Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

There will be a meeting of the Board of Directors in public on Wednesday 8 November 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** 3.1 To approve the Minutes of the Board meeting held in public on 13 September 2023 3.2 To approve the Minutes of the Annual Public Meeting held on 27 September 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***	**Non-Executive Director appointment and Board committee membership** 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
11.35	**9***	**Chief Executive's report** To receive the report of the Chief Executive	For receipt
Performance, strategy and assurance			**Purpose**
11.45	**10***	**Performance reports** *The items in this section will be discussed with reference to the Integrated Report and other specific reports* 10.1 Innovation and improvement 10.2* Finance 10.3 Workforce 10.4* Quality (including nurse staffing report and biannual nursing and midwifery staffing update) 10.5 Access standards	For receipt
12.20	**11***	**Strategy update** To receive the report of the Director of Strategy and Major Projects	For receipt
12.30	**12***	**Patient and Public Involvement Framework** To receive the report of the Director of Corporate Affairs and the Chief Nurse	For approval
12.45	**13***	**Education, learning and development** To receive the report of the Director of Workforce	For receipt
13.00	**14***	**Learning from deaths** To receive the report of the Medical Director	For receipt
13.05	**15***	**Board Assurance Framework and Corporate Risk Register** To receive the report of the Director of Corporate Affairs and the Chief Nurse	For receipt

Items for information/approval – not scheduled for discussion unless notified in advance			
13.15	**16***	**Board assurance committees – Chairs' reports** 16.1 Performance Committee: 1 November 2023 16.2 Quality Committee: 1 November 2023	For receipt
Other items			**Purpose**
	17	**Any other business**	
13.20	**18**	**Questions from members of the public**	
	19	**Date of next meeting** The next meeting of the Board of Directors will be held on Wednesday 17 January 2024 at 11.00.	For note
	20	**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	**21**	**Close**	

NHS
Cambridge University Hospitals
NHS Foundation Trust

Minutes of the meeting of the Board of Directors held in public on Wednesday 13 September 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	
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 Louise Allen	Consultant Paediatric Ophthalmologist (for item 85/23 only)
Mr J Clarke	Trust Secretary (Minutes)
Ms E Glover Bengtsson	Deloitte LLP (Observer)
Dr M Diggons	Junior Doctors Forum Chair *(for item 93/23 only)*
Ms J MacDougall	Guardian of Safe Working *(for item 93/23 only)*
Ms J Nicholson	Deputy Director of Clinical Quality *(for item 91/23 only)*
Ms C Patterson	Freedom to Speak Up Guardian *(for item 92/23 only)*

81/23 Welcome and apologies for absence

The Chair welcomed everyone to the meeting.

Apologies for absence are recorded in the attendance summary.

82/23 Declarations of interest

Standing declarations of interest of Board members were noted.

83/23 Minutes of the previous meeting

The minutes of the Board of Directors' meeting held in public on 12 July 2023 were approved as a true and accurate record.

84/23 Board action tracker and matters arising not covered by other agenda items

Received and noted: the action tracker.

85/23 Patient story

Lorraine Szeremeta, Chief Nurse, presented the patient story.

DigiVis was a self-testing platform for vision evaluation which made a significant difference to patients and their families by enabling self-administered testing of visual acuity. In cases where patients experienced a loss of vision, the ability to protect the remaining vision enabled the patient to maintain a quality of life that would potentially otherwise be lost.

`

Board members watched a video describing the experience of six-year old Rita and her family.

Dr Louise Allen, Consultant Paediatric Ophthalmologist, joined the Board meeting and explained the importance of early detection of a change in vision. It was noted that one of the key challenges in monitoring the vision of children was that they lack the same degree of awareness as adults, and typically did not raise concerns about changes in a timely way.

As a result of having a digital tool available, the service could have increased confidence that care was being monitored on a regular basis, and families experienced greater flexibility in their appointments and interactions with the service. For example, instead of travelling to the hospital every three months, the service was able to offer a combination of virtual and face-to-face appointments to suit the needs of the family.

The following points were made in discussion:

1. Recognising the local development of the platform, Board members were keen to understand the key enablers that had supported the project in getting off the ground. It was noted that, prior to the Covid-19 pandemic, seed funding had been received from the Addenbrooke's Charitable Trust (ACT) to develop a downloadable

product. Through additional Medical Research Council funding, it had been possible to develop a web-based application. Having been able to demonstrate that the product worked, and was clinically effective, uptake had increased and it was now being used by several other organisations regionally and nationally.

2. In the patient story, Rita's family had noted the challenges of spending prolonged periods of time within the hospital. These included having their nutrition and hydration needs met, where their experience had been better at another hospital within the region. It was agreed that consideration should be given as to how families were supported in such circumstances.
3. The importance of working with patients and their families to make iterative improvements to the product was highlighted. Noting the virtual nature of the tool, Board members sought to understand how safety was assured, particularly for younger children. It was explained that if a patient or clinician was not satisfied with the way that a test had been conducted, there was always the option to undertake additional tests within the hospital setting.
4. To ensure that the testing was being undertaken in a clinically-appropriate manner, the tool offered the option to undertake a video test, with the option to share the patient's screen to check accuracy. Other appointment methods also remained available and the team were able to manually book a face-to-face appointment if there were any concerns.
5. The Board thanked Dr Allen for attending the meeting. The Chair noted his thanks to Rita, and her family, for sharing her inspiring story and committed to writing to Rita to pass on this message on behalf of the Board.

Agreed:

1. To note the patient story.

86/23 Board committee membership and NED responsibilities

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

Noted:

1. As a result of the departure of Adrian Chamberlain, Non-Executive Director, on 31 August 2023, a number of amendments were proposed to the membership of Board committees and the responsibilities of Non-Executive Directors.
2. The report sought endorsement of the appointment of Sharon Peacock as the Trust's Senior Independent Director.
3. It was 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.

4. In relation to Board assurance committees, Annette Doherty would take on the role of Chair of the Performance Committee and Ian Jacobs would take on the role of Chair of the Addenbrooke's Futures Committee.
5. The Terms of Reference for the Addenbrooke's Futures Committee had been shared with the Board for approval.

The following points were made in discussion:

1. In relation to the scope of the Addenbrooke's Futures Committee, it would be helpful to distinguish between the factors within the control of CUH and those that were dependent on other partners or external factors.
2. Following the departure of Adrian Chamberlain, the Council of Governors' was undertaking an appointments process for a new Non-Executive Director.

Agreed:
1. To endorse the membership of Board committees as set out in the paper with effect from 1 September 2023.
2. To endorse the appointment of Sharon Peacock as the Trust's Senior Independent Director with effect from 1 September 2023.
3. To approve the terms of reference for the Addenbrooke's Futures Committee.

87/23 Chair's report

Mike More, Chair, presented the report.

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

88/23 Report from the Council of Governors

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

89/23 Chief Executive's report

Roland Sinker, Chief Executive, presented the report.

Noted:

1. The Trust continued to perform well relative to peers across the five areas of operational performance. This was despite the challenges nationally, which were being compounded by having to manage the prolonged period of industrial action.

2. The Care Quality Commission (CQC) had conducted an inspection in May 2023 of the Trust's Maternity Services as part of a wider national programme of maternity inspections. The Trust's rating for the Safe domain, and the core service overall, had declined from 'Good' to 'Requires Improvement'. The Well Led domain continued to be rated as 'Good'. There was recognition that 'Requires Improvement' for Maternity Services was not where the Trust should aspire to be and a robust action plan had been put in place to address the inspection findings. Additionally, the Trust would be undertaking a self-assessment of all core services against the CQC domains in the coming months.
3. Recent cases, including that of the conviction of Lucy Letby, emphasised the importance of the Board continuing to promote an open and transparent culture of speaking up and raising concerns.
4. The Trust had undertaken a review, in accordance with a request from NHS England, which concluded that there was no evidence of Reinforced Autoclaved Aerated Concrete (RAAC) planks having been utilised in the construction of any of the Trust's buildings on the Campus. As such there was judged to be a low risk of Trust buildings containing RAAC.
5. Over the next 12 months, the Trust would remain focused on the delivery of the operational strategy which would be supported by the opening of additional bed capacity.
6. As the Trust continued to develop its plans for 'Building for the Future', Board members were reminded that work on the Full Business Case for the Cambridge Cancer Research Hospital had now commenced.
7. The revised Outline Business Case for the Cambridge Children's Hospital would be presented to the national Joint Investment Committee in late September 2023, with work ongoing to close the funding gap.
8. The Trust remained committed to supporting integrated care through the Cambridgeshire South Care Partnership and was working with partners to seek to increase the pace of delivery over the coming months, including a focus on system productivity.

The following points were made in discussion:

1. For the benefit of public attendees, it was noted that detailed discussions had taken place in Board assurance committees on the key areas of workforce, operational performance, quality and finance.
2. The Trust was performing relatively well given the challenges arising from the need to manage more frequent periods of industrial action. Particular concern was expressed about the next phase of industrial action which would involve the consultant and junior doctor workforces both taking strike action at the same time. It was suggested that the seriousness of this strike action, and the impact on clinical services, was not something that many members of the public were readily aware of.
3. The periods of industrial action to date had resulted in thousands of patient appointments being postponed at CUH. In the most recent

round of industrial action, the Trust had cancelled 570 planned operations and around 2,000 day case appointments.

4. The Board discussed the impact of the prolonged period of industrial action on staff morale, with many staff finding themselves in a cycle of planning for action, implementing these plans and then debriefing in order to learn for the next period. The Trust, including through the Shelford Group, continued to strongly encourage all parties to come together to resolve the disputes for the benefit of patients.
5. While the CQC report on maternity services had highlighted several areas of excellent care and outstanding practice, it also included a Must Do action relating to medical staffing numbers in obstetrics. The service had been aware of the challenge prior to the inspection and was seeking to improve the position through external recruitment. Board members were informed that junior doctors were assigned to a region and worked on rotation in that locality for six months. Around The Trust would find out around six to eight weeks in advance who would be joining on rotation and at that stage would be able to determine whether all the gaps would be filled. It was noted that the past six months had proved especially challenging for obstetrics and, despite further attempts to recruit, the Trust had been unable to fill all of the vacancies.
6. As previously discussed, significant work had been undertaken to improve midwifery staffing levels. The national Safer Nursing Care Tool (SNCT) outlined safe staffing numbers for wards and departments. It was noted that an equivalent tool did not currently exist for medical staffing.
7. The Trust's workforce plan had been updated in line with the planned opening of additional bed capacity. Extensive work had been undertaken to deliver 4-5% growth across the workforce during what was an incredibly challenging time for the NHS locally and nationally.

Agreed:

1. To note the contents of the report.

90/23 Performance reports

The Board received the Integrated Performance Report for July 2023.

Access standards

Nicola Ayton, Chief Operating Officer, presented the update.

Noted:

1. At the end of July 2023, performance against the 4-hour emergency care standard was 70% compared with a target of 76% for the end of March 2024. The Trust remained ahead of its internal trajectory which had sought to achieve performance of 67.7% by the end of July 2023.

2. The Trust continued to perform well relative to peers on ambulance handover times. July 2023 was the third month in a row that the Trust had achieved all three national performance standards.
3. With regard to cancer waiting times, the Trust was performing well overall compared to peers and continued to achieve the 28-day faster diagnosis standard.
4. The Trust's elective performance continued to be adversely impacted by industrial action, with over 78 week waits increasing by five in month to a total of 84, compared to the national target of zero. This would not be achieved until industrial action was no longer a contributory factor.

Workforce

David Wherrett, Director of Workforce, presented the update.

Noted:

1. The NHS Long Term Workforce Plan was launched on 30 June 2023. The Trust was committed to the overall delivery aims and objectives of the plan.
2. The Trust continued to see positive trends across a number of recruitment and retention metrics. In particular, the Trust had seen an increase in staff retention and a reduction in the use temporary staffing. An increase in staff absence linked to short-term sickness was a source of concern and would be monitored closely.
3. CUH had been awarded a Pastoral Care Award by NHS England. This recognised the high standards of pastoral support available for internationally-recruited staff, who accounted for over 50% of the Trust's nursing staff over the past three years.
4. The Trust's winter staff vaccination programme for both flu and Covid-19 would commence shortly.
5. A staff pod area had recently been opened in the Deakin Centre providing a high-quality rest area for staff, with a self-service café and garden that was accessible 24 hours a day, 7 days a week. This had been well received by staff and work was ongoing to identify further spaces for such facilities.
6. A structured learning programme had been put in place to support the development of a Just and Learning Culture. With a number of high-profile cases in the news recently, the Trust was keen to continue to encourage staff to speak up and raise concerns.
7. A number of staff listening events had been held in response to the results of the 2022 NHS Annual Staff Survey. The feedback from these events was currently being reviewed.

Quality (including nurse staffing report)

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

Noted:

1. Work was ongoing to clear the backlog of open serious incident investigations in preparation for the implementation of the new Patient Safety Incident Response Framework (PSIRF).
2. In the context of the recent coverage of the appalling crimes committed by Lucy Letby, staff continued to be encouraged to speak up about any concerns through the range of channels available, including the Freedom to Speak Up Guardian. The Trust was also committed to the implementation of the PSIRF as a new way of learning from incidents.
3. Work was ongoing to improve the position in relation to hospital acquired pressure ulcers (HAPUs). Additional recruitment had been undertaken in the Falls Team and improvement methodology had been used to support making sustainable change in the area.
4. There had been an increase in the number of safeguarding referrals, particularly in relation to cases involving children with complex mental health needs. There was an emerging trend of patients being brought to the hospital as a place of safety and, in some cases, these patients remained in hospital for many days due to a lack of appropriate social care placements. Discussions were taking place with the Integrated Care Board (ICB) on the management of this cohort of patients.
5. The Hospital Standardised Mortality Ratio (HSMR) was 81.9 for the period between April 2022 and March 2023. The current annual figure placed the Trust top among its regional peers and compared favourably with other Shelford Group trusts, with performance banded as statistically 'lower than expected' for hospital mortality.

Finance

Mike Keech, Chief Finance Officer, presented the update.

Noted:

1. The current year involved a move away from a predominantly block-based contracting model to an activity-based model. There was recognition of an increased degree of complexity around the new model.
2. Some systems across the country were currently in financial turnaround.
3. The Trust's financial position was a £0.3m deficit in the year to date which was adverse to plan by £4.1m. The deficit position, and variance to plan, were predominantly driven by the impact of ongoing industrial action.
4. The Trust continued to deliver against an ambitious capital programme, with additional bed and theatre capacity scheduled to open in the coming weeks.

Improvement and transformation

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

Noted:

1. The Trust's three-year agreement with its improvement partner, the Institute for Healthcare Improvement (IHI), was coming to an end and would conclude with a final site visit in October 2023.
2. The Trust had been developing the ability to be self-sustaining and had commenced the delivery of in-house improvement programmes.
3. The impact of industrial action had contributed to a productivity and efficiency shortfall at the end of month 4. The ability to delivery against the current plans, and embed new schemes of work, had been challenging given the need to focus on the planning for and managing periods of industrial action.
4. The take up of the virtual ward programme continued to improve, with a wide range of services now included. On average, use of the virtual ward was freeing up 8.3 beds per day.
5. The Trust was entering the tenth year of its agreement with Epic for the delivery of the electronic patient record system. This presented an opportunity to reflect on next steps, including on delivering digital benefits across the wider Integrated Care System.

The following points were made in discussion of the performance updates:

1. The work undertaken on the productivity and efficiency programme during such a challenging period was acknowledged. The Performance Committee had discussed the need to focus on the key deliverables in the Operational Strategy that would support productivity and efficiency savings.
2. In relation to a question about the number of currently open serious incident investigations and whether the right resources were being allocated to achieve their closure, it was highlighted that progress was being made but was inevitably being impacted by the current industrial action.
3. Board members expressed concern about the cases of children requiring social care placements presenting to the Trust as a place of safety. The Board sought assurance regarding plans to improve the situation and ensure that more appropriate placements could be found in a timely manner. It was explained that the Trust had escalated its concerns and discussions were ongoing across the system to seek to improve the position.
4. It was requested that the elective and non-elective revenue positions were presented in the finance report in a way that demonstrated the impact of industrial action.
5. Concern was noted regarding the increase in the elective waiting list and assurance was sought as to how potential harm was being assessed and those with greatest clinical need were being prioritised. It was explained that all patients on a waiting list were graded using a P1 to P4 system, with P1 representing a requirement for urgent and life-threatening treatment, P2 representing the need for urgent treatment (including for cancer) through to P4 which would constitute minimally-invasive surgery that would typically cause a patient a

degree of day-to-day discomfort. Clinicians graded and regularly reviewed patients using the P1 to P4 system and would seek to balance this with the length of time they had been on the waiting list and the impact of their wait to date. As part of the ongoing dialogue, patients should be aware of where they were on the waiting list.

Agreed:
1. To note the Integrated Performance Report for July 2023.
2. To note the finance report for 2023/24 Month 4.
3. To note the nurse safe staffing report for July 2023.

91/23 Patient Safety Incident Response Framework

Lorraine Szeremeta, Chief Nurse, and Jane Nicholson, Deputy Director of Clinical Quality, presented the report.

Noted:
1. The Trust was required to transition to the new nationally-mandated framework by January 2024.
2. As part of the transition, there was a requirement to have a PSIRF Policy and Plan approved by the Board.
3. In addition to feedback received from the Integrated Care Board, the Policy and Plan had been reviewed and endorsed by the Management Executive and the Quality Committee.
4. The Trust was committed to embedding PSIRF, which would see investigations linked to improvements within patient care and safety.

Agreed:
1. To approve the CUH PSIRF Policy and Plan.

92/23 Freedom to Speak Up

Ian Walker, Director of Corporate Affairs, and Claire Patterson, Freedom to Speak Up Guardian (FTSUG), presented the report.

Noted:
1. The Trust's Freedom to Speak Up (FTSU) policy had been reviewed and updated in accordance with the new national template.
2. The National Guardian's Office had reported an increase in the number of concerns being raised by staff across the NHS. This was reflected in the local figures at CUH, with year-on-year growth in the number of concerns being raised via the FTSUG. In 2022/23 there had been 111 cases raised with the Freedom to Speak Up service while there had been almost 100 cases between April and September 2023.
3. Many of those who approached the FTSUG would first seek assurance that it was safe to speak up. In some cases, members of staff decided to pursue their concerns themselves after an initial

conversation with the FTSUG while in other cases they would seek the support of the FTSUG in taking forward the concerns. Only one case had been raised anonymously through the FTSUG in the year to date.

4. Speaking up was recognised as often being a brave step for staff to take and staff survey data indicated that staff with protected characteristics were less likely to feel confident to raise concerns. The FTSUG continued to work closely with the staff networks to build trust and demonstrate allyship and support for members.
5. The FTSUG continued to engage across all professions within the Trust and had recently presented to over 200 new doctors at induction.
6. There was recognition that the recent Lucy Letby case had been particularly challenging for many staff and the FTSUG had participated in a discussion of the issues raised by the case at an 08.27 staff briefing session.
7. A recent staff survey indicated that there were still staff who were unaware of the Freedom to Speak Up service and work continued to raise the profile of the service through a range of channels.

The following points were made in discussion:

1. While the work to raise the profile of the service was welcomed, it was questioned whether there was the potential for the service to be used in place of other Trust processes, for example to address human resources and grievance concerns. In response, the FTSUG explained that the role of the Guardian was clearly outlined by the National Guardian's Office and it was essential that all concerns raised by staff were positively received. The Trust has not experienced any instances of the Freedom to Speak Up process being used inappropriately. Sometimes the role of the FTSUG would be to help signpost and direct staff to existing Trust processes which could support them to raise and take forward their concerns.
2. The increase in the number of concerns being raised was welcomed as a measure of a positive culture where staff felt safe and empowered to speak up.
3. While the FTSUG was an important route for staff to be able to raise concerns, it was one of many channels available across the Trust for raising concerns. It was recognised that many staff would raise concerns with their line managers or supervisors in the first instance, and it was imperative that when they did so they were heard and felt listened to. This emphasised the importance of effective induction and training for managers in supporting staff to raise concerns.

Agreed:

1. To note the report from the Trust's Freedom to Speak Up Guardian.
2. To approve the revised CUH Freedom to Speak Up and Raising Concerns (Whistleblowing) policy.

93/23 Guardian of Safe Working

Jane MacDougall, Guardian of Safe Working, and Milly Ramus, Co-Chair of the Junior Doctors' Forum, presented the report.

Noted:

1. There had been a year-on-year increase in the number of exception reports since the start of the pandemic, with reports received from a broad range of specialities and very few linked to immediate patient safety or missed educational opportunities. There were concerns about under-reporting and work was continuing to better understand the current position.
2. Progress had been made in addressing issues previously identified with specific rotas for weekend working, with significant investment made to support additional posts. However, challenges remained in the Neonatal Intensive Care Unit and work continued to resolve the gaps.
3. The Junior Doctors' Forum continued to meet in person, with members of the Management Executive joining the second half of the meeting to enable effective two-way dialogue.
4. The impact of industrial action remained a concern and the Guardian of Safe Working noted their thanks to the Medical Staffing service for its efforts over the past few months.

The following points were made in discussion:

1. Board members acknowledged the work of the Medical Staffing team in supporting the Trust's response to industrial action, noting that there had been a significant increase in demands on the service.
2. The Junior Doctors' Forum had raised concerns about the timeliness of payments to staff undertaking locum shifts. It was noted that the need to manage industrial action had severely impacted the ability of the Medical Staffing team to undertake other tasks. Given that there was currently no indication of a resolution to the industrial action, efforts were being made to increase capacity within the team.

Agreed:

1. To receive the report from the Guardians of Safe Working.

94/23 Learning from Deaths

Ashley Shaw, Medical Director, presented the report.

Noted:

1. In line with the earlier discussion, mortality data across CUH was positive relative to peers and there had been no specific concerns raised through either Doctor Foster or the Structured Judgement Review process.

Agreed:
1. To note the learning from deaths report for 2023/24 Q1.

95/23 Research and development

Ashley Shaw, Medical Director, presented the report.

1. The Cambridge Biomedical Research Centre (BRC) annual report highlighted a number of key research achievements including in relation to early cancer detection, clinical outcomes in pregnancy and the development of a genetic obesity syndrome drug.
2. CUH hosted the National Institute for Health and Care Research (NIHR) BioResource which had recently launched the Children's and Young People's BioResource which aimed to improve access to research data.
3. Through the Improving Black Health Outcomes study, the BioResource was seeking to strengthen the understanding of those conditions more common in Black communities.

The following points were made in discussion:

1. Research was being undertaken regarding obesity and eating disorders to understand whether patients ate more in a controlled environment. It was envisaged that this could lead to an increase in therapeutic interventions that did not require surgery and other forms of treatment.

Agreed:
1. To note the research and development report.

96/23 Board Assurance Framework and Corporate Risk Register

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

Noted:
1. Board members were reminded that Board assurance committees reviewed at each of their meetings the risks on the Corporate Risk Register (CRR) and the Board Assurance Framework (BAF) for which they had oversight.
2. A number of the key agenda items and discussion points at this Board meeting were reflected across risks on the BAF and the CRR.
3. The work to develop medium-term risk trajectories for risks on the BAF had continued and these provided the Board with an opportunity to track how delivery of key milestones were impacting on the level of strategic risk. For example, it was envisaged that, other things being equal, the planned increase in bed capacity over the coming months

should support a reduction in the risk rating for BAF risk 001 on capacity and patient flow.

Agreed:

1. To receive and approve the current versions of the Board Assurance Framework and the Corporate Risk Register.

97/23 Amendment to the Trust Constitution

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

Noted:

1. In light of the recent departure of a staff governor, a proposal had been developed to enable a vacancy for an elected governor to be filled in certain circumstances through co-option until the next scheduled election.
2. An amendment to the Trust Constitution was required to enable the revised process to be implemented.

Agreed:

1. To approve the amendment to the Trust Constitution as set out in the paper.
2. To note that approval for the amendment to the Constitution would also be sought from the Council of Governors.

98/23 Medical and Nursing re-validation

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

Agreed:

1. To approve the annual report on medical revalidation and the statement of compliance.
2. To approve the annual report on nursing and midwifery revalidation.

99/23 Board assurance committees – Chairs' reports

Received: the following Chair's reports:

- Addenbrooke's 3 Committee: 27 July 2023
- Performance Committee: 6 September 2023
- Quality Committee: 6 September 2023

100/23 Any other business

There was no other business.

101/23 Questions from members of the public

1. *There has been a lot of coverage of Ryan's Rule and, potentially, Martha's Rule – in the press recently.*

   August and Bank Holidays can be vulnerable periods for patients in hospital. Senior doctors are often on holiday and new young doctors may be reluctant to challenge or call on more experienced colleagues.

   Family members can be more consistent observers of a patient's condition – or deterioration, than medical staff who are regularly changing owing to rota patterns.

   Does CUH have a rapid, well-advertised route for relatives to order a second opinion?

   The Medical Director responded:

   Ryan's rule is a state-wide response to a fatal case of missed sepsis in a boy Called Ryan Saunders in 2007 in Queensland, Australia. This empowers a parent or carer to ask the lead nurse on a shift to obtain a second opinion. If still not satisfied, they can call a phoneline to obtain the same. This is a state government initiative.

   Martha Mills is a recent tragic case at King's College Hospital, London, with similar themes of missed sepsis with fatal consequences. There are currently calls for a 'Martha's rule' in the UK.

   At CUH, we made a significant investment in a multidisciplinary 24/7 Rapid Response Team (RRT) in the early 2010s which provides cover for adult patients across the hospital. Escalation to this team can be made from any medical or nursing colleagues at any time.

   Recently, the RRT Call 4 Concern have been looking at how this service could be improved further, including to introduce an additional step where a Consultant or Senior trainee from the parent team must review the patient and speak to the family (face to face or phone call) within the next 24hrs to address any ongoing concerns. This is currently scheduled for discussion at the Trust's NMAC meeting.

   In the paediatric environment, with a smaller bed base, the nurses escalate concerns through their ward sister and matron, who could ask the on-call team to review any patient. Clinical teams also work closely as teams to get second opinions regularly.

2. *It is shocking that vulnerable children who are not clinically unwell are being brought to ED as the only 'place of safety' resource remaining to the 'community'. How are they dealt with in ED and generally for how long? May we also have an update on what arrangements your discussions with the ICB have led to?*

   The Chief Nurse and Chief Operating Officer responded:

   As highlighted in the board reports, there has been an emerging theme identified of children being brought to the Emergency Department as a place of safety due to a lack of available social care placements.

   How they are managed is dependent on individual cases and time spent in the ED can vary. At the time of writing the report three children had being admitted to inpatient ward areas (over a two month period) whilst a suitable placement was identified by the local authority.

   The length of time that the children stay in the hospital varies from a few hours while a suitable relative or foster carer is found to a number of days. This data is monitored through the joint safeguarding committee.

   As noted in the question, a system-wide meeting has been convened by the Cambridgeshire and Peterborough Integrated Care Board (ICB) medical director (at the request of CUH) to agree a system wide response to identification of pathways for these children. This group has only met once and therefore we are unable to report progress at this stage, but it should be noted this is an extremely complex situation to manage.

3. *Are you able to expand on the two recent most worrying serious incidents? For 169350 can you at least complete the description and, for 145227 which resulted in death, has the 'pending' review now taken place? Both sounded possibly avoidable.*

   The Chief Nurse responded:

   SLR169350 – Basal Cell Carcinoma Delay
   This case refers to a patient who underwent a Basal Cell Carcinoma excision in 2021. Ongoing reviews following surgery did not note reoccurrence, until 2022 when a biopsy recognised extensive reoccurrence. An investigation was commissioned to identify whether there were opportunities to recognise it earlier and why these were potentially missed. This is ongoing.

   SLR145227 – Choking episode
   The patient aspirated food when eating on the ward. Initially there were thought to be no gaps in care but it has since been highlighted that the patient may have had modified food recommendations from Speech and Language Therapy. An investigation was commissioned to explore

whether the patient's aspiration could have been prevented and why it was potentially not. The investigation is ongoing.

Both incidents followed normal governance processes, serious incidents were declared and investigations are under way.

4. *What amount of patients after a fractured limb are being asked to remove their own cast with no immediate follow up x-ray as there could still be damage which needs treatment and has this procedure been risk assessed ?*

   The Medical Director responded:

   Those patients with non-displaced fractures treated in a soft cast are often given instructions on how to take casts off themselves. They are directed to online material on how to take off the soft cast. This practice follows national guidance and we are not aware of any serious incidents at CUH arising as a consequence. We do not formally collect numbers of patients in whom this is done but it is typically fewer than five per clinic. We would be happy to review any individual case as needed.

5. *What percentage of patients are not informed by letter after discharge from a clinic as to what is there diagnosis?*

   The Medical Director responded:

   Most clinic template letters record the diagnosis at the top of the letter, if a diagnosis has been made. We do not formally monitor whether this has been included in the letter. Patients and GPs are usually written to by the clinician following discharge from clinic. We do not formally monitor whether this has been done. We would be happy to review any individual case as needed.

6. *Please can the Board of Directors advise as to the procedure to be followed, and timescale, regarding correcting provable factual errors in Complaints Final Decision Letters/Complaints Letters held on file (for a decade)?*

   The Chief Nurse responded:

   We work hard to ensure that all complaints responses are comprehensive and accurate. In the event that a response letter contains information which the recipient believes to be inaccurate, we would of course encourage the recipient to raise this with us so we can review the relevant content and correct it if necessary. If an error is identified within a patient's medical records, this can be addressed by the Information Governance Team.

102/23 Date of next meeting

The next meeting of the Board of Directors in public would be held on Wednesday 8 November 2023 at 11.00.

103/23 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: 13.40

Cambridge University Hospitals NHS Foundation Trust

Annual Public Meeting

Held on Wednesday 27 September 2023 at 17.00 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	
Dr A Doherty	Non-Executive Director		X
Mr M Keech	Chief Finance Officer	X	
Ms C Stoneham	Director of Strategy and Major Projects		X
Ms A Layne-Smith	Non-Executive Director		X
Prof P Maxwell	Non-Executive Director		X
Prof S Peacock	Non-Executive Director	X	
Prof I Jacobs	Non-Executive Director	X	
Dr A Shaw	Medical Director	X	
Mr R Sinker	Chief Executive	X	
Mr R Sivanandan	Non-Executive Director	X	
Ms L Szeremeta	Chief Nurse	X	
Mr I Walker *	Director of Corporate Affairs	X	
Mr D Wherrett	Director of Workforce	X	

** Non-voting member*

In attendance	Position
Ms C Charlton	Director of Capital, Estates and Facilities Management
Mr J Clarke	Trust Secretary (Minutes)
Dr N Stutchbury	Lead Governor

Members of the Council of Governors, staff and the public also attended virtually.

1. Welcome and introduction

Dr Mike More, Trust Chair, welcomed everyone to the meeting and thanked patients, staff and partners for their support during what had been another challenging year.

The Chair encouraged attendees to submit questions during the meeting and explained that they would be responded to by Board members during the question and answer section of the meeting. If there was not time to cover all of the questions during the meeting, the remaining ones would be answered outside the meeting and the responses would be included in the Minutes.

The Annual Report and Accounts for 2022/23 were received. These had been approved by the Board of Directors in June 2023 and laid in Parliament. The Annual Report and Accounts were available on the Trust website.

2. Lead Governor's report

Dr Neil Stutchbury, Lead Governor, presented his report on the activities of the Council of Governors over the past year, highlighting the following points:

- The continued focus of Governors on key areas of concern including access to services, staff experience and staff wellbeing.
- The Governor elections which had taken place earlier in year and had seen three existing governors being re-elected and four new governors being elected.
- Noting the pressure on the hospital as a result of the prolonged period of industrial action, the importance of learning the lessons from the planning and preparation for strike action.
- The decline across a number of key questions in the annual staff survey. There was recognition that further work was required to support staff wellbeing and experience.

The Lead Governor concluded by acknowledging the significant pressures faced by the Trust, praising the staff and leadership of the organisation, and encouraging members of the public to get involved in the work of the hospitals.

3. Chief Executive's report

Roland Sinker, Chief Executive, presented key developments over the past year and priorities for the period ahead. He expressed his thanks to patients, local communities, staff and partners.

The presentation began with the story of a patient who had taken part in a clinical trial which highlighted the importance of collaboration between partners on the Campus as part of the Cambridge life sciences ecosystem.

In reviewing the past year, a number of examples were given spanning the three themes of the Trust's strategy: improving patient care, supporting our staff and building for the future.

The success of the LocANTS service was highlighted. Using a cloud-based platform, consultants at the Trust were able to monitor babies remotely across the eastern region and facilitate rapid ambulance transfer to a more specialised neonatal critical care unit in the event of a baby's condition deteriorating.

The Trust had undertaken a number of staff listening events in response to the results of the 2022 NHS annual staff survey. The events had sought to hear from staff on areas of positive progress in relation to the domains of the NHS People Promise and areas where further improvements were required. The Trust continued to invest in the Good Work agenda, as a key component of the Trust's workforce commitments.

The ability to provide timely access to both elective and non-elective care remained a key challenge and industrial action continued to impact on the Trust's ability to reduce waiting lists. The opening of the Cambridge Movement Surgical Hub later in the autumn, which would provide three new operating theatres and 40 dedicated surgical beds for elective orthopaedic patients, would be a key milestone for the Trust.

While the recent Care Quality Commission (CQC) inspection of the Trust's Maternity Services highlighted a number of areas of strength and good practice, it also emphasised key areas for improvement which were already included in the Trust's maternity improvement plan. There was a particular focus on reviewing the medical staffing model.

Significant progress had been made in relation to new hospitals development. The Outline Business Case (OBC) for the Cambridge Cancer Research Hospital had received national approval and the OBC for the Cambridge Children's Hospital would shortly be considered by NHS England and the Department of Health and Social Care.

4. Questions

A number of questions from members of the public, both pre-submitted and raised during the meeting, were responded to by Board members:

Do any of the older parts of the hospital contain RAAC (Reinforced Autoclaved Aerated Concrete)? If so, what is the plan to deal with it?

The Chair invited the Director of Capital, Estates and Facilities Management to respond.

A review had been undertaken by a specialist structural engineer through a series of desktop and physical site inspections, in accordance with a request by NHS England. This had concluded that there was no evidence of RAAC planks having been used in the construction of any of the Trust's buildings across the Campus and as such there was a low risk of Trust buildings containing RAAC. Discussions were taking place with the landlords/providers of the other premises from which the Trust operated to confirm the position in regard to these buildings.

What does CUH consider the likely impact to be of the rebuilding of neighbouring RAAC hospitals (e.g. Hinchingbrooke, West Suffolk and Queen Elizabeth, King's Lynn)

The Chair invited the Chief Executive to respond.

It was noted that the eastern region had a high proportion of trusts where hospitals had been found to contain RAAC. Plans were in place to mitigate the risks and to progress redevelopment on these sites and CUH would be involved in discussions as required to support this work.

Does the hospital/Campus have a strategy which aims to reduce the carbon footprint, use of water etc. especially in the new builds?

The Chair invited the Director of Capital, Estates and Facilities Management to respond.

It was reported that CUH had a comprehensive environmental sustainability strategy in the form of its Action 50 Green Plan (Phase 1: 2022-24).

In the medium to longer-term, this involved transition away from the current gas-fired boiler-house and steam distribution to a new modular heat-pump driven Campus energy centre.

Is there a requirement that all teams have Sepsis training?

The Chair invited the Chief Nurse and Medical Director to respond.

It was explained that all nursing staff caring for adult patients were required to undertake an e-learning training module annually as part of their essential for role training. All midwifery staff had Sepsis training included within their annual training programme. The Trust was currently working on a Sepsis training programme for paediatric nursing staff.

Non-consultant medical staff undertook regular training and assessment covering all areas of their practice. Consultant medical staff undertook continuing professional development which was expected to cover all areas of their practice and was discussed at their annual appraisal. Medical staff could also access Sepsis on-line training although this was not mandated.

At Addenbrooke's there is a culture of "We know best". It is well known that suggestions to avoid the phenomenal waste of money and to implement more efficient procedures, etc. are simply ignored. Why is this and what can be done to improve?

The Chair invited the Chief Executive to respond.

CUH was pursuing a significant number of improvement and innovation programmes including Virtual Wards and outpatient transformation, and actively welcomed feedback and sought to learn from other organisations.

Despite the focus and desire to consistently improve and innovate, there was recognition that resources were finite and the Trust also sometimes had to say 'no' to some things.

The refresh of the terms of reference for the Addenbrooke's Futures Committee focused on an approach to continuous improvement.

We all know that our A&E Department is tired, too small and understaffed and that matters must get worse with the planned major expansion of housing in our catchment area. What is the situation with creating an expanded better staffed department and does the CQC report confirming this situation help us secure the required funding?

The Chair invited the Chief Executive to respond.

The A&E department was originally built to manage around 35,000 A&E attendances per annum compared to the current level of around 135,000 attendances per annum. Within the context of limited government capital to support new buildings, the Trust had developed a phased plan for A&E capacity expansion. Alongside this, the Trust's urgent and emergency care improvement programme, informed by regulatory findings, was focused on both the scope to increase resources and to use existing resources more effectively.

Are patients and carers entitled to ask for a second opinion from someone outside the team currently treating them (see the case of Martha Mills recently featured in the news)?

The Chair invited the Medical Director to respond.

It was noted that Ryan's Rule related to a state-wide response to a fatal case of missed Sepsis in a boy Called Ryan Saunders in 2007 in Queensland, Australia. This empowered a parent or carer to ask the lead nurse on a shift to obtain a second opinion. If still not satisfied, the parent

or carer was able to call a telephone line to ask for a second opinion. This was a state government initiative.

Martha Mills was a recent tragic case at King's College Hospital, London, with a similar theme of missed Sepsis with fatal consequences. There were currently calls for a 'Martha's rule' in the UK.

CUH had made a significant investment in a multidisciplinary 24/7 Rapid Response Team (RRT) in the early 2010s which provided cover for adult patients across the hospital. Escalation to this team could be made from any medical or nursing colleagues at any time.

Recently, the RRT had been looking at how this service could be improved further, including to introduce an additional step where a consultant or senior trainee from the parent team must review the patient and speak to the family (face-to-face or by phone call) within the following 24 hours to address any ongoing concerns.

In the paediatric environment, with a smaller bed base, nurses escalated concerns through their ward manager and matron, who could ask the on-call team to review any patient. Clinical teams also worked closely as teams and sought second opinions on a regular basis.

What assessment has the Trust made on the likely impact on staffing levels with the construction of both the Cancer Hospital and the Children's Hospital in Cambridge, and what conversations have the Trust had with local government, the Combined Authority, and with national government about:

- **housing solutions for key workers,**
- **transport solutions – in particular integrated transport that co-ordinates with changing shift times; and**
- **lifelong learning – in particular enabling adults looking to change career to move into healthcare and support professions? (Thinking in particular of new lifelong learning colleges in every town, as recommended by the House of Commons Education Select Committee in 2020)**

The Chair noted that CUH had commissioned detailed research in early 2020 to explore the housing needs of staff. This research highlighted the very well-known affordability challenges faced by the NHS workforce in the Greater Cambridge area.

The Cambridgeshire and Peterborough Integrated Care System (ICS) had recently commissioned updated research on the housing needs across the NHS in Cambridgeshire and Peterborough, including a new staff survey. The findings of this were due to be published in autumn 2023 and would be used to inform further discussions with partners, including in relation to the provision of key worker housing.

The construction of the new Cambridge South Railway Station was underway, with completion expected in 2025.

What plans is CUH making for expansion/alternative sites in the light of the proposed high level of population growth in Cambridgeshire (e.g. the Gove plan being spearheaded by Peter Freeman and the draft Local Plan)?

The Chair noted that capacity challenges could in part be linked to the growth in the local population. However, there was not a direct correlation between population growth and increases in funding. The Trust would continue to seek to contribute to and influence national discussions.

In my opinion Cambridge Hospitals established an outstanding Foundation Trust with a very able governing body made up of representatives of all interested parties with a huge combined experience profile. Surely a major source of knowledge and experience at a time when the NHS is in so much difficulty yet the Government, particularly those few members of the Cabinet who run the NHS, never publicly refer to nor as far as I know consult the Foundation Trust's side of the NHS management structure. Isn't this a huge waste of knowledge and experience?

The Chair noted that the Trust greatly valued the input of Governors, foundation trust members and the wider public. Opportunities were taken by the Trust where appropriate to help inform national NHS debate, planning and policy making.

CUH has plans to build two new hospitals. Please update members on the likely timetable for these, given recent developments (summarised below):

- **Cambridge Cancer Research Hospital: the NAO report in the summer shows a forecast hospital operational date of July 2027. The hospital has Outline Business Case approval, but full funding will not be released until it has Full Business Case approval. It does not yet have planning permission and the planning authority has asked for information about the hospital's impact on water supply – https://www.bbc.co.uk/news/uk-england-cambridgeshire-66650577. Further, it is unclear whether this hospital has a philanthropic funding target and whether it has met that target.**

The Chair invited the Chief Executive to respond.

It was noted that the Cambridge Cancer Research Hospital (CCRH) was in 'Cohort 2' of the Government's New Hospitals Programme and was one of 48 new hospitals the government had committed to build by 2030.

Significant progress continued to be made on the project, with the Outline Business Case having been approved by NHS England, the Department of Health and Social Care and HM Treasury in August 2023. It remained on track to be the first new hospital delivered in the east of England as part of the New Hospitals Programme.

Additional fundraising and philanthropy would be required to realise the vision, and both Addenbrooke's Charitable Trust (ACT) and Cambridge University Development and Alumni Relations (CUDAR) were actively working to secure additional significant donations.

Construction of the CCRH was due to begin in 2024, with completion expected in 2027. To support this, a full planning application had been submitted in January 2023. Consideration of the sustainability and environmental impact of new developments was important for future health and wellbeing and the Trust was working closely with the local authority and its partners to seek solutions that balanced the unique water safety requirements of a hospital development and wider future water resource implications.

- **Cambridge Children's Hospital: this hospital has been very long in the making. It has planning permission, but does not have Outline Business Case approval and has a stretching philanthropic funding target – https://www.bbc.co.uk/news/uk-england-cambridgeshire-65622233. It is also not part of the New Hospitals Programme and seems unlikely to be a DHSC priority, with many hospitals needing urgent rebuilding due to RAAC issues. Oral evidence to the Public Accounts Committee on 7 September makes clear that the precise extent (and therefore likely cost) of RAAC in hospitals is still being determined.**

The Chair invited the Chief Executive to respond.

The Trust was making good progress on its plans to build a new Children's Hospital for the east of England, the only region in the country currently without a specialist children's hospital. Planning permission for the hospital had been approved in March 2022. The Cambridge Children's Hospital (CCH) had never been funded through the national New Hospitals Programme (NHP) and there were no current plans for it to join the NHP. The £100m of government funding for CCH was committed in 2018 as part of funding via Sustainability and Transformation Partnerships and the Trust and its partners were

on track to achieve the target of securing £100m of philanthropic funding.

Funding a project of this scale was challenging. The first business case stage, the Strategic Outline Case, which was approved in 2020, gave an indicative cost for the project. It also outlined additional costs that would have to be modelled in the later stages of the business case process as the full scope of the project was developed. Projected costs had therefore risen as expected, particularly as external factors had impacted, including high rates of inflation and high construction costs. The Trust was working closely with NHS England on the costs and funding streams, alongside maximising the benefits for patients and parents in Cambridgeshire and across the east of England. The Outline Business Case for the CCH was scheduled for national review later in the month.

What progress is CUH making with its £100 million maintenance backlog?

The Chair invited the Director of Capital, Estates and Facilities Management to respond.

The Trust had committed capital funding of around £17 million for core and essential infrastructure, fire safety and high voltage infrastructure in 2023/24. This investment was focused on the highest risk areas. However, with an ageing estate, the overall maintenance backlog continued to increase.

Is the current scaffolding that can be seen around the site routine, or related to any forms of concrete problems?

It was noted that much of the current scaffolding related to repairs following recent adverse weather. As noted earlier in the meeting, there was no evidence of RAAC planks having been used in the construction of any of the Trust's buildings across the Campus.

Can we improve communication between various organisations which are involved in patient care – like ambulance services, care homes, GPs, etc? For example, an ambulance came to pick a patient up from the care home and nobody expected it or had any information on the booking of the ambulance. The patient was rushed to pack their belongings only to be told in the end that he will not be leaving care home.

While it was not possible to comment on an individual case, it was agreed that it was vital to continue to work on strengthening

coordination and collaboration between health and care partners.

Under the 'Patient Safety' heading, it is well known that sleep and rest are necessary for a speedy recovery. I had the experience of being on a ward with disruptive and violent dementia patients, and on my first night could not sleep at all. I guess the lack of space doesn't help this situation, but was frightened for my safety and that of the nurses who had to deal with them.

The Trust remained committed to providing appropriate environments for all patients, with a focus on seeking to reduce the number of patients with dementia being admitted to hospital where possible. A new dementia nurse had been recruited and the Trust continued to seek to ensure that patients with dementia who required admission were placed on the most appropriate ward for them. This included consideration as to whether there were appropriate alternatives, noting that ward environments could be bewildering and frightening for some patients with complex needs.

Is it possible that consideration of patients could be included in staff training with regard to quiet voices when people are trying to sleep at night, and also in the daytime if trying to sleep after an operation or on sleep-inducing medications? Please could staff remember that they have had a few hours sleep before their shift, but the patients have not?

There was recognition of the challenges caused by noise disturbances, particularly at night. The Trust had put in place a number of steps to address this, including the distribution of sleep well packs and ear plugs and encouraging use of soft shoes. Additionally, work was ongoing to address process challenges, including minimising the overnight admission of patients to wards.

Should the need arise, and the facilities were available, do you envisage 'nesting' patients at Royal Papworth Hospital again this winter?

It was noted that the Trust continued to develop the winter plan and was grateful to Royal Papworth Hospital for use of the 20 beds during the early part of 2023.

The Chair thanked everyone for attending the meeting and for their continued support for the hospitals.

Meeting closed: 18.32

The following questions were submitted but not responded to at the meeting due to time constraints. Written responses are therefore provided below.

Volunteering at the hospital - are there any opportunities for volunteering outside standard working hours?

The core volunteering opportunities at CUH currently run from 08.00 to 18.30, Monday to Friday. Subject to supervision and support, we can establish volunteering work outside of these hours so it is worth contacting our volunteering team to discuss options. We are currently reviewing our service with a view to expanding our offer; we know that volunteers provide an incredible amount of support to patients, visitors and staff and so there is more we are looking to do in the future.

Could we improve the complaint process? It is very frustrating for patients and their loved ones having to file complaints separately to hospital, care homes, ambulance – having to repeat the same often painful information about what's happened to them over and over and over again. Could we have centralised complaints system where involved bodies could review cases and respond to them? Can we approach Integrated Care Systems (ICSs)?

A centralised complaints system would not meet the needs for the majority of our complaints as often they are service/Trust related. If external agencies are involved, such as the ambulance service, we do offer to liaise and obtain a response and we would request written consent from the complainant for confidentiality reasons.

As part of the new complaints triage process, the complexity of complaints are explored to ensure we meet the expectations of our complainants. We have found that many complainants wish to go directly themselves to other services as often the complaints are unrelated and asking for responses from other services can delay our responses, especially as the care sector is not obliged to adhere to the NHS framework and agreed timeframes.

If a complex complaint has been submitted involving several agencies within the system, these are escalated to the ICS and a discussion is held to agree which partner is the most appropriate to lead the investigation and collate the feedback required. This would be relayed back to the complainant and a timeframe agreed.

Does the Trust have a strategy/plan in place when it comes to accommodation in Cambridge? We have had several new international recruits in my team who have and continue to struggle to find affordable and suitable accommodation in Cambridge.

The Trust provides over 900 units of accommodation (a mix of on-site and off-site) for staff commencing work at the hospital. Some staff live in this accommodation for extended periods. We have set aside a significant proportion of accommodation to support our international recruits in their initial six months of employment. During this time, our accommodation officer, who is based within recruitment, works with staff and local landlords and agents to try to find accommodation for these members of staff to move into. Affordability of housing is a major challenge in Cambridge and, while we continue to work with developers and local authority Housing Officers, this is likely to remain a key challenge for some time.

When will the traffic regulation order be activated to prevent 'rat running' and ease jams in the grounds?

The Trust continue to liaise with the operators to ensure that the system is working. Enforcement, however is the responsibility of the local police.

I was at King's Hospital and there was no food but junk food. I was there from 3pm to 3am and I was on my own. Could this be a problem if a person is diabetic?

We cannot comment on other hospitals. In terms of the provision of food at CUH, we operate a range of outlets, including a supermarket that generally is open during the week until 22.00 and at weekends until 20.00. We have a hot food offer through our Wellspring café during the day, although we recognise that options in the evenings would be via the supermarket or the Costa outlet which sells a range of foods, including sandwiches, toasted sandwiches and salads. Diabetics would usually be advised to ensure they always carry a snack and we would therefore advise someone with diabetes to bring a snack with them when they come to the hospital in case there is a delay in buying food from the available shops – sometimes, due to unforeseen circumstances, food outlets may need to close unexpectedly.

Given that recruitment is a big issue currently, what is going to change to ensure that the new hospital developments can be staffed?

The Trust maintains a detailed workforce plan which includes all new developments and changes in services, projected forward over several years. The Trust has invested to establish and deliver a detailed pipeline of staff to meet these plans – and has grown its staffing levels by over 4% in the past 12 months and 7% over the last 24 months. Like all health and care

providers, we experience a challenging labour market, and have some pockets of concern, but overall we are making good progress. The staffing position is set out in various Board papers including the Integrated Performance Report.

NHS
Cambridge University Hospitals
NHS Foundation Trust

Board of Directors (Part 1): Action Tracker

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

Key to RAG rating:

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

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 8 November 2023

Agenda item	6
Title	NED appointment and Board committee membership
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	n/a

Executive Summary

NED appointment

Following a competitive process, the Council of Governors has agreed the appointment of Dr James Morrow as a Non-Executive Director (NED) of CUH for an initial term of three years commencing on 1 November 2023. A copy of the press release announcing the appointment can be found at: CUH appoints a new Non-Executive Director | CUH. The vacancy was created following the departure of Adrian Chamberlain as a NED at the end of his term of office on 31 August 2023.

Board committee membership

This paper seeks the Board's approval of the proposed membership of Board committees following the appointment of James Morrow. It is proposed by the Trust Chair that James Morrow will be a member of the Quality Committee (filling the position previously held by Adrian Chamberlain) and the Addenbrooke's Futures Committee (filling the position previously held by Annette Doherty).

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

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:

- Note the appointment of Dr James Morrow as a Non-Executive Director for a three-year term commencing on 1 November 2023.
- Endorse the membership of Board committees with effect from 1 November 2023 as set out at Appendix 1.

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 November 2023 is as follows:

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

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 8 November 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

8 November 2023

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

1. Introduction

1.1 I have registered before that we stand in a very challenging environment and that we should not underestimate that. We are still dealing with the consequences of Covid across a range of aspects. Part of our strength is that we are not allowing the immediate issues of today to crowd out the shaping of the future. But we should not underestimate how challenging today's issues are. The challenging environment is also not unique to us.

1.2 The Care Quality Commission (CQC) has just published its national Annual State of Care Report for 2022/23. Some key points from that report are:

- A record number of people waiting for planned care and treatment, with a reported excess of 7 million people in such a position in June of this year, but acknowledgment that this probably understates the comparative position, given that there are higher referral barriers from GPs.
- Some reported increase in use of Urgent and Emergency Care through difficulties or perceived difficulties at community and primary level.
- Challenges and resourcing of social care services (made worse prospectively by the more recently announced concern that up to 60% of county upper tier authorities expect serious financial viability challenges within the next two years).
- Widespread concern about the resilience of staff and teams in such a context, which then compounds the risk to patient quality.
- Continuing concern that many of those who suffer the most are from ethnic minority communities or from socio-economic groups whose voice is most marginalised.

1.3 So, as I have said, a very challenging environment. But the CQC also report lots of innovation and continued commitment. As a Board, our responsibility is to recognise, acknowledge and seek recovery of the former whilst supporting and stimulating the latter.

Annual objectives

1.4 I presented to the Board of Directors in July 2023 a statement of Board objectives which I had presented to the Council of Governors (attached at Appendix 1).

Detailed below is a brief current assessment of where we are on these:

The Teams Who Work Together

As seen in the Integrated Performance Report, staff turnover, recruitment and retention activity all show positive trends. But we will need to understand that the underlying picture remains difficult and the National Workforce Plan is very long term. The Performance Committee has considered the option to reflect the positive trend in a lower risk assessment, while at the same time recognising that the picture is patchy across the Trust such as continuing constraints in critical care.

The Teams and Patients who are Diverse

The diagnostic report is still awaited. It is good to see a revised Patient and Public Involvement Framework, recently considered by Quality Committee and being received by the Board at this meeting, with some explicit focus on different patient groups. It is important that we reaffirm our continued commitment to promote and resource work on equality, diversity and inclusion (EDI) in the light of recent events. Patient safety fundamentally depends on mutual respect and understanding both of the differences in patients and in the teams who provide patient care. As a Trust, purposeful and resourced support for EDI is part and parcel of strong patient care.

Our Operational Performance, Patient Safety and Finance

The Integrated Performance Report incorporates benchmark data which shows how we are doing relative to peers. Our performance in emergency pathways, such as against the 4-hour waiting time standard, showed positive signals earlier in the year. In some cases, such as ambulance handovers, this has been maintained but there has been worrying deterioration which the clinical leaders, Executive and Board are giving attention to. Maternity services also remain an area of focus and support. Progress is made on many areas of elective throughput, to which release of theatres will further help.

Cancer waiting times stand well relative to national and regional benchmarks but we are all aware they need to continue to improve and there are specific sub-specialties which are challenged. Our financial outturn forecasts are in line with plan but with continuing medium-term issues to deliver recurring productivity savings. I do not think we have yet quite settled the metrics

relating to bed occupancy and reducing outpatient activity in such a way that they coherently guide our medium-term planning.

Innovating, Transforming and Improving

We had a positive discussion at the September 2023 Board meeting on the steps being taken. This builds onto the next stage in our improvement journey and methodology, linking digital capability more effectively into the transformational space, widening the techniques such as process re-engineering which are deployed within the Trust, and developing an environment which supports innovation (invention, adoption and roll-out). Between the time of writing and the Board meeting, we will have had a Board-to-Board session with our colleagues at Royal Papworth Hospital to capitalise on the benefits, yet unrealised at scale, of being close neighbours.

Integrating at Place

The last two years have been a period of frustration. The Chief Executive and I met with the Chair and Chief Executive of the Cambridgeshire and Peterborough Integrated Care Board (ICB), alongside other trust peers, earlier in the autumn to see whether we had a way forward and we are considering the options at the Addenbrooke's Future Committee later this month. For me we should be continuing to push hard on the benefits of vertical integration; we should, as highlighted in my earlier Objectives report, be more active ourselves within the hospital on the sub-specialty possibilities for reconfiguration of services; and we should trail vertical integration to move important initiatives.

Making Children's and Cancer Hospitals Inevitable and Irreversible

In a climate of immense pressure on public sector infrastructure investment capacity, I think we should pay huge credit to the hospital teams and partners who have taken us now, this quarter, to a position where both the Children and Cancer Hospital projects have had Outline Business Case approval. With cancer, this means we have appointed a construction partner and are in the process of establishing mechanisms for building the hospital, with an anticipation of commencing works in 2024. Likewise for the Children's Hospital, we await the go-ahead to appoint construction partners next spring, but again we envisage enabling works starting in 2024. In addition, by the time of the Board meeting, the Cambridge Movement Surgical Hub with 40 beds and three theatre orthopaedic capacity should have opened for service. My thanks to all the teams who have made that possible and are still working on the U Block opening later in the year.

Our role in the Cambridge Biomedical Campus

We continue to play a central role in the management and future development of the Campus. We look forward with interest as to the deliberations Government have had on the prospects and mechanisms for growth in the Cambridge sub-region, the benefits in housing our staff and the needs for enhanced health care provision. We are playing into all the thinking. We should be aware that the recent local political decision to abandon the Sustainable Travel Zone (congestion charging) for Cambridge does raise planning issues for us. The planning baselines have all assumed significant measures to change local transport patterns and so now we must look to local councils as to how these are now to be achieved. It is good to see that the construction partners for the Cambridge South Station, on the Campus, have now been appointed which keeps opening in 2025 on track.

How we govern ourselves

The Board will be considering the forthcoming recommendations of our external Well-led governance review at our awayday later in November.

And how our governance relates to others

The Chief Executive and I have regular discussions with our peers at the ICB.

Recent appointments

1.5 I would like to congratulate Professor Sharon Peacock CBE on her appointment as the 8th Master of Churchill College, Cambridge. Sharon succeeds Professor Athene Donald DBE FRS and will take up her new post in October 2024.

1.6 Dr James Morrow has been appointed as a Non-Executive Director on the Board of Directors. James is a Cambridgeshire GP and a Partner at Granta Medical Practices, and from 2019 to 2023 was Co-Chair of the Cambridgeshire South Care Partnership. From 2018 to 2022 James also served as a Board Member for the Cambridgeshire and Peterborough Sustainability and Transformation Partnership.

2. Pubic meeting with the Chair and Chief Executive

2.1 Alongside Roland Sinker, Chief Executive, and Ian Walker, Director of Corporate Affairs, I met with members of the public on 16 October 2023. The main topics covered included Covid transmission, industrial action, patient records, Emergency Department waits, Serious Incident reporting, Integrated Care Systems and staff support.

3. ‘You Made A Difference’ Awards

3.1 I was pleased to attend a ‘You Made A Difference’ award event on 23 October 2023. 62 individual nominations and 32 team nominations were received and I would like to personally congratulate the winners Mark Latimer, Paediatric Trauma and Orthopaedic Consultant, Joanne Denton, Vascular Studies Unit Medical Secretary, and the Neonatal Intensive Care Unit (NICU).

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
Presentation of Chair’s Award at the CUH Annual Staff Awards
Nursing Conference
Consultant Development Programme
Council of Governors’ Strategy Group
REACH (Race Equality and Cultural Heritage) Network Event
Rosie Hospital 40th Birthday Event
Opening of the Surgical Training Centre
Governors’ Nomination and Remuneration Committee

4.2 Other meetings attended during this period include:

Cambridge University Health Partners (CUHP) Board

5. Recommendation

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

Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Council of Governors: 28 June 2023

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

Executive Summary

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

Related Trust objectives	All Trust objectives
Risk and Assurance	n/a
Related Assurance Framework Entries	n/a
How does this report affect Sustainability?	n/a

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

Action required by the Council of Governors

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

Cambridge University Hospitals NHS Foundation Trust

28 June 2023

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

1. Introduction

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

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

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

2. Objectives for 2023/24

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

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

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

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

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

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

3. Recommendation

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

Appendix 1: Priorities and objectives for 2023/24

1. The Teams who Work Together

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

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

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

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

2. The Teams and Patients who are Diverse

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

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

3. Our Operational Performance, Patient Safety and Finance

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

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

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

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

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

4. Innovating, Transforming and Improving

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

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

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

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

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

5. Integrating at Place

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

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

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

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

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

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

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

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

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

7. Our role in the Cambridge Bio-Medical Campus

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

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

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

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

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

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

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

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

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

8. How we govern ourselves

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

We will look for an effective Governance Review.

9. And how our governance relates to others

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

We will look for the Chair influencing the ICB approach.

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 8 November 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

8 November 2023

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

1. Recent Governor meetings

1.1 We held a **Governor Forum** on 7 September 2023 where we shared our observations on Board sub-committees and discussed topics and agendas for upcoming meetings.

1.2 We held a **Council of Governors** (CoG) meeting on 20 September 2023. We reported some changes to the Council: Will Watson (staff governor) has stepped down; Susan van de Ven has joined representing the County Council; Prof John Clarkson has returned from sabbatical - CoG formally thanked Prof Dame Carol Black, who was seconded to represent the University of Cambridgein his absence. Following approval to change the constitution to co-opt the person with the next highest number of votes in the last election, Elisa Ferraro has replaced Will Watson as a staff governor. The meeting also accepted the annual report of the Trust's external auditor. Following the Chief Executive's report, a number of questions relating the industrial action and the cases of Lucy Letby and Martha Mills were answered.

1.3 The lead governor gave an overview of governor activities through the year at the **Annual Public Meeting** on 27 September 2023.

1.4 Governors of all four trusts in the **Cambridgeshire and Peterborough Integrated Care System** met together with John O'Brien (Chair of the Integrated Care Board (ICB)) and Jan Thomas (Chief Executive of the ICB) on 3 October 2023 to hear an update on progress with the integrated care strategy. In addition, we had a presentation from Julian Stanley, Chief Executive of Healthwatch, Cambridgeshire and a discussion on initiatives to increase Trust membership and engagement, led by Neil Stutchbury.

1.5 The scheduled Governor/NED quarterly meeting on 4 October 2023 was cancelled in lieu of a special CoG meeting (see paragraph 3.1) and to allow governors to meet with Deloitte as part of their external Well-led governance review. One of the topics for discussion (NHS England's regional research data platform project) will be deferred to a future meeting. Overall, governors spoke positively to Deloitte about the governance processes within CUH, and the good relationships governors have with the Board. Despite the serious challenges it has had to face in recent years, governors felt that overall, the Trust is well-led by its Board.

1.6 The Trust's Strategy team met the **Governor Strategy Group** on 16 October 2023 and presented an update to the Trust strategy, with its focus on short- and medium-term actions to manage bed occupancy, outpatient appointments and patient flow. Governors asked a range of questions in a lively debate on what everyone appreciates is a critical issue for improving productivity within the Trust.

1.7 We invited Heather Noble (Managing Director of the South Place) and Erin Lilley (Director, South Place) to outline the role and work of the Cambridgeshire South Care Partnership at our **Governor Seminar** on 18 October 2023. The South Place team with its limited resources focuses on constituting and supporting Integrated Neighbourhood teams, which implement local projects to improve care within primary care networks. Erin Lilley described a number of interesting case studies which showed how improvements can be made by bringing people from different service areas to work together on joint projects with common goals.

2. Upcoming Governor meetings

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

- Membership Engagement Strategy Implementation Group: 14 November 2023
- Governor Forum: 23 November 2023
- Governor Seminar: 7 December 2023
- Governors' Strategy Group: 11 December 2023
- Council of Governors: 20 December 2023

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 (NED) vacancy created by Adrian Chamberlain leaving the Board at the end of his second term. The group reconvened on 2 October 2023 and agreed to recommend the appointment of Dr James Morrow. This was approved at a special meeting of CoG on 4 October 2023 and James has subsequently accepted the post and commenced in the role on 1 November 2023. The Committee is now developing a plan over the next 18 months, considering lessons learned, to recruit replacements in due course for Sharon Peacock as a NED and Mike More as Chair.

3.2 The Lead Governor and Trust Secretariat are continuing their work to review the meetings at which governors attend, for example the Outpatient Experience, Clinical Ethics, Patient Experience, etc. to assure ourselves that a governor needs to attend, and that all such meetings have a nominated governor or governors attending regularly.

4. Recommendation

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

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 8 November 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

8 November 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 Conversations with patients and staff remain central to our understanding of the care being provided, and areas for development. The combination of these discussions with our data help CUH consider a range of issues, including e.g., insights from patients around care and the quality of estate; what is really impacting on staff engagement; or the rigour of some of the Trust processes around core elements of care.

1.3 The context for CUH remains challenging, with ongoing national discussions in relation to industrial action and funding for the NHS. As you will know from various aspects of our work, we are focused on addressing the differential experiences and outcomes for staff and patients with protected characteristics. We have been consistent in expressing how unacceptable this differential experience is. There has been some recent challenge to the way that many NHS and other public sector organisations are seeking to address inequalities. The Trust will continue to refine its existing plans in relation to equality, diversity and inclusion (EDI), to make positive change, and to move forward in line with the CUH strategy. Alongside some of these challenges, CUH is continuing to support positive national developments in a range of areas.

1.4 CUH continues to perform well in the five areas of operational performance relative to peers, but with areas of concern. As examples:

- Quality - a focus on long waits and maternity (considering both the CQC review, and the recent inquest outcome in relation to Vitamin K); and noting progress on complaints and outcomes.

- Workforce - a focus on inclusion; with work ongoing to encourage uptake for the staff survey and vaccination; and noting a strong position on recruitment, support for staff and recognition.

- Access - acknowledging significant disruption from industrial action, work is ongoing to tackle waiting times in urgent and emergency care where CUH is now in the bottom third nationally; and noting ongoing good performance in cancer, elective care and diagnostics.

- Finance - maintaining progress with our significant capital plan and making best use of our resources to deliver financial plans for CUH and the integrated care system for the coming years.

- Improvement, Innovation and Digital - continuing to deliver this year's financial plan, whilst finalising the forward plan for the portfolio.

1.5 CUH continues to make progress delivering the Trust strategy, with more to do in some areas. The Cambridge Movement Surgical Hub opened on 6 November 2023; and the Trust remains on track for U-block, neuro theatres, and the two community diagnostics centres. The Cambridge Children's Hospital OBC has been approved (with a Green Gateway rating; and a financial check in April 2024), joining the Cancer Research Hospital. Work will start on the ground for both early in 2024. Work to better align CUH, Royal Papworth Hospital and the University of Cambridge will start formally this month, and work is ongoing in relation to the Cambridge South Care partnership. We expect further progress on our strategies in relation to EDI, digital and sustainability; and the 5-year plan.

1.6 CUH continues to engage with partners across Cambridge on a wide range of areas from transport to housing.

1.7 In line with good practice the Trust will complete a full self-assessment against the current CQC framework over the next three months, focussing on those services that have not been reviewed recently. This self-assessment will complement the current external well-led governance review. The Trust focus in both will be on the core elements of running a good hospital.

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 nine 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 The vacancy rate for midwifery is significantly improved with plans to over recruit to support turn over. Work is also ongoing to review the Medical model.

Staffing numbers

2.5 While there has been an increase in the vacancy position across all nursing staff groups this is due to the financial ledger being updated with the agreed establishment budgets for 2023/24. The greatest impact from vacancies within nursing remains within the critical units with both paediatric critical care units (PICU and NICU) having to close to referrals from the region on occasion due to staffing constraints. The vacancy rate is however improving, with a strong recruitment pipeline.

2.6 The Emergency Department (ED) has also experienced nurse staffing challenges due to short term absence and the high volume of attendances. The department are supported in times of increased capacity with staff who are either redeployed from other clinical areas or temporary workers, as per escalation processes.

2.7 The high vacancy and turnover rates for Health Care Support Workers (HCSW) continues. This coupled with the demand for specialling patients across the Trust, is impacting fill rates in all areas

Serious Incidents (SIs)

2.8 There are currently 11 open SI investigations, an improved position from the previous report. Additional resources have also been allocated to support the team and to support completion of investigations and reports.

Hospital Standardised Mortality Ratio (HSMR)

2.9 HSMR in June 2023 was 70, with a 1-year rolling average of 76.5. This is banded as statically lower than expected and is the sixth lowest in the NHS.

Cambridge Movement Surgical Hub

2.10 To support reduction in waiting lists for elective orthopaedic and spinal surgery the Cambridge Movement Surgical Hub opened on 6 November 2023. The facility has three theatres and 40 beds and creates a new surgical centre of excellence.

Industrial Action

2.11 Further industrial action by members of the British Medical Association (BMA) and Hospital Consultants and Specialists Association (HCSA) took place from Tuesday 19 September to Saturday 23 September 2023 and from Monday 2 October to Thursday 5 October 2023. 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.

Managing infections during winter

2.12 The Trust has a multidisciplinary team who have established clear processes for the management of infective patients which are reviewed regularly. These include rapid identification of potentially infective patients, point of care testing, patient placement on the wards, policies for use of single rooms and cohorting. Policies for cleaning of spaces, moving patients and minimising bed closures are in place and shared with operational teams.

3. Access to Care

3.1 During September and October 2023 demand on our emergency pathways increased, with an additional 27 patients attending the ED each day on average compared to last year, equivalent to annual growth of 7%. This reflects the national trend and has placed additional pressures on our services, with our 4 hour performance reducing to 65% in September compared to 67% in August.

Despite these challenges we have maintained our position as one of the top trusts in the country for ambulance handovers over 60 minutes and we have nearly halved the number of patients waiting more than 12 hours in the department compared to last year. Continuing to reduce the time our patients spend in the Emergency Department is a key area of focus for the Trust.

3.2 Elective activity as a whole has been impacted by periods of industrial action during 2023/24. This may continue to be a factor in future months; no formal agreement to cease the action has been made but no industrial action is currently planned. In the context of these challenges, overall elective inpatient and day-case activity in the year to date represents 94% of planned levels, with day cases continuing to drive the majority of the variance. Despite being behind our plan for overall activity, focused work on elective pathways has seen a reduction in the number of patients waiting more than 65 weeks and 78 weeks on our waiting list. Across the region, CUH has the second-lowest proportion of patients waiting for cancer treatment over 62 days (7%).

3.3 With winter approaching, pressures on our services and our staff are likely to increase. To meet this challenge, we have developed a detailed winter plan which sets out how we will support the safe management of the Trust over the next few months which is being led by the Chief Operating Officer. This includes a focus on alternative pathways such as building capacity across our innovative virtual ward programme which now looks after 45 patients, as well as supporting our staff wellbeing during what will be a busy time.

3.4 **Emergency Department (ED).** Performance in September 2023 has increased to 64.9% compared to 59.4% in the previous year. Outflow from ED remains a significant issue due to high levels of inpatient occupancy.

3.5 **Referral to Treatment (RTT).** The total RTT waiting list decreased by 1% in September 2023. The total waiting list size is back within the planning submission for Month 6.

3.6 **Delayed discharges**. The number of beds lost to delayed discharges increased from 103 to 108 beds between August and September 2023.

3.7 **Cancer.** CUH has fallen behind target for the first time since the 28 day faster diagnosis standard commenced. This is due to the deterioration in skin performance. CUH has also experienced further deterioration in performance against the 2WW target.

3.8 **Operations.** Utilisation remained above peers and the national median at 78.4% for Quartile 4. Sessions used in September 2023 were high at 92.5%, and up to 97.4% when industrial action dates were excluded.

3.9 **Diagnostics.** Six week performance remained stable for September 2023 at 36.4%. Total activity was 2% higher than plan.

3.10 **Outpatients.** CUH continues to achieve an initial target of 110% of new activity, although this remains significantly below plan. Division C remains below 100% but data quality may be contributing to this. There was sustained falls in waiting list numbers for Divisions B and E.

4. Finance – Month 6

4.1 The Month 6 position for performance management purposes is a £3.5m deficit, this is adverse to our planned performance by £6.8m. The full year plan is for the Trust to deliver a break-even financial position.

4.2 The following points should be noted in respect of the Trust's Month 6 financial performance:

- Financial under performance is driven by £6.0m of increased pay expenditure arising from industrial action.

- A reduction to the Elective Payment Mechanism (EPM) target for April has provided £1.9m of support to the Trust YTD with a further £2.0m due by year end, partially mitigating the impact of industrial action.

- Additional adjustments are expected for subsequent industrial action months but this has not yet been confirmed.

- The position also includes £6.5m 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.

- In forecasting a year-end break-even position the Trust has assumed central financial support is provided to fully cover the adverse impact of industrial action.

4.3 The Trust has received an initial system capital allocation for the year of £35m 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.

4.4 At Month 6 the capital programme is ahead of plan with spend year to date of £19.4m against a budget of £14.6m. 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. Additionally, a workforce winter plan, focusing on the next six months has been developed, aligned to the five workforce commitments.

Good Work and Wellbeing

5.3 The autumn flu and Covid vaccination programme for CUH staff is underway. Vaccination clinics are taking place in the main hospital building this year to ensure accessing the clinics is as easy as possible. Outreach vaccination services to clinical areas where it may be more difficult to release staff to attend the main hospital clinics are also running. Flu vaccination clinics commenced on 18 September 2023 and over 4500 staff have now received their flu vaccine. Covid vaccination clinics commenced on 2 October 2023 and to date over 1300 staff have been vaccinated.

5.4 The Trust is committed to a workplace where all staff, including those living with disabilities, impairments and health conditions and those who are neurodiverse, feel they are supported and can thrive in their job. Over 100 line managers have attended bite-size training sessions over recent weeks to ensure they feel equipped in being aware of the importance of considering reasonable adjustments and understand how employees can access the Workplace Adjustments Service.

Resourcing

5.5 In the last 12 months CUH has grown its workforce by just over 4% with an increase in headcount across both clinical and non-clinical roles.

5.6 In September 2023 56 nurses joined the Trust, 10 of which were newly qualified. 48 Healthcare Support Workers also joined the Trust. Recruitment pipelines are good with over 200 nurses looking to join CUH in coming months. Retention is steadily improving and now sits at pre-pandemic levels.

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.

Ambition

5.8 A significant programme of work has been underway over the course of 2023 scoping the infrastructure required to deliver a dedicated management development programme for leaders and managers at CUH. A proposal for our Essentials for Leadership Excellence programme, including delivery and timeline will be presented to Management Executive with a view to launch this in January 2024.

Inclusion

5.9 The Trust marked Black History Month in October 2023 by undertaking a series of events that highlighted the importance of staff networks and the vital work that they do. A tree will be planted on the campus to symbolise the commitment to continue to grow and develop the Race Equality and Cultural Heritage (REACH) Network.

Relationships

5.10 Throughout the year the Trust has run a staff awards programme which, in September 2023, culminated in an awards ceremony held at the Corn Exchange. Kindly sponsored by ACT, the programme received over 1200 nominations acknowledging and celebrating the safe and excellent work of colleagues as well as the kindness shown to patients and to each other.

5.11 A series of compassionate leadership workshops to support leaders with planning for winter pressures is soon to be launched. These workshops use the learning from recent staff listening events and incorporate the requirement for increased relational leadership during periods where the Trust may experience increased workload pressures.

6. Innovation, Digital and Improvement

Innovation

6.1 The Trust considers innovation as central to improving the quality and access to care for our patients over the medium-term. It complements the Trust's commitment to establish a culture of sustainable continuous quality improvement (QI).

6.2 Over Summer 2023 an internal review was completed to understand how innovation currently occurs across the Trust and identify where staff can be better supported. This made a number of recommendations about how to strengthen the focus of innovation across the Trust, as well as identifying areas where additional resource will enhance our ability to deliver innovation. These will be mobilised over the coming year, beginning with the recruitment of a dedicated innovation team.

6.3 The Trust will underpin this by partnering with external organisations across the academic, industrial and public sector, as well as across our locality (e.g. the Cambridge Biomedical Campus, University of Cambridge), our system (e.g. with the Cambridgeshire and Peterborough Innovation Hub) and our region (e.g. through the Specialised Provider Collaborative).

7. Digital

7.1 Focus for the Trust's digital team remains on maintaining a safe and secure infrastructure, by keeping our software platforms, hardware and infrastructure up-to-date. The Trust continues to comply with nationally mandated changes; the move to NHS Mail and the transition to the new NHS Care Identify Service are almost complete.

7.2 A significant upgrade to the Trust's electronic patient records, Epic, took place in October 2023. This upgrade has significant changes that improves performance of the system and provides a modern platform for accelerating future developments; more than 400 early adopters are already live on the upgraded version.

7.3 Resourcing the digital teams to match the Trust's ambitions and demands remains challenging. This is reflected on the Trust's Corporate Risk Register (CRR) and Board Assurance Framework (BAF). Whilst work continues to address these workforce challenges, it is imperative that the teams' limited resources are prioritised to align with initiatives that directly support the Trust's strategic objectives. To facilitate this alignment, two new operationally led processes are being implemented, to prioritise Epic and technology developments.

7.4 Planning continues on the Trust's new Digital Board, which will align and govern digital commitments.

8. Improvement and Transformation

8.1 The Trust's three year contract with the Institute for Healthcare Improvement (IHI) culminated on 11 and 12 October 2023, with a final onsite visit by senior IHI colleagues. An end-of-year report is now awaited from the IHI.

8.2 To continue to build QI capability and capacity across the Trust, the improvement and transformation team has developed an internal faculty to deliver these programmes beyond the support of the IHI. The third wave of the Trust's improvement coach programme will conclude on 19 October 2023, with a celebration event for the 20 participants; this was delivered by the Trust's improvement and transformation team.

8.3 The improvement and transformation team continues to support colleagues with a number of strategic QI programmes of work across urgent and emergency care (also now involving the ED), virtual wards, outpatients, high volume low complexity procedures, reducing hospital acquired pressure ulcers, a complaints review, as well as work with the Trust's Purple Network to support colleagues with disabilities, long-term conditions and neurodiversity.

8.4 The virtual ward team has now on-boarded over 700 patients from 22 specialties since its inception in November 2022. Up to the end of August 2023, the team achieved a bed day saving of 2,561 bed days, the equivalent of 8.4 beds. On 20 November 2023 colleagues from University College Hospitals London and Guy's and St. Thomas' will visit the Trust to enable collective sharing of learning regarding outpatient improvements.

8.5 To support the Trust's priority focus of access to care and releasing net bed capacity and reducing referral to treatment (RTT) waiting times, the improvement and transformation and digital teams are supporting colleagues to make improvements across a number of agreed pathways (pneumonia, ENT and dermatology).

8.6 The Trust's productivity and efficiency requirement for 2023/24 is £53m and if met, will deliver an end-of-year break-even position.

As at Month 6, the Trust has delivered a £23.8m efficiency, against a year-to-date target of £25.5m, resulting in an under-performance of £1.68m, 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.

PART B

9. Strategy update

Strategy implementation

9.1 Following the launch of the Trust's refreshed strategy last year, focus continues on its implementation. The Board agreed that access to care is a primary strategic delivery lens for 2023/24, across all 15 commitments. Work is now concentrated on embedding delivery of improvements in medium-term access to care into our organisational priorities, through the business planning process, as well as other prioritisation mechanisms.

9.2 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

9.3 The Trust continues to work with partners across the Cambridgeshire South Care Partnership (CSCP), with colleagues increasingly involved in bilateral work with other organisations or via contributions to system forums, to improve care for people in and outside of hospital.

9.4 Examples of work include: involvement in the High Intensity Users programme design and implementation, an initiative which is targeted at people who frequently use emergency services; and the Home First programme which has been associated with improved discharge rates for patients with complex requirements.

9.5 The outcomes of all the initiatives will be to make it easier for patients to access the care they need in a timely way, reduce the pressure on the hospital and primary care colleagues, and make it easier to plan ahead.

Health Inequalities, Equality, Diversity and Inclusion

9.6 Work is ongoing with KPMG to strategically embed Equality, Diversity and Inclusion (EDI) and Health Inequalities considerations into the Trust's institutional audit process. One of the early areas for review is data quality in relation to patient protected characteristics.

9.7 The Trust is working in collaboration with ICS partnership organisations to develop and implement a refreshed ICS Health Inequalities strategy. A coordinated action plan is being developed to deliver against strategic priorities and align the Health Inequalities strategy to Prevention and Population Health Management programmes.

9.8 Discussions have been held to identify potential CUH-led/co-led projects which would be eligible for ICS Health Inequalities funding and a joint proposal has been developed with the University of Cambridge School of Clinical Medicine to address health inequalities through joint action to improve quality of data.

9.9 An ICS workforce engagement event was held in September 2023 to promote and facilitate alignment of workforce strategic priorities across the ICS. EDI is one of the ICB's strategic priorities and the event provided an opportunity to identify a set of common objectives for all partners.

Supporting our staff

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

Building for the future

New hospitals and the estate

9.11 The Community Diagnostic Centre (CDC) spoke at Wisbech has been operational for MRI and CT since April 2023 and is currently carrying out c.150 scans per week. Further services, including echocardiology and non-obstetric ultrasound, are expected to become live in November 2023. Work continues on the Ely CDC hub with a planned completion date in spring 2024.

9.12 Discussions are underway between CUH and Royal Papworth Hospital to strengthen partnership working between the two trusts. Projects to take forward agreed priorities were shared with both Boards in early November 2023 and are expected to explore the development of shared patient pathways, opportunities to work together on recruitment, training and staff development as well as collaboration on innovation and research.

9.13 The Cambridge Cancer Research Hospital (CCRH) team is working closely with our preferred construction partner, Laing O'Rourke, to optimise and finalise designs, whilst ensuring we open our hospital on time and deliver the maximum value for money. A Director of New Hospital Construction was appointed in July 2023, bringing a wealth of building industry knowledge and experience to the project. The CCRH team have also been working with the Cambridgeshire & Peterborough Combined Authority following our submission of a full planning application in January 2023, and are looking forward to a decision in the coming months.

9.14 The Cambridge Children's Hospital Outline Business Case was approved in principle by the NHS England and Department of Health and Social Care Joint Investment Committee on 29 September 2023. The approval, which is subject to a review of the Project's capital funding in April 2024, allows us to proceed to the Full Business Case stage of the project and means pre-construction enabling works can begin on the site of the new hospital early next year. The project's fundraising campaign remains in a strong position, with approximately £56m of its £100m target achieved and further pledges expected in the coming months.

Specialised Services

9.15 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 specialised services across the region.

9.16 Our current work programme includes tactical projects (which aim to deliver impact in the next 6-12 months) and two longer-term strategic programmes of work on neurosciences and innovation.

9.17 In neurosciences, we have begun to develop a regional strategy for neurosciences, engaging with stakeholders across the region to develop an understanding of the challenges and opportunities, and identifying potential areas of focus for the strategy. We will consolidate this work at an inaugural steering group meeting in mid-November 2023.

9.18 We have continued to progress tactical projects including exploring funding mechanisms to support the delivery of biologics therapies closer to home for patients with severe asthma and MS; and working through the information governance requirements to utilise video technology for remote diagnosis and management of epilepsy seizures across the East of England region.

9.19 We continue to engage with NHSE and ICBs through the East of England Joint Commissioning Committee to support preparation for the delegation of specialised services to ICBs in April 2024.

9.20 We are also developing a business plan to outline in more detail our ambitions for next year and anticipated resourcing requirements. The plan is currently being iterated with the seven providers in the EoE SPC.

Climate change

9.21 Government grant-funded work to further develop the Trust's heat decarbonisation plan has been tendered and commissioned with an initial focus on preparing a capital grant bid for early phase implementation.

9.22 High efficiency heat-pump technology, with significant solar energy input, has been installed in the new Cambridge Movement Surgical Hub – providing one of the lowest carbon heating and cooling systems to a healthcare building in the country.

9.23 The deployment of mobile nitrous cylinders, to replace the existing high carbon emission fixed network, has been successfully extended to Main Theatres and other surgery locations on site.

9.24 A feasibility study has been commissioned for the installation of an Entonox (significant greenhouse gas) central destruction unit in The Rosie.

9.25 Designs to install an on-site electric vehicle charging infrastructure have been drawn up.

9.26 There has been strong and innovative staff engagement during Cycling Month (August) and Climate Anxiety Month (September).

10. Recommendation

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

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 8 November 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 September 2023.
Previously considered by	Performance Committee, 1 November 2023

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

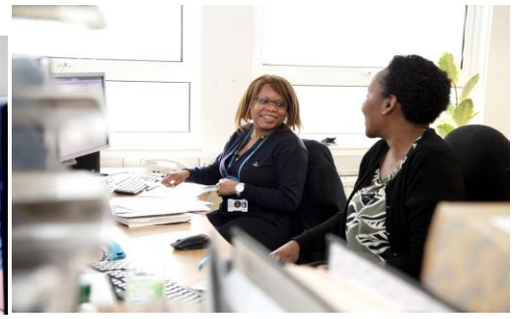
Related Trust objectives	All objectives
Risk and Assurance	The report provides assurance on performance during Month 6.
Related Assurance Framework Entries	BAF ref: 001, 002, 004, 007, 011
Legal implications/Regulatory requirements	n/a
How does this report affect Sustainability?	n/a
Does this report 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 September 2023.




NHS
Cambridge University Hospitals
NHS Foundation Trust





Integrated Report

Quality, Performance, Finance and Workforce to end September 23

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

Report compiled: 31 October 2023

Key

NHS
Cambridge University Hospitals
NHS Foundation Trust

Data variation indicators


Normal variance - all points within control limits

Negative special cause variation above the mean

Negative special cause variation below the mean

Positive special cause variation above the mean

Positive special cause variation below the mean

Target status indicators

Target has been and statistically is consistently likely to be achieved

Target failed and statistically will consistently not be achieved

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

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				Jul 23	Aug 23	Sep 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	Sep-23	90%	88.0%	84.0%	84.0%	⇔	86.3%	50.0%	86.3%
	Trust Compliance with Pressue Ulcer risk assessment tool & documentation within 6 hours of admission	Sep-23	90%	82.0%	79.0%	79.0%	⇔	80.8%	13.4%	80.8%
	% Rosie MDT Obstetric staff passed PROMPT emergencies training	Sep-23	90%	82.0%	86.8%	82.6%	⇩	81.0%	71.0%	81.0%
	% Rosie Obstetricians and Midwives passed fetal surveillance training	Sep-23	90%	81.0%	84.2%	88.0%	⇧	84.4%	72.0%	84.4%
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)	Sep-23	7%	7.0%	7.5%	7.5%	⇔	7.8%	14.0%	7.8%
Effective / Responsive	% of Early Morning Discharges (07:00-12:00)	Sep-23	20%	14.9%	16.0%	16.3%	⇧	15.6%	15.3%	15.8%
	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	Sep-23	80%	74.0%	70.6%	77.4%	⇧	75.3%	74.0%	75.0%
	Same day emergency care (SDEC)	Aug-23	30%	25.9%	26.8%	N/A	▪	25.3%	22.0%	21.8%
	Percentage of admissions over 65yo with dementia/delirium or cognitive impairment with a care plan in place	Sep-23	50%	74.0%	73.0%	79.0%	⇧	64.3%		64.3%
	SSNAP Domain 2: % of patients admitted to a stroke unit within 4 hours of clock start time (Team centred)	Sep-23	55%	50.5%	45.4%	49.1%	⇧	43.8%	29.2%	35.7%
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				Jul 23	Aug 23	Sep 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)	Aug-23	0	1	1	0	⇩	5	3	7
	E.coli Bacteraemias (Total Cases)	Aug-23	50% over 3 years	43	27	26	⇩	182	401	419
	C. difficile Infection (hospital onset and COHA* avoidable)	Aug-23	TBC	18	15	9	⇩	50	129	109
	Hand Hygiene Compliance	Aug-23	TBC	95.5%	94.1%	N/A	▪	94.1%	96.4%	95.0%
Clinical Effectiveness	% of NICE Technology Appraisals where funding was not procured within three months. ('last month')	Sep-23	100%	66.7%	33.3%	36.4%	⇧	60.5%	None recorded	60.5%
	% of external visits where expected deadline was met (cumulative for current financial year)	May-22	80%	N/A	N/A	N/A	▪	44.4%	N/A	40.0%
	% of NICE guidance relevant to CUH is returned by clinical teams within total deadline of 30 days.	Sep-23	80%	50.0%	0.0%	None recorded	⇧	35.7%	51.0%	42.5%
	100% of NCEPOD questionnaires (clinical and operational) relevant to CUH is returned by clinical teams within deadline ('last month').	Sep-23	100%	None recorded	None recorded	None recorded	⇔	75.0%	None recorded	75.0%
	85% of national audit's to achieve a status of better, same or met against standards over the audit year	Sep-23	85%	None recorded	75.0%	100.0%	⇧	92.3%	84.6%	90.0%
Nursing Quality Metrics	Blood Administration Patient Scanning	Sep-23	90%	99.6%	99.5%	99.9%	⇧	99.7%	99.7%	99.7%
	Care Plan Notes	Sep-23	90%	96.4%	95.8%	96.0%	⇧	96.0%	96.1%	96.1%
	Care Plan Presence	Sep-23	90%	99.7%	99.7%	99.8%	⇧	99.7%	99.6%	99.7%
	Falls Risk Assessment	Data reported in slides								
	Moving & Handling	Sep-23	90%	79.1%	74.4%	75.7%	⇧	76.6%	71.7%	74.2%
	Nurse Rounding	Sep-23	90%	99.2%	99.2%	99.3%	⇧	99.1%	99.2%	99.1%
	Nutrition Screening	Sep-23	90%	79.9%	73.4%	74.9%	⇧	76.8%	72.4%	74.7%
	Pain Score	Sep-23	90%	86.5%	84.6%	85.3%	⇧	85.3%	83.5%	84.4%
	Pressure Ulcer Screening	Data reported in slides								
	EWS									
	MEOWS Score Recording	Sep-23	90%	84.3%	85.2%	86.7%	⇧	85.4%	79.6%	82.5%
	PEWS Score Recording	Sep-23	90%	99.1%	99.3%	99.3%	⇧	99.2%	99.2%	99.2%
	NEWS Score Recording	Sep-23	90%	97.8%	97.7%	97.8%	⇧	97.7%	97.4%	97.5%
	VIP									
	VIP Score Recording (1 per day)	Sep-23	90%	91.2%	88.7%	86.0%	⇩	88.0%	85.2%	86.5%
	PIP Score Recording (1 per day)	Sep-23	90%	86.4%	87.5%	83.1%	⇩	86.2%	89.0%	87.8%
Patient Experience	Mixed sex accommodation breaches	Jun-20	0	N/A	N/A	N/A	▪	N/A	N/A	N/A
	Number of overdue complaints	Sep-23	0	74	41	50	⇧	326	172	449
	Re-opened complaints (non PHSO)	Sep-23	N/A	4	6	8	⇧	25	18	29
	Re-opened complaints (PHSO)	Sep-23	N/A	1	0	1	⇧	5	2	7
				Jul 23	Aug 23	Sep 23				
	Number of medium/high level complaints	Sep-23	N/A	9	11	13	⇧	86	257	217

Operational Performance

NHS Cambridge University Hospitals NHS Foundation Trust

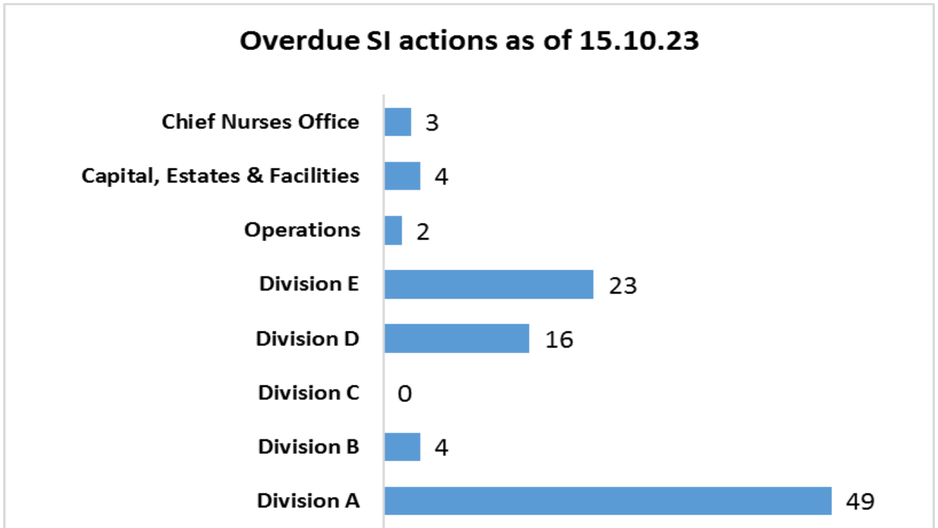
Point of delivery	Performance Standards	SPC variance	In Month Actual	In Month plan	Target	Target due by	Page
Urgent & Emergency Care	4hr performance	Normal variation	64.9%	71.0%	76.0%	Mar-24	Page 12
	12hr waits in ED (type 1)	Normal variation	6.8%	-	-	-	
	Ambulance handovers <15mins	Positive special cause variation	69.6%	65.0%	65.0%	Immediate	
	Ambulance handovers <30mins	Positive special cause variation	98.3%	95.0%	95.0%	Immediate	Page 13
	Ambulance handovers > 60mins	Positive special cause variation	0.2%	0.0%	0.0%	Immediate	
Cancer	Cancer patients < 62 days	Normal variation	70.0%	-	85.0%	Immediate	Page 20
	28 day faster diagnosis standard	Normal variation	70.1%	79.9%	75.0%	Immediate	Page 17
	31 day decision to first treatment	Normal variation	81.4%	-	96.0%	Immediate	Page 19
	2 week waits	Negative special cause variation	65.2%	-	93.0%		Page 18
Outpatients	First outpatients (consultant led)	Normal variation	109.5%	124.5%	-	-	Page 22
	Follow-up outpatients (consultant led)	Normal variation	108.8%	129.0%	-	-	Page 23
	Advice and Guidance Requests	Normal variation	9.7%	-	16.0%	Mar-23	
	Patients moved / discharged to PIFU	Normal variation	3.2%	7.5%	7.5%	Mar-23	Page 24
Diagnostics	Patients waiting > 6 weeks	Positive special cause variation	36.4%	27.3%	5.0%	Mar-24	Page 21
	Diagnostics - Total WL	Positive special cause variation	12,736	11,002	-	-	
RTT Waiting List	RTT Patients waiting > 65 weeks	Positive special cause variation	1097	616	0	Mar-23	Page 15
	RTT Patients waiting > 78 weeks	Normal variation	99	-	-	-	
	Total RTT waiting list	Negative special cause variation	62,964	63,102	-	-	Page 16
Productivity and efficiency	Non-elective LoS (days, excl 0 LoS)	Normal variation	8.5	-	-	-	
	Long stay patients (>21 LoS)	Normal variation	204	192	-	-	
	Elective LoS (days, excl 0 LoS)	Normal variation	5.0	-	-	-	
	Discharges before noon	Normal variation	16.3%	-	-	-	
	Theatre sessions used	Normal variation	601	-	-	-	
	In session theatre utilisation	Normal variation	78.4%	85.0%	85.0%	Sep-23	Page 26
	Virtual Outpatient Attendances	Negative special cause variation	19.4%	-	-	-	
	BADS Daycase Rate (local)	Normal variation	83.7%	-	-	-	Page 27
Surgical prioritisation	P2 (4 weeks) Including planned	Negative special cause variation	3,139	-	-	-	

Serious Incidents

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Data range	Period	Threshold	Current period	Mean	Variance	Special causes	Comments
Patient Safety Incidents	September 2020-August 2023 July 2023	Aug-23	-	**1514**	*1450*		-	last 5 months have been above the mean
Patient Safety Incidents per **1,000 admissions**			–	**85.8**	*90.8*		–	
Percentage of **moderate harm and above** patient safety incidents			≤ 2%	**3.2%**	*2.5%*		-	Driven by moderate harm incidents with last 10/12 months above the mean. Whereas combined severe harm and death have for the last 9 months been below the mean (Statistically significant decrease)
All Serious Incidents			-	**2**	*4.7*		-	

Ref	SI Title	STEIS SI Category	STEIS SI Sub categories	Actual Impact	Div.	Ward/ Dept.
SLR172708	Inadvertent reversal of therapeutic anticoagulation	Incident demonstrating existing risk that is likely to lead result in significant failure or harm	Medication incident	**Moderate**	A	NCCU (A2)
SLR172977	Delay in the recognition and escalation of a potential placental abruption in a twin pregnancy	Unexpected/potentially avoidable death	Maternity/Obstetric incident: baby only	**Death**	E	Sara Ward



Summary

Five SI reports were submitted to the ICS in September 2023. Compliance with the 60 day timeframe for September was 25% (1/4).

There are currently 101 (↑) overdue Serious Incident Actions. The patient safety team are working with divisional teams to review and close or theme open actions from SI's into improvement plans in preparation for transition to PSIRF.

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

Duty of Candour (DOC)

NHS
Cambridge University Hospitals
NHS Foundation Trust

Executive Summary

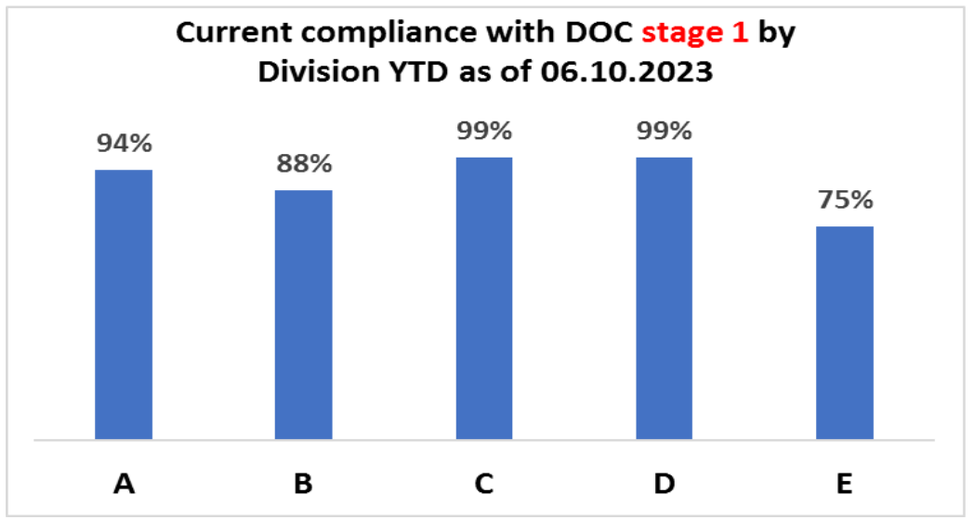
Trust wide **stage 1** DOC compliance for YTD as of 06.10.2023 is **93%** (340/367)

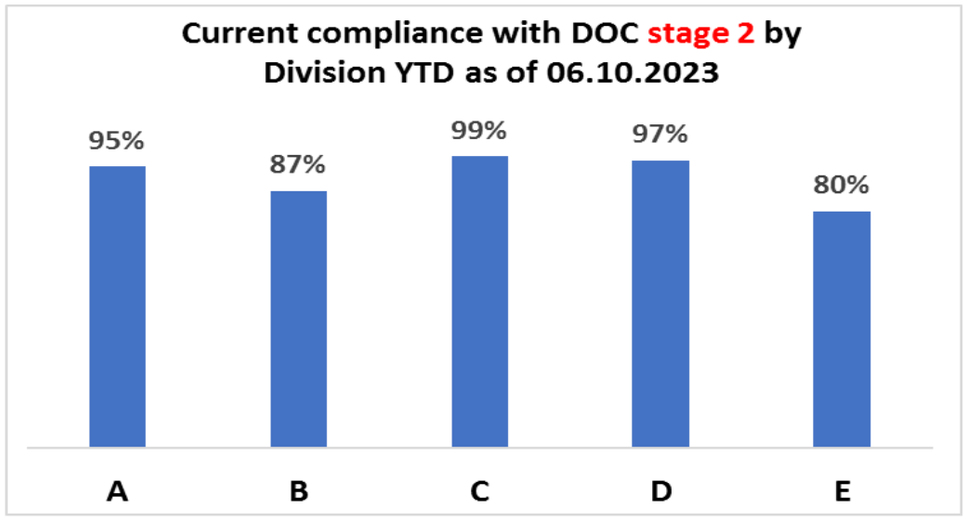
Trust wide **stage 2** DOC compliance for YTD as of 06.10.2023 is **90%** (247/275)

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.*





Falls

NHS Cambridge University Hospitals NHS Foundation Trust

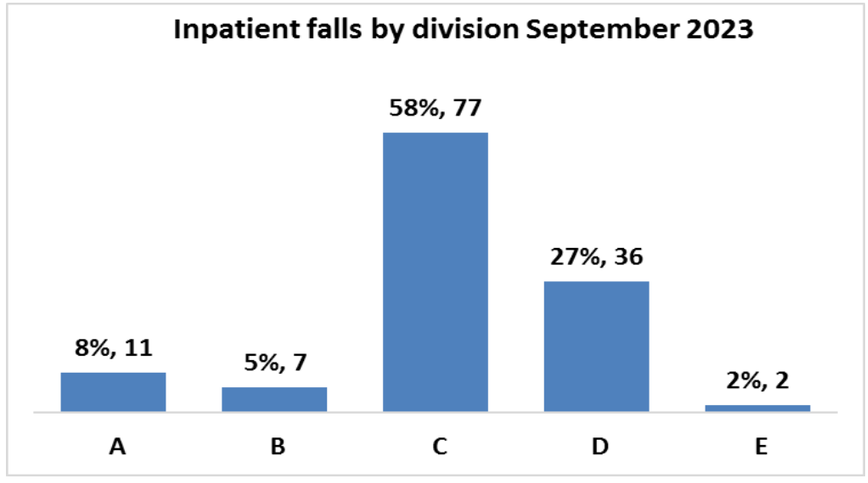
Indicator	Data range	Target	Sep-23	Mean	Variance	Special causes	Target status	Comments
All patient falls	September 2020 - August 2023	-	**133**	*154*			-	Within normal variance
Inpatient falls per **1,000 bed days**			**3.8**	*4.5*		-	-	Within normal variance
Moderate harm & above - inpatient falls		-	**2**	*4.5*		–	-	Within normal variance
Falls **risk screening** compliance within 12 hours of admission		≥ 90%	**84%**	*85%*			F	We were last compliant with this metric in June 2021
Falls KPI: patients 65 and over who have a **cognitive impairment** have an appropriate **care plan in place**		≥ 90%	**79%**	*29%*	H	SU11	?	Statistically significant upward shift in the last 11 months.

Summary

All falls are in normal variance which is an improved position on 2022.
There has been a significant improvement in compliance of patients identified as having cognitive impairment now having a care plan to support this aspect of their care (79%).
Risk factors continue to be: patients requiring the assistance of one to mobilise; patients with a previous fall; occur in the daytime ; and are unwitnessed.

QI update

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.
All ward areas have Falls champions in place supporting ward-based training and improvement.



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

Hospital Acquired Pressure Ulcers (HAPUs)

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Data range	Target	Sep-23	Mean	Variance	Target status	Comments
All hospital-acquired pressure ulcers	October 2020 - September 2023	-	**48**	30	H	-	The last 15 consecutive months have been above the mean. August and September 2023 have shown a statistically significant high point.
All HAPUs by date of occurrence per 1,000 bed days		–	**1.38**	0.89	H	-	The last 15 consecutive months have been above the mean.
Category 2, 3, 4, Suspected Deep Tissue Injury, and Unstageable HAPUs		–	**30**	17.0	H	-	The last 13 consecutive months have been above the mean, 6 of which have been statistically significant high points.
Category 1 hospital-acquired pressure ulcers		–	**18**	12.0		–	
Category 2 hospital-acquired pressure ulcers			**15**	12.0		–	7 of the last 8 months have been above the mean.
Unstageable HAPUs		–	**2**	1.5		–	
Suspected Deep Tissue Injury HAPUs by date of occurrence		-	**13**	3.6	H	-	Statistically significant high points in August and September 2023. 13/14 last consecutive months have been above the mean, 6 of which were statistically significant high points.
Medical device related HAPUs		–	**14**	6.9	H	–	Statistically significant upward shift in the last 7 months
Pressure Ulcer screening **risk assessment** compliance		90%	**79%**	80%		F	We have not been compliant with this metric in the last 3 years.

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 and or 4 HPAUs in September.
There is a statistically significant **increase** in HAPUs related to: Medical devices overall (14); Masks/Tubing' (9); Collars (2); and located on the occiput (2).
There is a statistically significant **decrease** in HAPUs related to: hips; ischial tuberosity; heels; and sacrum. The highest HAPUs in the last 12 months are from: sacrum and heels

QI update

Tissue Viability team challenged due to high vacancy rate - all posts will be filled by Dec 23.
The work in partnership with the Institute Health Improvement (IHI) to reduce incidence of HAPUs commenced in July. Current pilot ward/departments: ICU (D3), D9, J3, ED, M5.
CQUIN 12 for 2023/24 (*Assessment and documentation of pressure ulcer risk*) audit score for Q1 = 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**	September 2020- August 2023	Sep-23	≥95%	**89%**	*59%*		-	F	
Antibiotics administered within 60 mins from time patient **triggers** Sepsis (NEWS 5>) - **Emergency Department**				**89%**	*72%*		-	F	
All elements of the Sepsis Six Bundle delivered within 60 mins from time patient **triggers** Sepsis (NEWS 5>)- **Inpatient wards**				**38%**	*39%*		-	F	
Antibiotics administered within 60 mins from time patient triggers Sepsis (NEWS 5>) - **Inpatient wards**				**50%**	*75%*			F	

Sample size in month for above audits:

Inpatient = 8
ED = 9

Measuring & monitoring framework to be updated i.e. outcome data. Algorithm developed by Ari Ercole (CMOI) and yielded potential sample of 300 patients within month – validation process now underway.

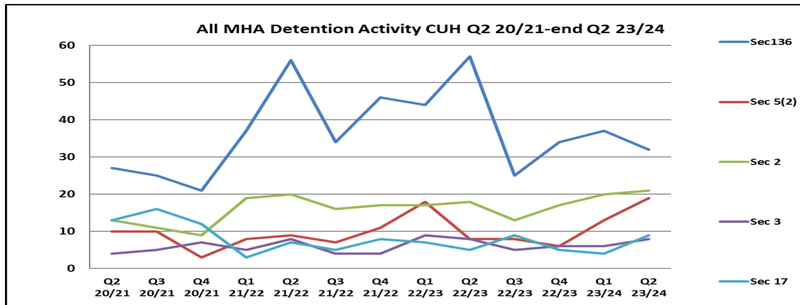
Update on PA QI project pending

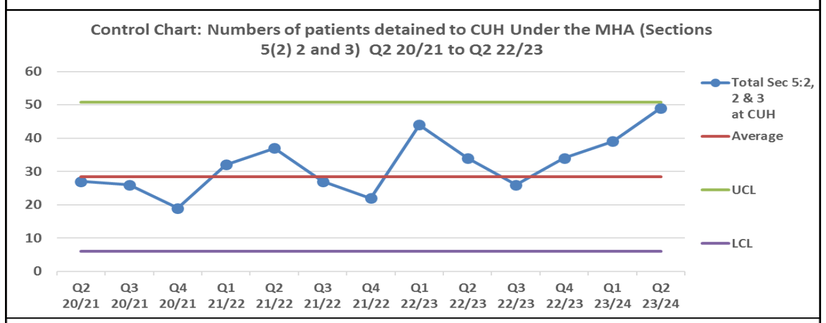
Sepsis QI corporate plan – driver diagram drafted - to be approved at next Sepsis Action Group meeting

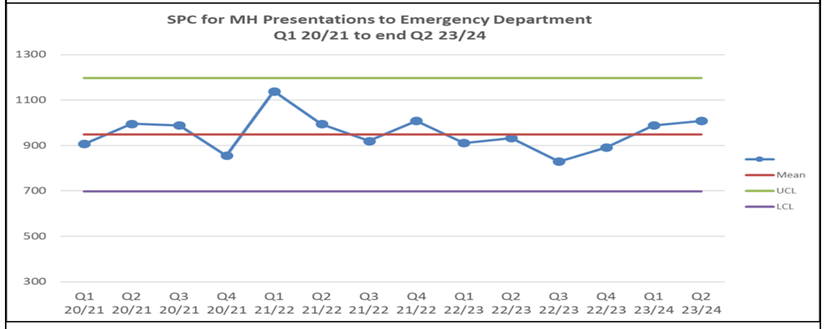
Sepsis QI Event planned for December 2023 to launch pilot area QI work

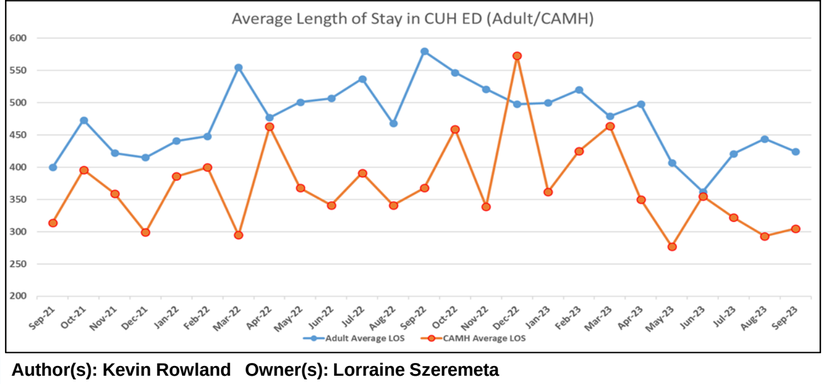
Mental Health - Q2 2023/24 (September)

Cambridge University Hospitals NHS Foundation Trust









End Q2 2023/24 (September)

- The number of patients detained at CUH in Q2 23/24 showed a 25.6% increase on Q1 23/24. Q2 data point falls only marginally under the upper control line.
- The number of patients detained at CUH in Q2 23/24 shows an increase of 43% when compared to Q2 22/23.
- The use of Section 5.2 of the Mental Health Act (MHA) has increased by 46% when compared to Q1.
- Despite unavailability of the Section136 suite, the number of Section136 presentations to CUH ED have reduced in Q2 by 16% compared to Q1.
- 72% of Section 136 MHA were rescinded on assessment in Q2.
- 47% of those detained on Section 5(2) were discharged from section following a psychiatric review in Q2.
- The numbers of patients brought to the emergency department in Q2 has shown the fourth quarterly increase, though remains within expected data control lines.
- CAMHS average length of stay remains lower than that of adults, likely through prioritisation of children and where vulnerable, are more likely to be admitted to an acute ward for their wellbeing and safeguarding.
- The CUH ED presentation/admission conversion rate for adults has remained statistically consistent.
- The CUH ED presentation/admission conversation rate for children has shown a sustained reduction through Q2 23/24.
- There were 24 delayed transfers of care to mental health inpatient care, with 91lost bed days in Q2.

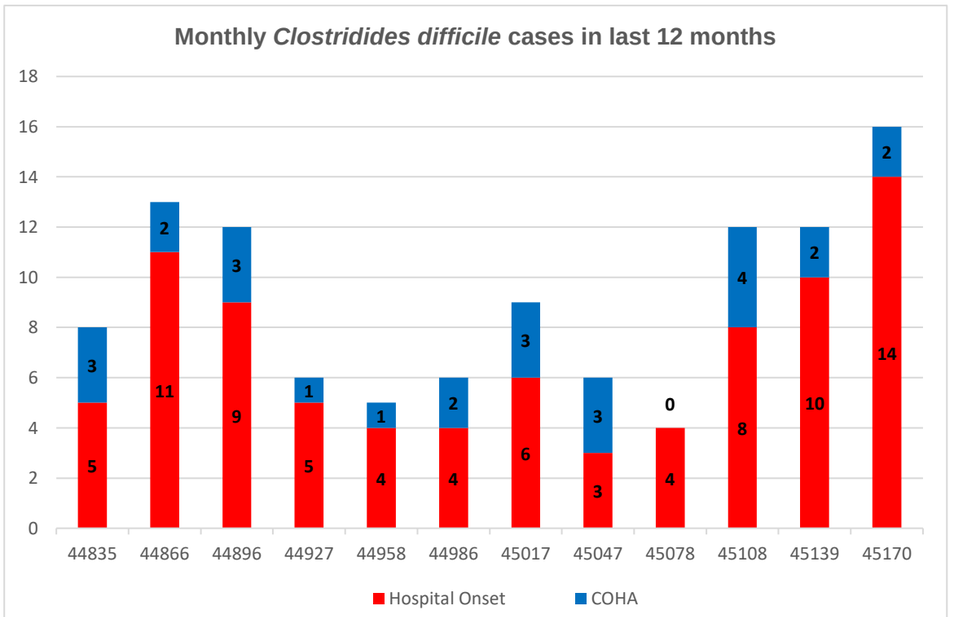
Ongoing work:

- A working sub group for the new gastroenterology ward U2 has been established with a focus on patient safety, including ligature risk management, and also ensuring the ward meets the needs of those patients with a severe eating disorder.
- Continued engagement with system review of Section 136 MHA pathways and prioritisation of implementation changes.
- Continued CUH engagement with Cambridgeshire Constabulary (CC) with Right Care, Right Person programme. Working group members have been identified for future groups
- Missing/AWOL Patients
- Section 136 MHA
- Conveyance of persons under Section 136 MHA
- Creation of new 'CUH Mental Health Patients Acute Bed Pathways, Bed Finding and Escalation Process Guidance' document. Created from collaborative working with partners, outlining pathways, processes and responsibilities.
- New Mental Health Training day for CUH clinical staff being developed which will include
- Mental Health Awareness, including an understanding as to why patients may attend CUH and what resources are available within the hospital and in the community
- Handling Conflict, difficult conversations and specialling
- Management of Eating disorder
- Management of the Mental Health Act and Mental Capacity Act
- Emotional labour and resilience

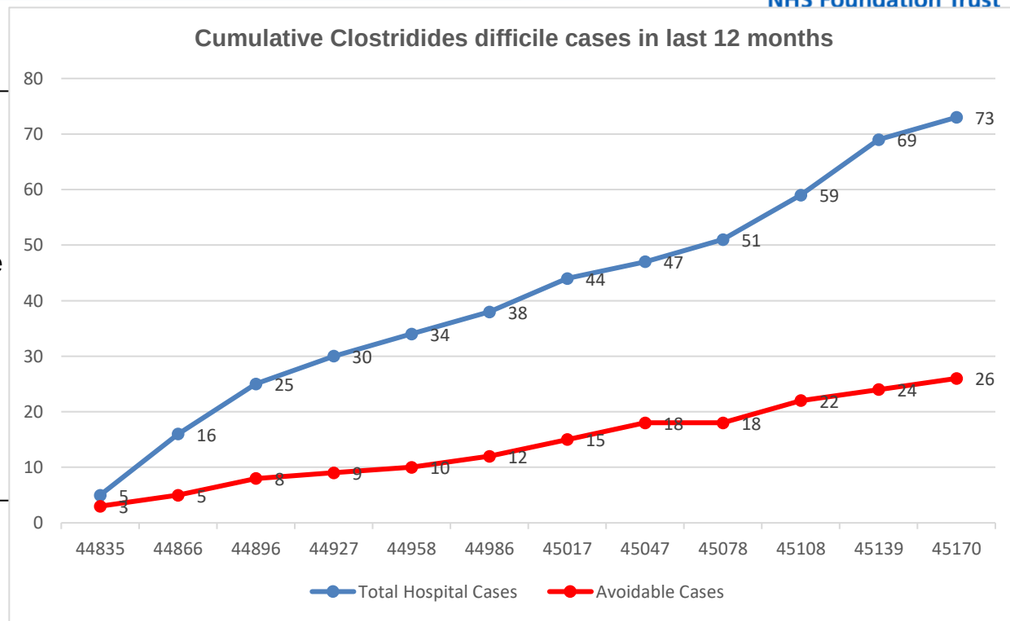
Author(s): Kevin Rowland Owner(s): Lorraine Szeremeta

Infection Control

Cambridge University Hospitals NHS Foundation Trust



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



CUH trend analysis

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

- 0 case of hospital onset MRSA bacteraemia in September 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*.

- 6 cases of hospital onset *C difficile* and 3 cases of COHA in September 2023.
- 31 hospital onset cases and 12 COHA cases year to date

4HR Performance

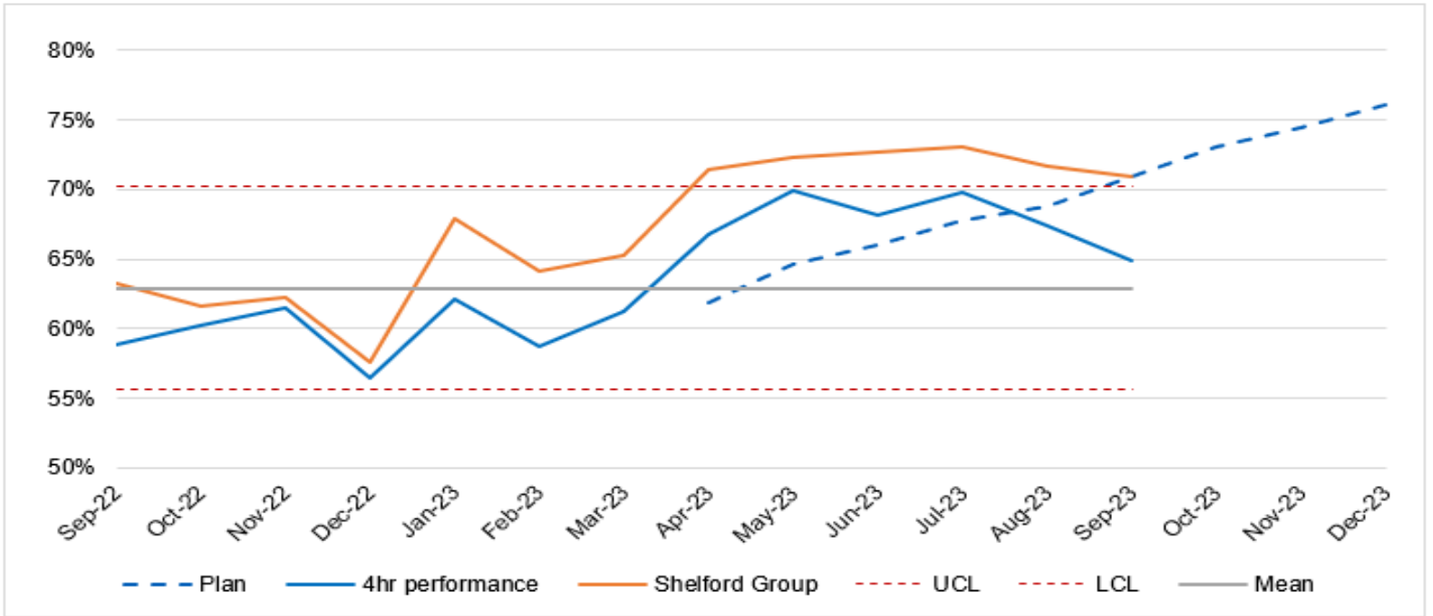
NHS
Cambridge University Hospitals
NHS Foundation Trust

Sep-23	Plan
64.9%	71.0%

SPC Variance
Normal variation

Shelford Group Avg (Aug-23)
71.6%

Three Month Trajectory		
Oct-23	Nov-23	Dec-23
73.1%	74.4%	76.1%



Highest breaches by specialty

Specialty	Performance	4hr Breaches
Emergency	59.0%	2,031
Medicine	27.7%	1,745
Paediatrics	40.8%	273
Surgery	28.6%	270
Orthopaedics	20.9%	227

Updates since previous month

4hr performance has increased to 64.9% compared to 59.4% in September 2022 despite a year-on-year increase in attendances of 7%. CUH remains in 81st position nationally, unchanged since August, reflecting the overall downward trend in national performance month-on-month.

Current issues

Outflow from the Emergency Department remains a significant issue during October due to high levels of in-patient occupancy. Work is on-going to improve length of stay, with a significant reduction seen in September, alongside on-going interventions such as reverse boarding and increasing the use of the discharge lounge.

Key dependencies

4hr performance is dependent on ED attendance levels, processing power within the department and optimised outflow into in-patient capacity.

Future actions

A detailed action plan is in place, based on the recent review of Emergency Department staffing levels and focuses on improving the management of rotas and removing variation, improving productivity in the UTC and closing the residual staffing gap identified by the review.

Ambulance Handovers > 60 minutes

NHS Cambridge University Hospitals NHS Foundation Trust

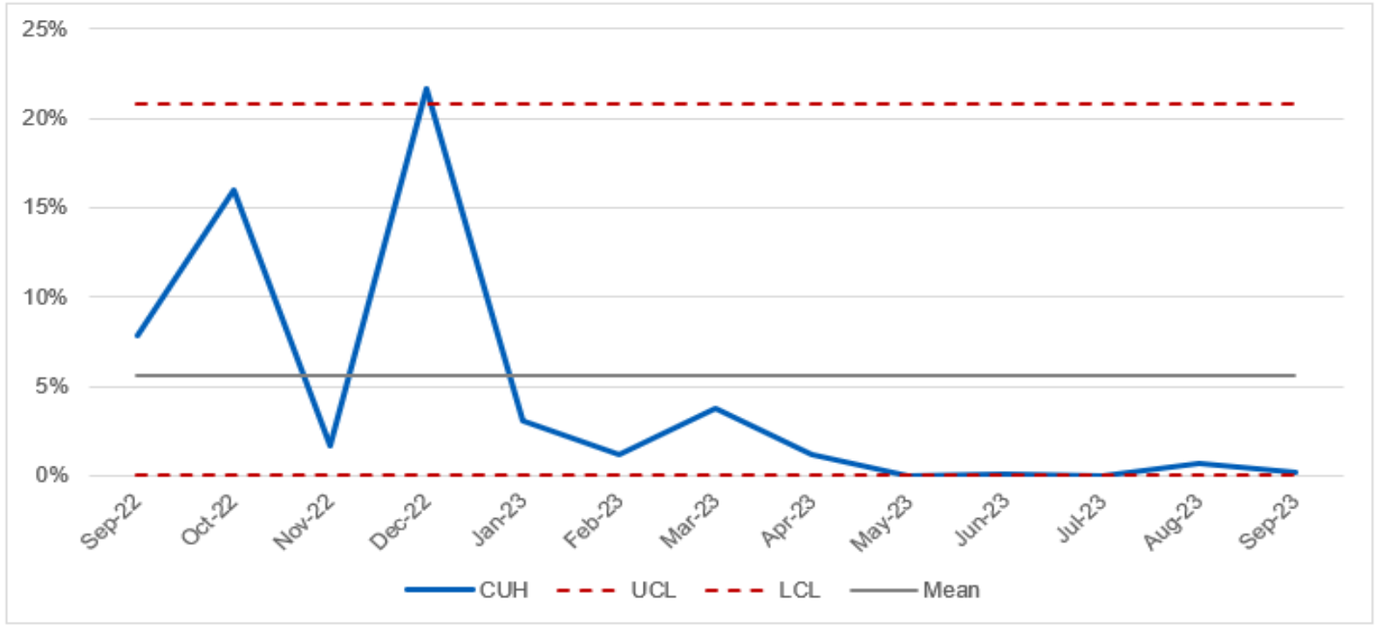
Sep-23	Target
0.24%	0

SPC Variance

Positive special cause variation

East of England > 60 minutes

Trust	% > 60mins
CUH	0%
Bedford	2%
Basildon	3%
Southend	3%
Hinchingbrooke	4%
Watford	4%
Colchester	4%
West Suffolk	4%
Milton Keynes	6%
Broomfield	6%
Peterborough	10%
Ipswich	11%
L&D	12%
Papworth	19%
Lister	22%
PAH	27%
James Paget	33%
QEH	33%
N&N	38%



Updates since previous month

CUH retained its position as the top-performing trust in the East of England for ambulance handover >60mins during September. The significant improvement in handover performance has been sustained since January 2023. By comparison, 8% of handovers took >60mins in September 2022.

Current issues

Crowding in the department due to lack of outflow to in-patient beds has impacted our ability to offload ambulance during October. In the October month to date our >60min handover performance increased to 2%.

Key dependencies

Handover performance is dependent on there being sufficient appropriate capacity within the Emergency Department to offload patients quickly. Handovers are also supported by the presence of a Hospital Ambulance Liaison Officer employed by the Ambulance Service to coordinate patient transfers.

Future actions

The Trust is working on a number of measures to support outflow from ED and reduce crowding, in addition to preserving rapid handover spaces to support the rapid offload of patients. It should be noted that our performance against >15min and >30min handovers both met the national target during September.

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

Overall fit test compliance for substantive staff

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%	248	146	59%	67	35	52%	129	69	53%	92	46	50%	94	42	45%	631	338	54%
Allied Health Professionals	-	-	-	56	23	41%	17	3	18%	1	1	100%	-	-	-	3	1	33%	77	28	36%
Estates and Ancillary (Porters and Security Personnel only)	115	71	62%	-	-	-	-	-	-	-	-	-	-	-	-	1	0	0%	116	71	61%
Medical and Dental	-	-	-	252	66	26%	-	-	-	189	78	41%	140	14	10%	225	66	29%	806	224	28%
Nursing and Midwifery Registered	1	0	0%	667	477	72%	4	2	50%	275	168	61%	156	99	63%	375	204	54%	1478	950	64%
Total	117	71	61%	1223	712	58%	88	40	45%	594	316	53%	388	159	41%	698	313	45%	3108	1611	52%

The data displayed as of 10/10/23. 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.

The percentage of mask fit testing in priority areas remains at 52%. The focus for mask fit testing remains among medical staff and allied health professionals due to ongoing low compliance .

Referral to Treatment > 65 weeks and > 78 weeks

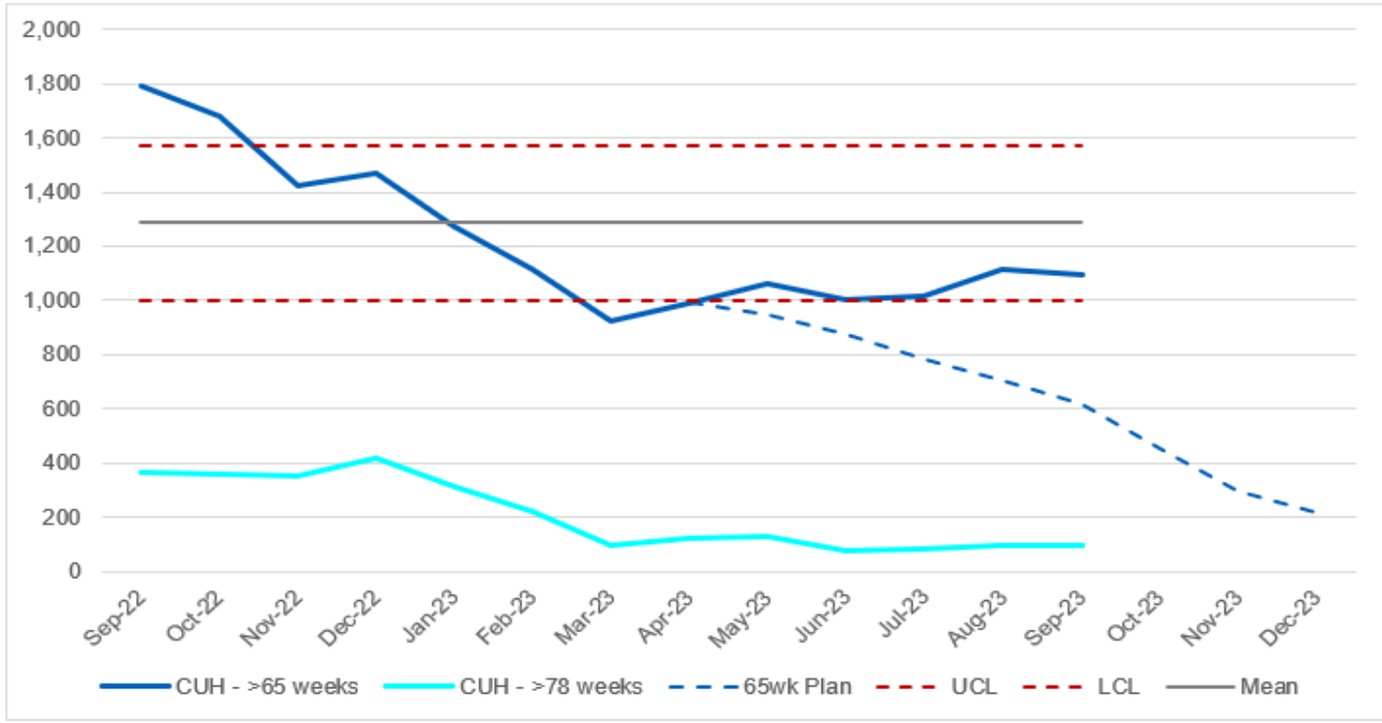
NHS
Cambridge University Hospitals
NHS Foundation Trust

65+ Weeks	
Sep-23	**Plan**
1097	616

SPC Variance
Positive special cause variation

% of WL over 65 weeks (Aug-23)	
CUH	1.76%
Shelford Group	1.80%

Three Month Forecast (65+ wks)		
Oct-23	**Nov-23**	**Dec-23**
456	296	220



Divisional Performance		
Division	**65+ weeks**	**78+ weeks**
A	207	13
B	113	8
C	31	1
D	595	73
E	151	4
Trust	**1,097**	**99**

Updates since previous month

* >78 week waits stable at 99 in September despite Industrial action. ENT accounted for 23, OMFS 17.
* >65 weeks decreased by 20, but now 481 adverse to plan to eradicate by March 2024.

Current issues

* Industrial action continues to impact progress with long wait reductions, however CUH is limiting a deterioration in long waits compared to the rate of growth nationally

Key dependencies

* Theatre capacity (Surgical Hub delayed)
* Recruitment to medical workforce vacancies
* Independent sector for ENT
* Continuation of insourcing OMFS to year end
* Commencement of Gynaecology insourcing

Future actions

* 65 week year end has been re-profiled given the impact of Industrial action. Forecast ~800>65 weeks. ENT and Gynaecology highest risk.
* Patient choice for alternative providers going live 31st October for patients waiting over 40 weeks.

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

Referral to Treatment Total Waiting List

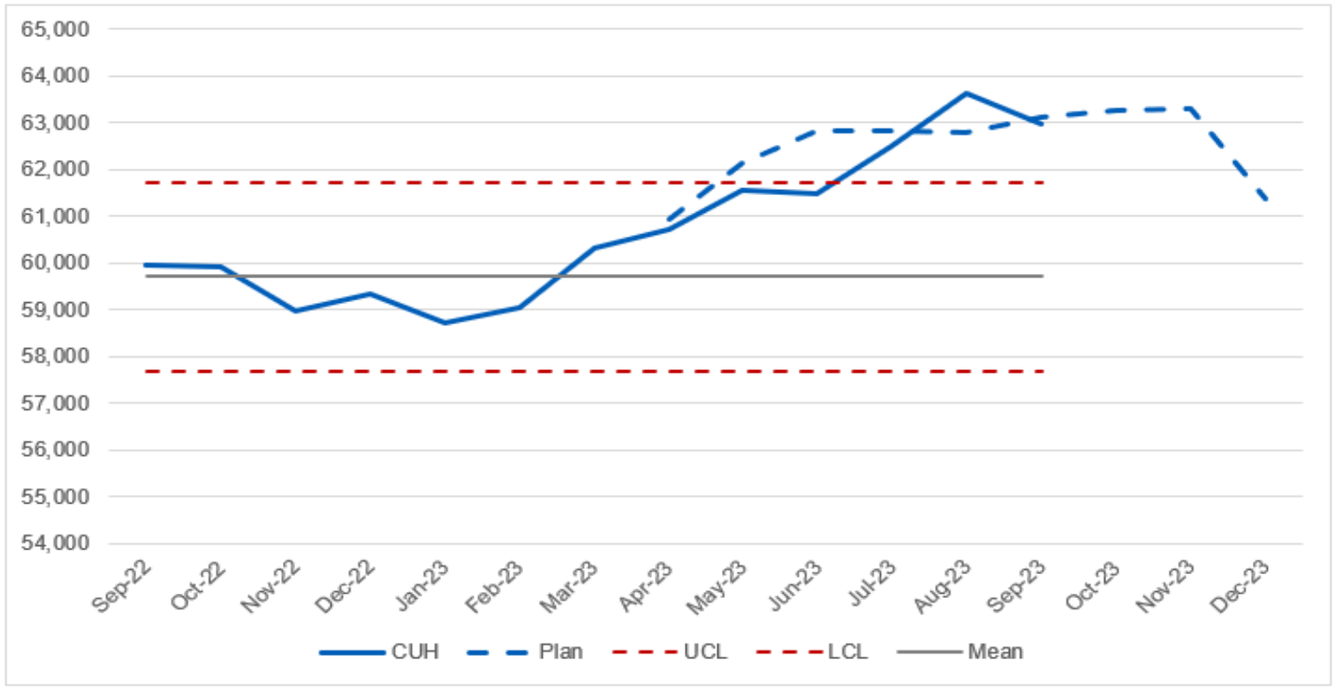
NHS
Cambridge University Hospitals
NHS Foundation Trust

Sep-23	Plan
62,964	63,102

SPC Variance
Negative special cause variation

Change in WL: Aug-23 vs. Jul-23	
CUH	+1.80%
Shelford Group	+0.49%

Three Month Forecast		
Oct-23	Nov-23	Dec-23
63,242	63,282	61,358



Waiting list by division

Division	Total Waiting List
A	12,881
B	6,015
C	4,759
D	29,540
E	9,764
Other	5
Trust	**62,964**

Updates since previous month

* Total RTT waiting list decreased by 1% in month.
* The total waiting list size is back within the planning submission for month 6.
* Clock starts are cumulatively 2.9% below plan year to date and were 5% below the month 6 plan.

Current issues

* Total stops (treatments) were on plan in September despite Industrial action, with higher non-admitted stops compensating for low admitted performance.
* The estimated lost clock stops due to Industrial action were ~490.

Key dependencies

* Demand (clock starts) remains within plan
* Outpatient and elective activity plans are met
* Resilience in administrative and clinical capacity to support pathway validation.

Future actions

* Waiting list reduction in month has been led by the non-admitted cohort.
* Rolling waiting list validation at 12 weeks is yielding a 7% removal rate.
* Continued drive to release capacity for new outpatients. 63% continue to await 1st appointment.

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

Cancer - 28 day faster diagnosis standard

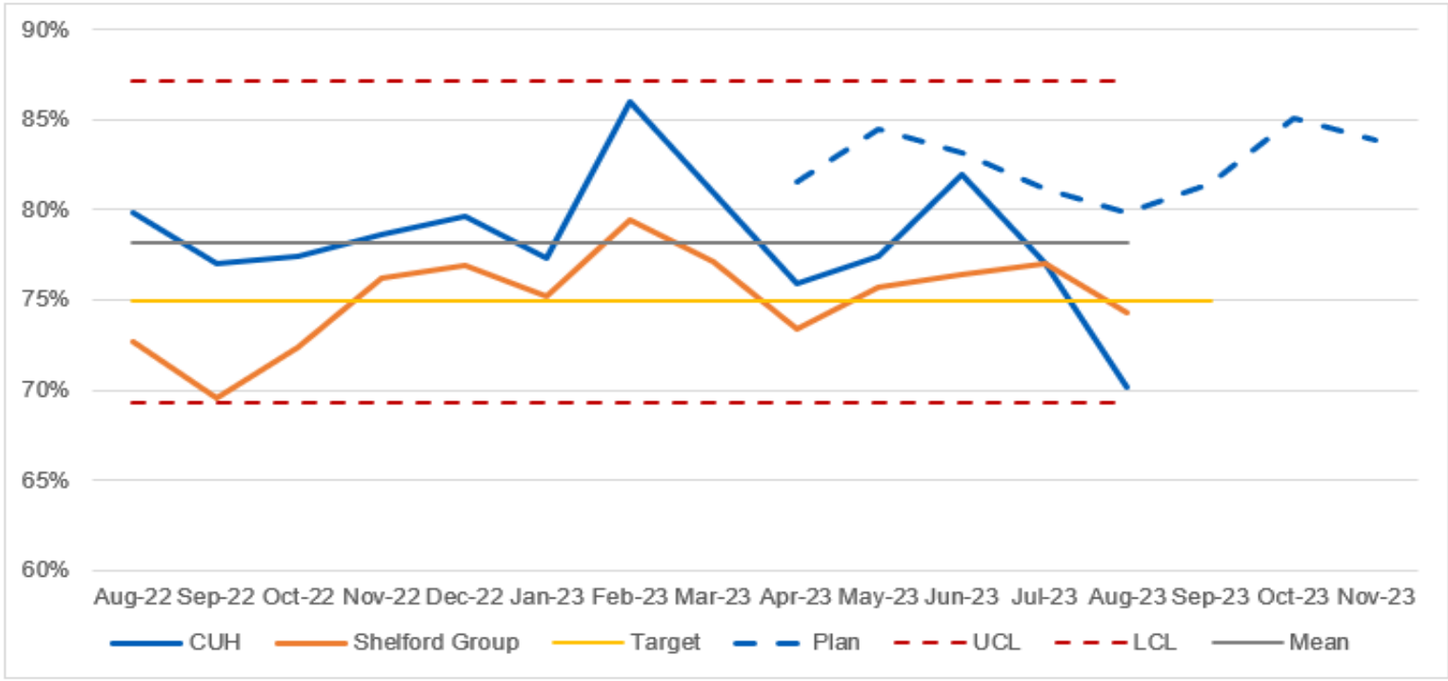
NHS
Cambridge University Hospitals
NHS Foundation Trust

Aug-23	Target
70.1%	75.0%

SPC Variance
Normal variation

Shelford Group Avg (Aug-23)
74.3%

Three Month Forecast		
Sep-23	Oct-23	Nov-23
81.4%	85.1%	83.9%



Cancer Site Overview

Site	Performance	Breaches
Skin	35.6%	335
Lower GI	78.2%	67
Gynaecological	52.1%	113
Head & Neck	72.3%	57
Urological	70.7%	46
Breast	96.2%	23
Haematological	38.5%	8
Sarcoma	43.8%	9
Upper GI	78.6%	6
Lung	97.8%	2
Childrens	94.4%	1
CNS/Brain	92.0%	2
Testicular	87.5%	1
Total	**70.1%**	**670**

Updates since previous month

CUH has fallen below target for the first time since the FDS standard commenced. This is due to the deterioration in Skin performance down to 35.6%. Delays within the skin pathway have increased following exceptional demand in June and insufficient capacity to recover the resulting backlog.

Current issues

Delays to 1st appointment in skin cancer, and pathology turn around times continue to impact performance across all sites. We forecast the Skin delays will result in below target performance from August to November based on the recovery plan in place for skin.

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 and pathology. System meeting with GIRFT team to focus on FDS performance in September was delayed until 31.10.23

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

Cancer - 2 week waits

NHS
Cambridge University Hospitals
NHS Foundation Trust

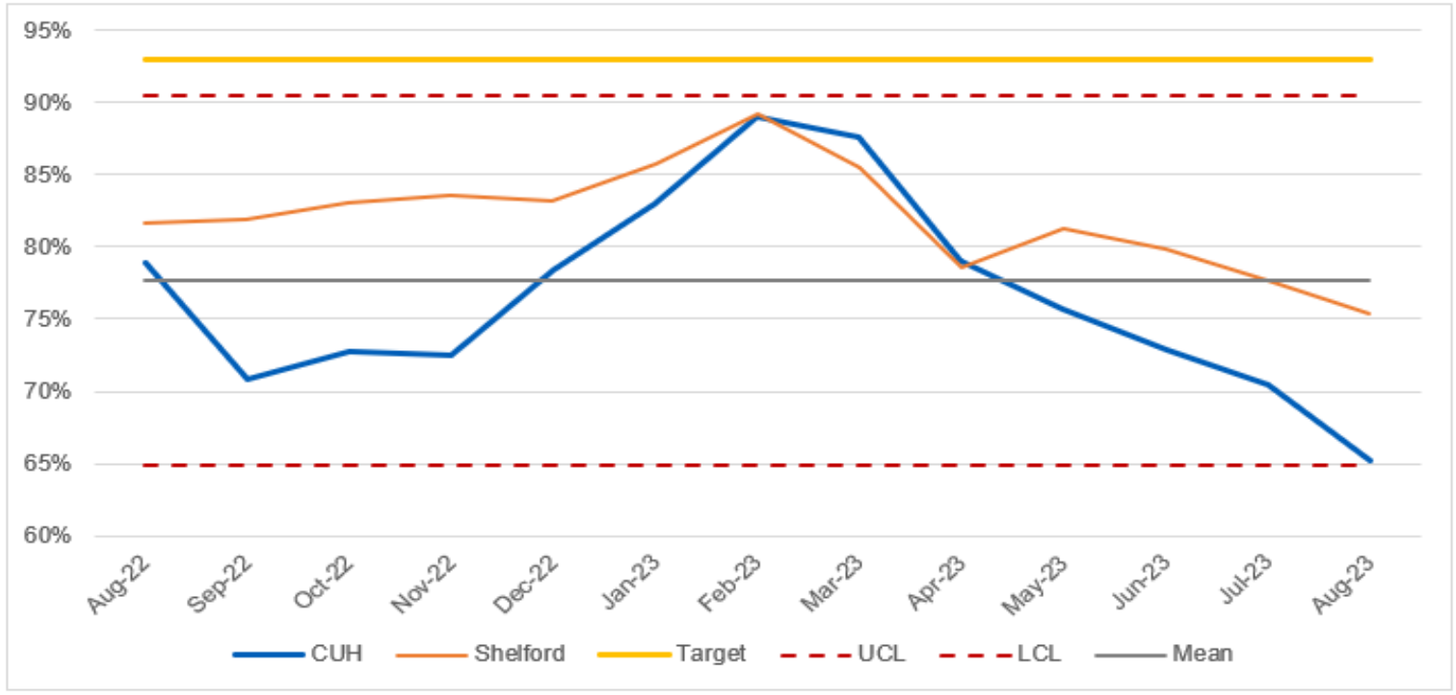
Aug-23	Target
65.2%	93.0%

SPC Variance

Negative special cause variation

Shelford Group Avg (Aug-23)

75.4%



Cancer Site Overview as of 24/10/2023

Site	Breaches
Skin	289
Gynaecological	7
Breast	10
Head & Neck	6
Lower GI	2
Sarcoma	3
Lung	0
Urological	0
CNS/Brain	1
Haematological	0
Upper GI	0
All	**318**

Updates since previous month

CUH has experienced further deterioration in performance against the 2WW target due to breaches in the skin cancer pathway. Referral demand remains average across the board however it is higher than pre covid particularly for sites such as skin.
2WW will no longer be monitored from October 2023

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. A recovery plan is in place with additional capacity from October.

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 Consultant
- Increased capacity in clinical fellow clinics.

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

Cancer - 31 days decision to treat to treatment

NHS
Cambridge University Hospitals
NHS Foundation Trust

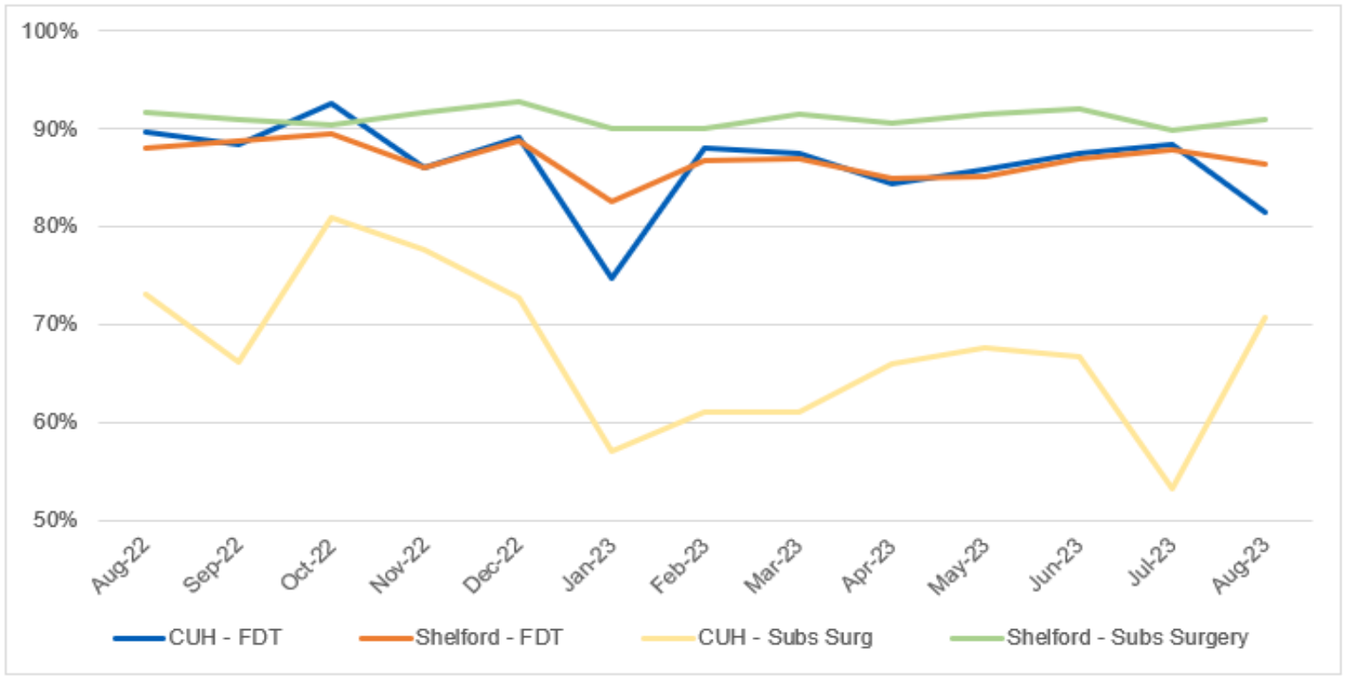
	Aug-23	Target
FDT	81.4%	96.0%
Subs Surgery	70.7%	94.0%

SPC Variance
Normal variation

Shelford Group Avg (Aug-23)	
FDT	86.4%
Subs Surgery	90.9%

Cancer Site Overview as of 19/09/2023

Site	Backlog
Breast	8
CNS/Brain	1
Gynaecological	4
Head & Neck	4
Haematological	0
HPB	4
Lower GI	9
Lung	0
Childrens	0
Sarcoma	0
Skin	17
Testicular	0
Upper GI	1
Urological	15
All	63



Updates since previous month

CUH continues to fall below target with 83% of the breaches in August relating to surgical capacity, the sites with the largest breaches are in Skin (33%), Prostate (20%), HPB (15%). Prostate have cleared their surgical backlog and from October are able to book within 31 days, prostate brachytherapy still remains below target .

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, and kidney surgery in October/November.
Continue to explore additional internal options for renal surgery.
Additional treatment capacity for skin has been agreed from October with additional cancer alliance funding.

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

Cancer - 62 days urgent referral to treatment

NHS
Cambridge University Hospitals
NHS Foundation Trust

Aug-23	Target
70.0%	85.0%

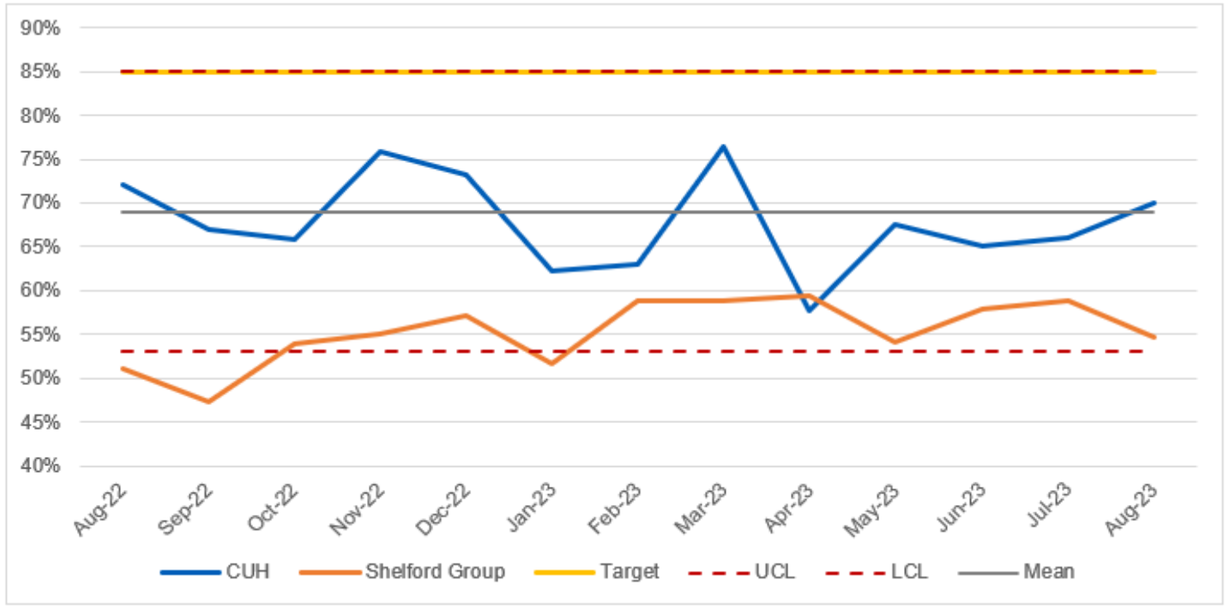
SPC Variance
Normal variation

Shelford Group Avg (Aug-23)
54.7%

Cancer Site Overview as of 19/09/2023

Site	Backlog
Breast	5
CNS/Brain	0
Gynaecological	15
Head & Neck	11
Other Haem Malignancies	3
Lower GI	19
Lung	2
NSS	1
Upper GI	5
Urological	26
Sarcoma	4
Skin	70
HPB	6
Childrens	0
Symptomatic Breast	0
All	*167*

Forecast backlog in Jul-23



Updates since previous month

CUH performance remains below target although is higher than the Shelford Group. 62% of breaches are CUH only patients and of that 85% were due to delays within CUH control such as delayed pathology reporting, outpatient and surgical capacity. 44% of referrals to CUH from regional hospitals were treated in the required 24 days.

Current issues

- Delays in pathology turn around times (currently at 20% within 7 days)
- Outpatient and surgical capacity
- Further impact of industrial action
- delays to diagnosis due to capacity (skin) resulting in adverse backlog recovery

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 31st December - this will impact performance from November. Urology have already seen an improvement in backlog which will result in improved performance.

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

Diagnostic Performance

NHS
Cambridge University Hospitals
NHS Foundation Trust

Sep-23	Plan
36.4%	27.3%

SPC Variance

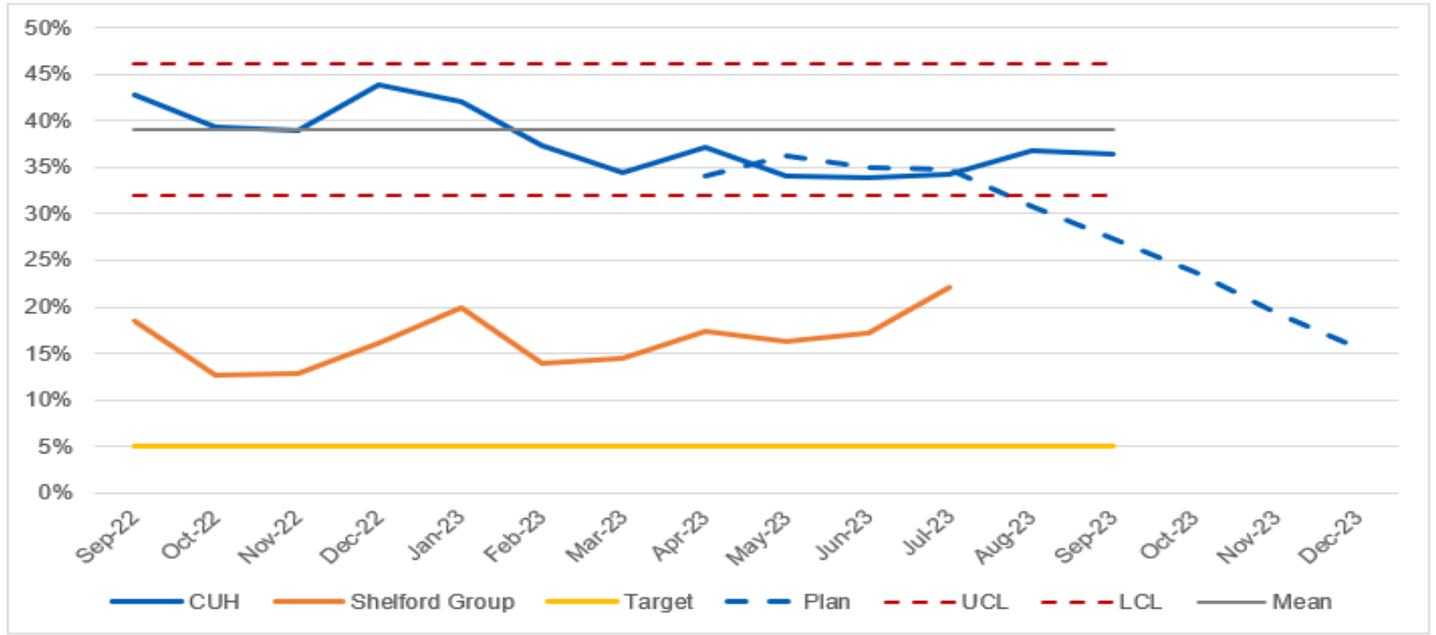
Positive special cause variation

Shelford Group Avg (Jul-23)

22.0%

Three Month Forecast

Oct-23	Nov-23	Dec-23
23.7%	19.3%	15.5%



Modality overview

Modality	% >6wks	Breaches
Echocardiography	73.6%	2065
Non obstetric ultrasound	28.3%	743
Audiology	69.9%	942
Magnetic Resonance Img'	18.3%	373
DEXA Scan	7.9%	52
Computed Tomography	16.4%	160
Urodynamics	62.1%	195
Neurophysiology	9.4%	22
Cystoscopy	10.0%	28
Gastroscopy	5.0%	30
Colonoscopy	0.8%	5
Respiratory physiology	10.4%	5
Barium Enema	16.7%	7
Flexi sigmoidoscopy	2.5%	3
Total		**4630**

Updates since previous month

* September 6wk performance has remained stable at 36.4%, but adverse to be planned improvement by month 6.
* The total waiting list reduced by just 54, with a reduction in >6ww of 82.
* Total activity was however 2% higher than plan, and is cumulatively 4% YTD.

Current issues

* Echo (+71) Audiology (+25) and Urodynamics (+17) deteriorated their 6ww position.
* Echo is 45% of the Trust total > 6 weeks. Current insourcing provider ceases end Nov 23. 20% of activity.
* 52% vacancy rate (10.5 wte) continues for Cardiac Physiologist who deliver the Echo service.

Key dependencies

* Ongoing use of insourcing for Echocardiography, required.
* Agency/locum staffing and enhanced bank rates whilst recruiting.
* Continued delivery of ICB capacity for Direct Access. Community Ultrasound to manage demand

Future actions

* Replacement insourcing provider identified. To be finalised for a Dec 23 start to avoid capacity gap.
* Enhanced bank rates in Echo approved until Jan 24.
* Echo workforce T&F group established. Associated Director of Workforce is Chair.
* Refer a friend scheme introduced.
No candidates via overseas agencies yet. Ongoing.

New Outpatient Attendances - % vs. Baseline

NHS
Cambridge University Hospitals
NHS Foundation Trust

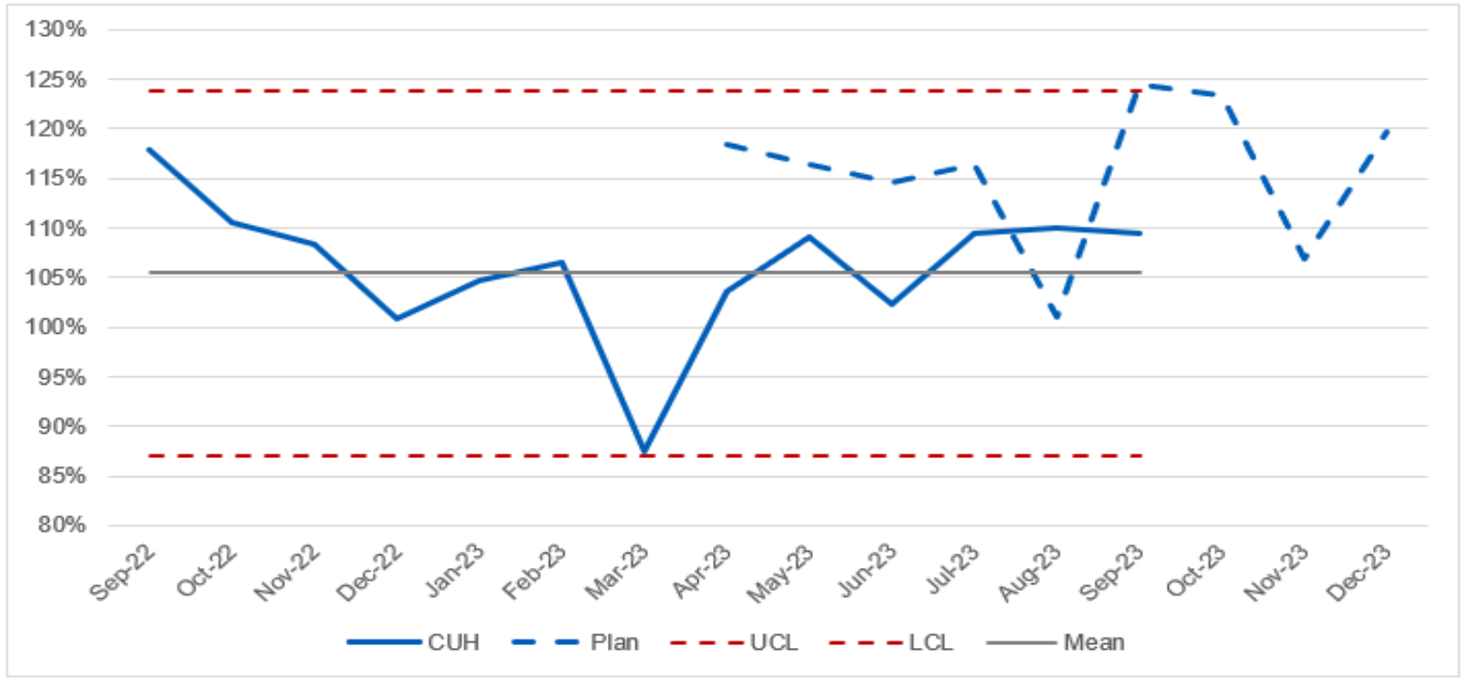
Sep-23	Plan
109.5%	124.5%

SPC Variance
Normal variation

Shelford Group Avg (Sep-23)
N/A

Three Month Forecast

Oct-23	Nov-23	Dec-23
123.3%	106.9%	119.8%



Divisional overview

Division	Performance
A	111.7%
B	106.0%
C	94.7%
D	110.4%
E	105.9%

Updates since previous month

We continue to achieve our initial target of around 110% of new activity, although this remains significantly below plan. Division C remains below 100% but data quality may be contributing to this. We are starting to see sustained falls in waiting list numbers for divisions B and E.

Current issues

Waiting list numbers for continue to rise in division C caused primarily by Respiratory medicine. However, this is a diagnostic clinic and should sit under elective planned patients. This is currently being investigated. This would help the divisional position.

Key dependencies

The opening and of the new surgical hub and recruitment of associated staff, potential in/outsourcing of some services we hope will have some impact but are risks.

Future actions

Continue to push the use of existing tools such as A&G, triage as well as exploring in sourcing further. Continue to build on the implementation of Cinapsis, an electronic ophthalmology referral tool, which allows direct referrals from community optometrists leading to improved quality of referrals.

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

Follow Up Outpatient Attendances - % vs. Baseline

NHS
Cambridge University Hospitals
NHS Foundation Trust

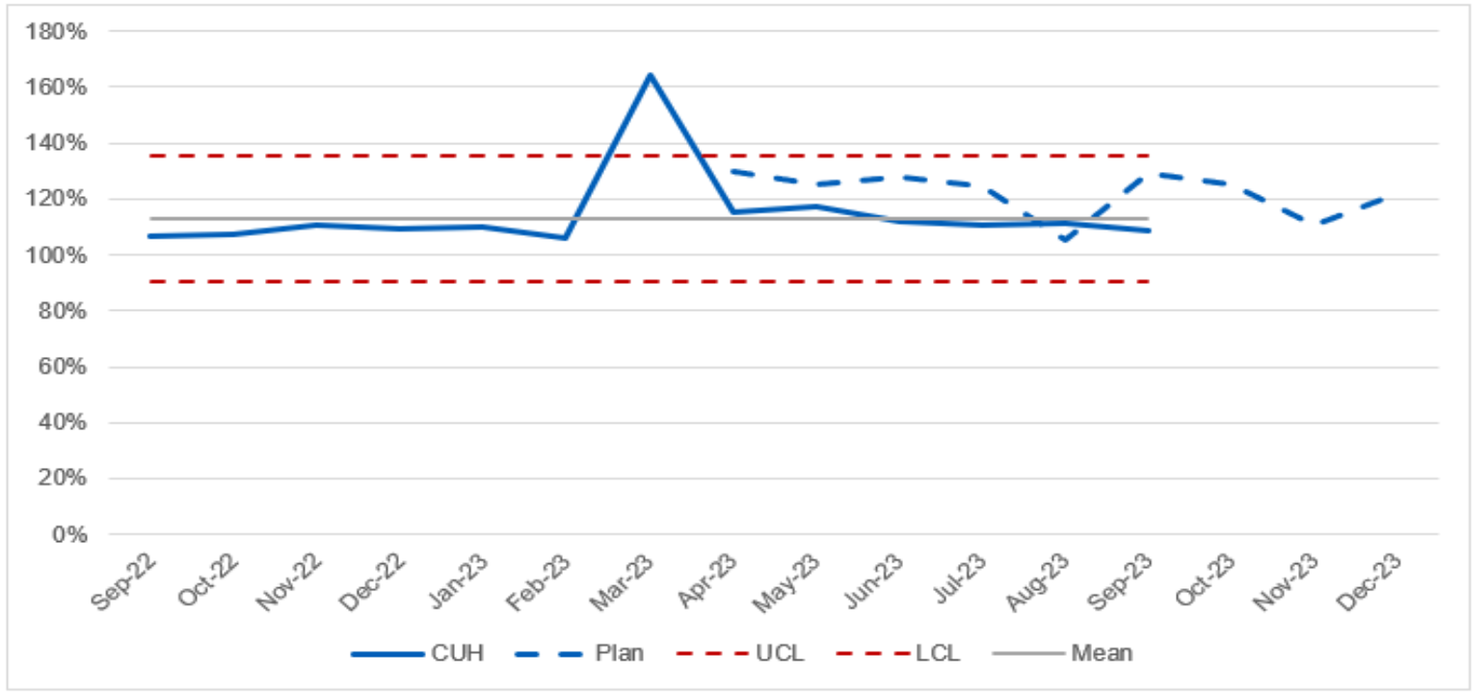
Sep-23	Plan
108.8%	129.0%

SPC Variance
Normal variation

Shelford Group Avg (Sep-23)
N/A

Three Month Forecast

Oct-23	Nov-23	Dec-23
125.4%	110.8%	122.0%



Divisional overview

Division	Performance
A	108.9%
B	99.1%
C	109.2%
D	108.3%
E	140.4%

Updates since previous month

F/U activity has increased remaining above the 105% target for end September. An in-depth look at numbers suggests some increase is driven by non-consultant FUs which were not recorded in 2019/20, now being recorded. The national target is to reach 75% by end 2023/24 which is highly unlikely to be met.

Current issues

Overdue Follow-up numbers continue to increase across divisions, some driven by loss of capacity due to IA and others due to long recruitment lead times for clinical staff.

Key dependencies

Increased use of PIFU and the speeding up of the PNP rollout of the biggest dependencies that will have on follow-up numbers.

Future actions

Continue to push services to adopt PNP as well as other pathway changes as advised by GIRFT.

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

PIFU Outpatient Attendances

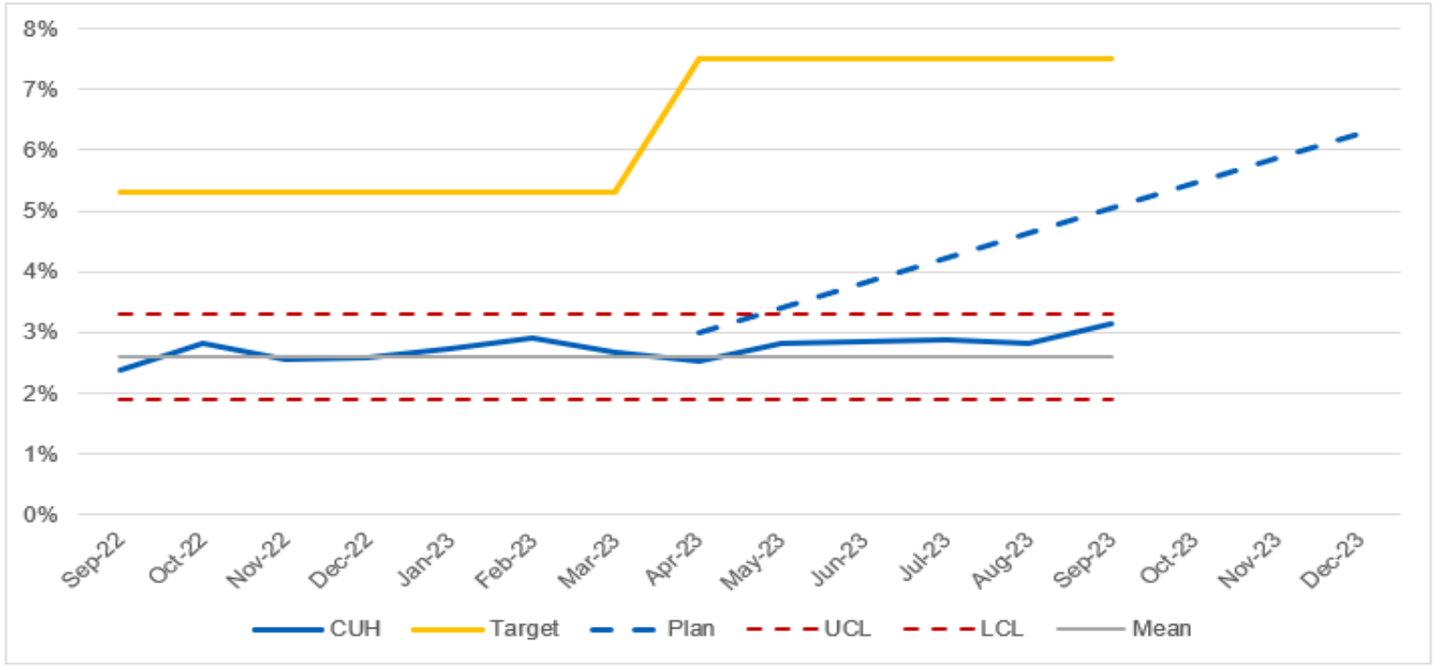
NHS
Cambridge University Hospitals
NHS Foundation Trust

Sep-23	Plan
3.2%	5.0%

SPC Variance
Normal variation

Shelford Group Avg (Sep-23)
N/A

Three Month Forecast		
Oct-23	Nov-23	Dec-23
5.5%	5.9%	6.3%



Divisional overview	
Division	Performance
A	8.0%
B	3.2%
C	2.0%
D	1.9%
E	2.5%

Updates since previous month

There is a consistent overall trend upwards in the use of PIFU but CUH is yet to reach the 5% target - our position as of September 2023 is 3.2%. Division A remains above 5%. The remaining divisions continue with an upward trajectory but are not yet near 5%.

Current issues

None

Key dependencies

Clinical engagement and willingness to adopt new ways of working.

Future actions

Continue to encourage pathway reviews supported by the Improvement and Transformation team.

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

Delayed discharges

NHS
Cambridge University Hospitals
NHS Foundation Trust

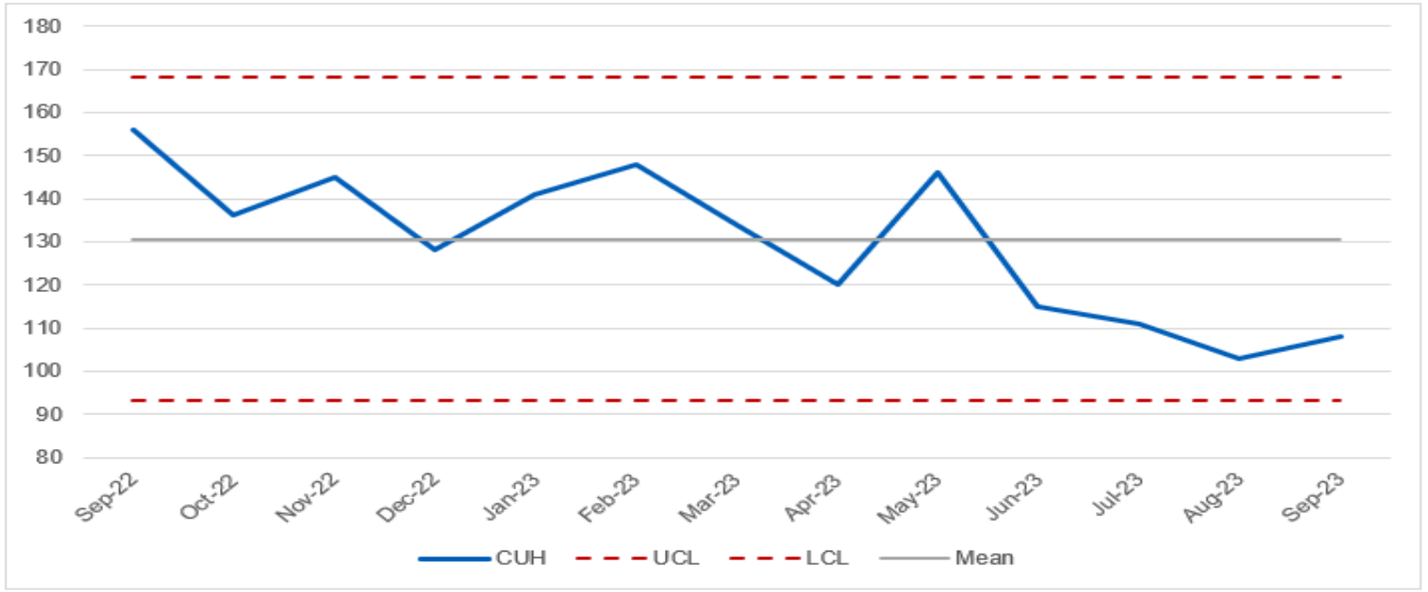
Sep-23	Target
108	N/A

SPC Variance
Normal variation

Shelford Group Avg (Sep-23)
N/A

Beds lost to delays - by pathway

Pathway	Beds lost
Pathway 1	42
Pathway 3	20
Pathway 2	25
Pathway 0	17
Internal Assessments	2
External Assessments	0
Triage	1
Unknown	0
Total	**108**



Updates since previous month

The number of beds lost to patients past their clinically fit date (CFD) increased from 103 to 108 beds between August and September.

Current issues

The highest number of beds is lost to patients on 'pathway 1' (care at home), predominately due to community capacity which is impacted by the availability of care workers.

Key dependencies

Delayed discharges are dependent on prompt referrals being made by CUH ahead of patients' CFDs and the timely actioning and delivery of care packages by community providers.

Future actions

There is a continued focus on the reduction of patients waiting >14 days post-CFD to be discharged on pathway 3. The local Transfer of Care Hub is coordinating an additional focus from system partners on the provision of intermediate care for patients awaiting longer-term packages of care.

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

Theatre Utilisation - Elective GIRFT Capped

NHS
Cambridge University Hospitals
NHS Foundation Trust

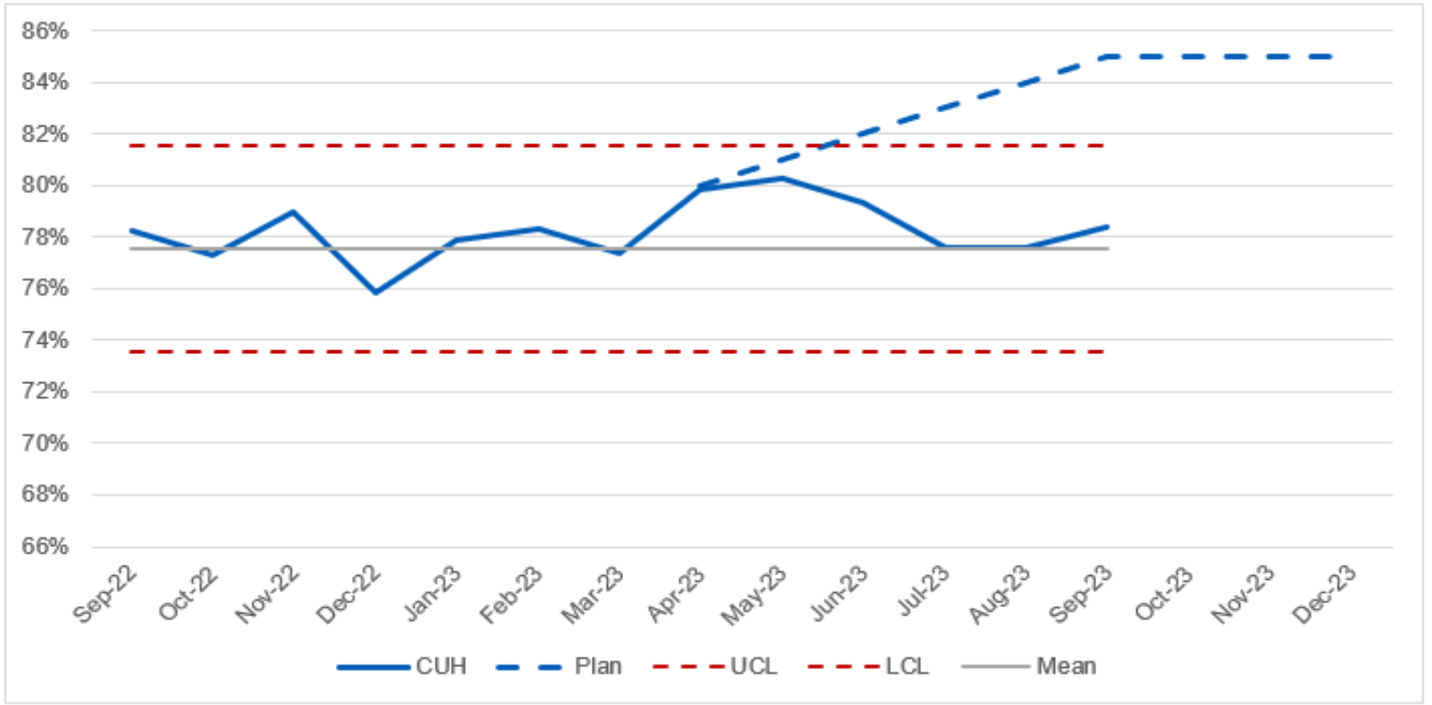
Sep-23	Plan
78.4%	85.0%

SPC Variance
Normal variation

Performance in the 2 weeks to 24/09/2023	
CUH	79.0%
Shelford Grp Median	74.5%

Three Month Forecast		
Oct-23	Nov-23	Dec-23
85.0%	85.0%	85.0%

Utilisation by department	
Department	Utilisation
ATC	80.3%
Main	79.4%
Rosie	82.1%
CEU	67.8%
Ely	71.3%
All	**78.4%**



Updates since previous month

* Utilisation at 78.4% (Quartile 4) and remains above peers and National median.
* Sessions used were high at 92.5%, and up to 97.4% when Industrial action dates are excluded.

Current issues

* Five specialities achieved over 85% utilisation in month. Eight were below 70% with Paed Surgery and Ophthalmology being most notable given volume.
* Short notice cancellations were highest YTD at 303.

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 6-4-1 oversight.

Future actions

* Delays in post-operative bed confirmation is sighted as a factor in delayed starts and increased turnaround times. Emergency length of stay should remain a focus of all Surgical Divisions.
* Ophthalmology delivered first 10 cataract HVLC session

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

BADS Daycase Rates

NHS
Cambridge University Hospitals
NHS Foundation Trust

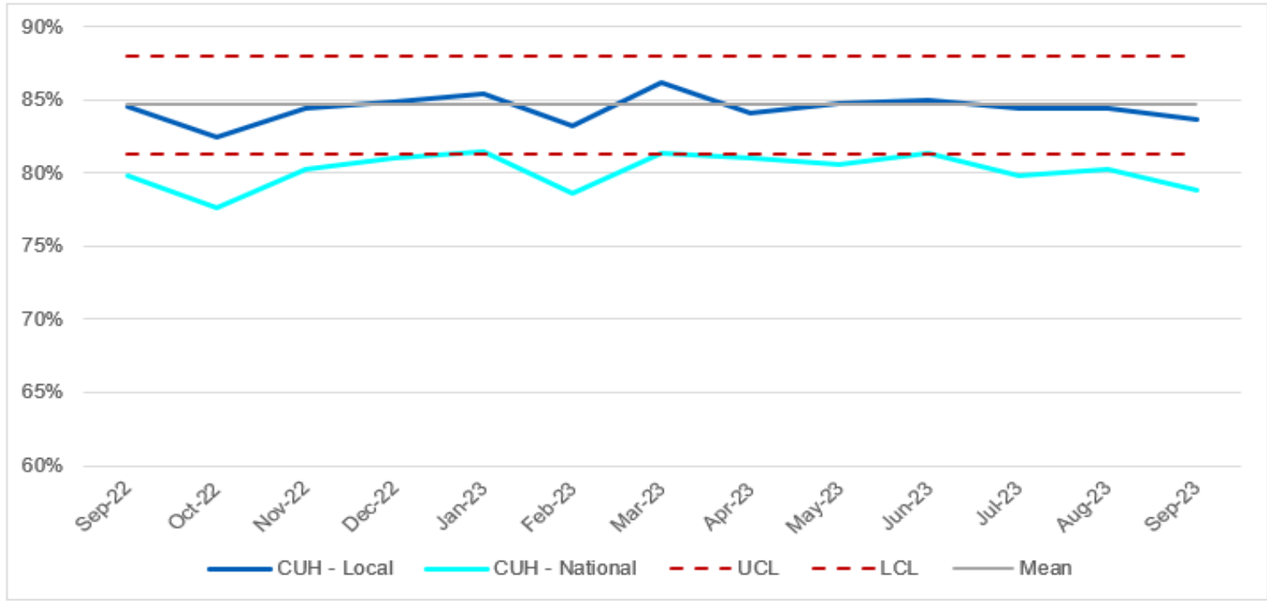
Sep-23	Target
83.7%	N/A

SPC Variance
Normal variation

Shelford Grp Median 3m to end of Jun '23
77.3%

BADS Section Day Case Rate for HVLC focus areas

	3 months to end of Jun '23			Sep-23
Specialty	**CUH**	**Shelford**	**Quartile**	**Local**
Orthopaedics	83.9%	81.3%	2	90.8%
ENT	67.6%	80.6%	1	76.5%
General	65.0%	66.0%	1	78.5%
Gynaecology	56.3%	64.1%	1	64.7%
Ophthalmology	98.9%	98.0%	2	99.6%
Urology	68.5%	68.7%	3	63.6%



Updates since previous month

* Model Hospital GIRFT data for Q1 2023/23 still shows performance in quartile 2.
* Local BADS reporting for zero LOS shows a reduction in September to 83.7%

Current issues

* Inaccurate recording of Intended Management. 43 zero LOS BADS procedures were recorded as inpatient intended management in September.
* Urology day case rate deteriorated in month and were 315 of the >0 LOS.

Key dependencies

* Correct data recording of Intended Management
* Effective patient flow on L2 daycase/23 hr stay
* Clinically led discharge criteria
* Timing of cases on Theatre list

Future actions

* Urology deep dive requested for next Surgery Programme Board

Incorrect intended management being circulated to specialties each month to encourage correct use at listing.

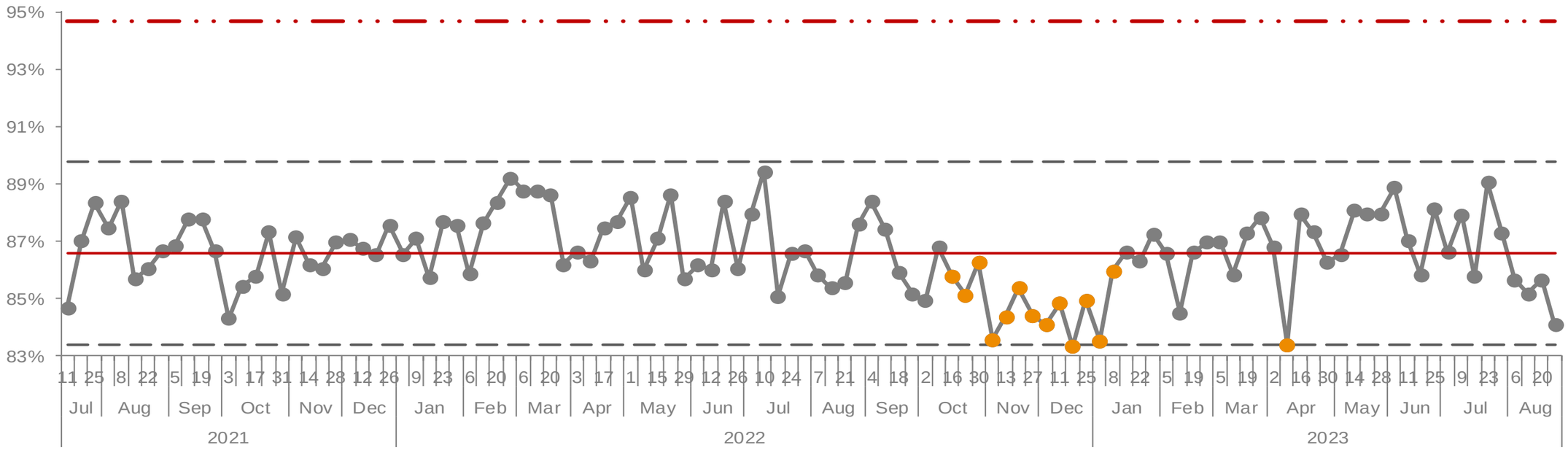
Author(s): Linda Clarke **Owner(s): Nicola Ayton**

Discharge Summaries

Cambridge University Hospitals NHS Foundation Trust

Discharge Summary Letters (Weekly)

Percent of discharge summaries sent in under 2 days



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 - Sep 23	Month	-	93.7%	95.3%	L	S7	-	For September the Good score increased by 1.7%, and after the dip to 92% in August, is now close to April and May scores of 94%. There was no change in the Poor score of 3.3%, which has been fairly consistent, except for July's score of a low 1.6%. **FOR SEP: there were 363 FFT responses collected from approx. 4251 patients.**
FFT Inpatient poor experience score	Jul 20 - Sep 23	Month	-	3.3%	1.8%		-	-	
FFT Outpatients good experience score	Apr 20 - Sep 23	Month	-	93.5%	94.9%	L	SP	-	For September, the Good and Poor scores remained the same compared to July and August. There were 8 FFT paediatric responses so the FFT scores mainly reflect adult clinics. **FOR SEP: there were 4897 FFT responses collected from approx. 28,891 patients.** The SPC icons shows special cause variations: high is a concern with having more than 7 consecutive months below/above the mean / low is a concern.
FFT Outpatients poor experience score	Apr 20 - Sep 23	Month	-	3.0%	2.4%	H	S7	-	
FFT Day Case good experience score	Apr 20 - Sep 23	Month	-	96.5%	96.5%		-	-	For September there was a 0.5% increase in the Good score, and the Poor score decreased by 1% compared to August. Both scores now match May scores, and are the best for the year. **FOR SEP: there were 1136 FFT responses collected from approx. 4,315 patients.**
FFT Day Case poor experience score	Apr 20 - Sep 23	Month	-	1.5%	1.7%		-	-	
FFT Emergency Department good experience score	Apr 20 - Sep 23	Month	-	79.7%	83.0%		-	-	For September the overall Good score decreased by 1% and is now the second lowest score for the year. The Poor score increased by 1.5% and 12.7% is the highest for the year. Both the adult and paeds Good score decreased, with the paeds score almost a 3% decline compared to August. Both the adult and a paeds Poor scores increased by 2% each. **FOR SEP: there were 896 FFT responses collected from approx. 5,273 patients**.
FFT Emergency Department poor experience score	Apr 20 - Sep 23	Month	-	12.7%	10.4%		-	-	
FFT Maternity (all FFT data from 4 touchpoints) good experience score	Jul 20 - Sep 23	Month	-	90.1%	94.9%		-	-	**FOR SEP:** Antenatal had 4 FFT response - 100% Good; Birth had 40 FFT responses out of 433 patients - 95% Good / 0% Poor; Postnatal had 47 FFT responses: LM had 5 FFT (the lowest for the year, compared to 86 in Apr) with 20% Good / 60% Poor, DU had 0 FFT, BU had 34 FFT with 91.2% Good / 6% Poor, and COU 100% Good from 8 responses. 0 FFT responses from Post Community. SEP **MATERNITY OVERALL:** Good score decreased by 3% and Poor score increased by 1.5% from 91 FFT responses.
FFT Maternity (all FFT data from 4 touchpoints) poor experience score	Jul 20 - Sep 23	Month	-	5.5%	1.9%	H	SP	-	

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 September 12 wards did not collect any FFT data.

Overall FFT in September, there was a mix of FFT scores. The two improved Good scores are inpatient Good score by 1.7%, and the day case Good score by 0.5%. The only Poor score that improved in September is the day case score of 1.5%, a 1% decline. There was no change in the Good and Poor scores for outpatients. The overall A&E Good score declined by 1% and the Poor score increased by 1.5%. This is from both adult and paediatric performance. Maternity Good score in September was 90%, a 10% decline compared to July, and is now the lowest Good score for the past 12 months. The maternity Poor score is 5.5%, a 4% increase compared to July, and is the highest Poor score for over 18 months. The declined maternity FFT scores are from both Birth and Postnatal performance.

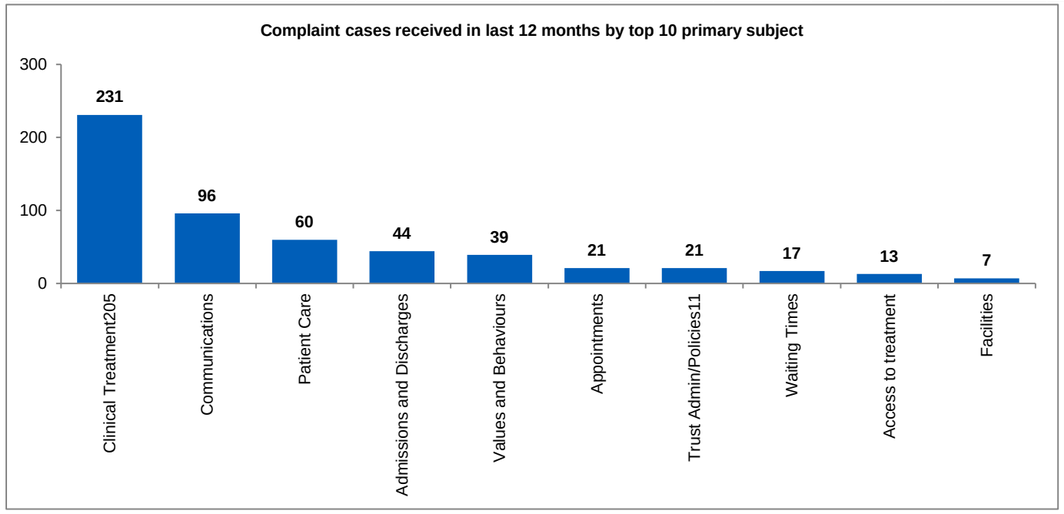
Please note starting in 2022, the Trust reduced the number of SMS being sent to adult patients. Instead of sending a text message to every adult patient that attend an OP/DU appointment, or presented to A&E, the Trust now sends a fixed number of SMS daily.

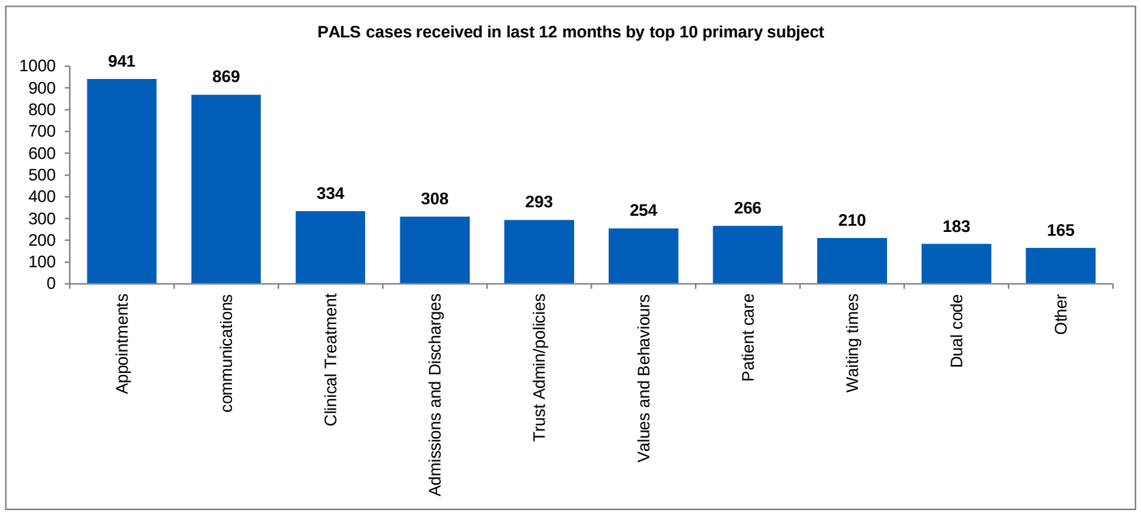
Author(s): Charlotte Smith/Kate Homan Owner(s): Clare Hawkins

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	Sep 19-Sep 23	month	-	44	55	H	SP	-	The number of complaints received between Sep 2019 - Sep 2023 is lower than normal variance.
% acknowledged within 3 days	Sep 19-Sep 23	month	95%	86%	73%		-	?	38 out of 44 complaints were acknowledged within 3 working days
% responded to within initial set timeframe (30, 45 or 60 working days)	Sep 19-Sep 23	month	50%	33%	30%	L	S7	?	99 complaints were responded to in September, 33 of the 99 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	Sep 19 -Sep 23	month	80%	40%	87%	L	SP	?	40 out of 99 complaints responded to in September were within the initial set time frame or within an agreed extension date.
% complaints received graded 4 to 5	Sep 19 -Sep 23	month	-	27%	34%		-	-	There were 12 complaints graded 4 severity, and 0 graded 5. These cover a number of specialties and will be subject to detailed investigations.
Compliments received	Sep 19 - Sep 23	month	-	23	32	L	S7	-	23 Compliments were registered during September and sent onto relevant staff for information





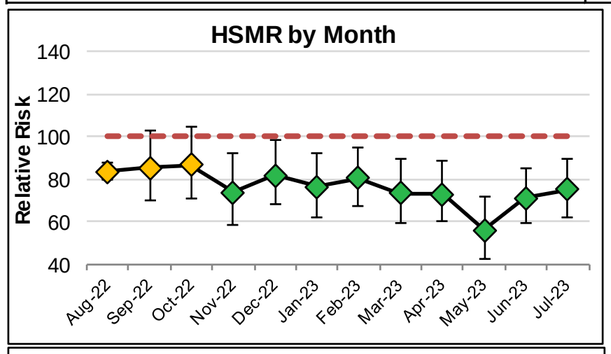
PHSO - One cases was taken for investigation in September 2023 by the Parliamentary and Health Service Ombudsman, a Division C complaint relating to care provided in 2018.
A backlog of complaint responses (550) declared in May 2023 has now been brought down to less than 100. A new process has been introduced 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 as an option rather than a written response.

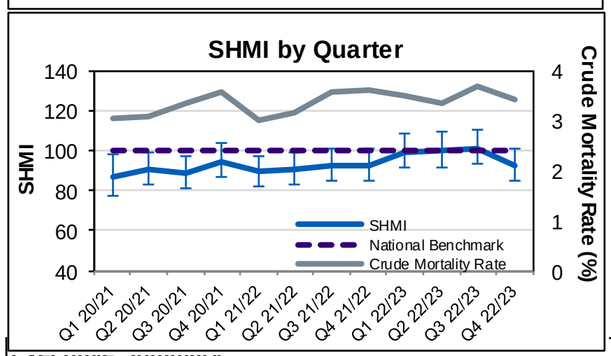
Author(s): Sue Bennison **Owner(s): Clare Hawkins**

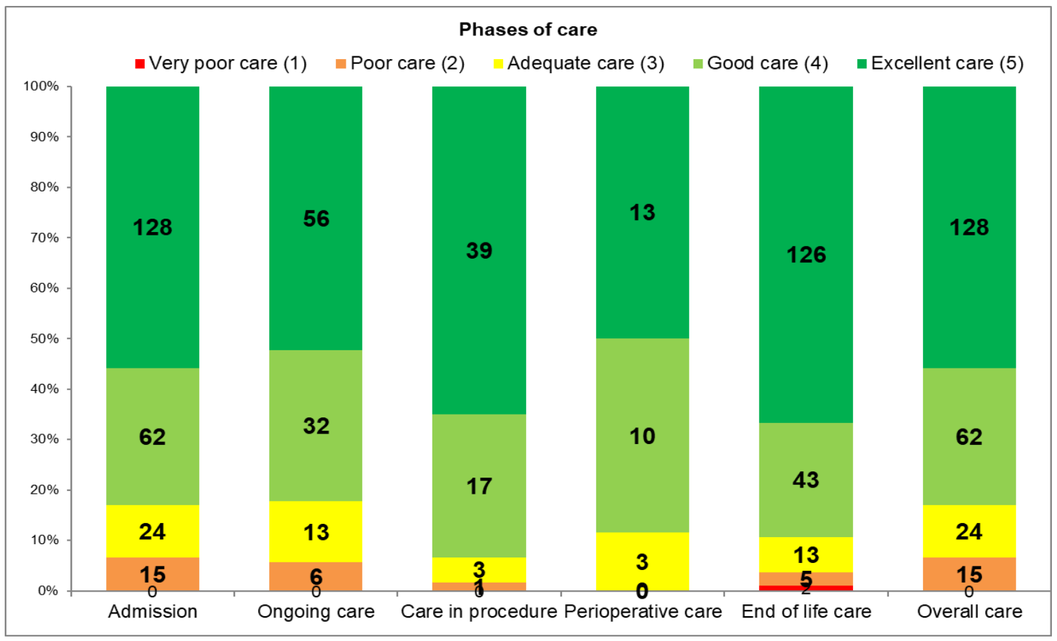
Learning from Deaths

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Data range	Sep-23	Mean	Variance	Comments
Total inpatient and Emergency department deaths	October 2018 - September 2023	**147**	*135*		
Total Emergency Department and Inpatient deaths **per 1000 admissions**		**8.5**	*8.5*		
Emergency department deaths per 1,000 attendances		**0**	*0.8*		Last 5 months have been below the mean
Inpatient deaths by 1,000 admissions		**10**	*10.2*		There was a statistically significant downward shift in the last 7 months
% of Emergency Department and Inpatient deaths in-scope for a Structured Judgement Review (SJR)		**N/A**	-		







Executive Summary

HSMR - The rolling 12 month (August 2022 to July 2023) HSMR for CUH is 76.18, this is 4th lowest within the London and ATHOL peer group. The rolling 12 month HSMR for the Shelford Peer group is 90.80.

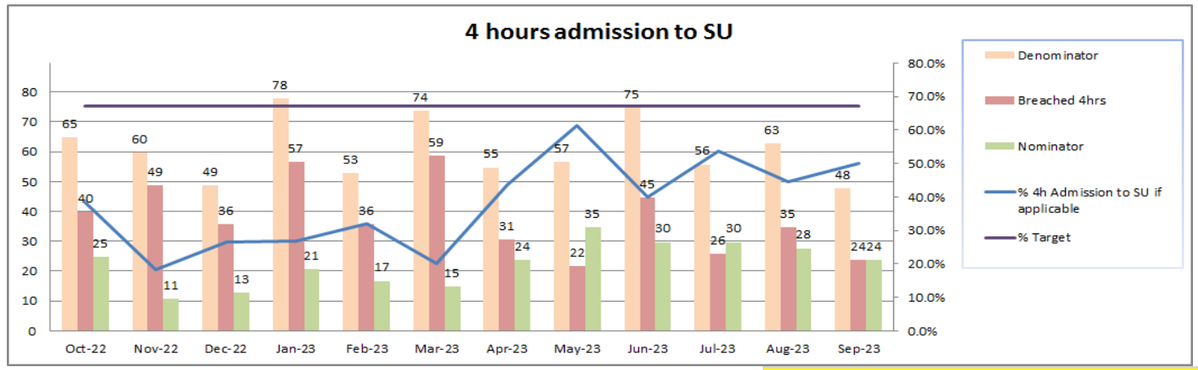
SHMI - The Summary Hospital-level Mortality Indicator (SHMI) for CUH in the latest period, May 2022 to April 2023 is 98.17.

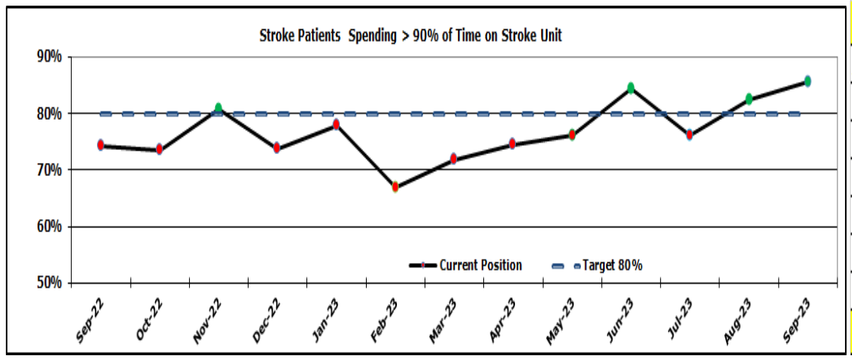
Alert - There is 1 alert for review within the HSMR and SHMI dataset this month.

There was one serious incident (SLR170040) associated with potentially/avoidable death commissioned in August 2023.

Stroke Care

NHS Cambridge University Hospitals NHS Foundation Trust





4h breaches to SU	MRN
Awaiting senior review	5
Bed Capacity	6
Initial assumption of migraine .asked for ED review as SAT nurse busy with pre-alert	1
Not referred on arrival	8
Outside window IVT and MDT. 14 referrals on same shift. MDT at same time of referral	1
SAT busy with thrombolysis/ possible MT patient	1
Unsure if new stroke. MRI confirmed	2
Total	24

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%)
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%
Aug-23		5					1	2					2				10	85.7%
Sep-23		6					1	1		2							10	82.5%
Summary	11	91	0	0	0	4	20	16	1	3	3	0	46	6	0	3	204	

90% target (80% Patients spending 90% IP stay on Stroke ward) was achieved for September 2023 = **82.5%**

Trust bed capacity (6) was the main factor contributing to breaches last month, with a total of 10 breaches in September 2023.

4hrs adm to SU (67%) target compliance was not achieved in September 2023 = 50.0%

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
- R2 SOP has now been approved at SMT and will be circulated more widely next month.
- The purpose of this SOP is to formalise the ringfencing of HASU beds for acute stroke cases (particularly out of hours) 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 Apr - Jun 2023 at Level B.
- Stroke Taskforce meetings remain in place, plus weekly review with root cause analysis undertaken for all breaches, with actions taken forward appropriately.
- The stroke bleep team continue to see over 200 referrals in ED a month, many of those are stroke mimics or TIAs. TIA patients are increasingly treated and discharged from ED with clinic follow up. Many stroke mimics are also discharged rapidly by stroke team from ED. For every stroke patient seen, we see three patients who present with stroke mimic.

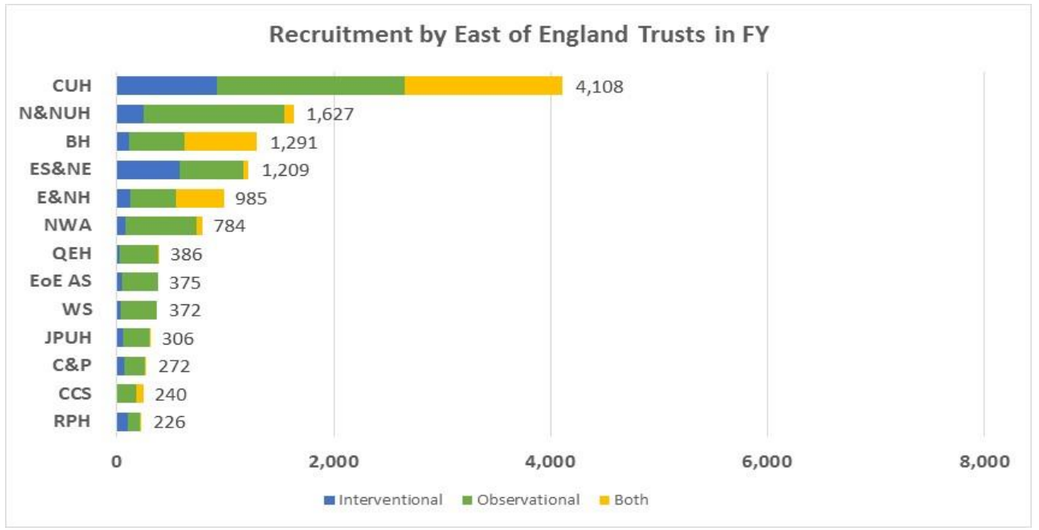
Author(s): Charles Smith Owner(s): Nicola Ayton

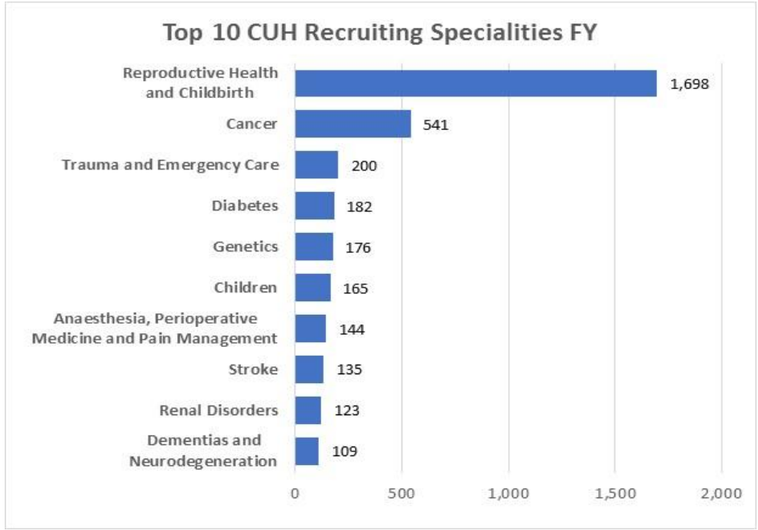
Clinical Studies

NHS
Cambridge University Hospitals
NHS Foundation Trust

Total Recruitment at end of Sept - FY 2023-24
4,108

Recruiting Studies at end of September for FY 2023-24			
Open	195	Non Commercial	199
Closed	25	Commercial	21
Suspended	0		
Total	**220**		





Situation as at end of Q2 2022/23 (Data cut: 12/10/2023)

* Total recruitment in the financial year to date: 4,108
* CUH accounted for 32% of total recruitment by Eastern Trusts in the financial year to date. Interventional only studies accounted for 22% of the CUH total, while Observational only studies accounted for 42% of the total. The remaining 35% were both Interventional and Observational .
* Recruitment to the Reproductive Health speciality accounted for 41% of all recruitment (1,698). Cancer accounted for 13% (541). All of the other individual specialities accounted for less than 5% of the total recruitment.
* There were 220 recruiting studies, of which 21 were Commercial, and 199 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

NHS
Cambridge University Hospitals
NHS Foundation Trust

Compliance

Assessed compliance with CNST MIS 10 Safety Actions Yr 5		
	Please identify unit	CUH
1	Perinatal Mortality review tool	W
2	MSDS	C
3	Transitional care / ATAIN	C
4	Clinical workforce planning	W
5	Midwifery Workforce planning	C
6	SBLCB V3	W
7	Listening to women, parentts & families / co-production with service users	C
8	Core competency framework / Multi-prof training	W
9	Board level assurance	C
10	HSIB (MNSI) /Early notification scheme	C
	Repayment of CNST (since introduction) Y/N and MIS yr	N

Evidence of SBLCB V3 Compliance		
Element		CUH
1	Reducing smoking in pregnancy	W
2	Fetal growth: Risk assessment , surveillance and management	W
3	Raising awareness of Reduced Fetal Movements	C
4	Effective Fetal monitoring during labour	W
5	Reducing preterm birth and optimising perinatal care	W
6	Management of pre-existing Diabetes in Pregnancy	W
	SBLCBv3 Fully compliant (National Tool)	N

Assessment against Ockenden Immediate and Essential Actions (IEA) – to achieve full compliance will all elements of each IEA		
		CUH
IEA1:	Enhanced Safety	W
IEA2:	Listening to Women & Families	C
IEA3:	Staff training & Working Together	W
IEA4	Managing complex pregnancy	W
IEA5:	Risk Assessment Throughout pregnancy	W
IEA6:	Monitoring Fetal wellbeing	W
	Fully compliant (self assessment)	W
	Fully compliant (regional assessment following insight visits)	

Key (current position)		Insert (to automatically
Compliant	Compliant with all aspects of element	C
Working towards / Partially compliant	Working towards (MIS & SBLCB) / Partially compliant (Ockendon)	W
Not compliant	Not compliant with all aspects of element	N

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

Maternity Dashboard

NHS Cambridge University Hospitals NHS Foundation Trust

Clinical Outcome Measures

KPI (see final slide for detail)	Measurement / Target		Trust Rate (current reporting period)
			CUH
Massive Obstetric Haemorrhage ≥ 1500 mls	**Vaginal birth**	**3.30%**	5.58
(as per NMPA descriptor, slide 8)	Caesarean	4.50%	6
3rd & 4th degree tear	SVD (unassisted)	Unassisted 2.5%	3.37
(as per NMPA descriptor, slide)	Instrumental (assisted)	Assisted 6.3%	12.50
Caesarean section (%age)	(see guidance document)	overall rate not required	
(primip, singleton , ceph, over 37/40, spontaneous labour)	Robson Group 1	N/A	18.5
[primip, singleton, over 37/40, who had labour induced (2a) or LSCS prior to labour (2b)]	Robson Group 2 **2a**	N/A	40%
	Robson Group 2 **2b**	N/A	100%
(Multip, at least 1 uterine scar, singleton, ceph, over 37/40)	Robson Group 5	N/A	91.5
Smoking at time of delivery		≤ 6%	6.7
Preterm birth			
Preterm birth rate	≤36+6 weeks (over 24+0/40) National ambition	≤6% annual rolling rate (Total PTB all babies 24-36+6))	8.71
	16+0 - 23+6 (SBLCBv3)	%age of all singleton births (live & stillborn)	6.75%
	24+0 - 36+6 (SBLCBv3)	%age of all singleton births (live & stillborn)	0.26%

MBRRACE stabilised & adjusted mortality rates per 1000 births with congenital abnormalities included/ excluded (annual only - 2021)			
Unit	**Stillbirth**	**Neonatal Death <7/7**	**Extended perinatal**
CUH	**4.16:1000**	**2.40:1000**	**6.49:1000**

KPI (see final slide for detail)	Measurement / Target		Trust Rate (current reporting period)
			CUH
Term admissions to NNU Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet.		<6% (of total births)	4.90%
		%age of total admissions that were avoidable	0.2% (Jul'23)
Optimisation (metrics to be determined locally as per SBLBCv3) **please see the implementation tool for technical guidance**			July'23 data (manual audit)
Right place of birth			
Percentage of singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU)		n/a	n/a
Antenatal corticosteroids			75% (+8% had full course but born after 7 days)
Percentage of babies born before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth		55%	
Magnesium sulphate			100%
Percentage of babies born before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth		90%	
IV antibiotics			
Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive IV intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection		90%	100%
Optimal Cord Clamping			
Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth.		75%	91%
Thermoregulation			Badgernet data (July'23)
Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5– 37.5°C and measured within one hour of birth		75-80%	57%
Early Maternal Breast milk			Badgernet data (July'23)
Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth.		50%	64%

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

Maternity Dashboard

NHS Cambridge University Hospitals NHS Foundation Trust

Sources / References	KPI	Goal	Target	Measure	Data Source	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-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	415	474	452	490	466	443	5477	
Antenatal Care ICS contracted booking KPI	Health and social care assessment <GA 12+6/40	> 90%	>=90% <90% and >=80% <80%	Booking Appointments	Epic	95.48%	83.06%	91.03%	89.11%	95.05%	86.75%		Data improvement made as now able to exclude all bookings that were a transfer of care after 13+0 weeks.
National Maternity Dashboard	Booking Appointments	For Information	N/A	Booking Appointments	Epic	310	431	379	358	343	400		(Pre-Feb data inaccurate due to data quality errors.)
Source - EPIC	Vaginal Birth (Unassisted)	For Information	N/A	SVDs in all birth settings	Rosie KPI's	47.47%	49.16%	48.45%	48.16%	49.79%	49.89%		
Source - EPIC	Home Birth	For Information	N/A	Planned home births (BBA is excluded)	Rosie KPI's	0.96%	0.21%	0.22%	1.63%	0.86%	1.13%		
Source - EPIC	Rosie Birth Centre Birth	For Information	N/A	Births on the Rosie Birth Centre	Rosie KPI's	13.73%	14.14%	15.71%	13.47%	13.52%	16.93%		
Source - EPIC	Rosie Birth Centre transfers	For information	N/A	Women admitted to RBC and subsequently transferred for birth	Rosie KPIs	47.06%	41.00%	31.96%	34.41%	42.39%	29.03%		
Source - EPIC	Induction of Labour	For Information	N/A	Women induced for birth	Rosie KPI's	38.20%	34.12%	33.48%	33.89%	33.48%	34.18%		
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	27.03%	30.16%	27.62%	28.64%	24.87%	34.88%		On CQC action plan for improvements to meet <10% target. Deep dive into causes to be undertaken this month.
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	10.27%	9.52%	11.05%	9.05%	10.05%	15.00%		On CQC action plan.
SBLCBV3 (Element 2)	Indication for IOL (SBLCBV3)	≥95%	≥90%	Percentage of IOL where reduced fetal movements is the only indication before 39 weeks	IOL Team	99.36%	98.75%	100%	100%	99.35%	99.32%		Updated to be reported as % compliant as per SBL version evidence request. Exceeding target.
Source - EPIC	Indication for IOL	100%	≥95%	Percentage of IOL with a valid indication as per guidance.	IOL Team	99.36%	100%	99.33%	100%	98.70%	100%		
Source - EPIC	Birth assisted by instrument (forceps or ventouse) (Instrumental)	For Information	N/A	Instrumental birth rate	Rosie KPI's	11.81%	12.03%	13.05%	12.04%	9.87%	9.48%		
Source - EPIC	CS rate (planned & unplanned)	For Information	N/A	C/S rate overall	Rosie KPIs	40.24%	38.40%	38.27%	39.18%	39.70%	40.18%		
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	20.30%	19.10%	18.30%	20.90%	16.10%	18.50%		
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	50.80%	50.50%	41.10%	55.10%	47.90%	51.00%		
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	1:3.75	1:3.24	1:2.93	1:3.68	1:2.98	1:3.53		
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	86.4%	88.1%	83.9%	83.3%	88.2%	91.5%		
CQIM / CNST	Women in RG1, RG2, RG5 combined contribution to the overall C/S rate.	66%	60-70%,	Relative contribution of the Robson group to the overall C/S Rate	Rosie KPIs	68.3%	72.0%	61.3%	67.2%	62.2%	68.5%		
Source - Rosie Divert Folder	Divert Status - incidence	0	<1	Incidence of divert for the perinatal service	Rosie Diverts	0	1	2	4	2	1		Closed for capacity and staffing.
Source - Rosie Divert Folder	Total number of hours on divert	For information	N/A		Rosie Diverts	0	15:30	27.25	98.20	27.50	18.08		
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	0	6	14	52	7	12		
Source - Rosie Divert Folder	Number of women giving birth in another provider organisation due to divert status	For information	N/A		Rosie KPIs	0	1	3	4	2	1		

Maternity Dashboard

NHS Cambridge University Hospitals NHS Foundation Trust

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	1:24.5	1:23.7	1:24.1	1:25.3	1:25.2	1:28		
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	1:23.7	1:23.7	1:23.8	1:23.4	1:23.4	1:24		
Safer Chilbrith / CNST	Supernumerary Delivery Unit Coordinator	100%	≥95%	Percentage compliance with Delivery Unit coordinator remaining supernumerary (no high risk 1:1 or labour 1:1 care as per MIS)	BR+ RF11	100%	100%	100%	100%	100%	100%		Susatined special cause of improving nature.
Source - CHEQS	Staff sickness as a whole	< 3.5%	<5%	ESR Workforce Data	CHEQs	5.30%	4.92%	4.57%	4.19%	4.29%			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	86.8%	88.4%	91.1%	91.7%				Special cause of improving nature.
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	73.97%	79.74%	81.22%	82%	86.80%	82.60%		Based on numbers booked into Nov training, non compliance escalated. Biggest area of non-compliance is anaesthetists and obstetric SHOs.
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	84%	83.6%	81%	80%	80%	75%		NICU Dr 71 %, NICU RN 64%, RMs 84%, MSWs 59 %. Non-compliance escalated to line managers and matrons.
CNST	Education and Training - Training Compliance for all staff groups: **K2**	>90% YTD	>85% YTD	Total multidisciplinary staff passed K2 competences.	Fetal surveillance MW	90.18%	86.60%	87.08%	81.00%	84.20%	80.60%		Non-compliance reported to line managers and matrons. Bank staff overdue are prevented from booking further shifts until compliant. Consultant compliance impacted by strike cover.
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.	Fetal surveillance MW	80.45%	84.52%	84.91%	82.00%	86.60%	88.00%		All staff currently not booked being allocated. Bank staff overdue are prevented from booking further shifts until compliant. Consultant compliance impacted by strike cover.
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	85.2%	87%	91.6%	92.6%	93.5%			Non-compliance reported to line managers, matrons and bank office.
Maternal morbidity													
CQC KLOE	Puerperal Sepsis	For information	N/A	Incidence of puerperal sepsis within 42 days of birth	CHEQs	0.49%	0.21%	0.22%	0.42%	0.43%			No data available for Sept due to staff leave.
Source - CHEQs	ITU Admissions in Obstetrics	For information	N/A	Total number of pregnant / postnatal women admitted to the intensive care unit	CHEQs / QSIS	1	0	0	0	0	2		
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	3.75%	3.75%	4.63%	5.84%	5.30%	5.58%		On CQC action plan including reporting by PPH working group. PPH education campaign planned for October.
NMPA	Massive Obstetric Haemorrhage ≥ 1500 mls - caesarean birth	≤4.5%	≤4.5%	Percentage of women with a PPH ≥1500mls (singleton births between 37+0-42+6) having a caesarean section	Rosie KPIs	2.90%	5.56%	3.62%	3.73%	6.08%	6.00%		PPH education campaign planned for October. On CQC action plan including reporting by PPH working group. No accretas this month.
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	5.42%	3.38%	1.55%	1.83%	3.04%	4.84%		
CQC KLOE	Maternal readmission rate	For information	N/A	Percentage of women readmitted to maternity service within 42 days of birth.	Rosie KPIs	1.55%	1.45%	2.59%	2.30%	2.56%	2.63%		
MBRRACE	Peripartum Hysterectomy	For information	N/A	Incidence of peripartum hysterectomy	CHEQs / QSIS	2	0	1	2	0	0		
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	0	0	0	0	0	1		Twin fetal surveillance.
Source - QSIS	Never Events	0	<1	DATIX	QSIS	0	0	0	0	0	0		

Maternity Dashboard

NHS Cambridge University Hospitals NHS Foundation Trust

Neonatal Morbidity													
MBRRACE / PMRT	Still Births per 1000 Births	3.33/1000 (Mbrrace 2021)	rolling rate	Incidence per 1000 births	CHEQs	2.94:1000	2.75:1000	2.93:1000	3.45:1000	3.81:1000	3.65:1000		Recently published ONS data reports national stillbirth rate is 3.9:1000 for EofE in 2022. MBRRACE benchmark due to be updated late 2023.
MBRRACE / PMRT	Stillbirths - number ≥ 22 weeks	<3	<6	MBBRACE	CHEQs	1	2	2	2	2	1		
SBLCBV3 (Element 2)	Babies born at <3rd centile at >37+6	For information	N/A	Percentage of all births <3rd centile 24+0-37+6 weeks (this gives a measure of effective detection and management of FGR)	CHQS + intergrowth 21st					33%	33%		
Epic	Number of birth injuries	0	<1	Percentage of babies born with a birth related injury	CHEQs	0	1	0	1	1	2		May birth injury not prevous reported (fractured clavicle). 2 birth injuries in Sept (skull fracture and fractured clavicle). All were consultant-led deliveries. No sequalae for infants injured, all were recognised complications following review.
NMPA	Babies born with an Apgar <7 at 5 minutes of age	For information	N/A	Percentage of babies born who have an Apgar score <7 at 5 minutes of age	Rosie KPIs	1.94%	1.27%	2.23%	1.66%	2.81%	1.59%		
CQC KLOE	Incidence of neonatal readmission	For information	N/A	Percentage of babies readmitted within 42 days of birth	Rosie KPIs	3.72%	3.83%	3.83%	4.07%	4.74%	4.82%		
ATAIN	Term Admission to NICU Rate	<6%	N/A	Rate	ATAIN report	6.0%	4.9%	4.0%	4.9%	4.9%	5.6%		
Quality													
CNST	1-1 Care in Labour	>95%	>90%	Percentage of women receiving 1:1 care in labour (excluding BBAs)	Rosie KPI's	99.8%	100.0%	100.0%	100.0%	100.0%	99.8%		
CQIM	Babies with a first feed of breastmilk	> 80%	>70%	Breastfeeding	Rosie KPI's	81.55%	83.65%	83.93%	83.37%	82.68%	81.41%		
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	5.60%	5.33%	4.72%	4.78%	4.78%	6.70%		
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 with manual checks	95%	91.9%	92.7%	89%	82.2%			New data for July and August. Compliance escalated to community matron who has advised that non-compliance could result in performance management, reminders at community morning meeting, comms to community MWs. Awaiting delivery of spare devices for new starters.
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 with manual checks	73%	69%	66%	87%	69.0%			New data for July and August. Compliance escalated to community matron who has advised that non-compliance could result in performance management, reminders at community morning meeting, comms to community MWs. Awaiting delivery of spare devices for new starters.
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				51.5%	71.7%	75.9%		"Take 5" messaging to staff already undertaken to improve compliance. Esclaated to matrons and ward managers.
Source - EPIC	VTE Assessment - PN	>95%	>95%	Percentage of women with a valid PN VTE risk assessment completed **within 4 hours** of birth.	CHEQs				85.2%	86.2%	85.2%		**93% completed within 6 hours, 97% completed within 12 hours. 0.09% not completed.** "Take 5" messaging to staff already undertaken to improve compliance. Esclaated to matrons and ward managers.

Finance

NHS
Cambridge University Hospitals
NHS Foundation Trust

Trust performance summary - Key indicators

Trust actual surplus / (deficit)

(£3.5m)	*Actual (adjusted)**
(£0.3m)	*Plan (adjusted)**
(£3.5m)	*Actual YTD (adjusted)**
£3.3m	*Plan YTD (adjusted)**

Elective Payment Mechanism (EPM)

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

	In month	YTD
EPM forecast actual	£17.8m	£107.0m
Target adj. block increase	£0.3m	£1.9m
EPM actual + block increase	£18.1m	£108.9m
EPM original plan	£19.6m	£118.7m
EPM original target	£18.2m	£110.0m

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

Net current assets

(£90.0m)	*Actual*
(£45.6m)	*Plan*

Debtor days

20	*This month*
20	*Previous month*

Payables performance (YTD) *

86.7%	*Value*
89.3%	*Quantity*

EBITDA

£14.0m	*Actual YTD*
£22.6m	*Plan YTD*

Capital expenditure

£3.3m	*Capital - actual spend in month*
£19.4m	*Capital - actual spend YTD*
£14.6m	*Capital – plan YTD*

Cash

Cash

£175.1m	*Actual*
£151.7m	*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.

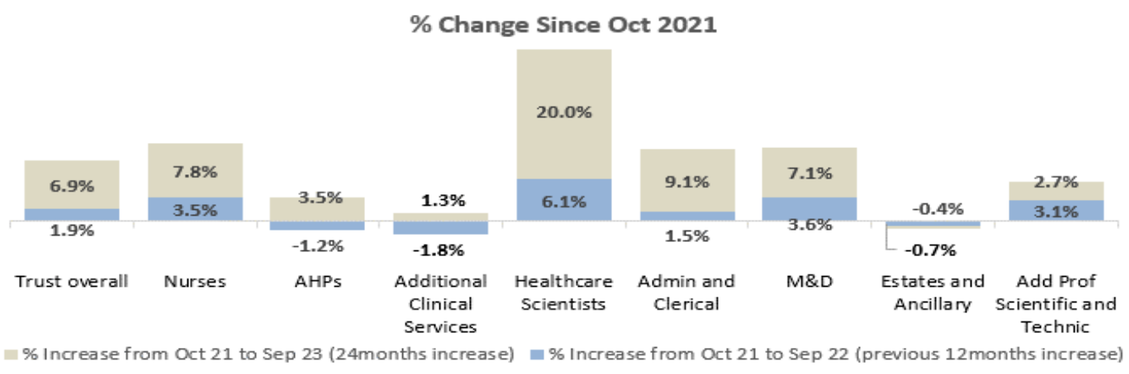
Author(s): Tim Saunders **Owner(s): Mike Keech**

Staff in Post

NHS
Cambridge University Hospitals
NHS Foundation Trust

12 Month Growth by Staff Group

Staff Group	Headcount		Headcount 12 Month growth		FTE		FTE 12 Month growth	
	Oct-22	Sep-23			Oct-22	Sep-23		
Add Prof Scientific and Technic	246	248	↑	0.8%	223	223	0	↑ 0.1%
Additional Clinical Services	1,954	2,004	↑	2.6%	1,801	1,833	32	↑ 1.8%
Administrative and Clerical	2,406	2,565	↑	6.6%	2,213	2,359	146	↑ 6.6%
Allied Health Professionals	735	766	↑	4.2%	651	681	30	↑ 4.6%
Estates and Ancillary	361	365	↑	1.1%	349	354	4	↑ 1.2%
Healthcare Scientists	644	734	↑	14.0%	604	699	95	↑ 15.6%
Medical and Dental	1,714	1,764	↑	2.9%	1,622	1,663	42	↑ 2.6%
Nursing and Midwifery Registered	3,856	3,970	↑	3.0%	3,549	3,654	105	↑ 3.0%
Total	**11,916**	**12,416**	↑	**4.2%**	**11,013**	**11,467**	**454**	↑ **4.1%**



Admin & Medical Breakdown

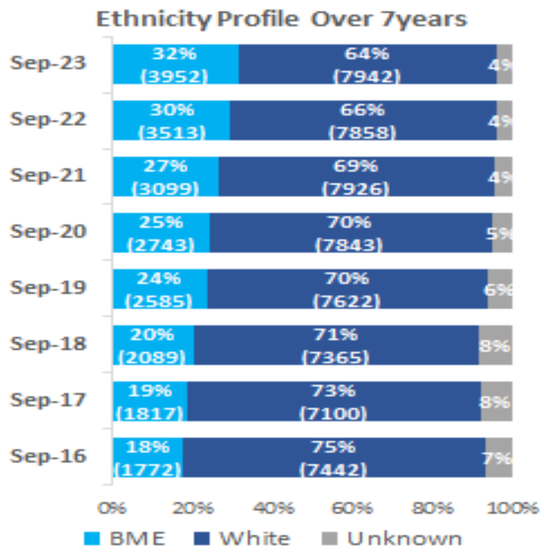
Staff Group	Oct-22	Sep-23	FTE 12 Month growth	
Administrative and Clerical	2,213	2,359	146	↑ 6.6%
of which staff within Clinical Division	1,081	1,152	71	↑ 6.5%
of which Band 4 and below	748	795	47	↑ 6.4%
of which Band 5-7	243	248	5	↑ 2.0%
of which Band 8A	44	54	9	↑ 21.1%
of which Band 8B	7	8	1	↑ 16.7%
of which Band 8C and above	39	47	8	↑ 20.1%
of which staff within Corporate Areas	895	957	62	↑ 7.0%
of which Band 4 and below	247	256	9	↑ 3.7%
of which Band 5-7	422	465	44	↑ 10.4%
of which Band 8A	88	89	1	↑ 1.0%
of which Band 8B	50	49	0	↓ -0.7%
of which Band 8C and above	88	97	9	↑ 10.1%
of which staff within R&D	237	250	13	↑ 5.5%
Medical and Dental	1,622	1,663	42	↑ 2.6%
of which Doctors in Training	672	676	4	↑ 0.5%
of which Career grade doctors	237	240	3	↑ 1.2%
of which Consultants	712	748	36	↑ 5.0%

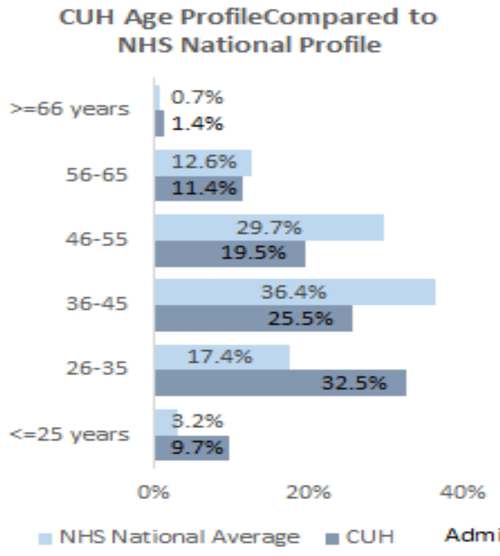
What the information tells us:
Overall the Trust saw a 4.1% growth in its substantive workforce over the past 12 months and 6.9% over the past 24 months. Growth over the past 12 months is lowest within the Additional Professional Scientific and Technical staff group, with an increase of 0.1%, and highest within Healthcare Scientists at 15.6%. This is in part due to data cleansing of the Genetics Counselling team (staff were re-coded from Additional Professional Scientific and Technical and Additional Clinical Services staff groups to the Healthcare Scientists staff group), and also due to new starters to the Trust - particularly within Genetics, Blood Sciences, Medical Physics and Clinical Engineering and Histopathology.

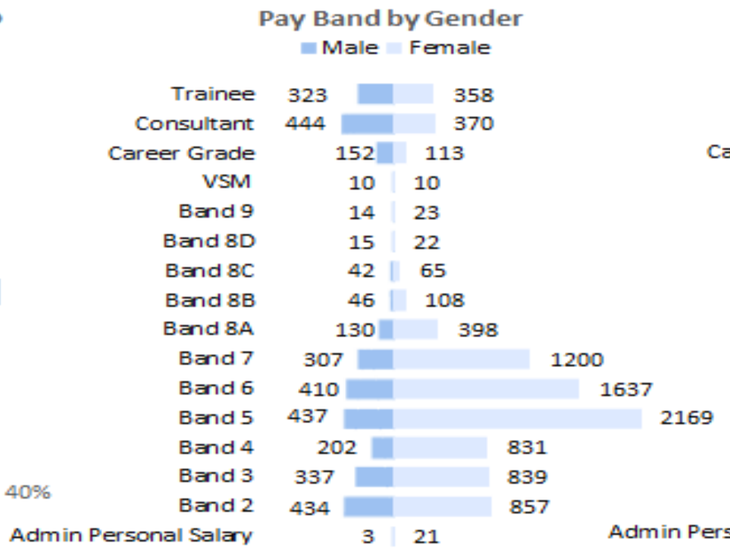
Author(s): Chloe Schafer, Amanda Wood **Owner(s): David Wherrett**

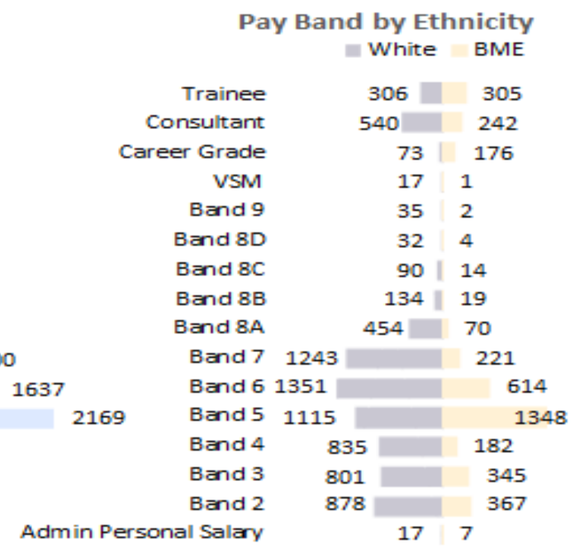
Equality Diversity and Inclusion (EDI)

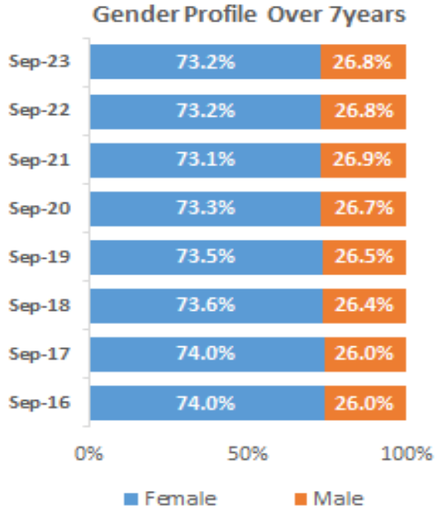
NHS
Cambridge University Hospitals
NHS Foundation Trust

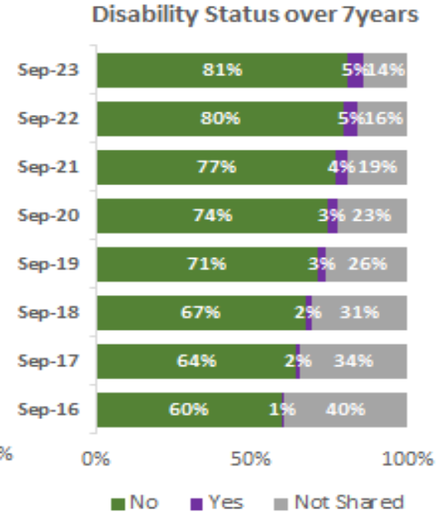


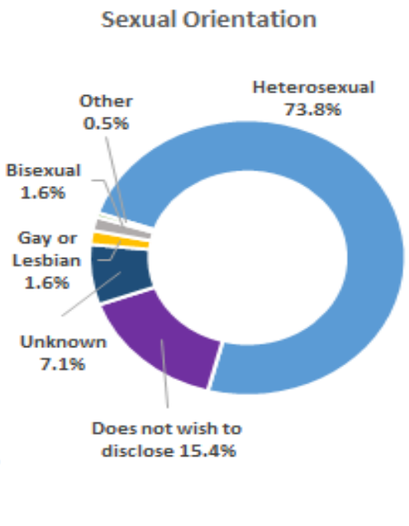












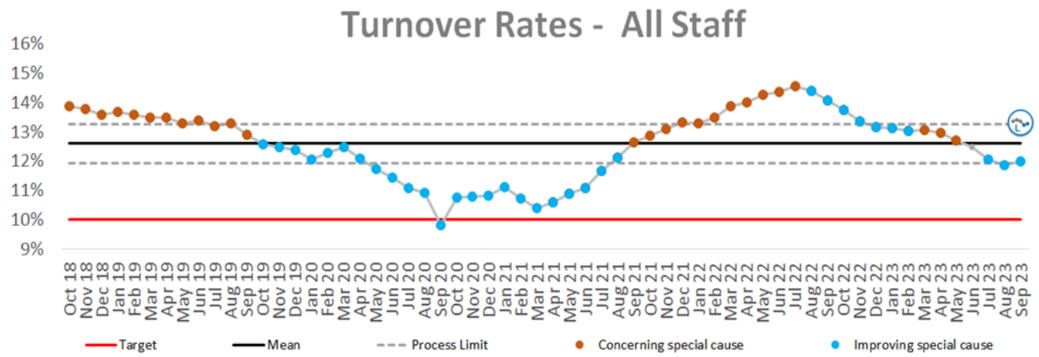
What the information tells us:

- 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 26.8% over the past seven years.
- The percentage of staff recording a disability increased by 4.6% to 5.4% over the seven year period. However, there are still significant gaps between the data recorded about our staff on ESR compared with the information staff share about themselves when completing the National Staff Survey.
- There remains a high proportion of staff who have, for a variety of reasons, not shared their sexual orientation.

Author(s): Chloe Schafer, Amanda Wood

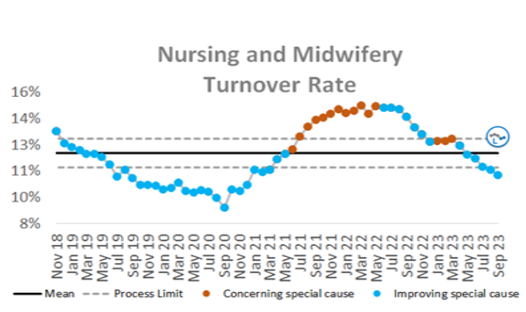
Owner(s): David Wherrett

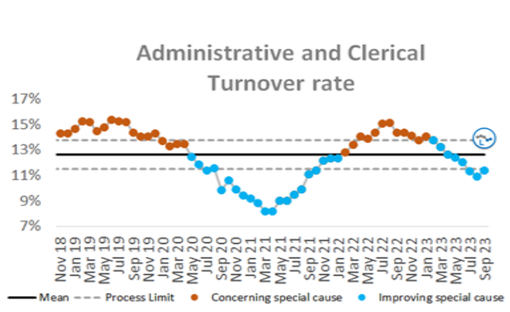
Staff Turnover

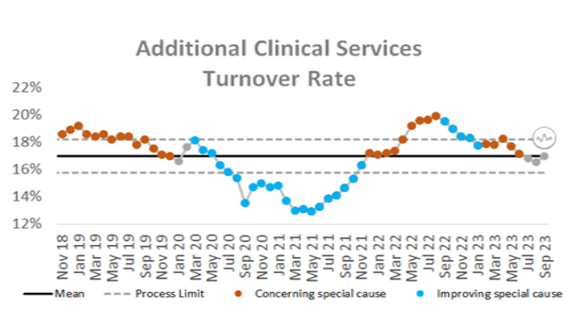


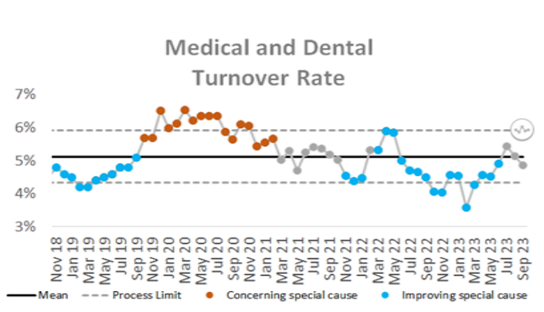
Background Information: Turnover describes the rate that employees leave an establishment. Staff turnover is calculated by the number of leavers from the Trust over the previous twelve months as a percentage of the total number of employed staff at a given time. (excludes all fixed term contracts including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

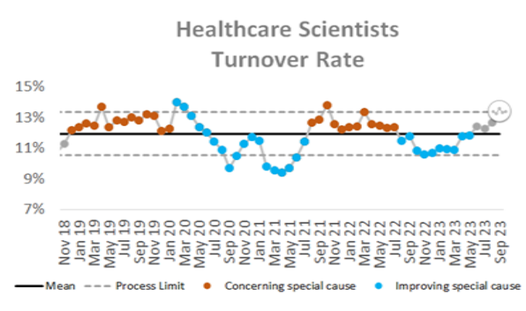
What the information tells us:
After a steady increase from March 2021 the Trust turnover rate has been decreasing since July 2022 - this month at 12% (0.1% higher than last month). This is more in line with pre-pandemic rates, and 0.9% lower than 4 years ago. Estates and Ancillary staff group has the highest increase of 2.8% to 16% in the last four years, but Additional Professional, Scientific and Technical and Administrative and Clerical staff groups have both seen a reduction in turnover from four years ago (3.4% and 3% reductions respectively). Within the staff groups, Additional Clinical Services have the highest turnover rate at 17% followed by Estates and Ancillary staff at 16%.

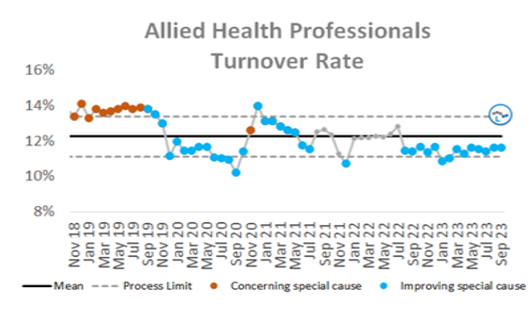


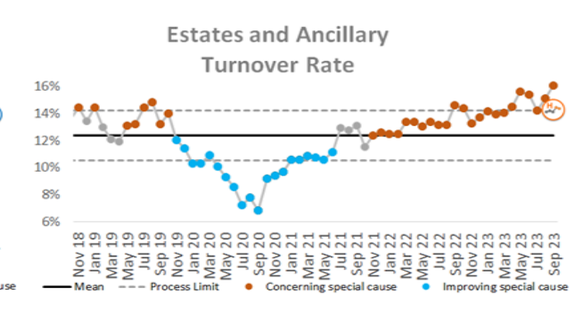


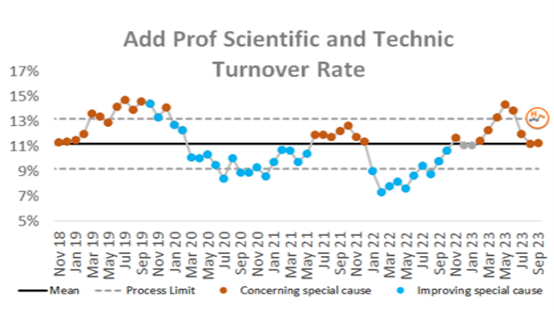








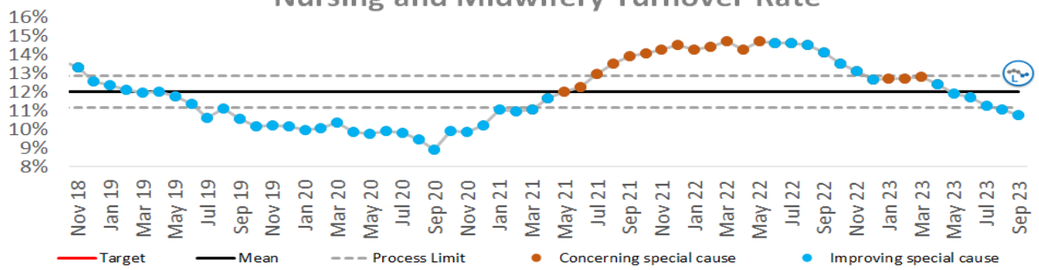




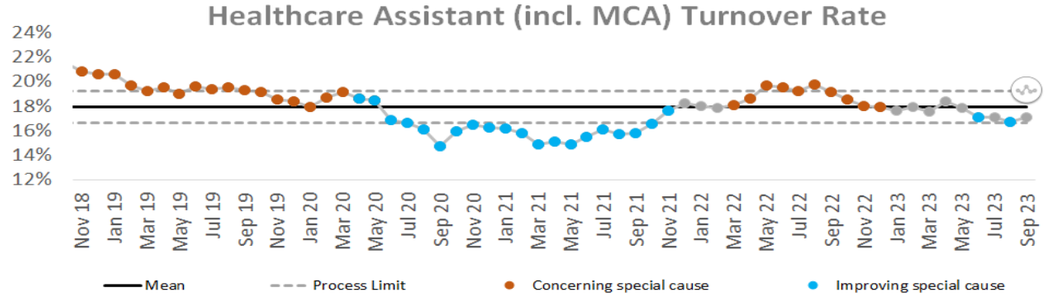
Turnover for Nursing & Midwifery Staff Group (Registered & Non-Registered)

NHS
Cambridge University Hospitals
NHS Foundation Trust

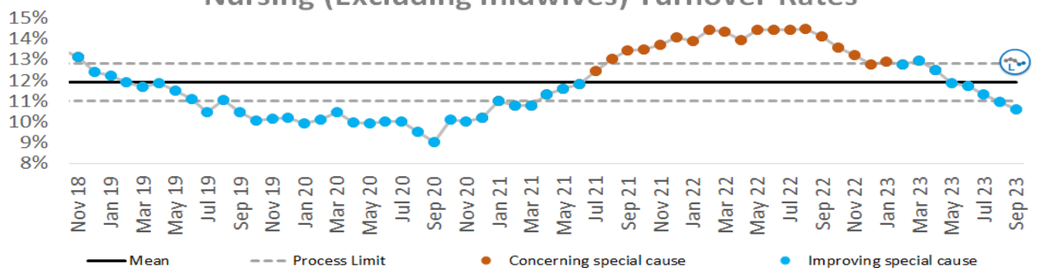
Nursing and Midwifery Turnover Rate



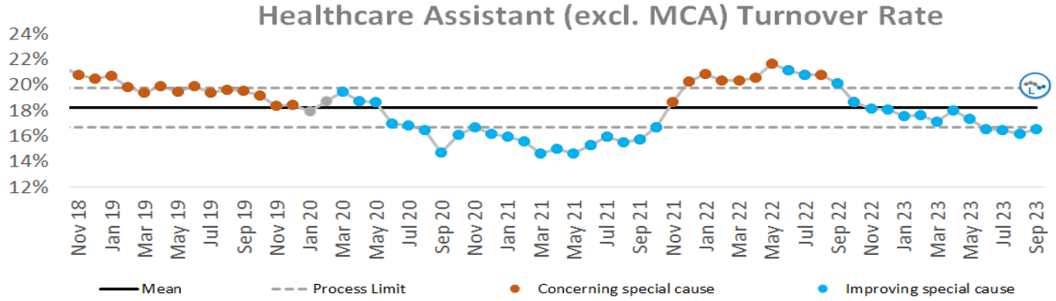
Healthcare Assistant (incl. MCA) Turnover Rate



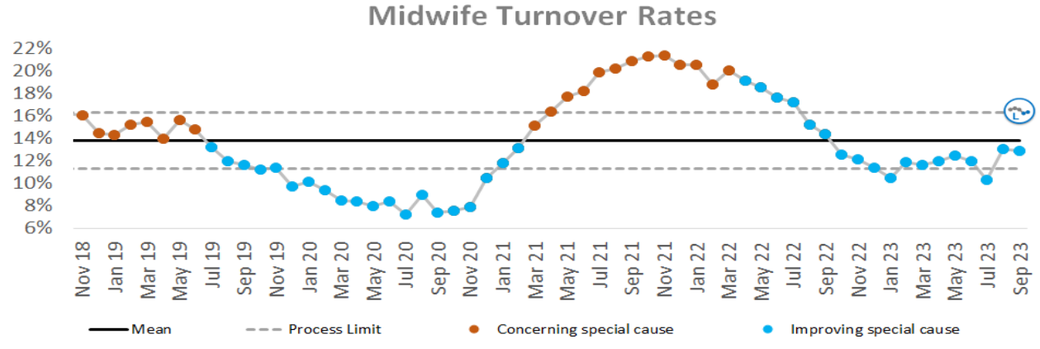
Nursing (Excluding midwives) Turnover Rates



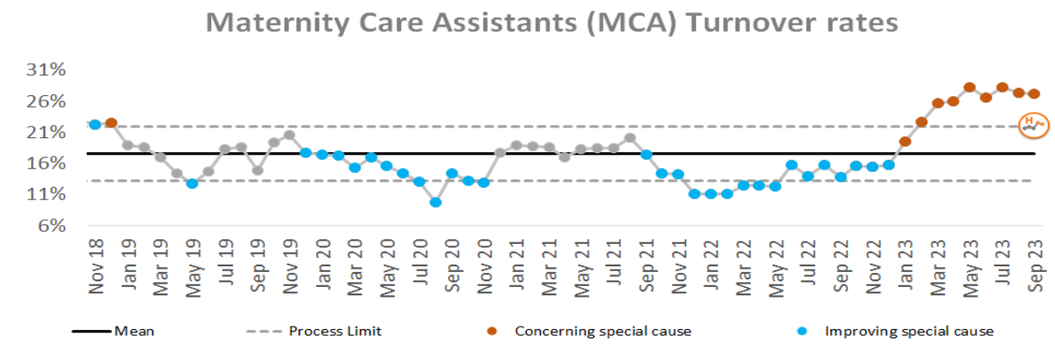
Healthcare Assistant (excl. MCA) Turnover Rate



Midwife Turnover Rates

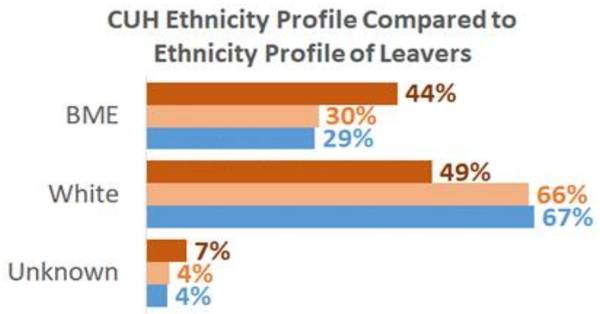


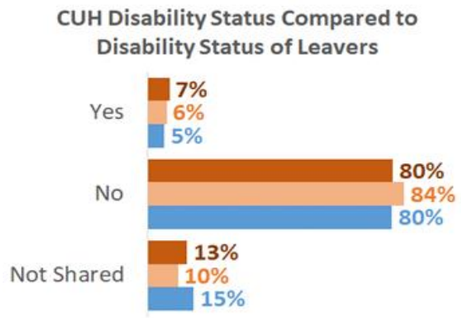
Maternity Care Assistants (MCA) Turnover rates

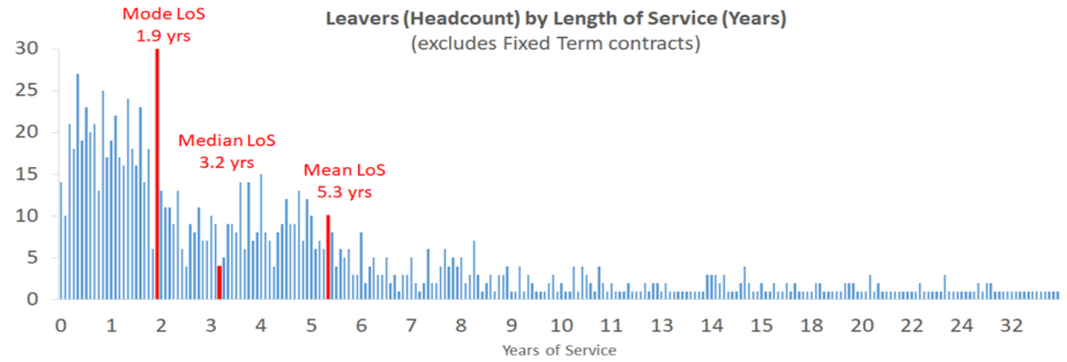


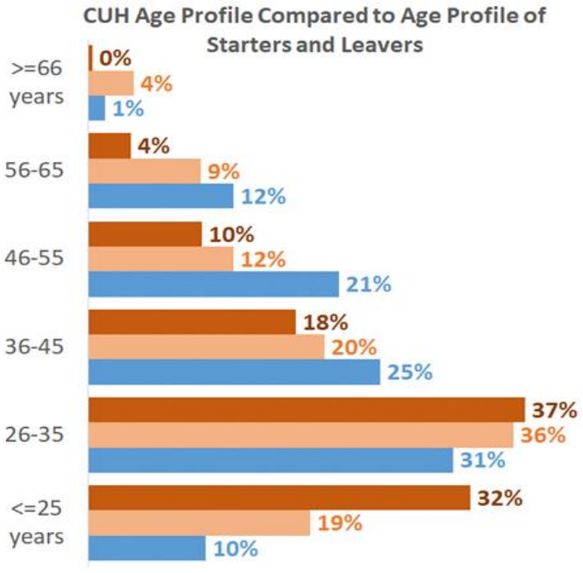
Starters & Leavers - last 12 months

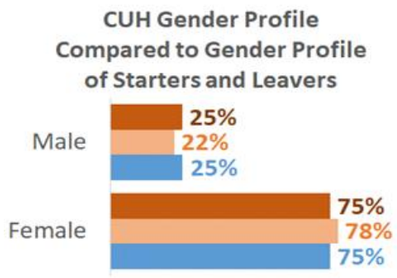
NHS
Cambridge University Hospitals
NHS Foundation Trust

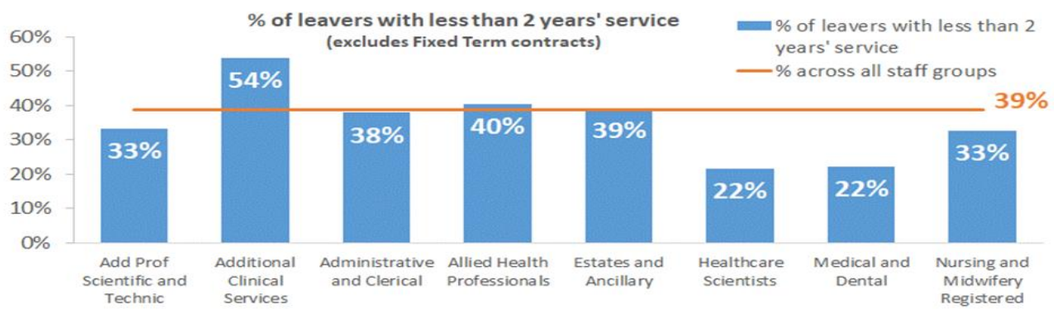












What the information tells us:

The majority of starters to, and leavers from the Trust in the last 12 months were aged 35 yrs. or under (69% 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 leaving the Trust, and of staff declaring a disability both starting and leaving the Trust. 44% 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 (39%), 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 31 (headcount) of the 1,166 leavers who were on permanent contracts left at this point. The average (mean) length of service was 5.3 years.

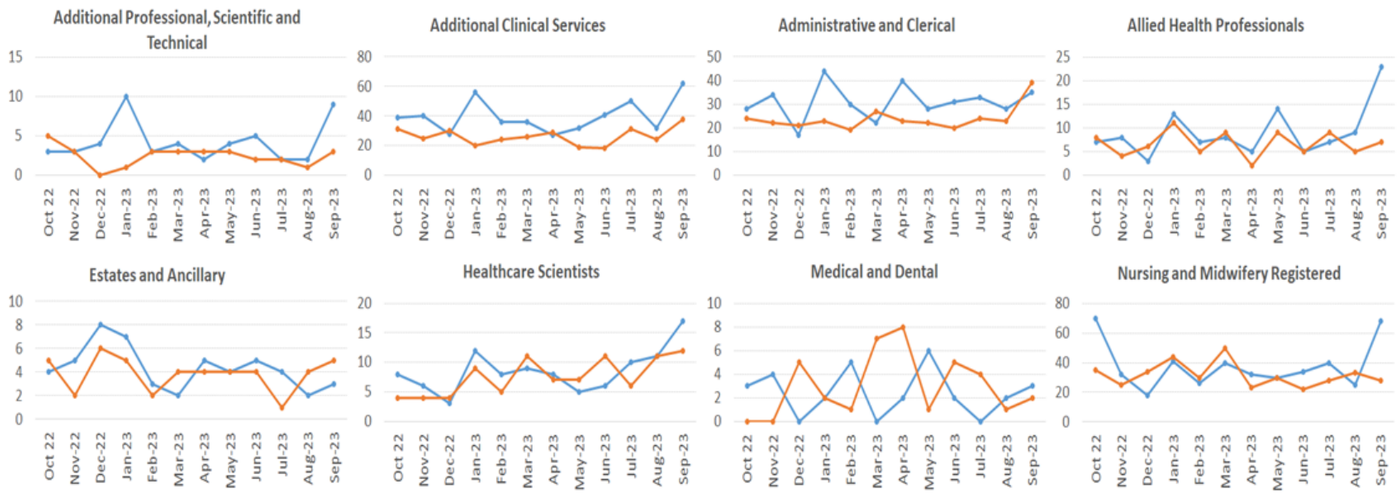
Excludes Fixed Term and Locum Medical and Dental staff, and staff leaving and returning to CUH (as bank only/retire and return etc.)

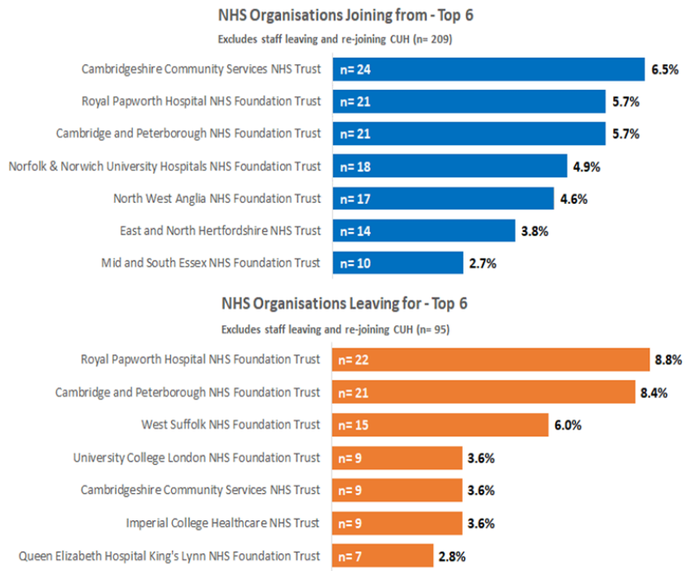
Author(s): Chloe Schafer, Amanda Wood

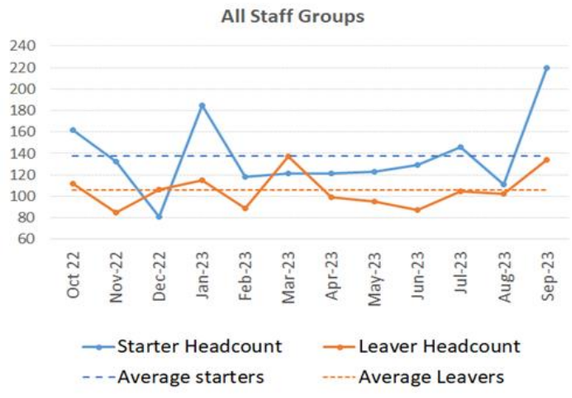
Owner(s): David Wherrett

Starters & Leavers - Last 12 months

Cambridge University Hospitals NHS Foundation Trust







Top 10 Leaving Reasons Excludes staff leaving and re-joining CUH (n= 95)	Number of Leavers (Headcount)	% of all Leavers
Voluntary Resignation - Relocation	369	29%
Voluntary Resignation - Work Life Balance	256	20%
Voluntary Resignation - Promotion	147	12%
Voluntary Resignation - Better Reward Package	97	8%
Voluntary Resignation - Other/Not Known	89	7%
Retirement Age	72	6%
Voluntary Resignation - Health	53	4%
Voluntary Resignation - Child Dependants	33	3%
End of Fixed Term Contract	31	2%
Voluntary Resignation - Lack of Opportunities	27	2%

What the information tells us:

The top three reasons for leaving are Voluntary Resignation - due to relocation (29%), for work/life balance (20%) and for promotion (12%).

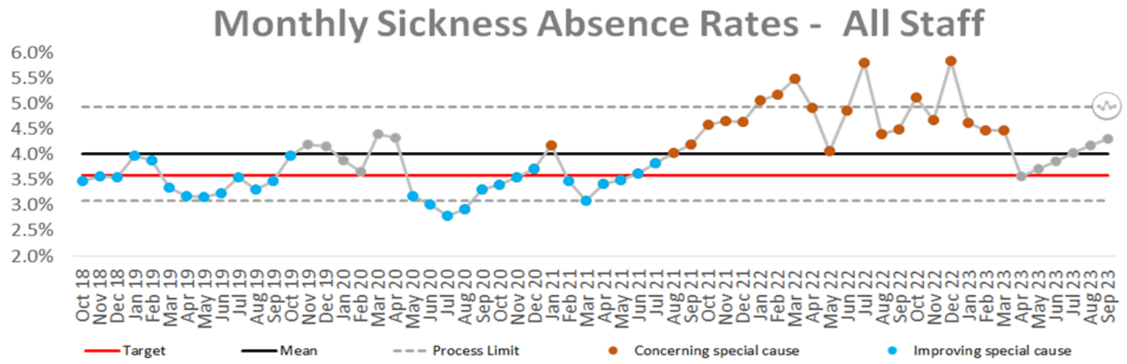
The top destination on leaving (other than unknown) for leavers over the past 12 months is another NHS Organisation. The most popular external NHS organisation to leave for is Royal Papworth NHS Foundation Trust. 12% of starters to the Trust were from Cambridgeshire Community Services NHS Trust or Royal Papworth NHS Foundation Trust. In the month of September alone the most popular destination on leaving (other than unknown) was to another NHS Organisation, with 18% of leavers in that month citing this reason on the P4 leavers form (24 individuals, of whom 50% had less than 2 years' service at CUH).

Author(s): Chloe Schafer, Amanda Wood

Owner(s): David Wherrett

Sickness Absence

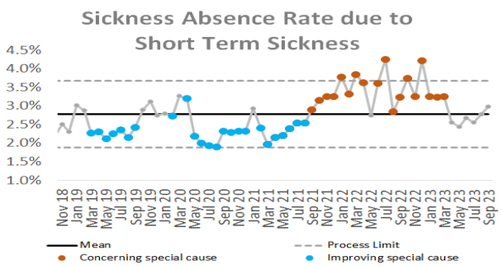
Cambridge University Hospitals NHS Foundation Trust

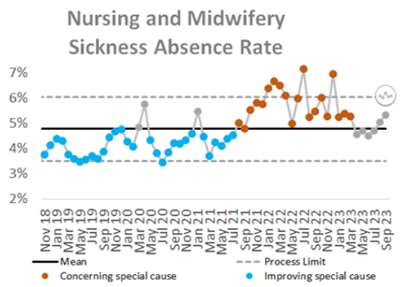


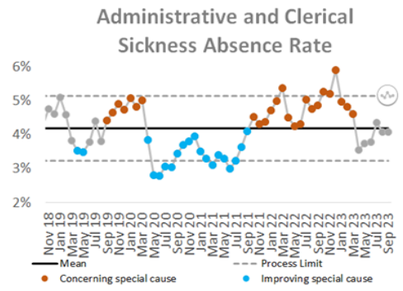
Background Information: Sickness Absence is a monthly metric and is calculated as the percentage of FTE days missed in the organisation due to sickness during the reporting month.

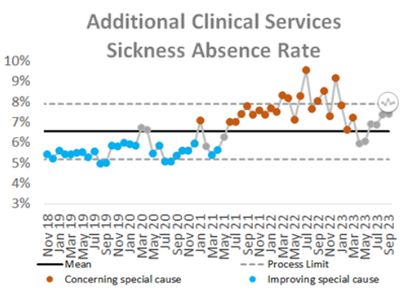
What the information tells us: The overall Monthly Sickness Absence has increased by 0.1% since last month, to 4.3% in September 2023. This is 0.2% lower than the same month last year (4.5%). The sickness absence rate due to short term illness is higher at 3% compared to long term sickness at 1.3%.

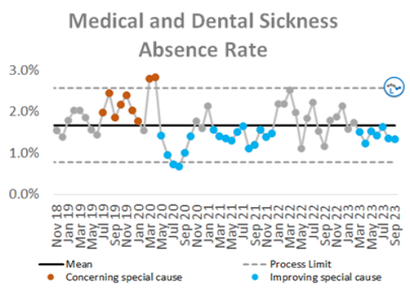
Estates and Ancillary staff group has the highest sickness absence rate at 7.7% (2.1% higher than 12 months ago), followed by Additional Clinical Services at 7.4% in September 2023.

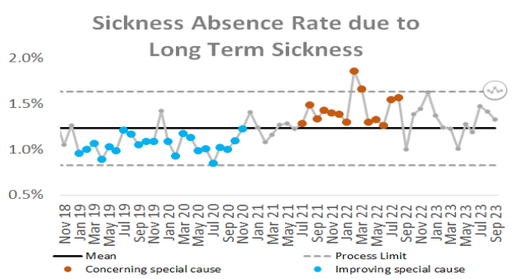


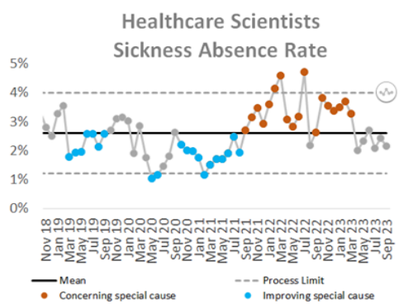


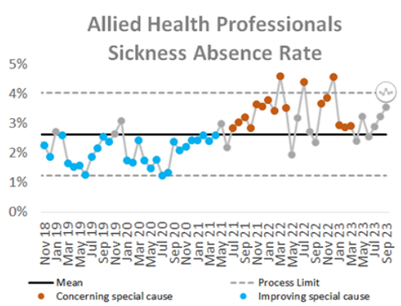


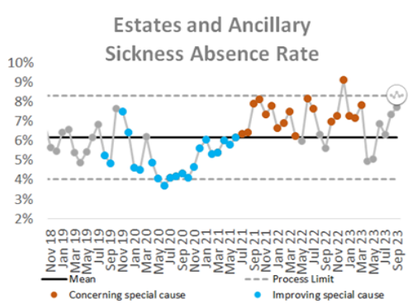


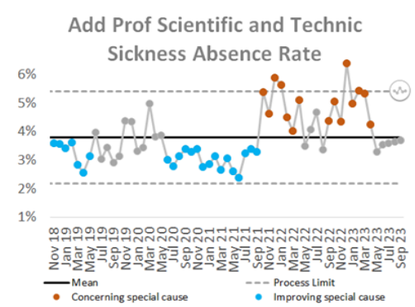










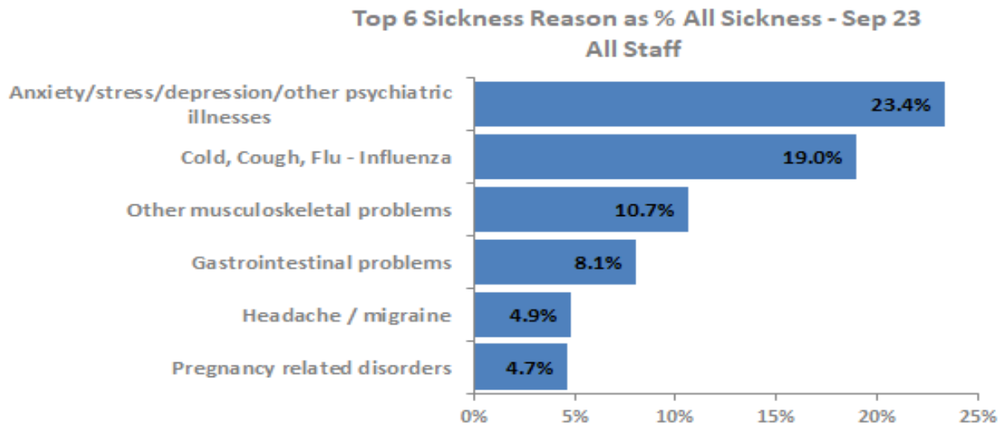


Author(s): Chloe Schafer, Amanda Wood

Owner(s): David Wherrett

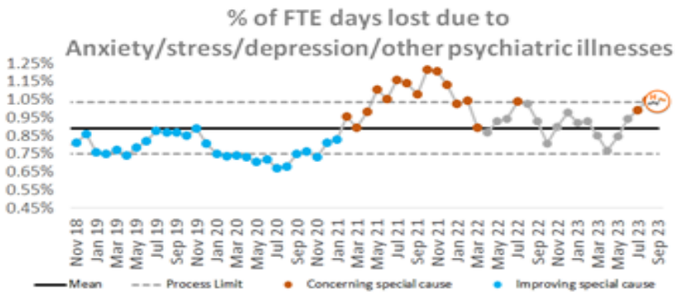
Top Six Sickness Absence Reason

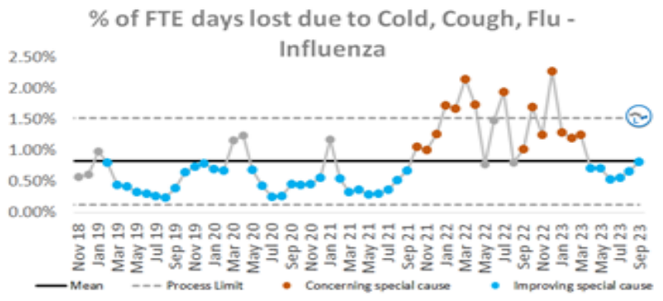
NHS
Cambridge University Hospitals
NHS Foundation Trust

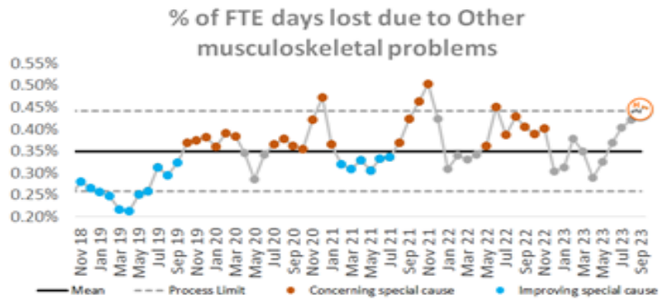


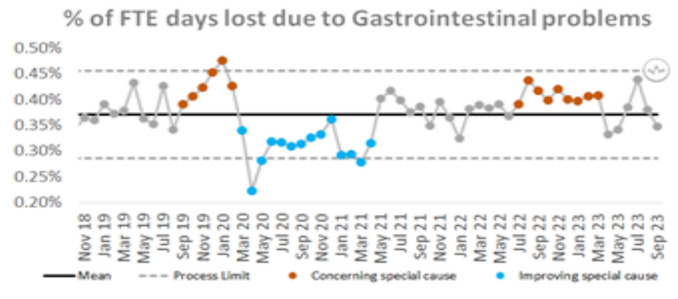
Background Information: Sickness Absence reason is provided as a percentage of all FTE days missed due to sickness during the reporting month.

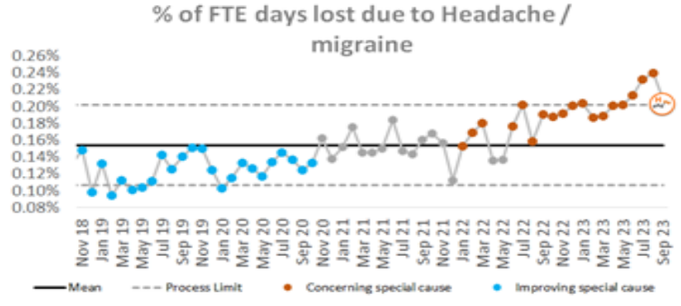
What the information tells us: The top reason for sickness absence is Anxiety/stress/depression/other psychiatric illnesses, with an absence rate of 1%, the same rate as last month, and 0.1% higher than September last year. As a percentage of all sickness absence, Anxiety/stress/depression/other psychiatric illnesses accounts for 23% of the overall figure. Absence due to Cold, Cough, Flu - Influenza is 0.2% higher than last month and 0.2% lower than the same month last year.

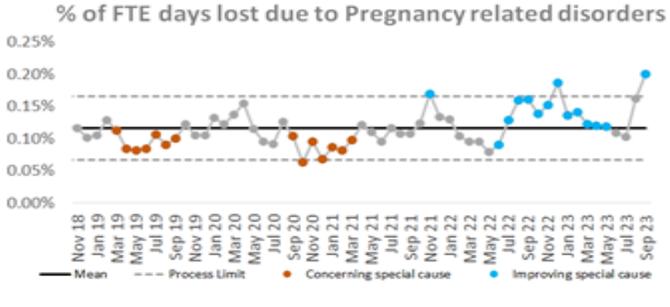






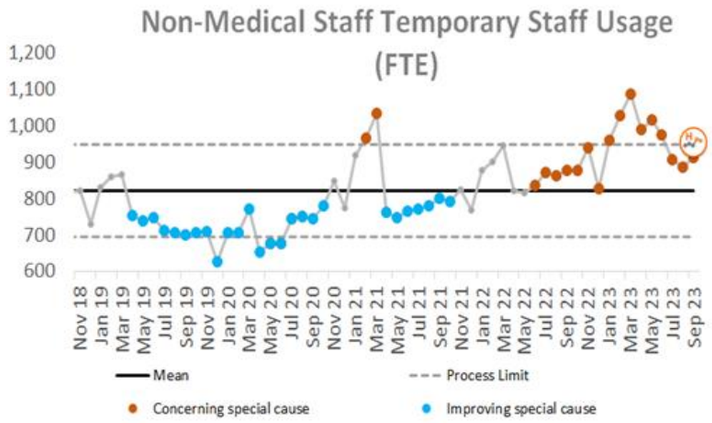


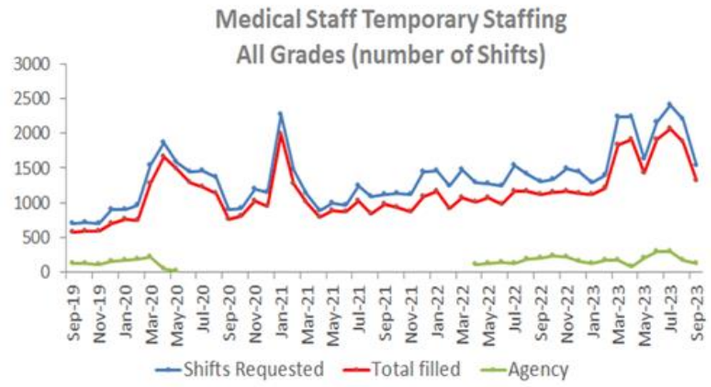




Temporary Staffing

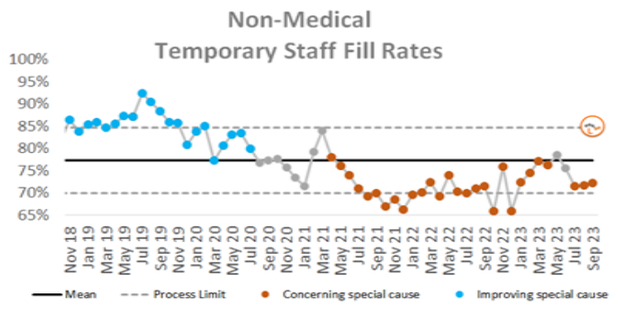
NHS
Cambridge University Hospitals
NHS Foundation Trust

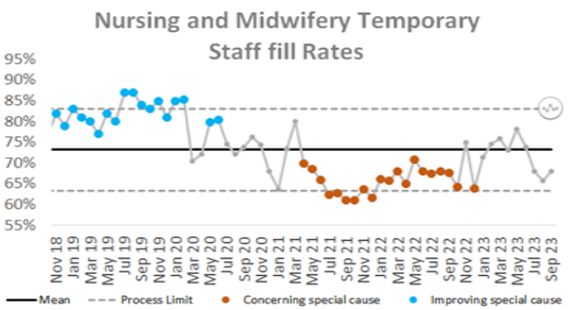


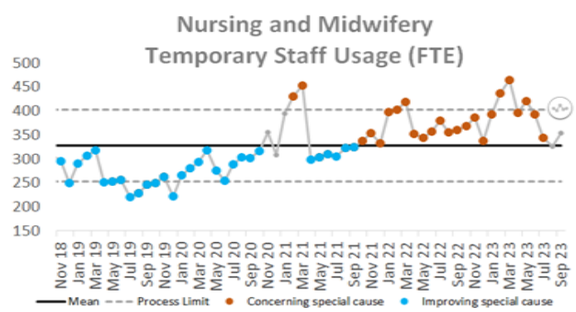


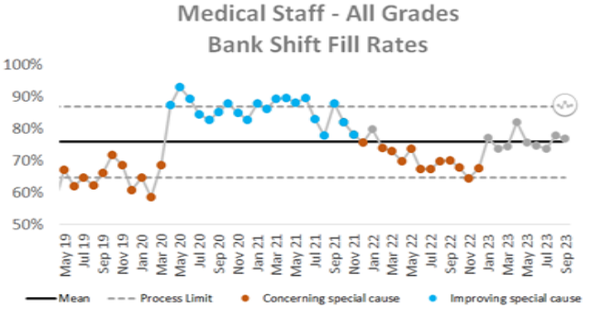
Background Information: The Trust works to ensure that temporary vacancies are filled with workers from staff bank in order to minimise agency usage, ensure value for money and to ensure the expertise and consistency of staffing.

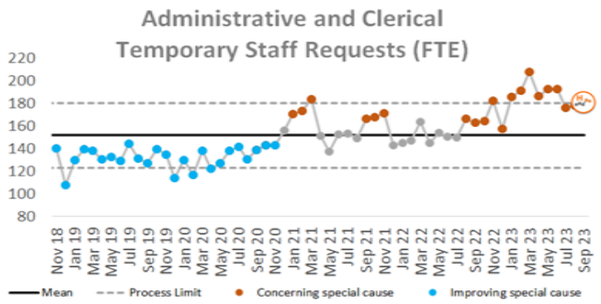
What the information tells us: Overall non-medical fill rates have remained static since August 2023, as an increase in requests has been matched by the increase in filled shifts. Top three reasons for request are vacancy (48%), increased workload (19%) and sickness requiring cover (15%). Nursing and midwifery agency usage decreased by 0.2 WTE from the previous month to 16.6 WTE. This accounts for 5% of the total nursing filled shifts.
Demand for temporary medical staff decreased by 30% from August. Fill rate increased slightly to 86%, with 215 shifts unfilled.

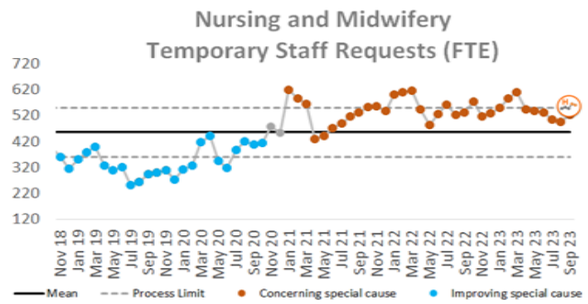


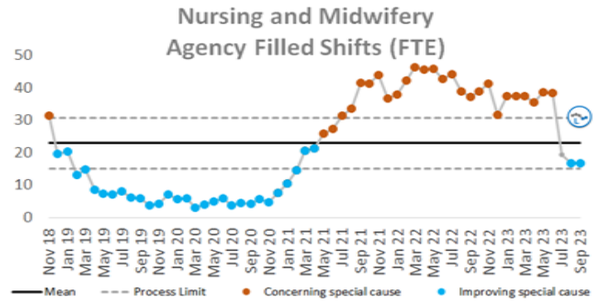


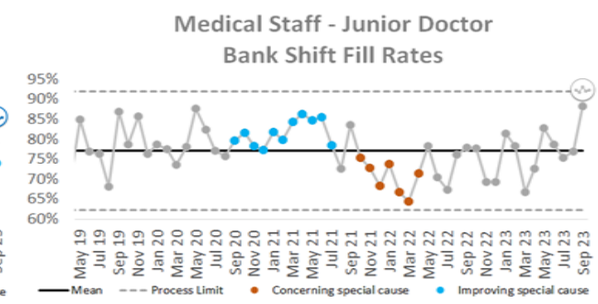




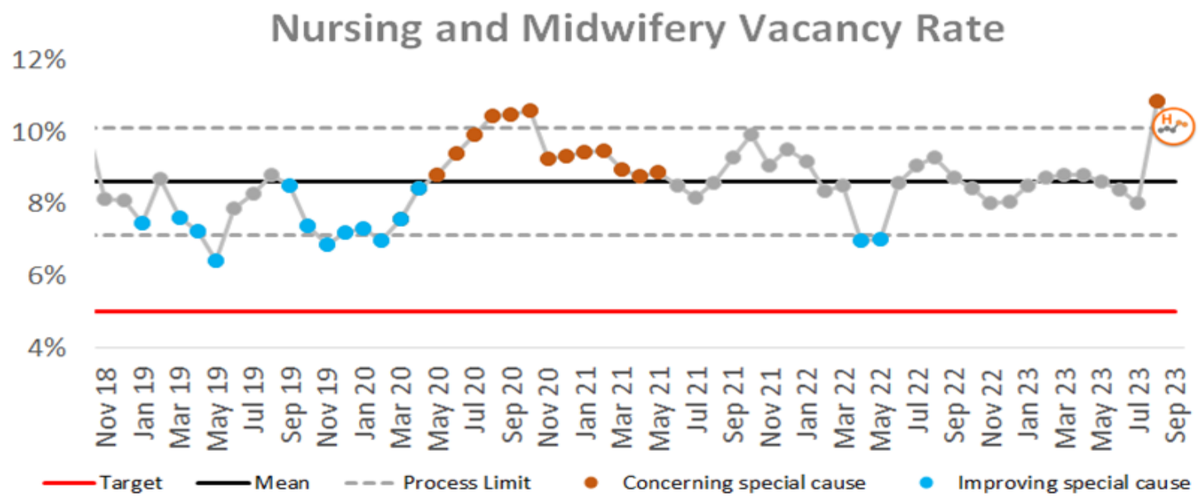


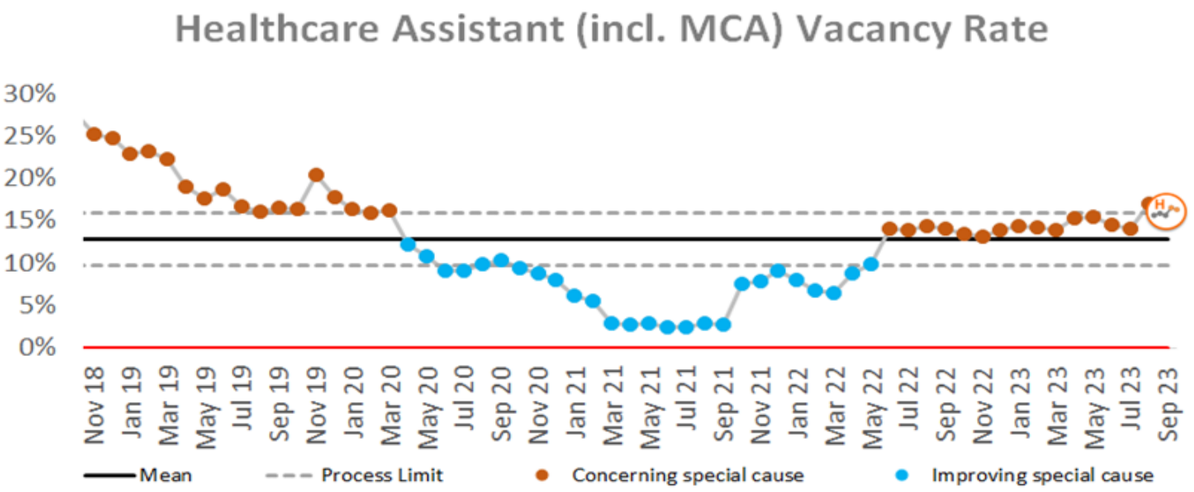






ESR Vacancy Rate





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

What the information tells us: 2023/24 budgets have now been loaded to ESR for Clinical and Corporate Divisions. This has increased the establishment for both Nursing and Midwifery and Healthcare Assistants, thereby increasing vacancy rates from August 2023.

The vacancy rate for Nursing and Midwifery is 10.1% as at end of September, which is 0.7% lower than last month. The vacancy rate for Healthcare Assistants is 15.9% as at end of September, which is 1.2% lower than last month.

Vacancy rates for both staff groups are above the target rate of 5% for Nurses and 0% for HCAs.

Annual Leave Update

Cambridge University Hospitals NHS Foundation Trust

Percentage of Annual Leave (AL) Taken – September 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	48,432	22,732	46.9%	97%
	Additional Clinical Services	376,280	191,355	50.9%	98%
	Administrative and Clerical	510,785	246,668	48.3%	96%
	Allied Health Professionals	151,962	75,279	49.5%	99%
	Estates and Ancillary	76,190	41,564	54.6%	97%
	Healthcare Scientists	153,110	71,038	46.4%	96%
	Medical and Dental	141,289	46,465	32.9%	31%
	Nursing and Midwifery Registered	805,615	411,986	51.1%	98%
	Trust	**2,263,662**	**1,107,087**	48.9%	88%
Annual Leave taken by Division	*Division*				
	Corporate	318,529	128,298	40.3%	96%
	Division A	422,389	172,511	40.8%	87%
	Division B	631,236	255,312	40.4%	94%
	Division C	282,064	108,181	38.4%	81%
	Division D	261,834	107,120	40.9%	85%
	Division E	246,290	103,284	41.9%	87%
	R&D	105,319	42,893	40.7%	97%

* Greater than 40% | Less than 30% | Between 30% and 40%

What the information tells us: The Trust's annual leave usage is at 98% of the expected usage at the end of the sixth month of the financial year. The highest rate of use of annual leave is within the Estates and Ancillary staff group, at 54.6%, followed by Nursing and Midwifery Registered at 51.1%.

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

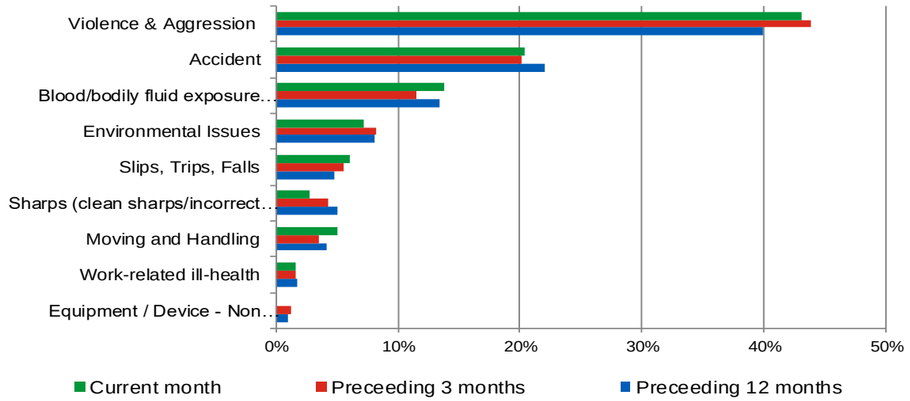
Background Information: Statutory and Mandatory training are essential for the safe and efficient delivery of the organisation services They are designed to reduce organisational risks and comply with local or national policies and government guidelines. Training can be undertaken on-line or by attending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

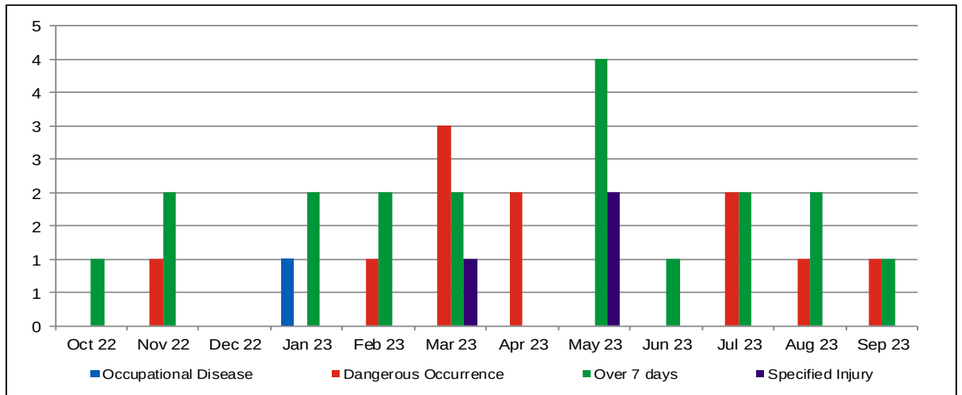
		Induction (95% or higher / Less than 80% / Between 80% and 94%)				Mandatory Training Competency (as defined by Skills for Health) (90% or higher / Less than 75% / Between 75% and 89%)																
						*Information Governance including GDPR and Cyber Security (95% or higher / Less than 80% / Between 80% and 94%)																
		Non-Medical		Medical																		
		Corporate Induction	Local Induction	Corporate Induction	Local Induction	Conflict Resolution	Equality, Diversity and Human Rights	Fire Safety	Health, Safety and Welfare	Infection Control	*Information Governance including GDPR and Cyber Security	Moving & Handling	Resuscitation	Safeguarding Adults 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)	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	
Delivery Method		cl	f2f	cl/	f2f	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	
Staff Requiring Competency		1,089	1,089	205	205	10,733	10,733	10,893	10,733	10,733	10,733	10,889	7,429	10,733	7,870	3,840	10,733	7,875	1,783	9,540	1,771	
Compliance by Division																						
Compliance by Division	Division A	(14)91.8%	(52)69.6%	(16)75.4%	(14)78.5%	(43)97.9%	(43)97.9%	(393)80.9%	(43)97.9%	(83)95.9%	(116)94.2%	(344)83.2%	(362)80.9%	(70)96.5%	(151)92.1%	(288)63.9%	(43)97.9%	(157)91.8%	(26)83.5%	(66)96.6%	(15)91.8%	92.3%
	Division B	(7)97.9%	(40)87.8%	(7)74.1%	(5)81.5%	(41)98.6%	(49)98.3%	(164)94.3%	(50)98.2%	(94)96.7%	(137)95.2%	(213)92.6%	(238)84.0%	(80)97.2%	(196)89.4%	(232)74.6%	(45)98.4%	(192)89.6%	(18)87.3%	(55)98.1%	(10)92.1%	95.3%
	Division C	(8)94.4%	(27)81.3%	(10)76.7%	(3)93.0%	(37)97.4%	(44)96.9%	(209)85.7%	(47)96.7%	(87)93.9%	(154)89.2%	(248)83.1%	(301)79.0%	(75)94.7%	(134)90.7%	(290)56.9%	(57)96.0%	(136)90.6%	(60)78.5%	(74)94.3%	(30)89.2%	91.0%
	Division D	(7)94.0%	(24)79.3%	(9)76.3%	(13)65.8%	(40)97.0%	(40)97.0%	(175)87.0%	(45)96.6%	(80)94.0%	(129)90.3%	(207)84.6%	(256)78.0%	(65)95.1%	(99)91.5%	(238)56.5%	(47)96.5%	(93)92.1%	(14)89.1%	(55)95.7%	(20)84.0%	91.8%
	Division E	(9)93.2%	(30)77.3%	(6)80.6%	(4)87.1%	(20)98.4%	(22)98.3%	(166)87.1%	(26)97.9%	(52)95.9%	(90)92.9%	(229)82.2%	(181)83.9%	(41)96.8%	(53)95.3%	(242)64.0%	(22)98.3%	(47)95.9%	(122)88.2%	(5)98.2%	(84)91.9%	93.1%
	Corporate	(6)95.5%	(26)80.3%	(1)0.0%	(1)0.0%	(24)98.3%	(29)97.9%	(72)94.8%	(31)97.8%	(65)95.3%	(75)94.6%	(64)95.4%	(24)85.1%	(38)97.3%	(10)94.0%	(26)77.2%	(29)97.9%	(14)91.8%	(5)80.0%	(36)97.4%	(3)85.7%	96.2%
	R & D	(0)100.0%	(16)75.8%			(7)98.5%	(9)98.0%	(18)96.1%	(9)98.0%	(12)97.4%	(10)97.8%	(27)94.1%	(13)92.1%	(11)97.6%	(7)96.2%	(22)82.0%	(9)98.0%	(6)96.7%	(1)94.1%	(6)98.7%	(1)85.7%	96.9%
	Breakdown of Medical staff compliance																					
	Consultant			(5)90.7%	(10)81.5%	(20)97.4%	(21)97.3%	(55)92.9%	(23)97.0%	(62)92.0%	(69)91.1%	(67)91.3%	(183)76.7%	(29)96.2%	(32)95.9%	(258)64.0%	(17)97.8%	(32)95.9%	(16)92.5%	(12)97.9%	(12)94.2%	93.6%
	Non Consultant			(44)70.9%	(30)80.1%	(64)87.1%	(70)85.9%	(101)79.7%	(76)84.7%	(110)77.9%	(152)69.4%	(137)72.4%	(415)47.9%	(96)80.7%	(214)72.8%	(414)42.3%	(84)83.1%	(196)75.2%	(48)68.0%	(142)76.9%	(42)74.7%	75.0%
	Compliance by Staff group																					
Compliance by Staff Group	Add Prof Scientific and Technic	(0)100.0%	(3)89.3%			(2)99.1%	(3)98.6%	(3)98.6%	(1)99.5%	(4)98.2%	(11)95.0%	(7)96.8%	(2)94.3%	(0)100.0%	(9)95.4%	(1)90.0%	(0)100.0%	(10)94.9%	(0)100.0%	(2)99.1%	(0)100.0%	97.9%
	Additional Clinical Services	(19)93.0%	(61)77.7%			(22)98.7%	(17)99.0%	(267)85.1%	(22)98.7%	(47)97.3%	(97)94.4%	(295)83.5%	(244)82.9%	(33)98.1%	(181)88.8%	(1)75.0%	(22)98.7%	(175)89.2%	(28)81.6%	(27)98.4%	(15)90.1%	93.1%
	Administrative and Clerical	(10)96.4%	(62)77.5%			(33)98.6%	(42)98.2%	(83)96.5%	(47)98.0%	(104)95.6%	(116)95.0%	(112)95.2%	(5)73.7%	(64)97.3%	(10)90.9%		(54)97.7%	(13)88.4%	(3)75.0%	(62)97.4%	(1)80.0%	96.6%
	Allied Health Professionals	(1)98.6%	(11)84.3%			(2)99.7%	(5)99.3%	(66)90.4%	(4)99.4%	(13)98.1%	(21)96.9%	(68)90.1%	(74)89.1%	(21)96.9%	(32)95.3%	(119)79.7%	(7)99.0%	(34)95.0%	(9)86.8%	(6)99.0%	(4)93.8%	95.8%
	Estates and Ancillary	(3)92.1%	(5)86.8%			(8)97.6%	(8)97.6%	(30)91.1%	(8)97.6%	(22)93.4%	(33)90.1%	(8)97.6%	(8)97.6%	(12)96.4%			(6)98.2%			(8)97.7%		95.6%
	Healthcare Scientists	(1)98.7%	(8)89.3%			(10)98.5%	(12)98.2%	(13)98.0%	(11)98.3%	(15)97.7%	(27)95.9%	(18)97.3%	(16)85.6%	(14)97.9%	(43)77.0%	(0)100.0%	(10)98.5%	(41)77.8%	(0)100.0%	(5)99.3%	(0)100.0%	96.7%
	Medical and Dental			(49)76.1%	(40)80.5%	(84)93.4%	(91)92.8%	(156)87.7%	(99)92.2%	(172)86.5%	(221)82.6%	(204)83.9%	(598)62.2%	(125)90.2%	(246)84.3%	(672)53.1%	(101)92.0%	(228)85.5%	(64)82.3%	(154)87.1%	(54)85.6%	85.5%
	Nursing and Midwifery Registered	(17)94.8%	(65)80.2%			(51)98.5%	(58)98.3%	(579)83.8%	(59)98.3%	(96)97.3%	(185)94.7%	(620)82.7%	(436)87.8%	(111)96.8%	(129)96.3%	(545)69.8%	(52)98.5%	(144)95.9%	(142)87.8%	(33)98.6%	(89)92.3%	94.0%
	Trust Total	(51)95.3%	(215)80.3%	(49)76.1%	(40)80.5%	(212)98.0%	(236)97.8%	(1197)89.0%	(251)97.7%	(473)95.6%	(711)93.4%	(1332)87.8%	(1375)81.5%	(380)96.5%	(650)91.7%	(1338)65.2%	(252)97.7%	(645)91.8%	(246)86.2%	(297)96.9%	(163)90.8%	93.5%

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:	**1924**	**392**	**279**	**604**	**308**	**204**	**52**	**85**
Accident	**423**	96	84	104	65	36	10	28
Blood/bodily fluid exposure (dirty sharps/splashes)	**258**	84	45	50	34	37	6	2
Environmental Issues	**156**	29	42	16	28	22	6	13
Equipment / Device - Non Medical	**18**	4	1	4	4	5	0	0
Moving and Handling	**79**	20	9	14	20	7	1	8
Sharps (clean sharps/incorrect disposal & use)	**96**	24	18	10	13	19	8	4
Slips, Trips, Falls	**92**	19	20	15	10	10	3	15
Violence & Aggression	**768**	107	57	389	123	60	17	15
Work-related ill-health	**34**	9	3	2	11	8	1	0





A total of 1,924 health and safety incidents were reported in the previous 12 months.

885 (46%) incidents resulted in harm. The highest reporting categories were violence and aggression (40%), accidents (22%) and blood/bodily fluid exposure (13%).

1,308 (68%) of incidents affected staff, 547 (28%) affected patients and 69 (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 (40%), violence & aggression (38%) and environmental issues (9%).

The highest reported incident categories for others were: violence & aggression (28%), slips, trips and falls (25%). And accidents/environmental issues (22%).

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

The highest reporting division was division C with 604 incidents. Of these, 64% related to violence & aggression.

In the last 12 months, the highest reported RIDDOR category was over 7 day injuries (56%).

In the last 12 months, 68% of RIDDOR incidents were reported to the HSE within the appropriate timescale.

In September 2023, 2 incidents were reported to the HSE:

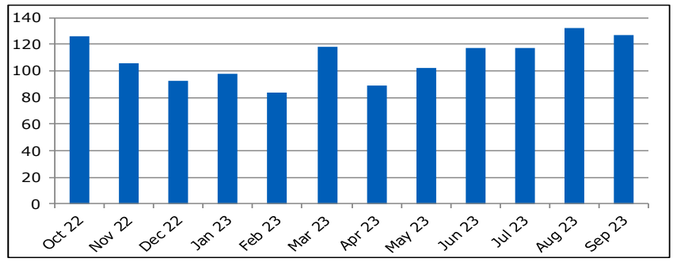
Over 7 day injury:
- The Injured Person (IP) was walking along a corridor when they were 'clipped' by a bed that was being pushed by another member of staff. The IP sustained damage to the posterior ligament and meniscus of the knee. The IP was on light duties/off work for over 7 days.

Dangerous occurrence:
- The IP was assisting in delivering a baby/pulling baby out of the uterus. The patient was Hep B positive. Appropriate first aid was administered and follow up with occupational health.

Health and Safety Incidents

NHS Cambridge University Hospitals

No. of health and safety incidents affecting staff:

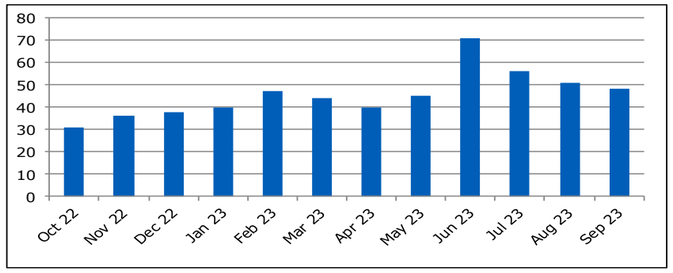


	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Total
Accident	16	19	14	12	14	21	13	13	14	14	23	18	**191**
Blood/bodily fluid exposure (dirty sharps/splashes)	32	14	20	20	12	20	18	22	23	14	22	23	**240**
Environmental Issues	6	1	6	4	2	8	8	10	14	7	17	10	**93**
Moving and Handling	2	1	2	5	8	9	3	5	7	5	4	7	**58**
Sharps (clean sharps/incorrect disposal & use)	8	10	5	5	7	3	10	3	7	7	8	3	**76**
Slips, Trips, Falls	4	6	4	8	7	4	6	8	3	10	5	10	**75**
Violence & Aggression	57	52	37	39	33	50	30	38	45	56	51	53	**541**
Work-related ill-health	1	3	4	5	1	3	1	3	4	4	2	3	**34**
Incident affecting Staff	**126**	**106**	**92**	**98**	**84**	**118**	**89**	**102**	**117**	**117**	**132**	**127**	**1308**

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

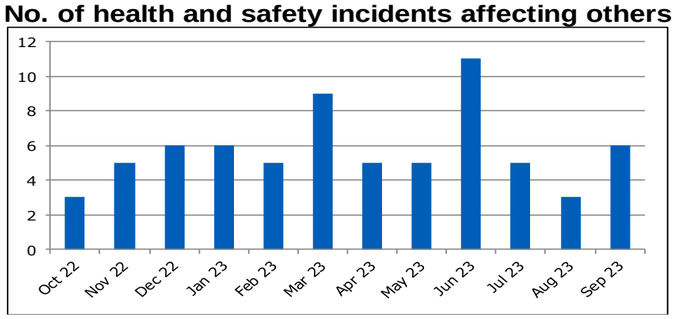
	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Total
No. of health & safety incidents	126	106	92	98	84	118	89	102	117	117	132	127	**1308**
Staff incident rate per month/year	1.0	0.9	0.8	0.8	0.7	1.0	0.7	0.8	1.0	1.0	1.1	1.0	**10.7**

No. of health and safety incidents affecting patients:



	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Total
Accident	13	15	19	19	17	21	13	19	29	14	20	18	**217**
Blood/bodily fluid exposure (dirty sharps/splashes)	0	0	3	2	0	1	3	2	2	2	0	2	**17**
Environmental Issues	3	8	7	3	5	1	2	4	6	3	4	2	**48**
Equipment / Device - Non Medical	1	3	1	2	1	0	0	1	2	6	1	0	**18**
Moving and Handling	0	3	2	1	4	2	1	2	3	0	1	2	**21**
Sharps (clean sharps/incorrect disposal & use)	1	0	1	0	2	3	2	0	4	3	0	2	**18**
Violence & Aggression	13	7	5	13	18	16	19	17	25	28	25	22	**208**
Total	**31**	**36**	**38**	**40**	**47**	**44**	**40**	**45**	**71**	**56**	**51**	**48**	**547**

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



	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Total
Accident	1	2	0	2	0	2	2	1	2	1	1	1	**15**
Blood/bodily fluid exposure (dirty sharps/splashes)	0	0	0	0	0	0	1	0	0	0	0	0	**1**
Environmental Issues	1	1	2	2	1	2	1	2	1	1	0	1	**15**
Sharps (clean sharps/incorrect disposal & use)	0	0	0	2	0	0	0	0	0	0	0	0	**2**
Slips, Trips, Falls	0	1	2	0	2	4	0	0	3	2	2	1	**17**
Violence & Aggression	1	1	2	0	2	1	1	2	5	1	0	3	**19**
Total	**3**	**5**	**6**	**6**	**5**	**9**	**5**	**5**	**11**	**5**	**3**	**6**	**69**

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 8 November 2023

Agenda item	10.2
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 M6
Previously considered by	Performance Committee, 1 November 2023

Executive Summary

The report provides details of financial performance during 2023/24 Month 6 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 6.
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 6 (September 2023).

Contents

Trust actual surplus / (deficit)

(£3.5m)	*Actual (adjusted)**
(£0.3m)	*Plan (adjusted)**
(£3.5m)	*Actual YTD (adjusted)**
£3.3m	*Plan YTD (adjusted)**

Elective Payment Mechanism (EPM)

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

	In month	YTD
EPM forecast actual	£17.8m	£107.0m
Target adj. block increase	£0.3m	£1.9m
EPM actual + block increase	£18.1m	£108.9m
EPM original plan	£19.6m	£118.7m
EPM original target	£18.2m	£110.0m

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

Net current assets

(£90.0m)	*Actual*
(£45.6m)	*Plan*

Debtor days

20	*This month*
20	*Previous month*

Payables performance (YTD) **

86.7%	*Value*
89.3%	*Quantity*

EBITDA

£14.0m	*Actual YTD*
£22.6m	*Plan YTD*

Capital expenditure

£3.3m	*Capital - actual spend in month*
£19.4m	*Capital - actual spend YTD*
£14.6m	*Capital – plan YTD*

Cash

Cash

£175.1m	*Actual*
£151.7m	*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.

Month 6 Financial Performance

- **The Month 6 year to date position is £3.5m deficit for performance management purposes**. This is adverse to our planned performance by £6.8m.

- The following key points should be noted:
  - This position includes £6.5m 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 £6.0m for additional pay expenditure and £9.8m for elective activity under performance.
  - A reduction to the EPM target for April has provided £1.9m of support to the Trust YTD with a further £2.0m due by year end, partially mitigating the impact of IA.
  - Further IA is planned in October which is expected to significantly increase the pressure on the Trust's finances.
  - Additional financial support is required for the Trust to deliver it's 23/24 financial plan.
  - NHSE has indicated that further reductions to the EPM target will be issued to support Trusts for the impact of continued IA.

- Income adverse variance of £6.5m - Clinical income is adverse to plan by £9.0m and Devolved income is favourable to plan by £2.5m. Please see pages 10-14.
- Pay adverse variance of £7.0m - this position is due to direct costs associated with IA (£6.0m) 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 (£4.0m). Please see pages 15-16.
- Non pay (including drugs) favourable variance of £4.9m - 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 6 YTD performance for the **EPM is £3.0m below target and £11.7m below plan,** prior to target adjustments to support the impact of IA.

Additional funding to support the impact of IA:

- The EPM target has been reduced by 2% for April's IA and we expect similar adjustments to be made for subsequent IA months but this has not yet been confirmed.
- At month 6 YTD the impact of this adjustment is an increase in block income payments of £1.9m.
- At month 6 YTD the adjusted **EPM performance is therefore £1.0m below target and £9.8m below plan**.
- The target adjustment will provide a further £2.0m of financial support to the Trust by the end of the financial year.
- If further adjustments to the Trust's EPM target are provided in support of IA, the Trust's assessment is that this will mitigate the Trust's financial impact of IA by the end of the financial year.

Productivity and Efficiency Programme (PEP)

- For 23/24 the efficiency requirement will be delivered via Covid cost reduction, central efficiencies, direct 'cost out' and productivity / growth schemes.
- 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 £48.2m and represent 90.8% of the total plan.
- The Month 6 PEP has an adverse position of £1.7m. Pay efficiencies are currently behind plan by £4.3m with non-pay efficiencies favourable to plan by £0.4m and Income efficiencies £2.2m 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.

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 6 the capital programme is ahead of plan with spend year to date of £19.4m against a budget of £14.6m. 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 6 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 which has been actioned from M5. The Trust expects to receive an additional £5.8m of non-recurrent funding to cover the budgeted cost of the pay award.

£ 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	Full Year Forecast	Full Year Variance
Clinical Income - exc. D&D*, EPM	64.2	59.9	(4.3)	384.0	379.1	(4.9)	773.4	771.1	(2.3)
Clinical Income - EPM variable	19.6	17.8	(1.8)	118.7	107.0	(11.7)	239.0	239.0	0.0
Clinical Income - D&D*	14.3	15.9	1.6	86.0	93.6	7.6	175.1	187.9	12.8
Devolved Income	15.3	13.9	(1.5)	92.0	94.5	2.5	183.9	184.1	0.2
Total Income	**113.4**	**107.5**	**(5.9)**	**680.6**	**674.1**	**(6.5)**	**1,371.4**	**1,382.1**	**10.7**
Pay	61.6	59.5	2.1	364.9	371.9	(7.0)	744.4	760.6	(16.2)
Drugs	15.9	16.7	(0.8)	95.5	103.0	(7.6)	191.2	204.7	(13.5)
Non Pay	32.9	31.9	1.0	197.7	185.1	12.5	397.4	381.4	16.0
Operating Expenditure	**110.4**	**108.1**	**2.3**	**658.1**	**660.1**	**(2.0)**	**1,333.0**	**1,346.7**	**(13.7)**
EBITDA	**3.0**	**(0.6)**	**(3.7)**	**22.6**	**14.0**	**(8.5)**	**38.4**	**35.4**	**(3.0)**
Depreciation, Amortisation & Financing	3.3	2.9	0.4	19.8	17.9	1.9	39.6	36.6	3.0
Reported gross Surplus / (Deficit)	**(0.3)**	**(3.6)**	**(3.3)**	**2.7**	**(3.8)**	**(6.6)**	**(1.2)**	**(1.2)**	**0.0**
Add back technical adjustments:									
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital donations/grants net I&E impact	0.1	0.1	0.0	0.6	0.4	(0.2)	1.2	1.2	0.0
Net benefit of PPE consumables transactions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit) NHS financial performance basis	**(0.2)**	**(3.5)**	**(3.3)**	**3.3**	**(3.5)**	**(6.8)**	**0.0**	**0.0**	**0.0**

Please note that the values reported in the above table and throughout the report are subject to rounding
* D&D – drugs and devices.

Note to forecast:

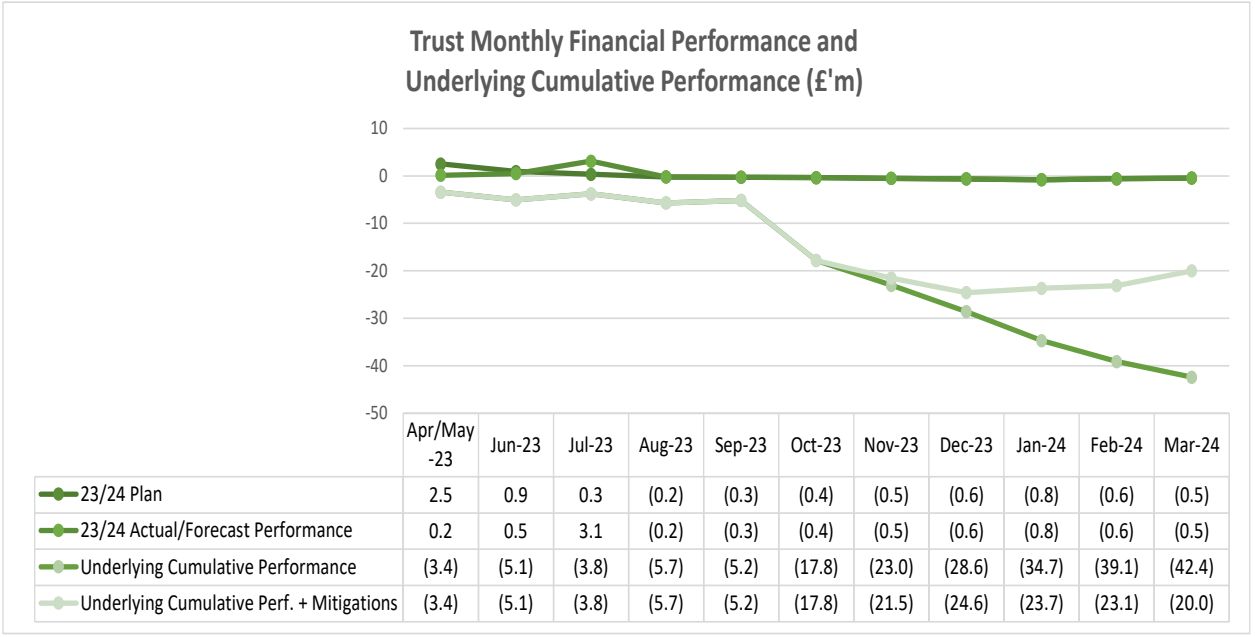
The forecast position assumes further NHSE support for the impact of Industrial Action is provided by financial year end.

Summary financial position

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 £42.4m**.
- Elective service productivity improvements could reduce the **underlying deficit to £20m.**
- This assessment is based on the Trust delivering the operational plan and receiving £6.7m from NHSE/I at Month 7 in support of the costs of Industrial Action.
- At Month 6, non-recurrent:
  - income benefits from the EPM baseline adjustments total £7.5m - (£15.0m full year).
  - support of £6.5m (£20.0m full year).
  - pay expenditure from Industrial Action totals £6.0m. This is expected to increase to £7.4m in Month 8 with no further costs forecast beyond that point.
- 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)	(3.8)	(5.7)	(5.2)	(17.8)	(23.0)	(28.6)	(34.7)	(39.1)	(42.4)
Underlying Cumulative Perf. + Mitigations	(3.4)	(5.1)	(3.8)	(5.7)	(5.2)	(17.8)	(21.5)	(24.6)	(23.7)	(23.1)	(20.0)

£'m	Actual M2 YTD	Actual M3 YTD	Actual M4 YTD	Actual M5 YTD	Actual 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**	**3.8**	**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	6.0	6.7	6.7	6.7	6.7	6.7	6.7
Industrial action income removed (recognised in M7 Surplus)	0.0	0.0	0.0	0.0	0.0	(6.7)	(6.7)	(6.7)	(6.7)	(6.7)	(6.7)
Underlying plan adjustments											
Non-recurrent support	(3.3)	(5.0)	(6.7)	(8.3)	(6.5)	(8.8)	(11.0)	(13.3)	(15.5)	(17.8)	(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)**	**(3.8)**	**(5.7)**	**(5.2)**	**(17.8)**	**(23.0)**	**(28.6)**	**(34.7)**	**(39.1)**	**(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)**	**(3.8)**	**(5.7)**	**(5.2)**	**(17.8)**	**(21.5)**	**(24.6)**	**(23.7)**	**(23.1)**	**(20.0)**

Full Year Plan – key messages

£'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	103.2	99.3	101.0	101.0	101.0	101.0	101.0	101.0	**1,202.1**
Other operating income	27.8	13.9	13.9	14.9	14.1	14.1	14.1	14.1	14.1	14.1	14.1	**169.3**
Total operating income	**224.5**	**112.3**	**112.3**	**118.1**	**113.4**	**115.1**	**115.1**	**115.1**	**115.1**	**115.1**	**115.1**	**1,371.4**
Employee expenses	(118.2)	(59.5)	(59.7)	(66.0)	(61.6)	(63.1)	(63.2)	(63.3)	(63.3)	(63.3)	(63.4)	**(744.4)**
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 income	1.2	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	**7.0**
Finance expense	(1.3)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	**(7.7)**
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:

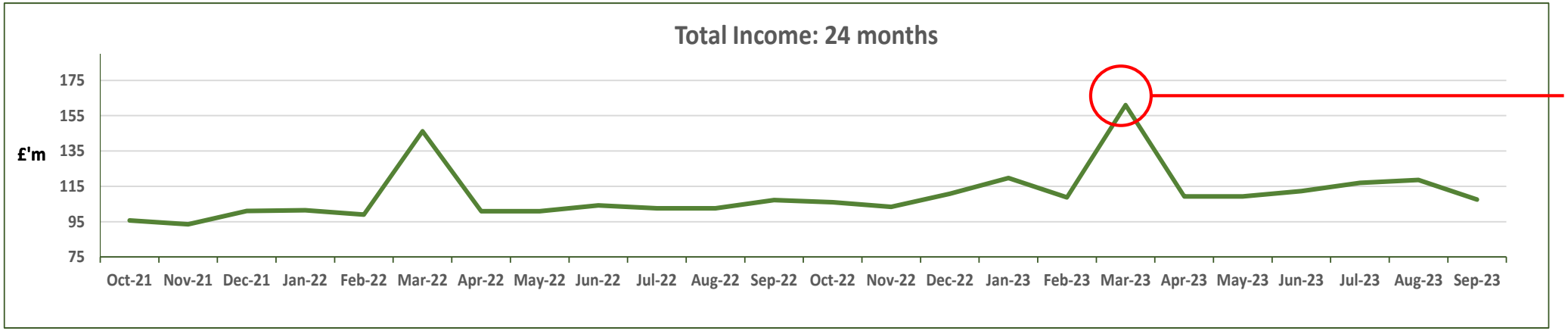
- The plan delivers a 23/24 break-even position on an NHS financial performance basis.
- It is assumed that any elective over-performance will be paid in full, the financial impact of IA will be fully mitigated by NHSE/I and that inflationary pressures will be contained within the modelled levels.
- 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.
- The plan for month 5 onwards has been updated to reflect the income and expenditure associated with the Medical Pay Award.

£'m	M6 YTD Plan	M6 YTD Actual	Variance	Key Variances
Operating income from patient care activities	596.0	587.3	(8.7)	Pass-through drugs income is higher than planned (£7.6m) and is driven by both cost and volume variations to plan. Injury cost recovery is £1.1m ahead of plan with Private Patients income £0.7m behind plan. Net other variable income elements are £0.7m ahead of plan.
Other operating income	84.6	86.8	2.2	The favourable variance of £2.2m is driven by Community Diagnostics Centre (CDC) income (£2.0m) and net other favourable variances of £0.2m. Fire safety works expenditure is in line with plan to m6.
Total income	**680.6**	**674.1**	**(6.5)**	
Employee expenses	(364.9)	(371.9)	(7.0)	The primary drivers of the adverse position are the direct impact of the Industrial Action (£6.0m) phasing of bank holidays in the plan (£0.5m) and associated slippage on delivery of planned productivity and efficiency (£4.3m). The impact of premium rates of bank and agency pay are largely offset by fully funded vacancies (including medical pay award) but present an ongoing financial risk.
Operating expenses excluding employee expenses	(310.6)	(305.7)	5.0	The favourable position is driven by lower than planned expenditure on cancer drugs including Car-T (£3.6m), Clinical negligence (Maternity incentive scheme) rebate (£1m) and other non-pay costs favourable to plan by £2.7m offset fire safety works ahead of plan (£1.0m) and CDC expenditure (£1.6m).
Operating surplus / (deficit)	**5.1**	**(3.5)**	**(8.5)**	
Finance costs				
Finance income	3.5	5.1	1.6	The Trust has received interest in excess of the plan - this is driven by higher interest rates payable on the Trust cash balances.
Finance expense	(3.9)	(3.5)	0.4	
PDC dividends payable/refundable	(2.0)	(2.0)	0.0	
Net Finance costs	**(2.3)**	**(0.4)**	**1.9**	
Reported gross surplus/(deficit)	**2.7**	**(3.8)**	**(6.6)**	
Add back technical adjustments:				
Impairments (AME)	0.0	0.0	0.0	
Capital donations/grants net I&E impact	0.6	0.4	(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	**3.3**	**(3.5)**	**(6.8)**	

Key messages:

- Year to date, on an NHS financial performance basis, the Trust is reporting a £3.5m deficit. This reflects under achievement against the plan by £6.8m.
- The under performance is explained by Industrial Action (IA) cost pressures in pay (£6.0m) offset by the adjustment to the EPM of £1.9m YTD. The Trust expects to receive additional funding to cover the pay related IA costs from NHSE.

£'m	In Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Elective admissions	13.5	11.9	(1.5)	67.1	68.3	1.2
Non-elective admissions	16.5	18.6	2.1	100.6	103.8	3.2
Outpatients - First	4.8	4.0	(0.8)	26.3	22.8	(3.5)
Outpatients - Follow-up	6.4	6.0	(0.3)	36.2	35.2	(1.1)
A&E	3.8	5.0	1.2	23.4	29.7	6.2
High-cost drugs income from commissioners	14.3	15.9	1.6	86.0	93.6	7.6
Other Clinical Income	38.8	32.1	(6.7)	249.0	226.3	(22.7)
Total Clinical Income	**98.1**	**93.6**	**(4.5)**	**588.7**	**579.7**	**(9.0)**
Devolved Income	15.3	13.9	(1.5)	92.0	94.5	2.5
Total Trust Income	**113.4**	**107.5**	**(5.9)**	**680.6**	**674.1**	**(6.5)**



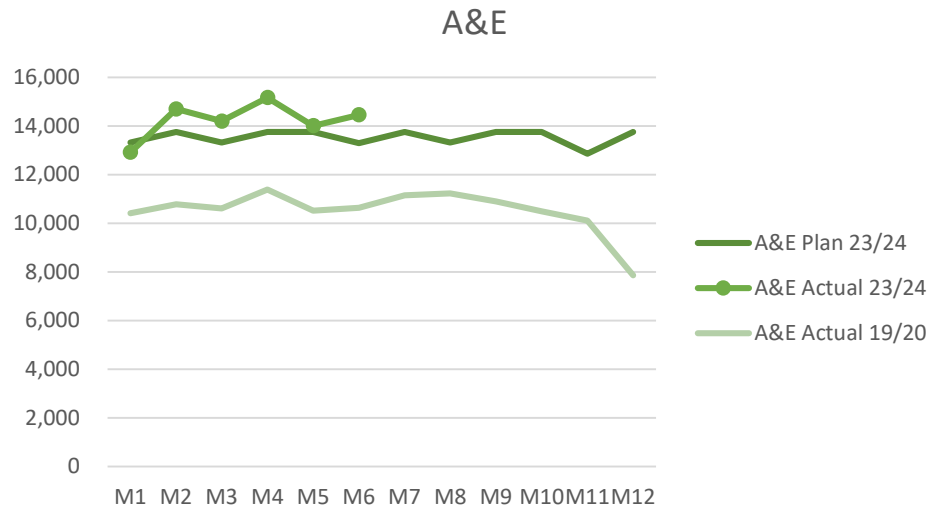
Note: The March 2023 figures include additional funding from NHSE/I for the non-consolidated pay award (£21.1m), the impact of R&D consortium arrangements accounted for in M12 (£13.6m), apprenticeship funding (£2.4m) and national PPE funding (£2.2m). All of which included matched expenditure in M12.

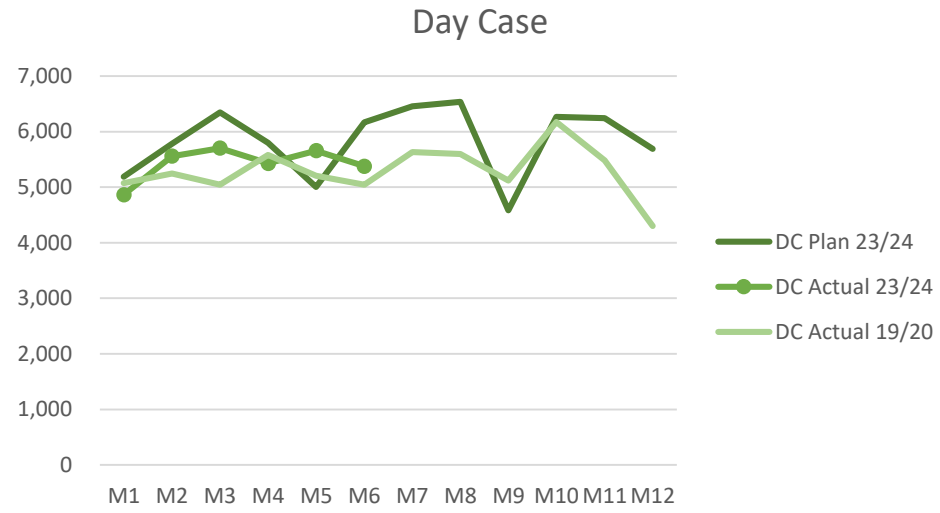
Key messages:

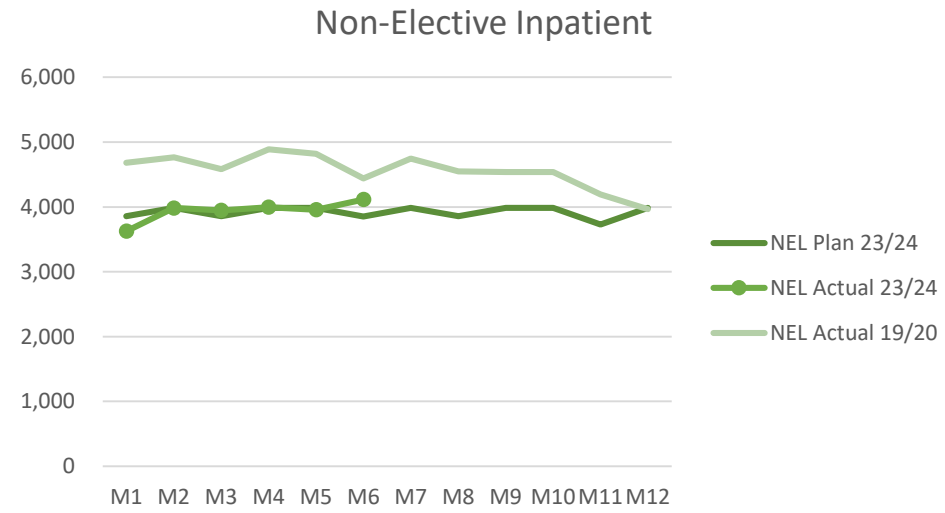
- The Trust income position is adverse to plan by £6.5m year to date.
- This is driven by a shortfall in Clinical income of £4.5m. EPM is performing £1.1m behind target year to date and £9.8m below plan. High-cost drugs income from commissioners (pass-through drugs and devices) has a £7.6m favourable variance to plan.
- Devolved income is favourable year to date by £2.5m - this includes favourable variances in Community Diagnostic Centre (£2.0m) fully offset within non-pay expenditure, NHS injury scheme (was RTA) is £1.1m ahead of plan whilst Private Patients income is £0.7m adverse to plan.
- The reported income position includes additional pay award funding of £6.8m to offset the cost of the Medical, VSM and a shortfall arising from the AfC pay award. It also recognises £2.9m (£5.8m full year) of non-recurrent income to support the overall pay award in year which remains under discussion with C&P ICB.

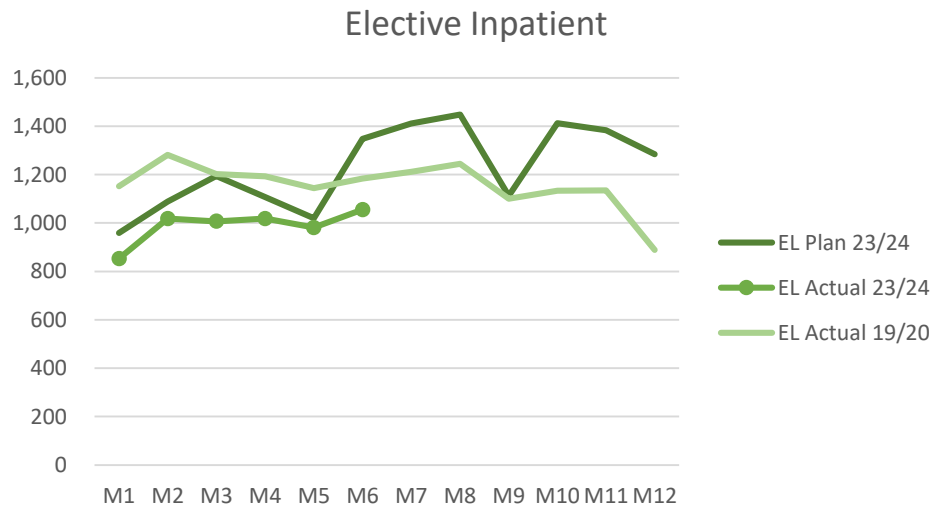
Clinical and other income

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



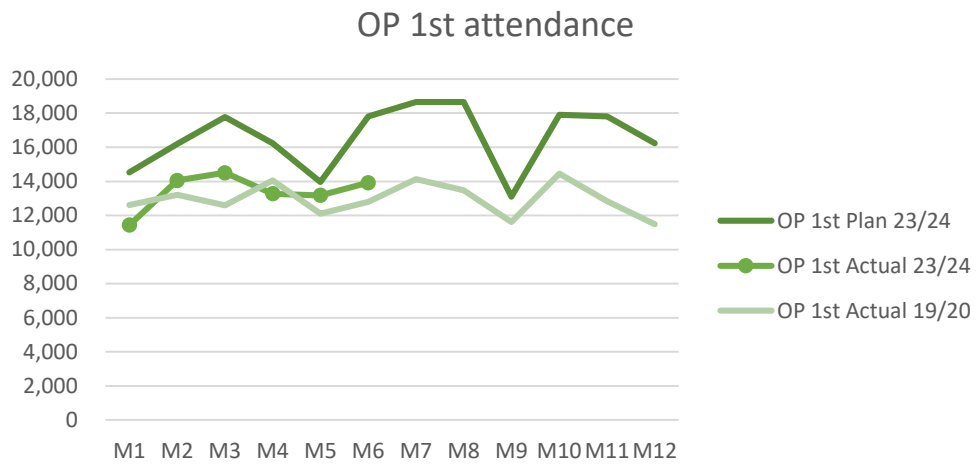


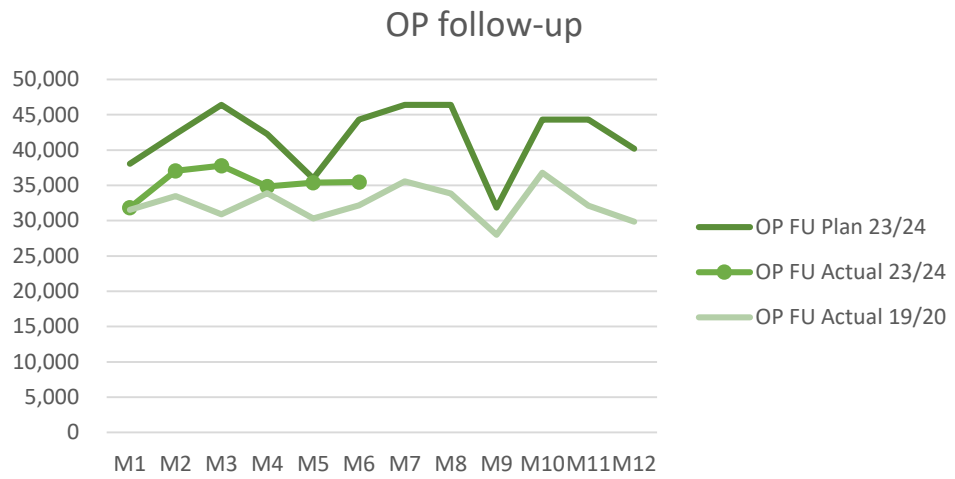


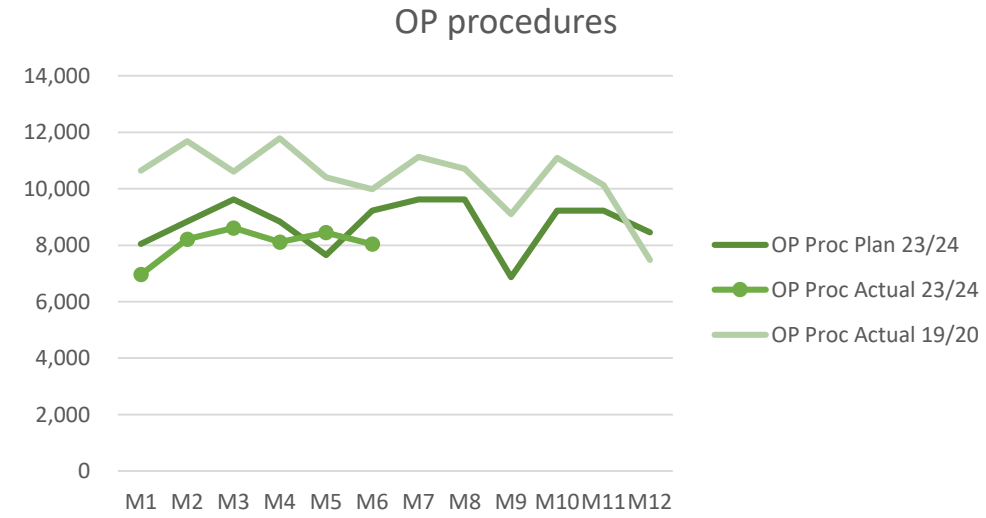


Clinical and other income (continued)

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







Key messages:

- A&E attendances continue to perform higher than both plan and 19-20 levels at month 6. Year to date, A&E is 5.2% above plan and in month 8.7% above plan.
- Non elective spells were slightly above plan at month 6. Year to date, NEL is 0.4% above plan and in month 6.7% above plan.
- Elective spells have a plan that is phased with a larger proportion towards the end of the year, despite this, year to date EL is 11.6% below plan, reportedly due to strike effects.
- Day cases performed below plan at month 6. Year to date, DC is 5.0% below plan, and in month 12.8% below plan.
- Outpatient 1st attendances continued to perform below plan at month 6. Year to date, OP 1st is 21.9% below plan, and in month below plan by 16.7%.
- Outpatient follow-up attendances continued to perform below plan at month 6. Year to date, OP FUP is 20.6% below plan, and in month is below plan by 14.8%.
- Outpatient procedures dropped back below plan at month 6. Year to date, OP proc are 7.4% below plan and in month 12.9% below plan.

Clinical Income – Elective Payment Mechanism (EPM) 1

EPM:
Elective activity recovery in 23/24 is via a 'variable' element of the contract, where Trusts are paid on PbR for a selection of activity including Elective Inpatients, Day-cases, Outpatient First attendances, Outpatients procedures and Chemotherapy.
In August the National Team released a detailed methodology for costing ERF as well as refreshed targets. In September actual performance data for months 1 to 3 were released using the latest tariff prices. The detailed methodology for costing is different from the initial approach taken, and has been checked for robustness. We have updated the targets and actuals based on this new methodology and will be using that going forwards.
The below table shows the outcome of the national methodology, with months 4 – 6 forecasted internally.

EPM is £3.0m below original target YTD which falls £11.7m below planned levels.

Commissioner	Month 06 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	7.3	5.7	(1.5)	7.8	5.7	(2.1)	43.9	40.4	(3.4)	47.1	40.4	(6.6)
C&P ICB	7.0	8.5	1.6	7.6	8.5	1.0	42.2	43.4	1.2	45.7	43.4	(2.3)
Associate ICBs	4.0	3.5	(0.5)	4.3	3.5	(0.8)	23.9	23.2	(0.7)	25.9	23.2	(2.7)
Total Variable	**18.2**	**17.8**	**(0.4)**	**19.6**	**17.8**	**(1.9)**	**110.0**	**107.0**	**(3.0)**	**118.7**	**107.0**	**(11.7)**

Clinical Income – Elective Payment Mechanism (EPM) 2

EPM – National Approach IA:
Fresh guidance was published in mid August on how the NHS plans to deal with IA in monitoring of these elective recovery plans. For the reporting period M1 – 6, a 2% target reduction has been actioned.

Using the latest national targets and monthly actuals, the equivalent table to the previous page with an updated reduced target can be seen below.

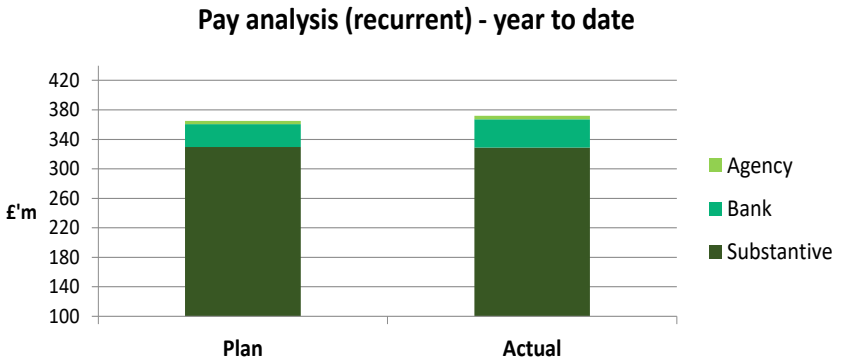
EPM is £1.0m below the adjusted target YTD and £9.8m below the adjusted plan after accounting for the increase in block payment.

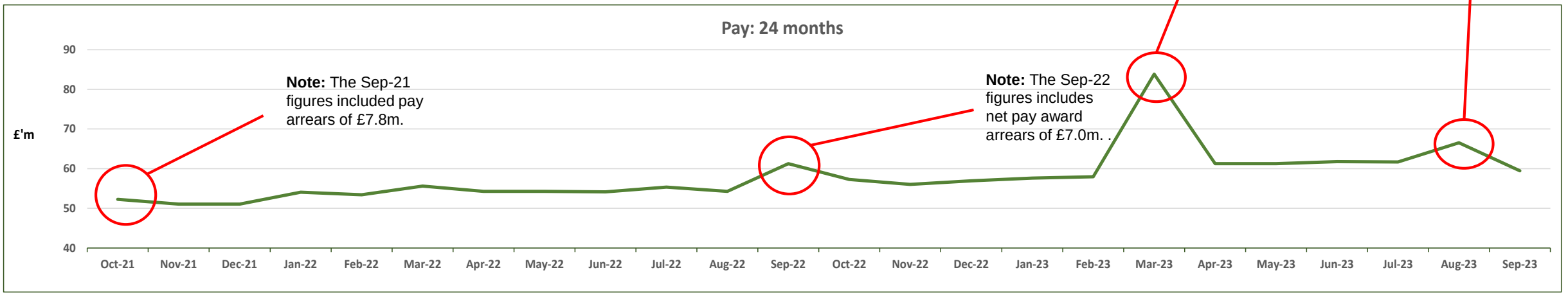
Please note – as at month 6 the centre has issued no adjustments for strikes in months 3, 4, 5 & 6.

Commissioner	Month 06 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	5.7	(1.4)	7.8	5.7	(2.1)	43.2	40.4	(2.7)	47.1	40.4	(6.6)
C&P ICB	6.8	8.5	1.7	7.6	8.5	1.0	41.4	43.4	2.0	45.7	43.4	(2.3)
Associate ICBs	3.9	3.5	(0.4)	4.3	3.5	(0.8)	23.5	23.2	(0.3)	25.9	23.2	(2.7)
Total Variable	**17.9**	**17.8**	**(0.1)**	**19.6**	**17.8**	**(1.9)**	**108.1**	**107.0**	**(1.0)**	**118.7**	**107.0**	**(11.7)**
Target adj. block increase	0.0	0.0	0.0	(0.3)	0.0	0.3	0.0	0.0	0.0	(1.9)	0.0	1.9
Total Overall	**17.9**	**17.8**	**(0.1)**	**19.3**	**17.8**	**(1.6)**	**108.1**	**107.0**	**(1.0)**	**116.8**	**107.0**	**(9.8)**

Key messages:

- The Trust has an adverse pay position of £7.0m in the year to date. The adverse impact of Industrial Action has been estimated at £6.0m year to date. A further £0.5m 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 pressure remains for both volume and cost of temporary staffing measures.
- Bank spend as a proportion of the year to date pay bill is 10.3% while agency spend for the same time period is 1.2%. This compared to 8.7% for bank and 1.3% for agency in 22/23. The main driver for the bank spend is the adverse impact of the Industrial Action and the additional shifts required to cover sickness and other vacancies although management action is has reduced the levels of bank enhancements offered and the volume of bank and agency shifts requested.
- The position includes vacancy factors and pay efficiency targets of £19.4m year to date.
- The reported position recognises the Agenda for Change (AfC) pay settlement of 5% which was paid in the June payroll and Medical and VFM settlements that are due to be paid in September payroll. The Trust has recognised additional income to cover pay award costs in excess of the 2.1% that was originally funded.





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	10.8	(0.4)	61.8	65.1	(3.3)
Allied Healthcare Professionals	3.4	3.7	(0.3)	20.5	22.3	(1.8)
Clinical Scientists & Technicians	5.8	5.6	0.2	34.0	33.5	0.6
Medical and Dental	20.1	18.4	1.7	119.5	123.3	(3.8)
Nursing	21.9	21.0	0.9	129.1	127.7	1.3
Total Pay Cost	**61.6**	**59.5**	**2.1**	**364.9**	**371.9**	**(7.0)**

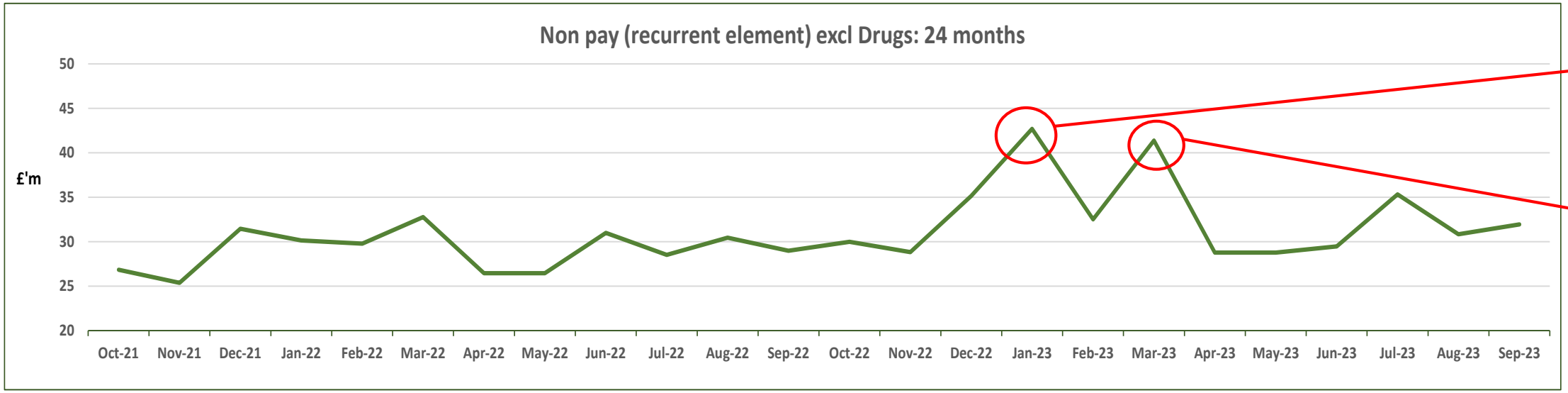
Pay - Employee type

£ 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	0.5	0.2	4.2	4.5	(0.3)
Bank	4.5	5.4	(0.9)	31.0	38.4	(7.5)
Contracted	0.4	0.6	(0.2)	2.1	3.0	(0.9)
Substantive	56.0	53.0	3.0	327.7	326.0	1.7
Total Pay Cost	**61.6**	**59.5**	**2.1**	**364.9**	**371.9**	**(7.0)**

Key messages:

- Pay expenditure has an adverse variance of £7.0m. Direct cost pressures resulting from industrial action in the year to date total £6.0m. This was mainly incurred within the Medical and Dental category.
- Operational pressures arising from high-levels of vacancies and sickness have been the major driver for a net £5.1m adverse variance across A&C and AHP staff groups.
- The favourable variance of £2.1m in month has largely been driven by the high-level of vacancies across medical staffing groups meaning actual pay award arears were lower than planned.
- Industrial action medical pay costs were forecast to be £0.6m lower than previous months due to the adjusted service models in response to the Junior and Consultant joint action.
- 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 6 position includes year to date vacancy factors of £17.6m and unallocated efficiency targets of £1.8m.
- The industrial action has adversely affected the Trust's ability to fully deliver the pay efficiency savings that were planned for the year to date so these schemes are £4.3m adverse to plan at Month 6.
- Agency spend year to date represents 1.2% of Trust wide pay expenditure. This is in line with performance in 22/23 and is significantly below the NHS E threshold target of 3.7% of total pay bill.

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 6, the Trust's non pay position is £5.0m favourable to plan with expenditure £0.3m favourable to plan in month.
- Favourable year to date variances total £8.1m within supplies and services and premises driven by lower than planned clinical activity and delays in inflationary pressures materialising. The in month position is adverse to plan by £0.5m and further work is being undertaken to understand the drivers of the GRNI position for the Trust. There is a benefit of £2.0m 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. A further £0.4m of Community Diagnostic Centre (CDC) costs were recognised in month 6 alongside a matching income value.
- Overall drugs expenditure is £7.6m adverse to plan 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 6 includes £2.0m of non-recurrent benefits arising from the reduction in credit loss on receivables.

£millions	In Month			Year to Date		
	Budget	**Actual**	**Variance**	**Budget**	**Actual**	**Variance**
Supplies and services	19.1	19.7	(0.6)	114.4	106.3	8.1
Drugs	15.9	16.7	(0.8)	95.5	103.0	(7.6)
Premises	7.9	7.4	0.5	47.6	44.6	2.9
Movement in credit loss on receivables	(0.4)	(0.5)	0.1	(2.5)	(2.0)	(0.5)
Clinical negligence	2.3	2.3	0.0	13.7	12.7	1.0
Efficiency savings	(0.2)	0.0	(0.2)	(1.2)	0.0	(1.2)
All other non pay	4.4	3.0	1.3	25.7	23.6	2.1
Total Non Pay	**48.9**	**48.7**	**0.3**	**293.2**	**288.2**	**5.0**

Key messages:

- The non pay position shows a £5.0m favourable year to date variance at month 6. 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 (£2.5m) offset by the increase in Injury Cost Recovery provision. It is expected that the Trust will deliver the planned position at year-end.

Non pay expenditure (continued)

£m	YTD Plan			YTD Actual Delivery			YTD Variance		
	Recurrent	Non-recurrent	Total	Recurrent	Non-recurrent	Total	Recurrent	Non-recurrent	Total
Pay	17.6	0.0	17.6	11.9	1.3	13.2	(5.7)	1.3	(4.3)
Non-pay	7.3	0.5	7.8	8.2	0.0	8.2	0.9	(0.5)	0.4
Income	0.1	0.1	0.1	1.9	0.5	2.4	1.8	0.4	2.2
	24.9	**0.6**	**25.5**	**22.0**	**1.8**	**23.8**	**(2.9)**	**1.2**	**(1.7)**

£m	Full Year Plan			Forecast Full Year Delivery			Variance		
	Recurrent	Non-recurrent	Total	Recurrent	Non-recurrent	Total	Recurrent	Non-recurrent	Total
Pay	34.5	0.0	34.5	25.6	4.4	30.0	(8.8)	4.4	(4.5)
Non-pay	17.4	1.0	18.4	19.0	0.0	19.0	1.6	(1.0)	0.6
Income	0.2	0.1	0.2	3.6	0.5	4.1	3.4	0.4	3.9
	52.0	**1.1**	**53.1**	**48.2**	**4.9**	**53.1**	**(3.8)**	**3.8**	**0.0**

Key messages:

- Please see the appendix for the detailed efficiency plan.
- The Trust has identified £56.2m efficiencies against a target of 53.1m and is forecasting £53.1m of in year delivery. Of this, £48.2m is recurrent, representing 90.8% of the total plan.
- The overall position at M6 shows an adverse position of £1.7m.
- The position shows pay efficiencies are currently behind plan by £4.3 with non-pay efficiencies favourable to the plan by £0.4m and Income efficiencies £2.2m 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	3.2	2.9	2.6	2.9	0.0	2.9	0.0	2.7	0.0	2.9	0.0	3.3	0.0	2.2	0.0	17.6	13.2	34.5	30.0
Total Non-pay Efficiencies	2.5	3.0	1.3	1.2	1.3	1.6	1.3	1.6	1.4	0.9	1.3	0.0	1.3	0.0	1.3	0.0	1.3	0.0	1.3	0.0	3.9	0.0	7.8	8.2	18.4	19.0
Total Income Efficiencies	0.0	0.6	0.0	0.6	0.0	0.3	0.0	0.4	0.0	0.5	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	2.4	0.2	4.1
Total Efficiencies - 2023/24	**8.4**	**7.1**	**4.4**	**3.9**	**4.2**	**3.7**	**4.0**	**5.1**	**4.3**	**4.0**	**4.2**	**0.0**	**4.3**	**0.0**	**4.0**	**0.0**	**4.2**	**0.0**	**4.7**	**0.0**	**6.2**	**0.0**	**25.5**	**23.8**	**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 6 capital expenditure position

Year to Date (Month 6)				Forecast		
	Budget	Actuals	Variance	Budget	Expenditure	Variance
	£m	£m	£m	£m	£m	£m
Programme						
Cambridge Movement Surgical Hub (CMSH)	6.5	6.0	0.5	7.0	7.0	-
Existing Estate/HV/Thrombectomy	1.1	4.4	(3.3)	13.2	16.4	(3.2)
Cancer Research Hospital (CCRH)	1.6	1.4	0.2	11.3	11.3	-
Medical Equipment Replacement	1.1	1.2	(0.0)	13.0	10.3	2.7
Children's Hospital (CCH)	0.9	1.4	(0.5)	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	0.4	0.1	0.3	1.2	1.2	(0.0)
Other Developments/PFI	2.3	4.6	(2.3)	10.5	9.9	0.6
Programme Total	**14.6**	**19.4**	**(4.8)**	**60.7**	**60.7**	**-**

Key Issues/Notes Year to Date

£19.4m has been invested YTD, compared to a budget of £14.6m; an overspend of £4.8m. This overspend is primarily due to the purchase of the surgical robot earlier in the year, and faster progress on the Surgical Skills Centre, than were budgeted; both of which are just timing issues.

The larger areas of spend this year have been:

- Cambridge Movement Surgical Hub (CMSH) - £6.0m
- Replacement Surgical Skills Centre (categorised above under 'Existing Estate') - £2.1m
- ACT-funded surgical robot (categorised under 'Other Developments') - £1.9m
- Cambridge Children's Hospital (CCH) - £1.4m
- Cambridge Cancer Research Hospital (CCRH) - £1.4m
- Replacement & Installation of Medical Equipment - £1.2m
- High Voltage (HV) network improvements - £0.8m
- Nuclear Medicine refurbishment - £0.3m

Key Issues/Notes Forecast

This year has seen the opening of the new Thrombectomy suite and refurbished Nuclear Medicine department, plus the commissioning of the ACT-funded second surgical robot. During November our capital programme will deliver the CMSH (3 theatres & 2 wards) and in December the 2 U wards. Other projects include the purchase of equipment for the CDC, as well as the replacement of 2 linear accelerators, the Cath Lab, 2 x-ray rooms and our existing surgical robot. We will also progress other larger projects, notably CCRH and CCH, as well as the reopening of 3 neuro theatres in the A block.

Since setting the budget we revised down the capital spend requirement for CCRH and CCH, which will also reduce the funding we receive for them. The annual budget is now £60.7m, unchanged from last month, and our forecast continues to align with the budget.

Capital expenditure by programme

Balance sheet

	M6 Actual £m
Non-current assets	
Intangible assets	19.8
Property, plant and equipment	542.7
Total non-current assets	**562.5**
Current assets	
Inventories	13.4
Trade and other receivables	47.6
Cash and cash equivalents	175.1
Total current assets	**236.1**
Current liabilities	
Trade and other payables	(214.3)
Borrowings	(13.8)
Provisions	(13.5)
Other liabilities	(84.6)
Total current liabilities	**(326.2)**
Total assets less current liabilities	**472.4**
Non-current liabilities	
Borrowings	(109.8)
Provisions	(9.5)
Total non-current liabilities	**(119.3)**
Total assets employed	**353.1**
Taxpayers' equity	
Public dividend capital	616.0
Revaluation reserve	47.0
Income and expenditure reserve	(309.9)
Total taxpayers' and others' equity	**353.1**

Balance sheet commentary at month 6

- The balance sheet shows total assets employed of £353.1m.
- Non-current liabilities at month 6 are £119.3m, of which £109.8m represents capital borrowing (including PFI and IFRS 16).
- Cash balances remain strong at month 6.
- The balance sheet includes £16.3m of resource to support the completion of the remedial fire safety works expected to be deployed over the coming years.

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 8 November 2023

Agenda item	10.4
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, 2 November 2023

Executive Summary

The nursing and midwifery safe staffing report for September 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 September 2023.

Monthly Nurse Safe Staffing

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Sponsoring executive director: Lorraine Szeremeta, Chief Nurse

Amanda Small, Deputy Chief Nurse

Christopher Gray, Lead Nurse Safer Staffing

Sarah Raper, Project Lead Nurse safe staffing

Board of Directors: 8 November 2023

Executive Summary

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

The vacancy position in September has decreased in all areas. The vacancy rate for registered children's nurses (RSCNs) is 21.1% (23.1% in August), maternity care assistants (MCAs) at 21.8% (24% in August), Health Care Support Workers (HCSWs) 15.6% (17.1% in August), registered nurses (RNs) 10.1% (10.9% in August) and Registered Midwifes (RMs) 5.31% (6.87% in August). The turnover rate in August remains high but has decreased for RNs to 10.6% from 11% in August, RSCNs to 15.4% from 15.9% in August and RMs to 12.9% from 13.1% in August. However, for HCSW (including MCA's) turnover has increased to 17.1% from 16.6% in August. The main reason for leaving for RN's, RM's, RSCN's and HCSW's is voluntary resignation – relocation. The leavers destination data demonstrates that 27.6% of RNs and 45.5% of RMs are leaving to take up employment in other NHS organisations. 15.2% of RMs are leaving for no employment compared to 8.4% of RNs. Conversely, the leavers destination is unknown for the majority of HCSWs (45.6%).

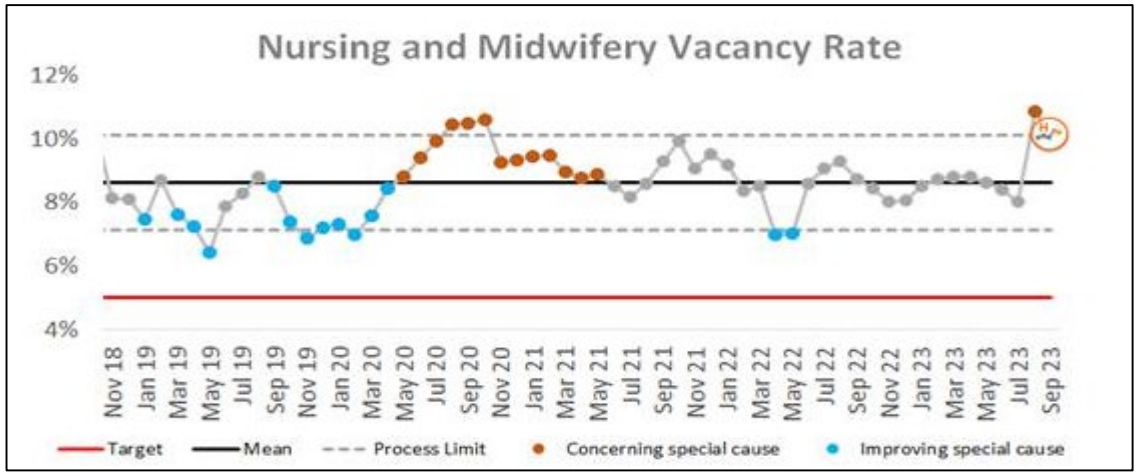
The planned versus actual staffing report demonstrates that 11 clinical areas reported <90% overall rota fill in September (17 in August). The overall fill rate for maternity has decreased to 90.8% compared to 88.9% in August. The total unavailability of the workforce working time in September has increased slightly to 27.5% (26.9% in August). The majority of unavailability (13.2%) is due to planned annual leave, sickness absence has increased in September to 7.6% from 5.8% in August. Additionally, 1.2% of working time was unavailable due to other leave, 3.5% was due to study leave and 2% was due to supernumerary time.

In order to mitigate staffing risks, the number of requests for bank workers remains high with an average of 2362 shifts per week requested for registered staff and 2081 shifts requested for Health care support workers and Maternity support workers per week with an average bank fill rate of 70.7% for registered staff and 63.6% for Health Care Support workers. In addition, the equivalent of 14.6 WTE agency workers are working across the divisions (increase from 4.00 WTE in August). Despite this, redeployment of nurses and midwives has remained necessary due to staff unavailability, with an average of 388.95 working hours being redeployed each day however staff have only been redeployed within their own division.

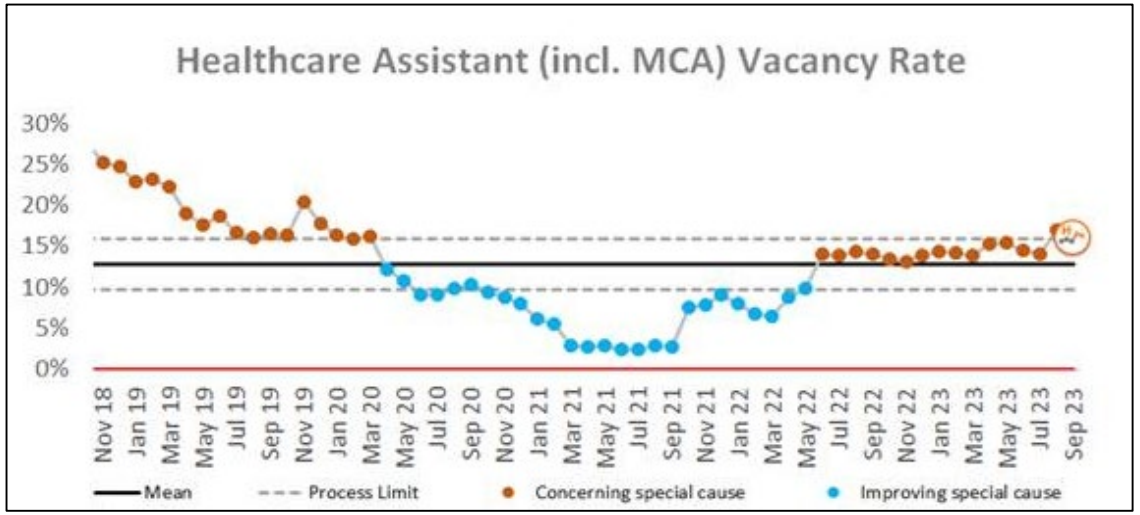
The number of occasions that 1 critical care nurse has needed to care for more than 1 level 3 patient has decreased in September to 79 occasions compared to 160 in August. Additionally, there have been 155 occasions in September where there has been no side room co-ordinator (240 in August). Any concerns 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 when vacancy and unavailability allows.

Combined Nursing and Midwifery Staffing Position Vacancy Rates

Graph 1. Nursing and midwifery vacancy rates



Graph 2. Healthcare Assistant vacancy rates



Vacancy position

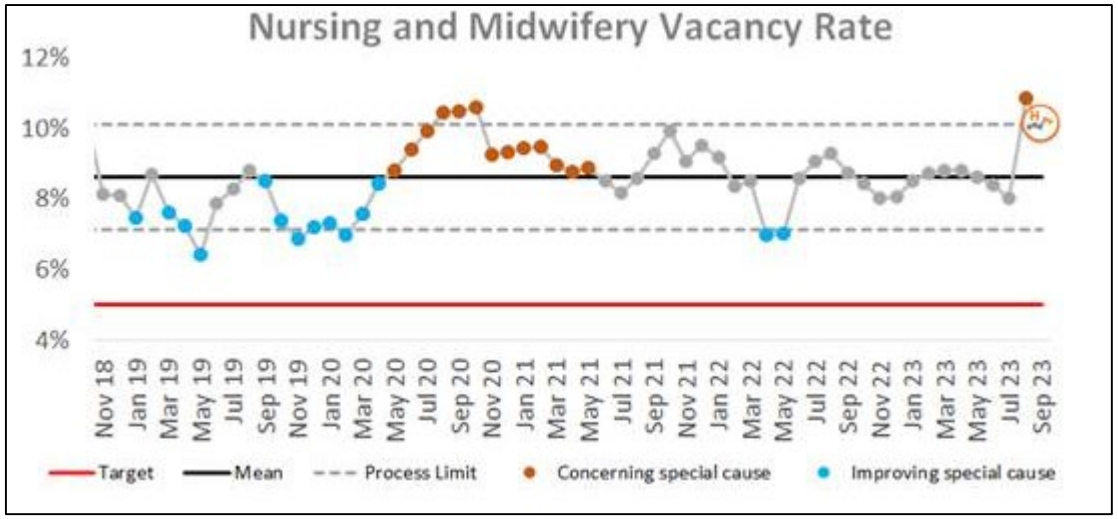
The vacancy data for August was reflective of the general ledger as the clinical division budgets had been loaded to ESR which led to an increased vacancy position as illustrated in Graph 1 and 2.

The combined vacancy rate for Registered Nurses (RNs) and Registered Midwives (RMs) has decreased to 10.1% in September from 10.9% in August. The vacancy rate for Health care support workers (HCSW's) (including Maternity Care Assistants (MCAs) has decreased to 15.9% in September from 17.1% in August. When broken down further into Nursing and Midwifery specific vacancies, the MCA workforce vacancy rate has decreased for September to 21.8% from 24.0% in August and the HCSW vacancy rate (excl MCA) has decreased from 17.1% in August to 15.6% in September.

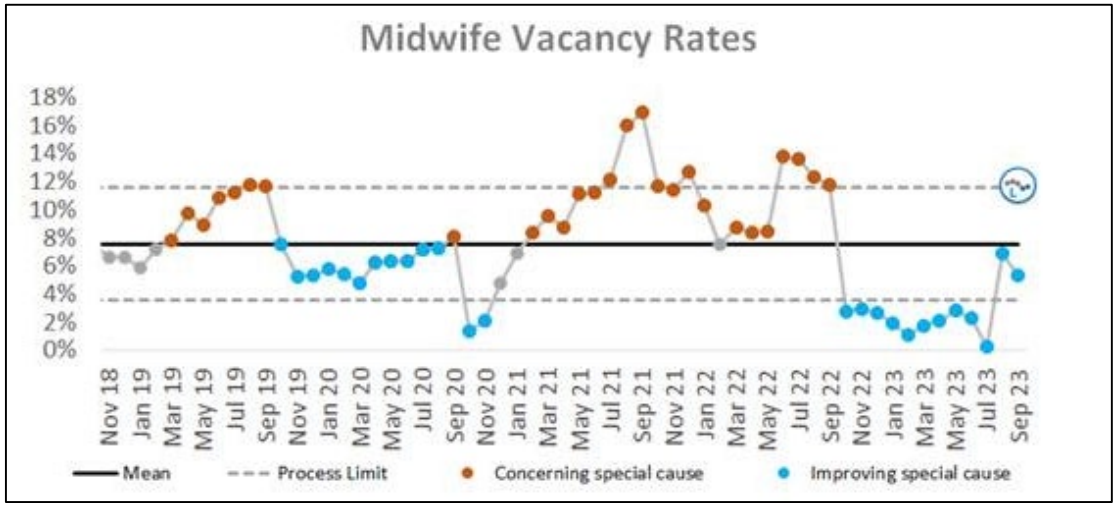
The HCSW (including MCAs) turnover rate remains high and has increased slightly to 17.1% in September from 16.6% in August. The main reason for HCSWs leaving is voluntary resignation – relocation (31.1%) and the next highest reason is voluntary resignation – work life balance (27.7%). The leavers destination is unknown for the majority of HCSWs (45.6%), 15.5% of HCSWs are leaving to take up employment in other NHS organisations and 10.7% are leaving for no employment.

Staffing Position Vacancy Rates for Registered Nurses and Registered Midwives

Graph 3. Registered Nurse vacancy rates



Graph 4. Registered Midwife vacancy rates



Vacancy position

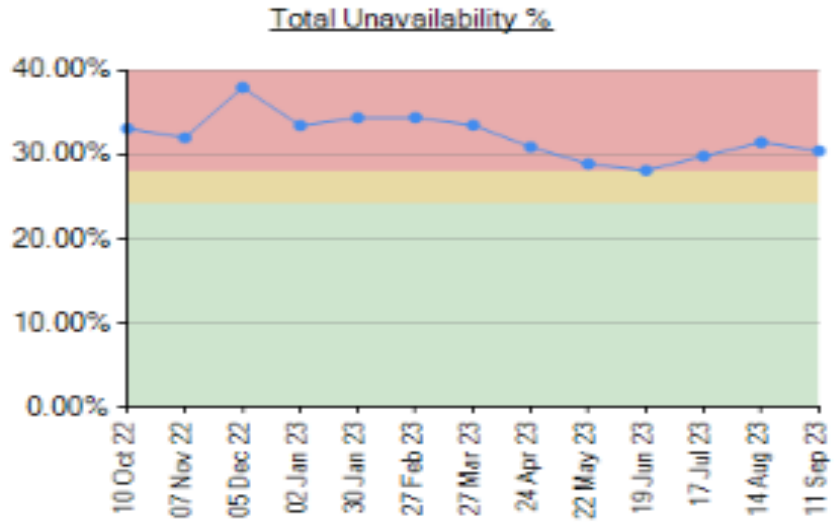
The vacancy rate for Registered Nurses working in adult areas has reduced slightly to 10.1% in September (10.9% in August) as illustrated in Graph 3. The vacancy rate for registered children's nurses has also decreased to 21.1% compared to 23.1% in August.

The vacancy rate for Registered Midwives has also reduced to 5.31% in September (6.87% in August).

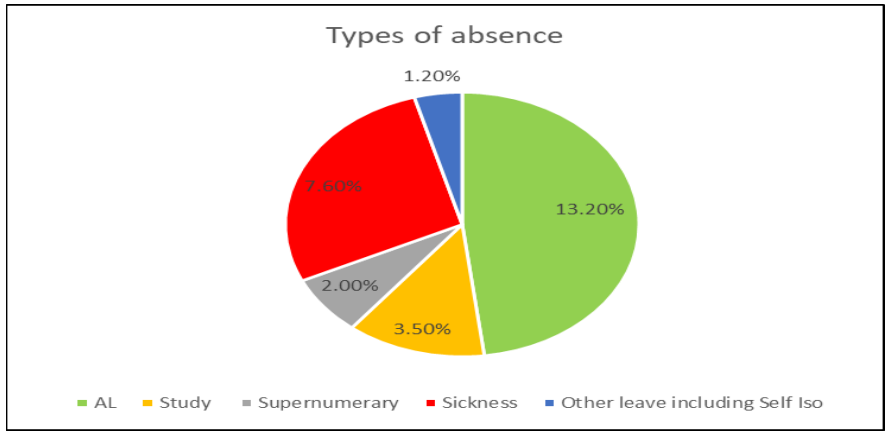
The turnover rate in September remains high but has decreased to 10.6% for RNs in adult areas (11.0% in August), 15.4% for Registered children's nurses (15.9% in August) and 12.9% for RMs (13.1% in August). The main reasons for RMs leaving is voluntary resignation – relocation (30.3%) and the next highest reason is voluntary resignation – work life balance (24.2%). The main reason for RN's leaving is voluntary resignation – relocation (43.4%). The leavers destination data demonstrates that 27.6% of RNs and 45.5% of RMs are leaving to take up employment in other NHS organisations. 15.2% of RMs are leaving for no employment compared with 8.4% of RNs.

Unavailability for Registered Nurses, Midwives and Health Care Support Workers

Graph 5. Unavailability of staff



Graph 6. Types of absence



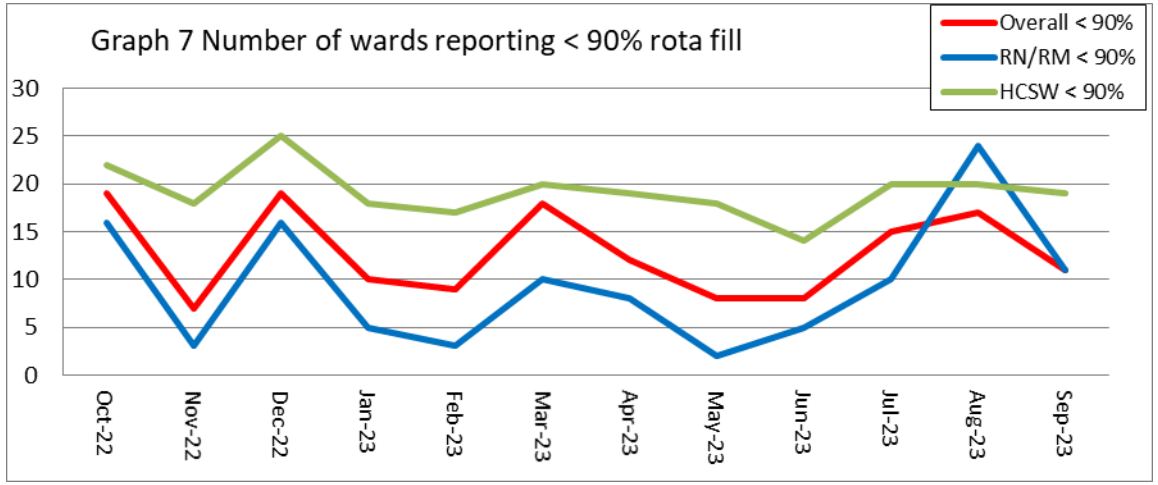
Unavailability of staff

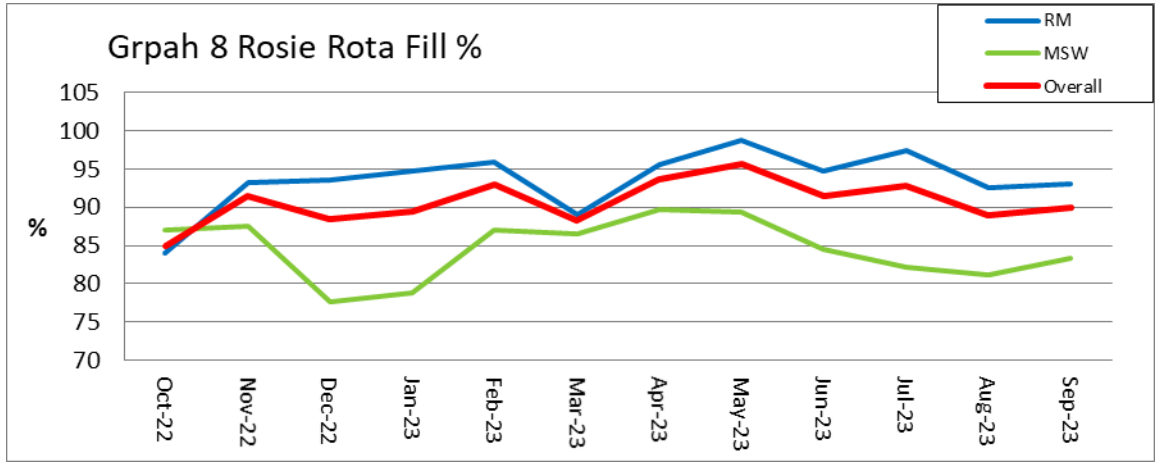
Unavailability relates to periods of time where an employee has been given leave from their regular duties. This might be due to circumstances such as annual leave, sick leave, study leave, carers leave etc.

The total unavailability of the workforce working time in September has increased slightly by 0.6% to 27.5% as illustrated in Graph 5.

Graph 6 illustrates the percentage breakdown of the type of unavailability. The majority of unavailability (13.2%) was due to planned annual leave which would have been accounted for in the department rosters this is slightly below the lower limit of headroom at 14%. There was a high percentage of unplanned leave that would have impacted upon fill rates within the rosters. In September, sickness absence has increased to 7.6% from 5.8% in August. Other leave has remained relatively static at 1.2%, 3.5% was due to study leave and 2% was due to supernumerary time.

Planned versus actual staffing





Planned versus actual staffing

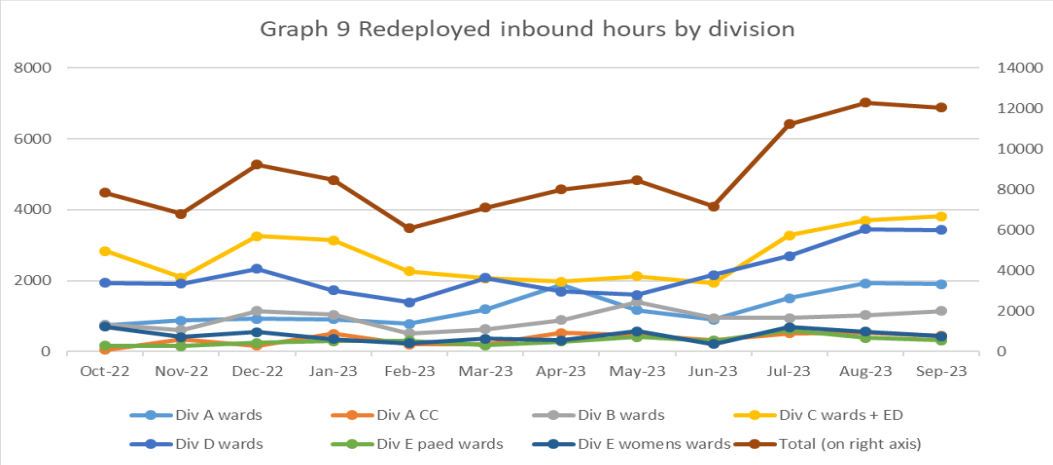
Graph 7 illustrates trend data for all wards reporting < 90% rota fill. The number of areas reporting <90% rota fill for registered RN/RM has decreased to 11 in September from 24 in August. The number of areas reporting <90% rota fill for HCSWs in September has remained static and high at 19. The number of ward areas reporting overall fill rates of <90% in September has decreased to 11 compared to 17 in August. 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 decreased in September to 79 occasions compared to 160 in August. Additionally, there have been 155 occasions in September where there has been no side room coordinator (240 in August). 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. There was also short term agreement to pay critical care trained staff bank enhancements to reduce the over all amount of breaches. 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 when vacancy allows.

Midwifery & MSW fill rate

Graph 8 illustrates that the overall fill rate for maternity has increased slightly to 90% in September form 88.9% in August which is lower than the 12-month average of 90.08%. The lowest fill rates have been seen on Lady Mary Ward (88%).

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 has stabilised after the increasing trend over the last 3 months with 388.95 working hours being redeployed per day in September (362 hours in August). This equates to 34 long day or night shifts per day. 760 of these hours were redeployments made outside of staff members own division to support patient safety. 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.

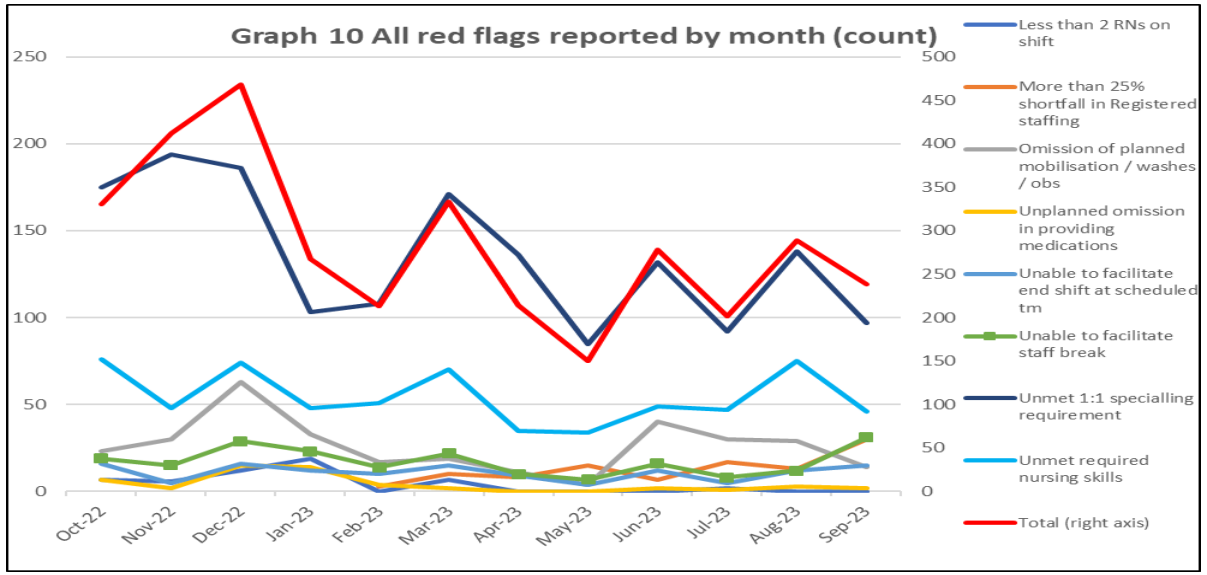
Nursing Pipeline

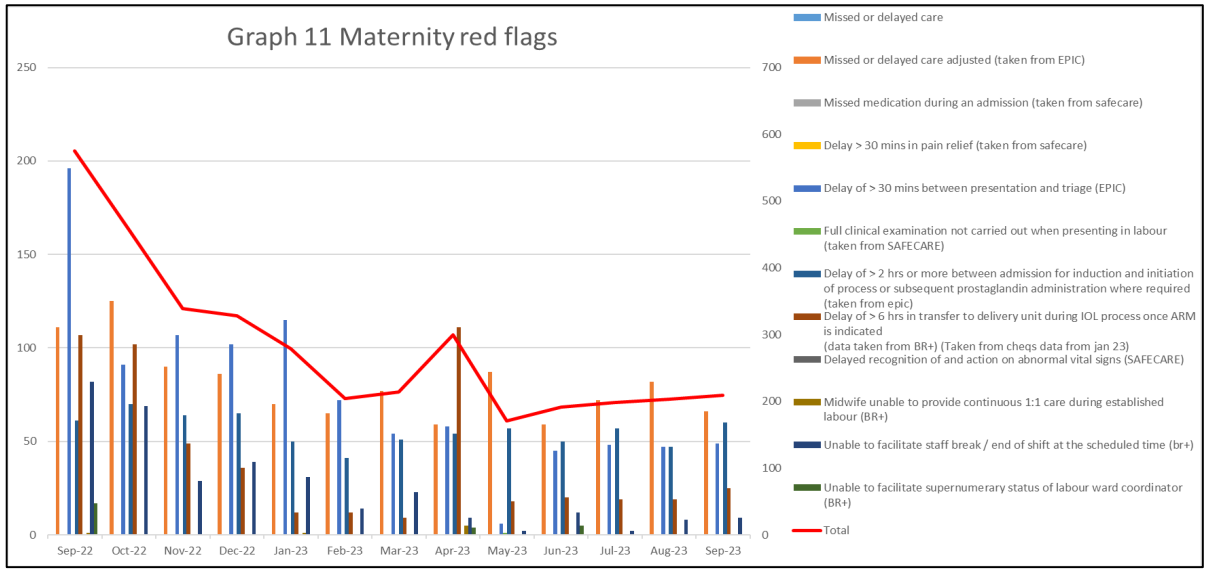
Appendix 2 provides detail on the forecasted position in relation to the number of adult RN vacancies based on FTE and includes UK experienced, UK newly qualified, apprenticeship route, EU and international up to March 2024. The current forecast demonstrates a year end band 5 RN vacancy position of 7.34% which is 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. The RN adult pipeline for 2023/24 now reflects this 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.

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 22.02% and a band 2 HCSW position of 8.32%.

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

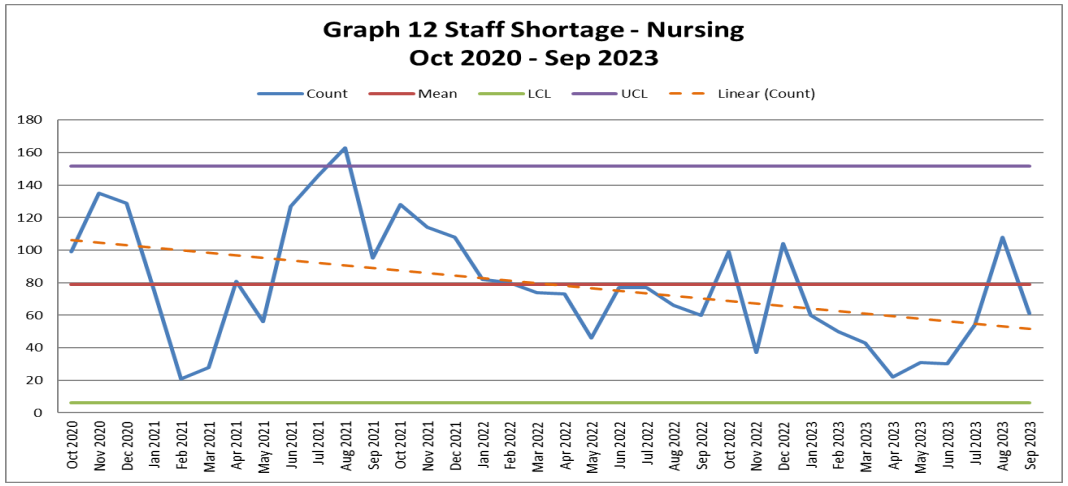
A staffing red flag event is a warning sign that something may be wrong with nursing or midwifery staffing. If a staffing red flag event occurs, the registered nurse or midwife in charge of the service should be notified and necessary action taken to resolve the situation.

Nursing red flags

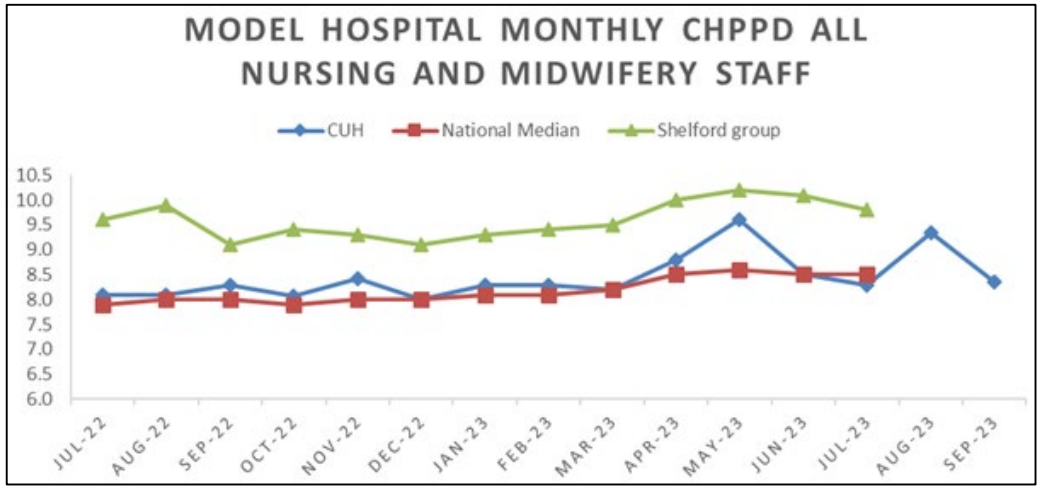
Graph 10 illustrates that there has been a decrease in the number of red flags reported with 238 reported in September. The highest number of red flags reported in September was in relation to an unmet 1:1 specialling requirement (97 compared with 138 in August). A trust wide improvement project focusing on specialling is being developed to review specialling across the organisation. There has been an increase in 3 reportable red flags in September with the remaining reducing. The increases were seen in more than 25% shortfall in registered staff (30 red flags in September compared to 13 in August), Unable to facilitate end shift at scheduled time (15 red flags in September compared to 12 in August) and Unable to facilitate staff break (31 red flags in September compared to 12 in August).

Maternity red flags

The number of maternity red flags have seen a small increase from 203 in August to 209 in September. Graph 11 illustrates the red flags that have been reported. The highest number of red flags reported is for missed or delayed care (31.6%). 23.4% 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 report.



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. In September there were 61 incidents reported compared to 108 in August.

The majority of the incidents related to staffing levels in September were reported by division C (22) with the highest reporting area being ward G5 (5). Safety continues to be monitored through the site safety meetings.

Care hours per patient day (CHPPD)

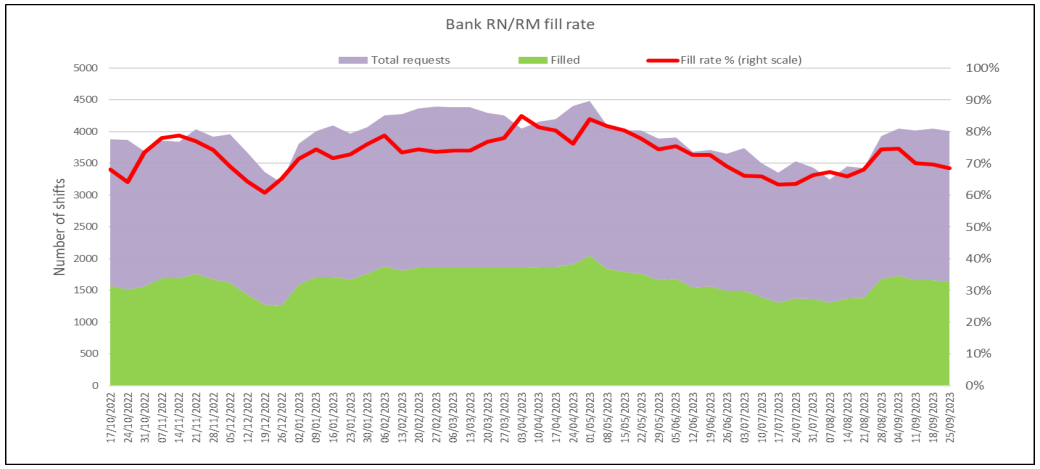
Care hours per patient day (CHPPD) is the total number of hours worked on the roster (clinical staff including AHPs) divided by the bed state captured at 23.59 each day. NHS Improvement began collecting care hours per patient day formally in May 2016 as part of the Carter Programme. All Trusts are required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

CUH CHPPD recorded decreased to 8.35 from 9.35 in August. This is below other Shelford hospitals (10.3).

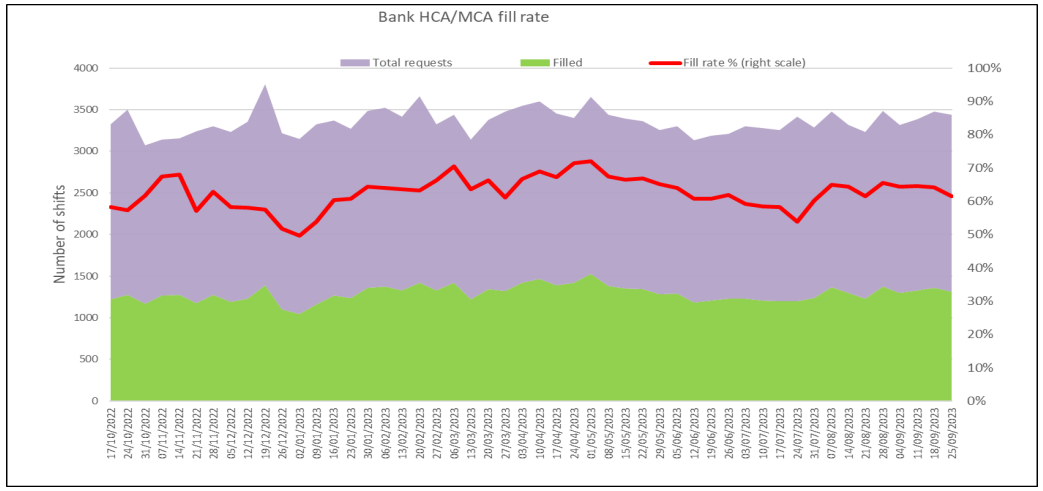
In maternity, from 1 April 2021, the total number of patients now includes babies in addition to transitional care areas and mothers who are registered as a patient. CHPPD for the delivery unit in September has decreased to 14.34 (16.11 in August.)

Bank Fill Rate and Agency Usage

Graph 14 Registered RN/RM Bank fill rate per week



Graph 15 HCSW/MSW bank fill rate per week



Bank fill rate

The Trust's Staff Bank continues to support the clinical areas with achieving safe staffing levels. Graph 15 and 16 illustrate the trends in bank shift fill rate per week. Overall, we continued to see a increase in September 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 2362 shifts per week with an average bank fill rate of 70.71% which is an increase from August (66.68%).

The number of requests for Health care support workers and Maternity support workers remains high with an average of 2081 shifts per week with an average bank fill rate of 63.63% this is a slight increase from August (62.73%).

In addition to bank workers we have the equivalent of 14.6 WTE agency workers working across the divisions to support staffing challenges in the short term. This agency usage had been reducing and there is a focus to reduce further as the substantive position increases however is an increase from the 4.00 WTE utilised in August (29.5 WTE in June, 14.75 WTE in July) .

Short term pay enhancements for bank shifts put in place earlier in the year to encourage a higher uptake of shifts were 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

	Sep-23								
	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	**81%**	97%	**84%**	**20.07**	can be dependent on sickness levels, acuity (and sudden increase in level 3s), bank fill rate (or lack of bank fill), flow out	GPIC Breaches. Potential delays to patient care and patient flow. Reduced supervisory time to mitigate may be considered. Reduction NQM and KPI's. Staff morale,retention of staff. Poor patient experience. Lack of abilty to be pre emptive due to clinical acuity.	Raised at 08:15, 4:15 and daily bronze, circulation of capacity and breaches list. To Ops centre; Ops matron also join safety huddle to enable discharge of wardables. PD and band 7s in numbers, Level 3 bank enhancements, agency RNs x5 CVs to date approved, continued management of sickness, internal transfer scheme, recruitment. Escalated at divisional level and discussed sit rep at divisional board
Division A	JOHN FARMAN ICU	192 - CRITICAL CARE MEDICINE - RISK MANAGED	**85%**	100%	**87%**	**24.96**	can be dependant on sickness levels, acuity (and sudden increase in level 3s), bank fill rate (or lack of bank fill), flow out	GPIC Breaches. Potential delays to patient care and patient flow. Reduced supervisory time to mitigate may be considered. Reduction NQM and KPI's. Staff morale,retention of staff. Poor patient experience. Lack of abilty to be pre emptive due to clinical acuity.	Raised at 08:15, 4:15 and daily bronze, ciruclation of capcity and breaches list. To Ops centre; Ops matron also join safety huddle to enable discharge of wardables. PD and band 7s in numbers, Level 3 bank enhancements, agency RNs x5 CVs to date approved, continued management of sickness, internal transfer scheme, recruitment. Escaalted at divisional level and discussed sit rep at divisional board
Division A	NCCU	192 - CRITICAL CARE MEDICINE - RISK MANAGED	**88%**	98%	90%	**27.58**	can be dependent on sickness levels, acuity (and sudden increase in level 3s), bank fill rate (or lack of bank fill), flow out	GPIC Breaches. Potential delays to patient care and patient flow. Reduced supervisory time to mitigate may be considered. Reduction NQM and KPI's. Staff morale, can drive sickness rates, retention of staff. Poor patient experience.	Raised at 08:15, 4:15 and daily bronze, circulation of capacity and breaches list. To Ops centre; Ops matron also join safety huddle to enable discharge of wardables. PD and band 7s in numbers, Level 3 bank enhancements, agency RNs x5 CVs to date approved, continued management of sickness, internal transfer scheme, recruitment. Escalated at divisional level and discussed sit rep at divisional board

Appendix 1: Exception report by Division

Sep-23

	Unit	Speciality	% fill registered	% fill care staff	Overall filled %	CHPPD	Analysis of gaps	Impact on Quality / outcomes	Actions in place
Division C	C5	361 - NEPHROLOGY - PROTECTED	87%	85%	86%	6.48	65 unfilled RN shifts 59 unfilled HCSW shifts 204 hours redeployed to C5	4 incidents, no mod+ harm Highest category: N/A – all had 1x incident 0x HAPU No patients with more than 1 incident 32% supervisory sister time 1 red flag for unmet nursing needs Matron quality audit: Bronze	Daily divisional mitigation; site safety escalation; weekly prospective staffing reporting and mitigation; divisional recruitment and retention strategy. Matron quality focus.
Division C	C6	301 - GASTROENTEROLOGY - STANDARD	90%	111%	99%	6.92	46 unfilled RN shifts 733 hours redeployed to C6	27 incidents, no mod+ harm Highest category: Fall (13) 0x HAPU One patient with 7x incidents and one with 4x incidents 22.7% supervisory sister time 9 red flags; 3 more than 25% shortfall in registered staffing; 1 omission of planned mobilisation/washes; 5 unmet specialling needs Matron quality audit: Bronze	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	88%	123%	98%	6.50	56 unfilled RN shifts 677 hours redeployed to D5	22 incidents, 1x mod+ harm (Cat 2 HAPU) Highest category: Security (10) 1x HAPU – Cat2 One patient with 4x incidents 45.4% supervisory sister time 16 red flags; 1 delay in providing pain relief; 1 more than 25% shortfall in registered staffing; 1 unable to facilitate end shift at scheduled time; 2 unable to facilitate breaks; 11 unmet specialling requirements Matron quality audit: Bronze	Daily divisional mitigation; site safety escalation; weekly prospective staffing reporting and mitigation; divisional recruitment and retention strategy. Matron quality focus.

Appendix 1: Exception report by Division

	Sep-23								
	Unit	Speciality	% fill registered	% fill care staff	Overall filled %	CHPPD	Analysis of gaps	Impact on Quality / outcomes	Actions in place
Division C	F6	430 - GERIATRIC MEDICINE - STANDARD	89%	112%	100%	**6.56**	50 unfilled RN shifts 316 hours redeployed to F6	27 incidents, no mod+ harm Highest category: Security (9) 2x HAPU – Cat1 (1), Cat 2 (1) One patient with 5x incidents 35.6% supervisory sister time 5 red flags; 1 more than 25% shortfall in registered staffing; 4 unmet specialling requirements Matron quality audit: Bronze	Daily divisional mitigation; site safety escalation; weekly prospective staffing reporting and mitigation; divisional recruitment and retention strategy. Matron quality focus.
Division C	G5	100 - GENERAL SURGERY - PROTECTED	90%	94%	91%	**6.53**	76 unfilled RN shifts 460 hours redeployed to G5	21 incidents, 1x mod+ harm Highest category: Medication (6) 1x HAPU – Cat 2 One patient with 3x incidents 43.2% supervisory sister time 22 red flags; 7 more than 25% shortfall in registered staffing; 7 unable to facilitate end shift at scheduled time; 3 unable to facilitate break; 1 unmet specialling requirement; 4 unmet required nursing skills Matron quality audit: Silver	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	86%	80%	84%	**7.48**	72 Unfilled RN shifts 46 Unfilled HCSW shifts 400 hours redeployed to N2	19 incidents, no mod+ harm Highest category: Pressure Ulcer (6) 1x HAPU – Cat1 No patients with more than 1 incident 42.9% supervisory charge nurse time 10 red flags; 1 more than 25% shortfall in registered staffing; 2 omission of planned medication/washes; 1 unable to facilitate staff break; 4 unmet specialling requirement; 1 unmet nursing skills Matron quality audit: silver	Daily divisional mitigation; site safety escalation; weekly prospective staffing reporting and mitigation; divisional recruitment and retention strategy. Matron quality focus.

Appendix 1: Exception report by Division

	Sep-23								
	Unit	**Speciality**	**% fill registered**	**% fill care staff**	**Overall filled %**	**CHPPD**	**Analysis of gaps**	**Impact on Quality / outcomes**	**Actions in place**
Division D	G3	300 - GENERAL MEDICINE - PROTECTED	**89%**	92%	90%	**6.41**	Majority of nursing staff are very junior affecting Skills Mix – 11 OSCE out of 23 nurses in establishment - currently 7 have obtained their NMC Pin completing nursing competencies	No Impact on NQM but Junior staff will need close supervision and support from senior sister and junior sisters and charge nurse	PD supporting ward manager with junior staff in completing and achieving Nursing competencies
Division D	K3	320 - CARDIOLOGY - STANDARD	**89%**	94%	91%	**5.37**	can be dependent on sickness levels, acuity and bank fill rate (or lack of bank fill)	No Impact on NQM as staffing is mitigated through SSM and within the division by redeploying staff from areas with capacity	Daily divisional mitigation; site safety escalation; weekly prospective staffing reporting and mitigation; divisional recruitment and retention strategy. Matron quality focus.
Division E	F3 COU	171 - PAEDIATRIC SURGERY - PROTECTED	**83%**	99%	**89%**	**6.97**	current vacancy 12.07% = 4wte RN & 2wte HCA. Pipeline in = 4wte RN meaning RN vacancy will be 0. HCA recruitment in progress.	no impact on NQM	regular staffing reviews, safety huddles and quality rounds
Division E	Lady Mary	501 - OBSTETRICS - RISK MANAGED	**88%**	**73%**	**81%**	**4.15**	Skills mix with junior workforce, increased acuity.	Staffing reviewed to ensure safe care, Staff moved within service to provide safe staffing.	Regular assessment by manager of the day & matron to ensure service requirements are met.

Appendix 2: Adult RN Recruitment pipeline

Adult band 5 RN position based on predictions and established FTE															
Month	UK based exp. applicants	Anglia Ruskin NQ (60% of graduates)	Other NQ	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		16	22	7	13	1531	1699	9.88%	167.87	15
Jul-23	1	1	2				19	23	16	10	1528	1699	10.06%	170.87	7
Aug-23	3	1					16	20	11	10	1753	1931	9.20%	177.64	9
Sep-23	7	3	2				35	47	16	7	1777	1951	8.90%	173.64	31
Oct-23	1	11	1				40	53	15	20	1795	1951	7.97%	155.57	38
Nov-23	8	3	2		21		27	61	15	14	1827	2020	9.53%	192.47	46
Dec-23	2			2			35	39	13	15	1838	2059	10.70%	220.17	26
Jan-24	3			2		2	30	37	13	15	1847	2059	10.26%	211.17	24
Feb-24	3			2			35	40	13	15	1859	2059	9.68%	199.17	27
Mar-24	5	27	7	2			35	76	13	15	1907	2059	7.34%	151.17	63
TOTAL	**43**	**51**	**14**	**8**	**40**	**2**	**309**	**506**	**155**	**157**	**1907**	**2059**	**7.34%**	**151.17**	**312**

Appendix 3: Paediatric RN and Band 2 HCSW Recruitment pipeline

Paediatric band 5 RN position based on predictions and established FTE												
Month	UK based exp. applicants	Anglia Ruskin NQ	Other NQ	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	171.13	229.70	25.50%	58.57	-0.53
Sep-23	1	3	1	2	7	3	2	173.13	229.70	24.63%	56.57	4
Oct-23	2	8	8	1	19	3	2	187.13	229.70	18.53%	42.57	16
Nov-23	1		2	1	4	3	3	185.13	229.70	19.40%	44.57	1
Dec-23	1			1	2	3	1	183.13	229.70	20.27%	46.57	-1
Jan-24			1	2	3	4	1	181.13	229.70	21.14%	48.57	-1
Feb-24	2			2	4	5	1	179.13	229.70	22.02%	50.57	-1
Mar-24	2			2	4	3	1	179.13	229.70	22.02%	50.57	1
TOTAL	13	13	13	14	55	38.53	17	179.13	229.70	22.02%	50.57	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	768	887	13.42%	119
Jul-23	14	3	17	16	760	887	14.32%	127
Aug-23	11	1	12	17	741	878	15.67%	138
Sep-23	25	2	27	12	756	888	14.93%	133
Oct-23	25	2	27	13	770	888	13.34%	118
Nov-23	35		35	13	792	936	15.44%	145
Dec-23	35		35	13	814	959	15.20%	146
Jan-24	35		35	13	836	959	12.91%	124
Feb-24	35		35	13	858	959	10.61%	102
Mar-24	35		35	13	880	959	8.32%	80
TOTAL	304	15	319	158	879.57	959.4	8.32%	79.83

Board of Directors

Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 8 November 2023

Agenda item	10.4
Title	Biannual nursing and midwifery safe staffing update
Sponsoring executive director	Lorraine Szeremeta, Chief Nurse
Author(s)	Amanda Small, Deputy Chief Nurse Meg Wilkinson, Director of Midwifery Christopher Gray, Lead Nurse for Safer Staffing
Purpose	To provide an overview of nurse and midwifery staffing capacity and compliance with the National Institute for Clinical Excellence (NICE) safe staffing, National Quality Board (NQB) standards and Clinical Negligence Scheme for Trusts (CNST) standards.
Previously considered by	Management Executive, 2 November 2023

Executive summary

This report provides an overview of registered nurse and midwifery staffing capacity and provides assurance of compliance with the National Institute for Clinical Excellence (NICE) safe staffing, National Quality Board (NQB) standards and Clinical Negligence Scheme for Trusts (CNST) standards. It is a requirement that every board of directors receives an annual establishment report with a further review on a biannual basis (National Quality Board, 2016).

This paper meets the requirements of the biannual update, providing an overview of safe staffing in relation to the approved budgeted establishment and cumulative oversight of care hours per patient day (CHPPD) over the past six months.

Related Trust objectives	Ensuring Clinical Excellence and Effectiveness; Improving Patient Safety; Improving Patient Experience;
Risk and Assurance	The paper provides assurance on the arrangements in place for reviewing nursing and midwifery safe staffing.
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 of Directors are asked to receive the six monthly updated nurse and midwifery staffing report in line with regulatory requirements and to note:

- The high vacancy rates for registered nurses (RNs), registered sick children's nurses (RSCNs) and Health Care Support Workers (HCSWs) remain despite a strong recruitment pipeline.
- Redeployment of both RNs and HCSWs will continue to be necessary over the winter period in response to increased demand on services coupled with the vacancy rates and high unavailability.
- Critical care nurse staffing remains an area of concern due to GPICS breaches, 4 beds remained closed at this time to mitigate staffing shortfalls.
- CUH Care Hours Per Patient Day (CHPPD) is aligned to the national median; however, when comparing to Shelford peers, the CUH CHPPD is below the Shelford median of between 9.1 – 12 CHPPD (CUH 8.5-9.6).
- A review of the neonatal staffing requirements has been undertaken in line with the British Association of Perinatal Medicine (BAPM) standards.
- In line with guidance, a Birthrate Plus® review was undertaken in maternity in 2022 which has resulted in an increased establishment to comply with the birth rate plus recommendation and Ockenden report.
- There has been a significant improvement in the registered midwives (RMs) vacancy rate and the midwife to birth ratio is 1:25 which is slightly below the midwifery establishment of 1:24.

Cambridge University Hospitals NHS Foundation Trust

8 November 2023

Board of Directors
Biannual nursing and midwifery safe staffing update
Lorraine Szeremeta, Chief Nurse

1. Purpose

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

1.2 In October 2018, NHS Improvement (NHSI) published the 'Developing Workforce Safeguards' guidance. This outlined how trusts' compliance with the 'triangulated approach' to safer staffing outlined within the NQB standards would be assessed. This triangulated approach combines evidence-based tools (e.g. Safer Nursing Care Tool (SNCT), professional judgement and outcomes. By implementing the document's recommendations, together with strong and effective governance, boards can be assured that workforce decisions will promote patient safety and compliance with regulatory standards.

1.3 At CUH the Safer Nursing Care Tool (SNCT) is used as the evidence base to guide nursing establishment reviews. The majority of adult wards utilise the adult inpatient ward SNCT or the adult acute assessment SNCT and the paediatric wards utilise the Children's and Young People SNCT (C&YP SNCT). Over the last year, the Emergency Department (ED) piloted the ED SNCT and CUH will utilise the results from this at the next establishment review. In areas where there is not an evidence based tool available to guide establishment reviews, professional judgement together with society or joint advisory guidelines are used to inform nursing establishments. The establishment review process was undertaken at the end of the last financial year and the board approved the recommended establishments in May 2023.

1.4 Birthrate plus® is the only national tool available for calculating midwifery staffing levels which has been endorsed by the National Institute for Health and Care Excellence (NICE). The tool considers the midwife-to-birth ratio and the mother's and baby's acuity and complexity for women throughout pregnancy, labour and the post-natal period, in both hospital and community settings. The most recent Birthrate Plus® review was undertaken at CUH from January to March 2022 with the next review due in 2025.

1.5 This report provides an overview of safe staffing in relation to the approved budgeted establishment and cumulative oversight of care hours per patient day (CHPPD) over the past six months. It also provides a comparison to peer organisations for the same time period.

2. National nursing and midwifery staffing context

2.1 Delivering sustainable, long-term growth in the nursing workforce is vital to ensuring that the health and social care system has the right workforce in the right numbers to support

high quality and safe care. As part of its manifesto pledges, the government committed in 2019 to growing the nursing workforce by 50,000 by March 2024.

2.2 The 50,000 Nurses Programme is overseen by a programme board chaired by the Minister of State for Health. It includes senior membership from the Department of Health and Social Care, NHS England (NHSE) and HM Treasury. The programme is split into three work streams:

1) Domestic recruitment including:
    - preregistration students
    - degree nurse apprentices
    - conversions from nursing associates and assistant practitioners to registered nurses
    - nurse return to practice

2) International recruitment.

3) Retention of existing staff and reducing the leaver rate.

2.3 According to figures released by NHSE in May 2023, there are 40,096 nursing vacancies in the NHS in England. Whilst nursing vacancies are still high, there are 43,000 more nurses working in the NHS now compared to September 2019. Therefore it is reported that the government is on track to deliver the 50,000 nursing workforce growth by March 2024.

2.4 The increase in nurses in employment has been due in part to the large number of international nurses that have been deployed. NHSE have supported organisations with funding to support overseas nurses in practice. This has resulted in CUH supporting the arrival of 72 international nurses since April 2023. Additionally, for the third consecutive year, there have been 26,000 enrolments to undergraduate nursing and midwifery programmes in England. This equates to a 16% increase in students commencing a nursing and midwifery programme compared to 2019.

2.5 Whilst there is relative certainty about the numbers of people who are commencing pre-registration courses or travelling to the UK to work, there is significant uncertainty related to retention of the existing workforce. The last 3 years have been some of the most challenging in the history of the NHS, and many staff have been placed under sustained and severe pressure. Thus targeted actions to retain staff have been identified within the nursing and midwifery retention action plan following completion of the NHSE retention self-assessment tool at CUH. Progress with these actions is monitored through the Nursing, Midwifery and Allied Health professionals committee (NMAAC).

2.6 NHS England published the NHS workforce long term plan in June 2023. This plan outlines a series of interventions to train, retain and reform the NHS workforce. In relation to training, the plan commits to:

- Training more nurses and midwives to have the right number of staff to care for service users. This will be achieved by almost doubling the number of adult nurse training places by 2031, with around 24,000 more nurse and midwife training places a year by 2031.

- As a result of this training expansion, the reliance on agency staff and international recruitment will reduce. In 15 years' time, it is expected that around 10% of the workforce will be recruited internationally, compared to nearly a quarter today.

2.6.1 The NHS workforce plan states that we will retain our dedicated NHS workforce by allowing greater flexibility and career progression and improving culture, leadership and wellbeing, while continuing to focus on equality and inclusion. This will be achieved by:

- Improving flexible working opportunities.
- Reforming the pension scheme so staff can partially retire or return to work seamlessly and continue building their pension after retirement.
- Ongoing national funding for continuing professional development for nurses, midwives and allied health professionals, so NHS staff are supported to meet their full potential.
- Improved childcare support to help enable NHS staff to stay in work, through changes made in the Spring Budget for working parents over the next three years.

2.6.2 The third aim of the NHS workforce plan is to reform the way in which healthcare staff work to have the right multidisciplinary skills and can harness new digital and technological innovations, allowing staff to focus on patient care. In relation to the nursing and midwifery workforce, this will include:

- Focusing on expanding enhanced, advanced and associate positions, such as nursing associates and advanced clinical practitioners.
- Taking advantage of the European Union (EU) Exit freedoms to explore reducing nurse clinical placement hours and supporting education institutions to allow trainees to join the nursing register up to four months earlier.

2.6.3 It is reported that when considering the NHS plan alongside retention measures could mean the health service has at least an extra 170,000 nurses in place by 2036/37. Additionally, NHSE have committed to training more nursing associates (NAs) so there will be 64,000 NAs working in the NHS by 2036/37, compared to about 4,600 now and increasing the number of advanced practitioners to 39,000 by 2036/27.

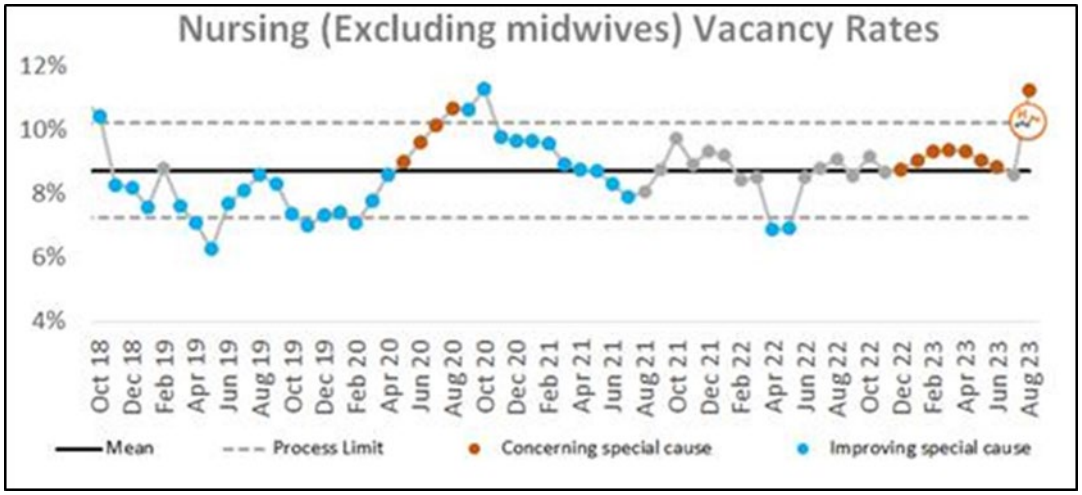
2.7 CUH continues to have success in recruiting to its Nursing Apprenticeship programme with 187 Higher Apprenticeship Assistant Practitioners on Course (Part 1) with 30 due to start September 2023, and 26 due to start January 2024. Additionally, there are 106 Degree Apprentice Nurses on course (part 2) with 35 due to commence October 2023. With regards to the Nursing Associate Apprenticeship, 3 are due to qualify in September 2023, 6 are on the course (started May 2023, due to qualify May 2025) and there is a plan to recruit 40-50 Nurse Associate Apprentices for spring 2024 and a further 40-50 in autumn 2024.

3. Nurse staffing

3.1. Nursing vacancy position

3.1.1 The last six months have remained challenging for the nursing workforce with high vacancy rates despite a strong recruitment pipeline. Figure 1 shows the CUH trend in nursing vacancy rates over the past four years. The Registered Nurse (RN) vacancy has remained static over the last 6 months at around 8%, however in August 2023 the financial ledger and Electronic Staff Record (ESR) was aligned with the budgeted position for 2023/24 resulting in a spike in vacancy to 10.9% for RN's.

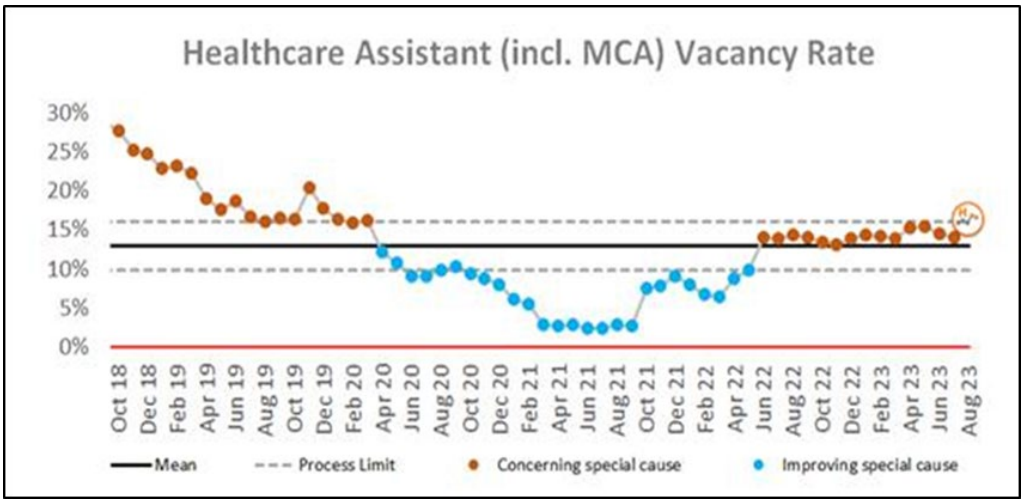
Figure 1: Registered Nurse vacancy rates



3.1.2 The vacancy rate for registered sick children nurses has been an increasing trend over the last six months with a vacancy rate of 20.4% in April 2023 compared to a vacancy position of 23.1% in August 2023.

3.1.3 The Health Care Support Worker (HCSW) vacancy rate has remained an area of concern, increasing over the last six months from 14.9% in April 2023 to 16.1% in August 2023. This is due in part to the low number of applications received for HCSW roles over the last six months coupled with a high turnover rate of 16.6%. Figure 2 illustrates the trend in vacancy rate for HCSWs over the past four years.

Figure 2: Health care support worker vacancy rates



3.1.4 Over the last twelve months it has been necessary to open additional contingency areas to manage the increased activity within the trust. In total, there are four additional contingency areas that have been opened regularly when demand requires. As these contingency areas do not have an established team, it has been necessary to redeploy staff from other areas and utilise temporary staff to ensure safe staffing levels can be achieved.

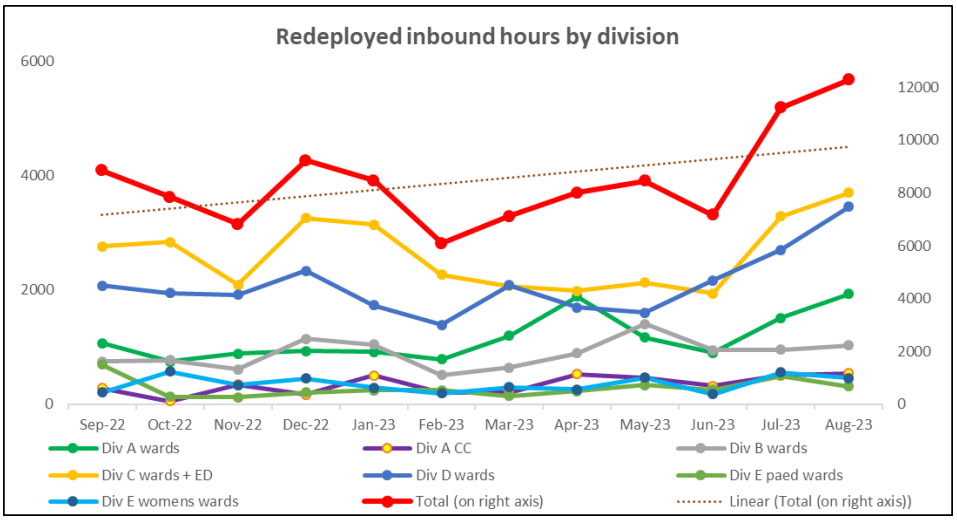
3.2. Redeployment of staff to maintain safe staffing levels

3.2.1 In order to support safe nurse staffing and to maintain patient safety across the trust, nursing staff have frequently been redeployed from their usual clinical area to alternative clinical areas where safe staffing levels are compromised. This has been managed in two ways, initially nursing staff are moved on a shift-by-shift basis by the divisional bleep holder to achieve the safest staffing levels across the division. The senior nurse of the day reviews all nurse and midwifery staffing levels at the site safety meeting which occurs three times a day. Further staff deployment across the trust takes place at this meeting to achieve the safest staffing levels across the entire trust including the contingency areas.

3.2.2 The operational pool established to reduce the number of substantive staff that are required to move to another ward area on a shift-by-shift basis has continued to be utilised. Both RNs and HCSWs can book into an operational pool shift via the bank office in the knowledge that they will be deployed to any area in the trust to work. The deployment of the operational pool staff is facilitated by the senior nurse of the day and operational matron at the site safety meetings where the areas who require staffing support are identified, this includes, where appropriate into maternity services. Over the past six months, work has been undertaken to reduce the pay costs associated with bank enhancements. As the bank enhancements have reduced on the operational pool shift, there has been less fill rate associated with these shifts however the average bank fill rate across the trust has remained static at 66.7% for RN's and 62.7% for HCSW's (August 2023). Thus suggesting that bank staff are booking shifts directly with clinical areas rather than booking into the operational pool.

3.2.3 While the operational pool does reduce the number of substantive staff that are required to move to an alternative area to work, there are still high numbers of substantive staff being redeployed on a shift-by-shift basis as illustrated in figure 3. The number of staff redeployed has been an increasing trend over the last six months.

Figure 3: Number of redeployed working hours per month



3.2.4 Over the past six months, the senior nursing team have met daily to ensure that there was oversight of staffing, safety, quality concerns and patient flow. Escalation of decision making that compromised recognised staffing ratios was provided to Management Executive and the operational site team as necessary. The Board of Directors has also been updated as part of the monthly safe staffing report.

3.2.5 It is expected that staff movement and deployment will continue to be necessary over the winter period as we respond to the increased demand on services and are required to staff additional capacity. However, every effort is being made to minimise staff movements where possible.

3.3. Care Hours per Patient Day (CHPPD)

3.3.1 CHPPD is the total number of hours worked on the roster (clinical staff), divided by the bed state captured at 23.59 each day. For the purposes of reporting, this is aggregated into a monthly position. It gives a single comparable figure that can represent both staffing levels and patient requirements. CHPPD can be used as a comparison between wards in a trust and also nationally to benchmark. It differentiates registered nurses/ midwives from HCSWs to ensure skill mix can be well described and that the nurse-to-patient ratio is visible.

3.3.2 The CHPPD data, along with Care Costs per Patient Day (CCPPD), are available on the Model Hospital to enable benchmarking. CHPPD trends had increased in the last financial year which reflected the demands on staffing higher level care areas during the pandemic however over the last six months this has reduced. CHPPD total for nursing and midwifery (including HCSWs) demonstrates that since April 2023, the CHPPD for CUH has ranged from 8.5 – 9.6 which is aligned to the national median of between 7.9– 8.5

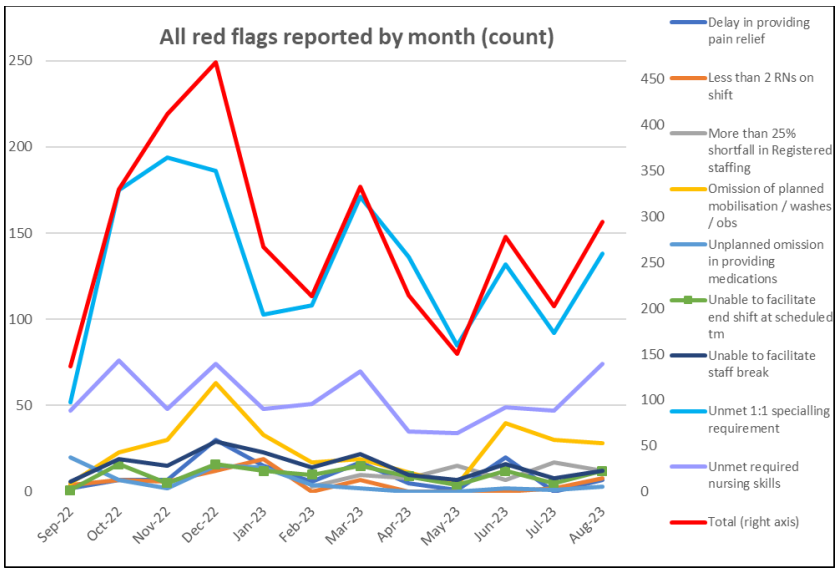
CHPPD. However, when comparing to our peer organisations (Shelford), CUH CHPPD is below the Shelford median of between 9.1 – 12 CHPPD.

3.4. Nursing red flags

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

3.4.2 Staffing red flags are reported monthly to the board of directors through the safe staffing paper. There has been a decreasing trend in the nursing red flags reported in the last financial year as illustrated in Figure 4.

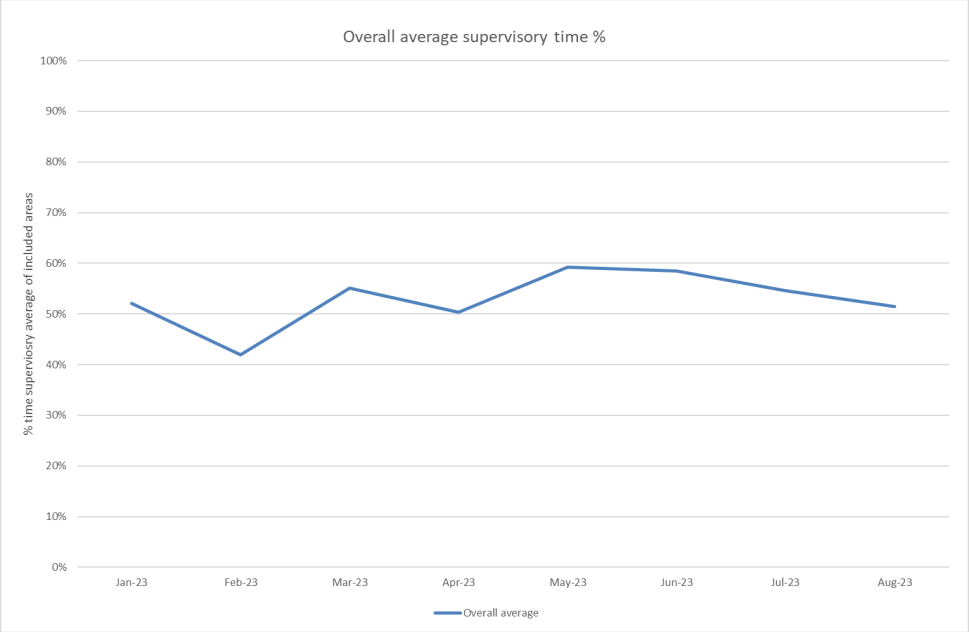
Figure 4: Nurse staffing red flags reported per month



3.5. Supervisory sister/charge nurse time

3.5.1 The Trust supports the ward senior sister/charge nurse to be in a supervisory capacity to enable delivery of high-quality care and positive patient experience. One of the commitments within the nursing, midwifery and allied health professional strategy was to ensure effective rostering to allow 100% supervisory sister/charge nurse time at ward level. Figure 5 below demonstrates that whilst this commitment has not been achieved due to staffing challenges over the last 6 months, there has been a gradual increase in the overall percentage of supervisory time. It is anticipated that sister/charge nurse supervisory time will improve in line with a decrease in vacancy rates and unavailability.

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



3.6. Critical care units

3.6.1 The critical care complex at CUH has 59 critical care beds, providing tertiary care for major trauma, liver and multivisceral transplantation, vascular, hepatobiliary and upper gastrointestinal patients. Safe staffing levels for critical care nursing are outlined within the guidelines for the provision of intensive care services (GPICS) which inform the establishment required for this specialist area.

3.6.2 Due to the critical care staffing being below the recommended GPICS guidance and the number of breaches of this guidance in particular the inability to provide 1-1 care for every level 3 patient and no availability of side room co-ordinators, the decision was taken by the divisional leadership team, Chief Nurse, Medical Director and Chief Operating Officer to reduce the critical care bed capacity to 52 beds during the last financial year. Recruitment has been ongoing to the vacant positions which has enabled 3 beds to be re-opened (55 beds now open in total).

3.6.3 The intention had been to open the remaining 4 closed beds by September 2023 however due to ongoing GPICS breaches caused by a vacancy position of 17.2% coupled with high unavailability (maternity leave and sickness), this has not been possible. Management Executive have oversight of these breaches and the mitigation that has been put in place to maintain patient safety. The Board of Directors has also been updated as part of the monthly safe staffing report.

3.6.4 A number of recruitment and retention initiatives have been put in place to attract and retain critical care skilled staff. This includes increasing the band 6 establishment, utilising the internal transfer process to enable nurses from other areas of the trust to transfer their employment to critical care and targeted in country, international recruitment. Additionally, bank enhancements have been utilised to encourage uptake of bank shifts and agency nurses have been working within the department.

3.7. Neonatal staffing

3.7.1 The British Association of Perinatal Medicine (BAPM) sets the standards for neonatal nurse staffing levels. The nursing establishment is activity adjusted using the BAPM neonatal clinical reference group nursing workforce calculator. The BAPM standard is that a Neonatal Intensive Care Unit (NICU) nurse establishment should be set for 90% activity. 80% of the nursing workforce should be RN and 70% of the total RN workforce should be qualified in specialty nurses (QIS) and hold a university accredited neonatal qualification.

3.7.2 NICU is funded for 12 intensive therapy unit (ITU - level 3) cots, 16 high dependency unit (HDU – level 2) cots and 12 special care baby unit (SCBU) cots. The BAPM standards for nurse staffing are calculated on the following:

- ITU 6.75 WTE per cot, as CUH have 12 ITU cots this is a staffing requirement of 81.0 WTE
- HDU 3.8 WTE per cot, as CUH have 16 HDU cots this is a staffing requirement of 60.8 WTE
- SCBU 2.44 WTE per cot, as CUH have 12 SCBU cots this is a staffing requirement of 29.28 WTE

Based on these calculations, the NICU establishment required to achieve BAPM standards is 171.08 WTE for 100% occupancy, 157.5 WTE for 90% occupancy, 139.36 WTE for 80% occupancy.

3.7.3 Recurrent 'Bridge the Gap' funding was previously awarded to CUH from NHSE via the operation delivery network (ODN) which enabled an increase in the nursing establishment to 164.34 WTE.

3.7.4 The required establishment for 90% occupancy is 157.5 WTE. For 90% activity, the target QIS will be 99.05 WTE RN. Based on the 2023 establishment and BAPM workforce calculator the current shortfall to achieve compliance on a BAPM occupancy of 90% is 26.64 WTE nursing workforce, the shortfall in QIS to achieve compliance for 90% activity is 24.29 WTE. This is due to the current band 6 vacancy of 22.62 WTE and Band 5 vacancy of 6.83 WTE.

3.7.5 A recruitment and retention plan is in place to address this shortfall which includes a very successful overseas recruitment programme, UK recruitment and retention initiatives. Within the neonatal workforce plan, the ambition is to develop more trainee Advanced Neonatal Nurse Practitioners (ANNPs) and Nursing Associate roles. In order to support the growth required in the number of QIS RN's, an in house university accredited Neonatal course has been developed. Due to the high vacancy in band 6 positions, the team are over recruiting to the band 5 positions in order to support progression through this QIS course.

3.7.6 Once recruitment is achieved, neonatal nurse staffing will meet the BAPM nursing workforce calculator, and BAPM standard of 90% occupancy. To mitigate any staffing shortages in the interim, a risk assessment of each critical care nursing allocation is undertaken to maintain compliance with BAPM one to one care for sick neonates.

4.1. Maternity staffing

4.1.1 Maternity teams must have sufficient and appropriate staffing capacity and capability to ensure safe, high quality and cost-effective care for women and their babies at all times. The National Quality Board improvement resource for maternity services (2018) outlined the requirement for organisations to use systematic evidence-based workforce planning tools, to be cross checked with professional judgement and benchmarked with peers.

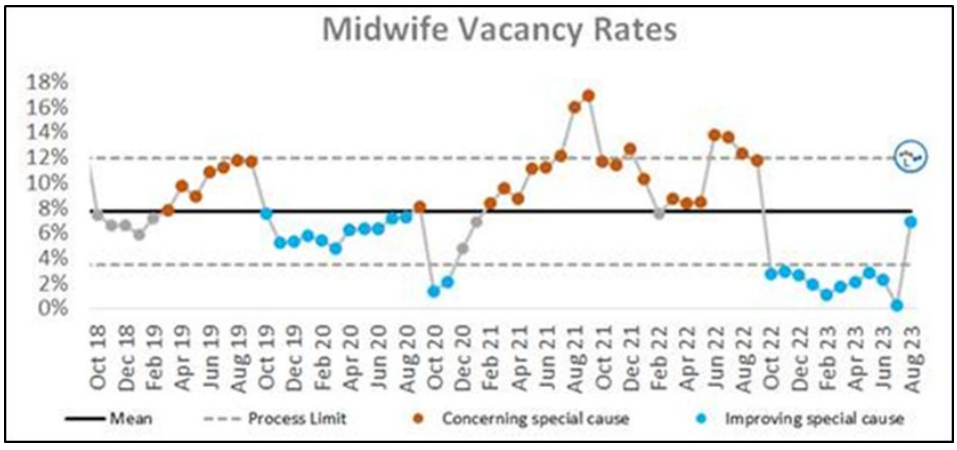
4.1.2 Birthrate plus® is the only national tool available for calculating midwifery staffing levels which has been endorsed by the National Institute for Health and Care Excellence (NICE). The tool considers the midwife-to-birth ratio and the mother's and baby's acuity and complexity for women throughout pregnancy, labour and the post-natal period, in both hospital and community settings. It is recommended that a birth rate plus review is conducted every 3 years. In line with midwifery staffing recommendations from the Ockenden report the trust executive board is required to provide evidence of funded establishment being compliant with the outcomes of BirthRate plus®.

4.1.3 CUH last undertook a Birthrate plus® review in 2022. The final report was published in August 2022 and will be repeated in 2025. The review recommended an increase in funded establishment of 9.16 WTE midwives. This increase in midwifery establishment was approved for the 2023/24 financial year.

4.2. Maternity vacancy position

4.2.1 There has been a significant improvement in the maternity workforce vacancy position over the last six months with vacancy rates reduced to 0.33% in July 2023 however, in August 2023 the financial ledger and Electronic Staff Record (ESR) was aligned with the budgeted position for 2023/24 resulting in a spike in vacancy to 6.87%. Figure 6 below illustrates the trend in midwifery vacancy rates over the past four years.

Figure 6: Registered Midwife vacancy rate



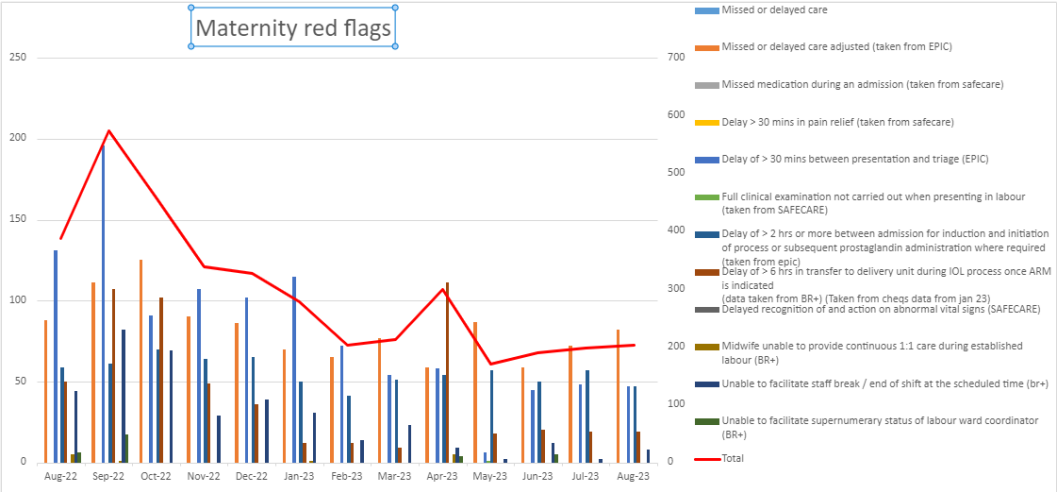
4.3. Midwifery red flag

4.3.1 The BirthRate Plus® acuity app is a ward acuity tool used to proactively assess the clinical needs of the women on the ward and match them against the staff available. Data is captured six times a day within the intrapartum areas and four times on ward based areas as a minimum. Management actions may include internal redeployment to support workload and escalation to the manager of the day for senior support.

4.3.2 A red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwifery bleep holder should be notified and are responsible for determining whether midwifery staffing is the cause, and the required action that is needed. Any unresolved flags should be escalated and management/mitigation put in place to ensure patient safety.

4.3.3 Figure 7 demonstrates the trend data for red flag reporting at the Rosie. The number of red flags reported over the last 6 months has been a decreasing trend. The most frequently reported maternity red flags were missed or delayed care. Staffing red flags are reported monthly to the board of directors through the safe staffing paper.

Figure 7: Maternity red flags



4.4. Planned verses actual maternity staffing levels

4.4.1 Figure 8 demonstrates the planned verses actual maternity staffing levels across the Rosie Hospital for the last 6 months (fill rates). The fill rates are reported monthly to the executive board in the safe staffing paper and the Head of midwifery provides an exception report when fill rates are less than 90% in any area.

Figure 8: Planned verses actual maternity staffing level

Month	Planned staffing	Actual staffing
April 2023	100%	95.6%
May 2023	100%	98.7%
June 2023	100%	94.7%
July 2023	100%	97.5%
Aug 2023	100%	92.2%

4.5. Midwife to Birth Ratio

4.5.1 The national average of midwife to birth ratio is 1:28 (dependent on unit acuity). The Rosie Hospital maternity services have a current funded establishment to support 1:24. Figure 9 illustrates the current midwife to birth ratio is slightly below this due to the vacancy position.

Figure 9: Maternity dashboard highlighting funded verses actual midwife to birth ratio

MW to birth ratio								Vacancy rate (as at August 23)		Obstetric staffing compliant
Unit	BR+ completed in last 3 yrs (please give date)	Full assessment (Yes/ No)	BR+ recommended ratio	Actual ratio	BR+ compliant - Full safe service offer	BR+ compliant - Delivery of CoC	Summary of gaps	Midwife nos	%age of total staff	
CUH	June 2022	Yes	1:28	1:25.2	No	No	Recommended 9.16 clinical MW posts. Business plan in place.	12.78	5.35%	Yes

4.6. Supernumerary Status of the Delivery Unit Co-ordinator

4.6.1 CUH use the Birthrate Plus® acuity tool to monitor and report compliance with 1:1 care in labour and supernumerary status of the labour ward co-ordinator.

4.6.2 The delivery unit co-ordinator should remain, at all times supernumerary, with no 1:1 caseload of their own, to provide the helicopter view of the unit. As a low risk area the birth centre is not required to have a supernumerary coordinator but does have a designated midwife in charge who is responsible for oversight of the ward.

4.6.2 Figure 10 demonstrated that supernumerary status of the coordinator has been 100% each month over the last six months. This was due to a change in the Maternity Incentive Scheme (MIS) definition around red flag capture in November 2022. New guidance was issued that stated only if the coordinator only was involved in 1:1 care in labour therefore not able to perform the duties of a coordinator with supernumerary helicopter view of the whole service would this be considered a non-compliance.

4.6.3 With regards to 1:1 care in labour, figure 10 demonstrates that this was maintained for 100% of the time with the exception of January 2023 where it was reported as 99.5% and April 2023 as 99.8%. When 1:1 care drops below 100% this is escalated to the operational bleep holder and manager on call. Escalation to divert measures are activated through the guideline to provide oversight and safety.

Figure 10: Compliance with 1-1 care in labour and supernumerary status of the delivery unit co-ordinator.

Month	Percentage of time supernumerary status of labour ward co-ordinator maintained	Percentage of time 1:1 care in labour maintained
January 2023	100%	99.5%
February 2023	100%	100%
March 2023	100%	100%
April 2023	100%	99.8%
May 2023	100%	100%
June 2023	100%	100%
July 2023	100%	100%

5. Recommendations

5.1 The Board of Directors are asked to receive the six monthly updated nurse and midwifery staffing report in line with regulatory requirements and to note:

- The high vacancy rates for registered nurses (RNs), registered sick children's nurses (RSCNs) and Health Care Support Workers (HCSWs) remain despite a strong recruitment pipeline.
- Redeployment of both RNs and HCSWs will continue to be necessary over the winter period in response to increased demand on services coupled with the vacancy rates and high unavailability.
- Critical care nurse staffing remains an area of concern due to GPICS breaches, 4 beds remained closed at this time to mitigate staffing shortfalls.
- CUH Care Hours Per Patient Day (CHPPD) is aligned to the national median; however, when comparing to Shelford peers, the CUH CHPPD is below the Shelford median of between 9.1 – 12 CHPPD (CUH 8.5-9.6).
- A review of the neonatal staffing requirements has been undertaken in line with the British Association of Perinatal Medicine (BAPM) standards.
- In line with guidance, a Birthrate Plus® review was undertaken in maternity in 2022 which has resulted in an increased establishment to comply with the birth rate plus recommendation and Ockenden report.
- There has been a significant improvement in the registered midwives (RMs) vacancy rate and the midwife to birth ratio is 1:25 which is slightly below the midwifery establishment of 1:24.

NHS
Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 8 November 2023

Agenda item	8
Title	Strategy update
Sponsoring executive director	Claire Stoneham, Director of Strategy and Major Projects
Author(s)	Matthew Zunder, Strategy Advisor; India Miller; Interim Director of Strategy; Denise Franks, Assistant Director of Planning and Development
Purpose	To update the Board on implementation of the Trust Strategy
Previously considered by	Management Executive, 2 November 2023

Executive Summary

In July 2022, the Trust agreed a revised Strategy, CUH Together 2025, with the focus now on its implementation and translation into delivery. Since then we have have identified ownership and accountability for delivery of the 15 commitments laid out in the strategy, with defined milestones and quantitative measures of progress. We have also confirmed that our strategic lens for 2024/25 will be on improving access to care, enabled by our workforce.

This report presents the four-monthly strategy update, aligned to the 15 commitments in the strategy. It presents an overview of activities undertaken from July to October 2023 with outlines of plans for the next four months. It also presents an overview of our progress in relation to access to care, including some key strategic metrics.

Related Trust objectives	All
Risk and Assurance	The Trust strategy is a key tool for addressing the major risks facing the Trust
Related Assurance Framework Entries	All
Legal / Regulatory / Equality, Diversity & Dignity implications?	n/a
How does this report affect Sustainability?	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 of Directors is asked to note the progress made over the last four months in delivering our strategy and our plans for the coming months.

Executive summary: how are we improving access to care in the short-, medium- and long-term?

Improving net bed capacity

- **Improving flow in the ED.** Improving flow in the ED is fundamental to improving net bed capacity in the rest of the hospital. Since July we have continued to improve performance in the ED despite a 4% increase in attendances between August and September, with fewer patients waiting more than 12 hours in the department and further improvements in ambulance handover times. We also drove activity through the Medical Assessment Unit (MAU) to support admission avoidance and reduce inpatient length of stay. Over the coming months we plan to implement an action plan to support Emergency Medicine focused on rostering, and improve performance in the Urgent Treatment centre by removing duplication.
- **Reducing inpatient length of stay.** We are continuing to drive inpatient length of stay savings to support outflow, including through our work with the ICS and Cambridgeshire South Care Partnership; we now have evidence to show that the Home First programme has been associated with improved discharge rates for patients with complex requirements. In surgery, we are focusing on improving discharges for day case procedures and identifying further opportunities to convert inpatient stays to 23 hour pathways; going forward we plan to explore overnight stays on our day surgery unit to support improvements in flow.
- **Increasing future capacity.** The Outline Business Case (OBC) for the Cambridge Cancer Research Hospital (CCRH) has been formally approved by NHS England and we have appointed a preferred construction partner; the Cambridge Children's Hospital (CCH) gained approval for its OBC from the national Joint Investment Committee. We have also developed a plan for release of clinic space adjacent to the Emergency Department.

Reducing waiting lists

- **Increasing activity and reducing backlogs.** By prioritising new-patient first appointments, we reduced the number of patients waiting longer than 65 weeks by 38% between August and September. In diagnostics, we have recovered MRI, CT and DEXA to pre-Covid waiting list levels.
- **Improving productivity through new pathways.** Adoption rates of Patient Not Present (PNP) and Patient Initiated Follow Up (PIFU) increased across several specialties, and our data is now showing evidence of an association between increased

use of PNP and reduced numbers of follow up appointments. Going forward we will develop plans for how to extend these initiatives more widely across the Trust. In surgery, we continued to drive and build on improvements in theatre utilisation.

- **Creating additional capacity.** The Wisbech Community Diagnostics Centre (CDC) is now fully open and we continued progress on Ely, which is due to open in the coming months. The Movement Surgical Hub is due to open in November and will provide protected beds, staff and theatre capacity.

Reducing the vacancy rate

- **Targeting current staffing gaps.** Our staff pipeline for Adult Nursing and Healthcare Support Workers are becoming stronger. For example, for Adult Nursing we anticipate, even with growth in establishment, reaching the 5% vacancy rate target by March 24. Midwifery remains fully established. We have delivered or are progressing a range of initiatives in areas identified as vacancy hotspots (hard-to-recruit-to positions and services). We are also refreshing the Trust retention strategy. A specific focus on time-to-recruit and applicant experience for those who wish to join Staff Bank is delivering results.
- **Ensuring that working at CUH is a good experience.** We continue to seek to understand the experiences and expectations of our staff through a variety of approaches. Through the Good Work agenda, we continue to focus on a range of benefits and offers for our staff, for example we have evaluated our existing financial wellbeing offers, we have opened a new high quality central staff rest area. We have commenced free quick access to unlimited on-line physiotherapy support fo complement our on-site staff physio offer.
- **Supporting appreciative and productive working relationships.** We continue to run the well-evaluated Senior Leaders and also new Consultant programme and are adding to that the new manager development programme (piloted in division A with the new build teams). We are had a high take of the Just & Learning Culture masterclasses which forms part of this culture-shaping programme of work. Appreciation of all that is good about CUH continues through the programmes of recognition events, such as the Annual Awards programme.

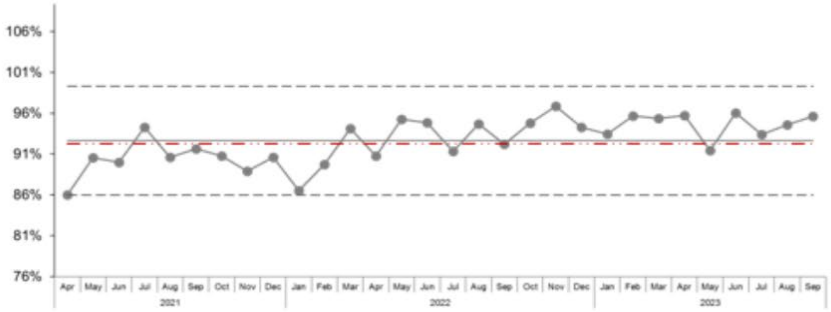
Presented below are the four key strategic measures aligned to access to care, enabled by workforce and underpinned by quality delivery. More detailed metrics are available in the Integrated Board Report.

Key Strategic Metrics – Access to Care

Target
Process Limits
Mean
Exceptional Variation (Deterioration)
Exceptional Variation (Improvement)

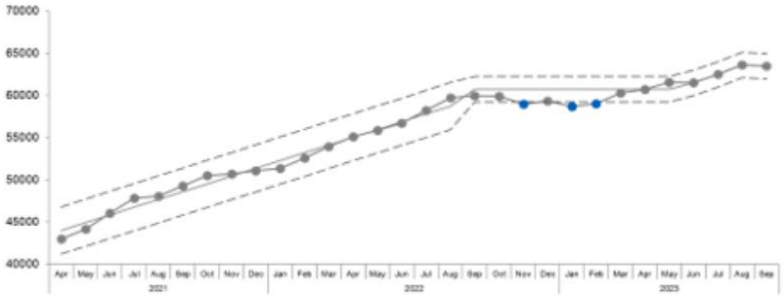
NHS CUH

G&A Bed Occupancy Rate



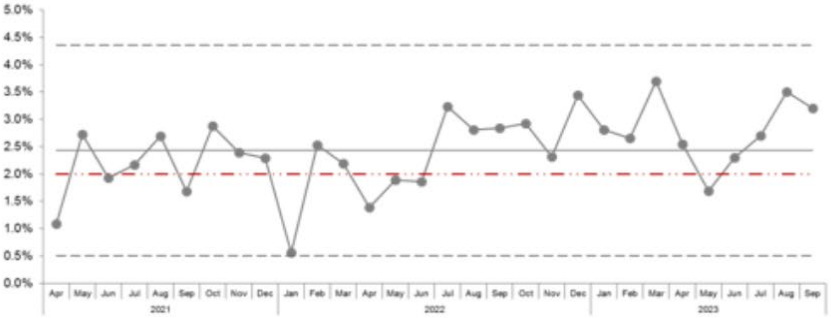
High bed occupancy is often a symptom of pressure on services, leading to the potential for increased risk of harm e.g. through hospital acquired infections, delays along the care pathway, longer lengths of stay and increased pressure on staff..

RTT Total Waiting List



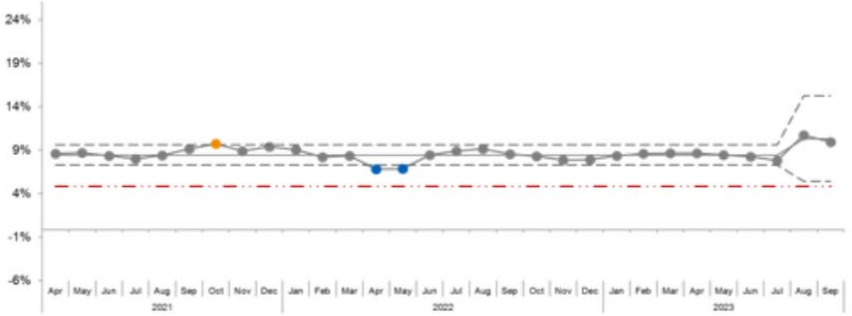
The improvements / levelling out of the RTT total waiting list since last summer has been impacted by industrial action over recent months.

Percentage of Moderate and Above Harm Patient Safety Incidents



Commentary - none

Nursing and Midwifery Vacancy Rate



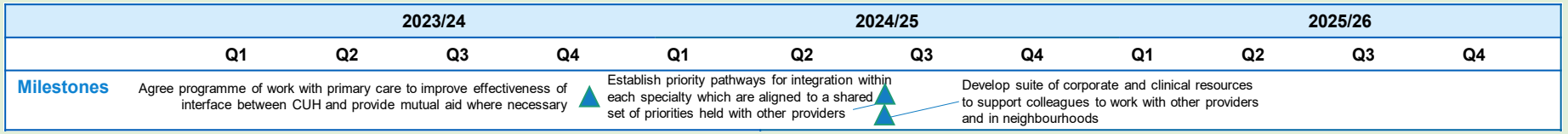
The increase in vacancy rate in August was due to the increase in budgeted FTE. If the budget from July had been used, the vacancy rate would have been 8.0%.

Improving patient care

Progress from July to October 2023	Key areas of focus for November to February 2024

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

Medium-term strategic trajectory: Significant progress continues to be made on integrated care through programmes led by the Cambridgeshire South Care Partnership (CSCP) e.g. High Intensity Users, integrated neighbourhoods, Home First – as well as by work led within CUH in partnership with others e.g. virtual wards, development of CDCs. However, the continued lack of consensus within our ICS on Accountable Business Unit (ABU) operating models has made it challenging to progress towards the vision we defined for integrated care last year, which relied on the ICB delivering structural changes such as the delegation of contracts to Place level. In this context, we are now seeking to define a revised approach to delivering our vision for integrated care, which should reduce the likelihood of BAF risk 010 occurring and accelerate progress towards improving the health of our local population.

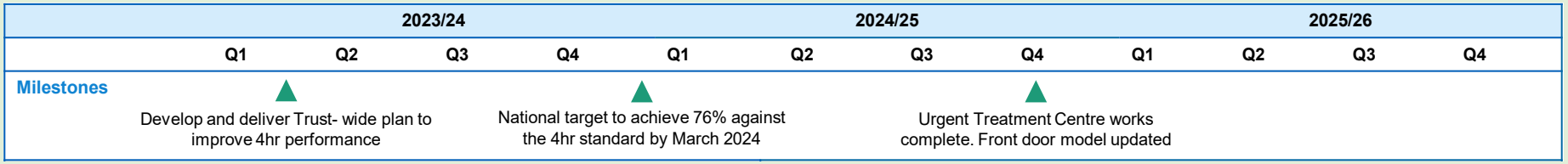


- Continued to host the Cambridgeshire South Care Partnership (CSCP) and support its thematic areas of work including High Intensity Users, and the Home First programme, which has now been associated with improved discharge rates for patients with complex requirements.
- Began to engage with the ICB regarding the delivery mechanisms for the Joint Forward Plan (JFP), and how Accountable Business Units (ABUs) will evolve to progress the priorities identified in the JFP.
- Began, to develop a proposed approach to progressing integrated care over the next year in partnership with the CSCP, in our current context.

- Discuss and agree the approach and objectives for progressing integrated care over the next year at the Addenbrooke's Futures Committee in November.
- Agree and allocate the resourcing required within CSCP and CUH to support the agreed objectives for integrated care over the next year.
- Agree with the Integrated Care Board (ICB) which priorities from the JFP will be delivered by CSCP and CUH.

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

Medium-term strategic trajectory: Over the last year, we have made significant progress on delivering improvements to our 4-hour performance, with an average 8% uplift compared to 2022/23, and are now on a trajectory to meet the national ambition of 76% by March 2024. This will support us to mitigate BAF risk 001, delivering more timely and responsive urgent and emergency care services. Over the next three years we will go further to sustain this improvement and deliver higher levels of performance through (i) realising efficiencies in our Urgent Treatment Centre pathways (ii) enhancing ED clinical staffing levels following the external review of the department (iii) creating additional space in the Urgent Treatment Centre through the development of Clinic 9.

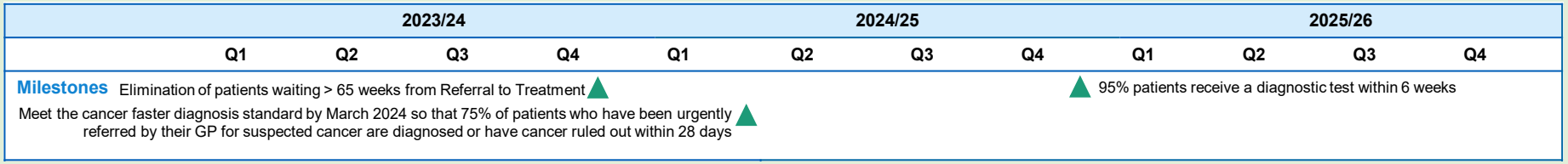


- Focused on reducing waits in the Emergency Department (ED). Attendances increased by 4% between August and September however, there was a reduction in patients waiting more than 12hrs in the department and an improvement in ambulance handover times.
- Remained in the national trend on performance on four hour waits in ED despite being below our trajectory of 71.0%.
- Drove activity through the Medical Assessment Unit to support admission avoidance and reduce inpatient length of stay.
- On-going focus on avoiding long waits and maintaining performance against ambulance handover metrics.
- Driving in-patient length of stay savings to support outflow.
- In-the moment management of breaches and overall performance through an expanded site team

- Implement the action plan to support Emergency Medicine including establishing clear and agreed rota rules to support Emergency Department staffing and identify the key rota pinch points. Medium term ambition: implement self-rostering.
- Address variation by standardising approaches to key roles and actions to create consistent operations day to day to provide a solid platform for future optimization.
- Improve performance in the Urgent Treatment Centre focusing on Emergency Nurse Practitioner & GP productivity and removing duplicative processes.
- Manage seasonal pressures and support emergency pathways during winter, with a focus on frail elderly patients, and managing infectious illnesses, feeding into the Trust's winter plan for 2023/24.
- Oversee progress of the above via the UEC Oversight Board, reporting into Management Executive on a regular basis, supported by detailed data analysis

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

Medium-term strategic trajectory: Our medium-term goal is to reduce our waiting lists to improve access to care, by increasing activity and improving productivity. We have made significant inroads towards in recent months through prioritising outpatient activity and increasing the adoption of outpatient productivity initiatives; as well as opening additional Community Diagnostic Centre capacity; and driving improvements in theatre utilisation and identifying opportunities to reduce length of stay. We now need to scale up our outpatient transformation programme, extending existing successful initiatives across the Trust, and maximise additional diagnostics and surgical capacity by redesigning clinical pathways, to reduce the risk that we cannot deliver timely and responsive elective care (BAF risk 001).



Outpatients

- Continued to prioritise new patient first appointments to ensure patients are waiting no longer than 65 weeks by March 2024; reduced from 6,352 patients in August to 3,910 patients as of 20th September.
- Adoption rates of Patient Not Present (PNP) and Patient Initiated Follow Up (PIFU) increased across many specialties. In July 2023 the CUH PIFU rate was 3.1%, ahead of Shelford peers at 2.1% and National provider median of 2.4%.
- Continued to refine the Outpatient Transformation Programme Board over time, which tracks progress monthly on outpatient projects across the Trust, using a data for improvement approach
- Doubled the monthly sign-up rate for MyChart through introducing automatic activation emails, which is significantly improving DNA rates for patients who register with the service.
- Embedded a focus on short- to medium-term outpatient productivity improvements in the business planning process, in line with the "access to care" strategic lens.

Surgery

Outpatients

- Develop a programme plan for outpatient transformation in the short-medium term, including how we will extend existing successful initiatives (e.g. PNP and PIFU) more widely across the Trust – and building in proposals developed through the business planning process and existing projects sponsored by the Outpatient Transformation Programme Board.
- Develop a medium-term Trust-wide outpatient strategy to improve outpatient productivity over the next 3 years, using our own learning, learning from other hospitals, Getting it Right First Time (GIRFT) and Royal College of Physicians guidance.
- Develop an outpatient transformation toolkit to provide practical advice to teams.
- Recruit additional staff to speed up the turnaround time for clinic room requests and explore different ways of booking rooms to minimise cancellations.
- Implement the Netcall patient portal when eHospital resources are available.

Surgery

- Continued to drive and build upon improvements in theatre utilisation, with projects for start times and better turnaround times. Outperformed peer data in Model Hospital.
- Focused on improved discharges for British Academy of Day Surgery (BADS) day case procedures.
- Collaborated with specialties and nursing team on Day Surgery Unit (DSU) to identify and escalate challenges to achieving 85% target.
- Finalised preparation to open the Surgical Movement Hub with three additional theatres (due to open in November 2023).
- Identified further opportunities to convert inpatient stays to 23hr pathways to improve surgical flow and release capacity.
- Expanded patient pathways via Surgical Assessment Unit to aid flow and relieve pressure on Emergency Department.
- Placed Pre-Operative Assessment (POA) team representatives on the regional team and developed earlier screening for risk factors that would prevent surgery, create cancellations, and increase length of stay.
- Planned for development of Post-Anaesthetic Care Unit (PACU) to support patients' post-op pathway.
-

Diagnostics

- Recovered MRI, CT and DEXA to pre-Covid waiting list levels
- Continued plans to recover Echo, MRI and Ultrasound backlogs and reduced the overall number of patients waiting >6 weeks for diagnostics.
- Opened Wisbech Community Diagnostics Centre (CDC) fully and continued progress on Ely CDC.

- Mitigate start delays and turnaround times by exploring 'overnight stays' on L2 Day Surgery Unit which do not impact the General & Acute bed pool.
- Reconfigure the L2 space to enable maximum workforce resilience in preparation for patients' pre-op.
- Revise the L2 DSU contingency policy to protect from inappropriate moves to improve flow.
- Focus on improving data quality, with regular updates on problem areas.
- Work with specialties to maximise opportunities for same day discharge, managing patient expectation, clear post-op notes and care, and use of the virtual ward.
- Open The Surgical Movement Hub in November 2023, providing protected beds, staff, and theatre capacity.
- Offer extended contracts to the (POA) team for their roles on the regional team. Ensuring CUH remains abreast of best-practice and latest innovations.
- Run a pilot for 'Surgery Hero', an app-based service which will support patients in their surgical journey, reducing cancellations on the day and maximising fitness.
- Expand SDEC pathways via Surgical Assessment Unit.
- Send CUH representation to the East of England Elective Care Improvement Network, attending webinars and workshops on latest developments.

Diagnostics

- Continue plans to recover Audiology, Echo and Ultrasound backlogs and further reduce the overall number of patients waiting >6 weeks for diagnostics.
- Increase the use of available modalities at Wisbech CDC and open new modalities
- Open Ely CDC including MRI, Respiratory Physiology, Echo and Ultrasound.

- Worked with the system to define and addressed increasing demand especially for Cardiac imaging and MRI.
- Aimed to recover Urodynamics by end of March 2024 with the appointment of new staff.

- Continue system work on cardiac imaging capacity and plan.
- Operationalise new insourcing contract in echo, explore outsourcing/insourcing options for Urodynamics and alternative pathways for Audiology.

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

Medium-term strategic trajectory: We are continuing work to develop a strategic plan for health inequalities (HI) and equality, diversity and inclusion (EDI), which will bring together key existing areas of work across the Trust and seek to embed HI and EDI across everything we do e.g. designing inclusion into service redesign, and considering how we involve diverse communities in our patient and public engagement work. We are also focused on collecting the right data (e.g. demographic data in MyChart) to understand the biggest disparities in patient experience and outcomes. The implementation of the strategic plan will contribute to the mitigation of BAF risk 008 in the short-medium term.

	2023/24				2024/25				2025/26			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Milestones			Establish and implement strategic HI plan		Work with the ICS to agree an approach and use of EDS tool (24/25)							
					Continued implementation of strategic HI plan							

- Begun to work with three pilot areas in Pneumonia, ENT and Dermatology to design inclusion into service redesign, with the goal of creating a blueprint for how to embed equity and inclusion to benefit patients and service users
- Continued to work with the Genomic Medicine Service Alliances (GMSA) and trusts across the region to expand access to genomic services.
- Promoted MyChart and work with e-hospital team to evaluate the impact including the mandatory demographic fields.
- Launched the updated CUH Transgender Care guidelines
- Worked with system partners regarding interpretation of local data.
- Continued focus on Equality Impact Assessment (EIA), building capacity, incorporating the Inclusive Decision-Making Framework to promote effective and inclusive decision making, with a focus on raised awareness / training for staff.
- Continued the development of the Patient and Public Engagement framework, which will establish an approach for how CUH will

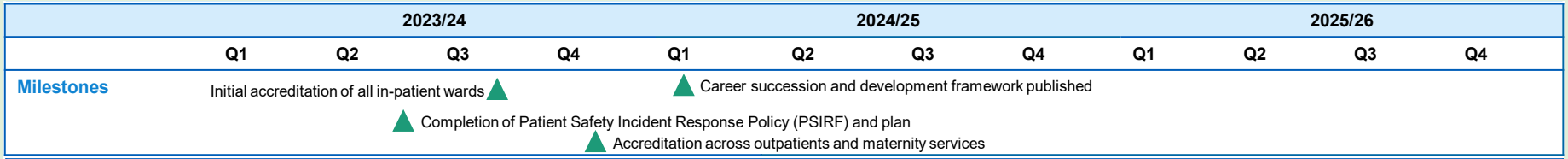
- Continue pilots to design inclusion into service redesign, including creating an evidence base utilising equality data and designing a future state where inclusion and equity is integral to the new service model
- Support the GMSA to continue expansion of genomics services
- Establish a smoking cessation service for inpatients across CUH
- Use MyChart demographic data to set the direction for reducing Health Inequalities and understand the benefits and opportunities associated with the health inequalities module/functionality in Epic.
- Ensure that the CUH Transgender Care Guidelines to ensure that the guidelines continue to reflect and incorporate clinical and operational best practice and develop a training/awareness offer to support staff and patients.
- Finalise the Equality Impact Assessment (EIA) guidance and process within the Trust, and develop a training/awareness offer to support staff with their understanding of the guidance and process.
- Launch the Patient and Public Engagement Framework, subject to ME and Board approval

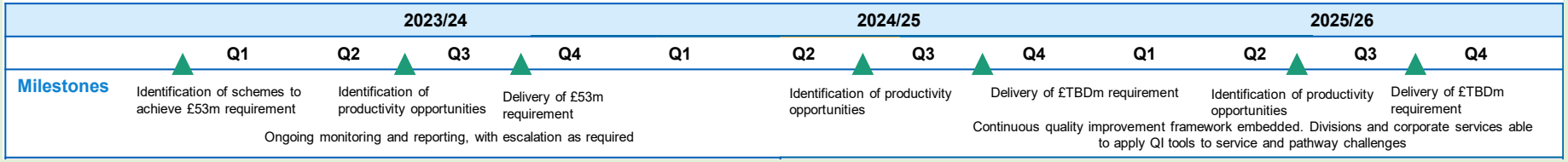
engage with patients and service users, including consideration of how we can engage with a diverse range of patients

- Hold an EDI development session in maternity services to support the continued implementation of the National Maternity Competency Framework focusing on LGBTQ+, ethnic minorities, and disabled patients.
- Influence the development of the health inequalities strategy and policy implementation at the ICS Health Improvement Board.

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

Medium-term strategic trajectory: We remain on track to continue improvements in the quality and safety of our services, including delivering new and wide-ranging training programmes; implementing the national Patient Safety Incident Response Framework (PSIRF), and ongoing QI work e.g. on hospital-acquired pressure ulcers. The roll out of PSIRF and efforts to continue expanding staff capabilities in delivering quality improvements will contribute to the mitigation of BAF risk 004 in the short-medium term.





- Completed a pilot of the Epic eConsent software to understand its full capabilities focusing on shared decision making between clinicians and patients.
- Maintained our compliance with the >95% venous thromboembolism (VTE) risk assessment target through ongoing support and education and change to Epic to streamline the VTE assessment process.
- Delivered a wide range of training ensuring online resources for doctors are up to date, easy to complete and effective, including simulation training in the management of major haemorrhage.
- Piloted the presence of a Mental Health Practitioner to support good decision making and ensure adherence to best practice guidelines.

- Recruit onto wave four of the improvement coach programme
- Commence development of a Quality Improvement (QI) bitesize training programme
- Work on reducing hospital acquired pressure ulcers, as part of a two-year QI collaborative with the IHI
- Implement the patient safety incident response framework (PSIRF) with a policy and plan approved and published
- Commence Trust wide training on PSIRF as mandatory for all staff
- Complete quality improvement programmes on identified areas
- Onboard new lead for the accreditation programme in Nov 23.

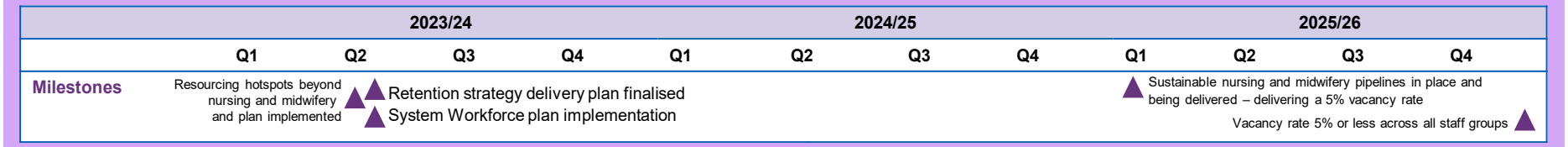
- Sustained progress in imaging backlog with focus on scanning activity, long waiting studies, demand management and preparing for activity at the Community Diagnostic Centres (CDCs). Approve through divisional transformation the options appraisal for CDCs.
- Supported the implementation of the Waiting List Initiative for reporting.
- Agreed the key areas of focus following the end of year three with the Institute for Healthcare Improvement (IHI).
- Concluded wave three of the improvement coach programme and agree dates for wave four.
- Continued work on reducing hospital acquired pressure ulcers, as part of a two-year quality improvement collaborative with the IHI.

Supporting our staff

Progress from July to October 2023	Key areas of focus for November to February 2024

Resourcing: We will invest to ensure that we are well staffed to deliver safe and high-quality care – with vacancy rates of 5% or less across all staff groups

Medium-term strategic trajectory: Progress is being made in relation to resourcing, improvement and being seen in relation to staff retention, impacting positively on vacancy rates. The trust continues to grow its workforce and has further plans to improve vacancy rates. This will contribute to improving the risk trajectory of BAF 007 in the coming months if we are able to move towards a 7.5% vacancy rate by March 2024.

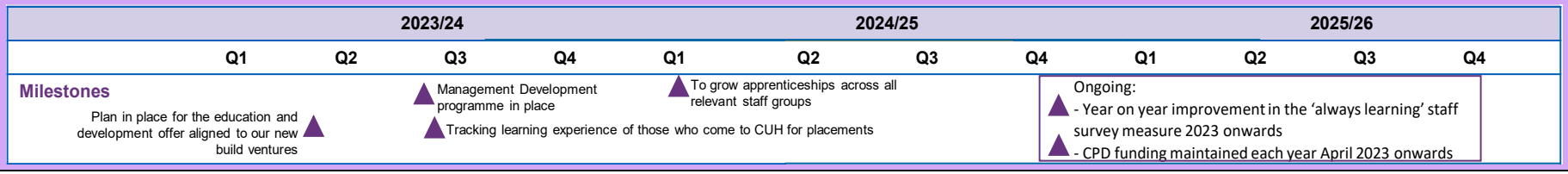


- Reviewed the Operational Site Management programme re impact and outcomes for effective site management.
- Delivered a suite of initiatives in vacancy hotspot areas to address hard-to-recruit-to positions / services.
- Developed and publish new centralised job descriptions, person specifications and advertisement templates to reduce bias in recruitment.
- Improved time to recruit and applicant experience for the Staff Bank.
- Review and refresh Trust retention strategy.

- Provide feedback following listening exercise and co-create with stakeholders a development plan for Operational Site Management
- Monitor and review hard to recruit hotspots, including closing areas where improvements achieved and identifying additional areas requiring support.
- Roll out updated job packs developed for all centrally recruited posts, including de-biasing recruitment activity
- Work with Improvement and Transformation on project to improve recruit and applicant experience for the staff bank.
- Review trust retention strategy and discuss at Workforce and Education Committee.

Ambition: We will enable professional and personal growth – developing our people is vital to individual and organisational success

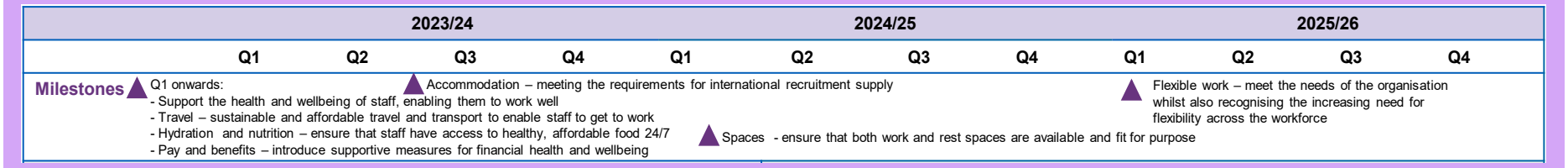
Medium-term strategic trajectory: Initial progress has been slower than planned due to resources over the summer period, however this will be mitigated over the 3-years trajectory (BAF Risk 007).



• Piloted the New Manager Development Programme with a cohort of circa 40 nurses (P&Q wards), with full roll out to new managers September / October 2023. • Reviewed the use of talent processes with divisions / directorates to date, which will inform work to develop a CUH talent management strategy and plan. Provided support for divisions and directorates to embed talent processes in their areas.	• Complete funding request for the New Manager Development Programme and deliver the programme in early 2024 • Produce a Strategy and Plan based on the Talent Review by end of 2023/24

Good Work: We strive to ensure that working here is a good experience – with a positive impact on our health, safety and well-being

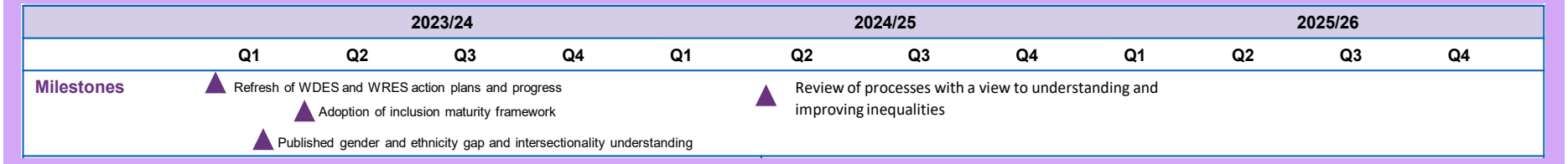
Medium-term strategic trajectory: This commitment is linked to BAF risk 013, the risk that we fail to maintain and improve the physical and mental health and wellbeing of our workforce. Initiatives developed in recent months (e.g. the financial wellbeing strategy and exploration of moral injury) build on the broad 'Good Work' model we have already developed, which identifies six priority areas to improve staff wellbeing. In order to mitigate BAF risk 013 we will need to further develop our work on cost of living pressures as well as responding to staff feedback through the staff survey and listening events.



• Developed and implemented a Financial Wellbeing Strategy with an offer of education and finance apps for staff. • Recruited a project manager for the Trauma Risk Management (TRiM) Service. Completed training provider tender and appointment, and implement plan, including identifying initial high intensity areas and scheduled training. • Explored the context of CUH as it relates to 'moral injury' by October, with findings provided to the Management Executive. • Delivered wellbeing conversation training (pilot) for managers, delivered to nursing colleagues in division B at band 6 and 7 level during July to October. • Commenced the 2023 autumn Flu & COVID vaccination campaign for staff. • Completed pilot trial offer of a new interactive digital back pain service for staff, to provide free instant access to unlimited physiotherapy sessions via the Flok Health app.	• Collect feedback from staff on the financial wellbeing implementation to improve future offer. • Successfully appoint a new Mental Health Nurse at OH to allow the TRiM programme to continue progress. • Complete autumn flu and Covid vaccination campaign for staff, with good uptake • Continue to improve OH metrics for both new starter screening and urgent referrals • Launch Flok Health app more widely

Inclusion: We will seek to drive out inequality – we are stronger as an organisation which values difference and inclusion

Medium-term strategic trajectory: A significant level of activity in underway. Through the work on the six high impact actions informed by reported staff experience, a consideration of evidence, and applying an improvement approach; it is anticipated there will be a measurable improvement in inequalities in the medium term, which will contribute to mitigating BAF risk 008.

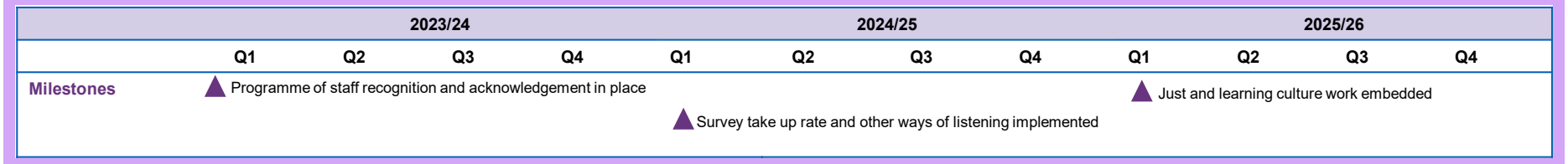


- Submitted Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) including bank WRES and gender pay gap data.
- Used the NHS National Equality, Diversity and Inclusion (EDI) Improvement Plan's 'six high impact actions', alongside listening events, to map the EDI and WRES/WDES action plans, before October.
- Co-produced staff network development and governance plan.
- Published ethnicity pay gap for the first time in addition to gender pay gap.

- Assess gaps in delivery of the NHS National Equality, Diversity and Inclusion Improvement Plan's 'six high impact actions' ahead of further actions to be implemented.
- Undertake further analysis of pay gap intersections to inform the EDI Strategy

Relationships: We value compassionate appreciative and productive working relationships – we will listen to each other, reflect and learn

Medium-term strategic trajectory: Second staff awards event took place in September 2023, staff listening events programme took place over the summer 2023, just and learning culture work commenced with positive feedback and work will continue to embed this going forwards. This will contribute to the mitigation of BAF risk 013.



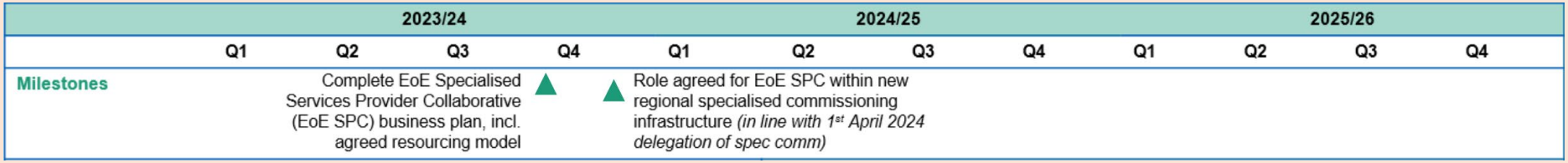
- Rolled out the Just & Learning Culture programme, to include launch of the Just & Learning Culture CUH Declaration and Leadership Masterclasses in July, and the development of a Just &

- Deliver calendar of events for 24/25 alongside Addenbrookes Charitable Trust

Learning Culture community of advocates and co-designers of methods to share learning and shape culture. • Continued to deliver the annual award process with divisional celebrations, shortlisting and awards-evening in September. • Delivered quality long service, retirement and volunteer recognition events as well as the NHS 75 celebration event to support relationship building.	• Continue to embed Just & Learning Culture programme and further increase uptake.

Building for the future

Progress from July to October 2023	Key areas of focus for November to February 2024
Specialised Services: We will work with hospitals across the East of England to provide high quality specialised care for more patients closer to home	
Medium-term strategic trajectory: The progress we have made on building relationships with NHSE, ICBs and providers across the region through the East of England Specialised Services Provider Collaborative (EoE SPC) brings us closer to our vision of improving specialised care in the East of England in the medium-long term. By formalising these relationships within the EoE SPC and embedding our role in the regional specialised commissioning infrastructure over the next year, we can expand our influence over time, with the goal of making more significant changes to specialised services development in the next 3 years. However, we continue to experience challenges in securing buy-in from NHSE and ICBs for our vision for improving specialised services which risks pushing timelines further out or even compromising our vision; this drives the continued amber risk rating for BAF risk 014 on specialised services.	



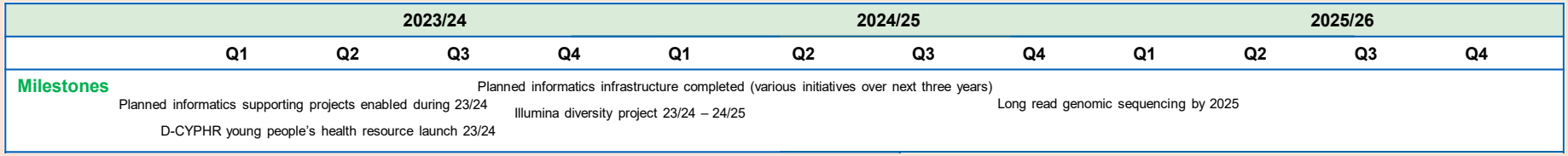
- Secured provider representation on the regional Joint Commissioning Committee, allowing us to directly influence decisions about the specialised services strategy across the region.
- Agreed scope and began to develop a regional strategy and vision for neurosciences, including engagement to date with 20+ stakeholders across the region.
- Agreed approach to transferring ownership of the regional dentistry transformation programme to Integrated Care Boards (ICBs) following the delegation of commissioning in April 2024; continued to progress quick wins, including appointing a regional sedation lead for each ICB; agreeing to pilot alternative sedation therapies in Hertfordshire and West Essex ICB; and progressing the business case to repatriate temporomandibular joint replacement services into the East of England.
- Continued to progress pilot projects which seek to demonstrate the benefits of transforming specialised services, including exploring funding mechanisms to support the delivery of biologics therapies closer to home for patients with severe asthma and MS; and working

- Engage with ICBs and NHSE through the Joint Commissioning Committee to support the delegation of specialised services in April 2024.
- Progress pilot projects to demonstrate the benefits of transforming specialised services, and agree any additional priorities to be progressed in 2024/25.
- Launch regional neurosciences strategy steering group to agree the overarching vision and priorities for the neurosciences' strategy; set up working groups to develop more detailed recommendations in each priority area.
- Agree ownership for delivery of all recommendations from the dentistry transformation programme, and approach to leading the programme going forward with ICBs.
- Secure agreement from all providers in the collaborative for the 2024/25 business plan (including objectives and priorities, resourcing and governance), gaining formal sign off by the end of the financial year.

through the Information Governance requirements to utilise video technology for remote diagnosis and management of epilepsy seizures across the East of England region. • Completed an early draft of the EoE SPC business plan for 2024/25.	

Research and Life Sciences: We will conduct world-leading research that improves care and drives economic growth

Medium-term strategic trajectory: In the medium-term we are looking to implement the strategic objectives of the NIHR Biomedical Research Centre (BRC) and Clinical Research Facility (CRF) and further develop the infrastructure to use of health data for research, building on the work of the NIHR BioResource, Gut Reaction and the strategy for the East of England Secure Data Environment (SDE) for Research and Development. We will also seek to remain at the forefront of genomics research, including through a programme of long read whole genome sequencing. Developing our innovation strategy and recruiting a substantive resource to lead this work will help us to address BAF risk 012 that our research fails to capitalise on opportunities to improve care today and generate new treatments for tomorrow.



Research • Launched the national Children and Young People's BioResource under the new name D-CYPHR planned for July. • Supported delivery of the East of England Secure Data Environment for Research and Development. • Built capacity for using health data for research. • Secure Data Environment programme approved by Management Executive subject to additional assurances around finance, governance and procurement. *Innovation* • Completed diagnostic review on current approach to innovation, including a review of the internal and external innovation landscape. • Support gained from the board on the approach and next steps for innovation.	*Research* • Built on the success of workshops with commercialisation partners Cambridge Enterprise and Health Tech Enterprise to enhance participation in innovation on campus. • Work with the Office of Life Sciences to develop metrics for genomic research in the UK. • Develop a framework for data research partnerships. • Review current landscape with Director of Digital to put in place structure for clinical research informatics. *Innovation* • Commission interim resource to establish innovation programme and deliver initial work packages. • Recruit substantive team to lead work on innovation.

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

Medium-term strategic trajectory: *New Hospitals:* Linked BAF risk 009. The cancer hospital is at a critical point in its development as we move from concept and strategy to delivery. Enabling works are set to begin in 2024 with the main build starting in early 2025. The work on transforming care will step up a gear as pathways are reviewed to realise the benefits of early cancer detection and precision medicine that are fundamental to the Case. Achieving all of this is predicated on a breadth of colleagues from across the project remaining on track with their aspects of the project. The Children's hospital OBC has received approval in principle subject to an affordability gateway in April 2024. The project was assessed as 'green' on its Government Gateway 2 review bringing confidence that the project is ready to proceed to the next stage. In the medium term we can expect new capacity to be fully open including the surgical movement hub and surge capacity enabling the acceleration of fire safety and compliance works. The Board sub-committee which provides oversight of the projects within the Addenbrooke's 3 programme has reviewed and updated its terms of reference to reflect the stage of project delivery our new hospitals are approaching with a focus on pathway delivery and partnership working to achieve the benefits. This is reflected in a name change from the Addenbrooke's 3 Committee to the Addenbrooke's Futures Committee.
Estates: Linked BAF risks 005 and 006. While we have made progress in delivering the capital and backlog programme and fire safety maintenance works, there is a risk that backlog maintenance investment is not keeping pace with the backlog maintenance burden. There are also risks that the functional suitability of existing spaces and buildings does not keep pace with expectation and revenue budgets are not sufficient to maintain the infrastructure. Adequately resourced capital and revenue budgets which includes services and project, and technical staff consistently into the future will place the Trust in the best possible position to maintain the existing environments and support new facilities as they come forward.

	2023/24				2024/25				2025/26			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Milestones	Cancer hospital FBC submission – Oct 2024 Cancer hospital construction start – May 2025 Cancer hospital construction end – Nov 2027			Children's hospital FBC submission – Oct 2024 (may be delayed) Children's hospital construction start - TBC			Surgical Movement Hub operational – November 2023 A-Block Theatres Re-open - February 2024 U-Block operational – January 2024			Histopathology operational – March 2025 Commence fire safety decant works – Jan 2024		

Addenbrooke's 3 - Phase 1

- Progressed the business case for the new Genomics laboratory.
- Opened the Wisbech Community Diagnostic Centre (CDC) spoke.
- Worked on the Ely CDC hub.
- Supported plan for release of clinic space adjacent to the Emergency Department (Clinic 9) to allow expansion of urgent care capacity.
- Commenced the baselining work to underpin the development of the strategy for the use of space vacated during phases one and two of Addenbrooke's 3.
- Completed the construction of the surgical movement hub.

Addenbrooke's 3 - Phase 1

- Submit the business case for expansion of the Genomics laboratory.
- Extend the range of diagnostics available at the Wisbech CDC spoke.
- Open the surgical movement hub and the surge capacity (U block)
- Agree the principles and begin to develop options for the use of space vacated during phase 1 and 2 of Addenbrooke's 3.
- Begin the work programme to release clinic space adjacent to the Emergency Department to allow expansion of urgent and emergency care.

Addenbrooke's 3 Phase 2 - Cambridge Cancer Research Hospital (CCRH)

- Received formal approval of the Outline Business Case (OBC) from NHS England.
- Welcomed Laing O'Rourke as preferred construction partner and commenced working with them to optimise and finalise designs.
- Appointed a Director of New Hospital Construction, Matt Allen, to lead the hospital design finalisation and build.
- Carried out a period of focused engagement and information sessions with staff over the summer, capturing their ideas and feedback.
- Worked with Patient Advisory Groups, including reaching out to regional groups to ensure the hospital meets the needs of patients.
- Worked closely with partners from the New Hospital Programme (NHP) and NHS England regional team to understand the new progressive assurance process as we move to Full Business Case (FBC).

Addenbrooke's 3 Phase 2 - Cambridge Children's Hospital (CCH)

- Gained approval for OBC from national Joint Investment Committee (JIC).
- Completed enabling-works package and initiate procurement.
- Finalised RIBA Stage 3.
- Focused on engagement with stakeholders, particularly staff and patients, as work develops on clinical, operational and workforce models.
- Continued progress towards £100m fundraising campaign.

Estates

- Delivered the capital programme, backlog programme and feasibilities and delivery of intermediate capital schemes.
- Continued the fire safety remedial works and the fire detection replacement and upgrade programme.
- Completed the Premises Assurance Model assessment on key compliance areas such as water, electricity, critical ventilation and

Addenbrooke's 3 Phase 2 - Cambridge Cancer Research Hospital (CCRH)

- Decision expected imminently on the full planning application submitted in January 2023, following a period of close engagement with the Cambridgeshire & Peterborough Combined Authority.
- Agree programme and cost plan together with our preferred construction partner, to ensure project delivers to budget and time, whilst maximising value for money and maintaining affordability.
- Progress development of FBC in collaboration with NHS England and the NHP ready for submission in 2024, with a key focus on benefits realisation.
- Work with the East of England Cancer Alliance on key focus areas such as workforce and planning an event with their regional Primary Care team.
- Commence a focused programme of engagement with stakeholders, particularly staff and patients, as work develops on clinical, operational and workforce models.

Addenbrooke's 3 Phase 2 - Cambridge Children's Hospital (CCH)

- Prepared for JIC capital funding review April 2024.
- Initiate enabling-works package.
- Review CCH future governance arrangements.
- Complete Royal Institute of British Architects (RIBA) Stage 3.
- Develop high level target operational model.
- Continue progress towards £100m fundraising campaign.

Estates

- Develop a Premises Assurance Model (PAM) governance board for ongoing monitoring of PAM areas within Capital Estates and Facilities Management.
- Develop risk register entries for safety and quality related aspects.
- Carry out the 5-yearly Six Facet Survey throughout 2024, commissioning 6 separate site surveys to look at different facets such as physical condition, space utilisation and environmental

continuation of instilling a culture of safety in Capital Estates and Facilities Management (CEFM).

management. Use the data gathered to develop the priority list for project funding.

Climate Change: We will tackle the climate emergency and enhance environmental sustainability

Medium-term strategic trajectory: We remain on a strong path to meet the carbon reduction target set out in Our Action 50 Green Plan (Phase 1: 2022:24). The essential organisational engagement elements of the plan continue to be pursued with a strong and concerted programme, although embedding the essential aspect of lifecycle thinking, as a devolved responsibility, into all consumption-related decision-making across the organisation remains challenging. The use of the 10% weighting for climate change/social value in tender specifications, and then delivering through contract management, is the strongest formal tool available at present and will continue to be pushed forward to establish it as standard and well-understood practice. Steps are also being taken to ensure that we are well placed strategically to push on into drafting the content for Phase 2 of the Trust's Green Plan through progressing heat decarbonisation, renewable power and circular economy medium to longer term projects.

	2023/24				2024/25				2025/26			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Milestones:					Action 50 Green Plan Phase 1 complete 10%reduction in CUH Carbon Emissions ▲			▲ Publication of Action 50 Green Plan Phase 2 Interim carbon reduction target to be set to reach Net zero by 2045				

- Assembled physical infrastructure plan for electric vehicle on-site charging points.
- Revised travel expenses policy to prioritise low-carbon travel.
- Prepared Public Sector Decarbonisation Scheme capital grant bid to install total heat-pump provision for the Frank Lee Centre and residential blocks.
- Installed high-efficiency heat pumps with solar panel link for new Movement Surgical Hub.
- Drafted guidance for net-zero/social value content in tender specifications.
- Delivered procurement changes and Trust-wide communications to meet requirements of Department of Environment, Food and Rural Affairs (Defra) single-use catering plastics ban.
- Scheduled and prepared for circular economy event at CUH in partnership with three closely aligned NHS trusts – University College London Hospitals, University Hospitals Sussex, Imperial College Healthcare.
- Delivered carefully themed staff engagement to encourage cycling, tackle climate anxiety and promote reuse.

- Draft Net-Zero e-learning using staff engagement and input collated during November's Think Green Education month.
- Submit environmental sustainability content into the new Essentials for Leadership Excellence programme.
- Draw up specifications for electric vehicle management connectivity and draft a usage policy.
- Complete first draft of detailed spatial designs for new net-zero enabled energy centre and associated distribution network and connectivity.
- Decommission Addenbrookes Treatment Centre's (ATC) piped nitrous network to negate high carbon emission losses.
- Embed net-zero/social value within tendered contract management processes.
- Secure Passivhaus certifier appointment for Cambridge Childrens' Hospital Stage 4 design phase.
- Draft climate change adaptation plan.

Digital: We will use technology and data to improve care

Medium-term strategic trajectory: The overall digital demands on the eHospital team continue to increase. However, as highlighted in BAF003, resourcing for the team continues to be a challenge and will be a major impediment towards delivering on the wider CUH Strategy. To address this, we will be putting together a digital workforce strategy that will take into consideration current-, medium- term ambitions and upcoming trust major projects. The scope of this will not only address how we increase central digital resources but also begin to explore how certain digital capabilities can be developed within clinical divisions and other corporate areas. This is consistent with closer alignment between operations and digital functions, a well-recognised marker of organisational digital maturity.

	2023/24				2024/25				2025/26			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Milestones	Digital Board & DPGs set up		▲ Digital strategy published ▲									

- Completed development and implementation of Epic upgrade to support changes for Smartcard authentication. This also included the most significant change to software foundations that Epic is built upon. This will deliver performance enhancements and make it easier for future Epic developments.
- Provided digital support to the development of Community Diagnostic Centres and Orthopaedics Hubs in collaboration with system partners.
- Created new Digital Prioritisation groups that ensure Digital resources focus on delivering the solutions which provide the most benefit to patients and staff.
- Finalised the closure of Addenbrooke's email addresses and moved to NHS.net email.

- Create a revamped digital board, a subcommittee of ME, that will oversee the delivery of the trust's digital strategy.
- Operationalise the digital prioritisation group for Epic-related change requests and agree on a strategy to deal with the backlog of requests.
- Define the resource requirements for a digital workforce plan to support upcoming major projects such as the Children's and Cancer hospitals, and possible Royal Papworth Epic Connect project and others.
- Agree on a technical solution to make information from Epic available on the NHS App.
- Prepare the groundwork for CUH's Healthcare Information and Management Systems Society (HIMSS) Level 7 revalidation that coincides with our 10-year Epic Implementation anniversary.
- Renew our board level strategic engagement with Telefonica Tech, our outsourced managed service IT provider, in preparation for key decisions around contract extensions after Nov 2026.

Implementing the Strategy

Progress from July to October 2023	Key areas of focus for November to February 2024
Communication: Communicate the Strategy to CUH staff, patients and partners	
• Completed distribution of 8,000+ leaflets, 100+ posters and 50+ laminated triangle templates to all divisions. • Delivered the Strategy communications campaign including, Connect pages, 08.27 talks. • Initiated the next stage of the communication campaign focused on 'Implementing the Strategy'.	• Attend team meetings with divisional colleagues to gain feedback on the leaflets and posters to seek improvements or give advice. • Work with Communications team to create highlight videos and blog articles focused on implementing the strategy. • Shoot a video highlighting the Histopathology move as part of implementing the strategy.
Capability: Build strategic awareness and capability among senior leaders at CUH	
• Completed training videos and content for the elective and non-elective Strategy sections in the New Managers Essential programme. • Worked with Corporate Nursing Midwifery and Allied Health Professional (AHP) leads to develop a Nursing Midwifery and AHP strategy engaging with more than 150 staff members.	• Complete the materials to be added to the New Managers Essentials training collaborating with Workforce, Improvement & Transformation and Sustainability. • Further support the development of the divisional strategy leads to ensure they are equipped with the skills they require. • Support Corporate Nursing Midwifery and AHP leads to communicate and embed the strategy. • Support colleagues in the creation of strategies for radiotherapy, imaging and therapies & dietetics.
Capacity: Recruit additional posts in Divisions, Operations and Strategy teams to support implementation	
• Continued work on divisional and corporate priorities via Strategy leads to free up capacity within divisions to work on major projects and strategy initiatives.	• Develop training materials for strategic skills to be delivered across Strategy and Major Projects and with key partner teams e.g. Divisional strategy leads, Operational Strategy, and others to be determined.
Planning: Develop an implementation plan for the Strategy, with quantified goals and synthesis across schemes	

• Embedded milestones and metrics, with a particular focus on the strategic lens of access to care and workforce, within the Strategy Board report as of July. • Began to embed and communicate the “access to care” strategic lens more widely across the Trust, through discussions with operational and clinical leaders, and focusing the 2024/25 business planning process on access to care.	• Enhance the links between the Strategy Board report and the BAF risk register, to ensure that we capture how our activity to deliver the strategy mitigates the strategic risks in the BAF. • Continue to embed the access to care strategic lens across the Trust, including through the business planning process, and develop more detailed implementation plans to deliver our medium-term access to care ambitions.

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 8 November 2023

Agenda item	12
Title	Patient and Public Involvement Framework
Sponsoring executive director	Ian Walker, Director of Corporate Affairs Lorraine Szeremeta, Chief Nurse
Author(s)	Sarah Booth, Director of Communications and Engagement Angie Ridley, Communications and Engagement Manager Neil Stutchbury, Lead Governor
Purpose	To approve the new CUH Patient and Public Involvement Framework
Previously considered by	Quality Committee, 1 November 2023

Executive Summary

The purpose of this document is to set out our vision, aims and approach to make sure we listen to and involve patients and our diverse communities in developing services and research at CUH. Care is better when people tell us what they need. By listening to and involving patients, carers and our diverse communities, we can tailor services to meet people's needs and preferences, so that they are designed and delivered more effectively.

The framework supports CUH's strategic priorities of improving patient care and building for the future by listening to and involving our patients and diverse communities, and supporting our staff through training and opportunities, to help us develop a culture of patient-centred care. It builds on the vision set out in our Communications and Engagement Strategy for CUH to be: "Known as an organisation where patients are at the centre of everything we do."

It complements the focus on patient safety partners set out in the new Patient Safety Incident Reporting Framework (PSIRF) and supports our vision to embed a just and learning culture that focuses on fairness and learning. The framework will also help to ensure that CUH sets a consistently high standard and approach to involving people, particularly those who face inequalities in access to, experience of, and outcomes from our services.

The Patient and Public Involvement Framework has been discussed and supported by Management Executive and the Quality Committee.

Related Trust objectives	Improving patient care; Supporting our staff; Building for the future
Risk and Assurance	If we do not involve patients and the public, then there is a risk that we do not improve services and experiences using the feedback of our patients and diverse communities.
Related Assurance Framework Entries	BAF 004, BAF 010
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 CUH Patient and Public Involvement Framework.

Cambridge University Hospitals NHS Foundation Trust

Patient and Public Involvement Framework

Introduction

The purpose of this document is to set out our vision, aims and approach to make sure we listen to and involve patients and our diverse communities in developing services and research at Cambridge University Hospitals NHS Foundation Trust (CUH).

CUH is a family of hospitals comprising Addenbrooke's and The Rosie. As part of the NHS, we deliver expert care for patients – locally, regionally and nationally and have ambitious plans to modernise our services for the future through our Addenbrooke's 3 programme. This includes building the Cambridge Children's Hospital and Cambridge Cancer Research Hospital.

Care is better when people tell us what they need. By listening to and involving patients, carers and our diverse communities, we can tailor services to meet people's needs and preferences, so that they are designed and delivered more effectively.

The framework supports CUH's strategic priorities of **improving patient care** and **building for the future** by listening to and involving our patients and diverse communities, and **supporting our staff** through training and opportunities, to help us develop a culture of patient-centred care. It builds on the vision set out in our Communications and Engagement Strategy for CUH to be: "Known as an organisation where patients are at the centre of everything we do."

It also complements the focus on patient safety partners set out in the new Patient Safety Incident Reporting Framework[1] (PSIRF) and supports our vision to embed a just and learning culture that focuses on fairness and learning.

Health inequalities

This framework will ensure CUH sets a consistently high standard and approach to involving people, particularly those who face inequalities in access to, experience of, and outcomes from our services.

Health inequalities are unfair, avoidable differences in people's access to and experience of health and care based on their circumstances and characteristics.

NHS England's Core20PLUS5[2] models for children and adults help us identify the communities most at risk of health inequalities. This includes those who live in the most deprived areas, people from some minority ethnic communities, people with sensory and learning disabilities, those who are digitally excluded and people with multiple long-term health conditions.

Ensuring the voices of people who experience health inequalities are heard and acted upon is an important part of helping us make our services work better for everyone.

[1] NHS England (2023) Patient Safety Incident Response Framework
[2] NHS England - Core20PLUS5 (adults) – an approach to reducing healthcare inequalities

About the framework

The framework is structured in three interlinking themes:

- **Patient and public voice partners** – to embed a co-production approach, ensuring that patient and public involvement groups and activities are active and inclusive, and people are supported to take part.

- **Engaging our diverse communities** – to build services that work for everyone, we must make sure we are listening to and involving people from across our diverse communities, particularly those who experience health inequalities. We will develop a community outreach programme, linking in with community partners.

- **Patients through our doors** – continue to develop patient surveys and tools to gather people's experiences at the point of care, empowering staff to make improvements locally.

Underpinning these is the expectation that we must act on what patients and our communities tell us and, whenever possible, let people know what we have done with their feedback.

It includes a set of recommendations and next steps to take forward the approach, including:

- Embedding a co-production and engagement approach for developing new services, service transformation and improvements, capital builds and the new patient safety incident reporting framework (PSIRF).

- Developing a system of training and support for patient and public involvement for staff, patients and public involvement participants. This includes developing a policy and process for paying involvement payments and out of pocket expenses.

- Appointing champions for co-production and patient involvement at Management Executive and Divisional level.

- Developing a community engagement outreach programme, with a differentiated approach to meet the needs of different groups. This includes the use of creative engagement through our CUH Arts programme.

- Broadening the options available to make it easy for patients to feedback on their care, including recruiting more survey volunteers, exploiting more informal opportunities for providing feedback and assessing possibilities for using MyChart.

- Working with the corporate nursing team to introduce shadowing and 'what matters to me' programmes to enable our staff to make changes to improve patient care.

As part of this, we will be working closely with the wider NHS, other public sector, voluntary and community sector organisations to involve our communities to improve the health of our local population.

We have worked with patients and CUH staff to co-produce this document, learning from the excellent work already carried out across CUH and within the local system, including local Healthwatch and other voice organisations.

We are also taking inspiration from work carried out elsewhere in the NHS including at Liverpool Heart and Chest Hospital and Cambridgeshire and Peterborough NHS Foundation Trust, as well NHS England's 'Working in partnership with people and communities[3]' guidance, published in July 2022.

[3] NHS England » Working in partnership with people and communities: statutory guidance

Our vision

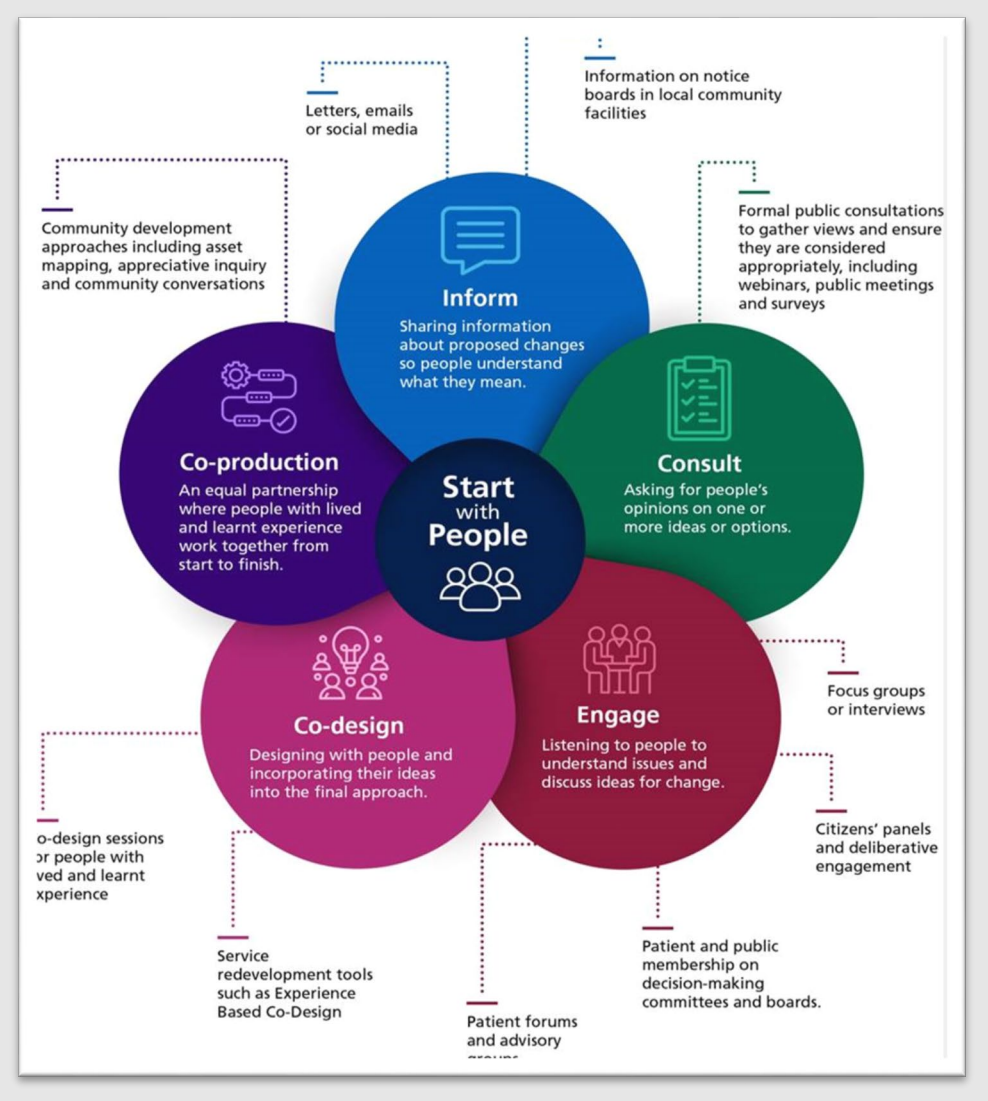
Patients are at the centre of everything we do, and we work with patients, carers and our diverse communities as equal partners in shaping services and developing research.

Our aims

We will support our staff, patients, carers and diverse communities to work together as equal partners to improve services and develop research at CUH. We aim to build a culture where we start with people, using different approaches to inform, consult, engage, co-design and co-produce services with our patients and communities.

Co-production is a way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and evaluation.

Figure 1 (below): Diagram taken from NHS England's Working in Partnership with People and Communities guidance illustrates how we will start with people and use different approaches to inform, consult, engage, co-design and co-produce services with them.



Starting with people, we will:

- **Inform:** share information about proposed changes so people understand what they mean.
- **Consult**: ask for people's opinions on one or more ideas or options when making changes to health services.
- **Engage**: listen to people to understand issues and discuss ideas for change.
- **Co-design**: design with people and incorporate their ideas into the final approach.
- **Co-produce**: maintain an equal partnership where people with lived experience work together from start to finish.

Inclusive services start with patient and public involvement and engagement. The framework will build on excellent work already taking place within CUH. And provide additional resources to help staff, patients and people in our diverse communities get involved at the level they choose.

We will actively go out into local communities to engage with people, listen to their experiences of services and provide a range of accessible involvement opportunities to expand the number and diversity of groups that can become involved in developing services at CUH.

Local people are at the centre of everything we do. This framework is therefore based on the following principles set out by the NHS nationally to guide how we engage with people across the communities we serve.

1. Centre decision making and governance around the voices of people and communities.
2. Involve people and communities at every stage and feed back to them how it has influenced activities and decisions.
3. Understand community's needs, experiences, and aspirations for health, using engagement to see if change is working.
4. Build relationships based on trust, especially with marginalised groups and those affected by health inequalities.
5. Work with local Healthwatch and the voluntary, community and social enterprise sector.
6. Provide clear and accessible public information.
7. Use community-centred approaches that empower people and communities, making connections to what works already.
8. Have a range of ways for people to take part.
9. Tackle system priorities and service reconfiguration in partnership with people and communities.
10. Learn from what works and build on the assets of all local health and care partners.

Where we are now

There are several public and patient involvement groups which are undertaking excellent work to support the development of services and research within our hospitals, including:

- Patient and carer participation groups within Addenbrooke's and the Rosie.
- A developed programme of creative patient, family and carer engagement and co-production within Cambridge Cancer Research Hospital and Cambridge Children's Hospital.
- Innovative CUH Arts engagement team who run creative workshops within CUH.
- Foundation Trust Membership of 8,000 patient and public members, with quarterly online listening sessions and Member events.
- CUH Patient and Public Involvement in Research Panel – supported by National Institute of Health Research (NIHR) Cambridge Biomedical Research Centre (BRC) who provide training, advice and support to help embed patient and public involvement in research.
- CUH's Patient Experience team manage patient surveys across CUH, including the Friends and Family Test and other statutory surveys. They offer advice and toolkits to CUH staff who want to involve people in service development; however, have limited resources to do this with.

What staff and patients told us

As part of developing this framework, we undertook two short surveys promoted via CUH staff contacts, social media and local partner organisations including Healthwatch and some of our local infrastructure charities to find out about people's experience of being involved in CUH. The surveys were completed by 170 people. See Appendix 1 for the full survey responses.

This was followed by two workshops with patients, Governors and members of the public which were attended by 28 people. See Appendix 2 for patient and public workshop responses.

We also held a staff workshop attended by 13 members of staff who were currently interested or involved in patient and public involvement activities to help us understand the current experiences of our PPI (Patient and Public Involvement) groups. See Appendix 3 for staff workshop feedback.

The next steps will include wider staff consultation when starting to implement the framework.

Key findings from staff and patient engagement

- **People value the opportunity to get involved for a variety of reasons,** including being able to learn more about an area of care, using their experiences of services to inform and improve future treatment, facilities, etc, and giving something back. For some patients, it was also a therapeutic part of their recovery.
- **Staff and patients identified disparities in how well-resourced different involvement groups are.** They also identified gaps in patient involvement opportunities, with no ability to get involved in service development in many areas. Patients wanted to see a 'gold standard' for how groups are run.
- **Staff value patient involvement to help develop services that better meet people's needs, but often do not know where to start.** They identified a need for training and support to enable them to engage diverse groups in the community and to co-produce service changes.
- **Diversity and inclusion**: patients and staff want to see more diversity in the people participating in patient involvement activities and identified the following areas for development:
    - **Reward and support**: a greater recognition of the value of patient and public involvement volunteers including a consistent level of support and training and a policy around expenses and involvement payments to ensure people are not excluded from participating due to the cost of taking part.
    - **Accessibility:** ensure that engagement opportunities are inclusive, for example providing information in Easy Read for people with a learning disability or providing interpreters for those who need them. And ensuring that there are routes for people who are not online to share their feedback and get involved.
    - **Community engagement:** a need to reach out into the local community and work with colleges, voluntary sector, religious and other groups to engage with people who would not normally get involved or share their view. There is a need to link up with members of communities to build trust and to provide information in an accessible format.
- **Creative engagement:** patients were positive about being involved in creative engagement activities, such as CUH arts workshops, to help develop the new Cancer Research Hospital. They suggested this could be rolled out more widely to gather insights from people who may not normally participate.
- **Feedback loop:** patients identified the importance of a feedback loop so that they know what has happened to the feedback they give.
- **Senior-level endorsement for patient involvement:** staff suggested creating a Key Performance Indicator (KPI) that places patient co-production on a par with clinical care and safety. This would help leaders understand the value of patient involvement and the potential cost benefit of doing so.

Overall, there was a consensus that CUH needs to do more to ensure we are hearing from and involving people from across the diverse communities we serve, particularly those who experience inequalities in accessing care.

Our approach

Our Patient and Public Involvement Framework is structured around three interlinking themes: patient and public voice partners, engaging our diverse communities and patients through our doors.

Within each of these are a range of involvement approaches that cover: **informing**, **engaging**, **co-designing** and **co-producing** solutions. Any proposal to change the access to or scope of a service will trigger the statutory duty to consult.

Patient and public voice partners	Engaging our diverse communities	Patients through our doors

• We will recruit patient, carer and public voice partners and embed a co-production approach for
  ○ Developing new services.
  ○ Service transformation and improvements.
  ○ Capital builds.
  ○ Patient Safety Incident Reporting Framework (PSIRF)
• We will ensure patient and public involvement groups and activities are well run and inclusive and people are supported to take part.
• We will ensure there is patient and public representation on key decision-making groups and boards.
• We will make it easy to find out how to get involved in patient and public involvement at CUH and feedback on your care.
• We will recruit champions for patient and public involvement at Board and Divisional level.
	• We will listen to people to understand their experiences by:
	  ○ Developing a community outreach programme, linking in with community partners to engage our diverse communities.
	  ○ Using creative arts engagement to help explore people's ideas around service change.
	  ○ Running workshops, focus groups and patient listening sessions.
	  ○ Using feedback from engagement sessions to support patient groups.
	• We will keep people informed and engaged via the CUH Foundation Trust Membership.
	• We will use the CUH website and social media to keep patients and the public engaged and informed.
		• We will continue to develop patient surveys, including:
		  ○ Friends and Family Test.
		  ○ National survey programme.
		  ○ Project or service specific surveys.
		• We will use patient engagement tools like 'patient shadowing' and 15 steps to understand what care is like for patients and help make changes.
		• We will enable our staff to make changes to patient care using real-time feedback.

Feedback loop: we will act on feedback from our patients, carers, and diverse communities and, whenever possible, we will let people know what we have done with the ideas and experiences they've shared.		

There is no 'one size fits all' and we want people to be able to get involved at the level they choose: from filling in a survey, joining a listening session or sharing their views at a creative community engagement event, to being part of a patient group and supporting the co-production of services.

Patient and public voice partners

Embedding a co-production approach

Co-production is defined by The Coalition for Personalised Care as: “A way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and evaluation.’

The Cambridge Cancer Research Hospital is being developed in partnership with patients through a combination of co-production and creative community engagement. The approach has enabled staff, patients, and people in the wider community to contribute their ideas and insights into the development of the new services, helping to shape them from the very beginning.

> **Case study: Cambridge Cancer Research Hospital PAG**
>
> Patients are involved in the Cambridge Cancer Research Hospital (CCRH) project in two main ways; the Patient Advisory Group (PAG) and the Patient Network.
>
> The PAG was set up from the Addenbrooke's Cancer Patient Partnership Group, which has been involved in improving services at the hospital for more than a decade. The PAG currently has 16 members, with each member sitting on a workstream of the project. Members are integrated into the project as equal partners and are involved in decision making, with co-chairs Fiona Carey and Neil Stutchbury sitting on the Joint Delivery Board. The PAG also holds monthly test and challenge design meetings to review the designs of an area of the hospital and invite the wider Patient Network members to share views and thoughts.
>
> The Patient Network is a more informal way of being involved in the development of the hospital and has around 90 members. Patients who have been or are being treated for cancer, and carers with experience of looking after someone with cancer are invited to participate depending on how much time they can give. Their involvement ranges from filling in short surveys to attending open PAG meetings and having the opportunity to hear from the project team at virtual Network events.
>
> The PAG is supported by a number of members of staff on the CCRH project – including the Lead Nurse/Head of Co-Production, the Transformation workstream, and Communications and Engagement workstream.

We want to learn from and build on the incredible work undertaken as part of both the Cambridge Cancer Research Hospital and the Cambridge Children’s Hospital, to help us embed a similar approach when developing new services, undertaking service transformation and improvements and capital builds at CUH.

The new Patient Safety Incident Response Framework (PSIRF) also provides a new way of introducing Patient Safety Partners to support learning from incidents.

Patient and public involvement groups within CUH work differently, depending on how and why they are funded, who they are engaging with and what resources they have. Some have paid staff and resources, whilst others are managed by staff as part of their existing role.

Some groups undertake community engagement activities to help inform their activities and use these insights to offer ideas and insights to help improve care and work with staff to co-produce improvements.

Case study: CUH Directions App

The CUH Directions App, launched in April 2023, helps patients and visitors to Addenbrooke's and the Rosie find their way around our hospitals. It's available to download on both Apple and Android devices.

It was the idea of CUH volunteer Mike, a member of the Outpatients Experience Group (OEG) who co-led the project with staff. The team worked with a range of different departments across CUH from Estates and Facilities and Information Governance to Communications and IT.

The group spent a lot of time testing the app with the hospital guides, CUH's learning disabilities team, as well as Cam Sight, a charity that supports local people living with low-vision and blindness, to help make sure the App was accessible. They are now working on the next upgrade, due in autumn 2023, which we are hoping will incorporate Google Translate and text to speech functionality.

The OEG includes nine patient members who meet monthly with staff to support improvement to the outpatients' department. The CUH Directions App is only one project they support, and the group offer regular feedback on trust initiatives.

"It's been a really positive experience for everyone involved, we've learnt a lot about inter-disciplinary co-operation, and we all enjoyed the shared excitement around the launch of the app." Mike, patient member of OEG

The OEG meets monthly online and is chaired by Ally Perkins, deputy operations manager – outpatients, who supports the group in addition to her operational duties, often giving her own time to ensure the participants are supported.

We recommend that CUH:

1. Embed a co-production approach for developing new services, service transformation and improvements, capital builds and the Patient Safety Incident Response Framework (PSIRF).

Support for staff and people to work together

We are creating a Head of Patient and Public Engagement role to develop a consistent approach to supporting staff and people in our communities to work together, so that patient and public involvement groups and activities are well run and inclusive.

This includes:

- Developing support for staff, including patient and public involvement training and resources to help staff work in a meaningful and productive way with patients and the public.
- Developing a system of support for patient and public involvement voice participants to help them contribute effectively to decision-making.
- Providing communications support to help promote involvement opportunities, tell the stories of patient and public involvement and share learning, so staff and participants do not feel like they are 'reinventing the wheel.'

Involvement and co-production should be seen as part of everyone's role, but staff need to be supported to enable this to happen. This includes ensuring that groups have administrative support and staff have the worktime allocated to do this in.

We recommend that CUH:

2. Develop a system of support for patient and public involvement, including training and support for staff, patients and public involvement participants, to be led by the Head of Patient and Public Engagement.
3. Ensure patient and public involvement groups and activities are appropriately resourced and staff are allocated time to undertake patient and public involvement work.

Involvement and expenses payment

Diversity remains an issue for patient and public involvement groups that do not offer expenses or involvement payments. CUH staff currently report that they are losing potentially valuable participants who choose to give their time and insights elsewhere due the lack of a clear policy on expenses and the inability to offer involvement payments.

> "We will never have a properly diverse representation if the only people who can afford to be involved are those for whom arranging stand-in care, filling up the car, or getting on the bus isn't a problem."
> -- Fiona Carey, Co-Chair, Cambridge Cancer Research Hospital PAG

NHS England's 'Reimbursing expenses and paying involvement payments guidance'[4] sets out three levels of payment support the organisation should consider offering, including involvement payments of £150 per day / £75 per half day for people in roles that "demonstrate strategic and accountable leadership and decision-making activity". NIIHR's interim public payment policy[5] outlines recommended rates of payment for contributors graded according to the anticipated time taken for a task. Locally, Cambridgeshire and Peterborough NHS Foundation Trust has a Reimbursement Policy, offering a reimbursement rate of £12 per hour for people recruited to patient involvement roles[6].

[4] NHS England (2023) Working with our patient and public voices (PPV) partners: Reimbursing expenses and paying involvement payments
[5] NIHR (2022) NIHR public contributor payment policy | NIHR
[6] CPFT (2023) Involvement Opportunities [Date checked 08/09/2023]

Other organisations, including local Healthwatch, also offer involvement payments for some roles. A wider discussion is needed to develop a policy that meets the needs of CUH, is clear and fair, and is in step with what other partners within the local health and care system are doing.

The Rosie Maternity and Neonatal Voices group has developed an inclusive operating model of co-production and community engagement, offering training, and involvement payments based on NHS England's reimbursement policy.

> **Case study: Rosie Maternity and Neonatal Voices (RMNV)**
>
> RMNV is a group of local parents, birth worker volunteers and staff representing the voices of birthing women and people, their partners and families to improve and develop maternity and neonatal services at the Rosie Hospital.
>
> Their role is strategically embedded within the hospital and members are routinely involved in listening to diverse patients' experiences through a broad and inclusive programme of digital and face to face engagement, and co-producing service improvements.
>
> Parents recently worked with staff to develop the SEED project, (Supporting, Empowering, Enhancing Development), to improve the experience of parents caring for babies in the neonatal unit. The SEED programme aims to create an equal partnership, so parents are fully integrated within the care team and given the support to learn the necessary skills in their baby's care. The SEED project has been shortlisted for the British Association of Perinatal Medicine Awards 2023.
>
> The group is funded by Cambridgeshire and Peterborough Integrated Care System (ICS). RMVP gives involvement payments to its two co-chairs and to parent partners when they are doing a role that the chair might have done. RMNV members can access training via the ICS, as well as buying in additional training when needed.

We recommend that CUH:

4. Develop an organisation-wide patient and public involvement expenses and payments policy.
5. Develop an organisation-wide policy to ensure access adjustments can be made to allow people to take part in patient and public involvement activities as well as an easy way for CUH staff to ensure that patient and public voice representatives can access this, without it being dependent on departmental budgetary allocations.

Next steps: additional discussions will need to be undertaken to progress policy recommendations and agree budget allocations and approach.

Championing Patient and Public Involvement

Staff want to see senior-level endorsement for patient and public involvement and co-production activities to embed a culture change within the organisation. This is important so that senior leaders can:

- Embed the principle of listening to and involving patients, carers and our diverse communities in developing services and research at CUH.
- Ensure that staff have sufficient resources including time to work with patient, carer and public voice participants to develop their projects and services.
- Develop the expectation that patient, carer and public voice representatives should be included in decision-making meetings.
- Measure and evaluate co-production and involvement activities to ensure they are making a real difference and that the process is following the agreed principles.

Staff suggest that creating a Key Performance Indicator (KPI) that placed patient co-production on a par with clinical care and safety, might lead to understanding the value of patient involvement in developing more inclusive and effective services.

> **Case study: Active - Children and young people's board**
>
> Active is the children and young people's board at CUH and is made up of young people aged 8 to 18 years. There are currently around ten committed members who work with staff and attend regular sessions at the hospital.
>
> The group meets for eight sessions per year and work on projects to improve children and young people's patient experience. Active meetings are hands-on, fun and engaging, using creativity and play to make sure everyone can participate at their own level and motivation.
>
> Active members have been involved in several co-production projects including:
> - co-producing child-friendly information for children coming to the hospital
> - improving waiting areas for children and young people
> - heading up their own projects such as the "teens in hospital" campaign.
>
> During Covid times the group worked with staff online and continued to innovate, culminating in a series of leaflets to help support mental well-being.
>
> Children and young people come to Active as patients or siblings of a young person with hospital experience. Some would like to pursue a career in healthcare. Active members mention how they often enjoy developing their skills and experience in healthcare settings. For those who want to, there is opportunity for taking on leader roles.
>
> Active was established in 2007 and has been supported by Kirsty Lothian; a youth worker and a former children's nurse for the past 13 years. The role is funded for two days a week.

Both the RMNV and Active – children and young people's board findings are reported to the Women and Children's Services Divisional Board (Division E) to make sure that patient and public insights are considered at senior decision-making level in the organisation.

We recommend that CUH:

6. Appoint champions for co-production and patient involvement at Management Executive and Divisional level to help embed a culture of patient and public involvement across the trust.
7. Incorporate a KPI around patient and public involvement within the refresh of CUH's accountability framework.

Next steps: Hold additional discussions with the Board to progress recommendations.

Engaging our diverse communities

Listening to people to understand their experiences

To build services that work for everyone, we must make sure that we are listening to and involving people from across our diverse communities, particularly those who experience health inequalities.

Anecdotal evidence from our patient and public involvement groups, and data from our patient listening sessions and survey responses, show a lack of diversity in who we hear from, and that we are not always effectively involving people who face barriers to accessing care.

Local research from Healthwatch Cambridgeshire[7] found that people often experience a combination of barriers, which in turn can lead to a shorter life span, in poorer health. Common themes from their report included:

- Communication barriers, particularly for people whose first language isn't English, people with sensory and learning disabilities and neurodiverse people.
- The rising cost of living impacting on people's ability to afford suitable housing, eat a healthy diet and to access health and care services.
- Digital exclusion making it harder for people to access online information or services.
- The lack of public transport in rural locations making it more challenging and expensive to attend appointments.
- Social and cultural attitudes, including discrimination, with people reporting feeling judged and of having health and wellbeing needs dismissed as mental health issues.

The barriers that people face when accessing healthcare can also make it harder for them to feed back about their care or get involved in co-production. We need to go out into the community to engage with people in the way that works for them, rather than expect them to come to us, for example through a trusted community leader or working with a local voice organisation.

[7] Healthwatch Cambridgeshire (2023) **Tackling Health Inequalities**

Case study: improving services for people with learning disabilities

Speak Out Cambridgeshire acts as a voice organisation for people with a learning disability and autistic people aged 14 or above. It runs consultations and regular drop-ins to give people a say on all sorts of issues, and to influence decisions.

CUH learning disability nurse Cheryl Exley has worked on various projects with the Speak Out Council including helping the members develop three films about Learning Disability Nurses and Hospital passports as part of their Treat Me Well project.

Most recently, Cheryl has worked with the group on their health and hospitals project where the group investigated the experiences of local people with learning disabilities and autistic people. This project was commissioned by the local ICS and its findings will be used to help make care better for people with learning disabilities in CUH and across other organisations.

As part of the Cambridge Cancer Research Hospital work described earlier, we are undertaking a targeted programme of community outreach engagement. This has included visiting a diverse range of groups across the eastern region, including targeted minority ethnic community groups and people from more deprived communities.

Through this targeted approach we can feed people's ideas into service improvement through existing patient and public involvement groups, or by setting up new groups to co-design solutions.

Creative engagement

Working with CUH Arts, creative engagement can be an effective technique at engagement sessions to:

- Encourage people to attend the session and participate.
- Facilitate rich engagement, particularly around topics that can be sensitive or challenging.
- Ensure the session is inclusive, accessible and engaging for all age groups.
- Encourage people to open up and share their experiences in a way that isn't a one-on-one conversation or an intimidating group conversation.
- Create non-verbal feedback on services or experiences which can help to shape current or future services – e.g., through drawing, images, sculpting.
- Provide a positive, enjoyable and meaningful experience for participants.
- Create good news stories to share.

Case study: CUH Arts engagement for the Children's Hospital

CUH Arts have pioneered a new approach to engaging patients, families and staff in the process of designing the new hospital. The team has brought in artists to deliver a variety of creative engagement activities designed to help participants reflect on their previous experiences of being in hospital and articulate their vision for the future. This has included:

- The People's Test: across four facilitated creative Zoom workshops led by writer Hannah-Jane Walker, eight young people came up with "The People's Test" – a series of creative tasks to assess the ability of prospective architects to listen, interact and collaborate with children and young people. This ensured that their voices were heard from the very beginning of the process.
- Schools Workshops: tailor-made art packs designed by artist Jacquie Campbell were sent out by post for use in a series of online interactive workshops exploring hospital school design. Developed in partnership with the CCH schools workstream, the feedback from these sessions has affected current provision as well as the designs for the new hospital school.
- Dream Den at RAREfest: designed in partnership with parents from the Unique Feet patient group, artist Hilary Cox Condron designed an engagement activity where children were invited to collaboratively build a den over the course of the event. This allowed us to open up conversations with children and families with rare diseases about the kinds of environments that help them to feel welcome, safe and thought about.
- Luton Carnival: a series of in-person workshops at Luton Sixth Form to explore the topic of mental health. The workshops inspired the creation of costumes for the carnival parade, plus public creative engagement activities at the event that attracted over 250 participants.
- Artist-led design workshop at Hawkins\Brown: artist Josh Bilton led children and families through a day of creative activities at the architects' offices in London. The activities were designed to help participants reflect on the latest designs and allow the architects to revise their plans based on their feedback.

Through this work we have been able to build strong, trusting relationships with participants and gain rich feedback for the project.

Participants have appreciated the opportunity to express their views through making and creating, with one commenting: "*Sometimes it's hard to know where to begin with a subject as emotive as school, and I've found that the creative tasks have helped me vocalise the issues [we] faced and how things could be improved for children in the future*."

Our Head of Patient and Public Engagement will lead our approach to working with diverse communities, co-ordinating this across the Trust so that we share learning and do not duplicate effort.

We recommend that CUH:

8. Co-ordinate a targeted trust-wide community engagement programme that enables us to hear from our diverse communities, particularly those who are more likely to face health inequalities and barriers to accessing care.
9. Link with statutory, voluntary and community sector partners, including Cambridgeshire and Peterborough Integrated Care Partnership (ICS), local Integrated Neighbourhood teams and local Healthwatch to make best use of resources across the local area.
10. Promote CUH Foundation Trust Membership as way of helping people be part of the CUH family and stay informed of opportunities to get involved in service improvement at CUH.
11. Partner our outreach work, where appropriate, with an artist to facilitate an activity and encourage conversation and participation.

Next steps: Work with the CUH Arts team to see what is needed to expand the community arts outreach programme as this would require additional funding.

Working with community partners

By working with Healthwatch and voluntary and community partners, we can use their expertise and insights to help us reach more diverse communities and get an independent view on how we can improve services. This then gives us the opportunity to work with patients and members of our local community to co-design changes to services.

> **Case study: Healthwatch Cambridgeshire – Community Champions project**
>
> A team of 12 local Health Champions were trained and supported by Healthwatch Cambridgeshire to investigate the experiences of people living in Cambridge, East Cambridgeshire and South Cambridgeshire. The group were supported to undertake two community research projects and published the following reports:
>
> - The future of urgent and emergency care at Addenbrooke's: the Health Champions co-designed a questionnaire and undertook structured interviews with more than 80 people.
> - Tackling health inequalities: the Health Champions held a series of focus groups to understand the barriers to care for people who experience health inequalities. They gathered the experiences of a wide range of people spanning a variety of locations and backgrounds, including rough sleepers, Gypsy Traveller groups and people whose first language is not English.
>
> The project was jointly funded by CUH and the Cambridgeshire South Care Partnership to help with two projects and the insights have been used to help develop short, medium and long-term improvements to services to support access to care for local people.

We recommend that CUH:

12. Commission engagement activities from local voluntary, community sector and Healthwatch partners as this acknowledges and invests in their community expertise and is another way of getting independent feedback.

Website information and social media

We will continue our programme of patient stories shared across our CUH website and social media which helps to inform and educate other patients about experiences and increase public and patient participation.

We will also continue to inform people about our work, including helping people to manage their health, through our patient information leaflets, now all available digitally via the CUH website.

We are planning to develop CUH as a YouTube health partner so that the channel becomes a dedicated area where we provide patient information videos. This means that if a patient has a particular health condition, we can provide some tips to manage it. The Mayo Clinic did this well and created online communities of patients with the same condition, providing a support system for patients.

In addition, when we promote a positive story about new research findings or innovations, we often include a patient video. We will take that one step further by including a video from a consultant offering tips if you live with this type of condition. In this way, it helps to build up community/ patient support groups if people reply to the video and share experiences.

We recommend that CUH:

13. Develop YouTube as our social media resource for wider patient information and continue our approach to telling patient stories.

Patients through our doors

The Communications and Engagement Team will work with the Corporate Nursing Team to develop a culture of welcoming feedback from patients and enabling staff to make improvements locally.

Friends and Family Test and the national survey programme

Our Patient Experience Team will continue to manage the Friends and Family Test (FFT) and the National Survey Programme, supporting local teams to understand their data.

FFT survey is available in different formats including hardcopy, online, children's and Easy Read surveys. Survey devices are available on most wards for staff or volunteers to offer to patients to complete the survey. Hard copy surveys are available on wards where survey devices are unavailable and comment cards are available in outpatient clinics and wards. QR codes are increasingly used, and SMS survey messages are being rolled out more widely, having been successfully implemented for the Emergency Department, outpatients and day units.

Additional statistical analysis resources would be beneficial to ensure that CUH is optimising the feedback from patients and using it to inform improvements.

Engagement surveys

The Patient Experience Team will continue to support services to develop surveys to get feedback about specific initiatives or services, encouraging services to co-develop surveys with patients.

The Team will work with the Head of Patient and Public Engagement to ensure that the approach is right and that engagement activities are co-ordinated across the trust.

Head of Patient and Public Engagement and the Patient Experience Team will develop a joint approach to ensure that insights shared through patient surveys and community engagement can inform patient groups.

We recommend that CUH:

14. Broaden the options available to make it easy for patients to feedback on their care, including recruiting more survey volunteers, exploiting more informal opportunities for providing feedback and assessing possibilities for using MyChart.
15. Provide additional statistical analysis support to ensure that patient data is appropriately analysed, understood and used to improve patient care.

Next steps: Hold additional discussions and possible budgetary allocations to replace devices and recruit for support from a statistician.

Using real time feedback

Working with the Corporate Nursing Team, support staff (including patient groups) to use different engagement tools to work alongside patients to improve services, for example patient shadowing to enable staff to 'walk in patients' shoes' by following them during the visit to the hospital.

This can help staff to gain an insight into the experience of patients to improve care.

> **Case study: Majoring on the minor'**
>
> Liverpool Heart and Chest Hospital pioneered an approach called 'majoring on the minor'. Centred around their patient experience vision, patients gave real time feedback on the little things that would make a big difference to their experience. Frontline staff were empowered to make those changes.
>
> For example, people wearing glasses said it would help their experience if their glasses were waiting in the recovery room after surgery. Other patients felt anxious waiting to go into theatre and so a large mural of a meadow was introduced into the forward wait area in theatre. Patients fed back that it helped them to relax.
>
> Manchester University NHS Foundation Trust introduced the 'what matters to me' approach, again empowering frontline staff to respond to feedback from patients and make immediate improvements.

We recommend that CUH:

16. Work with the corporate nursing team to introduce shadowing and 'what matters to me' programmes and empower staff to make changes to improve patient care.

Next steps and recommendations

Our Patient and Public Involvement Framework has been co-produced with staff and patients, and sets out the vision that:

> **"Patients are at the centre of everything we do, and we work with patients, carers and our diverse communities as equal partners in shaping services and developing research."**

The framework aims to develop a structure to support our staff, patients, carers and diverse communities to work together as equal partners to improve services and develop research at CUH. And build a culture where we start with people and use different approaches to inform, consult, engage, co-design and co-produce services with our patients and communities.

Summary of recommendations

Patient and public voice partners	
1	Embed a co-production approach for developing new services, service transformation and improvements, capital builds and the Patient Safety Incident Response Framework (PSIRF).
2	Develop a system of support for patient and public involvement including training and support for staff, patients and public involvement participants, to be led by the Head of Patient and Public Engagement.
3	Ensure patient and public involvement groups and activities are given the administrative support they need.
4	Develop an organisation-wide patient and public involvement expenses and payments policy.
5	Develop an organisation wide policy to ensure access adjustments can be made to allow people to take part in patient and public involvement activities.
6	Appoint champions for co-production and patient involvement at Management Executive and Divisional level.
7	Incorporate a KPI around patient and public involvement within the refresh of CUH's accountability framework.
Engaging our diverse communities	
8	Co-ordinate a targeted trust-wide community engagement programme that enables us to hear from our diverse communities, particularly those who are more likely to face health inequalities and barriers to accessing care.
9	Link with statutory, voluntary and community sector partners, including Cambridgeshire and Peterborough Integrated Care Partnership (ICS), local Integrated Neighbourhood teams and local Healthwatch to make best use of resources across the local area.
10	Promote CUH Foundation Trust Membership as way of helping people be part of the CUH family and stay informed of opportunities to get involved in service improvement at CUH.
11	Partner our outreach work, where appropriate, with an artist to facilitate an activity and encourage conversation and participation.

12	Commission engagement activities from local voluntary, community sector and Healthwatch partners as this acknowledges and invests in their community expertise and is another way of getting independent feedback.
13	Develop YouTube as our social media resource for wider patient information and continue our approach to telling patient stories.
Patients through our doors	
14	Broaden the options available to make it easy for patients to feedback on their care, including recruiting more survey volunteers, exploiting more informal opportunities for providing feedback and assessing possibilities for using MyChart.
15	Provide additional statistical analysis support to ensure that patient data is appropriately analysed, understood and used to improve patient care.
16	Work with the corporate nursing team to introduce shadowing and 'what matters to me' programmes and empower staff to make changes to improve patient care.

Immediate next steps

- Recruit a Head of Patient and Public Engagement — we expect them to be in post by early 2024.
- Discuss the requirement for a dedicated budget to support patient and public involvement activities and a process to manage this.
- Develop a detailed delivery plan which will be subject to resources and budgets. Our initial priorities for the first six to nine months will be to:
    - Develop a patient and public involvement expenses and payments policy.
    - Begin to plan and implement a targeted programme of community engagement.
    - Start to develop a system of support and training for patients and staff to enable the embedding of a co-production and engagement approach for new services, service transformation and improvements, capital builds and PSIRF.

NHS
Cambridge University Hospitals
NHS Foundation Trust

Appendices Patient and Public Involvement Framework

Appendix 1: Patient and public survey results

Methodology

Two short surveys promoted via CUH staff contacts, social media, and local partner organisations, including Healthwatch and some of our local infrastructure charities.

- Survey 1: Help us develop patient and community involvement in our hospitals survey to gather the views of people who are currently involved in patient engagement activities within CUH or a close partner organisation – 35 responses.
- Survey 2: Members and community survey to gather the views of CUH patient and public Foundation Trust members and the wider community – 135 responses.

The questions for the two surveys were very similar, but targeted to identify what learning could be identified from those who were currently involved in patient and public involvement activities, and those who were not. However, learning from the two surveys identified a big overlap and many people are involved in multiple groups and activities.

This was followed by two workshops with patients, Governors and members of the public which were attended by 28 people in total.

Key findings

- **People value the opportunity of having their say, being part of patient experience or research development,** saying it was an opportunity to learn more about an area of care, 'give something back', help improve services for others, and for some was also a therapeutic part of their recovery. Patients also felt that involving patients and carers was an important thing for CUH to do.
- **Patients reported disparities in how well-resourced different patient engagement and research involvement groups are.** Some are well supported by CUH staff, but that the resourcing of these groups seems 'uneven and patchy', suggesting training for CUH staff setting up groups, and a 'gold standard' for how a group should operate. Patients wanted to know what other co-production / patient experience groups were operating so they could share learning.
- **Patients observed a lack of diversity** in the people participating in the engagement groups and listening sessions they attended, noting an absence of children and young people,

people from more deprived communities and people from minority ethnic communities. They made a number of suggestions to help improve this.

- **Patient involvement and expense payments —** patients identified the lack of a CUH policy on this as a major barrier to including more people. “People shouldn’t be out of pocket to volunteer.”
- **Extra training and support to take part in patient engagement groups / co-production activities —** patients identified that people can be dis-incentivised from taking part because they feel that they do not have particular skills or educational qualifications and may therefore feel their views are less valid.
- Patients suggested providing other kinds of rewards to people to incentivise taking part, such as references or training.
- **Patients identified digital exclusion and the timing** of meetings as further barriers to people taking part in online meetings.
- **Developing a community engagement programme** - patients identified a need to reach out into the local community and work with colleges, voluntary sector, religious and other groups to engage with people who would not normally get involved or share their view. Linking up with trusted members of communities to build trust. And emphasised the importance of providing information in an accessible format.
- **Patients were positive about being involved in creative engagement activities,** such as CUH arts workshops to help develop the new Cancer Research Hospital, which generated ideas in a different way. They suggested this could be rolled out more widely to gather insights from people who may not normally participate and may better suite people who are neuro divergent.
- **Patients identified the importance of a feedback loop** so that they know what has happened to the feedback they give.
- **Access adjustments** – make sure that any engagement activity is accessible to people with a disability, for example providing information in an accessible format for disabled people, e.g., Easy Read.

Summary of survey responses

Why people get involved

People who completed both the survey and who came to the workshops reported a wide range of experiences of getting involved in engagement activities within CUH, including:

- Completing a survey after a hospital appointment
- Being a member of a patient experience or research group
- Contacting PALS (Patient Advice and Liaison Service) to raise a concern or comment on care within CUH
- Taking part in a patient listening session or a creative engagement workshop
- Being a Governor and taking part in working groups to develop services

“It's nice to feel that you can offer something back to a place that has treated you”

"It has been a great support to me through my cancer journey. It's good to be able to talk with others going through the same experience."

How could CUH better support you to be involved?

We asked people how we could better support their involvement, and this is what they said:

- **Need an expenses and remuneration policy.** "Remuneration would help improve diversity."
- **Training and support –** examples include training in communication skills, group management, chairing meetings, outreach and improving diversity of membership. Also, better signposting to training that is already available, including the opportunity to get certificates of completion.
- **Knowledge & contact with other co-production groups** to learn from each other and share best practice. Need to know which groups exist, what they are involved with and with whom, etc.

Feedback about surveys

One third of the people who completed survey 2 (33%) said they had completed a survey after receiving care from CUH, with the majority finding this a good way for them to share their views.

- "I'm happy to complete surveys as I can participate wherever I am"

But others identified issues, including the survey not asking the right question.

- "Have been asked to rate some services but have just spent 16 hours mainly in A&E with my husband, who then could not be discharged the following day because no doctor was available—and no survey seems interested in this sort of experience, yet it must be very common."

Patients suggested ways to make surveys more accessible:

- "Surveys that are available in other languages or with translations."
- "Offer different ways of completing surveys, not just written on iPads. Follow up with people who have given feedback. Make the changes that need to be made and keep to them. Often times it feels like there's no point because nothing changes."

One person felt their views would not be wanted, saying: "I'm thinking you probably want more involvement from minority groups, of which I couldn't be considered a member, being an old, white, middle-class man."

It is important that CUH hears from all patient groups so the Trust must be mindful in its communications, so people are not discouraged from sharing their experience because they think the organisation is not interested.

Feedback about listening sessions

- "The listening sessions seem to cover a lot of patient groups, but due to them taking place in the working day this does limit the attendance of patients so you may only reach a specific group of people."
- "Listening sessions and other active participation outside of surveys tends to be set up at very difficult times for people working or caring for small children. Late afternoon or weekend options would occasionally be nice."

Community engagement / different ways to get involved

- “Going out to specific community groups to offer listening session would help different people get involved - people that would not usually sign up to a workshop or fill in a survey.”
- “Perhaps have patient ambassadors in towns and villages who publicise what the hospital is doing and engage their community in patient groups. They could put articles in local newsletters etc, communicate information etc.”
- “Maybe link more with the voluntary sector who are more closely in touch with those communities whose voices are not always heard.”
- “Attend events, provide BSL Interpreters and live captions, advertise in community focussed ways and "shout about" the events you are holding so that everyone is aware.”

Increasing diversity / barriers to getting involved

- “Lots of patients are put off by the fact you want to interview like they are applying for a job. Not everyone has degrees etc. it doesn’t mean they don’t have good ideas.”
- “Some may find using the computer difficult so how else can you communicate otherwise they are disenfranchised.”
- “Some people may also be intimidated by a listening session and prefer a more private means of communicating their experience.”
- “Even in Ely centre there are areas where we simply have poor signal and IT coverage which makes many of the digital offerings hard if not impossible to use.”

Follow through so patients know what has happened / close the feedback loop

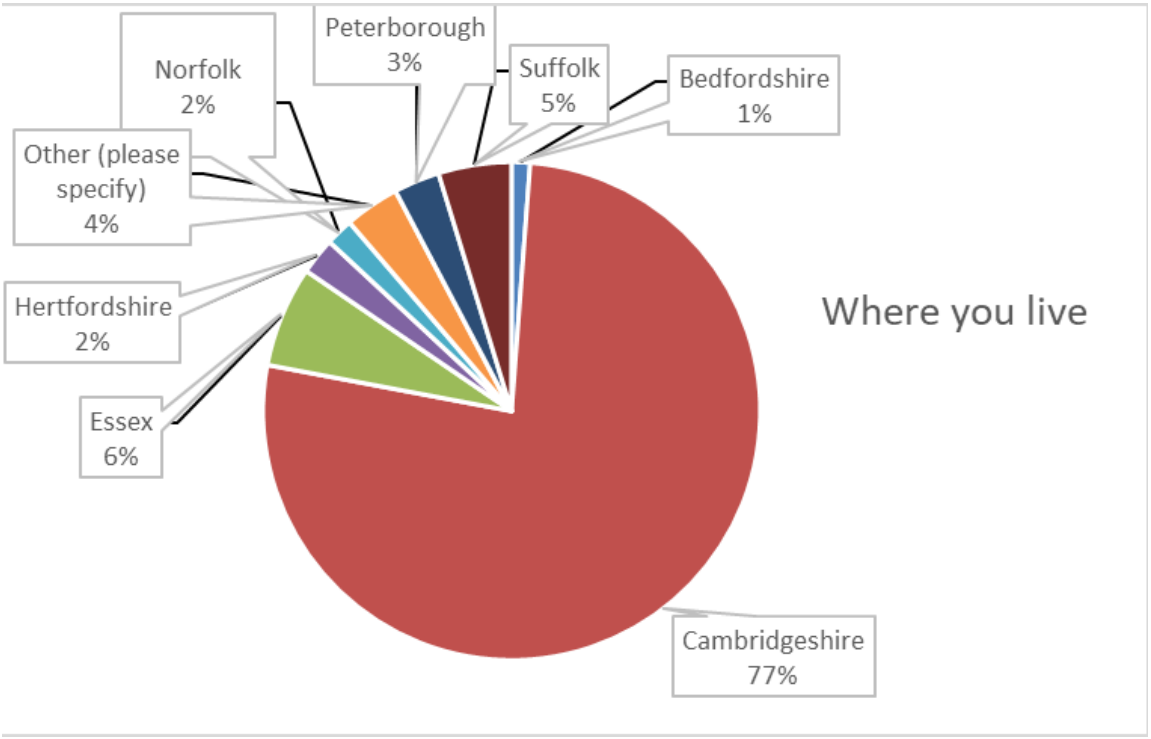
- “The hospital is really good at listening to patients, but I think that part of what patients hope to achieve is positive change or to know how the information they provide is used. What happens after the surveys, patients’ stories, listening session?”

Other feedback

- “As far as training to attend a group, I think it would be good to know what the expectations of your role in that capacity.”
- “Some level of reward would certainly help me to remain interested and make me feel valued.”
- “I do not think it is reasonable to demand that patients take minutes at meetings. It is not possible for a patient to concentrate and participate fully during a meeting if they also have to take down minutes.”

Who we heard from

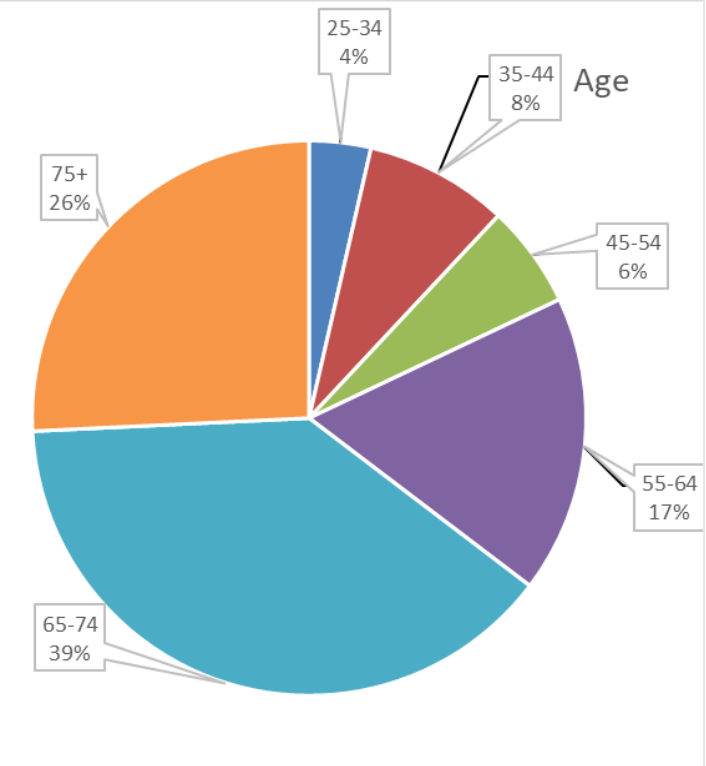
Where people live



The majority (77%) of the people we heard from for this piece of work lived in Cambridgeshire.

For future engagement work it may be helpful to ask people for postcode data to enable us to assess whether we are successfully engaging with people from across our communities, including those from the most deprived areas.

Age of respondents



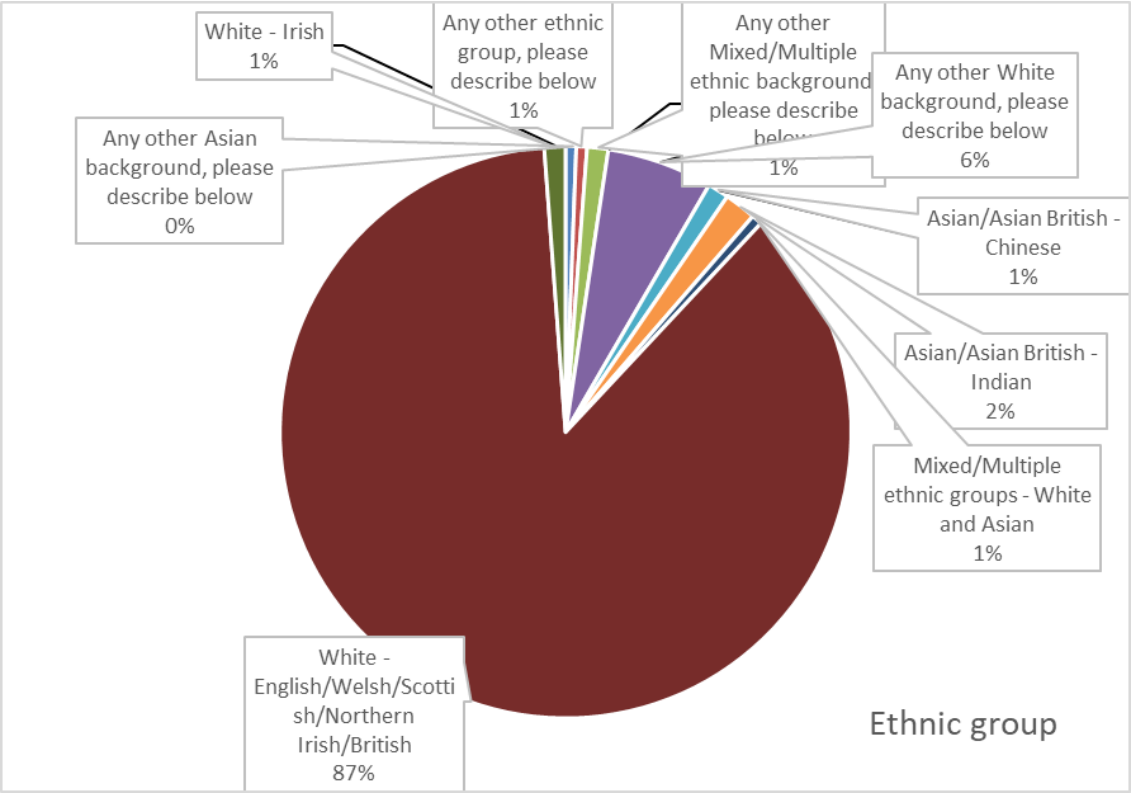
Age	Cambs & Pboro %	This survey %
15 to 24	11.9	0
25 to 34	14.2	4
35 to 44	13.6	8
45 to 54	13.3	6
55 to 64	11.8	17
65 to 74	9.4	39
75 to 84	5.9	26

Although it is not an exact match, to give an idea of how this data compares with our potential patient population, we have compared it in the table below to the Cambridgeshire Insight's data for Cambridgeshire and Peterborough.

It shows that most people we are engaging are aged 65 plus. Proportionately, we are not hearing as much from people aged 19 to 34.

For this survey we did not hear from anyone under the age of 18, although we did visit the Active children's board group to learn about how they engage with CUH's services.

Ethnic identity of respondents



Although it is not an exact match, we have again compared this data with that available from Cambridgeshire Insights data.

	Cambs & Pboro %	**This survey %**
Asian, Asian British or Asian Welsh	7.9	4
Black, Black British, Black Welsh, Caribbean or African	2.1	0
Mixed or Multiple ethnic groups	3	2
White	85.4	88
Other ethnic groups	1.7	7

This does not give us the granular detail that would be helpful to understand who we are hearing from. But does show that for this survey, we did not really reach into our local Black or Asian populations.

Other demographic data

Sex of respondents.

30% of our respondents identified as men and 69% as women. This compares to 49% of the local population being male and 51% female.

Sexuality of respondents

95% of our respondents identified as heterosexual, 2% as lesbian or gay, with 4% preferring to self-describe. The latest data from the Office of National Statistics shows that an estimated 3.1% of the UK population aged 16 years and over identified as lesbian, gay or bisexual (LGB) in 2020.

Disability of respondents

44% of people told us they had a disability or a long-term health condition.

Appendix 2: Patient workshop feedback

Amalgamated feedback from two patient workshops.

What do we mean by involvement and general comments

1. Accessibility. People can feel disenfranchised by everything being digital and needing an App. Older people and disabled people are less likely to use mobile phones. Plus, not all mobile phones are smart.
2. Patients need a route to be able to feedback on care that is not really a complaint, for example where could have been provided in a better way, or to praise care. PALs are busy with real complaints, so do not feel like the right route. Surveys not always that helpful in feeding something back.
3. Importance of feedback loop, so that people know that their feedback has been heard and responded to.
4. Recognising the expertise of voluntary and community sector — CUH needs to recognise this more and collaborate more. Example of new hospital, working closely with relevant vol organisations. Suggestion of running focus groups with charities attending to speak about experiences, the current CUH processes, research etc.
5. Should consider symposium / patient and carer events around particular health topics involving patients and carers. Getting people with specific health conditions together. Beneficial to people's wellbeing, makes you realise not the only one. Benefit of visiting the hospital for 'something good.' Or perhaps added to a meds for members lecture with expert. Include an opportunity to give feedback.

Beyond surveys - how do we learn from the rich feedback from patients when leave CUH?

6. Regular focus groups were held for each ward area before COVID, and governors were always involved. It would be for a certain ward, and they would invite patients who had been on that ward. At the end would create a summary and some action points.
7. Diversity of patients is in the building – do more to capture people's views before they leave. "Harnessing the people that we already have in the building and trying to make the most of that."
8. Chatting to patients on wards before they leave hospital – although this not appropriate for all patients, for example people with dementia. Also mentioned importance of carer / family member role and including them, esp. when person lacks capacity.
9. Involve staff, they have experience of listening and in facing patients all the time and must have a wealth of information. Although acknowledge their resource is limited and under pressure. Potential to work more with volunteers to be the eyes and ears of Addenbrooke's to help gather patient feedback before people have left.

Developing more inclusive patient experience groups

10. Make sure that there are clear expectations about patient engagement / involvement roles “everyone is there to add something, to contribute to the group. They know what is expected.” People’s roles within the group should be clear, so that they know what the objectives are and how their feedback will be used.
11. Issue raised by some that there is no-one in the hospital to raise concerns with about groups that are not working well. Need a problem-solving route if things are not working well. PALS felt too busy and not for things that are not a complaint.
12. Every group needs a basic accessible, explanation. Terms of reference document is too complicated. Need something simpler that is easy to read on one side of A4 rather than lots of pages.
13. Critical success factors for making patient involvement work well
    - That staff involved with the project actively want patient involvement and not just ticking a box. When staff want an actively seek out patient's views, it does work so much better.
    - Needs to be well organised by staff so that people are welcomed and feel valued. Good learning from groups like Cancer Patient Partnership group.

Co-design and co-production

14. Conversation about terminology and the terms co-design / co-production as jargon. Use of language - “working in partnership with patients.”
15. Positive experience of being involved in the cancer hospitals. “I think the way that you've done things is superb and that should be the gold standard which every single online focus, group, patient panel, all of them should be run by that standard and any that don't run by that standard just need to be dissolved.”
16. Need to offer some remuneration to people who participate. INHR funded panels are considering remuneration and CRUK (Cancer Research UK) are going to do it. Offering people the opportunity to be remunerated does give access to people who might not otherwise join in. (This is something that is in development within CUH, in terms of looking at a tiered approach depending on the role that people are in.)
17. Money changes relationships, so any decision on involvement payments should be handled carefully as may change nature of relationship and be seen more as paid than volunteering.
18. Supporting people to get involved: people can be dis-incentivised from taking part because they feel that they do not have the IT skills, public speaking skills, etc. And they feel that they their views somehow are less valid than others because they feel that they are not as eloquent. But their voice and their contributions are as valid as anyone else’s.
19. Accessible involvement – should offer people the equipment they need to participate if they would be required to attend regularly.

20. One patient group Chair said there was a big problem not knowing what else is going on, they said that they: "... keep feel like we are reinventing the wheel. We are floundering in terms of improving diversity. We need to know who else is doing what and what is worked well. Should have a published list of groups."

21. Important to set clear expectations for people within group, so that they know what is expected.

How do we listen to and involve a broad range of people from different backgrounds?

22. Reaching out and going to community events – example given of going to Wisbech and speaking with migrant workers to get their views. "And we asked them about how you could make the environment more welcoming to them when they came into the new cancer hospital, for example, and they said seeing something that was familiar, so in this case it might be flags from their countries."

23. Arts to connect - if you take something from diverse cultures and bring them in to an environment, such as ethnic arts, that makes people feel comfortable and they can recognize things and we can be a little bit more creative about how we relate to different cultures and people with different backgrounds. Linking the experience of going out and speaking then with thinking about how you can make a place more welcoming.

24. Having questions to ask people at events, whether they be specific or open is important.

25. Providing information in different formats / languages for people as needed. But going beyond this and working closely with communities when developing materials and going out to them so that not breaching cultural etiquette or doing something that taboo.

26. Reaching out to different group, including religious and community groups.

27. Reaching out to homeless people / street sleepers – through voluntary and community partners. Example of a hospital who has a homeless outreach person working within trust to encourage homeless people to participate in healthcare.

28. Concern raised about diversity of groups that has been part of, for example there are no people with learning disabilities.

29. Encouraging participation of young people by offering rewards, such as a references and training.

30. Timing of meetings as if always during the day, then difficult to get people who are in work or education through the day, it is not possible for them to join.

31. Suggest an approach Sixth Form colleges – to reach out to the young people as these students have more flexibility in their time. All the 6th forms will require them to have an element of volunteering.

32. Is difficult to reach out to patients. Information about patient engagement group in blue pack given to cancer patients on diagnosis, but people reported not having got this.

33. Need a policy on remuneration – it causes unquiet and is a barrier to many, many people. When have a policy, then needs to be rolled out. It should not cost you to be involved. We are now losing people to other orgs who give involvement payments / expenses.
34. Other ways of rewarding people for involvement, such as certificates, training a reference. So that they are getting something out of it. “You may get a clientele if offer money.”
35. Needs to be a recognition than not all people online / digitally able for whatever reason, disabled people are less likely to have a smart phone or be online.
36. More targeted publicity about how to get involved – it is difficult to find out how to get involved.
37. Tie into events such as religious festivals, LGBT history month, etc to help engage people from diverse groups. Possible tie in with what’s happening in the city (council).

Creative involvement

It is not just the art that you see on the walls, music, dance, sound, nature, plants.

38. Discussed a variety of ways of being creative, using music, dance, sound and traditional arts, and photography. Arts could also include things like voice, singing or cooking. What is good is that people are doing things and doing things together.
39. Suggestion that it would be good to have a sensory garden at CUH, with raised beds, so that you could get a wheelchair around and people could touch the plants. Would be soothing and a quiet place to go. Or could have a vegetable garden or something similar.
40. Link to schools. Suggestion of a pack about Addenbrooke’s to go to schools and volunteers to visit local sixth forms and schools to talk to children/teenagers about CUH. Arthur Rank do this very well.
41. Creative involvement may suit people who are neuro-divergent, who may be shyer.
42. Like to see a programme of science / medicine related events, the science stuff is much more hidden now it is the Cambridge event.
43. Suggest introducing nature walks - tie into health
44. There was the suggestion that walking football and other walking sport activities were an effective way to create a fun activity and engage people.

Appendix 3: Staff workshop feedback

Notes from meeting, includes summary of conversation and some comments from group chat.

Attendees: Gina Edwards, CUH Cancer Patient Experience Group; Joanna Worley, Cambridge Cancer Centre and the University of Cambridge; Justine Kane; Kirsty Lothian, Active; Aloma Onyemah (EDI - Equality, Diversity and Inclusion); Ally Perkins, deputy operational manager outpatients; James Taylor, project manager; Pai Fagelman, senior programme manager; Kathy Walshe; Carole Proctor, Outpatients; Joanne Fearn, improvement and transformation team; Caroline Zwierzchowska-dod, Co-Chair, Rosie Maternity and Neonatal Voices; Elaine Champman, Co-production Lead for Cambridge Cancer Research Hospital; Clare Hawkins, Sarah Booth, Director Communications and Engagement

Themes

Recognition of volunteers and a consistent level of support for them.

45. Consistent level of support for patients / public volunteers - patients have reported differing experiences of being supported in groups across trust – some very good and some poor.
46. Patient participation volunteers are not classed as CUH volunteers, and therefore do not get a badge. Experience of a volunteer who had been invited to a CUH award nomination event for their contribution and were refused entry to the Frank Lee until a staff member could get there and use their staff badge to get them in.
47. Suggestion that patients could come under the volunteer services umbrella as then would get badge and ability to access training
48. Recognition of volunteers – such as ‘you made a difference’ another way to reward volunteers
49. Celebrating people having a voice. Some of active volunteers grown up doing co-production. A lot of Active co-ordination role is around skill building and giving people the confidence to have a voice. “Ultimately it might be it might be that people feel so empowered and skilled that they want to lead a project.”
50. Rosie Chairs working at a strategic governance level of maternity on participation, voice level 4 rates, not time in this to manage volunteers, so need to re-evaluate how peer to peer volunteer role will continue.

Processes

51. Involvement and expenses payments: to get diverse involvement and be inclusive, need to acknowledge that patients give up their time, and have a policy for paying volunteer expenses and involvement payments in line with NHS England’s Patient Participation policy. Need something that is clear and straightforward, otherwise a danger of becoming something that we just play lip service to. There are good examples of paying patient time in research, but easier as patient involvement cost can be included in grant applications. NHS E Policy.
52. Process needed for reasonable adjustments - have been asked by a patient to pay for reasonable adjustments for a disabled patient to take part in group. There is no trust policy on this and have no budget in department for this.
53. Important that the new framework does not place restrictions on existing groups around the number of members and specific diversity criteria, etc.

54. Discussion on the merit or otherwise of restricting length of tenure on groups. It was agreed that whilst this might be a good idea for some groups, e.g., cancer patients so that we are not “keeping people stuck in cancer land longer than they need to be.” But it is not beneficial or necessary for other groups, such as children’s. No one size fits all. “The patients I've seen, the more they work with us and learn to understand the hospital, the more ideas they have for co-production and our patients are now confident enough to lead on the project.”

55. Rosie Maternity and Neonatal Voices (RMNV) sits outside trust in terms of how they are funded, so not as restricted in some of how operate. There is the statutory surveying but alongside this RMNV does own surveys and this triangulates data and can bring in experiences when people who can reflect more on experience, so people share “when they are ready, which can be up to 3 yrs. later”. Go into the most vulnerable communities, to listen in a way that is right for them. We do gather demographic data to see who not hearing from currently.

56. NIHR (National Institute for Health Research) Cambridge BRC has the following online Patient and Public Involvement training sessions for researchers in 2023:

    - Introduction to PPI (Patient and Public Involvement)
    - PPI Toolkits: Ways to involve the public in research
    - How to Build and Maintain PPI Groups
    - Running successful PPI Focus Groups
    - Planning inclusive PPI
    - Evaluating PPI
    - Using PPI to help communicating your research

Support for staff

57. CUH staff are unclear about the difference between engagement and co-production. No staff training on co-production. Currently no link up between different staff members who are involved in co-production and other patient involvement / engagement activities.

58. Suggestion of a monthly newsletter of upcoming engagement events and opportunities as do not know what is happening - e.g., RMNV applied for a stall at Pride and did not get one but could have piggy backed on main CUH stall.

Strategy

59. Question asking what the strategy is around patient, public service, user involvement and then what the delivery plan is, i.e., procedures, and how we do it, budgets etc. Identify priorities, linking to CUH 2025 strategy, ICS (Integrated Care System) strategic priorities, core 20plus. How are we going to deliver, over what timescale, and how prioritise.

60. A strategy to support an engagement framework should ensure we align with CUH 2025 strategy and key priorities around health inequalities and patient, service user and visitor EDI priorities - system wide reference points such as CORE20+5 etc (link acute sector provision for example around cancer, heart disease - with community screening initiatives, smoking cessation work in local authority/primary care - so many contact points - where we can link/should join up and collaborate with other organisations - who are already out there in communities - we don't need to re-invent the wheel.

Community engagement / People who experience health inequalities / diversity

61. Need to look beyond CUH to the wider ICS, and other organisations when thinking about involving people and engaging people. Collaboration with system partner, for example - linking engagement with services who operate/delivery community screening services, etc.

62. Engagement - Need to reach out into the community and have a co-ordinated engagement plan. Need to build up trust with our communities, so that they can rely on us. Can piggyback onto existing events organised by organisations such as local authorities and faith leaders. Pride this year but could do bigger next year. Separately but linking it up, to make sure that any co-production activities links in with the right voices in engagement to support co-production.

63. Large population of people that we should be engaging with, but mostly we are trying to engage with the same people. Find a way to coordinate and bring the feedback back to everybody and implement it as needed. Example of Cancer Centre where have an outreach and engagement lead

64. Need to find innovative ways of engaging people in genuine conversations about their lived experience of care - find a way to connect - link with system partners and go out in to the community - many hard to reach groups/those at risk of exclusion/seldom heard from groups - unlikely to come to us pro-actively or fill out surveys - it’s about conversations and dialogue - with people where they are (in many cases not likely to be on CUH site)

65. Online meetings have opened meetings to some who would not be able to attend face to face. Patients in one group like meeting online and struggle to arrange face to face events. Keeping options open for people who cannot come to online meetings.

66. RMNV – work to identify vulnerable patient groups within maternity through knowing patient population, looking at national and local data and following up by identifying group to visit to engage with that patient group.

67. Outpatients – identify that people who DNA (did not attends) more than once are at more risk from health inequalities and the reason they are struggling to attend their appointments is due to the disadvantages that they face. Changed terminology to ‘missed appointments.” Project in Sheffield Children's hospital to help patients get to appointments / holding appointments in community so easier for patients to attend.

Beyond surveys

68. Surveys can work as a catalyst, working with the patients that are engaged in co-production to say, “these are the things we want to understand more.” And then go out and do more focus target work.

69. Patient experience surveys – collect same demographic categories as on Epic, but not picking up deprivation there. (Qs – Does this include Gypsy and Travellers?)

Co-production

70. Discussion around the need to make sure that if something is co-produced with patients, how can it become integrated / accepted within CUH? Need a clear process to develop and value things that are developed in partnership with patients. Example from Active, co-production with young people to improve care for teens in hospital: however, this has not been integrated into everyday care. How do we make sure this happens?

71. Within cancer services - developed patient reported outcomes which have been embedded as metrics to use as a guide to how to change and direct service needs. Creating a KPI that places patient co-production on a par with clinical care and safety, might lead to understanding the value of patient involvement and therefore possible a cost benefit that might help build a case to cover costs for patients’ time.

72. Improvement and transformation team – promoting and utilising co-production in the key projects and programmes across the trust based on national priorities that are aimed at reflecting patient priorities. Team's role to bring co-production and patient engagement to the table for discussion in each of those programmes and projects. Flagging that improvement work and projects and programmes is another route to champion co-production and patient engagement in the work that we are doing. But do not think we are making the most of the opportunity currently because we do not always know the best way.

73. A big part of co-production is patients producing their own ideas and need to ensure that this remains part of how patient groups able to work. “At RMNV the work plan is co-produced and service user led, trust and ICB (Integrated Care Board) priorities are included but service user priorities are king.” RMNV can be commissioned to run co pro training if useful.

74. Senior management must support co-pro otherwise goes nowhere - finding from a lit review I did as part of the MSc degree. – Elaine Chapman

Practical

75. RMNV are going hybrid, but the tech is not great for that. If CUH could buy an owl system that would really help!
76. Patients and the public have different needs and interests. How will we unify things, do we need a platform, like voice global or will we just sign post to different PPI/E opportunities on the Trust's website?

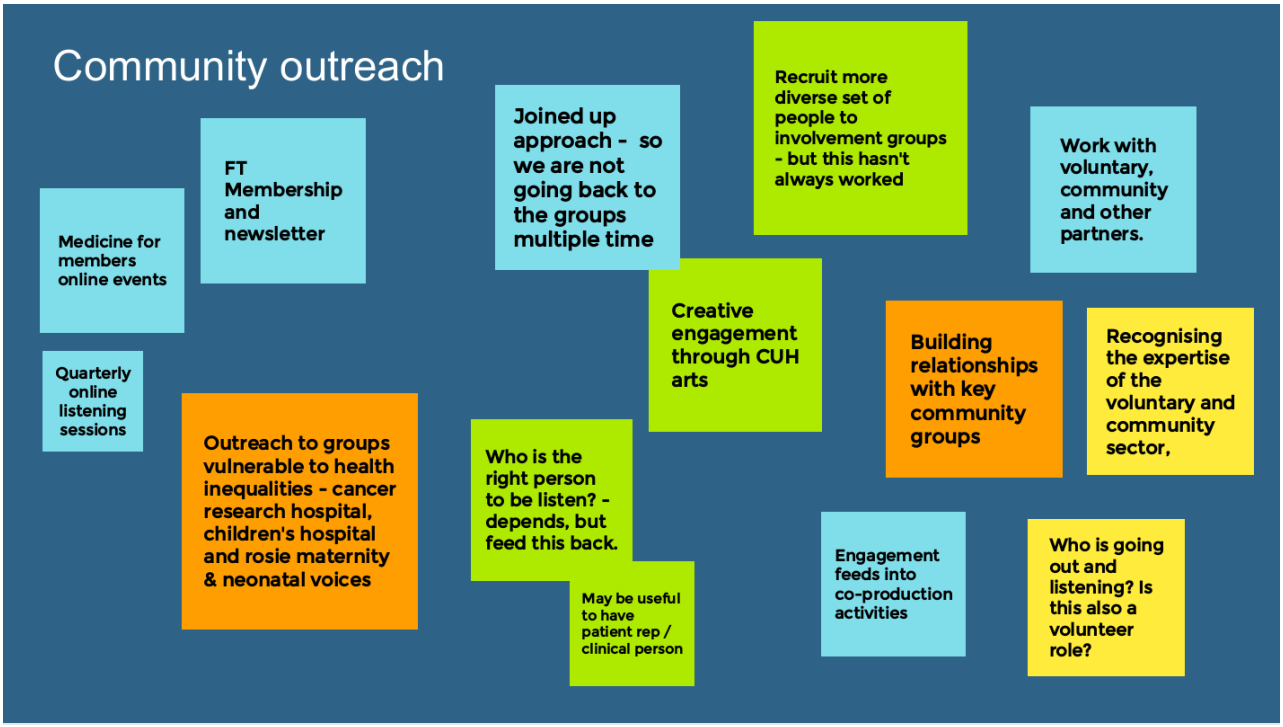
Notes from an additional co-production workshop with I&T team

77. It is a lot of work to co-ordinate co-production effectively, whose job is it to do this? More support would be good.
78. Whose responsibility is it to recruit patients to take part in co-production activities?
79. Could there be a box to tick in MyChart about people's willingness to help with service improvement opportunities?
80. Blocks to co-production around the bureaucracy, time, and resources.
81. For some, there is a fear of involving patients — 365-degree feedback can be difficult if there is not a culture of learning from feedback.
82. Going straight to the source – getting real time patient feedback and using this as a starting point
83. Suggest ways to reward services that are co-produced.

Appendix 4: Working group discussion

The working group discussed the findings of the staff and patient workshops using a jam board to help structure their thinking.

Click here to see the jam board.



Patients through our doors

Patient surveys - in different formats for people after outpatient appointments. - text messages

Statutory surveys

National inpatient survey - small sample but are good response rates. Yearly survey

iPads on wards - patients can ask at any time - but do they know this?

PLACE assessment / and mini-PLACE (estates)

A way for staff to implement changes based on patient feedback. institute for healthcare improvement - ho to use feedback to make change?

Extend text messages following discharge to fill in survey

Patient engagement surveys to help improve a service

Patient informal feedback

There are comment card boxes in wards / clinic

FFT on trust website

co-production on surveys - making sure these make sense to patients

Lacking proper data analysis - better statistical analysis of what we are getting and pulling out the these

Better promotion of feedback methods

Patient shadowing - which trust?

Anything else important to be aware of / include?

NHS E have lots of resources on co-production / co-design

What about public involvement in governance? Governors, board meetings in public, etc

Enable and support staff - all legitimate approaches. Projects may require different combinations

Idea that these are all part of involving

Co-pro week starts 3 July

Patient/ public at all board meetings

How this ties into strategic objectives around things like reducing health inequalities,

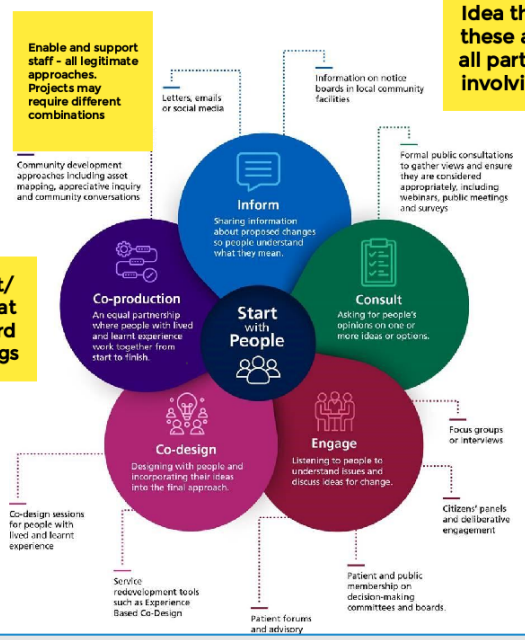
Some definitions of terminology

Accessible information and opportunities to get involved

Important in promoting co-pro to measure impact.

How do we celebrate success!!

How can we capture good-practice



Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 8 November 2023

Agenda item	13
Title	Multi-professional Education, Learning and Development
Sponsoring executive director	David Wherrett, Director of Workforce
Author(s)	Karen Clarke, Associate Director of Workforce Ruchi Sinnatamby, Clinical Sub Dean for CUH Sanjay Ojha, Director of Post Graduate Medical Education Gary Parlett, Head of Education, Nursing, Midwifery and Allied Health Professionals
Purpose	To provide the Board of Directors with an update on education, learning, training and development across CUH
Previously considered by	Management Executive, 2 November 2023

Executive Summary

This paper provides an update on multi-professional education, learning and development activity. This paper sets out progress since the last Board report aligned to themes set out in the Trust's Multi-professional Education, Learning and Development Strategy.

Related Trust objectives	Improving patient care; Supporting our staff
Risk and Assurance	Inadequately trained staff Inability to recruit and retain staff Inability to develop shortage skills and staff
Related Assurance Framework Entries	BAF ref: 007, 13
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 which specifically updates on themes 1, 2, 3 and 6 of the Trust’s Multi-professional Education, Learning and Development Strategy 2023-2026.

Cambridge University Hospitals NHS Foundation Trust

8 November 2023

Board of Directors
Report on Multi-professional Education, Learning, Development and Training
David Wherrett, Director of Workforce

1. Introduction / Background

1.1 This paper provides an update on multi-professional education, learning and development at CUH; its purpose is to provide information about a number of key developments, against the Trust's priorities, since the last report to the Board in July 2023.

CUH Education, Learning and Development Strategy 2023 – 2026

1.2 The Trust's multi-professional education, learning and development strategy for the period 2023 – 2026 was discussed and agreed at the July board. The six themes are summarised below.

Key themes

Theme 1: Learning Experience
Learners across all academic pathways will have a positive and successful learning experience during their placements with CUH; we will aim for excellence in our delivery and in the environment in which it's delivered.
Theme 2: Continuous Development
Continuous professional development (CPD) and multi-professional learning for all staff groups throughout their career with CUH
Theme Three: Apprenticeships and widening access
We embrace and invest in innovative access routes for development to contribute to future sustainable workforce supply and development.
Theme 4: Leadership and management development:
Committed to building capability and confidence of our leaders and line managers
Theme 5: Innovation and collaboration
Adopting new approaches in multi-professional learning and development supporting new roles and routes to education learning and development
Theme 6: Modern fit for purpose education facilities and resources:
An ambitious approach to contemporary, fit for purpose education environments, technological advances and resources

This report provides updates on Themes 1, 2, 3 and 6.

2. Theme 1: Learning experience

CUH provides a range of formal learning experiences for a range of staff including undergraduate and postgraduate students who spend time with the Trust as part of formal education/rotation programmes. This element of strategy sets out our ambition learners across all academic pathways have a positive and successful learning experience during their placements with CUH.

2.1 National Education and Training Survey (NETS) – all learners

The NETS survey was launched on 3rd October 2023 and is running until the end of November 2023. This survey, led by NHSE, seeks the views of all learners who are undertaking healthcare education programmes which include a practice placement or training post in healthcare. The NETS survey seeks student/learner feedback about their experiences of undertaking a practice placement in the NHS with a focus on areas of good practice along with aspects that require improvement. A summary of NETS data for CUH will be presented in a future board report.

2.2 Undergraduate Medical Education (UGME)

The second annual NHSE Self-Assessment return, a process for all NHS organisations to carry out their own quality evaluation against a set of standards around healthcare education and training for those employed by the NHS across all staff groups has, this year, enabled us to highlight achievements in the undergraduate medicine education. Achievements submitted on behalf of CUH include the following:

- Qualitative student evaluations are strongly positive with respect to the excellence of teaching and the broad range and wealth of clinical learning opportunities available on some placements at CUH. This is particularly notable for student selected placements in specialist and tertiary referral settings. Students also value and make the most of opportunities to undertake audit, quality improvement and research projects on these placements many of which are presented at national and international conferences.

- The Clinical Communication Skills programme for medical students, run centrally at CUH, has been commended by the GMC in their latest Quality Assurance Feedback communication (February 2023)

- Undergraduate medical teaching faculty have opportunities to access a range of in-house faculty development opportunities through the Clinical School. Medical Education CPD accredited Away Days are run twice a year and are free to attend. The IFME (Integrated Foundations of Medical Education) programme is an Advance HE accredited teaching the teachers programme enabling staff to reach the standard of Associate Fellow of the Higher Education Academy (AFHEA) and accredited for CPD points. This

is free of charge to CUH staff who teach Cambridge medical students and further progression is also available via PGCert, Diploma and Masters programmes run through the Institute of Continuing Education of the University.

The most significant challenge in providing a positive learning experience for medical students submitted through this process, also flagged at the recent Quality Assurance visit by the School of Clinical Medicine, at CUH is capacity. For most placements, this relates primarily to education organisation, supervision and guidance capacity. Whilst all consultants are allocated a fraction of job plan time for undergraduate education (0.125PA) and a small number receive a greater allocation for specific activities, there is a lack of consistent tariff funded time for consultant placement leads when compared with other Clinical School partner acute trusts which has compounded the effect of increased student numbers, particularly with respect to monitoring attendance and completing end of placement assessments.

Additionally, unlike other acute trust partners of the University, CUH does not currently employ clinical teaching fellows (CTFs) for undergraduate education. CTFs with dedicated teaching time would be well placed to organise placements, monitor attendance and support students and conduct induction/end-of-placement meetings. CUH teaching leads, working together with the Clinical School have been endeavoring to implement CTFs at CUH particularly in dermatology and acute care where the needs are greatest.

Capacity is also a challenge for clinical skills teaching provision. Since the expansion of student numbers, we have a relative under staffing of clinical skills tutors with a consequent challenge to deliver all core practical skills teaching in a timely manner to all students and to remediate struggling students. There are potential safety risks to patients.

These challenges have been raised with the Trust. The Trust has been working on a model to calculate realistic undergraduate medical education provision costs and whilst this continues, further investment in these key areas has not been progressed.

2.3 Post Graduate Medical Education (PGME)

GMC National Training Survey for Doctors in Training

The CUH results for the annual GMC Survey of all doctors in training have been received. A summary is attached as Appendix 1. This highlights that CUH had:

- 57 red outliers (negative scores, in the lowest quartile nationally, highlighting areas of concern requiring action) in 2023 compared to 29 in 2022. The majority of the red outliers are in the four specialties: Obstetrics and Gynaecology (21), Medical Oncology (6), Endocrinology and Diabetes (5) and Gastroenterology (4). The majority are in the domains of workload

(re-occurring since 2021), regional teaching (re-occurring since 2019) and clinical supervision (re-occurring since 2019). CUH ranked 9th out of 10 for the number of red outliers.

- 24 green (positive) outliers in 2023 compared to 23 in 2022. The majority of the green outliers are in the specialties: Core Surgical Training (5), Clinical Pharmacology and Therapeutics (3) and Plastic Surgery (3). The Trust ranked 10th for the number of green outliers (no change from 2022).

- Overall, the Trust ranked 5th for overall satisfaction (no change from 2022).

The Medical Director and Director of Postgraduate Medical Education met with the specialty leads and trainees of all specialties with red outliers to explore issues and to discuss how best to improve training. Action plans addressing the concerns were formulated and returned to NHSE.

The patient safety (6) and undermining comments (1) that were raised during the survey were investigated, actions taken and responses sent to NHSE.

NHS England Quality Framework Meeting

The NHS England Workforce, Training and Education Quality Framework is the process by which NHS England in the East of England evaluates, manages and improves the quality of education and training for all healthcare learners.

Concerns have been escalated to NHS England in relation to Obstetrics and Gynaecology trainees at CUH. Concerns include a lack of senior support for on-calls, inadequate supervision for GP Specialty Trainees and Foundation Year 2 doctors when reviewing patients, bullying and undermining, lack of induction and inadequate shadowing periods for junior doctors before starting the on-call rota.

Consequently, the trust has been notified of the inclusion of O&G onto the NHS England Quality Improvement Register. NHS England's Regional Education Quality Team is visiting the Trust on the 8th November to meet the trainees and trainers in Obstetrics and Gynaecology, with a view to assist them in understanding the impact of the highlighted challenges on education and training placements.

The Trust has acknowledged these concerns, triangulating data from the Freedom to Speak Up Guardian and feedback from the GP Training Program Directors and is taking action to address the issues. A Medical Obstetric Safety Group chaired by Amanda Cox (Deputy Medical Director) has been established to focus on patient safety in obstetrics and gynaecology. The primary role of the group will be to look at medical staffing, the model for care delivery from a medical workforce perspective and the training and support received by junior and specialty doctors.

2.4 Non-Medical Education

Pre-Registration Learner Experience

The CUH student placement quality monitoring survey is now in use for all nursing learners following a period of pilot testing over the last 9 months. Data from this process forms a quarterly report, which can be divided by division and ward areas for feedback, to give ward areas more control of their feedback and actions. Data from the survey tool feeds into the Non-Medical Education Quality Dashboard.

Feedback from learners undertaking nursing placements at CUH indicates high levels of satisfaction with nursing placements across CUH with satisfaction being in the region of 80% over the last quarter. Emerging themes from narrative feedback include learners feel that they are well supported whilst at CUH and have frequent opportunities to develop new knowledge and skills. Areas for development include ensuring that learners always feel supernumerary and a need to work more closely with partner Universities to ensure that information given to learners is consistent.

The survey will now be rolled out across additional groups of pre-registration learners with the aim of all non-medical pre-registration learners being invited to participate in the survey by March 2024.

3. Theme 2: Continuous development

This element of strategy sets out our ambition to consistently seek to support the continued development of all our workforce across throughout their career at CUH.

3.1 Post Graduate Medical Education CPD

The trust continues to offer a range of postgraduate medical development opportunities including:

- Educational Supervisors Teaching Programme: A new Educational Supervisors training programme focusing on leadership has been developed for all educational supervisors at CUH. The first course was delivered on the 26th September with positive feedback from all attendees.

- Foundation Training: The feedback from the annual FY1 and FY2 Exit surveys was excellent. The FYs felt well supported and comments included '*Addenbrooke's is a great hospital to work in, all of the staff are motivated and friendly. Well organised placements.'* They did report that the workload was high, and there were occasions that they were left to work alone due to staff absences.

- Leadership Programmes: Both Learning to Lead and Leading for Excellence programmes have started their next cohorts. There has been significant interest in both programmes.

3.2 Non-Medical Continuous Professional Development (CPD)

NHS Pastoral Care Quality Award

CUH was awarded the NHS Pastoral Care Quality Award for internationally recruited Nurses and Midwives during the last quarter; this award recognises the diligent and intensive work carried out by colleagues within both recruitment and the non-medical Clinical Education Team. The award confirms that the Trust has met a set of standards for best practice pastoral care that have been collaboratively developed. Achievement of this award demonstrates the Trust's commitment to supporting internationally recruited Nurses and Midwives at every stage from recruitment and beyond. The award is valid for a 3-year period after which a reassessment will be undertaken.

Review of Clinical Support Worker Induction and Education

A review of Clinical Support Worker education and development was undertaken in June 2023. This review highlights a need to align the amount of supernumerary time that is allocated to bank and substantive healthcare support workers along with a need to optimise early completion of the accelerated Care Certificate. The findings from this review have led to the development of a new education and development pathway for Clinical Support Workers which will be introduced from February 2024. The new education and development pathway offers teaching and learning activities interspersed with time spent in clinical areas so that new knowledge and skills can be applied to practice. An intensive period of support will underpin newly recruited Clinical Support Workers during the first weeks of their employment with the Trust. This will be consolidated by a new HCSW preceptorship programme which will support ongoing development during the first year of employment as a Clinical Support Worker.

New preceptorship programme for Nurses, Midwives and Allied Health Professionals.

Over the last year, NHS England has published the National Preceptorship Framework for Nursing (September 2022) and the National Preceptorship Framework for Midwifery (March 2023); work is currently underway to develop an Allied Health Professions Preceptorship Framework.

A proposal for a new 18-month CUH preceptorship programme was approved by the Nursing, Midwifery and Allied Health Professionals Advisory Committee in June 2023. This proposal outlined how CUH will meet the requirements needed to comply with the published framework, as well as, achieving a gold standard allowing us to apply for the National Preceptorship Interim Quality

Mark. Delivery of the new preceptorship programme will commence in January 2024.

4. Theme 3: Apprenticeships and widening access

This element of strategy sets out our commitment to embrace and invest in innovative access routes for development to contribute to future sustainable workforce supply and development.

Nursing Associate apprenticeship pathway

The Trust's nursing apprenticeship pathway will change from March 2024. The Trust has decided, as a result of financial challenges and value for money considerations, taken the step to change the focus to a Nursing Associate (NA) apprenticeship replacing the current four-year Registered Nurse degree apprenticeship.

The 324 staff currently undertaking the nursing degree apprenticeship will be supported to complete this and gain promotion to a Registered Nurse (Band 5) position.

One of the key benefits of the NA programme is that upon qualification and registration with the Nursing & Midwifery Council (NMC) staff are promoted to a Nursing Associate (band 4) position and are able to care for patients more holistically freeing up registered nurses (Band 5) to undertake and manage more complex patient care.

There has been small cohorts of NA programmes to date; 17 Nursing Associates are currently working at CUH and a further six are undertaking the nursing associate apprenticeship programme.

There has been increased interest across CUH to embrace the Nursing Associate role especially since the role is now able to undertake enhanced roles such as; administration of Intravenous medication. All divisions are identifying opportunities to embrace the role in specific clinical specialities. The ambition is to alter the CUH registered workforce so that 10% will be registered nursing associates by 2030.

The Trust will offer 100 NA apprenticeship places per annum, with priority given to internal staff as well as advertising and promoting the role externally. There will be two cohorts March and September every year working in partnership with Anglia Ruskin University.

Graduations for apprentices in science and occupational therapy

Science Graduations

We are delighted that in September 2023, 5 Healthcare Science Degree apprentices graduated from the University of Hertfordshire. 3 of the apprentices are based in genomics, 1 from tissue typing and 1 from Haemostasis. All 5 apprentices have successfully progressed into band 5 posts. Two of the apprentices joined CUH as direct entry apprentices 5 years ago working through a Level 3 Laboratory Technician apprenticeship onto the degree programme.

Occupational Therapy

The Trust celebrated its first graduate from the Occupational Therapy Apprenticeship who has been promoted to a registered Occupational Therapist (Band 5) position; the individual now acts as a role model for others following this career path.

The Prince's Trust

The Trust had worked in partnership with the Prince's Trust for 10 years prior to COVID. The Prince's Trust training programme helps young people aged 16-30 into employment. These young people spend 2 weeks learning employability skills in a classroom setting and then had 2 weeks of work placements. CUH was delighted to be able to return the programme in 2023 albeit smaller than our previous cohorts.

The Prince's Trust put forward 7 young people for this year's summer programme; the participants gained work experience at CUH and also with RPH and Medirest; placements included housekeeping/catering, medical education, occupational therapy and estates and facilities. We hope to see larger cohorts from 2024. All will be supported to gain employment at CUH or our partner organisations.

5. Theme 6: Modern fit for purpose education facilities and resources

This element of strategy sets out our commitment to securing improved facilities to meet our aspirations for quality education, learning and development.

Simulation Centre

The Centre continues to deliver local, regional, and national courses which supports training and development of the multi-professional healthcare workforce. The Centre is currently fully booked, and there are aspirations to expand the offering of simulation courses which will require additional simulation space.

The Trust is moving forward with the AI-Driven Virtual Reality (VR) training. The Simulation Centre team are collaborating with Anglia Ruskin University on familiarising patients with the transplant journey through immersive simulations, with the aim of reducing pre-operative stress levels. The aim is to mitigate the occurrence of post-transplant PTSD by proactively preparing patients for the emotional and physical challenges they may face. The immersive experience can provide patients with a sense of control and familiarity with the journey ahead.

The Cambridge Surgical Training Centre.

The new centre opened in early September, and within 3 weeks of opening delivered three courses, which all received excellent feedback. The calendar is full up until January 2024, and we are receiving an increasing number of enquires to book the facility in 2024.

The Centre was formally opened by Dr Mike More, Chair on 30th October 2023.

6. Recommendation

6.1 The Board is asked to receive this section of the report which specifically updates the Board on themes 1, 2, 3 and 6 of the Trust's Multi-professional Education, Learning and Development Strategy and work plan.

2023 GMC Survey Results

Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

8 November 2023

Context – Impact of covid on training:

- Loss of educational opportunities – “craft” specialities especially (Surgery; Anaesthetics; Procedure-intensive)
- Reduced outpatient training - limited clinic space
- Change in outpatient training – transition from face-to-face consultations to remote consultations.
- Increased workload
- Increased risk of Trainee / Trainer Burnout

Context – Impact of Industrial Action

- Further loss of educational opportunities:
  - Cancelled clinics
  - Cancelled operating theatre lists
  - Cancelled procedure lists
- Increased consultant workload with reduced time for training.

GMC Survey – Indicators for trainees

Questions are based around distinct themes, or, ‘indicators’, which are as follows:

- Overall Satisfaction
- Clinical Supervision
- Clinical Supervision OOH
- Reporting systems
- Workload
- Teamwork
- Handover
- Educational governance
- Educational supervision
- Supportive environment
- Induction
- Adequate experience
- Curriculum coverage
- Feedback
- Local teaching
- Regional Teaching
- Study Leave
- Rota design

GMC Survey – Indicators for trainers

Questions are based around distinct themes, or, ‘indicators’, which are as follows:

- Supportive environment
- Support for trainers
- Curriculum coverage
- Time for training
- Resources for trainers
- Trainer development
- Rota design
- Educational governance
- Handover
- Work load
- Overall satisfaction
- Burnout

Additional question areas (not indicators in the reporting tool)

- Working Less Than Full Time
- Undergraduate teaching responsibilities

National Findings:

- >70,000 doctors in training and trainers completed the survey.
  - 74% of trainees (49022 doctors) – Down 2% from 2022
  - 38% of trainers (21689 doctors) – Up 4% from 2022

<u>Quality of Training:</u>

- 74% Trainees rate teaching as good / very good
- 83% Trainees rate workplace training as good / very good
- 86% Trainees describe clinical supervision as good / very good
- 89% Trainers enjoy this role.

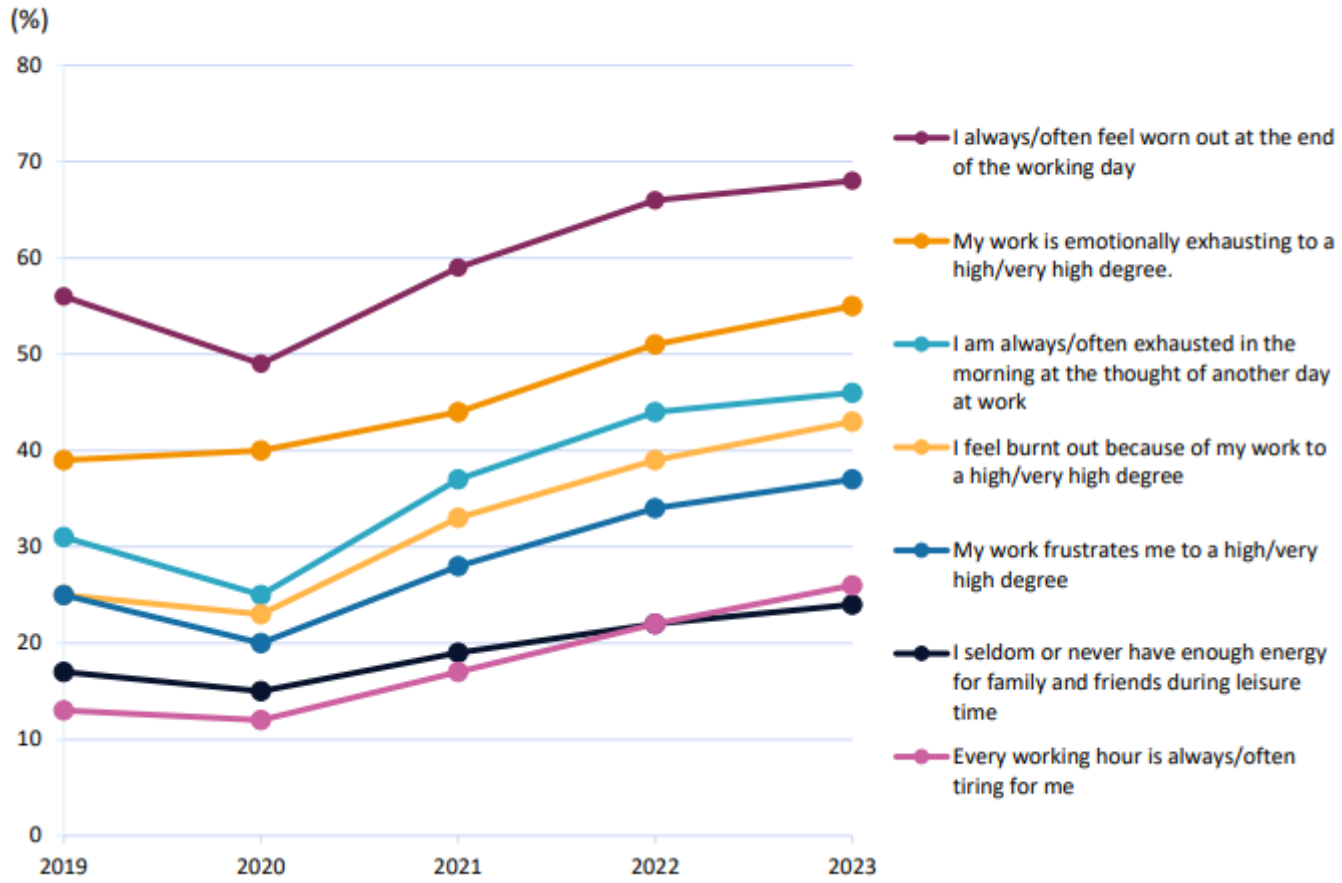
National Findings:

- 45% Trainees describe intensity of work as heavy or very heavy
- 68% Trainees always or often “worn out” at end of working day

- 66% Trainees at moderate – high risk of burnout
- 52% Trainers at moderate – high risk of burnout

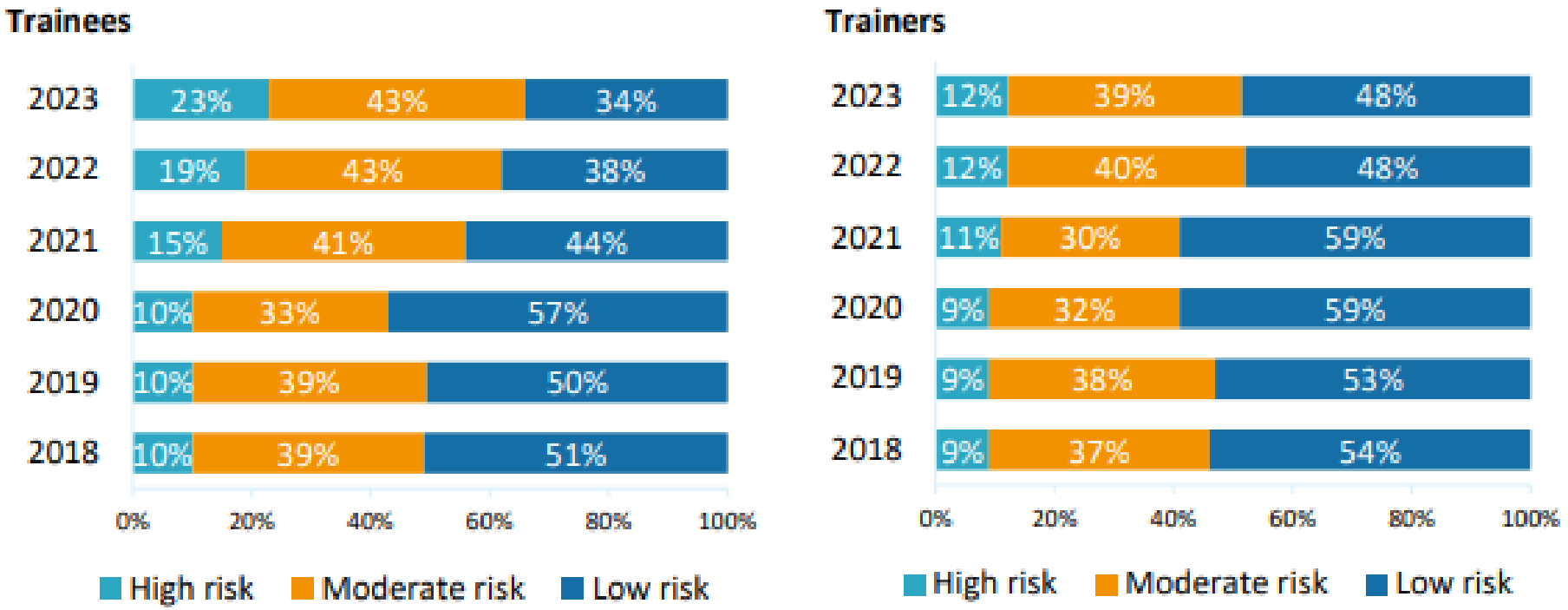
Trainees – Burnout risk

Figure 4: Trainees – Negative responses to individual burnout questions, 2019 – 2023



Risk of burnout

Figure 8: Trainees and trainers – Calculated risk of burnout 2018 – 2023



National Findings:

Time to train?

- 33% Secondary Care Trainers unable to use all time allocated for the purpose of training (conflicting workload pressures).

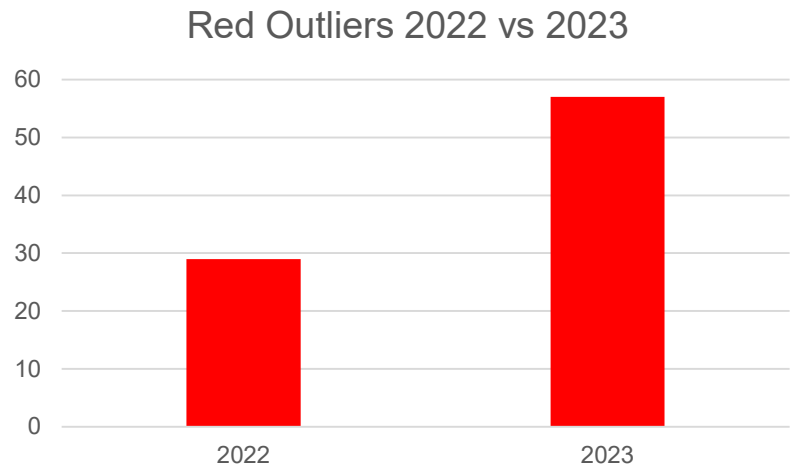
- 23% Trainers have not had an Educational Appraisal in the last 12 months.

GMC NTS survey
CUH Data

CUH Report 2023

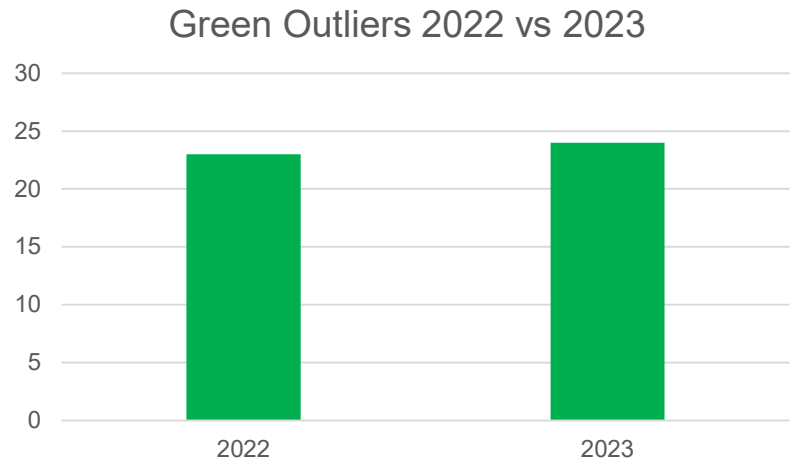
2022 Results

- Total Number or Red Outliers: 29
- Total Number of Green Outliers: 23

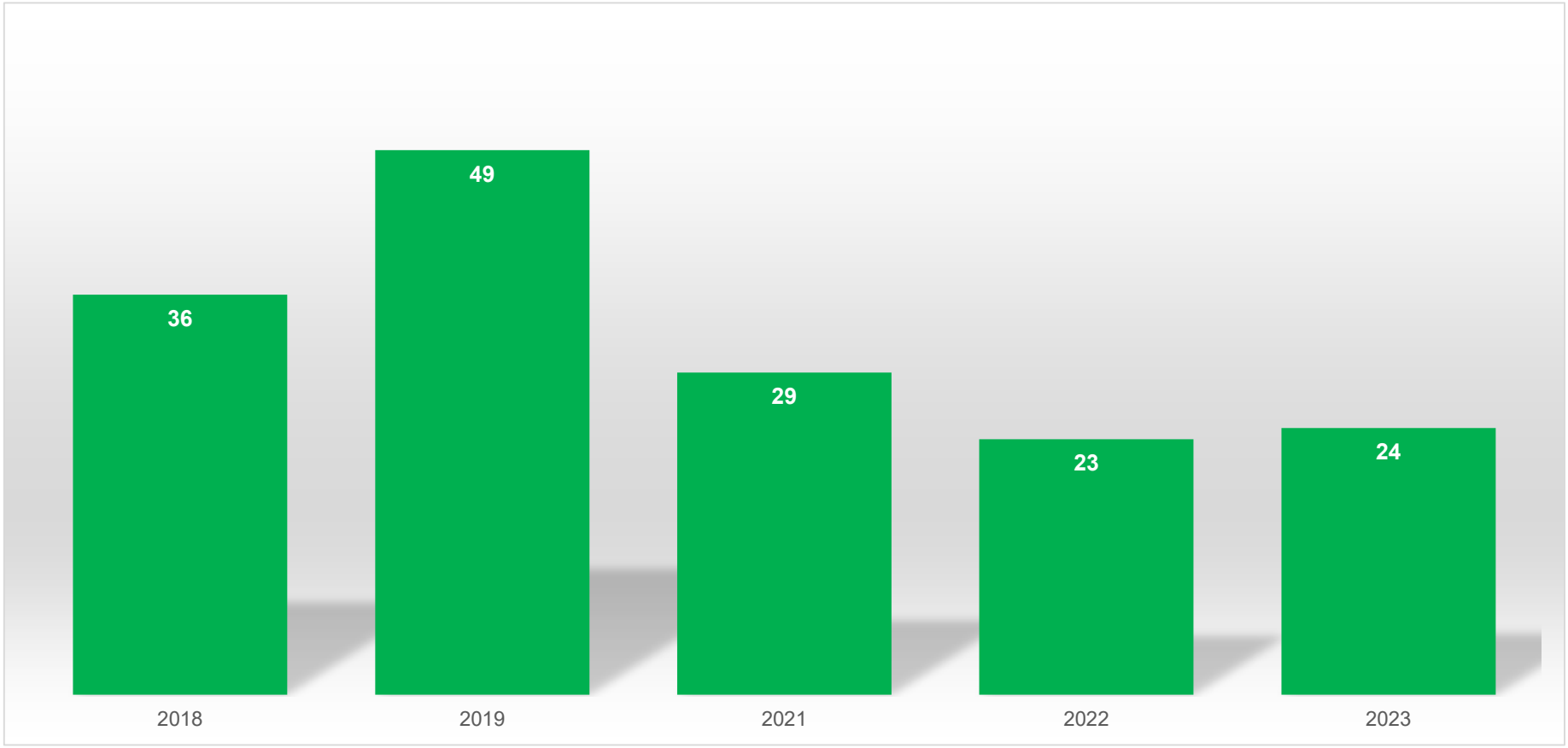


2023 Results

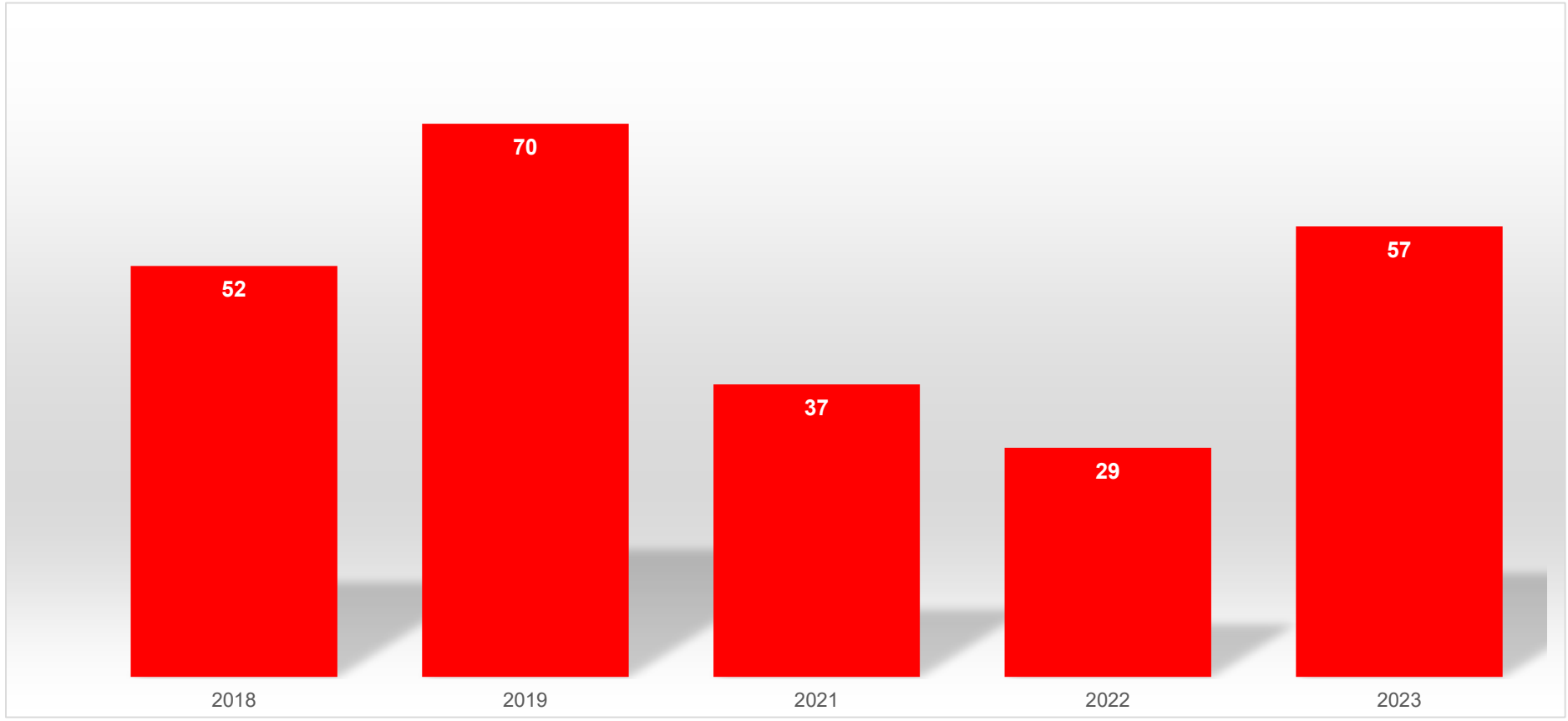
- Total Number or Red Outliers: 57
- Total Number of Green Outliers: 24



CUH Report Green Outliers 2018 - 2023



CUH Report Red Outliers 2018 - 2023



2022 GMC Survey Results

CUH – Red Flags by domain

Overall Satisfaction	1
Clinical Supervision	1
Clinical Supervision out of hours	
Reporting systems	1
Work Load	5
Teamwork	2
Handover	2
Supportive environment	2
Induction	
Adequate Experience	3

Curriculum Coverage	
Educational Governance	1
Educational Supervision	1
Feedback	
Local Teaching	2
Regional Teaching	4
Study Leave	1
Rota Design	3
Facilities	

2023 GMC Survey Results

CUH – Red Flags by domain

Overall Satisfaction	4
Clinical Supervision	3
Clinical Supervision out of hours	4
Reporting systems	1
Work Load	10
Teamwork	1
Handover	3
Supportive environment	4
Induction	2
Adequate Experience	3

Curriculum Coverage	
Educational Governance	2
Educational Supervision	1
Feedback	1
Local Teaching	1
Regional Teaching	8
Study Leave	4
Rota Design	4
Facilities	1

Specialties with 4 or more red outliers

2023

- **Obstetrics and gynaecology** - 21 Red outliers
  - 13 for GP Training
  - 8 for FY2 Training

- **Medical oncology (6) -** *Overall Satisfaction, Work Load, Teamwork, Supportive Environment, Adequate Experience, Regional Teaching*
- **Endocrinology and diabetes mellitus (5) –** *Educational Governance, Educational Supervision, Regional Teaching, Study Leave, Rota Design*
- **Gastroenterology (4) -** *Work Load, Regional Teaching, Study Leave, Rota Design*

2022

Only 1 specialty **Obstetrics and gynaecology (5)** *Overall Satisfaction, Adequate Experience, Educational Governance, Local Teaching, Rota Design*

Red outliers recurring in 2022 & 2023

Clinical radiology

- Clinical Supervision (red outlier continuously since at least 2019)
- Regional Teaching (red outlier continuously since at least 2019)

Endocrinology and diabetes mellitus

- Study Leave (re-occurring since 2021)

General Surgery

- Workload (re-occurring since 2021)

Neurosurgery

- Workload (red outlier continuously since at least 2019)

Medical microbiology

- Supportive Environment (re-occurring since 2022 – response date too low in previous years)

Ophthalmology

- Workload (re-occurring since 2022)

Why the sharp increase in red outliers?

- The 2022 GMC survey had a very low regional response rate – in part related to the change to being a non-mandatory survey since 2021.
- Hence for some specialty programs – eg Obstetrics and Gynecology for GP trainees and FY2 trainees, there was no report last year as there were less than 3 respondents in each category.
- However, there are clearly issues related to workload with red flags in this domain across 10 departments (18% of all Red flags).

Specialties with 3 or more green outliers

Course Surgical Training (CST) (5) - *Overall Satisfaction, Reporting Systems, Teamwork, Supportive Environment, Facilities*

Clinical Pharmacology and Therapeutics (3)

Reporting Systems, Rota Design, Facilities

Plastic Surgery (3)

Reporting Systems, Local Teaching, Facilities

Overall Satisfaction

- Achieved 1 Green Outlier for Overall Satisfaction for CST.
- 4 red outliers for Overall Satisfaction in Core Anaesthetics, GP program - Obstetrics and Gynaecology, F2 program Obstetrics and Gynaecology F2, and Medical oncology.
- For comparison, in 2022 we had 0 Green outliers for Overall Satisfaction and 1 Red for Obstetrics and Gynaecology.

Shelford Group – Red Outliers 2023

Rank	Trust	No. Red Outliers	Rank 2022	Movement
1st	University College London Hospitals NHS Foundation Trust	17	2nd	Up 1
2nd	King's College Hospital NHS Foundation Trust	21	7th	Up 5
3rd	Imperial College Healthcare NHS Trust	24	1st	Down 2
4th	Oxford University Hospitals NHS Foundation Trust	31	6th	Up 2
5th	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	32	3rd	Down 2
6th	Guy's and St Thomas' NHS Foundation Trust	47	4th	Down 2
7th	Manchester University NHS Foundation Trust	49	8th	Up 1
8th	Sheffield Teaching Hospitals NHS Foundation Trust	53	9th	Up 1
9th	**Cambridge University Hospitals NHS Foundation Trust**	**57**	**5th**	**Down 4**
10th	University Hospitals Birmingham NHS Foundation Trust	68	10th	No Change

Shelford Group – Green Outliers 2023

Rank	Trust	No. Green Outliers	Rank 2022	Movement
1st	University College London Hospitals NHS Foundation Trust	81	2nd	Up 1
2nd	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	59	1st	Down 1
3rd	Imperial College Healthcare NHS Trust	54	4th	Up 1
4th	Guy's and St Thomas' NHS Foundation Trust	49	3rd	Down 1
5th	Oxford University Hospitals NHS Foundation Trust	33	5th	No Change
6th	Manchester University NHS Foundation Trust	33	8th	Up 2
7th	King's College Hospital NHS Foundation Trust	30	7th	No Change
8th	University Hospitals Birmingham NHS Foundation Trust	29	6th	Down 2
9th	Sheffield Teaching Hospitals NHS Foundation Trust	27	9th	No Change
10th	**Cambridge University Hospitals NHS Foundation Trust**	**24**	**10th**	**No Change**

Shelford Group – Overall Satisfaction

No change in position for any trust

Rank	Trust / Board	2022 Score	2023 Score	2022 Rank	Rank Movement
1st	University College London Hospitals NHS Foundation Trust	82.76	82.79	1st	No Change
2nd	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	80.55	79.78	2nd	No Change
3rd	Imperial College Healthcare NHS Trust	80.07	79.59	3rd	No Change
4th	Guy's and St Thomas' NHS Foundation Trust	79.14	79.13	4th	No Change
5th	Cambridge University Hospitals NHS Foundation Trust	77.33	77.12	5th	No Change
6th	Oxford University Hospitals NHS Foundation Trust	76.56	76.50	6th	No Change
7th	King's College Hospital NHS Foundation Trust	75.75	76.12	7th	No Change
8th	Manchester University NHS Foundation Trust	74.81	75.91	8th	No Change
9th	Sheffield Teaching Hospitals NHS Foundation Trust	73.97	75.10	9th	No Change
10th	University Hospitals Birmingham NHS Foundation Trust	72.51	72.89	10th	No Change

Cambridge and Peterborough ICS & Shelford Group – Overall Satisfaction

2023 Rank	Trust / Board	Indicator	Score	2022 Rank	Movement
1st	University College London Hospitals NHS Foundation Trust	Overall Satisfaction	82.79	3rd	Up 2
2nd	Cambridgeshire Community Services NHS Trust	Overall Satisfaction	82.50	1st	Down 1
3rd	Cambridgeshire and Peterborough NHS Foundation Trust	Overall Satisfaction	80.87	2nd	Down 1
4th	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	Overall Satisfaction	79.78	4th	No Change
5th	Imperial College Healthcare NHS Trust	Overall Satisfaction	79.59	5th	No Change
6th	Guy's and St Thomas' NHS Foundation Trust	Overall Satisfaction	79.13	6th	No Change
7th	Cambridge University Hospitals NHS Foundation Trust	Overall Satisfaction	77.12	7th	No Change
8th	Oxford University Hospitals NHS Foundation Trust	Overall Satisfaction	76.50	8th	No Change
9th	North West Anglia NHS Foundation Trust	Overall Satisfaction	76.44	11th	Up 2
10th	King's College Hospital NHS Foundation Trust	Overall Satisfaction	76.12	9th	Down 1
11th	Manchester University NHS Foundation Trust	Overall Satisfaction	75.91	10th	Down 1
12th	Sheffield Teaching Hospitals NHS Foundation Trust	Overall Satisfaction	75.10	12th	No Change
13th	Royal Papworth Hospital NHS Foundation Trust	Overall Satisfaction	72.94	13th	No Change
14th	University Hospitals Birmingham NHS Foundation Trust	Overall Satisfaction	72.89	14th	No Change

Summary

1. Increasing number of red flags - most frequent indicator across departments is workload.

2. Falling number of green flags – despite reputation of trust as a very strong educational provider.

3. Overall satisfaction minimally changed over last 12 months.

Plan – strategic:

- Provision of effective simulation facilities to replace missed training opportunities.
- Development of Digital Health and Surgical Training Centre.
- Development of Telemedicine Training room.
- Educational Supervisor Training Program.
- Identify trainees (and trainers) at risk of burnout
  - Wellbeing support
  - Risk correlated with workload – align with workforce planning strategy.

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to Board of Directors: 8 November 2023

Agenda item	14
Title	Learning from Deaths Quarterly Report
Sponsoring executive director	Ashley Shaw, Medical Director
Authors	Amanda Cox, Deputy Medical Director Chris Edgley, Patient Safety Lead Lauren Lambert, Data Analyst
Purpose	For Information and discussion
Previously considered by	Management Executive, 2 November 2023

Executive Summary

Between July 2023 – September 2023 [Q2], there were 424 deaths; of these 18 [4%] were in the Emergency Department, the remainder were inpatient deaths.

- 15% [63/424] met the criteria for a Structured Judgement Review [SJR] during Q2.
- 2% [1/63] of the SJRs completed within Q2 identified significant problems in care [scores 1-3].

Between July 2023 and September 2023, there were three serious incident in relation to an unexpected/potentially avoidable death reported to the commissioners. There have been no Prevention of Future Deaths ordered between July 2023 and September 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 Q2.

Cambridge University Hospitals NHS Foundation Trust

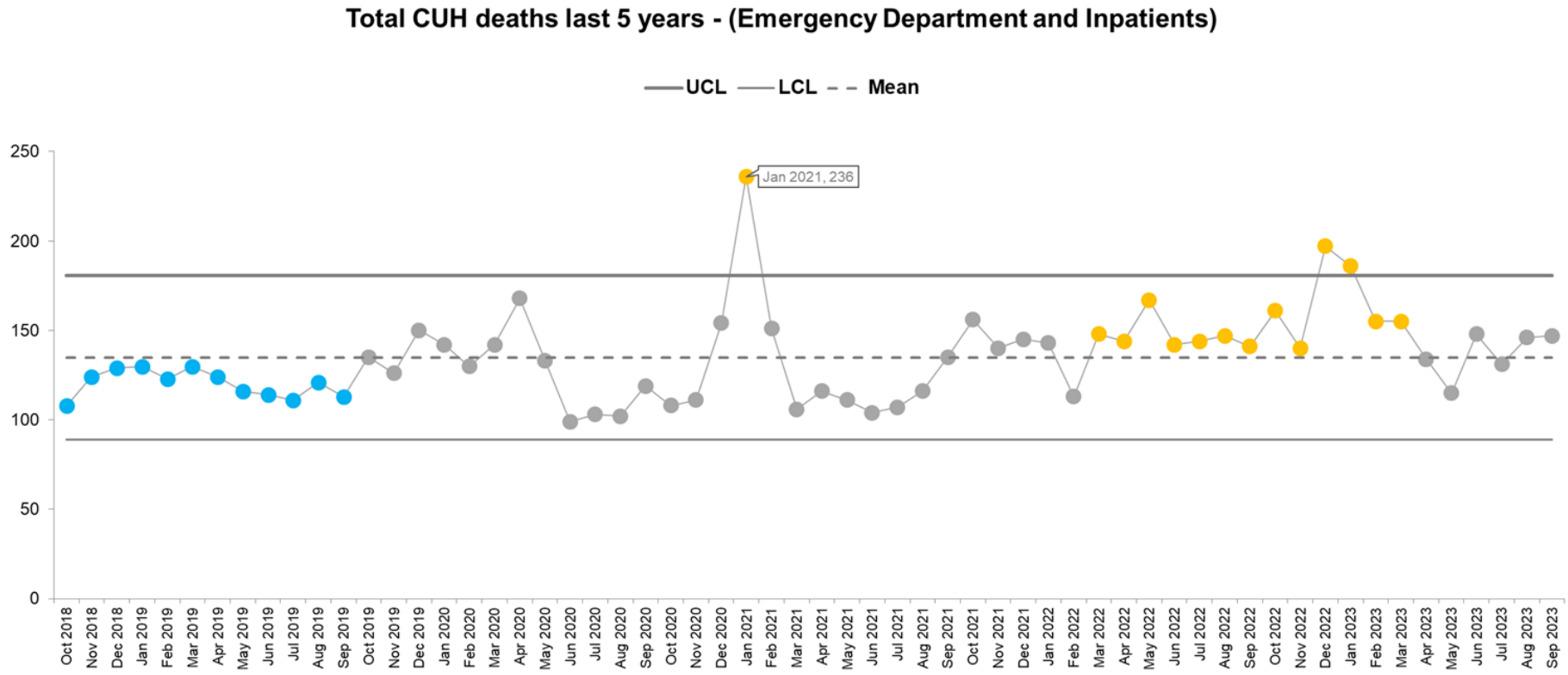
8 November 2023

Board of Directors
Learning from Deaths Quarterly Report

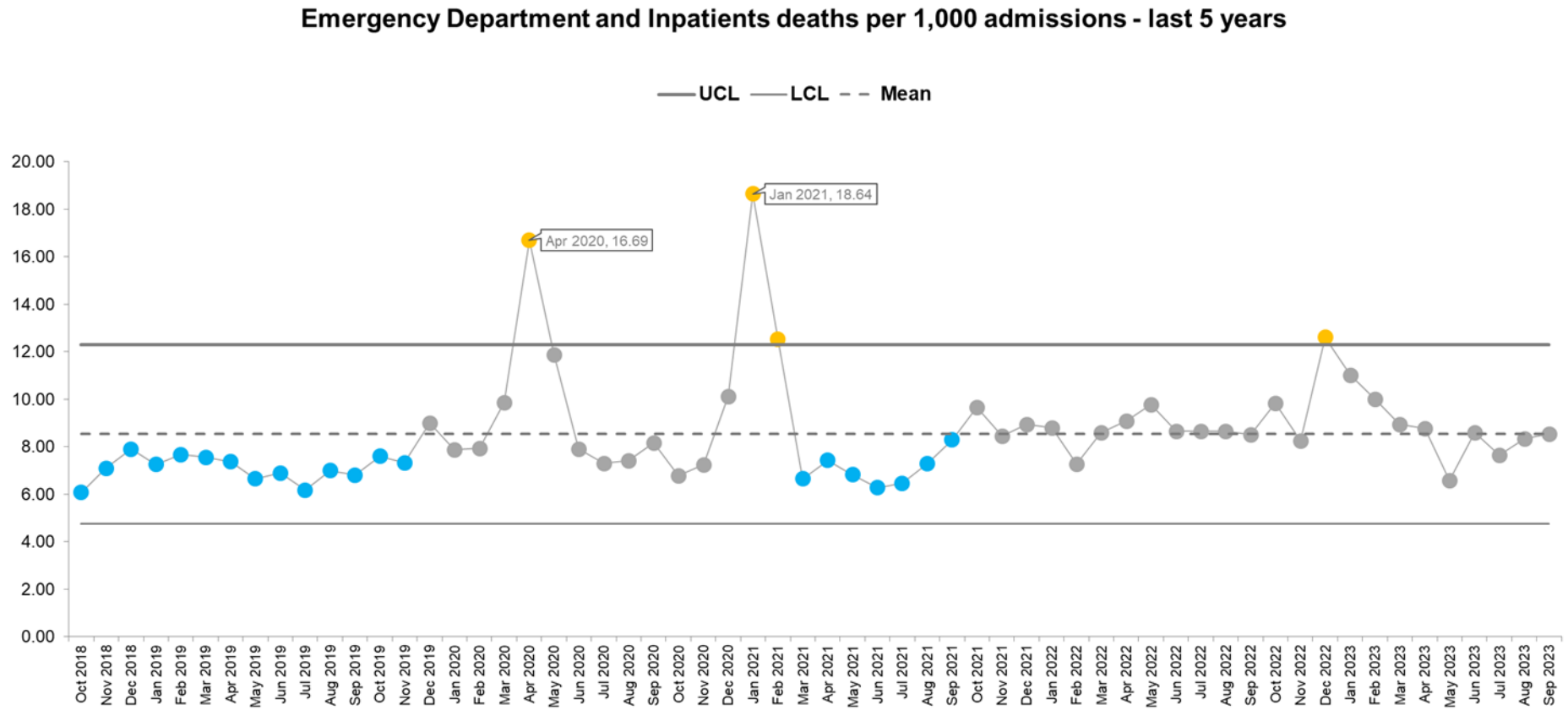
1. Number of deaths in Quarter

There were 424 deaths between July 2023 and September 2023 [Q2] [Emergency Department [ED] and inpatients], of which 4% [18/424] were in the ED and 96% [406/424] were inpatient deaths.

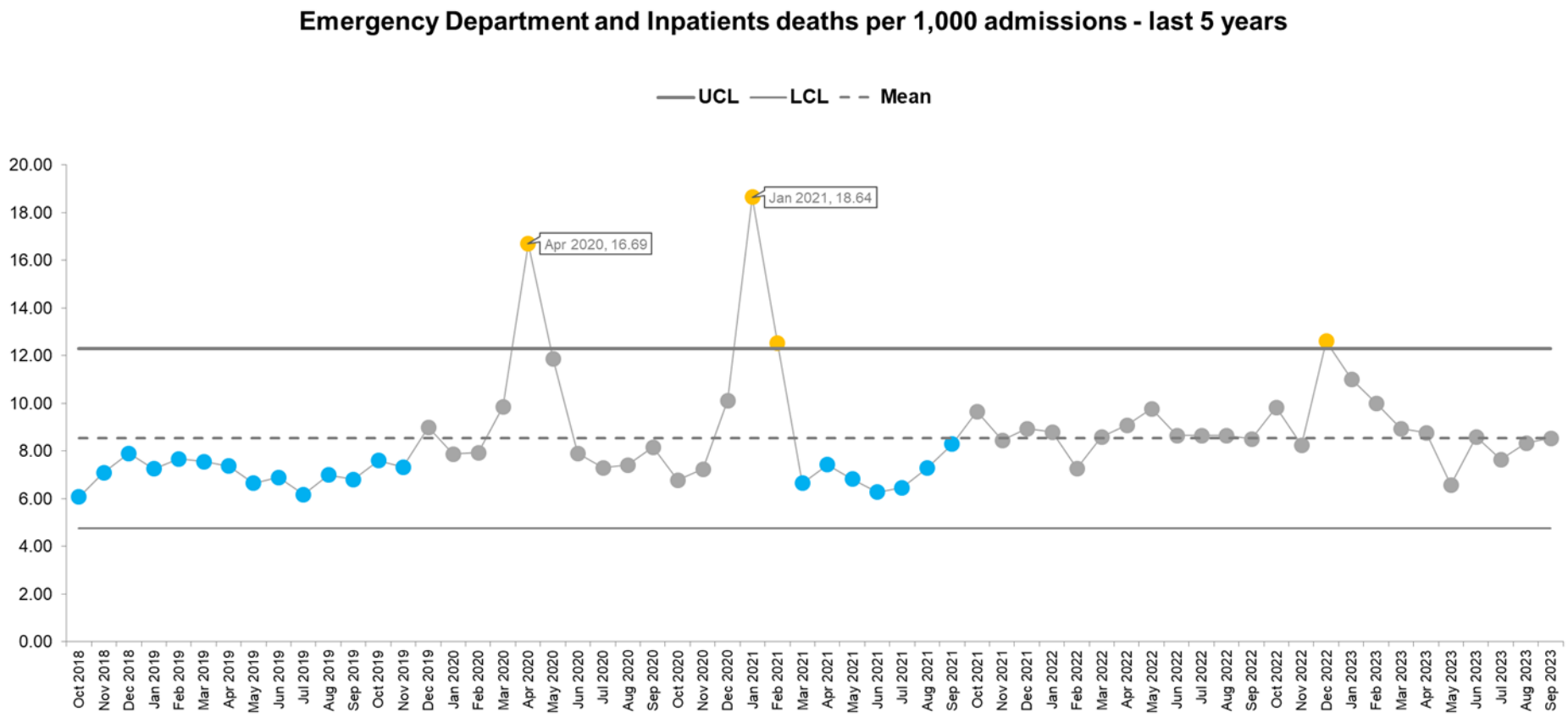
Graph 1 shows total CUH deaths [inpatients and ED] that have been recorded on Epic from Oct 2018 to September 2023



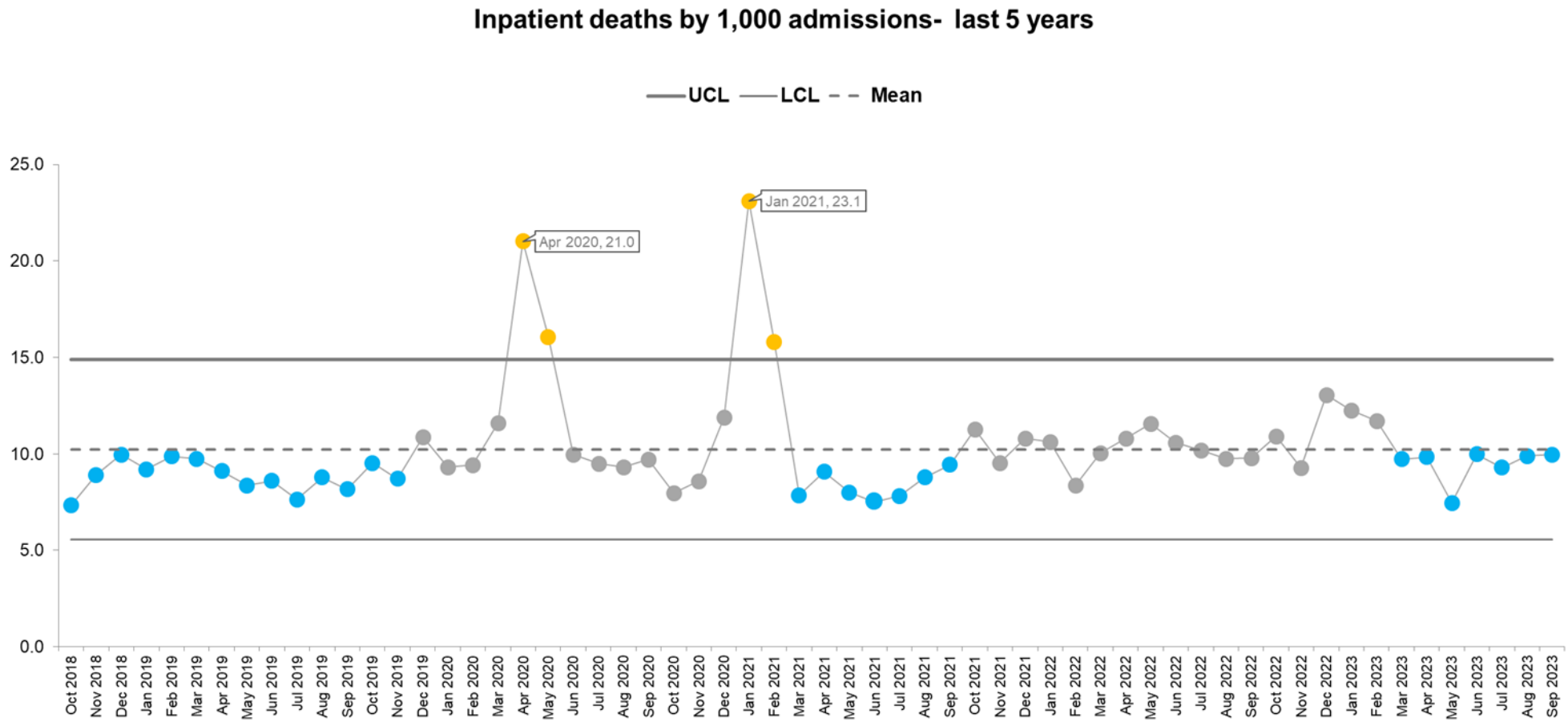
Graph 2 demonstrates total CUH deaths per 1,000 admissions that have been recorded on Epic from October 2018 to September 2023.



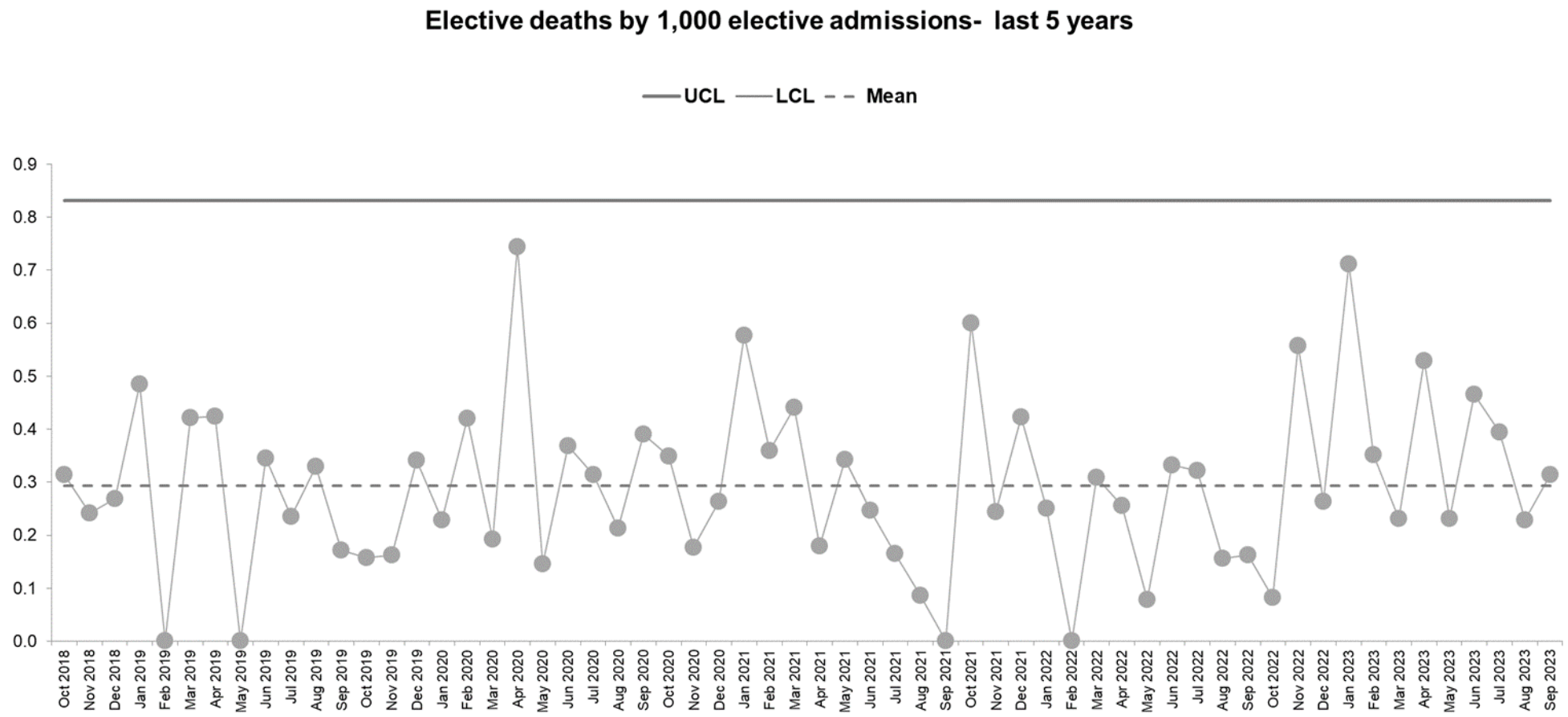
Graph 3 shows Emergency Department deaths per 1000 Emergency Department admissions from October 2018 to September 2023.



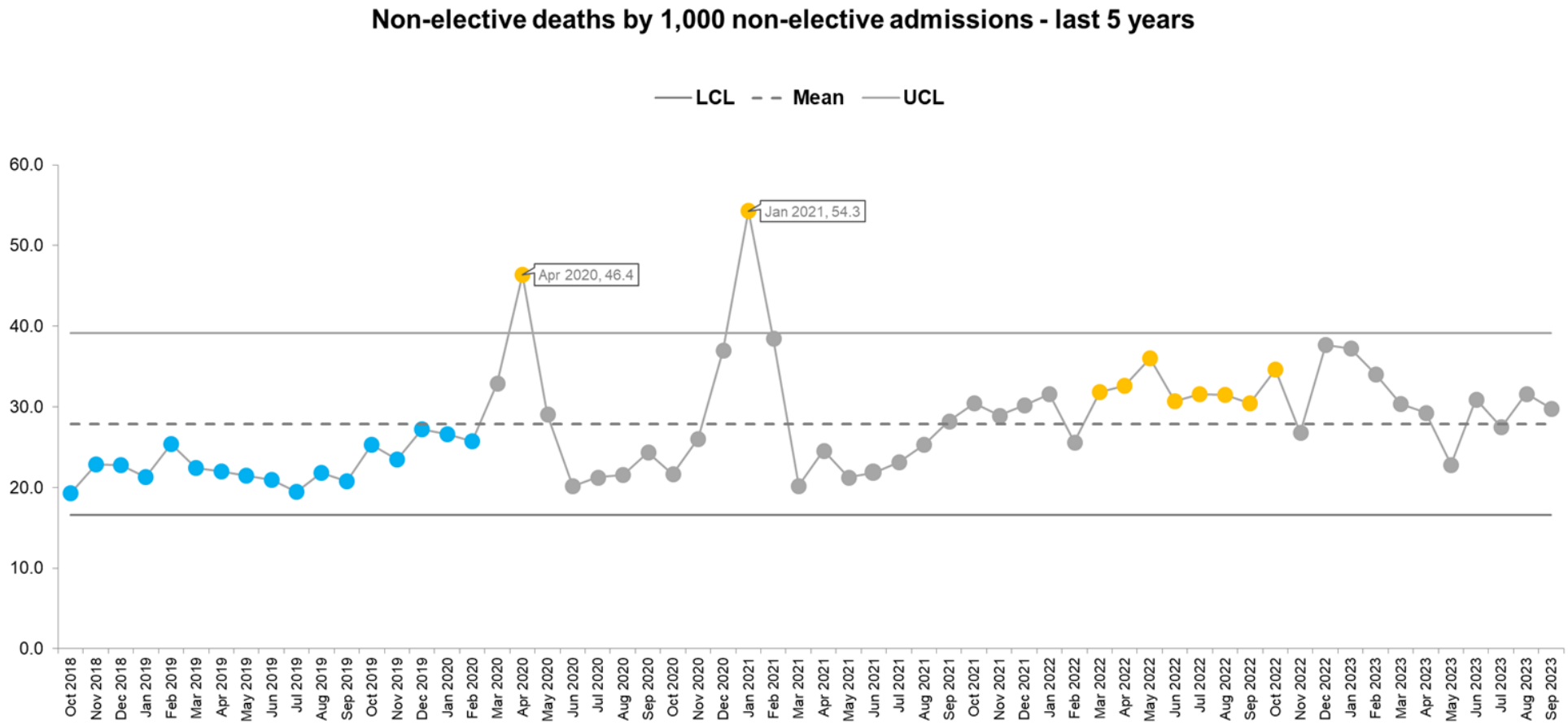
Graph 4 shows inpatient deaths per 1000 inpatient admissions from October 2018 to September 2023.



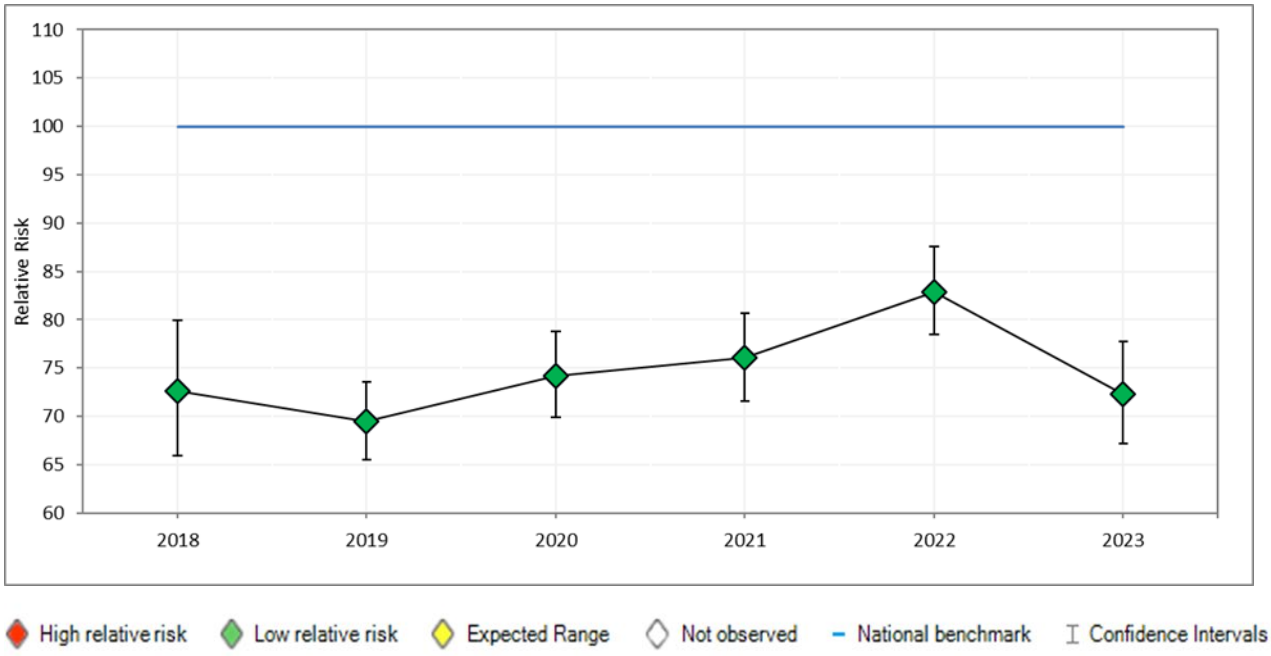
Graph 4a shows inpatient elective admission deaths by 1000 elective admissions, from October 2018 to September 2023. There is currently normal variation in the number of inpatient elective admission deaths.



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 May 2018 to April 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 Q2 of 2023-2024 financial year

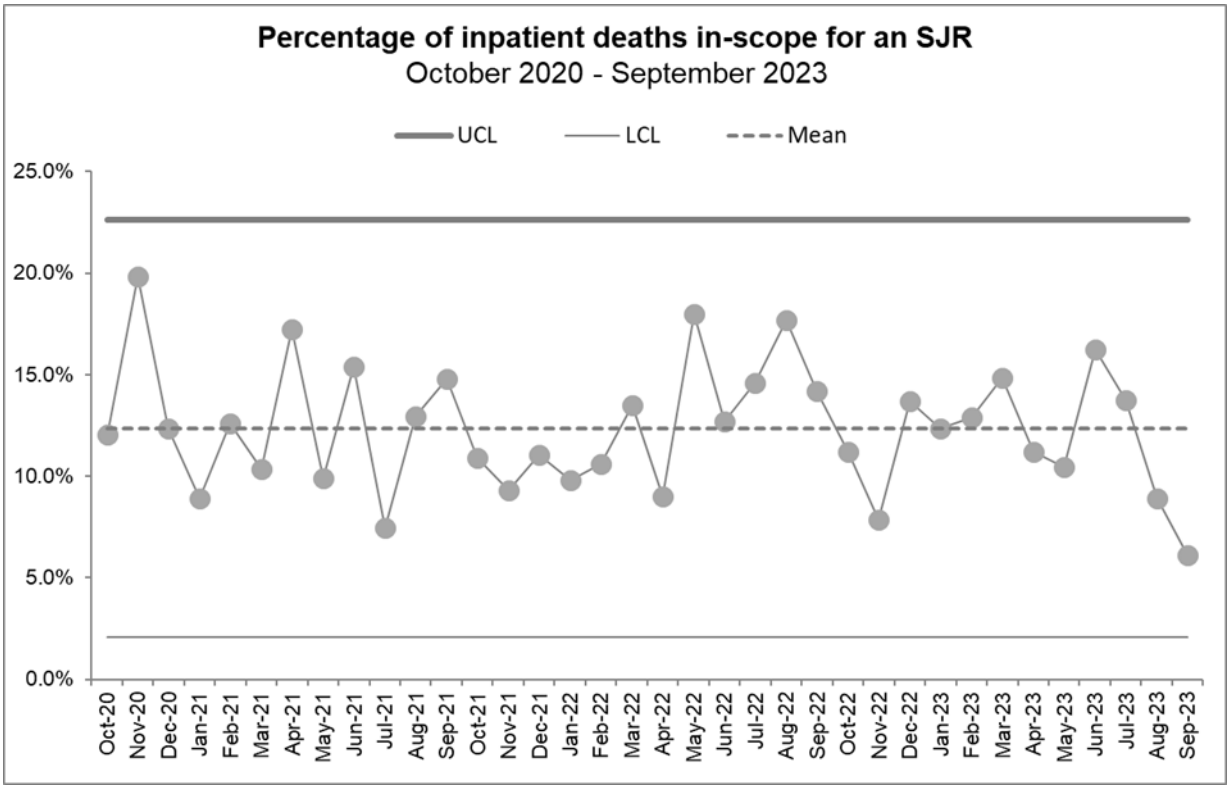
Learning from deaths summary												
KPI	No. of deaths in month	No. of deaths in-scope	Compliance with SJRs		Problems in Care Identified [score 1-3]	Serious Incidents triggered by SJRs	% of problems in care (by deaths 'in scope')		% of all deaths with problems in care (by total deaths in month)		SJRs triggered by family/ carers	SJR training compliance	PFD issued to CUH
			Number received	Number due			Month	Quarter	Month	Quarter			
Jul-23	131	23	39% 9 23		0	1	0% 0 9	4% 1 25	0% 0 131	0% 1 424	1	44% 4 9	0
Aug-23	146	21	33% 7 21		1	1	14% 1 7		1% 1 146		0	100% 7 7	0
Sep-23	147	19	47% 9 19		0	1	0% 0 9		0% 0 147		0	111% 10 9	0

3. Structured judgement review [SJR] compliance

3.1. Deaths in-scope

Between July 2023 and September 2023, 15% [63/424] 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 Oct 2020 to September 2023. There is currently normal variation.



Of the 63 in-scope deaths identified in Q2, 40% of SJRs [25/63] have been completed to date.

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

4.1. SI investigations commissioned between July 2023 – September 2023

There have been three SI commissioned in relation to an unexpected death between July and September 2023.

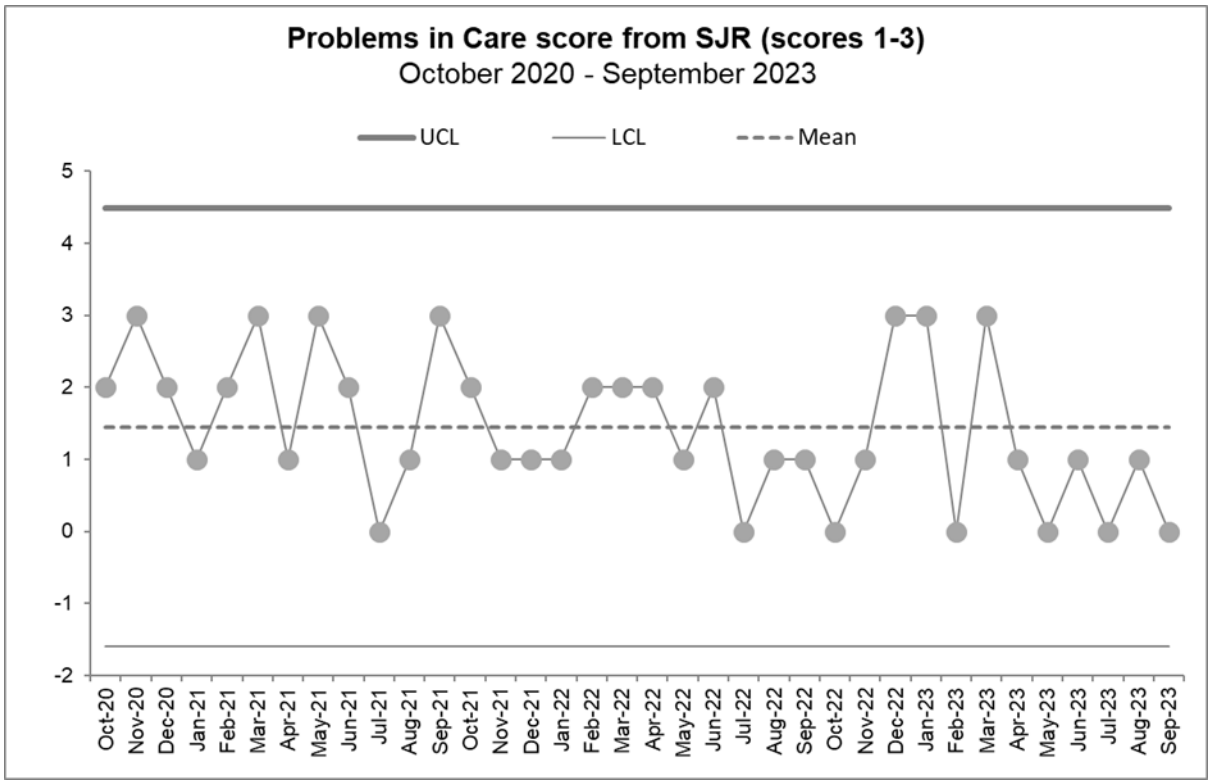
4.2. Structure Judgement Review problems in care scores

One SJR has highlighted less than satisfactory care between July 2023 and September 2023. A secondary review of the SJR is currently being undertaken by another speciality before deciding in the level of investigation required. 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 July 2023 - September 2023 is 2% [1/63]. 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.*
Jul-23	0	0	0	0	2	4
Aug-23	0	0	1	0	4	3
Sep-23	0	0	0	1	7	2

Graph 7 shows the number of SJRs with problems in care score of 1-3 from October 2020 to September 2023. There is currently normal variation.



5. Structured judgement reviews triggered by family/carers

There were no SJRs initiated by family/carers concerns between July 2023 and September 2023.

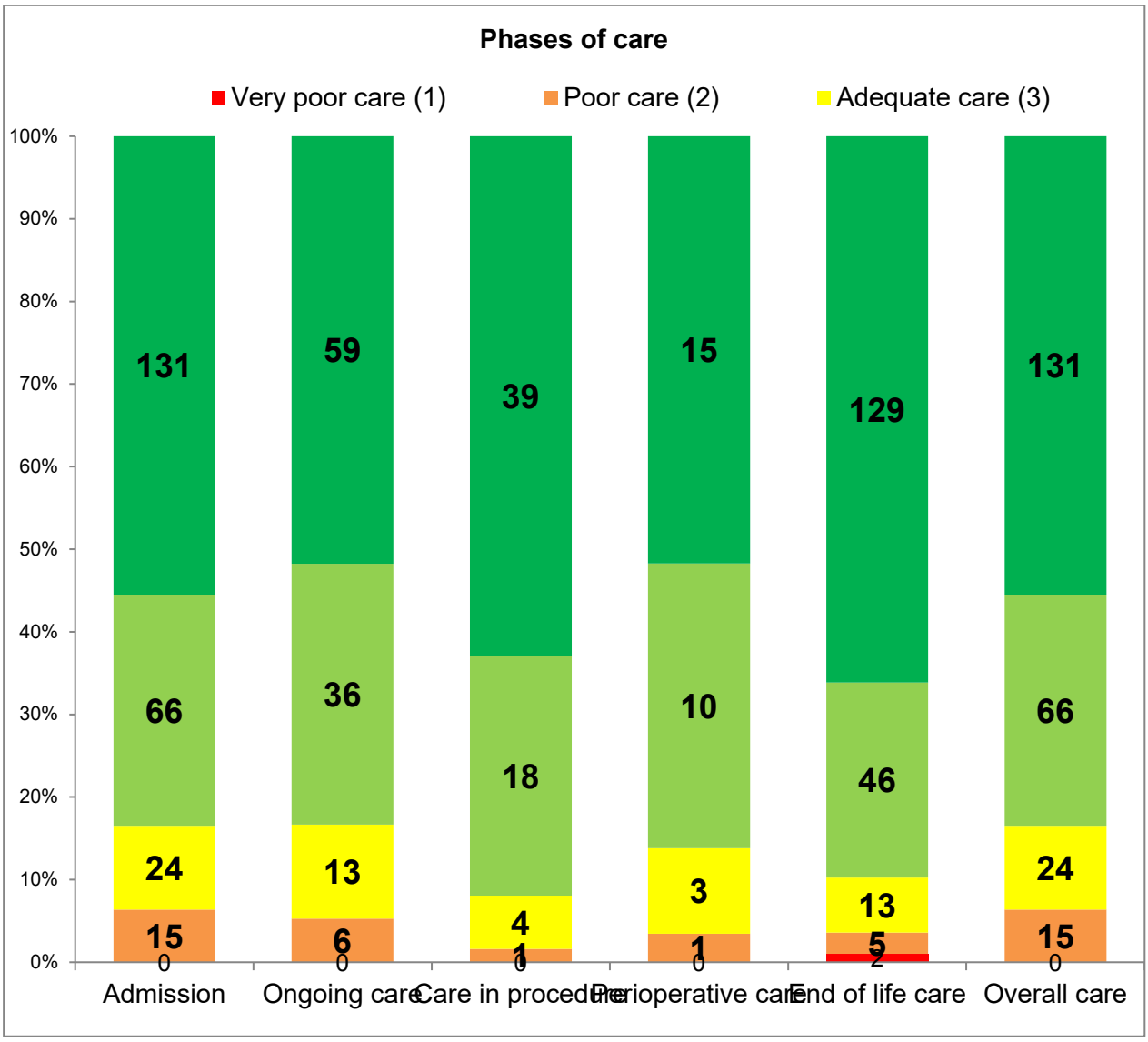
6. Prevention of future death reports issued to Cambridge University Hospitals

There have been no Prevent Future Death reports issued to CUH in this quarter.

7. Learning

7.1. Learning from phases of care

Scores allocated to each of the phases of care are displayed in the graph below for all completed SJRs between October 2022 to September 2023:



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

8. Learning from deaths improvement plan:

The Learning From Deaths Quality Improvement Group meets on a monthly. The current focus of the group is digitalising the SJR process (QSIS/Datix) and reviewing what extra information can be extracted through this process.

Board of Directors

NHS
Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 8 November 2023

Agenda item	15
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, 26 October 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 September 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 26 October 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, including the reduction in BAF risk 007 from 20 to 16.

Cambridge University Hospitals NHS Foundation Trust

8 November 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 September 2023).

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 October 2023 version of the BAF is attached at Appendix 2. It incorporates updates from monthly reviews undertaken since the last report to the Board in September 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. From this month, the separate Strategy Update report (agenda item 11) describes key milestones for the strategic commitments over the next three years. Going forward, these will be used to support discussion and development of the medium-term risk trajectories in the BAF. In addition, as requested by the Performance Committee, a combined presentation of the BAF medium-term risk trajectories will be developed for future reports.

2.5 In terms of key amendments to individual BAF risks during this two-month period, the following are highlighted:

September 2023

- The Board oversight committee for BAF risks 010, 012 and 014 has been amended to be the new Addenbrooke's Futures Committee; and the Addenbrooke's Futures Committee has been added along with the Performance Committee as the Board oversight committee for BAF risk 009.

- 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 in the next two months.

- Further consideration has been given as to whether the impact of ongoing industrial action should be included as a separate BAF risk. The following points have been taken into consideration in these discussions:
    - The direct impacts of industrial action on patient flow, waiting lists, staffing and finances in particular are already covered on the CRR (risk CR57) and through individual risks on the BAF.
    - A separate BAF risk could seek to capture the potential wider impact of ongoing industrial action on the Trust's ability to plan more broadly and progress its strategic agenda.
    - The latter could become an increasing challenge as action continues through the winter, but 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.

On balance, the view from discussions as part of the monthly BAF reviews and at the Risk Oversight Committee was not to add a separate BAF risk on the impact of industrial action.

October 2023

- Following discussion at the Performance Committee meeting in early October 2023, the Risk Oversight Committee reviewed continued progress in relation to staff recruitment and retention. It noted that the risk is currently rated as 20 (I4xL5) and was increased to this level (from a rating of 16) in October 2020 to reflect the more challenging recruitment pipeline at that time, particularly for international recruitment, and wider labour market uncertainty.

  While there remain key hotspot areas (e.g. Allied Health Professionals), plans have been developed and are being implemented to help address these. And overall, the recruitment pipeline is judged to have returned to its pre-pandemic strength with headcount growth of 4% over the past 12 months and 7% over the past 24 months. The overall staff vacancy rate has now fallen to around 9%. Recent months have seen the nursing and midwifery and Healthcare Assistant vacancy rates running at levels close to those at the start of the pandemic.

  In relation to retention, overall staff turnover was running at around 12-13%. It fell during the pandemic and then rose to around 15% in summer 2022, but has now reduced to around pre-pandemic levels.

- On this basis, the Risk Oversight Committee agreed that the current risk rating should be reduced to I4xL4=16 from November 2023, and that the forward risk trajectory and key milestones should be reviewed accordingly.

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 – *proposed reduction to 16 from November 2023)*
- 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)

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 43 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, including the reduction in BAF risk 007 from 20 to 16.

Appendix 1: Corporate Risk Register summary, October 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)	Aug-23	Sept-23	Oct-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 the 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 Addenbrooke's Treatment Centre	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	Retaining staff due in part 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)	Aug-23	Sept-23	Oct-23
CR60	Demand and substantive staff in Patient Advice and Liaison Service and Complaints Department	Responsive	Chief Nurse	Quality	4x5=20 (Red)	**4x4=16** (Red)	4x3=12 (Amber)	Same	Same	**Decreased**
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)	**4x5=20 (Red)**	4x2=8 (Amber)	Same	**Increased**	**Same**
CR29	Imaging reporting backlog	Responsive	Chief Operating Officer	Performance	4x5=20 (Red)	**4x3=12 (Amber)**	4x1=4 (Yellow)	Same	**Decreased**	**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)	Same	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**
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

CRR Ref	Title	CQC Domain	Executive Director	Assurance Committee	Inherent rating (C x L)	Current rating (C x L)	Target rating (C x L)	Aug-23	Sept-23	Oct-23
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 a suitably skilled workforce	Well-led	Director of Workforce	Workforce	3x5=15 (Red)	3x4=12 (Amber)	3x2=6 (Yellow)	Same	Same	**Same**
CR20	Expansion of the Cambridge Biomedical Campus impacting access to and from the Campus	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

CRR Ref	Title	CQC Domain	Executive Director	Assurance Committee	Inherent rating (C x L)	Current rating (C x L)	Target rating (C x L)	Aug-23	Sept-23	Oct-23
CR43c	Insufficient midwifery staffing across Maternity Services	Safe	Chief Nurse	Quality	4x5=20 (Red)	4x3=12 (Amber)	4x2=8 (Amber)	Decreased	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	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)	Same	Same	**Same**
CR25	Compliance with the Accessible Information Standard	Safe	Chief Nurse	Quality	4x5=20 (Red)	3x3=9 (Amber)	3x2=6 (Yellow)	Same	Same	**Same**
CR32	Cyber security protection	Safe	Director of Innovation, Digital and Improvement	Audit	5x3=15 (Red)	4x2=8 (Amber)	4x1=4 (Yellow)	Same	Same	Same

Cambridge University Hospitals NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust
Board Assurance Framework: October 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 and industrial action, 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	Performance Committee/ Addenbrooke's Futures
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	Addenbrooke's Futures
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	Addenbrooke's Futures
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	Addenbrooke's Futures

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	October 2023

Lead Executive	Chief Operating Officer
Board monitoring committee	Performance, Quality

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	4	5	20
Current (Oct 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 April 2024.
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 initiatives to reduce UEC demand.

Assurances on controls

How do we gain assurance that the controls are working?

1. Reporting to Management Executive (ME), Urgent and Emergency Care (UEC) Oversight 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.

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	Actions to address gaps in controls and assurances	Due date
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 – Cambridge Movement Surgical Hub. 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.		C1. Review of Accountability Framework by Director of Operational Strategy with outcome to Management Executive (ME) and Performance Committee (PC). C2. Recruitment plan being implemented in phases. C3a: Construction in progress with reporting to ME and PC. Bed reconfiguration plan being developed by Capacity and Configuration Group. C3b: Theatre construction works and recruitment. C3c: Available following fire improvement works to A Block. C3d: Works to proceed pending relocation of Orthotics and Prosthetics. C4. Urgent Community Response Programme being coordinated by ICB and reported to the System Resilience Group on a monthly basis.	December 2023 December 2023 December 2023 November 2023 April 2024 February 2025 Ongoing

Risk score	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 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 (Oct 23)	4x5=20	
~~January 2024~~ April 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 and industrial action, 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	October 2023

Lead Executive	Chief Nurse and Medical Director
Board monitoring committee	Quality

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	5	3	15
Current (Oct 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	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 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 (Oct 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	October 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 (Oct 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.
5. New prioritisation process agreed in October 2023 for Epic change requests, Telefonica Tech bespoke requests and non-Epic software deployment; benchmarking of prioritisation process with Johns Hopkins.

Deployment

6. Telefonica Tech transformation programme.
7. Implementation plan for Digital Strategy in development.
8. 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, including for the New Hospital projects and strategic partnerships. **Deployment** C2. New Digital Board to be put in place. C3. Implementation plan for Digital Strategy. C4. Establishment of methodology for the definition and tracking of benefits of IT investments. C5. Corporate oversight and assurance of key IT risks within federated IT model.	

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.	March 2024
Deployment C2. Implementation of new Digital Board assuring Digital Strategy implementation plan.	January 2024
C3. Development of Digital Strategy implementation plan.	April 2024
C4. Develop, agree and embed benefits definition methodology and tracking approach.	April 2024
C5. Inclusion of approach within Digital Board terms of reference and through appropriate membership of Digital Board (i.e. Finance, Estates, etc.)	April 2024

Risk score	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23
	16	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 (Oct 23)	**4x4=16**	
June 2024	**4x3=12**	Successful implementation of new Digital Board, agreement of Digital Strategy implementation plan and agreed approach to benefits tracking.

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	October 2023

Lead Executive	Chief Nurse and Medical Director
Board monitoring committee	Quality

Risk rating	Impact	Likelihood	Total
Initial (Nov 22)	4	3	12
Current (Oct 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) – CUH PSIRF Policy and Plan approved by Board in September 2023.
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. Implementation of PSIRF. C2. Lack of bandwidth across a range of staff groups to focus on quality improvement programmes. C3. Development and implementation of CUH Patient and Public Involvement (PPI) Strategy.	

Actions to address gaps in controls and assurances	Due date
C1. Mandatory and role-specific PSIRF training being undertaken ahead of ICS-agreed transition date. C2. Ongoing recruitment programme to seek to fill vacancies to establishment. C3a. Further work on PPI Strategy for ME and Board approval. C3b. Identification of resourcing requirements for implementation of Strategy.	January 2024 November 2023 December 2023

Risk score	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23
	12												
	Risk reformulated in November 2022 to reflect strategy refresh	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**

BAF 004: Risk trajectory

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Oct 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	October 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 (Oct 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).
7. Access negotiated with local managers for ongoing servicing, maintenance

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.

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	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 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 (Oct 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	October 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 (Oct 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 – full compliance achieved by end of September 2023 and reported to Board of Directors in October 2023.
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 escalated 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. 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. Ongoing programme with agreed timelines, tracking and reporting to CFRS and Board of Directors.	C1. End November 2023 C2. November 2023 C3. End 2027

Risk score	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 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 (Oct 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	October 2023

Lead Executive	Director of Workforce
Board monitoring committee	Workforce and Education

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	4	4	16
Current (Oct 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. October 2023

Risk score	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 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 (Oct 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	October 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 (Oct 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. Active Staff Networks – REACH, LGBTQ+, Purple and Open Minds.
6. Health Inequalities Operations Group established.
7. Interim Director of EDI appointed and in post from March 2023 to undertake EDI diagnostic and support development of EDI Strategy and Plan.

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
C1a. Comprehensive assessment of EDI work across CUH. C1b. Overarching EDI Strategy and Plan to be agreed, including to deliver NHS EDI Improvement Plan and High Impact Actions. C2. Implementation of EDI Strategy and Plan.	

Actions to address gaps in controls and assurances	Due date
C1a. Undertake EDI and health inequalities diagnostic assessment. C1b. Strategy Group to develop draft for Board approval. C2. Interim EDI Director to work with partners internally and externally on implementation on first phase of EDI Plan.	March 2024 Ongoing

Risk score	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23
	Risk reframed in January 2023			**16**	**16**	**16**	**16**	**16**	**16**	**16**	**16**	**16**	**16**

BAF 008: Risk trajectory

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Oct 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	October 2023

Lead Executive	Director of Strategy and Major Projects
Board monitoring committee	Addenbrooke's Futures/ Performance

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	3	4	12
Current (Oct 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 Futures 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. Planning application ongoing.
7. Approval in principle for CCH OBC, with national support for scheme provided by Joint Investment Committee (JIC) in September 2023.

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 Futures Committee.
3. Addenbrooke's Futures 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.
7. Green rating for CCH Gateway Review.
8. CCH will be subject to a further capital availability check in April 2024.

Further affordability check planned for April 2024. 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	Actions to address gaps in controls and assurances	Due date
C1. Impact of high rates of inflation on development costs for new hospitals.		C1. Ongoing discussions with NHP team on funding issues.	Ongoing
C2. Within CCH and CCRH, a preferred form of legal relationship has been indicated by the CUH Board. Initial progress with the University of Cambridge on an outline agreement, regarding the determination of risk premia and cost allocation, has been good but further work is required.		C2. Detailed legal work ongoing with University of Cambridge to develop the outline agreement into a final allocation of cost and risk for Board review ahead of FBC submission.	February 2024 April 2024
C3. While clearance for CCH has been provided for enabling works, a further capital affordability check is required by JIC in order to access the PDC funding in 2024/25 and enter into a commitment with a Principal Supply Chain Partner.		C3. Further work to support capital affordability check of the CCH by Joint Investment Committee.	Ongoing
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.		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.	October 2023
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.		C5. Revised governance arrangements agreed by CUH Board in October 2023 and to be implemented and embedded in period ahead, including appointment of Independent Chair of Construction Board and Board Adviser role.	January 2024

Risk score	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23
	16	16	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 (Oct 23)	**4x4=16**	
April 2024	**4x3=12**	CCRH FBC approved nationally and construction commenced. Positive outcome of CCH capital affordability check.
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	Lead Executive	Director of Strategy and Major Projects and Chief Operating Officer
Latest review date	October 2023	Board monitoring committee	Addenbrooke's Futures

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	*Risk reframed in Oct 20*		
Current (Oct 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. C6. Review opportunities and options for CUH to progress integrated care agenda at pace.		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. C6. Paper for discussion at Addenbrooke's Futures Committee.	December 2023 March 2024 December 2023 November 2023

Risk score	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 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 (Sep 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	October 2023

Lead Executive	Chief Finance Officer
Board monitoring committee	Performance

Risk rating	Impact	Likelihood	Total
Initial (Dec 20)	*Risk reframed in Dec 20*		
Current (Oct 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	Actions to address gaps in controls and assurances	Due date
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 is having an adverse impact on the Trust's financial performance in 2023/24 through higher pay spend and reduced income (due to lower activity volumes). National mitigations for the financial impact of industrial action have not been agreed for industrial action beyond April 2023. 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.		C1. Ongoing monitoring of risks and impact on the Trust and ICB financial plan. C2. Discussed by Management Executive, Performance Committee and Board in May 2023, with follow-up in September 2023. Programme of work in place to identify opportunities and areas of potential investment to improve underlying productivity and performance are being pursued. A financial strategy is in development to provide a clearer framework for decision making in relation to areas for investment to support productivity improvements (due November 2023) – see also C5. 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. C4. Risk identified in plan submission and discussed by Board in May 2023. Impact of industrial action monitored and quantified on a monthly basis. Representations made through the ICB, NHSE regional team and via the Shelford Group on the need for national support to mitigate the financial consequences of industrial action. C5a. Development of long-term financial strategy as part of the Trust-wide strategy, with circulation through governance groups in autumn 2023. C5b. ICB-led development of medium-term financial plan	Ongoing November 2023 Ongoing Ongoing November 2023 January 2024

		aligned to Trust business planning process. C6. Ongoing monitoring of risks through ICB CFO group, with reporting to Performance Committee.	Ongoing

Risk score	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23
	16	16	16	16	16	16	16	12	12	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 (Oct 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	October 2023

Lead Executive	Director of Strategy and Major Projects
Board monitoring committee	Addenbrooke's Futures

Risk rating	Impact	Likelihood	Total
Initial (Aug 20)	3	3	9
Current (Oct 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	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 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 (Oct 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	October 2023

Lead Executive	Director of Workforce
Board monitoring committee	Workforce and Education

Risk rating	Impact	Likelihood	Total
Initial (Apr 21)	4	4	16
Current (Oct 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 incorporated in Workforce Commitments.
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. Staff annual flu vaccination and Covid-19 booster vaccination programme underway since September 2023.
5. Established equality, diversity and inclusion networks and events promoting health and wellbeing.
6. Public health offer (lifestyle health checks, support and advice – smoking cessation, weight management).
7. 24/7 employee assistance programme (Health Assured) offering practical advice, counselling and support.
8. 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.
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	

Actions to address gaps in controls and assurances	Due date
C1. Management Executive has received and reviewed costed	Ongoing

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.		options, and Capital Advisory Board has allocated funding for initial schemes to be progressed. Initial schemes implemented and further ones being developed and implemented. C2. Development of further plans through 'Good Work' Group, including agreement of 2023/24 programme. C3. Undertake a series of Staff Listening Events with report to Management Executive on planned actions. C4. Work underway to produce and agree a suicide prevention policy and plan.	Ongoing November 2023 November 2023

Risk score	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 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 (Oct 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	October 2023

Lead Executive	Director of Innovation, Digital and Improvement
Board monitoring committee	Addenbrooke's Futures

Risk rating	Impact	Likelihood	Total
Initial (Oct 22)	4	3	12
Current (Oct 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
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 on participation in governance forums, both now and after full delegation of specialised commissioning in April 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.	March 2024 October 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.	October 2023 March 2024

Risk score	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23
	12	12	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 (Oct 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	October 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 (Oct 23)	**4**	**4**	**16**

Change since last month
⟺

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. C2. E-learning package for environmental sustainability. C3. Programme underway. C4. Ongoing work to align corporate policies. C5. Ensure detailed sustainability input to all refurbishments and new schemes.	October 2023 September 2023 November 2023 Phase 1 scoped and delivered March 2024 Ongoing

Risk score	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23
	New risk added in March 2023					**16**	**16**	**16**	**16**	**16**	**16**	**16**	**16**

BAF 015: Risk trajectory – to follow

	Risk rating IxL	Key milestones/actions to deliver risk trajectory
Current (Sep 23)	**4x4=16**	
October 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

NHS
Cambridge University Hospitals
NHS Foundation Trust

CHAIR'S KEY ISSUES REPORT

ISSUES FOR REFERRAL / ESCALATION

ORIGINATING BOARD / COMMITTEE:	Performance Committee	**DATE OF MEETING:**	1 November 2023
CHAIR:	Annette Doherty	**LEAD EXECUTIVE DIRECTOR:**	Chief Operating Officer, Chief Finance Officer
RECEIVING BOARD / COMMITTEE:	Board of Directors, 8 November 2023		

AGENDA ITEM	DETAILS OF ISSUE	FOR APPROVAL / ESCALATION / ALERT/ ASSURANCE / INFORMATION?	CORPORATE RISK REGISTER / BAF REFERENCE	PAPER ATTACHED (Y/N)
5	**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 was a detailed discussion of the risks for which the committee has an oversight role. There had been no significant changes in month. 3. It was suggested that an additional line should be added to the BAF to track the record of delivery against risk trajectories forecasted so that PC can track whether risk mitigations put in place are having an impact on the risk score	For information	All CRR and BAF risks	N
6	**Implementation plan for medium-term strategy - performance and improvement** 1. While the position currently showed a shortfall of £1.7m on efficiency at £24m ytd, the expectation is that the Trust will meet its productivity and efficiency target by year end.	For information	All BAF risks	N

	2. All divisions were being asked to focus on recurrent rather than non-recurrent schemes to deliver the efficiency plan to ensure the Trust is in a good position at the beginning of 2024/25. The Chair requested a deep dive into Division C productivity and efficiency progress and plans for a subsequent meeting. COO and Chair to agree timing. 3. Mid-term implementation plan – the committee noted that good progress had been made with the strategy. Having been discussed at a high level for some time there was now a need for greater detail on how the plan was to be implemented. A timetable with key milestones to measure progress is required, focussing on the key strategic themes of improving bed capacity and transforming outpatient services. A more detailed plan for transforming outpatient services including progress made to date was requested for a subsequent PC meeting - timing TBD. 4. The importance of having a 5 year financial plan to reflect the vision of the strategy was discussed.			
7	**Draft financial strategy** 1. The committee received an update on the draft financial strategy which set out the context of the financial position and the challenges that the Trust will face over the next few years. Following input and comment from the committee the final version would be submitted to the Board in December. 2. The committee was supportive of the ambitious financial strategic plan and gave input for the next version including the cost base and key capital expenditure requirements, more detailed measurable KPIs and more specific timeframes.	For information	BAF 011	n/a
8 8.1	**Operational Performance** 1. The committee was updated on the current position. 2. Performance against the 4-hr standard in ED continued to decline and this was a cause for concern. This would continue to receive focus to resolve with an action plan developed.	For information	BAF 001	N

	3. Winter planning development had gone well and the emphasis would now be on implementation. 4. The report from the external review of ED had been received. This had highlighted a number of areas within the department that need to be addressed. The committee was informed of progress with measures being taken to resolve these issues which included investing in more clinical staff, improving rostering and refining models of care. The committee would continue to be updated on the progress of the action plan.			
9	**Medical staffing plan for maternity** 1. The committee was updated on the actions being taken to resolve the medical staffing issue highlighted in the recent CQC report. A report had been commissioned to determine the appropriate staffing numbers at consultant and junior doctor levels. The final report is expected in January 2024. In the interim two new obstetric consultants had been appointed. 2. The response to the CQC maternity report was being monitored by the Quality Committee and further updates on the specific medical staffing issue would be brought to Performance Committee in due course.	For information	CR 43b	n/a
10 10.1	**Finance reports** 1. The committee received a report of the Month 6 financial position. 2. The Month 6 position was forecasting breakeven for the year. 3. Elective performance was down on 2019/20 levels but had made good progress throughout the year. This would continue to improve with the opening of new capacity. 4. The capital update for month 6 showed that spending was £4.8m ahead of plan. This was no cause for concern. 5. The £8.4m over commitment in the plan had been largely mitigated by slippage of £7.9m that had already been identified. There were no other risks for the committee to be aware of.	For information	BAF 011	N

11	**Capital Project Delivery reporting** 1. The committee received and noted an update from the Director of Capital, Estates and Facilities Management. 2. There were no new risks for escalation. 3. It was confirmed that the Movement Hub was ready to go live on 6 November.	For information	BAF 001, 002, 009	N

NHS
Cambridge University Hospitals
NHS Foundation Trust

CHAIR'S KEY ISSUES REPORT

ISSUES FOR REFERRAL / ESCALATION

ORIGINATING BOARD / COMMITTEE:	Quality Committee	**DATE OF MEETING:**	1 November 2023
CHAIR:	Sharon Peacock	**LEAD EXECUTIVE DIRECTOR:**	Chief Nurse / Medical Director
RECEIVING BOARD / COMMITTEE:	Board of Directors, 08 November 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 Deputy Chief Nurse and Medical Director presented the report to the committee. 2. Capacity and waits within the Emergency Department (ED) remained a concern with a 4% increase in attendances between August 2023 and September 2023. Despite this increase a reduction in patients waiting more than 12 hours in the department and an improvement in ambulance handovers had been seen. 3. The Hospital Standardised Mortality Ratio (HSMR) was 70 in June 2023, with a one year rolling average of 76.5. This is statically lower than expected and is the 6th lowest in the NHS. 4. The committee noted the ongoing work to manage seasonal infections over the winter. 5. The committee discussed Martha's rule. It was acknowledged that the government have been supportive of the measure but no guidance has been issued, Introduction of the rule would give patients and their families the right to a second care opinion.	Information/ Assurance	BAF 001, 004	N

	Adult inpatients - Currently CUH have a critical care outreach team (known as the Rapid Response Team) for adult inpatients. This team can be requested by physicians and senior nurses to evaluate patients that appear to be deteriorating rapidly. This team has been in place for several years and work has begun to allow for direct contact to the service by patients and families. Paediatric inpatients – CUH has 50 general paediatric beds split over a number of specialities. If staff are concerned that a patient is deteriorating they can contact the Acute Paediatric Consultant on-call or the Paediatric Intensive Care Unit (PICU) team for an assessment and extra support. The committee recognised the importance of culture when staff are seeking second opinions. Nurses and Junior Doctors need to feel comfortable and confident to seek a second opinion.			
5.2	Patient Safety and Experience Overview 1. The report covered the period up until the end of September 2023. 2. Normal variance in the amount of patient safety incidents had been reported. However, Division A and E both had statistical increases in reporting. 3. At the time of reporting, 11 Serious Incident investigations were open, six on track and five off track, with four overdue. An update was provided on the day of the meeting that a further three investigations had been closed since the report had been produced. 4. Hospital Acquired Pressure Ulcers (HAPUs) continued to increase, with Critical Care Units the highest location for HAPUs in September. 5. Falls were within normal variance. Recruitment to the falls team continued, with three additional vacancies approved an under the recruitment process.			

6. 6.1	**Maternity** Maternity Update 1. The committee noted the Core Competency Framework Version 2 Training Needs Analysis (TNA). 2. The Maternity Improvement Oversight Board (MIOB) has been established helping to oversee the maternity improvement work, with the first meeting due in November. 3. Gaps within the middle grade Obstetrician rota remained, with the requirement for consultants to continue to provide cover. Recent Consultant Obstetrician interviews had been successful with two offers made and accepted. 4. The maternity team continue to work on delivering against the CQCs one 'Must Do' and 12 'Should Do's'. 5. The committee also discussed Post-Partum Hemorrhage rates, the Saving Babies Lives Care Bundle and a Healthcare Safety Investigation Branch (HSIB) report.	Information/ Assurance	CR 05f, CR 43b, CR 43c	N
7.	**Patient and Public Involvement Framework** 1. The committee were provided with an oversight of the new Patient and Public Involvement Framework, which outlines the CUH approach to how we listen to and involve patients and the public. 2. The focus on including our diverse communities in developing services and research was highlighted. 3. The framework was co-produced with patients, staff and a number of external stakeholders through a series of workshops and surveys. 4. The framework has an emphasis on barriers and highlights plans to increase voices of those in harder to access communities. 5. The committee noted this would be an evolving piece of work and would require updating as time goes on.	Information/ Assurance	BAF 004, 010	N

8.	**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. 2. The committee discussed future meetings focusing on risks not frequently discussed e.g. medical devices.	Information/ Assurance	All CRR and BAF risks	N