Board of Directors

Cambridge University Hospitals
NHS Foundation Trust

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**There will be a meeting of the Board of Directors in public on Wednesday 18 January 2023 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**<br>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<br><br>A full list of interests is available from the Director of Corporate Affairs on request | For note |
| | **3*** | **Minutes of the previous Board meeting**<br>To approve the Minutes of the Board meeting held in public on 9 November 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**<br>To hear a patient story | For receipt |

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|---|---|---|---|
| **11.20** | **6*** | **Chair's report**<br>To receive the report of the Chair | For receipt |
| **11.25** | **7*** | **Report from the Council of Governors**<br>To receive the report of the Lead Governor | For receipt |
| **11.30** | **8*** | **Chief Executive's report**<br>To receive the report of the Chief Executive | For receipt |
| **Performance, strategy and assurance** | | | **Purpose** |
| **11.40** | **9*** | **Performance reports**<br>*The items in this section will be discussed with reference to the Integrated Report and other specific reports*<br><br>9.1* Quality (including nurse staffing report)<br>9.2 Workforce<br>9.3 Access standards<br>9.4 Improvement<br>9.5* Finance | For receipt |
| **12.25** | **10*** | **CNST Maternity Incentive Scheme**<br>To receive the report of the Chief Nurse | For approval |
| **12.35** | **11*** | **Research and development**<br>To receive the report of the Medical Director | For receipt |
| **12.45** | **12*** | **Guardian of Safe Working**<br>To receive the report of the Medical Director | For receipt |
| **12.55** | **13*** | **Freedom to Speak Up**<br>To receive the report of the Director of Corporate Affairs | For receipt |
| **13.05** | **14*** | **Voluntary services annual report**<br>To receive the reports of the Director of Workforce | For receipt |
| **13.15** | **15*** | **Board committee terms of reference**<br>To receive the report of the Director of Corporate Affairs | For approval |
| *Items for information/approval – not scheduled for discussion unless notified in advance* | | | |
| | **16*** | **Board assurance committees – Chairs' reports**<br>16.1 Performance Committee: 11 January 2023<br>16.2 Quality Committee: 11 January 2023<br>• Infection Control Annual Report 2021/22 | For receipt |

| Other items | | | Purpose |
|---|---|---|---|
| | **17** | **Any other business** | |
| **13.20** | **18** | **Questions from members of the public** | |
| | **19** | **Date of next meeting**<br>The next meeting of the Board of Directors will be held on Wednesday 8 March 2023 at 11.00. | For note |
| | **20** | **Resolution**<br>That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (NHS Act 2006 as amended by the Health and Social Care Act 2012). | |
| **13.30** | **21** | **Close** | |

NHS
Cambridge
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# Minutes of the meeting of the Board of Directors held in public on Wednesday 9 November 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 |
| Mr M Keech | Chief Finance Officer | X | |
| Mr N Kirby | Interim Director of Strategy and Major Projects | X | |
| Ms A Layne-Smith | Non-Executive Director | X | |
| Prof P Maxwell | Non-Executive Director | X | |
| Prof I Jacobs | Non-Executive Director | X | |
| Prof S Peacock | Non-Executive Director | X | |
| Dr A Shaw | Medical Director | X | |
| Mr R Sinker | Chief Executive | X | |
| Mr R Sivanandan | Non-Executive Director | | X |
| Ms L Szeremeta | Chief Nurse | X | |
| Mr I Walker | Director of Corporate Affairs * | X | |
| Mr D Wherrett | Director of Workforce | X | |

** Non-voting member*

| In attendance | Position |
|---|---|
| Ms E Chisanga | Race Equality Project Lead (for item 112/22) |
| Ms K Clarke | Associate Director of Workforce (for item 113/22) |
| Ms E Grint | Equality, Diversity and Inclusion Project Manager (for item 112/22) |
| Ms M Jacot | Head of Equality, Diversity and Inclusion (for item 112/22) |
| Mr S Ojha | Director of Postgraduate Medical Education (for item 113/22) |
| Dr N Stutchbury | Lead Governor |
| Ms M Wilkinson | Director of Midwifery |
| Ms C Collick | Secretariat Officer (minutes) |

## 100/22 Welcome and apologies for absence

The Chair welcomed everyone to the meeting.

Apologies for absence are recorded in the attendance summary.

**101/22 Declarations of interest**

Standing declarations of interest of Board members were noted.

**102/22 Minutes of the previous meetings**

The minutes of the Board of Directors' meeting held in public on 12 October 2022 were approved as a true and accurate record.

The minutes of the Annual Public Meeting held on the 28 September 2022 were approved as a true and accurate record.

**103/22 Board action tracker and matters arising not covered under other agenda items**

**Received and noted**: the action tracker.

**104/22 Staff story**

David Wherrett, Director of Workforce, presented two staff stories as context to the later agenda item on the Workforce Race and Disability Equality Schemes.

The first told the story of Rachel, a staff member at CUH, who had initially struggled in the workplace due to dyspraxia. However, after moving to a new department, Rachel's working experience had significantly improved. A video of Rachel's story was shown.

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

1. It was observed that the story emphasised the importance of cultural intelligence and awareness, giving appropriate consideration to individuals' experience work and their working environment.
2. Rachel's line manager had been critical in supporting positive change. It would be powerful to share the story with teams across the organisation.

The second story was about May, a Specialist Support Nurse. She was the first Muslim Specialist Support Nurse in her field, working in an area with little diversity. May had spoken about her experience at a recent Black History Month event, highlighting the lack of promotion of Black, Asian and Minority Ethnic staff, the lack of diversity in some areas and 'living in fear of discrimination'. May had praised the support of her colleagues who helped her to express herself. However, she would be leaving the Trust and had cited a lack of diversity as the main reason for her decision.

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

1. Board members emphasised the importance of continued work to improve the experience of Black, Asian and Minority Ethnic staff, as set out in the Workforce Race Equality Scheme action plan
2. In response to a question, it was noted that induction and training materials for staff members joining from overseas included advice and sources of support in relation to many of the issues highlighted by May.

**Agreed:**
1. To thank Rachel and May for sharing their stories.

**105/22 Chair's report**

Mike More, Chair, presented the report.

**Noted:**
1. In addition to the items included in the report, the Chair expressed thanks on behalf of the Board to Amanda Rowley, Head of Midwifery, who was leaving the Trust to take up a new role.

**Agreed:**
1. To note the report of the Chair.

**106/22 Report from the Council of Governors**

Neil Stutchbury, Lead Governor, presented the report.

**Noted**:
1. Since the previous report in October 2022, a number of governors from CUH and the other provider foundation trusts in the county had attended a workshop to discuss the Cambridgeshire and Peterborough Integrated Care System (ICS). This session had focused on the establishment and implementation of the ICS and the implications for the role of foundation trust governors in supporting the wider ICS.

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

**107/22 Chief Executive's report**

Roland Sinker, Chief Executive, presented the report.

**Noted**:

1. The health and care system remained under extreme pressure and the Trust continued to experience significant challenges, particularly in relation to Emergency Department waiting times and staffing levels.
2. However, alongside these challenges, the Trust was performing relatively strongly in terms of clinical outcomes, access to cancer care, elective recovery, financial delivery, and service improvement and transformation.
3. The Trust had mobilised for the fourth time since February 2020 to manage the anticipated winter pressures, applying the lessons from the pandemic. A Winter Taskforce had been established, with a focus on maximising and expanding capacity, safety and efficiency, communication and engagement, supporting staff and new models of care for winter.
4. Staff health and wellbeing was a key focus of the workforce strategy, including providing support where possible with the rising cost of living.

The following points were made in discussion:

1. The Chair noted that the Performance and Quality Committees had discussed the cases of two patients who had waited for over 60 hours in the Emergency Department (ED). It was recognised that these long waits were not acceptable, although unfortunately they did reflect the experience of many hospitals nationally. Full harm reviews had been undertaken in both cases which indicated that the patients had not come to harm. However, the reviews had identified a number of issues in relation to patient care and experience and action was being taken to address these.
2. An enhanced process to track potential harm to patients with long stays in the Emergency Department was being established.
3. Planning continued for possible industrial action by several unions. Effective and timely communication with patients would be a key priority.

**Agreed:**

1. To note the contents of the report.

**108/22 Performance reports**

*Finance*

Mike Keech, Chief Finance Officer, presented the update.

**Noted:**

1. The year-to-date position at month 6 was a surplus of £2.4m. The full-year plan remained for a breakeven financial position.
2. The Cambridgeshire and Peterborough Integrated Care System (ICS) remained on track against its financial plan in the year to date.

3. Key areas of risk were being closely monitored, including higher than expected inflationary pressures, Covid costs exceeding budgeted levels and non-receipt of Elective Recovery Fund income.
4. The Trust's capital spend for the year to date was £15.0m, £11.0m below plan. The underspend was expected to be recovered by year end.

*Improvement and transformation*

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

**Noted:**
1. The Improvement and Transformation team continued to support a number of initiatives aimed at reducing length of stay in ED.
2. The team was also working with colleagues in Outpatients, focusing on nurse-led virtual clinics in gastroenterology, use of electronic referral systems in ophthalmology and waiting list and clinic template reviews in gynaecology. Additional improvement projects are being scoped.
3. The virtual ward programme had gone live with its first patient on 31 October 2022.
4. The Trust continued to work with its improvement partner, the Institute for Healthcare Improvement (IHI), on embedding a culture of sustainable continuous improvement.
5. Plans were in place to undertake the latest upgrade of the Epic patient record system over the coming weekend.

*Access standards*

Nicola Ayton, Chief Operating Officer, presented the update.

**Noted**:
1. The Winter Taskforce continued to meet, focusing on the key areas outlined by the Chief Executive earlier in the meeting.
2. Urgent and emergency care services had remained under significant pressure during September 2022.
3. Ambulance handovers in excess of 60 minutes were at 8% compared with the national average of 11% and an East of England average of 17%.
4. Emergency Department waiting times continued to be longer than the regional and national averages and remained a major area of focus. The virtual ward and the frailty unit were now operational.
5. Outpatient and elective activity was at or above 100% of pre-Covid levels.
6. NHS England had set out key requirements and standards in relation to winter resilience and ambulance handovers, performance against which would be monitored by the Winter Taskforce.

*Workforce*

David Wherrett, Director of Workforce, presented the update.

**Noted:**

1. 40 nurses and 21 midwives had joined the Trust in October 2022.
2. 83 new Health Care Support Workers (HCSW) had joined the Trust in September and October 2022.
3. There was a key focus on filling vacant Band 2–4 positions.
4. The winter vaccination programmes for flu and Covid-19 had commenced. Uptake for flu was currently 40% and uptake for Covid-19 was currently 38%, in line with figures in other NHS organisations. Work was continuing to raise awareness and promote take up of the vaccines.

*Quality (including nurse staffing report)*

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

**Noted:**

1. Action plans had been developed and were being implemented in response to the increase in the number of falls and hospital acquired pressure ulcers.
2. The Complaints team and Patient Advise and Liaison Service remained under significant pressure, with high sickness rates and vacancies coupled with increased complexity of contacts. This had resulted in longer waiting times for responses. An external process review of the service had been completed and an improvement plan was being developed.
3. All maternity units were scheduled to be inspected by the Care Quality Commission (CQC) by early 2023. To support preparation for this, the NHS England regional team would be conducting a peer review of the Trust's maternity unit using CQC methodology.
4. A national amber alert had been issued by NHS Blood and Transplant relating to a shortage of red cell products. This alert had subsequently been reduced to a 'pre-amber' level and the 20 CUH patients who had experienced treatment delays as a result of the impact of the national alert were currently being rebooked.

The following points were made in discussion:

1. It was noted that compliance on the key performance indicator for taking lying and standing blood pressure for patients aged 65 and over within 48 hours of admission was 16.1% against a 90% target, and it was asked what was being done to improve this position. The Chief Nurse explained that this was being addressed as part of the Trust's falls plan, with awareness and training being key to improving compliance.
2. In response to a question, it was confirmed that the 2023/24 financial allocation remained uncertain. A recent NHS England report highlighted the scale of pressures on the national budget.

3. The data on elective day case activity shown on page 5 of the Integrated Performance Report was incorrect. The correct figures for September 2022 as a percentage of the pre-Covid baseline were 103% in-month and 105% year to date.

**Agreed:**
1. To note the Integrated Performance Report for September 2022.
2. To note the finance report for 2022/23 Month 6.
3. To note the nurse safe staffing report for September 2022.

**109/22 Biannual nursing and midwifery establishment update**

Lorraine Szeremeta, Chief Nurse, presented the report.

**Noted**:
1. The past six months had remained challenging in terms of nurse staffing with high vacancy rates despite a strong recruitment pipeline.
2. The sharp increase in the nurse vacancy rate in July 2022 reflected the approved investment following the previous establishment review being included in the electronic staff record and financial ledger.
3. Nursing staff continued to be redeployed from their usual clinical area to alternative clinical areas to support safe nurse staffing and to maintain patient safety across the Trust.
4. The most frequently raised red flags were in relation to unmet 1:1 specialling requirements. A Trust-wide improvement project focusing on specialling, which had been paused during the pandemic, was now recommencing.
5. A Birthrate Plus® review of midwifery staffing had been undertaken between January and March 2022 and had recommended an increase on the current funded establishment of 10.06 midwives. The recommendation from the divisional triumvirate was that, that due to the current level of midwifery vacancies, the funded establishment should remain unchanged in-year and a proposal to meet the Birthrate Plus® recommended establishment would be included in budget setting for 2023/24. A business case would be developed for consideration by the Investment Committee.

**Agreed:**
1. To note that high vacancy rates for Registered Nurses (RNs), Registered Midwives (RMs) and Health Care Support Workers (HCSWs) remained despite a strong recruitment pipeline.
2. To note that an additional 48 WTE RNs and 37 WTE HCSWs were required above the budgeted establishment to safely staff the identified contingency areas.
3. To note that redeployment of both RNs and HCSWs would continue to be necessary over the winter period in response to increased demand on services.
4. To note that CUH Care Hours Per Patient Day (CHPPD) were aligned to the national median; however, when compared to Shelford peers, the

CUH CHPPD was below the Shelford median of 9.2–10 CHPPD (CUH 8.1-8.4).

5. To note that there had been an increase in unavailability with sickness absence increasing from 6.8% to 9% and annual leave increasing from 13.5% to 17.5%. There was a focused project led by the lead for safer staffing to understand the drivers for unavailability and develop associated actions to decrease unavailability.
6. To note that a review of neonatal staffing requirements had been undertaken in line with the British Association of Perinatal Medicine (BAPM) standards.
7. To note, in line with guidance, that a Birthrate Plus® review had been undertaken in maternity, with recommendations made regarding future establishments.
8. To note the action plan to achieve 100% compliance with 1-1 care in labour and supernumerary status of the labour ward co-ordinator.

**110/22 Reading the Signals, Maternity and Neonatal Services in East Kent**

Lorraine Szeremeta, Chief Nurse, and Meg Wilkinson, Director of Midwifery, presented the report.

**Noted**:

1. Dr Bill Kirkup's report 'Reading the Signals, Maternity and Neonatal Services in East Kent' had been published on 19 October 2022.
2. Four key action areas were identified within the report:
    - Key action area 1: Monitoring safe performance – finding signals among noise
    - Key action area 2: Standards of clinical behaviour – technical care is not enough
    - Key Action Area 3: Flawed team working – pulling in different directions
    - Key Action Area 4: Organisational behaviour – looking good while doing badly
3. The Board paper outlined relevant elements of the Trust's current Maternity Improvement Plan in relation to the four key action areas.
4. The CUH Maternity Service was currently undertaking a detailed gap analysis of the Kirkup findings using a multi-disciplinary approach, and any gaps identified which were not covered in the current Maternity Improvement Plan would be incorporated into the relevant workstreams within the Plan.

The following points were made in discussion:

1. The Non-Executive Director Perinatal Safety Champion noted that key action areas highlighted in the Kirkup report were included in the Trust's Maternity Improvement Plan and he had observed a positive approach in Maternity Services to implementing the Plan. Nevertheless, there remained significant challenges related to capacity and staffing

pressures, which it was important for the Quality Committee and the Board to continue to focus on.
2. In relation to missed opportunities to identify issues and implement change highlighted in the Kirkup review, it was noted that the Trust's Maternity Service regularly sought external input and peer review as an important element of improvement.
3. It was acknowledged that the key action areas from the Kirkup review were equally applicable to other clinical services areas and would be important for all service leads to give due consideration to the findings and learning through their governance arrangements.

**Agreed:**
1. To note the publication, findings and four key actions of the Kirkup independent investigation of Maternity and Neonatal Services in East Kent.
2. To note how the issues identified were already reflected in the CUH Maternity Improvement Plan.
3. To note that a CUH gap analysis of the Kirkup report was currently being undertaken to identify any additional actions which needed to be added to the Maternity Improvement Plan.
4. That assurance on Maternity Services would continue to be provided to the Board via the Quality Committee and the Board-level Executive and Non-Executive Perinatal Safety Champions.

**111/22 Strategy update**

Nick Kirby, Interim Director of Strategy and Major Projects, presented the report.

**Agreed**:
1. To note the progress made in recent months in delivering the CUH strategy and the commitments for the coming months.

**112/22 Workforce Race Equality and Workforce Disability Equality Schemes**

David Wherrett, Director of Workforce, presented the reports.

*Workforce Race Equality Scheme (WRES)*

**Noted**:
1. The process to recruit a Director of Equality, Diversity and Inclusion had commenced.
2. The Trust's WRES action plan was focused on indicators which had not shown improvement and had been co-produced with the Race Equality and Cultural Heritage staff network.
3. The three priority areas in the action plan had been identified as leadership and management, talent and career progression, and tackling racial harassment and abuse from patients and the public and staff.

4. It was vital for Board members to show personal leadership and advocacy in relation to equality, diversity and inclusion and to reflect on their own personal commitments and contributions. This included, but was not limited to, the protected characteristics of race and disability.

The following points were made in discussion:

1. It remained the case that Black and Minority Ethnic staff were under-represented in senior Trust positions, including on the Management Executive and the Board of Directors.
2. Cultural awareness should be an important attribute in making decisions on appointing candidates to senior roles.
3. The importance of improving awareness of the WRES action plan and investing in cultural intelligence programmes were highlighted.
4. It was agreed that more could be done to support Black and Minority Ethnic staff to successfully prepare and apply for more senior roles.
5. It was noted that 22% of staff from a Black and Minority Ethnic background had experienced bullying and harassment from other staff compared with 17% of staff from a white background. It was vital to deliver the further steps outlined in the action plan to support tackling racism in the workplace and to work with the staff network to explore additional actions which could be introduced.

**Agreed**:

1. To note the latest WRES dataset.
2. To note the refreshed WRES actions.
3. To note the employer commitment to implementing the East of England Ant-racism strategy, tackling racism and discrimination, to be an anti-racist organisation.
4. To ensure their personal information on ESR was updated, including on ethnicity.
5. To consider personal actions and commitment to progress race equality and inclusion at CUH as part of the broader inclusion agenda.

*Workforce Disability Equality Scheme*

**Noted**:

1. The report sets out the latest annual Workforce Disability Equality Standard (WDES) metrics. The Trust had improved on three of the 10 WDES metrics since 2021.
2. Key areas for improvement and focus in the WDES action plan had been identified as:
    - Continued support to the Purple Network.
    - Promoting the new Workplace Adjustment Service.
    - Continued development of resources and staff stories focusing on neurodiversity.
    - Improving organisational understanding of neurodiversity.
    - Encouraging disabled staff to become Diversity and Inclusion Panellists and reverse mentors.
    - Increasing recruitment of disabled staff.

- Improve staff sharing of disability/health conditions at commencement of employment and during their career.

3. National staff survey data demonstrates that staff with disabilities consistently had a poorer experience than staff without a disability.

The following points were made in discussion:

1. Further internal work was required on ensuring staff were comfortable to declare disabilities on the Electronic Staff Record.
2. The importance of providing support to those with hidden disabilities was emphasised, ensuring line managers had the awareness and appropriate tools to provide the required support.
3. The focus on a more centralised approach to workplace adjustments, where appropriate, was welcomed.

**Agreed**:

1. To note the WDES metrics, changes from 2021 and the engagement of staff with disabilities, health conditions and neuro-differences.
2. Note that the WDES position set out in this paper sat alongside the Trust's overarching commitment to workforce inclusion across a range of protected characteristics.
3. The updated action plan and report for publication on the CUH website.
4. To align this work with other Trust priorities to ensure everything we do contributes to a fairer and more inclusive place to work for all staff, taking best practice from priorities such as: current race equality discussions; the Trust's approach to bullying, harassment and violence in the workplace; recruitment and resourcing; just and learning culture.
5. To ensure their personal information on ESR was updated, including disability status.
6. To consider personal actions and commitment to progress disability equality and inclusion at CUH as part of the broader inclusion agenda.

In conclusion, the Chair thanked all those who had contributed to the reports and emphasised the accountability of the Board, collectively and as individual members, for creating the right conditions to improve equality, diversity and inclusion across the organisation.

**113/22 Education, learning, training and development**

Sanjay Ojha, Post Graduate Medical Director, presented the report.

**Noted:**

1. The Trust's Multi-professional Education, Learning and Development Group (MPELDG) had met in October 2022 and had undertaken a review of the Trust's multi-professional education, learning and development strategy. It was agreed that the strategy should retain its current eight themes, ensuring that specific areas of work aligned with the overall CUH strategy and system priorities.

2. The Trust had received the results of the 2022 General Medical Council (GMC) survey, with 660 doctors in training at CUH invited to complete the survey. A positive trend in the number of red outliers (negative indicators) had been seen.
3. The Trust had entered into a leasehold agreement to relocate the Digital Health and Surgical Training Centre to Barnwell Road in Cambridge.
4. The Clinical Education Team continued to provide a high level of support to internationally-recruited nurses and midwives. In order to enhance the support provided to overseas colleagues, the Clinical Education Team had recently appointed an Integration and Pastoral Care Coach.

**Agreed:**
1. To receive and note the report.

**114/22 Learning from Deaths**

Ashley Shaw, Medical Director, presented the report.

**Agreed:**
1. To receive the learning from deaths report for 2022/23 Q2.

**115/22 Board Assurance Framework and Corporate Risk Register**

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

**Noted:**
1. The Board Assurance Framework (BAF) included 14 risks, 10 of which were Red rated.
2. Work continued to update the BAF in line with the strategy refresh and to incorporate medium-term risk trajectories.

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

**116/22 Risk Management Strategy and Policy**

Lorraine Szeremeta, Chief Nurse, presented the report.

**Agreed:**
1. To approve the revised Risk Management Strategy and Policy.

**117/22 Board assurance committees – Chairs' reports**

**Received**: the following Chairs reports.

- Workforce and Education Committee: 20 September 2022
- Addenbrooke's 3 Committee: 28 September 2022
- Performance Committee: 2 November 2022
- Quality Committee: 2 November 2022

**118/22 Any other business**

There was no other business.

**119/22 Questions from members of the public**

*Why are there such long clearance times for Immunisation and Infection Screening Questionnaires (ISQs) which are causing placement delays for students coming to Addenbrooke's, e.g. from August to now, and these are still not resolved?*

The Director of Workforce responded.

The team was making progress with the backlog in clearances and the August backlog had been cleared. Delays in ISQ clearance were due to a combination of reasons, including sickness absence rates in the Occupational Health (OH) nursing team, a high turnover rate and existing vacancies in the OH team, increased recruitment activity across the Trust and a system upgrade which had caused the clearance process to take longer. This had been addressed by use of bank and agency staff, risk assessing those awaiting ISQ clearance, use of administrative support from the wider workforce and an ongoing recruitment drive for unfilled OH vacancies.

*With A&E stretched to the limit and GPs not functioning in the same way, leaving patients with nowhere to go except A&E, why is an urgent treatment centre not a priority? Why is there no Walk-in Centre in Cambridge despite many other areas with smaller populations having Walk-in Centres? (Clinic 9 is not a Walk-in Centre.)*

The Chief Operating Officer responded.

We have an urgent treatment centre (UTC) at CUH within the Clinic 9 building. We recently agreed to invest in further developing Clinic 9 to increase capacity and waiting space there. This will improve the facilities for the minors/GP streamed patients, but will also mean that a greater proportion of patients attending ED can be managed through the UTC as well and help protect the main ED for high acuity patients needing to be close to resuscitation facilities.

Although CUH UTC is not a walk-in centre, patients who arrive at ED, but are suitable for the UTC, are redirected there.

There is currently a national plan to align UTCs and walk-in minor injuries units (MIUs) so that patients can walk in on the day as well as being offered booked appointments via 111. Work is taking place across Cambridgeshire, led by the Integrated Care Board, to develop a plan to enable this. The CUH UTC will need to offer walk-in access from September 2023 as part of this review

*Throughout the many years that we have been attending the Board there have been multiple initiatives, internal and external, to deal with A&E flow. Now another 'Improvement and Transformation Team' (ITT) is reported as suggesting 'a number of initiatives…to reduce patient length of stay…[and] stream patients to more appropriate settings'. The Board has heard this so many times yet we have now reached record attendances and instances of 60 hour waits. What are these ITT initiatives and can there be any realistic expectation that they will make any difference?*

The Director of Improvement and Transformation responded.

We understand your frustration but continue to work hard to improve the service for our patients and staff.

Sitting under our Urgent and Emergency Care Programme Board, we have a number of workstreams. For example, the Medical Assessment Unit opened in October on EAU3 and EAU4 with the aim of reducing the number or medical patients and the time they spend in the Emergency Department. Patients are streamed from the ED front door, clinic 5 same day emergency care and specialty clinics. In the pilot, 547 patients were streamed to the seated waiting area from ED and over three quarters were discharged. The mean time in the ED for medical patients fell by 40 minutes.

This week, the Frailty Assessment Unit opened on ward G2 with the aim of providing comprehensive geriatric assessment to patients outside the ED. Among other quality metrics, this aims to enable more patients to be discharged on the same day reducing the risks of inpatient admission including deconditioning. A six- month pilot designed to increase the number of patients being assessed by Urology rather than within the ED is currently being analysed.

I hope that gives some assurance that we are working on things that are making a difference and will continue to.

*You set out under your 'good work agenda' six highly desirable ambitions for the workforce but you give no detail and at least four (Accommodation, Transport, Space, Cost-of-living in Cambridge) look currently intractable. What, if any, actual progress has been made?*

The Director of Workforce responded.

Progress has been made in subsidising the cost of travelling to the Campus by bus and parking onsite for staff. Work is underway to explore creation of additional onsite affordable accommodation. Reduced cost hot food will be provided to staff onsite this winter in addition to free tea and coffee supplies for staff which have been rolled out across the Trust. Plans to make ambitions a reality include a trial of free period products for staff, additional secure and covered bicycle storage, improved staff rooms and improved break-out space. Financial support and advice for staff, especially at this time, is provided through a number of initiatives and will include the introduction of 'wage stream' later this month.

In addition, it was agreed to provide written responses to the following questions. These were as follows:

*The CQC's October report 'highlights a number of key concerns nationally' but there is no detail given. What specific key concerns apply to CUHT, in what areas, what will be done to address them and when?*

The CQC's national state of health care and social care in England report for 2021/22 was published recently. The report highlights a number of key areas of concern:

- Gridlocked care particularly in emergency pathways.
- Access to care across all sectors.
- Inequalities of care.
- The quality of maternity care.
- Care for people with a learning disability and autistic people.
- Mental health services struggling to meet the needs of children and young people.
- Ongoing problems with the Deprivation of Liberty Safeguards process.

There is nothing specifically in this report that we are not already working on at CUH. For example:

- Access to care – significant work is being undertaken on access to both emergency and elective care.
- Inequalities in care and accessibility – a key theme of the refreshed CUH Strategy. We are working to appoint a director level post to support the development of our overarching strategy.
- Workforce challenges (staff shortages, impact on patient care, staff morale, developing workforce) – 'Good Work' programme, long-term plan to improve recruitment, retention and workforce pool in Cambridgeshire and Peterborough.
- Maternity care – progressing the Ockenden and Kirkup report actions, new Director of Midwifery post appointed to, external visits to provide scrutiny and share learning.

- People with a learning disability and autistic people – Learning Disabilities Improvement Plan with Patient Experience Group oversight. Participated in the national review by the CQC and working through improvements.
- Children and young people's mental health - Children's Hospital programme with a focus on integrating physical and mental health, working with the wider system.
- Deprivation of Liberty Safeguards – appointment of a lead to complement the existing Safeguarding Team to develop training packages and implement the new standards in 2023; oversight at Safeguarding Committee.

*'Non-receipt of forecast ERF income'. Is this income from elective work or the cash injection politically promised to the NHS in the summer but, as far as I know, so far unpaid. Is it known if or when the latter funding will appear?*

ERF stands for Elective Recovery Fund. This is a scheme implemented by NHS England that provides additional income to trusts where activity exceeds certain thresholds (set as a percentage of 2019/20 activity levels). The intention of the fund is to support trusts with the costs associated with increasing activity to reduce waiting lists. There remains uncertainty about how the ERF funding will be distributed this year.

While not specifically identified in the question, we assume that the cash injection referred to may relate to the £500m 'Adult Social Discharge Fund'. We understand that this fund is designed to support discharges in to the community, with funding directed towards care home operators and providers of domiciliary care services. These funding decisions are not directly determined by the Trust and therefore the question may be better directed towards the Integrated Care Board.

**120/22 Date of next meeting**

The next meeting of the Board of Directors in public would be held on Wednesday 18 January 2023 at 11.00.

**121/22 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: 13.55*

NHS
Cambridge University Hospitals
NHS Foundation Trust

**Board of Directors (Part 1): Action Tracker**

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

**Key to RAG rating:**

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

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

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# Report to the Board of Directors: 18 January 2023

| | |
|---|---|
| **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

**18 January 2023**

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

## 1. Introduction

1.1 The challenges facing NHS and care services across the country over recent months have been obvious and acute. Various factors have been in play in creating this situation, many of which are outside the control of the Trust and some of which are long standing.

1.2 The approach of the Board to a very challenged set of circumstances is built on some key principles: an open and honest leadership culture; a positive and "can-do" approach so that as a whole the hospital does not get ground-down by events but instead is solution-orientated; an excellent executive team working cohesively and strategically; a strong clinical leadership in depth across the hospital actively engaged in strategy and operations; and a very active listening culture in which Board actions are attuned to our team's needs.

1.3 Underpinning this is a recognition that the safety and quality of patient care is under pressure and in which daily and hourly judgements are having to be made by the executive team and clinicians across the hospital. The Board's focus is to try to ensure that within this context we are doing all we can to optimise patient care and avoiding as much patient risk as possible, and to attune our efforts in the various sub-committees to this end.

1.4 Over Christmas and the New Year, we saw very challenged circumstances with high numbers of patients in the Emergency Department, high patient acuity and bed occupancy. Our basic fundamental approach to operations held and we have maintained elective capacity. We have also seen some improvement in the position since then.

1.5 I would like to thank all of our staff for their tireless hard work and dedication during this very challenging time. Without them, we are nothing. I know that we have some of the best people in the NHS in this hospital and we all united in our determination to do all we can to return to a position of strong patient care.

1.6 I would like to congratulate Ewen Cameron, Director of Improvement and Transformation, on his appointment as the new Chief Executive of West Suffolk NHS Foundation Trust. Having originally trained in Cambridge, Ewen returned to the Trust as a Consultant Gastroenterologist with an interest in Endoscopy in 2007 and has held a range of posts across CUH including: Clinical Lead for Endoscopy, Clinical Director of the Cambridge Bowel Cancer Screening Centre, Divisional Director for Medicine, Divisional Director for Division C and Interim Chief Operating Officer. We wish Ewen all the best in his new role and thank him for his hard work and dedication at CUH.

1.7 Afzal Chaudhry, Director of Digital, has left the Trust. Afzal has worked at CUH as a Consultant in Nephrology, Transplantation and General Medicine since 2008 and held the position of Clinical Lead for IT/Chief Clinical Information Officer from 2011 until 2019. Afzal led CUH through Epic implementation in 2014, and subsequent digital developments as part of our continuous eHospital digital transformation journey, to become the most digitally-enabled Trust in England. We thank Afzal for his commitment and hard work at CUH and wish him all the best.

1.8 I regret to inform the Board that Patient Governor Brian Arney has tendered his resignation from the Council of Governors. As a Patient Governor with a particular interest in patient safety and wellbeing, Brian has many years' experience as a Public Governor with both South Essex Partnership University NHS Foundation Trust and Essex Partnership University NHS Foundation Trust and will be sorely missed. I would like to formally thank Brian for his service and contributions to the Council of Governors and wish him well for the future.

1.9 Many NHS staff have been recognised in this year's New Year Honours list ahead of the health service's 75th birthday. I would personally like to congratulate the following:

- Professor Isobel Heyman, a consultant psychiatrist at Cambridgeshire and Peterborough NHS Foundation Trust, who works with children and young people at CUH, has been awarded an MBE for services to child and adolescent mental health services.
- Professor Krishna Chatterjee, Consultant Endocrinologist at Cambridge University Hospitals and Director of NIHR Cambridge Clinical Research Facility has been awarded a CBE for his ground-breaking work on endocrine disorders.
- Beth Blane, research assistant and laboratory manager at the University of Cambridge, has been awarded an MBE for services to pathogen genome sequencing and her role in helping to track Covid variants during the pandemic. Beth previously trained as a biomedical scientist at the Clinical Microbiology and Public Health Laboratory based at CUH.

- Ann Radmore, former Regional Director for NHS England, East of England, has been awarded a CBE for services to the NHS.

## 2. Pubic meeting

2.1 I was unable to join Ian Walker, Director of Corporate Affairs, and Ewen Cameron when they met with members of the public on 19 December 2022. The topics covered included Serious Incidents, car parking, staff sickness and the Federated Data Platform.

## 3. Diary

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

**CUH**
Performance Committee
Quality Committee
Remuneration and Nomination Committee
Children's Board
Governor/NED Quarterly meeting
Brainbow Charities Christmas Party for patients and their families

My thanks to Adrian Chamberlain for chairing the Council of Governors' meeting in December which I was unable to attend.

3.2 Other meetings attended during this period include:

Cambridge Biomedical Campus (CBC) Local Liaison Group Meeting
CUHP, Cambridge City and SCDC discussion
Meeting with new Vice Chancellor of University of Cambridge
The Cambridgeshire and Peterborough Integrated Care Partnership Board/Health and Well Being Board

## 4. Recommendation

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

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

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# Report to the Board of Directors: 18 January 2023

| | |
|---|---|
| **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

**18 January 2023**

**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 15 November 2022. We discussed the recently approved strategy refresh and the scenarios developed for the five-year plan.

1.2 The **Membership Engagement Strategy Implementation Group** met on 15 November 2022 to discuss progress on implementing the strategy agreed earlier in the year. Good progress is being made in several areas, although increasing the age and ethnic diversity of our membership remains challenging.

1.3 A **Governor Seminar** was held on 8 December 2022 at which we heard two presentations: an overview by Sandie Smith, CEO of Healthwatch Cambridgeshire, on how Healthwatch is ensuring patient involvement in the Integrated Care System (ICS); and an update from Carin Charlton on the Trust's Green Plan and work to minimise the hospitals' carbon footprint.

1.4 A **Regional Lead Governors** meeting was held on 9 December 2022. One of the aims of this group is to support each other and share best practice. We discussed the number and composition of each other's Council of Governors: CUH is about average in terms of numbers of governors, though most other trusts have removed the distinction between patient and public governors. We also discussed the implications of new Integrated Care Boards (ICBs) on the role of trust governors. Some trust CoGs had involved their ICB Chair in the recruitment of new trust NEDs and Chairs and found this to be a positive experience.

1.5 **A Council of Governors** (CoG) meeting was held on 19 December 2022. This was the first face-to-face meeting of the Council of Governors since the Covid pandemic. Governors were offered a tour beforehand to see where the new buildings are going up and we ended the meeting with a social event. Those who could not make the meeting in person were able to connect in remotely. The meeting was well attended and governors and NEDs enjoyed meeting each other in person, some for the first time. We collected feedback to enable us to decide whether and when to go back to face to face meetings (see 1.6 below). Governors asked questions relating to the nurse's strike, pressure due to flu/Covid, staff vacancies and patient safety (falls) and the proposed congestion charge.

1.6 We held our **quarterly meeting with Non-Executive Directors** on 11 January 2023 and discussed whether the way we seek assurance needs to be adapted in the light of the extreme pressure the hospital and wider NHS is under. The Board has a culture of openness and challenge which set the framework for honest assessment of the issues. It is focusing on key targets, especially ambulance handovers, Emergency Department (ED) waits, capacity planning and discharge, i.e. optimising patient flow. On a question about the Patient Advice and Liaison Service (PALS), Sharon Peacock reported back on a report the Chief Nurse had recently commissioned and will be monitoring improvements at Quality Committee.

1.7 Using the feedback from the face-to-face December CoG, we also discussed whether to move meetings back to a face-to-face and/or hybrid format. A range of views were expressed, emphasising on the one hand the convenience and greater productivity afforded by virtual meetings, and on the other, the benefits of meeting each other physically, forming more productive relationships and being able to seek assurance more effectively. A decision on the future format for meetings will be made by the Trust Chair, the Lead Governor and the Director of Corporate Affairs.

## 2 Upcoming Governor meetings

2.1 The next three months' meetings of governors are as follows:

- Governor Strategy Group: 16 January 2023
- Governor Forum: 21 February 2023
- Council of Governors: 22 March 2023

## 3 Other Governor activities

3.1 In the lead governor's new year message to governors, he reflected on the likely areas we will be seeking assurance on. These by and large are the areas the Board is already focused on and those which have the greatest impact on patients and staff:

- Pressure on ED and patient flow
- The progression of the capital projects to create more capacity
- The development of integrated care in our region
- Staff recruitment, retention and well-being
- Patient safety and their experience using hospital services
- How the Board is shaping strategy to meet future trends, e.g. population growth in our area, more complex cases, ongoing Covid/flu outbreaks, local transport/accommodation needs for staff and patients, opportunities for technology, Artificial Intelligence (AI), sharing patient data, etc.

## 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: 18 January 2023

| | |
|---|---|
| **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

**18 January 2023**

**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 Health and care is facing a challenging period. However, there is significant variation between and within organisations and systems. Alongside the widely portrayed challenges there are also multiple examples of excellent care and innovation. Thank you to all staff and patients.

1.3 CUH has performed well over the winter so far, with periods of acute pressure. However, as a Trust we do continue to hold increased levels of risk. The pressures have come from winter demand and reducing elective waits, combined with a range of infectious respiratory illnesses, and industrial action. The two periods of industrial action were very difficult and required close working between CUH and RCN colleagues to get to a balanced position. Challenges have been met through intensive and excellent teamwork to deliver the Operational Strategy and Winter Task Forces, agreed by the Board in spring 2022. Actions include changes to the central operational function of the hospital, regular communications, support to staff, and additional capacity with partners at Royal Papworth Hospital, in the community and through virtual wards. November and current performance is particularly strong on ambulance handovers, maintaining elective care, and cancer waits. The Trust is working on waits in the Emergency Department (ED). Performance in most other areas remains strong e.g., finance; and the Trust awaits the results of the annual staff survey.

1.4 Looking ahead the Trust and ICB partners will continue to actively manage day to day delivery of the operational strategy; alongside the 15 programmes in the three domains of the strategy, with appropriate flexible prioritisation.

Planned 2 years ago, the opening of 56 beds in U block in the summer; and the 40 bedded 3 theatres elective orthopaedic centre in late summer will be important for care delivery.

1.5 In Building for the Future the Trust and partners have submitted Outline Business Cases for the Children's and Cancer Hospitals - negotiation continues on additional capital for Children's. Work is ongoing to improve care across the southern place (noting the need to balance pathway improvements with possible contractual changes), alignment with Royal Papworth Hospital, eastern region specialised services, and better engaging partners and stakeholders on the operation of the Biomedical Campus and how it can develop. The Trust and partners have submitted a devolved model in the bid to host the eastern Regional Research Delivery Network, to complement the strong Biomedical Research Centre.

1.6 The Trust and partners continue to work with national colleagues, encouraging resolution of industrial action; aligning stakeholders on simplified plans and policy for the next 3-24 months; and a refreshed long term plan supported by appropriate enablers in workforce, innovation, digital and capital.

**Part A**

## 2. The five areas of operational performance

### 2.1 Quality

Areas of challenge

*Capacity*

2.2 Capacity challenges resulted in moving into contingency areas, and a number of medical patients not being placed in their specialty area. The Trust experienced longer waits in the ED.

*Staffing*

2.3 The vacancy position has decreased for Health Care Support Workers to 12.9%, Registered Children's Nurses to 20.1% and Registered Nurses to 8.7%. However the availability of nursing staff remains a challenge due to short term sickness. The areas of greatest concern are the critical care units (including the paediatric intensive care unit – PICU and Neonatal Intensive Care Unit - NICU).

*Maternity Diverts*

2.4 The Rosie has seen a reduction in the number of diverts since 6 October 2022; from October at 91 hours, November at 0 hours and December at 72 hours.

*Midwifery Staffing*

2.5 October 2022 saw a large cohort of 26 newly qualified Midwives start work in the Trust which has brought the Midwife to birth ratio to 1:23.5. It should be noted that these Midwives undergo a year of preceptorship and require ongoing support, but they seem to be settling in well.

*Industrial Action*

2.6 CUH met the threshold to participate in the Royal College of Nursing industrial action following the national ballot and were one of the hospitals chosen for members to participate in the action on 15 and 20 December 2022.

2.7 On both dates an incident management structure was put in place to ensure safety across the organisation. Following negotiation with the RCN strike committee, agreed areas were derogated from action (those areas that would be open on a Christmas day plus some cancer services).

2.8 Patient safety was maintained on both days using redeployment of staff who did not wish to take action, no safety incidents were raised on the days in relation to ward/department cover, one incident form was raised regarding staff feeling unable to take action as they were in a derogated area.

2.9 On day one of the strike elective cancer surgery was not derogated therefore lists were cancelled, by day two the lists were derogated and able to go ahead. One patient safety incident has been raised regarding cancellation of elective surgery on the strike days – this is currently being investigated to determine if the patient suffered any harm.

*Complaints & Patient Advice and Liaison Service (PALS) Contacts*

2.10 The services remain under pressure with increasing number of complaints and increased complexity of contacts. Additional temporary staffing, reduced opening hours and development of an improvement plan is underway.

*Hospital Acquired Pressure Ulcers (HAPUs) and falls*

2.11 The trend of increasing numbers of HAPUs across all areas of the hospital unfortunately continues. A similar trend is being noticed for falls. The thematic review of HAPU's was completed with themes now feeding into an overarching improvement plan. A similar approach is in progress for falls and a thematic review, working with ICB colleagues is in progress. Once completed, this will feed into a revised Falls Improvement Plan.

Areas of Success

2.12 Atrial Fibrillation Association Healthcare Pioneers Award: the CUH team received recognition for work with atrial fibrillation and stroke prevention. Members of the Stroke Prevention in Atrial Fibrillation service and Cardiac Rhythm Management team were invited to celebrate their AF Healthcare Pioneers award at The Palace of Westminster on 24 November as part of Global AF Awareness Week. The international award was presented for successes in delivering a multidisciplinary pathway leading to improved protection against AF-related strokes.

## 3. Access to Care

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

3.1 **Emergency Department (ED).** Overall ED attendances were 11,813 in November 2022, which is 567 (5.0%) higher than November 2019. This equates to a rise in average daily attendances from 375 to 394 over the same period. 1,262 patients had an ED journey time in excess of 12 hours, compared to 369 in November 2019. This represents 10.7% of all attendances, a reduction compared to 15.4% in October 2022.

3.2 **Referral to Treatment (RTT).** In November 2022 the total waiting list size reduced for a second month, a drop of 953 to 58,977.

3.3 **Delayed discharges**. For November 2022 the Trust reported 6.7%, which is an increase of 1.2% from the previous month. Within the 6.7%, 67% were attributable to Cambridgeshire and Peterborough ICB, and the remainder across a further eight ICB's.

3.4 **Cancer.** The volume of 2 week wait patients seen in October 2022 was 2.8% higher than in October 2019. 2 week wait breaches reduced by 27 to 590 in October 2022 leading to a marginal increase in performance of 72.7%. 75.9% were capacity related.

3.5 **Operations.** Compared to the 2019 baseline, elective theatre activity in November 2022 was at 95%, 207 operations behind plan.

3.6 **Diagnostics.** Total diagnostic activity in November 2022 delivered to 106.5% of the November 2019 baseline. The total waiting list size reduced by 257 to 13,570, and the volume of patients waiting over 6 weeks decreased by 155 this month.

3.7 **Outpatients.** In November 2022 outpatients delivered 105.5% new activity against baseline which has been adjusted for working days per month.

## 4. Finance – Month 8

4.1 The Month 8 year to date position is a £1.8m surplus and the Trust remains on target with our plan to deliver a break-even year-end financial position. Significant capital investment has continued in year in line with our plan supporting the creation of additional physical capacity for services. Planning guidance for 2023/24 was released on the 23rd December 2022 and the Trust is working with the health system to review the implications of the guidance. The Trust continues to anticipate a very challenging financial year in 2023/24.

4.2 The following points should be noted in respect of the Trust's Month 8 financial performance:

- The Month 8 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 £15.8m.
- The Trust has recognised Elective Recovery Fund (ERF) income of £12.3m year to date in line with plan. The Trust's expectation is that NHSE/I will support ERF funding for the 22/23 financial year but this has not yet formally been confirmed.

4.3 The Trust has received an initial system capital allocation for the year of £32.2m for its core capital requirements. In addition to this, we expect to receive further funding for the Children's Hospital (£3.7m), Cancer Hospital (£7.5m) and Orthopaedic Theatre Scheme (14.9m) and additional funding for theatre equipment (£4.1m). Together with capital contributions from ACT, this provides a total capital programme of at least £62.6m for the year.

4.4 The Trust has invested £30.1m of capital at Month 8, £7.0m below the planned figure of £37.1m. The Trust expects to recover this under performance by year-end and achieve the forecast plan of £62.6m of capital expenditure.

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/mitigated in year:

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

4.6 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 and Wellbeing, Resourcing, Ambition, Inclusion and Relationships. In addition the workforce Winter Plan has been developed to set out areas of focus that require immediate attention. It should also be noted that there is ongoing work in response to industrial action which impacts the Trust:

<u>Good Work and Wellbeing</u>

5.2 Vaccination clinics closed on 23 December 2022 with 7640 Covid vaccines and 8473 flu vaccines being administered to staff, with 58% of substantive staff being vaccinated. For comparison, 10,314 Covid vaccines and 8,890 flu vaccines were given to staff during last year's vaccination campaign. CUH have delivered the highest number of vaccines via hospital hubs in the region. Additional flu clinics will run on 17, 24 & 31 January 2023 to support the rise in flu cases in our hospitals and our communities.

5.3 Occupational Health capacity continues to be challenging. There are a number of mitigations in place to support service delivery and improve the timeliness of health screening for new starters in post.

5.4 Three new wellbeing facilitators commence in January 2023. They will work with managers and teams to help navigate the support available. Initially we will have three facilitators with ambition to grow the team to six in 12 months' time.

5.5 The provision of subsidised hot food for staff has been introduced (£2 options daily) including an "out of hours" offer. The Deakin pod work continues with completion expected in March 2023 to include a refurbished café style area with free tea and coffee, an atrium with seating for small groups, a quiet rest room and improved outside space. Further such pod locations are being explored with the ambition for easy access for all staff to good break space.

5.6 Work continues on accommodation and the high cost area supplement.

Resourcing

5.7 During November and December 2022 42 Adult Nurses, four Midwives and one Paediatric Nurse joined the Trust. We were also delighted to welcome 78 new Healthcare Support Workers.

5.8 Since January 2022 we have successfully recruited 54 Midwives which has resulted in a current vacancy rate of 1% in Midwifery for bands 5/6.

5.9 Retention remains a key focus and a strategy has been developed and shared both internally and with the wider system retention collaborative. Priority areas have been identified and actions are underway; one such priority area is looking at reducing the number of colleagues choosing to leave the Trust within 24 months of commencement.

Ambition

5.10 The Trust has now appointed Workforce Project leads for both the Cambridge Children's Hospital Project and the Cambridge Cancer Research Hospital.

5.11 The Trust returned to face to face induction on 6 February, 2023. The programme is held the first and third Monday of every month and is held in the hexagon at the Frank Lee. Also, a new admin academy induction programme was launched in December 2022 for all new admin staff in band 2 – 4.

5.12 The Workforce Learning and Development team responsible for CUH's core e-learning content and development has successfully acquired the Quality Mark Digital QMD award for the e-learning that we create. This is the only standard for the UKs health sector and it defines and endorses world class e-learning for the healthcare workforce. It is only awarded to those who have the highest quality of training that has been assessed and endorsed by the UKs Sector Skills Council for Health.

Inclusion

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

Relationships

5.14 The CUH Leadership Workshops Winter Series is operating between November 2022-March 2023, as part of the Workforce Directorate Winter Plan, and is designed to provide practical guidance to support the specific challenges faced by managers across the Trust this winter. Topics include Leading Teams Under Pressure, Balancing Competing Needs and Leading in Uncertain Times.
Since mid-November 2022 169 managers have booked in advance and 112 managers have attended. A further 56 managers have booked through to March 2023 and this figure will rise with further marketing.

## 6. Improvement and Transformation

Building Capability

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

6.2 The recommendations from the IHI's onsite annual visit in October 2022 have been discussed by Management Executive and a number of the proposals are now being taken forward. These include members of Management Executive being involved in quality improvement (QI) visits across the organisation, as well as sponsoring a number of strategic QI projects, such as work with the Purple Network to help improve the working lives of our staff with disabilities, reducing pressure ulcers and improving sickness absence.

6.3 In relation to the Trust's work with the IHI on building improvement capability and capacity across our 11,500 staff, wave two of the improvement programme for teams continues, with the 19 teams due to conclude the programme in June 2023.

*Urgent and emergency care*

6.4 The improvement and transformation team continues to support colleagues with a number of initiatives aimed to reduce the length of stay for patients in ED and/or to stream patients to more appropriate care settings, such as same day emergency care.

6.5 The Medical Assessment Unit on EAU3 and EAU4 continues to stream appropriate medical patients away from the ED, with an average of 31.6 patients streamed to it per day. The number of urology assessments undertaken on the Surgical Assessment Unit, rather than the ED, has increased from a mean of 1.6 patients per week (July 2021 – March 2022), to 7.1 patients per week (April – November 2022).

*Outpatients*

6.6 The improvement and transformation team continues to support colleagues with the Trust's outpatients programme. Examples of these QI projects include reducing unnecessary follow up appointments in gastroenterology, increasing use of the electronic referral system in ophthalmology and increased use of patient initiated follow ups in gynaecology.

*Virtual wards*

6.7 To date, the virtual ward team has successfully on-boarded over 100 patients, from across 19 specialities and recorded 911 nursing contacts in December 2022. One cancer patient discharged to the virtual ward last month, was able to spend her golden wedding anniversary at home with her husband, rather than staying on an inpatient ward.

<u>Productivity and efficiency</u>

6.8 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 the end of month 8, the Trust is £11k ahead of target, with a forecast year-end over-achievement of £16k; however, our greatest level of risk is the potential for premium spend (for example on agency, outsourcing and/or waiting list initiatives) to exceed agreed budget levels. Work has also begun with colleagues to capture schemes for 2023/24.

## PART B

## 7. Strategy update

Strategy engagement and implementation

7.1 Following the launch of the Trust's refreshed strategy in July 2022, focus continues on its implementation through engagement with colleagues throughout the organisation. New materials have been developed to support managers to set aligned strategies and plans for their local teams, to understand and explore how the strategy applies to them and to recognise how they contribute to its delivery.

7.2 As part of the development of the Trust's five-year strategy implementation plan, a Board Away Day was held to focus on what transformation initiatives could improve mid-term operational performance and to agree next steps on how to progress these.

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

Improving patient care

*Integrated Care*

7.4 The Trust continues to work with partners across the Cambridgeshire South Care Partnership (working across East Cambridgeshire, South Cambridgeshire and Cambridge City) to improve care for people in and outside of hospital.

7.5 Conversations are ongoing with the Integrated Care Board to determine what responsibilities and resources will be devolved to Cambridgeshire South Care Partnership to support local integration and transformation work. This includes setting priorities for 2023/24, with clear definition of scope and expected outcomes and impact.

7.6 CUH continues to engage directly with primary care to understand how it can improve patient care and address common issues for patients. The Clinical Lead for Integrated Care within the Cambridgeshire South Care Partnership has held meetings with the Cambridgeshire Local Medical Committee (LMC) to identify and initially prioritise these, a number of which are being progressed with operational and clinical colleagues.

7.7 Clinical specialties within CUH are also being supported to develop approaches for the joint delivery of care with other providers as part of the Cambridgeshire South Care Partnership's approach to Proactive Care.

7.8 A Healthwatch report on health inequalities and barriers to care for communities within our geography is being finalised. It will be presented to the ICB's Health Inequalities workstream, will inform the design of Integrated Neighbourhoods within the Cambridgeshire South Care Partnership and will be considered as part of CUH's ongoing work on equality, diversity and inclusion.

*Health Inequalities, Equality, Diversity and Inclusion*

7.9 The Trust has formed a Steering Group for improving equality, diversity and inclusion, and tackling health inequalities, across our staff and patients, which is a core element of our new strategy. We have sought learning from elsewhere and are recruiting an Interim Director to support us to develop and implement an ambitious strategy.

*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.

<u>Building for the future</u>

*New hospitals and the estate*

7.11 Significant milestones have been delivered across the breadth of major projects within phases one (immediate term priorities) and two (Cancer and Children's) of Addenbrooke's 3. Work has commenced on projects that fall within phase three (the acute hospital and Neurosciences).

7.12 Highlights from phase one include the Genomics Service business case, providing options to improve capacity and manage growth over the next 10 years, whilst delivering efficiencies and supporting the delivery of the Cancer and Children's hospitals. Phase one also includes the implementation of a Community Diagnostics Centre at the Princess of Wales Hospital in Ely.

7.13 The Cambridge Cancer Research Hospital (CCRH) project team submitted the CCRH Outline Business Case (OBC) to regulators and to the New Hospital Programme in October 2022. The project team are now working closely with regulators to respond to all queries in order to receive approval in spring 2023. Concurrently, detailed work continues on the final 'Full Business Case'. Meetings have also been held with our patients, staff and the University of Cambridge to refine the designs of the building and ensure all feedback is considered. The project team hope to submit the CCRH planning application in January 2023.The procurement process to engage a Private Sector Construction Partner (construction company) to complete the CCRH design has begun. Throughout all these elements, engagement with our many stakeholders continues to be a priority, ranging from our CCRH All Staff Briefing and Patient Advisory Group meetings, to a Westminster MP briefing on 16 November 2022, focused on personalised medicine and promoting understanding of and support for both the CCRH and Cambridge Children's Hospital (CCH) projects.

7.14 The CCH project team submitted its OBC to regulators and the NHP in December 2022. This followed on from sign off through CUH, Cambridgeshire and Peterborough NHS Foundation Trust and University of Cambridge governance structures. The project has also secured letters of support from local and regional commissioning groups.

The team are continuing to work closely with the NHP team to secure our position in an early cohort of the programme. The project's fundraising campaign has continued to see excellent progress, with nearly £40m of its £100m target achieved. The design of the building has also progressed well, enabling the team to seek to engage a construction partner in 2023.

7.15 Implementation of the phase two projects will release several ward and outpatient areas within the existing estate. Work has commenced to develop options for how the released capacity should be used. This includes enabling the acceleration of compliance works and creating opportunities to improve co-location of related services to allow staff to work more effectively and reduce unnecessary travel within the site for patients.

7.16 Phase three is currently in the scoping phase and includes development of a medium-term plan for emergency care by taking a transformative approach to review, evaluate and redesign the Urgent and Emergency Care services. This project is in recognition that a new acute hospital is likely to be over 10 years away and that the solutions already approved as part of phase one will not be sufficient to bridge this time span. This phase also includes the development of a region-wide strategy for the delivery of Neurosciences services working closely with the East of England Specialised Services Provider Collaborative.

*Specialised Services*

7.17 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).

7.18 Since November, the EoE SPC has re-confirmed our strategic priorities (Children's, Cancer and Neurosciences/Neurology) with the CEOs of our trusts, alongside tactical priorities to achieve rapid impact. We have further progressed opportunities for transformation, working with partners across the region e.g. developing proposals to address regional gaps in specialist and paediatric dentistry and severe asthma.

7.19 We continue to work with Integrated Care Boards and NHSE EoE to prepare for the delegation of specialised commissioning in April 2024. We are also aligning with ICBs and NHSE on transformation priorities for specialised services across the region, and how we can work together to progress these.

7.20 In early December 2022, CUH applied to NHS England's Provider Collaborative Innovators scheme, which provides a tailored support offer from NHSE to provider collaboratives, to accelerate efforts to transform and improve services.

7.21 Going forward, the Trust is seeking to make further progress against the priorities we have identified, particularly where there are opportunities to produce tangible benefits in the short- to mid-term. We will continue our engagement activities across the region and support our activities through evolving our governance and resourcing models over time. We will also be completing a mapping of research and innovation opportunities across the collaborative, to determine where the EoE SPC could add value.

*Climate change*

7.22 Work is ongoing to reduce the consumption and environmental impact of medical gases used to give pain relief and anaesthesia to patients through limiting the direct emissions of nitrous oxide and desflurane, both powerful greenhouse gases; desflurane use is now below the 5% threshold against other volatile gases. A mobile nitrous oxide destruction unit, which collects residual nitrous oxide from exhaled air and decomposes it, has been sourced and a trial will commence in The Rosie Hospital, in the New Year.

7.23 CUH has secured a grant from the Regional Greener NHS Team to baseline data in advance of commencing work on the Clean Air Hospital Framework, which is part of the Trust's Reducing Emissions programme. We have also been accepted for the NHS programme 'Step up a Gear' which is established to support mode shift to more sustainable and active travel options.

7.24 The directive issued by NHSE to apply net zero and social value in the procurement of NHS goods and services is now well embedded within the tender process and the Procurement and Sustainability teams work closely together to enable delivery of the policy.

7.25 The first CUH Green Takeover week, designed to push forward the Trust's commitment to tackle climate change, was held in November. This involved engaging with as many staff, partner organisations, and members of the public as possible to share the content of the Green Plan and raise awareness and participation in the delivery of its objectives.

## 8. Recommendation

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

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

# Report to the Board of Directors: 18 January 2023

| | |
|---|---|
| **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 November 2022. |
| **Previously considered by** | Performance Committee, 11 January 2023 |


**Executive Summary**
The Integrated Performance Report provides details of performance to the end of November 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.

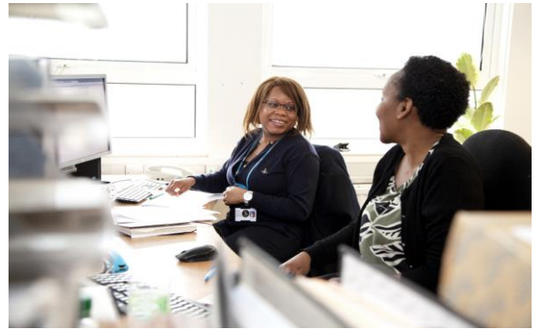

| | |
|---|---|
| Related Trust objectives | All objectives |
| Risk and Assurance | The report provides assurance on performance during Month 8. |
| Related Assurance Framework Entries | BAF ref: 001, 002, 004, 007, 011 |
| Legal implications/Regulatory requirements | n/a |
| How does this report affect 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 November 2022.




NHS
Cambridge University Hospitals
NHS Foundation Trust








# Integrated Report

## Quality, Performance, Finance and Workforce to end Nov 2022

Chief Finance Officer
Chief Nurse
Chief Operating Officer
Director of Workforce

Report compiled: 31 Dec 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;<br>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): Nicola Ayton, Mike Keech, Ashley Shaw, Lorraine Szeremeta, David Wherrett

# Quality Account Measures

Cambridge University Hospitals NHS Foundation Trust

2022/23 Performance Framework

## Performance Framework - Quality Indicators

| Domain | Indicator | Data to | Target | Sep 22 Previous Month-1 | Oct 22 Previous Month | Nov 22 Current status | Trend | FYtD | Previous FYR | LTM |
|---|---|---|---|---|---|---|---|---|---|---|
| **Infection Control** | MRSA Bacteraemia (avoidable hospital onset cases) | Nov-22 | 0 | 1 | 1 | 0 | ⇧ | 3 | 4 | 4 |
| | *E.Coli* Bacteraemias (Total Cases) | Nov-22 | 50% over 3 years | 33 | 42 | 37 | ⇩ | 276 | 384 | 404 |
| | *C. difficile* Infection (hospital onset and COHA* avoidable) | Nov-22 | TBC | 8 | 13 | 12 | ⇩ | 103 | 123 | 144 |
| | Hand Hygiene Compliance | Nov-22 | TBC | 96.4% | 96.3% | 96.8% | ⇧ | 97.0% | 97.5% | 97.2% |
| **Clinical Effectiveness** | % of NICE Technology Appraisals on Trust formulary within three months. ('last month') | Nov-22 | 100% | 71.4% | 50.0% | 42.9% | ⇩ | 53.6% | 33.8% | 48.7% |
| | % of external visits where expected deadline was met (cumulative for current financial year) | Nov-22 | 80% | N/A | N/A | N/A | ▪ | 44.4% | 38.5% | 43.5% |
| | 80% of NICE guidance relevant to CUH is returned by clinical teams within total deadline of 32 days. | Nov-22 | - | 20.0% | 0.0% | N/A | ▪ | 50.6% | 17.2% | 44.7% |
| | No national audit negative outlier alert triggered | Nov-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 | Nov-22 | 85% | N/A | 80.0% | N/A | ▪ | 60.7% | 84.6% | 67.5% |
| **Nursing Quality Metrics** | Blood Administration Patient Scanning | Nov-22 | 90% | 99.7% | 99.5% | 99.5% | ⇧ | 99.5% | 99.1% | 99.6% |
| | Care Plan Notes | Nov-22 | 90% | 96.6% | 96.2% | 96.5% | ⇧ | 96.6% | 95.8% | 96.3% |
| | Care Plan Presence | Nov-22 | 90% | 99.9% | 99.9% | 99.7% | ⇩ | 99.9% | 99.6% | 99.9% |
| | Falls Risk Assessment | Data reported in slides | | | | | | | | |
| | Moving & Handling | Nov-22 | 90% | 74.3% | 72.6% | 72.5% | ⇩ | 74.1% | 74.2% | 73.4% |
| | Nurse Rounding | Nov-22 | 90% | 99.5% | 99.2% | 99.2% | ⇧ | 99.4% | 99.6% | 99.5% |
| | Nutrition Screening | Nov-22 | 90% | 75.3% | 73.2% | 74.1% | ⇧ | 75.2% | 77.1% | 74.8% |
| | Pain Score | Nov-22 | 90% | 85.3% | 84.6% | 83.8% | ⇩ | 85.4% | 86.6% | 85.6% |
| | Pressure Ulcer Screening | Data reported in slides | | | | | | | | |
| | **EWS** | | | | | | | | | |
| | MEOWS Score Recording | Nov-22 | 90% | 58.7% | 67.5% | 65.1% | ⇩ | 63.0% | 63.1% | 63.0% |
| | PEWS Score Recording | Nov-22 | 90% | 99.1% | 99.2% | 99.3% | ⇧ | 99.2% | 99.2% | 99.2% |
| | NEWS Score Recording | Nov-22 | 90% | 97.5% | 97.3% | 97.2% | ⇩ | 97.3% | 96.6% | 97.0% |
| | **VIP** | | | | | | | | | |
| | VIP Score Recording (1 per day) | Nov-22 | 90% | 87.6% | 86.9% | 86.2% | ⇩ | 88.0% | 91.2% | 88.6% |
| | PIP Score Recording (1 per day) | Nov-22 | 90% | 91.6% | 85.9% | 89.3% | ⇧ | 88.9% | 88.4% | 89.3% |
| **Patient Experience** | Mixed sex accommodation breaches | Jun-20 | 0 | N/A | N/A | N/A | ▪ | N/A | N/A | N/A |
| | Number of overdue complaints | Nov-22 | 0 | 6 | 3 | 9 | ⇧ | 61 | 29 | 73 |
| | Re-opened complaints (non PHSO) | Nov-22 | N/A | 0 | 0 | 1 | ⇩ | 15 | 74 | 42 |
| | Re-opened complaints (PHSO) | Nov-22 | N/A | 0 | 1 | 1 | ⇔ | 2 | 4 | 3 |
| | | | | Sep 22 | Oct 22 | Nov 22 | | | | |
| | Number of medium/high level complaints | Nov-22 | N/A | 21 | 27 | 16 | ⇩ | 169 | 244 | 247 |



Author(s): Various

Owner(s): Oyejumoke Okubadejo

# Quality Summary Indicators

NHS Cambridge University Hospitals NHS Foundation Trust

2022/23 Performance Framework

## 2022/23 Quality Account Measures

| Domain | Indicator | Data to | Target | Sep 22 Previous Month-1 | Oct 22 Previous Month | Nov 22 Current status | Trend | FYtD | Baseline | LTM |
|---|---|---|---|---|---|---|---|---|---|---|
| **Safe** | Average % compliance with individual elements of NEWS2 escalation policy | Sep-22 | 85% | 43% | N/A | N/A | ▪ | 55.0% | 50.0% | 54.2% |
| | % of patients over 65 years of age who have a lying and standing blood pressure completed within 48 hours of admission | Nov-22 | 50% | 16.1% | 13.3% | 13.9% | ⇧ | 14.9% | 13.4% | 14.9% |
| | % of patients who have a VTE risk assessent undertaken within 14 hours of admission | Oct-22 | 95% | N/A | 95.3% | N/A | ▪ | 95.3% | N/A | 95.3% |
| | Average % compliance with blood cultures within 60 minutes of Sepsis diagnosis | Oct-22 | 95% | 100.0% | 33.0% | N/A | ▪ | 72.8% | 70.0% | 72.8% |
| **Patient Experience / Caring** | Healthcare Inequality: Percentage of patients in calendar month where ethnicity data is **not recorded** on EPIC CheQs demographics report (Ethnicity Summary by Patient) | Nov-22 | 7% | 12.2% | 13.1% | 13.6% | ⇧ | 12.2% | 14.0% | 12.0% |
| | Publication of actions and improvements undertaken as a result of feedback received from patients and their representatives | Nov-22 | 100% | 8.3% | 8.3% | 8.3% | ⇔ | 8.3% | 0.0% | 8.3% |
| **Effective / Responsive** | % of Early Morning Discharges (07:00-12:00) | Nov-22 | 20% | 17.9% | 17.5% | 16.6% | ⇩ | 16.5% | 15.3% | 16.2% |
| | 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** | Nov-22 | 80% | 89.8% | 72.2% | 72.1% | ⇩ | 75.5% | 74.0% | 76.0% |
| | Same day emergency care (SDEC) | Nov-22 | 30% | 14.9% | 15.6% | 24.0% | ⇧ | 18.5% | 22.0% | 19.6% |
| | **Quarterly** | | | Mar 22 | Jun 22 | Sep 22 | | | | |
| | SSNAP Domain 2: % of patients admitted to a stroke unit within 4 hours of clock start time (Team centred) | Sep-22 | 55% | N/A | 25.9% | 29.2% | ⇧ | 27.5% | 29.2% | 27.5% |
| **Staff Experience / Well-led** | Retention of band 5 nurses (quarterly) | Jun-22 | 88.5% | N/A | N/A | N/A | ▪ | N/A | 87.0% | N/A |
| | **Annual** | | | 2016 | 2017 | 2018 | | | | |
| | I feel secure about raising concerns re unsafe clinical practice within the organisation | | 78.0% | 75.0% | 73.0% | 74.0% | ⇧ | | 75.0% | |

# Operational Performance

Cambridge University Hospitals NHS Foundation Trust

Operational Performance

| POD | Performance Standards | SPC | Target | Target due by | Internal Target | In Month Actual | Actual |
|---|---|---|---|---|---|---|---|
| **Urgent & Emergency Care** More information on page 15 | Ambulance handovers <15mins | | 65% | Immediate | | 46% | |
| | Ambulance handovers <30mins | | 95% | Immediate | | 88% | |
| | Ambulance handovers > 60mins | L | 0 | Immediate | | 2% | |
| | 12hr waits in ED (type 1) | H | 2% | Immediate | 2% | 11% | |
| | Cancer patients < 62 days | L | 85% | Immediate | | 66% | |
| **Cancer** More information on pages 17,18 | 28 day faster diagnosis standard | | 75% | Immediate | 83.9% | 77.2% | |
| | 31 day decision to first treatment | L | 96% | Immediate | | 93% | |
| | Advice and Guidance Requests | | 16% | Mar-23 | 14% | 8.9% | |
| **Outpatient Transformation** More information on page 21 | Patients moved / discharged to PIFU | H | 5% | Mar-23 | 4.0% | 2.5% | |
| **Diagnostics** More information on page 19 | Patients waiting > 6 weeks | L | 5% | Mar-24 | | 39% | |
| **RTT Waiting List** More information on page 16 | RTT Patients waiting > 78 weeks | L | 0 | Mar-23 | 279 | 351 | |
| | RTT Patients waiting > 104 weeks | L | 0 | Jul-22 | - | 2 | |

| Productivity and Efficiency | SPC | In Month Actual | Actual |
|---|---|---|---|
| Non-elective LoS (days, excl 0 LoS) | H | 9.0 | |
| Long stay patients (>21 LoS) | L | 214 | |
| Elective LoS (days, excl 0 LoS) | | 6.2 | |
| Discharges before noon | H | 17% | |
| Theatre sessions used | | 1353 | |
| In session theatre utilisation | H | 83% | |
| utpatient ces | L | 20.5% | |

| | Nov-22 | Oct-22 | % change | Feb-20 | % change |
|---|---|---|---|---|---|
| - New | 33,634 | 30,913 | ↑9% | 28,700 | ↑17% |
| - Total WL | 13,570 | 13,827 | ↓2% | 8,708 | ↑56% |
| ys - Total WL | 58,977 | 59,930 | ↓2% | 34,097 | ↑73% |
| pathway) >62d | 134 | 146 | ↓8% | 56 | ↑139% |

| ritisation - WL | Nov-22 | Oct-22 | change |
|---|---|---|---|
| Including planned | 2,262 | 2,129 | ↑6% |
| P3 (3 months) | 5,493 | 5,480 | ↑0% |
| P4 | 3,516 | 3,511 | ↑0% |

**Key / notes**

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

Together-Safe | Kind | Excellent

# Acute Priorities Delivery

Cambridge University Hospitals NHS Foundation Trust

2022/23 Performance Framework

**Elective Inpatient Activity**

| | |
|---|---|
| 83% | In Month Actual |
| 62% | In Month Plan |
| 87% | YTD Actual |
| 79% | YTD Plan |

**Elective Daycase Activity**

| | |
|---|---|
| 97% | In Month Actual |
| 101% | In Month Plan |
| 104% | YTD Actual |
| 103% | YTD Plan |

**Emergency Admissions**

| | |
|---|---|
| 84% | In Month Actual |
| 89% | In Month Plan |
| 81% | YTD Actual |
| 93% | YTD Plan |

**New Outpatient Activity**

| | |
|---|---|
| 105% | In Month Actual |
| 92% | In Month Plan |
| 102% | YTD Actual |
| 99% | YTD Plan |

**Follow Up Outpatient Activity**

| | |
|---|---|
| 110% | In Month Actual |
| 110% | In Month Plan |
| 109% | YTD Actual |
| 120% | YTD Plan |

**Diagnostic activity (national planning submission)**

| | |
|---|---|
| 106% | In Month Actual |
| 131% | In Month Plan |
| 110% | YTD Actual |
| 125% | YTD Plan |

**RTT Clockstops (All)**

| | |
|---|---|
| 94% | In Month Actual |
| 92% | In Month Plan |
| 92% | YTD Actual |
| 100% | YTD Plan |

**RTT Clockstops (Admitted)**

| | |
|---|---|
| 87% | In Month Actual |
| 88% | In Month Plan |
| 84% | YTD Actual |
| 87% | YTD Plan |

**RTT Clockstops (Non admitted)**

| | |
|---|---|
| 97% | In Month Actual |
| 94% | In Month Plan |
| 94% | YTD Actual |
| 104% | YTD Plan |

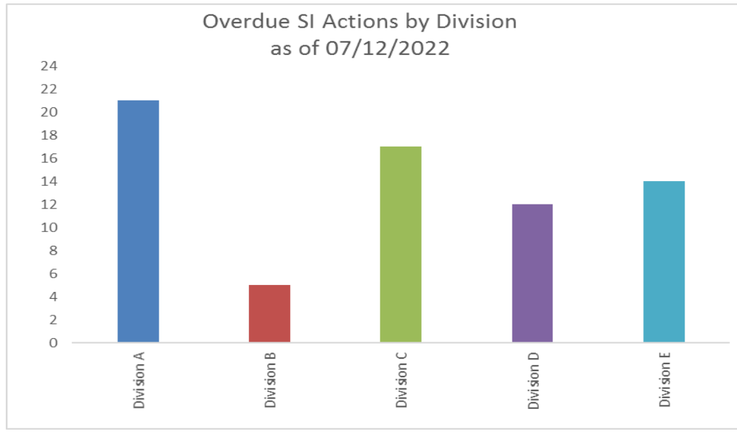
# Serious Incidents

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 | Dec 19- Nov 22 | month | - | 1553 | 1423 | | S7 | | The number of patient safety incidents is above normal variance. |
| Percentage of moderate and above patient safety incidents | Dec 19- Nov 22 | month | 2% | 2.3% | 2.0% | | - | | There is currently normal variance in the percentage of moderate and above patient safety incidents. |
| All Serious Incidents | Dec 19- Nov 22 | month | - | 5 | 5 | | - | | 5 Serious Incidents were declared with the ICB in November 2022, which is within normal variance for the trust. |
| Serious Incidents submitted to ICB within 60 working days | Dec 19- Nov 22 | month | 100% | 80% | 65% | | - | | 7 Serious Incidents were due to the ICB in Oct 2022, 4 of which were submitted within the 60 day target and the remaining 3 SIs have had extensions granted. |

| Ref | SI Title | STEIS SI Sub categories | Actual Impact | Division | Ward / Department |
|---|---|---|---|---|---|
| SLR142397 | HAPU | Pressure ulcer meeting | Severe / Major | Division A | Clinic 1 |
| SLR151120 | Missed Colonoscopy | Treatment delay | Severe / Major | Division C | Ward C4 |
| SLR151147 | Upper GI Bleed | | Death / Catastrophic | Division A | Division A Management |
| SLR152698 | Fall | Slips/trips/falls | Death / Catastrophic | Division A | Ward C7 |
| SLR152825 | Delayed Intervention-Major Trauma Paediatric Patient | Treatment delay | No Harm | Division A | Major Trauma Centre - TSO |
| SLR152908 | Deteriorating Patient | Treatment delay | Death / Catastrophic | Division D | Ward L5 |




**Executive Summary:**
A Thematic review of nine Hospital Acquired Pressure Ulcers was undertaken, with one Serious Incident report was submitted to the ICB for all nine cases in November 2022
To date the number of serious incident investigations declared in 2022 exceeds the numbers of last 4 years, resources for investigating have been limited due to competing clinical and operational priorities and resources within the central patient safety team. This has impacting compliance with the 60 day Target for submissions. Further use of alternative investigation methodology and thematic reviews in collaboration with the ICB will improve the investigation process.
There has been a continued increase of reported safety incidents affecting patients. These include Hospital Acquired Pressure Ulcers.

Together-Safe | Kind | Excellent

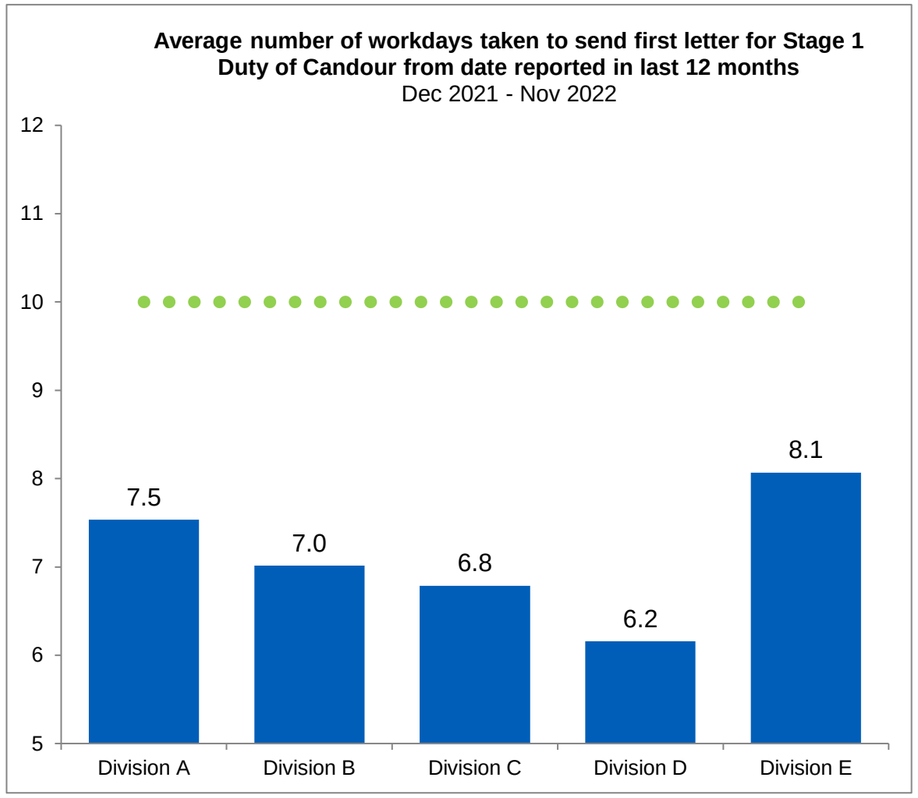

Author(s): Clare Miller
Owner(s): Oyejumoke Okubadejo

# Duty of Candour

NHS Cambridge University Hospitals NHS Foundation Trust

Safety and Quality

| Indicator | Data range | Period | Target | Current period | Mean | Variance | Special causes | Target status | Comments |
|---|---|---|---|---|---|---|---|---|---|
| Duty of Candour Stage 1 within 10 working days* | Nov 19 - Nov 22 | month | 100% | 54% | 70% | | - | | The system may achieve or fail the target subject to random variation. |
| Duty of Candour Stage 2 within 10 working days** | Nov 19 - Nov 22 | month | 100% | 27% | 65% | | - | | The system may achieve or fail the target subject to random variation. |




**Executive Summary**

Trust wide stage 1* DOC is compliant at 71% for all confirmed cases of moderate harm or above in November 2022. 54% of DOC Stage 1 was completed within the required timeframe of 10 working days in November 2022. The average number of days taken to send a first letter for stage 1 DOC in November 2022 was 5 working days.

Trust wide stage 2** DOC is compliant at 91% for all completed investigations into moderate or above harm in October 2022 and 27% 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 | Dec 19 - Nov 22 | month | - | 167 | 143.56 | | - | - | There were a total of 167 falls (inpatient, outpatient and day case) in November 2022. This is within normal variance. There has been an over all increase in the number of falls over the last 36 months. |
| Inpatient falls per 1000 bed days | Dec 19 - Nov 22 | month | - | 4.64 | 4.55 | | - | - | The Trust remains within normal variance. The rate of inpatient falls has shown a small increase over the last 36 months [ Dec 219 - 4.28 November 20222 - 4.64] |
| Moderate and above inpatient falls per 1000 bed days | Dec 19 - Nov 22 | month | - | 0.14% | 0.09% | | - | - | There were 5 falls categorised as Moderate or above harm in November 2022. The level of harm is classed according to injury and not lapses in care. This is within normal variance, however three has been an overall increase over the last 36 months, some of this increase is due to changes in reporting criteria. |
| Falls risk screening compliance within 12 hours of admission | Dec 19 - Nov 22 | month | 90.0% | 83.8% | 87.2% | | - | ? | 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 | Dec 19 - Nov 22 | month | 90.0% | 13.9% | 11.4% | L | | - | 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 | Dec 19 - Nov 22 | month | 90.0% | 31.9% | 15.2% | L | | - | Improvement work is ongoing to address continued low compliance in care planning for patients with a cognitive impairment. Changes are being made to the Falls Risk Screening to improve identification of cognitive impairment and prompt for care plans |
| Falls KPI: patients 65 and over requiring the use of a walking aid have access to one for their sole use | Dec 19 - Nov 22 | month | 90.0% | 67.8% | 76.8% | | | - | 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 Falls Champions are currently focusing on this.
New CUH specific care plans have been developed and EPIC changes are being worked on currently
Changes are being made to the Falls Risk Screening, this will prompt for confusion care plans , MCA for basic care and treatment and 4AT delirium assessments. The new Falls Risk Screening will also identify were the information to complete the screening was gained from i.e. patient, family/carer, notes, this is due to concerns that inaccurate information is being recorded for patients with confusion.
A thematic review of falls that met the serious incident criteria is being undertaken in collaboration with the CCG. The conclusion of this review will be triangulated with the existing Falls Quality Improvement plan and any appropriate changes will be made.
Changes to the incident report for falls on QSIS have been made to capture post falls care and staffing issues. The monthly falls report will be updated to capture and review this data.
Currently there is no resilience within the inpatient falls as there is only the Lead Falls Prevention Specialist, due to this and increasing demand a business case will be completed to increase the inpatient falls service.



Author(s): Debbie Quartermaine Owner(s): Oyejumoke Okubadejo

# Hospital Acquired Pressure Ulcers (HAPUs)

Cambridge University Hospitals NHS Foundation Trust

Safety and Quality

| Indicator | Data range | Period | Target | Current period | Mean | Variance | Special causes | Target status | Comments |
|---|---|---|---|---|---|---|---|---|---|
| All HAPUs by date of occurrence | Feb 18 - Nov 22 | month | - | 47 | 23 | H | SP | - | The total numbers of HAPU's for Nov are higher than September and October, which is over the Upper Control Limit. |
| To increase reporting of category 1 HAPU to achieve an upward trajectory in reporting by March 2022 | Feb 18 - Nov 22 | month | - | 15 | 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 - Nov 22 | month | - | 32 | 12 | H | SP | - | Category 2 and above HAPU's are over the upper control limit for November, and the mean trajectory remains on an upward slope. |
| Pressure Ulcer screening risk assessment compliance | Feb 18 - Nov 22 | month | 90% | 75% | 80% | L | SP | F | PU screening risk assessment compliance remains lower than the target of 90%. The QI plan is currently 47% achieved. |
| KPI downward trend of category 2, 3, 4, Suspected Deep Tissue Injury and Unstageable HAPUs by March 2022 | Apr 19 - Nov 22 | month | 9 | 32 | 11 | 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's remain on an upper trajectory, and unfortunately, it has been increased from 18 in September to 31 in November. This KPI has not been achieved so far and they will remain in the QI Plan. |

**Exec Summary**

HAPUs remain on an upper trajectory, and the total numbers of HAPUs for November are higher than September and November 2022, which is now over the Upper Control Limit.

HAPU incidents; Category 1 = 15, Category 2 = 24, Category 3 = 0, Category 4 = 0, SDTI = 7, Unstageable = 1

A thematic review is completed of all serious incidents relating to HAPUs from April to October 2022 . The quality improvement plan already incorporates actions from the review findings.

**QI Plan update:**

Face to face Tissue Viability training sessions have recommenced on CSSIP, preceptorship for Division A, C and D and PDN study days.

Sessions for QPO and International Nurses will commence in January 2023.

A new band 6 TVN has been appointed within the Emergency Department to facilitate the improvement of Pressure Ulcer Prevention at the beginning of the patients' hospital journey.

Change request for Epic updates have been submitted and approved for identifying accurate body location for skin inspection and prompts to assist in completing the Waterlow Risk Assessment tool.

Connect page for Tissue Viability have been updated for referrals and wound care treatment pathways.

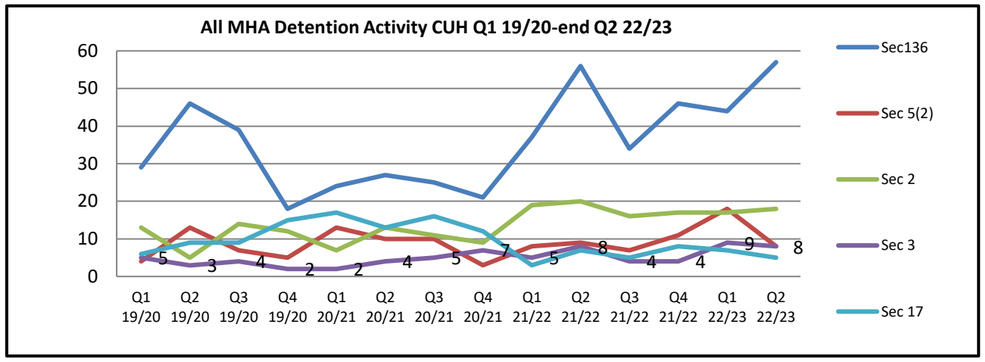
The up-to-date Tissue Viability folders have been delivered to the majority of clinical wards, relevant outpatient clinics and departments.

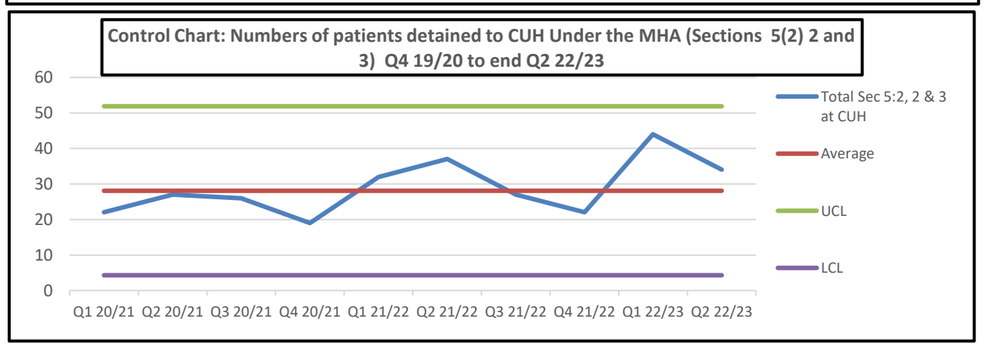
There is a plan to resume the Tissue Viability and Falls Steering Group meeting in the New Year 2023.

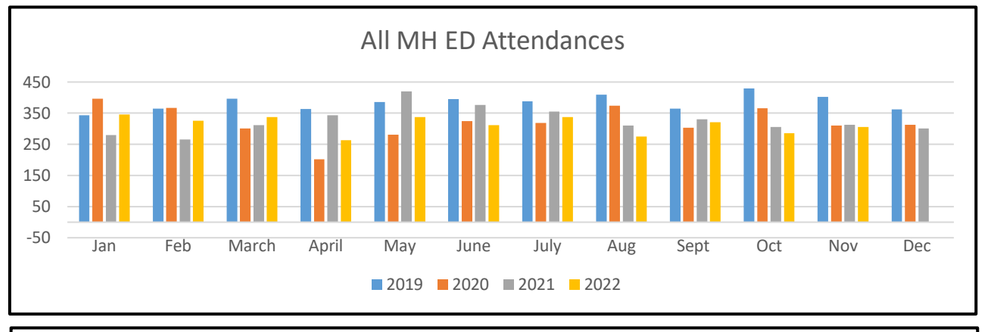
# Mental Health - Q1 2022/23

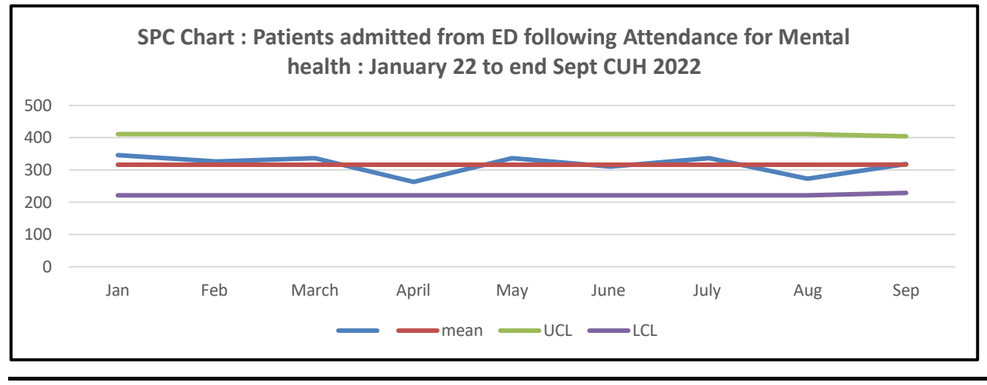
Cambridge University Hospitals NHS Foundation Trust

Mental Health




## Narrative

- The numbers of inpatients detained under the Mental Health Act has levelled out in Q2 22/23 following a slight increase in Q1 .That increase was largely accounted for by an increased use of Section 5(2) emergency Doctors Holding Power. There were 18 5(2) detentions in Q1 and 8 in Q2
- The numbers of patients brought to CUH on Sec 136 (place of safety) increased in Q2. The mean number of patients detained on Sec 136 per quarter since Q1 2019/20 is 35.4. In Q2 22/23 the number of 136's was 57 . There is historically an increase in use of Sec 136 in Q2 and this will be monitored. However it is becoming apparent that the use of Sec 136 is gradually returning to pre-pandemic levels. CUH was used as a place of safety when the 136 was full on 26 occasions in Q2 against 19 in Q1 . This likely relates to an overall increase in the use of Sec 136 by the police.
- The cumulative number of mental health presentations to ED in the period January to end November 2022 (3445) is 18.75% lower than for the same period 2019 (pre-pandemic) , 2.7% lower than 2020 and 5.5% lower than for the same period last year
- The number of individuals presenting to the ED at CUH with a mental health need in November 2022 (306) is 7% higher than October 2022 (286).
- The number of *adults* presenting to ED in November (263) represents a 5% decrease on October '22 (260) .
- The *cumulative* no of adults presenting at ED for MH reasons who were subsequently admitted to CUH in the period Jan-Nov 2022 shows a 13% decrease (400 admissions) in comparison to the same period 21/22 (461 admissions).
- Compared with October '22, (26), there was a 65% increase in CAMH aged patients presenting in ED in Nov '22 (43). Of these, 34.9% were subsequently admitted to a bed at CUH (10). It is unclear how many individuals attended
- For CAMH aged patients, the cumulative number of those admitted to a CUH bed from ED has reduced from 192 patients between Jan-Nov 2021 to 158 over the same period 2022, a 17.7% 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 consistently higher.

## Ongoing work:

- 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

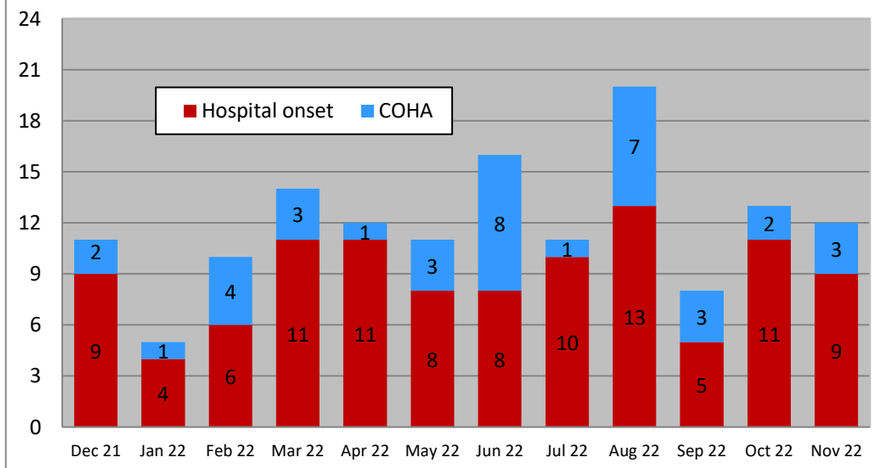
Together-Safe | Kind | Excellent

# Infection Control

Cambridge University Hospitals NHS Foundation Trust

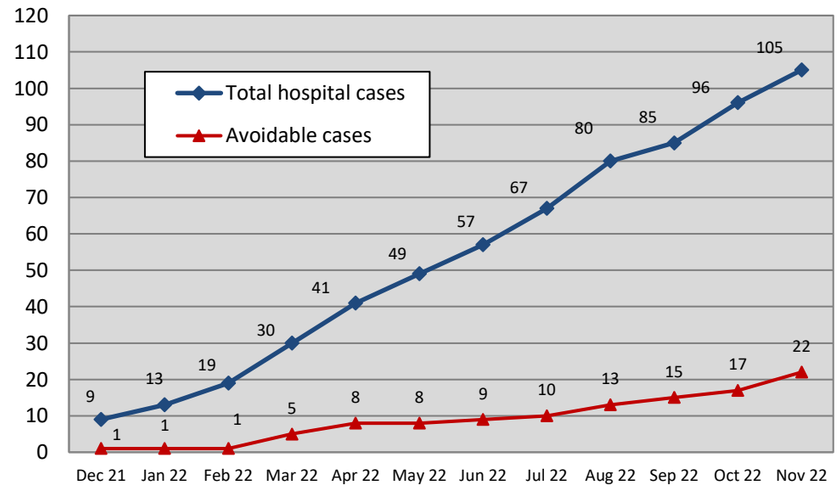


**Monthly *Clostridium difficile* cases in last 12 months**




* 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

**Cumulative *Clostridium difficile cases* in last 12 months**




**CUH trend analysis**

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

- No cases of hospital onset MRSA bacteraemia in November 2022
- 3 cases (2 unavoidable & 1 avoidable) hospital onset MRSA bacteraemia year to date

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

- 9 cases of hospital onset *C difficile* and 3 cases of COHA in November 2022.
- 75 hospital onset cases and 28 COHA case year to date (84 cases unavoidable, 17 avoidable and 2 pending).

**MRSA and C difficile key performance indicators**

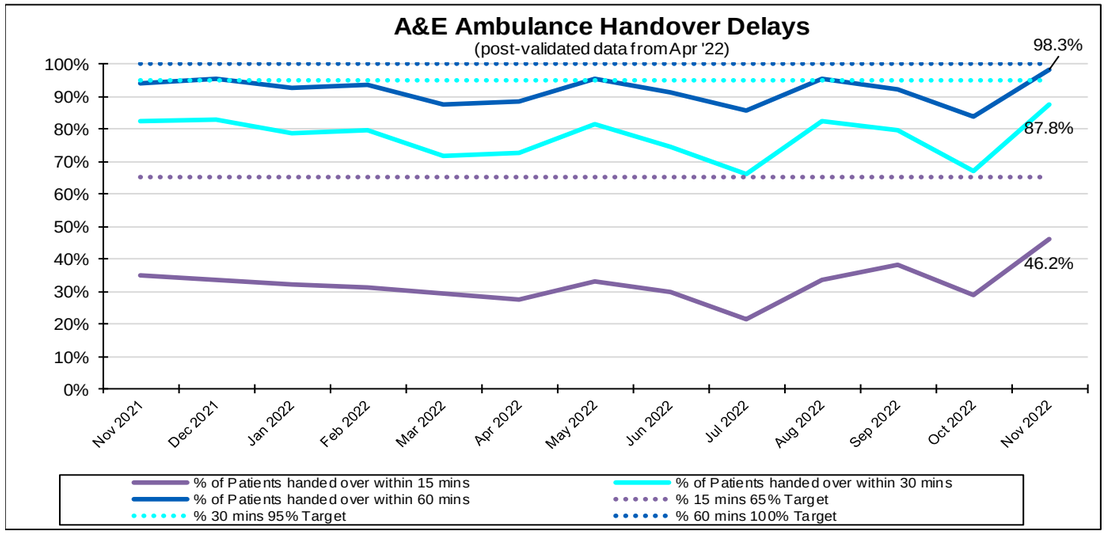
- Compliance with the MRSA care bundle (decolonisation) was 87.3% in November 2022 (75.6% in October 2022).
- The latest MRSA bacteraemia rate comparative data (12 months to October 2022) put the Trust 7th out of 10 in the Shelford Group of teaching hospitals.

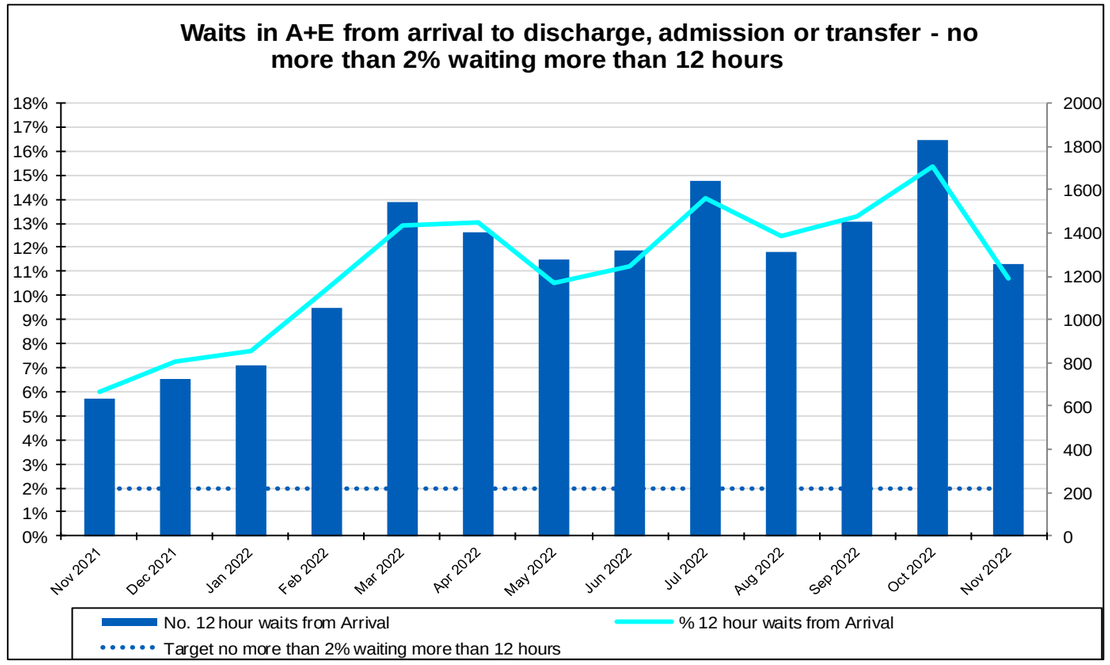
- Compliance with the *C. difficile* care bundle was 90.9% in November 2022 (92.6% in October 2022).
- The latest *C. difficile* rate comparative data (12 months to October 2022) put the Trust 9th out of 10 in the Shelford Group of teaching hospitals.

# Amb. Handovers & 12 Hr Waits From

NHS Cambridge University Hospitals NHS Foundation Trust

Operational Performance




| | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 |
|---|---|---|---|---|---|---|---|
| No. of Patients not handed over within 30 mins (Post-validation) | 449 | 583 | 735 | 398 | 443 | 674 | 278 |
| No. of Patients not handed over within 60 mins (Post-validation) | 107 | 202 | 313 | 97 | 172 | 326 | 38 |

**Demand**:
- ED attendances in November were 11,813. This is 567 (5.0%) higher than November 2019, equivalent to an increase from 375 to 394 attendances per day.
- Paediatric attendances showed the greatest proportional rise, increasing by 28.9% (+647) from November 2019.
- 1,262 patients had an ED journey time in excess of 12 hours compared to 369 in November 2019. This represents 10.7% of all attendances, a reduction compared to 15.4% in October.

**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:
- 498 patients were streamed from ED to our Medical Assessment Unit (MAU) and a further 510 patients to our Surgical Assessment Unit.
- 3,235 patients were streamed to the Urgent Treatment Centre (UTC), of which 1,854 patients were seen by a GP or ECP.

**Ambulance handovers:** In November 2022 we saw 2,275 conveyances to CUH which was a decrease of 21.6% (-627) compared to November 2019. Of these:
- 46.2% of handovers were clear within 15mins vs. 54.5% in November 2019
- 87.8% of handovers were clear within 30mins vs. 91.0% in November 2019
- 98.3% of handovers were clear within 60mins vs. 99.0% in November 2019.

**Overall:**
During November UEC performance improved significantly due to a focus on handover delays, patient waits and in-patient flow. Initiatives driving this improvement include the expansion of the MAU, the introduction of a new Frailty Unit and the '100-bed challenge' to improve outflow from the department. Ambulance handover delays in particular saw a significant improvement, with 60min handovers approaching pre-pandemic performance levels and CUH having the second best handover performance in the region. During December CUH, along with other regional and national providers, have seen a more challenging environment due to an increase of infectious illnesses and greater overall demand. The UEC Oversight Board and Winter Taskforce, led by the Chief Operating Officer, continue to oversee actions to drive performance during winter and formulate longer-term plans for improvement across our urgent and emergency care pathways.



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

# Fit Testing compliance for substantive staff

NHS
Cambridge University Hospitals
NHS Foundation Trust

Fit Testing compliance for substantive staff

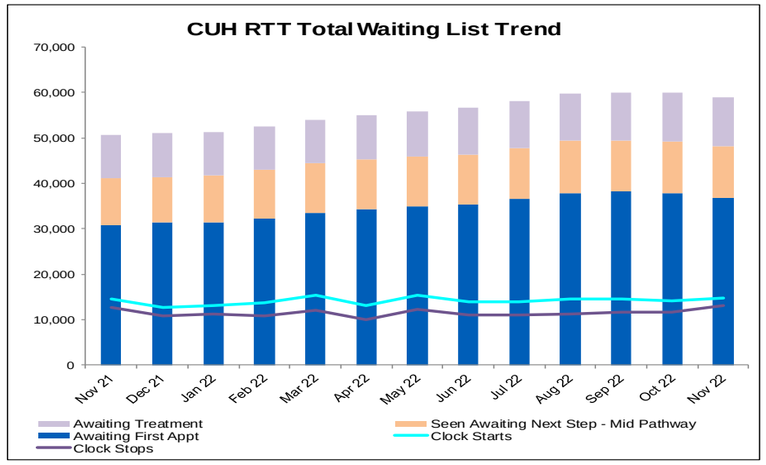
| Division | Corporate | | | Division A | | | Division B | | | Division C | | | Division D | | | Division E | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Staff Group | Number of Staff requiring testing | Total protected staff | % Total staff protected | Number of Staff requiring testing | Total protected staff | % Total staff protected | Number of Staff requiring testing | Total protected staff | % Total staff protected | Number of Staff requiring testing | Total protected staff | % Total staff protected | Number of Staff requiring testing | Total protected staff | % Total staff protected | Number of Staff requiring testing | Total protected staff | % Total staff protected | Number of Staff requiring testing | Total protected staff | % Total staff protected |
| Add Prof Scientific and Technical (Pharmacists only) | 6 | 4 | 67% | - | - | - | 130 | 85 | 65% | 1 | 1 | 100% | - | - | - | - | - | - | 137 | 90 | 66% |
| Additional Clinical Services | 9 | 7 | 78% | 168 | 91 | 54% | 56 | 31 | 55% | 93 | 57 | 61% | 72 | 34 | 47% | 59 | 32 | 54% | 457 | 252 | 55% |
| Allied Health Professionals | - | - | - | 51 | 13 | 25% | 115 | 53 | 46% | 1 | 0 | 0% | - | - | - | 1 | 1 | 100% | 168 | 67 | 40% |
| Estates and Ancillary (Porters and Securuty Personnel only) | 53 | 52 | 98% | 2 | 1 | 50% | - | - | - | - | - | - | - | - | - | - | - | - | 56 | 53 | 95% |
| Medical and Dental | - | - | - | 105 | 43 | 41% | 63 | 27 | 43% | 138 | 75 | 54% | 64 | 29 | 45% | 87 | 45 | 52% | 457 | 219 | 48% |
| Nursing and Midwifery Registered | - | - | - | 497 | 319 | 64% | 26 | 11 | 42% | 222 | 146 | 66% | 144 | 85 | 59% | 262 | 165 | 63% | 1151 | 726 | 63% |
| **Total** | **68** | **63** | **93%** | **823** | **467** | **57%** | **390** | **207** | **53%** | **455** | **279** | **61%** | **280** | **148** | **53%** | **409** | **243** | **59%** | 2426 | 1407 | 58% |

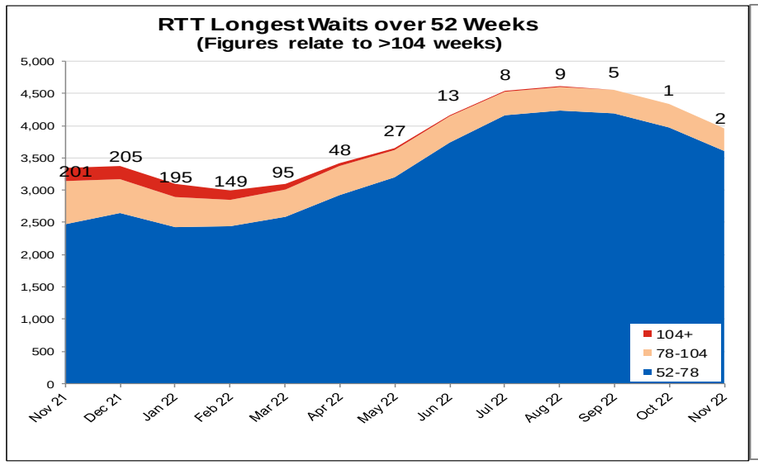
*The data displayed is at 20/12/22. This data reflects the current escalation areas requiring staff to wear FFP3 protection. This data set does not include Medirest, student Nurses, AHP students or trainee doctors. Conversations on fit testing compliance with the leads for the external entities take 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.*

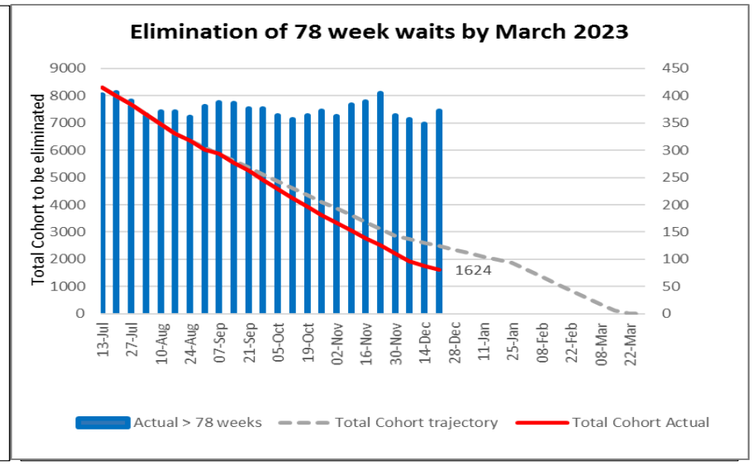
# Referral To Treatment - (RTT)

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

In November the total waiting list size reduced for a second month, a drop of 953 to 58,977. Our Month 8 planning submission had forecast growth to 53,690 so we are have reduced our variance to 9.8% above plan this month. Compared to pre-pandemic the waiting list has grown by 73%.

The number of patients joining the RTT waiting list (clock starts) were down by 0.3% on last month, but were still 2.7% higher than the same month in the baseline year. We had forecast continued referral growth of 2.3% above 2019 baseline and cumulatively year to date we are now 3.6% above planned levels. Clock start6.s (referrals) represented 25% of the total waiting list size in the month. Patients waiting to commence their first pathway step accounted for 62% of the total.

The number of RTT treatments (stops) delivered in November were up by 6.8% on last month, and represented 94.4% compared to November 2019. Non-admitted stops were 96.7% of baseline, and admitted stops were 86.9% of baseline. Total treatments were 2% above our submitted plan for November, but cumulatively we remain 8% below plan year to date. Together with the contribution from validations, the variance for total removals has reduced to 2.9% below plan year to date. The clearance time for the RTT waiting list (how long it would take to clear if no further patients were added) reduced to 20 weeks.
The 92nd percentile total waiting time reduced to 49 weeks.

The volume of patients waiting over 52 weeks reduced for the third consecutive month by 8.7% to 3,959. The last reported National figures show a continued growth of 2.4% growth. 1378 patients in total were treated who had waited over a year which was 10.6% of treatments. The specialties with the highest volumes over 52 weeks are ENT, OMFS (both with over 500), then Cardiology, Orthopaedics and Ophthalmology (each over 300). All of these bar Orthopaedics did have reduction in month.

The volume of patients waiting over 78 weeks reduced by 11 at the end of November to 351. 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 now 859 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. Mutual Aid support via the Regional and National process has been approved for Thyroid surgery within ENT and enhanced Independent Sector capacity will commence in Quarter 4. Slippage in the Insourcing capacity for OMFS has led the service to be off trajectory but it is expected this can be recovered in the new year.

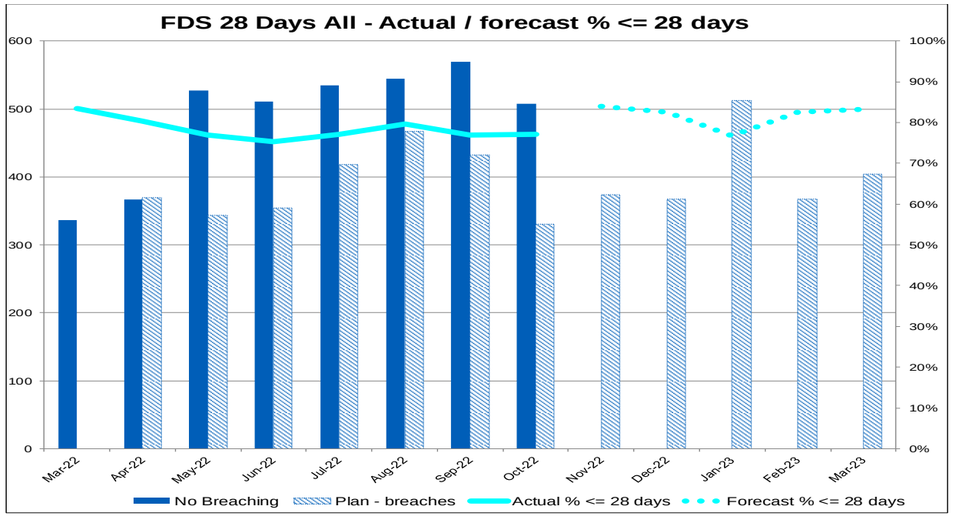
We reported two patient choice breaches over 104 weeks in November in ENT. We currently expect two 104 breaches in December one patient choice and one unfit due to COVID.

Nationally the RTT waiting list continues to rise, reaching 7.21 million in October 2022 with 5.5% of patients waiting over 52 weeks. CUH had 7.2% over 52 weeks and dropped to 4th highest of the 14 Acute Trusts in EoE. At 13.2% over 52 weeks, Norfolk and Norwich remains the greatest challenge in the Region followed by Mid and South Essex at 7.9%. We remain third highest amongst the Shelford Group with Birmingham the most challenged with 18.8% over 52 weeks.

# Cancer

National Targets

| Cancer Standards 22/23 | Target | Qtr 3 - 21/22 | Qtr 4 - 21/22 | Qtr 1 - 22/23 | Qtr 2 - 22/23 | Oct-22 |
|---|---|---|---|---|---|---|
| 2Wk Wait (93%) | 93% | 81.8% | 78.9% | 83.3% | 75.2% | 72.7% |
| 2wk Wait SBR (93%) | 93% | 43.9% | 35.5% | 55.1% | 32.1% | 17.7% |
| | | | | | | |
| 31 Day FDT (96%) | 96% | 91.0% | 94.3% | 91.0% | 89.9% | 92.6% |
| 31 Day Subs (Anti Cancer) (98%) | 98% | 100.0% | 100.0% | 100.0% | 99.7% | 100.0% |
| 31 Day Subs (Radiotherapy) (94%) | 94% | 98.3% | 93.7% | 85.1% | 88.2% | 86.1% |
| 31 Day Subs (Surgery) (94%) | 94% | 83.0% | 89.0% | 82.9% | 69.7% | 81.0% |
| **31 Day - Combined** | **96%** | | **94.2%** | **89.3%** | **88.7%** | **90.4%** |
| FDS 2WW (75%) | 75% | 85.3% | 81.3% | 78.0% | 78.9% | 79.2% |
| FDS Breast (75%) | 75% | 98.0% | 94.6% | 96.6% | 92.4% | 88.5% |
| FDS Screen (75%) | 75% | 65.7% | 64.5% | 64.6% | 63.4% | 54.0% |
| **FDS - Combined** | **75%** | | **80.6%** | **77.4%** | **78.0%** | **77.2%** |
| 62 Day from Urgent Referral with reallocations (85%) | 85% | **73.2%** | **73.0%** | **73.2%** | **69.6%** | **66.1%** |
| 62 Day from Screening Referral with reallocations (90%) | 90% | **68.9%** | **61.4%** | **53.8%** | **56.2%** | **62.9%** |
| 62 Day from Consultant Upgrade with reallocations (50% - CCG) | 50% | 51.2% | 74.2% | 62.9% | 75.0% | 54.5% |
| **62 Day Reallocations - Combined** | 85% | | **67.7%** | **70.7%** | **68.0%** | **65.4%** |




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

The volume of 2ww patients seen in October 2022 was 2.8% higher than in October 2019. 2ww breaches reduced by 27 to 590 in October leading to a marginal increase in performance at 72.7%. 75.9% were capacity related. Breast remain the site with the majority of breaches with 49% , followed by Skin at 36%. The breaches that were due to capacity reflected an ongoing average wait of 23 days for Breast and 32 days for Skin during October. The National 2WW performance was higher at 77.7%. For symptomatic breast referrals our performance improved but remained well below National at 17.7% compared to 75.7%, with the service clinically prioritising the suspected cancer referrals.

Our combined performance on the Faster Diagnosis standard within 28 days remained ahead of target at 77.2%. National average was 68.5% for FDS.

The 62 day Urgent standard performance declined further in October to 66.1%. This remained ahead of performance Nationally of 60.29%. There were 50.5 accountable breaches of which 40 were CUH only pathways. Of the total breaches 27.5 of these delays were provider initiated delays, within which 6 were in the diagnostic phase . 19.5 were due to late referrals of which 8 were treated within 24 days of transfer. Complex pathways requiring multiple diagnostic tests reduced this month with 6.5 breaches. Breaches spanned 11 cancer sites, with the highest volumes by site being Lower GI with 15, then Urology with 13.5, skin with 10.5, and breast and Gynaecology both with 5.5. The 62 day screening standard incurred 12 breaches this month, between Breast and Lower GI. Performance was 62.9% compared to higher National performance at 67%. Delays were split equally at 33% for provider delays, patient choice or medical/complex pathways . 83% of the screening breaches were in Lower GI.

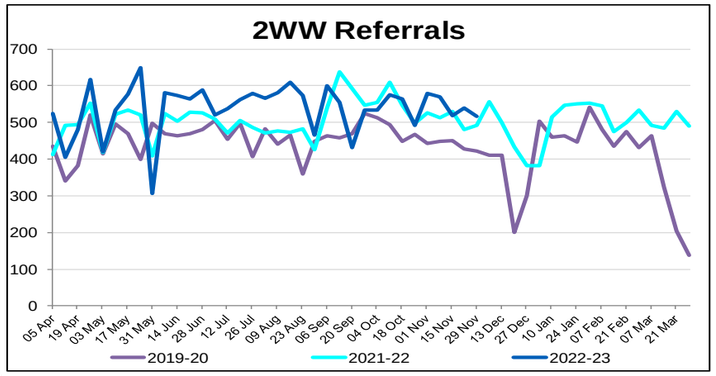
The 31 day FDT standard improved in October to 92.6%, and was above National at 91.9%. The subsequent surgery standard also improved to 81% against National of 80.8%. Elective capacity accounted for 85% of those exceeding 31 days, Breast and Skin specifically accounted for 26.4% of the breaches each. The subsequent radiotherapy performance improved, but remained below standard in October at 86.1% due to capacity. Performance is forecast to improve further from November.

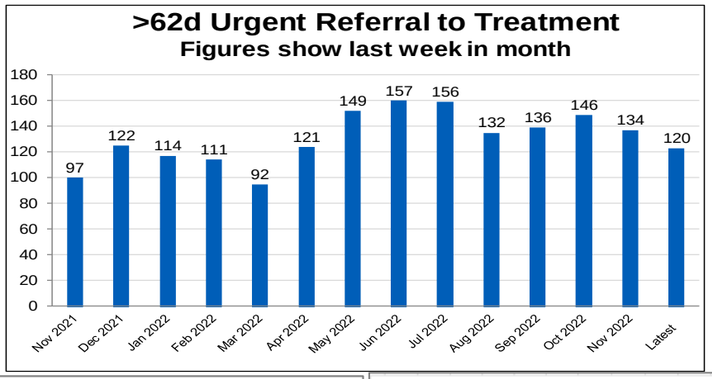
29 pathways waited >104 days for treatment in October. 22 were shared pathways with the highest volume from a single Trust being NWAFT with 13. Seven CUH pathways exceeded 104 days across LGI, Skin and Urology. Capacity delays and Complex diagnostic delays were the reasons. The RCAs have been reviewed by the MDT Lead Clinicians and the Cancer Lead Clinician for the Trust and to date all pathways were classed as 'no harm' or 'low harm'.

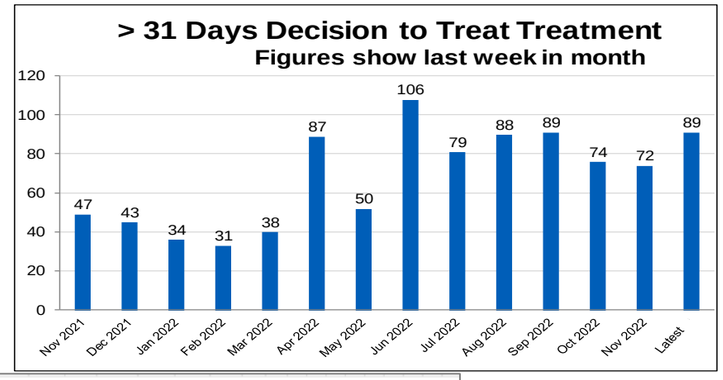
# Cancer

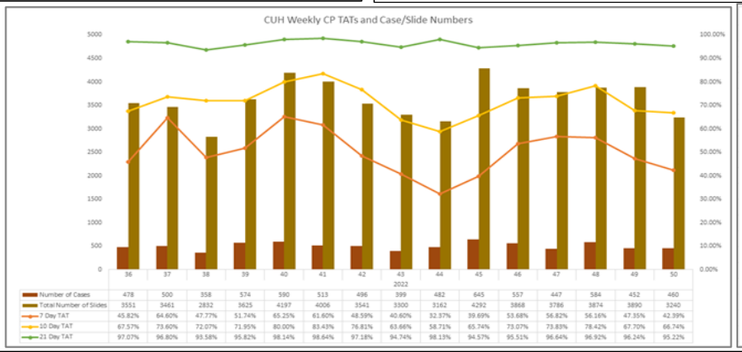
Cambridge University Hospitals NHS Foundation Trust

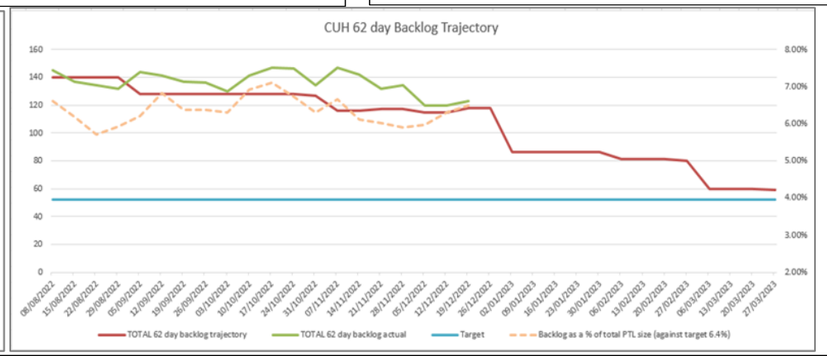
National Targets




**Current position**

Over the past four weeks 2WW suspected cancer referral demand reduced and was in line with the same baseline period in 2019. 2ww breaches rose further in November in Breast, but from December there is improvement in both Breast and Skin with both sites having >100 less patients waiting over 14 days. Breast additional capacity has not resulted in a return to 2ww compliance by the end of the year as forecast due to unexpected sickness in the team. Recovery will be achieved by the end of January 23.. The RCN strikes in December will have impacted 2ww capacity as these services were not derogated in the RCN definitions.

We are monitoring the number of patients waiting longer than 62 days from referral to treatment against our recovery trajectory submitted to the Cancer Alliance. The backlog > 62 days has decreased to 123, just 5 behind trajectory. Representing 6.4% of the total cancer waiting list over 62 days, this is still the best performing in the EoE Region. The highest variances from plan are in HPB, Skin and Urology. The majority of patients on a HPB and Urology pathway are late referrals from other providers; we are closely monitoring the actions for all sites through the Operational Taskforce and Divisional Executive meetings. 61% of backlog are CUH only pathways, of which Skin are 23% and Urology has increased to 22%. Of the Inter Trust backlog, 53% is Urology.
We saw an improvement in histology turn around times within 7 days in month however the latest report shows a reduction again, performance remained above the 50% needed to support the trajectory with the exception of the last week when it dropped to 42%.

The number of patients waiting over 31 days for treatment has increased to 118 from 96 last month. 76% are booked for treatment. Skin account for 47% of the delays across both Dermatology and Plastics. Urology account for 22% with 62% of the delays in kidney surgery, all due to surgical capacity. Breast have maintained their backlog at 11% of the delays which are due to surgical capacity. Medical workforce gaps in Urology are impacting on the service with the position not having improved from last month. HPB continue with delays to surgery and RFA treatment, a business case is in progress for additional resource.

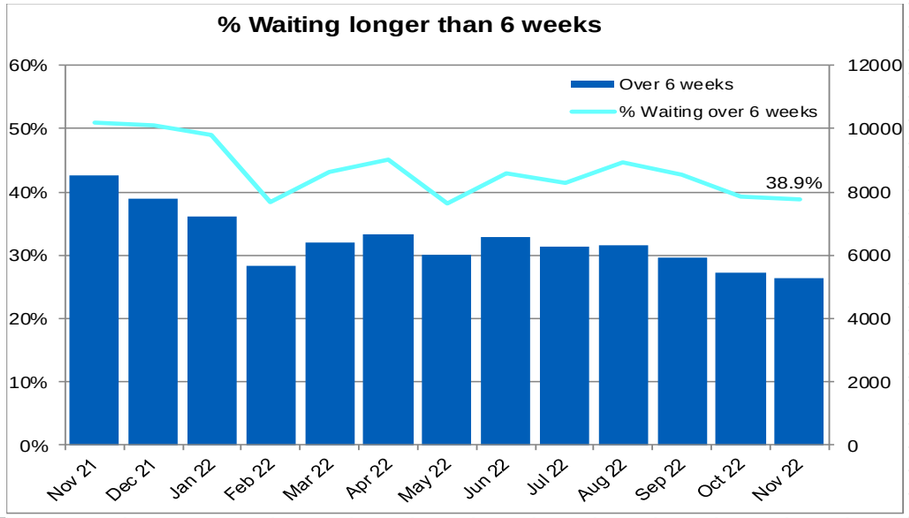
Chemotherapy and Radiotherapy treatments were derogated during the RCN strikes. 35 cancer pathway surgical cases were cancelled which will impact on performance. A prioritised group of P2 cancer surgical cases were derogated on the second day of Industrial action.

# Diagnostics

Cambridge University Hospitals NHS Foundation Trust

Operational Performance

| Change from previous month: | | Nov-22 | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Waiting List | | | | Scheduled Activity | | Total Activity | |
| Deteriorated / Improved | | Total Waiting List | Variance from Feb 2020 | | %> 6 weeks | Scheduled Activity | Variance from Nov-19 Baseline | Total Activity | Variance from Nov-19 Baseline |
| Imaging | Magnetic Resonance Imaging | 2867 | 1962 | 46% | 44.9% | 2939 | 116.2% | 3369 | 115.5% |
| | Computed Tomography | 1819 | 1038 | 75% | 39.7% | 3135 | 112.9% | 6233 | 112.0% |
| | Non-obstetric ultrasound | 3412 | 1876 | 82% | 46.4% | 3756 | 103.2% | 4484 | 99.2% |
| | Barium Enema | 36 | 31 | 16% | 13.9% | 30 | 106.1% | 38 | 134.3% |
| | DEXA Scan | 485 | 648 | -25% | 9.5% | 694 | 133.0% | 694 | 130.1% |
| Physiological Measurement | Audiology | 739 | 338 | 119% | 43.8% | 410 | 88.1% | 410 | 88.1% |
| | Echocardiography | 2177 | 967 | 125% | 48.8% | 1449 | 114.8% | 1841 | 116.7% |
| | Neurophysiology | 132 | 269 | -51% | 2.3% | 267 | 84.4% | 284 | 87.2% |
| | Respiratory physiology | 53 | 24 | 121% | 77.4% | 30 | 136.4% | 32 | 138.8% |
| | Urodynamics | 278 | 93 | 199% | 57.2% | 73 | 124.4% | 73 | 124.4% |
| Endoscopy | Colonoscopy | 580 | 539 | 8% | 0.2% | 421 | 86.6% | 435 | 88.3% |
| | Flexi sigmoidoscopy | 145 | 106 | 37% | 10.3% | 55 | 59.7% | 78 | 65.3% |
| | Cystoscopy | 169 | 236 | -28% | 7.1% | 365 | 93.9% | 371 | 92.5% |
| | Gastroscopy | 678 | 581 | 17% | 2.7% | 525 | 83.5% | 579 | 79.0% |
| **Total Diagnostic Waiting List** | | **13570** | **8708** | **56%** | **38.9%** | **14149** | **107.1%** | **18921** | **106.5%** |




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

Total diagnostic activity in November delivered to 106.5% of November 2019 baseline. Scheduled activity only, which addresses our waiting list, delivered 107% this month. The total waiting list size reduced by 257 to 13,570, and the volume of patients waiting over 6 weeks decreased by 155 this month so the > 6 weeks performance improved to 38.9%. The Mean waiting time was stable at 7 weeks. Nationally published data for October 2022 shows National performance of 27.5%. From a Regional perspective of the 14 Acute Trusts in EoE, CUH were ranked 11/14 with Kings Lynn, E&N Herts and now NWAFT having a slower recovery rate.

**Imaging** activity overall achieved above baseline levels for total activity and scheduled activity at 109% and 111% respectively. The waiting list reduced by 687.

- **CT** reduced their long waits over 6 weeks by 86 in month leading to a 3.1% improvement in performance. The total waiting list, whilst still improving remains ~781 above baseline. CUH will had access to the CT mobile based at NWAFT for 3 weeks in December however two thirds of patients declined to travel for their scan. This will be a challenge to address for Community Diagnostic Centre locations. The total waiting list is forecast to recover to baseline by year end, but the proportion over 6 weeks will actually start to worsen again as we are left with Cardiac CT over 6 weeks. The System is looking to get a specialist cardiac CT to support this backlog clearance. CUH CT is ranked 13/14 for recovery of 6ww performance in the Region with only East & North Herts further behind.
- **MRI** total waiting list continued to reduce in month, but the volume over 6 weeks increased leading to a deterioration to 44.9%. The service is still ~900 above baseline and are not forecasting recovery by year end. Underachievement of activity in the mobile scanner based at NWAFT continues, and unplanned downtime of the other mobile unit at CUH has led to cancelled and rescheduled activity. Additional capacity will still be required to mitigate the next MRI replacement in Feb 2023. CUH MRI % recovery remains 12/14 in the Region after E&N Herts and Kings Lynn.
- **Dexa** have recovered their total waiting list to baseline levels, and reduced the > 6 weeks waits from 75 to 46 in month leading to performance of 9.5%.
- **Ultrasound** total waiting list saw a big reduction of 430 in month, but the >6 week waits increased by 88 which meant performance deteriorated to 46..4%. Activity in month was higher than previous month and above baseline for scheduled activity. High sickness and vacancies within the department for admin and sonographers mean that the waiting list has plateaued again into December. Ultrasound recovery is particularly challenging in our ICS with NWAFT being the slowest to recover in the Region, and CUH 11/14.

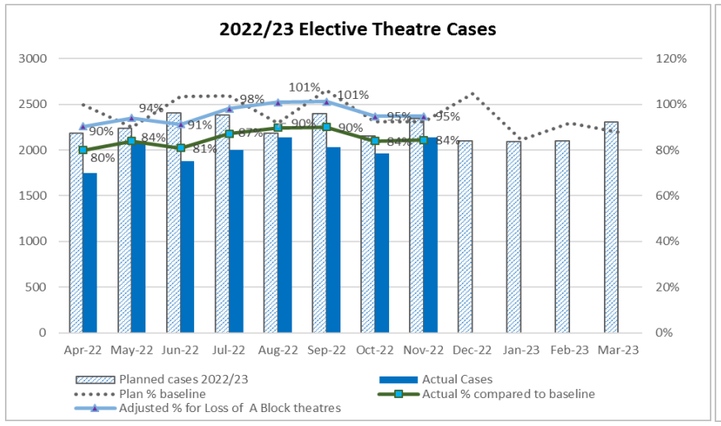
**Physiological measurement** saw a waiting list increase of 273 in November within which Echocardiography increased by 173 and Audiology 115. Activity across the group was 108% of baseline. Following the slippage in activity in Echocardiography due to equipment faults in August and September, funding has been agreed for additional actions in Echocardiography to achieve recovery in April 2023. These actions for further outsourcing and extending current insourcing arrangements still need to be finalised and operationalised. We are now ranked 10/14 for Echo recovery across the EoE with three Trusts still having over 60% of patient waiting over 6 weeks.

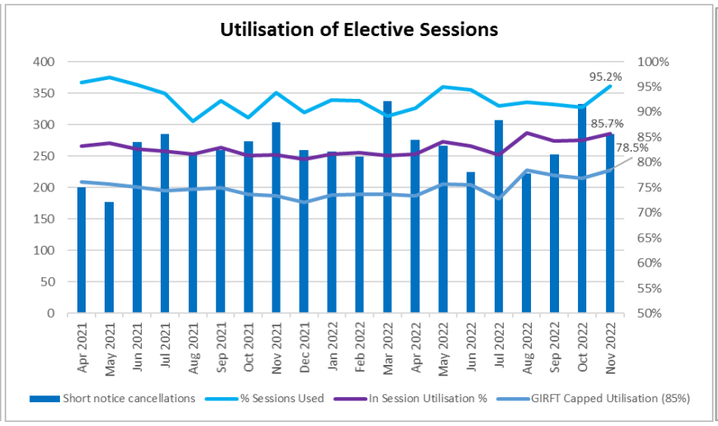
**Endoscopy** modalities had 25 more patients over 6 weeks in month so collective performance did drop to 2.9% in month but is still one of the best performing in Region.

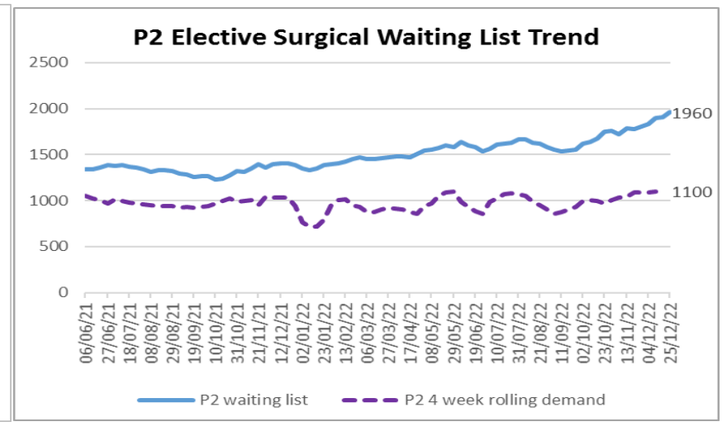
# Operations

Cambridge University Hospitals NHS Foundation Trust

Operational Performance




Compared to 2019 baseline, Elective theatre activity in November was at 84% for a second consecutive month. Taking account of the loss of the A Block theatres from our capacity, this would bring the performance up to 95 %. Our plan for November 2022 was to deliver 93% of baseline so we fell short by 207 operations.

- Productivity in November improved with 95.2% of sessions used, achieving our aim of 95%.
- In-session utilisation improved to 85.7% against our internal aim of 90%. Against the GIRFT Capped Utilisation metric our performance improved to 78.5% in November against the required 85%, and demonstrates an improving trend in year.
- Short notice cancellations in elective sessions in November were 285 cases. This equated to 489 hours of theatre time. 35% of cancellations were for clinical reasons. 12% were due to patient cancellations, and 11% due to both bed capacity and higher priority cases.
- Ely in-session utilisation improved to 81.8% but remained very low on the GIRFT Capped Utilisation measure at 61%.
- On the background of very low performance in October, the Cambridge Eye Unit did show an improvement in session uptake to over 95% and in-session utilisation to 80.5% . Capped utilisation was up to 67%.
- With both Ely and the CEU uninterrupted by winter bed pressures these remain the areas where further utilisation gains are the focus of improvement. Surgery Programme Board has reassigned a number of sessions at Ely from January given the underutilisation of some specialities.
- The weekend elective activity shows eighteen cases undertaken by ENT, Urology and Breast in November.

The number of P2 patients awaiting surgery has increased by a further 10% from last month to 1,960. The highest increase has been in Plastic Surgery which represented 24% of the increase. The four week rolling P2 demand has now been consistently above 1000 for the past 7 weeks, peaking at 1100 in the most recent week. The volume waiting over 4 weeks has increased by 216 over the past month to 1161. The Surgical Prioritisation Group continues to allocate theatre capacity based on the P2 demand as the dominant principle, but specialties then need to align their medical workforce to also match that as a priority which is dependent on flexibility with job plans.

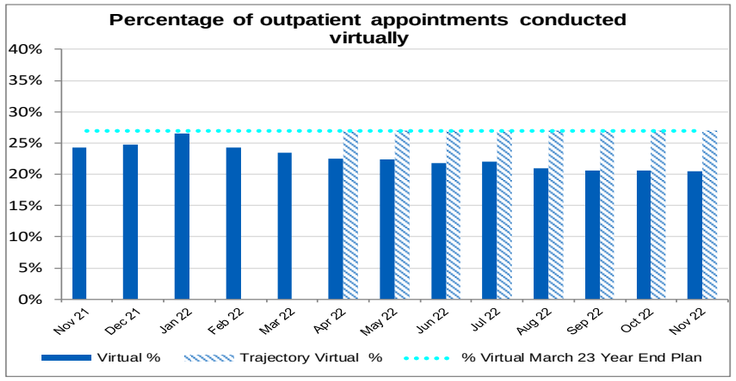
A further National GIRFT team visit to our ICS was undertaken on 1st December with Professor Tim Briggs, National Clinical Director for Elective Recovery in attendance.

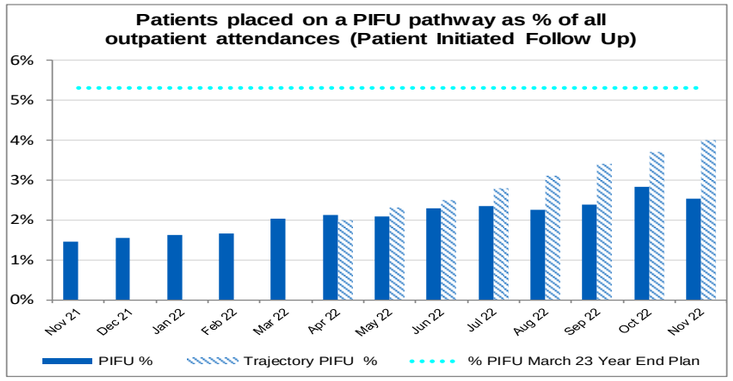
- GIRFT noted significant progress since the last visit on 29th June and reflected it as a very positive meeting.
- The strong clinically led and data driven Governance structure for HVLC Theatre Efficiency was remarked upon. James Wheeler as Chair of Surgery Programme Board led the visit for CUH.
- Increasing rates of day case surgery is another key objective of the HVLC programme, and this is an area where the system was noticed to have already delivered demonstrable improvements.
- Professor Briggs was pleased the CUH team had visited the South West Ambulatory Orthopaedic Centre in Exeter and also Northumbria to see how they run their HVLC surgical hubs. He noted the positive effect it had on the multi-disciplinary team. Professor McCaskie had presented that the average length of stay for hip and knee replacement has started to reduce at CUH following the adoption of some of the learning, and GIRFT were keen to see this reflected in future Model Hospital metrics.
- The recommendations focused on further system level working that should be pursued; to harmonise pathways further by sharing learning; to re-evaluate the utilisation of the Hinchingbrooke theatres at system level; to look at joint system appointments with the CUH surgical hub development; and to have further system level discussion to address unwarranted variation.

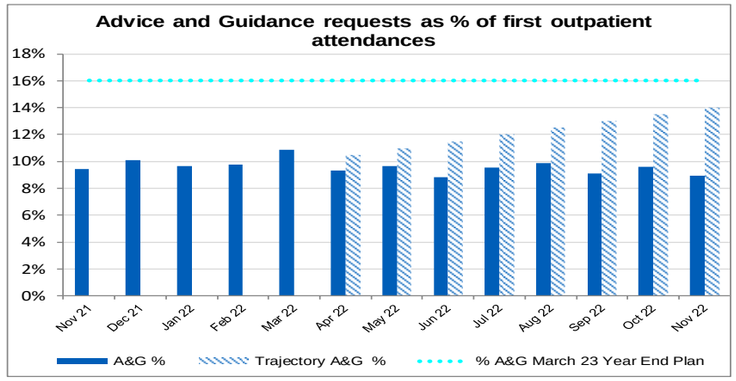
# Outpatients

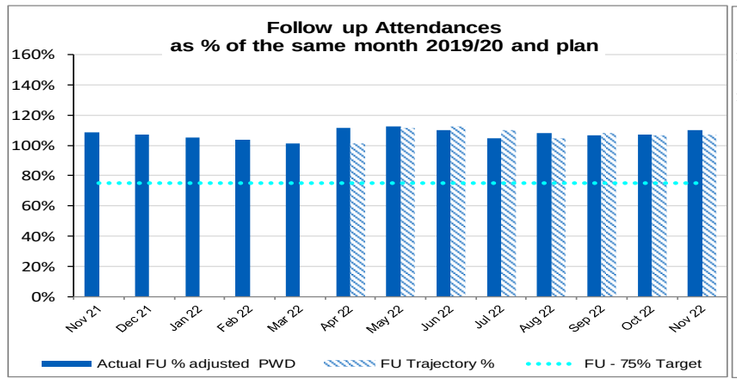
Cambridge University Hospitals NHS Foundation Trust

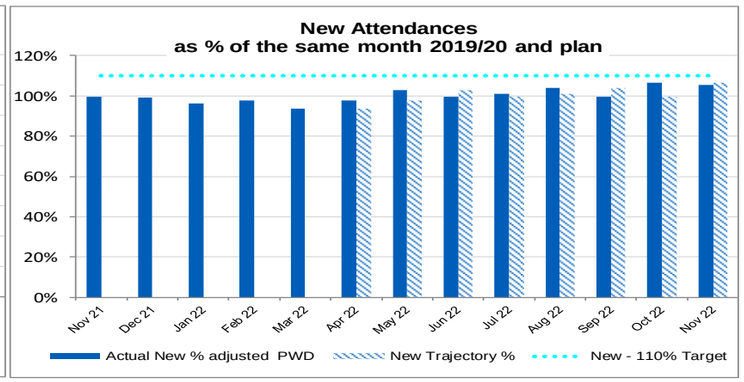
Operational Performance




In November outpatients delivered 105.5% new activity against baseline which has been adjusted for working days per month. This is a slight decrease from October of 1.1%, and it is essential we continue to perform above 100% to reduce backlogs. Follow-up numbers performed above baseline at 110.2% on an upward trend from previous months, this figure is also adjusted for working days per month. Divisions are testing a combination of pathway redesign, waiting list initiatives and clinic template changes to further increase new activity. GIRFT Outpatients guidance for 12 specialties, published November 2022, further supports specialties to test change ideas including waiting list initiatives, specialist advice, virtual appointments, DNAs and PIFU. An NHSE data opportunity tool enables specialties to benchmark with and learn from other Trusts e.g. on new: follow up ratio, virtual, PIFU, DNA and other metrics.

Early tests of 'patient not present' reviews demonstrate potential. A new SOP will be available in December 2022 to support specialties to test this change idea. Patient pathways are being redesigned to reduce follow ups e.g. in Gastroenterology, Nephrology and Gynaecology.

PIFU numbers have decreased slightly to 2.5% and are still below trajectory. Several specialties are focusing on increasing PIFUs as part of pathway redesign. In November divisions tested whether patients waiting for an overdue follow up were suitable for PIFU and in several cases a PIFU was placed – this activity should continue and expand. Specialties are also considering whether DNA patients can be moved onto a PIFU e.g. Gynaecology.

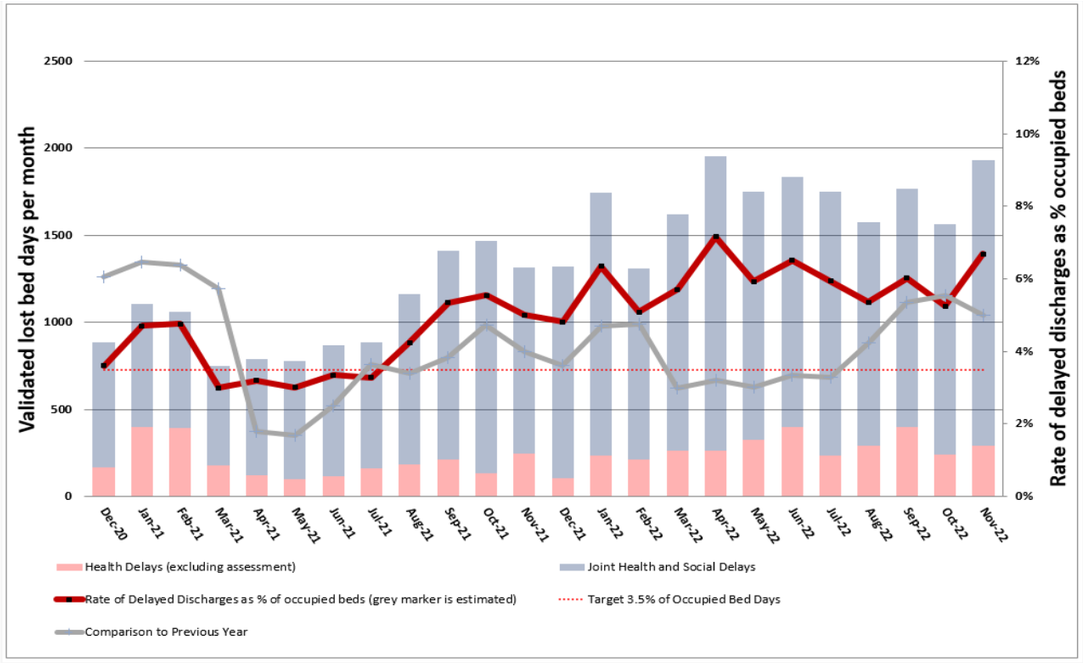
The Trust is not achieving the 16% target for Advice and Guidance, in November achieving only 8.9%. Currently in our external reporting for outpatient attendances Diagnostic Imaging activity is included. As this is recorded as new activity it adversely affects the reported A&G% performance pushing our numbers down. When removed our number is much closer to 16%. We are continuing to work with the ICS and national teams on how to resolve this issue in a consistent way.

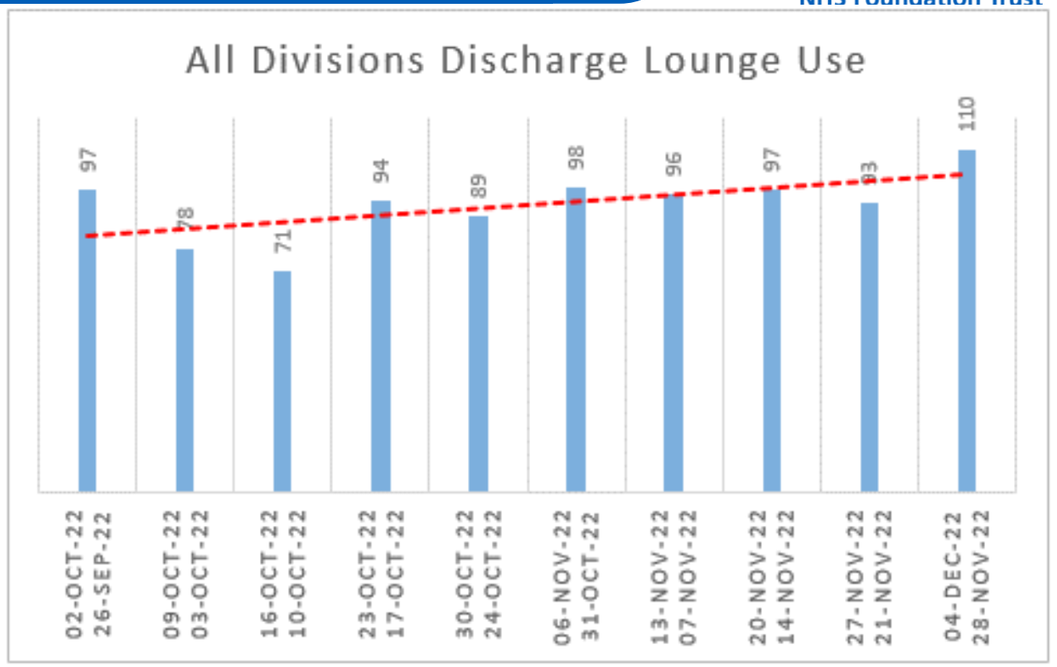
Virtual consultations continue to perform poorly against the target of 25%, currently running at 20%. We still performed over 19,000 virtual consultations in November but this is down from over 22,000 in the previous

# Delayed Discharges

Cambridge University Hospitals NHS Foundation Trust

Operational Performance



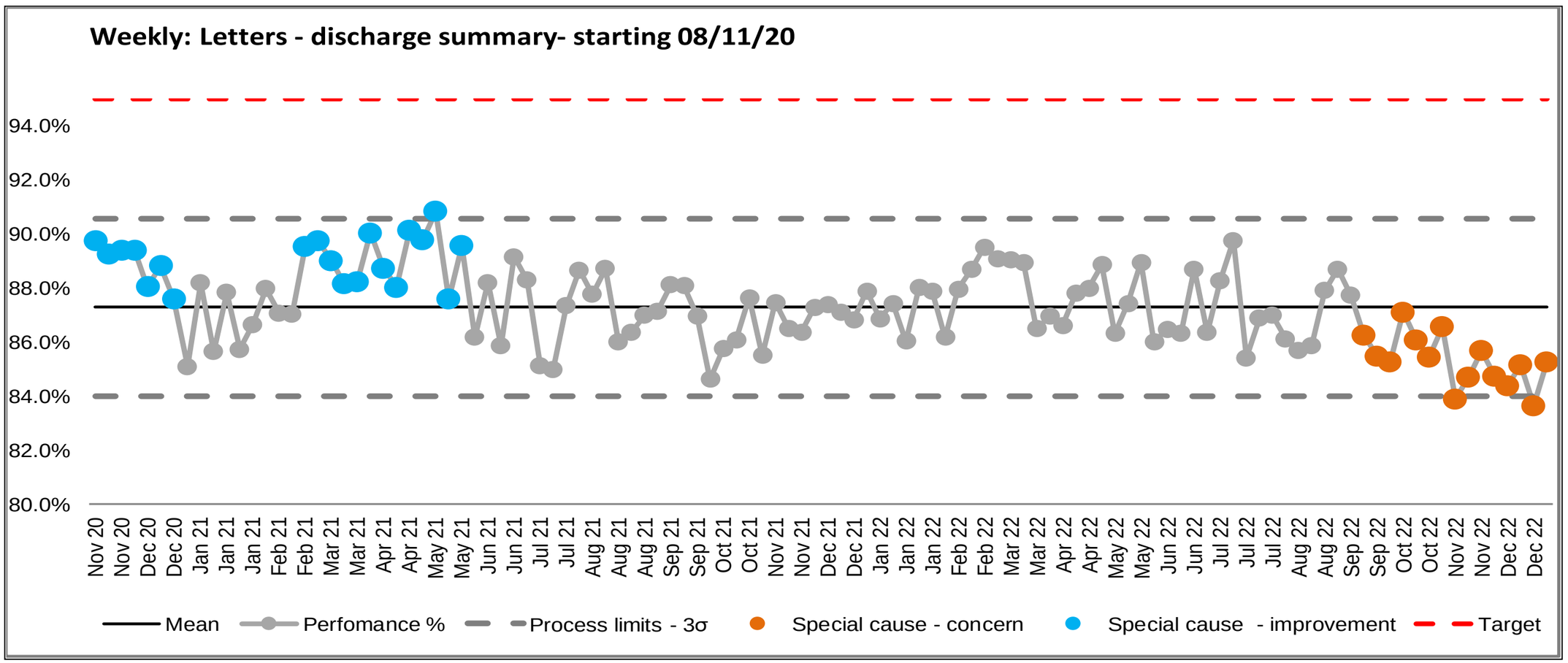

The Hospital Discharge Service Requirements guidance was last updated on September 2022. For this November data, you will see above 2 graphs.
The graph on the left looks at the overall lost bed days for the month, spanning back over the previous 12 months (similar to the previous integrated performance reports). The graph on the right looks at the average discharge lounge use for all divisions on a weekly basis.
For November 2022, we are reporting 6.7%, which is a sharp increase of 1.2% from the previous reporting month (an increase of 366 lost bed days).
Within the 6.7%, 67% were attributable to Cambridgeshire and Peterborough ICB, and the remainder across a further 8 ICB's. *Please note that we have referred to delays per CCG instead of Local Authority.*
In relation to lost bed days for Cambridgeshire and Peterborough overall for November (1306) this has been an increase in overall lost bed days from October (936) which equates to a 39% increase in the last month.
For out of county patients, we continue to see a sustained elevated number of ICBs that our patients are from and waiting care provision with the overall lost bed days associated for out of area ICBs at 629. There has not been any significant changes over the last month
For the total delays (local and 'out of area') within November for Care Homes were 50% equating to 967 lost bed days for this counting period (a 31% increase from October); domiciliary care (inclusive of Pathway 1 and Pathway 3) at 26% of the total lost bed days for the month, at 507, stable from the previous month (495 in October).
For community bedded intermediate care (inclusive of waits for national specialist rehabilitation units), the overall lost bed days is currently at 262, of which 58% are out of county. Locally, this number is largely reflective of the specialist rehabilitation unit delays with minimal lost bed days associated with community hospital rehabilitation

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

# Discharge Summaries

Cambridge University Hospitals NHS Foundation Trust

Operational Performance




**Discharge summaries**

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

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

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



Author(s): James Boyd

Owner(s): Ashley Shaw

# Patient Experience - Friends & Family Test (FFT)

Cambridge University Hospitals NHS Foundation Trust

Patient Experience

The good experience and poor experience indicators omit neutral responses.

| Indicator | Data range | Period | Target | Current period | Mean | Variance | Special causes | Target status | Comments |
|---|---|---|---|---|---|---|---|---|---|
| FFT Inpatient good experience score | Jul 20 - Nov 22 | Month | - | 96.0% | 95.8% | | - | - | For November there was a 1% increase in the Good score compared to October, and no change in the Poor score. The number of November FFT responses improved slightly, compared to October responses of 289, which was the lowest number of FFT collected for the year. Pre pandemic # of FFT responses is 850-950. **FOR NOV: there were 318 FFT responses collected from approx. 3,882 patients.** |
| FFT Inpatient poor experience score | Jul 20 - Nov 22 | Month | - | 2.0% | 1.5% | | - | - | |
| FFT Outpatients good experience score | Apr 20 - Nov 22 | Month | - | 93.4% | 95.1% | L | SP | - | For November, both the Good score and Poor score remained the same compared to October, and September. The Poor score is still 3.3% and is the highest score since last year. There were 7 FFT responses collected from paediatric clinics so the FFT scores mainly reflect adult clinics. **FOR NOV: there were 4,936 FFT responses collected from approx. 28,370 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 Outpatients poor experience score | Apr 20 - Nov 22 | Month | - | 3.3% | 2.3% | H | SP | - | |
| FFT Day Case good experience score | Apr 20 - Nov 22 | Month | - | 94.2% | 96.5% | L | SP | - | For November, the Good score decreased by 0.5% compared to October, and the Poor score increased by 0.5%. F**OR NOV: there were 972 FFT responses collected from approx. 3,952 patients.** |
| FFT Day Case poor experience score | Apr 20 - Nov 22 | Month | - | 2.6% | 1.7% | | - | - | |
| FFT Emergency Department good experience score | Apr 20 - Nov 22 | Month | - | 76.0% | 84.4% | L | SP | - | For November the Good score increased by 5.5% compared to October. The Poor score decreased by 4% compared to October. It is mainly Adult FFT scores that improved and impacted the overall data. Adult FFT compared to Oct; 7% increase in Good score / 6% decrease in Poor score. Paeds FFT compared to Oct; 1.7% increase in Good score / 2.5% increase in Poor score. **FOR NOV: there were 820 FFT responses collected from approx. 5,168 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 - Nov 22 | Month | - | 15.2% | 9.6% | H | SP | - | |
| FFT Maternity (all FFT data from 4 touchpoints) good experience score | Jul 20 - Nov 22 | Month | - | 93.5% | 94.8% | | - | - | **FOR NOV:** Antenatal had 8 FFT responses; 87.5% Good score / 0% Poor. Birth had 85 FFT responses out of 455 patients; 94.1% Good score / 1.2% Poor score (1% decreased Good score / 3% improved Poor score compared to Oct). Postnatal had 91 FFT responses: LM had 47 FFT with 95.7% Good / 0% Poor, DU had 3 FFT with 100% Good / BU had 30 FFT with 90% Good / 3.3% Poor, and COU 100% Good from 10 responses. 0 FFT responses from Post Community. **NOV MATERNITY OVERALL:** Good score improved by 3% compared to Oct, and the Poor score decreased by 3%. There were 184 FFT responses collected. |
| FFT Maternity (all FFT data from 4 touchpoints) poor experience score | Jul 20 - Nov 22 | Month | - | 1.6% | 1.8% | | - | - | |

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 November 18 wards did not collect any FFT data.

Overall FFT in November, the Good and Poor scores remained about the same for inpatient, outpatient and day case, although the inpatient Good score did increase slight by 1%, from 95.2% in October to 96%. Overall ED Good score improved by 5.5% and the Poor score also improved by 4%. The Adult ED scores impacted both Good and Poor overall scores: Good score 76% from 70.6% in October and Poor score 15.2% from 19.5% in October. The Paeds ED Good score improved by 1% to 83.8%, however the Poor score increased by 3% to 10.1% from 7.4% in October. For Maternity, antenatal and postnatal Good scores improved compared to October, and this impacted the overall maternity Good score with a 3% increase in the score. Birth and Postnatal Poor scores also improved in November and this is reflected in the overall maternity score of 1.6% compared to 4.3% in October.

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.



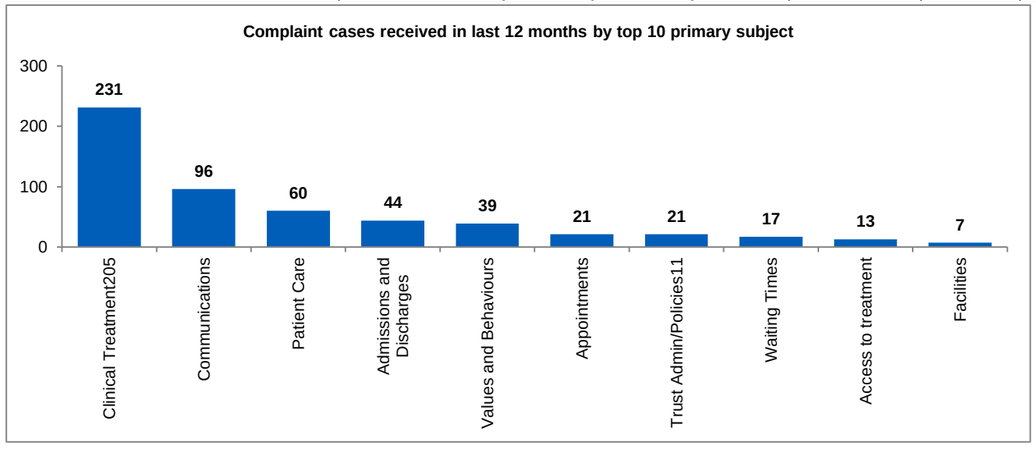
Author(s): Charlotte Smith/Kate Homan Owner(s): Oyejumoke Okubadejo

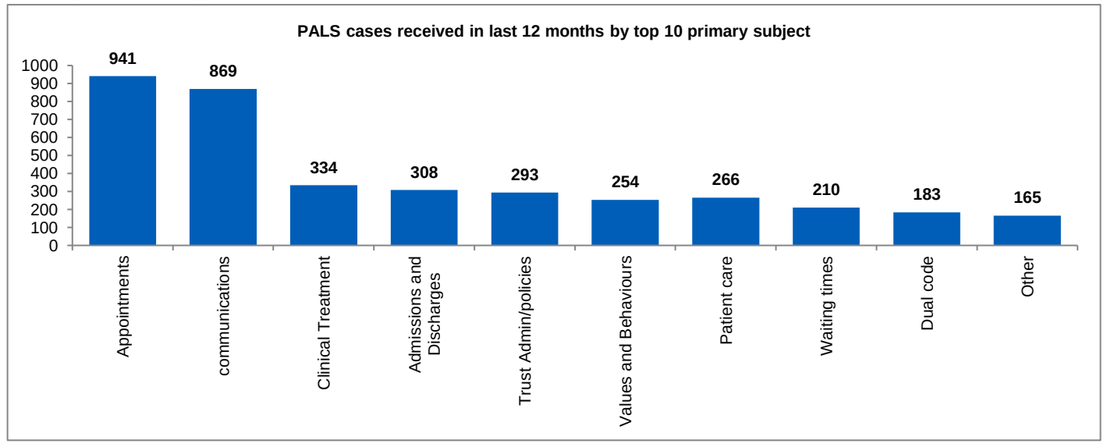
# PALS and Complaints Cases

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 | Nov 19 -Nov 22 | month | - | 80 | 53 | H | SP | - | The number of complaints received between Nov 2019 - Nov 2022 is higher than normal variance. |
| % acknowledged within 3 days | Nov 19 - Nov 22 | month | 95% | 71% | 93% | L | SP | ? | 57 out of 80 complaints received in November were acknowledged within 3 working days. |
| % responded to within initial set timeframe (30, 45 or 60 working days) | Nov 19 - Nov 22 | month | 50% | 18% | 31% | | - | ? | 34 Complaints were responded to in November, 6 of the 34 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 | Nov 19 - Nov 22 | month | 80% | 68% | 90% | | - | ? | 23 out of 34 complaints responded to in November were within the initial set time frame or within an agreed extension date. |
| % complaints received graded 4 to 5 | Nov 19 - Nov 22 | month | - | 29% | 35% | | - | - | There were 23 complaints graded 4 severity, and 0 graded 5. These cover a number of specialties and will be subject to detailed investigations. |
| Compliments received | Nov 19 - Nov 22 | month | - | | 34 | | - | - | Compliment numbers have not been added due to administrative staff shortages |




**PHSO** - One complaint was accepted by the PHSO for investigation in November 2022, this was a Division C case, relating to a patient's discharge.. **Completed actions** Due to current workload actions have not been reported this month.



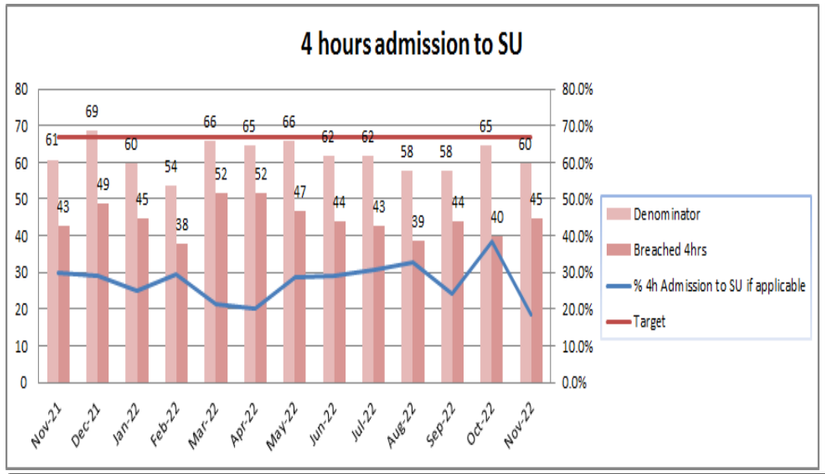
Author(s): Sue Bennison

Owner(s): Oyejumoke Okubadejo

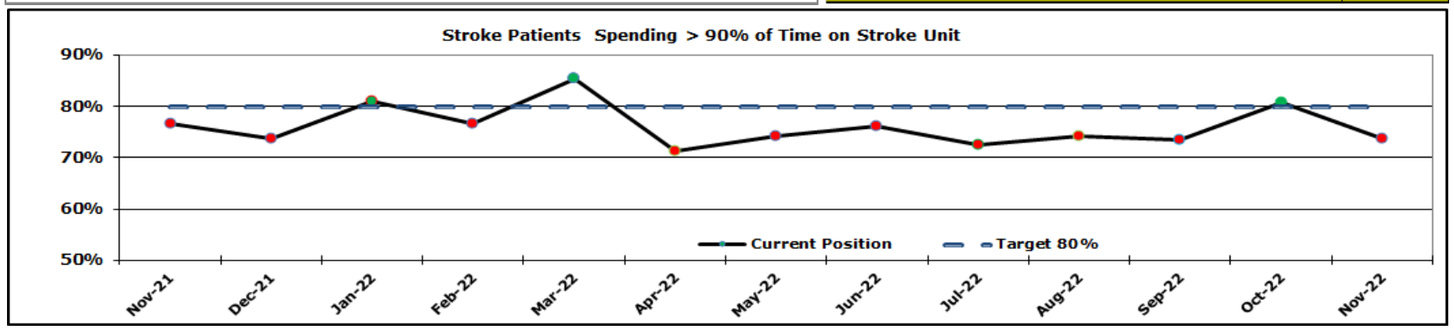
# Stroke Care

NHS Cambridge University Hospitals NHS Foundation Trust

Stroke Measures




| Theme | Pt |
|---|---|
| Trust Bed Capacity | 34 |
| Awaitin senior medical review | 5 |
| Delayed referral | 4 |
| Unclear presentation - initially not thought to be a stroke | 2 |
| Not referred on arrival | 2 |
| Stroke Nurse busy with another thrombolysis call | 1 |
| Palliative. Appropriately placed | 1 |
| Total | 49 |




Breach reasons for not achieving 90% IP stay on Stroke ward 2022/23 and Monthly Stroke position

| Month | Stroke Bed Capacity * No outliers * | Trust Bed Capacity * Outliers * | Suspected COVID-19 patient | COVID-19 - Stroke ward closed | Operational decision - patient moved off the unit to accommodate an acute stroke | Delay in medical review in ED | Delay in referral to Stroke Team | Clinical - Appropriate pathway for patient | Difficult presentation | Not referred to stroke team | Delayed diagnosis | Clinician's decision to place patient on different ward | Unclear presentation | Difficult diagnosis / Complex patient | Failure to request stroke bed | Resource capacity | Number of breaches | Month Position (Target 80%) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Nov-21 | | 5 | 1 | | | | | 1 | | 1 | 2 | | 3 | 1 | | 1 | 15 | 76.6% |
| Dec-21 | | 11 | | | | | | 4 | | 2 | | | 1 | | | 2 | 20 | 73.7% |
| Jan-22 | | 2 | | | | | | 1 | | 3 | 1 | | 1 | | | 4 | 12 | 81.0% |
| Feb-22 | | 7 | 1 | | | 1 | | 1 | | 1 | | | 2 | 1 | | | 14 | 76.7% |
| Mar-22 | | 6 | 1 | | | 1 | | | | | | | 2 | | | | 10 | 85.3% |
| Apr-22 | | 8 | | | | 2 | | 3 | | | | | 4 | | | 2 | 19 | 71.2% |
| May-22 | 3 | 1 | | | | 4 | | | | 1 | | | 4 | 3 | | 2 | 18 | 73.1% |
| Jun-22 | 3 | 1 | | | | 1 | | 1 | | | | | 7 | | | 1 | 14 | 75.0% |
| Jul-22 | 6 | 5 | | | | 1 | | 2 | | | | | 1 | 1 | | 3 | 19 | 72.5% |
| Aug-22 | 2 | 10 | | | | | | 2 | | | | | 1 | | | 1 | 16 | 68.0% |
| Sep-22 | | 11 | | | | | 1 | | | | | | 5 | | | | 17 | 73.4% |
| Oct-22 | 1 | 7 | | | | | 1 | | | 1 | | | 1 | | | 1 | 12 | 80.9% |
| Nov-22 | | 8 | | | | | 2 | 1 | | | | | 3 | 2 | | 1 | 17 | 73.8% |
| Summary | 15 | 82 | 3 | 0 | 0 | 10 | 4 | 16 | 0 | 9 | 3 | 0 | 35 | 8 | 0 | 18 | 203 | |

**Continued non-compliance with 4hr admission targets due to bed capacity on Ward R2.**

**Key Actions**

- The Mixed-sex HASU bay on R2 has been open since May 22- monitoring of SSA breaches
- Relaunch of Stroke Taskforce meetings from Dec 22
- Phase 2 of regional Thrombectomy service expected from Jan 23
- Stroke AI project in progress
- National SSNAP data shows Trust performance from Apr - Jun 22 at Level B.
- 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.



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

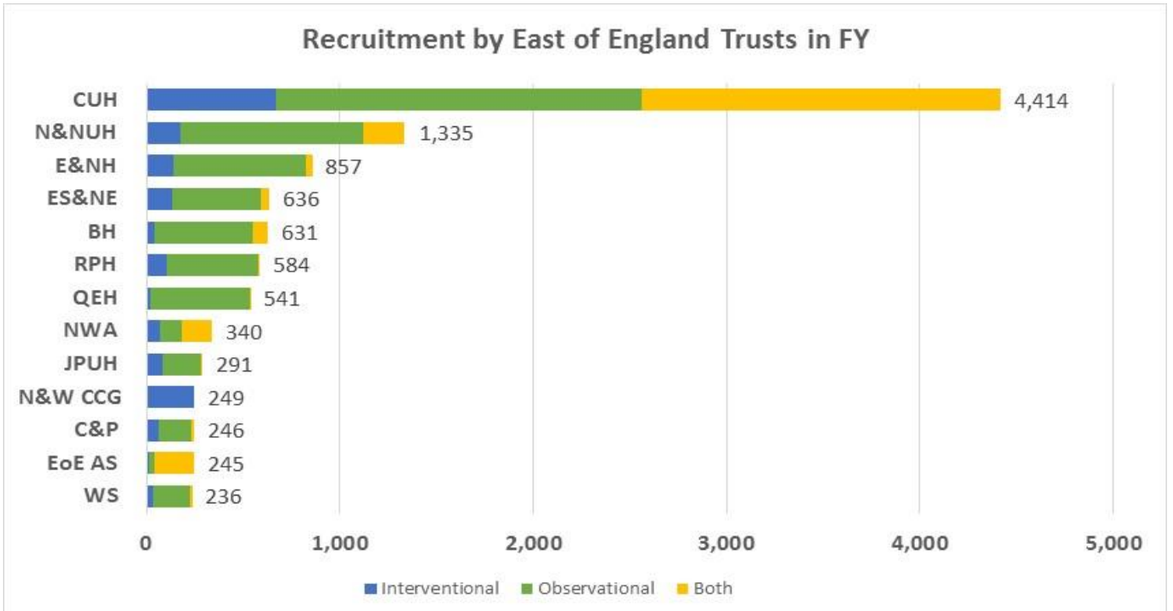
# Clinical Studies

NHS
Cambridge University Hospitals
NHS Foundation Trust

Clinical Studies Measures


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

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





**Situation as at end of September 2022**

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

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

# Maternity Dashboard

NHS
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Maternity Measures

## East of England Regional Perinatal Quality Oversight Group Highlight Report (v19.2)

| LMNS: | Reporting period: November 2022 | Overall System RAG: (Please refer to key next slide) |
|---|---|---|

KEY: CQC DOMAINS
Outstanding
Good
Requires Improvement
Inadequate

### REGULATORY BODIES

### CQC DOMAINS

| Maternity unit rating | CUH (Jan 2017) | | | | | | Y (date of last inspection ) | | | | | | Z (date of last inspection ) | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| S - Safe<br>E - Effective<br>C - Caring<br>R - Responsive<br>W – Well led | S | E | C | R | W | Action Plan Status:<br>To commence<br>Progressing<br>Completed | S | E | C | R | W | Action Plan Status:<br>To commence<br>Progressing<br>Completed | S | E | C | R | W | Action Plan Status:<br>To commence<br>Progressing<br>Completed |
| Rating (last inspection) | | | | | | | | | | | | | | | | | | |

| | |
|---|---|
| **CQC alerts** (active alerts & year) | Ref C260/AS Puerperal sepsis July 2019 |
| **CQC warning notice** | n/a |
| **Regulatory letters from coroner** | n/a |
| **Maternity Safety Support Programme** | Not in maternity safety support programme |

**CQC Maternity survey results (2021)**

| | CUH |
|---|---|
| CQC Maternity survey overall rating - improvement since previous year (2019) (Y/N) | TBC – '21 results currently embargoed |
| ***Survey scores:*** | |
| Start of your care during pregnancy | |
| Antenatal check ups | |
| During your pregnancy | |
| Your labour and birth | |
| Staff caring for you | |
| Care in hospital after birth | |
| Feeding your baby | |
| Care at home after birth | |
| **Other surveys** | |
| GMC survey results (2022) overall satisfaction | Guidance required |
| Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work | 71% (2020, entire division) |
| Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to receive treatment | 85% (2020, entire division) |
| Proportion of speciality trainees in O&G responding with excellent or good on how they would rate the quality of clinical supervision out of hours | 92.5% (2021) |

# Maternity Dashboard

NHS
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NHS Foundation Trust

Maternity Measures

## Assessed compliance with CNST MIS 10 Safety Actions

| | Please identify unit | CUH |
|---|---|---|
| 1 | Perinatal Mortality review tool | |
| 2 | MSDS | |
| 3 | ATAIN | |
| 4 | Clinical workforce planning | |
| 5 | Midwifery Workforce planning | |
| 6 | SBLCB V2 | If K2 compliance not achieved then SA6 fails. |
| 7 | Service user feedback / Maternity Voice Partnership | |
| 8 | Core competency framework / Multi-prof training | 12/12/22 update PROMPT compliance <90% but trajectory following 20 Dec study >90% . K2 compliance trajectory by 5/1/23 >90%. |
| 9 | Board level assurance | |
| 10 | HSIB / Early notification scheme | |
| | Repayment of CNST (since introduction) Y/N and MIS yr | N |

| Key (current position ) | |
|---|---|
| Compliant | Compliant with all aspects of element |
| Working towards / Partially complaint | Working towards (MIS & SBLCB) / Partially compliant (Ockendon) |
| Not compliant | Not compliant with all aspects of element |

## Evidence of SBLCB V2 Compliance

| Element | Please identify unit | CUH |
|---|---|---|
| 1 | Reducing smoking | |
| 2 | Risk assessment , prevention & surveillance of pregnancies at risk of fetal growth restriction | |
| 3 | Reduced Fetal Movements | |
| 4 | Effective Fetal monitoring during labour | CTG study day compliance now >90%. K2 competency assessments >75% and trajectory for the end of the year is for >90%. |
| 5 | Reducing pre-term birth | Fetal fibronectin machines training planned process being implemented for quantitative pre term assessment. |
| 6 | Diabetes in Pregnancy (not in use at present) | |

## Assessment against Ockenden Immediate and Essential Actions (IEA) – to achieve full compliance will all elements of each IEA

| Please identify unit | CUH |
|---|---|
| IEA1 : Enhanced Safety | |
| IEA2: Listening to Women & Families | |
| IEA3: Staff training & Working Together | |
| iEA4: Managing complex pregnancy | |
| IEA5: Risk Assessment Throughout pregnancy | |
| IEA6: Monitoring Fetal wellbeing | |
| IEA7 Informed consent : | |
| • Fully compliant (self assessment ) | |
| • Fully compliant (regional assessment following insight visit ) | |

# Maternity Dashboard

NHS Cambridge University Hospitals NHS Foundation Trust

Maternity Measures

| Trust | CNST MIS Safety Actions achieved (out of 10) | | | | Ockendon investment (Total allocation) | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Yr 1 (2019/20) | Yr 2 (2020/21) | Yr 3 (2021/22) | Yr 4 (2022/23) | | | | | | |
| X | 10 | 10 | 10 | TBC | P | | | | | |

| | CUH |
|---|---|
| 1. Freedom to speak up / Whistle blowing themes | • None received this month |
| 2. Themes from Maternity Serious Incidents (SIs) | • None received this month |
| 3. Themes arising from Perinatal Mortality Review Tool | • No concerns this month following the reviews |
| 4. Listening to women (sources, engagement / activities undertaken) | • PALS themes: staff rudenenss/attitude, communication issues, lack of showering facilities for partners, appointment delays, 2 complaints with multiple issues<br>• Formal and informal complaints received from women who don't have a CS date scheduled<br>• Positive feedback about birth experience received |
| 5. Listening to staff (eg activities undertaken, surveys and actions taken as a result) | • Weekly forum held by DOM and HOM<br>• Feedback via staff facebook page re training issues received and noted for next year's planning |

# Maternity Dashboard

NHS Cambridge University Hospitals NHS Foundation Trust

## Maternity Measures

| Sources / References | KPI | Goal | Target | Measure | Data Source | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | SPC | Narrative and Actions taken for Red/Amber/Special cause concerning trend results |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| National Maternity Dashboard | Births | For information | N/A | Births per month | Rosie KPI's | 422 | 447 | 431 | 455 | 421 | 469 | 434 | 446 | 464 | 476 | 504 | 461 | | |
| Antenatal Care ICS contracted booking KPI | Health and social care assessment <GA 12+6/40 | > 90% | >=90% <90%- >80% <80% | Booking Appointments | Epic | 70.65% | 73.21% | 76.89% | 73.05% | 71.40% | 69.90% | 70.64% | 73.24% | 75.69% | 75.45% | 69.74% | 74.00% | | Working with informatics team to remove women who transfer care after 12+6 weeks as these are currently included in the KPI. Bookings working group underway. |
| National Maternity Dashboard | Booking Appointments | For Information | N/A | Booking Appointments | Epic | 562 | 612 | 582 | 720 | 654 | 615 | 664 | 568 | 551 | 550 | 532 | 611 | | |
| Source - EPIC | Vaginal Birth (Unassisted) | For Information | N/A | SVD's in all birth settings | Rosie KPI's | 50.47% | 47.42% | 52.43% | 51.42% | 49.16% | 48.82% | 54.60% | 51.12% | 59.05% | 52.31% | 52.18% | 50.76% | | |
| Source - EPIC | Home Birth | For Information | N/A | Planned home births (BBA exc) | Rosie KPI's | 1.18% | 1.56% | 2.08% | 1.53% | 1.42% | 1.7% | 1.84% | 1.34% | 1.29% | 0.84% | 0.59% | 1.08% | | |
| Source - EPIC | Rosie Birth Centre Birth | For Information | N/A | Births on Rosie Birth Centre | Rosie KPI's | 15.16% | 14.76% | 16.93% | 14.5% | 11.87% | 14.92% | 17.1% | 15% | 15.52% | 16.38% | 17.46% | 15.40% | | |
| Source - EPIC | Rosie Birth Centre transfers | For information | N/A | Women admitted to RBC and subsequently transferred for birth | Rosie KPIs | 12.32% | 12.79% | 9.91% | | | | | | | | 8.81% | 14.95% | | Reported for first time from Oct 22. National averages = 40% (primip) 13% (multip) for transfers from alongside midwifery units to obstetric care (Oxford NPEU, 2020). |
| Source - EPIC | Induction of Labour | For Information | N/A | Women induced for birth | Rosie KPI's | 33.73% | 34.47% | 30.16% | 31.61% | 31.80% | 31.87% | 30% | 29.80% | 26.50% | 30.00% | 27.65% | 34.29% | | |
| NICE - Red Flag | Delay in commencement of Induction | 0% | <10% | % of Inductions postponed >2 hours | Red Flags | 33.00% | 42.00% | 23.00% | 41.00% | 40.00% | 53.00% | 36% | 36.00% | 32.60% | 32.28% | 37.43% | 33.33% | | Affected by Sara ward staffing where some staff remain supernumery. |
| NICE - Red Flag | Delay in continuation of Induction | 0% | <10% | % of Induction continuation was delayed for > 6 hours | Red Flags | | | | | | | | | 13.81% | 16.40% | 16.58% | 11.46% | | Affected by 30% junior staffing and supernumery status on both Sara ward and delivery unit. |
| SBLCBV2 | Indication for IOL (SBLCBV2) | NA | NA | % of IOL where reduced fetal movements is the only indication before 39 weeks | IOL Team | | | | | | | | | | | 2.67% | 0% | | |
| Source - EPIC | Indication for IOL | 100% | ≥95% | Percentage of IOL with a valid indication as per guidance. | IOL Team | | | | | | | | | | | 100% | 100% | | |
| Source - EPIC | Birth assisted by instrument (forceps or ventouse) ( Instrumental) | For Information | N/A | Instrumental birth rate | Rosie KPI's | 10.9% | 11.18% | 10.67% | 10.32% | 9.02% | 11.94% | 10.6% | 12.55% | 12.93% | 10.5% | 13.29% | 13.23% | | |
| Source - EPIC | CS rate (planned & unplanned) | For Information | N/A | C/S rate overall | Rosie KPIs | 38.62% | 41.38% | 36.89% | 38.24% | 41.80% | 39.23% | 34.80% | 36.32% | 35.78% | 37.18% | 34.52% | 36.00% | | |
| CQIM / CNST | Women in RG*1 having a CS with no previous births: nullip spontaneous labour) | For information | 10% | Relative contribution of the Robson group to the overall C/S Rate | Rosie KPIs | 9.9% | 9.2% | 13.8% | 6.3% | 8.5% | 9.2% | 8.6% | 14.2% | 9.6% | 11.9% | 12.6% | 8.4% | | |
| CQIM / CNST | Women in RG*2 having a C/S with no previous births: nullip induced labour, nullip pre-labour LSCS | For Information | For Information | Relative contribution of the Robson group to the overall C/S Rate | Rosie KPIs | 30.2% | 30.4% | 23.9% | 24.6% | 31.3% | 26.1% | 25.8% | 27.2% | 18.1% | 28.2% | 29.9% | 27.7% | | |
| 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 | | | | | | | | | | 1:2.4 | 1:2.4 | 1:3.3 | | Ratio is consistently <2:1. A lower ratio may indicate a high induction/prelabour CS issue which may indicate a high-risk primiparous population where you are likely to therefore have a high CS rate. (NB Sept + Oct ratios simplified for easier comparison.) Robson Group data being discussed by obstetric consultant team. |
| CQIM / CNST | Women in RG*5. Multips with 1 or 2+ previous C/S | For Information | For Information | Relative contribution of the Robson group to the overall C/S Rate | Rosie KPIs | 26.5% | 19.6% | 31.4% | 25.1% | 25.6% | 23.4% | 31.1% | 23.5% | 32.5% | 23.2% | 30.5% | 31.9% | | |
| CQIM / CNST | Women in RG1, RG2, RG5 combined contribution to the overall C/S rate. | 66% | 60-70%, | | Rosie KPIs | 66.6% | 59.2% | 69.1% | 56.0% | 65.4% | 58.7% | 65.5% | 64.9% | 60.2% | 63.3% | 73.0% | 68% | | |
| Source - Rosie Divert Folder | Divert Status - incidence | 0 | <1 | Incidence of divert for the perinatal service | Rosie Diverts | 0 | 1 | 4 | 3 | 4 | 7 | 1 | 4 | 4 | 6 | 4 | 0 | | |
| Source - Rosie Divert Folder | Total number of hours on divert | For information | N/A | | Rosie Diverts | 0 | 47 | 61 | 88 | 190 | 148 | 23 | 103 | 100 | 86 | 109 | 0 | | |
| Source - Rosie Divert Folder | Admissions during divert status | For information | N/A | | CHEQs | | | | | | | | | | | 24 | 0 | | |
| Source - Rosie Divert Folder | No. of women giving birth in another provider organisation due to divert status | For information | N/A | | Rosie KPIs | 0 | 2 | 0 | 0 | 0 | 6 | 0 | 0 | 1 | 1 | 4 | 0 | | |

# Maternity Dashboard

NHS Cambridge University Hospitals NHS Foundation Trust

Maternity Measures

| Sources / References | KPI | Goal | Target | Measure | Data Source | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | SPC | Narrative and Actions taken for Red/Amber/Special cause concerning trend results |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Workforce** | | | | | | | | | | | | | | | | | | | |
| Birth Rate Plus | Midwife/birth ratio (actual)** | 1:24 | <1.28 | Total permanent and bank clinical midwife WTE*/Births (rolling 12 month average) | Finance | 1:27:3 | 1:27.5 | 1:27 | 1:26.2 | 1:27.2 | 1:25.4 | 1:27.2 | 1:28.2 | 1:28.2 | 1:28.3 | 1:25.1 | 1:23.5 | | |
| Birth Rate Plus | Midwife/birth ratio (funded)** | For information | 1.24.1 | Total clinical midwife funded WTE*/Births (rolling 12 mth ave) | Finance | 1:23:6 | 1:23:8 | 1:24 | 1:23.4 | 1:23.4 | 1:23.4 | 1:23.3 | 1:23.3 | 1:23.3 | 1:23.3 | 1:23.3 | 1:23.2 | | Midwife/birth ratio based on the BR+ methodology |
| Safer Chilbrith / CNST | Supernumerary Delivery Unit Coordinator | 100% | ≥95% | % compliance with Delivery Unit coordinator remaining supernumerary (no caseload of their own during a shift) | Red Flags / BR+ | 71% | 95% | 73% | | 72% | 67% | 41% | 63% | 70% | 60% | 57% | 100% | | From 11/10/22 BirthRate+ red flag reporting updated to reflect revised CNST requirements. There were no occasions when SN status of the coordinator was lost to 1:1 care provision in October and November. |
| Source - CHEQS | Staff sickness as a whole | < 3.5% | <5% | ESR Workforce Data | CHEQs | 6.43% | 6.62% | 6.87% | 7.22% | 7.59% | 7.63% | 7.69% | 7.95% | 7.72% | 7.26% | 6.91% | | | This is reported 1 month behind from CHEQ's. Clinical psychology support now in place. New PMA commenced in post 12 Dec. Most common reason for sickness is now cold, cough, flu. |
| Core Competency Framework | Education & Training - mandatory training - overall compliance (obs and gynae) | >92% YTD | >75% YTD | Total Obs and Gynaecology Staff (all staff groups) compliant with mandatory training | CHEQs | 87.10% | 87.50% | 87.50% | 87.80% | 87.50% | 87.50% | 86.40% | 86.50% | 87.30% | 87.10% | | | | This is reported 2 months behind on CHEQS. As of Jan 2023 clinical staff will be given a day for training following PROMPT f2f (bank or within their hours) to complete DOT training. |
| CNST | Education and Training - Training Compliance for all staff groups: **Prompt** | >90% YTD | >85% YTD | Total multidisciplinary obstetric staff compliant with annual Prompt training | PD | 52.47% | 53.86% | 57.05% | 58.84% | 61.28% | 60.91% | 61.00% | 65.56% | 75.77% | 67.83% | 74.76% | 87.27% | | Improving |
| CNST | Education and Training - Training Compliance for all staff groups: **NBLS** | >90% YTD | >85% YTD | Total multidisciplinary staff compliant with annual NBLS training | Resus Services | | | | | | | 55.00% | | 58.00% | 60% | 66% | 93% | | Additional training dates added for November to meet revised CNST training compliance deadline of 5 December. On track to meet 90% trajectory for all staff groups. |
| CNST | Education and Training - Training Compliance for all staff groups: **K2** | >90% YTD | >85% YTD | Total multidisciplinary staff passed CTG competence threshold of 80%. | PD | 77.89% | 76.39% | 76.12% | 79.85% | 81.00% | 83.39% | 83.39% | 84.62% | 80.00% | 77.78% | 74.15% | 88.41% | | Matrons addressing individuals regarding non-compliance. CNST deadline for >90% extended to 5 Jan 2023. |
| CNST | Education and Training - Training Compliance for all Staff Groups - **Fetal Surveillance Study Day** | >90% YTD | >85% YTD | Total multidisciplinary staff compliant with annual fetal surveillance study day attendance. | PD | | | | | | | | | | | | 91.56% | | |
| Core competency Framework | Education & Training - mandatory training - **midwifery compliance**. | >92% YTD | >75% YTD | Proportion of midwifery compliance with mandatory training, inclusive of mandated e-learning and mandated face to face sessions. | CHEQs | 90% | 89.9% | 89.4% | 89.7% | 89.2% | 89.5% | 89.20% | 84.50% | 85.70% | 90.80% | 89.30% | | | This is reported 1 month behind from CHEQs |
| **Maternal Morbidity** | | | | | | | | | | | | | | | | | | | |
| CQC KLOE | Puerperal Sepsis | For information | N/A | Incidence of puerperal sepsis within 42 days of birth | CHEQs | | | | | | | | | | 0.64% | 0.01% | 1.32% | | |
| Source - CHEQs | ITU Admissions in Obstetrics | For information | N/A | Total number of pregnant / postnatal women admitted to the intensive care unit | CHEQs | 0 | 0 | 1 | 2 | 0 | 1 | 1 | 0 | 1 | 0 | 1 | 0 | | |
| NMPA | Massive Obstetric Haemorrhage ≥ 1500 mls - vaginal birth | ≤2.5% | ≤2.5% | Percentage of women with a PPH >1500mls (singleton births between 37+0-42+6) having a vaginal birth | Rosie KPIs | 4.09% | 4.90% | 4.89% | 2.96% | 2.08% | 6.62% | 2.48% | 2.95% | 3.16% | 2.24% | 6.35% | 4.96% | | PPH working group reviewing audit findings from Oct 22. Normal variation seen. Ongoing face to face training being delivered by S&Q team with focus on early intervention and accurate visual assessment to ensure prompt escalation. Ongoing PPH spotchecks. |
| NMPA | Massive Obstetric Haemorrhage ≥ 1500 mls - caesarean birth | ≤4.3% | ≤4.3% | Percentage of women with a PPH >1500mls (singleton births between 37+0-42+6) having a caesarean section | Rosie KPIs | 2.20% | 4.60% | 1.80% | 1.23% | 1.82% | 6.67% | 3.45% | 0.98% | 0.73% | 2.47% | 4.54% | 3.31% | | |
| NMPA | 3rd/ 4th degree tear rate | ≤3.5 | <5% | % of women with a vaginal birth having a 3rd or 4th degree tear (spontaneous and assisted by instrument) singleton baby in cephalic position between 37+0 and 42+6. | Rosie KPIs | 2.72% | 0.38% | 2.21% | 1.81% | 2.05% | 2.48% | 2.83% | 3.90% | 4.06% | 2.01% | 4.87% | 2.72% | | |
| CQC KLOE | Maternal readmission rate | For information | N/A | % of women readmitted to maternity service within 42 days of birth. | Rosie KPIs | 1.93% | 1.35% | 2.79% | 1.31% | 2.62% | 2.35% | 1.38% | 1.80% | 2.59% | 1.05% | 0.60% | 1.54% | | |
| MBRRACE | Peripartum Hysterectomy | For information | N/A | Incidence of peripartum hysterectomy | QSIS | | | | | | | | | | | 0 | 0 | | |
| MBRRACE | Direct Maternal Death | 0 | <1 | | QSIS | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |

# Maternity Dashboard

NHS Cambridge University Hospitals NHS Foundation Trust

Maternity Measures

| Sources / References | KPI | Goal | Target | Measure | Data Source | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | SPC | Narrative and Actions taken for Red/Amber/Special cause concerning trend results |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Governance** | | | | | | | | | | | | | | | | | | | |
| Source - QSIS | Total number of Serious Incidents (SIs) | 0 | <1 | Serious Incidents | QSIS | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | | |
| Source - QSIS | Never Events | 0 | <1 | DATIX | QSIS | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| **Neonatal Morbidity** | | | | | | | | | | | | | | | | | | | |
| MBRRACE / PMRT | Still Births per 1000 Births | 3.33/1000 (Mbrrace 2021) | | Incidence per 1000 births | CHEQs | 0.84/1000 | 0.44/1000 | 0.86/1000 | 0.21/1000 | 1.26/1000 | 0.42/1000 | 0.43/1000 | 0.88/1000 | 0/1000 | 0.42/1000 | 0.50/1000 | 0/1000 | | |
| MBRRACE / PMRT | Stillbirths - number ≥ 22 weeks | <3 | <6 | MBBRACE | CHEQs | 2 | 1 | 2 | 1 | 3 | 2 | 1 | 2 | 0 | 2 | 1 | 0 | | |
| Epic | Number of birth injuries | 0 | <1 | Percentage of babies born with a birth related injury | CHEQs | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| NMPA | Babies born with an Apgar <7 at 5 minutes of age | For information | N/A | Percentage of babies born who have an Apgar score <7 at 5 minutes of age | Rosie KPIs | | 1.35% | 2.09% | 1.75% | 1.66% | 2.35% | 1.38% | 1.57% | 3.02% | 0.84% | 1.59% | 0.86% | | |
| CQC KLOE | Incidence of neonatal readmission | For information | N/A | % of babies readmitted within 42 days of birth | Rosie KPIs | | 3.14% | 3.94% | 4.81% | 4.28% | 3.84% | 3.92% | 3.81% | 3.02% | 3.15% | 4.76% | 4.12% | | |
| SBLCBV2 | Babies born at <3rd centile at >37+6 | For information | N/A | Incidence | CHEQs | | | | | | | | | | | | | | Awaiting new CHEQS report |
| ATAIN | Term Admission to NICU Rate | <6% | N/A | Rate | CHEQs | | | | | | | | | | 4.20% | 6.15% | 5.42% | | |
| ATAIN / CNST | Expected Term Admissions to NICU | For information | N/A | Inclusive of congenital abnormality and tertiary referral babies with planned term admission to NICU | Badgernet / CHEQs | | | | | | | | | | | | | | New metric was expected Nov 22 but delayed. |
| ATAIN / CNST | Unexpected Term Admissions to NICU | For Information | N/A | Incidence of term admissions to NICU that were unplanned prior to birth | Badgernet / CHEQs | | | | | | | | | | | | | | New metric was expected Nov 22 but delayed. |
| **Quality** | | | | | | | | | | | | | | | | | | | |
| CNST | 1-1 Care in Labour | >95% | >90% | Percentage of women receiving 1:1 care in labour (excluding BBAs) | Rosie KPI's | 99.52% | 99.78% | 98.83% | 98.65% | 100% | 98.69% | 100% | 100% | 99.56% | 99.80% | 99.59% | 100% | | |
| CQIM | Babies with a first feed of breastmilk | > 80% | >70% | Breastfeeding | Rosie KPI's | 84.09% | 83.10% | 83.01% | 79.59% | 82.89% | 81.22% | 84.33% | 79.4% | 84.07% | 82.55% | 82.56% | 84.8% | | |
| 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 | 6.26% | 4.79% | 5.89% | 6.95% | 3.37% | 5.02% | 3.95% | 8.25% | 5.97% | 3.82% | 5.21% | 3.74% | | |
| CNST / SBLCBV2 / CQIM | CO Monitoring at booking | ≥95% | Green = ≥95%, amber = <95% and ≥84%, red = <85% | Compliance with recording CO Monitoring reading at booking appointment (excluding out of area) | Smoking Report | | | | | | | | 89.97% | 92.74% | 91.95% | 99.10% | 98.60% | | |
| CNST / SBLCBV2 / CQIM | CO Monitoring at 36 weeks | >95% | Green = >95%, amber = <95% and >84%, red = <85% | Compliance with recording CO Monitoring reading at 36 week appointment (excluding out of area) | Smoking Report | | | | | | | | 72.81% | 85.61% | 84.56% | 82.70% | 61.00% | | 80% CNST target met. SBLCBv2 included in annual in-service mandatory training. IST cancelled due to clinical pressures. |
| Source - Epic | VTE Assessment - PN | >95% | >95% | % of women with a valid PN VTE risk assessment completed following birth. | CHEQs | | | | | | | | | | | | | | Awaiting new CHEQS report |
| Source - EPIC | VTE Assessment - AN | >95% | >95% | Percentage of women with a valid VTE risk assessment completed on admission to hospital | CHEQs | | | | | | | | | | | | | | Awaiting new CHEQS report |

# 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)** |
| £1.8m | *Actual YTD (adjusted)** |
| £1.7m | *Plan YTD (adjusted)** |

### Covid-19 expenditure and system Covid-19 funding

| | |
|---|---|
| £1.7m | *Covid actual in month* |
| £1.8m | *Covid plan in month* |
| £1.8m | *Covid funding in month* |
| £15.8m | *Covid actual YTD* |
| £15.2m | *Covid plan YTD* |
| £14.7m | *Covid funding YTD* |

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

***Net current assets***

| | |
|---|---|
| (£72.4m) | |
| (£54.2m) | |

***Debtor days***

| | |
|---|---|
| 21 | *This month* |
| 20 | *Previous month* |

***Payables performance (YTD) *****

| | | |
|---|---|---|
| *Actual* | 86.7% | *Value* |
| *Plan* | 88.7% | *Quantity* |

### Cash and EBITDA

***Cash***

| | |
|---|---|
| £161.5m | *Actual* |
| £166.8m | *Plan* |

***EBITDA***

| | |
|---|---|
| £27.7m | *Actual YTD* |
| £30.1m | *Plan YTD* |

### Capital expenditure

| | |
|---|---|
| £9.6m | *Capital - actual spend in month* |
| £30.1m | *Capital - actual spend YTD* |
| £37.1m | *Capital – plan YTD* |

### Elective Recovery Fund (ERF)

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

| | |
|---|---|
| £2.5m | *ERF forecast actual in month* |
| £2.5m | *ERF plan in month* |
| £12.3m | *ERF forecast actual YTD* |
| £12.3m | *ERF plan YTD* |

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

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

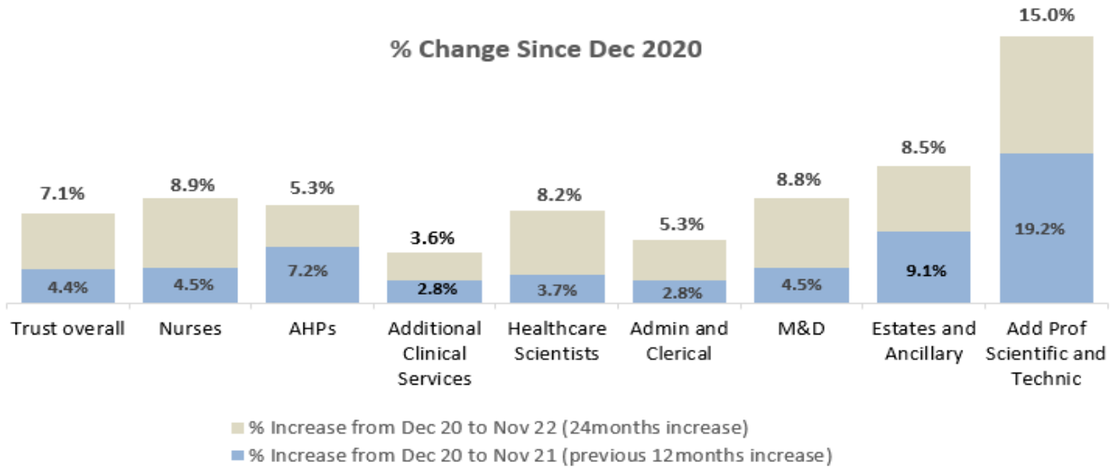
# Staff in Post

Cambridge University Hospitals NHS Foundation Trust

Workforce: Staff in Post

## 12 Month Growth by Staff Group

| Staff Group | Headcount Dec-21 | Headcount Nov-22 | Headcount 12 Month growth | FTE Dec-21 | FTE Nov-22 | FTE 12 Month growth |
|---|---|---|---|---|---|---|
| Add Prof Scientific and Technic* | 238 | 240 | 0.8% | 220 | 216 | -1.5% |
| Additional Clinical Services | 1,938 | 1,967 | 1.5% | 1,785 | 1,811 | 1.4% |
| Administrative and Clerical | 2,390 | 2,425 | 1.5% | 2,182 | 2,230 | 2.2% |
| Allied Health Professionals* | 750 | 739 | -1.5% | 667 | 654 | -2.0% |
| Estates and Ancillary | 371 | 365 | -1.6% | 360 | 353 | -1.9% |
| Healthcare Scientists | 630 | 649 | 3.0% | 590 | 610 | 3.4% |
| Medical and Dental | 1,656 | 1,720 | 3.9% | 1,567 | 1,624 | 3.7% |
| Nursing and Midwifery Registered | 3,705 | 3,868 | 4.4% | 3,402 | 3,564 | 4.8% |
| **Total** | **11,678** | **11,973** | **2.5%** | **10,773** | **11,062** | 2.7% |




## Admin & Medical Breakdown

| Staff Group | Dec-21 | Nov-22 | FTE 12 Month growth |
|---|---|---|---|
| **Administrative and Clerical** | 2,182 | 2,230 | 47 2.2% |
| *of which staff within Clinical Division* | 1,083 | 1,087 | 4 0.4% |
| *of which Band 4 and below* | 768 | 753 | -15 -1.9% |
| *of which Band 5-7* | 224 | 242 | 18 8.1% |
| *of which Band 8A* | 43 | 44 | 1 2.5% |
| *of which Band 8B* | 8 | 7 | -1 -6.4% |
| *of which Band 8C and above* | 40 | 40 | 0 -0.5% |
| ***Areas*** | 878 | 900 | 22 2.5% |
| *of which Band 4 and below* | 251 | 248 | -3 -1.2% |
| *of which Band 5-7* | 412 | 424 | 12 2.8% |
| *of which Band 8A* | 76 | 88 | 12 16.0% |
| *of which Band 8B* | 53 | 52 | -1 -2.5% |
| *of which Band 8C and above* | 86 | 89 | 3 3.2% |
| ***of which staff within R&D*** | 221 | 242 | 21 9.5% |
| | | | |
| ***Medical and Dental*** | 1,567 | 1,624 | 57 3.7% |
| *of which Doctors in Training* | 647 | 671 | 24 3.8% |
| *of which Career grade doctors* | 234 | 236 | 2 0.9% |
| *of which Consultants* | 686 | 717 | 31 4.5% |

**What the information tells us:**

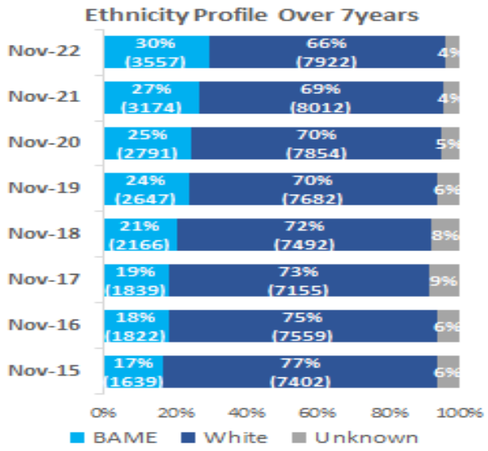
Overall the Trust saw a 2.7% growth in its substantive workforce over the past 12 months and 7.1% over the past 24 months. Growth over the past 24 months is lowest within Additional Clinical Services at 3.6% and highest within Add Prof Scientific and Technic at 15%. Data cleansing of AHPs in April 2022 resulted in 30 Operating Department Practitioners being re-coded into Nursing and Midwifery staff group. This is showing in the data as a 2% decrease for AHPs. When removing ODPs from the data the AHP staff group has in fact seen a 2.2% increase overall in the last 12 months; however, Therapeutic Radiographers have decreased by 9.2% (reduction of 7.24 FTE).

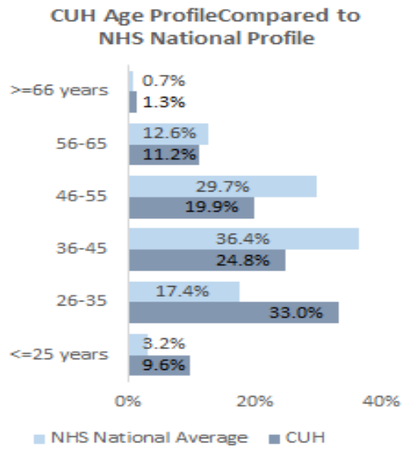
*Operating Department Practitioner roles were regroup from Add Prof Scientific and Technic to Allied Health Professionals on ESR from June 21 . This change has been updated for historical data set to allow for accurate comparison

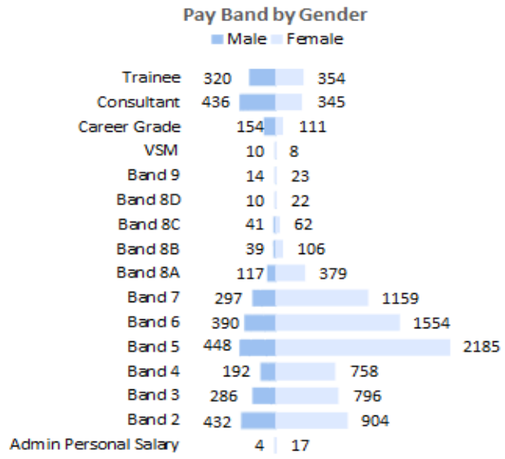
# Equality Diversity and Inclusion (EDI)

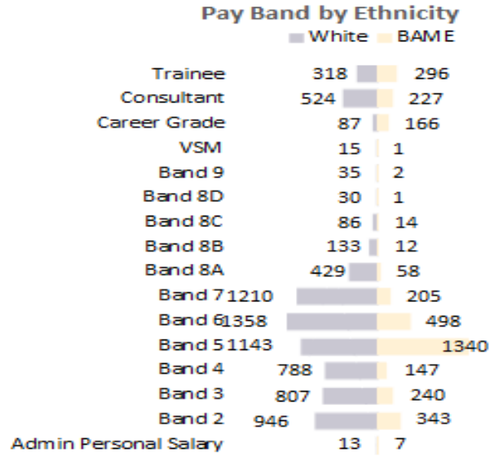
Cambridge University Hospitals NHS Foundation Trust

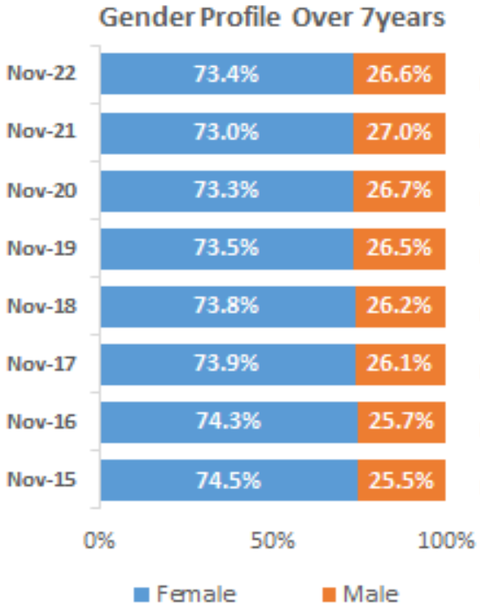
Workforce: Equality Diversity and Inclusion (EDI)

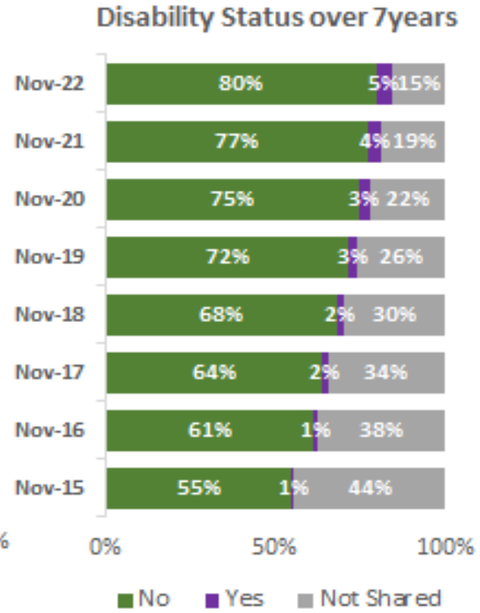


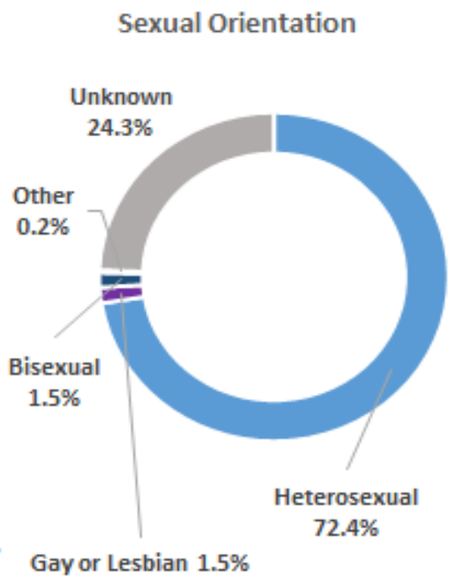



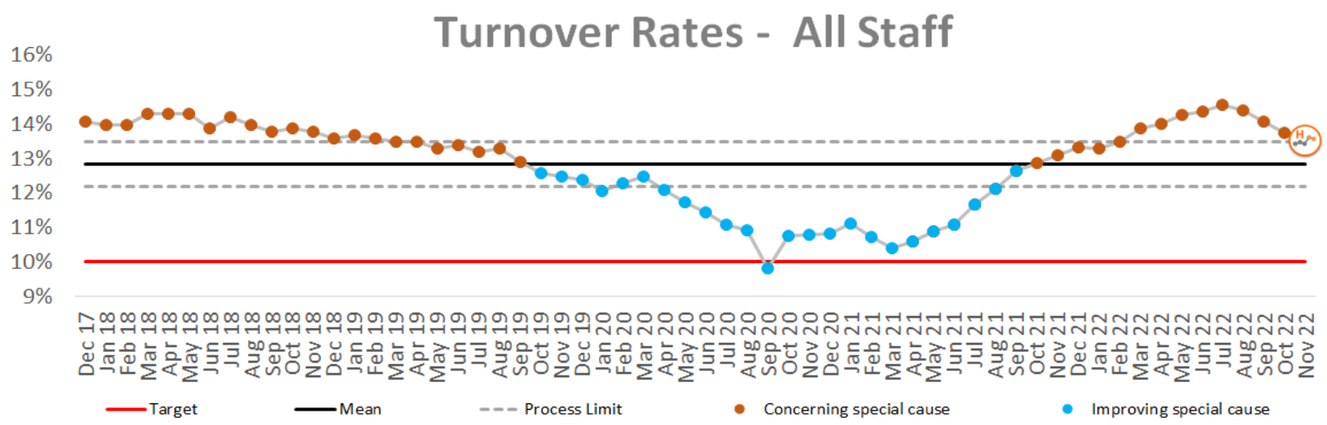

**What the information tells us:**

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

# Staff Turnover

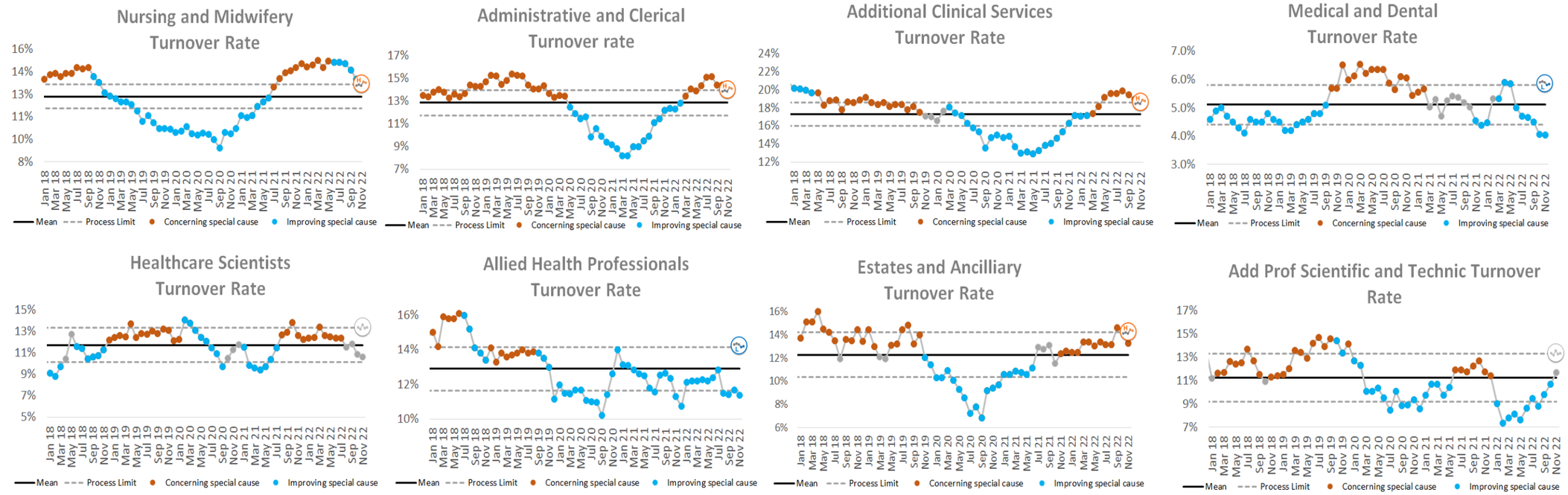
Cambridge University Hospitals NHS Foundation Trust

Workforce: Staff Turnover




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

**What the information tells us:**
After a steady increase over the past eighteen months the Trust turnover rate has been decreasing since July - this month at 13.4%. This is more in line with pre-pandemic rates, however still 1% higher than 3 years ago. Nursing and Midwifery staff group have the highest increase of 3% to 13.1% in the last three years, followed by Estates and Ancillary with an increase of 1.9% to 13.3%. Within the staff groups, Additional Clinical Services have the highest turnover rate at 18.4% followed by Administrative and Clerical staff at 14.1%.



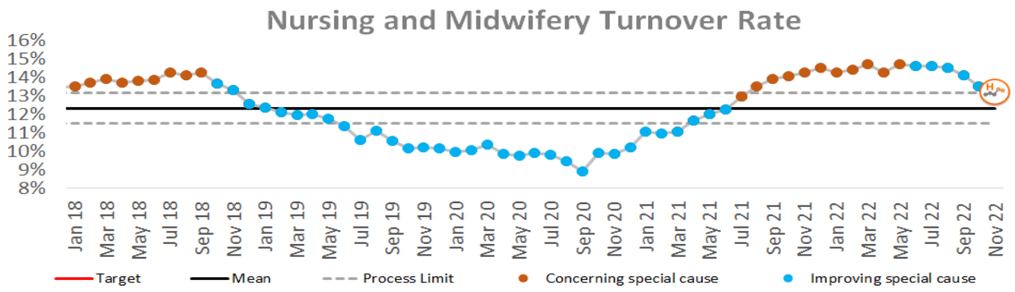


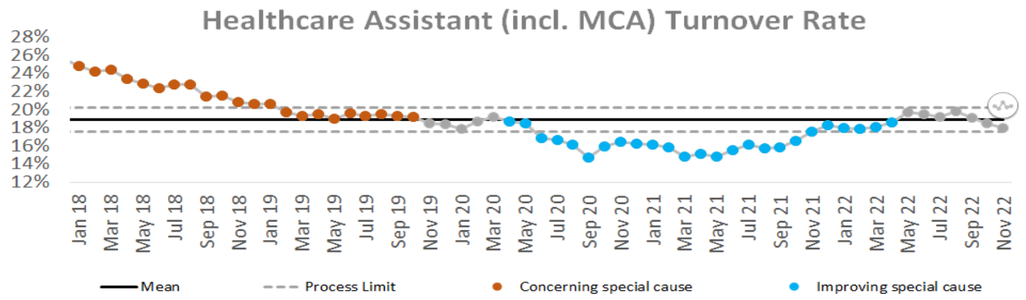
Author(s):Tosin Okufuwa, Amanda Wood
Owner(s): David Wherrett
Together-Safe | Kind | Excellent

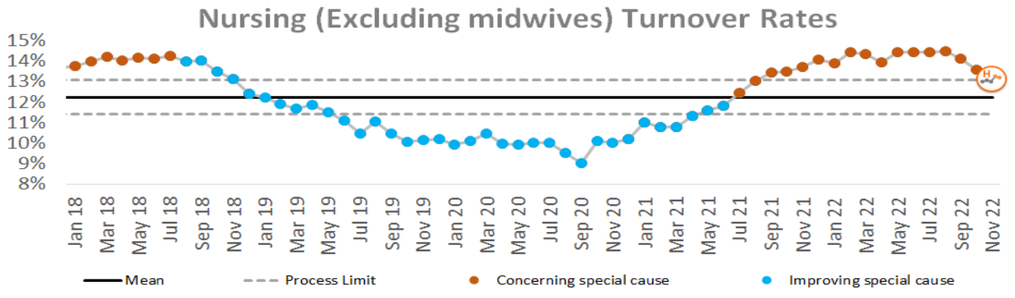
# Turnover for Nursing & Midwifery Staff Group (Registered & Non-Registered)

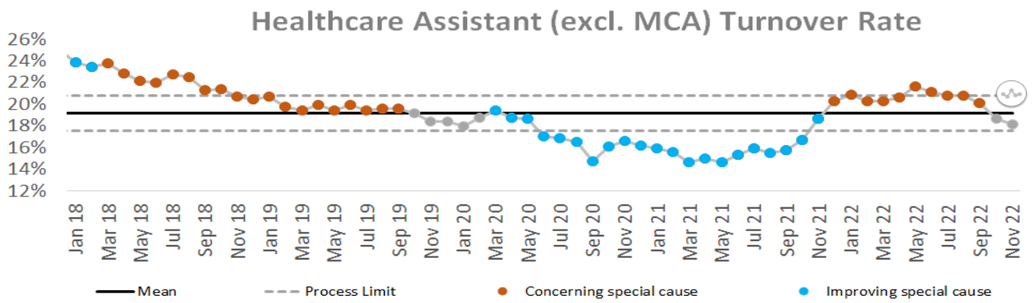
NHS Cambridge University Hospitals NHS Foundation Trust

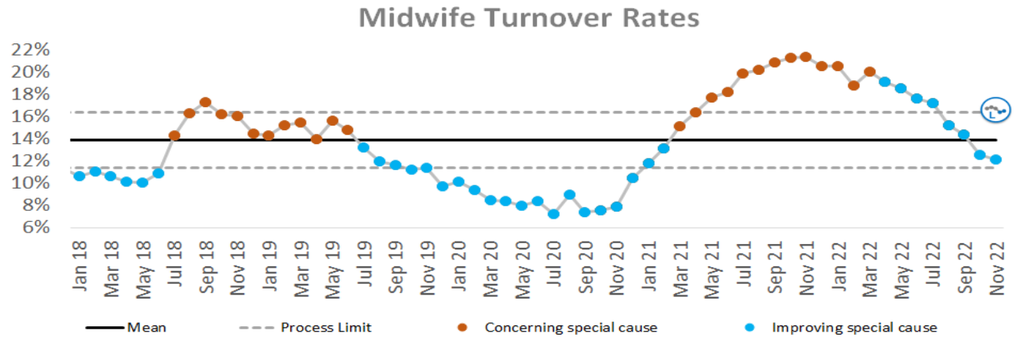
Workforce: Turnover rate for Nursing & Midwifery Staff Group

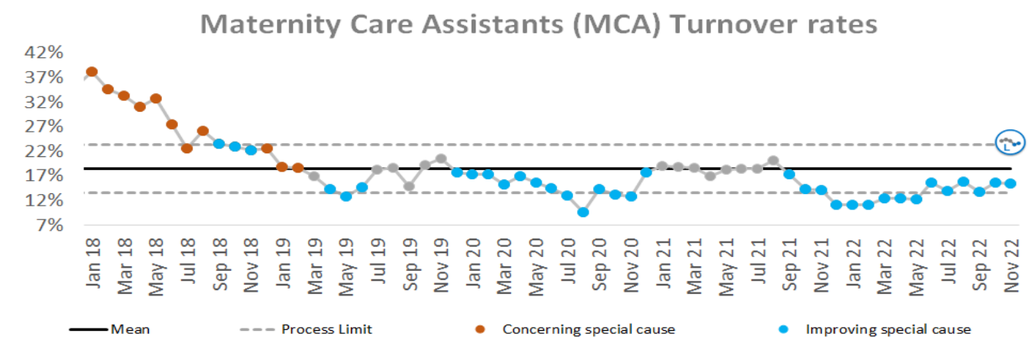


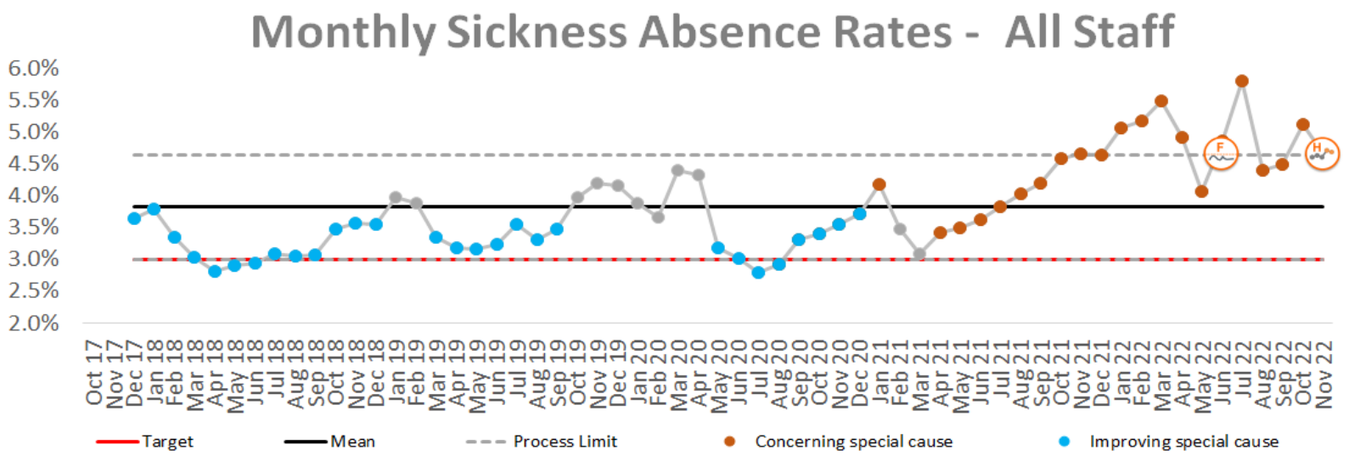



Author(s): Tosin Okufuwa, Amanda Coulier Owner(s): David Wherrett

# Sickness Absence

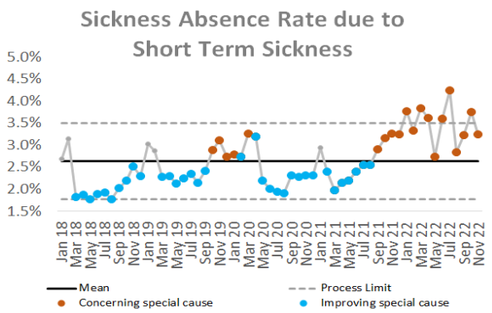
Cambridge University Hospitals NHS Foundation Trust

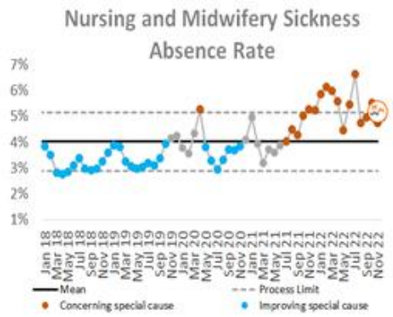
Workforce: Sickness Absence

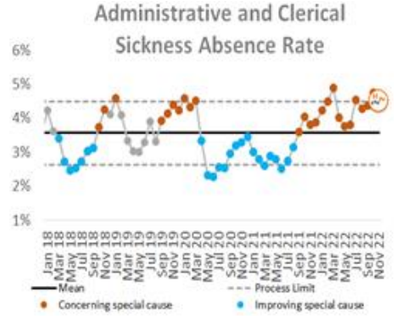


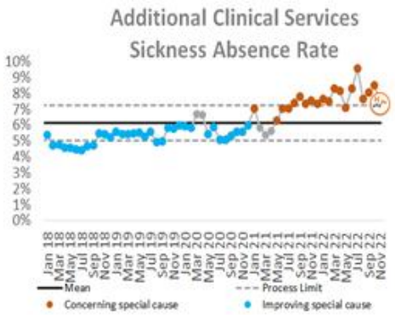

**Background Information**: Sickness Absence is a monthly metric and is calculated as the percentage of FTE days missed in the organisation due to sickness during the reporting month.

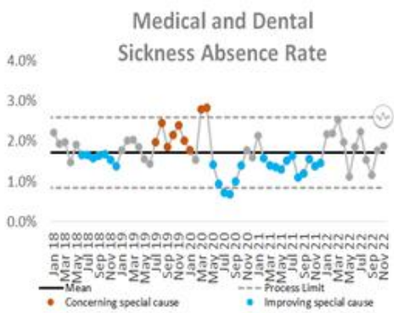
**What the information tells us:** The overall Monthly Sickness Absence is above average at 4.7%. This is 0.4% lower than last month, October 2022 (5.1%) and the same rate as November last year (4.7%). The sickness absence rate due to short term illness is higher at 3.2% compared to long term sickness at 1.4%. Additional Clinical Services have the highest sickness absence rate at 7.32% followed by Estates at 7.28%.

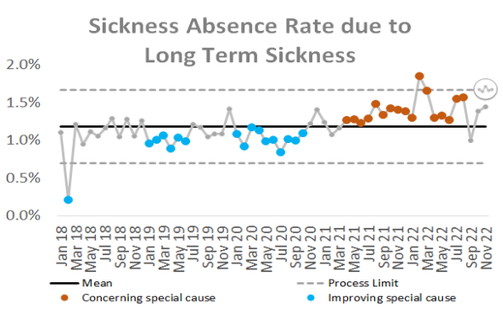


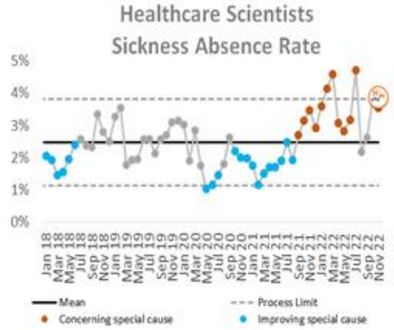



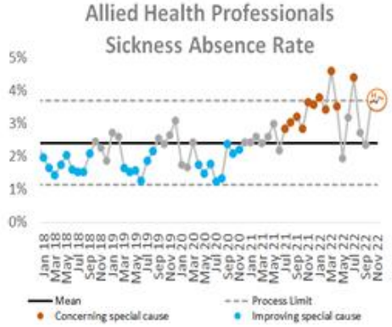



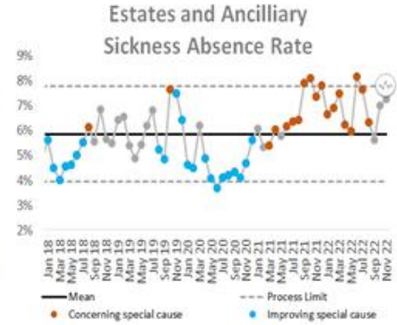



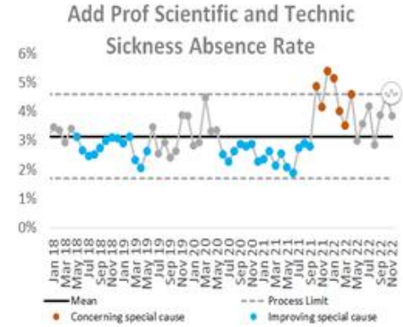





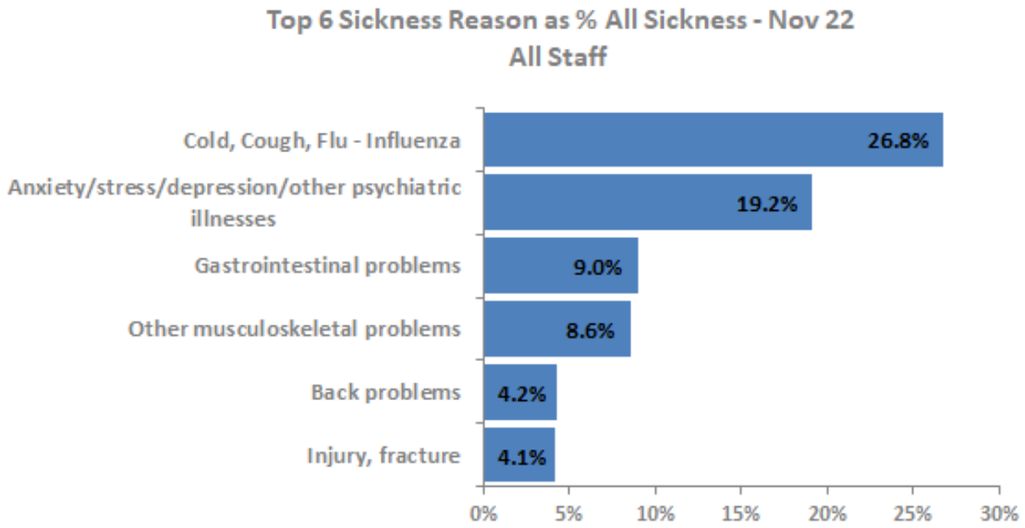

Author(s): Tosin Okufuwa, Amanda Wood

Owner(s): David Wherrett

# Top Six Sickness Absence Reason

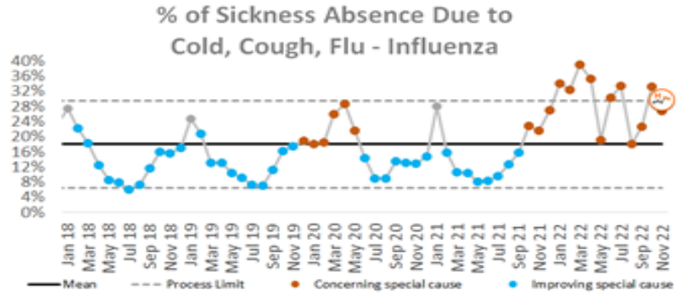
Cambridge University Hospitals NHS Foundation Trust

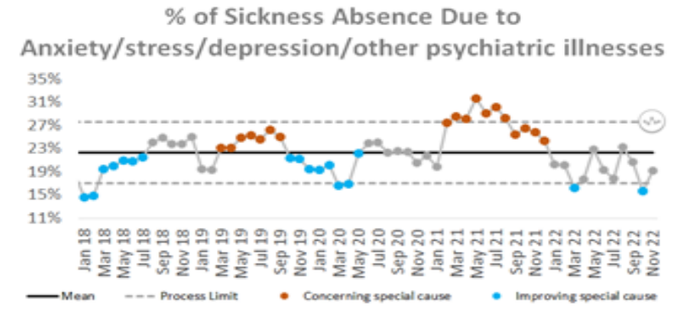
Workforce: Top Six Sickness Absence

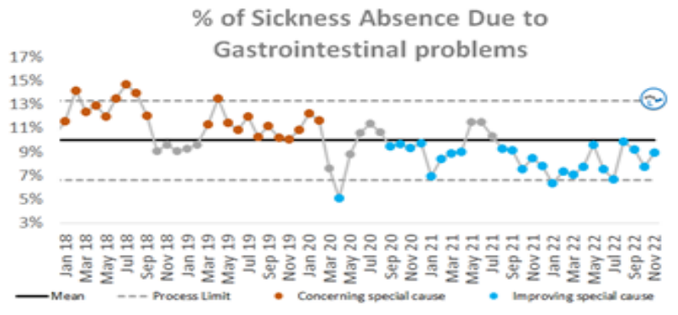


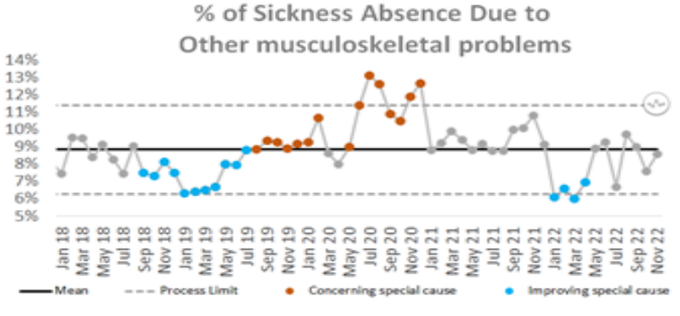

**Background Information: Sickness** Absence reason is provided as a percentage of all FTE days missed due to sickness during the reporting month.

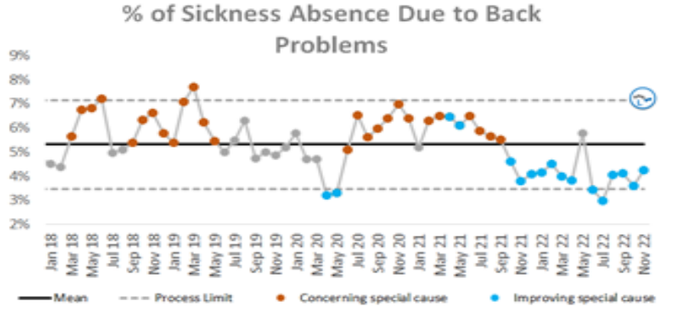
**What the information tells us:** The highest reason for sickness absence is influenza-related sickness, which saw a decrease from last month of 6.4% to 26.8% of all sickness in November 2022. Anxiety/stress/depression/other psychiatric illnesses increased by 3.5% to account for 15.7% of all sickness in November 2022.
Potential Covid-19 related sickness absence (this includes chest & respiratory problems, influenza related sickness and infectious diseases) accounts for 31.5% of all sickness absence in November 2022, compared to 39.2% from the previous month.

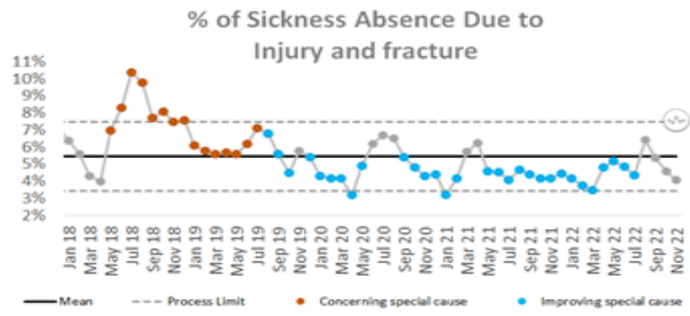




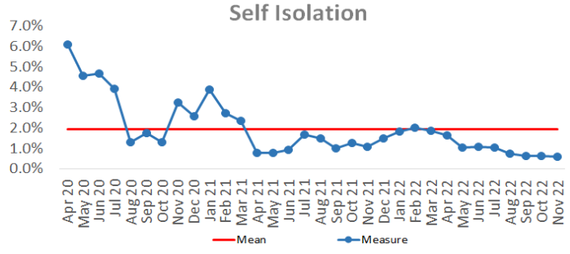

Author(s):Tosin Okufuwa, Amanda Wood Owner(s): David Wherrett

# Covid-19 Related Absence

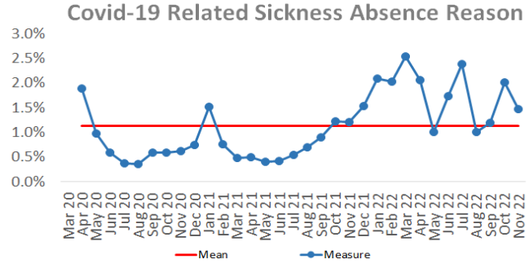
Cambridge University Hospitals NHS Foundation Trust

Workforce: Covid-19 Related Absence

Monthly Absence Rate Due to Self Isolation



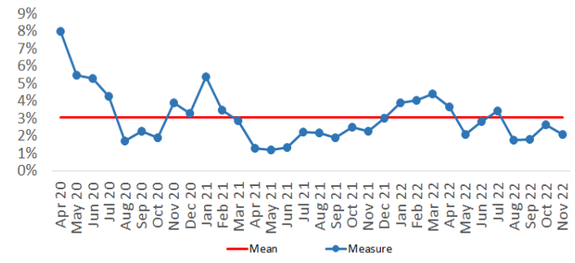

Monthly Absence Rate Due to Covid-19 Related Sickness Absence Reason



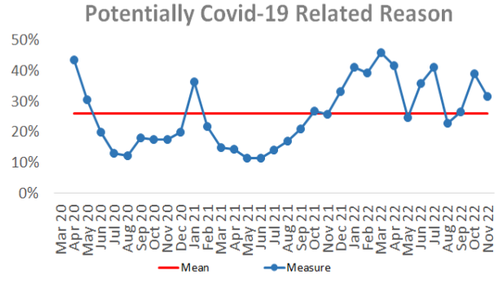

**Background Information: Monthly** absence figures due to Covid-19 are presented. This provides monthly absence information relating to FTE lost due to Self Isolation and potentially Covid-19 Related Sickness Absence (this includes chest & respiratory problems, influenza related sickness and infectious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

**What the information tells us:** The Trust's monthly absence rate due to Self Isolation has remained the same at 0.6%. Monthly absence rate due to potential Covid-19 related sickness has decreased by 0.5% to 1.5% in November 2022. Overall, absence rates due to Covid-19 related sickness and self isolation decreased by 0.6% to 2.1%.

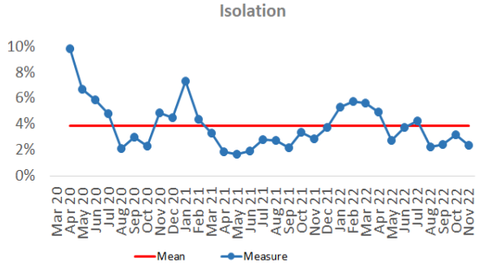
Monthly Absence Rate Due to Self Isolation & C19 Related Sickness Absence



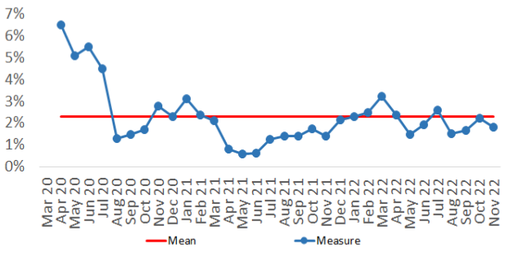

% of Sickness Absence Due to Potentially Covid-19 Related Reason



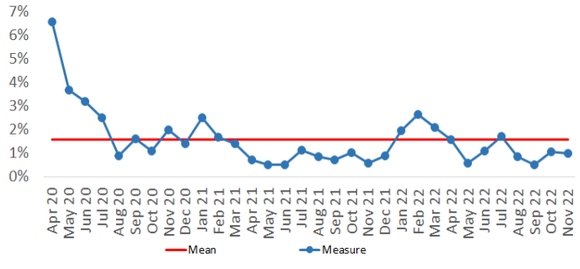

Nursing and Midwifery Registered
Monthly Absence Rate due to C19 Related Sickness/Self Isolation



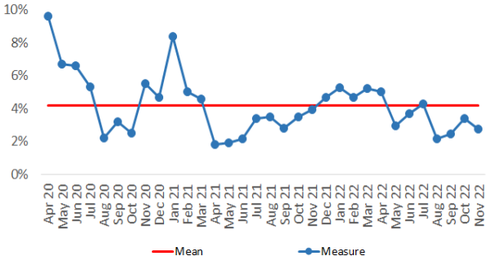

Administrative and Clerical
Monthly Absence Rate due to C19 Related Sickness/Self Isolation



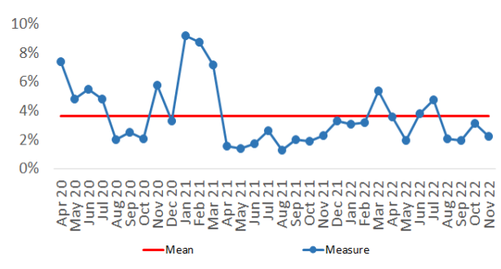

Medical and Dental
Monthly Absence Rate due to C19 Related Sickness/Self Isolation



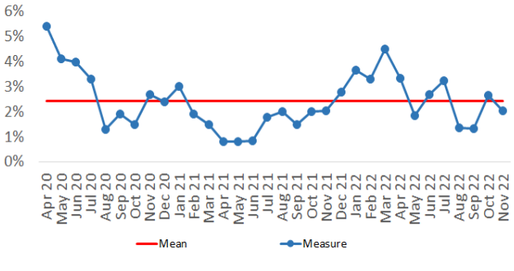

Additional Clinical Services
Monthly Absence Rate due to C19 Related Sickness/Self Isolation




Estates and Ancilliary
Monthly Absence Rate due to C19 Related Sickness/Self Isolation




Other Clinical Services (AHPs, HCS & Add. Prof.)
Monthly Absence Rate due to C19 Related Sickness/Self Isolation





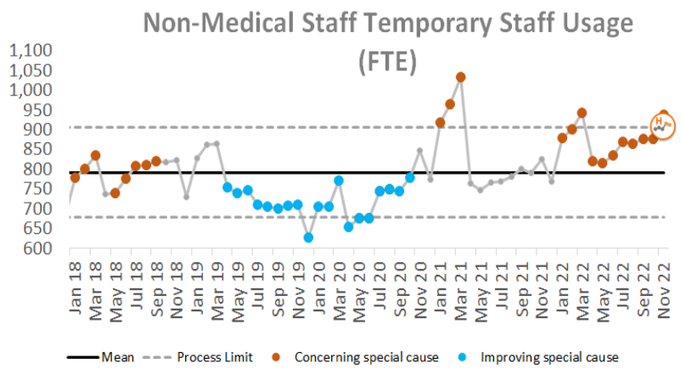

Author(s): Tosin Okufuwa, Amanda Wood

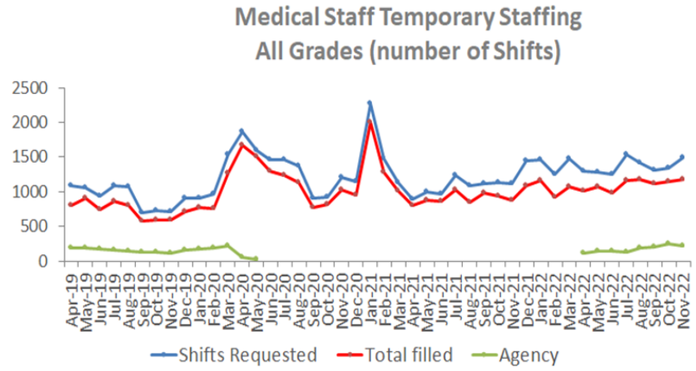
Owner(s): David Wherrett

# Temporary Staffing

Cambridge University Hospitals NHS Foundation Trust

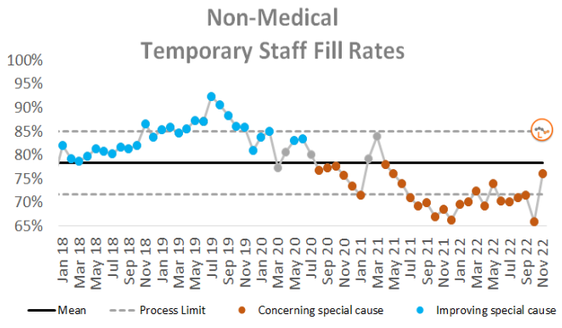
Workforce: Temporary Staffing

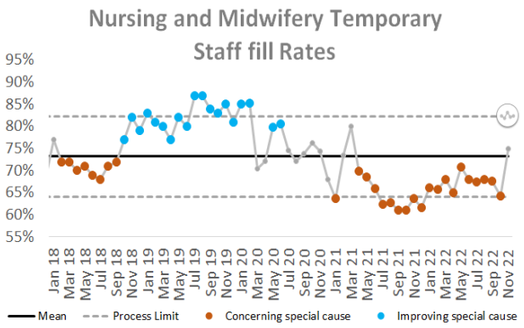


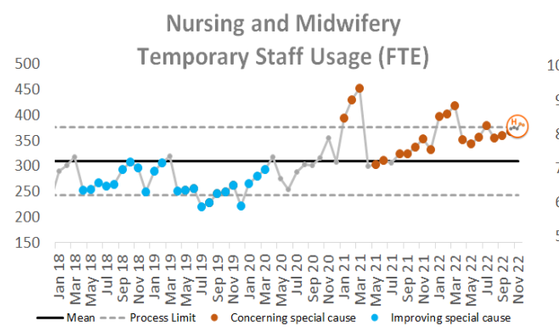



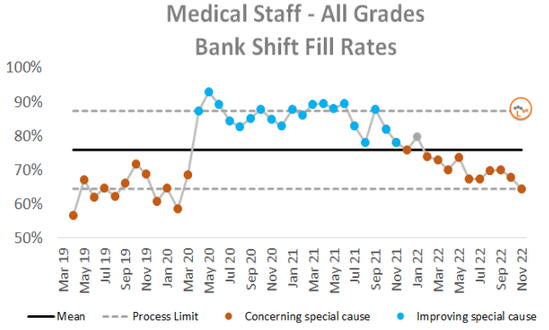

**Background Information**: The Trust works to ensure that temporary vacancies are filled with workers from staff bank in order to minimise agency usage, ensure value for money and to ensure the expertise and consistency of staffing.

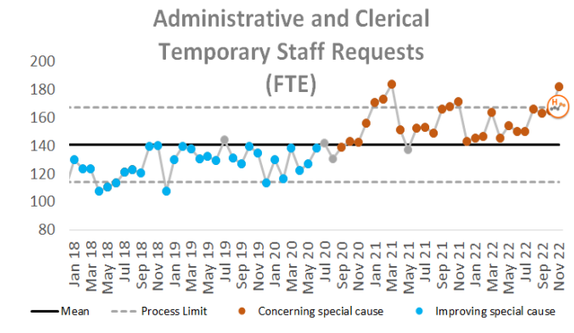
**What the information tells us:** Demand for non-medical temporary staff decreased by 7.2% from the previous month to 1,235 WTE. Top three reasons for request includes vacancy (48%), increased workload (18%) and sickness (14%). Nursing and midwifery agency usage increased by 2.5 WTE from the previous month to 41.3 WTE. This accounts for 11% of the total nursing filled shifts. Overall, fill rate has improved by 10% from last month to 76% in November 2022.

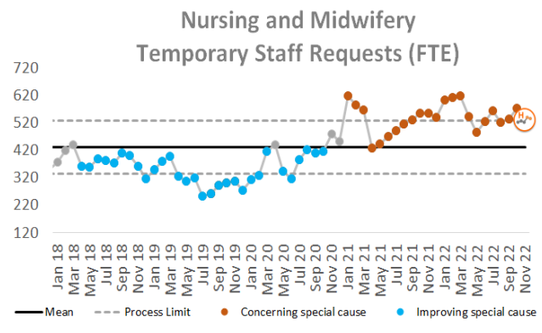


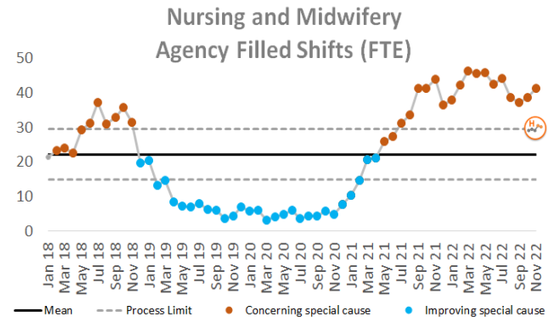



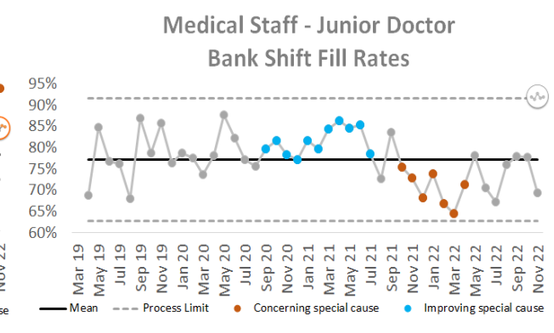



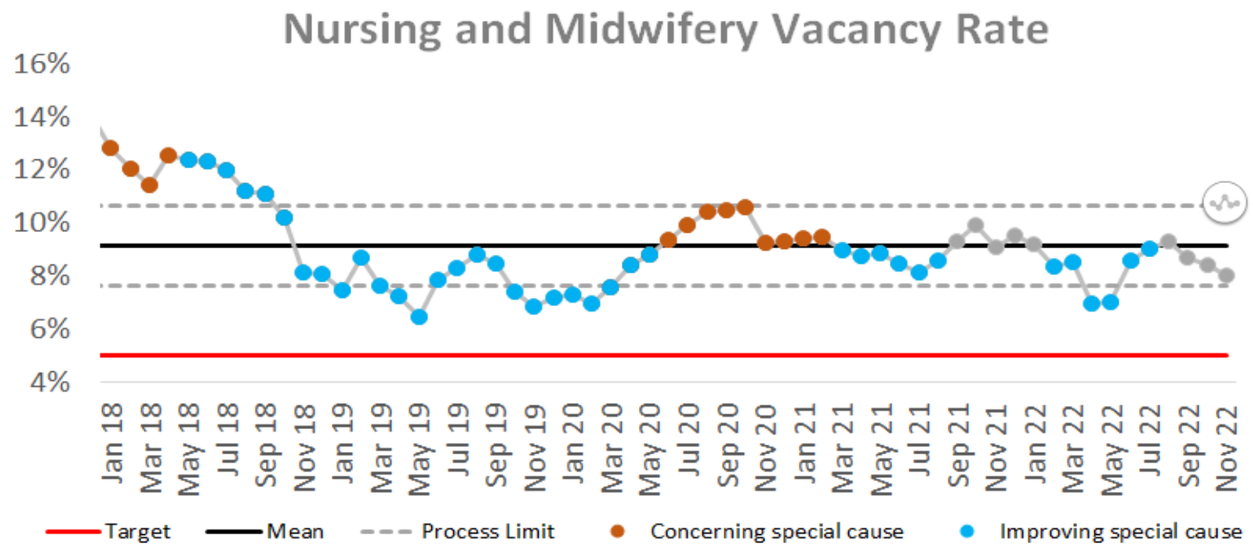



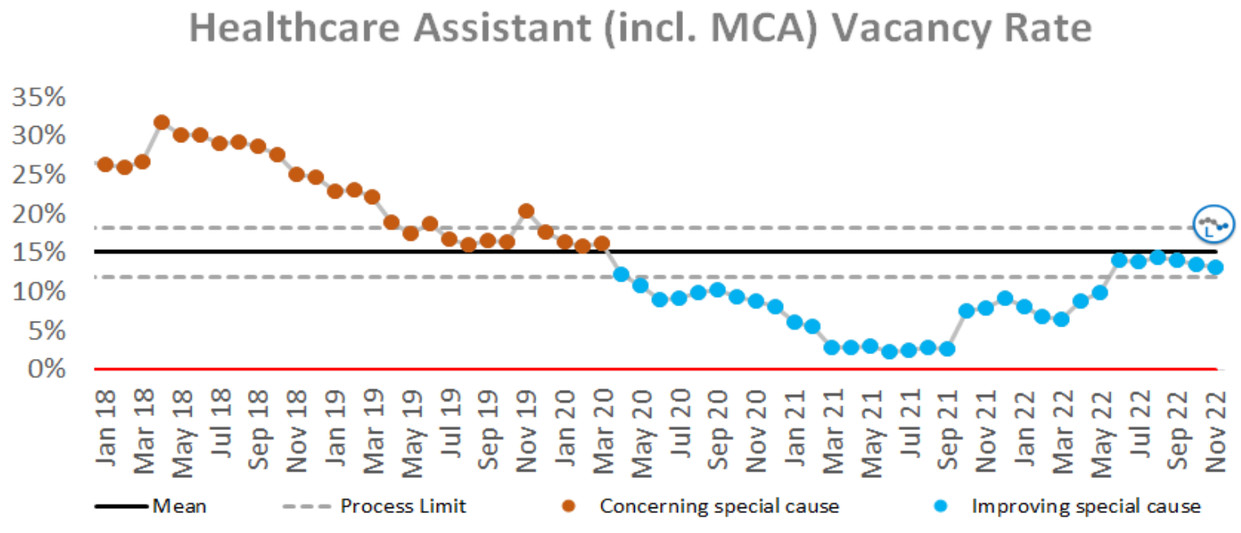

*Please note that temporary Medical staffing data was not available at the time of reporting and hence not updated

# ESR Vacancy Rate

Cambridge University Hospitals NHS Foundation Trust

Workforce: ESR Vacancy Rate




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

**What the information tells us:** The vacancy rate for both Healthcare Assistants and Nursing and Midwifery remained below the average rate at 13.1% and 8.0% respectively. This is a decrease for both groups from last month. However, the vacancy rate for both staff groups are above the target rate of 5% for Nurses and 0% for HCAs.



Author(s): Tosin Okufuwa, Amanda Wood

Owner(s): David Wherrett

# Annual Leave Update

Cambridge University Hospitals NHS Foundation Trust

Percentage of Annual Leave (AL) Taken – Nov 22 Breakdown (source: Healthroster)

| | 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 | 48,300 | 28,657 | 59.3% | 97% |
| | Additional Clinical Services | 365,357 | 227,326 | 62.2% | 98% |
| | Administrative and Clerical | 470,804 | 277,183 | 58.9% | 96% |
| | Allied Health Professionals | 144,575 | 88,040 | 60.9% | 99% |
| | Estates and Ancillary | 76,463 | 50,471 | 66.0% | 98% |
| | Healthcare Scientists | 136,759 | 80,229 | 58.7% | 97% |
| | Medical and Dental | 141,646 | 51,806 | 36.6% | 36% |
| | Nursing and Midwifery Registered | 760,466 | 481,659 | 63.3% | 98% |
| | **Trust** | **2,144,371** | **1,285,371** | 59.9% | 89% |
| *Annual Leave taken by Division* | *Division* | | | | |
| | Corporate | 296,101 | 178,579 | 60% | 95% |
| | Division A | 407,637 | 244,938 | 60% | 87% |
| | Division B | 590,383 | 353,706 | 60% | 93% |
| | Division C | 276,722 | 161,215 | 58% | 81% |
| | Division D | 251,831 | 153,394 | 61% | 86% |
| | Division E | 230,070 | 143,610 | 62% | 85% |
| | R&D | 91,627 | 49,929 | 54% | 94% |

* Greater than 53% | Less than 40% | Between 40% and 53%

**What the information tells us:** The Trust's annual leave usage is 90% of the expected usage after the eighth month of the financial year. Overall usage is 59.9% compared to the expected 67%. The highest rate of use of annual leave is within the Estates and Ancillary staff group, followed by Nursing and Midwifery Registered staff at 66% and 63% respectively.

Not all medical staff record annual leave on the Healthroster system. Local recording is permitted. The percentage of annual leave taken should not be considered representative for medical staff.

# Mandatory Training by Division and Staff Group

Cambridge University Hospitals NHS Foundation Trust

Workforce: Mandatory Training

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

| | | Induction | | | | Mandatory Training Competency (as defined by Skills for Health) | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Non-Medical | | Medical | | | | | | | | | | | | | | | | |
| | | Corporate Induction | Local Induction | Corporate Induction | Local Induction | Conflict Resolution | Equality, Diversity and Human Rights | Fire Safety | Health, Safety and Welfare | Infection Control | Information Governance including GDPR and Cyber Security | Moving & Handling | Resuscitation | Safeguarding Adults | Safeguarding Adult Lvl 2 | Safeguarding Children Lvl 1 | Safeguarding Children Lvl 2 | Safeguarding Children Lvl 3 | Prevent Level Three (WRAP) | Total Compliance |
| Frequency | | | | | | 3 yrs | 3 yrs | 2 yrs/1yr | 3yrs | 2 yrs | 1 yr | 2 yrs/1yrs | 2 yrs/1yrs | 3 yrs | 3 yrs | 3 yrs | 3 yrs | 3 yrs/1yr | 3 yrs | |
| Delivery Method | | cl | f2f | cl/ | f2f | cl/e/ | cl/e/ | cl/e/ | cl/e/ | cl/e/ | cl/e/ | cl/e/ | cl/el | cl/e/ | cl/el | cl/el | cl/el | cl/el | cl | |
| Staff Requiring Competency | | 999 | 997 | 420 | 419 | 10,603 | 10,603 | 10,798 | 10,603 | 10,603 | 10,603 | 10,804 | 7,364 | 10,603 | 7,810 | 10,603 | 7,796 | 1,853 | 1,485 | |
| Compliance by Division | | | | | | | | | | | | | | | | | | | | |
| Compliance by Division | Division A | (19)88.9% | (38)77.8% | (18)83.9% | (11)90.1% | (48)97.6% | (46)97.7% | (302)85.4% | (49)97.6% | (96)95.3% | (178)91.2% | (259)87.5% | (354)80.8% | (64)96.8% | (175)90.7% | (48)97.6% | (162)91.4% | (90)62.8% | (44)77.6% | 92.0% |
| | Division B | (16)94.2% | (42)84.7% | (9)84.5% | (8)86.2% | (52)98.1% | (63)97.7% | (233)91.6% | (67)97.6% | (139)95.0% | (192)93.0% | (345)87.6% | (300)79.5% | (81)97.1% | (197)89.0% | (64)97.7% | (177)90.0% | (22)82.5% | (10)92.1% | 93.4% |
| | Division C | (18)89.9% | (37)79.3% | (14)89.6% | (10)92.5% | (51)96.6% | (62)95.9% | (229)85.3% | (70)95.4% | (91)94.0% | (180)88.1% | (272)82.6% | (310)78.7% | (87)94.2% | (132)91.0% | (62)95.9% | (130)91.2% | (65)74.7% | (27)89.5% | 90.4% |
| | Division D | (6)93.5% | (25)72.8% | (13)81.2% | (10)85.5% | (48)96.3% | (53)96.0% | (186)86.0% | (58)95.6% | (93)92.9% | (172)86.9% | (270)79.7% | (302)73.2% | (67)94.9% | (119)89.6% | (52)96.0% | (98)91.5% | (32)76.6% | (29)78.7% | 89.7% |
| | Division E | (7)93.5% | (21)80.4% | (8)79.5% | (9)76.9% | (28)97.7% | (29)97.6% | (191)85.1% | (37)97.0% | (73)94.0% | (121)90.1% | (302)76.5% | (229)80.5% | (58)95.2% | (129)89.1% | (35)97.1% | (100)91.6% | (265)75.1% | (82)89.0% | 89.7% |
| | Corporate | (13)90.0% | (27)79.1% | (6)14.3% | (6)14.3% | (35)97.4% | (44)96.7% | (83)93.9% | (46)96.6% | (68)95.0% | (113)91.6% | (92)93.2% | (24)84.0% | (65)95.2% | (16)90.3% | (54)96.0% | (16)90.5% | (8)55.6% | (4)75.0% | 94.4% |
| | R & D | (1)97.7% | (4)90.9% | | | (6)98.6% | (8)98.1% | (19)95.5% | (7)98.3% | (18)95.7% | (22)94.8% | (38)91.0% | (14)90.5% | (11)97.4% | (10)94.2% | (10)97.6% | (10)94.2% | (3)66.7% | (1)83.3% | 95.9% |
| | Breakdown of Medical staff compliance | | | | | | | | | | | | | | | | | | | |
| | Consultant | | | (7)86.0% | (12)76.0% | (17)97.7% | (19)97.4% | (46)93.8% | (23)96.9% | (47)93.6% | (74)89.9% | (41)94.4% | (173)76.8% | (27)96.3% | (43)94.2% | (18)97.6% | (39)94.8% | (31)86.3% | (17)91.6% | 93.2% |
| | Non Consultant | | | (61)83.5% | (42)88.6% | (82)88.4% | (87)87.7% | (122)82.8% | (108)84.8% | (143)79.8% | (208)70.7% | (164)76.9% | (471)46.2% | (133)81.2% | (208)76.0% | (108)84.8% | (200)77.0% | (100)52.2% | (37)76.7% | 77.5% |
| Compliance by Staff Group | Compliance by Staff group | | | | | | | | | | | | | | | | | | | |
| | Add Prof Scientific and Technic | (0)100.0% | (1)95.5% | | | (4)98.2% | (4)98.2% | (5)97.7% | (4)98.2% | (8)96.3% | (14)93.6% | (10)95.4% | (8)75.0% | (4)98.2% | (19)90.4% | (4)98.2% | (17)91.1% | (6)14.3% | (6)14.3% | 95.3% |
| | Additional Clinical Services | (35)85.4% | (43)82.0% | | | (28)98.4% | (30)98.3% | (260)85.4% | (28)98.4% | (67)96.1% | (139)91.9% | (365)79.5% | (310)77.9% | (39)97.7% | (200)87.3% | (30)98.3% | (178)88.7% | (50)67.9% | (17)82.3% | 91.3% |
| | Administrative and Clerical | (18)92.2% | (40)82.7% | | | (57)97.4% | (65)97.1% | (90)95.9% | (67)97.0% | (113)94.9% | (163)92.6% | (121)94.5% | (2)77.8% | (97)95.6% | (14)87.6% | (83)96.3% | (12)89.6% | (5)16.7% | (2)66.7% | 95.4% |
| | Allied Health Professionals | (3)95.4% | (16)75.4% | | | (6)99.1% | (8)98.7% | (80)87.8% | (9)98.6% | (28)95.6% | (40)93.7% | (136)79.4% | (111)83.1% | (14)97.8% | (34)94.8% | (8)98.7% | (36)94.5% | (12)80.3% | (5)91.8% | 93.2% |
| | Estates and Ancillary | (4)87.9% | (4)87.5% | | | (4)98.8% | (4)98.8% | (20)94.0% | (4)98.8% | (7)97.9% | (23)93.1% | (2)99.4% | (2)99.4% | (6)98.2% | (6)98.2% | (4)98.8% | | | | 97.3% |
| | Healthcare Scientists | (0)100.0% | (6)81.8% | | | (6)99.0% | (10)98.3% | (31)94.8% | (9)98.5% | (22)96.3% | (37)93.8% | (44)92.7% | (18)83.8% | (8)98.7% | (40)77.9% | (8)98.7% | (21)87.1% | (3)83.3% | (1)94.4% | 95.6% |
| | Medical and Dental | | | (68)83.8% | (54)87.1% | (99)93.1% | (106)92.7% | (168)88.4% | (131)90.9% | (190)86.9% | (282)80.5% | (205)85.8% | (644)60.3% | (160)88.9% | (251)84.4% | (126)91.3% | (239)85.2% | (131)69.9% | (54)85.0% | 85.1% |
| | Nursing and Midwifery Registered | (20)94.7% | (84)77.6% | | | (64)98.1% | (78)97.7% | (589)83.4% | (82)97.6% | (143)95.8% | (280)91.8% | (695)80.4% | (440)87.6% | (105)96.9% | (220)93.7% | (62)98.2% | (190)94.5% | (278)76.2% | (112)88.0% | 92.3% |
| | Trust Total | (80)92.0% | (194)80.5% | (68)83.8% | (54)87.1% | (268)97.5% | (305)97.1% | (1243)88.5% | (334)96.8% | (578)94.5% | (978)90.8% | (1578)85.4% | (1533)79.2% | (433)95.9% | (778)90.0% | (325)96.9% | (693)91.1% | (485)73.8% | (197)86.7% | 91.9% |

Greater than 94% | Less than 80% | Between 80% and 94%

Greater than 89% | Less than 75% | Between 75% and 89%



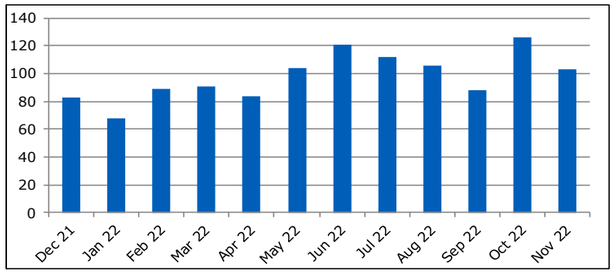
Author(s): Tosin Okufuwa, Amanda Coulier Owner(s): David Wherrett

# Health and Safety Incidents

Cambridge University Hospitals NHS Foundation Trust

Health and Safety

## No. of health and safety incidents affecting staff:

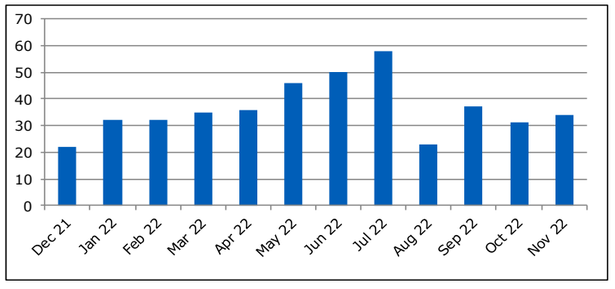



| | Dec 21 | Jan 22 | Feb 22 | Mar 22 | Apr 22 | May 22 | Jun 22 | Jul 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Accident | 12 | 17 | 16 | 21 | 16 | 15 | 14 | 20 | 15 | 18 | 16 | 18 | **198** |
| Blood/bodily fluid exposure (dirty sharps/splashes) | 12 | 15 | 17 | 18 | 17 | 16 | 19 | 20 | 16 | 13 | 32 | 14 | **209** |
| Environmental Issues | 4 | 1 | 5 | 4 | 10 | 4 | 7 | 20 | 16 | 1 | 6 | 1 | **79** |
| Moving and Handling | 7 | 5 | 3 | 4 | 3 | 3 | 5 | 2 | 4 | 7 | 2 | 0 | **45** |
| Sharps (clean sharps/incorrect disposal & use) | 3 | 2 | 7 | 3 | 6 | 8 | 4 | 8 | 10 | 5 | 8 | 9 | **73** |
| Slips, Trips, Falls | 9 | 4 | 6 | 8 | 7 | 8 | 7 | 3 | 5 | 10 | 4 | 6 | **77** |
| Violence & Aggression | 34 | 22 | 32 | 29 | 23 | 45 | 61 | 36 | 36 | 34 | 57 | 52 | **461** |
| Work-related ill-health | 2 | 2 | 3 | 4 | 2 | 5 | 4 | 3 | 4 | 0 | 1 | 3 | **33** |
| **Total** | **83** | **68** | **89** | **91** | **84** | **104** | **121** | **112** | **106** | **88** | **126** | **103** | **1175** |

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

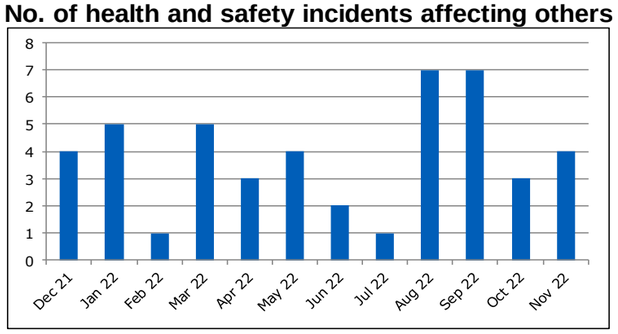
| | Dec 21 | Jan 22 | Feb 22 | Mar 22 | Apr 22 | May 22 | Jun 22 | Jul 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No. of health & safety incidents | 83 | 68 | 89 | 91 | 84 | 104 | 121 | 112 | 106 | 88 | 126 | 103 | **1175** |
| Staff incident rate per month/year | 0.8 | 0.6 | 0.8 | 0.8 | 0.8 | 1.0 | 1.1 | 1.0 | 1.0 | 0.8 | 1.2 | 0.9 | **10.7** |

## No. of health and safety incidents affecting patients:




| | Dec 21 | Jan 22 | Feb 22 | Mar 22 | Apr 22 | May 22 | Jun 22 | Jul 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Accident | 7 | 11 | 11 | 17 | 19 | 25 | 20 | 20 | 8 | 13 | 13 | 13 | **177** |
| Blood/bodily fluid exposure (dirty sharps/splashes) | 3 | 0 | 1 | 4 | 2 | 1 | 1 | 1 | 0 | 3 | 0 | 0 | **16** |
| Environmental Issues | 4 | 0 | 4 | 3 | 2 | 1 | 4 | 12 | 2 | 0 | 3 | 8 | **43** |
| Equipment / Device - Non Medical | 0 | 1 | 2 | 1 | 0 | 1 | 1 | 2 | 1 | 0 | 1 | 3 | **13** |
| Moving and Handling | 0 | 3 | 1 | 1 | 0 | 0 | 5 | 2 | 2 | 1 | 0 | 3 | **18** |
| Sharps (clean sharps/incorrect disposal & use) | 3 | 3 | 2 | 1 | 0 | 0 | 3 | 2 | 2 | 2 | 1 | 0 | **19** |
| Violence & Aggression | 5 | 14 | 11 | 8 | 13 | 18 | 16 | 19 | 8 | 18 | 13 | 7 | **150** |
| **Total** | **22** | **32** | **32** | **35** | **36** | **46** | **50** | **58** | **23** | **37** | **31** | **34** | **436** |

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



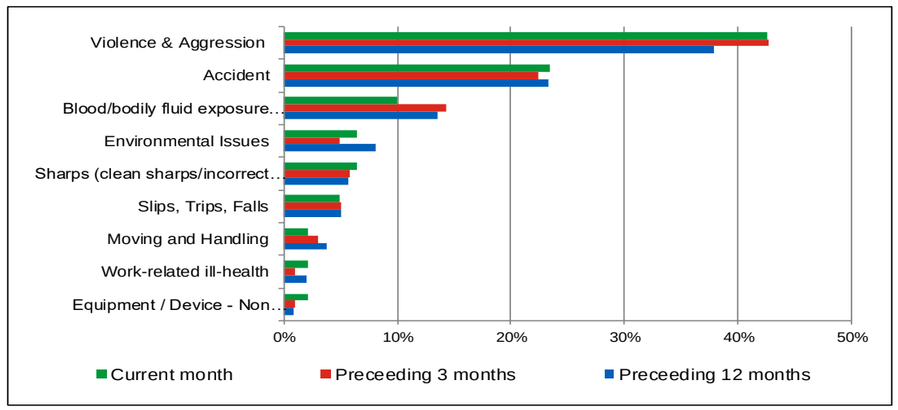

| | Dec 21 | Jan 22 | Feb 22 | Mar 22 | Apr 22 | May 22 | Jun 22 | Jul 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Accident | 1 | 1 | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 3 | 1 | 2 | **11** |
| Environmental Issues | 1 | 3 | 0 | 1 | 0 | 2 | 0 | 0 | 2 | 1 | 1 | 0 | **11** |
| Sharps (clean sharps/incorrect disposal & use) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | **1** |
| Slips, Trips, Falls | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 1 | **6** |
| Violence & Aggression | 1 | 1 | 1 | 3 | 3 | 0 | 0 | 1 | 3 | 2 | 1 | 1 | **17** |
| **Total** | **4** | **5** | **1** | **5** | **3** | **4** | **2** | **1** | **7** | **7** | **3** | **4** | **46** |

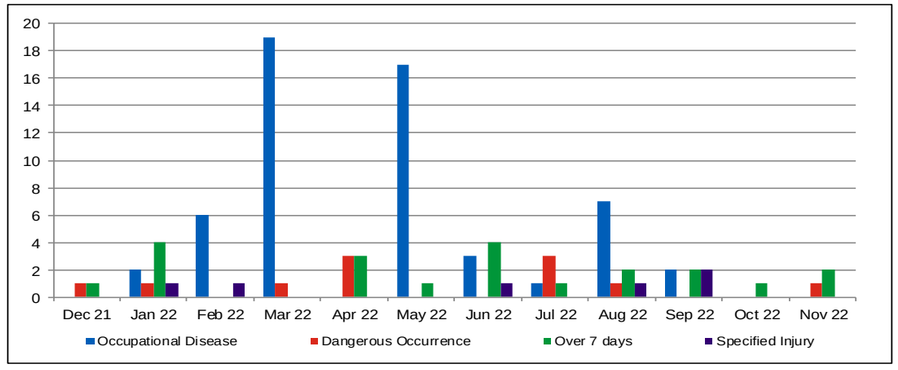
# Health and Safety Incidents

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: | **1657** | **323** | **253** | **475** | **310** | **163** | **48** | **85** |
| Accident | **386** | 88 | 79 | 81 | 66 | 37 | 3 | 32 |
| Blood/bodily fluid exposure (dirty sharps/splashes) | **225** | 62 | 41 | 42 | 45 | 28 | 6 | 1 |
| Environmental Issues | **133** | 20 | 33 | 7 | 25 | 27 | 6 | 15 |
| Equipment / Device - Non Medical | **13** | 2 | 0 | 4 | 3 | 4 | 0 | 0 |
| Moving and Handling | **63** | 10 | 15 | 11 | 14 | 5 | 2 | 6 |
| Sharps (clean sharps/incorrect disposal & use) | **93** | 35 | 18 | 12 | 9 | 10 | 7 | 2 |
| Slips, Trips, Falls | **83** | 27 | 15 | 9 | 5 | 9 | 6 | 12 |
| Violence & Aggression | **628** | 70 | 45 | 307 | 138 | 41 | 12 | 15 |
| Work-related ill-health | **33** | 9 | 7 | 2 | 5 | 2 | 6 | 2 |




A total of 1,657 health and safety incidents were reported in the previous 12 months.

806 (49%) incidents resulted in harm. The highest reporting categories were violence and aggression (38%), accidents (23%) and blood/bodily fluid exposure (14%).

1,175 (71%) of incidents affected staff, 436 (26%) affected patients and 46 (3%) affected others i.e. contractors and members of the public.

The highest reported incident categories for staff were: violence and aggression (39%), blood/bodily fluid exposure (18%) and accidents (17%).

The highest reported incident categories for patients were: accidents (41%), violence & aggression (34%) and environmental issues (10%).

The highest reported incident categories for others were: violence and aggression (37%), environmental issues (24%) and accidents (24%).

Staff incident rate is 10.7 per 100 members of staff (by headcount) over a rolling 12 month period.

The highest reporting division was division C with 475 incidents. Of these, 65% related to violence & aggression.

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

In November 2022, 3 incidents were reported to the HSE:
Over 7 day injury (2)

- The Injured Person (IP) was moving a trolley of lead aprons and the wheels caught on a rubber joint on the floor, causing the trolley to topple over. The IP tripped on the falling trolley sustaining a soft tissue sprain to the right hip and elbow.
- The IP was working from a step ladder when they missed their footing and fell. The IP experienced pain in the knee and shoulder.

Dangerous occurrence (1)

- A patient on the ward tested positive for COVID-19 on 26.10.2022. The patient was booked to attend the lung function for tests on 27.10.2022. The patient was collected and brought down for lung function tests, however the patient was not well enough to undertake the tests and was returned to the ward. The staff in lung function were not aware of the patient's COVID-19 positive status until after the patient had returned to the ward. COVID-19 positive patients should not attend lung function due to the risk to other patients. The physiologist who saw the patient wore a surgical mask. There has been no known transmission as a result of this near miss.



Author(s): Helen Murphy

Owner(s):

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

# Report to the Board of Directors: 18 January 2023

| | |
|---|---|
| **Agenda item** | 9.1 |
| **Title** | Nurse safe staffing |
| **Sponsoring executive director** | Lorraine Szeremeta, Chief Nurse |
| **Author(s)** | Amanda Small, Interim Deputy Chief Nurse<br>Sarah Raper, Roster Support Lead<br>Annesley Donald, Deputy Director of Workforce |
| **Purpose** | To provide the Board with the monthly nurse safe staffing report. |
| **Previously considered by** | Management Executive, 12 January 2023 |

## Executive Summary

The nursing and midwifery safe staffing report for November 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 November 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: 18 January 2023**

# Executive Summary

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

The vacancy position has decreased slightly in November for Health Care Support Workers (HCSWs) to 12.9% from 13.3% in October, Registered children's nurses (RSCNs) to 20.1% from 21.3% in October and Registered Nurses (RNs) to 8.7% compared to 9.2% in October. The vacancy position for Registered Midwifes (RMs) has remained relatively static at 2.9% compared to 2.8% in October. Conversely the vacancy position for maternity care assistants (MCA's) has increased slightly to 17.3% from 16.3% in October.

Turnover rate remains high at 13.2% for RNs, 12.2% for RMs, 15.1% for RSCNs and 18.0% for HCSWs. The main reason for leaving for RNs, HCSWs and RSCNs is voluntary resignation – relocation whereas for RMs it is cited as being due to Voluntary resignation – work/life balance.

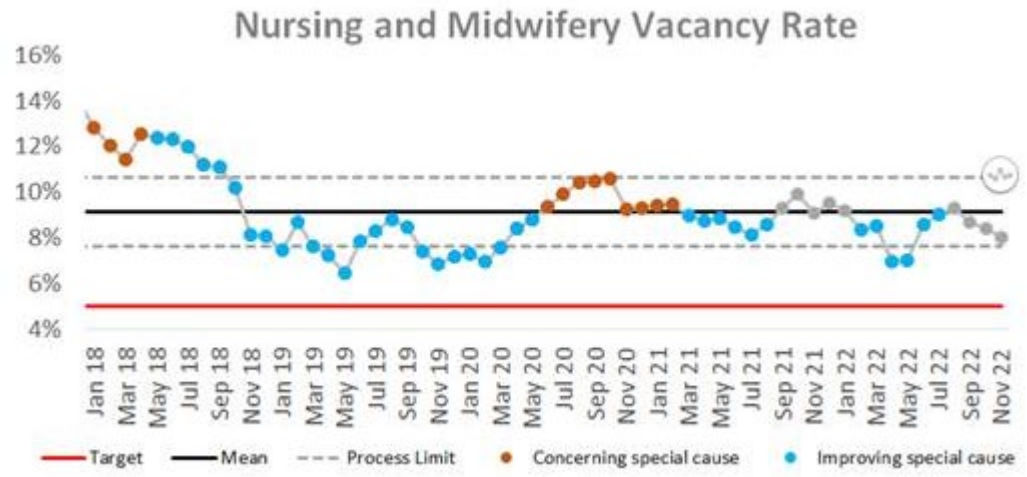
The planned versus actual staffing report demonstrates that 7 clinical areas reported <90% rota fill in November. The overall fill rate for maternity has increased to 91.4% compared to 85% in October. The total unavailability of the workforce working time in November has decreased slightly to 28.2% from 29.9% in October. The majority of unavailability (12.8%) is due to planned annual leave, sickness absence has reduced slightly at 8.1% compared with 9.3% in October. Additionally, 1.6% of working time was unavailable due to other leave which is comparable to October (1.5%), 3.5% was due to study leave and 2.1% was due to supernumerary time.

In order to mitigate staffing risks, the number of requests for bank workers remains high with an average of 2181 shifts per week requested for registered staff and 1928 shifts requested for Health care support workers and Maternity support workers per week with an average bank fill rate of 76.8% for registered staff and 63.4% for Health Care Support workers. In addition, the equivalent of 38.8WTE agency workers are working across the divisions. Despite this, redeployment of nurses and midwives has remained necessary due to staff unavailability, with an average of 220 working hours being redeployed each day of which 97.8% of the redeployed hours have been within division.

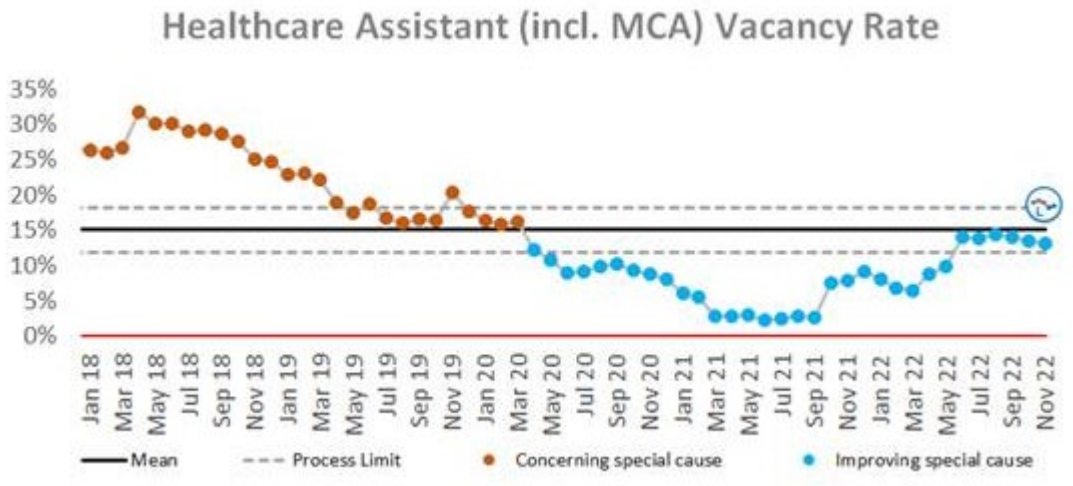
There has been a decrease in the number of occasions that 1 critical care nurse has needed to care for more than 1 level 3 patient in November (50 occasions compared to 108 in October). Additionally there have been 131 occasions where there has been no side room co-ordinator (165 in October). Any concerns with regards to critical care staffing are escalated through the senior nurse of the day. Staffing has been supported through the use of temporary workers (agency and bank), bank enhancements and registered staff (non critical care trained) are redeployed from the operational pool and clinical areas on a shift by shift basis. Critical care bed capacity remains at 52 beds rather than 59 beds whilst recruitment is ongoing to the vacant positions however it has been necessary to open an additional bed at times to support capacity.

# Combined Nursing and Midwifery Staffing Position Vacancy Rates

**Graph 1. Nursing and midwifery vacancy rates**




**Graph 2. Healthcare Assistant vacancy rates**



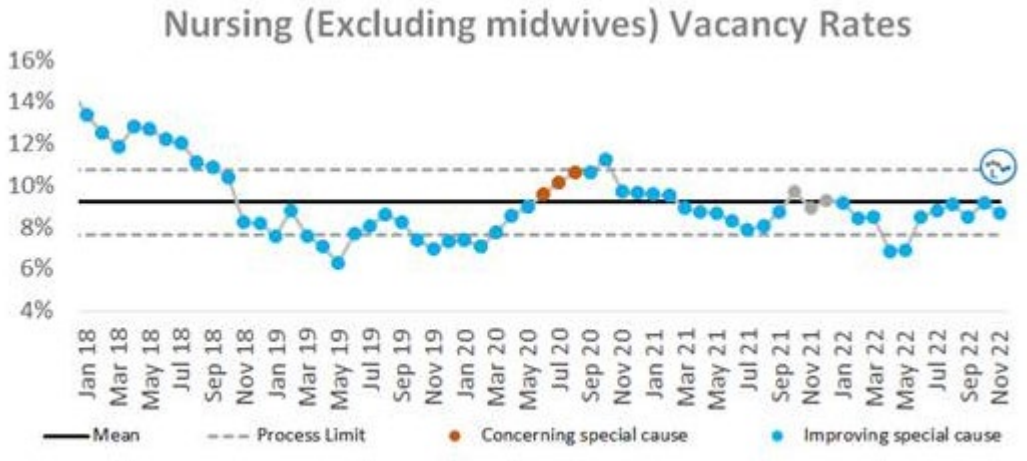

## Vacancy position

The combined vacancy rate for Registered Nurses (RNs) and Registered Midwives (RMs) has decreased slightly in November to 8.0% from 8.5% in October. The vacancy rate for Health care support workers (HCSWs) (including Maternity Care Assistants (MCAs) has also decreased to 13.1% from 13.5% in October. When broken down further into Nursing and Midwifery specific vacancies, the MCA workforce vacancy rate has increased from 16.3% in October to 17.3% in November. Conversely, the HCSW vacancy rate (excl MCA) has decreased slightly to 12.9% from 13.3% in October.

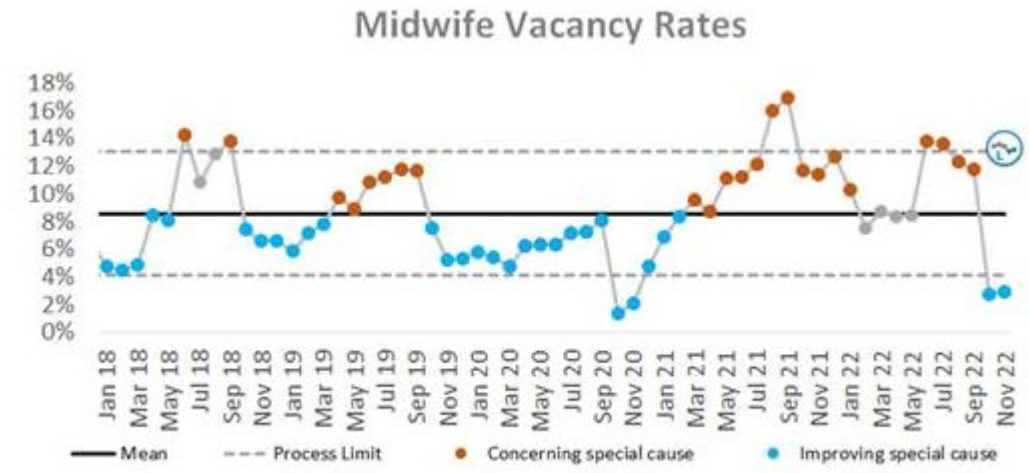
The HCSW (including MCAs) turnover rate remains high at 18.0% compared to 18.5% in October. The main reason for HCSWs leaving remains voluntary resignation – relocation (29.2%) and the next highest reason is voluntary resignation – work life balance (26.5%). The leavers destination is unknown for the majority of HCSWs (48.8%), 16.4% of HCSW's are leaving to take up employment in other NHS organisations and 14.2% are leaving for no employment.

# Staffing Position Vacancy Rates for Registered Nurses and Registered Midwives

**Graph 3. Registered Nurse vacancy rates**




**Graph 4. Registered Midwife vacancy rates**




**Vacancy position**

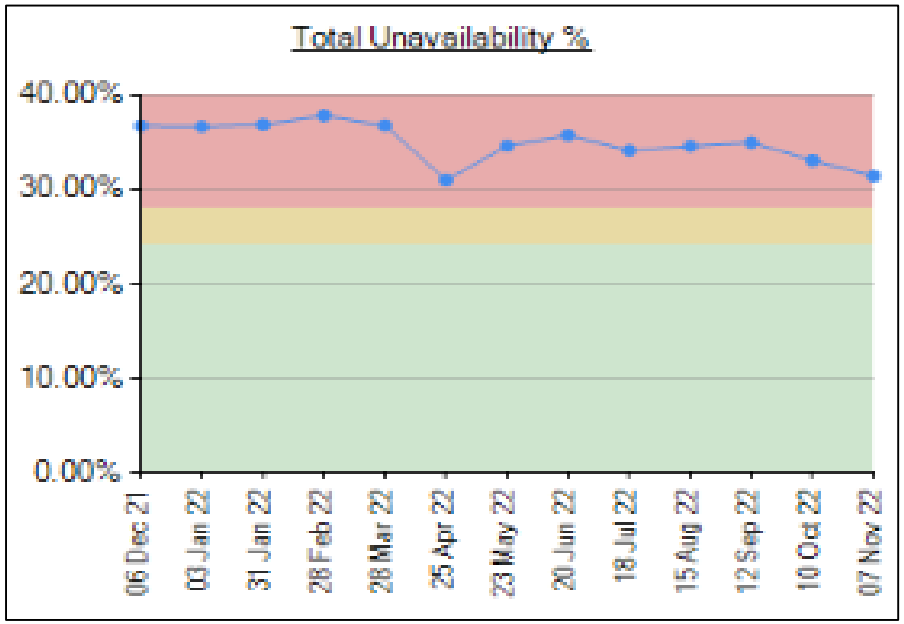
The vacancy rate for Registered Nurses working in adult areas has decreased slightly to 8.7% compared to 9.2% in October. The vacancy rate for registered children's nurses has also decreased to 20.1% from 21.3% in October.

The vacancy rate for Registered Midwives illustrates a sharp increase in Graph 4 in June however this was due to the work that had been undertaken to align the workforce Electronic Staff Record (ESR) and financial ledger to reflect the additional approved investment in maternity workforce. The actual vacancy rate had remained static for a number of months. Over the last 3 months, there has been a decreasing trend in the vacancy rate from 13.0% in July to 2.91% in November.

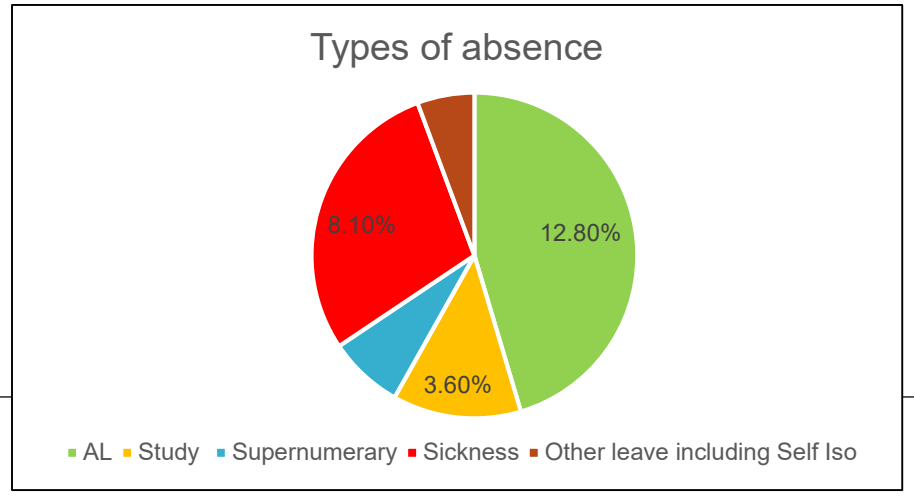
The turnover rate in November remains high at 13.2% for RNs in adult areas (13.6% in October), 15.1% for Registered children's nurses (15.4% in October) and 12.2% for RMs (12.6% in October). The main reason for leaving is voluntary resignation – relocation for RNs (50.1%). The main reasons for RMs leaving is voluntary resignation – work life balance (25.8%) whereas for RNs the main reason for leaving is voluntary resignation – relocation (49.9%). The leavers destination data demonstrates that 33.8% of RNs and 35.5% of RMs are leaving to take up employment in other NHS organisations. 29% of RMs are leaving for no employment compared with 6.8% of RNs.

# Unavailability for Registered Nurses, Midwives and Health Care Support Workers

**Graph 5. Unavailability of staff**




**Graph 6. Types of absence**



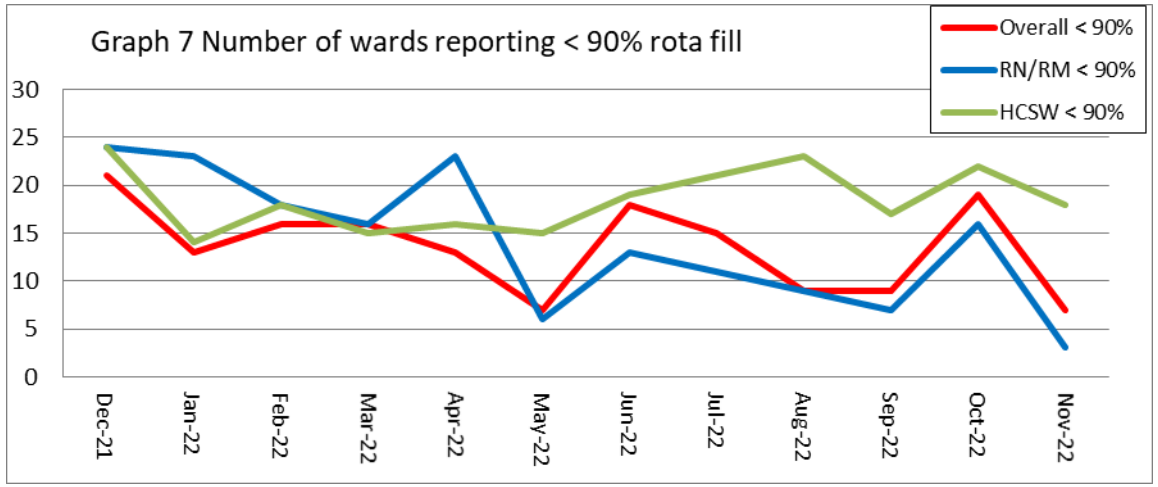

**Unavailability of staff**

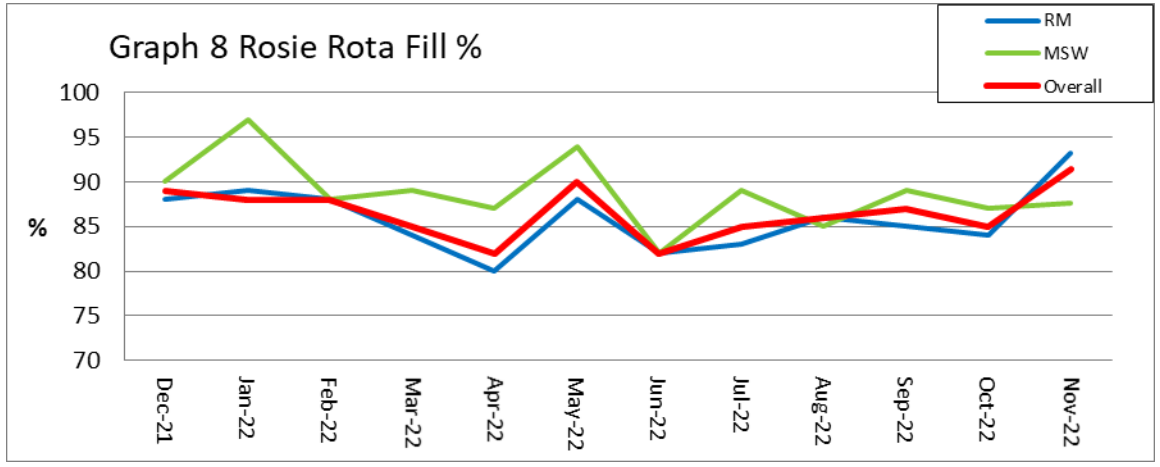
Unavailability relates to periods of time where an employee has been given leave from their regular duties. This might be due to circumstances such as annual leave, sick leave, study leave, self isolation, carers leave etc.

The total unavailability of the workforce working time in November has decreased slightly to 28.2% from 29.9% in October as illustrated in Graph 5.

Graph 6 illustrates the percentage breakdown of the type of unavailability. The majority of unavailability (12.8%) 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 November, sickness absence has reduced slightly at 8.1% compared with 9.3% in October. Additionally, 1.6% of working time was unavailable due to other leave which is comparable to October (1.5%), 3.5% was due to study leave and 2.1% was due to supernumerary time.

# Planned versus actual staffing




**Planned versus actual staffing**

Graph 7 illustrates trend data for all wards reporting < 90% rota fill. The number of areas reporting <90% rota fill for registered RN/RM has significantly decreased in November with 3 areas reporting <90% fill rates compared to 16 in October. There has also been a slight decrease in the number of areas reporting <90% rota fill for HCSWs in November with 18 clinical areas reporting HCSW fill rates of <90% compared with 22 in October. The number of ward areas reporting overall fill rates of <90% in November has also decreased to 7 from 19 in October.

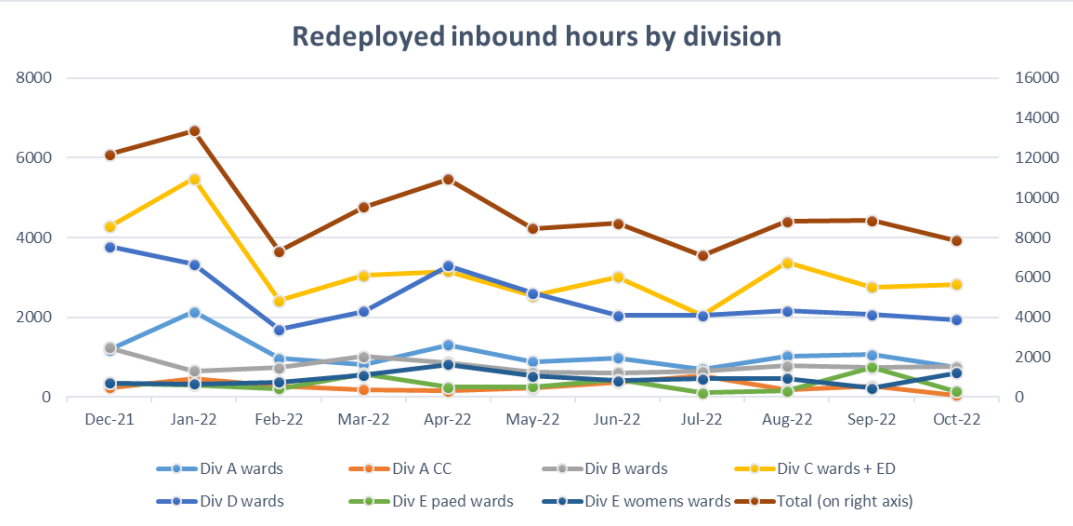
Division E reported the most areas (5) across paediatrics and maternity with overall fill rates of <90%. Division A and C reported 1 area each with overall fill rates of <90%. Appendix 1. details the exception reports for all areas reporting fill rates of <90%.

There has been a decrease in the number of occasions that 1 critical care nurse has needed to care for more than 1 level 3 patient in November (50 occasions compared to 108 in October). Additionally there have been 131 occasions where there has been no side room co-ordinator (165 in October). Any concerns with regards to critical care staffing are escalated through the senior nurse of the day. Staffing has been supported through the use of temporary workers (agency and bank), bank enhancements and registered staff (non critical care trained) are redeployed from the operational pool and clinical areas on a shift by shift basis. Critical care bed capacity remains at 52 beds rather than 59 beds whilst recruitment is ongoing to the vacant positions however it has been necessary to open an additional bed at times to support capacity.

**Midwifery & MSW fill rate**

Graph 8 illustrates that the overall fill rate for maternity has increased to 91.4% compared to 85% in October. The lowest fill rates have been seen on the Rosie Birth Centre (87%).

# 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 November has decreased slightly with an average of 220 working hours being redeployed per day compared with 253 hours in October. This equates to 19 long day or night shifts per day. The majority of redeployments are within division (97.8% compared to 2.2% 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.

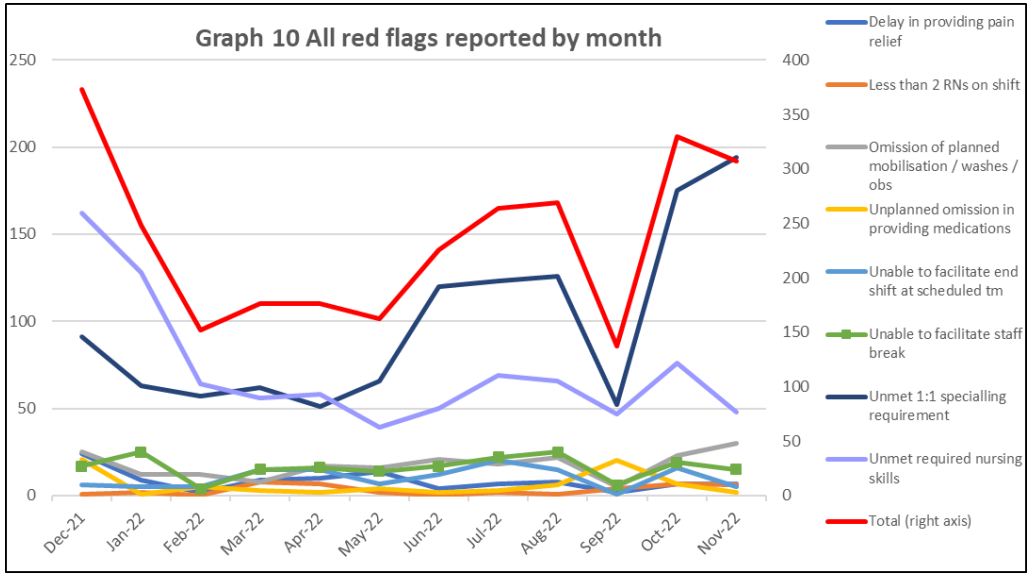
# Nursing Pipeline

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 10.74% which is 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.

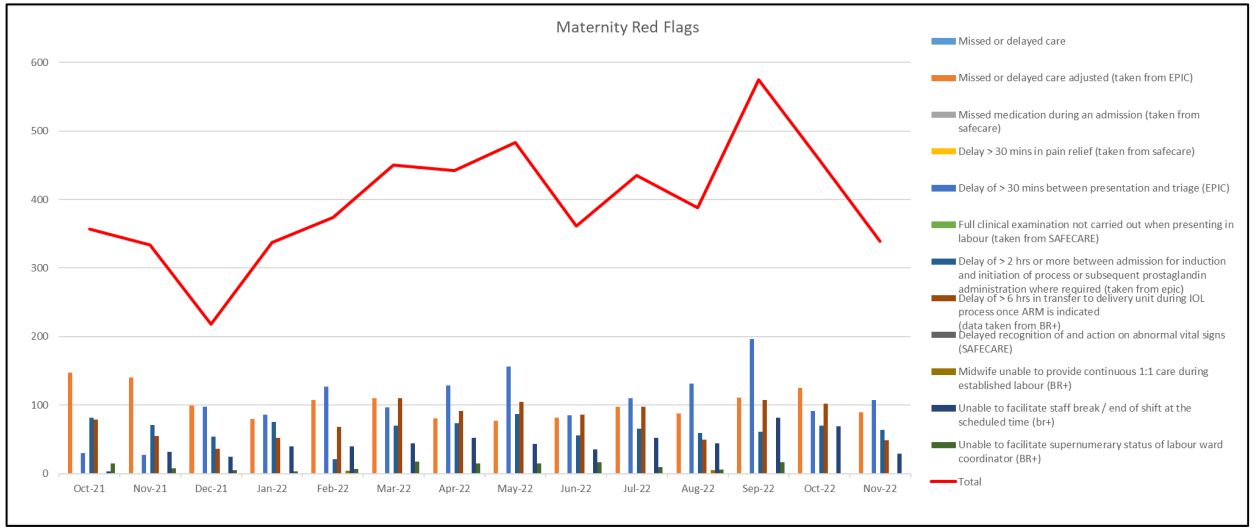
Appendix 3 provides detail on the forecasted position in relation to the number of Paediatric band 5 RN and HCSW vacancies up to March 2023. Numbers are based on those interviewed and offered positions in addition to planned campaigns. The current forecast demonstrates a year end band 5 Paediatric RN vacancy position of 21.92% and a band 2 HCSW position of 2.0%.

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.

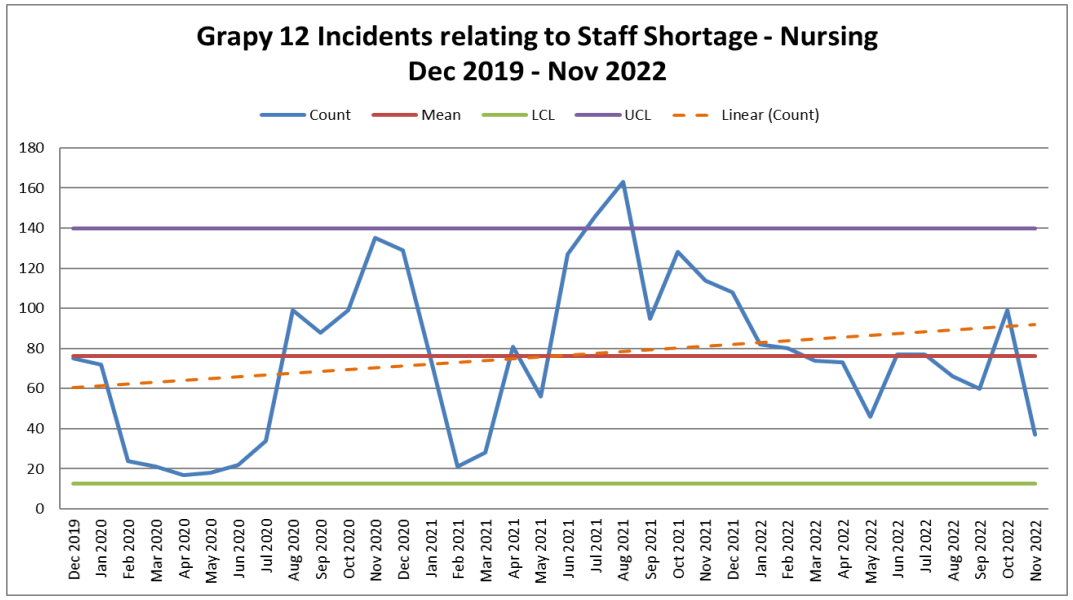
## Nursing red flags

Graph 10 illustrates that the number of red flags reported in November has decreased from 330 to 307. The highest number of red flags reported in November was in relation to an unmet 1:1 specialling requirement (194 compared with 175 in October). A trust wide improvement project focusing on specialling is being developed to review specialling across the organisation. Additionally, 48 red flags were reported in relation to an unmet required nursing skills compared with 76 in October.

## Maternity red flags

The number of maternity red flags reported over the last 3 months has been a decreasing trend with 575 reported in September compared to 339 in November. Graph 11 illustrates the red flags that have been reported. In November, 31.6% of these red flags were due to a delay of >30mins between presentation and triage, 26.5% were due to missed or delayed care and 18.9% were due to a delay of > 2 hrs or more between admission for induction and initiation of process or subsequent prostaglandin administration where required. This is reflective of the high levels of activity and difficulty in maintaining flow.

# Safety and Risk

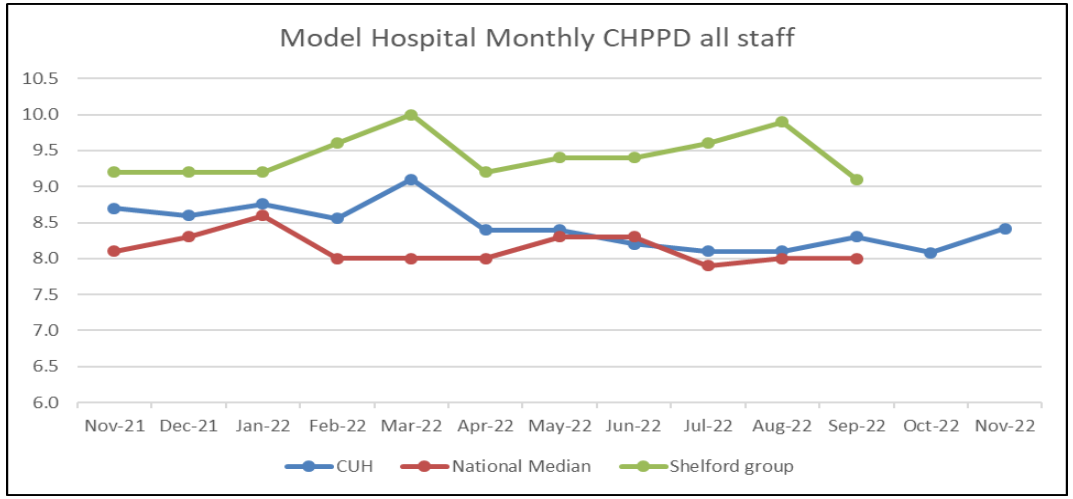



## Incidents reported relating to staff shortages

Graph 12 illustrates the trend in Safety Learning Reports (SLRs) completed in relation to nurse staffing. There were 37 incidents reported relating to nurse staffing in November which has decreased from the number reported in October (99).

The majority of the incidents related to staffing levels in November were reported by division C (18). Within Division C, the staffing incidents reported were spread across the division with Ward D5 reporting the most incidents (6). Safety continues to be monitored through the site safety meetings.

# Graph 13: Care Hours Per Patient Day (CHPPD)




## Care hours per patient day (CHPPD)

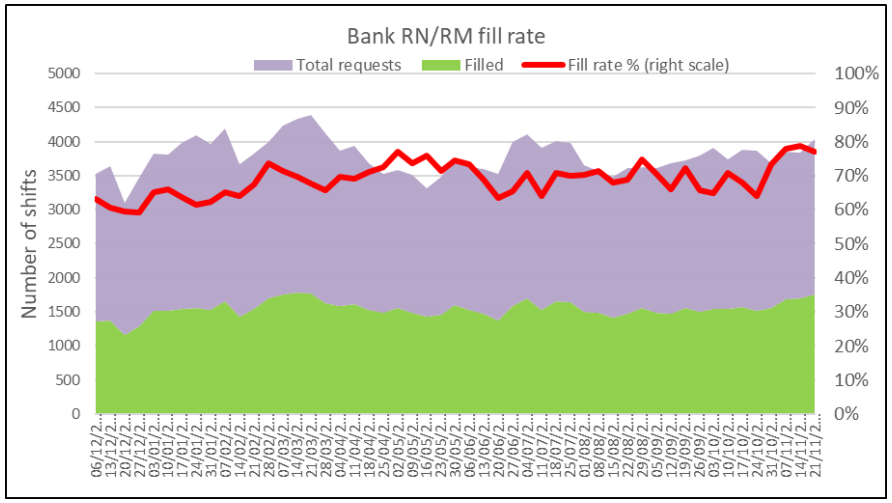
Care hours per patient day (CHPPD) is the total number of hours worked on the roster (clinical staff including AHPs) divided by the bed state captured at 23.59 each day. NHS Improvement began collecting care hours per patient day formally in May 2016 as part of the Carter Programme. All Trusts are required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

CUH CHPPD recorded for November has increased slightly to 8.42 from 8.1 in October which is comparable to the national median of 8.0 however is lower than other Shelford hospitals (9.1).

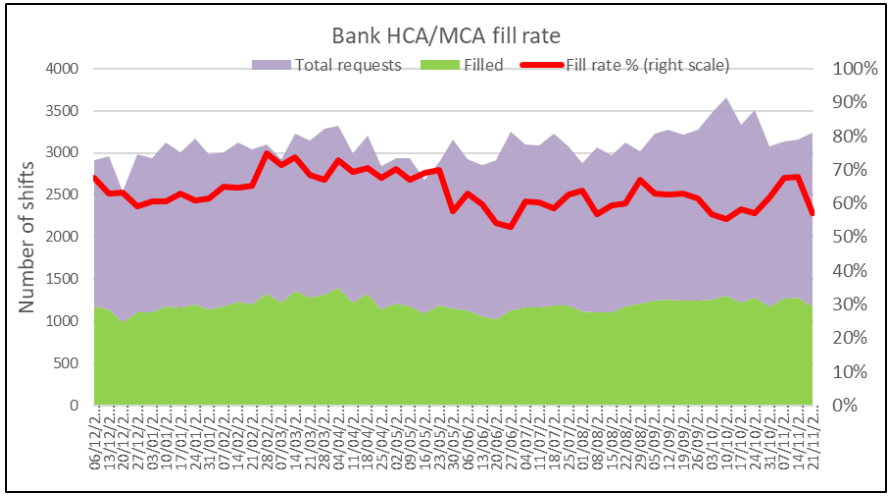
In maternity, from 1 April 2021, the total number of patients now includes babies in addition to transitional care areas and mothers who are registered as a patient. CHPPD for the delivery unit in November was 14.42 which is higher than October (11.85).

# 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

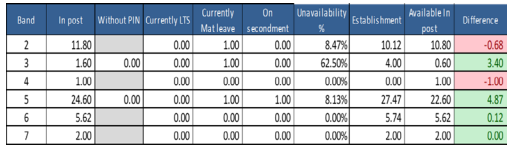
The Trust's Staff Bank continues to support the clinical areas with achieving safe staffing levels. Graph 14 and 15 illustrate the trends in bank shift fill rate per week. Overall we have seen an increase in bank shift requests for registered staff over the last 6 months to mitigate those areas who have less than a rota fill of 90%. The number of requests for registered staff is an average of 2181 shifts per week requested and an average bank fill rate of 76.8%.

The number of requests for Health care support workers and Maternity support workers remains high with an average of 1928 shifts per week requested and an average bank fill rate of 63.4%.

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

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

# Appendix 1: Exception report by Division – Division A and C

| Division A | % fill registered | % fill care staff | Overall filled % | CHPPD | Analysis of gaps | Impact on Quality / outcomes | Actions in place |
|---|---|---|---|---|---|---|---|
| C8 | 95% | 82% | 89% | 6.24 | Issues raised regarding staff morale and engagement. Listening events for C8 staff have captured anxieties and needs. Have changed the way in which the team were working as it meant higher ratios than budgeted for with SNCT. Leading to poor morale and engagement with low fill rate.  | 7 red metrics, 2 amber 9 green. Pressure ulcer screening, nutrition and falls remain red. Given the group of [patients elderly, frail these are concerning. Highlight unable to separate ortho and neurosurgery metrics. Staffing concerns seen within incidents and staff feedback. Direct impact on staff engagement and retention. | Daily divisional mitigation in place 0815 to identify areas of safety and patient concerns with all Matrons, band 7 and NIC. Retention and recruitment strategy in place to support. Listening events established. |

| Band | In post | Without PIN | Currently LTS | Currently Mat leave | On secondment | Unavailability % | Establishment | Available In post | Difference |
|---|---|---|---|---|---|---|---|---|---|
| 2 | 11.80 | | 0.00 | 1.00 | 0.00 | 8.47% | 10.12 | 10.80 | -0.68 |
| 3 | 1.60 | 0.00 | 0.00 | 1.00 | 0.00 | 62.50% | 4.00 | 0.60 | 3.40 |
| 4 | 1.00 | | 0.00 | 0.00 | 0.00 | 0.00% | 0.00 | 1.00 | -1.00 |
| 5 | 24.60 | 0.00 | 0.00 | 1.00 | 1.00 | 8.13% | 27.47 | 22.60 | 4.87 |
| 6 | 5.62 | | 0.00 | 0.00 | 0.00 | 0.00% | 5.74 | 5.62 | 0.12 |
| 7 | 2.00 | | 0.00 | 0.00 | 0.00 | 0.00% | 2.00 | 2.00 | 0.00 |

| Division C | % fill registered | % fill care staff | Overall filled % | | Analysis of gaps | Impact on Quality / outcomes | Actions in place |
|---|---|---|---|---|---|---|---|
| G5 | 93% | 79% | 89% | 6.50 | 88 unfilled HCSW gaps in November. 4.52 HCSW vacancies, 1.8 WTE non-effective. No HCSW in pipeline. HCSW rostering KPI's within normal range. | 18 SLRs raised; 1accident; 2 equipment; 5 fall; 1 implementation of care; 1 IPC; 4 medication; 1 nutrition/hydration; 2 POC testing; 1 security, 3 red metrics, BCMA scanning, patient scanning and blood product scanning. 5 amber metrics, catheter documentation, falls screening, moving and handling, PU screening and VIP score recording. Concerns raised by IPC team regarding poor compliance with IPC practices on multiple occasions. | Daily divisional mitigation; site safety escalation; weekly prospective staffing reporting and mitigation; divisional recruitment and retention strategy. Matron quality focus. |

# Appendix 1: Exception report by Division – Division E

| Division E | % fill registered | % fill care staff | Overall filled % | CHPPD delivered | Analysis of gaps | Impact on Quality / outcomes | Actions in place |
|---|---|---|---|---|---|---|---|
| Neonatal ICU | 89% | 60% | 85% | 11.68 | Current shortfall of 13.89 with 11.96 being band 6 QIS WTE RN vacancy and 8.86 WTE Nursery Nurses, 5 RN awaiting PIN or pipeline. 2.83 WTE pipeline out. | No impact on NQM ,patient experience feedback. Impact on staff wellbeing as reported by senior team. Not compliant with BAPM standards at times of high acuity and occupancy.Regional and national working for capacity. | Support from CPFand PD and support staff. Rate 3 for all staff. New starters commencing in November.Clear staffing escvalation plan. |
| PICU | 90% | 104% | 91% | 25.93 | Current shortfall of 17.4 WTE with 12.6 WTE Band 6 QIS RN vacancy , 5 band 5 and 6 band 6 WTE pipeline in. 5.7 WTE pipeline out, promotions to band 6 after bridging course | 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 plus for all staff. Plan for support from the ODN to support repatriation , band 5 -6 bridging the gap development resulted in offers to 6 new band 6's. |
| Rosie Birth Centre | 87% | 86% | 87% | 11.95 | Vacancy and maternity leave in this area | Delays to discharges and potentially risk 1:1 care in labour | New starters will come to this area and community as their last SN placement, this is planned but may not see impact for couple of months on roster |
| F3 COU | 90% | 86% | 89% | 6.43 | Current shortfall of 5.4 WTE RN vacancy and 1.5 HCSW, 2 WTE pipeline in. 2.4 WTE pipeline out. | Positive patient experience feedback. Minimal delays to theatre starts related to staffing. Starting 24/7 opening from December. | Three times review a day of occupancy and staffing. Rate 3 for all staff. Support from unit when possible. |
| Delivery Unit | 93% | 72% | 88% | 14.42 | Vacancy rate across area. IR's have some continued SN time to support adaptation and use of CTG monitors | Potential delays to IOL and transfers to PN ward | IR's due to come of SN status and new starters will be in numbers from November |
| Lady Mary | 90% | 86% | 89% | 4.22 | Vacancy rate and sickness absence in this area | Delays to discharges and Infant Feeding support | New starters due from next month once out of SN status will positively impact |

# Appendix 2: Adult RN Recruitment pipeline

| Adult band 5 RN position based on predictions and established FTE | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Month | UK based exp. applicants | Anglia Ruskin NQ (60% of graduates) | Other NQ | NAP | Return to Practice | Overseas | Total New Starters | Leavers FTE | Promotions and transfer out of scope- retained by the trust | Staff in post FTE | ESR Establishment FTE | Vacancy rate based on established FTE | No. of vacancies based on established FTE | Starter leaver variance |
| *Apr-22* | 7 | | | | | 25 | 32 | 15 | 14 | **1584** | **1768** | **10.41%** | **184.12** | **17** |
| *May-22* | 8 | | | 17 | | 20 | 45 | 25 | 7 | **1597** | **1768** | **9.67%** | **171** | **20** |
| *Jun-22* | 1 | | | | | 23 | 24 | 14.4 | 13 | **1594** | **1768** | **9.86%** | **174.4** | **9.6** |
| *Jul-22* | 6 | | | 9 | | 29 | 44 | 24 | 14 | **1600** | **1768** | **9.52%** | **168.4** | **20** |
| *Aug-22* | 5.2 | | 0.45 | | | 23 | 29 | 22.6 | 4 | **1591** | **1699** | **6.33%** | **107.47** | **6.05** |
| *Sep-22* | 3 | 1 | | 0 | | 22 | 26 | 18 | 14 | **1585** | **1699** | **6.68%** | **113.47** | **8** |
| *Oct-22* | 3 | 2 | 6 | | | 12 | 23 | 19 | 13 | **1576** | **1699** | **7.21%** | **122.47** | **4** |
| *Nov-22* | 3 | 1 | | | | 13 | 17 | 10 | 26 | **1557** | **1699** | **8.33%** | **141.47** | **7** |
| *Dec-22* | 5 | 1 | | 16 | | 5 | 27 | 18 | 15 | **1551** | **1699** | **8.68%** | **147.47** | **9** |
| *Jan-23* | 3 | | | 6 | | 21 | 30 | 18 | 15 | **1548** | **1699** | **8.86%** | **150.47** | **12** |
| *Feb-23* | 2 | | | | | 2 | 4 | 18 | 15 | **1519** | **1699** | **10.56%** | **179.47** | **-14** |
| *Mar-23* | 5 | 5 | 5 | | | 15 | 30 | 18 | 15 | **1516** | **1699** | **10.74%** | **182.47** | **12** |
| **TOTAL** | **51** | **10** | **11** | **48** | **0** | **210** | **331** | **220** | **165** | **1516** | **1698.95** | **10.74%** | **182.47** | **110.65** |

# Appendix 3: Paediatric RN and Band 2 HCSW Recruitment pipeline

| Paediatric band 5 RN position based on predictions and established FTE | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Month | UK based exp. applicants | Anglia Ruskin NQ | Other NQ | NAP | Overseas | Total New Starters FTE | Leavers FTE (based on leavers in the last 12 months) | Promotions and transfer out of scope- retained by the trust | Staff in post FTE | ESR Establishment FTE | Vacancy rate based on established FTE | No. of vacancies based on established FTE | Starter leaver variance |
| *Apr-22* | 2 | | | | | 2 | 1 | 2 | 187.42 | 284.41 | 34.10% | 96.99 | 1 |
| *May-22* | | | | | 5 | 5 | 8 | 1 | 183.42 | 284.41 | 35.51% | 100.99 | -3 |
| *Jun-22* | 1 | | | | 0 | 1 | | 1 | 183.42 | 284.41 | 35.51% | 100.99 | 1 |
| *Jul-22* | 1 | | 1 | | 1 | 3 | 2 | 1 | 183.42 | 284.41 | 35.51% | 100.99 | 1 |
| *Aug-22* | | | 1 | | 3 | 4 | 2 | 2 | 170.89 | 213.73 | 20.04% | 42.84 | 2.47 |
| *Sep-22* | 1 | | 1 | | 0 | 2 | 2 | 1 | 170 | 213.73 | 20.51% | 43.84 | 0 |
| *Oct-22* | 2 | 3 | 4 | | 6 | 15 | 5 | 0 | 180 | 213.73 | 15.83% | 33.84 | 10 |
| *Nov-22* | | 2 | 2 | | 1 | 5 | 6 | 3 | 176 | 213.73 | 17.70% | 37.84 | -1 |
| *Dec-22* | | 1 | | | 1 | 2 | 6 | 1 | 171 | 213.73 | 20.04% | 42.84 | -4 |
| *Jan-23* | | 2 | 1 | | 1 | 4 | 4 | 1 | 170 | 213.73 | 20.51% | 43.84 | 0 |
| *Feb-23* | | | | | 1 | 1 | 2 | 1 | 168 | 213.73 | 21.45% | 45.84 | -1 |
| *Mar-23* | 2 | | | | 1 | 3 | 3 | 1 | 167 | 213.73 | 21.92% | 46.84 | 0 |
| **TOTAL** | **9** | **8** | **10** | **0** | **20** | **47** | **40.53** | **15** | **166.89** | **213.73** | **21.92%** | **46.84** | **6.47** |

| Band 2 HCSW position based on predictions and established FTE | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Month | UK based applicants | Apprenticeship (direct entry) | Total New Starters FTE | Leavers FTE | Staff in post FTE | ESR Establishment FTE | Vacancy rate based on established FTE | No. of vacancies based on established FTE |
| *Apr-22* | 15 | | 15 | 16 | 812 | 947 | 14.3% | 135 |
| *May-22* | 17 | | 17 | 21 | 808 | 970 | 16.7% | 162 |
| *Jun-22* | 27.8 | | 27.8 | 13 | 823 | 970 | 15.2% | 148 |
| *Jul-22* | 21 | | 21 | 16 | 828 | 970 | 14.7% | 143 |
| *Aug-22* | 18 | 8 | 26 | 2 | 745 | 855 | 12.9% | 110 |
| *Sep-22* | 17 | 4 | 21 | 11 | 755 | 855 | 11.7% | 100 |
| *Oct-22* | 20 | 9 | 29 | 14 | 770 | 855 | 10.0% | 85 |
| *Nov-22* | 17 | 11 | 28 | 13 | 785 | 855 | 8.2% | 70 |
| *Dec-22* | 14 | | 14 | 15 | 784 | 855 | 8.3% | 71 |
| *Jan-23* | 29 | | 29 | 20 | 793 | 855 | 7.3% | 62 |
| *Feb-23* | 10 | | 10 | 15 | 788 | 855 | 7.9% | 67 |
| *Mar-23* | 25 | 40 | 65 | 15 | 838 | 855 | 2.0% | 17 |
| **TOTAL** | **230.8** | **72** | **302.8** | **171** | **838** | **855** | **2.0%** | **17** |

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

# Report to the Board of Directors: 18 January 2023

| | |
|---|---|
| **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 M8 |
| **Previously considered by** | Performance Committee, 11 January 2023 |

## Executive Summary

The report provides details of financial performance during 2022/23 Month 8 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 8. |
| 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 8.

## Contents

## Trust actual surplus / (deficit)

| | |
|---|---|
| (£0.5m) | *Actual (adjusted )** |
| (£0.5m) | *Plan (adjusted)** |
| £1.8m | *Actual YTD (adjusted)** |
| £1.7m | *Plan YTD (adjusted)** |

## Covid-19 expenditure and system Covid-19 funding

| | |
|---|---|
| £1.7m | *Covid actual in month* |
| £1.8m | *Covid plan in month* |
| £1.8m | *Covid funding in month* |
| £15.8m | *Covid actual YTD* |
| £15.2m | *Covid plan YTD* |
| £14.7m | *Covid funding YTD* |

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

***Net current assets***

| | |
|---|---|
| (£72.4m) | *Actual* |
| (£54.2m) | *Plan* |

***Payables performance (YTD) *****

| | | |
|---|---|---|
| *Actual* | 86.7% | *Value* |
| *Plan* | 88.7% | *Quantity* |

***Debtor days***

| | |
|---|---|
| 21 | *This month* |
| 20 | *Previous month* |

## Cash and EBITDA

***Cash***

| | |
|---|---|
| £161.5m | *Actual* |
| £166.8m | *Plan* |

***EBITDA***

| | |
|---|---|
| £27.7m | *Actual YTD* |
| £30.1m | *Plan YTD* |

## Capital expenditure

| | |
|---|---|
| £9.6m | *Capital - actual spend in month* |
| £30.1m | *Capital - actual spend YTD* |
| £37.1m | *Capital – plan YTD* |

## Elective Recovery Fund (ERF)

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

| | |
|---|---|
| £2.5m | *ERF forecast actual in month* |
| £2.5m | *ERF plan in month* |
| £12.3m | *ERF forecast actual YTD* |
| £12.3m | *ERF plan YTD* |

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

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

## Month 8 Financial Performance

- **The month 8 year to date position is a £1.8m surplus for performance management purposes**. This is broadly in line with the Trust financial plan.
- The month 8 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 £6.4m and fire prevention works income and expenditure underperformance of £5.1m (as the phasing of works are not aligning to the plan).
- The pay expenditure position is £4.6m adverse to plan year to date largely due to the September payment of the national pay award arrears of £7.8m for which the Trust was funded in full from a nationally mandated uplift to NHS Commissioner block payments. The underlying favourable variance is largely due to slippage on planned investments including the investment in a higher proportion of level 2/3 beds in critical care.
- Whilst the Trust is operating in line with its plan, within this position the delays in investment in additional operational capacity are further contributing to productivity shortfalls, as discussed below.

## Productivity

- The Trust is operating broadly in line with its expenditure plan at month 8 year to date but continues to perform below its planned levels of productivity.
- At month 8 the under performance in clinical activity can be valued at £18.6m. A shortfall of £19.5m from planned care services is due to operational pressures and limitations, including as a result of staffing vacancies. In year the Trust remains protected from this shortfall through the block funding arrangement but this represents a significant performance challenge to be addressed in advance of the new year.
- There has been an estimated increase in expenditure levels of £14-16m associated with operational delivery/capacity.
- Overall, with the reduction in productivity and additional capacity investments in year, we are performing at a c.£34-36m 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 £15.8m of Covid-19 associated expenditure year to date which is £0.6m above the plan.
- The Trust has received £14.7m 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 £12.3m year to date in line with plan and based on a fair share allocation. For the full year the Trust has planned to receive £29.7m of ERF funding.
- NHS England has provided some assurance that the planned ERF will be funded in full for 22/23 at system level therefore the Trusts continues to report full income recognition with no clawback. The final process for calculating the value of ERF has not yet been published at the time of this report and therefore there remains an element of risk associated with this income.
- 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 8 our cumulative position is in line with plan, with efficiencies of £42.0m achieved.
- Pay efficiencies are currently ahead of plan by £1.8m. Within this, recurrent initiatives are (£2.3m) adverse to plan and non-recurrent schemes are £4.1m ahead of plan.
- For non-pay efficiencies, initiatives are (£0.5m) adverse to plan, reporting achievement of £15.1m against plan of £15.7m.
- Income efficiencies are reporting adverse to plan by (£1.3m) driven by a shortfall in non-recurrent scheme delivery. This measure includes the non-recurrent campus development project income receipt of £4m.
- The latest full year efficiency forecast identifies full delivery of the plan however there is a significant estimated shortfall in recurrent savings of £4.9m. 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.

## 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 (£4.1m). Together with capital contributions from ACT, this would provide a total capital programme of £62.6m for the year.
- The Trust has invested £30.1m in it's capital programme so far - £7m below the planned figure of £37.1m. The year-end forecast however, remains in line with the plan of £62.6m of capital expenditure in year.
- The Trust's cash position remains strong and the 13 week cash flow forecast does not identify any need for additional revenue cash support in the foreseeable future.

## FY22/23 Financial Plan

- It should be noted that the following key areas of risk still remain and have been included as part of the overall plan submission, to be monitored in year:
    1) Inflation pressures above the (revised) funded level
    2) Covid-19 costs exceeding budgeted levels (e.g. due to an increase in Covid rates)
    3) Non receipt of forecast ERF income

- The following point should also be noted in respect of the 22/23 financial plan:
    1) The plan retains CUH support to our ICS of £11m to ensure that all ICS organisations can deliver break-even financial performance.

- **In addition to those risks highlighted above, going into 23/24, the Trust is also carrying the following risks due to in year performance:**
    1) Productivity levels performing below plan carrying forward a productivity gap to 23/24 posing a financial risk if the current block funding financial framework is changed
    2) Under delivery of recurrent efficiencies carrying forward a recurrent cost pressure to 23/24

## FY23/24 Financial Plan

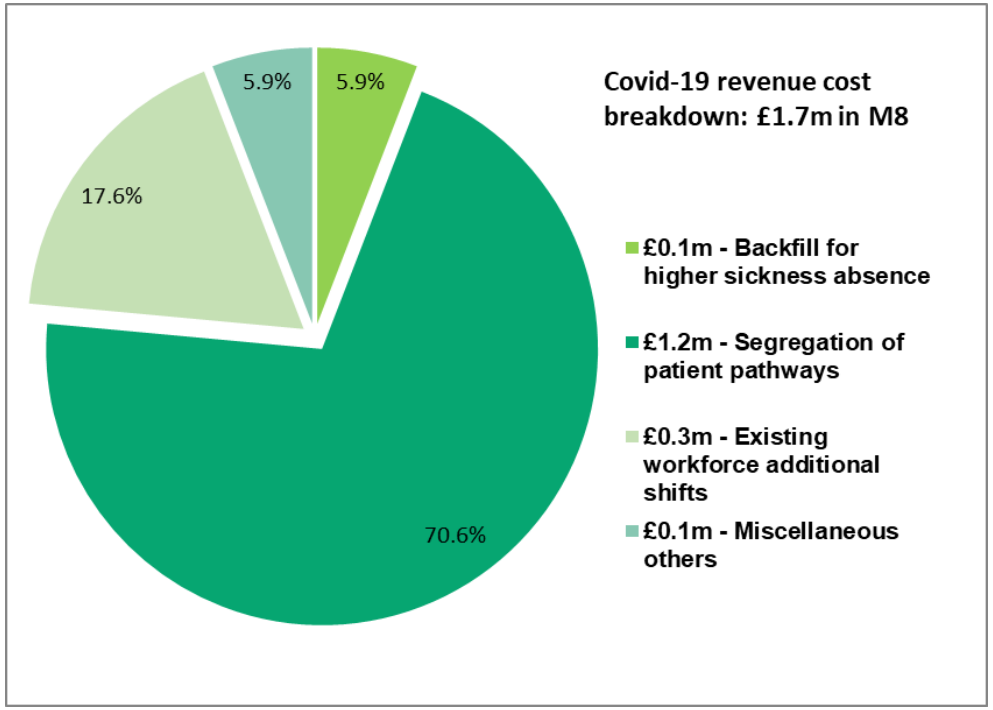
- On 23rd December 2022, NHS England (NHSE) released its 2023/24 planning priorities and operational planning guidance. The Trust is working with the health system to review the implications of this guidance and further updates will be provided over the coming months.

# Month 8 performance against plan

| | In Month | | | | Year to Date | | | | Full Year |
|---|---|---|---|---|---|---|---|---|---|
| ***£ Millions*** | **Budget** | **Actual** | **Variance** | **Variance (Exc. Covid & Pay Award)** | **Budget** | **Actual** | **Variance** | **Variance (Exc. Covid & Pay Award)** | **Budget** |
| Clinical Income - exc. D&D* | 70.4 | 74.4 | 4.0 | 3.2 | 561.9 | 568.0 | 6.2 | (2.9) | 858.9 |
| Clinical Income - D&D* | 13.5 | 9.8 | (3.7) | (3.7) | 107.9 | 114.3 | 6.4 | 6.4 | 161.9 |
| Covid - Income top-up & outside envelope | 1.8 | 1.8 | 0.0 | 0.0 | 14.4 | 14.7 | 0.3 | 0.3 | 21.6 |
| ERF income | 2.5 | 2.5 | 0.0 | 0.0 | 12.3 | 12.3 | 0.0 | 0.0 | 29.7 |
| Devolved Income | 15.0 | 14.9 | (0.1) | (0.1) | 123.4 | 118.3 | (5.1) | (5.1) | 163.3 |
| **Total Income** | **103.1** | **103.4** | **0.3** | **(0.6)** | **820.0** | **827.8** | **7.7** | **(1.3)** | **1,235.4** |
| Pay | 55.2 | 54.9 | 0.3 | 1.1 | 432.2 | 436.2 | (4.0) | 4.3 | 656.4 |
| Drugs | 14.4 | 15.8 | (1.4) | (1.4) | 115.3 | 122.3 | (7.0) | (7.0) | 173.0 |
| Non Pay | 28.6 | 28.3 | 0.3 | 0.4 | 227.0 | 225.8 | 1.2 | 1.6 | 341.3 |
| Covid - Pay | 1.2 | 1.1 | 0.1 | 0.1 | 10.0 | 10.6 | (0.7) | (0.4) | 14.4 |
| Covid - Drugs | 0.0 | 0.0 | 0.0 | 0.0 | 0.3 | 0.2 | 0.1 | 0.1 | 0.4 |
| Covid - Non pay | 0.6 | 0.5 | 0.0 | 0.0 | 5.2 | 5.0 | 0.2 | 0.2 | 7.4 |
| **Operating Expenditure** | **100.0** | **100.7** | **(0.7)** | **0.1** | **789.9** | **800.1** | **(10.2)** | **(1.1)** | **1,192.9** |
| **EBITDA** | **3.1** | **2.6** | **(0.4)** | **(0.4)** | **30.1** | **27.7** | **(2.4)** | **(2.4)** | **42.5** |
| Depreciation, Amortisation & Financing | 3.5 | 3.2 | 0.3 | 0.3 | 28.4 | 26.6 | 1.7 | 1.7 | 42.5 |
| **Reported gross Surplus / (Deficit)** | **(0.5)** | **(0.6)** | **(0.1)** | **(0.1)** | **1.7** | **1.0** | **(0.7)** | **(0.7)** | **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 | 0.7 | 0.7 | 0.7 | 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** | **0.0** | **1.7** | **1.8** | **0.0** | **0.0** | **0.0** |

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

## Summary financial position




**Key messages:**

The Trust has recorded £1.7m of Covid expenditure in month 8, bringing the total year to date for 22/23 to £15.8m. This represents a £0.6m adverse variance against the plan of £15.2m.

The main areas of Covid investment in Month 8 are:

- Segregation of patient pathways £1.2m
- Existing workforce covering additional shifts £0.3m
- 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 8 reports at £1.8m, which is a reduction on year to date average. 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) | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr & May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Corporate | £1.3 | £1.5 | £1.3 | (£1.0) | £1.4 | £0.6 | £0.6 | £0.2 | £0.2 | £0.6 | £0.4 |
| Division A | £1.2 | £1.7 | £1.2 | £1.1 | £0.7 | £0.4 | £0.4 | £0.3 | £0.3 | £0.3 | £0.3 |
| Division B | £0.4 | £0.3 | £0.5 | £0.5 | £0.9 | £0.4 | £0.3 | £0.3 | £0.4 | £0.4 | £0.4 |
| Division C | £0.5 | £0.6 | £0.5 | £0.5 | £0.7 | £0.3 | £0.4 | £0.4 | £0.4 | £0.4 | £0.5 |
| Division D | £0.2 | £0.2 | £0.1 | £0.2 | £0.5 | £0.3 | £0.3 | £0.1 | £0.2 | £0.1 | £0.1 |
| Division E | £0.1 | £0.2 | £0.2 | £0.3 | £0.4 | £0.1 | £0.2 | £0.2 | £0.2 | £0.2 | £0.0 |
| **Total** | **£3.7** | **£4.5** | **£3.9** | **£1.5** | **£4.5** | **£2.2** | **£2.2** | **£1.6** | **£1.6** | **£2.0** | **£1.7** |

Elective Activity Recovery Period

## Covid-19 expenditure overview

# Full Year Plan – key messages

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

**Key messages:**

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

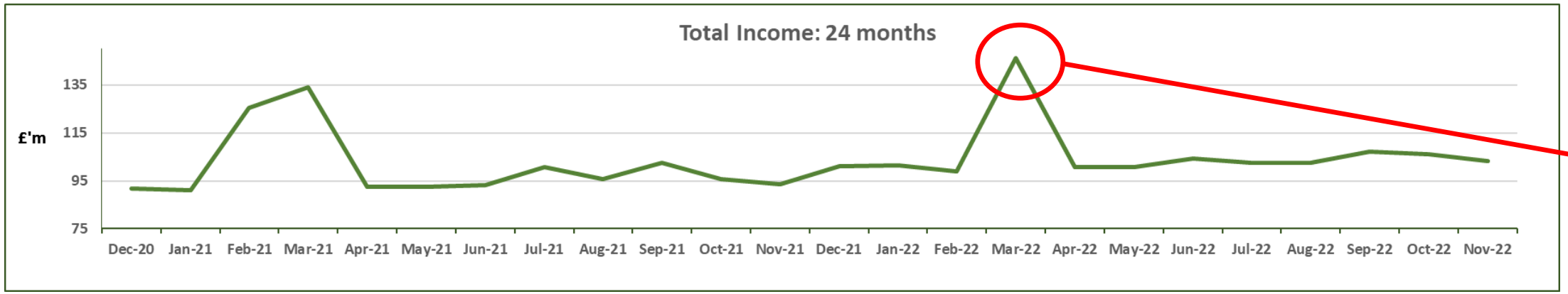
| £'m | M8 YTD Plan | M8 YTD Actual | Variance | Key Variances |
|---|---|---|---|---|
| Operating income from patient care activities | 705.8 | 718.6 | 12.8 | Income over performance remains largely driven by the national pay award funding of £9.0m.The remaining variance derives from drugs over achievement, with lower CAR-T (£4.6m) and Cancer Drugs Funds (£3.2m) income fully offset by other high cost drugs, leading to net over performance of £6.4m. |
| Other operating income | 114.2 | 109.1 | (5.0) | Shortfall in income recognition is attributable to fire prevention works expenditure being lower than planned by (£5.1m). |
| **Total income** | **820.0** | **827.8** | **7.7** | |
| Employee expenses | (442.2) | (446.9) | (4.7) | Overspend is largely driven by the national pay award of £8.6m. Corresponding income over performance is reported above. This is partially offset by slippage on planned investments across a number of areas, predominantly seven critical care beds which remain largely closed due to staff vacancies. Overall there is Trust wide slippage in Medical Staffing against the 22/23 sustainability agenda. This has resulted in increased Bank and Agency spend incurred at premium rates. |
| Operating expenses excluding employee expenses | (369.0) | (374.5) | (5.5) | Uplifted operating expenditure in month to provide for the Board approved staff benefit award. Trust wide increase in aged debt and staff risk provisions to reflect year to date financial position. |
| **Operating surplus / (deficit)** | **8.8** | **6.4** | **(2.4)** | |
| Finance costs | | | | |
| Finance income | 0.0 | 1.7 | 1.7 | Due to the significant increase in bank interest rates nationally, a year to date alignment of finance income was completed for H1, with current interest income for the year reporting at £1.7m.<br>A full year forecast of this measure is expected to achieve income of c.£2.5-3.5m. |
| Finance expense | (4.8) | (4.8) | 0.0 | |
| PDC dividends payable/refundable | (2.3) | (2.3) | 0.0 | |
| **Net Finance costs** | **(7.1)** | **(5.4)** | **1.7** | |
| **Reported gross surplus/(deficit)** | **1.7** | **1.0** | **(0.7)** | |
| Add back technical adjustments: | | | | |
| Impairments (AME) | 0.0 | 0.0 | 0.0 | |
| Capital donations/grants net I&E impact | 0.0 | 0.7 | 0.7 | |
| Net benefit of PPE consumables transactions | 0.0 | 0.0 | 0.0 | |
| **Surplus/(Deficit) - NHS financial performance basis for the year to date** | **1.7** | **1.8** | **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 £1.8m.
- 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 | 12.6 | 0.6 | 96.1 | 89.6 | (6.5) |
| Non-elective admissions | 15.2 | 16.8 | 1.5 | 121.8 | 118.9 | (2.9) |
| Outpatients | 10.4 | 10.0 | (0.4) | 83.4 | 70.4 | (13.0) |
| A&E | 2.0 | 3.6 | 1.5 | 16.3 | 20.1 | 3.8 |
| High-cost drugs income from commissioners | 13.5 | 12.9 | (0.6) | 107.9 | 114.3 | 6.4 |
| Other NHS Clinical Income | 30.6 | 27.5 | (3.1) | 244.2 | 260.0 | 15.8 |
| Covid - Income top-up & outside envelope | 1.8 | 1.8 | 0.0 | 14.4 | 14.7 | 0.3 |
| ERF | 2.5 | 2.5 | 0.0 | 12.3 | 12.3 | 0.0 |
| Pay award adjustment | 0.0 | 0.8 | 0.8 | 0.0 | 9.0 | 9.0 |
| **Total Clinical Income** | **88.1** | **88.5** | **0.4** | **696.6** | **709.5** | **12.9** |
| Devolved Income | 15.0 | 14.9 | (0.1) | 123.4 | 118.3 | (5.1) |
| **Total Trust Income** | **103.1** | **103.4** | **0.3** | **820.0** | **827.8** | **7.7** |

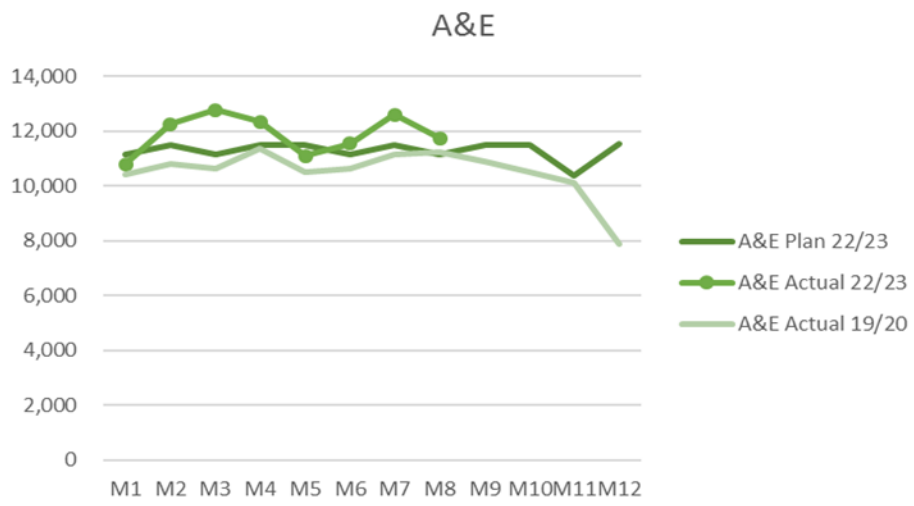
**Note:** The March 2022 figures include additional funding from NHSE/I for the extra 6% NHS pension contribution (£24.6m), The impact of R&D projects accounted for in M12 (£10.9m), apprenticeship funding (£2.4m), national PPE funding (£2.8m) and an NIHR R&D grant (£11.0m). All of which included matched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

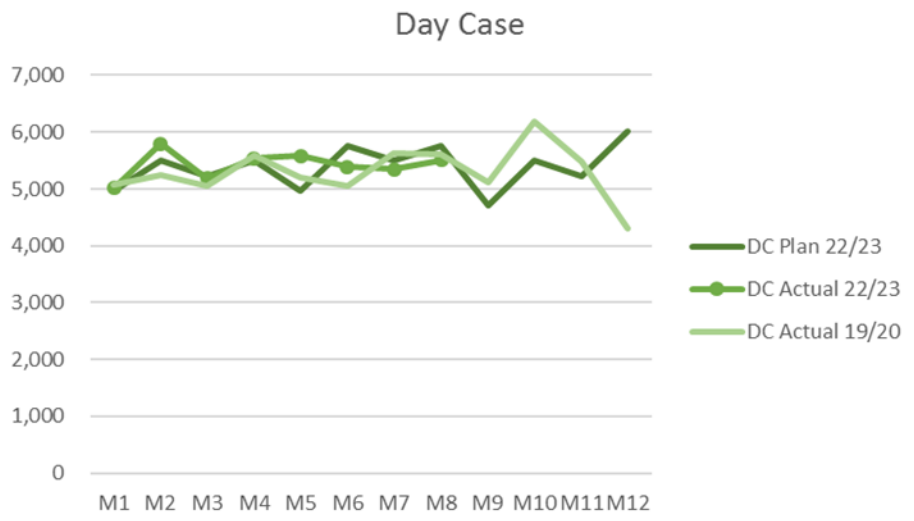
**Key messages:**

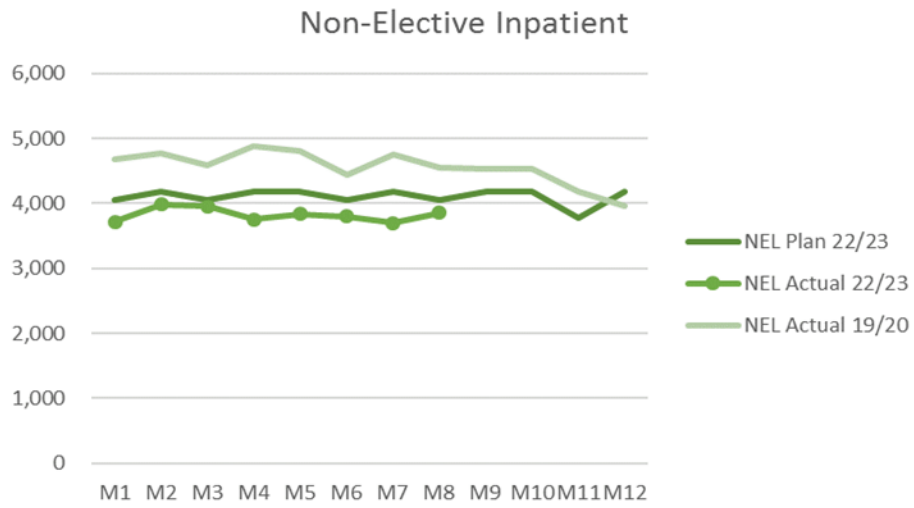
- The values included in the table for elective, non elective, outpatients and A&E income are as per regular reporting methods (PbR view). As the Trust's clinical income is predominantly through block contracts a block top-up is included within other clinical income.
- The total clinical income includes income earnt from NHS and devolved administration commissioners and NHS arms length bodies. The headings reported above align to NHS E/I reporting categories.
- Year to date there is a favourable variance of £6.4m relating to high-cost drugs pass-through expenditure, which includes an under-performance by the Car-T service along with the Cancer Drugs Fund, which are both fully offset by over-performance for other high cost drugs.
- The Other NHS Clinical Income category includes £9.0m of additional pay award funding – this was provided in month 6 to cover the additional costs of the national pay settlements for Consultants, Agenda for Change staff and Very Senior Managers.
- 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 £5.1m year to date. This is largely driven by fire prevention works expenditure being lower than plan (£5.1m).

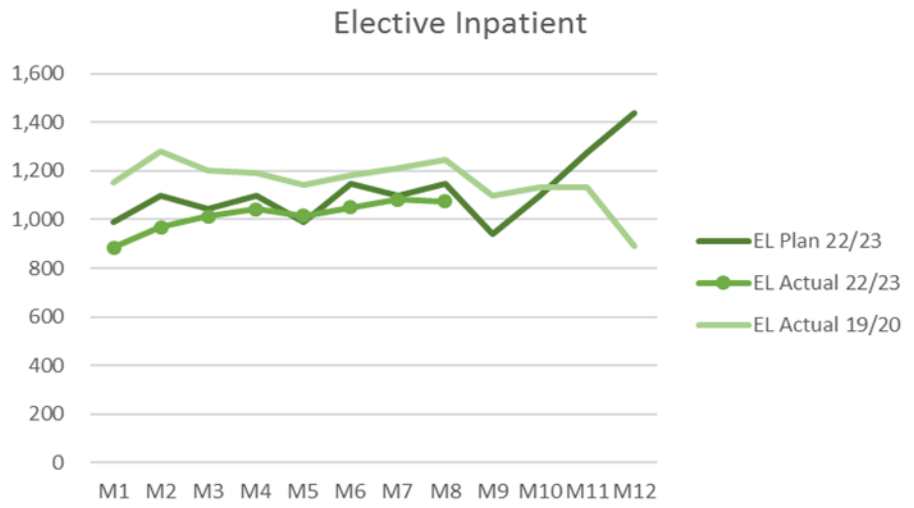
# Clinical and other income

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



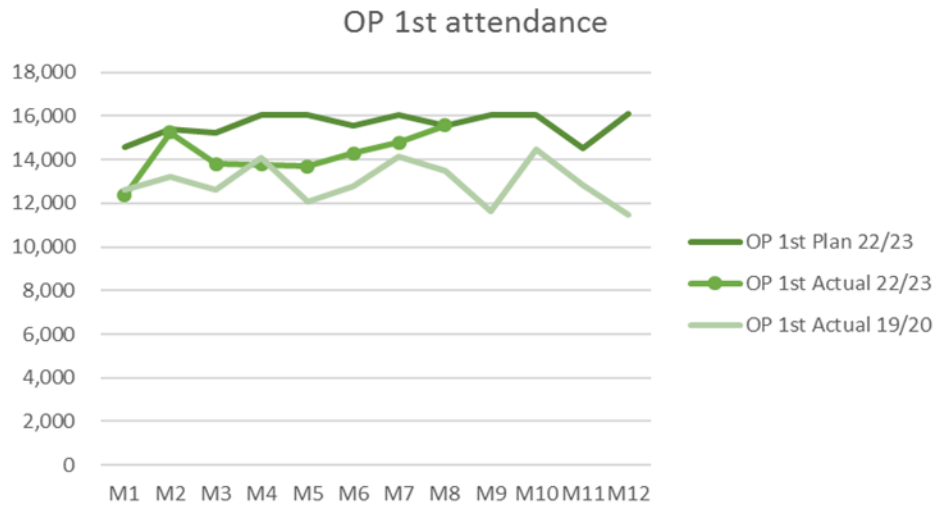



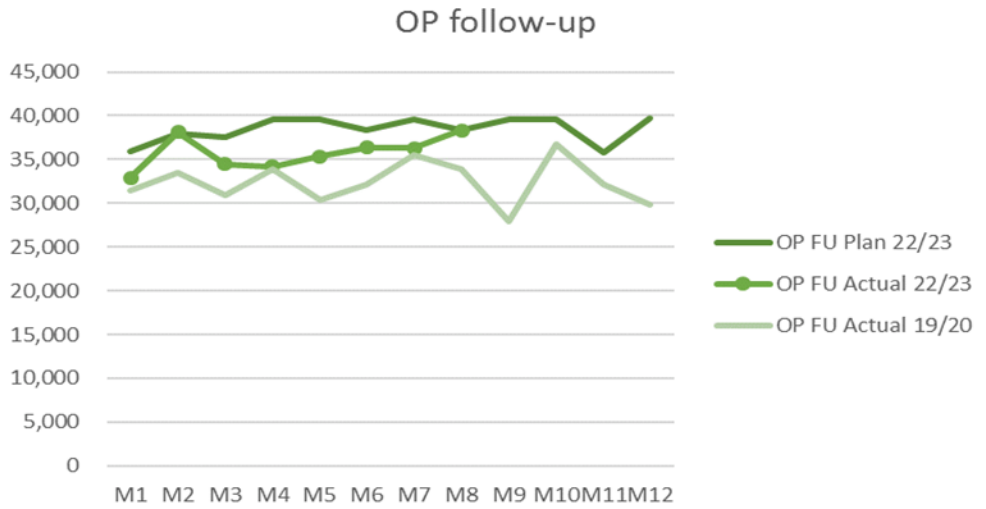



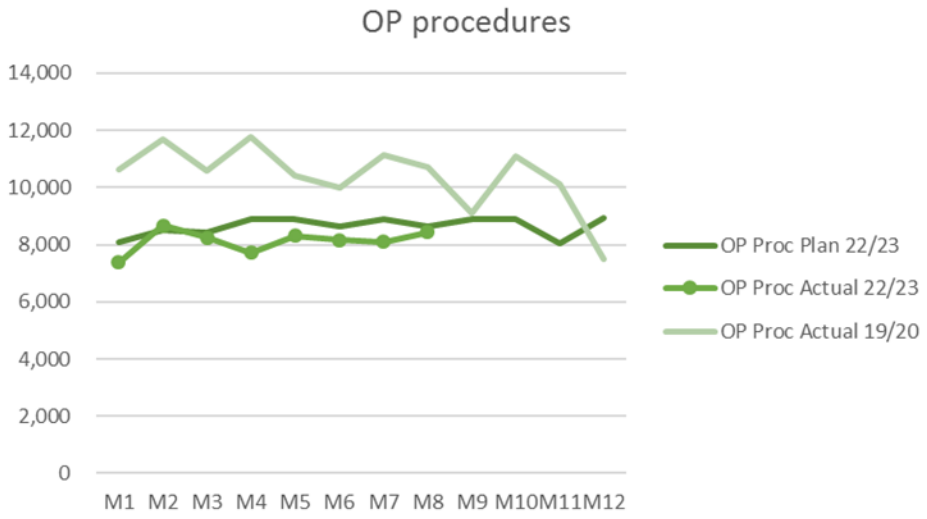




## Clinical and other income (continued)

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




**Key messages:**

- A&E attendances are higher than both plan and 19-20 levels at month 8. Year to date and in month report above plan, at 5.0% and 5.4%, respectively.
- Non elective spells move closer to plan at month 8, whilst remaining below 19-20 actuals. Year to date, NEL is 7.0% below plan and in month 4.8%.
- Elective spells remain steadily below both plan and 19/20 levels at month 8. It is notable that the phasing of the plan increases in the last quarter due to planned capacity works. Year to date EL is 5.6% below plan, and in month 6.4%.
- Day cases are lower than plan at month 8, yet close to 19/20 actuals. Year to date, DC are broadly in line with plan, however in month reports below plan by 4.3%.
- Outpatient first attendances align to planned activity levels in month 8. Year to date, OP FA are 8.7% below plan.
- Outpatient follow-up attendances report in line with plan for month 8. Year to date, OP FUP remain below plan, reporting at 6.8% activity shortfall.
- Outpatient procedures are close to plan in month 8 yet considerably below 19/20 levels. Year to date, OP proc are 5.8% below plan and in month 2.2%.

# Clinical Income – Elective Recovery Fund (ERF)

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

Please note:- due to rounding the M1-8 plan figures add to £12.3m.

**ERF:**

- Planned ERF in months 1 to 3 is £0.8m per month, £1.6m for months 4 to 6, and £2.5m for months 7 and 8, totaling £12.3m (phased plan in table above).
- **The Trust has received verbal assurance from NHSE/I that the H1 ERF will be awarded in full at 50% of the full year plan value, and further, that H2 will not be subject to clawback.**
- NHSE and other organisations have now enacted the above and paid 50% in full at month 6.
- The tables on the right are the initial regionally published ERF performance percentages of current year priced volume weighted activity against the equivalent 19/20 values, for months 1 to 3 (published October 2022). No further national data has been published.
- The Trust has not yet received written confirmation of the change to the ERF payment process and we are still in expectation of this in the coming months.
- Due to the complexity of the CUH portfolio of NHS Commissioners we will be seeking formal clarification from them that they will be funding ERF in line with our agreed plans and the NHSE/I update.

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

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

Please note: M4-8 national data not yet available

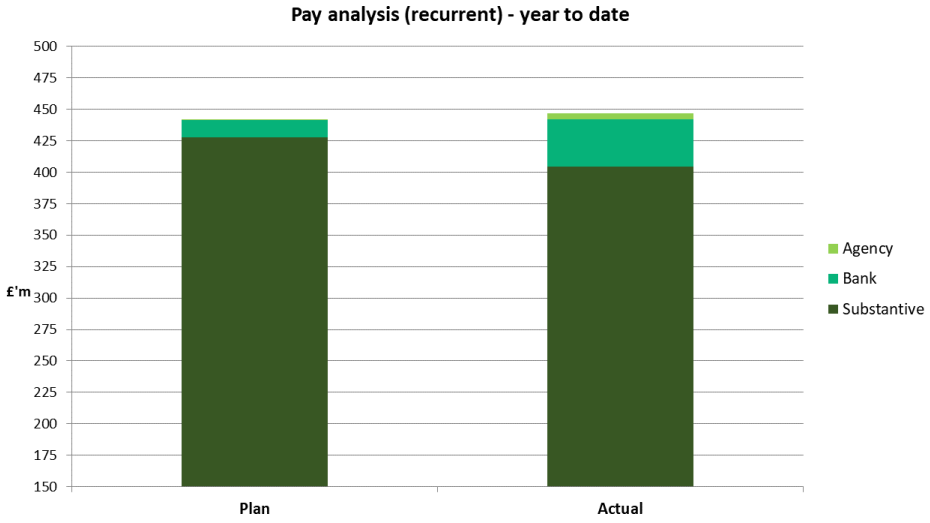
**Key messages:**

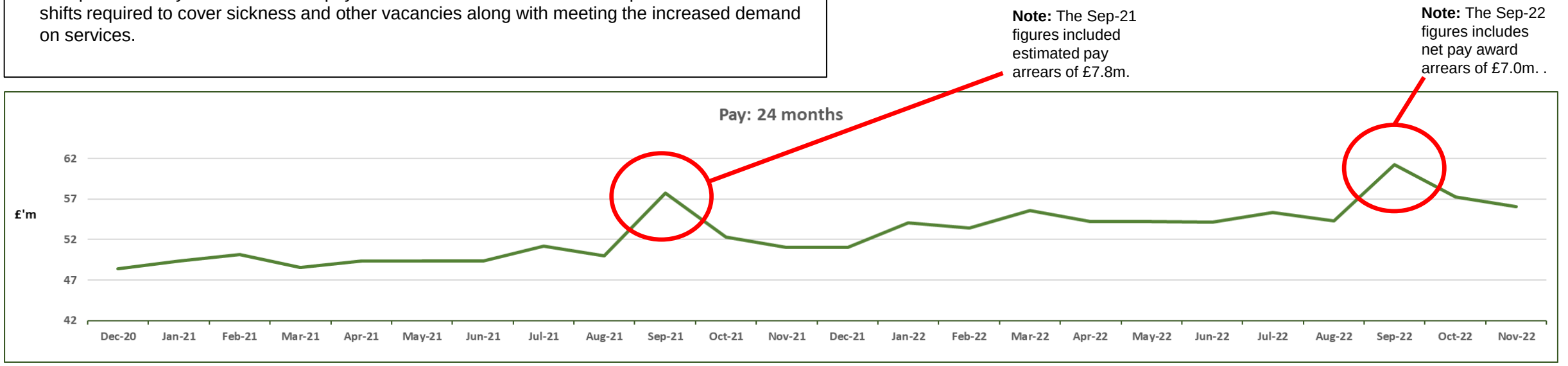
- At the end of month 8, the Trust is reporting a £4.6m adverse position on pay with a £0.4m favourable position in month. The year to date position is driven by c£8.6m of national pay award arrears for Consultants, Agenda for Change staff over and above the 2% levels accrued earlier in the year. This expenditure is funded by additional clinical income.

- Excluding the pay award the key driver for the underlying favourable position is slippage on planned investments across a number of areas, predominantly seven critical care beds which remain closed due to staff vacancies. Overall there is Trust-wide slippage in Medical Staffing against the 22/23 sustainability agenda. This has resulted in increased Bank and Agency spend incurred at premium rates. Pay slippage is partially offset by pressures on Covid pay expenditure (£0.7m).

- The Trust continues to take actions to restore and maintain services in a Covid safe environment and has invested £10.6m of Covid pay related spend in the financial year to date.

- Bank spend as a proportion of the total 22/23 pay bill is 8.4%, while agency spend for the same time period is only 1.1% of the total pay bill. The main driver for the bank spend is the additional shifts required to cover sickness and other vacancies along with meeting the increased demand on services.




**Note:** 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 | Variance (exc. Pay Award) | Budget | Actual | Variance | Variance (exc. Pay Award) |
| **Non Covid:** | | | | | | | | |
| Administrative & Clerical | 8.3 | 8.2 | 0.1 | 0.2 | 66.1 | 64.9 | 1.2 | 2.6 |
| Allied Healthcare Professionals | 3.3 | 3.2 | 0.1 | 0.1 | 26.2 | 24.9 | 1.3 | 1.8 |
| Clinical Scientists & Technicians | 5.4 | 4.9 | 0.5 | 0.6 | 42.2 | 39.1 | 3.1 | 3.9 |
| Medical and Dental Staff | 18.6 | 17.6 | 1.0 | 1.2 | 147.5 | 141.8 | 5.8 | 7.7 |
| Nursing | 20.2 | 19.6 | 0.6 | 0.9 | 159.2 | 154.2 | 5.0 | 8.4 |
| Other Pay Costs | 1.2 | 1.4 | (0.2) | (0.1) | 10.3 | 11.3 | (1.0) | (0.8) |
| Efficiency savings | (1.8) | (0.0) | (1.8) | (1.8) | (19.3) | (0.0) | (19.3) | (19.3) |
| **Subtotal for non-covid** | **55.2** | **54.9** | **0.3** | **1.1** | **432.3** | **436.2** | **(4.0)** | **4.4** |
| | | | | | | | | |
| **Covid:** | | | | | | | | |
| Administrative & Clerical | 0.2 | 0.1 | 0.1 | 0.1 | 1.5 | 1.4 | 0.1 | 0.1 |
| Allied Healthcare Professionals | 0.1 | 0.0 | 0.0 | 0.0 | 0.7 | 0.5 | 0.2 | 0.2 |
| Clinical Scientists & Technicians | 0.0 | 0.0 | (0.0) | (0.0) | 0.2 | 0.2 | 0.0 | 0.0 |
| Medical and Dental Staff | 0.3 | 0.2 | 0.1 | 0.1 | 2.5 | 2.1 | 0.4 | 0.4 |
| Nursing | 0.6 | 0.6 | (0.0) | (0.0) | 4.6 | 6.0 | (1.4) | (1.3) |
| Other Pay Costs | 0.1 | 0.1 | (0.0) | (0.0) | 0.4 | 0.5 | (0.0) | (0.0) |
| **Subtotal for covid** | **1.2** | **1.1** | **0.1** | **0.1** | **10.0** | **10.6** | **(0.7)** | **(0.4)** |
| | | | | | | | | |
| **Total Pay Cost** | **56.4** | **56.0** | **0.4** | **1.2** | **442.2** | **446.9** | **(4.6)** | **4.0** |

**Key messages:**

- Non Covid pay expenditure reports an adverse variance of £4.0m year to date.
- Covid expenditure is £0.7m adverse to plan. This is driven by higher usage of bank and agency nursing staffing than planned.

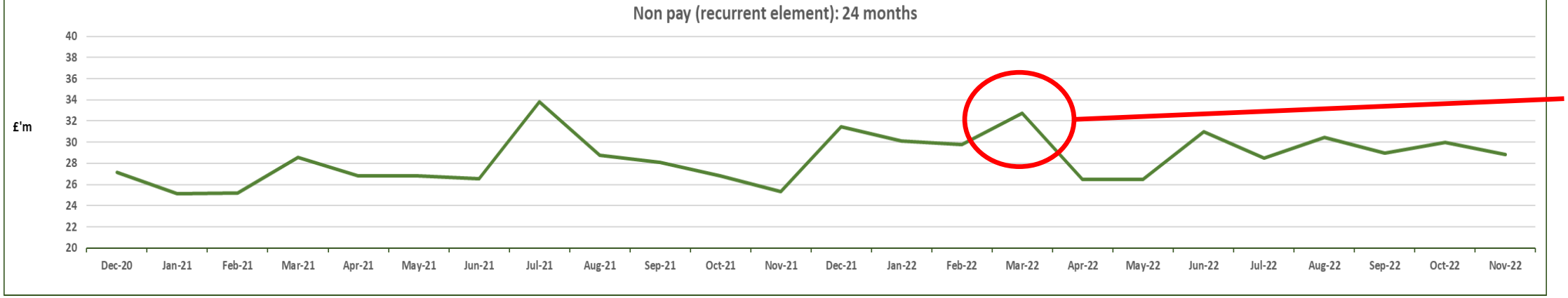
# Pay expenditure (continued)

| | In Month | | | | Year to Date | | | |
|---|---|---|---|---|---|---|---|---|
| *£ Millions* | Budget | Actual | Variance | Variance (exc. Pay Award) | Budget | Actual | Variance | Variance (exc. Pay Award) |
| **Non Covid:** | | | | | | | | |
| Agency | 0.0 | 0.6 | (0.5) | (0.5) | 0.2 | 3.9 | (3.8) | (3.8) |
| Bank | 1.3 | 4.8 | (3.4) | (3.4) | 10.9 | 32.4 | (21.5) | (20.9) |
| Contracted | 0.2 | 0.4 | (0.2) | (0.2) | 1.7 | 2.5 | (0.7) | (0.7) |
| Substantive | 53.7 | 49.2 | 4.5 | 5.2 | 419.5 | 397.4 | 22.1 | 29.8 |
| **Subtotal for non-covid** | **55.2** | **54.9** | **0.3** | **1.1** | **432.3** | **436.2** | **(4.0)** | **4.4** |
| **Covid:** | | | | | | | | |
| Agency | 0.1 | 0.1 | (0.0) | (0.0) | 0.6 | 1.1 | (0.5) | (0.5) |
| Bank | 0.3 | 0.3 | 0.1 | 0.1 | 2.7 | 5.1 | (2.5) | (2.3) |
| Contracted | 0.0 | 0.0 | (0.0) | (0.0) | 0.0 | 0.0 | (0.0) | (0.0) |
| Substantive | 0.8 | 0.8 | 0.0 | 0.0 | 6.7 | 4.3 | 2.4 | 2.5 |
| **Subtotal for covid** | **1.2** | **1.1** | **0.1** | **0.1** | **10.0** | **10.6** | **(0.7)** | **(0.4)** |
| **Total Pay Cost** | **56.4** | **56.0** | **0.4** | **1.2** | **442.2** | **446.9** | **(4.6)** | **4.0** |

**Key messages:**

- Non Covid substantive and contracted staff expenditure is £21.3m below budget in the year to date however the Trust has incurred offsetting Bank and Agency expenditure which are adverse to budget by £21.5m and £3.8m respectively.
- Whilst the overall full year pay plan figures align to the Trust wide-view, the plan for Bank and Agency is understated. NHSE/I are aware of this position and are taking it into account for performance management purposes.

# Pay expenditure (continued)




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

**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 8, the Trust's non pay position is £5.5m adverse to plan (including Covid costs) with an in month adverse movement of £1.1m.
- The in month adverse movement was primarily driven by drugs expenditure and an increase in the level of miscellaneous operating expenditure in line with increased risk provisions and board approved staff support initiatives. These cost pressures are fully offset by lower than planned expenditure for Clinical Supplies which included the Trust inflation funding reserves.
- The year to date adverse variance of £5.5m includes adverse movements of £7.0m for Drugs, £4.9m impairment of receivables, £10.1m of miscellaneous expenditure including operational expenditure of £4.8m, £1.9m untaken annual leave provisions, £1.9m staff risk provision; offset by favourable variances on Clinical supplies and services of £14.9m. Included within this, is the lower than planned fire prevention works expenditure of £5.1m.
- Overall Drugs expenditure is £7.0m adverse to plan. The adverse variances are funded by commissioners and are largely driven by neurology and clinical immunology drugs, with the balance spread across a range of service areas and pass-through drugs and devices. Some offset has been provided by a reduction in volume of Car-T in the year to date, totalling at £3.3m as at month 8. Costs historically fluctuate from month to month so this area of expenditure will be monitored closely over the remainder of the financial year.
- In month 8, Covid non-pay expenditure performed in line with plan. Year to date there is a favourable variance of £0.3m.

| *£millions* | In Month Budget | In Month Actual | In Month Variance | In Month Variance exc. Pay Award | Year to Date Budget | Year to Date Actual | Year to Date Variance | Year to Date Variance exc. Pay Award |
|---|---|---|---|---|---|---|---|---|
| **Non Covid:** | | | | | | | | |
| Drugs | 14.4 | 15.8 | (1.4) | (1.4) | 115.3 | 122.3 | (7.0) | (7.0) |
| Clinical Supplies | 17.0 | 12.1 | 5.0 | 5.0 | 135.5 | 120.6 | 14.9 | 14.9 |
| Misc Other Operating expenses | 0.1 | 3.4 | (3.3) | (3.3) | 0.2 | 10.3 | (10.1) | (10.1) |
| Premises | 4.6 | 4.9 | (0.3) | (0.3) | 37.0 | 38.9 | (1.9) | (1.5) |
| Clinical Negligence | 2.0 | 2.0 | 0.0 | 0.0 | 16.2 | 16.2 | 0.0 | 0.0 |
| Other non pay costs ( including CIP ) | 4.7 | 5.3 | (0.5) | (0.5) | 37.5 | 34.7 | 2.8 | 2.8 |
| ***Total Recurrent*** | ***43.0*** | ***43.5*** | ***(0.5)*** | ***(0.5)*** | ***341.6*** | ***343.0*** | ***(1.3)*** | ***(0.9)*** |
| Other non pay costs | 0.2 | 0.3 | (0.0) | (0.0) | 1.9 | 1.6 | 0.3 | 0.3 |
| Receivables impairment net of reversals | (0.2) | 0.4 | (0.5) | (0.5) | (1.3) | 3.5 | (4.9) | (4.9) |
| ***Total Non-recurrent*** | ***0.1*** | ***0.6*** | ***(0.6)*** | ***(0.6)*** | ***0.6*** | ***5.1*** | ***(4.6)*** | ***(4.6)*** |
| **Subtotal for non-covid** | ***43.0*** | ***44.1*** | ***(1.1)*** | ***(1.1)*** | ***342.2*** | ***348.1*** | ***(5.9)*** | ***(5.4)*** |
| **Covid:** | | | | | | | | |
| Drugs | 0.0 | 0.0 | 0.0 | 0.0 | 0.3 | 0.2 | 0.1 | 0.1 |
| Clinical Supplies | 0.2 | 0.2 | 0.0 | 0.0 | 2.2 | 2.0 | 0.2 | 0.2 |
| Misc Other Operating expenses | 0.0 | 0.1 | (0.1) | (0.1) | 0.4 | 0.4 | (0.0) | (0.0) |
| Premises | 0.1 | 0.1 | (0.0) | (0.0) | 0.5 | 0.4 | 0.1 | 0.1 |
| Clinical Negligence | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Other non pay costs ( including CIP ) | 0.2 | 0.2 | 0.1 | 0.1 | 2.1 | 2.1 | 0.0 | 0.0 |
| ***Subtotal for covid*** | ***0.6*** | ***0.6*** | ***0.0*** | ***0.0*** | ***5.5*** | ***5.1*** | ***0.3*** | ***0.3*** |
| **Total Non Pay** | **43.6** | **44.7** | **(1.1)** | **(1.0)** | **347.7** | **353.2** | **(5.5)** | **(5.1)** |

**Key messages:**

- The non pay position shows a £5.5m adverse year to date variance at month 8. The key drivers for this position are described on the earlier page.
- The negative budget for Receivables impairment net of reversals relates to a budgeted reduction in the level of Aged Debt. Changes in this metric are reported each quarter.

# Non pay expenditure (continued)

| £'m | M2 YTD | | M3 | | M4 | | M5 | | M6 | | M7 | | M8 | | M9 | | M10 | | M11 | | M12 | | YTD | | Forecast | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| Total Pay Efficiencies | 1.8 | 2.5 | 1.5 | 1.7 | 3.8 | 4.0 | 2.4 | 2.7 | 2.3 | 3.1 | 2.2 | 1.9 | 1.8 | 1.8 | 1.6 | | 2.5 | | 2.1 | | 2.4 | | 15.8 | 17.7 | 24.5 | 25.7 |
| Total Non-pay Efficiencies | 3.4 | 3.0 | 1.7 | 1.7 | 2.1 | 1.6 | 2.6 | 2.2 | 1.5 | 1.8 | 2.2 | 2.3 | 2.3 | 2.5 | 2.4 | | 1.9 | | 2.3 | | 1.4 | | 15.7 | 15.1 | 23.8 | 22.5 |
| Total Income Efficiencies | 5.6 | 5.6 | 0.8 | 0.8 | 0.8 | 0.7 | 0.8 | 0.8 | 0.8 | (0.3) | 0.8 | 1.0 | 0.8 | 0.6 | 0.8 | | 0.8 | | 0.8 | | 0.8 | | 10.5 | 9.2 | 13.7 | 13.8 |
| **Total Efficiencies - 2022/23** | **10.8** | **11.1** | **4.0** | **4.2** | **6.7** | **6.3** | **5.7** | **5.7** | **4.6** | **4.6** | **5.2** | **5.2** | **4.9** | **4.9** | **4.9** | **0.0** | **5.2** | **0.0** | **5.2** | **0.0** | **4.6** | **0.0** | **42.0** | **42.0** | **62.0** | **62.0** |

**Key messages:**

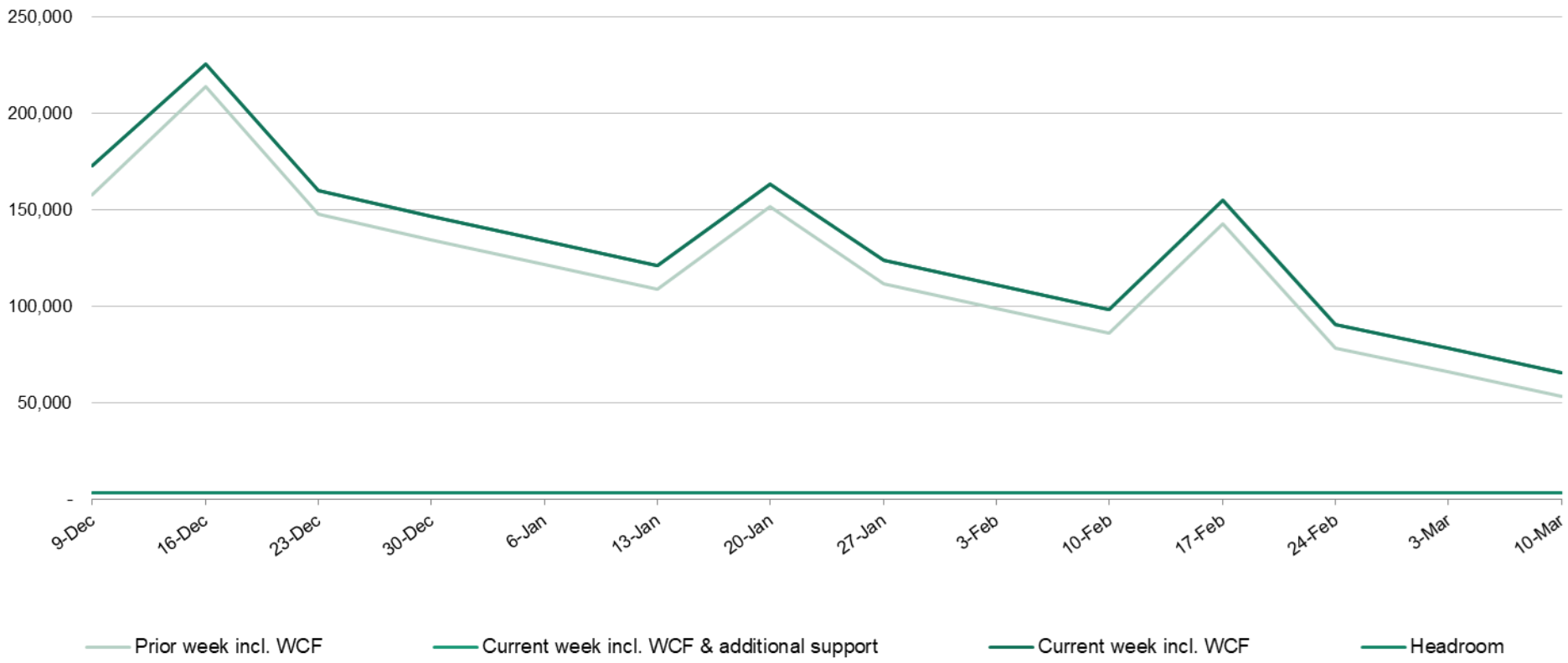
- The Trust has identified £62.0m of efficiencies in line with plan; £42.7m are forecast to be recurrent. The plan includes £11.0m of non-recurrent savings that fund current year System support requirements.
- At month 8, the cumulative position reports in line with plan, with efficiencies of £42.0m achieved.
- Pay efficiencies are currently ahead of plan by £1.8m. Within this, recurrent initiatives are (£2.3m) adverse to plan and non-recurrent schemes are £4.1m ahead of plan.
- For non-pay efficiencies, initiatives are (£0.5m) adverse to plan, reporting achievement of £15.1m against plan of £15.7m.
- Income efficiencies are reporting adverse to plan by (£1.3m) driven by a shortfall in non-recurrent scheme delivery. This measure includes the non-recurrent campus development project income receipt of £4m.
- The latest full year efficiency forecast identifies full delivery of the plan however there is a significant estimated shortfall in recurrent savings of £4.9m. 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 appendices for detailed efficiency plan schedules.

| | YTD Plan | | | YTD Actual Delivery | | | YTD Variance | | |
|---|---|---|---|---|---|---|---|---|---|
| £m | Recurrent | Non-recurrent | Total | Recurrent | Non-recurrent | Total | Recurrent | Non-recurrent | Total |
| Pay | 15.4 | 0.5 | 15.8 | 13.1 | 4.6 | 17.7 | (2.3) | 4.1 | 1.8 |
| Non-pay | 15.2 | 0.5 | 15.7 | 13.9 | 1.3 | 15.1 | (1.3) | 0.8 | (0.5) |
| Income | 0.4 | 10.1 | 10.5 | 0.5 | 8.7 | 9.2 | 0.1 | (1.4) | (1.3) |
| | **31.0** | **11.0** | **42.0** | **27.5** | **14.5** | **42.0** | **(3.5)** | **3.5** | **0.0** |

| | Full Year Plan | | | Forecast Full Year Delivery | | | Variance | | |
|---|---|---|---|---|---|---|---|---|---|
| £m | Recurrent | Non-recurrent | Total | Recurrent | Non-recurrent | Total | Recurrent | Non-recurrent | Total |
| Pay | 23.8 | 0.7 | 24.5 | 20.8 | 4.9 | 25.7 | (3.0) | 4.2 | 1.2 |
| Non-pay | 23.2 | 0.6 | 23.8 | 21.2 | 1.3 | 22.5 | (2.0) | 0.7 | (1.3) |
| Income | 0.6 | 13.1 | 13.7 | 0.8 | 13.1 | 13.8 | 0.1 | (0.0) | 0.1 |
| | **47.6** | **14.4** | **62.0** | **42.7** | **19.3** | **62.0** | **(4.9)** | **4.9** | **0.0** |

# Efficiency Plan & Delivery

## CUH 13 week rolling cash flow forecast (£000)




**Key messages:**

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

# Appendices

# Month 8 capital expenditure position

| Year to Date (Month 8) | | | | Forecast | | |
|---|---|---|---|---|---|---|
| Programme | Budget £m | Actuals £m | Variance £m | Budget £m | Expenditure £m | Variance £m |
| Orthopaedic theatres | 8.5 | 11.5 | (3.0) | 14.9 | 14.9 | - |
| Theatre equipment & infrastructure | 2.3 | - | 2.3 | 4.1 | 4.1 | - |
| P&Q ward modifications | 1.4 | - | 1.4 | 2.5 | 2.5 | - |
| Existing Estate/HV | 4.7 | 3.4 | 1.3 | 9.3 | 9.4 | (0.1) |
| Cancer Research Hospital (CCRH) | 3.6 | 2.2 | 1.4 | 5.3 | 5.3 | - |
| Thrombectomy | 3.9 | 4.7 | (0.8) | 5.9 | 5.3 | 0.6 |
| Medical Equipment Replacement | 1.9 | 0.9 | 1.0 | 3.4 | 3.4 | - |
| Children's Hospital (CCH) | 3.5 | 3.0 | 0.5 | 5.9 | 5.9 | - |
| Nuclear Medicine | 2.0 | 2.3 | (0.3) | 3.0 | 3.3 | (0.3) |
| e Hospital/Legacy Systems | 1.8 | 0.2 | 1.6 | 3.0 | 3.5 | (0.5) |
| Other Developments/PFI | 3.6 | 2.0 | 1.5 | 5.3 | 5.0 | 0.4 |
| **Programme Total** | **37.1** | **30.1** | **7.0** | **62.6** | **62.6** | **-** |

**Key Issues/Notes Year to Date**

£30.1m has been invested YTD, against a budget of £37.1m. The larger areas of spend this year have been:

- Orthopaedic theatres - £11.5m
- Thrombectomy - £4.7m
- Children's Hospital (CCH) - £3.0m
- Nuclear Medicine refurbishment - £2.3m
- Cancer Research Hospital (CCRH) - £2.2m

Spend has caught up slightly with YTD budget in M8 but is still behind budget across most areas of the capital plan. YTD we have spent only 66% of the respective budget.

**Key Issues/Notes Forecast**

The annual budget has increased by £0.2m since last month due to the provision of additional funding from ACT for the Ophthalmology refurb and an MoU received for the purchase of a Radiotherapy phantom training aid.

Our forecast for 22/23 is in line with the budget of £62.6m, with a requirement for forecast projects to slip by £0.7m to achieve the budget by year end. There are risks around the delivery of the larger Estates projects and plans are being put in place to manage and mitigate any further slippage.

# Capital expenditure by programme

**Balance sheet**

| | M8 Actual £m |
|---|---|
| **Non-current assets** | |
| Intangible assets | 24.2 |
| Property, plant and equipment | 496.6 |
| **Total non-current assets** | **520.8** |
| **Current assets** | |
| Inventories | 11.8 |
| Trade and other receivables | 69.5 |
| Cash and cash equivalents | 161.5 |
| **Total current assets** | **242.8** |
| **Current liabilities** | |
| Trade and other payables | (201.0) |
| Borrowings | (8.8) |
| Provisions | (8.2) |
| Other liabilities | (97.2) |
| **Total current liabilities** | **(315.2)** |
| **Total assets less current liabilities** | **448.4** |
| **Non-current liabilities** | |
| Borrowings | (116.4) |
| Provisions | (13.1) |
| **Total non-current liabilities** | **(129.5)** |
| **Total assets employed** | **318.9** |
| **Taxpayers' equity** | |
| Public dividend capital | 583.3 |
| Revaluation reserve | 37.5 |
| Income and expenditure reserve | (301.9) |
| **Total taxpayers' and others' equity** | **318.9** |

## Balance sheet commentary at month 8

- The balance sheet shows total assets employed of £318.9m.
- Non-current liabilities at month 8 are £129.5m, of which £116.4m represents capital borrowing (including PFI and IFRS 16).
- Cash balances remain strong at month 8.
- The balance sheet includes £26.7m 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

# Report to the Board of Directors: 18 January 2023

| | |
|---|---|
| **Agenda item** | 10 |
| **Title** | CNST Maternity Incentive Scheme |
| **Sponsoring executive director** | Lorraine Szeremeta, Chief Nurse |
| **Author(s)** | Claire Garratt, Head of Midwifery |
| **Purpose** | To provide the Board with assurance that all 10 CNST standards for the fourth year (2022) have been met. |
| **Previously considered by** | Quality Committee, 11 January 2023 |

## Executive Summary

NHS Resolution is operating a fourth year of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme to continue to support the delivery of safer maternity care. The attached paper provides the Board of Directors with the oversight and assurance on the 10 CNST standards. Following extensive work as set out in the paper, backed by detailed evidence, compliance with the standards was reviewed by the Management Executive and subsequently the Quality Committee at its meeting on 11 January 2023, and the Committee agreed to recommend to the Board that the standards have been met for 2022.

The report should be read in the context of the Trust's comprehensive Maternity Improvement Plan, which also incorporates action plans resulting from the Ockenden and Kirkup reviews of maternity services in other NHS trusts. An update was most recently provided to the Board of Directors in November 2022 as part of a report on the Kirkup review, and updates are provided bimonthly to each meeting of the Board's Quality Committee. In addition, there are regular Safety Champion meetings involving the Board-level Perinatal Safety Champions.

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|---|---|
| Related Trust objectives | Improving patient care |
| Risk and Assurance | The paper provides assurance on compliance with the CNST maternity standards. |
| 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”? | Yes |

**Action required by the Board of Directors**

The Board is asked to:

- Receive the report.
- Note that all required evidence has been reviewed at the Division E CNST governance meeting, demonstrating achievement of the 10 maternity safety actions as set out in the safety actions and technical guidance document.
- Note that associated evidence was reviewed and approved by the Integrated Care Board (ICB) deputy chief nurse on 22 December 2022 and 3 January 2023 prior to confirming to the ICB Accountable Officer that CUH is compliant with the 10 safety actions. The report will be submitted to the LMNS (Local Maternity and Neonatal System) Board on 19 January 2023.
- Confirm that it is satisfied that the evidence has been provided of meeting all 10 safety standards to enable the Chief Executive to sign off and final submission to NHS Resolution by 12.00 on 2 February 2023 via NHS Resolution’s Board declaration form.
- Note that the Trust CEO will ensure that the ICB AO is appraised of the Maternity Incentive Scheme safety actions evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are fully assured and in agreement with the compliance submission to NHS Resolution.
- Note that all evidence is available on request.

# Cambridge University Hospitals NHS Foundation Trust

**18 January 2023**

**Board of Directors**
**CNST Maternity Incentive Scheme**
**Lorraine Szeremeta, Chief Nurse**
**Claire Garratt, Head of Midwifery**

## 1. Introduction

1.1 Maternity Services at Cambridge University Hospitals NHS Foundation Trust are required to evidence the provision of safe, effective, responsive, caring, and well-led services, in line with the Fundamental Standards of Care, as outlined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

1.2 In line with these regulatory requirements and the maternity transformation programme, Maternity Services engage with a series of externally mandated quality improvement programmes including the national Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme operated by NHS Resolution. As part of the latter, the Trust must demonstrate compliance with all 10 maternity safety standards (see Section 5).

1.3 As in the previous three years, trusts contribute an additional 10% of their CNST maternity insurance premium to create a central CNST Maternity Incentive Fund. Trusts then receive financial distributions from this Fund if they are able to demonstrate compliance with the 10 maternity safety standards referenced above.

1.4 This paper provides a summary demonstrating compliance with the 10 safety standards for CNST, which helps to ensure that the care provided to women and their children within maternity services continues to improve, resulting in high quality outcomes and a positive experience. This has been presented to the Quality Committee, which supported at its meeting on 11 January 2023 the submission to the Board based on compliance with all 10 standards.

## 2. Background

### NHS Resolution CNST Maternity Incentive Scheme

2.1 NHS Resolution is operating a fourth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care and that as in previous years, the scheme incentivises 10 maternity safety actions. Trusts that can demonstrate they have achieved all of the 10 safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and individual trusts will also receive a share of any unallocated funds.

2.2 Due to the Covid-19 pandemic, in December 2021, a national decision was made by NHS Resolution to pause the reporting for year 4 of the scheme. Trusts were asked to continue to apply the principles of the scheme and to continue to report to MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK), NHS Digital and HSIB (Healthcare Safety Investigation Branch).

2.3 The scheme's advisory group reconvened on 28 February 2022 and a decision was made to relaunch the scheme on 6 May 2022.

## 3. Governance

3.1 The Maternity Services leadership team have set fortnightly CNST governance meetings with key internal stakeholders, supported by project management through the Division's Senior Improvement and Transformation Manager.

3.2 The Maternity Services leadership team has continued with regular CNST governance meetings during the past year involving key internal stakeholders. The content of this paper demonstrates the current position.

3.3 The key stakeholders who took part in the CNST Governance meetings and ensure actions were met are as follows:

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| Head of Midwifery |
| Deputy Head of Midwifery |
| Div E Operations Manager |
| Divisional Patient Safety Lead and Neonatal Consultant |
| Lead Midwife for Safety and Governance |
| Lead Midwife for Quality and Patient Experience |
| Clinical Director for Women's Services |
| Obstetric Consultant |
| Practice Development Lead Midwife |
| Neonatal Clinical Risk Manager |
| Anaesthetic Consultant |
| Perinatal Resuscitation Officer |
| Matron for Neonatal Services |
| Senior Application Analyst / Report Writer, eHospital |
| Division E Project Manager |

## 4. Assessment

4.1 The service is able to fully evidence that Maternity Services at CUH meet the 10 standards. A descriptor of the activities necessary to meet the standards is outlined first. Following this, for each standard a narrative around the evidence has been provided. The detailed evidence is available on request.

## 5. The 10 standards

| **1. Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?** |
|---|
| The following applies from 6 May 2022 onwards:<br>• All perinatal deaths eligible to be notified to MBRRACE-UK from 6 May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death.<br>• When suitable for PMRT review, the tool is commenced within 2 months of the death of a baby (95% compliance required) and at least 50% reviewed by an MDT. The draft report must be generated within 4 months and published within 6 months of the death.<br>• The parents must be notified that a review will take place and that their perspectives and any questions and/or concerns they have about their care and that of their baby have been sought (95% compliance required). |
| **Evidence** |
| A multi-disciplinary team has reviewed all perinatal deaths meeting the following criteria using the MBRRACE-UK Perinatal Mortality Review Tool (PMRT). Quarterly reports have continued to be submitted via the Trust-wide Learning from Deaths Committee, including details of the reviews and action plans. These reports have also been shared with the Maternity Safety champions.<br>All parents (n=22) have been informed of the local review of their care and that of their baby. Local audits have been conducted (PRN10880 and PRN10882) in line with local policy: Learning from Deaths. |

| **2. Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?** |
|---|
| • By 31st October 2022, Trusts have an up-to-date digital strategy for maternity services aligned with the wider Trust Digital Strategy and reflecting the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with the LMNS and ICB. There must be dedicated Digital Leadership within the service and engagement with the NHSE&I (NHS England & NHS Improvement) Digital Child Health and Maternity Programme.<br>• Trust Boards to assure themselves at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) pass the associated data quality criteria for MSDS data submissions relating to July 2022 activity. July 2022 data must |

contain: a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation (for 90% of women); a Complex Social Factor Indicator (at antenatal booking) (for 95% of women); antenatal personalised care plan fields (for 95% of women); and valid ethnic category (for 90% of women).

**Evidence**

The Maternity Services Data Set (MSDS) is a patient-level data set which captures information about Maternity Services activity relating to mothers and babies from the point of the first booking appointment until discharge from maternity services. Data from the MSDS is used to evidence whether organisations pass the associated data quality criteria for the Clinical Quality Improvement Metrics (CQIMs) on the National Maternity Dashboard.

A digital maternity strategy for the maternity service, reflecting the 7 success measures within the What Good Looks Like Framework and aligning with the wider Trust digital strategy was approved within the organisation and by the Integrated Care Board in September 2022. This will function as an enabler and provide direction and structure when facilitating future digital improvements. In addition, the maternity service has dedicated digital leadership from the Digital Midwife, Lead Midwife for Quality and Patient Experience, Project Managers within Division E and dedicated data analysts who work on MSDS data requirements within the informatics team.

10 of the 11 CQIMs passed the associated data quality criteria for data submissions relating to activity in July 2022. This is evidenced by the monthly scorecard issued by NHS Digital and the exemption confirmation email for BMI reporting (permits exclusion of out of area women).

**3. Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?**

- Neonatal transitional care (TC) pathways are jointly approved by maternity and neonatal teams. Neonatal teams are involved in decision making and planning care for all babies in transitional care. This pathway is fully implemented and audited quarterly.
- A data recording process for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place.
- Commissioner returns for Healthcare Resources Groups 4/XA04 activity as per neonatal critical care minimum data set are available on request to be shared with the ODN, LMNS and commissioners to inform capacity planning.
- Avoiding Term Admissions Into Neonatal units (ATAIN) reviews are undertaken at least quarterly and include all transfers and admissions, regardless of length of stay. The number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or

admitted to the neonatal unit due to capacity or staffing issues are also reported.
- An action plan to address local findings TC audits and ATAIN reviews has been agreed with the maternity and neonatal safety champions and at Board level.
- TC audit result, ATAIN reviews and progress on the ATAIN action plan are shared with the maternity, neonatal and Board level safety champions, the LMNS and at the ICS quality surveillance meeting.

**Evidence**

Transitional Care supports resident mothers as primary care providers for babies with care requirements more than normal newborn care. Implementation of transitional care has the potential to prevent admissions to the neonatal unit, and to provide additional support for small and/or late pre-term babies and their families (BAPM 2017). Transitional care is a service, rather than a location, and in CUH can be provided on Delivery Unit, Lady Mary Ward (the postnatal ward), Obstetric Close Observation Unit and Charles Wolfson Ward (low-dependency paediatric ward).
Pathways into transitional care at CUH have been jointly approved and implemented by the maternity and neonatal teams, with neonatal involvement in decision making and planning of care for all babies in transitional care, evidenced by the current guideline and quarterly audits (PRN10222).

Findings are shared at local ATAIN group meetings, with the maternity, neonatal and Board level safety champions, the LMNS at the Operational Delivery Group (ODG). CNST requirements include that this data and action plan progress are also submitted to the Integrated Care System (ICS) quality surveillance meeting each quarter. This is evidenced via the minutes from the ICB System Quality Group Assurance meeting.
CUH captures transitional care activity using CHEQS reporting. A further data recording process for babies transferred to the Neonatal Unit but not admitted, regardless of length of stay has been set up manually and will be included within the NICU operational policy.
Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per the Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 are available should a request be made by the Director of East of England Neonatal Operational Delivery Network (ODN).
Reviews of term admissions continue monthly and as well as a review of the term admissions these also specifically include:

- All neonatal unit transfers or admissions regardless of their length of stay.
- Numbers of transfers to the neonatal unit that would have met current transitional care admission criteria but were transferred or admitted to the neonatal unit due to capacity of staffing issues (zero between April-October 2022).
- Number of babies that were transferred or admitted or remained on neonatal units because of their need for nasogastric tube feeding (zero between April-October 2022).

The ATAIN working group meets monthly to review term admissions data and to identify, plan and implement improvements. The minutes and action plan of the ATAIN working group evidence rationale for developing the agreed actions to

address identified and modifiable factors for admission to transitional care and prevent avoidable admissions to NICU. This has been agreed with the maternity and neonatal safety champions and board level champion. The findings, action plan and progress with the action plan of the ATAIN working group are shared with the maternity, neonatal and Board level safety champions, and the LMNS via the Operational Delivery Group.

All minutes and slides are available on request.

**4. Can you demonstrate an effective system of clinical workforce planning to the required standard?**

**1.Obstetric medical workforce:**

- The obstetric consultant team and maternity senior management team acknowledge and commit to incorporating into the service the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'. Compliance with clinical situations when a consultant is required to attend in person as per the document is monitored. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. This should be shared with the Trust board, the board-level safety champions as well as LMNS.

**2. Anaesthetic medical workforce:**

- A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients (ACSA standard 1.7.2.1)

**3. Neonatal medical workforce:**

- The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing.

**4.Neonatal nursing workforce:**

- The neonatal unit meets the service specification for neonatal nursing standards.

**Evidence**

**Obstetric medical workforce:**
The Division can demonstrate engagement with the Royal College of Obstetricians and Gynaecologists (RCOG) workforce document "Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service" https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/

A monthly audit (PRN 4799) is undertaken to monitor compliance with the RCOG standards which are written into the local Delivery Unit operational policy. Between 29 July and 31 October 2022, 2 cases were non-compliant in the month of September. It is currently not possible to reliably audit compliance for 1 standard – "request to attend debrief". The 2 cases have been reviewed by two obstetric consultant and a local action plan has been agreed with the MDT to address this and to ensure effective, formal review of ongoing non-compliance. The action plan which has been presented at the perinatal safety champions meeting in December 2022. In order to meet the requirement of Safety Action 4 section a, part 2, the non-compliance and improvement plan is due to be presented to the LMNS Board on 19 January 2023 as this has not yet been undertaken. This will still meet the CNST deadline of 2nd February.

**Anaesthetic medical workforce:**
The service is able to evidence compliance with Anaesthesia Clinical Services Accreditation (ACSA). All evidence has been reviewed and accepted by the CNST working party and is available in the CNST year 4 evidence log. Anaesthetic rotas are available as evidence.

**Neonatal medical workforce:**
The neonatal unit meets the British Association of Perinatal Medicine (BAPM) National standards of junior medical staffing. This is evidenced in the GIRFT report from December 2020. A copy of the medical rotas is available in the CNST year 4 evidence log.

**Neonatal nursing workforce:**
Progress against the action plan to achieve compliance with BAPM standards was included within the November 2022 safer staffing report and accepted by the Board of Directors (BoD). The updated action plan has been shared with the Neonatal ODN and the Royal College of Nursing to meet the evidential requirements within this standard.

**5. Can you demonstrate an effective system of midwifery workforce planning to the required standard?**

- A systematic, evidence-based process to calculate midwifery staffing establishment is completed.
- Trust Board to evidence midwifery staffing budget reflects establishment as calculated in Birthrate Plus tool.
- The midwifery coordinator in charge of labour ward has supernumerary status (defined as having no caseload of their own during their shift), to ensure there is an oversight of all birth activity within the service.
- All women in active labour receive one-to-one midwifery care.
- Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period.

**Evidence**

A midwifery workforce report was presented to NMAAC (Nursing, Midwifery and Allied Health Professionals Committee) and the Board of Directors in November 2022. The report demonstrated compliance with all minimum evidential requirements within Safety Action 5 apart from the midwifery red flag – loss of supernumerary (SN) status of the delivery unit coordinator. A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE, 2015). The BirthRate+ live acuity tool was introduced at CUH in May 2021 and enables the capture of real time data on staffing and acuity and is the tool used to capture midwifery red flags.

Technical guidance around this red flag definition changed on 11 October 2022 and was further outlined 1 December 2022, which means that the service can now evidence full compliance with this standard.

From 11th October an additional red flag was therefore added to BR+ to enable accurate capture of any occurrence where there was loss of SN status to the provision of 1:1 care. RF10 remains on the red flag report but is only used to capture when the delivery unit coordinator is giving episodes of care that are not 1:1. There have been no episodes of loss of SN status as defined by the revised guidance since 11 October and no reported cases prior to 11th October where the DU Coordinator was providing 1:1 care.

A midwifery establishment review was undertaken by BirthRate+ in 2022. The final report was received in September 2022 and included in the safer staffing report to the Board in November 2022. The service is currently reviewing the recommendations for a small number of additional clinical midwives and a further report will be presented to the Trust Board when this work is complete.

The Trust is required to demonstrate 1:1 care in active labour. Compliance over the CNST reporting period of 6 May to 5 Dec 2022 has ranged from 98.69% to 100% (2 months were 100% compliant). Non-compliance was presented to the Board in November 2022 as part of the safer staffing report. Mitigation when 1:1 care cannot be achieved is though the escalation to divert policy and internal redeployment of staff to ensure areas and staffing levels are safe utilising the role of the operational bleep holder and Manager of the day where required. An action plan was presented to the Board at this time as per CNST requirements.

**6. Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two (SBLCBv2)?**

- Trust Board level consideration of how its organisation is complying with SBLCBv2, published in April 2019. Each element of the SBLCBv2 should have been implemented. The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements.

**Evidence**

Quarterly care bundle submissions have been completed throughout 2021/22 and will continue to be submitted until data submission requirements for the MSDS are met. The relevant data items for the indicators within this element are recorded or being developed for inclusion within CUH's Maternity Information System.

**Element 1: Reducing smoking in pregnancy**

The Trust is able to demonstrate that the following requirements of safety action 6 are met and an audit report (PRN10782) has been submitted to QSIS as evidence (NB: no targets were set for the audited elements).

**Element 2: Risk assessment and surveillance for fetal growth restriction**

In-house audit (PRN10553) demonstrated that CNST compliance >95% is achieved for risk assessment and appropriate USS follow-up.
A quarterly audit of all babies born <3rd centile >37+6 weeks' gestation is undertaken (PRN8170, PRN9472) and submitted six-monthly.
The percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue have been generated and reviewed as evidenced by audit report PRN4882 which demonstrated 100% compliance with the standards for review and action.
Local risk assessment and management of growth disorders in multiple pregnancy comply with NICE guidance as evidenced by a baseline assessment tool for NG137 completed in April 2022.

**Element 3: Raising awareness of reduced fetal movements**

In-house audit (PRN10797) demonstrates 100% compliance for the process indicators of women receiving information about reduced fetal movements and women attending with reduced fetal movements have computerised cardiotocograph. (CNST minimum requirement >80%)

**Element 4: Effective fetal monitoring during labour**

The SBLCBV2 element 4 is fully implemented. The annual MDT CTG study day is consistent with Ockenden recommendations and includes antenatal and intrapartum fetal monitoring in labour, how to use local CTG machines, intermittent auscultation, electronic fetal monitoring, system level issues including human factors, escalation processes, confirmation bias and situational awareness. As of 04/01/2023 CTG study day compliance over a 12-month consecutive period was 92.74% and K2 competency assessment compliance over a 12-month consecutive period was 91.38% (target compliance >90%).

**Element 5: Reducing pre-term births**
In-house audit (PRN10756) of compliance with process indicators for element 5 has been completed as per CNST requirements. This standard and relevant action plan are monitored through MatNeoSIP quality improvement meetings and the LMNS has oversight of this data via Badgernet, providing external scrutiny.

**7. Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?**

- MVP Terms of Reference (ToR) reflect core principles outlined in 'Implementing Better Births: A resource pack for Local Maternity Systems' MVP ToR. Meeting minutes demonstrate how service users are listened to and regular feedback is obtained, that actions are in place to demonstrate that listening has taken place and evidence of service developments resulting from coproduction between service users and staff.
- Written confirmation from the service user chair that they are being remunerated and that they and other service user members of the MVP committee are able to claim out of pocket expenses.
- The MVP's work programme is agreed by the LMNS board.
- Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation.
- Evidence that the MVP Chair is invited to attend maternity governance meetings and that actions from maternity governance meetings, including complaints' response processes, trends and themes, are shared with the MVP.

**Evidence**

The Rosie Maternity and Neonatal Voice Partnership (RMNVP) have an agreed Terms of Reference (minimum evidence requirement) in line with the Implementing Better Births resource pack. The Chair is remunerated, and the remuneration reflects the time commitment and requirements of the role given the agreed work programme. The chair, and other service user members can claim out of pocket expenses in a timely way.

The RMNVP meet formally four times a year, including an AGM. Meetings are minuted, demonstrating how service users are listened to, with actions forming part of the RMNVP work plan (agreed at the RMNVP meeting and LMNS board). This work plan provides evidence of subsequent coproduction plans between staff and service users and the results are evidenced within the RMNVP Annual Report. Actions from maternity governance meetings, including complaints response processes, trends and themes are shared with the MVP.

The RMNVP prioritises hearing the voices of Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation through 121 listening sessions, a project to visit traveller sites in the area, peer visits to

Children's Centre groups in areas of deprivation and development of a visual / easy read short survey. The RMNVP is also reviewing MNVP membership to ensure it is more ethnically diverse, capturing ethnicity in local feedback surveys and prioritising voices from these communities through a standing agenda item.

As per CNST and Ockenden requirements, the MVP chair is invited to attend maternity governance meetings and actions from governance meetings, including complaints' response processes, trends and themes are shared with the RMNVP.

**8. Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?**

From year 4 in August 2021:

- The local training plan includes all six core modules of the Core Competency Framework over 3 years.
- 90% of each relevant maternity unit staff group have attended an 'in house' one day multi-professional training day that includes maternity emergencies, an 'in house' one day multi-professional antenatal and intrapartum fetal monitoring study day, and neonatal life support training or a Newborn Life Support (NBLS) course.

**Evidence**

The local training plan is aligned to the six core modules of the Core Competency Framework over 3 years, as demonstrated by the Rosie Training Needs Analysis.
CNST specifies staff compliance of >90% for the following training days and competencies:

**Fetal surveillance training**
This is delivered in the Trust via a CTG study day and K2 competency assessment. As of 04/01/2023 the CTG study day compliance over a 12-month consecutive period is 92.74% across the MDT, including SHO GP trainees. As of 04/01/2023 K2 compliance over a 12-month consecutive period is 91.38%.

**PROMPT training**
**Pr**actical **O**bstetric **M**ulti **P**rofessional **T**raining (PROMPT) training dates, as of 04/01/2023, over a 12-month consecutive period, compliance is 93.94% across the MDT.

**Neonatal resuscitation training**
Compliance of 93% was demonstrated as of 06/12/2022 over a consecutive 12-month period for all relevant staff members requiring training as per CNST guidance.

**9. Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?**

- The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-quality-surveillance-model.
- Board level safety champions present a locally agreed dashboard to the Board quarterly, including the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022.
- Trust Boards have reviewed current staffing in the context of the letters to systems on 1 April 2022 and 21 September 2022 regarding the roll out of Midwifery Continuity of Carer as the default model of care. A decision has been made by the Board as to whether staffing meets safe minimum requirements to continue rollout of current or planned continuity teams, or whether rollout should be suspended.
- Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP).

**Evidence**

The role of the Board Level Safety Champion is to "develop strong partnerships, that promote the professional cultures needed to deliver better care and play a central role in ensuring that mothers and babies continue to receive the safest care possible by adopting best practice" (*Maternity and neonatal safety champions Toolkit, September 2020).* Our Board level champions Dr Mike Knapton until April 2022 and Professor Ian Jacobs from April 2022 continue to support quality improvement by working with the designated improvement leads across perinatal services to ensure learning and improvements are shared within the Trust and across regional networks.

We have continued to have a nominated obstetrician, neonatologist and midwife who are jointly responsible for championing maternity safety locally, making appropriate links with the board, the local maternity clinical network and the Maternal and Neonatal Safety Improvement Programme (MatNeoSIP).

The Board level champions have met regularly with the maternity safety champions and have been updated on locally identified issues in part using the Perinatal Quality Surveillance Model. These updates have also included discussions regarding safety intelligence, the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues.

Sharing insights and good practice between providers, their LMNS, ICS and regional quality groups should be optimised. The board level safety champions have been

able to attend some of these groups and participate in regional sharing and learning. They have attended Patient Safety Network meetings and Local Mat/neo system meetings and CUH chaired the regional perinatal safety champions meeting with the chief midwifery officer for the East of England on 8th February 2022.

The Board level Safety Champion continues to hear service user feedback by attendance at the Rosie Maternal and Neonatal Voice Partnership (RMNVP). They have also reviewed the continuity of carer action plan and continue to support this being the default model of care offered to all women by March 2024, prioritising those most likely to experience poor outcome. Feedback from this intelligence, the staff survey and 'all staff meetings' have been used to update the safety dashboard which is displayed in all staff areas. This reflects actions and progress made on the identified concerns raised by staff. The three key areas are safe staffing levels, staff wellbeing and communication.

The Trust remains committed to the implementation of continuity of carer at CUH. Target dates to deliver continuity of carer have been removed at national level.

Due to the increased risk facing women from Black, Asian and minority ethnic backgrounds and from the most deprived areas of poor outcomes, CUH is prioritising women from these groups. This is reported through the monthly highlight reporting and the integrated performance report (IPR) submission. The Board level Safety Champion is fully cited on progress against the action plan with minuted monthly updates.

Engagement at MatNeoSIP Patient Safety Network events have continued during year 4. The Trust continues to engage with these events and has attended two of these in the spring of 2022.

**10. Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?**

From 1 April – 5 Dec 2022:

- All qualifying cases reported to HSIB.
- All qualifying Early Notification (EN) cases reported to NHS Resolution's Early Notification Scheme.
- For all qualifying cases the Trust Board are assured that the family have received information on the role of HSIB and NHS Resolution's EN scheme; and there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.

**Evidence**

Qualifying incidents of term deliveries following labour that resulted in severe brain injury are reported to NHS Resolution's Early Notification Scheme. In accordance with the statutory duty of candour families are advised of enquires to be undertaken:

- 100% (n=1) of our cases that occurred for the period 1 April 2021 to 5th December 2022 have been reported in accordance with the statutory duty of candour.
- 100% (n = 3) of the cases that occurred for the period 1st April 2021 to 5th December 2022 have been reported to the Healthcare Safety Investigation Branch (HSIB) in accordance with the statuary duty of candour.

All eligible maternity incidents were reported to the Healthcare Safety Investigation Branch (HSIB) which then notified NHS Resolution of the cases.

## 6. Conclusions

*Assurance*

6.1 Assurance that the evidence meets the CNST requirements is outlined below:

- The Head of Midwifery reviewed all evidence against the detailed 'minimal evidence required' to provide assurance to the Divisional Bronze meeting where CNST standards and evidence were discussed on 18 December 2022.
- The CNST working group with the Director of Midwifery, the deputy chief nurse of the ICB and the Lead Quality midwife from the LMNS reviewed all evidence on 22 December 2022 and 3 January 2023 prior to final sign off.
- Papers detailing the implementation of all 10 safety standards with all outstanding evidence was reviewed and agreed by the Quality Committee on 7 September 2022 and 11 January 2023.

*Risks*

6.2 Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

*Next steps*

6.3 CNST is an annual requirement and the team have received notification of year 5 of the scheme which is due to be launched in spring 2023. The service needs to ensure that all stakeholders (internal and external) are clear on the expectations of the standards and ensure they are recurring items on directorate meeting work plans.

6.4 As in previous years, an After-Action Review (AAR) will be undertaken for all stakeholders to look at lessons learned and provide an opportunity for stakeholders to share what worked well, and what could be improved.

## 7. Recommendations

7.1 The Board of Directors is asked to:

- Receive the report.
- Note that all required evidence has been reviewed at the Division E CNST governance meeting, demonstrating achievement of the 10 maternity safety actions as set out in the safety actions and technical guidance document.
- Note that associated evidence was reviewed and approved by the Integrated Care Board (ICB) deputy chief nurse on 22 December 2022 and 3 January 2023 prior to confirming to the ICB Accountable Officer that CUH is compliant with the 10 safety actions. The report will be submitted to the LMNS (Local Maternity and Neonatal System) Board on 19 January 2023.
- Confirm that it is satisfied that the evidence has been provided of meeting all 10 safety standards to enable the Chief Executive to sign off and final submission to NHS Resolution by 12.00 on 2 February 2023 via NHS Resolution's Board declaration form.
- Note that the Trust CEO will ensure that the ICB AO is appraised of the Maternity Incentive Scheme safety actions evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are fully assured and in agreement with the compliance submission to NHS Resolution.
- Note that all evidence is available on request.

Board of Directors

Cambridge University Hospitals
NHS Foundation Trust

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# Report to the Board of Directors: 18 January 2023

| | |
|---|---|
| **Agenda item** | 11 |
| **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, 5 January 2023 |

## Executive Summary

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

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

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

**Action required by the Board of Directors**

The Board is asked to receive the report.

# Cambridge University Hospitals NHS Foundation Trust

**18 January 2023**

**Board of Directors**

**Research and Development**

**John Bradley, Director of R&D**

## 1. NIHR Cambridge Biomedical Research Centre (BRC)

1.1 The outcome of the National Institute for Health and Care Research (NIHR) Biomedical Research Centre competition was announced publicly in October 2022. The NIHR Cambridge BRC was re-designated as one of 20 Biomedical Research Centres, which were awarded a total of £800m to translate scientific discoveries from the laboratory into the clinic. The NIHR Cambridge Biomedical Research Centre was awarded £86.2m.

## 2. NIHR BioResource

2.1 Cambridge University Hospitals hosts the NIHR BioResource, a national recallable resource involving over 120 NHS organisations and over 250,000 volunteers from the general population, and patients with rare and common diseases. It is one of four key infrastructures supporting population level genomic projects in the Life Science Industrial Strategy. Following a successful regional launch at St Michael's High School, Rowley Regis, West Midlands the NIHR Young People's BioResource will be launched nationally in 2023.

2.2 In November 2022, the Department of Health and Social Care (DHSC) confirmed that the NIHR BioResource has been awarded £16,998,161 funding for the period 1 December 2022 to 30 November 2024.

## 3. Patient and Public Involvement

### Gut Reaction

3.1 The Health Data Research (HDR) Hub for Inflammatory Bowel Disease (IBD) which is led by Cambridge University Hospitals was announced the winner of the Public and Patient Involvement and Engagement Award at HDR UK's Annual Scientific Conference (Winners announced for HDR UK's Annual Awards - HDR UK).

### Health Data Research

*Secure Data Environment for Research & Development*

3.2 An Expression of Interest led by Mark Avery on behalf of Cambridge University Health Partners, with Cambridge University Hospitals as the lead NHS organisation, set out the case for all six Integrated Care Boards in the East of

England to engage on behalf of their local systems in the development of a delivery plan and business case for a **sub-national Secure Data Environment for Research & Development**. The application has led to an award of £299,917 to further develop the plans.

*Cambridge University Hospitals-European Bioinfomatics Institute collaboration; inpatient trajectories and drug exposures of older adults*

3.3 This database of electronic health records (EHR) of all patients 65 years or older admitted non-electively to Addenbrooke's Hospital since EPIC hospital records began in October 2014 is held at the European Molecular Biology Laboratory - European Bioinformatics Institute (EMBL-EBI). Longitudinal descriptors including investigations, physiological measurements, drug treatments and outcome variable provide a heterogeneous, high-dimensional dataset to develop machine learning algorithms.

3.4 Data extracted from the EHR is run through an automated anonymisation protocol, which removes patient identifiers from free text fields and provides a unique study code. Admission events are also anonymised and assigned an independent unique study code. It is not possible for researchers to link these study codes back to original identifiers, or use the codes to cross reference data released from EPIC for other research projects. Age is provided as a 5-year age band, date of admission converted to month of admission, and only the occurrence rather than date of inpatient death, or death within 30 days after discharge, is provided. Discharge and admission specialties and diagnostic codes at discharge are provided as broad categories and high-level ICD-10 codes. Anonymised data is then uploaded to a private and password protected STP site hosted by the EBI server.

3.5 The first report of applying Machine Learning techniques to model longitudinal clinical data has been published in iScience[1]. It demonstrates that clinical time-series numerical data can be processed into a research ready dataset for Machine Learning in order to understand how elderly patients use emergency inpatient hospital services and factors associated with negative outcomes.

## 4. Cambridge led COVID-19 clinical trials

4.1 **HEAL-COVID** (HElping to Alleviate the Longer-term consequences of COVID-19), 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 1,000 participants from over 100 NHS trusts.

4.2 **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 receiving immunosuppression for a renal transplant. The study is a 'platform trial', which allows new drugs to be added. The first drug to be evaluated is niclosamide, a

[1] Using Machine Learning to Model Older Adult Inpatient Trajectories from Electronic Health Records Data: iScience (cell.com)

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

## 5. Recommendations

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

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

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# Report to the Board of Directors: 18 January 2023

| | |
|---|---|
| **Agenda item** | 12 |
| **Title** | Quarterly Report on Safe Working Hours: Doctors and Dentists in Training (2022/23 Q2) |
| **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, 5 January 2023 |

## Executive Summary

This is the second quarterly report for 2022/23, based on a national template, 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 September 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<br>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 note the 2022/23 Q2 report from the Guardian of Safe Working.

# Cambridge University Hospitals NHS Foundation Trust

**18 January 2023**

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

## 1. Introduction

1.1 The annual Guardian of Safe Working 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 started 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.

1.2 The Q2 report describes the Trust's position from July to September 2022. The number of exception reports (ERs) submitted (n=236) is higher than Q1 2022/23 (n=207) and increased compared to Q2 last year (n=116). Most rotas are compliant with the Terms & Conditions of Service (TCS).

1.3 There has been significant progress on the weekend working issue; out of the original 11 non-compliant rotas only 3 (A&E, Transplant and NICU) 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 posts created.

1.4 Recruitment into Paediatric Intensive Care Unit (PICU) posts has been arranged. However, recruitment into the 15 new posts in A&E has been challenging and some posts remain unfilled. Medical Staffing are hopeful that there will only be one rota still working > 1:3 weekends by February 2022 (Neonatal Intensive Care Unit (NICU)).

1.5 Gaps in other rotas also continue to be a major concern (both here and nationally). The Trust has recently agreed to an uplift to locum payments to bring these into line with other hospitals across the East of England.

1.6 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.

1.7 The JDF (chaired by a trainee) has now met twice in person (with a virtual link). Senior management joins in the second half of the meeting 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 Board engagement here continues to be more positive than in some other trusts in the region.

## 2. 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 | Q2 2022/23 |
| | |
| Total number of exception reports received | 236 |
| Number relating to immediate patient safety issues | 1 |
| Number relating to hours of working | 206 |
| Number relating to pattern of work | 7 |
| Number relating to educational opportunities | 15 |
| Number relating to service support available to the doctor | 8 |
| | |
| Total number work schedule reviews | 5 |
| Total value of fines levied | £89.43 |
| | |
| 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 (July) | 1 | 52 | 3 | 3 | 4 | 62 |
| MONTH 2 (August) | 0 | 79 | 1 | 1 | 2 | 83 |

| | | | | | | |
|---|---|---|---|---|---|---|
| MONTH 3 (Sept) | 0 | 75 | 3 | 4 | 9 | 91 |
| **QUARTER** | **1** | **206** | **7** | **8** | **15** | **236** |

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 236 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 & Acute Medicine again this quarter possibly reflecting the re-organisation of these rotas last year.

3.2 Trends in Exception Reporting

Levels of exception reporting in Q2 (n=236) were higher than those in Q1 2022 (n=207) and higher than those last year in Q2 2021 (n=116). They are slightly lower compared to those in Q2 2019 pre-Covid (n=261). Reporting of missed educational opportunities and service support issues has increased but remains low. The number of immediate safety concerns is the same as in 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 (July) | 0 | 44 | 0 | 6 | 50 |
| MONTH 2 (August) | 0 | 70 | 0 | 7 | 77 |
| MONTH 3 (Sept) | 0 | 89 | 3 | 11 | 100 |
| **QUARTER 2** | **0** | **203** | **3** | **24** | **227** |

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 has agreed to fund 15 new medical posts. Recruitment is in progress but is proving challenging and posts are not yet filled. |
| August 2021 | Transplant | Review to assess weekend working > 1:3 weekends. Single post required. Work schedule completed. Business case submitted. |
| August 2021 | PICU | Review to reduce weekend working – Agreement to fund 2 extra posts – recruitment completed. Thus resolved. |
| August 2021 | NICU | Review continues to reduce weekend working. Will require 3 new posts (2 junior rota, one senior rota). |
| July 2022 | Ophthalmology | Increase in out of hours activity. 8 week monitoring period arranged until mid November – review following this. |
| July 2022 | Neurology / Stroke | Changes to service configuration – 2 new posts approved with 1:18 full shift. Combined overnight service. Recruitment issues. |

4.1 Commentary

There are currently three active work schedule reviews (NICU - left over from previous quarters and Ophthalmology & Neurology / Stroke - new reviews). There are now only two rotas (NICU and Transplant) that are not yet able to reduce weekend working to 1:3 or less as per the new TCS (2019). The ED rotas will be compliant when recruitment into the recently funded new posts has been achieved.

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

| Department | Safety concern raised | Action(s) proposed and/or taken |
|---|---|---|
| 7/07 Paediatrics | Rota gap with heavy workload overnight. | Consultant provided extensive on site support and team stepped up to help. |

## 6. Fines

Fines levied against departments this quarter:

| Department | Detail | Total value of fine levied |
|---|---|---|
| **Total fines levied** | Neonatology | £89.43 |

| | TOTAL |
|---|---|
| Balance at end of last quarter | **£5881.30** |
| Fines incurred this quarter | **£55.89** |
| Cumulative total | **£5825.41** |
| Total paid to trainees (£) | **£33.54** |
| Total spent (£) | **£89.43** |
| Balance at end of this quarter | **£5791.87** |

## 7. Junior doctor forums and junior doctor engagement

7.1 The JDF was held monthly on Zoom until August. The virtual platform was working reasonably well, with senior management and others (Medical Director, Director of Medical Education, 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. However, it was decided to resume meetings face to face in the Doctors' Mess with a virtual link, starting in September 2022. Issues discussed included the rotas in A&E and weekend working, rota gaps, 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 TCS

8.1 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

9.1 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.

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

9.3 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.

9.4 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 and 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

10.1 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 region and nationally. Last year levels of reporting reverted to pre-Covid levels and have now exceeded these. The number of immediate safety concerns is again very low this quarter. Despite the loss of training opportunities, trainees rarely submit educational ERs, although there has been an increase this quarter. Rota gaps continue to be problematic; this has implications for working hours and patient safety.

10.2 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).

10.3 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. CUH 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=7) last year. The Trust has committed significant funding (> £1 million) to new medical posts in A & E and PICU in Q1 of this year. Recruitment to the posts in A & E is in progress but is proving challenging. Rotas have been rewritten and we are optimistic that there will only be one unresolved rota remaining (NICU) by February 2023.

10.4 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. Hospitals are under pressure to address the backlog of patient care and there continues to be a risk that training will not be prioritised.

10.5 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.

10.6 The 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. Monthly meetings of the JDF are once more being held in person in an attempt to boost attendance.

10.7 Exception reporting suggests that working hours remained mostly compliant in Q2 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 focussed on the persistent backlog of patient care post pandemic recovery and how best to ensure training (including catch up training) alongside service within the amended (2019) 2016 Terms and Conditions for Service.

## 11. Recommendations

11.1 The Board of Directors is asked to note the 2022/23 Q2 report from the Guardian of Safe Working.

## 12. 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.<br>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). |

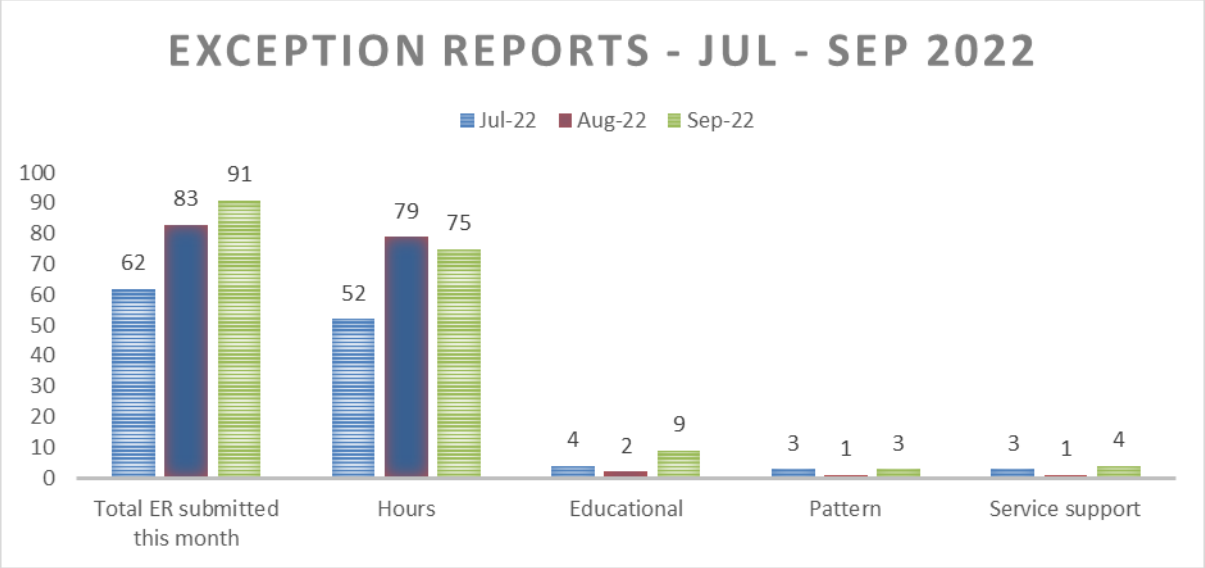
| | |
|---|---|
| Work schedule | A work schedule is a document that sets out the intended learning outcomes (mapped to the educational curriculum), the scheduled duties of the doctor, time for quality improvement, research and patient safety activities, periods of formal study (other than study leave), 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.<br>A work schedule review can be triggered by one or more exception reports, or by a request from either the doctor or the employer.<br>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

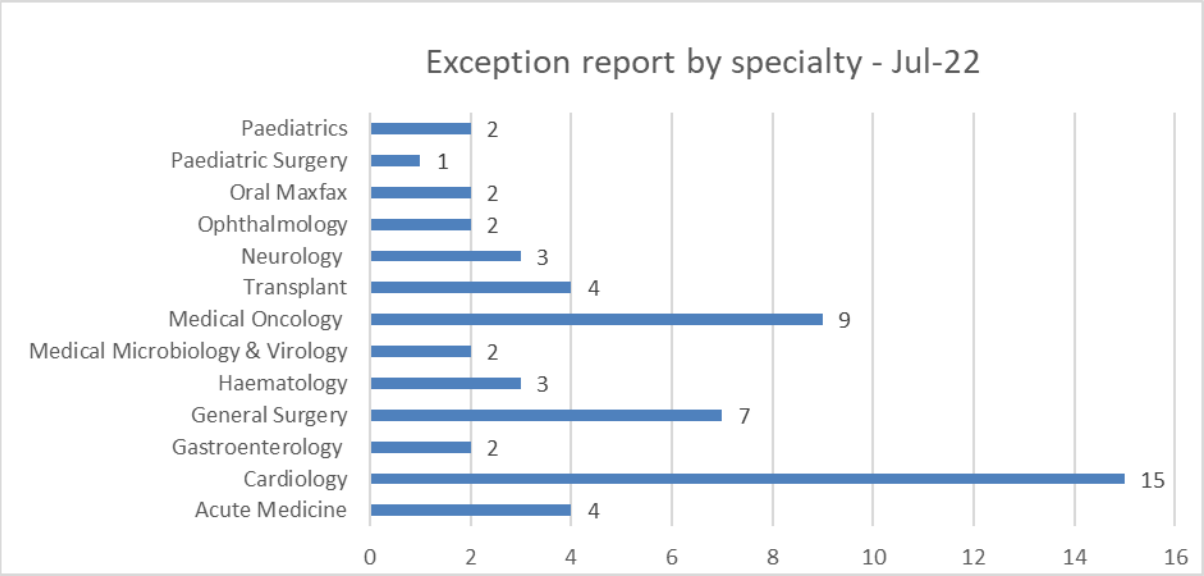
## July - September 2022

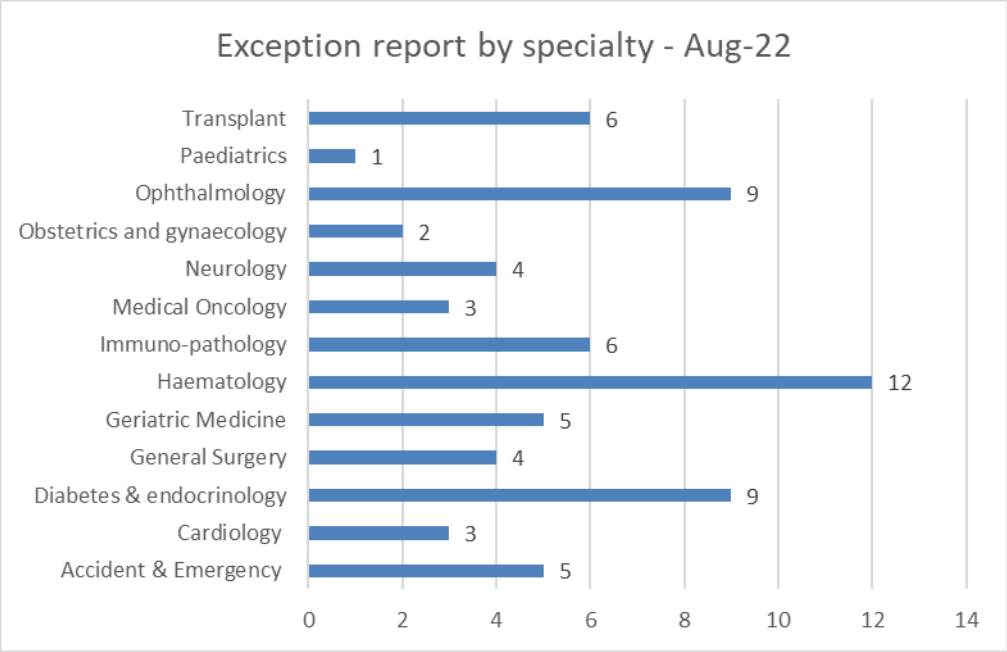
**Overview:**

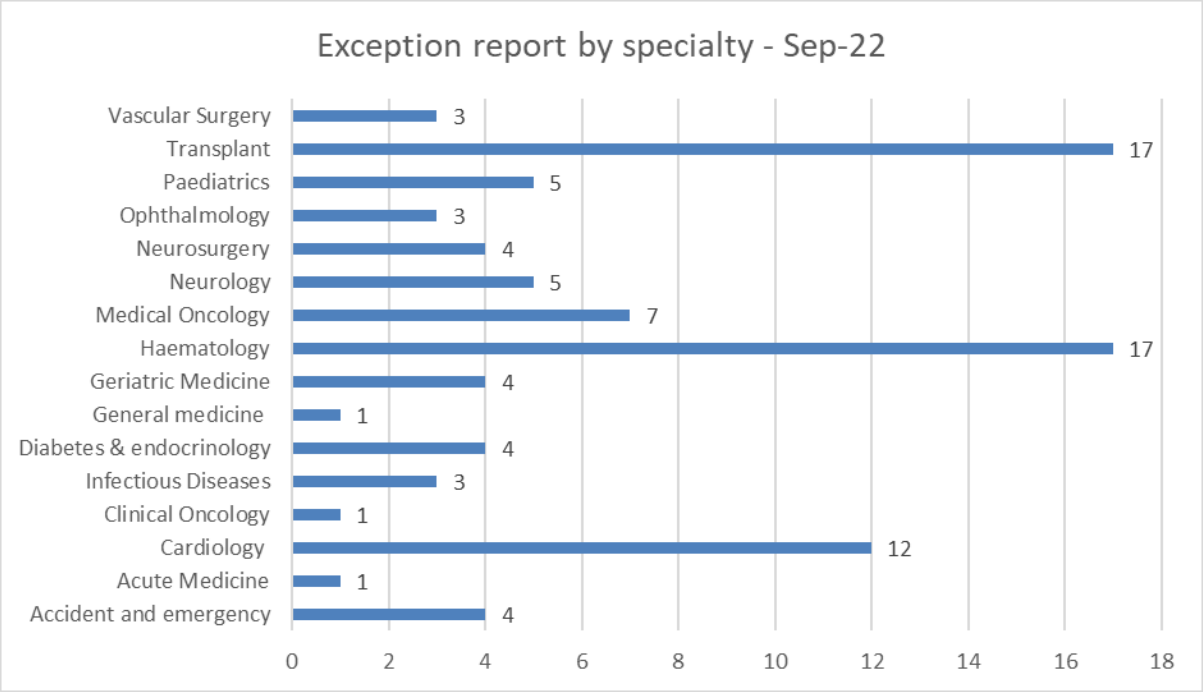



- 236 exceptions reported for Jul – Sep 2022
- 206 hours related which includes overtime and additional hours
- 15 related to educational or missed training opportunities
- 7 pattern related where work differs to established rota/ work schedule
- 8 service support related

**Specialty breakdown:**

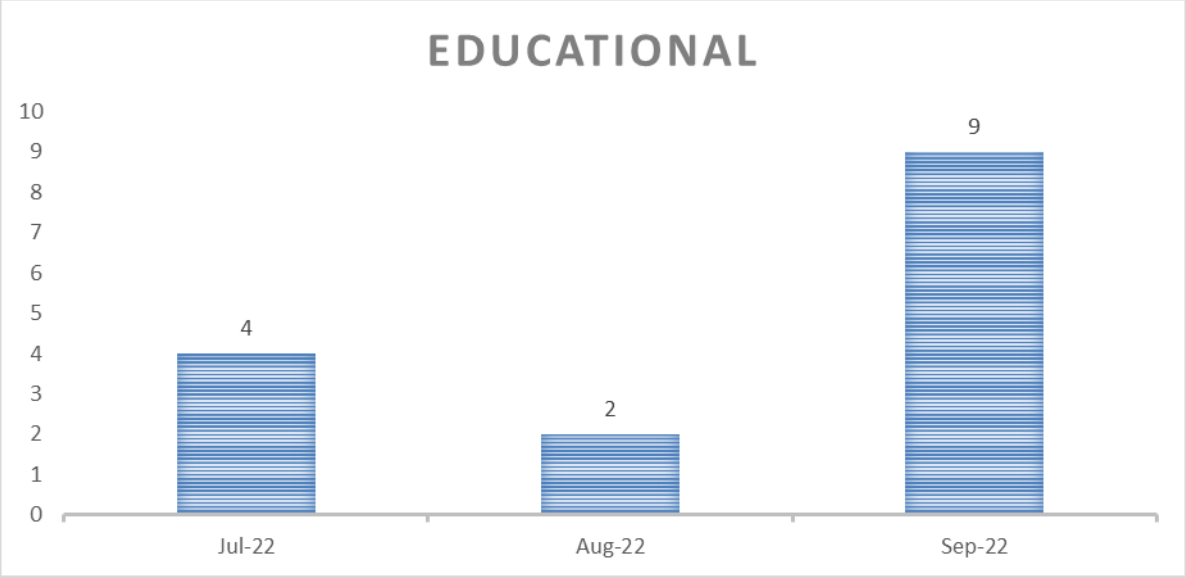





**Category breakdown:**

***Educational:***



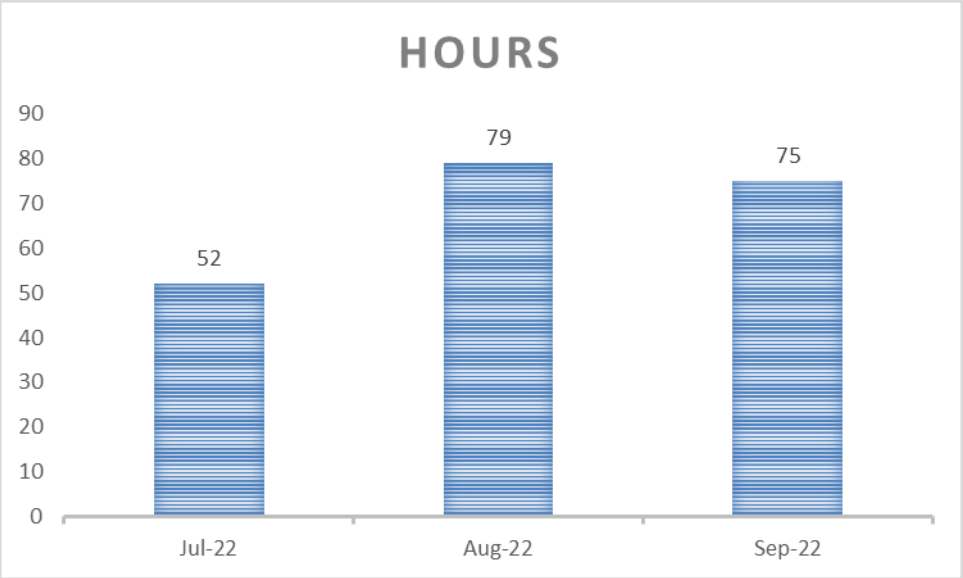

A total of 15 exceptions have been received in regards to education or missed training opportunities.

Infectious Diseases - 2
Acute Medicine – 1
Cardiology – 1
Neurology – 3
Oncology – 1

Haematology – 2
Transplant – 2
Paediatrics – 3

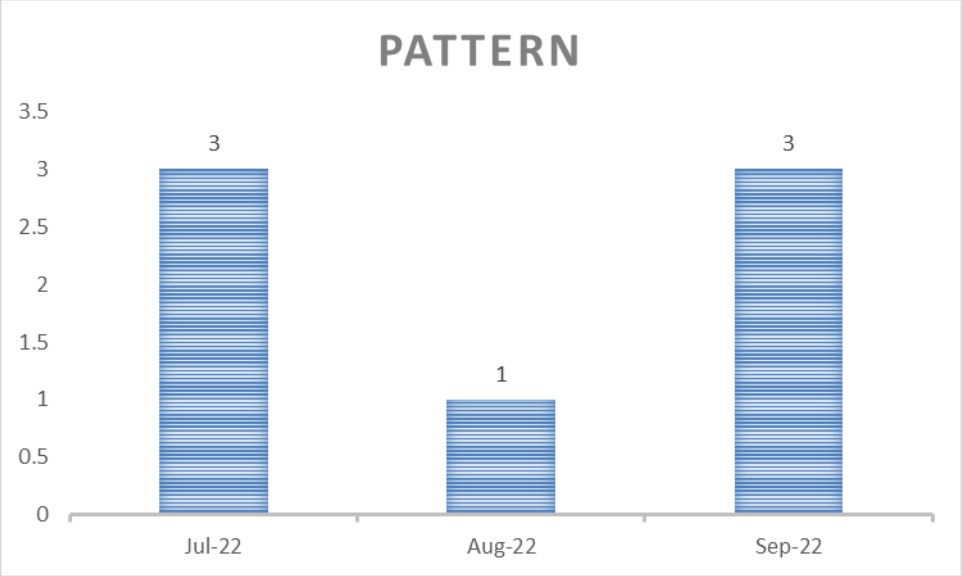
*Reasons include missing teaching or training due to staff shortages/ busy departments.*

***Hours:***




A total of 206 exceptions have been received in regards to education or missed training opportunities.

***Pattern:***

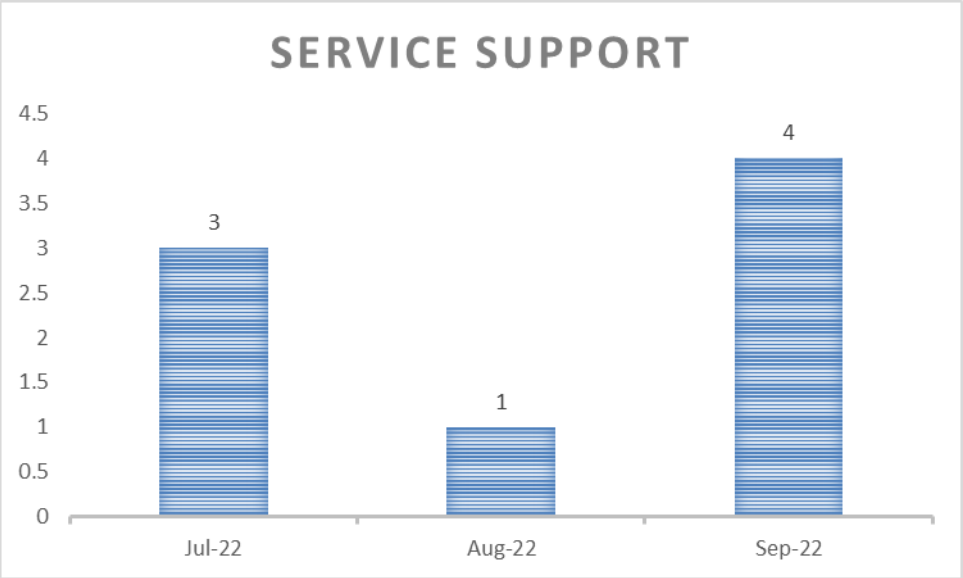



A total of 7 exceptions have been received in regards to pattern of working.

Neurology – 2
Haematology – 1
Neurosurgery – 1
Transplant – 2
Medical microbiology and virology - 1

***Service Support:***

A total of 8 exceptions have been received in regards to service support.




Gastroenterology – 1
Infectious diseases – 1
Paediatrics – 2
Neurology – 1
Transplant – 2
Cardiology – 1

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

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# Report to the Board of Directors: 18 January 2023

| | |
|---|---|
| **Agenda item** | 13 |
| **Title** | Freedom to Speak Up Guardian report |
| **Sponsoring executive director** | Ian Walker, Director of Corporate Affairs |
| **Author(s)** | Francesca Taylor, Freedom to Speak Up Guardian |
| **Purpose** | To inform the Board of progress on the Speaking Up Service. |
| **Previously considered by** | Management Executive, 12 January 2023 |

## Executive Summary

This report provides the Board with a six-monthly update from the Freedom to Speak Up Guardian covering the period April to September 2022.

| | |
|---|---|
| Related Trust objectives | All Trust objectives |
| Risk and Assurance | The report provides assurance on the steps being taken to promote open and transparent speaking up culture. |
| Related Assurance Framework Entries | BAF risks 007, 013 |

| | |
|---|---|
| How does this report affect Sustainability? | n/a |
| Does this report reference the Trust's values of “Together: safe, kind and excellent”? | The Trust’s Safe value:<br>“I never walk past; I always speak up” |

**Action required by the Board of Directors**

The Board is asked to receive and discuss the six-monthly report from the Trust’s Freedom to Speak Up Guardian.

# Cambridge University Hospitals NHS Foundation Trust

**18 January 2023**

**Board of Directors**
**Freedom to Speak Up Guardian report**
**Francesca Taylor, Freedom to Speak Up Guardian**

## 1. Introduction

1.1 The creation of the Freedom to Speak Up Guardian (FTSUG) role was one of the recommendations of Sir Robert Francis' Freedom to Speak Up review following the Mid Staffordshire Public Inquiry.

1.2 The Director of Corporate Affairs is the Executive lead for raising concerns and speaking up. Annette Doherty is the link Non-Executive Director for Freedom to Speak Up.

1.3 This report provides the Board with an update of the activity and progress of the Freedom to Speak Up Service over the six month period (April to September 2022) since the previous report in July 2022.

## 2. Progress to date

2.1 In addition to ongoing case management (see Section 3), the Freedom to Speak Up Guardian has continued a programme of visits and meetings with a range of wards and departments, focusing on those where other indicators (e.g. staffing and incident data) indicate particular pressures. These are used to raise awareness of the service and the importance of a speaking up culture. They have also supported the recruitment of new Freedom to Speak Up Listeners.

2.2 As noted in the previous report to the Board, a key priority has been to review and reinvigorate the network of local Freedom to Speak Up Listeners. Working closely with the Equality, Diversity and Inclusion team, a recruitment exercise has been undertaken, incorporating positive action statements, to encourage a diverse pool of applicants.

2.3 28 new Listeners have been recruited and, together with those previous Listeners who have confirmed that they wish to continue in the position, we now have 53 registered local Listeners across the organisation. We have recruited a broadly even spread of Listeners across the clinical divisions, with between 8 and 11 Listeners in each division (although R&D currently only has one Listener). 68% of newly recruited Listeners are working in Bands 2 to 6.

2.4 Two full-day training sessions were held for Listeners were held in December 2022 and a further three sessions are taking place in January 2023. The training programme includes an introduction to the role; a session on equality, diversity and inclusion; a speaker from Employee Relations; and scenario-based group work.

2.5 Working in collaboration with the Communications Team, the Freedom to Speak Up intranet pages have been refreshed and a new set of communication materials have been developed for distribution. These include a video about the service. Although outside the formal data reporting period, a number of awareness-raising events were held during the national Freedom to Speak Up month in October 2022. Going forward, monthly updates are planned in the CUH staff Bulletin.

2.6 During the period, the Freedom to Speak Up Guardian has secured slots on additional Trust induction programmes, including the corporate induction programme and the overseas nurse induction programme.

2.7 The CUH Raising Concerns procedure is currently being reviewed against the National Guardian's Office framework and updated in line with the revised national policy from NHS England.

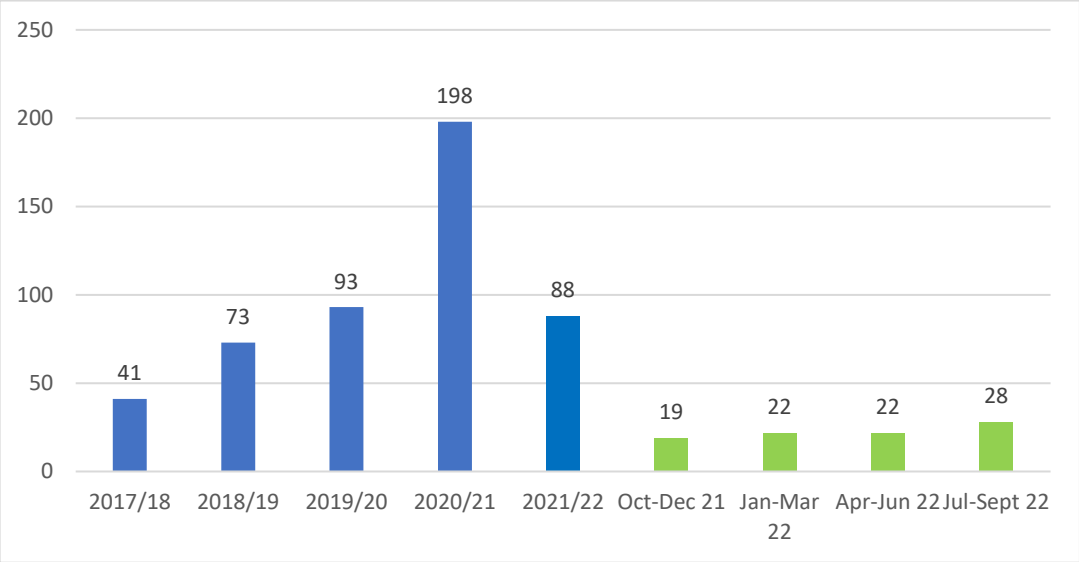
2.8 The Freedom to Speak Up Guardian is a member of the East of England regional FTSUG network which meets on a quarterly basis. A Community of Practice has recently formed within the East of England Network.

2.9 The interim Freedom to Speak Up Guardian will be going on maternity leave at the end of January 2023. The Trust is currently advertising for the substantive role, with interviews scheduled for the end of January 2023. Interim arrangements will be put in place to cover the period until a new Guardian takes up post.

## 3. Concerns raised, April to September 2022

3.1 In the six month period from April to September 2022, the number of concerns reported to Freedom to Speak Up service remained relatively stable at the rate of 20-25 cases per quarter which has been seen since April 2021. There was an increase in September and particularly October 2022 (19 cases in the month) but this has subsequently fallen back.

**Chart 1: Number of staff contacts to CUH Speaking Up service**




3.2 Of the 50 staff members raising concerns in the first half of 2022/23, the highest numbers by staff group were Nursing and Midwifery (18) and Administrative and Clerical/ Maintenance and Ancillary (12). These have historically been the staff groups most frequently accessing the service, at or above average as a proportion of the size of the total workforce group (see Appendix 1, Table 1a).

3.3 From April 2022, the National Guardian's Office revised the concern theme categories, condensing them to four categories: inappropriate attitudes and behavior; patient safety and quality; bullying and harassment; and worker safety and well-being.

3.4 The most common theme of concerns raised during the past six month period (see Appendix 1, Table 1b) was inappropriate attitudes and behaviour which featured in 41% of the concerns raised. The themes relating to patient safety and quality and worker safety and wellbeing were present in 25% and 26% respectively of concerns raised. Bullying and harassment was a theme in 7% of cases brought to the Guardian over the last six month period.

3.5 Table 1d at Appendix 1 compares CUH with the other Shelford Group trusts for the previous financial year (2021/22). Table 1e provides the Shelford Group comparison for 2022/23 Q1 based on the new category definitions (Q2 data has not yet been reconciled nationally). While there are significant differences in reported case numbers across the trusts, CUH has been below the Shelford Group average in recent quarters reflecting a sharp increase in cases numbers in particular trusts.

3.6 The majority of cases were raised by individuals contacting the Raising Concerns confidential email account or the Guardian by phone. There was one concern raised anonymously during this period.

3.7 A more detailed breakdown of the data is provided at Appendix 1. The relevant findings from the 2022 Annual Staff Survey will be provided in the next six-monthly report in July 2023.

3.8 It is important to emphasise that the Freedom to Speak Up service is one, albeit a very important, route through which concerns are raised in the Trust. Staff are encouraged to raise concerns with their line managers where possible and appropriate as this is often the most effective way of achieving a timely resolution. The vast majority of concerns are managed and resolved successfully at local level. Concerns are also raised through other channels including trades unions and professional bodies, Employee Relations, HR Consult and Heads of Workforce, the Chaplaincy service and external regulators (e.g. the Care Quality Commission). This report should not, therefore, be taken as providing a comprehensive overview of raising concerns.

## 4. Governance

4.1 In line with national recommendations, the Board of Directors has previously agreed to receive a six-monthly report on Freedom to Speak Up. An annual report is also presented to the Audit Committee.

## 5. Recommendations

5.1 The Board of Directors is asked to receive and discuss the six-monthly report from the Trust's Freedom to Speak Up Guardian.

## Appendix 1: Analysis of Freedom to Speak Up concerns raised

**Table 1a: Concerns raised with the CUH Speaking Up service by occupational group**

| | April – September 2022 | | 2021/22 (April – March) | | 2020/21 (April – March) | | 2019/20 (April – March) | |
|---|---|---|---|---|---|---|---|---|
| **Occupational group** | **Number** | **% of group workforce** (CHEQS Sept 2022) | **Number** | **% of group workforce** (CHEQS Mar 2022) | **Number** | **% of group workforce** (CHEQS Mar 2021) | **Number** | **% of group workforce** (CHEQS Mar 2020) |
| Admin & Clerical; Maintenance/Ancillary | 12 | 0.4 | 25 | 0.9 | 64 | 2.4 | 30 | 1.2 |
| Nursing & Midwifery | 18 | 0.5 | 33 | 0.9 | 67 | 1.8 | 35 | 1.0 |
| Health Care Assistant/ Nursing Associates | 5 | 0.3 | 8 | 0.4 | 19 | 1.0 | 7 | 0.4 |
| Ancillary and Technical | Data now included in Admin & Clerical / Maintenance/ Ancillary above | | | | | | | |
| Add Prof, Tech and Scientific, Healthcare Scientist | Data now included in Allied Health Professionals below | | | | | | | |
| Medical and Dental | 4 | 0.2 | 3 | 0.2 | 14 | 0.9 | 4 | 0.3 |
| Allied Health Professionals | 9 | 0.5 | 13 | 0.8 | 25 | 1.7 | 15 | 1.6 |
| Other | 2 | - | 6 | - | 9 | - | 2 | - |
| **TOTAL** | **50** | **0.4** | **88** | **0.7** | **198** | 1.7 | **93** | **0.8** |

A.1 Table 1a also shows the number of staff within each occupational group raising concerns as a percentage of the total workforce for that occupational group. In the period of April to September 2022 the trends remain the same as the previous reporting periods:

- Compared to the Trust average, staff in the Admin & Clerical/Maintenance and Ancillary, Nursing & Midwifery and Allied Health Professionals groups are more likely to raise concerns.

- Compared to the Trust average, staff in the Medical and Dental and Healthcare Assistant groups are much less likely to raise concerns.

Work continues to seek to better understand the drivers of these differences. There are likely to be a number of factors at play including awareness of the FTSU service, access to other channels for raising concerns and varying levels of staff engagement across occupational groups.

**Table 1b: Concerns raised with the CUH Speaking Up Service by category**

| | | April – September 2022 | | 2021/22 (April – March) | | 2020/21 (April – March) | | 2019/20 (April – March) | |
|---|---|---|---|---|---|---|---|---|---|
| **New concern category (from April 2022)** | **Previous concern category (up to April 2022)** | **Number** | **%** | **Number** | **%** | **Number** | **%** | **Number** | **%** |
| Inappropriate attitudes and behaviours | Behaviour/ relationships | 25 | 41 | 42 | 22 | - | - | - | - |
| | Behaviour/ attitude | | | - | - | 75 | 27 | 43 | 29 |
| Patient safety and quality | Patient safety and quality | 15 | 25 | 22 | 11 | - | - | - | - |
| | Patient related | | | - | - | 34 | 17 | 24 | 16 |
| Bullying and harassment | Bullying and harassment | 4 | 7 | 22 | 11 | - | - | - | - |
| Worker safety and wellbeing | Trust processes in practice | 16 | 26 | 38 | 20 | 107 | 31 | 38 | 26 |
| | Management support | | | 45 | 23 | 49 | 20 | 32 | 22 |
| | Capacity/workload/training | | | 14 | 7 | 22 | 5 | 9 | 6 |
| | Worker safety | | | 9 | 5 | - | - | - | - |
| Unknown | Unknown | 1 | 2 | - | - | - | - | - | - |
| **Total** | | **61** | | **192** | | **287** | | **146** | |

A.2 Some concerns cover more than one theme, i.e. in this period (April – September 2022) 50 individuals raised concerns across 61 themes. The main theme raised in concerns for this reporting period was inappropriate attitudes and behaviours accounting for 41% of all concerns raised in this six month period. The themes patient safety and quality and worker safety and wellbeing also both featured regularly in concerns, being brought to the FTSUG in 25% and 26% of cases respectively.

**Table 1c: Concerns raised with the CUH Speaking Up Service by Division from April to September 2022**

| | Theme of concern | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Division** | **Inappropriate attitudes and behaviours** | **Patient safety and quality** | **Bullying and harassment** | **Worker safety and wellbeing** | **Unknown** | **Total themes** | **Total cases** | **Total workforce** | **% of total workforce** |
| A | 3 | - | - | 1 | - | 4 | 4 | 2,259 | 0.2 |
| B | 6 | 7 | - | 4 | - | 17 | 13 | 3,058 | 0.4 |
| C | 3 | 3 | 2 | 4 | - | 12 | 11 | 1,639 | 0.7 |
| D | 8 | 2 | 1 | 2 | - | 13 | 11 | 1,499 | 0.7 |
| E | - | 3 | - | 4 | - | 7 | 4 | 1,406 | 0.3 |
| Corporate | 2 | - | 1 | - | - | 3 | 3 | 1,455 | 0.2 |
| R&D | 2 | - | - | - | - | 2 | 2 | 476 | 0.4 |
| Unknown | 1 | - | - | 1 | 1 | 3 | 2 | - | - |
| **Grand total** | **25** | **15** | **4** | **16** | **1** | **61** | **50** | **11,792** | **0.4** |

**Table 1d: Shelford Group FTSU comparisons, April 2021 – March 2022**

| | April 2021 – March 2022 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Trust** | **Q1 Total cases** | **Q1 Patient safety and quality cases** | **Q1 Bullying and harassment cases** | **Q2 total cases** | **Q2 Patient safety and quality cases** | **Q2 Bullying and harassment cases** | **Q3 total cases** | **Q3 Patient safety and quality cases** | **Q3 Bullying and harassment cases** | **Q4 Total cases** | **Q4 Patient safety and quality cases** | **Q4 Bullying and harassment cases** |
| CUH | 25 | 5 | 6 | 22 | 7 | 6 | 19 | 8 | 2 | 24 | 1 | 5 |
| GSTT | 67 | 1 | 11 | 38 | 0 | 6 | 78 | 5 | 25 | 54 | 3 | 13 |
| Imperial | No data | No data | No data | No data | No data | No data | No data | No data | No data | No data | No data | No data |
| King's | 29 | 10 | 14 | 40 | 7 | 24 | 62 | 11 | 20 | 63 | 5 | 25 |
| Manchester | 24 | 6 | 7 | 32 | 6 | 10 | 37 | 11 | 12 | 35 | 6 | 17 |
| Newcastle | 11 | 0 | 6 | 16 | 1 | 6 | 15 | 2 | 5 | 13 | No data | 3 |
| Oxford | 21 | 6 | 18 | 17 | 8 | 10 | 43 | 12 | 22 | 39 | 9 | 18 |
| Sheffield | 6 | 1 | 1 | 10 | 1 | 3 | 10 | 2 | 3 | 9 | 3 | 2 |
| UCLH | 40 | 0 | 2 | 30 | 0 | 10 | 16 | 0 | 2 | 24 | 0 | 5 |
| Birmingham | 23 | 1 | 9 | No data | No data | No data | 28 | 4 | 7 | 14 | 2 | 6 |
| **Average** | **27** | **3** | **8** | **26** | **4** | **9** | **37** | **6** | **12** | **31** | **4** | **10** |

**Table 1e: Shelford Group FTSU comparisons, Quarter 1 April – June 2022**

| Trust | Q1<br>Total cases | Q1<br>Patient safety and quality cases | Q1<br>Worker safety and wellbeing | Q1<br>Bullying and harassment cases | Q1<br>Inappropriate attitudes or behaviours |
|---|---|---|---|---|---|
| CUH | 21 | 8 | 4 | 3 | 12 |
| GSTT | 55 | 7 | 0 | 11 | 12 |
| Imperial | No data | No data | No data | No data | No data |
| King's | 83 | 20 | 20 | 41 | 13 |
| Manchester | 40 | 6 | 6 | 6 | 9 |
| Newcastle | 20 | 0 | 0 | 10 | 2 |
| Oxford | 15 | 7 | 7 | 0 | 2 |
| Sheffield | 3 | 1 | 1 | 0 | 2 |
| UCLH | 24 | 0 | 0 | 6 | 13 |
| Birmingham | No data | No data | No data | No data | No data |
| **Average** | **33** | **6** | **5** | **10** | **8** |

A.3 Comparisons between CUH data and Shelford Group comparisons (from NGO data) are provided in Table 1d and 1e. Nationally there is a wide disparity between the number of cases and resources allocated to speaking up services in trusts which makes direct comparisons difficult

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

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# Report to the Board of Directors: 18 January 2023

| | |
|---|---|
| **Agenda item** | 14 |
| **Title** | Voluntary Services Annual Report |
| **Sponsoring executive director** | David Wherrett, Director of Workforce |
| **Author(s)** | Maggie Brown, Voluntary Services Manager |
| **Purpose** | To provide the Board with an update on the work of voluntary services. |
| **Previously considered by** | Management Executive, 12 January 2023 |

## Executive Summary

This paper provides an update on the work of the Voluntary Services Team following the last report to the Board of Directors in September 2020. It describes the continued return of volunteers to their positions following the significant and necessary disruption of the volunteering service during the period of the COVID19 pandemic (the suspension of volunteers from March 2020), and the gradual return of volunteers off and on site at CUH campus. The development plans is also covered in this report.

| | |
|---|---|
| Related Trust objectives | Improving patient care<br>Supporting our staff |
| Risk and Assurance | Inadequately trained staff and volunteers, inability to recruit and retain staff and volunteers; and inability to develop shortage skills and staff. |
| Related Assurance Framework Entries | n/a |

| | |
|---|---|
| How does this report affect Sustainability? | There are a number of regulatory requirements relating to appointment and placement of volunteers. |
| Does this report reference the Trust's values of “Together: safe, kind and excellent”? | Yes |

**Action required by the Board of Directors**

The Board is asked to note:

- The role and work of the Voluntary Services (VS) team and the strong links with volunteer partner organisations.
- The impact of Covid-19 on the CUH volunteering function.
- Current activity to return volunteers and recruit new volunteers.
- Plans for new campaigns in 2023.

# Cambridge University Hospitals NHS Foundation Trust

**18 January 2023**

**Board of Directors**
**Voluntary Services Report**
**Maggie Brown, Voluntary Services Manager**

## 1. Introduction

1.1 This report provides an update and overview of Voluntary Services activities since the last report to the Board of Directors in September 2020.

1.2 The Trust has a long-established volunteer programme and remains committed to providing a voluntary service team to support a wide range of interesting and rewarding roles for volunteers that will make a positive impact on patients, visitors and staff.

1.3 We know that volunteers make a unique contribution by giving their time and dedication to the roles they perform. The impact is particularly beneficial for patients that are frail, lonely, isolated and anxious. Having a conversation, undertaking an activity (such as a game or puzzle), reading, patting a dog or simply being a listening ear can make a great difference to a patient. These interactions can lead to improving a patient's mood, to increased appetite, better nutrition, increased mobility and mental engagement and make a tangible difference to patient outcomes, also providing positive experience for relatives, friends and carers.

1.4 Volunteers may devote their time for a range of reasons: some for altruistic reasons, wanting to make a difference; others to say thank you for the support they/their loved ones received; for new and different challenges and for others it can be a stepping stone into employment in healthcare. For young people it offers exposure to the wide variety of career options available which can influence future career/employment choices.

1.5 CUH has strong links with a range of volunteer partner organisations. Many of these organisations work closely with services across CUH to support/offer guidance to patients and relatives (e.g. Maggie's, Care Network). The Royal Voluntary Services provide café's for visitors and staff; they will return their volunteer assistant roles within ED in the coming months. The majority of these services were suspended during the Covid-19 pandemic. St Johns Ambulance volunteers were active within the Emergency Department during the pandemic and their volunteers remain in place. A summary of the core volunteer partner organisations is provided at Appendix 1.

1.6 All volunteer partner organisations have a Memorandum of Understanding with CUH that is managed by Recruitment Services on an annual basis to ensure there is governance and reassurance about safe volunteering appointment processes in place.

## 2. Background

2.1 The CUH Voluntary Services (VS) team work closely with managers/staff within wards, clinics and departments to develop, implement and support established and new volunteer roles. They provide support to all volunteers, always providing a warm welcome and a listening ear when they visit the VS office. The VS team also supports the chaplaincy service in support of chaplaincy volunteers.

2.2 The voluntary services manager is involved in a number of forums across various services, these include: Dementia working and strategy groups, Patient Experience committee, Outpatient Experience Group, and Frailty Flagship including good links with the head of CUH Arts. This allows discussion of volunteering activity, scoping new roles.

2.3 CUH Voluntary Services is a member of the National Association of Volunteer service managers (NAVSM) whose mission is to enhance the experience of patients, carers, the public and staff in the NHS. Sharing and learning from best practice through this forum and also the Shelford Group ensures the service keeps abreast of new initiatives and support for maintenance and development of the service.

2.4 CUH typically had around 430 CUH volunteers actively registered each year. In the year prior to Covid-19 (1 April 2019 to early March 2020) volunteers contributed approximately 34,000 hours. There are 15 (core) wards where volunteering is well established and forms a routine part of the ward structure and around a further five wards that support either regular or occasional volunteering involving just a small number of volunteers.

2.5 CUH has a wide range of volunteer roles. Our core roles continue to be Ward volunteers, Guides and PAT dogs. Our volunteers range in age from 16 – 88yrs and there are eight PAT dogs (Lola, Digby, Baloo, Pablo, Poppy, Jack, Alfie and Nala).

2.6 CUH chaplaincy volunteers provide an important service to our patients offering patients the opportunity of a spiritual visit or just a quiet, mindful space. Chaplaincy volunteers are locally managed by Chaplaincy staff team. A summary of the chaplaincy volunteer service is attached at Appendix 2.

2.7 The Young Persons Programme (YPP) has been in place for over a decade; it continues to be a very popular programme. It offers up to 150 places for 16 – 19 year olds in higher education over three cohorts (January, August and

October). It provides the opportunity to gain communication skills, increased confidence and excellent insight into the world of work and the NHS. We know that for some it confirms their plans for a career in the NHS and for many others it has raised awareness and interest. All participants receive an achievement certificate and badge and a reference, useful for university or employment applications.

2.8 Supporting volunteers is vitally important; this includes:

- Volunteer induction
- Allocating new volunteers an experienced volunteer mentor during their first week
- A dedicated young person's co-ordinator
- Supervision and monitoring process to support volunteers. This assists in gaining useful feedback.
- Keeping in touch with volunteers; we do this through:
    - Regular communication – volunteers bulletin and magazine and seeing volunteers on shift
    - Opportunities for further training and development
    - Long Service and volunteer lunch
    - Christmas parties including one for our PAT dogs – and their owners
    - Careers event for the YPP and an end of cohort celebration event

## 3. Impact of Covid-19 for CUH voluntary services

3.1 The full voluntary services function was suspended during Covid-19 from 23 March 2020 to May 2022.

3.2 The VS team were deployed in different areas of the Trust for some of this period, whilst retaining a presence and support for our volunteers. This including the following:

- Regular phone calls to volunteers during the first year, with more of a focus in the second year on those we considered particularly lonely or vulnerable
- Cards, celebrations and small gifts during volunteer week and Christmas.
- Weekly edition of the volunteer magazine with articles of interest and keeping in touch with all volunteers

3.3 During the pandemic some CUH clinics were relocated offsite and some volunteers were able to return; this included:

- Creation of a new offsite volunteer marshall role at the Newmarket Road Park and Ride Phlebotomy clinic. Volunteers were first recruited to this role from October 2020 and continue to date

- Creation of a new volunteer marshall role at the pre-procedure swab pod at Gog Magog. Volunteers were first recruited in July 2021 and ceased in May 2022 with the reduction in use of this service due to the easing of restrictions
- There was a temporary period from July 2021 to February 2022 for guides and ward volunteers in 'green' areas and wheelchair volunteers; further recruitment to these roles was paused from February 2022 – May 2022 when the Covid-19 rates increased due to the Omicron strain of Covid.
- Chaplaincy volunteers were allowed to return from July 2021 and remained in place.
- A 'virtual' YPP programmes ran in November 2020, February 2021 and January 2022. This initial idea was to enable volunteers to offer contact with patients via iPads, under supervision, based at the Deakin Centre. It became clear early on that this would create a distraction for ward staff so these short programmes moved to the provision of informative sessions with the commitment to offer some ward based volunteering when we were able to do so. The sessions included: an insight into volunteering, career opportunities, understanding dementia, nutrition, safeguarding and communication skills.

## 4. Volunteer Services activity since May 2022

4.1 In May 2022 the suspension of volunteers was lifted, the team were given permission to commence the return of all roles and this was the key focus of the team in the first few months. This entailed working closely with wards and departments and encouraging volunteers to consider returning to CUH.

4.2 We are disappointed that a large number of volunteers decided not to return despite a great deal of support and encouragement from the voluntary services and the chaplaincy teams. We understand from other Trusts and organisations that this has been a trend experienced elsewhere.

4.3 The Voluntary Services team was able to continue the pre-employment processes for applicants that had been paused due to the pandemic and to recommence advertising for new volunteers with the knowledge that some of our long-standing volunteers would choose not to return.

4.3 For the young volunteers that had not been able to experience ward volunteering the team provided an opportunity to join a two week programme in May 2022, July 2022 or a four week programme in August 2022.

4.4 Working closely with our CUH colleagues in Infection Control, Health and Safety and Occupational Health, Voluntary Services staff have a current record of 181 volunteers, comprising 133 who have returned, 38 YPP and 10 newly recruited volunteers. Despite the reduced numbers of volunteers the main roles back in place include:

- Guides
- Clinic volunteers in the Breast clinic and clinic 4a and plans to return to other clinic areas
- Radio Addenbrooke's CUH is back on air
- Breastfeeding Peer to Peer support volunteers have returned to the Rosie.
- Chaplaincy volunteers
- Wheelchair collection
- Courtesy Bus volunteer

There are discussions with managers to return the following volunteer roles:

- Patient Survey volunteers
- Dance and Movement volunteers
- Discharge Lounge volunteers
- Library volunteers
- PALS Information leaflet support volunteer

4.5 Managers/services have not been seeking or requesting a full and immediate return of all volunteers/roles, therefore the current numbers returning and recruitment to new volunteers is meeting demand. However, we anticipate by the spring the position will change. Volunteering campaigns and plans are in place to return to previous numbers, work towards increasing these and the creation of new roles.

4.6 The Young Person's Programme (YPP) is back in place providing a 10 week programme for up to 50 students each October and January. There are 38 on the current programme, and 55 will commence on the January 2023 programme. The Voluntary Services team decided to retain a four week summer programme, established during the pandemic. This will provide more placements for young people to volunteer during the college summer holidays. The access to career information and awareness sessions introduced during Covid-19 has been retained due to the feedback received.

4.7 The Voluntary Services team has previously attempted to broaden the reach of the YPP to areas of social deprivation. A focus on Fenland schools/colleges generated very little interest; we understand the main reason is the distance young people would have to travel and the time this would take. We are also aware that North West Anglia NHS Foundation Trust has similar programmes that would mean less distance to travel. There will be a continued focus on broadening reach and accessibility to volunteering and improving connections with communities to improve engagement.

4.8 A number of the young volunteers choose to continue their volunteer placement after the programme and many go onto to mentor and supervise future young volunteers. This opportunity provides broader transferable skills and knowledge.

## 5. Volunteering campaigns

5.1 Volunteer recruitment campaigns currently includes a standing advertisement on the CUH website, Indeed website, new large on-site banners, attendance at a range of recruitment events and more recently the Mill Road fair to promote awareness. The CUH Voluntary Services website showcases volunteering and the wide range of roles and support available.

5.2 There is currently 62 prospective volunteers at the offer stage with 10 due to commence, 35 in pre-employment processes and 17 chaplaincy volunteers undertaking introductory pre-selection training. To speed up the recruitment of some volunteers the process of requesting 'special dispensation' has been applied where guaranteed supervision while on duty could be put in place.

5.3 There is joint work with Recruitment Services regarding social media campaigns, improving branding and materials to attract a broad range of applications including a focus on equality, diversity and inclusion.

5.4 In addition to this we will expand volunteering promotions to colleges and universities for all those aged 16+ enabling wider access to day-time volunteering across all roles at any time of the year, in addition to the YPP. We also intend to explore Duke of Edinburgh award volunteering roles.

## 6. Conclusion

6.1 We are ambitious to return to our pre-Covid number of volunteers. This is a primary role over the coming months. We have a range of plans in place for recruiting new volunteers as well as working with managers to expand the range of volunteering roles.

6.2 We will continue to encourage young people to join our programmes; and ensure this is promoted across all schools/colleges to widen access. We know volunteering at CUH can make a difference for a young person's confidence and awareness of future career opportunities as well as their presence being valued by wards, patients and colleagues.

## 7. Recommendations

7.1 The Board of Directors is asked to note:

- The role and work of the Voluntary Services (VS) team and the strong links with external voluntary partner organisations.
- The impact of Covid-19 on the CUH volunteering function.
- Current activity to return volunteers and recruit new volunteers.
- Plans for new campaigns in 2023.

## 8. Appendices

Appendix 1: Volunteer Partner organisations
Appendix 2: CUH Chaplaincy volunteer service

**Appendix 1**

## CUH Volunteer Partner Organisations

| Organisation | Website | |
|---|---|---|
| **Addenbrooke's Charitable Trust (ACT)** | https://act4addenbrookes.org.uk/ | |
| **Addenbrooke's Liver Transplant Association (ALTA)** | https://alta.org.uk/ | |
| **Cam Sight** | https://www.camsight.org.uk/ | |
| **Care Network** | https://care-network.org.uk/ | |
| **Caring Together** | https://www.caringtogether.org/ | |
| **Disability Cambridgeshire** | https://disability-cambridgeshire.org.uk/ | |
| **Laughter Specialists** | https://thelaughterspecialists.co.uk/ | |
| **Maggie's Centres** | https://www.maggies.org | |
| **Rays of Sunshine** | https://raysofsunshine.org.uk/ | |
| **Read for Good** | https://readforgood.org | |
| **Royal Voluntary Service (RVS)** | https://www.royalvoluntaryservice.org.uk/ | |
| **SSAFA – The Armed Forces Charity** | https://www.ssafa.org.uk/ | |
| **Theodora Children's Charity** | https://theodora.co.uk | |

**Appendix 2**

**A summary of the Chaplaincy Services at CUH and RPH**
**Ged McHale – Deputy Lead Chaplain and team lead for Chaplaincy Volunteers**

Chaplaincy volunteering is managed on a day to day basis by the Chaplaincy Team; we work closely with the Voluntary Services department and Recruitment Services function.

In the past there has been up to 105 chaplaincy volunteers; this provided the equivalent each week of approximately 5 whole time chaplains. Across CUH and RPH they offered vital pastoral care for patients, their family and for staff.

CUH had to suspend all volunteering at the start of the pandemic. The loss of chaplaincy volunteers provided the Chaplaincy Team with a clear idea of how much contact our volunteers had with the wards and how much they contribute to the presence and work of the Chaplaincy Team. The backfill of chaplains was insufficient to fill the gap and the visiting numbers dropped not just significantly but dramatically. Both patients and staff felt the loss of their presence, particularly patients who were COVID free and had an increased need for support while suffering the effects of loneliness and isolation.

While our volunteers were suspended the Chaplaincy Team established a routine of contact and support, conducting monthly sessions of reflection and update over zoom, alongside a programme of individual phone calls. We also send out a monthly email update, sometimes containing news, sometimes with a more reflective tone. The effect was to maintain a sense of connection with our chaplaincy volunteers while they were unable to be with us. This pattern of contact has stood us in good stead as they have been returning, since the updates have prepared them to some extent for the changes that they have inevitably encountered. Another effect of these monthly group conversations was to make plain to us how committed our Chaplaincy volunteers are to their hospital visiting, and what a great ‘heart’ they have for us who were and are working at the hospital throughout the pandemic.

This ‘heart’ has continued with their return, giving them a special awareness of the pressures that the staff are under and the need for support for the staff, as much as for the patients.

We are delighted that since July 2020 we have been able to start returning our volunteers with pleasure and renewed appreciation. 69 volunteers remain on our list 57 of whom have now returned. 17 of these volunteers are also on a Sunday rota for the distribution of Holy Communion to those for whom this is important in their spiritual life. Between 2020 and the present day 32 have decided to leave us.

We are recruiting new chaplaincy volunteers. They are recruited from a multi-faith forum and also through the channels used by Voluntary Services. Upon selection they undertake a 10 week formation programme comprising 40 contact hours. This year we began a completely new programme, with a focus on equipping Chaplaincy volunteers

for sustainable visiting on the wards and at the bedside. We used a combination of classroom teaching and theory; classroom practice of listening skills; phased ward visits under one to one supervision and consistent group reflective practice for well-being and sustainability. This stage of the programme will end with a personal interview to determine whether it is right and safe for a volunteer to go forward as a chaplaincy volunteer, and what the best placement for them might be. Going into the future we are planning regular ongoing formation sessions for further equipping. All the team have taken part in the formation programme for the potential new volunteers.

In September we were able to welcome 17 volunteers onto this training programme. These candidates have been impressive, again, with their commitment and their desire to contribute to the life of the hospital, having expressed an interest more than two years ago, and being prepared to wait all that time until they could begin more concretely. We are hopeful that after the final assessment interview all 17 will complete the programme successfully and be able to join us in spring 2023.

While I have overall management of the Chaplaincy volunteers the whole team are involved in enabling volunteers to contribute to our service. Our administrative staff co-ordinate their work on a daily basis. A rota of band 6 chaplains facilitate monthly reflective practice for designated volunteer groups, and have weekly pastoral care of those individuals.

My involvement with the Chaplaincy volunteers has taught me that there is great potential for ongoing development. I am looking forward to continuing in this role and to developing a more consistent and structured hierarchy of care, formation and integration into the work of Chaplaincy, for the benefit of our Chaplaincy Team, our Chaplaincy volunteers, all at the service of our CUH family.

**Ged McHale**
**Deputy Lead Chaplain and team lead for Chaplaincy Volunteers**

Cambridge University Hospitals NHS Foundation Trust

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# Report to the Board of Directors: 18 January 2023

| | |
|---|---|
| **Agenda item** | 15 |
| **Title** | Board committee terms of reference |
| **Sponsoring executive director** | Ian Walker, Director of Corporate Affairs |
| **Author(s)** | As above |
| **Purpose** | To approve the terms of reference of Board committees following scheduled review. |
| **Previously considered by** | Relevant Board Committee and consultation with Committee Chairs |

## Executive Summary

The terms of reference of Board Committees require that they are reviewed at least every two years. These scheduled reviews have been undertaken by each committee in recent months. Changes are proposed to the terms of reference of other committees as follows:

- Audit Committee:
  - The terms of reference were most recently updated in September 2021 and will be reviewed by the Committee at its next meeting in February 2023. The outcome of the review will be reported to the Board.

- Performance Committee:
  - 3.2 – describe the cross-over in Non-Executive Director membership between the Performance Committee and the Workforce and Education Committee as being desirable rather than essential.
  - 8.5 – delete the duty of reviewing CQUIN progress.

    - 8.6 – delete the duty to receive a twice yearly report on Service Line Reporting, with updates to be incorporated as required as part of reporting on the financial plan.
    - 8.12 – delete the duty to receive an annual report on procurement systems and controls as this is covered by the Audit Committee.

- Quality Committee:
    - 8.6 – delete this duty on the basis that the review of progress on quality improvement programmes is already covered under duties 8.2 to 8.4 in relation to Quality Plan and Quality Account objectives.
    - 8.9 – remove Maternity Care from the list of annual reports and add a separate specific duty relating to Maternity Services being a standing item on Quality Committee agendas.

- Workforce and Education Committee:
    - 3.2 – describe the cross-over in Non-Executive Director membership between the Performance Committee and the Workforce and Education Committee as being desirable rather than essential.
    - 8.2 – update to align with the current list of Workforce commitments.
    - 8.4 – add reference to receipt of the Workforce Disability Equality Standard (WDES).

- Addenbrooke's 3 Committee
    - 2.1 – provide some additional context on the Addenbrooke's 3 programme.
    - 4.1 – add the Chief Executive of Royal Papworth Hospital NHS Foundation Trust to the list of standing attendees in line with previous agreement.

- Remuneration and Nomination Committee:
    - Clarify that any post where remuneration was in excess of the top of Agenda for Change Band 9 should be within the remit/oversight of the Committee.
    - 8.8 – clarify that the succession planning role is related to those covered by the remit of the Committee.
    - Include a responsibility for oversight of the Local Clinical Excellence Awards (LCEAs) framework and its outputs, including from the perspective of protected characteristics. The Committee should not, however, have a role in the decision making on the allocation of LCEA funding.
    - Include a role for the Committee in reviewing the pay framework and its outputs from a gender pay gap perspective.

Subject to the approval of the Board, the revised terms of reference will be published on the Trust's website.

Appendix 1 sets out, for information, the current membership of Board committees.

| Related Trust objectives | All Trust objectives |
|---|---|
| Risk and Assurance | The Board Committees are part of the overall framework for managing risk and assurance in the Trust. |
| 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 approve the proposed changes to Board Committee terms of reference.

## Appendix 1: Board committee membership

The membership of the committees of the Board is determined by the Chair of the Trust in consultation with the Board of Directors.

The membership as of 1 January 2023 is as follows:

| Board Committee | Membership |
|---|---|
| Audit Committee | NEDs: Daniel Abrams (Chair), Annette Doherty, Sharon Peacock |
| Remuneration and Nomination Committee | All Non-Executive Directors. Chaired by Ali Layne-Smith |
| Quality Committee | NEDs: Sharon Peacock (Chair), Adrian Chamberlain, Rohan Sivanandan<br>Executive Directors: Chief Nurse and Medical Director |
| Performance Committee | NEDs: Adrian Chamberlain (Chair), Daniel Abrams, Ian Jacobs<br>Executive Directors: Chief Finance Officer, Chief Operating Officer and Medical Director |
| Workforce and Education Committee | NEDs: Rohan Sivanandan (Chair), Ali Layne-Smith, Patrick Maxwell<br>Executive Directors: Director of Workforce, Chief Nurse and Medical Director |
| Addenbrooke's 3 Committee | NEDs: Annette Doherty (Chair), Ian Jacobs, Patrick Maxwell<br>Executive Directors: Director of Strategy and Major Projects, Chief Nurse, Medical Director |

Cambridge University Hospitals NHS Foundation Trust

# CHAIR'S KEY ISSUES REPORT

## ISSUES FOR REFERRAL / ESCALATION

| | | | |
|---|---|---|---|
| **ORIGINATING BOARD / COMMITTEE:** | Performance Committee | **DATE OF MEETING:** | 11 January 2023 |
| **CHAIR:** | Adrian Chamberlain | **LEAD EXECUTIVE DIRECTOR:** | Chief Operating Officer, Chief Finance Officer |
| **RECEIVING BOARD / COMMITTEE:** | Board of Directors, 18 January 2023 | | |

| AGENDA ITEM | DETAILS OF ISSUE | FOR APPROVAL / ESCALATION / ALERT/ ASSURANCE / INFORMATION? | CORPORATE RISK REGISTER / BAF REFERENCE | PAPER ATTACHED (Y/N) |
|---|---|---|---|---|
| **5** | **IT quarterly update and virtual wards update**<br>1. The committee was updated on the digital strategy. Work had been undertaken on developing new prioritisation processes and governance mechanisms for digital related activity. A paper would go to Management Executive (ME) in due course.<br>2. The latest version of Epic was now in use following an upgrade in November 2022 and the Trust had transitioned to NHSMail and Teams.<br>3. Work was being undertaken on disaster recovery/business continuity with a paper to go to ME and Audit Committee in due course.<br>4. Use of MyChart had increased significantly in October and November 2022 largely due to staff booking Covid boosters. The underlying trend was steady state.<br>5. The EPIC contract was approaching its end date and would need to be extended while considering the approach to | For information | BAF 003 | n/a |

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| | procurement. The committee would be kept informed of progress.<br>6. Progress with the virtual wards programme continued with a wide range of specialties involved. Progress had been slower than hoped but the recruitment of dedicated medical resource would have a significant effect on the numbers of patients using the ward. | | | |
| **6**<br>6.1 | **Operational Performance**<br>1. The committee was updated on the positive outcomes of enacting the Operational Strategy and the efforts of the Winter Taskforce on the metrics for November.<br>2. There had been a significant improvement in ambulance handover times with only 2% >60mins compared to 27% regional and 13% national averages.<br>3. 12 hour waits had improved significantly. Urgent Emergency Care (UEC) performance and delivery had seen improvements whilst continuing with elective activity.<br>4. Cancer performance had continued well compared to peers.<br>5. Some outcomes had seen a decline in December due to a rapid rise in flu and Covid admissions. Bed occupancy over the Christmas period had been much higher than had been the case in previous years.<br>6. Initial data for January had shown improvements in performance.<br>7. National requirements for 2023/24 would include a return to reporting against the 4 hour wait target.<br>8. Work was underway to plan for optimal use of additional capacity as it becomes available.<br>9. Reasons for the significant increase in paediatric ED attendance and admissions included reduced immunity following Covid lockdowns; advice to take children directly to ED if concerned; increased incidence of respiratory illness in the community and perceived lack of GP appointments. | For information | BAF 001, 002, 007 | n/a |

| | | | | |
|---|---|---|---|---|
| **7** | **Finance Report**<br>Financial position Month 8<br>1. The committee received and noted the content of the report from the Chief Finance Officer.<br>2. There was a £1.8m surplus year to date and breakeven by end of the year was on track.<br><br>Month 8 Capital Update<br>1. The committee received and noted the content of the Month 8 Capital report.<br>2. Expenditure was £7m behind plan but this was expected to be recovered in Q4.<br><br>NHS Financial position<br>1. Planning guidance had been issued in late December. Further technical guidance expected at the end of January would address gaps in the published guidance.<br>2. The following points were highlighted:<br>• Elective Recovery Fund (ERF) to be maintained for 2023/24<br>• Efficiency requirements confirmed at between 2.25% and 3% similar to those agreed for 2022/23<br>• Inflation funding confirmed as fully funded at 4.5% for non-pay and 2% for pay. There had been no detail on how allocations would be adjusted if inflation exceeds these levels<br>• Growth funding will continue to be allocated subject to negotiation with the system on the Trust's allocation. | | BAF 011 | |
| **8** | **Capital Project Delivery reporting**<br>The committee received and noted an update from the Director of Capital, Estates and Facilities Management.<br>1. All current projects are running to plan with no significant issues to report. | | BAF 009 | |

| | | | | |
|---|---|---|---|---|
| | 2. The team was congratulated on maintaining the timelines for these projects | | | |
| **9** | **Board Assurance Framework and Corporate Risk Register**<br>1. The committee received and noted the current version of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR).<br>2. The Risk Oversight Committee (ROC) had met on 22 December. BAF risk 001 remains at 20.<br>3. A detailed risk assessment had been undertaken prior to opening the ward for medically fit patients at RPH.<br>4. The possibility of increasing BAF risk 010 would be discussed at the next ROC meeting. | For information | All | n/a |

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# CHAIR'S KEY ISSUES REPORT

## ISSUES FOR REFERRAL / ESCALATION

| | | | |
|---|---|---|---|
| **ORIGINATING BOARD / COMMITTEE:** | Quality Committee | **DATE OF MEETING:** | 11 January 2023 |
| **CHAIR:** | Sharon Peacock | **LEAD EXECUTIVE DIRECTOR:** | Chief Nurse / Medical Director |
| **RECEIVING BOARD / COMMITTEE:** | Board of Directors, 18 January 2023 | | |

| AGENDA ITEM | DETAILS OF ISSUE: | FOR APPROVAL / ESCALATION / ALERT/ ASSURANCE / INFORMATION? | CORPORATE RISK REGISTER / BAF REFERENCE | PAPER ATTACHED (Y/N) |
|---|---|---|---|---|
| **5.** | **Lead Executives' Report and Patient Safety and Experience Overview**<br>Lead Executives' Report<br>1. The Medical Director presented the report to the committee.<br>2. CUH had received an Atrial Fibrillation Association Healthcare Pioneers Award for work with atrial fibrillation and stroke prevention.<br>3. Capacity remained a major concern with significant issues experienced over the Christmas and the New Year period. Higher levels of occupancy than in previous years and reduced staffing had put strain on the hospital, but improvements are now being seen.<br>4. The Complaints and Patient Advise and Liaison Service (PALS) remained under pressure with an increase in complaints and complexity of contact.<br>5. The Trusts Immunology service underwent an accreditation visit from the Royal College of Physicians (RCP). All aspects of the | Information/ Assurance | | N |

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|---|---|---|---|---|
| | service were reviewed and the RCP team were highly complementary of the team.<br><br><u>Patient Safety and Experience Overview</u><br>1. The report covered the period up until the end of October 2022.<br>2. Normal variance in the amount of patient safety incidents had been reported.<br>3. Hospital Acquired Pressure Ulcers (HAPUs) and falls continued to increase, although falls remained within normal variance the increase was of concern. A HAPUs thematic review had been completed and was feeding into the improvement plan.<br>4. The number of complaints received between October 2019 – October 2022 was of higher than normal variance. The committee were provided with assurance that the PALS team were adequately supported and an improvement plan was in place.<br>5. The committee discussed HAPUs and falls in detail and agreed an in-depth review would take place at the next meeting.<br><br><u>Quality Account update</u><br>1. The committee received and discussed an update on the Trust's performance against the Quality Account priorities. | | | |
| **6.** | **Annual PLACE Report**<br>1. The first annual Patient Led Assessment of the Care Environment (PLACE) assessment had taken place in October/November 2022 since these were paused nationally due to Covid-19.<br>2. Assessment teams which include patient assessors, assessed several areas in line with the national requirements across the mandated categories. The assessments are designed to be 'as found on the day', and is only a snapshot of the area on the day.<br>3. For most categories, the scores are several percentage points lower than those observed in 2019. A number of actions have been put in | Information/ Assurance | | N |

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|---|---|---|---|---|
| | place to mitigate these lower scores such as feedback to individual wards for local action, easy fixes such as amenities, signage and patient gowns to be immediately addressed and the food related actions to be overseen by the Nutritional Steering Committee. | | | |
| **7.** | **CQC Urgent and Emergency Care Action Plan**<br>1. The Trust was inspected on 21 March 2022 during an un-announced visit in parallel with a CQC system review of Urgent and Emergency Care.<br>2. The committee received an update on progress with the action plan. | Information/ Assurance | BAF 001 | N |
| **8.** | **Maternity**<br><u>Maternity Report</u><br>1. The committee noted that the vacancy rate within midwifery had shown improvement with 2.91% gap as of the 30 November 2022.<br>2. Work on the Maternity Quality Improvement Plan continued. The Improvement Plan consists of 304 actions identified from gap analysis which was undertaken within Maternity Services, when completed assurance of compliance with actions, national standards, guidance and regulatory requirements will be met.<br><br><u>Clinical Negligence Scheme for Trusts (CNST) Evidence</u><br>1. As of 4 January 2023 the service can evidence that it meets all 10 safety actions for Year 4. | Information/ Assurance | | N |
| **9.** | **Infection Control Annual Report**<br>1. The Infection Control annual report collates and summarises information related to healthcare associated infection (HCAI) for the period from April 2021 until the end of March 2022.<br>2. It was highlighted to the committee that one of the biggest concerns moving forward is the ageing facilities and estate of the Trust. Covid-19 had highlighted the lack of isolation facilities (i.e. side | Information/ Assurance | | Y |

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|---|---|---|---|---|
| | rooms) and inadequate ventilation in some clinical and non-clinical areas. Due to the increasing capacity pressures there is no available space for wards to decant for deep cleans. | | | |
| **10.** | **Pharmacy**<br><u>Pharmacy and Medicines Optimisation audit report</u><br>1. The report provides a summary of pharmacy and medicines optimisation audits and service evaluations completed between June 2022 and Dec 2022.<br>2. The report also provides an update on related improvement projects.<br>3. Routine audits of compliance with medicines storage and security policy have been embedded and are completed on a digital platform.<br>4. There had been sustained improvement across many audit results following a programme of improvement projects.<br>5. Audits are now completed using a digital platform, this has resulted in a reduction in audit time and enhanced completion rate.<br><br><u>Medicines Optimisation Annual Report</u><br>1. The report provides a summary of medicines optimisation work completed during 2021/22 and described transformation plans over the next year.<br>2. Recruitment of technicians remained a challenge, subsequently the pipeline for trainee technicians had been enhanced over 21/22. The pharmacy workforce strategy continued to have a clear focus on wellbeing, EDI and continuing to invest in and support our teams.<br>3. The team had a successful Medicines and Healthcare products Regulatory Agency (MHRA) Good Practice for Clinical trials (GCP) inspection in November 21 with no findings for pharmacy.<br>4. The Medicines Optimisation strategy had been refreshed in August 2021. The refreshed strategy underpinned transformation plans | Information/ Assurance | | N |

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|---|---|---|---|---|
| | incorporating a focus on working collaboratively across the Integrated Care Board (ICB) for 22/23 with the established strategic and governance structure.<br>5. It was agreed that the committee would be kept informed of the pharmacy team's work on future innovations e.g. virtual wards and home care. | | | |
| **11.** | **Board Assurance Framework (BAF) and Corporate Risk Register (CRR)**<br>1. The committee received and discussed the current version of the Board Assurance Framework and Corporate Risk Register.<br>2. It was noted a risk relating to winter pressures had been re-escalated and a maternity capacity risk had been added to the CRR.<br>3. The committee noted the detailed risk assessment of opening a satellite ward at Royal Papworth Hospital.<br>4. A risk on the impact of industrial action at CUH had also been added. | Information/ Assurance | | N |

Board of Directors

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# Report to the Board of Directors: 18 January 2023

| | |
|---|---|
| **Agenda item** | 16.2 |
| **Title** | Infection Control Annual Report 2021/22 |
| **Sponsoring executive director** | Ashley Shaw, Medical Director |
| **Author(s)** | As above |
| **Purpose** | To receive the annual report |
| **Previously considered by** | Quality Committee, 11 January 2023 |

## Executive Summary

The Trust's Infection Control Annual Report for 2021/22 is attached. It was received and endorsed by the Quality Committee at its meeting on 11 January 2023.

| | |
|---|---|
| Related Trust objectives | Improving patient care, Supporting our staff |
| Risk and Assurance | The paper provides assurance on arrangements in place for infection prevention and control. |
| 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 | Yes |

**Actions required by the Board of Directors**
The Board is asked to receive the Infection Control Annual Report for 2021/22.

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# Infection Prevention & Control Annual Report

Addenbrooke's Hospital | Rosie Hospital

## Contents

1 Audit plan for 2022-23

2 Methodologies used for assurance

# Infection Prevention & Control annual report 2021-22

## Executive summary

This annual report collates and summarises information related to healthcare associated infection (HCAI) for the period from April 2021 until the end of March 2022. It also describes the management structure and oversight of the approach we take to prevent and control infection, the policies and procedures we use and the methodologies employed for assurance.

Covid19 affected every part of the hospital in 2020/21 and 2021/22 and the infection prevention & control team has been involved in all aspects of this. This report summarises some of the efforts and results of that involvement.

It also describes the efforts made to tackle other infections such as *C. difficile* and MRSA, as well as compliance against aspects of the Hygiene Code.

One of the ongoing problems that the Trust faces are its ageing facilities. Covid19 has highlighted the lack of isolation facilities (i.e. side rooms) and inadequate ventilation in some clinical and non-clinical areas.

I would finally like to thank our Infection Prevention and Control team for their dedication and professionalism in unprecedented times; without their commitment, expertise and unlimited devotion we would undoubtedly have seen many more Covid-related deaths and disruption to our clinical services. I would also like to thank all of our colleagues across the Trust for their continuing efforts to avoid preventable infections in our hospitals. This is a key priority for the Trust and we will continue to maintain our efforts to ensure we consistently provide a safe, clean environment for the treatment of our patients.

**Dr A Shaw**

**Medical Director and Director of Infection Prevention & Control**

**November 2022**

## Introduction

Cambridge University Hospitals NHS Foundation Trust (CUH) is a 1,100 bedded hospital with over 11,000 staff caring for elective and emergency admissions from the local community as well as delivering tertiary services for many specialties on a regional and national basis.

This annual report details the work the Trust has undertaken this year to ensure we discharge our statutory duties in meeting the standards for the prevention and control of infection as detailed in the Hygiene Code (Table 1) which is used by the Care Quality Commission (CQC) to monitor compliance with legislation by the Health & Social Care Act 2008. It describes the work of the infection control team and wider staff, both clinical and operational, to reduce the harm associated with infection.

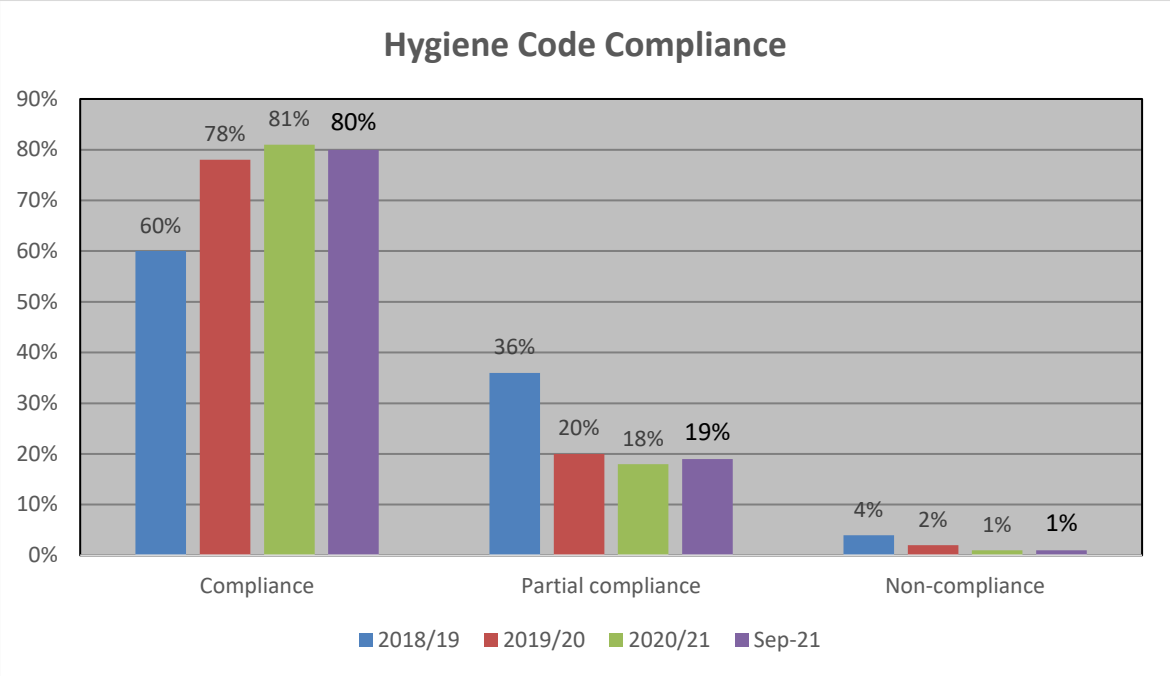
**Table 1. The Hygiene Code Compliance Criteria**

| | |
|---|---|
| **1** | **Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.** |
| **2** | **Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.** |
| **3** | **Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.** |
| **4** | **Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion.** |
| **5** | **Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.** |
| **6** | **Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.** |
| **7** | **Provide or secure adequate isolation facilities.** |
| **8** | **Secure adequate access to laboratory support as appropriate.** |
| **9** | **Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.** |
| **10** | **Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.** |

The CQC visited the Trust in 2018/19 but did not specifically assess infection control practices. Work continues to provide the Trust with the assurance that infection prevention & control standards are being upheld.

The reporting format for this document includes compliance against each of the ten criteria of the Hygiene Code. The overall percentage full compliance against the Hygiene Code standards (137 in total) is 80% as documented in Figure 1. The main areas of improvement have been due to improved reporting and review of IPC policies within the Estates team.

**Figure 1: Trust Hygiene Code Overall Compliance**




# Performance report

## Criterion 1: Systems to manage and monitor the prevention and control of infection

These systems should use risk assessments to assess how susceptible service users are and any risks that their environment and other service users may pose to them.

This criterion links with Hygiene Code Outcome 6 and Regulation 24 relating to co-operating with other providers in the CQC guidance about compliance.

The Trust has in place:

- a Board level agreement outlining their collective responsibility for minimising risks of infection and how this is to be achieved
- a Director of Infection Prevention & Control accountable to the Chief Executive and the Board
- mechanisms in place by which the Board ensures sufficient resources are available to secure effective prevention & control of healthcare associated infection (HCAI)
- measures to ensure that relevant staff, contractors and other persons directly or indirectly concerned with patient care receive suitable and sufficient information, training and supervision in measures required to prevent or minimise HCAI
- a programme of audit and quality improvement to ensure key policies and practices are being implemented appropriately
- a policy addressing patient movement between departments, within and between healthcare establishments

- a designated decontamination lead
- a designated antibiotic pharmacist and a consultant microbiologist with an antimicrobial stewardship role.

## Risk assessment

The Trust has in place suitable and sufficient assessment of risks to patients receiving healthcare with respect of HCAI. These are benchmarked against national best practice, clinical judgment and local risk assessment. The Trust monitors risks of infection through data collection, audit and review of clinical incident reporting. These findings and a review of current risk assessments are reported to the Infection Prevention & Control Committee (IPCC) and the findings are used to inform future actions and strategy.

Corporate and local HCAI risk assessments are available on the Trust's Risk Register and the risk rating report for high risks is reviewed on a quarterly basis by the Quality and Risk committees. Existing control measures and further preventative measures are identified for action and monitored through divisional governance meetings.

The Trust has a robust incident reporting system through which staff can report adverse incidents such as deviation from a clinical guideline or poor practice that may be detrimental to patient care. The IPC team have daily oversight of all incidents reported and will provide expert guidance and advice as required to mitigate any further risk or patient harm. A full report triangulating themes from infection control incidents, complaints from patient and visitors and identified risks is submitted bi-monthly to the IPCC and corrective actions and escalation agreed. Each MRSA bacteraemia is subject to a root cause analysis (RCA) and is reported via the incident reporting system. An RCA meeting is held within the Trust which is attended by:

- clinicians responsible for the patient's care
- Ward manager or deputy from the relevant clinical area
- members of the infection control team
- the CCG lead infection control nurse to provide external scrutiny and ensure transparency in our systems and processes

Actions are identified and disseminated at Divisional governance meetings and to the Board of directors and IPCC. Any deaths occurring as a result of an MRSA bacteraemia are reported as a serious incident in line with the National Framework.

Every patient diagnosed with *Clostridium difficile* infection (CDI) is reviewed regularly by an Infection Prevention Control Nurse (IPCN). The IPCNs assist in the correct clinical placement of the patient. Where possible all cases are placed in a single room. Staff are supported in their decision making processes by the risk assessment tool for prioritisation of patients who require isolation. As for the MRSA bacteraemia, the same process applies and each case has an RCA completed, which includes:

- a review of predisposing antibiotic therapy
- the use of proton pump inhibitors
- current antibiotic treatment
- other predisposing variables including compliance with relevant IP&C practices

A meeting is held fortnightly to discuss these cases; learning and action points are disseminated. In cases of CDI which result in death, colectomy, or are the result of a cluster of infections (i.e. ≥2 cases in the same clinical area within a 28 day period), more information is gathered and they are reported as a serious incident if indicated.

Meetings are held on a daily basis, if required, to manage infection outbreaks particularly in relation to gastrointestinal and respiratory infections including norovirus and influenza. These are held in conjunction with Trust operations centre, estates and facilities staff, on-call managers and the infection control team.

## Infection control management, including the role of the DIPC

The Chief Executive (CEO) has overall corporate responsibility for the control of infection within Cambridge University Hospitals NHS Foundation Trust (CUH). The Medical Director (MD) is the Trust designated Director of Infection Prevention & Control (DIPC) and is supported in this role by one of the Deputy Medical Directors who acts as Deputy DIPC.

The infection prevention & control team (IPCT) comprises medical and nursing infection prevention control professionals who are responsible for the day-to-day operation of the infection control service including:

- surveillance and mandatory reporting
- the provision of IPC policies
- an audit programme to ensure that key policies and practices are implemented appropriately
- provision of advice to clinical and management colleagues including:
    - monitoring of infection risks
    - on-going staff education and training
    - appropriate advice in response to major outbreaks of communicable infections

The IPCNs have designated areas of responsibility across the organisation and members of the IPCT provide a 24 hour on-call service for provision of infection control advice to clinical and managerial colleagues.

The IPCT reports to the IPCC and is directly accountable to the Corporate Head of Nursing and the DIPC.

The DIPC is responsible for leading the IPCT and reports directly to the chief executive and the board of directors (see appendix 1 for DIPC responsibilities).

The IPCT is responsible for day to day management of infection control and liaises closely with the DIPC as required (see appendix 2 for IPCT responsibilities).

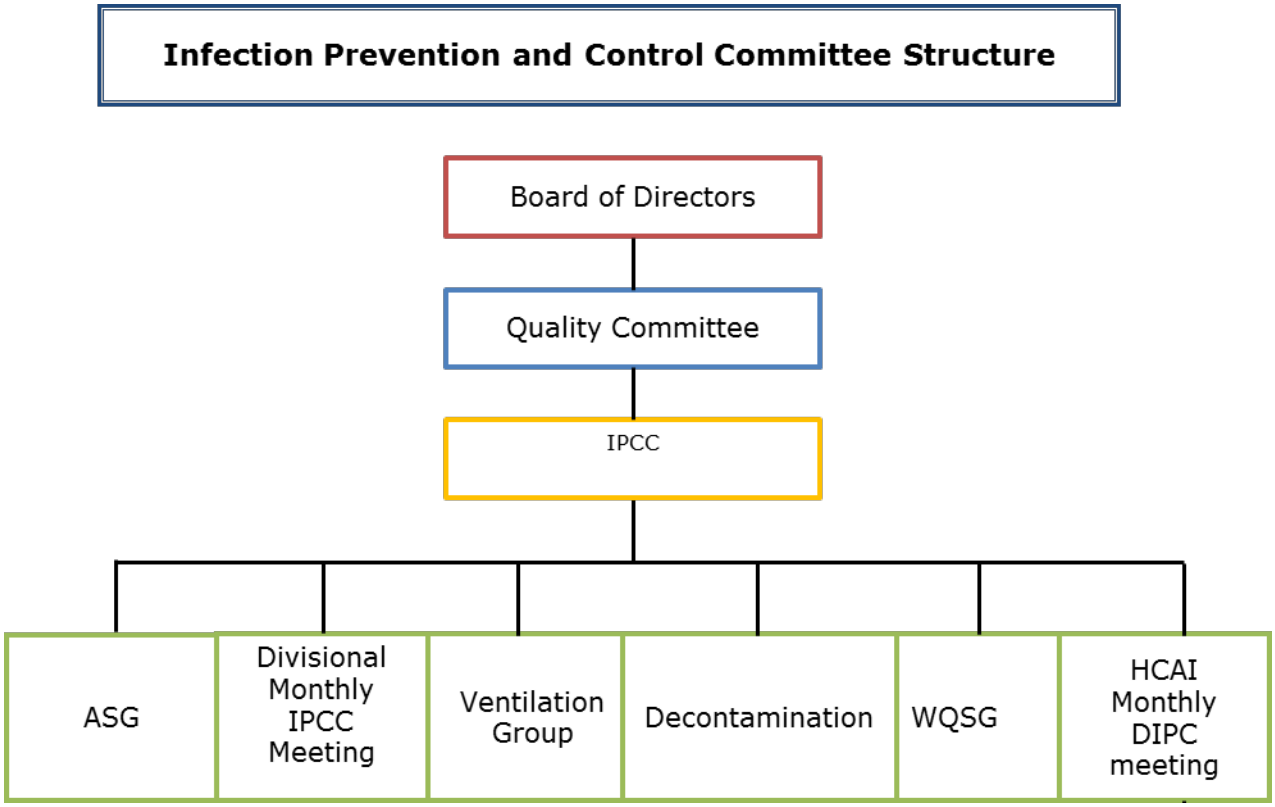
The IPCT consists of:

- Director Infection Prevention & Control (DIPC; Medical Director)
- Deputy Medical Director / Deputy Director of Infection Prevention & Control
- Corporate Head of Nursing
- Infection prevention & control lead nurse

- Consultant Microbiologist / Infection control doctor (ICD)
- Infection prevention & control clinical nurse specialists (5.45WTE down from 5.85WTE in 2020/21)
- Surgical site infection surveillance nurses (0.8 WTE)
- Health care assistant for infection control (1 WTE)
- Clinical educator for infection control (1 WTE)
- Information analyst (1 WTE)
- Personal assistant (1 WTE)

During the COVID19 pandemic and the change in priorities and focus, one of the IPC specialist nurses was seconded to become the COVID lead nurse, working in collaboration with the operational team. The role provided immediate access to expert clinical advice and operational oversight to ensure that compliance with rapidly evolving national policy guidelines were promptly embedded. Another senior IPC nurse was seconded to support with all aspects of safe use of respiratory protective equipment (RPE). They were back-filled for a short time by nurses from other disciplines. There is ongoing review of the establishment and priorities of the IPCT.

**Figure 2: The Infection Control Structure for 2020/21**




**Key:**

IPCC: Infection Prevention Control Committee
ASG: Antimicrobial Stewardship Group
WQSG: Water Quality Steering Group
HCAI: Healthcare Associated Infection
DIPC: Director of Infection Prevention & Control

The team is further supported by other consultants in microbiology and virology, estates & facilities and an antimicrobial pharmacist.

The IPCC meets every three months. Membership comprises:

- Representatives from the ICT
- Nominated infection control leads from all clinical divisions
- Representatives from other relevant groups within the Trust (Central Sterile Services Department, Occupational Health, Estates)
- Public Health England (PHE)
- Clinical Commissioning Group (CCG)

The Infection Prevention & Control Committee (IPCC) reports to the Quality and Risk Committee and is responsible for supervising the delivery of the annual infection control priorities and audit programme and the infection control annual report, as well as identifying risks relating to infection control via review of risk assessments and incident reports.

The Trust has devolved accountability for HCAI to divisional level via the divisional directors and heads of nursing and through nominated infection control leads in each clinical department. The clinical department leads have responsibility for implementing specific infection control practices and achieving key performance targets for their directorates.

The infection control leads are responsible for implementing and monitoring infection control policies in their clinical areas with support as required from members of the IPCT. Infection prevention & control consultant leads report to their divisional directors within the divisional clinical governance framework.

The Matrons / ward managers have day to day responsibility and accountability for infection prevention & control and delivering a safe and clean care environment. They report directly to their operations managers. See appendix 3 and appendix 4 for identified roles and responsibilities.

The key working structures for infection control are summarised in appendix 5.

During the COVID19 response, members of the infection prevention & control team (IPCT) have led or contributed to the following committees which are summarised below

## Assurance framework

## Infection prevention & control is an integral part of the clinical and corporate governance framework.

Infection prevention & control is recorded as a risk to patient safety in the Trust's board assurance framework. This framework identifies the key control measures in place and the means by which the board of directors are assured that those controls are operating effectively. The main source of assurance is the monthly performance report to the Board showing current infection levels and reporting on actions, initiatives and audits of compliance with key IPC policies (e.g. hand hygiene).

The DIPC reports regularly to the board of directors on performance against target; key issues and actions relating to serious bloodstream infections (MRSA, MSSA, *E. coli, Klebsiella* spp. and *Pseudomonas aeruginosa*) as well as *Clostridium difficile* and other infection issues when relevant.

The infection prevention & control annual report is produced by the consultant microbiologist and the DIPC for presentation to the board of directors and is in the public domain. It summarises the current situation with regards infection control practice within the Trust and highlights the resources needed to manage infection related risks in the coming year.

The monthly infection control reports are available to all Trust staff via Connect and business intelligence tool (QlikView) and are disseminated to key internal and external networks.

The Trust, via the deputy chief nurse or infection control lead nurse, reports to the CCG monthly or more frequently if required on the incidence of MRSA bacteraemia, *Clostridium difficile* and any declared infection outbreaks (e.g. norovirus).

The Trust, via the deputy chief nurse, infection control doctor and lead nurse reports to the Clinical Commissioning Group (CCG) monthly on MRSA bacteraemias and *Clostridium difficile* and, where there is non-compliance with monthly agreed targets as per the agreed contract.

The Trust also reports notifiable infections to PHE.

## Key Infections

### COVID19

Covid19 has had an impact on every aspect of clinical care in CUH. Infection prevention & control, working closely with colleagues in virology, microbiology and infectious diseases provided clinical and operational advice and helped implement and embed national guidelines and policies to all departments across the trust. These teams fed into the Trust command and control structure which coordinated the Trust response to the pandemic reflecting national policy utilising a bronze, silver and gold level model of accountability and decision making. The infection control bronze group provided expert opinion and advice reflecting the evolving national guidance to inform the Trust IP&C strategy. It also contributed to a number of other workstreams relevant to the Trust Covid response including the PPE bronze group, RPE bronze group, patient and staff testing taskforce, cohorting and configuration task force, Covid outbreak meetings and root cause analysis meetings for HCAI cases.

There were 152 deaths in patients with Covid19 (either on the death certificate or within 28 days of a positive swab) in 2021/22 compared to 346 for the preceding year.

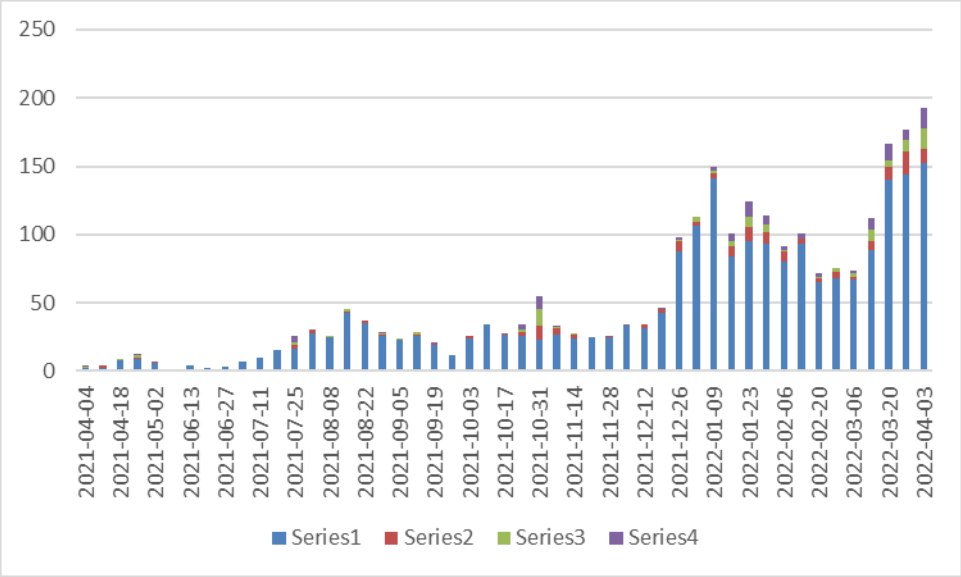



**Figure 3: Hospital Acquired COVID Cases at CUH**

Series 1: Community cases
Series 2 Possible HCAI cases
Series 3: Probable HCAI cases
Series 4: Definite HCAI cases

### Methicillin Resistant *Staphylococcus aureus* (MRSA)

### Bacteraemias

The 2021/22 ceiling was set at zero avoidable cases reflecting national expectations; however, there were two case of hospital onset MRSA bacteraemia that was considered to be avoidable (figure 4; stable since 2019/10). There were two bacteraemias that were considered to be unavoidable.

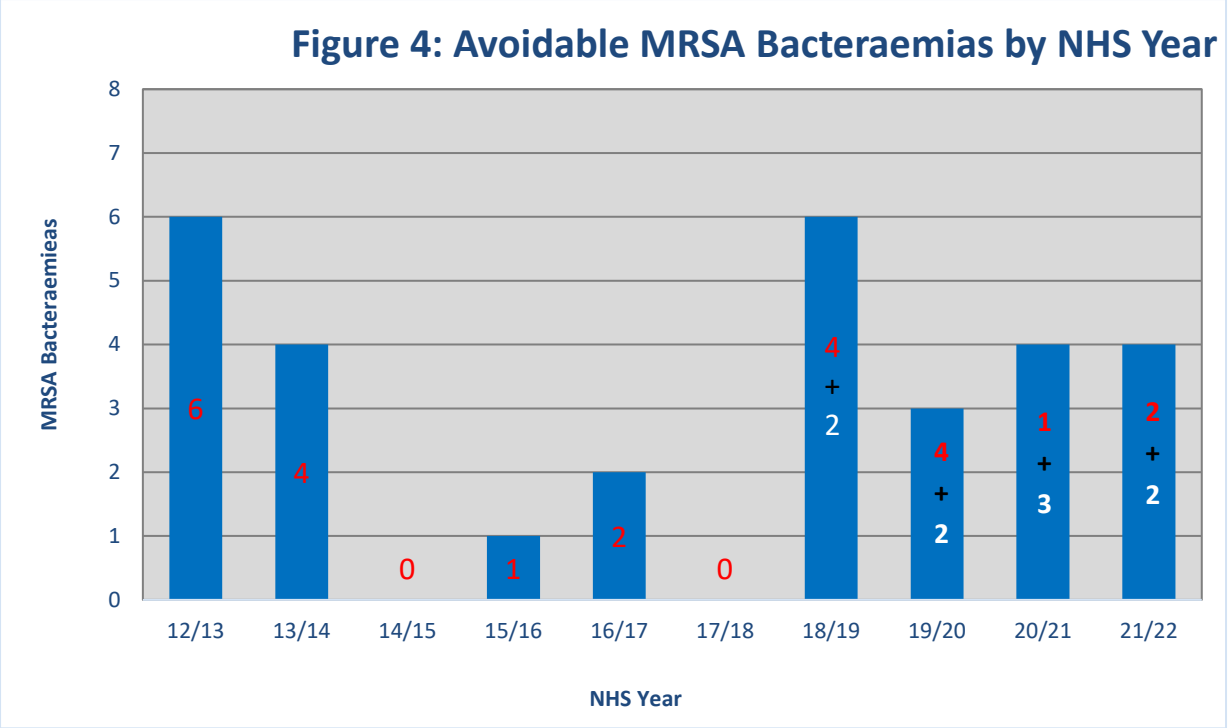



**Table 2: CUHFT position amongst the Shelford Group for all hospital-onset MRSA bacteraemia cases**

It is of interest to note the figures and trends reported at CUH follow those reported nationally by Public Health England at:

https://www.gov.uk/government/statistics/mrsa-bacteraemia-annual-data

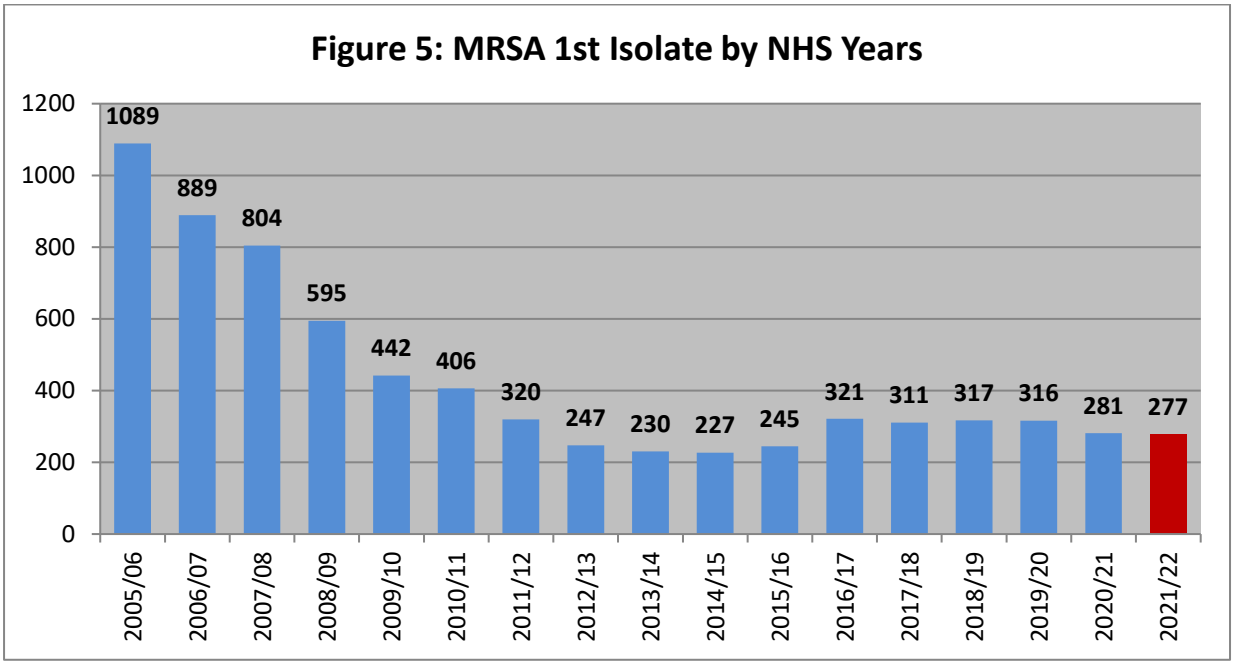
| | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 |
|---|---|---|---|---|---|---|---|---|---|---|
| Sheffield Teaching Hospitals | 0.5 | 0.7 | 0.4 | 0 | 0.4 | 0.6 | 0.4 | 0.6 | 0.8 | 0.0 |
| The New castle upon Tyne Hospitals | 1.0 | 1.5 | 0.8 | 1.4 | 1.5 | 0.6 | 0.4 | 0.2 | 0.3 | 0.0 |
| King's College Hospital | 0.9 | 1.9 | 0.8 | 0.7 | 1.3 | 1.0 | 1.7 | 0 | 0.9 | 0.8 |
| Oxford University Hospitals | 1.0 | 0.9 | 1.6 | 0.5 | 1.5 | 0.3 | 0.6 | 1.1 | 2.8 | 0.8 |
| University Hospitals Birmingham | 1.4 | 1.3 | 0.5 | 1.5 | 1.6 | 0.2 | 0.5 | 1.4 | 0.3 | 0.9 |
| Cambridge University Hospitals | 1.9 | 1.3 | 0 | 0.9 | 0.9 | 0.3 | 1.8 | 0.9 | 1.4 | 1.2 |
| Guy's & St. Thomas' | 0.5 | 1.1 | 0.4 | 0.4 | 1.1 | 1.1 | 1.1 | 2.3 | 1.4 | 1.4 |
| Manchester University | 1.6 | 1.7 | 0.5 | 1.3 | 1.5 | 0.3 | 1.1 | 1.0 | 2.1 | 1.4 |
| University College London Hospitals | 2.3 | 2.3 | 1.1 | 0.8 | 0.8 | 0.4 | 0.4 | 1.6 | 2.2 | 1.4 |
| Imperial College Healthcare | 2.9 | 2.9 | 1.7 | 1.7 | 1.1 | 0.3 | 0.8 | 0.8 | 1.8 | 3.1 |

Rate, per 100,000 bed-days = (n hospital onset cases /average daily occupancy * n days in period) x 100,000

## MRSA acquisition

The term acquisition refers to someone who has been found to be MRSA-positive for the first time and includes isolates from samples taken for clinical purposes (e.g. wounds, urine, sputum etc.) and also routine skin swabs taken during MRSA screening of patients (representing colonisation i.e. present on the skin). Figure 5 shows the number of new

acquisitions of MRSA. There was a rise in numbers in 2016/17 to 321 compared to 245 in 2015/16; this remained relatively stable until last year; this drop was thought to reflect lower numbers of patients treated because of Covid19 so it's encouraging that this has been maintained.




**Outbreaks**

There were two MRSA outbreaks in CUH during 2021/22; one occurred on a Medicine for the Elderly ward and the other occurred on a surgical ward. Both involved 4 patients and were confirmed as outbreaks by typing methods. Interventions by the IPCT controlled the outbreaks. There were no associated bacteraemias or deaths.

***Clostridium difficile***

There were 93 cases of hospital-onset *C. difficile* infection (CDI) in 2021/22, which represents a rise since 2020/21 (Figure 6). CDI can be life-threatening; one patient had the infection recorded in part one of their death certificate (Table 3).

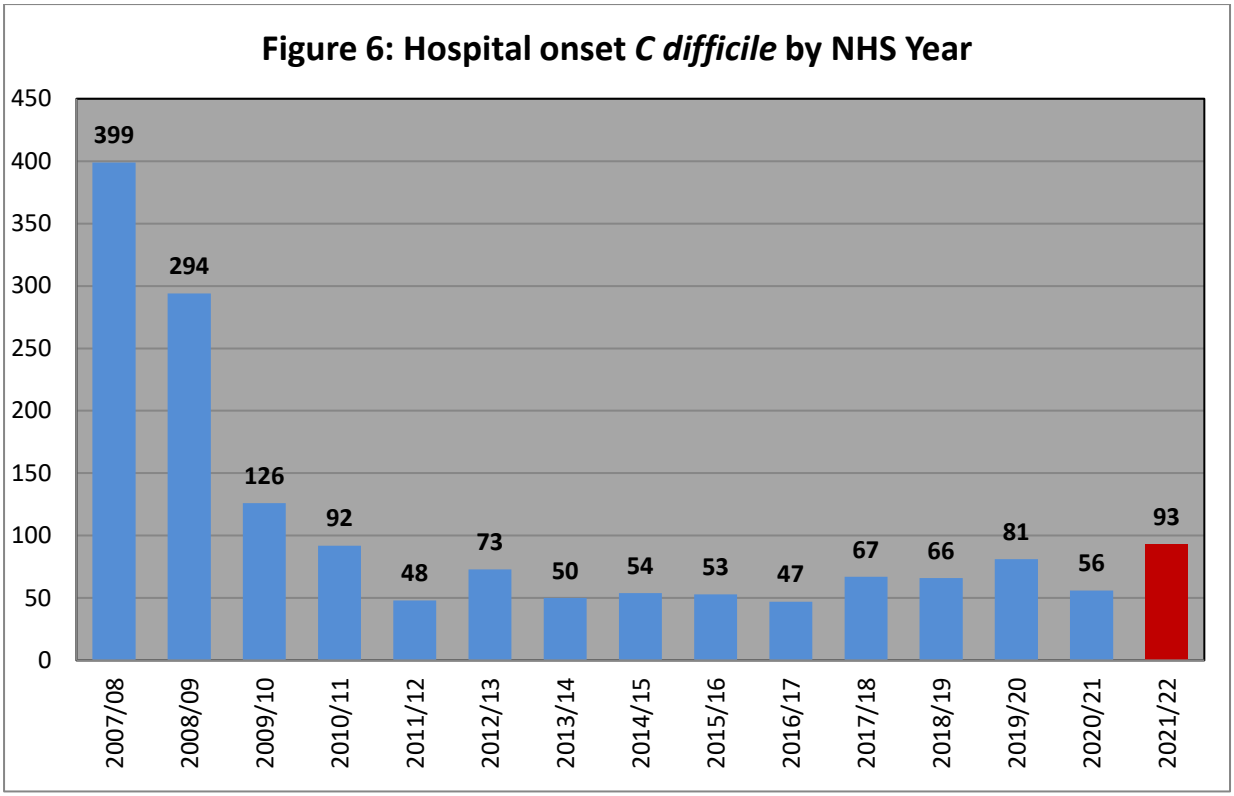



**Table 3: CDI on part 1 and 2 of death certificates**

| Year | 09/10 | 10/11 | 11/12 | 12/13 | 13/14 | 14/15 | 15/16 | 16/17 | 17/18 | 18/19 | 19/20 | 20/21 | 21/22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Part 2 | 14 | 4 | 2 | 6 | 7 | 9 | 5 | 2 | 3 | 4 | 2 | 5 | 1 |
| Part 1 | 3 | 2 | 0 | 1 | 2 | 3 | 3 | 1 | 4 | 3 | 3 | 3 | 1 |

Within the Shelford Group, CUH was 8th in 2021/22 (it has been between 5th and 8th over the last 4-5 years; table 4).

**Table 4 - CUHFT Position amongst the Shelford Group April 2012 - March 2022 for CDI**

| Organisation code | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 |
|---|---|---|---|---|---|---|---|---|---|---|
| Guy's & St. Thomas' | 15.2 | 13.5 | 16.5 | 15.1 | 10.7 | 8.9 | 6.2 | 7.0 | 10.2 | 12.7 |
| King's College Hospital | 17.5 | 14.3 | 16.3 | 18.1 | 15.1 | 18.3 | 16.5 | 13.7 | 14.5 | 13.5 |
| Imperial College Healthcare | 31.2 | 18.7 | 22.6 | 20.9 | 17.8 | 18.5 | 14.3 | 17.0 | 14.2 | 16.0 |
| Oxford University Hospitals | 23.2 | 13.9 | 13.9 | 14.2 | 13.1 | 18.5 | 14.4 | 13.4 | 22.5 | 18.1 |
| University Hospitals Birmingham | 18.6 | 18.9 | 17.3 | 15.3 | 19.2 | 15.7 | 16.8 | 15.9 | 17.5 | 18.1 |
| Manchester University | 19.0 | 15.1 | 17.2 | 15.4 | 17.3 | 19.6 | 17.2 | 15.6 | 24.2 | 21.5 |
| Sheffield Teaching Hospitals | 17.8 | 13.7 | 16.3 | 14.7 | 20.3 | 15.4 | 16.4 | 21.3 | 24.6 | 24.6 |
| Cambridge University Hospitals | 23.5 | 15.9 | 17.1 | 16.7 | 14.5 | 20.2 | 19.5 | 21.9 | 16.5 | 24.7 |
| The New castle upon Tyne Hospitals | 15.4 | 18.2 | 18.4 | 19.4 | 15.4 | 18.9 | 16.8 | 18.3 | 20.8 | 27.5 |
| University College London Hospitals | 20.5 | 37.1 | 40.2 | 36.4 | 34.2 | 27.7 | 22.2 | 18.7 | 34.7 | 28.8 |

Rate, per 100,000 bed-days = (n hospital onset cases /average daily occupancy * n days in period) x 100,000

Of these 93 cases, case note review and multidisciplinary discussion demonstrated no lapse in care for 83 patients. Delays in sending a sample constituted the majority of the identified lapses in care and inappropriate antibiotic use was also noted. These findings are shown in Table 4 which also demonstrates the progress in improving process and procedures over the last few years.

**Table 4: Reasons given for lapses in care for patients with *C. difficile* infection**

| | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 | Total |
|---|---|---|---|---|---|---|---|---|---|
| Delay in sample collection | 12 | 10 | 4 | 3 | 3 | 5 | 4 | | **41** |
| Delay in sample collection and isolation | 11 | 7 | 5 | 1 | 3 | 2 | | 2 | **31** |
| Delay in isolation | 6 | 8 | 4 | 2 | 2 | | | | **22** |
| Issues w ith antibiotic stew ardship | 1 | 0 | 2 | 3 | 0 | 2 | 1 | 2 | **11** |
| Delay in isolation and poor documentation | 0 | 0 | 0 | 5 | 0 | | | 1 | **6** |
| CDT outbreak on C10 & J2 | 0 | 0 | 0 | 0 | 5 | | | 1 | **6** |
| Delay in sampling/isolation, poor documentation | 0 | 0 | 0 | 0 | 4 | 1 | | | **5** |
| Poor hand hygiene | 1 | 1 | 0 | 0 | 0 | | | | **2** |
| Delay in sampling and antibiotic issue | 0 | 0 | 0 | 0 | 2 | | 1 | 1 | **4** |
| Wrong sample collection | 1 | 0 | 0 | 0 | 1 | | | | **2** |
| Delay in sampling and CDT infection diagnosis. | 0 | 0 | 0 | 0 | 1 | 1 | | | **2** |
| Other | 3 | 1 | 1 | 3 | 2 | 3 | 1 | 3 | **17** |
| **Total** | **35** | **27** | **16** | **17** | **23** | **14** | **7** | **10** | **149** |

## *E. coli* bacteraemia

All hospital onset *E. coli* bacteraemias are reviewed by the IPCT in order to assess their likely source and consider whether or not they were preventable. There were 117 hospital onset *E. coli* bacteraemias in 2021/22. This represents a continuing rise in numbers (with the dip in 2020/21 possibly due to lower number of patients). The source was considered to the urinary tract in 33 (28%), biliary tract (22; 19%), and gastrointestinal tract (20; 17%). These are reviewed in table 5.

We as an organisation recognise this as a significant issue and will work closely with colleagues across the healthcare system to address this as a priority.

**Table 5: Sources of hospital onset *E. coli* bacteraemias**

| Source of infection | 2018/2019 | | 2019/2020 | | 2020/2021 | | 2021/2022 | |
|---|---|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % | Number | % |
| Lower Urinary Tract | 27 | 26% | 21 | 19% | 19 | 17.6% | 28 | 23.9% |
| Unknown | 23 | 22% | 14 | 13% | 25 | 23.1% | 26 | 22.2% |
| Hepatobiliary | 14 | 14% | 27 | 25% | 21 | 19.4% | 22 | 18.8% |
| Gastrointestinal or Intraabdominal collection | 9 | 9% | 12 | 11% | 16 | 14.8% | 20 | 17.1% |
| Intravascular device | 6 | 6% | 9 | 8% | 12 | 11.1% | 10 | 8.5% |
| Upper Urinary Tract | 15 | 15% | 16 | 15% | 7 | 6.5% | 5 | 4.3% |
| Lower Respiratory Tract | 3 | 3% | 5 | 5% | 4 | 3.7% | 2 | 1.7% |
| No underlying focus of infection | 1 | 1% | 1 | 1% | 1 | 0.9% | 2 | 1.7% |
| Genital system | | | | | 1 | 0.9% | 2 | 1.7% |
| Skin or Soft Tissue infection | 4 | 4% | 2 | 2% | 2 | 1.9% | | |
| Bone and Joint (no prosthetic material) | | | 1 | 1% | | | | |
| Cardiovascular or Vascular | | | 1 | 1% | | | | |
| Central Nervous System | | | 1 | 1% | | | | |
| upper respiratory | 1 | 1% | | | | | | |
| **Total** | **103** | | **110** | | **108** | | **117** | |

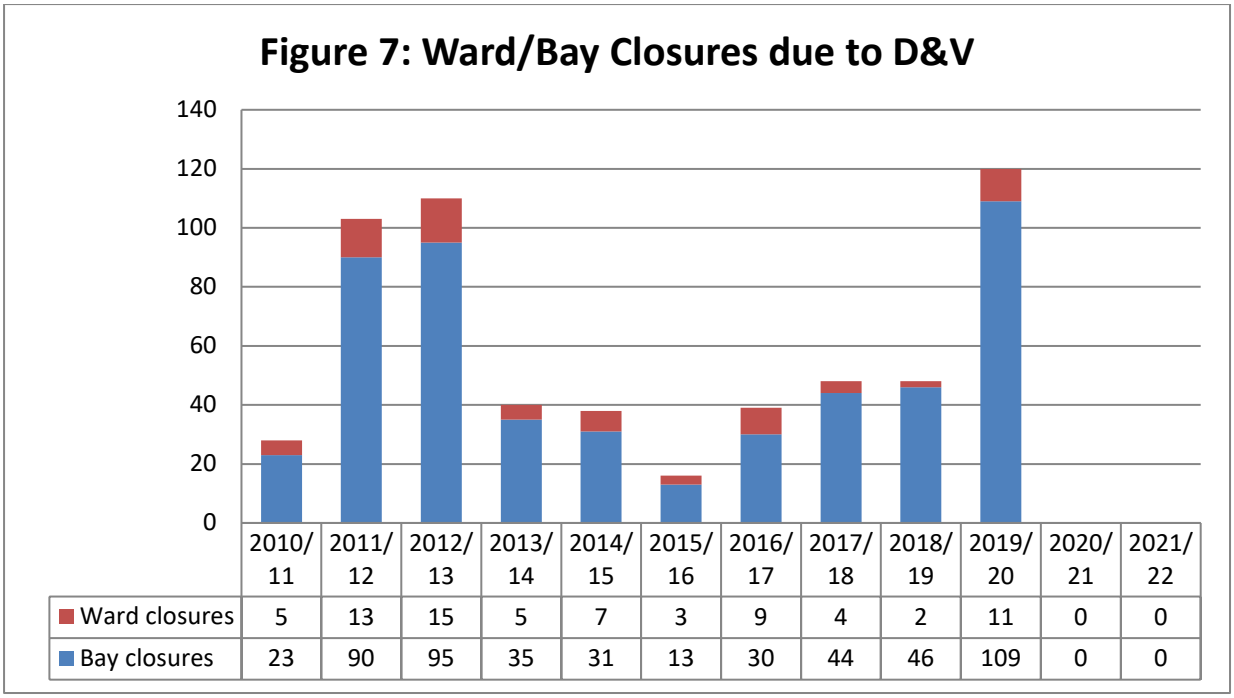
## Carbapenemase Producing Enterobacterales (CPE)

Carbapenemase producing Enterobacterales (CPE) are Gram negative bacteria that are resistant to most antibiotics. They can cause colonisation (with no evidence of infection) or clinically significant infection. CUH had one case in 2015/16, 17 in 2016/17, 24 in 2017/18 39 in 2018/19, 26 in 2019/20, 20 in 2020/21 and 18 in 2021/22. Five were clinical samples and 13 were screening swabs. There were two episodes on different wards of outbreaks involving three patients. There has been a rise in the number of CPE screens that the laboratory processes due to increased awareness and evolving screening criteria. Most remain either OXA-48 or NDM-1.

## Norovirus

Norovirus infection is a short-lived vomiting and diarrhoeal illness, which is readily transmitted from one person to another. The virus can be caught from the environment or shared equipment that has become contaminated. In hospitals, large numbers of patients, staff and visitors may be affected, which can disturb the normal working of the hospital and cause distress to those affected. It is difficult to prevent infection coming into the hospital when there are high numbers of infected people in the community who need admission and when patients incubating the virus may be transferred from referring hospitals.

Norovirus cases normally impact on the Trust from October to April each year with cases peaking January to April. There were again no outbreaks / ward closures in 2021/22 as was the case in 2020/21. For this same period in 2019/20 there were 226 confirmed cases which was noticeably more than the 100 cases in the same period in 2018/19. The corresponding increase in ward and bay closures are shown in Figure 7.




| | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ward closures | 5 | 13 | 15 | 5 | 7 | 3 | 9 | 4 | 2 | 11 | 0 | 0 |
| Bay closures | 23 | 90 | 95 | 35 | 31 | 13 | 30 | 44 | 46 | 109 | 0 | 0 |

**Influenza**

There were 28 cases of hospital-onset influenza and no outbreaks / bay / ward closures from a total of 102 cases in 2021/22. There were 14 cases of HCAI-onset influenza in 2020/21 and no outbreaks in 2020/21.

**Tuberculosis**

CUH implemented an enhanced screening policy for TB amongst staff during 2018-19. Since operationalising the policy the occupational health and respiratory teams have identified multiple cases requiring specialist investigation and treatment ahead of commencing in work, in particular; with potentially vulnerable patients. There continues to be an intense focus on screening and prevention of TB transmission, through the screening and health management of CUH staff. The increased activity has been large but also of significant benefit.

**Surgical site infection (SSI)**

Surgical procedures can be complicated by infection. This is usually a minor superficial infection of the surgical wound, although more serious deep-seated infections do occasionally occur. The risk of infection varies with the particular type and site of surgery. Surgery associated with the gastrointestinal tract, for example, has a much higher infection rate than 'clean' surgery, such as the elective insertion of a prosthetic hip joint. On-going surveillance of surgical site infection is used within the Trust as one measure of the quality of surgery, to identify areas where further investigation or improvement

might be required. Currently the Department of Health requires all Trusts to provide data from elective orthopaedic implant surgery (either hip or knee), repair of neck of femur or reduction of long bone fracture for one three-month time period.

Surgical Site Surveillance (SSS) is performed for individual types of surgery in 3 month blocks. During 2021/22surveillance was undertaken for fractured neck of femur from April to June 2021, when the infection rate was 0.9% (national rate was 0.8%) which is similar to 2020/21.

Large bowel surveillance was undertaken all year round. The quarterly rates for large bowel surgery were 6.2%, 5.6%, 10.9% and 11.5% (national rate of 8.2%). Small bowel surgery surveillance was performed for three quarters. The quarterly rates for small bowel surgery were 8.6%, 8.1% and 10.5% (national rate of 7%).

The Surgical Site Surveillance nurses liaise with the surgical teams to confirm the category of infections identified and meetings occurred with infection control and the surgeons when rates were higher than the national average in order to identify any actions necessary to reduce the incidence of SSI.

**Lassa fever**

A patient admitted in February 2022 was diagnosed with Lassa fever. The patient was transferred to the High Consequence Infectious Diseases Unit in London for ongoing care. Infection control and occupational health (OH) were involved in contact-tracing patients and staff who had contact with the patient according to PHE criteria. No patients were considered to be at risk of acquiring Lassa fever but 886 staff were ultimately assessed by OH (table 6).

**Table 6: Summary of contact tracing activity**

| | | | | **Results** | |
|---|---|---|---|---|---|
| **Risk Category** | **Total** | **Potential Symptoms** | **Tested** | **Negative** | **Positive** |
| Category 3 | 134 | 44 | 29 | 29 | 0 |
| Category 2 | 142 | 9 | 6 | 6 | 0 |
| Category 1 | 386 | | | | |
| Category 0 | 224 | | | | |
| Total checked | 886 | | | | |

Category 3 were deemed as highest risk of exposure and had to isolate at home (for the first 14 days) and provide daily temperature reports for 21 days. Staff in this risk group were not able to return to clinical work for 21 days. Category 2 were low risk but were still requested to self-monitor for 21 days and Category 1 were deemed no risk from Lassa fever. This represented a huge strain on OH, and severely affected the functioning of Critical Care. No staff caught Lassa fever.

## Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

This criterion links with Outcome 10, Regulation 15 safety and suitability of premises contained in CQC guidance about compliance.

The IPCT, in collaboration with the estates and facilities team and the decontamination lead, monitors standards of cleanliness within the Trust and promotes best practice by ensuring the following:

- The Trust has a cleaning strategy developed by the estates and facilities team in collaboration with the ICT and approved by the IPCC.
- The provision of policies for:
    - the maintenance of the environment
    - provision of cleaning services
    - linen, laundry and uniforms
    - decontamination of the environment and equipment
- Staff are suitably trained and hold adequate competencies for their roles.
- There are designated managers for the cleaning of the environment and the cleaning and decontamination of equipment.
- Ward nurses are responsible for cleaning medical equipment and the immediate bed-space. Environmental cleaning is provided by the Trust's cleaning contractor, Medirest. A system is currently in place whereby different levels of cleaning are provided using a RAG rating scheme, depending on the infection status of the patient. As an example, non-infected patients receive a ‘green clean’ which involves the bed space being cleaned with a chlorine-based product. A patient infected with *C. difficile* will have their bed space cleaned with a chlorine-based product and then cleaned using hydrogen peroxide vapour (HPV), known as a ‘red clean’.
- In addition to routine cleaning, the IPCT can request additional cleaning in the event of an infection outbreak or increased incidence of an infection. This ‘reactive cleaning’ can take the form of:
    - Enhanced clean: When additional Medirest staff are allocated to an area to clean communal areas such as patient bays, toilets, dirty utility rooms and touch points.
    - Rolling clean: When an empty bay is used to decant patients within that given ward so that each bay is cleaned on rotation. Depending on the reason for the clean and time available, bays may undergo an HPV or ultraviolet light clean in addition to cleaning with a chlorine-based product.
    - Deep clean: When a bay or side room is empty for sufficient time to allow for a full red clean. There was, until December 2015, the availability of a spare ‘decant’ ward where a whole ward would be proactively moved to a decant facility so that the home ward could undergo a deep clean. This facility was not available since 2016/17 due to capacity issues and as a result the formal deep clean programme has been suspended since. This is seen as a significant risk, particularly for the control of *C. difficile* infection, and the intention is to reinstate the programme as soon as possible. The lack of decant facility has been included on the Trust risk register.

- IPCNs are involved in all aspects of cleaning services, including contract negotiations, deciding on cleaning priorities and monitoring of service delivery at ward level.
- Senior clinical nurses / matrons have personal responsibility for delivering a safe and clean environment. The nurse in charge of any clinical area has direct responsibility for ensuring that cleanliness standards are maintained throughout the shift, including use of appropriate escalation procedures where necessary.
- Ensuring via regular audit and ward inspection visits that all parts of the premises are suitable for the purpose, kept clean and maintained in good physical repair and condition. The audit results are fed back to the wards and incorporated into the nursing quality metric report which provides information monthly by ward and Trust division.
- PLACE (patient led assessments of the care environment) visits are undertaken and the findings and recommendations are actioned. These are managed by Hotel Services rather than the IPCT.
- The cleaning arrangements detail the standards of cleanliness required in each part of the premises and that cleaning schedules and frequencies are publicly available.
- There is adequate provision of suitable hand washing facilities and antibacterial hand rubs, including risk assessments of placement of alcohol-based products.
- Correct procedures are in place for the delivery of food services, including food hygiene and food brought into the organisation by patients, staff and visitors.
- Advising on waste disposal. There is a clinical waste incineration facility on site with an associated ‘energy from waste’ heat recovery system. This facility is compliant with the Environment Agency Permitted Waste Incineration Directive.
- There is a programme of planned, preventative maintenance, including pest control and the management of potable and non-potable water supplies.
- Ensuring the supply and provision of linen and laundry including uniforms which reflects health service guidance HSG (95)18 hospital laundry arrangements for used and infected linen.
- Ensuring the Trust has effective arrangements for the appropriate decontamination of instruments and other equipment. The Trust is fully compliant with HBN/13 and has registration under MDD93/42/EEC.
- There is a designated decontamination lead with responsibility for ensuring that the decontamination policy is implemented in relation to the organisation and takes account of national guidance.
- Appropriate procedures are followed for acquisition and maintenance of decontamination equipment.
- A monitoring system is in place to ensure decontamination processes are fit for purpose and meet required standards:
    - risk assessment
    - weekly water testing and feedback of results
    - machine checks
    - maintenance with available records
- A monitoring system is in place to ensure safe and adequate equipment cleaning in line with High Impact Intervention No. 8 Decontamination of Equipment.

*Legionella* spp. and *Pseudomonas aeruginosa* are two bacteria that are capable of living in hospital water systems and have the potential to cause clinically significant infections in patients. The Water Quality Steering Group (WQSG) meet regularly to discuss matters related principally to Legionella spp. and *Pseudomonas aeruginosa*. Membership of this group includes the Estates department, infection control and patient safety / risk. Microbiological control of *Legionella* is achieved by:

- Temperature: the Trust employs temperature control as the primary method of *Legionella* control within the domestic water systems (as far as is reasonably practicable). This is achieved by maintaining temperatures of:
    - Cold water at temperatures of < 20°C
    - Stored hot water at >60°C (where exceeding 15 litres storage)
- Avoidance of Stagnation: experience has shown that avoiding stagnation is highly important in keeping bacterial counts within acceptable limits. This is achieved by the following:
    - Removing any 'blind ends' on distribution pipework so far as is practicable
    - Ensure all 'Dead-Legs' (e.g. low use taps) are either flushed or removed including any associated pipework
    - Minimising stored water
    - Designing and installing new or modified systems so that the risk of stagnation is minimised
- Maintain cleanliness
- Pipework, distribution, storage, plant and outlets shall be maintained in a clean condition at all times as far as is reasonably practicable to avoid providing nutrients to bacteria.

*Legionella* contamination continues to be detected in some water outlets in the Trust. This is caused by the water heaters being 40 years old, water piping being made of galvanised steel (which in parts is heavily corroded) and some areas with poor water flow rates. Some of the piping in C & D block has been replaced but the piping in other wards still require urgent replacement. Silver-copper ionisation was reintroduced due to its antibacterial properties in order to reduce the growth of these organisms. This is achieved by injecting the copper and silver ions into various parts of the system and maintaining levels of these ions to the supplier's specifications. In addition to this, flushing is also performed across the Trust. Despite the risks associated with an aging water system no patient contracted a hospital onset legionella infection in 2021/22.

Testing for *Pseudomonas aeruginosa* in augmented care areas (i.e. dialysis units and intensive care units) is also performed. Positive results were recorded from the John Farman intensive care unit (JVF) and NCCU. Remedial action is promptly taken by the estates department to reduce the risk to patients and this is discussed at the WQSG. The number of positive outlets continues to fall year on year.

Covid19 has highlighted that a number of clinical areas (i.e. wards, outpatients, certain radiology departments) in the trust comply with the ventilation standards to which they were designed to achieve but do not comply with standards that apply to new builds. This is inevitable bearing in mind the age of the estate, some of which is over 60 years old.

A number of mitigating factors have been put in place to try and address these shortcomings and the issue is on the trust risk register.

Windows are left open when at all possible to improve airflow, social distancing measures are strictly enforced and 'air scrubbers' have been introduced into certain areas to try and improve ventilation whenever possible.

## Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance

- We have systems in place to manage and monitor the use of antimicrobials to ensure inappropriate and harmful use is minimised and patients with severe infections such as sepsis are treated promptly with the correct antibiotic. These systems draw on national and local guidelines, monitoring and audit tools such as NICE guidelines, guidance on patient group directions, the TARGET toolkit in primary care and Start Smart then Focus in secondary care (SSTF).
- There is an Antibiotic Stewardship Group (ASG), which meets quarterly, is responsible for developing, implementing and monitoring the organisation's stewardship programme. Membership of this committee includes representation from microbiology/infectious diseases, pharmacy, each clinical division and the organisations' director of infection prevention. The committee reports to the IPCC and Joint Therapeutics & Drug Committee (JDTC).
- We have numerous antimicrobial policies drawing on national guidance (including the British National Formulary, Public Health England the National Institute of Care Excellence) that takes account of local antimicrobial resistance patterns. They cover diagnosis, treatment and prophylaxis of common infections and prescribers are encouraged to record allergy status, reason for antimicrobial prescription, dose and duration of treatment. Adherence to prescribing guidance and compliance with in hospital post-prescribing review at 48-72 hours is monitored and audited on a regular basis, with data fed back to prescribers and incorporated into patient safety reporting systems to divisional level. Benchmarking is used to demonstrate progress in antimicrobial stewardship. Guidelines are available on Merlin and via an app (Rx Guidelines).
- Providers have access to timely microbiological diagnosis, susceptibility testing and reporting of results. Prescribers have access at all times to Clinical Microbiologists who can advise on appropriate choice of antimicrobial therapy.
- We report local antimicrobial susceptibility data and information on antimicrobial consumption to national surveillance bodies as mandated.
    - 2021/22 marked the beginning of a return to previous levels of antimicrobial consumption following the significant spike noted during the first year of the COVID-19 pandemic. The effects of the COVID-19 pandemic continued to be felt, most notably with numbers of admissions remaining lower compared to pre-pandemic levels, affecting denominator data of antimicrobial consumption.
    - Total antibiotic and meropenem consumption expressed as DDDs/1000 admissions fell by 2.6% and 10.2%, respectively, compared to 2020/21. However, the reduction in total antibiotic consumption failed to meet the National Contract target of a 2% decrease compared to the 2018 financial year baseline. The consumption of the Access (narrow spectrum) category of AWaRe antibiotics as a proportion of total remained stable at 35%, meaning a reduction in absolute DDDs/1000 admissions of broad spectrum

antibiotics was achieved. In addition, a significant decrease in high-cost antifungal prescribing was achieved.

- With CQUIN work cancelled, additional AMS rounds were implemented successfully to improve the choice and duration of antibiotics for common infections encountered in acute medicine, in particular community acquired pneumonia and urinary tract infections. Additional efforts in promoting education
- CUH is faced with additional challenging targets for 2022/23, including a National Contract target to reduce broad and last resort antibiotic use (Watch and Reserve) by 4.5% compared to the 2018 financial year baseline, and two CQUINs on the management of urinary tract infections and community acquired pneumonia. The strategic priorities for 2022/23 include:
- Focus on the National Contract and CQUIN work
- Continued engagement with the EPIC team to improve on reporting and feedback of antimicrobial consumption, infection and resistance rates at directorate and specialty level
- Continued engagement with the EPIC team and relevant specialties to update antibiotic ordersets
- Expand educational activities targeting prescribers
- To actively engage with the System-wide Antimicrobial Network Group and the nascent East of England Antimicrobial Prescribing and Medicines Optimisation Subgroup to facilitate regional and national priorities and quality improvement initiatives
- All prescribers receive induction and training in prudent antimicrobial use and are familiar with the antimicrobial resistance and stewardship competencies.
- On-going support and sharing good practice of antimicrobial stewardship (AMS) and infection control in Uganda as part of a Fleming Fund grant.

The Antimicrobial Strategy document was updated in 2019 and is available here and includes references to recent national guidance. The Antifungal Stewardship Strategy was updated in September 2019.

## Criterion 4: Provide suitable accurate information on infections to any person concerned with providing further support or nursing/ medical care in a timely fashion

This criterion links with Outcome 6, Regulation 14 co-operating with other providers contained in CQC guidance about compliance.

The movement of patients within the Trust is included in key policy documents such as the admission and discharge policies and the patient transfer policy. The IPCT works jointly with bed managers, operations centre staff and with estates and facilities services in planning patient admissions, transfers, discharges and movements between departments and other healthcare facilities.

Local Trust infection control policies require information on potential infection hazards to be forwarded to other institutions before patients are transferred out of the Trust.

The IPCT liaises with the discharge planning team and infection control information is included in all documentation.

## Criterion 5: Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people

The Trust is able to demonstrate that responsibility for infection prevention & control is effectively devolved to all professional groups by means of inclusion in all job descriptions and mandatory inclusion in appraisal documentation including for medical staff.

Compliance with mandatory training and completion of appraisal are reported monthly in the corporate balanced scorecard. This is monitored at executive level at the Management Executive.

The Trust is compliant with national MRSA screening guidance, including the screening of all emergency patients. Compliance is audited and reported monthly in the infection control report.

Point prevalence audits of compliance with antibiotic prescribing are undertaken and reported regularly by the antibiotic pharmacist.

The Trust monitors compliance with the appropriate isolation of patients, including time to isolation. This is reported monthly in the infection control report.

## Criterion 6: All care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

Criterion 6 refers to the training and education of staff, which include Trust staff, including bank nursing staff, Contractors and volunteers. Induction and mandatory update training is provided for all staff, this includes hand hygiene: standard precautions and isolation precaution training is provided for the clinical and support staff, and the responsibility for Infection Prevention and Control are contained within the job descriptions in accordance with the Hygiene Code.

In addition to the Induction and update training, the IPCT also provide training for the Link Practitioners and senior and junior medical staff. The training for medical staff includes:

- isolation policy
- antimicrobial prescribing
- blood culture guidance
- management of exposure to blood borne viruses

The ability to deliver face to face training was curtailed by the pandemic but virtual / on-line training continued. The training and assessment is therefore provided in a number of formats;

- e-learning
- face to face
- practical assessment (FY1)
- training packs for locum/agency staff

The Trust works across the health economy on infection prevention & control measures, including working with the Health Protection Unit, Public Health England, CCG and Regional Epidemiology Unit.

Compliance with induction training, mandatory training and appraisal is reported quarterly in the Trust's operational balanced scorecard.

Line managers are notified of non-attenders at induction and mandatory training. It is the responsibility of the line manager to ensure that non-attenders are followed up and complete their training.

Fit testing for respiratory protective equipment is undertaken for all staff in high risk areas. This has been significantly expanded since the expansion in Covid19 cases, in line with national guidance. Fit testing was assigned to a new fit testing team; compliance was around 65% in 2021/22.

## Criterion 7: Provide or secure adequate isolation facilities

The Trust recognises the need to maintain and expand facilities for patient isolation for infectious purposes, while recognising the need to provide single room facilities for patients requiring privacy for other reasons.

To assist staff the Trust has an isolation policy and organism-specific policies detailing the need for isolation. Staff are also assisted in their decision-making through the provision of a risk assessment tool for prioritisation of patients who require isolation. This has been reviewed several times during 2021/22.

Failure to observe recommended isolation procedures results in the generation of an incident report and if appropriate, emergency control measures as outlined by the IPCT and/or the local Consultant in Communicable Disease Control.

The Trust has the ability to cohort patients where necessary including in the event of a cluster or outbreak of a specific organism. The decision to classify the incidence of any infectious disease as an outbreak is taken by the IPCT in consultation with the infection control doctor or duty microbiologist/ virologist. Broadly, an outbreak can be defined as:

- an incident in which two or more people experiencing a similar illness are linked in time/ place
- a greater than expected rate of infection compared with the usual background rate for the place and time where the outbreak has occurred
- a single case for certain rare diseases such as diphtheria, botulism, rabies, viral haemorrhagic fever, polio

The Trust has in place infection control training programmes for all staff including external contractors. Training programmes are identified through the use of infection control training needs analysis.

## Criterion 8: Secure adequate access to laboratory support as appropriate

The laboratory services are provided by Public Health England (PHE) and are located on site. The local Trust microbiology department has full UKAS accreditation, which requires the provision of appropriate protocols and standard operating procedures.

There is provision of seven day laboratory working and 24 hour access to microbiology and virology advice.

There is a close working relationship with the IPCT; Microbiology Consultants are active participants in the CDI scrutiny panel meetings and there is a monthly meeting between the ICT, virology and microbiology teams to address on-going and new issues.

There are also facilities available for rapid Covid testing (e.g. Samba / Cepheid) outside the PHE laboratory.

## Criterion 9: Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.

A comprehensive IPC document section is available, via the Trust's document library, which identifies all infections and infectious conditions which require isolation or specific infection control management and describes any specific precautions required.

The IPC documents also identify clinical situations where isolation precautions may be required before any infection risk has been confirmed (e.g. patients with pyrexia of unknown origin from abroad).

The IPCT is responsible for the maintenance and updating of the infection control policies, procedures and guidance documents. There are currently a number of infection control documents which are evidence based and reflect national guidance documents. Approval for such documents is via the IPCC and ratification is via the Quality and Risk Committee.

The antimicrobial prescribing policy is the joint responsibility of the consultant microbiologist and antibiotic pharmacist and is approved by the Antimicrobial Stewardship Group (ASG) which reports to the JDTC.

The decontamination policies and procedures are the responsibility of the decontamination lead.

All ICP polices carry a three yearly review date, or sooner in the light of new evidence. The review schedule is monitored within the annual infection control programme and by the Trust documents administrator. Compliance with key policies is audited according to a schedule included in the annual programme.

The IPCT also collaborates with others such as the central venous access team in developing guidelines such as the central venous access devices (CVAD) – criteria for referral to the vascular access team (VAT).

Clinical directorates are required to include audit of compliance with basic IPC policies as part of clinical governance programme. This is monitored by the IPCT.

**Criterion 10: Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care**

The Trust is compliant with Criterion 10, and provides a comprehensive portfolio of policies which address;

- induction training of new staff
- annual update for existing staff
- Occupational health measures

All staff have access to occupational health advice and out of hour's access to medical advice in the event of exposure to a blood borne virus or an alert organism.

There is a screening and immunisation programme which is in accordance with national guidance, specifically 'immunisation against infectious diseases'; including pre-employment screening and on-going health screening for communicable diseases where indicated.

Vaccination data of staff for Covid19 are:

- First dose Covid: 97%
- Second dose Covid: 96%
- Booster Covid: 75%

The uptake of vaccination against influenza in 2021/22 was 64% (substantive staff).

The Trust is working towards reducing occupational exposure to blood borne viruses including the prevention of sharps injuries by the use of safer sharps products where available, including the blood culture sampling system and intravenous cannula.

**Objectives for 2021/22**

| Number | Objective | Completion date | Outcome |
|---|---|---|---|
| 1 | Improve Trust compliance with Hygiene code and review quarterly to monitor progress | March 2022 | Not met |
| 2 | MRSA bacteraemia – no avoidable cases of trust onset MRSA bacteraemia | March 2022 | Not met |
| *3* | *C. difficile* – maintain or improve on 25% of total cases as avoidable trust onset C. difficile | March 2022 | Not met |
| 4 | Gram Negative bacteraemias – reduce trust onset *E. coli* bacteraemia by 20% | March 2022 | Not met |

| | | | |
|---|---|---|---|
| 5 | In conjunction with operations staff identify a method to re-commence the deep clean programme | March 2022 | Not met |
| 6 | Maintain infection control walkabouts to wards, outpatients and other departments to monitor environment and practices | March 2022 | Met |
| 7 | Commence POC testing in ED for influenza & RSV in addition to COVID-19 | October 2021 | Met |
| 8 | Identify clinical areas with poor ventilation and initiate mitigating measures in line with national IPC guidance | December 2021 | Met |
| 9 | Review staffing of IPC team in line with increased requirements arising from opening of new clinical facilities and on-going demands due to COVID-19 | March 2022 | Ongoing |

**Reasons for not meeting objectives / actions taken**

1 The trust has achieved what is achievable now; most non-compliances are now related to the structure of the building
2 The MRSA bacteraemias were caused by poor wound care and line care. Ongoing input is being provided to improve care across the organisation
3 There has been a national increase in CDI cases. However, there are issues related to antimicrobial stewardship and cleaning that need to be addressed in the meantime
4 There has also been a national increase in E. coli bacteraemia rates.
5 This action is linked to point 3. It hasn't been possible to recommence it due to capacity issues.

**Objectives for 2022/23 and 2023/24**

| Number | Objective | Completion date | Actions |
|---|---|---|---|
| 1 | Identify a method to re-commence the deep clean programme | March 2023 | Discuss with board and ops centre |
| 2 | *C. difficile*: maintain the total cases as avoidable HCA - *C. difficile*. | March 2023 | To start a QI programme to enable this |
| 3 | Ventilation: initiate mitigating measures in line with national IPC guidance | March 2023 | Discuss with estates |
| 4 | MRSA bacteraemia – no avoidable cases of trust onset MRSA bacteraemia | March 2023 | |
| 5 | Gram Negative bacteraemias – reduce trust onset *E. coli* bacteraemia by 20% | March 2023 | ICNs to reduce mandatory surveillance on DCS and instead spend time on useful stuff |
| 6 | Review staffing of IPC team in line with increased requirements arising from opening of new clinical facilities and on-going demands due to COVID-19 | March 2023 | |

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Published: September 2021

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Appendix 1

# Infection Control Audit plan 2022

| Key Policy compliance | Audits performed | Frequency | Owner | Evidence / Circulation of data |
|---|---|---|---|---|
| **MRSA Policy** | Compliance with screening | Monthly | IPC Data Analyst | Monthly IC Report and circulated to divisional leads |
| | Compliance with Decolonisation | Monthly | IPCN team | Monthly IC report. Quality dashboard to CCG |
| ***C. difficile* Policy** | Compliance with care bundle | Monthly | IPCN team | IC Monthly report. Quality dashboard to CCG |
| | Compliance with antibiotic protocols | Bi Monthly | | RCA scrutiny minutes |
| **Cleaning & Disinfection Policy** | Medirest monitoring | Monthly | Hotel Services | Report to Ward Cleanliness meetings |
| | Equipment cleaning | Monthly | IPCN team | KPI for Medical equipment dept. |
| | Commode Audit | Annual | Vernacare | Report generated by Vernacare. Circulated Trust wide and taken to IPCC |
| | MDT ward visits | 3-4 wards daily | IPCN team / Medirest /Matrons | Reports / Action plans given to Matrons & Ward Managers |
| **Hand Hygiene** | Hand hygiene audits | Bi-monthly | Ward Managers | Nursing Quality Metrics monthly and agenda item at IPCC |
| | Hand hygiene audits | As required and selection monthly | IPCN Team | Reported at monthly meeting with DIPC and Internal circulation as required |
| **Urinary Catheter care** | Safety thermometer | Monthly | Ward Managers | Safety thermometer report |
| | Care of Urinary catheters | Monthly | IPCN Team | Monthly IC report. Quality dashboard to CCG |
| **Isolation Policy** | Barrier Nursing | Trust wide annual but also incorporated into MDT visits | IPCN team | Annual report circulated Trust wide. MDT reports to wards/ Matrons |
| | Use of PPE | Currently 3-4 wards daily | IPCN team | Reports / Action plans given to Matrons & Ward Managers |
| **Sharps Management** | Trust wide audit undertaken By Daniels | Annual | Daniels /IPCN team | Circulated Trust wide and taken to IPCC |

| Ward & departmental Audits | Purpose | Frequency | Owner | Evidence / Circulation of data |
|---|---|---|---|---|
| **General Wards** | Audit IC practices and ward cleanliness | Initially 3-4 wards daily. Plan for monthly on going. | IPCN team / Medirest /Matrons | Themes and on-going issues escalated to IC action group. Action plans for Matrons |
| **Theatres** | Audit Theatre Practices , Theatre Environment and cleanliness | 6 monthly for Main , Rosie , Neuro and DSU theatres | IPCN team / Medirest /Matrons | Audit reports to Theatre managers. |
| | | Yearly for POW | IPCT | Audit reports to Theatre managers. |
| **Critical Care Units** | Audit IC practices and environmental cleanliness | Currently every 3 weeks approximately | IPCN team / Medirest /Matrons | Audit reports and action plans to Matrons |
| **Emergency Dept** | Audit IC practices and environmental cleanliness | Monthly | IPCN team / Medirest /Matrons | Audit reports and action plans to Matrons |
| **Dialysis Units** | Audit IC practices, compliance with Dialysis regulations and environmental cleanliness | Once a Year unless problems identified | IPCN team | Audit reports and action plans to dialysis managers and Matrons |
| **Outpatients** | Audit IC practices and environmental cleanliness | 6 monthly | MDT | Audit reports and action plans to clinic lead and Matron |
| **Mortuary** | Service evaluation of IC practices and environmental cleanliness | Yearly | IPCN team | Audit report and action plan to departmental lead |
| **Endoscopy** | Audit IC practices and environmental cleanliness | 6 monthly | IPCN team / Medirest /Matrons | Audit report and action plan to departmental lead & Matron |
| **Cambridge Eye Unit** | Audit Theatre Practices , Theatre Environment and cleanliness | Yearly | IPCT | Audit reports to Theatre managers. |
| **Kefford House** | Audit IC practices and environmental cleanliness | Yearly | IPCN team | Audit report and action plan to departmental lead & Matron |
| **Emmeline Centre** | Audit IC practices and environmental cleanliness | Yearly | IPCN team | Audit report and action plan to departmental lead |
| **Physio gym/hydro pool** | Audit IC practices, environmental cleanliness and pool monitoring. | 2 yearly due 2021 | IPCN team | Audit report and action plan to departmental lead |
| **ALAC** | Audit IC practices and environmental cleanliness | Due 2021 | IPCN team | Audit report and action plan to departmental lead |
| **OT dept.** | Audit IC practices and environmental cleanliness | Due June 2021 | IPCN team | Audit report and action plan to departmental lead |
| **K2** | Audit IC practices and environmental cleanliness | Yearly | IPCN team | Audit report and action plan to ward manager and Matron |
| **Neuro Angiography** | Audit IC practices and environmental cleanliness | Yearly | IPCN team | Audit report and action plan to departmental lead |

| | | | | |
|---|---|---|---|---|
| **Vascular Access** | Audit IC practices and environmental cleanliness | Yearly | IPCN team | Audit report and action plan to departmental lead |
| **Angiography - Level 4** | Audit IC practices and environmental cleanliness | Yearly | IPCN team | Audit report and action plan to departmental lead |
| **Ultra sound - Level 3** | Audit IC practices and environmental cleanliness | Due September 2022 | IPCN team | Audit report and action plan to departmental lead |

## Appendix 2 Methodologies used for Assurance

| | Method | Practice | Frequency | Outcomes | Reported to |
|---|---|---|---|---|---|
| Internal | Audit | Hand hygiene | Fortnightly | Any serious lapses reported to Senior staff | All Senior staff via CHEQS and discussed at divisional monthly meetings meeting |
| | Audit | Cleaning Scores | Weekly for high risk areas.<br>Fortnightly for medium risk areas<br>Monthly for low risk areas | Reasons behind areas falling below standards investigated by Root Cause Analysis and problems rectified | Senior Nursing staff via email. Also, discussed at monthly cleaning meetings |
| | Report generated from Epic to monitor compliance with VIP score documentation | Intravascular catheter sites | Monthly | | Senior Nurses via CHEQS |
| | Root Cause Analysis – scrutiny meetings with IPCT, clinical team and the CCG | CDI or MRSA bacteraemia | Monthly (where they occur) | | Learning shared across the organisation |
| | Audit of practice documented on Epic. | Care bundles for urinary catheter care, MRSA decolonisation, C. difficile management and ventilator associated pneumonia | Monthly | Any lapses identified fed back to wards involved. | CCG via the quality dashboard. Reported in Infection Control Performance Report. Specific issues discussed at monthly divisional meetings |
| | Audit/ Service Evaluation | Evaluation of any processes undertaken, observations of practice and condition of furniture and fittings | Yearly for clinics and departments such as theatres, quarterly for critical care areas. | Audit or service evaluation reports and action plan generated. | Report to Senior staff in area visited. Specific issues discussed at monthly divisional meetings |

| | Method | Practice | Frequency | Outcomes | Reported to |
|---|---|---|---|---|---|
| Internal | Audit | Practical aspects of Infection Control such as isolation nursing management and equipment cleaning | Varies from monthly to six monthly | Any lapses identified fed back to Wards involved. Audit frequency increased if indicated | Ward Managers , Divisional monthly meetings and Infection Prevention and Control Committee |
| | Mini PLACE visits | Service evaluation including food quality | Monthly | Report generated by team. | Areas visited and presented at monthly cleaning meeting. |
| Benchmarking | Audit data | Numbers of HCAI | Monthly | Report produced and outcomes of RCA Meetings detailed. | Infection Control Performance Report and Board of Directors report. |
| External | Mandatory reporting of HCAI - triangulation with national surveillance data | National surveillance data held by PHE compared with Trust reports | Quarterly | Reconciliation of mandatory reporting data to ensure accuracy | PHE and DH |
| | Monthly review of CDI and MRSA, , E. coli and MSSA bacteraemias by PHE | PHE surveillance data for each Trust in East of England reviewed | Monthly | Trends monitored and any high numbers reviewed with Trust ICT to ensure actions taken | PHE and Trust ICT |
| | Feedback of any CPE confirmed by national reference lab | Weekly feedback of reference lab data relating to the Trust to ensure action taken | Weekly | Trust ICT were aware of all confirmed CPE. | Trust ICT |