Council of Governors

Cambridge University Hospitals
NHS Foundation Trust

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There will be a meeting of the Council of Governors on Wednesday 20 December 2023 at 17.30 in the Committee Room, School of Clinical Medicine, Addenbrooke's Hospital, Hills Road, Cambridge CB2 0QQ (and via videoconference)

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

AGENDA

General Business			Purpose
17.30	**1.**	**Welcome and apologies for absence**	For note
	2.	**Declarations of interest** Copies of the Register of Governors' interests are available from the Trust Secretariat	For note
17.35	**3.***	**Minutes of the previous meeting** To approve the minutes of the meeting held on 20 September 2023	For approval
	4.*	**Council of Governors action tracker and matters arising not covered by other items on the agenda**	For review
17.40	**5.***	**Composition of the Council of Governors** To receive the report of the Director of Corporate Affairs	For receipt
17.45	**6.***	**Chair's Report** To receive the report of the Trust Chair	For receipt

17.55	**7.***	**Chief Executive's Report (including Integrated Performance Report)** To receive the report of the Chief Executive	For receipt
18.45	**8.***	**Governors' Reports** **8.1 Lead Governor** To receive the report of the Lead Governor **8.2 Membership Engagement Strategy Implementation Group** To receive the report of the Group **8.3 Governors' Strategy Group** To receive the report of the Group	For receipt
Items for information			**Purpose**
18.55	**9.**	**Any other business** Items of any other business to be identified to the Secretary in advance of the meeting	For note
	10.	**Date of the next meeting** The next meeting of the Council of Governors will be on Wednesday 27 March 2024 at 17.00	
19.00	**11.**	**Close of meeting**	

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Minutes of the meeting of the Council of Governors held on Wednesday 20 September 2023 at 17.00 in Rooms 8 and 9, Deakin Centre, Addenbrooke's Hospital, Hills Road, Cambridge CB2 0QQ (and via videoconference)

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

John Clarkson	Partnership Governor (University of Cambridge)	X	
In attendance			
Mr D Abrams	Non-Executive Director		
Mr R Arora	External Auditor, Mazars LLP		
Mr J Clarke	Trust Secretary (Minutes)		
Dr A Doherty	Non-Executive Director		
Prof I Jacobs	Non-Executive Director		
Ms A Layne-Smith	Non-Executive Director		
Dr S Peacock	Non-Executive Director		
Mr R Sinker	Chief Executive		
Mr R Sivanandan	Non-Executive Director		
Mr I Walker	Director of Corporate Affairs		

22/23 Apologies for absence

Apologies for absence received from Governors are recorded in the attendance summary.

The Chair informed Governors that Will Watson had stepped down from his post as a Staff Governor. The Chair thanked Will for his work as a Staff Governor. The Chair also thanked Cllr Gerri Bird and Professor Dame Carol Black for their service as Partnership Governors and welcomed Cllr Susan van de Ven to the Council.

23/23 Declarations of Interest

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

24/23 Minutes of the previous meeting

The minutes of the meeting of the Council of Governors held on 28 June 2023 were approved as a true and accurate record.

25/23 Council of Governors action tracker and matters arising not covered by other items on the agenda

Received and noted: The action tracker.

26/23 Composition of the Council of Governors

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

Noted:

1. There had been a number of changes to the composition of the Council of Governors since the previous meeting in June 2023.
2. Will Watson had stood down as a Staff Governor and there was a separate paper on the agenda relating to the arrangements for filling the vacancy created.
3. Cambridgeshire County Council had confirmed on 29 June 2023 the appointment of Cllr Susan van de Ven as its Partnership Governor nominee for a period of 12 months, in succession to Cllr Gerri Bird.
4. The University Council had approved the re-appointment of Professor John Clarkson as its Partnership Governor nominee for the period from 1 September 2023 to 31 August 2026, in succession to Professor Dame Carol Black who had undertaken the role while Professor Clarkson was on sabbatical.

Agreed:

1. To note the changes to the composition of the Council of Governors since the previous meeting.

27/23 External Auditor's annual report

Rajesh Arora, External Auditor - Mazars LLP, presented the annual report of the External Auditor.

Noted:

1. On an annual basis, External Audit carried out an audit in accordance with the National Audit Office code of practice. The annual report summarised the work undertaken during 2022/23.
2. The audit report, issued on 29 June 2023, gave an unqualified opinion on the financial statements for the year ending 31 March 2023.
3. There were no significant weaknesses identified through the audit or inconsistencies between the content of the Trust's Annual Report and the auditor's internal knowledge of the Trust.
4. The audit required a value for money assessment to be undertaken which sought to test whether the Trust had made proper arrangements for securing economy, efficiency and effectiveness in the use of resources. No value for money concerns had been identified.
5. Four areas of risk were highlighted and an overview was provided of the actions taken to test and mitigate the risk exposure.

The following points were made in discussion:

1. Governors were given an overview of the financial challenge faced by the NHS nationally. There was a sizeable national deficit and

trusts were required to submit financial plans on the basis of a number of underlying assumptions. As additional funding opportunities arose, the Trust had been able to move from a position where a planned deficit was proposed to a break-even position at year end.
2. The current financial landscape presented significant challenges but, through the audit work, the auditors were assured by and supportive of the approach taken by the Trust to successfully achieve the outlined position.
3. The year-end financial position had been delivered with the deployment of some non-recurrent resources.
4. Work was ongoing to develop the Trust's approach to innovation and productivity which would be key for delivering the 2024/25 financial plan.
5. Through an internal audit report received during the year, assurance had been provided in relation to the internal financial controls in place, with the auditors noting that the CUH system was among the most robust they had observed. Despite this, the Trust would not be complacent and would continue to keep its financial control system under review.
6. Governors were informed that the key audit risks included in the report were standard risks which auditors would expect to identify as part of their audit work.

Agreed:
1. To receive the annual report of the External Auditors for 2022/23.
2. To thank Mazars LLP and the Audit Committee for their ongoing scrutiny and oversight of the Trust's financial governance arrangements and controls.

28/23 Chair's report

Received and noted: the Chair's report.

29/23 Chief Executive's Report (including Integrated Performance Report)

Roland Sinker, Chief Executive, presented the report.

Noted:
1. Governors were provided with an overview of the five areas of operational performance, as well as an update on the Trust strategy.
2. The operating context remained challenging, with increasing waiting lists, industrial impact and the impact on public

confidence in the NHS of cases such as the events at the Countess of Chester Hospital.

3. Operationally, the Trust continued to perform well relative to peers in the Shelford Group.
4. As part of the national focus on maternity services, the Care Quality Commission (CQC) had undertaken an inspection of the Trust's maternity services in May 2023. The inspection report had been published on 1 September 2023, with an overall rating of 'Requires Improvement'. The Well-led domain for maternity services was rated as 'Good' and the Trust's overall rating of 'Good' remained unchanged. A comprehensive maternity improvement plan was in place.
5. Financially the Trust remained in a strong position. There would need to be an enhanced focus on improving both organisational and system productivity to deliver the 2023/24 and 2024/25 financial plans.
6. The opening of the Cambridge Movement Surgical Hub remained on track.
7. The Trust continued to progress its plans under the Building for the Future strategic theme, including the development of the business cases for both the Cambridge Cancer Research Hospital and the Cambridge Children's Hospital.
8. While progress on integrated care was not as fast as the Trust would like, work continued with Integrated Care System partners and through the Cambridgeshire South Care Partnership to plan and implement pathway improvements.

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

1. *Both the Chair and Chief Executive's reports note the Lucy Letby case and provide reassurance in relation to monitoring processes within the organisation. Are the NEDs assured that staff know how to raise concerns and that they feel safe to do so? Is there assurance that the Freedom to Speak Up service is adequately promoted and resourced? One of the failings in this case was that multiple warnings were ignored and the trail of deaths continued as her case was reviewed and then dropped, and then finally reopened. What assurance do the NEDs have that staff disciplinary matters are dealt with quickly and that we don't currently have any long drawn out investigations that could bring risk to the hospital, either from issues over patient care, or from staff who may have been unfairly treated.*

   The following points were made in response:

- The verdict in the trial of Lucy Letby had been discussed at the Quality Committee and the Board of Directors in September 2023.
- The Quality Committee had received assurance in relation to processes within the Trust's Neonatal services. It had also discussed in this context the importance of the role of the Medical Examiner's Office and reporting to the Board of Directors on learning from deaths; the Trust's Freedom to Speak Up service; the Fit and Proper Person requirements; and the implementation of the Patient Safety Incident Response Framework.
- The Trust's Freedom to Speak Up Guardian had presented her six-monthly report to the Board in September 2023. The Trust continued to promote a culture of speaking up and raising concerns through a range of channels.

2. *In the light of the tragic case of Martha Mills, who developed an infection, then sepsis and was not referred to an appropriate ICU unit. She subsequently died. What assurance do NEDs have that the sepsis protocols at CUH would result in a different outcome for cases such as Martha and what is the current position in CUH for patients and their carers to ask for a second opinion?*

The following points were made in response:

- Ryan's rule was 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, they could call a phone line to obtain a second opinion. This was a state government initiative.
- The recent tragic case of Martha Mills at King's College Hospital, London had similar themes of missed Sepsis with fatal consequences. There were currently calls for a 'Martha's rule' in the UK.
- At CUH, a significant investment had been made 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 colleague at any time.
- Recently, the RRT Call 4 Concern 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 via a phone call) within 24 hours to address any ongoing concerns. This was currently scheduled for discussion at the Nursing and Midwifery Advisory Council meeting.

3. *Today sees industrial action by both consultants and junior doctors. Appointments and operations will have been cancelled and a "Christmas Day cover" has been promised by the unions. This clearly puts the hospital under extreme pressure, creates delays in patient care and may put patient safety at risk. Please could NEDs provide what assurance they can that the lessons from previous industrial action have been applied and that all steps have been taken to minimise the number of cancelled appointments and operations and that patients will not come to harm because of industrial action at CUH.*

   The following points were made in response:

   - There had been a sense of relative calm during the day. The Emergency Department had been fairly quiet earlier in the day but had got progressively busier.
   - Early indications were that most of the consultant workforce had chosen not to take industrial action but a large number of junior doctors had taken industrial action.
   - Decisions regarding appointment cancellations had been taken later than in previous periods of strike action, with the Trust seeking to maintain as much elective activity as possible.
   - The media had reported that negotiations had resumed between the Government and the British Medical Association in relation to the consultant dispute. The Shelford Group continued to urge both parties to reach a resolution as quickly as possible.

4. *How serious are the new Covid variants and what precautions, if any, are being put in place to safeguard patients and staff? Is it likely that mask-wearing will become compulsory again? Are staff members being offered boosters at the Deakin Centre?*

The following points were made in response:

- The Trust was not currently experiencing a significant number of patients requiring hospitalisation due to Covid-19.
- The staff flu vaccination programme had commenced and the staff Covid-19 vaccination programme would begin shortly. Both vaccination programmes would be available to Governors.
- The Trust continued to monitor data on Covid-19 cases and variants, with regular modelling meetings taking place.
- Through the ZOE Symptom tracker, there appeared to be a slow increase in the number of Covid-19 cases. There were a number of variants, with Pirola BA.2.86 receiving the greatest attention at present.

5. *The availability of water supplies is affecting the development of new housing around Cambridge. Is this also affecting the on-site construction projects such as CCRH, CCH, new accommodation, etc. and if this is a risk, are the NEDs assured that CUH is in dialogue with the appropriate authorities to develop measures to mitigate the risks?*

   The following points were made in response:

   - The Trust had recognised water supply as an issue the development of the CCRH.
   - Peter Freeman, who had been appointed by the Government as the Chair of the Cambridge Delivery Group and the national growth lead for Cambridge, had recently visited the Campus and discussed plans for the new hospitals and other developments.
   - There also remained challenges in relation to congestion and wider transport networks in the context of the development of the new hospitals.
   - Work continued to support the development of the Cambridge South Station and the East West Rail network. It was disappointing that plans to improve transport links to Haverhill would not be proceeding given the significant number of staff who travelled to work from that area.

Agreed:

1. To note the report.
2. That responses to other questions from Governors would be circulated separately following the meeting.

30/23 Governors' reports

Lead Governor

Neil Stutchbury, Lead Governor, presented the report.

Noted:

1. Three of the four lead governors within the Cambridgeshire and Peterborough Integrated Care System (ICS) had met with the Chair of the Integrated Care Board in September in advance of a system-wide event for governors taking place on 3 October 2023.
2. The event was intended to improve the understanding of the key priorities and objectives of the ICS.

Agreed:

1. To note the report of the Lead Governor.

Membership Engagement Strategy Implementation Group

Julia Loudon, Governor, presented the report.

Noted:

1. Governors had received a presentation on the development of a Trust-wide Patient and Public Involvement Framework.
2. The group had discussed ways to continue to promote membership and were supportive of making all Medicine for Members lectures available to both members and non-members.

Agreed:

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

31/23 Amendment to the Trust Constitution

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

Noted:

1. Other than very limited circumstances, the Trust's Constitution did not currently allow for filling a patient, public or staff governor vacancy which arose between scheduled elections via co-option of a candidate from the most recent election.
2. As a result, this could lead to circumstances where a governor vacancy was held for a prolonged period of time.
3. The recent departure of a staff governor had prompted a proposal to amend the Constitution in order to enable greater flexibility to fill vacancies which arose between elections. A preferred option,

which had been approved by the Board of Directors at its meeting on 13 September 2023, was set out in the paper.

The following points were made in discussion:

1. The proposal was a pragmatic response to a situation which could readily occur and would apply to the patient, public and staff constituencies. In the event of the departure of a partnership governor, the Trust would ask the partner organisation to nominate another representative.
2. Recognising the challenges faced by many trusts in filling governor positions, it was noted that CUH continued to be successful in maintaining a full complement of governors across all constituencies. The most recent governor elections had been contested in each of the patient, public and staff constituencies.

Agreed:

1. To approve the amendment to the Trust Constitution to enable a patient, public or staff governor vacancy to be filled at the earliest opportunity through co-option until the next scheduled election, provided that this occurred ahead of the publication of the Notice of Election for the next scheduled election.
2. To note that the Trust Constitution would be updated accordingly.

32/23 Any other business

There was no other business.

33/23 Date of next meeting

The next meeting of the Council of Governors in public would be held on Wednesday 20 December 2023 at 17.30.

Meeting closed: 18.38

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Council of Governors: Action Tracker

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

Cambridge University Hospitals NHS Foundation Trust

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Report to the Council of Governors: 20 December 2023

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

Executive Summary

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

1. In August 2023, Will Watson stood down as a Staff Governor. Following the amendment to the Trust Constitution agreed at the last Council of Governors' meeting, Elisa Ferraro took up the position of Staff Governor from 1 October 2023 to 30 June 2024.

2. Neil Stutchbury, Patient Governor, was re-appointed to the role of Lead Governor for a second two year term from 1 October 2023 to 30 September 2025.

3. Cambridgeshire City Council confirmed on 15 November 2023 the appointment of Cllr Rachel Wade as its Partnership Governor nominee for a period of 12 months. Cllr Wade succeeds Cllr Mairead Healy in this role.

4. Jane Biddle, Public Governor, was re-appointed to the role of Deputy Lead Governor for a second two year term from 1 December 2023 to 30 November 2025.

5. In November 2023, David Noble stood down as a Patient Governor. Following the amendment to the Trust Constitution agreed at the last Council of Governors' meeting, Josiane Chuisseu took up the position of Patient Governor from 1 December 2023 to 30 June 2024.

Related Trust objectives	All Trust objectives
Risk and Assurance	n/a
Related Assurance Framework Entries	n/a
Legal / Regulatory / Equality, Diversity & Dignity implications?	The composition of the Council is defined by the Trust Constitution.
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	n/a

Action required by the Council of Governors

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

Composition of the Council of Governors as at 8 December 2023

Public (7)		Patient (8)		Staff (4)		Partnership (10)		
Samira Addo	1st term (2024)	Josiane Chuisseu	1st term (2024)	Frank Allan	1st term (2026)	Peter St George-Hyslop	University of Cambridge	2nd term (Jun 2024)
John Lee Allen	1st term (2024)	Ruth Greene	3rd term (2025)	Elisa Ferraro	1st term (2024)	Karen Woodey	Campus Research Organisations	1st term (Jan 2024)
Jane Biddle	3rd term (2026)	Elizabeth Howe	2nd term (2026)	Mahad Nur	1st term (2025)	Rachael Cubberley	Anglia Ruskin University	1st term (Jun 2025)
Chris Cumberland	1st term (2026)	Julia Loudon	3rd term (2024)	Gill Shelton	1st term (2024)	Susan van de Ven	Cambridgeshire County Council	1st term (Jun 2024)
Gemma Downham	1st term (2024)	Howard Sherriff	2nd term (2025)	[redacted]		John Clarkson	University of Cambridge	2nd term (Aug 2026)
Melissa Lee	2nd term (2025)	Robin Stevens	1st term (2026)			Rachel Wade	Cambridge City Council	1st term (Nov 2024)
Carina Tyrrell	2nd term (2026)	Neil Stutchbury	3rd term (2026)			Stephen Webb	Royal Papworth Hospital NHS Foundation Trust	1st term (Oct 2023)
[redacted]		Adele White	2nd term (2024)			Stephen Legood	Cambridgeshire and Peterborough NHS Foundation Trust	3rd term (Feb 2024)
						-	[Public health – Cambridgeshire County Council]	-
						-	[nomination of the former Cambridgeshire and Peterborough CCG]	-

The figure in ( ) refers to the end of the current term of office.
First term was served from 1 July 2013 to 30 June 2016.

Terms of service

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

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

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

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

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

2. Vacancy procedure (elected governors)

2.1 In the event of a vacancy for an elected member of the Council of Governors arising outside of the normal election cycle, the vacancy shall be filled as follows:

a) The next highest polling candidate in the relevant constituency at the most recent election, who is willing to take office and who secured at least 10% of the total number of ballots in the relevant constituency, shall be co-opted to fill the vacant seat on the Council of Governors until the next scheduled election, provided the co-option commences prior to the publication of the Notice of Election for the next scheduled election.

b) In the event that it is not possible to fill the vacancy on the basis of a) above, the seat shall be left vacant until the next scheduled election unless the vacancy results in one or more of following occurring:

(i) The Council of Governors will not be quorate.
(ii) The number of vacancies in either the public, patient or staff constituency is greater than 50% of the places in the relevant constituency.

c) In the event that b) (i) and/or (ii) above apply, and there is greater than six months until the next scheduled election, a by-election shall be convened for all current vacancies. The six months shall be calculated from the date of issuing of the formal Notice of Election. The successful candidates in the election will be elected for the remaining components of the departing governors' terms.

3. Vacancy procedure (partnership governors)

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

Council of Governors

Cambridge University Hospitals NHS Foundation Trust

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Report to the Council of Governors: 20 December 2023

Agenda item	6
Title	Chair's Report
Sponsoring director	Mike More, Trust Chair
Author(s)	As above
Purpose	To receive the Chair's report.
Previously considered by	n/a

Executive Summary

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

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

Action required by the Council of Governors

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

Cambridge University Hospitals NHS Foundation Trust

20 December 2023

Council of Governors
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-19 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 Earlier this month we apologised unreservedly to all of our patients for two data breaches which happened in 2020 and 2021 and which recently came to light. Both were the result of mistakenly including patient information in Excel spreadsheets in response to Freedom of Information Act requests. The information included the patients' names, hospital numbers and some medical information. No home addresses or dates of birth were included, and we have found no evidence in either case of the information being accessed or shared any further. The first breach related to 22,073 patients booked for maternity care at The Rosie Hospital between 2 January 2016 and 31 December 2019. The second breach related to 373 cancer patients on clinical trials.

We published a statement on our website and shared this with local and regional media. We also established a dedicated freephone helpline so that any patients who are concerned their data is involved can speak to us if they wish to, and set up a dedicated email helpline.

I briefed the Lead Governor shortly before the announcement and there was an opportunity for me to discuss the breaches with a wider group of Governors on 7 December 2023. We have informed the Information Commissioner's Office about both data breaches and have taken immediate steps to strengthen our FOI process to ensure that this kind of human error does not take place again. We are also commissioning an external review of our FOI process.

1.3 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.

1.4 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

1.5 I presented to the Council of Governors in June 2023 a statement of Board objectives (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

1.6 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 took up her new post in October 2024.

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

Cambridge University Hospitals
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Report to the Council of Governors: 28 June 2023

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

Executive Summary

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

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

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

Action required by the Council of Governors

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

Cambridge University Hospitals NHS Foundation Trust

28 June 2023

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

1. Introduction

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

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

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

2. Objectives for 2023/24

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

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

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

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

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

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

3. Recommendation

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

Appendix 1: Priorities and objectives for 2023/24

1. The Teams who Work Together

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

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

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

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

2. The Teams and Patients who are Diverse

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

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

3. Our Operational Performance, Patient Safety and Finance

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

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

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

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

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

4. Innovating, Transforming and Improving

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

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

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

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

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

5. Integrating at Place

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

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

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

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

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

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

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

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

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

7. Our role in the Cambridge Bio-Medical Campus

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

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

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

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

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

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

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

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

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

8. How we govern ourselves

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

We will look for an effective Governance Review.

9. And how our governance relates to others

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

We will look for the Chair influencing the ICB approach.

Council of Governors

Cambridge University Hospitals NHS Foundation Trust

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Report to the Council of Governors: 20 December 2023

Agenda item	7
Title	Chief Executive's report
Sponsoring executive director	Roland Sinker, Chief Executive
Author(s)	As above
Purpose	To receive and note the contents of the report.
Previously considered by	n/a

Executive Summary

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

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

Action required by the Council of Governors

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

Cambridge University Hospitals NHS Foundation Trust

20 December 2023

Council of Governors
Chief Executive's Report
Roland Sinker, Chief Executive

1. Introduction/background

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

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




NHS
Cambridge University Hospitals
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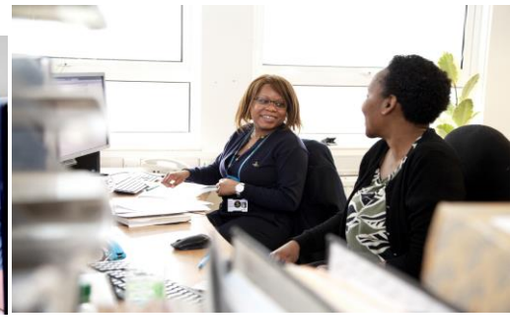




Integrated Report

Quality, Performance, Finance and Workforce to end October 23

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

Report compiled: 30 November 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				Aug 23	Sep 23	Oct 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	Oct-23	90%	84.0%	84.0%	86.0%	⇧	86.3%	50.0%	86.3%
	Trust Compliance with Pressue Ulcer risk assessment tool & documentation within 6 hours of admission	Oct-23	90%	79.0%	79.0%	80.0%	⇧	80.6%	13.4%	80.6%
	% Rosie MDT Obstetric staff passed PROMPT emergencies training	Oct-23	90%	86.8%	82.6%	94.6%	⇧	82.9%	71.0%	82.9%
	% Rosie Obstetricians and Midwives passed fetal surveillance training	Oct-23	90%	84.2%	88.0%	91.4%	⇧	85.4%	72.0%	85.4%
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)	Oct-23	7%	7.5%	7.5%	7.4%	⇩	7.7%	14.0%	7.7%
Effective / Responsive	% of Early Morning Discharges (07:00-12:00)	Oct-23	20%	16.0%	16.3%	14.6%	⇩	15.5%	15.3%	15.6%
	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	Oct-23	80%	70.6%	77.4%	67.4%	⇩	74.1%	74.0%	74.7%
	Same day emergency care (SDEC)	Oct-23	30%	26.8%	26.1%	24.9%	⇩	25.4%	22.0%	23.7%
	Percentage of admissions over 65yo with dementia/delirium or cognitive impairment with a care plan in place	Oct-23	50%	73.0%	79.0%	79.0%	⇔	65.7%		65.7%
	SSNAP Domain 2: % of patients admitted to a stroke unit within 4 hours of clock start time (Team centred)	Oct-23	55%	45.4%	49.1%	45.7%	⇩	44.1%	29.2%	36.8%
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				Aug 23	Sep 23	Oct 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)	Oct-23	0	1	0	0	⇔	5	3	5
	E.coli Bacteraemias (Total Cases)	Oct-23	50% over 3 years	27	26	44	⇧	252	401	414
	C. difficile Infection (hospital onset and COHA* avoidable)	Oct-23	TBC	15	16	13	⇩	79	129	117
	Hand Hygiene Compliance	Oct-23	TBC	94.1%	93.4%	93.4%	⇩	93.9%	96.4%	94.5%
Clinical Effectiveness	% of NICE Technology Appraisals where funding was not procured within three months. ('last month')	Oct-23	100%	33.3%	36.4%	50.0%	⇧	59.6%	None recorded	59.6%
	% of NICE guidance relevant to CUH is returned by clinical teams within total deadline of 30 days.	Oct-23	80%	0.0%	None recorded	None recorded	⇔	35.7%	51.0%	45.9%
	100% of NCEPOD questionnaires (clinical and operational) relevant to CUH is returned by clinical teams within deadline ('last month').	Oct-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	Oct-23	85%	75.0%	100.0%	100.0%	⇔	93.8%	84.6%	89.3%
Nursing Quality Metrics	Blood Administration Patient Scanning	Oct-23	90%	99.5%	99.9%	99.9%	⇩	99.7%	99.7%	99.7%
	Care Plan Notes	Oct-23	90%	95.8%	96.0%	95.7%	⇩	95.9%	96.1%	96.0%
	Care Plan Presence	Oct-23	90%	99.7%	99.8%	99.5%	⇩	99.7%	99.6%	99.6%
	Falls Risk Assessment	Data reported in slides								
	Moving & Handling	Oct-23	90%	74.4%	75.7%	74.9%	⇩	76.3%	71.5%	74.4%
	Nurse Rounding	Oct-23	90%	99.2%	99.3%	99.0%	⇩	99.1%	99.1%	99.1%
	Nutrition Screening	Oct-23	90%	73.4%	74.9%	74.9%	⇧	76.5%	72.3%	74.8%
	Pain Score	Oct-23	90%	84.6%	85.3%	85.2%	⇩	85.3%	83.2%	84.4%
	Pressure Ulcer Screening	Data reported in slides								
	EWS									
	MEOWS Score Recording	Oct-23	90%	85.2%	86.7%	88.8%	⇧	85.9%	79.5%	83.3%
	PEWS Score Recording	Oct-23	90%	99.3%	99.3%	99.3%	⇩	99.2%	99.2%	99.2%
	NEWS Score Recording	Oct-23	90%	97.7%	97.8%	97.7%	⇩	97.7%	97.4%	97.5%
	VIP									
	VIP Score Recording (1 per day)	Oct-23	90%	88.7%	86.1%	84.3%	⇩	87.4%	84.9%	86.3%
	PIP Score Recording (1 per day)	Oct-23	90%	88.2%	83.8%	77.4%	⇩	85.1%	89.3%	87.1%
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	Oct-23	0	37	58	90	⇧	418	172	538
	Re-opened complaints (non PHSO)	Oct-23	N/A	10	11	8	⇩	43	18	47
	Re-opened complaints (PHSO)	Oct-23	N/A	0	1	0	⇩	5	2	6
				Aug 23	Sep 23	Oct 23				
	Number of medium/high level complaints	Oct-23	N/A	11	12	22	⇧	107	257	211

Operational Performance

NHS Cambridge University Hospitals NHS Foundation Trust

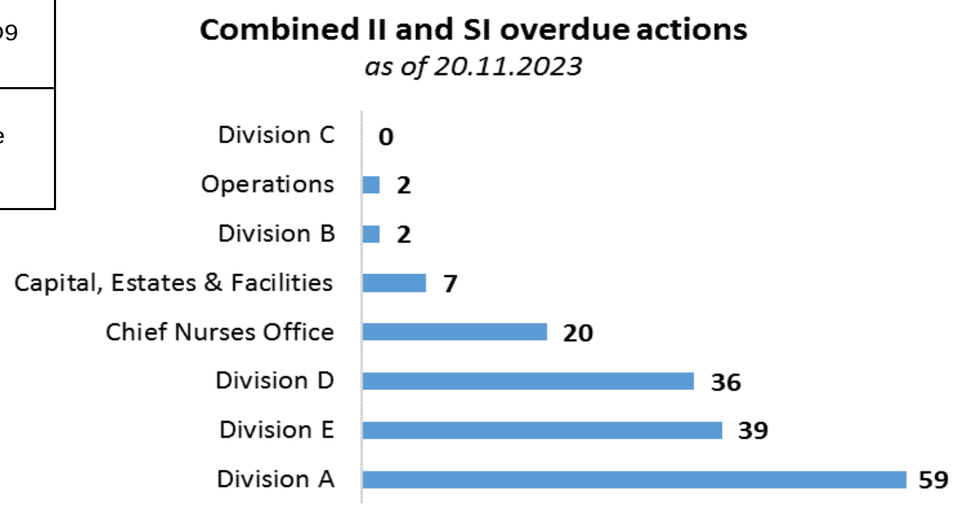
Point of delivery	Performance Standards	SPC variance	In Month Actual	In Month plan	Target	Target due by	Page
Urgent & Emergency Care	4hr performance	Normal variation	60.1%	73.1%	76.0%	Mar-24	Page 13
	12hr waits in ED (type 1)	Normal variation	12.2%	-	-	-	
	Ambulance handovers <15mins	Positive special cause variation	58.7%	65.0%	65.0%	Immediate	
	Ambulance handovers <30mins	Positive special cause variation	92.4%	95.0%	95.0%	Immediate	Page 14
	Ambulance handovers > 60mins	Positive special cause variation	2.1%	0.0%	0.0%	Immediate	
Cancer	Cancer patients < 62 days	Normal variation	68.7%	-	85.0%	Immediate	Page 21
	28 day faster diagnosis standard	Negative special cause variation	66.8%	81.4%	75.0%	Immediate	Page 18
	31 day decision to first treatment	Normal variation	87.9%	-	96.0%	Immediate	Page 20
	2 week waits	Normal variation	65.5%	-	93.0%		Page 19
Outpatients	First outpatients (consultant led)	Normal variation	111.6%	125.6%	-	-	Page 23
	Follow-up outpatients (consultant led)	Normal variation	111.6%	136.3%	-	-	Page 24
	Advice and Guidance Requests	Normal variation	10.6%	-	16.0%	Mar-23	
	Patients moved / discharged to PIFU	Normal variation	3.3%	7.5%	7.5%	Mar-23	Page 25
Diagnostics	Patients waiting > 6 weeks	Positive special cause variation	36.6%	23.7%	5.0%	Mar-24	Page 22
	Diagnostics - Total WL	Normal variation	13,530	10,444	-	-	
RTT Waiting List	RTT Patients waiting > 65 weeks	Positive special cause variation	1043	456	0	Mar-23	Page 16
	RTT Patients waiting > 78 weeks	Normal variation	99	-	-	-	
	Total RTT waiting list	Negative special cause variation	62,725	63,242	-	-	Page 17
Productivity and efficiency	Non-elective LoS (days, excl 0 LoS)	Normal variation	8.2	-	-	-	
	Long stay patients (>21 LoS)	Positive special cause variation	188	211	-	-	
	Elective LoS (days, excl 0 LoS)	Normal variation	5.7	-	-	-	
	Discharges before noon	Normal variation	14.6%	-	-	-	
	Theatre sessions used	Normal variation	670	-	-	-	
	In session theatre utilisation	Normal variation	77.0%	85.0%	85.0%	Sep-23	Page 27
	Virtual Outpatient Attendances	Negative special cause variation	19.6%	-	-	-	
	BADS Daycase Rate (local)	Normal variation	85.2%	-	-	-	Page 28
Surgical prioritisation	P2 (4 weeks) Including planned	Negative special cause variation	3,165	-	-	-	

Serious Incidents

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Data range	Period	Threshold	Current period	Mean	Variance	Special causes	Comments
Patient Safety Incidents	November 2020-October 2023 July 2023	Oct-23	-	**1595**	*1454*		-	Last 6 months have been above the mean
Patient Safety Incidents per **1,000 admissions**				**90**	*91*		–	
Percentage of **moderate harm and above** patient safety incidents			≤ 2%	**2.3%**	*2.5%*		-	This category for the Trust overall is driven by moderate harm incidents with last 5 months above the mean. Whereas combined severe harm and death are at a statistically significant decrease (last 10 months below the mean). **Division E** has been above the mean for the last 4 months; the last 2 months have been statistically significant high points.
All Serious Incidents			-	**2**	*4.6*		-	

Ref	SI Title	STEIS SI Category	STEIS SI Sub categories	Actual Impact	Div.	Ward/ Dept.
SLR175813	Deteriorating patient - ward D9	Unexpected/potentially avoidable death	Sub-optimal care of the deteriorating patient	Death	B	Ward D9
SLR176550	Deteriorating patient - Daphne Ward	Unexpected/potentially avoidable death	Sub-optimal care of the deteriorating patient	Death	E	Daphne ward



Summary

Six SI reports were submitted to the ICS in September 2023. Compliance with the 60 day timeframe for October was 50% (2/4).

There are currently **165 overdue actions** from investigations: **93** (↓) **Serious Incident** actions and **74 Internal (RCA) Investigation** 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

Duty of Candour (DOC)

Cambridge University Hospitals NHS Foundation Trust

Data YTD as of 16.11.2023

Trust wide **stage 1** DOC compliance is **98%** (390/400)

Trust wide **stage 2** DOC compliance is **86%** (297/344)

There is a notable reduction in compliance with stage 2.

- Table 1 gives the divisional detail for 2023 YTD
- Table 2 shows details for 2022 - actions have been taken to support divisions to prioritise these newly identified cases.

A new process and reporting function is to be introduced to improve oversight of compliance

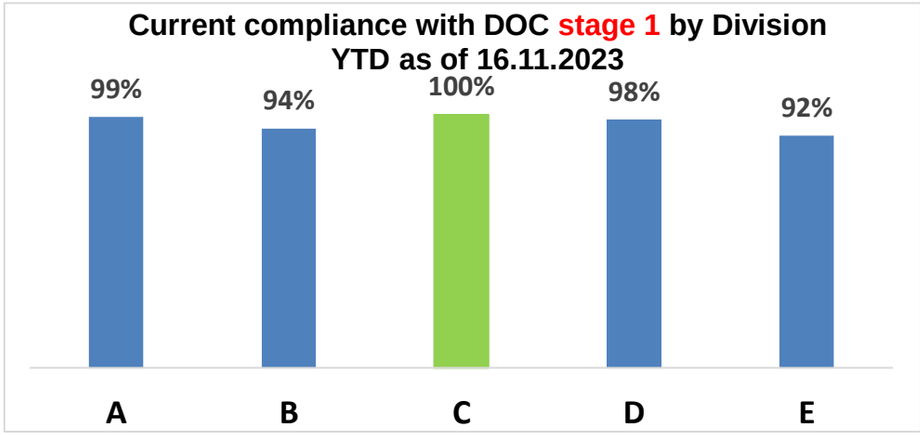


Table 1. Overdue DOC Stage 2 - 2023 YTD

2023 YTD	A	B	C	D	E	Total
Required	123	23	90	57	51	344
Completed	103	20	85	45	44	297
Compliance	84%	87%	94%	79%	86%	86%

Table 2. Stage 2 -Outstanding from 2022

Month/Year	A	B	C	D	E	Total
Mar-22	2					2
Apr-22			1		1	2
May-22					1	1
Jun-22	1					1
Aug-22					2	2
Sep-22	1	1				2
Total	**4**	**1**	**1**	**0**	**4**	**10**

Indicator definitions

Stage 1 *is notifying the patient (or family) of the incident and sending a DOC stage 1 letter*

Stage 2 *is sharing of the relevant investigation findings (where the patient has requested this response).*

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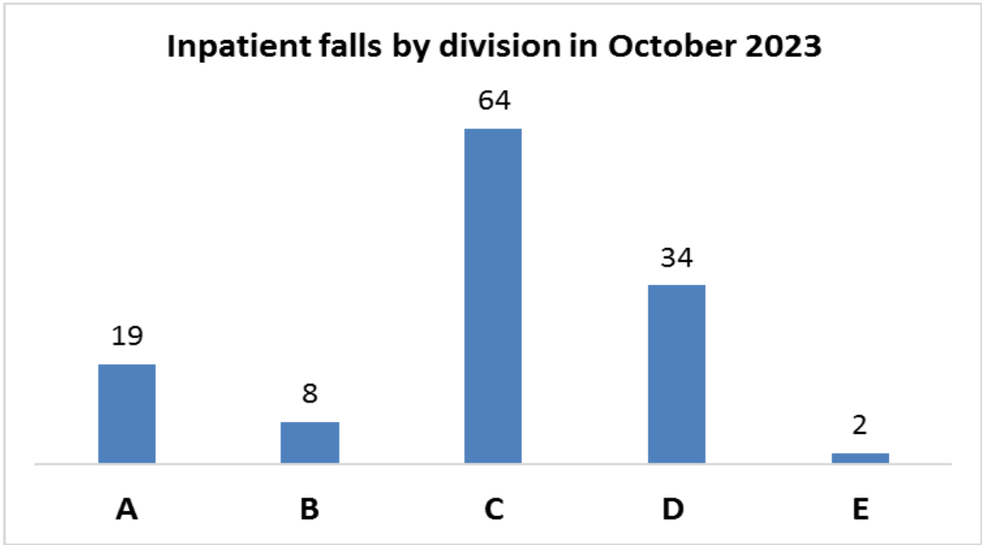
Falls

NHS
Cambridge University Hospitals
NHS Foundation Trust

Indicator	Data range	Target	Oct-23	Mean	Variance	Special causes	Target status	Comments
All patient falls	November 2020 - October 2023	-	**117**	*148*			-	Last 4 months below the mean
Inpatient falls per **1,000 bed days**			**3.2**	*4.5*		-	-	Last 4 months below the mean
Moderate harm & above - inpatient falls		-	**4**	*4.4*		–	-	Last 5 months are below the mean.
Falls **risk screening** compliance within 12 hours of admission		≥ 90%	**86%**	*85%*			F	We were last compliant with this metric in June 2021

Summary
All falls are in normal variance.
Risk factors continue to be: patients requiring the assistance of one to mobilise; patients with a previous fall; occur in the daytime; and unwitnessed falls.
In October 2023 there were 3 moderate harm falls and 1 serious harm (latter was in ED - intracranial haemorrhage and admission to NCCU - awaiting gap analysis)

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.



Hospital Acquired Pressure Ulcers (HAPUs)

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Data range	Target	Oct-23	Mean	Variance	Target status	Comments
All hospital-acquired pressure ulcers	November 2020 - October 2023	-	**49**	31		-	The last 16 consecutive months have been above the mean. August and October 2023 have shown a statistically significant high point.
All HAPUs by date of occurrence per 1,000 bed days		–	**1.36**	0.92		-	The last 16 consecutive months have been above the mean.
Category 2, 3, 4, Suspected Deep Tissue Injury, and Unstageable HAPUs		–	**35**	18.7		-	The last 16 consecutive months have been above the mean. August and October 2023 have shown a statistically significant high point.
Category 1 hospital-acquired pressure ulcers		–	**14**	12.1		–	
Category 2 hospital-acquired pressure ulcers			**19**	12.8		–	Last 6 months have been above the mean.
Unstageable HAPUs		–	**1**	1.6		–	
Suspected Deep Tissue Injury HAPUs by date of occurrence		-	**14**	4.0		-	Statistically significant high points in August, September, and October 2023. 15/17 last consecutive months have been above the mean.
Medical device related HAPUs		–	**15**	7.6		–	Statistically significant upward shift in the last 8 months.
Pressure Ulcer screening **risk assessment** compliance		90%	**80%**	80%			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 HAPUs September but one category 4 HAPU.
There is a statistically significant increase in HAPUs related to Medical devices overall (15) and from 'mask/tubing'.
There is a statistically significant increase in HAPUs related to sacrum (11). 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.

Sepsis

Cambridge University Hospitals NHS Foundation Trust

Indicator	Data range	Period	Target	Current period	Mean	Variance	Comments
All elements of the Sepsis Six Bundle delivered within 60 mins from time patient triggers Sepsis (NEWS 5>) - **Emergency Department**	November 2020-October 2023	Oct-23	≥95%	**60%**	*59%*		
Antibiotics administered within 60 mins from time patient **triggers** Sepsis (NEWS 5>) - **Emergency Department**				**80%**	*72%*		
All elements of the Sepsis Six Bundle delivered within 60 mins from time patient triggers Sepsis (NEWS 5>)- **Inpatient wards**				**40%**	*39%*		
Antibiotics administered within 60 mins from time patient **triggers** Sepsis (NEWS 5>) - **Inpatient wards**				**50%**	*75%*		
All elements of the Sepsis Six Bundle delivered within 60 mins from time patient triggers Sepsis (NEWS 5>) - **Maternity**				**33%**	*32%*		
Antibiotics administered within 60 mins from time patient **triggers** Sepsis (NEWS 5>) - **Maternity**				**100%**	*95%*		

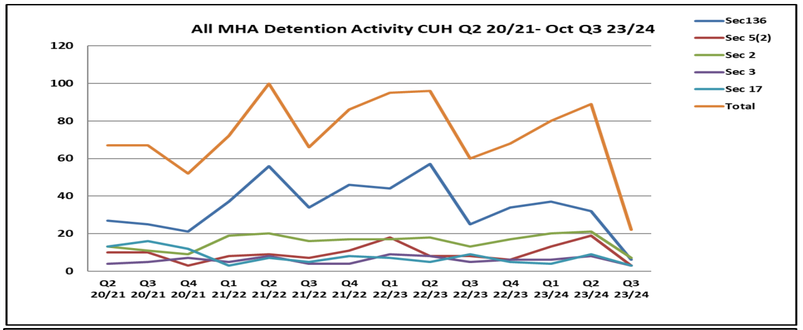
Sample size in month for above audits:

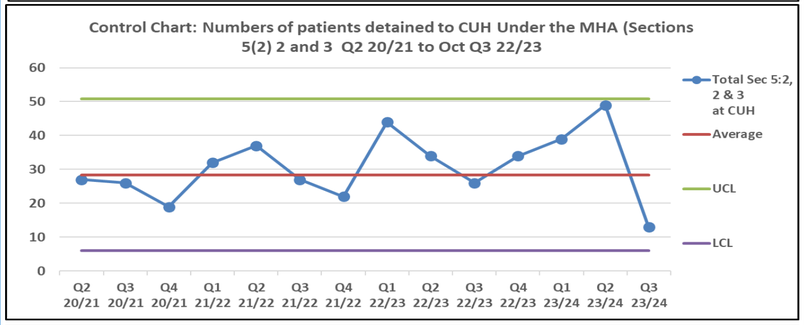
Inpatients = 10
ED-Adult = 15
Maternity inpatients = 9

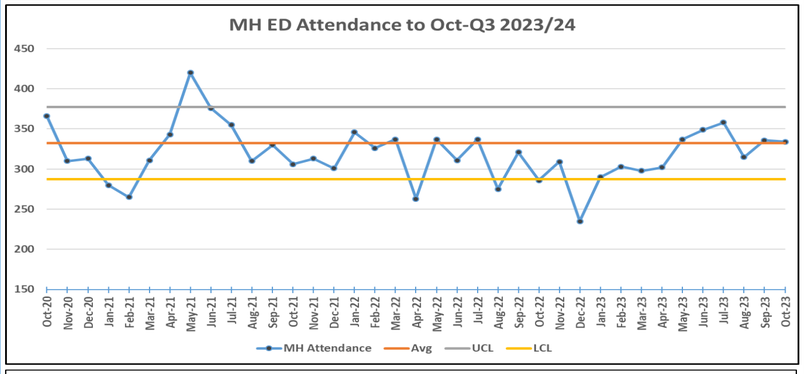
- Measuring & monitoring framework being updated i.e. outcome data. Algorithm developed by Ari Ercole (CMOI) and yielded potential sample of 300 patients within month – validation process underway.
- Sepsis QI corporate plan – driver diagram drafted - to be approved at November Sepsis Action Group meeting
- Setting up QI pilot areas - vascular and renal teams
- 42 Sepsis and Deteriorating patient champions have been embedded across the organisation and will be supporting the QI plan

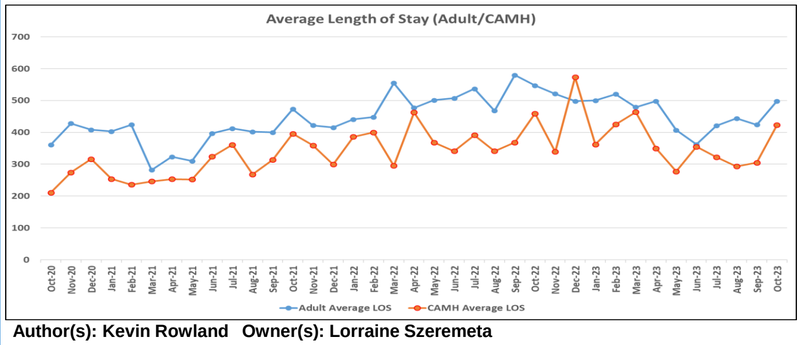
Mental Health - Q2 2023/24 (September)

NHS Cambridge University Hospitals NHS Foundation Trust









Q3 2023/24 (October)

- Q3 October showed a reduction in the use of the Mental Health Act (MHA) compared to the first month of the previous two quarters, in line with historical reductions moving into Winter. CUH was used six times as place of safety under Section 136 MHA in October.
- 2 x Section 136 MHA were rescinded. Three were conveyed to another place of safety and 1x Section 136 MHA lapsed. None were converted to a further section of the MHA.
- Of the total 3 x section 5(2) MHA in October, two were discharged from formal detention.
- The numbers of patients brought to the Emergency Department in October has shown the data remains within expected data control lines.
- Following funding applications, £220k has been approved for investment into;
  - The MH assessment room in ED to be equipped to provide a safe and private environment for psychiatric assessments.
  - Improving the D2 single rooms, creating 1 anti-ligature and general improvements to the environment.
- CAMH and Adult average length of stay in the Emergency Department increased for both groups, whilst the admission conversion rate reduced for CAMH and increased for adults. The CAMH reduction represented a 5th consecutive reduction in conversion rate. All data remained within expected controls.
- There were 9 delayed transfers of care to mental health inpatient care in October, with 65 lost bed days.

Ongoing work:

- Following meeting with Local Authority AMHP leads, it was agreed that an audit of Section 136 MHA at CUH would be helpful in identifying specific completion issues in Section B form completion.
- The New Mental Health Study day for CUH clinical staff has been advertised through the Trust Networks and is creating positive interest. The study day will take place monthly throughout 2024. Interfacing with the CUH Staff Wellbeing Service, Staff Wellbeing Practitioners will support the delivery of the session to ensure staff mental wellbeing is also promoted and supported. The study day 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 disorders
  - Management of the Mental Health Act and Mental Capacity Act
  - Emotional labour and resilience
- The Cambridgeshire Constabulary Right Care Right Person 'Concern for Welfare request' part of the programme went live on the 20th November 2023. This contingent affects community based services and the public. Working groups for the below are due to start in sequence, with CUH attendance.
  - Missing/AWOL Patients
  - Section 136 MHA
  - Conveyance of persons under Section 136 MHA- Launch
- The CUH Procedure for Statutory Notifications, specifically around reporting patient deaths whilst under or liable to be under a Section of the Mental Health Act document has been reviewed and updated. This will go to the CUH Mental Health Committee for approval.

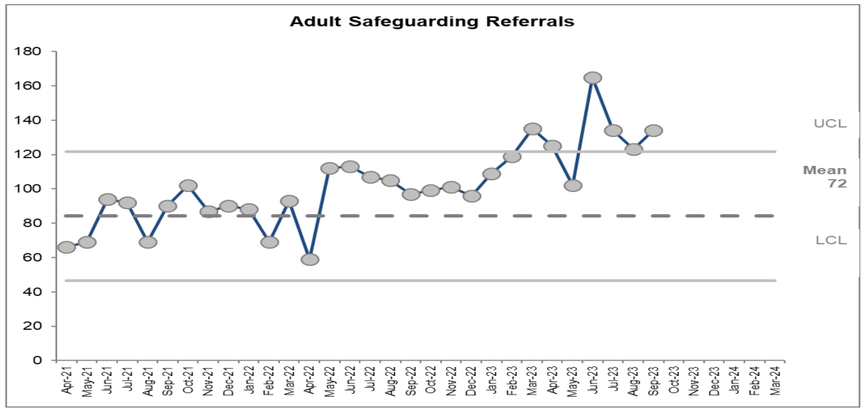
Author(s): Kevin Rowland Owner(s): Lorraine Szeremeta

Safeguarding

NHS Cambridge University Hospitals NHS Foundation Trust

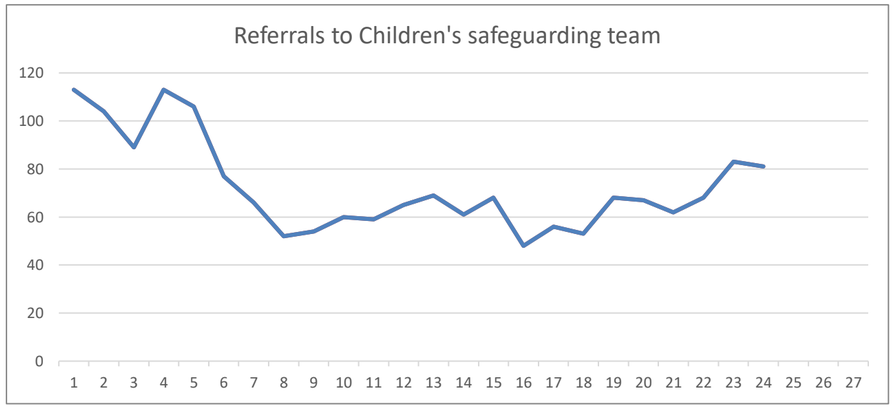
Adult Safeguarding

Referrals to the safeguarding team in Q2 have remained consistent with Q1 23/24. When compared to Q2 22/23, there has been a 27% increase in referrals. This quarter has seen an increase in the number of those referrals that were shared with the Local Authority from 43% in Q1 to 51% in Q2. A total of 391 referrals were made to the Adult Safeguarding Team this quarter compared to 393 in Q1 (this figure does not include DOLs requests). The top 3 reporting themes were neglect/acts of omission which has seen a significant increase from 27% of the referrals in Q1 to 40% in Q2, domestic abuse with 23% of victims being identified as male, and an increase in the number of concerns relating to drug /alcohol dependency which has seen a 72% increase compared with Q1. DoLS requests for urgent authorisations have also seen an 18% increase from 56 in Q1 23/24 to 66 in Q2 23/24.



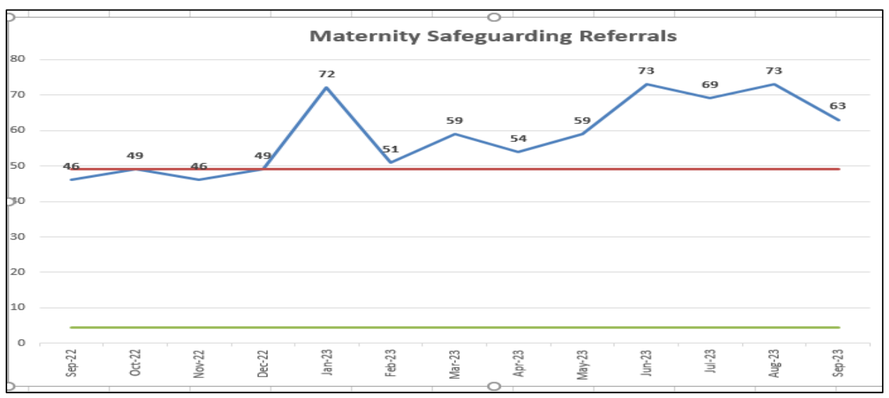
Childrens Safeguarding

There has been a decrease in the number of referrals to the children safeguarding team over the last quarter with a total of 180 referrals compared to 224 in Q1 23/24. Top 3 referral themes continue to be children' mental health and neglect which reflect the Cambridge and Peterborough safeguarding partnership board priorities. New to this quarter is an increase in concerns relating to substance misuse which like adults and maternity has seen an increase though not as significant and parental mental ill health. The total number of beds days used to accommodate a child as a place of safety or for social reasons has seen an increase from 56 days in Q1 to 83 in Q2.



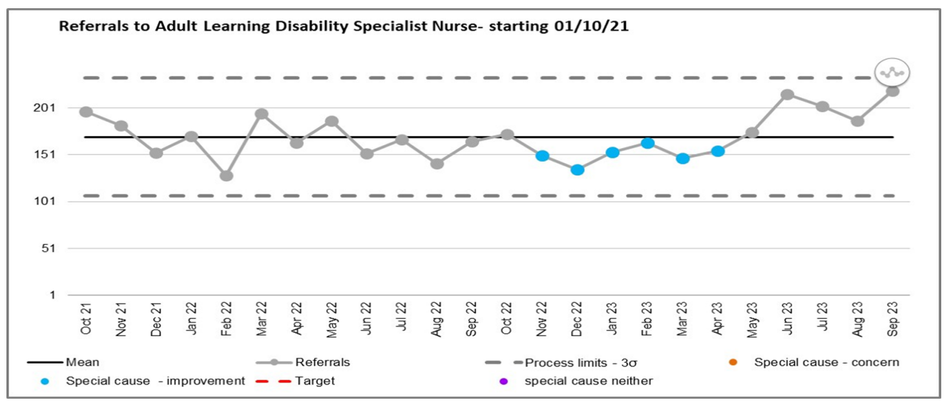
Maternity safeguarding

Referrals to the maternity safeguarding team in Q2 remain high though there was a slight drop in the final month of Q2. A further reduction in referrals to children's social care was seen again this quarter with only 26 in Q2 compared to 32 in Q1. There has been a significant increase in the number of strategy meetings attended by maternity rising sharply from 7 in Q1 to 19 in Q2 though this has been accompanied by a drop in the number of CP conferences requiring a maternity report or attendance from 21 to 15 with meetings having been moved back to face to face from virtual from September. The top 3 referral themes in Q2 have been for historical safeguarding concerns and domestic abuse as was seen in Q1 but with drugs and alcohol overtaking mental health, which is aligned with adults which has seen a sharp rise.



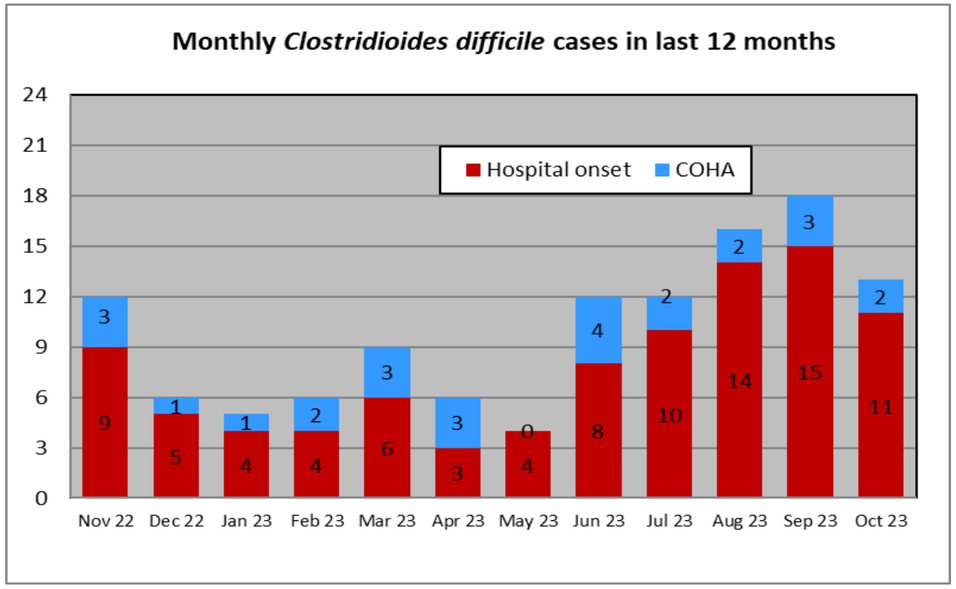
Learning disabilities

During Q4 there have been 546 referrals to the adult learning disability specialist nurse which is a 17% increase from Q1 23/24. The children's referral data is not illustrated on the graph but has seen an decrease from 44 in Q1 to 34 in Q2. For adults the top 3 referral teams were gastro/colorectal, respiratory and neurology whilst in children's services the top 3 reasons for referral were for admission planning, inpatient support and advice, and MDT/complex cases with autism featuring as the most common referral diagnosis.

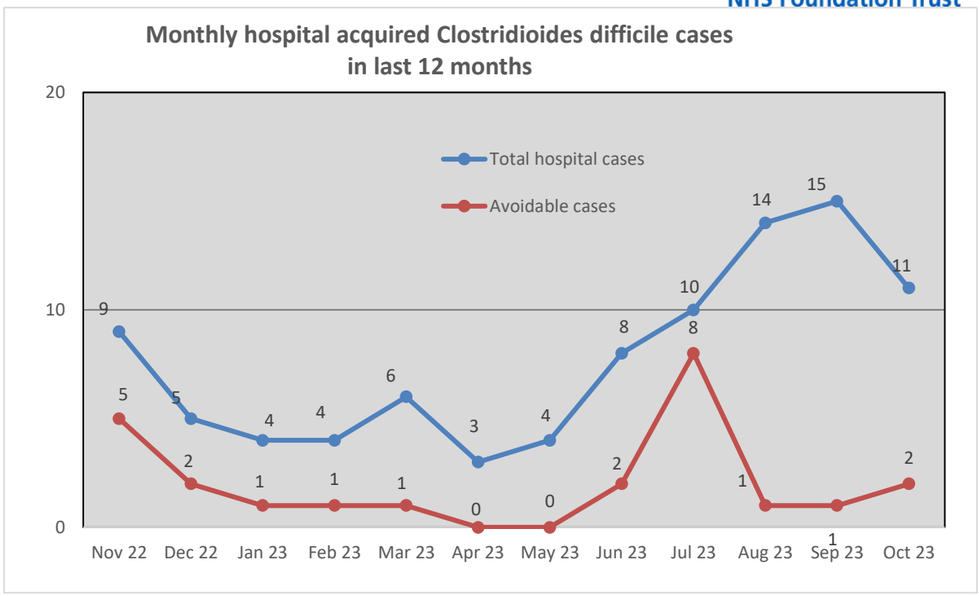


Infection Control

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 cases of hospital onset MRSA bacteraemia in October 2023
- 5 cases (3 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*.

- 11 cases of hospital onset *C difficile* and 2 cases of COHA in October 2023.
- 56 hospital onset cases and 16 COHA cases year to date (40 cases unavoidable, 17 avoidable and 14 pending).

MRSA and C difficile key performance indicators

- Compliance with the MRSA care bundle (decolonisation) was 97.8% in October 2023 (77.5% in September 2023).

- Compliance with the *C. difficile* care bundle was 90% in October 2023 (88% in September 2023).

4HR Performance

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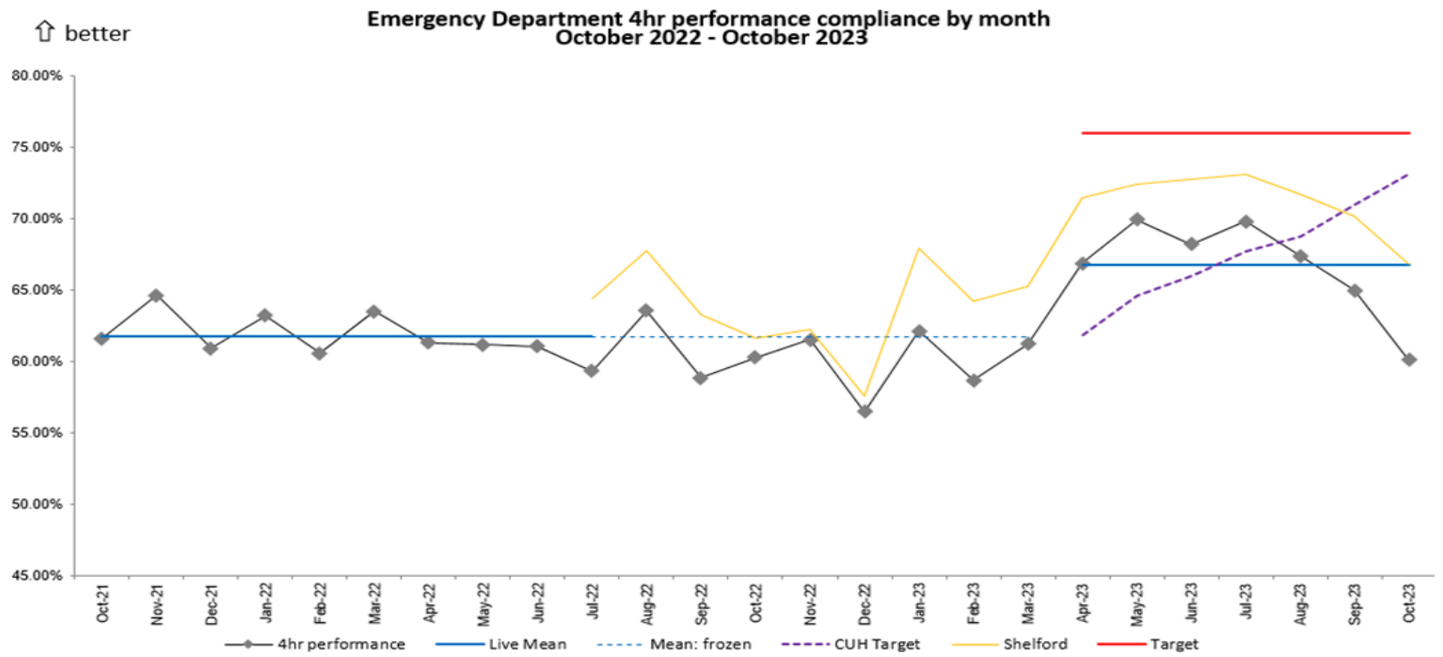
Oct-23	Plan
60.1%	73.1%

SPC Variance
Normal variation

Shelford Group Avg (Sep-23)
70.9%

Three Month Trajectory		
Nov-23	Dec-23	Jan-24
74.4%	76.1%	78.1%



Highest breaches by specialty

Specialty	Performance	4hr Breaches
Emergency	50.6%	2,549
Medicine	23.1%	1,980
Paediatrics	38.2%	328
Surgery	24.7%	302
Orthopaedics	19.3%	271

Updates since previous month

- Performance declined to 60.1% in October, down from 64.9% in September and below the target of 73.1%
- CUH ranked in the fourth quartile for performance nationally, down from the third quartile in September.

Current issues

- Average time to initial medical assessment increased to 2hrs 30mins in October, up from 2hrs 15mins in September
- Average time from arrival to specialty referral was 5hrs 47mins, beyond the 4hr target

Key dependencies

- Increase in demand of 4.8% vs. October 2022
- Availability of bed capacity for outflow
- Efficiency of front door triage and streaming processes

Future actions

- A turnaround team has been created to address the recent decrease in 4hr performance
- This will be led by the Deputy COO with reporting to the CEO via weekly escalation meetings with the COO/MD/CNO.

Ambulance Handovers > 60 minutes

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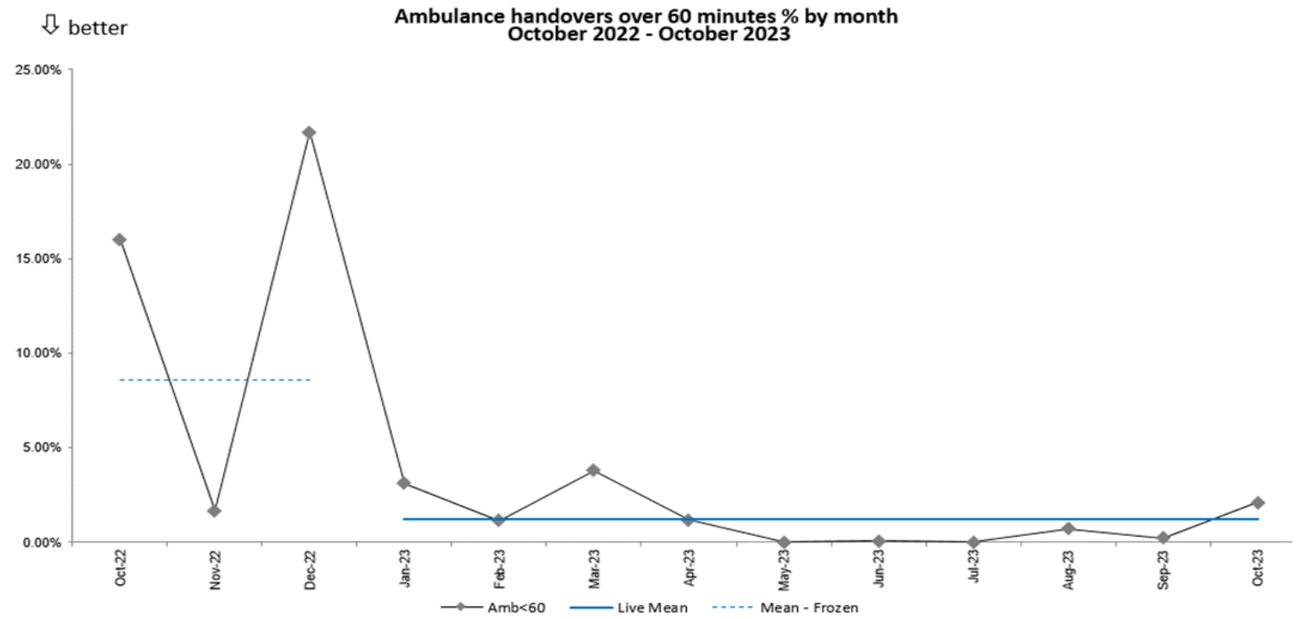
Oct-23	Target
2.1%	0%

SPC Variance

Positive special cause variation

East of England > 60 minutes

Trust	<60mins
CUH	**2%**
Bedford	2%
Watford	2%
Milton Keynes	5%
Basildon	8%
West Suffolk	9%
Colchester	9%
Hinchingbrooke	9%
Broomfield	10%
Southend	14%
Luton and Dunstable	15%
EoE average	**17%**
Papworth	18%
Ipswich	21%
Lister	24%
Peterborough City	25%
James Paget	34%
Queen Elizabeth	40%
Princess Alexandra	43%
Norfolk and Norwich	59%



Updates since previous month

- Ambulance handovers >60mins increased to 2.1% in October, up from 0.3% in September
- Despite this increase, CUH was the joint top-performing trust in the region

Current issues

- Higher numbers of patients in the Emergency Department contributed towards issues offloading ambulances during October

Key dependencies

- Availability of Hospital Ambulance Liaison Officers (HALOs) to coordinate the rapid offload of ambulances
- Preserving rapid handover spaces
- Rollout of the Call Before You Convey pilot

Future actions

- Continued focus on maintaining low handover delays by optimising the transfer process and utilising rapid handover spaces as appropriate.

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

Overall fit test compliance for substantive staff

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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%	254	146	57%	67	35	52%	132	69	52%	94	44	47%	91	43	47%	639	337	53%
Allied Health Professionals	-	-	-	57	24	42%	17	3	18%	1	1	100%	-	-	-	3	1	33%	78	29	37%
Estates and Ancillary (Porters and Security Personnel only)	114	67	59%	-	-	-	-	-	-	-	-	-	-	-	-	1	0	0%	115	67	58%
Medical and Dental	-	-	-	250	65	26%	-	-	-	192	77	40%	144	12	8%	228	67	29%	814	221	27%
Nursing and Midwifery Registered	-	-	-	683	493	72%	4	2	50%	279	171	61%	156	97	62%	374	197	53%	1496	960	64%
Total	115	67	58%	1244	728	59%	88	40	45%	604	318	53%	394	153	39%	697	308	44%	3142	1614	51%

The data displayed as of 8/11/23. 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

Referral to Treatment > 65 weeks and > 78 weeks

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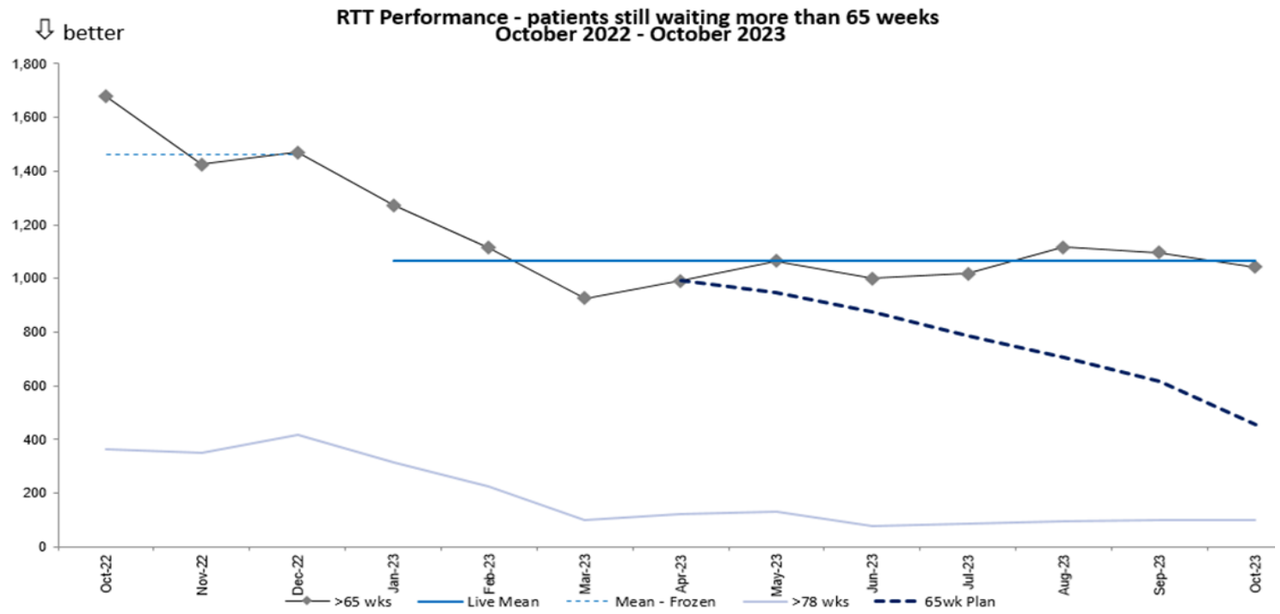
65+ Weeks	
Oct-23	**Plan**
1043	456

SPC Variance
Positive special cause variation

% of WL over 65 weeks (Sep-23)	
CUH	1.74%
Shelford Group	1.68%

Three Month Forecast (65+ wks)		
Nov-23	**Dec-23**	**Jan-24**
296	220	150



Divisional Performance		
Division	**65+ weeks**	**78+ weeks**
A	219	20
B	99	8
C	31	0
D	510	60
E	184	11
Trust	**1,043**	**99**

Updates since previous month

>78 week waits stable at 99 in October despite Industrial action and delay in Surgical Hub opening. ENT accounted for 17, T&O and OMFS 12
>65 weeks decreased by 54, but now 587 adverse to original plan to eradicate by March 2024.

Current issues

Industrial Action continued to impact progress with long wait reductions. Benchmark data shows that between Aug and Sept, CUH limited deterioration in > 78 weeks waits to 2%, compared to 13% Nationally and 24% within the Shelford Group.

Key dependencies

Theatre capacity (Surgical Hub opened 6/11/23)
Recruitment to medical workforce vacancies
Independent Sector for ENT.
Continuation of Insourcing OMFS to year end.
Gynaecology Insourcing (commenced 25/11/23)

Future actions

65 week year end forecast of ~800 >65 weeks is being monitored weekly at Specialty level. ENT and Gynaecology are the highest risk but are ahead of trajectory.
Patient Choice for alternative providers launched. 3.7% (100) of invited cohort responded. Four offers.

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

Referral to Treatment Total Waiting List

NHS
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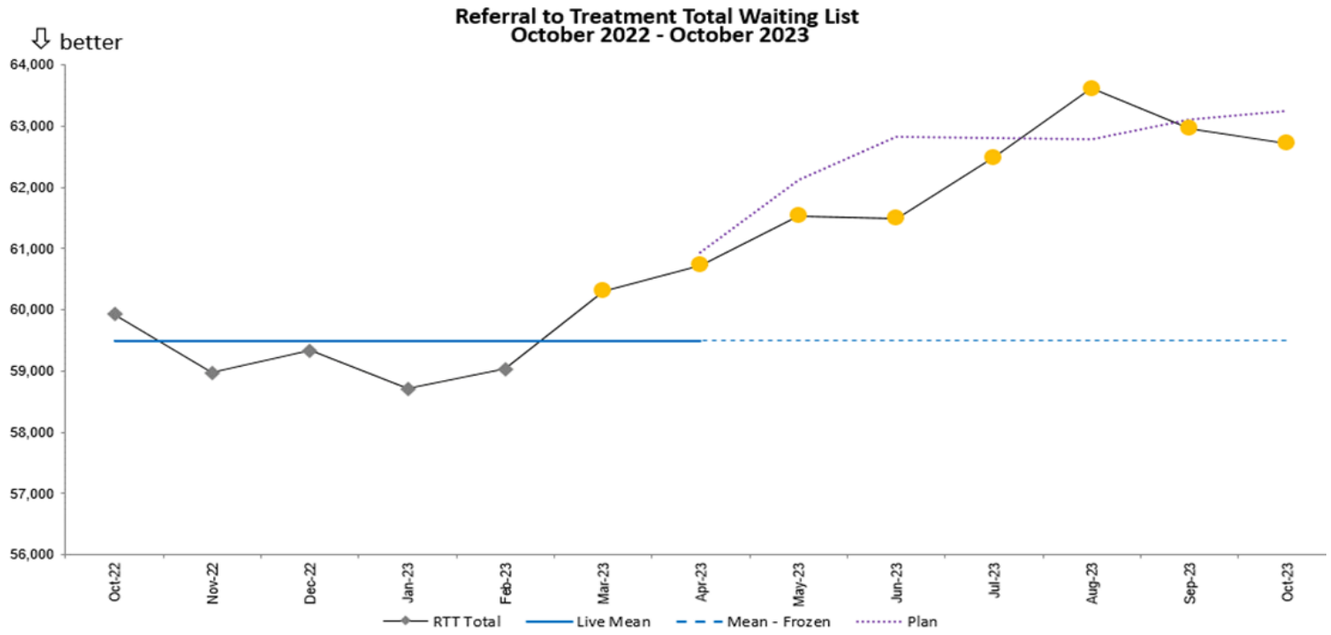
Oct-23	Plan
62,725	63,242

SPC Variance
Negative special cause variation

Change in WL: Sep-23 vs. Aug-23	
CUH	-1.02%
Shelford Group	-0.77%

Three Month Forecast		
Nov-23	Dec-23	Jan-24
63,282	61,358	61,186



Waiting list by division	
Division	Total Waiting List
A	12,694
B	6,156
C	4,808
D	29,413
E	9,647
Other	7
Trust	**62,725**

Updates since previous month

Total RTT waiting list decreased by 0.4% in month.
The total waiting list size is 138 lower than the planning submission for month 7.
Clock starts are cumulatively 2.8% below plan year to date and only 1.7% below the month 7 plan.

Current issues

Total stops (treatments) were above plan in Oct despite Industrial Action, with higher non-admitted stops compensating for low admitted performance.
The estimated lost clock stops due to Industrial Action were ~330.

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

Continued focus on releasing capacity for new outpatients. Those awaiting 1st appointment (61.8% of total waiting list) reduced by 848 in month despite higher clock starts.
Rolling waiting list validation at 12 weeks is yielding a 6% removal rate.

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

Cancer - 28 day faster diagnosis standard

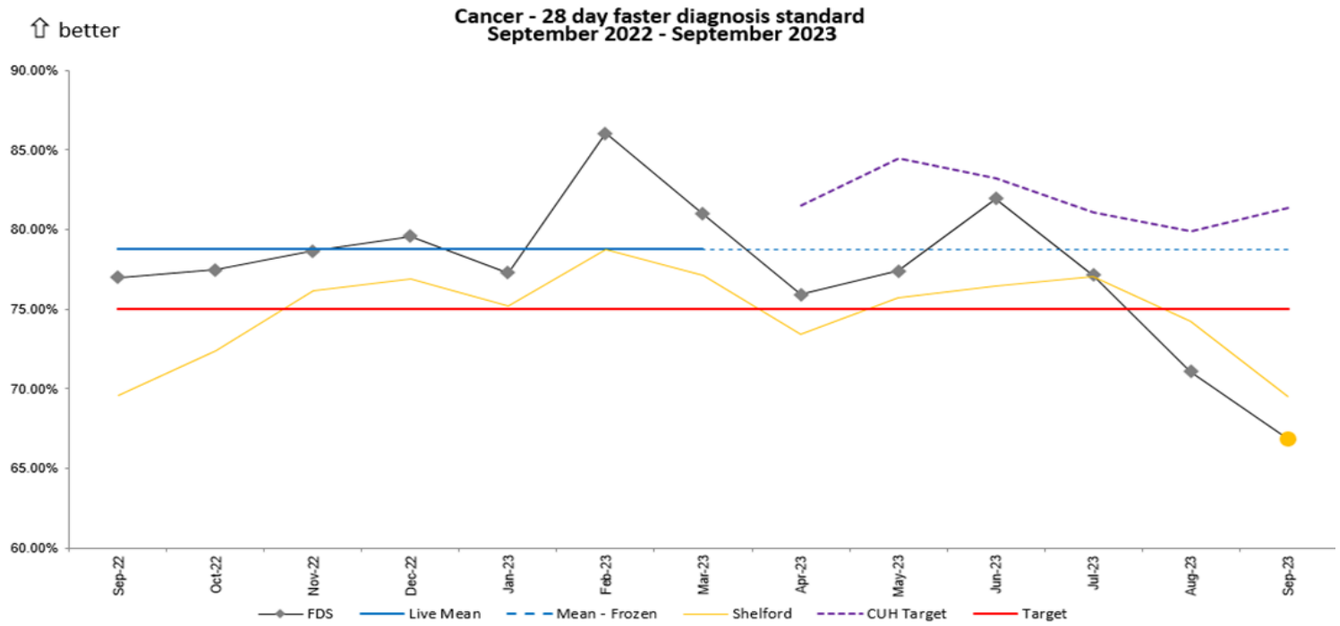
NHS
Cambridge University Hospitals
NHS Foundation Trust

Sep-23	Target
66.8%	75.0%

SPC Variance
Negative special cause variation

Shelford Group Avg (Sep-23)
69.5%

Three Month Forecast		
Oct-23	Nov-23	Dec-23
85.1%	83.9%	82.6%



Cancer Site Overview

Site	Performance	Breaches
Skin	34.8%	519
Lower GI	78.2%	64
Gynaecological	59.2%	87
Head & Neck	75.7%	51
Urological	69.3%	51
Breast	96.2%	23
Haematological	36.4%	7
Sarcoma	50.0%	13
Upper GI	90.9%	2
Lung	93.4%	4
Childrens	90.9%	3
CNS/Brain	100.0%	0
Testicular	94.1%	1
Total	**66.8%**	**825**

Updates since previous month

CUH has continued to perform below for FDS. This is due to the continued deterioration in Skin performance down to 34.8%. Delays within the skin pathway have increased following exceptional demand in June and insufficient capacity to recover the resulting backlog. Pathology turn around times also continue to delay diagnosis and impact on this target.

Key dependencies

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

Current issues

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

Future actions

Actions are in place as part of the Cancer Improvement Plan. Focus continues on skin, gynae, urology and pathology. System meeting with GIRFT took place on 31.10.23, positive feedback on CUH strong performance for FDS. Request was to work across ICB to narrow the gap in performance across the system.

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

Cancer - 2 week waits

NHS
Cambridge University Hospitals
NHS Foundation Trust

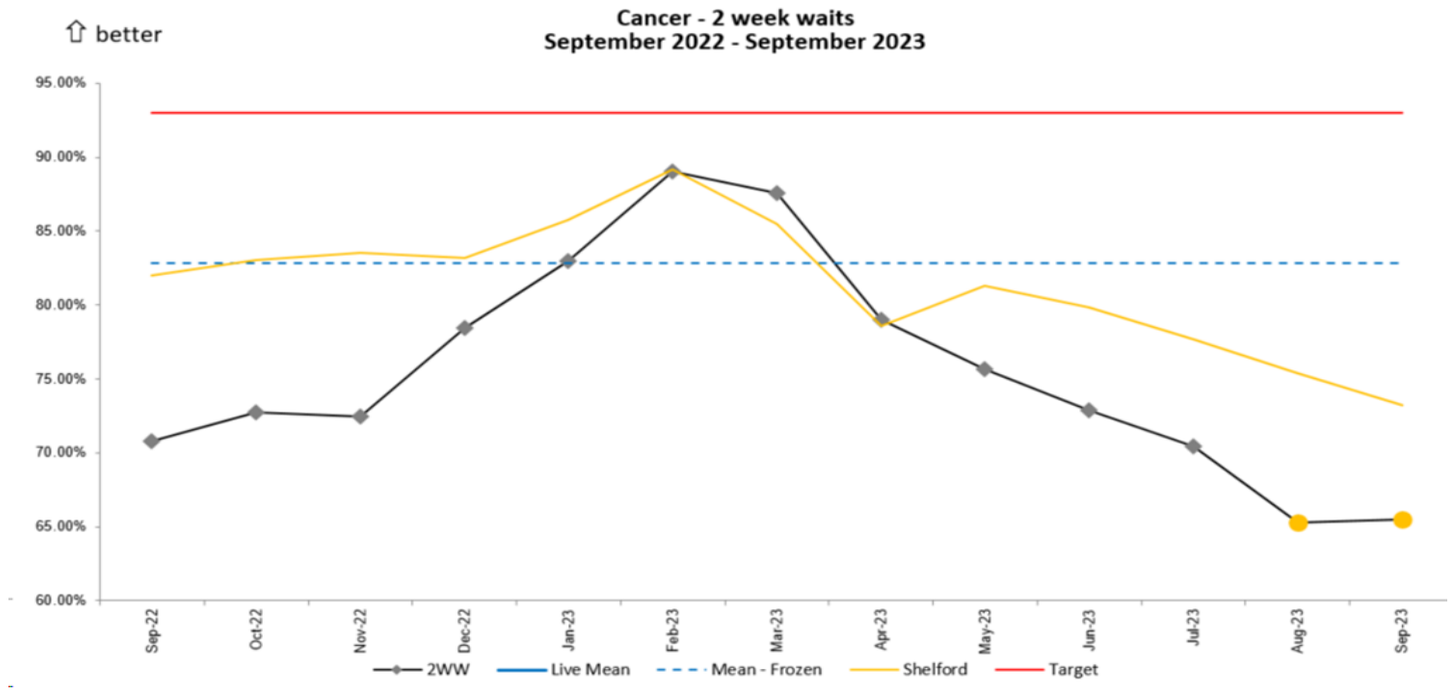
Sep-23	Target
65.5%	93.0%

SPC Variance
Normal variation

Shelford Group Avg (Sep-23)
73.3%

Cancer Site Overview as of 27/11/2023

Site	Breaches
Skin	35
Gynaecological	2
Breast	16
Head & Neck	2
Lower GI	4
Sarcoma	
Lung	
Urological	
CNS/Brain	
Haematological	
Upper GI	
All	



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.

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. This will be the final month of reporting 2 week wait performance as it is no longer a national metric 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.

Cancer - 31 days decision to treat to treatment

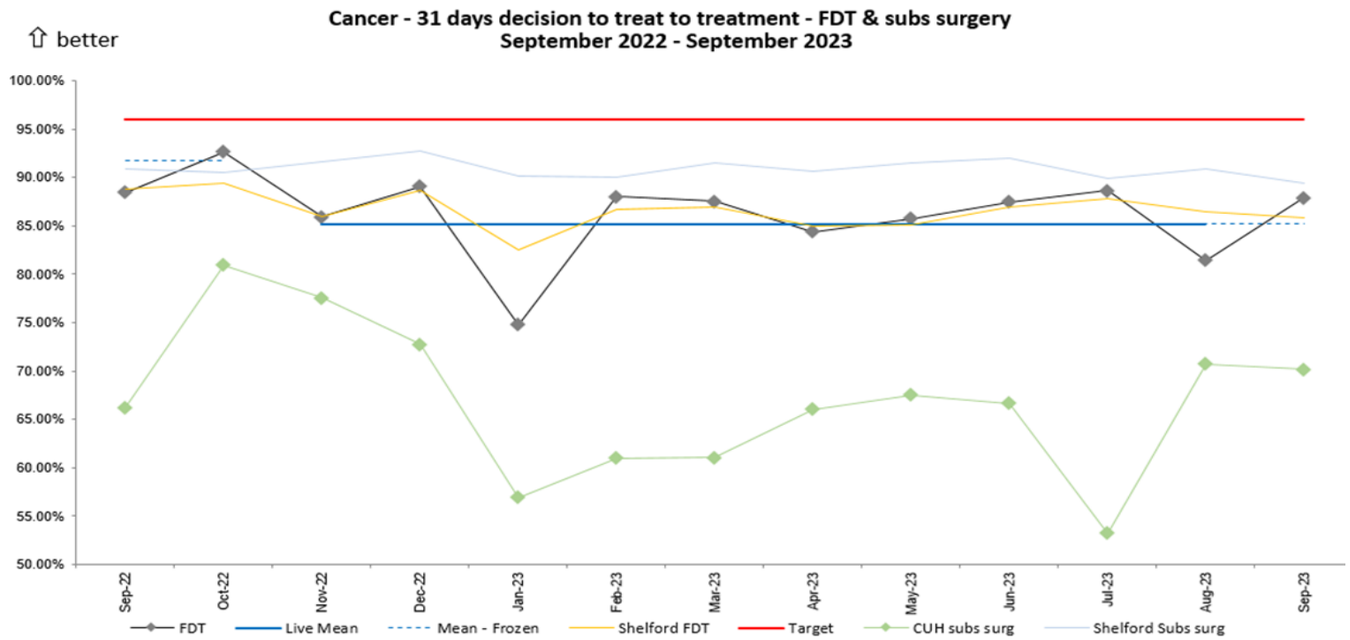
NHS
Cambridge University Hospitals
NHS Foundation Trust

	Sep-23	Target
FDT	87.9%	96.0%
Subs Surgery	70.2%	94.0%

SPC Variance
Normal variation

Shelford Group Avg (Sep-23)	
FDT	85.8%
Subs Surgery	89.4%

Cancer Site Overview as of 21/11/2023	
Site	Backlog
Breast	21
CNS/Brain	0
Gynaecological	3
Head & Neck	3
Haematological	0
HPB	8
Lower GI	2
Lung	1
Childrens	0
Sarcoma	0
Skin	45
Testicular	0
Upper GI	0
Urological	17
All	100



Updates since previous month

CUH continues to fall below target with 94% of the breaches in September relating to surgical capacity, the sites with the largest breaches are in Skin (23%), LGI (19%), and Kidney (17.9%).

Current issues

Access to sufficient theatre capacity within 31 days remains an issue across multiple cancer sites. Radiotherapy suffered a 2 day shut down on 1 linac due to equipment failure, this along with record referral numbers in October has resulted in a number of breaches particularly in breast and urology. The service is working extended days and weekends to recover.

Key dependencies

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

Future actions

Continued focus on lower GI, HPB, skin, and kidney surgery in November/December.
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

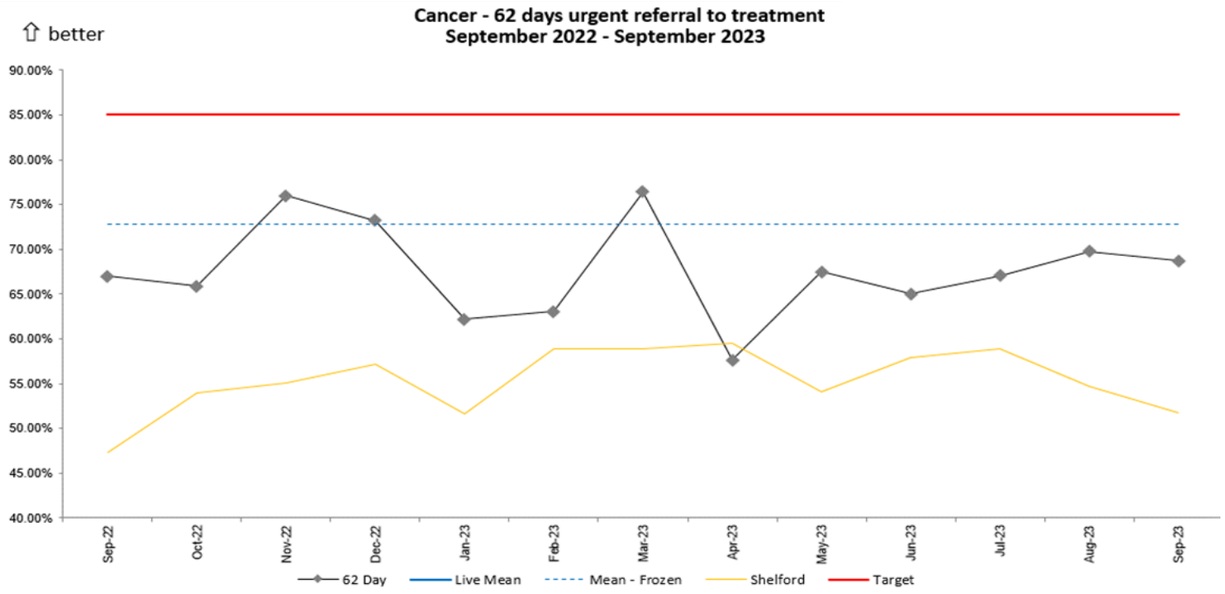
Sep-23	Target
68.7%	85.0%

SPC Variance
Normal variation

Shelford Group Avg (Sep-23)
51.8%

Cancer Site Overview as of 21/11/2023

Site	Backlog
Breast	5
CNS/Brain	1
Gynaecological	15
Head & Neck	12
Other Haem Malignancies	4
Lower GI	7
Lung	8
NSS	0
Upper GI	1
Urological	29
Sarcoma	4
Skin	93
HPB	7
Childrens	0
Symptomatic Breast	0
All	*186*



Updates since previous month

CUH performance remains below target although continues to be higher than the Shelford Group. 52% of breaches are CUH only patients and of that 66% were due to delays within CUH control such as delayed pathology reporting, outpatient and surgical capacity. 33% of referrals to CUH from regional hospitals were treated in the required 24 days, this reduction is due to referrals without the required diagnostics being completed at referring trusts.

Current issues

- Delays in pathology turn around times (currently at 32% 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
- Improved regional compliance with the Inter provider transfer policy, including all diagnostics being completed prior to tertiary referral.

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

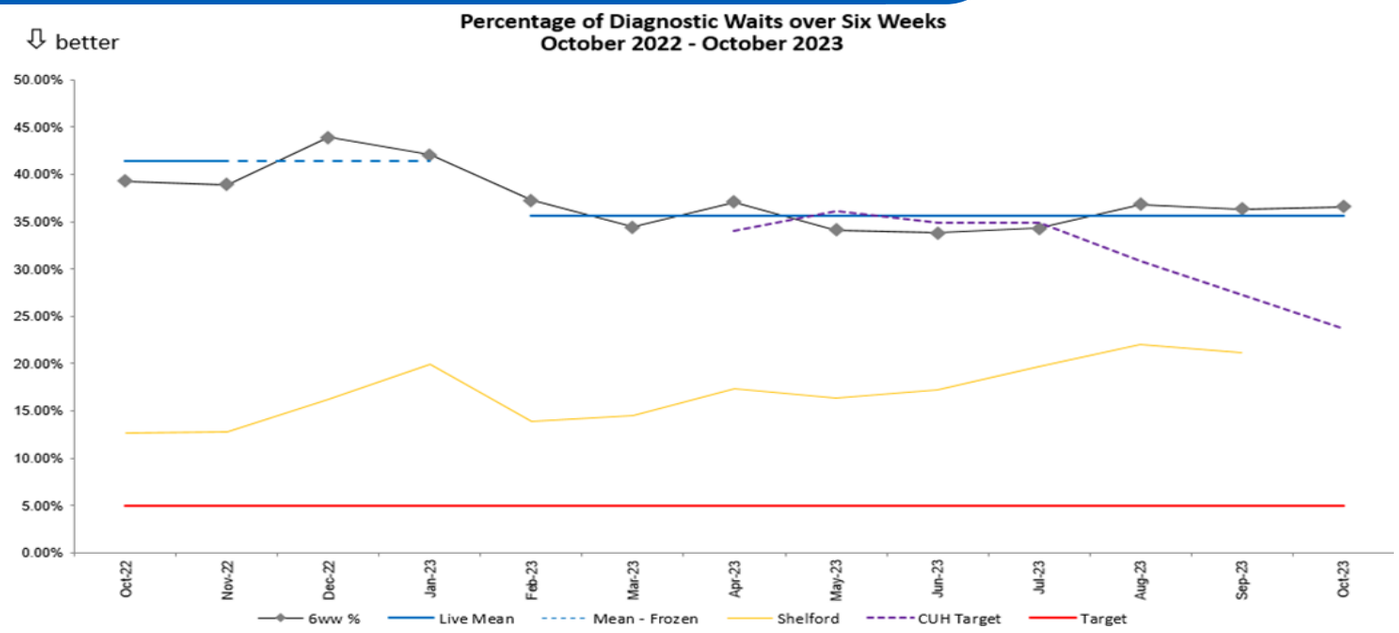
NHS
Cambridge University Hospitals
NHS Foundation Trust

Oct-23	Plan
36.6%	23.7%

SPC Variance
Positive special cause variation

Shelford Group Avg (Sep-23)
21.2%

Three Month Forecast		
Nov-23	Dec-23	Jan-24
19.3%	15.5%	9.3%



Modality overview

Modality	% >6wks	Breaches
Echocardiography	68.8%	2397
Non obstetric ultrasound	30.3%	783
Audiology	68.7%	994
Magnetic Resonance Img'	14.1%	305
DEXA Scan	8.5%	52
Computed Tomography	13.8%	127
Urodynamics	59.4%	203
Neurophysiology	**4.7%**	9
Cystoscopy	10.6%	32
Gastroscopy	**4.8%**	28
Colonoscopy	**0.3%**	2
Respiratory physiology	20.0%	7
Barium Enema	14.5%	8
Flexi sigmoidoscopy	**0.0%**	0
Total		**4947**

Updates since previous month

October 6wk performance has remained stable at 36.6%, but significantly adverse to the planning assumption for improvement.
The total waiting list increased by 794 due to a catch up of administrative backlog for echo orders. The volume >6 weeks increased by 317 for the same reason.

Current issues

Echo (+332) Audiology (+52) and Ultrasound (+40) deteriorated their >6ww position.
Echo is 48% of the Trust total > 6 weeks. Current Insourcing provider ceases end Nov 23, a new provider has been identified to commence in Dec 23.
52% vacancy rate (10.5 wte) continues for Cardiac Physiologists 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

Refer a friend scheme introduced and out to advert.
Enhanced bank rates in Echo approved until Jan 24.
No progress via overseas recruitment agencies.
6 candidates shortlisted for Band 7 Physiologists (7.5 wte vacancies)
Support from RPH Physiologists being taken forward by workforce leads.

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

New Outpatient Attendances - % vs. Baseline

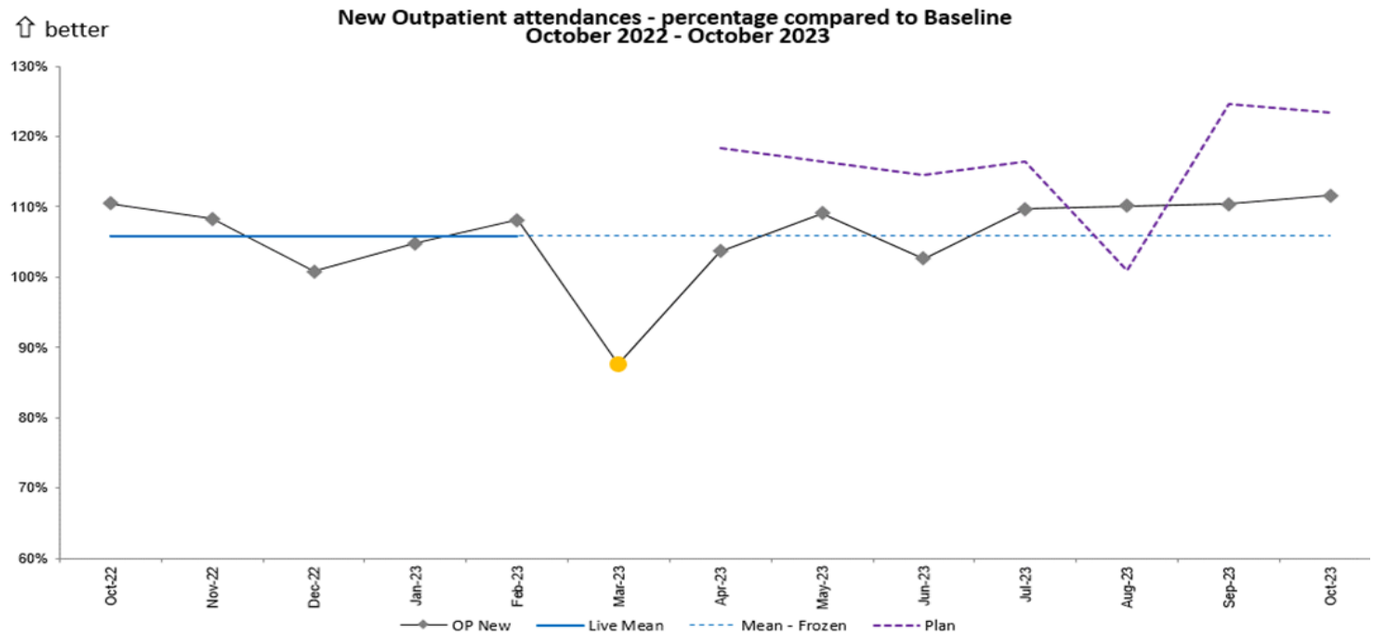
NHS
Cambridge University Hospitals
NHS Foundation Trust

Oct-23	Plan
111.6%	123.3%

SPC Variance
Normal variation

Shelford Group Avg (Sep-23)
N/A

Three Month Forecast		
Nov-23	Dec-23	Jan-24
106.9%	119.8%	111.3%



Divisional overview	
Division	Performance
A	112.1%
B	110.1%
C	96.8%
D	114.0%
E	103.9%

Updates since previous month

CUH new activity remains adversely below plan for end March 2024, however, the most recent data point in October evidences the strongest performance for over 12 months. Division D continues to be the highest performer.

Current issues

New OP appts waiting list remains high at 64,344 in October. The rate of rise has slowed, the median for the past six months is 0.5%, compared to 1.5% for the previous year. The rate has been lower than the current median of 0.5% for the past 3 months, reaching -0.1% in October 2023.

Key dependencies

We have asked that specialties
use the GIRFT Outpatients guidance and checklist and the Further Faster handbooks published in August / September 2023, to help implement further action, and also use the NHSE data opportunity tool that enables specialties to
benchmark with and learnfrom other Trusts e.g. on new:follow up ratio, virtual, PIFU, DNA and other rates.

Future actions

A greater volume, pace and spread is needed to achieve the required scale of change.

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

Follow Up Outpatient Attendances - % vs. Baseline

NHS
Cambridge University Hospitals
NHS Foundation Trust

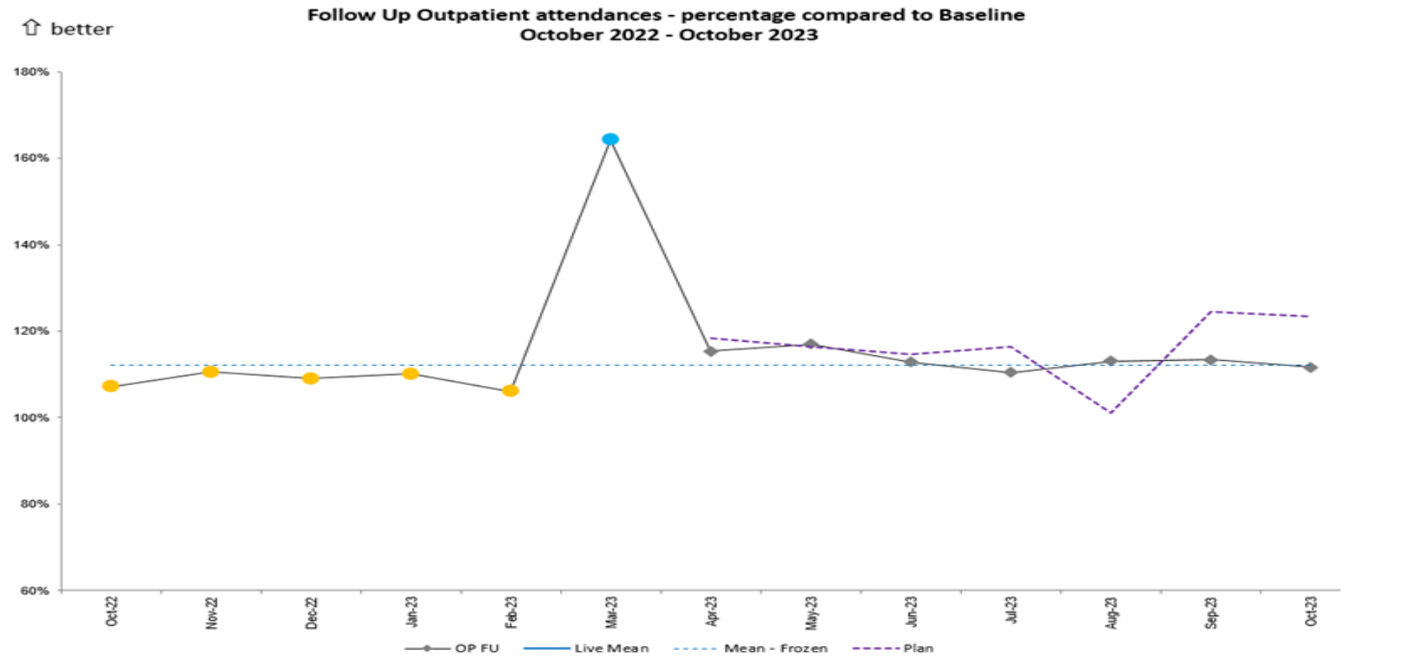
Oct-23	Plan
111.6%	125.4%

SPC Variance
Normal variation

Shelford Group Avg (Oct-23)
N/A

Three Month Forecast

Nov-23	Dec-23	Jan-24
110.8%	122.0%	116.2%



Divisional overview

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

Updates since previous month

CUH follow up activity has increased in 2023 and remains adversely above the 100% CUH target for end March 2024. A more in-depth look at the numbers suggests some of this increase is driven by non-consultant follow ups which were not recorded in 2019/20, now being recorded.

Current issues

The number of overdue follow-ups has steadily increased for the last 2 and a half years, reaching 57,367 in October 2023. All divisions have overdue follow-ups on their risk registers. Division E overdue follow ups have plateaued, further monitoring is needed to see if the halted increase turns into a favourable decrease.

Key dependencies

Action being taken to address overdue follow ups includes waiting list validation and initiatives, and pathway redesign including PIFU, and early tests of Patient Not Present (PNP) remote monitoring. 4 specialties are currently using PNP, with 6 more in the eHospital build pipeline, and several others having planning discussions to introduce PNP.

Future actions

The national target is to reach 75% by end 2023/24 which is highly unlikely to be met. However, for five consecutive months activity has been lower than the current median, reaching 112.4% in October 2023.

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

PIFU Outpatient Attendances

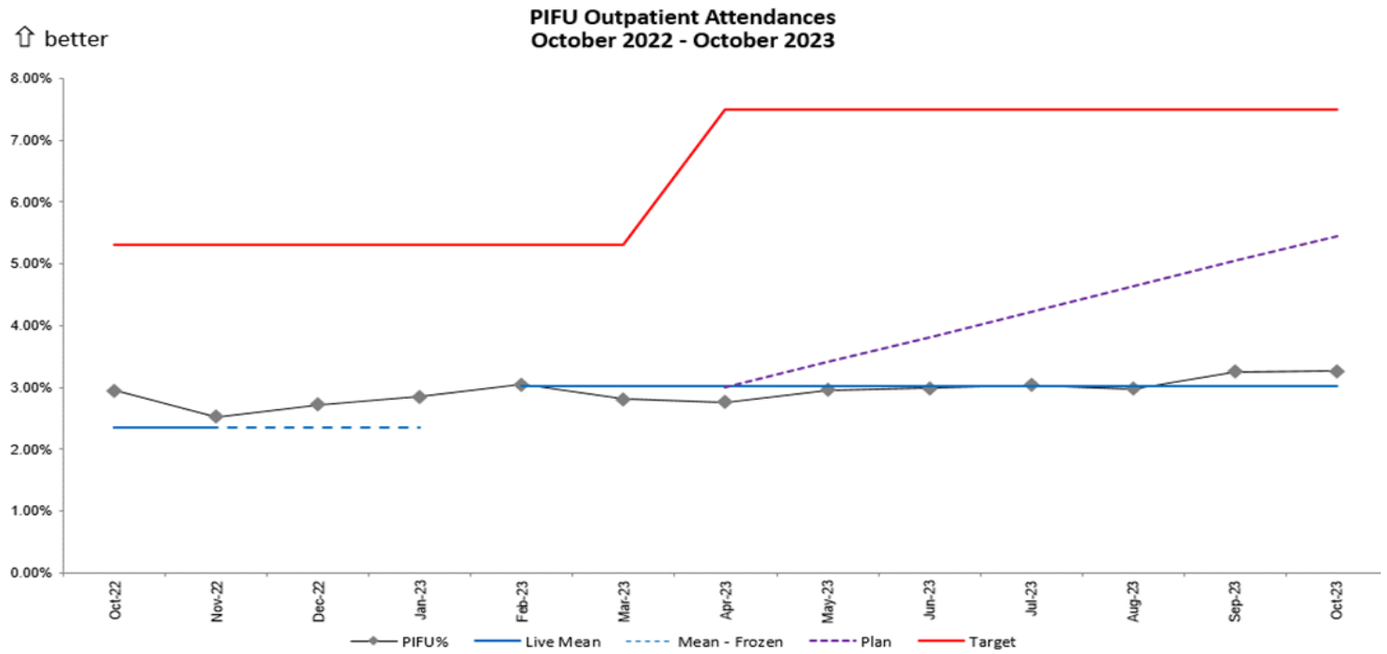
NHS
Cambridge University Hospitals
NHS Foundation Trust

Oct-23	Plan
3.3%	5.5%

SPC Variance
Normal variation

Shelford Group Avg (Oct-23)
N/A

Three Month Forecast		
Nov-23	Dec-23	Jan-24
5.9%	6.3%	6.7%



Divisional overview	
Division	Performance
A	7.9%
B	3.8%
C	1.3%
D	1.8%
E	3.1%

Updates since previous month

There is a consistent trend upwards in the use of PIFU but CUH is yet to reach the 7.5% target for end March 2024. The rate of rise is slow, with the median for the last six months increasing to 3.3%. Division A is the only Division to meet, and exceed, the 7.5% target.

Current issues

None

Key dependencies

CHEQS data shows the correlation between PIFU and reduced follow ups. As of 07 November 2023, of the 70,527 PIFU orders placed since 2019 – 43,070 have expired. 92% expired with no follow up taking place which equates to 39,616 follow ups being saved / avoided due to a PIFU being in place.

Future actions

Further action is needed to accelerate the pace and scale of PIFU increase. Divisions are encouraged to use monthly data provided by the Improvement and Transformation team, to review PIFU usage at specialty and consultant level, and target action.

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

Delayed discharges

NHS
Cambridge University Hospitals
NHS Foundation Trust

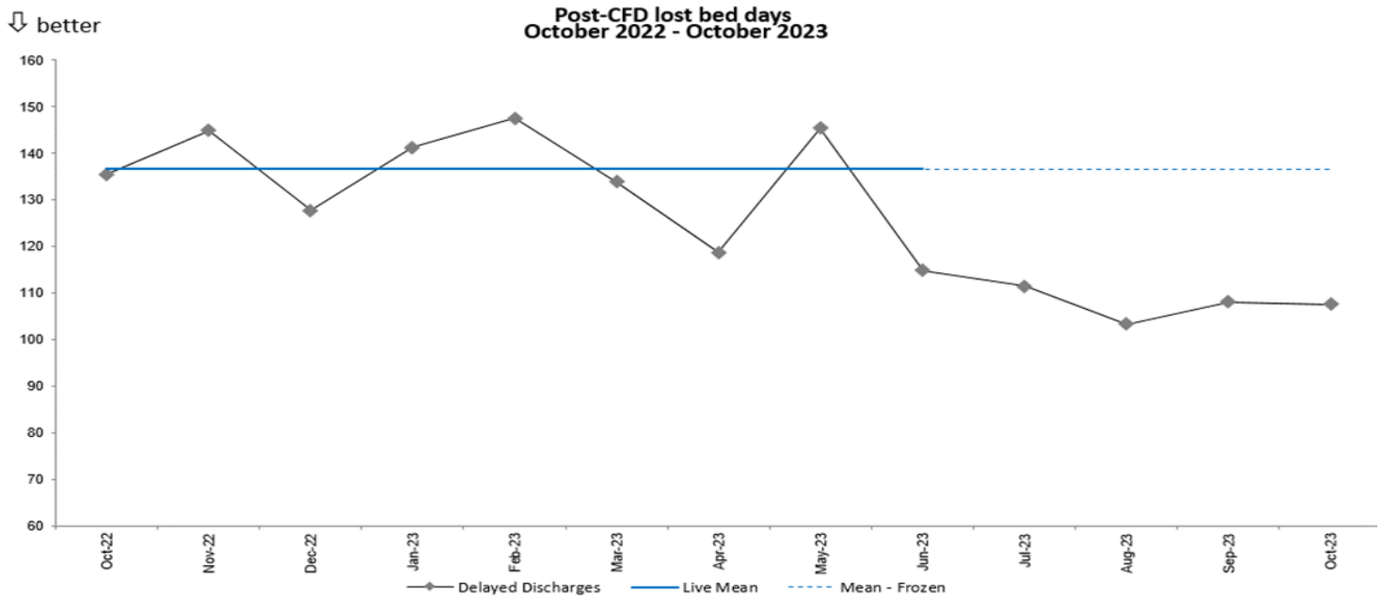
Oct-23	Target
108	N/A

SPC Variance
Normal variation

Shelford Group Avg (Oct-23)
N/A

Beds lost to delays - by pathway

Pathway	Beds lost
Pathway 1	40
Pathway 3	25
Pathway 2	17
Pathway 0	20
Internal Assessments	4
External Assessments	0
Triage	0
Unknown	2
Total	**108**



Updates since previous month

- The Trust lost 108 beds to patients who remained in hospital beds after their clinically fit date
- This is primarily due to patients awaiting packages of care in the community

Current issues

- Patients awaiting a package of care at home (pathway 1) represented the single largest contribution to beds lost to delayed discharges in October (40 beds)

Key dependencies

- Availability of packages of care on a timely basis
- Availability of staff to provide packages of care
- Timely agreement of of funding streams to support care

Future actions

- On-going work with the ICB to streamline pathways, including additional resources provided to the Transfer of Care Hub
- Analysis of data to identify specific areas of delay.

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

Theatre Utilisation - Elective GIRFT Capped

NHS
Cambridge University Hospitals
NHS Foundation Trust

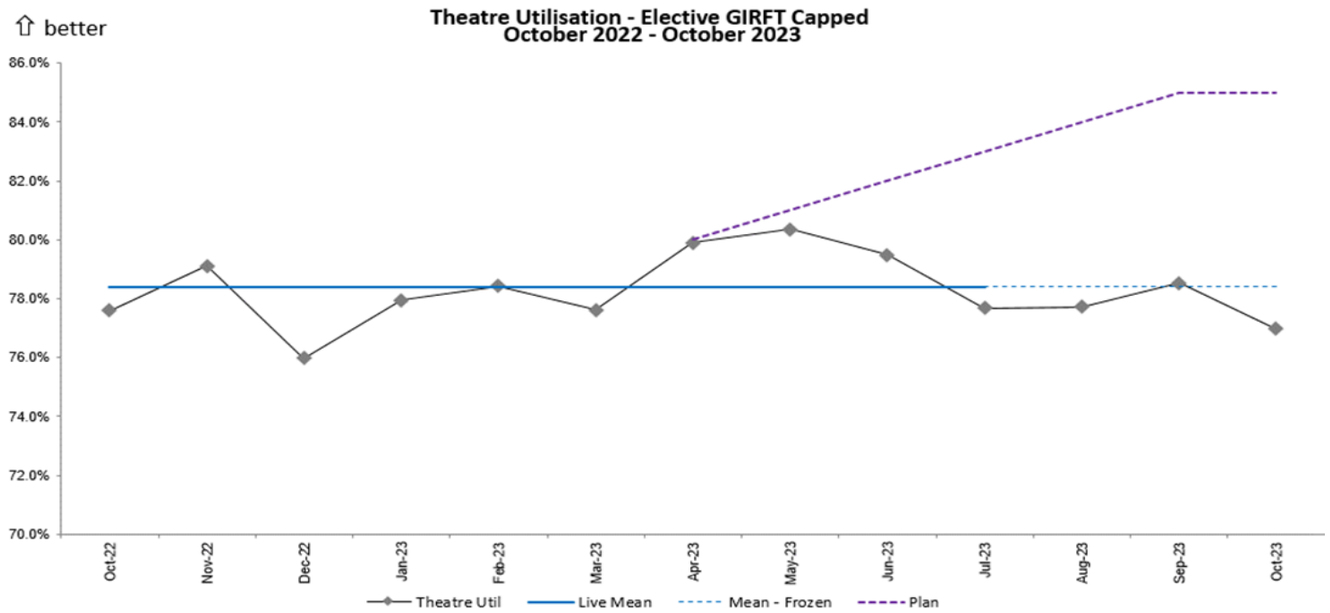
Oct-23	Plan
77.0%	85.0%

SPC Variance
Normal variation

Performance in the 2 weeks to 22/10/2023	
CUH	77.0%
Shelford Grp Median	77.0%

Three Month Forecast		
Nov-23	Dec-23	Jan-24
85.0%	85.0%	85.0%

Utilisation by department	
Department	Utilisation
ATC	75.2%
Main	78.4%
Rosie	81.6%
CEU	71.2%
Ely	74.4%
All	**77.0%**



Updates since previous month

Utilisation at 77% was a deterioration, and below National median for three of the 4 weeks in October.
Sessions used were high at 90.2%, and up to 95.9% when Industrial Action dates are excluded.

Current issues

ATC Utilisation dropped to 5% below their avearge for the year in October. Five specialties achieved over 85% utilisation in month. Ten were below 70%
Short notice cancellations were highest YTD at 327. 30% for clinical reasons, 19% patient CNA/DNA

Key dependencies

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

Future actions

Good practice for utilising stand by patients to mitigate for short notice cacnellations to be more widely shared.
Constraints in surgical bed availability is a factor in delayed starts, increased turnaround times, and cancellations.
Emergency length of stay should remain a focus of all Surgical Divisions.

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

BADS Daycase Rates

NHS
Cambridge University Hospitals
NHS Foundation Trust

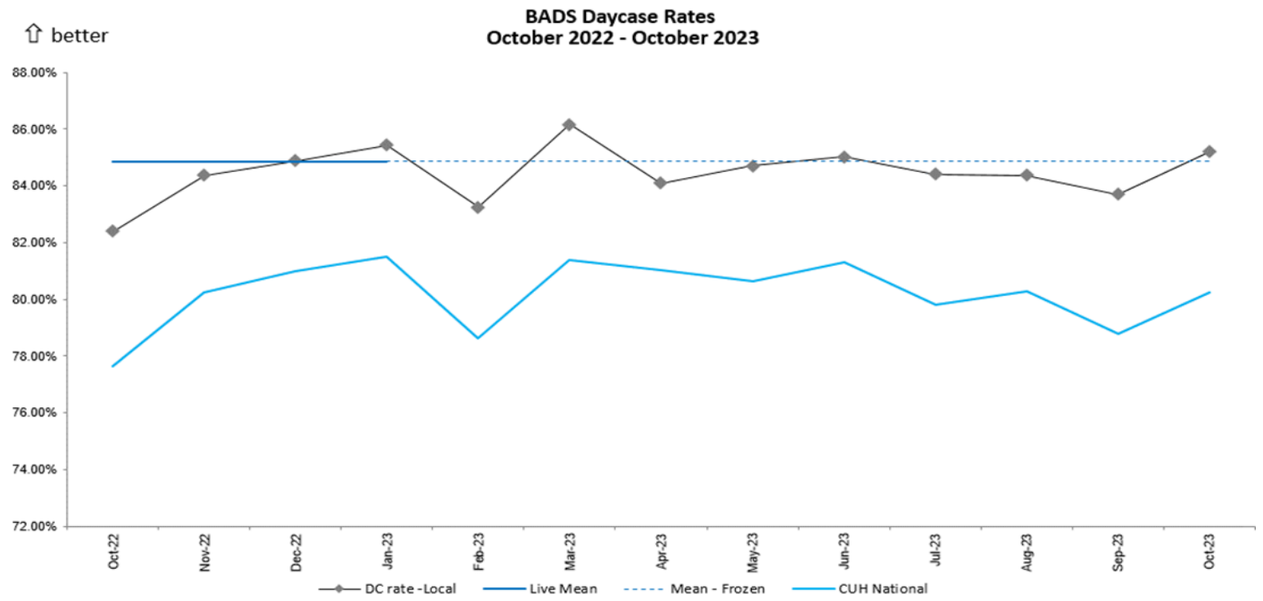
Oct-23	Target
85.2%	N/A

SPC Variance
Normal variation

Shelford Grp Median 3m to end of Jul '23
77.1%

BADS Section Day Case Rate for HVLC focus areas

	3 months to end of Jul '23			Oct-23
Specialty	**CUH**	**Shelford**	**Quartile**	**Local**
Orthopaedics	84.8%	83.1%	2	90.3%
ENT	682.0%	82.7%	1	81.5%
General	65.0%	66.0%	1	70.9%
Gynaecology	58.9%	65.1%	2	77.8%
Opthalmology	98.9%	98.1%	3	99.7%
Urology	68.0%	68.6%	2	76.4%



Updates since previous month

Model Hospital GIRFT data for 3months to Aug 2023 still shows low performance in quartile 1.
Local BADS reporting for zero LOS shows GIRFT expectation at 85.2% was met in October.

Current issues

Inaccurate recording of Intended Management. 60 zero LOS BADS procedures were recorded as in-patient intended management in October.
General Surgery day case rate deteriorated in month. 12% of the >0 LOS. were Lap Chole.

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

Incorrect intended management being circulated to Specialties each month to encourage correct use at listing.
Board rounding at 10am, 12pm and 2pm within L2DSU to ensure daycases progressing.

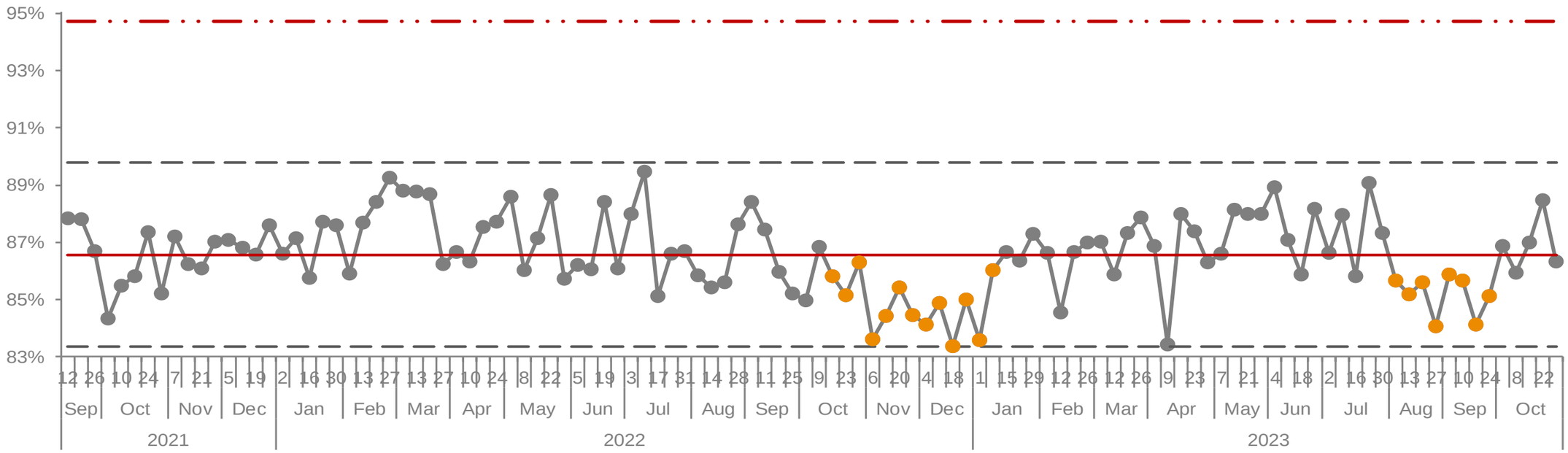
Author(s): Linda Clarke **Owner(s): Nicola Ayton**

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 - Oct 23	Month	-	91.7%	95.2%	L	SP	-	For October the Good score decreased by 2%, and is now the lowest for the year. The Poor score increased by 1% and is now the same score in June, and is the highest for the year. **FOR OCT: there were 447 FFT responses collected from approx. 4204 patients.**
FFT Inpatient poor experience score	Jul 20 - Oct 23	Month	-	4.3%	1.9%	H	SP	-	
FFT Outpatients good experience score	Apr 20 - Oct 23	Month	-	94.1%	94.8%	L	S7	-	For October, the Good slightly increased by 0.6% compared to August. The Poor score remained the same compared to September. There were 4 paediatric FFT responses (8 paeds responses in Aug) so the FFT scores mainly reflect adult clinics. **FOR OCT: there were 5238 FFT responses collected from approx. 30,023 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 - Oct 23	Month	-	3.0%	2.5%	H	S7	-	
FFT Day Case good experience score	Apr 20 - Oct 23	Month	-	96.0%	96.5%		-	-	For October there was a 0.5% decrease in the Good score, and the Poor score remained the same, compared to August. The Good score has remained above 96% for the past 3 months, and the Poor score under 2% for 2 months. **FOR OCT: there were 1229 FFT responses collected from approx. 4,678 patients.**
FFT Day Case poor experience score	Apr 20 - Oct 23	Month	-	1.6%	1.7%		-	-	
FFT Emergency Department good experience score	Apr 20 - Oct 23	Month	-	75.8%	82.8%		-	-	For October the overall Good score decreased by 4% and is now the lowest score for the year. The Poor score increased by 2.5% and 12.7% is the highest for the year. Both the adult and paeds Good score decreased, with the paeds Good score a 4% decline, compared to August. Both the adult and paeds Poor scores increased: adult by 1.5% and paeds by 5%. **FOR OCT: there were 921 FFT responses collected from approx. 5,531 patients**.
FFT Emergency Department poor experience score	Apr 20 - Oct 23	Month	-	15.2%	10.5%		-	-	
FFT Maternity (all FFT data from 4 touchpoints) good experience score	Jul 20 - Oct 23	Month	-	89.5%	94.8%		-	-	**FOR OCT:** Antenatal had 2 FFT response - 50% Good; Birth had 42 FFT responses out of 468 patients - 95% Good / 2.4% Poor; Postnatal had 51 FFT responses: LM had 23 FFT (improvement from 5 in Sep) with 82.6% Good / 4.3% Poor, DU had 3 FFT with 100% Good, BU had 22 FFT with 86.4% Good / 4.5% Poor, and COU 100% Good from 3 responses. 0 FFT responses from Post Community. **OCT MATERNITY OVERALL:** Good score decreased by 0.6% and Poor score decreased by 2% from 95 FFT responses.
FFT Maternity (all FFT data from 4 touchpoints) poor experience score	Jul 20 - Oct 23	Month	-	3.2%	2.0%		-	-	

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.

There continues to be a mix of FFT scores each month. Outpatients is the only FFT Good score that improved, but very slightly by 0.6%. Inpatients, day case, ED and maternity all had declined Good scores, with ED having the largest decline of 4%. However, compared to October 2022, ED has improved both Good score (by 6%) and Poor score (5%). There was no improved FFT Poor scores: Outpatients and day case Poor scores remained the same in October compared to September. Maternity Good score had a slight decrease of 0.6% and continues to be the lowest Good score for the past 12 months. The maternity Poor score improved by 2% and is from improved scores in birth and postnatal.

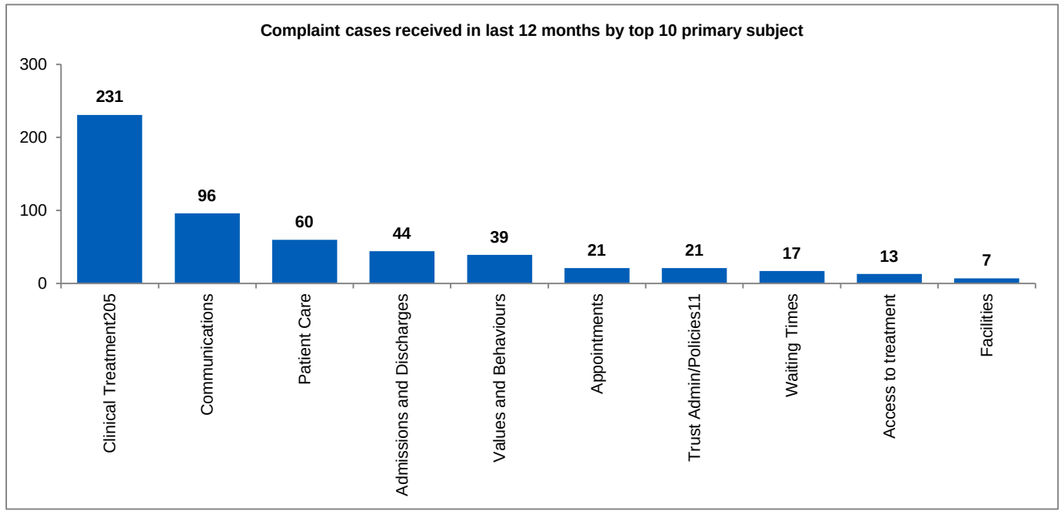
Please note starting in 2022, the Trust reduced the number of SMS being sent to adult patients. Instead of sending a text message to every adult patient that attend an OP/DU appointment, or presented to A&E, the Trust now sends a fixed number of SMS daily.

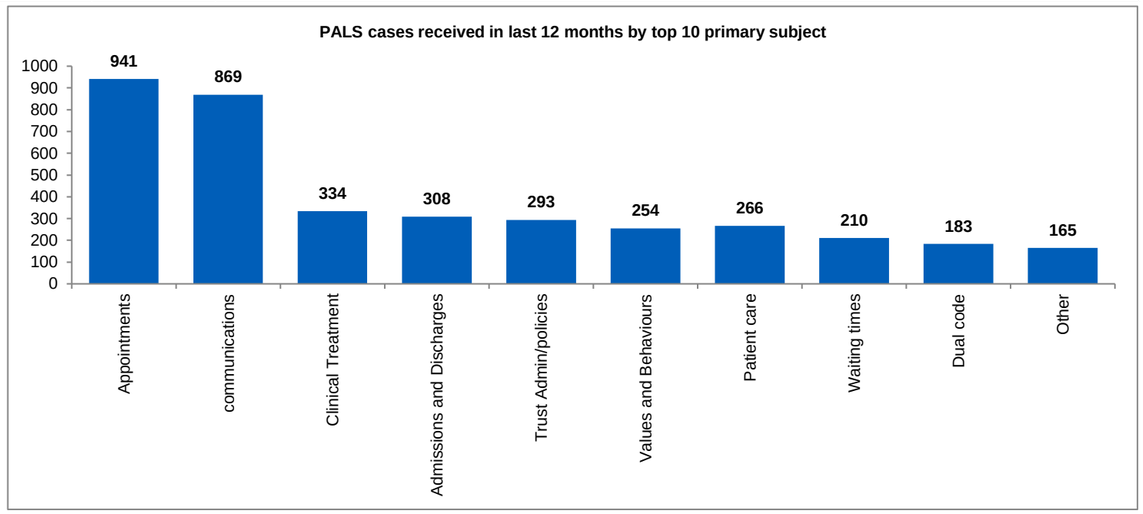
Author(s): Charlotte Smith/Kate Homan Owner(s): Clare Hawkins

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	Oct 19- Oct 23	month	-	57	55	H	SP	-	The number of complaints received between October 2019 - October 2023 is higher than normal variance.
% acknowledged within 3 days	Oct 19-Oct 23	month	95%	84%	73%		-	?	48 out of 57 complaints were acknowledged within 3 working days
% responded to within initial set timeframe (30, 45 or 60 working days)	Oct 19-Oct 23	month	50%	25%	30%	L	S7	?	136 complaints were responded to in October, 34 of the 136 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	Oct 19 -Oct 23	month	80%	35%	87%	L	SP	?	47 out of 136 complaints responded to in October were within the initial set time frame or within an agreed extension date.
% complaints received graded 4 to 5	Oct 19 -Oct 23	month	-	39%	34%		-	-	There were 16 complaints graded 4 severity, and 6 graded 5. These cover a number of specialties and will be subject to detailed investigations.
Compliments received	Oct 19 - Oct 23	month	-	47	32	L	S7	-	47 Compliments were registered during October and sent onto relevant staff for information





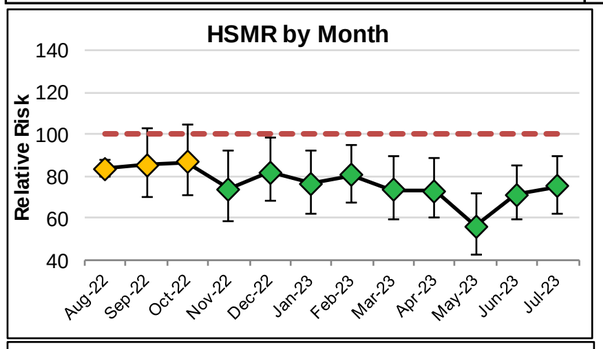
PHSO - There were no cases taken for investigation in October 2023 by the Parliamentary and Health Service Ombudsman.
A backlog of complaint responses (550) declared in May 2023 has now been brought down to less than 60. A new process has been introduced within the complaints team to try to resolve issues 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.

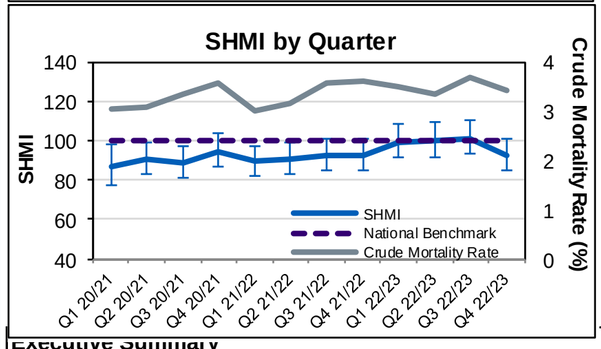
Author(s): Sue Bennison **Owner(s): Clare Hawkins**

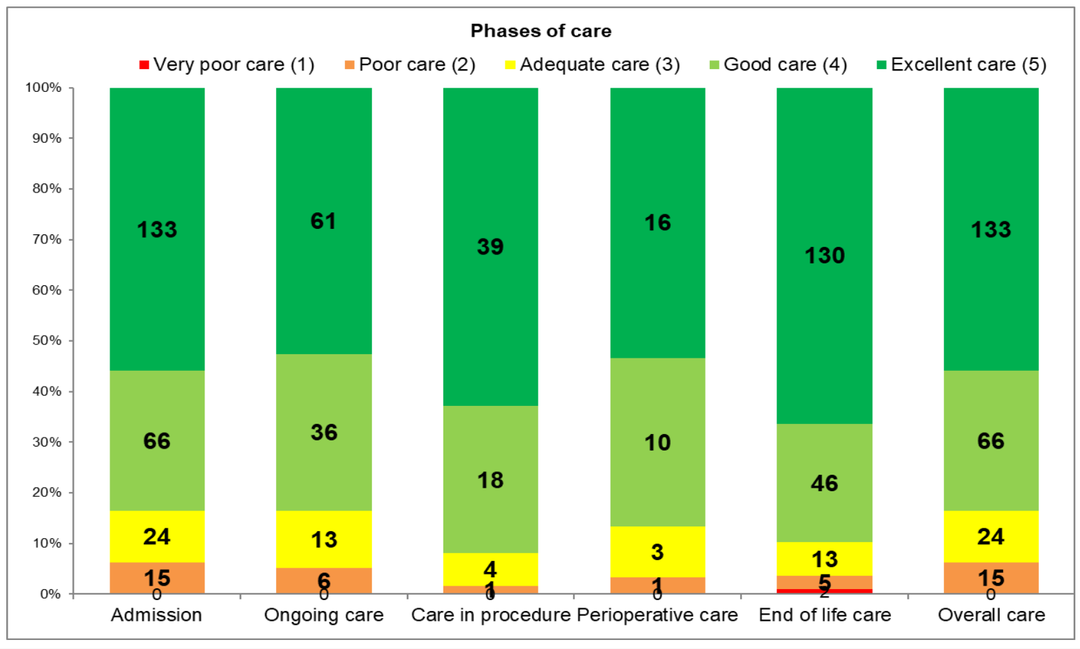
Learning from Deaths

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Data range	Oct-23	Mean	Variance	Comments
Total inpatient and Emergency department deaths	November 2018 - October 2023	**150**	*136*		
Total Emergency Department and Inpatient deaths **per 1000 admissions**		**8.5**	*8.6*		
Emergency department deaths per 1,000 attendances		**0**	*0.8*		Last 6 months have been below the mean
Inpatient deaths by 1,000 admissions		**9.9**	*10.3*		There was a statistically significant downward shift in the last 8 months
% of Emergency Department and Inpatient deaths in-scope for a Structured Judgement Review (SJR)		**13%**	*20%*		In October 2023 20 SJRs were commissioned.







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 were **two serious incidents categorised as potentially/avoidable death** commissioned in October 2023; both of the subcategory, suboptimal care of the deteriorating patient.

Stroke Care

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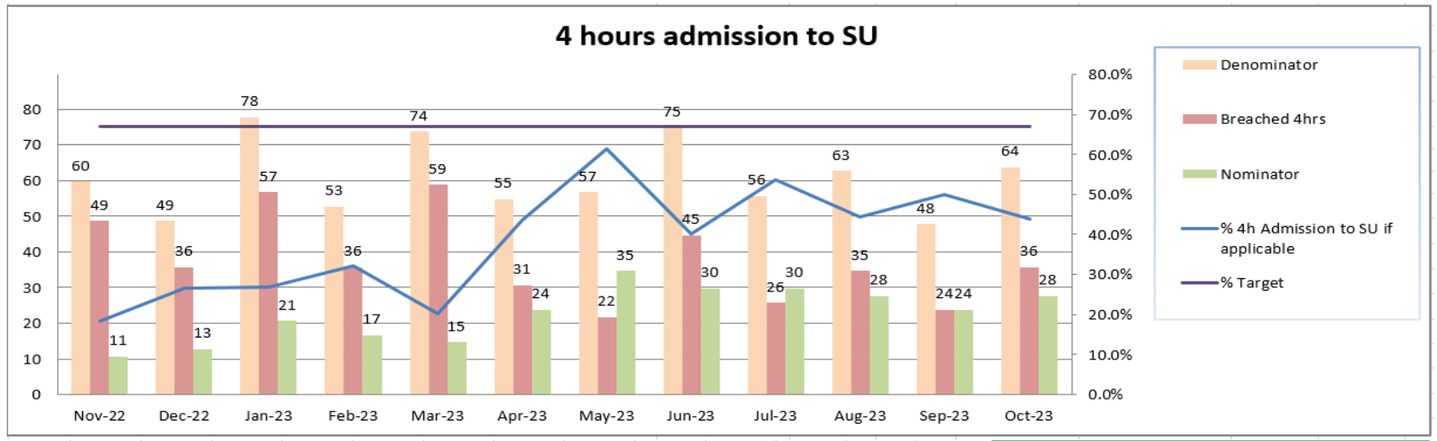

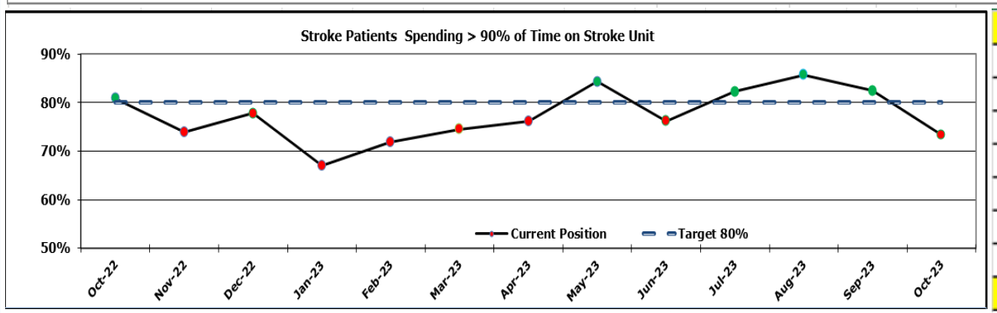

4hrs to SU	Count of MRN
Awaiting Senior review	8
Delay to stroke review	1
Late referral to stroke	1
Not referred on arrival	7
Patient unwell and unstable	1
Trust bed capacity	14
Unclear presentation. MRI confirmed stroke	4
Grand Total	36

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 *	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	Resource capacity	Number of breaches	Month Position (Target 80%)
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%
Oct-23		16			2	1					1			20	73.3%
Summary	11	80	0	4	21	16	1	3	3	0	42	6	3	187	

90% target (80% Patients spending 90% IP stay on Stroke ward) was not achieved for October 2023 = **73.3%**

Trust bed capacity (16) was the main factor contributing to breaches last month, with a total of 20 breaches in October 2023.

4hrs adm to SU (67%) target compliance was not achieved in October 2023 = 43.8%

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.
- Meeting with new head of patient flow scheduled for November to help embed and increase awareness of R2 pathway
- Currently in discussion with ED to change pathway for Stroke Alert notification – will explore paramedic contacting SAT directly to reduce delays between patient arrival and SAT in ED.
- 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

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

Clinical Studies

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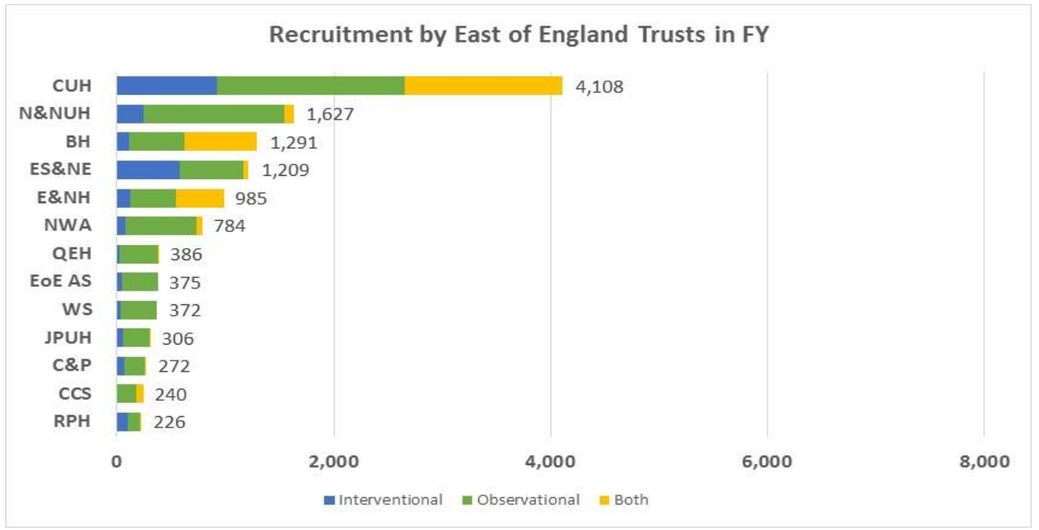
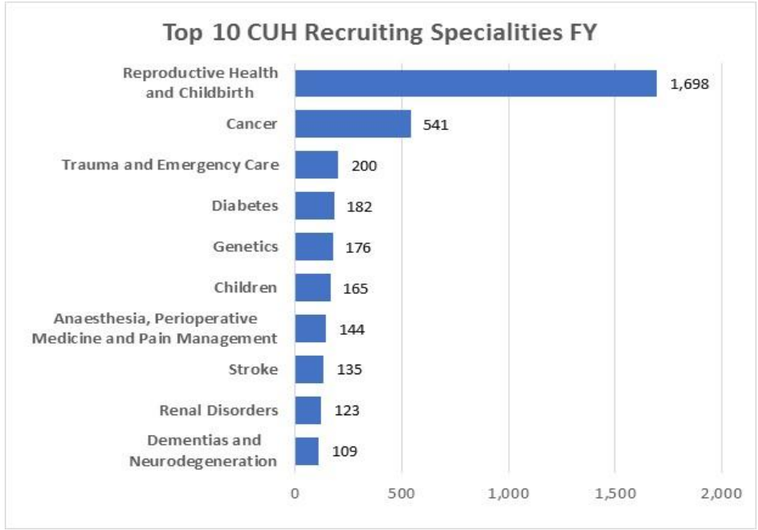
Total Recruitment at end of Sept - FY 2023-24
4,108

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

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Compliance

Assessed compliance with CNST MIS 10 Safety Actions Yr 5		
	Please identify unit	CUH
1	Perinatal Mortality review tool	C
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	CUH
IEA3:	Staff training & Working Together	W
IEA4	Managing complex pregnancy	W
IEA5:	Risk Assessment Throughout pregnancy	W
IEA6:	Monitoring Fetal wellbeing	W
IEA7:	Informed Consent	W
Fully compliant (self assessment)		N
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

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Clinical Outcome Measures

KPI	Measurement / Target			Trust Rate (current reporting period)
				CUH
Massive Obstetric Haemorrhage ≥ 1500 mls	**Vaginal birth**		**3.30%**	4.61
(as per NMPA descriptor, slide 8)	Caesarean		4.50%	3.97
3rd & 4th degree tear	SVD (unassisted)		Unassisted 2.5%	3.46
(as per NMPA descriptor, slide)	Instrumental (assisted)		Assisted 6.3%	8.30
Caesarean section (%age)	(see guidance document)		overall rate not required	
(primip, singleton , ceph, over 37/40, spontaneous labour)	Robson Group 1		N/A	12.9%
[primip, singleton, over 37/40, who had labour induced (2a) or LSCS prior to labour (2b)]	Robson Group 2	**2**	N/A	47.0%
		2a		100.0%
(Multip, at least 1 uterine scar, singleton, ceph, over 37/40)	Robson Group 5		N/A	77.4%
Smoking at time of delivery			≤ 6%	5.98%
Preterm birth				
Preterm birth rate	≤36+6 weeks (over 24+0/40)		≤6% annual rolling rate (Total PTB all	8.95
	16+0 - 23+6 (SBLCBv3)		%age of all singleton births (live & stillborn)	0.0%
	24+0 - 36+6 (SBLCBv3)		%age of all singleton births (live & stillborn)	6.3%

MBRRACE stabilised & adjusted mortality rates per 1000 births with congenital abnormalities included/ excluded (annual only)

Unit	Stillbirth	Neonatal Death < 7/7	Extended perinatal
CUH	**4.16:1000**	**2.40:1000**	**6.49:1000**

KPI	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) Sept'23	5.6
		%age of total admissions that were avoidable	0.2% (Aug)
Optimisation (metrics to be determined locally as per SBLBCv3) **please see the impleentation tool for technical guidance**			Aug'23 data
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		n/a	100.0%
Antenatal corticosteroids			
Percentage of babies born before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth		target: 55%	62.5%
Magnesium sulphate			
Percentage of babies born before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth		target: 90%	83%
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		target: 90**% for <37 weeks**	85.7%
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.		target: 75%	69% (74% <37 weeks)
Thermoregulation			
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		target: 75-80%	71.4%
Early Maternal Breast milk			
Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth.		target: 50%	27.0%

Maternity Dashboard

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KPI	Goal	Target	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	SPC	Narrative and Actions taken for Red/Amber/Special cause concerning trend results
Activity										
Births	For information	N/A	474	452	490	466	443	472	5445	
Health and social care assessment <GA 12+6/40	> 90%	>=90% <90% and >=80% <80%	83.06%	91.03%	89.11%	95.05%	86.75%	99.09%		Report corrected and now able to exclude transfer of care bookings.
Booking Appointments	For Information	N/A	431	379	358	343	400	330		
Vaginal Birth (Unassisted)	For Information	N/A	49.16%	48.45%	48.16%	49.79%	49.89%	51.48%		
Home Birth	For Information	N/A	0.21%	0.22%	1.63%	0.86%	1.13%	1.69%		
Rosie Birth Centre Birth	For Information	N/A	14.14%	15.71%	13.47%	13.52%	16.93%	15.04%		
Rosie Birth Centre transfers	For information	N/A	41.00%	31.96%	34.41%	42.39%	29.03%	37.96%		
Birth assisted by instrument (forceps or ventouse) (Instrumental)	For Information	N/A	12.03%	13.05%	12.04%	9.87%	9.48%	10.17%		
CS rate (planned & unplanned)	For Information	N/A	38.40%	38.27%	39.18%	39.70%	40.18%	37.71%		
Women in RG*1 having a caesarean section with no previous births: nullip spontaneous labour	For information	10%	19.10%	18.30%	20.90%	16.10%	18.50%	12.90%		
Women in RG*2 having a caesarean section with no previous births: nullip induced labour, nullip pre-labour LSCS	For Information	For Information	50.50%	41.10%	55.10%	47.90%	51.00%	57.30%		
Ratio of women in RG1 to RG2	Ratio of >2:1	N/A	1:3.24	1:2.93	1:3.68	1:2.98	1:3.53	1:5		
Women in RG*5. Multips with 1 or 2+ previous C/S	For Information	For Information	88.1%	83.9%	83.3%	88.2%	91.5%	77.4%		
Women in RG1, RG2, RG5 combined contribution to the overall C/S rate.	66%	60-70%,	72.0%	61.3%	67.2%	62.2%	68.5%	60.1%		
Induction of Labour rate	For Information	N/A	34.12%	33.48%	33.89%	33.48%	34.18%	31.84%		
Delay in commencement of Induction (IOL)	0%	<10%	30.16%	27.62%	28.64%	24.87%	34.88%	28.74%		CQC workstream for IOL improvements, including improvements to report errors.
Delay in continuation of Induction (IOL)	0%	<10%	9.52%	11.05%	9.05%	10.05%	15.00%	14.37%		CQC workstream for IOL improvements, including improvements to report errors.

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Indication for IOL (SBLCBV3)	0%	5-10%	2%	0%	0%	5%	0%	7%		Data amended to report as per SBLv3 (denominator should be IOLs before 39 weeks, previously reported all IOLs).
Indication for IOL	100%	≥95%	100%	99.33%	100%	98.70%	100%	97%		
Divert Status - incidence	0	<1	1	2	4	2	1	1		Diverted preterms/high risk cases due to NICU closure (capacity and staffing). No other units able to accept preterm admissions, so no one diverted, except for 1 woman who was low-risk, full term. This was due to a 1 hour period when maternity acuity and staffing meant we went on full divert.
Total number of hours on divert	For information	N/A	15:30	27.25	98.20	27.50	18.08	21.25		Partial divert to preterm/high-risk only for 20.25 hours.
Admissions to Rosie during divert status	For information	N/A	6	14	52	7	12	10		
Number of women giving birth in another provider organisation due to divert status	For information	N/A	1	3	4	2	1	1		
Number of IUTs declined due to maternity services capacity/staffing	0%	0%				8	1	0		**New data reported.** Refusal in Sept was due to DU capacity (gest 34 weeks from Watford, pt declined another hospital). Aug refusals: Total of 4 <28 weeks. Divert impacted - 1 refused <2 hours before divert initiated and 1 during divert who was <28 weeks. 3 for staffing alone, the rest were staffing/capacity in combination with
Workforce										
Midwife/birth ratio (actual)**	1:24	<1.28	1:23.7	1:24.1	1:25.3	1:25.2	1:25.1	1:23.1		
Midwife/birth ratio (funded)**	For information	1.24.1	1:23.7	1:23.8	1:23.4	1:23.4	1:23.1	1:23.1		
Supernumerary Delivery Unit Coordinator	100%	≥95%	100%	100%	100%	100%	100%	98%		Improving special cause
Staff sickness as a whole	< 3.5%	<5%	4.92%	4.57%	4.19%	4.29%	4.37%			Improving special cause
Education & Training - mandatory training - overall compliance (obstetrics and gynaecology)	>92% YTD	>75% YTD	88.4%	91.1%	91.7%	93.0%				Improving special cause
Education and Training - Training Compliance for all staff groups: **Prompt**	>90% YTD	>85% YTD	79.74%	81.22%	82%	86.80%	82.60%	94.56%		Improving special cause
Education and Training - Training Compliance for all staff groups: **NBLS**	>90% YTD	>85% YTD	83.6%	81%	80%	80%	75%	75%		Additional sessions added for Nov and Dec. CNST MIS Yr 5 SA8 at risk due to non-compliance. CNST MIS yr 5 have reduced target compliance to 80% for 12 weeks to account for strikes therefore by 1 December we need to achieve 80% compliance to achieve MIS yr 5.
Education and Training - Training Compliance for all staff groups: **K2**	>90% YTD	>85% YTD	86.60%	87.08%	81.00%	84.20%	80.60%	91.20%		Consultant K2 = 71.4%. 4 conslutants non-compliant and need 3 to complete before the end of Nov for MIS year 5 compliance.
Education and Training - Training Compliance for all Staff Groups - **Fetal Surveillance Study Day**	>90% YTD	>85% YTD	84.52%	84.91%	82.00%	86.60%	88.00%	91.40%		All grous >90% - final compliance for CNST submission
Education & Training - mandatory training - **midwifery compliance**.	>92% YTD	>75% YTD	87%	91.6%	92.6%	93.5%	93%			

Maternity Dashboard

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Maternal morbidity										
Puerperal Sepsis	For information	N/A	0.21%	0.22%	0.42%	0.43%	no data provided	0.42%		Figure is 0.42% for October
ITU Admissions in Obstetrics	For information	N/A	0	0	0	0	2	1		1 admission due to malaria infection, IUT with no antenatal care
Massive Obstetric Haemorrhage ≥ 1500 mls - vaginal birth	≤3.3%	≤3.3%	3.75%	4.63%	5.84%	5.30%	5.58%	4.61%		CQC workstream. November PPH education campaign week delivered.
Massive Obstetric Haemorrhage ≥ 1500 mls - caesarean birth	≤4.5%	≤4.5%	5.56%	3.62%	3.73%	6.08%	6.00%	3.97%		
3rd/ 4th degree tear rate	≤3.5	<5%	3.38%	1.55%	1.83%	3.04%	4.84%	4.33%		Increase in instrumental delivery 3rd degree tear rate. Half of cases had no documentation for hands on technique. Plan for increased training via PD as well as by specialist.
Maternal readmission rate	For information	N/A	1.45%	2.59%	2.30%	2.56%	2.63%	1.63%		
Peripartum Hysterectomy	For information	N/A	0	1	2	0	0	0		
Direct Maternal Death	0	<1	0	0	0	0	0	0		
Governance										
Total number of Serious Incidents (SIs)	0	<1	0	0	0	0	1	0		
Never Events	0	<1	0	0	0	0	0	0		
Neonatal Morbidity										
Still Births per 1000 Births	3.33/1000 (Mbrrace 2021)	rolling rate	2.75:1000	2.93:1000	3.45:1000	3.81:1000	3.65:1000	3.85:1000		Recently published ONS data reports national stillbirth rate is 3.9:1000 for EofE in 2022. MBRRACE benchmark due to be updated late 2023.
Stillbirths - number ≥ 22 weeks	<3	<6	2	2	2	2	1	2		
Number of birth injuries	0	<1	1	0	1	1	2	0		
Babies born with an Apgar <7 at 5 minutes of age	For information	N/A	1.27%	2.23%	1.66%	2.81%	1.59%	2.99%		

Maternity Dashboard

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Incidence of neonatal readmission	For information	N/A	3.83%	3.83%	4.07%	4.74%	4.82%	8.26%		Working party within ATAIN group being established.
Term Admission to NICU Rate	<6%	N/A	4.9%	4.0%	4.9%	4.9%	5.6%	6.4%		Normal variation seen. All October cases currently under review and avoidable cases will be presented at ATAIN meeting.
Quality										
1-1 Care in Labour	≥95%	≥90%	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%		
Babies with a first feed of breastmilk	≥80%	≥70%	83.65%	83.93%	83.37%	82.68%	81.41%	78.25%		Compliance impacted by high number of blank data fields (23.7%). Teaching re infant feeding documentation now added into QPO and Epic tip sheet in new starter pack as of this month.
SATOD (Smoking at Time of Delivery)	< 6%	Green = <6%, Amber = 6.1% - 7.9 %, Red = >8	5.33%	4.72%	4.78%	4.78%	6.70%	5.98%		
CO Monitoring at booking	≥95%	Green = ≥95%, amber = <95% and ≥84%, red = <85%	92%	93%	89%	82%	87%	97%		
CO Monitoring at 36 weeks	≥95%	Green = >95%, amber = <95% and >84%, red = <85%	69%	66%	62%	67%	60%	65%		Propose CO monitoring at every AN appointment. Need to review straw stock first.
VTE Assessment - AN	≥95%	≥95%	64%	68%	52%	72%	76%	78%		
VTE Assessment - PN	≥95%	≥95%	89%	89%	87%	86%	85%	84%		Guideline recommends prophylaxis by 4-8 hours post birth. 99% VTE completed in the PN period.
VTE Assessment - PN	≥95%	≥95%				94%	95%	95%		For MDT review whether time frame for compliance should be 8 hours.

Finance

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Trust performance summary - Key indicators

Trust actual surplus / (deficit)

(£0.4m)	*Actual (adjusted)**
(£0.4m)	*Plan (adjusted)**
(£3.8m)	*Actual YTD (adjusted)**
£3.0m	*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	£17.1m	£124.1m
Target adj. block increase	£0.3m	£2.3m
EPM actual + block increase	£17.4m	£126.4m
EPM original plan	£20.6m	£139.3m
EPM original target	£18.7m	£128.7m

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

Net current assets

(£92.4m)	*Actual*
(£45.5m)	*Plan*

Debtor days

20	*This month*
20	*Previous month*

Payables performance (YTD) **

87.1%	*Value*
89.7%	*Quantity*

EBITDA

£16.7m	*Actual YTD*
£25.4m	*Plan YTD*

Capital expenditure

£3.9m	*Capital - actual spend in month*
£23.3m	*Capital - actual spend YTD*
£18.4m	*Capital – plan YTD*

Cash

Cash

£171.5m	*Actual*
£149.8m	*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

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12 Month Growth by Staff Group

Staff Group	Headcount		Headcount 12 Month growth	FTE		FTE 12 Month growth	
	Nov-22	Oct-23		Nov-22	Oct-23		
Add Prof Scientific and Technic	240	250	4.2%	216	225	8	3.9%
Additional Clinical Services	1,967	2,043	3.9%	1,811	1,867	57	3.1%
Administrative and Clerical	2,425	2,592	6.9%	2,230	2,387	158	7.1%
Allied Health Professionals	739	775	4.9%	654	691	37	5.7%
Estates and Ancillary	365	372	1.9%	353	360	7	2.0%
Healthcare Scientists	649	747	15.1%	610	712	102	16.7%
Medical and Dental	1,720	1,772	3.0%	1,624	1,667	43	2.7%
Nursing and Midwifery Registered	3,868	4,030	4.2%	3,564	3,715	151	4.2%
Total	**11,973**	**12,581**	**5.1%**	**11,062**	**11,625**	**563**	**5.1%**

Admin & Medical Breakdown

Staff Group	Nov-22	Oct-23	FTE 12 Month growth	
Administrative and Clerical	2,230	2,387	158	7.1%
of which staff within Clinical Division	1,087	1,164	77	7.1%
of which Band 4 and below	753	795	42	5.6%
of which Band 5-7	242	256	14	5.8%
of which Band 8A	44	55	11	25.1%
of which Band 8B	7	8	1	13.5%
of which Band 8C and above	40	49	9	22.1%
of which staff within Corporate Areas	900	969	69	7.7%
of which Band 4 and below	248	266	18	7.2%
of which Band 5-7	424	470	46	10.9%
of which Band 8A	88	88	0	0.2%
of which Band 8B	52	51	-1	-1.8%
of which Band 8C and above	89	95	6	6.7%
of which staff within R&D	242	254	11	4.7%
Medical and Dental	1,624	1,667	43	2.7%
of which Doctors in Training	671	670	-2	-0.3%
of which Career grade doctors	236	251	15	6.5%
of which Consultants	717	747	30	4.2%

What the information tells us:

Overall the Trust saw a 5.1% growth in its substantive workforce over the past 12 months and 7.8% over the past 24 months. Growth over the past 12 months is lowest within the Estates and Ancillary staff group, with an increase of 2%, and highest within Healthcare Scientists at 16.7%. The increase in Healthcare Scientists 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.

Equality Diversity and Inclusion (EDI)

NHS
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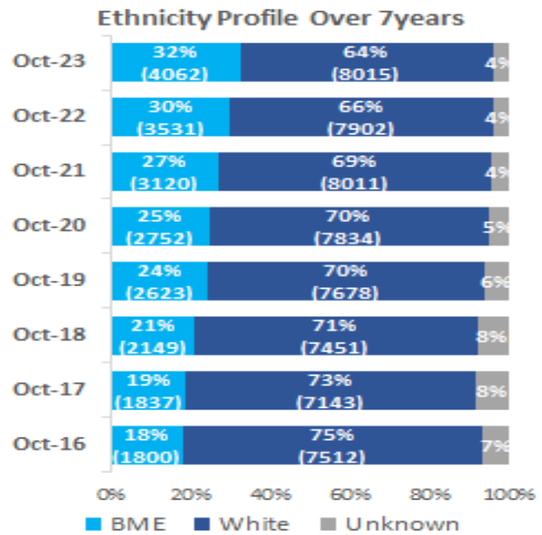
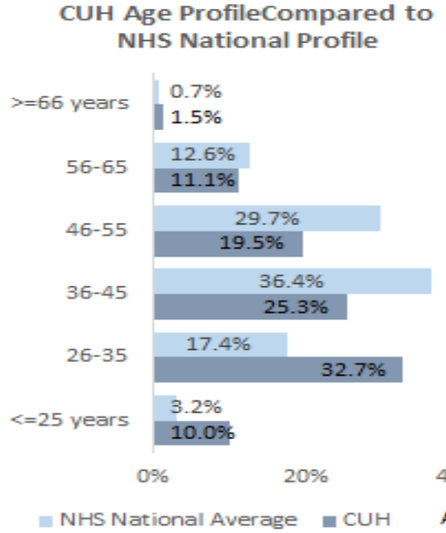
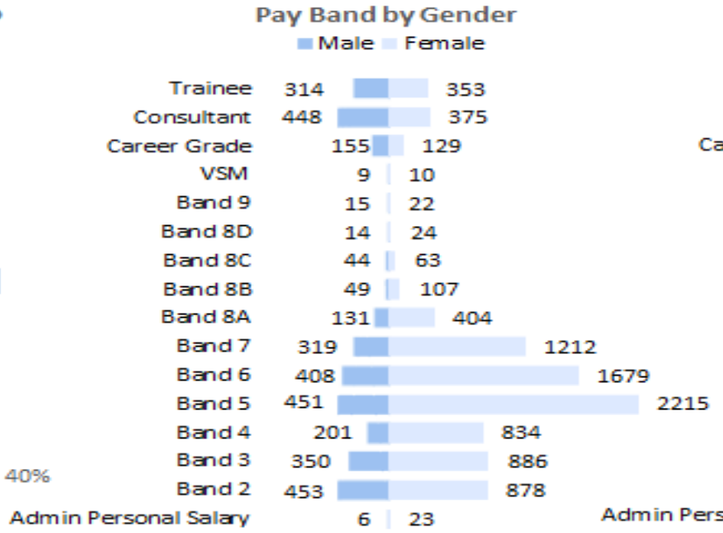
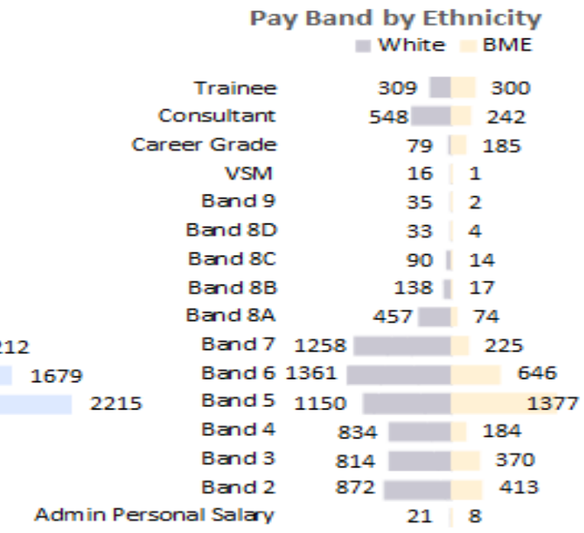
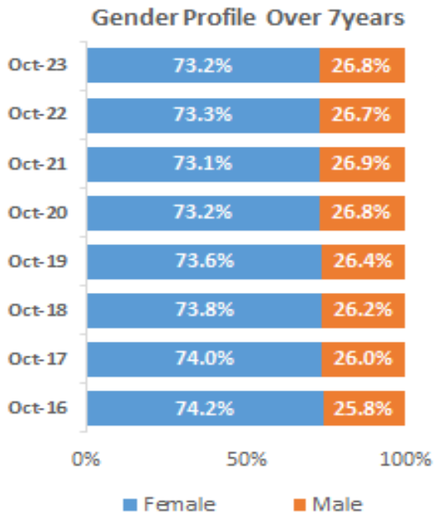
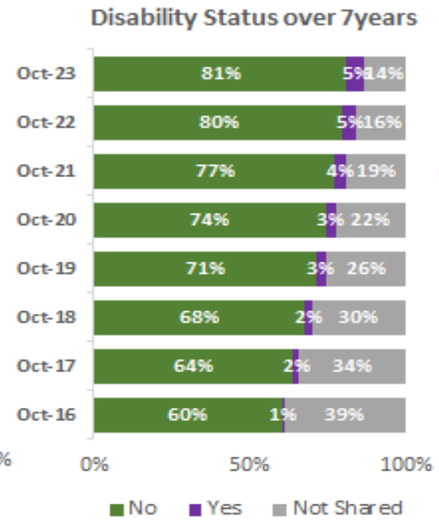


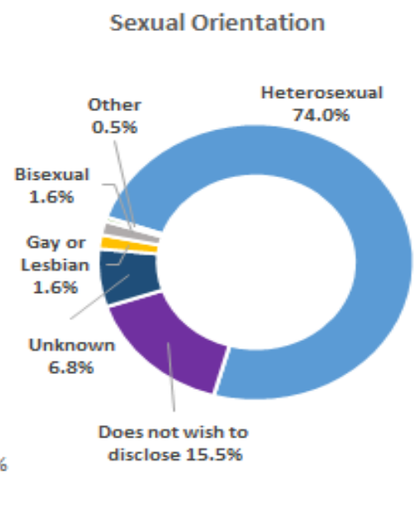












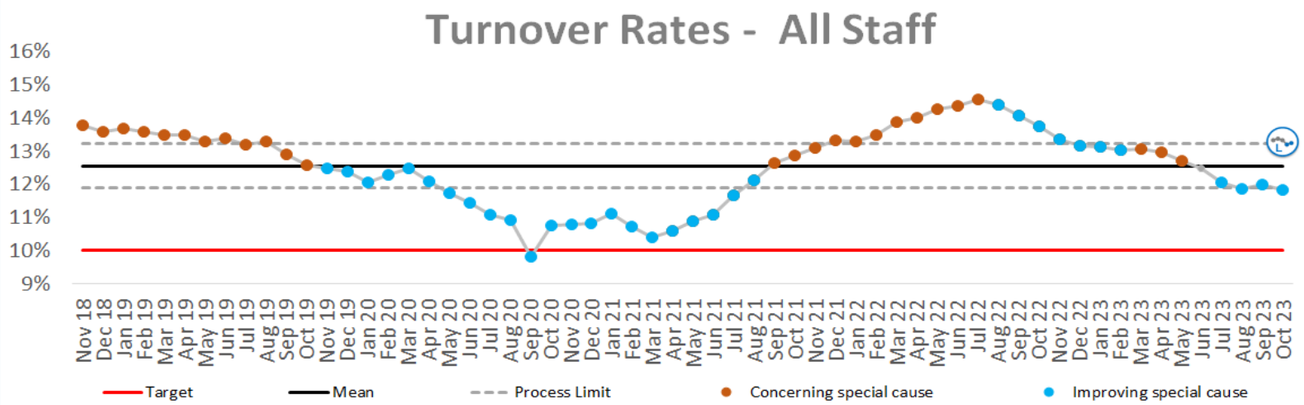
What the information tells us:

- CUH has a younger workforce compared to NHS national average. The majority of our staff are aged 26-45 which accounts for 58% of our total workforce.
- The percentage of BME workforce increased significantly by 14% over the 7 year period and currently make up 32% of the CUH substantive workforce.
- The percentage of male staff increased by 1% to 26.8% 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**

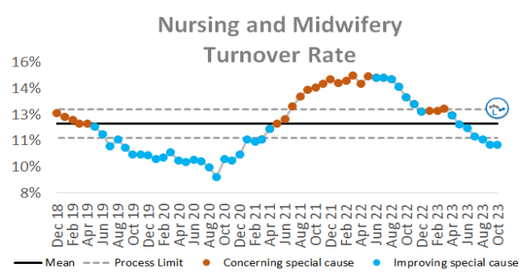
Staff Turnover

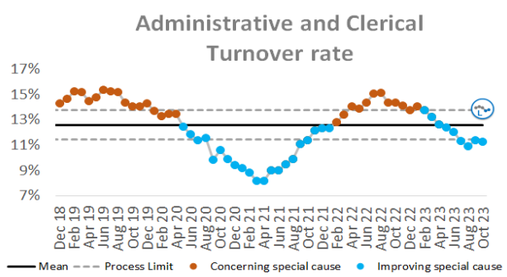
Cambridge University Hospitals NHS Foundation Trust

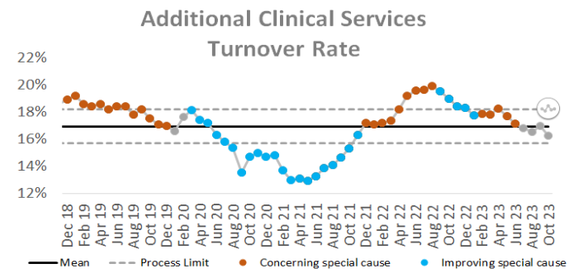


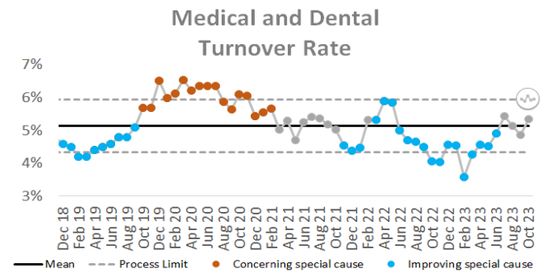
Background Information: Turnover describes the rate that employees leave an establishment. Staff turnover is calculated by the number of leavers from the Trust over the previous twelve months as a percentage of the total number of employed staff at a given time. (excludes all fixed term contracts including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

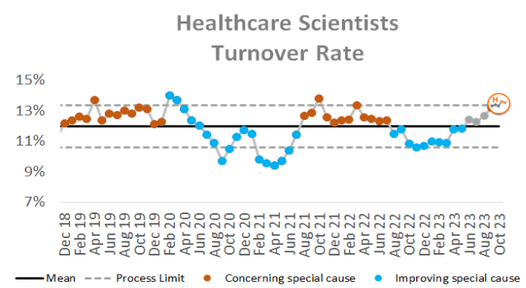
What the information tells us:
After a steady increase from March 2021 the Trust turnover rate has been decreasing since July 2022 - this month at 11.8% (0.2% lower than last month). This is more in line with pre-pandemic rates, and 0.8% lower than 4 years ago. Estates and Ancillary staff group has the highest increase of 1.3% to 15.3% 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 (3.8% and 2.8% reductions respectively). Within the staff groups, Additional Clinical Services have the highest turnover rate at 16.3% followed by Estates and Ancillary staff at 15.3%.

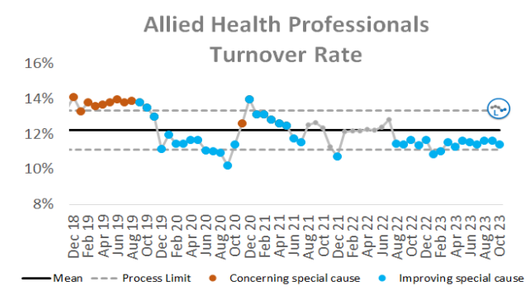


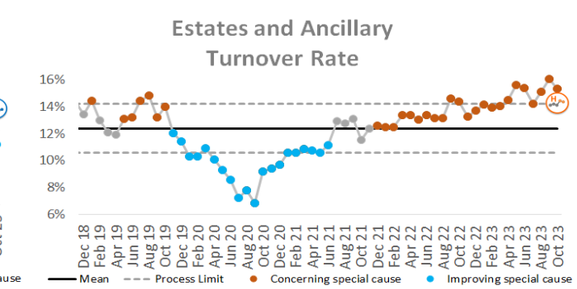


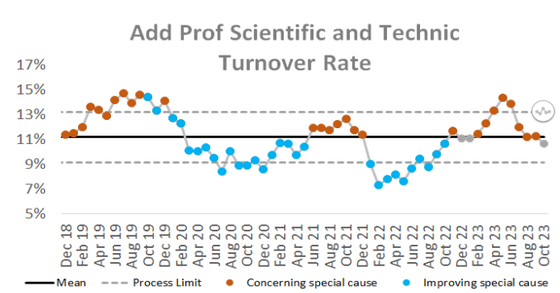












Turnover for Nursing & Midwifery Staff Group (Registered & Non-Registered)

NHS
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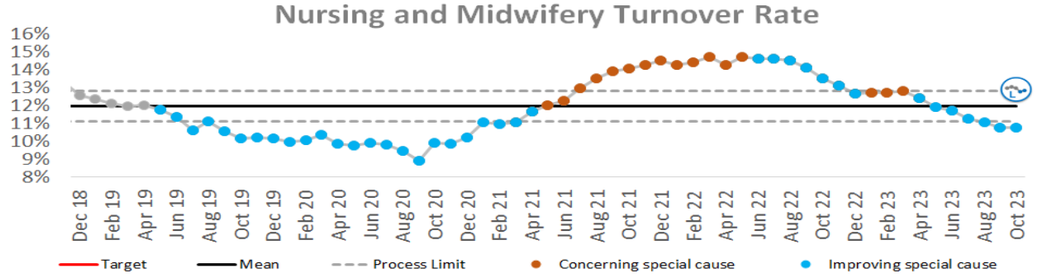
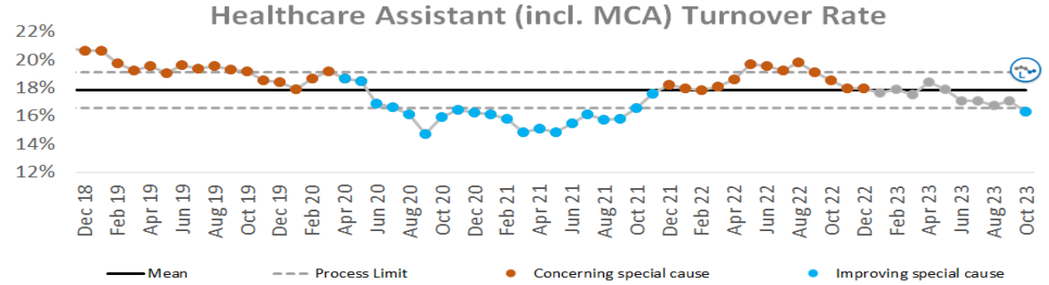
NHS Foundation Trust

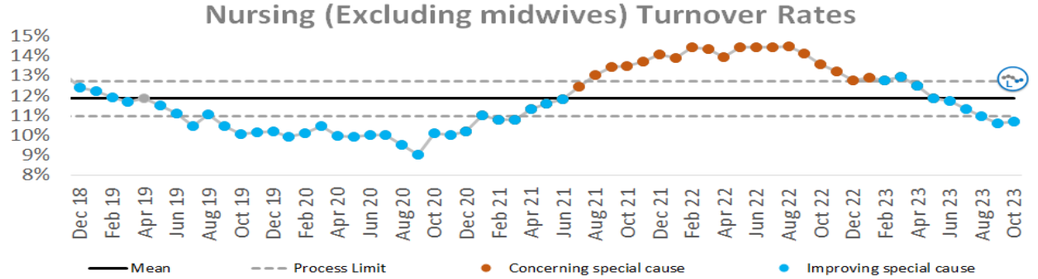
Nursing and Midwifery Turnover Rate



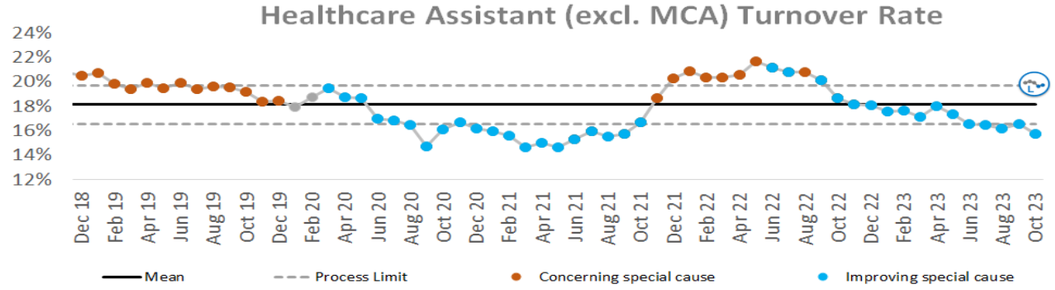
Healthcare Assistant (incl. MCA) Turnover Rate



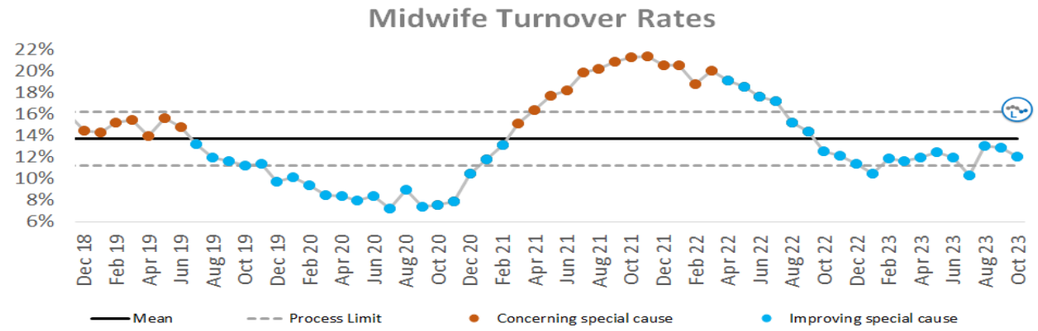
Nursing (Excluding midwives) Turnover Rates



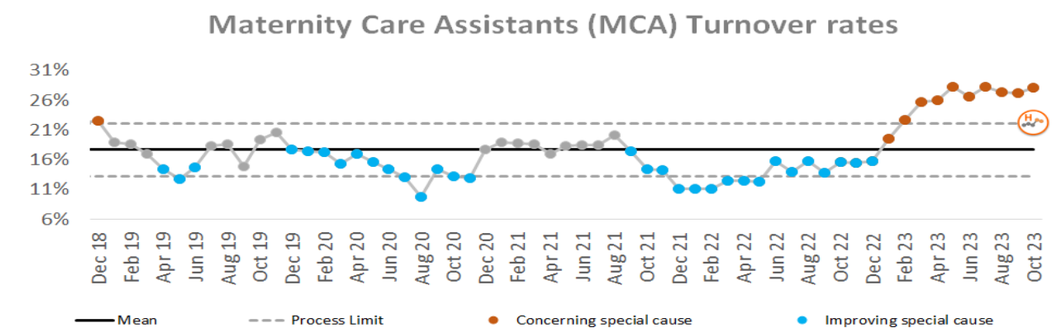
Healthcare Assistant (excl. MCA) Turnover Rate



Midwife Turnover Rates

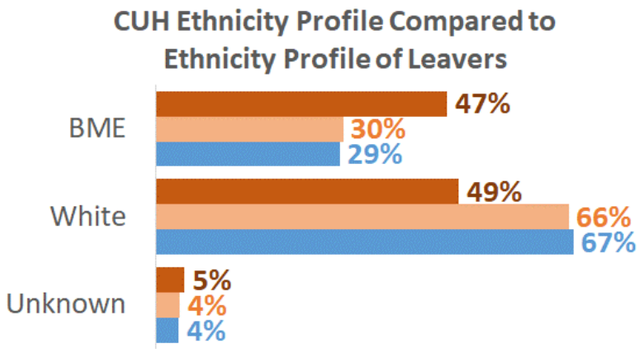


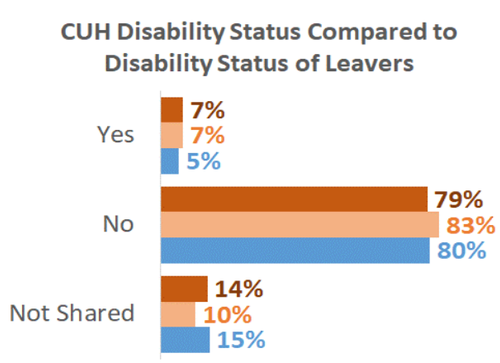
Maternity Care Assistants (MCA) Turnover rates

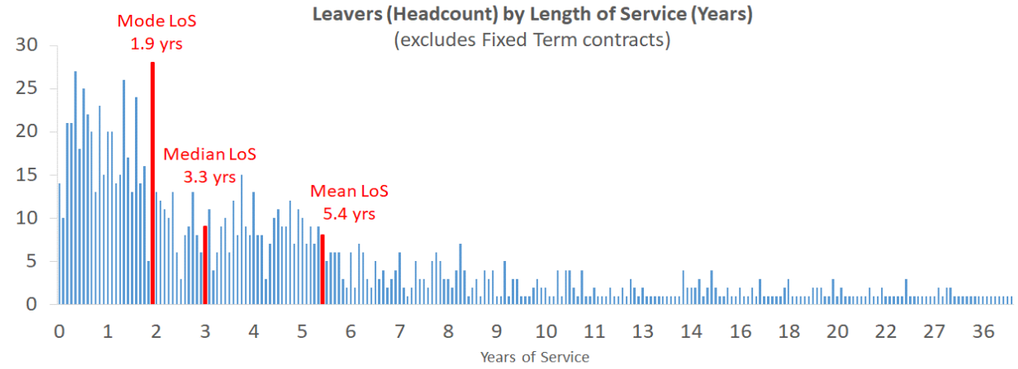


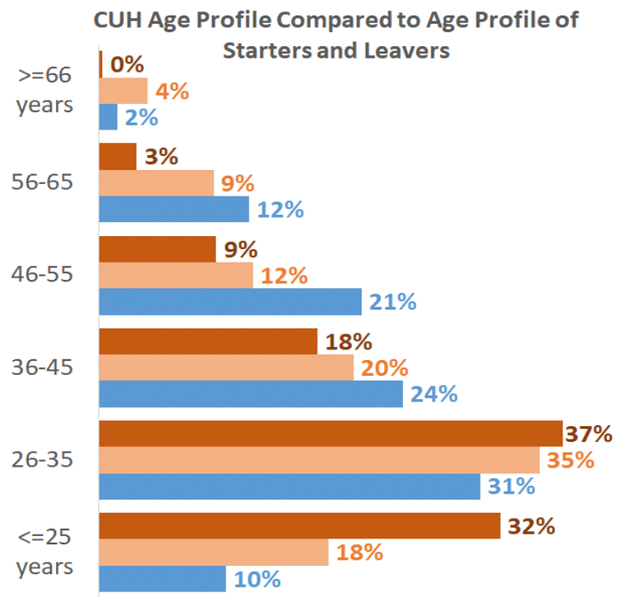
Starters & Leavers - last 12 months

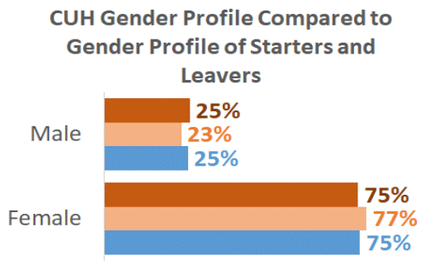
NHS
Cambridge University Hospitals
NHS Foundation Trust

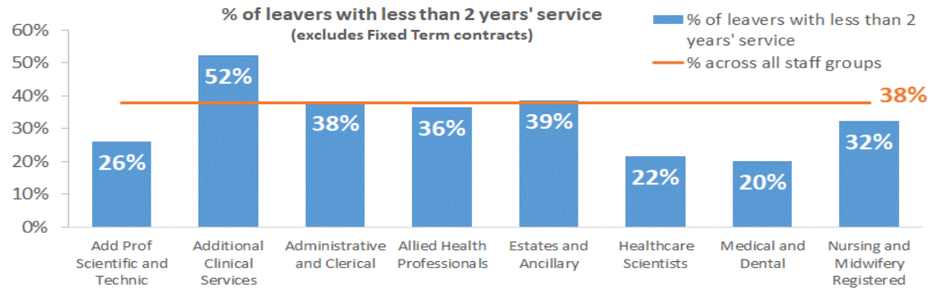












What the information tells us:

The majority of starters to, and leavers from the Trust in the last 12 months were aged 35 yrs. or under (70% and 54% 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. 47% of our starters in the last 12 months were from black and minority ethnic groups, compared to 29% of the staff profile.

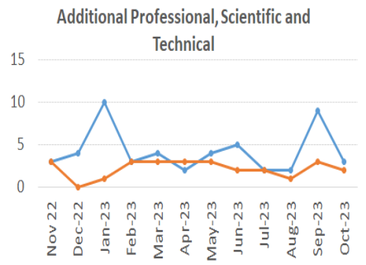
A significant proportion of leavers leave the Trust within 2 years of starting (38%), and within Additional Clinical Services staff group there is a much greater proportion than average - 52%. The most common length of service (mode) upon leaving is 1.9 years – in the last 12 months 28 (headcount) of the 1,169 leavers who were on permanent contracts left at this point. The average (mean) length of service was 5.4 years.

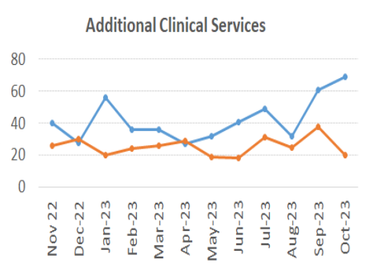
Excludes Fixed Term and Locum Medical and Dental staff, and staff leaving and returning to CUH (as bank only/retire and return etc.)

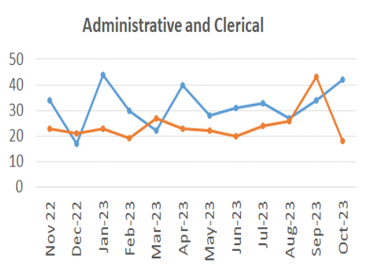
Author(s): Chloe Schafer, Amanda Wood **Owner(s): David Wherrett**

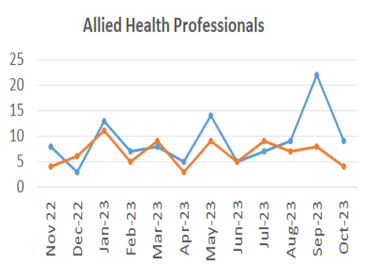
Starters & Leavers - Last 12 months

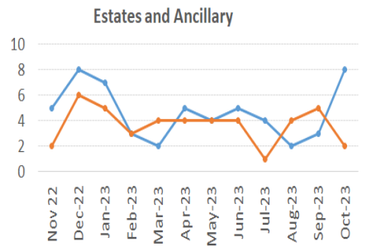
NHS
Cambridge University Hospitals
NHS Foundation Trust

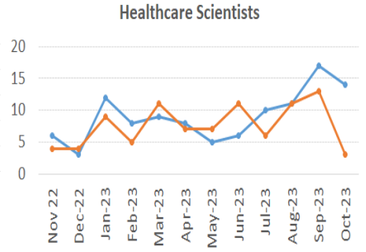


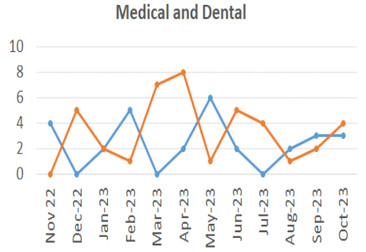


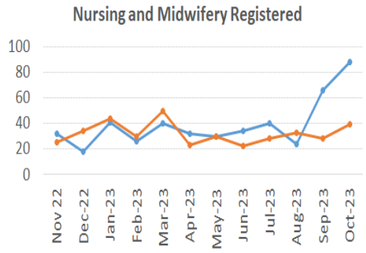


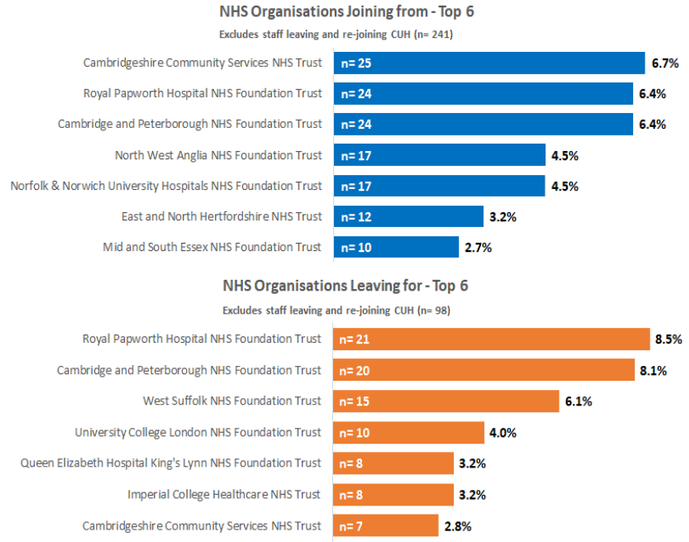


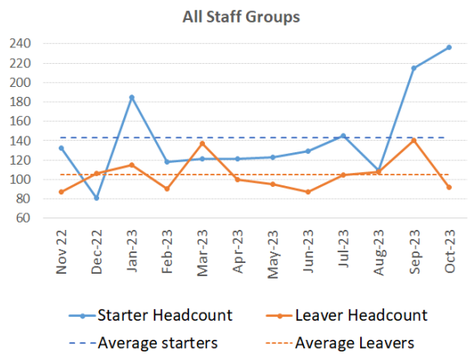












Top 10 Leaving Reasons Excludes staff leaving and re-joining CUH (n= 98)	Number of Leavers (Headcount)	% of all Leavers
Voluntary Resignation - Relocation	372	29%
Voluntary Resignation - Work Life Balance	257	20%
Voluntary Resignation - Promotion	147	12%
Voluntary Resignation - Other/Not Known	89	7%
Voluntary Resignation - Better Reward Package	88	7%
Retirement Age	70	6%
Voluntary Resignation - Health	55	4%
End of Fixed Term Contract	32	3%
Voluntary Resignation - Child Dependants	32	3%
Voluntary Resignation - Lack of Opportunities	28	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) over the last 12 months is to another NHS organisation. The most popular external NHS organisation to leave for is Royal Papworth NHS Foundation Trust. 13% of starters to the Trust were from Cambridgeshire Community Services NHS Trust or Royal Papworth NHS Foundation Trust. In the month of October alone the most popular destination on leaving (other than unknown) was to another NHS organisation, with 18.5% of leavers in that month citing this reason on the P4 leavers form (17 individuals, of whom 47% had less than 2 years' service at CUH).

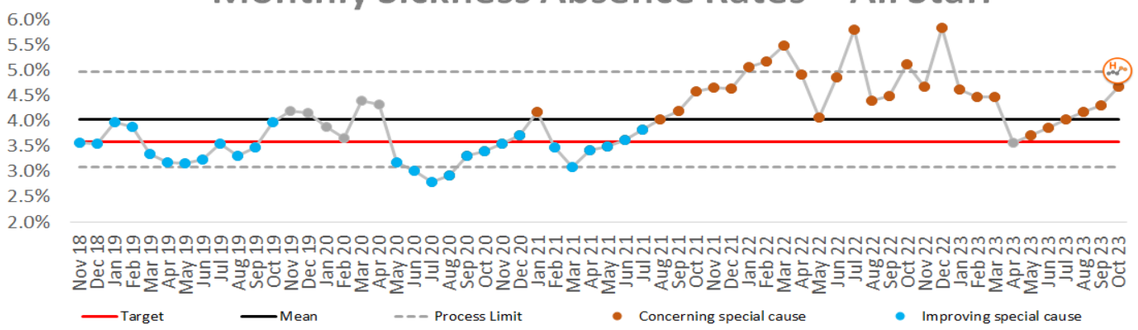
Author(s): Chloe Schafer, Amanda Wood

Owner(s): David Wherrett

Sickness Absence

Cambridge University Hospitals NHS Foundation Trust

Monthly Sickness Absence Rates - All Staff

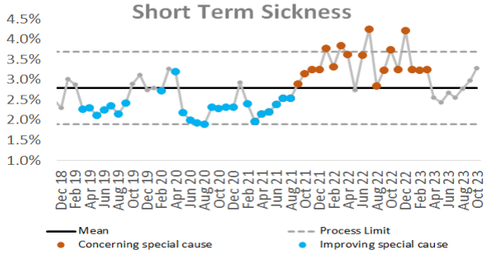


Background Information: Sickness Absence is a monthly metric and is calculated as the percentage of FTE days missed in the organisation due to sickness during the reporting month.

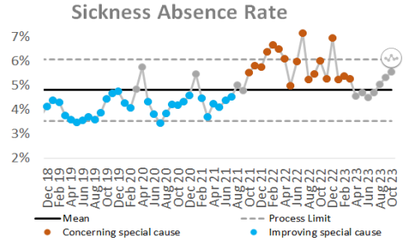
What the information tells us: The overall monthly sickness absence has increased by 0.4% since last month, to 4.7% in October 2023. This is 0.5% lower than the same month last year (5.1%). The sickness absence rate due to short term illness is higher at 3.3% compared to long term sickness at 1.4%.

Estates and Ancillary staff group has the highest sickness absence rate at 8.3% (1.3% higher than 12 months ago), followed by Additional Clinical Services at 8% in October 2023.

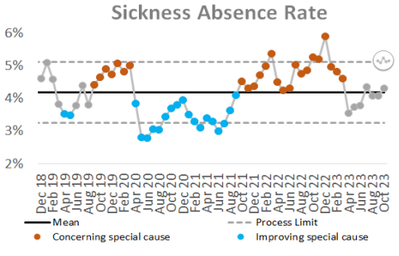
Sickness Absence Rate due to Short Term Sickness



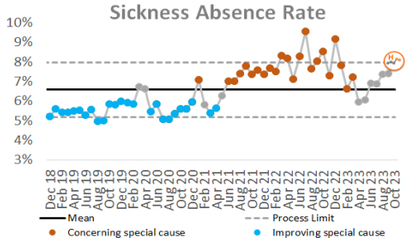
Nursing and Midwifery Sickness Absence Rate



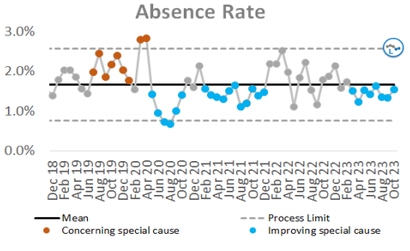
Administrative and Clerical Sickness Absence Rate



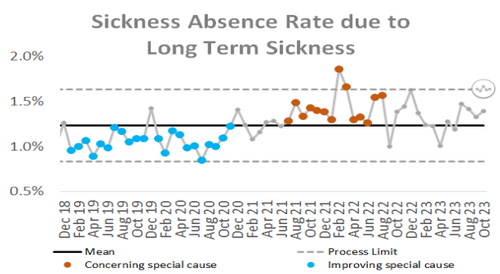
Additional Clinical Services Sickness Absence Rate



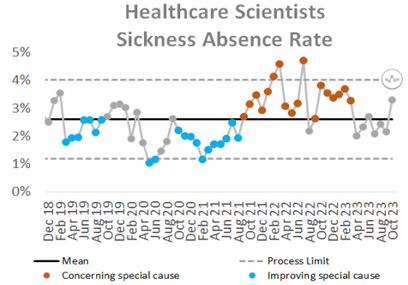
Medical and Dental Sickness Absence Rate



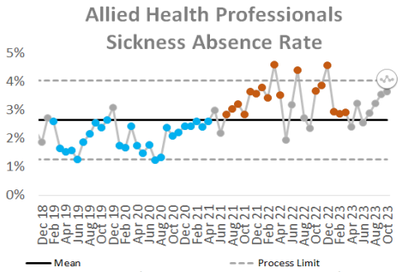
Sickness Absence Rate due to Long Term Sickness



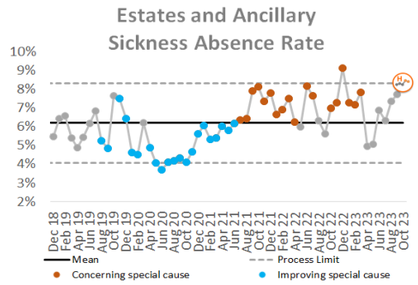
Healthcare Scientists Sickness Absence Rate



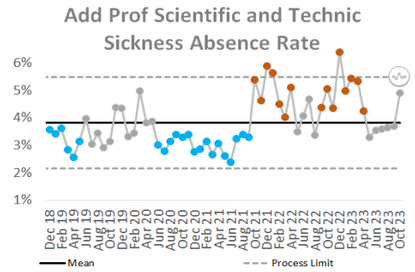
Allied Health Professionals Sickness Absence Rate



Estates and Ancillary Sickness Absence Rate



Add Prof Scientific and Technic Sickness Absence Rate



Top Six Sickness Absence Reason

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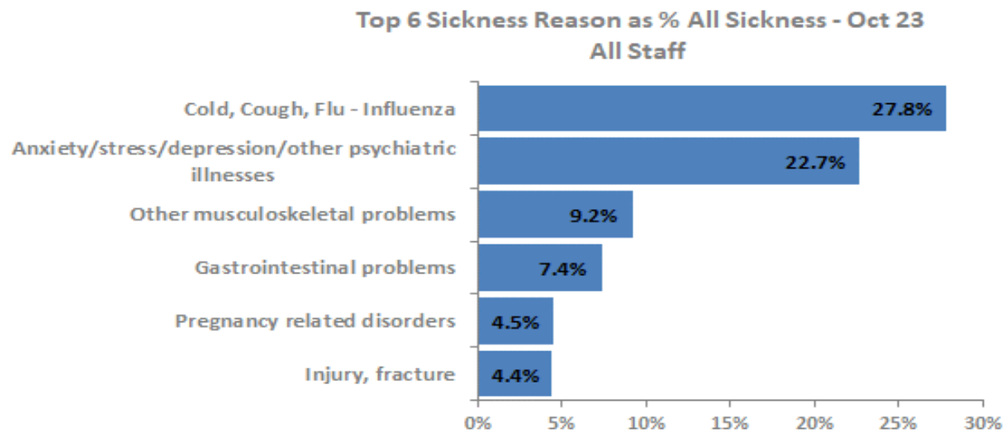
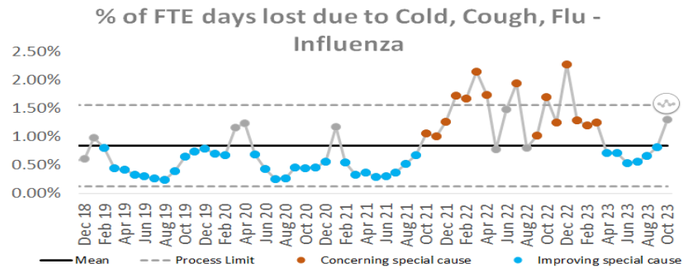
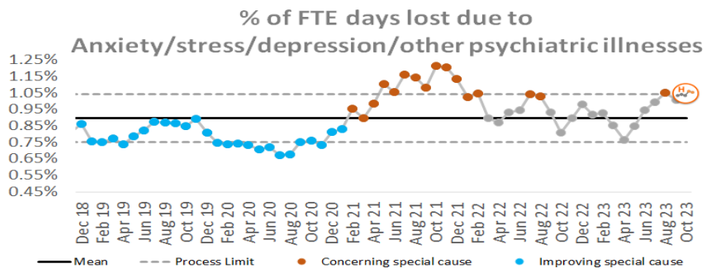


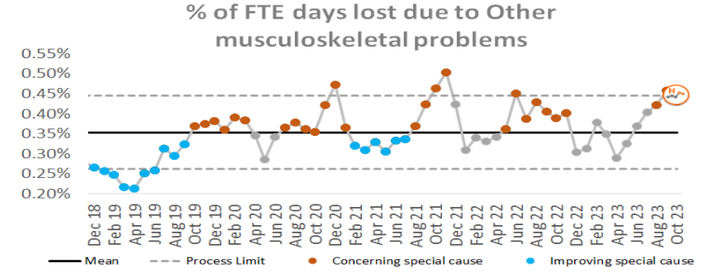
Background Information: Sickness Absence reason is provided as a percentage of all FTE days missed due to sickness during the reporting month.

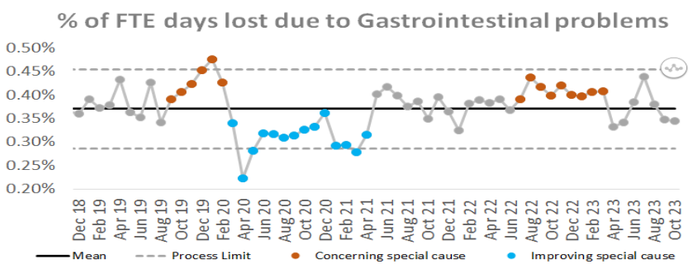
What the information tells us: The top reason for sickness absence in October 2023 is Cold, Cough, Flu - Influenza, with an absence rate of 1.3%. This is 0.5% higher than last month, but 0.4% lower than September last year. As a percentage of all sickness absence Cold, Cough, Flu - Influenza accounts for 27.8% of the overall figure.

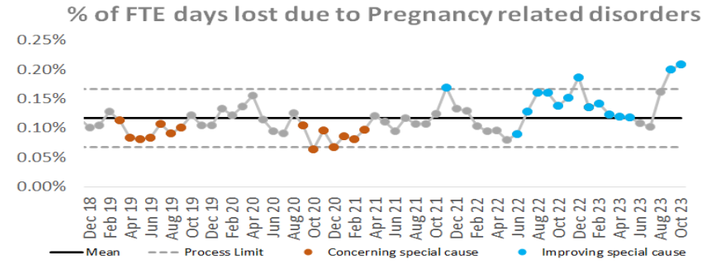
Absence due to Anxiety/stress/depression/other psychiatric illnesses has increased by 0.1% from last month to 1.06%, which accounts for 22.7% of all absence in October 2023.

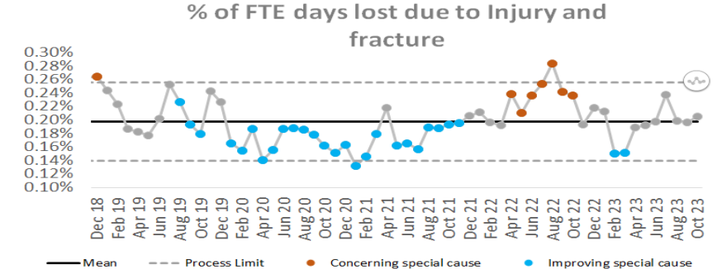








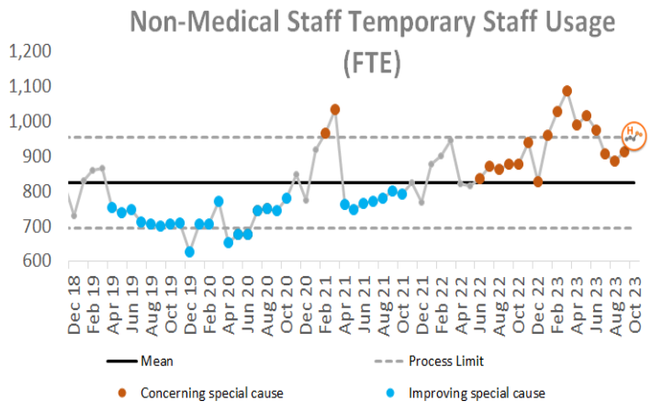


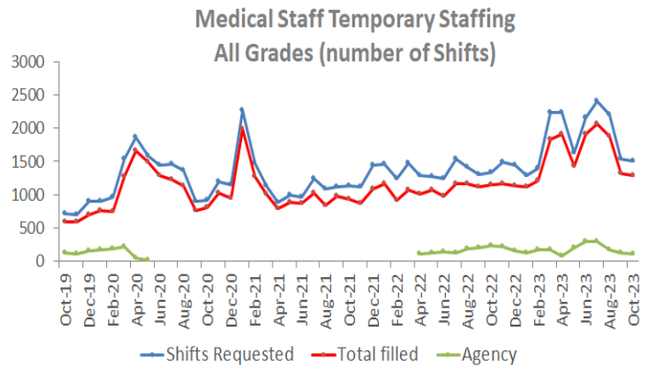


Author(s): Chloe Schafer, Amanda Wood **Owner(s): David Wherrett**

Temporary Staffing

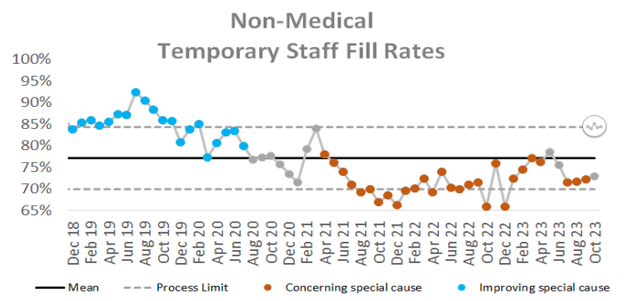
Cambridge University Hospitals NHS Foundation Trust

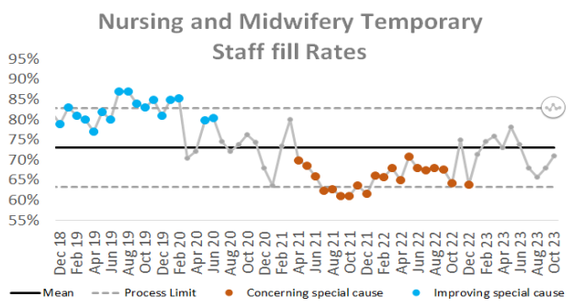


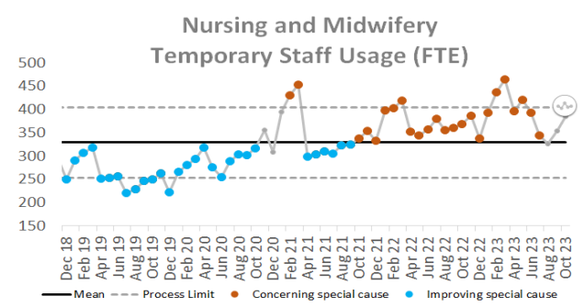


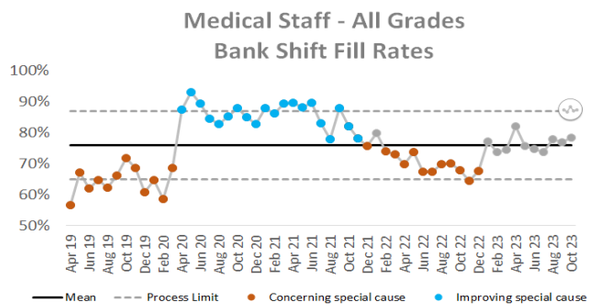
Background Information: The Trust works to ensure that temporary vacancies are filled with workers from staff bank in order to minimise agency usage, ensure value for money and to ensure the expertise and consistency of staffing.

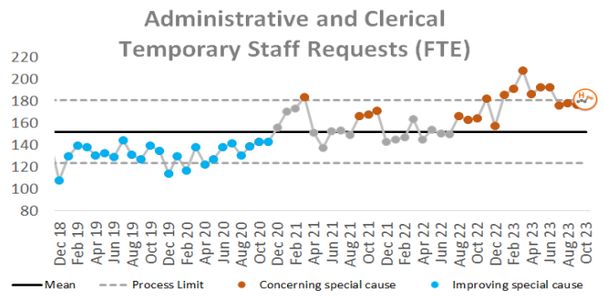
What the information tells us: Overall non-medical fill rates have increased by 0.9% from last month, as an increase in requests of 2.6% has been exceeded by the 3.5% increase in filled shifts. Top three reasons for request are vacancy (47%), increased workload (21%) and sickness requiring cover (15%). Nursing and midwifery agency usage decreased by 1.3 WTE from the previous month to 15.4 WTE. This accounts for 4% of the total nursing filled shifts. Demand for temporary medical staff decreased by 2% from September. Fill rate remained stable at 86%, with 215 shifts unfilled.

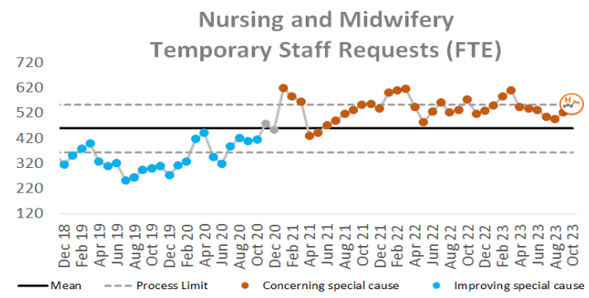


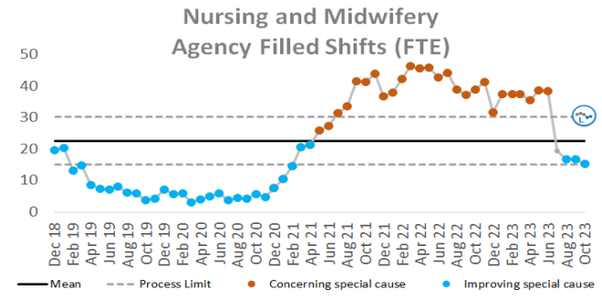


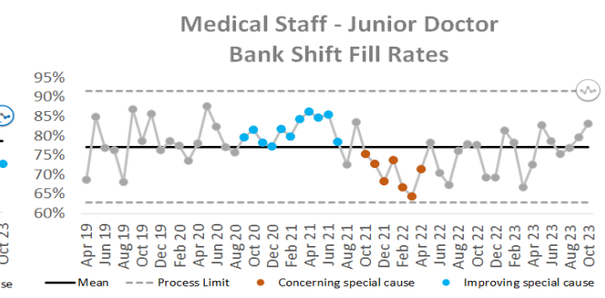










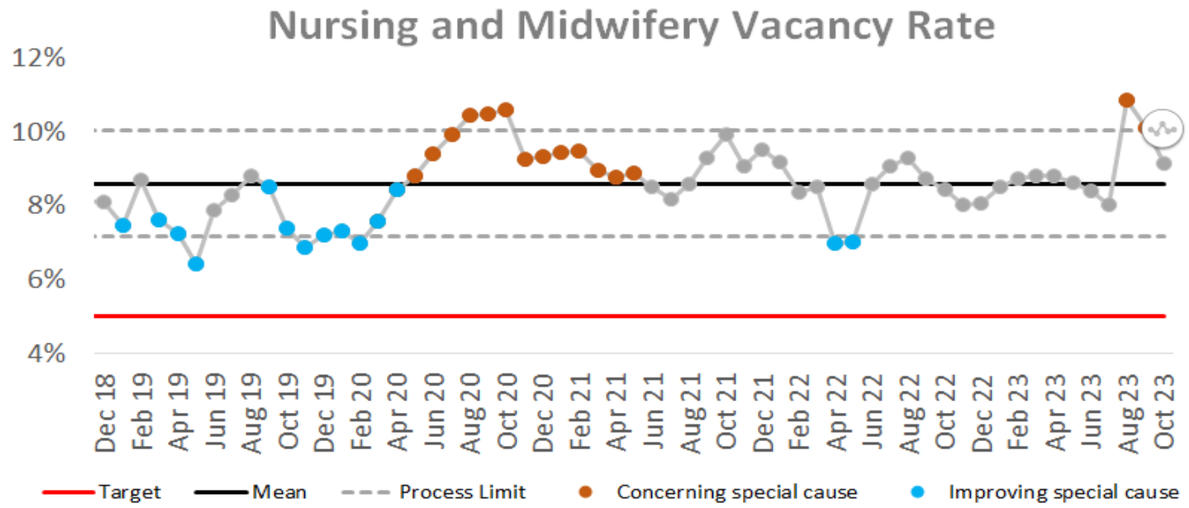


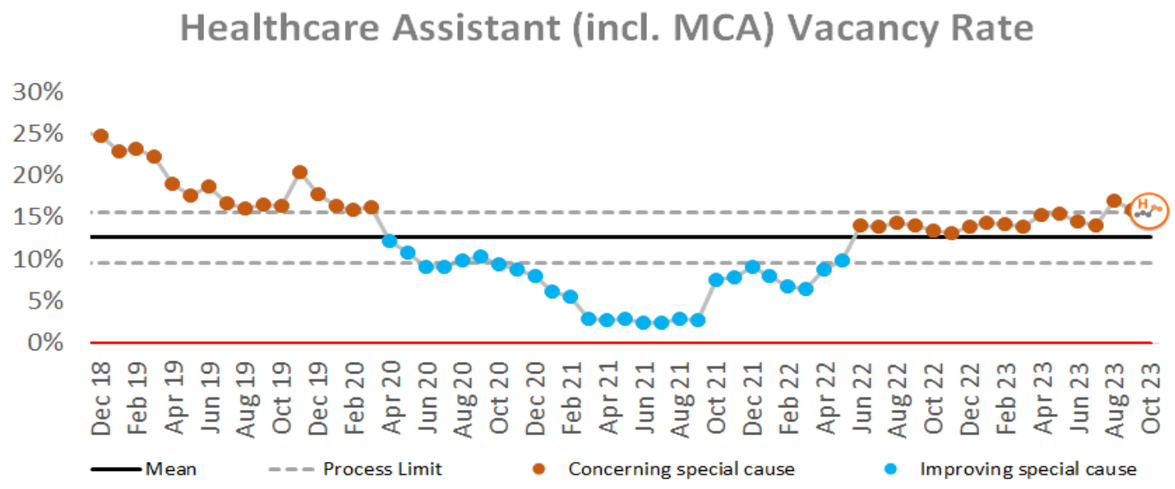
Author(s): Chloe Schafer, Amanda Wood

Owner(s): David Wherrett

ESR Vacancy Rate

Cambridge University Hospitals NHS Foundation Trust





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

What the information tells us: 2023/24 budgets were loaded to ESR for Clinical and Corporate Divisions from August 2023, which increased the establishment for both Nursing and Midwifery and Healthcare Assistants.

Since August the vacancy rate for Nursing and Midwifery has been decreasing, and is 9.1% as at the end of October, which is 1% lower than last month. The vacancy rate for Healthcare Assistants is 15.9% as at end of October - the same as 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 – October 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	48,587	25,905	53.3%	97%
	Additional Clinical Services	375,600	214,815	57.2%	97%
	Administrative and Clerical	511,769	282,392	55.2%	96%
	Allied Health Professionals	153,122	86,061	56.2%	99%
	Estates and Ancillary	76,643	46,418	60.6%	97%
	Healthcare Scientists	154,348	80,617	52.2%	96%
	Medical and Dental	140,996	51,203	36.3%	35%
	Nursing and Midwifery Registered	807,970	469,037	58.1%	98%
	Trust	**2,269,035**	**1,256,449**	55.4%	88%
Annual Leave taken by Division	*Division*				
	Corporate	316,644	176,169	55.6%	95%
	Division A	423,044	234,515	55.4%	87%
	Division B	630,717	344,105	54.6%	93%
	Division C	280,971	150,769	53.7%	80%
	Division D	264,346	147,767	55.9%	85%
	Division E	249,890	147,810	59.1%	86%
	R&D	103,424	55,313	53.5%	95%

* Greater than 47% | Less than 35% | Between 35% and 47%

What the information tells us: The Trust's annual leave usage is at 95% of the expected usage at the end of the seventh month of the financial year. The highest rate of use of annual leave is within the Estates and Ancillary staff group, at 60.6%, followed by Nursing and Midwifery Registered at 58.1%.

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

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.

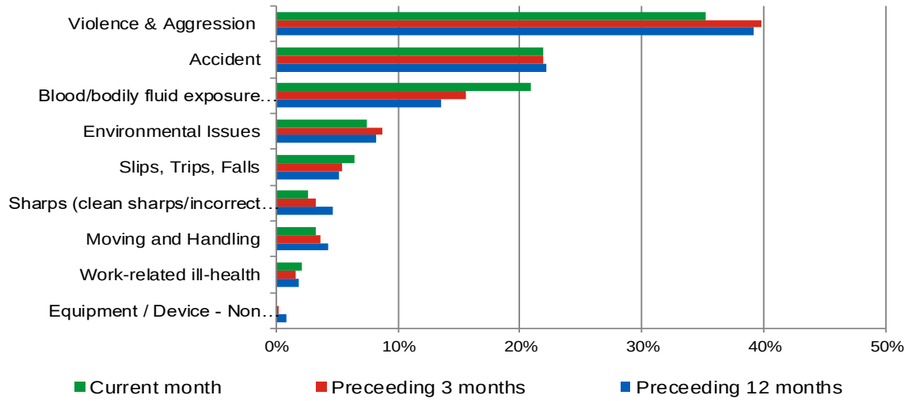
Thresholds for **Induction** & Information Governance incl. GDPR & Cyber Security training	Less than 80%	80% to 94%	95% or higher
Thresholds for **Core Mandatory** training excl. Information Governance incl. GDPR & Cyber Security training	Less than 75%	75% to 89%	90% or higher

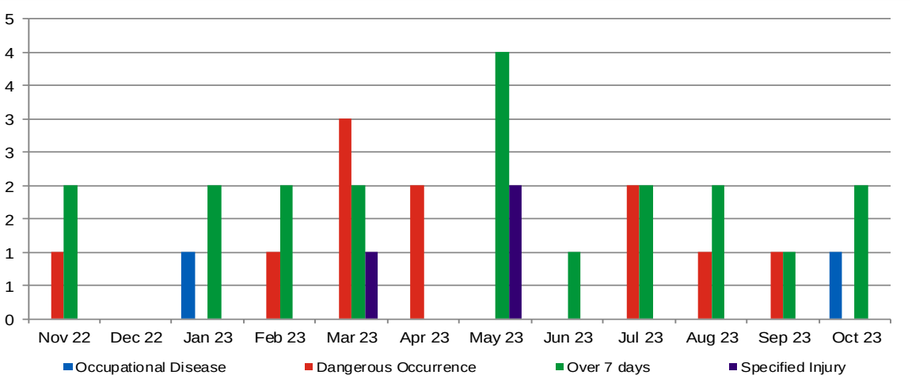
		No. Staff Requiring Competency	Frequency	Delivery Method	Trust Total	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental: Consultant	Medical and Dental: Non-Consultant	Nursing and Midwifery Registered
Ind'tn	Corporate Induction	1,187	3 yrs	el	(50)95.2%	(0)100.0%	(22)92.4%	(8)96.9%	(4)94.5%	(2)94.7%	(0)100.0%	(3)92.9%	(29)72.4%	(14)95.0%
	Local Induction	1,187	3 yrs	el	(225)81.0%	(3)89.3%	(60)79.2%	(48)81.5%	(13)82.2%	(4)89.5%	(10)85.9%	(9)78.6%	(15)85.7%	(63)77.7%
Other Core Mandatory	Conflict Resolution	11,238	3 yrs	el	(202)98.2%	(1)99.6%	(16)99.1%	(30)98.8%	(3)99.6%	(2)99.4%	(2)99.7%	(19)97.6%	(85)88.7%	(44)98.8%
	Equality, Diversity and Human Rights	11,238	3 yrs	el	(237)97.9%	(2)99.1%	(15)99.2%	(38)98.4%	(3)99.6%	(3)99.1%	(4)99.4%	(21)97.3%	(90)88.0%	(61)98.3%
	Health, Safety and Welfare	11,238	3 yrs	el	(264)97.7%	(1)99.6%	(20)98.9%	(43)98.2%	(3)99.6%	(3)99.1%	(4)99.4%	(22)97.2%	(105)86.0%	(63)98.2%
	Information Governance including GDPR and Cyber Security	11,238	1 yr	el	(690)93.9%	(4)98.2%	(98)94.5%	(80)96.7%	(19)97.3%	(31)90.9%	(26)96.2%	(62)92.0%	(183)75.6%	(187)94.8%
	Basic Prevent Awareness	9,474	3 yrs	el	(276)97.1%	(1)99.5%	(25)98.5%	(62)97.4%	(5)99.2%	(8)97.6%	(6)99.1%	(15)97.4%	(122)79.1%	(32)98.7%
	Prevent Level Three (WRAP)	1,759	3 yrs	el	(139)92.1%	(0)100.0%	(10)93.3%	(0)100.0%	(3)95.1%		(0)100.0%	(9)95.6%	(38)76.7%	(79)93.1%
Resuscitation	Adult Basic Life Support Practical - 1 Year	383	1 yr	f2f	(80)79.1%		(23)75.5%		(0)100.0%					(57)80.1%
	Adult Basic Life Support Practical - 2 Year	6,992	4 yrs	f2f	(845)87.9%	(2)94.3%	(153)88.5%	(5)84.4%	(42)93.9%		(7)93.9%	(143)81.6%	(278)63.0%	(215)93.4%
	Advanced Life Support	11	4 yrs	f2f	(4)63.6%				(0)100.0%					(4)60.0%
	Advanced Paediatric Life Support	104	2 yrs	f2f	(52)50.0%									(52)50.0%
	Basic Life Support e-learning	7,345	1 yr	el	(800)89.1%	(2)94.3%	(127)90.9%	(2)93.8%	(44)93.6%		(8)93.0%	(93)88.0%	(250)66.7%	(274)92.3%
	Immediate Life Support (ILS)	636	1 yr	f2f	(142)77.7%		(3)25.0%	(0)100.0%			(1)93.8%			(138)77.6%
	Newborn Basic Life Support (NBLS)	507	1 yr	Blended	(156)69.2%	(1)0.0%	(35)53.3%					(6)64.7%	(5)50.0%	(109)73.0%
	Paediatric Basic Life Support (PBLS)	2,464	1 yr	Blended	(572)76.8%	(1)90.9%	(202)64.6%		(56)91.8%		(7)92.1%	(41)65.0%	(51)50.0%	(214)75.9%
	Paediatric Immediate Life Support (PILS)	364	1 yr	f2f	(84)76.9%		(1)0.0%		(0)100.0%					(83)77.0%
Fire	Fire Evacuation	5,659	1 yr	f2f/el	(806)85.8%	(1)94.7%	(228)83.7%	(2)93.1%	(49)90.9%	(13)82.9%	(0)100.0%			(513)85.6%
	Fire Safety Awareness	11,238	2 yrs	el	(432)96.2%	(1)99.6%	(44)97.5%	(52)97.8%	(12)98.3%	(17)95.0%	(8)98.8%	(45)94.2%	(142)81.1%	(111)96.9%
Infect Ctrl	Infection Prevention and Control - Level 1 - 2 Years	4,120	2 yrs	el	(179)95.7%	(1)96.9%	(8)96.7%	(71)97.0%	(0)100.0%	(20)94.0%	(9)98.5%	(1)95.2%	(59)79.1%	(10)95.4%
	Infection Prevention and Control - Level 2 - 2 Years	7,119	2 yrs	el	(300)95.8%	(1)99.5%	(38)97.5%	(0)100.0%	(11)98.3%	(0)100.0%	(1)98.9%	(54)92.9%	(88)81.2%	(107)96.8%
Moving & Handling	Moving and Handling - Level 1	11,238	2 yrs	el	(560)95.0%	(3)98.7%	(75)95.8%	(73)97.0%	(12)98.3%	(7)97.9%	(10)98.5%	(59)92.4%	(162)78.4%	(159)95.5%
	Moving and Handling - Level 2	5,710	2 yrs	f2f	(783)86.3%	(1)94.7%	(217)84.8%	(2)88.9%	(44)92.7%	(0)100.0%	(3)96.5%			(516)85.5%
	Patient Moving and Handling - e-learning	5,712	1 yr	el	(345)94.0%	(1)94.7%	(102)92.9%	(1)94.1%	(18)97.0%	(0)100.0%	(1)98.8%			(222)93.8%
Safeg'dg Adults	Safeguarding Adults - Level 1	7,558	3 yrs	el	(284)96.2%	(2)99.1%	(33)98.2%	(62)97.4%	(0)100.0%	(5)98.5%	(9)98.7%	(12)84.8%	(106)36.9%	(55)96.9%
	Safeguarding Adults - Level 2	4,057	3 yrs	el	(275)93.2%	(4)97.9%	(37)97.4%	(13)90.9%	(6)94.3%		(1)99.4%	(13)83.3%	(129)23.2%	(72)95.9%
	Safeguarding Adults - Level 3	3,833	3 yrs	el	(1305)66.0%	(1)90.0%	(1)75.0%	(1)0.0%	(119)79.8%		(0)100.0%	(250)64.9%	(401)43.6%	(532)70.5%
Safeg'dg Children	Safeguarding Children - Level 1	11,238	3 yrs	el	(390)96.5%	(3)98.7%	(36)98.0%	(59)97.5%	(10)98.6%	(8)97.6%	(11)98.4%	(26)96.7%	(140)81.4%	(97)97.3%
	Safeguarding Children - Level 2	7,726	3 yrs	el	(423)94.5%	(8)95.9%	(52)96.4%	(13)91.3%	(21)96.9%		(1)99.4%	(31)96.0%	(156)79.2%	(141)96.0%
	Safeguarding Children - Level 3	1,438	3 yrs	f2f/el	(212)85.3%	(0)100.0%	(16)83.7%	(3)75.0%	(9)85.9%		(0)100.0%	(15)92.3%	(31)75.6%	(138)84.9%
	Safeguarding Children - Level 3 - 1 Year	334	1 yr	f2f/el	(48)85.6%		(11)79.2%					(5)61.5%	(11)45.0%	(21)91.5%
Overall Compliance					93.3%	98.5%	94.3%	97.5%	95.8%	96.6%	98.5%	91.1%	74.5%	93.1%

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:	**1950**	**403**	**289**	**602**	**313**	**204**	**54**	**85**
Accident	**433**	99	90	104	63	36	11	30
Blood/bodily fluid exposure (dirty sharps/splashes)	**265**	88	47	54	33	35	6	2
Environmental Issues	**160**	29	44	19	27	25	5	11
Equipment / Device - Non Medical	**17**	4	1	4	4	4	0	0
Moving and Handling	**83**	20	10	15	22	7	1	8
Sharps (clean sharps/incorrect disposal & use)	**92**	24	14	9	14	18	9	4
Slips, Trips, Falls	**100**	21	21	15	11	13	3	16
Violence & Aggression	**763**	106	59	380	129	57	18	14
Work-related ill-health	**37**	12	3	2	10	9	1	0





A total of 1,950 health and safety incidents were reported in the previous 12 months.

882 (45%) incidents resulted in harm. The highest reporting categories were violence and aggression (39%), accidents (22%) and blood/bodily fluid exposure (14%).

1,315 (67%) of incidents affected staff, 559 (29%) affected patients and 76 (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 (37%) and environmental issues (9%).

The highest reported incident categories for others were: violence & aggression (28%), slips, trips and falls (26%) and 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 602 incidents. Of these, 63% 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, 64% of RIDDOR incidents were reported to the HSE within the appropriate timescale.

In October 2023, 3 incidents were reported to the HSE:

Over 7 day injury:

- The Injured Person (IP) was crossing the road (on site). A dip in the road caused the IP to twist their ankle and fall to the floor. The IP suffered a suspected fracture of scaphoid and has been unable to undertake their normal duties for over 7 days.
- The IP slipped on water which lay on the floor surrounding a sink. The IP experienced pain and sustained bruising to their head, ear, neck, shoulder and arm. The IP has been off work for over 7 days as a result of this incident.

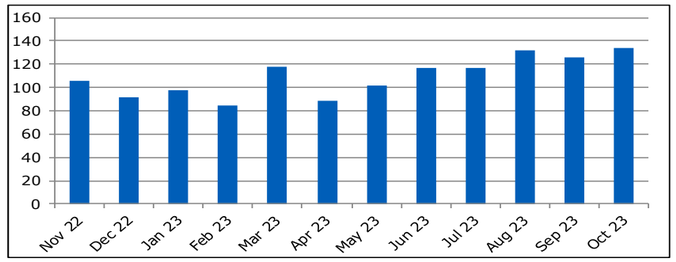
Occupational disease:

- A staff member's skin became itchy. Staff member self-referred to OH for review and work-related contact dermatitis was diagnosed. Unclear what the trigger is but it is thought that the most likely cause are gloves. OH advised non clinical duties until hands have healed. OH confirmed the current hand care regime is correct.

Health and Safety Incidents

NHS Cambridge University Hospitals

No. of health and safety incidents affecting staff:

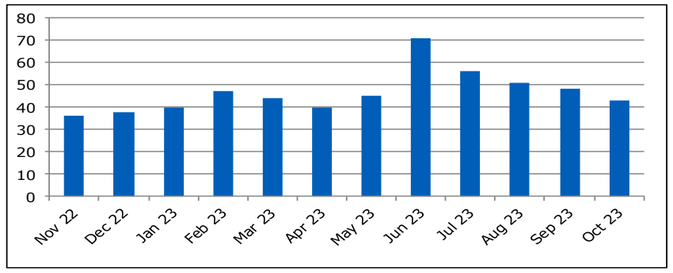


	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Total
Accident	19	14	12	14	21	13	13	14	14	23	17	20	**194**
Blood/bodily fluid exposure (dirty sharps/splashes)	14	20	20	12	20	18	22	23	14	22	23	35	**243**
Environmental Issues	1	6	4	2	8	8	10	14	7	17	10	7	**94**
Moving and Handling	1	2	5	8	9	3	5	7	5	4	7	2	**58**
Sharps (clean sharps/incorrect disposal & use)	10	5	5	7	3	10	3	7	7	8	3	5	**73**
Slips, Trips, Falls	6	4	8	7	4	6	8	3	10	5	10	9	**80**
Violence & Aggression	52	37	39	33	50	30	38	45	56	51	53	52	**536**
Work-related ill-health	3	4	5	1	3	1	3	4	4	2	3	4	**37**
Total	**106**	**92**	**98**	**84**	**118**	**89**	**102**	**117**	**117**	**132**	**126**	**134**	**1315**

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

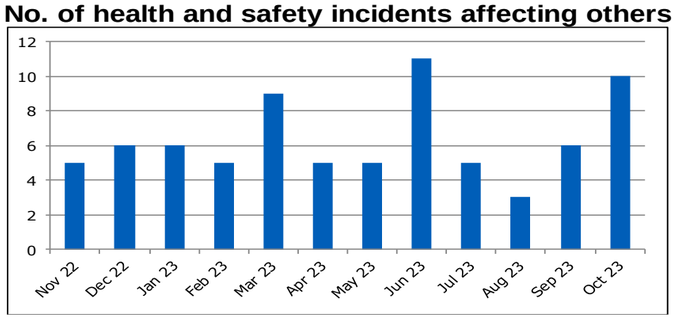
	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Total
No. of health & safety incidents	106	92	98	84	118	89	102	117	117	132	126	134	**1315**
Staff incident rate per month/year	0.9	0.7	0.8	0.7	1.0	0.7	0.8	0.9	0.9	1.1	1.0	1.1	**10.7**

No. of health and safety incidents affecting patients:



	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Total
Accident	15	19	19	17	21	13	19	29	14	20	18	20	**224**
Blood/bodily fluid exposure (dirty sharps/splashes)	0	3	2	0	1	3	2	2	2	0	2	4	**21**
Environmental Issues	8	7	3	5	1	2	4	6	3	4	2	4	**49**
Equipment / Device - Non Medical	3	1	2	1	0	0	1	2	6	1	0	0	**17**
Moving and Handling	3	2	1	4	2	1	2	3	0	1	2	4	**25**
Sharps (clean sharps/incorrect disposal & use)	0	1	0	2	3	2	0	4	3	0	2	0	**17**
Violence & Aggression	7	5	13	18	16	19	17	25	28	25	22	11	**206**
Total	**36**	**38**	**40**	**47**	**44**	**40**	**45**	**71**	**56**	**51**	**48**	**43**	**559**

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



	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Total
Accident	2	0	2	0	2	2	1	2	1	1	1	1	**15**
Blood/bodily fluid exposure (dirty sharps/splashes)	0	0	0	0	0	1	0	0	0	0	0	0	**1**
Environmental Issues	1	2	2	1	2	1	2	1	1	0	1	3	**17**
Sharps (clean sharps/incorrect disposal & use)	0	0	2	0	0	0	0	0	0	0	0	0	**2**
Slips, Trips, Falls	1	2	0	2	4	0	0	3	2	2	1	3	**20**
Violence & Aggression	1	2	0	2	1	1	2	5	1	0	3	3	**21**
Total	**5**	**6**	**6**	**5**	**9**	**5**	**5**	**11**	**5**	**3**	**6**	**10**	**76**

Cambridge University Hospitals
NHS Foundation Trust

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Report to the Council of Governors: 20 December 2023

Agenda item	8.1
Title	Report of 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 Lead Governor and 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 Lead Governor and 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 Council of Governors

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

Cambridge University Hospitals NHS Foundation Trust

20 December 2023

Council of Governors
Report of the Lead Governor
Neil Stutchbury

1. Recent Governor meetings

1.1 The Trust's Annual Public Meeting took place on 27 September. The Lead Governor gave an update on some of the key issues the governors had been engaged with during the year along with some of the issues we had assured ourselves on.

1.2 John O'Brien, Chair of the Cambridgeshire and Peterborough Integrated Care Board (ICB) hosted a meeting for all governors from the four foundation trusts that make up the Cambridgeshire and Peterborough Integrated Care System. Jan Thomas, Chief Executive of the ICB gave a presentation on the ICB strategy; Julian Stanley Chief Executive of Healthwatch Cambridgeshire and Peterborough gave a presentation on the initiatives Healthwatch is engaged with; and the CUH lead governor led a session on engaging with members.

1.3 Instead of the quarterly meeting with NEDs on 4 October, we met with Deloitte who had been commissioned to undertake an external review of how well-led CUH is against the national well-led framework. We were asked about the various ways in which governors are able to pick up what is going on at the Trust (e.g. observing board assurance committees) and to seek assurance from NEDs (e.g. at our quarterly meetings and Council of Governors). Deloitte commented that in comparison with some other trusts, the governing group was very functional and had a good relationship with the board.

1.4 The Governors' Strategy Group met on 16 October and we discussed the strategic focus on managing bed capacity and outpatient appointments. These two metrics are strong indicators of operational performance and are critical areas to manage to avoid an over-allocation of beds and long waits for appointments. A summary is available in the meeting papers.

1.5 We invited Heather Noble, Managing Director of the Cambridgeshire South Care Partnership (South Place) and Erin Lilley, a South Place programme director to present the role and work of South Place at a governor seminar on 18 October. South Place is a small team focused on setting up 'Integrated Neighbourhoods', which broadly map to Primary Care Networks, for delivering better more joined-up care locally.

1.6 We held a governor forum on 23 November, which we used to update each other on different meetings we had attended, such as the board assurance committees.

1.7 We held a governor seminar on 7 December where we had a presentation on the new Public and Patient Involvement framework. The proposal to set up a framework to enable staff to involve patients in projects designed to improve patient experience was approved by the Board on 8 November. A number of governors had contributed to developing the strategy.

1.8 The Governor Strategy Group met on 11 December. We reviewed the year's meetings and discussed what topics we could look at for next year's meetings. Overall both staff and governors found the meetings very valuable as they generally provide slightly different perspectives than is normally found in internal meetings. Alex Cavanagh and Sue Broster presented a paper on how to foster innovation in our region. The aim is to simplify and support the translation of good ideas from staff in the hospital and university into products and services for the benefit of patients.

2. Upcoming Governor meetings

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

- Governor/NED quarterly: 24 January 2024
- Governor Seminar: 8 February 2024
- Governor Forum: 27 February 2024
- Governor's Nomination and Remuneration Committee: 27 February 2024
- Membership Engagement Strategy Group: 5 March 2024
- Council of Governors: 27 March 2024

3. Other Governor activities

3.1 The Governors' Nomination and Remuneration Committee ran a recruitment exercise over the summer to fill the Non-Executive Director vacancy created by the departure of Adrian Chamberlain at the end of his second term of office. The Council of Governors met on 4 October and approved the recommendation to appoint Dr James Morrow as a Non-Executive Director. James started his new role on 1 November.

3.2 One of the public governors, Chris Cumberland, was asked to join the panel to interview for a new board adviser on major capital projects, which are now entering their construction phases. We were pleased to be involved in this key board appointment.

3.3 Following the resignation of David Noble as patient governor, Josiane Chuisseu, who received the next highest number of votes in the May 2023 elections, was appointed as a patient governor. We are pleased to welcome Josiane to the Council. We also welcome Susan van de Ven and Rachel Wade as the new County Council and City Council partnership governors respectively.

3.4 Governors have discussed and documented their collective appraisals of the performance of the Chair and Non-Executive Directors. Our inputs have been sent to the Secretariat for compilation into the overall feedback.

4. Recommendation

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

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Report to the Council of Governors: 20 December 2023

Agenda item	8.2
Title	Membership Engagement Strategy Implementation Group
Sponsoring executive director	Ian Walker, Director of Corporate Affairs
Author(s)	Namoo Boodoo, Membership Manager
Purpose	To update on the key achievements in 2023. To present the Patient and Public Involvement Framework and discuss how it will support membership.
Previously considered by	n/a

Executive Summary

This report summarises the activities of the Membership Engagement Strategy Implementation Group.

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

Action required by the Council of Governors

The Council is asked to receive and note the report.

Cambridge University Hospitals NHS Foundation Trust

20 December 2023

Council of Governors

Membership Engagement Strategy Implementation Group

1. The Membership Engagement Strategy Implementation Group met on 14 November 2023. The following governors were present: Julia Loudon, Neil Stutchbury, Ruth Greene, Samira Addo and Carina Tyrrell. Jason Clarke (Trust Secretary), Namoo Boodoo (Membership Manager), Sarah Booth (Director of Communications and Engagement) and Angie Ridley (Communications and Engagement Manager) also attended.

2. The Membership Manager provided an update on the key achievements in 2023 for the two strategy themes: 'Make the offer clear' and 'Provide regular, engaging communications'. A revised delivery timeline for 2024/25 was also presented.

3. The Communications and Engagement Manager and the Director of Communications and Engagement presented the approved Patient and Public Involvement (PPI) Framework. The promotion of Trust membership has been incorporated into the framework, as a way of keeping people linked in and informed about opportunities to get involved in service development and research at CUH.

4. The group agreed for two governors to speak to the Foxton Women's Institute on 4 June 2024. Neil Stutchbury will discuss this opportunity with governors in the governors' forum.

Cambridge University Hospitals
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Report to the Council of Governors: 20 December 2023

Agenda item	8.3
Title	Governors' Strategy Group
Sponsoring executive director	n/a
Author(s)	Julia Loudon, Patient Governor
Purpose	To summarise the activities of the Governors' Strategy Group.
Previously considered by	n/a

Executive Summary

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

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

Action required by the Council of Governors

The Council is asked to note the report covering the two most recent meetings of the Governors' Strategy Group held on 16 October 2023 and 11 December 2023.

Cambridge University Hospitals NHS Foundation Trust

20 December 2023

Council of Governors

Governors' Strategy Group – 16 October 2023

1. The Governors' Strategy Group met on 16 October 2023. Present were: Mike More (Chair), Jason Clarke (Trust Office), Matthew Zunder and India Miller (Strategy team) and governors (Gemma Downham, Julia Loudon and Neil Stutchbury). Gill Shelton (staff governor) gave apologies.

2. The agenda covered updates on (i) CUH strategy implementation, focusing on access of care, and (ii) the Cambridge Children's Hospital.

CUH strategy implementation

3. India Miller presented an update on the strategy relating to access to care, covering:

    - An update on analysis to forecast the future demand for beds and the outpatient waiting list (if we do nothing), together with (i) activities designed to reduce these through, for example, length of stay reduction and virtual wards, and (ii) proposed metrics against which to measure progress.
    - Outpatient transformation and innovation, including patient-not-present (PNP), patient-initiated follow-up, pathway redesigns, community diagnostics and triage to diagnostics.
    - Enabling resources (e.g. digital), budget, business planning and communications will all be critical to CUH's ability to improve access to care in the medium and long term.

4. Discussion points raised by governors included:

    - IM confirmed that the selected metrics (net bed capacity, waiting list and vacancy rate) reflect important areas where medium-term improvements in performance for patients across inpatient, outpatient, elective/non-elective services.
    - Of the outpatient services, certain projects (e.g. PNP; patient initiated follow-up) will be appropriate for certain specialties. Expansion of day surgery with same-day discharge will benefit capacity. For inpatients, length of stay reduction will be a priority, though it was noted that the risk of re-admission with early discharges will be reviewed.
    - Governors asked whether there is sufficient evidence that Virtual Wards can be significantly expanded. It was noted that more experience of CUH and other virtual ward implementation will inform this.

- How CUH plans align with the wider system strategies was discussed. It was noted that improved access to care will be a common goal across the system, but there will be ongoing discussion with system partners to understand the priorities of each area.
- During the discussion it was agreed that success will require the right thought leaders to ensure the buy-in of staff and patients to the changes. Transparency and wide communication about successes with project implementation is critical, such that everyone can see how their contribution is working towards large-scale change.

Cambridge Children's Hospital

5. Malcom McFrederick provided an update, including:

    - A reminder of the vision - that as well as paediatric physical and mental services, this regional hub for the east of England would have a research institute and school facilities.
    - The outline business case has been approved in principle, and the final business case is targeted for 2024, with build commencing mid-2025.
    - The hospital will provide benefits across the region including provision of specialist services, standardisation of access to care, training and education, strengthening of research networks, and support preventative care. By supporting paediatric patients from across the region, it will also enable some adult bed capacity to be freed up in regional trusts.

6. Discussion points raised by governors included:

    - It was confirmed that parents and children, as well as broad discussions with district hospitals, regional leaders and the existing mental health collaborative, would all be involved in the design of services.
    - Research ongoing at the Cambridge Cancer Research Hospital will be coordinated with the research into paediatric cancers that will be conducted at the Children's Hospital.
    - How patients would move from paediatric to adult services in the new model. It was confirmed that workshops are being held to identify how this could best work, and once pathways have been developed it is hoped that such initiatives could be implemented ahead of the build completion.
    - Regarding funding for the hospital, it was confirmed that many funding sources are being developed - as well as the government and CUH/CPFT, ACT is making good progress against its target, and the University of Cambridge is in discussions with regard to research funding. Pledges and gifts so far mean that more than half of the £100m target has been achieved.

Governors' Strategy Group: 11 December 2023

1. The Governors' Strategy Group met on 11 December 2023. Present were: Mike More, Jason Clarke (Trust Office), Dan Northam, Alex Cavanagh and Matthew Zunder (Trust strategy team), and John Clarkson, Julia Loudon, Gill Shelton and Neil Stutchbury (governors).

2. The group took the opportunity to discuss the year's Strategy Group meetings, discussing what members had found to be the most helpful discussions and areas for improvement. Points raised during this review included:

    - The range of topics and depth of analysis covered, but focusing on one or two main topics at each meeting.
    - The inclusivity of the group and the broad range of perspectives provided during discussions.
    - How the strategy feels more inclusive and decisive than previously, which is important as everyone in the Trust needs to feel that their work is important.
    - The group has been helpful in teasing out the strategic concepts.
    - Recognition of challenges - for example, how CUH strategies align both internally and with those of other parts of the system, as priorities for each part will vary.
    - Discussion of strategic resilience, ensuring that the team can respond to dynamic changes affecting strategies, and that this should continue to be considered as strategies are developed. MM noted that this is a live discussion at Board level.
    - The Strategy Team commented that working with governor group is insightful and that they benefit from the ideas and perspectives provided. It is particularly valuable to have a staff governor who can provide a perspective on behalf of the Trust's workforce.
    - It would be helpful to have papers circulated a week in advance of the meetings.
    - Going forward, it would be useful to have input on topics for discussion from the broader governor group. NS agreed to follow up with the Council of Governors on this.

Innovation updates

3. Alex Cavanagh presented an update on innovation programmes at CUH. These include:

    - Innovations that had already been delivered and were bringing benefit to both (i) CUH (e.g. the programme will enable CUH expertise to be provided remotely to patients at other hospitals; aid capacity challenges; free up consultant time) and (ii) patients (able to be treated at/nearer to home).
    - Pathway/productivity Innovations that can be taken into the new hospitals.

- Engaging with the Integrated Care System innovation group.
- Collaborations and shared learnings across the region whereby innovations developed at any regional centre could be tested/applied at other centres.

4. In addition to these examples, stakeholder interviews have identified areas on which to focus going forward. This included frustration with a current lack of clarity on where/how to get support and resources for new initiatives.

5. Discussion points raised by governors included:

    - It would be useful to clarify innovations based on invention vs process change, and to look at new ideas from all sides. It was agreed that more nuance on this would be helpful.
    - Within innovation, ideas developed elsewhere that can be applied at CUH should be included. It was noted that CUH key priorities should inform on which external innovations should be explored.
    - It was agreed that managing people's expectations was important, emphasising that providing a better service to patients is the overarching ambition.
    - Further thought will be given to future-proofing, given the range of relative unknowns in the provision of healthcare in the future.
    - Improving productivity is key, and governors asked (i) how quickly the innovations presented during the meeting were developed and (ii) whether the strategic framework would deliver such innovations more quickly in future. It was confirmed that the process up to now had been unclear and complicated, so simplifying/signposting this will be important for future projects and will significantly reduce time to delivery.

6. Going forward, dates for 2024 meetings would be proposed and agenda topics would be based on discussion between governors and the Strategy Team.