Board of Directors

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Cambridge University Hospitals
NHS Foundation Trust

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There will be a meeting of the Board of Directors in public on Wednesday 13 September 2023 at 11.00

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

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

AGENDA

General business			Purpose
11.00	**1**	**Welcome and apologies for absence**	For note
	2	**Declarations of interest** To receive any declarations of interest from Board members in relation to items on the agenda and to note any changes to their register of interest entries A full list of interests is available from the Director of Corporate Affairs on request	For note
	3*	**Minutes of the previous Board meeting** To approve the Minutes of the Board meeting held in public on 12 July 2023	For approval
	4*	**Board action tracker and matters arising not covered by other items on the agenda**	For review
11.05	**5**	**Patient story** To hear a patient story	For receipt

11.20	**6***	**Board committee membership and NED responsibilities** To receive the report of the Director of Corporate Affairs	For approval
11.25	**7***	**Chair's report** To receive the report of the Chair	For receipt
11.30	**8***	**Report from the Council of Governors** To receive the report of the Lead Governor	For receipt
11.30	**9***	**Chief Executive's report** To receive the report of the Chief Executive	For receipt
Performance, strategy and assurance			**Purpose**
11.40	**10***	**Performance reports** *The items in this section will be discussed with reference to the Integrated Report and other specific reports* 10.1* Quality (including nurse staffing report) 10.2 Workforce 10.3 Access standards 10.4* Finance 10.5 Innovation and improvement	For receipt
12.15	**11***	**Patient Safety Incident Response Framework** To receive the report of the Chief Nurse	For approval
12.25	**12***	**Freedom to Speak Up** To receive the report of the Director of Corporate Affairs and the Freedom to Speak Up Guardian	For approval
12.40	**13***	**Guardian of Safe Working** To receive the quarterly report of the Medical Director	For receipt
12.50	**14***	**Learning from deaths** To receive the report of the Medical Director	For receipt
12.55	**15***	**Research and development** To receive the report of the Medical Director	For receipt
13.05	**16***	**Board Assurance Framework and Corporate Risk Register** To receive the report of the Director of Corporate Affairs and the Chief Nurse	For receipt

13.10	**17***	**Amendment to the Trust Constitution** To receive the report of the Director of Corporate Affairs	For approval
Items for information/approval – not scheduled for discussion unless notified in advance			
13.15	**18***	**Medical and nursing revalidation** To receive the reports of the Medical Director and Chief Nurse	For receipt
	19*	**Board assurance committees – Chairs' reports** 19.1 Addenbrooke's 3 Committee: 27 July 2023 19.2 Performance Committee: 6 September 2023 19.3 Quality Committee: 6 September 2023	For receipt
Other items			**Purpose**
	20	**Any other business**	
13.20	**21**	**Questions from members of the public**	
	22	**Date of next meeting** The next meeting of the Board of Directors will be held on Wednesday 8 November 2023 at 11.00.	For note
	23	**Resolution** That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (NHS Act 2006 as amended by the Health and Social Care Act 2012).	
13.30	**24**	**Close**	

NHS
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Minutes of the meeting of the Board of Directors held in public on Wednesday 12 July 2023 at 11.00 via videoconference

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

** Non-voting member*

In attendance	Position
Dr A Black	Co-Chair of the Junior Doctors' Forum (for item 74/23 only)
Dr A Burke	Clinical Consultant (for item 67/23 only)
Mr J Clarke	Trust Secretary (Minutes)
Ms K Clarke	Associate Director of Workforce (for item 73/23 only)
Mr J Davies	Deputy Medical Director
Dr A Gupta	Consultant in Anaesthesia and Neuro Critical Care (for item 73/23 only)
Dr J MacDougall	Guardian of Safe Working (for item 74/23 only)
Ms I Miller	Interim Director of Strategy
Dr N Stutchbury	Lead Governor

63/23 Welcome and apologies for absence

The Chair welcomed everyone to the meeting.

It was noted that this was the final Board meeting prior to Adrian Chamberlain leaving his role as a Non-Executive Director and Senior Independent Director on 31 August 2023. On behalf of the Board, the Chair thanked Adrian for his service over the past six years.

Apologies for absence are recorded in the attendance summary.

64/23 Declarations of interest

Standing declarations of interest of Board members were noted.

65/23 Minutes of the previous meeting

The minutes of the Board of Directors' meeting held in public on 10 May 2023 were approved as a true and accurate record.

66/23 Board action tracker and matters arising not covered by other agenda items

Received and noted: the action tracker.

67/23 Patient story

Lorraine Szeremeta, Chief Nurse, presented the patient story.

Brainbow was the UK's first rehabilitation service for children and young people with brain tumours. It was a unique partnership between a number of independent charities, including Anna's Hope, Camille's Appeal and others. The service provided co-ordinated specialist neuro rehabilitation assessment and treatment through a multi-disciplinary team approach. Through this, Brainbow sought to help children and young people with brain tumours to reach their full potential.

Board members watched a video describing the experience of Zain, who had been diagnosed with a brain tumour in December 2022, and his father.

Dr Amos Burke, Clinical Consultant, joined the Board meeting for this agenda item.

The following points were made in discussion:

1. Brainbow was an excellent example of a service which spanned the emotional, educational, physical and mental health needs of children and young people across the East of England. The nature of the conditions meant that they often had a significant impact on the wider family.

2. There was a lack of neuro rehabilitation services for children nationally. In the absence of Brainbow, there was no alternative provision covering such a breath of multi-disciplinary services.
3. The multi-disciplinary co-ordination was a significant factor in the success of the service, with the professional and personal commitment of the team essential in helping to create a positive environment for children and their families.
4. Families had expressed gratitude for the development and mainstreaming of the service. Its success had helped to inform the national strategy for specialist neuro rehabilitation services and it was hoped that the approach could be replicated across the country.
5. Brainbow currently had a caseload of around 200 families, which the service considered to be manageable going forward. There was currently limited transition to adult services at 16, as many young people remained in education until they were at least 19. As such, there was a gap in provision for older teenagers and young adults.
6. The charity partners formed part of the Brainbow management group and the service provided a strong example of service co-production.
7. There was scope to utilise the learning from Brainbow's approach to multi-disciplinary working to other programmes across the Trust, including in the context of the Cambridge Children's Hospital (CCH) and the Cambridge Cancer Research Hospital (CCRH).

Agreed:
1. To note the patient story.
2. To thank Zain and his family for sharing their powerful and moving story.
3. To thank Dr Burke for attending for the discussion.

68/23 Chair's report

Mike More, Chair, presented the report.

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

69/23 Report from the Council of Governors

Neil Stutchbury, Lead Governor, presented the report.

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

70/23 Chief Executive's report

Roland Sinker, Chief Executive, presented the report.

Noted:

1. Board members heard a reflection on the current NHS landscape, with recognition of the challenges faced by patients seeking timely access to services.
2. The Trust had recently had to manage a five-day period of industrial action by junior doctors, with a further two days of strike action by consultants to follow. Since December 2022, significant resources had been directed to planning for industrial action and the performance data demonstrated the adverse impact on elective waiting lists. In addition to the direct impact of strike action on patient care and the Trust's financial position, the cycle of preparing for industrial action – including postponing and re-booking appointments – was placing a significant strain on teams across the hospitals.
3. Following the decline in the response rate to the NHS national staff survey and in the results across a number of the NHS People Promise domains, the Board had agreed to undertake a targeted programme of staff listening events in order to better understand the experiences of staff which were driving these results. The output of these events would be available in the early autumn in advance of the launch of the 2023 annual staff survey.
4. Work continued on the development of an integrated Equality, Diversity and Inclusion (EDI) and Health Inequalities strategy for the organisation.
5. The Trust was continuing to progress a number of workstreams in support of its building for the future objectives. The revised Outline Business Case for the Cambridge Children's Hospital was due to be reviewed by the national Joint Investment Committee in the autumn.
6. The Trust continued to plan for the opening of additional capacity over the next six months including the surgical movement centre and the two U-block wards, and the re-opening of the neurosurgery theatres in A Block.
7. The Trust continued to work in collaboration with key partners, including Royal Papworth Hospital and the University of Cambridge, to make the case for improved infrastructure including in relation to travel and transport.
8. The Trust continued to mark important events including thanking colleagues who had recently retired, celebrating nominees in the CUH Annual Awards, and marking Windrush 75 and the 75th birthday of the NHS.

The following points were made in discussion:

1. The NHS Long Term Workforce Plan had recently been published and provided a strategic approach to the development of the NHS workforce across three key themes of 'train', 'retain' and 'reform'. The plan emphasised the importance of transformation and innovation to develop a workforce fit for the future.

Agreed:

1. To note the contents of the report.

71/23 Performance reports

The Board received the Integrated Performance Report for May 2023.

Access standards

Nicola Ayton, Chief Operating Officer, presented the update.

Noted:

1. The latest operational performance data had been discussed in detail at the July 2023 meeting of the Performance Committee, with a focus on access to elective and non-elective care.
2. For the first time since 2017, the Trust had met each of the nationally-mandated targets for ambulance handovers in the most recent period. In May 2023, CUH was the best performing Trust in the region and the joint highest provider nationally.
3. During May 2023, 70% of all ambulance handovers took place within 15 minutes, with 98% taking place within 30 minutes and none exceeding 60 minutes. This represented a significant improvement in performance and was the result of a whole hospital effort to improve against a number of key quality, safety and workforce metrics.
4. The Trust had recently returned to reporting against the national 4-hour standard and had set out its trajectory to achieve the nationally-mandated target of 76% by the end of the year. Before was above trajectory in June 2023.
5. The Trust's ability to reduce elective waiting lists had been significantly affected by the impact of industrial action which had led to the postponement of scheduled appointments.
6. In June 2023, there were still 73 patients who had waited more than 78 weeks for treatment.
7. The Trust continued to perform well against key cancer waiting time targets relative to its peers.

Workforce

David Wherrett, Director of Workforce, presented the update.

Noted:

1. As noted earlier in the meeting, the NHS Long Term Workforce Plan had been published on 30 June 2023. The Trust would work with Cambridgeshire and Peterborough Integrated Care System (ICS) partners and others to develop plans to achieve the key ambitions set out in the Workforce Plan.
2. Taking account of forthcoming industrial action by consultant members of the British Medical Association (BMA), the Trust would have been subject to 27 days of industrial action since December 2022. The prolonged nature of this action was having a significant impact on patients and staff.
3. The Integrated Performance Report indicated a number of positive trends in key workforce metrics, including turnover, retention, growth

against plan, sickness absence and temporary staffing. The improvement in these areas meant that the Trust had been able to withdraw some of the pay premia that were previously applied to support levels of staffing required to provide safe and effective services.

Quality (including nurse staffing report)

Lorraine Szeremeta, Chief Nurse, and Justin Davies, Deputy Medical Director, presented the update.

Noted:

1. The Trust continued to progress plans to implement the new national Patient Safety Incident Response Framework (PSIRF). This would provide the Trust with a greater degree of freedom within which to undertake incident investigations and secure the associated learning. The Trust's PSIRF policy and plan would be presented to the Board of Directors in September 2023.
2. The Trust had started to roll out the new mandatory PSIRF training, with Level 1a and 1b training uptake currently around 50%.
3. The Quality Committee continued to monitor the position on falls and hospital acquired pressure ulcers.
4. Significant system challenges remained in relation to the implementation of effective mental health pathways, particularly for complex eating disorder patients. The Trust continued to escalate its concerns to the wider system, emphasising the need for a collaborative approach to support the placement of patients in the most appropriate setting for their condition.
5. Work was ongoing within the Patient Advice and Liaison Service (PALS) to clear the complaints backlog, with the backlog having been reduced by over 200 cases in the past nine weeks. As part of the new process, the team would seek to resolve more complaints at an earlier stage in the process through improved communication and engagement with the complainant.
6. The Trust continued to await the publication of the Care Quality Commission's report of its inspection of Maternity Services in May 2023. The Trust would develop a detailed action plan to address identified areas for improvement and progress would be reviewed by the Quality Committee.
7. No safety incidents had been reported to date as a direct consequence of industrial action. The Trust continued to prioritise access to urgent and emergency care during periods of industrial action.

Finance

Mike Keech, Chief Finance Officer, presented the update.

Noted:

1. The report covered the combined month 1 and month 2 financial position. The Trust was reporting an adverse variance against its

financial plan of £2.4m, driven largely by the impact of industrial action. There was national guidance for organisations regarding financial reporting in the context of industrial action and it had been assumed that an element of lost income could be recovered.

2. It was anticipated that the 2024/25 financial year would be particularly challenging and planning was already underway to prepare for this. It was imperative for the Trust to remain as close to plan as possible for the remainder of 2023/24 to ensure that it could go into 2024/25 in the strongest possible financial position.
3. The Trust would continue to focus on delivering planned productivity and efficiency improvements as part of the plan to resolve the underlying pressures across 2023/24 and 2024/25.

Improvement and transformation

Sue Broster, Director of Innovation, Digital and Improvement, presented the update.

Noted:

1. A reconfiguration of the portfolio for the role of Director of Innovation, Digital and Improvement was currently being undertaken. The output of this work would be discussed at a future meeting of the Board of Directors.
2. The Improvement and Transformation team had been supporting divisions and corporate teams to identify and capture productivity and efficiency schemes in support of the achievement of their allocated target requirements, using benchmarking data to highlight key areas of opportunity and working with the associated teams to work up supporting plans. These plans covered a number of key enablers including the virtual ward, digital and outpatient transformation, and initiatives to support reductions in length of stay.
3. The virtual ward had successfully managed over 500 patients to date, with overwhelmingly positive feedback. It was estimated that the availability of the virtual ward enabled the Trust to save seven beds on average per day, which could be used for those patients with a greater clinical need. Given this success, the Trust was looking into the scope to expand the arrangement across paediatric services.
4. The Trust had recently delivered its first course for internal improvement coaches which had been run independently of the Institute for Healthcare Improvement.
5. Work continued to deliver improvements across the digital agenda, including enhancements to the functionality of MyChart.

The following points were made in discussion:

1. The recent five days of junior doctor strike action, followed by a further two days during the initial summer holiday period, added additional complexity to the challenges that the Trust already faced in maintaining safe urgent and emergency care services and preserving as much elective activity as possible during industrial action periods.

In addition to the delivery of safe, high quality care, it was important to ensure that staff were adequately supported.

2. As a result of planning for industrial action over a period of nine months, the Trust had been able to develop and embed effective processes which had helped to reduce the impact of strike action. Nevertheless, the impact on staff of the additional work required to plan and prepare for industrial action should not be underestimated.
3. There was a significant opportunity cost of planning for industrial action in terms of programmes of work to deliver elective recovery.
4. It was difficult to quantify patient harm caused as a result of industrial action. Harm could result both for patients whose current treatment was being delayed and for patients who were still waiting to be seen. While no actual harm had been reported to date, the Trust had seen a significant increase in the number of complaints linked to delays in treatment and longer waiting times. Additionally, there was some evidence of an increase in cases of aggression towards staff.
5. The lack of beds in the community for patients with eating disorders continued to be escalated by the Trust as a significant risk at system level.
6. Many staff continued to face significant challenges in terms of the cost of living, particularly given high housing costs in and around Cambridge and the absence of any high-cost area pay supplement.

Agreed:

1. To note the Integrated Performance Report for May 2023.
2. To note the finance report for 2023/24 months 1 and 2.
3. To note the nurse safe staffing report for May 2023.

72/23 Strategy update

India Miller, Interim Director of Strategy, presented the report.

Noted:

1. The Board had approved the Trust's refreshed strategy in summer 2022. Following the discussions at the Board awayday in May 2023, clear lines of accountability had been developed for each of the 15 strategic commitments.
2. Since the away day, the Strategy team had also worked to identify key milestones and quantitative measures of progress.
3. As previously agreed by the Board, the 'strategic lens' for 2023/24 would be improving access to care, with a particular focus on net bed capacity, reducing waiting lists and reducing vacancy rates.
4. Actions required to support the development of key performance metrics across the short, medium and long term had been identified, with a focus on improving flow in the Emergency Department and prioritising outpatient first appointments.

The following points were made in discussion:

1. In response to a question regarding the delivery of neighbourhood-based care and the Home First programme to support the integrated discharge initiative, it was noted that Home First remained a key strategic initiative across system providers and work was ongoing to develop the vision and supporting structure.
2. Work was being undertaken to identify 'high intensity' users of frailty services within the Cambridgeshire South Care Partnership and put in place a range of targeted interventions aimed at reducing their number of Emergency Department attendances.
3. The Performance Committee continued to discuss the operational strategy for the next five years and the initiatives which had the greatest potential to address the projected bed deficit.
4. In the short term, the Trust remain focused on developing a detailed business plan for the provider collaborative, which would include the approach to resourcing and developing a programme plan for 2023/24.

Agreed:

1. To note the progress made over the past four months in delivering against the CUH Together 2025 strategy and the plans for the coming months.

73/23 Education, learning, training and development

Karen Clarke, Associate Director of Workforce, and Dr Arun Gupta, Director of the Cambridge Digital Health and Surgical Training Centre, presented the report.

Noted:

1. The report highlighted the themes that made up the Trust's multi-disciplinary education, learning and development strategy. Work had been undertaken to develop a revised strategy for 2023-2026 with a smaller number of key themes.
2. Each of the key themes within the revised strategy included a specific equality, diversity and inclusion commitment.
3. As part of a three-year funding allocation from Health Education England (HEE), the Trust received £1.33m per annum for Continuous Professional Development (CPD) relating to nurses, midwives and Allied Health Professionals. The Trust had been informed that it would receive a similar level of funding for a further year, following the merger of HEE into NHS England.
4. Arun Gupta gave a presentation on the new Cambridge Digital Health and Surgical Training Centre, emphasising its focus on delivering education and training using state of the art technology including augmented reality solutions.

The following points were made in discussion:

1. The revised strategy included a focus on changing the approach to teaching and education across a range of formal learning programmes at undergraduate, postgraduate and apprenticeship levels.

2. There was scope to explicitly link the revised strategy to the key aims of the NHS Long Term Workforce Plan.
3. It would be important to provide feedback to NHS England on funding routes and mechanisms that would support the implementation of the NHS Long Term Workforce Plan.

Agreed:

1. To note the report and the update on themes 1, 2, 3 and 6 of the Trust's multi-professional education, learning and development strategy and work plan.
2. To support the changes reflected in the revised 2023-26 strategy.

74/23 Guardian of Safe Working

Dr Jane MacDougall, Guardian of Safe Working, and Dr Alex Black, Co-Chair of the Junior Doctors' Forum, presented the report.

1. There had been an increase in the number of exception reports submitted in Q4 2022/23 compared with the previous quarter.
2. Since the previous report to the Board in March 2023, there had been significant progress on the challenges related to weekend rotas, with only three of the original 11 non-compliant rotas remaining where trainees were working more than the recommended maximum of 1:3 weekends.
3. This has been supported by the addition of 15 new posts in the Emergency Department, although recruitment to these had proved challenging.
4. The Junior Doctors' Forum had returned to holding in-person meetings and provided staff with an opportunity to express concerns to senior management.
5. The Board heard about a variance in staffing numbers across the region, particularly for overnight shifts. Despite the industrial action challenges, relationships at a local Trust level had remained relatively positive, with open and engaging discussions being held across several key forums and with key stakeholders.

The following points were made in discussion:

1. In relation to the challenges in filling posts in the Emergency Department, it was indicated that there had been an issue with the quality and attractiveness of the job descriptions. There was also recognition that the recruitment process could take time and it was suggested that the adverts were publicised too late in relation to the availability of the new cohort of junior doctors.
2. It had been suggested at the Junior Doctors' Forum that full clinical service provision posts were not desirable to many who had a preference for part of the time being allocated to specialist interests.
3. While there had been a concern during the pandemic that missed training opportunities would result in a need to provide training extensions, this did not currently appear to be a material issue.

4. Under reporting of exception reports remained a concern for CUH as well as nationally. Work was ongoing to understand the areas of commonality and difference between exception reporting data and the results of the General Medical Council (GMC) trainee survey.
5. While there was a general view that training quality across the country was high, significant concerns remained about trainee experience and potential 'burn out'.
6. Additionally, through the Junior Doctors' Forum, a theme around micro aggressions had been identified. The importance of ensuring that concerns were highlighted through the exception reporting process was emphasised as this would enable the Trust to undertake a deep dive and systematically work through the underlying factors.

Agreed:
1. To receive the quarterly and annual reports from the Guardian of Safe Working.

75/23 Amendment to Trust Constitution

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

Noted:
1. The Local Government Boundary Commission for England had concluded a review of the electoral arrangements in East Hertfordshire. This had resulted in new ward arrangements which did not directly match the existing arrangements. As such there was a requirement to amend the Trust's Constitution to reflect the revised local ward arrangements.
2. The Trust had implemented changes in similar circumstances as a result of a review in the Braintree and Uttlesford Council area in 2015 and following the creation of West Suffolk Council in 2019. In both cases, the Trust had slightly extended the scope of its public constituency to ensure that all previous areas were retained, and no current members were excluded because of local government boundary changes. The proposed amendment followed this precedent.
3. The Council of Governors had approved the amendment at its meeting in March 2023.

Agreed:
1. To approve the amendment to the Public Constituency as set out in the paper.
2. To update the Trust Constitution to reflect the amendments that had been agreed by the Council of Governors and the Board of Directors.

76/23 Board assurance committees – Chairs' reports

Received: the following Chair's reports:

- Audit Committee: 27 June 2023
- Workforce and Education Committee: 28 June 2023
- Performance Committee: 5 July 2023
- Quality Committee: 5 July 2023
    - Safeguarding annual report
    - Health and Safety annual report

77/23 Any other business

There was no other business.

78/23 Questions from members of the public

1. *In a recent primary care bulletin, NHS England asked ICBs to work with GP Practices and other primary care providers, to develop local clinical care pathways for covid oral anti virals and IV treatments. It is understood that General Practitioners and others lack the necessary knowledge, skills and facilities to provide these treatments and that the BMA has recommended that they do not do so.*

1a. What is the local situation regarding the continuation of the CMDU facility at Addenbrooke's?

The Deputy Medical Director responded:

The Covid Medicines Delivery Unit (CMDU) at Addenbrooke's Hospital was decommissioned approximately two months ago.

1b. *Would Addenbrooke's be in a position to advocate for its CMDU to continue as a commissioned service?*

As per NHS England policy, this was handed over to our Integrated Care Board (ICB) partners and so is not planned to continue at CUH.

1c. I ask this question as someone who would need treatment with IV monoclonal antibodies, in the event of contracting a Covid infection and whose GP Practice does not have the facility to provide this treatment.

The ICB were exploring pathways for IV administration within the community and so this would now fall within their remit.

2. *We understand that the Cleaning and Catering Services are coming up for tender. Insourcing would bring huge benefits to the hospital, staff and patients. It would ensure a loyal, reliable, committed workforce in Cleaning and Catering who know they are valued. This would be a far better use of funds than handing over lots of money to private companies who exist to make profits. Will you be taking them back in house on full NHS contracts?*

   The Chief Finance Officer responded.

   The Catering and Cleaning services have been outsourced for some time. Staff are valued for what they do, and many of them have worked at the Trust for a long time. We are now at a point where we are determining the future of the service, and options are being considered. When determining the future strategy, it is not just cost that is a consideration, but also operational effectiveness, wider knowledge resources to draw from and expertise in both catering and cleaning functions.

3. Can you clarify if the properties on Greenlands Estate belong to Addenbrooke's Charitable Trust and not Addenbrooke's NHS Trust?

   3a. When were they transferred in ownership?

   3b. How was this transaction carried out, who authorised it and the purchase process of selling an NHS property portfolio and taxpayers asset?

   The Director of Corporate Affairs responded:

   The properties in question on Greenlands belong to Addenbrooke's Charitable Trust and not to Cambridge University Hospitals NHS Foundation Trust.

   The ownership was transferred when Addenbrooke's Charitable Trust gained independent status in 2017 following changes to charity law and guidance from the Department of Health. This was done with full legal counsel and the support of the Board of the hospital trust and all appropriate documentation.

   Addenbrooke's Charitable Trust is the only charity dedicated to supporting Addenbrooke's and the Rosie, and the objects of the charity remain to support the furtherance of work at the hospitals.

   The hospital works closely with the Charity and is assured that the charity takes very seriously its responsibilities and the work they do to support the hospital and our patients. There are also two hospital representatives on the Addenbrooke's Charitable Trust Trustee Board who operate as Link Trustees to represent the hospitals.

We are aware that Addenbrooke's Charitable Trust have appointed managed agents to support the lettings of the properties to NHS staff and this seems the most effective way of taking care of the tenants while the Addenbrooke's Charitable Trust team focus on their core purpose to raise funds for the hospital.

79/23 Date of next meeting

The next meeting of the Board of Directors in public would be held on Wednesday 13 September 2023 at 11.00.

80/23 Resolution

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

Meeting closed: 13.30

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Board of Directors (Part 1): Action Tracker

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

Key to RAG rating:

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

Board of Directors

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Report to the Board of Directors: 13 September 2023

Agenda item	6
Title	Board committee membership and NED responsibilities
Sponsoring executive director	Ian Walker, Director of Corporate Affairs
Author(s)	As above
Purpose	To agree the proposed membership of Board committees.
Previously considered by	Board of Directors, 9 March 2022

Executive Summary

Board committee membership

This paper seeks the Board's approval of the proposed membership of Board committees following a review undertaken by the Trust Chair. The review has taken account of the vacancy created when Adrian Chamberlain's term of office as a Non-Executive Director (NED) came to an end on 31 August 2023.

The following changes are planned:

- Annette Doherty becomes Chair of the Performance Committee, succeeding Adrian Chamberlain.
- Ian Jacobs becomes Chair of the former Addenbrooke's 3 Committee, succeeding Annette Doherty. It is proposed to revise the remit of this Committee and to rename it the Addenbrooke's Futures Committee (see below).

Other changes will follow in due course following completion of the current recruitment exercise to appoint to the NED vacancy created by Adrian Chamberlain's departure, including filling the resulting vacancy on the Quality Committee.

Consistent with the above, Appendix 1 sets out the proposed membership of Board committees with effect from 1 September 2023.

Senior Independent Director

Adrian Chamberlain was also the Trust's Senior Independent Director (SID). Following consultation with members of the Board of Directors and the Council of Governors, the Trust Chair has asked Sharon Peacock to take on the SID role with effect from 1 September 2023.

Addenbrooke's Futures Committee

With the focus of the Cambridge Cancer Research Hospital and the Cambridge Children's Hospital projects shifting more towards delivery, it is proposed to rename the Addenbrooke's 3 Committee as the Addenbrooke's Futures Committee and to more clearly focus its purpose on the future of clinical care and research at CUH, including clinical operating models, pathway transformation, integrated care, specialised services, innovation and research.

Following consultation with Committee members, the proposed terms of reference for the Addenbrooke's Futures Committee are attached for Board approval.

Related Trust objectives	All objectives
Risk and Assurance	The Board Committees are part of the overall framework for managing risk and assurance in the Trust.
Related Assurance Framework Entries	n/a
Legal implications/Regulatory requirements	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	n/a

Action required by the Board of Directors

The Board is asked to:

- Endorse the membership of Board committees with effect from 1 September 2023 as set out at Appendix 1.
- Endorse the appointment of Sharon Peacock as the Trust's Senior Independent Director with effect from 1 September 2023.
- Approve the terms of reference for the Addenbrooke's Futures Committee.

Appendix 1: Board committee membership

The membership of the committees of the Board is determined by the Chair of the Trust in consultation with the Board of Directors.

The membership with effect from 1 September 2023 is as follows:

Board Committee	**Membership**
Audit Committee	NEDs: Daniel Abrams (Chair), Annette Doherty, Prof Sharon Peacock
Remuneration and Nomination Committee	All Non-Executive Directors. Ali Layne-Smith (Chair)
Quality Committee	NEDs: Prof Sharon Peacock (Chair), Rohan Sivanandan, *Vacancy* Executive Directors: Chief Nurse and Medical Director
Performance Committee	NEDs: Annette Doherty (Chair), Daniel Abrams, Prof Ian Jacobs Executive Directors: Chief Finance Officer, Chief Operating Officer and Medical Director
Workforce and Education Committee	NEDs: Rohan Sivanandan (Chair), Ali Layne-Smith, Prof Patrick Maxwell Executive Directors: Director of Workforce, Chief Nurse and Medical Director
Addenbrooke's Futures Committee	NEDs: Prof I Jacobs (Chair), Annette Doherty, Prof Patrick Maxwell Executive Directors: Director of Strategy and Major Projects, Chief Nurse, Medical Director, Director of Innovation, Digital and Improvement

Appendix 2: Addenbrooke's Futures Committee terms of reference

CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

ADDENBROOKE'S FUTURES COMMITTEE

TERMS OF REFERENCE

1. Authority

1.1 The Addenbrooke's Futures Committee is constituted as a standing committee of the Board of Directors and has no executive powers, other than those specifically delegated in these terms of reference. Its constitution and terms of reference are set out below and can only be amended with the approval of the Board of Directors.

1.2 The Committee is directly accountable to the Board of Directors and is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee or contractor of the Trust and all employees and contractors are directed to cooperate with any request made by the Committee.

1.3 The Committee is authorised by the Board of Directors to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

2. Purpose

2.1 The Committee will provide assurance to the Board of Directors on the future of clinical care and research at CUH, working with partners in the local system and across the Eastern region, in the context of the development of new hospitals and the wider Cambridge Biomedical Campus (CBC). This covers the Trust's ambitions for transforming care and developing the hospital site over the next 10–15 years, addressing the poor quality of some of the estate and facilitating improvements in clinical quality, while remaining at the heart of an integrated care system and working collaboratively with academic and industry partners. It will do so by:

- Providing oversight of the future proposed developments on the CBC as part of the Addenbrooke's 3 hospital redevelopment programme, including the clinical operating model, ensuring that they are aligned with the Trust's strategy.
- Ensuring that the overall benefits of the existing new hospitals developments are delivered, including pathway transformation and transition into the new facilities.

- Monitoring the development, delivery and impact of the Trust's research activity, including through the Cambridge Biomedical Research Centre (Cambridge BRC), working with Cambridge University Health Partners (CUHP) and liaising with the University of Cambridge and other research partners.
- Reviewing the progress of the Trust's engagement with and contribution to integrated care (including through the Cambridgeshire South Care Partnership) and specialised services (through the Specialised Services Provider Collaborative).
- Horizon scanning in relation to innovations in healthcare delivery in the UK and internationally to inform discussion of the previous points.
- Ensuring strategic coherence between all of the above elements.
- Seeking assurance that associated key risks, particularly as included on the Board Assurance Framework and the Corporate Risk Register, are being effectively managed and mitigated.

2.2 The Trust's Performance Committee will retain responsibility for reviewing and recommending business cases associated with the Addenbrooke's 3 programme (with a value in excess of £4 million) to the Board of Directors, and for the oversight of the delivery of new hospitals construction projects. The Chairs of the Addenbrooke's Futures Committee and the Performance Committee will liaise closely in this regard.

2.3 The Chair of the Committee will engage with and invite contributions from the Chairs of other Board assurance committees on key issues relevant to the responsibilities of those committees.

3. Membership

3.1 The members of the Committee shall be appointed by the Board of Directors and comprise:

- Three Non-Executive Directors
- Director of Strategy and Major Projects
- Medical Director
- Director of Innovation, Digital and Improvement
- Chief Nurse

3.2 The Director of Capital, Estates and Facilities Management, the Director of CUHP and the Director of Major Projects will be invited to attend all meetings. Other Non-Executive Directors will have a standing invitation to attend meetings should they so wish. Other Executive Directors and other Trust staff will be invited to attend for specific agenda items with the agreement of the Chair of the Committee.

3.2 One Non-Executive Director will be appointed as the Chair of the Committee by the Board of Directors.

3.3 The Chief Executive will identify an Executive lead for the Committee.

3.4 A quorum shall be three members, comprising two Non-Executive Directors and one Executive Director. In exceptional circumstances, an Executive Director member may send an appropriate nominated deputy in their place and this will count towards the quorum.

3.5 Members should make every effort to attend all meetings of the Committee and will be required to provide an explanation to the Chair of the Committee if they fail to attend more than two meetings in a financial year. If a member fails to attend more than three meetings in a financial year, the Chair of the Committee will consider with the Chair of the Trust the appropriate action to be taken. The Committee Secretary will monitor attendance by members and report this to the Chair of the Committee on a regular basis.

4. Attendance and secretariat

4.1 The Council of Governors may nominate up to two governors to attend each meeting of the Committee to observe proceedings. The observation of Board assurance committees by governors shall be subject to conditions agreed by the Board of Directors. The Chair of the Committee may in exceptional circumstances exclude governors from being present for specific items.

4.2 The Director of Corporate Affairs will ensure that the Trust Secretariat provides a Secretary to the Committee and appropriate administrative support to the Chair and committee members. This will include agreement of the agenda with the Chair and Executive leads, collation and circulation of papers, producing the minutes of the meetings, keeping a record of agreed actions and follow up, and advising the Chair and members of the Committee as appropriate.

5. Frequency of meetings

5.1 Meetings will generally be held every two months.

5.2 The Chair may convene additional meetings of the Committee if necessary to consider business that requires urgent attention.

6. Reporting

6.1 The Committee will receive a regular report from the Executive lead covering issues for escalation.

6.2 The minutes of the Committee's meetings will be circulated for information to all members of the Board of Directors. An exception report will be presented to the next meeting of the Board of Directors following each Committee meeting to draw attention to any matters that require disclosure or escalation to the Board. The Chair of the Committee will work with the Chair of the Trust to ensure that this reporting responsibility is discharged effectively.

6.3 The Committee will provide an annual report to the Board of Directors on the effectiveness of its work and findings, including its review of relevant Board Assurance Framework entries and regulatory compliance. This will be based on an annual effectiveness review to be undertaken by the Committee which will inform its forward work plan.

7. Review

7.1 The terms of reference will be reviewed by the Committee and approved by the Board of Directors at least every two years.

8. Specific duties

8.1 Receive reports at meetings that support the committee in managing the issues and risks to be highlighted by the Executive lead for the Addenbrooke's 3 programme. The Committee will work to ensure that:

- The Addenbrooke's 3 programme and its constituent projects are aligned with the Trust's strategy as set by the Board of Directors, specifically in relation to clinical services, research, teaching and commercial developments.
- The Addenbrooke's 3 programme and its constituent projects reflect current and future clinical pathways of care, with a focus on improving patient outcomes and experience. An update on the delivery of the Cambridge Cancer Research Hospital and the Cambridge Children's Hospital will be brought to every other meeting.
- The Addenbrooke's 3 programme reflects appropriately the Trust's role at the heart of an integrated care system, including the development of integrated care pathways linked to primary and community care.
- The Addenbrooke's 3 programme appropriately reflects the Trust's role as the lead specialist provider for the East of England and the development of the Specialised Services Provider Collaborative.

8.2 Receive reports on the following areas covering progress, issues and risks related to:

- Developments in the research agenda linking the University of Cambridge and CUH, with particular emphasis on implications of research advances for CUH planning and opportunities for CUH to support research developments.
- Progress of the Cambridge BRC, CUHP and of links with other research partners.
- Clinical, research and wider benefits of the Cambridge Cancer Research Hospital and the Cambridge Children's Hospital.
- Future developments under the Addenbrooke's 3 programme, including an acute hospital and facilities for neuro services, and work to develop the maturing partnership with Royal Papworth Hospital NHS Foundation Trust.

- New models of integrated care and evolved care pathways across primary, secondary and community care and the development of the Cambridgeshire South Care Partnership (including the contribution of CUH specifically and the implications for the organisation).
- New models of specialised services and evolved care pathways with other secondary and tertiary providers across the East of England and the development of the Specialised Services Provider Collaborative (including the contribution of CUH specifically and the implications for the organisation).
- The Trust's agreed strategy on innovation.

The Committee will expect to take reports on at least two of these areas at each of its meetings, with each area generally being subject to review twice a year.

8.3 Receive and review those entries on the Board Assurance Framework (BAF) and the Corporate Risk Register (CRR) which are to be overseen by the Committee, and other key programme risks, and ensure that they are appropriately reflected on the Committee's work programme to enable the Committee to gain assurance on the effectiveness of the controls in place and progress in addressing gaps in control and assurance.

8.4 Review the overall approach of the Addenbrooke's 3 programme to communications and stakeholder engagement (including engagement with staff, patients and carers, the public and partners).

8.5 Review the findings of Internal and External Audit reports and any other external reports covering matters within the remit of the Committee, seeking assurance that appropriate actions are identified and implemented in response to findings and recommendations.

8.6 Review any issues referred to the Committee by the Board of Directors.

8.7 Develop an annual work programme agreed by the Committee to discharge the duties as set out above.

8.8 Undertake an annual review of the effectiveness of the Committee to inform the Committee's annual report to the Board of Directors and the following year's work programme.

8.9 Undertake any other responsibilities as delegated by the Board of Directors.

Date approved:
Approved by: Board of Directors
Next review date:

Board of Directors

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Report to the Board of Directors: 13 September 2023

Agenda item	7
Title	Chair's Report
Sponsoring director	Mike More, Trust Chair
Author(s)	As above
Purpose	To receive the Chair's report.
Previously considered by	n/a

Executive Summary

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

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

Action required by the Board of Directors

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

Cambridge University Hospitals NHS Foundation Trust

13 September 2023

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

1. Introduction

1.1 Schools are back, so the weather has improved. Although the summer has not reached the heat of last year, nonetheless it has been an intensive period for all in the Trust. There is much on our collective minds, as covered in items on the agenda. The Board and its various assurance sub-committees will have a busy autumn as we engage on a number of fronts.

1.2 One of the things uppermost in all our minds are the consequences and implications of the tragedy and awfulness of the Lucy Letby case. The Inquiry will no doubt reveal much and recommendations for practice and process will inevitably and rightly ensue. But it is important as a Board that we register the profound nature of the case, and of the importance of maintaining public and staff confidence. We prioritise patient safety and quality and we are realistic about the challenges and risks to patient safety in the current climate of resource pressures and post-pandemic waiting lists. Ensuring patient safety is a function of various levels: at the individual patient care level; at the clinical service data level; at wider Trust levels of data review and comparison; at Trust wide scrutiny and review; and at the assurance or otherwise thereby given at Board level. It is also, fundamentally about the culture of openness and the absence of defensiveness that the Board must exemplify and require.

1.3 The Quality Committee looked at this in early September 2023 and will continue to seek active assurance. We cannot be complacent – on principle. But we have reason to believe that some of our specific procedures in neo-natal care, and some of the Trust-wide approaches such as in the independent review thresholds for unexpected deaths, and the role of the Medical Examiner, that the Medical Director initiated a few years ago, are such as would not have allowed a case of such a pattern here. But as I say, we cannot and must not be complacent. Nor should we focus only on neonatal care as such a malign mindset could apply in other clinical settings.

1.4 I am, though, heartened that while being appalled and having a sense of betrayal, our teams in neonatal care have felt strong support from within the Trust and from patients and their families who have expressed a deep sense of gratitude.

1.5 The Care Quality Commission (CQC) issued its inspection report on Maternity Services at the beginning of the month. This illustrated the challenges we face and which as a Board we have been interrogating over recent months. It did not tell us anything which we were not already sighted on and it is good to see, for example, that the position on midwifery staffing has improved. But we do need to try and accelerate actions, especially in Obstetrics and Gynaecology medical staffing, where there is common analysis of the problems. This will be an important next step.

1.6 The continued exposure to industrial action is very concerning. With the next planned actions, in which there will be an overlap of Junior Doctor and Consultant action, we will have experienced 34 days of industrial action since the beginning of the year. It is deeply frustrating and worrying that we seem to have reached a long-term attritional state, with no evident resolution in prospect. As a Trust we are not party to the disputes, and therefore can take no decisions which will affect their prolongation. We are, though, very much aware of the consequences of the strikes – in lengthening waiting times, in patient anxiety as elective services continually get deferred, in the amount of operational and clinical leadership and management time which has to go into managing the periods of strike action and the destabilising effects this has on longer-term service improvement initiatives. It is impossible precisely to quantify but the Board has clear recognition that there are consequences in the most important dimensions of all: patient safety and access to care.

1.7 In the next Chair's report I will provide an update against the objectives as reported to the last Board meeting.

2. Royal Papworth Hospital

2.1 I would like to take this opportunity to congratulate Dr Jag Ahluwalia on his appointment as the new Chair of Royal Papworth Hospital (RPH) NHS Foundation Trust, effective from February 2024. I look forward to our strengthening association between RPH and CUH for the benefit of patients.

2.2 I also wish to thank Adrian Chamberlain, whose tenure as a CUH Non-Executive Director ended at the end of August 2023, for his very active and positive service as a member of the CUH Board.

3. 'You Made A Difference' Awards

3.1 I was pleased to attend a 'You Made A Difference' award event on 25 July 2023. 77 individual nominations and 41 team nominations were received and I would like to personally congratulate the winners: Yasmin Begum, a Staff Nurse on the Neurosciences Critical Care Unit; and J2, the Trauma High Dependency Unit.

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. Diary

4.1 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
CUH/Greater Cambridge Partnership meeting
Hosting a visit of Her Excellency, Dr Auxillia Mnangagwa, First Lady of the Republic of Zimbabwe

4.2 Other meetings attended during this period include:

Integrated Care Board (ICB)
ICB Board Strategy Development session
Integrated Care Partnership/Health and Wellbeing Board
Cambridge Biomedical Campus (CBC) visit from the Head of Homes England, Peter Freeman
NHS England CEO and Chairs Event

5. Recommendation

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

Board of Directors

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Report to the Board of Directors: 13 September 2023

Agenda item	8
Title	Report from the Lead Governor
Sponsoring executive director	n/a
Author(s)	Neil Stutchbury, Lead Governor of the Council of Governors
Purpose	To summarise the activities of the Council of Governors, highlight matters of concern and note successes.
Previously considered by	n/a

Executive Summary

The report summarises the activities of the Council of Governors.

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

Action required by the Board of Directors

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

Cambridge University Hospitals NHS Foundation Trust

13 September 2023

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

1. Recent Governor meetings

1.1 We held our quarterly meeting with Non-Executive Directors on 5 July 2023 which we dedicated to an open discussion on staffing and productivity. The Government's workforce plan, published the week before provided a fitting context for one of the major challenges facing CUH: responding to increased demand by increasing activity while not increasing cost. A strong case was put forward for managing bed occupancy and outpatient appointments as ways of improving productivity.

1.2 The **Membership Engagement Strategy Group** met on 18 July 2023 and discussed progress against our plan for increasing involvement of members of the hospital. We have created a video aimed at attracting people to sign up as members and get involved in their local hospital. We also decided to open Medicine for Members lectures to non-members in order to widen participation and attract more people to become members.

1.3 Lead governors across the East Anglia region met on 10 August 2023 to update each other on what is happening at their trusts. I had sent the video to the group to stimulate a discussion on how other trusts are attracting and retaining members. No one else had yet made a video, but many trusts had been proactive by putting up stands in the hospital and outside local supermarkets. One trust has a goal that each governor has to attract six new members each year. Most trusts run health talks like our Medicine for Members series.

2. Upcoming Governor meetings

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

- Governor Forum: 7 September 2023
- Council of Governors: 20 September 2023
- Annual Public Meeting: 27 September 2023
- Governor-NED quarterly meeting: 4 October 2023
- Governors' Strategy Group: 16 October 2023
- Governor seminar: 18 October 2023 (presentation on integrated care and the Cambridgeshire South Care Partnership)

3. Other Governor activities

3.1 The Governors' Nomination and Remuneration committee ran a recruitment exercise over the summer to fill the Non-Executive Director vacancy created by Adrian Chamberlain leaving the Board at the end of his second term of office. A high quality shortlist was identified and five candidates were interviewed on 13 July 2023. After further deliberation during August, we hope to make a final decision on the appointment in the coming weeks. The candidates have been kept informed.

3.2 The Lead Governor and Trust Secretariat have consulted governors on who would like to observe board assurance committees and attend Council of Governors' committees. In order to widen opportunities for governors to observe NEDs in action, we have increased the number of observers to four (observing in pairs) for some committee meetings. Governors and the chairs of all the board assurance committees have been consulted on the changes. We are now reviewing the remaining meetings which governors attend (for example, Outpatient Experience, Clinical Ethics and Patient Experience) to satisfy ourselves that a governor needs to attend, and that all such meetings have a nominated governor or governors attending regularly.

3.3 Will Watson has resigned as staff governor as his job has changed and he is now working full-time at Royal Papworth Hospital. Consequently we have considered how we can refill this vacancy without having to wait until the next election cycle. A paper is being taken to the Board of Directors and the Council of Governors to recommend an amendment to the Constitution to allow the staff member who had the next highest number of votes in the most recent election to be co-opted onto the Council of Governors for the period to the next election.

3.4 Cambridgeshire County Council has appointed Susan van de Ven as its partnership governor replacing Gerri Bird.

4. Recommendation

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

Board of Directors

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Report to the Board of Directors: 13 September 2023

Agenda item	9
Title	Chief Executive's report
Sponsoring executive director	Roland Sinker, Chief Executive
Author(s)	As above
Purpose	To receive and note the contents of the report.
Previously considered by	n/a

Executive Summary

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

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

Action required by the Board of Directors

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

Cambridge University Hospitals NHS Foundation Trust

13 September 2023

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

1. Introduction/background

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

1.2 The context for CUH remains challenging, including the national waiting list position for patients, increasing damage from industrial action, and the implications of the Letby and other cases. Alongside this there are positive national developments including the NHS workforce plan, the opening of additional capacity and investment in strengthened digital infrastructure - and the very high quality care being provided by individuals and teams across the country. An active debate on the future of public services and the potential for economic growth should intensify over the next 18 months.

1.3 CUH continues to perform well in the five areas of operational performance relative to peers, but with areas of concern. While services and staff remain under real pressure, complicated by industrial action, care remains broadly very good.

1.4 On quality our focus remains on maternity where we recognise a high quality CQC report at Requires Improvement, not a position we should be in. The report shows a good service but with some areas for improvement, nearly all of which were already understood and being worked on, particularly around staffing. There were no surprises and work on the pre-existing action plan will continue. In addition work continues on quality relating to patients waiting longer than we would like, complaints and the implications of staffing; and on the many areas of real strength including outcomes. In line with plans CUH will be reviewing all services against the CQC framework as we go through the next 3-6 months. In relation to the Letby case, CUH will maintain ongoing review of the wide range of processes to assess service provision - in line with current national guidance.

1.5 In other areas of operational performance: on waiting times we continue to improve on the emergency pathway (noting that the next phase of improvement will be important) and make progress on elective waits in the face of industrial action; on workforce our listening events have completed and recruitment continues, with further work to support staff (both internally and also considering actions in relation to our external environment); on finance we remain broadly on plan with a strong balance sheet and work to do on the five year financial strategy, including identifying where we will invest and the approach to take with our ICB system partners on whole system productivity; and on improvement, innovation and digital there is a combined focus on in-year productivity and a refreshed approach to longer term transformation. While very challenging this position can be compared to periods at CUH tackling very serious financial, access or quality issues. Staying ahead will be critical to providing appropriate care to patients and support to staff over the next one to five years.

1.6 Looking to the next 12 months our five part workforce strategy will continue and the listening events with staff will provide us with more of a steer on how we can better support our colleagues. For patients, the Trust has agreed the next phase of the operational strategy and we anticipate the opening of the 40 bedded three theatres elective orthopaedic centre in October 2023, the 56 additional beds in U-block over Christmas, and the three neurosurgical theatres before financial year end. Work also continues on the 15 programmes in the three domains of the strategy, in particle through the lens of access to care. We expect further progress on our strategies in relation to EDI and sustainability.

1.7 In Building for the Future, the Trust and partners are now moving towards the Full Business Case for the Cambridge Cancer Hospital and preparing to build; and are submitting the Outline Business Case for the Children's Hospital for national review in the autumn, requiring a good deal of flexibility and negotiation on approach. Fundraising remains key to both programmes. Work is also 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. It is encouraging to see the progress in building 1000 Discovery Drive on the Biomedical Campus (to house amongst others some of the Trust pathology services); work on the Cambridge South station; contributions to plans for the sustainable travel zone; ongoing progress on securing accommodation and office space for CUH; and plans for the new Maggie's Centre.

1.8 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 three to 24 months; and a refreshed long term plan supported by appropriate enablers in workforce, innovation, digital and capital.

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

1.10 In line with good practice the Trust is undertaking a Well-led external governance review this autumn, and alongside will be considering appropriate leadership, resourcing and structures to support the current plan.

1.11 We continue to mark important moments across the Trust, with our partners, including thank you events for colleagues retiring, and the CUH Annual Awards planned for the early autumn.

Part A

2. The five areas of operational performance

2.1 Quality

2.2 CUH retains its overall focus on quality and safety across all areas of the Trust, with eight areas of particular update this reporting period.

Emergency care and patient flow

2.3 Further information on urgent and emergency care and patient flow is detailed in Section 3 of this report.

Maternity

2.4 An announced focussed CQC inspection was conducted in May 2023 of the Rosie Hospital as part of a wider national programme of inspections of maternity.

2.5 The final report has been received by CUH and was published on the CQC website on 1 September 2023.

2.6 In summary, whilst there is no impact on the Trust Overall rating of 'Good', the core service rating for Maternity (Safe) declined from 'Good' to 'Requires Improvement', with findings that mirrored the themes outlined by the CQC summarising their progress so far nationally – there were no 'outlier' non-conformities compared to other Trusts inspected. The well led domain was rated as 'Good'.

2.7 The Trust was issued with one "Must" and 13 "Should Dos".

Staffing numbers

2.8 The greatest impact from vacancies within nursing is upon the paediatric critical care units (PICU & NICU) with both units having to close to referrals from the region on occasion due to staffing constraints.

2.9 Whilst the Trust has seen a slightly improving picture within adult critical care, this has deteriorated over the last month due to an increase of short term sickness. This coupled with a consistently higher than normal acuity of patients resulting in a higher proportion of level 3 (Intensive Care) patients requiring care has led to an increase in the reported number of breaches of the guidelines for the provision of intensive care (GPICS) standards.

The intention had been to open the remaining closed beds by September 2023 however this will need to be reviewed taking into consideration the short term absence rate. It should be noted that the vacancy rate is improving and there is a strong recruitment pipeline.

2.10 There is an increasing trend in the vacancy and turnover rates for Health Care Support Workers (HCSW). This coupled with the high demand for specialling patients (one to one observation) across the Trust, is impacting fill rates across all wards resulting in a shortage of HCSWs on a shift by shift basis. There are a number of initiatives being piloted to address retention of this workforce including access to pastoral support through the clinical education team and identified peer buddies.

2.11 Midwifery vacancy rates have significantly improved in recent months and this risk reduction has been reflected on the Corporate Risk Register (CRR) following discussion at Risk Oversight Committee (ROC).

2.12 The greater risk lies within the medical workforce, this is a concern highlighted in the recent CQC inspection.

2.13 Adequate staffing with the correct skill is a 'Must' do identified within the CQC report.

Complaints and Patient Advice and Liaison Service (PALS)

2.14 The PALS and complaints departments continue to receive a high volume of new cases, in both services. For complaints in June 2023 an exceptionally high number of complaints were received by the Trust (90 cases) and work has been undertaken to identify the trends and themes related to this. In July 2023 56 formal complaints were received, with the numbers for August 2023 predicted to be the same.

2.15 Work continues on the improvement plan. For complaints, the service remains divided into two teams with one team focusing on the backlog cases and another trialling new processes supported by the Improvement and Transformation team. Progress has been made with 300 cases now closed from the initial backlog of 540. In addition 120 new complaints cases have been closed since May 2023. Data from the new cases initiative shows that cases are now being closed within shorter timeframes through the use of alternative methods of resolution such as telephone calls complainants and meetings.

2.16 The complaints department remains on track to meet the team's objective of clearing the backlog by November 2023.

Serious Incidents (SI)

2.17 Clearing the backlog of open SI investigations remains a priority with currently 23 open investigations (20 on track). Additional resources allocated to support the team remain and extensions requested from the Integrated Care System to support completion of investigations and reports where needed. Work is ongoing to progress the new Patient Safety Incident Response Framework (PSIRF) implementation plans via key patient safety working groups.

Hospital Standardised Mortality Ratio (HSMR)

2.18 The HSMR was 81.9 (April 2022 to March 2023), 71.0 in the month of March 2023 and banded as statistically 'lower than expected'.

2.19 There are no areas which have been flagged for concern by Dr Foster.

2.20 The Trust is 1 of 2 within the regional peer group with an HSMR banded as statistically 'lower than expected' over the 12 month period. The Trust is 1 of 6 within the Shelford Group with an HSMR banded as statistically 'lower than expected' over the 12 month period.

Industrial Action

2.21 Further industrial action by both the junior and consultant medical workforce has taken place. Any associated harm to patients continues to be assessed. To maintain safety on a daily basis elective patient lists continue to be clinically prioritised resulting in a number of planned cancellations.

Children Requiring Social Care Placements

2.22 There is an emerging theme of children being brought to the ED as a place of safety due to a lack of available social care placements. Data is being captured on the average length of stay of these children which will be reported through the joint safeguarding committee. A system wide meeting has been convened by the Cambridgeshire and Peterborough Integrated Care Board (ICB) Medical Director to agree a system wide response to identification of pathways for these children.

3. Access to Care

3.1 The Trust has retained a focus on urgent and emergency care, sustaining improvements in the pathway. Due to on-going actions our long waits in ED (12hrs or more) were at 4% of attendances, lower than both the regional and national averages. In July 2023 we met all national targets for ambulance handovers for the third month in a row, with no patients waiting over 60 minutes, making CUH the joint top performing trust in England. 4hr performance, against which the Trust re-started performance reporting in May, has sustained an 8% improvement compared to last year. Delivering 4hr performance remains a key target for the Trust.

3.2 Elective activity as a whole continues to be significantly impacted by periods of industrial action during 2023/24. Whilst some account was taken of this in our planned figures for April, in line with national guidance, activity was not adjusted for industrial action in May onwards. This will continue to impact our elective performance against trajectory as long as it continues. In the context of these challenges, overall elective in-patient and day-case activity in the year to date represents 93% of planned levels, with day cases driving the majority of the variance. We have continued to reduce our cohort of patients waiting over 52-weeks, but our cohorts of patients waiting over 65-week and 78-weeks has remained flat compared to June. Across the region, CUH has the second-lowest proportion of patients waiting for cancer treatment over 62 days. We will continue to focus on delivering improvement across our emergency and elective pathways during 2023/24 in line with our operational strategy.

3.3 **Emergency Department (ED).** Performance in August 2023 has decreased slightly, reaching 67.0% in the month to date, against a plan of 68.8%. Outflow and processing power in ED has been challenged during August 2023 due to higher bed occupancy and staffing gaps.

3.4 **Referral to Treatment (RTT).** The total RTT waiting list grew by 1.6 % in July 2023. The total waiting list size was 0.5% lower than the planning submission for Month 4.

3.5 **Delayed discharges**. The number of beds lost to delayed discharges decreased to 111 in July 2023, down slightly from 115 in June 2023. This represents a significant proportion (>10%) of our overall in-patient bed base.

3.6 **Cancer.** CUH remains above target and above Shelford Group performance for the 28 day faster diagnosis standard. CUH has experienced further deterioration in performance against the 2WW target due to breaches in the skin cancer and sarcoma pathway. Referral demand remains higher than average.

3.7 **Operations.** Capped Utilisation dropped in July 2023 to 77.1% (Quartile 3) but remains consistent with peers. Sessions used in July 2023 were down to 84.8%, improving to 96.3% when industrial action dates are excluded.

3.8 **Diagnostics.** Six week performance remains ahead of plan for July 2023. Total activity in July 2023 was 1% higher than plan driven by unscheduled and surveillance diagnostics.

3.9 **Outpatients.** While still performing below plan, July 2023 was an improvement with new attendances at 109.4%. Division A were the best performing at 114.6%. Both divisions B and D delivered over 100% of baseline with divisions C and E falling below.

4. Finance – Month 4

4.1 The Month 4 position for performance management purposes is a £0.3m deficit, this is adverse to plan by £4.1m. The full year plan is to deliver a break-even financial position. The Trust remains broadly on track to deliver this year, whilst continuing to focus on the major improvement and transformation schemes and the longer term financial plan.

4.2 The following points should be noted in respect of the Trust's Month 4 financial performance:

- Financial under performance is driven by £4.1m of increased pay expenditure arising from industrial action (IA).
- In line with national directives the Trust has accounted for all commissioners funding elective activity at least in line with the agreed baselines to partially support the impact of IA. Elective income from commissioners who are under performing has therefore been assumed at £3.1m in the year to date position.
- Further IA is planned for August and September 2023 which is expected to significantly increase the pressure on the Trust's finances.
- In forecasting a year-end break-even position the Trust has assumed central financial support is provided to fully cover the adverse impact of the IA.
- The position also includes £6.7m of non-recurrent funding which the Trust plans to increase to £20m by the end of the year. Improvements in productivity and changes to the current funding regime will be required to replace this support for next financial year if the Trust is to maintain break-even financial performance.

4.3 Since finalising the Month 4 position NHSE have provided two updates on how they plan to provide additional funding to Trust's to support the impact of IA:

- Updated guidance as to the Educational Performance Measure (EPM) calculation.
- That financial support for the impact of IA will be provided through a reduction to the EPM targets - expected to be -2% for April's IA. We expect similar adjustments to be made for subsequent IA months but this has not yet been confirmed.

4.4 If the IA support is implemented in line with this draft proposal, the Trust's assessment is that this will broadly mitigated the Trust's financial impact of IA, exceeding the £3.1m of support assumed in the Month 4 position and returning the Trust to plan.

4.5 The Trust has received an initial system capital allocation for the year of £35.0m for its core capital requirements. In addition to this, we hope to receive further funding for the Children's Hospital (£3.5m), Cancer Hospital (£11.3m), and Community Diagnostics £0.8m, together with capital contributions from ACT totalling £7.4m and technical adjustments in respect of PFI, the Trust's capital budget for the year totals £60.7m.

As a counter-measure against likely slippage an £8.4m over-commitment has been built into the 2023/24 capital plan which will be monitored closely throughout the year.

4.6 At Month 4 the capital programme is ahead of plan with spend year to date of £13.9m against a budget of £9.3m. This reflects a number of projects spending earlier than originally expected and does not indicate any actual overspending against project budgets. The forecast spend for the year remains on budget at £60.7m.

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. At the time of writing the trust has been notified of joint strike action by junior doctors and consultant medics, which would have significant operational impact.

Good Work and Wellbeing

5.3 The Joint Committee on Vaccination and Immunisation (JCVI) has announced its advice regarding persons who will be eligible for Covid-19 booster vaccines this autumn. As in previous years, this includes frontline health care workers.

5.4 Planning is underway to deliver both a flu and Covid-19 booster vaccination programme to CUH staff in autumn 2023. Vaccination clinics will take place in the main hospital building this year, with flu vaccination clinics due to begin in September. The Covid vaccination programme will commence once the vaccine becomes available.

5.5 In August 2023 the Trust launched the first staff pod as part of the CUH good work agenda. This is a rest space for staff, open 24 hours a day, with kitchen facilities, comfortable seating and an outdoor seating area. It is hoped that this staff pod, kindly funded by ACT, will be the first of many dedicated staff spaces.

Resourcing

5.6 The Registered Nurse (RN) vacancy rate is currently 8.6% and the Health Care Support Worker (HCSW) vacancy rate is 13.6% against a CUH ambition of 5% or less. There continues to be considerable work in recruiting and retaining staff including RNs and HCSWs.

5.7 A number of vacancy hotspot areas, those where there are particular challenges to recruiting and retaining staff, have been identified with an improvement programme underway to provide focus and attention to these areas.

5.8 The Trust has been awarded, by NHS England, the Pastoral Care Award. This is a national award that recognises high standards of pastoral support for internationally recruited staff.

5.9 Funding has been received by NHS England to support the international recruitment of Allied Health professional staff to work in the Cambridge Diagnostic Centres, opening in September 2023.

Ambition

5.10 To coincide with the implementation of the Patient Safety Incident Response Framework, CUH is undertaking a broad programme of work to embed a Just and Learning Culture across the organisation. A key starting point for the programme was a series of masterclasses during July, delivered by Suzette Woodward (Visiting Professor of Patient Safety for Imperial College University London) and attended by 220 senior leaders. Further opportunities for deepening understanding and developing ways of implementing our five principles and five commitments are planned for all staff groups from September.

5.11 A record 29 participants from CUH were successful in applying to the ICS systems leadership programme Leading Beyond Boundaries, which will commence in September 2023. In addition to deepening knowledge and building skills around systems leadership, participants from the NHS, local councils, fire, police and prison services, and voluntary and community organisations will form a cohort of systems leadership champions to support the integration and implementation of systems working across Cambridgeshire and Peterborough.

Inclusion

5.12 During July 2023 the Race Equality and Cultural Heritage (REACH) network hosted Career Development workshops for black and minority ethnic staff. Over 60 staff participated and both workshops and mentoring sessions evaluated incredibly well. More positive action events and programmes are planned to support career progression of BAME staff who are under-represented at senior levels of the Trust.

5.13 July 2023 also saw the trust's Open Minds Network host a staff picnic as part of their Tackling Loneliness campaign.

5.14 Congratulations to Ruby Lopez, Neonatal Nurse and Cultural Ambassador, who has been shortlisted for the Compassionate and Inclusive Leader Award at this year's National BAME Health and Care Awards. Now in its fourth year, the awards highlight BAME leaders and role models making a difference in UK health and social care.

Relationships

5.15 In the 2022 NHS National Staff Survey we saw a continuation of the recent deterioration in staff engagement scores. Throughout June and July 2023, 127 staff members attended a series of 'Building the Future Together' staff engagement workshops, aligned to the themes of the NHS People Promise, which aimed to help us better understand what we have heard from staff through recent surveys, and identify and capture what is working well. Key findings and recommendations from these events are being presented to Management Executive in September, while work is already underway to prepare for the 2023 National Staff Survey which will launch in October.

5.16 CUH and RPH hosted a joint birthday party to celebrate 75 years of the NHS. Kindly supported by ACT, staff from both hospitals were invited to attend a BBQ on the campus Green and Garden space whilst enjoying live music and interactive stalls.

5.17 We look forward to our annual staff awards ceremony in September 2023, celebrating with finalists and winners chosen for their commitment, impact and dedication to CUH. Over 1000 nominations were received with each of these being recognised and thanked.

6. Improvement and Transformation

6.1 The Trust retains its focus on delivering for this year, whilst refining plans for innovation, digital and improvement in the longer term.

Building quality improvement (QI) capability and capacity

6.2 The Trust's three-year term with its improvement partner, the Institute for Healthcare Improvement (IHI), will conclude in September 2023. A final output of this partnership will be the IHI's annual onsite visit on 11-12 October 2023.

6.3 In order to ensure that the Trust is self-sustaining beyond its partnership with the IHI, Trust staff are continuing to deliver QI capability and capacity building programmes, with coaching support from the IHI.

Outpatients

6.4 Support for the Trust's outpatient transformation programme continues to be provided by the improvement and transformation team across a number of initiatives including the roll out of patient not present and patient initiated follow up, with the aim of reducing follow up appointments and increasing the number of new appointments.

6.5 A data for improvement approach has been adopted across this programme. New outpatients seen have been running at 100.9% of the 2019/20 figure since April 2022, with monthly natural variation occurring due to staff changes and strikes. The rate of increase in the total number of new outpatients waiting is stable. Divisions A and B have seen a reduction in the total number of new outpatients waiting.

6.6 The number of outpatient follow ups seen has been stable at 113% of the 2019/20 figures for the last year. Overdue follow ups continue to rise with a stable rate of 1.7% per month, with monthly variation. Divisions A and B have seen a reduction in the total number of overdue follow ups.

Virtual wards

6.7 The virtual ward model of care continues to grow. To date, the virtual ward team has admitted over 600 patients and the ward has an average length of stay (LoS) of eight days. The virtual ward has saved approximately 2,018 physical bed days to the end of June 2023, equivalent to 8.3 beds per day an increase from 7.3 beds per day at the end of April 2023. At the end of Month 4, implementation of the virtual ward model of care has realised a saving of £410k.

Clinical pathways in place include cardiology, ileostomy, tuberculosis and acute respiratory medicine. Endoscopy, knee arthroplasty and bone marrow transplant pathways are due to follow shortly. The use of a virtual ward model for paediatrics is also being explored with clinical teams.

Urgent and emergency care (UEC)

6.8 The improvement and transformation team continues to support colleagues with same day emergency care (SDEC) for medical and surgical patients, with a number of initiatives aimed at reducing the LoS for patients in the ED and the provision of alternative pathways to refer patients directly to the appropriate assessment unit.

6.9 Recent ward reconfiguration to support patient flow for acute medicine and frailty pathways launched in August 2023. The improvement and transformation team are helping to track and display performance of the medical assessment unit (MAU), frailty unit, acute hub and department of medicine for the elderly (DME) wards following pathway reconfiguration. These will be used to monitor performance and collect a baseline for future QI work.

6.10 Having identified inequity of bed allocation as a barrier to improving patient flow, the acute medical team has worked closely with the operations centre to ensure greater parity for patients requiring transfer from the MAU. This has improved patient flow out of the unit, resulting in a decrease in LoS in both EAU3 and EAU4. Within a four week period, the LoS for EAU3 patients placed on trolleys reduced by 696 minutes / day (from an average of 1,423 minutes / day, in the 5 months prior). LoS also reduced for EAU4 patients by 845 minutes / day, compared previously to an average of 1,958 minutes / day. MAU service redesign has contributed to a year-to-date saving of £93k.

6.11 Surgical pathway redesign continues to focus on optimising ambulatory pathways to the surgical assessment unit (SAU) from the ED and includes abdominal pain patients, oral and maxillofacial patients, as well as nurse-led discharges to support patient flow from the unit. These projects are scheduled to go-live in September 2023.

Productivity and efficiency

6.12 The Trust's efficiency requirement for 2023/24 is £53m and if met, will deliver an end-of-year break-even position. The current value of both fully developed plans and those with plans under development is £46.2m; there is a focus now on developing plans for an additional £9.7m of identified ideas without a confirmed plan.

If all identified schemes were delivered in full, this would lead to a delivery figure of £55.8m, an over-achievement of £2.8m. 96% of identified schemes will deliver savings recurrently.

6.13 As at Month 4, the Trust has delivered a £14.7m efficiency against a year-to-date plan of £17.1m, resulting in under-performance of £2.4m, with national industrial action contributing to an increase in pay costs and reduction in productivity. However, after accounting for the expected mitigations for the financial impact of industrial action, financial performance is forecast to meet plan. With the continued focus on delivering against the current productivity and efficiency opportunities, as well as the development of new schemes, more significant financial measures, are not required at this stage.

Digital

6.14 The Trust is entering year 10 of our use of Epic, our electronic health record system. CUH were the first in the UK to implement Epic which provides a single integrated view of the whole patient journey at CUH. This has led to many efficiency and safety benefits which has been independently recognised when we achieved HIMSS Stage 7, the highest level of digital maturity, in 2020. This 10 year milestone provides an opportune moment for reflection and to build on this foundation to accelerate our efforts in exploiting our digital capabilities and data to improve the care we deliver. Key elements include closer integration between digital with clinical and operational team at CUH, building data analytics capabilities to provide greater insights from our data and greater collaboration with wider system such as the Cambridgeshire & Peterborough Integrated Care System. The Trust will also look to form strategic partnership with academic and industry partners to catalyse our efforts.

PART B

7. Strategy update

Strategy implementation

7.1 Following the launch of the Trust's refreshed strategy in 2022, focus continues on its implementation. The Board has agreed that access to care is a primary strategic delivery lens for 2023/24, across all 15 commitments. Work continues on assessing how and to what extent current and planned initiatives will allow us to address this challenge in the short-, medium- and long-term.

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

Improving patient care

Integrated Care

7.3 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.

7.4 Projects include ICS pathway work in respiratory, diabetes, frailty and cardiovascular disease, as well as engagement in end-of-life and urgent care multi-professional and multi-organisation groups.

7.5 The Trust's collaborative work with East Cambridgeshire and Cambridge City has been recognised in this year's Health Service Journal awards where our partnerships have been shortlisted in the categories of Reducing Healthcare Inequalities for Children and Young People, and Provider Collaborative of the Year.

Health Inequalities, Equality, Diversity and Inclusion

7.6 The Trust continues to work on the development of an integrated Equality, Diversity and Inclusion (EDI) and Health Inequalities Strategy for the organisation. An EDI and Health Inequalities Diagnostic report is in the final stages of development and will be presented at Trust Board in October 2023. The report sets out the key themes and evidence from a comprehensive analysis of the current Trust position with respect to Equality, Diversity, Inclusion and Health Inequalities reduction.

7.7 In July 2023 the EDI Strategy Group participated in a deep-dive session into health inequalities. The session, which included guest speakers, provided an opportunity to explore the role of acute providers in health inequalities reduction, and to learn alongside and with other organisations.

7.8 We are also seeking ways to embed EDI and Health Inequalities into the Trust's business as usual. For instance, we are developing a proposed approach to service redesign which incorporates equity, and exploring how inclusion can be designed into our annual business planning process.

Supporting our staff

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

Building for the future

New hospitals and the estate

7.10 The Community Diagnostic Centre (CDC) spoke at Wisbech has been operational for MRI and CT since April 2023. Further services, including echocardiology and non-obstetric ultrasound, are expected to become live in September 2023. Work continues on the Ely CDC hub with a planned completion date in spring 2024.

7.11 Following a diagnostic assessment to scope the opportunities for further strategic collaboration between CUH and Royal Papworth Hospital, projects are being agreed that will form the focus of the next stage of this partnership. The projects will be exploring the development of shared patient pathways as well as opportunities to work together on recruitment, training and staff development. The proposed portfolio is expected to be shared internally with Trust Boards in October this year.

7.12 In early August 2023 we received formal approval from NHS England that the Outline Business Case (OBC) for the Cambridge Cancer Research Hospital (CCRH) had been approved. This is a major milestone as it represents the unofficial moment when HM Treasury and the Department for Health and Social Care commit to take a case to its final stage. At around the same time we agreed to enter a contract with the international construction company Laing O'Rourke to become our formal construction partner. The next year will see the production and submission of the Full Business Case (FBC) and the hoped for approval to construct the CCRH.

7.13 The Cambridge Children's Hospital OBC was signed off by the CUH Board in June 2023 and is currently under review by regional and national teams. The OBC will be taken to the national Joint Investment Committee in autumn 2023 for approval. 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 the summer. The team are also developing enabling works construction plans aiming to start in 2024. The project's fundraising campaign remains in a strong position, with over £45m of its £100m target achieved and further pledges expected in the coming months.

Specialised Services

7.14 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 June 2023, the EoE SPC secured provider representation on the East of England Joint Commissioning Committee – a statutory committee established by NHS England and EoE ICBs to manage regional delegation of specialised services.

7.15 In July 2023, the Board agreed that EoE SPC should begin reporting to the Addenbrooke's 3 Committee on a quarterly basis.

7.16 The EoE SPC continues to progress several specialised services transformation projects across the East of England region. These projects include working with several other trusts in the region to deliver biologic therapies for severe asthma and Multiple Sclerosis patients closer to home; and supporting the delivery of video monitoring software for remote diagnosis and management of epilepsy seizures.

We have also begun a longer-term project to develop a region-wide neurosciences strategy, beginning with an initial diagnostic assessment to identify the biggest challenges and opportunities.

7.17 The EoE SPC will provide a draft business plan for Board approval in autumn 2023. The business plan will articulate in more detail what we want EoE SPC to achieve in the next year, outline anticipated resource requirements and propose a proportionate overarching governance model to support delivery of our shared objectives.

Climate change

7.18 A £1m grant has been secured from the Government's Low Carbon Skills Fund to develop CUH's Heat Decarbonisation Plan, transitioning the campus from burning gas for steam to high efficiency electric heating and a new hot water network.

7.19 Following a successful trial, the ATC theatres have permanently switched to the use of mobile nitrous cylinders and agreed to the decommissioning of the centralised pipe network.

7.20 The Clinical Purchasing Evaluation Group has been re-established to secure actions to switch from single-use to reusable clinical items, e.g. agreement to trial reusable venous tourniquets.

7.21 Two teams have successfully achieved the Green, Bronze, Silver and Gold levels of the 'Think Green Impact' programme, demonstrating their application of a carefully tailored set of actions that drive down the Trust's environmental impacts and improve their workspaces. Activities in the toolkit range from energy and water use, to what we purchase and throw away, how we travel etc., which will help us meet our carbon reduction targets for a climate-safe future.

7.22 More widely across the Trust, there has been strong staff engagement focused on recycling and use of plastics alongside site sustainability tours.

8. Recommendation

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

Board of Directors

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Together
Safe
Kind
Excellent

Report to the Board of Directors: 13 September 2023

Agenda item	10
Title	Integrated Report
Sponsoring executive director	Chief Operating Officer, Chief Nurse, Medical Director, Director of Workforce, Chief Finance Officer
Author(s)	As above
Purpose	To update the Board of Directors on performance during July 2023.
Previously considered by	Performance Committee, 6 September 2023

Executive Summary

The Integrated Performance Report provides details of performance to the end of July 2023 across quality, access standards, workforce and finance. It provides a breakdown where applicable of performance by clinical division and corporate directorate and summarises key actions being taken to recover or improve performance in these areas.

Related Trust objectives	All objectives
Risk and Assurance	The report provides assurance on performance during Month 4.
Related Assurance Framework Entries	BAF ref: 001, 002, 004, 007, 011
Legal implications/Regulatory requirements	n/a
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of “Together: safe, kind and excellent”?	n/a

Action required by the Board of Directors

The Board is asked to note the Integrated Performance Report for July 2023.




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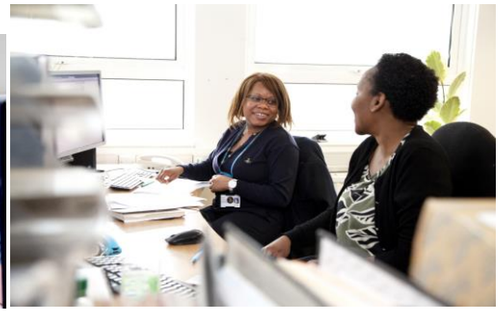



Integrated Report

Quality, Performance, Finance and Workforce to end July 23

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

Report compiled: 31 August 2023

Key

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Data variation indicators

- Normal variance - all points within control limits
- H — Negative special cause variation above the mean
- L — Negative special cause variation below the mean
- H — Positive special cause variation above the mean
- L — Positive special cause variation below the mean

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

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

Quality Account Measures 2023/24

NHS Cambridge University Hospitals NHS Foundation Trust

2023/24 Quality Account Measures				May 23	Jun 23	Jul 23				
Domain	Indicator	Data to	Target	Previous Month-1	Previous Month	Current status	Trend	FYtD	Baseline	LTM
Safe	% Trust Compliance with Falls Risk assessment & documentation within 12 hours of admission	Jul-23	90%	89.0%	87.0%	88.0%	⇧	87.5%	50.0%	87.5%
	Trust Compliance with Pressue Ulcer risk assessment tool & documentation within 6 hours of admission	Jul-23	90%	84.2%	80.0%	82.0%	⇧	81.6%	13.4%	81.6%
	% Rosie MDT Obstetric staff passed PROMPT emergencies training	Jul-23	90%	79.4%	81.2%	78.0%	⇩	78.1%	71.0%	78.1%
	% Rosie Obstetricians and Midwives passed fetal surveillance training	Jul-23	90%	84.5%	88.0%	81.0%	⇩	83.5%	72.0%	83.5%
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)	Jul-23	7%	8.4%	8.0%	7.0%	⇩	8.0%	14.0%	8.0%
Effective / Responsive	% of Early Morning Discharges (07:00-12:00)	Jul-23	20%	14.9%	16.1%	14.9%	⇩	15.3%	15.3%	15.9%
	Percentage of in-patient discharges on a Saturday and Sunday compared to the rest of the week (calculated as the average daily discharges on Sat/Sun divided into the average daily discharges Mon-Fri). Excludes day cases. 80% (of weekday rate) Additional Filters Simple Discharges, G&A etc	Aug-23	80%	82.7%	72.3%	74.0%	⇧	N/A	74.0%	N/A
	Same day emergency care (SDEC)	Jul-23	30%	25.4%	25.2%	25.9%	⇧	24.9%	22.0%	20.9%
	Percentage of admissions over 65yo with dementia/delirium or cognitive impairment with a care plan in place	Jul-23	50%	69.2%	77.0%	74.0%	⇩	61.3%		61.3%
	SSNAP Domain 2: % of patients admitted to a stroke unit within 4 hours of clock start time (Team centred)	Jul-23	55%	39.8%	47.6%	50.5%	⇧	42.3%	29.2%	32.9%
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%	

Quality Summary Indicators

NHS Cambridge University Hospitals NHS Foundation Trust

Performance Framework - Quality Indicators				May 23	Jun 23	Jul 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)	Jul-23	0	0	1	1	⇔	4	3	6
	E.coli Bacteraemias (Total Cases)	Jul-23	50% over 3 years	43	27	43	⇧	155	401	421
	C. difficile Infection (hospital onset and COHA* avoidable)	Jun-23	TBC	4	12	N/A	▪	22	129	112
	Hand Hygiene Compliance	Jul-23	TBC	93.4%	94.2%	95.5%	⇧	94.1%	96.4%	95.2%
Clinical Effectiveness	% of NICE Technology Appraisals where funding was not procured within three months. ('last month')	Jul-23	100%	100.0%	66.7%	66.7%	⇔	90.0%	N/A	90.0%
	% of NICE guidance relevant to CUH is returned by clinical teams within total deadline of 30 days.	Jul-23	80%	33.3%	40.0%	50.0%	⇧	38.5%	51.0%	43.1%
	100% of NCEPOD questionnaires (clinical and operational) relevant to CUH is returned by clinical teams within deadline ('last month').	Jul-23	100%	N/A	75.0%	N/A	▪	75.0%	N/A	75.0%
	85% of national audit's to achieve a status of better, same or met against standards over the audit year	Jul-23	85%	N/A	N/A	N/A	▪	100.0%	84.6%	82.9%
Nursing Quality Metrics	Blood Administration Patient Scanning	Jul-23	90%	99.7%	99.3%	99.6%	⇧	99.7%	99.6%	99.6%
	Care Plan Notes	Jul-23	90%	95.7%	96.0%	96.4%	⇧	96.0%	96.3%	96.2%
	Care Plan Presence	Jul-23	90%	99.8%	99.7%	99.7%	⇧	99.7%	99.7%	99.7%
	Falls Risk Assessment	Data reported in slides								
	Moving & Handling	Jul-23	90%	78.0%	77.1%	79.1%	⇧	77.3%	72.4%	74.1%
	Nurse Rounding	Jul-23	90%	99.2%	98.8%	99.2%	⇧	99.1%	99.2%	99.2%
	Nutrition Screening	Jul-23	90%	79.4%	77.1%	79.8%	⇧	78.2%	73.1%	74.8%
	Pain Score	Jul-23	90%	85.1%	85.8%	86.5%	⇧	85.4%	83.9%	84.4%
	Pressure Ulcer Screening	Data reported in slides								
	EWS									
	MEOWS Score Recording	Jul-23	90%	85.4%	85.3%	84.3%	⇩	85.2%	77.8%	80.2%
	PEWS Score Recording	Jul-23	90%	99.4%	98.9%	99.1%	⇧	99.1%	99.2%	99.2%
	NEWS Score Recording	Jul-23	90%	97.7%	97.4%	97.8%	⇧	97.6%	97.4%	97.5%
	VIP									
	VIP Score Recording (1 per day)	Jul-23	90%	87.8%	88.1%	91.2%	⇧	88.2%	85.6%	86.4%
	PIP Score Recording (1 per day)	Jul-23	90%	88.6%	87.3%	85.6%	⇩	86.5%	89.6%	88.7%
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	Jul-23	0	59	75	60	⇩	221	172	368
	Re-opened complaints (non PHSO)	Jul-23	N/A	1	2	2	⇔	9	18	15
	Re-opened complaints (PHSO)	Jul-23	N/A	1	2	1	⇩	4	2	6
				May 23	Jun 23	Jul 23				
	Number of medium/high level complaints	Jul-23	N/A	11	25	9	⇩	62	257	231

Operational Performance

NHS Cambridge University Hospitals NHS Foundation Trust

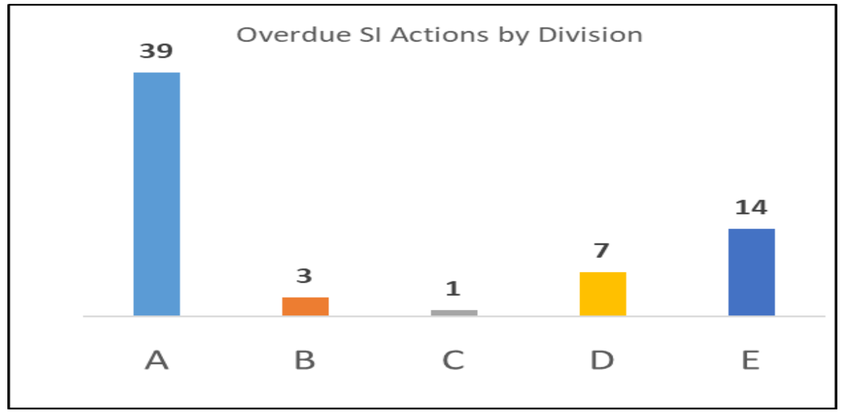
Point of delivery	Performance Standards	SPC variance	In Month Actual	In Month plan	Target	Target due by	Page
Urgent & Emergency Care	4hr performance	Normal variation	69.8%	67.7%	76.0%	Mar-24	Page 13
	12hr waits in ED (type 1)	Positive special cause variation	4.4%	-	-	-	
	Ambulance handovers <15mins	Positive special cause variation	76.4%	65.0%	65.0%	Immediate	
	Ambulance handovers <30mins	Positive special cause variation	99.3%	95.0%	95.0%	Immediate	Page 14
	Ambulance handovers > 60mins	Positive special cause variation	0.0%	0.0%	0.0%	Immediate	
Cancer	Cancer patients < 62 days	Normal variation	65.0%	-	85.0%	Immediate	Page 21
	28 day faster diagnosis standard	Normal variation	81.9%	81.1%	75.0%	Immediate	Page 18
	31 day decision to first treatment	Normal variation	87.5%	-	96.0%	Immediate	Page 20
	2 week waits	Normal variation	72.9%	-	93.0%		Page 19
Outpatients	First outpatients (consultant led)	Normal variation	109.4%	116.4%	-	-	Page 23
	Follow-up outpatients (consultant led)	Normal variation	110.4%	124.7%	-	-	Page 24
	Advice and Guidance Requests	Positive special cause variation	10.2%	-	0.0%	Mar-23	
	Patients moved / discharged to PIFU	Positive special cause variation	2.9%	7.5%	7.5%	Mar-23	Page 25
Diagnostics	Patients waiting > 6 weeks	Normal variation	34.3%	34.9%	5.0%	Mar-24	Page 22
	Diagnostics - Total WL	Positive special cause variation	13,403	13,189	-	-	
RTT Waiting List	RTT Patients waiting > 65 weeks	Positive special cause variation	1018	786	0	Mar-23	Page 16
	RTT Patients waiting > 78 weeks	Positive special cause variation	84	-	-	-	
	Total RTT waiting list	Negative special cause variation	62,491	62,810	-	-	Page 17
Productivity and efficiency	Non-elective LoS (days, excl 0 LoS)	Normal variation	8.2	-	-	-	
	Long stay patients (>21 LoS)	Positive special cause variation	201	192	-	-	
	Elective LoS (days, excl 0 LoS)	Normal variation	5.4	-	-	-	
	Discharges before noon	Normal variation	14.9%	-	-	-	
	Theatre sessions used	Normal variation	595	-	-	-	
	In session theatre utilisation	Normal variation	77.1%	83.0%	85.0%	Sep-23	Page 27
	Virtual Outpatient Attendances	Negative special cause variation	18.9%	-	-	-	
	BADS Daycase Rate (local)	Normal variation	84.4%	-	-	-	Page 28
Surgical prioritisation	P2 (4 weeks) Including planned	Negative special cause variation	3,021	-	-	-	

Serious Incidents

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
Patient Safety Incidents	Aug 2020-July 2023	Jul-23	-	**1457**	*1444*		-	-	
Patient Safety Incidents per **1,000 admissions**	Aug 2020-July 2023	Jul-23	–	**84.9**	*91.6*		–	–	
Percentage of **moderate harm and above** patient safety incidents	Aug 2020-July 2023	Jul-23	≤ 2%	**2.7%**	*2.3%*		-	-	
All Serious Incidents	Aug 2020-July 2023	Jul-23	—	**2**	*4.8*		-	-	

Ref	SI Title	STEIS SI Sub categories	Actual Impact	Division	Ward / Department
SLR169350	Delayed diagnosis of BCC recurrence (complaint)	Diagnostic incident including delay meeting (including	Severe / Major	Division D	Clinic 3
SLR145227	Choking incident	Pending review	Death / Catastroph	Division C	Ward F6



Executive Summary

Five SI reports were submitted to the ICS in July. Compliance with the 60 day timeframe for July was 0% (0/2).

Compliance by extensions dates due in July was 75% (3/4)

Resources for investigating have been limited due to competing clinical and operational priorities within divisions and resources within the central patient safety team. This is impacting compliance with the 60 day/agreed extension target for submissions.

There are currently 69 (↑) overdue Serious Incident Actions : 57% (39) of which are in Division A .

Author(s): Jane Nicholson **Owner(s): Oyejumoke Okubadejo**

Duty of Candour (DOC)

NHS
Cambridge University Hospitals
NHS Foundation Trust

Executive Summary

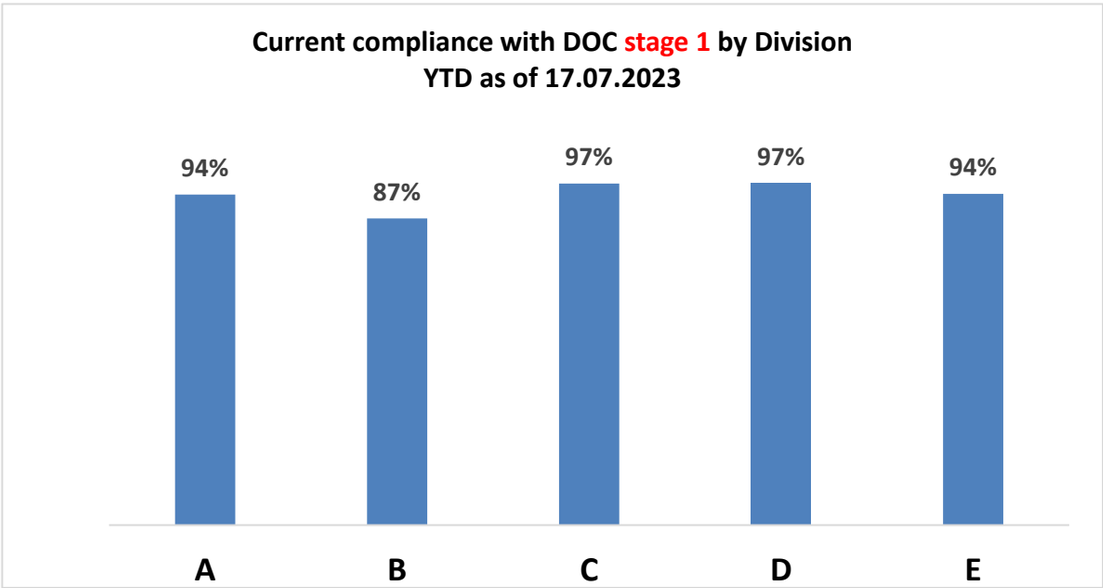
Trust wide **stage 1** DOC compliance for YTD as of 17.07.2023, is **95%** (252/266)

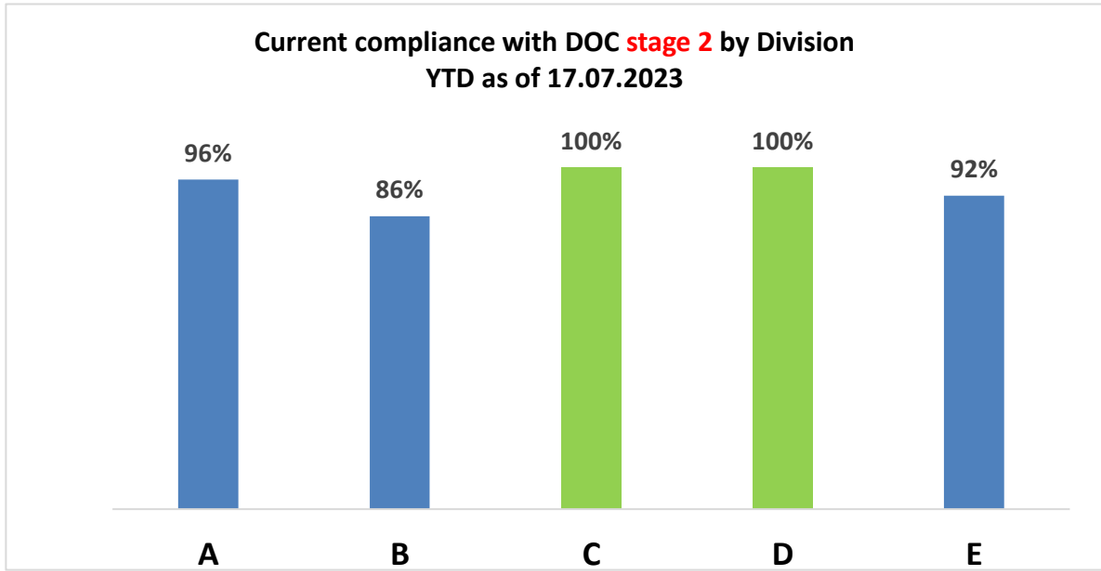
Trust wide **stage 2** DOC compliance for YTD as of 17.07.2023, is **97%** (208/215)

Indicator definitions

Stage 1 is notifying the patient (or family) of the incident and sending a DOC stage 1 letter, within 10 working days from date incident reported (or 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(s): Christopher Edgley

Owner(s): Oyejumoke Okubadejo

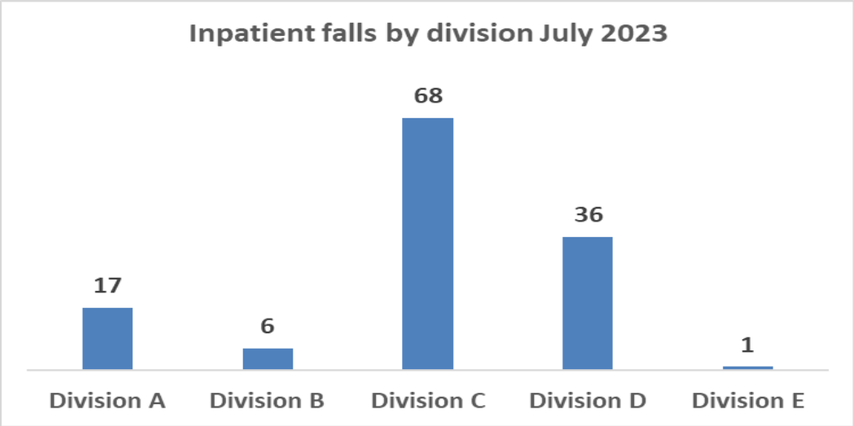
Falls

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Data range	Target	Jul-23	Mean	Variance	Special causes	Target status	Comments
All patient falls	Aug 2020-July 2023	-	**135**	*154*			-	
Inpatient falls per **1,000 bed days**	Aug 2020-July 2023		**3.6**	*4.6*		-	-	
Moderate harm & above inpatient falls per 1,0000 bed days	Aug 2020-July 2023	-	**0.085**	*0.142*		–	-	There was 1 moderate harm and 2 severe harm fall incidents in July 2023
% of inpatients falls associated with a history of falls	Aug 2020-July 2023		**73%**	*64%*	H	SU12		Statistically significant upward shift in the last 12 months.
Falls **risk screening** compliance within 12 hours of admission	Aug 2020-July 2023	≥ 90%	**88%**	*85%*			?	The trust overall has not been compliant since June 2021
Falls KPI: patients 65 and over who have a **cognitive impairment** have an appropriate **care plan in place**	Aug 2020-July 2023	≥ 90%	**74%**	*26%*	H	SU9	?	Statistically significant upward shift in the last 9 months.

Executive Summary

Recruitment is in progress to expand the Falls prevention and management service from one practitioner to a team of three, in order to strengthen our resource for improvement work.



Author(s): Debbie Quartermaine & Jane Nicholson **Owner(s): Oyejumoke Okubadejo**

Hospital Acquired Pressure Ulcers (HAPUs)

NHS
Cambridge University Hospitals
NHS Foundation Trust

Indicator	Data range	Period	Target	Current period	Mean	Variance	Target status	Comments
All hospital-acquired pressure ulcers	August 2020 - July 2023	Jul-23	-	**34**	29	H	-	Last 13 months above the mean
All HAPUs by date of occurrence per 1,000 bed days	August 2020 - July 2023	Jul-23	–	**0.96**	0.87	H	-	Last 13 months above the mean
Category 2, 3, 4, Suspected Deep Tissue Injury, and Unstageable HAPUs	August 2020 - July 2023	Jul-23	–	**23**	16.0	H	-	Last 12 months above the mean
Category 1 hospital-acquired pressure ulcers	August 2020 - July 2023	Jul-23	–	**11**	11.8		–	
Category 2 hospital-acquired pressure ulcers	August 2020 - July 2023	Jul-23	-	**17**	11.3		–	9 of the last 10 months have been above the mean
Unstageable HAPUs	August 2020 - July 2023	Jul-23	–	**2**	1.4		–	
Suspected Deep Tissue Injury HAPUs by date of occurrence	August 2020 - July 2023	Jul-23	-	**4**	2.9	H	-	Last 13 months above the mean
Pressure Ulcer screening **risk assessment** compliance	August 2020 - July 2023	Jul-23	90%	**82%**	80%		F	Last 4 months have been above the mean ending downward shift from June 2022-March 2023. 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 categories of Suspected deep tissue injury and Category 2 . There were no category 3 or 4 HPAUs in month.
The previously reported high number of HAPUs associated with devices is in normal variance. Incidence on ears, heels, and sacrum showing reduction.
There is some improvement in the PU risk screening/assessment compliance data.

QI Plan update

A new Band 6 TVN within the Emergency Department is still awaiting recruitment. Lead TVN recruitment has not been successful yet; currently out for 3rd round - supported by national comms plan.
The work in partnership with the Institute Health Improvement (IHI) and the Transformation& improvement team to reduce incidence of HAPUs, will be formally launched on 19.07.2023 - workshop 3 arranged for 05.07.2023. All pilots ward/departments confirmed: ICU (D3), D9, J3, ED, M5. New corporate HAPU QIP in place, designed via IHI workshops.
CQUIN 12 (Assessment and documentation of pressure ulcer risk) data collection for Q1 has been submitted: overall audit score was 74% (CQUIN payment basis: minimum 70%; maximum 85%).

Author(s): Jane Nicholson **Owner(s): Oyejumoke Okubadejo**

Sepsis

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
All elements of the Sepsis Six Bundle delivered within 60 mins from time patient triggers Sepsis (NEWS 5>) - **Emergency Department**	June 2020-July 2023	Jul-23	*95%*	**73%**	*58%*		-	F	Elements of the sepsis 6 bundle that have impacted on the overall compliance for July 23 are antibiotic administration within an hour of triggering sepsis (87%), and Blood culture (80%)
Antibiotics administered within 60 mins from time patient **triggers** Sepsis (NEWS 5>) - **Emergency Department**			*95%*	**87%**	*71%*		-	?	The average time between patient triggering sepsis (NEWS 2 of 5 and above) and prescription of antibiotics is 47.4 Mins in July 23 and the average time between prescription of antibiotics and administrating was 21.1 Mins. A combined average time of almost 70 Mins. 10 minutes above national standard
All elements of the Sepsis Six Bundle delivered within 60 mins from time patient triggers Sepsis (NEWS 5>)- **Inpatient wards**			*95%*	**80%**	*39%*	SU7	-	F	In the last seven months have been above the mean. Elements of the sepsis 6 bundle that have impacted on the overall compliance for July 23 are Lactate (60%) and Monitoring (40%)
Antibiotics administered within 60 mins from time patient triggers Sepsis (NEWS 5>) - **Inpatient wards**			*95%*	**100%**	*75%*			?	The last four months compliance has been at 100%. The average time between patient triggering sepsis (NEWS 2 of 5 and above) and prescription of antibiotics is 46.6 Mins in July 23 and the average time between prescription of antibiotics and administrating was 44.6 Mins. A combined average time of almost 91 Mins, 30 Mins above national standard

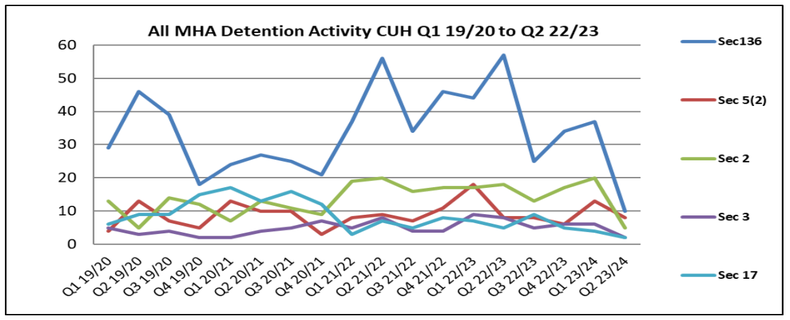
Sample size in month for above audits:
Inpatient = 5,
ED = 15

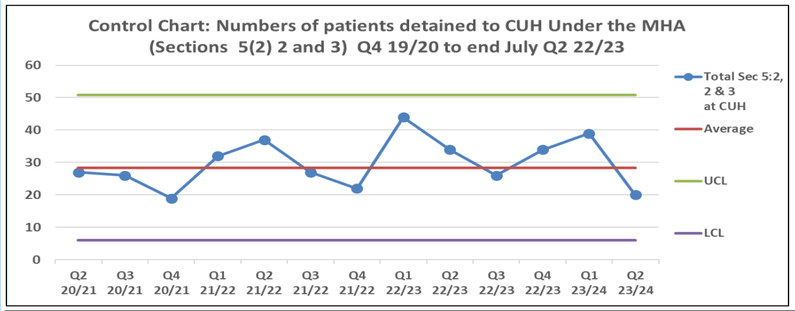
- Measuring & monitoring framework to be expanded e.g. outcome data. In discussion with Ari Ercole and E-Hospital team
- Update on PA QI project pending and whether to expand this service
- Sepsis QI corporate plan in development - ready for sign off at Sepsis Action Group next meeting
- Sepsis QI Event planned for October 2023 to launch pilot area QI work

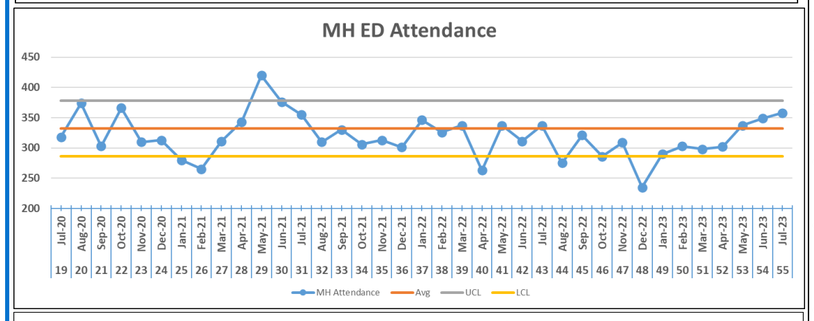
Author(s): Stephanie Fuller **Owner(s): Heman Joshi**

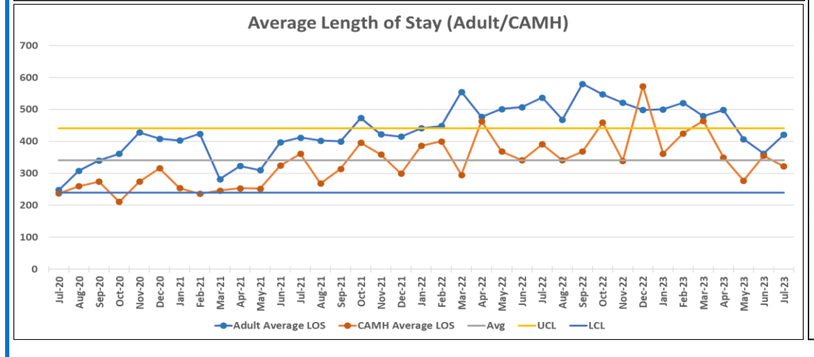
Mental Health - Q1 2023/24 (July)

NHS Cambridge University Hospitals NHS Foundation Trust









Narrative

Data has been adjusted from previous reports to reflect financial years rather than calendar years

Q2 2023/24 (July)

- Of the section 136 MHA (x10) attendances at CUH ED in July 23, 100% were rescinded following mental health assessment.
- July 2023 showed monthly reduction in Section 136 presentation to Emergency department.
- Use of Sections 5(2), 2 and 3 were high in July 2023 at CUH, representing 71% of the average expected in a quarter. This is in line with Q2 data being historically high, and does suggest Q2 23/24 will experience high levels of MHA intervention.
- July 2023 Emergency Attendances show a third data point over the average (358). July 23/24 data represents highest number of attendances per month since June 2021.
- The CAMH ED attendance/admitted conversion rate has reduced over June and July 2023 to average 24.8%, against a 6 month high of CAMH presentation at ED, suggesting effective management of presentations to ED.
- The refreshed process and escalation for mental health bed finding, performed by CUH Mental Health Team, Operations Matrons and Liaison Psychiatric Service is embedded with all parties and communication of information is good. Plans to build a 'MH bed Tracker', based on a 'repatriation' unit that monitors delayed discharge performance are now being explored. This will also allow both out of area and local bed finding to be tracked, delays recorded accurately and give a platform for parties involved to communicate and record updates

Ongoing work:

- The Mental Health Work List is now live on EPIC. This tool, based on a 'repatriation list' will include all patients deemed medically fit for discharge and requiring a specialist mental health inpatient bed. It will enable centralised communication between teams (Ops matrons, CUH MH team, psych liaison), recording calls, actions and updates to bed finding activities. All parties that will use the work list will receive training. The Work List will also enable improved data including:

  - number of delayed discharges
  - lost bed days
  - receiving mental health Trust
  - accumulative data to monitor performance

- A request for a new CHEQS report has been made to create a monthly report that will extract the above data from the work list, and create ongoing data.
- New division slide set for MH Governance Meeting was piloted by Division A in July 2023. Following this, the lead for mental health has met again with divisions DQMs to review. Ongoing work will increased focus around learning, action plans and assurances relating to incidents, quality, risks and complaints.
- The Lead for Mental Health will be visiting the Norfolk and Norwich Acute Hospital in September. areas of interest will include:

  - Management of Eating Disorders and system based collaboration with care provision, planning and transfers.
  - Management of Mental health presentations in ED, and avoidance of admissions to acute wards
  - Integration of mental health Care in the acute setting
  - Management of section 136 MHA papers (part B) in the ED setting.
  - All ligature risk assessments for identified areas have been completed. Action plans have been created, with 3/12 action plan follow up review visits arranged from the CUH Mental Health Team.

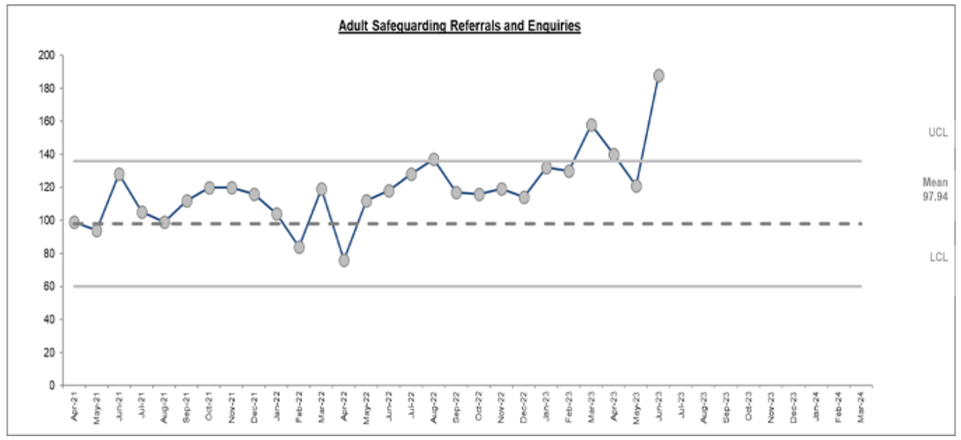
- CUH are engaged with development of Right Care, Right Person local model following Cambridgeshire Constabulary expressing motivation to align with this initiative, where the Police will stop attending mental health incidents in the community unless there is risk to life or others. There is a strategic group and more recently a task and finish group created.

Safeguarding

NHS Cambridge University Hospitals NHS Foundation Trust

Adult Safeguarding

Referrals to the safeguarding team have continued to increase with Q1 23/24 seeing an increase of 43% of referrals compared to the same quarter in 22/23. There has also been an 8% increase in Q1 compared to the previous Q4 report from 22/23. A total of 393 referrals were made to the Adult Safeguarding Team this quarter compared to 363 in Q4 (this figure does not include DOLs requests). The top 3 reporting themes were neglect/acts of omission, domestic abuse with a 43% increase compared to Q4, and financial abuse which has seen a significant increase of 157% in Q1 compared with Q4. The team have also received a significant increase of 124% in the number of Prevent information sharing requests received from the ICB.

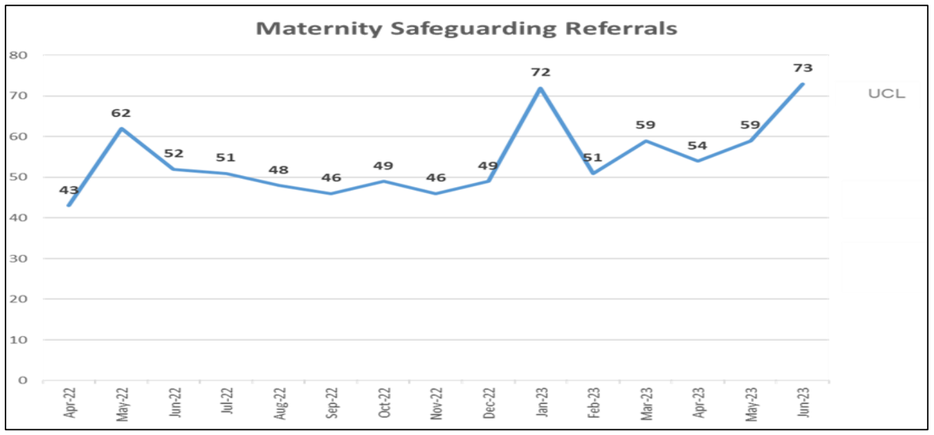


Childrens Safeguarding

There has been an increase to the children safeguarding team over the last quarter with a total of 224 referrals compared to 194 in Q4 22/23. Top 3 referral themes were mental health and neglect which have been seen in previous quarters and reflect the Partnership board priorities. New to this quarter is animal bites and the team will be undertaking a piece of work to support frontline practitioners in understanding their responsibilities around this. The team have also started reporting on how many beds days are used to accommodate a child as a place of safety. For Q1 this has been 56 days.

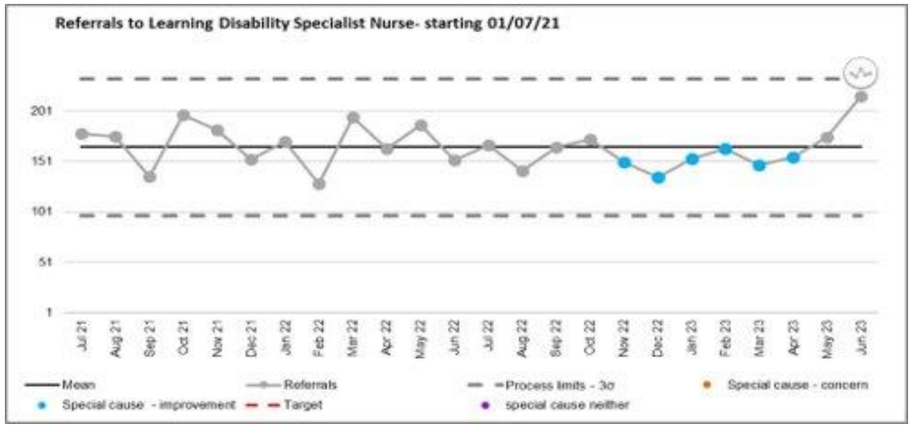
Maternity safeguarding

The sharp increase seen in referrals to the maternity safeguarding team in January 23 continues to be seen in the data from June. This was accompanied by a slight drop in referrals to children's social care with only 32 compared to Q4 which was 39. The top 3 referral themes have been for historical safeguarding concerns, domestic abuse and mental health.



Learning disabilities

During Q4 there have been 546 referrals to the adult learning disability specialist nurse which is a 17% increase from Q4 22/23. The children's referral data is not illustrated on the graph but has also seen an increase from 37 in Q4 to 44 in Q1. For adults the top 3 referral teams were gastro/colorectal , general medical and respiratory whilst in children's services the top 3 reasons for referral were for planned admissions preparation, outpatient visit preparation and inpatient support and advice.



Infection Control

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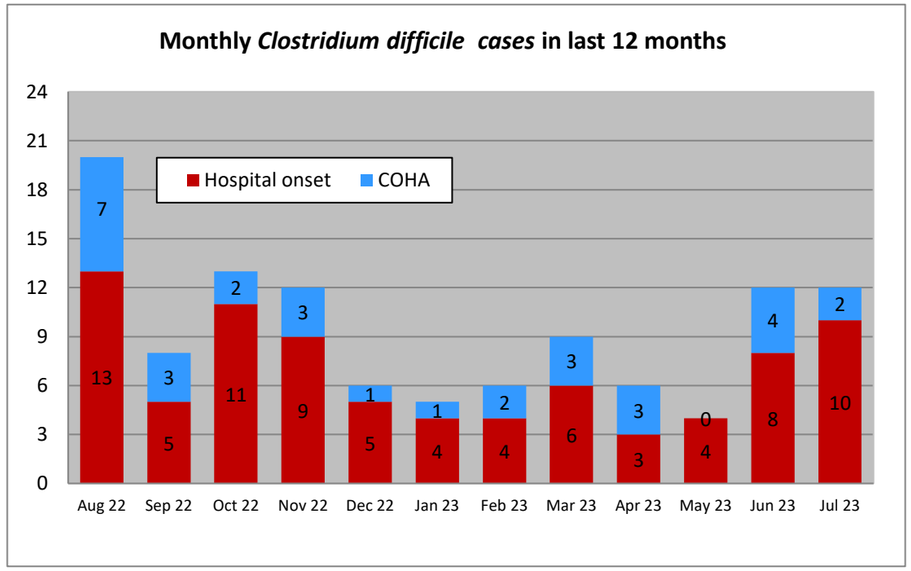
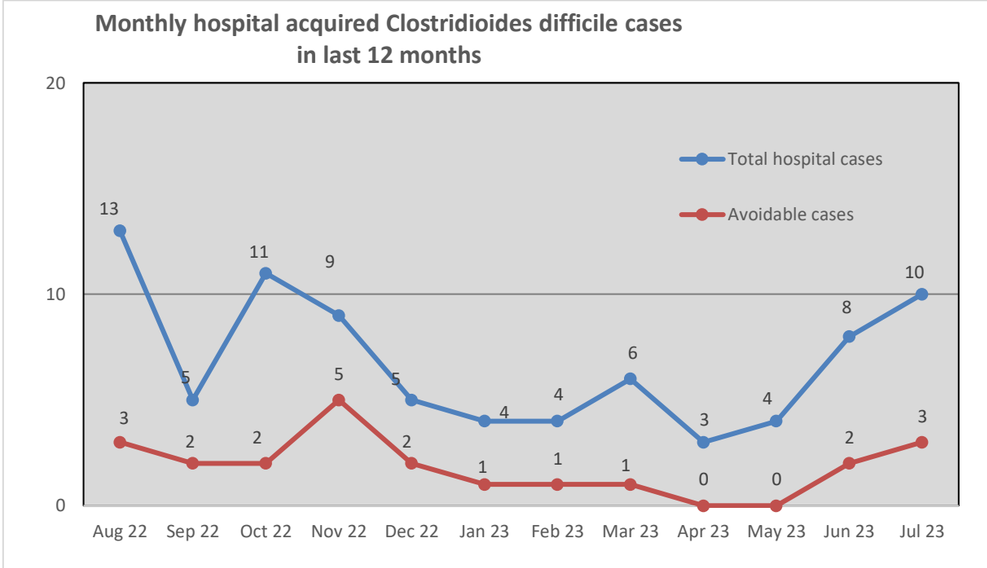


* COHA - community onset healthcare associated = cases that occur in the community when the patient has been an inpatient in the Trust reporting the case in the previous four weeks



CUH trend analysis

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

- 1 case of hospital onset MRSA bacteraemia in July 2023
- 4 cases (2 unavoidable & 2 avoidable hospital onset MRSA bacteraemia year to date)

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

- 10 cases of hospital onset *C difficile* and 2 cases of COHA in July 2023.
- 25 hospital onset cases and 9 COHA cases year to date (20 cases unavoidable, 5 avoidable and 8 pending).

MRSA and C difficile key performance indicators

- Compliance with the MRSA care bundle (decolonisation) was 97.6% in July 2023 (83.1% in June 2023).
- The latest MRSA bacteraemia rate comparative data (12 months to June 2023) put the Trust 5th out of 10 in the Shelford Group of teaching hospitals.

- Compliance with the *C. difficile* care bundle was 93.0% in July 2023 (92.0% in June 2023).
- The latest *C. difficile* rate comparative data (12 months to June 2023) put the Trust 4th out of 10 in the Shelford Group of teaching hospitals.

4HR Performance

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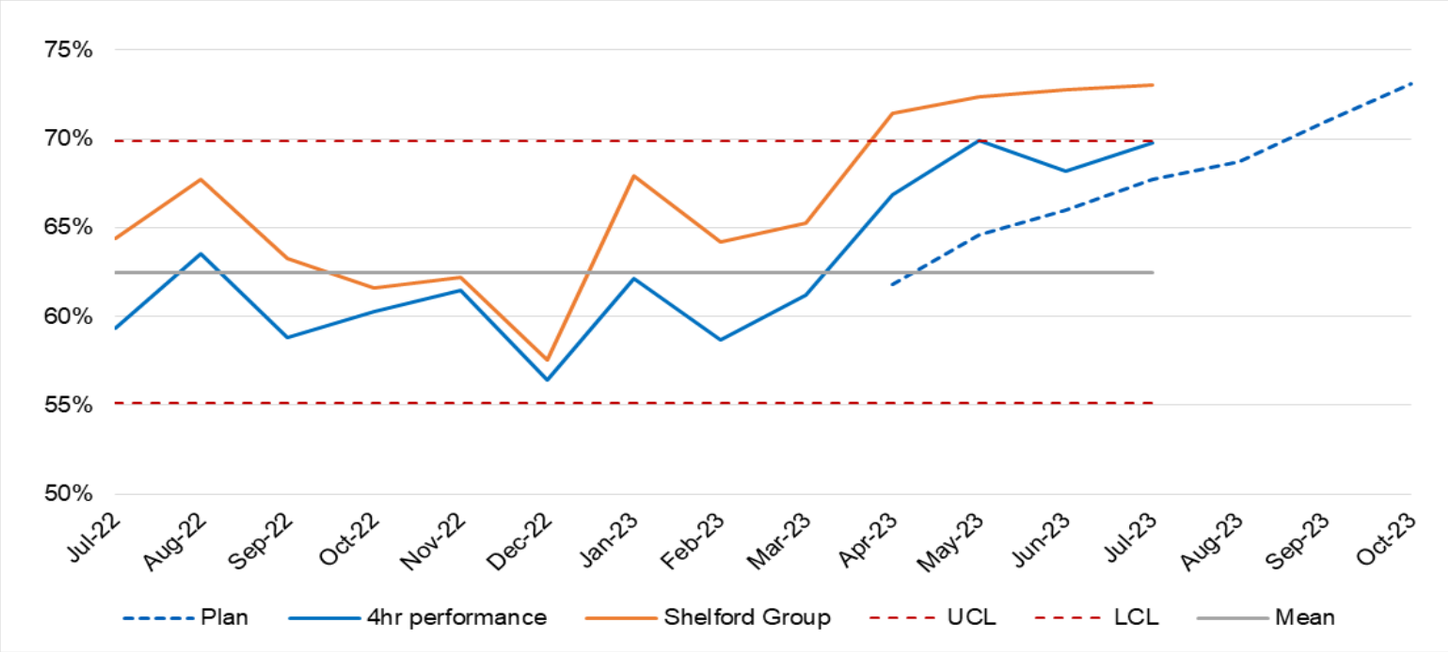
Jul-23	Plan
69.8%	67.7%

SPC Variance
Normal variation

Shelford Group Avg (Jul-23)
73.0%

Three Month Trajectory		
Aug-23	Sep-23	Oct-23
68.8%	71.0%	73.1%



Highest breaches by specialty

Specialty	Performance	4hr Breaches
Emergency	62.7%	1,905
Medicine	36.9%	1,447
Surgery	35.6%	244
Orthopaedics	28.4%	197
Paediatrics	52.8%	182

Updates since previous month

- July performance of 69.8% exceeded plan of 67.7%, meaning that the plan has been met in each month of the year to date
- 12hr waits from arrival also improved, falling from 8.1% of attendances in June to 4.4% in July

Current issues

- Performance in August has decreased slightly, reaching 67.0% in the month to date (1st-29th) against plan of 68.8%
- Outflow and processing power in ED has been challenged during August due to higher bed occupancy and staffing gaps

Key dependencies

- On-going delivery of the 4hr trajectory is dependent on continued focus by Emergency Medicine, particularly across non-admitted pathways
- Outflow from ED is dependent on low occupancy

Future actions

- The Emergency Department operations team is focusing on learning lessons from breaches, reviewing all patients breaching between 4-6hrs after arrival
- Continued focus on the MAU to support outflow

Author(s): James Hennessey **Owner(s): Nicola Ayton**

Ambulance Handovers > 60 minutes

NHS
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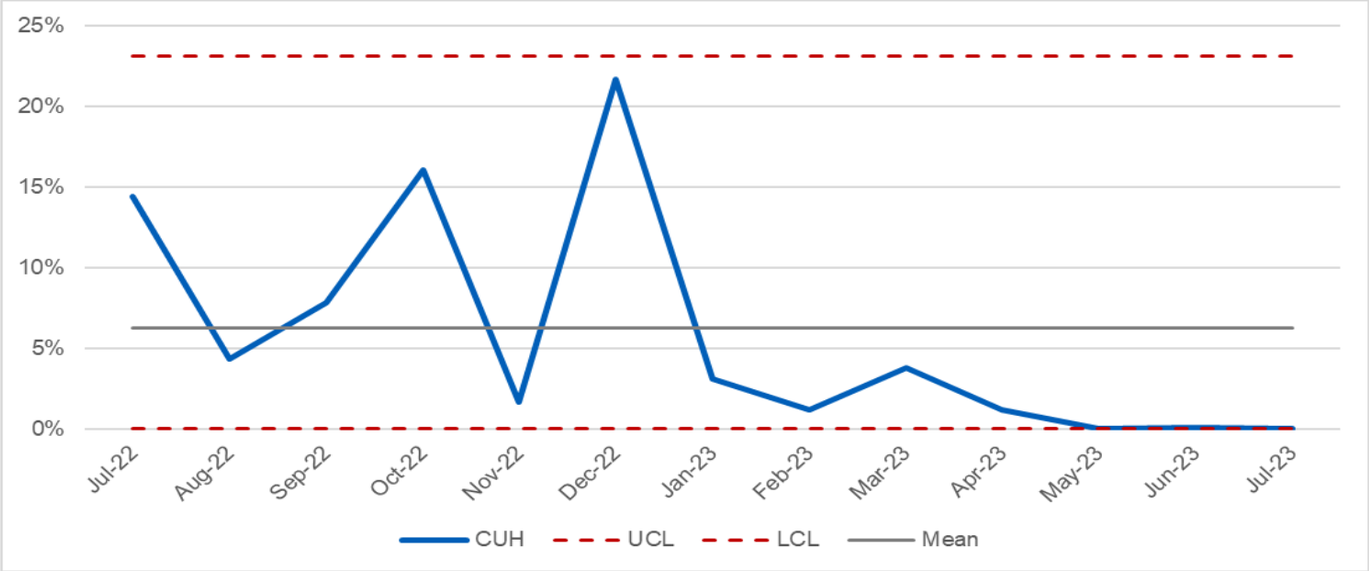
Jul-23	Target
0.0%	0.0%

SPC Variance
Positive special cause variation



East of England > 60 minutes

Trust	% > 60mins
CUH	0%
Bedford	4%
West Suffolk	5%
Basildon & Thurrock	10%
Hinchingbrooke	10%
Colchester	11%
Broomfield	12%
James Paget	13%
Watford	16%
Southend	19%
Luton & Dunstable	20%
PCH	20%
Ipswich	22%
Lister	23%
QEH	38%
PAH	41%
Norfolk and Norwich	53%

Updates since previous month

- Ambulance performance in July met all three national performance metrics for the third month in a row
- CUH performance in July makes it equal top performer in England

Current issues

- The number of ambulance delays has increased slightly during the August MTD (1st-29th) due to lack of suitable space to offload in the ED
- Despite these challenges, delays over an hour are still low, at 0.8%

Key dependencies

- The avoidance of ambulance delays is dependent on the availability of suitable clinical space to perform rapid handovers
- Shift fill for the HALO to support rapid offloads

Future actions

- On-going focus on delivering the three national performance metrics for ambulance handovers by preserving rapid handover spaces on the medical assessment unit
- Liaising with EEAST re HALO cover

Author(s): James Hennessey **Owner(s): Nicola Ayton**

Overall fit test compliance for substantive staff

NHS Cambridge University Hospitals NHS Foundation Trust

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	1	0	0%	237	139	59%	66	30	45%	123	68	55%	87	45	52%	85	41	48%	599	323	54%
Allied Health Professionals	-	-	-	56	20	36%	17	3	18%	1	1	100%	-	-	-	3	1	33%	77	25	32%
Estates and Ancillary (Porters and Security Personnel only)	120	84	70%	-	-	-	-	-	-	-	-	-	-	-	-	1	0	0%	121	84	69%
Medical and Dental	-	-	-	253	65	26%	-	-	-	177	58	33%	137	11	8%	217	65	30%	784	199	25%
Nursing and Midwifery Registered	1	0	0%	671	478	71%	4	2	50%	275	175	64%	152	99	65%	365	206	56%	1468	960	65%
Total	122	84	69%	1217	702	58%	87	35	40%	576	302	52%	376	155	41%	671	313	47%	3050	1591	52%

The data displayed as of 22/08/23. 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.

Mask Fit Test compliance has increased to 52 %. The agreed Trust target for priority areas is 80%. Currently 11 nursing teams and 1 medical team have achieved compliance of 80% or above.

Referral to Treatment > 65 weeks and > 78 weeks

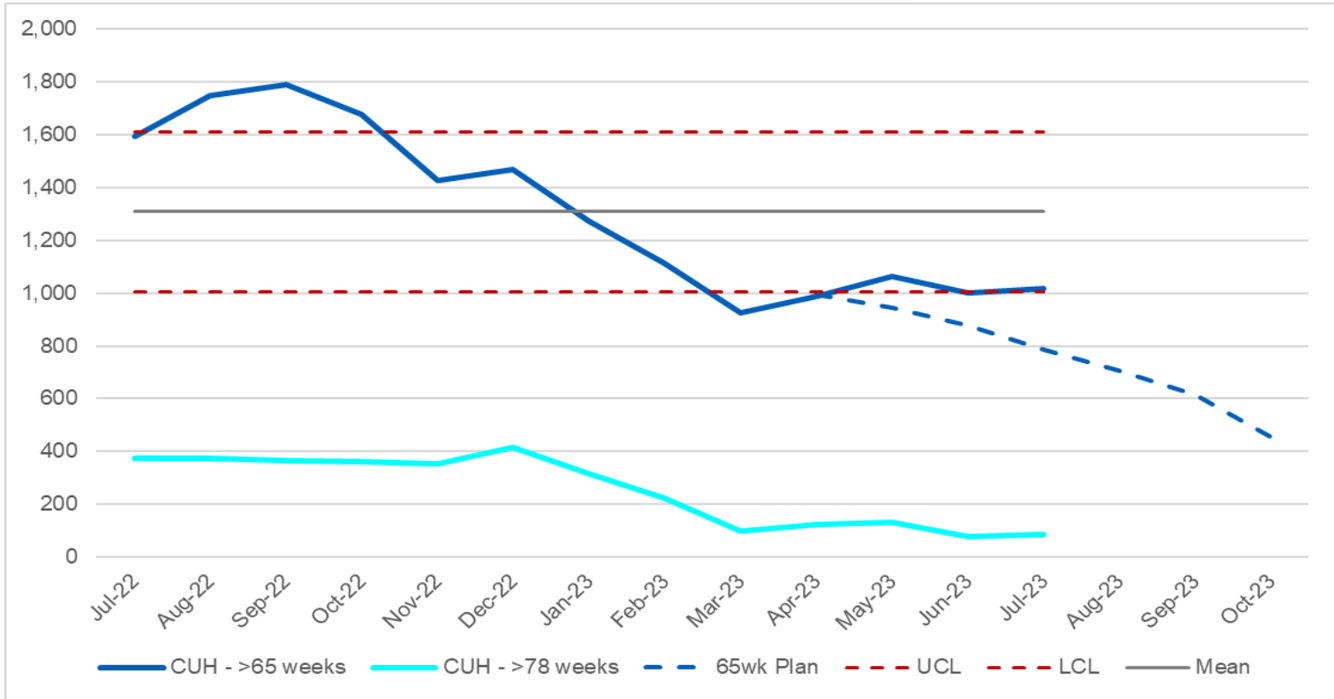
NHS Cambridge University Hospitals NHS Foundation Trust

65+ Weeks	
Jul-23	Plan
1,018	786

SPC Variance
Positive special cause variation

% of WL over 65 weeks (Jun-23)	
CUH	1.6%
Shelford Group	1.7%

Three Month Forecast >(65 wks)		
Aug-23	Sep-23	Oct-23
706	616	456



Divisional Performance

Division	65+ weeks	78+ weeks
A	169	13
B	100	0
C	23	0
D	609	68
E	117	3
Trust	**1,018**	**84**

Updates since previous month

- >78 week waits increased by 5 to 84 in July. ENT accounted for 22, Dermatology 13 and OMFS 13.
- 1 >104 week wait reported for July, treatment completed in August.

Current issues

- New aim from NHSE to see all patients within the end of year 65 wk cohort awaiting first OPA by end October 2023. Largest risk Gynaecology.
- Ongoing prioritisation of urgent/cancer activity due to cumulative impact of industrial action (IA).

Key dependencies

- Theatre capacity
- Recruitment to medical workforce vacancies
- Independent Sector for ENT.
- Continuation of Insourcing OMFS to year end.

Future actions

- Step down plan outlined for 65 week max at risk.
- Gynaecology seeking mutual aid and exploring insourcing options. One locum has commenced.
- Dermatology skin pathway transformation under review. Additional capacity needs to be sought.

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

Referral to Treatment Total Waiting List

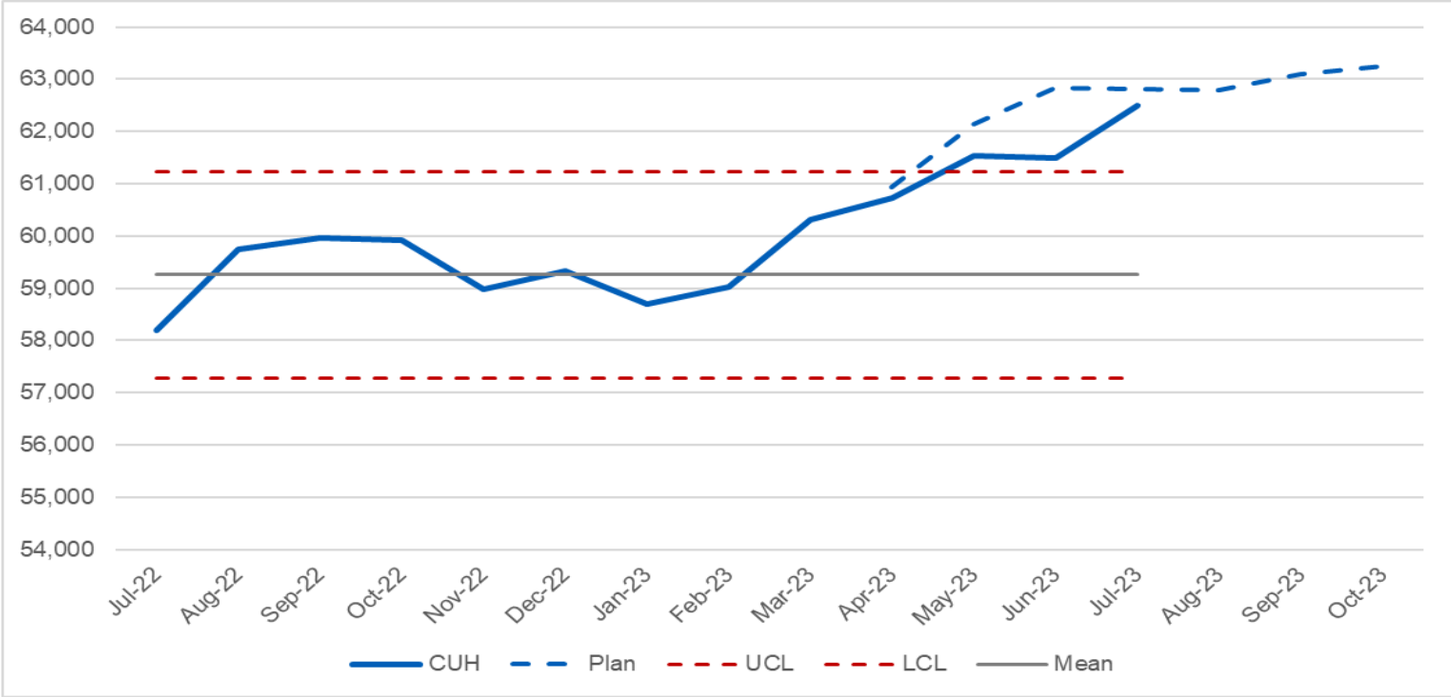
NHS Cambridge University Hospitals NHS Foundation Trust

Jul-23	Plan
62,491	62,810

SPC Variance
Negative special cause variation

Change in WL: Jun-23 vs. May-23	
CUH	-0.1%
Shelford Group	+0.2%

Three Month Forecast		
Aug-23	Sep-23	Oct-23
62,790	63,102	63,242



Waiting list by division

Division	Total Waiting List
A	12,974
B	6,317
C	4,288
D	28,873
E	10,035
Trust	**62,491**

Updates since previous month

- Total RTT waiting list increased by 1.6% in July.
- The total waiting list size was 0.5% lower than the planning submission for Month 4.
- Clock starts are cumulatively 2.4% below plan year to date.

Current issues

- Total stops (treatments) were 4% below plan in July with the impact felt from 5 weekdays of Industrial Action.
- The estimated lost clock stops due to Industrial Action in July were ~605. Without this treatments would have exceeded plan.

Key dependencies

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

Future actions

- Continued drive to release capacity for new outpatients. Non-admitted remains 81% of the waiting list and 63% await 1st appointment. GIRFT producing Go Further Go Faster guidance.
- Waiting list validation every 12 weeks in place.

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

Cancer - 28 day faster diagnosis standard

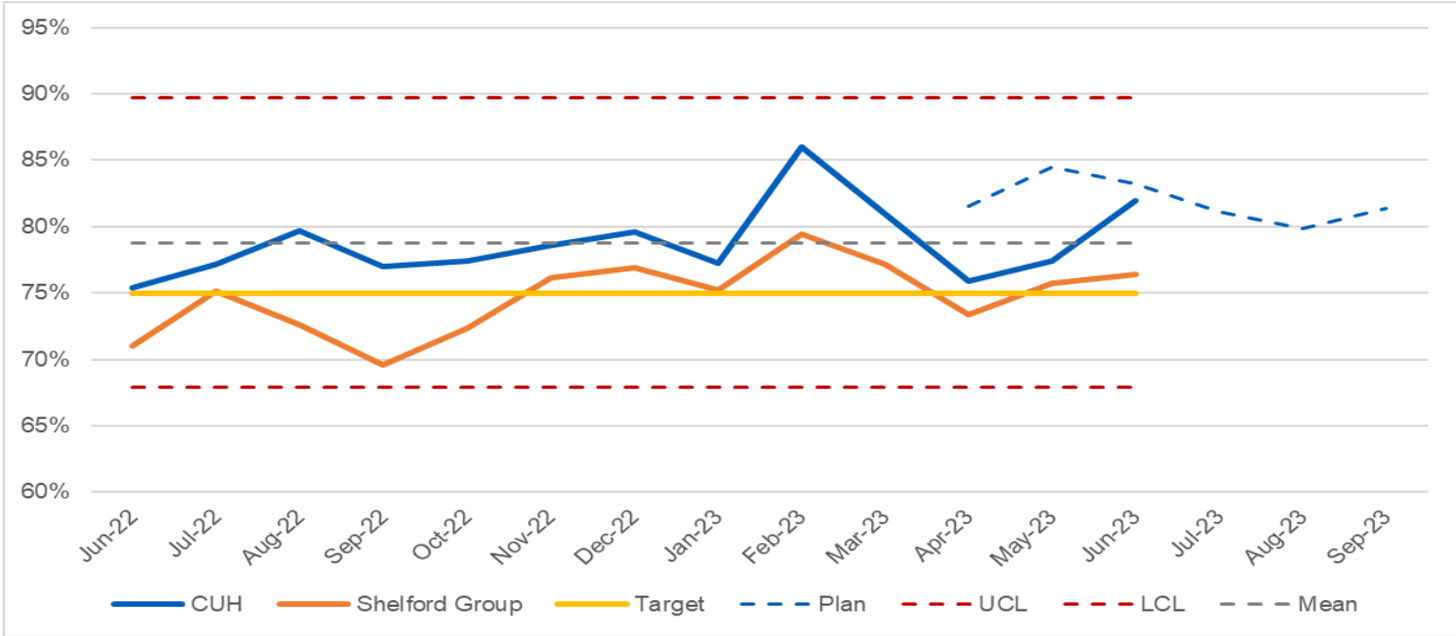
NHS Cambridge University Hospitals NHS Foundation Trust

Jun-23	Target
81.9%	75.0%

SPC Variance
Normal variation

Shelford Group Avg (Jun-23)
76.4%

Three Month Forecast		
Jul-23	Aug-23	Sep-23
81.1%	79.9%	81.4%



Cancer Site Overview

Site	Performance	Breaches
Skin	79.2%	101
Lower GI	77.2%	71
Gynaecological	62.4%	67
Head & Neck	75.9%	48
Urological	61.0%	53
Breast	95.6%	29
Haematological	61.5%	5
Sarcoma	27.8%	13
Upper GI	74.1%	7
Lung	95.6%	4
Childrens	97.6%	1
CNS/Brain	96.0%	1
Testicular	100.0%	0
Total	**81.9%**	**400**

Updates since previous month

CUH remains above target and above Shelford Group performance. Following the recent announcement regarding changes to national cancr waiting times targets CUH is in a strong position as already compliant for the 28 day FDS standard, services will now work towards the 80% target by 2024-25

Current issues

Delays to 1st appointment in skin cancer, and pathology turn around times continue to impact performance across all sites.
Lower GI lower performance is due to people on a screening pathway choosing to delay their appointment; work will commence with the screening hub to improve.

Key dependencies

- Pathology turn around times recovering to above 50% in 7 days
- Additional ad hoc activity in skin to reduce 2ww backlog.

Future actions

Actions are in place as part of the Cancer Improvement Plan. Focus continues on skin, urology, gynae and pathology. Focus on Urology improved compliance from September with a new co-ordinator role commencing from 21.08.23. System meeting with GIRFT team to focus on FDS performance in September.

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

Cancer - 2 week waits

NHS Cambridge University Hospitals NHS Foundation Trust

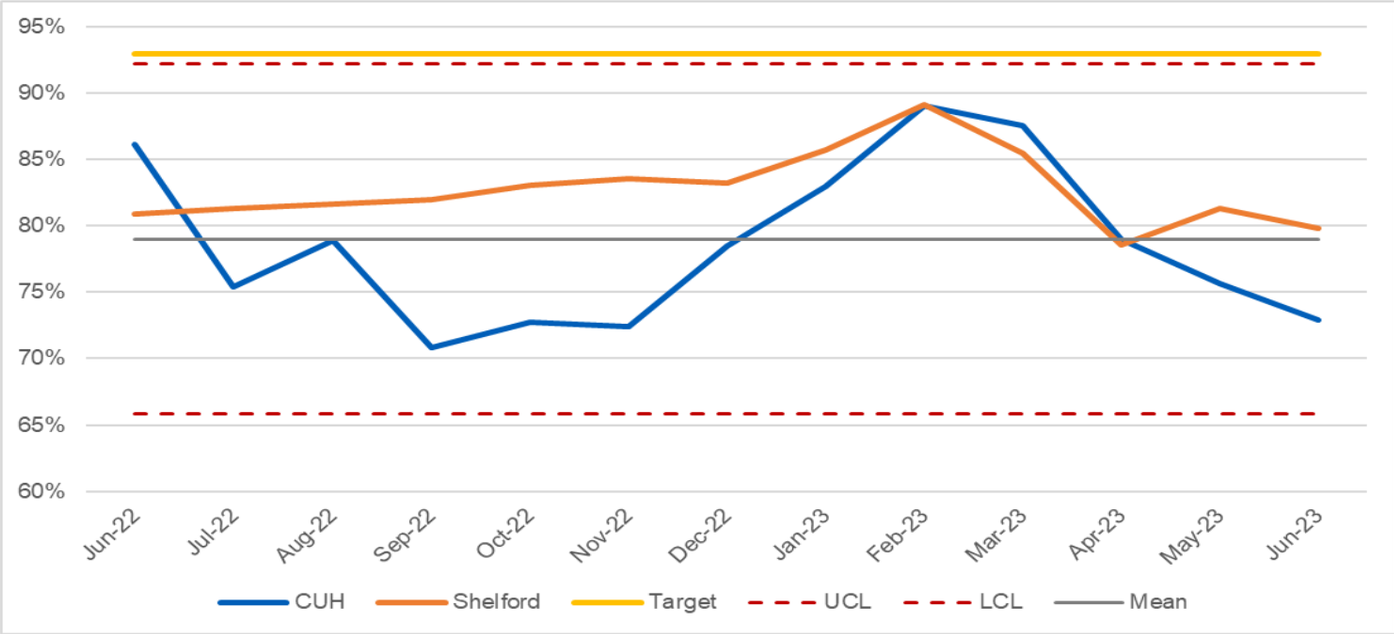
Jun-23	Target
72.9%	93.0%

SPC Variance
Normal variation

Shelford Group Avg (Jun-23)
79.9%

Cancer Site Overview as of 18/07/2023

Site	Breaches
Skin	456
Gynaecological	6
Breast	9
Head & Neck	4
Lower GI	8
Sarcoma	6
Lung	1
Urological	0
CNS/Brain	0
Haematological	0
Upper GI	1
All	**492**



Updates since previous month

CUH has experienced further deterioration in performance against the 2WW target due to breaches in the skin cancer and sarcoma pathway. Referral demand remains higher than average

Current issues

Breaches along the skin pathway continue to be the main reason for below standard performance; this is due to capacity constraints within dermatology and plastics.

Key dependencies

- Stable 2WW referral demand
- Continued additional clinics in derm and plastics to meet skin/sarcoma referral demand

Future actions

Short and long term actions agreed for skin:
- Additional adhoc clinics
- Recruitment of additional locum Consultnat
- Increased capacity in clinical fellow clinics.

Cancer - 31 days decision to treat to treatment

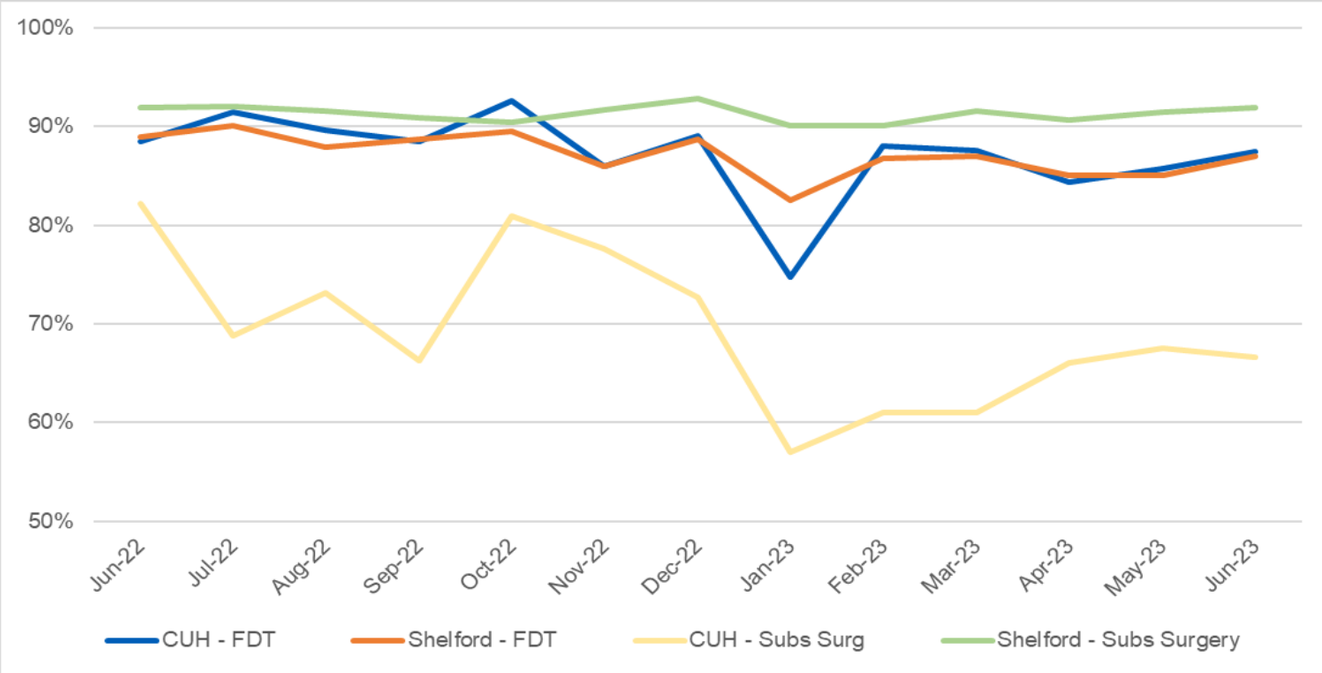
NHS Cambridge University Hospitals NHS Foundation Trust

	Jun-23	Target
FDT	87.5%	96.0%
Subs Surgery	66.7%	94.0%

SPC Variance
Normal variation

Shelford Group Avg (Jun-23)	
FDT	87.0%
Subs Surgery	92.0%

Backlog as of 15/08/2023	
Site	Backlog
Skin	51
Urological	30
HPB	26
LGI	8
Gynae	7
H&N	6
Breast	3
Sarcoma	1
CNS	0
Haem	0
Lung	0
Paeds	0
UGI	0
All	132



Updates since previous month

CUH continues to fall below target with 90% of the breaches in June for surgery, the sites with the largest breaches are in Skin (24%), Kidney (14.6%), HPB (14.6%), Lower GI (13.3%).

Current issues

Access to sufficient theatre capacity within 31 days remains an issue across multiple cancer sites, with the cumulative impact of industrial action putting further additonal pressure on surgical activity for cancer.

Key dependencies

Ongoing prioritisation of theatre allocation to P2/cancer surgery.
Engagement from clinical teams to undertake additional / respond flexbiliy to available capacity.
Ongoing use of Independent sector to support Breast.

Future actions

Continued focus on lower GI, HPB, skin, kidney and prostate surgery in September/October.
Seek mutual aid for P3/P4 cancer surgery in prostate if internal solutions cannot be found; explore additional internal options for renal surgery.

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

Cancer - 62 days urgent referral to treatment

NHS Cambridge University Hospitals NHS Foundation Trust

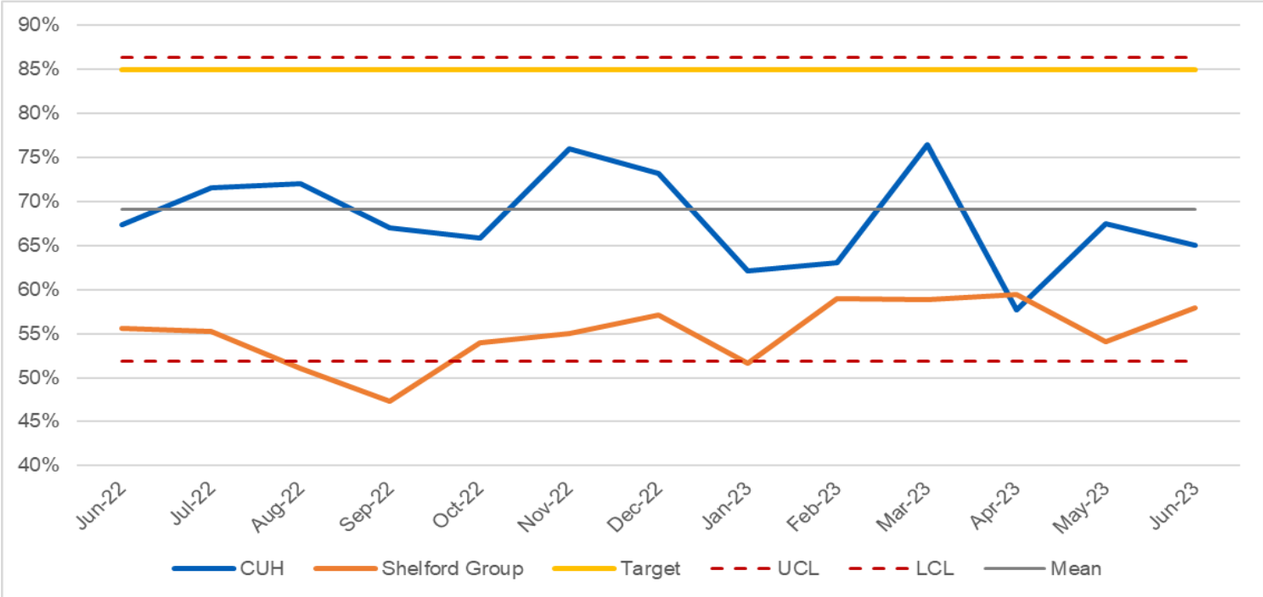
Jun-23	Target
65.0%	85.0%

SPC Variance
Normal variation

Shelford Group Avg (Jun-23)
57.9%

Backlog as of 15/08/2023

Site	Backlog
Skin	46
Urology	44
Gynae	15
Lower GI	15
Head & Neck	7
HPB	3
Breast	2
Haem	2
Sarcoma	2
CNS/Brain	1
Lung	1
Upper GI	1
NSS	0
Symptomatic Breast	0
All	*139*
Forecast backlog in Aug-23	80



Updates since previous month

CUH performance remains below target although is higher than the Shelford Group. 54% of breaches are CUH only patients and of that 69% were due to delays within CUH control such as delayed pathology reporting, outpatient and surgical capacity. 28% of referrals to CUH from regional hospitals were treated in the required 24 days.

Current issues

- Delays in pathology turn around times (currently at 26% within 7 days)
- Outpatient and surgical capacity
- Late referrals to CUH from referring providers, highest volume being for urology.
- Further impact of industrial action

Key dependencies

- Continuing achievement of 28 day FDS
- Pathology turn around times recovering to above 50% in 7 days
- Reduced late referrals from regional teams

Future actions

There is an extensive improvement plan in place which is reviewed monthly; there is a focus on Skin, Urology and Gynae with specific recovery actions to 30th September - this will impact performance from October.

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

Diagnostic Performance

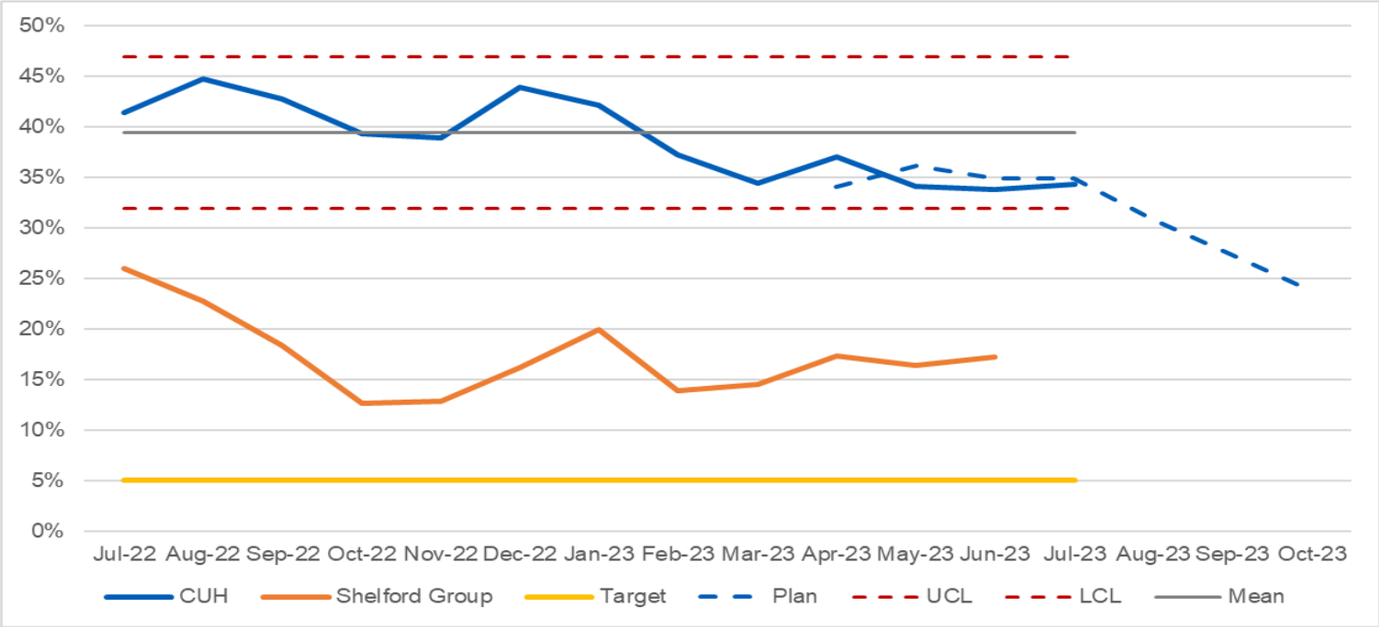
NHS Cambridge University Hospitals NHS Foundation Trust

Jul-23	Plan
34.3%	34.9%

SPC Variance
Normal variation

Shelford Group Avg (Jun-23)
17.3%

Three Month Forecast		
Aug-23	Sep-23	Oct-23
30.9%	27.3%	23.8%



Modality overview

Modality	% >6wks	Breaches
Echocardiography	71.4%	1976
Non obstetric ultrasound	28.3%	692
Audiology	60.4%	821
Magnetic Resonance Img'	20.9%	490
DEXA Scan	16.2%	136
Computed Tomography	18.3%	230
Urodynamics	47.0%	131
Neurophysiology	15.6%	45
Cystoscopy	17.2%	44
Gastroscopy	3.3%	20
Colonoscopy	0.5%	4
Respiratory physiology	18.2%	4
Barium Enema	5.3%	2
Flexi sigmoidoscopy	0.8%	1
Total		**4596**

Updates since previous month

- July 6wk performance remains ahead of plan.
- There was slight deterioration in month to 34.3% This was due to a reduction in the total waiting list of 477 whilst also a reduction in >6 ww of 99.
- Total activity in July was 1% higher than plan driven by unscheduled and surveillance diagnostics.

Current issues

- % Performance improved in all modalities in July with the exception of Echocardiography and MRI.
- MRI was due to reduction in total waiting list size, but Echo saw 8% growth in >6ww, up by 152.
- High staff vacancies continue to be the main risk to delivery, with Echo in particular at 50% (13wte)

Key dependencies

- Ongoing use of Insourcing for Echocardiography, required to be extended from Sept 23 to year end.
- Continued delivery of ICB capacity for Direct Access Community Ultrasound to manage demand.
- Agency/locum staffing and enhanced bank rates whilst recruiting.

Future actions

- Requests for continued enhanced bank rates beyond September in Imaging and Echo.
- Approaching overseas agencies to support recruitment options for Echo.
- Ongoing support for the retention and development of existing cardiac physiologists. RRP now aligned across the ICS.

New Outpatient Attendances- % vs. Baseline

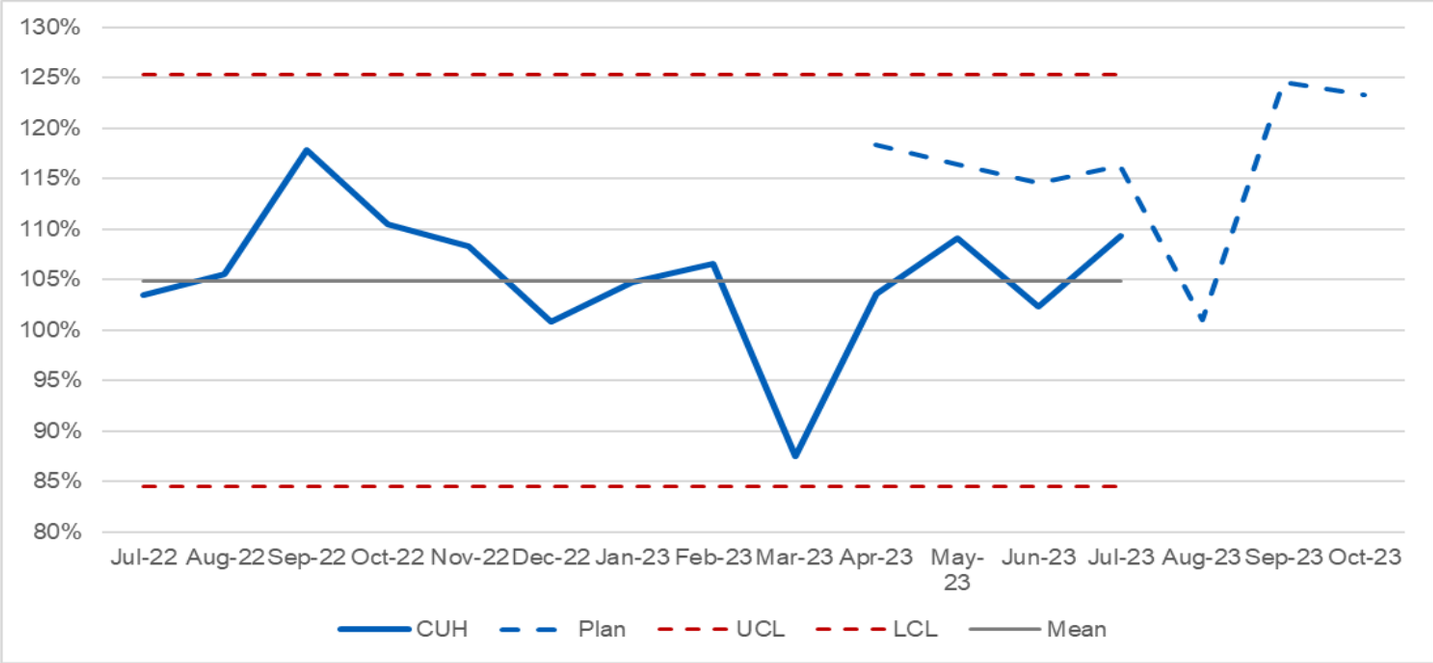
NHS Cambridge University Hospitals NHS Foundation Trust

Jul-23	Plan
109.4%	116.4%

SPC Variance
Normal variation

Shelford Group Avg (Jul-23)
N/A

Three Month Forecast		
Aug-23	Sep-23	Oct-23
101.0%	124.5%	123.3%



Divisional overview	
Division	Performance
A	114.6%
B	109.9%
C	97.6%
D	109.2%
E	90.5%

Updates since previous month

While still performing below plan July was an improvement with new attendances at 109.4%. Division A were the best performing at 114.6%. Both divisions B and D delivered over 100% of baseline with divisions C and E falling below..

Current issues

Division E continues to struggle with shortages of medical workforce in gynaecology, as well as impacts from industrial action. Enhanced validation and processes are being introduced to ensure maximum efficiencies. Additional clinics are being introduced where possible

Key dependencies

A number of areas are reporting shortages in medical staff as well as increasing impacts from industrial action are impacting on new appointments. Future performance will be heavily based around these.

Future actions

All services are continuing to explore and implement new processes such as PNP to reduce the number of follow-up appointments needed which can be repurposed to increase new capacity. Rheumatology has performed well using this approach..

Author(s): Andi Thornton Owner(s): Nicola Ayton

Follow Up Outpatient Attendances - % vs. Baseline

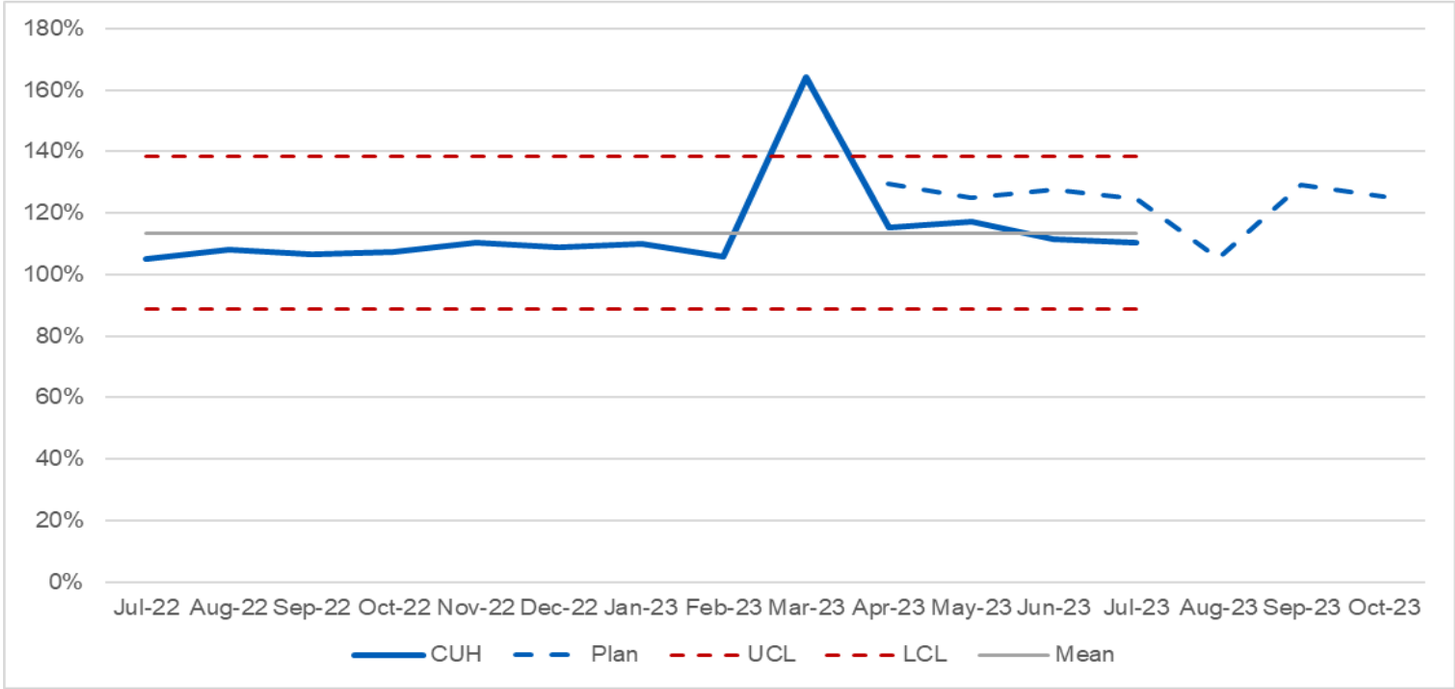
NHS Cambridge University Hospitals NHS Foundation Trust

Jul-23	Plan
110.4%	124.8%

SPC Variance
Normal variation

Shelford Group Avg (Jul-23)
N/A

Three Month Forecast		
Aug-23	Sep-23	Oct-23
105.2%	129.0%	125.4%



Divisional overview	
Division	Performance
A	115.9%
B	107.3%
C	107.9%
D	108.8%
E	131.8%

Updates since previous month

We continue to see high levels of follow-up activity as well as a continued uptrend in the total number of overdue follow-ups. Some areas such as Rheumatology have seen their overdue follow-ups reduce thanks to the implementation of PNP.

Current issues

There is a national asked to reduce outpatient follow-up activity to 75% of 2019/20 activity levels. We continue to remain a long way from that target. However, there is causation that to reduce the backlog we need to increase activity temporarily.

Key dependencies

Many areas are submitting requests to eHospital for the creation of PNP clinic templates. It is hoped that this will have a dramatic impact on reducing follow-up attendances to free up capacity for increased new attendances. eHospital resources to create the clinics remains a key dependency.

Future actions

Roll-out of PNP clinics across Diabetes,, Endocrinology, Ophthalmology, Cardiology, Nephrology and Respiratory

Author(s): Andi Thornton Owner(s): Nicola Ayton

PIFU Outpatient Attendances

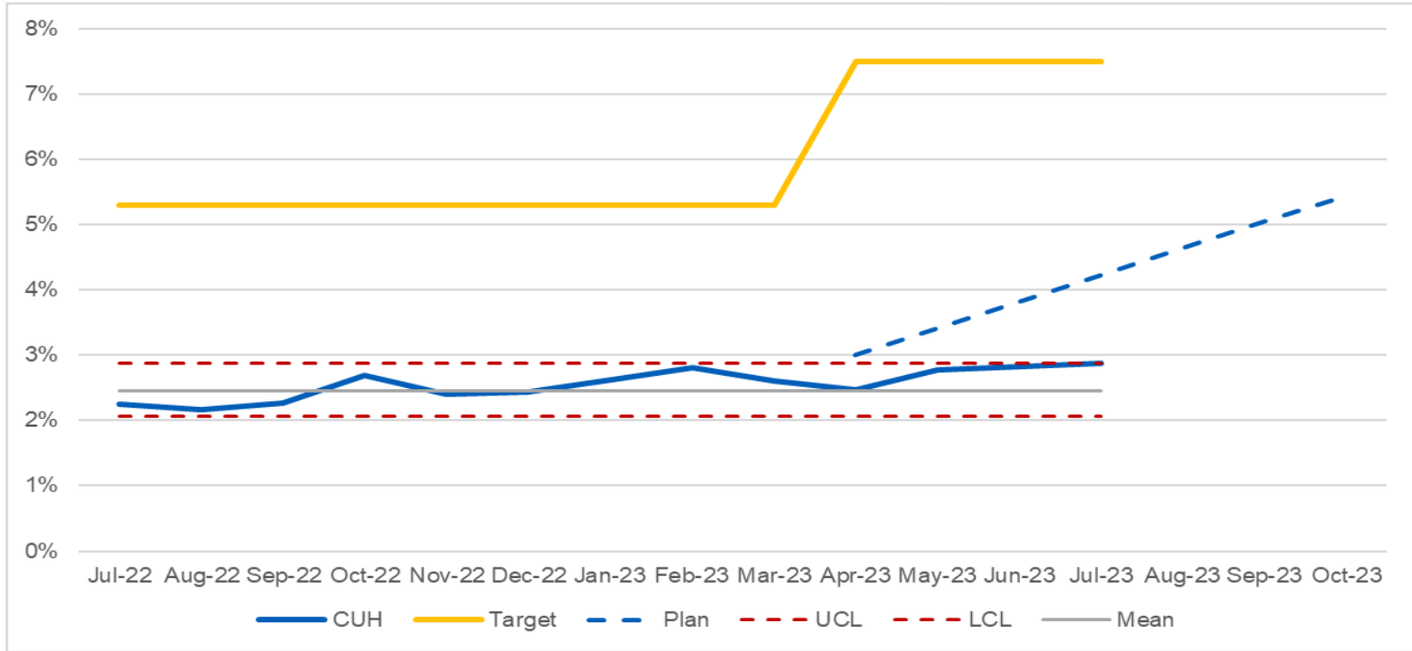
NHS Cambridge University Hospitals NHS Foundation Trust

Jul-23	Plan
2.9%	4.2%

SPC Variance
Positive special cause variation

Shelford Group Avg (Jul-23)
N/A

Three Month Forecast		
Aug-23	Sep-23	Oct-23
4.6%	5.1%	5.5%



Divisional overview	
Division	Performance
A	6.9%
B	2.9%
C	1.6%
D	1.8%
E	2.5%

Updates since previous month

We have seen an increase in the use of PIFU across a number of specialties, with division A continuing to perform well ahead of the rest of other divisions and above the 4.2% plan at 6.9%.

Current issues

Implementation of PIFU pathways is variable across specialties. Mor

Key dependencies

Clinical teams must review pathways to ensure they maximise the opportunity to use PIFU where appropriate.

Future actions

Continued work on pathways supported by the Improvement and Transformation team to maximise the opportunities of PIFU.

Author(s): Andi Thornton Owner(s): Nicola Ayton

Delayed discharges

NHS
Cambridge University Hospitals
NHS Foundation Trust

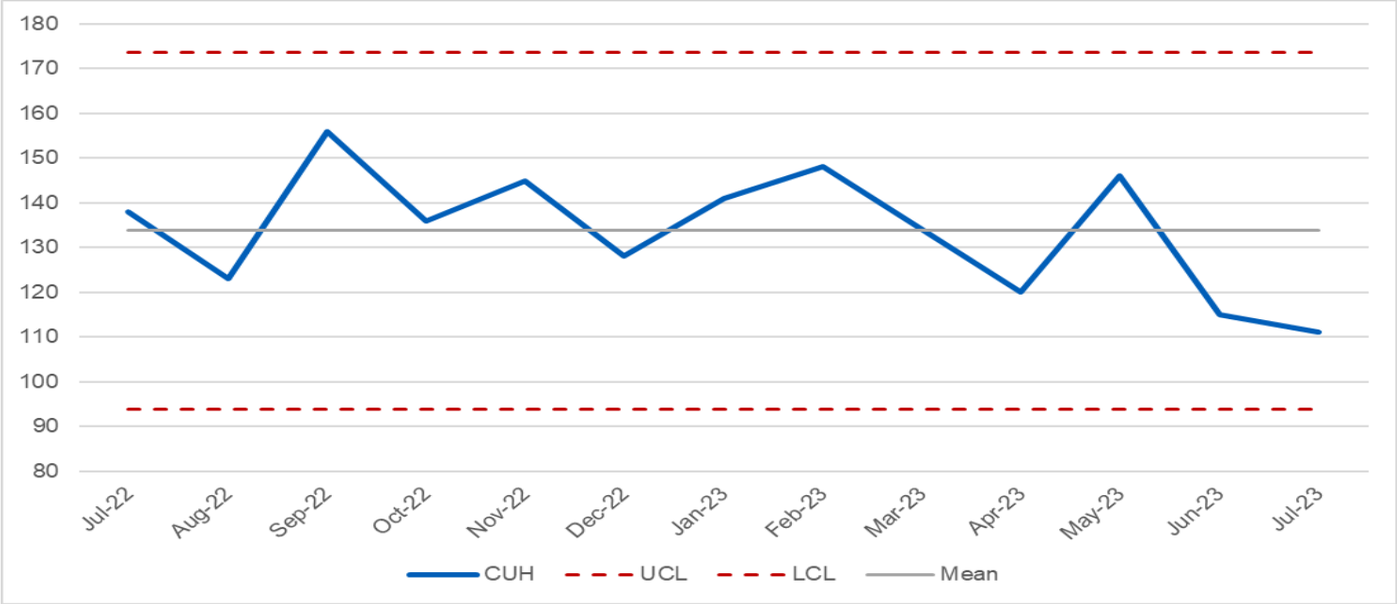
Jul-23	Target
111	N/A

SPC Variance
Normal variation

Shelford Group Avg (Jul-23)
N/A

Beds lost to delays - by pathway

Pathway	Beds lost
Pathway 1	43
Pathway 3	25
Pathway 2	21
Pathway 0	17
Internal Assessments	4
External Assessments	1
Triage	1
Unknown	0
Total	**111**



Updates since previous month

- Bed lost to delayed discharges decreased to 111 in June, down slightly from 115 in June. This represents a significant proportion (>10%) of our overall in-patient bed base

Current issues

- Staffing challenges across certain pathways remain, particularly pathway 1 for which a dedicated recruitment campaign is on-going

Key dependencies

- Referrals must be made on a timely basis by the Trust and processed quickly by the system to reduce delays to discharge from the hospital
- Community staffing across all care pathways

Future actions

- On-going work with the Home First team and Transfer of Care Hub to reduce delays lost to pathway 1 (patients looked after at home)
- New social prescriber post to be put in place to coordinate discharges for Uttlesford patients

Author(s): James Hennessey **Owner(s): Nicola Ayton**

Theatre Utilisation - Elective GIRFT Capped

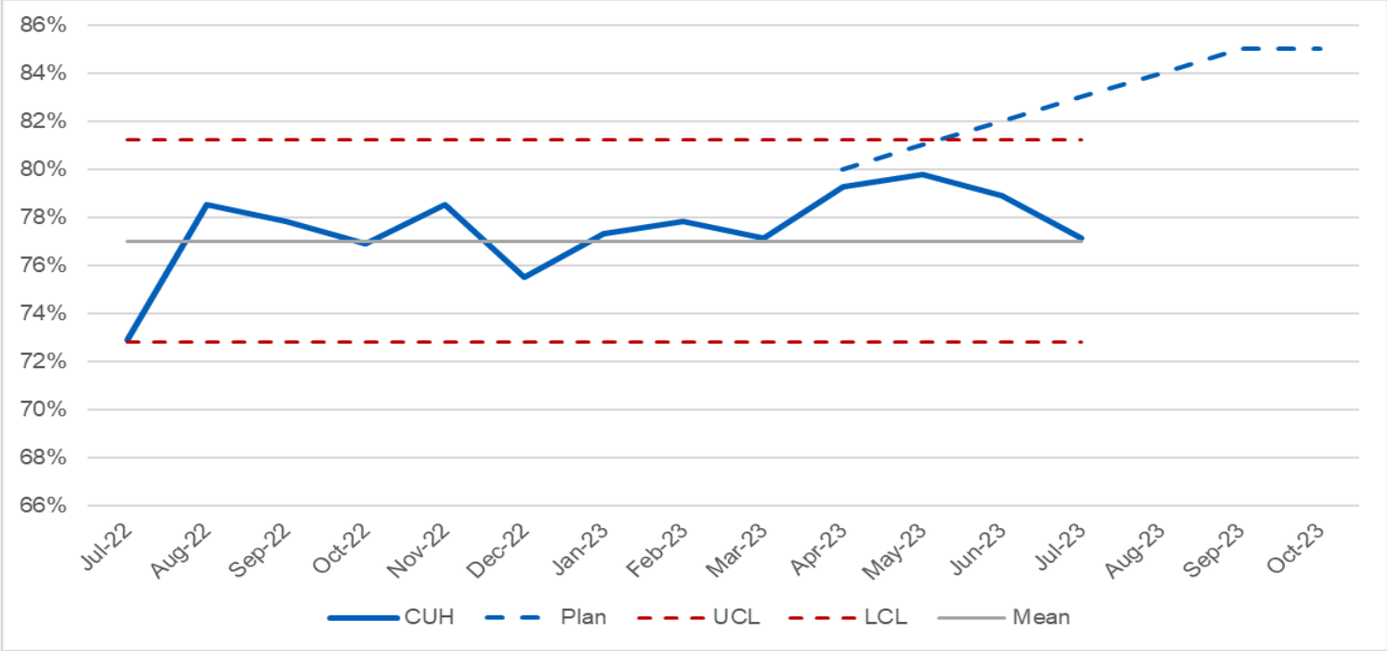
NHS Cambridge University Hospitals NHS Foundation Trust

Jul-23	Plan
77.1%	83.0%

SPC Variance
Normal variation

Performance in the 2 weeks to 30/07/23	
CUH	77.6%
Shelford Grp Median	77.5%

Three Month Forecast		
Aug-23	Sep-23	Oct-23
84.0%	85.0%	85.0%



Utilisation by department

Department	Utilisation
ATC	78.6%
Main	78.1%
Rosie	78.7%
CEU	69.0%
Ely	69.8%
All	**77.1%**

Updates since previous month

- Capped Utilisation dropped in July to 77.1% (Quartile 3) but remains consistent with peers.
- Sessions used in July were down to 84.8%, improving to 96.3% when Industrial Action dates are excluded.

Current issues

- Despite a lower month overall, in the 2nd week of July we achieved highest capped utilisation to date 82%.
- 31% of the short notice cancellations (80) fell in the first week of the month pulling utilisation down to 75%.

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.

Future actions

- New proposed scheduling templates for Ely have now been shared with Plastic surgery and General Surgery.
- Surgical movement hub will support reduction in short notice cancellations. 10% have been in Orthopaedics and Neuro due to trauma / emergencies.

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

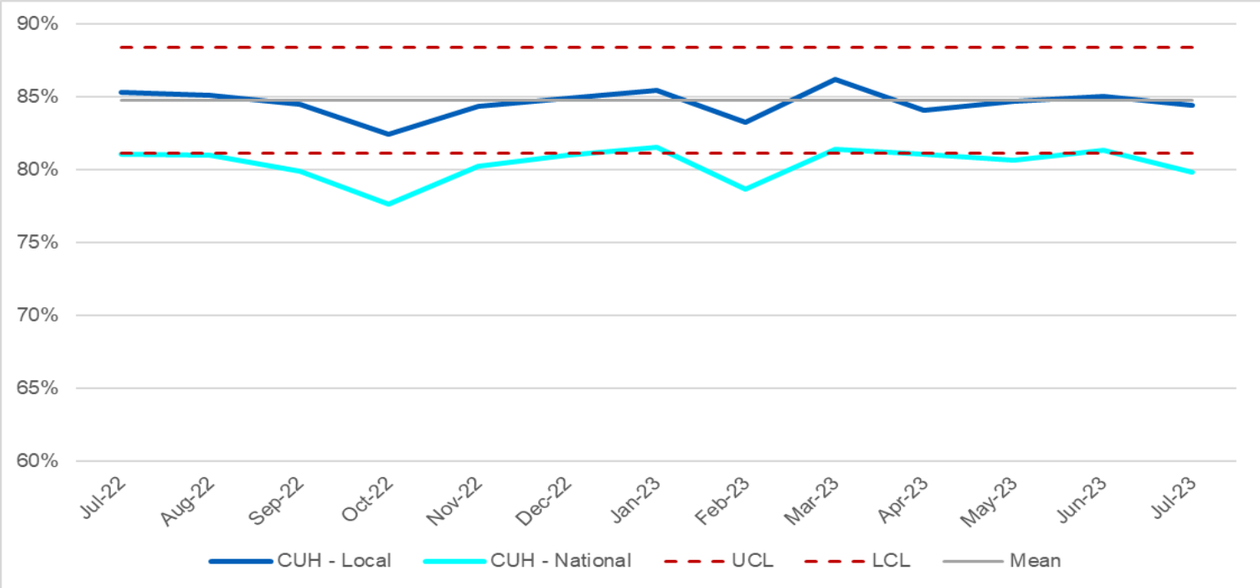
BADS Daycase Rates

NHS Cambridge University Hospitals NHS Foundation Trust

Jul-23	Target
84.4%	85%

SPC Variance
Normal variation

Shelford Grp Median 3m to end of Apr '23
77.0%



BADS Section Day Case Rate for HVLC focus areas

3 months to end of Apr '23				Jul-23
Specialty	**CUH**	**Shelford**	**Quartile**	**Local**
Orthopaedics	82.9%	79.9%	2	92.6%
ENT	72.3%	83.3%	1	78.7%
General	63.0%	65.0%	1	79.2%
Gynaecology	57.2%	65.0%	1	81.4%
Opthalmology	97.4%	98.2%	1	98.9%
Urology	67.2%	67.2%	2	71.4%

Updates since previous month

- Model Hospital GIRFT data 3 months to Apr-23 shows performance at 77.7%, quartile 2.
- Local BADS reporting in July shows 84.4%, just below the expected 85% target

Current issues

- Inaccurate recording of Intended Management as daycase reflects in poorer performance externally
- 45 zero LOS BADS procedures were recorded as in-patient intended management in July.

Key dependencies

- Correct data recording of Intended Management
- Effective patient flow on L2 daycase / 23 hr stay
- Clinically led discharge criteria.

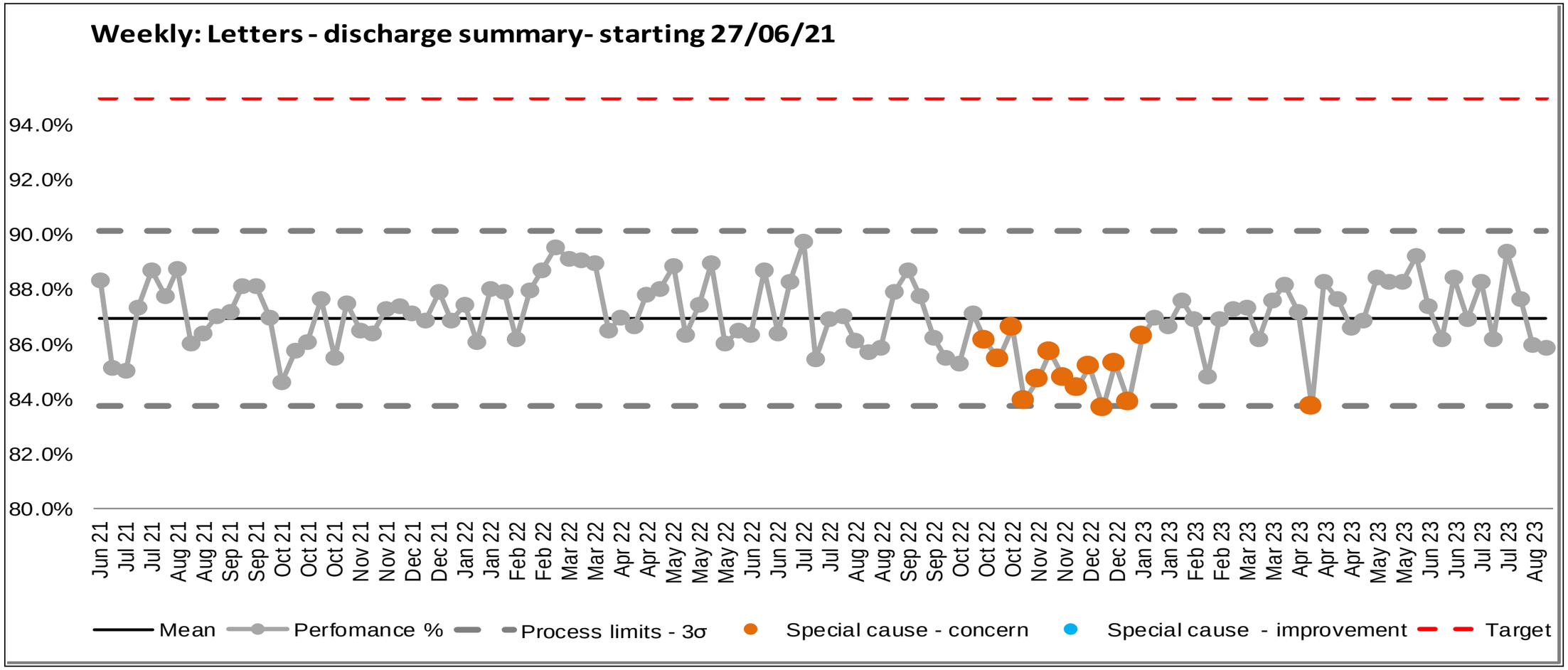
Future actions

- 84.4% reflects that 199 potential BADS cases stayed in >0 LOS in July. 115 /199 were managed as 23hr stay through non-inpatient ward capacity.
- ENT (18 Thyroid and Parotid) and Vascular (10 Carotid) are the services with highest volume having an inpatient ward stay.

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

Discharge Summaries

NHS
Cambridge University Hospitals
NHS Foundation Trust



Discharge summaries

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

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

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

Author(s): James Boyd **Owner(s): Ashley Shaw**

Patient Experience - Friends & Family Test (FFT)

NHS Cambridge University Hospitals NHS Foundation Trust

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 - Jul 23	Month	-	94.7%	95.5%	L	S7	-	For July the Good score increased by 2% and the Poor score also improved by 2.5%. The Poor score of 1.6% is the lowest since February . **FOR JUL: there were 431 FFT responses collected from approx. 4017 patients.**
FFT Inpatient poor experience score	Jul 20 - Jul 23	Month	-	1.6%	1.7%		-	-	
FFT Outpatients good experience score	Apr 20 - Jul 23	Month	-	93.2%	94.9%	L	SP	-	For July, the Good score declined slightly by 0.8%, and with the decline in June, this is now about a 2% decline compared to May. The Poor score did not change and has maintained at 3% since May. There were 5 FFT response collected from clinic 6 so the FFT scores mainly reflect adult clinics. **FOR JUL: there were 3896 FFT responses collected from approx. 26,235 patients.** The SPC icon shows special cause variations: high is a concern with having more than 7 consecutive months below/above the mean.
FFT Outpatients poor experience score	Apr 20 - Jul 23	Month	-	3.2%	2.4%	H	SP	-	
FFT Day Case good experience score	Apr 20 - Jul 23	Month	-	95.1%	96.5%		-	-	For July there was a 1% decrease in the Good score, and a very small increase of 0.6% in the Poor score. Both scores have remained consistent with no more than 1% change throughout the last 12 months. **FOR JUL: there were 738 FFT responses collected from approx. 3.370 patients.**
FFT Day Case poor experience score	Apr 20 - Jul 23	Month	-	2.7%	1.7%		-	-	
FFT Emergency Department good experience score	Apr 20 - Jul 23	Month	-	81.0%	83.1%		-	-	For July the overall Good score increased by 4% compared to June, and the Poor score also improved by 1%. The improved scores are from the adult patient experience: adult Good score improved by 5%, and the Poor score improved by 3%. The paediatric experience declined in July: the Good score decreased by 2%, and the Poor score increased by 7%. **FOR JUL: there were 585 FFT responses collected from approx. 4105 patients**. The low number of responses is from fewer SMS being sent to patients.
FFT Emergency Department poor experience score	Apr 20 - Jul 23	Month	-	11.8%	10.3%		-	-	
FFT Maternity (all FFT data from 4 touchpoints) good experience score	Jul 20 - Jul 23	Month	-	99.2%	95.1%		-	-	**FOR JUL:** Antenatal had 5 FFT response - 100% Good; Birth had 55 FFT responses out of 481 patients - 100% Good; Postnatal had 63 FFT responses: LM had 25 FFT with 96% Good / 4% Poor, DU had 2 FFT with 100% Good / BU had 28 FFT with 100% Good, and COU 100% Good from 8 responses. 0 FFT responses from Post Community. **JUL MATERNITY OVERALL:** Good score increased by 2% and Poor score increased by 1%. There were 123 FFT responses collected.
FFT Maternity (all FFT data from 4 touchpoints) poor experience score	Jul 20 - Jul 23	Month	-	0.8%	1.8%		-	-	

FFT data starts from April 2020 for day case, ED and OP FFT (SMS used to collect FFT), and inpatient and maternity FFT data starts with July 2020 due to Covid-19 restrictions on collecting FFT data. For NHSE FFT submission, wards still not collecting FFT are not being included in submission. In July 9 wards did not collect any FFT data.

Overall FFT in July, there was variation in the Good and Poor scores. Inpatient and adult A&E FFTGood and Poor scores improved. Paediatric A&E saw a decline in both Good and Poor scores compared to June. Day case FFT Good and Poor scores declined and the Outpatients Good score declined. However both day case and outpatients continue to maintain strong FFT scores. Maternity Good score improved by 2%, mainly from Lady Mary, however Lady Mary had a 4% Poor FFT score.

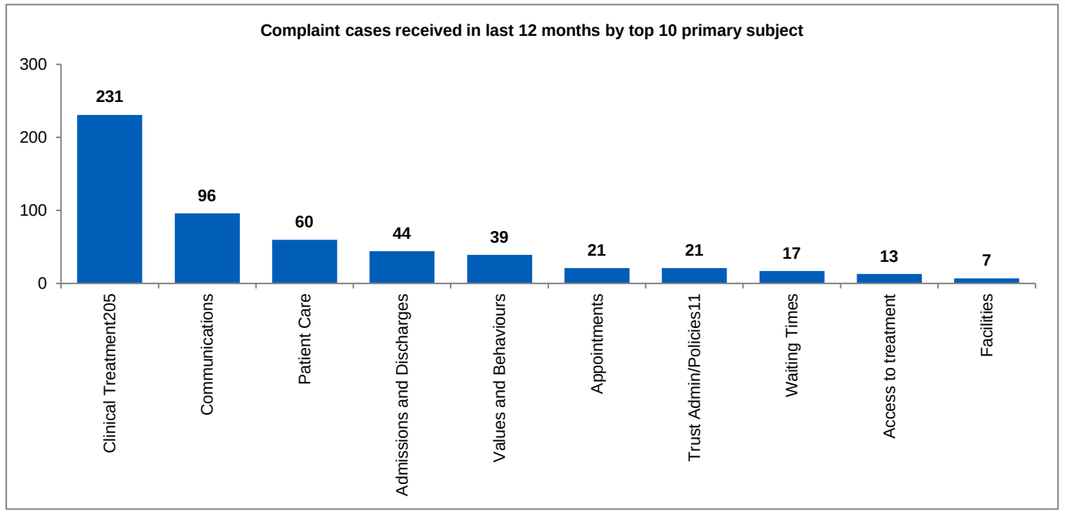
Please note starting in 2022, the Trust reduced the number of SMS being sent to adult patients. Instead of sending a text message to every adult patient that attend an OP/DU appointment, or presented to A&E, the Trust now sends a fixed number of SMS daily.

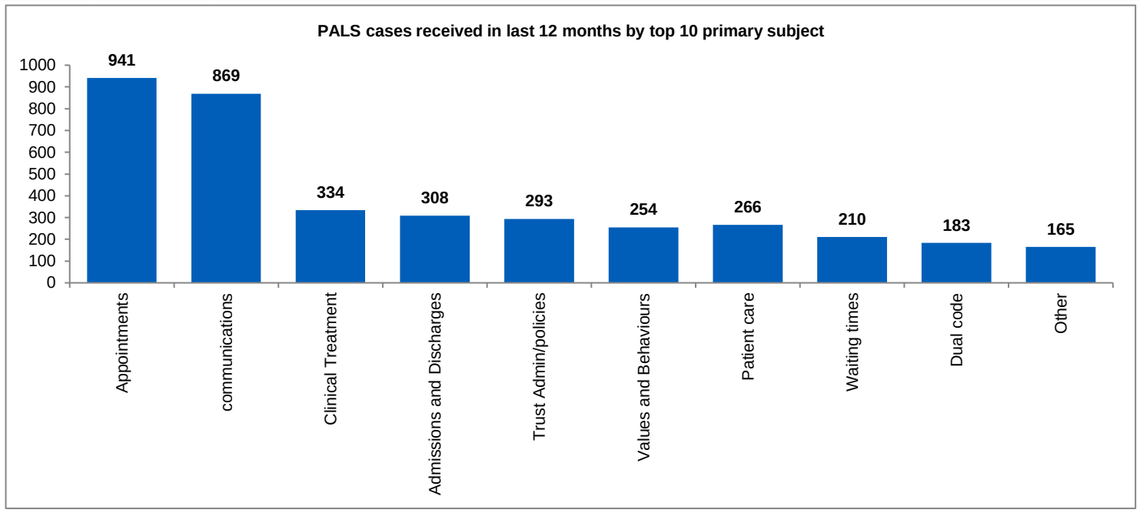
Author(s): Charlotte Smith/Kate Homan Owner(s): Clare Hawkins

PALS and Complaints Cases

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
Complaints received	July 19-July 23	month	-	55	55	H	SP	-	The number of complaints received between July 2019 - July 2023 is higher than normal variance.
% acknowledged within 3 days	July 19-July 23	month	95%	89%	73%		-	?	49 out of 55 complaints were acknowledged within 3 working days
% responded to within initial set timeframe (30, 45 or 60 working days)	July19-July 23	month	50%	35%	30%	L	S7	?	145 complaints were responded to in July, 51 of the 145 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	July19 -July 23	month	80%	49%	87%	L	SP	?	71 out of 145 complaints responded to in July were within the initial set time frame or within an agreed extension date.
% complaints received graded 4 to 5	July19 -July 23	month	-	16%	34%		-	-	There were 8 complaints graded 4 severity, and 1 graded 5. These cover a number of specialties and will be subject to detailed investigations.
Compliments received	July19 - July 23	month	-	14	32	L	S7	-	14 Compliments were registered during July and sent onto relevant staff for information





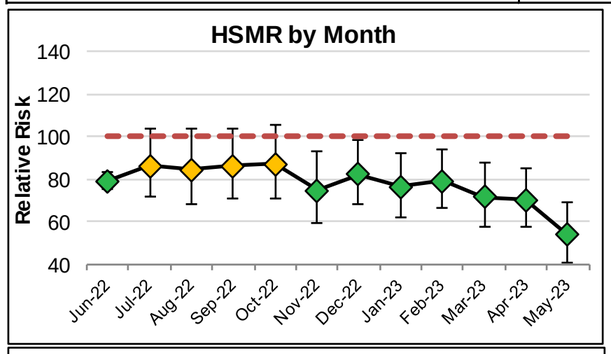
PHSO - One case was taken for investigation in July 2023 relating to care provided in 2020.
A backlog of complaint responses (550) declared in May 2023 has now been brought down to under 300. A new process has been introduced within the complaints team to try to resolve issues raised much quicker by engaging the Divisions at the outset to reduce the number of lengthy responses. Meetings and telephone conversations are being offered to all complainants.

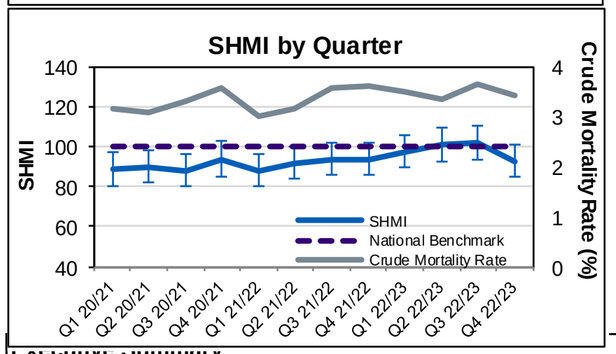
Author(s): Sue Bennison **Owner(s): Clare Hawkins**

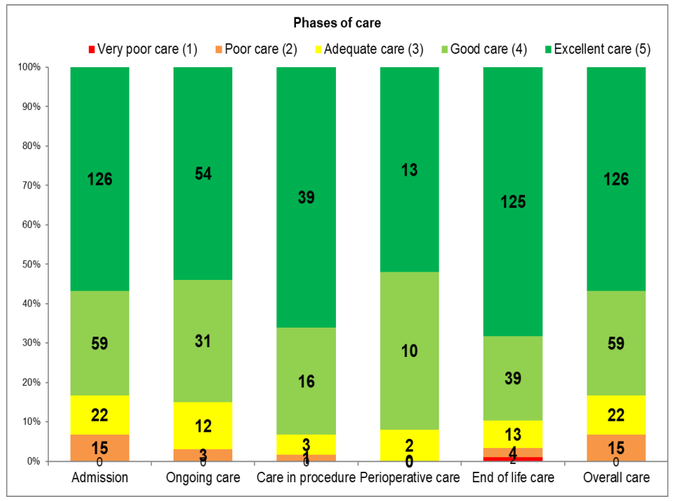
Learning from Deaths

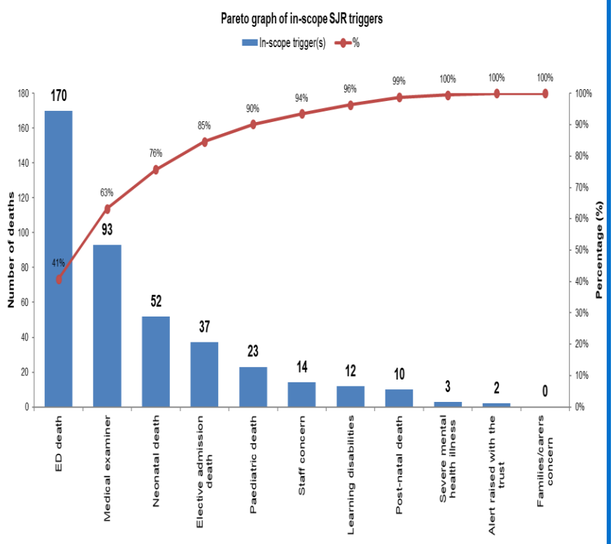
NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Data range	Period	Current period	Mean	Variance	Target status	Comments
Total inpatient and Emergency department deaths	**August 2018 - July 2023**	Jul-23	**131**	*134*		–	May 2023 saw end of 14 month upward shift.
Emergency Department and Inpatient deaths **per 1000 admissions**			**7.6**	*9*			
Emergency department deaths			**3.0**	*8.7*	H	–	July 2023 saw end of an 11 month statistically significant increase
Inpatient deaths			**128**	*125*		–	
% of Emergency Department and Inpatient deaths in-scope for a Structured Judgement Review (SJR)			**18%**	*21%*		-	In July 2023, 23 SJRs were commissioned









Executive Summary

HSMR - The rolling 12 month (June 2022 to May 2023) HSMR for CUH is 77.23, this is 4th lowest within the London and ATHOL peer group. The rolling 12 month HSMR for the Shelford Peer group is 92.23.

SHMI - The Summary Hospital-level Mortality Indicator (SHMI) for CUH in the latest period, April 2022 to March 2023 is 97.89.

Alert - There are 0 alerts for review within the HSMR and SHMI dataset this month.

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

Stroke Care

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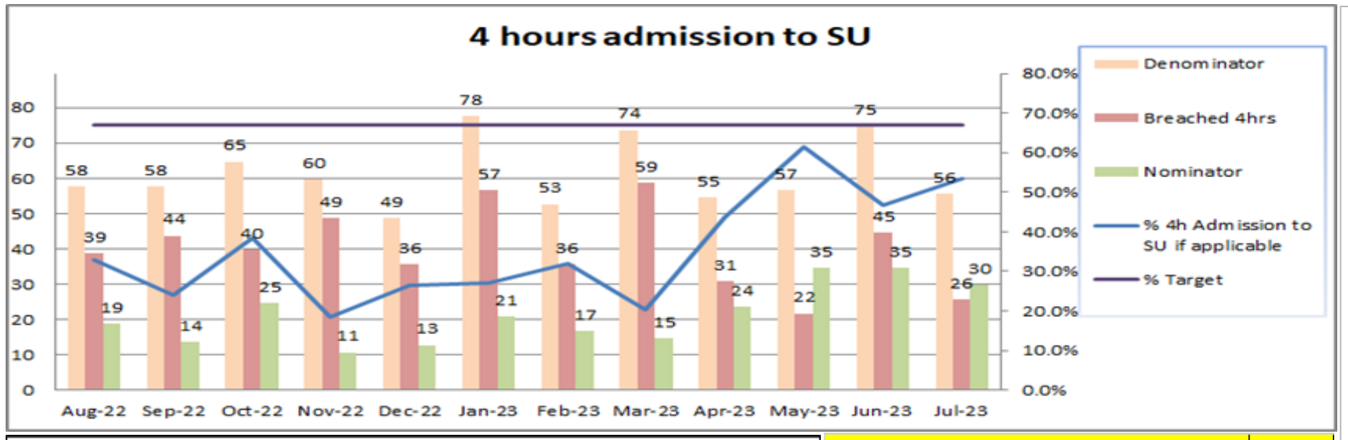

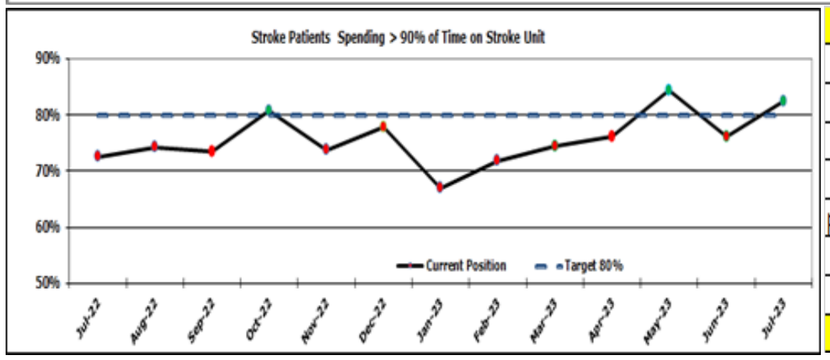

4hrs to SU breach themes	Pts
Awiting senior review	5
ED busy	1
Not referred on arrival	8
Not thought to be a stroke. CT confirmed bleed	2
patient deteriorating-requiring airway management	1
Trust bed capacity	4
unclear/MRI confirmed stroke	5
Grand Total	26

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%)
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%
May-23	1	2					3						3	1			10	84.4%
Jun-23	2	5						4					9				20	76.2%
Jul-23		5				2		1					4				12	82.4%
Summary	19	90	0	0	0	3	18	16	1	1	3	0	46	7	0	7	219	

90% target (80% Patients spending 90% IP stay on Stroke ward) was achieved for July 2023 = **82.4%**

Trust bed capacity (5) was the main factor contributing to breaches last month, with a total of 12 breaches in July 2023.

4hrs adm to SU (67%) target compliance was not achieved in July 2023 = 53.6**%**

Key Actions

- Work continues to protect 2 x ring-fenced beds on R2 (one male and one female)
- 20% of the stroke unit bed base is occupied by general medical outliers
- Introduced nurse participation at the twice daily neuro bed huddles is helping to manage bed base and ensure appropriate patients are allocated to R2
- 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.
- ACP role to support stroke unit has been agreed. JD is being finalised and recruitment process has been approved
- National SSNAP data shows Trust performance from Jan - Mar 2023 at Level B.
- 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

Author(s): Charles Smith Owner(s): Nicola Ayton

Clinical Studies

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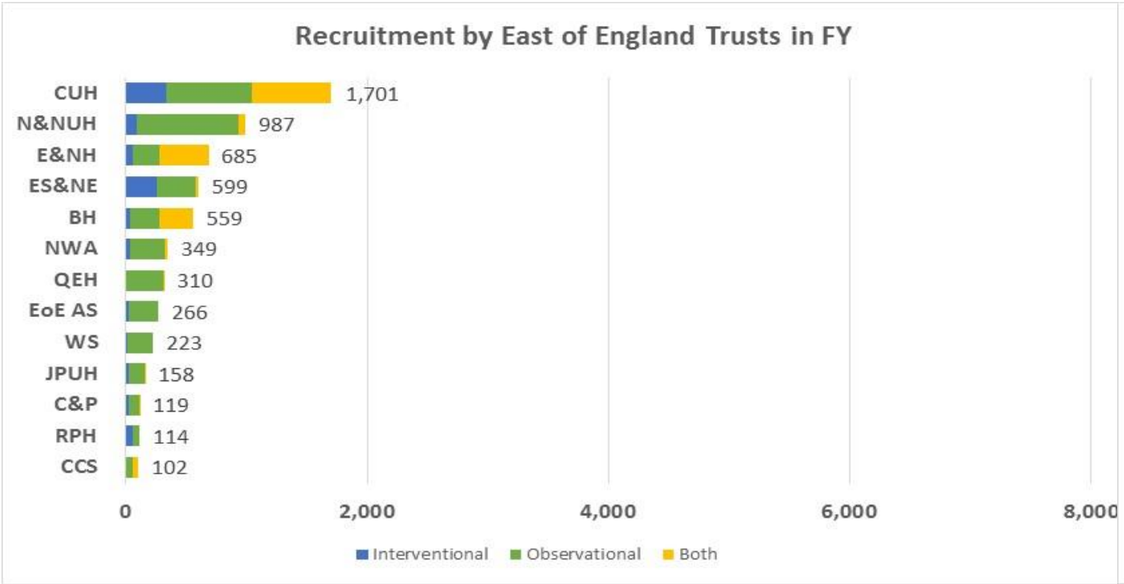
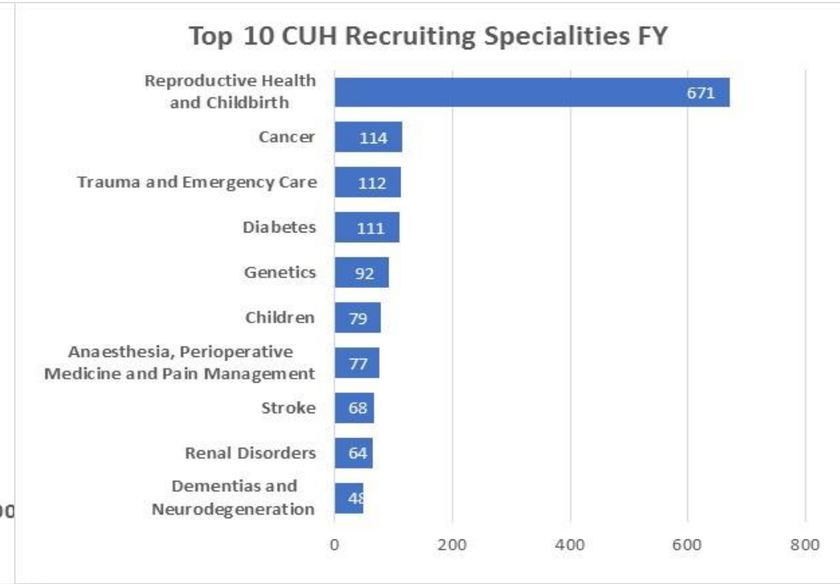
Total Recruitment at end of June - FY 2023-24

1,701

Recruiting Studies at end of June for FY 2023-24

Open	201	Non Commercial	185
Closed	10	Commercial	26
Suspended	0		
Total	**211**		





Situation as at end of Q1 2023/24

* Total recruitment in the financial year to date: 1,701
* CUH accounted for 27% of total recruitment by Eastern Trusts in the financial year to date. Interventional only studies accounted for 34% of the total, while Observational only studies accounted for 19% of the total. The remaining 42% were both Interventional and Observational .
* Recruitment to the Reproductive Health speciality accounted for 39% of all recruitment (671). All of the other individual specialities accounted for less than 10% of the total recruitment.
* There were 211 recruiting studies, of which 26 were Commercial, and 185 Non-Commercial.

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

Author(s): Stephen Kelleher **Owner(s):**

Maternity Dashboard

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

KEY: CQC DOMAINS
Outstanding
Good
Requires Improvement
Inadequate

LMNS:	Reporting period:	Overall System RAG:

REGULATORY BODIES

CQC DOMAINS

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

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

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

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
Other surveys	
GMC survey results (2022) overall satisfaction	Guidance required

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

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Assessed compliance with CNST MIS Yr 4 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)	

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 RMNVP. 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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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	• **FTSU** – community medicines management. Escalated to chief pharmacist and ongoing working group in place.
2. Themes from Maternity Serious Incidents and HSIB reports	**SI report published following abruption and IUD recommendations include:** • Symptoms that continue and appear to be out of proportion to the working diagnosis need reconsideration and re-evaluation of all the evidence • Not all vomiting is secondary to infection and therefore a blanket 'ban' on any woman with vomiting being transferred to Clinic 23 is inappropriate. • Adherence to the MEOWS Escalation Protocol. • Ensure there is clarity regarding the roles of the supernumerary shift lead and Site Safety Midwife • Review current processes and guidance locally for ensuring the timely review and follow up of test results **Oncology maternal death HSIB report received:** no safety recommendations for CUH
3. Themes arising from Perinatal Mortality Review Tool	• Lack of referral to preterm surveillance clinic for next pregnancy – education planned & Epic risk assessment build about to be commenced. • Post discharge bereavement support following loss on NICU.
4. Listening to women (sources, engagement / activities undertaken)	• **Complaint themes (n=5) and concerns (n=3) themes:** communication, clinical treatment and for concerns requests for appointments • **2 compliments received:** staff member in USS professional and kind; in community excellent care from Emerald team midwives • **Birth Afterthoughts service feedback:** positive experience, gave closure, gave clarity, helpful for understanding of care and implications for future birth. Some negative experiences reported around LMW, how bad news was delivered at USS, didn't feel listened to on RBC leading to delay in pain relief. • **Overall FFT feedback:** Good = 99.2% (2% increase compared to June); Poor = 0.8% (0.8% increase compared to June).
5. Listening to staff (eg activities undertaken, surveys and actions taken as a result)	• **PMA identified themes via staff feedback:** DU culture highlighted by B6 midwives including lack of support for B5 midwives and students on DU – escalated to matron. B6 brunch drop-in arranged by lead PMA to facilitate support and gather feedback but due to unit acuity it could not go ahead.

Maternity Dashboard

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Sources / References	KPI	Goal	Target	Measure	Data Source	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-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 KPI's	438	454	415	474	452	490	5508	
Antenatal Care ICS contracted booking KPI	Health and social care assessment <GA 12+6/40	> 90%	>=90% <90% and >=80% <80%	Booking Appointments	Epic	91.69%	91.69%	95.48%	83.06%	91.03%	89.11%	H	Return to face to face in ANC and community clinics phased in from 1 July.
National Maternity Dashboard	Booking Appointments	For Information	N/A	Booking Appointments	Epic	303	361	310	431	379	358		
Source - EPIC	Vaginal Birth (Unassisted)	For Information	N/A	SVD's in all birth settings	Rosie KPI's	53.88%	57.05%	47.47%	49.16%	48.45%	48.16%		
Source - EPIC	Home Birth	For Information	N/A	Planned home births (BBA is excluded)	Rosie KPI's	0.23%	1.32%	0.96%	0.21%	0.22%	1.63%		
Source - EPIC	Rosie Birth Centre Birth	For Information	N/A	Births on the Rosie Birth Centre	Rosie KPI's	17.58%	14.32%	13.73%	14.14%	15.71%	13.47%		
Source - EPIC	Rosie Birth Centre transfers	For information	N/A	Women admitted to RBC and subsequently transferred for birth	Rosie KPIs	35.19%	43.00%	47.06%	41.00%	31.96%	34.41%		
Source - EPIC	Induction of Labour	For Information	N/A	Women induced for birth	Rosie KPI's	29.93%	29.13%	38.20%	34.12%	33.48%	33.89%		
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	24.85%	31.29%	27.03%	30.16%	27.62%	28.64%	L	Special cause of improving nature. NB: Red flag of 2 hours is based on time of "commencement of IOL" in NICE guidance, but locally reported based on administration of first prostaglandin.
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	7.27%	5.52%	10.27%	9.52%	11.05%	9.05%	L	Special cause of improving nature.
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%	0.64%	1.25%	0%	0%		
Source - EPIC	Indication for IOL	100%	≥95%	Percentage of IOL with a valid indication as per guidance.	IOL Team	100%	100%	99.36%	100%	99.33%	100%		6 were outside guidance but had a consultant plan.
Source - EPIC	Birth assisted by instrument (forceps or ventouse) (Instrumental)	For Information	N/A	Instrumental birth rate	Rosie KPI's	10.73%	10.57%	11.81%	12.03%	13.05%	12.04%		
Source - EPIC	CS rate (planned & unplanned)	For Information	N/A	C/S rate overall	Rosie KPIs	34.47%	42.95%	40.24%	38.40%	38.27%	39.18%		
CQIM / CNST	Women in RG*1 having a caesarean section with no previous births: nullip spontaneous labour	For information	10%	Relative contribution of the Robson group to the overall C/S Rate	Rosie KPIs	14.70%	14.90%	20.30%	19.10%	18.30%	20.90%		
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	48.90%	59.80%	50.80%	50.50%	41.10%	55.10%		
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	1:3.14	1:4.69	1:3.75	1:3.24	1:2.93	1:3.68		
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	79.1%	91.5%	86.4%	88.1%	83.9%	83.3%		
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	60.9%	60.0%	68.3%	72.0%	61.3%	67.2%		
Source - Rosie Divert Folder	Divert Status - incidence	0	<1	Incidence of divert for the perinatal service	Rosie Diverts	1	2	0	1	2	4		2 due to capacity and staffing, 1 due to capacity and 1 due to staffing and NICU capacity. **Above average birth rate: 9% increase compared to July 22 birthrate and induction rate 10% higher than average of last 6 months.**
Source - Rosie Divert Folder	Total number of hours on divert	For information	N/A		Rosie Diverts	16:50	20:50	0	15:30	27.25	98.20		
Source - Rosie Divert Folder	Admissions to Rosie during divert status	For information	N/A	Numberof women admitted to the Rosie during divert based on Admissions Report	CHEQs	8	7	0	6	14	52		NB: Previously reported data not correct (under-reported) - data now taken from Chqs admissions.
Source - Rosie Divert Folder	Number of women giving birth in another provider organisation due to divert status	For information	N/A		Rosie KPIs	0	0	0	1	3	4		

Maternity Dashboard

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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	1:24	1:23.6	1:24.5	1:23.7	1:24.1	1:25.3		
Birth Rate Plus	Midwife/birth ratio (funded)**	For information	1.24.1	Total clinical midwife funded WTE*/Births (rolling 12 month average based on the BR+ methodology)	Finance	1:23.8	1:23.7	1:23.7	1:23.7	1:23.8	1:23.4		
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%	H	Special cause of improving nature.
Source - CHEQS	Staff sickness as a whole	< 3.5%	<5%	ESR Workforce Data	CHEQs	6.19%	5.74%	5.30%	4.92%	4.57%		L	Special cause of improving nature.
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	90.2%	88.9%	86.8%	88.4%				
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	84.53%	70.58%	73.97%	79.74%	81.22%			No data available for July due to lack of admin support within PD to cleanse dot data. Over 480 staff members on dot who need to attend Prompt.
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	87%	87%	84%	83.6%	81%	80%	H	NICU Dr 77%, NICU RN 66%, RMs 88%, MSWs 54%
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	84.56%	85.71%	90.18%	86.60%	87.08%	81.00%		MWs 83% / Obs 68% - drop in midwife compliance as MW list updated and some had been missed. Escalation process in place for non-compliance for bank and substantive staff.
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	86.46%	72.11%	80.45%	84.52%	84.91%	82.00%		MWs 83% / Obs 71%. Escalation process in place for non-compliance for bank and substantive staff.
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	88.7%	87.3%	85.2%	87%	91.6%			This is reported 1 month behind from CHEQs.
Maternal morbidity													
CQC KLOE	Puerperal Sepsis	For information	N/A	Incidence of puerperal sepsis within 42 days of birth	CHEQs	0.46%	0.46%	0.49%	0.21%	0.22%	0.42%		
Source - CHEQs	ITU Admissions in Obstetrics	For information	N/A	Total number of pregnant / postnatal women admitted to the intensive care unit	CHEQs	2	1	1	0	0	0		
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	6.82%	7.17%	3.75%	3.75%	4.63%	5.84%		
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	3.28%	1.32%	2.90%	5.56%	3.62%	3.73%		
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	7.22%	2.95%	5.42%	3.38%	1.55%	1.83%		
CQC KLOE	Maternal readmission rate	For information	N/A	Percentage of women readmitted to maternity service within 42 days of birth.	Rosie KPIs	2.84%	2.64%	1.55%	1.45%	2.59%	2.30%		
MBRRACE	Peripartum Hysterectomy	For information	N/A	Incidence of peripartum hysterectomy	QSIS	1	1	2	0	1	2		2 x accretas
MBRRACE	Direct Maternal Death	0	<1		QSIS	0	0	0	0	0	0		
Governance													
Source - QSIS	Total number of Serious Incidents (SIs)	0	<1	Serious Incidents	QSIS	1	0	0	0	0	0		
Source - QSIS	Never Events	0	<1	DATIX	QSIS	0	0	0	0	0	0		

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

Maternity Dashboard

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Neonatal Morbidity													
MBRRACE / PMRT	Still Births per 1000 Births	3.33/1000 (Mbrrace 2021)		Incidence per 1000 births	CHEQs	2.75:1000	3.67:1000	2.94:1000	2.75:1000	2.93:1000	3.45:1000		normal variation all 3 cases reviewed using PMRT with themes shared
MBRRACE / PMRT	Stillbirths - number ≥ 22 weeks	<3	<6	MBBRACE	CHEQs	3	3	1	2	2	2		
Epic	Number of birth injuries	0	<1	Percentage of babies born with a birth related injury	CHEQs	0	0	0	0	0	1		Fractured humorous - 24 rapid review confirmed known complication of forcep delivery.
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	0.69%	2.01%	1.94%	1.27%	2.23%	1.66%		
CQC KLOE	Incidence of neonatal readmission	For information	N/A	Percentage of babies readmitted within 42 days of birth	Rosie KPIs	5.28%	5.91%	3.72%	3.83%	3.83%	4.07%		
SBLCBV2	Babies born at <3rd centile at >37+6	For information	N/A	Incidence	CHEQs								Awaiting new CHEQS report
ATAIN	Term Admission to NICU Rate	<6%	N/A	Rate	CHEQs	4.2%	4.6%	6.0%	4.9%	4.0%	4.7%		(NB: June ATAIN data rounded incorrectly to 3.9% instead of 4.0% - amended.)
Quality													
CNST	1-1 Care in Labour	>95%	>90%	Percentage of women receiving 1:1 care in labour (excluding BBAs)	Rosie KPI's	100.0%	100.0%	99.8%	100.0%	100.0%	100.0%		
CQIM	Babies with a first feed of breastmilk	> 80%	>70%	Breastfeeding	Rosie KPI's	84.02%	84.12%	81.55%	83.65%	83.93%	83.37%		
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	3.02%	5.73%	5.60%	5.33%	4.72%	4.78%		
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	96%	94%	95%					No accurate data due to staff absence - plan in place to back date and report 3 months in August. (Usually reported 1 month behind due to manual data quality checking).
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	78%	77%	73%					No accurate data due to staff absence - plan in place to back date and report 3 months in August. (Usually reported 1 month behind due to manual data quality checking).
Source - Epic	VTE Assessment - AN	>95%	>95%	Percentage of women with a valid VTE risk assessment completed within 14 hours of admission to hospital.	CHEQs								Not reporting as errors in report identified Jun'23 - previous data incorrect and removed. Quality checking updated report and hope to report Aug 23 data.
Source - EPIC	VTE Assessment - PN	>95%	>95%	Percentage of women with a valid PN VTE risk assessment completed within 4 hours of birth.	CHEQs								Not reporting as errors in report identified Jun'23 - previous data incorrect and removed. Quality checking updated report and hope to report Aug 23 data.

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

Finance

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Trust performance summary - Key indicators

Trust actual surplus / (deficit)

(£1.0m)	*Actual (adjusted)**
£0.3m	*Plan (adjusted)**
(£0.3m)	*Actual YTD (adjusted)**
£3.8m	*Plan YTD (adjusted)**

Elective Payment Mechanism (EPM)

EPM replaces ERF in 23/24 for the variable element of elective performance.

£16.6m	*EPM forecast actual in month*
£18.1m	*EPM plan in month*
£16.6m	*EPM target in month*
£65.4m	*EPM forecast actual YTD*
£72.3m	*EPM plan YTD*
£66.5m	*EPM target YTD*

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

Net current assets

(£85.9m)	*Actual*
(£48.7m)	*Plan*

Debtor days

17	*This month*
16	*Previous month*

Payables performance (YTD) *

85.4%	*Value*
88.6%	*Quantity*

EBITDA

£11.5m	*Actual YTD*
£16.6m	*Plan YTD*

Capital expenditure

£7.3m	*Capital - actual spend in month*
£13.9m	*Capital - actual spend YTD*
£9.3m	*Capital – plan YTD*

Cash

Cash

£195.6m	*Actual*
£151.1m	*Plan*

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

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

Author(s): Rebekah Grainger **Owner(s): Mike Keech**

Staff in Post

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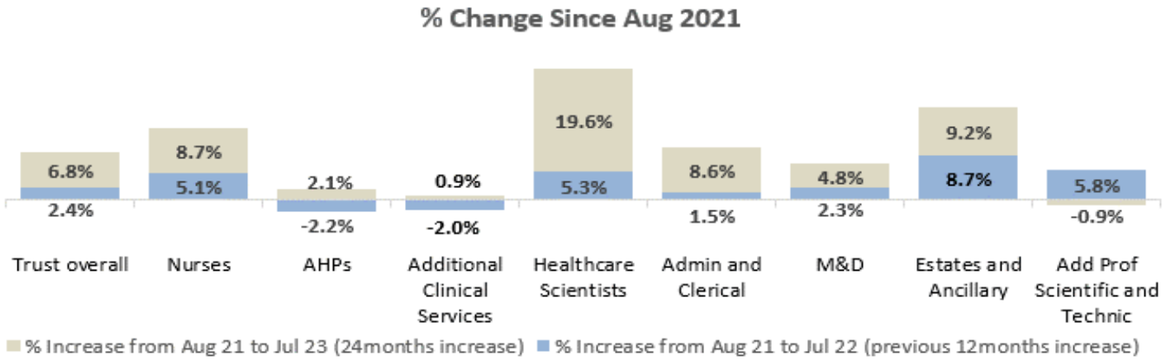
12 Month Growth by Staff Group

Staff Group	Headcount Aug-22	Headcount Jul-23	Headcount 12 Month growth	FTE Aug-22	FTE Jul-23	FTE 12 Month growth	
Add Prof Scientific and Technic	253	236	-6.7%	230	212	-18	-7.9%
Additional Clinical Services	1,923	1,998	3.9%	1,772	1,830	57	3.2%
Administrative and Clerical	2,380	2,552	7.2%	2,186	2,345	159	7.3%
Allied Health Professionals	724	742	2.5%	637	659	22	3.5%
Estates and Ancillary	366	369	0.8%	354	358	4	1.2%
Healthcare Scientists	646	721	11.6%	606	686	79	13.0%
Medical and Dental	1,691	1,703	0.7%	1,599	1,607	8	0.5%
Nursing and Midwifery Registered	3,805	3,930	3.3%	3,498	3,616	118	3.4%
Total	**11,788**	**12,251**	**3.9%**	**10,883**	**11,312**	**429**	**3.9%**



Admin & Medical Breakdown

Staff Group	Aug-22	Jul-23	FTE 12 Month growth	
Administrative and Clerical	2,186	2,345	159	7.3%
of which staff within Clinical Division	1,074	1,140	66	6.2%
of which Band 4 and below	749	789	40	5.4%
of which Band 5-7	233	250	17	7.1%
of which Band 8A	45	50	5	11.8%
of which Band 8B	7	8	1	16.7%
of which Band 8C and above	39	42	3	7.4%
of which staff within Corporate Areas	879	949	71	8.0%
of which Band 4 and below	244	259	15	6.3%
of which Band 5-7	412	456	44	10.6%
of which Band 8A	86	88	2	2.5%
of which Band 8B	51	52	2	3.3%
of which Band 8C and above	86	94	8	8.9%
of which staff within R&D	234	256	22	9.4%
Medical and Dental	1,599	1,607	8	0.5%
of which Doctors in Training	651	648	-3	-0.5%
of which Career grade doctors	243	228	-15	-6.1%
of which Consultants	704	730	26	3.7%

What the information tells us:
Overall the Trust saw a 3.9% growth in its substantive workforce over the past 12 months and 6.8% over the past 24 months. Growth over the past 24 months and past 12 months is showing as lowest within the Additional Professional Scientific and Technical staff group, with a decrease of 0.9% and 7.9% respectively, and highest within Healthcare Scientists at 19.6% and 13% respectively. This is largely due to data cleansing of the Genetics Counselling team, where staff were re-coded from Additional Professional Scientific and Technical and Additional Clinical Services staff groups to the Healthcare Scientists staff group.

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

Equality Diversity and Inclusion (EDI)

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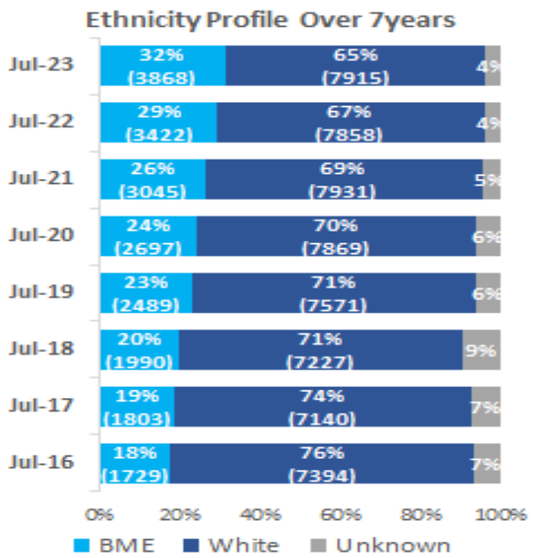

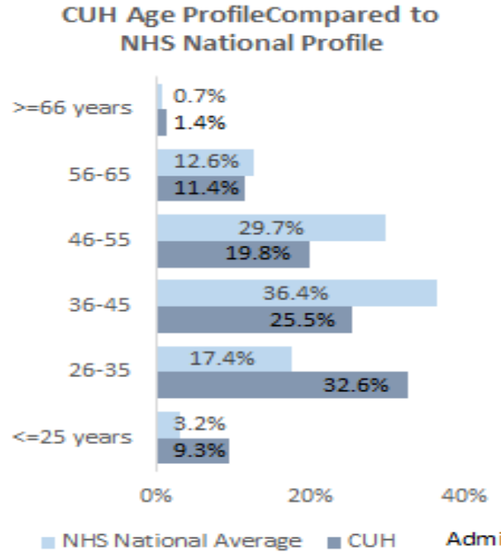

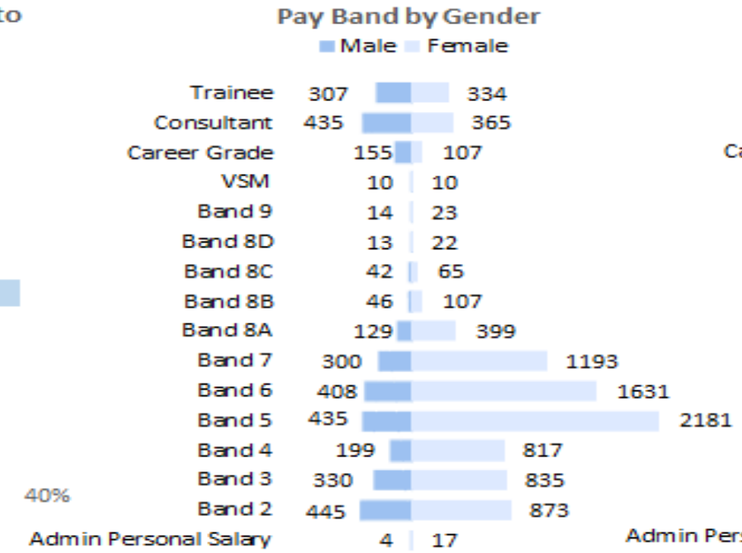

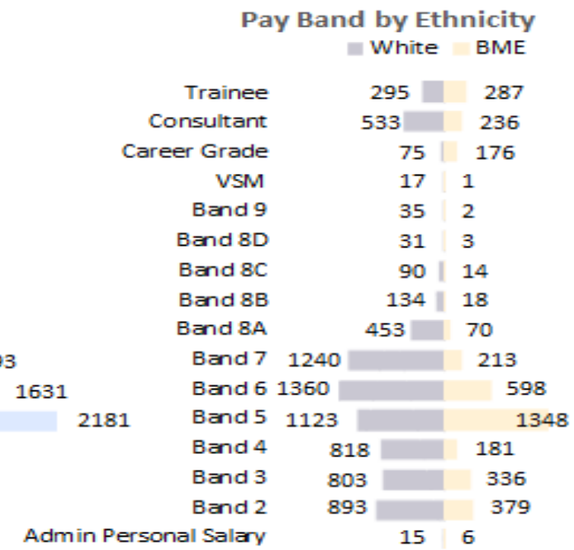

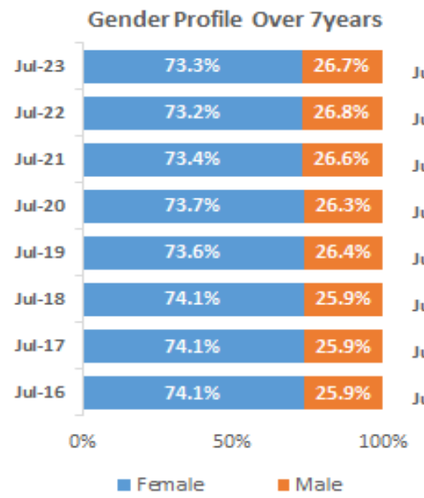

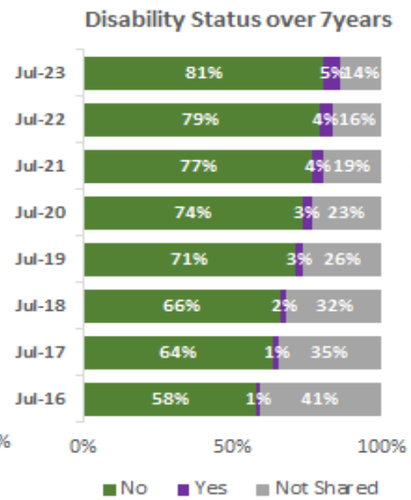

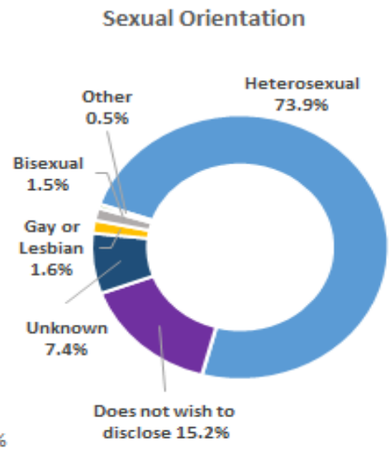

What the information tells us:

- 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 14% over the 7 year period and currently make up 32% of the CUH substantive workforce.
- The percentage of male staff increased by 1% to 26.7% over the past seven years.
- The percentage of staff recording a disability increased by 4.5% to 5.3% over the seven year period. However, there are still significant gaps between the data recorded about our staff on ESR compared with the information staff share about themselves when completing the National Staff Survey.
- There remains a high proportion of staff who have, for a variety of reasons, not shared their sexual orientation.

Staff Turnover

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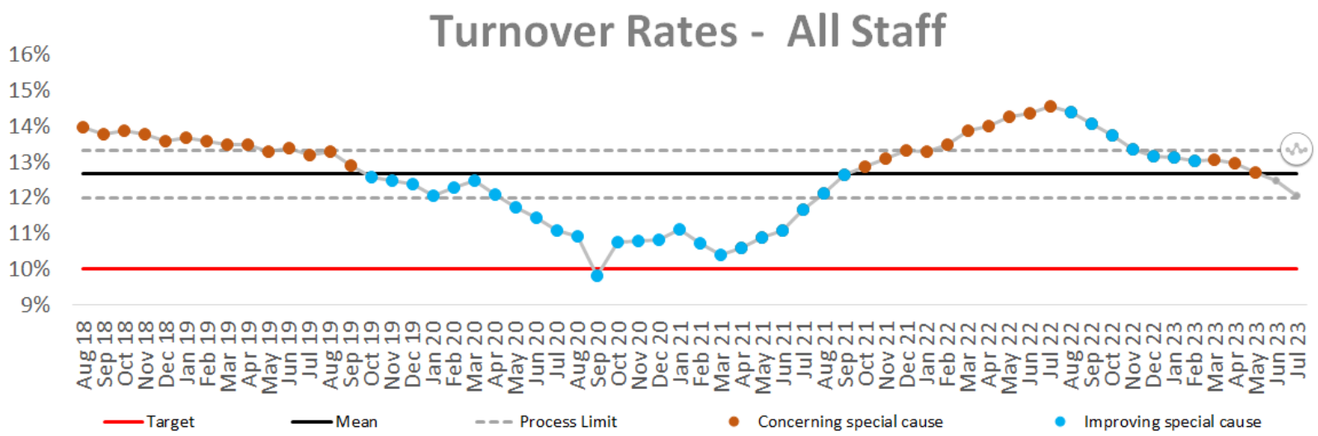
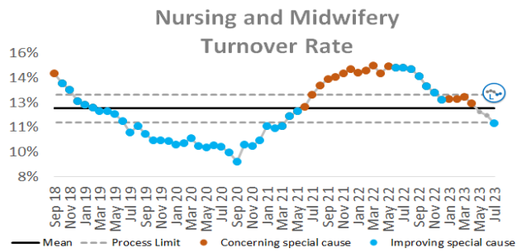
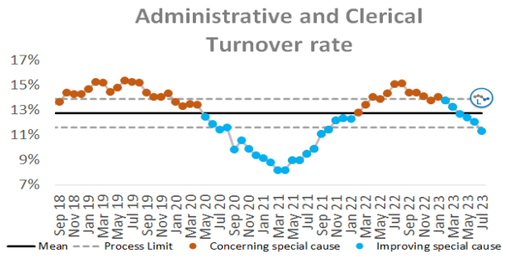
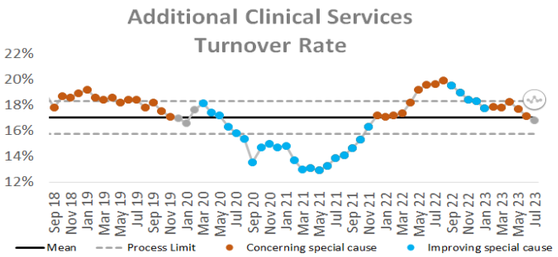


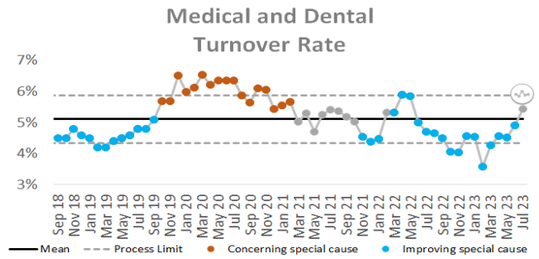
Background Information: Turnover describes the rate that employees leave an establishment. Staff turnover is calculated by the number of leavers from the Trust over the previous twelve months as a percentage of the total number of employed staff at a given time. (excludes all fixed term contracts including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

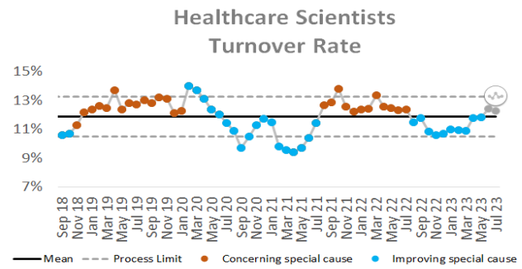
What the information tells us:
After a steady increase from March 2021 the Trust turnover rate has been decreasing since July 2022 - this month at 12.1% (0.4% lower than last month). This is more in line with pre-pandemic rates, and 1.2% lower than 4 years ago. Medical and Dental staff group has the highest increase of 0.6% to 5.4% in the last four years, followed by Nursing and Midwifery, with an increase of 0.2% to 11.3% in the last four years. Within the staff groups, Additional Clinical Services have the highest turnover rate at 16.8% followed by Estates and Ancillary staff at 14.2%.

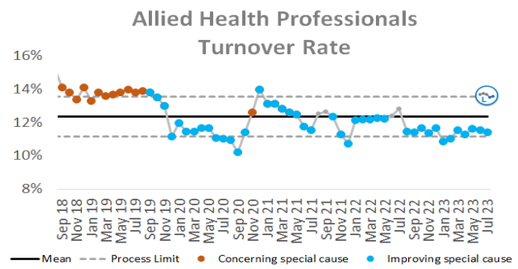


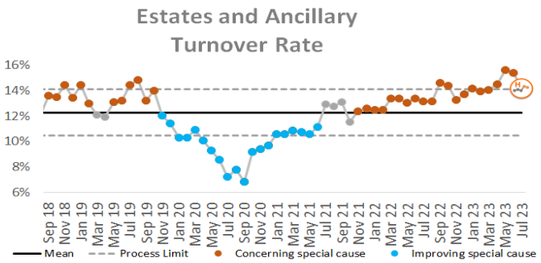


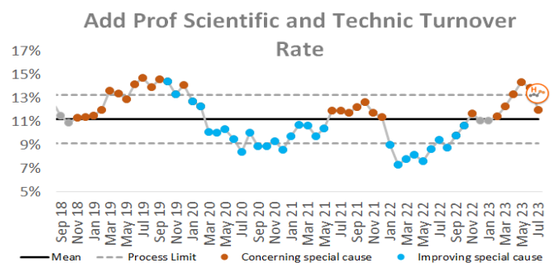












Turnover for Nursing & Midwifery Staff Group (Registered & Non-Registered)

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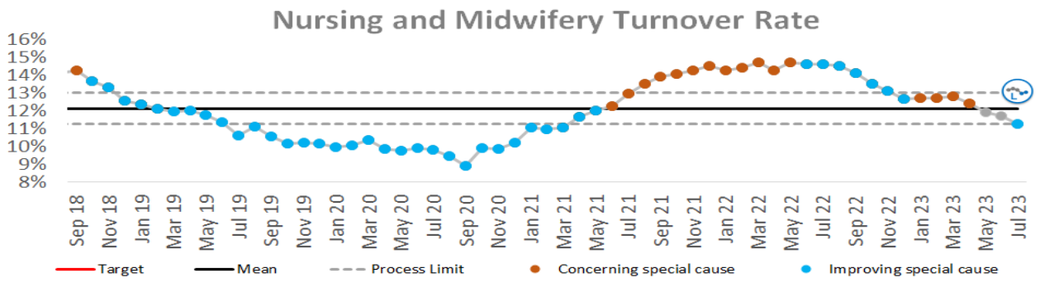

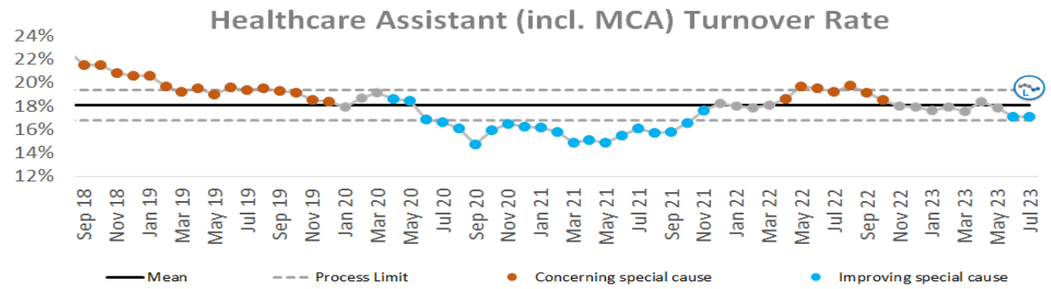

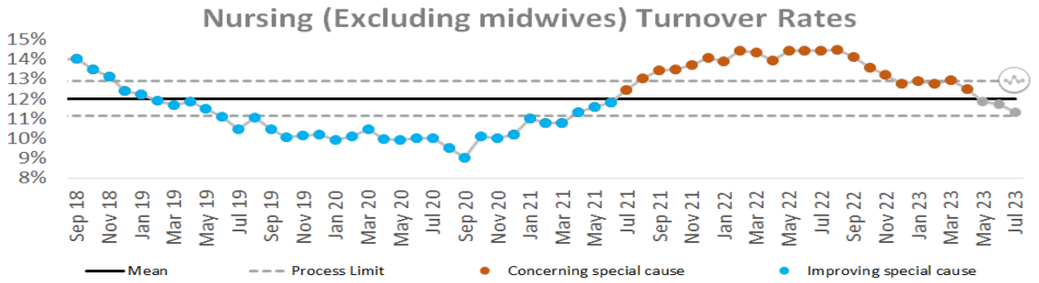

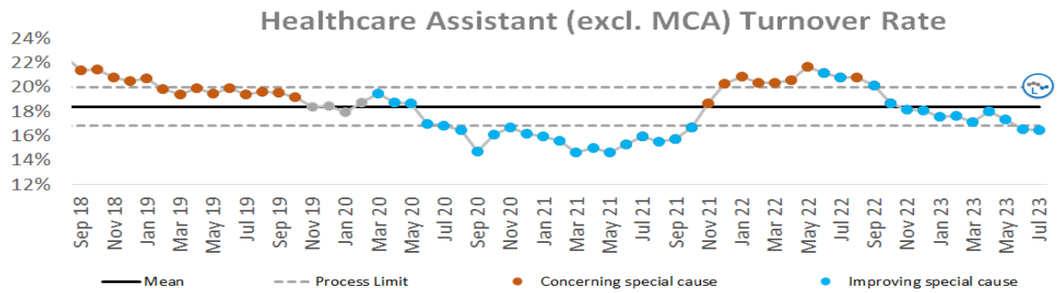

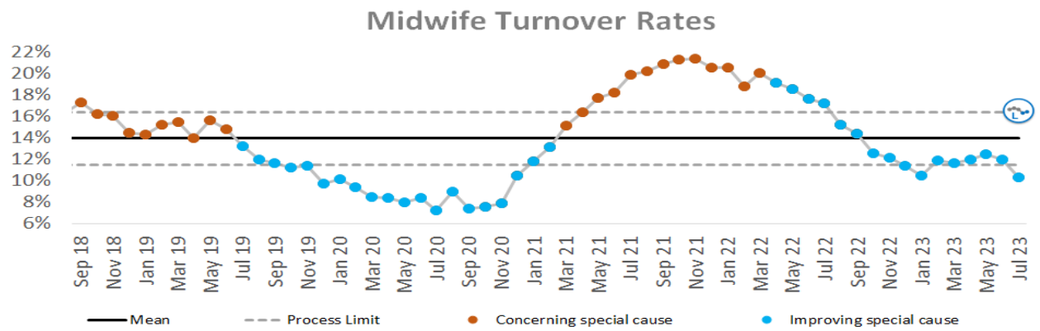

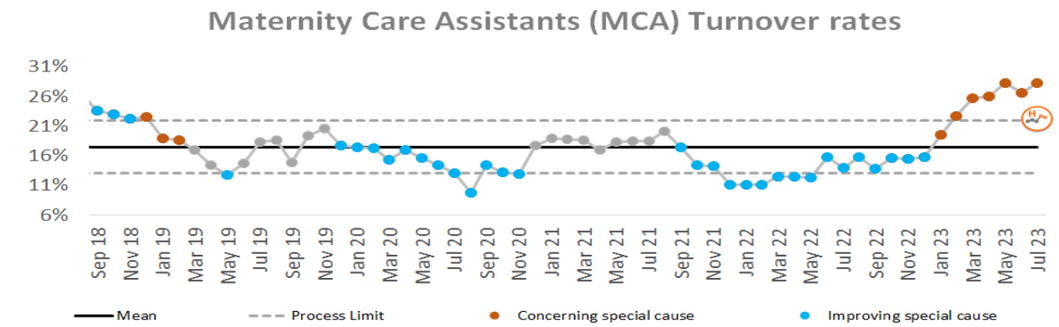

Starters & Leavers - last 12 months

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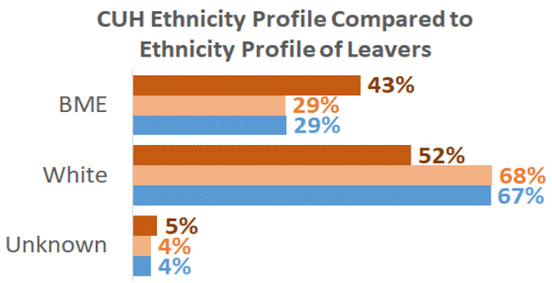
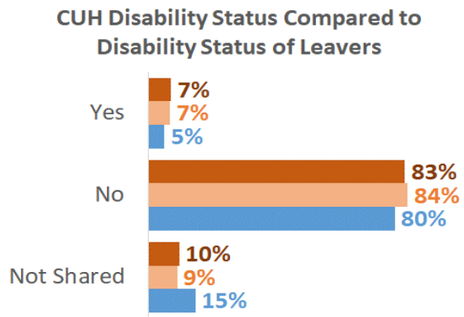
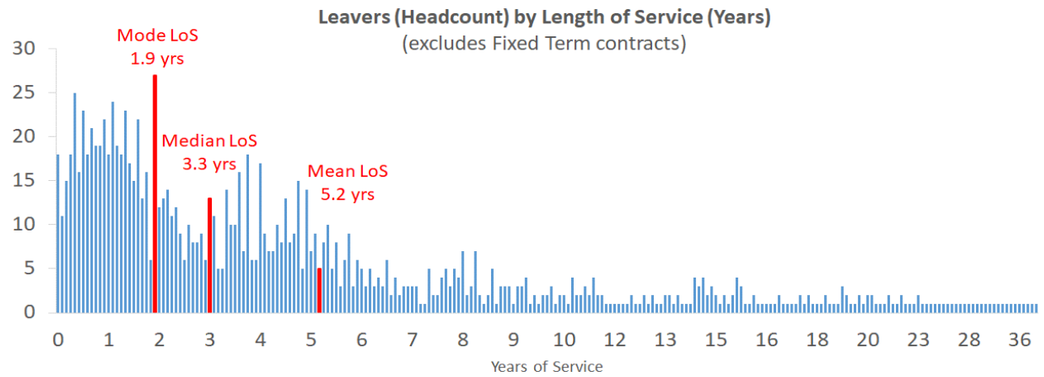
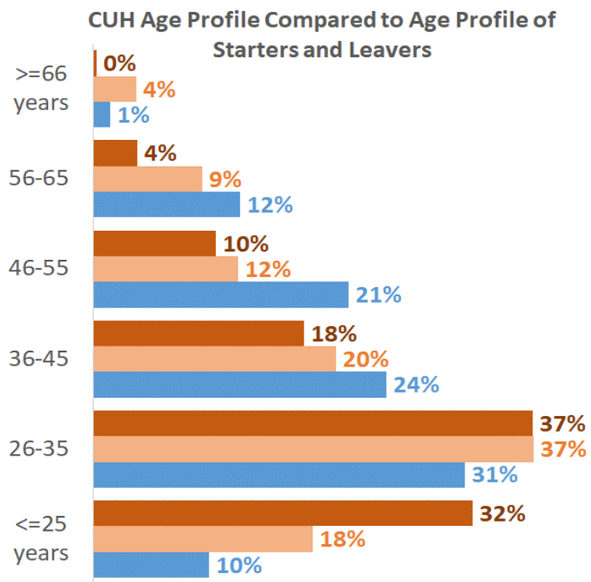
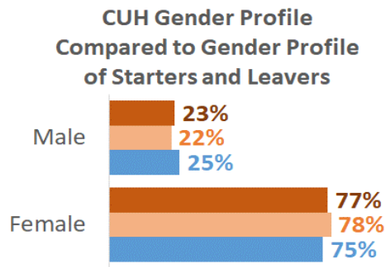
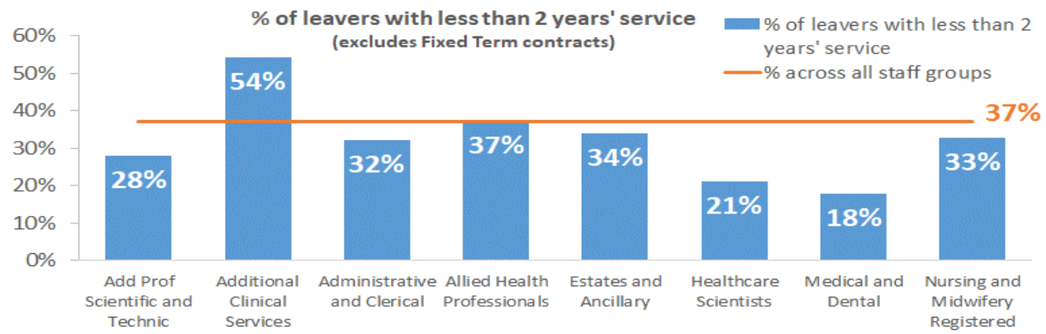












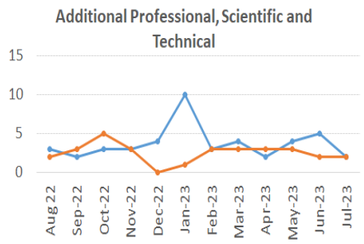
What the information tells us:
The majority of starters to, and leavers from the Trust in the last 12 months were under the age of 35 (68% and 55% respectively), which are higher than the proportion of staff in post of this age (41%). Gender and disability status are generally equally represented in the starters and leavers data when compared to the Trust profile, however there is a slightly higher proportion of females and staff declaring a disability both starting and leaving the Trust. 43% of our starters in the last 12 months were from black and minority ethnic groups, compared to 29% of the staff profile. 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 1.9 years – in the last 12 months 27 (headcount) of the 1,194 leavers who were on permanent contracts left at this point. The average (mean) length of service was 5.2 years.

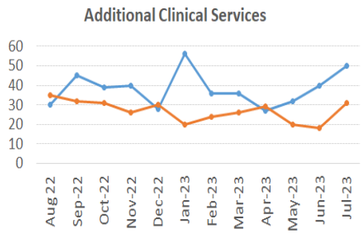
Excludes Fixed Term and Locum Medical and Dental staff, and staff leaving and returning to CUH (as bank only/retire and return etc.)

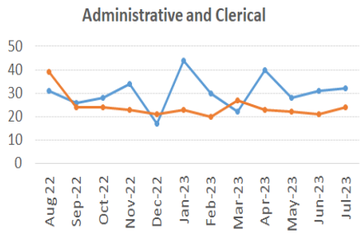
Author(s): Chloe Schafer, Amanda Wood **Owner(s): David Wherrett**

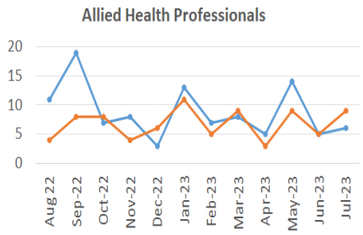
Leavers - Last 12 months

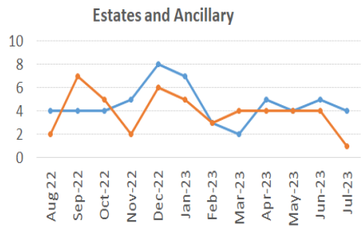
Cambridge University Hospitals NHS Foundation Trust

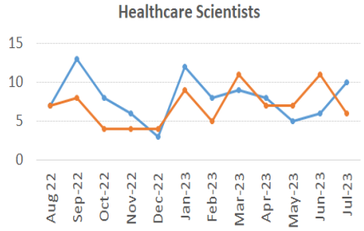


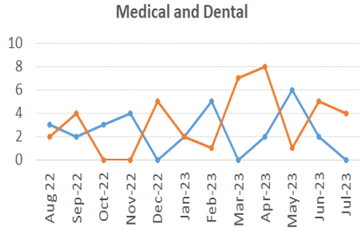


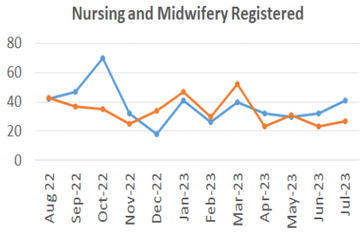


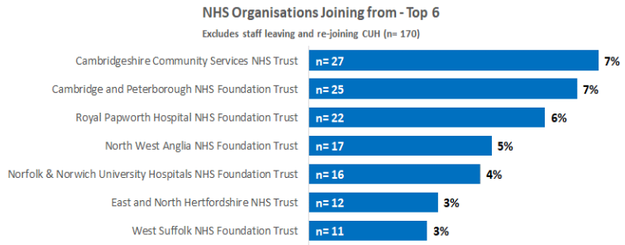


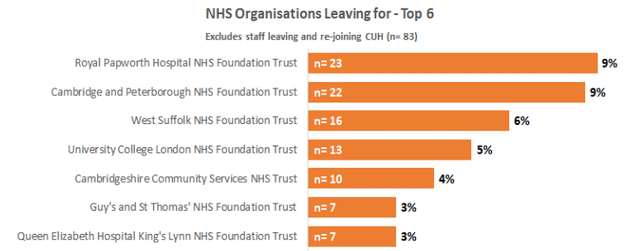


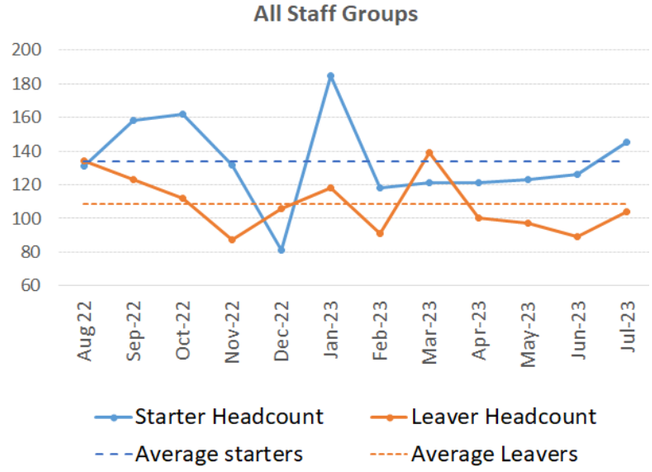












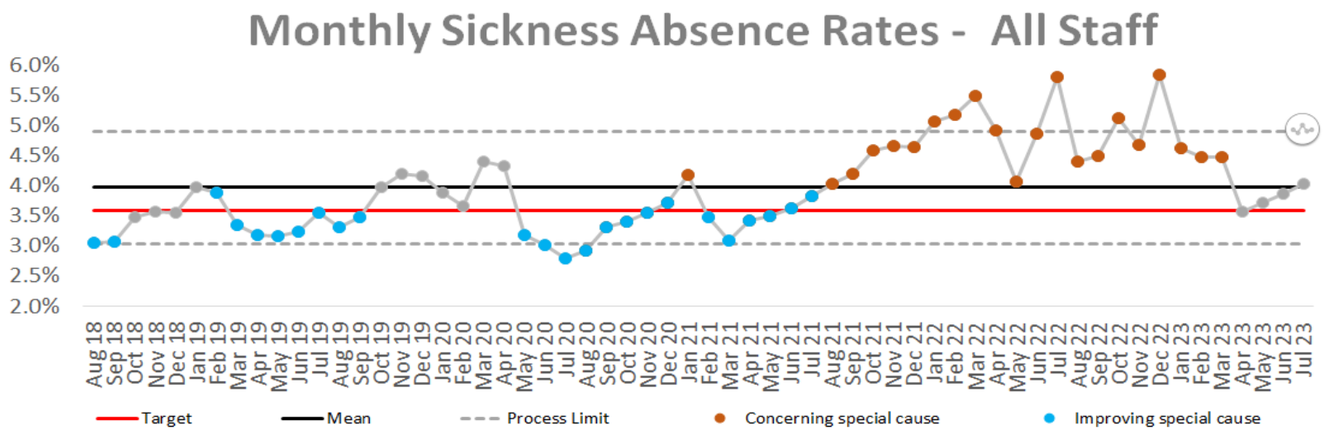
Top 10 Leaving Reasons Excludes staff leaving and re-joining CUH (n= 83)	Number of Leavers (Headcount)	% of all Leavers
Voluntary Resignation - Relocation	364	28%
Voluntary Resignation - Work Life Balance	256	20%
Voluntary Resignation - Promotion	157	12%
Voluntary Resignation - Better Reward Package	107	8%
Voluntary Resignation - Other/Not Known	93	7%
Retirement Age	67	5%
Voluntary Resignation - Health	58	4%
Voluntary Resignation - Child Dependants	42	3%
End of Fixed Term Contract	36	3%
Voluntary Resignation - Lack of Opportunities	29	2%

What the information tells us:
The top three reasons for leaving are Voluntary Resignation - due to relocation (28%), for work/life balance (20%) and for promotion (12%).
The top destination on leaving (other than unknown) for leavers over the past 12 months is another NHS Organisation. The most popular external NHS organisation to leave for is Royal Papworth Hospital NHS Foundation Trust. 14% of starters to the Trust were from Cambridgeshire Community Services NHS Trust or Cambridge and Peterborough NHS Foundation Trust. In July 2023 the most popular destination on leaving (other than unknown) was to another NHS Organisation, with 16% of leavers in July citing this reason on the P4 leavers form (17 individuals, of whom 35% had less than 2 years' service at CUH).

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

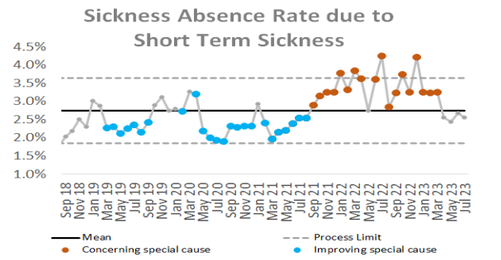
Sickness Absence

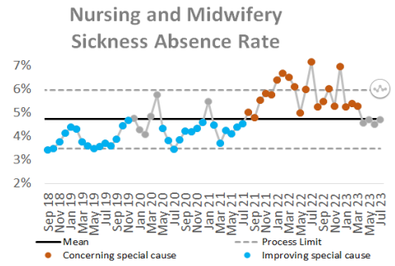
NHS
Cambridge University Hospitals
NHS Foundation Trust

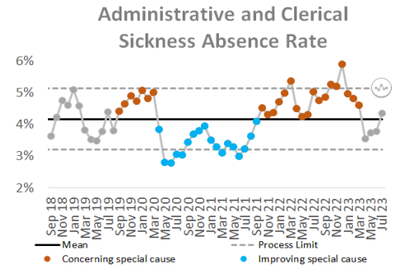


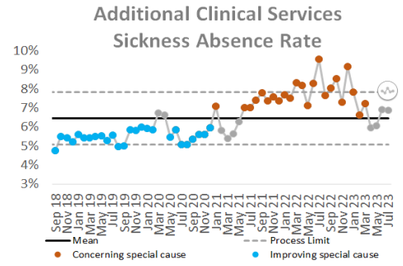
Background Information: Sickness Absence is a monthly metric and is calculated as the percentage of FTE days missed in the organisation due to sickness during the reporting month.

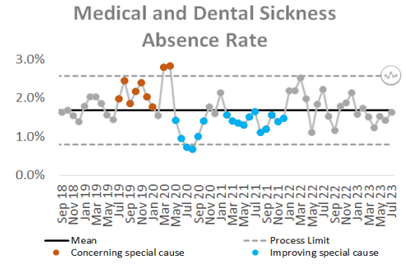
What the information tells us: The overall Monthly Sickness Absence has increased by 0.2% since last month, and has risen to just above average at 4% in July 2023. This is 1.8% lower than July last year (5.8%). The sickness absence rate due to short term illness is higher at 2.6% compared to long term sickness at 1.5%. Additional Clinical Services has the highest sickness absence rate, at 6.9% in July 2023, followed by Estates and Ancillary at 6.3%.

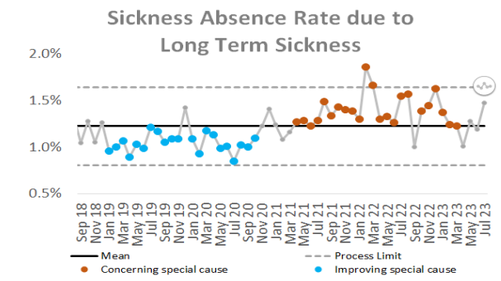


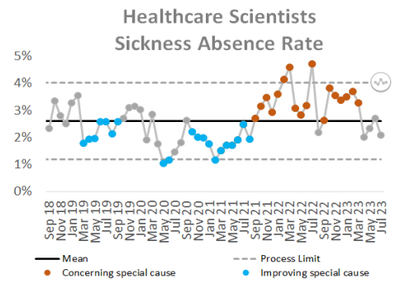


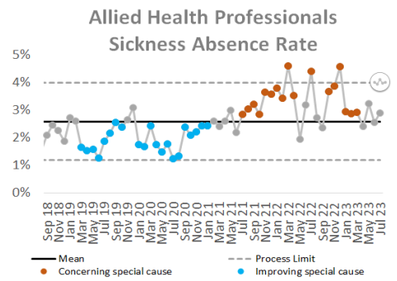


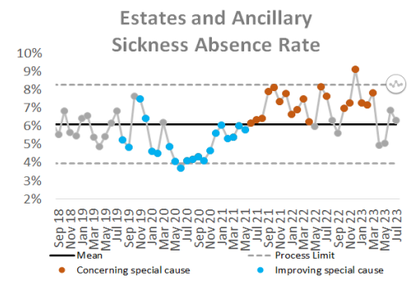


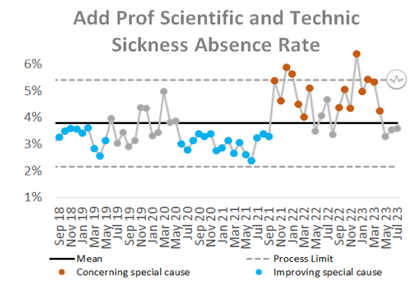










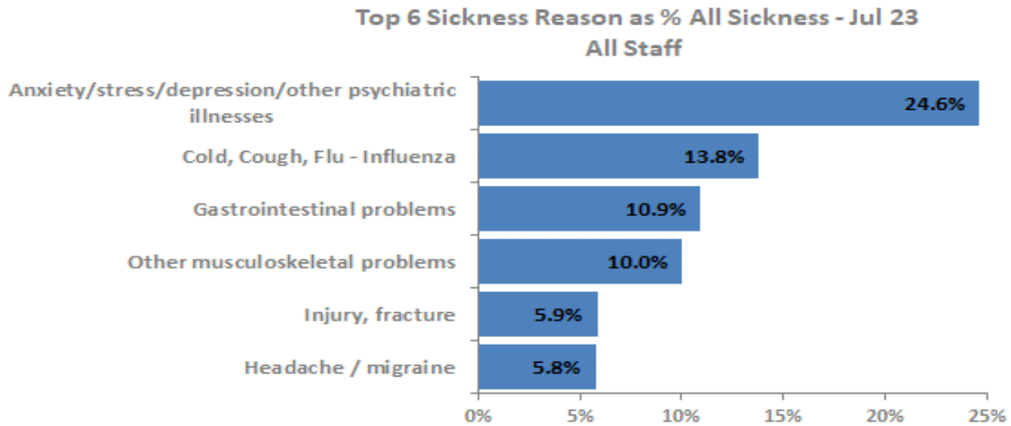


Author(s): Chloe Schafer, Amanda Wood

Owner(s): David Wherrett

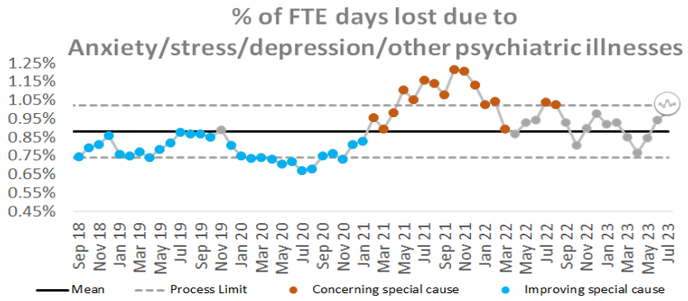
Top Six Sickness Absence Reason

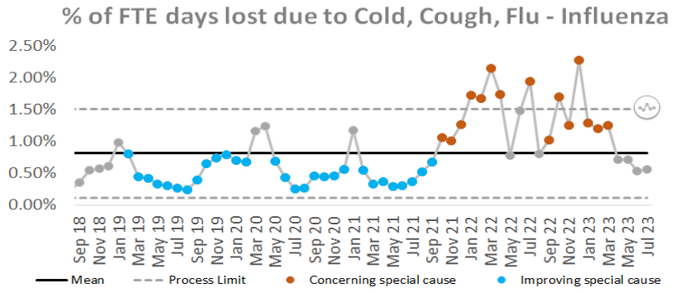
NHS
Cambridge University Hospitals
NHS Foundation Trust

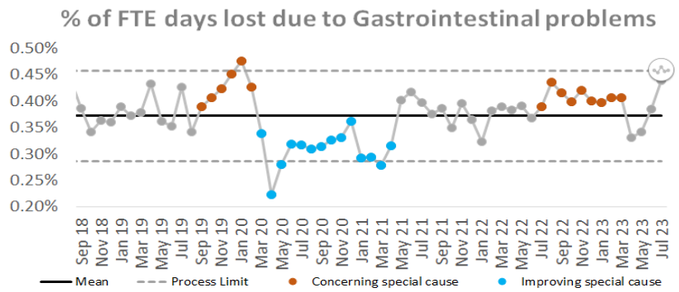


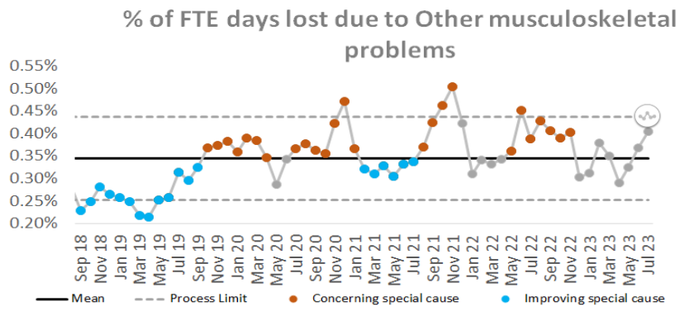
Background Information: Sickness Absence reason is provided as a percentage of all FTE days missed due to sickness during the reporting month.

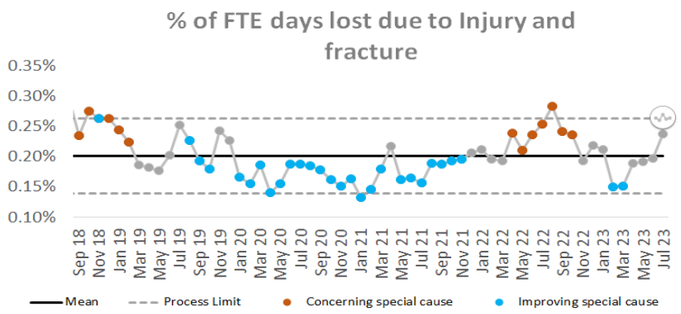
What the information tells us: The top reason for sickness absence is Anxiety/stress/depression/other psychiatric illnesses, with an absence rate of 0.9%, which is 0.1% higher than last month, and the same rate as June last year. As a percentage of all sickness absence, Anxiety/stress/depression/other psychiatric illnesses accounts for 24.4% of the overall figure. Absence due to Cold, Cough, Flu - Influenza is 0.2% lower than last month and is 0.9% lower than the same month last year.

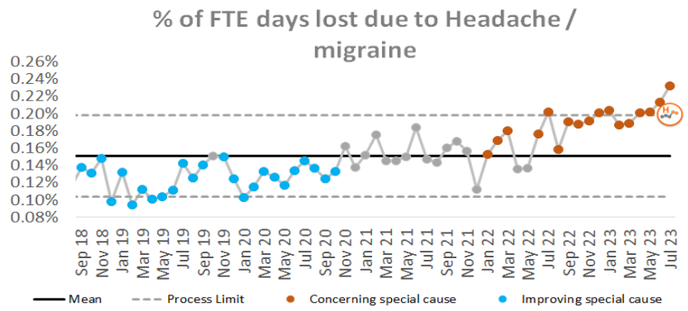








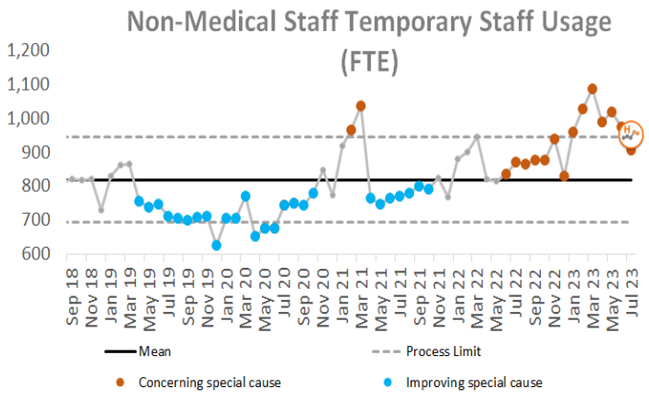


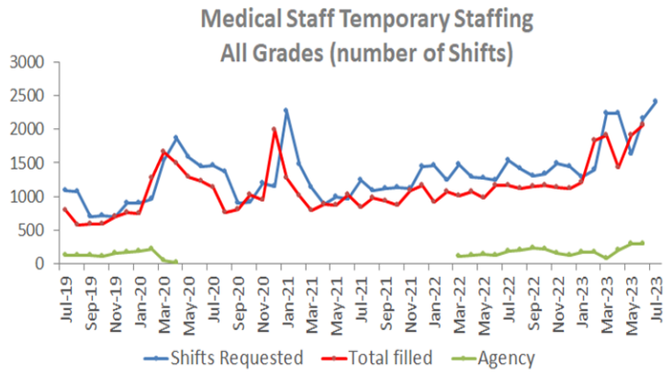


Author(s): Chloe Schafer, Amanda Wood **Owner(s): David Wherrett**

Temporary Staffing

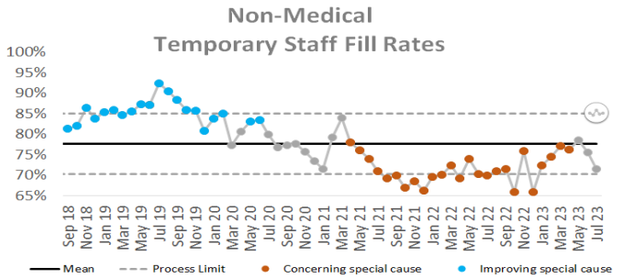
NHS
Cambridge University Hospitals
NHS Foundation Trust

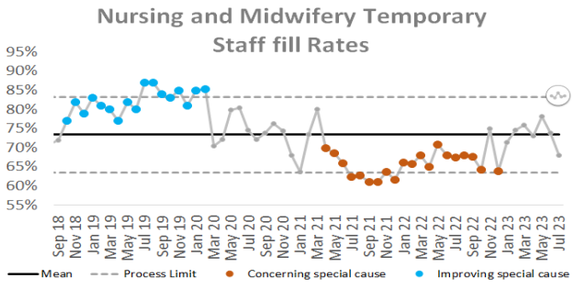


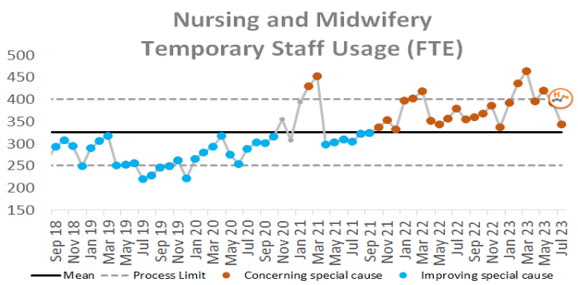


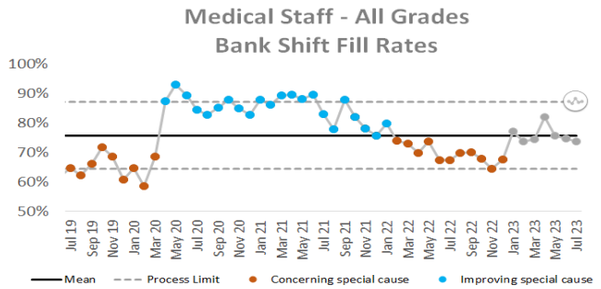
Background Information: The Trust works to ensure that temporary vacancies are filled with workers from staff bank in order to minimise agency usage, ensure value for money and to ensure the expertise and consistency of staffing.

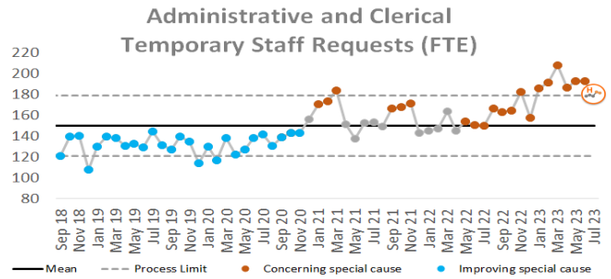
What the information tells us: There has been a significant decrease in agency use in July 2023 - down by just under 22 WTEs overall, with reductions seen in Divisions A, C, D, E and Corporate. Partly as a result of enhancements ceasing on Ops Pool Bank shifts, we have seen an overall reduction in fill rates. However other factors likely to be influencing this are that July is part of a peak period for annual leave to be taken, and also the back payment made to substantive staff at the end of June 2023 may have meant that individuals were more financially stable at this point.
Top three reasons for request are vacancy (48%), increased workload (19%) and specialling (14%). Nursing and midwifery agency usage decreased by 19.1 WTE from the previous month to 19.3 WTE. This accounts for 6% of the total nursing filled shifts. Demand for temporary medical staff reached its highest level in July due to industrial action. Fill rate decreased slightly from last month to 86%, with 335 shifts left unfilled.

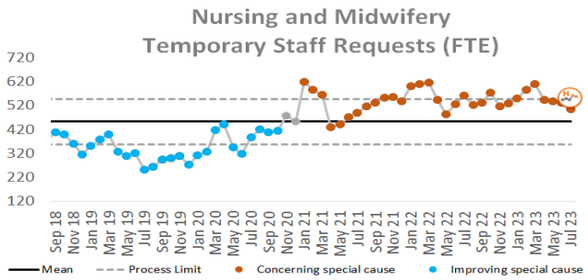


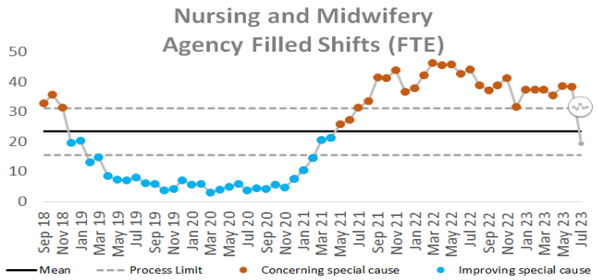


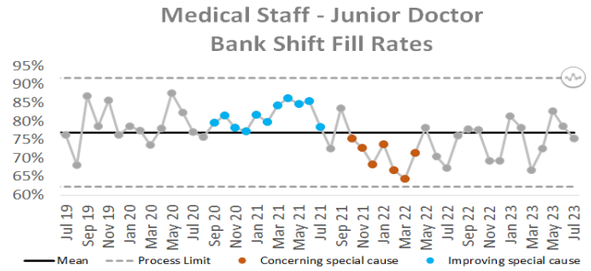








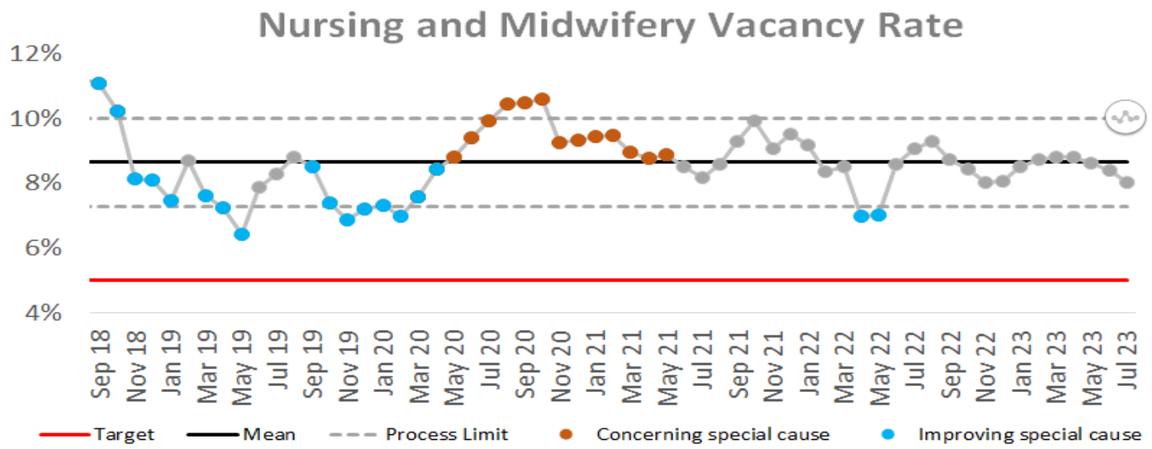




Author(s): Chloe Schafer, Amanda Wood **Owner(s): David Wherrett**

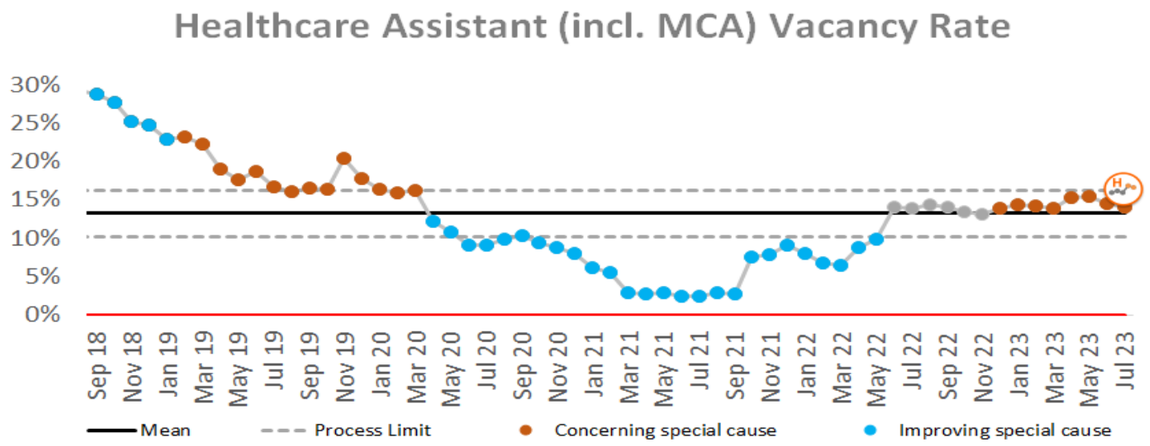
ESR Vacancy Rate

NHS
Cambridge University Hospitals
NHS Foundation Trust



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

What the information tells us: The vacancy rate for Nursing and Midwifery has decreased by 0.4% to at 8% in July 2023. The vacancy rate for Healthcare Assistants has decreased by 0.5% from last month to 14%. Vacancy rates for both staff groups are above the target rate of 5% for Nurses and 0% for HCAs.



Annual Leave Update

NHS
Cambridge University Hospitals
NHS Foundation Trust

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

	Staff Group	Total Entitlement (Hrs)	Total AL Taken (Hrs)	*% AL Taken	% of staff with Entitlement recorded on Healthroster
Annual Leave taken by Staff Group	Add Prof Scientific and Technic	47,659	17,319	36.3%	98%
	Additional Clinical Services	382,241	150,626	39.4%	98%
	Administrative and Clerical	512,396	179,794	35.1%	96%
	Allied Health Professionals	148,914	56,516	38.0%	99%
	Estates and Ancillary	78,764	31,785	40.4%	98%
	Healthcare Scientists	154,049	54,229	35.2%	98%
	Medical and Dental	141,376	37,925	26.8%	37%
	Nursing and Midwifery Registered	806,435	309,742	38.4%	99%
	Trust	**2,271,834**	**837,936**	36.9%	89%
Annual Leave taken by Division	*Division*				
	Corporate	317,328	115,983	36.5%	96%
	Division A	423,942	160,003	37.7%	88%
	Division B	634,460	236,278	37.2%	94%
	Division C	280,950	100,830	35.9%	81%
	Division D	263,156	94,350	35.9%	86%
	Division E	245,911	90,939	37.0%	87%
	R&D	106,087	39,554	37.3%	96%

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

What the information tells us: The Trust's annual leave usage is 111% of the expected usage at the end of the fourth month of the financial year. The highest rate of use of annual leave is within the Estates and Ancillary staff group, at 40.4%, followed by Additional Clinical Services at 39.4%.

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

Mandatory Training by Division & Staff Group

NHS Cambridge University Hospitals NHS Foundation Trust

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 95% or higher | Less than 80% | Between 80% and 94%

	Non-Medical		Medical	
	Corporate Induction	Local Induction	Corporate Induction	Local Induction
Frequency				
Delivery Method	cl	f2f	cl/	f2f
Staff Requiring Competency	1,141	1,141	567	567
Compliance by Division				
Division A	(14)92.1%	(57)68.0%	(32)77.3%	(13)90.8%
Division B	(12)96.5%	(47)86.1%	(17)76.1%	(5)93.0%
Division C	(12)92.4%	(25)84.1%	(35)78.3%	(11)93.2%
Division D	(5)95.6%	(17)85.0%	(25)74.0%	(14)85.4%
Division E	(9)94.3%	(28)82.2%	(20)77.8%	(7)92.2%
Corporate	(9)93.4%	(33)75.9%	(1)85.7%	(1)85.7%
R & D	(0)100.0%	(17)71.7%		
Breakdown of Medical staff compliance				
Consultant			(4)92.3%	(5)90.4%
Non Consultant			(126)75.5%	(46)91.1%
Compliance by Staff group				
Add Prof Scientific and Technic	(0)100.0%	(3)85.7%		
Additional Clinical Services	(23)91.9%	(52)81.7%		
Administrative and Clerical	(13)95.2%	(60)78.0%		
Allied Health Professionals	(1)98.7%	(15)81.0%		
Estates and Ancillary	(5)88.1%	(12)71.4%		
Healthcare Scientists	(2)97.7%	(8)90.8%		
Medical and Dental			(130)77.1%	(51)91.0%
Nursing and Midwifery Registered	(17)95.2%	(74)79.2%		
Trust Total	(61)94.7%	(224)80.4%	(130)77.1%	(51)91.0%

Mandatory Training Competency (as defined by Skills for Health) 90% or higher | Less than 75% | Between 75% and 89%

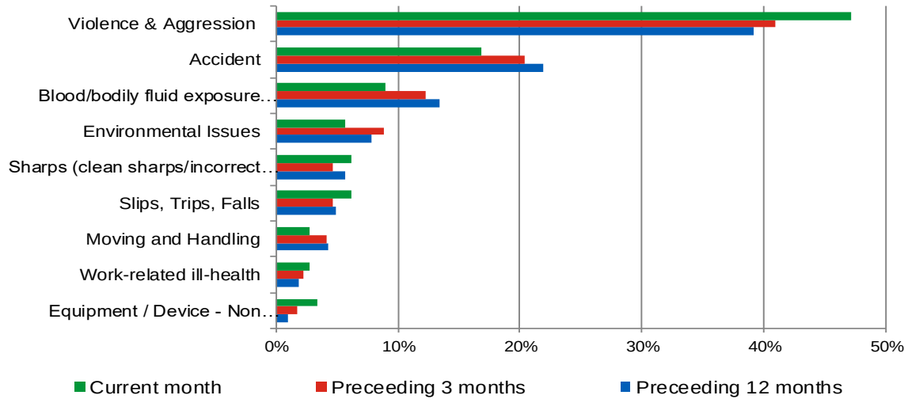
*Information Governance including GDPR and Cyber Security 95% or higher | Less than 80% | Between 80% and 94%

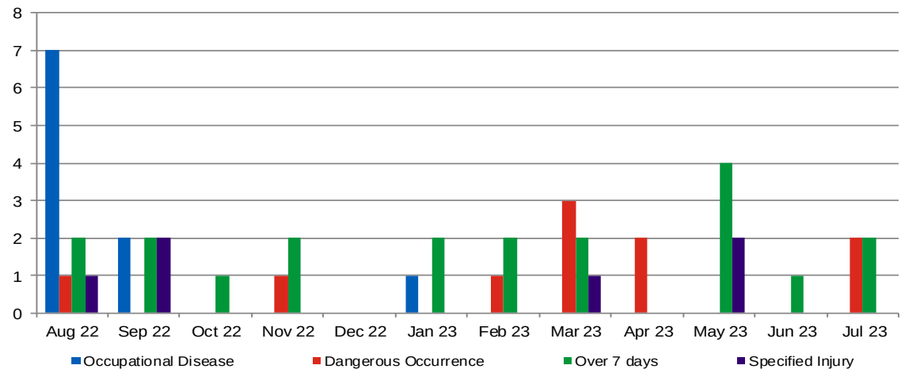
	Conflict Resolution	Equality, Diversity and Human Rights	Fire Safety	Health, Safety and Welfare	Infection Control	*Information Governance including GDPR and Cyber Security	Moving & Handling	Resuscitation	Safeguarding Adults Lvl 1	Safeguarding Adults Lvl 2	Safeguarding Adults Lvl 3	Safeguarding Children 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/e/	cl/e/	cl/e/	cl/e/	cl/e/	cl/el	cl/e/	cl/el	cl/e/	cl/el	el	cl/el	cl/el	cl/el	cl	cl	cl	
Staff Requiring Competency	11,024	11,024	11,179	11,024	11,024	11,024	11,183	7,457	11,024	7,894	3,651	11,024	7,904	1,841	9,500	1,800	7,474	
Compliance by Division																		
Division A	(40)98.1%	(48)97.7%	(384)82.2%	(56)97.3%	(105)95.0%	(162)92.3%	(355)83.5%	(332)82.7%	(77)96.3%	(143)92.6%	(321)57.7%	(45)97.9%	(147)92.4%	(57)71.6%	(50)97.4%	(27)86.2%	(117)93.9%	92.4%
Division B	(48)98.3%	(54)98.1%	(201)93.1%	(61)97.9%	(137)95.2%	(180)93.7%	(283)90.2%	(254)82.7%	(95)96.7%	(194)89.3%	(285)67.5%	(65)97.7%	(197)89.2%	(24)83.0%	(60)97.9%	(9)92.8%	(85)94.1%	94.4%
Division C	(50)96.7%	(57)96.2%	(230)85.2%	(70)95.4%	(106)93.0%	(173)88.6%	(263)83.0%	(277)80.4%	(87)94.3%	(112)92.2%	(296)48.9%	(67)95.6%	(113)92.1%	(59)77.9%	(66)94.9%	(24)90.9%	(123)91.4%	91.1%
Division D	(47)96.6%	(55)96.0%	(218)84.3%	(60)95.6%	(114)91.7%	(153)88.8%	(241)82.7%	(249)78.5%	(80)94.1%	(94)92.0%	(265)48.9%	(65)95.2%	(92)92.2%	(21)83.7%	(60)95.3%	(20)84.1%	(112)90.4%	90.8%
Division E	(33)97.5%	(34)97.4%	(186)86.0%	(44)96.6%	(71)94.6%	(123)90.6%	(271)79.6%	(217)81.2%	(70)94.7%	(89)92.4%	(318)53.4%	(40)96.9%	(76)93.5%	(155)85.4%	(6)97.8%	(140)86.8%	(94)91.9%	91.2%
Corporate	(39)97.2%	(44)96.9%	(98)93.0%	(48)96.6%	(93)93.3%	(80)94.3%	(87)93.8%	(27)83.9%	(61)95.6%	(13)92.6%	(37)67.5%	(50)96.4%	(16)91.1%	(12)53.8%	(48)96.6%	(4)81.0%	(11)94.0%	94.8%
R & D	(9)98.0%	(12)97.4%	(28)93.9%	(10)97.8%	(14)96.9%	(32)93.0%	(33)92.8%	(18)89.2%	(16)96.5%	(8)95.7%	(27)77.3%	(13)97.1%	(10)94.6%	(1)94.1%	(10)97.8%	(3)62.5%	(6)96.5%	95.6%
Breakdown of Medical staff compliance																		
Consultant	(19)97.5%	(17)97.7%	(50)93.4%	(20)97.4%	(60)92.1%	(69)90.9%	(57)92.5%	(158)79.5%	(23)97.0%	(33)95.7%	(294)58.1%	(15)98.0%	(30)96.1%	(24)89.6%	(11)98.0%	(13)93.9%	(35)95.2%	94.1%
Non Consultant	(102)87.9%	(113)86.5%	(158)81.2%	(140)83.3%	(177)78.9%	(267)68.2%	(219)73.9%	(418)51.6%	(162)80.7%	(208)75.7%	(435)25.4%	(141)83.2%	(204)76.3%	(82)57.7%	(123)80.5%	(69)64.4%	(209)74.7%	77.2%
Compliance by Staff group																		
Add Prof Scientific and Technic	(2)99.1%	(2)99.1%	(8)96.3%	(1)99.5%	(5)97.7%	(13)94.0%	(14)93.5%	(4)89.7%	(0)100.0%	(7)96.5%	(3)70.0%	(0)100.0%	(9)95.4%	(2)75.0%	(1)99.5%	(0)100.0%	(1)98.1%	97.3%
Additional Clinical Services	(18)99.0%	(24)98.6%	(275)84.7%	(28)98.4%	(60)96.5%	(120)93.1%	(330)81.6%	(267)81.2%	(44)97.5%	(184)88.6%	(1)66.7%	(30)98.3%	(176)89.1%	(28)81.9%	(28)98.3%	(20)86.8%	(83)93.9%	92.6%
Administrative and Clerical	(55)97.6%	(64)97.2%	(114)95.1%	(69)97.0%	(150)93.5%	(135)94.2%	(135)94.2%	(5)75.0%	(90)96.1%	(11)90.1%		(81)96.5%	(13)88.5%	(9)25.0%	(77)96.8%	(2)50.0%	(15)88.0%	95.5%
Allied Health Professionals	(5)99.2%	(5)99.2%	(72)89.3%	(7)98.9%	(22)96.6%	(24)96.3%	(88)86.9%	(89)86.7%	(18)97.3%	(32)95.2%	(158)72.3%	(8)98.8%	(34)94.9%	(9)86.4%	(5)99.2%	(5)92.1%	(26)96.1%	95.1%
Estates and Ancillary	(9)97.4%	(8)97.7%	(37)89.3%	(11)96.8%	(26)92.4%	(36)89.5%	(9)97.4%	(9)97.4%	(15)95.6%			(9)97.4%			(13)96.3%			94.6%
Healthcare Scientists	(11)98.3%	(14)97.9%	(28)95.8%	(10)98.5%	(27)95.9%	(31)95.3%	(38)94.3%	(24)77.1%	(13)98.0%	(38)79.1%	(0)100.0%	(10)98.5%	(40)78.4%	(1)94.1%	(9)98.6%	(0)100.0%	(3)98.1%	95.9%
Medical and Dental	(121)92.4%	(130)91.8%	(208)87.0%	(160)90.0%	(237)85.1%	(336)78.9%	(276)82.7%	(576)64.7%	(185)88.4%	(241)85.2%	(729)43.3%	(156)90.2%	(234)85.6%	(106)75.1%	(134)88.7%	(82)79.9%	(244)84.3%	84.9%
Nursing and Midwifery Registered	(45)98.7%	(57)98.4%	(603)83.1%	(63)98.2%	(113)96.8%	(208)94.1%	(643)82.0%	(409)88.5%	(121)96.5%	(140)96.0%	(658)63.1%	(51)98.5%	(145)95.9%	(174)85.0%	(33)98.6%	(118)89.7%	(176)95.1%	93.8%
Trust Total	(266)97.6%	(304)97.2%	(1345)88.0%	(349)96.8%	(640)94.2%	(903)91.8%	(1533)86.3%	(1374)81.6%	(486)95.6%	(653)91.7%	(1549)57.6%	(345)96.9%	(651)91.8%	(329)82.1%	(300)96.8%	(227)87.4%	(548)92.7%	92.7%

Health and Safety Incidents

NHS Cambridge University Hospitals

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:	**1827**	**379**	**280**	**561**	**296**	**180**	**48**	**83**
Accident	**400**	91	81	100	59	34	6	29
Blood/bodily fluid exposure (dirty sharps/splashes)	**244**	76	47	45	35	33	7	1
Environmental Issues	**143**	30	37	13	24	21	8	10
Equipment / Device - Non Medical	**18**	3	1	5	4	5	0	0
Moving and Handling	**79**	18	10	16	19	6	1	9
Sharps (clean sharps/incorrect disposal & use)	**104**	29	17	12	16	17	8	5
Slips, Trips, Falls	**90**	23	18	14	10	8	2	15
Violence & Aggression	**715**	102	63	353	119	49	15	14
Work-related ill-health	**34**	7	6	3	10	7	1	0





A total of 1,827 health and safety incidents were reported in the previous 12 months.

843 (46%) incidents resulted in harm. The highest reporting categories were violence and aggression (39%), accidents (22%) and blood/bodily fluid exposure (13%).

1,245 (68%) of incidents affected staff, 508 (28%) affected patients and 74 (4%) affected others i.e. 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 (15%).

The highest reported incident categories for patients were: accidents (39%), violence & aggression (37%) and environmental issues (9%).

The highest reported incident categories for others were: violence & aggression (28%), environmental issues (23%) and accidents/slips, trips and falls (22%).

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 561 incidents. Of these, 63% related to violence & aggression.

In the last 12 months, the highest reported RIDDOR category was over 7 day injuries (43%). In the last 12 months, 78% of RIDDOR incidents were reported to the HSE within the appropriate timescale. In July 2023, 4 incidents were reported to the HSE:

Over 7 day injury:

- The Injured Person (IP) wanted to identify what was on a pallet but the labels were facing the wall. The IP pulled the pallet manually to access the labels, rather than use the pallet truck, at this point the IP felt severe pain to his arm. The IP attended A&E and was diagnosed with a strain/sprain.
- The IP was assisting with a lateral transfer of a patient between two beds. As the patient was being transferred, the patient slipped off the PAT slide and began to fall between the beds. At this moment the IP jumped up onto the bed to prevent the patient falling completely. The patient was then successfully transferred. The IP experienced pain in their left knee.

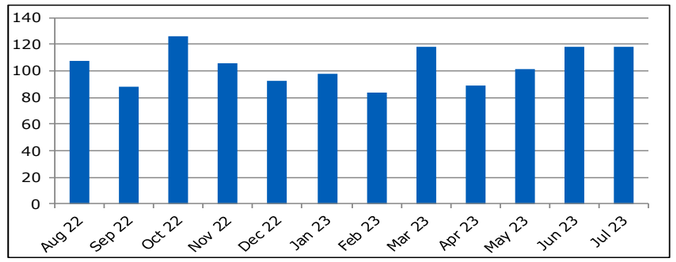
Dangerous occurrence:

- Whilst attempting to suture a patients A line, the suture needle pierced the IPs finger. The IP was wearing appropriate PPE at the time. The patient was Hep C positive.
- The IP had undertaken a central venous cannulation on an HIV positive patient. Whilst clearing away the suture needle, the IP sustained a graze to the left forefinger.

Health and Safety Incidents

NHS Cambridge University Hospitals

No. of health and safety incidents affecting staff:

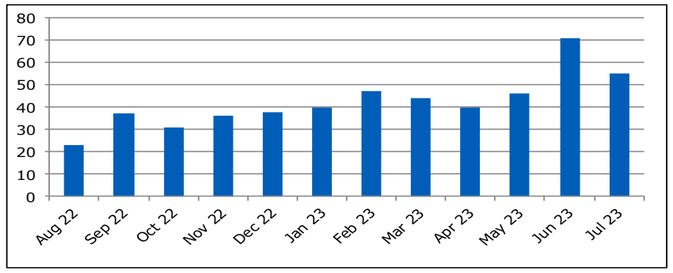


	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Total
Accident	15	18	16	19	14	12	14	21	13	13	14	15	**184**
Blood/bodily fluid exposure (dirty sharps/splashes)	17	13	32	14	20	20	12	20	18	21	23	14	**224**
Environmental Issues	16	1	6	1	6	4	2	8	8	10	14	6	**82**
Moving and Handling	4	7	2	1	2	5	8	9	3	5	7	5	**58**
Sharps (clean sharps/incorrect disposal & use)	10	5	8	10	5	5	7	3	10	3	7	8	**81**
Slips, Trips, Falls	5	10	4	6	4	8	7	4	6	8	3	9	**74**
Violence & Aggression	36	34	57	52	37	39	33	50	30	38	46	56	**508**
Work-related ill-health	4	0	1	3	4	5	1	3	1	3	4	5	**34**
Total	**107**	**88**	**126**	**106**	**92**	**98**	**84**	**118**	**89**	**101**	**118**	**118**	**1245**

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

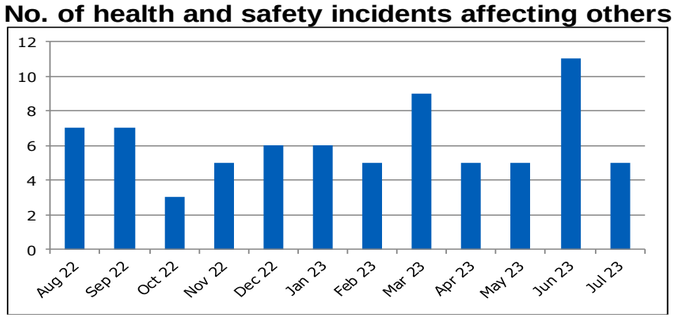
	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Total
No. of health & safety incidents	107	88	126	106	92	98	84	118	89	101	118	118	**1245**
Staff incident rate per month/year	0.9	0.7	1.0	0.9	0.8	0.8	0.7	1.0	0.7	0.8	1.0	1.0	**10.3**

No. of health and safety incidents affecting patients:



	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Total
Accident	8	13	13	15	19	19	17	21	13	19	29	14	**200**
Blood/bodily fluid exposure (dirty sharps/splashes)	0	3	0	0	3	2	0	1	3	3	2	2	**19**
Environmental Issues	2	0	3	8	7	3	5	1	2	4	6	3	**44**
Equipment / Device - Non Medical	1	0	1	3	1	2	1	0	0	1	2	6	**18**
Moving and Handling	2	1	0	3	2	1	4	2	1	2	3	0	**21**
Sharps (clean sharps/incorrect disposal & use)	2	2	1	0	1	0	2	3	2	0	4	3	**20**
Violence & Aggression	8	18	13	7	5	13	18	16	19	17	25	27	**186**
Total	**23**	**37**	**31**	**36**	**38**	**40**	**47**	**44**	**40**	**46**	**71**	**55**	**508**

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



	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Total
Accident	0	3	1	2	0	2	0	2	2	1	2	1	**16**
Blood/bodily fluid exposure (dirty sharps/splashes)	0	0	0	0	0	0	0	0	1	0	0	0	**1**
Environmental Issues	2	1	1	1	2	2	1	2	1	2	1	1	**17**
Sharps (clean sharps/incorrect disposal & use)	1	0	0	0	0	2	0	0	0	0	0	0	**3**
Slips, Trips, Falls	1	1	0	1	2	0	2	4	0	0	3	2	**16**
Violence & Aggression	3	2	1	1	2	0	2	1	1	2	5	1	**21**
Total	**7**	**7**	**3**	**5**	**6**	**6**	**5**	**9**	**5**	**5**	**11**	**5**	**74**

Board of Directors

NHS
Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 13 September 2023

Agenda item	10.1
Title	Nurse safe staffing
Sponsoring executive director	Lorraine Szeremeta, Chief Nurse
Author(s)	Amanda Small, Deputy Chief Nurse Sarah Raper, Roster Support Lead Annesley Donald, Deputy Director of Workforce
Purpose	To provide the Board with the monthly nurse safe staffing report.
Previously considered by	Management Executive, 31 August 2023

Executive Summary

The nursing and midwifery safe staffing report for July 2023 is attached. Page 2 of the report includes an Executive Summary.

Related Trust objectives	Improving patient care, Supporting our staff
Risk and Assurance	Insufficient nursing and midwifery staffing levels
Related Assurance Framework Entries	BAF ref: 007
Legal / Regulatory / Equality, Diversity & Dignity implications?	NHS England & CQC letter to NHSFT CEOs (31.3.14) NHS Improvement Letter – 22 April 2016; NHS Improvement letter re: CHPPD – 29 June 2018; NHS Improvement – Developing workforce safeguards October 2018

How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of “Together: safe, kind and excellent”?	n/a

Action required by the Board of Directors

The Board is asked to receive and note the nurse safe staffing report for July 2023.

Monthly Nurse Safe Staffing

NHS
Cambridge University Hospitals
NHS Foundation Trust

Sponsoring executive director: Lorraine Szeremeta, Chief Nurse

Amanda Small, Deputy Chief Nurse

Christopher Gray, Lead Nurse Safer Staffing

Sarah Raper, Project Lead Nurse safe staffing

Together
Safe
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Board of Directors: September 2023

Executive Summary

NHS CUH

This slide set provides an overview of the Nursing and Midwifery staffing position for July 2023.

The vacancy position in July has remained relatively static for registered children's nurses (RSCNs) at 21.6% (21% in June), Health Care Support Workers (HCSWs) at 14% and maternity care assistants (MCAs) at 23.1%. There has been a decrease in the vacancy rate for registered nurses (RNs) to 8% (8.4% in June) and Registered Midwifes (RMs) to 0.33% in July from 2.35% in June. The turnover rate in July has but remains high but has reduced in RNs and RMs at 11.3% for RNs (11.7% in June), 11.3% for RMs (12% in June) . For RSCNs the turnover factor has increased 16.1% for July (15.3% in June) and has remained static for HCSW (including MCA's) at 17.1%. The main reason for leaving for RNs, RMs and RSCNs is voluntary resignation – relocation whereas for HCSWs it is voluntary resignation – work life balance. The leavers destination data demonstrates that 26.4% of RNs and 48.1% of RMs are leaving to take up employment in other NHS organisations. 14.8% of RMs are leaving for no employment compared with 8.4% of RNs. Conversely, the leavers destination is unknown for the majority of HCSWs (48.3%).

The planned versus actual staffing report demonstrates that 15 clinical areas reported <90% overall rota fill in July (8 in June). The overall fill rate for maternity has increased to 92.8% compared to 91.4% in June. The total unavailability of the workforce working time in July has increased by 1% to 26.4%. The majority of unavailability (14.6%) is due to planned annual leave, sickness absence has increased in July to 6.9 % from 5.4% in June. Additionally, 1.0% of working time was unavailable due to other leave, 2.3% was due to study leave and 1.6% was due to supernumerary time.

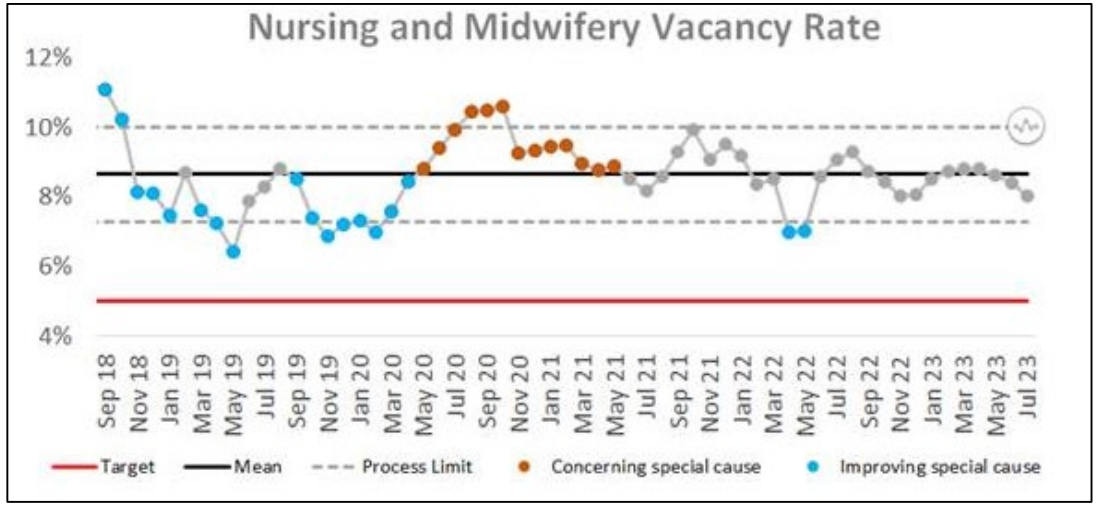
In order to mitigate staffing risks, the number of requests for bank workers remains high with an average of 2145 shifts per week requested for registered staff and 2057 shifts requested for Health care support workers and Maternity support workers per week with an average bank fill rate of 64.74% for registered staff and 58.78% for Health Care Support workers. In addition, the equivalent of 14.75WTE agency workers are working across the divisions (29.5 WTE June). Despite this, redeployment of nurses and midwives has remained necessary due to staff unavailability, with an average of 362 working hours being redeployed each day of which all of the redeployed hours have been within the staff members own division.

The number of occasions that 1 critical care nurse has needed to care for more than 1 level 3 patient has increased slightly in July to 39 occasions compared to 37 in June. It should be noted that this is not solely attributed to staffing rather that we have seen an increased level of acuity in critical care leading to a higher proportion of patients requiring level 3 care. Additionally, there have been 160 occasions in June where there has been no side room co-ordinator (134 in June). Any concerns with regards to critical care staffing are escalated through the senior nurse of the day. Staffing has been supported through the use of temporary workers (agency and bank) and registered staff (non critical care trained) are redeployed from the operational pool and clinical areas on a shift by shift basis. Critical care have opened 3 of the beds that were closed due to staffing resulting in 55 open beds rather than 59 beds. Recruitment is ongoing to the vacant positions with a plan to open the remaining 4 beds in September 2023.

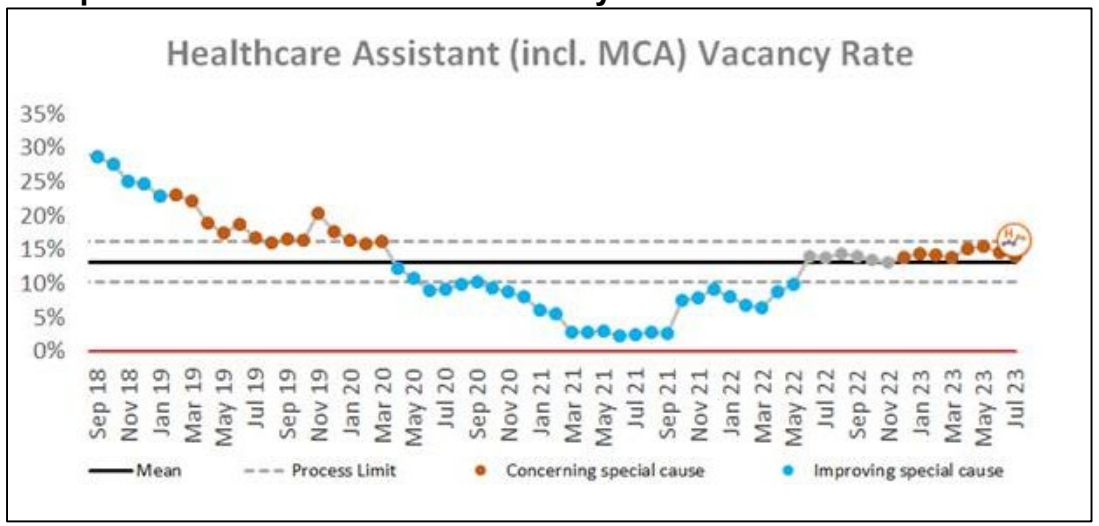
Combined Nursing and Midwifery Staffing Position Vacancy Rates

NHS CUH

Graph 1. Nursing and midwifery vacancy rates



Graph 2. Healthcare Assistant vacancy rates



Vacancy position

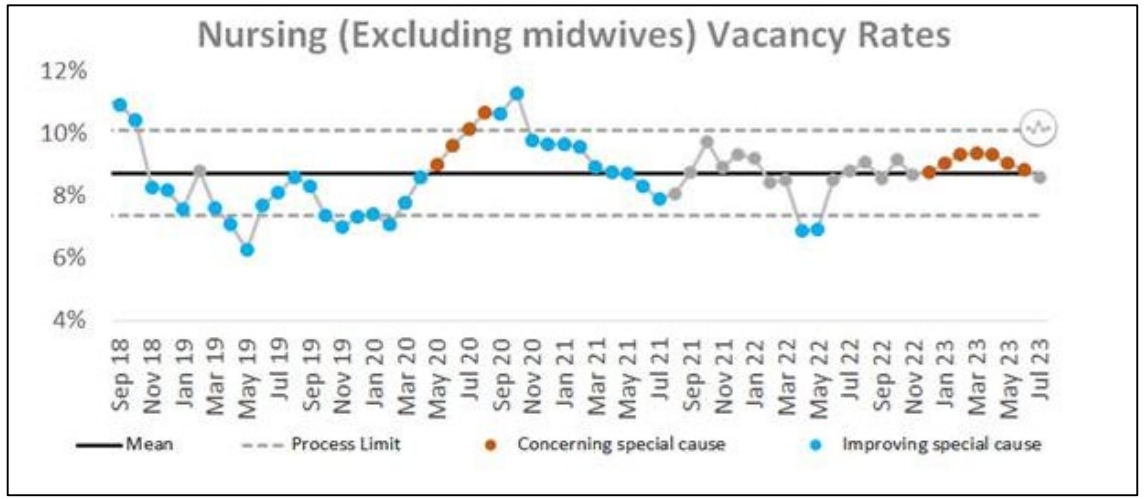
The combined vacancy rate for Registered Nurses (RNs) and Registered Midwives (RMs) has improved slightly to 8% in July from 8.4% in June. The vacancy rate for Health care support workers (HCSWs) (including Maternity Care Assistants (MCA's) has reduced by 1.5% to 14% July (15.5% June). When broken down further into Nursing and Midwifery specific vacancies, the MCA workforce vacancy rate has reduced to 23.1% in July from 26.9% in June. The HCSW vacancy rate (excl MCA) has reduced to 14% from 14.9% in June.

The HCSW (including MCAs) turnover rate remains high static at 17.1%. The main reason for HCSWs leaving is voluntary resignation – work life balance (28.7%) and the next highest reason is voluntary resignation – relocation (26.3%). The leavers destination is unknown for the majority of HCSWs (48.3%), 14.8% of HCSWs are leaving to take up employment in other NHS organisations and 12% are leaving for no employment.

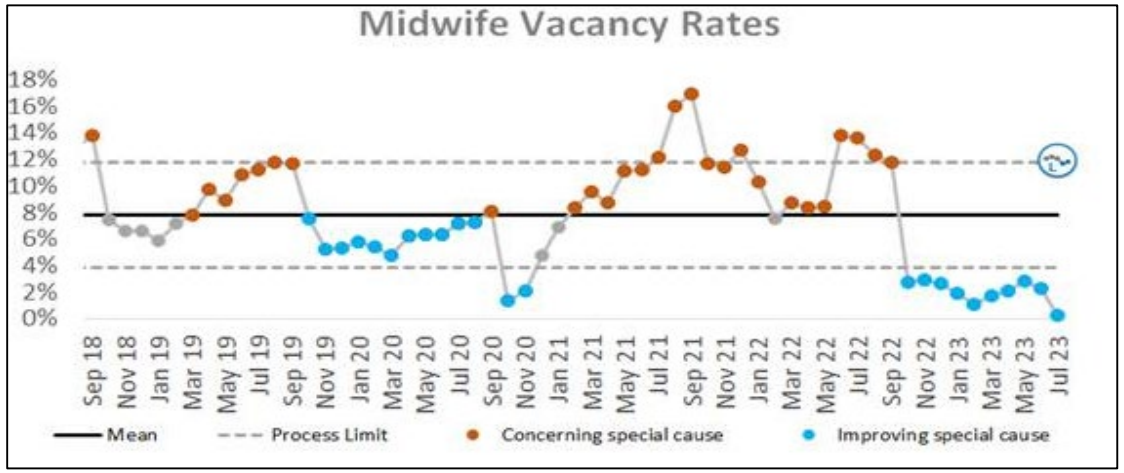
Staffing Position Vacancy Rates for Registered Nurses and Registered Midwives

NHS CUH

Graph 3. Registered Nurse vacancy rates



Graph 4. Registered Midwife vacancy rates



Vacancy position

The vacancy rate for Registered Nurses working in adult areas has reduced slightly to 8% (8.4% in June) as illustrated in Graph 3. The vacancy rate for registered children's nurses has remained relatively static at 21.6% compared to 21% in June.

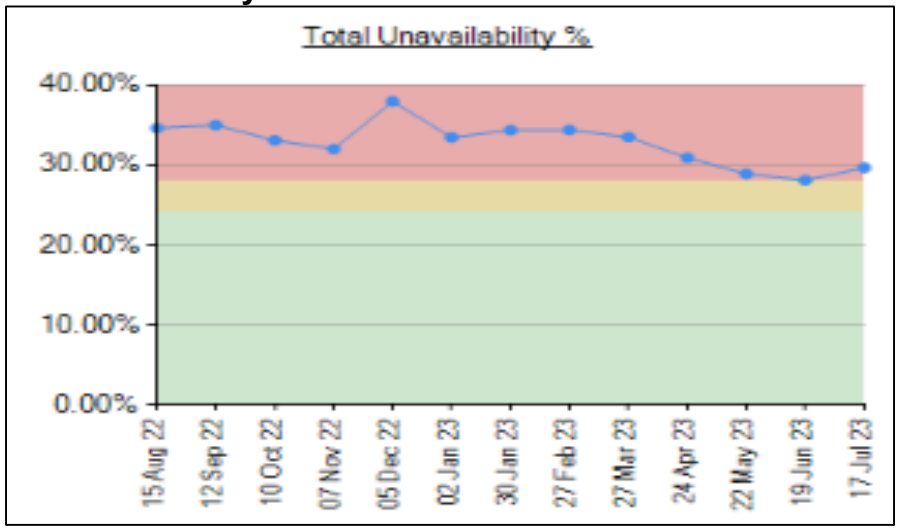
The vacancy rate for Registered Midwives illustrates a sharp increase in Graph 4 in June 22, this was due to the work that had been undertaken to align the workforce Electronic Staff Record (ESR) and financial ledger to reflect the additional approved investment in the maternity workforce. Over the last 6 months, there has been a decreasing trend in the vacancy rate from 13.0% in July 2022 to 1.74% in March. There had been a further improvement in July 2023 to 0.33% (2.35% in June).

The turnover rate in July remains high at 11.3% for RNs in adult areas (11.7% in June), 16.1% for Registered children's nurses (15.2% in June) and 11.3% for RMs (12% in June). The main reasons for RMs leaving is voluntary resignation – relocation (33.3%) and the next highest reason is voluntary resignation – work life balance (22.2%). The main reason for RNs leaving is voluntary resignation – relocation (43.7%). The leavers destination data demonstrates that 26.4% of RNs and 48.1% of RMs are leaving to take up employment in other NHS organisations. 14.8% of RMs are leaving for no employment compared with 8.4% of RNs.

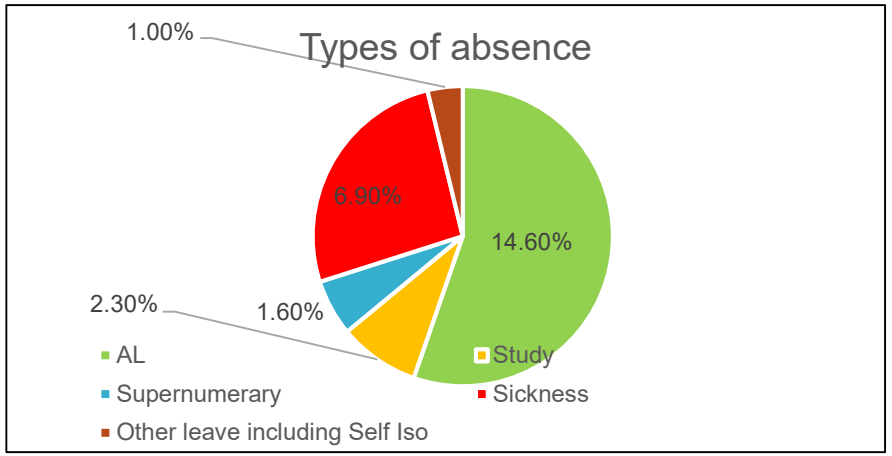
Unavailability for Registered Nurses, Midwives and Health Care Support Workers

NHS CUH

Graph 5. Unavailability of staff



Graph 6. Types of absence



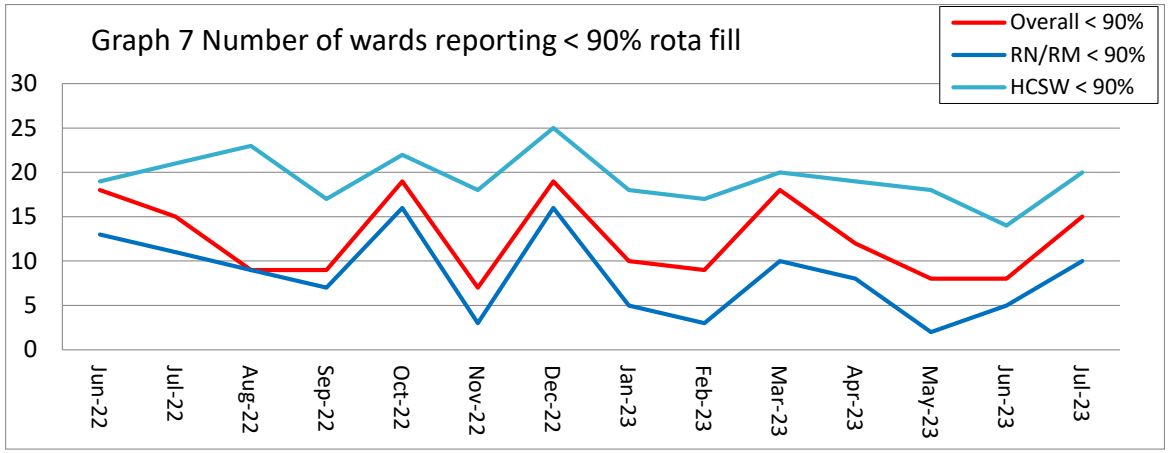
Unavailability of staff

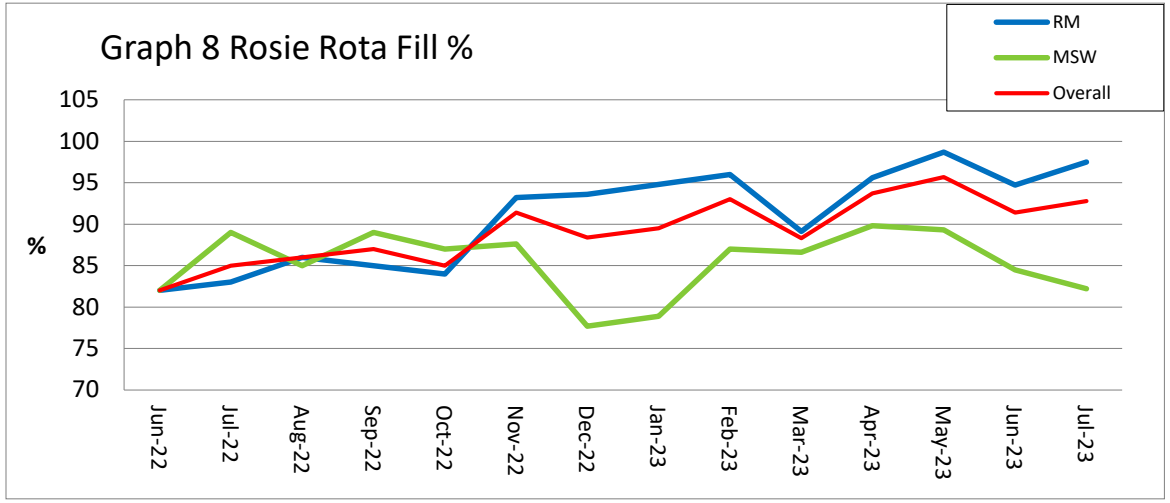
Unavailability relates to periods of time where an employee has been given leave from their regular duties. This might be due to circumstances such as annual leave, sick leave, study leave, carers leave etc.

The total unavailability of the workforce working time in July 23 has increased by 1% to 26.4% as illustrated in Graph 5.

Graph 6 illustrates the percentage breakdown of the type of unavailability. The majority of unavailability (14.6%) was due to planned annual leave which would have been accounted for in the department rosters this is within the headroom of 16%. There was a high percentage of unplanned leave that would have impacted upon fill rates within the rosters. In July, sickness absence has increased after last month reduction to 6.90% from 5.7% in June. Other leave remains at 1% which has been a reducing trend. 2.3% was due to study leave and 1.6% was due to supernumerary time.

Planned versus actual staffing





Planned versus actual staffing

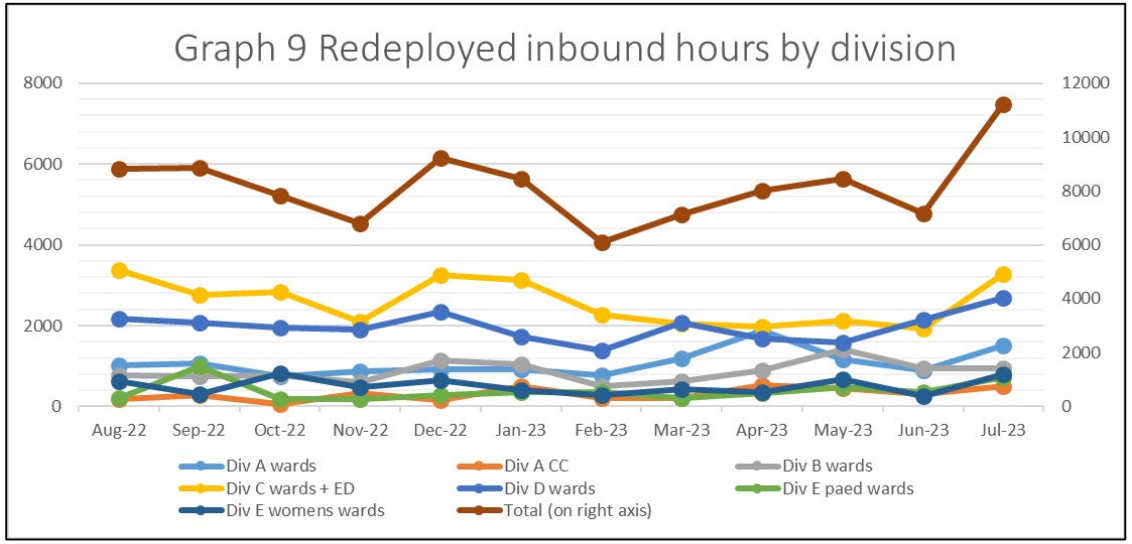
Graph 7 illustrates trend data for all wards reporting < 90% rota fill. The number of areas reporting <90% rota fill for registered RN/RM has increased to 10 in July from 5 in June. 3 of these new areas are within children services. There has also been a increase in the number of areas reporting <90% rota fill for HCSWs in July with 20 compared to 14 in June. The number of ward areas reporting overall fill rates of <90% in July has increased to 15 compared to 8 in June. Appendix 1. details the exception reports for all areas reporting RN/RM fill rates of <90%.

The number of occasions that 1 critical care nurse has needed to care for more than 1 level 3 patient has increased in July to 39 occasions compared to 37 in June. It should be noted that this is not soley attributed to staffing rather that we have seen an increased level of acuity in critical care leading to a higher proportion of patients requiring level 3 care. Additionally, there have been 160 occasions in July where there has been no side room coordinator (134 in June). Any concerns with regards to critical care staffing are escalated through the senior nurse of the day. Staffing has been supported through the use of temporary workers (agency and bank) and registered staff (non critical care trained) are redeployed from the operational pool and clinical areas on a shift-by-shift basis. Critical care have opened 3 of the beds that were closed due to staffing resulting in 55 open beds rather than 59 beds. Recruitment is ongoing to the vacant positions with a plan to open the remaining 4 beds in September 2023.

Midwifery & MSW fill rate

Graph 8 illustrates that the overall fill rate for maternity has increased slightly to 92.8% in July form 91.4% in June this is still higher than 12-month average of 88.84%. The lowest fill rates have been seen on Lady Mary Ward (84%).

Staff deployment



Staff deployment

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

The number of substantive staff redeployed had been an increasing trend over the last 2 months however, and after the reduction in June, there has been a sudden increase to 362 working hours being redeployed per day in July (peak of 231 hours in June). This equates to 32 long day or night shifts per day. All of these redeployments were made within the staff members own division.
The largest increase was seen in division C and D. Staffing is also being supported by the operational pool whereby bank staff book a bank shift on the understanding that they will work anywhere in the trust where support is required.

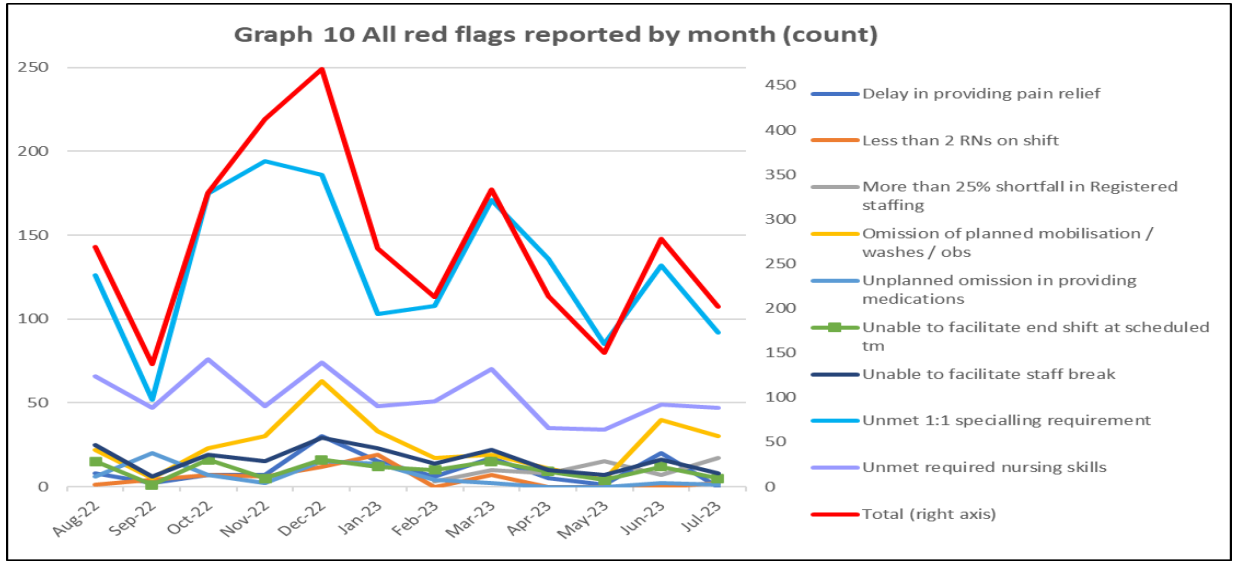
Nursing Pipeline

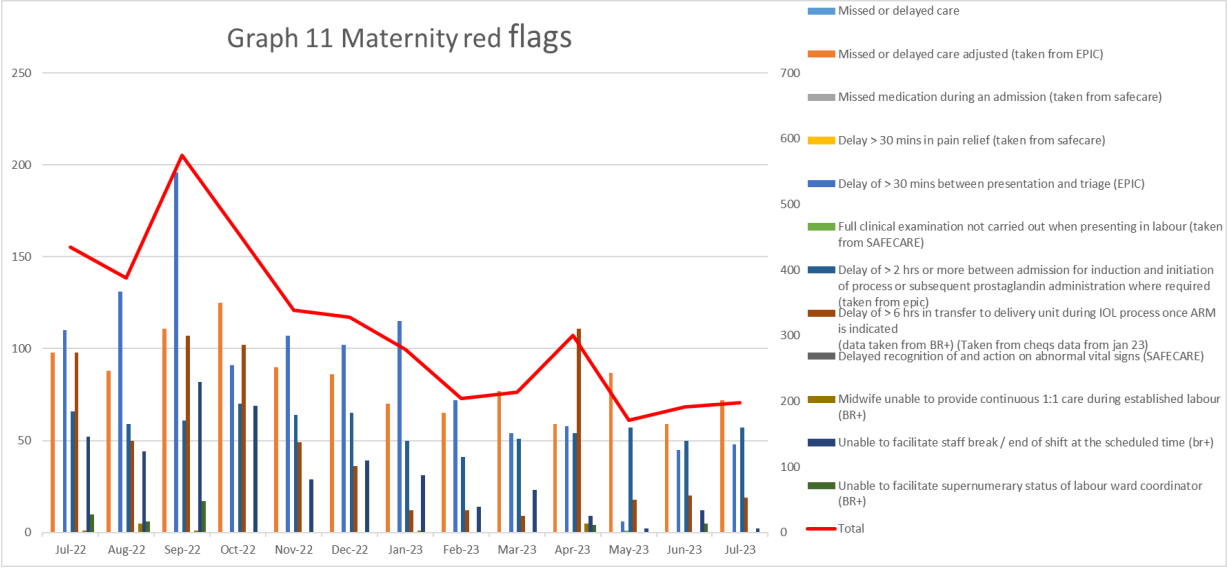
Appendix 2 provides detail on the forecasted position in relation to the number of adult RN vacancies based on FTE and includes UK experienced, UK newly qualified, apprenticeship route, EU and international up to March 2024. The current forecast demonstrates a year end band 5 RN vacancy position of 9.55% which is significantly above the target of 5%. This is due in part to the reliance on international recruitment and the increased national and international competition for such staff resulting in fewer deployments to CUH. Please note that vacancy data is using March 2023 budget as the 2023/24 budgets have not yet been loaded to ESR. The RN adult pipeline for 2023/24 now reflects the reduction in international recruitment. This is a national concern and has been escalated to NHS England. Work is being undertaken to explore RN Recruitment initiatives including increasing the International Recruitment pay band and reducing our shortlisting criteria. A paper is currently underway to propose these initiatives for consideration by Management Executive.

Appendix 3 provides detail on the forecasted position in relation to the number of Paediatric band 5 RN and HCSW vacancies up to March 2024. Numbers are based on those interviewed and offered positions in addition to planned campaigns. The current forecast demonstrates a year end band 5 Paediatric RN vacancy position of 22.40% and a band 2 HCSW position of 5.43%. Due to limited CSSIP capacity the permanent HCSW numbers recruited are expected to be reduced in August. This is due to only one CSSIP being held and a large intake of MSW, TSW, Bank HCSW and displaced nurses with limited the spaces available.

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

Red flags





Red Flags

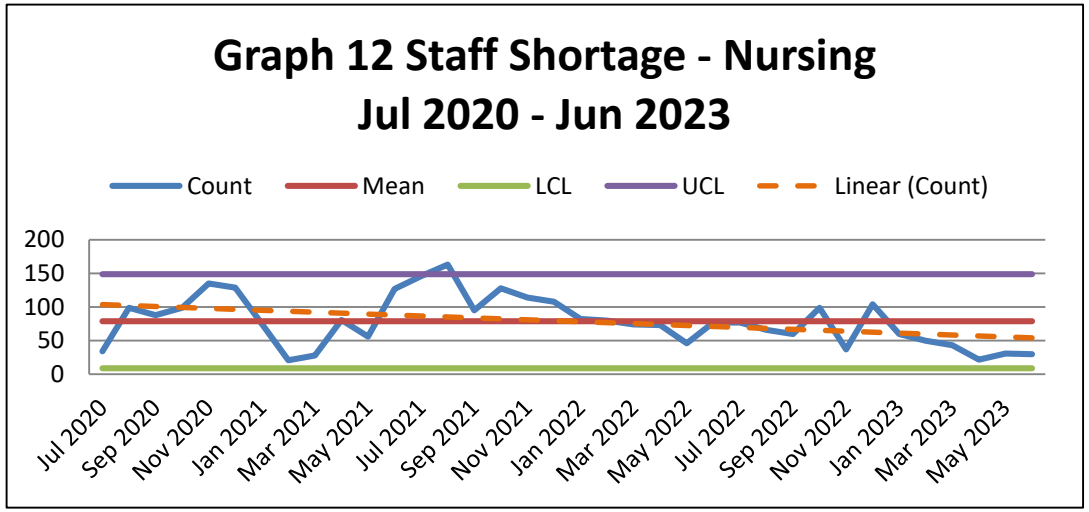
A staffing red flag event is a warning sign that something may be wrong with nursing or midwifery staffing. If a staffing red flag event occurs, the registered nurse or midwife in charge of the service should be notified and necessary action taken to resolve the situation.

Nursing red flags

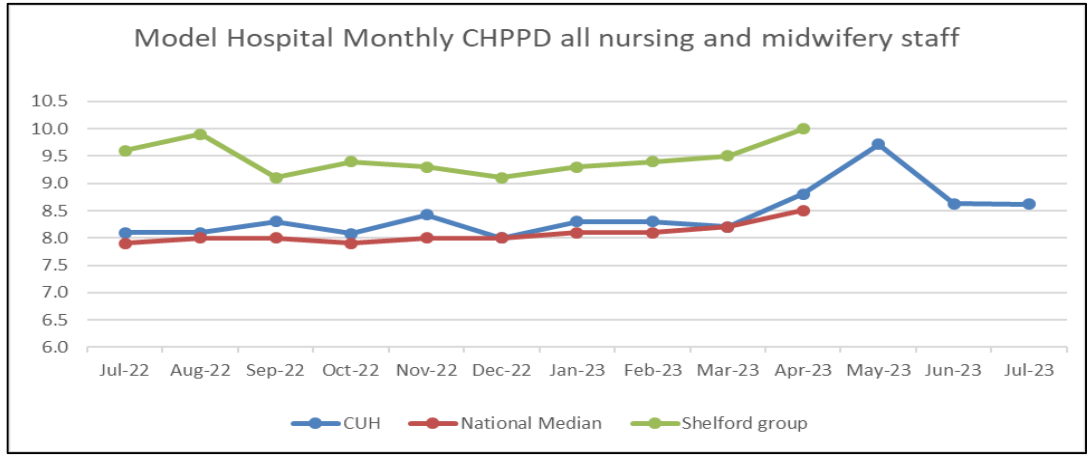
Graph 10 illustrates that there has been a decrease in the number of red flags reported with 202 reported in June. The highest number of red flags reported in July was in relation to an unmet 1:1 specialling requirement (92 compared with 132 in June). A trust wide improvement project focusing on specialling is being developed to review specialling across the organisation. All red flags have seen an decrease expect for more than 25% shortfall of RNs (7 in June compared to 17 in July). In July 2 red flags were reported for less than 2 RN on shift these were within A block however on further exploration these were resolved by redeploying operational pool staff.

Maternity red flags

The number of maternity red flags reported over the last 6 months has been a decreasing trend with 575 reported in September 22 compared to 198 in July 23. Graph 11 illustrates the red flags that have been reported. The largest red flag reported is for missed or delayed care 36.4%. 24.2% of red flags reported were due to a delay of >30mins between presentation and triage. This is a known area of concern as highlighted in the recent CQC inspection however after reduction in May to 4% this has now increased back to levels seen in March.



Graph 13: Care Hours Per Patient Day (CHPPD)



Incidents reported relating to staff shortages

Graph 12 illustrates the trend in Safety Learning Reports (SLRs) completed in relation to nurse staffing. This has been a decreasing trend over the last 6 months January to June, however there has been an increase reported in July to 54 but this continues to be under the mean.

The majority of the incidents related to staffing levels in July were reported by division A (17) with the highest reporting areas being ICU D3 (7). Division E were the second highest reporting division with 14 incidents related to staffing levels. The staffing incidents reported were highest in the Neonatal intensive care unit (6). Safety continues to be monitored through the site safety meetings.

Care hours per patient day (CHPPD)

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

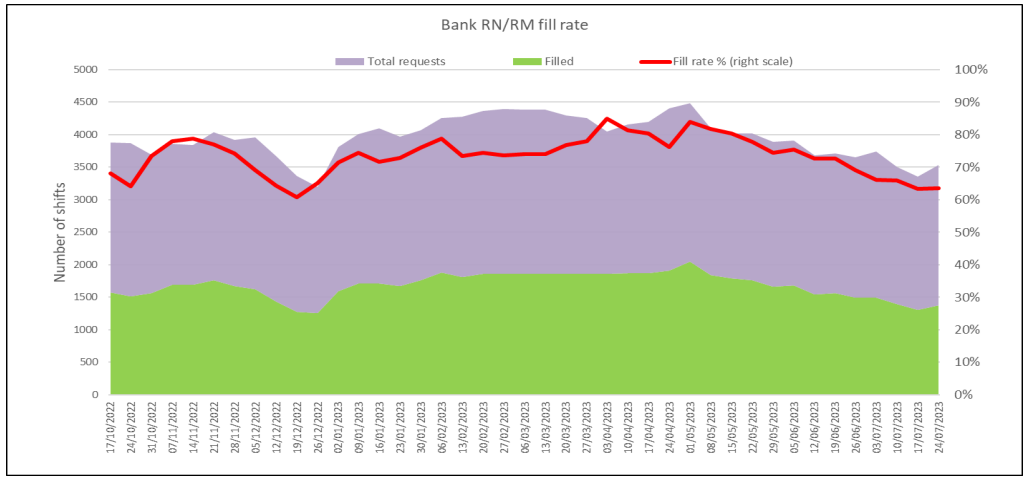
CUH CHPPD recorded for July has decreased from the peak of May 23 of 9.71 and has remained stable against 8.63 for June 2023. This is comparable to other Shelford hospitals (9.3).

In maternity, from 1 April 2021, the total number of patients now includes babies in addition to transitional care areas and mothers who are registered as a patient. CHPPD for the delivery unit in July has decreased to 14.43 (17.14 in June).

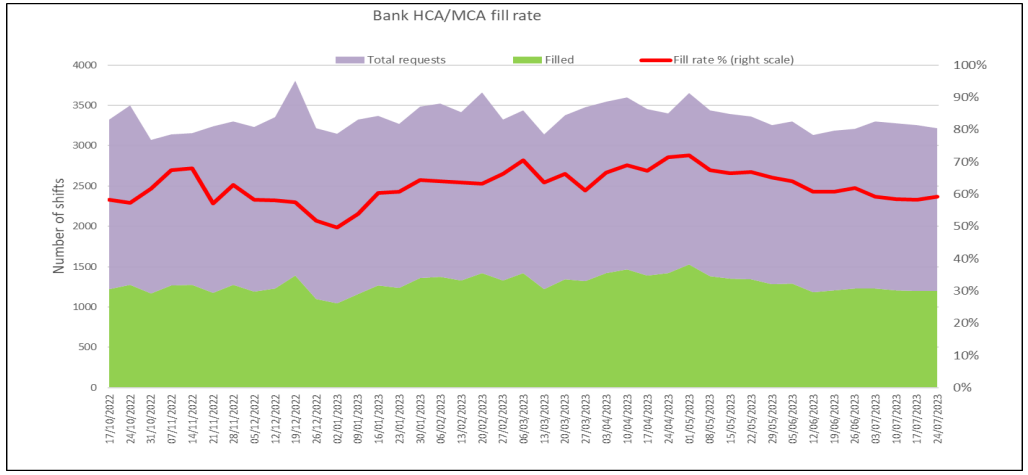
Bank Fill Rate and Agency Usage

NHS CUH

Graph 14 Registered RN/RM Bank fill rate per week



Graph 15 HCSW/MSW bank fill rate per week



Bank fill rate

The Trust's Staff Bank continues to support the clinical areas with achieving safe staffing levels. Graph 15 and 16 illustrate the trends in bank shift fill rate per week. Overall, we continue to see a decrease in July for bank shift requests for registered staff to mitigate those areas who have less than a rota fill of 90% or to cover an unmet specialling need. The number of requests for registered staff is an average of 2145 shifts per week with an average bank fill rate of 64.74% this a reduction from June 73.78% .

The number of requests for Health care support workers and Maternity support workers remains high with an average of 2057 shifts per week with an average bank fill rate of 58.78% this is also a further reduction from June 62.67%.

In addition to bank workers we have the equivalent of 14.75WTE agency workers working (29.5 WTE in June) across the divisions to support staffing challenges in the short term. This agency usage is reducing and there is a focus to reduce further as the substantive position increases.

Short term pay enhancements for bank shifts put in place earlier in the year to encourage a higher uptake of shifts have reduced in July with these now only being targeted to those areas with the highest vacancy. There has been a slight reduction in bank fill in correlation with this but not a significant decrease. This trend will continue to be monitored. Any bank enhancements in place are reviewed regularly (at least on a 6 weekly basis) through the weekly bank enhancement meeting and are for fixed periods of time.

Appendix 1: Exception report by Division

NHS CUH

	Jul-23						Report from the Divisional Head of Nursing please submit to Meleta Barson		
	Unit	Speciality	% fill registered	% fill care staff	Overall filled %	CHPPD	Analysis of gaps	Impact on Quality / outcomes	Actions in place
Division A	D4	192 - CRITICAL CARE MEDICINE - STANDARD	88%	83%	87%	21.41	Target CHPPD achieved, suggesting safe staffing. Sickness remains high across critical care. On D4 ranges between 7.8- 12%. vacancy gap at 21 WTE across CC		Sickness managed in the informal and formal process. Recruitment ongoing . Staff moved across units to mitigate risk.
Division A	JOHN FARMAN ICU	192 - CRITICAL CARE MEDICINE - RISK MANAGED	85%	97%	87%	24.96	Target CHPPD achieved, suggesting safe staffing Sickness remains high across critical care. On D4 ranges between 6.1-10.5%. vacancy gap at 21 WTE across CC		Sickness managed in the informal and formal process. Recruitment ongoing . Staff moved across units to mitigate risk
Division A	NCCU	192 - CRITICAL CARE MEDICINE - RISK MANAGED	88%	97%	89%	28.39	Target CHPPD achieved, suggesting safe staffing Sickness remains high across critical care. On D4 ranges between 7.9- 15%. vacancy gap at 21 WTE across CC		Sickness managed in the informal and formal process. Recruitment ongoing . Staff moved across units to mitigate risk
Division E	D2	171 - PAEDIATRIC SURGERY - STANDARD	89%	115%	94%	9.79	current vacancy rate 30% 9.16wte RN & 4.31wte HCA. We have 7wte RN & 4wte HCA in pipeline. = net position to fil 3.89wte	increased pressure on staff to ensure adequate skill mix. No impact on patient experience feedback.	regular safety huddles & quality rounds. Regular reviews of staffing levels & patient acuity.
Division E	Neonatal ICU	422 - NEONATOLOGY - RISK MANAGED	88%	54%	86%	13.22	Target CHPPD achieved, suggesting safe staffing. 19.83wte RN vacancies. 11wte in pipeline in, 4.49 in pipeline out. Net position to fill =13.32wte.	Increased pressure on QIS to ensure skill mix / safe staffing levels. No impact of NQM or patient experience.	regular safety huddles & quality rounds. Regular reviews of staffing levels & patient acuity.
Division E	PICU	192 - CRITICAL CARE MEDICINE - RISK MANAGED	71%	105%	74%	30.02	24.67wte RN vacancy, 6wte in pipeline in, 0.46wte RN in pipeline out. Net position = 19.13wte RN vacancy.	Vacancy rate is reducing with current pipeline. Work ongoing with recruitment & retention plans. Ongoing pressure on QIS to maintain adequate skill mix. Activity varied over July. No impact on NQM or patient experience.	regular safety huddles & quality rounds. Regular reviews of staffing levels & patient acuity.

Appendix 1: Exception report by Division

	Jul-23						Report from the Divisional Head of Nursing please submit to Meleta Barson		
Division C	C5	361 - NEPHROLOGY - PROTECTED	89%	87%	88%	7.04	5 WTE RN gaps, 6 WTE HCSW gaps 106 RN outbound hours to other areas. 444 RN inbound from other areas. Supervisory Band7 time = 68.1% 3 red flags raised.	No increase in incidents reported for this ward, all low or no harm. NQM - Green, BCMA remains red Matrons quality round - Bronze scoring aligned with accreditation tool and improving	Daily divisional mitigation; site safety escalation; weekly prospective staffing reporting and mitigation; divisional recruitment and retention strategy. Matron quality focus.
Division C	D5	301 - GASTROENTEROLOGY - STANDARD	84%	96%	88%	7.00	2 WTE RN gaps, 5 WTE HCSW gaps 284 RN outbound hours to other areas. 639 RN inbound from other areas.432 RN inbound to D5. Supervisory Band7 time = 43.2% 6 red flags raised.	No increase in incidents reported for this ward, 1 severe major #NOF and staffing below establishment at that time. NQM - Green, BCMA remains red Matrons quality round - Bronze scoring aligned with accreditation tool and improving	Daily divisional mitigation; site safety escalation; weekly prospective staffing reporting and mitigation; divisional recruitment and retention strategy. Matron quality focus.
Division C	G4	300 - GENERAL MEDICINE - STANDARD	89%	84%	87%	6.46	9.5 WTE HCSW gaps 73 RN outbound hours to other areas. 811 RN inbound to G4. Supervisory Band7 time = 15.2% 6 red flags raised.	No significant increase in incidents reported for this ward, all low or no harm. NQM - Green, BCMA remains red Concerns raised by IPC team regarding poor compliance with hand hygiene. Matrons quality round - Bronze scoring aligned with accreditation tool and improving Increased falls against previous month	Daily divisional mitigation; site safety escalation; weekly prospective staffing reporting and mitigation; divisional recruitment and retention strategy. Matron quality focus.
Division C	N2	300 - GENERAL MEDICINE - RISK MANAGED	89%	94%	91%	8.53	Target CHPPD achieved, suggesting safe staffing		
Division D	A5	150 - NEUROSURGERY - RISK MANAGED	90%	151%	117%	10.03	Target CHPPD achieved, suggesting safe staffing	inconsistent fill from bank and agency, increased nursing workload	Risk mitigated via safe staffing meetings, staff from green area redeployment to areas that are high risk, ER adviser supporting Senior nurses in Sickness and Absence Management

Appendix 2: Adult RN Recruitment pipeline

NHS CUH

Adult band 5 RN position based on predictions and established FTE															
Month	UK based exp. applicants	Anglia Ruskin NQ (60% of graduates)	Other NQ	Nursing Associates	NAP	Return to Practice	Overseas	Total New Starters	Leavers FTE	Promotions and transfer out of scope- retained by the trust	Staff in post FTE	ESR Establishment FTE	Vacancy rate based on established FTE	No. of vacancies based on established FTE	Starter leaver variance
Apr-23	5	2			12		9	28	9	11	1534	1699	9.70%	164.87	19
May-23	1	3			5		12	21	14	12	1529	1699	10.00%	169.87	7
Jun-23	4				2		11	17	7	13	1526	1699	10.18%	172.87	10
Jul-23	1	1	2				19	23	16	10	1523	1699	10.35%	175.87	7
Aug-23	3	1					17	21	15	10	1519	1699	10.59%	179.87	6
Sep-23	6	4					33	43	15	14	1533	1788	14.25%	254.67	28
Oct-23	5	20	7				20	52	15	20	1550	1788	13.29%	237.67	37
Nov-23	3				21		25	49	15	14	1570	1788	12.18%	217.67	34
Dec-23	2			2			30	34	15	15	1574	1826	13.82%	252.37	19
Jan-24	2			2		2	30	36	15	15	1580	1826	13.49%	246.37	21
Feb-24	6			2			35	43	15	15	1593	1826	12.78%	233.37	28
Mar-24	5	40	7	2			35	89	15	15	1652	1826	9.55%	174.37	74
TOTAL	**43**	**71**	**16**	**8**	**40**	**2**	**276**	**490**	**166**	**164**	**1652**	**1826**	**9.55%**	**174.37**	**290**

Appendix 3: Paediatric RN and Band 2 HCSW Recruitment pipeline

NHS CUH

Paediatric band 5 RN position based on predictions and established FTE												
Month	UK based exp. applicants	Anglia Ruskin NQ	Other NQ	Overseas	Total New Starters FTE	Leavers FTE (based on leavers in the last 12 months)	Promotions and transfer out of scope- retained by the trust	Staff in post FTE	ESR Establishment FTE	Vacancy rate based on established FTE	No. of vacancies based on established FTE	Starter leaver variance
Apr-23	1				3	2		164.39	213.73	23.09%	49.34	1
May-23					0	2	2	160.39	213.73	24.96%	53.34	-2
Jun-23	2	2			4	6	1	157.39	213.73	26.36%	56.34	-2
Jul-23	1			3	4	3	1	157.39	213.73	26.36%	56.34	1
Aug-23			1		1	2	2	154.86	213.73	27.54%	58.87	-0.53
Sep-23	1		1	1	3	2	1	154.86	213.73	27.54%	58.87	1
Oct-23	2	8	11	2	23	5	2	170.86	213.73	20.06%	42.87	18
Nov-23	1	8	2	2	13	5	3	175.86	213.73	17.72%	37.87	8
Dec-23	1				1	6	1	169.86	213.73	20.53%	43.87	-5
Jan-24			1	2	3	4	1	167.86	213.73	21.46%	45.87	-1
Feb-24	2			2	4	5	1	165.86	213.73	22.40%	47.87	-1
Mar-24	2			2	4	3	1	165.86	213.73	22.40%	47.87	1
TOTAL	13	18	16	14	63	44.53	16	165.86	213.73	22.40%	47.87	1

Band 2 HCSW position based on predictions and established FTE								
Month	UK based applicants	Apprenticeship (direct entry)	Total New Starters FTE	Leavers FTE	Staff in post FTE	ESR Establishment FTE	Vacancy rate based on established FTE	No. of vacancies based on established FTE
Apr-23	18	1	19	18	768	887	13.43%	119
May-23	16	1	17	10	775	887	12.64%	112
Jun-23	20	5	25	7	793	887	10.62%	94
Jul-23	14	3	17	16	794	887	10.50%	93
Aug-23	11	1	12	13	793	887	10.62%	94
Sep-23	21	4	25	13	805	945	14.84%	140
Oct-23	25	14	39	13	831	945	12.09%	114
Nov-23	30		30	13	848	945	10.29%	97
Dec-23	30		30	13	865	968	10.69%	104
Jan-24	30		30	13	882	968	8.94%	87
Feb-24	30		30	13	899	968	7.18%	70
Mar-24	30		30	13	916	968	5.43%	53
TOTAL	275	29	304	155	915.84	968.4	5.43%	52.56

Board of Directors

NHS
Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 13 September 2023

Agenda item	9.4
Title	Finance report
Sponsoring executive director	Mike Keech, Chief Finance Officer
Author(s)	As above
Purpose	To update the Board on financial performance in 2023/24 M4
Previously considered by	Performance Committee, 6 September 2023

Executive Summary

The report provides details of financial performance during 2023/24 Month 4 and in the year to date. A summary is set out in the Chief Finance Officer's message on pages 3-5 of the report.

Related Trust objectives	All Trust objectives
Risk and Assurance	The report provides assurance on financial performance during Month 4.
Related Assurance Framework Entries	BAF ref: 011
Legal / Regulatory / Equality, Diversity & Dignity implications?	n/a
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	n/a

Action required by the Board of Directors

The Board is asked to note the finance report for 2023/24 Month 4 (July 2023).

NHS CUH

Contents

NHS CUH

Trust actual surplus / (deficit)

(£1.0m)	*Actual (adjusted)**
£0.3m	*Plan (adjusted)**
(£0.3m)	*Actual YTD (adjusted)**
£3.8m	*Plan YTD (adjusted)**

Elective Payment Mechanism (EPM)

EPM replaces ERF in 23/24 for the variable element of elective performance.

£16.6m	*EPM forecast actual in month*
£18.1m	*EPM plan in month*
£16.6m	*EPM target in month*
£65.4m	*EPM forecast actual YTD*
£72.3m	*EPM plan YTD*
£66.5m	*EPM target YTD*

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

Net current assets

(£85.9m)	*Actual*
(£48.7m)	*Plan*

Debtor days

17	*This month*
16	*Previous month*

Payables performance (YTD) *

85.4%	*Value*
88.6%	*Quantity*

EBITDA

£11.5m	*Actual YTD*
£16.6m	*Plan YTD*

Capital expenditure

£7.3m	*Capital - actual spend in month*
£13.9m	*Capital - actual spend YTD*
£9.3m	*Capital – plan YTD*

Cash

Cash

£195.6m	*Actual*
£151.1m	*Plan*

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

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

Trust performance summary - Key indicators

Month 4 Financial Performance

- **The Month 4 year to date position is a £0.3m deficit for performance management purposes**. This is adverse to our planned performance by £4.1m.

- The following key points should be noted:
  - This position includes £6.7m of non-recurrent support which the Trust plans to increase to £20m by the end of the year.
  - Financial under performance is predominantly due to the impact of Industrial Action (IA), estimated at £4.1m for additional pay expenditure and £6.9m for elective activity under performance.
  - The Trust has partially mitigated the impact of IA through the protection of the Elective Payment Mechanism (EPM) income from under performing Commissioners, in line with guidance, at £3.1m.
  - Further IA is planned in August which is expected to significantly increase the pressure on the Trust's finances.
  - Additional financial support is expected to be required for the Trust to deliver it's 23/24 financial plan.
  - Following the production of the Month 4 position, NHSE have provided further updates as to the basis of the EPM calculation and the draft approach to supporting Trusts for the impact of IA. The forecast implications of these are provided in this report.

- Income adverse variance of £1.1m - Clinical income is adverse to plan by £5.5m and Devolved income is favourable to plan by £4.4m. Please see pages 10-14.
- Pay adverse variance of £8.6m - this position is due to costs associated with IA (£4.1m), the phasing impact of bank holidays (£0.7m) and the adverse impact of IA on the Trust's ability to fully deliver the efficiency savings that were planned for the year to date (£4.5m). Please see pages 15-16.
- Non pay (inc. drugs) favourable variance of £4.6m - this position is driven by lower than planned activity and additional inflationary pressures not being identified so far. Please see pages 17-18.

Covid-19 Expenditure

- The Trust has received £5m of funding to cover Covid-19 expenditure in 23/24. The Trust is no longer required to report Covid-19 expenditure to NHSE and the Trust's internal reporting processes have been simplified.

Elective Payment Mechanism (EPM)

- The ERF schemes from previous years have now ended. Elective activity recovery in 23/24 is being incentivised via a 'variable' element of contract, where Trusts are paid on Payments by Results (PbR) for a selection of activity including Elective Inpatients, Day-cases, Outpatient First attendances, Outpatients procedures and Chemotherapy, known as the EPM.
- At month 4 YTD performance for the **EPM is £1.1m below target and £6.9m below plan**.

- **Additional funding to support the impact of IA:**
  - NHSE directed Trusts to accrue income at individual Commissioner levels to agreed baseline values where activity is below the targets in Months 1 to 4. On this basis the Trust has accrued £3.1m of income bringing the total reported performance for **EPM to £2.0m above target, £3.8m below plan**.
  - Since finalising the Month 4 position NHSE have provided two updates:
    1. Updated guidance as to the EPM calculation moving the Trust assessment of under performance (pre support) from £6.9m to £8.5m YTD.
    2. That financial support for the impact of IA will be provided through a reduction to the EPM targets - expected to be -2% for April's IA. We expect similar adjustments to be made for subsequent IA months but this has not yet been confirmed.
  - If the IA support is implemented in line with this draft proposal, including future month's adjustments, the Trust's assessment is that this will mitigate the Trust's financial impact of IA, exceeding the £3.1m of support assumed in the Month 4 position and returning the Trust to plan by the end of the financial year.

Productivity and Efficiency Programme (PEP)

- For 23/24 the efficiency requirement will be delivered via Covid cost reductions, efficiency & transformation and productivity & growth.
- The current forecast is full delivery of the £53.1m target; however, the Trust may need to consider an increase in the allocated cost reduction requirements if slippage against productivity plans continues and the associated planned income is not received.
- Recurrent efficiencies currently total £51.0m and represent 96% of the total plan.
- Month 4 reports PEP with an adverse position of £2.4m. Pay efficiencies are currently behind plan by £4.5m with non-pay efficiencies favourable to plan by £0.7m and Income efficiencies £1.4m ahead of plan.
- The impact of ongoing IA means that planned productivity improvements driven by increased activity have not been achieved. Additionally the Trust has needed to pay premium rates to cover staffing gaps.
- The Trust will continue to develop the plans across 23/24 with the aim to increase productivity and deliver the planned cost efficiency schemes.

NHS CUH

Cash and Capital Position

- The Trust has received an initial system capital allocation for the year of £35.0m for its core capital requirements. In addition to this, we hope to receive further funding for the Children's Hospital (£3.5m), Cancer Hospital (£11.3m), and Community Diagnostics £0.8m, Together with capital contributions from ACT totalling £7.4m and technical adjustments in respect of PFI, the Trust's capital budget for the year totals £60.7m. As a counter-measure against likely slippage an £8.4m over-commitment has been built into the 23/24 capital plan.
- At Month 4 the capital programme is ahead of plan with spend year to date of £13.9m against a budget of £9.3m. This reflects a number of projects spending earlier than originally expected and does not indicate any actual overspending against project budgets. The forecast spend for the year remains on budget at £60.7m.
- The Trust's cash position remains strong and the 13 week cash flow forecast does not identify any need for additional revenue cash support in the foreseeable future. The closing cash position for 22/23 was unexpectedly high due to grant receipts late in the financial year and we have been unable to adjust the 23/24 plan to take account of this revised opening position (although the cash flow forecast has been updated). As a result, the actual cash position at Month 4 appears better than plan.

FY23/24 Financial Plan

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

  a) No allowance has been made in the plan for the impact of IA. The expectation is that the cost of the on-going action and the associated impact on elective income will require national support.

  b) Additional inflationary pressures over and above planned levels cannot be managed by the Trust and would require additional funding.

  c) The Trust has assumed that other ICBs adhere to national guidance, for example on the flow of Elective Payment Mechanism funding;

- The following points should also be noted in respect of the 23/24 financial plan:

  1) The plan assumes that the Medical and Dental pay award being higher than the current funded assumption of 2.1% will be mitigated through an additional national funding allocation.

Month 4 performance against plan

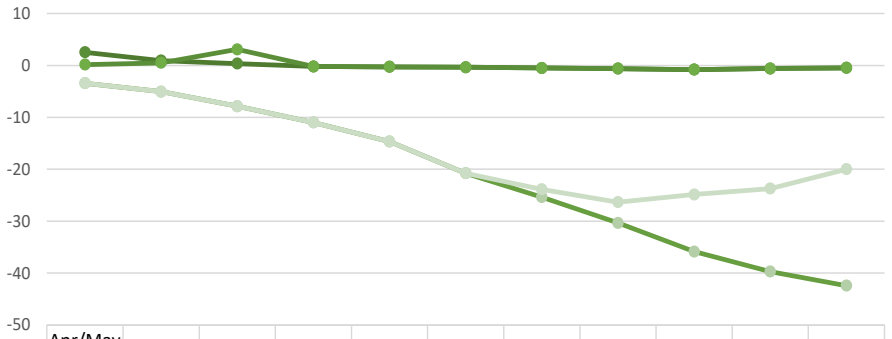
£ Millions	In Month Budget	In Month Actual	In Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Full Year Budget
Clinical Income - exc. D&D*	82.8	80.0	(2.9)	331.3	321.5	(9.8)	996.1
Clinical Income - D&D*	14.3	16.3	2.0	57.3	61.6	4.3	175.1
Devolved Income	15.1	20.7	5.5	60.5	64.9	4.4	186.2
Total Income	**112.3**	**117.0**	**4.7**	**449.1**	**447.9**	**(1.1)**	**1,357.4**
Pay	59.7	61.7	(2.0)	237.3	245.9	(8.6)	730.4
Drugs	15.9	18.0	(2.1)	63.7	68.2	(4.5)	191.2
Non Pay	33.1	35.3	(2.2)	131.5	122.3	9.1	397.4
Operating Expenditure	**108.7**	**115.0**	**(6.3)**	**432.5**	**436.4**	**(3.9)**	**1,319.0**
EBITDA	**3.5**	**2.0**	**(1.6)**	**16.6**	**11.5**	**(5.1)**	**38.4**
Depreciation, Amortisation & Financing	3.3	2.9	0.4	13.2	12.0	1.2	39.6
Reported gross Surplus / (Deficit)	**0.2**	**(0.9)**	**(1.2)**	**3.4**	**(0.5)**	**(3.9)**	**(1.2)**
Add back technical adjustments:							
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital donations/grants net I&E impact	0.1	(0.1)	(0.2)	0.4	0.2	(0.2)	1.2
Net benefit of PPE consumables transactions	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit) NHS financial performance basis	**0.3**	**(1.0)**	**(1.4)**	**3.8**	**(0.3)**	**(4.1)**	**(0.0)**

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

Trust underlying performance

Key messages:

- 23/24 actual performance is forecast to meet plan but due to a range of non-recurrent items, outlined below, the Trust is forecasting an **underlying deficit of £42m**.
- Elective service productivity improvements could reduce the **underlying deficit to £20m.**
- This assessment is based on the Trust delivering the operational plan and receiving £5.3m from NHSE/I at Month 5 in support of the costs of Industrial Action.
- At Month 4, non-recurrent:
  - income benefits from the EPM baseline adjustments total £5.0m - (£15.0m full year).
  - support of £6.7m (£20.0m full year).
  - pay expenditure from Industrial Action totals £4.1m. This is expected to increase to £5.3m in Month 5 - no further costs are forecast at this stage.
- The Trust is planning to exit the year with an underlying monthly deficit which annualises at over £7m, if unfunded in 24/25.



	Apr/May -23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
23/24 Plan	2.5	0.9	0.3	(0.2)	(0.3)	(0.4)	(0.5)	(0.6)	(0.8)	(0.6)	(0.5)
23/24 Actual/Forecast Performance	0.2	0.5	3.1	(0.2)	(0.3)	(0.4)	(0.5)	(0.6)	(0.8)	(0.6)	(0.5)
Underlying Cumulative Performance	(3.4)	(5.1)	(7.9)	(11.0)	(14.7)	(20.8)	(25.4)	(30.3)	(35.9)	(39.7)	(42.4)
Underlying Cumulative Perf. + Mitigations	(3.4)	(5.1)	(7.9)	(11.0)	(14.7)	(20.8)	(23.9)	(26.3)	(24.9)	(23.7)	(20.0)

£'m	Actual M2 YTD	Actual M3 YTD	Actual M4 YTD	Forecast M5 YTD	Forecast M6 YTD	Forecast M7 YTD	Forecast M8 YTD	Forecast M9 YTD	Forecast M10 YTD	Forecast M11 YTD	Forecast M12 YTD
NHS performance surplus / (deficit) - cumulative	**0.2**	**0.7**	**(0.3)**	**3.6**	**3.3**	**3.0**	**2.5**	**1.8**	**1.0**	**0.5**	**0.0**
Non-recurrent adjustments for Industrial Action											
Industrial action pay costs removed	2.2	3.0	4.1	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3
Industrial action income removed (recognised in M5 Surplus)	0.0	0.0	0.0	(5.3)	(5.3)	(5.3)	(5.3)	(5.3)	(5.3)	(5.3)	(5.3)
Underlying plan adjustments											
Non-recurrent support	(3.3)	(5.0)	(6.7)	(8.3)	(10.0)	(11.7)	(13.3)	(15.0)	(16.7)	(18.3)	(20.0)
Baseline adjustment (EPM funding)	(2.5)	(3.8)	(5.0)	(6.3)	(7.5)	(8.8)	(10.0)	(11.3)	(12.5)	(13.8)	(15.0)
CUH service performance											
Exit expenditure run rate 23/24 is unfunded in 24/25	0.0	0.0	0.0	0.0	(0.5)	(3.3)	(4.5)	(5.9)	(7.7)	(8.1)	(7.4)
Underlying 23/24 position - Exit run-rate	**(3.4)**	**(5.1)**	**(7.9)**	**(11.0)**	**(14.7)**	**(20.8)**	**(25.4)**	**(30.3)**	**(35.9)**	**(39.7)**	**(42.4)**
Mitigations											
Elective service exit run rate 23/24 increase	0.0	0.0	0.0	0.0	0.0	0.0	0.5	1.0	2.0	4.0	7.4
Elective service productivity increase	0.0	0.0	0.0	0.0	0.0	0.0	1.0	3.0	9.0	12.0	15.0
Mitigations	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**1.5**	**4.0**	**11.0**	**16.0**	**22.4**
Underlying 23/24 position - Mitigated Position	**(3.4)**	**(5.1)**	**(7.9)**	**(11.0)**	**(14.7)**	**(20.8)**	**(23.9)**	**(26.3)**	**(24.9)**	**(23.7)**	**(20.0)**

Full Year Plan – key messages

NHS CUH

£'m	M1&2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	23/24 Total
Operating income from patient care activities	196.8	98.4	98.4	98.4	98.4	100.1	100.1	100.1	100.1	100.1	100.1	**1,190.7**
Other operating income	27.8	13.9	13.9	13.9	13.9	13.9	13.9	13.9	13.9	13.9	13.9	**166.7**
Total operating income	**224.5**	**112.3**	**112.3**	**112.3**	**112.3**	**114.0**	**114.0**	**114.0**	**114.0**	**114.0**	**114.0**	**1,357.4**
Employee expenses	(118.2)	(59.5)	(59.7)	(60.2)	(60.4)	(61.9)	(62.0)	(62.1)	(62.1)	(62.1)	(62.2)	**(730.4)**
Operating expenses excluding employee expenses	(103.3)	(51.6)	(51.9)	(52.0)	(51.9)	(52.1)	(52.2)	(52.2)	(52.4)	(52.1)	(51.9)	**(623.6)**
Operating Surplus/(Deficit)	**3.1**	**1.2**	**0.6**	**0.1**	**0.0**	**(0.1)**	**(0.2)**	**(0.3)**	**(0.5)**	**(0.3)**	**(0.2)**	**3.4**
Finance expense	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	**(0.7)**
PDC dividends payable/refundable	(0.7)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	**(3.9)**
Net finance costs	(0.8)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	**(4.6)**
Surplus/(Deficit) for the Period/Year	**2.3**	**0.8**	**0.2**	**(0.3)**	**(0.4)**	**(0.5)**	**(0.6)**	**(0.7)**	**(0.9)**	**(0.7)**	**(0.6)**	**(1.2)**
Add back technical adjustments:												
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Capital donations/grants net I&E impact	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	**1.2**
Net benefit of PPE consumables transactions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Surplus/(Deficit) - NHS financial performance basis for the Period/Year	**2.5**	**0.9**	**0.3**	**(0.2)**	**(0.3)**	**(0.4)**	**(0.5)**	**(0.6)**	**(0.8)**	**(0.6)**	**(0.5)**	**(0.0)**

Key messages:

- The Trust plan delivers a 23/24 break-even position on an NHS financial performance basis.
- It is assumed that any elective over-performance will be paid in full, the financial impact of IA will be fully mitigated by NHSE/I and that inflationary pressures will be contained within the modelled levels.
- Productivity and efficiency schemes totalling £53.1m are included within the overall plan. The programme will be delivered via improved productivity combined with cash releasing efficiencies.

£'m	M4 YTD Plan	M4 YTD Actual	Variance	Key Variances
Operating income from patient care activities	393.5	388.3	(5.2)	Pass-through drugs income is higher than expected (£7.6m) however, this is offest by below plan Cancer drugs fund and Car-T activity (£3.3m combined), the shortfall in planned elective baseline over-performance not delivered due to Industrial Action (£6.9m) and other variable income elements variances (£2.3m), and a shortfall for Private Patients income (£0.3m).
Other operating income	55.6	59.6	4.0	The favourable variance of £4.0m is driven by fire safety works (£2.2m) and Community Diagnostics Centre income (£1.1m) and net other favourable variances of £2.3m offset by an adverse variance of £1m for R&D (due to timing of the income recognition).
Total income	**449.1**	**447.9**	**(1.1)**	
Employee expenses	(237.3)	(245.9)	(8.6)	The primary drivers of the adverse position are the direct impact of the Industrial Action (£4.1m) phasing of bank holidays in the plan (£0.7m) and associated slippage on delivery of planned productivity and efficiency (£4.5m). The impact of premium rates of bank and agency pay are largely offset by funded vacancies but present an ongoing financial risk.
Operating expenses excluding employee expenses	(206.8)	(202.2)	4.6	The favourable position is driven by lower than planned expenditure for R&D (£1.0m), lower than planned expenditure on cancer drugs including Car-T (£3.3m), Clinical negligence (Maternity incentive scheme) rebate (£1m) offset fire safety works ahead of plan (£2.2m) and CDC expenditure (£1.1m). Net other non-pay costs are favourable to plan by £2.6m.
Operating surplus / (deficit)	**5.0**	**(0.1)**	**(5.1)**	
Finance costs				
Finance income	2.3	3.2	0.9	Cash balances have remained higher than planned and therefore the Trust has received interest in excess of the plan.
Finance expense	(2.6)	(2.3)	0.3	
PDC dividends payable/refundable	(1.3)	(1.3)	0.0	
Net Finance costs	**(1.5)**	**(0.4)**	**1.2**	
Reported gross surplus/(deficit)	**3.4**	**(0.5)**	**(3.9)**	
Add back technical adjustments:				
Impairments (AME)	0.0	0.0	0.0	
Capital donations/grants net I&E impact	0.4	0.2	(0.2)	
Net benefit of PPE consumables transactions	0.0	0.0	0.0	
Surplus/(Deficit) - NHS financial performance basis for the year to date	**3.8**	**(0.3)**	**(4.1)**	**Net position reports a deficit of (£4.1m) against plan primarily driven by the financial impact of the Industrial Action.**

Key messages:

- Year to date, on an NHS financial performance basis, the Trust reports a deficit of (£0.3m). This reflects under achievement of plan by £4.1m.
- The under performance is explained by Industrial Action cost pressures in pay (£4.1m) – the Trust expects to receive additional funding to cover these costs from NHSE.

Plan performance FY23/24 (continued)

£'m	In Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Elective admissions	11.5	11.7	0.3	41.4	44.3	3.0
Non-elective admissions	17.0	18.6	1.6	67.1	67.6	0.5
Outpatients - First	4.4	4.4	0.0	17.7	14.9	(2.7)
Outpatients - Follow-up	6.1	6.6	0.5	24.5	23.2	(1.3)
A&E	4.0	5.1	1.1	15.6	19.2	3.6
High-cost drugs income from commissioners	14.3	16.3	2.0	57.3	61.6	4.3
Other Clinical Income	39.8	33.5	(6.3)	165.0	152.2	(12.8)
Total Clinical Income	**97.2**	**96.3**	**(0.8)**	**388.6**	**383.1**	**(5.5)**
Devolved Income	15.1	20.7	5.5	60.5	64.9	4.4
Total Trust Income	**112.3**	**117.0**	**4.7**	**449.1**	**447.9**	**(1.1)**

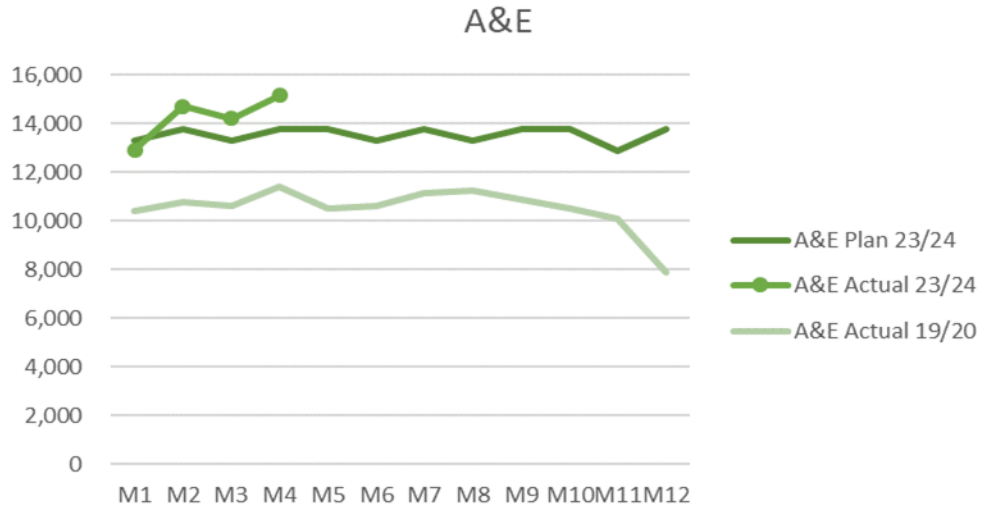
Note: The March 2023 figures include additional funding from NHSE/I for the non-consolidated pay award (£21.1m), the impact of R&D consortium arrangements accounted for in M12 (£13.6m), apprenticeship funding (£2.4m) and national PPE funding (£2.2m). All of which included matched expenditure in M12.

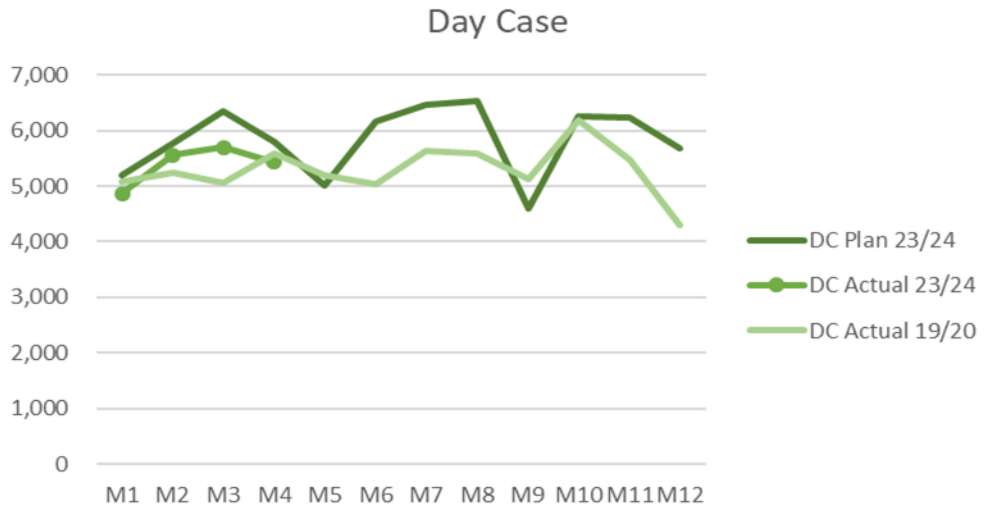
Key messages:

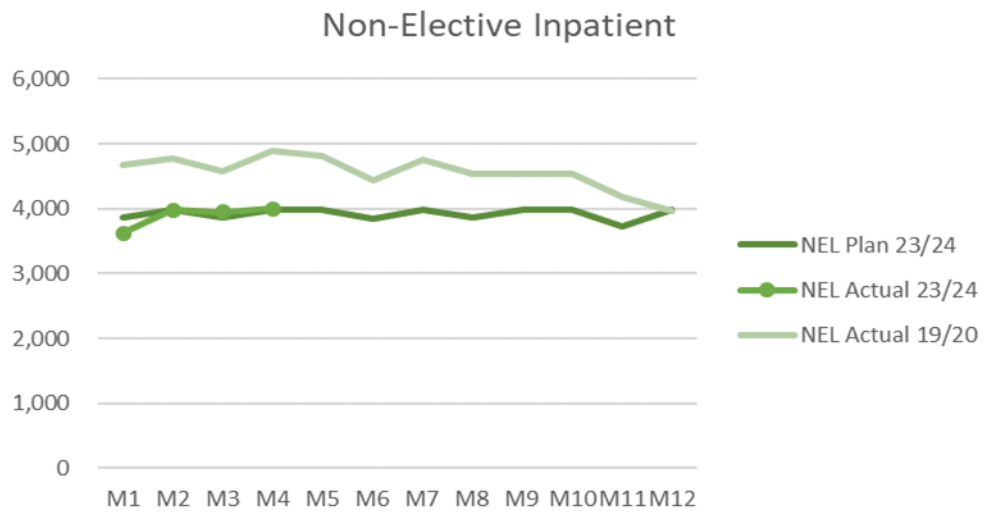
- The Trust income position is adverse to plan by £1.1m year to date.
- This is driven by a shortfall in Clinical income of £5.5m. EPM is performing £2.0m ahead of target year to date and £3.8m below plan. High-cost drugs income from commissioners (pass-through drugs and devices) reports a £4.3m favourable variance to plan, however, Cancer Drugs and Car-T are £1.7m below plan.
- Devolved income is favourable year to date by £4.4m - this includes favourable variances for fire safety works (£2.2m), Community Diagnostic Centre (£1.1m) and an adverse variance for R&D income (£1.0m) - these variances are fully offset within non-pay expenditure. There are £2.1m of favourable variances across a range of income generating/recharging activities.
- The reported income position includes the planned recognition of £5.0m of non-recurrent income support.

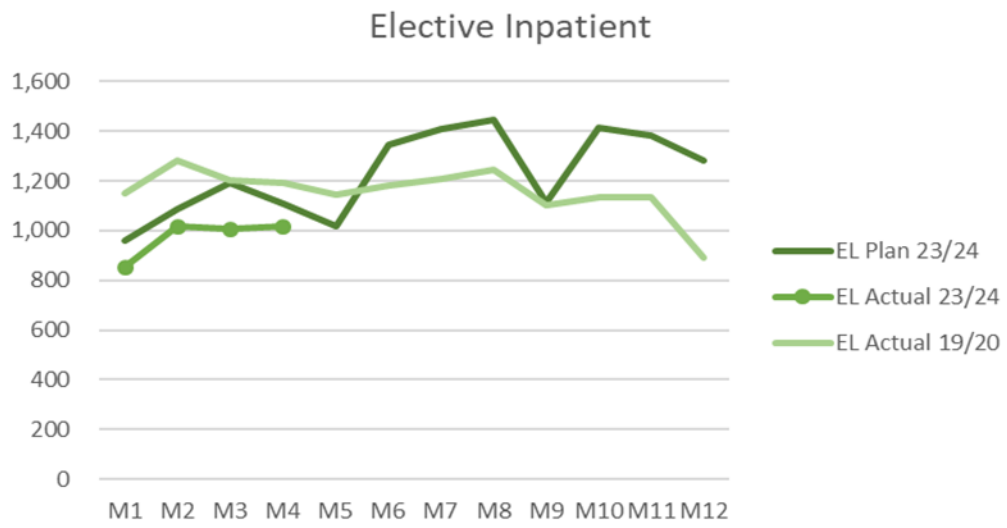
Clinical and other income

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



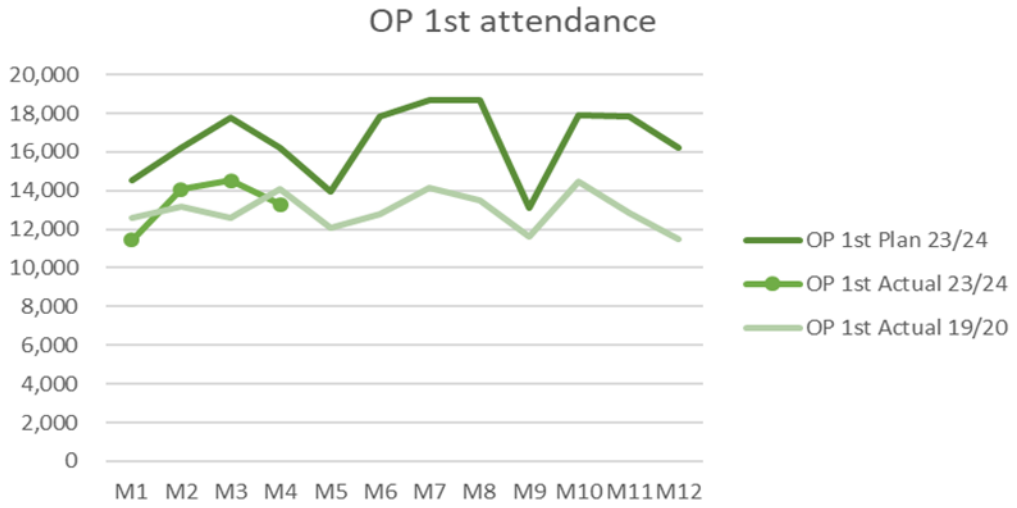


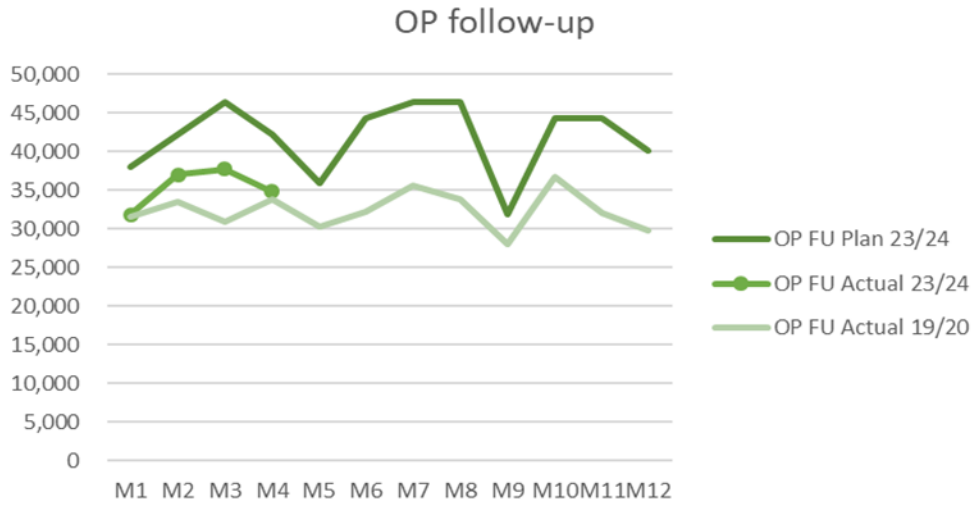


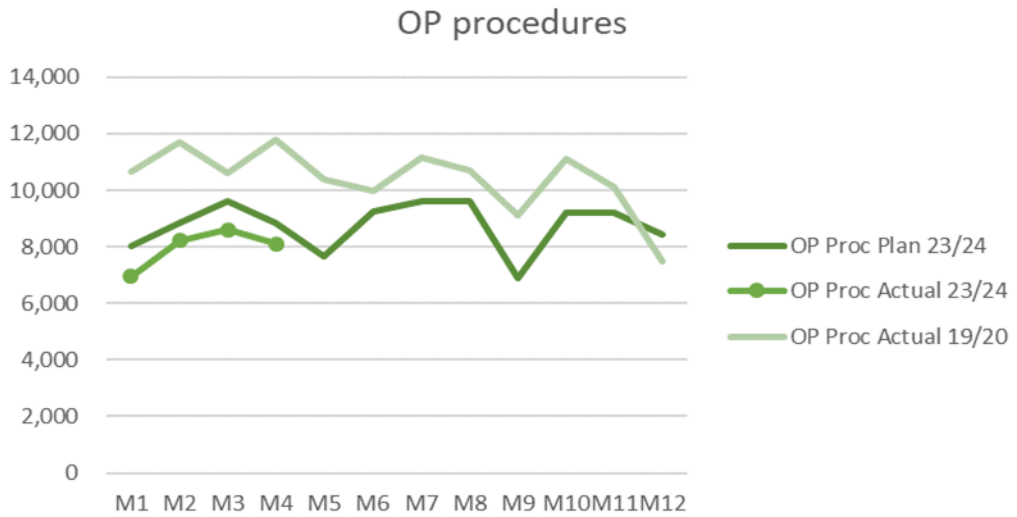


Clinical and other income (continued)

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







Key messages:

- A&E attendances continue to perform above both plan and 19/20 levels at month 4. Year to date, A&E reports 5% above plan, and 10% in month.
- Non elective spells report in line with plan at month 4 and year to date.
- The plan for Elective spells is phased with a higher weighting towards the latter part of the financial year. Despite this, year to date EL reports 10% below plan, largely driven by the effect of industrial action.
- Day cases performed below plan at month 4. Year to date, DC is 7% below plan, and in month 6% below plan, driven by industrial action.
- Outpatient first attendances continued to perform below both plan and 19/20 activity levels at month 4. Year to date, OP 1st reports at 18% below plan, consistent with in month values.
- Outpatient follow-up attendances performed below plan at month 4. Year to date, OP FUP is 16% below plan. OP FUPs are no longer part of the Elective element.
- Outpatient procedures performed below plan and 19/20 levels at month 4. Year to date, OP proc report at 10% below plan.

Clinical and other income (continued)

Clinical Income – Elective Payment Mechanism (EPM) 1

NHS CUH

EPM:
At month 4 YTD actual performance, based on the previously used methodology, for the **EPM is £1.1m below target which falls £6.9m below plan**.

Commissioner	Month 04 23/24						YTD 23/24					
	Target £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Target £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
NHSE	7.1	7.1	0.0	7.7	7.1	(0.6)	28.5	26.8	(1.6)	30.9	26.8	(4.1)
C&P ICB	5.9	6.3	0.4	6.4	6.3	(0.1)	23.6	25.6	2.0	25.7	25.6	(0.0)
Associate ICBs	3.6	3.2	(0.4)	3.9	3.2	(0.7)	14.5	12.9	(1.5)	15.7	12.9	(2.8)
Total	**16.6**	**16.6**	**(0.0)**	**18.1**	**16.6**	**(1.5)**	**66.5**	**65.4**	**(1.1)**	**72.3**	**65.4**	**(6.9)**

EPM – Updated National Approach:
Post finalising Month 04 detailed methodology for costing ERF as well as refreshed targets and actual performance data for month 1 &2 have ben released by NHSE.
The detailed methodology for costing is different from the initial approach taken.
We have updated the targets and actuals based on this new methodology and will be using that going forwards.

The below table shows the impact of this new methodology, with months 3 & 4 forecasted internally. **EPM is £2.5m below target which falls £8.5m below plan.**

Commissioner	Month 04 23/24						YTD 23/24					
	Target £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Target £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
NHSE	7.2	7.3	0.1	7.9	7.3	(0.6)	29.3	27.4	(1.9)	31.8	27.4	(4.5)
C&P ICB	6.9	7.0	0.1	7.5	7.0	(0.5)	28.2	27.8	(0.4)	30.3	27.8	(2.4)
Associate ICBs	3.9	4.0	0.1	4.3	4.0	(0.3)	16.0	15.7	(0.3)	17.3	15.7	(1.6)
Total	**18.1**	**18.3**	**0.2**	**19.8**	**18.3**	**(1.5)**	**73.4**	**70.9**	**(2.5)**	**79.4**	**70.9**	**(8.5)**

Clinical Income – Elective Payment Mechanism (EPM) 2

NHS CUH

EPM:
The Trust is accruing income above actual EPM performance for Month 4 YTD in recognition of **previous** national guidance to support Trusts impacted by IA.
Accrual to plan: As per guidance provided by the regional finance team **for month 4**, individual ICB under performance is being accrued to plan – totalling £3.1m.
Over performance: Individual Commissioner over performance has been retained in the month 4 YTD position – totalling £2.0m.
TOTAL EPM: The Trusts recognised **EPM at Month 4 is therefore £2.0m above target, due to adjustments but £3.8m below plan.**

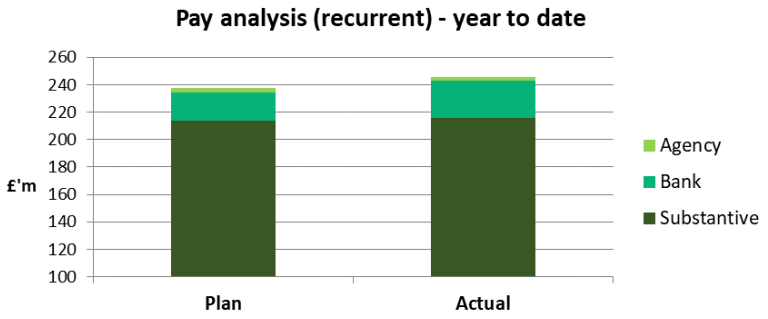
Commissioner	Month 04 23/24						YTD 23/24					
	Target £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Target £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
NHSE	7.1	7.1	0.0	7.7	7.1	(0.6)	28.5	28.5	0.0	30.9	28.5	(2.5)
C&P ICB	5.9	6.3	0.4	6.4	6.3	(0.1)	23.6	25.6	2.0	25.7	25.6	(0.0)
Associate ICBs	3.6	3.6	0.0	3.9	3.6	(0.3)	14.5	14.5	0.0	15.7	14.5	(1.3)
Total	**16.6**	**17.0**	**0.4**	**18.1**	**17.0**	**(1.1)**	**66.5**	**68.6**	**2.0**	**72.3**	**68.6**	**(3.8)**

EPM – National Approach:
NHSE have now published a draft approach to supporting Trusts for the impact of IA. This includes an in month target reduction for April and expected further reductions for other IA months, that flow through to year end. This totals £2.9m YTD and is forecast at £10.8m for the full year.
TOTAL EPM: The Trusts forecast **EPM under this methodology would be £0.4m above target at Month 04 and £8.5m below plan.**

Commissioner	Month 04 23/24						YTD 23/24					
	Target £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Target £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
NHSE	6.5	7.3	0.9	7.9	7.3	(0.6)	28.2	27.4	(0.9)	31.8	27.4	(4.5)
C&P ICB	6.1	7.0	0.9	7.5	7.0	(0.5)	27.0	27.8	0.8	30.3	27.8	(2.4)
Associate ICBs	4.6	4.0	(0.6)	4.3	4.0	(0.3)	15.3	15.7	0.4	17.3	15.7	(1.6)
Total	**17.2**	**18.3**	**1.2**	**19.8**	**18.3**	**(1.5)**	**70.5**	**70.9**	**0.4**	**79.4**	**70.9**	**(8.5)**

Key messages:

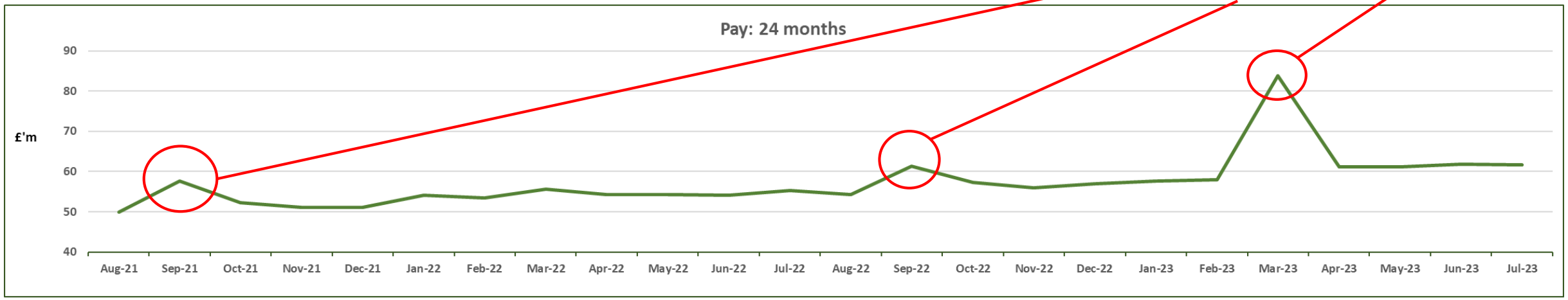
- The Trust has an adverse pay position of £8.6m in the year to date. The adverse impact of industrial action has been estimated at £4.1m year to date. A further £0.7m of enhanced costs driven by the number of bank holidays in April and May not reflected in the budget phasing. The current operating environment including high-levels of vacancies and sickness means that there is pressure on both the volume and cost of temporary staffing measures.
- Bank spend as a proportion of the year to date pay bill is 10.9% while agency spend for the same time period is 1.3%. This compared to 8.7% for bank and 1.2% for agency in 22/23. The main driver for the bank spend is the increasing adverse impact of the Industrial Action and the additional shifts required to cover sickness and other vacancies.
- The position includes vacancy factors and pay efficiency targets of £13.7m year to date.
- The reported position recognises the Agenda for Change (AfC) pay settlement of 5% which was paid in the June payroll. The Trust continues to accrue pay awards at 2.1% for other staff groups awaiting national agreements. In line with previous pay settlements the Trust would expect to receive additional income to cover costs in excess of the 2.1% that is currently funded.



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

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

Note: The Mar-23 figure includes non-consolidated pay award (£21.1m).



Note: For comparability purposes the chart reports average values for months 1 & 2, in line with external reporting requirements month 1 values are not reported in isolation. Additionally, central NHS pension contributions are excluded from March '22 and March '23 totals.

Pay expenditure – trend and year to date

Pay - Staff group

£ Millions	In Month Budget	In Month Actual	In Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance
Administrative & Clerical	10.4	10.9	(0.5)	40.9	43.5	(2.6)
Allied Healthcare Professionals	3.4	3.8	(0.4)	13.6	14.8	(1.2)
Clinical Scientists & Technicians	5.7	5.6	0.1	22.6	22.2	0.4
Medical and Dental	18.7	19.7	(1.0)	74.7	79.2	(4.4)
Nursing	21.5	21.7	(0.1)	85.5	86.3	(0.8)
Total Pay Cost	**59.7**	**61.7**	**(2.0)**	**237.3**	**245.9**	**(8.6)**

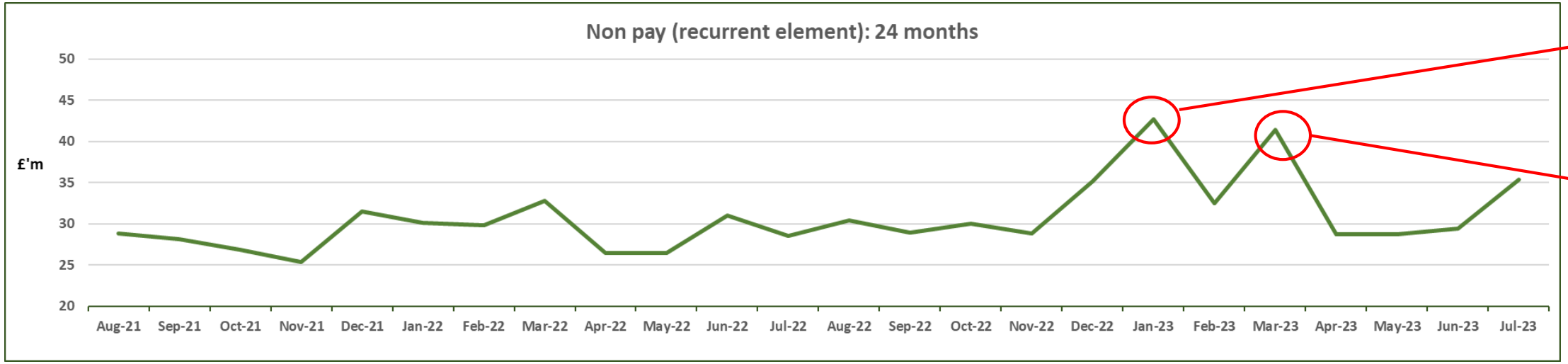
Pay - Employee type

£ Millions	In Month Budget	In Month Actual	In Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance
Agency	0.7	1.1	(0.4)	2.8	3.3	(0.5)
Bank	5.2	7.2	(2.0)	20.7	26.7	(6.1)
Contracted	0.4	0.5	(0.2)	1.4	1.8	(0.5)
Substantive	53.5	52.9	0.6	212.4	214.0	(1.6)
Total Pay Cost	**59.7**	**61.7**	**(2.0)**	**237.3**	**245.9**	**(8.6)**

Key messages:

- Pay expenditure has an adverse variance of £8.6m. Direct cost pressures resulting from industrial action in the year to date total £4.1m. This was mainly incurred within the Medical and Dental category.
- The pay budget was not phased to reflect the five bank holidays in April and May meaning the net enhanced pay costs were not funded in the reported periods (£0.7m adverse variance at Month 4). The impact of this phasing issue will unwind over the future months.
- The Trust is working with ICS partners to highlight the need for financial support to cover the adverse financial impact of the industrial action.
- The Month 4 position includes year to date vacancy factors of £12.5m and unallocated efficiency targets of £1.2m.
- The industrial action has adversely affected the Trust's ability to fully deliver the efficiency savings that were planned for the year to date so these schemes are £4.5m adverse to plan at Month 4.
- Agency spend year to date represents 1.3% of Trust wide pay expenditure. This is broadly in line with performance in 22/23.
- Non-recurrent pay costs of £4.8m are included in the year to date position. As noted above these costs relate to the premium costs of the industrial action and phasing impact of bank holidays year to date.

Pay expenditure (continued)



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

Note: M10 increase driven by £10.1m technical adjustment to a key IT contract

Note: The following non-recurrent / pass-through items have led to the March 2023 increase; R&D consortium grossing up and pass-through expenditure (£29.8m), National PPE (£2.2m) and Notional apprenticeship fund (£2.4m)

Key messages:

- At the end of month 4, the Trust's non pay position is £4.6m favourable to plan however expenditure was adverse to plan by £4.3m in month.
- The in month variance was driven fire safety works (£3.6m) and Community Diagnostic Centre (CDC) costs (£1.1m). These variances are fully offset by increased devolved income.
- Favourable year to date variances total £7.0m within supplies and services and premises driven by lower than planned clinical activity and delays in inflationary pressures materialising. The Trust has realised a benefit of £1.2m due to a reduction in movement in credit loss on receivables and a £1m Clinical negligence rebate relating to the 22/23 Maternity incentive scheme .
- Overall drugs expenditure reports £4.5m adverse to plan. Within this Cancer Drugs and Car-T are £3.3m lower than planned with other pass-through drugs fully offsetting this variance to report an overspend. The Trust expects to receive additional funding to cover the additional pass-through expenditure.
- Costs historically fluctuate from month to month so this area of expenditure will be kept under review to establish whether the current cost pressure is sustained in future months.
- The position at month 4 includes £1.2m of non-recurrent benefits arising from the reduction in credit loss on receivables.

Non pay expenditure

£millions	In Month			Year to Date		
	Budget	**Actual**	**Variance**	**Budget**	**Actual**	**Variance**
Supplies and services	19.1	22.5	(3.4)	76.2	71.1	5.1
Drugs	15.9	18.0	(2.1)	63.7	68.2	(4.5)
Premises	8.0	7.4	0.6	31.7	29.8	1.9
Movement in credit loss on receivables	(0.4)	(0.1)	(0.3)	(1.7)	(1.2)	(0.5)
Clinical negligence	2.3	1.2	1.0	9.1	8.1	1.0
Efficiency savings	(0.2)	0.0	(0.2)	(0.6)	0.0	(0.6)
All other non pay	4.4	4.4	(0.0)	16.7	14.6	2.1
Total Non Pay	**49.0**	**53.4**	**(4.3)**	**195.1**	**190.5**	**4.6**

Key messages:

- The non pay position shows a £4.6m favourable year to date variance at M4. The key drivers for this position are described on the previous page.
- The negative budget for movement in credit loss on receivables (bad debt provisions) relates to a planned improvement in the level of aged debt (£1.7m) offset by the increase in Injury Cost Recovery provision. It is expected that the Trust will deliver the planned position at year-end.
- The position at M4 includes £1.2m net non-recurrent benefits from 'Movement in credit loss on receivables'.

Non pay expenditure (continued)

£m	YTD Plan Recurrent	YTD Plan Non-recurrent	YTD Plan Total	YTD Actual Delivery Recurrent	YTD Actual Delivery Non-recurrent	YTD Actual Delivery Total	YTD Variance Recurrent	YTD Variance Non-recurrent	YTD Variance Total
Pay	11.9	0.0	11.9	7.3	0.1	7.4	(4.6)	0.1	(4.5)
Non-pay	4.8	0.3	5.1	5.8	0.0	5.8	1.0	(0.3)	0.7
Income	0.1	0.0	0.1	1.4	0.0	1.5	1.4	0.0	1.4
	16.7	**0.4**	**17.1**	**14.5**	**0.2**	**14.7**	**(2.2)**	**(0.2)**	**(2.4)**

£m	Full Year Plan Recurrent	Full Year Plan Non-recurrent	Full Year Plan Total	Forecast Full Year Delivery Recurrent	Forecast Full Year Delivery Non-recurrent	Forecast Full Year Delivery Total	Variance Recurrent	Variance Non-recurrent	Variance Total
Pay	34.5	0.0	34.5	26.9	2.0	28.9	(7.6)	2.0	(5.6)
Non-pay	17.4	1.0	18.4	20.0	0.0	20.0	2.6	(1.0)	1.7
Income	0.2	0.1	0.2	4.1	0.2	4.2	3.9	0.1	4.0
	52.0	**1.1**	**53.1**	**51.0**	**2.1**	**53.1**	**(1.0)**	**1.0**	**0.0**

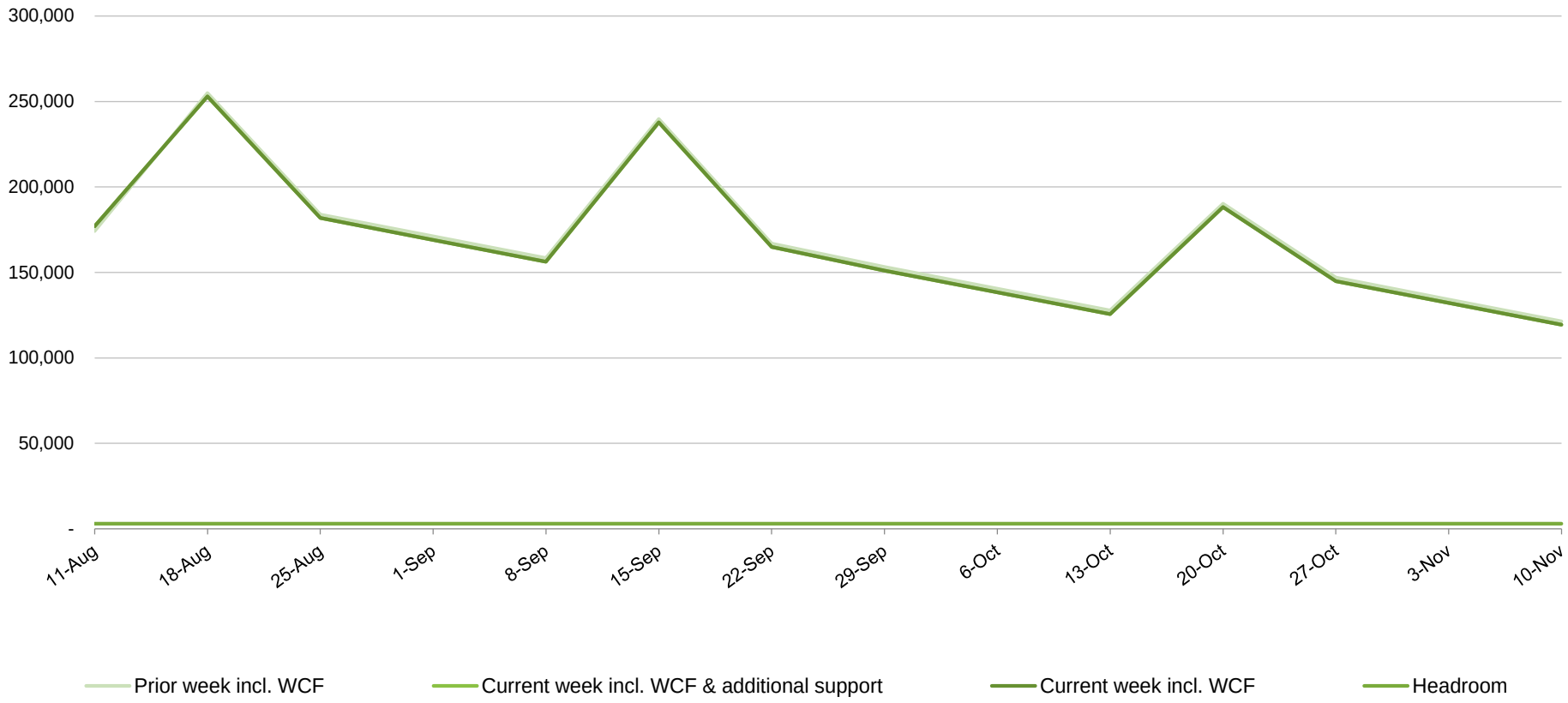
Key messages:

- Please see the appendix for the detailed efficiency plan.
- The Trust has identified £55m efficiencies against a target of 53.1m, forecasting £53.1m delivery. Of this, £51.0m is recurrent, representing 96% of the total plan.
- The overall position at M4 shows and adverse position of £2.4m.
- The position shows pay efficiencies are currently behind plan by £4.5m with non-pay efficiencies favourable to the plan by £0.7m and Income efficiencies £1.4m ahead of plan.
- The impact of ongoing Industrial Action means that planned productivity improvements driven by increased activity have not been achieved. Additionally the Trust has needed to pay premium rates to cover staffing gaps.
- The Trust will continue to develop plans across 23/24 with the aim to increase productivity and deliver the planned cost efficiency schemes.

£'m	M2 YTD		M3		M4		M5		M6		M7		M8		M9		M10		M11		M12		YTD		Forecast	
	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual
Total Pay Efficiencies	5.9	3.6	3.1	2.0	2.9	1.8	2.7	0.0	2.9	0.0	2.9	0.0	2.9	0.0	2.7	0.0	2.9	0.0	3.3	0.0	2.2	0.0	11.9	7.4	34.5	28.9
Total Non-pay Efficiencies	2.5	3.0	1.3	1.2	1.3	1.6	1.3	0.0	1.4	0.0	1.3	0.0	1.3	0.0	1.3	0.0	1.3	0.0	1.3	0.0	3.9	0.0	5.1	5.8	18.4	20.0
Total Income Efficiencies	0.0	0.6	0.0	0.6	0.0	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	1.5	0.2	4.2
Total Efficiencies - 2023/24	**8.4**	**7.1**	**4.4**	**3.9**	**4.2**	**3.7**	**4.0**	**0.0**	**4.3**	**0.0**	**4.2**	**0.0**	**4.3**	**0.0**	**4.0**	**0.0**	**4.2**	**0.0**	**4.7**	**0.0**	**6.2**	**0.0**	**17.1**	**14.7**	**53.1**	**53.1**

Efficiency Plan & Delivery

CUH 13 week rolling cash flow forecast (£000)



Key messages:

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

Appendices

Month 4 capital expenditure position

	Year to Date (Month 4)			Forecast		
	Budget £m	Actuals £m	Variance £m	Budget £m	Expenditure £m	Variance £m
Programme						
Cambridge Movement Surgical Hub (CMSH)	2.7	3.9	(1.2)	7.0	7.0	-
Existing Estate/HV	0.9	2.5	(1.7)	12.6	12.3	0.2
Cancer Research Hospital (CCRH)	1.5	0.5	1.0	11.3	11.3	-
Thrombectomy	0.6	0.6	-	0.6	0.6	-
Medical Equipment Replacement	0.2	0.8	(0.6)	13.2	13.2	-
Children's Hospital (CCH)	0.6	1.4	(0.8)	3.5	3.5	-
Nuclear Medicine	0.2	0.3	(0.1)	0.2	0.3	(0.1)
Community Diagnostic Hub/Centre (CDC)	0.5	0.0	0.5	0.8	0.8	-
eHospital/Legacy IT Systems	0.2	0.1	0.2	1.2	1.2	-
Other Developments/PFI	1.9	3.8	(1.9)	10.3	10.4	(0.1)
Programme Total	**9.3**	**13.9**	**(4.6)**	**60.7**	**60.7**	**-**

Key Issues/Notes Year to Date

£13.9m has been invested YTD, compared to a budget of £9.3m; an overspend of £4.6m. This overspend is primarily due to the purchase of the surgical robot (£2.0m) earlier in the year than budgeted, along with other projects progressing ahead of budget, all of which are just timing issues. For context, during the first third of the year we have only spent 23% of the annual budget.

The larger areas of spend this year have been:

- Cambridge Movement Surgical Hub (CMSH) - £3.9m
- ACT funded second surgical robot (caegorised above under 'Other Developements/PFI') - £2.0m
- Cambridge Children's Hospital (CCH) - £1.4m
- Replacement Surgical Skills Centre (categorised above under 'Existing Estate') - £0.9m
- High Voltage (HV) network improvements - £0.8m
- Replacement & Installation of Medical Equipment - £0.8m
- Thrombectomy - £0.6m
- Cambridge Cancer Research Hospital (CCRH) - £0.5m
- Nuclear Medicine refurbishment - £0.3m

Key Issues/Notes Forecast

This year has already seen the opening of the new Thrombectomy suite. Later in the year our capital programme will deliver the CMSH (3 theatres & 2 wards), 2 U wards, Nuclear Medicine refurbishment, CDC and an additional surgical robot. Additionally there will be the replacement of 2 linear accelerators, an MRI, the Cath Lab, 2 x-ray rooms and a surgical robot. We will also progress other larger projects, notably CCRH and CCH, as well as the reopening of 3 theatres in the A block.

The full-year forecast continues to align with the annual budget.

Capital expenditure by programme

Balance sheet

	M4 Actual £m
Non-current assets	
Intangible assets	19.8
Property, plant and equipment	542.8
Total non-current assets	**562.6**
Current assets	
Inventories	13.4
Trade and other receivables	34.1
Cash and cash equivalents	195.6
Total current assets	**243.1**
Current liabilities	
Trade and other payables	(205.1)
Borrowings	(26.3)
Provisions	(13.2)
Other liabilities	(84.4)
Total current liabilities	**(329.0)**
Total assets less current liabilities	**476.7**
Non-current liabilities	
Borrowings	(110.2)
Provisions	(9.5)
Total non-current liabilities	**(119.7)**
Total assets employed	**357.0**
Taxpayers' equity	
Public dividend capital	616.0
Revaluation reserve	47.0
Income and expenditure reserve	(306.0)
Total taxpayers' and others' equity	**357.0**

Balance sheet commentary at month 4

- The balance sheet shows total assets employed of £357.0m.
- Non-current liabilities at month 4 are £119.7m, of which £110.2m represents capital borrowing (including PFI and IFRS 16).
- Cash balances remain strong at month 4.
- The balance sheet includes £16.5m of resource to support the completion of the remedial fire safety works expected to be deployed over the coming years.

Trust balance sheet

Board of Directors

NHS
Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 13 September 2023

Agenda item	11
Title	Patient Safety Incident Response Framework (PSIRF)
Sponsoring executive director	Lorraine Szeremeta, Chief Nurse
Author(s)	Dr Oyejumoke Okubadejo, Director of Clinical Quality Jane Nicholson, Deputy Director of Clinical Quality
Purpose	To approve the PSIRF Policy and associated Plan.
Previously considered by	Quality Committee, 6 September 2013

Executive Summary

The NHS Patient Safety Strategy, published in 2019 (updated in February 2021), outlines changes to the NHS approach to safety. A key element of this strategy is the Patient Safety Incident Response Framework (PSIRF), released in August 2022. This new framework replaces the current Serious Incident Framework (SIF). NHS trusts are required to have a clear plan of transition by autumn 2023; of which a key milestone is to have our Trust PSIRF Policy and Plan approved within this timeframe.

Related Trust objectives	Improving patient care
Risk and Assurance	The paper provides assurance on the arrangements in place for CUH to implement the national Patient Safety Incident Response Framework.
Related Assurance Framework Entries	BAF risk: 004
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of “Together: safe, kind and excellent”?	n/a

Action required by the Board of Directors

The Board is asked to approve the CUH PSIRF Policy and Plan.

Cambridge University Hospitals NHS Foundation Trust

13 September 2023

Board of Directors
PSIRF Policy and Plan
Dr Oyejumoke Okubadejo, Director of Clinical Quality and Jane Nicholson, Deputy Director of Clinical Quality

1. Introduction

1.1 The NHS Patient Safety Strategy, published in 2019 and subsequently updated in February 2021, outlines key changes to the NHS approach to safety.

1.2 The Patient Safety Incident Response Framework (PSIRF) is an important part of the national Patient Safety Strategy. The PSIRF was released in August 2022 with the purpose of replacing the Serious Incident Framework (SIF 2015).

1.3 The transition from SIF to PSIRF has required organisations to commence the process from September 2022 onwards with the aim of completing transition in autumn 2023. Organisations are required to develop and publish their own PSIRF Policy and Plan setting out how the PSIRF will be applied in the organisation.

2. CUH PSIRF Policy and Plan

2.1 The CUH PSIRF Policy and Plan are based on our 12 months of preparation work and are in line with the requirements set out in the national PSIRF implementation guidance. Oversight has been provided via a Trust PSRIF Implementation Group.

2.2 The developing Policy and Plan have been shared with the Quality team at the Cambridgeshire and Peterborough Integrated Care Board (ICB) as part of the collaborative working during the preparation phases; feedback has been incorporated into our final drafts.

2.3 The Policy and Plan have been reviewed by the Management Executive and by the Quality Committee and formal approval is required by the CUH Board of Directors prior to submission to our ICB – the latter's sign off is a requirement of their oversight role to support our transition from SIF to PSIRF.

2.4 Our PSIRF Policy and Plan propose a date of January 2024 for our transition to PSIRF. Further preparation is required in terms of training staff and devising further guidance and toolkits. The PSIRF training programme has been led by our ICB and does not start until October 2023. The corporate Patient Safety team has been prioritised for training in cohort 1 to expedite the remaining preparation required for transition.

3. Next steps

3.1. Continue to progress PSIRF implementation plans and development work via key patient safety working groups. This ongoing work is detailed in our current PSIRF implementation and improvement plan and implementation group.

3.2. Continue to support the implementation preparation via the PSIRF training programmes and communication plan.

4. Recommendations

4.1 The Board of Directors is asked to approve the CUH PSIRF Policy and Plan.

5. Appendices

Appendix 1: CUH PSIRF Policy
Appendix 2: CUH PSIRF Plan

Cambridge University Hospitals NHS Foundation Trust

Patient safety incident response policy

Effective date: 01 January 2024

Estimated refresh date: July 2025

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External Authorise	Cambridge and Peterborough Integrated Care Board		

Contents

1. Purpose

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how Cambridge University Hospital NHS Foundation Trust will approach the development and maintenance of effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The national PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

Previous national frameworks have described when and how to investigate a serious incident, PSIRF focuses on embedding continuous and sustainable learning and improvement.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF, which we can also align to our existing Trust values of *Together; Safe, Kind and Excellent*:

- compassionate engagement and involvement of those affected by patient safety incidents (kind)
- application of a range of system-based approaches to learning from patient safety incidents (safe)
- considered and proportionate responses to patient safety incidents and safety issues (safe, kind, excellent)
- supportive oversight focused on strengthening response system functioning and improvement (kind and excellent)

This policy should be read in conjunction with our current patient safety incident response plan, which is a separate document setting out how this policy will be implemented. [insert hyperlink]

2. Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across our Trust.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident. There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement.

The principal aims of other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, where determination of liability or cause of death may sit within their remit, differ from a patient safety response and are therefore outside of the scope of this policy.

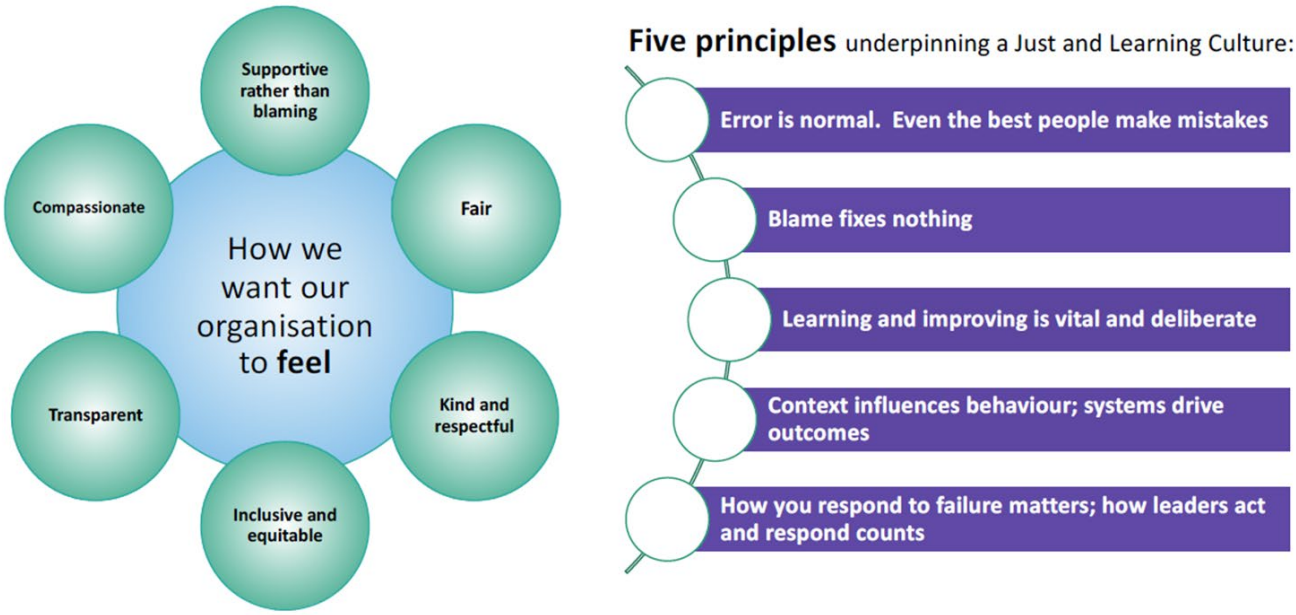
Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

3. Our patient safety culture

Our Trust is committed to the principles of the NHS Just culture guide to ensure the fair, open, and transparent treatment of staff who are involved in patient safety incidents. Our Trust recognises the significant impact being involved in a patient safety incident can have on staff and the value of ensuring we have a restorative culture.

We are committed to continue building on our strong foundations of the just culture principles already embedded in our review of patient safety incidents. Our Trust launched in 2023 a Just and Learning Culture manifesto that is underpinned by five guiding principles (see figure 1) and an improvement programme of work.

Figure 1. CUH vision and Just and learning culture manifesto principles



A just culture is based on the principles of systems thinking. In order to strengthen our systems approach to investigation of patient safety incidents, we will be moving to a new methodology called Systems Engineering Initiative for Patient Safety (SEIPS).

Our collaborative improvement work across our patient safety strategy and just culture will focus on:

- PSIRF requirement to support all those affected by a patient safety incident – staff, patients, families, and carers.

- Strengthen our culture of open and transparent reporting of patient safety events.
- Capture valid information that reflects our safety culture (both qualitative and quantitative), reflecting the experiences of our staff, patients, families, and carers.
- Will align to the national guidance for improving patient safety culture (2023).

4. Patient safety partners

The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England. The role is part of the national patient safety strategy's framework for involving patients in patient safety improvement.

The PSP role is designed to help NHS organisations ensure that patients, carers, or other lay people support and contribute to governance and management processes for patient safety. The role can include:

- membership of safety and quality committees whose responsibilities include the review and analysis of safety data
- involvement in patient safety improvement projects
- working with organisation boards to consider how to improve safety
- involvement in staff patient safety training
- participation in investigation oversight groups.

This new role both across the NHS and within our Trust will evolve over time. The main purpose of the role is to be a voice for the patients and community who utilise our services and ensure that patient safety is at the forefront of all that we do. Our PSPs will work across our ICS in collaboration with the PSP community of practice, to support cross-system learning and also support for the role.

The PSPs will be supported within our Trust by a named Patient Safety Specialist. The PSPs will undertake training aligned to national standards for the role, as well as other relevant training based on the experience and knowledge of each individual PSP.

5. Addressing health inequalities

Our Trust recognises that the NHS has a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

The principles of just culture and a systems based approach to investigation (such as SEIPS) are designed to consider inequalities when both learning and improving following a patient safety incident.

Our current focus and our PSIRF improvement plan address the principles and standards described in the PSIRF national guidance for Engaging and involving patents, families, and staff following a patient safety incident. Engagement with those affected by a patient safety incident and their involvement in patient safety incident investigations must take account of individual needs. Wherever possible our Trust will ensure:

- Patient safety partners will be involved in co-producing the design, delivery, and review of the processes outlined in the PSRIF guidance
- The diversity of the patient partners involved in any planning will be considered to ensure they reflect the population the organisation serves
- Barriers to effective communication will be identified as soon as possible and reasonable adjustments made. This includes easy access to language services and access to information.

We will also ensure that our patient safety learning response toolkit prompts considerations of inequalities to assist identification of any aspects of health inequalities that may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics. When constructing our safety actions in response to any incident we will consider inequalities.

Our patient safety education strategy will ensure programmes are designed to raise awareness of Equality Diversity and Inclusion.

We will use and evolve our data insight systems and processes to identify any disproportionate patient safety risk to patients from across the range of protected characteristics.

Our PSIRF policy and plan will align with and be informed by recommendations from our Trust strategic review of Equality Diversity and Inclusion, currently taking place in 2023

6. Engaging and involving patients, families and staff following a patient safety incident

Our Trust recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. PSIRF supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

We recognise and acknowledge the significant impact patient safety incidents can have on patients, their families, carers, and our staff. As part of our current PSIRF improvement plan, an Engagement and Involvement group has been formed to develop further the foundations of our systems that support compassionate engagement and involvement of those affected (patients, families, and staff), in line with national PSIRF standards.

Patients, families, and carers

Our patient safety investigators will engage and support patients, families, and carers throughout the process of a PSII. Where patients and families wish to be involved in the investigation process our investigators will ensure their needs are met and contributions valued; including contributing to the PSII terms of reference. All patients and families will be asked what level of involvement they would like.

Our divisional leadership teams will support patient and family engagement and involvement across all patient safety learning responses and will continue as they do now, to ensure Being Open and Duty of Candour standards are met.

To support compassionate engagement with patients, families and carers our divisional leadership teams will utilise as appropriate, additional resources within our Trust, e.g. Bereavement team, Chaplaincy, department specific clinical psychologists, Patient Advice and Liaison Service (PALS).

Patients and families will be offered a meeting with the appropriate divisional leaders to discuss learning response findings and actions planned to improve the service, as required. Where a PSII was undertaken the patient safety investigator may also attend the meeting.

Staff with engagement responsibilities will undergo PSIRF engagement and involvement training; this will be a part of our sustainable patient safety education strategy.

For staff

Our Trust is committed to the principles of Just Culture in response to a patient safety incident. Our Just Culture improvement work will strengthen our infrastructure and resources that ensure our workforce are supported by a restorative culture. This ongoing work will ensure our leaders, workforce teams, policies and procedures are aligned in terms of the just culture values.

The role and responsibilities of a leader in our Trust will be supported by a sustainable just culture education programme.

7. Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

Our Trust will take a considered and proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement. To help us get this balance right, between learning and improvement efforts, our PSIRF

Plan is based on our patient safety risk profile and knowledge of our local ongoing improvement work

7.1 Resources and training to support patient safety incident response

Our Trust has committed to ensuring that we fully embed PSIRF and meet its requirements. We have therefore used the NHS England PSIRF standards (2022) to frame the resources and training required to allow for this to happen.

Our Trust will utilise both internal and (if required) external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response process to provide required expertise and advice.

Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given time to participate in learning responses.

All Trust managers will work within our just and restorative culture principles and work within this framework to ensure psychological safety.

PSII

Patient safety incident investigations (PSIIs) will be led by our corporate team of patient safety investigations and supported by the wider corporate patient safety team, divisions, and subject matter experts. The staff we have identified to lead on PSIIs are trained in compliance with the national training requirements and have the capacity in their work plan to lead PSIIs.

Other learning responses

- Other learning responses will be led by staff trained in the required learning response tool e.g. After Action Review. They will also be compliant with national patient safety training requirements i.e. Levels 1 and 2, engagement and involvement.
- Learning responses will not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff.
- A learning response lead will be nominated by the Division and the individual should have an appropriate level of seniority and influence within our Trust – this

may depend on the nature and complexity of the incident and response required, but learning responses are led by staff at band 8a and above.

- The corporate patient safety team will support learning responses wherever possible and can provide advice on cross-system and cross-divisional working where this is required.
- Governance arrangements will be in place to ensure that learning responses are not undertaken by staff working in isolation.

Training

Our Trust has implemented a patient safety training package to ensure that all staff are aware of their responsibilities in reporting and responding to patient safety incidents and to comply with the NHS England Health Education England Patient Safety Training Syllabus. The Level 1 and 2 modules are accessed via our Trust online training system (DOT).

Our initial training programme to support the transition to PSIRF (PSII, Oversight, Engagement and Involvement) has been provided by an accredited external provider, in collaboration with our ICB.

Our Trust has formed a Patient safety education strategy group to devise our patient safety education programmes going forward. This will ensure we have a sustainable and resourced plan to develop our patient safety expertise within our organisation.

The required competencies are those outlined in the national Patient Safety incident response standards.

7.2 Our patient safety incident response plan

Our PSIRF Plan details how our Trust intends to respond to patient safety incidents over a period of 18 months. It is informed by our patient safety risk profile and stakeholder engagement.

The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred, the needs of those affected, and emerging risks.

7.3 Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

Prior to each formal PSIRF policy review, a rigorous planning exercise will be undertaken every three years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, a wide review of organisational data e.g. PSII reports, improvement plans, staff and patient experience, inequalities data, incident reporting data, and stakeholder engagement

As our current PSIRF policy is new, it will be reviewed in 18 months' time (in collaboration with Cambridge and Peterborough Integrated Care Board), with a formal review at two years. Our first PSIRF Plan will be reviewed and updated at 15 months to bring us into a 12 month annual review cycle each March.

Both documents will be published on our external website.

8. Responding to patient safety incidents

8.1 Patient safety incident reporting arrangements

All our staff are responsible for reporting any potential or actual patient safety incidents on RLDatix (our electronic incident reporting system). RLDatix is configured to the national reporting database, Learning from Patient Safety Events (LFPSE).

The corporate patient safety team will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for our Trust.

Divisions will have daily review mechanisms in place to ensure that patient safety incidents can be responded to proportionately and in a timely fashion. This should include consideration and prompting to service teams where Duty of Candour applies.

8.2. Patient safety incident response decision-making

Outside of the nationally mandated requirement for PSIIs, PSIRF itself sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement.

Our Trust has developed its own response mechanisms to balance the effort between learning through responding to incidents and improvement work. In the work to create our plan we have analysed our patient safety risk data and via engagement with key internal and external stakeholders have built our patient safety risk profile. We have used this intelligence to agree our local priorities for a learning response, including, PSII and our process for responding to other patient safety incidents.

Triage

Divisions and the corporate patient safety team will be responsible for reviewing and responding to all patient safety incidents in line with our PSIRF policy and plan.

The corporate patient safety team will undertake a daily review of all newly reported patient safety incidents and undertake a triage process for potential incidents

requiring a PSII and/or require reporting externally – see the triage algorithm in **appendix 1.**

Working collaboratively with the divisions, the patient safety team will support the identification of incidents with potential for learning and improvement or, an unexpected level of risk. These incidents will require the division to undertake a rapid review within 72 hours. This appraisal will be reviewed by the corporate patient safety team and where appropriate the case will be presented to our Trust patient safety Learning Response Review Panel.

Where it is thought a PSII may be required

Our Trust patient safety Learning Response Review Panel (LRRP) will meet weekly to ensure timely consideration of an emerging risk. This forum will support the decision-making process for incidents requiring a PSII – see PSII decision making algorithm in **appendix 2.**

The patient safety Learning Response Review Panel will also:

- identify any immediate learning (which should be shared via an appropriate platform)
- any mitigation identified by the rapid review or, that is still required to prevent recurrence
- Duty of Candour requirements and immediate needs of the patient, family of carer
- Define the terms of reference for the PSII
- Clarify the required timeframe for completion of the PSII report
- Assign a Patient Safety Investigator to lead the PSII
- Designate subject matter expert input required for the PSII or highlight any cross system working that may be necessary
- Check on staff support required for any staff impacted by the incident

Where an incident does not meet the requirement for PSII, our Trust patient safety Learning Response Review Panel may request any of the other Learning response processes or, closure of the incident at a local level, with due consideration of any Duty of Candour requirement being met, and will indicate how immediate learning is to be shared.

Patient Safety Improvement Group (SIG)

The patient safety improvement group will provide:

- Oversight of the operation and decision-making of our Trust patient safety Learning Response Review Panel
- Provide sign off for completed PSIIs. Final sign off of PSII's will be by the Executive Chief Nurse or Medical Director.
- Ensure safety actions and improvement work is adequately directed and resourced.

The Patient Safety Improvement Group will report through its Chairs Key Issues (CKI's) to the Management Executive if there are any areas of concern. Through this mechanism the Board will be assured that it meets expected oversight standards but also understands the ongoing and dynamic patient safety and improvement profile within the organisation.

8.3. Responding to cross-system incidents/issues

The Patient Safety team will forward those incidents identified as presenting potential for significant learning and improvement for another provider directly to that organisation's patient safety team or equivalent. Where required, summary reporting can be used to share insight with another provider about their patient safety profile.

Our Trust will work with partner providers and the relevant ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents. The Patient Safety team will act as the liaison point for such working and will have supportive operating procedures to ensure that this is effectively managed.

Our Trust will defer to the ICB for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. We anticipate that the ICB will give support with identifying a suitable reviewer in such circumstances and will agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

8.4. Timeframes for learning responses

Timeframes for patient safety incident investigations (PSIIs)

Where a PSII for learning is indicated, the investigation must be started as soon as possible. The standard timeframe for a local-led PSII to be submitted to our Trust Patient Safety Improvement Group for approval of findings, is three months. The timeframe will be decided by the patient safety Learning Response Panel; no local PSII should take longer than six months.

The time frame for completion of a PSII will be agreed with those affected by the incident, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

In exceptional circumstances (e.g., when a partner organisation requests an investigation is paused, or the processes of an external body delays access to information) our Trust can consider whether to progress the PSII and determine whether new information indicates the need for further investigative activity once this is received. This would require a decision by our Trust Patient Safety Learning Response Review panel.

In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between our Trust and those affected.

Timescales for other forms of learning response

A learning response must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date.

8.5. Safety action development and monitoring improvement

Our Trust acknowledges that any form of patient safety learning response will allow the circumstances of an incident or set of incidents to be understood, but that this is only the beginning. The aim of PSIRF is to help organisations translate this learning into effective safety actions to reduce risk.

To achieve successful improvement, safety action development will be led and supported in a collaborative way between Divisions, the corporate patient safety team, and the Improvement & Transformation team.

Safety action development

Our Trust will use the process for development of safety actions as outlined by NHS England in the Safety Action Development Guide (2022) as follows:

1. Agree areas for improvement – a PSII will identify areas for improvement rather than make recommendations for safety actions.
2. Define the context – this will allow agreement on the approach to be taken to safety action development.
3. Define safety actions to address areas of improvement – focussed on the system and in collaboration with teams involved
4. Prioritise safety actions to decide on testing for implementation
5. Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics
6. Safety actions will be clearly written and follow SMART principles and have a designated owner

Safety Action Monitoring

Our Trust will have systems and processes in place to design, implement, and monitor safety actions using an integrated approach to reduce risk and limit the potential for future harm. Safety actions will be uploaded to the Datix actions module to support tracking and oversight.

Safety actions will continue to be monitored within the Divisions' governance arrangements to ensure that any actions put in place remain impactful and

sustainable. Divisional reporting on the progress with safety actions including the outcomes of any measurements will be made to our Trust Patient Safety and Assurance Group (PSAG).

For safety actions with wider significance, oversight will be provided by our Trust patient Safety Improvement Group (SIG) with escalation through to the Management Executive as appropriate.

8.6. Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. Our Trust has several overarching safety improvement plans in place, created in response to the outcomes of patient safety incident learning, and other external influences such as national quality improvement initiatives.

In response to PSIRF our Trust will consider the following forms of improvement plans to support oversight:

- creating individual safety improvement plans that focus on a specific service, pathway or location
- collectively reviewing output from learning responses to single incidents when it is felt that there is sufficient understanding of the underlying, interlinked system issues
- creating a safety improvement plan to tackle broad areas for improvement (ie overarching system issues).
- creating an organisation-wide safety improvement plan summarising improvement work

The Divisions will work collaboratively with the Safety and Quality Support department (SQS) and the Improvement & Transformation service to ensure there is an aligned approach to development of plans and resultant improvement efforts.

Monitoring of progress with regard to safety improvement plans will be overseen by reporting (by the designated improvement plan lead) to PSAG and our Trust patient Safety Improvement Group on a scheduled basis.

9. Oversight roles and responsibilities

Principles of oversight

The leadership and management functions of PSIRF oversight are wider and more multifaceted compared to previous response approached. PSIRF requires NHS providers, integrated care boards (ICBs) and regulators i.e. Care Quality Commission (CQC), to design their systems for oversight in a way that allows organisations to demonstrate improvement as the outcome of learning response processes.

In order to achieve this our Trust will underpin our processes with the national PSIRF oversight principles:

1. Improvement is the focus
2. Blame restricts insight
3. Learning from patient safety incidents is a proactive step toward improvement
4. Collaboration is key
5. Psychological safety allows learning to occur
6. Curiosity is powerful

Responsibilities

Alongside our local stakeholders (regional, ICB, CQC) we have specific organisational PSIRF oversight responsibilities. Our Trust has designated the Executive Chief Nurse as the executive PSIRF lead, a role in which they are supported by all members of the executive team. The responsibilities include:

1. Ensuring that the organisation meets the national patient safety standards

- To oversee the development, review and approval of our Trust's policy and plan ensuring that they meet the expectations set out in the patient safety incident response standards. The policy and plan will promote a restorative and just culture.
- To achieve the development of the plan and policy our Trust will supported by internal resources within the corporate patient safety team led by the Director of Clinical Quality (who reports to the Chief Nurse) and the Deputy Medial Director for Patient Safety, who reports to the Executive Medical Director.
- To define its patient safety and safety improvement profile, our Trust will undertake a thorough review of available patient safety incident insight and engagement with internal and external stakeholders.

2. Ensuring that PSIRF is central to overarching safety governance arrangements

- Our Trust Board will receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms such as the Quality Committee and Management Executive. The Quality Committee bi-monthly safety reporting will comprise oversight question responses to ensure that our Trust Board has a formative and continuous understanding of PSIRF implementation and standards, including the impact of changes following incidents.
- The Patient Safety Assurance Group (PSAG) will provide assurance to the Management Executive and the Quality Committee on our compliance with national PSIRF standards. Divisions will be expected to report on their patient safety incident learning responses and outcomes to PSAG. This will include reporting on ongoing monitoring and review of the patient safety incident response plan and delivery of safety actions and improvement.
- Our Trust patient safety Learning Response Review Panel (LRRP) will have oversight of learning responses to be considered for a PSII.
- Divisions will have arrangements in place to manage the local response to patient safety incidents and ensure that escalation procedures as described in the patient safety incident response section of this policy are effective.

3. Quality assuring learning response outputs

- Our Trust Patient safety improvement group (SIG) will have oversight of the operation and decision-making of LRRP, provide sign off for completed PSIIs (ensuring they are conducted to the highest standards and to support the executive sign off process), ensure that learning is shared, and safety improvement work is effectively directed and resourced.

Training to support Oversight

Our oversight training to support the transition to PSIRF has been provided by an accredited external provider (in collaboration with our ICB) and all training for the oversight role is in compliance with national PSIRF standards.

Policy update oversight

Updates made to the PSIRF policy and associated plan will have oversight from the Divisions, PSAG, Quality Committee, with approval via our Management Executive, internal and ICB Boards.

10. Complaints and appeals

We recognise there may be occasions when patients, families, or carers are dissatisfied with the organisation's response to patient safety incidents.

Patients, families, and carers will be guided to raise any concerns with the Engagement Lead for the learning response. The Engagement Lead is the person who leads engagement and involvement of those affected by a patient safety incident.

Where the learning response is a PSII, the Engagement Lead will be the patient safety incident investigator. For other local-led learning responses the Engagement Lead will be the Learning Response Lead. Where a nationally mandated learning response is led by an external body the Engagement Lead should be clarified by the patient safety Learning Response Review Panel and assigned in relation to the complexity of the case and the needs of the patient, family, or carer.

An alternative point of contact for patients, families, and carers to raise concerns about our response to a patient safety incident is our Patient Advice and Liaison Service (PALS). This service will immediately make contact with the Engagement Lead and the corporate patient safety team to raise awareness. All information will be recorded in the appropriate section on Datix, in the safety incident module.

It is important for the Engagement Lead to address any issue raised at the earliest opportunity as this may reduce the risk of escalation and increases the possibility of finding a satisfactory resolution to the problem.

Where issues cannot be resolved patients, families, or carers will be guided to make a formal complaint using our Trust complaints process. Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner.

Complaints and concerns raised by patients, families or carers can be valuable aids in improving our services. Lessons learnt from complaints and concerns raised related to a patient safety learning response, will be incorporated into our experience data collection, which will inform our PSIRF improvement work.

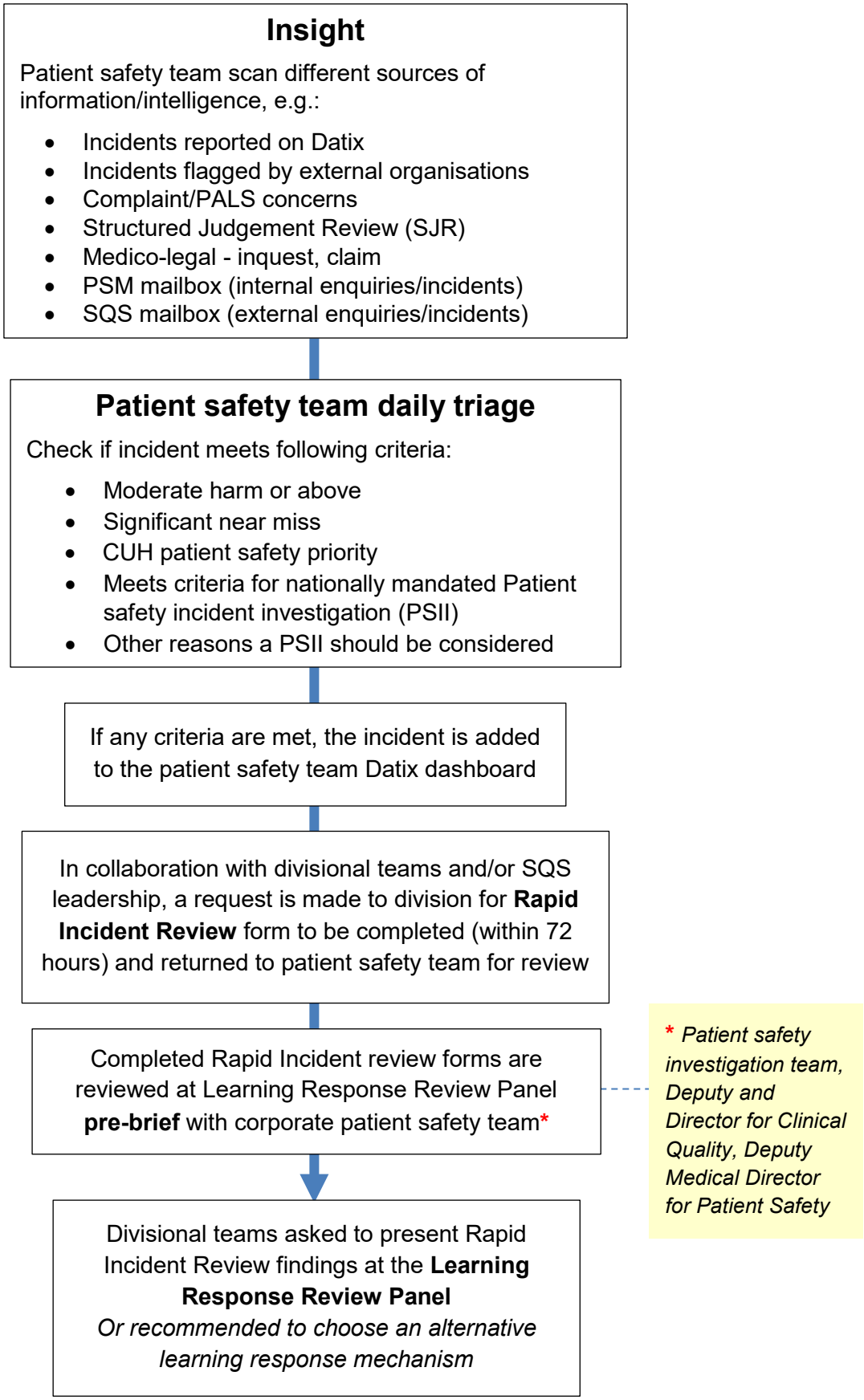
Associated documents

- CUH (2023) Patient Safety Incident Response Plan
- CUH (2023) Just and Learning Culture Manifesto

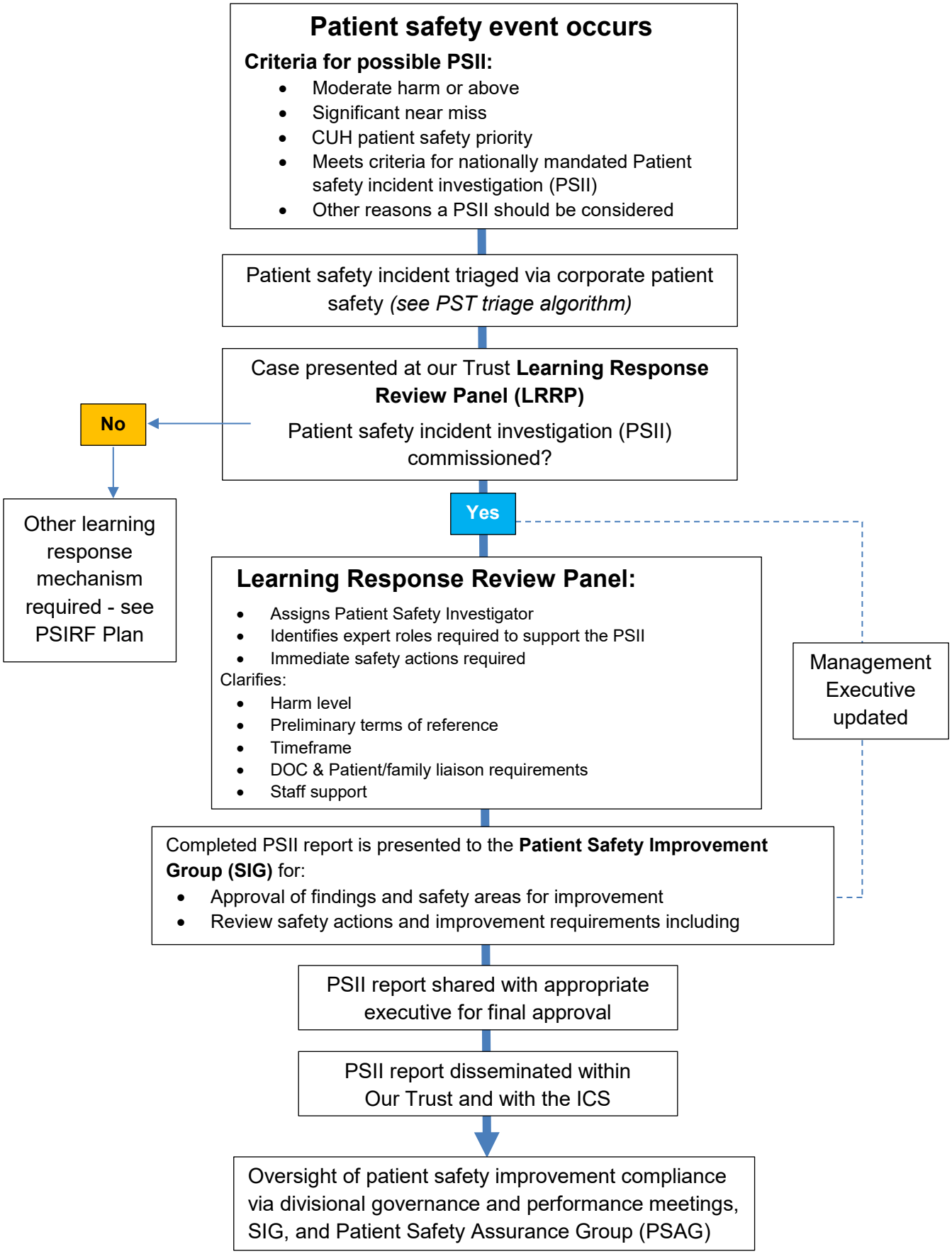
References

- NHS England (2022) **Patient Safety Incident Response Framework.** B1465-1.-PSIRF-v1-FINAL.pdf (england.nhs.uk)
- NHS England (2022) **Patient safety incident response standards** B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf (england.nhs.uk)
- NHS England (2022) Patient Safety Incident Response Framework supporting guidance **Guide to responding proportionately to patient safety incidents** B1465-3.-Guide-to-responding-proportionately-to-patient-safety-incidents-v1.1.pdf (england.nhs.uk)
- NHS England (2022) Patient Safety Incident Response Framework supporting guidance **Engaging and involving patients, families and staff following a patient safety incident** B1465-2.-Engaging-and-involving...-v1-FINAL.pdf (england.nhs.uk)
- NHS England (2022) **Safety action development guide** https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf
- NHS England (2022) **Patient Safety Incident Response Framework supporting guidance Oversight roles and responsibilities specification** B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf (england.nhs.uk)
- NHS A Just culture guide

Appendix 1. Corporate Patient Safety Incident Triage Process



Appendix 2. PSII decision-making process.



Cambridge University Hospitals NHS Foundation Trust

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Estimated refresh date: 31 March 2025

	Name	Title	Date
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Contents

1. Introduction

The Patient Safety Incident Review Framework (PSIRF) is a key element of the National Patient Safety Strategy. The PSIRF sets out the NHS approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The purpose of this PSIRF Plan is to provide guidance and clarity as to how Cambridge University Hospitals NHS Foundation Trust (CUH) intends to respond to patient safety incidents over a period of 15 months, from January 2024 to March 2025.

The PSIRF Plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety incidents occur, the needs of those affected, and emerging risks.

The aim of our PSIRF Plan is to continually improve and respond and as such this document will be renewed annually (each April).

Our PSIRF Plan should be read in conjunction with our PSRF Policy (2023). The latter provides further detail on our PSIRF governance systems and processes for the implementation and oversight of the framework as a whole.

A glossary of terms used can be found at Appendix A

2. Our services

Cambridge University Hospital NHS Foundation Trust is one of the largest trusts in the United Kingdom. The trust comprises Addenbrookes and the Rosie, offering general as well as specialist and women's and maternity care. As well as being a local hospital delivering care through Addenbrookes and the Rosie for its local community, the trust is also a:

- major trauma centre for the East of England
- regional centre providing specialist services such as organ transplantation, cancer, neurosciences, paediatrics and genetics.
- leading national centre for specialist treatment for rare or complex conditions

- government-designated biomedical research centre
- one of six academic health science centres in the United Kingdom
- university teaching hospital
- partner in the development of the Cambridge Biomedical Campus Summary
- partner in the Cambridgeshire and Peterborough Sustainability and Transformation Partnership.

3. Defining our patient safety improvement profile

The Board and Management Executive are committed to a culture of improvement and have prioritised improvement as key to supporting the delivery of our strategy and future sustainability.

The Trust have partnered with the Institute for Healthcare Improvement (IHI), to help us undertake a number of key enabling activities, including building improvement capability and capacity, which will allow all of our staff to develop and deliver improvements independently.

To help define our current improvement profile, we reviewed a listing of improvement work currently underway and registered on Life QI within our Trust. There were 148 registered projects with most of these being around review of processes, pathways, productivity, and efficiency.

There are currently continuous patient safety improvement programmes for: inpatient falls prevention, hospital-acquired pressure ulcer prevention (supported by the IHI 2023-2025); management of sepsis; managing patients at risk of acute deterioration. There are also a number of maternity quality improvement programmes linked to the national Maternity and Neonatal Safety Improvement Programme (MatNeoSIP).

Learning for improvement

Trust oversight of all patient safety learning responses will be led by the corporate patient safety team, via triangulation of patient safety events to identify emergent themes of patient safety risks and areas for improvement. A regular review will be undertaken, reporting to the Patient Safety Improvement group. An annual review will also be undertaken to inform the annual cycle of PSIRF and our Trust to ensure

patient safety improvement priorities are a key element of our annual quality improvement strategy.

4. Defining our patient safety incident profile

The patient safety incident response framework enables organisations to choose what areas of care it needs to focus on, based on its local context. In order to identify our local patient safety risk priorities a patient safety risk profile was created. The future intention is to revise our patient safety profile annually, to inform annual updates to the PSIRF Plan.

Devising the patient safety risk profile is a collaborative process. Our profile to inform our PSIRF Plan for 2023-2024 involved the following stakeholders:

- **Staff** via incidents reported on Datix, our electronic risk management system
- **Patients** via a review of themes identified in complaints and Patient advice and liaison service (PALS) concerns
- **Patient safety specialist** roles via the corporate patient safety team
- **Leadership via the Management Executive team**

CUH aims to incorporate wider consultation into future PSIRF planning:

- *Stronger triangulation and analysis of data across: complaints/PALS; incidents; learning from deaths; risks; audit, claims and inquest; experience data; quality improvement programs.*
- *Patient perspectives via the introduction of Patient Safety Partners and via experience data from those patients and families impacted by a patient safety incident investigation.*
- *From staff via data from those impacted by a patient safety incident investigation.*
- *From Leadership via broader consultation with divisional teams.*
- *Analysis of our health inequalities data*
- *From appreciative inquiry approach*

The current CUH patient safety risks were identified through the following data:

- Analysis of reported Datix patient safety and organisational incidents (01.01.2019-31.03.2023). The analysis focused on this four year period to provide a base for look back and we also analysed our data in the last 12 months, to show a more current context.
- Our root cause analysis (RCA) investigations, i.e. serious incidents, internal investigations, gap analysis (falls and pressure ulcer investigation method)
- Complaints and PALS concerns related to patient safety
- Expert patient safety forums, e.g. deteriorating patient, falls, pressure ulcers.
- Structured judgement reviews (Learning from deaths process)
- Medicines safety committee
- Freedom to speak up guardian – themes from contacts
- Trust risk register overview of patient safety risks
- Current quality improvement priorities supported by the Improvement and transformation team.

Our patient safety risk profile and subsequent consultations with stakeholders, as described above, enabled us to identify the requirements for our **local** patient safety incident response plan (Section 6).

5. Our patient safety incident response plan: national requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include a referral to an external body, depending on the nature of the event.

Patient safety events that are mandated to undergo a locally-led patient safety incident investigation (PSII) are Never Events and deaths thought more likely than not, due to problems in care.

Table 1 sets out the nationally mandated responses required for specific patient safety events. The table also identifies where a locally-led PSII may also be appropriate as well as the mandated externally-led process.

The CUH Patient Safety Improvement group (SIG) will have oversight of the identified areas for improvement from each the externally-led investigations.

For further details of mandated requirements see the NHSE PSIRF supporting guidance, Guide to responding proportionately to patient safety incidents.

Table 1. Mandatory investigation requirements

	Event	Action required	Lead body for the response
1	Incidents meeting the **Never Events** criteria (2018 list or its replacement).	**Locally-led PSII**	CUH
2	**Deaths thought more likely than not due to problems in care** (incidents meeting the learning from deaths criteria for PSII)	**Locally-led PSII**	CUH
3	**Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies**, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	**Locally-led PSII**	CUH
4	**Deaths of persons with learning disabilities**	Refer for Learning Disability Mortality Review (LeDeR) **Locally-led PSII (or other response) may be required** alongside the LeDeR – organisations should liaise with this	Local authority via the LeDeR programme
5	**Child deaths**	Refer for Child Death Overview Panel review **Locally-led PSII (or other response) may be required** alongside the panel review – organisations should liaise with the panel	Child Death Overview Panel

6	**Mental health-related homicides**	Referred to the NHS England **Regional Independent Investigation Team** (**RIIT**) for consideration for an independent PSII **Locally-led PSII may be required**	As decided by the RIIT
7	**Maternity and neonatal** incidents meeting **Healthcare Safety Investigation Branch (HSIB)** criteria (or Special Healthcare Authority [SpHA] criteria when in place)	Refer to HSIB of SpHA for independent PSII *See also appendix B of Guide to responding proportionately to patient safety incidents.*	HSIB
8	**Safeguarding incidents** in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to female genital mutilation, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead. Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults board	Our local designated professionals for child and adult safeguarding
9	**Incidents in NHS screening programmes**	Refer to local screening quality assurance service for consideration of locally-led learning response See: Guidance for managing incidents in NHS screening programmes	CUH

10	**Deaths in custody** (e.g. police custody, in prison, etc.) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the **Prison and Probation Ombudsman** (**PPO**) or the **Independent Office for Police Conduct** (**IOPC**) to carry out the relevant investigations Healthcare organisations must fully support these investigations where required to do so	PPO or IOPC
11	**Domestic homicide**	A domestic homicide is identified by the police usually in partnership with the **community safety partnership** (**CSP**) with whom the overall responsibility lies for establishing a review of the case Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	CSP

6. Our patient safety incident response plan: local focus

On the basis of our patient safety risk profile we considered that the incident types set out in table 2 require prioritisation for consideration as a PSII. The decision making process for the commissioning of a PSII is via our Trust patient safety **Learning response review panel**; the process is detailed in our PSIRF Policy.

Table 2: Local priorities incidents requiring PSII

	Incident type	Description	Estimated PSIIs in 15 months
1	Medication	A medication incident where there has been, or there is potential for harm; particular where improvement work is not in place or, not yet having effect/benefit.	Maximum of 3
2	Falls	A fall where there are contributory factors that have potential to inform our current falls improvement plan.	One
3	Lost to follow-up	Potential for/harm as a consequence of follow up appointments not being made.	Maximum of 3
4	Suboptimal care of the deteriorating patient	1. Delayed response to deterioration due to non-compliance with early warning scoring tool or the sepsis six bundle. 2. Communication across specialist teams and clinical wards/departments, including responding to abnormal blood results	Maximum of 3
5	Unexpected readmission	Unexpected readmission within 48 hours of discharge where discharge arrangements were not effective or acute clinical deterioration was not anticipated.	Maximum of 3

Where an incident does not align to the category descriptions in table 2 it may still be considered for a PSII via the Learning response review panel. The triage pathway for a patient safety event to be considered for a PSII by this group is detailed in our PSIRF Policy.

When determining whether an incident meets the threshold for a PSII the following criteria will be considered:

i. the views of those affected, including patients and their families

ii. capacity available to undertake a learning response

iii. what is known about the factors that lead to the incident(s)

iv. whether improvement work is underway to address the identified contributory factors

v. whether there is evidence that improvement work is having the intended effect/benefit

vi. if the Trust and ICB are satisfied risks are being appropriately managed.

PSII capacity

The current capacity of the organisation to undertake PSIIs is estimated to be 43 for the 15-month timeframe of this plan. No more than three PSIIs related to the incidents listed in table 2 should be undertaken in the 15-month period covered by this plan. Not all incidents listed in table 2 may require three PSIIs, this decision making will be based on context and improvement work already in progress.

Of the 43 estimated PSII capacity during the timeframe of this plan, we anticipate the following distribution of resource:

- 19 will be related to the nationally mandated PSIIs of Never Events (4) and deaths associated with problems in care (15).
- 13 for the patient safety priority incidents identified in table 2
- leaving capacity for 11 PSIIs for emergent patient safety incidents.

Alternative Learning Response mechanisms

For incidents where a PSII is not appropriate, a range of learning response mechanisms are supported by our Trust.

1. Where incidents result in death, the following are required:
   - Perinatal mortality review tool – stillbirths and neonatal deaths
   - Structured judgement review (SJR) – in alignment with the Learning from deaths policy.
2. For key local patient safety risks (listed in table 3), standardised guidance has been devised to support a consistent and equitable learning response.

Table 3. Planned learning response guidance for our key local patient safety risks

Patient safety incident type or issue	Planned response	Learning and improvement oversight
In patient falls	1. Hot debrief 2. Falls After Action Review (AAR) - informed by falls audit tool	Annual thematic review and Falls audit. Falls Quality Steering group to support centrally led improvement plans.
Hospital-acquired pressure ulcers (HAPU), categories: 3; 4; unstageable (necrotic)	1. HAPU AAR - informed by HAPU audit tool	IHI HAPU QI programme. Tissue Viability Quality Steering group to support centrally led improvement plans. Annual thematic review and HAPU audit.
Hospital-acquired infections (HAI), including catheter associated UTIs, and outbreaks	1. HAI investigation tool 2. Outbreak review tool	Trust Infection Prevention and Control committee to support centrally led improvement plans.
Missing/absconded patient	1. Hot debrief 2. After Action Review where concerns identified.	Trust Safeguarding committee to support centrally led improvement plans
Clinical emergency requiring **2222 call**	1. Hot debrief led by Rapid Response Team 2. Where concerns in care are identified, an AAR led by local leadership	Trust Patient at Risk of deterioration group to support centrally led improvement plans
Hospital-acquired thrombosis (HAT)	1. HAT review tool 2. AAR where gaps in care are identified by the HAT review process.	Learning oversight at our Trust Venous Thromboembolism group to support centrally led improvement plan

Where an incident does not fall into any of the categories detailed in tables 1 and 2, the divisional teams should decide on the appropriate learning response mechanism. The learning responses used in our Trust are:

- Multi-professional patient safety review (PSR)
- After Action Review (AAR)
- Audit
- Thematic analysis – this process may also be supported by a Risk Oversight Group where appropriate.

The application of these learning response tools should be led by appropriately trained staff and information recorded in Datix. Further guidance on these learning response mechanisms may be found in our Trust *Patient Safety Learning Response Procedure* (2023).

Our Trust intends to develop our capacity and capability to learn from good care. Currently staff report to our Datix system, incidents reflecting good care (GREATix) to support cross-system learning. With our transition to LFPSE our intention is to build on our learning from excellence reporting process and to further develop the principles of learning from safety 2.

Appendix A. Glossary of terms

CUH - Cambridge University Hospitals NHS Foundation Trust

After Action Review (AAR)

A structured, facilitated discussion of an event, the outcome of which gives the individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of those involved.

Multi-professional patient safety review (PSR)

An in-depth process of review with input from different healthcare professions. This may be used to review a single or multiple patient safety incident, to explore a safety theme, pathway, or a process. Aim is to understand how care is delivered in the real world i.e., work as done, using experts of that lived experience. The review can be structured around a system model such as SEIPS.

Never Event

Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers. The definition of what constitutes a Never Event is determined by NHS England.

2018-Never-Events-List-updated-February-2021.pdf (england.nhs.uk)

Patient Safety Incident Response Framework (PSIRF)

This is a national framework applicable to all NHS organisations commissioned outside of primary care. The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Patient Safety Incident Response (PSIRF) Plan

An organisation's PSIRF Plan should specify the methods it intends to use to maximise learning and improvement and how these will be applied to different patient safety incidents. It should be based on a thorough understanding of the organisation's patient safety incident profile, ongoing improvement priorities, available resources, and the priorities of stakeholders including patients.

Patient Safety Incident Response (PSIRF) Policy

An organisation's PSIRF Policy should describe its overall approach to responding to and learning from patient safety incidents for improvement and identify the systems and processes in place to integrate the four key aims of PSIRF. It should describe how those affected by a patient safety incident will be engaged, what governance processes for oversight are in place and how learning responses are translated into improvement and integrated into wider improvement work across the organisation.

Patient Safety Incident Investigation (PSII)

A PSII is an in-depth review of a single patient safety incident or cluster of events to understand what happened, how, and why. PSIIs are conducted to identify underlying system factors that contributed to an incident and to identify areas for improvement. The organisation then agrees improvement plans to effectively and sustainably address those system factors and help deliver safer care for our patients. CUH will be using the SIEPS model when undertaking a PSII.

System Engineering Initiative for Patient Safety (SEIPS)

SEIPS is a framework for understanding outcomes within a complex socio-technical systems such as healthcare. It describes how a work system (socio-technical) can influence processes (work done), which in turn shape outcomes. The work systems consist of six elements: external environment; internal environment; tools and technology; tasks; and people. The model proposes people cannot be separated from their work system, therefore patient safety incidents result from multiple interactions between work factors. When a learning response thoroughly examines the different work system components and their interactions, safety actions can focus on wider systems issues, not individuals.

Structured Judgement Review (SJR)

Our Trust follows the Royal College of Physicians model for best practice in mortality review, namely the SJR tool. The SJR blends traditional, clinical judgement-based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. This allows the identification of deaths assessed as more likely than not to be due to problems in care; these cases then may need to progress to a PSII to identify system learning and improvement.

Thematic Analysis

The thematic analysis tool is used to identify patterns that show links or identify issues. Thematic reviews can be used for multiple purposes and can use both qualitative and quantitative data. They are commonly used as a learning response tool to aggregate findings from multiple incidents to identify interlinked contributory factors to inform/direct improvement efforts. It can also be used to identify themes across areas for improvement as well as assessing the impact of safety improvement plans.

Risk Oversight Group (ROG)

The purpose of commissioning a ROG is to ensure the immediate management of a newly identified patient safety issue where there is a current or potential risk of serious harm or death. This is a task and finish group to help: quantify the impact on patients past and current; support the required patient safety learning response method, and lead on the implementation of immediate improvement actions to effectively manage the risk.

Board of Directors

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Together
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Report to the Board of Directors: 13 September 2023

Agenda item	12
Title	Freedom to Speak Up Guardian report
Sponsoring executive director	Ian Walker, Director of Corporate Affairs
Author(s)	Claire Patterson, Freedom to Speak Up Guardian
Purpose	To inform the Board of progress on the Speaking Up Service.
Previously considered by	Management Executive, 7 September 2023

Executive Summary

This report provides the Board with a six-monthly update from the Freedom to Speak Up Guardian covering the period to the end of March 2023, together with an update on more recent activity and developments.

Related Trust objectives	All Trust objectives
Risk and Assurance	The report provides assurance on the steps being taken to promote open and transparent speaking up culture.
Related Assurance Framework Entries	BAF risks 007, 008, 013

Does this report reference the Trust's values of “Together: safe, kind and excellent”?	The Trust’s Safe value: “I never walk past; I always speak up”

Action required by the Board of Directors

The Board is asked to:

- Receive and discuss the six-monthly report from the Trust’s Freedom to Speak Up Guardian.
- Approve the CUH Freedom to Speak Up and Raising Concerns (Whistleblowing) policy.

Cambridge University Hospitals NHS Foundation Trust

13 September 2023

Board of Directors
Freedom to Speak Up Guardian report
Claire Patterson, Freedom to Speak Up Guardian

1. Introduction

1.1 The creation of the Freedom to Speak Up Guardian (FTSUG) role was one of the recommendations of Sir Robert Francis' Freedom to Speak Up review following the Mid Staffordshire Public Inquiry. There are now over 800 Guardians in post across the NHS with over 20,000 cases being raised with them each year.

1.2 The Trust's previous FTSUG left the role in February 2023 and interim cover arrangements were put in place by the Director of Corporate Affairs until the new FTSUG, Claire Patterson, took up post in May 2023. Having previously been a part-time role, the position has now been established on a full-time basis.

1.3 The Director of Corporate Affairs is the Executive lead for raising concerns and speaking up and meets regularly with the FTSUG. Annette Doherty is the link Non-Executive Director for Freedom to Speak Up, and met with the FTSUG most recently in late August 2023.

1.4 This report provides the Board with an update on the activity and progress of the Freedom to Speak Up service over the last six-month period (October 2022 to March 2023) since the previous report to the Board in January 2023, together with a brief summary of more recent developments.

2. Update on progress

2.1 The new FTSUG has completed the National Guardian's Office (NGO) training for Guardians and the mandated three-month reflective conversation in order to be fully registered with the NGO.

2.2 The first weeks in post have been focused on holding introductory meetings with key stakeholders across The Trust. The FTSUG has visited a number of wards and departments and engaged with staff in these areas. She has also attended a number of CUH meetings, including with the Staff Networks to introduce herself and raise the profile of the Speaking Up service. Further meetings are planned including with the Junior Doctors' Forum and

attendance at a range of induction events is planned. Most recently, the FTSUG spoke to 230 junior doctors as part of their induction programme.

2.3 The FTSUG also links in with FTSUGs in other trusts, within both Cambridgeshire and Peterborough and the wider east of England region. This includes attending regional network meetings to provide support and to share knowledge and best practice. Mentoring support is being provided by an experienced FTSUG in a local trust.

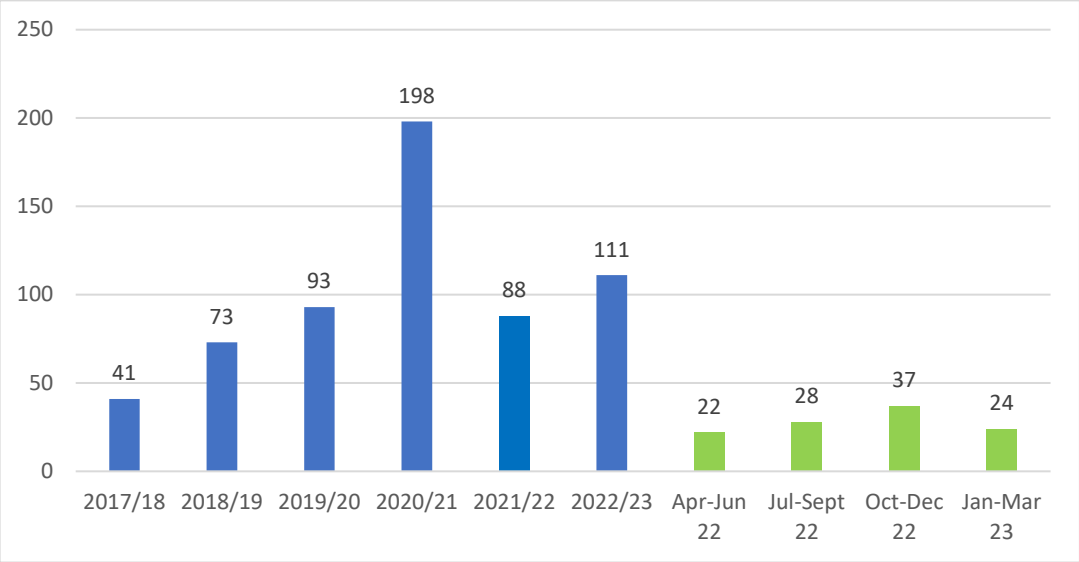
3. Concerns raised, October 2022 to March 2023

3.1 The Speaking Up service has maintained a consistent and responsive presence and has continued to provide support to staff, including signposting and escalating concerns for resolution/action in a timely way.

3.2 As reported in the previous Board report, the number of staff contacts to the Speaking Up service rose sharply in the first year of the Covid-19 pandemic, with twice as many contacts in 2020/21 than in 2019/20 (*see Chart 1 – blue bars for annual data*). After returning to pre-pandemic levels in 2021/22, contacts rose by around 25% in 2022/23, continuing the positive upward trend. Further details are provided in Table 1a at Appendix A.

3.3 In the six month period covered by this report, from October 2022 to March 2023, 61 concerns were raised with the service giving an annual figure for 2022/23 of 111 cases.

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



3.4 Of those that raised concerns, the Nursing and Midwifery workforce accounted for almost twice as many approaches (46) as the next highest group, administrative and clerical workers, with 24 cases reported to the FTSU Guardian. Medical and Dental staff accounted for only five cases.

3.5 There has been a change in the collection of categorisation of concern themes for the 2022/23 period, with four categories now being collected by the NGO. These are Worker Safety and Wellbeing, Patient Safety and Quality, Bullying and Harassment and Other Inappropriate Attitudes and Behaviours. The most common theme in the past year (see Table 1b) was Worker Safety and Wellbeing which featured in 35% of the concerns raised, closely followed by inappropriate attitudes and behaviours which were identified in 33% of cases. Issues related to Worker Safety and Wellbeing included a number of concerns related to application of HR processes, including the grievance process both from those raising a grievance and those having a case brought against them.

3.6 As shown in Table 1e, there is significant variability in reporting rates across Shelford Group trusts, which in part will reflect different approaches to data collection as well as the level of investment in the service and the range of alternative routes available for raising concerns. A Shelford Group FTSUG Forum is currently being established to share practice and experience and to better understand these differences.

3.7 The majority of CUH cases were raised by individuals contacting the Raising Concerns email account, with a small number using the confidential Raising Concerns phone line. There were no concerns that were raised anonymously during this period although one individual was only willing to give limited information that did not allow for them to be contacted directly. In each case, the FTSUG has discussed the concerns with those raising them and sought to agree a way forward. Of the 57 concerns raised in the six months to March 2023, two remain open.

3.8 It is important to emphasise that the Freedom to Speak Up service is one of a number of routes through which concerns are raised in the Trust. Staff are encouraged to raise concerns with their line managers where possible and appropriate as this is often the most effective way of achieving a timely resolution. It is encouraging that around 75% of respondents to the Trust's Pulse Survey state that they can raise concerns with their manager. This is the route championed by the National Guardian's Office with the phrase "Speaking Up – Business As Usual" being part of the NGO narrative and communications. Many concerns are managed and resolved successfully at this local level.

3.9 Concerns are also raised through other channels including trades unions and professional bodies, HR Consult and Heads of Workforce, the Guardian for Safe Working Hours and the Chaplaincy service. This report should not, therefore, be taken as providing a comprehensive overview of raising concerns across the organisation.

3.10 While the report formally covers the period to March 2023, it is noteworthy that there have been a significant number of cases raised via the Freedom to Speak Up service in recent months – 37 cases between April and June 2023 and a further 51 cases in July and August. If this pattern continues, 2023/24 will show a significant increase in annual cases compared to the previous year.

4. NHS National Staff Survey results 2022

4.1 The 2022 National Staff Survey results, published in spring 2023, showed both nationally and for CUH a drop in staff confidence in raising concerns and in the belief that concerns that are raised would be addressed. Mirroring the pattern across the majority of survey questions, the dip in the CUH results exceeded the benchmark group national median in all cases. While previously the CUH results for the speaking up national staff survey questions were significantly above the national average, they are now only marginally so.

4.2 Table 1h shows the results from the local Pulse Survey completed in Q1 of 2023. While the questions are not a direct comparison to those in the national survey, they give a flavour of the mood when considering raising concerns. This shows a decline in the four questions considering how secure individuals feel about raising concerns, with the decline most marked in the question “I feel confident that the organisation would address concerns raised” falling by 2.3% to below 50%. Fear and futility are both well-known barriers to speaking up and a loss in confidence that concerns would be addressed will in itself risk further inhibiting speaking up. More encouragingly, however, there was an increase in the proportion of staff saying that they know how to contact the FTSUG and that they would feel secure in raising concerns with the FTSUG.

4.3 Individuals who respond that have a protected characteristic continue to feel less safe to speak up than those without a protected characteristic, and the decline in the national staff survey results for CUH between 2021 and 2022 was greater for those with a protected characteristic than for those without. Details are provided in Table 1g. The largest fall was for respondents identifying as LGBTQ+ with 10% fewer reporting in 2022 than in 2021 that they feel safe to speak up about things that concern them in the organisation. The new FTSUG has met with the staff network chairs and the

Director and Head of Equality, Diversity and Inclusion and will be prioritising opportunities to engage with staff with protected characteristics to identify how we can increase their confidence to raise concerns and whether there are additional routes for doing so which would help.

4.4 Feedback is encouraged from those who raise concerns and the NGO asks trusts to submit data on this. An anonymous feedback form has been developed in conjunction with colleagues in Governance and EDI and this is now sent monthly to individuals who have raised concerns where the case has been closed. By sending this to multiple individuals on a monthly basis it allows for the collection to be separated from the case and anonymity maintained. As more data is collected over the coming months, we will be in a position to provide reporting, including on the demographics and protected characteristics of those who have raised concerns, as well as on their experience of doing so.

5. Local support for the FTSUG

5.1 The new FTSUG has contacted all of the Freedom to Speak Up Listeners currently in post to offer introductions and confirm that they would like to continue in the role. As reported in January 2023, there are now around 50 listeners across CUH. Discussions are continuing between the FTSUG, the Head of Equality, Diversity and Inclusion and the Staff Networks to ensure that, through additional recruitment, there is a more diverse Listener group which is representative of the workforce. At present 7% of listeners are from a BAME background (compared to 28% for CUH staff as a whole); 18% declare a disability (compared to 5% for CUH staff as a whole); and 11% are gay/lesbian/bisexual (compared to 3% for CUH staff as a whole).

5.2 Over the next 12 months, the FTSUG aims to continue the work previously undertaken in raising the profile of the FTSU Listeners, and recruiting new Listeners. Updated promotional material has been produced and distributed to areas and will be distributed further across the site. Having met with Listeners, the new Guardian will attend key meetings within their departments to share the messages of Speaking Up. Arrangements have been made to attend induction days for new starters with support from a medical consultant with a keen interest in Listening Up when attending the medical inductions.

6. Peer support

6.1 The local Guardian network, in line with the Cambridgeshire and Peterborough Integrated Care System footprint, continues to meet regularly to share best practice and ideas. The East of England regional FTSUG network meets on a quarterly basis. A Community of Practice has been

developed locally to provide a reflective environment to discuss cases and the challenges of being a FTSUG. The CUH FTSUG is a member of these networks.

7. Freedom to Speak Up policy

7.1 The FTSUG and Director of Corporate Affairs have undertaken a review of the CUH Raising Concerns procedure to ensure that it is aligned with national expectations following an updated national policy from the National Guardian's Office and NHS England. Trusts are required to adopt the updated national policy by January 2024.

7.2 The Raising Concerns procedure is one of the group of Trust policies and procedures where approval is reserved to the Board of Directors.

7.3 The revised version is attached at Appendix 1 for Board approval. They key amendments from the previous version are as follows:

- To broaden the title and scope from raising concerns to freedom to speak up more widely, in line with the national template. As part of this, the policy more clearly signposts the range of internal options for colleagues who wish to speak up.
- To give the document the added weight of a policy rather than a procedure.
- To explicitly acknowledge that colleagues with protected characteristics can find it particularly difficult to speak up.
- To recognise the duty of care the Trust has to those who are being investigated as a result of concerns being raised.
- To ensure that all elements of the new national policy template have been incorporated.

8. Countess of Chester case

8.1 The appalling crimes committed by the nurse Lucy Letby at the Countess of Chester Hospital inevitably and rightly emphasise the importance of everyone working in the health service feeling safe to speak up about any concerns and being confident that there will be a prompt and appropriate response.

8.2 At CUH we will continue to strive for a culture where everyone feels safe to speak up and raise concerns and where they can be confident that their concerns will be heard and responded to. As part of our ongoing communications and awareness on Freedom to Speak Up, we have recently included messaging in the CUH Bulletin following the verdict in the trial of Lucy Letby and we held a dedicated discussion session on the weekly 08.27

covering speaking up, just and learning culture and the new patient safety incident response framework. Management Executive has emphasised the need for continued regular awareness raising of the various routes for raising concerns and the responsibility of managers and leaders to be visible, accessible and open to hearing and responding to concerns. Further awareness raising will take place during national Speak Up month in October.

9. Governance

9.1 In line with national recommendations, the Board of Directors has previously agreed to receive a six-monthly report on Freedom to Speak Up. The Audit Committee also reviews arrangements for raising concerns on an annual basis (scheduled for 27 September 2023). The next Board report is scheduled for January 2024.

10. Recommendations

10.1 The Board of Directors is asked to:

- Receive and discuss the six-monthly report from the Trust's Freedom to Speak Up Guardian.
- Approve the CUH Freedom to Speak Up and Raising Concerns (Whistleblowing) policy.

Appendix A: Analysis of Freedom to Speak Up concerns raised
Table 1a: Concerns raised with the CUH Speaking Up service by occupational group

	2022/23 (October-March)		**2022/23 (April-September)**		**2021/22 (April-March)**		**2020/21 (April – March)**	
Occupational group	**Number**	**% of group workforce** (CHEQS Mar 2022)	**Number**	**% of group workforce** (CHEQS Sept 2022)	**Number**	**% of group workforce**) (CHEQS Sept 2021)	**Number**	**% of group workforce** (CHEQS Mar 2021)
Admin & Clerical; Maintenance/Ancillary	15	0.5	12	0.4	25	0.9	64	2.4
Nursing & Midwifery	28	0.7	18	0.5	33	0.9	67	1.8
Health Care Assistant/ Nursing Associates	8	0.4	6	0.3 (now additional clinical services)	8	0.4	19	1.0
Ancillary and Technical	Data now included in Admin & Clerical/Maintenance/Ancillary above							
Add Prof, Tech and Scientific, Healthcare Scientist	Data now included in Allied Health Professionals below							
Medical and Dental	1	0.05	4	0.2	3	0.2	14	0.9
Allied Health Professionals	8	0.2	6	0.2	13	0.8	25	1.7
Other	1		2		6		9	
TOTAL	**61**	**0.5**	**50**	**0.4**	**88**	**0.7**	**198**	1.7

A.1 Table 1a also shows the number of staff within each occupational group raising concerns as a percentage of the total workforce for that occupational group. In the 2022-23 period, the following points stand out:

- Compared to the Trust average, Nursing & Midwifery and Allied Health Professionals groups are the most likely to raise concerns.
- Compared to the Trust average, staff in the Medical and Dental group are much less likely to raise concerns.

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

Table 1b: Concerns raised with the CUH Speaking Up Service by category (concern categories from 2019-22)

	2021/22 (April – March)		2020/21 (April – March)		2019/20 (April - March)	
Concern category	**Number**	**%**	**Number**	**%**	**Number**	**%**
Behaviour/ relationships	42	22	-	-	-	
Behaviour/attitude	-	-	75	27	43	29
Trust processes in practice	38	20	107	31	38	26
Management support	45	23	49	20	32	22
Patient safety and quality	22	11	-	-	-	-
Patient related	-	-	34	17	24	16
Capacity/workload/training	14	7	22	5	9	6
Bullying and harassment	22	11	-	-	-	-
Worker safety	9	5	-	-	-	
TOTAL	**192**		**287**		**146**	

A.2 Some concerns raised by one individual may cover more than one theme.

Table 1c: Concerns raised with the CUH Speaking Up Service by category (data categories from 2023)

	2022/23 Quarter 4 January-March		2022/23 Quarter 3 October-December		2022/23 Quarter 2 June-September		2022/23 Quarter 1 April-June	
Concern category	**Cases**	**%**	**Cases**	**%**	**Cases**	**%**	**Cases**	**%**
Worker Safety and Wellbeing	11	38	20	43	12	35	4	15
Bullying and Harassment	3	10	10	21	1	3	3	11
Patient Safety and Quality	3	10	9	19	7	21	8	31
Other Inappropriate Attitudes or Behaviours	12	41	8	17	14	41	11	42
TOTAL	**29**		**47**		**34**		**26**	

Table 1d: Concerns raised with the CUH Speaking Up service by division from October 2022 to March 2023

Job Role	Worker Safety and Wellbeing	Bullying and Harassment	Patient Safety and Quality	Other Inappropriate Attitudes and Behaviours	Total Themes	Total Cases	Total Workforce	% Total in division raising concerns
A	4	-	-	2	6	5	2303	0.2
B	3	2	1	7	13	11	3182	0.3
C	3	2	2	-	7	5	1685	0.3
D	3	-	1	-	4	3	1493	0.2
E	6	1	6	4	17	10	1477	0.7
Corporate	6	5	2	7	20	18	1579	1.1
R&D	1	3	-	-	4	4	392	1.0
Not Known	-	5	-	-	5	5	-	-
Grand Total	**26**	**18**	**12**	**20**	**76**	**61**	**12111**	**0.5**

A.3 Over the last 6 month period the Corporate Division and Research and Development accessed the service proportionally more than other areas and Divisions A&D accessed the service less than average. However, there is no evidence of a consistent pattern in the Divisional breakdown over time.

Table 1e: Shelford Group FTSU comparisons, 2022/23 Q1-Q3

Trust	Q1 Total cases	Q1 Patient safety and quality cases	Q1 Bullying and harassment cases	Q2 Total cases	Q2 Patient safety and quality cases	Q2 Bullying and harassment cases	Q3 Total cases	Q3 Patient safety and quality cases	Q3 Bullying and harassment cases	Q4 Total Cases	Q4 Patient safety and quality cases	Q3 Bullying and harassment cases
CUH	21	8	3	28	7	0	36	8	10	24	3	3
GSTT	55	7	11	73	5	11	69	5	10	93	3	10
Imperial	No data	No data	No data	71	3	11	No data	No data	No data	84	15	25
King's	83	20	41	62	17	17	63	8	19	77	13	12
Manchester	40	6	6	19	2	2	43	14	5	32	13	9
Newcastle	20	0	10	21	2	2	15	0	2	No data	No data	No data
Oxford	51	9	22	22	3	9	34	15	16	68	1	9
Sheffield	3	1	0	7	1	1	11	2	8	7	1	2
UCLH	24	0	6	19	0	3	45	2	7	30	0	2
Birmingham	No data	No data	No data	27	1	15	42	9	15	72	8	20
Average	**37**	**6**	**12**	**35**	**4**	**7**	**40**	**7**	**10**	**54**	**6**	**10**

A.4 Comparisons between CUH data and Shelford Group comparisons (from NGO data) are provided in Table 1d. Nationally there is a wide disparity between the number of cases and resources allocated to speaking up services in Trusts which makes direct comparisons difficult.

Table 1f: NHS National Staff Survey

		% of staff selecting 'Agree'/'Strongly Agree'						
Staff Survey Question		**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**Difference from 2021 to 2022**
Q17a I would feel secure raising concerns about unsafe clinical practice	CUH	73.1	73.8	76.1	75.3	75.9	71.3	**-4.6%**
	Benchmark Median	69.4	69.8	70.8	71.8	73.9	70.6	**-3.3%**
Q17b I am confident that my organisation would address my concern	CUH	61.4	63.7	65.8	64.8	62.3	56.7	**-5.6%**
	Benchmark Median	57.4	57.3	59.1	59.1	57.6	55.0	**-2.6%**
Q21e I feel safe to speak up about anything that concerns me in this organisation	CUH	-	-	-	69.5	67.5	63.2	**-4.3%**
	Benchmark Median	-	-	-	65.0	60.7	60.0	**-0.7%**
Q21f If I spoke up about something that concerned me I am confident my organisation would address my concern	CUH	-	-	-	-	55.5	50.3	**-5.2%**
	Benchmark Median	-	-	-	-	47.9	46.9	**-1.0%**

Table 1g: National Staff Survey results for Q21e (I feel safe to speak up about anything that concerns me in this organisation) broken down by protected characteristic

Disability	2020	2021	2022	Diff
Disabled	63%	61%	**54%**	**-7%**
Non- Disabled	71%	69%	**66%**	**-3%**
Ethnicity	2020	2021	**2022**	**Diff**
BAME	67%	64%	**58%**	**-6%**
White	71%	69%	**66%**	**-3%**
Sexuality	2020	2021	**2022**	**Diff**
Gay, Lesbian, Bisexual and Other	67%	66%	**56%**	**-10%**
Heterosexual or Straight	71%	68%	**64%**	**-4%**
I would prefer not to say	58%	55%	**56%**	**-1%**

Table 1h: CUH Pulse Survey 2023 Q1 (data collection April 2023)

Pulse point/Picker survey questions	2022	2023	Diff
I feel secure to raise concerns/speak up	66.9%	65.7%	-1.2%
I feel confident that the organisation would address concerns raised	51.6%	49.3%	-2.3%
I can raise concerns with my manager	75.8%	75.6%	-0.2%
When concerns are raised in my area we learn from them	61.1%	60.1%	-1%
I know how to contact the Speaking Up Guardian	60%	63%	+3%
I would feel secure raising concerns with the Speaking Up Guardian	52.5%	53.6%	+1.1%

Policy

Freedom to Speak Up and Raising Concerns (Whistleblowing)

Key messages

- The Trust welcomes and encourages speaking up and will listen. By speaking up at work you will be playing a vital role in helping to keep improving our services for our patients and the working environment for our staff.
- This policy is for all workers and we want to hear all our workers' concerns.
- The Trust is committed to a culture of openness and honesty and is supportive of colleagues who have concerns, including over possible danger, risk, wrongdoing or malpractice.
- If you raise a concern under this policy, you will not be at risk of losing your job or suffering any detriment because you have raised it.
- If you have a concern, please act promptly. The sooner that it gets raised, the sooner it can be dealt with.
- The Trust recognises that some groups with protected characteristics can find it particularly difficult to speak up and we will continue to work with Equality, Diversity and Inclusion colleagues to identify and remove barriers to speaking up.
- To raise a concern, first speak to your line manager or supervisor. If, for whatever reason, you do not feel able to, there are a range of people you can contact including the Freedom to Speak Up Guardian or the Director of Corporate Affairs, either verbally or in writing.
- The confidential telephone line to contact the Freedom to Speak Up team is extension 586535 (direct dial 01223 586535) or you can use the confidential email address: cuh.raisingconcerns@nhs.net

1 Scope

The NHS People Promise commits to ensuring that "*we each have a voice that counts, that we all feel safe and confident to speak up, and take the time to really listen to understand the hopes and fears that lie behind the words*".

This is a Trust-wide policy which applies to all workers, whichever part of the organisation you work in. It may be amended with the approval of the Trust's Board of Directors.

For clarity, the policy applies to:

- all staff holding a contract of employment with the Trust (including directors), irrespective of professional group or role

- bank workers
- agency workers
- locum workers
- students
- trainees
- junior doctors
- staff holding honorary contracts
- staff of external contractors
- volunteers
- governors

We value all concerns raised by **anyone.**

2 Purpose

The purpose of this policy is as follows:

- To ensure that all staff can speak up and raise any matters of concern they may have including about a possible danger, risk, wrongdoing or malpractice including safety, fraud, bribery or theft, that might affect patients, colleagues or the wider organisation.
- To clarify the responsibilities that staff and others have when concerns are raised.
- To provide a mechanism which complies with the Public Interest Disclosure Act (further information on this legislation can be found on the Protect website).

This policy should be used in combination with The Trust's being open and duty of candour policy regarding the obligations of staff concerning communications with patients, relatives or carers about any shortcomings in care or treatment.

3 Introduction

All of us at one time or another have concerns about what is happening at work. Often these are easily resolved. However, sometimes it can be difficult to know what to do.

You may be worried about speaking up and raising a concern, and you may think it best to keep it to yourself, perhaps feeling that it is none of your business or that it is only a suspicion. You may feel that raising the matter would be disloyal to colleagues, to managers or to the Trust, or be worried about the consequences of doing so.

This policy is in place to encourage you to speak up about any concern you may have and to reassure you that it is safe to do so. It is intended to support you to do so at an early stage and in the right way. Rather than wait for proof, we would prefer you to raise the matter when it is still a concern so that it can be investigated and acted upon as soon as possible. It doesn't matter if you turn out to be mistaken as long as you are genuinely concerned and raise this in good faith.

Speaking up helps the organisation to identify opportunities for improvement that we might not otherwise know about. The Trust will not tolerate anyone being prevented or deterred from speaking up or being mistreated because they have spoken up.

We know that some groups in our workforce feel they are seldom heard or are reluctant to speak up. We also know that workers with protected characteristics, including those with disabilities, or from a minority ethnic background or the LGBTQ+ community do not always feel able to speak up. We will continue to work with Equality, Diversity and Inclusion colleagues to identify and remove barriers to speaking up.

4 What can I speak up about?

You can speak up about anything that affects patient care or your working life. This could be something which doesn't feel right to you: for example, a way of working or a process that isn't being followed; you feel you are being discriminated against; or you feel the behaviours of others are affecting your wellbeing, or that of your colleagues or patients. You might for example have a concern about unsafe patient care, unsafe working conditions, inadequate induction or training of staff, suspicions of fraud or concerns about bullying and harassment.

Speaking up is about all of these things. It captures a range of issues, some of which may be appropriately managed through other existing policies or processes, for example the grievance and dignity at work policy or the anti-fraud, bribery and corruption policy.

As an organisation, we will listen and work with you to identify the most appropriate way of responding to the issue you raise.

5 Feel safe to speak up

It is recognised that speaking up and raising a concern can be a difficult experience for some staff and managers must consider concerns fully and sympathetically.

If you raise a concern in good faith under this policy, you will not be at risk of losing your job or suffering any form of reprisal as a result. The Trust will not

tolerate the harassment or victimisation of anyone raising a concern. Nor will we tolerate any attempt to bully you into not speaking up. Any such behaviour is a breach of our Trust values and, if upheld following investigation, could result in disciplinary action.

Providing you are acting honestly, it does not matter if you are mistaken or if there is an innocent explanation for your concerns.

6 Confidentiality

The most important aspect of your speaking up is the information you can provide, not your identity. You have a choice about how you speak up:

- **Openly**: you are happy that the person you speak up to knows your identity and that they can share this with anyone else involved in responding.
- **Confidentially**: you are happy to reveal your identity to the person you choose to speak up to on the condition that they will not share this without your consent.
- **Anonymously**: you do not want to reveal your identity to anyone. This can make it difficult for others to ask you for further information about the matter and may make it more complicated to act to resolve the issue. It also means that you might not be able to access any extra support you need and receive any feedback on the outcome.

We hope you will feel comfortable raising your concern openly, but we also appreciate that you may want to raise it confidentially or anonymously.

If you choose to raise concerns confidentially, we will keep your identity confidential unless required to disclose it by law (for example, by the police) or in circumstances where confidentiality cannot be kept, e.g. in relation to patient care and safety, criminal activity, safeguarding, and health and safety.

7 Who can I speak up to?

You can speak up to any of the people or organisations listed below in person, by phone or in writing (including email). Whichever route you choose, please be ready to explain as fully as you can the information and circumstances that have given rise to your concern.

Speaking up internally

Step one

Most speaking up happens through conversations with line managers (or lead clinicians, tutors or supervisors) where concerns are raised and resolved quickly in the course of the day-to-day management of activities in your area. We strive for a culture where that is normal, everyday practice and encourage you to explore this option – it may well be the easiest and simplest way of resolving matters.

Step two

However, you have other options in terms of who you can speak up to internally, depending on what feels most appropriate to you:

- A senior manager or director with responsibility for the issues you are speaking up about.
- If you are a student, your education provider which will have its own policy for speaking up.
- The Patient Safety team (where concerns relate to patient safety or wider quality): add-tr.patientsafety@nhs.net
- The Workforce team (where concerns relate to HR and workforce issues) who are available Monday-Friday 08:00-17:00 and can be contacted by email cuh.hr.consult@nhs.net or on extension 257000.
- Local Counter Fraud team (where concerns relate to fraud) Connect 2 - Local Counter Fraud Specialist
- Our Freedom to Speak Up (FTSU) Guardian – Claire Patterson - who can be contacted by email cuh.raisingconcerns@nhs.net or by the confidential raising concerns phone line (extension 586535 or direct dial 01223 586535). The Freedom to Speak Up Guardian can support you to speak up if you feel unable to do so by other routes. The Guardian will ensure that people who speak up are thanked for doing so, that the issues they raise are responded to, and that the person speaking up receives feedback on the actions taken. You can find out more about the FTSU Guardian role here.
- Freedom to Speak Up Listeners – a group of CUH staff specially trained to listen to your concern and signpost you to appropriate support. A list of local Listeners can be found on Connect: Connect 2 - Speak up listeners

- Our Executive Director with responsibility for Freedom to Speak Up and Raising Concerns – Ian Walker, Director of Corporate Affairs – who provides senior support for our Freedom to Speak Up Guardian and is responsible for reviewing the effectiveness of our Freedom to Speak Up arrangements.

If you feel unable to raise the concern yourself, you may request support from a trade union representative or work colleague. If you wish to remain anonymous, your concern may be raised by your trade union representative or a work colleague on your behalf.

If you do not work for the Trust, you should contact in the first instance the Freedom to Speak Up Guardian or the Director of Corporate Affairs who will support you to raise your concern and direct you to others as appropriate.

Speaking up externally

If you do not feel comfortable in speaking up to someone within the Trust, you can speak up externally to:

- Care Quality Commission (CQC) for quality and safety concerns about the services it regulates – you can find out more about how the CQC handles concerns here.
- NHS England for concerns about: GP surgeries, dental practices, optometrists, pharmacies, how NHS trusts and foundation trusts are being run, NHS procurement and patient choice and the national tariff.

  NHS England may decide to investigate your concern themselves, ask your employer or another appropriate organisation to investigate (usually with their oversight) and/or use the information you provide to inform their oversight of the relevant organisation. The precise action they take will depend on the nature of your concern and how it relates to their various roles.

  Please note that neither the Care Quality Commission nor NHS England can get involved in individual employment matters, such as a concern from an individual about feeling bullied.
- NHS Counter Fraud Authority for concerns about fraud and corruption, using their online reporting form or calling their Freephone line 0800 028 4060.

If you would like to speak up about the conduct of a member of staff, you can do this by contacting the relevant professional body such as the General Medical Council, Nursing and Midwifery Council, Health & Care Professions Council, General Dental Council, General Optical Council or General Pharmaceutical Council.

Remember that if you are a healthcare professional you almost certainly have a professional duty to report a concern. If in doubt, please raise it.

8 What will happen when I speak up?

The Trust is committed to the principles of the Freedom to Speak Up review[1] and its vision for raising concerns and will respond in line with them. We are committed to listening to our staff, learning lessons and improving patient care and the culture of the organisation.

On receipt by the Freedom to Speak Up service, your concern will be recorded and you will receive an acknowledgement within three working days. The confidential central record will record the date the concern was received, whether you have requested anonymity or confidentiality, a summary of the concerns and dates when we have given you updates or feedback.

Appendix A sets out the key steps we will follow when you speak up.

Resolution and investigation

We support our managers/supervisors to listen to the issue you raise and take action to resolve it wherever possible. In most cases, it's important that this opportunity is fully explored, which may be with facilitated conversations and/or mediation. You should be fully informed about how the matter is being handled, how you will be kept updated and within what timeframe you will receive feedback.

Where an investigation is needed, this will be objective and conducted by someone who is suitably independent (this might be someone outside the organisation or from a different part of the organisation) and trained in investigations. The investigation will be objective and evidence-based. It will reach a conclusion within a reasonable timescale (which we will notify you of) and a report will be produced that focuses on identifying and rectifying any issues and learning lessons to prevent problems recurring.

Any employment issues that have implications for you/your capability or conduct identified during the investigation will be considered separately.

We may decide that your concern would be best looked at under a specific existing policy or another process; for example, our grievance and dignity at work policy. If so, we will discuss that with you and the relevant timelines will apply.

When you raise the concern it will be helpful to know what you think the outcome should be. If you have any personal interest in the matter, please tell us at the outset.

[1] *Sir Robert Francis QC (2015), Freedom to Speak Up: an independent report into creating an open and honest reporting culture in the NHS.*

Where possible, we will give you feedback on the outcome of any investigation. Some investigations can be complex and time-consuming – we will keep you updated on the progress of the investigation, and will agree with you how regular these updates will be. Please note, however, that we may not be able to tell you about the precise actions we take where this would infringe a duty of confidence we owe to another person. While we cannot guarantee that we will respond to all matters in the way that you might wish, we will strive to handle the matter fairly and properly. If you have raised a concern anonymously, we will not be able to respond directly or investigate in full without sufficient detail about the area concerned.

If you remain dissatisfied after the steps for raising a concern described above have been followed, the matter may be referred to the Chair of the Trust's Board of Directors who will review the actions taken so far in accordance with this policy and identify any necessary actions to ensure the concern has been investigated appropriately and a response given.

Where individuals or teams are the subject of an investigation following concerns being raised, we will fulfil our duty of care to those individuals and teams. We will ensure that they are offered appropriate support during the investigation process, they are have a named contact, and are updated regularly on the progress of the investigation, the timeframe for completion and the outcome, while recognising the need for confidentiality in some cases.

9 Communicating with you

We will treat you with respect at all times and will thank you for speaking up. We will discuss the issues with you to ensure we understand exactly what you are worried about. If we decide to investigate, we will tell you how long we expect the investigation to take and agree with you how to keep you up-to-date with its progress. Wherever possible, we will share the full investigation report with you (while respecting the confidentiality of others and recognising that some matters may be strictly confidential; as such it may be that we cannot even share the outcome with you).

As noted in the previous section, we will also ensure that those who are subject to any investigation are supported and communicated with on a regular basis.

10 How we learn from your speaking up

We want speaking up to improve the services we provide for patients and the environment our staff work in. Where we identify improvements that can be made, we will ensure necessary changes are made, and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate.

11 Training

We encourage all workers to complete the national on-line 'Speak Up' core training module which can be accessed via the Learning Directory in DOT. There is also a 'Listen Up' module for managers and a 'Follow Up' module for senior leaders.

12 Review

We will seek feedback from workers about their experience of speaking up. We will review the effectiveness of this policy and our local process annually, with the outcome published through regular Freedom to Speak Up reporting to the Board of Directors and changes made as appropriate.

13 Board oversight

The Board of Directors supports staff raising concerns and wants you to feel free to speak up. In addition to the Executive Director lead for Freedom to Speak Up (Ian Walker, Director of Corporate Affairs), there is a link Non-Executive Director for Freedom to Speak Up (Annette Doherty).

The Board will receive a report every six months providing a thematic overview of speaking up by our staff to our Freedom to Speak Up Guardian. We will include similar high level information in the Trust's Annual Report.

14 Advice and support

We recognise that deciding to raise a concern can be extremely difficult and stressful for individuals who may be concerned about the impact on themselves and their colleagues. Occupational Health, Health Assured (the Trust's free confidential counselling service – telephone 0800 783 2808) or the Chaplaincy service can provide emotional support to staff involved in raising a concern.

Your professional body, trades union and/or defence organisation may also be able to provide support and information.

The Trust will not tolerate harassment or victimisation of a worker who has raised a concern. If you feel you are being subjected to such treatment as a result of raising a concern, you should inform the manager dealing with your concern or another senior manager who should take appropriate action, including using the Trust's disciplinary procedure or grievance and dignity at work procedure where applicable to remedy the situation.

You can access a range of health and wellbeing support via NHS England:

- Support available for our NHS people.

- Looking after you: confidential coaching and support for the primary care workforce.

NHS England has a Speak Up Support Scheme that you can apply to for support.

You can also contact the following organisations:

- Speak Up Direct provides free, independent, confidential advice on the speaking up process.
- The charity Protect provides confidential and legal advice on speaking up.
- The Trades Union Congress provides information on how to join a trade union.
- The Law Society may be able to point you to other sources of advice and support.
- The Advisory, Conciliation and Arbitration Service gives advice and assistance, including on early conciliation regarding employment disputes.

15 Making a 'protected disclosure'

A protected disclosure is defined in the Public Interest Disclosure Act 1998. This legislation allows certain categories of worker to lodge a claim for compensation with an employment tribunal if they suffer as a result of speaking up. The legislation is complex and to qualify for protection under it, very specific criteria must be met in relation to who is speaking up, about what and to whom. To help consider whether you might meet these criteria, please seek independent advice from Protect - Speak up stop harm (protect-advice.org.uk) or a legal representative.

16 National Freedom to Speak Up Guardian

The national Freedom to Speak Up Guardian can independently review how staff have been treated having raised concerns where NHS trusts and foundation trusts may have failed to follow good practice, working with some of the bodies listed elsewhere in this policy to take action where needed.

17 The media

A member of staff might also contemplate the possibility of disclosing their concern to the media. Any employee considering such a disclosure should bear in mind that this action may result in them losing 'whistleblowing' protection under the law, and could potentially compromise the investigation process into the concerns.

It is strongly recommended that any employee who is contemplating making a disclosure to the media seeks specialist guidance from professional or other representative bodies. You may wish to discuss matters further with colleagues and line managers as appropriate. Before taking any such action, the employee should:

- Consult the Trust's media handling policy
- Inform the Director of Corporate Affairs (see the *Who can I speak up to?* section above) of their intention

18 Social Media

Social media is an important way for people to share opinions, information and knowledge but is unlikely to be an appropriate vehicle for speaking up and raising concerns. Further information is provided in the Trust's Social Media Policy.

Requests to post anonymously on the CUH staff Facebook page are reviewed by the Communications team and individuals may be directed to alternative routes for raising concerns, including the FTSU Guardian.

19 Monitoring compliance with and the effectiveness of this document

The Director of Corporate Affairs will review the effectiveness of this policy on an ongoing basis in conjunction with the Director of Workforce and the Freedom to Speak Up Guardian. The Board of Directors will receive a twice-yearly report from the Freedom to Speak Up Guardian.

20 Associated documents

- Anti-fraud, bribery and corruption policy
- Being open and the duty of candour policy and procedure
- Management of complaints and concerns policy and procedure
- Disciplinary procedure
- Grievance and dignity at work procedure
- Media handling policy
- Social Media Policy

Equality and diversity statement

This document complies with the Cambridge University Hospitals NHS Foundation Trust service equality and diversity statement.

Disclaimer

It is **your** responsibility to check against the electronic library that this printed out copy is the most recent issue of this document.

Document management

Approval:			
JDTC approval:	n/a		
Owning department:	Corporate Affairs		
Author(s):	Claire Patterson		
Pharmacist:	n/a		
File name:	Freedom to Speak Up and Raising Concerns (Whistleblowing) Policy, Version 1 September 2023		
Supersedes:	Raising Concerns procedure Version 11, March 2020		
Version number:	1	Review date:	September 2026
Local reference:		Document ID:	2828

Appendix A: What will happen when I speak up?

We will:

- Thank you for speaking up
- Help you identify the options for resolution
- Signpost you to health and wellbeing support
- Confirm what information you have provided consent to share
- Support you with any further next steps and keep in touch with you

Steps towards resolution:

- Engagement with relevant senior managers (where appropriate)
- Referral to Human Resources (HR) process
- Referral to patient safety process
- Other type of appropriate investigation, mediation, etc.

Outcomes:

- The outcomes will be shared with you wherever possible, along with learning and improvement identified

Escalation:

- If resolution has not been achieved, or you are not satisfied with the outcome, you can escalate the matter to the senior lead for Freedom to Speak Up or to the Chair of the Trust.
- Alternatively, if you think there are good reasons not to use internal routes, speak up to an external body, such as the Care Quality Commission (CQC) or NHS England.

Board of Directors

NHS
Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 13 September 2023

Agenda item	13
Title	Quarterly Report on Safe Working Hours: Doctors and Dentists in Training (2023/24 Q1)
Sponsoring executive director	Dr Ashley Shaw, Medical Director
Author(s)	Dr Jane MacDougall, Guardian of Safe Working
Purpose	To receive the report on safeguarding working hours.
Previously considered by	Management Executive, 7 September 2023

Executive Summary

This is the first quarterly report for the year 2023/24, based on a national template, to the Board of Directors by the Guardian of Safe Working. This role supports the implementation and maintenance of the 2016 national contract for Doctors in Training and provides an independent oversight of their working hours. The process of exception reporting provides data on their working hours and can be used to record safety concerns related to these and rota gaps. In addition, it can identify missed training opportunities. Reporting to the Board of Directors is a stipulated requirement of this role and this report reflects the position at 30th June 2023. The Trust has 672 doctors in training who have all transferred to the 2016 Terms and Conditions of Service.

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

Action required by the Board of Directors

The Board is asked to note the 2023/24 Q1 report from the Guardian of Safe Working.

Cambridge University Hospitals NHS Foundation Trust

13 September 2023

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

1. Introduction

1.1 The annual Guardian of Safe Working report for 2022-3 described the pattern of exception reporting after the covid-19 pandemic. Last year the number of exception reports continued to increase and were considerably higher than pre-pandemic levels. More exception reports were submitted for missed training opportunities, but these were still a small proportion of the total. The previously noted cyclical variation with more reports submitted in September & October (as new doctors start work) and over the winter (winter pressures and staff vacancies) persisted. Overall working hours were considered safe on most rotas despite all the service pressures. However, areas of concern continued to include under reporting, loss of training and rota gaps.

1.2 The Q1 report describes the Trust's position from April to June. The number of ERs submitted (n=227) is slightly less than Q4 2022-23 (n=250) but higher than Q1 last year 2022-23 (n=207). Levels are also higher than pre-Covid (n=107, Q1 2019-20). Most rotas are compliant with the Terms & Conditions of Service (TCS).

1.3 There has been significant progress on the weekend working issue; out of the original 11 non-compliant rotas only 3 (EM, Transplant, NICU) rotas remain where trainees are working more than the recommended maximum of 1:3 weekends. Significant investment in extra posts in EM and PICU has been agreed and posts created. Recruitment into PICU posts has been arranged. Recruitment into the 15 new posts in EM has been challenging but all posts are now filled in EM & transplant and rotas from August will be compliant leaving just the NICU rota to address.

1.4 Gaps in other rotas also continue to be a major concern (both here and nationally). The workload of the medical staffing department has further increased around the times of industrial action given the need to reschedule rotas and provide appropriate cover for patient care.

1.5 Clinical and educational supervisors do appear to be more supportive of trainees when they exception report. There is increasing recognition that Doctors who are tired can make poor clinical decisions. ER data can be used to drive change and improvements in rotas and working hours and thus improve patient care, and this is perhaps now being more widely recognised.

1.6 The JDF (chaired by a trainee) is now meeting in person (with a virtual link). Senior management joins in the second half of the meeting to listen to trainee concerns. The JDF chairs are invited to attend Board of Directors' meetings and

provide direct feedback to the Board. The Regional GOSW network (chaired by the CUH GOSW) meets virtually every two months. Benchmarking from this group provides reassurance that Trust Board engagement here continues to be more positive than at some other Trusts in the EOE.

2. High level data

Number of doctors / dentists in training (total):	672
Number of doctors / dentists in training on 2016 TCS (total):	672
Number of doctors / dentists on local contracts (Clinical Fellows):	235
Total junior doctor/ dentist establishment:	907
Reference period of report	Q1 2023/2024
Total number of exception reports received	227
Number relating to immediate patient safety issues	2
Number relating to hours of working	212
Number relating to pattern of work	10
Number relating to educational opportunities	5
Number relating to service support available to the doctor	0
Total number work schedule reviews	3
Total value of fines levied	£198.38
Amount of time available in job plan for Guardian to do the role:	2 PAs/8hrs/week
Admin support provided to the Guardian:	1 WTE
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

3. Exception Reports

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

	Immediate safety concerns (ISC)	**Total hours of work**	**Pattern of Work**	**Service support available**	**Educational opportunities**	**TOTAL**
MONTH 1 (April)	1	65	5	0	0	70
MONTH 2 (May)	1	73	3	0	4	80
MONTH 3 (June)	0	74	2	0	1	77
QUARTER	**2**	**212**	**10**	**0**	**5**	**227**

Note: An immediate safety concern report is NOT an additional report but is identified within a report submitted for any other reason and therefore is not counted in the total column (there were 227 reports of which 2 had ISCs).

3.1 Commentary

The number of exception reports has increased and is now higher than in 2021 and 2022. Exception reports were received from a broad range of specialities including General Surgery, Acute and Speciality medicine, Emergency Medicine, Haematology, Oncology, Immunology, Neurology & Neurosurgery, Ophthalmology, T & O, Maxillary-Facial Surgery, Obstetrics & Gynaecology, Neonatology and Paediatrics. Educational ERs have been received from anaesthetics, General Surgery, Geriatrics, Obstetrics & Gynaecology and Paediatrics.

3.2 Trends in Exception Reporting

Levels of exception reporting in Q1 (n=227) were slightly lower compared to those in Q4 2022-23 (n=250) but higher than those last year in Q1 2022-23 (n=207). They are also higher compared to those in Q1 2019-20 pre covid (n=107). Reporting of missed educational opportunities remains low. There were no exception reports linked to service support issues. The number of immediate safety concerns remains low and has reduced from the last quarter.

3.3 Resolutions

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

	TOIL granted	**Payment for additional hours**	**Work schedule reviews**	**No action**	**TOTAL**
MONTH 1 (April)	0	28	0	4	32
MONTH 2 (May)	0	57	0	5	62
MONTH 3 (June)	0	60	0	7	67
QUARTER	**0**	**145**	**0**	**16**	**161**

3.4 Commentary

All trainees who submitted exception reports this quarter were asking for payment for extra hours worked rather than time off in lieu (TOIL) which is the preferred option to improve their wellbeing. This is primarily because the reasons for reporting are rota gaps or a high workload and therefore additional TOIL would only compound the problem.
The discrepancies in totals in this table reflect the timings of ER submission and sign off.

4. Work schedule reviews

Month	Specialty/Department & Grade	Details of work schedule review
August 2021	A & E/ ED rotas	Review to reduce weekend working – previously > 1: 3 weekends. The Trust agreed to fund 15 new medical posts. Recruitment has been completed and with rotas changed from August 2023, trainees will now be working no more than 1:3 weekends.
August 2021	Transplant	Review to reduce weekend working - previously > 1:3 weekends. Single post agreed and recruitment completed. Rota now compliant.
August 2021	NICU	Review continues to reduce weekend working. Will require 3 new posts (2 junior rota, one senior rota). Awaiting budget setting.

4.1 Commentary

There were no new work schedules this quarter. Two of the previous 3 work schedule reviews are completed. There is now only one rota (NICU) that has not yet been able to reduce weekend working to 1:3 or less as per the new TCS (2019). Progress to resolve this has been held up by the impact of industrial action on the medical staffing department's workload.

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

Department	Safety concern raised	Action(s) proposed and/or taken
Medicine Core GIM in Transplant dept	Breaks could not be taken – concern expressed over work duties on transplant service and impact on patient care	Discussed with dept

6. Fines

Fines levied against departments this quarter (break down calculations delayed for same reason as in item 4.1 above):

Department	Detail	Total value of fine levied
Total fines levied	Clinical Pharmacology April 2023	£198-38

	TOTAL
Balance at end of last quarter	**£6333.52**
Fines incurred this quarter	**£198.38**
Cumulative total	**£198.38**
Total paid to trainees (£)	**£198.38**
Total spent (£)	**£0**
Balance at end of this quarter	**£6531.90**

7. Junior doctor forums and junior doctor engagement

7.1 The JDF is now being held face to face in the Doctors' Mess with a virtual link since September 2022. Senior management (various of Medical Director, DME, LTFT lead, Medical Staffing lead and team, Workforce Lead & Freedom to Speak up Guardian) join for the second half of the meeting. Issues discussed included the rotas in EM and weekend working, rota gaps, locum rates & industrial action. The importance of exception reporting was emphasised and is encouraged.

8. Doctors and dentists in training not on 2016 TCS

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

9. Assurance processes

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

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

- Requesting trainee feedback – a survey of juniors

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

9.3 Benchmarking takes place regionally and nationally via the GOSW who is chair of Regional GOSW network and arranges minuted meetings of the regional network every two months and attends national meetings on alternate months.

9.4 A survey of trainees' views of exception reporting was distributed by the JDF in Q4 2020-21 (please see summary in Q4 report). We will plan to repeat the trainee survey later this year.

10. Key Issues and Summary

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

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

10.3 The revised TCS (2019) advised that trainees should not work more frequently than 1:3 weekends, as discussed in previous reports. CUHFT had a number of rotas (n=11, mostly EM and intensive care) which required trainees to work more than 1 in 3 weekends. Exemptions were agreed in September 2019 but were not renewed. Several rotas were resolved (n=8) in 2021. The Trust committed significant funding (> £1 million) to new medical posts in EM, PICU & transplant in Q1 of last year. Recruitment to these new posts is now complete and rotas rewritten for August this year. The NICU rota remains unresolved.

10.4 Concerns were previously expressed that some individuals would require an extension to their training due to the impact of the Covid pandemic particularly for the craft specialities but this did not appear to have been necessary last year. We are awaiting the outcome of ARCPs this summer as a measure of adequate training progress. Hospitals are under pressure to address the backlog of patient care and there continues to be a risk that training will not be prioritised.

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

10.6 The Junior Doctors Forum (JDF) has the potential to identify, discuss and jointly address, with the Medical Director, Medical Staffing, the Guardian and the Postgraduate Medical Education Centre, rota and training issues as they arise. Improving the working conditions and morale of junior doctors is important as it will aid recruitment and retention, reducing rota gaps and will thus improve patient safety. Monthly meetings of the JDF are once more being held in person which has improved attendance.
Exception reporting suggests that working hours remained mostly compliant in Q1 and patient safety has rarely been compromised. There are extra hours worked on some rotas and continuing problems with rota gaps that cannot be filled with locums. Concerns now are focussed on the persistent backlog of patient care post pandemic recovery and how best to ensure training alongside service within the amended (2019) 2016 Terms and Conditions for Service.

11. Recommendations

11.1 The Board of Directors is asked to note the 2023/24 Q1 report from the Guardian of Safe Working.

12. Appendices

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

Appendix 1: Glossary of Terms and Abbreviations

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

Director of Medical Education (DME)	The DME is a member of consultant medical staff and an employee of the employer / host organisation who leads on the delivery of postgraduate medical and dental education in the Local Education Provider (LEP), ensuring that doctors receive a high quality educational experience and that GMC/GDC standards are met, together with the strategic direction of the organisation and Health Education England (HEE). The DME is responsible for delivering the educational contract between the LEP/ lead provider (LP) and HEE local team. For the purposes of these terms and conditions, where reference is made to the DME, the responsibilities described may be discharged by a nominated deputy to the DME.

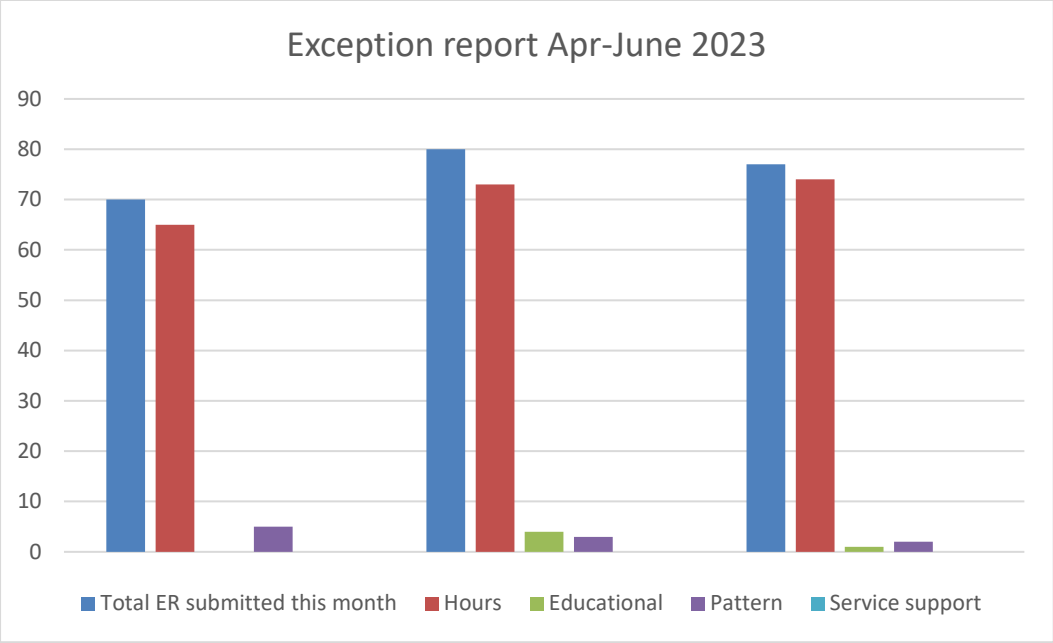
Doctor or dentist in training	A doctor or dentist in postgraduate medical or dental education undertaking a post of employment or a series of posts of employment in hospital, general practice and/or other settings.
Educational review	An educational review is a formative process which enables doctors to receive feedback on their performance and to reflect on issues that they have encountered. Doctors will be able to raise concerns relating to curriculum delivery and patient safety. This will include regular discussions about the work schedule.
Educational supervisor	A named individual who is selected and appropriately trained to be responsible for supporting, guiding and monitoring the progress of a named trainee for a specified period of time. The educational supervisor may be in a different department, and occasionally in a different organisation, to the trainee. Every trainee should have a named educational supervisor and the trainee should be informed of the name of the educational supervisor in writing. This definition also covers approved clinical supervisors in GP practice placements.
Episodes of work	Periods of continuous work within an on call period separated by periods of rest.
Exception reporting	Mechanism used by doctors to inform the employer when their day- to-day work varies significantly and/or regularly from the agreed work schedule. Primarily these variations will be differences in total hours of work, pattern of hours worked, in the educational opportunities and support available to the doctor.
Guardian of safe working hours	A senior appointment made jointly by the employer / host organisation and junior doctors, who ensures that issues of compliance with safe working hours are addressed by the doctor and/or employer/host organisation, as appropriate and provides assurance to the Board of the employing organisation that doctors' working hours are safe.
On-call	A doctor is on-call when they are required by the employer to be available to return to work or to give advice by telephone but are not normally expected to be working on site for the whole period. A doctor carrying an ‘on-call’ bleep whilst already present at their place of work as part of their scheduled duties does not meet the definition of on-call working.

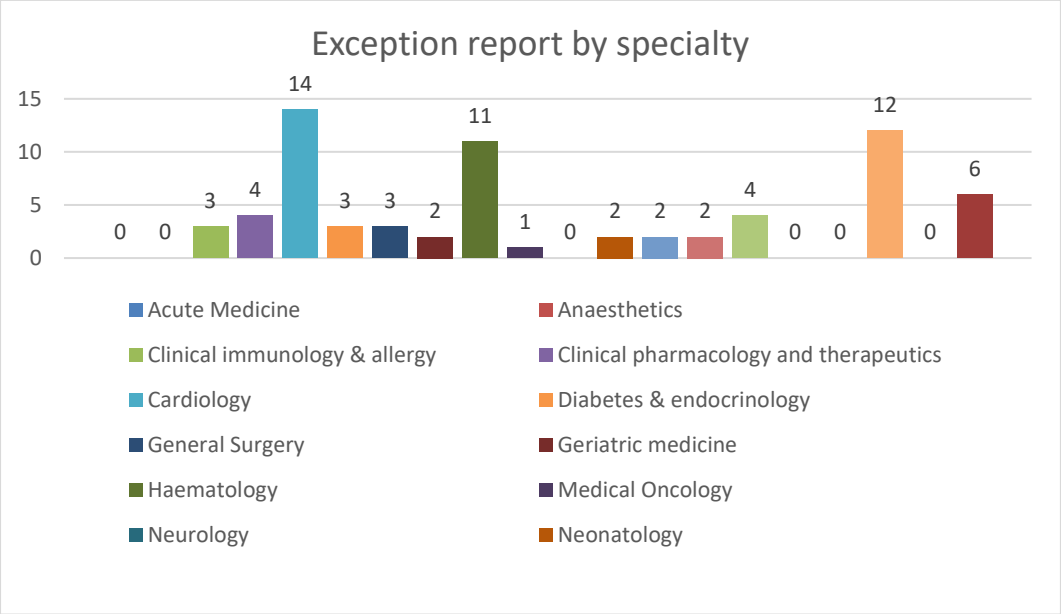
On-call period	An on-call period is the time that the doctor is required to be on call (as defined above) by their employer.
Placement	For the purposes of these TCS, a placement is a setting into which a doctor is placed to work for a fixed period of time in a post or posts in order to acquire the skills and competencies relevant to the training curriculum, as described in the work schedule.
Post	For the purposes of these TCS, a post has approval by the GMC/HEE for the purposes of postgraduate medical and dental education. Each approved post is located within an employer or host organisation.
Rota	The working pattern of an individual doctor or group of doctors.
Rota cycle	The number of weeks' activity set out in a rota, from which the average hours of a doctor's work and the distribution of those hours are calculated.
Rotation	A rotation is a series of placements made by the HEE local office into posts with one or more employers or host organisations. These can be at one or more locations.
Senior independent director	Non-executive director appointed by the board of directors to whom concerns regarding the performance of the guardian of safe working hours can be escalated where they are not properly resolved through the usual channels.
Shift	The period which the employer schedules the doctor to be at the work place performing their duties, excluding any on-call duty periods.
Training programme	Training programmes and training posts are approved by the GMC or (for dental programmes) HEE. Learning environments and posts used for training are recommended for approval by HEE for the purpose of postgraduate medical/dental education. Time spent in those posts/environments allows the doctor to acquire and demonstrate the competencies to progress through the training pathway for their chosen specialty (including general practice) and to acquire a Certificate of Completion of Training (CCT).

Work schedule	A work schedule is a document that sets out the intended learning outcomes (mapped to the educational curriculum), the scheduled duties of the doctor, time for quality improvement, research and patient safety activities, periods of formal study (other than study leave), and the number and distribution of hours for which the doctor is contracted.
Work schedule review	A work schedule review is a formal process by which changes to the work schedule may be suggested and/or agreed. A work schedule review can be triggered by one or more exception reports, or by a request from either the doctor or the employer. A work schedule review should consider safe working, working hours, educational concerns and/or issues relating to service delivery.
WTR reference period	Reference period as defined in the Working Time Regulations 1998 (as amended), currently 26 weeks.

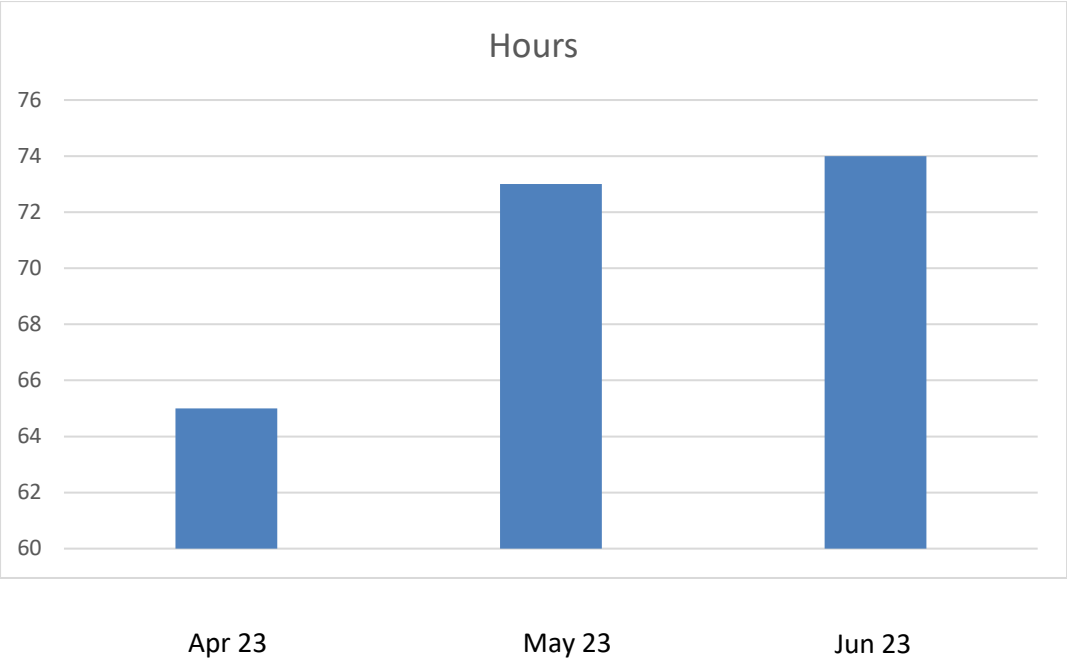
Appendix 2: Exception report data

April - June 2023

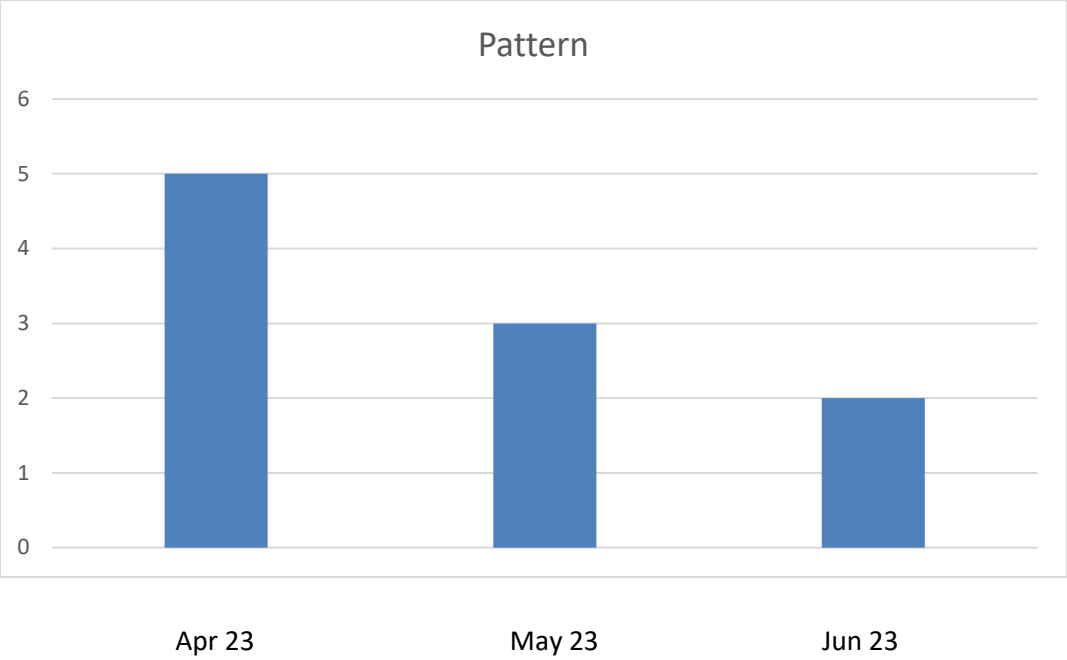




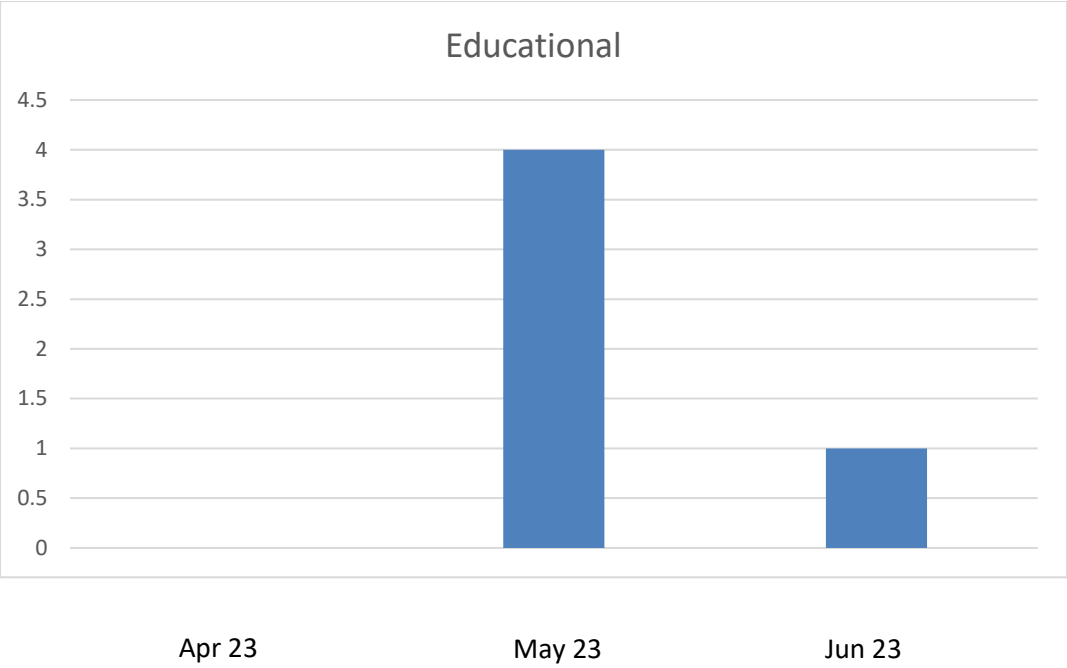
Exception reports by theme: Hours



Exception reports by theme: Pattern



Exception reports by theme: Educational



Board of Directors

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Cambridge University Hospitals
NHS Foundation Trust

Together
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Kind
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Report to Board of Directors: 13 September 2023

Agenda item	14
Title	Learning from Deaths Quarterly Report
Sponsoring executive director	Ashley Shaw, Medical Director
Author[s]	Amanda Cox, Deputy Medical Director Chris Edgley, Patient Safety Lead
Purpose	For Information and discussion
Previously considered by	Management Executive, 7 September 2023

Executive Summary

Between April 2023 and June 2023 [Q1], there were 397 deaths; of these 32 [8%] were in the Emergency Department, the remainder were inpatient deaths.

- 22% [86/397] met the criteria for a Structured Judgement Review [SJR] during Q1.
- 1% [1/86] of the SJRs completed within Q1 identified significant problems in care [scores 1-3].

Between April 2023 and June 2023, there was one serious incident in relation to an unexpected/potentially avoidable death reported to the commissioners. There have been no Prevention of Future Deaths ordered between April 2023 and June 2023.

On a quarterly basis, representatives from across the system are invited to join the Learning from Deaths Committee. This includes CPFT, ICB, East of England Ambulance Trust, Royal Papworth and the Senior Coroner for Cambridgeshire and Peterborough with the focus on developing reliable and robust pathways to share learning both within and across organisational boundaries.

Related Trust objectives	Improving patient care
Risk and Assurance	The report provides assurance on the arrangements in place to ensure learning from deaths.
Related Assurance Framework Entries	n/a
Legal implications/Regulatory requirements	n/a
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of “Together: safe, kind and excellent”?	n/a

Action required by the Board of Directors
The Board is asked to receive the learning from deaths report for 2023/24 Q1.

Cambridge University Hospitals NHS Foundation Trust

13 September 2023

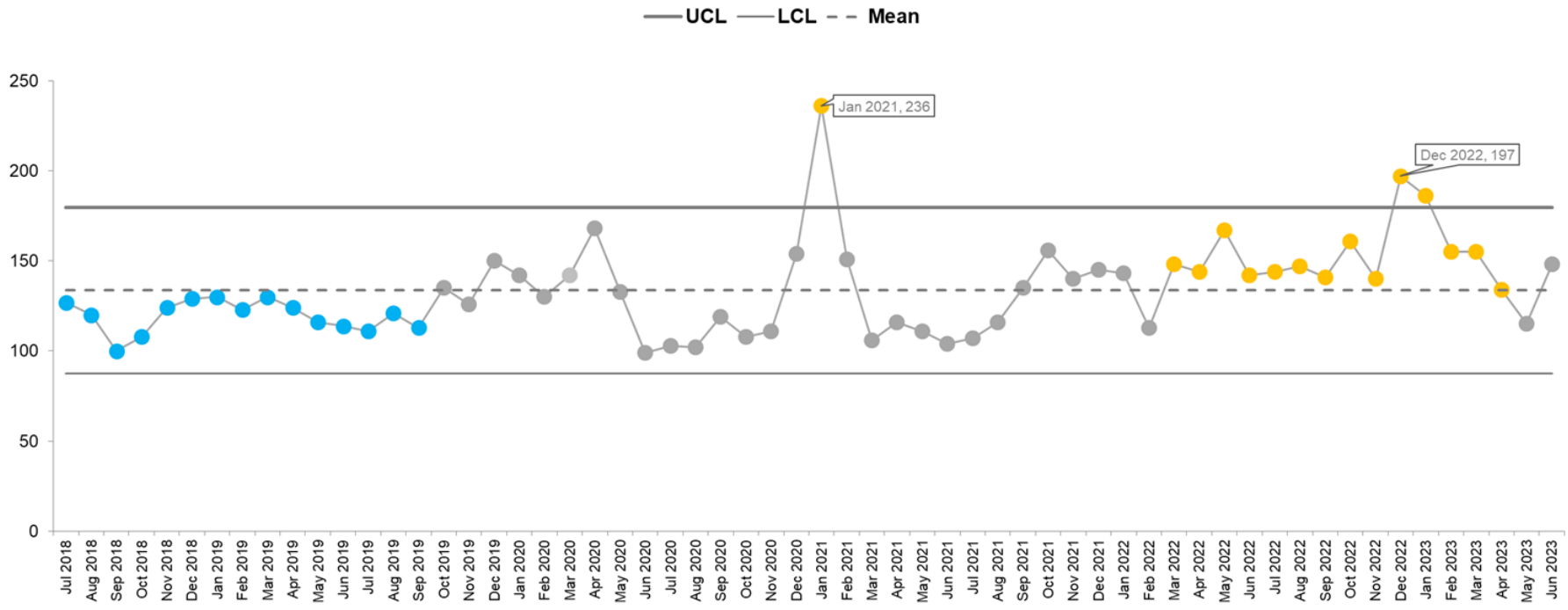
Board of Directors
Learning from Deaths Quarterly Report

1. Number of deaths in Quarter

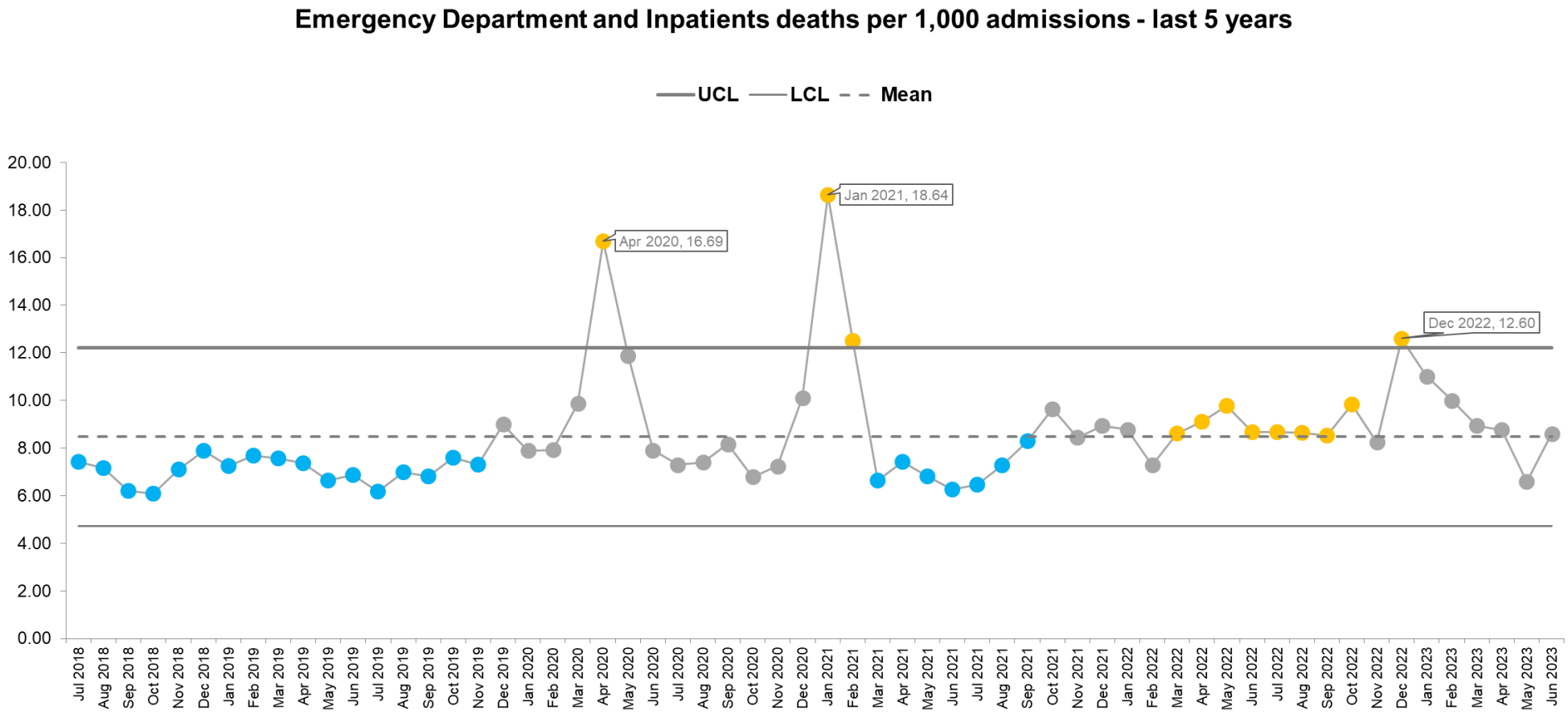
There were 397 deaths between April 2023 and June 2023 [Q4] [Emergency Department [ED] and inpatients], of which 22% [86/397] were in the ED and 78% [311/397] were inpatient deaths.

Graph 1 shows total CUH deaths [inpatients and ED] that have been recorded on Epic from July 2018 to June 2023

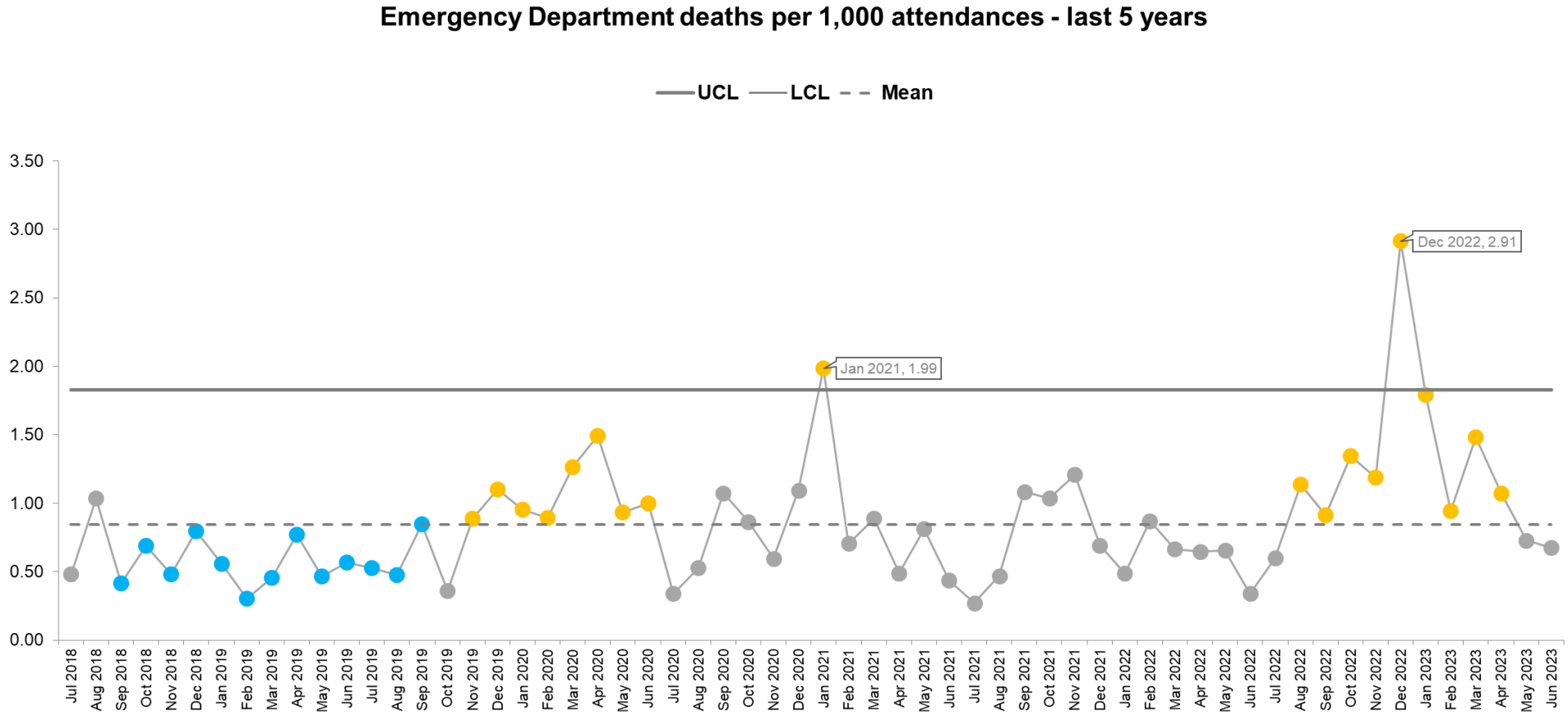
Total CUH deaths last 5 years - (Emergency Department and Inpatients)



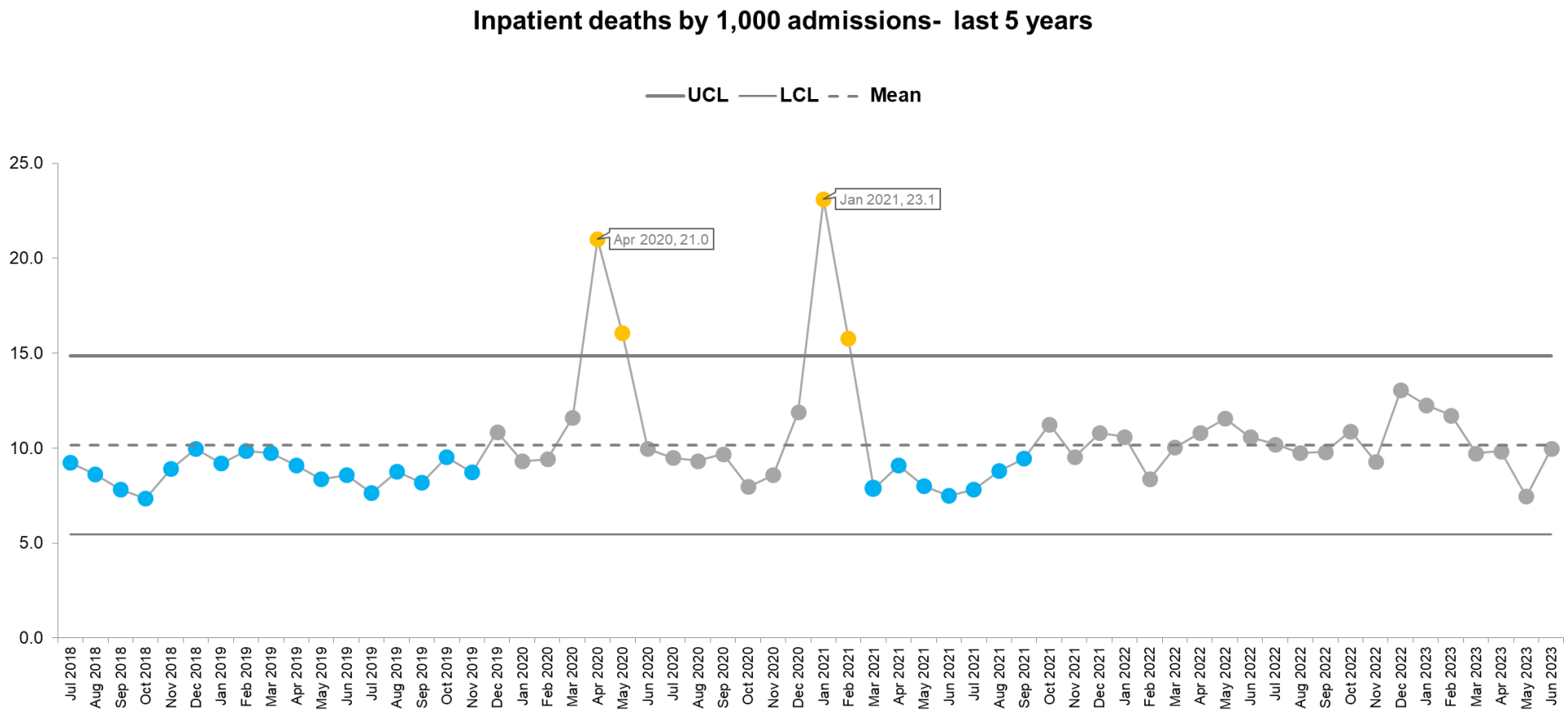
Graph 2 demonstrates total CUH deaths per 1,000 admissions that have been recorded on Epic from July 2018 to June 2023.



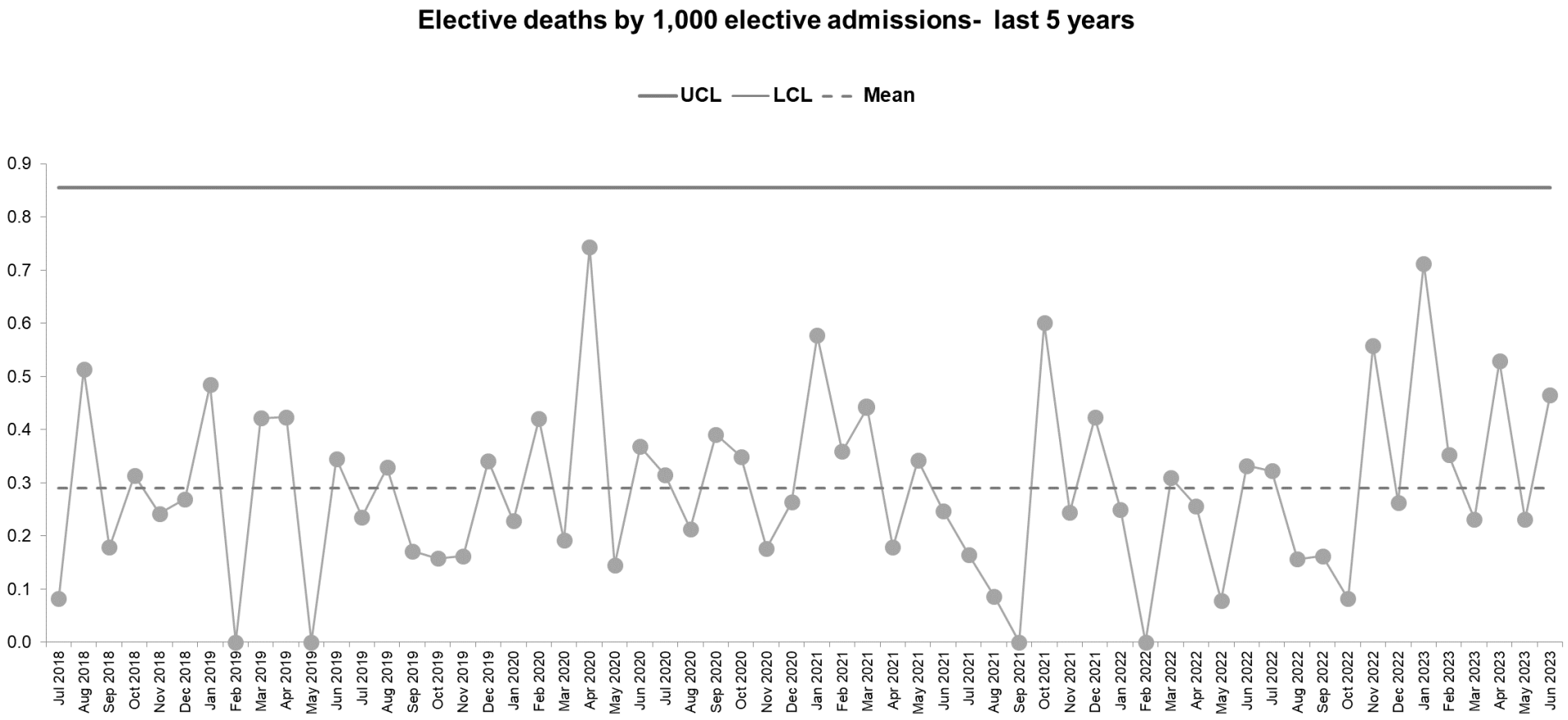
Graph 3 shows Emergency Department deaths per 1000 Emergency Department admissions from July 2018 to June 2023.



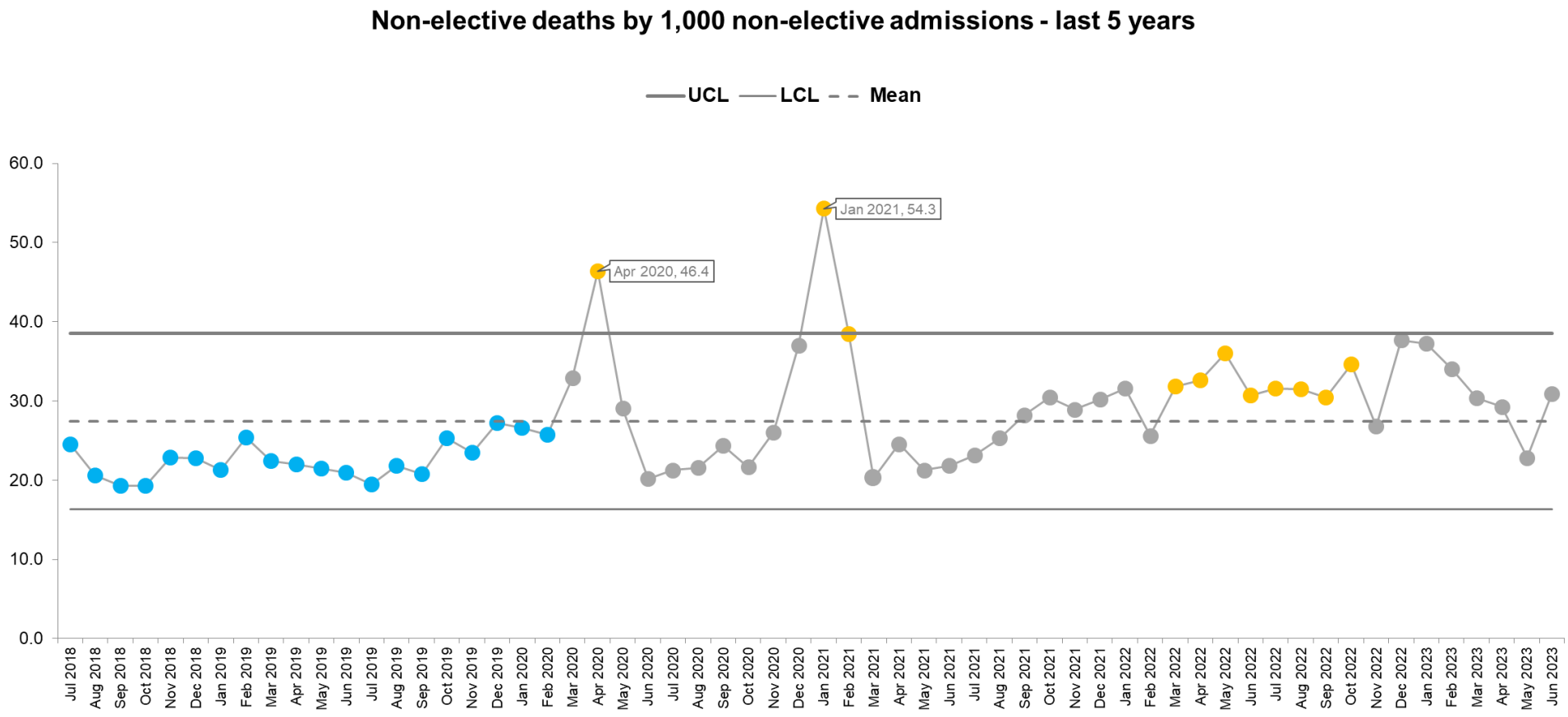
Graph 4 shows inpatient deaths per 1000 inpatient admissions from July 2018 to June 2023. There is currently normal variance.



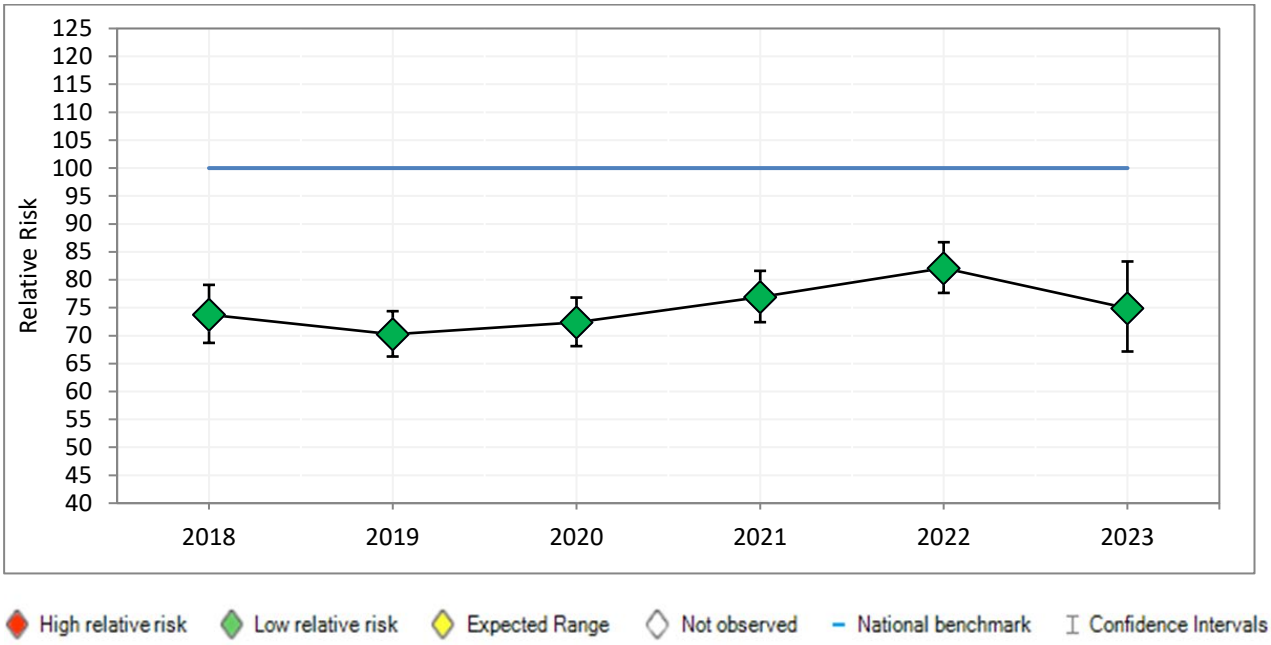
Graph 4a shows inpatient elective admission deaths by 1000 elective admissions, from July 2018 to June 2023. There is currently normal variation in the number of inpatient elective admission deaths.



Graph 4b shows inpatient deaths in a non-elective admission by 1,000 non-elective admissions from July 2018 to June 2023 and it is currently within normal variation.



Graph 5 displays the latest Hospital Standardised Mortality Ratio [HSMR] figures by month from April 2018 to March 2023



2. Mortality case review process – Structure Judgement Review [SJR]

The table below shows a summary of learning from deaths key performance indicators [KPIs] in Q1 of 2023-2024 financial year

Learning from deaths summary														
KPI	No. of deaths in month	No. of deaths in-scope	Compliance with SJRs		Problems in Care Identified [score 1-3]	Serious Incidents triggered by SJRs	% of problems in care (by deaths 'in scope')		% of all deaths with problems in care (by total deaths in month)		SJRs triggered by family / carers	SJR training compliance	PFD issued to CUH
			Number received	Number due			Month	Quarter	Month	Quarter			
Apr-23	134	28	64% 18	28	1	0	6% 1	18	1% 1	134	0	89% 16	18	0
May-23	115	22	45% 10	22	0	0	0% 0	10	0% 0	115	0	70% 7	10	0
Jun-23	148	36	33% 12	36	0	1	0% 0	12	0% 0	148	0	83% 10	12	0

3% 1 40

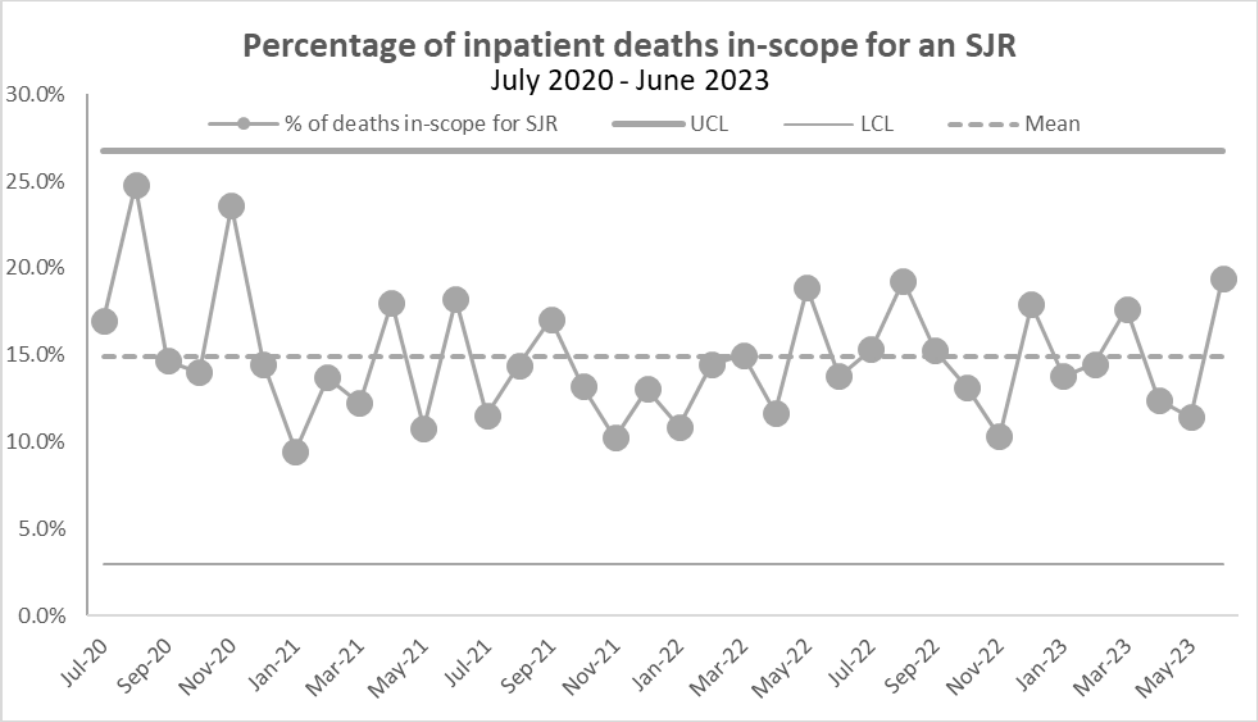
0% 1 397

3. Structured judgement review [SJR] compliance

3.1. Deaths in-scope

Between April 2023 and June 2023, 22% [86/397] met the criteria for a Structured Judgement Review [SJR].

Graph 6 shows the percentage of inpatient deaths that are in-scope for an SJR over time from July 2020 to June 2023. There is currently normal variation.



Of the 100 in-scope deaths identified in Q1, 45% of SJRs [47/86] have been completed to date. The compliance figures for each division are shown in the table below.

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

4.1. SI investigations commissioned between April 2023 – June 2023

There has been one SI commissioned in relation to an unexpected death between April and June 2023.

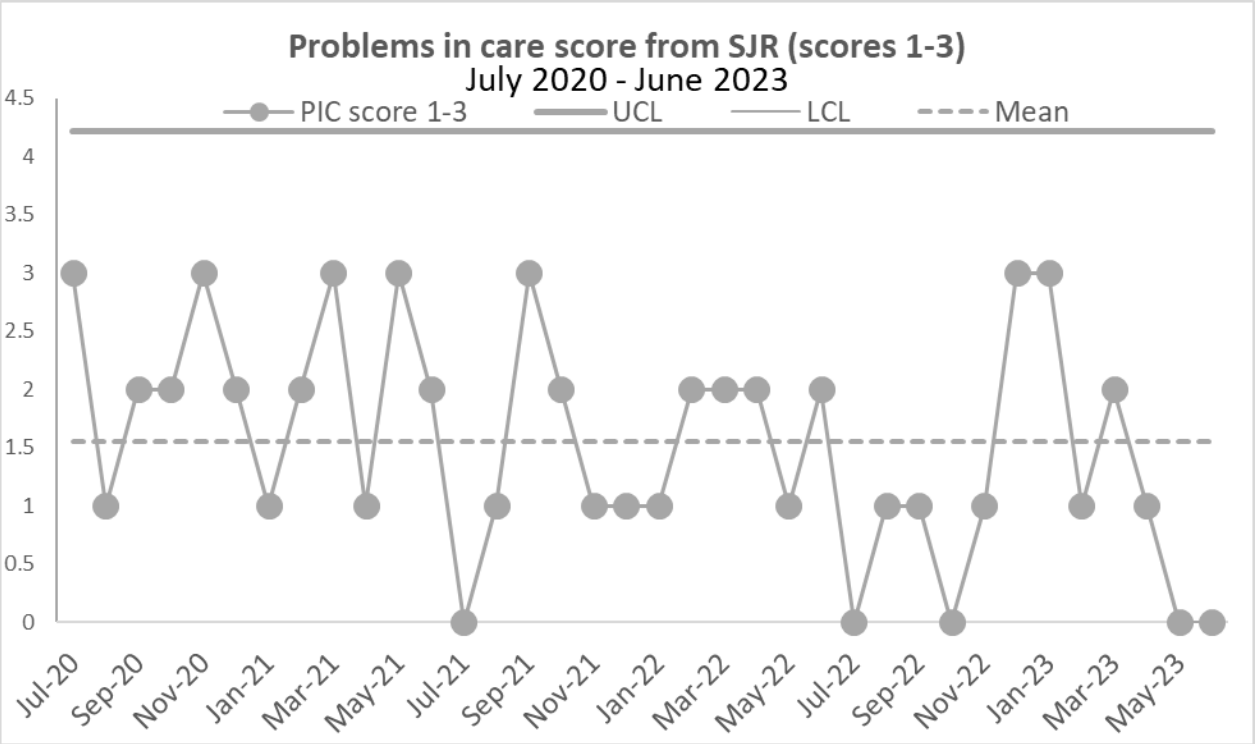
4.2. Structured Judgement Review problems in care scores

One SJR has highlighted less than satisfactory care between April 2023 and June 2023. The SJRs is being investigated as a Serious Incident by an external Trust with CUH input. The SJR will be shared with the Coroner for information.

The percentage of deaths with problems in care [scores1-3] identified through the SJR process, from April 2023 - June 2023 is 1% [1/86]. The distribution of these scores are shown in the table below:

	Poor quality of care [1]	Less than satisfactory [2]	Room for improvement [3]	Room for improvement [4]	Room for improvement [5]	Good practice [6]
	Multiple aspects of clinical &/or organisational care that were well below what you consider acceptable.	*Several aspects of clinical &/or organisational care that were well below what you consider acceptable*	*Aspects of both clinical and organisational care that could have been better.*	*Aspects of organisational care that could have been better and may have had an impact on the patient's outcome.*	*Aspects of clinical care that could have been better but not likely to have had an impact on the outcome.*	*A standard that you consider acceptable.*
Apr-23	0	0	1	1	3	11
May-23	0	0	0	0	2	6
Jun-23	0	0	0	1	0	8

Graph 7 shows the number of SJRs with problems in care score of 1-3 from July 2020 to June 2023. There is currently normal variation.



5. Structured judgement reviews triggered by family/carers

5.1 There were no SJRs initiated by family/carers concerns between April 2023 and June 2023.

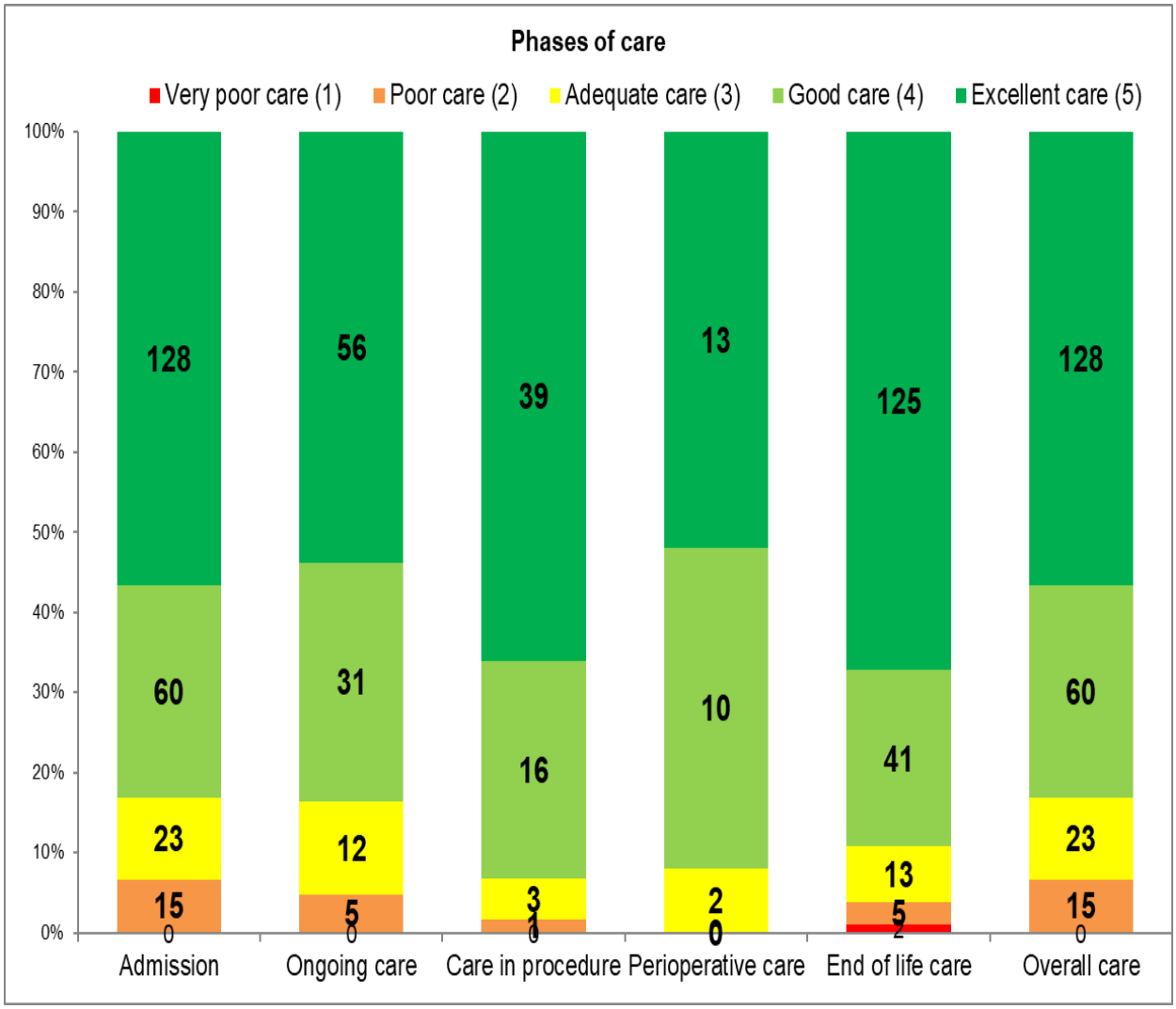
6. Prevention of future death reports issued to Cambridge University Hospitals

6.1 There have been no Prevent Future Death reports issued to CUH in this quarter.

7. Learning

Learning from phases of care

7.1 Scores allocated to each of the phases of care are displayed in the graph below for all completed SJRs between September 2022 to August 2023.



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

8. Learning from deaths improvement plan

8.1 A new Learning From Deaths Quality Improvement Group has been set-up. Initial focus of the group is digitalising the SJR process and reviewing what extra information can be extracted through this process.

Board of Directors

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Report to the Board of Directors: 13 September 2023

Agenda item	15
Title	Research and Development
Sponsoring executive director	Ashley Shaw, Medical Director
Author(s)	John Bradley, R&D Director
Purpose	To provide an update on Research and Development activity
Previously considered by	Management Executive, 7 September 2023

Executive Summary

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

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

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

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

Cambridge University Hospitals NHS Foundation Trust

13 September 2023

Board of Directors

Research and Development

John Bradley, Director of R&D

1. NIHR Cambridge Biomedical Research Centre and Clinical Research Facility

1.1 The national Institute for Health and Care Research (NIHR) have provided feedback on the final Biomedical Research Centre (BRC) annual report for the period to October 2022, commending the BRC on a number of activities, including early cancer research, and the major clinical impact achieved in pregnancy outcomes, Setmelanotide for severe obesity syndromes, and the Cytosponge®-TFF3 for detection of precancerous Barrett's oesophagus. The contribution of the NIHR BioResource to national infrastructure was recognised, and the impressive number of major grants awards received during the lifetime of the contract was noted.

1.2 The BRC and NIHR Clinical Research Facility hosted a successful visit by a team from NIHR on 20 June 2023.

2. NIHR BioResource

2.1 Cambridge University Hospitals hosts the NIHR BioResource, one of four key infrastructures supporting population level genomic projects in the Life Science Industrial Strategy. A key focus this year has been to reach groups often under-represented in research.

2.2 D-CYPHR, the Children and Young People's BioResource was launched nationally in July 2023 to recruit children up to the age of 15 who provide information about their health and lifestyle, access to their health records, and a saliva sample from which DNA can be extracted. During the first month over 1700 expressions of interest have been received and over 500 children have consented.

2.3 The Improving Black Health Outcomes study aims to recruit people from Black communities, with and without health conditions that are commoner in Black communities, including diabetes, pregnancy/childbirth complications and sickle cell disease. Study set up has involved extensive patient and public involvement, with the aim of starting recruitment in Q4 of 2023.

3. Health Data Research

Cambridge led Covid-19 clinical trials

3.1 PROTECT-V (PROphylaxis for vulnerable paTiEnts at risk of COVID-19 infecTion), CI Rona Smith, is evaluating the use of agents to prevent COVID-19 in vulnerable patients, including kidney patients on dialysis or receiving immunosuppression for a renal transplant. The study is an international partnership between the NHS, academia, industry and charities including Addenbrooke's Charitable Trust is a 'platform trial', which allows new drugs to be added.

3.2 Niclosamide, a drug used to treat intestinal worms that has shown activity against SARS-CoV-2 in the laboratory and was delivered as a nasal spray, was found not to prevent infection in vulnerable patients. 1653 patients were randomsied to receive the niclosamide or placebo arm, making it the largest pre-exposure prophylaxis study of a repurposed agent conducted globally.

3.3 Sotrovimab, a fully humanised neutralising monoclonal antibody directed against the spike protein of SARS-CoV-2 was added in 2022, and recruitment to the sotrovimab arm is ongoing.

4. Recommendations

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

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Report to the Board of Directors: 13 September 2023

Agenda item	16
Title	Board Assurance Framework and Corporate Risk Register
Sponsoring executive director	Ian Walker, Director of Corporate Affairs Lorraine Szeremeta, Chief Nurse
Author(s)	Jumoke Okubadejo, Director of Clinical Quality; Elke Pieper, Head of Risk and Patient Outcomes; Ian Walker, Director of Corporate Affairs
Purpose	To receive the latest versions of the BAF and CRR.
Previously considered by	Risk Oversight Committee, 24 August 2023

Executive Summary

The Board Assurance Framework (BAF) and the Corporate Risk Register (CRR) are refreshed on a monthly basis through discussion with the Executive Director leads for each risk and presented to the Risk Oversight Committee for review. The risks are assigned to Board assurance committees for oversight and they are also received by the Board four times a year (most recently in May 2023).

This paper provides the Board with the latest version of the BAF which contains 15 principal risks to the achievement of the Trust's strategic objectives. 10 of these risks are currently rated at 15 or above.

The paper also provides a summary of the current CRR risks, as reviewed by the Risk Oversight Committee on 24 August 2023.

Related Trust objectives	All objectives
Risk and Assurance	The report sets out the principal risks to achievement of the Trust's strategic objectives.
Related Assurance Framework Entries	All BAF entries.
Legal implications/Regulatory requirements	The BAF is a key document which informs the Annual Governance Statement.
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	n/a

Action required by the Board of Directors

The Board is asked to receive and approve the current versions of the Board Assurance Framework and the Corporate Risk Register.

Cambridge University Hospitals NHS Foundation Trust

13 September 2023

Board of Directors
Board Assurance Framework and Corporate Risk Register
Ian Walker, Director of Corporate Affairs
Lorraine Szeremeta, Chief Nurse

1. Introduction

1.1 The Board Assurance Framework (BAF) provides a structure and process which enables the Board of Directors to focus on the principal risks which might compromise the achievement of the Trust's strategic objectives. The BAF identifies the key controls which are in place to manage and mitigate those risks and the sources of assurance available to the Board regarding the effectiveness of the controls. The BAF is received by the Board four times a year (most recently in May 2023 - the April 2023 version).

1.2 The Board also receives a report four times a year on the Corporate Risk Register (CRR) to provide additional assurance that key operational risks are being effectively managed.

1.3 Board assurance committees review both the BAF and the CRR risks assigned to them at each meeting. The BAF and CRR are refreshed on a monthly basis in discussion with the lead Executive for each risk and then reviewed by the Risk Oversight Committee.

2. Board Assurance Framework

2.1 The August 2023 version of the BAF is attached at Appendix 1. It incorporates updates from monthly reviews undertaken since the last report to the Board in May 2023. These have been reviewed by the respective Board assurance committees.

2.2 There are currently 15 risks on the BAF, unchanged from the previous version received by the Board.

2.3 A detailed log of monthly amendments and updates to the BAF as reviewed by the Risk Oversight Committee is available to Board members on request. There have been a number of updates to controls and assurances and to actions to address gaps in controls and assurance over the past month.

2.4 As Board members are aware, the BAF now includes medium-term trajectories for each of the BAF risks, indicating how the level of risk is expected to change over time in response to the implementation of actions

within the Trust's control and/or or anticipated external developments. This work is intended to support the Board in tracking risk profiles over time and assessing risk trajectories against the Trust's risk appetite.

2.5 In terms of key amendments to individual BAF risks during this four-month period, the following are highlighted:

- BAF 011: the Chief Finance Officer updated the risk to reflect the delivery of the 2022/23 financial plan and the agreement of a break-even financial plan for 2023/24. The Risk Oversight Committee agreed a recommendation from the Chief Finance Officer to reduce the current risk from I4xL4=16 to I4xL3=12 following delivery of 2022/23 financial plan and agreement of a financially-sustainable 2023/24 plan. (*May 2023*)

- BAF 001: this risk was refreshed to reflect the revised Operational Strategy which was endorsed by the Performance Committee and the Board of Directors in June 2023. The previous focus on the response to winter and Covid was removed. (*June 2023*)

- BAF 009: there are ongoing discussions relating to (i) realigning this risk from a focus on business case delivery towards a broader focus on longer-term capacity and the Addenbrooke's 3 programme; and (ii) reviewing how key delivery risks (relating to both construction and service redesign/transformation) are best managed in the context of a review of CCRH/CCH governance, project risk registers and reporting. Recommendations will be brought to the Risk Oversight Committee over the next few months. (*August 2023*)

- Conversations have taken place as to whether the impact of ongoing industrial action is appropriately reflected within the BAF and the CRR. It was noted that the direct impacts of industrial action on patient flow, waiting lists, staffing and finances in particular are covered on the CRR (risk CR57) and through individual risks on the BAF. Consideration was given through these discussions as to whether a separate BAF risk should be created to capture the potential wider impact of ongoing industrial action on the Trust's ability to plan more broadly and progress its strategic agenda. It was recognised that this could become an increasing challenge if action continues through the autumn and winter, but it was noted that the opportunities for the Trust to mitigate this, beyond the current activities of lobbying and highlighting the adverse impact of industrial action, are relatively limited. The Committee agreed to further review the position at its next meeting. (*August 2023*)

2.6 Of the 15 current BAF risks, 10 are ‘Red’ rated at 20, 16 or 15 as follows:

- Capacity and patient flow (20)
- Fire safety (20)
- Estates backlog maintenance and statutory compliance (20)
- Staffing availability (20)
- Effective prioritisation of patients in greatest clinical need (16)
- Equality, diversity and inclusion (16)
- Staff health and wellbeing (16)
- Prioritisation of IT resources (16)
- New hospitals development (16)
- Environmental sustainability and carbon reduction (16)

The financial sustainability risk has been reduced from a rating of 16 to 12 since the May 2023 Board meeting.

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

2.8 The table below summarises the mapping of the BAF risks to the Trust’s strategic commitments (as appended to the BAF).

Table 1: Strategic commitments and associated BAF risks

Strategic objective	Associated BAF risks
A1	010
A2	001
A3	001, 002
A4	004, 008
A5	002, 004
B1	007
B2	007
B3	013
B4	008
B5	013
C1	010, 014
C2	012
C3	005, 006, 009
C4	015
C5	003

3. Corporate Risk Register

3.1 The risks on the CRR are reviewed on an ongoing basis by the Risk Oversight Committee and the relevant Board assurance committees.

3.2 The current CRR is summarised at Appendix 1. There are currently 45 risks on the CRR.

4. Recommendations

4.1 The Board of Directors is asked to receive and approve the current versions of the Board Assurance Framework and the Corporate Risk Register.

Appendix 1: Corporate Risk Register summary, August 2023

CRR Ref	Title	CQC Domain	Executive Director	Assurance Committee	Inherent rating (C x L)	Current rating (C x L)	Target rating (C x L)	Jun-23	Jul-23	Aug-23
CR04b	Medical device repairs and planned preventative maintenance	Safe	Medical Director	Quality	4x5=20 (Red)	4x5=20 (Red)	4x2=8 (Amber)	Same	Same	Same
CR05a	Insufficient urgent and emergency capacity to meet patients' needs	Responsive	Chief Operating Officer	Performance	4x5=20 (Red)	4x5=20 (Red)	3x4=12 (Amber)	Same	Same	Same
CR05c	Insufficient outpatient capacity to meet patients' needs	Responsive	Chief Operating Officer	Performance	4x5=20 (Red)	4x5=20 (Red)	3x4=12 (Amber)	Same	Same	Same
CR05d	Insufficient diagnostic capacity to meet patients' needs	Responsive	Chief Operating Officer	Performance	4x5=20 (Red)	4x5=20 (Red)	4x2=8 (Amber)	Same	Same	Same
CR05e	Insufficient surgery capacity to meet patients' needs	Responsive	Chief Operating Officer	Performance	4x5=20 (Red)	4x5=20 (Red)	3x4=12 (Amber)	Same	Same	Same
CR42a	Compliance with Fire Safety Regulations – Trust-wide buildings	Safe	Director of Capital, Estates and Facilities Management	Board	5x5=25 (Red)	5x4=20 (Red)	5x3=15 (Red)	Same	Same	Same
CR42b	Compliance with the Fire Safety Regulations in A Block	Safe	Director of Capital, Estates and Facilities Management	Board	5x5=25 (Red)	5x4=20 (Red)	3x3=9 (Amber)	Same	Same	Same
CR42c	Fire safety systems in the ATC	Safe	Director of Capital, Estates and Facilities Management	Board	5x5=25 (Red)	5x4=20 (Red)	5x2=10 (Amber)	Same	Same	Same
CR50	Staffing levels in e-Hospital department	Responsive	Director of Innovation, Digital and Improvement	Performance	5x5=25 (Red)	4x5=20 (Red)	3x2=6 (Yellow)	Same	Same	Same
CR54	Attracting and retaining staff due to increasing cost of living	Safe	Director of Workforce	Workforce	4x5=20 (Red)	4x5=20 (Red)	4x4=16 (Red)	Same	Same	Same
CR57	Industrial action	Well-led	Director of Workforce/Chief Operating Officer	Performance	5x4=20 (Red)	4x5=20 (Red)	3x3=9 (Amber)	Same	Same	Same
CR58b	Meeting statutory requirements or standards required for accreditation – Division B	Responsive	Medical Director	Quality	4x5=20 (Red)	4x5=20 (Red)	4x2=8 (Amber)	Same	Same	Same

CRR Ref	Title	CQC Domain	Executive Director	Assurance Committee	Inherent rating (C x L)	Current rating (C x L)	Target rating (C x L)	Jun-23	Jul-23	Aug-23
CR60	Demand and substantive staffing in Patient Advice and Liaison Service and Complaints Department	Responsive	Chief Nurse	Quality	4x5=20 (Red)	4x5=20 (Red)	4x3=12 (Amber)	Same	Same	Same
CR04a	Replacement of unsupported/aging/unsuitable medical equipment	Safe	Medical Director	Performance	5x4=20 (Red)	4x4=16 (Red)	4x3=12 (Amber)	Same	Same	Same
CR05f	Insufficient capacity within maternity services	Safe	Chief Operating Officer	Quality	4x5=20 (Red)	4x4=16 (Red)	4x3=12 (Amber)	Same	Same	Same
CR05g	Use of designated contingency capacity	Safe	Chief Operating Officer	Performance	4x5=20 (Red)	4x4=16 (Red)	4x2=8 (Amber)	Same	Same	Same
CR07	Failure to reduce incidence of Healthcare Acquired Infections	Safe	Medical Director	Quality	5x5=25 (Red)	4x4=16 (Red)	4x2=8 (Amber)	Same	Same	Same
CR29	Imaging reporting backlog	Responsive	Chief Operating Officer	Performance	4x5=20 (Red)	4x4=16 (Red)	4x1=4 (Yellow)	Same	Same	Same
CR41	Pathways for patients with mental health conditions	Responsive	Chief Nurse	Quality	4x4=16 (Red)	4x4=16 (Red)	4x1=4 (Yellow)	Same	Same	Same
CR43a	Insufficient staffing on adult wards	Safe	Chief Nurse	Quality	4x5=20 (Red)	4x4=16 (Red)	3x3=9 (Amber)	Reduced	Same	Same
CR43b	Insufficient medical staffing across Maternity Services	Safe	Medical Director	Quality	4x5=20 (Red)	4x4=16 (Red)	**4x2=8 (Amber)**	Same	Same	Same
CR43c	Insufficient midwifery staffing across Maternity Services	Safe	Chief Nurse	Quality	4x5=20 (Red)	**4x3=12 (Amber)**	**4x2=8 (Amber)**	Same	Same	**Decreased**
CR45a	Failure to meet patients' equality and diversity needs	Well-led	Chief Nurse	Quality	4x4=16 (Red)	4x4=16 (Red)	3x2=6 (Yellow)	Same	Same	Same
CR45b	Equality and diversity in the CUH workforce	Well-led	Director of Workforce	Workforce	4x4=16 (Red)	4x4=16 (Red)	4x3=12 (Amber)	Same	Same	Same
CR46	Expiry of LMB Building Lease Housing Histopathology Services	Well-led	Director of Capital, Estates and Facilities Management	Performance	4x5=20 (Red)	4x4=16 (Red)	4x1=4 (Yellow)	Same	Same	Same
CR52	Potential short-term supply shortages	Safe	Chief Finance Officer/ Medical Director	Quality	5x4=20 (Red)	4x4=16 (Red)	4x3=12 (Amber)	Same	Same	Same

CR59	Impact of climate change on delivery of services at CUH	Responsive	Director of Capital, Estates and Facilities Management	Performance	4x5=20 (Red)	4x4=16 (Red)	3x2=6 (Yellow)	Same	Same	Same
CR03	Water quality	Safe	Director of Capital, Estates and Facilities Management	Quality	5x5=25 (Red)	5x3=15 (Red)	5x2=10 (Amber)	Same	Same	Same
CR10	Capacity and resilience in the High Voltage Electrical Infrastructure	Safe	Director of Capital, Estates and Facilities Management	Performance	5x4=20 (Red)	5x3=15 (Red)	5x2=10 (Amber)	Same	Same	Same
CR38	Deteriorating patients and Sepsis	Safe	Chief Nurse	Quality	5x4=20 (Red)	5x3=15 (Red)	5x1=5 (Yellow)	Same	Same	Same
CR42d	Fire Alarm – operation of fire system evacuation signal	Safe	Director of Capital, Estates and Facilities Management	Board	5x5=25 (Red)	5x3=15 (Red)	5x2=10 (Amber)	Same	Same	Same
CR17	Maintaining suitably skilled workforce	Well-led	Director of Workforce	Workforce	3x5=15 (Red)	3x4=12 (Amber)	3x2=6 (Yellow)	Same	Same	Same
CR20	Expansion of the Cambridge Biomedical Campus impacting access to and from the Campus due to inadequate local transport	Safe	Director of Capital, Estates and Facilities Management	Performance	4x4=16 (Red)	4x3=12 (Amber)	3x2=6 (Yellow)	Same	Same	Same
CR23b	Performance of FM contract in the Addenbrooke's Treatment Centre (ATC)	Responsive	Director of Capital, Estates and Facilities Management	Performance	4x3=12 (Amber)	4x3=12 (Amber)	4x2=8 (Amber)	Same	Same	Same
CR23c	Delivery of services under the PFI Project Agreement	Responsive	Director of Capital, Estates and Facilities Management	Performance	4x3=12 (Amber)	4x3=12 (Amber)	3x3=9 (Amber)	Same	Same	Same
CR24	Compliance with critical ventilation requirements	Safe	Director of Capital, Estates and Facilities Management	Performance	4x4=16 (Red)	4x3=12 (Amber)	4x2=8 (Amber)	Same	Same	Same

CR44	Meeting blood transfusion regulation	Safe	Medical Director	Quality	4x4=16 (Red)	4x3=12 (Amber)	3x2=6 (Yellow)	Same	Same	Same
CR49	RAAC panel failure at other hospitals	Responsive	Chief Operating Officer	Performance	5x3=15 (Red)	4x3=12 (Amber)	3x3=9 (Amber)	Same	Same	Same
CR55	Radio pharmacy services provisions	Safe	Medical Director	Quality	4x5=20 (Red)	3x4=12 (Amber)	3x2=6 (Yellow)	Same	Increased	Same
CR58d	Meeting statutory requirements or standards required for accreditation – Division D	Responsive	Medical Director	Quality	4x5=20 (Red)	4x3=12 (Amber)	4x2=8 (Amber)	Same	Same	Same
CR58e	Meeting statutory requirements or standards required for accreditation – Division E	Responsive	Medical Director	Quality	4x5=20 (Red)	4x3=12 (Amber)	4x2=8 (Amber)	Same	Same	Same
CR61	Impact on Trust-wide operational activity due to lack of flow through 'Goods In'	Responsive	Chief Finance Officer	Performance	3x5=15 (Red)	3x4=12 (Amber)	3x2=6 (Yellow)		NEW	Same
CR25	Compliance with the Accessible Information Standard	Safe	Chief Nurse	Quality	4x5=20 (Red)	3x3=9 (Amber)	3x2=6 (Yellow)	Same	Same	Same
CR56	Resource and capacity within the Occupational Health department	Safe	Director of Workforce	Performance	4x4=16 (Red)	**2x3=6 (Yellow)**	2x3=6 (Yellow)	Same	Same	**Decreased**
CR32	Cyber security protection	Safe	Director of Innovation, Digital and Improvement	Audit	5x3=15 (Red)	4x2=8 (Amber)	4x1=4 (Yellow)	Same	Decreased	Same

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Cambridge University Hospitals NHS Foundation Trust
Board Assurance Framework: August 2023
Board Assurance Framework overview – ranked by current risk rating

Risk ref.	Current risk score	Risk description	Lead Executive	Board monitoring committee
001	20	Due to physical capacity constraints and sub-optimal patient flow, the Trust is not able to deliver timely and responsive urgent and emergency care services, sustainably increase activity levels to reduce waiting lists, while at the same time managing future surges in seasonal viruses and providing decant capacity to address fire safety and backlog maintenance, which adversely impacts on patient outcomes and experience.	Chief Operating Officer	Performance and Quality
005	20	A failure to sufficiently prioritise and address estate infrastructure and safety system risks and their ongoing maintenance impacts on patient and staff safety, continuity of clinical service delivery, regulatory compliance and reputation.	Director of Capital, Estates & Facilities Mgt	Performance
006	20	As a result of a failure to address fire safety statutory compliance priorities due to insufficient capital funding and decant capacity, there is a risk of fire causing harm to patients and staff and impacting on continuity of clinical service delivery.	Director of Capital, Estates & Facilities Mgt	Board of Directors
007	20	There is a risk that the Trust does not have sufficient staff with appropriate skills to deliver its plans now and in the future which results in poorer outcomes for patients and poorer experience for patients and staff.	Director of Workforce	Workforce and Education
002	16	Due to the ongoing impact of delays resulting from the Covid-19 pandemic, there is a risk that the Trust is not able to effectively identify and diagnose those patients in greatest clinical need which could result in harm, poorer outcomes and worse experience for patients.	Chief Nurse and Medical Director	Quality
008	16	There is a risk that the Trust does not reduce inequality of opportunity and discrimination both within its workforce and in the provision of its services, caused by a failure to develop and implement a robust Equality, Diversity and Inclusion Strategy, which leads to poor staff and patient experience and sub-optimal patient outcomes.	Director of Workforce and Chief Nurse	Board of Directors, Workforce and Education, and Quality
013	16	There is a risk that we fail to maintain and improve the physical and mental health and wellbeing of our workforce which impacts adversely on individual members of staff and our ability to provide safe patient care now and in the future.	Director of Workforce	Workforce and Education
003	16	The Trust does not prioritise and deploy to best effect the limited resources available for IT investment to support staff to deliver improved patient care and experience.	Director of Innovation, Digital and Improvement	Audit
009	16	New hospitals proposals are not developed, approved and/or built in a timely way resulting in the need to maintain poor quality facilities for an extended period of time and a failure to realise the clinical, operational and wider benefits.	Director of Strategy and Major Projects	Addenbrooke's 3/ Board of Directors
015	16	As a result of a failure to deliver the CUH Green Plan, the Trust does not enhance environmental sustainability and reduce its direct carbon emissions by 10% by 2025 (as a key step towards the national commitment to halve carbon emissions before 2032 and deliver net zero carbon by 2045) nor develop and deliver a credible adaptation plan, which impacts on organisational reputation and regulatory compliance and increases the susceptibility of our services to the effects of climate change.	Director of Capital, Estates & Facilities Mgt	Board of Directors
011	12	There is a risk that the Trust, as part of the Cambridgeshire and Peterborough ICS, is unable to deliver the scale of financial improvement required in order to achieve a breakeven or better financial performance within the funding allocation that has been set for the next three years, leading to regulatory action and/or impacting on the ability of the Trust to invest in its strategic priorities and provide high quality services for patients.	Chief Finance Officer	Performance
004	12	The Trust does not continuously improve the quality, safety and experience of all its services which adversely impacts on patient outcomes and experience and on organisational reputation.	Chief Nurse and Medical Director	Quality
010	12	The Trust does not work effectively with partners across the Cambridgeshire and Peterborough Integrated Care System (ICS) and the Cambridgeshire South Care Partnership resulting in a failure to sustain and improve services for local patients and regulatory intervention and/or the recurrence of a financial deficit.	Director of Strategy and Major Projects and Chief Operating Officer	Board of Directors
014	12	The Trust does not work effectively with regional partners (particularly regarding specialised services) resulting in a failure to sustain and improve services for regional patients and regulatory intervention and/or the recurrence of a financial deficit.	Director of Innovation, Digital and Improvement	Board of Directors
012	9	The Trust and our industry and research partners – convened through Cambridge University Health Partners (CUHP) – fail to capitalise on opportunities to improve care for more patients now, generate new treatments for tomorrow and power economic growth in life sciences in Cambridge and across the region.	Director of Strategy and Major Projects	Board of Directors

BAF risk	001	**Due to physical capacity constraints and sub-optimal patient flow, the Trust is not able to deliver timely and responsive urgent and emergency care services, sustainably increase activity levels to reduce waiting lists, while at the same time managing future surges in seasonal viruses and providing decant capacity to address fire safety and backlog maintenance, which adversely impacts on patient outcomes and experience.**

Current risk rating:

20

Strategic objective	A2, A3
Latest review date	August 2023

Lead Executive	Chief Operating Officer
Board monitoring committee	Performance, Quality

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	4	5	20
Current (Aug 23)	**4**	**5**	**20**

Change since last month
⟺

Related BAF and Corporate Risk Register entries

ID	Score	Summary risk description
BAF 002	16	Effective prioritisation of patients
BAF 005/006	20	Estates backlog/fire safety compliance
BAF 007	20	Meeting workforce demand
CR43	20	Staffing on adult inpatient wards
CR05	20	Capacity
CR08	20	Winter pressures

Key controls

What are we already doing to manage the risk?

1. Operational Strategy 2023/24 agreed by ME and Board.
2. Operational Programme Delivery Team (OPDT) to drive implementation of Operational Strategy.
3. Inpatient Flow Group meeting fortnightly with a focus on addressing blocks to flow. Supported by Ward Processes and Discharge Processes sub-groups.
4. Capacity and Configuration fortnightly meeting with a focus on right-sizing divisional bed allocations and delivering length of stay savings.
5. Ward T2 for medically-fit patients awaiting onward placement/support.
6. Use of day case areas and '+1' beds as additional inpatient contingency space when required.
7. Completion of refurbishment of three Neuro Theatres by Nov 2023.
8. Development of expanded virtual ward offering to create additional acute capacity.
9. Use of independent sector and other off-site physical capacity, including surgical capacity at Ely.
10. Whole system focus on recovery and demand management via Cambridgeshire South Care Partnership, with focus on improving discharge timeliness for patients with complex care packages and

Assurances on controls

How do we gain assurance that the controls are working?

1. Reporting to Management Executive (ME), Urgent and Emergency Care (UEC) Programme Board and Capacity Oversight Group.
2. Reporting to Performance and Quality Committees and Board of Directors on implementation of capacity and flow programmes/objectives.
3. Ongoing review of core emergency and elective care metrics through Integrated Performance Report.
4. Virtual ward programme governed through Division C governance arrangements.
5. System reporting to Health Gold, System Leaders and ICS Board.
6. ICS and regional oversight through, e.g. System Resilience Group and Unplanned Care Board.

initiatives to reduce UEC demand. 11. Ongoing programme of Executive meetings with specialties. 12. Engagement with Royal Papworth to create new pathways to support flow and outcomes.	

Gaps in control	Gaps in assurance
C1. Effective implementation of Accountability Framework to support divisional engagement with inpatient flow initiatives. C2. Operational Programme Delivery Team not fully established until 2023/24Q3. C3. Use of additional on-site physical capacity: C3a: U Block 56-bed unit to provide additional medical bed capacity and fire decant capacity – completion of construction and operational plan needed. C3b: Use of 3 theatres/40-beds (P&Q) unit for elective surgical capacity. C3c: 3 currently closed neurosurgery theatres in A Block. C3d: ED Urgent Treatment Centre (UTC) expansion scheme. C4: System working to respond to growth in both elective and non-elective demand.	

Actions to address gaps in controls and assurances	Due date
C1. Review of Accountability Framework by Director of Operational Strategy with outcome to Management Executive (ME) and Performance Committee (PC).	September 2023
C2. Recruitment plan being implemented in phases.	December 2023
C3a: Construction in progress with reporting to ME and PC.	December 2023
Bed reconfiguration plan being developed by Capacity and Configuration Group.	
C3b: Theatre construction works and recruitment.	October 2023
C3c: Available following fire improvement works to A Block.	November 2023
C3d: Works to proceed pending relocation of Orthotics and Prosthetics.	November 2024
C4. Urgent Community Response Programme being coordinated by ICB and reported to the System Resilience Group on a monthly basis.	Ongoing

Risk score	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
	20	20	20	20	20	20	20	20	20	20	20	20	20

BAF 001: Risk trajectory

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Aug 23)	4x5=20	
January 2024	4x4=16	Opening of 56-bed unit (U-Block), Elective Movement Hub (P2/Q2 and 3 theatres) and 3 A Block theatres, backed by workforce model. Delivery of significant length of stay savings coordinated by Capacity and Configuration Group.
June 2025	4x3=12	Additional ED UTC capacity backed by workforce model; initial progress on demand management through system pathway changes (link to BAF ref: 010).
September 2025	4x2=8	Significant system progress on demand management and pathway changes to increase out-of-hospital care.

BAF risk	002	**Due to the ongoing impact of delays resulting from the Covid-19 pandemic, there is a risk that the Trust is not able to effectively identify and diagnose those patients in greatest clinical need which could result in harm, poorer outcomes and worse experience for patients.**

Current risk rating: 16

Strategic objective	A3, A5
Latest review date	August 2023

Lead Executive	Chief Nurse and Medical Director
Board monitoring committee	Quality

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	5	3	15
Current (Aug 23)	4	4	16

Change since last month
⟺

Related BAF and Corporate Risk Register entries		
ID	Score	Summary risk description
BAF 001	20	Capacity and patient flow
CR 57	20	Impact of industrial action

Key controls
What are we already doing to manage the risk?

1. Maximisation of capacity across theatres, outpatients and diagnostics – see BAF risk 001 - within constraints of responding to Covid-19 waves.
2. Review of balance between Covid/non-Covid and emergency/ elective activity, informed by data, ethical input and professional judgement.
3. All surgical specialties undertaking at least weekly clinical prioritisation reviews in line with national and Royal College guidance, feeding into decisions by Surgical Prioritisation Group.
4. Waiting list harm review process to minimise risk to patient safety.
5. Review of complaints and incidents and potential/actual harm at SIERP.
6. Messaging to patients and public on what to expect while waiting and who to contact with concerns, including letters to long-waiting patients.

Assurances on controls
How do we gain assurance that the controls are working?

1. Comparative data monitored by NHSE against other centres.
2. Review of harm review process by Management Executive in March/April 2021 and Quality Committee in May 2021, with external legal input.
3. Ongoing assurance role for Quality Committee on harm review process.
4. Outcomes data monitored through Board and Quality Committee.
5. Waiting lists monitored against trajectory.
6. Established monitoring of patient feedback and experience.
7. Robust oversight of delivery of actions through relevant taskforce boards.
8. Close monitoring of incident reporting (including no harm/near miss) overseen by SIERP, Patient Safety Group and through IPR to Board – including capturing learning to improve processes.

Gaps in control	Gaps in assurance
C1. Insufficient physical/staffing capacity to reduce waiting lists by increasing diagnostic/treatment volumes. C2. Patients not presenting to GPs during pandemic. C3. Maintaining effective contact with patients on waiting lists. C4. Impact of industrial action on elective waiting lists.	

Actions to address gaps in controls and assurances	Due date
C1. See BAF risks 001 and 007.	See 001 and 007
C2. Emphasising national/local messaging via website/social media on importance of continuing to access NHS services.	Ongoing
C3. Implementation of validation letter and survey; writing to long-waiting patients; information on CUH website and to GPs.	Ongoing
C4. Industrial action planning to minimise impact of strike action on waiting list increases.	Ongoing

Risk score	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
	16	16	16	16	16	16	16	16	16	16	16	16	16

BAF 002: Risk trajectory

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Aug 23)	**4x4=16**	
March 2024	**4x3=12**	Ability to manage and prioritise will remain compromised until elective waiting list reduces significantly, which will be facilitated by a cumulative increase in capacity from opening of 56-bed unit (U-Block), elective orthopaedic facility (P2/Q2 and 3 theatres), re-opening of 3 A Block theatres and additional ED UTC capacity.
September 2025	**4x2=8**	Further progress in reducing elective waiting lists through significant productivity improvement, new models of care (including new workforce models) and new ways of working.

BAF risk	003	**There is a risk that the Trust does not invest in, prioritise and deploy IT resources effectively to support achievement of the Trust's strategic priorities.**

Current risk rating: 16

Strategic objective	C5
Latest review date	August 2023

Lead Executive	Director of Innovation, Digital and Improvement
Board monitoring committee	Audit

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	4	3	12
Current (Aug 23)	4	4	16

Change since last month
⟺

Related BAF and Corporate Risk Register entries

ID	Score	Summary risk description
BAF 011	16	Financial sustainability
CR50	16	eHospital team staffing

Key controls
What are we already doing to manage the risk?

Investment

1. Commodity IT services through Telefonica Tech.
2. 6-12 monthly cycle for deploying additional infrastructure and new Epic versions/EPR work programme.
3. Workforce to ensure the application, data and infrastructure environments are reliable secure, sustainable and resilient, and compliant with regulatory requirements through delivering a robust infrastructure and application lifecycle management

Prioritisation

4. Digital Strategy approved by Board of Directors; prioritisation through divisions/Digital Prioritisation Board to ensure alignment with strategy (under development) with cases for change supported by robust benefit cases.

Deployment

5. Telefonica Tech transformation programme.
6. Implementation plan for Digital Strategy in development.
7. Digital Board to monitor delivery against the strategy (under development).

Assurances on controls
How do we gain assurance that the controls are working?

Investment

1. Review of monthly performance reports and annual review of Telefonica Tech service by eHospital SMT Board and Digital Board; Internal Audit programme reviewed by Audit Committee. Regular reports to Performance Committee.
2. Implementation programmes including operational support to undertake upgrade work. Epic upgrade completed in November 2022 and planned move to Epic Hyperdrive in late 2023.
3. Monthly review at eHospital SMT. Regular reports to Performance Committee and Digital Board.

Prioritisation

4. Regular reports to Digital Board, Management Executive and Performance Committee.

Deployment

5. Transformation Benefits plans reviewed by eHospital SMT Board and Digital Board. Internal audit of transformation programme benefits realisation.
6. Reports to Performance Committee on Digital Strategy implementation.
7. New Digital Board to monitor delivery against the strategy with oversight of benefits realisation (in development).

Gaps in control	Gaps in assurance
Investment C1. Sufficient staffing to enable/align with digital aspirations. **Prioritisation** C2. Robust Trust-wide prioritisation process for digital change requirements aiming to maximise the benefits derived from the Trust's digital resources. C3. Establishment of methodology for the definition of benefits of IT investments. **Deployment** C4. New Digital Board to be put in place. C5. Implementation plan for Digital Strategy. C6. Establishment of IT investment benefits tracking approach.	

Actions to address gaps in controls and assurances	Due date
Investment C1a. Undertake gap analysis on resourcing. C1b. Recruitment and retention plan to be revised and implemented.	March 2024
Prioritisation C2. New prioritisation process for Epic change requests, Telefonica Tech bespoke requests and non-Epic software deployment; strengthened Digital Board; benchmarking of prioritisation process with Johns Hopkins.	September 2023
C3. Develop, agree and embed benefits definition methodology as part of business case process.	September 2023
Deployment C4. Implementation of new Digital Board assuring Digital Strategy implementation plan.	September 2023
C5. Development of Digital Strategy implementation plan.	September 2023
C6. Develop, agree and embed benefits tracking approach.	September 2023

Risk score	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
	16												
	Risk redefined	16	16	16	16	16	16	16	16	16	16	16	16

BAF 003: Risk trajectory

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Aug 23)	4x4=16	
September 2023	4x3=12	Successful implementation of new IT prioritisation and benefits process and associated governance.
June 2024	4x2=8	Funding of additional staffing and successful implementation of recruitment and retention plan.

BAF risk	004	**The Trust does not continuously improve the quality, safety and experience of all its services which adversely impacts on patient outcomes and experience and on organisational reputation.**

Current risk rating:
12

Strategic objective	A5
Latest review date	August 2023

Lead Executive	Chief Nurse and Medical Director
Board monitoring committee	Quality

Risk rating	Impact	Likelihood	Total
Initial (Nov 22)	4	3	12
Current (Aug 23)	4	3	12

Change since last month
Risk refreshed in Nov 22

Related BAF and Corporate Risk Register entries		
ID	Score	Summary risk description
CR 44	12	Blood transfusion regulations
CR 07	16	Infection prevention and control
CR 38	15	Deteriorating patients and Sepsis

Key controls
What are we already doing to manage the risk?

1. Regular monitoring of quality metrics through CUH governance structure, recognising impact on quality through other BAF risks (including capacity and staffing).
2. CUH Ward Accreditation programme being rolled out to provide ward to board reporting – linked to improvement programme, including ward-led improvement huddles. [*temporarily paused in June 2023 subject to recruitment exercise – appointee due to commence in late October 2023*]
3. Implementation of NHS Patient Safety Strategy and updating of CUH Safety Strategy in line with new national Patient Safety Incident Response Framework (PSIRF).
4. Introduction and embedding of Patient Safety Specialist and Patient Safety Partners.
5. Delivery of PSIRF implementation training programme across the Trust, including Just Culture programme.
6. Ongoing investment in leadership training for clinical leaders using Institute for Healthcare Improvement (IHI) methodology.
7. Implementation of a digital patient consent process.
8. Ongoing evolution of Learning from Deaths process.
9. Active participation in quality improvement initiatives at Cambridgeshire and Peterborough Integrated Care Board (ICB) level.

Assurances on controls
How do we gain assurance that the controls are working?

1. Reporting to Patient Experience, Clinical Effectiveness and Patient Safety Groups, including on Ward Accreditation outcomes.
2. Divisional quality meetings and monthly Performance Review meetings.
3. Reporting to Quality Committee and Board of Directors via Integrated Performance Report (IPR).
4. Oversight through ICB System Quality Meetings.
5. Outcome of CQC inspections and review of CQC outlier reports.
6. CQC peer review programme and Matron Quality Rounds.
7. Findings of reviews commissioned by the Trust.
8. Clinical Fridays and Executive visits.
9. Clinical audit programme.
10. Ongoing feedback from patients and staff.

Gaps in control	Gaps in assurance
C1. PSIRF policy and plan requires Board approval.	

Actions to address gaps in controls and assurances	Due date
C1. Policy and plan under development for review by	September 2023

C2. Lack of bandwidth across a range of staff groups to focus on quality improvement programmes. C3. Development and implementation of CUH Patient Engagement Strategy.		Management Executive, Quality Committee and Board of Directors. C2. Ongoing recruitment programme to seek to fill vacancies to establishment. C3a. Further work on Patient Engagement Strategy for ME and Board approval. C3b. Identification of resourcing requirements for implementation of Strategy.	Ongoing October 2023 December 2023

Risk score	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
	12	**12**	**12**										
	Risk reformulated in November 2022 to reflect strategy refresh			**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	

BAF 004: Risk trajectory

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Aug 23)	**4x3=12**	
March 2024	**4x2=8**	PSIRF implemented; Patient Engagement Strategy approved, resourced and being implemented; reduced Trust-wide staffing pressures facilitating participation in quality improvement programmes (at both Trust and system levels).

BAF risk	005	**A failure to sufficiently prioritise and address estate infrastructure and safety system risks and their ongoing maintenance impacts on patient and staff safety, continuity of clinical service delivery, regulatory compliance and reputation.**

Current risk rating:

20

Strategic objective	C3
Latest review date	August 2023

Lead Executive	Director of Capital, Estates and Facilities Management
Board monitoring committee	Performance

Risk rating	Impact	Likelihood	Total
Initial (Sep 17)	5	4	20
Current (Aug 23)	**5**	**4**	**20**

Change since last month
⟺

Related BAF and Corporate Risk Register entries		
ID	**Score**	**Summary risk description**
BAF 001	20	Capacity and patient flow
BAF 006	20	Fire safety compliance
CR 03	15	Water quality
CR 07a/07b	12	Infection control
CR 10	15	Electrical infrastructure resilience
CR 23b	12	FM contract performance in the ATC
CR 24	12	Ventilation requirements
CR42a	20	Safety Risk and non-compliance with the Fire Safety Regulation – Trust-wide buildings
CR 42b	20	Non-compliance with fire safety regulation in A block
CR42c	20	Failure of fire safety systems in the ATC
CR42d	15	Fire Alarm risks – operation of fire system evacuation signal

Key controls
What are we already doing to manage the risk?

1. Policies, procedures and protocols in place to support management of building and engineering maintenance and direct future life safety infrastructure systems and compliance works.
2. Skilled maintenance and engineering staff including specialist and local contractors.
3. Appropriate technical appointments and training in line with Health Technical Memoranda (HTM), with specialist sub-groups of the Capital, Estates and Facilities Management (CEFM) Health and Safety Group that monitors compliance.
4. 2019 condition survey provides the platform for annual desktop refresh of backlog maintenance risk and investment requirement.
5. Capital allocation via the Capital Advisory Board.
6. Divisional risk register and entries onto the Corporate Risk Register (CRR).

Assurances on controls
How do we gain assurance that the controls are working?

1. Compliance reporting to CEFM Health and Safety Group.
2. Appointments maintained, contracts in place.
3. 2019 asset survey in line with national methodology.
4. Annual updates on risks and investment requirements to CAB.
5. Backlog maintenance a component of the core capital programme.
6. CEFM board /Director review risks for potential escalation to CRR.
7. QSIS reports of failures/incidents.
8. Infection Prevention and Control reports.
9. Training records.

7. Access negotiated with local managers for ongoing servicing, maintenance and repairs.	

Gaps in control	Gaps in assurance
C1. Not all policies monitored in line with their effectiveness statements, although regular Authoring Engineer (AE) audits. C2. Some assets are not maintained in line with best practice. Recruitment challenges for skilled staff. Not sufficient staff funded to undertake the maintenance and remedial works. C3. Capital allocation does not meet all the high risks, and allocation is on a year-by-year basis, not multi-year. Allocation for prioritised risk issues, with in-year re-prioritisation. C4. Operational capacity often prioritised.	A1. Continue to improve reporting.

Actions to address gaps in controls and assurances	Due date
C1. Systematic programme over multiple years to test efficiency to be put in place. Ask AEs to specifically test elements of policy.	Ongoing
C2. Business planning submissions to reference need and compounding risk associated with underinvestment in infrastructure and systems.	Ongoing
C3. Continue to review scope for multi-year allocations.	Ongoing
C4.Capacity Oversight Group to agree planned capacity release. Unplanned capacity release will remain a challenge.	Ongoing

Risk score	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
	20	20	20	20	20	20	20	20	20	20	20	20	20

BAF 005: Risk trajectory

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Aug 23)	5x4=20	Multi-year capital allocation, with project infrastructure and operational capacity in place for 2023/24. Initial single year capital allocation agreed at CAB in March 2023. Inadequate revenue budget allocated to maintain, repair and replace the infrastructure and systems. Budget setting submission quantifies the requirement for additional resources to undertake maintenance services that are currently unfunded.
April 2024	5x4=20	6 facet survey undertaken to re-baseline position (works appointed and commenced).

BAF risk	006	**As a result of a failure to address fire safety statutory compliance priorities due to insufficient capital funding and decant capacity, there is a risk of fire causing harm to patients and staff and impacting on continuity of clinical service delivery.**

Current risk rating:

20

Strategic objective	C3
Latest review date	August 2023

Lead Executive	Director of Capital, Estates and Facilities Management
Board monitoring committee	Board of Directors

Risk rating	Impact	Likelihood	Total
Initial (Dec 17)	5	4	20
Current (Aug 23)	**5**	**4**	**20**

Change since last month
⟺

Related BAF and Corporate Risk Register entries		
ID	**Score**	**Summary risk description**
BAF 001	20	Capacity and patient flow
BAF 005	20	Life safety critical infrastructure systems
CR42a	20	Safety Risk and non-compliance with the Fire Safety Regulation – Trust-wide buildings
CR 42b	20	Non-compliance with fire safety regulation in A block
CR42c	20	Failure of fire safety systems in the ATC
CR42d	15	Fire Alarm risks – operation of fire system evacuation key switches

Key controls

What are we already doing to manage the risk?

1. Fire Policy in place.
2. Mandatory fire safety training in place for all staff.
3. Multi-year Fire Safety remedial programme approved and being delivered.
4. Ring-fenced multi-year funds to support fire safety – average of £6m deployed in 2021/22 and 2022/23.
5. Discreet remedial and improvement capital programmes of work - including the £10m A-Block programme of works,
6. Future decant capacity plan, with capacity available from December 2023 for dedicated fire and maintenance decant work.
7. Capital projects developed with appropriately appointed fire safety professionals where appropriate.
8. Ongoing fire safety risk assessment programme.
9. Pro-active and reactive management of fire safety risk.

Assurances on controls

How do we gain assurance that the controls are working?

1. Authorising Engineer (AE) baseline audit returned 16 satisfactory elements, 10 medium priority recommendations and 0 high priority recommendations.
2. Mandatory training reported as part of wider mandatory training in IPR. Low compliance escalate to Management Executive in July 2023.
3. Ongoing reporting to Cambridgeshire Fire and Rescue Service (CFRS) and quarterly to Board of Directors.
4. Visibility of ring-fenced funds being deployed at Capital Advisory Board (CAB).
5. Agreed corporate strategy to utilise the equivalent of one ward for fire safety works throughout the year.
6. Building control sign-off, Head of Fire Safety oversight.
7. Fire safety team audits and walkrounds, and incident investigation.
8. Visits and advice from NHS England estates and fire safety team.

Gaps in control	Gaps in assurance
C1. Some procedural documents beyond review date. C2. Average mandatory fire training compliance figures below Trust standard. C3. Fire Safety Risk Assessments beyond review date. C4. Outstanding Stage 1 and Stage 2 fire compliance works.	

Actions to address gaps in controls and assurances	Due date
C1. Build AE recommendations into annual programme of works. C2. Review fire training approach with Learning and Development Team (escalated low compliance to Management Executive in July 2023). C3. Plan in place with on-target trajectory to achieve 100% compliance by end of September 2023. C4. Ongoing programme with agreed timelines, tracking and reporting to CFRS and Board of Directors.	C1. September 2023 C2. September 2023 C3. September 2023 C4. End 2027

Risk score	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
	20	20	20	20	20	20	20	20	20	20	20	20	20

BAF 006: Risk trajectory

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Aug 23)	5x4=20	Multi-year capital programme in delivery, ring-fenced funds across multiple years secured. Decant capacity under construction.
2023/24 Q4	4x4=16	Decant capacity operational and Stage 2 works can commence. Stage 1 works continue and fire alarm works near completion.
February 2024	4x4=16	Completion of building works reduces fire risks in A Block.
End 2027	4x3=12	Continuation of programme of fire safety works, Stage 2 works at or nearing completion.

BAF risk	007	**There is a risk that the Trust does not have sufficient staff with appropriate skills to deliver its plans now and in the future which results in poorer outcomes for patients and poorer experience for patients and staff.**

Current risk rating: 20

Strategic objective	B1, B2
Latest review date	August 2023

Lead Executive	Director of Workforce
Board monitoring committee	Workforce and Education

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	4	4	16
Current (Aug 23)	4	5	20

Change since last month
⟺

Related BAF and Corporate Risk Register entries		
ID	**Score**	**Summary risk description**
BAF 001	20	Capacity and patient flow
CR43	20	Insufficient staffing on adult inpatient wards
CR54	20	Cost of living

Key controls
What are we already doing to manage the risk?

Recruitment

1. Multi-source recruitment pipeline for nursing and medical recruitment, including apprenticeships, local, national and international supply.
2. Comprehensive calendar of recruitment - CUH and part of wider system.
3. Daily review and programme of redeployment of staff to maintain safety.
4. Identification of staffing requirements and review of staffing ratios and ways of working in response to capacity pressures.
5. Use of Bank enhancements and agency with governance and scrutiny.
6. Ongoing recruitment for 56-bed unit and in July 2022 for recruitment for 40-bed unit.
7. Changes to recruitment plan to attract candidates to roles traditionally recruited locally, in context of relatively high local employment levels.
8. Investment at scale in new registered nursing supply route: Graduate Nurse Apprenticeships.
9. Outline plan for the Trust to become an anchor institution for learning.
10. Collaboration on international recruitment of nurses and midwives with east of England partners.
11. Development of new roles such as Nursing Associate role (first recruitment wave completed).
12. Accommodation Officer providing support, advice and guidance on housing issues.

Retention

1. Data analysis to identify reasons for attrition to develop response plan.

Assurances on controls
How do we gain assurance that the controls are working?

1. Daily site safety meetings to evaluate staff levels and mitigate against shortfalls.
2. Weekly pay review meetings to consider bank fill rates vs enhanced payments.
3. Monthly nursing/midwifery safe staffing report to Board of Directors, including tracking of progress against nursing pipeline through safe staffing Board report from Chief Nurse.
4. Monthly data in Integrated Performance Report on turnover, vacancies, bank/agency fill rates/etc. reviewed by Performance Committee and Board.
5. Staff Survey (annual and quarterly FFT) recommender scores.
6. Quarterly reporting to Board by Guardian of Safe Working for junior doctors.
7. Workforce and Education Committee oversight (quarterly).
8. Data analysis in place to track areas of concern and impact of interventions on retention.

2. Development of retention plan focusing on five workforce priorities. 3. Benchmarking with regional and national trusts to review recruitment and retention premium (RRP) payments and put in place where required. 4. Enhanced wellbeing and good work programme, supported by ACT. 5. Partnership working on real living wage, transport and accommodation.	

Gaps in control	Gaps in assurance	Actions to address gaps in controls and assurances	Due date
C1. Increasing competition for international recruits due to increase in international demand. C2. Shortage of affordable accommodation in Cambridge impacting on employee attraction and retention. C3. Workforce plans for 40/56 bed units identified and recruitment commenced but not complete. C4. National shortage of training places in specific professions. C5. Relatively high vacancy rates for admin and clerical roles.		C1a. Broaden pipeline to reduce dependency on any one recruitment stream. Work with wider group of international agencies to increase pipeline of "ready now" nurses. C2a. Working with partners on sourcing affordable, accessible accommodation including conversion of on-site space. C2b. Raising issue of scope for funded high cost of living allowance for Cambridge. C3a. Strong pipelines in place and targeted campaigns continue (6 month lead time). C3b. Working with system partners. C4a. Introduction of AHP apprenticeship roles. C4b. Work regionally and nationally to identify options to increase training places within C&P system, including apprenticeships across nursing, admin and AHPs. C5. Centralisation of admin recruitment process launched in November 2022 with further work to develop; and flexible working drive. Review of progress to Management Executive in September 2023.	C1 – March 2024 aim to achieve overall 7.5% vacancy rate C2a. Ongoing C2b. Ongoing C3. Ongoing C4. Ongoing C5. September 2023

Risk score	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
	20	20	20	20	20	20	20	20	20	20	20	20	20

BAF 007: Risk trajectory

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Aug 23)	4x5=20	
March 2024	4x4=16	Achievement of overall 7.5% vacancy rate by March 2024 taking account of staffing additional capacity.
September 2024	4x3=12	Maintain overall 7.5% vacancy rate and secure positive position on retention and work availability through work on accommodation, cost of living, etc.

BAF risk	008	**There is a risk that the Trust does not reduce inequality of opportunity and discrimination both within its workforce and in the provision of its services, caused by a failure to develop and implement a robust Equality, Diversity and Inclusion Strategy, which leads to poor staff and patient experience and sub-optimal patient outcomes.**

Current risk rating:

16

Strategic objective	B4
Latest review date	August 2023

Lead Executive	Director of Workforce and Chief Nurse
Board monitoring committee	Board of Directors, Workforce and Education Committee, Quality Committee

Risk rating	Impact	Likelihood	Total
Initial (Jan 23)	4	4	16
Current (Aug 23)	4	4	16

Change since last month
n/a

Related BAF and Corporate Risk Register entries		
ID	Score	Summary risk description
CR45	12	Failure to meet patients' equality and diversity needs
CR tbc	16	Failure to achieve greater workforce equality and diversity

Key controls
What are we already doing to manage the risk?

1. Explicit inclusion of health inequalities and inclusion in the CUH strategic commitments agreed by the Board in July 2022.
2. Non-Executive Director appointment with equality, diversity and inclusion (EDI) skills and experience.
3. Establishment of an EDI Strategy Group, chaired by the Chief Executive, to develop an overarching EDI Strategy and Plan for CUH.
4. Work programmes in place on both staff and patient EDI.
5. Health Inequalities Operations Group established.
6. Interim Director of EDI appointed and in post from March 2023.

Assurances on controls
How do we gain assurance that the controls are working?

1. Oversight by Executive-led Equality, Diversity and Dignity Steering Group.
2. Reporting to Quality Committee, Workforce and Education Committee, and Board of Directors.
3. Patient and staff survey results with breakdowns by protected characteristics.

Gaps in control	Gaps in assurance
C1. Comprehensive assessment of EDI work across CUH. C2. Overarching EDI Strategy and Plan to be agreed. C3. Implementation of EDI Strategy and Plan.	

Actions to address gaps in controls and assurances	Due date
C1. Interim EDI Director to undertake EDI and health inequalities diagnostic assessment.	October 2023
C2. Strategy Group to develop draft for Board approval.	2023/24 Q4
C3. Interim EDI Director to work with partners internally and externally on implementation on first phase of EDI Plan.	Ongoing

Risk score	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
	Risk reframed in January 2023					16	16	16	16	16	16	16	16

BAF 008: Risk trajectory

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Aug 23)	**4x4=16**	
March 2024	**4x3=12**	EDI Strategy and Plan approved by Board and first phase of Plan implemented.
March 2026	**4x2=8**	Subsequent phases of EDI Strategy and Plan implemented and KPIs being achieved on a consistent basis.

BAF risk	009	**New hospitals proposals are not developed, approved and/or built in a timely way resulting in the need to maintain poor quality facilities for an extended period of time and a failure to realise the clinical, operational and wider benefits.**

Current risk rating:

16

Strategic objective	C3
Latest review date	August 2023

Lead Executive	Director of Strategy and Major Projects
Board monitoring committee	Addenbrooke's 3/ Board of Directors

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	3	4	12
Current (Aug 23)	**4**	**4**	**16**

Change since last month
⟺

Related BAF and Corporate Risk Register entries

ID	Score	Summary risk description
CR05a-g	16-20	Insufficient capacity for patient needs
CR20	8	Access to/from the campus due to inadequate local transport
BAF 001	20	Capacity and patient flow
BAF 005	20	Estates backlog
BAF 006	20	Fire safety
BAF 010	12	Effective ICS working
BAF 012	9	Impact of Trust and industry/research partners

Key controls

What are we already doing to manage the risk?

1. Joint Strategic Board (JSB) and underpinning governance including Joint Delivery Board (JDB) and workstreams in place for Cambridge Children's Hospital (CCH) and for Cambridge Cancer Research Hospital (CCRH).
2. New Construction Director role covering both CCH and CCRH recruited and started work in July 2023.
3. Regular reporting to ME and Addenbrooke's 3 Board committee in place.
4. Monthly progress meetings with NHSE/I (regional & national) and DHSC and regular engagement with New Hospitals Programme (NHP).
5. CCRH/CCH Outline Business Cases (OBCs) approved by CUH Board in October/December 2022 respectively and submitted to national bodies. CCRH OBC approved by HM Treasury in August 2023.
6. CCRH proceeding as part of the Government's NHP. Laing O'Rourke appointed as Principal Supply Chain Partner/preferred construction partner in August 2023.
7. No further funding available for CCH at present but agreement secured with NHSE/DHSC in March 2023 to a funded work programme leading to

Assurances on controls

How do we gain assurance that the controls are working?

1. Monthly reporting on progress to JDBs and six weekly to JSBs. Progress reported and areas for escalation raised and resolved.
2. Addenbrooke's 3 programme work plan actively monitored in working group meeting and progress reported at Addenbrooke's 3 Board committee.
3. Addenbrooke's 3 Board committee overseeing progress and providing input to the overarching Addenbrooke's 3 programme and strategy.
4. Performance Committee review/sign off and Board sign off of business cases ahead of submission to regulators and proactive engagement with commissioners to determine final content and approval process.
5. The PBC options describe the phases of development of the CUH campus over the next 10-15 years.
6. Aspects of the business cases are shared with NHSE and DHSC on a regular basis for comment and input, to increase familiarity with our plans ahead of formal sign off.

CCH OBC re-submission and review in September 2023. 8. All projects and their business cases underpinned by core objectives such as being an active partner within our ICS and region; transforming models of care; digital enablement; accelerating research benefits locally, regionally and nationally. 9. Fundraising campaigns in place for CCH and CCRH. Cornerstone gift secured for CCH. Work underway on commercial strategies. 10. Patient and public engagement plans in place for both CCRH and CCH. 11. Addenbrooke's 3 Programme Business Case (PBC) submitted in May 2021.	

Gaps in control	Gaps in assurance
C1. Impact of high rates of inflation on development costs for new hospitals. C2. Within CCH and CCRH, while a preferred form of legal relationship has been indicated by the CUH Board, the determination of risk premia and cost allocation are subject to negotiation with the University of Cambridge. C3. While modest project funding has been secured to support the CCH OBC revisions and subsequent approvals process requirements, confirmation of full project funding needed to progress to the next stage will not be provided until further through the OBC approvals process. C4. There is no allocated funding before at least 2025 for any further Addenbrooke's 3 projects, resulting in an impact on the ability of CUH to address ED physical capacity constraints (see BAF risk 001) and critical infrastructure issues (see BAF risk 005). This also limits opportunities to make significant changes to models of care enabled through the A3 projects. C5. With progression of CCRH to FBC stage, further assurance required to ensure the governance arrangements and capabilities evolve to address different nature of risks.	

Actions to address gaps in controls and assurances	Due date
C1. Ongoing discussions with NHP team on funding issues.	Ongoing
C2. Negotiations with University of Cambridge underway to determine allocation of cost and risk, which will receive Board review ahead of FBC submission.	October 2023
C3. Work programme agreed with NHSE and DHSC to enable re-submission and review of CCH OBC by Joint Investment Committee. Revised OBC approved by CUH Board in June 2023.	October 2023
C4. PBC for Addenbrooke's 3 describes phased plans for CUH campus for short (next 18 months), medium (2021–2025) and longer term (2025+). Work to identify potential estates redevelopment/upgrade opportunities arising from delivery of CCRH and CCH.	Ongoing
C5. New governance arrangements to be established to ensure provisions are robust for overall programme workstreams, as set out in OBC management case. Initial version of these arrangements brought to Board in July 2023, drawing on findings from relevant audits.	September 2023

Risk score	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
	12	12	16	16	16	16	16	16	16	16	16	16	16

BAF 009: Risk trajectory

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Aug 23)	**4x4=16**	
October 2023	**4x3=12**	CCH OBC approved nationally, allowing move to procurement phase and production of FBCs.
April 2024	**4x3=12**	CCRH FBC approved nationally and construction commenced. [CCH timeline to be confirmed.]
March 2027	**4x2=8**	CCRH completed. [CCH timeline to be confirmed.]

BAF risk	010	**The Trust does not work effectively with partners across the Cambridgeshire and Peterborough Integrated Care System (ICS) and the Cambridgeshire South Care Partnership resulting in a failure to sustain and improve services for local patients and regulatory intervention and/or the recurrence of a financial deficit.**

Current risk rating:

12

Strategic objective	A1
Latest review date	August 2023

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

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	*Risk reframed in Oct 20*		
Current (Aug 23)	4	3	12

Change since last month
⟺

Related BAF and Corporate Risk Register entries		
ID	Score	Summary risk description
BAF 009	16	New hospitals development proposals
BAF 011	16	Financial sustainability

Key controls
What are we already doing to manage the risk?

1. Setting Integrated Care as a major priority in the Trust's refreshed Strategy. Identifying how our processes need to change to support this and establishing a multi-year work plan for Integrated Care, in consultation with corporate and divisional teams.
2. Participating in ICS/Integrated Care Board (ICB) working groups and processes including the System Strategic Planning Group (with oversight of the Joint Forward Plan and key system developments) and system Operational Planning.
3. Hosting Cambridgeshire South Care Partnership (CSCP); agreeing 'Framework for Integrated Care' as a vision and roadmap; co-chairing the CSCP Joint Strategic Board to set direction.
4. Leading urgent and emergency care (UEC) and discharge transformation programmes; developing pathway transformation between primary and secondary care; developing integrated teams in primary care.
5. Ongoing involvement in work on redevelopment of services at Hinchingbrooke Hospital.

Assurances on controls
How do we gain assurance that the controls are working?

1. Regular communication with ICS/ICB Executive to shape programmes of work and escalate issues.
2. Regular updates to Management Executive from the Cambridgeshire South Care Partnership Joint Strategic Board and bimonthly reporting to the Board of Directors.
3. Feedback and intelligence from Executive Team participation in, and leadership of some, system-wide groups. Contribution to Joint Forward Plan through existing system groups (with CUH representation) and dedicated Management Executive session on 17 April 2023.

Gaps in control	Gaps in assurance
C1. Arrangements not yet confirmed regarding the devolution of resource and accountability from the ICB to the	

Actions to address gaps in controls and assurances	Due date
C1. Executive engagement with ICB/other providers to define a clear and ambitious mandate for the Cambridgeshire South	October 2023

Cambridgeshire South Care Partnership. C2. Not all providers are investing sufficiently to design and implement integrated models of care. C3. Tight financial positions at CUH and at the ICB lead to short-term, ad-hoc, at-risk funding for work that requires sustained support. C4. Clinical transformation in CUH and with partners is crowded out by workforce requirements associated with sustaining core services. C5. Fragilities in sections of primary care constrain progress on collaborative work through the Cambridgeshire South Care Partnership.		Care Partnership backed by appropriate resource. C2. Work with Cambridgeshire South Care Partnership board to identify shared transformation priorities and pilot new approaches. Develop a repeatable process to identify, grow and spread these. C3. Develop a methodology to quantify shared risk / reward / benefits for collaborative projects and evolve CUH's investment approach to support this. C4. Develop a proposal for allocating capacity across providers (including additional backfill) to support clinical engagement in pathway redesign. C5. Partnership exploring options for increasing resilience in primary care.	December 2023 March 2024 March 2024 July 2023

Risk score	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
	12	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**

BAF 010: Risk trajectory

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Aug 23)	**4x3=12**	
September 2025	**4x2=8**	Significant progress in delivering year 1 and 2 system objectives including significant productivity improvements and embedding of new models of care (including new workforce models) and new ways of working.

BAF risk	011	**There is a risk that the Trust, as part of the Cambridgeshire and Peterborough ICS, is unable to deliver the scale of financial improvement required in order to achieve a breakeven or better financial performance within the funding allocation that has been set for the next three years, leading to regulatory action and/or impacting on the ability of the Trust to invest in its strategic priorities and provide high quality services for patients.**

Current risk rating:

12

Strategic objective	All
Latest review date	August 2023

Lead Executive	Chief Finance Officer
Board monitoring committee	Performance Committee

Risk rating	**Impact**	**Likelihood**	**Total**
Initial (Dec 20)	*Risk reframed in Dec 20*		
Current (Aug 23)	**4**	**3**	**12**

Change since last month
⟺

Related BAF and Corporate Risk Register entries		
ID	**Score**	**Summary risk description**
BAF 001	20	Capacity to restore services
BAF 003	12	Deployment of IT resources
BAF 010	12	Effective ICS working
CR 57	20	Impact of industrial action

Key controls
What are we already doing to manage the risk?

Financial planning and strategy

1. Development of financial plan and budget for the 2023/24 financial year, underpinned by credible assumptions and realistic but stretching productivity and efficiency assumptions. Approved by Board in May 2023.
2. Financial input into development of system financial plans for Integrated Care Board (ICB) and oversight through Financial Planning and Performance Group (FPPG) within the ICB governance. Break-even 2023/24 financial plan for ICB approved by ICB governing body and supported by regulators.
3. Oversight of the development of plans for the Cambridgeshire South Care Partnership.
4. Improvement and Transformation team oversight of Trust's productivity and efficiency programme. Regular review of schemes and scheme identification against targets through divisional performance meetings.
5. Active engagement/involvement in national work to inform development and design of NHS funding regime, directly and through others.

Financial control

6. Controls in place via Investment Committee to ensure appropriate governance and financial control on expenditure decisions, including mechanism to ensure cases are appropriately prioritised through

Assurances on controls
How do we gain assurance that the controls are working?

1. Oversight of financial plan delivery through Management Executive, Performance Committee and Board of Directors.
2. Updates on ICB system plans and financial performance to Performance Committee and Board.
3. Oversight of Cambridgeshire South Partnership planning through Performance Committee, Audit Committee and Board of Directors.
4. Monitoring of improvement programme through Divisional Performance Meetings, Improving Together Steering Group, Performance Committee and Board of Directors.
5. Updates on NHS financial regime provided to Management Executive, Performance Committee and Board of Directors.
6. Key financial controls reviewed on an annual basis by the Trust's internal auditors. Assurance over the design and effectiveness of financial controls provided by the Trust's Audit Committee. Investment decisions reported to Management Executive on a monthly basis.
7. Monthly financial performance reporting through divisional performance meetings, Management Executive, Performance Committee and Board.
8. Key financial controls reviewed on an annual basis by the Trust's internal auditors. Assurance over the design and effectiveness of financial controls provided by the Trust's Audit Committee.

investment decision process/framework.

7. Regular reviews of the Trust's financial performance through monthly internal and external financial reporting cycle, including regular assessments of the Trust's underlying financial position and use of forecasting tools to identify financial risks and mitigations.
8. Effective design and implementation of key financial controls to ensure expenditure is reasonable, justifiable and represents value for money. Key controls - financial system controls, vacancy control procedures, segregation of duties, and procurement/contract management processes.

Gaps in control	Gaps in assurance
C1. Macroeconomic environment, including supply constraints, inflation and pressure on public sector finances may lead to additional financial pressure above funded levels or reduction in funding available to Trust. Ability to control these largely outside Trust's direct control. C2. The breakeven position in the 2023/24 financial plan is achieved on a non-recurrent basis, requiring the delivery of additional productivity improvements to ensure the Trust has a financially sustainable exit position in 2023/24. C3. The national NHS payment framework includes activity-based payments for elective care. The Trust's plan includes the delivery of stretching activity plans which, if not achieved, would lead to a reduction in the Trust's income and a risk delivery of the financial plan. C4. Ongoing industrial action will have an adverse impact on the Trust's financial performance in 2023/24 (both cost and income). C5. Lack of a long-term financial strategy and plan to secure a sustainable financial future for the Trust as part of the ICB. C6. Limited control over the financial and operational performance of other organisations in the ICB which may impact the Trust's financial performance.	

Actions to address gaps in controls and assurances	Due date
C1. Ongoing monitoring of risks and impact on the Trust and ICB financial plan.	Ongoing
C2. Discussed by Management Executive, Performance Committee and Board in May 2023, with a programme of work in development to identify opportunities and potential investment to improve underlying productivity and performance.	September 2023
C3. Risk identified in plan submission and discussed by Board in May 2023. Monthly monitoring of income performance and ongoing review of capacity plans (with oversight from the Capacity Oversight Group) given reliance on new physical capacity (beds and theatres) being available for use.	Ongoing
C4. Risk identified in plan submission and discussed by Board in May 2023. Impact of industrial action monitored and quantified on a monthly basis.	Ongoing
C5. Development of long-term financial strategy as part of the Trust-wide strategy, with circulation through governance groups in autumn 2023.	October 2023
C6. Ongoing monitoring of risks through ICB CFO group, with reporting to Performance Committee.	Ongoing

Risk score	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
	16	16	16	16	16	16	16	16	16	12	12	12	12

BAF 011: Risk trajectory

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
April 2023	**4x4=16**	
May 2023	**4x3=12**	Delivery of a 2022/23 financial position in line with plan. Development and agreement of a financially-sustainable plan and budget for the 2023/24 financial year. **Achieved**
Current (Aug 23)	**4x3=12**	
November 2023	**4x3=12**	Delivery of the 2023/24 financial plan as at month 6, and a clear and agreed longer-term financial plan (2-3 years) which delivers a financially-sustainable financial performance for the Trust and the ICB.
April 2026	**4x2=8**	Consistent delivery of Trust and ICB sustainable financial plans over 3-4 years.

BAF risk	012	**The Trust and our industry and research partners – convened through Cambridge University Health Partners (CUHP) – fail to capitalise on opportunities to improve care for more patients now, generate new treatments for tomorrow and power economic growth in life sciences in Cambridge and across the region.**

Current risk rating:

9

Strategic objective	C2
Latest review date	August 2023

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

Risk rating	**Impact**	**Likelihood**	**Total**
Initial (Aug 20)	3	3	9
Current (Aug 23)	**3**	**3**	**9**

Change since last month
⟺

Related BAF and Corporate Risk Register entries		
ID	**Score**	**Summary risk description**
BAF 009	16	New hospitals development proposals

Key controls

What are we already doing to manage the risk?

1. CBC Strategy Group is undertaking public consultation on a vision for 2050, setting out how the Campus can bring together the right set of research, education, healthcare delivery and industry partners; and what opportunities and requirements this generates for transport and other infrastructure, people and skills. CUH taking a leading role in community engagement with issues raised being actively addressed.
2. The Group is also supporting development of the Campus expansion proposals, including Campus improvements and work on masterplanning. CUH masterplanning work to be aligned.
3. CUH is a founding member of CBC Ltd spanning key current occupants of the CBC. This will drive forward implementation of the Vision.
4. CUH is engaging, alongside Campus partners, with Peter Freeman (Chair of the nationally formed Cambridge Delivery Group) on development of the Cambridge life sciences ecosystem.
5. Specific work on how CBC can support ICS, in particular elective recovery and diagnostics; and wider priorities inc. economic growth/levelling up.
6. Research and innovation recognised as priority within CUH Strategy with visibility at Board and Management Executive, quarterly reporting on specific deliverables and a new Innovation Committee to drive delivery. Innovation Landing Zone model being adopted to support partnering opportunities with external organisations which could benefit patients. Diagnostic review underway in summer 2023 to identify barriers/ enablers of innovation and suggest actions to expand capacity. Digital

Assurances on controls

How do we gain assurance that the controls are working?

1. Regular updates to Board of Directors on CUHP, CBC and life sciences, most recently in April 2021.
2. Board Committee established for Addenbrooke's 3 programme to increase Non-Executive scrutiny, including of how we are working with and contributing to our campus and other partners. Significant discussion on CUHP and CUH masterplan took place in March 2022.
3. Strategy refresh considering partnerships as a major plank, including how we build capacity and capability internally to work as effective partners.
4. Involving partners in key CUH governance groups, particularly on major projects.
5. Executives participating in CBC Ltd working group on Campus development proposals and appropriate ICS and regional NHS groups.
6. Regular engagement with Government and other national bodies to assess how Cambridge is perceived. Cambridge Life Sciences Council now established, with first meeting in May 2022, chaired by David Prior.
7. External input and expertise from NHS, academic and industry partners to provide independent advice and challenge. BRC to maintain model of internal assurance on direction/impact and external review of research programme to provide independent challenge.

strategy for CUH includes opportunities to enhance and maximise the wider benefits of this key resource for research. 7. Ongoing work within BRC and across wider research and innovation programme to build diversity in the research leadership community (e.g. through BRC programme senior roles). 8. Ongoing objective to develop world-class research infrastructure at the Cambridge Biomedical Research Centre and Clinical Research Facility. This is recognised through the positive Research Excellence Framework (REF) outcome for University of Cambridge. 9. Supporting engagement between the Eastern Genomics Laboratory Hub and Illumina to address capacity challenges, broaden joint research projects and embed genomics fully within new hospital builds. 10. Broadening partnerships with industry and the University, including extending work with the Institute for Manufacturing (IfM) to RPH, CPFT, AZ, GSK, primary care and other NHS trusts across the East of England. Discussions to begin on broadening IfM type partnership to other areas of the University of Cambridge. BRC and BioResource taking explicit steps to collaborate with research partners across UK to achieve impact for populations beyond our local geography. 11. Ongoing project with Royal Papworth Hospital to identify opportunities for greater strategic collaboration. 12. Work ongoing with other trusts across the East of England on the specialist provider collaborative, focused on improving access to specialist care within the region, including exploring opportunities to collaborate on research and innovation.	

Gaps in control	Gaps in assurance
C1. National work to promote Cambridge's distinct contribution. C2. Buy-in and commitment from all partners to make the most of our collective opportunities, working through differences in priorities as they arise.	

Actions to address gaps in controls and assurances	Due date
C1a. Involving Campus partners in regional/national media.	Ongoing
C1b. Implementation of Cambridge offer.	Ongoing
C2a. Further work on a clear 'manifesto' for Cambridge Life Sciences being undertaken, drawing in thought leaders from across the Campus.	Ongoing
C2b. Further work with University of Cambridge to extend partnerships to new areas.	Ongoing

Risk score	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
	9	9	9	9	9	9	9	9	9	9	9	9	9

BAF 012: Risk trajectory

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Aug 23)	**3x3=9**	
Ongoing	**3x3=9**	Given the dynamic nature of the sector, it seems unlikely that it is possible to mitigate the risk to a lower level over the medium term.

BAF risk	013	**There is a risk that we fail to maintain and improve the physical and mental health and wellbeing of our workforce which impacts adversely on individual members of staff and our ability to provide safe patient care now and in the future.**

Current risk rating:

16

Strategic objective	B3, B5
Latest review date	August 2023

Lead Executive	Director of Workforce
Board monitoring committee	Workforce and Education

Risk rating	**Impact**	**Likelihood**	**Total**
Initial (Apr 21)	4	4	16
Current (Aug 23)	**4**	**4**	**16**

Change since last month
⟺

Related BAF and Corporate Risk Register entries		
ID	**Score**	**Summary risk description**
BAF 007	20	Meeting workforce demand
CR54	20	Cost of living

Key controls

What are we already doing to manage the risk?

1. Staff Wellbeing Strategy in development.
2. Occupational Health offer with a range of services in place including health pre-employment support, health surveillance programme and management referral pathways.
3. Staff psychological wellbeing and support offer, collaborating with system partners (inc. CPFT), and complemented by Chaplaincy offer.
4. Covid-19 health risk assessment (Version 7) process in place, comprehensive Covid-19 in-house test and trace system and on-site vaccination programme. Range of measures to maintain a Covid secure environment under regular review.
5. Annual flu vaccination and Covid-19 booster vaccination programmes – After Action Review completed in April 2023 and action plan developed.
6. Established equality, diversity and inclusion networks and events promoting health and wellbeing.
7. Public health offer (lifestyle health checks, support and advice – smoking cessation, weight management).
8. 24/7 employee assistance programme (Health Assured) offering practical advice, counselling and support.
9. Developed a model of 'Good Work' with six priority areas including a programme of support for staff wellbeing, cost of living assistance and staff amenities. Food and transport cost support measures, including car parking subsidy, free Park and Ride bus travel and subsidised hot food offer, continued and funded for 2023/24.

Assurances on controls

How do we gain assurance that the controls are working?

1. Management Executive oversight on key programmes of work via taskforce reporting and reporting on specific issues.
2. Reporting to Workforce and Education Committee.
3. Reporting to Health and Safety and Infection Prevention and Control Committees; and Covid-19 Secure Taskforce.
4. Safe Effective Quality Occupational Health Services (SEQOHS) independent accreditation.
5. National and local staff survey evidence on staff health and wellbeing and collation of learning from staff stories.
6. Reporting to Regional People Board via the Regional Health Safety and Wellbeing Group.
7. Chief Executive-led working group on 'Good Work' reporting to Management Executive. Update provided to Management Executive and Board of Directors in November 2022, with endorsement of 2023/24 programme.
8. Wellbeing Team in place – three Wellbeing Facilitators Trust-wide.

Gaps in control	Gaps in assurance
C1. Inadequate provision of staff rest spaces and other amenities. C2. Further work required on measures to support staff with cost of living pressures. C3. Increase understanding of staff feedback from Staff Survey. C4. No agreed suicide prevention policy in place.	

Actions to address gaps in controls and assurances	Due date
C1. Management Executive has received and reviewed costed options, and Capital Advisory Board has allocated funding for initial schemes to be progressed. Initial schemes implemented and further ones being developed and implemented.	Ongoing
C2. Development of further plans through 'Good Work' Group, including agreement of 2023/24 programme.	Ongoing
C3. Undertake a series of Staff Listening Events with report to Management Executive on planned actions.	August 2023
C4. Work underway to produce and agree a suicide prevention policy and plan.	November 2023

Risk score	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
	16	16	16	16	16	16	16	16	16	16	16	16	16

BAF 013: Risk trajectory

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Aug 23)	4x4=16	Avoid further increase in risk though range of interventions including psychological support, staff recognition and cost of living support.
March 2024	4x3=12	Reduced sickness absence; improved staff engagement and wellbeing scores as measured through national staff survey.
March 2026	4x2=8	Improvement in staff engagement and wellbeing (measured as above) sustained over a further two-year period.

BAF risk	014	**The Trust does not work effectively with regional partners (particularly regarding specialised services) resulting in a failure to sustain and improve services for regional patients and regulatory intervention and/or the recurrence of a financial deficit.**

Current risk rating:

12

Strategic objective	C1
Latest review date	August 2023

Lead Executive	Director of Innovation, Digital and Improvement
Board monitoring committee	Board of Directors

Risk rating	Impact	Likelihood	Total
Initial (Oct 22)	4	3	12
Current (Aug 23)	**4**	**3**	**12**

Change since last month
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Related BAF and Corporate Risk Register entries		
ID	**Score**	**Summary risk description**
BAF 009	16	New hospitals development proposals
BAF 011	16	Financial sustainability
BAF 012	9	Impact of Trust and industry/research partners

Key controls
What are we already doing to manage the risk?

1. Setting Specialised Services as a major priority in the Trust's refreshed Strategy.
2. Working with other trusts in the region through the East of England Specialised Provider Collaborative (East of England SPC), including quarterly CEO meetings.
3. Engaging with key stakeholders (NHS England Specialised Commissioning, Joint Commissioning Board, ICBs, providers, networks) to prioritise opportunities for specialised services.
4. Influencing NHS England on specialised commissioning developments by participating in / leading Shelford Group forums on specialised services.

Assurances on controls
How do we gain assurance that the controls are working?

1. Regular EoE SPC meetings to continue to progress agenda.
2. Regular updates to Management Executive and Board of Directors.
3. Feedback and intelligence from Executive Team participation in, and leadership of some, national and regional groups.

Gaps in control	Gaps in assurance
C1. ICBs and regional commissioning teams do not engage with providers on changes to specialised services (e.g. lack of representation in key governance forums). C2. EoE SPC partners do not co-invest/commit to changes to services and/or funding is short term and ad hoc, making it difficult to sustain the collaborative's work over time.	

Actions to address gaps in controls and assurances	Due date
C1. Continue engaging with ICB leads and NHS England regional team to secure participation in governance forums, both now and after full delegation of specialised commissioning in April 2024.	March 2024
C2. Obtain support from CEOs to co-resource the collaborative and expand over time; continue investment from CUH; develop business plan to define the objectives and resourcing approach across members.	September 2023

C3. There is a lack of clear governance meaning that key decisions relating to the collaborative (e.g. prioritisation of resourcing) are not made. C4. Clinical transformation in CUH and with partners is crowded out by urgent pressures to sustain current services.		C3. Establish clearer governance through developing a business plan, to be agreed by CEOs. C4. Deliver transformation projects in neuro, paediatrics and dentistry with measurable benefits for staff, patients and trusts, which encourage CUH and partners to continue investing in the EoE SPC.	September 2023 March 2024

Risk score	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
			12	12	12	12	12	12	12	12	12	12	12

BAF 014: Risk trajectory

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Aug 23)	4x3=12	
April 2025	4x2=8	Development of revised national commissioning framework; transfer of commissioning activities into ICBs; collaboratives established and delivering on key priorities.

BAF risk	015	**As a result of a failure to deliver the CUH Green Plan, the Trust does not enhance environmental sustainability and reduce its direct carbon emissions by 10% by 2025 (as a key step towards the national commitment to halve carbon emissions before 2032 and deliver net zero carbon by 2045) nor develop and deliver a credible adaptation plan, which impacts on organisational reputation and regulatory compliance and increases the susceptibility of our services to the effects of climate change.**

Current risk rating:

16

Strategic objective	C4
Latest review date	August 2023

Lead Executive	Director of Capital, Estates and Facilities Management
Board monitoring committee	Board of Directors

Risk rating	**Impact**	**Likelihood**	**Total**
Initial (Mar 23)	4	4	16
Current (Aug 23)	**4**	**4**	**16**

Change since last month
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Related BAF and Corporate Risk Register entries

ID	**Score**	**Summary risk description**
BAF 005	20	Life safety critical infrastructure systems
BAF 009	16	New hospitals development proposals
CR 59	16	Impact of climate change on delivery of services at CUH
CR 20	12	Transport access to the CBC

Key controls

What are we already doing to manage the risk?

1. Commitment to tackle climate emergency and enhance environmental sustainability within CUH Strategy.
2. Board approved Green Plan in place until 2024.
3. Environmental sustainability policies and procedures in place.
4. Board appointed executive lead for climate change response, NED Champion and appropriately qualified and experienced Environmental Sustainability and Energy Management Team.
5. Suite of training resources.
6. Engagement programme
7. Environmental sustainability credentials of new hospital builds (CCRH and CCH) and ongoing improvements to the estate, buildings and infrastructure via all backlog maintenance work to critical infrastructure and new and major refurbishment capital schemes.
8. Heat Decarbonisation strategic plan developed at masterplan level. Grant funding developing aspects of the masterplan into RIBA Stage 3.

Assurances on controls

How do we gain assurance that the controls are working?

1. Corporate Strategy - reporting three times a year as part of overall strategy update to Board of Directors on progress in delivering strategic commitment on climate change.
2. Delivery of implementation plan associated with Our Action 50 Green Plan and early preparation commenced on the Green Plan 2025 and beyond.
3. Governance, reporting and monitoring structure in place
4. Reporting to Management Executive twice a year on progress and to Board of Directors annually. Heat Decarbonisation update to Addenbrooke's 3 Committee in July 2023.
5. Uptake and utilisation data on available training resources feeding into the balanced score card reporting.
6. Evidence of ongoing awareness campaign and evaluation
7. BREEAM assessments and NHS Net Zero Building Standard, environmental sustainability credentials of new hospital builds. Potential internal audit for Q3/4 2023/24.

Gaps in control	Gaps in assurance
C1. Governance, reporting and monitoring plan 50% complete in delivery. C2. Additional training resources in preparation. C3. Preparation of Green Plan for 2025 and beyond. C4. Corporate policies (such as procurement, workforce and investment) are not aligned to environmental sustainability ambitions. C5. Delivery of building enhancements/retrofitting and delivery of sustainability measures as standard in refurbishments and new schemes.	

Actions to address gaps in controls and assurances	Due date
C1. Governance, reporting and monitoring structure fully implemented and functioning.	October 2023
C2. E-learning package for environmental sustainability.	September 2023
C3. Programme underway.	November 2023
C4. Ongoing work to align corporate policies.	Phase 1 scoped and delivered March 2024
C5. Ensure detailed sustainability input to all refurbishments and new schemes.	Ongoing

Risk score	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23
	New risk added in March 2023							16	16	16	16	16	16

BAF 015: Risk trajectory – to follow

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Aug 23)	4x4=16	
September 2023	4x4=16	Outcome of decarbonisation funding bid to progress detailed design of a decarbonisation scheme.
December 2025	4x4=16	Achievement of CUH aim to reduce direct carbon emissions by 10%.
End 2027	4x4=16	CCRH and CCH schemes in place with environmental sustainability measures incorporated.
2032	4x3=12	CUH achievement of national commitment to halve carbon emissions.

Annex 1: Trust risk scoring matrix and grading

	Likelihood				
Impact	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost certain**
Catastrophic 5	5	10	15	20	25
Major 4	4	8	12	16	20
Moderate 3	3	6	9	12	15
Minor 2	2	4	6	8	10
Negligible 1	1	2	3	4	5

Risk Assessment	Grading
15 – 25	**Extreme**
8 – 12	**High**
4 – 6	**Medium**
1 – 3	**Low**

Annex 2: Trust strategic commitments, July 2022

	A	B	C
	Improving patient care	**Supporting our staff**	**Building for the future**
1	**Integrated care:** We will work with NHS, other public sector and voluntary sector organisations to improve the health of our local population	**Resourcing:** We will invest to ensure that we are well staffed to deliver safe and high quality care	**Specialised services:** We will work with hospitals across the East of England to provide high quality specialised care for more patients closer to home
2	**Emergency care:** When patients come to the hospital in an emergency we will treat them, and help them to return home, quickly	**Ambition:** We will invest in education, learning, development and new ways of working	**Research and life sciences:** We will conduct world-leading research that improves care and drives economic growth
3	**Planned care:** When patients need planned care we will see them as quickly and efficiently as possible	**Good work:** We will strive to ensure that working at CUH will positively impact our health, safety and well-being	**New hospitals and the estate:** We will maintain a safe estate and invest in new facilities to improve care for patients locally, regionally, and nationally
4	**Health inequalities:** We will tackle disparity in health outcomes, access to care and experience between patient groups	**Inclusion:** We will seek to drive out inequality, recognising that we are stronger when we value difference and inclusion	**Climate change:** We will tackle the climate emergency and enhance environmental sustainability
5	**Quality, safety and improvement:** We will continuously improve the quality, safety and experience of all our services	**Relationships:** We will foster compassionate and enabling working relationships	**Digital:** We will use technology and data to improve care

Board of Directors

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Report to the Board of Directors: 13 September 2023

Agenda item	17
Title	Amendment to the Trust Constitution
Sponsoring executive director	Ian Walker, Director of Corporate Affairs
Author(s)	As above
Purpose	To seek approval to amend the Trust Constitution in relation to filling a vacancy created by the departure of a Governor between scheduled elections.
Previously considered by	n/a

Executive Summary

Other than in very limited circumstances, the Trust's Constitution does not currently provide for filling a patient, public or staff governor vacancy which arises between scheduled elections via co-option of a candidate from the most recent election. This means that a vacancy can persist for a prolonged period. In the context of the recent departure of a staff governor, this paper considers options for amending the Constitution and recommends an amendment in order to be able to fill an individual vacancy through co-option until the next scheduled election (see Appendix 2).

Related Trust objectives	All Trust objectives
Risk and Assurance	n/a
Related Assurance Framework Entries	n/a

Legal / Regulatory / Equality, Diversity & Dignity implications?	The electoral rules are set out in the Trust Constitution and therefore any changes require the approval of both the Board of Directors and the Council of Governors.
How does this report affect environmental Sustainability?	n/a
Does this report reference the Trust's values of “Together: safe, kind and excellent”?	n/a

Action required by the Board of Directors

The Board is asked to:

- Approve the amendment to the Trust Constitution as set out at Appendix 2 of the paper.
- Note that, subject to approval of the amendment by both the Board of Directors and the Council of Governors, the Trust Constitution will be updated accordingly.

Cambridge University Hospitals NHS Foundation Trust

13 September 2023

Board of Directors
Amendment to the Trust Constitution
Ian Walker, Director of Corporate Affairs

1. Introduction

1.1 In general, amendments to the Trust Constitution require the approval of both the Board of Directors and the Council of Governors. This paper outlines a proposed amendment in relation to filling a patient, public or staff governor vacancy created by the departure of a governor between scheduled elections.

2. Current Constitutional position

2.1 The rules governing the election of patient, public and staff governors to the CUH Council of Governors are set out in the Trust Constitution (Section 14 and Annex 5).

2.2 Section 14 of the Constitution describes the arrangements to be followed in the event that a vacancy arises within the patient, public or staff constituency outside of the normal annual election cycle. The relevant wording is set out at Appendix 1. In summary, unless the vacancy results in the Council of Governors not being quorate and/or the number of vacancies being greater than 50% in the relevant constituency, then the Constitution requires that the vacancy is held until the next scheduled election.

3. Staff governor vacancy

3.1 Since the completion of the last governor election cycle in spring/early summer 2023, a staff governor vacancy has arisen as a result of the recent resignation of Will Watson.

3.2 Under the current Constitution, with all other elected governor positions filled, there would be a requirement to hold this position vacant until the next scheduled election in 2024. On this basis, the vacant staff governor position would not be filled until 1 July 2024.

3.3 There were seven staff governor candidates in the recent election for the one position which was available at that time. The successful candidate received 355 votes, with the votes received by the other six candidates ranging from 345 to 173. So there is a pool of candidates from the recent

election who received a significant share of the votes. The election outcome is shown at Appendix 3.

4. Options for filling an elected governor vacancy

4.1 In discussion with the Trust Chair and the Lead Governor, the following options have been considered in relation to filling an elected (patient, public or staff) governor vacancy that arises:

(i) Maintain the current Constitutional position and hold the vacancy until the next scheduled election (except in the extreme where the vacancy results in the Council being inquorate or a constituency vacancy rate of over 50%).

(ii) Amend the Constitution such that the governor candidate with the next highest number of votes in the relevant constituency in the most recent election is co-opted as a governor until the next scheduled election.

(iii) Amend the Constitution such that the governor candidate with the next highest number of votes in the relevant constituency in the most recent election is co-opted as a governor until the end of the term of office of the departing governor.

(iv) Amend the Constitution such that there is the requirement to convene a by-election to fill the vacancy, provided there is greater than, say, six months until the next scheduled election.

4.2 Option (i) has the benefit of simplicity in that a Constitutional change is not required and the vacancy is filled as part of the scheduled election cycle. However, it means that a position could be left vacant for up to (or slightly in excess of) 12 months despite there being candidates who recently participated in an election, received a substantial proportion of the votes and could take on the role with immediate effect. In terms of comparing Options (ii) and (iii), it is common practice within the Constitutions of NHS foundation trusts that any co-option of elected governors is for a period until the next scheduled elections, in order to maintain the primacy of the electoral process. This is also the position in terms of the more limited provision in the current CUH Constitution for a governor to be co-opted. Option (iv) – a by-election for a single vacancy – would be administratively and financially onerous in terms of running an additional election within what would be a period of a few months since the previous election.

4.3 On the basis of the above, the recommendation of the Trust Chair and the Lead Governor is to amend the Constitution to enable a patient, public or staff governor vacancy to be filled at the earliest opportunity through co-

option until the next scheduled election, i.e. Option (ii) above, provided this occurs ahead of the publication of the Notice of Election for the next scheduled election. If the circumstances of the most recent election do not permit co-option, then it is proposed that the vacancy is held until the next scheduled election, with a by-election only being undertaken in the extreme circumstance which is currently included in the Constitution whereby the vacancy would leave the Council of Governors inquorate or with a constituency vacancy rate in excess of 50%.

4.4 The proposed revised wording for the Constitution to deliver this amendment is set out at Appendix 2.

4.5 If this amendment was agreed by the Board of Directors and the Council of Governors in September 2023, the aim would be to fill the current staff governor vacancy with effect from 1 October 2023, with the individual being co-opted onto the Council of Governors for the period until 30 June 2024. The individual would have the opportunity to stand in the 2024 election.

4.6 For completeness, it should be emphasised that this paper relates to patient, public and staff governors. In the event that a partnership governor stood down during their term of office, the Trust would seek a new individual from the nominating organisation.

5. Recommendation

5.1 The Board of Directors is asked to:

- Approve the amendment to the Trust Constitution as set out at Appendix 2 of the paper.
- Note that, subject to approval of the amendment by both the Board of Directors and the Council of Governors, the Trust Constitution will be updated accordingly.

Appendix 1: Current wording of Section 14 of the CUH Constitution

14. Council of Governors – election of governors

14.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules which are set out in Annex 5.

14.2 An election, if contested, shall be by secret ballot.

14.3 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 either the Public, Patients' or Staff Constituency is greater than 50% of the places in the relevant constituency.

14.4 In the event of 14.3 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.

Appendix 2: Proposed revised wording of Section 14 of the CUH Constitution

14. Council of Governors – election of patient, public and staff governors

14.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules which are set out in Annex 5.

14.2 An election, if contested, shall be by secret ballot.

14.3 In the event of a vacancy for an elected member of the Council of Governors arising outside of the normal election cycle, the vacancy shall be filled as follows:

a) The next highest polling candidate in the relevant constituency at the most recent election, who is willing to take office and who secured at least 10% of the total number of ballots in the relevant constituency, shall be co-opted to fill the vacant seat on the Council of Governors until the next scheduled election, provided the co-option commences prior to the publication of the Notice of Election for the next scheduled election.

b) In the event that it is not possible to fill the vacancy on the basis of a) above, the seat shall be left vacant until the next scheduled election unless the vacancy results in one or more of following occurring:

(i) The Council of Governors will not be quorate.
(ii) The number of vacancies in either the public, patient or staff constituency is greater than 50% of the places in the relevant constituency.

c) In the event that b) (i) and/or (ii) above apply, and there is greater than six months until the next scheduled election, a by-election shall 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.

Appendix 3: Outcome of 2023 staff governor election

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

Board of Directors

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Report to the Board of Directors: 13 September 2023

Agenda item	18.1
Title	Medical Revalidation
Sponsoring executive director	Ashley Shaw, Medical Director
Author(s)	John Firth, Responsible Officer and Deputy Medical Director Alison Risker, Associate Director of Workforce Beverley Collins, Revalidation and Compliance Support Manager
Purpose	To provide assurance to the Board that the Trust as healthcare provider is discharging its duties under the Responsible Officer Regulations, and to the Chief Executive in signing the 2022/23 Designated Body Statement of Compliance (Section 7).
Previously considered by	Management Executive, 7 September 2023

Executive Summary

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

Related Trust objectives	Improving patient care Supporting our staff
Risk and Assurance	See purpose above
Related Assurance Framework Entries	BAF ref: 007
How does this report affect Sustainability?	Successful revalidation of doctors with a prescribed connection to the Trust is required for the continuation of their legal medical practice in the UK.
Does this report reference the Trust's values of “Together: safe, kind and excellent”?	n/a

Action required by the Board of Directors

The Board is asked to:

- Receive the report which will be shared, along with the annual audit, with the higher level responsible officer at NHS England (East) Region.
- Approve the designated body statement of compliance, Section 7, confirming that the organisation, as a designated body, is in compliance with the regulations. This is submitted annually to the higher level responsible officer at NHS England (East) Region.

Designated Body Annual Board Report

Section 1 – General:

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

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

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

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

Yes Action from last year: Possible procurement and implementation of a new appraisal platform Comments: Funding has been approved Action for next year: procure and implement of a new appraisal platform

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

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

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

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

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

Actions from last year: n/a Comments: The HLRO has discussed organizing a system of peer reviews within the region and we have indicated that we are willing to participate in this Action for next year: n/a

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

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

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1] Action from last year: 1098 doctors were appraised in 2022/23. 40 doctors were approved for a missed appraisal by the RO whilst 13 doctors had an unapproved missed appraisal Comments: further detail is available in table 1; see appendix 1 Action for next year: to continue to ensure that doctors are appraised

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

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

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

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

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

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

Action from last year: The Trust has 174 trained appraisers of which 166 appraised in the 2022/23 appraisal round Comments: The Trust will continue to recruit new appraisers Action for next year: To continue the recruitment and training processes

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

Action from last year: 8 new appraisers were trained during the 2022/23 appraisal round. No appraisers were due to receive refresher training in 2022/23. Comments: n/a Action for next year: To continue with the recruitment and training processes for new and current appraisers.

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

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

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

Section 2b – Appraisal Data

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

Name of organisation: Cambridge University Hospitals NHS Foundation Trust	
Total number of doctors with a prescribed connection as at 31 March 2023	1280
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	1098
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	182
Total number of agreed exceptions	169

Section 3 – Recommendations to the GMC

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

Action from last year: n/a

Comments: 184 recommendations were made to the GMC:

- 174 positive revalidation recommendations
- 9 deferral recommendations
- 1 non-engagement recommendation

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

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

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

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

Action from last year: n/a

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

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

Section 4 – Medical governance

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

Action from last year: n/a

Comments: Clinical governance mechanisms are well embedded in the Trust

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

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

Action from last year: n/a
Comments: Mechanisms for monitoring conduct and performance of doctors are well established in the Trust
Action for next year: to continue with the Trust's agreed practice

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

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

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

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

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

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

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

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

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

Section 5 – Employment Checks

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

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

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

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of actions since last Board report:**

- **1280 prescribed connections**
- **1098 doctors have a completed appraisal**
- **184 recommendations were made to the GMC**
- **8 new appraisers were trained**

- **Actions still outstanding: none**

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

- **New actions:** Procure and implement a new appraisal platform

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

- **1097 as at 31 March 2019**
- **1136 as at 31 March 2020**
- **1195 as at 31 March 2021**
- **1231 as at 31 March 2022**
- **1280 as at 31 March 2023**

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

Section 7 – Statement of Compliance:

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

Signed on behalf of the designated body

(Chief executive)

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

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

Role: Chief Executive

Date: _ _ _ _ _ _ _ _ _ _

Appendix 1 – 2022/2023 Appraisal Data:

Doctors with a connection at 31 March 2022	Number of Prescribed Connections	Completed Appraisal (1)		Approved incomplete or missed appraisal (2)		Unapproved incomplete or missed appraisal (3)		Appraisal Not Required		Total
		No	%	No	%	No	%	No	%	No
Consultant	876	831	95	28	3	5	1	12	1	876
Staff grade, associate specialist, specialty doctor	25	24	96	0	0	0	0	1	4	25
Temporary or short-term contract holders	378	242	64	12	3	8	2	116	31	378
Other	1	1	100	0	0	0	0	0	0	1
Total	1280	1098	86	40	3	13	1	129	10	1280

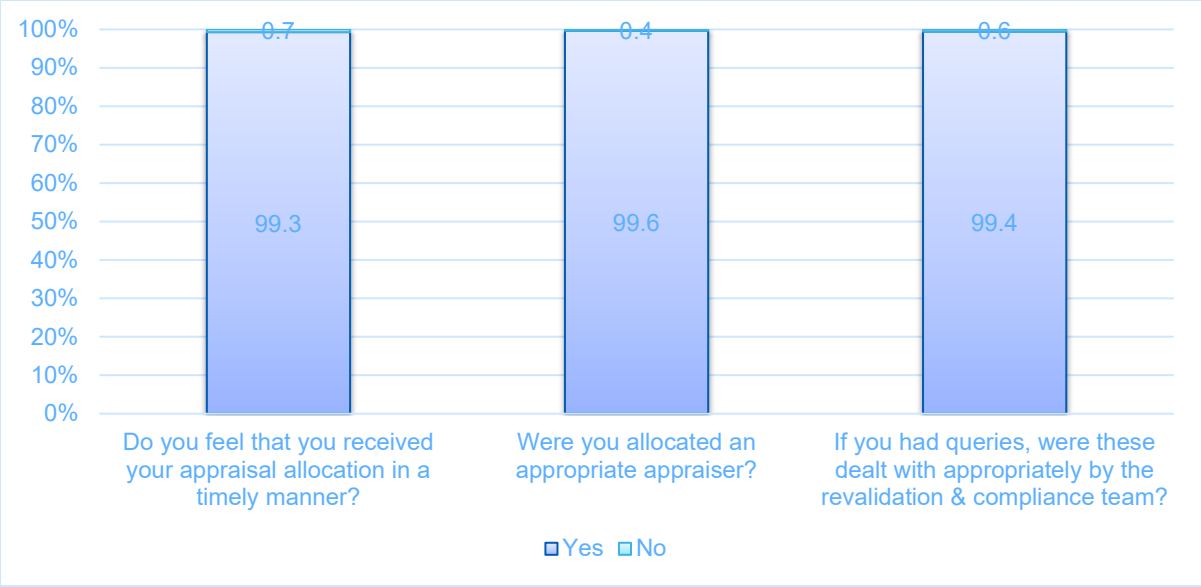
Reason for approved missed appraisal (2)	Number	%
Maternity Leave	20	50
Adoption leave	2	5
Sickness absence	6	15
Other doctor factors	9	23
Appraiser availability	2	5
Administration factors	1	3
Total category 2	40	100

Reason for unapproved missed appraisal (3)	Number	%
Offered an appraisal but not completed	13	100
Total category 3	13	100

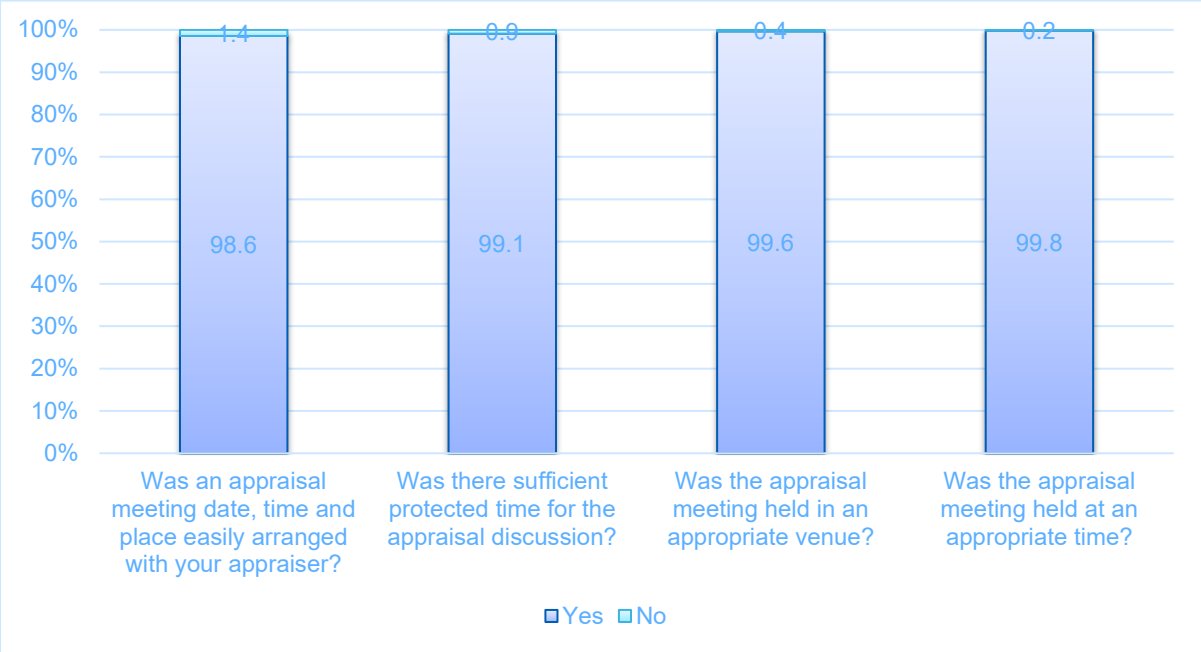
Appendix 2 – Appraiser QA Summary Feedback Report:

Appraisal Year:	2022/23
Overall number of appraisee respondents:	558
Number of appraisees invited to respond	806
% Response Rate	69%

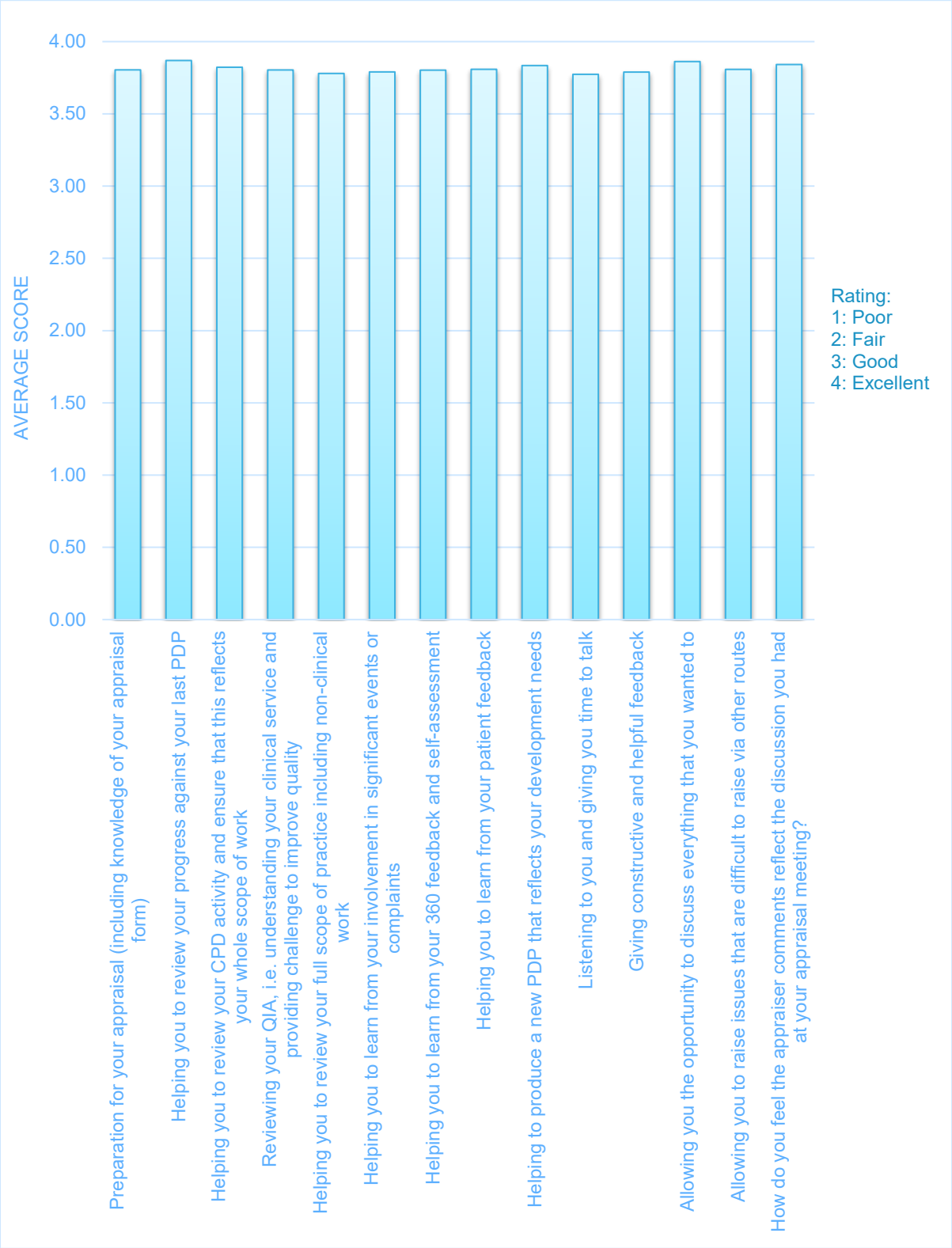
Administration and Management of the Appraisal System



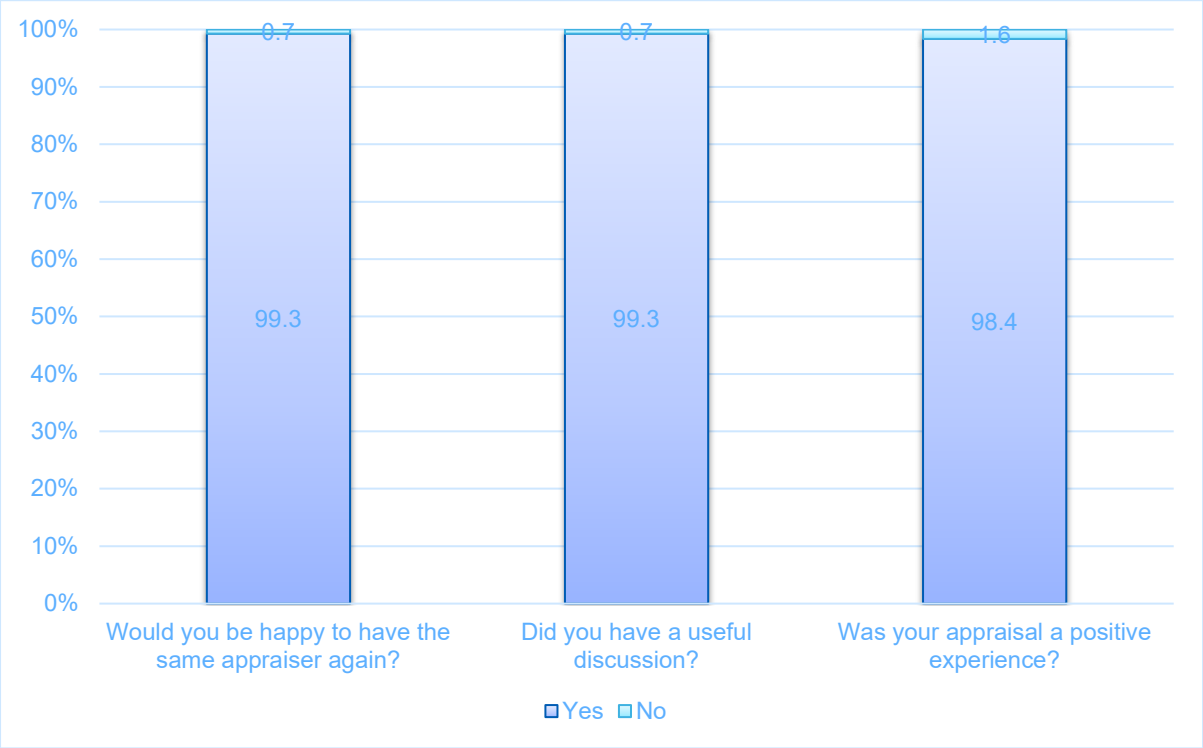
Organisation of the appraisal meeting



Appraiser Skills



Overall experience



Appendix 3 – Quality Assurance of Appraisal Inputs and Outputs:

Total number of appraisals completed		**1098**
	Number of appraisal portfolios sampled (to demonstrate adequate sample size)	Number of the sampled appraisal portfolios deemed to be acceptable against standards
Appraisal inputs		
Scope of work: Has a full scope of practice been described?	264	255
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	264	261
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	264	246
Patient feedback exercise: Has a patient feedback exercise been completed? (only relevant for appraisal before revalidation date)	69	54
Colleague feedback exercise: Has a colleague feedback exercise been completed? (only relevant for appraisal before revalidation date)	69	67
Review of complaints: Have all complaints been included?	264	260
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	264	257
Is there sufficient supporting information from all the doctor's roles and places of work?	264	249
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)? Explanatory note: For example • Has a patient and colleague feedback exercise been completed? • Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)? • Have all types of supporting information been included?	264	246
Appraisal Outputs		
Appraisal Summary	264	264
Appraiser Statements	264	264
Personal Development Plan (PDP)	264	263

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Report to the Board of Directors: 13 September 2023

Agenda item	18.2
Title	Nursing and midwifery revalidation
Sponsoring executive director	Lorraine Szeremeta, Chief Nurse
Author(s)	Amanda Small, Deputy Chief Nurse
Purpose	To provide assurance that Cambridge University Hospitals NHS foundation trust staff are meeting the nursing and midwifery revalidation requirements.
Previously considered by	Management Executive, 7 September 2023

Executive Summary

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

Related Trust objectives	Improving patient care Supporting our staff
Risk and Assurance	The report provides assurance on compliance with revalidation requirements.
Related Assurance Framework Entries	n/a
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of “Together: safe, kind and excellent”?	n/a

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

Cambridge University Hospitals NHS Foundation Trust

September 2023

Board of Directors
Nursing and midwifery revalidation
Amanda Small, Deputy Chief Nurse

1. Background

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

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

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

2. Requirements of Revalidation

2.1 Revalidation requires NMC registrants to evidence:

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

3. Revalidation data

3.1 In 2023, 911 staff members were due to revalidate. Table 1 demonstrates the number of staff who are due to revalidate each month.

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

Year	Revalidation Date	Number of staff
2023	Jan	53
	Feb	83
	Mar	64
	Apr	62
	May	44
	Jun	62
	Jul	58
	Aug	91
	Sep	205
	Oct	86
	Nov	55
	Dec	48
2023 Total		911

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

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

4. Governance arrangements

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

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

- Ongoing face to face training is available from the clinical education support team as required for both registrants and confirmers.
- There are support pages on the Trust intranet which has links to the NMC website.

5. Recommendations

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

Cambridge University Hospitals NHS Foundation Trust

CHAIR'S KEY ISSUES REPORT

ISSUES FOR REFERRAL / ESCALATION

ORIGINATING BOARD / COMMITTEE:	Addenbrooke's 3 Committee	DATE OF MEETING:	27 July 2023
CHAIR:	Annette Doherty	LEAD EXECUTIVE DIRECTOR:	Director of Strategy and Major Projects
RECEIVING BOARD / COMMITTEE:	Board of Directors, 13 September 2023		

AGENDA ITEM	DETAILS OF ISSUE:	FOR APPROVAL / ESCALATION / ALERT/ ASSURANCE / INFORMATION?	CORPORATE RISK REGISTER / BAF REFERENCE	PAPER ATTACHED (Y/N)
5.	**Specialised services provider collaborative** 1. The committee was given an overview of the progress being made in the development of the East of England Specialised Provider Collaborative (EoE SPC) particularly with regard to neurosciences strategy which has been identified as a priority area. 2. NHS England has launched a national programme for neurosciences that CUH has been asked to lead on for the EoE. Neuro provision in EoE is limited with NNUH being the only other hospital in the region with designated neuro beds. This leads to many patients having to go out of region for treatment, in most cases to London. The committee agreed that repatriating services from London would benefit both patients and CUH. 3. The benefits of the strategy to CUH and research partners were discussed and it was noted that the University of Cambridge has a long established academic centre for neurosciences research.	Information	BAF 009	N

	With EoE trials being CUH based the trials teams are keen to improve accessibility across the region. 4. The next steps would be to further develop understanding of the challenges and opportunities in neurosciences across the EoE, based on data analysis and interviews with key stakeholders across the region, and to assemble an expert panel to test the proposed KLOEs and agree the areas of work to take forward. 5. The meeting was also given an overview of the wider specialised services collaborative and how this aligned with other projects in the Addenbrooke's 3 agenda. 6. The committee recognised the importance of the collaborative and the Trust's position within it to influence its development for the benefit of patients. 7. The committee will receive quarterly updates on the SPC going forward.			
6.	**Decarbonisation masterplan strategy** 1. The committee had received a paper detailing the Trust's ambition to decarbonise the existing estate by switching from fossil fuels providing hot water and heating to greener alternative fuels, mostly heat pumps which are very efficient. This will be done in parallel with upgrading existing buildings to reduce heat loss. The Trust had been successful in securing £1m grant funding toward the next implementation phase. 2. The work will be undertaken in two phases with the bulk of work being in developing the Energy Centre to serve the majority of the estate, and standalone units for the residences and the Frank Lee. The Cancer Hospital and Children's Hospital will have their own standalone heat pumps but can be connected to the energy centre when it is completed. 3. The committee congratulated the team on a visionary piece of work that had their support, and on their successes in gaining government funding.		BAF 015	

	4. It was noted that the University is also looking at decarbonisation. The Trust and University would work together on this where appropriate. CUHP would be kept aware of the Trust's plans as the programme would influence the overall energy strategy for the campus. Communication with campus stakeholders would be critical			
7.	**CUH/RPH collaboration – next steps** 1. The committee considered working draft papers for a proposed Board to Board meeting of CUH and RPH in September/October 2023 following the review of opportunities that had been commissioned in March - May 2023. Reports on the review had been given to the committee at its two previous meetings. 2. The papers, while not complete, provided the committee with an outline of the direction of travel and set out priority areas that need to be focused on, initial thinking around the implementation programme and governance structures. 3. The committee welcomed a clearer governance structure for the relationship. It was suggested that regular reports to the committee could be written into the terms of reference. 4. The committee was encouraged that both organisations were clearly committed to the collaboration and recognised this as an opportunity to develop clinical pathways for the benefit of patients.		BAF 012	
8	**Project delivery update** 1. The business case for the CCH was undergoing review by the regional team before submission to the Joint Investment Committee (JIC) in September. 2. Fundraising for the CCH continues well with the likelihood we will be over halfway by September which would be well timed for the submission to JIC. 3. A joint construction director for the CCRH and CCH was in post initially working two days a week.	Review		N

	4. Work on genomics was progressing to provide extra activity. 5. An update on cancer pathways will be presented to the September meeting. 6. Work on the legal agreement with the University was progressing with a framework agreement expected to be given to the various parties by September and the drawing up of the legal agreement by the end of the year.			
9	**Review of Board Assurance Framework Risks and Corporate Risk Register** 1. The committee received and noted the current version of the Board Assurance Framework. 2. There is one BAF risk (009) for which the A3 Committee has oversight and no CRR risks for which it has oversight. 3. BAF risk 009 may be open to division as we approach implementation and construction phases of the CCRH. This is being discussed with the Risk Oversight Committee. 4. BAF Risk 014 – specialised services. A3 Committee would be a key committee to monitor this risk in addition to the Board.	Information/ Assurance		N

Cambridge University Hospitals NHS Foundation Trust

CHAIR'S KEY ISSUES REPORT

ISSUES FOR REFERRAL / ESCALATION

ORIGINATING BOARD / COMMITTEE:	Performance Committee	DATE OF MEETING:	6 September 2023
CHAIR:	Annette Doherty	LEAD EXECUTIVE DIRECTOR:	Chief Operating Officer, Chief Finance Officer
RECEIVING BOARD / COMMITTEE:	Board of Directors, 13 September 2023		

AGENDA ITEM	DETAILS OF ISSUE	FOR APPROVAL / ESCALATION / ALERT/ ASSURANCE / INFORMATION?	CORPORATE RISK REGISTER / BAF REFERENCE	PAPER ATTACHED (Y/N)
5	**Secure Data Environment (SDE)** 1. The Committee reviewed and discussed the case ahead of seeking Board approval.			N
6 6.1	**Medium term strategy and productivity improvement programme** <u>Medium term strategy</u> 1. The Committee was given an update on progress in the strategy with the focus on improving access to care. 2. The clinical pathways identified for particular focus are pneumonia, one within ENT and virtual wards. 3. Three strategic metrics chosen, to enable the Board to measure progress on improving access to care, are net bed capacity, the referral to treatment (RTT) waiting list and the staff vacancy rate.	For information		n/a

6.2	4. The next steps to achieve the ambition would include more detailed consideration of the financial cost and required infrastructure and alignment of capabilities; focus on the three agreed pathways; planning within divisions and corporate functions to put in place the pace and scale of change required; clear ownership for delivery, and consideration of the cultural enablers required to support the change. 5. The meeting supported the ambition and the plan. There will be monthly updates to the Committee on progress and more detail on implementation plans. <u>Productivity improvement programme</u> 1. The Committee was updated on the progress toward delivering the Trust's 2023/24 productivity and efficiency requirement of £53m. 2. The value of current fully developed plans and plans still under development is £46.2m. There is focus on developing plans for an additional £9.7m of ideas that have been identified but do not yet have a confirmed plan. Delivering all identified plans in full will result in an overachievement of £2.8m. 3. Year to date there had been an under-performance of £2.4m which had been affected by industrial action that had contributed to an increase in pay costs. 4. There is a focus on supporting the programmes identified in the strategy to improve access to care.			
7 7.1	**Operational Performance** 1. The committee was updated on the current position. 2. Ambulance handover times continued to perform well with all standards for handover targets continuing to be met. This is now considered to be embedded and is no longer subject to specific focus. 3. Performance against the 4-hr standard in ED had been 70% in July placing the Trust in the third quartile nationally. Performance was slightly down in August. Areas that would			n/a

7.3	help improve performance have been identified and it was hoped that it should be possible to attain 82% by the end of the financial year. 4. 12 hour waits had reduced to 4% in July against 8% in June. The aim is to reach 2%. 5. There were approximately 100 patients waiting 78 weeks for treatment largely due to the effect of industrial action. The Trust's performance was similar to comparable trusts regionally and nationally. 6. 62 day cancer waits are ahead of the Shelford group average. The faster diagnosis standard is receiving focus nationally due to the better outcomes for patients. CUH is performing significantly better than the Shelford group average. 7. Over the coming weeks there would be focus on re-establishing the governance for winter planning with an update to the next meeting. <u>Emergency Preparedeness, Resilience and Response (EPRR) Core standards</u> 1. The Trust had undertaken a self-assessment against the NHS England and NHS Improvement EPRR core standards. 2. The paper confirmed that the Trust was fully compliant. 3. The Committee approved the report.			
8	**Finance reports** 1. The committee received a report of the Month 4 financial position. 2. The Month 4 position was showing an adverse variance to plan but still forecasting breakeven for the year. The position is complicated by the effects of industrial action and how the centre plans to mitigate it. This will feed through in the next month's reports.	For information	001/010	n/a

	3. There has been confirmation of how the EPM (Elective Payment Mechanism) will work. In light of the industrial action the target the Trust will be performance assessed against has been reduced. Details of how this will be spread across the year are awaited. 4. Industrial action will continue to affect the organisation's ability to improve productivity and move into 2024/25 in a good position. 5. The planning round for 2024/25 will be underway in the next two months.			
9	**Capital Project Delivery reporting** The committee received and noted an update from the Director of Capital, Estates and Facilities Management. 1. There were no points for escalation. 2. The A block – fire safety checks are underway 3. Movement hub – on track to open on 5 October. 4. NCCU – works in the unit would be added to the tracker for the next meeting.		011	n/a
10	**Board Assurance Framework and Corporate Risk Register** 1. The committee received and noted the current version of the Board Assurance Framework and Corporate Risk Register. 2. There had been no significant changes in month. 3. There had been discussion at the recent risk register meetings about how the significant impact of industrial action is reflected on risk registers.		005/006/015	n/a

Cambridge University Hospitals NHS Foundation Trust

CHAIR'S KEY ISSUES REPORT

ISSUES FOR REFERRAL / ESCALATION

ORIGINATING BOARD / COMMITTEE:	Quality Committee	DATE OF MEETING:	6 September 2023
CHAIR:	Sharon Peacock	LEAD EXECUTIVE DIRECTOR:	Chief Nurse / Medical Director
RECEIVING BOARD / COMMITTEE:	Board of Directors, 13 September 2023		

AGENDA ITEM	DETAILS OF ISSUE:	FOR APPROVAL / ESCALATION / ALERT/ ASSURANCE / INFORMATION?	CORPORATE RISK REGISTER / BAF REFERENCE	PAPER ATTACHED (Y/N)
5. 5.1	**Lead Executives' Report and Patient Safety and Experience Overview** Lead Executives' Report 1. The Chief Nurse and Medical Director presented the report to the committee. 2. The committee noted that the maternity CQC Inspection report had been received, this would be discussed under the maternity item. 3. The committee focused on the conviction of Lucy Letby noting that an independent inquiry had been announced by the Department of Health and Social Care. Monitoring patient safety remains a priority and the patient safety mechanisms in place or planned were outlined to the committee: • Medical Examiners – in place since 2021, medical examiners offer independent scrutiny of all deaths not investigated by a coroner • Patient Safety Incident Response Framework (PSIRF) – due to be implemented across the NHS PSIRF will change the way patient safety incidents are responded too, allowing a better focus on data and incident occurrence understanding	Information/ Assurance		N

	• Freedom to Speak up – the Trust has a freedom to speak up service in place since 2016, and additional awareness raising and communications had taken place Trust wide in recent weeks. The Freedom to Speak Up report would be received by the Board in September 2023. • Fit and Proper Persons Requirements – NHS England recently strengthened the Fit and Proper Persons (FPP) Framework with the inclusion of additional background checks. This assessment will be refreshed annually and for the first time, recorded on Electronic Staff Record (ESR) so that it is transferable to other NHS organisations as part of their recruitment processes. 4. It was recognised that crimes of this nature could have been carried out in any service across the NHS, monitoring of data for spikes and patterns in all areas would continue. 5. A briefing paper on the process of reviewing Neonatal Deaths was presented to the committee. 6. The committee agreed to discuss Martha's Rule at the next meeting. 7. The HSMR was 81.9 (April 22 to March 2023), 71.0 in the month of March and banded as statistically 'lower than expected'. There are no areas which have been flagged for concern by Dr Foster.			
5.2	Patient Safety and Experience Overview 1. The report covered the period up until the end of July 2023. 2. Normal variance in the amount of patient safety incidents had been reported. 3. At the time of reporting 18 Serious Incident investigations were open, 12 on track and six overdue. 4. Patient falls was within normal variance, with 88% of falls risk assessments completed within 12 hours. 5. Hospital Acquired Pressure Ulcers (HAPUs) continued to increase, thematic reviews had taken place to identify contributors to the			

5.3	increase and action plans were now in place to help reduce the numbers. Pressure ulcer risk screening / assessment compliance had shown a slight improvement over the last four months. Quality Account 1. The Trust's priorities for the annual Quality Account were agreed in March 2023. 2. The Quality Account measures have been refreshed in the monthly integrated performance report to the Board.			
6. 6.1	**Maternity** Maternity Update 1. Vacancies within midwifery continue to be an improving picture with a vacancy rate on 30 June 2023 of 2.35%. 2. The Maternity Improvement plan was 71% complete, Ockenden 1 report actions were 76% complete. Final Ockenden report actions were 54% complete. Work continued, however some progress remains challenging due to workforce vacancies, medical strikes and cross-border pathways, requiring Integrated Care Board (ICB) level input. 3. The committee discussed at length gaps in the women's services middle grade medical staffing rota. These gaps require consultants cover which in turn can lead to the cancellation of outpatient appointments and specialist clinics. It was noted that although there is no block on recruitment, filling these gaps has proved difficult and junior doctor gaps are not identified until late in the rota planning stage. The divisional team continue to work with medical staffing on a recruitment plan and the Committee agreed that this was a high priority.	Information/ Assurance	CRR 05f, 43b, 43c	N

6.2	CQC Inspection of Maternity Services 1. The CQC inspection of the Rosie Hospital took place on the 11 May 2023 as part of a wider national programme of maternity inspections. 2. Two domains were reviewed, 'safe' and 'well-led', with a focus on five key lines of enquiry - triage, infection prevention and control, flow, workforce, leadership and culture. 3. While the rating for the Well-Led domain remains 'Good', the rating for the safe domain and the rating for the core service overall has declined from 'Good' to 'Requires Improvement'. The areas for improvement identified by the CQC were already recognised in the Trust's Maternity Improvement Plan. 4. The Trust's overall rating of 'Good' has not been impacted. 5. One 'Must Do' and 13 'Should Do's' had been identified by the CQC. 6. A Maternity Improvement Board would be implemented to help monitor progress made against the recommendations.			
7.	**Emergency Department Quality Metrics** 1. A new set of quality metrics had been developed and are in the pilot process to drive quality improvement. 2. Data is held on a central dashboard and reviewed through a monthly divisional governance process. 3. Matrons quality round was developed, with an audit tool also developed to record what matrons see when stood amongst patients in a busy department. 4. Work to improve and maintain Sepsis compliance continued.	Information/ Assurance	BAF 001	N
8.	**HAPU Thematic Review Progression** 1. An Institute of Healthcare Improvement (IHI)-supported quality improvement programme was initiated in response to the increasing	Information/ Assurance	BAF 004	N

	number of HAPUs within the organisation. This programme of work is set to run between April 2023 and March 2025. 2. A quality improvement plan had been created supported by the Trust's Tissue Viability Quality Steering Group. 3. In addition to the improvement plan, clinical areas joining as a pilot site was launched. Each area will identify aims and be supported by fortnightly coaching from IHI facilitators, leadership from Matrons and Heads of Nursing, support from the Tissue Viability Nursing team and data support.			
9.	**Patient Safety Incident Response Framework (PSIRF) Policy and Plan** 1. The committee endorsed the PSIRF policy and plan for approval by the Board of Directors.	Information/ Assurance		N
10.	**Annual Patient Experience Report** 1. The Annual Patient Experience Report covers 2022/23. 2. Friends and Family Test (FFT) survey: the Trust maintained a strong overall 'Good' score in 2022/23, with some areas having no change, or 1% or less decrease in score compared to 2021/22. For 2022/23, the Trust collected 84,786 FFT responses, 47,232 responses less than the previous year (132,018). The decrease in responses is believed to be linked to method of collection and the reliance on clinical staff in inpatient areas to distribute and collect the responses. To improve response volumes, the use of SMS (text) survey methodology will be rolled out to include inpatient areas in 2024. 4. In 2022/23 CUH received 921 complaints, which was a 47% increase on the previous year's total of 621. 5. In the results for the National Cancer Patient Experience Survey 2021 CUH scored an overall care rating of 9.1 out of 10.	Information/ Assurance		N

11.	**Board Assurance Framework (BAF) and Corporate Risk Register (CRR)** 1. The committee received and discussed the current version of the Board Assurance Framework and Corporate Risk Register. The quality impact of emergency care waiting times and elective waiting lists remained significant risks.	Information/ Assurance	BAF 001, 002	N