**NHS**
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**University Hospitals**
**NHS Foundation Trust**

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**There will be a meeting of the Council of Governors on Wednesday 28 March 2023 at 17.30 in the Committee Room, Ground Floor, School of Clinical Medicine, Addenbrooke's Hospital, Hills Road, Cambridge CB2 0QQ (and via videoconference)**

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

**AGENDA**

| General Business | | | Purpose |
|---|---|---|---|
| 17.30 | 1. | **Welcome and apologies for absence** | For note |
| | 2. | **Declarations of interest** Copies of the Register of Governors' interests are available from the Trust Secretariat | For note |
| 17.35 | 3.* | **Minutes of the previous meeting** To approve the minutes of the meeting held on 22 March 2023 | For approval |
| | 4.* | **Council of Governors action tracker and matters arising not covered by other items on the agenda** | For review |
| | 5.* | **Composition of the Council of Governors** To receive the report of the Director of Corporate Affairs | For receipt |
| 17.40 | 6.* | **Chair's Report** To receive the report of the Trust Chair | For receipt |
| 17.45 | 7.* | **Priorities and objectives for 2023/24** To receive the report of the Trust Chair | For review |

| | | | |
|---|---|---|---|
| **18.00** | **8.*** | **Chief Executive's Report (including Integrated Performance Report)**<br>To receive the report of the Chief Executive | For receipt |
| **18.45** | **9.*** | **Governors' Reports**<br><br>**9.1 Lead Governor**<br>To receive the report of the Lead Governor<br><br>**9.2 Governors' Strategy Group**<br>To receive the report of the Governors' Strategy Group | For receipt |
| **Items for information** | | | **Purpose** |
| **18.55** | **10.** | **Any other business**<br>Items of any other business to be identified to the Secretary in advance of the meeting | For note |
| | **11.** | **Date of the next meeting**<br>The next meeting of the Council of Governors will be on Wednesday 20 September 2023 at 17.00 | |
| **19.00** | **12.** | **Close of meeting** | |

**Cambridge University Hospitals NHS Foundation Trust**

**Minutes of the meeting of the Council of Governors held on
Wednesday 22 March 2023 at 17.30 in Rooms 8 and 9, Deakin Centre,
Addenbrooke's Hospital, Hills Road, Cambridge CB2 0QQ
(and via videoconference)**

| Member | Position | Present | Apologies |
|---|---|---|---|
| Dr M More | Trust Chair | X | |
| Dr S Addo | Public Governor | X | |
| Dr J  Allen | Public Governor | X | |
| Dr J Biddle | Public Governor | X | |
| Cllr G Bird | Partnership Governor (Cambridgeshire County Council) | | X |
| Prof Dame C Black | Partnership Governor (University of Cambridge) | | X |
| Dr R Cubberley | Partnership Governor (Anglia Ruskin University) | X | |
| Mr D Dean | Public Governor | | X |
| Ms G Downham | Public Governor | X | |
| Miss R Greene | Patient Governor | X | |
| Cllr M Healy | Partnership Governor (Cambridge City Council) | | X |
| Ms M Lee | Public Governor | X | |
| Mr S Legood | Partnership Governor (Cambridgeshire and Peterborough NHS Foundation Trust) | | X |
| Dr J Loudon | Patient Governor | X | |
| Mr D Noble | Patient Governor | | X |
| Mr M Nur | Staff Governor | X | |
| Dr C Roberts | Patient Governor | X | |
| Ms P Rushton-Ray | Staff Governor | | X |
| Ms G Shelton | Staff Governor | X | |
| Dr H Sherriff | Patient Governor | X | |
| Prof P St George Hyslop | Partnership Governor (University of Cambridge) | | X |
| Dr N Stutchbury | Patient Governor and Lead Governor | X | |
| Dr C Tyrrell | Public Governor | X | |
| Dr W Watson | Staff Governor | X | |
| Mrs A White | Patient Governor | | X |
| Dr S Webb | Partnership Governor (Royal Papworth Hospital NHS Foundation Trust) | | X |
| Ms K Woodey | Partnership Governor (Campus Research and Funding Organisations) | | X |

| In attendance | |
|---|---|
| Mr D Abrams | Non-Executive Director |
| Mr A Chamberlain | Non-Executive Director |
| Dr A Doherty | Non-Executive Director |
| Prof I Jacobs | Non-Executive Director |
| Ms A Layne-Smith | Non-Executive Director |
| Prof P Maxwell | Non-Executive Director |
| Ms A Onyemah | Interim Director of Equality, Diversity and Inclusion |
| Mr R Sinker | Chief Executive |
| Mr R Sivanandan | Non-Executive Director |
| Dr A Shaw | Medical Director |
| Mr D Wherrett | Director of Workforce |
| Mr I Walker | Director of Corporate Affairs |
| Mr J Clarke | Trust Secretary (Minutes) |

**01/23**     **Apologies for absence**

Apologies for absence received from governors are recorded in the attendance summary.   In addition, apologies were received from Sharon Peacock, Non-Executive Director.

The Council of Governors was informed that, since its last meeting, Mr Brian Arney, Patient Governor, had decided to step down from the role with immediate effect.

**02/23**     **Declarations of Interest**

No additional interests or changes to previously declared interests were reported.

**03/23**     **Minutes of the previous meeting**

The minutes of the meeting of the Council of Governors held on 19 December 2022 were approved as a true and accurate record.

**04/23**     **Council of Governors action tracker and matters arising not covered by other items on the agenda**

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

**05/23**     **Chair's report**

**Received and noted:** the Chair's report.

**06/23**    **Chief Executive's Report (including Integrated Performance Report)**

Roland Sinker, Chief Executive, presented the report.

**Noted:**
1. The health and social care system continued to face a challenging period. Key performance indicators used to measure performance showed significant variation across organisations and local systems. Despite these challenges, the Trust was delivering high quality care to its patients thanks to the efforts of staff across the hospitals.
2. The Board and Board committees continued to provide appropriate challenge and oversight of the key domains of performance, including:
    • Elective backlog and waiting list management.
    • Timely ambulance handovers.
    • Waiting times in the Emergency Department (ED).
    • Cancer standards.
3. The Trust would re-commence reporting against the 4-hour emergency care standard within the next six to eight weeks after a prolonged period of participation in the national pilot.
4. The next financial year would be incredibly challenging for the Trust and the wider health system. Despite this, CUH was in a strong financial position and was working with the Cambridgeshire and Peterborough Integrated Care Board (ICB) to submit its 2023/24 financial plan.
5. There were a large number of major work programmes being undertaken, including the development of an updated operational strategy, responding to the recent national staff survey results, completing the construction of the new bed capacity and progressing the plans for the Cambridge Cancer Research Hospital and the Cambridge Children's Hospital.
6. The Trust continued to strengthen its leadership to support the delivery of key strategic aims across CUH and the wider Cambridgeshire and Peterborough system. Welcomes were extended to Aloma Onyemah as Interim Director of Equality, Diversity and Inclusion, and to Heather Noble as Managing Director for the Cambridgeshire South Care Partnership. Dr Wai Keong Wong would be joining the Trust as the new Director of Digital in May 2023.

The following points were made in discussion:

1. In response to a question on new hospitals funding, it was noted that a number of hospitals within the national New Hospitals Programme would be fully government funded. Others would involve a mix of government funding, fundraising and philanthropy.
2. Work was currently being undertaken to identify options for closing the funding gap for the Cambridge Children's Hospital. A revised Outline Business Case was due to be submitted for consideration by the national Joint Investment Committee in September 2023.
3. The Addenbrooke's 3 Committee and Performance Committee received regular updates on both the Cambridge Children's Hospital and the Cambridge Cancer Research Hospital.

The Chair invited the Lead Governor to introduce questions from Governors.

1. *As we all know, there was a 72-hour junior doctor strike from Monday last week. Please could NEDs describe how lessons learned from the earlier nurses' strike have been applied in this case to minimise the impact on patients and, if it is not too early to say, what the impact on patients has been (for example number of cancelled operations, impact on waiting times for planned care, increase in wait times in ED, delays in cancer diagnosis, etc.). Is there a contingency plan in the event of a consultants' strike?*

   The following points were noted in response:

   - The operational, medical and nursing teams had learnt a considerable amount from the pandemic and recent strikes in the management of major incidents.
   - As a consequence, the Trust was able to establish relatively quickly what services could be safely run and what activity would need to be postponed.
   - Senior medical staff had covered all rotas for the duration of the strike.
   - In the event of a strike by consultants, the approach that would be taken was clear but the impact it would have was less clear at this stage.
   - There had been no material change in ED waiting times over the three days of industrial action. There had been a brief increase in Type 2 attendances and the 'redirection to other services' letter had been utilised to support decompressing the ED.
   - The Trust had postponed 16% (1,891 episodes) of elective activity that was planned for the three days of strike action. The majority of this had been outpatient appointments.
   - Unfortunately, the Trust had had to postpone seven day case/inpatient cancer cases, two new referrals and 41 review

patients. The Trust had not postponed any two-week wait referrals.
- The Trust had postponed 16 elective patients within the 78-week wait cohort of which nine had been rebooked for before the end of March 2023. Out of the seven patients not rebooked by the end of March 2023, six were booked in April 2023 and one was yet to be rebooked. These seven patients would be classified as 78-week wait breaches due to industrial action.
- All postponed appointments would need to be rebooked in clinical priority order.

2. *The Chief Executive's report mentions that 'a process for capturing, reporting and acting on harm for patients who have long waits in the ED has been developed by the divisional leadership and patient safety teams.' Can we hear more about this what this involves, and are the NEDs assured that priorities for improvement can be identified and implemented on the basis of the data?*

The following points were noted in response:

A process for capturing, reporting and acting on harm for patients who had long waits in the ED had been developed by the divisional leadership and patient safety teams.

There would be three elements to the reviews:

- Intermittent audit of nursing care (nursing actions and basic care provision to mitigate harm in the moment), reported to the divisional governance meeting and overseen at executive divisional meetings.
- Monthly review of incidents reported Trust-wide to correlate with ED long waits, themes and trending, stratified by length of wait, specialty, type of harm (missed medication, falls, skin damage etc.), with reporting to the Patient Safety and Assurance Group bi-monthly. This would be included in the integrated performance and patients safety reports.
- Patient journey time-stamping, reporting directly to divisions as a measure against divisional specialty performance and data supporting quality improvement planning.

A governance process was currently being agreed.

3. *High levels of nursing vacancies across the workforce is an NHS-wide problem. How does the CUH picture compare with others regionally and in the Shelford group? While nursing and HCW vacancies remain high, it was good to read in the Chief Executive's report that the vacancy level for midwives has significant reduced. However, the report also specifically highlights nurse shortages in NICU, PICU and adult ICU. What specific steps are being taken to attract ICU-specialty staff to these areas? Are the NEDs assured that we are fully optimising all routes to support recruitment to all vacancies?*

The following points were noted in response:

CUH had a growing workforce, increasing by 6.8% over the past two years. By March 2023 CUH had, for the first time, over 12,000 members of staff.

CUH had committed to deliver a sub-5% vacancy rate across all staff groups. For nurses this meant returning to the pre-pandemic vacancy position.

In the past three years:
- 6,609 staff had joined CUH as new recruits.
- Our nursing workforce had grown by 9.2% in the last 24 months.

The current vacancy rate for nursing and midwifery was 8.5% (at its height in 2018 it reached 22%) with a turnover rate of 12.7%.

The focus was to build a sustainable registered nursing recruitment pipeline built on a model of:
- One third, UK traditional undergraduate education.
- One third, UK trained to degree level through an in-house Nurse Apprenticeship Programme (NAP).
- One third international recruitment.

The staffing position, retention and recruitment pipelines were discussed at the Trust's Workforce and Education Committee.

*Registered Nurses in Paediatrics*

Paediatric nursing was an outlier, with a vacancy rate of 18.8% across all bands and a turnover rate of 15.7%. Registered Nurse vacancies stood at 59 on a headcount of 313.

The following actions were identified:

- Regular rolling adverts for both Band 5 and Band 6 on the CUH Careers page.
- ICU/PICU had taken part in a Paediatric recruitment event on 18 March 2023. 13 successful candidates were identified across all

6

of Paediatric (Band 5) positons and these would not be available to start until later in the year.

- There were 23 expressions of interest applications from students at Anglia Ruskin University, some of whom would be allocated to NICU/PICU (due to start later in 2023).
- Through the international recruitment pipeline, CUH had one PICU Band 5 nurse and 1 NICU nurse arriving in April 2023. Four more NICU interviews were imminent.

*Registered Nurses in ICU*

- While the Band 5 nurse position in critical care showed a vacancy rate of 23% (against a total headcount of 259.83), when taking into account the 35 new starters pending, the remaining gap was 9%, just below the Trust average.
- On 19 March 2023 the Trust ran a newly-qualified nurse recruitment event and a further six candidates applied for Band 5 positions in ICU at the Trust. These applicants would be interviewed shortly.
- The Trust continued to advertise and interview regularly for ICU nurses via the centralised nurse recruitment process.
- The move to additional Band 6s in the ICU establishments had supported retention through providing a clear development path.

4. *The Virtual Ward programme is saving 5-7 beds per day, making these available for patients who need to be admitted. Over the short period that Virtual Wards have been in operation, what is working well (perhaps better than expected) and what is proving to be a challenge? How do the NEDs assure themselves of the safety and effectiveness of this programme?*

The following points were noted in response:

- The virtual ward was a national programme which aimed to reduce length of stay by managing patients in their own homes.
- CUH had treated over 100 patients on the virtual ward with a wide variety of clinical problems and with a very good safety record.
- The key challenge for the team in the coming months was to build the numbers of patients within the service at any given time.

**Agreed:**
1. To note the report.
2. To note the responses to the questions and that any additional questions would be responded to separately outside the meeting.

**07/23**  **Governors' Reports**

**Lead Governor**

Neil Stutchbury, Lead Governor, presented the report.

**Noted:**
1. The Governors' Nomination and Remuneration Committee had met on 21 February 2023 and received feedback from the Senior Independent Director on the annual appraisal of the Trust Chair and from the Chair on the annual appraisals of the Non-Executive Directors.
2. The Lead Governors of the four NHS foundation trusts within the Cambridgeshire and Peterborough Integrated Care System had met the Chair of the Integrated Care Board (ICB), John O'Brien, for a regular catch up. They had discussed the meeting with governors held in October 2022 and agreed to make this an annual event. The ICB had indicated that it would not be nominating a partnership governor to sit on the CUH Council of Governors.

**Agreed:**
1. To note the report of the Lead Governor.


**Governor's Strategy Group**

Julia Loudon, Governor, presented the report.

**Agreed:**
1. To note the report of the Governor's Strategy Group.


**Membership Engagement Strategy Implementation Group**

Julia Loudon, Patient Governor, presented the report.

**Agreed:**
1. To note the report of the Membership Engagement Strategy Implementation Group.

**08/23**     **Amendment to the Public Constituency**

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

**Noted:**
1. The Local Government Boundary Commission for England had recently completed a periodic electoral review of East Hertfordshire District Council. This proposed new ward arrangements did not directly match the existing arrangements as reflected in the Trust's Public Constituency.
2. As a result, a constituency change was required and it was proposed to follow a similar approach to that adopted previously in such circumstances.
3. In order to ensure that all previously included areas were retained in the Public Constituency, the proposal would result in a slightly expanded scope of the Trust's Public Constituency, with the following four wards of East Hertfordshire District Council included under the new ward arrangements:
   a. Buntingford (this covered a different area to the existing Ward)
   b. Braughing & Standon
   c. The Mundens
   d. Little Hadham & The Pelhams

**Agreed:**
1. To approve the amendment to the Public Constituency as set out in the paper.
2. To note that, subject to approval of the amendment by the Board of Directors, the Trust Constitution would be updated accordingly.


**09/23**     **Any other business**

**Noted:**
1. The Director of Corporate Affairs provided an update on the Governor Election timetable and the next steps in the election process.


**10/23**     **Date of next meeting**

The next meeting of the Council of Governors in public would be held on Wednesday 28 June 2023 at 17.30.


*Meeting closed: 18.49*

**Council of Governors: Action Tracker**

| Minute | Action | Lead | Target date | Status | RAG rating |
|--------|--------|------|-------------|--------|------------|
| There are no outstanding actions | | | | | |

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# Report to the Council of Governors: 28 June 2023

| Agenda item | 5 |
| --- | --- |
| **Title** | Changes to the Council of Governors since the previous meeting |
| **Sponsoring executive director** | Ian Walker, Director of Corporate Affairs |
| **Author(s)** | As above |
| **Purpose** | To note changes to the composition of the Council of Governors. |
| **Previously considered by** | n/a |

**Executive Summary**

Since the previous meeting of the Council of Governors in March 2023, there have been the following changes to the composition of the Council of Governors:

1. Neil Stutchbury, Jane Biddle and Carina Tyrrell were re-elected to the Council of Governors in the 2023 elections. Each will start their new three-year term of office on 1 July 2023.

2. Elizabeth Howe and Robin Stevens were elected as Patient Governors, Chris Cumberland was elected as a Public Governor and Frank Allan was elected as a Staff Governor in the 2023 elections. Each will start their first three-year term of office on 1 July 2023.

3. Colin Roberts and Polly Rushton-Ray did not stand for re-election and David Dean was not re-elected in the 2023 elections. They will therefore leave the Council of Governors on 30 June 2023.

4. Cambridge City Council confirmed in May 2023 the re-appointment of Cllr Mairead Healy as a partnership governor for a further 12 months.

A summary of the outcome of the 2023 elections is attached.

| Related Trust objectives | All Trust objectives |
|---|---|
| Risk and Assurance | n/a |
| Related Assurance Framework Entries | n/a |
| Legal / Regulatory / Equality, Diversity & Dignity implications? | The composition of the Council is defined by the Trust Constitution. |
| 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 Council of Governors**

The Council of Governors is asked to note the change to the composition of the Council since the previous meeting.

## Composition of the Council of Governors as at 1 July 2023

| Public (7) | | Patient (8) | | Staff (4) | | Partnership (10) | | |
|---|---|---|---|---|---|---|---|---|
| Samira Addo | 1st term (2024) | Robin Stevens | 1st term (2026) | Mahad Nur | 1st term (2025) | Peter St George-Hyslop | University of Cambridge | 2nd term (Jun 2024) |
| John Lee Allen | 1st term (2024) | Ruth Greene | 3rd term (2025) | Frank Allan | 1st term (2026) | Karen Woodey | Campus Research Organisations | 1st term (Jan 2024) |
| Jane Biddle | 3rd term (2026) | Julia Loudon | 3rd term (2024) | Gill Shelton | 1st term (2024) | Rachael Cubberley | Anglia Ruskin University | 1st term (Jun 2025) |
| Chris Cumberland | 1st term (2026) | David Noble | 1st term (2024) | William Watson | 1st term (2024) | Gerri Bird | Cambridgeshire County Council | 2nd term (Jun 2023) |
| Gemma Downham | 1st term (2024) | Elizabeth Howe | 1st term (2026) | | | Carol Black | University of Cambridge | 1st term (Aug 2023) |
| Melissa Lee | 2nd term (2025) | Howard Sherriff | 2nd term (2025) | | | Mairead Healy | Cambridge City Council | 3rd term (May 2024) |
| Carina Tyrrell | 2nd term (2026) | Neil Stutchbury | 3rd term (2026) | | | Stephen Webb | Royal Papworth NHS Foundation Trust | 1st term (Oct 2023) |
| | | Adele White | 2nd term (2024) | | | Stephen Legood | Cambridgeshire and Peterborough NHS Foundation Trust | 3rd term (Feb 2024) |
| | | | | | | - | [Public health – Cambridgeshire County Council] | - |
| | | | | | | - | [nomination of the former Cambridgeshire and Peterborough CCG] | - |

The figure in ( ) refers to the end of the current term of office.

1. **Terms of service**

1.1   All governors are eligible to serve up to nine years in office. The nine years is calculated cumulatively.

1.2   Elected governors may serve single terms of up to three years. Elected governors who are elected for part terms are eligible to serve up to a maximum of nine years, therefore may only be eligible for a reduced length of service in a final term.

1.3   The Council of Governors cannot extend appointments beyond the nine year maximum limit or (for elected governors) individual terms beyond three years.

1.4   The Trust and individual nominating organisations will agree a review cycle which will normally be a maximum of three years between reviews.

1.5   Governors may only hold one governor role at a time, therefore may not be a governor at another trust while being a CUH governor.

2. **Vacancy procedure (elected governors)**

2.1   In the event of a vacancy arising outside of the normal election cycle, the vacancy will be filled at the next scheduled election unless the number of vacancies will result in one or more of following occurring:

   a)   The Council of Governors will not be quorate.

   b)   The number of vacancies in the Public, Patient or Staff Constituency is greater than 50% of the places in the relevant constituency.

2.2 In the event of a) or b) applying, the following will be implemented:

a) Candidates from the last scheduled election who secured at least 10% of the overall number of ballots in the relevant constituency may be co-opted to the Council of Governors until the next scheduled election.

b) In the event of the number of vacancies exceeding the number of potential or actual co-options, and there is greater than six months until the next scheduled election, a by-election will be convened for all current vacancies. The six months shall be calculated from the date of issuing of the formal notice of election. The successful candidates in the election will be elected for the remaining components of the departing governors' terms.

## 3. Vacancy procedure (partnership governors)

3.1 In the event of a vacancy arising for a partnership governor, the Trust will contact the nominating organisation and seek a new nomination.

**CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST**

**ELECTION TO THE COUNCIL OF GOVERNORS**

**CLOSE OF VOTING: 5PM ON 15 MAY 2023**

## CONTEST: Patient

| RESULT | | 3 to elect |
|---|---|---|
| STUTCHBURY, Neil | 500 | **ELECTED** |
| HOWE, Elizabeth | 473 | **ELECTED** |
| STEVENS, Robin | 267 | **ELECTED** |
| CHUISSEU , Josiane | 214 | |
| ANDREWS, Jeffery James | 202 | |
| LATTA, Hafida | 185 | |

| | | |
|---|---|---|
| Number of eligible voters | | 3,675 |
| Votes cast by post: | 371 | |
| Votes cast online: | 309 | |
| Total number of votes cast: | | 680 |
| Turnout: | | 18.5% |
| Number of votes found to be invalid: | | 1 |
| Total number of valid votes to be counted: | | 679 |

## CONTEST: Public

| RESULT | | 3 to elect |
|---|---|---|
| BIDDLE, Jane A | 345 | **ELECTED** |
| TYRRELL, Carina | 321 | **ELECTED** |
| CUMBERLAND, Chris | 256 | **ELECTED** |
| WARD, Jacqueline | 190 | |
| DYBOWSKI, Richard | 188 | |
| DEAN, David | 184 | |
| AMINPOUR, Gita | 145 | |
| SAUNDERS , Stephen | 143 | |
| BELL, Lenja | 143 | |
| TRAJKOVSKI, Daniel | 105 | |

| | | |
|---|---|---|
| Number of eligible voters | | 4,547 |
| Votes cast by post: | 412 | |
| Votes cast online: | 331 | |
| Total number of votes cast: | | 743 |
| Turnout: | | 16.3% |
| Number of votes found to be invalid: | | 7 |
| Total number of valid votes to be counted: | | 736 |

### CONTEST: Staff

| RESULT | | 1 to elect |
|---|---|---|
| ALLAN, Frank | 355 | **ELECTED** |
| FERRARO, Elisa | 345 | |
| JEYAKUMAR , Jeevline | 246 | |
| CHINIGHALLA, Raju | 240 | |
| DAVIDSON, Bill | 231 | |
| BOYD, Simon | 218 | |
| JOHNSON, Vernon James | 173 | |

| | | |
|---|---|---|
| Number of eligible voters | | 12,278 |
| Votes cast online: | 1,808 | |
| Total number of votes cast: | | 1,808 |
| Turnout: | | 14.7% |
| Number of votes found to be invalid: | | 0 |
| Total number of valid votes to be counted: | | 1,808 |

Civica Election Services can confirm that, as far as reasonably practicable, every person whose name appeared on the electoral roll supplied to us for the purpose of the election:-

a) was sent the details of the election and

b) if they chose to participate in the election, had their vote fairly and accurately recorded

The elections were conducted in accordance with the rules and constitutional arrangements as set out previously by the Trust, and CES is satisfied that these were in accordance with accepted good electoral practice.

All voting material will be stored for 12 months.

**Ciara Hutchinson**
**Returning Officer**
**On behalf of Cambridge University Hospitals NHS Foundation Trust**

**Cambridge University Hospitals**
**NHS Foundation Trust**

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## Report to the Council of Governors: 28 June 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 Council of Governors

The Council of Governors is asked to note the contents of the report.

**Cambridge University Hospitals NHS Foundation Trust**

**28 June 2023**

**Council of Governors**
**Chair's Report**
**Mike More, Trust Chair**

**1.      Introduction**

1.1    We have experienced further rounds of industrial action since the last Council of Governors' meeting in late March 2023.

1.2    These have been difficult events to navigate for all concerned. Planning for them has taken a huge amount of time of leaders and colleagues throughout the Trust. The most recent action also had a considerable amount of uncertainty until very late on, which meant planning confidence could not be as assured as we would wish.

1.3    As a Board of Directors, and a body with no role in any negotiations, we inevitably have to navigate a fine balance. On the one hand, to understand and engage with the concerns which drive strike action, including long-term patient safety and to recognise the legitimacy of such action; on the other hand, to be very concerned about the consequences for patient safety and anxiety. This was an especially difficult balance to strike in the most recent action.

1.4    The Trust, together with the Shelford Group, has been clear and public on the need for resolution in the best interests of all concerned.


**2.      Pubic meeting**

2.1    With Roland and Ian, I met with members of the public on 24 April 2023. The topics covered included industrial action, staffing, housing, delayed discharges, stroke admissions and Serious Incident (SI) reporting.


**3.      'You Made A Difference' Awards/Staff Awards**

3.1    I was pleased to attend 'You Made A Difference' award events 27 March 2023 and 25 April 2023. 104 individual nominations were received and I would like to personally congratulate the winners George Phillips, Rishi Rallan and Ann Taylor.

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

**4.    Long Service Awards**

4.1    I attended the CUH Long Service Awards on 4 and 5 May 2023. It was a pleasure to meet and chat with so many members of staff celebrating important milestones at the Trust, and it further highlighted how lucky we are to have such a dedicated, talented and loyal workforce. To put this into context:

- 343 members of staff are celebrating 10 years' service
- 213 members of staff are celebrating 20 years' service
- 31 members of staff are celebrating 30 years' service
- 10 members of staff are celebrating over 40 years' service
- Cumulatively staff have completed 8,722 years at CUH

4.2    I would like to thank everyone who attended these fantastic events and also those that helped organise them. It was a great success.

**5.    Governor elections**

5.1    The 2023 Governor elections concluded in May 2023 and I would like to congratulate Jane Biddle, Neil Stutchbury and Carina Tyrrell on their re-election to the Council of Governors for the next three years.

5.2    I would also like to welcome to the Council Elizabeth Howe and Robin Stevens who have been elected as Patient Governors; Chris Cumberland who has been elected as a Public Governor; and Frank Allan who has been elected as a Staff Governor.  All four will take up their three-year terms on 1 July 2023 and I look forward to working with them.

5.3    Sadly we have to say goodbye to three Governors, David Dean, Polly-Ruston-Ray and Colin Roberts, who leave the Council at the end of this month.  All three have made a significant contribution to the work of the Council of Governors – we thank them for their service and wish them well for the future.

**6.    King's Birthday Honours List**

6.1    I am sure that Governors will wish to join me in congratulating Roland Sinker on being awarded a CBE for services to healthcare in His Majesty The King's Birthday Honours list which was published recently.

**7. Diary**

7.1 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
Audit Committee
Addenbrooke's 3 Committee
Workforce and Education Committee
Board of Directors
Council of Governors
NED Quarterly meeting
Consultant Development Programme
Council of Governors' Strategy Group
Medicine for Members: Robotic in Surgery
12,000th Employee Celebration

7.2 Other meetings attended during this period include:

NHS Providers Chair and Chief Executives meeting
Health and Wellbeing Board/ICP meeting
Cambridgeshire and Peterborough ICS Chairs meeting
Public Health Genomics Dinner,Trinity College
Ramsden Dinner, St Catharine's College

**8. Recommendation**

8.1 The Council of Governors is asked to note the contents of the report.

**NHS**

**Cambridge University Hospitals**
**NHS Foundation Trust**

**Together**
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# Report to the Council of Governors: 28 June 2023

| Agenda item | 7 |
|---|---|
| Title | Priorities and objectives for 2023/24 |
| Sponsoring director | Mike More, Trust Chair |
| Author(s) | As above |
| Purpose | To endorse the proposed objectives. |
| Previously considered by | Governors' Nomination and Remuneration Committee, 6 June 2023 |

**Executive Summary**

The Council of Governors decided in 2022 to extend the tenure of the Trust Chair until September 2025 in view of the value of some continuity at this time. A specific requirement of this decision was the agreement of a set of clear and stretching objectives from April 2023. The Governors' Nomination and Remuneration Committee has discussed these in draft with the Chair and they are attached at Appendix 1 for consideration and endorsement by the Council of Governors.

| 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 Council of Governors**

The Council of Governors is asked to review and endorse the proposed objectives for the Chair and that the objectives form a basis for regular reporting by the Chair to the Council of Governors during the year.

**Cambridge University Hospitals NHS Foundation Trust**

**28 June 2023**

**Council of Governors**
**Priorities and objectives for 2023/24**
**Mike More, Trust Chair**

## 1.    Introduction

1.1    Last year the Council of Governors agreed to extend the end of the Chair's tenure from April 2023 to September 2025. The motivation of so doing was to secure some continuity as the Trust emerged from the exceptional circumstances of the Covid-19 pandemic, and as certain key projects, such as the creation of Integrated Care Systems and the possibility of Children's and Cancer Hospitals, are at critical stages.

1.2    There is very good reason as to why non-executive tenures, including of the Chair, are of fixed term. This is mainly to do with the role of the non-executive members of the Board to provide independence of perspective, freshness of challenge and the bringing to bear of relevant and current wider experience to the benefit of the Trust.

1.3    The Chair, after consideration, was happy to commit to an extended period so long as the Council was happy that he continued. He is clear, though, that the principle of fixed tenure is an important one and such that, even if there were continued volatility in 2025, the Trust must make arrangements for a new Chair to be effective from September 2025. The Chair also supports the idea of explicit objectives as a mechanism by which the Board of Directors and Council of Governors can evaluate the contribution of the Chair in leading the Board.

## 2.    Objectives for 2023/24

2.1    The Chair had produced a similar objectives document to append to his reports to the Board and Council of Governors in the early part of his tenure. These had fallen in abeyance largely through a degree of repetition with the Chief Executive's reports, but they are nonetheless helpful in forming a framework for evaluation, direction and prioritisation.

2.2    In considering the objectives, it is important to recognise what the role of Chair is and therefore what kind of objectives these are. The Chair sees his role as primarily about encouraging and delivering a strong and open culture in the organisation, where good and informed challenge and scrutiny can apply to our decisions and practices such as to optimise the performance of the Trust, where decision making is of excellent quality and in which our

longer-term stewardship of the Trust in the interests of patients and communities is paramount. A large part of this is achieved through the way the Board and its sub-committees work, both in formal and informal mode.

2.3     This means that the objectives are not those characteristic of Executive functions, where SMART (Specific, Measurable. Achievable, Relevant and Time-Bound) applies. As a Trust, the Board and the Council of Governors are both aware and regularly appraised of detailed targets and data across the range of our activities. The objectives are also wide, in the sense that the Board has oversight and leadership across the complex whole that is CUH.

2.4     The Governors' Nomination and Remuneration Committee discussed this at its meeting on 6 June 2023 and felt that this was an appropriate approach but made the suggestion that there would be merit in giving a sense against each area of what success or failure might look like. These are included within Appendix 1.

2.5     It is also important that the objectives are not allowed to be put on the shelf. The Chair proposes that they are attached as an appendix to his regular reports to the Council of Governors, thereby allowing commentary in-year on progress and/or concerns.

## 3.     Recommendation

3.1     The Council of Governors is asked to review and endorse the proposed objectives for the Chair and that the objectives form a basis for regular reporting by the Chair to the Council of Governors during the year.

**Appendix 1: Priorities and objectives for 2023/24**

**1.      The Teams who Work Together**

We are nothing without our workforce who, Together, are Safe, Kind and Excellent.

As a Board, we know that the last three years have put immense pressure on the colleagues who provide or support front-line healthcare. Colleagues remain in the most part proud of the hospital in which they work and committed to providing excellent health care. But we are aware of the pressures people are under, the concerns that these represent for many in providing safe healthcare and the consequences in terms of morale and the recruitment and retention of staff.

We will continue to assure ourselves that all efforts will be maintained to deliver on the five strands of our workforce strategy and that we will listen appreciatively to the results of staff survey and develop appropriate responses.

*We will look for positive impact in metrics for retention and recruitment and the indicators for well-being and satisfaction of staff.*

**2.      The Teams and Patients who are Diverse**

Our appointment to the role of Director for Equality, Diversity and Inclusion is an important milestone in trying to reflect the needs and aspirations of *all* our colleagues and also in promoting the sensitive and thoughtful care of *all* our patients, whatever their background, disability, ethnicity, religion, gender or sexual orientation. We know that there are many deep issues at play which hold back progress in this area, but as a Board we will want to be assured that we develop an approach and plan which will make substantial progress in our capability to reflect the differences in our teams and our patients.

*We will look for meaningful engagement and ownership by the Trust of the analysis and proposed actions emerging from the work of the Director for EDI during the course of the year.*

**3.      Our Operational Performance, Patient Safety and Finance**

Waiting lists, elective treatment, A&E attendances, Maternity, Critical Care and many other areas will continue to be of central importance and challenge. Our more strategic operational approach has borne fruit over recent months, with the important but limited aim of mitigating against the unacceptable performance outcomes which would otherwise have been inevitable. Now we see encouraging signs of a more sustained improvement across a wide range

of indicators, which is a credit to the revised strategic approach. But there is a lot more to do and a continued challenging environment.

Recent and current (at time of writing) industrial action occupies a lot of management time and affects patient waiting lists, recovery trajectories and prospective financing. We are seeing patient experience being compromised and patient satisfaction at NHS level also being eroded. The complexities and delay in delivering enhanced bed capacity has had a constraining effect and we will need to be satisfied on the delivery of the physical build programme and our ability to finance and staff the enhanced capacity once available. Financial planning for 2023/24 has been difficult and we face considerable risks in the medium term.

As a Board we will focus on all these areas and will need to strengthen our approach to comparative performance in terms of length of stay and recovery trajectory. We will also build on the work done over the last year, mainly in Performance Committee, to translate the Trust's broad strategic ambitions into workable and achievable medium term deliverables, with a particular focus on bed supply and demand and occupancy. Given our qualities we owe it to patients to be an upper quartile/decile performer. As a Board, we have understood that in a time where patient safety is under pressure across all our activity it is fundamental to have a strong open and honest culture which is always appreciative of what our teams are doing but never complacent about the risks.

***We will look for sustained improvement which reflects our capability and responsibility to be an upper decile/quartile performer. We will look for revised metrics based on the core issue of bed occupancy and availability in order to navigate our way strategically through the next three years. We will look for increased bed numbers through delivery of U block.***

4.      Innovating, Transforming and Improving

We are at a pivot point. We have rightly invested heavily in time to support and develop an improvement culture across the Trust. This is about developing an improvement culture and methodology across the full range of our services and inevitably has an element of bottom-up about it. It marked an important change from the cost reduction approach of a few years ago.  All the evidence from other hospitals and healthcare providers in the UK and elsewhere suggests that a consistent and patient approach to this bears fruit.

We now, though, need to get to the next stage whereby this methodology is applied to effect wider strategic and transformational change, aligned with our operational needs and our vision for a clinical operating model as articulated through our Addenbrooke's 3 programme. This also means tying the approach to our Digital Strategy. There are difficult issues here, not least how we address the constrained flexibility in the Epic budget and resourcing. A new approach is necessary here. I am also keen that we add a much more disciplined systems-

engineering approach to pathway design, including outside the hospital, where appropriate. We are also undertaking a review of the relationship between ourselves and Royal Papworth Hospital (RPH).

I want to see us emerge with a stronger collaborative vision of how we interrelate in benefit of patients and clinical research. And we are taking a leadership role in a Provider Collaborative in taking forward the opportunities of stronger specialist commissioning on behalf of patients across the East of England. Across all these areas and in current patient experience, we are seeing important emphasis on working with patients in the design of services and I am keen that these steps get ever more impactful.

***We will look for firm steps in taking forward our enhanced transformation capacity, for a marked change in specialist commissioning in the East of England and for a new relationship between CUH and RPH for the benefit of patients.***


5.      **Integrating at Place**

Part of the architecture for integrating health and care we created some few years ago was built around the concept of Place. This was the idea that any area, such as the catchment area of a hospital as District General Hospital (DGH), was in part an administrative convenience, when people's access to and experience of health care was much more grounded in local communities, such as parts of the City like Newnham or Parkside or Arbury or villages like Shelford and Sawston or Soham. On this basis we worked to reflect local communities in securing the co-terminosity of emerging Primary Care Networks with the Think Communities network of the County Council, by which the voluntary sector was grouped. The principal idea behind this is that we are able to divert and promote much greater access to specialist and diagnostic activity from hospital to community, in such a way that we make substantial inroads into preventing unnecessary hospital admissions, which is in the interests of patients.

We have made some progress on this – we were able, for example, to navigate urgent and emergency care and discharges over the last few winter months with much greater effect using this architecture. However, I am anxious that over the next two years or so we will have begun to populate this integrated approach at much greater scale and pace. This is partly internal – how are we setting this expectation for our own clinicians, where appropriate for the speciality?; and is partly external – how are we promoting the confidence among primary care colleagues, councils and other trusts and the ICB?

We will need to move away from the language of mergers to the language of re-forming models of care and align the various levers to achieve this aim. An example which will benefit from this approach is the roll-out of Virtual Wards.

*We will look for much greater scale and pace in moving towards integrated models of care focused on Place. I will feel much of my time as Chair will have failed and been a waste of time unless we see significant movement.*

**6.    Making the Children's and Cancer Hospitals inevitable and irreversible/Capital Projects**

A huge amount of work has been done by many people in Cambridge and across the region in creating genuine excitement and enthusiasm for these two projects. We are now at the Full Business Case (FBC) level for the cancer project and our tasks in the coming months are: i) to complete the FBC; ii) bridge the non-Government funding gap; and iii) create the appropriate governance oversight as we move to procurement/commissioning and construction phases.

We are not at the same formal Government stage with Children, although there is quite extraordinary enthusiasm and energy behind the regional stakeholder support. Our task is to keep the project on government sightlines and it is encouraging that NHS England have supported continuing work over coming months. Our task is to make it impossible for government not to take it forward.

The Trust has done extraordinarily well in progressing these projects to the level of government interest and stakeholder support that they have. We have also done well in working through the clinical possibilities in new physical provision with the Surge Centres, which is coming on stream this year. However, we face and experience a very difficult construction climate and have had supply chain disruption which has caused delays. We are learning from this. We will appoint an independent Board Adviser to engage and support on the governance and assurance on capital construction. We may need to obtain short-term independent support to provide such assurance early in the process for capital construction of the Cancer Hospital.

*We will look for good effective steps as we move to construction phase for the Cancer Hospital so as to secure that being operational from 2027 and continued government support for the Children's Hospital.*

**7.    Our role in the Cambridge Bio-Medical Campus**

As a Trust we are a three-legged stool, and like any stool to be functional we have to keep the three legs in some sort of harmony. First, as a provider of hospital services, from DGH to highly specialist; second, as a teaching institution; and third, as a research institution with a particular focus on translation research and innovation.

We are an anchor institution within the Cambridge Biomedical Campus (CBC) and critical to its ongoing development as one of the leading academic health science centres in Europe. The CBC reached a tipping point shortly before the Covid-19 pandemic whereby the incremental and organic growth was a sign of energy and success but in which governance was a bit messy, institutional differences tended to crowd out a common vision, and there was a lack of focal point, for example, for the planning or transport authorities or local residents when they wanted to "talk to the Campus".

Primarily under the auspices of Cambridge University Health Partners, of which we are a member, a lot of work has been done in order to move the campus forward. We now see a much stronger coherent Cambridge vision for Clinical Life Sciences research, embracing us and associated campuses in the area; we now see much greater connectedness in submitting proposals to the Local Planning Authorities; and we see better engagement and trust with local neighbours. It was great to see the Campus' growth proposals being taken forward in the Local Plan process and this will be important both for the campus itself but also the opportunity to secure enhanced housing provision for our staff. It is also great to see the Government/Network Rail commitment to the Cambridge South Station on the campus, which will open up new strategic transport and housing corridors which we need to use to our staff's benefit. We support the recently announced route proposals for East West Rail and note the explicit government/Network Rail referencing of the importance of the CBC in their decision-making.

I am not sure that we have fully worked up our strategic approach to housing and we must make sure that the housing consequences of the EW Rail Route, in Cambourne and wider afield, and the Cambridge South Station, are fully exploited. It is a well-known phenomenon that transport routes and termini have a major impact on housing and housing developers. We are also central to some very current political issues such as the Cambridge congestion debate.

We will need to continue to play our part on this overall theme, through ongoing dialogue with the planning and transport authorities and local residents. We will need to continue to facilitate the opportunity to foster innovation and start up capacity within the campus and to ensure opportunity for enhanced Histopathology and Genome Sequencing space.

We also need to develop the debate about what should now be seen strategically as a Campus asset as opposed to a hospital asset. We will need to take shorter-term decisions about the Hospital Concourse but we need to have a firm plan about the options for Campus-provided assets.

I'm minded, also, to strengthen our Board assurance role for clinical research and using the Addenbrooke's 3 committee as the appropriate vehicle for this.

Within our educational role, I am keen that as a Board we continue to place more emphasis on our contribution to undergraduate teaching and also our ever important role to think creatively and well about how we contribute to the UKs workforce development.

***We will look for a continued strong position of the Biomedical Campus in the Local Plan, advantage taken of enhanced housing opportunities and better transport links. We will look for the unique role we play in the NHS/Life Sciences relationship to continue to strengthen.***

8.   **How we govern ourselves**

We are commissioning a governance review to be undertaken by the end of the calendar year. It is the right time for us to reflect formally on our fitness for purpose and to think about how needs have changed since our last CQC visit. This will also be the opportunity to think about what future proofing of our governance is appropriate in the context of Children's, Cancer and Place. It will also be an opportunity to reflect on what the Trust will be looking for in the office of my successor Chair.

***We will look for an effective Governance Review.***

9.   **And how our governance relates to others**

We have been active players within the Cambridgeshire and Peterborough Health and Care system over the past 6 years. Our leadership role is different now than when I was chairing the STP/ICS. The Trust CEO sits on the ICB Board and I sit on the Partnership Board. ICBs are faced with difficult and challenging circumstances and as a Trust we have experienced some difficult conversations, especially around the approach to the Financial Plan and to Place. It is important that the Chair and CEO continue to try to support and influence the development of the ICB and to use this as a platform in which the capacity of the Trust in areas such as health prevention and promotion are supported.

***We will look for the Chair influencing the ICB approach.***

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# Report to the Council of Governors: 28 June 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 Council of Governors**

The Council of Governors is asked to note the contents of the report.

**Cambridge University Hospitals NHS Foundation Trust**

**28 June 2023**

**Council of Governors**
**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 continues to face a difficult period, made more challenging by industrial action. 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 continues to perform well relative to peers as we move out of winter. However, as a Trust we do continue to hold increased levels of risk, including: waits in the Emergency Department (ED); additional patients in wards and contingency areas; and waits for planned care. The pressures come from ongoing demand and reducing elective waits, and industrial action. All the periods of industrial action have been very difficult to manage and have required close working between CUH and colleagues to get to a balanced position. The most recent industrial action, with no agreed exemptions/safety mitigations until very late, exposed our patients and staff to very high levels of risk. Beyond this immediate pressure, ongoing industrial action frays relationships and is a significant distraction. The Trust continues to urge all sides to resolve the disputes.

1.4   These challenges continue to be 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 in the community and through virtual wards. The Operational Strategy is being refreshed. Current performance is particularly strong on ambulance handovers and cancer waits.

The Trust is working on waits in the ED, the return to the 4 hour standard, and elective waits (in the context of cancellations due to industrial action). Performance in most other areas remains strong but with a good deal of work to do e.g. on finance, using our strong position to deliver a challenging financial plan agreed for the system for 2023/24; or on the results of the staff survey, engaging in a focus group led exercise to understand and respond to a relative downward trend for the first time in seven years.

1.5     Looking ahead the Trust and Integrated Care Board (ICB) partners will continue to actively manage day to day delivery of the Operational Strategy. This includes the opening of 56 beds; and the 40-bedded three theatres elective orthopaedic centre later this year. The opening date of this capacity may move and will be in the context of reconfiguring our bed plan, and continued work on delayed transfers of care. Work continues on the 15 programmes in the three domains of the strategy, with appropriate flexible prioritisation - in particular looking at how to bridge the capacity/ workforce challenges to continue to bring our waiting lists down. Work on improvement, innovation and digital will be key in this.

1.6     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 (RPH), 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. It is encouraging to see the progress in building 1000 Discovery Drive on the Biomedical Campus, and ongoing progress on securing accommodation and office space for CUH and with plans for the new Maggie's Centre.

1.7     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.

1.8     The Trust is also contributing to work in life sciences including; adoption of innovation, clinical trials and improvement in centres for innovation and improvement.

1.9     The Trust welcomes Sue Broster as our new Board Executive Director of Innovation, Digital and Improvement, following an extensive recruitment process. Sue is a consultant in NICU and previous holder of the post on an interim basis. We wish Sue all the best.

**Part A**

**2.      The five areas of operational performance**

**2.1     Quality**

*Emergency care*

2.2     Ongoing capacity and waits within the Emergency Department (ED) remain an area of focus and concern in relation to quality.  However, in April, the Trust has seen an improvement in performance against the 4-hour emergency care standard, achieving 68% compared to planned levels of 61.8%. This is a step change in terms of our performance (in March we achieved 61.6%) and demonstrates how our collective efforts are delivering real impact. The performance of 12 hour waits and ambulance offload delays in the April has also shown significant improvement compared to March.

*Elective care*

2.3     RAG-rated performance in March 2023 either improved or stayed the same compared to February 2023 for 20 out of 21 metrics.

2.4     Performance against the standards is being monitored by the Acute Priorities Assurance Group with dedicated programme boards focused on delivering the activity plans and identifying opportunities for improvement and transformation.

*Nursing*

2.5     The vacancy position for Registered Nurses (RNs), Registered Children's Nurses (RSCN) and Health Care Support Workers (HCSWs) has remained fairly static over the past couple of months.

2.6     Concern remains in the paediatric workforce, particularly in the paediatric critical care units (PICU and NICU). This has resulted in both units having to close to referrals from the region on occasion.

2.7    In adult critical care, we are seeing a slightly improving picture which is allowing for the gradual reopening of closed beds (one reopened in month) although we are continuing to report breaches of the standards at times.

2.8    The vacancy within the HCSW role, coupled with the high demand for specialing patients (one to one observation) across the Trust, is impacting fill rate across all wards resulting in a shortage of HCSWs on a shift-by-shift basis.

*Midwifery*

2.9    Over the last four months there has been a decreasing trend in the vacancy rate for registered midwives from 13% in July 2022 to 1.1% in February 2023. This is due in part to the large cohort of 26 newly qualified midwives who commenced work in the Trust in October 2022. It should be noted that these midwives undergo a year of preceptorship and require ongoing support.

2.10   Main areas of concern regarding workforce remains within the medical rota. A further risk in maternity is the requirements of triage and compliance with this standard is being impacted by workforce constraints.

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

2.11   The PALS and complaints services continue to receive a high volume of new cases, in both services, with significant backlogs. Work continues on the improvement plan.

*Harm Free Care*

2.12   As a result of a number of falls serious incidents declared between April and November 2022 sharing similar themes, a thematic review was commissioned by the Serious Incident Executive Review Panel (SIERP) and agreed with the ICB.

2.13   A falls improvement plan is being developed to address themes within the report.

*Serious Incidents (SI)*

2.14   There are currently 22 open SI investigations as at time of submitting this report. Additional resources have been allocated to support the team and extensions requested from the ICS to support completion of investigations and reports.

*Hospital Standardised Mortality Ratio (HSMR)*

2.15 The HSMR was 81.58 in month and 82.62 (year to Dec 22). A review of excess deaths within the ED in December 2022 did not demonstrate any themes within the hospital but is thought to reflect the conditions outside the Trust combined with a high level of circulating respiratory viruses.

## 3. Access to Care

The Trust continued to focus on urgent and emergency care (UEC), recovering elective waiting times and planning for the industrial action during March and April 2023. In our UEC pathways we sustained our improvement to ambulance handovers, achieving the best performance of all trusts in the region during April 2023 and performing in the top quartile of providers nationally. From 1 May 2023 we recommenced reporting the 4 hour standard (patients should spend no more than four hours in the Emergency Department from the time of arrival to when they leave), after being part of the national pilot of alternative targets since May 2019. As part of this work we are driving forward actions to reduce time spent in the ED which we recognise supports patient outcomes and experience. The number of patients waiting more than 78 weeks for treatment reduced by 56% from 225 in February 2023 to 100 in March 2023. We will continue to focus on these areas across 2023/24 in line with our operational strategy.

3.1 **Emergency Department (ED).** Overall ED attendances were 11,721 in March 2023, which is 725 (6.5%) higher than March 2019. This equates to an increase in average daily attendances from 355 to 378 over the same period. 1,449 patients had an ED journey time in excess of 12 hours, compared to 10 in March 2019. This represents 12.4% of all attendances.

3.2 **Referral to Treatment (RTT).** The year ended with a total waiting list size of 60,308. This was an increase of 12% across the year and 18.6% against our planning assumptions.

3.3 **Delayed discharges**. During March 2023 the Trust lost 3,739 bed days to patients beyond their clinically fit date. This equated to 121 beds, broadly in line with the historic monthly average.

3.4 **Cancer.** The volume of two week wait (2ww) patients seen in February 2023 was 13.5% higher than in February 2020. 2ww breaches reduced to 244 in February 2023 from 326 in January 2023 leading to an improvement in performance at 89%.

3.5    **Operations.** Elective theatre activity throughout 2022/23 delivered to 84% of the 2019/20 baseline. Adjusted for the loss of A Block theatres performance increased to 94%.

3.6    **Diagnostics.** Total diagnostic activity in March 2023 delivered to 97.8% of the March 2019 baseline. The total waiting list size reduced by 690 to 13,260, and the volume of patients waiting over six weeks reduced by 114.

3.7    **Outpatients.** In February 2023 outpatients delivered 103% new activity against the baseline which had been adjusted for working days per month. This was an improvement compared to the previous month and slightly ahead of trajectory.

**4.    Finance – Month 12**

4.1    The Month 12 year end position for performance management purposes is a £0.1m surplus, in line with NHS England expectations. However, the Trust's reported financial position in the financial accounts is expected to show a gross deficit of £1.2m. The difference relates to allowances adjustments for performance management purposes, including the net impact of depreciation from donated assets at £1.2m and a national PPE stock adjustment of £0.1m.

4.2    The following points should be noted in respect of the Trust's Month 12 financial performance:

- Covid-19 related expenditure for the year totals £21.1m compared to £45.5m in 21/22.

- Elective Recovery Fund (ERF) mechanism funding for the year totals £26.8m.

- The Trust has reported non-recurrent income and expenditure for additional non-consolidated pay awards in line with NHS England guidance at £21.7m.

4.3    The Trust received an initial system capital allocation for the year of £32.2m for its core capital requirements. In addition to this, the Trust received further funding for the Children's Hospital (£3.7m), Cancer Hospital (£7.5m) Surgical Movement Hub (£14.9m), additional theatre equipment (£4.1m) and Endoscopy equipment (£1.0m). Together with capital contributions from ACT, the Trust's capital budget for the year was £66.5m. Against the initial capital budget the Trust invested £67.1m in its capital programme in 2022/23.

4.4     Planning work for 2023/24 continues with the Trust submitting its final plan on 4 May 2023. The Trust, working closely with system colleagues, expects to submit a break-even plan for the 2023/24. Delivery of the plan for the 2023/24 financial year will require an increased focus on productivity opportunities, particularly in the context of the return to activity based payments for elective care.

## 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.

5.2     It should also be noted that there is ongoing work in response to industrial action which impacts the trust. We have experienced four consecutive days of strikes undertaken by our junior doctors after the Easter bank holiday weekend. At the time of writing the RCN has rejected the pay offer put forward by the government and strike action has been announced for the period 30 April to 1 May 2023 (originally 2 May). Unison has accepted the Government's pay offer and there will be a national NHS Staff Council meeting on 2 May 2023 with national health unions to determine whether there is collective support for the Government's pay offer or not.

Good Work and Wellbeing

5.3     Occupational Health (OH) continue with the planning and implementation of a number of immunisation catch up programmes to protect staff and patients. These include, pertussis, diphtheria, and smallpox (for protection against Mpox). The BCG catch up programme for certain staff groups is the first programme that has been successfully rolled out and is now nearing completion.

5.4     Updated UKHSA guidance on managing healthcare staff with symptoms of a respiratory infection or a positive Covid-19 test result has recently been issued. In response the staff testing guidance for workers who contract or are exposed to the Covid-19 virus has changed. Work is underway to issue updated FAQs and a revised individual staff risk assessment for those with health vulnerabilities, in order to support staff and managers with the application of the new guidance. In addition, Trust guidance on mask wearing has been updated, reducing the need for the majority of staff working in the hospital to wear surgical masks for normal duties.

5.5     The Trust's wellbeing facilitators are actively working with 30 teams and departments across all divisions, talking with managers and teams to join up with the support offer available. The feedback received by the team has been really positive. Impact measurement of the facilitators work is being developed as is formalising how thematic learning is shared and used.

5.6     The POD in the Deakin Centre is now open, offering a rest space with access to refreshments. Phase two of the space development will be completed by the end of June 2023 with the creation of comfortable quiet space and staff only outside rest space.

Resourcing

5.7     During April 2023 we welcomed 25 Adult Nurses, three Midwives and four Paediatric Nurses to the Trust. We were also delighted to welcome 42 new Healthcare Support Workers of which 24 joined the Staff Bank.

5.8     The process for centralised admin recruitment continues to receive positive feedback throughout the divisions with 29 new administrators joining the Trust and a further 77 under offer. Four months into the new way of working a post implementation review is currently underway, which will include seeking candidate feedback.

5.9     Retention remains a key focus with a strategy in place focussing on improvements in utilisation of data (understanding reasons why colleagues leave the organisation), improvements in how we welcome, induct and support staff in their first 24 months and how we retain staff in the later stages of their career. Our nursing and midwifery team are also implementing actions associated with the NHSE retention self-assessment tool for this staff group. In addition, we are working closely with the ICB team and ICS partners to collaborate on further ways in which we can make improvements at a system level to retain staff within Cambridgeshire and Peterborough.

Ambition

5.10    A new CUH management & leadership development programme for managers across the Trust is currently in development, involving stakeholders from finance, strategy and improvement and transformation who are working with the Learning and Organisational Development team to co-design and shape the technical management skills and subsequent learning pathways. The programme's aim is to provide the essential knowledge and understanding to enable our managers to be as effective as possible in their roles.

Managers will gain skills and knowledge of both technical management (process, policy and procedure) and the leadership behaviours required to build inclusive, compassionate and positive workplace cultures supporting the delivery and ambition of our 5 CUH Workforce Commitments. A pilot cohort commences in July 2023 using our new intake of managers for P and Q wards.

5.11   The consultant development programme recommenced in April 2023 with 40 consultants participating over two cohorts. A further two cohorts are scheduled for the autumn. The programme aims to ensure that recently appointed consultants understand how to make best use of CUH operational systems and can work effectively as leaders with others within and across clinical teams.

5.12   The appraisal season for the 2022 – 2023 period opened on 18 April until 17 September 2023. Its aim is a reflective, supportive conversation to include health and well-being, a look back at the previous year and also how colleagues may wish to develop their career going forwards. Guidance for both appraiser and those being appraised has been published and workshops are running throughout the appraisal period.

Inclusion

5.13   The WRES implementation group met to discuss latest NHS WRES metrics 5-8 from 2022 staff survey results and the ethnicity pay gap report which available now on the public website.

5.14   A neurodiversity working group, supported by Lexxic, (a specialist psychological consultancy who help us focus on supporting and valuing the talents of neurodivergent minds, empowering individuals to be their best selves), is starting to implement neuro-inclusive action plans with a focus on recruitment adjustments, to support and empower staff, both existing and those joining CUH.

5.15   Funding for a second cohort for the reverse mentoring programme has been approved and will launch alongside a range of aligned equality, diversity and inclusion learning events over the summer.

5.16   New Co-chairs for the purple staff network, open minds and LGBT+ staff networks have been elected for 2-year terms of office from 1 April 2023 and are preparing their key priorities.

<ins>Relationships</ins>

5.17 In April 2023, Management Executive approved a proposal for a programme of work to promote and embed a Just and Learning Culture across CUH. This builds on previous work undertaken within Clinical Quality in relation to patient safety, and within workforce in relation our ER processes. This programme of work is designed to deepen understanding across the organisation of a Just and Learning Culture, embed its principles into our practice and begin to grow a just and learning culture community within the Trust.

5.18 There has been a fantastic response to the CUH annual awards call for nominations with some fantastic stories being shared about the incredible work and impact of colleagues across the organisation. We look forward to sharing some of these with you in due course.


**6. Improvement and Transformation**

<ins>Building QI capability and capacity</ins>

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

6.2 The recommendations from the IHI's onsite annual visit in October 2022 continue to be progressed. A rolling programme of QI visits across the organisation has been established for members of Management Executive, with 12 undertaken to date. In addition, the Management Executive-sponsored QI projects are all progressing (work with the Purple Network to help improve the working lives of our staff with disabilities, improving the Trust's complaints process, improving sickness absence and a collaborative to reduce the incidence and of hospital acquired pressure ulcers).

6.3 In relation to the Trust's work with the IHI on building improvement capability and capacity across our 12,000 staff, wave two of the improvement programme for teams will conclude with a celebration event on 8 June 2023 and wave two of the leading for improvement programme will conclude on 18 May 2023. Wave three of the improvement coach programme will commence on 31 May 2023, for 22 participants, with Trust staff delivering this programme, rather than IHI colleagues.

<u>Urgent and emergency care</u>

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

<u>Outpatients</u>

6.5 The improvement and transformation team continues to support colleagues with the Trust's outpatient's programme. Examples of these QI projects include: reducing unnecessary follow up appointments in nephrology; reducing unnecessary initial new appointments in gastroenterology; increasing the use of patient initiated follow ups (PIFU) and reducing patient waiting lists in gynaecology

<u>Virtual wards</u>

6.6 To date, the virtual ward team has admitted 306 patients from across 26 specialties, with 57 admissions in March 2023.

<u>Productivity and efficiency</u>

6.7 The Trust's 2022/23 efficiency requirement of £62m has been exceeded by £54k, which is a significant Trust-wide achievement.

6.8 Confirmation of the Trust's 2023/24 efficiency requirement is awaited, but is expected to be no less than £53m. In addition to cost-out schemes, productivity/efficiency opportunities around reducing LoS, improving theatre utilisation, transforming outpatient practices and the use of digital solutions will be key to delivering activity and financial plans for 2023/24.


**PART B**

**7. Strategy update**

<u>Operational Planning</u>

7.1 The Trust, and other system partners, have submitted operational plans for 2023/34 to the ICS, presenting detailed information on how we will meet nationally-specified activity and financial targets focused on recovering core services and productivity, making progress in delivering the key ambitions in the Long Term Plan, and continuing transformation of the NHS for the future. The ICS submitted a system operational plan to NHSE at the end of March.

<u>Strategy implementation</u>

7.2    Following the launch of the Trust's refreshed strategy in 2022, focus continues on its implementation including definition / refinement of headline metrics and deliverables alongside associated reporting to track progress against delivery of the 15 commitments.

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

<u>Improving patient care</u>

*Integrated Care*

7.4    The Trust continues to work with partners across the Cambridgeshire South Care Partnership (CSCP), working across East Cambridgeshire, South Cambridgeshire and Cambridge City, to improve care for people in and outside of hospital. Following the arrival of a new Managing Director for CSCP, Heather Noble, the Partnership is refreshing its objectives for 2023/24.

7.5    Conversations are ongoing with the Integrated Care Board to inform the final version of the local Joint Forward Plan and determine what responsibilities and resources will be devolved to the CSCP.

7.6    The Clinical Lead for Integrated Care continues to hold meetings with the Cambridgeshire Local Medical Committee (LMC) to identify areas for future collaboration.

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 CSCP's approach to Proactive Care.

7.8    Alongside this, the Trust is establishing a medium-term programme of work to ensure that its processes and planning approach support staff to engage in collaborative projects with other partners.

*Health Inequalities, Equality, Diversity and Inclusion*

7.9    The Trust's new Interim Director for Equality, Diversity and Inclusion (EDI), Aloma Onyemah, commenced in post in March 2023. She will lead an ambitious 12-month programme of work which will build on the progress the Trust has made in recent years, as well as deliver a step change in our approach.

7.10 The three-stage programme consists of:

- **Diagnostic phase** (0-3 months): This will include a baseline assessment and mapping of current activities alongside a full analysis of current strategies, practices and plans linked to the EDI agenda. It will also include a thorough stakeholder engagement process and seek to establish good practice, making linkages with communities to explore how we can learn from or develop alongside;

- **Establish a strategic plan** (3-6 months): The outputs and learning from the diagnostics stage will inform the articulation of a strategic plan involving both internal and external stakeholders in order to deliver lasting and sustained improvement. The plan will formulate and communicate recommendations on the way in which the Trust's EDI functions, systems, policies and procedures can ensure that maximum progress can be made across workforce, patient services and health inequalities;

- **Commence implementation** (6-12 months): Once an overall approach has been collectively established, the Trust will work with partners internally and externally to begin implementation of the EDI strategic plan. This will involve establishing a model of inclusive leadership to enable delivery, and building of capacity and capability to deliver against key priorities across all portfolios

7.11 Aloma has joined the CUH EDI Strategy Group which includes both Executive and Non-Executive members. The Group met most recently on 28 April 2023 and engaged in a facilitated group activity focused on EDI at CUH. This included discussion of:

- How we create a shared understanding of ED&I at CUH.

- The diversity triple aim and what a truly inclusive hospital would look like.

- The science of inclusion and how a state of high inclusion might be attained.

- What inclusion means at an individual level and our experiences of inclusion.

- A matrix model to measure ED&I organisational maturity, where CUH sits currently and our potential ambition over the next 3-5 years.

7.12   In the coming weeks the Interim Director of EDI will lead a session at the Board Away Day on 24 May and present on the development of the EDI and Health Inequalities Strategic Plan at the Board Seminar on 14 June.

<u>Supporting our staff</u>

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

<u>Building for the future</u>

*New hospitals and the estate*

7.14   Progress is being made on the delivery of a Community Diagnostic Centre hub at the Princess of Wales Hospital in Ely. A smaller Centre (spoke model) opened at North Cambs Hospital in Wisbech in April 2023, initially providing CT and MRI services.

7.15   Work on the development of a business case for the expansion of the regional genomics service to support service growth and the ambitions of the Cancer and Children's hospitals projects is progressing well.  A piece of scoping work is taking place to explore opportunities for strategic collaboration between CUH and Royal Papworth Hospital. This will go to Trust management teams for review in May/June 2023.

7.16   The current focus for the Cambridge Cancer Research Hospital project is the selection of a Private Sector Construction Partner who should be in place by June 2023. Final approval of our Outline Business Case (OBC) from the Secretary of State and HM Treasury is expected shortly and the Cancer Hospital team has commenced working on the Full Business Case which will need to be submitted to and approved by the NHS England (NHSE) New Hospitals Programme to unlock the allocated capital. This work includes how services will transition to the new building and the anticipated benefits that will be released, as well as articulation of how care will be provided in the new facility. In parallel, both the full Cancer Hospital and enabling works planning applications will be considered by the Cambridge City Council Planning Committee in July 2023.

7.17   The Cambridge Children's Hospital project submitted its OBC to regulators in December 2022. Working with NHSE and the Department of Health and Social Care (DHSC) over the last two months, the Children's Hospital team have developed a revised proposal of alternative capital funding sources for the project. Further work is now underway to work up the detail of this proposal and to update the OBC accordingly. This is expected to conclude with a revised OBC being signed off by the Trust Board this summer and a final decision on the OBC at the Joint Investment Committee in autumn 2023.

In parallel, the project is continuing to progress the design of the hospital with the Royal Institute of British Architects (RIBA) stage 3 report due for completion in May 2023. The team are also developing enabling works construction plans aiming to start in January 2024. The project's fundraising campaign remains in a strong position, with over £41m of its £100m target achieved.

7.18 Progress continues against phase three projects within the Addenbrooke's 3 programme. A proposal is being developed for an approach to the management of capacity that is released when the Cancer and Children's hospitals are completed, to ensure that there is strategic alignment in the use of space and that operational, infrastructure and staff and patient well-being priorities are considered in designating how the space is optimally used. Other phase three projects include the development of a regional strategy for neurosciences in collaboration with partners across the East of England.

*Specialised Services*

7.19 The Trust, as part of the East of England Specialised Services Provider Collaborative (EoE SPC), continues to work with partners to support the transformation of care delivery across the region, in alignment with regionally prioritised clinical areas of focus. This collaboration includes regular engagement in discussions with ICBs and NHSE in relation to commissioning of specialised services as well as close working with the Shelford Group and other national bodies to inform and shape this important agenda.

7.20 Progress to date includes:

- **Neurosciences:** Advancing the formation of a neurosciences vision and strategy across the region. An initial focus on Multiple Sclerosis pathway transformation aims to deliver specialised treatments closer to home and highly specialised treatment within the region. The collaborative has been asked by NHSE to lead on the national neurology transformation programme for the EoE.

- **Respiratory:** Supporting centres across the Provider Collaborative to sustainably increase the breadth of treatments offered for severe asthma patients; supporting the delivery of specialised care as close to home as possible and optimising services delivered at CUH.

- **Paediatrics:** Working in collaboration with the Operational Delivery Network and Cambridge Children's Hospital, we have identified key barriers to delivering optimal pathways – from paediatric intensive care provision to enabling community care – with a plan to co-ordinate efforts for improvement.

- **Dentistry:** We have delivered a comprehensive review, with recommendations, to support NHSE in the transformation and implementation of secondary care dental services**.**

7.21 We are also focused on the development of a business plan, formalizing governance processes and infrastructure and agreeing future resourcing arrangements.

*Climate change*

7.22 The Trust continues to make strong progress with projects to reduce the carbon impacts of anaesthetic gases including the successful trial of a mobile nitrous cylinder in the ATC and Rosie theatres which has now been extended to Main Theatres, and a mobile nitrous destruction unit being trialled in The Rosie.

7.23 Interim locations for 35 electric vehicle charging points on Campus have been identified and agreed under the planning proposals for the Cambridge Cancer Research Hospital, and a CCTV project to improve cycle parking security has been completed.

7.24 The Campus Heat Decarbonisation Plan has been completed and approved as an exemplar.

7.25 The fully upgraded CUH Think Green Impact Programme for small teams has been re-launched internally and a very successful sustainable travel and transport week was delivered at the end of March for staff that covered cycling, car-sharing, trains and bus services. The CUH Sustainability social media presence has also recorded a major increase in staff engagement.


## 8.    Recommendation

8.1 The Council of Governors is asked to note the contents of the report.

**NHS**
**Cambridge University Hospitals**
**NHS Foundation Trust**

# Integrated Report

**Quality, Performance, Finance and Workforce**
**to end April 2023**

Chief Finance Officer
Chief Nurse
Chief Operating Officer
Director of Workforce
Medical Director

# Key

## Key

### Data variation indicators

Normal variance - all points within control limits

Negative special cause variation above the mean

Negative special cause variation below the mean

Positive special cause variation above the mean

Positive special cause variation below the mean

### Rule trigger indicators

**SP**   One or more data points outside the control limits

**R7**   Run of 7 consecutive points;
H = increasing, L = decreasing

**S7**   shift of 7 consecutive points above or below the mean; H
= above, L = below

### Target status indicators

**P**   Target has been and statistically is consistently likely to be achieved

**F**   Target failed and statistically will consistently not be achieved

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

**Executive Summary**

Owner(s): Nicola Ayton, Mike Keech, Ashley Shaw, Lorraine Szeremeta, David Wherrett

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# Quality Account Measures 2023/24

**NHS Cambridge University Hospitals NHS Foundation Trust**

**2023/24 Performance Framework**

| Domain | Indicator | Data to | Target | Feb 23 Previous Month-1 | Mar 23 Previous Month | Apr 23 Current status | Trend | FYtD | Baseline | LTM |
|---|---|---|---|---|---|---|---|---|---|---|
| **Safe** | % Trust Compliance with Falls Risk assessment & documentation within 12 hours of admission | Jan-23 | 90% | N/A | N/A | 85.0% | ▪ | N/A | 50.0% | N/A |
| | Trust Compliance with Pressue Ulcer risk assessment tool & documentation within 6 hours of admission | Apr-23 | 90% | N/A | N/A | 80.3% | ▪ | 80.3% | 13.4% | N/A |
| | % MDT Obstetric staff passed fetal surveillance training and PROMPT emergencies training | Jan-23 | 90% | N/A | N/A | N/A | ▪ | N/A | N/A | N/A |
| **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) | Apr-23 | 7% | N/A | N/A | 8.4% | ▪ | 8.4% | 14.0% | N/A |
| **Effective / Responsive** | % of Early Morning Discharges (07:00-12:00) | Apr-23 | 20% | 15.6% | 15.1% | 15.5% | ⇧ | 15.5% | 15.3% | 16.0% |
| | 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 | Apr-23 | 80% | 74.4% | 70.7% | 74.5% | ⇧ | 74.5% | 74.0% | 75.6% |
| | Same day emergency care (SDEC) | Apr-23 | 30% | 22.5% | 17.8% | 23.2% | ⇧ | 23.2% | 22.0% | 19.2% |
| | Percentage of admissions over 65yo with dementia/delirium or cognitive impairment with a care plan in place | Apr-23 | | N/A | N/A | 43.1% | ▪ | 43.1% | | N/A |
| | **Quarterly** | | | Q2 22/23 | Q3 22/23 | Q4 22/23 | | | | |
| | SSNAP Domain 2: % of patients admitted to a stroke unit within 4 hours of clock start time (Team centred) | Mar-23 | 55% | 29.2% | 27.0% | 25.9% | ⇩ | 26.9% | 29.2% | 26.9% |
| **Staff Experience / Well-led** | Trust Vacancy Rate (Band 5) Nurses | Jun-22 | 5.0% | N/A | N/A | N/A | ▪ | 8.4% | 12.0% | 7.6% |
| | **Annual** | | | 2016 | 2017 | 2018 | | | | |
| | National Staff Survey - "I feel secure about raising concerns re unsafe clinical practice within the organisation" | 2018 | 78% | 75.0% | 73.0% | 74.0% | ⇧ | | 75% | |

Page 2     Author(s): Various     Owner(s): Oyejumoke Okubadejo

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# Quality Summary Indicators

**2022/23 Performance Framework**

| Performance Framework - Quality Indicators | | | | Feb 23 | Mar 23 | Apr 23 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Domain | Indicator | Data to | Target | Previous Month-1 | Previous Month | Current status | Trend | FYtD | Previous FYR | LTM |
| Infection Control | MRSA Bacteraemia (avoidable hospital onset cases) | Apr-23 | 0 | 0 | 0 | 2 | ⇧ | 2 | 3 | 5 |
| | E.coli Bacteraemias (Total Cases) | Apr-23 | 50% over 3 years | 24 | 33 | 42 | ⇧ | 42 | 401 | 412 |
| | C. difficile Infection (hospital onset and COHA* avoidable) | Apr-23 | TBC | 6 | 9 | 6 | ⇩ | 6 | 129 | 123 |
| | Hand Hygiene Compliance | Apr-23 | TBC | 94.2% | 94.7% | 93.5% | ⇩ | 93.5% | 96.4% | 96.0% |
| Clinical Effectiveness | % of NICE Technology Appraisals on Trust formulary within three months. ('last month') | Apr-23 | 100% | 100.0% | 100.0% | N/A | ▪ | N/A | 91.3% | 93.4% |
| | % of external visits where expected deadline was met (cumulative for current financial year) | May-22 | 80% | N/A | N/A | N/A | ▪ | 44.4% | N/A | 40.0% |
| | 80% of NICE guidance relevant to CUH is returned by clinical teams within total deadline of 32 days. | Apr-23 | - | 66.7% | 80.0% | 33.3% | ⇩ | 33.3% | 51.0% | 58.4% |
| | No national audit negative outlier alert triggered | Apr-23 | 0 | 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 | Apr-23 | 85% | 80.0% | N/A | 100.0% | ▪ | 100.0% | 68.8% | 70.6% |
| Nursing Quality Metrics | Blood Administration Patient Scanning | Apr-23 | 90% | 99.7% | 99.7% | 100.0% | ⇧ | 100.0% | 99.6% | 99.6% |
| | Care Plan Notes | Apr-23 | 90% | 96.2% | 95.7% | 96.0% | ⇧ | 96.0% | 96.4% | 96.4% |
| | Care Plan Presence | Apr-23 | 90% | 99.4% | 99.7% | 99.6% | ⇩ | 99.6% | 99.8% | 99.8% |
| | Falls Risk Assessment | Data reported in slides | | | | | | | | |
| | Moving & Handling | Apr-23 | 90% | 72.9% | 72.0% | 74.8% | ⇧ | 74.8% | 73.1% | 73.3% |
| | Nurse Rounding | Apr-23 | 90% | 99.3% | 99.1% | 99.2% | ⇧ | 99.2% | 99.3% | 99.3% |
| | Nutrition Screening | Apr-23 | 90% | 72.1% | 73.4% | 76.1% | ⇧ | 76.1% | 73.9% | 74.1% |
| | Pain Score | Apr-23 | 90% | 83.2% | 84.3% | 84.3% | ⇩ | 84.3% | 84.5% | 84.4% |
| | Pressure Ulcer Screening | Data reported in slides | | | | | | | | |
| | **EWS** | | | | | | | | | |
| | MEOWS Score Recording | Apr-23 | 90% | 72.5% | 73.4% | 74.5% | ⇧ | 74.5% | 65.2% | 66.0% |
| | PEWS Score Recording | Apr-23 | 90% | 99.0% | 99.1% | 99.2% | ⇧ | 99.2% | 99.2% | 99.2% |
| | NEWS Score Recording | Apr-23 | 90% | 97.3% | 97.6% | 97.6% | ⇧ | 97.6% | 97.4% | 97.4% |
| | **VIP** | | | | | | | | | |
| | VIP Score Recording (1 per day) | Apr-23 | 90% | 84.5% | 86.6% | 85.5% | ⇩ | 85.5% | 86.6% | 86.5% |
| | PIP Score Recording (1 per day) | Apr-23 | 90% | 83.4% | 88.4% | 81.9% | ⇩ | 81.9% | 89.2% | 88.8% |
| 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 | Apr-23 | 0 | 42 | 16 | 14 | ⇩ | 14 | 172 | 184 |
| | Re-opened complaints (non PHSO) | Apr-23 | N/A | 0 | 2 | 4 | ⇧ | 4 | 18 | 21 |
| | Re-opened complaints (PHSO) | Apr-23 | N/A | 0 | 0 | 0 | ⇔ | 0 | 2 | 2 |
| | | | | Feb 23 | Mar 23 | Apr 23 | | | | |
| | Number of medium/high level complaints | Apr-23 | N/A | 22 | 20 | 16 | ⇩ | 16 | 257 | 257 |

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# Operational Performance

| Point of delivery | Performance Standards | SPC variance | In Month Actual | In Month plan | Target | Target due by | Page |
|---|---|---|---|---|---|---|---|
| **Urgent & Emergency Care** | 4hr performance | Normal variation | 67% | 62% | 76% | Mar-24 | **Page 13** |
| | 12hr waits in ED (type 1) | Normal variation | 10% | - | - | - | |
| | Ambulance handovers <15mins | Positive special cause variation | 63% | 65% | 65% | Immediate | |
| | Ambulance handovers <30mins | Normal variation | 94% | 95% | 95% | Immediate | |
| | Ambulance handovers > 60mins | Normal variation | 1% | 0% | 0% | Immediate | **Page 14** |
| **Cancer** | Cancer patients < 62 days (urgent) | Normal variation | 76% | - | 85% | Immediate | **Page 21** |
| | 28 day faster diagnosis standard | Normal variation | 81% | 82% | 75% | Immediate | **Page 18** |
| | 31 day decision to first treatment | Normal variation | 88% | - | 96% | Immediate | **Page 20** |
| | 2 week waits | Normal variation | 88% | - | 93% | Immediate | **Page 19** |
| **Outpatients** | First outpatients (consultant led) | Normal variation | 102% | 98% | - | - | **Page 23** |
| | Follow-up outpatients (consultant led) | Normal variation | 115% | 127% | - | - | **Page 24** |
| | Advice and Guidance Requests | Positive special cause variation | 11% | - | 0% | Mar-23 | |
| | Patients moved / discharged to PIFU | Normal variation | 3% | 3% | 8% | Mar-23 | **Page 25** |
| **Diagnostics** | Patients waiting > 6 weeks | Positive special cause variation | 37% | 34% | 5% | Mar-24 | **Page 22** |
| | Diagnostics - Total WL | Positive special cause variation | 13,236 | 12,265 | - | - | |
| **RTT Waiting List** | RTT Patients waiting > 65 weeks | Positive special cause variation | 990 | 993 | 0 | Mar-24 | **Page 16** |
| | RTT Patients waiting > 78 weeks | Positive special cause variation | 123 | - | - | - | |
| | Total RTT waiting list | Negative special cause variation | 60,729 | 60,936 | - | - | **Page 17** |
| **Productivity and efficiency** | Non-elective LoS (days, excl 0 LoS) | Normal variation | 9.3 | - | - | - | |
| | Long stay patients (>21 LoS) | Normal variation | 219 | 197 | - | - | |
| | Elective LoS (days, excl 0 LoS) | Normal variation | 5.6 | - | - | - | |
| | Discharges before noon | Normal variation | 16% | - | - | - | |
| | Theatre sessions used | Normal variation | 514 | - | - | - | |
| | In session theatre utilisation | Normal variation | 79% | 80% | 85% | Sep-23 | **Page 27** |
| | Virtual Outpatient Attendances | Negative special cause variation | 19% | - | - | - | |
| | BADS Daycase Rate (local) | Normal variation | 86% | - | - | - | **Page 28** |
| **Surgical prioritisation** | P2 (4 weeks) Including planned | Negative special cause variation | 2,601 | - | - | - | |

# Serious Incidents

**Safety and Quality**

| Indicator | Data range | Period | Target | Current period | Mean | Variance | Special causes | Target status | Comments |
|---|---|---|---|---|---|---|---|---|---|
| Patient Safety Incidents | May 2020-April 2023 | Apr-23 | - | **1338** | *1427* | ◆ | - | - | Currently within normal variance. 8 out of the last 10 months have been above the mean. |
| Patient Safety Incidents per **1,000 admissions** | May 2020-April 2023 | Apr-23 | – | **88** | *93* | ◆ | – | – | |
| Percentage of **moderate harm and above** patient safety incidents | May 2020-April 2023 | Apr-23 | ≤ 2% | **2.5%** | *2.3%* | (variance icon) | - | - | In April 2023: 27 moderates; 7 severe; no deaths |
| All Serious Incidents | May 2020-April 2023 | Apr-23 | — | **1** | *4.8* | (variance icon) | - | - | |
| Serious Incidents submitted to ICB within 60 working days (or agreed extension) | May 2020-April 2023 | Apr-23 | 100% | **50%** | *64%* | (variance icon) | - | | 2/4 SI reports submitted on time in April 2023 |

| Ref | SI Title | STEIS SI Sub categories | Actual Impact | Division | Ward / Department |
|---|---|---|---|---|---|
| SLR160775 | Pressure ulcer underneath plaster cast | Unexpected/potentially avoidable injury causing serious | Severe | Division A | NCCU (A2) |

**Executive Summary:**

In April 2023, one new SI was comissioned.

2/4 SI reports, that were due in April, were submitted to the ICS on time. A total of 3 completed SI reports were submitted in April.

Resources for investigating have been limited due to competing clinical and operational priorities and resources within the central patient safety team. This is impacting compliance with the 60 day target for submissions. Additional interim staff are in place to support with investigations.

There are currently 74 overdue Serious Incident Actions : 38% (28) of which are in Division A.

**Never Events by year 2015 – 2023**

| Year | Count |
|---|---|
| 2015 | 1 |
| 2016 | 4 |
| 2017 | 5 |
| 2018 | 2 |
| 2019 | 9 |
| 2020 | 2 |
| 2021 | 3 |
| 2022 | 4 |
| 2023 | 0 |
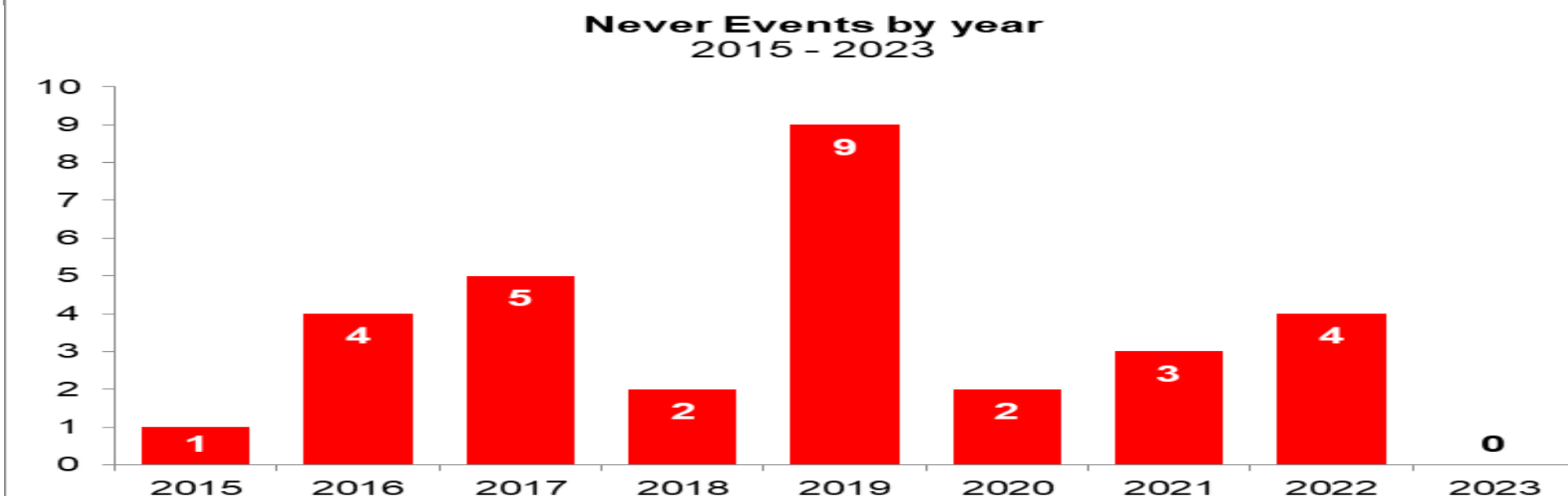
**Overdue SI Actions by Division**

| Division | Count |
|---|---|
| A | 28 |
| B | 10 |
| C | 7 |
| D | 16 |
| E | 13 |
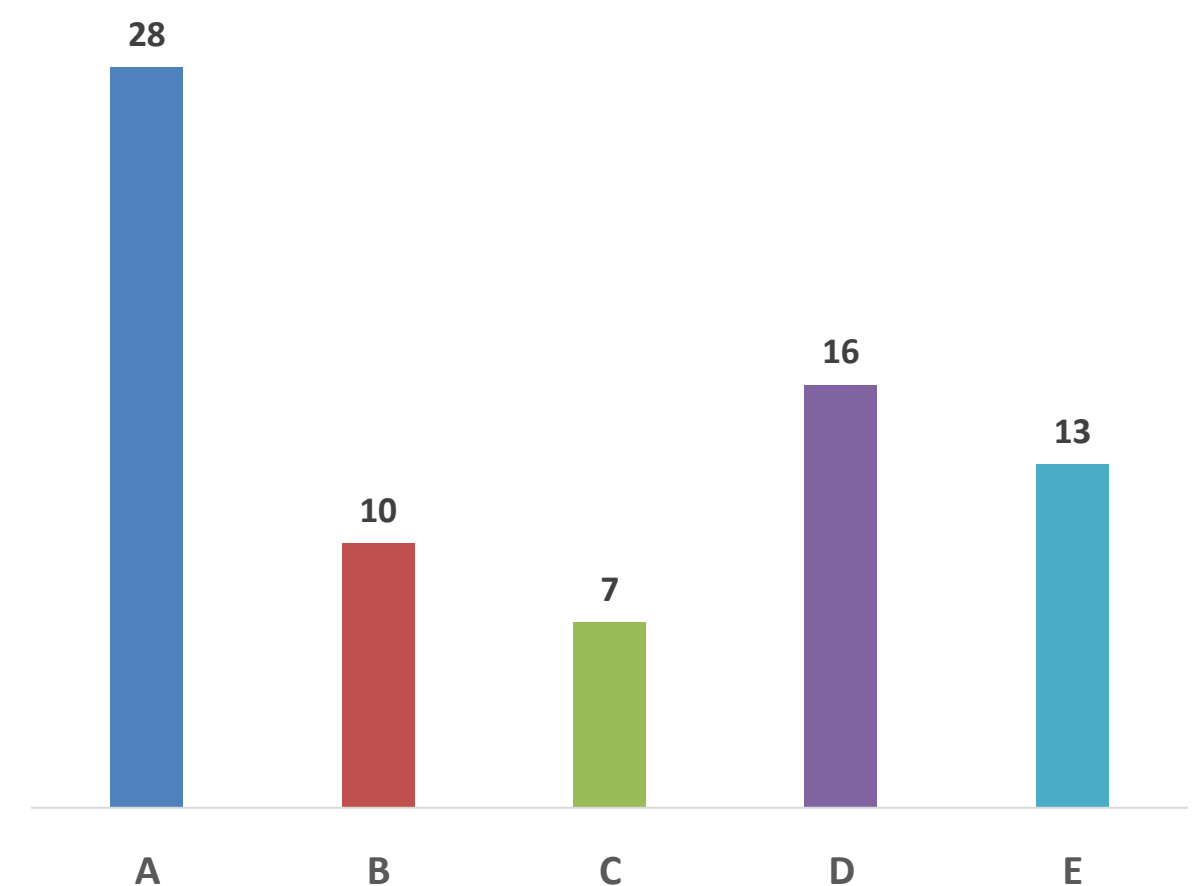
# Duty of Candour

| Indicator | Data range | Period | Target | Current period | Mean | Variance | Special causes | Target status | Comments |
|-----------|-----------|--------|--------|----------------|------|----------|----------------|---------------|----------|
| Duty of Candour Stage 1 within 10 working days* | May 20 - Apr 23 | month | 100% | **71%** | 71% | (variance icon) | - | (?) | Within normal variance and compliance target not reached. |
| Duty of Candour Stage 2 within 10 working days** | May 20 - Apr 23 | month | 100% | **70%** | 66% | (variance icon) | - | (?) | Within normal variance and compliance target not reached. |

## Safety and Quality

**Average number of workdays taken to send first letter for Stage 1 Duty of Candour from date reported in last 12 months**
**May 2022 - Apr 2023**

| Division | Value |
|----------|-------|
| Division A | 6 |
| Division B | 10 |
| Division C | 9 |
| Division D | 6 |
| Division E | 11 |
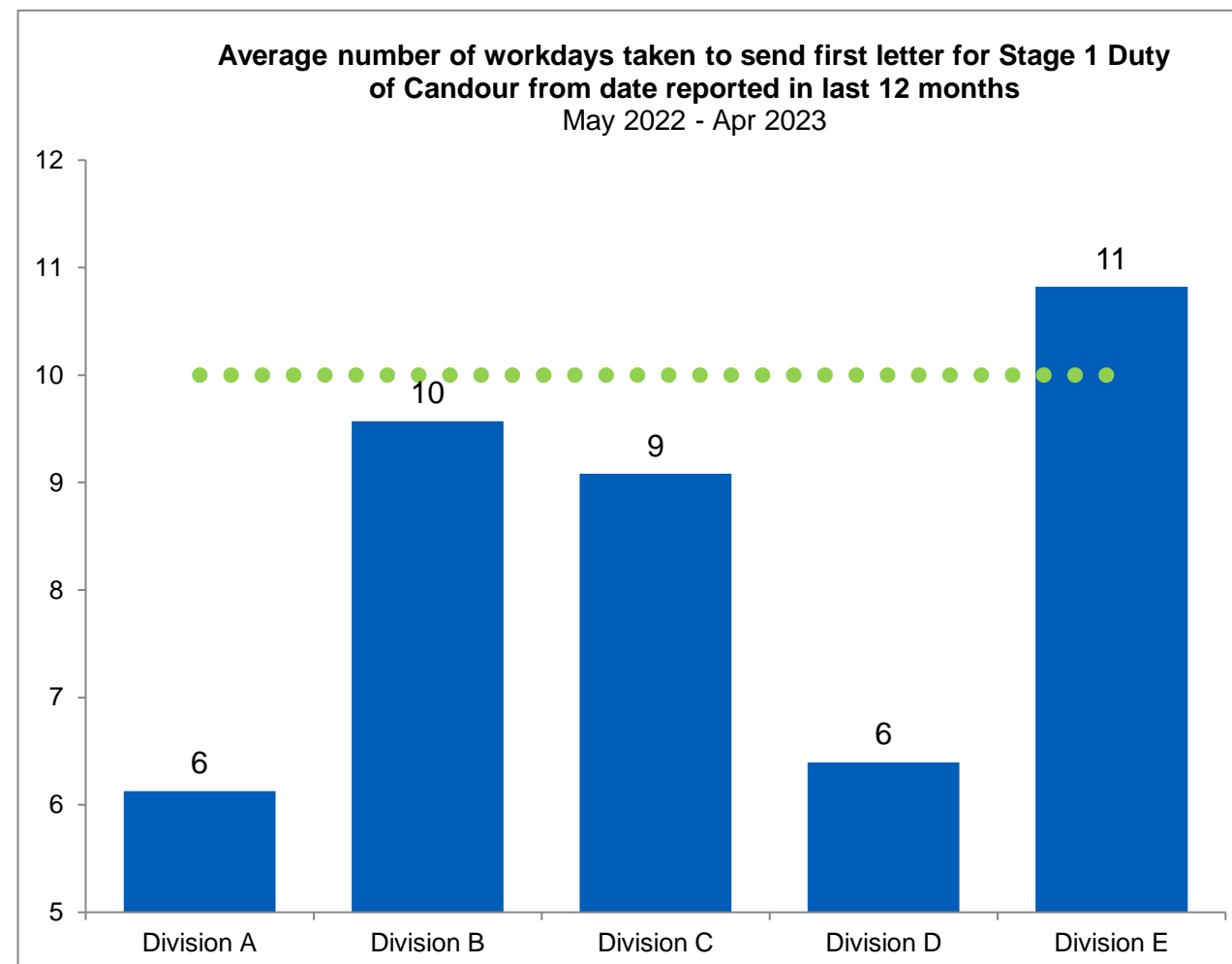
### Executive Summary

Trust wide stage 1* DOC is compliant at 76% for all confirmed cases of moderate harm or above in April 2023. 71% of DOC Stage 1 was completed within the required timeframe of 10 working days in April 2023. The average number of days taken to send a first letter for stage 1 DOC in April 2023 was 6 working days.

Trust wide stage 2** DOC is compliant at 83% for all completed investigations into moderate or above harm in April 2023 and 70% 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 via Divisional Governance.

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.

Author: Christopher Edgley        Owner(s): Oyejumoke Okubadejo        *Together-Safe* | Kind | Excellent

# Falls

| Indicator | Data range | Period | Target | Current period | Mean | Variance | Special causes | Target status | Comments |
|-----------|-----------|--------|--------|---------------|------|----------|----------------|---------------|----------|
| **All** patient falls by date of occurrence | May 2020-April 2023 | Apr-23 | - | 142 | *149.4* | | | - | April saw an end to the last 9 months being above the mean. |
| Inpatient falls per **1,000 bed days** | May 2020-April 2023 | Apr-23 | | 3.96 | *4.5* | | - | - | Currently showing normal variance. |
| **Moderate harm and above** inpatient falls per 1,000 bed days | May 2020-April 2023 | Apr-23 | - | 0.14% | *0.0* | | – | - | Currently showing normal variance. There was only one fall in April 2023 ≥ moderate harm. |
| Falls **risk screening** compliance within 12 hours of admission | May 2020-April 2023 | Apr-23 | ≥ 90% | 85.50% | *85.55%* | L | SD7 | F | The last 7 months have been below the mean - statistically significant downward shift. The trust overall has not been compliant since June 2021 |
| Falls KPI; patients 65 and over have a **Lying and Standing Blood Pressure** (LSBP) completed within 48hrs of admission | May 2020-April 2023 | Apr-23 | ≥ 90% | 20.2% | *12.74%* | H | HP | F | The last 2 months have been a single high data point - significant improvement: April 2023 is highest compliance score to date. Goal remains ≥ 90% |
| Falls KPI: patients 65 and over who have a **cognitive impairment** have an appropriate **care plan in place** | May 2020-April 2023 | Apr-23 | ≥ 90% | 41.40% | *19.20%* | H | HP | F | The last 3 months have been a single high data point - significant improvement; April 2023 was the highest score to date. Goal remains ≥ 90% |
| Falls KPI: patients 65 and over requiring the use of a **walking aid** have access to one for their sole use | May 2020-April 2023 | Apr-23 | ≥ 90% | 72.4% | *73.81%* | L | SD27 | F | Since February 2021 the compliance score has been below the mean. An issue with understanding of this question has been identified; therefore changes to the question were made in January 2023 . |

**Executive Summary**

It has been identified, via the Falls Champions monthly reports, that some areas have achieved a significant improvement in completion of LSBP. A review of these areas has been undertaken to identify how this has been achieved and a combination of measures that have been identified has been shared to all Falls Champions.

New CUH specific confusion care plans went live in EPCI in May 2023

An EPIC change request has been submitted to develop a multifactorial, multidisciplinary falls tab. This will allow for easier assessment, treatment and care planning for patients using a multidisciplinary approach.
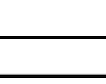
A thematic review of falls that met the serious incident criteria has being undertaken in collaboration with the Integrated Care System (ICS). The conclusion of this review will be triangulated with the existing Falls Quality Improvement plan and any appropriate changes will be made.

Changes to the incident report for falls on QSIS have been made to capture post falls care and staffing issues. The monthly falls report was expected to be updated to capture and review this data from April 2023, howver this was delayed due to rescoruce issues, with a new ate planned for June 2023.

The Falls QI plan is under constant review.

There are plans to expand the inpatient falls team from the current Lead Falls Prevention Specialist, to a team of 3 plus some Consultant time.

*Safety and Quality*

# Hospital Acquired Pressure Ulcers (HAPUs)

**NHS Cambridge University Hospitals NHS Foundation Trust**

Safety and Quality

| Indicator | Data range | Period | Target | Current period | Mean | Variance | Special causes | Target status | Comments |
|---|---|---|---|---|---|---|---|---|---|
| All Hospital-acquired pressure ulcers | May 2020-April 2023 | Apr-23 | - | 35 | 28 | H | SU10 | - | There is a statistically significant increase in HAPUs over the last consecutive 10 months - upward shift. |
| All HAPUs by date of occurrence per 1,000 bed days | May 2020 - April 2023 | Apr-23 | – | 1.0 | 0.9 | H | SU10 | | There is a statistically significant increase in HAPUs per 1,000 bed days over the last consecutive 10 months - upward shift. |
| Category 2, 3, 4, Suspected Deep Tissue Injury, and Unstageable HAPUs | May 2020 - April 2023 | Apr-23 | – | 27.0 | 14.0 | H | SU10 | | There is a statistically significant increase in HAPUs of category 2 and above over the last consecutive 10 months - upward shift. |
| Category 1 hospital-acquired pressure ulcers | May 2020 - April 2023 | Apr-23 | – | 8.0 | 11.7 | | – | – | Normal variance |
| Category 2 hospital-acquired pressure ulcers | May 2020-April 2023 | Apr-23 | - | 12 | 11.0 | | – | – | 8 out of the last 10 months have been above the mean. |
| Unstageable HAPUs | May 2020 - April 2023 | Apr-23 | – | 5 | 2.0 | | – | – | 6 out of the last 7 months have been above the mean. |
| Suspected Deep Tissue Injury HAPUs by date of occurrence | May 2020-April 2023 | Apr-23 | - | 10 | 2.7 | H | SU10 | - | There is a statistically significant increase in SDTI HAPUs over the last consecutive 10 months - upward shift. |
| Pressure Ulcer screening risk assessment compliance | May 2020-April 2023 | Apr-23 | 90% | 80% | 80% | L | – | F | There is a statistically significant downward shift in compliance in the last 10 months.. We have not been compliant with this metric in the last 3 years. |

**Exec Summary**
The increase in HAPUs is being driven by an increase in the category of  Suspected deep tissue injury, unstageables, and Category 2
There were no category 3 or 4 HPAUs in April 2023

**QI Plan update**
Tissue viavility Champions Study Day held on 18th May 2023.
A new Band 6 TVN within the Emergency Department is being advertised to reinforce Pressure Ulcer Prevention care plan at the beginning of patients' hospital journey.
The Epic body map visual aid for skin inspections is now live.
Epic Change Request for redesigning the Wound Assessment LDAs is currently underway.
The work in partnership with the Institute Health Improvement (IHI) and the Transformation team to reduce incidence of HAPUs has commenced and the first workshop took place on 28th April. There are also weekly catch-up meetings to monitor the progress of the programme.
The plan to resume the Tissue ViabilityQuality Steering Group meeting is currently underway.
CQUIN 12 (Assessment and documentation of pressure ulcer risk) has commenced in April 2023

Author(s): Yaping Lian          Owner(s): Oyejumoke Okubadejo

**Together–Safe | Kind | Excellent**

# Sepsis

Safety and Quality

| Indicator | Data range | Period | Target | Current period | Mean | Variance | Special causes | Target status | Comments |
|---|---|---|---|---|---|---|---|---|---|
| **Trust internal data** | | | | | | | | | |
| All elements of the Sepsis Six Bundle delivered within 60 mins from time patient triggers Sepsis (NEWS 5>) - Emergency Department | Apr-23 | Monthly | 95% | **62%** | 55% | | - | F | Elements of the sepsis 6 bundle that have impacted on the overall compliance for April 23 are antibiotic administration within an hour of triggering sepsis (69%) and IV fluids (58%) |
| Antibiotics administered within 60 mins from time  patient **triggers** Sepsis (NEWS 5>) - Emergency Department | Apr-23 | Monthly | 95% | **69%** | 71% | | - | ? | The average time between patient triggering sepsis (NEWS 2 of 5 and above) and prescription of antibiotics was 50.5 mins in April 23. |
| All elements of the Sepsis Six Bundle delivered within 60 mins from time patient **triggers** Sepsis (NEWS 5>)- Inpatient wards | Apr-23 | Monthly | 95% | **71%** | 32% | | - | ? | Elements of the sepsis 6 bundle that have impacted on the overall compliance for April 23 are senior review (71%), blood cultures (71%), and Lactate (57%) |
| Antibiotics administered within 60 mins from time patient triggers Sepsis (NEWS 5>)  - Inpatient wards | Apr-23 | Monthly | 95% | **100%** | 68% | | | ? | The average time between patient triggering sepsis (NEWS 2 of 5 and above) and prescription of antibiotics was 120 mins in April 23. |
| Antibiotics administered within 60 mins of patient being **diagnosed** with Sepsis - Emergency Department | Apr-23 | Monthly | 95% | **85%** | 91% | | - | ? | Average door to needle time for March 23 was 63mins, thisis a reduction in delay of 55 mins in Feb 23 a a decrease in Jan 23. The average time between antibiotic prescription and administration was 34 mins.  The average prescription and administration time of antibiotics together was 90.4 mins for |
| Antibiotics administered within 60 mins of patient being **diagnosed** with Sepsis - Inpatient wards | Apr-23 | Monthly | 95% | **100%** | 71% | | - | ? | The average time between antibiotic prescription and administration was 28 mins. |

Author(s): Stephanie Fuller          Owner(s): Amanda Cox

*Together*–**Safe** | **Kind** | **Excellent**

## Mental Health

**Ongoing work:**
Further data exploration is required to understand the data associated with;

i)  those transferred to an alternative PoS from CUH ED and rationale for initial conveyance to CUH ED.
ii)  those presenting under Sec136 MHA, and how many of this number are frequent attenders and the effectiveness of high intensity user plans of care.
iii)  who has brought CAMHS pts into ED i.e. other organisations, parents etc.
iv)  why have they been brough to ED? Place of safety or Medical need?
v)  what children's services were they concurrently receiving support from?

This will be a focus of the team over the next few months in partnership with the ICB to explore and understand this data, in order to work toward reducing unnecessary emergency department presentation.

Aligning with work carried out with the ICS 136 pathway group, CUH and CPFT are developing compliance methods to ensure that required statutory Sec 136 MHA data is collected and available for audit.

Ligature assessments reviews are currently in progress 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. Contemporary actions plans will be completed.

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.

A CUH Rapid Tranquilisation Policy and Protocol review for both adults and young people is due to commence in May 23, with clinical staff from both CUH and CPFT.
Mental health bed finding processes and escalation is currently under review, with a view to also improve quantitative data around delayed discharges.

Raw data around bed days representing delayed discharges due to need for MH specialist beds has been sourced, although it is noted that refinement is required. For example, a more recent patient stay that was recognised as a delayed discharge by the clinical team, did not feature in the data which may indicate error in recording process of delayed discharge after being medically fit for discharge.

The Medical Emergency for Eating Disorders (MEEDS) document is currently being reviewed with latest guidance. An eating disorder oversight committee will re-convene following a period without the

Narrative

Data has been adjusted from previous reports to reflect financial years rather than calendar years
Section (Sec) 136 Mental Health Act (MHA) presentation at CUH Emergency Department (ED)
  - Year 21/22 x 176
  - Year 22/23 x 160 (Representing reduction of 9% over 21/22)

Over year 22/23
-9.4% of Sec 136 MHA presentations were converted to a further detaining section of the MHA, to CUH, or an alternative hospital.
-71% of Sec 136 MHA presentations were rescinded/lapsed or patient absconded.
-21% Sec136 MHA presentations were transferred to alternative place of safety (PoS)
-Previous 3 years have shown increased incidents of CUH ED used as PoS where Sec 136 suite in use/unavailable.
-Data shows a real need for system alternatives to implementation of Sec 136 MHA, and more appropriate PoS that can offer proportionate and timely support. -CUH MH are currently engaged in the ICB led, system partners Sec 136 MHA pathway review, which includes;
i) Roles and responsibilities
ii) Conveyance
iii) Place of safety facilities
iv) Efficient use of alternative system resource
-CAMH aged patients presenting to ED reduced through 22/23, in comparison to 21/22, by 13%.
-CAMH age average conversion rate from ED presentation to inpatient admission increased in 22/23 (40.6%) by 3% when compared to 21/22 (37.6%)
-Adult age conversion rate from ED MH presentation to inpatient admission remained consistent with a decrease of 0.4% in 22/23 ( 13.2%) when compared to 21/22 (13.6%)


All MHA Detention Activity CUH Q1 19/20-end Q4 22/23


Section 136 at CUH SPC Chart. Q4 19/20 to April Q1 23/24


SPC Chart for all MH presentations to ED at CUH from Jan 2022 to end March 2023


SPC Chart for CAMH aged ED attendance at January 2022 to end April 2023

Author(s): Claire Ward   Owner(s): Lorraine Szeremeta   Together-Safe | Kind | Excellent

# Safeguarding

**NHS**
**Cambridge University Hospitals**
**NHS Foundation Trust**

Safety and Quality
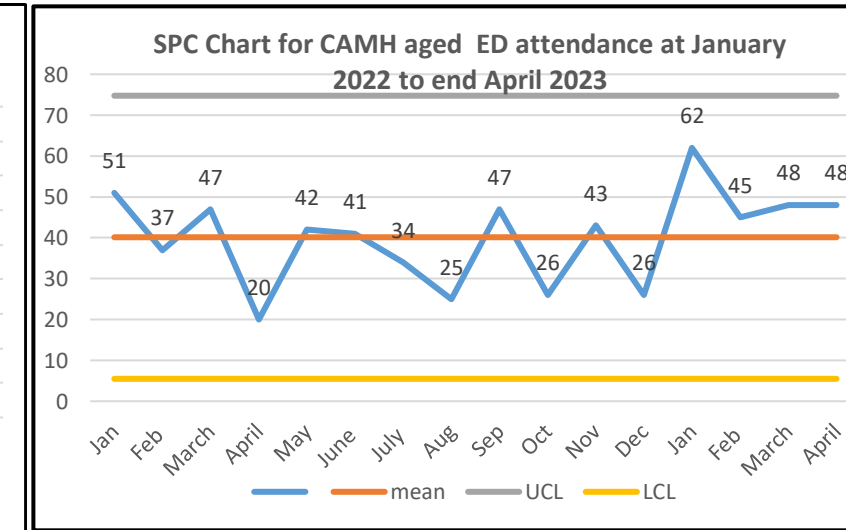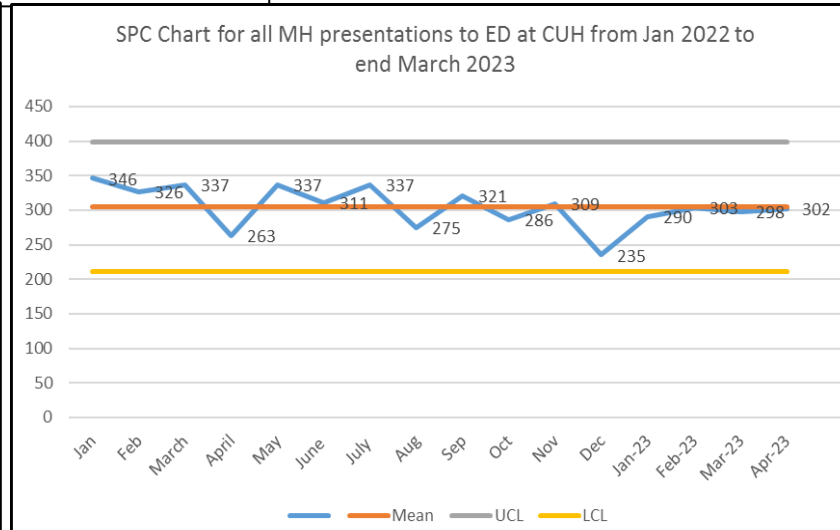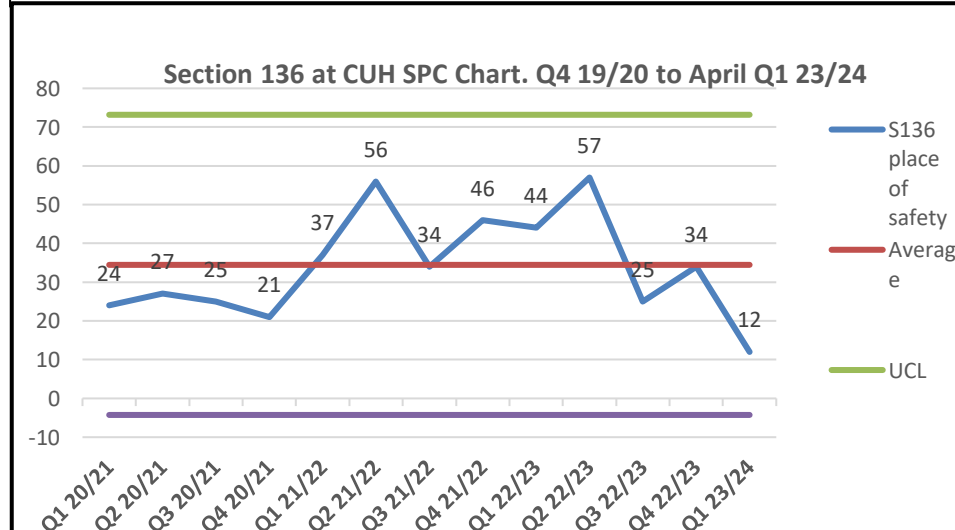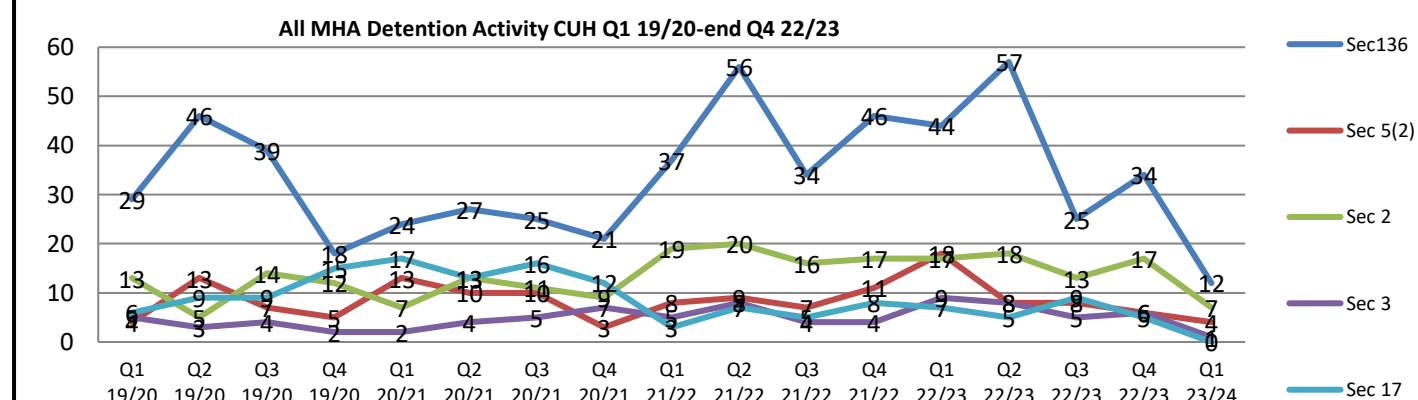
## Adult Safeguarding

Referrals to the safeguarding team have continued to increase year on year. There has been a 45% increase in referrals in Q4 22/23 compared to the same time period in 21/22. A total of 363 referrals were made to the Adult Safeguarding Team this quarter compared to 296 in Q3 (this figure does not include DOLs requests). The largest number of referrals relate to concerns of neglect or acts of omission (36%). 17% of referrals related to domestic abuse concerns.



## Childrens

Whilst there has been a slight increase in referrals to the paediatric safeguarding team this quarter, there has been a 31.9% decrease in the total year referrals (761) compared to the last financial year (1119). This could be linked to the pandemic where more families, children and young people were in crisis during lock downs resulting in an increase in referral numbers. Mental Health concerns continue to be the consistent theme dominating Children's social care referrals.



## Maternity safeguarding

There was a sharp increase in referrals to the maternity safeguarding team in January 2023 however this did not translate to an increase in referrals to children's social care. There were 39 referrals to childrens social care during Q4 which is a reduction compared to other quarters. Of these, 26 cases related to domestic or sexual abuse.
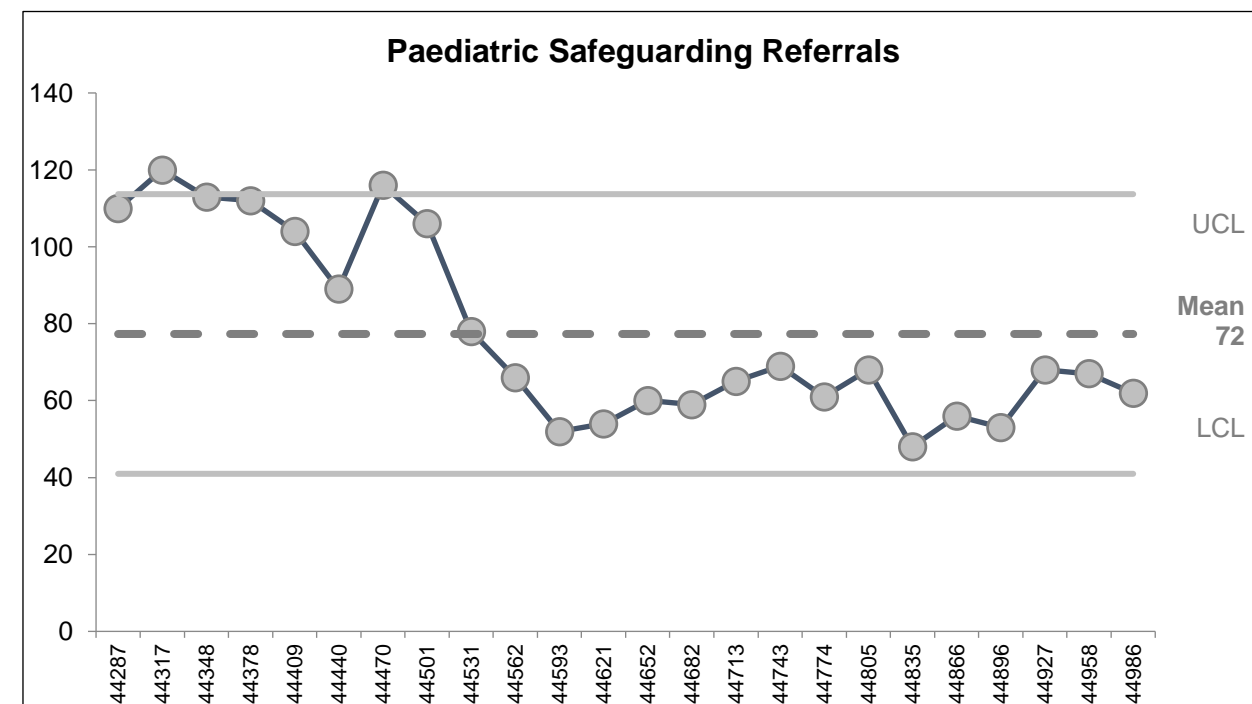


## Learning disabilities

During Q4 there have been 465 referrals to the learning disability specialist nurse which is a 1.5% increase from Q3 22/23 and a 6.5% decrease when comparing against Q4 2021. 6% (27) referrals were from external partners who alerted the LD specialist nurse prior to the patient being admitted/reviewed within the trust. 94% (438) of referrals were internal. The electronic flag within EPIC has improved the timeliness of these referrals.

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# Infection Control
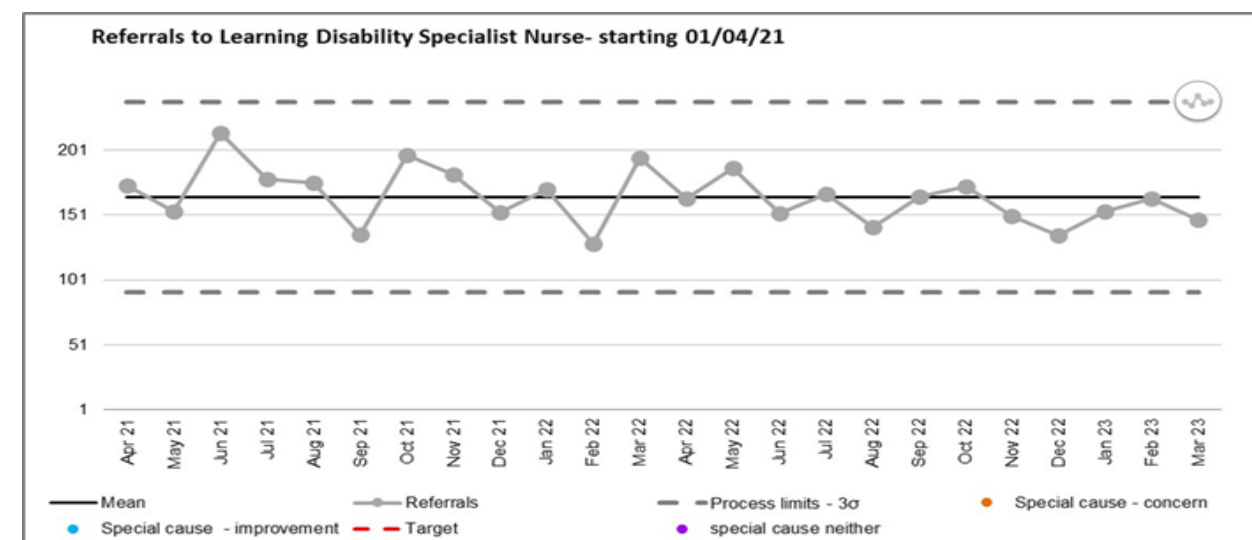
**Monthly *Clostridium difficile* cases in last 12 months**



Legend: ■ Hospital onset  ■ COHA

| Month | Hospital onset | COHA |
|-------|---------------|------|
| May 22 | 8 | 3 |
| Jun 22 | 8 | 8 |
| Jul 22 | 10 | 1 |
| Aug 22 | 13 | 7 |
| Sep 22 | 5 | 3 |
| Oct 22 | 11 | 2 |
| Nov 22 | 9 | 3 |
| Dec 22 | 5 | 1 |
| Jan 23 | 4 | 1 |
| Feb 23 | 4 | 2 |
| Mar 23 | 6 | 3 |
| Apr 23 | 3 | 3 |
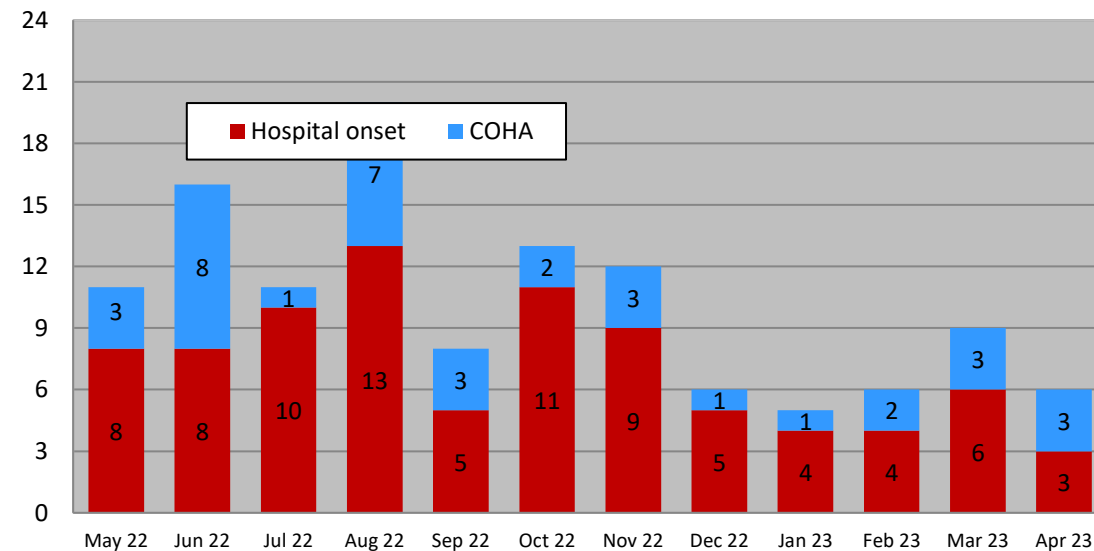
\* COHA - community onset healthcare associated = cases that occur in the community when the patient has been an inpatient in the Trust reporting the case in the previous four weeks

**Cumulative hospital acquired *Clostridium difficile* cases in 2022/2023**



Legend: Total hospital cases, Avoidable cases

| Month | Total hospital cases | Avoidable cases |
|-------|---------------------|-----------------|
| Apr 22 | 11 | 3 |
| May 22 | 19 | 3 |
| Jun 22 | 27 | 4 |
| Jul 22 | 37 | 5 |
| Aug 22 | 50 | 8 |
| Sep 22 | 55 | 10 |
| Oct 22 | 66 | 12 |
| Nov 22 | 75 | 17 |
| Dec 22 | 80 | 19 |
| Jan 23 | 84 | 20 |
| Feb 23 | 88 | 21 |
| Mar 23 | 94 | 21 |
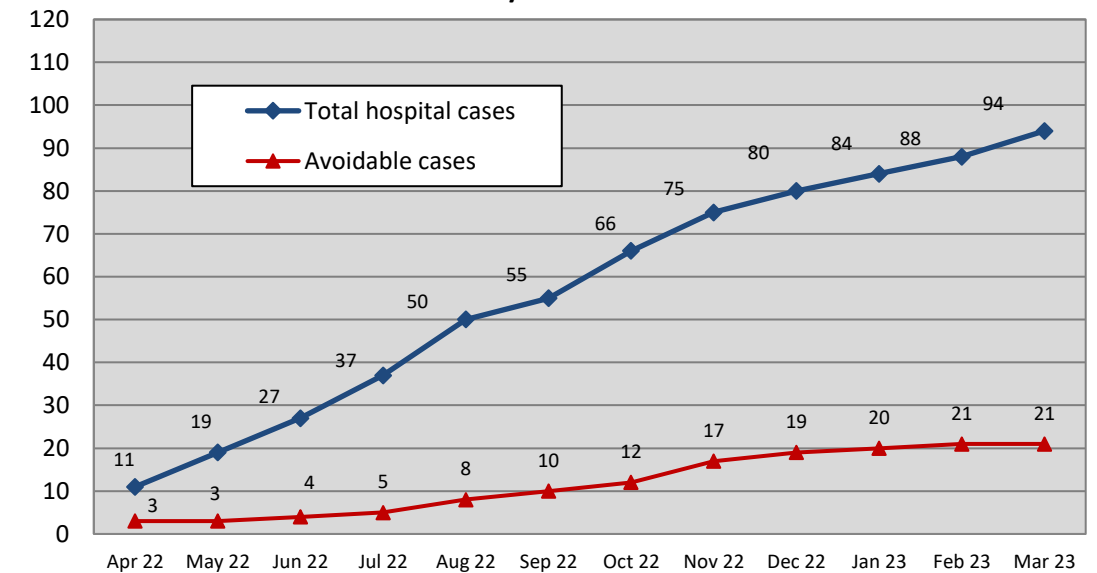
## CUH trend analysis

MRSA bacteraemia ceiling for 2023/24 is zero avoidable hospital acquired cases.

• 2 cases of hospital onset MRSA babacteraemia in April 2023
• 2 cases (2 unavoidable & 0 avoidable) hospital onset MRSA bacteraemia year to date

*C. difficile* ceiling for 2023/24 is 109 cases for both hospital onset and COHA\*.

▪ 3 cases of hospital onset *C difficile* and 3 cases of COHA in April 2023.
• 3 hospital onset cases and 3 COHA cases year to date (0 cases unavoidable, 0 avoidable and 3 pending).

## MRSA and C difficile key performance indicators

▪ Compliance with the MRSA care bundle (decolonisation) was 83.9% in April 2023 (85.6% in March 2023).
▪ The latest MRSA bacteraemia rate comparative data (12 months to March 2023) put the Trust 4th out of 10 in the Shelford Group of teaching hospitals.

▪ Compliance with the *C. difficile* care bundle was 87.5% in April 2023 (91.6% in March 2023).
▪ The latest *C. difficile* rate comparative data (12 months to March 2023) put the Trust 7th out of 10 in the Shelford Group of teaching hospitals.

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# 4HR PERFORMANCE

| Apr-23 | Plan |
|--------|------|
| 67.3% | 61.8% |

**SPC Variance**

Normal variation

**Shelford Group Avg (Apr-23)**

71.5%

**Three Month Trajectory**

| May-23 | Jun-23 | Jul-23 |
|--------|--------|--------|
| 64.6% | 66.0% | 67.7% |

## SPC - 4hr performance (including MIU)



Legend: —— 4hr performance  —— Mean  ······ 23/24 Trajectory  —— Shelford Group

## Highest breaches by specialty

| Specialty | 4hr breaches | Performance |
|-----------|--------------|-------------|
| Emergency | 1,662 | 61.23% |
| Medicine | 1,607 | 26.28% |
| Paediatrics | 213 | 48.55% |
| Surgery | 172 | 43.97% |
| ENT | 113 | 44.06% |
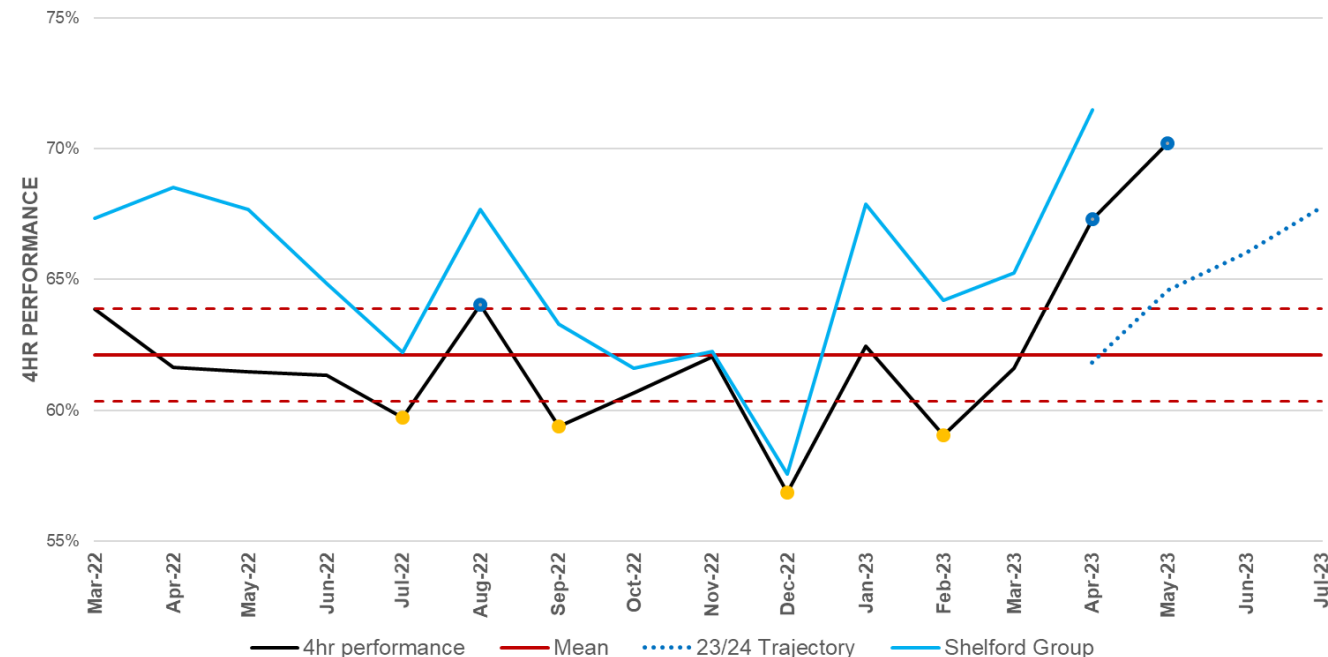
## Updates since previous month

- ED 4hr standard plan developed, focusing on breaches between 4hrs and 4hrs 30, UTC GP & minors, time to initial assessment and use of existing ED capacity
- Improvement to 67.3% in April and ~73% in May MTD
- Governance via UEC Oversight Board chaired by COO

## Key dependencies

- High in-patient occupancy rates impacts ability to flow admitted patients from the ED
- SDEC activity relies on good outflow from medical and surgical assessment units
- Sufficient and appropriately qualified staffing

## Current issues

- Insufficient cubicle capacity to see patients
- Variable staffing levels/experience in the UTC

## Future actions

- Further development of ED action plan, implementation of tests of change to improve efficiency in the department
- Fortnightly review of plans and performance monitoring via Management Executive
- Peer review exercise on 27th June

**Page 13**

# Ambulance Handovers > 60 minutes

**NHS Cambridge University Hospitals NHS Foundation Trust**

| Apr-23 | Target |
|--------|--------|
| 1.2% | 0% |

## SPC Variance

Normal variation

## East of England > 60 minutes*

| Trust | Handovers >60mins |
|-------|-------------------|
| CUH | 0% |
| Milton Keynes | 1% |
| West Suffolk | 2% |
| ESNEFT | 4% |
| West Herts | 6% |
| Bedford | 9% |
| Mid & South Essex | 10% |
| NWAFT | 17% |
| E&NHT | 22% |
| James Paget | 26% |
| PAH Harlow | 28% |
| QEH | 46% |
| Norfolk & Norwich | 55% |

### SPC - Ambulance handovers >60mins

Handovers >60mins — Mean
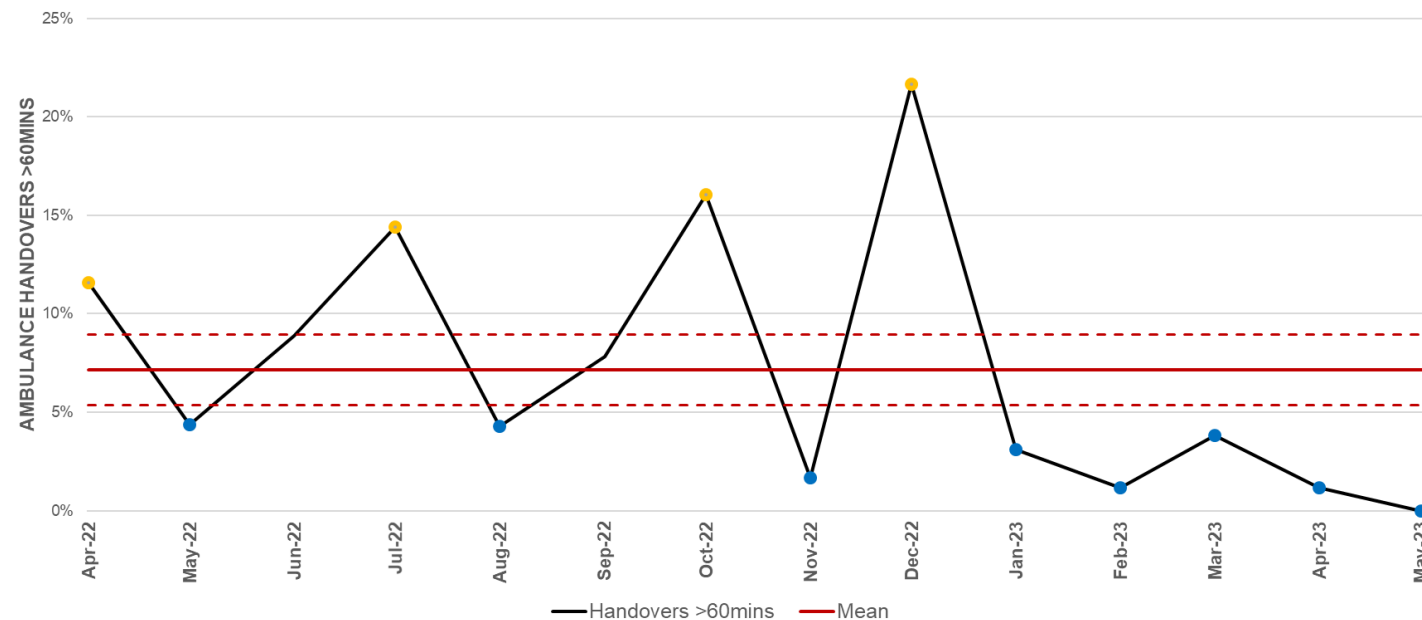
### Updates since previous month

- Ambulance delays in April continue to improve, with handover <15mins showing their highest performance since April 2019
- CUH was the highest performing trust in the East of England during April and in the top quartile nationally
- There have been zero 60-min delays during May MTD

### Current issues

- 'Batching' of ambulances still takes places where a number arrive at the same time, impacting our ability to offload
- The number of ambulance conveyances to CUH rose in April by 11% compared to the 22/23 average

### Key dependencies

- Ambulance handover performance is dependent on measures coordinated by the ICB to reduce conveyances, e.g. 'Call before you Convey'
- HALO shifts support handovers but are frequently unfilled

### Future actions

- Maintain the significant improvement in handover performance through tight operational focus and real-time management of handover delays

**Page 14**

*East of England data relates to w/e 14th May (latest available)*

# Overall fit test compliance for substantive staff
## As of 09 May 2023

| 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 |
| Additional Clinical Services | 34 | 26 | 76% | 232 | 109 | 47% | 59 | 19 | 32% | 122 | 66 | 54% | 93 | 23 | 25% | 81 | 29 | 36% | 621 | 272 | 44% |
| Allied Health Professionals | - | - | - | 59 | 11 | 19% | 15 | 4 | 27% | 1 | 0 | 0% | - | - | - | 3 | 1 | 33% | 78 | 16 | 21% |
| Estates and Ancillary (Porters and Security Personnel only) | 85 | 49 | 58% | - | - | - | - | - | - | - | - | - | - | - | - | 1 | 1 | 100% | 86 | 50 | 58% |
| Medical and Dental | - | - | - | 250 | 57 | 23% | - | - | - | 179 | 67 | 37% | 153 | 19 | 12% | 214 | 55 | 26% | 796 | 198 | 25% |
| Nursing and Midwifery Registered | - | - | - | 639 | 391 | 61% | 4 | 2 | 50% | 272 | 157 | 58% | 145 | 62 | 43% | 377 | 175 | 46% | 1437 | 787 | 55% |
| Total | 119 | 75 | 63% | 1180 | 568 | 48% | 78 | 25 | 32% | 574 | 290 | 51% | 391 | 104 | 27% | 676 | 261 | 39% | 3018 | 1323 | 44% |

*The data displayed as of 09/05/23. 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.*

Author(s): Brad Lintern          Owner(s): Lorraine Szeremeta

*Together-Safe | Kind | Excellent*

# Referral to Treatment > 65 weeks and > 78 weeks

**NHS**
**Cambridge University Hospitals**
NHS Foundation Trust

| Apr-23 | Plan |
|--------|------|
| 990 | 993 |

### SPC Variance

Positive special cause variation

### Shelford Group Avg (Apr-23)

65wks: Shelford average = 2.0% vs. CUH 1.6%
78wks: Shelford average = 0.2% vs. CUH 0.2%

### Three Month Forecast (>65wks)

| May-23 | Jun-23 | Jul-23 |
|--------|--------|--------|
| 946 | 876 | 786 |

### Highest 65wk+ waits by specialty

| Specialty | Waiting |
|-----------|---------|
| ENT | 179 |
| Dermatology | 80 |
| Trauma & Orthopaedics | 76 |
| Urology | 74 |
| Cardiology | 73 |
| Ophthalmology | 70 |
| Maxillo-Facial Surgery | 69 |
| General Surgery | 52 |
| Gynaecology | 50 |
| Oral Surgery | 43 |

**SPC - RTT long waits**



Legend: 65wk waits — Mean — 23/24 Trajectory — 78wk waits
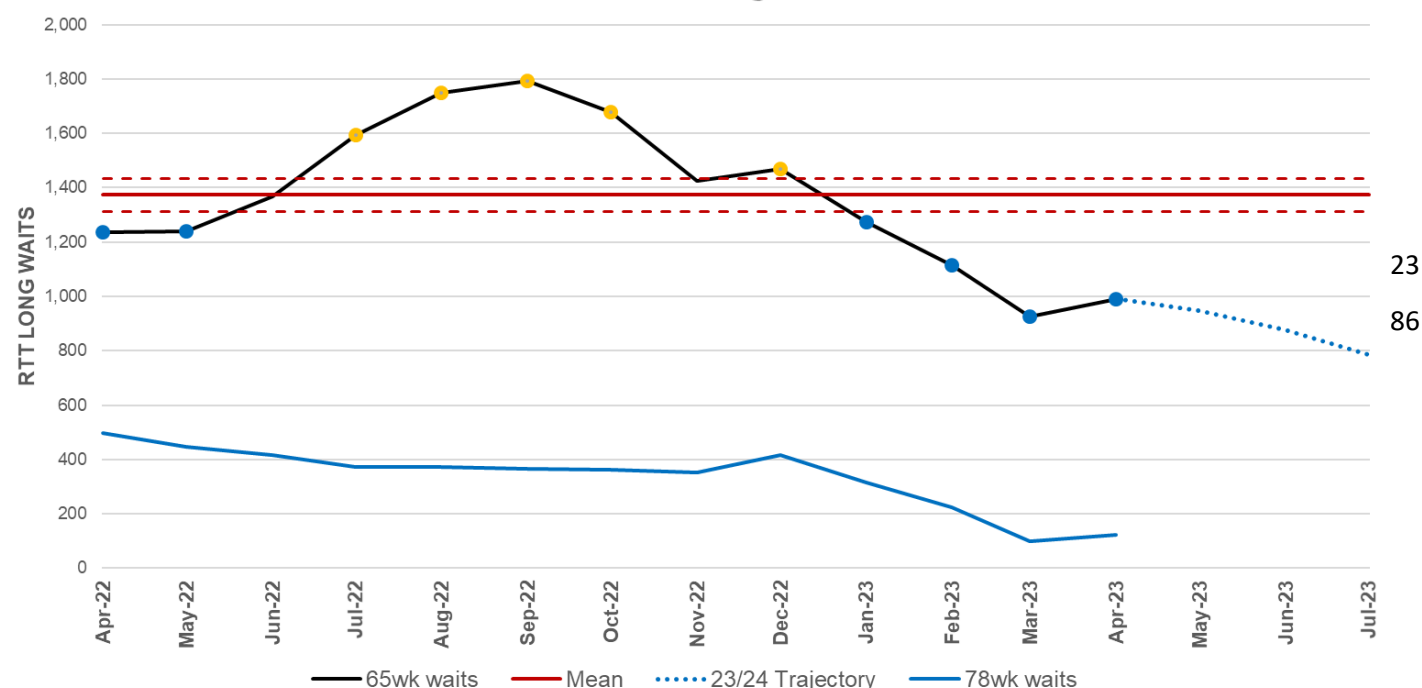
### Updates since previous month

- >78 week waits increased by 23 in April
- NHSE have extended eradication of >78 week waits to end of Q1. 347 remaining to treat to deliver this
- 2 unforecast >104 week waits reported for April

### Key dependencies

- Theatre capacity
- Administrative and operational resilience
- Mutual aid for OMFS, Cardiology
- Independent Sector for ENT

### Current issues

- Cumulative impact of industrial action disruption.
- Competing demands of urgent and cancer surgery
- Complex and consultant specific case mix.
- Non-elective pressures on surgical capacity

### Future actions

- Weekly trajectories set for 78 weeks clearance by specialty to end of Q1. ENT and OMFS highest risk
- Step down plan outlined for 65 week max by end of 2023/24. End of Nov aim for non-admitted cohort

**Page 16**

# Referral to Treatment Total Waiting List

**NHS**
Cambridge
University Hospitals
NHS Foundation Trust

| Apr-23 | Plan |
|--------|------|
| 60,729 | 60,936 |

## SPC Variance
Negative special cause variation

## Shelford Group Avg
N/A

## Three Month Forecast

| May-23 | Jun-23 | Jul-23 |
|--------|--------|--------|
| 62,129 | 62,829 | 62,810 |

### SPC - RTT Total waiting list



Legend: —— RTT Total WL   —— Mean   ······ 23/24 Trajectory

## Waiting list by division

| Division | Apr | Change vs. March |
|----------|-----|------------------|
| A | 12,397 | 0.1% |
| B | 6,679 | 0.9% |
| C | 3,854 | -10.1% |
| D | 27,923 | 1.8% |
| E | 9,869 | 2.5% |
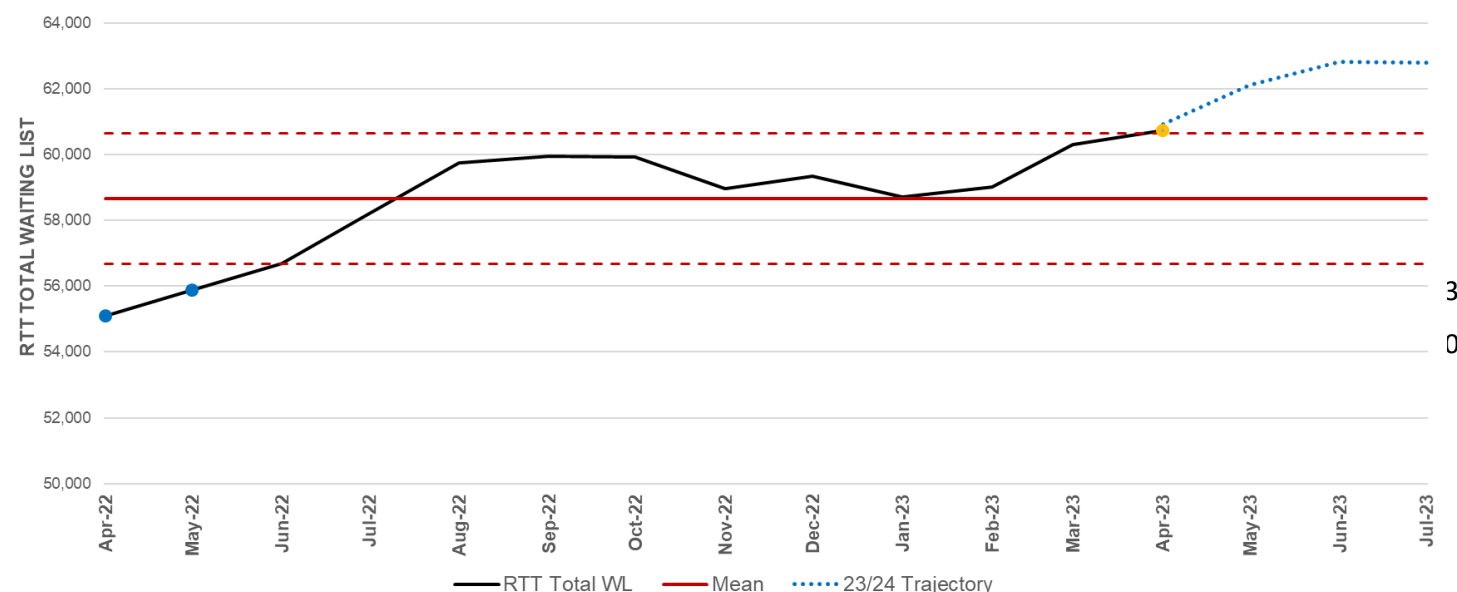
## Updates since previous month
- Total RTT waiting list grew by 0.7 % in April.  This was a growth of 421 pathways
- The total waiting list size was 0.3% lower than the planning submission for Month 1

## Key dependencies
- Demand (clock starts) remains within plan
- Outpatient and elective activity plans are met
- Resilience in administrative roles supporting pathway validation

## Current issues
- Admitted stops were 5% (116)  below Month 1 plan, mitigated by higher than planned non-admitted stops and validation contribution
- BMA Industrial Action impact was 260 fewer admitted stops and 620 fewer non-admitted stops in April

## Future actions
- Monthly monitoring of demand and activity
- Continued drive to release capacity for new outpatients via more productive/alternative delivery of follow up. Non-admitted is 81% of the waiting list

**Page 17**

# Cancer - 28 day faster diagnosis standard

| Mar-23 | Target |
|---|---|
| 81.0% | 75.0% |

## SPC Variance
Normal variation

## Shelford Group Avg (Mar-23)
77.1%

## Three Month Forecast
| Apr-23 | May-23 | Jun-23 |
|---|---|---|
| 81.5% | 84.5% | 83.2% |

### SPC - Cancer 28 day Faster Diagnostic Standard



Legend: Cancer FDS % — Mean — 23/24 Trajectory — Shelford Group

Y-axis: % CANCER DIAGNOSES <28 DAYS

## Cancer Site Overview

| Cancer site | 28 FDS % |
|---|---|
| Central Nervous System/Brain | 100.0% |
| Testicular | 100.0% |
| Lung | 97.1% |
| Breast | 95.2% |
| Skin | 81.2% |
| Upper GI | 81.0% |
| Head & Neck | 74.2% |
| Children's | 73.3% |
| Lower GI | 72.4% |
| Urological | 68.4% |
| Gynaecological | 64.0% |
| Haematological | 58.8% |
| Sarcoma | 25.0% |
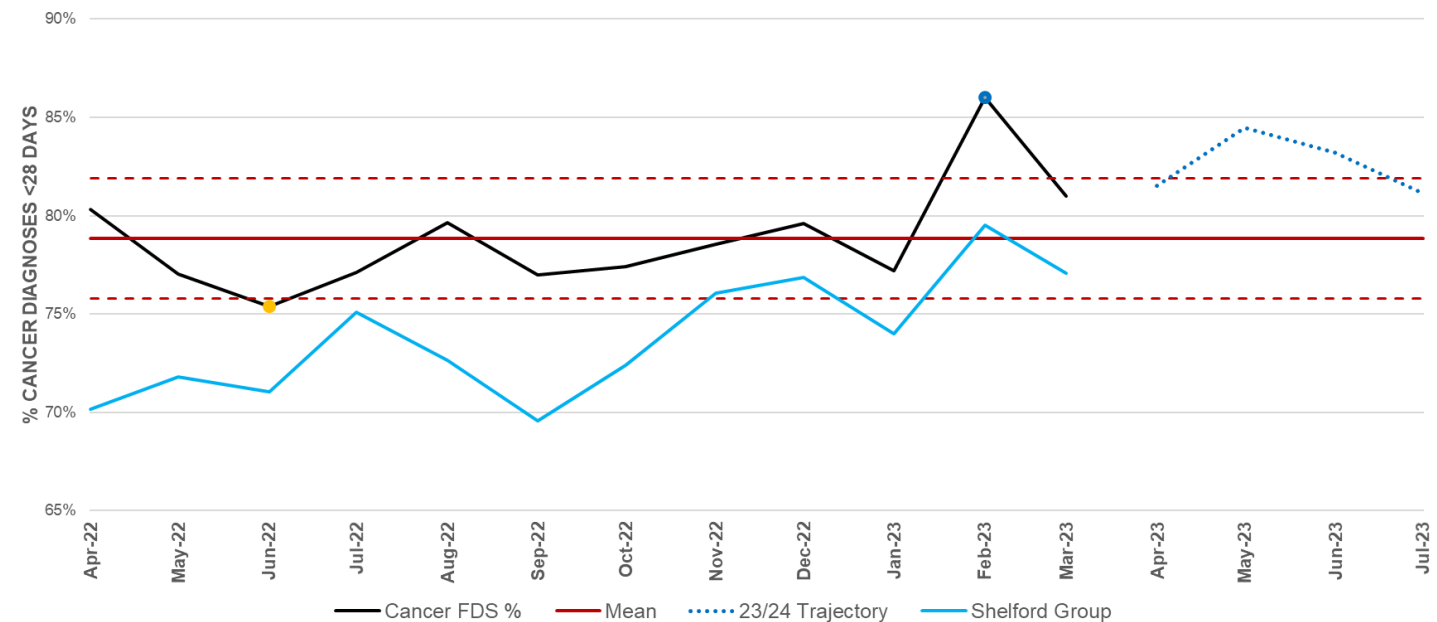
## Updates since previous month
- CUH remains above Shelford Group performance
- Performance has deteriorated in the last month due to delays in the skin and gynae pathways

## Current issues
- Delays to diagnostics in skin cancer and pathology turnaround times continue to impact performance.
- Actions are in place as part of the Cancer Improvement Plan

## Key dependencies
- Improved compliance to 50% minimum for pathology turn around times.
- Additional ad hoc activity in skin to reduce backlog

## Future actions
- Focus on the Urology pathways commenced in May, this will including working across the system drive change and improve compliance across prostate, bladder and kidney

**Page 18**

# Cancer - 2 week waits

**NHS**
Cambridge
University Hospitals
NHS Foundation Trust

| Mar-23 | Target |
|--------|--------|
| 87.6% | 93.0% |

## SPC Variance

Normal variation

## Shelford Group Avg (Mar-23)

85.5%

## Cancer Site Overview

| Cancer site | 2WW % |
|-------------|-------|
| Central Nervous System/Brain | 100.0% |
| Haematological | 100.0% |
| Testicular | 100.0% |
| Upper GI | 100.0% |
| Urological | 99.4% |
| Lung | 94.9% |
| Lower GI | 91.8% |
| Head & Neck | 89.8% |
| Breast | 88.7% |
| Children's | 84.6% |
| Gynaecological | 82.6% |
| Skin | 81.8% |

### SPC - Cancer 2WW



Y-axis: % URGENT CANCER REFERRALS SEEN <2wks (65% to 100%)
X-axis: Apr-22 to Mar-23

Legend: Cancer 2WW, Mean, Target, Shelford Group
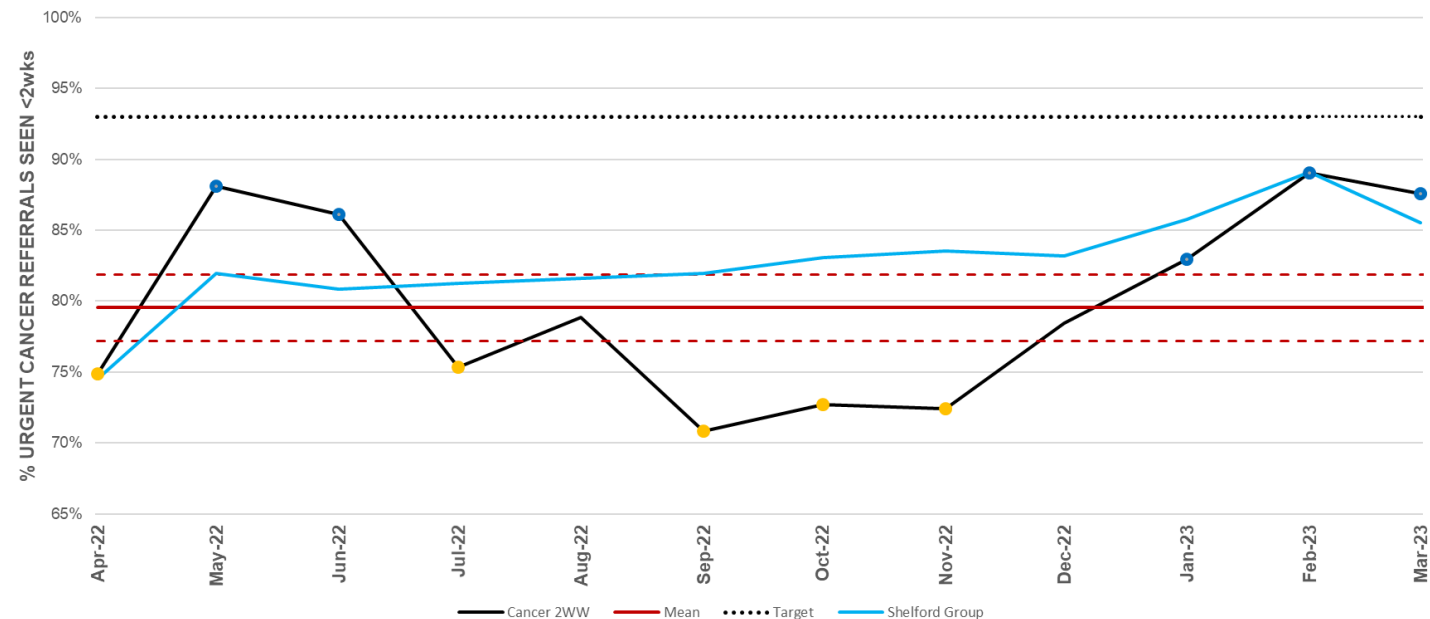
## Updates since previous month

 - CUH has continued to recover performance against the 2WW target but performance still falls below the 93% standard
 - Breast continued to improve performance with full recovery from May

## Current issues

 - Breaches along the skin pathway are the main reason for below-standard performance
 - Gynae had an increase in breaches due to sickness in the team which will continue until June
 - 66.7% of breaches in April were due to capacity

## Key dependencies

 - High 2WW referral rates impact our ability to see patients within the two-week target
 - Sufficient capacity required to deliver target activity

## Future actions

 - Additional ad hoc activity in skin (Plastics) to ensure patients can be seen within 14 days on a skin and sarcoma pathway

# Cancer - 31 days decision to treat to treatment

| Mar-23 | Target* |
|--------|---------|
| 87.5% | 96.0% |

## SPC Variance

Normal variation

## Shelford Group Avg (Mar-23)

86.9%

## Cancer Site Overview

| Cancer site | 31D % |
|-------------|-------|
| Central Nervous System/Brain | 100.0% |
| Children's | 100.0% |
| Gynaecological | 100.0% |
| Haematological | 100.0% |
| Lower GI | 100.0% |
| Lung | 100.0% |
| Sarcoma | 100.0% |
| Skin | 87.3% |
| Head & Neck | 85.7% |
| Breast | 84.0% |
| Urological | 81.4% |
| Other | 75.0% |
| Upper GI | 58.3% |

### SPC - Cancer 31 days from decision to treat to treatment



Legend: CUH 31D, Mean, Target, Shelford Group, CUH 31D (surgery)
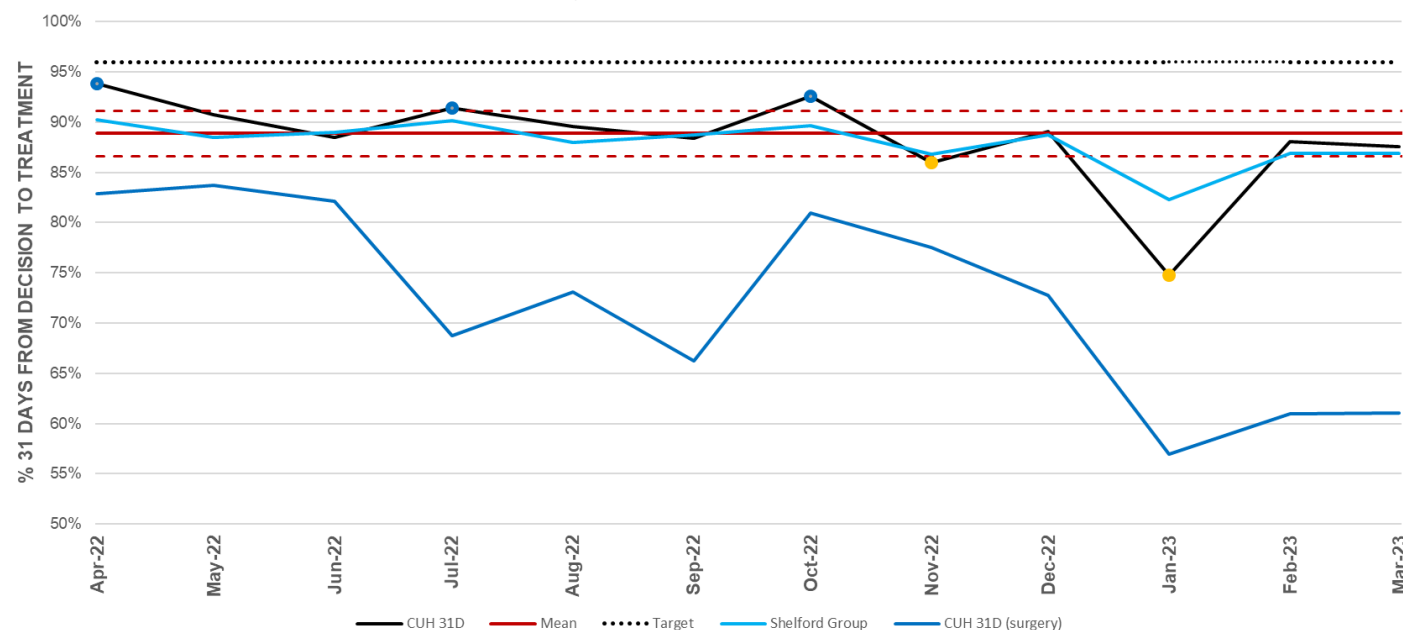
## Updates since previous month

- CUH continues to fall below target with 92% of the breaches in March for surgery (target = 96%)
- Specialties howing the lowest performance levels were Urology (30%), HPB (23%), Breast (19%) and Skin 16%)

## Current issues

- Access to theatre lists within 31 days remains an issue across multiple cancer sites. Due to the recent industrial action and bank holidays, surgical activity has been reduced which has contributed to the backlog

## Key dependencies

- Additional theatre lists available to services and engagement from clinical teams to undertake additional activity

## Future actions

- Focus on kidney cancer surgical lists in June to reduce backlog.

# Cancer - 62 days urgent referral to treatment

**NHS Cambridge University Hospitals NHS Foundation Trust**

| Mar-23 | Target |
|--------|--------|
| 76.4% | 85.0% |

### SPC Variance
Normal variation

### Shelford Group Avg (Mar-23)
58.6%

### Cancer Site Overview

| Cancer site | 62D % |
|-------------|-------|
| Central Nervous System/Brain | 100.0% |
| Other Haem Malignancies | 100.0% |
| Sarcoma | 100.0% |
| Skin | 92.0% |
| Lung | 83.3% |
| Lower GI | 78.6% |
| Breast | 72.7% |
| Gynaecological | 71.4% |
| Urological | 68.1% |
| Head & Neck | 44.4% |
| Upper GI | 36.4% |
| Other | 33.3% |

## SPC - Cancer 62 days from urgent referral to treatment



Legend: CUH 62D — Mean ····· Target — Shelford Group
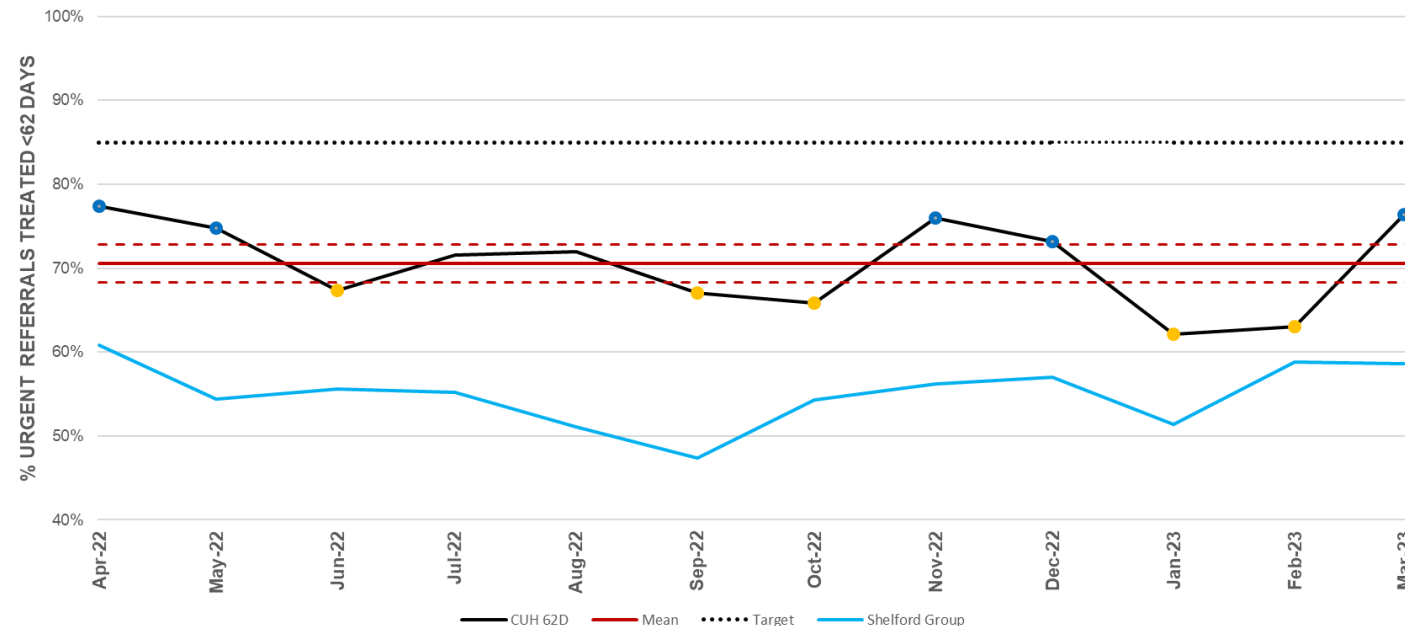
### Updates since previous month
- CUH has improved performance since February and is consistently above the Shelford Group average but below target of 85.0%
- 25% of breaches in March were due to patient-related delays/complex pathways

### Current issues
- Delays in pathology turn around times
- Outpatient and surgical capacity
- Late referrals to CUH from regional teams

### Key dependencies
- Achieving 28 day FDS
- Pathology turnaround times remaining above 50% in 7 days (currently at 22%)
- Reduced late referrals from regional teams

### Future actions
- There is an extensive improvement plan in place which is reviewed monthly
- From May there will be a focus on Skin, Urology, Gynae and Head & Neck

# DM01 Performance

| Apr-23 | Plan |
|--------|------|
| 37.1%  | 34.0% |

## SPC Variance

Positive special cause variation

## Shelford Group Avg (Apr-23)

14.5%

## Three Month Forecast

| May-23 | Jun-23 | Jul-23 |
|--------|--------|--------|
| 36.2%  | 34.9%  | 34.9%  |

## Modality overview

| Modality | % >6wks |
|----------|---------|
| Audiology | 67.5% |
| Echocardiography | 67.3% |
| Urodynamics | 47.2% |
| Non obstetric ultrasound | 36.9% |
| Imaging | 29.8% |
| Magnetic Resonance Imaging | 29.6% |
| Computed Tomography | 23.8% |
| Respiratory physiology | 22.6% |
| Cystoscopy | 20.0% |
| DEXA Scan | 17.4% |
| Neurophysiology | 12.8% |
| Barium Enema | 10.0% |
| Flexi sigmoidoscopy | 5.4% |
| Endoscopy | 5.0% |
| Gastroscopy | 3.5% |
| Colonoscopy | 1.3% |

### SPC - % 6wk diagnostic waits



Legend: Diagnostics >6wks — Mean — 23/24 Trajectory — Shelford Group
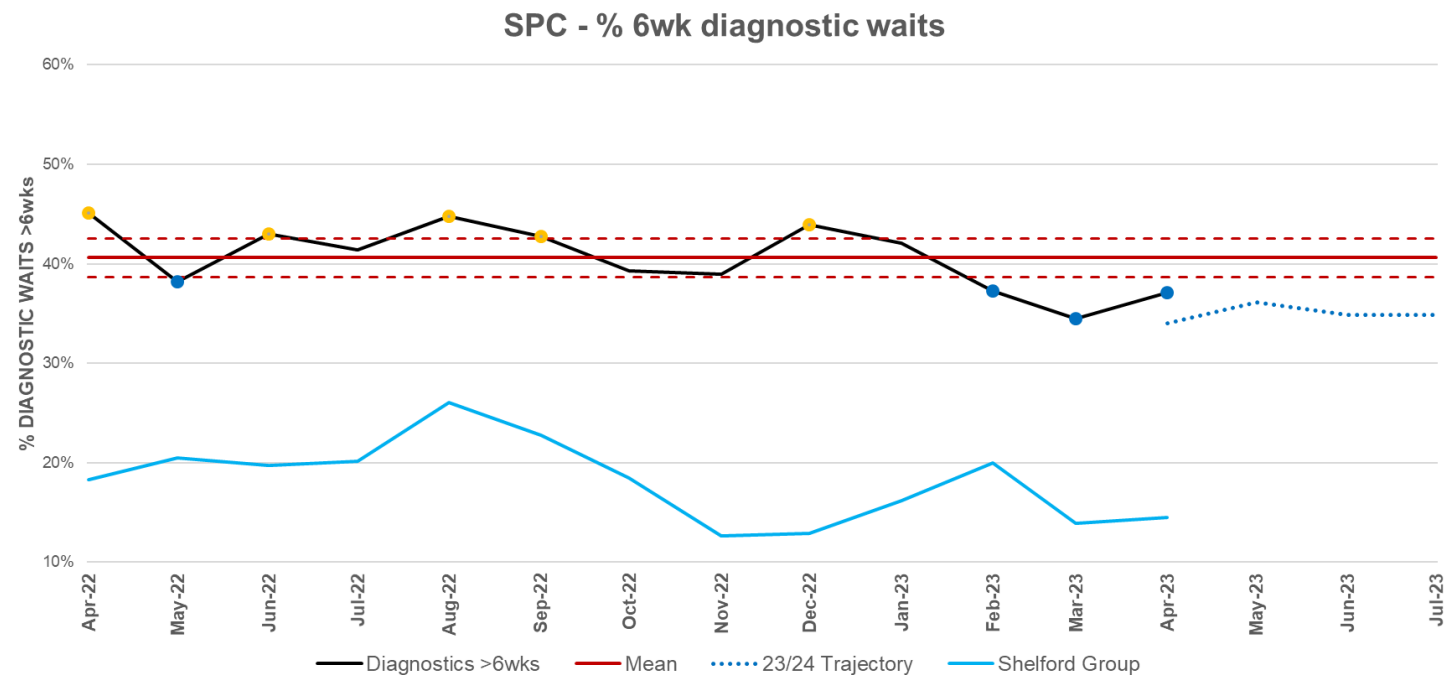
## Updates since previous month

- April's 6wk performance deteriorated by 2.6% in month, an increase of 332 requests > 6 wks
- Total activity was 6% higher than plan, 18% higher than last month and 120% of baseline

## Current issues

- Total waiting list actually reduced in April. CT and MRI making good improvements
- >6 weeks grew in Audiology, Echo & Ultrasound
- High staff vacancies are the main risk to delivery

## Key dependencies

- On-going use of Insourcing for Echocardiography
- On-going use of independent sector mobile and community capacity for Imaging modalities
- Agency and locum staffing

## Future actions

- Audiology exploring support within region
- Echocardiography reviewing recruitment and retention premium. ICS working group established
- Ely Community Diagnostic Centre for H2

**Page 22**

# New Outpatient Attendances

| Apr-23 | Plan |
|---|---|
| 102.2% | 98.4% |

**SPC Variance**

Normal variation

**Shelford Group Avg**

N/A

**Three Month Forecast**

| May-23 | Jun-23 | Jul-23 |
|---|---|---|
| 103.8% | 103.4% | 104.6% |

### SPC - New Outpatient attendances



Legend: New OP vs. 19/20 — Mean — 23/24 Trajectory

Y-axis: % NEW OP APPOINTMENTS VS. 2019/20

### Divisional overview

| Division | Performance |
|---|---|
| A | 103.8% |
| B | 106.4% |
| C | 91.6% |
| D | 104.3% |
| E | 94.1% |
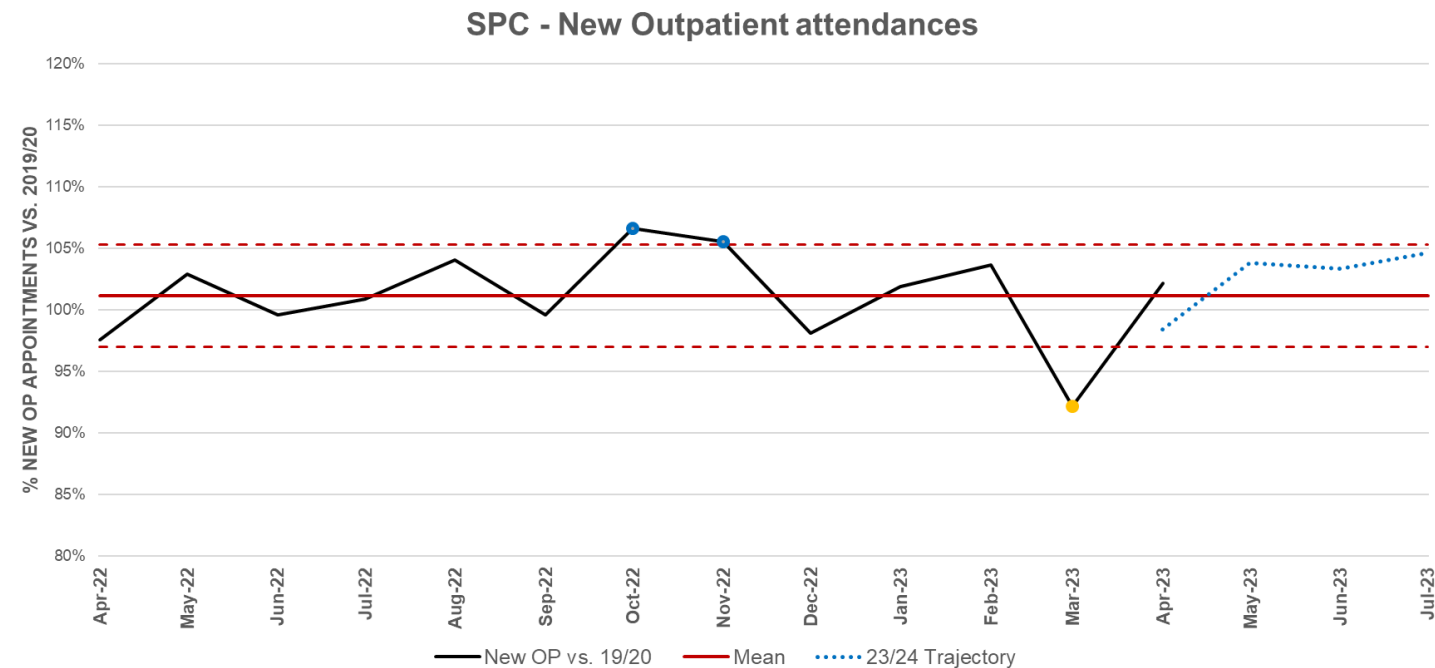
### Updates since previous month

New activity remains below 110% target but ahead of plan. Divisions performing below plan are Division C, driven by a change in data recording, and Division E where additional templates and clinics are being set up to increase new appts

### Current issues

Further action needed to increase new activity and achieve sustained change. Increasing capacity through increasing staffing levels will not be enough. To achieve outpatient targets we need to redesign pathways and change ways of working

### Key dependencies

Specialties continue to use the GIRFT Outpatients guidance to help implement further action and the NHSE data opportunity tool for benchmarking with and learn from other Trusts e.g. on new:follow up ratio, virtual, PIFU, DNA and other rates

### Future actions

Divisions and specialties need to further test change ideas including clinic template changes, waiting list initiatives, specialist advice, remote appointments, DNAs and PIFU. A greater volume, pace and spread of this action is needed to achieve the required scale of change

# Follow Up Outpatient Attendances

**NHS**
**Cambridge University Hospitals**
NHS Foundation Trust

| Apr-23 | Plan |
|--------|------|
| 115.2% | 127.4% |

## SPC Variance

Normal variation

## Shelford Group Avg

N/A

## Three Month Forecast

| May-23 | Jun-23 | Jul-23 |
|--------|--------|--------|
| 131.5% | 134.7% | 131.1% |

### SPC - Follow-up Outpatient attendances



Legend: Follow-up OP vs. 19/20 — Mean — 23/24 Trajectory
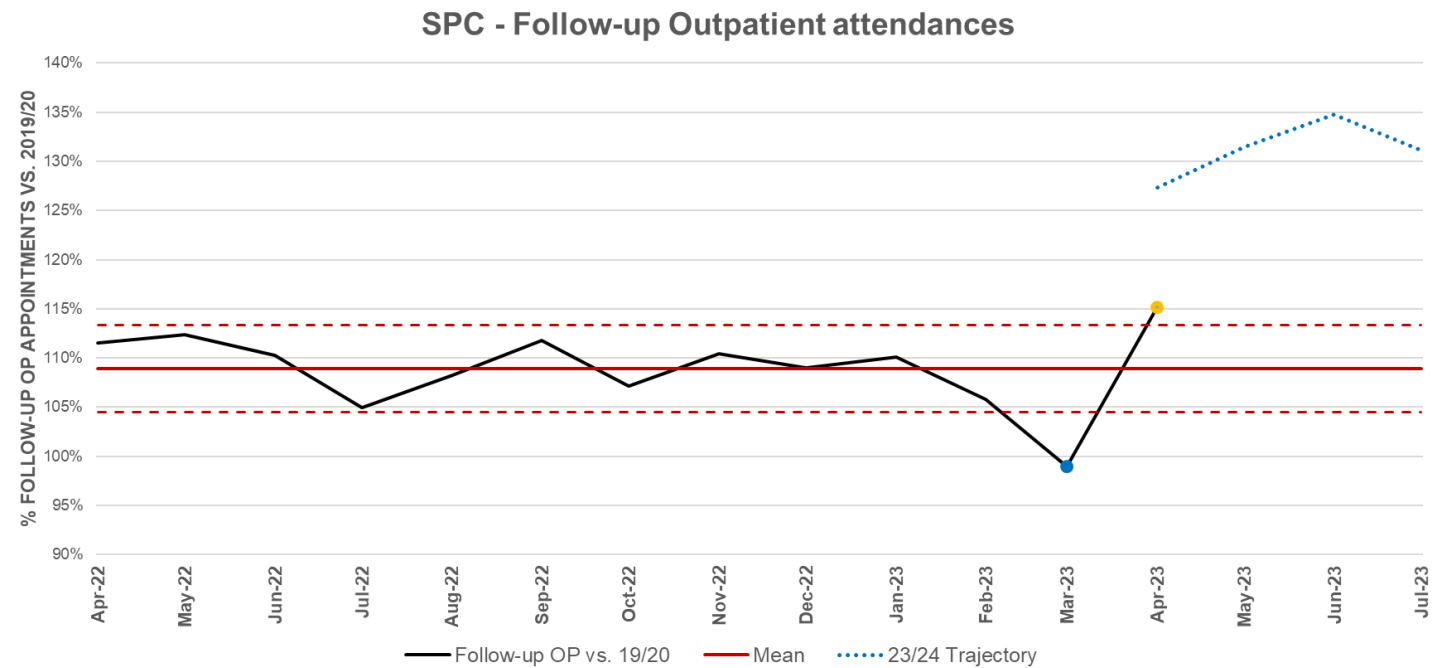
## Divisional overview

| Division | Performance |
|----------|-------------|
| A | 111.3% |
| B | 114.2% |
| C | 117.2% |
| D | 108.8% |
| E | 151.4% |

## Updates since previous month

Compared with the 2019/20 baseline the % of follow ups per month has increased over the last 2 years but stabilised at ~110% which is negatively higher than the CUH target of 105% and the national target of 75%

## Current issues

Further changes are needed to our ways of working to significantly reduce follow-up activity and achieve a sustained decrease which take time to test and implement. Lack of eHospital resources may also cause delays to PNP implementation

## Key dependencies

Patient Not Present (PNP) is one tool to be considered as patient pathways are reviewed and redesigned to reduce follow-ups.  This requires eHospital resources and specialities to develop pathways and templates

## Future actions

Actions being taken to address overdue follow ups include waiting list validation and initiatives, early tests of 'patient not present' reviews, and consideration of suitability of overdue follow up patients to be placed on a PIFU pathway

# PIFU Outpatient Attendances

| Apr-23 | Plan |
|---|---|
| 2.5% | 3.0% |

## SPC Variance
Normal variation

## Shelford Group Avg
N/A

## Three Month Forecast

| May-23 | Jun-23 | Jul-23 |
|---|---|---|
| 3.4% | 3.8% | 4.2% |

**SPC - Patient-initiated follow-ups**



Y-axis: % PATIENTS MOVED / DISCHARGED TO PIFU (1.0% – 5.0%)
X-axis: Apr-22 to Jul-23

Legend: PIFU % — Mean ⋯ 23/24 Trajectory
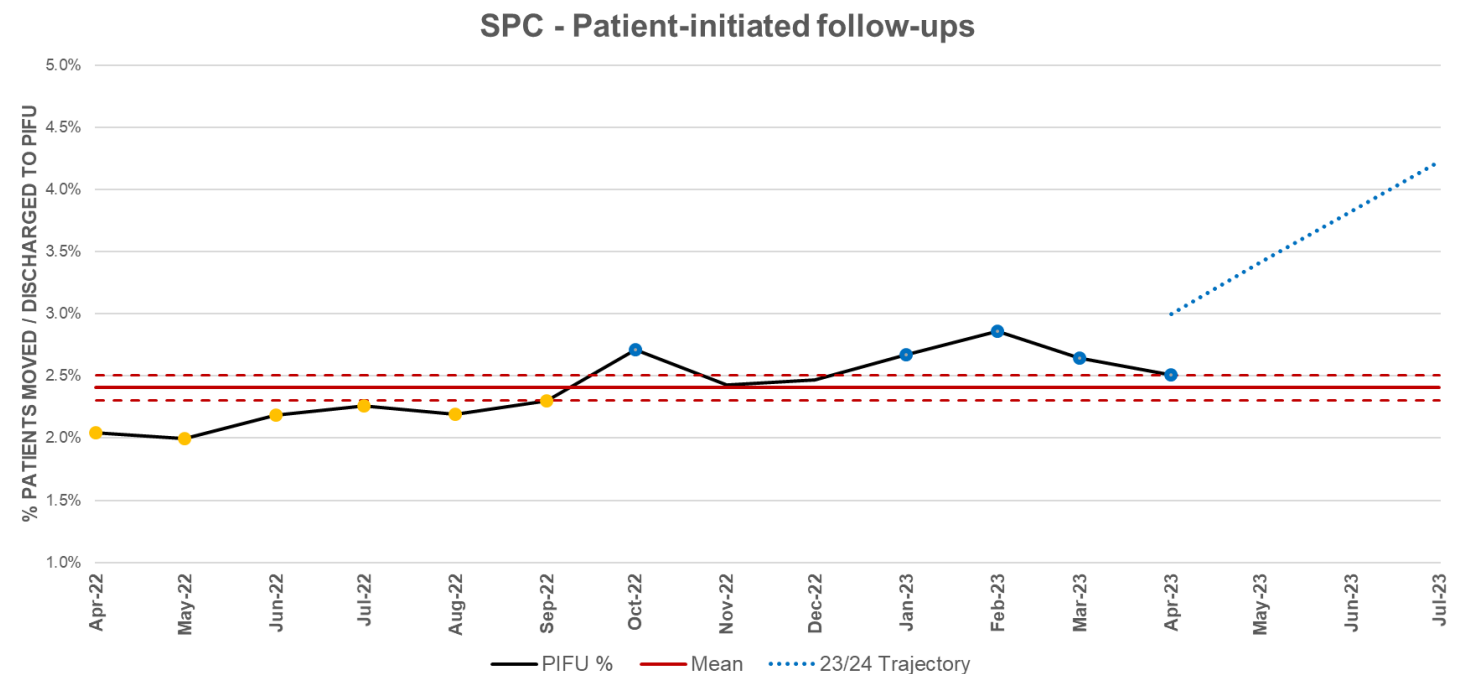
## Divisional overview

| Division | Performance |
|---|---|
| A | 5.9% |
| B | 2.9% |
| C | 0.8% |
| D | 1.6% |
| E | 1.8% |

## Updates since previous month
There is a consistent overall trend upwards of the use of PIFU but CUH is yet to reach the 5% target. Further actions to more rapidly increase our use of PIFU are being developed to accelerate the pace and scale of increase

## Key dependencies
Template rebuilding and eHospital resources to implement reporting changes

## Current issues
Recognised difficulties with achieving PIFU in the Transplant directorate. Clinical teams have discussed at length and conversations continue. There is substantial clinical concern around PIFU for this patient group

## Future actions
- Specialties are focusing on increasing PIFU as part of pathway redesign. Some have increased usage by targeting particular patient groups e.g. overdue follow ups, DNAs
- Divisions will use monthly data provided to review PIFU usage at specialty and consultant level to target actions

# Delayed discharges

**NHS Cambridge University Hospitals NHS Foundation Trust**

| Apr-23 | Target |
|--------|--------|
| 116.1 | N/A |

| SPC Variance |
|--------------|
| Normal variation |

| Shelford Group Avg |
|--------------------|
| N/A |

| Three Month Forecast | | |
|--------|--------|--------|
| May-23 | Jun-23 | Jul-23 |
| N/A | | |

### SPC - Beds lost to delayed discharges



## Bed days lost by pathway

| Total beds lost to delays | Apr-23 | %total |
|---------------------------|--------|--------|
| Pathway 1 | 37.9 | 33% |
| Pathway 2 | 26.4 | 23% |
| Pathway 3 | 25.4 | 22% |
| Being assessed - Internal | 15.0 | 13% |
| Pathway 0 | 7.9 | 7% |
| Being assessed - External | 3.4 | 3% |
| Data quality | 0.1 | 0% |
| TOTAL | 116.1 | - |
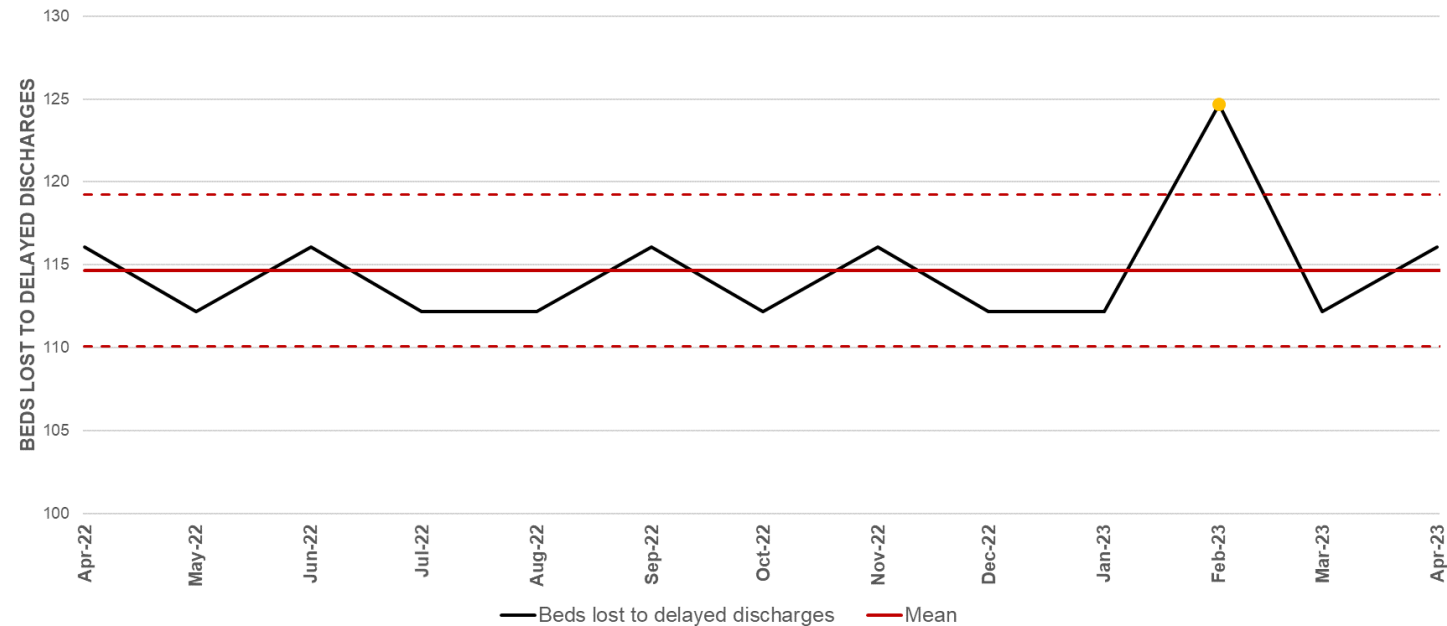
## Updates since previous month

- Over the last 12 months the Trust has lost an average of 115 beds to patients past their clinically fit date (CFD). In April that increased to 116.
- The majority of beds (77%) were lost to complex discharge pathways 1-3

## Key dependencies

- Effective implementation of the Transfer of Care Hub to support the prompt processing of referrals for packages of care
- Working across the ICB to jointly manage complex pathways

## Current issues

- One third of all beds lost to post-CFD delays relate to pathway 1 (support to recover at home) as domiciliary care capacity is insufficient to meet demand
- ~40 beds are lost to out-of-county patients, with whom we have less direct influence

## Future actions

- Pilots of Trusted Assessors and Discharge to Assess to identify opportunities to streamline complex pathways
- Utilisation of the new national 'Discharge Ready' metric to identify areas for improvement
- Focused recruitment to pathway 1 to increase capacity

# Theatre Utilisation - Elective GIRFT Capped

**NHS**
Cambridge
University Hospitals
NHS Foundation Trust

| Apr-23 | Plan |
|--------|------|
| 79.2% | 80.0% |

## SPC Variance
Normal variation

## Shelford Group Avg
N/A

## Three Month Forecast
| May-23 | Jun-23 | Jul-23 |
|--------|--------|--------|
| 81.0% | 82.0% | 83.0% |



SPC - Theatre utilisation (elective GIRFT capped)

— % Theatre utilisation   — Mean   ······ 23/24 Trajectory
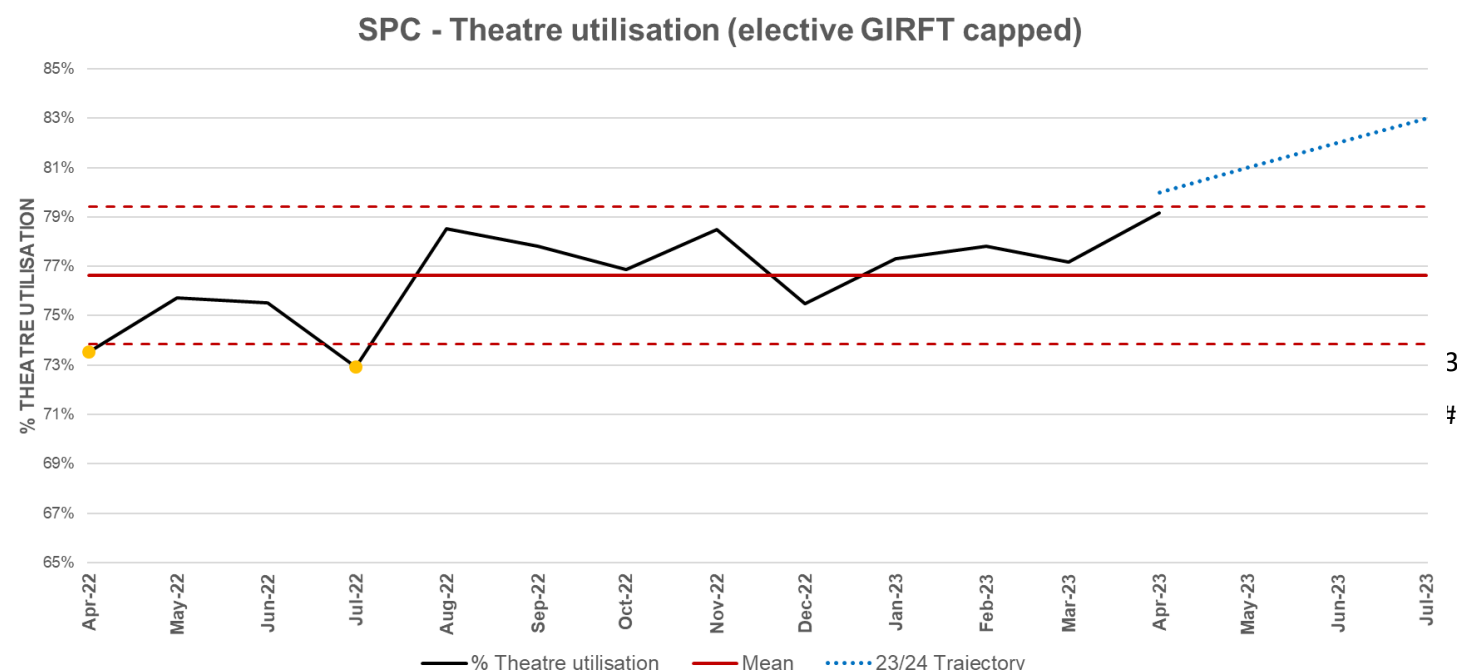
## Utilisation by department

| Department | Utilisation |
|------------|-------------|
| ATC | 82% |
| Main | 80% |
| Rosie | 80% |
| CEU | 71% |
| Ely | 67% |

## Updates since previous month
- April capped utilisation was 79%, improving to 80% when the BMA strike dates are excluded
- Sessions used in April were 96.9% when strike dates are excluded.

## Key dependencies
- Low short notice cancellations
- Ability to readily back fill cancellations requiring pool of pre-assessed patients
- Efficient start times and turnaround times
- Optimum scheduling with 6-4-2 oversight.

## Current issues
- The majority of our theatres are in Main and ATC where capped utilisation is highest at 80% and 82%
- The CEU and Ely locations is where the focus of improvement continues.

## Future actions
- Focus on templating Ely sessions commencing with Digestive Diseases and Orthopaedics
- Identification of Paediatrics and Neurosurgery as areas of focus for start time delays. Paediatrics to benchmark with peers.

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# BADS Daycase Rates

| Mar-23 | Target |
|--------|--------|
| 86.3% | N/A |

## SPC Variance

Normal variation

## National Avg (Mar-23)

81.4%

## Three Month Forecast

| Apr-23 | May-23 | Jun-23 |
|--------|--------|--------|
| N/A | | |

### SPC - % BADS Daycase rate



## BADS Section Day Case Rate for HVLC focus areas

| | 3 Months to Jan 2023 | | | Mar-23 |
|--------------|------|-----------------|----------|------------------|
| | CUH | Shelford Peers | Quartile | CUH using 0 LOS |
| Orthopaedics | 84.4% | 81.5% | 2 | 92.4% |
| ENT | 77.2% | 80% | 1 | 81% |
| General Surgery | 66% | 71% | 1 | 81.1% |
| Gynaecology | 51.5% | 63.9% | 1 | 78.9% |
| Ophthalmology | 97.8% | 98.2% | 2 | 99.1% |
| Urology | 69% | 69.6% | 2 | 71.6% |
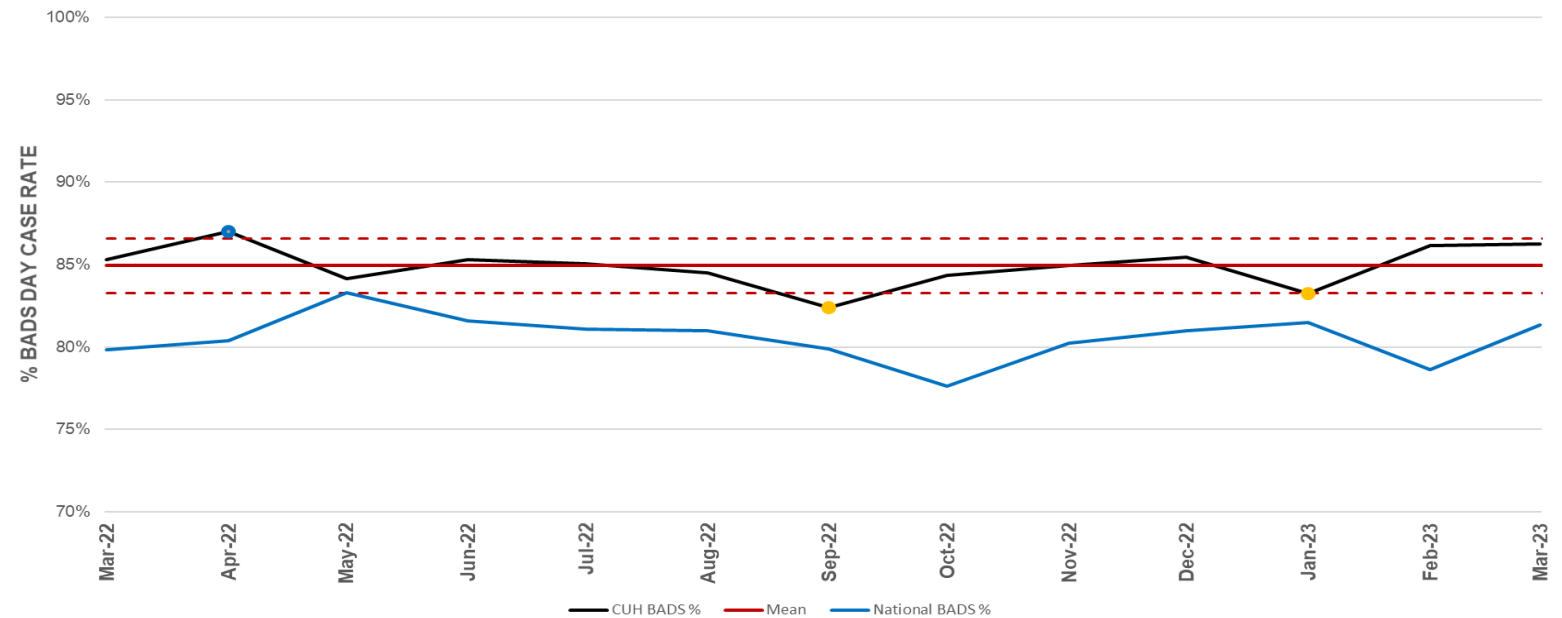
## Updates since previous month

- Model Hospital GIRFT data 3 months to Jan-23 shows improvement to 80.3%
- Local BADS reporting to Mar-23 shows 86.3%.

## Current issues

- Inaccurate recording of Intended Management as daycase reflects in poorer performance externally
- 103 zero LOS BADS procedures were recorded as in-patients in Q4.

## Key dependencies

- Correct data recording of Intended Management
- Effective patient flow on L2DSU
- Clinically led discharge criteria.

## Future actions

- Ongoing focus on lap chole where performance benchmarks very poorly nationally
- Lap chole and hernia nurse led discharge focus in L2
- Increase Urology access to Ely capacity now equipment for key BADS procedures is in place.

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# Discharge Summaries

**NHS**
**Cambridge University Hospitals**
**NHS Foundation Trust**

**Weekly: Letters - discharge summary- starting 28/03/21**

Operational Performance

94.0%
92.0%
90.0%
88.0%
86.0%
84.0%
82.0%
80.0%

71%

Mar 21, Apr 21, Apr 21, May 21, May 21, Jun 21, Jun 21, Jul 21, Jul 21, Aug 21, Aug 21, Aug 21, Sep 21, Sep 21, Oct 21, Oct 21, Nov 21, Nov 21, Dec 21, Dec 21, Jan 22, Jan 22, Jan 22, Feb 22, Feb 22, Mar 22, Mar 22, Apr 22, Apr 22, May 22, May 22, Jun 22, Jun 22, Jul 22, Jul 22, Jul 22, Aug 22, Aug 22, Sep 22, Sep 22, Oct 22, Oct 22, Nov 22, Nov 22, Dec 22, Dec 22, Jan 23, Jan 23, Jan 23, Feb 23, Feb 23, Mar 23, Mar 23, Apr 23, Apr 23, May 23

— Mean — Perfomance % — Process limits - 3σ ● Special cause - concern ● Special cause - improvement — — Target

**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          **Together-Safe | Kind | Excellent**

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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 - Apr 23 | Month | - | 94.4% | 95.7% | | - | - | For April there was no change in the Good score, however the Poor score increased by 1% compared to March and is now the higest for the past 13 months. The number of FFT responses declined by 50 responses compared to March, and is one of the lowest for the past 12 months. 14 wards did not collected FFT. Pre pandemic # of FFT responses is 850-950. **FOR APR: there were 305 FFT responses collected from approx. 3,3554 patients.** |
| FFT Inpatient poor experience score | Jul 20 - Apr 23 | Month | - | 3.0% | 1.5% | | - | - | |
| FFT Outpatients good experience score | Apr 20 - Apr 23 | Month | - | 94.3% | 95.0% | | | - | For April there was no change in the Good score or the Poor score compared to March . The Poor score of 2.6% is very low and not a concern. There was 1 FFT response collected from paediatric clinics so the FFT scores mainly reflect adult clinics. **FOR APR: there were 4,359 FFT responses collected from approx. 23,801 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 - Apr 23 | Month | - | 2.6% | 2.4% | H | S7 | - | |
| FFT Day Case good experience score | Apr 20 - Apr 23 | Month | - | 97.0% | 96.5% | | - | - | For April there was a small increase in Good score from 96.4% in March to 97%. There was no change in the Poor score compared to March. Both scores have remained consistent with no more than 1% change throughout the last 12 months. **FOR APR: there were 997 FFT responses collected from approx. 3,933 patients.** |
| FFT Day Case poor experience score | Apr 20 - Apr 23 | Month | - | 1.7% | 1.7% | | - | - | |
| FFT Emergency Department good experience score | Apr 20 - Apr 23 | Month | - | 81.7% | 83.6% | L | S7 | - | For April the overall Good score improved by 6% compared to March, and the Poor score also improved by 4.5%. The adult Good score of 82.1% and the Poor score of 11.8% are the strongest scores since 2021. The paeds Good score improved 3% compared to March and the Poor score improved 4.5%. **FOR APR: there were 870 FFT responses collected from approx. 4,999 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 - Apr 23 | Month | - | 11.0% | 10.1% | H | S7 | - | |
| FFT Maternity (all FFT data from 4 touchpoints) good experience score | Jul 20 - Apr 23 | Month | - | 93.5% | 94.9% | | - | - | **FOR APR:** Antenatal had 3 FFT response; 66.7% Good / 33.3% Poor. Birth had 53 FFT responses out of 411 patients; 98.1% Good / 2% Poor. Postnatal had 113 FFT responses: LM had 86 FFT with 89.5% Good / 7.0% Poor (scores declined compared to Mar), DU had 4 FFT with 100% Good / BU had 19 FFT with 100% Good, and COU 100% Good from 4 responses. 0 FFT responses from Post Community. **APR MATERNITY OVERALL:** Good score decreased by 2% and Poor score increased 2% compared to March. The change in overall scores is from both Antenatal and Postnatal Lady Mary. There were 169 FFT responses collected. |
| FFT Maternity (all FFT data from 4 touchpoints) poor experience score | Jul 20 - Apr 23 | Month | - | 4.7% | 1.8% | | - | - | |

71%

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 April, some Good scores remained consistent such as outpatient and inpatient. A&E had a 6% increase in the Good score and the improvement is from both adult and paediatrics. Maternity had a 2% decrease in the Good score, mainly from antenatal and Lady Mary. The Poor FFT score had no change for day case and outpatientts, but a 4.5% improvment for A&E, again from both adult and paediatrics. The Poor score for inpatient increased by 1% and a 2.5 increase for maternity. This was from antenatal, and Lady Mary.

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.

Patient Experience

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

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# PALS and Complaints Cases

| Indicator | Data range | Period | Target | Current period | Mean | Variance | Special causes | Target status | Comments |
|---|---|---|---|---|---|---|---|---|---|
| Complaints received | Apr19 - Apr 23 | month | - | 60 | 55 | H L | SP | - | The number of complaints received between Apr 2019 - Apr 2023 is higher than normal variance. |
| % acknowledged within 3 days | Apr 19 - Apr 23 | month | 95% | | 73% | L | SP | ? | 44 out of 60 complaints were acknowledged within 3 working days |
| % responded to within initial set timeframe (30, 45 or 60 working days) | Apr 19 - Apr 23 | month | 50% | 25% | 30% | L | S7 | ? | 64 complaints were responded to in April, 16 of the 64 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 | Apr 19 - Apr 23 | month | 80% | 58% | 87% | L | SP | ? | 37 out of 64 complaints responded to in April were within the initial set time frame or within an agreed extension date. |
| % complaints received graded 4 to 5 | Apr 19 -Apr 23 | month | - | 29% | 34% | | - | - | There were 17 complaints graded 4 severity, and 0 graded 5. These cover a number of specialties and will be subject to detailed investigations. |
| Compliments received | Apr 19 - Apr 23 | month | - | 7 | 32 | L | S7 | - | Compliment numbers are lower than usual due to administrative staff shortages |

**Complaint cases received in last 12 months by top 10 primary subject**

| Subject | Value |
|---|---|
| Clinical Treatment205 | 231 |
| Communications | 96 |
| Patient Care | 60 |
| Admissions and Discharges | 44 |
| Values and Behaviours | 39 |
| Appointments | 21 |
| Trust Admin/Policies11 | 21 |
| Waiting Times | 17 |
| Access to treatment | 13 |
| Facilities | 7 |

**PALS cases received in last 12 months by top 10 primary subject**

| Subject | Value |
|---|---|
| Appointments | 941 |
| communications | 869 |
| Clinical Treatment | 334 |
| Admissions and Discharges | 308 |
| Trust Admin/policies | 293 |
| Values and Behaviours | 254 |
| Patient care | 266 |
| Waiting times | 210 |
| Dual code | 183 |
| Other | 165 |

**PHSO** - There were no complaints accepted by the PHSO for investigation in April 2023.   **Completed actions** Due to current workload actions have not been reported this month.

Safety and Quality

**NHS Cambridge University Hospitals NHS Foundation Trust**

**Mortality**

| Indicator | Data range | Period | Current period | Mean | Variance | Special causes | Target status | Comments |
|---|---|---|---|---|---|---|---|---|
| **Total inpatient and Emergency department deaths** | May 2016- April 2020 | Apr-23 | **134** | *135.7* | | | – | April saw the end of a 13 month upward shift |
| **Emergency department** deaths | | | **13** | *7.9* | H | | – | There is a statistically significant increase with the last consecutive 9 months being above the mean - upward shift. |
| **Inpatient** deaths | | | **121** | *127.8* | | | – | 12 out of the last 14 months have been above the mean |
| Emergency Department and Inpatient deaths **per 1000 admissions** | | | **8.80** | *8.60* | | | - | |
| % of Emergency Department and Inpatient deaths in-scope for a Structured Judgement Review (SJR) | | | **16%** | *18%* | | - | - | In April 2023, 18 SJRs were commissioned and 3 PMRTs were commissioned |

**HSMR by Month**



**SHMI by Quarter**



**Phases of care in last 12 months**



**Pareto graph of in-scope SJR triggers in last 12 months**
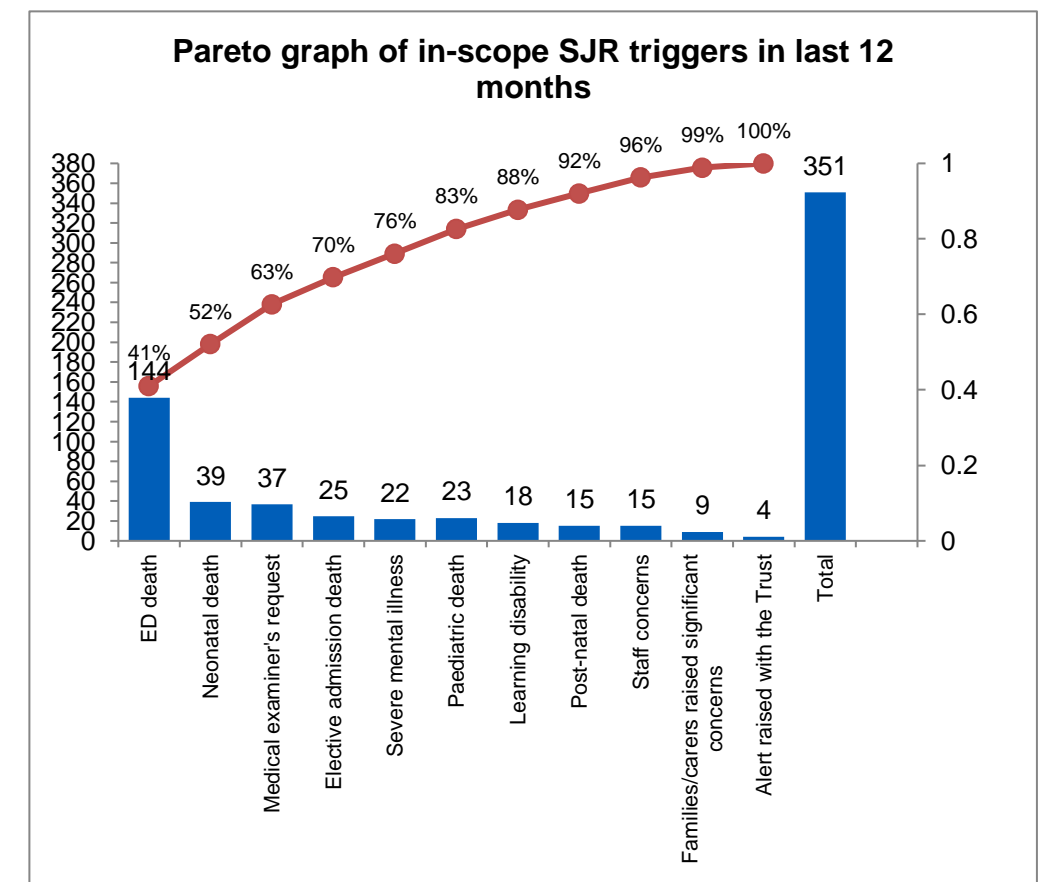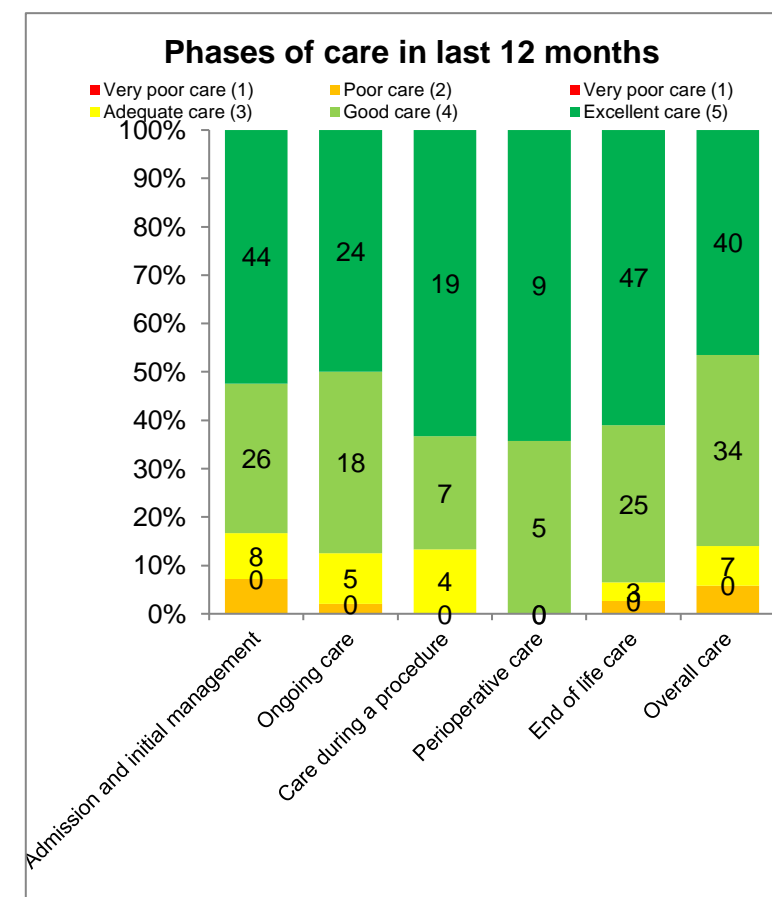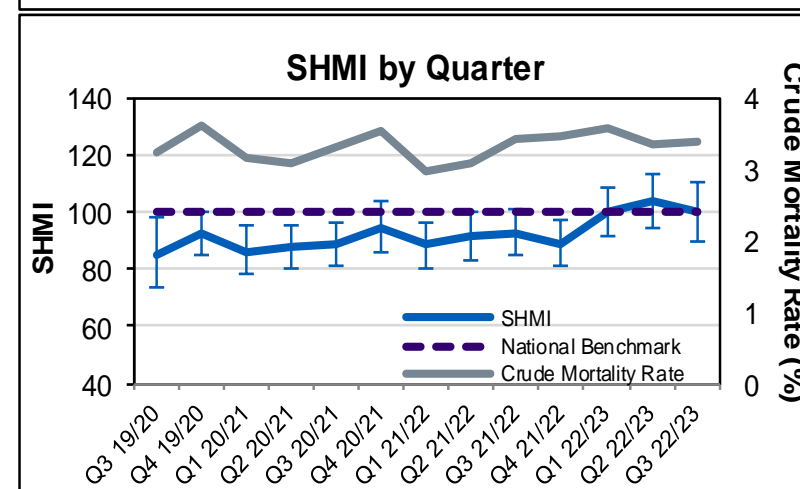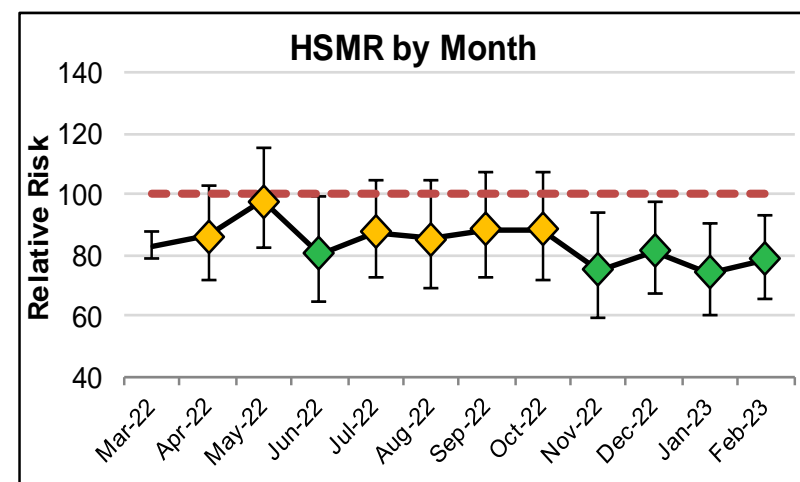


**Executive Summary**

**HSMR -** The rolling 12 month (March 2022 to February 2023) HSMR for CUH is 83.67, this is 6th lowest within the London and ATHOL peer group. The rolling 12 month HSMR for the Shelford Peer group is 94.15. **SHMI -** The Summary Hospital-level Mortality Indicator (SHMI) for CUH in the latest period, December 2021 to November 2022 is 96.52. **Alert -** There are 3 alerts for review within the HSMR and SHMI dataset this month.

There were no serious incidents associated with potentially/avoidable death commissioned in April 2023

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# Stroke Care

**NHS Cambridge University Hospitals NHS Foundation Trust**

## Stroke Measures

### 4 hours admission to SU



Legend: Denominator · Breached 4hrs · % 4h Admission to SU if applicable · Target
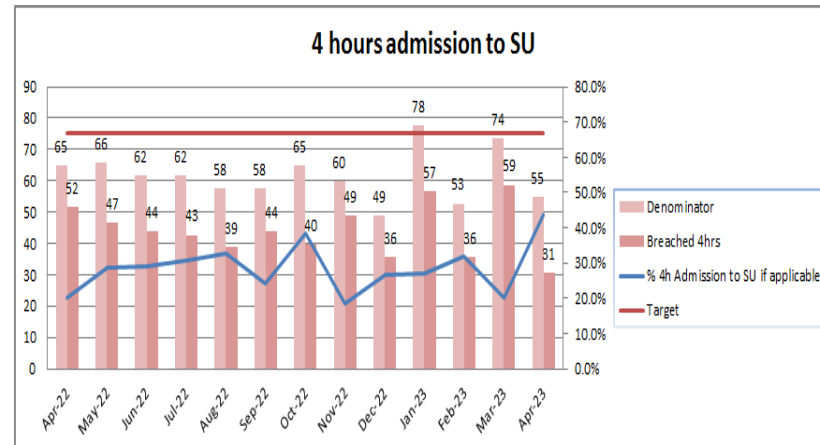
| Themes | Pt |
|---|---|
| Awaiting senior review | 3 |
| Difficult diagnosis. MRI confirmd new stroke | 2 |
| Inpatient Stroke | 1 |
| Stroke Bed Capacity | 3 |
| Not referred on arrival | 6 |
| Trust Bed Capacity | 16 |
| **Total** | **31** |
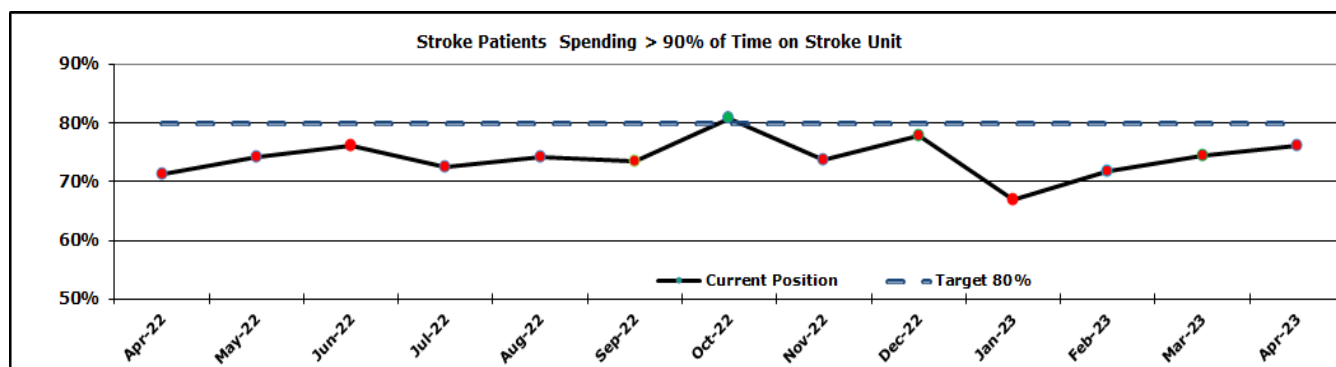
**90% target (80% Patients spending 90% IP stay on Stroke ward)** was not achieved for April 2023 = **76.2%**
'Trust Bed Capacity' (6) was the main factor contributing to breaches last month, with a total of 15 cases in April 2023.

**4hrs adm to SU (67%)** target compliance was not achieved in April = **43.6%**

#### Key Actions

- On 3rd December 2019 the Stroke team received approval from the interim COO to ring-fence one male and one female bed on R2. This is enabling rapid admission in less than 4 hours. The Acute Stroke unit continues to see and host a high number of outliers. Due to Trust challenges with bed capacity the service is unable to ring-fence a bed at all times. Instead it is negotiated on a daily basis according to the needs of the service and the Trust.
- 20% of the stroke unit bed base is occupied by general medical outliers
- We are writing a SOP for both R2 and Lewin wards that will help bed management particularly overnight to ensure 2 beds are kept available for acute stroke cases and to ensure agreed national nursing levels for stroke units are maintained at all times.
- We have put in bids to pilot an ACP role on the stroke unit to help with lack of junior staff and to do nurse led discharges to help flow.
- We have put in a bid to the CCG for an 8a coordinator role to help coordintate flow from the ED = to the HASU - to R2 and then to the community ESD beds and ESD and to lewin and T2/RPH beds.
- National SSNAP data shows Trust performance from Oct - Dec 22 at Level B.
- Stroke Taskforce meetings remain in place, plus weekly review with root cause analysis undertaken for all breaches, with actions taken forward appropriately.
- The stroke bleep team continue to see over 200 referrals in ED a month, many of those are stroke mimics or TIAs. TIA patients are increasingly treated and discharged from ED with clinic follow up. Many stroke mimics are also discharged rapidly by stroke team from ED. For every stroke patient seen, we see three patients who present with stroke mimic.

### Stroke Patients Spending > 90% of Time on Stroke Unit



Legend: Current Position · Target 80%

### 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%) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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% |
| Dec-22 | 1 | 6 | | | | | 1 | | 1 | | | | 4 | | | | 13 | 73.5% |
| Jan-23 | | 14 | | | | | 3 | 4 | | | | | 6 | | | 1 | 28 | 67.1% |
| Feb-23 | 2 | 7 | | | | | 1 | 2 | | | | | 6 | | | | 18 | 71.9% |
| Mar-23 | 1 | 9 | | | | 2 | 3 | 1 | | | 1 | | 3 | 2 | | | 22 | 74.4% |
| Apr-23 | 3 | 6 | | | | | 3 | | | | 2 | | | 1 | | | 15 | 76.2% |
| **Summary** | **22** | **93** | **0** | **0** | **0** | **10** | **15** | **16** | **1** | **2** | **3** | **0** | **45** | **9** | **0** | **12** | **228** | |

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

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# Clinical Studies

**NHS**
**Cambridge University Hospitals**
NHS Foundation Trust

## Total Trust Recruitment in FY
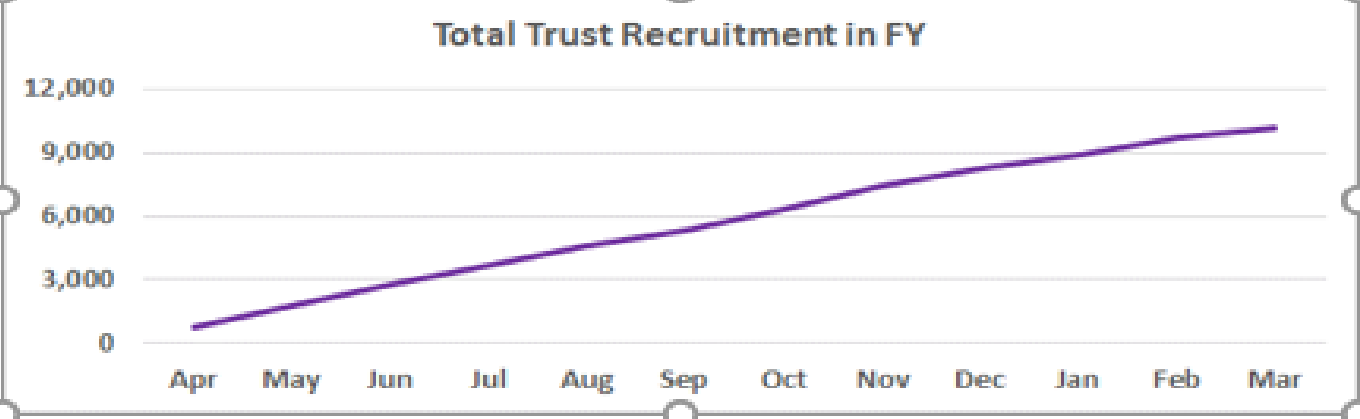


## Total Recruitment at end of FY 2022-23

| 10,150 |
|---|

## Recruiting Studies at end of FY 2022-23

|  |  | |  |  |
|---|---|---|---|---|
| Open | 264 | Non Commercial | 274 |
| Closed | 63 | Commercial | 56 |
| Suspended | 3 | | |
| Total | 330 | | |

## Recruitment by East of England Trusts in FY

| Trust | Value |
|---|---|
| CUH | 10,150 |
| E&NH | 3,689 |
| N&NUH | 3,491 |
| ES&NE | 2,690 |
| BH | 1,712 |
| QEH | 1,158 |
| JPUH | 1,150 |
| RPH | 1,102 |
| C&P | 835 |
| WS | 805 |
| NWA | 795 |
| EoE AS | 654 |
| CCS | 416 |

■ Interventional  ■ Observational  ■ Both

## Top 10 CUH Recruiting Specialities FY

| Speciality | Value |
|---|---|
| Reproductive Health and Childbirth | 3,077 |
| Cancer | 1,653 |
| Trauma and Emergency Care | 1,077 |
| Diabetes | 635 |
| Genetics | 564 |
| Children | 523 |
| Anaesthesia, Perioperative Medicine and Pain Management | 458 |
| Stroke | 455 |
| Renal Disorders | 381 |
| Dementias and Neurodegeneration | 374 |

**Situation as at end of FY March 2023** (Data cut taken on 6th April.)

* Total recruitment in the financial year to date: 10,150
* CUH accounted for 35% of total recruitment by Eastern Trusts in the financial year to date. Interventional only studies accounted for 17% of the total, while Observational only studies accounted for 49% of the total. The remaining 34% were both Interventional and Observational .
* Recruitment to the Reproductive Health speciality accounted for 27% of all recruitment (3,077). Second was Cancer (1,653). All of the other individual specialities accounted for less than 10% of the total recruitment.
* There were 330 recruiting studies, of which 56 were Commercial, and 274 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 .

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# Maternity Dashboard

## East of England Regional Perinatal Quality Oversight Group Highlight Report (v19.8)

**KEY: CQC DOMAINS**

| | |
|---|---|
| Outstanding | |
| Good | |
| Requires Improvement | |
| Inadequate | |

NHS England
East of England

| LMNS: | Reporting period: | Overall System RAG: |
|---|---|---|
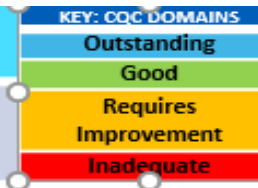
### REGULATORY BODIES
### CQC DOMAINS

**Maternity Measures**

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

71%

| CQC alerts (active alerts & year) | Ref C260/AS Puerperal sepsis July 2019 | |
|---|---|---|
| CQC warning notice (29a) | n/a | |
| Regulatory letters from coroner (28) | n/a | |
| Maternity Safety Support Programme (Date of entry / stage) | Not in maternity safety support programme | |

### QC Maternity survey results (2021)

| | CUH |
|---|---|
| CQC Maternity survey overall rating – improvement since previous year (Y/N) | N |

| Survey scores: | 2022 v 2021 |
|---|---|
| Start of your care during pregnancy | 5.7 v 5.1 |
| Antenatal check ups | 8.0 v 7.7 |
| During your pregnancy | 8.3 v 8.3 |
| Your labour and birth | 7.5 v 7.9 |
| Staff caring for you | 7.8 v 8.2 |
| Care in hospital after birth | 7.6 v 6.9 |
| Feeding your baby | 8.2 v 7.9 |
| Care at home after birth | 7.1 v 7.2 |

### External stakeholder concerns (please give brief reason)

| Trust | CUH |
|---|---|
| Strategic oversight Framework Score | Regional team to complete |
| NMC concerns | 0 |
| GMC concerns | 0 |
| RCM concerns | 0 |
| HEE concerns | 0 |
| HSIB concerns | 0 |
| CQC concerns | 0 |
| Total number of stakeholder concerns | 0 |

### Other surveys

| | |
|---|---|
| GMC survey results (2022) overall satisfaction | Guidance required |

1 |

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# Maternity Dashboard

**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 | |
| 7 | Service user feedback / Maternity Voice Partnership | |
| 8 | Core competency framework / Multi-prof training | |
| 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 |

If 'not compliant' or working towards / partially compliant' please give reason why, mitigation and action needed to achieve compliance on slide 7

## 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 | |
| 5 | Reducing pre-term birth | |
| 6 | Diabetes in Pregnancy (not in use at present) | |
| | SBLCBv2 Fully compliant (National Tool) | YES |
| | SBLCBv2 Fully compliant (Regional assessment) | |

71%

## 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 | Rosie Hospital Strategy to be co produced with MVP Resource needed for SI reviews across the LMNS |
| IEA2: Listening to Women & Families | |
| IEA3: Staff training & Working Together | Ongoing work with monitoring training via a dashboard |
| iEA4: Managing complex pregnancy | Notification of pregnancy pathway |
| IEA5: Risk Assessment Throughout pregnancy | Cross border working and PCSP compliance |
| IEA6: Monitoring Fetal wellbeing | |
| IEA7 Informed consent : | Informed choice and consent policy co production underway |
| • Fully compliant (self assessment) | Partially compliant and working towards |
| • Fully compliant (regional assessment following insight visit ) | |

Author(s):   Owner(s): Claire Garratt

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# Maternity Dashboard

**Additional intelligence**

NHS

## 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) | | | | | |
| CUH | 10 | 10 | 10 | 10 | TBC | | | | |

| | 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 | • Lack of referral to preterm surveillance cross border issues |
| 4. Listening to women (sources, engagement / activities undertaken) | • **Complaint themes (n=7) and concerns (7) themes:** delays in care and pain relief, delay in responding to test results, issues with staff attitude and conflicting information, issues with communication with community midwives, concerns regarding birth centre safe staffing levels.<br>• FFT good responses Jan-Apr'23: Delivery Unit = 97.4%, RBC 96.8%, LMW 93.&%, **OCOU 100%** |
| 5. Listening to staff (eg activities undertaken, surveys and actions taken as a result) | • Entonox safe use video shared with staff via email and facebook<br>• Community listening event and day workshop – realigned community teams to improve geographical working<br>• PMA engagement with staff addressing themes of return to work anxiety on a 1:1 basis and additional PMA/PD support put in place. |

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# Maternity Dashboard

**NHS Cambridge University Hospitals NHS Foundation Trust**

**Maternity Measures**

| Sources / References | KPI | Goal | Target | Measure | Data Source | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 | Apr-23 | SPC | Narrative and Actions taken for Red/Amber/Special cause concerning trend results |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Activity** | | | | | | | | | | | | | |
| National Maternity Dashboard | Births | For information | N/A | Births per month | Rosie KPIs | 461 | 443 | 437 | 438 | 454 | 415 | | |
| Antenatal Care ICS contracted booking KPI | Health and social care assessment <GA 12+6/40 | > 90% | >=90% <90% and >=80% <80% | Booking Appointments | Epic | 74.00% | 76.00% | 89.90% | 91.69% | 91.69% | 95.48% | | |
| National Maternity Dashboard | Booking Appointments | For Information | N/A | Booking Appointments | Epic | 611 | 614 | 467 | 303 | 361 | 310 | | |
| Source - EPIC | Vaginal Birth (Unassisted) | For Information | N/A | SVD's in all birth settings | Rosie KPIs | 50.76% | 49.44% | 47.37% | 53.88% | 57.05% | 47.47% | | |
| Source - EPIC | Home Birth | For Information | N/A | Planned home births (BBA is excluded) | Rosie KPIs | 1.08% | 1.58% | 0.92% | 0.23% | 1.32% | 0.96% | | |
| Source - EPIC | Rosie Birth Centre Birth | For Information | N/A | Births on the Rosie Birth Centre | Rosie KPIs | 15.40% | 13.32% | 13.73% | 17.58% | 14.32% | 13.73% | | |
| Source - EPIC | Rosie Birth Centre transfers | For information | N/A | Women admitted to RBC and subsequently transferred for birth | Rosie KPIs | 14.95% | 9.63% | 46.32% | 35.19% | 43.00% | 47.06% | | |
| Source - EPIC | Induction of Labour | For Information | N/A | Women induced for birth | Rosie KPIs | 34.29% | 34.17% | 34.57% | 29.93% | 29.13% | 38.20% | | |
| NICE - Red Flag | Delay in commencement of Induction (IOL) | 0% | <10% | Percentage of Inductions where Induction commencement was postponed >2 hours (flag 1) | Red Flags | 33.33% | 33.16% | 27.47% | 24.85% | 31.29% | 27.03% | | Review needed of reporting parameters as differs to NICE guidance which defines red flag as >2 hours from "beginning process" and we report beginning of preocess as administering prostaglandins which doesn't account for pre-IOL observations, consent process and CTG. |
| NICE - Red Flag | Delay in continuation of Induction (IOL) | 0% | <10% | Percentage of Induction continuation when suitable for ARM delayed for more than 6 hours (flag 3) | Red Flags | 11.46% | 9.36% | 7.14% | 7.27% | 5.52% | 10.27% | | Rate of IOL in April (38%) almost 10% higher than previous 2 months. |
| SBLCBV2 | Indication for IOL (SBLCBV2) | NA | NA | Percentage of IOL where reduced fetal movements is the only indication before 39 weeks | IOL Team | 0% | 0% | 0.55% | 0% | 0% | 0.64% | | 1 x RFM IOL <39 weeks |
| Source - EPIC | Indication for IOL | 100% | ≥95% | Percentage of IOL with a valid indication as per guidance. | IOL Team | 100% | 100% | 97.80% | 100% | 100% | 99.36% | | 1 x RFM IOL <39 weeks |
| Source - EPIC | Birth assisted by instrument (forceps or ventouse) ( Instrumental) | For Information | N/A | Instrumental birth rate | Rosie KPIs | 13.23% | 11.29% | 11.67% | 10.73% | 10.57% | 11.81% | | |
| Source - EPIC | CS rate (planned & unplanned) | For Information | N/A | C/S rate overall | Rosie KPIs | 36.00% | 39.28% | 40.96% | 34.47% | 42.95% | 40.24% | | |
| CQIM / CNST | Women in RG*1 having a caesarean section with no previous births: nullip spontaneous labour | For information | 10% | Relative contribution of the Robson group to the overall C/S Rate | Rosie KPIs | 15.4% | 12.8% | 12.90% | 14.70% | 14.90% | 20.30% | | |
| CQIM / CNST | Women in RG*2 having a caesarean section with no previous births: nullip induced labour, nullip pre-labour LSCS | For Information | For Information | Relative contribution of the Robson group to the overall C/S Rate | Rosie KPIs | 47.4% | 49.6% | 53.10% | 48.90% | 59.80% | 50.80% | | |
| 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 | 1:3.28 | 1:5.72 | 1:5.45 | 1:3.14 | 1:4.69 | 1:3.75 | | |
| 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 | 75.7% | 84.3% | 90.7% | 79.1% | 91.5% | 86.4% | | |
| CQIM / CNST | Women in RG1, RG2, RG5 combined contribution to the overall C/S rate. | 66% | 60-70%, | Relative contribution of the Robson group to the overall C/S Rate | Rosie KPIs | 68% | 66.9% | 61.5% | 60.9% | 60.0% | 68.3% | | |
| Source - Rosie Divert Folder | Divert Status - incidence | 0 | <1 | Incidence of divert for the perinatal service | Rosie Diverts | 0 | 3 | 3 | 1 | 2 | 0 | | |
| Source - Rosie Divert Folder | Total number of hours on divert | For information | N/A | | Rosie Diverts | 0 | 93 | 16.5 | 12 | 20.5 | 0 | | |
| Source - Rosie Divert Folder | Admissions during divert status | For information | N/A | | CHEQs | 0 | 0 | 0 | 0 | 2 | 0 | | |
| Source - Rosie Divert Folder | Number of women giving birth in another provider organisation due to divert status | For information | N/A | | Rosie KPIs | 0 | 5 | 2 | 0 | 0 | 0 | | |

Author(s):

Owner(s): Claire Garratt

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# Maternity Dashboard

**Maternity Measures**

## Workforce

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Birth Rate Plus | Midwife/birth ratio (actual)** | 1:24 | <1.28 | Total permanent and bank clinical midwife WTE*/Births (rolling 12 month average) | Finance | 1:23.5 | 1:23.4 | 1:23.5 | 1:24 | 1:23.6 | 1:24.5 | | | |
| Birth Rate Plus | Midwife/birth ratio (funded)** | For information | 1.24.1 | Total clinical midwife funded WTE*/Births (rolling 12 month average) | Finance | 1:23.2 | 1:23.3 | 1:23.3 | 1:23.8 | 1:23.7 | 1:23.7 | | | Midwife/birth ratio based on the BR+ methodology |
| Safer Chilbrith / CNST | Supernumerary Delivery Unit Coordinator | 100% | ≥95% | Percentage compliance with Delivery Unit coordinator remaining supernumerary (no caseload of their own during a shift) | Red Flags / BR+ | 100% | 100% | 100% | 100% | 100% | 100% | | | |
| Source - CHEQS | Staff sickness as a whole | < 3.5% | <5% | ESR Workforce Data | CHEQS | 6.63% | 6.51% | 6.36% | 6.19% | 5.74% | | | | This is reported 1 month behind from CHEQs. |
| Core Competency Framework | Education & Training - mandatory training - overall compliance (obstetrics and gynaecology) | >92% YTD | >75% YTD | Total Obstetric and Gynaecology Staff (all staff groups) compliant with mandatory training | CHEQS | 88.6% | 87.1% | 89.8% | 90.2% | | | | | This is reported 2 months behind on CHEQS. |
| 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 | 87.27% | 93.94% | | 84.53% | 70.58% | 73.97% | | | March PROMPT cancelled due to medical strikes. Ongoing sessions from April onwards are overbooked so that backlog can be caught up. |
| 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 | 93% | 89% | 86% | 87% | 87% | 84% | | | MW compliance = 88%, NICU medical = 77%, NICU nursing = 78% |
| 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 | 88.41% | 91.38% | 89.58% | 84.58% | 85.71% | 90.18% | | | |
| 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% | 92.74% | | 86.46% | 72.11% | 80.45% | | | Difficulties with medical team attendance and this is being addressed by obstetric lead for fetal surveillance. |
| Core competency Framework | Education & Training - mandatory training - **midwifery compliance**. | >92% YTD | >75% YTD | Proportion of midwifery compliance with mandatory training, inclusive of mandated e-learning and mandated face to face sessions. | CHEQS | 89.9% | 85.1% | 88.5% | 88.7% | 87.3% | | | | 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 | 1.32% | 0.92% | 0.93% | 0.46% | 0.46% | 0.49% | | | |
| 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 | 0 | 2 | 1 | 1 | | | short ITU admission for sepsis |
| NMPA | Massive Obstetric Haemorrhage ≥ 1500 mls - vaginal birth | ≤3.3% | ≤3.3% | Percentage of women with a PPH >1500mls (singleton births between 37+0-42+6) having a vaginal birth | Rosie KPIs | 4.98% | 6.00% | 6.05% | 6.82% | 7.17% | 3.75% | | | Notable improvement seen - less than 4% for the first time since Sept'22. |
| NMPA | Massive Obstetric Haemorrhage ≥ 1500 mls - caesarean birth | ≤4.5% | ≤4.5% | Percentage of women with a PPH ≥1500mls (singleton births between 37+0-42+6) having a caesarean section | Rosie KPIs | 2.99% | 3.68% | 3.97% | 3.28% | 1.32% | 2.90% | | | |
| NMPA | 3rd/ 4th degree tear rate | ≤3.5 | <5% | Percentage of women with a vaginal birth having a 3rd or 4th degree tear (spontaneous and assisted by instrument) singleton baby in cephalic position between 37+0 and 42+6. | Rosie KPIs | 3.20% | 2.40% | 5.24% | 7.22% | 2.95% | 5.42% | | | 3.6% for unassisted births (green) / 12.5% for assisted birth (red) |
| CQC KLOE | Maternal readmission rate | For information | N/A | Percentage of women readmitted to maternity service within 42 days of birth. | Rosie KPIs | 1.54% | 2.06% | 2.26% | 2.84% | 2.64% | 1.55% | | | |
| MBRRACE | Peripartum Hysterectomy | For information | N/A | Incidence of peripartum hysterectomy | QSIS | 0 | 0 | 0 | 1 | 1 | 2 | | | both anticipated as percreta cases |
| MBRRACE | Direct Maternal Death | 0 | <1 | | QSIS | 0 | 0 | 0 | 0 | 0 | 0 | | | |

71%

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# Maternity Dashboard

**Maternity Measures**

71%

### Governance

| Source | Metric | Target | Threshold | Description | Source | M1 | M2 | M3 | M4 | M5 | M6 | Trend | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Source - QSIS | Total number of Serious Incidents (SIs) | 0 | <1 | Serious Incidents | QSIS | 0 | 0 | 0 | **1** | 0 | 0 | | |
| Source - QSIS | Never Events | 0 | <1 | DATIX | QSIS | 0 | 0 | 0 | 0 | 0 | 0 | | |

### Neonatal Morbidity

| Source | Metric | Target | Threshold | Description | Source | M1 | M2 | M3 | M4 | M5 | M6 | Trend | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MBRRACE / PMRT | Still Births per 1000 Births | 3.33/1000 (Mbrrace 2021) | | Incidence per 1000 births | CHEQs | | | 3.12:1000 | 2.75:1000 | **3.67:1000** | 2.94:1000 | | |
| MBRRACE / PMRT | Stillbirths - number ≥ 22 weeks | <3 | <6 | MBBRACE | CHEQs | 0 | 1 | 2 | 3 | 3 | 1 | | |
| Epic | Number of birth injuries | 0 | <1 | Percentage of babies born with a birth related injury | CHEQs | 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 | 0.86% | 1.35% | 1.84% | 0.69% | 2.01% | 1.94% | | |
| CQC KLOE | Incidence of neonatal readmission | For information | N/A | Percentage of babies readmitted within 42 days of birth | Rosie KPIs | 4.12% | 3.84% | 4.30% | 5.28% | 5.91% | 3.72% | | |
| 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 | 5.2% | **7.2%** | **6.9%** | 4.2% | 4.6% | **6.0%** | | Cases currently under review and will be reported at next monthly ATAIN meeting |
| 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

| Source | Metric | Target | Threshold | Description | Source | M1 | M2 | M3 | M4 | M5 | M6 | Trend | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CNST | 1-1 Care in Labour | >95% | >90% | Percentage of women receiving 1:1 care in labour (excluding BBAs) | Rosie KPI's | 100% | 100% | 99.5% | 100.0% | 100.0% | 99.8% | | |
| CQIM | Babies with a first feed of breastmilk | > 80% | >70% | Breastfeeding | Rosie KPI's | 84.8% | 83.52% | 82.15% | 84.02% | 84.12% | 81.55% | | |
| CNST / SBLCBV2 / PHE | SATOD (Smoking at Time of Delivery) | < 6% | Green = <6%, Amber = 6.1% - 7.9 %, Red = >8 | % of women identified as smoking at the time of delivery | Rosie KPIs | 3.74% | 7.34% | 6.41% | 3.02% | 5.73% | 5.60% | | |
| 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 | 98.6% | 86% | 95% | 96% | 94% | | | Reported 1 month behind due to manual audit. |
| 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 | **76%** | **63%** | **82%** | **78%** | **77%** | | | Reported 1 month behind due to manual audit. Non-compliance in community being followed-up with individuals. |
| Source - Epic | VTE Assessment - PN | >95% | >95% | Percentage of women with a valid PN VTE risk assessment completed within 4 hours of birth. | CHEQs | | | | | 82.6% | **85.2%** | | Report is new and currently under review to understand if this working correctly. |
| Source - EPIC | VTE Assessment - AN | >95% | >95% | Percentage of women with a valid VTE risk assessment completed on admission to hospital | CHEQs | | | | | **50.9%** | **51.5%** | | Report is new and currently under review to understand if this working correctly. |

Author(s):     Owner(s): Amanda Rowley

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# Staff in Post

**Workforce: Staff in Post**

## 12 Month Growth by Staff Group

| Staff Group | Headcount May-22 | Headcount Apr-23 | | Headcount 12 Month growth | FTE May-22 | FTE Apr-23 | | FTE 12 Month growth |
|---|---|---|---|---|---|---|---|---|
| Add Prof Scientific and Technic* | 244 | 257 | ⬆ | 5.3% | 224 | 236 | 12 ⬆ | 5.5% |
| Additional Clinical Services | 1,935 | 1,964 | ⬆ | 1.5% | 1,801 | 1,825 | 25 ⬆ | 1.4% |
| Administrative and Clerical | 2,403 | 2,497 | ⬆ | 3.9% | 2,197 | 2,277 | 80 ⬆ | 3.7% |
| Allied Health Professionals* | 724 | 741 | ⬆ | 2.3% | 640 | 656 | 17 ⬆ | 2.6% |
| Estates and Ancillary | 369 | 369 | ➡ | 0.0% | 352 | 356 | 4 ⬆ | 1.2% |
| Healthcare Scientists | 639 | 667 | ⬆ | 4.4% | 590 | 631 | 41 ⬆ | 7.0% |
| Medical and Dental | 1,668 | 1,718 | ⬆ | 3.0% | 1,581 | 1,630 | 49 ⬆ | 3.1% |
| Nursing and Midwifery Registered | 3,799 | 3,887 | ⬆ | 2.3% | 3,488 | 3,578 | 89 ⬆ | 2.6% |
| **Total** | **11,781** | **12,100** | ⬆ | **2.7%** | **10,872** | **11,190** | **318 ⬆** | **2.9%** |

### % Change Since Apr 2021



- % Increase from May 21 to Apr 23 (24months increase)
- % Increase from May 21 to Apr 22 (previous 12months increase)

## Admin & Medical Breakdown

| Staff Group | May-22 | Apr-23 | FTE 12 Month growth | | |
|---|---|---|---|---|---|
| **Administrative and Clerical** | 2,197 | 2,277 | 80 | ⬆ | 3.7% |
| *of which staff within Clinical Division* | 1,090 | 1,119 | 29 | ⬆ | 2.7% |
| of which Band 4 and below | 764 | 770 | 7 | ⬆ | 0.9% |
| of which Band 5-7 | 230 | 251 | 21 | ⬆ | 8.9% |
| of which Band 8A | 47 | 47 | 0 | ⬇ | -0.2% |
| of which Band 8B | 7 | 7 | 0 | ⬆ | 5.7% |
| of which Band 8C and above | 41 | 43 | 1 | ⬆ | 3.6% |
| *of which staff within Corporate Areas* | 875 | 909 | 34 | ⬆ | 3.9% |
| of which Band 4 and below | 249 | 244 | -5 | ⬇ | -2.1% |
| of which Band 5-7 | 413 | 434 | 21 | ⬆ | 5.1% |
| of which Band 8A | 80 | 86 | 7 | ⬆ | 8.2% |
| of which Band 8B | 52 | 54 | 1 | ⬆ | 2.6% |
| of which Band 8C and above | 82 | 92 | 11 | ⬆ | 12.8% |
| *of which staff within R&D* | 232 | 249 | 17 | ⬆ | 7.4% |
| | | | | | |
| **Medical and Dental** | 1,581 | 1,630 | 49 | ⬆ | 3.1% |
| of which Doctors in Training | 644 | 663 | 19 | ⬆ | 3.0% |
| of which Career grade doctors | 244 | 245 | 1 | ⬆ | 0.5% |
| of which Consultants | 693 | 722 | 29 | ⬆ | 4.2% |

71%

**What the information tells us:**

Overall the Trust saw a 2.9% growth in its substantive workforce over the past 12 months and 5.7% over the past 24 months. Growth over the past 24 months is lowest within Additional Clinical Services, with a decrease of 1.2%, and highest within Healthcare Scientists at 8.6%. Growth over the past 12 months is lowest within Estates and Ancillary with an increase of 1.2%, and highest within Healthcare Scientists at 7%.

*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
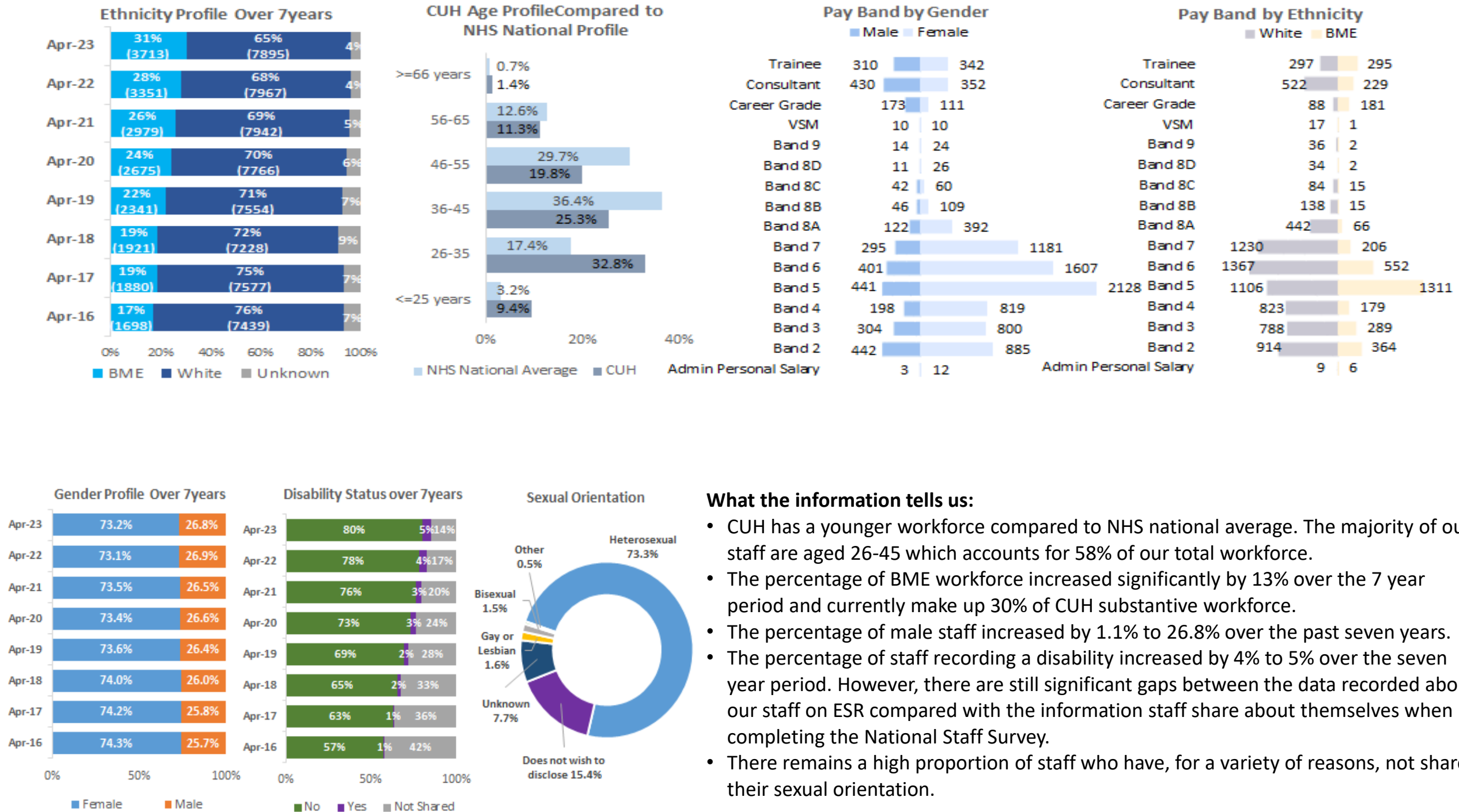
# Equality Diversity and Inclusion (EDI)

**Workforce: Equality Diversity and Inclusion (EDI)**

## Ethnicity Profile Over 7 years

| | BME | White | Unknown |
|---|---|---|---|
| Apr-23 | 31% (3713) | 65% (7895) | 4% |
| Apr-22 | 28% (3351) | 68% (7967) | 4% |
| Apr-21 | 26% (2979) | 69% (7942) | 5% |
| Apr-20 | 24% (2675) | 70% (7766) | 6% |
| Apr-19 | 22% (2341) | 71% (7554) | 7% |
| Apr-18 | 19% (1921) | 72% (7228) | 9% |
| Apr-17 | 19% (1880) | 75% (7577) | 7% |
| Apr-16 | 17% (1698) | 76% (7439) | 7% |

Legend: BME / White / Unknown

## CUH Age Profile Compared to NHS National Profile

| Age | NHS National Average | CUH |
|---|---|---|
| >=66 years | 0.7% | 1.4% |
| 56-65 | 12.6% | 11.3% |
| 46-55 | 29.7% | 19.8% |
| 36-45 | 36.4% | 25.3% |
| 26-35 | 17.4% | 32.8% |
| <=25 years | 3.2% | 9.4% |

Legend: NHS National Average / CUH

## Pay Band by Gender

| | Male | Female |
|---|---|---|
| Trainee | 310 | 342 |
| Consultant | 430 | 352 |
| Career Grade | 173 | 111 |
| VSM | 10 | 10 |
| Band 9 | 14 | 24 |
| Band 8D | 11 | 26 |
| Band 8C | 42 | 60 |
| Band 8B | 46 | 109 |
| Band 8A | 122 | 392 |
| Band 7 | 295 | 1181 |
| Band 6 | 401 | 1607 |
| Band 5 | 441 | 2128 |
| Band 4 | 198 | 819 |
| Band 3 | 304 | 800 |
| Band 2 | 442 | 885 |
| Admin Personal Salary | 3 | 12 |

## Pay Band by Ethnicity

| | White | BME |
|---|---|---|
| Trainee | 297 | 295 |
| Consultant | 522 | 229 |
| Career Grade | 88 | 181 |
| VSM | 17 | 1 |
| Band 9 | 36 | 2 |
| Band 8D | 34 | 2 |
| Band 8C | 84 | 15 |
| Band 8B | 138 | 15 |
| Band 8A | 442 | 66 |
| Band 7 | 1230 | 206 |
| Band 6 | 1367 | 552 |
| Band 5 | 1106 | 1311 |
| Band 4 | 823 | 179 |
| Band 3 | 788 | 289 |
| Band 2 | 914 | 364 |
| Admin Personal Salary | 9 | 6 |

71%

## Gender Profile Over 7 years

| | Female | Male |
|---|---|---|
| Apr-23 | 73.2% | 26.8% |
| Apr-22 | 73.1% | 26.9% |
| Apr-21 | 73.5% | 26.5% |
| Apr-20 | 73.4% | 26.6% |
| Apr-19 | 73.6% | 26.4% |
| Apr-18 | 74.0% | 26.0% |
| Apr-17 | 74.2% | 25.8% |
| Apr-16 | 74.3% | 25.7% |

Legend: Female / Male

## Disability Status over 7 years

| | No | Yes | Not Shared |
|---|---|---|---|
| Apr-23 | 80% | 5% | 14% |
| Apr-22 | 78% | 4% | 17% |
| Apr-21 | 76% | 3% | 20% |
| Apr-20 | 73% | 3% | 24% |
| Apr-19 | 69% | 2% | 28% |
| Apr-18 | 65% | 2% | 33% |
| Apr-17 | 63% | 1% | 36% |
| Apr-16 | 57% | 1% | 42% |

Legend: No / Yes / Not Shared

## Sexual Orientation

- Heterosexual 73.3%
- Other 0.5%
- Bisexual 1.5%
- Gay or Lesbian 1.6%
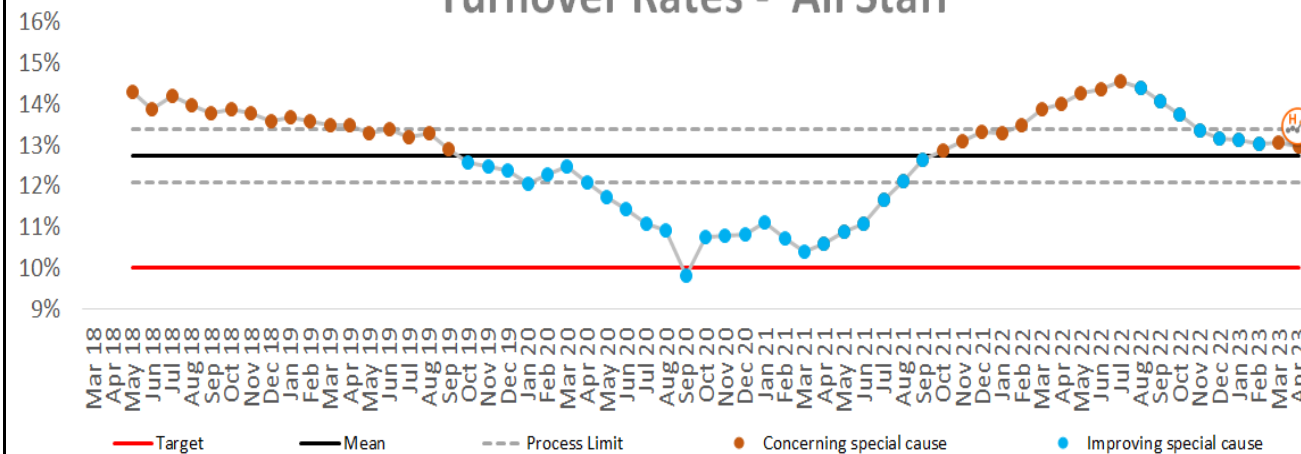- Unknown 7.7%
- Does not wish to disclose 15.4%

## 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 BME 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 1.1% to 26.8% 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.

Author(s): Chloe Schafer, Amanda Coulier   Owner(s): David Wherrett

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# Staff Turnover

**NHS Cambridge University Hospitals NHS Foundation Trust**
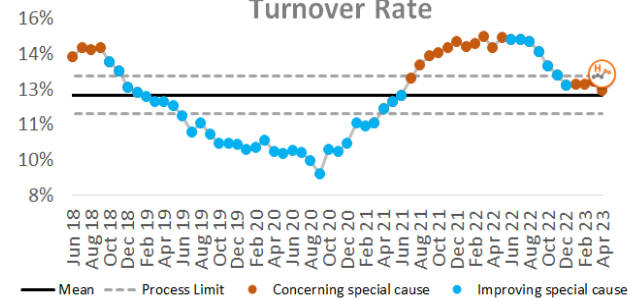
## Turnover Rates - All Staff



**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).
cluding junior doctor).

**What the information tells us:**
After a steady increase from March 2021 the Trust turnover rate has been decreasing since July 2022 - this month at 13%. This is more in line with pre-pandemic rates, however still 1.2% higher than 3 years ago. Estates and Ancillary staff group have the highest increase of 5.2% to 14.5% in the last three years, followed by Additional Professional, Scientific and Technical with an increase of 3% to 13.3%. Within the staff groups, Additional Clinical Services have the highest turnover rate at 18.2% followed by Estates and Ancillary staff at 14.5%.
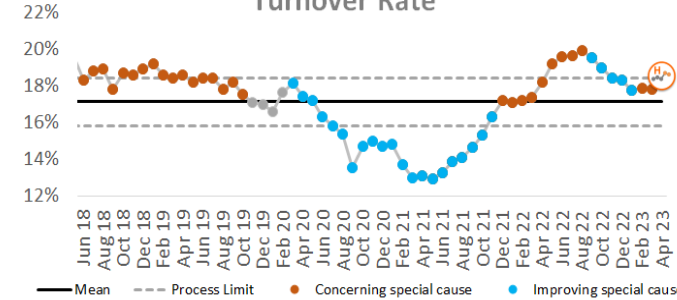
71%

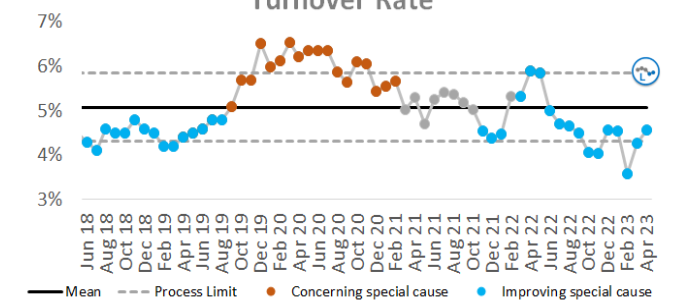### Nursing and Midwifery Turnover Rate


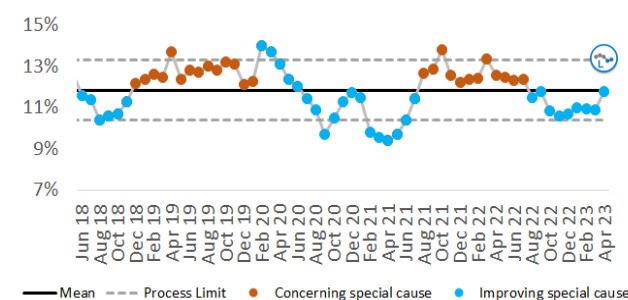
### Administrative and Clerical Turnover rate
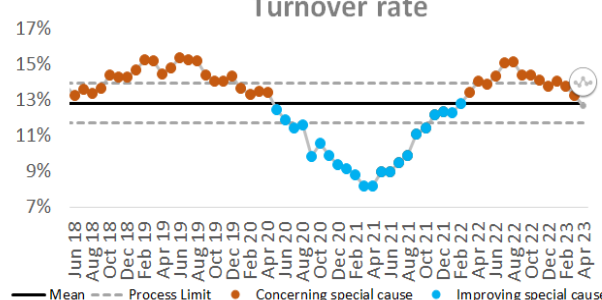


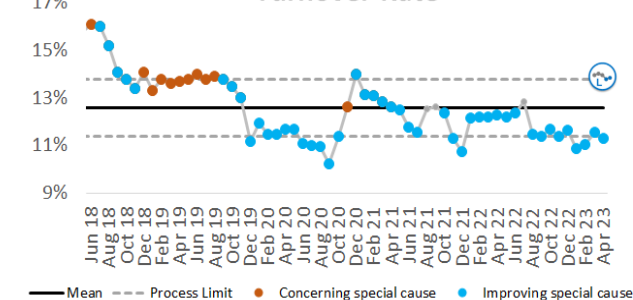### Additional Clinical Services Turnover Rate
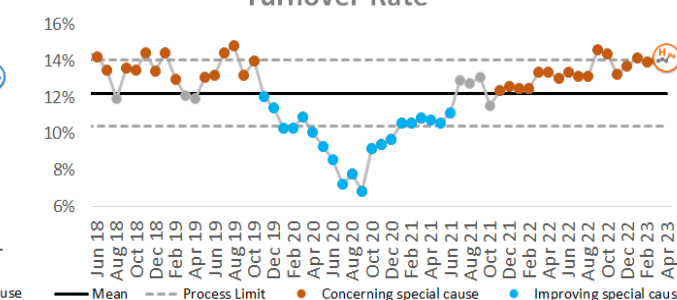


### Medical and Dental Turnover Rate



### Healthcare Scientists Turnover Rate
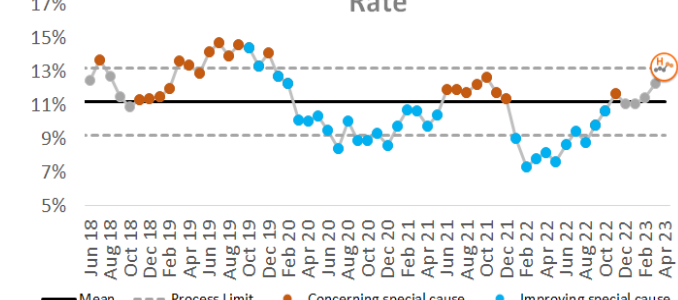


### Allied Health Professionals Turnover Rate
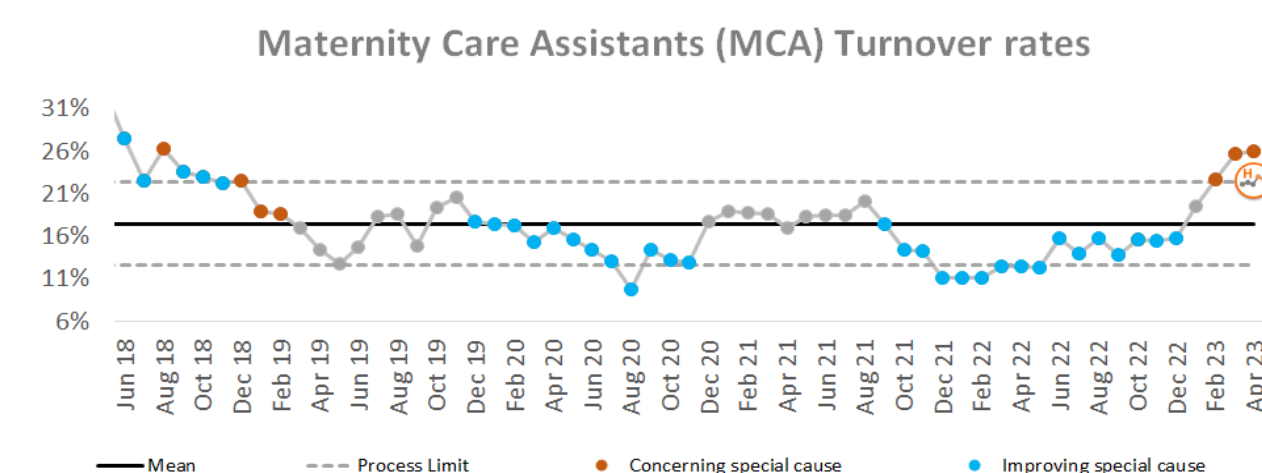


### Estates and Ancilliary Turnover Rate



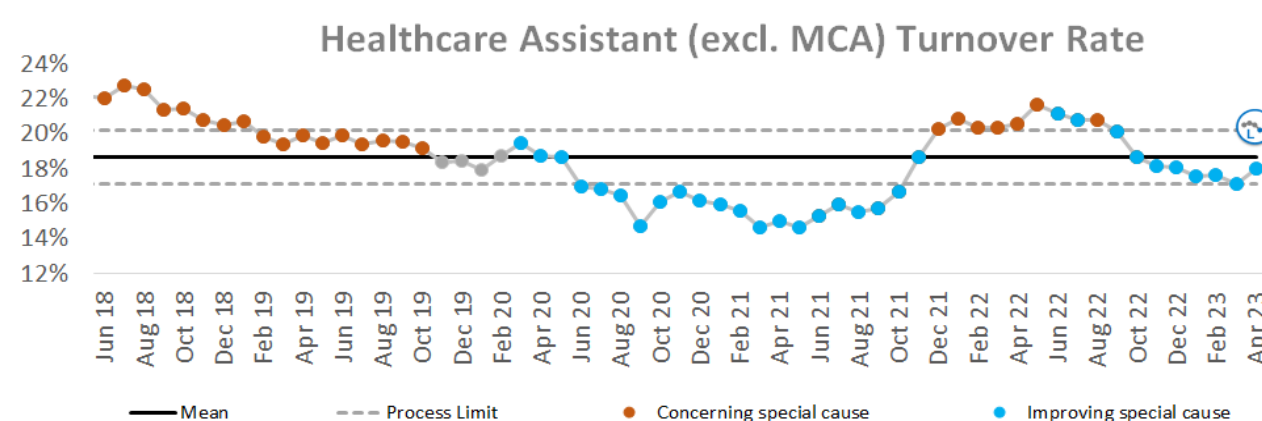### Add Prof Scientific and Technic Turnover Rate

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

Nursing and Midwifery Turnover Rate



Healthcare Assistant (incl. MCA) Turnover Rate



Nursing (Excluding midwives) Turnover Rates



Healthcare Assistant (excl. MCA) Turnover Rate



Midwife Turnover Rates



Maternity Care Assistants (MCA) Turnover rates

Author(s): Chloe Schafer, Amanda Coulier     Owner(s): David Wherrett

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*Excludes Fixed Term and Locum Medical and Dental staff, and staff leaving and returning to CUH (as bank only/retire and return etc.)*



CUH Age Profile Compared to Age Profile of Leavers

| Age | Leavers | Staff in post |
|---|---|---|
| >=66 years | 3% | 1% |
| 56-65 | 11% | 12% |
| 46-55 | 11% | 21% |
| 36-45 | 19% | 24% |
| 26-35 | 37% | 31% |
| <=25 years | 19% | 10% |

CUH Gender Profile Compared to Gender Profile of Leavers

| Gender | Leavers | Staff in post |
|---|---|---|
| Male | 22% | 25% |
| Female | 78% | 75% |

CUH Ethnicity Profile Compared to Ethnicity Profile of Leavers

| Ethnicity | Leavers | Staff in post |
|---|---|---|
| BME | 28% | 28% |
| White | 69% | 68% |
| Unknown | 3% | 4% |

CUH Disability Status Compared to Disability Status of Leavers

| Status | Leavers | Staff in post |
|---|---|---|
| Yes | 7% | 5% |
| No | 83% | 79% |
| Not Shared | 10% | 16% |

Division of Staff in Post Compared to Division of Leavers

| Division | Leavers | Staff in post |
|---|---|---|
| Corporate | 13% | 12% |
| Division A | 19% | 15% |
| Division B | 27% | 27% |
| Division C | 13% | 14% |
| Division D | 12% | 13% |
| Division E | 12% | 13% |
| R and D | 4% | 6% |

92%   69%   58%   92%
71%   71%   57%   100%

■ Leavers last 12 months   ■ Average of staff in post during period

CUH Staff Group Profile Compared to Staff Group Profile of Leavers

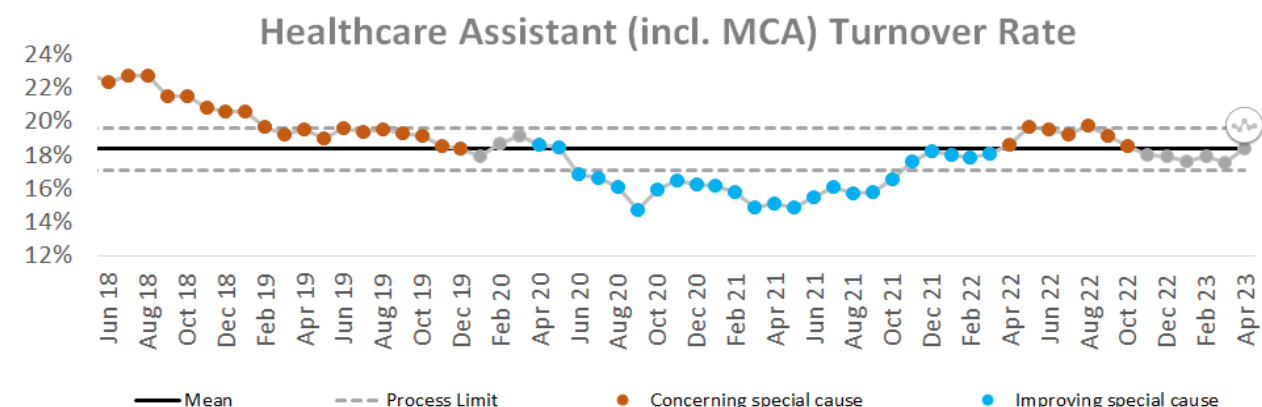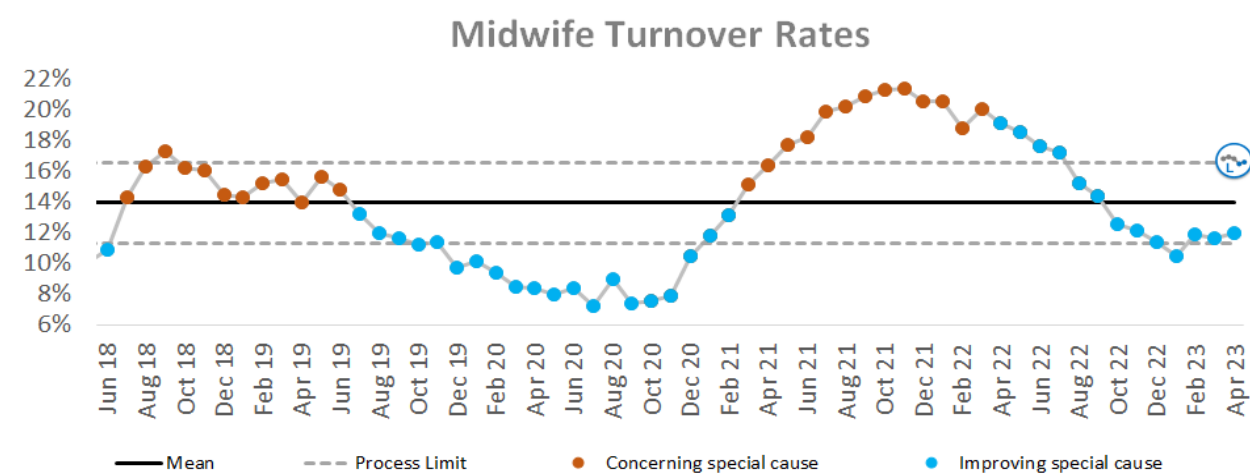| Staff Group | Leavers | Staff in post |
|---|---|---|
| Add Prof Scientific and Technic | 2% | 3% |
| Additional Clinical Services | 18% | 25% |
| Administrative and Clerical | 22% | 23% |
| Allied Health Professionals | 7% | 6% |
| Estates and Ancillary | 3% | 4% |
| Healthcare Scientists | 6% | 6% |
| Medical and Dental | 7% | 2% |
| Nursing and Midwifery Registered | 35% | 32% |

% of leavers with less than 2 years' service (excludes Fixed Term contracts)

| Staff Group | % |
|---|---|
| Add Prof Scientific and Technic | 38% |
| Additional Clinical Services | 54% |
| Administrative and Clerical | 31% |
| Allied Health Professionals | 31% |
| Estates and Ancillary | 31% |
| Healthcare Scientists | 23% |
| Medical and Dental | 23% |
| Nursing and Midwifery Registered | 32% |

■ % of leavers with less than 2 years' service
— % across all staff groups — 37%

Leavers (Headcount) by Length of Service (Years) (excludes Fixed Term contracts)

Mode LoS = 1.1 yrs
Median LoS = 3.2 yrs
Mean LoS = 5.1 yrs

**Workforce: Leavers**

## What the information tells us:

The majority of leavers from the Trust in the last 12 months were under the age of 35 (55%), which is higher than the proportion of staff in post of this age (41%). Gender, ethnicity profile and disability status are all generally equally represented in the leavers data when compared to the Trust profile, however there is a slightly higher proportion of females and staff declaring a disability leaving the Trust. There were a slightly higher proportion of leavers from Divisions C, D and E and R&D, compared to the average headcount in these divisions.
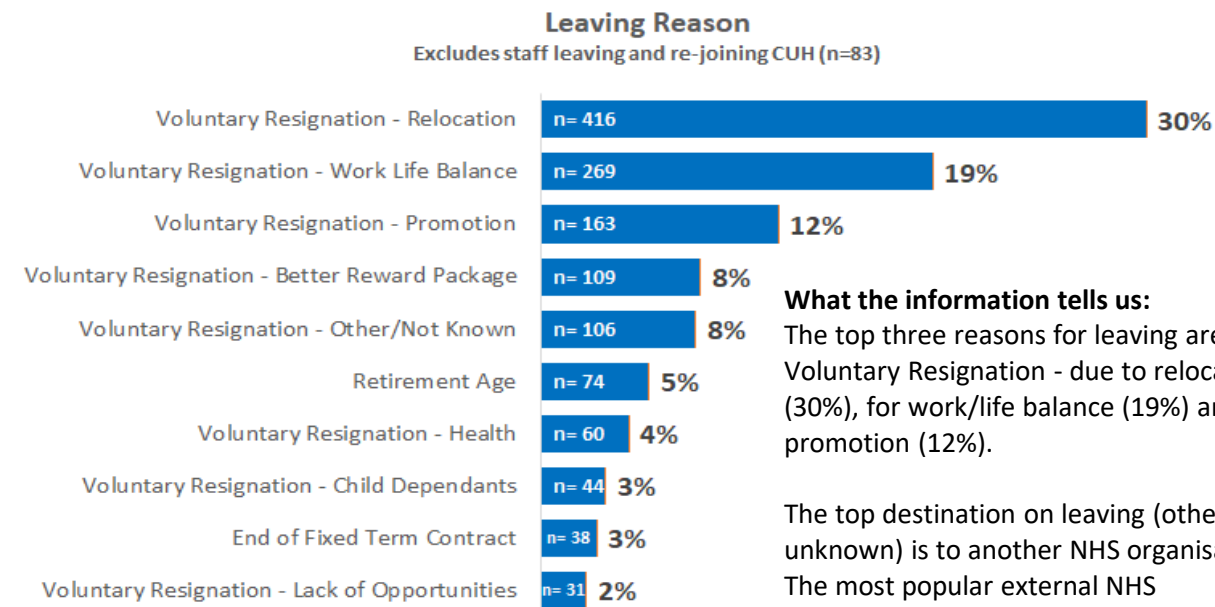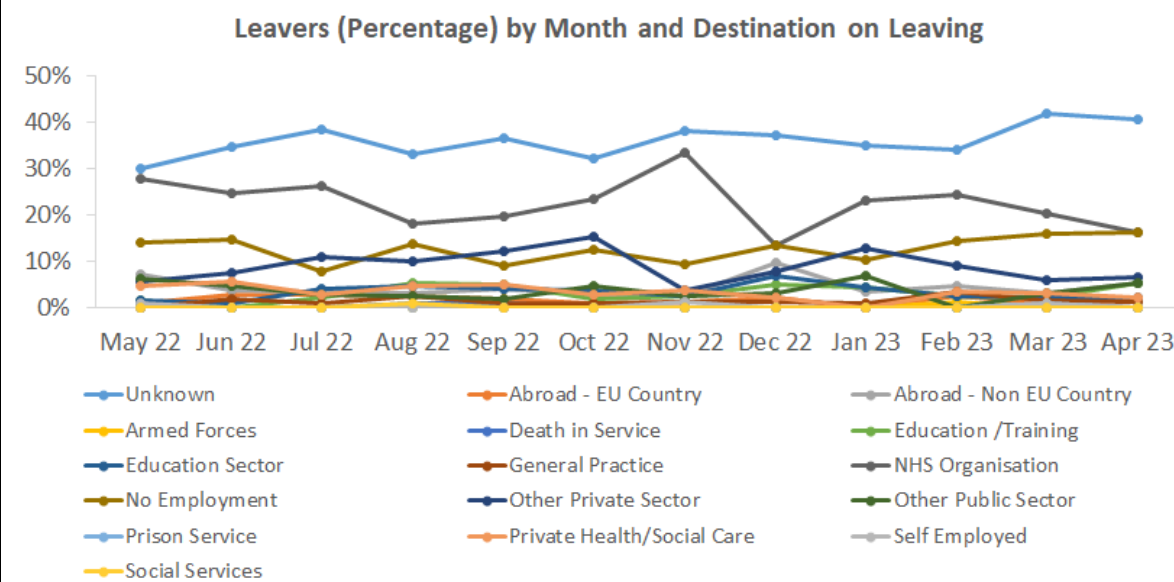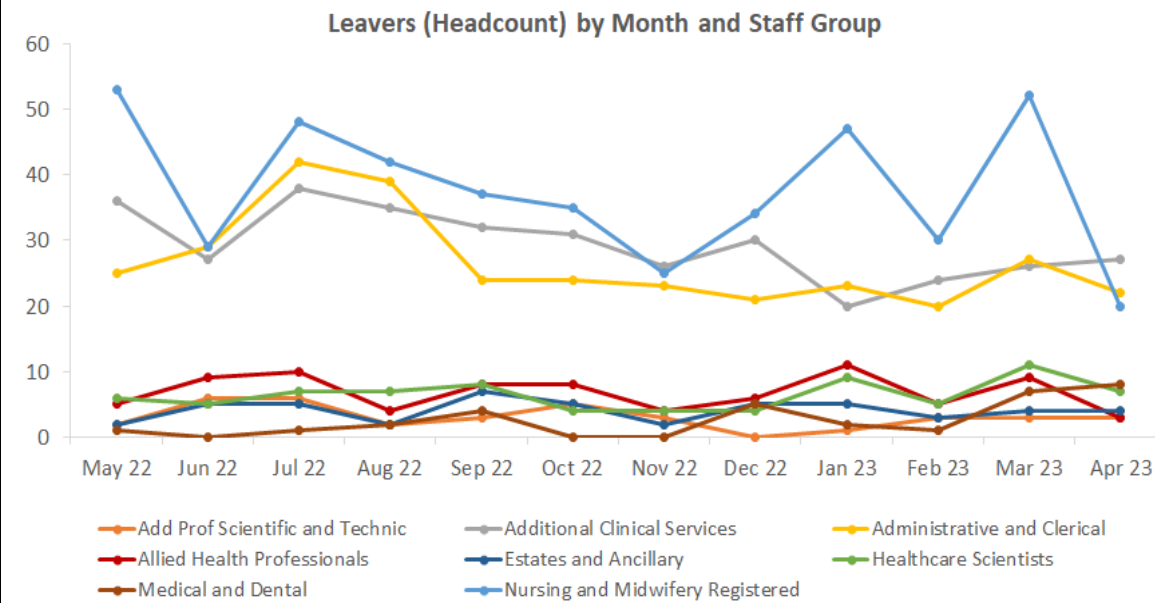
A significant proportion of leavers leave the Trust within 2 years of starting (37%), and within Additional Clinical Services staff group there is a much greater proportion than average - 54%. The most common length of service (mode) upon leaving is 1.1 years – in the last 12 months 28 (headcount) of the 1,276 leavers who were on permanent contracts left at this point. The average (mean) length of service was 5.1 years.

Author(s): Chloe Schafer, Amanda Coulier     Owner(s): David Wherrett

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# Leavers - Last 12 months

*Excludes Fixed Term and Locum Medical and Dental staff, and staff leaving and returning to CUH (as bank only/retire and return etc.)*
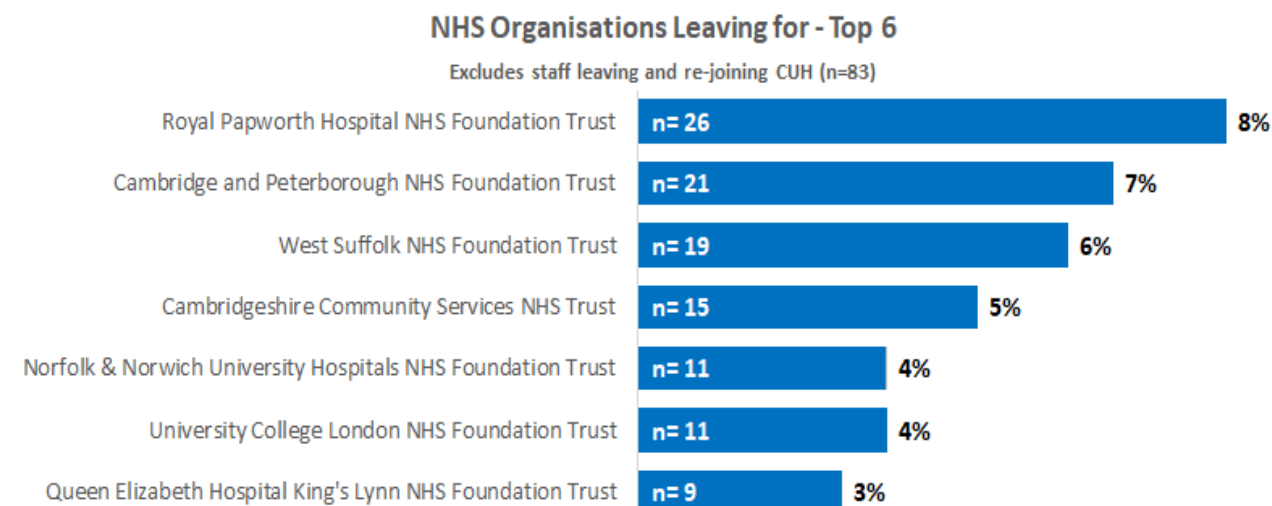
**Workforce: Leavers**

## Leavers (Headcount) by Month and Staff Group



Legend:
- Add Prof Scientific and Technic
- Additional Clinical Services
- Administrative and Clerical
- Allied Health Professionals
- Estates and Ancillary
- Healthcare Scientists
- Medical and Dental
- Nursing and Midwifery Registered

## Leaving Reason
### Excludes staff leaving and re-joining CUH (n=83)

| Reason | n | % |
|---|---|---|
| Voluntary Resignation - Relocation | n= 416 | 30% |
| Voluntary Resignation - Work Life Balance | n= 269 | 19% |
| Voluntary Resignation - Promotion | n= 163 | 12% |
| Voluntary Resignation - Better Reward Package | n= 109 | 8% |
| Voluntary Resignation - Other/Not Known | n= 106 | 8% |
| Retirement Age | n= 74 | 5% |
| Voluntary Resignation - Health | n= 60 | 4% |
| Voluntary Resignation - Child Dependants | n= 44 | 3% |
| End of Fixed Term Contract | n= 38 | 3% |
| Voluntary Resignation - Lack of Opportunities | n= 31 | 2% |

92%   69%   58%   92%

71%   71%   57%   100%

**What the information tells us:**
The top three reasons for leaving are Voluntary Resignation - due to relocation (30%), for work/life balance (19%) and for promotion (12%).

The top destination on leaving (other than unknown) is to another NHS organisation. The most popular external NHS organisation to leave for is Royal Papworth Hospital NHS Foundation Trust.
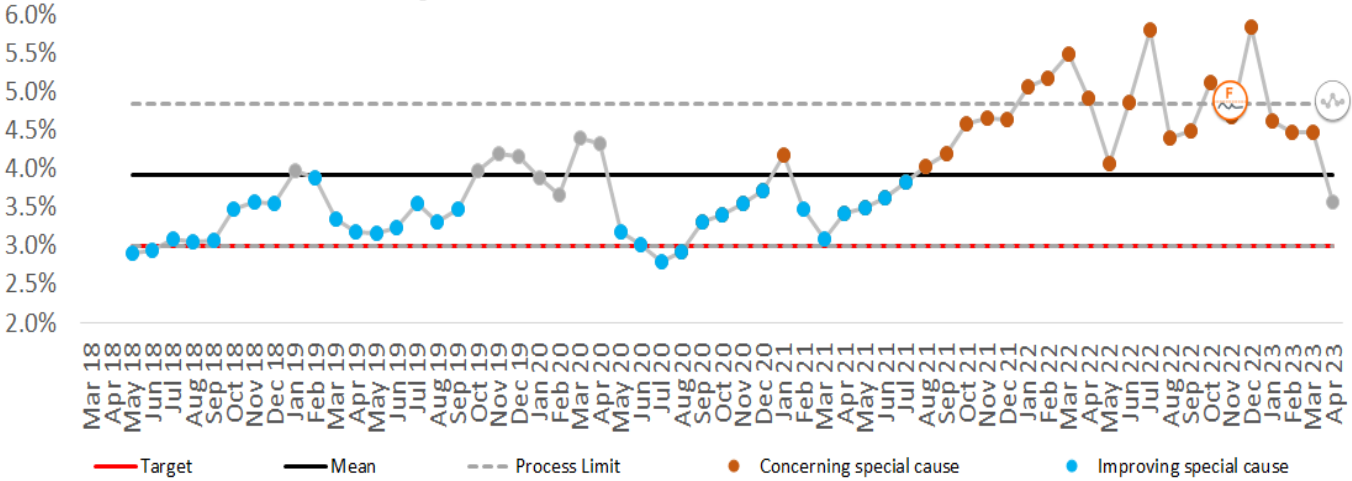
## Leavers (Percentage) by Month and Destination on Leaving



Legend:
- Unknown
- Abroad - EU Country
- Abroad - Non EU Country
- Armed Forces
- Death in Service
- Education /Training
- Education Sector
- General Practice
- NHS Organisation
- No Employment
- Other Private Sector
- Other Public Sector
- Prison Service
- Private Health/Social Care
- Self Employed
- Social Services

## NHS Organisations Leaving for - Top 6
### Excludes staff leaving and re-joining CUH (n=83)

| Organisation | n | % |
|---|---|---|
| Royal Papworth Hospital NHS Foundation Trust | n= 26 | 8% |
| Cambridge and Peterborough NHS Foundation Trust | n= 21 | 7% |
| West Suffolk NHS Foundation Trust | n= 19 | 6% |
| Cambridgeshire Community Services NHS Trust | n= 15 | 5% |
| Norfolk & Norwich University Hospitals NHS Foundation Trust | n= 11 | 4% |
| University College London NHS Foundation Trust | n= 11 | 4% |
| Queen Elizabeth Hospital King's Lynn NHS Foundation Trust | n= 9 | 3% |

Author(s): Chloe Schafer, Amanda Wood       Owner(s): David Wherrett

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# Sickness Absence

**Workforce: Sickness Absence**

### Monthly Sickness Absence Rates - All Staff



Legend: Target — Mean — Process Limit — Concerning special cause — Improving special cause

**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 has dropped below average to 3.6% in April 2023. This is 0.9% lower than last month and 1.4% lower than April last year (4.9%). The sickness absence rate due to short term illness is higher at 2.6% compared to long term sickness at 1%. Additional Clinical Services have the highest sickness absence rate at 6% followed by Estates and Ancillary at 5%.

71%

### Sickness Absence Rate due to Short Term Sickness
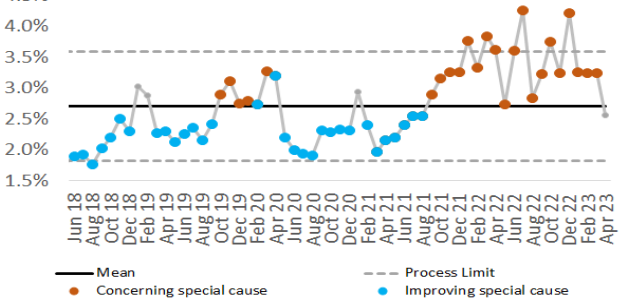


### Nursing and Midwifery Sickness Absence Rate
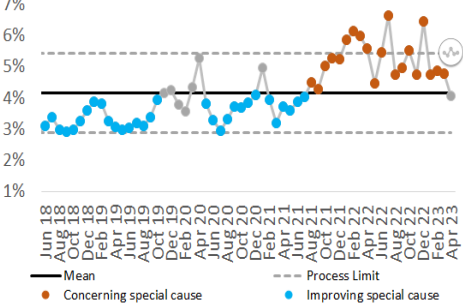


### Administrative and Clerical Sickness Absence Rate
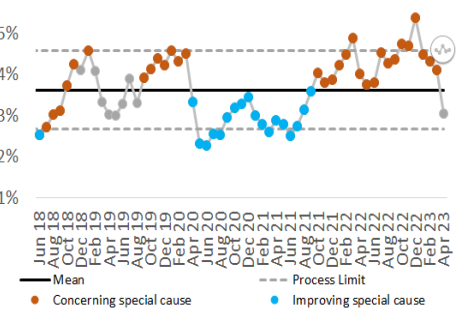


### Additional Clinical Services Sickness Absence Rate
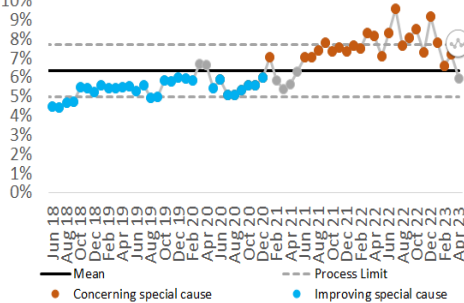


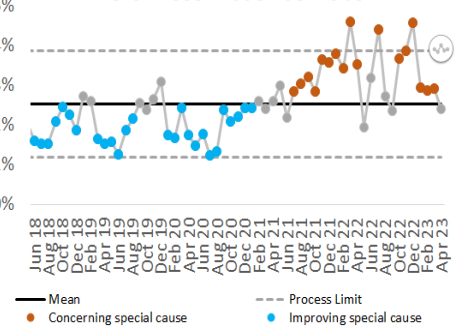### Medical and Dental Sickness Absence Rate
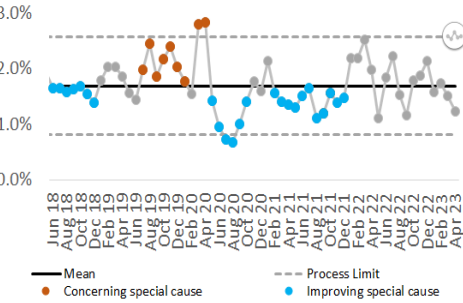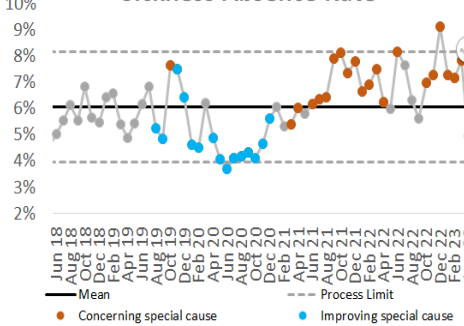


### Sickness Absence Rate due to Long Term Sickness
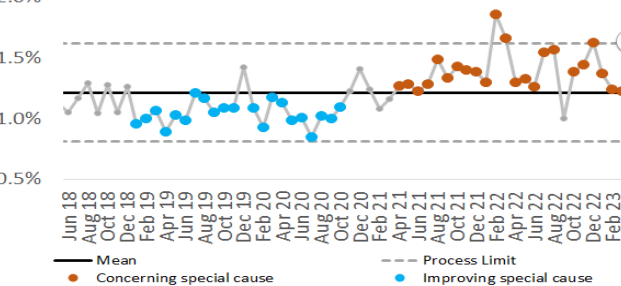


### Healthcare Scientists Sickness Absence Rate
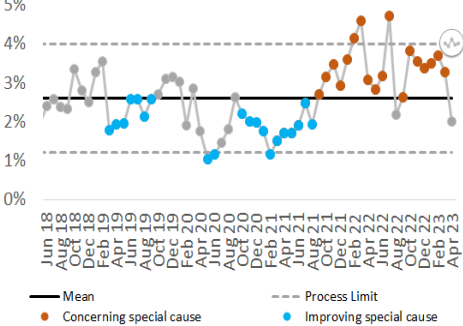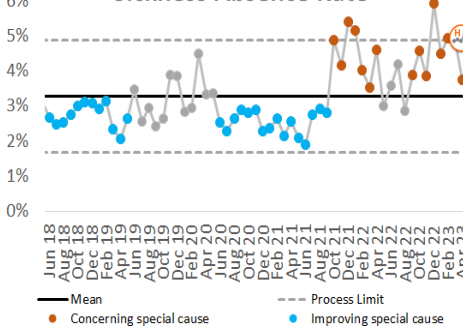


### Allied Health Professionals Sickness Absence Rate
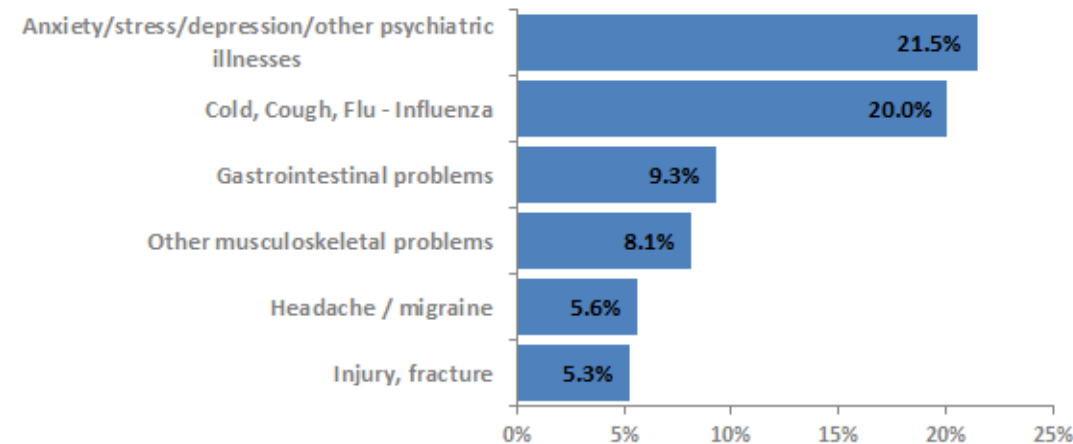


### Estates and Ancilliary Sickness Absence Rate



### Add Prof Scientific and Technic Sickness Absence Rate

# Top Six Sickness Absence Reason

**NHS Cambridge University Hospitals** NHS Foundation Trust

## Top 6 Sickness Reason as % All Sickness - Apr 23
### All Staff

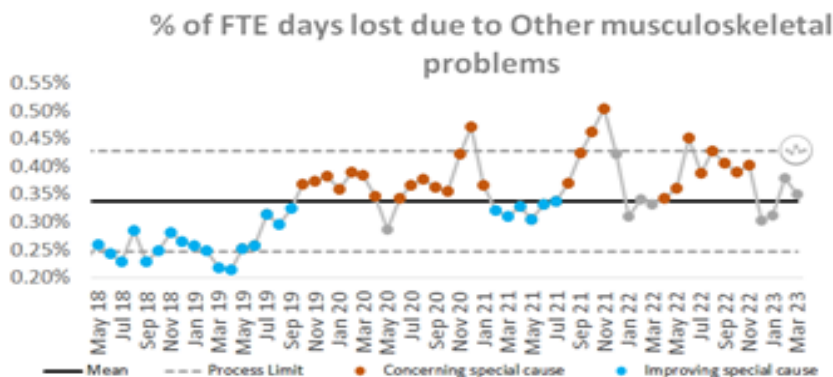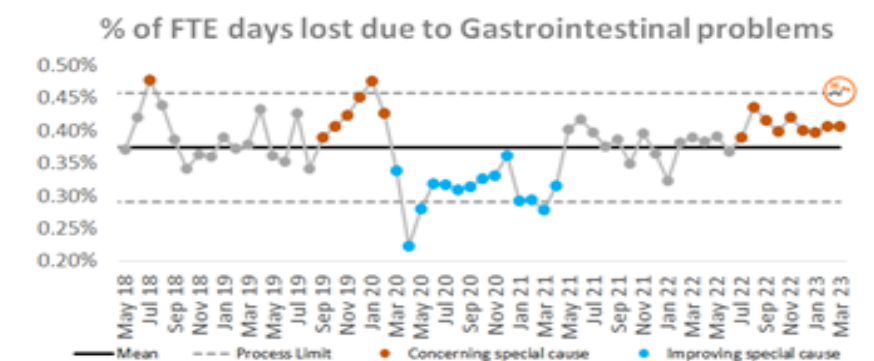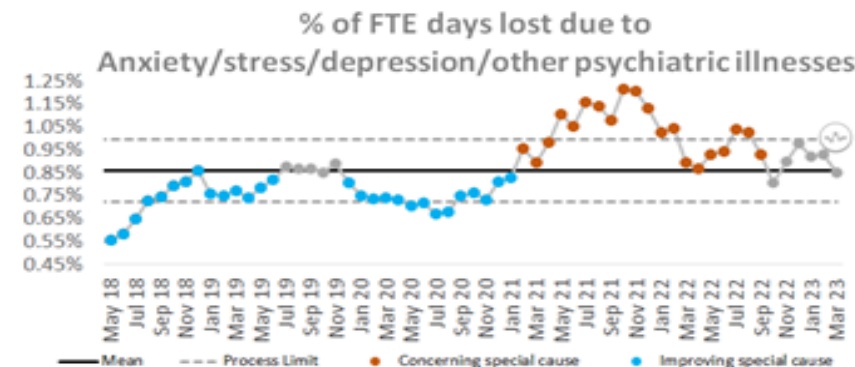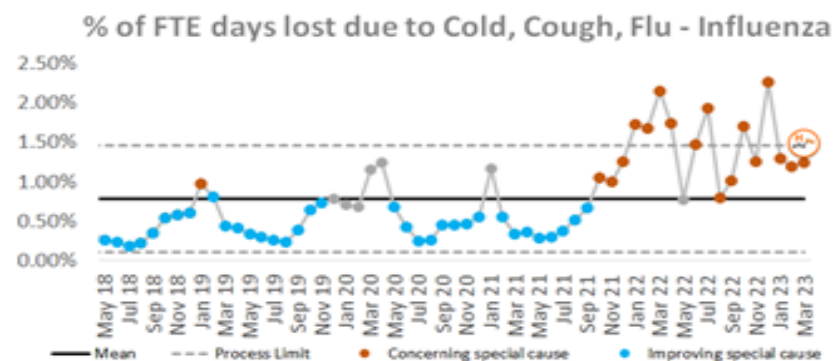| Reason | % |
|---|---|
| Anxiety/stress/depression/other psychiatric illnesses | 21.5% |
| Cold, Cough, Flu - Influenza | 20.0% |
| Gastrointestinal problems | 9.3% |
| Other musculoskeletal problems | 8.1% |
| Headache / migraine | 5.6% |
| Injury, fracture | 5.3% |

**Background Information:** Sickness Absence reason is provided as a percentage of all FTE days missed due to sickness during the reporting month.
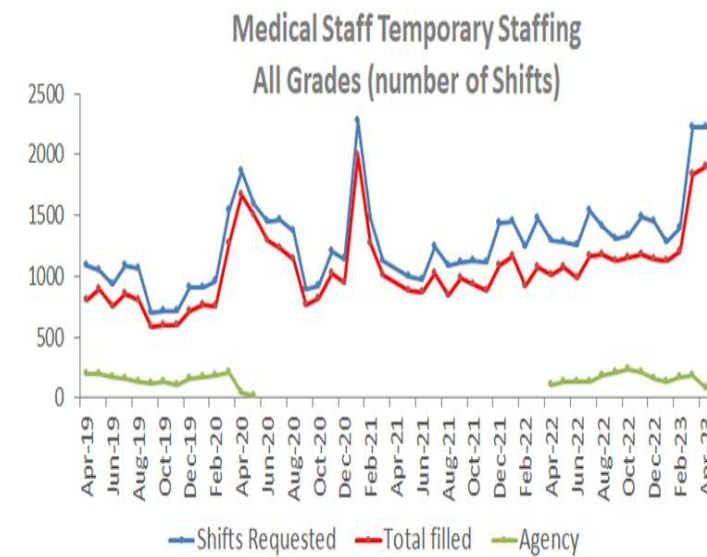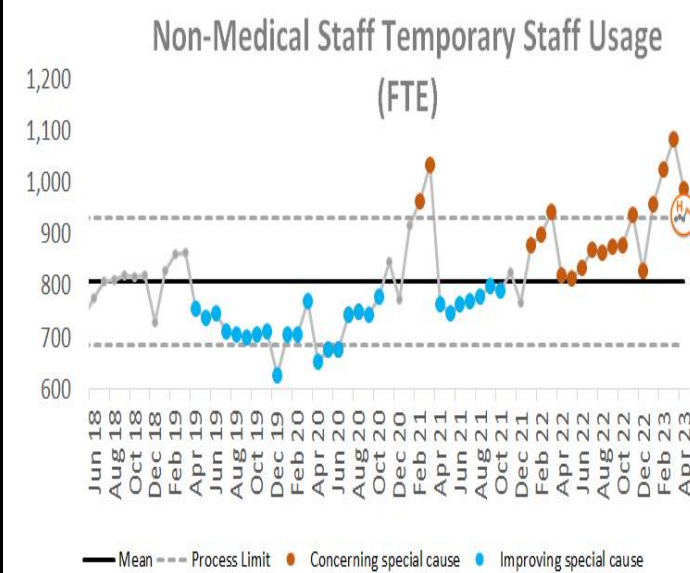
**What the information tells us:** The top reason for sickness absence is Anxiety/stress/depression/other psychiatric illnesses, with an absence rate of 0.8% - down by 0.1% from last month, and 0.1% lower than the same month last year. As a percentage of all sickness absence, Anxiety/stress/depression/other psychiatric illnesses accounts for 21% of the overall figure. Absence due to Cold, Cough, Flu - Influenza reduced by 0.5% from last month and is 1% lower than the same month last year.

71%

% of FTE days lost due to Cold, Cough, Flu - Influenza

% of FTE days lost due to Anxiety/stress/depression/other psychiatric illnesses

% of FTE days lost due to Gastrointestinal problems

% of FTE days lost due to Other musculoskeletal problems

% of FTE days lost due to Genitourinary & gynaecological disorders

% of FTE days lost due to Back Problems

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### Non-Medical Staff Temporary Staff Usage (FTE)



Mean — Process Limit ● Concerning special cause ● Improving special cause

### Medical Staff Temporary Staffing All Grades (number of Shifts)



Shifts Requested — Total filled — Agency

**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 7.9% from March to 1,298 WTE, due to the Easter Bank Holidays which occurred in April. Top three reasons for request are vacancy (46%), increased workload (18%) and specialling (14%). Nursing and midwifery agency usage decreased by 1.8 WTE from the previous month to 35.5 WTE. This accounts for 9% of the total nursing filled shifts. Overall, fill rate has decreased by 1% from last month to 76% in April 2023. Demand for temporary medical staff continued to be higher than average in April due to industrial action. Fill rate increased by 3% from last month to 86%, with 323 shifts left unfilled.
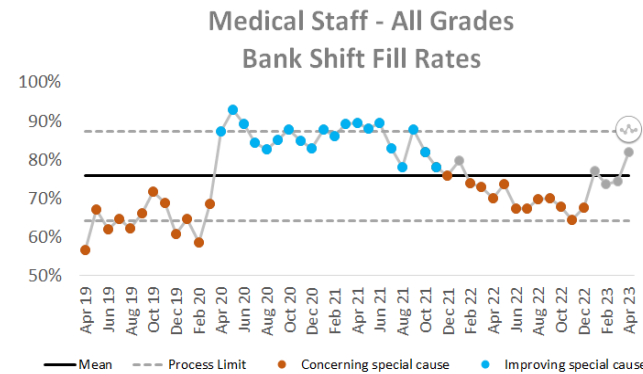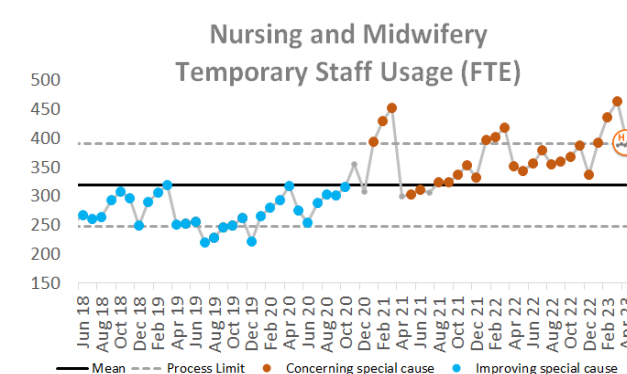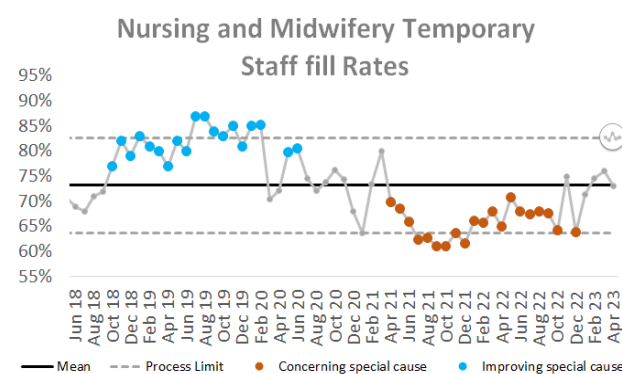
92%          69%      58%      92%

71%          71%      57%      100%

### Non-Medical Temporary Staff Fill Rates



### Nursing and Midwifery Temporary Staff fill Rates



### Nursing and Midwifery Temporary Staff Usage (FTE)



### Medical Staff - All Grades Bank Shift Fill Rates



### Administrative and Clerical Temporary Staff Requests (FTE)



### Nursing and Midwifery Temporary Staff Requests (FTE)



### Nursing and Midwifery Agency Filled Shifts (FTE)



### Medical Staff - Junior Doctor Bank Shift Fill Rates

# ESR Vacancy Rate

## Nursing and Midwifery Vacancy Rate



- Target
- Mean
- Process Limit
- Concerning special cause
- Improving special cause

71%

**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.

## Healthcare Assistant (incl. MCA) Vacancy Rate



- Mean
- Process Limit
- Concerning special cause
- Improving special cause
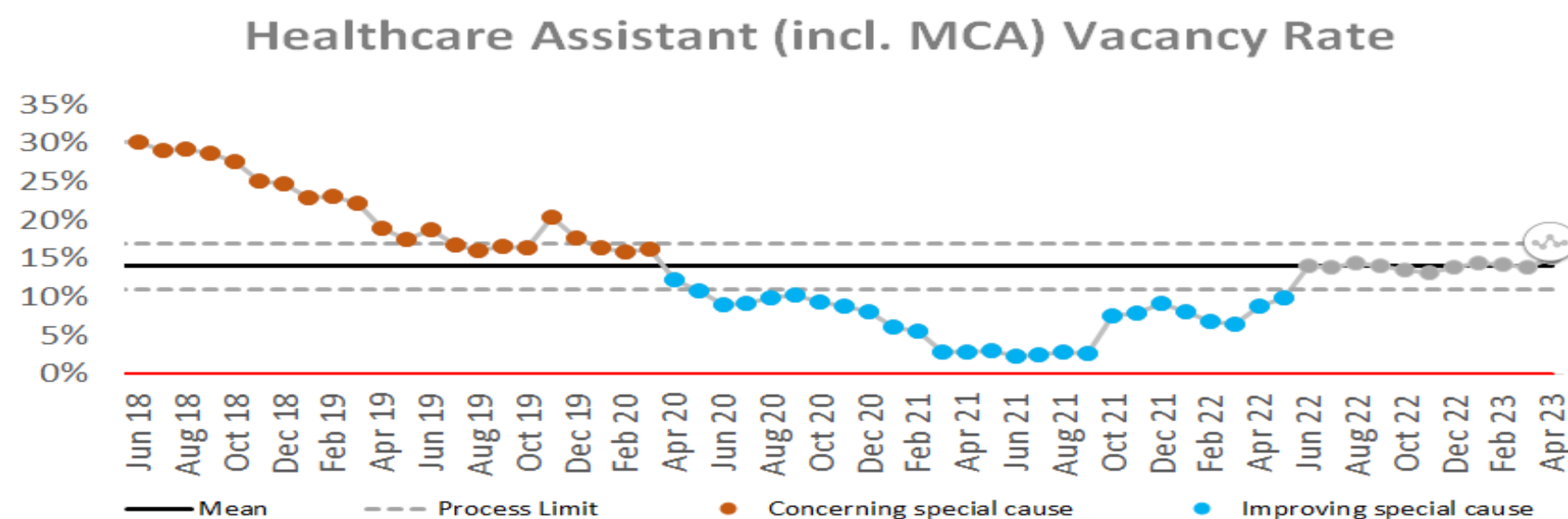
**What the information tells us:** The vacancy rate for Nursing and Midwifery has remained at 8.8% in April 2023. The vacancy rate for Healthcare Assistants has increased by 1.3% from last month to 15.2%. Vacancy rates for both staff groups are above the target rate of 5% for Nurses and 0% for HCAs.

Workforce: ESR Vacancy Rate

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

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# Annual Leave Update

**NHS Cambridge University Hospitals NHS Foundation Trust**

Percentage of Annual Leave (AL) Taken – April 23 Breakdown (source: Healthroster)

| Staff Group | Total Entitlement (Hrs) | Total AL Taken (Hrs) | *% AL Taken | % of staff with Entitlement recorded on Healthroster |
|---|---|---|---|---|
| Add Prof Scientific and Technic | 52,389 | 2,743 | 5.2% | 98% |
| Additional Clinical Services | 376,262 | 32,290 | 8.6% | 98% |
| Administrative and Clerical | 506,038 | 30,290 | 6.0% | 97% |
| Allied Health Professionals | 148,761 | 9,495 | 6.4% | 99% |
| Estates and Ancillary | 78,503 | 5,516 | 7.0% | 99% |
| Healthcare Scientists | 142,806 | 8,817 | 6.2% | 97% |
| Medical and Dental | 138,904 | 8,849 | 6.4% | 37% |
| Nursing and Midwifery Registered | 794,344 | 61,454 | 7.7% | 99% |
| **Trust** | **2,238,007** | **159,454** | **7.1%** | **89%** |
| *Division* | | | | |
| Corporate | 311,936 | 19,683 | 6.3% | 96% |
| Division A | 416,787 | 30,819 | 7.4% | 87% |
| Division B | 624,439 | 45,837 | 7.3% | 94% |
| Division C | 279,761 | 19,678 | 7.0% | 81% |
| Division D | 260,757 | 18,534 | 7.1% | 86% |
| Division E | 244,722 | 19,104 | 7.8% | 87% |
| R&D | 99,605 | 5,799 | 5.8% | 96% |

*Annual Leave taken by Staff Group*
*Annual Leave taken by Division*

**\*** Greater than 7% | Less than 5% | Between 5% and 7%

**What the information tells us:** The Trust's annual leave usage is 85% of the expected usage at the end of the first month of the financial year. The highest rate of use of annual leave is within the Additional Clinical Services staff group, followed by Nursing and Midwifery Registered, at 8.6% and 7.7% 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.

71%

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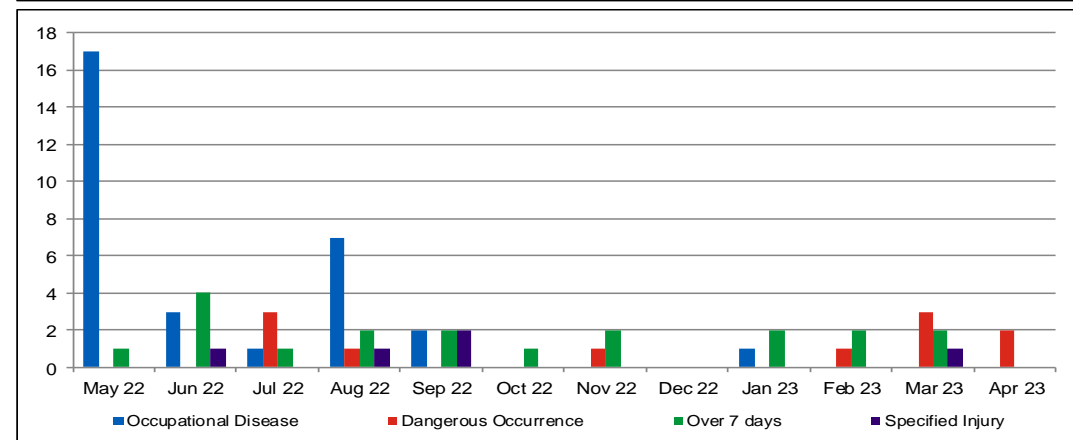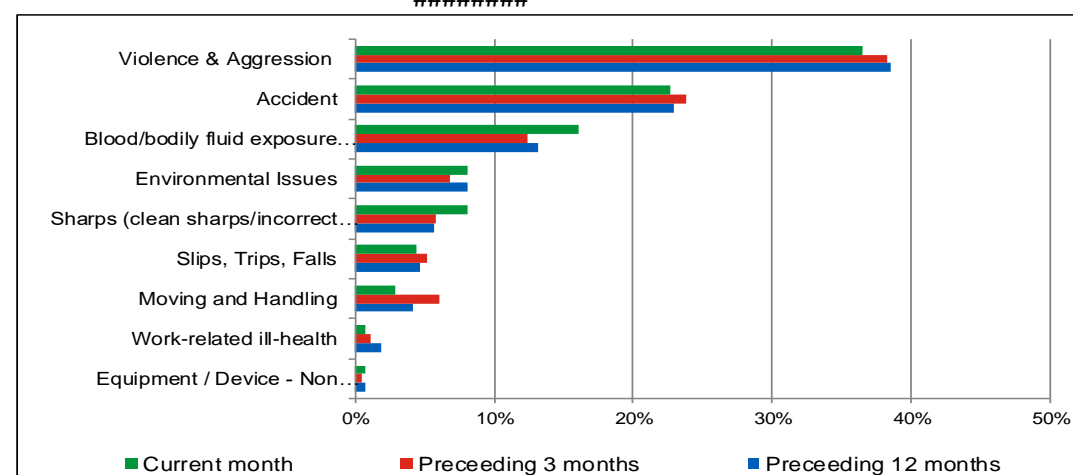
Workforce: Mandatory Training

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

**Induction** — Greater than 94% | Less than 80% | Between 80% and 94%

**Mandatory Training Competency (as defined by Skills for Health)** — Greater than 89% | Less than 75% | Between 75% and 89%

| | Non-Medical Corporate Induction | Non-Medical Local Induction | Medical Corporate Induction | Medical 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 Lvl 1 | Safeguarding Adults Lvl 2 | Safeguarding Adults Lvl 3 | Safeguarding Children Lvl 1 | Safeguarding Children Lvl 2 | Safeguarding Children Lvl 3 | Basic Prevent Awareness | Prevent Level Three (WRAP) | Mental Capacity Act (MCA) & Deprivation of Liberty Safeguards (DoLS) | 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 | 3 yrs/1yr | 3 yrs | 3 yrs | 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/el | cl | cl | cl | |
| **Staff Requiring Competency** | 1,118 | 1,117 | 482 | 482 | 10,876 | 10,876 | 11,023 | 10,876 | 10,876 | 10,876 | 11,023 | 7,349 | 10,876 | 7,844 | 3,838 | 10,876 | 7,826 | 1,887 | 9,350 | 1,845 | 7,542 | |
| **Compliance by Division** | | | | | | | | | | | | | | | | | | | | | | |
| Division A | (17)90.6% | (63)65.2% | (25)78.4% | (19)83.6% | (59)97.1% | (63)96.9% | (385)81.4% | (71)96.5% | (112)94.5% | (180)91.2% | (303)85.3% | (334)82.0% | (91)95.5% | (173)90.8% | (540)31.6% | (51)97.5% | (172)90.9% | (73)67.6% | (61)96.8% | (63)71.4% | (115)93.8% | 91.6% |
| Division B | (16)95.0% | (50)84.4% | (20)69.2% | (10)84.6% | (85)97.0% | (94)96.7% | (255)91.2% | (94)96.7% | (169)94.1% | (246)91.4% | (349)87.9% | (264)81.9% | (135)95.3% | (229)87.5% | (525)40.9% | (83)97.1% | (212)88.2% | (27)80.4% | (92)96.7% | (10)91.9% | (101)93.4% | 93.0% |
| Division C | (16)90.6% | (51)70.2% | (26)80.6% | (28)79.1% | (52)96.5% | (67)95.5% | (252)83.6% | (76)94.9% | (122)91.9% | (190)87.3% | (278)81.9% | (294)79.1% | (94)93.7% | (123)91.4% | (498)26.3% | (66)95.6% | (122)91.5% | (65)75.8% | (65)95.0% | (38)85.8% | (109)92.5% | 90.2% |
| Division D | (6)93.5% | (24)73.9% | (28)67.1% | (24)71.8% | (64)95.2% | (77)94.2% | (281)79.4% | (83)93.8% | (150)88.8% | (212)84.2% | (304)77.7% | (309)73.0% | (99)92.6% | (136)88.3% | (421)23.6% | (71)94.7% | (121)89.6% | (34)75.9% | (63)95.0% | (27)79.2% | (119)89.8% | 88.0% |
| Division E | (8)95.1% | (40)75.5% | (19)75.0% | (14)81.6% | (59)95.6% | (55)95.9% | (233)82.6% | (68)94.9% | (97)92.7% | (156)88.2% | (293)78.1% | (210)82.1% | (89)93.3% | (130)89.1% | (463)34.0% | (45)96.6% | (112)90.7% | (206)80.9% | (7)97.5% | (277)74.3% | (98)91.7% | 88.7% |
| Corporate | (11)91.7% | (33)75.2% | (0)100.0% | (0)100.0% | (53)96.1% | (59)95.7% | (101)92.7% | (64)95.3% | (98)92.9% | (149)89.2% | (126)90.9% | (34)79.0% | (71)94.8% | (14)91.7% | (67)42.2% | (54)96.1% | (14)91.8% | (8)60.0% | (60)95.6% | (5)75.0% | (15)92.2% | 93.4% |
| R & D | (2)96.4% | (13)76.8% | | | (14)96.8% | (17)96.1% | (26)94.1% | (15)96.6% | (17)96.1% | (36)91.8% | (40)91.0% | (18)87.9% | (19)95.7% | (11)93.8% | (49)57.8% | (11)97.5% | (12)93.2% | (6)62.5% | (8)98.2% | (4)42.9% | (6)96.4% | 94.7% |
| **Breakdown of Medical staff compliance** | | | | | | | | | | | | | | | | | | | | | | |
| Consultant | | | (7)85.4% | (11)77.1% | (29)96.1% | (25)96.6% | (80)89.2% | (31)95.8% | (80)89.2% | (94)87.3% | (80)89.2% | (149)80.2% | (41)94.5% | (51)93.2% | (508)25.9% | (25)96.6% | (55)92.7% | (27)88.1% | (16)97.0% | (31)85.2% | (43)94.3% | 91.9% |
| Non Consultant | | | (111)74.4% | (84)80.6% | (90)88.3% | (99)87.1% | (153)80.1% | (128)83.4% | (173)77.5% | (241)68.7% | (207)73.1% | (436)49.8% | (160)79.2% | (218)74.6% | (748)7.7% | (128)83.4% | (207)76.0% | (91)55.0% | (129)80.2% | (85)57.9% | (211)75.5% | 76.0% |
| **Compliance by Staff group** | | | | | | | | | | | | | | | | | | | | | | |
| Add Prof Scientific and Technic | (0)100.0% | (5)84.4% | | | (6)97.4% | (7)97.0% | (13)94.4% | (8)96.6% | (14)94.0% | (19)91.8% | (20)91.4% | (4)89.5% | (10)95.7% | (21)89.4% | (5)50.0% | (4)98.3% | (17)91.1% | (2)75.0% | (4)98.3% | (0)100.0% | (1)98.1% | 94.6% |
| Additional Clinical Services | (28)90.3% | (66)77.2% | | | (41)97.7% | (48)97.3% | (300)83.4% | (48)97.3% | (75)95.7% | (163)90.7% | (315)82.5% | (250)82.2% | (61)96.5% | (218)86.4% | (3)0.0% | (37)97.9% | (201)87.5% | (34)78.6% | (41)97.5% | (40)74.4% | (70)94.9% | 91.6% |
| Administrative and Clerical | (15)94.0% | (51)79.7% | | | (88)96.2% | (98)95.7% | (132)94.2% | (103)95.5% | (181)92.1% | (232)89.9% | (188)91.8% | (4)81.8% | (119)94.8% | (12)88.9% | (1)0.0% | (98)95.7% | (14)87.3% | (5)37.5% | (102)95.6% | (3)50.0% | (15)89.0% | 93.9% |
| Allied Health Professionals | (2)97.3% | (20)72.6% | | | (14)97.9% | (18)97.3% | (82)87.9% | (16)97.6% | (33)95.0% | (41)93.8% | (121)82.2% | (105)84.3% | (28)95.8% | (40)94.0% | (302)47.4% | (15)97.7% | (42)93.7% | (14)78.5% | (8)98.7% | (5)92.2% | (28)95.8% | 93.4% |
| Estates and Ancillary | (8)83.0% | (13)72.3% | | | (5)98.6% | (5)98.6% | (17)95.1% | (6)98.3% | (13)96.2% | (27)92.2% | (7)98.0% | (7)98.0% | (7)98.0% | | (4)98.8% | | (7)98.0% | | (7)98.0% | | | 96.6% |
| Healthcare Scientists | (2)96.4% | (11)80.4% | | | (19)96.9% | (16)97.4% | (36)94.2% | (16)97.4% | (29)95.3% | (47)92.3% | (47)92.4% | (26)75.5% | (17)97.2% | (43)75.8% | (0)100.0% | (7)98.9% | (24)84.9% | (1)94.4% | (14)97.7% | (1)93.8% | (4)97.4% | 94.8% |
| Medical and Dental | | | (118)75.5% | (95)80.3% | (119)92.1% | (124)91.8% | (233)84.6% | (159)89.5% | (253)83.3% | (335)77.9% | (287)81.0% | (585)63.9% | (201)86.7% | (269)83.3% | (1256)16.0% | (153)89.9% | (262)83.8% | (118)72.5% | (145)87.8% | (116)71.8% | (254)84.2% | 83.4% |
| Nursing and Midwifery Registered | (21)94.3% | (108)70.7% | | | (94)97.3% | (116)96.7% | (720)79.7% | (115)96.7% | (167)95.2% | (305)91.2% | (708)80.1% | (489)86.0% | (155)95.5% | (213)93.9% | (996)43.2% | (63)98.2% | (205)94.1% | (245)79.6% | (35)98.5% | (259)78.1% | (191)94.6% | 91.7% |
| **Trust Total** | (76)93.2% | (274)75.5% | (118)75.5% | (95)80.3% | (386)96.5% | (432)96.0% | (1533)86.1% | (471)95.7% | (765)93.0% | (1169)89.3% | (1693)84.6% | (1463)80.1% | (598)94.5% | (816)89.6% | (2563)33.2% | (381)96.5% | (765)90.2% | (419)77.8% | (356)96.2% | (424)77.0% | (563)92.5% | 91.2% |

# Health and Safety Incidents

**NHS**
**Cambridge University Hospitals**
NHS Foundation Trust

| 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: | 1798 | 360 | 281 | 528 | 306 | 187 | 54 | 82 |
| Accident | 412 | 88 | 81 | 102 | 59 | 41 | 6 | 35 |
| Blood/bodily fluid exposure (dirty sharps/splashes) | 237 | 73 | 41 | 42 | 41 | 31 | 8 | 1 |
| Environmental Issues ######## | 146 | 30 | 33 | 9 | 25 | 27 | 9 | 13 |
| Equipment / Device - Non Medical ######## | 14 | 3 | 1 | 3 | 3 | 4 | 0 | 0 |
| Moving and Handling ######## | 74 | 17 | 15 | 14 | 14 | 5 | 1 | 8 |
| Sharps (clean sharps/incorrect disposal & use) | 103 | 31 | 20 | 13 | 15 | 14 | 6 | 4 |
| Slips, Trips, Falls ######## | 84 | 20 | 17 | 18 | 6 | 7 | 4 | 12 |
| Violence & Aggression ######## | 694 | 91 | 66 | 323 | 137 | 53 | 15 | 9 |
| Work-related ill-health ######## | 34 | 7 | 7 | 4 | 6 | 5 | 5 | 0 |

## Health and Safety

Legend: ■ Current month  ■ Preceeding 3 months  ■ Preceeding 12 months

Legend: ■ Occupational Disease  ■ Dangerous Occurrence  ■ Over 7 days  ■ Specified Injury

A total of 1,798 health and safety incidents were reported in the previous 12 months.

879 (49%) incidents resulted in harm. The highest reporting categories were violence and aggression (39%), accidents (23%) and blood/bodily fluid exposure (13%).

1,247 (69%) of incidents affected staff, 491 (27%) affected patients and 60 (3%) affected others ie contractors and members of the public.

The highest reported incident categories for staff were: violence and aggression (41%), blood/bodily fluid exposure (18%) and accidents (16%).

The highest reported incident categories for patients were: accidents (41%), violence & aggression (35%) and environmental issues (10%).

The highest reported incident categories for others were: accidents (25%), environmental issues (25%) and violence & aggression (23%).

Staff incident rate is 10.3 per 100 members of staff (by headcount) over a rolling 12 month period.

The highest reporting division was division C with 528 incidents. Of these, 61% related to violence & aggression.

In the last 12 months, the highest reported RIDDOR category was occupational disease (47%).

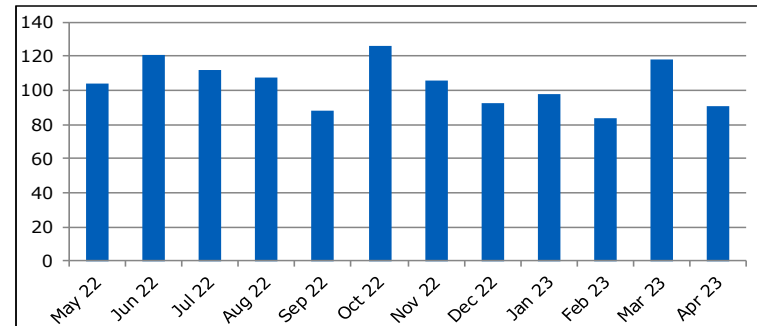In the last 12 months, 53% of RIDDOR incidents were reported to the HSE within the appropriate timescale.

In April 2023, 2 incidents were reported to the HSE:
➢ Dangerous occurrence: Whilst trying to get venous access, the Injured Person (IP) removed a cannula from the patients left forearm and punctured their left index finger. The patient is Hep C positive. Appropriate first aid was administered and follow up with occupational health.
➢ Dangerous occurrence: During a liver transplant, on a Hepatitis B positive patient, the IP sustained a needlestick from the suture needle. The IP encouraged the finger to bleed (no blood came out) and washed it under running water. The IP attended Occupational Health for appropriate follow up.

Author(s): Helen Murphy   Owner(s):

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**Health and Safety** (sidebar)

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



| | May 22 | Jun 22 | Jul 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Dec 22 | Jan 23 | Feb 23 | Mar 23 | Apr 23 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Accident | 15 | 14 | 20 | 15 | 18 | 16 | 19 | 14 | 12 | 14 | 21 | 16 | 194 |
| Blood/bodily fluid exposure (dirty sharps/splashes) | 16 | 19 | 20 | 17 | 13 | 32 | 14 | 20 | 20 | 12 | 20 | 18 | 221 |
| Environmental Issues | 4 | 7 | 20 | 16 | 1 | 6 | 1 | 6 | 4 | 2 | 8 | 8 | 83 |
| Moving and Handling | 3 | 5 | 2 | 4 | 7 | 2 | 1 | 2 | 5 | 8 | 9 | 3 | 51 |
| Sharps (clean sharps/incorrect disposal & use) | 8 | 4 | 8 | 10 | 5 | 8 | 10 | 5 | 5 | 7 | 3 | 9 | 82 |
| Slips, Trips, Falls | 8 | 7 | 3 | 5 | 10 | 4 | 6 | 4 | 8 | 7 | 4 | 6 | 72 |
| Violence & Aggression | 45 | 61 | 36 | 36 | 34 | 57 | 52 | 37 | 39 | 33 | 50 | 30 | 510 |
| Work-related ill-health | 5 | 4 | 3 | 4 | 0 | 1 | 3 | 4 | 5 | 1 | 3 | 1 | 34 |
| **Total** | **104** | **121** | **112** | **107** | **88** | **126** | **106** | **92** | **98** | **84** | **118** | **91** | **1247** |

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

| | May 22 | Jun 22 | Jul 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Dec 22 | Jan 23 | Feb 23 | Mar 23 | Apr 23 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No. of health & safety incidents | 104 | 121 | 112 | 107 | 88 | 126 | 106 | 92 | 98 | 84 | 118 | 91 | **1247** |
| Staff incident rate per month/year | 0.9 | 1.0 | 0.9 | 0.9 | 0.7 | 1.0 | 0.9 | 0.8 | 0.8 | 0.7 | 1.0 | 0.8 | **10.3** |

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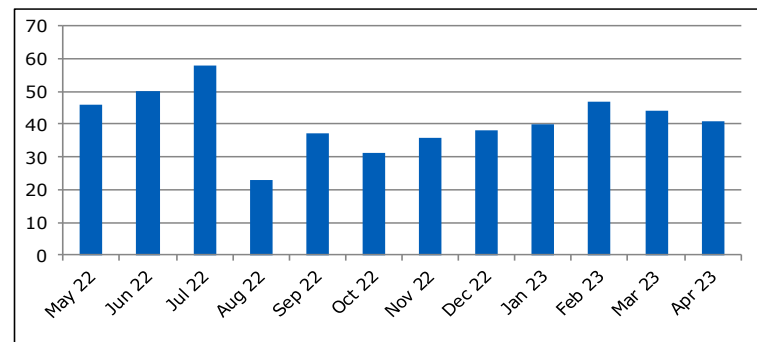


| | May 22 | Jun 22 | Jul 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Dec 22 | Jan 23 | Feb 23 | Mar 23 | Apr 23 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Accident | 25 | 20 | 20 | 8 | 13 | 13 | 15 | 19 | 19 | 17 | 21 | 13 | 203 |
| Blood/bodily fluid exposure (dirty sharps/splashes) | 1 | 1 | 1 | 0 | 3 | 0 | 0 | 3 | 2 | 0 | 1 | 3 | 15 |
| Environmental Issues | 1 | 4 | 12 | 2 | 0 | 3 | 8 | 7 | 3 | 5 | 1 | 2 | 48 |
| Equipment / Device - Non Medical | 1 | 1 | 2 | 1 | 0 | 1 | 3 | 1 | 2 | 1 | 0 | 1 | 14 |
| Moving and Handling | 0 | 5 | 2 | 2 | 1 | 0 | 3 | 2 | 1 | 4 | 2 | 1 | 23 |
| Sharps (clean sharps/incorrect disposal & use) | 0 | 3 | 2 | 2 | 2 | 1 | 0 | 1 | 0 | 2 | 3 | 2 | 18 |
| Violence & Aggression | 18 | 16 | 19 | 8 | 18 | 13 | 7 | 5 | 13 | 18 | 16 | 19 | 170 |
| **Total** | **46** | **50** | **58** | **23** | **37** | **31** | **36** | **38** | **40** | **47** | **44** | **41** | **491** |

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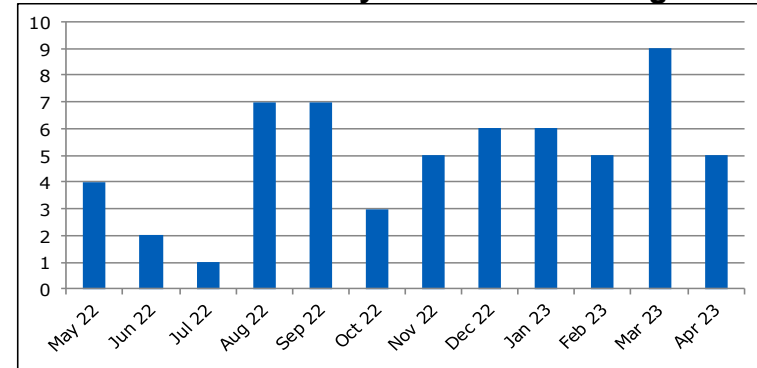


| | May 22 | Jun 22 | Jul 22 | Aug 22 | Sep 22 | Oct 22 | Nov 22 | Dec 22 | Jan 23 | Feb 23 | Mar 23 | Apr 23 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Accident | 2 | 1 | 0 | 0 | 3 | 1 | 2 | 0 | 2 | 0 | 2 | 2 | 15 |
| Blood/bodily fluid exposure (dirty sharps/splashes) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| Environmental Issues | 2 | 0 | 0 | 2 | 1 | 1 | 1 | 2 | 2 | 1 | 2 | 1 | 15 |
| Sharps (clean sharps/incorrect disposal & use) | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 3 |
| Slips, Trips, Falls | 0 | 1 | 0 | 1 | 1 | 0 | 1 | 2 | 0 | 2 | 4 | 0 | 12 |
| Violence & Aggression | 0 | 0 | 1 | 3 | 2 | 1 | 1 | 2 | 0 | 2 | 1 | 1 | 14 |
| **Total** | **4** | **2** | **1** | **7** | **7** | **3** | **5** | **6** | **6** | **5** | **9** | **5** | **60** |

Author(s): Helen Murphy          Owner(s):

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## Report to the Council of Governors: 28 June 2023

| | |
|---|---|
| **Agenda item** | 9.1 |
| **Title** | Report of the Lead Governor |
| **Sponsoring executive director** | n/a |
| **Author(s)** | Neil Stutchbury, Governor |
| **Purpose** | To receive the report of the Lead Governor |
| **Previously considered by** | n/a |

**Executive Summary**

This report summarises the activities of the Lead Governor since the previous meeting of the Council of Governors.

| | |
|---|---|
| Related Trust objectives | n/a |
| 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 Council of Governors**

The Council is asked to note the report of the lead Governor.

# Cambridge University Hospitals NHS Foundation Trust

**28 June 2023**

**Council of Governors**
**Report from the Lead Governor**
**Neil Stutchbury**

## 1.    Recent Governor meetings

1.1    The **Governor/NED Quarterly** meeting was held on 12 April, which was the second day into a junior doctors' strike. The strike and its impacts formed much of the discussion. NEDs assured governors that the Shelford Group had signed a letter imploring the government to meet with the British Medical Association to resolve the strike, as indeed had the NHS Confederation. A large number of operations were cancelled, which included elective and some cancer operations. The Quality Committee will be reviewing data to ascertain any harm caused to patients and to get assurance that the right decisions were taken on prioritising cancelled operations.

1.2    A **Governor Strategy Group** meeting was held on 17 April. The strategy team presented a paper on the new way specialised services will be commissioned in the east of England (EoE): via the "East of England Specialised Provider Collaborative", instead of centrally via NHS England. CUH is by far largest specialised provider in EoE and these services contribute about 40% of CUH's annual income. India Miller outlined some of the challenges and opportunities the new arrangements will bring.

1.3    The **Lead Governors** of the four foundation trusts within the Cambridgeshire and Peterborough Integrated Care System met the chair of the Integrated Care Board, John O'Brien, for a regular catch up on 21 April. John gave an update on the progress with planning and finalising the 2023/24 budget. Laura Halstead, Head of Communications and Marketing attended to explain her approaches to communicating with partners and the public. She asked for ideas on how to reach communities we represent. I invited her to a meeting I organised on 11 May with Erin Lilley (Cambridgeshire South Care Partnership) and Julian Stanley and Karen Igho (Healthwatch) to agree ways to connect the integrated care system to primary care patients.

1.4    Keith Grimswade has stepped down from the Lead Governor role at Cambridge and Peterborough NHS Foundation Trust and has been replaced by Andrea Hill.

1.5  A **Governor Seminar** was held on 26 April. Aloma Onyemah, the Trust's Interim Director of Equality, Diversity and Inclusion (EDI), spoke on her initial impressions and her plans to develop an EDI strategy. David Wherrett, Director of Workforce, presented the results of the 2022/23 staff survey. Not unsurprisingly given the increasing pressure on staff, the rising cost of living and the impact of industrial action, the results were down from previous years across the board. David noted that CUH had slipped back from 3rd in the Shelford group to 6th on the advocacy questions. Staff governors expressed in their own words what it feels like to work at CUH and these comments very much reflected the tone of the survey. David reported that the results and the management response would be communicated in May, and this would be followed by a series of listening exercises in July along the lines of 'CUH Reflects'.

1.6  We held a **Governor Forum** on 17 May which we used to catch up the recent election results (see below) and to update on board assurance committee meetings which we had observed.

1.7  A **Governors' Nomination and Remuneration Committee** meeting was held on 6 June where we discussed the process for recruiting a new NED to replace Adrian Chamberlain, who leaves at the end of his second term in August 2023. We are looking for candidates with clinical (specifically GP) experience as well as digital technology, and ideally with a vested interest in CUH. Interviews are planned for 13 July. An additional Council of Governors' meeting will follow the interviews to approve the appointment.

1.8  We held a **Governor Seminar** on 6 June focused on clinical research and how the university, hospital, industry and patients collaborate to discover new medicines and design new devices. Sarah Burge from the University of Cambridge and Ann Russell, an experienced patient advocate, both presented. Miles Parkes, Director of the Cambridge Biomedical Research Centre, joined us towards the end of the meeting for a brief update on how the hospital engages with clinical research. Governors were very grateful for the time they gave to briefing them.

1.9  We held a **Governor Strategy Group** meeting on 12 June where Claire Stoneham, Alex Cavanagh and Matthew Zunder outlined the content and discussions on the Trust strategy that were covered at a recent Board away day. More detail can be found in the Governor Strategy Group report for the Council of Governor's meeting.

## 2.    Upcoming Governor meetings

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

- The Trust Constitution Committee meeting will be moved from 28 June to a later date
- Governor-NED quarterly meeting: 5 July 2023
- Membership Engagement Strategy Implementation Group: 18 July 2023
- Governor Forum: 7 September 2023
- Council of Governors' meeting: 20 September 2023
- Annual Public Meeting: 27 September 2023

## 3.    Other Governor activities

3.1   Governor elections were held in May 2023. The results are detailed in a separate report for the Council of Governors meeting. It is with great sadness that one of the outcomes was that David Dean, public governor since 2017, was not re-elected. David has been an outstanding governor and has engaged very strongly with all aspects of his role as governor. In particular, he has been Deputy Lead Governor, has been involved in two rounds of NED appointments, observed the Performance Committee and been a member of several governor committees. Throughout his tenure he has committed himself to the role and exemplified how governors should seek assurance from NEDs; he has held NEDs to account on a range of issues, including finance, performance and staffing. He will be greatly missed by all governors and NEDs alike. We wish him well and hope he can stay involved with the hospital in another capacity.

## 4.    Recommendation

4.1   The Council of Governors is asked to note the activities over the past three months.

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## Report to the Council of Governors: 28 June 2023

| | |
|---|---|
| **Agenda item** | 9.2 |
| **Title** | Governors' Strategy Group |
| **Sponsoring executive director** | n/a |
| **Author(s)** | Julia Loudon, Patient Governor |
| **Purpose** | To summarise the activities of the Governors' Strategy Group. |
| **Previously considered by** | n/a |

**Executive Summary**

This report summarises the activities of the Governors' Strategy Group.

| | |
|---|---|
| Related Trust objectives | n/a |
| 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 Council of Governors**

The Council is asked to note the report covering the two most recent meetings of the Governors' Strategy Group held on 17 April 2023 and 12 June 2023.

# Cambridge University Hospitals NHS Foundation Trust

**28 June 2023**

**Council of Governors**

**Governors' Strategy Group - 17 April 2023**

1. The Governors' Strategy Group met on 17 April 2023. Present were: Mike More, Jason Clarke (Trust Office), Matthew Zunder (Strategy Group), Sue Broster and Lizzie Gifford from the Trust's Improvement & Transformation team, and governors (David Dean, Julia Loudon, Neil Stutchbury and Gill Shelton).

2. The topic discussed was the East of England (EoE) Specialised Provider collaborative. **Mike More** commented that while CUH is the largest provider of specialised services (eg kidney dialysis, chemotherapy, major trauma, severe asthma and neonatal intensive care) within the EoE, historically, the EoE region has had relatively less in-house specialised activity, and lower funding, than other regions. There is now an opportunity to bring together the EoE's largest providers of acute specialised services (Essex, Suffolk, Norfolk, Cambridgeshire, Bedfordshire and East/North Herts) into a collaborative that will provide these services across the region. Funding of the collaborative would be based on population/fair-share allocation and, as a result, there should be a net gain for the EoE region.

3. Further background information, and slides covering details of the collaborative, were presented by **Sue Broster** and **Lizzie Gifford**, including:

   - A range of specialised services are currently provided by CUH. These make an important contribution to the Trust's revenue.

   - With the introduction of integrated care, funding for such services is moving from NHSE to the Integrated Care Boards (ICBs). The intention is that this funding model will i) enable improved understanding for the whole pathway of care and ii) help deliver the agenda for change in the EoE. By Apr 24 ICBs will have responsibility for commissioning up to 80% of specialised services.

   - Many patients in the eastern region have to travel long distances every month to receive treatment at specialised centres. As well as increasing the number of services available for all patients, introduction of the collaborative will:
     - attract more funding to the area, providing opportunities for other centres in the region to provide these services
     - enable earlier intervention, which will prevent some patients needing more complex care. With care delivered earlier and locally, secondary care provision will be more resilient.
     - increase patient volumes, meaning resources will be made available to provide beds, staff and space to deliver specialised services
     - benefit patient care, staff recruitment & retention, innovation, research and education, and financial sustainability.

- It was noted that the allocation of capital budgets to provide infrastructure for the provision of these services has yet to be clarified.

- The vision for the EoE collaborative is to 'achieve the best outcomes for the population of the EoE by delivering integrated, preventative, high-quality care closer to home,' in alignment with regionally prioritised clinical areas of focus. Priority specialties are cancer, paediatrics, cardio-respiratory and neurosciences.

1. During the discussion the following points were made:

- The trusts are engaging with the ICBs and NHSE to negotiate with regard to contracts and commissioning of specialised services.

- Governors asked whether regions that are further on with their collaboratives have provided useful learnings for the development of the EoE collaborative. It was commented that while some regions are further advanced, each area is focused on their specialised areas of focus, which are different to the priorities in the EoE. As a result, all regions have different modes to best deliver their collaboratives.

- The EoE collaborative is rightly quite ambitious. The team is working closely with Shelford Group colleagues and national bodies to inform and shape this important agenda, and well as meeting regularly with south London hospitals, gaining learnings in relation to finance and governance.

- It was acknowledged that there are risks to be managed, but overall there should be a net gain to both the region and to the Trust. For example, if services such as biologics can be delivered to patients closer to home, patients will benefit from the reduced need to travel and CUH will have extra capacity to deliver more at the Trust. However the financial arrangements will be challenging - it was noted that the CUH Finance Director is closely involved in the development of the collaborative.

- The group agreed that the collaborative provides a good opportunity to improve patient care across the region. Governors look forward to hearing more about the plans and progress of the initiative.


**Governors' Strategy Group: 12 June 2023**

1. Present were: Mike More, Matthew Zunder, Alex Cavanagh and Clare Stoneham (the Trust strategy group), and David Dean, Julia Loudon, Neil Stutchbury and Gill Shelton (governors).

2. Governors were updated on the outputs from the board away-day on implementation of the strategy. **Mike More** summarised the objectives of the Board discussions, which included

- identifying ways to ensure everyone in the Trust can see how they can contribute to the delivery of the strategy

- discussing how the Board could transform a broad framework of strategy into tangible outcomes and medium-term aims and objectives

- how a set of metrics would be developed to demonstrate progress being made in each area of strategy.

3. **Claire Stoneham** summarised the background, the strategy triangle and the 15 commitments across the three priorities of 1) improving patient care, 2) supporting staff, and 3) building for the future. For each objective, information on plans for 2023/24 timeframe, and where the Trust should be in 3 and 5 years' time, was provided.

4. Discussion points raised by governors included:

*Improving patient care*

- Transformation is clearly critical; as well as digital transformation (which is ongoing), it would be useful to also include transformations that will have cross-CBC benefits - for example the new hospitals, enhanced scientific and research collaborations, and improved access to the hospitals via Cambridge South station - should be included here.

- More information on 'how' enhancements will be delivered is needed. Some improvements in performance/transformation depend on things over which CUH has little control. National workforce shortages - for example in radiology resources, which are critical for improved diagnostics throughput - will impact the Trust's ability to achieve its strategic objectives.

- It was suggested that the longer term objectives should be even bolder. For example: - for example,
    - in diagnostic testing, 6 weeks in 5 years' time does not feel like a stretch objective. By aiming higher, patient experience would be improved and more people would get into treatment more quickly.
    - Could the proposed reduction in out-patient follow-up appointments to (patient-led follow-up) be a 3 yr rather than a 5 yr target?

*Supporting staff*

- Given the range of issues identified, governors questioned whether the 3-5 year targets are ambitious enough to meet the challenges.

- It was suggested that the EDI objectives should be more stretching, and a funded post focused on addressing EDI issues would be helpful.

- Governors noted the serious challenges with longer term recruitment in the face of huge shortages of clinical staff in the UK and globally. It was commented that increased numbers of staff and budget will address the issues; we need to redesign clinical procedures to improve efficiency while maintaining excellent and safe patient care. It was agreed it would be helpful to have a more granular sense of where improvement is needed.

*Building for the future*

- Governors agreed that some ongoing, significant projects already in place would assuring a strong mid- and long-term future for the Trust. Such projects include
    - growing expertise in genomics
    - early detection initiatives
    - the building of new wards and hospitals (Cancer and Children's hospitals)
    - the development of specialised collaboratives (as discussed at the GSG meeting on 16 April).

5. **Alex Cavanagh** presented the strategic lens as to how access to care will be improved while maintaining high quality care; how metrics will be developed and how these will combine to define future objectives relating to capacity management.

    Discussion points raised by governors were:

    - Effectively improving access of care while maintaining/improving quality is a critical balance. Governors would like to see examples of how this balance is managed as ways to improve access of care are identified.

    - The plan for reducing vacancy levels was not clearly defined during the meeting. Given high vacancies have always been a challenge, and the situation across the NHS is getting worse, we need reassurance that the planned reduction is achievable. While it was noted that many initiatives are being introduced to address the challenge, governors felt that some indication of what these are, and which are expected to make the most difference, would be helpful.

    - MM noted that the metrics will have to be adjusted over time, taking account of things that CUH cannot control but ensuring we get the weighting correct.

The Strategy group thanked governors for their valuable comments, which will be considered as the strategy is further developed and delivered.

**Julia Loudon**
**June 2023**