the Trust's own financial planning and control arrangements, including the development of a long-term financial strategy and plan.

- Risk 013 (physical and mental health and wellbeing of staff): updated to explicitly reference cost of living assistance, including support for travel costs.

2.5 Of the 13 current BAF risks, nine 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)

2.7 The Trust's risk scoring matrix is appended to the BAF for reference.

2.8 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
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 33 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, September 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)	Jul-22	Aug-22	Sep-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
CR43b	Medical and midwifery staffing in maternity services	Safe	Chief Nurse	Quality	4x5=20 (Red)	4x5=20 (Red)	2x3=6 (Yellow)			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
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
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 Facilities Management	Performance	4x3=12 (Amber)	4x3=12 (Amber)	4x2=8 (Amber)	Same	Same	Same
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)	Same	Reduced	Same

Cambridge University Hospitals
NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust
Board Assurance Framework: September 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
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
009	12	Campus development proposals fail to meet the needs of the Trust and the ICS and are not developed, approved 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
010	12	The Trust does not work effectively with partners across the Integrated Care System (ICS), within the local Integrated Care Partnership/South Alliance and across the east of England (particularly in relation to specialised services), resulting in a failure to improve services for local and 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	September 2022

Lead Executive	Chief Operating Officer
Board monitoring committee	Performance, Quality

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	4	5	20
Current (Sep 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

Key controls

What are we already doing to manage the risk?

1. Operational strategy 22/23 agreed by ME and Board.
2. 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 – including use of EAU3 as discharge lounge, EAU4 as assessment area and 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.
12. Whole system focus on recovery and demand management via South

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).

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. Uncertainty over nature of further Covid-19 waves.		C1a. Implementation of Winter Plan 22/23 and Covid surge plans as required, taking account of learning from previous waves and maintaining non-Covid activity where possible. C1b. Restoring non-Covid activity as quickly as possible following Covid waves.	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 May 2023 (delayed from previous date of November 2022).	May 2023
C2b: Use of 40-bed unit for elective surgical capacity.		C2b: Construction works and recruitment underway with scheduled opening date of June 2023.	June 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 approval being sought in October 2022.	March 2024
C3: Response to growth in non-elective demand.		C3. Revised plan developed with system partners and being implemented, overseen by System Resilience Group. Focus on Virtual Wards; 2-hour urgent community response model; and transfer of care hub for winter 2022/23.	Ongoing

Risk score	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 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 (Sep 22)	4x5=20	
June 2023	4x4=16	Opening of 56-bed unit (U-Block) and elective orthopaedic facility (P2/Q2 and 3 theatres).
March 2024	4x3=12	Re-opening of 3 A Block theatres and additional ED UTC capacity.

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	September 2022

Lead Executive	Chief Nurse and Medical Director
Board monitoring committee	Quality

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	5	3	15
Current (Sep 22)	**4**	**4**	**16**

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

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.	
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	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun22	Jul 22	Aug 22	Sep 22
	20	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 (Sep 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	September 2022

Lead Executive	Director of Improvement and Transformation
Board monitoring committee	Audit

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	4	3	12
Current (Sep 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	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun22	Jul 22	Aug 22	Sep 22
	12	**12**	**12**	**12**	**12**	**16**	**16**	**16**	**16**	**16**	**16**	**16**	
Risk redefined													**16**

BAF 003: Risk trajectory

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Sep 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	September 2022

Lead Executive	Chief Nurse and Medical Director
Board monitoring committee	Quality

Risk rating	Impact	Likelihood	Total
Initial (Jun 19)	4	3	12
Current (Sep 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	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 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	September 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 (Sep 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	Actions to address gaps in controls and assurances	Due date
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.	A1. Not all infrastructure failures are reported, as staff respond to emergencies and deal with these as they arise.	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. Work continues to improve overall governance, data quality and pace of the statutory compliance groups, using Premises Assurance Model.		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. Not all failures can result in replacement and proactive replacement is not always possible.		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	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 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	September 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 (Sep 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 –

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.

works commenced in September 2020 with first phase completed in June 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.	C1. Ongoing – CFRS updated regularly.
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.	C2.-C6. Ongoing and incremental, with priority on fire alarm works over culture work.
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.	C7. See C1. A1. See C1.

Risk score	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 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	September 2022

Lead Executive	Director of Workforce
Board monitoring committee	Workforce and Education

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	4	4	16
Current (Sep 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. 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. C3. Continued high levels of staff unavailability due to levels of sickness absence. C4. Workforce plans for 40/56 bed units identified and recruitment commenced but not complete. C5. National shortage of training places in specific professions. C6. Increasing vacancy rates for admin and clerical roles.		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. C2a. Working with partners on sourcing affordable, accessible accommodation including conversion of on-site space. Use of additional accommodation at Waterbeach being progressed (available from September 2022). C2b. Raising issue of scope for funded high cost of living allowance for Cambridge. C3a. Prospective review of rosters and daily review of staffing. C3b. Increasing enhancements to support operations pool fill. C4a. Strong pipelines in place and targeted campaigns continue (6 month lead time). C4b. Working with system partners. 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. C6. Large A&C advertising campaign, centralisation of admin recruitment process and flexible working drive.	C1 – March 2023 aim to achieve 5% vacancy rate (0% for nursing) C2a. March 2023 C2b. Ongoing C3. Ongoing C4. Ongoing C5. Ongoing C6. March 2023

Risk score	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 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 (Sep 22)	4x5=20	
March 2023	4x4=16	Achievement of overall 5% vacancy rate (0% nurse vacancy rate) by March 2023.
March 2024	4x3=12	Maintain reduced vacancy rate and secure positive position on retention 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	September 2022

Lead Executive	Director of Workforce
Board monitoring committee	Workforce and Education

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	4	3	12
Current (Sep 22)	4	4	16

Change since last month
⟺

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	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22
	16	16	16	16	16	16	16	16	16	16	16	16	16

BAF risk	009	**Campus development proposals fail to meet the needs of the Trust and the ICS and are not developed, approved 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: 12

Strategic objective	C3
Latest review date	September 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 (Sep 22)	**3**	**4**	**12**

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. Director-led Addenbrooke's 3 working group meeting fortnightly.
3. Regular reporting to ME and Addenbrooke's 3 Board committee in place.
4. Monthly progress meetings with NHSE/I (regional & national) and DHSC and regular engagement with New Hospitals Programme (NHP).
5. Cancer SOC approved in November 2021 including approval of 2021/22 drawdown.
6. Addenbrooke's 3 Programme Business Case (PBC) submitted in May 2021.
7. 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.
8. 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.

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.
5. CCRH and CCH OBC submission dates both moved to September/October 2022 and aligned with University of Cambridge timelines.
6. The PBC options describe the phases of development of the CUH campus over the next 10-15 years.
7. 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. Phase 1 work being developed into business cases/proposals for sharing externally. Histopathology case approved by Board in June 2022 and case for addition of three theatres to the 40-bedded unit approved in July 2022.

9. Supporting ICS partners in development of Community Diagnostics Hub at Princess of Wales Ely. 10. Fundraising campaigns in place for CCH and CCRH. Cornerstone gift secured for CCH. Work underway on commercial strategies. 11. Addenbrooke's 3 Phase 1 priorities identified with governance in place. Business case for 56-bed unit submitted to regulators. Approval given for £14.9m funding for addition of theatres to 40 bedded unit. 12. Learning from Covid-19, e.g. positive changes to models of care delivery, ways of working and design, being incorporated into development of Addenbrooke's 3 projects. 13. Patient engagement plan being redeveloped and due to be launched later in 2022. 14. Addenbrooke's 3 materials being developed to support conversations.	

Gaps in control	Gaps in assurance	Actions to address gaps in controls and assurances	Due date
C1. Following communication from DHSC on 2 October 2020 that only funding for CCRH will be allocated before 2025, through the Hospital Infrastructure Plan (HIP), in the current spending review the following gaps have been identified: C1a. Funding value for CCRH not confirmed – but sufficient funding thought to have been earmarked. All NHP schemes being impacted by high rate of inflation. C1b. Any additional CCH scope will need to be defined in OBC. C1c. 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).		C1a. Confirmation being sought on funding envelope for CCRH. C1b. Costs versus benefits of any scope increase for CCH to be described within the OBC. C1c. PBC for Addenbrooke's 3 describes phased plans for CUH campus for short (next 18 months), medium (2021–2025) and longer term (2025+).	Ongoing By July 2022 Ongoing
C2. Engagement and involvement plan and materials for all stakeholders, e.g. ICS partners/patients, in development.		C2. Communications and engagement plan shared with Addenbrooke's 3 Committee (June and September 2021). Draft materials shared initially with the Committee in January 2022 and now being further developed.	December 2022
C3. Full governance structure and resource for phase 3 developments, e.g. acute hospital, on hold due to funding.		C3. Will be established once scope of project is defined and funding secured.	tbc

Risk score	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22
	12	12	12	12	12	12	12	12	12	12	12	12	12

BAF risk	010	**The Trust does not work effectively with partners across the Integrated Care System (ICS), within the local Integrated Care Partnership/South Alliance and across the east of England (particularly in relation to specialised services), resulting in a failure to improve services for local and regional patients and regulatory intervention and/or the recurrence of a financial deficit.**

Current risk rating: 12

Strategic objective	A1, C1
Latest review date	September 2022

Lead Executive	Director of Strategy and Major Projects
Board monitoring committee	Board of Directors

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	4	3	12
Current (Sep 22)	4	3	12

Change since last month
⟺

Related BAF and Corporate Risk Register entries

ID	Score	Summary risk description
BAF 009	12	Campus development proposals
BAF 011	16	Financial sustainability

Key controls

What are we already doing to manage the risk?

Integrated Care System

1. Integrated Care Board (ICB) went live on 1 July 2022.
2. System Delivery Director in post focused on elective recovery and implementation of the Long Term Plan (LTP).
3. Fully involved in ICS and regional planning and coordination for 2022/23 including detailed revision of plans into June 2022. Internal business planning for 2022/23 was aligned to ICS priorities.
4. CUH Executives lead and some contribute to all system-wide groups on Covid recovery, financial performance, workforce, estates, digital, etc.
5. Leadership and Organisational Development programme has been commenced, with expert external facilitators.

Integrated Care Partnership

6. South Provider Alliance driving clinical service transformation for local population, including supporting winter resilience through discharge and flow, with business cases being developed for services to be up and running ahead of winter 2022/23.
7. Alliance evolving into a more formal structure, with governance proposals agreed by CUH and South Place boards. Interim MD for ICP in post to lead development, based at CUH. Wider team supporting with further resources agreed. Engagement to define joint working approach.
8. Work commencing on medium-term strategy for South Place including building capacity and capability to take on appropriate functions in a

Assurances on controls

How do we gain assurance that the controls are working?

1. Regular communication with ICB partners and the regional team, enabling concerns to be raised and issues discussed at an early stage.
2. Feedback and intelligence from Executive Team participation in, and leadership of some, system-wide groups.
3. Regular review of performance data at system level.
4. Triangulation of system-wide planning assumptions to ensure a consistent approach across all partners.
5. ICS and South Place development discussed regularly at Management Executive and Board of Directors.
6. Ongoing partner, peer and regional team feedback on ICS and South Place planning and development.
7. Regular engagement with national teams on emerging policy and legislation, including through Shelford Group.

safe, planned and phased manner. Will dovetail with ICS Most Capable Provider (MCP) Framework process being shaped alongside partners.

Specialised services

9. Commencing work on formation of provider collaborative(s) with other trusts in east of England, including proposals for taking on appropriate specialised commissioning responsibilities. Data analysis work complete. Chief Executives' meeting held with agreed next steps.
10. Actively engaging with specialised commissioners and ICBs across the region. Resource from CUH secured and in post; co-investment across other trusts and regional team being agreed.

Other

11. CUH working with Shelford Group and other experts to develop roles as an "anchor institution", including how as an employer, purchaser and partner we can support economic recovery, tackle inequalities and "level up". Discussion at CUH Board awayday in May and November 2021 and incorporated in summer 2022 strategy refresh.
12. Digital strategy work identifies opportunities to use technology and data to improve population health and service integration.

Gaps in control	Gaps in assurance
C1. Ongoing operation as ICS dependent on financial framework and relations with regional team – progress made on national financial plan, more work needed on clear plan for delivery of LTP priorities and financial efficiencies. C2. Available time for ICS and South Place development activities being compromised by recovery planning and operational stretch, meaning that change happens too slowly. C3. Legislative and financial framework in 2022/23 may drive unhelpful changes or force the pace of change too quickly. C4. More work required on South Place development plan and MCP process to govern potential transfer of responsibilities over 12-18m period from July 2022, inc. additional resource. C5. Development of CUH "anchor institution" and health inequalities proposition. C6. Co-investment in specialised services team from partners.	

Actions to address gaps in controls and assurances	Due date
C1. Agreeing and implementing a clear plan to become an ICP, work currently underway and is well-developed. System work commencing on planning for 2022/23 following national guidance and financial framework, as well as a medium-term financial plan.	September 2022
C2. Work on recovery, Covid response and winter planning.	Ongoing
C3. Work with Shelford Group and Government to ensure policy framework supports development of systems like C&P.	Ongoing
C4. Skeleton team in place; working group meeting across CUH teams; commencing engagement with ICS to shape process; plan to secure additional non-recurrent support if required.	December 2023 August 2022
C5. Anchor institution, ICS, ICP and provider collaborative development fully reflected in CUH strategy.	Complete
C6. CUH posts agreed to catalyse co-investment from partners.	

Risk score	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 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	September 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 (Sep 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 a 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 the development of system financial plans for the Integrated Care Board (ICB) and oversight through the Financial Planning and Performance Group (FPPG) within the ICB governance.
3. Oversight of the development of plans for the Integrated Care Partnerships to ensure risks and opportunities are understood.
4. Improvement and Transformation team oversight of the Trust's improvement programme and development of a transformation programme.
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 in respect of Covid-related investments).
7. Regular reviews of the Trust's financial performance through the monthly

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 ICP planning through Performance Committee, Audit Committee and Board.
4. Monitoring of improvement programme through Divisional Performance Meetings, Improving Together Steering Group, Performance Committee and Board.
5. Updates on NHS financial regime provided to Management Executive, Performance Committee and Board.
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.
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.

internal and external financial reporting cycle, including regular assessments of the Trust's underlying financial position. 8. Effective design and implementation of key financial controls to ensure expenditure is reasonable, justifiable and represents value for money. Key controls include financial system controls, vacancy control procedures, segregation of duties, and procurement and contract management processes.	

Gaps in control	Gaps in assurance	Actions to address gaps in controls and assurances	Due date
C1. The macroeconomic environment, including supply constraints and inflation, as well as the prevalence of Covid, may lead to additional financial pressure above funded levels. The ability to control these pressures is largely outside the Trust's direct control.		C1a. Ongoing monitoring of risks and impact on the Trust and ICB financial plan.	Ongoing
		C1b. Development of new financial forecasting tools to provide a more responsive approach to identifying financial risk and mitigations.	September 2022
C2. Lack of a coordinated cross-divisional approach to prioritisation of investment cases outside of the budget setting process.		C2. Implementation of a sub-group of the Investment Committee (Investment Committee Prioritisation Group) to prioritise investment in accordance with an agreed investment framework.	August 2022
C3. Development 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.	September 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. in receipt of Elective Recovery Funding).		C4. Ongoing monitoring of risks through FPPG, with reporting to Performance Committee.	Ongoing

Risk score	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22
	16	16	16	16	16	16	16	16	16	16	16	16	16

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	September 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 (Sep 22)	3	3	9

Change since last month: ⟺

Related BAF and Corporate Risk Register entries		
ID	Score	Summary risk description
BAF 009	12	Campus 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	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 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	September 2022

Lead Executive	Director of Workforce
Board monitoring committee	Workforce and Education

Risk rating	Impact	Likelihood	Total
Initial (Apr 21)	4	4	16
Current (Sep 22)	4	4	16

Change since last month

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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 place.
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.
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'.

(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	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22
	16	16	16	16	16	16	16	16	16	16	16	16	16

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

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Report to the Board of Directors: 12 October 2022

Agenda item	14.1
Title	Medical Revalidation
Sponsoring executive director	Ashley Shaw, Medical Director
Author(s)	John Firth, Responsible Officer and Deputy Medical Director Alison Risker, Associate Director of Workforce Beverley Collins, Revalidation and Compliance Support Manager
Purpose	To provide assurance to the Board that the Trust as healthcare provider is discharging its duties under the Responsible Officer Regulations, and to the Chief Executive in signing the 2021/22 Designated Body Statement of Compliance (Section 7)
Previously considered by	Management Executive, 1 September 2022

Executive Summary

CUH is the Designated Body for 1,195 doctors and has a statutory requirement to provide annual appraisals for these doctors and make revalidation recommendations when required.

Related Trust objectives	Improving patient care; Supporting our staff
Risk and Assurance	See purpose above
Related Assurance Framework Entries	BAF ref: 007

Legal / Regulatory / Equality, Diversity and Dignity implications?	The Medical Profession (Responsible Officers) Regulations 2010 (as amended 2013), and The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012
How does this report affect Sustainability?	Successful revalidation of doctors with a prescribed connection to the Trust is required for the continuation of their legal medical practice in the UK
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 which will be shared, along with the annual audit, with the higher level responsible officer at NHS England (East) Region.
- Approve the designated body statement of compliance, Section 7, confirming that the organisation, as a designated body, is in compliance with the regulations. This is submitted annually to the higher level responsible officer at NHS England (East) Region.

Designated Body Annual Board Report

Section 1 – General:

The board of Cambridge University Hospitals NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: n/a Comments: Dr John Firth was appointed as RO from 1 November 2017 Action for next year: n/a

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: n/a Comments: With nationally mandated change in requirements of appraisal discussions the MAG form will no longer be supported by NHS England. The Trust will need to review how appraisals will be undertaken and it is likely that a new appraisal platform will be required. Action for next year: Possible procurement and implementation of a new appraisal platform

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: n/a Comments: There is a process in placed to ensure that an accurate record is maintained Action for next year: n/a

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: n/a Comments: The medical appraisal and revalidation policy is reviewed in line with the Trust schedule Action for next year: n/a

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: n/a Comments: COVID-19 has restricted the ability to conduct a peer review Action for next year: n/a

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: n/a Comments: Support is provided to this cohort of staff Action for next year: n/a

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1] Action from last year: 1061 doctors were appraised in 2021/22. 32 doctors were approved for a missed appraisal by the RO whilst 1 doctors had an unapproved missed appraisal Comments: further detail is available in table 1; see appendix 1 Action for next year: to continue to ensure that doctors are appraised

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: n/a

[1] For organisations that have adopted the Appraisal 2020 model (recently updated by the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

Comments: the Trust is following the escalation process as per the medical appraisal and revalidation policy Action for next year: to continue with the Trust's agreed practice

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: n/a Comments: The medical appraisal and revalidation policy is reviewed in line with the Trust schedule Action for next year: n/a

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: The Trust has 171 trained appraisers of which 169 appraised in the 2021/22 appraisal round Comments: The Trust will continue to recruit new appraisers Action for next year: To continue the recruitment process

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: 22 new appraisers were trained during the 2021/22 appraisal round. 147 Appraisers received refresher training Comments: n/a Action for next year: To continue with the recruitment and training processes for new and current appraisers.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: n/a Comments: These figures are presented to the Board as an appendix to this report Action for next year: to continue with the Trust's agreed practice

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: Cambridge University Hospitals NHS Foundation Trust	
Total number of doctors with a prescribed connection as at 31 March 2022	**1231**
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	**1061**
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	**170**
Total number of agreed exceptions	**169**

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: n/a Comments: 145 recommendation were made to the GMC: ● 133 positive revalidation recommendations ● 12 deferral recommendations

The deferral recommendations were all due to insufficient evidence for a recommendation to revalidate.

All recommendations were made to the GMC by the doctors' submission dates. No recommendations were rejected by the GMC.

Action for next year: to continue with the Trust's agreed practice

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: n/a

Comments: All doctors are contacted in relation to their revalidation recommendation

Action for next year: to continue with the Trust's agreed practice

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: n/a

Comments: Clinical governance mechanisms are well embedded in the Trust

Action for next year: to continue with the Trust's agreed practice

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: n/a

Comments: Mechanisms for monitoring conduct and performance of doctors are well established in the Trust

Action for next year: to continue with the Trust's agreed practice

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: n/a Comments: There is a well-established process for dealing with FTP concerns, supported by appropriate Trust policies Action for next year: to continue with the Trust's agreed practice

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: n/a Comments: This data is reported to the Board on a quarterly basis Action for next year: to continue with the Trust's agreed practice

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: n/a Comments: The Trust follows the guidance stated in Information flows to support medical governance and responsible officer statutory function, NHS England, 11 August 2016 Action for next year: to continue with the Trust's agreed practice

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: n/a Comments: The Trust follows the guidance stated in Information flows to support medical governance and responsible officer statutory function, NHS England, 11 August 2016 Action for next year: to continue with the Trust's agreed practice

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: n/a Comments: There is a system in place to undertake quarterly audit, with reports sent to the workforce compliance committee Action for next year: to continue with the Trust's agreed practice

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of actions since last Board report:**
- **1231 prescribed connections**
- **1061 doctors have a completed appraisal**
- **145 recommendations were made to the GMC**
- **22 new appraisers were trained**
- **Actions still outstanding: none**

- **Current Issues:** With nationally mandated change in requirements of appraisal discussions and the MAG form no longer being supported by NHS England the Trust will need to review how appraisals will be undertaken and it is likely that a new appraisal platform will be required.

- **New actions:** Possible procurement and implementation of a new appraisal platform

Overall conclusion: The number of prescribed connections continues to increase: -

- **1097 as at 31 March 2019**
- **1136 as at 31 March 2020**
- **1195 as at 31 March 2021**
- **1231 as at 31 March 2022.**

The Trust is constantly recruiting and training appraisers to meet the rising appraisal demand.

Section 7 – Statement of Compliance:

The Board of Cambridge University Hospitals NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

(Chief executive)

Official name of designated body: Cambridge University Hospitals NHS Foundation Trust

Name: Roland Sinker Signed: _ _ _ _ _ _ _ _ _ _ _

Role: Chief Executive

Date: _ _ _ _ _ _

Appendix 1 – 2021/2022 Appraisal Data:

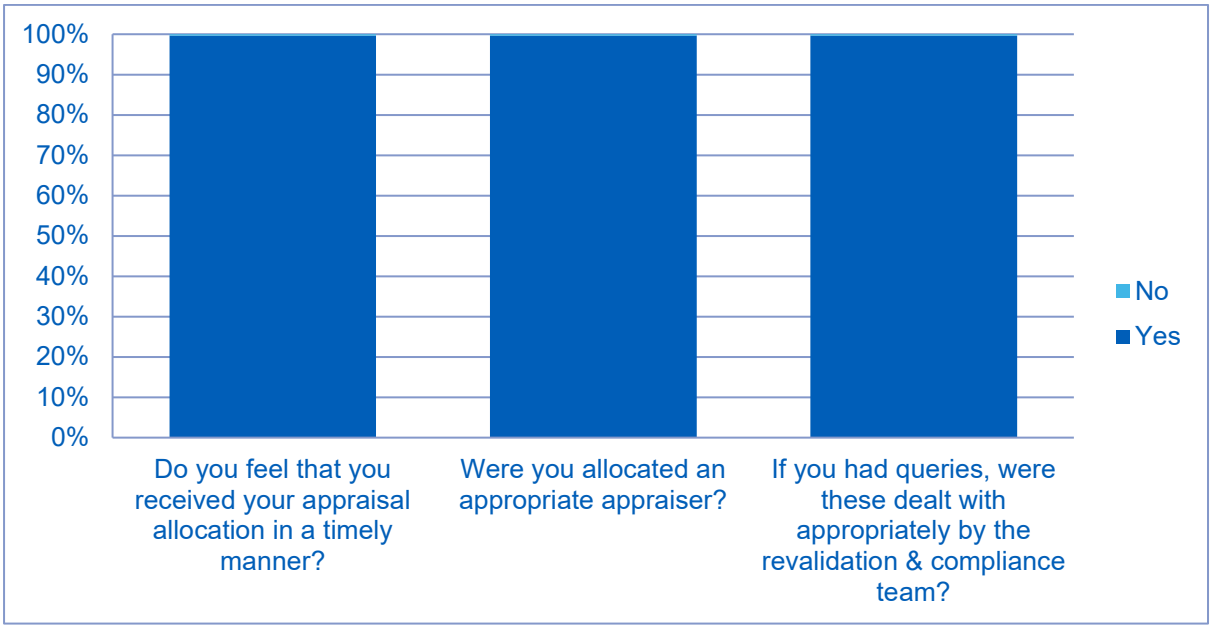
Doctors with a connection at 31 March 2022	Number of Prescribed Connections	Completed Appraisal (1)		Approved incomplete or missed appraisal (2)		Unapproved incomplete or missed appraisal (3)		Appraisal Not Required		Total
		No	%	No	%	No	%	No	%	No
Consultant	848	812	96	21	2	1	0	14	2	848
Staff grade, associate specialist, specialty doctor	23	22	96	1	4	0	0	0	0	23
Temporary or short-term contract holders	358	225	63	10	3	0	0	123	34	358
Other	2	2	100	0	0	0	0	0	0	2
Total	1231	1061	86	32	3	1	0	137	11	1231

Reason for approved missed appraisal (2)	Number	%
Maternity Leave	17	53
Ill health	5	16
COVID-19	2	6
Other doctor reason	5	16
Admin factors	3	9
Total category 2	32	100

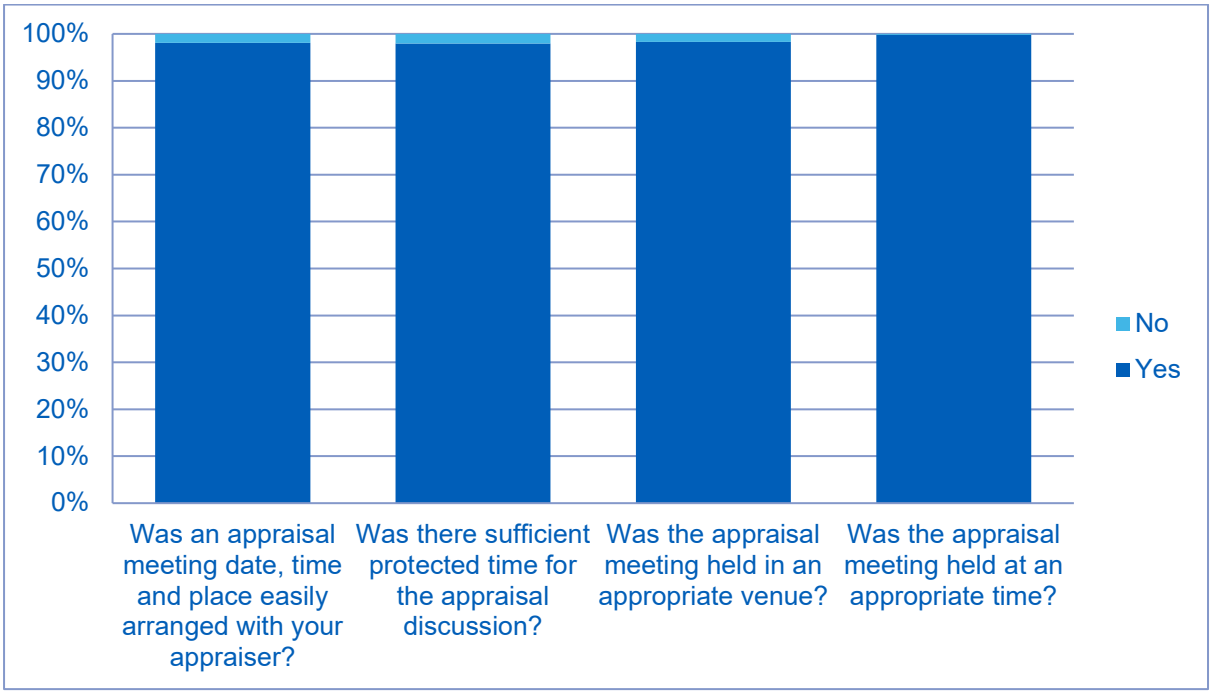
Appendix 2 – Appraiser QA Summary Feedback Report:

Appraisal Year:	2021/22
Overall number of appraisee respondents:	592
Number of appraisees invited to respond	1133
% Response Rate	52%

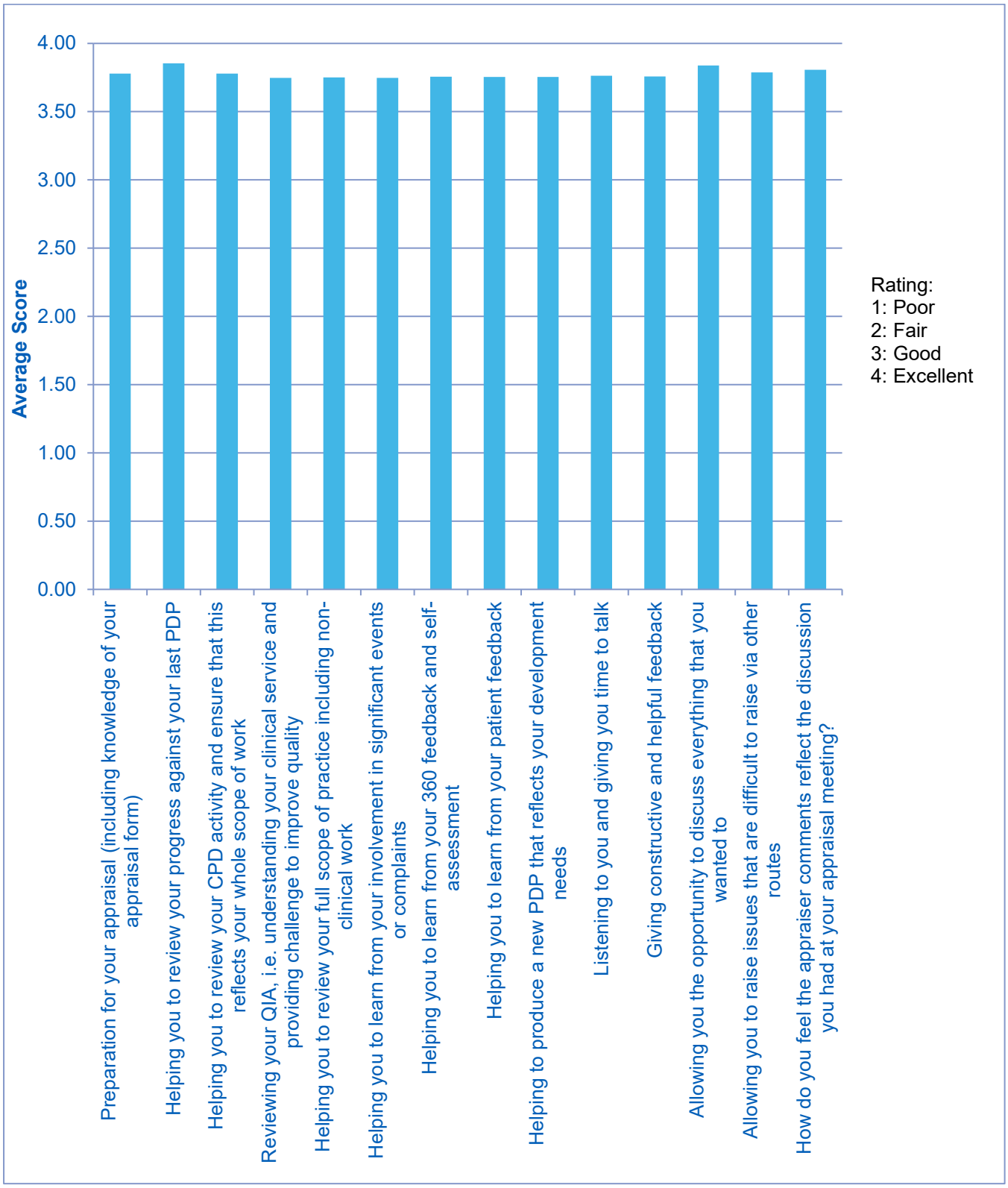
Administration and Management of the Appraisal System



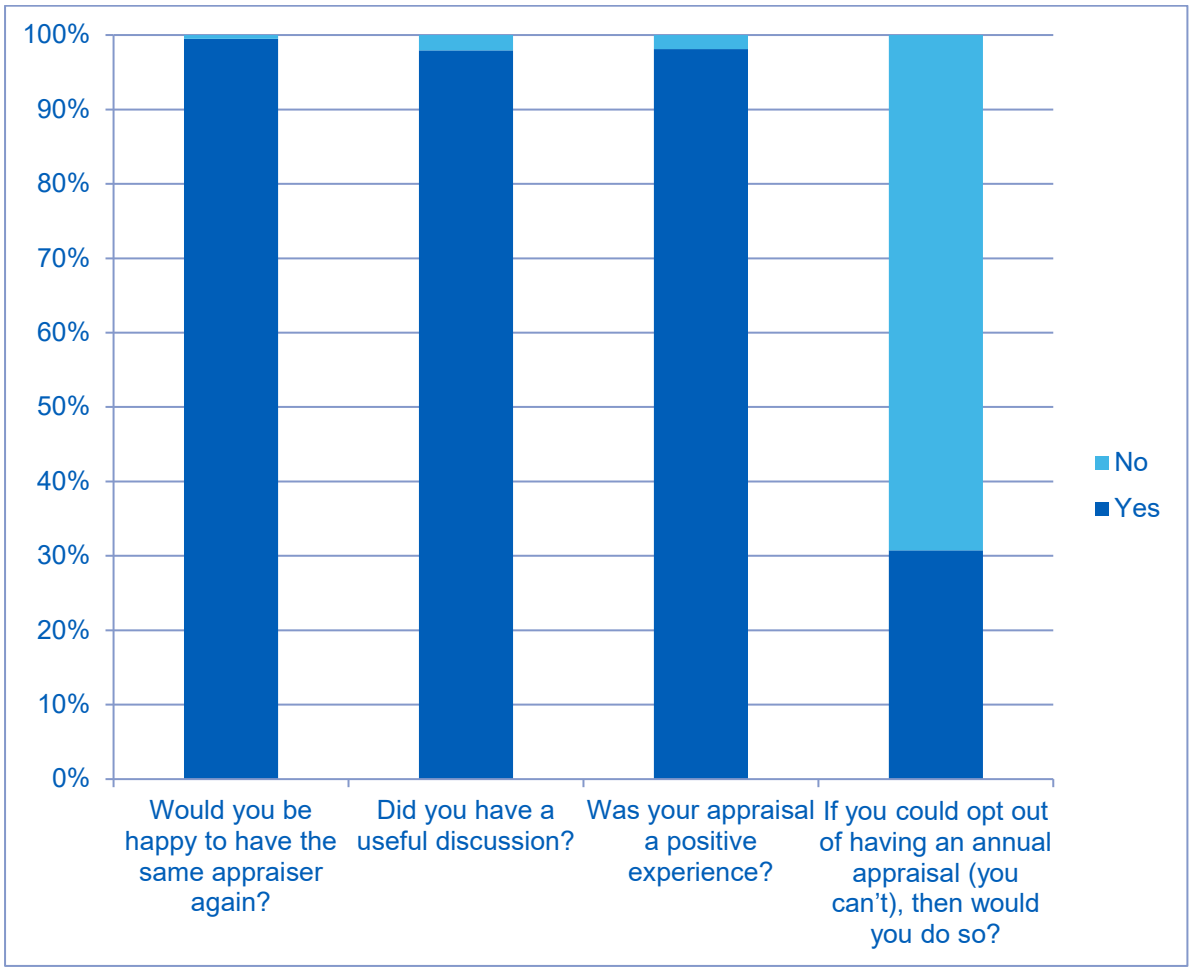
Organisation of the appraisal meeting



Appraiser Skills



Overall experience



Appendix 3 – Quality Assurance of Appraisal Inputs and Outputs:

Total number of appraisals completed		**1060**
	Number of appraisal portfolios sampled (to demonstrate adequate sample size)	Number of the sampled appraisal portfolios deemed to be acceptable against standards
Appraisal inputs		
Scope of work: Has a full scope of practice been described?	339	334
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	339	332
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	339	291
Patient feedback exercise: Has a patient feedback exercise been completed? (only relevant for appraisal before revalidation date)	113	93
Colleague feedback exercise: Has a colleague feedback exercise been completed? (only relevant for appraisal before revalidation date)	113	102
Review of complaints: Have all complaints been included?	339	333
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	339	333
Is there sufficient supporting information from all the doctor's roles and places of work?	339	323
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)? Explanatory note: For example • Has a patient and colleague feedback exercise been completed? • Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)? • Have all types of supporting information been included?	339	317
Appraisal Outputs	339	339
Appraisal Summary	339	339
Appraiser Statements	339	336
Personal Development Plan (PDP)	339	339

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

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Report to the Board of Directors: 12 October 2022

Agenda item	14.2
Title	Nursing and midwifery revalidation
Sponsoring executive director	Lorraine Szeremeta, Chief Nurse
Author(s)	Amanda Small, Deputy Chief Nurse
Purpose	To provide assurance that Cambridge University Hospitals NHS foundation trust staff are meeting the nursing and midwifery revalidation requirements.
Previously considered by	Management Executive, 1 September 2022

Executive Summary

The nursing and midwifery revalidation process of renewing Nursing and Midwifery Council (NMC) registration every three years came into force on 1 April 2016. At Cambridge University Hospitals NHS foundation trust (CUH) revalidation is reviewed and monitored through the annual appraisal process to enable staff to keep up to date with the requirements and to discuss progress and development with their line manager. This paper provides an overview of the number of staff who have or are due to revalidate this calendar year and provides assurance that CUH have had no breaches or non-compliance with the NMC revalidation process.

Related Trust objectives	Improving patient care; Supporting our staff
Risk and Assurance	The report provides assurance on compliance with revalidation requirements.
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 receive the annual report on nursing and midwifery revalidation and to note that there are no issues requiring escalation.

1. Background

1.1 The revalidation process of renewing Nursing and Midwifery Council (NMC) registration came into force on 1 April 2016.

1.2 The purpose of revalidation is to improve public protection by making sure that Registered Nurses and Registered Midwives continue to remain fit to practice throughout their career. It encourages registrants to seek feedback from patients and colleagues, to reflect upon the Code of practice by having a professional discussion with another Registered Nurse or Midwife, to undertake professional development and, importantly, to seek confirmation that they have met the requirements to remain on the register from a third party.

1.3 At CUH we review and monitor the revalidation process through the yearly appraisal process to enable staff to keep up to date with the requirements and to discuss progress and development with their line manager.

2. Requirements of Revalidation

2.1 Revalidation requires NMC registrants to evidence:

- Practising at least 450 hours during the last three years (900 if they wish to practise both as a Nurse and a Midwife).
- At least 35 hours of continuing professional development (CPD) 20 of which must be participatory.
- Professional indemnity arrangements are in place.
- Capability of safe and effective practise by obtaining at least five pieces of practise related feedback and reflecting on them linking their thoughts to the NMC Code.
- At least five reflective accounts based on CPD, feedback and the NMC Code.
- A health and character declaration.
- Third party confirmation of the above during the final 12 months preceding the date of revalidation.

3. Revalidation data

3.1 In 2022, 348 staff members were due to revalidate. Table 1 demonstrates the number of staff who are due to revalidate each month.

Table 1: Number of staff due to revalidate per month until calendar year end

Year	Revalidation Date	Total
2022	Feb	1
	May	1
	Jul	1
	Aug	9
	Sep	160
	Oct	88
	Nov	61
	Dec	27
Grand Total		**348**

3.2 At this stage in the year, CUH have had no breaches or non-compliance with NMC revalidation.

3.3 Any staff whose PIN (registration) numbers are no longer valid are immediately escalated through the electronic staff record (ESR) to the relevant team leader/manager. Four cases have been escalated this year to date.

4. Governance arrangements

4.1 The process is embedded as business as usual at CUH as outlined below:

- Revalidation data is tracked and managed through the Electronic Staff Record (ESR) which links to the NMC interface. This data is checked monthly and reminder e-mails are sent to staff two months prior to their end date.
- The appraisal policy makes reference to the requirements for revalidation. Appraisal compliance is monitored and reported via the Divisional monthly performance meetings.
- An e-learning package is available on DOT (the Trust's e-learning system) to support registrants with revalidation and reflection.
- Ongoing face to face training is available from the clinical education support team as required for both registrants and confirmers.
- There are support pages on the Trust intranet which has links to the NMC website.

5. Recommendations

5.1 The Board of Diretcors is asked to receive the annual report on nursing and midwifery revalidation and to note that there are no issues requiring escalation.

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

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Report to the Board of Directors: 12 October 2022

Agenda item	15.2
Title	Health and Safety Annual Report 2021/22
Sponsoring executive director	David Wherrett, Director of Workforce
Author(s)	Helen Murphy, Head of Health and Safety
Purpose	To receive the annual report
Previously considered by	Quality Committee, 6 July 2022

Executive Summary

The Health and Safety Annual Report for 2021/22 is attached. It was received and endorsed by the Quality Committee at its meeting on 6 July 2022.

Related Trust objectives	Improving patient care, Supporting our staff
Risk and Assurance	The paper provides assurance on arrangements in place in relation to health and safety.
Related Assurance Framework Entries	n/a
Legal / Regulatory / Equality, Diversity & Dignity implications?	Health and Safety at Work Act 1974
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent	Yes

Actions required by the Board of Directors
The Board is asked to receive the Health and Safety Annual Report for 2021/22.

Health and Safety

Annual Report 2021/22

Executive Summary

- The purpose of this annual report is to provide summary information on the management of health and safety at CUH for the period between 1 April 2021 and 31 March 2022.
- The health and safety team have continued to support the Trust's response to COVID-19 during 2021/22.
- A new health and safety strategy has been developed to set the direction for effective health and safety at CUH over the next 5 years.
- A number of health and safety risks and significant issues are addressed in section 4 of the annual report.
- There were 3 significant incidents in 2021/22. The details of these are set out in section 5 of the annual report.
- There were 1,460 health and safety incidents reported in 2021/22. The top three incident categories remain the same as previous years – violence and aggression, accidents, and blood/bodily fluid exposures.
- The staff incident rate is 9.8 staff members harmed per 100 workers (a decrease against last year's rate of 11.6).
- 48% of incidents reported resulted in actual harm (3% increase from last year).
- There were 31 non-COVID RIDDORs reported to the HSE in 2021/22 (9 less than last year).
- 77% (24) of RIDDORs were reported to the HSE within the appropriate timescales. The other 23% (7) were due to late reporting to the health and safety team that the incident was RIDDOR reportable. Reporting timescales were 70% in 2020/21.
- The HSE followed up 3 RIDDORs during 2021/22, but no enforcement action was taken.
- Since the beginning of the pandemic, there have been 139 COVID-19 RIDDORS reported to the HSE; of which 37 were reported during 2021/22 – the majority being cases of disease where there is reasonable evidence to suggest that the member of staff contracted COVID from their work.
- The health and safety team carried out 170 COVID-19 spot checks during 2021/22 in place of the monthly health and safety audit programme which was paused during the pandemic.
- A health and safety management self-assessment audit was carried out in 2021/22. The results were encouraging and demonstrated that suitable arrangements for managing health and safety are established within local departments and services.
- The Trust's annual dangerous goods audit was carried out during 2021/22 and 32 recommendations were made for improvement.
- Questions on health and safety were included in the Quarter 4 National Quarterly Pulse Survey (NQPS) carried out by Picker on behalf of the organisation. The results

showed that 66.9% of staff felt that 'CUH was concerned about their health and safety'. This is lower than previous years and is disappointing as the Trust put a number of measures in place to protect staff during the pandemic. However, it is probably a reflection of the last 2 years and the enormous pressure staff have been under and continue to feel from large waiting lists and reduced staffing due to COVID.

- Staff responded to say that adequate staffing, facilities, space, equipment and rest breaks would greatly improve their health and safety. These are issues that continue to be raised by staff, and although not easy to 'fix', the Trust is committed to make improvements in these areas where possible.
- H&S committee continues to meet on a two monthly basis, chaired by the Director of Workforce. A summary of its work and sub-committees can be found in section 10 of this report.
- As at March 2022, compliance with health and safety core mandatory training was at 95.9% (compared to 96.2% in March 2021). Despite the pandemic, compliance has remained high.
- 87% of all current managers and supervisors have completed the online training module 'Health and Safety Awareness for Managers' (compared to 84% last year).
- Objectives for 2021/22 are set out in section 14 of this report. These are aligned with the Trust's H&S strategy.

Health and Safety

Annual Report 2021/22

1. Introduction

1.1 Welcome to this year's health and safety annual report. The purpose of this report is to provide summary information on the management of health and safety at CUH for the period between 1 April 2021 and 31 March 2022.

1.2 At CUH, we are committed to protecting the health and safety of all our staff and other persons who may be affected by our activities in accordance with the Health and Safety at Work Act 1974. Our commitment is underpinned by our Health and Safety Policy and our new five year strategy *'Safer culture, safer systems, safer workforce: embedding health and safety in everything we do'* that sets the direction for effective health and safety management at CUH (see section 3)

1.3 We observe the HSE's model for managing health and safety (HSG65) and continue to assess ourselves against ISO 45001, the international standard on occupational health and safety that provides good practice guidance on establishing and integrating health and safety within overall management systems.

1.4 We aim to develop a culture that strives for continuous improvement in health and safety. One that embodies strong leadership commitment and high levels of staff engagement. Where our workforce work safely in all that they do and where risks are proactively identified and managed.

1.5 We believe that no-one should be harmed at work and therefore our ultimate goal we strive for is to ensure that everyone who works or visits our hospital goes home safe and healthy every day.

2. COVID-19 response

2.1 The Head of Health and Safety is a member of the Secure Environment Taskforce and during 2021/22 the team has continued to provide support to staff on the completion of COVID-19 risk assessments, advice on restrictions and what is/isn't permitted, reporting of COVID-related RIDDORs and undertaking spot-check inspections (see section 8.1).

2.2 As we enter a new phase of 'Living with Covid', the team is advising the Trust on HSE requirements and when the completion of risk assessments is necessary. The Trust's COVID risk assessment has been updated to reflect the relaxing of restrictions in the Trust for reducing the transmission of COVID infection.

3. Health and safety strategy 2021-2026

3.1 During 2021/22 a new five year health and safety strategy *'Safer culture, safer systems, safer workforce: embedding health and safety in everything we do'* was developed to set the direction for effective health and safety management at CUH The strategy supports the Trust's aims and objectives as laid out in the corporate strategy and its associated workforce strategy. It also supports and contributes to the provision and delivery of our values of *Together – safe, kind and excellent*.

3.2 Our vision is that by 2026 we will have evolved into an organisation where *'heatlh and safety is embedded within everything we do'*. We will aim to provide a 'safer culture, safer systems, and safer workforce as described below:

- **Safer culture** – having a strong, positive health and safety culture that embodies strong leadership commitment and high levels of staff engagement
- **Safer systems** – having effective H&S management systems and risk-based safety systems that are integrated into all our services and activities so that risks are proactively identified and managed
- **Safer workforce** – having a workforce who work safely to the agreed processes and procedures and who '*Think safety, Act safely'*, in all that they do.

3.3 The strategy comprises of the following five strategic priorities to guide us towards our vision. Each of which is mutually dependent on one another:

- Leadership and commitment
- Collaboration and partnership working
- Communication
- Training and competence
- Compliance and assurance

3.4 The key challenge for this strategy is to how to build upon the progress made from the previous strategy and further embed health and safety into the operations of a large, complex and highly pressured organisation.

3.5 It has also been an incredibly difficult last 2 years. We have been under relentless pressure to respond to COVID-19, both professionally and personally. And it's still not over. Staff continue to feel the pressure as the Trust faces the surges in demand for non-COVID-19 related treatments and large waiting lists. Staff are tired and they need time to recover. Therefore, we will ensure that we support our workforce whilst embedding this strategy and simplify where we can.

3.6 As there is already a well-established foundation of good health and safety management at CUH, it is not envisaged that the success of this strategy will be heavily reliant on extensive investment; however, it will require commitment from the Board, senior management and the involvement of our staff, partners and other stakeholders to set the direction for effective health and safety management, ensuring systems are in place and properly resourced and that significant risks are being managed.

3.7 The strategy was approved by the Health and Safety Committee in November 2021 and will be monitored and reviewed on a regular basis. There will be an annual progress report to the Board of Directors each year. The Director of Workforce will also remain operationally appraised at his monthly meetings with the Head of Health and Safety.

3.8 A summary of the strategy can be found in Appendix 1.

4. Health and safety risks and significant issues

4.1 Shared workplaces

4.1.1 Recent cases at CUH have identified a lack of clarity on health and safety responsibilities within existing shared workplace written agreements. This has led to safety being compromised in parts of the premises.

4.1.2 The Property Team are reviewing existing agreements with solicitors to ensure that they contain express and unambiguous terms in respect of health and safety responsibilities. So that all parties are clear on what they are responsible for.

4.1.3 The Trust owes non-delegate health and safety duties and cannot simply opt out of these duties through a written agreement. Therefore, where the written agreement states that at a tenant is responsible for health and safety, there is still a responsibility for the Trust to monitor or follow-up with the tenant to check that they are discharging their duties appropriately. The Property Team are currently looking at the best way to implement and manage this going forwards.

4.2 New or reconfigured services/departments/wards

4.2.1 It is important that when establishing new or reconfiguring services/departments/ wards, that any health and safety implications are considered and mitigated in advance.

4.2.2 One example of this involves patient transfers from the P&Q wards (discharge wards). Despite the wards being operational the issue of how emergency transfers are carried out safely during out of hours, when there is no rapid response available from EEAST, have yet to be resolved.

4.2.3 In these situations it has been proposed that the patient is transferred via 'trolley transfer over-land'.

4.2.4 These transfers are required approximately 1-2 times a month and although should only be required in extreme situations, there are concerns regarding the safety of staff and patients involved in these transfers.

4.2.5 The health and safety team are now working with support services and operational teams to resolve the matter by carrying out a walk-through of the route, undertaking a risk assessment, ensuring staff are trained and that appropriate equipment is available such as a robust transfer trolley. However, this work should have been completed prior to the wards becoming operational.

4.3 Electromagnetic fields (EMF)

4.3.1 Further work is required to ensure compliance with the Control of Electromagnetic Fields Regulations 2016.

4.3.2 Health and Safety are working jointly with Head of Radiation Protection and liaising with key teams to help them implement the requirements.

4.3.3 It is anticipated that an external contractor will be required to assist with the identification of sources and the measurement of employee's potential exposure to EMF.

4.4 Violence and aggression

4.4.1 Violence and aggression is overseen and monitored by the Trust Security team and associated committees. Due to the nature of the services provided by the Trust and the acuity of our patients, violence and aggression remains a risk within the Trust. Incidents of physical violence averages at 20 assaults per month with the vast majority (97%) committed by patients whist direct care is being provided.

4.4.2 A review of data has not been able to conclude whether a particular staff group is targeted or whether patient behaviour is indiscriminate. Further review of the incident reporting system is needed to ensure that this information is captured.

4.4.3 During 2021/22 there were a total of 22 written warnings, 4 exclusions and 65 arrests were made on-site by local police, resulting in 22 criminal charges.

4.4.4 Systems are in place to support the management of violence and aggression risks and the Trust's Violence and Aggression Policy lays out clear and identified steps, with supporting actions for managing incidents and challenging behaviours.

4.4.5 Face to face training has been restricted due to COVID, however where requested or identified as a significant risk, training has been delivered. A request for breakaway training to be mandatory has been submitted to the Mandatory Training Group. This proposal is fully supported by the Health and Safety Committee.

4.4.6 A separate annual report is produced by the Head of Security.

4.5 Contractor management

4.5.1 Contractors/subcontractors are considered a risk due to inconsistent health and safety management of third parties working on site. As COVID-19 restrictions lift the Health and Safety team will resume its monthly audit programme which will include a new audit of contractor management. Departments and areas will be assessed on whether they are following requirements as set out in the Trust's contractor management policy.

4.5.2 As a high user of contractors, a separate audit was carried out in Capital, Estates and Facilities in July 2021 to identify if appropriate risk assessments and method statements (RAMS) had been provided by contractors prior to undertaking maintenance work on site as required by the Trust's contractor management policy.

4.5.3 The audit identified that RAMS were not available for the large majority of works. In 42% of cases, generic risk assessments were available but no method statement was provided. There was no information provided for the remaining 58% of contractors. There was also limited evidence that works had been completed or completed to the required standard and there was no documented evidence that spot-checks of works were being carried out.

4.5.4 The results were escalated to the CEFM Health and Safety Committee who agreed to put together a plan on how the gaps are to be addressed going forward.

4.6 Staff wellbeing, stress and burnout

4.6.1 It is well known that staff stress and burnout was an issue in the NHS workforce long before COVID-19. However, COVID has exacerbated existing problems with chronic excessive workload and increased working hours, plus the effects of emotional strain from staff experiences.

4.6.2 Staff wellbeing must remain a priority if we are to attract and retain skilled staff, keep them physically and mentally well, and provide high quality care to patients and service users.

4.6.3 At the heart of the solution to workforce stress and burnout is better workforce planning to ensure that services have the right number of people, with the right mix of skills. The Trust has a long-term plan on how staff shortages will be tackled. We may not be able to solve the issues around burnout overnight but we can at least give staff confidence that a long term solution is in place.

4.6.4 The additional support provided to staff during the pandemic is also being maintained as the Trust returns to business as usual. This includes coordinated access to psychologists, pastoral support including from chaplaincy, staff mental health service, Occupational Health, 24/7 employee assistance programme, counselling, doctors for doctors and staff wellbeing hub resources.

4.7 Bulk gas storage areas, compounds and manifolds

4.7.1 It has been identified that a review of all bulk gas storage areas, compounds and manifolds on-site is required to assess their compliance with the Dangerous Substances and Explosive Atmospheres Regulations 2016 and associated HSE guidance.

3.5.2 In addition, there needs to be clarity on which organisation is responsible for the health and safety of each gas storage area, compound or manifold. This comes back to having clearly defined workplace agreements setting out which organisation is responsible for health and safety compliance.

3.5.3 This issue was raised at the Capital, Estates and Facilities Health and Safety Group who have agreed to arrange an audit of all areas by a competent DSEAR contractor.

4.8 Permit to work

4.8.1 The Trust still has no written permit to work policy. This has been raised with Capital, Estates and Facilities who have agreed to create a policy.

4.8.2 Once written, there will also be a requirement for it to be audited on a regular basis to ensure that it is being complied with.

4.9 Lack of assurance on the Trust's health and safety management system

4.9.1 No internal audit of the health and safety management system has occurred since September 2016.

4.9.2 There are currently no plans to audit health and safety in 2022/23 as it currently sits as a 'medium' risk on the audit plan and the 'high' risk areas tend to absorb the limited audit resource.

4.10 Workplace transport safety

4.10.1 Workplace transport safety (eg vehicle movements on-site) continues to be a risk. However, good progress has been made in relation to mitigating the risks within the main service yard. This includes providing a marshal for the area, improved road markings and establishing a user group to co-ordinate and monitor activities.

4.10.2 An action plan to address the site safety audit carried out by AECOM in October 2019 is in progress of being delivered. A large number of small-scale recommendations have been completed (such as cutting back vegetation, replacement of broken lighting, installation of lighting) and the larger-scale recommendations have been packaged into a series of schemes and investment provided. A further audit is planned once the works are complete. The risk currently sits on the corporate risk register as a high risk (current risk rating 12).

4.10.3 The tragic death of a member of staff in October 2021 who was involved in a road traffic accident external to the CUH campus whilst travelling to work, was a stark reminder of why it is important to have effective arrangements in place to manage the risks from vehicle movements on site.

4.11 Sharps training for medical staff

4.11.1 Contrary to Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, medical teams are currently not receiving any training on sharps. This has been raised by the Head of Health and Safety at the Mandatory Training Advisory Group (MTAG) and also directly with the medical lead for education.

4.11.2 The medical lead for education has stated that the sharps training will not be relevant to all medical teams due to their role, professional status, and speciality and therefore, rather than it being 'mandated' for all medical teams it should be

more targeted to those teams and roles which frequently use sharps. This is the approach currently being undertaken with the roll out of blood transfusion training.

4.11.3 In order to identify staff, a review of cost centres (to differentiate between specialities) and a review of position numbers (to differentiate between grades) will need to be undertaken. It is acknowledged that this is large piece of work but it is the only way that this can be done.

4.11.4 Going forward, MTAG need to ensure that this review is carried out and that sharps training is provided to medical teams who are exposed to a risk of injury from sharps in accordance with regulation 6 and schedule 1 of the sharps regulations.

4.12 Seating at work

4.12.1 In 2015 a member of staff was injured when she went to sit down on a wheeled stool which inadvertently rolled away from her. Following the incident, the member of staff claimed for compensation for personal injury against the Trust.

4.12.2 The Trust defended the case but unfortunately were unsuccessful at trial that took place at the end of June 2021.

4.12.3 The judge found in the claimant's favour. She found that the Trust breached its duty of care towards the claimant by failing to risk assess the suitability of wheeled stools prior to their introduction in the area.

4.12.4 The judge made it clear that the stools were not defective, and that they may well be entirely suitable to be used in other areas of the Trust but in her view were just not suitable or necessary for the particular area where the incident occurred.

4.12.5 Following the judgement, solicitors advised the Trust to put in a process to ensure that prior to introducing any new seating in an area that their suitability is risk assessed.

4.12.6 Since March 2021, another 13 incidents have been reported involving seating at work. The majority of incidents have occurred in clinical areas where wheeled chairs are used on hard flooring. Hard flooring increases the speed at which the chair/stool moves increasing the risk of a fall/injury. In addition to the above incidents, further injuries have been caused by staff tripping over the chair/stool bases, and faulty chairs eg chair backs breaking off.

4.12.7 The health and safety team have drafted a new *Seating at Work Procedure*. This reflects HSE requirements and includes a checklist for managers to use to help them identify the features required to ensure the seating is suitable for its intended use eg.whether it requires wheels, brakes or wipe clean upholstery.

4.12.8 In addition the health and safety team are working with procurement to identify key providers for the purchase of office and specialist seating (eg theatre stools, laboratory seating, etc) and with infection control colleagues to ensure the most appropriate upholstery is fitted as standard for seating to be used in clinical areas.

4.12.9 Whilst the above actions will help to ensure that seating purchased going forward is suitable for the environment, task and individual, there is a significant quantity of existing seating within the Trust. Some of which, will not be suitable or meet HSE requirements and therefore continue to pose a risk of injury.

4.12.10 Further discussion is needed at the Health and Safety Committee on the following two proposals:

- review of all seating in the Trust and replace where it is found to be unsuitable.

- removal of wheeled seating from clinical areas except where specifically required for the task eg DSE use (over an hour) or surgery/dentistry seating and replace with suitable static seating.

5 Significant health and safety incidents

5.1 Helipad incident 21.04.21 (SLR 114591)

5.1.1 In February 2022 the US Air Force (USAF) at Mildenhall Air Base contacted CUH requesting permission to use the helipad located on site for a military training exercise to support the transfer of critically injured or ill patients. It was advised that the aircraft involved in the exercise would be a CV-22 Osprey Helicopter. Rola-trac (the manufacturer of the helipad) were consulted who advised that it was not suitable to land a CV-22 Osprey on the helipad due to its weight, generated heat and downforce. It was therefore agreed for the Osprey to land on a grass area, adjacent to the helipad but within its perimeter fencing.

5.1.2 On 21.04.21 the training exercise went ahead as planned, however, despite landing on the grass area, upon departure the downwash from the Osprey caused the helipad to detach itself from its securing pegs and fly up into the air, accompanied by clouds of debris and associated helipad underlay. Fortunately, no-one was harmed but it was considered a significant near-miss and caused disruption to the Helicopter Emergency Medical Service (HEMS). The incident received significant press attention, not only locally but also nationally and internationally.

5.1.3 Although the USAF had carried out a risk assessment, liaised with Rola-trac and carried out a site inspection prior to the training exercise no concerns were raised in relation to landing adjacent to the helipad. Since the incident, it has been agreed that Ospreys are no longer permitted to use the site.

5.1.4 The incident flagged up gaps in relation to the management and operations of the helipad. There was a draft and unsigned standard operating procedure (SOP) which did not clearly articulate the health and safety responsibilities of CUH or the number of other third parties who use the helipad, including amongst others EAST, EAAA, MAGPAS and UKSAR. This included lack of clarity on responsibilities in relation to incident management, risk assessments, co-ordination of aircraft operations, liaison between parties, and site maintenance and upkeep. The SOP is now in the process of being re-written with contribution from all parties. However, there is a question as to whether a more formal agreement is required between all parties.

5.1.5 The incident has again highlighted the importance of ensuring that prior to establishing new services or facilities that health and safety responsibilities in respect of CUH and third parties are clearly defined and documented in a written formal agreement and signed by all parties. By doing so, it will help to ensure that health and safety is appropriately managed and that there is suitable co-ordination, as required by legislation, between all parties involved.

5.1.6 The current helipad site closes on 13 May 2022 when a new temporary site will be opened not far from the previous site. Any agreements will need updating in light of this to ensure that they remain reflective of the new arrangements.

5.2 Plant Room motor incident 04.04.21 (SLR 113422)

5.2.1 A mechanical engineer was working in the BU8 theatre plant room on 04.04.2021. Whilst working on a problematic AHU supply motor for theatres 5/6, his fingers became trapped between the pulley and belts. The injured person sustained

fractures to his index and middle fingers and an amputation of 2.5cm of his ring finger on his right hand.

5.2.2 The findings of the investigation identified the immediate cause of the incident was the positioning of the injured persons fingers on the inside of the belts, whilst the belts were in motion. At the time of the incident, the guarding on the belts and pulleys had been removed in order to investigate the fault with the motor. The investigation was unable to substantiate the mechanical engineer's account that the motor was isolated at the time of the incident, however, it is considered unsafe practice, due to the risk of entrapment/drawing in, to place fingers in the belts of a motor when there is any risk of movement, whether powered or manual.

5.2.3 It was identified that there were time constraints associated with the work, due to the scheduling of full theatres lists on 06.04.2021. This may have been a contributory factor.

5.2.4 There were a number of wider system concerns identified as part of the investigation, including:

- gaps in risk assessment documentation for the activities undertaken by engineering and maintenance staff
- lack of work instructions and safety procedures for working on motors and other foreseeable activities carried out by engineering and maintenance staff
- equipment not maintained in line with manufacturer's instructions
- gaps in training records
- proximity of emergency stop button
- permit to work paperwork incomplete

5.2.5 The incident was reported to the HSE as a specified injury – amputation of finger. The HSE contacted CUH on 15 April 2021 requesting the injured person's contact details and a drawing of where the amputation occurred and whether it was below the first joint of the tip of their finger. This information was provided, but no further contact was made by the HSE. The individual involved has since made a claim against the Trust for personal injury.

5.2.6 A comprehensive action plan was put in place following the incident and the responsible manager has stated that the majority of actions for improvement have now been completed. CEFM need to ensure that going forward regular audits are carried out on the completion and implementation of required safety documentation for planned and reactive tasks, including risk assessments and safe systems of work.

5.3 Emergency Department Window Restrictor Incident (SLR 132857)

5.3.1 On 17 January 2022 a patient who was being red specialled managed to escape from a high level window in the emergency department which led to a drop of approximately 20ft. Fortunately the patient managed to reach floor level safely, however it was reported as a significant near miss and an investigation launched into how the incident occurred.

5.3.2 The key findings from the investigation were:

- The ED window from which the patient managed to escape did not have window restrictors fitted in accordance with MHRA Estates and Facilities Alerts EFA/2013/002 and EFA/2014/003 and Health Building Note 00-10 part D.
- There was no evidence trail on the approach taken to comply with the above Estates and Facilities alerts in 2013 and 2014 eg whether it was a risk based approach or blanket approach.

- Despite six monthly window planned preventative maintenance in the area it was not identified that restrictors were missing from these windows
- There was no complete asset list of openable windows for the site
- There was no comprehensive record of reactive repairs carried out on windows documented on Solar.

5.3.3 As a result of the incident a comprehensive review of all windows on site was carried out immediately by the Capital, Estates and Facilities (CEFM) team. Starting with high risk patient areas first, where openable windows did not have any restrictors in place or where they were faulty, new restrictors were fitted. An asset list of windows was also collated and recorded and the Director of CEFM wrote to all maintenance and engineering staff reminding them again of the importance of asset surveys, PPMs and associated remedial works.

5.3.4 To-date 509 new restrictors have been fitted. Half of them are on the ground floor. There have been challenges in completing the programme due to access issues caused by COVID and clinical activity.

6 RIDDORs

6.1 Non-covid RIDDORs

6.1.1 A total of 31 non-COVID RIDDORs were reported to the HSE under the RIDDOR regulations during 2021/22. This is 9 less than last year.

6.1.2 The table below provides a breakdown of the categories of reportable incidents and a comparison to the previous 2 years.

	Slips, Trips & Falls	**Moving & Handling**	**Accident** (cuts, burns & collisions)	**Blood/ bodily fluid Exposure** (needlestick /blood splash)	**Physical Assault** (patient to staff)	**Other**	**Total 2021/22**	Total 2020/21	*Total 2019/20*
Over 7 day injuries	5	3	1	0	7	0	**16 (52%)**	28 (70%)	*29 (46%)*
Specified injuries	4	0	1	0	1	0	**6 (19%)**	4 (10%)	*11 (17%)*
Dangerous Occurrences	0	0	1	6	0	0	**7 (23%)**	6 (15%)	*22 (35%)*
Occupational Disease	0	0	0	0	0	2	**2 (6%)**	2 (5%)	*0 (0%)*
Death	0	0	0	0	0	0	**0 (0%)**	0 (0%)	*1 (2%)*
Total 2021/22	**9 (29%)**	**3 (10%)**	**3 (10%)**	**6 (19%)**	**8 (26%)**	**2 (6%)**	**31**		
Total 2020/21	8 (20%)	9 (23%)	10 (25%)	3 (8%)	6 (15%)	4 (10%)		*40*	
Total 2019/20	*19 (30%)*	*11 (17%)*	*14 (22%)*	*12 (19%)*	*3 (5%)*	*4 (6%)*			*63*

6.1.3 77% (24) of RIDDORs were reported to the HSE within the appropriate timescales. The other 23% (7) were due to late reporting to the health and safety team that the incident was RIDDOR reportable. Reporting rates were 70% in 2020/21.

6.1.4 The Health and Safety Team investigate all RIDDOR reportable incidents (except those passed to the CQC) to understand what happened, why they happened and to identify any actions that need to be taken to prevent similar incidents from occurring in the future. An investigation report is produced following each investigation together with recommendations for improvement. A copy of each

report is provided to the responsible manager and reports are also available, upon request, to the Trust's medico-legal department and the HSE.

6.1.5 The majority of RIDDORs (52%) were over 7 day injuries and were the result of physical assaults, slips, trips and falls, moving and handling activities and accidents (contact injury). There were 7 physical assaults from patients to staff that led to the staff members having more than 7 days off work.

6.1.6 Specified injuries accounted for 19% (6) of RIDDORs. 5 were fractures resulting from trips/falls and 1 related to the amputation of a finger after it was drawn into a plant motor.

6.1.7 There were 7 (23%) dangerous occurrences reported. 6 were due to blood exposures from dirty needlestick injuries and blood splashes onto mucous membranes. The remaining 1 incident relates to an exposure to hazardous substances (a small amount of pertex splashed close to a staff member's eye whilst a new bottle was being opened).

6.1.8 There were 2 occupational diseases reported (6%). One of these related to a case of Carpal Tunnel Syndrome where the staff member's work involved regular use of vibrating tools. The second was a case of tendinitis. The tendinitis was caused by the member of staff undertaking extra clinics due to staff shortages. The additional work involved carrying out procedures which required the staff member to adopt prolonged grips, movements or forces with their hands. Both of these cases were followed up by the HSE. In the case of the carpal tunnel syndrome they requested the contact details for the staff member affected. This information was provided and no further contact was made from the HSE regarding this incident. In relation to the case of tendinitis, the HSE requested further information on the work undertaken, evidence of risk assessments and contact details of the staff member affected. This information was provided and subsequently the HSE confirmed that no further action would be taken.

6.1.9 The HSE is currently updating 'reporting injuries, diseases and dangerous occurrences in health and social care': guidance for employers' (HSIS1 rev. 3).

6.2 COVID-19 RIDDORs

6.2.1 Since the beginning of the pandemic, 139 COVID-related RIDDORs have been reported to the Health and Safety Executive, of which 37 were reported in 2021/22.

6.2.2 A breakdown of COVID-19 RIDDOR types is provided below.

RIDDOR type	2020/21	2021/22	Total No. reported
Cases of disease	82	35	117
Dangerous occurrences	15	1	16
Occupational disease	5	1	6
Death	0	0	0
Total	102	37	**139**

6.2.3 Cases of disease is where there is reasonable evidence to suggest that the member of staff contracted COVID from their work. Health and safety work with the Occupational Health physicians to identify these cases. There were 35 cases reported in 2021/22 (95% of all cases).

6.2.4 A high number (18) of cases of disease were reported in March 2022, it is helpful to clarify that this partially reflects prevalence at the time but also the practicalities of them being assessed such that they were not all from that month.

6.2.5 Dangerous occurrence is where there has been a failure in safe systems of work that resulted (or could have resulted) in exposure to COVID-19. The 1 case reported in 2021/22 related to a sample which had tested positive for COVID but that was incorrectly reported as negative. The patient was subsequently treated as negative by all staff involved in their care and the error was only discovered following their discharge. However, there is no evidence that this resulted in an occupational exposure.

6.2.6 Occupational disease is where there is a confirmed diagnosis from a doctor that a member of staff has contracted a reportable disease. The 1 case in 2021/22 related to a diagnosis of occupational dermatitis from the wearing of FFP3 masks. The member of staff has now been fit tested on 2 alternative masks.

6.3 RIDDORs followed up by the Health and Safety Executive (HSE)

6.3.1 During 2021/22 the HSE contacted the Trust for further information on 3 non-COVID RIDDOR reportable incidents (they followed up 1 RIDDOR in 2020/21).

6.3.2 The first case was in relation to the incident with the plant motor and finger amputation (see section 5.2 for details).

6.3.3 The other two cases were in relation to the dangerous occurrences reported relating to carpal tunnel syndrome and tendonitis (see section 6.1.8 for details).

7 Health and safety Incidents

7.1 At the end of 2021/22, there were 1,460 health and safety incidents reported via QSiS (Quality and Safety Information System). This is a decrease of 110 incidents compared to the previous year.

7.2 The staff incident rate is 9.8 staff members harmed per 100 workers (a decrease against last year's rate of 11.6). This falls below the Trust's target of a maximum of 10 accidents per 100 members of staff.

7.3 48% of incidents reported resulted in actual harm (3% increase from last year).

7.4 The top three incident categories this year remain the same as previous years – violence and aggression, accidents, and blood/bodily fluid exposures.

7.5 A summary of health and safety incidents can be found in Appendix 2. The data is compared to 2019/20 and 2020/21 incident statistics.

8 Health and safety audits

8.1 Health and safety monthly audit programme

8.1.1 The health and safety audit programme was paused at the beginning of the pandemic. Monthly COVID spot-check inspections of non-clinical areas have been carried out in their place since February 2021. The purpose of the inspections was to identify whether local departments were complying with the Trust's COVID-secure guidelines and whether there were any additional measures required in order to reduce the risk of COVID-19 transmission in their workplace.

8.1.2 A total of 170 non-clinical departments were checked against 16 key standards. A spot-check proforma was developed to assist with the inspections and to ensure a consistent approach was taken by all observers.

8.1.3 The results were good in many areas; the majority of workplaces had hand sanitisers and cleaning materials and staff were complying with mask wearing and social distancing measures. The most common areas requiring improvement were: ensuring maximum occupancy numbers were displayed, ensuring instructions for cleaning frequently touched surfaces/hi-touch items were displayed and ensuring the completion of the most up-to-date risk assessment.

8.1.4 All findings from the spotchecks were fedback to the areas observed and a summary provided to both the Covid Secure Environment Taskforce and Health and Safety Committee.

8.1.5 The Health and Safety Committee agreed to discontinue the COVID spot checks at the end of March 2022, with the health and safety audit programme resuming from May 2022.

8.2 Health and safety management self-assessment audit

8.2.1 In addition to the COVID spot-checks, a Trust-wide health and safety self-assessment audit was undertaken to review the arrangements in place for managing health and safety within local departments and services. This is the second Trust-wide self-assessment, the first being undertaken in 2018.

8.2.2 The arrangements were audited against the five key areas detailed within the Managers' Health and Safety Toolkit. The five key areas are:

- Control of health and safety risks
- Provision of information and training
- Consulting and communicating on health and safety matters
- Reporting and investigating safety events
- Providing a safe and healthy work environment

8.2.3 The self-assessment audit was distributed to 168 pre-selected areas across the Trust. Of which, 95% (160/168) responded.

8.2.4 Compliance against the five key areas detailed within the Managers' Health and Safety Toolkit is as follows (including a comparison to the 2018 results):

Key areas	Compliance 2018	Compliance 2021
Control of health and safety risks	Minor non-compliance	Good compliance
Provision of information and training	Good compliance	Good compliance
Consulting and communicating on health and safety matters	Moderate non-compliance	Minor non-compliance
Reporting and investigating safety events	Good compliance	Good compliance
Providing a safe and healthy work environment	Minor non-compliance	Minor non-compliance

8.2.5 The results were encouraging and demonstrated that suitable arrangements for managing health and safety are established within local departments and services.

8.2.6 Although examples of good practice were identified, there were areas that required further improvement. These included:

- Managers liaise with each another if workplaces are shared.
- Managers and contractors ensure that clear communication and close co-operation is established at the beginning of any project or service contract.
- Managers ensure that contractors are supervised in line with the risk profile of the ad hoc project or service contract.
- Emergency arrangements are put in place and all staff are provided with information/training on what to do should an adverse event occur.
- A health and safety law poster is displayed in every area

8.2.7 The results of the audit were presented to the September 2022 Health and Safety Committee and disseminated to divisions. Individual action plans were created for each division and are monitored by the health and safety team.

8.3 Dangerous Goods Safety Audit

8.3.1 The dangerous goods safety audit is an annual statutory requirement in accordance with Carriage of Dangerous Goods and Use of Pressure Equipment Regulations 2009 (CDG) which implement ADR 2017 (European agreement). The audit is organised and co-ordinated by the health and safety team each year.

8.3.2 During 2021/22 three in-depth visits were carried out at CUH (under strict covid precautions) by the Trust's Dangerous Goods Safety Advisor (DGSA). Areas visited included a selection of laboratories and gas storage areas, radiotherapy physics and nuclear medicine, pharmacy, sterile services and waste management.

8.3.3 Virtual dangerous goods awareness training was also offered to departments.

8.3.4 Subsequent to these visits, an annual report was written by the Trust's DGSA which made 32 recommendations for improvement. The report and accompanying action plan were shared with all areas visited.

8.3.5 Areas will be re-audited in 2022/23. The DGSA will check that previous recommendations have been addressed.

9 Staff health and safety survey

9.1 The Trust's health and safety survey is an integral part of our CUH health and safety strategy and the Trust's workforce plan on keeping staff safe and healthy. The results of the survey are used to identify any areas for improvement of local health and safety arrangements and practices and to increase involvement and engagement with staff.

9.2 Questions on health and safety were included in the Quarter 4 National Quarterly Pulse Survey (NQPS) carried out by Picker on behalf of the organisation. All answers were anonymous and the number of questions that could be asked was limited to eight and one free text question, so essentially it is just a snapshot of people's perceptions of and attitudes to health and safety. Overall, 4,169 members of staff responded to the survey.

9.3 The table below shows the comparison to previous years. 2020/21 data is missing as different questions were asked during the height of the pandemic and therefore comparisons cannot be made.

Questions	2017/18	2018/19	2019/20	2021/22
CUH is concerned with my health and safety	70%	72%	74%	66.9%

I am clear about my rights and responsibilities in relation to workplace health and safety	83%	91%	90%	84.9%
I have received the necessary health and safety training to perform my job in a safe manner	No data	No data	91%	87.4%
I have adequate time to undertake my job safely (new question)	No data	No data	67%	61.5%
I have what I need (equipment, space, resources) to work safely (new question)	No data	No data	67%	61.4%
Written health and safety risk assessments exist in my area of work	No data	79%	79%	79.4%
There are written safety procedures, protocols and safe working practices in place related to my work	76%	84%	82%	81.6%
I feel free to voice concerns or make suggestions about health and safety in my area of work	82%	84%	82%	71.8%

9.4 The results are probably a reflection of the last 2 years and the enormous pressure staff have been under and still continue to feel from large waiting lists and reduced staffing due to covid. It is disappointing that with all the measures the Trust put in place to protect staff during the pandemic that the results for 'CUH is concerned with my health and safety' are not better.

9.5 The free text *question 'Please give 3 suggestions that you feel would give the biggest improvement to health and safety'* gives us some clues as to where staff feel improvement is most needed. See below the word cloud that summarises the comments received.

9.6 The most frequent comments provided were in relation to ensuring there is adequate staffing, facilities, space, equipment and rest breaks. These are issues that continue to be raised by staff, and although not easy to 'fix', the Trust is committed to make improvements in these areas where possible.

9.7 The survey results were also provided by protected characteristic eg gender, age, sexual orientation, health condition and ethnicity. The following conclusions could be drawn from this data:

- Those who preferred not to describe their gender, scored lower compared to those who described themselves as female/male.

- The results of BME staff were better than those who described themselves as white.
- Staff who were older (above age of 51) scored higher than younger staff (apart from those under the age of 20).
- Those who preferred not to describe their sexual orientation scored lower than those who did provide their sexual orientation.
- Staff who said they had a physical or mental health condition scored lower than those who did not say they had a physical or mental health condition.

9.8 The results of the survey will be discussed at the May 2022 Health and Safety Committee and divisional breakdowns will be disseminated and discussed at divisional health and safety meetings.

9.9 In line with the CUH health and safety strategy it is planned to carry out more in-depth surveys of specific areas or teams to accurately measure their health and safety culture. These will gather staff perceptions on a number of health and safety areas including management commitment and leadership, communication, competence and training, engagement, resources, incident management and management of change. Results will be reported back to the Health and Safety Committee, and any areas of improvement followed-up with local managers.

10 The Health and Safety Committee and its sub-committees

10.1 Health and Safety Committee

10.1.1 The Health and Safety Committee meets every two months and is chaired by the Director of Workforce. Representatives from each clinical division and a number of specialist teams attend alongside Trade Union health and safety respresentatives.

10.1.2 There are a number of core agenda items discussed at each meeting, such as updates from each division and from specialist teams and there is a focus on incidents and RIDDORs and lessons learnt. Additional agenda items are included for any new concerns or issues and for any items escalated from its sub-committees.

10.1.3 Following each committee meeting a report is submitted to the Management Executive with items for escalation, information and assurance.

10.1.4 The committee's terms of reference were reviewed and agreed at the September 2021 committee meeting.

10.2 Capital, Estates & Facilities Health and Safety Group

10.2.1 This sub-committee continues to meet monthly (apart from August and December) and is chaired by the Director of Capital, Estates and Facilities Management and is attended by senior managers and specialists from within the division.

10.2.2 The committee continues to be an effective forum for discussing a wide range of estates-specific health and safety matters. It is chaired by the Director of CEFM, who continues to provide strong and active leadership and commitment to health and safety, which is key to enriching a positive health and safety culture. Significant investment has also been provided to resolve health and safety matters and the Director of CEFM has also personally overseen key health and safety projects. As a result, action plans are now more swiftly being progressed, staff are being held to account when there is lack of progress and there is now a greater sense of urgency around matters.

10.3 Health and Wellbeing at Work Group

10.3.1 This group meets on a quarterly basis and is chaired by a Consultant Occupational Health Physician. Attendance has been poor over the last year despite the Chair's best efforts to increase engagement. It did lack a representative from the workforce division for some time but someone has now been identified to attend.

10.3.2 The chair is currently arranging meetings for 2022.

10.3.3 Further work is required on how the Trust manages and monitors staff wellbeing, stress and burnout.

10.4 Safer Sharps Group

10.4.1 There was a meeting of the Safer Sharps Committee on 11 January 2022 following its hiatus since October 2019. Further meetings are scheduled for 2022.

10.4.2 A new chair has been appointed from the corporate nursing division. The terms of reference for the group has been revised and a gap analysis undertaken to identify how the Trust complies with the Safer Sharps regulations.

10.4.3 The committee was initially established to implement the Safer Sharps regulations; the longer-term plan is to ensure that there are robust processes to provide assurance on the management of sharps in accordance with the regulations.

10.5 Radiation Protection Committee

10.5.1 The Radiation Protection Committee continues to meet on a quarterly basis and is chaired by the Divisional Director of Division B. It continues to monitor assurance in relation to all matters relating to radiation safety and regulations. Key issues this year are summarised below.

10.5.2 The Care Quality Commission inspected the Trust on 21st October under the Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER). These regulations are related to patient safety and therefore reported though the Clinical Effectiveness Group rather than the Health & Safety Committee. For interest however, the Trust did receive an *improvement notice* in relation to training records for roles related to medical radiation exposures. A large scale exercise was carried out to seek assurance of training (or to advise completion of DOT training) for many specialities across the Trust. Evidence was sent to, and accepted by, CQC who closed the inspection on 14th February 2022. Follow up work includes the development of an IRMER refresher training course on DOT and clarification of process for maintaining training records within each speciality.

10.5.3 The Health and Safety Executive inspected a nearby NHS Trust and issued improvement notices in relation to work with radioactive materials. One of these notices requires that all staff preparing or administering radioactive materials to become *Classified Workers* due to the risk of a contamination accident. This has arisen from a national shift in HSE policy. As a result, EARRPS have started to issue advice to all departments involved in the preparation or administration of radioactive materials to classify their staff due to the risk of a contamination accident. Actions required to classify staff include rigorous management of personal radiation monitoring and annual medical surveillance reviews by occupation health. This is going to significantly increase the number of Classified Workers supported by the Trust's radiation protection service as well as related occupational health services (who have been consulted with).

11 Health and safety training

11.1 As at March 2022, compliance with health and safety core mandatory training was at 95.9% (compared to 96.2% in March 2021). All staff have to undertake this training on induction to the Trust and every 3 years thereafter. Despite the pandemic, compliance has remained high.

11.2 Local induction (of which health and safety is a core component) training rates were 82.4% for non-medical and 87.8% for medical staff. Compliance rates for medical staff has increased significantly since last year (50.7%).

11.3 Levels of compliance with mandatory training are monitored by the Mandatory Training Group of which the Head of Health and Safety is a member.

11.4 All staff who are registered on ESR as having a line management responsibility are expected to complete the online training module 'Health and Safety Awareness for Managers'. By the end of 2021/2022, 87% of all current managers and supervisors had completed the training, compared to 84% in 2020/21. Training rates are monitored by the Health and Safety Team and included in H&S papers for divisional quality and performance meetings to increase compliance.

11.5 Board health and safety training is required every 2 years and training is next due in December 2022.

12 H&S policies & procedures

12.1 No new health and safety policies or procedures were developed in 2021/22.

12.2 The health and safety team are responsible for 37 policies, procedures and guidance documents on Merlin. All of which are in date.

12.3 The Health and Safety Policy requires review by July 2022 and the statement of intent signed by the Chief Executive needs updating as this currently refers to the Trust's commitment to keeping staff and patients safe during the COVID-19 pandemic.

13 Key performance indicators

13.1 A summary of key health and safety performance indicators can be found in Appendix 3.

14 Objectives 2022/23

14.1 Review the Trust's Health and Safety Policy and Statement of Intent and update as required.

14.2 Focus on reducing the health and safety risks/significant issues as identified in section 4.

14.3 Resume the Trust's health and safety monthly audit programme.

14.4 Undertake a review of all H&S related policies and guidance documents, and identify any gaps in assurance. Ensure that any gaps are addressed and that the Health and Safety Committee is adequately assured.

14.5 Develop a process and undertake more in-depth surveys of specific areas or teams to accurately measure their health and safety culture.

14.6 Develop a communication procedure on how health and safety is communicated within the organisation, and externally ie with contractors, visitors and regulatory

authorities. This will include creating an annual communication plan for health and safety, to ensure that information on health and safety is regularly communicated within the Trust.

14.7 In line with the Trust's health and safety strategy, make health and safety risk assessment training a mandatory requirement for all managers and supervisors. This is to address the gap in skills and knowledge that is currently evident amongst managers in carrying out suitable and sufficient risk assessments. It is proposed that rather than having a new eLearning package that this is added to the current mandatory 'Health and Safety Awareness for Managers' training.

14.8 Where not already in place, ensure that all divisions/corporate areas have health and safety meetings to provide a forum at a local level for the escalation and discussion of health and safety matters. Led by local leaders, it is proposed that these divisional/directorate meetings report to the Health and Safety Committee.

14.9 Continue to investigate a digital solution for the completion and recording of health and safety risk assessments and other health and safety documentation eg audits, workplace inspections, etc.

Appendix 1 – Health and Safety Strategy 2021-2026 (summary)

VISION	Health and safety is embedded in everything we do				
AIM	'Safer culture, safer systems, safer workforce'				
OUTCOME	Everyone who works or visits our hospital goes home safe and healthy every day				
PRIORITY AREAS	**LEADERSHIP & COMMITMENT**	**COLLABORATION & PARTNERSHIP WORKING**	**COMMUNICATION**	**TRAINING & COMPETENCE**	**COMPLIANCE & ASSURANCE**
CORE ELEMENTS	Strong & visible leadership & commitment Effective resourcing Effective health and safety management system H&S integrated into key business decisions and processes Continuous improvement in H&S Statement of intent H&S strategy & policy Clear organisational roles, responsibilities Accountability not blame H&S is a top priority alongside operations, finance and patient safety	Effective consultation Good working relationships established with site partners, tenants and others Staff side H&S representatives consulted and supported Effective H&S committee & other consultative meetings Shared workplace agreements explicit on H&S responsibilities Service level agreements include H&S terms and conditions Contractor management	Clear communication process and plan Meaningful, relevant, accurate & understandable information Two-way dialogue Clear communications Effective communication upwards, downwards and across the organisation Procedures and source of support that are practical and easily understood Organisational learning & feedback Variety of communication methods used	All staff are trained to undertake their job safely & effectively H&S staff induction training Leadership H&S training Line Manager H&S Training Risk assessment training & competency H&S competencies/training requirements articulated in all job roles/descriptions Competency based assessments Training is recorded and evaluated Competent H&S advice	Compliance with legislation & H&S policies Corporate audit programme KPI monitoring Regular reporting & escalation Governance framework Formal workplace inspections Benchmarking H&S corporate and divisional risk registers Established & effective H&S management systems in place
ENABLERS & ACTIONS	Develop a H&S senior leaders training programme that focuses on the importance of having an effective H&S management system Develop and undertake department/team based H&S surveys to measure H&S culture. Establish divisional/ directorate H&S meetings Introduce health & safety inspections & walkabouts 1:1 meetings with senior leaders to bring their attention to the H&S policy, their responsibilities and commitment to H&S Review our H&S culture surveys Refresh our H&S strategy, statement of intent & policy Revitalise the H&S Committee	Establish closer working relationships with safety representatives, site partners & tenants and identify key contacts Work with property colleagues to strengthen shared workplace agreements and that H&S responsibilities are clearly articulated Work with commissioning colleagues to ensure service level agreements include H&S as a core component Undertake regular contractor audits Develop consultation process for new/revised H&S policies, procedures, guidance, etc. Improve collaboration with medical staff & teams Review the benefit of reward schemes Issue guidance to managers on the benefits of effective collaboration and consultation Promote the benefits of feedback mechanisms ie suggestion boxes, formal staff/management meetings	Develop a communications procedure and plan Ensure important Trustwide H&S communications are led from the top of the organisation Provide guidance for managers on effective H&S communication Ensure H&S communications are clear and understandable by all Use a variety of communication methods i.e. newsletters, posters Introduce awareness campaigns on specific H&S risks & control measures Review H&S procedures and sources of support to ensure they articulate responsibilities and actions to be taken in clear and understandable terms Include information on H&S on CUH's public website Deliver promotional campaigns to encourage reporting of H&S incidents Ensure there is an effective system of organisational learning and feedback from H&S incidents	Carry out a full review and refresh of all H&S training content and material including H&S Awareness for Managers & risk assessment training and guidance Develop senior leader training Establish H&S risk assessment training as a mandatory training programme for managers Refresh the proactive risk assessment programme Check that H&S competencies/ training requirements are articulated in job descriptions roles Promote recording & evaluation of local H&S training Encourage use of competency based assessments Create a H&S team development programme	Develop further compliance standards to cover all our undertakings Provide a more systematic approach to monitoring risks, non-compliance and actions Refresh corporate audit activities Seek independent audit of H&S management system Add significant H&S risks to the Operational Risk Register Review KPIs and develop new KPIs for % of actions completed Carry out a gap analysis with ISO 45001 Continue to investigate a digital solution for risk assessments Develop procurement standards Undertake regular benchmarking

APPENDIX 2 – Health and Safety Incidents 2021/22

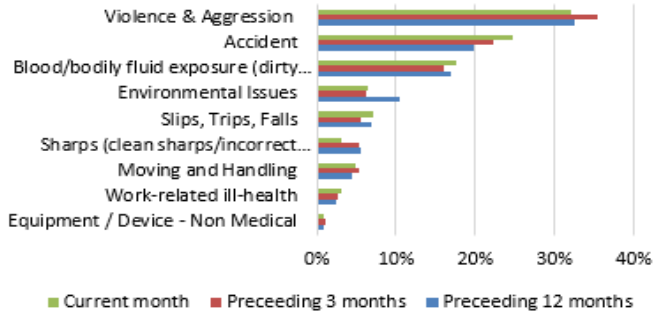
	2019/20	2020/21	2021/22
Total incidents reported	1,540	1,570	1,460
% resulting in harm	45% (852)	45% (711)	48% (697)
Type of persons affected	Staff – 75% (1,157) Patients – 20% (300) Other – 5% (83)	Staff – 74% (1,158) Patients – 24% (371) Other – 2% (41)	Staff – 73% (1,063) Patients – 24% (348) Other – 3% (49)
Highest reported categories	Violence & aggression (24%) Accidents (21%) Blood/bodily fluid exposure (19%)	Violence & aggression (33%) Accidents (16%) Blood/bodily fluid exposure (15%)	Violence & aggression (32%) Accidents (20%) Blood/bodily fluid exposure (17%)
Highest reported incident categories for staff	Blood/bodily fluid exposure (24%) Violence & aggression (23%) Accidents (18%)	Violence & aggression (28%) Blood/bodily fluid exposure (19%) Accidents (15%)	Violence & aggression (32%) Blood/bodily fluid exposure (21%) Accidents (16%)
Highest reported incident categories for patients	Accidents (33%) Violence & aggression (31%) Environmental issues (19%)	Violence & aggression (48%) Accidents (22%) Environmental issues (16%)	Violence & aggression (33%) Accidents (30%) Environmental issues (15%)
Highest reported incident categories for others*	Accidents (29%) Violence & aggression (28%) Slips, trips and falls (25%)	Violence & aggression (46%) Environmental issues (22%) Accidents (20%)	Violence & aggression (39%) Accidents (22%) Slips, trips and falls (18%)
Staff incident rate per 100 members of staff (by headcount) over a rolling 12 month period	10.5	11.6	9.8

** Others includes visitors, contractors and members of the public*

***Accidents include: contact injuries, collisions, burns, etc.*

Health and safety incidents affecting staff, patients & others ie contractors and members of the public (March 2022)

No. of health and safety incidents reported by division:	Trustwide	Division A	Division B	Division C	Division D	Division E	Corporate	CEFM
No. of health and safety incidents reported in a rolling 12 month period:	1460	308	224	435	248	136	39	70
Accident (contact injuries, burns etc)	291	66	72	52	40	34	7	20
Blood/Bodily Fluid Exposure (dirty sharps/splashes)	246	73	44	54	41	27	5	2
Environmental Issues	154	30	30	24	31	24	5	10
Equipment/Device - Non Medical	13	1	1	5	6	0	0	0
Moving and Handling	64	12	12	15	16	5	1	3
Sharps (clean sharps/incorrect disposal & use)	82	39	8	10	4	13	6	2
Slips, Trips, Falls	101	24	23	13	9	13	6	13
Violence & Aggression	474	50	27	260	93	16	8	20
Work-Related Ill-health	35	13	7	2	8	4	1	0



A total of 1,460 health and safety incidents were reported in the previous 12 months.

697 (48%) incidents resulted in harm. The highest reporting categories were violence and aggression (32%), accidents (20%) and blood/bodily fluid exposure (17%).

1,063 (73%) of incidents affected staff, 348 (24%) affected patients and 49 (3%) affected others ie contractors and members of the public.

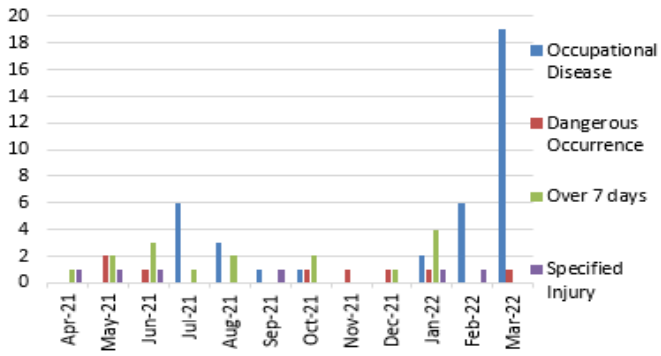
The highest reported incident categories for staff were: violence and aggression (32%), blood/bodily fluid exposure (21%) and accidents (16%).

The highest reported incident categories for patients were: violence & aggression (33%), accidents (30%) and environmental issues (15%).

The highest reported incident categories for others were: violence and aggression (39%), accidents (22%) and slips, trips and falls (18%).

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

The highest reporting division was division C with 435 incidents. Of these, 60% related to violence & aggression.



In the last 12 months, the highest reported RIDDOR category was occupational disease (56%). 47% of RIDDOR incidents were reported to the HSE within the appropriate timescale. In March 2022, 20 incidents were reported to the HSE:

Case of Disease (19)

- Covid-19: 18 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.
- Occupational Dermatitis: A member of staff experienced itching around their nose and subsequently developed a grade 1 pressure ulcer whilst wearing an FFP3 mask. This was diagnosed as occupational dermatitis by occupational health.

Dangerous Occurrence (1)

- While opening a new bottle of pertex a small amount splashed close to the eye of a staff member. Staff member immediately washed their eye with cold water. First aider was called and washed the eye using eyewash. Staff member was taken to A&E for further examination. Eye was washed again in A&E who confirmed that the mucous membrane and cornea was not affected. Skin around eye slightly irritated.

Appendix 3 – Health and Safety key performance indicators

H&S key performance indicators	Reporting period	Position	21/22 Target (if applicable)	Comments
1. H&S policy arrangements				
1.1 Signed and in-date statement of intent (every 3 years)	As at 31.03.22	**Yes**	Yes	Last signed November 2020 in light of pandemic. Needs review following pandemic
1.2 H&S Policy is Board approved and in-date (every 3 years)	As at 31.03.22	**Yes**	Yes	Next review date is July 2022
1.3 An annual H&S report has been produced	As at 31.03.22	**Yes**	Yes	Went to H&S committee (28.07.21) and Quality Committee (03.11.21)
1.4 The Board have received a copy of the annual report	As at 31.03.22	**Yes**	Yes	Went to the Board on 10.11.21
2. H&S committee and its sub-committees				
2.1 No. of H&S committees held against plan	April 21 – March 22	**5/6**	6/6	Held bi-monthly. January 22 committee cancelled due to Coronavirus
2.2 Review of H&S committee TOR in last 2 years	As at 31.03.22	**Yes**	Yes	Reviewed at September 2021 H&S Committee
2.3 No. of Estates H&S committees held against plan	April 21 - March 22	**10/10**	10/10	Held monthly (apart from Aug and Dec)
2.4 No. of Radiation Safety Committees held against plan	April 21 - March 22	**4/4**	4/4	Held quarterly
2.5 No. of Health at Work Committees held against plan	April 21 - March 22	**2/4**	4/4	Held quarterly
2.6 No. of Safer Sharps Committees held against plan	April 21 – March 22	**1/4**	4/4	Held quarterly
3. H&S Incidents & RIDDORs				
3.1 No. of H&S incidents reported	As at 31.03.22 (rolling 12m)	**1,460**	n/a	2020/21 = 1,570
3.2 Staff incident rate per 100 members of staff (headcount)	As at 31.03.22 (rolling 12m)	**9.8**	<10	31.03.21 = 11.6 (decreased since last year)
3.3 % of H&S incidents resulting in actual harm	As at 31.03.22 (rolling 12m)	**48%**	n/a	31.03.21 = 45% (increased since last year)
3.4 No. of RIDDORs reported to the HSE	April 21 – March 22	**31**	<40 last year	9 less RIDDORs reported compared to last year
3.5 % of RIDDORs reported to the HSE within reporting timeframes	April 21 – March 22	**77%** ⇧	>70% last year	7% increase compared to last year
3.6 No. of RIDDORs followed-up by the HSE	April 21 – March 22	**3**	0	1x amputation, 1x carpal tunnel syndrome, 1x tendonitis
3.7 No. of HSE enforcement action/notices in the last 12 months	As at 31.03.22	**0**	0	
3.8 No. of HSE enforcement action/notices issued against CUH	As at 31.03.22	**10**	n/a	1996 (H&S management; 4 improvement notices), 2005 (patient burn; 1 prosecution), 2010 (working at height; 1 prohibition notice), 2013 (needlestick injury; 1 notice of contravention), 2015 (sharps; 1 improvement notice & 1 notice of contravention), 2018 (outpatient fall; 1 notice of contravention)
4. H&S Training				
4.1 Board H&S Training undertaken (every 2 years)	As at 31.03.22	**Yes**	Yes	Board received H&S training in December 2020. Next due December 2022
4.2 % of staff with H&S core mandatory training	As at 31.03.22	**95.9%**	95%	Mandatory training for all staff
4.3 % of staff receiving H&S local induction	As at 31.03.22	**82.4 – 87.85**	95%	87.5% medical staff and 82.4% for non-medical
4.4 % of managers with H&S awareness training (line manager essentials)	As at 31.03.22	**87%** ⇧	95%	Essential training for staff with managerial/supervisory responsibilities. 84% in 20/21
5. H&S policies, procedures & guidance				
5.1 No of H&S policies/procedures published – responsibility of H&S	As at 31.03.22	**37**	n/a	
5.2 % of H&S guidance documents in-date	As at 31.03.22	**100%**	100%	
5.3 No. of new H&S guidance documents produced	April 19 – March 22	**0**	n/a	
6. Staff H&S culture survey				
6.1 H&S survey undertaken (annually)	April 2021– March 2022	**Yes**	Yes	Carried out in Quarter 4 of NQPS
6.2 CUH is concerned with my health and safety	21/22 NQPS Qtr 4 survey	**66.9%** ⇩	<5% difference to last yr	Result 20/21 = 74%
6.3 I am clear about my rights/responsibilities in relation to workplace H&S	21/22 NQPS Qtr 4 survey	**84.9%** ⇩	<5% difference to last yr	Result 20/21 = 90%
6.4 I have received the necessary H&S training to do my job safely	21/22 NQPS Qtr 4 survey	**87.4%** ⇩	<5% difference to last yr	Result 20/21 = 91%
6.5 I have adequate time to undertake my job safely	21/22 NQPS Qtr 4 survey	**61.5%** ⇩	<5% difference to last yr	Result 20/21 = 67%
6.6 I have what I need (equipment, space, resources) to work safely		**61.4%** ⇩	<5% difference to last yr	Result 20/21 = 67%
6.7 Written health and safety risk assessments exist in my area of work	21/22 NQPS Qtr 4 survey	**79.4** ⇧	<5% difference to last yr	Result 20/21 = 79%
6.8 Written H&S procedures, protocols & safe working practices exist	21/22 NQPS Qtr 4 survey	**81.6%** ⇩	<5% difference to last yr	Result 20/21 = 82%
6.9 I feel free to voice concerns or make suggestions about H&S	21/22 NQPS Qtr 4 survey	**71.8%** ⇩	<5% difference to last yr	Result 20/21 = 82%