Board of Directors

Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

There will be a meeting of the Board of Directors in public on Wednesday 17 January 2024 at 11.00

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

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

AGENDA

General business			Purpose
11.00	**1**	**Welcome and apologies for absence**	For note
	2	**Declarations of interest** To receive any declarations of interest from Board members in relation to items on the agenda and to note any changes to their register of interest entries A full list of interests is available from the Director of Corporate Affairs on request	For note
	3*	**Minutes of the previous Board meeting** To approve the Minutes of the Board meeting held in public on 8 November 2023	For approval
	4*	**Board action tracker and matters arising not covered by other items on the agenda**	For review
11.05	**5**	**Patient story** To hear a patient story	For receipt

11.25	6*	**Chair's report** To receive the report of the Chair	For receipt
11.30	7*	**Report from the Council of Governors** To receive the report of the Lead Governor	For receipt
11.35	8*	**Chief Executive's report** To receive the report of the Chief Executive	For receipt
Performance, strategy and assurance			**Purpose**
11.45	9*	**Performance reports** *The items in this section will be discussed with reference to the Integrated Report and other specific reports* 9.1 Workforce 9.2* Quality (including nurse staffing report) 9.3 Access standards 9.4* Finance 9.5 Innovation, digital and improvement	For receipt
12.30	10*	**CNST Maternity Incentive Scheme** To receive the report of the Chief Nurse	For approval
12.45	11*	**Research and development** To receive the report of the Medical Director	For receipt
13.00	12*	**Guardian of Safe Working** To receive the report of the Medical Director	For receipt
Items for information/approval – not scheduled for discussion unless notified in advance			
13.15	13*	**Risk Management Strategy and Policy** To receive the report of the Chief Nurse	For approval
	14*	**Board assurance committees – Chairs' reports** 14.1 Performance Committee: 10 January 2024 14.2 Quality Committee: 10 January 2024 • Infection Control Annual Report 2022/23	For receipt
Other items			**Purpose**
	15	**Any other business**	
13.20	16	**Questions from members of the public**	

	17	**Date of next meeting** The next meeting of the Board of Directors will be held on Wednesday 13 March 2024 at 11.00.	For note
	18	**Resolution** That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (NHS Act 2006 as amended by the Health and Social Care Act 2012).	
13.30	**19**	**Close**	

Minutes of the meeting of the Board of Directors held in public on Wednesday 8 November 2023 at 11.00 via videoconference

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

** Non-voting member*

In attendance	Position
Ms V Amiss-Smith	Specialist Nurse, Paediatrics *(for item 108/23 only)*
Ms S Booth	Director of Communications and Engagement *(for item 115/23 only)*
Mr J Clarke	Trust Secretary (Minutes)
Ms I Miller	Acting Director of Strategy *(for item 114/23 only)*
Dr S Ohja	Director of Postgraduate Medical *Education (for item 116/23 only)*
Ms A Ridley	Communications and Engagement Manager *(for item 115/23 only)*
Ms K Stohr	Consultant Orthopaedic Surgeon *(for item 108/23 only)*
Dr N Stutchbury	Lead Governor
Ms H Swaine	Specialist Nurse, Paediatrics *(for item 108/23 only)*
Mr M Zunder	Strategy Adviser *(for item 114/23 only)*

104/23 Welcome and apologies for absence

The Chair welcomed everyone to the meeting and extended a particular welcome to Dr James Morrow who was attending his first public meeting as a Board member.

Apologies for absence are recorded in the attendance summary.

On behalf of the Board of Directors, the Chair expressed condolences to the family of Roy Male CBE, a former Chief Executive of Addenbrooke's Hospital, whose death had been announced recently.

105/23 Declarations of interest

Standing declarations of interest of Board members were noted.

106/23 Minutes of the previous meeting

The minutes of the Board of Directors' meeting held in public on 13 September 2023 were approved as a true and accurate record.

107/23 Board action tracker and matters arising not covered by other agenda items

Received and noted: the action tracker.

108/23 Patient story

Lorraine Szeremeta, Chief Nurse, presented the patient story. Victoria Amiss-Smith, Helen Swain and Kuldeep Stohr joined the meeting for this agenda item.

Board members watched a video describing the experience of Benjamin and his family during his care pathway, which had commenced after sustaining a fracture to his arm.

The story emphasised the need to place a strong focus on both the physical and mental health needs of paediatric patients and highlighted the importance of the vision for the Cambridge Children's Hospital (CCH).

The following points were made in discussion:

1. The CCH, a collaboration between CUH, Cambridgeshire and Peterborough NHS Foundation Trust and the University of Cambridge, would provide a platform to deliver services for children across the region in a different way. The aim was to ensure that the right child was able to receive the right level of physical and mental health care in the right place.
2. While recognising the opportunities that the CCH would provide in the future, there was also a need to focus on more immediate opportunities to improve care for children.
3. During his treatment, the care team had become aware of Benjamin's anxiety and had sought to provide additional support for his mental health needs. As part of this, the team had attempted to make a

referral to Child and Adolescent Mental Health Services (CAMHS) but had been informed that, in the absence of major psychological trauma, there was a waiting list of two to three years.

4. A business case for paediatric psychology had been developed and it was hoped that a service could be provided as part of the CCH.
5. The story highlighted that there was scope to improve food options and availability, and other amenities, for families. It was noted that access to affordable food, particularly for parents and carers of children staying in hospital, had been identified as an issue in previous patient stories and it was agreed that an update would be provided at a future Board meeting.

Agreed:

1. To note the patient story.
2. To thank Benjamin and his family for sharing his story and that the Chair would write to Benjamin to convey these thanks on behalf of the Board.
3. To receive an update at a future Board meeting on access to affordable food for parents and carers.

109/23 Non-Executive Director appointment and committee membership

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

Noted:

1. Following a competitive recruitment process, the Council of Governors had approved the appointment of Dr James Morrow as a Non-Executive Director (NED).
2. It was proposed that James Morrow would be a member of the Quality Committee and the Addenbrooke's Futures Committee, filling the positions previously held by Adrian Chamberlain and Annette Doherty respectively.

Agreed:

1. To note the appointment of Dr James Morrow as a Non-Executive Director.
2. To endorse the revised membership of Board committees with effect from 1 November 2023 as outlined in the report.

110/23 Chair's report

Mike More, Trust Chair, presented the report.

Agreed:

1. To note the report of the Chair.

111/23 Report from the Council of Governors

Neil Stutchbury, Lead Governor, presented the report.

Agreed:

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

112/23 Chief Executive's report

Roland Sinker, Chief Executive, presented the report.

Noted:

1. The health and social care sectors remained under significant pressure, with the national elective waiting list currently in excess of 7 million patients and rising.
2. The disputes between the British Medical Association and the Government remained unresolved, although it appeared that negotiations were taking place.
3. The financial outlook for 2024/25 remained challenging.
4. There was an active debate at national level following a recent letter from the Secretary of State for Health and Social Care to Integrated Care Boards regarding spending on equality, diversity and inclusion (EDI) posts. CUH remained committed to taking pro-active steps to address the differential experiences and outcomes for both staff and patients with protected characteristics.
5. The Cambridge Movement Surgical Hub, consisting of three theatres and 40 beds, had opened on 6 November 2023 and would support a reduction in the waiting lists for elective orthopaedic and spinal surgery.
6. The Trust's external well-led governance review was ongoing. In addition, the Trust would be undertaking a self-assessment against the current Care Quality Commission (CQC) framework over the next three months, with a focus on the core services which had not been subject to CQC inspection within the past two years.

The following points were made in discussion:

1. Board members confirmed their commitment to improving the experience of patients and staff from an EDI perspective.
2. A decision had been taken by Cambridgeshire County Council not to proceed with the proposed sustainable travel zone in Cambridge. Noting the current congestion challenges, and the need for improvements to public transport, there was recognition that a long-term solution was still required.

Agreed:

1. To note the contents of the report.

113/23 Performance reports

The Board received the Integrated Performance Report for September 2023.

Access standards

Nicola Ayton, Chief Operating Officer, presented the update.

Noted:
1. There had been a detailed discussion of key performance metrics at the Performance Committee meeting on 1 November 2023.
2. The Trust continued to perform well, and was consistently in the top quartile nationally, in relation to ambulance handover times.
3. The Trust's performance against the 4-hour emergency care standard had deteriorated since August 2023 and was below its planned trajectory. An internal improvement plan had been developed.
4. However, there had been a decrease in the number of 12-hour Emergency Department waits, with the Trust performing better than in the same period in 2022.
5. The Trust's ability to deliver elective care continued to be compromised by periods of industrial action.
6. While the Trust was the second best performer in the East of England on the cancer 62-day waiting time standard, work was continuing to reduce waiting times in relation to haematology and skin cancer.
7. Winter planning was on track and the Winter Taskforce had been established.

Workforce

David Wherrett, Director of Workforce, presented the update.

Noted:
1. The annual flu and Covid-19 staff vaccination programmes were underway.
2. The Trust remain committed to the implementation of the Workforce Disability Equality Standard (WDES) action plan. A Workplace Adjustments Service had been launched earlier in the year, providing a centralised budget for physical equipment and adaptations to working environments.
3. The CUH workforce had grown by just over 4% in the past 12 months across both clinical and non-clinical areas. Six to nine months ago, the Trust had been concerned about recruitment pipelines, but significant progress had been made across a range of areas. The international recruitment pathway remained essential to the Trust's recruitment plans.
4. The Trust's annual awards programme had culminated in an awards ceremony at the Cambridge Corn Exchange on 28 September 2023, sponsored by the Addenbrooke's Charitable Trust.

Quality (including nurse staffing report)

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

Noted:

1. The Hospital Standardised Mortality Ratio (HSMR) for July 2023 was 76.5, making CUH the best performing trust outside London.
2. While there was still work to do, considerable progress had been made in relation to the management of Sepsis.
3. Overcrowding in the Emergency Department waiting room remained a significant concern and work continued with colleagues across the operations, medical and nursing teams to improve the position.
4. An inquest had recently taken place into to the tragic death of a baby following failure to administer Vitamin K. The serious incident investigation had identified a number of recommendations and process improvements.
5. A maternity improvement programme and oversight board had been established to oversee the action plan arising from the CQC inspection of the Trust's maternity services. The membership of the oversight board included a number of external stakeholders.
6. The Trust remained on track to implement the new Patient Safety Incident Response Framework (PSIRF) from January 2024.
7. Significant progress had been made through a targeted approach in reducing the complaints backlog from around 560 earlier in the year to around 80 at present. The aim was to eliminate the backlog by the end of the calendar year.
8. The Board received the six-monthly nursing and midwifery staffing report. Nursing and midwifery establishments were set using an agreed national methodology.
9. There continued to be significant challenges in adult critical care staffing, with weekly oversight of the position.

Finance

Mike Keech, Chief Finance Officer, presented the update.

Noted:

1. The Month 6 financial report showed a year-to-date deficit of £3.5m against a planned surplus of £3m.
2. Industrial action was highlighted as a key contributor to the deviation from the financial plan, through the impact of both higher pay costs and reduced activity.
3. The Trust continued to perform favourably compared to peers. Nationally, there was an adverse financial variance of almost £800m. Further information was awaited from the national team on financial support to address the impact of industrial action.
4. The Trust's capital programme was currently ahead of plan, with spend in the year to date of £19.4m against the budget of £14.6m.

5. The next two years would be financially challenging, given a lack of clarity regarding further investment and ongoing political uncertainty. The Trust would need to focus on the basics of financial control and delivering sustainable improvements in productivity and efficiency.
6. Work was being undertaken to link the medium-term strategy with the financial strategy.

Innovation, digital and improvement

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

Noted:

1. The Trust's three-year contract with the Institute for Healthcare Improvement (IHI) had ended in October 2023. The aim was for the Trust to be self-sufficient and further develop its internal improvement capability and capacity. The Trust's improvement resources would be focused on meeting what would be challenging financial, quality and performance targets over the next two years.
2. The portfolio of the Director of Innovation, Digital and Improvement was being reviewed to strengthen the links between the innovation, digital and improvement agendas. These would be key enablers for delivering the Trust's productivity and efficiency targets for 2023/24 and 2024/25.
3. A diagnostic review of the innovation agenda was underway, with innovation regarded as central to improving quality and access to care for patients over the medium term.

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

1. Board members welcomed the significant work undertaken to reduce the backlog of complaints.
2. Given the current financial position, assurance was sought on the confidence of achieving the annual financial plan for 2023/24. It was noted that, while the Trust was in a strong position compared with many peers, it was not possible to provide full assurance at this stage on the delivery of the plan given the current uncertainties in relation to industrial action and wider system challenges.
3. The decline in performance against the 4-hour emergency care standard was a cause for concern. Given the approaching winter period, assurance was sought that plans were in place to maintain safety for urgent and emergency care patients. It was explained that the recent decline in performance was being taken very seriously given that the 4-hour standard was a core indicator of safe emergency care. Extensive work was being undertaken to implement an improvement plan and the recommendations of two peer reviews.
4. There had been robust challenge at the recent meeting of the Quality Committee regarding the medical staffing models in both the Emergency Department and Maternity services and assurance had

been sought on the work underway to review medical staffing in both services.

5. In the absence of a high cost area supplement, the high cost of living in and around Cambridge remained a constraining factor in the ability of the Trust to recruit and retain staff, particularly in lower pay bands. The Trust had an obligation to provide appropriate living arrangements for international recruits and subsequently to support staff to move into their own accommodation. The Trust's Accommodation Officer continue to provide support to staff in this regard.
6. The Trust was currently in the top quartile nationally in the delivery of the staff vaccination programme. The ambition remained to achieve pre-pandemic levels of uptake but this was proving very challenging for all trusts.

Agreed:

1. To note the Integrated Performance Report for September 2023.
2. To note the finance report for 2023/24 Month 6.
3. To note the nurse safe staffing report for September 2023.
4. To note the biannual nursing and midwifery establishment report.

114/23 Strategy update

Claire Stoneham, Director of Strategy and Major Projects, India Miller, Acting Director of Strategy, and Matthew Zunder, Strategy Adviser, presented the report.

Noted:

1. The CUH Strategy was refreshed in July 2022, with the establishment of 15 strategic commitments across the three themes of improving patient care, supporting our staff and building for the future.
2. The Board had confirmed that the key 'strategic lens' for 2023/24 and 2024/25 would be improving access to care, enabled by our workforce.
3. Non-Executive Directors had sought an articulation of the direction of travel against the strategic commitments and work was in progress to describe medium-term trajectories across each of the three themes, linking these to Board Assurance Framework risks. This report included a first step in the articulation of these trajectories.

The following points were made in discussion:

1. The inclusion of medium-term strategic trajectories in the report was welcomed.
2. It would be important to retain the ability to react flexibly to new challenges as they arose.

Agreed:

1. To note the progress made over the last four months in delivering the CUH strategy and the plans for the period ahead.

115/23 Patient and public involvement framework

Sarah Booth, Director of Communications and Engagement, Angie Ridley, Patient Engagement Manager, and Neil Stutchbury, Lead Governor, presented the report.

Noted:

1. The Patient and public involvement (PPI) framework would support the Trust's strategic priorities of improving patient care and building for the future by listening to and involving our patients and diverse communities. Having been co-produced, the framework drew on research and feedback from patients, staff and the wider public, with active engagement from wider community stakeholders such as Healthwatch and other voice organisations.
2. In developing the framework, the Trust had incorporated learning from other organisations, as well as NHS England's statutory 'Working in partnership with people and communities' guidance, which was grounded in best practice.
3. The framework established an ambitious vision for PPI, supported by 16 key recommendations.
4. The Trust would be seeking to develop a system of support and training for patients and staff to enable a co-production and engagement approach to be embedded for new services, service transformation and improvements, capital builds and PSIRF.
5. It was planned to appoint a Head of Patient and Public Involvement who would be responsible for overseeing the implementation of the plan.

The following points were made in discussion:

1. Rohan Sivanandan had offered to act as a NED champion for PPI.
2. It was essential that there was consideration of the impact of differentiated outcomes and levels of access across various community groups. An approach to PPI that may work for some groups may not adequately meet the needs of all local communities.
3. There should be strong consideration of the neuro diverse community as part of the implementation of the plan.
4. It was questioned to what extent the consultation on the PPI framework had been successful in reaching out to historically under-represented groups. It was noted that, while this had happened to some extent, there was more to do to link with harder-to-reach communities in ways that worked for them. In some situations, this might be through trusted community leaders, the integrated care system or Healthwatch.
5. Work had begun with the Gypsy, Roma and Traveller community to strengthen relationships, underpinned by the key principles of the PPI framework.

Agreed:

1. To approve the CUH Patient and Public Involvement (PPI) Framework.
2. That Rohan Sivanandan would act as NED champion for PPI.

116/23 Education, learning and development

David Wherrett, Director of Workforce, and Sanjay Ohja, Director of Postgraduate Medical Education, presented the report.

Noted:

1. The refreshed education, learning and development strategy for 2023–2026 had been agreed in July 2023 and was underpinned by six key themes. The strategy sought to provide clarity on the multi-professional education, learning and development offer for all staff.
2. The Trust has invested heavily in apprenticeship programmes, with up to 500 nursing apprentices at any one time. Despite this investment, there was recognition that the current model had become increasingly challenging to deliver because the training hours requirement made the scheme financially unaffordable in its current form.
3. As a result, the Trust's nursing apprenticeship pathway would change from March 2024 from the current four-year Registered Nurse degree apprenticeship to a Nursing Associate apprenticeship.
4. The Trust had raised these challenges with the Chief People Officer for NHS England, seeking clarity as to how organisations could be better supported to provide apprenticeship schemes.
5. The first of the strategy's key themes related to the learning experience of staff, including undergraduate and postgraduate students who spent their time with the Trust as part of formal education/rotation programmes.
6. The Trust had recently received the results for the annual General Medical Council (GMC) survey. The challenging context of the working landscape was outlined to Board members, with the impact of the pandemic, limited ability to deliver outpatient training, the switch from face-to-face training to predominantly virtual training and industrial action highlighted as key drivers of the results.
7. Against Shelford Group peers, the Trust ranked fifth for overall satisfaction, the same as in 2022.
8. There were 24 green (positive) outliers in 2023 compared to 23 in 2022, with most of these in Core Surgical Training, Clinical Pharmacology and Therapeutics and Plastic Surgery. This represented a marked improvement on previous years, given that Plastic Surgery had recently been flagged on the national risk register.
9. The survey results noted 57 red (negative) outliers, an increase from 29 in 2022. Of the 57 red outliers, 21 were reported in Obstetrics and Gynaecology.
10. 20% of the red outliers received related to workload, which had been a recurring theme since 2021. Work was ongoing through the

Guardian of Safe Working to address the issues and ensure that there was accurate local data for the Trust to analyse and report against.

11. The sixth theme of the strategy related to ensuring that there were modern, fit-for-purpose education facilities and resources. The Trust had some world-class training facilities which had been recognised at a national level by NHS England and commercial research partners.

The following points were made in discussion:

1. Noting the decision to change the nursing apprenticeship pathway, clarification was sought as to whether other organisations were doing likewise in the face of financial challenges and value for money considerations. It was highlighted that the Trust was unique in terms of the scale of its current programme and having made this work successfully prior to the recent changes.
2. There was a need for the Trust to have a robust GMC survey improvement plan, with focused attention on the areas where there were a significant number of red outliers.
3. Since the GMC survey had become non-mandatory in 2021, the response rate had fallen from around 98% to 70%.
4. The results for Obstetrics and Gynaecology were of significant concern. It was noted that there was no report for the service in the previous year because there had been an insufficient number of responses.

Agreed:

1. To note the quarterly report, specifically the updates on themes 1, 2, 3 and 6 of the Trust's Multi-profession Education, Learning and Development Strategy 2023–2026.

117/23 Learning from deaths

Ashley Shaw, Medical Director, presented the report.

1. Between July 2023 and September 2023 there were 424 deaths reported at CUH. Of these, 4% were in the Emergency Department and the remainder were inpatient deaths. These figures were within the normal expected range.
2. The Trust's HSMR figures had been decreasing during 2023.
3. During the reporting period, 63 deaths met the criteria for a Structured Judgement Review (SJR). Of these, only one SJR identified significant problems in care where room for improvement and poor care in some areas of the pathway were identified.

Agreed:

1. To receive the learning from deaths report for 2023/24 Q2.

118/23 Board Assurance Framework and Corporate Risk Register

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

Noted:

1. Board members were reminded that Board assurance committees reviewed risks on the Corporate Risk Register (CRR) and the Board Assurance Framework (BAF) at each of their meetings.
2. Suggestions on the presentation of the BAF made at the Performance Committee meeting on 1 November 2023 would be incorporated in due course.
3. As previously discussed by the Board, work had been undertaken to identify medium-term risk trajectories on the BAF and to link these to key milestones in the Trust strategy.
4. At the Risk Oversight Committee in October 2023, it was proposed that BAF risk 007 should be reduced from 4x5=20 to 4x4=16 given the positive progress in relation to staff recruitment and retention.

Agreed:

1. To approve the current versions of the Board Assurance Framework and the Corporate Risk Register, including the reduction in BAF risk 007 from 20 to 16.

119/23 Board assurance committees – Chairs' reports

Received: the following Chair's reports:

- Performance Committee: 1 November 2023
- Quality Committee: 1 November 2023

120/23 Any other business

There was no other business.

121/23 Questions from members of the public

1. *In his report the Chair (1.2) quotes the CQC as saying that the national figure of over seven million waiting for diagnosis/treatment is likely to be an underestimate because of the 'higher referral barriers for GPs'. What are these barriers, who imposes them and which specialities are they thought to affect? Do you have evidence that cases, when they finally reach you, are more serious and/or more difficult to treat?*

The Medical Director responded:

We are not aware of any concerns being raised that advice and guidance is being used as a barrier to referral in CUH, or that advice and guidance has led to worse outcomes in any cases.

At CUH we enable GPs to access specialist advice via advice and guidance for all specialities. This is in addition to, not instead of, the route for referral.

Consultants can also reject a referral with advice if they feel the patient's condition can still be appropriately managed within primary care. We would hope that this is seen locally as a helpful tool.

We cannot offer comment directly on whether there is evidence that when patients reach secondary care they are more serious/difficult to treat. It is suggested that this could certainly occur as a consequence of long waiting times alone, and for that reason efforts to support only patients who really need specialist care rather than just specialist advice are helpful to reduce waiting lists over time.

2. *There is only one brief reference that I can see (CEO's report) to the tragic 'vitamin K' baby death which has been widely reported in the press. One contributing factor mentioned in the report findings was either staff confusion in using/understanding the relevant (Epic?) software or failure in the software itself. How do you ensure that the system is safely operational and that staff – new staff in particular – are competent and confident with reading and entering data unsupervised in a system that is now universal use from consultant to junior HCA?*

The Director of Innovation, Digital and Improvement responded:

This case involved a baby born prematurely who was admitted to the Neonatal Intensive Care Unit (NICU) and did not receive Vitamin K. Several weeks later, the baby tragically died. The hospital commissioned an external review shortly after the events which identified several important issues, some of those related to the electronic patient record.

As a fully digitised hospital, all documentation, prescribing and administration of medications are carried out within our electronic patient record system, Epic.

There was no specific software failure. Epic functioned as designed and expected. Following a serious incident review, opportunities were identified to optimise the electronic patient record to reduce the likelihood of recurrence.

One of these recommendations included the inclusion of a prompt to consider Vitamin K prescription as part of the admission process. As a hospital we also took this as an opportunity to make additional changes to further streamline other aspects of the admission and handover process.

These updates are live in the Epic system.

All staff members have the appropriate mandatory training relevant to their role before their Epic log in is activated as part of their Trust induction. Vitamin K administration and prescribing is included as part of the initial on-boarding training. More recently, we have started a programme of annual refresher training called THRIVE available for all staff.

3. *As a recent in-patient and out-patient travelling always by guided bus I have noted that for much of every day the bus route around and through the Campus is nose-to-tail slow-moving or stationary cars, buses and vans. Do you monitor the pollution which must be terrifyingly high near clinical units?*

The Director of Corporate Affairs responded:

Air pollution is monitored by Cambridge City Council (Environmental Health) on the roads in and around CUH. Although the annual averages have shown a marginal increase since 2020, figures for the key marker of NO_2 concentrations remain well within the air quality objective of 40µg/m3. However, this will mask local peaks that come with excessive congestion on site. Recent local roadworks (especially the A1307 near Worts Causeway) and work at Great Shelford junction with Addenbrooke's Road caused major disruption and traffic jams from the middle to the end of October and into November – this may have been the cause of the observed excessive tailbacks through the Campus.

Further steps we are taking include:

- Currently trialling an innovative air quality monitoring project in the Service Yard, with the findings to be collated from January 2024.
- Continuing to discourage single occupancy vehicle travel, while encouraging and subsidising the use of the Babraham and Trumpington Park & Ride sites alongside a cycling support programme.
- Switching to electric vehicles via the Trust car purchase salary sacrifice scheme. To facilitate the switch to CUH business miles by electric vehicles, we are currently working on providing the necessary charging infrastructure. This will be further boosted in 2024 with the provision of electric vehicle charging at Babraham Park & Ride.

- Stagecoach and Whippet (bus operators) have recently introduced a significant fleet of electric buses The U service is now fully electric. CUH has introduced two courtesy buses to help with travel around the Campus (both electric vehicles) and as new vehicles are purchased for the business fleet, these will all be electric vehicles.

122/23 Date of next meeting

The next meeting of the Board of Directors in public would be held on Wednesday 17 January 2024 at 11.00.

123/23 Resolution

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

Meeting closed: 13.21

Board of Directors (Part 1): Action Tracker

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

Key to RAG rating:

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

Board of Directors

Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 17 January 2024

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

Executive Summary

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

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

Action required by the Board of Directors

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

Cambridge University Hospitals NHS Foundation Trust

17 January 2024

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

1. Introduction

1.1 New Year is a time for resolution, renewal and looking forward. And so it is with us – as new facilities have begun to come on stream, and will continue to do so over coming months; as we build on what I think have been decisive steps in progressing the Cancer Research Hospital and the Children's Hospital over the last year into the next phase such that we can say we will have built them over the next few years; as we look to maintain and build upon the progress made in recruitment and retention of our teams; and so I could go on across a range of opportunities and prospects.

1.2 But all this has also to be situated in the very challenging and challenged context within which we operate. There is a real fear that we are now normalised to industrial action without prospect of end. That is awful. Patient waiting lists are not acceptable and the actual and potential harm and anxiety to patients is immense. The opportunity cost of time spent in planning for industrial action and the ensuing fatigue should not be underestimated. As a Board we cannot take this context as acceptable, even if many of the solutions are outside of our control. And we need very vigorously to resist normalising this.

1.3 We also know as a Board we need to think hard about underlying cultures which are being created by the situation we are in. Without understanding the cultures, we won't find the right ways through. A recent national survey by MDDUS, cited by the Nuffield Trust, reported significant "moral distress" among clinicians. We have commissioned some work in this area, and I look forward to its conclusions.

1.4 Once again, I want to thank the teams who worked so hard to prepare for and manage the industrial action we experienced over Christmas and the New Year. Relative to others we managed quite well and did not see the same pressures as some. That was down to hard work for which as a Board we are very grateful.

1.5 It was sad to hear of the death of Professor Sir Roy Calne a few days ago. We were delighted that he and his wife Patsy joined us in 2018 to celebrate the 50th anniversary of the first European (and only second worldwide) successful liver transplant in Addenbrooke's Hospital; and to name the transplant unit at Addenbrooke's after Roy in 2021. He was also part of the team which did the first ever liver, heart and lung transplant alongside Professor John Wallwork, who I wish well as he stands down as Chair of Royal Papworth Hospital at the end of January 2024. I don't think it an over-exaggeration to say that much of the international reputation of Addenbrooke's rests on Roy's contribution to transplant surgery those decades ago.

1.6 In December 2023 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 (FOI) 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.

2. New hospitals appointments

2.1 I am delighted to welcome Mark Bullock as the Independent Chair of the Cambridge Cancer Research Hospital Construction Programme Board. Mark was until recently the CEO of Balfour Beatty UK Construction Services.

2.2 Processes are ongoing to appoint a Board Adviser with construction skills and experience to advise the CUH Board on new hospitals construction. Following a competitive interview process, an offer has been made and I will be able to provide further information in due course.

3. 'You Made A Difference' Awards

3.1 I was pleased to attend 'You Made A Difference' award events on 5 December 2023 and 9 January 2024. 137 individual nominations were received and I would like to personally congratulate the winners, Samantha Fennelly, Junior Sister on PICU, Victoria Monson, Senior Physiotherapist, and Kieron Cave, Porter.

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
Board of Directors
Council of Governors
Audit Committee
Governors' Nomination and Remuneration Committee
Workforce and Education Committee
Performance Committee
Quality Committee
Diwali Staff Celebration Event
Armistice Day
Children's Hospital Regional Ambassadors event
Regional MP Briefing
Winter staff social event
Governor Seminar
Council of Governors' Strategy Group
REACH Staff Network Christmas social event
Staff Carol Service
Brainbow Christmas Party

4.2 Other meetings attended during this period include:

Introductory meeting with new Chair of Cambridgeshire and Peterborough NHS Foundation Trust
Evelyn Trust Patrons Dinner
Trumpington Residents Association Members Meeting

5. Recommendation

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

Together
Safe
Kind
Excellent

Report to the Board of Directors: 17 January 2024

Agenda item	7
Title	Report from the Lead Governor
Sponsoring executive director	n/a
Author(s)	Neil Stutchbury, Lead Governor of the Council of Governors
Purpose	To summarise the activities of the Council of Governors, highlight matters of concern and note successes.
Previously considered by	n/a

Executive Summary

The report summarises the activities of the Council of Governors.

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

Action required by the Board of Directors

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

Cambridge University Hospitals NHS Foundation Trust

17 January 2024

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

1. Recent Governor meetings

1.1 We held a **Governor Forum** on 23 November which we used to update each other on different meetings we had attended, such as the board assurance committees.

1.2 We held a **Governor Seminar** on 7 December where we had a presentation on the new Public and Patient Involvement Framework, led by the Communications and Engagement team. The framework to enable staff to involve patients in all projects designed to improve patient experience was approved by the Board on 8 November. A number of governors had contributed to developing the approach.

The Trust Chair and Director of Corporate Affairs joined us for the second half of the meeting to describe the background to two data breaches communicated on 6 December, which resulted from the accidental release of patient data as part of Excel spreadsheets supporting Freedom of Information requests. The Chair gave assurance to governors on the steps taken to investigate the severity of the breaches and to identify those potentially affected. Governors agreed that the Trust had taken appropriate steps in communicating openly about the breaches and were assured that action had been taken to minimise the risk of such a breach happening again.

1.3 The **Governors' Strategy Group** met on 11 December. We reviewed the year's meetings and discussed potential topics for the next year's meetings. Overall both staff and governors found the meetings very valuable as they generally provided slightly different perspectives than was 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.

1.4 The **Council of Governors** met on 20 December. The Council welcomed Josiane Chuisseu as a Patient Governor, replacing David Noble who stepped down last year, and Cllr Rachel Wade, appointed by Cambridge City Council as a Partnership Governor, succeeding Cllr Mairead Healy.

The Trust Chair gave Governors an update on the data breaches (see above). It appears that there is no evidence that personal data had been accessed. Only a few patients affected had called the helpline, suggesting that the information provided was effective in answering many queries. Governors were assured that the situation, though a significant breach in patient confidentiality, was well-

managed and the right steps had been taken to minimise the risk of future data breaches. Governors also sought assurance on tracking health inequalities, the winter plan, pressures on ED and the uptake of Covid and flu vaccinations by staff members.

In its closed session, the Council approved the re-appointment of Mazars as the Trust's external auditor. It also approved an extension of Sharon Peacock's term of office as a Non-Executive Director (NED) to 31 March 2025 to take into account the six-month period during which she stepped down from the Board to take up her role advising the government on Covid-19.

2. Upcoming Governor meetings

2.1 The next three months' meetings are as follows:

- Governor-NED quarterly meeting: 24 January 2024
- Governor seminar: 8 February 2024
- Membership Engagement Strategy Implementation Group: 5 March 2024

3. Other Governor activities

3.1 The Chair of the Governors' Nomination and Remuneration Committee and the Lead Governor are working with the Director of Corporate Affairs to develop plans for recruiting replacements for Sharon Peacock as a NED and Mike More as Chair.

3.2 The Lead Governor attended a meeting with lead governors of foundation trusts in the East Anglia region on 8 December. This group meets quarterly to compare governance across different trusts and to share best practice. We discussed governor relationships with our Integrated Care Boards (ICBs) and found a wide range of experience across the region, with some having good links and some having very few. We also discussed the appointment process and terms for lead and deputy lead governors and discovered that practices are far from consistent.

3.3 The Lead Governor is meeting John O'Brien, Chair of the Cambridgeshire and Peterborough Integrated Care Board (ICB), along with the lead governors of the other three foundation trusts within the integrated care system, on 15 January for a catch up on the activities of the ICB and updates from governors of the four trusts. The Lead Governor is also attending a meeting hosted by Heather Noble, Managing Director of the Cambridgeshire South Care Partnership, on 16 January for people involved in integrated care in the region to share progress and success stories.

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

4. Recommendation

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

Board of Directors

Together
Safe
Kind
Excellent

Report to the Board of Directors: 17 January 2024

Agenda item	8
Title	Chief Executive's report
Sponsoring executive director	Roland Sinker, Chief Executive
Author(s)	As above
Purpose	To receive and note the contents of the report.
Previously considered by	n/a

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

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

Action required by the Board of Directors
The Board is asked to note the contents of the report.

Cambridge University Hospitals NHS Foundation Trust

17 January 2024

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

1. Introduction/background

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

1.2 There are a range of well understood current challenges facing health and care, including industrial action, recruitment, access to care and waiting times, quality, and access to capital. These challenges are increasingly crystallising within some providers and some integrated care systems. However alongside these difficulties the NHS is delivering across a wide range of areas from the Grail Galleri cancer test and the cancer vaccines launchpad, to the opening of elective surgical centres and community diagnostics hubs, to the funded national workforce plan.

1.3 CUH continues to tackle these challenges and opportunities; and the next 24 months will see the Trust retain its focus on the five areas of operational performance, and the three pillars of the strategy. Alongside this, the Trust will also continue to refresh and develop services and corporate departments, as appropriate. This refresh will draw on the findings of the recently conducted governance review, the Trust's externally validated CQC self-assessment and a rolling programme assessing a range of departments. Much of this work will be supporting areas already identified as opportunities for change and will see developments in resourcing and approach.

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, the emergency pathway, staffing and maternity (considering the CQC review); and noting progress on complaints and outcomes.

- **Workforce** - a focus on inclusion and development; understanding a low uptake for the staff survey and vaccination, in line with much of the NHS; 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 As discussed widely, the Trust was responsible for two material data breaches, which were tackled in November and December 2023. These were unacceptable breaches and we apologise unreservedly to all of our patients. The two breaches were in relation to information provided in response to Freedom of Information requests. In both cases the Trust acted to remove the data, prevent further data submissions, and support the patients involved. The Trust will be conducting an external review of the Freedom of Information process; and is looking at other uses of data within CUH.

1.8 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. As indicated in section 1.4, these two reviews will form part of a more comprehensive assessment and plan to enable CUH to thrive over the coming years in a changing environment.

Part A

2. The five areas of operational performance

2.1 Quality

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

Emergency care and patient flow

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

Maternity

2.4 The vacancy rate for midwifery has significantly improved with plans to over recruit to support staff turnover. There has also been an improvement in leaving rates since April 2023. Maternity support worker vacancy rates remain high with work ongoing around recruitment and retention.

2.5 A CQC action plan, to address actions identified as part of the recent inspection, is being managed through the Maternity Improvement Oversight Board. There were currently six workstreams, with each being led by a senior midwife and obstetrician.

Paediatric Nutrition Action Plans 2023-2024

2.6 Paediatric Nutrition Action Plans are linked to the Nutrition Standards and Paediatric Fundamentals of Care and integrate patient experience where relevant.

2.7 To better understand the current situation regarding paediatric provision for parents a mapping exercise was undertaken on each ward and specific areas of work identified going forward.

Staffing numbers

2.8 There has been an increase in the vacancy position across the Registered Nurse (RN) and Health Care Support Worker (HCSW) establishments due to the opening of the Surgical Movement Hub. The greatest impact from vacancies within nursing remains within the critical care units with both paediatric critical care units (PICU & NICU) having to close to referrals from the region on occasion due to staffing constraints.

2.9 The adult critical care unit has continued to report breaches with the guidelines for the provision of intensive care (GPICS) standards due to vacancy however this is an improving picture with a reduction in the number reported. However the vacancy rate is improving, there is a strong recruitment pipeline and the short term sickness rate has significantly reduced.

2.10 The Emergency Department has 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.

Patient Safety Incident Response Framework (PSIRF)

2.11 The Trust has gone live with transition to the PSIRF framework from 1 January 2024. The new governance processes and structures to support roll out and implementation is in place with formal meetings commencing in month. Work is ongoing to close overdue serious incident actions from the previous framework aligning actions to existing and new improvement work streams where possible.

Hospital Standardised Mortality Ratio (HSMR)

2.12 The Hospital Standardised Mortality Ratio in August 2023 was 72.5, with a 1-year rolling average of 75.6. This is banded as statically lower than expected and is the 7th lowest in the NHS.

Industrial Action

2.13 Further industrial action by members of the British Medical Association (BMA) and Hospital Consultants and Specialists Association (HCSA) took place from 07:00 Wednesday 20 December 2023 to 07:00 Saturday 23 December 2023 and from 07:00 Wednesday 3 January 2024 to Tuesday 9 January 2024. Both periods of Industrial Action were in the form of a full withdrawal of labour.

2.14 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.

Complaints and PALS Service

2.15 The PALS and Complaints department continues to receive a high volume of new cases, in both services. Work has continued on the improvement plan with support from the Improvement and Transformation team. The initial backlog caseload of 550 complaints on 8 May 2023 has now reduced to 37 at the close of play on 15 December 2023. Data from the new cases initiative shows that cases are now being closed within shorter timeframes with the use of alternative methods of resolution such as telephone calls to complainants and face to face meetings. Further improvement work will continue in the New Year to take forward the learning and actions from complaints and focusing on KPI's.

3. Access to Care

3.1 During November and December 2023 demand on our emergency pathways increased, with an additional 11 patients attending the ED each day on average compared to last year, equivalent to annual growth of 3%. Despite this additional pressure, 4hr performance improved from 56.5% in December 2022 to 62.7% in December 2023.

3.2 In the context of this additional demand and the period of Industrial Action at the end of December 2023, we have maintained our position as one of the top trusts in the country for ambulance handovers over 60 minutes and we have reduced the number of patients waiting more than 12 hours in the department by nearly 20% compared to last year. Continuing to reduce the time our patients spend in the ED is a key area of focus for the Trust.

3.3 Elective activity as a whole has been impacted by periods of industrial action during 2023/24 and this will continue to be a factor in future months until a formal agreement to cease the action has been reached. In the context of these challenges, overall elective inpatient and day case activity in the year to date represents 92% 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 the number of patients waiting more than 65 weeks reduce from 990 to 851 between April-November and patients waiting for more than 78 weeks reduce from 123 to 103 over the same period.

Across the region, CUH has treated 70% of cancer patients on the 62-day pathway compared to the national average of 63%.

3.4 Over the last few months our winter plan has been put in motion to address the additional seasonal pressures on our services and staff, led by the Chief Operating Officer. As part of this plan, additional inpatient capacity will be opened in January 2024 to support the increase in demand and support the safe management of the Trust over the rest of winter and in future years. We have also continued to develop alternative pathways to use our capacity as effectively as possible, and our innovative virtual ward programme now looks after an average of 60 patients, equivalent to two in-patient wards, an increase from 20 patients in April.

3.5 **Emergency Department (ED).** Performance increased slightly from 60.1% in October 2023 to 61.3% in November 2023. This compares to 66.8% performance across the Shelford Group. High occupancy rates continues to limit flow out of the ED for admitted patients.

3.6 **Referral to Treatment (RTT).** The total RTT waiting list decreased by 1.3% in month. The total waiting list size is 1,358 lower than the planning submission for Month 8. Clock starts are cumulatively 2.4% below plan year to date but only 0.3% below the Month 8 plan.

3.7 **Delayed discharges**. The number of beds lost to delayed discharges increased from 108 in October 2023 to 121 in November 2023. Of these, 97 (80%) related to external complex pathways.

3.8 **Cancer.** CUH has continued to perform below the faster diagnosis standard, with a forecast recovery of December 2023. This is due to the deterioration in Skin performance since July which is improving month on month.

3.9 **Operations.** Theatre utilisation across November 2023 was 77.7%. However during two weeks in the month we did deliver above 80%, the highest utilisation weeks since July 2023.

3.10 **Diagnostics.** Six week performance in November 2023 improved to 34.2%. The total waiting list increased by 574, with a reduction in the > 6 week cohort of 117.

3.11 **Outpatients.** CUH new activity remains adversely below the 115% target for end March 2024, however, there is a trend upwards in the last six months. November 2023 was the strongest performance over the last 12 months.

4. Finance – Month 8

4.1 The Month 8 position for performance management purposes is a £3.0m surplus, following national financial support for the impact of Industrial Action (IA). This is favorable to our planned year to date performance by £0.5m. 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 8 financial performance:

- NHSE have announced further support for the impact of IA which now totals £16.9m for the Trust across the following three elements:

  1. Reductions to the elective service target of 4% - forecast additional income by year end of £7.8m.

  2. A specialised commissioned services target adjustment – forecast additional income by year end of £3.2m.

  3. A block payment to support the impact of IA on pay expenditure – agreed with C&P ICB at £5.9m.

- These payments will support the Trust to mitigate the impact of IA and have enabled the Trust to return to performing at financial plan for Month 08.

- The position also includes £7.0m of non-recurrent funding which the Trust plans to increase 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.

- The additional IA taking place in December 2023 and January 2024 is likely to create a further pressure of £6.0m. The Trust expects this pressure to be mitigated over the remainder of the year; however NHS England has not yet confirmed whether additional financial support will be made available.

4.3 The Trust has received an initial system capital allocation for the year of £35.0m for its core capital requirements. In addition to this, we hope to receive further funding for the Children's Hospital (£3.5m), Cancer Hospital (£11.3m), and Community Diagnostics (£0.8m) and Secure Data Environments (£1.8m). 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 £62.8m.

As a counter-measure against likely slippage an £8.4m over-commitment has been built into the 23/24 capital plan.

4.4 At Month 8 the capital programme is ahead of plan with spend year to date of £27.9m against a budget of £22.6m. 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 £62.8m.

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 supporting staffing capacity and people staying well 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 has been in place from September 2023. Covid vaccinations clinics closed on 15 December 2023 and flu clinics run until 31 January 2024. 7193 Covid vaccinations have been administered (49% of frontline staff) and, to date, 8386 flu vaccinations have been given (57% of frontline staff).

5.4 The Trust has run a programme of Winter Wellness sessions focusing on self-care and has covered topics such as diet and exercise, sleep and financial wellbeing. These sessions have been well attended and reviewed positively with requests for more opportunities like this running through the year.

Resourcing

5.5 In the last 12 months CUH has grown its workforce by 6.1% which has been deliberate and targeted growth. The nursing workforce has grown by 5.2%, driven by strong recruitment to vacancies and we now have 107 more Healthcare Scientists compared with the previous 12 months, addressing a known shortfall (this is a growth of 17.5%)

5.6 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. Hotspot areas that have seen huge progress are Cardiac Physiology, Audiology and Band 5 physiotherapists.

Ambition

5.7 The Nursing Associate Pathway (NAP) model has formed an important part of Band 5 nurse recruitment pipeline, with the aim of contributing a third of new recruits via this route. There are currently 315 undertaking NAP, with cohorts qualifying every year to 2027 - 2028.

Over the last 18 months the Nursing Midwifery Council (NMC) have introduced changes to student requirements in terms of supernumerary practice and study time in order to gain professional registration. Education CUH and other Trusts have raised concerns nationally to highlight that the current degree level apprenticeships is not financially viable until such time the hours restriction is altered.

In light of this a decision has been made to change CUH's focus to Nursing Associate apprenticeship routes; this leads to a foundation degree through a 24 month training programme. From April 2024 CUH will offer a minimum of 100 places per annum for both existing and new staff.

Inclusion

5.8 Through investment and focus in our EDI Staff networks we have seen a marked increase in engagement, including attendance at network events. A programme of work has been developed for 2024 to build on this progress. The reverse mentoring programme for executive and senior leaders re-commences in February 2024 and has good engagement and take up.

Relationships

5.9 Throughout 2023 the Trust ran a series of staff recognition events including the annual staff awards programme. The schedule for 2024 has been developed with emphasis on bringing colleagues together, acknowledging interdependencies between their roles, and expressing gratitude for each other.

5.10 A series of compassionate leadership workshops have been delivered as part of the workforce winter plan. 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 has appointed Boston Consulting Group (BCG), to work alongside the Director of Innovation, Digital and Improvement to build on the recommendations of the innovation review undertaken in summer 2023 and support the development of a dedicated innovation programme at CUH.

6.2 The focus of this work is three-fold: establishing the programme's vision, architecture (including governance and resourcing) and a prioritised pipeline of innovation projects. The short-term output of this will be a suitably-resourced and structured innovation programme that can drive the delivery of high-impact innovations for direct and indirect patient benefit, such as reducing length of stay and waiting lists, thereby supporting the Trust's priority around access to care.

6.3 In support of our focus on innovation, the Trust continues to work closely with Cambridge University Health Partners and wider NHS colleagues, including on the development of an innovation landing zone and associated digital innovation portal. The arrival in mid-2023 of a Head of Innovation at Cambridgeshire and Peterborough Integrated Care System (ICS) has provided additional opportunity for partnership working and sharing of learning across the ICS.

6.4 Beyond the ICS, the Trust is exploring how our innovation work can have a broader impact across the region through our forthcoming new regional hospitals (the Cambridge Children's Hospital and Cambridge Cancer Research Hospital) and through our involvement in the East of England Specialised Services Provider Collaborative.

Digital

6.5 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.

6.6 A significant upgrade to the Trust's electronic patient records, Epic, took place in October 2023. This upgrade had substantial changes which improved performance of the system and provided a modern platform for accelerating future developments.

6.7 Resourcing the digital team to match the Trust's ambitions and demands remains challenging. This is reflected on the Trust's Corporate Risk Register and Board Assurance Framework. Whilst work continues to address these workforce challenges, the teams' limited resources will be 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. The Technology Digital Prioritisation Group has commenced activity.

6.8 The Trust's new Digital Board will commence in February 2024, which will align and govern Trust-wide digital commitments.

Improvement and Transformation

6.9 The Trust is continuing to build quality improvement (QI) capability and capacity across the organisation.

6.10 The improvement and transformation team continue to support colleagues with a number of strategic QI programmes of work across urgent and emergency care, including the emergency department, virtual wards, outpatients, high volume low complexity procedures, reducing hospital acquired pressure ulcers, a complaints review, as well as supporting colleagues to identify productivity and efficiency schemes for 2024/25.

6.11 From its inception in November 2022 until the end of November 2023, the virtual ward team has on-boarded over 969 patients from 22 specialties, achieving a saving of 4,000 bed days, the equivalent of 10.1 beds. During November 2023 the average occupancy for the virtual ward was 55 patients. The team celebrated receiving their 1,000th patient last month, with a referral from ward N2 and between 24 and 27 December 2023 achieved an average occupancy of 63 patients.

6.12 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 continue to support colleagues to make improvements across a number of agreed pathways, including pneumonia, hearing loss and tinnitus, along with skin cancer.

6.13 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 8, the Trust has delivered a £33.7m efficiency, against a year-to-date target of £33.96m, resulting in an under-performance of £234k, 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

7. Strategy update

Strategy implementation

7.1 The Board has agreed that access to care will remain as the primary strategic delivery lens for 2024/25, as it was in 2023/24, and work has been concentrated on embedding delivery of improvements in short and medium-term access to care into our organisational priorities. This has been particularly focused on the 2024/25 business planning process, which is currently underway, as well as other prioritisation mechanisms such as developing a strategic plan for outpatients and Length of Stay (LoS) and updating the Trust's Accountability Framework.

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

Improving patient care

Integrated Care

7.3 The Trust continues to work with partners across the Cambridgeshire South Care Partnership (CSCP) to improve care for people in and outside of hospital and support reduction of the need for unplanned hospital care.

7.4 A project currently underway is the further development of a primary-secondary Virtual Neuro Multi-Disciplinary Team (MDT) initiative. This expansion will allow the model to move from a single-list integrated Primary Care Network (PCN), currently operating at Granta Medical Practices, into a multi-system, multi-list PCN – which is much more common across the NHS. The model, once fully evaluated, could then be adapted to other specialties, with the potential to substantially replace advice and guidance (A&G), support professional development and reduce attendances at CUH.

Supporting our staff

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

Building for the future

New hospitals and the estate

7.6 The new Cambridge Surgical Movement Hub, providing three theatres and two inpatient wards, opened on 6 December 2023 and has cared for over 200 patients since its opening. The new U-block surge unit will provide a further 56 inpatient beds and is due to open in early 2024, providing additional capacity over winter as well as much needed decant capacity to support the Trust to carry out essential maintenance works.

7.7 The Cambridge Cancer Research Hospital (CCRH) team has been focusing in the last months on engagement with our many stakeholders, as work develops on the clinical, operational and workforce models for CCRH, as well as how the project will ensure the envisaged benefits are realised. This has included attending events across the region to share updates and request feedback, such as at the Hunts Cancer Network Conference in November 2024, as well as working with both our staff and commissioners. The project team also continues to work closely with our preferred construction partner on the building designs and programme and is awaiting the outcome from the Cambridgeshire and Peterborough Combined Authority of our full planning application submitted in January 2023.

7.8 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 in autumn 2023. The approval is subject to a review of the project's capital funding in April 2024. The project is now proceeding to its Full Business Case stage and pre-construction enabling works are planned to begin on the site of the new hospital by March 2024. 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

7.9 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.

7.10 Our current work programme includes four pilot projects (which aim to deliver impact in the next 6-12 months) covering severe asthma, multiple sclerosis (MS), epilepsy and paediatric long-term ventilation, and three longer-term strategic programmes of work on neurosciences, dentistry and innovation.

7.11 In asthma, we have begun EoE-wide roll out of video technology for remote diagnosis and management of epilepsy seizures in children, with three sites live and many others on the journey to becoming live; in 2024/25, the project will also extend to adults. We have also now defined service requirements for supporting the delivery of biologics therapies for severe asthma and MS patients at Lister and Ipswich hospitals respectively and are currently exploring funding options.

7.12 In neurosciences, we are developing an East of England regional strategy. In November 2023 we completed a diagnostic review, engaging with stakeholders across the region to identify key challenges and opportunities to inform an initial vision, objectives and priorities. We established a neurosciences steering group and a number of clinically-led groups who will develop more detailed actionable proposals in Q1 2024/25.

7.13 In dentistry, clinically-led groups have now submitted their recommendations to the Secondary Care Dental Steering Group for addressing medium and long-term sustainability and capacity issues. We have now started to implement some of those recommendations including appointing regional sedation leads. By March 2024 we expect to complete the repatriation of temporomandibular joint (TMJ) services from Oxford to Luton and have set up a pilot to deliver alternative sedation in Hertfordshire and West Essex.

7.14 We plan to create a Research and Innovation advisory group within the collaborative with the aim of developing a harmonised adoption process for new innovations to increase participation and spread across our region. The group will draw on the expertise from Mid and South Essex NHSFT's innovation team, to make it easier for us to engage with commercial partners and overcome barriers for testing, trailing and procuring new treatment options.

7.15 We also continue to engage with NHSE and ICBs through the East of England Specialised Services Joint Commissioning Committee (JCC) to support preparation for the delegation of specialised services to ICBs in April 2024. We will support the JCC to develop a commissioning strategy for specialised services which it plans to complete in 2024/25.

8. Recommendation

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

Board of Directors

Together
Safe
Kind
Excellent

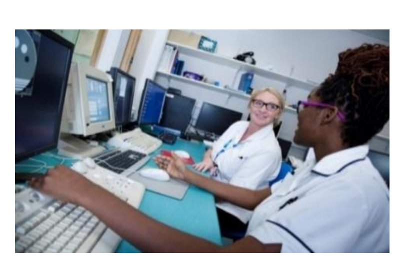
Report to the Board of Directors: 17 January 2024

Agenda item	9
Title	Integrated Report
Sponsoring executive director	Chief Operating Officer, Chief Nurse, Medical Director, Director of Workforce, Chief Finance Officer
Author(s)	As above
Purpose	To update the Board of Directors on performance during November 2023.
Previously considered by	Performance Committee, 10 January 2024

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

Related Trust objectives	All objectives
Risk and Assurance	The report provides assurance on performance during Month 8.
Related Assurance Framework Entries	BAF ref: 001, 002, 004, 007, 011
Legal implications/Regulatory requirements	n/a
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	n/a

Action required by the Board of Directors
The Board is asked to note the Integrated Performance Report for November 2023.



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: 31 December 2023

Key

Data variation indicators

Normal variance - all points within control limits

Negative special cause variation above the mean

Negative special cause variation below the mean

Positive special cause variation above the mean

Positive special cause variation below the mean

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

2023/24 Quality Account Measures				Sep 23	Oct 23	Nov 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%	86.0%	N/A	▪	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%	80.0%	N/A	▪	80.6%	13.4%	80.6%
	% Rosie MDT Obstetric staff passed PROMPT emergencies training	Nov-23	90%	82.6%	94.6%	92.4%	⇩	84.1%	71.0%	84.1%
	% Rosie Obstetricians and Midwives passed fetal surveillance training	Nov-23	90%	88.0%	91.4%	91.4%	⇔	86.1%	72.0%	86.1%
Patient Experience / Caring	Healthcare Inequality: Percentage of patients in calendar month where ethnicity data is **not recorded** on EPIC Cheqs demographics report (Ethnicity Summary by Patient)	Nov-23	7%	7.5%	7.4%	7.1%	⇩	7.7%	14.0%	7.7%
Effective / Responsive	% of Early Morning Discharges (07:00-12:00)	Nov-23	20%	16.3%	14.6%	17.3%	⇧	15.7%	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	Nov-23	80%	77.4%	67.4%	73.8%	⇧	74.0%	74.0%	74.8%
	Same day emergency care (SDEC)	Nov-23	30%	26.1%	24.9%	24.9%	⇩	25.3%	22.0%	23.8%
	Percentage of admissions over 65yo with dementia/delirium or cognitive impairment with a care plan in place	Oct-23	50%	79.0%	79.0%	N/A	▪	65.7%		65.7%
	SSNAP Domain 2: % of patients admitted to a stroke unit within 4 hours of clock start time (Team centred)	Nov-23	55%	49.1%	45.7%	43.6%	⇩	44.0%	29.2%	38.2%
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%	

Key:
- Red: Adverse to absolute target or a deterioration in performance from baseline
- Amber: Adverse to target, but an improvement from baseline
- Green: Favourable to target

Author(s): Various **Owner(s): Oyejumoke Okubadejo**

Quality Summary Indicators

Performance Framework - Quality Indicators

Domain	Indicator	Data to	Target	Sep 23 Previous Month-1	Oct 23 Previous Month	Nov 23 Current status	Trend	FYtD	Previous FYR	LTM
Infection Control	MRSA Bacteraemia (avoidable hospital onset cases)	Nov-23	0	0	0	1	⇧	6	3	6
	E.coli Bacteraemias (Total Cases)	Nov-23	50% over 3 years	26	44	28	⇩	280	401	405
	C. difficile Infection (hospital onset and COHA* avoidable)	Nov-23	TBC	16	13	18	⇧	97	129	123
	Hand Hygiene Compliance	Nov-23	TBC	93.4%	93.4%	95.3%	⇧	94.1%	96.4%	94.3%
Clinical Effectiveness	% of NICE Technology Appraisals where funding was not procured within three months. ('last month')	Nov-23	100%	36.4%	50.0%	0.0%	⇩	57.1%	None recorded	57.1%
	% of NICE guidance relevant to CUH is returned by clinical teams within total deadline of 30 days.	Nov-23	80%	None recorded	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').	Nov-23	100%	None recorded	None recorded	0.0%	⇩	60.0%	None recorded	60.0%
	85% of national audit's to achieve a status of better, same or met against standards over the audit year	Nov-23	85%	100.0%	100.0%	83.3%	⇩	90.9%	84.6%	88.2%
Nursing Quality Metrics	Blood Administration Patient Scanning	Nov-23	90%	99.9%	99.9%	99.5%	⇩	99.7%	99.8%	99.7%
	Care Plan Notes	Nov-23	90%	96.0%	95.7%	96.2%	⇧	96.0%	96.1%	96.0%
	Care Plan Presence	Nov-23	90%	99.8%	99.5%	98.6%	⇩	99.5%	99.6%	99.5%
	Falls Risk Assessment	Data reported in slides								
	Moving & Handling	Nov-23	90%	75.7%	74.9%	76.3%	⇧	76.3%	71.3%	74.7%
	Nurse Rounding	Nov-23	90%	99.3%	99.0%	99.0%	⇧	99.1%	99.1%	99.1%
	Nutrition Screening	Nov-23	90%	74.9%	75.0%	75.5%	⇧	76.4%	71.8%	74.9%
	Pain Score	Nov-23	90%	85.3%	85.2%	84.6%	⇩	85.2%	83.1%	84.5%
	Pressure Ulcer Screening	Data reported in slides								
	EWS									
	MEOWS Score Recording	Nov-23	90%	86.7%	88.9%	86.8%	⇩	86.0%	80.6%	84.3%
	PEWS Score Recording	Nov-23	90%	99.3%	99.3%	99.1%	⇩	99.2%	99.2%	99.2%
	NEWS Score Recording	Nov-23	90%	97.8%	97.7%	97.7%	⇩	97.7%	97.4%	97.6%
	VIP									
	VIP Score Recording (1 per day)	Nov-23	90%	86.1%	84.3%	87.3%	⇧	87.4%	84.8%	86.5%
	PIP Score Recording (1 per day)	Nov-23	90%	83.7%	77.4%	75.5%	⇩	83.8%	88.9%	85.8%
Patient Experience	Mixed sex accommodation breaches	Jun-20	0	N/A	N/A	N/A	▪	N/A	N/A	N/A
	Number of overdue complaints	Nov-23	0	59	87	38	⇩	453	172	562
	Re-opened complaints (non PHSO)	Nov-23	N/A	11	8	9	⇧	52	18	55
	Re-opened complaints (PHSO)	Nov-23	N/A	1	0	0	⇔	5	2	5
				Sep 23	Oct 23	Nov 23				
	Number of medium/high level complaints	Nov-23	N/A	12	22	14	⇩	121	257	207

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

Operational Performance

Point of delivery	Performance Standards	SPC variance	In Month Actual	In Month plan	Target	Target due by	Page
Urgent & Emergency Care	4hr performance	Normal variation	61.3%	74.4%	76.0%	Mar-24	**Page 12**
	12hr waits in ED (type 1)	Normal variation	11.4%	-	-	-	
	Ambulance handovers <15mins	Positive special cause variation	62.0%	65.0%	65.0%	Immediate	
	Ambulance handovers <30mins	Positive special cause variation	92.6%	95.0%	95.0%	Immediate	**Page 13**
	Ambulance handovers > 60mins	Positive special cause variation	2.6%	0.0%	0.0%	Immediate	
Cancer	Cancer patients < 62 days	Normal variation	66.7%	-	85.0%	Immediate	**Page 19**
	28 day faster diagnosis standard	Normal variation	70.2%	85.1%	75.0%	Immediate	**Page 17**
	31 day decision to first treatment	Normal variation	91.2%	-	96.0%	Immediate	**Page 18**
Outpatients	First outpatients (consultant led)	Positive special cause variation	114.2%	120.3%	-	-	**Page 21**
	Follow-up outpatients (consultant led)	Normal variation	117.0%	132.1%	-	-	**Page 22**
	Advice and Guidance Requests	Normal variation	10.2%	-	16.0%	Mar-23	
	Patients moved / discharged to PIFU	Positive special cause variation	3.4%	7.5%	7.5%	Mar-23	**Page 23**
Diagnostics	Patients waiting > 6 weeks	Positive special cause variation	34.2%	19.3%	5.0%	Mar-24	**Page 20**
	Diagnostics - Total WL	Normal variation	14,104	9,745	-	-	
RTT Waiting List	RTT Patients waiting > 65 weeks	Positive special cause variation	851	296	0	Mar-23	**Page 15**
	RTT Patients waiting > 78 weeks	Normal variation	103	-	-	-	
	Total RTT waiting list	Negative special cause variation	61,924	63,282	-	-	**Page 16**
Productivity and efficiency	Non-elective LoS (days, excl 0 LoS)	Positive special cause variation	8.6	-	-	-	
	Long stay patients (>21 LoS)	Positive special cause variation	193	194	-	-	
	Elective LoS (days, excl 0 LoS)	Normal variation	5.0	-	-	-	
	Discharges before noon	Normal variation	17.3%	-	-	-	
	Theatre sessions used	Positive special cause variation	755	-	-	-	
	In session theatre utilisation	Normal variation	77.7%	85.0%	85.0%	Sep-23	**Page 25**
	Virtual Outpatient Attendances	Negative special cause variation	19.8%	-	-	-	
	BADS Daycase Rate (local)	Normal variation	83.4%	-	-	-	**Page 26**
Surgical prioritisation	P2 (4 weeks) Including planned	Negative special cause variation	3,217	-	-	-	

Author(s): Various **Owner(s): Nicola Ayton**

Serious Incidents

Indicator	Data range	Period	Threshold	Current period	Mean	Variance	Special causes	Comments
Patient Safety Incidents	December 2020-November 2023 July 2023	Nov-23	-	**1531**	*1458*		-	There is a statistically significant increase with the last 7 months being above the mean
Patient Safety Incidents per **1,000 admissions**				**87**	*91*		–	
Percentage of **moderate harm and above** patient safety incidents			≤ 2%	**2.1%**	*2.5%*		-	Severe harm incidents are showing a statistically significant downward shift in the last 7 months. **Division E** has been above the mean for the last 6 months
All Serious Incidents			-	**0**	*4.5*		-	

Patient safety incidents (PSIs)

In November 2023 there were 31 moderate harm incidents and one severe harm incident.

PSIs of moderate harm and above are in normal variance; the majority of these are moderate harms coming from hospital-acquired pressure ulcers.

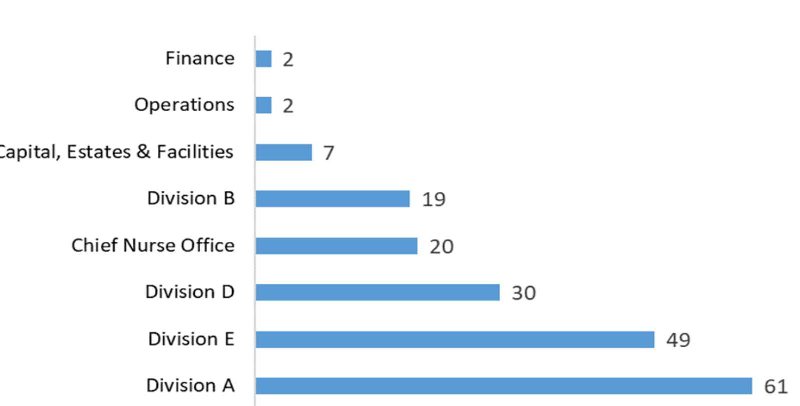
Severe harm incidents are showing a statistically significant **downward** shift in the last 7 months.

Serious Incidents

Three SI reports were submitted to the ICS in November 2023.
Compliance with the 60 day timeframe for October was 33% (1/3).

There are currently 199 overdue actions from investigations: 128 (↑) Serious Incident actions and 71 (↓) 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 to PSIRF.



Duty of Candour (DOC)

Data as of 14.12.2023

Trust wide stage 1 DOC compliance is 96% (414/432)

Trust wide stage 2 DOC compliance is 90% (340/376)

There is a notable reduction in compliance with stage 2.

- Table 1 gives the divisional detail and overall compliance as of 14.12.2023.

- Table 2 shows details for 2022 only - 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.

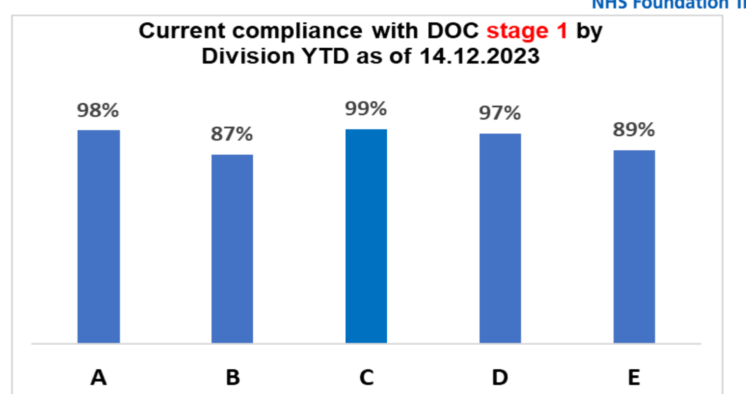


Table 1. Outstanding DOC Stage 2 - Total

Total outstanding	A	B	C	D	E	Total
Required	131	33	96	57	59	376
Completed	116	24	94	54	52	340
Compliance	89%	73%	98%	95%	88%	90%

Table 2. Stage 2 -Outstanding from 2022

Month/Year	A	B	C	D	E	Total
Mar-22	2					2
Apr-22					1	1
Jun-22	1					1
Jul-22						0
Aug-22	1				1	2
Sep-22				1		1
Oct-22	1					1
Dec-22		3				3
Total	5	3	0	1	2	11

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).*

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

Falls

Indicator	Data range	Target	Nov-23	Mean	Variance	Special causes	Target status	Comments
All patient falls	December 2020 - November 2023	-	**149**	*160*			-	
Inpatient falls per **1,000 bed days**			**4.2**	*4.8*		-	-	Last 6 months below the mean
Moderate harm & above - inpatient falls		-	**2**	*4.4*		–	-	Last 5 months are below the mean.
Falls **risk screening** compliance within 12 hours of admission		≥ 90%	**87%**	*85%*			F	We were last compliant with this metric in June 2021

Summary

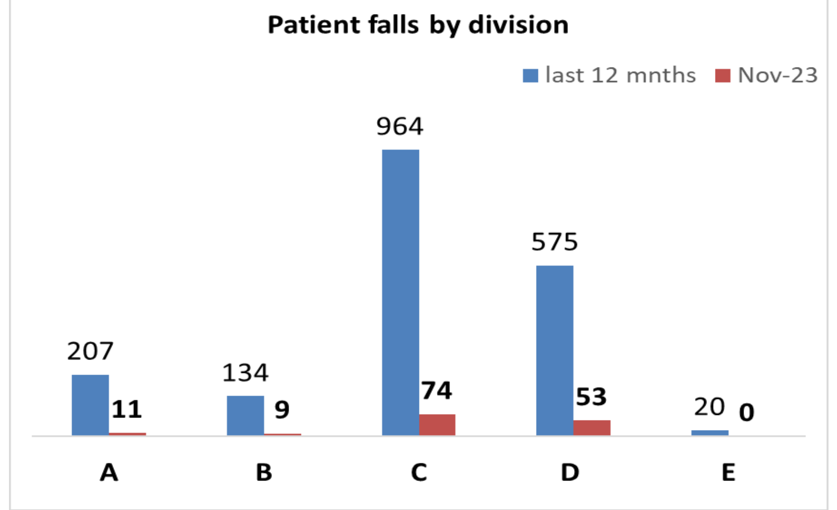
All falls are in normal variance including higher harm falls.

In November 2023 there were 2 moderate harm falls

QI update

Two new staff have joined the Falls prevention in November/ December.

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



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

Hospital Acquired Pressure Ulcers (HAPUs)

Indicator	Data range	Target	Nov-23	Mean	Variance	Target status	Comments
All hospital-acquired pressure ulcers	December 2020 - November 2023	-	**48**	32	H	-	The last 17 consecutive months have been above the mean.
All HAPUs by date of occurrence per 1,000 bed days		–	**1.34**	0.94	H	-	16 out of the last 17 months have been above the mean.
Category 2, 3, 4, Suspected Deep Tissue Injury, and Unstageable HAPUs		–	**32**	19.4	H	-	Last 20 months have been above the mean
Category 1 hospital-acquired pressure ulcers		–	**16**	12.1		–	
Category 2 hospital-acquired pressure ulcers			**18**	13.2		–	There has been a statistically significant increase in the last 7 months
Unstageable HAPUs		–	**0**	1.6		–	
Suspected Deep Tissue Injury HAPUs by date of occurrence		-	**14**	4.4	H	-	Statistically significant high points in the last three months.
Medical device related HAPUs		–	**13**	7.7	H	–	Statistically significant upward shift in the last 9 months.
Pressure Ulcer screening **risk assessment** compliance		90%	**81%**	79%		F	We have not been compliant with this metric in the last 3 years.

Summary
The increase in HAPUs is being driven by an increase in the categories of Suspected deep tissue injury and Category 2 . There were no category 3 or 4 HAPUs in November.
There is a statistically significant increase in HAPUs related to Medical devices overall and from 'mask/tubing'.
There is a statistically significant increase in HAPUs related to sacrum. The highest HAPUs in the last 12 months are from sacrum and heels.

QI update
Tissue Viability team now fully recruited (December 2023).
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.

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

Sepsis

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%	**71%**	*59%*		9 out of the last 10 months have been above the mean
Antibiotics administered within 60 mins from time patient **triggers** Sepsis (NEWS 5>) - **Emergency Department**				**79%**	*72%*		5 out of the last 6 months have been above the mean
All elements of the Sepsis Six Bundle delivered within 60 mins from time patient triggers Sepsis (NEWS 5>)- **Inpatient wards**				**50%**	*38%*		9 out of the last 11 months have been above the mean
Antibiotics administered within 60 mins from time patient **triggers** Sepsis (NEWS 5>) - **Inpatient wards**				**79%**	*72%*		5 out of the last 6 months have been above the mean

Sample size in month for above audits:
Inpatients = 10
ED-Adult = 15
Maternity inpatients = no data received

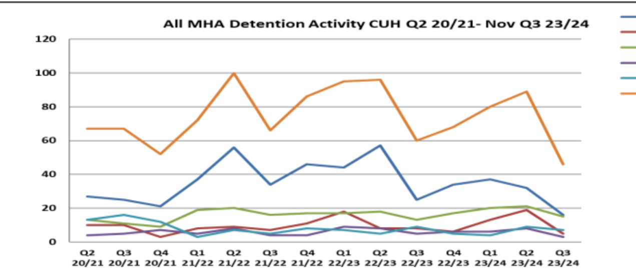
- Sepsis QI corporate plan – approved at November 2023 Sepsis Action Group meeting

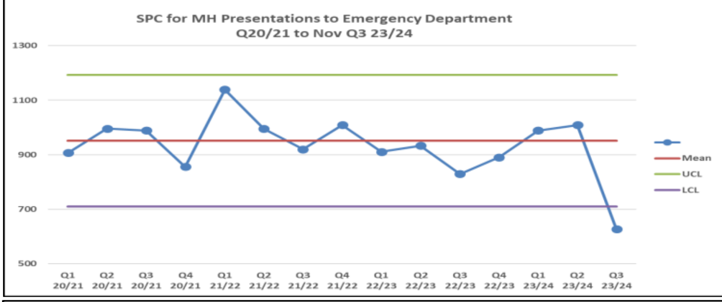
- Setting up QI pilot wards to support sepsis bundle compliance - vascular and renal teams

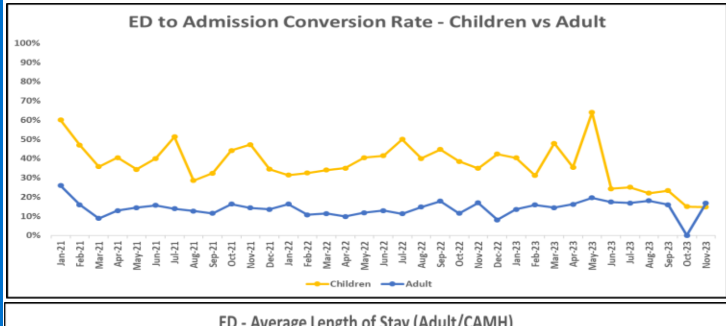
- 42 Sepsis and Deteriorating patient champions are in place across the organisation and will be supporting the QI plan

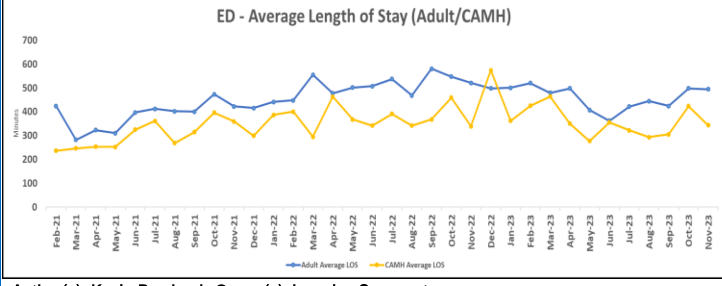
Author(s): Stephanie Fuller **Owner(s): Heman Joshi**

Mental Health - Q2 2023/24 (September)









Q3 2023/24 (November)

- Q3, to date, continues to show a reduction in the use of sections 136 and 5(2) of the Mental Health Act (MHA) compared with the previous 2023/24 quarters. CUH was used 10 times as place of safety under Section 136 MHA in November.

- 5 x Section 136 MHA were rescinded.
- 4 x 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 2 x section 5(2) MHA in November, both were converted to Section 2 of the MHA

- The numbers of patients attending the Emergency Department for mental health issues in Q3 to date remains within expected data control lines. 293 attendances in November represents an 11% decrease in MH attendances over the previous 4 year November average.

- Length of ED stay and conversion rate to admission for adults and children remain stable.

- There were no rectifiable mistakes with MHA section paperwork in November at time of detention.

- There was an invalid Section 5(2) MHA in October which has been investigated in November. Processing of completed MHA paperwork was incorrect which has led to the section being invalid. Learning has been identified and actions for quality improvement undertaken by the CUH Division.

- There were 13 delayed transfers of care to specialist mental health inpatient care in October, with 70 lost bed days.

Ongoing work:

- The new Mental Health Study day for CUH clinical staff has received a positive response through high numbers of enrolment via the Dept. of Teaching booking page. The study day is fully booked until April 2024. 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.

- Following the launch of the new adult mental health study day, there have been requests for a study day for children and young persons mental health study day. The CAMHS psychological medicine Team have been approached and scoping will commence in the new year.

- The Cambridgeshire Constabulary Right Care Right Person (RCRP) 'response review' to 'Missing or AWOL patients from health care providers' has commenced, with CUH and partner engagement. Changes in police response and escalation processes will influence review of the CUH Missing Patient procedure document.

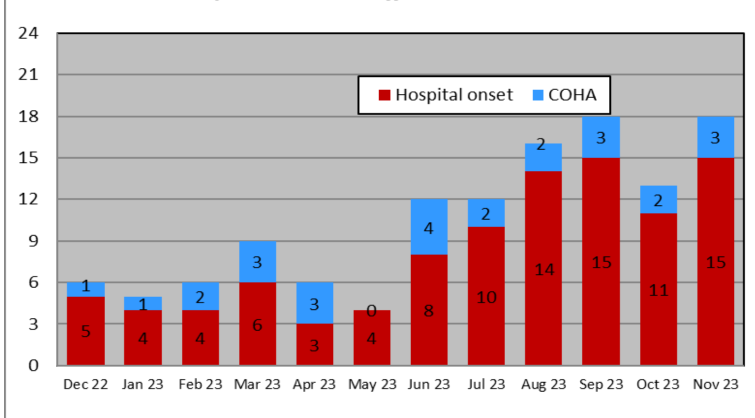
- Following a successful programme to support CUH clinical areas to complete ligature risk assessments where patients with mental health issues are most likely to be cared for, the CUH Mental Health Team are now supporting those areas with reviews of their action plans.

- The CUH Mental Health Team will soon have early access to the new gastroenterology ward, U2, in order to complete risk assessments in those areas where patients with an eating disorder will be medically cared for.

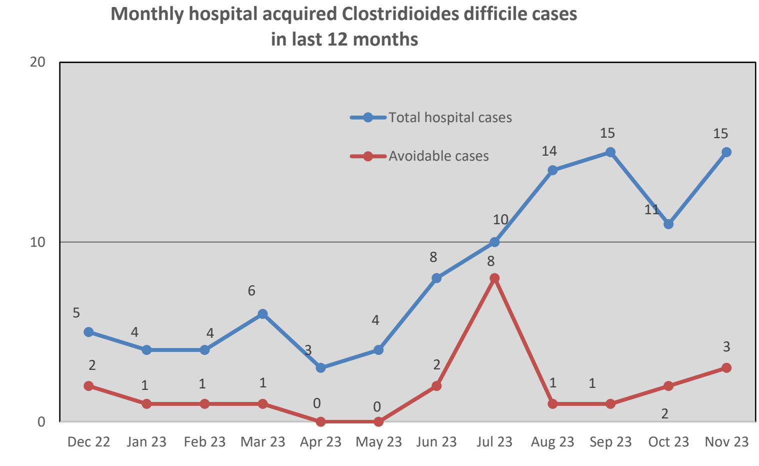
- A business plan has been submitted by CPFT to CUH regarding increasing the provision
- of the Liaison Psychiatry Team. In summary the increased provision would increase the out of hours Emergency Department resource and allow for out of hours CUH inpatient ward cover. The increase in resource would include both medical and non-medical staff.

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

Infection Control



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



CUH trend analysis

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

• 1 case of community onset MRSA bacteraemia in November 2023

• 6 cases (1 community, 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*.

▪ 15 cases of hospital onset *C difficile* and 3 cases of COHA in November 2023.

• 71 hospital onset cases and 19 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 84% in November 2023 (97.8% in October 2023).

▪ The latest MRSA bacteraemia rate comparative data (12 months to October 2023) put the Trust 7th out of 10 in the Shelford Group of teaching hospitals.

▪ Compliance with the *C. difficile* care bundle was 74% in November 2023 (90% in October 2023).

▪ The latest C. difficile rate comparative data (12 months to October 2023) put the Trust 5th out of 10 in the Shelford Group of teaching hospitals.

4HR Performance

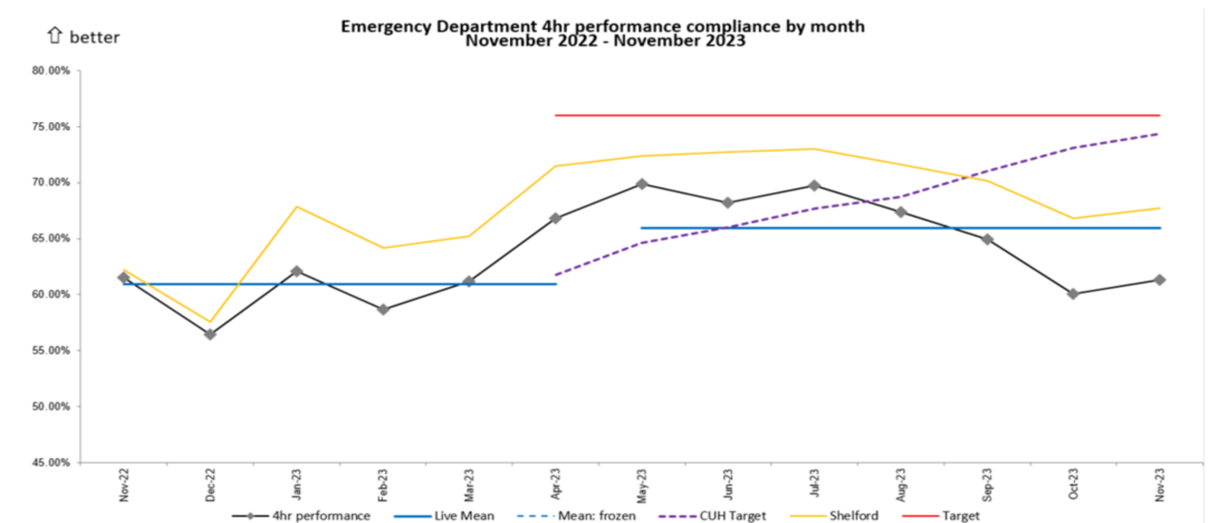
Cambridge University Hospitals NHS Foundation Trust

Nov-23	Plan
61.3%	74.4%

SPC Variance
Normal variation

Shelford Group Avg (Oct-23)
66.8%

Three Month Trajectory		
Dec-23	Jan-24	Feb-24
76.1%	78.1%	79.8%



Highest breaches by specialty

Specialty	Performance	4hr Breaches
Emergency	56.6%	2,262
Medicine	24.4%	1,904
Paediatrics	38.1%	453
Orthopaedics	14.5%	282
Surgery	32.6%	265

Updates since previous month

- 4hr performance increased slightly from 60.1% in October to 61.3% in November. This compares to 66.8% performance across the Shelford group
- Two-thirds of breaches occurred under Medicine or Emergency specialties

Current issues

- The Trust continues to see high levels of attendances, with an increase of 6.0% compared to November 2022
- High occupancy rates continues to limit flow out of the Emergency Department for admitted patients

Key dependencies

- High attendance rates and the infection status of patients impacts the functional capacity of the department
- Staffing levels impact the processing power of ED, particularly during periods of industrial action

Future actions

- The Trust will continue its weekly meetings chaired by the CEO to monitor and improve 4hr performance
- Bed occupancy and patient flow are a focus in January, particularly to support medical beds and improve outflow

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

Ambulance Handovers > 60 minutes

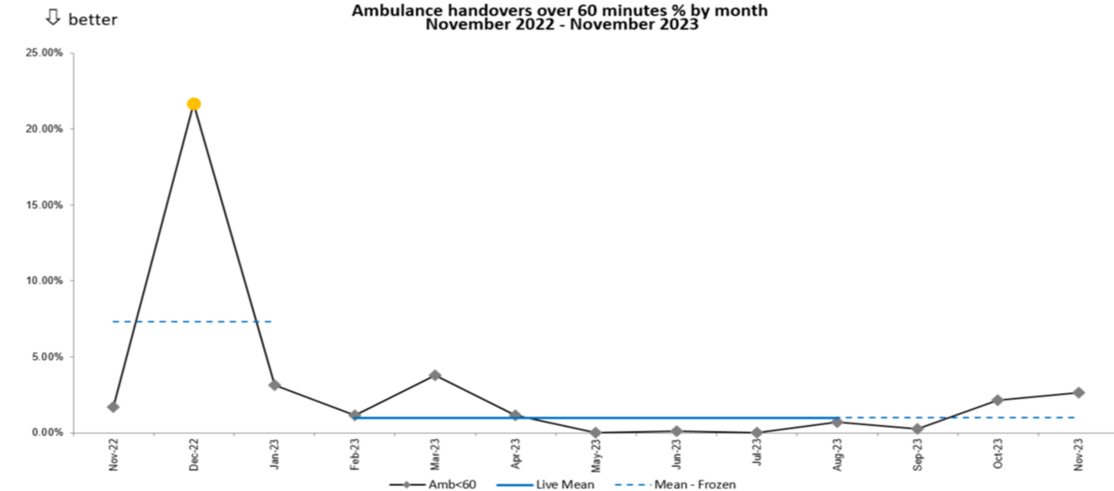
NHS
Cambridge University Hospitals
NHS Foundation Trust

Nov-23	Target
2.6%	0%

SPC Variance
Normal variation

East of England > 60 minutes

Trust	Performance
Bedford	2%
Watford General	2%
CUH	2.6%
Milton Keynes	5%
Basildon & Thurrock	8%
Hinchingbrooke	9%
Colchester General	9%
West Suffolk	9%
Broomfield	10%
Southend	14%
L&D	15%
Papworth	18%
Ipswich	21%
Lister	24%
Peterborough City	25%
James Paget	34%
Queen Elizabeth	40%
Princess Alexandra	43%
N&N	59%



Updates since previous month

- Ambulance handovers >60mins increased slightly from 2.1% to 2.6% between October and November
- This is significantly better than regional and national performance of 13.2% and 10.1% respectively

Current issues

- High levels of attendances and limited outflow contribute towards crowding in the Emergency Department and continue to impact offloads

Key dependencies

- HALOs (Hospital Ambulance Liaison Officers) continue to support rapid handovers, but these are impacted if shift fill is poor
- Onward impact from other sites where CUH is required to support ambulance diverts and intelligent conveyancing

Future actions

- Creation of additional dedicated rapid handover spaces to support offloads
- On-going focus on preserving space in the ambulance bay and dedicated nurse in charge to facilitate handovers

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

Overall fit test compliance for substantive staff

Division	Corporate			Division A			Division B			Division C			Division D			Division E			Total		
Staff Group	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected
Additional Clinical Services	1	0	0%	265	144	54%	67	35	52%	146	73	50%	93	39	42%	93	42	45%	665	333	50%
Allied Health Professionals	-	-	-	59	24	41%	17	2	12%	1	1	100%	-	-	-	3	1	33%	80	28	35%
Estates and Ancillary (Porters and Security Personnel only)	121	66	55%	-	-	-	-	-	-	-	-	-	-	-	-	1	0	0%	122	66	54%
Medical and Dental	-	-	-	247	61	25%	-	-	-	177	64	36%	141	12	9%	224	64	29%	789	201	25%
Nursing and Midwifery Registered	-	-	-	688	507	74%	4	2	50%	295	176	60%	136	78	57%	369	201	54%	1492	964	65%
Total	122	66	54%	1259	736	58%	88	39	44%	619	314	51%	370	129	35%	690	308	45%	3148	1592	51%

The data displayed as of 19/12/23. This data reflects the current escalation areas requiring staff to wear FFP3 protection. This data set does not include Medirest, student Nurses, AHP students or trainee doctors. Conversations on fit testing compliance with the leads for the external entities take place on a regular basis. These leads provide assurance on compliance and maintain fit test compliance records. Fit test compliance for Bank and Agency staff working in 'red' areas is checked at the start of each shift and those not tested to a mask in stock are offered fit testing and/or provided with a hood. Security and Access agency staff are not deployed to 'red' areas inline with local policy.

Referral to Treatment > 65 weeks and > 78 weeks

65+ Weeks	
Nov-23	**Plan**
851	296

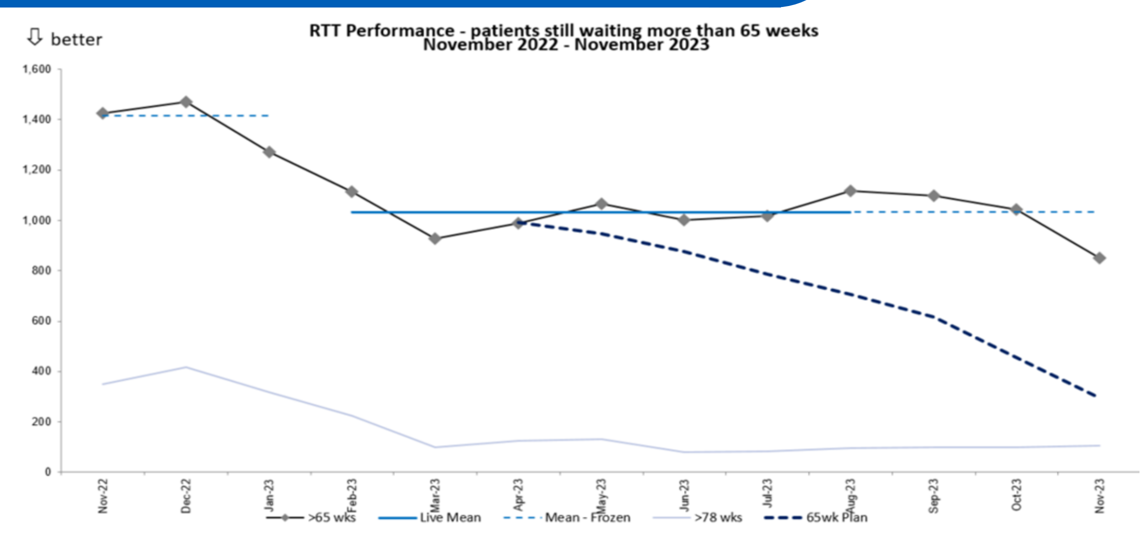
SPC Variance
Normal variation

% of WL over 65 weeks (Oct-23)	
CUH	1.66%
Shelford Group	1.53%

Three Month Forecast (65+ wks)		
Dec-23	**Jan-24**	**Feb-24**
220	150	80

Divisional Performance

Division	65+ weeks	78+ weeks
A	185	21
B	55	9
C	19	0
D	460	59
E	132	14
Trust	**851**	**103**



Updates since previous month

>78 week waits remained relatively stable, up by 4 to 103. Improvement was seen in ENT (10), which had previously been the highest specialty. OMFS rose to 16, and Ophthalmology to 11.
>65 weeks decreased by 18% to 851. Notable reductions in ENT, Gynae, Urology and T&O.

Current issues

Ophthalmology > 78 week relates to National shortage of corneal transplant tissue. This is being assigned in cohorts to ensure equity across NHSE and is not within CUH control.
OMFS relates to access for General Anaesthetic cases requiring Main Theatre competing with P2.

Key dependencies

Theatre capacity (Surgical Hub opened 6/11/23)
Recruitment to medical workforce vacancies
Independent Sector in ENT. Exploring Gynae.
Continuation of Insourcing OMFS and Gynae.
Cessation of Industrial Action.

Future actions

Re-submitted year end forecast of ~800 >65 weeks remains on trajectory.
Absolute focus on >78 week cohort for elimination in Quarter 4. Additional bank enhancements agreed for Sunday theatre sessions to support this aim. Highest risks Cardiology, Gynaecology, OMFS

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

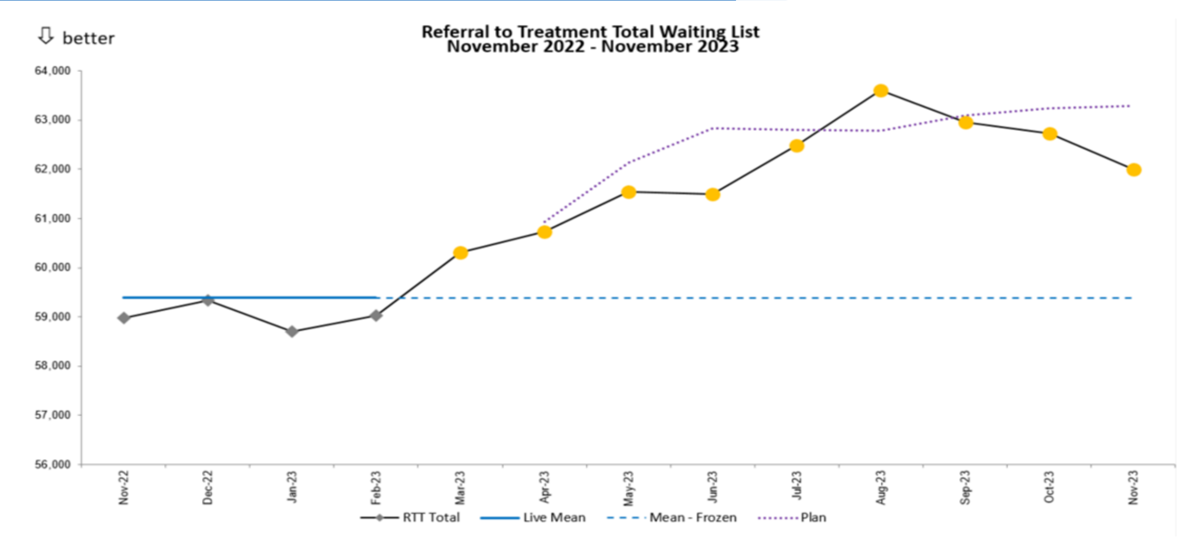
Referral to Treatment Total Waiting List

Nov-23	Plan
61,924	63,282

SPC Variance
Negative special cause variation

Change in WL: Oct-23 vs. Sep-23	
CUH	-0.38%
Shelford Group	+1.27%

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



Waiting list by division

Division	Total Waiting List
A	12,430
B	6,177
C	4,750
D	29,005
E	9,557
Other	5
Trust	**61,924**

Updates since previous month

Total RTT waiting list decreased by 1.3% in month.
The total waiting list size is 1,358 lower than the planning submission for month 8.
Clock starts are cumulatively 2.4% below plan year to date but only 0.3% below the month 8 plan.

Current issues

Total stops (treatments) were 11% above plan in Nov with non-admitted overperformance compensating for admitted performance at 97% of plan.
Given the delay to the Surgical Hub opening until 6th November, the admitted performance against plan was strong.

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.
Cessation of Industrial Action (as was the case in November)

Future actions

Continued focus on releasing capacity for new outpatients. Those awaiting 1st appointment reduced to 60.5% of total waiting list in November, 1,274 less.
Rolling waiting list validation at 12 weeks is yielding a 6% removal rate.

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

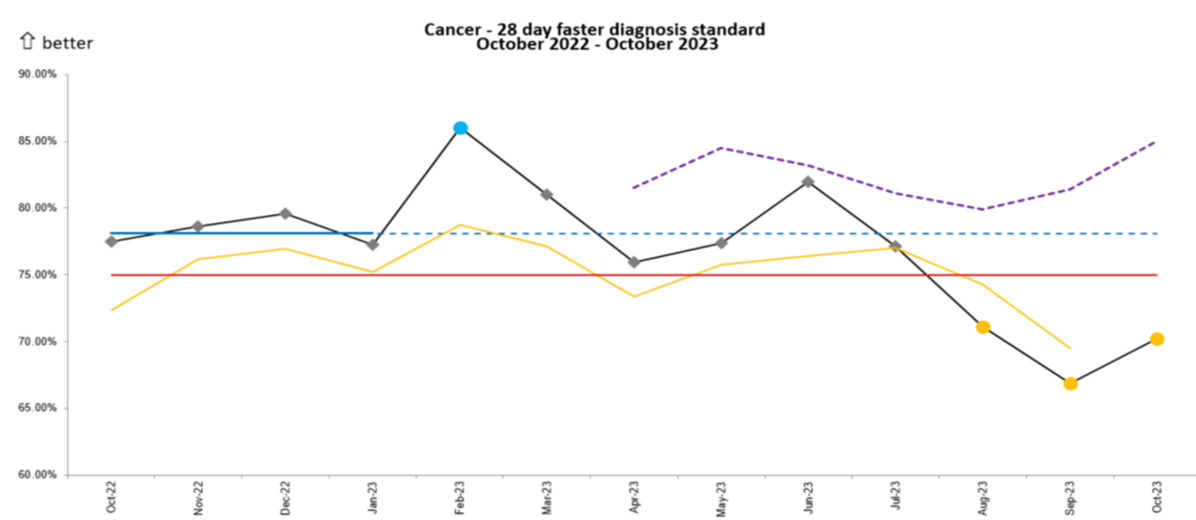
Cancer - 28 day faster diagnosis standard

Oct-23	Target
70.2%	75.0%

SPC Variance
Negative special cause variation

Shelford Group Avg (Sep-23)
69.5%

Three Month Forecast		
Nov-23	Dec-23	Jan-24
83.9%	82.6%	76.8%



Cancer Site Overview

Site	Performance	Breaches
Skin	42.3%	537
Lower GI	86.7%	40
Gynaecological	78.5%	53
Head & Neck	73.6%	66
Urological	66.3%	57
Breast	97.1%	16
Haematological	56.3%	7
Sarcoma	60.9%	9
Upper GI	84.4%	5
Lung	96.4%	3
Childrens	96.8%	1
CNS/Brain	100.0%	0
Testicular	100.0%	0
Total	**70.2%**	**794**

Updates since previous month

CUH has continued to perform below for FDS, with a forecast recovery of December 2023 - recovery has actually been achieved from November. This is due to the deterioration in Skin performance since July which is improving month on month. Pathology turn around times also continue to delay diagnosis and impact on this target. FDS recovery will be achieved from November, ahead of forecast.

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 October based on the recovery plan in place for skin.
Urology have achieved FDS for the first time ever in November, one of very few Urology teams nationally to do this.

Key dependencies

- Pathology turn around times recovering to above 25% in 7 days
- Additional ad hoc activity in skin to reduce 2ww backlog

Future actions

Actions are in place as part of the Cancer Improvement Plan. Focus continues on skin, gynae, urology and pathology. System meeting with GIRFT took place on 31.10.23, work has commenced across the ICB to align pathways and share best practice - particular focus on skin, LGI and Urology.

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

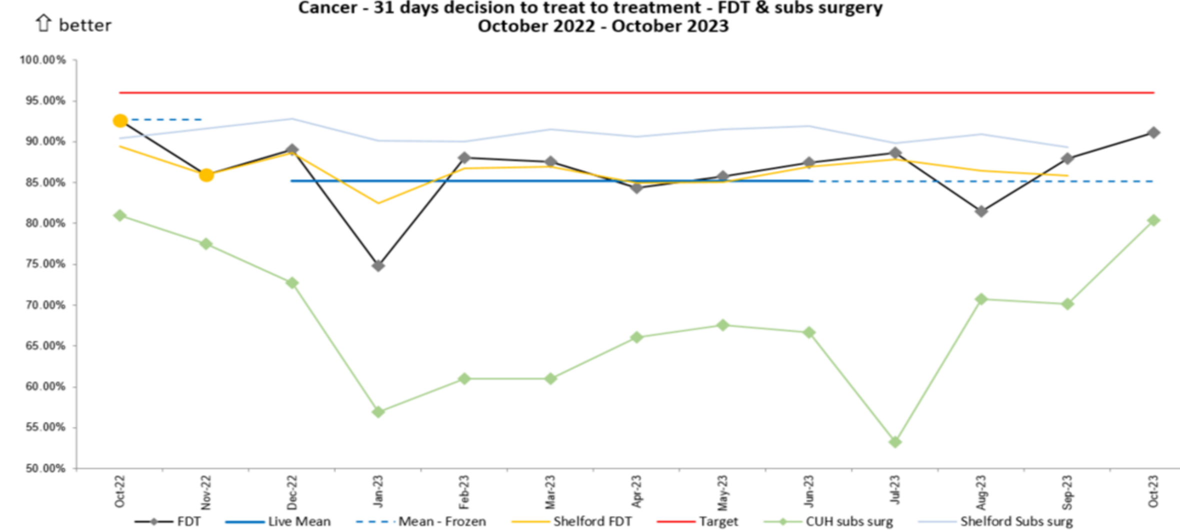
Cancer - 31 days decision to treat to treatment

	Oct-23	Target
FDT	91.2%	96.0%
Subs Surgery	80.4%	94.0%

SPC Variance
Normal variation

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

Cancer Site Overview as of 19/12/2023	
Site	Backlog
Breast	14
CNS/Brain	0
Gynaecological	6
Head & Neck	3
Haematological	0
HPB	5
Lower GI	2
Lung	1
Childrens	0
Sarcoma	1
Skin	70
Testicular	0
Upper GI	0
Urological	7
All	109



Updates since previous month

CUH continues to fall below target with 95.7% of the breaches in October relating to surgical capacity, the sites with the largest breaches are in Skin (29.7%), LGI (23.4%), HPB (10.6%) and Breast (10.6%). Kidney have reduced their breaches further to 8% and from November are able to book within 31 days.

Current issues

Access to sufficient theatre capacity within 31 days remains an issue across multiple cancer sites. Following the Radiotherapy equipment failure in October, along with record referral numbers in October and November has resulted in a number of breaches particularly in breast and urology. The service is working extended days and weekends to recover but due to the Christmas period and ongoing high referral volumes this will not be until January.

Key dependencies

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

Future actions

Continued focus on lower GI, HPB, and skin surgery in December/January.
Additional treatment capacity for skin has been agreed from October with additional cancer alliance funding.

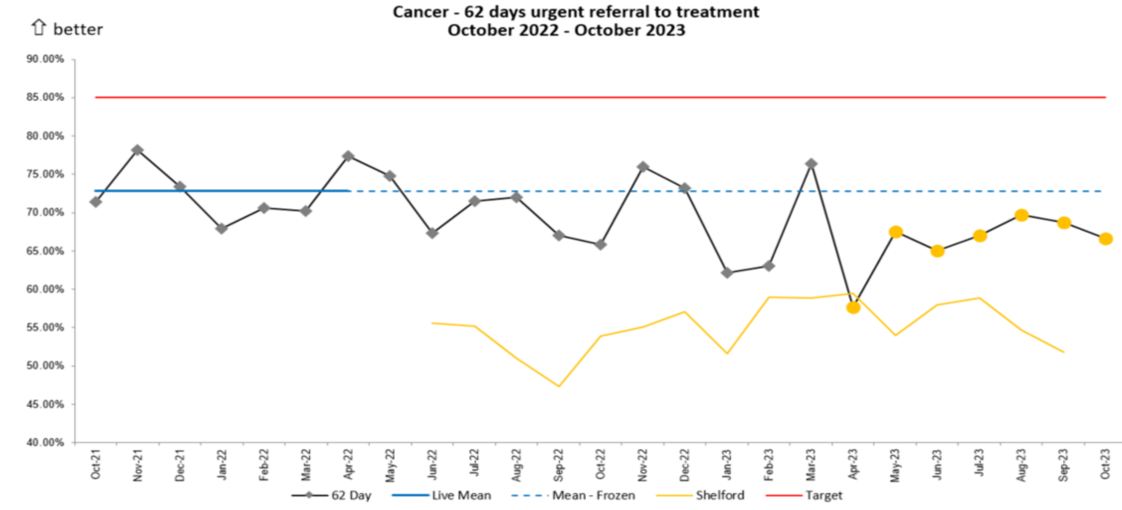
Author(s): Linda Clarke **Owner(s): Nicola Ayton**

Cancer - 62 days urgent referral to treatment

Oct-23	Target
66.7%	85.0%

SPC Variance
Negative special cause variation

Shelford Group Avg (Sep-23)
51.8%



Cancer Site Overview as of 19/12/2023

Site	Backlog
Breast	5
CNS/Brain	0
Gynaecological	21
Head & Neck	11
Other Haem Malignancies	3
Lower GI	14
Lung	10
NSS	0
Upper GI	2
Urological	19
Sarcoma	2
Skin	50
HPB	7
Childrens	0
Symptomatic Breast	0
All	*144*

Updates since previous month

CUH performance remains below target although continues to be higher than the Shelford Group. 60% of breaches are CUH only patients and of that 73% 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. The 62 day backlog has reduced by 48 patients in the last 6 weeks.

Current issues

- Delays in pathology turn around times (currently at 27% 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 25% 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. From Q4 a focus on skin, H&N and Gynae will result in an improvement in performance from Q1 2024/25. Urology have continued to see backlog reductions and are at their lowest backlog ever.

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

Diagnostic Performance

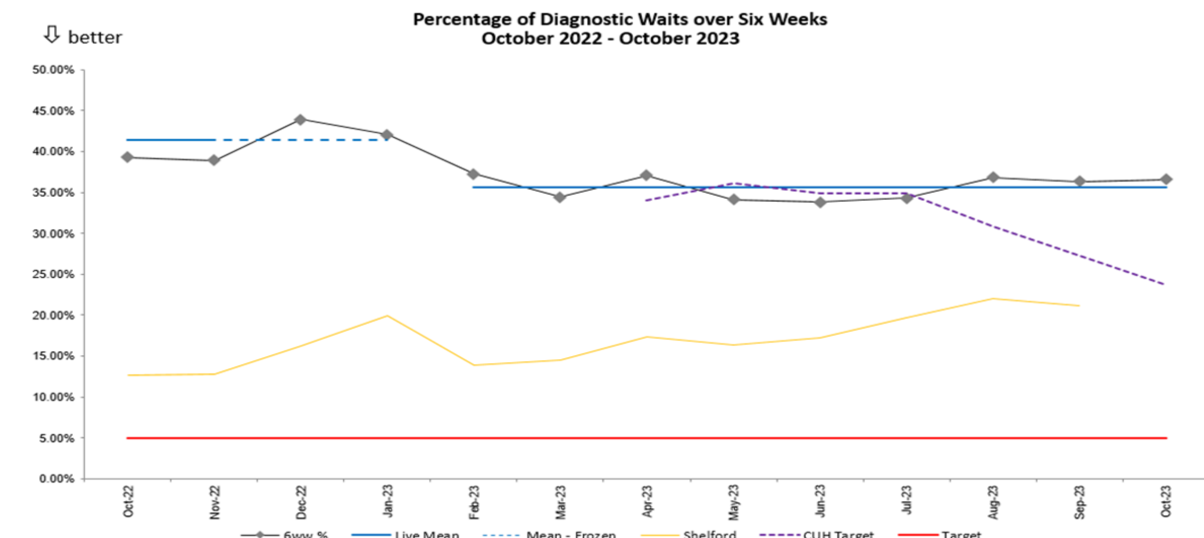
Nov-23	Plan
34.2%	19.3%

SPC Variance
Normal variation

Shelford Group Avg (Oct-23)
22.0%

Three Month Forecast

Dec-23	Jan-24	Feb-24
15.5%	9.3%	6.7%



Modality overview

Modality	% >6wks	Breaches
Echocardiography	69.1%	2476
Non obstetric ultrasound	31.1%	744
Audiology	67.6%	942
Magnetic Resonance Img'	11.2%	282
DEXA Scan	2.7%	19
Computed Tomography	7.5%	84
Urodynamics	61.5%	198
Neurophysiology	2.1%	4
Cystoscopy	10.4%	33
Gastroscopy	3.1%	19
Colonoscopy	0.9%	6
Respiratory physiology	21.4%	9
Barium Enema	23.0%	14
Flexi sigmoidoscopy	0.0%	0
Total		**4830**

Updates since previous month

November 6wk performance improved to 34.2%.
5 modalities achieved < 5% over 6 weeks.
The total waiting list increased by 574, with a reduction in the > 6 week cohort of 117.
Largest waiting list increases were in CT (204) and MRI (364), but both also reduced > 6 week cohort .

Current issues

Echo (+79) was the only notable deterioration in their >6ww position. This now accounts for 51% of the Trust total > 6 weeks.
New Insourcing provider has not commenced in December leading to a further capacity gap.
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

6 candidates interviewed for Band 7 Physiologists and 4.6WTE posts offered. However, start dates will not be until March through to August.
ICB to strengthen the activity of the Echo Task and Finish Group. Actions not developing.
Request to ICB to support a re-direction of appropriate Audiology referrals to Specsavers.

New Outpatient Attendances - % vs. Baseline

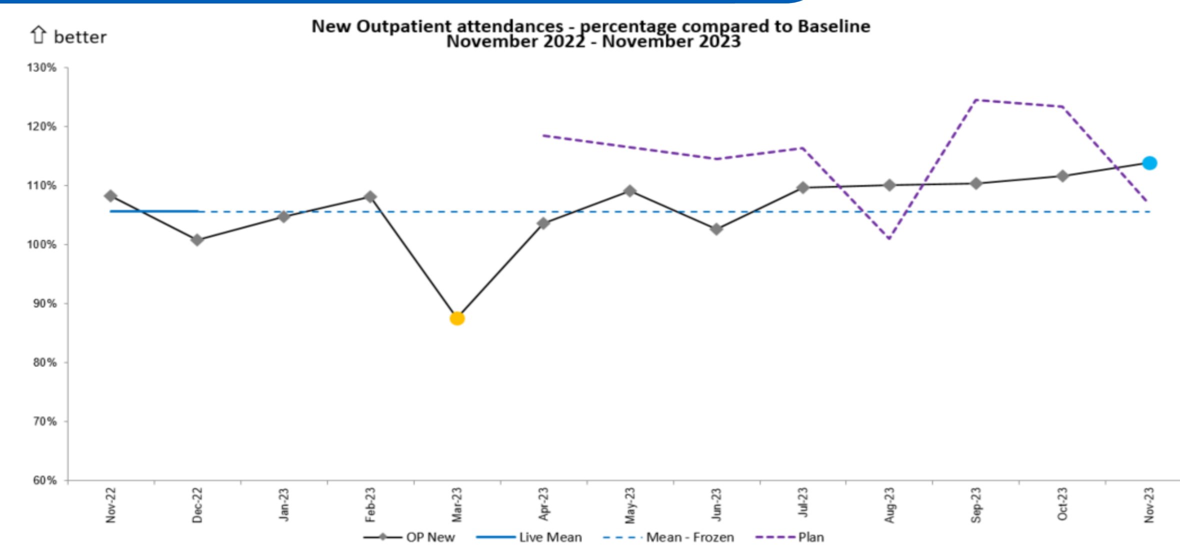
NHS
Cambridge University Hospitals
NHS Foundation Trust

Nov-23	Plan
114.2%	106.9%

SPC Variance
Positive special cause variation

Shelford Group Avg (Oct-23)
N/A

Three Month Forecast		
Dec-23	Jan-24	Feb-24
119.8%	111.3%	119.5%



Divisional overview	
Division	Performance
A	117.1%
B	110.9%
C	91.9%
D	114.5%
E	114.1%

Updates since previous month

CUH new activity remains adversely below the 115% CUH target for end March 2024, however, there is a trend upwards in the last 6 months. November is the strongest performance over the last 12 months. Div D's performance remains strong and Div E has seen recent improvement.

Current issues

The number of new outpatient appointments on the waiting list remains high at 64,034 in November 2023. However, the rate of rise per month has slowed with a significant trend downwards in the rate of rise for the last 6 months. The new appointment waiting lists for Divisions A, B and E have all decreased over the past six months.

Key dependencies

November has shown positive numbers we know that December and January will be difficult as we will have lost more activity to industrial action. It is essential that all services continue to review and risk assess patients to ensure patients are seen based on clinical priority.. A number of services have started using Patient not Present which we hope to see gradually increase in the coming months.

Future actions

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 against. We are also now starting to develop a longer term OP strategy.

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

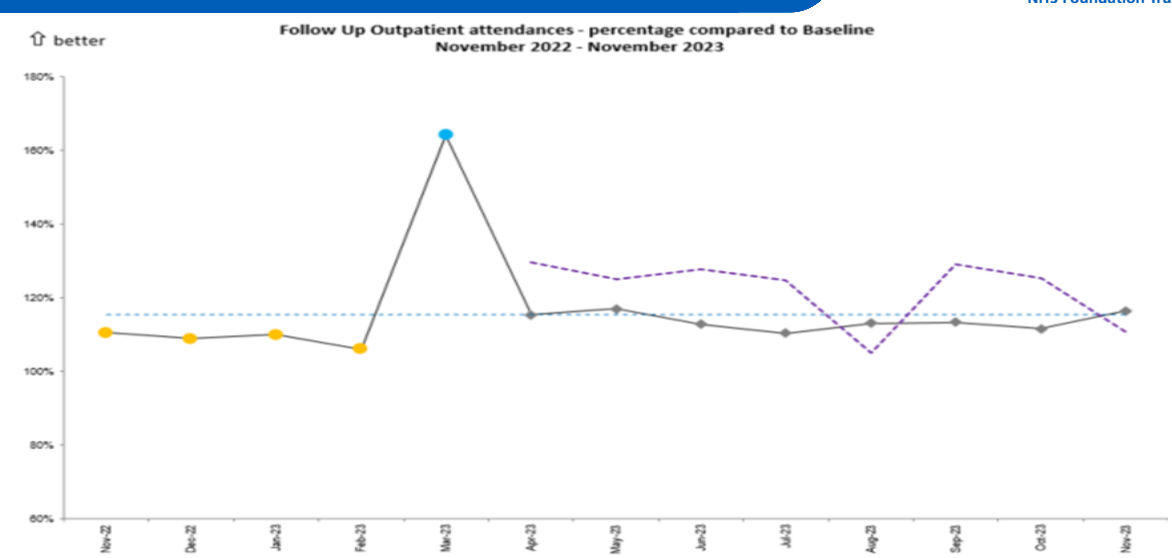
Follow Up Outpatient Attendances - % vs. Baseline

Nov-23	Plan
117.0%	110.8%

SPC Variance
Normal variation

Shelford Group Avg (Nov-23)
N/A

Three Month Forecast		
Dec-23	Jan-24	Feb-24
122.0%	116.2%	123.9%



Divisional overview

Division	Performance
A	105.5%
B	121.7%
C	117.4%
D	114.4%
E	132.1%

Updates since previous month

CUH follow up activity has increased in 2023 and remains adversely above the 100% CUH target for end March 2024. Analysis suggests some of this increase is driven by non-consultant follow ups which were not recorded in 2019/20, now being recorded. The national target to reach 75% by end 2023/24 will not be met.

Current issues

The number of overdue follow-ups remains high, reaching 55,145 in November 2023. All divisions have overdue follow-ups on their risk registers. The rate of rise of overdue follow-ups is stable with natural variation since April 2021.

Key dependencies

EHospital resources remains critical to delivering the Epic changes required for PNP builds. Meetings are being convened between the improvement and Transformation Director, Outpatient Clinical Director and specialty leads to encourage the pace of change.

Future actions

Action being taken to address overdue follow ups include waiting list validation/initiatives and pathway redesign including PIFU, and Patient Not Present (PNP). 4 specialties are currently using PNP, 6 more have clinics built in Epic but no activity yet. Three specialities are in the eHospital PNP build pipeline, others are having planning to introduce PNP. This action needs to be encouraged at pace.

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

PIFU Outpatient Attendances

Nov-23	Plan
3.4%	5.9%

SPC Variance
Positive special cause variation

Shelford Group Avg (Nov-23)
N/A

Three Month Forecast		
Dec-23	Jan-24	Feb-24
6.3%	6.7%	7.1%

⇧ better

PIFU Outpatient Attendances
November 2022 - November 2023

8.00%
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%

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

PIFU% Live Mean Mean - Frozen Plan Target

Divisional overview	
Division	**Performance**
A	7.6%
B	3.9%
C	1.9%
D	2.1%
E	3.1%

Updates since previous month

There is a consistent overall 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 3.9% from 3.6% since October 2022. Division A is the only Division to meet, and exceed, the 7.5% target.

Current issues

None

Key dependencies

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.

Future actions

CHEQS data shows correlation between PIFU and reduced follow ups. As of 15 December 2023, of the 74,634 PIFU orders placed since 2019 – 45,533 have expired. 91.5% expired with no F/U activated which equates to 41,668 F/Us saved / avoided. Further action is needed to accelerate the pace and scale of PIFU increase.

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

Delayed discharges

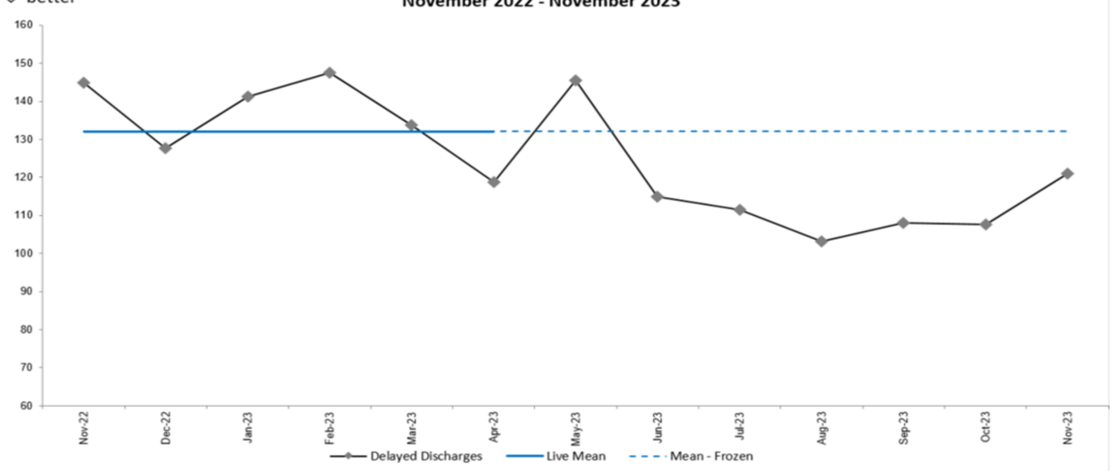
Nov-23	Target
121	N/A

SPC Variance
Normal variation

Shelford Group Avg (Nov-23)
N/A

Beds lost to delays - by pathway

Pathway	Beds lost
Pathway 1	52
Pathway 3	24
Pathway 2	21
Pathway 0	19
Internal Assessments	3
External Assessments	1
Triage	1
Unknown	0
Total	**121**



Updates since previous month

- Beds lost to delayed discharges increased from 108 in October to 121 in November
- Of these, 97 (80%) related to external complex pathways 1-3

Current issues

- Lack of sufficient, appropriate and timely packages of care for patients with complex discharge requirements

Key dependencies

- There is a high dependency on staffing levels in community care to create sufficient capacity for patient needs
- The Trust should ensure referrals for care packages are made on a timely basis

Future actions

- On-going analysis of discharge delay data to identify opportunities for improvement
- Significant programme of work coordinated by the ICB to improve the timeliness of care

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

Theatre Utilisation - Elective GIRFT Capped

NHS Cambridge University Hospitals NHS Foundation Trust

Nov-23	Plan
77.7%	85.0%

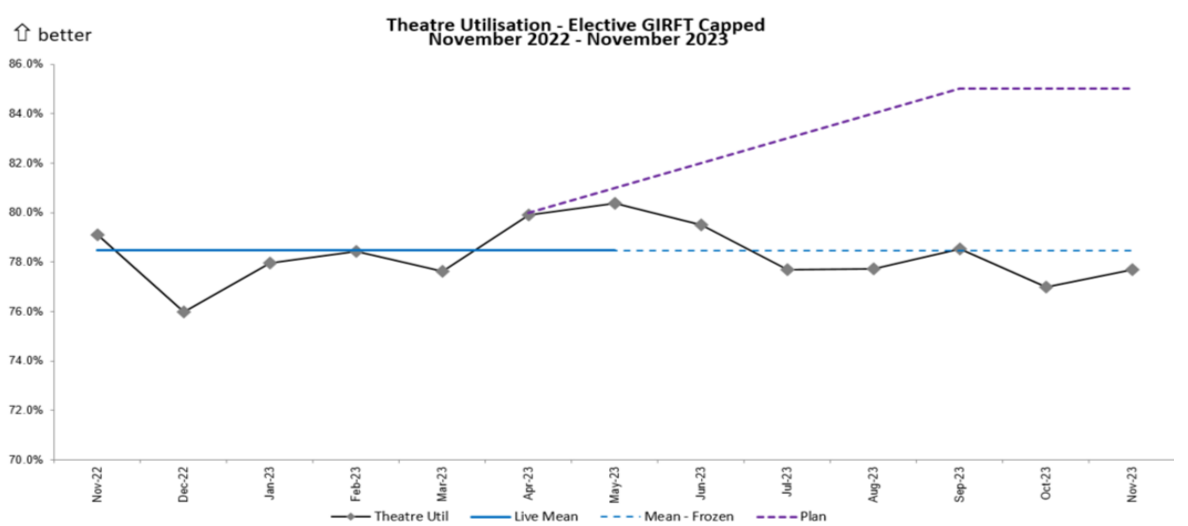
SPC Variance
Normal variation

Performance in the 2 weeks to 03/12/2023	
CUH	78.2%
Shelford Grp Median	76.9%

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

Utilisation by department

Department	Utilisation
ATC	78.5%
Main	77.7%
Rosie	73.2%
CMSH	83.4%
CEU	73.3%
Ely	72.2%
All	**77.7%**



Updates since previous month

Utilisation across November was 77.7% , but in two weeks in the month we did deliver above 80%, the highest utilisation weeks since July. Performance is in Quartile 3. Sessions used were high at 95.3%

Current issues

Four specialties achieved over 85% utilisation in month. Seven in the paediatric specialties were below 70% .
Short notice cancellations were highest YTD at 426. 30% clinical reason, 15% patient initiated, 15% higher priority cases. 27% were prior to the day.

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 cancellations to be more widely adopted.
Cancellation data suggests this should be targeted at Ophthalmology and Paediatric Surgery as a priority where bed capacity is less of a constraint.

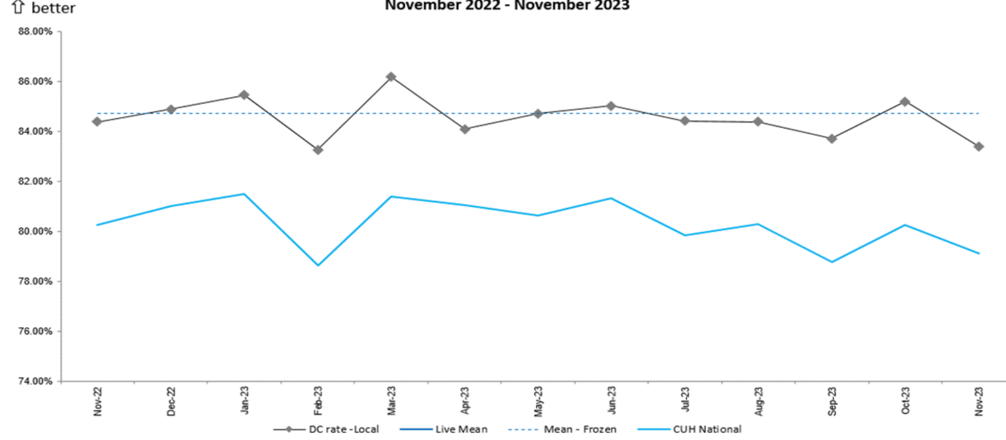
Author(s): Linda Clarke **Owner(s): Nicola Ayton**

BADS Daycase Rates

Nov-23	Target
83.4%	N/A

SPC Variance
Normal variation

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



BADS Section Day Case Rate for HVLC focus areas

3 months to end of Aug '23				Nov-23
Specialty	**CUH**	**Shelford**	**Quartile**	**Local**
Orthopaedics	84.5%	82.9%	2	86.9%
ENT	70.7%	82.4%	1	77.3%
General	62.0%	66.0%	1	71.9%
Gynaecology	55.8%	63.9%	1	71.4%
Ophthalmology	98.7%	98.2%	2	98.6%
Urology	69.3%	68.8%	3	68.6%

Updates since previous month

Model Hospital GIRFT data for 3months to Sep 2023 still shows low performance in quartile 1.
Local BADS reporting for zero LOS shows a deterioration to 83.4% in November.

Current issues

Inaccurate recording of Intended Management. 50 zero LOS BADS procedures recorded as inpatient.
9% of the >0 LOS. were Lap Chole, 8% Urology HOLEP, 6% Simple mastectomy. 50% >0 LOS were 23hr stay so did not use Inpatient capacity.

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

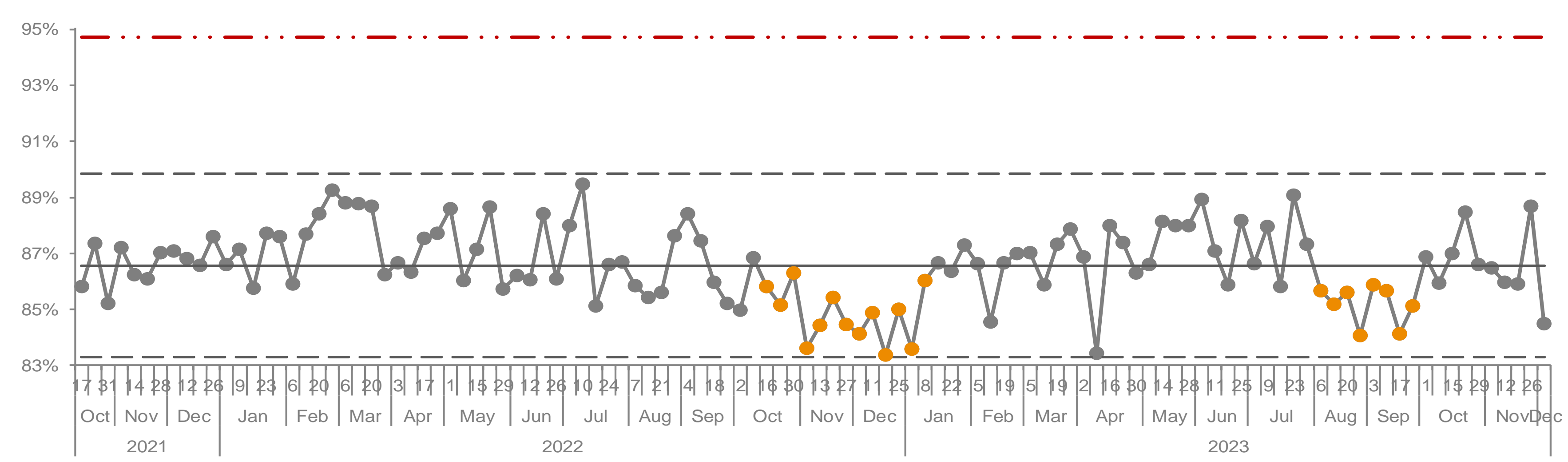
Incorrect intended management being circulated to Specialties each month to encourage correct use at listing.
Board rounding at 10am, 12pm and 2pm within L2DSU to ensure daycases progressing.

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

Discharge Summaries

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)

The good experience and poor experience indicators omit neutral responses.

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
FFT Inpatient good experience score	Jul 20 - Nov 23	Month	-	91.8%	95.1%	L	SP	-	For November, there was no change in the Good score or the Poor score. The Good score remains 2.5% lower compared to the start of the year, and 2.5% lower compared to same time last year. The Poor score remains 1% higher compared to the start of the year, and 1.5% highter compared to same time last year. **FOR NOV: there were 413 FFT responses collected from approx. 4,209 patients.**
FFT Inpatient poor experience score	Jul 20 - Nov 23	Month	-	4.1%	1.9%	H	SP	-	
FFT Outpatients good experience score	Apr 20 - Nov 23	Month	-	93.8%	94.8%	L	S7	-	For November, there was no change in the Good score or the Poor score. Both scores are remaining consistent with less than 1% change. There were 10 paediatric FFT responses so the FFT scores mainly reflect adult clinics. **FOR NOV: there were 5,325 FFT responses collected from approx. 26,940 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 - Nov 23	Month	-	3.0%	2.5%	H	S7	-	
FFT Day Case good experience score	Apr 20 - Nov 23	Month	-	95.2%	96.4%		-	-	For November, there was a 1% decrease in the Good score, and a 1% increase in the Poor score, compared to October. Although both scores are the lowest/highest for the year, it is not a concern. The Good score remains above 95% and the Poor score below 3%. **FOR NOV: there were 1,202 FFT responses collected from approx. 4,683 patients.**
FFT Day Case poor experience score	Apr 20 - Nov 23	Month	-	2.7%	1.8%		-	-	
FFT Emergency Department good experience score	Apr 20 - Nov 23	Month	-	78.2%	82.7%		-	-	For November the Good score improved by 2% compared to October, but is still about 4% lower compared to the start of the year. The Poor score also improved by 2% compared to October and is 2% higher compared to the start of the year. The adult FFT scores improved, but the paeds FFT scores declined, compared to October. **FOR NOV: there were 967 FFT responses collected from approx. 6,044 patients**.
FFT Emergency Department poor experience score	Apr 20 - Nov 23	Month	-	13.1%	10.6%		-	-	
FFT Maternity (all FFT data from 4 touchpoints) good experience score	Jul 20 - Nov 23	Month	-	85.4%	94.6%	L	SP	-	**FOR NOV:** Antenatal had 6 FFT response - 100% Good; Birth had 34 FFT responses out of 456 patients - 85.3% Good / 6% Poor; Postnatal had 49 FFT responses: LM had 14 FFT (compared to 72 responses beginning of the year) with 71.4% Good / 14.3% Poor, DU had 1 FFT with 100% Good, BU had 31 FFT with 87.1% Good / 6.5% Poor, and COU 100% Good from 2 responses. 0 FFT responses from Post Community. **NOV MATERNITY OVERALL:** Good score decreased by 4% and Poor score increased by 2.5% from 89 FFT responses.
FFT Maternity (all FFT data from 4 touchpoints) poor experience score	Jul 20 - Nov 23	Month	-	6.7%	2.1%	H	SP	-	

FFT data starts from April 2020 for day case, ED and OP FFT (SMS used to collect FFT), and inpatient and maternity FFT data starts with July 2020 due to Covid-19 restrictions on collecting FFT data. For NHSE FFT submission, wards still not collecting FFT are not being included in submission. In September 12 wards did not collect any FFT data.

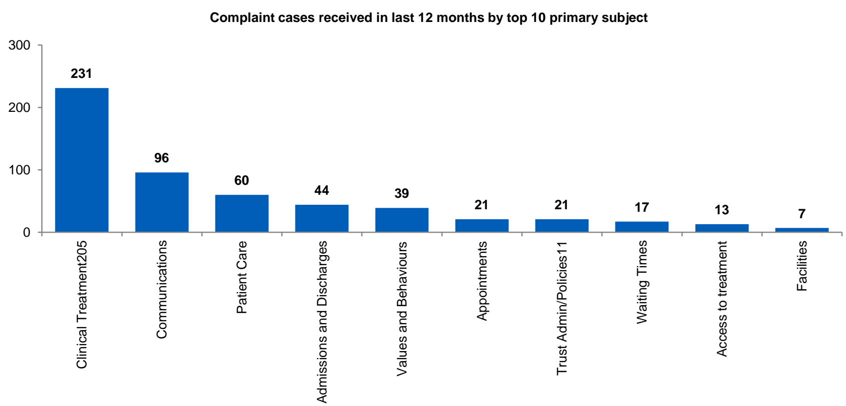
There continues to be a mix of FFT scores each month. Both inpatient and outpatient FFT scores remained the same compared to October. The inpatient Good score is the lowest for the year, and the Poor score is 1% higher than previous months. Outpatients FFT scores have remained steady yet the SPC icon shows a concern, but with the Good score close to 95% and the Poor score 3%, there is no concern. Day case FFT scores slightly increased/decreased, but like outpatients FFT scores, there is no concern. Adult ED FFT improved with both the Good score (4.5% increase) and the Poor score (2.5% decrease). However paeds ED FFT scores did not improve, with the Good score decreasing 6% and the Poor score increasing 1%, compared to October. Maternity FFT scores also did not improve, with the overall Good score decreasing by 4% (85.4%) and the Poor score increasing by 3.5% (6.7%). These scores are now the lowest/highest ever recorded. November FFT scores from Rosie Birth Unit and from Lady Mary impacted the overall Maternity FFT results.

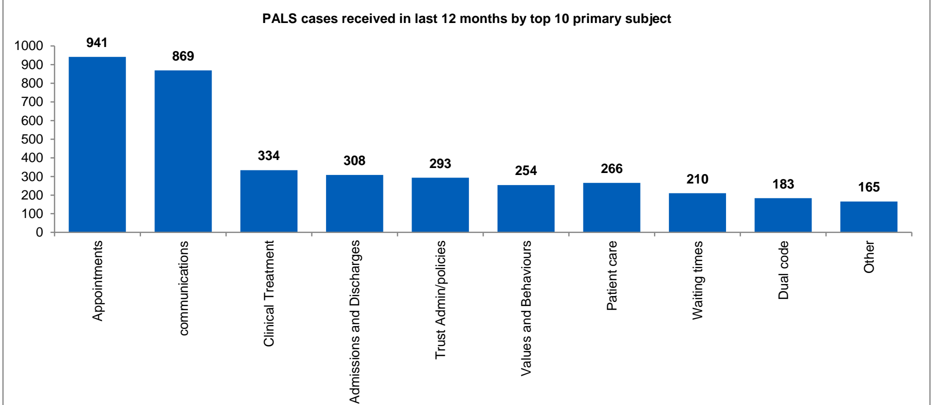
Please note starting in 2022, the Trust reduced the number of SMS being sent to adult patients. Instead of sending a text message to every adult patient that attend an OP/DU appointment, or presented to A&E, the Trust now sends a fixed number of SMS daily.

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

PALS and Complaints Cases

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
Complaints received	Nov 19- Nov 23	month	-	68	55	H	SP	-	The number of complaints received between November 2019 - November 2023 is higher than normal variance.
% acknowledged within 3 days	Nov 19-Nov 23	month	95%	86%	73%		-	?	59 out of 68 complaints were acknowledged within 3 working days
% responded to within initial set timeframe (30, 45 or 60 working days)	Nov 19-Nov 23	month	50%	49%	30%	L	S7	?	99 complaints were responded to in November, 45 of the 99 met the initial time frame of either 30.45 or 60 days.
Total complaints responded to within initial set timeframe or by agreed extension date	Nov 19 -Nov 23	month	80%	55%	87%	L	SP	?	54 out of 99 complaints responded to in November were within the initial set time frame or within an agreed extension date.
% complaints received graded 4 to 5	Nov 19 -Nov 23	month	-	19%	34%		-	-	There were 12 complaints graded 4 severity, and 1 graded 5. These cover a number of specialties and will be subject to detailed investigations.
Compliments received	Nov 19 -Nov 23	month	-	23	32	L	S7	-	23 Compliments were registered during November and sent onto relevant staff for information



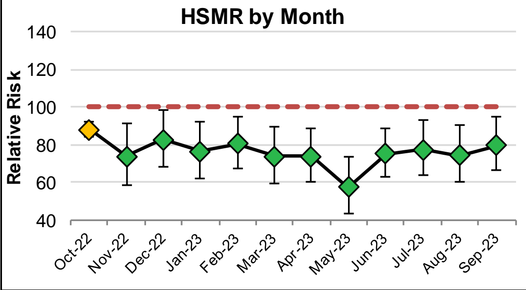


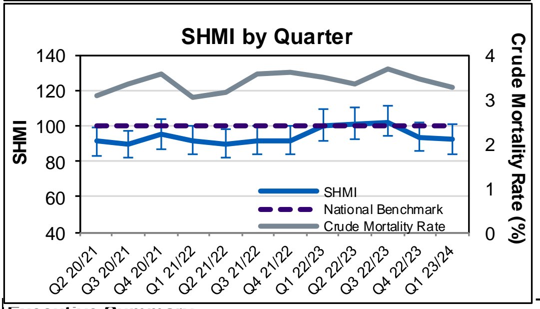
PHSO - There were no cases taken for investigation in November 2023 by the Parliamentary and Health Service Ombudsman.
A backlog of complaint responses (550) declared in May 2023 has now been brought down to less than 35. A new process has been introduced within the complaints team to try to resolve 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.

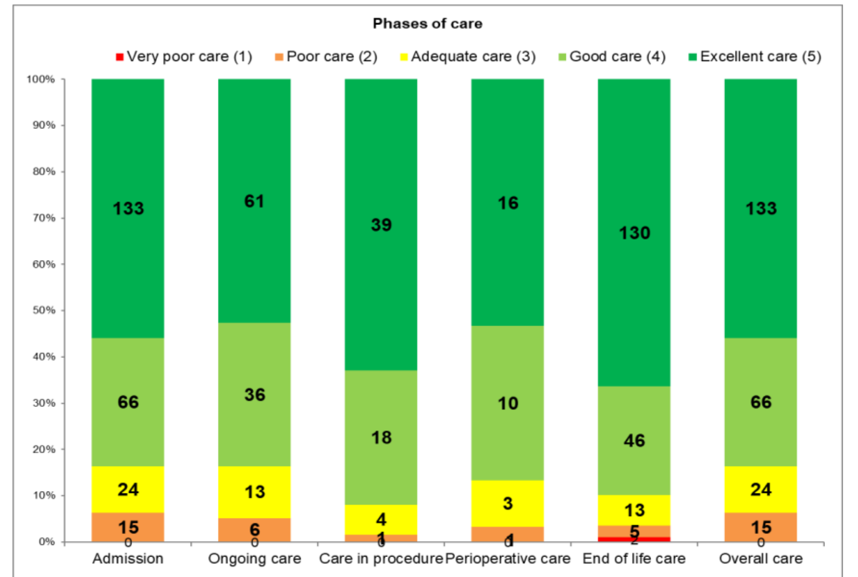
Author(s): Sue Bennison **Owner(s): Clare Hawkins**

Learning from Deaths

Indicator	Data range	Nov-23	Mean	Variance	Comments
Total inpatient and Emergency department deaths	December 2018 - November 2023	**133**	*136*		
Total Emergency Department and Inpatient deaths **per 1000 admissions**		**7.4**	*8.6*		
Emergency department deaths per 1,000 attendances		**0**	*0.8*		
Inpatient deaths by 1,000 admissions		**8.3**	*10.3*		There was a statistically significant downward shift in the last 9 months
% of Emergency Department and Inpatient deaths in-scope for a Structured Judgement Review (SJR)		**21%**	*20%*		In November 2023 28 SJRs were commissioned.







Executive Summary

HSMR - The rolling 12 month (August 2022 to July 2023) HSMR for CUH is 75.98, this is 5th lowest within the London and ATHOL peer group. The rolling 12 month HSMR for the Shelford Peer group is 90.81.

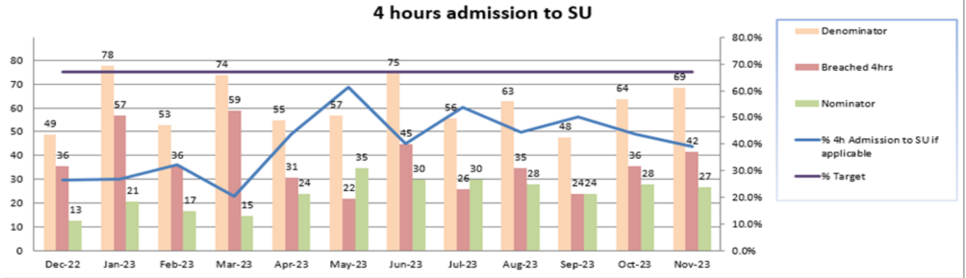
SHMI - The Summary Hospital-level Mortality Indicator (SHMI) for CUH in the latest period, July 2022 to June 2023 is 97.17.

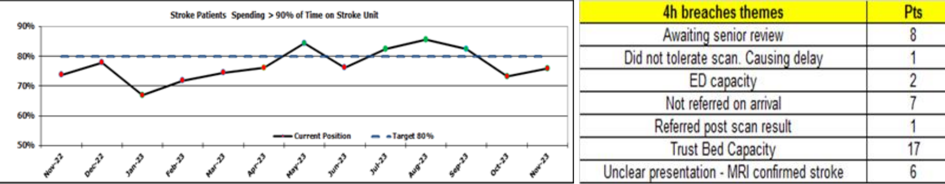
Alert - There are 2 alerts for review within the HSMR and SHMI dataset this month.

There were **no serious incidents categorised as potentially/avoidable death** commissioned in November 2023.

Author(s): Chris Edgley **Owner(s): Amanda Cox**

Stroke Care





4h breaches themes	Pts
Awaiting senior review	8
Did not tolerate scan. Causing delay	1
ED capacity	2
Not referred on arrival	7
Referred post scan result	1
Trust Bed Capacity	17
Unclear presentation - MRI confirmed stroke	6

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%)
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%
Nov-23		12				4	2				2			20	75.9%
Summary	10	101	0	4	20	21	3	2	3	0	43	6	2	215	

90% target (80% Patients spending 90% IP stay on Stroke ward) was not achieved for November 2023 = **75.9%**

Trust bed capacity (12) was the main factor contributing to breaches last month, with a total of 20 breaches in November 2023.

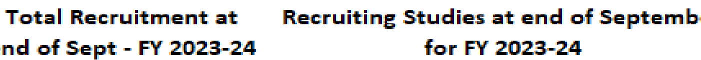
4hrs adm to SU (67%) target compliance was not achieved in November 2023 = 39.1**%**

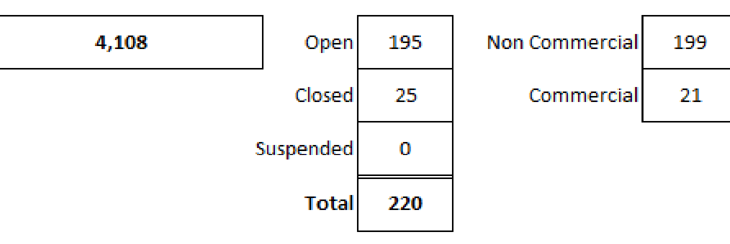
Key Actions

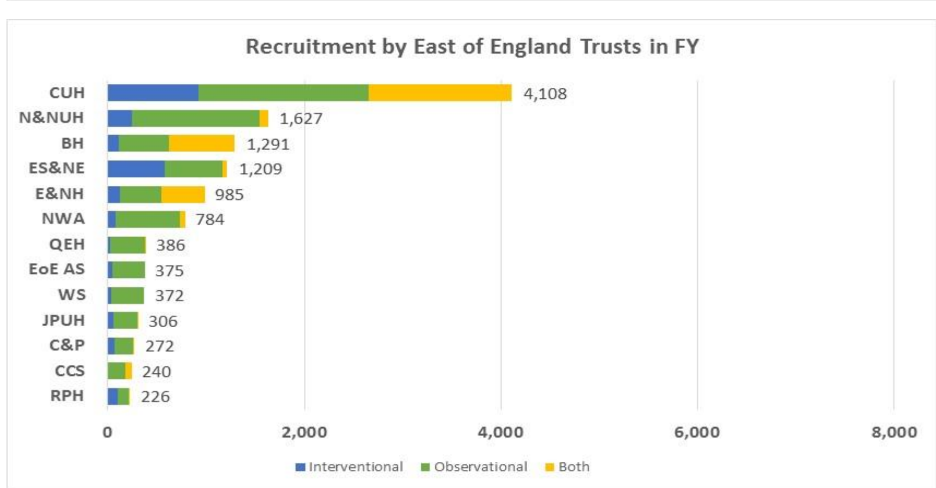
- Work continues to protect 2 x ring-fenced beds on R2 (one male and one female)
- Ops team met with new head of patient flow in November and she is supportive of helping to increase awareness of R2 pathway and the importance of protecting the stroke bedbase
- Currently in discussion with ED to change 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 and recruitment process has started for the new year
- National SSNAP data shows Trust performance from July -Sept 2023 at Level A. The team is forumulating a plan to try to maintain this progress
- Stroke Taskforce meetings remain in place, plus weekly review with root cause analysis undertaken for all breaches, with actions taken forward appropriately.
- The stroke bleep team continue to see over 200 referrals in ED a month, many of those are stroke mimics or TIAs. TIA patients are increasingly treated and discharged from ED with clinic follow up. Many stroke mimics are also discharged rapidly by stroke team from ED. For every stroke patient seen, we see three patients who present with stroke mimic.
- Working with acute med team to establish TIA ambulatory service in clinic 5 to help support admission avoidance and reduce presentations in ED.

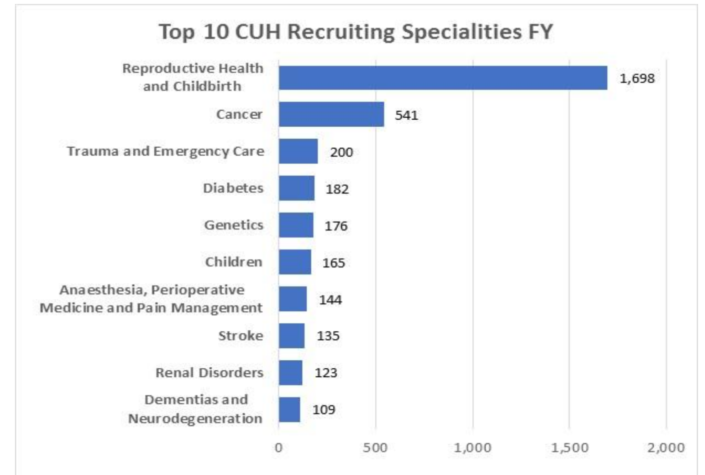
Author(s): Charles Smith   Owner(s): Nicola Ayton

Clinical Studies









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

Compliance

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

Evidence of SBLCB V3 Compliance		
1	Reducing smoking in pregnancy	W
2	Fetal growth: Risk assessment , surveillance and management	C
3	Raising awareness of Reduced Fetal Movements	W
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

Assessment against Ockenden Immediate and Essential Actions (IEA) – to achieve full compliance will all elements of each IEA		
IEA1:	Enhanced Safety	W
IEA2:	Listening to Women & Families	C
IEA3:	Staff training & Working Together	C
IEA4	Managing complex pregnancy	W
IEA5:	Risk Assessment Throughout pregnancy	W
IEA6:	Monitoring Fetal wellbeing	C
IEA7:	Informed Consent	W

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

Clinical Outcome Measures

KPI	Measurement / Target			Numerator / Denominator		
				Numerator	denominator	%
Massive Obstetric Haemorrhage ≥ 1500 mls	Vaginal birth		3.30%	16	272	5.88%
(as per NMPA descriptor, slide 8)	Caesarean		4.50%	6	150	4.00%
3rd & 4th degree tear	SVD (unassisted)		Unassisted 2.5%	8	215	3.72%
(as per NMPA descriptor, slide)	Instrumental (assisted)		Assisted 6.3%	5	56	8.93%
Caesarean section (%age)	(see guidance document)		overall rate not required			
(primip, singleton , ceph, over 37/40, spontaneous labour)	Robson Group 1		N/A	25	103	24.3%
[primip, singleton, over 37/40, who had labour induced (2a) or LSCS prior to labour (2b)]	Robson Group 2	2	N/A	28	84	33.3%
		2a		24	24	100.0%
(Multip, at least 1 uterine scar, singleton, ceph, over 37/40)	Robson Group 5		N/A	34	44	77.3%
Smoking at time of delivery			≤ 6%	13	458	2.84%
Preterm birth						
Preterm birth rate	≤36+6 weeks (over 24+0/40) National ambition		≤6% annual rolling rate (Total PTB all babies 24-36+6))	487	5429	8.97%
	16+0 - 23+6 (SBLCBv3)		%age of all singleton births (live & stillborn)	0	447	0.00%
	24+0 - 36+6 (SBLCBv3)		%age of all singleton births (live & stillborn)	25	447	5.59%

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		Numerator	denominator	%
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)	27	472	5.7%
	%age of total admissions that were avoidable	1	25	4% (Sept'23, 0.2% of all births)
Optimisation (metrics to be determined locally as per SBLBCv3) **please see the implementation tool for technical guidance**		Sept'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 care unit (NICU)	local agreement %	3	3	100%
Antenatal corticosteroids				
Percentage of babies born before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth	local agreement 55%	4	7	57%
Magnesium sulphate				
Percentage of babies born before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth	local agreement 90%	4	4	100%
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	local agreement 90%	2	2	100% for up to 34 weeks (53% for up to 37 weeks)
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.	local agreement 75%	6	7	86% for up to 34 weeks (85% for up to 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	local agreement 75%	4	7	57%
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.	local agreement 50%	1	7	14%

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

Maternity Dashboard

KPI	Goal	Target	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	SPC	Narrative and Actions taken for Red/Amber/Special cause concerning trend results
Activity										
Births	For information	N/A	452	490	466	443	472	469	5453	
Health and social care assessment <GA 12+6/40	> 90%	>=90% <90% and >=80% <80%	91.03%	89.11%	95.05%	86.75%	99.09%	94.74%		10 removed from bookings denominator were late bookings due to transfer of care
Booking Appointments	For Information	N/A	379	358	343	400	330	352		
Vaginal Birth (Unassisted)	For Information	N/A	48.45%	48.16%	49.79%	49.89%	51.48%	48.83%		
Home Birth	For Information	N/A	0.22%	1.63%	0.86%	1.13%	1.69%	0.85%		
Rosie Birth Centre Birth	For Information	N/A	15.71%	13.47%	13.52%	16.93%	15.04%	13.86%		
Rosie Birth Centre transfers	For information	N/A	31.96%	34.41%	42.39%	29.03%	37.96%	43.16%		
Birth assisted by instrument (forceps or ventouse) (Instrumental)	For Information	N/A	13.05%	12.04%	9.87%	9.48%	10.17%	11.94%		
CS rate (planned & unplanned)	For Information	N/A	38.27%	39.18%	39.70%	40.18%	37.71%	38.38%		
Women in RG*1 having a caesarean section with no previous births: nullip spontaneous labour	For information	10%	18.30%	20.90%	16.10%	18.50%	12.90%	24.30%		
Women in RG*2 having a caesarean section with no previous births: nullip induced labour, nullip pre-labour LSCS	For Information	For Information	41.10%	55.10%	47.90%	51.00%	57.30%	48.10%		
Ratio of women in RG1 to RG2	Ratio of >2:1	N/A	1:2.93	1:3.68	1:2.98	1:3.53	1:5	1:2.08		
Women in RG*5. Multips with 1 or 2+ previous C/S	For Information	For Information	83.9%	83.3%	88.2%	91.5%	77.4%	77.3%		
Women in RG1, RG2, RG5 combined contribution to the overall C/S rate.	66%	60-70%,	61.3%	67.2%	62.2%	68.5%	60.1%	61.7%		
Induction of Labour rate	For Information	N/A	33.48%	33.89%	33.48%	34.18%	31.84%	31.66%		
Delay in commencement of Induction (IOL)	0%	<10%	27.62%	28.64%	24.87%	34.88%	28.74%	25.95%		CQC workstream for IOL improvements, including improvements to report errors.
Delay in continuation of Induction (IOL)	0%	<10%	11.05%	9.05%	10.05%	15.00%	14.37%	10.81%		CQC workstream for IOL improvements, including improvements to report errors.
Indication for IOL (SBLCBV3)	0%	5-10%	0%	0%	5%	0%	7%	6%		Data amended to report as per SBLv3 (denominator should be IOLs before 39 weeks, previously reported all IOLs).
Indication for IOL	100%	≥95%	99.33%	100%	98.70%	100%	97%	99%		2 outside guidance (both RFM) without consultant plan

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

Maternity Dashboard

Divert Status - incidence	0	<1	2	4	2	1	1	2		1st divert for 3:50 due to DU flood - no one diverted. 2nd divert for 26:30 hours due to maternity capacity, 1 woman diverted.
Total number of hours on divert	For information	N/A	27.25	98.20	27.50	18.08	21.25	30.20		
Admissions to Rosie during divert status	For information	N/A	14	52	7	12	10	21		
Number of women giving birth in another provider organisation due to divert status	For information	N/A	3	4	2	1	1	1		1 woman diverted to Ipswich for ongoing IOL - normal birth and no complications.
Number of IUTs declined due to maternity services capacity/staffing	0%	0%			8	1	0			Data pending for Nov.
Workforce										
Midwife/birth ratio (actual)**	1:24	<1.28	1:24.1	1:25.3	1:25.2	1:25.1	1:23.1	1:22.4		
Midwife/birth ratio (funded)**	For information	1.24.1	1:23.8	1:23.4	1:23.4	1:23.2	1:23.1	1:23.1		
Supernumerary Delivery Unit Coordinator	100%	≥95%	100%	100%	100%	100%	98%	100%		
Staff sickness as a whole	< 3.5%	<5%	4.57%	4.19%	4.29%	4.37%	4.49%			Reports one month behind.
Education & Training - mandatory training - overall compliance (obstetrics and gynaecology)	>92% YTD	>75% YTD	91.1%	91.7%	93.0%	92.7%	91.1%			Reports one month behind.
Education and Training - Training Compliance for all staff groups: **Prompt**	>90% YTD	>85% YTD	81.22%	82%	86.80%	82.60%	94.56%	92.41%		CNST MIS year 5 compliance target exceeded for all staff groups.
Education and Training - Training Compliance for all staff groups: **NBLS as per MIS requirements**	>90% YTD	>85% YTD	81%	80%	80%	75%	75%	81%		CNST MIS year 5 modified compliance target exceeded for all staff groups. Action plan in place to achieve 90% compliance by 1 March 2024.
Education and Training - Training Compliance for all staff groups: **K2**	>90% YTD	>85% YTD	87.08%	81.00%	84.20%	80.60%	88.10%	91.20%		CNST MIS year 5 compliance target exceeded for all staff groups.
Education and Training - Training Compliance for all Staff Groups - **Fetal Surveillance Study Day**	>90% YTD	>85% YTD	84.91%	82.00%	86.60%	88.00%	84.50%	91.40%		CNST MIS year 5 compliance target exceeded for all staff groups.
Education & Training - mandatory training - **midwifery compliance**.	>92% YTD	>75% YTD	91.6%	92.6%	93.5%	93%	90%			Reports one month behind.

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

Maternity Dashboard

Maternal morbidity										
Puerperal Sepsis	For information	N/A	0.22%	0.42%	0.43%	0.46%	0.43%	0.44%		
ITU Admissions in Obstetrics	For information	N/A	0	0	0	2	1	1		IUT from another Trust following SAH, admitted directly to NCCU (Em CS).
Massive Obstetric Haemorrhage ≥ 1500 mls - vaginal birth	≤3.3%	≤3.3%	4.63%	5.84%	5.30%	5.58%	4.61%	5.88%		CQC workstream. November PPH education campaign week delivered.
Massive Obstetric Haemorrhage ≥ 1500 mls - caesarean birth	≤4.5%	≤4.5%	3.62%	3.73%	6.08%	6.00%	3.97%	4.00%		
3rd/ 4th degree tear rate	≤3.5	<5%	1.55%	1.83%	3.04%	4.84%	4.33%	4.80%		Ongoing OASi training for medical and midwifery teams.
Maternal readmission rate	For information	N/A	2.59%	2.30%	2.56%	2.63%	1.63%	2.38%		
Peripartum Hysterectomy	For information	N/A	1	2	0	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	1	0	0		
Never Events	0	<1	0	0	0	0	0	0		
Neonatal Morbidity										
Still Births per 1000 Births	3.52/1000 (Mbrrace 2023)	rolling rate	2.93:1000	3.45:1000	3.81:1000	3.65:1000	3.85:1000	3.85:1000		Recently published ONS data reports national stillbirth rate is 3.9:1000 for EofE in 2022. MBRRACE benchmark due to be released 14 Dec 2023. No stillbirths in November.
Stillbirths - number ≥ 22 weeks	<3	<6	2	2	2	1	2	0		
Number of birth injuries	0	<1	0	1	1	2	0	0		
Babies born with an Apgar <7 at 5 minutes of age	For information	N/A	2.23%	1.66%	2.81%	1.59%	2.99%	1.28%		
Incidence of neonatal readmission	For information	N/A	3.83%	4.07%	4.74%	4.82%	8.26%	4.21%		
Term Admission to NICU Rate	<6%	N/A	4.0%	4.9%	4.9%	5.6%	5.7%	6.4%		Oct ATAIN rate updated following ATAIN reviews 27/11/23 - initially misreported as too high.

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

Maternity Dashboard

Quality										
1-1 Care in Labour	≥95%	≥90%	100.0%	100.0%	100.0%	99.8%	100.0%	99.6%		
Babies with a first feed of breastmilk	≥80%	≥70%	83.93%	83.37%	82.68%	81.41%	78.25%	80.73%		
SATOD (Smoking at Time of Delivery)	< 6%	Green = <6%, Amber = 6.1% - 7.9 %, Red = >8	4.72%	4.78%	4.78%	6.70%	5.98%	2.84%		
CO Monitoring at booking	≥95%	Green = ≥95%, amber = <95% and ≥84%, red = <85%	93%	89%	82%	87%	97%	91%		CO monitoring at every AN appointment introduced in Dec to encourage standardised practice and thereby improve compliance.
CO Monitoring at 36 weeks	≥95%	Green = >95%, amber = <95% and >84%, red = <85%	66%	62%	67%	60%	65%	76%		CO monitoring at every AN appointment introduced in Dec to encourage standardised practice and thereby improve compliance.
VTE Assessment - AN	≥95%	≥95%	68%	52%	72%	76%	78%	90%		Improving special cause.
VTE Assessment - PN	≥95%	≥95%	96%	98%	94%	95%	95%	96%		

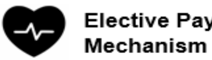
Finance

NHS Cambridge University Hospitals NHS Foundation Trust

Trust performance summary - Key indicators

Trust actual surplus / (deficit)

Value	
£6.8m	*Actual (adjusted)**
(£0.5m)	*Plan (adjusted)**
£3.0m	*Actual YTD (adjusted)**
£2.5m	*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	£20.4m	£144.5m
Target adj. block increase	£0.9m	£6.5m
EPM actual + block increase	£21.3m	£151.0m
EPM original plan	£22.3m	£161.6m
EPM original target	£20.4m	£149.1m

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

Net current assets

Value	
(£82.8m)	*Actual*
(£44.6m)	*Plan*

Debtor days

Value	
25	*This month*
20	*Previous month*

Payables performance (YTD) **

Value	
86.8%	*Value*
89.8%	*Quantity*

EBITDA

Value	
£31.6m	*Actual YTD*
£28.1m	*Plan YTD*

Capital expenditure

Value	
£4.6m	*Capital - actual spend in month*
£27.9m	*Capital - actual spend YTD*
£22.6m	*Capital – plan YTD*

Cash

Cash

Value	
£148.5m	*Actual*
£148.7m	*Plan*

Legend *£ in million* — *In month* (light green) — *YTD* (dark green)

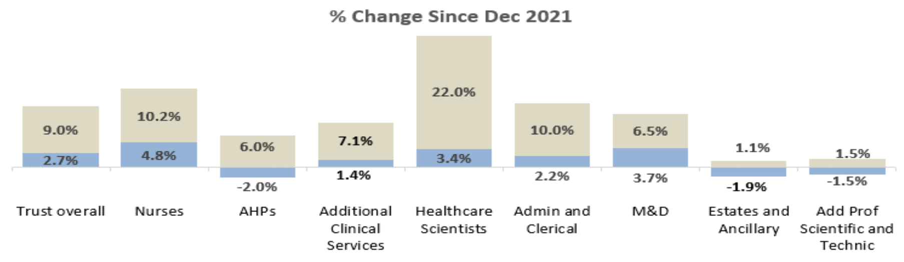
* On a control total basis, excluding the effects of impairments and donated assets
** Payables performance YTD relates to the Better Payment Practice Code target to pay suppliers within due date or 30 days of receipt of a valid invoice.

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

Staff in Post

12 Month Growth by Staff Group

Staff Group	Headcount		Headcount 12 Month growth		FTE		FTE 12 Month growth	
	Dec-22	Nov-23			Dec-22	Nov-23		
Add Prof Scientific and Technic	247	247	⇨	0.0%	223	223	0 ↑	0.1%
Additional Clinical Services	1,949	2,092	↑	7.3%	1,793	1,911	118 ↑	6.6%
Administrative and Clerical	2,430	2,607	↑	7.3%	2,233	2,402	169 ↑	7.6%
Allied Health Professionals	739	793	↑	7.3%	655	708	52 ↑	8.0%
Estates and Ancillary	364	375	↑	3.0%	353	364	11 ↑	3.3%
Healthcare Scientists	651	754	↑	15.8%	612	719	107 ↑	17.5%
Medical and Dental	1,735	1,772	↑	2.1%	1,636	1,668	33 ↑	2.0%
Nursing and Midwifery Registered	3,869	4,067	↑	5.1%	3,566	3,750	184 ↑	5.2%
Total	**11,984**	**12,707**	↑	**6.0%**	**11,070**	**11,745**	**675** ↑	**6.1%**



Admin & Medical Breakdown

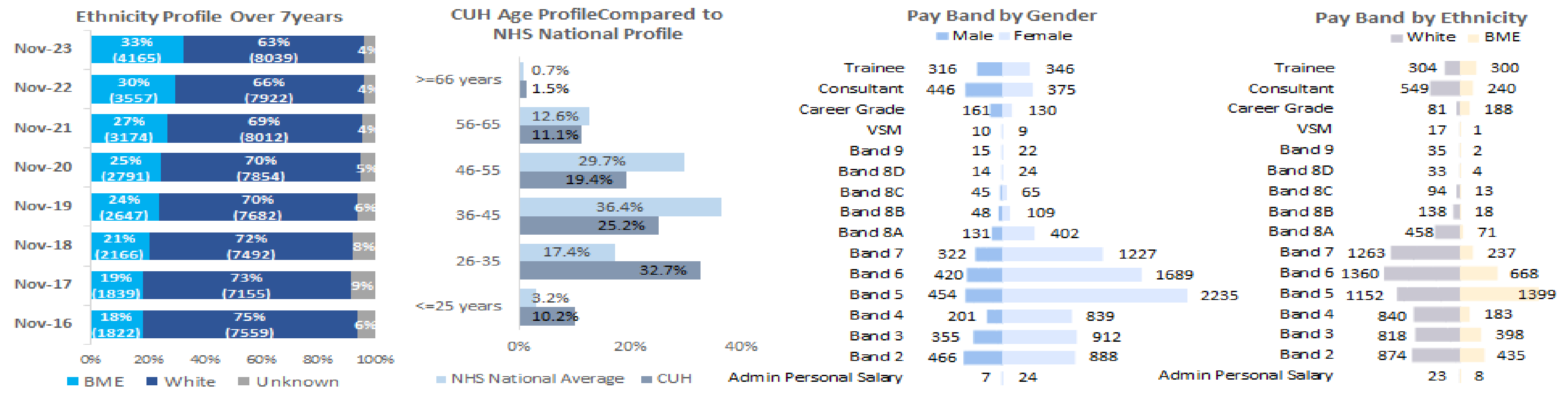
Staff Group	Dec-22	Nov-23	FTE 12 Month growth		
Administrative and Clerical	2,233	2,402	169	↑	7.6%
of which staff within Clinical Division	1,090	1,171	81	↑	7.4%
of which Band 4 and below	753	794	42	↑	5.5%
of which Band 5-7	245	265	20	↑	8.2%
of which Band 8A	44	52	8	↑	17.2%
of which Band 8B	7	7	0	⇨	0.0%
of which Band 8C and above	41	53	12	↑	28.8%
of which staff within Corporate Areas	902	974	73	↑	8.1%
of which Band 4 and below	247	267	20	↑	8.0%
of which Band 5-7	426	472	46	↑	10.7%
of which Band 8A	87	91	4	↑	4.8%
of which Band 8B	53	51	-2	↓	-3.7%
of which Band 8C and above	89	94	5	↑	5.9%
of which staff within R&D	241	256	15	↑	6.1%
Medical and Dental	1,636	1,668	33	↑	2.0%
of which Doctors in Training	669	667	-3	↓	-0.4%
of which Career grade doctors	248	257	9	↑	3.7%
of which Consultants	718	745	26	↑	3.7%

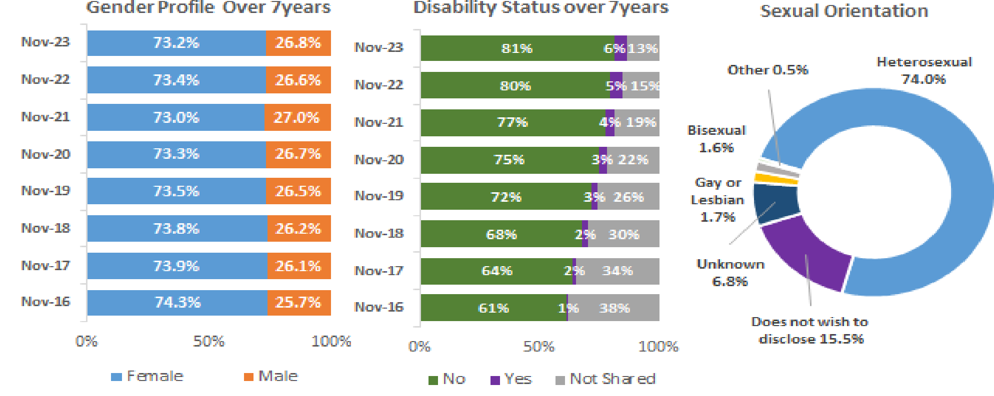
What the information tells us:

Overall the Trust saw a 6.1% growth in its substantive workforce over the past 12 months and 9% over the past 24 months. Growth over the past 12 months is lowest within the Additional Professional, Scientific and Technical staff group, with an increase of 0.1%, and highest within Healthcare Scientists at 17.5%. 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.

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

Equality Diversity and Inclusion (EDI)



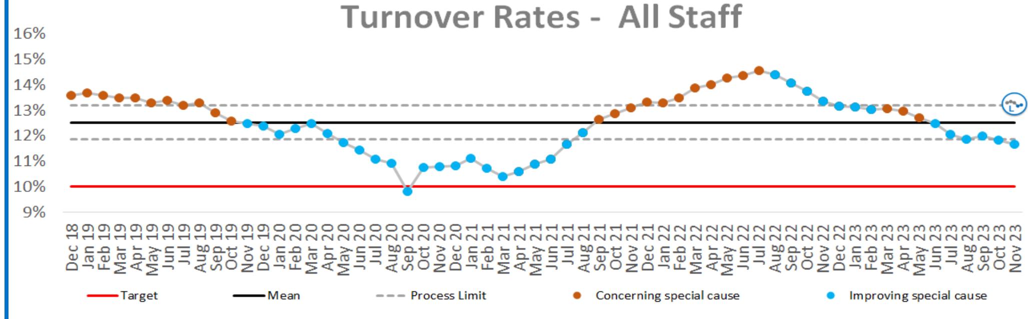


What the information tells us:

- CUH has a younger workforce compared to NHS national average. The majority of our staff are aged 26-45 which accounts for 58% of our total workforce.
- The percentage of BME workforce increased significantly by 15% over the 7 year period and currently make up 33% 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 4.7% to 5.5% over the seven year period. However, there are still significant gaps between the data recorded about our staff on ESR compared with the information staff share about themselves when completing the National Staff Survey.
- There remains a high proportion of staff who have, for a variety of reasons, not shared their sexual orientation.

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

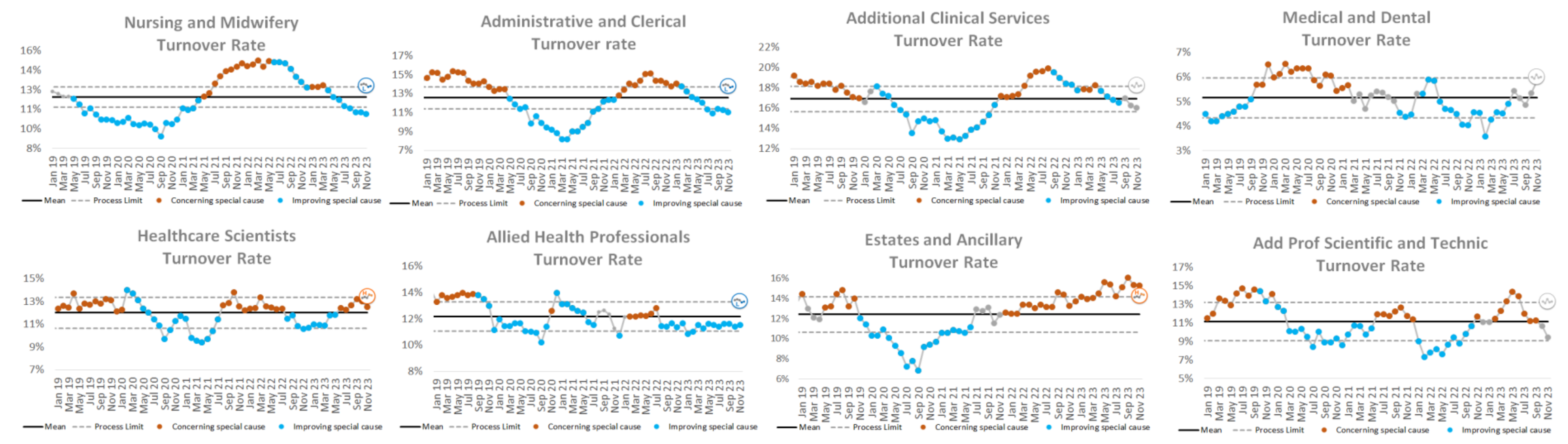
Staff Turnover



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

What the information tells us:

After a steady increase from March 2021 the Trust turnover rate has been decreasing since July 2022 - this month at 11.7% (0.1% 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 3.2% to 15.2% 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 (3.9% and 3.1% reductions respectively). Within the staff groups, Additional Clinical Services have the highest turnover rate at 16% followed by Estates and Ancillary staff at 15.2%.



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

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

Nursing and Midwifery Turnover Rate

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

Healthcare Assistant (incl. MCA) Turnover Rate

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

Nursing (Excluding midwives) Turnover Rates

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

Healthcare Assistant (excl. MCA) Turnover Rate

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

Midwife Turnover Rates

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

Maternity Care Assistants (MCA) Turnover rates

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

CUH Ethnicity Profile Compared to Ethnicity Profile of Leavers

BME 50% 30% 30%
White 46% 66% 67%
Unknown 4% 4% 4%

CUH Disability Status Compared to Disability Status of Leavers

Yes 7% 7% 6%
No 78% 83% 80%
Not Shared 15% 11% 14%

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

Mode LoS 0.3 yrs
Median LoS 3.3 yrs
Mean LoS 5.4 yrs

0 5 10 15 20 25 30

0 1 2 3 4 5 6 7 8 9 10 12 13 15 16 19 20 23 28 43

Years of Service

CUH Age Profile Compared to Age Profile c Starters and Leavers

>=66 years 0% 4% 1%
56-65 3% 9% 12%
46-55 9% 12% 21%
36-45 18% 20% 24%
26-35 37% 35% 31%
<=25 years 32% 19% 10%

CUH Gender Profile Compared to Gender Profile of Starters and Leavers

Male 26% 23% 25%
Female 74% 77% 75%

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

% of leavers with less than 2 years' service
% across all staff groups 38%

0% 10% 20% 30% 40% 50% 60%

Add Prof Scientific and Technic 25%
Additional Clinical Services 54%
Administrative and Clerical 39%
Allied Health Professionals 32%
Estates and Ancillary 40%
Healthcare Scientists 21%
Medical and Dental 18%
Nursing and Midwifery Registered 34%

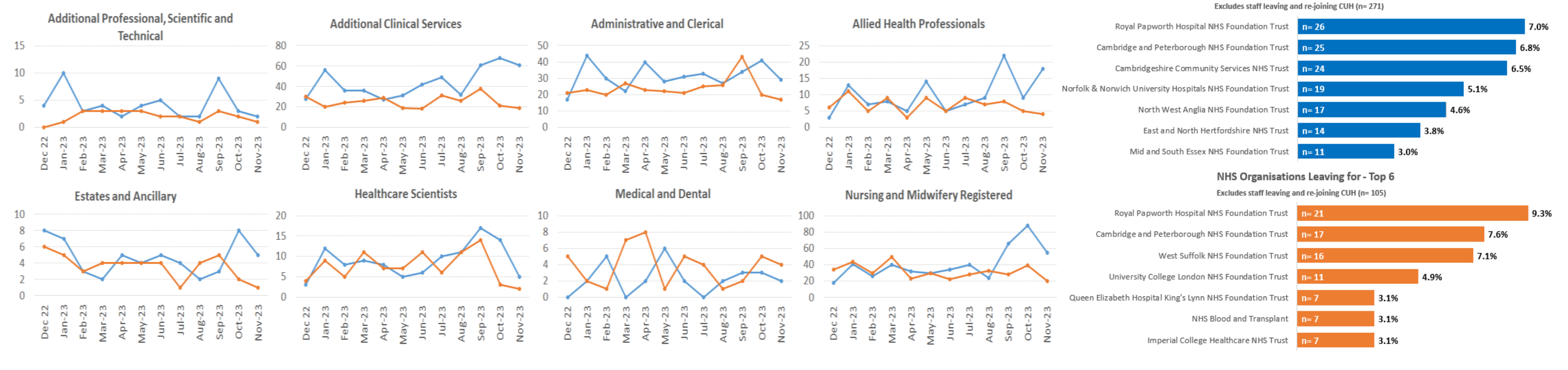
What the information tells us:

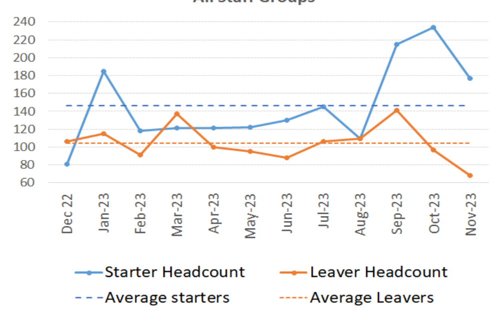
The majority of starters to, and leavers from the Trust in the last 12 months were aged 35 yrs. or under (69% and 54% respectively), which are higher than the proportion of staff in post of this age (41%). Gender and disability status are generally equally represented in the starters and leavers data 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. 50% of our starters in the last 12 months were from black and minority ethnic groups, compared to 30% 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 - 54%. The most common length of service (mode) upon leaving has dropped to just under 4 months (0.33 yrs) – in the last 12 months 28 (headcount) of the 1,156 leavers who were on permanent contracts left at this point . Of these 28, 39% were Administrative and Clerical and 36% were Additional Clinical Services staff group. The average (mean) length of service remains at 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.)

Starters & Leavers - Last 12 months





Top 10 Leaving Reasons Excludes staff leaving and re-joining CUH (n= 105)	Number of Leavers (Headcount)	% of all Leavers
Voluntary Resignation - Relocation	374	30%
Voluntary Resignation - Work Life Balance	247	20%
Voluntary Resignation - Promotion	137	11%
Voluntary Resignation - Other/Not Known	95	8%
Voluntary Resignation - Better Reward Package	88	7%
Retirement Age	73	6%
Voluntary Resignation - Health	53	4%
End of Fixed Term Contract	33	3%
Voluntary Resignation - Child Dependants	31	2%
Voluntary Resignation - Lack of Opportunities	28	2%

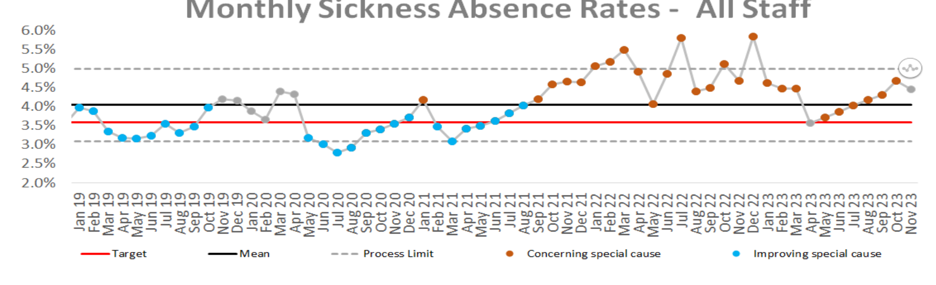
What the information tells us:

The top three reasons for leaving are Voluntary Resignation - due to relocation (30%), for work/life balance (20%) and for promotion (11%). 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, and join from, is Royal Papworth NHS Foundation Trust. 13.8% of starters to the Trust were from Royal Papworth NHS Foundation Trust or Cambridge and Peterborough NHS Foundation Trust.

In the month of November alone the most popular destinations on leaving (other than unknown) were to another NHS organisation, or to no employment, with a total of 23.5% of leavers in that month citing one of these reasons on the P4 leavers form (16 individuals, of whom 44% had less than 2 years' service at CUH).

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

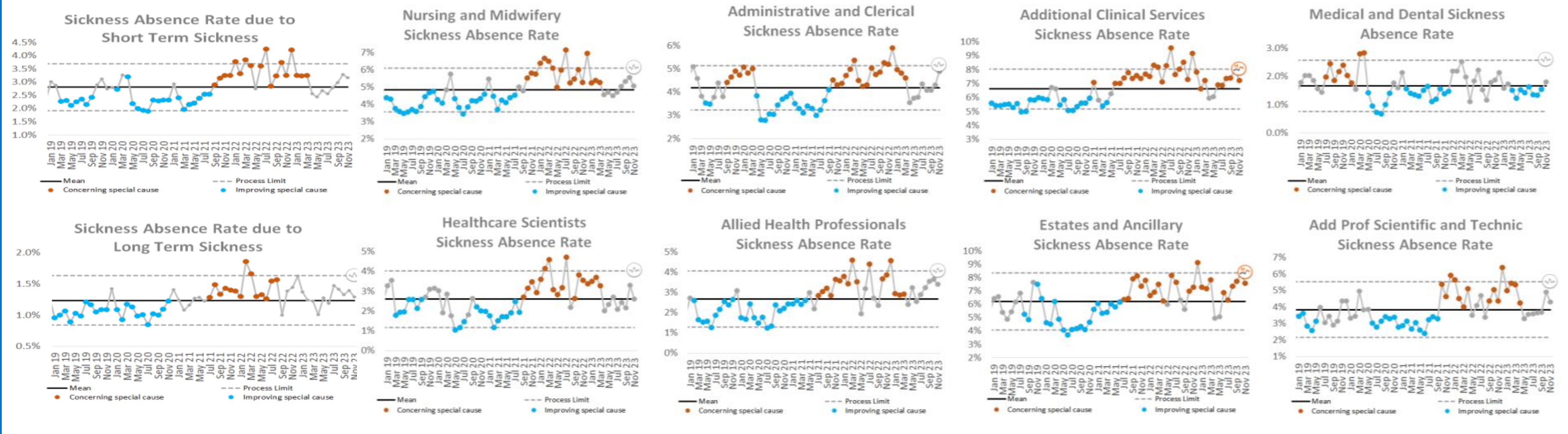
Sickness Absence



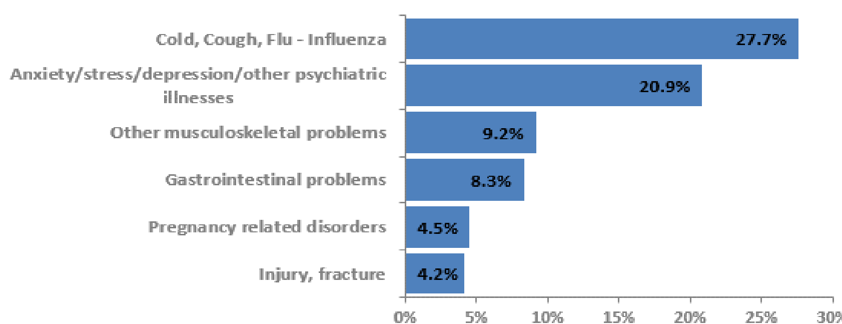
Background Information: Sickness Absence is a monthly metric and is calculated as the percentage of FTE days missed in the organisation due to sickness during the reporting month.

What the information tells us: The overall monthly sickness absence has decreased by 0.2% since last month, to 4.5% in November 2023. This is 0.2% lower than the same month last year (4.7%). The sickness absence rate due to short term illness is higher at 3.2% compared to long term sickness at 1.3%.

Estates and Ancillary staff group has the highest sickness absence rate at 7.6% (0.3% higher than 12 months ago), followed by Additional Clinical Services at 7.2% in November 2023.



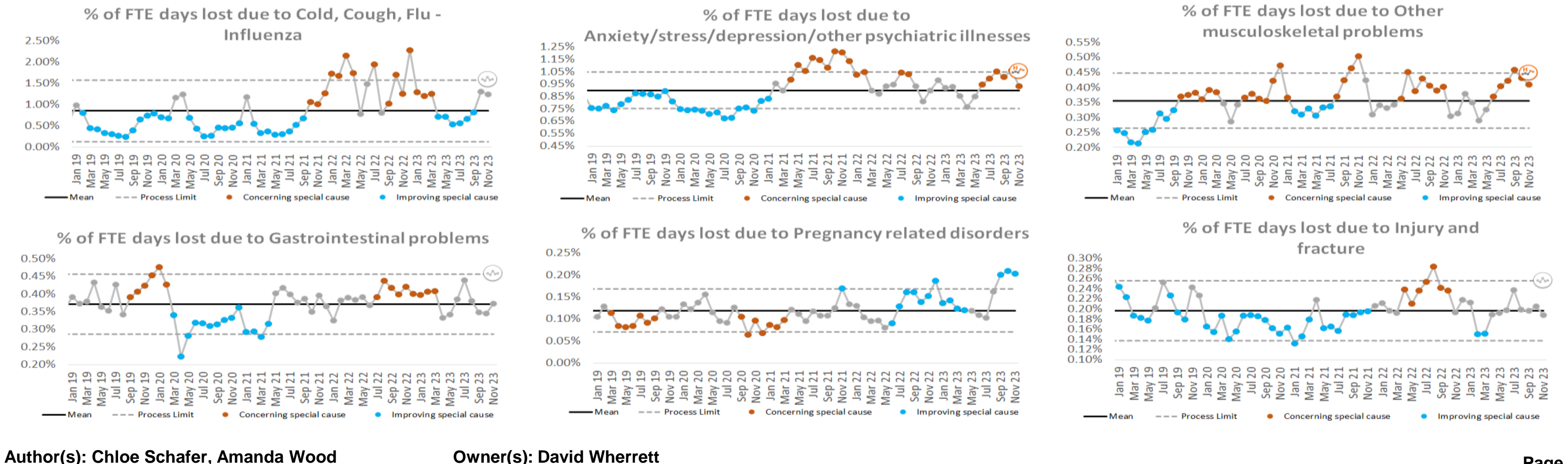
Top Six Sickness Absence Reason



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

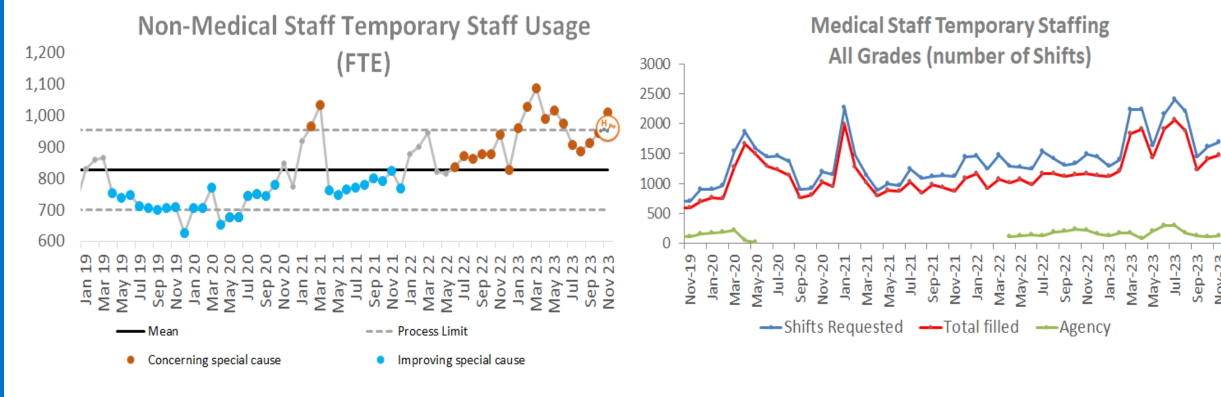
What the information tells us: The top reason for sickness absence in October 2023 is Cold, Cough, Flu - Influenza, with an absence rate of 1.3%. This is 0.5% higher than last month, but 0.4% lower than September last year. As a percentage of all sickness absence Cold, Cough, Flu - Influenza accounts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



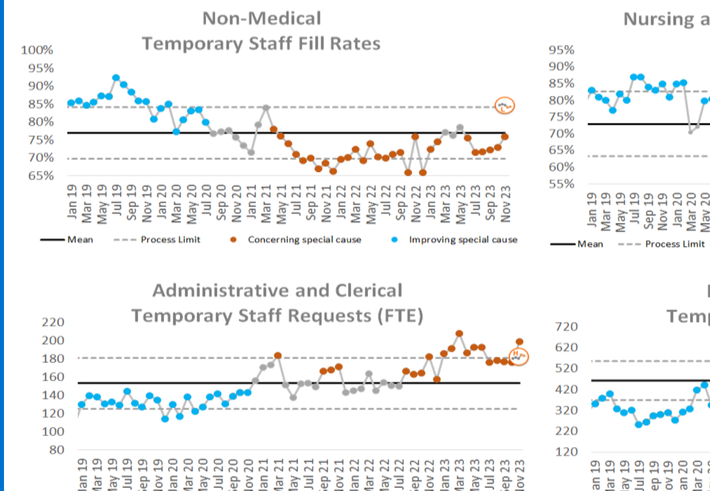
Author(s): Chloe Schafer, Amanda Wood
Owner(s): David Wherrett

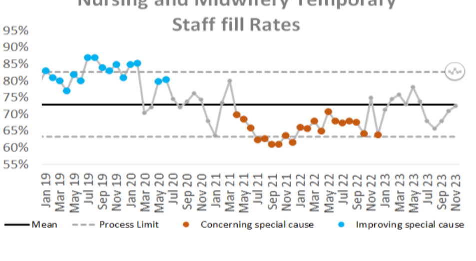
Temporary Staffing

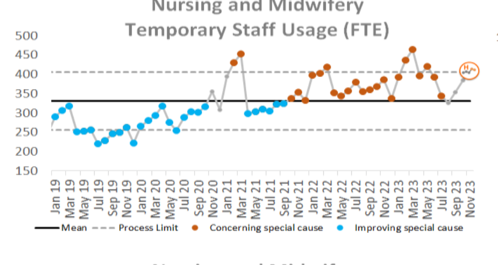


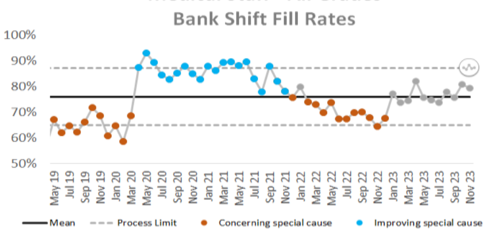
Background Information: The Trust works to ensure that temporary vacancies are filled with workers from staff bank in order to minimise agency usage, ensure value for money and to ensure the expertise and consistency of staffing.

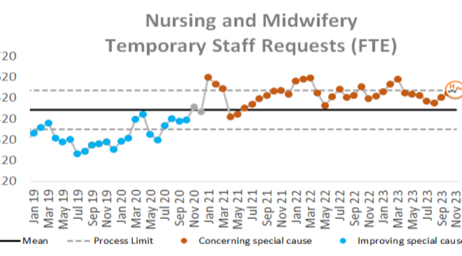
What the information tells us: Overall non-medical fill rates have increased again from last month, with a 2.4% increase in requests and a 6.8% increase in FTE worked in November 2023. Top three reasons for request are vacancy (45%), increased workload (23%) and sickness requiring cover (15%). Nursing and midwifery agency usage increased by 2.8 WTE from the previous month to 18.2 WTE. This accounts for 4% of the total nursing filled shifts. Demand for temporary medical staff increased by 5% from October. Fill rate remained stable at 87%, with 217 shifts unfilled.

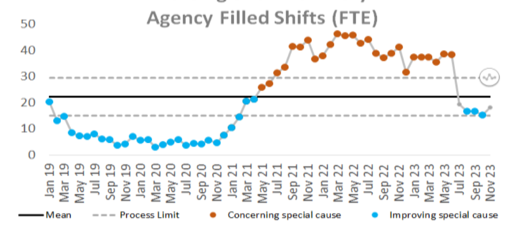


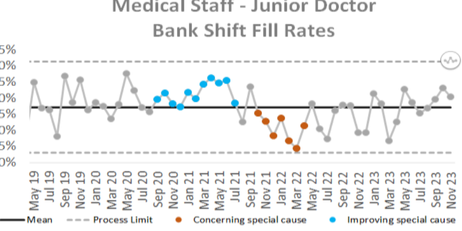




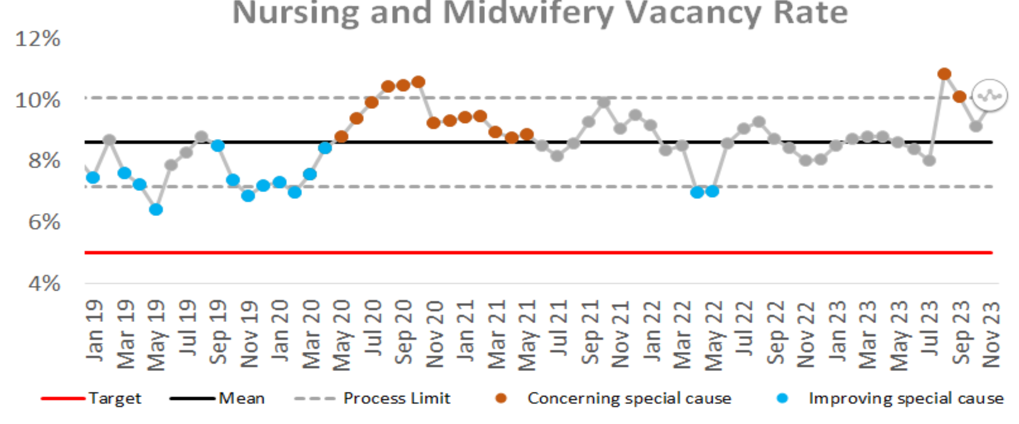


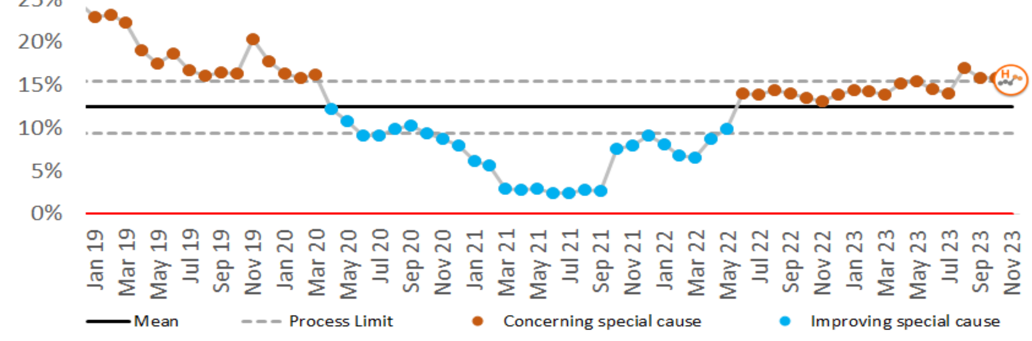






ESR Vacancy Rate





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

What the information tells us: 2023/24 budgets were loaded to ESR for Clinical and Corporate Divisions from August 2023, which increased the establishment for both Nursing and Midwifery and Healthcare Assistants. The new wards and theatres for the Surgical Movement Hub opened in November, increasing the Nursing and Health Care Support Worker establishments again this month.

The vacancy rate for Nursing and Midwifery has increased from last month to 9.9% as at end of November, which is 1.9% higher than the same month last year. The vacancy rate for Healthcare Assistants is 14.8% as at end of November - a decrease of 1.1% from last month, and 1.7% higher than November last year.

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 – November 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	48,079	28,117	58.5%	98%
	Additional Clinical Services	376,991	241,206	64.0%	97%
	Administrative and Clerical	512,322	310,174	60.5%	96%
	Allied Health Professionals	154,684	95,568	61.8%	99%
	Estates and Ancillary	77,759	51,156	65.8%	98%
	Healthcare Scientists	155,970	90,610	58.1%	97%
	Medical and Dental	140,066	54,420	38.9%	31%
	Nursing and Midwifery Registered	809,157	522,386	64.6%	99%
	Trust	**2,275,028**	**1,393,638**	61.3%	88%
	Division				
Annual Leave taken by Division	Corporate	319,483	193,356	60.5%	96%
	Division A	426,443	261,901	61.4%	87%
	Division B	633,534	379,495	59.9%	93%
	Division C	284,449	172,806	60.8%	81%
	Division D	258,120	162,513	63.0%	84%
	Division E	249,269	164,044	65.8%	84%
	R&D	103,730	59,523	57.4%	95%

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

What the information tells us: The Trust's annual leave usage is at 92% of the expected usage at the end of the eighth month of the financial year. The highest rate of use of annual leave is within the Estates and Ancillary staff group, at 65.8%, followed by Nursing and Midwifery Registered at 64.6%.

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

Background Information: Statutory and Mandatory training are essential for the safe and efficient delivery of the organisatio n 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

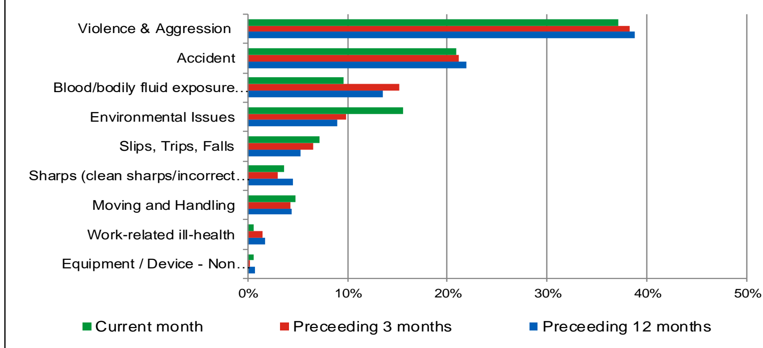
Thresholds for **Core Mandatory** training excl. Information Governance incl. GDPR & Cyber Security training: Less than 75% | 75% to 89% | 90% or higher

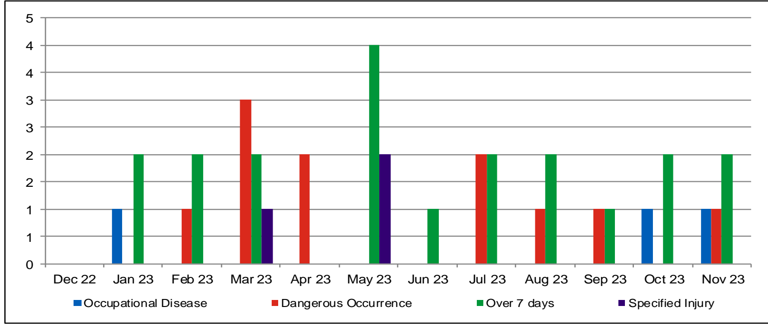
		No. Staff Requiring Competency	Frequency	Delivery Method	Trust Total	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental		Nursing and Midwifery Registered
												Consultant	Non-Consultant	
Ind'tn	Corporate Induction	1,434	3 yrs	el	(40)96.1%	(0)100.0%	(17)93.9%	(5)98.0%	(3)95.9%	(2)94.3%	(0)100.0%	(4)90.9%	(100)73.1%	(13)95.2%
	Local Induction	1,434	3 yrs	el	(310)78.4%	(2)92.6%	(59)78.9%	(51)80.0%	(11)85.1%	(3)91.4%	(14)81.6%	(12)72.7%	(97)73.9%	(61)77.5%
Other Core Mandatory	Conflict Resolution	11,530	3 yrs	el	(234)98.0%	(3)98.7%	(19)99.0%	(25)99.0%	(8)98.9%	(3)99.1%	(4)99.4%	(30)96.2%	(89)89.5%	(53)98.5%
	Equality, Diversity and Human Rights	11,530	3 yrs	el	(279)97.6%	(4)98.3%	(21)98.9%	(33)98.6%	(11)98.5%	(5)98.5%	(7)99.0%	(29)96.3%	(98)88.5%	(71)98.0%
	Health, Safety and Welfare	11,530	3 yrs	el	(296)97.4%	(2)99.1%	(28)98.5%	(36)98.5%	(8)98.9%	(5)98.5%	(6)99.1%	(29)96.3%	(111)86.9%	(71)98.0%
	Information Governance including GDPR and Cyber Security	11,530	1 yr	el	(601)94.8%	(6)97.4%	(100)94.6%	(55)97.7%	(26)96.4%	(19)94.5%	(19)97.3%	(57)92.7%	(150)82.3%	(169)95.3%
	Basic Prevent Awareness	9,676	3 yrs	el	(302)96.9%	(3)98.6%	(26)98.5%	(57)97.7%	(9)98.6%	(5)98.5%	(6)99.1%	(19)96.7%	(129)79.1%	(48)98.0%
	Prevent Level Three (WRAP)	1,848	3 yrs	el	(159)91.4%	(0)100.0%	(10)93.4%	(0)100.0%	(3)95.2%		(0)100.0%	(8)96.1%	(60)73.5%	(78)93.4%
Resuscitation	Adult Basic Life Support Practical - 1 Year	390	1 yr	f2f	(76)80.5%		(19)80.4%	(1)0.0%	(0)100.0%					(56)80.6%
	Adult Basic Life Support Practical - 2 Year	7,178	4 yrs	f2f	(830)88.4%	(2)93.9%	(150)88.9%	(2)92.6%	(37)94.8%		(4)96.6%	(127)83.7%	(288)66.1%	(220)93.3%
	Advanced Life Support	11	4 yrs	f2f	(4)63.6%				(0)100.0%					(4)60.0%
	Advanced Paediatric Life Support	105	2 yrs	f2f	(46)56.2%									(46)56.2%
	Basic Life Support e-learning	7,537	1 yr	el	(761)89.9%	(2)93.9%	(108)92.4%	(3)89.3%	(45)93.7%		(8)93.3%	(80)89.7%	(250)70.6%	(265)92.6%
	Immediate Life Support (ILS)	645	1 yr	f2f	(132)79.5%		(2)50.0%				(4)77.8%			(126)79.8%
	Newborn Basic Life Support (NBLS)	541	1 yr	Blended	(201)62.8%	(1)0.0%	(36)54.4%	(1)0.0%				(6)62.5%	(6)80.6%	(151)63.4%
	Paediatric Basic Life Support (PBLS)	2,543	1 yr	Blended	(549)78.4%	(0)100.0%	(195)66.4%		(53)92.5%		(5)94.5%	(36)70.0%	(49)60.5%	(211)76.7%
	Paediatric Immediate Life Support (PILS)	372	1 yr	f2f	(92)75.3%				(0)100.0%					(92)75.1%
Fire	Fire Evacuation	5,780	1 yr	f2f/el	(736)87.3%	(1)94.1%	(200)86.1%	(1)96.0%	(53)90.5%	(10)87.8%	(1)97.7%			(470)87.0%
	Fire Safety Awareness	11,530	2 yrs	el	(429)96.3%	(3)98.7%	(48)97.4%	(39)98.4%	(18)97.5%	(9)97.4%	(10)98.6%	(36)95.4%	(153)82.0%	(113)96.9%
Infect Ctrl	Infection Prevention and Control - Level 1 - 2 Years	4,382	2 yrs	el	(186)95.8%	(0)100.0%	(10)96.6%	(54)97.7%	(1)98.7%	(14)95.9%	(8)98.7%	(1)95.5%	(72)79.4%	(26)90.7%
	Infection Prevention and Control - Level 2 - 2 Years	7,149	2 yrs	el	(252)96.5%	(2)98.9%	(35)97.7%	(0)100.0%	(16)97.5%	(0)100.0%	(1)98.9%	(43)94.3%	(77)84.6%	(78)97.7%
Moving & Handling	Moving and Handling - Level 1	11,530	2 yrs	el	(532)95.4%	(2)99.1%	(73)96.0%	(54)97.8%	(22)96.9%	(6)98.3%	(9)98.7%	(53)93.2%	(161)81.0%	(152)95.8%
	Moving and Handling - Level 2	5,822	2 yrs	f2f	(831)85.7%	(4)76.5%	(225)84.7%	(3)78.6%	(48)92.3%		(6)93.2%			(545)84.9%
	Patient Moving and Handling - e-learning	5,824	1 yr	el	(301)94.8%	(1)94.1%	(73)95.0%	(1)92.3%	(22)96.5%		(2)97.7%			(202)94.4%
Safeg'dg Adults	Safeguarding Adults - Level 1	7,727	3 yrs	el	(299)96.1%	(4)98.2%	(39)97.9%	(52)97.9%	(2)98.4%	(3)99.1%	(10)98.6%	(12)84.4%	(111)39.0%	(66)96.3%
	Safeguarding Adults - Level 2	4,164	3 yrs	el	(301)92.8%	(4)97.9%	(36)97.6%	(14)90.1%	(5)96.0%		(1)99.4%	(12)84.2%	(143)21.4%	(86)95.2%
	Safeguarding Adults - Level 3	3,965	3 yrs	el	(1213)69.4%	(0)100.0%	(1)75.0%	(1)0.0%	(104)82.6%		(0)100.0%	(206)71.2%	(405)49.9%	(496)72.9%
Safeg'dg Children	Safeguarding Children - Level 1	11,530	3 yrs	el	(410)96.4%	(3)98.7%	(43)97.7%	(52)97.9%	(13)98.2%	(6)98.3%	(9)98.7%	(26)96.7%	(152)82.1%	(106)97.1%
	Safeguarding Children - Level 2	7,955	3 yrs	el	(448)94.4%	(7)96.5%	(56)96.2%	(16)89.2%	(22)96.9%		(1)99.4%	(28)96.4%	(171)79.9%	(147)95.9%
	Safeguarding Children - Level 3	1,506	3 yrs	f2f/el	(234)84.5%	(0)100.0%	(14)85.6%	(3)75.0%	(9)86.2%		(0)100.0%	(14)92.8%	(46)72.8%	(148)84.3%
	Safeguarding Children - Level 3 - 1 Year	334	1 yr	f2f/el	(43)87.1%		(12)78.2%	(0)100.0%				(2)84.6%	(9)52.6%	(20)91.9%
Overall Compliance					93.5%	98.1%	94.6%	98.0%	95.5%	97.6%	98.5%	91.9%	76.7%	93.2%

Health and Safety Incidents

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:	**1971**	**397**	**304**	**618**	**304**	**206**	**56**	**86**
Accident	**433**	100	96	106	60	35	11	25
Blood/bodily fluid exposure (dirty sharps/splashes)	**268**	86	52	52	31	40	5	2
Environmental Issues	**176**	33	45	26	25	27	7	13
Equipment / Device - Non Medical	**15**	4	1	4	5	1	0	0
Moving and Handling	**87**	22	11	16	22	7	2	7
Sharps (clean sharps/incorrect disposal & use)	**88**	22	12	11	14	17	8	4
Slips, Trips, Falls	**105**	19	24	16	11	11	4	20
Violence & Aggression	**764**	100	61	385	126	58	19	15
Work-related ill-health	**35**	11	2	2	10	10	0	0





A total of 1,971 health and safety incidents were reported in the previous 12 months.

888 (45%) incidents resulted in harm. The highest reporting categories were violence and aggression (39%), accidents (22%) and blood/bodily fluid exposure (14%).

1,314 (67%) of incidents affected staff, 578 (29%) affected patients and 79 (4%) affected others ie contractors and members of the public.

The highest reported incident categories for staff were: violence and aggression (40%), blood/bodily fluid exposure (19%) and accidents (14%).

The highest reported incident categories for patients were: accidents (40%), violence & aggression (38%) and environmental issues (9%).

The highest reported incident categories for others were: slips, trips and falls (28%), violence & aggression (27%) 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 618 incidents. Of these, 62% related to violence & aggression.

In the last 12 months, the highest reported RIDDOR category was over 7 day injuries (54%). In the last 12 months, 62% of RIDDOR incidents were reported to the HSE within the appropriate timescale. In November 2023, 4 incidents were reported to the HSE:

Over 7 day injury:

- The Injured Person (IP) was assisting the doctor with rolling a patient for a lumbar puncture procedure. The patient became very distressed and feel backwards towards the doctor. The IP tried to hold the patient in position and injured their back. The IP has subsequently been off work for over 7 days.
- A patient required an NG tube insertion. Whilst attempting to undertake the tube insertion the patient became agitated and started to kick. The IP was kicked in their abdominal area. The IP has subsequently been off work for over 7 days.

Occupational disease:

- The affected person used Immersol-Zeiss microscope oil. The affected person has been diagnosed with dermatitis on their left han d. The affected person has recently moved to a new role and no longer uses the substance.

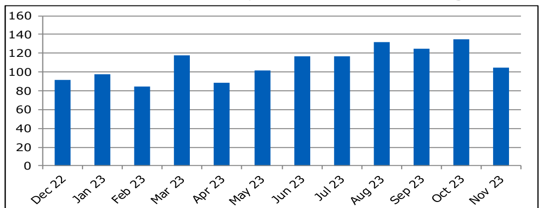
Dangerous occurrence:

- Agitated patient scratched IP and drew blood. The patient is Hep C positive. positive. Appropriate first aid was administered and follow up with occupational health.

Health and Safety Incidents

NHS Cambridge University Hospitals

No. of health and safety incidents affecting staff:

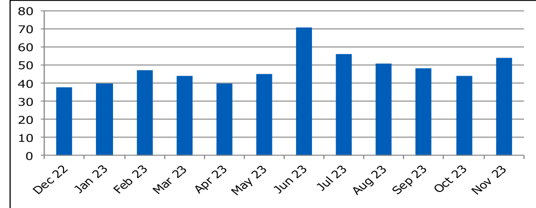


	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Total
Accident	14	12	14	21	13	13	14	14	23	17	20	13	**188**
Blood/bodily fluid exposure (dirty sharps/splashes)	20	20	12	20	18	22	23	14	22	23	36	16	**246**
Environmental Issues	6	4	2	8	8	10	14	7	17	10	7	13	**106**
Moving and Handling	2	5	8	9	3	5	7	5	4	7	2	7	**64**
Sharps (clean sharps/incorrect disposal & use)	5	5	7	3	10	3	7	7	8	3	5	5	**68**
Slips, Trips, Falls	4	8	7	4	6	8	3	10	5	10	9	9	**83**
Violence & Aggression	37	39	33	50	30	38	45	56	51	52	52	41	**524**
Work-related ill-health	4	5	1	3	1	3	4	4	2	3	4	1	**35**
Total	**92**	**98**	**84**	**118**	**89**	**102**	**117**	**117**	**132**	**125**	**135**	**105**	**1314**

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

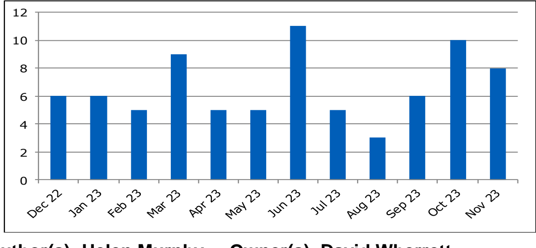
	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Total
No. of health & safety incidents	92	98	84	118	89	102	117	117	132	125	135	105	**1314**
Staff incident rate per month/year	0.7	0.8	0.7	1.0	0.7	0.8	0.9	0.9	1.1	1.0	1.1	0.9	**10.7**

No. of health and safety incidents affecting patients:



	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Total
Accident	19	19	17	21	13	19	29	14	20	18	21	19	**229**
Blood/bodily fluid exposure (dirty sharps/splashes)	3	2	0	1	3	2	2	2	0	2	4	0	**21**
Environmental Issues	7	3	5	1	2	4	6	3	4	2	4	12	**53**
Equipment / Device - Non Medical	1	2	1	0	0	1	2	6	1	0	0	1	**15**
Moving and Handling	2	1	4	2	1	2	3	0	1	2	4	1	**23**
Sharps (clean sharps/incorrect disposal & use)	1	0	2	3	2	0	4	3	0	2	0	1	**18**
Violence & Aggression	5	13	18	16	19	17	25	28	25	22	11	20	**219**
Total	**38**	**40**	**47**	**44**	**40**	**45**	**71**	**56**	**51**	**48**	**44**	**54**	**578**

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



	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Total
Accident	0	2	0	2	2	1	2	1	1	1	1	3	**16**
Blood/bodily fluid exposure (dirty sharps/splashes)	0	0	0	0	1	0	0	0	0	0	0	0	**1**
Environmental Issues	2	2	1	2	1	2	1	1	0	1	3	1	**17**
Sharps (clean sharps/incorrect disposal & use)	0	2	0	0	0	0	0	0	0	0	0	0	**2**
Slips, Trips, Falls	2	0	2	4	0	0	3	2	2	1	3	3	**22**
Violence & Aggression	2	0	2	1	1	2	5	1	0	3	3	1	**21**
Total	**6**	**6**	**5**	**9**	**5**	**5**	**11**	**5**	**3**	**6**	**10**	**8**	**79**

Board of Directors

Together
Safe
Kind
Excellent

Report to the Board of Directors: 17 January 2024

Agenda item	9.2
Title	Nurse safe staffing
Sponsoring executive director	Lorraine Szeremeta, Chief Nurse
Author(s)	Amanda Small, Deputy Chief Nurse Sarah Raper, Roster Support Lead Annesley Donald, Deputy Director of Workforce
Purpose	To provide the Board with the monthly nurse safe staffing report.
Previously considered by	Management Executive, 11 January 2024

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

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

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

Action required by the Board of Directors

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

Monthly Nurse Safe Staffing

Sponsoring executive director: Lorraine Szeremeta, Chief Nurse

Amanda Small, Deputy Chief Nurse

Christopher Gray, Lead Nurse Safer Staffing

Sarah Raper, Project Lead Nurse safe staffing

Together
Safe
Kind
Excellent

Board of Directors: 17 January 2024

Executive Summary

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

The vacancy position in November for Registered Nurses (RNs) has increased slightly from 9.9% in October to 10.6%. This increase is due in part to the opening of the new surgical hub and the electronic staff record (ESR) reflecting the increased establishment. In all other areas there has been a reduction in the vacancy rate. For registered children's nurses (RSCNs) the vacancy rate is 18.9% (20.1% in October), Health Care Support Workers (HCSWs) 14.8% (15.4% in October) and Maternity Care Assistants (MCAs) 19.3% (25.5% in October). The turnover rate in November remains high but has decreased in all areas with the exception of RMs which has increased slightly from 12.15% in October to 13.5% in November. RNs has reduced to 10.4% (10.8% in October), RSCNs to 14.2% (15.7% in October) and HCSWs (including MCAs) to 15.8% (16.3% in October). The main reason for leaving for all staff groups is voluntary resignation – relocation. The leavers destination data demonstrates that 27.5% of RNs and 35.1% of RMs are leaving to take up employment in other NHS organisations. 18.9% of RMs are leaving for no employment compared to 9.1% of RNs. Conversely, the leavers destination is unknown for the majority of HCSWs (46.2%). Midwifery vacancy rate for November 0.14% over recruited over all. There is also no gaps within the Specialist Midwifery staffing establishment since Birth Rate+ review in August 2022 with an overall over establishment of 0.27wte.

The planned versus actual staffing report demonstrates that 7 clinical areas reported <90% overall rota fill in November (15 in October). The overall fill rate for maternity has increased to 93.3% compared to 88% in October. The total unavailability of the workforce working time in November has decreased by 1.2% to 25.4%. The majority of unavailability (11.6%) is due to planned annual leave, sickness absence has reduced in November to 7.0% (7.7% in October). Additionally, 1.2% of working time was unavailable due to other leave, 3.4% was due to study leave and 2.10% was due to supernumerary time. With regards to midwifery where the overall fill rate has dropped this is mitigated through acuity assessment and redeployment of non clinical, managerial and specialist staff to cover gaps. Where safety concerns arise escalation to divert policy is activated to balance risk and maintain safety. During these incidences 1:1 care is maintained and supernumerary status of the coordinator as a priority.

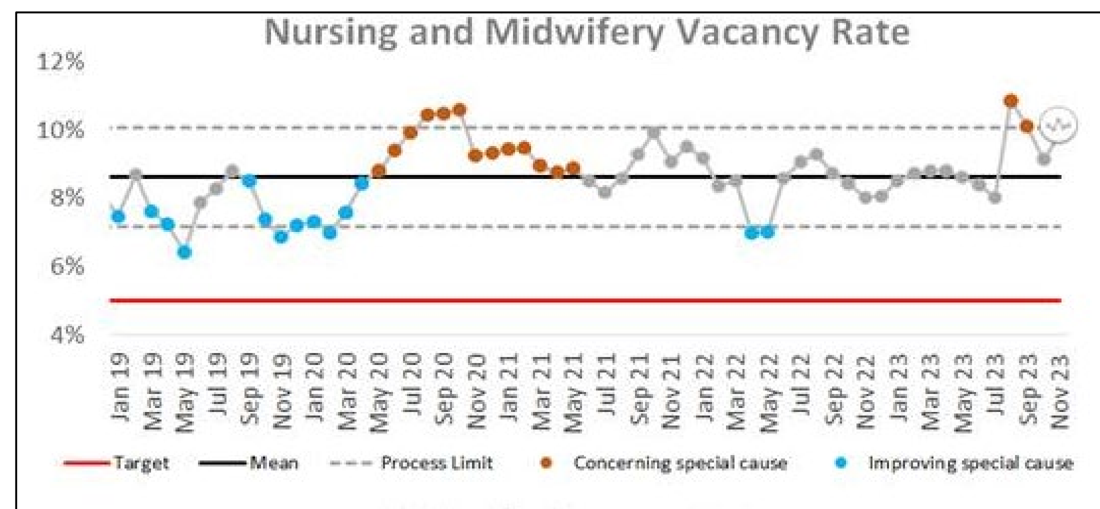
Executive Summary

In order to mitigate staffing risks, the number of requests for bank workers remains high with an average of 2639 shifts per week requested for registered staff and 2,441 shifts requested for Health care support workers and Maternity support workers per week with an average bank fill rate of 76.% for registered staff and 59.9% for Health Care Support workers. In addition, the equivalent of 13.09 WTE agency workers are working across the divisions (12.9 WTE in October). Despite this, redeployment of nurses and midwives has remained necessary due to staff unavailability, with an average of 335.882 working hours being redeployed each day of which there is a continued need to redeploy staff out of their division 144 hours in total (200 hours in October).

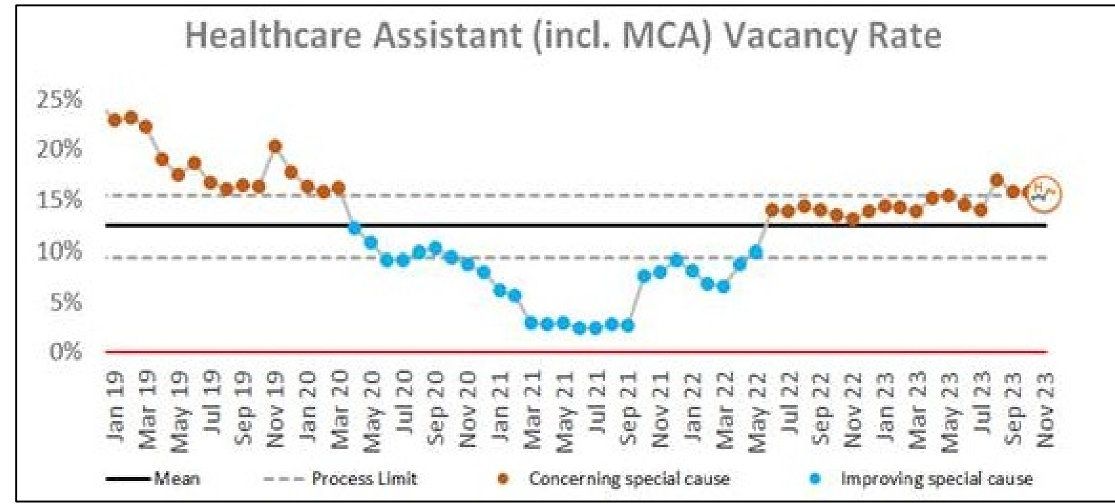
The number of occasions that 1 critical care nurse has needed to care for more than 1 level 3 patient has decreased in November to 4 occasions compared to 7 in October. Additionally, there have been 53 occasions in November where there has been no side room co-ordinator (74 in October). Any concerns with regards to critical care staffing are escalated through the senior nurse of the day. Staffing has been supported through the use of temporary workers (agency and bank), enhanced bank rates and registered staff (non critical care trained) are redeployed from the operational pool and clinical areas on a shift by shift basis. Critical care have opened 3 of the beds that were closed due to staffing resulting in 55 open beds rather than 59 beds. Recruitment is ongoing to the vacant positions with a plan to open the remaining 4 beds when vacancy allows.

Combined Nursing and Midwifery Staffing Position Vacancy Rates

Graph 1. Nursing and midwifery vacancy rates



Graph 2. Healthcare Assistant vacancy rates



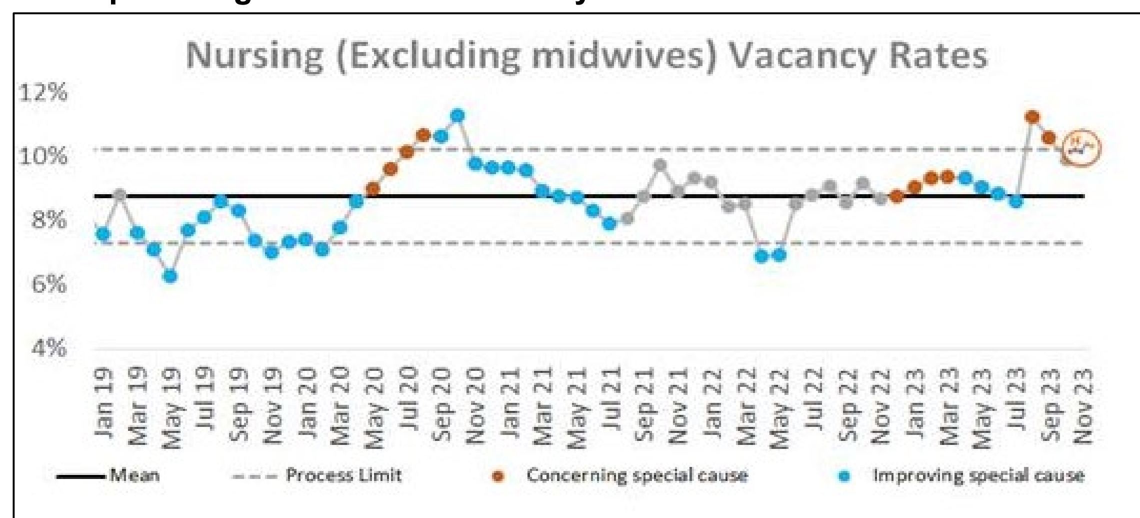
Vacancy position

The combined vacancy rate for Registered Nurses (RNs) and Registered Midwives (RMs) has increased slightly to 9.9% in November from 9.1% in October. This is due to the opening of the new surgical hub and the additional nursing posts being reflected in an increased nursing establishment on the electronic staff record (ESR). The vacancy rate for Health care support workers (HCSWs) (including Maternity Care Assistants (MCAs) has reduced to 14.8% in November (15.9% in October). When broken down further into Nursing and Midwifery specific vacancies, the MCA workforce vacancy rate has decreased to 19.3% for November from 25.5% in October. The HCSW vacancy rate (excl MCA) has also decreased to 14.8% from 15.4% in October.

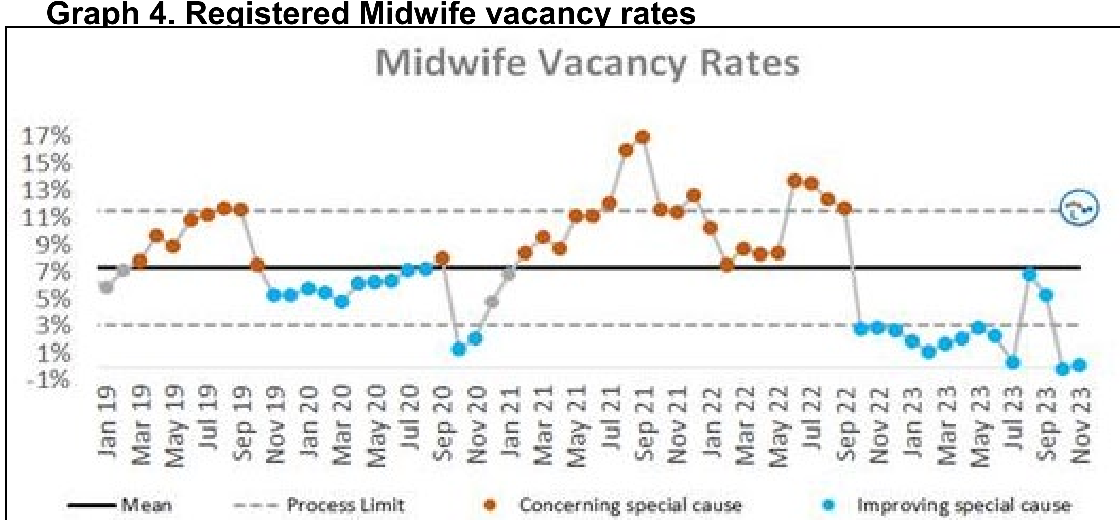
The HCSW (including MCAs) turnover rate remains high but is a decreasing trend (15.8% in November from 16.3% in October). The main reason for HCSWs leaving is voluntary resignation – relocation (32.3%) and the next highest reason is voluntary resignation – work life balance (25.1%). The leavers destination is unknown for the majority of HCSWs (46.2%), 15.4% of HCSWs are leaving to take up employment in other NHS organisations and 10.3% are leaving for no employment.

Staffing Position Vacancy Rates for Registered Nurses and Registered Midwives

Graph 3. Registered Nurse vacancy rates



Graph 4. Registered Midwife vacancy rates



Vacancy position

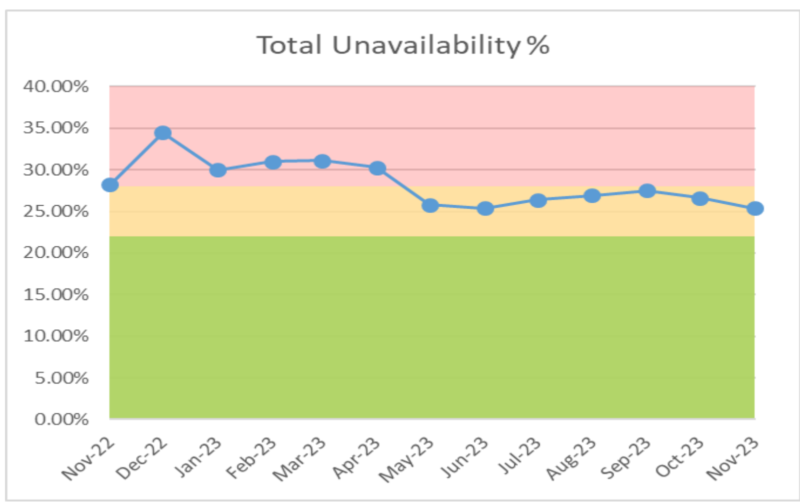
The vacancy rate for RNs working in adult areas has increased to 10.6% in November (9.9% in October) as illustrated in Graph 3, this is due in part to the opening of the surgical hub. Conversely, the vacancy rate for registered children's nurses has decreased to 18.9% compared to 20.1% in September.

The vacancy rate for Registered Midwives has increased to 0.14% for November compared to -0.1% in October as illustrated in Graph 4.

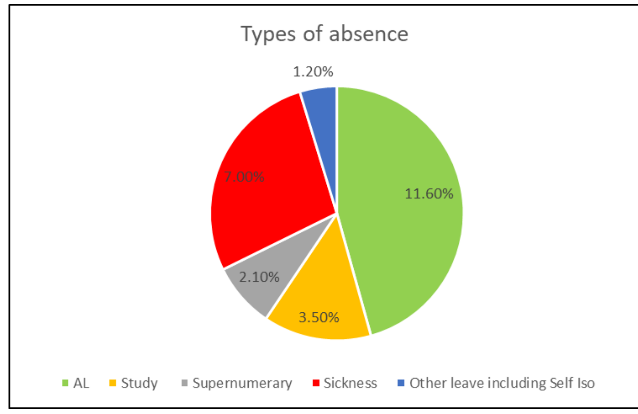
The turnover rate in November remains high but has slightly decreased to 10.4% for RNs in adult areas (10.8% in October) and to 14.2% for Registered children's nurses (15.7% in October). Conversely, turnover has increased for RMs to 13.5% (12.15% in October). The main reasons for RMs leaving is voluntary resignation – relocation (35.1%) and the next highest reason is voluntary resignation – work life balance (21.6%). The main reason for RN's leaving is voluntary resignation – relocation (41.3%). The leavers destination data demonstrates that 27.5% of RNs and 35.1% of RMs are leaving to take up employment in other NHS organisations. 18.9% of RMs are leaving for no employment compared with 9.1% of RNs.

Unavailability for Registered Nurses, Midwives and Health Care Support Workers

Graph 5. Unavailability of staff



Graph 6. Types of absence



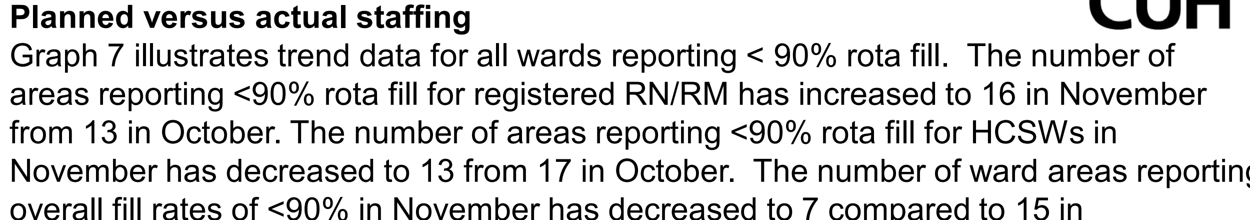
Unavailability of staff

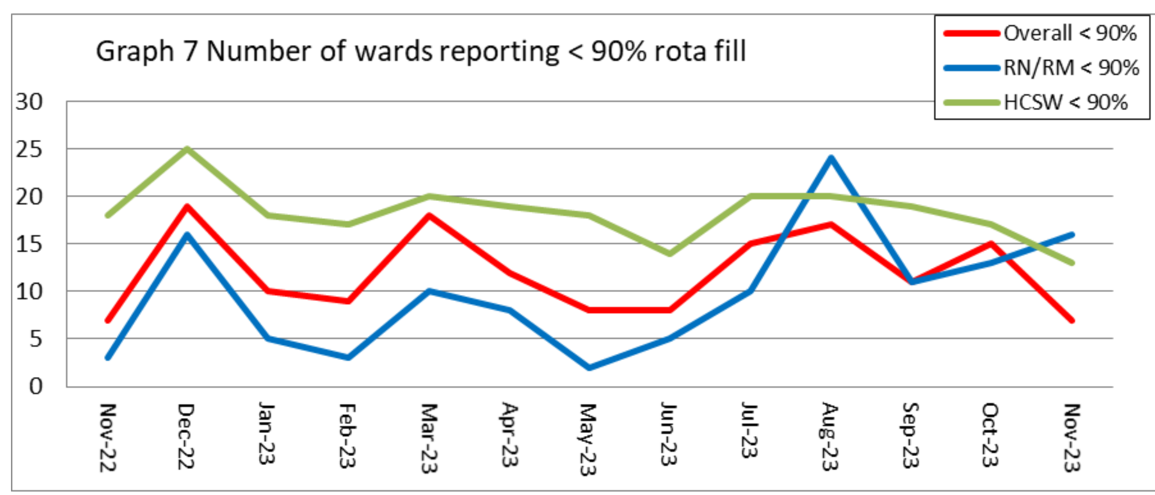
Unavailability relates to periods of time where an employee has been given leave from their regular duties. This might be due to circumstances such as annual leave, sick leave, study leave, carers leave etc.

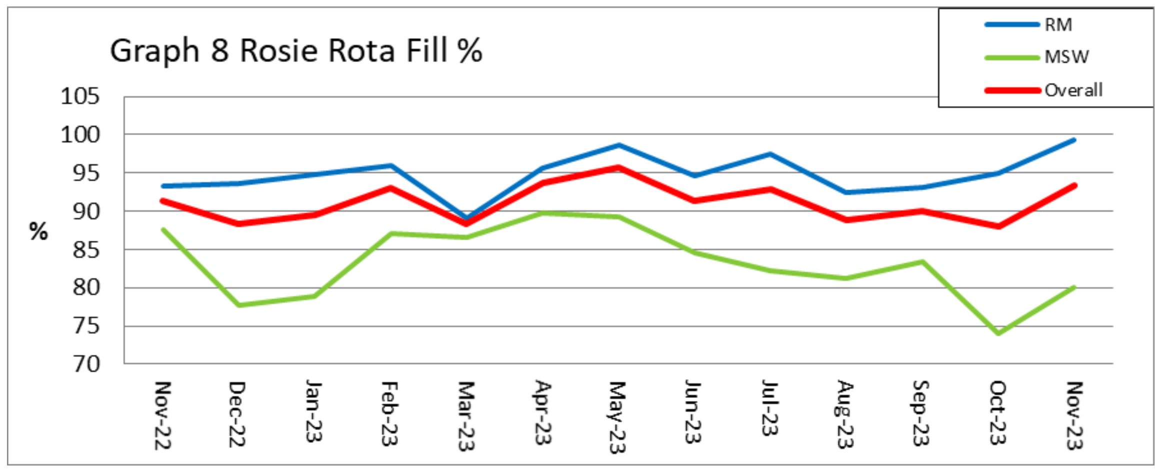
The total unavailability of the workforce working time in November 23 has decreased by 1.2% to 25.4% as illustrated in Graph 5.

Graph 6 illustrates the percentage breakdown of the type of unavailability. The majority of unavailability (11.6%) was due to planned annual leave which would have been accounted for in the department rosters. There was a high percentage of unplanned leave that would have impacted upon fill rates within the rosters. In November, sickness absence has remained high but has reduced slightly to 7.0% (7.70% in October). Other leave has remained static at 1.2%, 3.5% was due to study leave and 2.10% was due to supernumerary time.

Planned versus actual staffing







Planned versus actual staffing

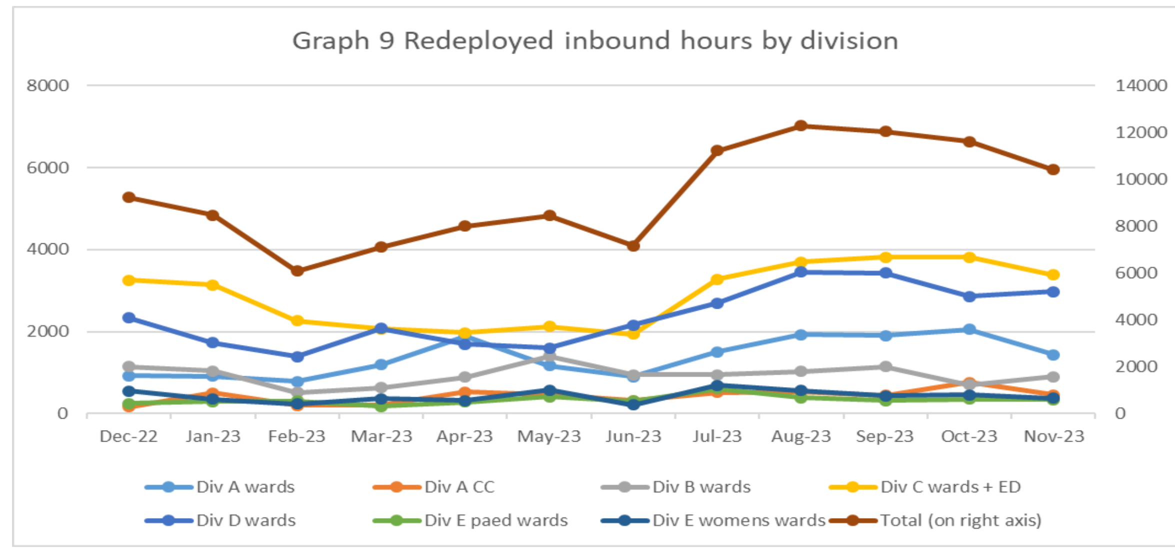
Graph 7 illustrates trend data for all wards reporting < 90% rota fill. The number of areas reporting <90% rota fill for registered RN/RM has increased to 16 in November from 13 in October. The number of areas reporting <90% rota fill for HCSWs in November has decreased to 13 from 17 in October. The number of ward areas reporting overall fill rates of <90% in November has decreased to 7 compared to 15 in October. Appendix 1. details the exception reports for all areas reporting RN/RM fill rates of <90%.

The number of occasions that 1 critical care nurse has needed to care for more than 1 level 3 patient has decreased in November to 4 occasions compared to 7 in October. Additionally, there have been 53 occasions in November where there has been no side room coordinator (74 in October). Any concerns with regards to critical care staffing is escalated through the senior nurse of the day. Staffing has been supported through the use of temporary workers (agency and bank) and registered staff (non critical care trained) are redeployed from the operational pool and clinical areas on a shift-by-shift basis. There was also short term agreement to pay critical care trained staff bank enhancement to reduce the over all amount of GPICS breaches. Critical care have opened 3 of the beds that were closed due to staffing resulting in 55 open beds rather than 59 beds. Recruitment is ongoing to the vacant positions with a plan to open the remaining 4 beds when vacancy allows.

Midwifery and MSW fill rate

Graph 8 illustrates that the overall fill rate for maternity has increased slightly to 93.3% in November form 88% in October which is higher than the 12-month average of 91.1%. The lowest fill rates have been seen on Lady Mary Ward (88%). Mitigated through redeployment of staff where required to meet acuity needs.

Staff deployment



Staff deployment

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

The number of substantive staff redeployed has continued to reduce after the increasing trend over 3 months of July to September with 335.882 working hours being redeployed per day in November (374.6 hours in September). This equates to 29.21 long day or night shifts per day. 144 of these hours were redeployments made outside of staff members own division to support patient safety (October 200 hours). Staffing is also being supported by the operational pool whereby bank staff book a bank shift on the understanding that they will work anywhere in the trust where support is required.

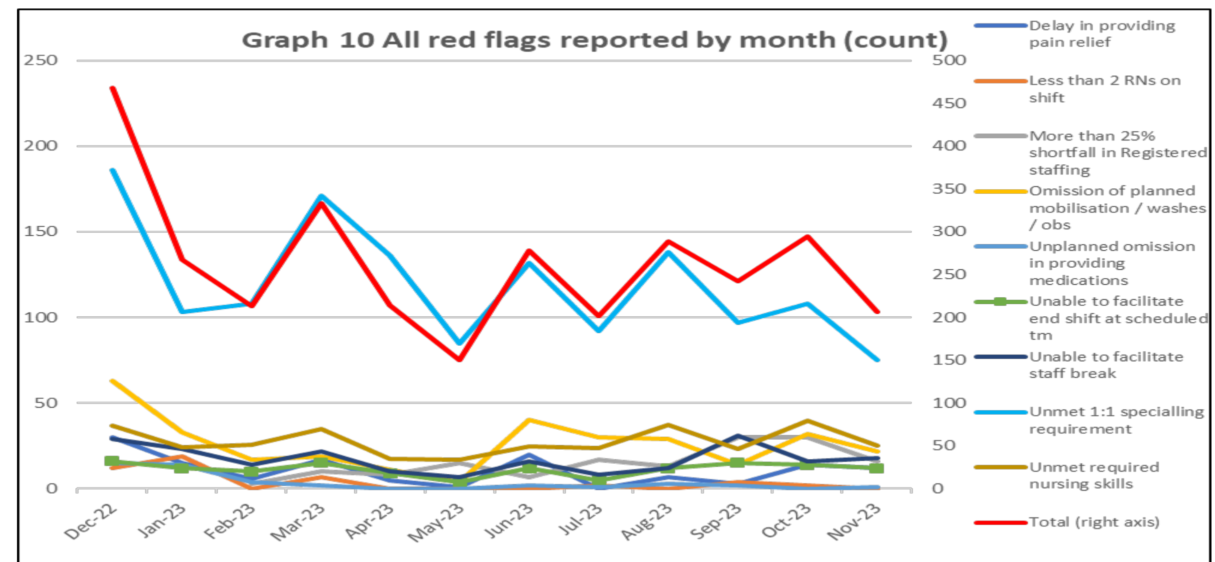
Nursing Pipeline

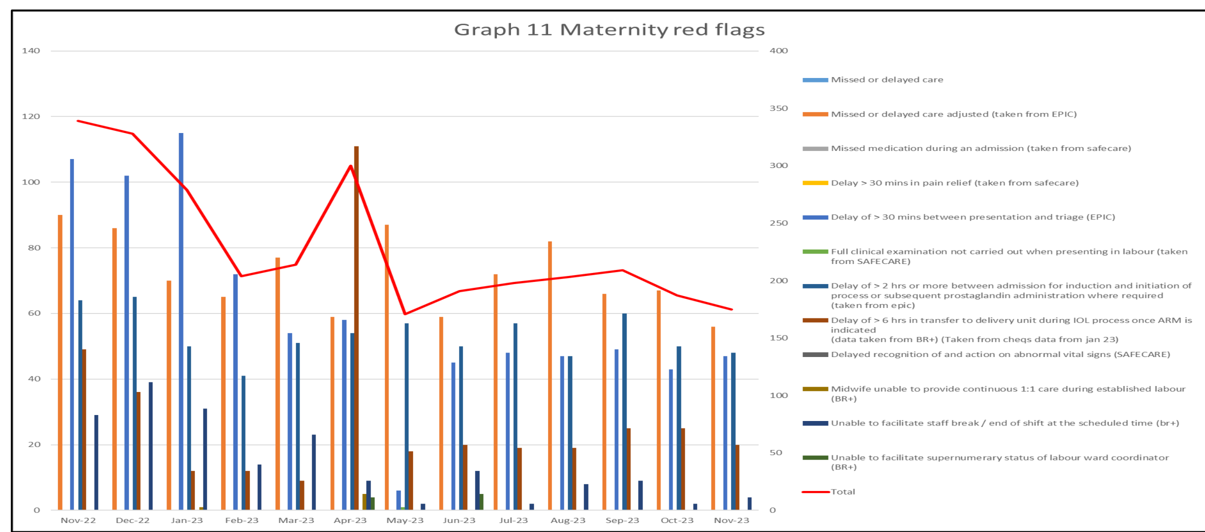
Appendix 2 provides detail on the forecasted position in relation to the number of adult RN vacancies based on FTE and includes UK experienced, UK newly qualified, apprenticeship route, EU and international up to March 2024. The current forecast demonstrates a year end band 5 RN vacancy position of 0.92% which is below the target of 5%. The RN adult pipeline for 2023/24 now reflects the reduction in international recruitment. This is a national concern and has been escalated to NHS England. Work is being undertaken to explore RN Recruitment initiatives including increasing the International Recruitment pay band and reviewing our shortlisting criteria.

Appendix 3 provides detail on the forecasted position in relation to the number of Paediatric band 5 RN and HCSW vacancies up to March 2024. Numbers are based on those interviewed and offered positions in addition to planned campaigns. The current forecast demonstrates a year end band 5 Paediatric RN vacancy position of 16.38% and a band 2 HCSW position of 5.65%.

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

Red flags





Red Flags

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

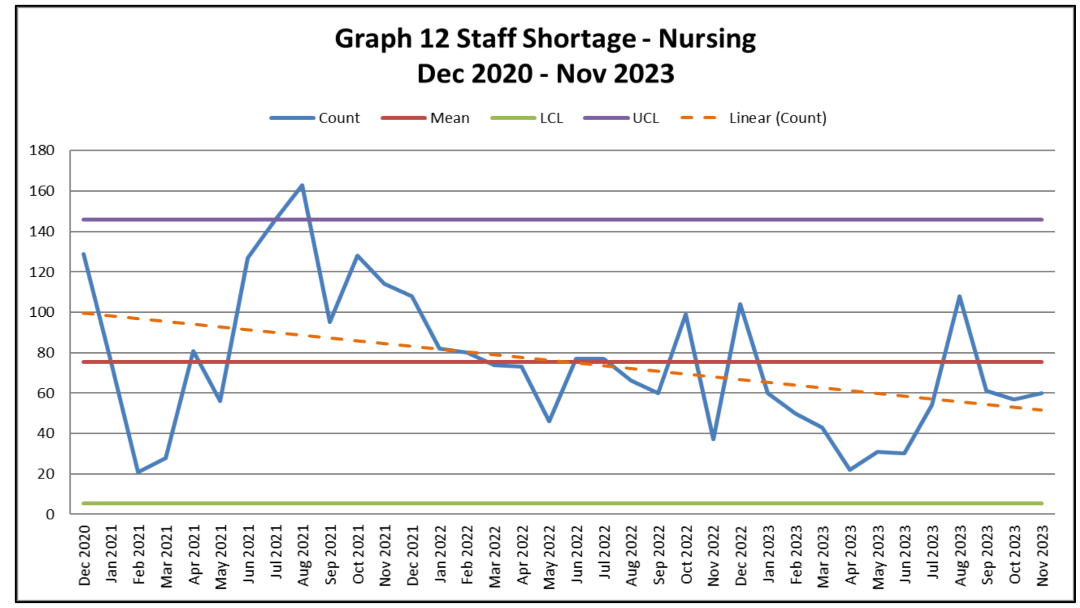
Nursing red flags

Graph 10 illustrates that there has been a decrease in the number of red flags reported with 206 reported in November. The highest number of red flags reported in November was in relation to an unmet 1:1 specialling requirement (75 compared with 108 in October). A trust wide improvement project focusing on specialling is being developed to review specialling across the organisation. There has been an increase in 2 reportable red flags in November with the remaining all reducing. The increases were seen in: Unplanned omission in providing medications 1 (0 in October), Delay in pain relief 14 (3 in September) and unable to facilitate staff breaks 18 (16 in October).

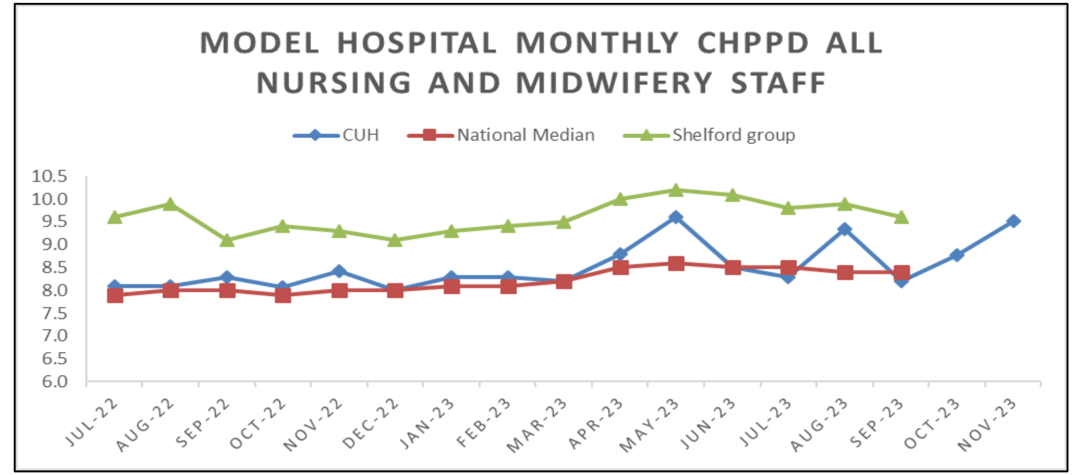
Maternity red flags

The number of maternity red flags has decreased from 187 in October to 175 in November. Graph 11 illustrates the red flags that have been reported with the highest reported being for missed or delayed care 32.0%. All other red flags have seen a reduction with the exception of Delay >30 mins between presentation and triage 23% in October to 27% in November. This is a known area of concern as highlighted in the recent CQC report. High numbers of unresolved red flags that cannot be mitigated will trigger escalation to divert policy with actions including:- redeployment of staff to higher acuity areas, seeking support from system for elective work such as caesarean sections and inductions of labour.

Safety and Risk



Graph 13: Care Hours Per Patient Day (CHPPD)



Incidents reported relating to staff shortages

Graph 12 illustrates the trend in Safety Learning Reports (SLRs) completed in relation to nurse staffing. In November there were 60 incidents reported compared to 57 in October.

The majority of the incidents related to staffing levels in October were reported by division D (15) with the highest reporting area being D7 (7).

Care hours per patient day (CHPPD)

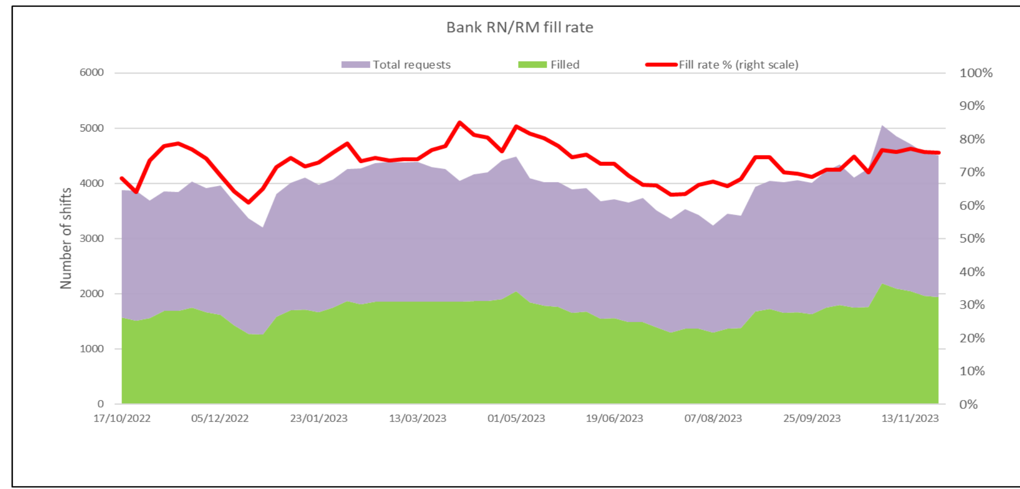
Care hours per patient day (CHPPD) is the total number of hours worked on the roster (clinical staff including AHPs) divided by the bed state captured at 23.59 each day. NHS Improvement began collecting care hours per patient day formally in May 2016 as part of the Carter Programme. All Trusts are required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

CUH CHPPD recorded for November has increased to 9.52 from 8.78 in October however this remains below other Shelford hospitals (10.3).

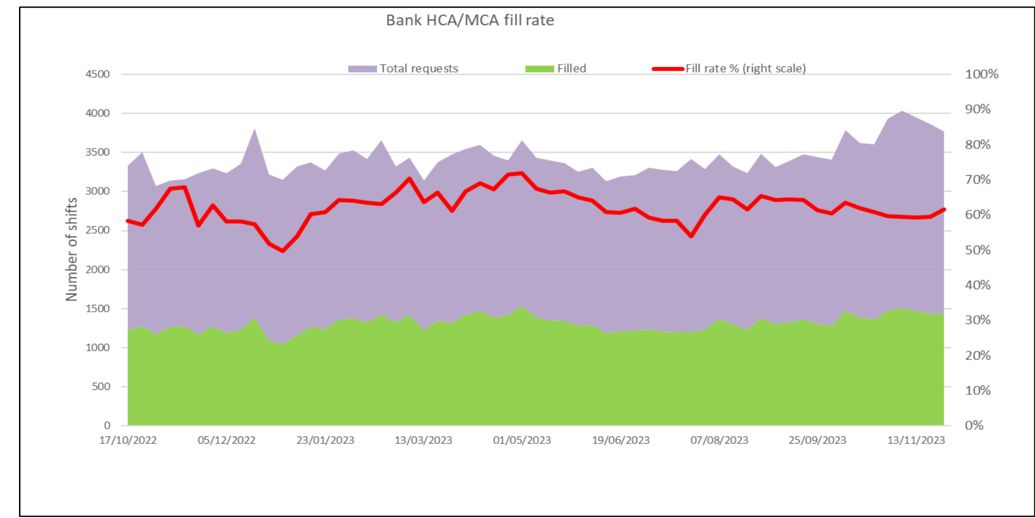
In maternity, from 1 April 2021, the total number of patients now includes babies in addition to transitional care areas and mothers who are registered as a patient. CHPPD for the delivery unit in September has decreased to 15.02 for November (15.68 in October).

Bank Fill Rate and Agency Usage

Graph 14 Registered RN/RM Bank fill rate per week



Graph 15 HCSW/MSW bank fill rate per week



Bank fill rate

The Trust's Staff Bank continues to support the clinical areas with achieving safe staffing levels. Graph 14 and 15 illustrate the trends in bank shift fill rate per week. Overall, we continued to see a increase in November for bank shift requests for registered staff to mitigate those areas who have less than a rota fill of 90% or to cover an unmet specialling need. The number of requests for registered staff is an average of 2639 shifts per week with an average bank fill rate of 76% which is an increase from 71.61% in October.

The number of requests for Health care support workers and Maternity support workers remains high with an average of 2441 shifts per week with an average bank fill rate of 59.9% this is a slight decrease from 61.71% in October.

In addition to bank workers we have the equivalent of 13.09 WTE agency workers working (12.9 WTE in October) across the divisions to support staffing challenges in the short term. This agency usage had been reducing but to support the emergency department and critical care there has been a need to increase to support safe staffing.

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

Appendix 1: Exception report by Division

	Nov-23								
	Unit	**Speciality**	**% fill registered**	**% fill care staff**	**Overall filled %**	**CHPPD**	**Analysis of gaps**	**Impact on Quality / outcomes**	**Actions in place**
Division A	C7	301 - GASTROENTEROLOGY - RISK MANAGED	89%	114%	98%	**7.43**	turnover and mat leave- Overseas RNs recruited but need 4 months lead in time until can be counted in the numbers	Impacting on nurse: patients ratios, delays to personal care, assessments, medication. Increased workload on those staff on duty. Use of bank and agency can at times impact on skill mix	8:15am and 4:15 pm nursing huddle to review gaps as well as at key stages throughout the day. Enhancements in place as well as agency use. B7 working clinically. Create of a C7 book for staff new to the ward to help them understand the day routines and key aspect of their patient group.
Division A	C8	110 - TRAUMA & ORTHOPAEDICS - RISK MANAGED	93%	79%	87%	**6.89**	Opening of the movement hub- staff from C8 recruited there- internal redeployment from other wards to cover gaps. There were also new overseas nurses who were in their orientation period. Sickness does not appear to be a factor Down 1 HCA, occasionally 2	Prioritising those patients requiring 1:1 specials for HCA meant less HCAs available for the rest of the ward so potential delays to assisting patients with hygiene needs, obs, mobilising	8:15am and 4:15 pm nursing huddle to review gaps as well as at key stages throughout the day. Validation of specials by matrons so that resources can be effectively shared. Use of bank and review of week to move staff from a well staffed day to a less well staffed day
Division A	D8	110 - TRAUMA & ORTHOPAEDICS - PROTECTED	86%	140%	107%	**9.18**	Opening of the movement hub- staff from D8 recruited there. Overseas RNs recruited but need 4 months lead in time until can be counted in the numbers. Down 1 RN, occasionally 2- some sickness but not excessive	Impacting on nurse: patients ratios, delays to personal care, assessments, medication. Increased workload on those staff on duty.	8:15am and 4:15 pm nursing huddle to review gaps as well as at key stages throughout the day. Use of bank and review of week to move staff from a well staffed day to a less well staffed day. Band 7 working clinically
Division A	D6 SAU	100 - GENERAL SURGERY - RISK MANAGED	95%	81%	91%	**4.47**	A number of new starters not yet working clinically. Maternity leave and some unauthorised leave begin managed with HR support.	Prioritising those patients requiring 1:1 specials for HCA meant less HCAs available for the rest of the ward so potential delays to assisting patients with hygiene needs, obs, mobilising	8:15am and 4:15 pm nursing huddle to review gaps as well as at key stages throughout the day. Validation of specials by matrons so that resources can be effectively shared. Recruit to vacancies. Use of bank and review of week to move staff from a well staffed day to a less well staffed day
Division A	L4	100 - GENERAL SURGERY - PROTECTED	88%	108%	94%	**7.14**	x2 RNs moved to the Surgical movement hub. New starters anticipated (x2 RNs and x1 Overseas nurse)Overseas RNs recruited but need 4 months lead in time until can be counted in the numbers	Impacting on nurse: patients ratios, delays to personal care, assessments, medication. Increased workload on those staff on duty.	8:15am and 4:15 pm nursing huddle to review gaps as well as at key stages throughout the day. Use of bank and review of week to move staff from a well staffed day to a less well staffed day. Band 7 working clinically
Division A	OIR	192 - CRITICAL CARE MEDICINE - STANDARD	88%	90%	88%	**35.71**	OIR at times remained open over the weekend which required bank support. Acuity patients requiring OIR post op	Adaptions to recovering patient to ensure patients safety if short of RNs, NIC will also take patients and support form main recovery overnight	8:15am and 4:15 pm nursing huddle to review gaps as well as at key stages throughout the day. Use of bank and Band 7 working clinically. If able request support form ICU to redeploy staff there

	Unit	Speciality	% fill registered	% fill care staff	Overall filled %	CHPPD	Analysis of gaps	Impact on Quality / outcomes	Actions in place
Division B	C9	370 - MEDICAL ONCOLOGY - PROTECTED	99%	65%	88%	15.46	HCA gap due to 50% vacancy gap in small team and movement of HCA's away from C9 due to greater need elsewhere in Division.	Greater pressure on RN's to fulfil HCA role on ward, leading to potential delays in care delivery	Recruitment to HCA vacancies ongoing
Division B	L5 Haematology	370 - MEDICAL ONCOLOGY - PROTECTED	102%	88%	98%	11.39	HCA gap due to 50% vacancy gap in small team and movement of HCA's away from C9 due to greater need elsewhere in Division.	Greater pressure on RN's to fulfil HCA role on ward, leading to potential delays in care delivery	Recruitment to HCA vacancies ongoing
Division C	C5	361 - NEPHROLOGY - PROTECTED	85%	96%	89%	7.77	244 outbound hours 370 inbound hours 1 red flag- unmet 1:1 specialling 72 unfilled RN shifts 83 unfilled HCSW shifts 18% roster unfilled	• 19x incidents, 0x mod+ harm • Highest category: Falls (8) • 1x HAPU • 2x patients with more than 2 incidents (3x incidents each)	Daily divisional mitigation; site safety escalation; weekly prospective staffing reporting and mitigation; divisional recruitment and retention strategy. Matron quality focus.
Division C	D5	301 - GASTROENTEROLOGY - STANDARD	87%	118%	96%	7.23	158 outbound hours 602 inbound hours 2 red flags- 1 unmet 1:1 specialling; 1 unmet required nursing skills 66 unfilled RN shifts 18% roster unfilled High unused contracted hours	• 14x incidents, 0x mod+ harm • Highest category: Security (3) • 0x HAPU • 0x patients with more than 2 incidents	Daily divisional mitigation; site safety escalation; weekly prospective staffing reporting and mitigation; divisional recruitment and retention strategy. Matron quality focus.
Division C	EAU 3 MAU	300 - GENERAL MEDICINE - STANDARD	99%	62%	84%	7.27	134 outbound hours 222 inbound hours 1 red flag- more than 25% shortfall in registered staffing 60 unfilled HCSW shifts 17% roster unfilled High unused contracted hours High HCSW A/L in week 3 of Nov/Dec rota and no rostered A/L in week 4	• 9x incidents, 0x mod+ harm • Highest category: Admission (2) • 0x HAPU • 0x patients with more than 2 incidents	Daily divisional mitigation; site safety escalation; weekly prospective staffing reporting and mitigation; divisional recruitment and retention strategy. Matron quality focus.

	Unit	Speciality	% fill registered	% fill care staff	Overall filled %	CHPPD	Analysis of gaps	Impact on Quality / outcomes	Actions in place
Division C	EAU 4	300 - GENERAL MEDICINE - STANDARD	87%	102%	93%	7.61	241 outbound hours 478 inbound hours 2 red flags - 1 unmet 1:1 specialling; 1 unmet required nursing skills 63 unfilled RN shifts 17% roster unfilled High unused contracted hours	• 21x incidents, 0x mod+ harm • Highest category: Fall (5) • 0x HAPU • 0x patients with more than 2 incidents	Daily divisional mitigation; site safety escalation; weekly prospective staffing reporting and mitigation; divisional recruitment and retention strategy. Matron quality focus.
Division C	EAU 5	300 - GENERAL MEDICINE - STANDARD	88%	113%	97%	8.26	317 outbound hours 340 inbound hours 2 red flags - 2 unmet 1:1 specialling 60 unfilled RN shifts 17% roster unfilled	• 22x incidents, 0x mod+ harm • Highest category: Transfer (7) • 0x HAPU • 1x patients with more than 2 incidents (3)	Daily divisional mitigation; site safety escalation; weekly prospective staffing reporting and mitigation; divisional recruitment and retention strategy. Matron quality focus.
Division C	F4	300 - GENERAL MEDICINE - RISK MANAGED	88%	131%	105%	8.72	111 outbound hours 408 inbound hours 2 red flags - 2 unmet 1:1 specialling 38 unfilled RN shifts 21% roster unfilled High unused contracted hours	• 3x incidents, 1x mod+ harm (Hospital acquired VTE) • Highest category: N/A as 1 of each category • 0x HAPU • 0x patients with more than 2 incidents	Daily divisional mitigation; site safety escalation; weekly prospective staffing reporting and mitigation; divisional recruitment and retention strategy. Matron quality focus.
Division C	F6	430 - GERIATRIC MEDICINE - STANDARD	88%	104%	96%	7.73	275 outbound hours 198 inbound hours 1 red flags - 1 unmet 1:1 specialling 21 unfilled RN shifts 21% roster unfilled High unused contracted hours	• 18x incidents, 0x mod+ harm • Highest category: Pressure Ulcers (6) • 3x HAPU: Cat 1 (2), SDTI (1) • x patients with more than 2 incidents	Daily divisional mitigation; site safety escalation; weekly prospective staffing reporting and mitigation; divisional recruitment and retention strategy. Matron quality focus.

	Unit	Speciality	% fill registered	% fill care staff	Overall filled %	CHPPD	Analysis of gaps	Impact on Quality / outcomes	Actions in place
Division C	G5	100 - GENERAL SURGERY - PROTECTED	92%	87%	90%	7.49	75 outbound hours 296 inbound hours 16 red flags- 9 unable to facilitate end shift at scheduled time; 4 unable to facilitate staff break; 3 unmet nursing skills 43 unfilled HCSW shifts 12% roster unfilled	• 14x incidents, 2x mod+ harm (HAPU Cat 2) • Highest category: Medication/pressure ulcers (4) • 2x HAPU: Cat 2 (2) • 1x patients with more than 2 incidents (3)	Daily divisional mitigation; site safety escalation; weekly prospective staffing reporting and mitigation; divisional recruitment and retention strategy. Matron quality focus.
Division C	N2	300 - GENERAL MEDICINE - RISK MANAGED	84%	91%	86%	7.77	126 outbound hours 423 inbound hours 81 unfilled RN shifts 74 unfilled HCSW shifts 21% roster unfilled High unused contracted hours High % HCSW A/L week 1	• 21x incidents, 1x mod+ harm, Cat 2 (1) • Highest category: Fall (6) • 1x HAPU: Cat 2 (1) • 1x patient with more than 2 incidents (3)	Daily divisional mitigation; site safety escalation; weekly prospective staffing reporting and mitigation; divisional recruitment and retention strategy. Matron quality focus.
Division C	T2	430 - GERIATRIC MEDICINE - STANDARD	100%	82%	92%	6.32	252 outbound hours 106 inbound hours 1 red flag- more than 25% shortfall in registered staffing 39 unfilled HCSW shifts 9% roster unfilled Inconsistent A/L management	• 15x incidents, 1x mod+ harm (Fall resulting in #clavicle) • Highest category: Fall (7) • 0x HAPU • 0x patients with more than 2 incidents	Daily divisional mitigation; site safety escalation; weekly prospective staffing reporting and mitigation; divisional recruitment and retention strategy. Matron quality focus.
Division D	A3	400 - NEUROLOGY - STANDARD	87%	105%	94%	8.35	Primary staffing RN Gaps noted for Night Shift 12 Days and Late Shifts 11 Days with multiple HCA gaps also noted throughout the month period. Some of this is caused by additional duties for Enhanced observations. No shift noted as more then 1 RN short. Risk of gaps RN related due to increase in bed base with no additional establishment with reliance on bank as technical 6 neuro contingency beds whilst awaiting improvement in critical care staffing. Reviewing this against the CHHPD noted variation in total patient numbers dependant on Day of Surgery information also being input or not. This leads to inconsistent reporting of CHPPD.	We have seen no rise in QSIS related to impact of patient care as a result of the staffing shortfall. When reviewed against theatre start times, we see no correlation in staffing shortfall days to delays in starting theatre.	Review of Safe Care Data daily to ensure that we present an accurate picture of ward patients (decision around inclusion of DOSA patient group). Monday and Wednesday neuro senior team meetings in place to review this week next week staffing and look at mitigation. Ongoing review of Enhancements for RN and HCA's in place.

	Unit	Speciality	% fill registered	% fill care staff	Overall filled %	CHPPD	Analysis of gaps	Impact on Quality / outcomes	Actions in place
Division D	A4	400 - NEUROLOGY - RISK MANAGED	89%	113%	100%	9.34	RN Gaps noted on almost every shift. This has been caused by an increase in 908 bleep uptake by the band 6 team to cover for other sickness and multiple instances of staff moves to support areas with less resilient staffing numbers primarily C8. This is compounded by 2 x RN on long term sickness and a 4.0 WTE actual vacancy rate on rota. Reviewing CHPPD noting slight rise in 1a and 1b patient tough only minor	We have not seen a rise in incidents over the month period. We have noted a slight rise in general complaints relating to timing and provision of care.	Agreement for temporary use of Agency staff to support current vacancies. Active recruitment into Band 5 and 2 roles with a healthy pipeline at present. Monday and Wednesday neuro senior team meetings in place to review this week, next week staffing and look at mitigations.
Division D	K3 CCU	320 - CARDIOLOGY - STANDARD	98%	87%	97%	9.43	CCU RN Gaps noted, staff moved from other areas or K3 to cover however not moved on MAPs, ward manager made aware. HCA Gaps are primarily caused by unmet specialling demand, other GAPs in substantive staff noted due to staff movement versus non-rostering.	We have seen no rise in Incidents / PALS reports around care due to the above gaps.	All shifts are posted as early as possible to bank. Staff reminded of the importance of redeploying staff on MAPs to ensure good quality audit trail.
Division E	C2	420 - PAEDIATRICS - STANDARD	85%	158%	95%	12.44	current vacancy rate of 16.7%. 4.29wte RN vacancy & 4.01wte HCA vacancy. Pipeline in = 2.0wte RN & 5.0wte HCA. Pipeline out 1.0wte RN. Net position to fill =3.29wte RN & 0.99wte HCA.	increased pressure on staff to ensure adequate skill mix. No impact on patient experience feedback.	regular safety huddles & quality rounds. Regular reviews of staffing levels & patient acuity. Paediatric recruitment event planned for Spring 2024. Recruitment & retention proposal going to IC as part of 5% hotspot clinics.
Division E	C3	420 - PAEDIATRICS - PROTECTED	82%	147%	100%	11.94	current vacancy rate 5.37%. 074wte RN vacancy & 2.57wte HCA vacancy. 3.23wte HCA in pipeline in, 1.0wte in pipeline out. 1.22wte RN in pipeline out.	increased pressure on staff to ensure adequate skill mix. No impact on patient experience feedback.	regular safety huddles & quality rounds. Regular reviews of staffing levels & patient acuity. Paediatric recruitment event planned for Spring 2024. Recruitment & retention proposal going to IC as part of 5% hotspot
Division E	F3 COU	171 - PAEDIATRIC SURGERY - PROTECTED	87%	107%	94%	7.82	current vacancy factor 5.99%. RN vacancy 1.42wte & HCA vacancy 0.66wte. 3.97wte RN in pipeline in and 2.0wte HCA. 5.33wte RN in pipeline out, leaving net position to fill of 2.78wte RN.	increased pressure on staff to ensure adequate skill mix. No impact on patient experience feedback.	regular safety huddles & quality rounds. Regular reviews of staffing levels & patient acuity. Paediatric recruitment event planned for Spring 2024. Recruitment & retention proposal going to IC as part of 5% hotspot
Division E	Neonatal ICU	422 - NEONATOLOGY - RISK MANAGED	97%	86%	96%	14.70	current vacancy factor 20.1%. RN vacancy 29.49wte, 3.55wte HCA. Pipeline in 7.60wte RN & 1.0wte HCA. Pipeline out 2.0wte RN. Net position to fill 23.89wte RN.	Increased pressure on QIS to ensure skill mix / safe staffing levels. No impact of NQM or patient experience.	regular safety huddles & quality rounds. Regular reviews of staffing levels & patient acuity. Paediatric recruitment event planned for Spring 2024. Recruitment & retention proposal going to IC as part of 5% hotspot
Division E	Lady Mary	501 - OBSTETRICS - RISK MANAGED	98%	76%	88%	4.71	Target CHPPD achieved, suggesting safe staffing Poor skill mix	Target CHPPD achieved, suggesting safe staffing Poor skill mix	Staffing reviewed to ensure safe care, Staff moved within service to provide safe staffing.
Division E	Rosie Birth Centre	501 - OBSTETRICS - RISK MANAGED	100%	65%	91%	15.02	Target CHPPD achieved, suggesting safe staffing	Delayed care, Staffing reviewed and redeployed	Staffing reviewed to ensure safe care, Staff moved within service to provide safe staffing.
Division E	Sara Ward	501 - OBSTETRICS - RISK MANAGED	100%	80%	94%	6.42	Target CHPPD achieved, suggesting safe staffing	Delayed care, Staffing reviewed and redeployed	Staffing reviewed to ensure safe care, Staff moved within service to provide safe staffing.
Division E	Delivery Unit	501 - OBSTETRICS - RISK MANAGED	100%	69%	93%	13.61	Target CHPPD achieved, suggesting safe staffing	Delayed care, Staffing reviewed and redeployed	Staffing reviewed to ensure safe care, Staff moved within service to provide safe staffing.

Appendix 2: Adult RN Recruitment pipeline

Adult band 5 RN position based on predictions and established FTE															
Month	UK based exp. applicants	Anglia Ruskin NQ (60% of graduates)	Other NQ	Nursing Associates	NAP	Return to Practice	Overseas	Total New Starters	Leavers FTE	Promotions and transfer out of scope-retained by the trust	Staff in post FTE	ESR Establishment FTE	Vacancy rate based on established FTE	No. of vacancies based on established FTE	Starter leaver variance
Apr-23	5	2			12		9	28	9	11	1534	1699	9.70%	165	19
May-23	1	3			5		12	21	14	12	1529	1699	10.01%	170	7
Jun-23	4				2		16	22	7	13	1531	1699	9.89%	168	15
Jul-23	1	1	2				19	23	16	10	1528	1699	10.06%	171	7
Aug-23	3	1					16	20	11	10	1753	1931	9.20%	178	9
Sep-23	7	3	2				35	47	16	7	1777	1951	8.90%	174	31
Oct-23	1	11	2				40	54	14	12	1635	1759	7.05%	124	40
Nov-23	7	3	1				29	40	10	15	1650	1784	7.52%	134	30
Dec-23	7	4			18		49	78	13	15	1700	1784	4.71%	84	65
Jan-24	10						53	63	13	15	1735	1784	2.75%	49	50
Feb-24	3						63	66	13	15	1773	1822	2.73%	50	53
Mar-24	5	18			3		35	61	13	15	1806	1822	0.92%	17	48
TOTAL	**54**	**46**	**7**	**0**	**40**	**0**	**376**	**601**	**149**	**150**	**1806**	**1822**	**0.92%**	**17**	**374**

Appendix 3: Paediatric RN and Band 2 HCSW Recruitment pipeline

Paediatric band 5 RN position based on predictions and established FTE														
Month	UK based exp. applicants	Anglia Ruskin NQ	Other NQ	NAP	Nursing Associate Apprentice	Overseas	Total New Starters FTE	Leavers FTE (based on leavers in the last 12 months)	Promotions and transfer out of scope-retained by the trust	Staff in post FTE	ESR Establishment FTE	Vacancy rate based on established FTE	No. of vacancies based on established FTE	Starter leaver variance
Apr-23	1						3	2	0	164.39	213.73	23.09%	49	1
May-23							0	2	2	160.39	213.73	24.96%	53	-2
Jun-23	2	2					4	6	1	157.39	213.73	26.36%	56	-2
Jul-23	1					3	4	3	1	157.39	213.73	26.36%	56	1
Aug-23			1				1	2	2	171.13	229.70	25.50%	59	-0.53
Sep-23	1	3	1			2	7	3	2	173.13	229.70	24.63%	57	4
Oct-23	2	13				1	16	5	0	184.13	229.70	19.84%	46	11
Nov-23		1				1	2	0	1	193.75	236.50	18.08%	43	2
Dec-23	2	1				2	5	3	1	194.75	236.50	17.65%	42	2
Jan-24			1			2	3	4	1	192.75	236.50	18.50%	44	-1
Feb-24	2					2	4	3	1	192.75	236.50	18.50%	44	1
Mar-24	2				5	2	9	3	1	197.75	236.50	16.38%	39	6
TOTAL	13	20	3	0	5	15	58	35.53	13	197.75	236.50	16.38%	39	6

Band 2 HCSW position based on predictions and established FTE									
Month	UK based applicants	Apprenticeship (direct entry)	Nursing Associate Apprentices	Total New Starters FTE	Leavers FTE	Staff in post FTE	ESR Establishment FTE	Vacancy rate based on established FTE	No. of vacancies based on established FTE
Apr-23	18	1		19	18	768	887	13.42%	119
May-23	16	1		17	10	775	887	12.63%	112
Jun-23	20	5		25	7	768	887	13.42%	119
Jul-23	14	3		17	16	760	887	14.32%	127
Aug-23	11	1		12	17	741	878	15.67%	138
Sep-23	25	2		27	12	756	888	14.93%	133
Oct-23	28	2		30	8	772	905	14.72%	133
Nov-23	33	3		36	10	788	926	14.94%	138
Dec-23	10	2	3	15	12	791	926	14.62%	135
Jan-24	30		6	36	10	817	926	11.81%	109
Feb-24	30		26	56	12	861	950	9.34%	89
Mar-24	30		15	45	10	896	950	5.65%	54
TOTAL	265	20	50	335	142	896	949.7	5.65%	53.7

Board of Directors

Together
Safe
Kind
Excellent

Report to the Board of Directors: 17 January 2024

Agenda item	9.4
Title	Finance report
Sponsoring executive director	Mike Keech, Chief Finance Officer
Author(s)	As above
Purpose	To update the Board on financial performance in 2023/24 M8
Previously considered by	Performance Committee, 10 January 2024

Executive Summary

The report provides details of financial performance during 2023/24 Month 8 and in the year to date. A summary is set out in the Chief Finance Officer's message on pages 3-5 of the report.

Related Trust objectives	All Trust objectives
Risk and Assurance	The report provides assurance on financial performance during Month 8.
Related Assurance Framework Entries	BAF ref: 011
Legal / Regulatory / Equality, Diversity & Dignity implications?	n/a
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	n/a

Action required by the Board of Directors

The Board is asked to note the finance report for 2023/24 Month 8 (November 2023).

Title	Page
Trust performance summary – Key indicators	2
CFO Message	3-5
Summary financial position	6
Trust underlying performance	7
Plan performance FY22/23	8-9
Clinical and other income	10-12
Elective Payment Mechanism	13-14
Pay expenditure	15-16
Non-pay expenditure	17-18
Efficiency plan	19
Cash flow forecast	20
Appendices	21

Contents

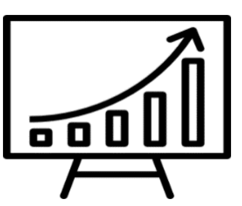
Trust actual surplus / (deficit)

Value	Measure
£6.8m	Actual (adjusted)*
(£0.5m)	Plan (adjusted)*
£3.0m	Actual YTD (adjusted)*
£2.5m	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	£20.4m	£144.5m
Target adj. block increase	£0.9m	£6.5m
EPM actual + block increase	£21.3m	£151.0m
EPM original plan	£22.3m	£161.6m
EPM original target	£20.4m	£149.1m



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

Net current assets

Value	Measure
(£82.8m)	*Actual*
(£44.6m)	*Plan*

Debtor days

Value	Measure
25	*This month*
20	*Previous month*

Payables performance (YTD) **

Value	Measure
86.8%	*Value*
89.8%	*Quantity*

EBITDA

Value	Measure
£31.6m	*Actual YTD*
£28.1m	*Plan YTD*

Capital expenditure

Value	Measure
£4.6m	*Capital - actual spend in month*
£27.9m	*Capital - actual spend YTD*
£22.6m	*Capital – plan YTD*

Cash

Cash

Value	Measure
£148.5m	*Actual*
£148.7m	*Plan*

Legend *£ in million* — *In month* (light green) — *YTD* (dark green)

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

Trust performance summary - Key indicators

Month 8 Financial Performance

- **The Month 8 year to date position is £3.0m surplus for performance management purposes**. This position is favourable to our planned performance by £0.5m.

- The following key points should be noted:
  - This position includes £7.0m of non-recurrent support.
  - Financial under performance is predominantly due to the impact of Industrial Action (IA), estimated at £10.6m for elective activity under performance.
  - A reduction to the EPM target for April has provided £2.3m of support to the Trust YTD with a further £1.6m due by year end, partially mitigating the impact of IA.
  - NHSE has confirmed that a further reduction to the EPM target of 2% alongside Specialised Commissioning target smoothing and a block funding payment will support Trusts to fully mitigate the impact of IA. This is expected to be broadly the case for CUH with the forecast value of the total NHSE support being estimated at £16.9m against a total IA impact of £18.8m year to date.
  - The additional IA taking place in December and January is likely to create a further pressure of £6.0m. The Trust expects this pressure to be mitigated by the future months impact of the reduction in the EPM target and continued underspends in non pay.

- Income adverse variance of £4.1m - Clinical income is adverse to plan by £2.5m and Devolved income is favourable to plan by £6.6m. Please see pages 10-14.
- Pay adverse variance of £5.7m - this position is due to direct costs associated with IA (£5.9m) and the adverse impact of IA on the Trust's ability to fully deliver the efficiency savings that were planned for the year to date (£3.5m). Please see pages 15-16.
- Non pay (including drugs) favourable variance of £5.1m - this position is driven by lower than planned activity and additional inflationary pressures not being identified so far. Please see pages 17-18.

Covid-19 Expenditure

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

Elective Payment Mechanism (EPM)

- The ERF schemes from previous years have now ended. Elective activity recovery in 23/24 is being incentivised via a 'variable' element of contract, where Trusts are paid on Payments by Results (PbR) for a selection of activity including Elective Inpatients, Day-cases, Outpatient First attendances, Outpatients procedures and Chemotherapy, known as the EPM.
- At month 8 YTD performance for the **EPM is £4.6m below target and £17.1m below plan,** prior to target adjustments to support the impact of IA.

Additional funding to support the impact of IA:

- NHSE have now announced further support for the impact of IA including the following three elements:
  1. A further target reduction of 2% - forecast additional income by year end of £3.9m
  2. A Specialised Commissioning target 'smoothing' adjustment – forecast additional income by year end of £3.2m
  3. A block payment to support the impact of IA – agreed with C&P ICB at £5.9m.
- The above items are in addition to the previous 2% target adjustment for April's IA.
- At month 8 YTD the impact of the target and smoothing adjustments is an increase in income payments of £7.0m and £5.9m block payment IA support.
- At month 8 YTD the adjusted **EPM performance is £2.9m above target and £10.6m below plan**.
- The target adjustments will provide a further £4.0m of financial support to the Trust by the end of the financial year.
- The total NHSE support for IA is now estimated at £16.9m against forecast IA costs of £24.8m.

Productivity and Efficiency Programme (PEP)

- For 23/24 the efficiency requirement will be delivered via Covid cost reduction, central efficiencies, direct 'cost out' and productivity / growth schemes.
- The current forecast is full delivery of the £53.1m target; however, the Trust may need to consider an increase in the allocated cost reduction requirements if slippage against productivity plans continues and the associated planned income is not received.
- Recurrent efficiencies currently total £46.8m and represent 88.1% of the total plan.
- The Month 8 PEP has an adverse position of £0.2m. Pay efficiencies are currently behind plan by £3.5m with non-pay efficiencies favourable to plan by £0.9m and Income efficiencies £2.4m ahead of plan.
- The impact of ongoing IA means that planned productivity improvements driven by increased activity have not been achieved. Additionally the Trust has needed to pay premium rates to cover staffing gaps.
- The Trust will continue to develop the plans across 23/24 with the aim to increase productivity and deliver the planned cost efficiency schemes.

CFO message (continued)

Cash and Capital Position

- The Trust received an initial system capital allocation for the year of £35.0m for its core capital requirements. In addition to this, we expect to receive further funding for the Children's Hospital (£3.5m), Cancer Hospital (£11.3m), Community Diagnostics (£0.8m), and Secure Data Environments (1.8m). 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 £62.8m. As a counter-measure against likely slippage an £8.4m over-commitment has been built into the 23/24 capital plan.
- At Month 8 the capital programme is ahead of plan with spend year to date of £27.9m against a budget of £22.6m. 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 £62.8m.
- The Trust's cash position remains strong and the 13 week cash flow forecast does not identify any need for additional revenue cash support in the foreseeable future. The closing cash position for 22/23 was unexpectedly high due to grant receipts late in the financial year and we have been unable to adjust the 23/24 plan to take account of this revised opening position (although the cash flow forecast has been updated). As a result, the actual cash position at Month 8 appears better than plan.

FY23/24 Financial Plan

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

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

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

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

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

  1) The plan assumes that all pay awards are fully funded. The Trust expects to receive additional non-recurrent funding to support the budgeted cost of the pay award.

NHS CUH

£ Millions	In Month			Year to Date			Full Year	Full Year	Full Year
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Clinical Income - exc. D&D*, EPM	63.2	75.6	12.4	512.1	516.0	4.0	779.7	771.4	(8.3)
Clinical Income - EPM variable	22.3	20.4	(1.9)	161.6	144.5	(17.1)	232.7	227.3	(5.4)
Clinical Income - D&D*	14.3	15.8	1.4	114.6	125.3	10.7	175.1	188.4	13.3
Devolved Income	15.3	19.5	4.2	122.6	129.2	6.6	183.9	190.0	6.1
Total Income	**115.1**	**131.3**	**16.1**	**910.9**	**915.0**	**4.1**	**1,371.4**	**1,377.1**	**5.7**
Pay	63.2	62.6	0.5	491.2	496.9	(5.7)	744.4	753.0	(8.6)
Drugs	15.9	17.3	(1.3)	127.4	137.6	(10.2)	191.2	206.3	(15.1)
Non Pay	33.3	36.4	(3.1)	264.2	248.9	15.3	397.4	381.4	16.0
Operating Expenditure	**112.4**	**116.3**	**(3.9)**	**882.8**	**883.4**	**(0.6)**	**1,333.0**	**1,340.6**	**(7.6)**
EBITDA	**2.7**	**14.9**	**12.2**	**28.1**	**31.6**	**3.5**	**38.4**	**36.5**	**(2.0)**
Depreciation, Amortisation & Financing	3.3	3.0	0.3	26.4	23.9	2.5	39.6	37.4	2.3
Reported gross Surplus / (Deficit)	**(0.6)**	**12.0**	**12.6**	**1.7**	**7.7**	**6.0**	**(1.2)**	**(0.9)**	**0.3**
Add back technical adjustments:									
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital donations/grants net I&E impact	0.1	(5.1)	(5.2)	0.8	(4.7)	(5.5)	1.2	0.9	(0.3)
Net benefit of PPE consumables transactions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit) NHS financial performance basis	**(0.5)**	**6.8**	**7.3**	**2.5**	**3.0**	**0.5**	**0.0**	**0.0**	**0.0**

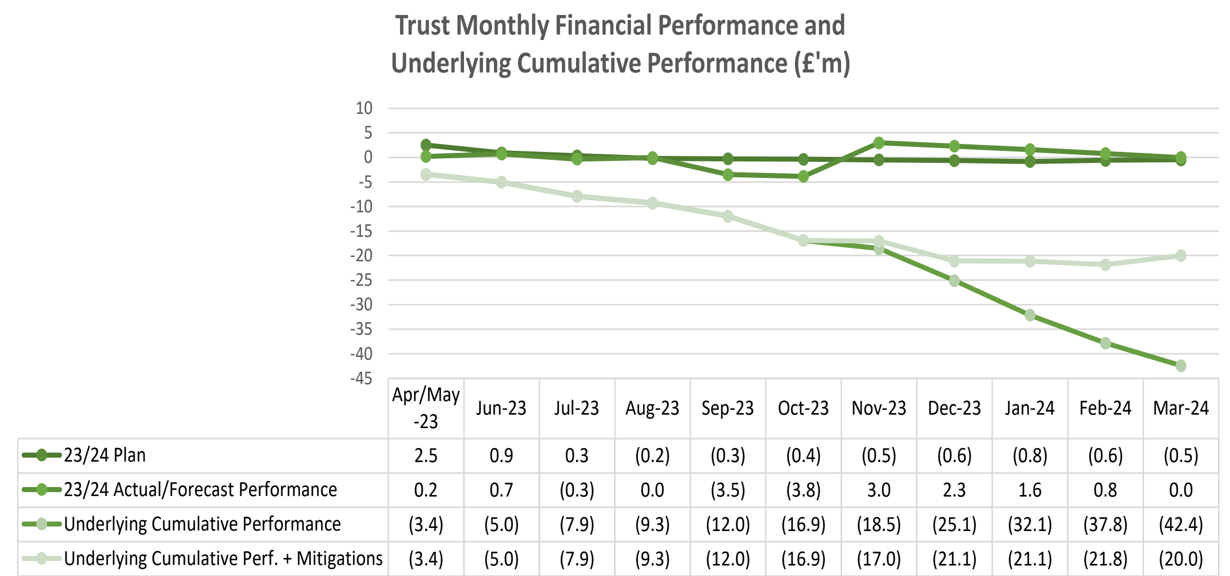
Please note that the values reported in the above table and throughout the report are subject to rounding
* D&D – drugs and devices.

Summary financial position

Trust underlying performance

Key messages:

- 23/24 actual performance is forecast to meet plan but due to a range of non-recurrent items, outlined below, the Trust is forecasting an **underlying deficit of £42.4m**.
- Elective service productivity improvements could reduce the **underlying deficit to £20m.**
- This assessment is based on the Trust delivering the operational plan and receipt of £5.9m from NHSE/I at Month 8 in support of the costs of Industrial Action.
- At Month 8, non-recurrent:
    - income benefits from the EPM baseline adjustments total £10.0m - (£15.0m full year).
    - support of £7.0m (£20.0m full year).
    - Industrial Action pay cost totals £5.9m and is now forecast to increase by £2-3m by M10.
- The Trust is planning to exit the year with an underlying monthly deficit which annualises at over £7.4m, if unfunded in 24/25.



	Apr/May -23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
23/24 Plan	2.5	0.9	0.3	(0.2)	(0.3)	(0.4)	(0.5)	(0.6)	(0.8)	(0.6)	(0.5)
23/24 Actual/Forecast Performance	0.2	0.7	(0.3)	0.0	(3.5)	(3.8)	3.0	2.3	1.6	0.8	0.0
Underlying Cumulative Performance	(3.4)	(5.0)	(7.9)	(9.3)	(12.0)	(16.9)	(18.5)	(25.1)	(32.1)	(37.8)	(42.4)
Underlying Cumulative Perf. + Mitigations	(3.4)	(5.0)	(7.9)	(9.3)	(12.0)	(16.9)	(17.0)	(21.1)	(21.1)	(21.8)	(20.0)

£'m	Actual M2 YTD	Actual M3 YTD	Actual M4 YTD	Actual M5 YTD	Actual M6 YTD	Actual M7 YTD	Actual M8 YTD	Forecast M9 YTD	Forecast M10 YTD	Forecast M11 YTD	Forecast M12 YTD
NHS performance surplus / (deficit) - cumulative	**0.2**	**0.7**	**(0.3)**	**0.0**	**(3.5)**	**(3.8)**	**3.0**	**2.3**	**1.6**	**0.8**	**0.0**
Non-recurrent adjustments for Industrial Action											
Industrial action pay costs removed	2.2	3.0	4.1	5.3	6.0	5.9	5.9	7.0	8.9	8.9	8.9
Industrial action income removed (recognised in M8 Surplus)	0.0	0.0	0.0	0.0	0.0	0.0	(5.9)	(7.0)	(8.9)	(8.9)	(8.9)
Underlying plan adjustments											
Non-recurrent support	(3.3)	(5.0)	(6.7)	(8.3)	(6.5)	(6.9)	(7.0)	(10.2)	(13.5)	(16.8)	(20.0)
Baseline adjustment (EPM funding)	(2.5)	(3.8)	(5.0)	(6.3)	(7.5)	(8.8)	(10.0)	(11.3)	(12.5)	(13.8)	(15.0)
CUH service performance											
Exit expenditure run rate 23/24 is unfunded in 24/25	0.0	0.0	0.0	0.0	(0.5)	(3.3)	(4.5)	(5.9)	(7.7)	(8.1)	(7.4)
Underlying 23/24 position - Exit run-rate	**(3.4)**	**(5.0)**	**(7.9)**	**(9.3)**	**(12.0)**	**(16.9)**	**(18.5)**	**(25.1)**	**(32.1)**	**(37.8)**	**(42.4)**
Mitigations											
Elective service exit run rate 23/24 increase	0.0	0.0	0.0	0.0	0.0	0.0	0.5	1.0	2.0	4.0	7.4
Elective service productivity increase	0.0	0.0	0.0	0.0	0.0	0.0	1.0	3.0	9.0	12.0	15.0
Mitigations	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**1.5**	**4.0**	**11.0**	**16.0**	**22.4**
Underlying 23/24 position - Mitigated Position	**(3.4)**	**(5.0)**	**(7.9)**	**(9.3)**	**(12.0)**	**(16.9)**	**(17.0)**	**(21.1)**	**(21.1)**	**(21.8)**	**(20.0)**

Full Year Plan – key messages

£'m	M1&2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	23/24 Total
Operating income from patient care activities	196.8	98.4	98.4	103.2	99.3	101.0	101.0	101.0	101.0	101.0	101.0	**1,202.1**
Other operating income	27.8	13.9	13.9	14.9	14.1	14.1	14.1	14.1	14.1	14.1	14.1	**169.3**
Total operating income	**224.5**	**112.3**	**112.3**	**118.1**	**113.4**	**115.1**	**115.1**	**115.1**	**115.1**	**115.1**	**115.1**	**1,371.4**
Employee expenses	(118.2)	(59.5)	(59.7)	(66.0)	(61.6)	(63.1)	(63.2)	(63.3)	(63.3)	(63.3)	(63.4)	**(744.4)**
Operating expenses excluding employee expenses	(103.3)	(51.6)	(51.9)	(52.0)	(51.9)	(52.1)	(52.2)	(52.2)	(52.4)	(52.1)	(51.9)	**(623.6)**
Operating Surplus/(Deficit)	**3.1**	**1.2**	**0.6**	**0.1**	**0.0**	**(0.1)**	**(0.2)**	**(0.3)**	**(0.5)**	**(0.3)**	**(0.2)**	**3.4**
Finance income	1.2	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	**7.0**
Finance expense	(1.3)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	**(7.7)**
PDC dividends payable/refundable	(0.7)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	**(3.9)**
Net finance costs	(0.8)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	**(4.6)**
Surplus/(Deficit) for the Period/Year	**2.3**	**0.8**	**0.2**	**(0.3)**	**(0.4)**	**(0.5)**	**(0.6)**	**(0.7)**	**(0.9)**	**(0.7)**	**(0.6)**	**(1.2)**
Add back technical adjustments:												
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Capital donations/grants net I&E impact	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	**1.2**
Net benefit of PPE consumables transactions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Surplus/(Deficit) - NHS financial performance basis for the Period/Year	**2.5**	**0.9**	**0.3**	**(0.2)**	**(0.3)**	**(0.4)**	**(0.5)**	**(0.6)**	**(0.8)**	**(0.6)**	**(0.5)**	**0.0**

Key messages:

- The plan delivers a 23/24 break-even position on an NHS financial performance basis.
- It is assumed that any elective over-performance will be paid in full, the financial impact of IA will be fully mitigated by NHSE/I and that inflationary pressures will be contained within the modelled levels.
- Productivity and efficiency schemes totalling £53.1m are included within the overall plan. The programme will be delivered via improved productivity combined with cash releasing efficiencies.
- The plan for month 5 onwards has been updated to reflect the income and expenditure associated with the Medical and VSM Pay Award.

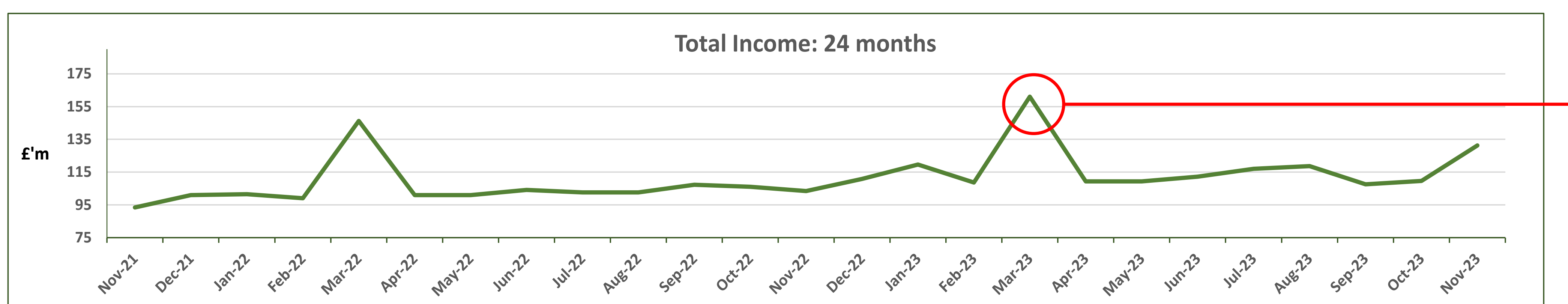
£'m	M8 YTD Plan	M8 YTD Actual	Variance	Key Variances
Operating income from patient care activities	798.0	795.6	(2.4)	Pass-through drugs income is higher than planned (£10.7m) and is driven by both cost and volume variations to plan. Injury cost recovery is £0.9m ahead of plan with Private Patients income £0.8m behind plan. Net other variable income elements are £13.2m behind the plan.
Other operating income	112.8	119.4	6.6	The favourable variance of £6.6m is driven by Community Diagnostics Centre (CDC) income (£2.8m) and Donated Asset Income (£5.5m). Fire safety works expenditure is £1.6m behind the plan at month 8.
Total income	**910.9**	**915.0**	**4.1**	
Employee expenses	(491.2)	(496.9)	(5.7)	The primary drivers of the adverse position are the direct impact of the Industrial Action (£5.9m), the impact of premium rates of bank and agency pay and associated slippage on delivery of planned productivity and efficiency (£3.5m). are largely offset by fully funded vacancies (including medical pay award) but present an ongoing financial risk.
Operating expenses excluding employee expenses	(415.0)	(409.9)	5.1	The favourable position is driven by lower than planned expenditure on cancer drugs including Car-T (£3.5m), Clinical negligence (Maternity incentive scheme) rebate (£1.7m).
Operating surplus / (deficit)	**4.8**	**8.3**	**3.5**	
Finance costs				
Finance income	4.7	6.7	2.0	The Trust has received interest in excess of the plan - this is driven by higher interest rates payable on the Trust cash balances.
Finance expense	(5.2)	(4.6)	0.5	
PDC dividends payable/refundable	(2.6)	(2.6)	0.0	
Net Finance costs	**(3.1)**	**(0.6)**	**2.5**	
Reported gross surplus/(deficit)	**1.7**	**7.7**	**6.0**	
Add back technical adjustments:				
Impairments (AME)	0.0	0.0	0.0	
Capital donations/grants net I&E impact	0.8	(4.7)	(5.5)	
Net benefit of PPE consumables transactions	0.0	0.0	0.0	
Surplus/(Deficit) - NHS financial performance basis for the year to date	**2.5**	**3.0**	**0.5**	

Key messages:

- Year to date, on an NHS financial performance basis, the Trust is reporting a £3.0m surplus. This means the Trust is ahead of the plan by £0.5m.
- The over performance is explained by the receipt of Industrial Action (IA) funding; this includes funding to cover the IA pay pressures (£5.9m), a further 2% adjustment to the EPM target (estimated £2.6m year to date and £3.9m full year) alongside Specialised Commissioning target smoothing (estimated £2.1m year to date £3.2m full year).

Plan performance FY23/24 (continued)

£'m	In Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Elective admissions	14.4	12.0	(2.4)	95.6	92.2	(3.4)
Non-elective admissions	16.5	16.5	0.0	134.2	137.0	2.8
Outpatients - First	5.0	4.2	(0.8)	36.2	31.1	(5.1)
Outpatients - Follow-up	6.7	6.2	(0.5)	49.6	47.5	(2.1)
A&E	3.8	5.2	1.3	31.2	40.0	8.7
High-cost drugs income from commissioners	14.3	15.8	1.4	114.6	125.3	10.7
Other Clinical Income	39.1	51.9	12.8	326.8	312.8	(14.0)
Total Clinical Income	**99.8**	**111.7**	**11.9**	**788.3**	**785.8**	**(2.4)**
Devolved Income	15.3	19.5	4.2	122.6	129.2	6.6
Total Trust Income	**115.1**	**131.3**	**16.1**	**910.9**	**915.0**	**4.1**



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

Key messages:

- The Trust income position is favourable to plan by £4.1m year to date.
- This is driven by a shortfall in Clinical income of £2.4m year to date. The Trust has recognised £5.9m of IA pay funding in month (to offset costs incurred in M1 to 7) and £4.7m EPM IA adjustments. High-cost drugs income from commissioners (pass-through drugs and devices) has a £10.7m favourable variance to plan.
- Devolved income is favourable year to date by £6.6m - this includes favourable variances for Community Diagnostic Centre (£2.8m), NHS injury scheme (£0.9m) and donated income (£5.5m) and adverse variances for fire safety works (£1.6m) and Private Patients income (£0.8m).
- The reported income position includes additional pay award funding of £6.8m to offset the cost of the Medical, VSM and a shortfall arising from the AfC pay award. Non-recurrent funding of £5.8m to support the overall budgeted impact of the pay award in year which remains under discussion with C&P ICB. Of this £1.3m has been recognised year to date.

Clinical and other income

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

A&E

16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0

M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12

A&E Plan 23/24
A&E Actual 23/24
A&E Actual 19/20

Day Case

7,000
6,000
5,000
4,000
3,000
2,000
1,000
0

M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12

DC Plan 23/24
DC Actual 23/24
DC Actual 19/20

Non-Elective Inpatient

6,000
5,000
4,000
3,000
2,000
1,000
0

M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12

NEL Plan 23/24
NEL Actual 23/24
NEL Actual 19/20

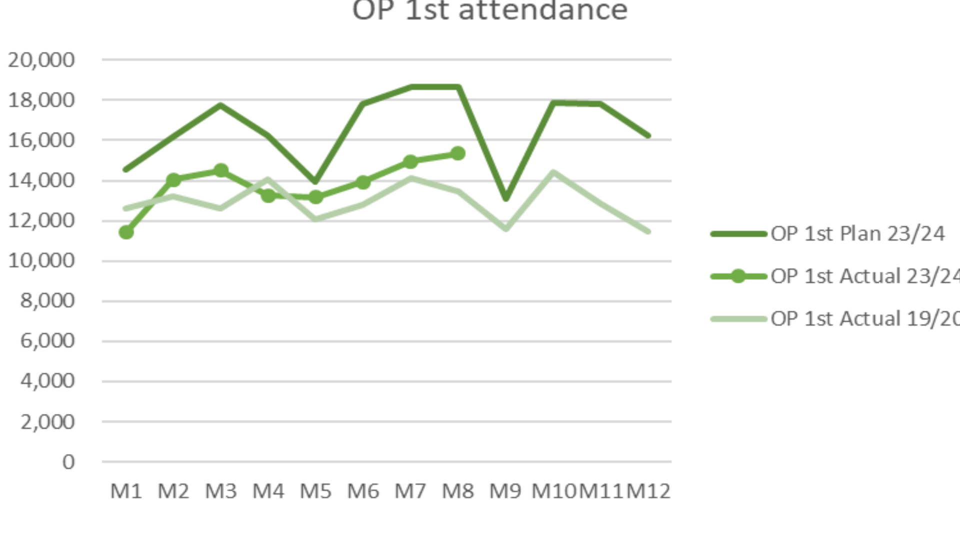
Elective Inpatient

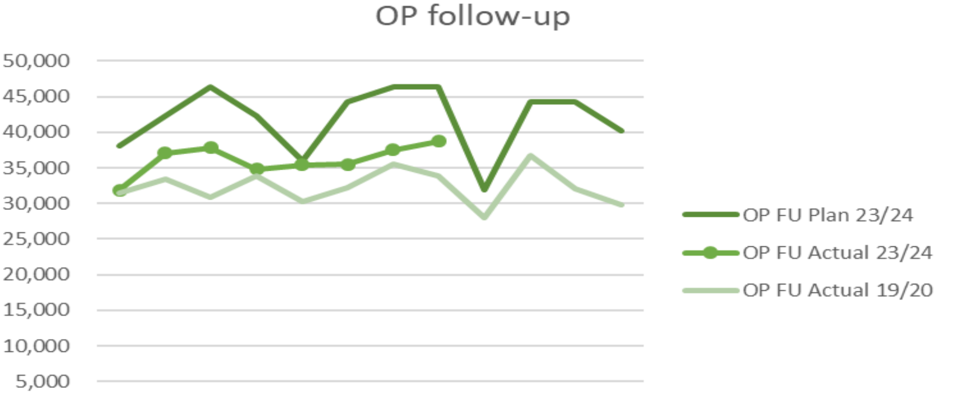
1,600
1,400
1,200
1,000
800
600
400
200
0

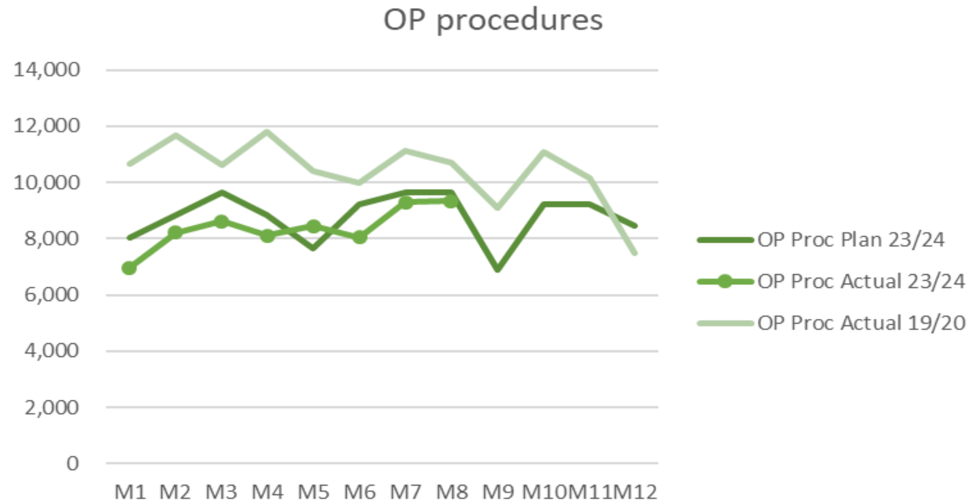
M1 M2 M3 M4 M5 M6 M7 M8 M9 M10 M11 M12

EL Plan 23/24
EL Actual 23/24
EL Actual 19/20

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







Key messages:

- A&E attendances continue to perform higher than both plan and 19-20 levels at month 8. Year to date, A&E is 4.7% above plan and in month 5.4% above plan.
- Non elective spells were above plan at month 8. Year to date, NEL is 1.6% above plan and in month 5.8% above plan.
- Elective spells have a plan that is phased with a larger proportion towards the end of the year. The additional capacity from the Hub has allowed for an above average performance in month 8 yet activity still remains below plan. Year to date, EL is 14.8% below plan and in month 14.9% below plan, but in line with 19-20 month 8.
- Day cases performed below plan at month 8. Year to date, DC is 6.2% below plan, and in month 8.8% below plan.
- Outpatient 1st attendances have had their highest performing month of the year at month 8 yet are still below plan. Year to date, OP 1st are 17.3% below plan, and in month below plan by 17.8%.
- Outpatient follow-up attendances continued to perform below plan at month 8. Year to date, OP FUP is 15.7% below plan, and in month is below plan by 16.6%.
- Outpatient procedures performed close to plan at month 8. Year to date, OP proc are 6.3% below plan and in month 3.1% below plan.

Clinical Income – Elective Payment Mechanism (EPM) 1

EPM:
Elective activity recovery in 23/24 is via a ‘variable’ element of the contract, where Trusts are paid on PbR for a selection of activity including Elective Inpatients, Day-cases, Outpatient First attendances, Outpatients procedures and Chemotherapy.
In August the National Team released a detailed methodology for costing ERF and this has been used in our reporting going forward. In November actual performance data for months 1 to 5 were released using the latest tariff prices.
The below table shows the outcome of the national methodology, with months 6 – 8 forecasted internally.

EPM is £4.6m below original target YTD which falls £17.1m below planned levels.

Please note:
An internal estimate for the impact of the new movement hub opening in month 8 has been included in the table below.
As EPM performance is in an open period throughout the year, the forecast EPM value included below has not been fully recognised in the reported position this month, anticipating a drop in full year performance over winter and due to further IA in December and January.
The Trust has received £5.9m (full year effect) support from NHSE/I for Industrial Action staff cost pressures.

Commissioner	Month 08 23/24						YTD 23/24					
	Target £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Target £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
NHSE	8.1	7.9	(0.2)	8.8	7.9	(0.9)	59.4	55.2	(4.2)	64.0	55.2	(8.8)
C&P ICB	7.9	7.7	(0.2)	8.6	7.7	(0.9)	57.3	58.2	0.9	62.3	58.2	(4.1)
Associate ICBs	4.5	4.0	(0.5)	4.9	4.0	(0.9)	32.4	30.3	(2.1)	35.3	30.3	(5.0)
M8 estimate Hub extra capacity impact	0.0	0.8	0.8	0.0	0.8	0.8	0.0	0.8	0.8	0.0	0.8	0.8
Total	**20.4**	**20.4**	**(0.0)**	**22.3**	**20.4**	**(1.9)**	**149.1**	**144.5**	**(4.6)**	**161.6**	**144.5**	**(17.1)**

Clinical Income – Elective Payment Mechanism (EPM) 2

EPM – National Approach IA:
Guidance was first published in mid August on how the NHS plans to deal with IA in monitoring of these elective recovery plans. Initially, a 2% target reduction was actioned. A further target reduction of 2% has recently been announced to support the impact of industrial action since June. This has been applied to month 8 reporting.

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

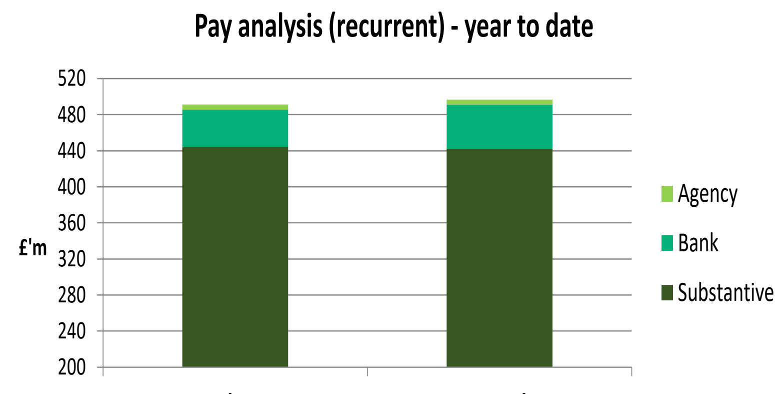
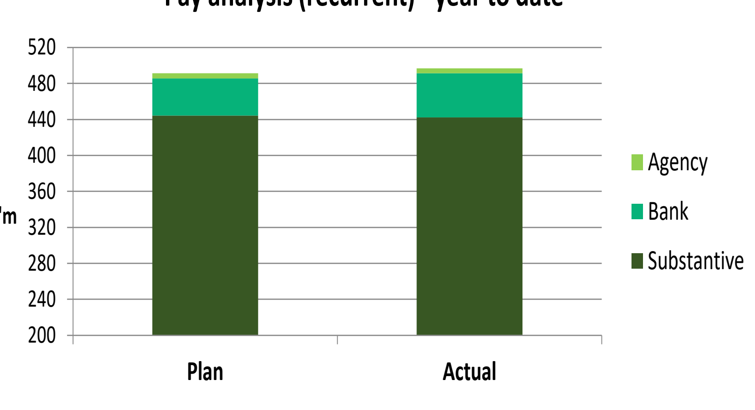
EPM is £2.9m above the adjusted target YTD and £10.6m below the adjusted plan after accounting for the increase in block payment.

Please note:
An internal estimate for the impact of the new movement hub opening in month 8 has been included in the table below.
As EPM performance is in an open period throughout the year, the forecast EPM value included below has not been fully recognised in the reported position this month, anticipating a drop in full year performance over winter and due to further IA in December and January.
The Trust has received £5.9m (full year effect) support from NHSE/I for Industrial Action staff cost pressures.

Commissioner	Month 08 23/24						YTD 23/24					
	Target £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Target £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
NHSE	7.5	7.9	0.4	8.8	7.9	(0.9)	55.2	55.2	(0.0)	64.0	55.2	(8.8)
C&P ICB	7.6	7.7	0.1	8.6	7.7	(0.9)	55.1	58.2	3.0	62.3	58.2	(4.1)
Associate ICBs	4.3	4.0	(0.3)	4.9	4.0	(0.9)	31.2	30.3	(0.9)	35.3	30.3	(5.0)
M8 estimate Hub extra capacity impact	0.0	0.8	0.8	0.0	0.8	0.8	0.0	0.8	0.8	0.0	0.8	0.8
Total Variable	**19.4**	**20.4**	**1.0**	**22.3**	**20.4**	**(1.9)**	**141.6**	**144.5**	**2.9**	**161.6**	**144.5**	**(17.1)**
Target adj. block increase	0.0	0.0	0.0	(0.9)	0.0	0.9	0.0	0.0	0.0	(6.5)	0.0	6.5
Total Overall	**19.4**	**20.4**	**1.0**	**21.4**	**20.4**	**(1.0)**	**141.6**	**144.5**	**2.9**	**155.1**	**144.5**	**(10.6)**

Key messages:

- The Trust has an adverse pay position of £5.7m in the year to date. The adverse impact of Industrial Action has been assessed at £5.9m year to date. The current operating environment including high-levels of vacancies and sickness means that pressure remains for both volume and cost of temporary staffing measures.
- Bank spend as a proportion of the year to date pay bill is 9.9% while agency spend for the same time period is 1.1%. This compared to 8.7% for bank and 1.3% for agency in 22/23. The main driver for the bank spend is the adverse impact of the Industrial Action and the additional shifts required to cover sickness and other vacancies although management action is has reduced the levels of bank enhancements offered and the volume of bank and agency shifts requested.
- The position includes vacancy factors and pay efficiency targets of £24.2m year to date.
- The reported position recognises the Agenda for Change (AfC) pay settlement of 5% which was paid in the June payroll and Medical and VFM settlements that are due to be paid in September payroll. The Trust has recognised additional income to cover pay award costs in excess of the 2.1% that was originally funded.

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

Pay expenditure – trend and year to date

Pay - Staff group

£ Millions	In Month			Year to Date		
	Budget	Actual	Variance	Budget	Actual	Variance
Administrative & Clerical	10.5	11.1	(0.6)	82.8	87.1	(4.3)
Allied Healthcare Professionals	3.9	3.7	0.2	28.3	29.7	(1.4)
Clinical Scientists & Technicians	6.0	5.6	0.3	46.0	45.0	1.0
Medical and Dental	20.4	20.1	0.2	160.2	163.6	(3.4)
Nursing	22.4	22.1	0.4	173.9	171.5	2.4
Total Pay Cost	**63.2**	**62.6**	**0.5**	**491.2**	**496.9**	**(5.7)**

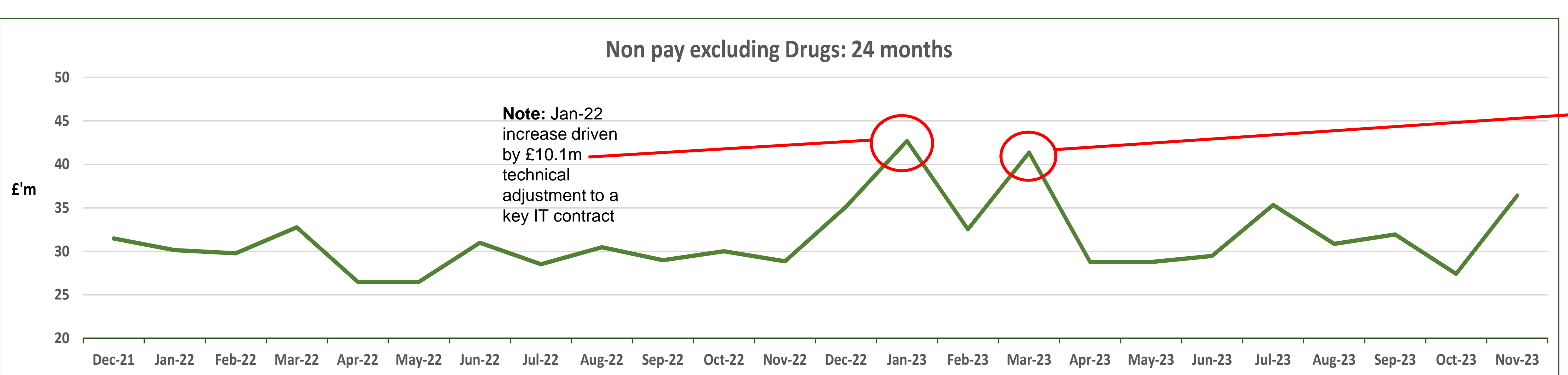
Pay - Employee type

£ Millions	In Month			Year to Date		
	Budget	Actual	Variance	Budget	Actual	Variance
Agency	0.7	0.5	0.2	5.6	5.7	(0.1)
Bank	5.2	5.0	0.2	41.3	49.1	(7.8)
Contracted	0.4	0.4	(0.1)	2.8	3.9	(1.1)
Substantive	57.0	56.8	0.2	441.5	438.3	3.3
Total Pay Cost	**63.2**	**62.6**	**0.5**	**491.2**	**496.9**	**(5.7)**

Key messages:

- Pay expenditure has an adverse variance of £5.7m. Direct cost pressures resulting from industrial action in the year to date total £5.9m. This was mainly incurred within the Medical and Dental category.
- The favourable variance of £0.5m in month has largely been driven by the high-level of vacancies across staffing groups.
- The Month 8 position includes year to date vacancy factors of £21.8m and unallocated efficiency targets of £2.4m.
- The industrial action has adversely affected the Trust's ability to fully deliver the pay efficiency savings that were planned for the year to date so these schemes are £3.5m adverse to plan at Month 8.
- Agency spend year to date represents 1.1% of Trust wide pay expenditure. This is in line with performance in 22/23 and is significantly below the NHS E threshold target of 3.7% of total pay bill.
- NHSE has provided additional funding to the ICS to offset the Industrial Action pay costs incurred in the year to date. The Trust has received confirmation that it will receive £5.9m of funding and this has been recognised in the Month 8 position.

Pay expenditure (continued)



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

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

Key messages:

- At the end of month 8, the Trust's non pay position is £5.1m favourable to plan with expenditure £4.5m adverse to plan in month driven by costs across a number of areas including provision inflation and confirmed staff benefits of £2.0m.
- Favourable year to date variances total £14.9m across supplies and services and premises driven by lower than planned clinical activity and delays in inflationary pressures materialising. There is a benefit of £2.3m due to a reduction in movement in credit loss on receivables and a £1.7m Clinical negligence rebates relating to the 22/23 Maternity incentive scheme allocations. An additional £0.4m of Community Diagnostic Centre (CDC) costs were recognised in month 8 alongside a matching income value.
- Overall drugs expenditure is £10.2m adverse to plan with other pass-through drugs fully offsetting this variance to report an overspend. The Trust expects to receive additional funding to cover the additional pass-through expenditure.
- Costs historically fluctuate from month to month so this area of expenditure will be kept under review to establish whether the current cost pressure is sustained in future months.
- The position at month 8 includes £2.3m of non-recurrent benefits arising from the reduction in credit loss on receivables.

Non pay expenditure

£millions	In Month			Year to Date		
	Budget	**Actual**	**Variance**	**Budget**	**Actual**	**Variance**
Supplies and services	19.6	18.2	1.4	153.7	138.8	14.9
Drugs	15.9	17.3	(1.3)	127.4	137.6	(10.2)
Premises	8.1	7.8	0.3	63.7	59.5	4.2
Movement in credit loss on receivables	(0.4)	0.1	(0.5)	(3.3)	(2.3)	(1.0)
Clinical negligence	2.3	2.3	(0.0)	18.3	16.6	1.7
Efficiency savings	(0.2)	0.0	(0.2)	(1.6)	0.0	(1.6)
All other non pay	3.9	8.0	(4.1)	33.5	36.4	(2.9)
Total Non Pay	**49.2**	**53.7**	**(4.5)**	**391.6**	**386.5**	**5.1**

Key messages:

- The non pay position shows a £5.1m favourable year to date variance at month 8. The key drivers for this position are described on the previous page.
- The negative budget for movement in credit loss on receivables (bad debt provisions) relates to a planned improvement in the level of aged debt (£3.3m) offset by the increase in Injury Cost Recovery provision. It is expected that the Trust will deliver the planned position at year-end.

Non pay expenditure (continued)

£m	YTD Plan			YTD Actual Delivery			YTD Variance		
	Recurrent	Non-recurrent	Total	Recurrent	Non-recurrent	Total	Recurrent	Non-recurrent	Total
Pay	23.3	0.0	23.3	15.0	4.9	19.9	(8.3)	4.8	(3.5)
Non-pay	9.8	0.7	10.4	11.3	0.0	11.3	1.5	(0.7)	0.9
Income	0.1	0.1	0.2	2.5	0.1	2.6	2.4	(0.0)	2.4
	33.2	**0.8**	**34.0**	**28.8**	**4.9**	**33.7**	**(4.4)**	**4.2**	**(0.2)**

£m	Full Year Plan			Forecast Full Year Delivery			Variance		
	Recurrent	Non-recurrent	Total	Recurrent	Non-recurrent	Total	Recurrent	Non-recurrent	Total
Pay	34.5	0.0	34.5	24.2	6.3	30.5	(10.3)	6.3	(4.0)
Non-pay	17.4	1.0	18.4	19.2	0.0	19.2	1.8	(1.0)	0.8
Income	0.2	0.1	0.2	3.4	0.1	3.5	3.3	0.0	3.3
	52.0	**1.1**	**53.1**	**46.8**	**6.4**	**53.2**	**(5.2)**	**5.3**	**0.1**

Key messages:

- Please see the appendix for the detailed efficiency plan.
- The Trust has identified £58.0m efficiencies against a target of £53.1m and is forecasting £53.1m of in year delivery. Of this, £46.8m is recurrent, representing 88% of the total plan.
- The overall position at M8 shows an adverse position of £0.2m.
- The position shows pay efficiencies are currently behind plan by £3.5m with non-pay efficiencies favourable to the plan by £0.9m and Income efficiencies £2.4m ahead of plan.
- The impact of Industrial Action meant that planned productivity improvements driven by increased activity have not been achieved. Additionally the Trust has needed to pay premium rates to cover staffing gaps.
- The Trust will continue to develop plans across 23/24 with the aim to increase productivity and deliver the planned cost efficiency schemes.

£'m	M2 YTD		M3		M4		M5		M6		M7		M8	
	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual
Total Pay Efficiencies	5.9	3.6	3.1	2.0	2.7	1.8	2.7	3.2	2.9	2.6	2.9	3.9	2.9	2.7
Total Non-pay Efficiencies	2.5	3.0	1.3	1.2	1.3	1.6	1.3	1.6	1.4	0.9	1.3	1.4	1.3	1.7
Total Income Efficiencies	0.0	0.6	0.0	0.6	0.0	0.3	0.0	0.4	0.0	0.5	0.0	(0.1)	0.0	0.3
Total Efficiencies - 2023/24	**8.4**	**7.1**	**4.4**	**3.9**	**4.0**	**3.7**	**4.0**	**5.1**	**4.3**	**4.0**	**4.2**	**5.3**	**4.3**	**4.6**

£'m	M9		M10		M11		M12		YTD		Forecast	
	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual
Total Pay Efficiencies	2.7	0.0	2.9	0.0	3.3	0.0	2.2	0.0	23.3	19.9	34.5	30.6
Total Non-pay Efficiencies	1.3	0.0	1.3	0.0	1.3	0.0	3.9	0.0	10.4	11.3	18.4	18.8
Total Income Efficiencies	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	2.6	0.2	3.7
Total Efficiencies - 2023/24	**4.0**	**0.0**	**4.2**	**0.0**	**4.7**	**0.0**	**6.2**	**0.0**	**34.0**	**33.7**	**53.1**	**53.1**

Efficiency Plan & Delivery

CUH 13 week rolling cash flow forecast (£000)

Key messages:

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

Appendices

Month 8 capital expenditure position

NHS CUH

	Year to Date (Month 8)			Forecast		
	Budget £m	Actuals £m	Variance £m	Budget £m	Expenditure £m	Variance £m
Programme						
Cambridge Movement Surgical Hub (CMSH)	7.0	6.4	0.6	7.0	6.5	0.6
Existing Estate/HV/Thrombectomy	3.0	5.9	(3.0)	13.4	13.4	0.0
Cancer Research Hospital (CCRH)	2.0	3.1	(1.1)	11.3	11.3	-
Medical Equipment Replacement	2.0	3.9	(1.9)	12.8	10.8	2.1
Children's Hospital (CCH)	1.4	1.8	(0.4)	3.5	3.5	-
Nuclear Medicine	0.2	0.3	(0.1)	0.2	0.3	(0.1)
Community Diagnostic Hub/Centre (CDC)	0.5	0.1	0.3	0.8	0.8	-
eHospital/Legacy IT Systems	0.5	0.3	0.2	3.0	3.8	(0.7)
Other Developments/PFI	6.1	6.0	0.0	10.7	12.5	(1.8)
Programme Total	**22.6**	**27.9**	**(5.3)**	**62.8**	**62.8**	**-**

Key Issues/Notes Year to Date

£27.9m has been invested YTD, compared to a budget of £22.6m; an overspend of £5.3m. This overspend is primarily due to earlier than budgeted spend on Medical Equipment replacement, Surgical Skills Centre, Backlog Maintenance, Rosie theatre expansion and the Discovery Drive fitout project; all of which are just timing issues - their full year forecasts are in line with budget.

The larger areas of spend this year have been:

- Cambridge Movement Surgical Hub (CMSH) - £6.4m
- Replacement & Installation of Medical Equipment - £3.9m
- Cambridge Cancer Research Hospital (CCRH) - £3.1m
- Replacement Surgical Skills Centre (categorised above under 'Existing Estate') - £2.2m
- ACT-funded surgical robot (categorised under 'Other Developments') - £1.9m
- Cambridge Children's Hospital (CCH) - £1.8m
- High Voltage (HV) network improvements - £0.8m
- Nuclear Medicine refurbishment - £0.3m

Key Issues/Notes Forecast

This year has seen the opening of the CMSH (3 theatres attached to wards P2 & Q2), the new Thrombectomy suite and the refurbished Nuclear Medicine department, plus the commissioning of the ACT-funded second surgical robot. In January the 2 U wards will open, as well as projects including the purchase of equipment for the CDC and a Secure Data Environment for R&D work, in additional the replacement of the Cath Lab, 2 x-ray rooms, our existing surgical robot, and preparatory work for 2 linear accelerators. We will also progress other larger projects, notably CCRH and CCH, as well as the reopening of 3 neuro theatres in the A block (which will be just into the new financial year).

Since setting the budget we revised down the capital spend requirement for CCRH and CCH, which will also reduce the funding we receive for them. In October we received MoU funding of £1.8m for the Secure Data Environment, another MoU for £0.2m for estates improvements to support Mental Health patients, and ACT funding of £0.1m for PCR machines, which has increased our annual budget to £62.8m. Our forecast continues to align with the budget.

Capital expenditure by programme

Balance sheet

	M8 Actual £m
Non-current assets	
Intangible assets	19.8
Property, plant and equipment	545.3
Total non-current assets	**565.1**
Current assets	
Inventories	13.4
Trade and other receivables	64.9
Cash and cash equivalents	148.5
Total current assets	**226.8**
Current liabilities	
Trade and other payables	(194.5)
Borrowings	(13.1)
Provisions	(13.5)
Other liabilities	(88.5)
Total current liabilities	**(309.6)**
Total assets less current liabilities	**482.4**
Non-current liabilities	
Borrowings	(108.9)
Provisions	(9.5)
Total non-current liabilities	**(118.3)**
Total assets employed	**364.0**
Taxpayers' equity	
Public dividend capital	616.0
Revaluation reserve	47.0
Income and expenditure reserve	(299.0)
Total taxpayers' and others' equity	**364.0**

Balance sheet commentary at month 8

- The balance sheet shows total assets employed of £364.0m.
- Non-current liabilities at month 7 are £118.3m, of which £108.9m represents capital borrowing (including PFI and IFRS 16).
- Cash balances remain strong at month 8.
- The balance sheet includes £15.8m of resource to support the completion of the remedial fire safety works expected to be deployed over the coming years.

Trust balance sheet

Board of Directors

Together
Safe
Kind
Excellent

Report to the Board of Directors: 17 January 2024

Agenda item	12
Title	CNST Maternity Incentive Scheme
Sponsoring executive director	Lorraine Szeremeta, Chief Nurse
Author(s)	Meg Wilkinson, Director of Midwifery Hannah Missfelder-Lobos, Clinical Director for Women's Services Claire Garratt, Head of Midwifery Emma Rose, Lead Midwife for Quality and Patient Experience
Purpose	To provide assurance on compliance with the maternity safety standards for year 5 of CNST Maternity Incentive Scheme.
Previously considered by	Quality Committee, 10 January 2024

Executive Summary

As part of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), operated by NHS Resolution, the Trust is required to demonstrate compliance with 10 maternity safety actions. The detailed evidence required to support the compliance assessment has been collated and reviewed by the Trust's Maternity Services team and through the divisional governance structure, resulting in the conclusion that the Trust is able to fully evidence compliance with all 10 of the safety actions. The Trust's evidence has also been reviewed by the Cambridgeshire and Peterborough Integrated Care Board's Maternity Team, which has agreed with CUH's internal assessment of compliance with all 10 safety actions.

At its meeting on 10 January 2024, the Trust's Quality Committee received and discussed a more detailed version of the attached report. In addition to agenda items over the past year which have provided the Committee with evidence and assurance in relation to compliance, the Quality Committee discussed compliance with each of the

safety actions and agreed a recommendation to the Board of Directors that the Trust is able to fully evidence compliance with all 10 of the MIS year 5 safety actions.

Related Trust objectives	Improving patient care
Risk and Assurance	This paper provides assurance in relation to compliance with the CNST MIS year 5 safety actions.
Related Assurance Framework Entries	BAF ref: 004
Legal / Regulatory / Equality, Diversity & Dignity implications?	n/a
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	n/a

Action required by the Board of Directors

The Board is asked to:

- Receive the report.
- Agree the recommendation of the Quality Committee that the Trust is able to fully evidence compliance with all 10 of the MIS year 5 safety actions.
- Approve the Trust's Chief Executive signing the Board Declaration form (summary sheet attached at Appendix 2) confirming agreement with the compliance submission to NHS Resolution.
- Note that the deadline for submission of the completed Board Declaration (also to be signed by the Accountable Officer of the ICB) is 1 February 2024 at 12.00.

Cambridge University Hospitals NHS Foundation Trust

17 January 2024

Report to the Board of Directors

CNST Maternity Incentive Scheme

Director of Midwifery, Clinical Director for Women's Services, Head of Midwifery, Lead Midwife for Governance and Safety, and Lead Midwife for Quality and Patient Experience

1. Introduction

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

1.2 In line with these regulatory requirements and the maternity transformation programme, Maternity Services engage with a series of externally-mandated quality improvement programmes including the national Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) operated by NHS Resolution. As part of the latter, the Trust must demonstrate compliance with all 10 maternity safety actions (see Appendix 1).

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

1.4 This paper summarises the Trust's self-assessment against the 10 maternity safety actions and the conclusion that the Trust is able to fully evidence compliance with all 10 of the safety actions.

1.5 The Trust's evidence has also been reviewed by the Cambridgeshire and Peterborough Integrated Care Board's Maternity Team, which has agreed with CUH's internal assessment of compliance with all 10 safety actions. This was reported to the ICB Board meeting on 12 January 2024.

1.6 At its meeting on 10 January 2024, the Trust's Quality Committee received and discussed a more detailed version of this report. In addition to agenda items over the past year which have provided the Committee with evidence and assurance in relation to compliance, the Quality Committee discussed compliance with each of the safety actions and agreed a recommendation to the

Board of Directors that the Trust is able to fully evidence compliance with all 10 of the MIS year 5 safety actions.

2. Summary position against the 10 safety actions

2.1 This section provides an update on the position and assurance relevant to each safety action.

2.2 All evidence has been submitted to the ICB and the LMNS (Local Maternity and Neonatal System) for their detailed review.

2.3 The reporting timeframe for all safety actions is 30 May 2023 to 7 December 2023 unless otherwise stated.

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

2.4 A multi-disciplinary team has reviewed all perinatal deaths meeting the following criteria using the MBRRACE-UK Perinatal Mortality Review Tool (PMRT):

- All late fetal losses – 22+0 to 23+6 weeks gestation
- All stillbirths from 24+0 weeks gestation
- All neonatal deaths up to 28 days from birth

2.5 Notification of all eligible deaths to MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) has been within seven working days.

2.6 During the reporting period, 29 cases were under review with one completed. All parents have been informed of the local review of their care and that of their baby. 100% of these cases have had parents' perspectives of care and any questions sought. For the reporting period, a PMRT (Perinatal Mortality Review Tool) summary has been submitted to the Board up to and including 22 September 2023 and the next report is due in January 2024 which will include the remaining timeframe up to and including 7 December 2023.

2.7 100% of PMRT reviews were conducted within two months of the death (target 95%) and 100% were completed to the draft report stage within four months of the death and published within six months (target 60%).

2.8 Quarterly reports have continued to be submitted via the Trust-wide Learning from Deaths Committee, including details of the reviews and action plans. These reports have also been shared with the Board level safety champions.

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

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

2.10 As shown in Table 1, the monthly scorecard demonstrates the Trust meets the MIS year 5 requirement for passing the data quality rating for 10 of the 11 CQIMs in July 2023.

Table 1: Trust assurance that 10 CQIMs pass the associated data quality criteria

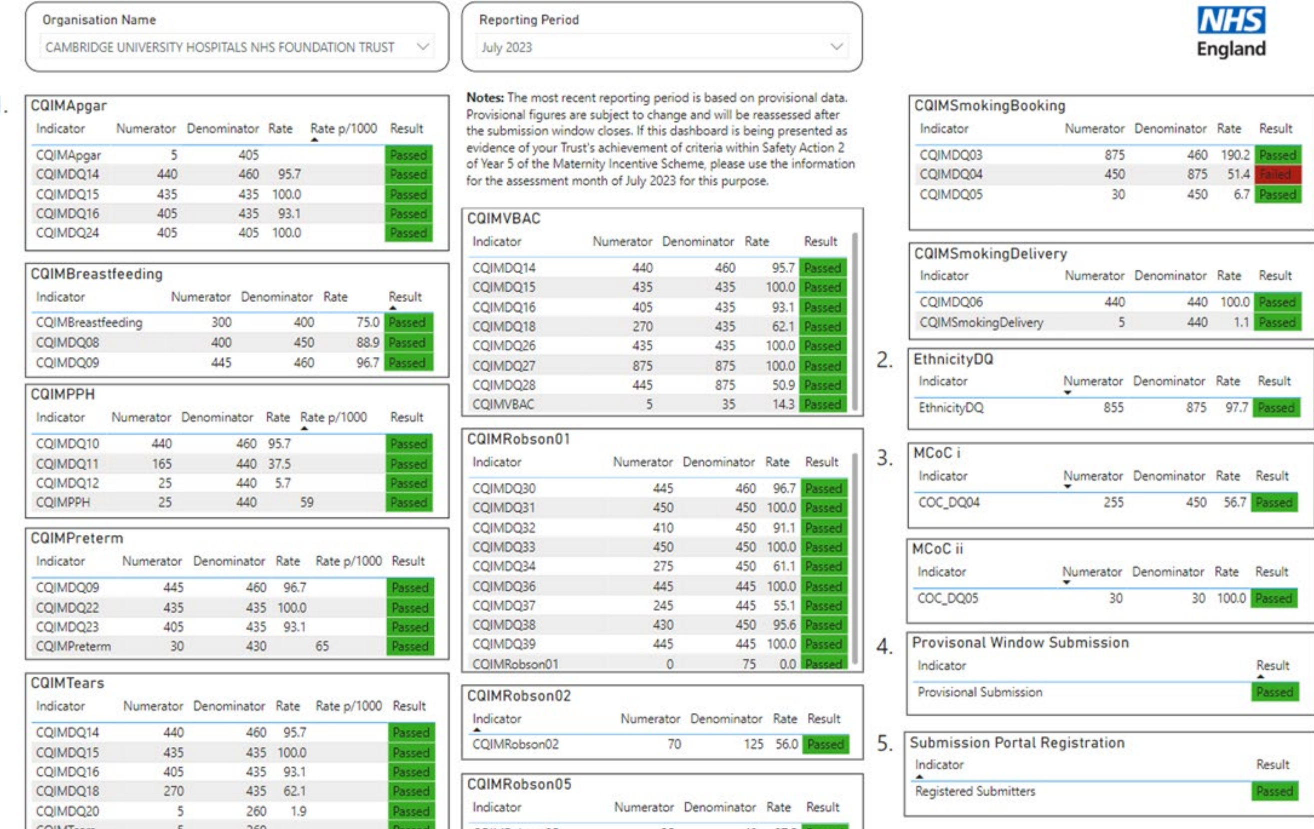
Indicator	Data quality rating
Babies that were fully or partially breastfed at 6 to 8 weeks old	
Babies who were born preterm	Passed
Babies with a first feed of breast milk	Passed
Babies with an APGAR score between 0 and 6	Passed
Caesarean section rate for Robson Group 1 women	Passed
Caesarean section rate for Robson Group 2 women	Passed
Caesarean section rate for Robson Group 5 women	Passed
Women who had a 3rd or 4th degree tear at delivery	Passed
Women who had a PPH of 1,500ml or more	Passed
Women who were current smokers at booking appointment	Failed
Women who were current smokers at delivery	Passed
Women with a vaginal birth following a caesarean section	Passed

2.11 We currently do not pass the indicator 'Women who were current smokers at booking appointment'. This is because the data quality checks rely on completion of all booking assessments within three days of the first appointment. During the Covid-19 pandemic a split booking system of a telephone appointment followed by a face to face appointment (both with midwives) was introduced to accommodate the challenges of a partially shielding workforce and the need to reduce in-person appointments in hospital clinics and GP surgeries. Following the pandemic this split booking process has continued due to community midwifery staffing pressures and reduced availability of clinical space on and off-site. This has meant that the telephone element of the booking appointment was needed to maintain a safe service. Since summer 2023 we have been phasing out these split bookings and in January 2024 all bookings undertaken by the Rosie community midwifery team will be a single face to face appointment. This will then improve the data quality rating for the MSDS CQIM. Final data submission on the MSDS dashboard is visible 2 months after the end of month

data release, therefore it is anticipated that the January data quality will be visible by April 2024.

2.12 In July 2023 data contained valid ethnic category for 97.7% of women booked in the month, exceeding the MIS year 5 90% target – see Table 2, 3rd column, point number 2.

Table 2: Ethnicity data quality (source: Microsoft Power BI)



Organisation Name: CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

Reporting Period: July 2023

NHS England

1.

CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMApgar	5	405			Passed
CQIMDQ14	440	460	95.7		Passed
CQIMDQ15	435	435	100.0		Passed
CQIMDQ16	405	435	93.1		Passed
CQIMDQ24	405	405	100.0		Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	300	400	75.0	Passed
CQIMDQ08	400	450	88.9	Passed
CQIMDQ09	445	460	96.7	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	440	460	95.7		Passed
CQIMDQ11	165	440	37.5		Passed
CQIMDQ12	25	440	5.7		Passed
CQIMPPH	25	440		59	Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	445	460	96.7		Passed
CQIMDQ22	435	435	100.0		Passed
CQIMDQ23	405	435	93.1		Passed
CQIMPreterm	30	430		65	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	440	460	95.7		Passed
CQIMDQ15	435	435	100.0		Passed
CQIMDQ16	405	435	93.1		Passed
CQIMDQ18	270	435	62.1		Passed
CQIMDQ20	5	260	1.9		Passed
CQIMTears	5	260			Passed

Notes: The most recent reporting period is based on provisional data. Provisional figures are subject to change and will be reassessed after the submission window closes. If this dashboard is being presented as evidence of your Trust's achievement of criteria within Safety Action 2 of Year 5 of the Maternity Incentive Scheme, please use the information for the assessment month of July 2023 for this purpose.

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	440	460	95.7	Passed
CQIMDQ15	435	435	100.0	Passed
CQIMDQ16	405	435	93.1	Passed
CQIMDQ18	270	435	62.1	Passed
CQIMDQ26	435	435	100.0	Passed
CQIMDQ27	875	875	100.0	Passed
CQIMDQ28	445	875	50.9	Passed
CQIMVBAC	5	35	14.3	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	445	460	96.7	Passed
CQIMDQ31	450	450	100.0	Passed
CQIMDQ32	410	450	91.1	Passed
CQIMDQ33	450	450	100.0	Passed
CQIMDQ34	275	450	61.1	Passed
CQIMDQ36	445	445	100.0	Passed
CQIMDQ37	245	445	55.1	Passed
CQIMDQ38	430	450	95.6	Passed
CQIMDQ39	445	445	100.0	Passed
CQIMRobson01	0	75	0.0	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	70	125	56.0	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	35	40	87.5	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	875	460	190.2	Passed
CQIMDQ04	450	875	51.4	Failed
CQIMDQ05	30	450	6.7	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	440	440	100.0	Passed
CQIMSmokingDelivery	5	440	1.1	Passed

2. EthnicityDQ

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	855	875	97.7	Passed

3. MCoC i

Indicator	Numerator	Denominator	Rate	Result
COC_DQ04	255	450	56.7	Passed

MCoC ii

Indicator	Numerator	Denominator	Rate	Result
COC_DQ05	30	30	100.0	Passed

4. Provisonal Window Submission

Indicator	Result
Provisional Submission	Passed

5. Submission Portal Registration

Indicator	Result
Registered Submitters	Passed

2.13 The Trust has suspended Midwifery Continuity of Carer (due to high staffing vacancies in 2021-2022) and therefore under MIS year 5 terms, this aspect of safety action 2 does not need to be captured in MSDS reporting.

2.14 As evidenced by Tables 1 and 2, the Trust continues to submit data to the MSDS and can confirm that there are two members of the Trust's information management team who are registered to submit MSDS data to the SDCS Cloud.

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

2.15 The Trust continues to provide transitional care to infants in line with the principles of the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice (2017). The pathways were jointly approved and

implemented by the maternal and neonatal teams. Transitional care (TC) has the potential to prevent admissions to the neonatal unit, reduce separation of infants from their mothers and facilitates additional support for small and/or late pre-term babies and their families (BAPM 2017).

2.16 TC is a service, rather than a location, and in CUH it is provided on Delivery Unit, Lady Mary Ward (the postnatal ward), Obstetric Close Observation Unit and Charles Wolfson Ward (low-dependency paediatric ward). Local guidelines and operational policies support this service and outline clear pathways of care and staffing levels. At present the Trust is not fully compliant with the BAPM recommendation to offer TC to infants born at gestation 34+0 to 34+6 weeks. MIS year 5 requires that an action plan for providing this with clear timeframes is signed off and this was received by the Quality Committee in January 2024.

2.17 The neonatal team are involved in decision making and planning of care for babies in TC, evidenced by the neonatal TC guideline and quarterly audits (PRN11808). Audit findings are shared at the ATAIN (Avoiding Term Admissions into Neonatal units) group meetings and any themes or areas of concern identified inform the ATAIN action plan.

2.18 The ATAIN working group meets every 1-2 months (more frequently than the MIS year 5 quarterly minimum) to review term admissions data and to identify, plan and implement improvements. A robust process is in place whereby all admissions to the neonatal unit of infants of 37 or more weeks' gestation are reviewed by maternity and neonatal representatives. Admissions that are identified as potentially avoidable, i.e. where mother and baby may not have needed to be separated had care been provided differently, are then presented to the wider ATAIN group meeting for discussion and identification of themes. These multi-professional meetings are minuted and KPIs are tracked by SPC to identify areas of concern and improvement.

2.19 An ATAIN scorecard and progress with the ATAIN action plan are reported at directorate and divisional governance, to the perinatal safety champions and at the LMNS Safety & Quality Operational Group, as per MIS year 5 guidance, ensuring oversight of the ATAIN programme.

2.20 Version 8 of the ATAIN action plan was previously approved by Quality Committee and the LMNS in July 2022. As of November 2023 this action plan was 98% complete (49/50 actions) and therefore a new ATAIN action plan (v9) was developed by the ATAIN group. This was approved by the directorate quadrumvirate (which includes the HoM, obstetric and neonatal clinical directors, and operational lead) on 12 December 2023 and presented to Board level safety champions on 18 December 2023 and divisional governance on 19 December 2023. Request for approval by the LMNS and ICB which meets in January 2024 has been sought and additional approval was provided by the Quality Committee in January 2024.

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

a) ***Obstetric medical workforce:***

2.21 MIS year 5 requires that Trusts ensure the RCOG guidance on engagement of short- and long-term locums is met. Audit (PRN11591) has demonstrated 100% compliance with the long-term locums employed in the period 01/05/2023 to 31/10/2023. No short-term locums are employed by the Trust within maternity services. The reporting timeframe for this is 6 months of activity after February 2023.

2.22 A local review of our compliance with the RCOG guidance on compensatory rest for consultants and senior speciality and specialist doctors are working as non-resident on-call out of hours, demonstrated that on 16 out of 18 occasions (89%) consultants were able to get adequate compensatory rest. However, the arrangements for this is informal. A new obstetric rota is being trialled from 2 Jan 2024 to incorporate a different way of working and covering on calls and will be reviewed over 3-6 months. Alongside this, a review of medical staffing is being undertaken and a business plan developed to increase obstetrics and gynaecology medical staffing within division E as part of the CQC maternity improvement plan.

2.23 A monthly rolling audit (PRN11486) of local compliance with the RCOG workforce document 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service' demonstrates 100% compliance between 30 May 2023 and 31 October 2023. Audit is currently underway to confirm compliance up to the end of the reporting period of 7 December 2023. To date it has not been possible to audit standard 3 – attendance at debriefs – as there has been no mechanism to collect this data and debriefs are usually ad hoc. It has been identified that the lead Professional Midwifery Advocate will coordinate a structured approach to debriefs as of January 2024 and collect data regarding consultant attendance to ensure that going forward this standard can be effectively audited.

2.24 As per MIS requirements, a process is in place whereby non-compliant episodes of care are reviewed at unit level (the weekly maternity MDT (multidisciplinary) rapid review meeting) for oversight and identification of departmental learning and implementation of actions plans if required.

b) ***Anaesthetic medical workforce:***

2.25 The service is able to evidence compliance with Anaesthesia Clinical Services Accreditation (ACSA) through the obstetric anaesthetic medical rotas. These have been reviewed and accepted by the CNST working party and are available in the MIS year 5 evidence log on the maternity shared drive.

c) *Neonatal medical workforce:*

2.26 The neonatal unit meets the British Association of Perinatal Medicine (BAPM) National standards of junior medical staffing as evidenced by the Rosie neonatal medical workforce template previously presented to Board for MIS year 4 compliance and the medical rotas. These have been reviewed and accepted by the CNST working party and are available if requested.

d) *Neonatal nursing workforce:*

2.27 A workforce review paper detailing gaps in BAPM nursing staffing compliance was included in the October 2023 bi-annual midwifery and nursing staffing paper submitted to the Board of Directors. An action plan to achieve BAPM compliance was submitted to the Quality Committee in January 2024 and will be shared with the Neonatal Operational Delivery Network and the LMNS Safety & Quality operational group to meet the evidential requirements within this standard.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

2.28 A midwifery establishment review was presented to the Board of Directors in May 2023 and in November 2023. The report demonstrated compliance with all minimum evidential requirements including use of BirthRate+ to systematically calculate the required establishment.

2.29 The current funded establishment for Midwifery was increased in 2023 and now fully aligns with the recommendations from the most recent BirthRate+ review (2022). This includes the funding for specialist midwife posts.

2.30 A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE, 2015). The BirthRate+ live acuity tool was introduced at CUH in May 2021 and enables the capture of real time data on staffing and acuity and is the tool used to capture midwifery red flags. The Trust Escalation to Divert Status Plan for Maternity Services Policy provides mitigation and escalation action to minimise the impact of red flag events, including redeployment of staff to ensure high acuity areas are safely staffed and utilisation of the operational bleepholder (site safety midwife) and Manager of the Day/on-call night manager. In MIS year 4 an action plan was required due to non-compliance with the 2 reportable red flags – Supernumerary labour ward coordinator status and one to one care in labour. Following completion of this action plan and an intensive requirement and retention plan, these standards are now compliant, as described in points 2.30 and 2.31 below.

2.31 The Trust is required to demonstrate 100% compliance with supernumerary labour ward coordinator status. Table 3 provides the data from BirthRate+ for 30 May to 7 December 2023. In October there was one event where this wasn't achieved, however, as a one-off event CNST MIS guidance states that the Trust can still declare compliance.

Table 3: Supernumerary labour ward coordinator status

May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Up to 7 Dec-23
100%	100%	100%	100%	100%	98%	100%	100%

2.32 The Trust is required to demonstrate one to one care in active labour. Table 4 provides the data from the CHEQS births and deliveries report.

Table 4: 1:1 care in active labour

May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Up to 7 Dec-23
100%	100%	100%	100%	100%	100%	100%	100%

Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

2.33 The Saving Babies' Lives Care Bundle version three (SBLv3) brings together six elements of care that are recognised as evidence-based and/or best practice, utilising an improvement-focused care bundle approach to tackle stillbirth and early neonatal death. SBLv3 was published in July 2023.

2.34 The six elements of the SBLv3 are:

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movements
4. Effective fetal monitoring during labour
5. Reducing pre-term births
6. Pregestational diabetes [new element in this version]

2.35 For MIS year 5, in line with the Three-Year Delivery Plan for Maternity and Neonatal Services, Trusts are expected to provide assurance to the Trust Board and ICB that they are on track to fully implement all six elements by March 2024. Assurance is monitored via quarterly quality improvement discussions with the ICB, using the new national implementation tool which became available to the Trust mid-August 2023.

2.36 To evidence adequate progress against this deliverable by the MIS submission deadline, providers are required to demonstrate implementation of 70% of all interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element. The percentages are calculated using the national tool following evidence review and confirmation of implementation by the LMNS and ICB.

2.37 CUH met with the LMNS and ICB as per the quarterly schedule of meetings agreed and tracked implementation and evidence using the national tool.

2.38 The LMNS and ICB have formerly confirmed that CUH have met the requirements of CNST MIS year 5 for all 6 elements (Table 5).

Table 5: Board confirmation of Trust compliance with SBLCBv3

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	95%	Partially implemented	95%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 5	Preterm birth	Partially implemented	74%	Partially implemented	74%	CNST Met
Element 6	Diabetes	Partially implemented	67%	Partially implemented	67%	CNST Met
All Elements	TOTAL	Partially implemented	81%	Partially implemented	81%	CNST Met

2.39 The quarter 1 implementation tool and the evidence submitted demonstrating implementation and compliance are available in the SBLCBv3 evidence folder within the maternity shared drive and has also been submitted to the FutureNHS workspace as per SBLCBv3 requirements.

2.40 Where compliance for interventions has not yet been achieved, or where an intervention has not yet been fully implemented, an action plan for how the Trust plans to fully implement the intervention by 30 March 2024 has been presented and agreed by the ICB as per the requirements of CNST MIS year 5. The action plans are contained within the quarter 1 implementation tool and relevant audits which are summarised in Appendices 5-8). These are also available in the SBLCBv3 evidence folder within the maternity shared drive and on the FutureNHS workspace.

Safety Action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users

2.41 Trusts must ensure a funded, user-led maternity and neonatal voices partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP guidance. In 2020 The Rosie was proud to become one of the first NHS provider organisations to have a joint maternity and neonatal voice partnership which extended the remit of coproduction and service voice to the entire perinatal service. This is now the national standard as a core intervention for provision of a safe service and is well-embedded within the provision of care at the Rosie.

2.42 The Rosie MNVP has an agreed Terms of Reference outlining minimum number of service users and MDT attendance required to be quorate, reflecting the commitment to co-production and listening to service user voice. Meetings are minuted and held quarterly, including an AGM where the allocation of funds and the next year's co-produced action plan are agreed. Themes from patient complaints and maternity KPIs are shared and discussed at the meetings. The Rosie MNVP chair also attends the monthly directorate governance meetings, enabling check and challenge from a patient experience perspective.

2.43 The Rosie MNVP is funded through the LMNS and the chair is remunerated. The chair and other service user members are able to claim out of pocket expenses in a timely way.

2.44 As per MIS year 5 requirements, an annual work plan is co-produced with the Rosie MNVP (submitted to the Quality Committee in January 2024), utilising the findings of the annual CQC maternity survey data publication, including analysis of free text data. The workplan includes actions to ensure ethnic minority voices are heard and those of women living in areas with high levels of deprivation, as well as those of bereaved families. Progress against the work plan is monitored by the safety champions and LMNS Board. This workplan is also regularly monitored by the Trust's Patient Experience Group and the LMNS Board.

2.45 Trusts are expected to ensure neonatal and maternity service user feedback is collated and acted upon, with evidence of reviews of themes and subsequent actions being monitored by the local safety champions (the local governance reporting process which supports this has been reviewed by the Quality Committee in January 2024). The non-executive maternity safety champion has also attended a Rosie MNVP meeting in 2023.

2.46 In 2023 the Rosie MNVP launched a multi-lingual listening telephone service to support patient feedback. The Rosie MNVP Annual Report, the Rosie Hospital Communications Guide and the recent 15 Steps Report provide evidence of previous co-production and proactive gathering of patient feedback.

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house' one day multi professional training?

2.47 A local training plan is in place to implement all six core modules of version 2 of the Core Competency framework (CCFv2) over a 3-year period. This successfully launched 11 December 2023 with the introduction of a week-long training programme for the Rosie Hospital multi-professional maternity services team (a copy of the programme was submitted to the Quality Committee in January 2024).

2.48 The plan was been agreed by the maternity quadrumvirate before sign-off by the Trust Board and the LMNS and ICB in September 2023.

2.49 As per MIS year 5 requirements the training plan is based on the "How to" Guide developed by NHS England and includes the 6 core modules and four key principles:

1) Service user involvement in developing and delivering training.
2) Training is based on learning from local findings from incidents, audit, service user feedback and investigation reports. This should include reinforcing learning from what went well.
3) Promote learning as a multidisciplinary team.
4) Promoted shared learning across a Local Maternity and Neonatal System.

2.50 Trusts are also required to demonstrate 90% attendance of relevant staff groups over a 12 month period ending 1 December 2023 against the current core competency training requirements and in line with MIS year 5 guidance. Compliance with this has been reported to directorate and divisional governance. 90% compliance was achieved for fetal surveillance training and obstetric emergencies training (see Tables 6-8). 90% compliance was not achieved for neonatal resuscitation training which was 81% overall. However, on 23 October 2023 NHS Resolution issued confirmation that in light of the national medical strikes and pressures this placed on staff attendance at mandatory training they have temporarily reduced the 90% compliance target to 80% as long as an action plan to improve compliance within 12 weeks is agreed by Trust Board. The action plan was presented to and approved by the Quality Committee in January 2024.

Fetal surveillance training

2.51 This is delivered in-house via a Multi-disciplinary Team (MDT) Cardiotocograph (CTG) study day and online K2 competency assessment. As of 01/12/2023 overall compliance for this was 91% with over 90% achieved in each relevant staff group (Tables 6 and 7).

Table 6: CTG study day training compliance as of 01/12/2023

Staff Type	Total	Trained	Compliant YTD %
Midwife	303	274	**90.4%**
Consultant Obstetrician	14	14	**100%**
Registrar Obstetrician	20	20	**100%**
Grand Total	**336**	**307**	**91.4%**

Table 7: K2 competencies compliance as of 01/12/2023

Staff Type	Total	Trained	Compliant YTD %
Midwife	282	259	**91.8%**
Consultant Obstetrician	14	13	**92.8%**
Registrar Obstetrician	12	12	**100%**
Grand Total	**308**	**281**	**91.2%**

PROMPT training

2.52 **Pr**actical **O**bstetric **M**ulti **P**rofessional **T**raining (PROMPT) is the obstetric emergency training delivered via in-house face-to-face MDT training and online eLearning videos and quizzes. As of 01/12/2023 overall compliance for this was 92.41% with >90% achieved in each relevant staff group (Table 8).

Table 8: PROMPT training compliance as of 01/12/2023

Staff Type	Compliance
Midwife	92.72%
MSW	90.48%
Consultant anaesthetist	92.31%
Consultant obstetrician	92.86%
Anaesthetic registrar	92.31%
Obstetric Registrar and SHO	93.55%
Grand total	**92.41%**

Neonatal resuscitation training

2.53 Locally this is referred to as Newborn Basic Life Support (NBLS) training. As of 01/12/2023 overall compliance for this was 81% with >80% achieved in each relevant staff group (Table 9). An action plan for achieving 90% compliance in each group is included in the action plan presented to the Quality Committee in January 2024.

Table 9: NBLS training compliance as of 01/12/2023

Staff Type	Eligible population for CNST	Number compliant	Compliant %
Neonatal Intensive Care Unit (NICU) Medical	43	36	84
NICU Nursing	78	64	81
Midwifery	264	212	80
MSW	30	25	83
Grand Total	415	337	**81%**

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

2.54 The role of the Board Level Safety Champion is to “develop strong partnerships, that promote the professional cultures needed to deliver better care and play a central role in ensuring that mothers and babies continue to receive the safest care possible by adopting best practice” (*Maternity and neonatal safety champions Toolkit, September 2020).* The role of the safety champions and the Perinatal Quality Surveillance Model are well-embedded within the Trust.

2.55 Our Board level safety champions, the Chief Nurse and designated non-executive director support quality improvement by listening to staff and service user concerns and working with designated leads across perinatal services to ensure learning and improvements are shared within the Trust and the LMNS and ICB.

2.56 We have continued to have nominated obstetric, neonatal and midwifery safety champions who are jointly responsible for championing maternity safety locally, reporting to the Board level safety champions and the LMNS and ICB.

2.57 As per MIS year 5 requirements, the Board level champions meet bi-monthly with the maternity safety champions where they are cited on and discuss locally identified issues, safety intelligence, serious incidents, the Trust claims scorecard (at least twice), quality improvement work and progress on this,

service user and staff feedback, concerns and complaint themes, and the actions being taken to address any issues.

2.58 The Board level safety champions have also met at least twice with a representative of the quadrumvirate as per MIS year 5 requirements.

2.59 The directorate highlight report which incorporates the perinatal quality surveillance model minimum data set, is also shared with Board level safety champions and the LMNS and ICB monthly.

2.60 Both Board level safety champions have registered on the FutureNHS workspace.

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (*known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023*) and to NHS Resolution's Early Notification (EN) scheme from 6 December 2022 to 7 December 2023?

2.61 All qualifying cases in the time frame 6 December 2022 to 7 December 2023 have been reported to HSIB/MNSI (5/5) and NHS Resolution's EN scheme. In accordance with Regulation 20 of the Health and Social Care Act 2008, statutory duty of candour has been undertaken for 100% families and they have also been advised of enquires to be undertaken as per HSIB/MNSI and the EN scheme.

3. Next steps

3.1 In order to be eligible for payment under the scheme, NHS trusts must submit their completed Board Declaration by 1 February 2024 and must comply with the following conditions:

1. Trusts must achieve **all** ten maternity safety actions.
2. The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services.
3. The Trust Board declaration form must be signed and dated by the Trust's Chief Executive Officer (CEO) to confirm that:
    - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.
    - There are no reports covering either year 2022/23 or 2023/24 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such

reports should be brought to the MIS team's attention before 1 February 2024.

4. In addition, the CEO of the Trust will ensure that the AO for their Integrated Care System (ICS) is apprised of the MIS year 5 safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

3.2 A review of the evidence referred to in this document has also been undertaken by LMNS and ICB representatives. On 10 January 2024 the authors of this report met with the LMNS and ICB to confirm that the evidence requirements have been met. This conformation was provided by the LMNS and ICB and they will therefore be recommending to the ICB Accountable Officer to approve the Board Declaration form.

4. Recommendation

4.1 The Board of Directors is asked to:

- Receive the report.
- Agree the recommendation of the Quality Committee that the Trust is able to fully evidence compliance with all 10 of the MIS year 5 safety actions.
- Approve the Trust's Chief Executive signing the Board Declaration form (summary sheet attached at Appendix 2) confirming agreement with the compliance submission to NHS Resolution.
- Note that the deadline for submission of the completed Board Declaration (also to be signed by the Accountable Officer of the ICB) is 1 February 2024 at 12.00.

Appendix 1: CNST Maternity Incentive Scheme Year 5 Safety Standards

Safety action 1:
Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Safety action 2:
Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Safety action 3:
Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

Safety action 4:
Can you demonstrate an effective system of clinical workforce planning to the required standard?

Safety action 5:
Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Safety action 6:
Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Safety action 7:
Listen to women, parents and families using maternity and neonatal services and coproduce services with users

Safety action 8:
Can you evidence the following 3 elements of local training plans and 'in-house' one day multi professional training?

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

Safety action 10:
Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (*known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023*) and to NHS Resolution's Early Notification (EN) scheme from 6 December 2022 to 7 December 2023?

Maternity Incentive Scheme - Board declaration form

Trust name	**Cambridge University Hospitals NHS Foundation Trust**
Trust code	**T022**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	No	Yes	-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**9**	**1**		
Total sum requested			**-**	

Sign-off process confrming that:

* The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2023/24) or the previous financial year (2022/23)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.
* If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

Electronic signature of Trust Chief Executive Officer (CEO):	
For and on behalf of the Board of	Cambridge University Hospitals NHS Foundation Trust
Name:	Roland Sinker
Position:	Chief Executive
Date:	

Electronic signature of Integrated Care Board Accountable Officer:	
For and on behalf of the board of	
Name:	
Position:	
Date:	

Board of Directors

Together
Safe
Kind
Excellent

Report to the Board of Directors: 17 January 2024

Agenda item	11
Title	Research and Development
Sponsoring executive director	Ashley Shaw, Medical Director
Author(s)	John Bradley, R&D Director
Purpose	To provide an update on Research and Development activity
Previously considered by	Management Executive, 11 January 2024

Executive Summary

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

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

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

Action required by the Board of Directors

The Board is asked to receive the report.

Cambridge University Hospitals NHS Foundation Trust

17 January 2024

Board of Directors

Research and Development

John Bradley, Director of R&D

1. Innovation - NIHR HealthTech Research Centre

1.1 A team led by Professor Peter Hutchinson has been awarded £3m to establish a NIHR (National Institute for Health Research) HealthTech Research Centre (HRC) specialising in conditions affecting the brain and spine. The NIHR HRC aims to support new technologies designed to improve the experience of people affected by these conditions, and make these technologies more widely available. Identification of unmet need through structured workshops with patients and professionals will be progressed in parallel with meetings with providers of solutions, in particular small and medium-sized enterprises.

1.2 Promising solutions identified from this process will undergo a comprehensive review of their potential by patients, and legal and medical experts before proceeding to the next stage. The evaluation process will include design and delivery of studies and dissemination of findings. Implementation of evaluated solutions will be delivered in partnership, including with Academic Health Science Networks and NHS Commissioning Groups.

1.3 The HRC will focus on five clinical themes: 1. Prevention and Education; 2. Acute Care and Monitoring; 3. Diagnostics; 4. Restoration; and 5. Life Course. An important aspect will be training the next generation of health technology researchers, and formation of a national network with NHS, academic, industrial, public body and charity partners.

2. Health Informatics

2.1 A Memorandum of Understanding (MOU) between CUH and the Department for Health and Social Care (DHSC) for the Capital Award related to the East of England Sub-National Secure Data Environment (SDE) for Research and Development was signed in November 2023. A website for the SDE was launched in December 2023 - https://www.eoe-securedataenvironment.nhs.uk. The initial focus will be on cardiovascular disease, reflecting the health and care priorities of Integrated Care Systems (ICSs) across the East of England, and a protocol for the initial use case was submitted to the NHS Health Research authority in January 2024. In addition, the SDE plans to pilot inclusion of several consented NIHR BioResource datasets.

3. Metrics – 'Research Reset'

3.1 The NIHR Research Reset Programme was established to build back a thriving, sustainable and diverse R&D portfolio within the NHS following the pandemic. As part of the Programme, NIHR have assessed whether commercial studies that are open on the Clinical Research Network (CRN) portfolio are delivering to time and target. Of the 121 open commercial portfolio studies sponsored by CUH, 90% have been assessed as 'on track'. NIHR have indicated that future NIHR competitions will include an assessment, as part of the selection process, that applying NHS trusts and their university partners can demonstrate that they are actively managing their portfolios as sponsors. This will consider whether portfolios are at/near 80%.

4. Inclusivity

D-CYPHR

4.1 D-CYPHR, the NIHR Children and Young People's BioResource, was launched nationally in July 2023 to recruit children up to the age of 15 who provide information about their health and lifestyle, access to their health records and consent to be contacted about research studies. To date over 2,500 children have consented, of whom over 1,000 have provided a saliva sample from which DNA can be extracted. This brings the total number of children and young people enrolled in the NIHR BioResource to over 2,500, including children who have rare diseases or inflammatory bowel disease.

Improving Black Health Outcomes (IBHO)

4.2 The Improving Black Health Outcomes study was launched in December 2023 and is recruiting people from Black communities, with and without health conditions that are more common in Black communities, including diabetes, pregnancy/childbirth complications and sickle cell disease.

5. NIHR Cambridge Biomedical Research Centre – Scientific Advisory Board

5.1 The NIHR Biomedical Research Centre will be reviewed by an international Scientific Advisory Board on 25 and 26 April 2024.

6. Recommendations

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

Board of Directors

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 17 January 2024

Agenda item	12
Title	Quarterly Report on Safe Working Hours: Doctors and Dentists in Training (2023/24 Q2)
Sponsoring executive director	Dr Ashley Shaw, Medical Director
Author(s)	Dr Jane MacDougall, Guardian of Safe Working
Purpose	To receive the report on safeguarding working hours.
Previously considered by	Management Executive, 11 January 2024

Executive Summary

This is the second quarterly report for the year 2023/24, based on a national template, to the Board of Directors by the Guardian of Safe Working. This role supports the implementation and maintenance of the 2016 national contract for Doctors in Training and provides an independent oversight of their working hours. The process of exception reporting provides data on their working hours and can be used to record safety concerns related to these and rota gaps. In addition, it can identify missed training opportunities. Reporting to the Board of Directors is a stipulated requirement of this role and this report reflects the position at 30 September 2023. The Trust has 672 doctors in training who have all transferred to the 2016 Terms and Conditions of Service.

Related Trust objectives	Improving patient care Supporting our staff
Risk and Assurance	Assurance involves the development of key performance indicators, benchmarking, peer review and audit.
Related Assurance Framework Entries	n/a
Legal / Regulatory / Equality, Diversity & Dignity implications?	Safeguards around doctors' hours are outlined in national terms and conditions. These stipulate that the Guardian of Safe Working Hours "shall report no less than once every quarter to the Board".
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	n/a

Action required by the Board of Directors

The Board is asked to note the 2023/24 Q2 report from the Guardian of Safe Working.

Cambridge University Hospitals NHS Foundation Trust

17 January 2024

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

1. Introduction

1.1 The annual Guardian of Safe Working (GoSW) report for 2022-23 described the pattern of exception reporting after the Covid-19 pandemic. Last year the number of exception reports continued to increase and were considerably higher than pre-pandemic levels. More exception reports (ERs) were submitted for missed training opportunities, but these were still a small proportion of the total. The previously noted cyclical variation with more reports submitted in September and October (as new doctors start work) and over the winter (winter pressures and staff vacancies) persisted. Overall working hours were considered safe on most rotas despite all the service pressures. However, areas of concern continued to include under reporting, loss of training and rota gaps.

1.2 This Q2 report describes the Trust's position from July to September. The number of ERs submitted (n=284) is more than in Q1 (n=227) and higher than Q2 last year 2022-23 (n=236). Levels are also higher than pre-Covid (n=261, Q2 2019-20). Most rotas are compliant with the Terms & Conditions of Service (TCS).

1.3 There has been significant progress on the weekend working issue; out of the original 11 non-compliant rotas there are now no rotas remaining where trainees are working more than the recommended maximum of 1:3 weekends. Significant investment in extra posts in Emergency Medicine (EM) and PICU has been agreed and posts created. Recruitment into PICU and NICU posts has been arranged. Recruitment into the 15 new posts in EM has been challenging but all posts are now filled and rotas re-organised.

1.4 Gaps in other rotas also continue to be a major concern (both here and nationally). The workload of the medical staffing department has further increased around the times of industrial action given the need to reschedule rotas and provide appropriate cover for patient care.

1.5 Clinical and educational supervisors do appear to be more supportive of trainees when they exception report. ER data can be used to drive change and improvements in rotas and working hours and thus improve patient care, and this is perhaps now being more widely recognised. However, we continue to receive feedback that trainees are reluctant to submit ERs as they feel unsupported and criticised if they do.

1.6 The Junior Doctors' Forum (JDF) – co-chaired by two trainees – is now meeting in person. Senior management joins in the second half of the meeting to listen to trainee concerns. The JDF chairs are invited to attend Board of Directors'

meetings and provide direct feedback to the Board. The Regional GOSW network (chaired by the CUH GOSW) meets virtually every two months. Benchmarking from this group provides reassurance that Board engagement here continues to be more positive than at some other trusts in the East of England.

2. High level data

Number of doctors / dentists in training (total):	672
Number of doctors / dentists in training on 2016 TCS (total):	672
Number of doctors / dentists on local contracts (Clinical Fellows):	235
Total junior doctor/ dentist establishment:	907
Reference period of report	Q2 2023/2024
Total number of exception reports received	284
Number relating to immediate patient safety issues	8
Number relating to hours of working	257
Number relating to pattern of work	13
Number relating to educational opportunities	12
Number relating to service support available to the doctor	0
Total number work schedule reviews	4
Total value of fines levied	£0
Amount of time available in job plan for Guardian to do the role:	2 PAs/8hrs/week
Admin support provided to the Guardian:	1 WTE
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

3. Exception Reports

Total number of exception reports received per month within this quarter:

	Immediate safety concerns (ISC)	Total hours of work	Pattern of Work	Service support available	Educational opportunities	TOTAL
MONTH 1 (July)	0	84	3	0	1	88
MONTH 2 (August)	2	93	8	2	7	110
MONTH 3 (September)	6	80	2	0	4	86
QUARTER	**8**	**257**	**13**	**2**	**12**	**284**

Note: An immediate safety concern report is NOT an additional report but is identified within a report submitted for any other reason and therefore is not counted in the total column (there were 284 reports of which 8 had ISCs).

3.1 Commentary

The number of exception reports has increased and is now higher than in 2021 and 2022. Exception reports were received from a broad range of specialities including General Surgery, Acute and Speciality Medicine, Emergency Medicine, Haematology, Oncology, Immunology, Neurology & Neurosurgery, Ophthalmology, Trauma & Orthopaedics, Maxillary-Facial Surgery, Obstetrics & Gynaecology, Neonatology and Paediatrics. Educational ERs have been received from Acute Medicine, Anaesthetics, Geriatrics, Medical Oncology, Obstetrics & Gynaecology and Paediatrics.

3.2 Trends in Exception Reporting

Levels of exception reporting in Q2 (n=284) were higher compared to those in Q1 2023-24 (n=227) and higher than those last year in Q2 2022-23 (n=236). They are also higher compared to those in Q2 2019-20 pre-Covid (n=261). Reporting of missed educational opportunities remains low. There were only 2 exception reports linked to service support issues. The number of immediate safety concerns remains low but has increased from the last quarter.

3.3 Resolutions

Total number of exception reports per month within this quarter resulting in:

	TOIL granted	**Payment for additional hours**	**Work schedule reviews (new)**	**No action**	**TOTAL**
MONTH 1 (July)	0	77	0	4	81
MONTH 2 (August)	0	82	0	7	89
MONTH 3 (September)	0	56	0	6	62
QUARTER	**0**	**215**	**0**	**17**	**232**

3.4 Commentary

All trainees who submitted exception reports this quarter were asking for payment for extra hours worked rather than time off in lieu (TOIL) which is the preferred option to improve their wellbeing. This is primarily because the reasons for reporting are rota gaps or a high workload and therefore additional TOIL would only compound the problem.
The discrepancies in totals in this table reflect the timings of ER submission and sign off.

4. Work schedule reviews

Month	Specialty/Department & Grade	Details of work schedule review
August 2023	Emergency Department	Review to reduce weekend working – previously > 1: 3 weekends. The Trust has funded 15 new medical posts. Recruitment has been completed and with rotas changed from August 2023, trainees will now be working no more than 1:3 weekends. However, new review started following Professor Cooke's report – further staffing and rota and process change required to meet patient demand.
2023	Neurology Stroke	Workforce reviews required for both departments due to the new Regional thrombectomy service.
2023	Obstetrics & Gynaecology	Workforce review to address training and other service concerns within this department. Will include review of patient pathways.

4.1 Commentary

There were three new work schedules this quarter. All three previous work schedule reviews related to weekend working (EM, NICU & Transplant) are completed. There is a new review in the EM department following the publication of a report into patient demand/waiting times. The development of a regional service for thrombectomy has implications for staffing. A combination of high workload, long waiting lists and poor feedback from the GMC trainee survey is driving a wide ranging workforce and process review in O&G.

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

Department	Safety concern raised	Action(s) proposed and/or taken
14/08 Haematology Oncology (x2)	Stayed late to complete procedure in relapsed leukemia patient. Procedure abandoned as no theatre capacity within appropriate timeframe	Discussed with consultant – arranged for next day

13/09 Acute Medicine HST (X2)	Ward rounds and other duties on EAU5 required completing.	Consultant aware
13/09 Acute Medicine IM3	Ward rounds not completed – stayed late to complete.	Consultant aware
14/09 Medicine GIM FHO (x2)	Stayed late to ensure deteriorating patient was safe. Not enough staff available to manage this patient and others. Stayed late to stabilise dementia patient and complete other tasks.	Escalated appropriately Problems contacting PAs to ask for help – discussed with ward nurses and clinical supervisor
14/09 Haematology ST4	Clinic over run.	Asked to stay by consultant

6. Fines

Fines levied against departments this quarter (break down calculations delayed for same reason as in item 4.1 above):

Department	**Detail**	**Total value of fine levied**
Total fines levied	Nil in Q2	£0

	TOTAL
Balance at end of last quarter	**£6,531.90**
Fines incurred this quarter	**£0**
Cumulative total	**£6,531.90**
Total paid to trainees (£)	**£0**
Total spent (£)	**£0**
Balance at end of this quarter	**£6,531.90**

7. Junior Doctors' Forum and junior doctor engagement

7.1 The JDF is now being held face to face in the Doctors' Mess with a virtual link since September 2022. Senior management (various of Medical Director, Director of Medical Education, Less Than Full-Time Training (LTFT) lead,

Medical Staffing lead and team, Workforce Lead and Freedom to Speak up Guardian) join for the second half of the meeting. Issues discussed included rota gaps, locum rates and industrial action. The importance of exception reporting was emphasised.

8. Doctors and dentists in training not on 2016 TCS

8.1 Non-consultant, non-training grade doctors are able to exception report alongside their trainee colleagues using the same system and processes. So far we have not received many exception reports from this staff group.

9. Assurance processes

9.1 The following assurance processes have been put in place to provide assurance on the Guardian role and the appropriate implementation of the new junior doctors' contract:

- Development of key performance indicators for example establishment and sustainability of JDF and response times to exception reports.
- Benchmarking via the Regional and National Guardians' networks.
- Peer review – ask other trusts/Guardians to review our processes.
- Audit of exception reporting process (annual).
- Requesting trainee feedback – a survey of juniors

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

9.3 Benchmarking takes place regionally and nationally via the GOSW who is chair of the Regional GOSW network and arranges minuted meetings of the regional network every two months and attends national meetings in alternate months.

9.4 A survey of trainees' views of exception reporting was distributed by the JDF in Q4 2020-21 (please see summary in Q4 report). We will plan to repeat the trainee survey later this year.

10. Key Issues and Summary

10.1 Levels of exception reporting decreased during the Covid pandemic with the subsequent lockdown, cancellation of many NHS activities and the redeployment of staff and was consistent across the EOE region and nationally. Last year levels of reporting reverted to pre-Covid levels and have now exceeded these. The number of immediate safety concerns has increased this quarter but numbers are still low. Rota gaps continue to be problematic; this has implications for working hours and patient safety. Despite the loss of training opportunities with increasing service pressures, trainees rarely submit educational ERs.

10.2 Covid-19 affected the interpretation of exception reporting data for the past three years. Under reporting continues to be a concern here and nationally and does not necessarily reflect the (anonymous) GMC trainee survey. Exception reporting

of “immediate safety concerns” is considered in parallel with incident reporting by outside bodies including the CQC. There is work to be done around the definition of “immediate safety concern” as there may be under or inappropriate reporting.

10.3 The revised TCS (2019) advised that trainees should not work more frequently than 1:3 weekends, as discussed in previous reports. CUHFT had 11 rotas (mostly EM and intensive care) which required trainees to work more than 1:3 weekends. Exemptions were agreed in September 2019 but were not renewed. 8 rotas were resolved in 2021. The Trust committed significant funding (> £1 million) to new medical posts in EM, PICU, NICU and Transplant last year. Recruitment to these new posts was completed and rotas rewritten for August 2023, so this issue is now resolved.

10.4 Concerns were previously expressed that some individuals would require an extension to their training due to the impact of the Covid pandemic particularly for the craft specialities but this did not appear to have been necessary last year. We are awaiting the outcome of ARCPs this summer as a measure of adequate training progress. Hospitals are under pressure to address the backlog of patient care and there continues to be a risk that training will not be prioritised.

10.5 We are keen to ensure that clinical and educational supervisors and trainees remain engaged with the process of exception reporting and recognise its value in providing data that can be used to effect change. We are continuing to work on this by attending educational supervisor meetings and induction, whether in person, in a video or on-line.

10.6 The Junior Doctors Forum (JDF) has the potential to identify, discuss and jointly address, with the Medical Director, Medical Staffing, the Guardian and the Postgraduate Medical Education Centre, rota and training issues as they arise. Improving the working conditions and morale of junior doctors (probably at an all-time low) is increasingly important as it will aid recruitment and retention, reducing rota gaps and will thus improve patient safety. Monthly meetings of the JDF are once more being held in person which has improved attendance.

10.7 Exception reporting suggests that working hours remained mostly compliant in Q2 and patient safety has rarely been compromised. There are extra hours worked on some rotas and continuing problems with rota gaps that cannot be filled with locums. Concerns now are focussed on the persistent backlog of patient care post pandemic recovery and how best to ensure training alongside service within the amended (2019) 2016 Terms and Conditions for Service.

11. Recommendations

11.1 The Board of Directors is asked to note the 2023/24 Q2 report from the Guardian of Safe Working.

12. Appendices

Appendix 1: Glossary of terms and abbreviations
Appendix 2: Graphs of Exception Reporting data

Appendix 1: Glossary of Terms and Abbreviations

F1	Foundation Doctor Year 1
F2	Foundation Doctor Year 2
StR	Specialty Registrar
SpR	Specialist Registrar
ACAS	Advisory, Conciliation and Arbitration Service
ARCP	Annual review competency progression
CCT	Certificate of Completion of Training
COGPED	Committee of General Practice Education Directors
CQC	Care Quality Commission
DME	Director of Medical Education
FPP	Flexible pay premium / premia
GDC	General Dental Council
GMC	General Medical Council
GP	General Practitioner
HEE	Health Education England
JLNC	Joint Local Negotiating Committee
LTFT	Less than Full Time
NHSI	NHS Improvement
NIHR	National Institute for Health Research
OOP	Out Of Programme
OOPC	Out Of Programme (Career Break)
OOPE	Out Of Programme (Experience)
OOPR	Out Of Programme (Research)
OOPT	Out Of Programme (Training)
PIDA	Public Interest Disclosure Act 1998
SDM	Senior decision maker
SID	Senior independent director
TCS	Terms and Conditions of Service
WPBA	Workplace based assessment
WTR	The Working Time Regulations 1998 (as amended)

Director of Medical Education (DME)	The DME is a member of consultant medical staff and an employee of the employer / host organisation who leads on the delivery of postgraduate medical and dental education in the Local Education Provider (LEP), ensuring that doctors receive a high quality educational experience and that GMC/GDC standards are met, together with the strategic direction of the organisation and Health Education England (HEE). The DME is responsible for delivering the educational contract between the LEP/ lead provider (LP) and HEE local team. For the purposes of these terms and conditions, where reference is made to the DME, the responsibilities described may be discharged by a nominated deputy to the DME.

Doctor or dentist in training	A doctor or dentist in postgraduate medical or dental education undertaking a post of employment or a series of posts of employment in hospital, general practice and/or other settings.
Educational review	An educational review is a formative process which enables doctors to receive feedback on their performance and to reflect on issues that they have encountered. Doctors will be able to raise concerns relating to curriculum delivery and patient safety. This will include regular discussions about the work schedule.
Educational supervisor	A named individual who is selected and appropriately trained to be responsible for supporting, guiding and monitoring the progress of a named trainee for a specified period of time. The educational supervisor may be in a different department, and occasionally in a different organisation, to the trainee. Every trainee should have a named educational supervisor and the trainee should be informed of the name of the educational supervisor in writing. This definition also covers approved clinical supervisors in GP practice placements.
Episodes of work	Periods of continuous work within an on call period separated by periods of rest.
Exception reporting	Mechanism used by doctors to inform the employer when their day- to-day work varies significantly and/or regularly from the agreed work schedule. Primarily these variations will be differences in total hours of work, pattern of hours worked, in the educational opportunities and support available to the doctor.
Guardian of safe working hours	A senior appointment made jointly by the employer / host organisation and junior doctors, who ensures that issues of compliance with safe working hours are addressed by the doctor and/or employer/host organisation, as appropriate and provides assurance to the Board of the employing organisation that doctors' working hours are safe.
On-call	A doctor is on-call when they are required by the employer to be available to return to work or to give advice by telephone but are not normally expected to be working on site for the whole period. A doctor carrying an ‘on-call’ bleep whilst already present at their place of work as part of their scheduled duties does not meet the definition of on-call working.

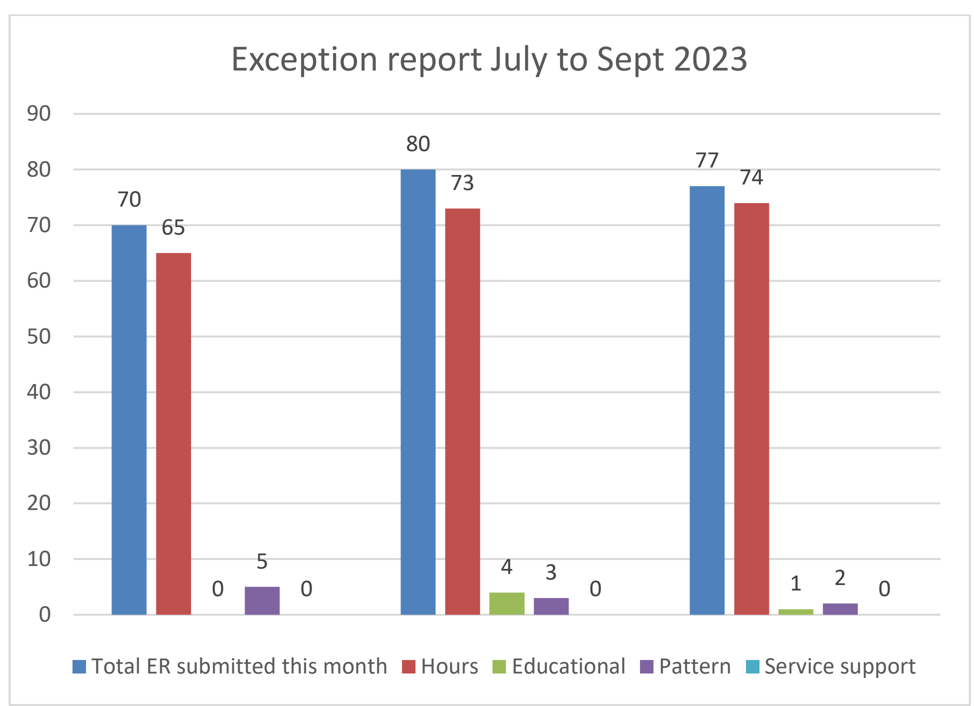
On-call period	An on-call period is the time that the doctor is required to be on call (as defined above) by their employer.
Placement	For the purposes of these TCS, a placement is a setting into which a doctor is placed to work for a fixed period of time in a post or posts in order to acquire the skills and competencies relevant to the training curriculum, as described in the work schedule.
Post	For the purposes of these TCS, a post has approval by the GMC/HEE for the purposes of postgraduate medical and dental education. Each approved post is located within an employer or host organisation.
Rota	The working pattern of an individual doctor or group of doctors.
Rota cycle	The number of weeks' activity set out in a rota, from which the average hours of a doctor's work and the distribution of those hours are calculated.
Rotation	A rotation is a series of placements made by the HEE local office into posts with one or more employers or host organisations. These can be at one or more locations.
Senior independent director	Non-executive director appointed by the board of directors to whom concerns regarding the performance of the guardian of safe working hours can be escalated where they are not properly resolved through the usual channels.
Shift	The period which the employer schedules the doctor to be at the work place performing their duties, excluding any on-call duty periods.
Training programme	Training programmes and training posts are approved by the GMC or (for dental programmes) HEE. Learning environments and posts used for training are recommended for approval by HEE for the purpose of postgraduate medical/dental education. Time spent in those posts/environments allows the doctor to acquire and demonstrate the competencies to progress through the training pathway for their chosen specialty (including general practice) and to acquire a Certificate of Completion of Training (CCT).

Work schedule	A work schedule is a document that sets out the intended learning outcomes (mapped to the educational curriculum), the scheduled duties of the doctor, time for quality improvement, research and patient safety activities, periods of formal study (other than study leave), and the number and distribution of hours for which the doctor is contracted.
Work schedule review	A work schedule review is a formal process by which changes to the work schedule may be suggested and/or agreed. A work schedule review can be triggered by one or more exception reports, or by a request from either the doctor or the employer. A work schedule review should consider safe working, working hours, educational concerns and/or issues relating to service delivery.
WTR reference period	Reference period as defined in the Working Time Regulations 1998 (as amended), currently 26 weeks.

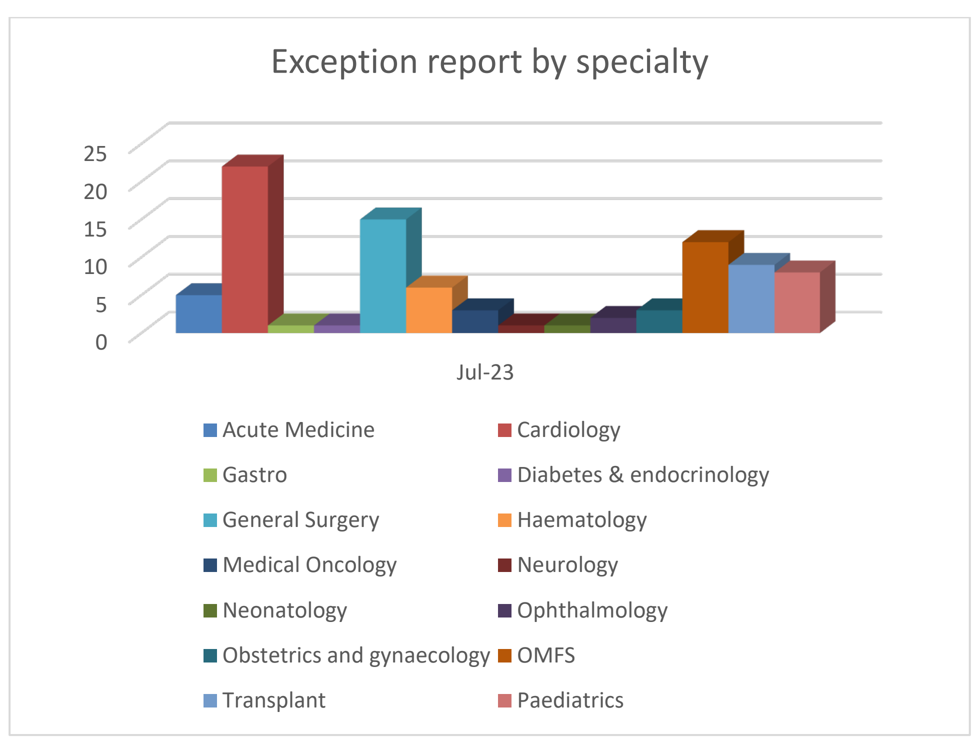
Appendix 2: Exception report data

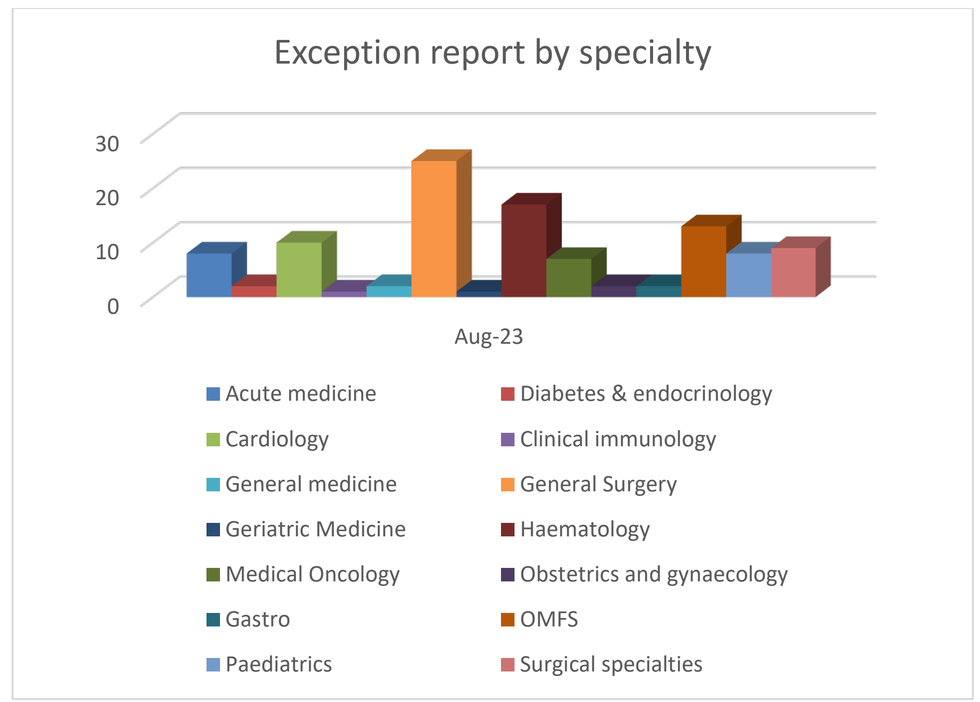
July - September 2023

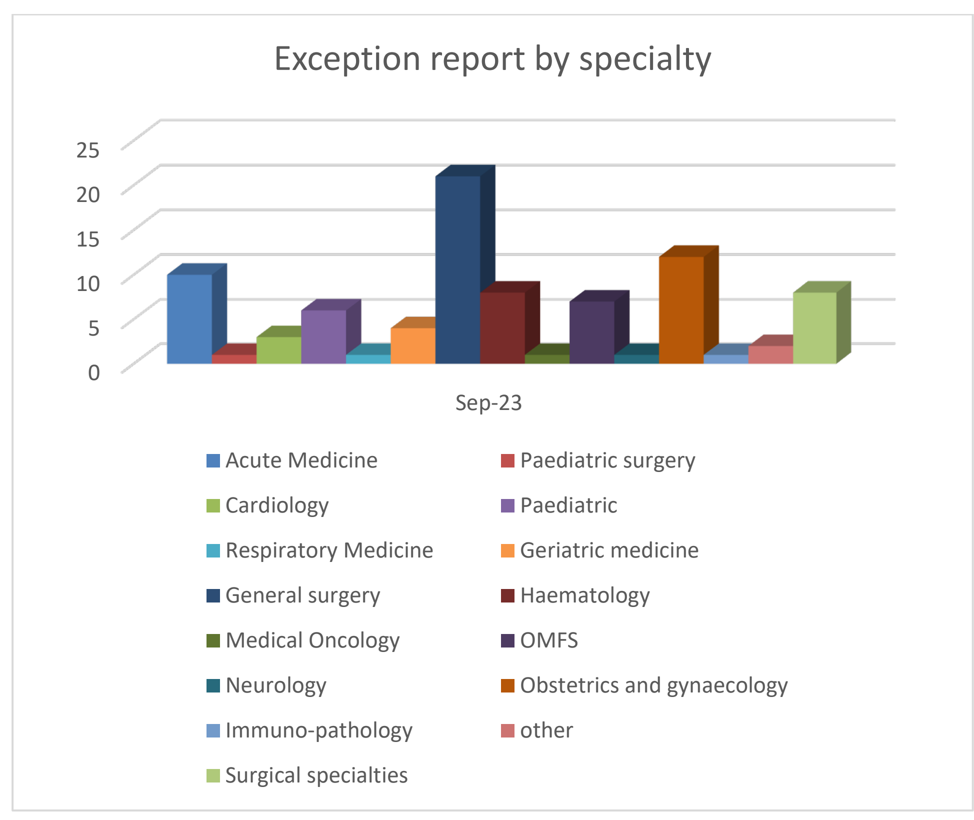
Overview:



Specialty breakdown:

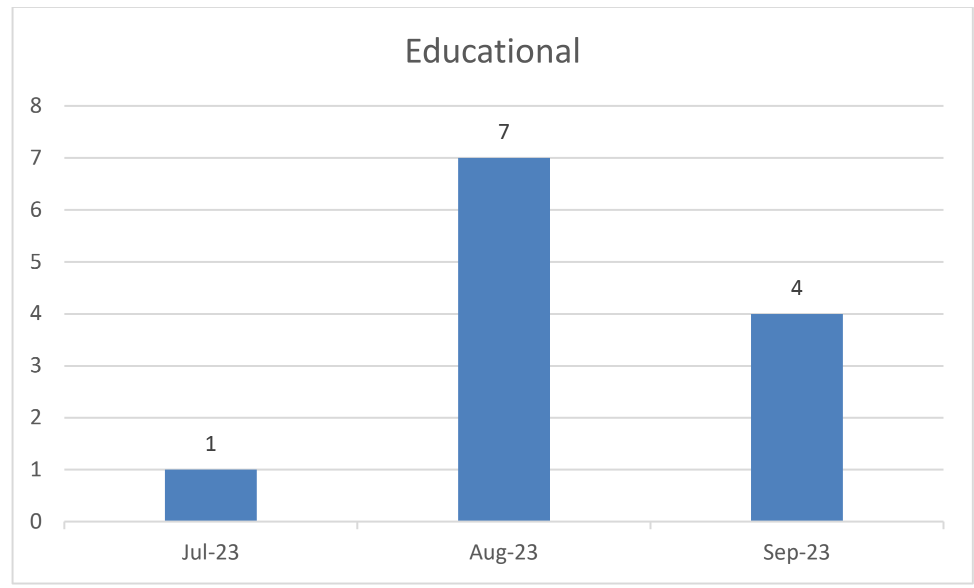



Exception report by specialty
30
20
10
0
Aug-23
Acute medicine
Diabetes & endocrinology
Cardiology
Clinical immunology
General medicine
General Surgery
Geriatric Medicine
Haematology
Medical Oncology
Obstetrics and gynaecology
Gastro
OMFS
Paediatrics
Surgical specialties


Exception report by specialty
25
20
15
10
5
0
Sep-23
Acute Medicine
Paediatric surgery
Cardiology
Paediatric
Respiratory Medicine
Geriatric medicine
General surgery
Haematology
Medical Oncology
OMFS
Neurology
Obstetrics and gynaecology
Immuno-pathology
other
Surgical specialties

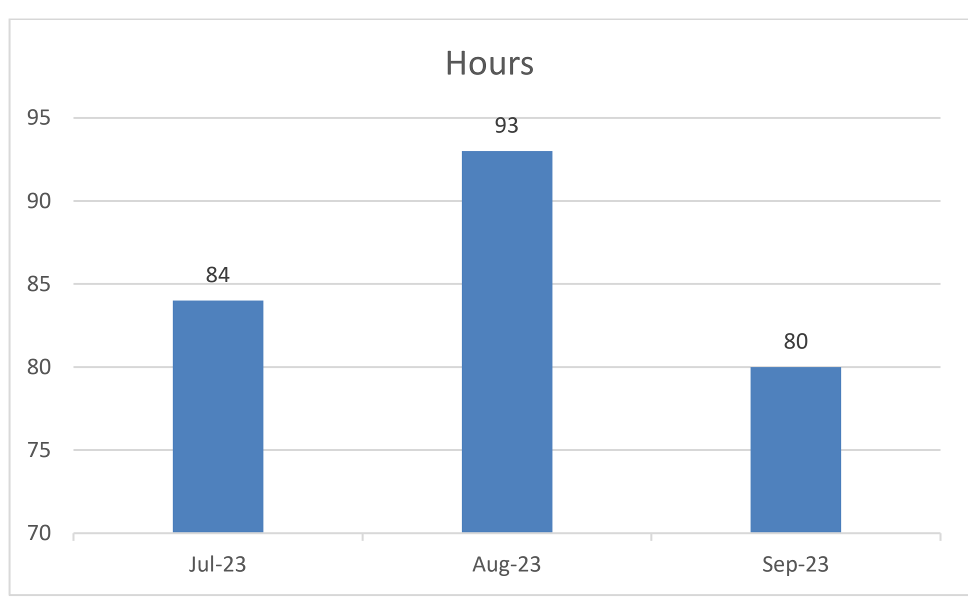
Category breakdown

Educational:

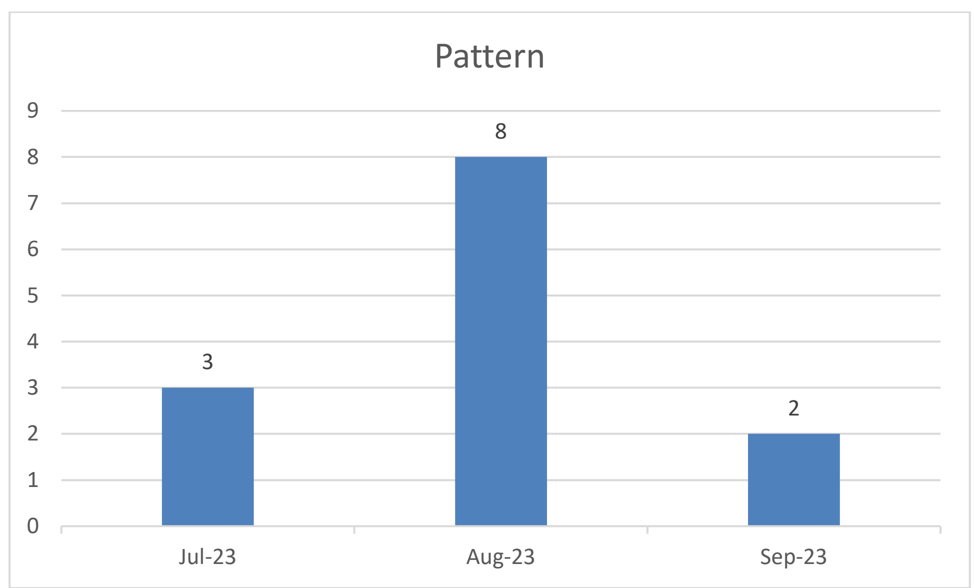


Medical oncology - 8
Acute Medicine – 1
Obstetrics and gynaecology-3
Reasons include missing teaching or training due to staff shortages/ busy departments.

Hours:

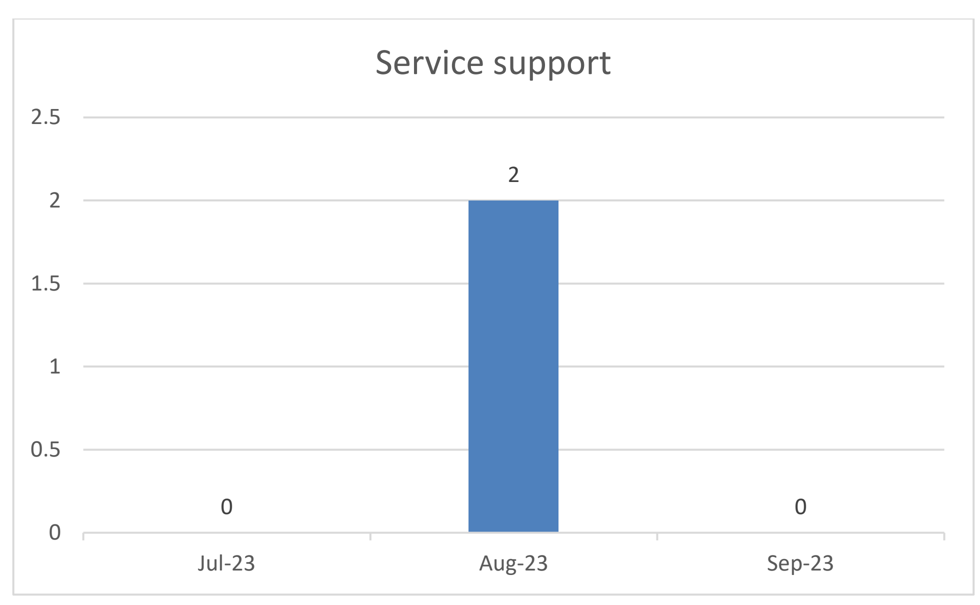


Pattern:



General surgery - 3
Haematology – 4
OMFS– 1
Paediatric surgery – 2
Paediatrics - 2
Surgical specialties - 1

Service Support:



General medicine – 2

Board of Directors

Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 17 January 2024

Agenda item	13
Title	Risk Management Strategy and Policy
Sponsoring executive director	Lorraine Szeremeta, Chief Nurse
Author(s)	Jumoke Okubadejo, Director of Clinical Quality
Purpose	To review and approve the revised Risk Management Strategy and Policy.
Previously considered by	Risk Oversight Committee, 23 November 2023

Executive Summary
The Risk Management Strategy and Policy has been reviewed by the Risk Oversight Committee in line with its annual review cycle. Minor amendments have been made to ensure that the policy remains current and these were agreed by the Risk Oversight Committee at its meeting on 23 November 2023.

The risk appetite statement, which forms part of the strategy and policy, has been reviewed as part of this process. While no changes have been proposed to the underlying risk appetite of the Trust, a further review will take place over the next six months taking account of the findings of the external Well-Led Governance Review.

Related Trust objectives	All Trust objectives
Risk and Assurance	The Trust strategy and policy sets out the framework for the management of risk by the Trust.
Related Assurance Framework Entries	All
Legal / Regulatory / Equality, Diversity & Dignity implications?	Compliance with the ‘Well-Led’ domain/CQC fundamental standards; Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of “Together: safe, kind and excellent”?	Yes

Action required by the Board of Directors

The Board is asked to approve the revised Risk Management Strategy and Policy.

Strategy and policy

Risk management strategy and policy 2023-2024

Key messages

- All staff must ensure that they identify all clinical and non-clinical risks to the delivery of safe, effective and high quality services.
- All staff must ensure that risks are assessed as soon as is reasonably practicable, identifying controls to mitigate negative impacts.
- When risks are identified and cannot be controlled effectively, risk leads are responsible for ensuring that they are escalated through the risk governance structure.
- Staff who manage risks on the risk register on behalf of the organisation must ensure that they receive training that is appropriate to their level of accountability and responsibility.

Summary

Cambridge University Hospitals NHS Foundation Trust's (the Trust) board recognises that the provision of healthcare and the activities associated with the treatment and care of patients, employment of staff, maintenance of premises and managing finances by their nature incur risks.

This document sets out the Trust's roles and responsibilities, accountability and systems and processes to enable robust risks management.

1 Scope

Trust-wide: Risk management activities applies equally to all staff and individuals employed by the Trust including; contractors, volunteers, students, locum, agencies and staff employed with honorary contracts.

2 Purpose

The document sets out strategic direction for risk management as it is both a statutory requirement and an important element of informed management decision-making at all levels of the organisation.

2.1 Strategy statement

The purpose of the risk management strategy is to provide the overarching principles, framework and processes to support managers and staff in the management of risk by ensuring that the Trust is able to deliver its objectives by

identifying and managing risks, enhancing opportunities and creating an environment that adds value to on-going operational activities.

The Trust is therefore committed to:

- Adopting best practice in the identification, evaluation and cost effective control of risks to ensure that they are reduced to an acceptable level or eliminated as far as is reasonably practical.
- Maximising opportunities to achieve the Trust's objectives and deliver core services provisions.

The Trust acknowledges that risks will always exist and never be fully eliminated and accepts responsibility for the residual risks when risks have been reduced to an acceptable level or eliminated as far as is reasonably practical.

The Trust's strategic aim is to make the effective risk management an integral part of the Trust's governance, which is underpinned by clear responsibility and accountability arrangements throughout the organisational structure of the Trust.

These arrangements are set out in the following documents:

- Standing orders of the Board of Directors
- Standing financial instructions
- Standing financial instructions: Scheme of delegation of authority from the board of directors
- Accountability framework.

The Trust has adopted a holistic approach to risk management incorporating both clinical and non-clinical operational risks as well as risks to the strategic objectives. It has a board assurance framework in place to monitor risks to the strategic objectives and an electronic risk register called QSiS for operational risks, including the corporate risk register.

2.2 Policy statement

The board of directors is committed to the active management of operational risk, providing better care and a safer environment for patients, staff and other stakeholders. The aim is to achieve this without compromising flexibility, innovation and best practice in the delivery of patient care and treatment and service delivery and development.

The board assurance framework supports the management of risks to delivery of the Trust's strategic objectives, providing visibility of these risks to the management executive and the board.

The purpose of the risk management policy is to identify the proactive systems used by the Trust to effectively identify and manage its risks with the aim of protecting patients, staff and members of the public as well as its assets.

The Trust accepts its corporate responsibility to provide the highest standards of patient care and staff safety and as such, the process of risk management is viewed as an essential component in maintaining and improving standards in the Trust.

The objective of the policy is to ensure that the Trust has an effective system for identifying and managing risks with the aim of:

- Achieving its objectives
- Protecting patients, staff and members of the public
- Protecting its assets.

3 Introduction

The Trust recognises that healthcare provision and the activities associated with caring for patients, employing staff, operating premises and managing finances all involve risk. Uncertainty of outcome is how risk is defined. Risk management includes identifying and assessing risks and responding to them.

Risk management is the responsibility of all staff and managers at all levels, and they are expected to take an active lead to ensure that risk management is a fundamental part of their operational area.

The Trust encourages an open and just culture that requires all Trust employees, contractors and third parties working within the Trust to operate within the systems and structures outlined herein, identifying, articulating, managing and escalating any risks where required.

Risk management is both a statutory requirement and also an integral part of good governance. It is a fundamental part of the total approach to quality, corporate and clinical governance and is essential to the Trust's ability to discharge its functions as a partner in the local health and social care community, as a provider of health services to the public and an employer of significant numbers of staff. It is expected that all risk management activities in the Trust will follow the process described in this document.
The Trust has adopted an integrated approach to the overall management of risk, irrespective of whether the risks are clinical, strategic, operational, environmental or financial.

4 Framework

This section describes the broad framework for the management of risk. Operational instructions for risk management, health and safety risk assessments, investigation of incidents and learning from incidents and central

alerts systems management are detailed in separate procedural documents (see section 16). The framework below explains the process for how risk is managed by the Trust:

Figure 1: Risk management process:

Figure 2: Operational governance framework
CUH Risk Management Strategy & Policy Operational Governance Framework 2023 (ii): *Adapted from Operational Risk Management Framework (Soneri Bank) 2017*

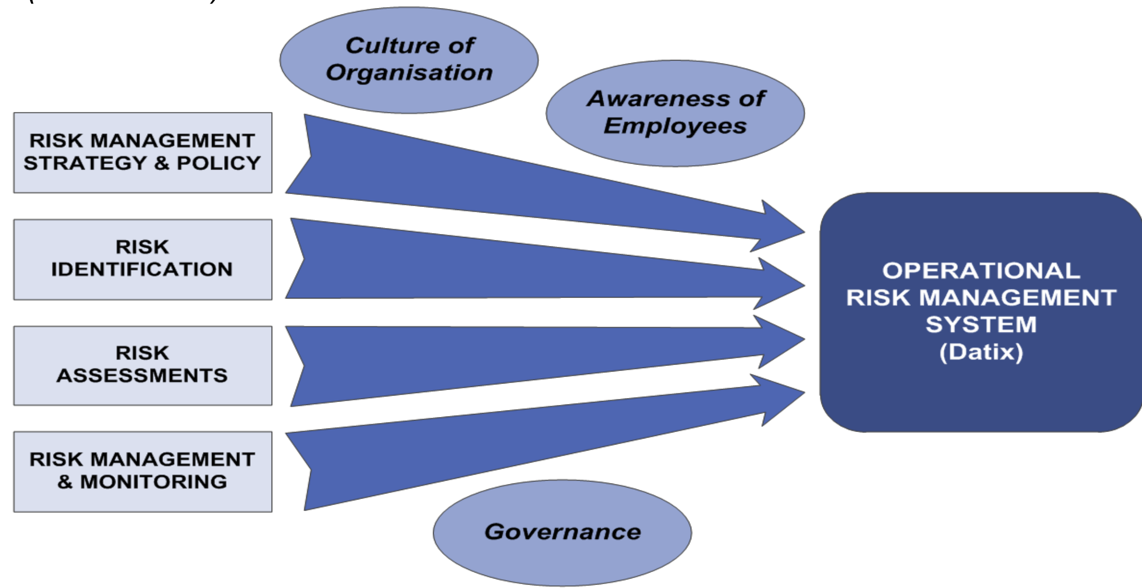
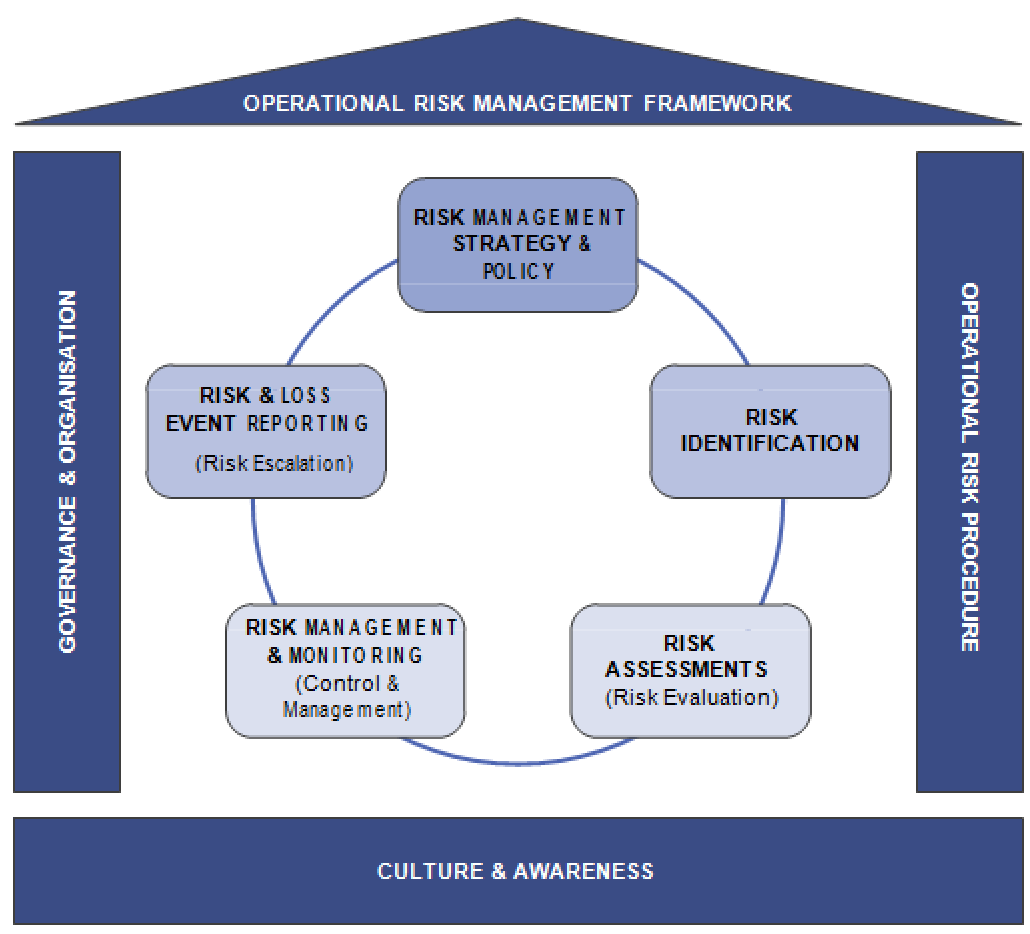


Figure 3: Governance framework:



5 Assurance framework

Assurance of achievement, weaknesses in delivery and key risks to the delivery of Trust objectives are reported through the assurance committees of the board. The Trust assurance committees receive reports to inform them of all significant risk exposures, material changes to risks and progress with milestones.

The Trust assurance committees are responsible for providing assurance on the management of corporate risks to the board of directors and are identified in appendix 2 and 3 of the accountability framework.

6 Risk appetite statement

Risk appetite is defined as the amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time. The Trust's risk appetite statement shows the level of risk that the board has agreed to take with regards to quality/ outcomes, compliance/ regulation, innovation, reputation, financial/ value for money and commercial. The risk appetite statement expresses the

organisation's agreed level of risk it is collectively willing to accept and provides guidance to the organisations on how much risk should / could be taken in the pursuit of operational or strategic delivery.

Risks throughout the organisation should be managed within the Trust's risk appetite, or where this is exceeded, consideration should be given to take further action to reduce the risk or to accept, after careful consideration, a higher risk tolerance.

The Trust's risk appetite statement will be communicated to relevant staff involved in the management of risk (see appendix 2 for statement and appendix 3 for the supporting risk matrix).

The Trust will review annually its risk appetite statements, updating these where appropriate. This includes the setting of risk tolerances at the different levels of the organisation, thresholds for escalation and authority to act, and evaluating the organisational capacity to handle risk. The periodic review and arising actions will be informed by an assessment of risk maturity, which in turn enables the board to determine the organisational capacity to control risk. The risk appetite review will consider:

- Risk leadership
- People
- Risk strategy and policy
- Partnerships
- Risk management process
- Risk handling
- Outcomes.

7 Risk management process

The Trust adopts a structured approach to risk management. Risks are identified, assessed, controlled and monitored, and where appropriate, escalated or de-escalated through the governance mechanisms of the Trust.

Board committees are involved in the Trust's governance of risk. These are underpinned by divisional and corporate committees that provide the oversight for specific aspects of the operational or strategic delivery and are set out in the accountability framework and the good practice guide - quality governance in action (see section 16). A risk management governance structure is in place and explained on the Trust intranet.

7.1 Sources of risk

Risks for inclusion on the operational risk register may be identified from a number of sources including horizon-scanning, business planning, operational service delivery, audits, incidents/near-misses, inspections, health and safety risk assessments, complaints and enforcement action.

Risks to the Trust's strategic objectives are identified through the annual review of the Trust strategic objectives and are included in the board assurance framework.

7.2 Risk management procedure

This risk management strategy and policy document is underpinned by a comprehensive risk management handbook which describes the process for effectively identifying, assessing, evaluating and monitoring risks. The document is held on the Trust's document management system.

The Trust's risk management cycle ensures that risks are identified, assessed, controlled, monitored, closed or accepted. When necessary, gaps in controls are escalated. These main stages are carried out through:

- Clarifying objectives
- Identifying risks to the objectives
- Assessing and scoring the risk
- Identifying controls and their effectiveness
- Identifying and record actions to mitigate the risk
- Regularly reviewing and monitoring the risk, with accepting residual risks or closing risks when at target level
- Escalation and de-escalation of risks.

These processes are explained in the risk management handbook and e-learning is provided to risk leads and risk owners. Enhanced support is provided by the central risk team, when required.

The operational risks are managed and monitored by the divisional senior leadership utilising the electronic risk register on QSIS.

Each division, directorate and specialty discusses their risk register, actions, and any required escalation through the accountability and quality governance framework.

7.3 Risk matrix

The Trust has adopted the risk matrix published by the National Patient Safety Agency to ensure that risks rated in the organisation fall broadly in line with other organisations. This also improves consistency of risk ratings within the organisation (see appendix 1).

7.4 Training and support

Support for staff involved in risk management - to support the successful implementation and embedding of the risk management strategy, policy and risk procedure the Trust has the following support in place for staff with a responsibility in risk management:

- All relevant staff are required to complete e-learning to access the Trust's risk module on QSiS.
- Risk owners are required to complete e-learning to enable them to articulate and manage risks on the risk register.
- Risk leads are required to complete e-learning to enable them to support risk owners, monitor risk management in their area of responsibility and escalate gaps in controls.
- Staff also have access to comprehensive guidance on the Trust intranet and advice by the risk team.

Board training – the Trust board will receive training every **two years**, to ensure that the requirements for understanding and discharging duties in relation to risk management at board level is reviewed and refreshed, thereby maintaining compliance with nationally agreed policy and practice.

Attendance/ participation records are co-ordinated centrally on the Trust's learning management system.

The Trust's management executive ensures monitoring arrangements are in place to review the overall effectiveness of the delivery of risk management training for board members and senior managers. Where such monitoring identifies deficiencies, recommendations will be agreed and an action plan developed and changes implemented accordingly.

7.5 Corporate risk register and board assurance framework

Risk management by the board is underpinned by a number of interlocking systems of control. The management executive risk oversight committee provides oversight, challenge and support to the divisions to manage their risks.

They review risk principally through the following three related mechanisms:

- **The board assurance framework (BAF)** sets out the strategic objectives of the Trust, identifies risks in relation to each strategic objective along with the controls in place and assurances available on their operation. The BAF is used to drive the board agenda.
- **The corporate risk register (CRR)** is the operational risk register including significant risks and actions plans where divisions cannot implement sufficient controls or they require executive oversight due to their Trust-wide nature or potentially high impact on the organisation

- **The annual governance statement** is signed by the chief executive as the accountable officer and sets out the organisational approach to internal control. This is produced at the year-end (following regular reviews of the internal control environment during the year) and scrutinised as part of the annual accounts process and brought to the board with the accounts.

The above is reported regularly to the board for assurance and with escalation of relevant significant risks where required. The quality and audit committees provide assurance on the robustness of risk management and support the board.

In addition, the risk management processes are currently reviewed annually by internal audit for external assurance.

The Trust risk management activities are a part of its overall commitment to effective clinical governance and patient safety. The risk management approach is underpinned by additional Trust policies supported by ongoing training including:

- All policies and procedures associated with healthcare acquired infections
- Business continuity planning policy
- Management of concerns and complaints policy
- Health and safety policy
- Health and safety risk assessments procedure
- Information governance and information security policy
- Management of incidents and serious incidents requiring investigation policy
- Management of safety alerts issued by the central alert system (CAS) policy and procedure
- Risk management handbook
- Safeguarding policies and procedures (adult and child)
- Perinatal services risk management strategy
- Violence and aggression management policy.

The Trust's systems of internal control are based on its on-going risk management programme that aims to:

- Identify principal risks to the achievement of goals set out in the annual plan.
- Evaluate the nature and extent of risks.

- Manage all risks effectively, efficiently and economically.
- Enable the completion of the annual governance statement.

8 Horizon scanning

Horizon scanning focuses on identifying, evaluating and managing changes in the risk environment, preferably before they manifest as a risk or become a threat to the organisation.

Horizon scanning helps identify positive areas for the Trust to develop its business and services and provides a steer toward taking opportunities where these arise. The Trust will work collaboratively with partner organisations and statutory bodies to horizon scan and be attentive and responsive to change.

By implementing formal mechanisms to horizon scan, the Trust will be better able to respond to changes or emerging issues in a planned, structured and co-ordinated way. Issues identified through horizon scanning should link into and inform the business planning process. As an approach it should consider ongoing risks to services.

The outputs from horizon scanning should be reviewed and used in the development of the Trust's strategic priorities, policy objectives and development. The scope of horizon scanning covers, but is not limited to:

- Legislation
- Government white papers
- Government consultations
- Socio-economic trends
- Trends in public attitude towards health
- International developments
- NHS England and NHS Improvement publications
- Local demographics
- Seeking stakeholders views
- Risk assessments.

All staff have a responsibility to bring potential issues identified in their areas which may impact on the Trust delivering on its objectives to the attention of their managers.

Board members have the responsibility to horizon scan and formally communicate matters in the appropriate form relating to their area of responsibility. The management executive undertakes regular horizon scanning with the support of the strategy team.

9 Delivering the strategy

Executive directors, senior management teams and departmental/operational managers within the Trust will:

- Take into account the Trust's quality priorities and strategic objectives when managing risks.
- Promote awareness and understanding of the benefits of proactive risk management, therefore developing a positive risk culture.
- Manage risks through their own clinical/ speciality, departmental, directorate, divisional structure in line with this document.
- Provide opportunities for training and ongoing support to ensure that staff are aware of the Trust's risk management processes and systems.

The Trust will:

- Ensure corporate ownership and accountability throughout the organisation for risk management.
- Promote and support the development and implementation of risk management through annual review of this document.
- Monitor the up-take of training in risk management.
- Review and up-date the risk management strategy and policy and resources underpinning this document to ensure that they remain in line with best practice.

10 Roles and responsibilities

10.1 Chief executive

The chief executive is the accountable officer for Cambridge University Hospitals NHS Foundation Trust and is accountable for ensuring that the Trust can discharge its legal duty for all aspects of risk. As accountable officer, the chief executive has overall responsibility for maintaining a sound system of internal control, as described in the annual governance statement.

Operationally, the chief executive has designated responsibility for implementation as outlined below. The chief executive chairs the management executive risk oversight committee. The management executive, as the group responsible for the corporate risk register, decides which risks require recording and managing corporately or should be included on the board assurance framework.

10.2 Executive directors

Executive directors are accountable to the chief executive and the board of directors for the maintenance of effective systems of internal control within their areas of responsibility. Executive directors are responsible for reporting on controls and assurances of the highest risks to the Trust objectives through the board assurance framework and corporate risk register and other identified significant risks.

Each director is responsible for risk management leadership including the implementation of and compliance with current Trust policies, and for ensuring sufficient resources have been allocated to undertake effective risk management of prioritised risks.

Executive directors are responsible for ensuring that the risks for which they are the executive leads on the corporate risk register and board assurance framework are reviewed on a monthly basis and that action plans for risk mitigations are implemented in a timely manner as agreed.

Leading by example, executive directors are fundamental in establishing and sustaining an environment of openness on risk management within their directorates.

10.3 Non-executive directors

Non-executive directors have responsibility for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust’s activities (clinical and non-clinical) that support achievement of the organisation’s policy. In particular, members of the audit committee will review the adequacy of the risk management policy, and receive regular monitoring information against the management of risks judged as significant within the board assurance framework and corporate risk register and provide assurance to the board of directors on the effectiveness of systems within the Trust designed to manage risk.

10.4 Chief nurse

The chief nurse is responsible for the executive leadership of risk management and the implementation of the processes and procedures set out in this policy. The chief nurse supports the executive and non-executive directors in carrying out their responsibilities for risk management and takes the lead, on behalf of the board of directors, for maintaining the corporate risk register that defines the principal risks to achieving the Trust’s operational delivery together with associated controls, sources of assurance and action plans. The chief nurse works closely with the director of clinical quality in all matters relating to organisational governance and risk.

10.5 Director of corporate affairs

The director of corporate affairs is the corporate governance lead for the organisation. The director of corporate affairs supports the executive and non-executive directors in carrying out their responsibilities for risk management and takes the lead, on behalf of the board of directors, for maintaining the board assurance framework that defines the principal risks to achieving the Trust's strategic objectives together with associated controls, sources of assurance and action plans. The director of corporate affairs also advises the board in relation to the decision-making regarding the Trust's annual risk appetite statement and on the Trust's annual governance statement. The director of corporate affairs works closely with the chief nurse and the director of clinical quality in all matters relating to organisational governance and risk.

10.6 Director of clinical quality

The director of clinical quality is the quality governance lead for the Trust and is responsible for the Trust's risk management strategy and policy. The director of clinical quality is accountable to the chief nurse and is responsible for promoting and ensuring the implementation of Trust-wide systems and processes to enable the Trust to meet its requirements in relation to risk, up to and including the corporate risk register. The director of clinical quality works closely with the director of corporate affairs and appropriate others, in all matters relating to organisational governance and risk.

The director of clinical quality has a responsibility to ensure the delivery of appropriate training to Trust staff that enables the correct identification, analysis and scoring of risk, together with maintaining the Trust's electronic integrated system for risk management.

10.7 Head of risk and patient outcomes

The head of risk and patient outcomes is accountable to the director of clinical quality. The post holder is responsible for:

- Promoting and supporting the implementation of Trust-wide systems of risk management (including an electronic risk register).
- Administering the Trust's corporate risk register on behalf of the director of clinical quality and the management executive.
- Reviewing annually the risk management strategy and policy and all underlying processes.
- Providing support and training to staff on matters associated with risk management.
- Providing assurance regarding data quality standards within the quality governance framework and to the assurance committees.

10.8 Risk management team

The risk management team are responsible for:

- Provide a database for managing risks for the organisation.
- Monitor the quality of new risks in line with agreed key performance indicators (KPIs) and processes as set out in this document.
- Provide training and be an expert resource to all staff involved in risk management.
- Support and manage the corporate risk register on behalf of the Trust board.
- Provide assurance to the management executive - risk oversight committee, performance, quality, workforce and audit committees (as appropriate) on risk management across the organisation.

10.9 Divisional senior leadership

Divisional directors are responsible for:

- Ensuring that appropriate and effective risk management processes are in place in their designated area and scope of responsibility.
- Implementing and monitoring any control measures identified.
- Ensuring risks are captured on the electronic risk register.
- Ensuring that gaps in controls are escalated where all reasonably practicable actions have been taken and the risk is not sufficiently controlled.
- Ensuring that local groups review risk registers on a regular basis to consider and plan actions being taken.

They are accountable for:

- Ensuring that clinical risks, health and safety risks, emergency planning and business continuity risks, relevant project and operational risks are identified and managed.
- Ensuring that risks are reviewed by an appropriate divisional group as part of performance monitoring, actions are taken to mitigate risks.
- Ensuring appropriate escalation of risks from services or directorates to divisional level within the defined tolerances and processes as set out in the risk management handbook.

10.10 Senior managers and senior staff

Senior managers take the lead on risk management in their services and are expected to:

- Identify risks to the safety, effectiveness and quality of services, finance, delivery of objectives and reputation.
- Oversee and support the risk owners and risk leads in the carrying out their duties with regards to risk management.
- Ensure that assurance and oversight of risk management in their area is managed through the governance framework.

10.11 Head of health and safety

The head of health and safety is accountable to the director of workforce and is responsible for promoting and supporting the implementation of Trust-wide systems for health and safety.

The head of health and safety is responsible for:

- Developing an effective health and safety management system that is compliant with statutory requirements.
- Supporting the implementation of the Trust’s health and safety policies and procedures.
- Providing competent advice and support to staff on health and safety matters.
- Monitoring corporate health and safety risks and escalating any concerns or significant delays.

10.12 Divisional quality manager / trust risk and corporate quality manager

The divisional quality manager or trust risk and corporate quality manager is responsible for:

- Ensure divisional ownership and accountability throughout the organisation for risk management.
- Coordinating reporting of relevant risk registers to the appropriate divisional committees.
- Liaising with and support risk leads in the division to ensure that each directorate/ specialty or department reviews their risks.
- Ensuring that there is clarity of who is responsible for creating and reporting risks registered within directorate/ specialty or department below the divisional level.
- Identifying new risk leads and notifying any changes to risk leads to the team managing the database holding the electronic risk register.
- Highlighting non-compliance with the Trust’s risk management strategy and policy.

- Managing and monitoring any escalation of gaps in controls or assurance on behalf of their division.
- Ensuring that the list of risk leads and any changes to risk owners is reflected on the electronic risk register and the risk team is informed of changes to risk leads.
- Ensuring the list of contacts for committees within the division is correct and any updates are sent to the team managing the database holding the electronic risk register.

10.13 All employees (permanent, temporary, contract)

All Trust employees including permanent temporary or contract have a duty and a responsibility to be ‘safety aware’ and co-operate in the identification and minimisation of risks.

Staff are responsible for:

Ensuring they are familiar with significant local hazards and know and use safe systems of work. If staff identify hazards or risks in the workplace they are responsible for taking immediate action to reduce the risk (for example wiping up a spillage, warning others or removing and reporting a piece of equipment identified as not working properly).

All Trust employees have a responsibility to identify risk, to report these to their line managers and where applicable to ensure that appropriate controls are being implemented to manage such risks.

11 Equality impact assessment

As part of the development of this strategy and policy its impact on equality has been reviewed. The purpose of the assessment is to minimise and, if possible, remove any disproportionate impact on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detrimental effects were identified.

12 Implementation and dissemination

Internally: This strategy and policy document is available to all staff via the Trust’s document management system (Merlin) and intranet site.

Externally: The reviewed policy will be sent to the Trust’s main commissioners and is freely available on request to Trust stakeholders.

13 Review

This strategy and policy will be reviewed annually.

14 Monitoring compliance with and the effectiveness of this document

The Trust will seek assurance that risk management activities and systems are being appropriately identified, articulated and managed through ongoing monitoring at the patient safety and assurance group and the risk oversight committee. The Trust seeks further assurance through a range of external sources including reviews by internal and external audit and Care Quality Commission inspections.

A monitoring dashboard has been developed to facilitate the monitoring of the key elements of this strategy and this is reviewed regularly at the patient safety and assurance group. The dashboard will be subject to annual review in support of the ongoing monitoring process by the director of clinical quality.

15 References

NHS England – Risk Management, Policy and Process Guide (2015).
National Patient Safety Agency - A risk matrix for risk managers (2008).

16 Associated documents

- All policies and procedures associated with healthcare acquired infections
- Business continuity planning policy
- Risk management handbook
- Risk management Connect pages
- Health and safety policy
- Health and safety risk assessments procedure
- Management of concerns and complaints policy
- Good practice guide - Quality governance in action
- Information governance and information security policy
- Management of incidents and serious incidents requiring investigation policy
- Management of safety alerts issued by the central alert system (CAS) policy and procedure
- Managing employee performance procedure
- Perinatal services risk management strategy
- Safeguarding policies and procedures (adult and child)
- Violence and aggression management policy

Equality and diversity statement

This document complies with the Cambridge University Hospitals NHS Foundation Trust service equality and diversity statement.

Disclaimer

It is **your** responsibility to check against the electronic library that this printed out copy is the most recent issue of this document.

Document management

Approval:		Board of directors - Oyejumoke Okubadejo		
JDTC approval:		n/a		
Owning department:		Safety and quality support		
Author(s):		Elke Pieper		
Pharmacist:		n/a		
File name:		Risk management strategy and policy 2023-2024 v16 Nov 2023		
Supersedes:		Risk management strategy and policy 2022-2023 v15 Nov 2022		
Version number:		16	Review date:	November 2024
Local reference:			Document ID:	2700

Appendix 1: CUH's risk matrix (based on National patient safety agency's risk matrix)

Table 1: Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table, then work along the columns in the same row to find the severity that best fits the risk. The consequence will be a number from 1 to 5, which is the number given at the top of the severity column. The consequence score may be determined by taking more than one domain into account. If the consequence score is different for the domains, e.g. 5 in one domain and 3 in another, an average can be calculated to reach a consensus across the domains (e.g. average of 4).

DESCRIPTOR	NEGLIGIBLE 1	MINOR 2	MODERATE 3	MAJOR 4
Injury (Physical/ Psychological)	►Adverse event requiring no/minimal intervention or treatment.	►Minor injury or illness – first aid treatment needed ►Health associated infection which may/did result in semi-permanent harm ►Increase in length of hospital stay by 1-3 days ►Affects 1-2 people	►Moderate injury or illness requiring professional intervention to resolve the issue ►RIDDOR / Agency reportable incident (4-14 days lost) ►Adverse event which impacts on a small number of patients ►Increased length of hospital stay by 4 – 15 days ►Affects 3-15 people	►Major injury / long term incapacity / disability (e.g. loss of limb) ►>14 days off work ►increased length of hospital stay >15 days ►Affects 16 – 50 people
Environmental Impact	►Potential for onsite release of substance	►Onsite release of substance but contained	►On site release of substance	►Offsite release of substance

Safety and quality support

DESCRIPTOR	NEGLIGIBLE 1	MINOR 2	MODERATE 3	MAJOR 4
	►Minimal or no impact on the environment	►Minor impact on the environment ►Minor damage to Trust property – easily remedied <£10K	►Moderate impact on the environment ►Moderate damage to Trust property – remedied by Trust staff / replacement of items required £10K - £50K	►Major impact on the environment ►Major damage to Trust property – external organisations required to remedy - associated costs >£50K
Staffing & Competence	►Short term low staffing level (<1 day) – temporary disruption to patient care ►Minor competency related failure reduces service quality <1 day	►On-going low staffing level - minor reduction in quality of patient care ►Unresolved trend relating to competency reducing service quality	►Ongoing low staffing resulting in moderate reduction in the quality of patient care ►Late delivery of key objective / service due to lack of staff ►Error due to ineffective training / competency	►Unsafe staffing level leading to a temporary service closure <5 days ►Uncertain delivery of key objective / service due to lack of staff ►Serious error due to ineffective training and / or competency

Safety and quality support

DESCRIPTOR	NEGLIGIBLE 1	MINOR 2	MODERATE 3	MAJOR 4
		► 75 % staff attendance at mandatory / key training	►50% - 75% staff attendance at mandatory / key training	►25%-50% staff attendance at mandatory / key training
Complaints/ Claims	►Informal / locally resolved complaint ►Potential for settlement / litigation <£500	►Overall treatment / service substandard ►Formal justified complaint ►Minor implications for patient safety ►Claim <£10K	►Justified complaint involving lack of appropriate care ►Moderate implications for patient safety ►Claim(s) between £10K - £100K	►Multiple justified complaints ►Findings of Inquest suggesting poor treatment or care ►Non-compliance with national standards implying significant risk to patient safety ►Claim(s) between £100K - £1M
Business/ Service Interruption	►Loss/Interruption of >1 hour; no impact on delivery of patient care / ability to provide services	►Short term disruption, of >8 hours, with minor impact	►Loss / interruption of >1 day ►Disruption causing impact on patient care ►Non-permanent loss of ability to provide service	►Loss / interruption of > 1 week. ►Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked ►Temporary service closure

Safety and quality support

DESCRIPTOR	NEGLIGIBLE 1	MINOR 2	MODERATE 3	MAJOR 4
Inspection/ Regulatory Compliance/ Statutory Duty	►Small number of recommendations which focus on minor quality improvement issues ►Minimal breach of guidance / statutory duty ►Minor non-compliance with standards	►Single failure to meet standards ►No audit trail to demonstrate that objectives are being met (NICE; HSE; NSF etc.)	►Challenging recommendations which can be addressed with appropriate action plans ►Single breach of statutory duty ►Non-compliance with > one core standard	►Enforcement action ►Multiple breaches of statutory duty ►Improvement Notice ►Trust rating poor in National performance rating ►Major non-compliance with core standards
Adverse Publicity / Reputation	►Rumours ►Potential for public concern	►Local Media – short term – minor effect on public attitudes / staff morale ►Elements of public expectation not being met	►Local media – long term – moderate effect – impact on public perception of Trust & staff morale	►National media <3 days – public confidence in organisation undermined ►Use of services affected
Information Governance/ IT	► Minor breach of confidentiality – readily resolvable ►Unplanned loss of IT facilities < half a day ►Health records / documentation incident – no adverse outcome	►Minor Breach with potential for investigation ►Unplanned loss of IT facilities < 1 day ►Health records incident / documentation incident – readily resolvable	►Moderate breach of confidentiality – potential for complaint 1 – 5 persons affected ►Health records documentation incident – patient care affected with short term consequence	►Serious breach of confidentiality – more than 5 person or Very sensitive information ►Unplanned loss of IT facilities >1 day but less than one week ►Health records / documentation incident – patient care affected with major consequence

Safety and quality support

DESCRIPTOR	NEGLIGIBLE 1	MINOR 2	MODERATE 3	MAJOR 4
Projects	►Insignificant cost increase ►Insignificant impact on value and/or time to realise declared benefits against profile	►<5% over project budget ►<5% variance on value and/or time to realise declared benefits against profile	►5 - 10% over project budget ►5 - 10% variance on value and/or time to realise declared benefits against profile	►10 - 25% over project budget ►10 - 25% variance on value and/or time to realise declared benefits against profile
Financial (Loss of contract / revenue / default payment)	►Small Financial loss < £1K ►Theft or damage of personal property <£50	►Loss <£1k - £50K ►Theft or loss of personal property <£750	►Loss of £50K - £500K ►Theft or loss of personal property >£750 - £10K	►Loss of £500K - £1M ►Theft or loss of personal property £10K - £50K
Fire Safety/General Security	►Minor short term (<1day) shortfall in fire safety system. ►Security incident with no adverse outcome	►Temporary (<1 month) shortfall in fire safety system / single detector etc (non-patient area) ►Security incident managed locally ►Controlled drug discrepancy – accounted for	►Fire code non-compliance / lack of single detector – patient area etc. ►Security incident leading to compromised staff / patient safety. ►Controlled drug discrepancy – not accounted for	►Significant failure of critical component of fire safety system (patient area) ►Serious compromise of staff / patient safety ►Loss of vulnerable adult resulting in major injury or harm ► Major controlled drug incident involving a member of staff

Table 2: Likelihood score (L)

In the second step, the probability of the risk occurring is estimated and then used to determine the likelihood score using the table below:

Description	1 RARE	2 UNLIKELY	3 POSSIBLE	4 LIKELY	5 ALMOST CERTAIN
Likelihood (How often might it /does it occur)	Likelihood of the risk occurring is less than 5%.	Likelihood of the risk occurring is between 5 and 20%.	Likelihood of the risk occurring is between 21 and 79%.	Likelihood of the risk occurring is between 80 and 95%.	Likelihood of the risk occurring is between 96 100%.
Probability	0-4%	5-20%	21-79%	80-95%	96-100%

Table 3: Risk scoring = Consequence x Likelihood (C x L)

Calculate the risk score of the risk by multiplying the consequence score by the likelihood score:
Consequence score (C) x Likelihood score (L) = risk score.

Likelihood score	Consequence score				
	1	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
5 - Almost certain (96-100%)	5	10	15	20	25
4 - Likely (80-95%)	4	8	12	16	20
3 - Possible (21-79%)	3	6	9	12	15
2 - Unlikely (5-20%)	2	4	6	8	10
1 - Rare (0-4%)	1	2	3	4	5

Risks Grading

In some cases it may be useful to categorise risks by risk grade and colour, which are shown below:

Risk Assessment	Grading
Red 15 – 25	Significant
Amber 8 – 12	High
Yellow 4 – 6	Medium
Green 1 – 3	Low

Appendix 2: Risk appetite statement[1] (October 2023)

The Trust recognises that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, staff, the local community and strategic partners. The below statements describe the Board of Director's risk appetite in relation to the primary risk groupings as set by the Good Governance Institute (2012) . This statement will guide the Board of Directors in its decision making in relation to the implementation of the Trust's strategy (CUH Together), associated plans and other matters impacting on the well-being of patients and staff. This statement will be kept under regular review by the Risk Oversight Committee.

Quality/ outcomes
The Board will be cautious in its approach to taking risks related to patient and staff safety, patient experience or clinical outcomes. Its tolerance for risk taking will be limited to decisions where the potential for adverse consequent effects on patient and staff safety, experience or outcomes are medium to low and the potential for mitigating actions are strong, supported by robust governance systems and practices. (**Risk appetite moderate**)

Compliance/ regulatory
The Board has a cautious risk appetite related to compliance and regulatory issues, including health and safety. It will make every effort to meet regulator expectations and comply with laws, regulations and standards that regulators have set, unless there is strong evidence or argument to challenge them. The Board is willing to take opportunities where positive gains can be anticipated and are within the regulatory environment. (**Risk appetite moderate**)

Innovation
The Board will actively seek opportunities for innovation, strategic transformation and developing effective external relationships and alliances, depending on the nature of the innovation being proposed. It will seek innovation that supports quality, patient safety and operational effectiveness. This means that it will support the adoption of innovative solutions that have been tried and tested elsewhere, which challenge current working practices and involve systems/technology developments as enablers of operational delivery. Other innovations will be limited to only essential developments and with decision-making held by senior management. (**Risk appetite significant**)

Reputation
The Board has a cautious approach to risks that will affect the Trust's reputation. Decisions with the potential to expose the Trust to additional scrutiny of its reputation will be considered carefully and progressed only with strong mitigations and careful management of any potential repercussions.
(**Risk appetite moderate**)

[1] *Bullivant J & Corbett-Nolan A (2012) Risk Appetite for NHS Organisations: A matrix to support better risk sensitivity in decision taking accessed from http://www.good-governance.org.uk/risk-appetite-for-nhs-organisations-a-matrix-to- support-better-risk-sensitivity-in-decision-taking/ on 26 April 2019.*

Safety and quality support

Financial/ Value for Money
The Board will adopt a cautious approach to financial risk and is prepared to accept the possibility of some limited financial loss. Value for money is still the primary concern but the Board is willing to consider other benefits or constraints. Resources will be generally restricted to existing commitments. (**Risk appetite moderate**)

Commercial
The Board has an open approach to commercial risk. It will support risk opportunities in business areas and markets where the potential to have significant commercial strength over its competitors is identified, and/or wishes to secure continuity to the benefits and outcomes for the Trust's patients and the wider community it operates in. (**Risk appetite high**)

Appendix 3: Risk appetite matrix

Risk Appetite for NHS Organisations
A matrix to support better risk sensitivity in decision taking

Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012

Risk levels ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting h levels of risk appetite because controls, forward scanning an responsiveness syste are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed o the best possible return stakeholders. Resources allocated in 'social capita confidence that process return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing bac on regulatory burden. Fr foot approach informs be regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking th mould' and challenging current working practice Investment in new techn as catalyst for operation delivery. Devolved autho management by trust rat than tight control is stan practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investm in communications has b confidence by public, pre and politicians that orga will take the difficult deci for the right reasons with benefits outweighing the
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

'Good is only good until you find better' – Maturity Matrices ® are produced under licence form the Benchmarking Institute.
Published by and © GGI Limited Old Horsmans, Sedlescombe, near Battle, East Sussex TN33 0RL UK. ISBN 978-1-907610-12-7

www.good-governance.

Appendix 4: Definitions

Assurance is the means by which the organisation, board of directors, Trust senior leadership, manager, or clinical lead know that the controls designed to manage/ mitigate risks are effective and being properly implemented. Assurance can be defined as positive or negative, and internal or external. External assurance is generally considered of greater value due to its objective source.

Board Assurance Framework (BAF) – The Assurance Framework provides the Trust with a simple but comprehensive method for the effective and focused management of the principal risks to meeting their objectives. It also provides a structure for the evidence to support the Chief Executive's Annual Governance Statement.

Consequence (impact) is the level of harm that has, or may be suffered and is measured at the Trust on a scale of 1 to 5.

Controls are actions, arrangements and/or systems that are intended to minimise the likelihood or severity of a risk. An effective control will always reduce the probability of a risk occurring. If this is not the case, then the control is ineffective and needs to be reconsidered. Controls are intended to improve resilience.

Gap in control indicates that further work needs to be undertaken to ensure that the control is fully functional or effective. Until the development and implementation of controls have been completed, they are recorded in gaps in control. A negative assurance (a poor internal audit report for example) highlights gaps in control.

Internal control is the process effected by the board of directors designed to provide reasonable assurance that the Trust's objectives will be met with regards to: (1) Effectiveness and efficiency of operations; (2) Reliability of financial reporting and (3) Compliance with applicable laws and regulations.

Likelihood is measured by the frequency of exposure to the hazard or the probability of an event occurring on a scale of 1 to 5.

Risk is the likelihood (probability) that an event with adverse consequences or impact (hazards) will occur in a specific time period, or as a result of a specific situation. This event may cause harm to patients, visitors, staff, property, or have an impact on the Trust reputation, corporate objectives, stakeholders or assets.

Risks differ from their hazard in that the former is the calculated probability of the event occurring whilst the consequences or impact measure the effect of the risk being realised as a hazard. Put simply, hazards represent risks that have been realised.

Risk appetite - at the organisational level, is the amount of risk exposure, or potential adverse impact from an event, that the organisation is willing to accept/ retain. Once the risk appetite threshold has been breached, risk management treatments and business controls are implemented to bring the exposure level back within the accepted range. The risk appetite may vary according to risk type.

Risk management is the systematic identification, assessment, treatment, monitoring and communication of risks. This process is followed by the application of current or planned resources to effectively control, monitor and minimise the overall likelihood (and in some instances, impact) of the identified risk.

Risk owner manage risks on behalf of the organisation and most likely is the person who enters the risk onto the risk module on Datix for the first time. The corporate risk register is owned by the executive directors of the management executive – risk oversight committee and the board assurance framework is owned by the Trust board of directors.

Risk lead: Role-based risk leads are responsible for risk oversight within divisions and corporate directorates.

Risk register is a management tool that allows the Trust to understand its comprehensive risk profile. It is simply a repository of risk information linking risks and controls for the whole organisation.

Strategic risks are those risks that can adversely affect the achievement of the Trust's corporate objectives and are identified, assessed and monitored by the board assurance framework.

Appendix 5: Risk management policy monitoring dashboard

Minimum requirement to be Monitored	Method of monitoring e.g. audit	Responsible individual	Frequency of Monitoring	Responsible individual/group/committee (including timescales) for:		
				Review of results	Development of action plan	Monitoring of action plan and implementation
Identification and management of risk: *Board Assurance Framework Review*	Process Review	Director of corporate affairs	Annually	Audit Committee	Director of corporate affairs	Board of Directors (BoD)
Chief Executive report to the Board of Directors re significant risks	Review	Director of corporate affairs	Monthly	BoD	Director of clinical quality	BoD
Corporate Risk Register	Review	Director of clinical quality	Monthly	Executive Risk Committee/ Assurance Committees	Executive Risk Committee/ Assurance Committees	BoD

Minimum requirement to be monitored	Method of monitoring eg audit	Responsible individual	Frequency of Monitoring	Responsible individual/group/committee (including timescales) for:		
				Review of results	**Development of action plan**	**Monitoring of action plan and implementation**
Managing risks locally: *Local management of risk*	Divisional performance reports	Divisional directors	Monthly	Monthly executive performance reviews	Divisional directors	Management executive (ME)/BoD
Training : *Risk management training for risk owners and role-based risk leads*	Annual report	Director of clinical quality	Annual	Workforce and Education Committee	Director of clinical quality	ME/BoD
Assurance committees: *Reporting arrangements into the assurance committees and to the board*	Self-assessment	Director of corporate affairs	Annual	BoD	Director of corporate affairs	BoD

CHAIR'S KEY ISSUES REPORT

ISSUES FOR REFERRAL / ESCALATION

ORIGINATING BOARD / COMMITTEE:	Performance Committee	**DATE OF MEETING:**	10 January 2024
CHAIR:	Annette Doherty	**LEAD EXECUTIVE DIRECTOR:**	Chief Operating Officer, Chief Finance Officer
RECEIVING BOARD / COMMITTEE:	Board of Directors, 17 January 2024		

AGENDA ITEM	**DETAILS OF ISSUE**	**FOR APPROVAL / ESCALATION / ALERT/ ASSURANCE / INFORMATION?**	**CORPORATE RISK REGISTER / BAF REFERENCE**	**PAPER ATTACHED (Y/N)**
5	**Board Assurance Framework and Corporate Risk Register** 1. There had been no significant changes in month. 2. Risk Oversight Committee (ROC) had approved the proposal to split Risk 009 (new hospitals) into two parts: 009a regarding implementation of the new hospitals would remain with Performance Committee and 009b regarding the development of the wider hospital estate and the new acute hospital would sit with the Addenbrooke's Futures Committee. 3. Following discussion at the previous Performance Committee meeting, ROC had agreed to raise the risk score for BAF risk 011 to 16 recognising the level of the financial challenge for next year. This would be monitored and reassessed once finance plans were in place for 2024/25. 4. BAF risk 010 – working effectively with partners across the ICS. There was discussion of the risk rating, with a strong	For information	All BAF entries	n/a

	view expressed by Non-Executive Directors that the current risk score should be increased. It was agreed that this should be discussed further at the Addenbrooke's Futures Committee, as the committee with assurance oversight for the risk.			
6	**Six-monthly IT update** 1. The committee was given an update on progress against the six workstreams, the key risks and challenges to delivery, key successes over the last six months and goals for the future. The committee endorsed the plan and acknowledged the success highlighted in the report. 2. It was noted that 90% of resources were being spent on foundational work and that this would limit the pace of innovation, risking CUH falling behind peers. It was anticipated that additional resources and investment would be required to speed up progress and this would need to be progressed through the business planning process. 3. The committee discussed the need to invest further in IT in order to fully realise the benefits of Epic and to allow more innovation to transform services and increase productivity. 4. The first meeting of the Digital Board would be held in February 2024. 5. There were ongoing discussions with NHSE about the future use of MyChart. 6. The committee recognised the importance of business planning in identifying key areas for investment in IT.	For information	001	n/a
7	**Operational Performance** 1. The committee acknowledged the planning and combined effort from across the Trust that had enabled a safe passage through the two periods of industrial action over Christmas and the New Year. 2. There had been a slight improvement in performance against the 4-hr standard in December to 62%. Cancer	For information	001	n/a

	targets were above the national and Shelford group averages. Ambulance handover times continued to be in the upper quartile nationally. 3. The Interim Deputy Chief Operating Officer attended the meeting to give an overview of progress with the turnaround programme in ED. 4. To date the focused work put in place had seen an improvement in non-admitted performance but there was still work to be done on admitted performance. Pathways from ED into the hospital and SDEC were being reviewed to identify areas for improvement. 5. Length of stay at 7.8 days had improved compared to the same period in 2022 when it was 8.4 days.			
8	**Finance reports** 1. The committee received a report of the Month 8 financial position which continues to forecast breakeven for the year. The Trust is performing well in comparison to peers. 2. The capital update for month 8 showed spending continuing ahead of plan. This was no cause for concern and is monitored by the Capital Advisory Board. 3. The committee received an interim update on business planning for 2024/25. 4. It was confirmed that the process used for this round of business planning would support the development of a three-year plan which would be based on a number of assumptions that would be refined over the three-year period. 5. National planning guidance had not yet been released. 6. There had been some excellent responses to the 'access to care' challenge for this round of planning. The totality of requests for growth in funding, etc. was unaffordable and a further round of prioritisation was underway. This would focus on the areas that would produce the productivity	For information	011	n/a

	improvement required and also help to identify the longer term ideas that would provide the most benefit for patients. 7. The committee congratulated the finance team on maintaining the budget plan for this year and on representing the Trust well in negotiations with the centre.			
10	**Capital Project Delivery reporting** 1. The committee received and noted an update from the Director of Capital, Estates and Facilities Management. 2. There were no new risks for escalation. 3. The U block, scheduled to open w/c 29 January, would be removed from the next report to be replaced by the NCCU scheme with a completion date in May 2024.	For information	005/006	n/a

CHAIR'S KEY ISSUES REPORT

ISSUES FOR REFERRAL / ESCALATION

<table>
<tr><td>ORIGINATING BOARD / COMMITTEE:</td><td colspan="2">Quality Committee</td><td colspan="2">DATE OF MEETING:</td><td>10 January 2024</td></tr>
<tr><td>CHAIR:</td><td colspan="2">Sharon Peacock</td><td colspan="2">LEAD EXECUTIVE DIRECTOR:</td><td>Chief Nurse / Medical Director</td></tr>
<tr><td>RECEIVING BOARD / COMMITTEE:</td><td colspan="5">Board of Directors, 17 January 2024</td></tr>
<tr><td>AGENDA ITEM</td><td colspan="2">DETAILS OF ISSUE:</td><td>FOR APPROVAL / ESCALATION / ALERT/ ASSURANCE / INFORMATION?</td><td>CORPORATE RISK REGISTER / BAF REFERENCE</td><td>PAPER ATTACHED (Y/N)</td></tr>
<tr><td>5.

<u>5.1</u></td><td colspan="2">Lead Executives' Report and Patient Safety and Experience Overview
<u>Lead Executives' Report</u>
1. The Chief Nurse and Medical Director presented the report to the committee.
2. Capacity and waits within the Emergency Department (ED) remained an area of focus. Despite an improvement in some performance metrics overcrowding was a particular concern.
3. Industrial action by members of the British Medical Association (BMA) and Hospital Consultants and Specialists Association (HCSA) took place from 07:00 Wednesday 20 December to 07:00 Saturday 23 December 2023 and from 07:00 Wednesday 3 January to Tuesday 9 January 2024.
4. The Hospital Standardised Mortality Ratio (HSMR) was 72.5 in August 2023, with a one year rolling average of 75.5. This is statically lower than expected and is the 7th lowest in the NHS.
5. The Patient Advice and Liaison Service (PALS) and complaints department continue to receive a high volume of new cases. Significant improvement in the backlog has been made.</td><td>Information/ Assurance</td><td>BAF 001, 002, 004</td><td>N</td></tr>
</table>

        5.2 5.3	6. The Patient Safety Incident Response Framework (PSIRF) was live as of 1 January 2024. 7. The committee also discussed the use of space at Royal Papworth Hospital, nursing vacancies, a Human Tissue Authority (HTA) Human Application License Incident notification and the Intensive Care National Audit and Research Centre (INCARC) quarter one quality report. Patient Safety and Experience Overview 1. The report covered the period up until the end of November 2023. 2. The committee noted the report. Quality Account Update 1. The committee noted the summary of the quarter 2 position.			
6. 6.1 6.2 6.3	**Maternity** Maternity Update 1. The committee noted the maternity report. CNST Report 1. The report confirmed compliance with the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) safety actions ahead of the 1 February 2024 submission deadline. The Trust is able to fully evidence all 10 of the MIS standards against the year 5 schedule. Maternity improvement update and Obstetrics and Gynaecology medical staffing workforce review 1. The committee noted the approval of three obstetric consultants, three gynaecology consultants, two senior registrars, two junior registrars, two SHOs, one operations manager and two medical	Information/ Assurance		N

	secretaries. These positions would help improve and stabilise the staffing and rotas within obstetrics and gynaecology.			
7.	**Infection Control Annual Report** 1. Cleaning remained a major focus for the Trust. Providing high standard and timely cleaning during outbreaks of infection helps to minimise further spread. 2. The Infection Prevention Control team identified the need for training and staff expansion. This would allow expertise to be provided for new building projects and the opening of new areas. 3. Task and Finish Groups for reducing avoidable C *difficile* infection and gram-negative bacteraemia infections had been established. 4. The committee also discussed the process of decanting wards for deep cleaning, essential estate work, anti-microbial stewardship and Covid mortality.	Information/ Assurance		Y
8.	**Annual PLACE Report** 1. The Annual PLACE assessment was undertaken in November 2023. 2. Assessments are carried out on cleanliness, condition/appearance, food, privacy and dignity, dementia and disability. All scores had improved from the 2022 inspection. 3. All comments were shared with wards and clinics, including local managers for addressing. 4. Environmental issues and comments would be worked into the environmental improvement plan. 5. Comments and issues related to dementia will be reviewed at the Dementia Steering Group to ensure follow up. 6. Food related comments and issues would be reviewed by the Nutrition Steering Group.	Information/ Assurance		N

9.	**Clinical Audit Mid-Year Report** 1. The committee were informed that all national audits and enquiries continued to perform as expected, and no concerns were identified for quarter three 2023-24.	Information/ Assurance		N
10.	**End of Life Annual Report** 1. The committee were provided with the End of Life Annual Report, informing the committee of good practice, quality themes and improvement work undertaken in 2022–23. 2. Work with the Integrated Care System (ICS) on developing a system strategy continued. 3. The Trust had commissioned nurse-led beds at Arthur Rank Hospice to support end of life care, with patients and families who were transferred positive about the service. 4. The committee agreed the next update would include information on the mortuary and medical examiners.	Information/ Assurance		N
11.	**Pharmacy** Medicines Optimisation Annual Report 1. Automation continued to expand with a new robot in pharmacy stores and an electronic cabinet in the controlled drugs dispensary. 2. Annual Epic upgrades continue to improve functionality, including directing clinical practice based on acuity and high-risk medication, tracking of medications and support for bespoke builds e.g. virtual wards. 3. Nearly 8,000 patients are supported via medicines homecare. The recent House of Lords report on homecare has highlighted the requirement for adequate resources for planned transformation. Medicines Optimisation Audit Report 4. There has been sustained improvement across many audit results following a series of improvement projects.	Information/ Assurance		N

	5. The automated electronic controlled drugs cabinet has removed paper-based processes such as controlled drugs registers, with an ambition to expand to clinical areas. 6. Many pharmacy audits are now completed via a digital platform.			
12.	**Board Assurance Framework (BAF) and Corporate Risk Register (CRR)** 1. The committee received and discussed the current version of the Board Assurance Framework and Corporate Risk Register.	Information/ Assurance		N

Board of Directors

Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Board of Directors: 17 January 2024

Agenda item	16.2
Title	Infection Control Annual Report 2022/23
Sponsoring executive director	Ashley Shaw, Medical Director
Author(s)	As above
Purpose	To receive the annual report
Previously considered by	Quality Committee, 10 January 2024

Executive Summary

The Trust's Infection Control Annual Report for 2022/23 is attached. It was received and endorsed by the Quality Committee at its meeting on 10 January 2024.

Related Trust objectives	Improving patient care, Supporting our staff
Risk and Assurance	The paper provides assurance on arrangements in place for infection prevention and control.
Related Assurance Framework Entries	n/a
Legal / Regulatory / Equality, Diversity & Dignity implications?	n/a
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent	Yes

Actions required by the Board of Directors

The Board is asked to receive the Infection Control Annual Report for 2022/23.

Infection Prevention & Control Annual Report 2022/2023

Contents

Executive Summary

Introduction

Performance report

1 Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
Key infections
- COVID-19
- MRSA bacteraemia
- *Clostridium difficile* Infection
- *E. coli* bacteraemia
- Carbapenemase Producing Enterobacterales (CPE)
- Norovirus
- Influenza
- Surgical site infections

2 Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3 Provide suitable accurate information on infections to service users and their visitors.
4 Provide suitable accurate information on infections to any person concerned with providing further support or nursing/ medical care in a timely fashion.
5 Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.
6 Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.
7 Provide or secure adequate isolation facilities.
8 Secure adequate access to laboratory support as appropriate.

Clinical care protocols

9 Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

Healthcare workers

10 Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

Objectives

Appendices

1 Audit plan for 2023-24

2 Methodologies used for assurance

Infection Prevention & Control annual report 2022-2023

Executive summary

This annual report collates and summarises information related to healthcare associated infection (HCAI) for the period from April 2022 until the end of March 2023. It also describes the management structure and oversight of the approach we take to prevent and control infection, the policies and procedures we use and the methodologies employed for assurance.

Although we continued to focus on the management and approach for our patients and staff with covid19, the team have been pivotal in the design and planning for our surgical mobility hub, the Cancer and Childrens hospital This report summarises some of the efforts and results of that involvement and how we have addressed and mitigated those issues which were highlighted during covid19 such as our ageing estate, lack of isolation facilities (i.e. side rooms) and inadequate ventilation in some clinical and non-clinical areas.

The report also describes the efforts made to manage other infections such as C. difficile, CPE and MRSA, as well as compliance with the Hygiene Code. The report also describes the rapid, efficient and safe response in managing high consequence diseases such as MPOX and Congo Crimean Haemorrhagic fever.

I would finally like to thank our Infection Prevention and Control team for their continued dedication and professionalism.

I would also like to thank all of our colleagues across the Trust for their continuing efforts to avoid preventable infections in our hospitals. This is a key priority for the Trust and we will continue to maintain our efforts to ensure we consistently provide a safe, clean environment for the treatment of our patients.

Dr A Shaw

Medical Director and Director of Infection Prevention & Control

January 2024

Introduction

Cambridge University Hospitals NHS Foundation Trust (CUH) is a 1,100 bedded hospital with over 11,000 staff caring for elective and emergency admissions from the local community as well as delivering tertiary services for many specialties on a regional and national basis.

This annual report details the work the Trust has undertaken from April 2022 to March 2023 to ensure we discharge our statutory duties in meeting the standards for the prevention and control of infection as detailed in the Hygiene Code (Table 1) which is used by the Care Quality Commission (CQC) to monitor compliance with legislation by the Health & Social Care Act 2008. It describes the work of the infection control team and wider staff, both clinical and operational, to reduce the harm associated with infection.

Table 1: The Hygiene Code Compliance Criteria

1	**Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of**

	service users and any risks that their environment and other users may pose to them.
2	**Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.**
3	**Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.**
4	**Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion.**
5	**Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.**
6	**Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.**
7	**Provide or secure adequate isolation facilities.**
8	**Secure adequate access to laboratory support as appropriate.**
9	**Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.**
10	**Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.**

The CQC visited the Trust in 2018/19 and the Rosie hospital in March 2023 and the feedback in relation to ward cleanliness and infection control practice was very positive. Work continues to provide the Trust with the assurance that infection prevention and control standards are being upheld.

The reporting format for this document includes compliance against each of the ten criteria of the Hygiene Code. The overall percentage full compliance against the Hygiene Code standards (169 in total) is 81% as documented in Figure 1.

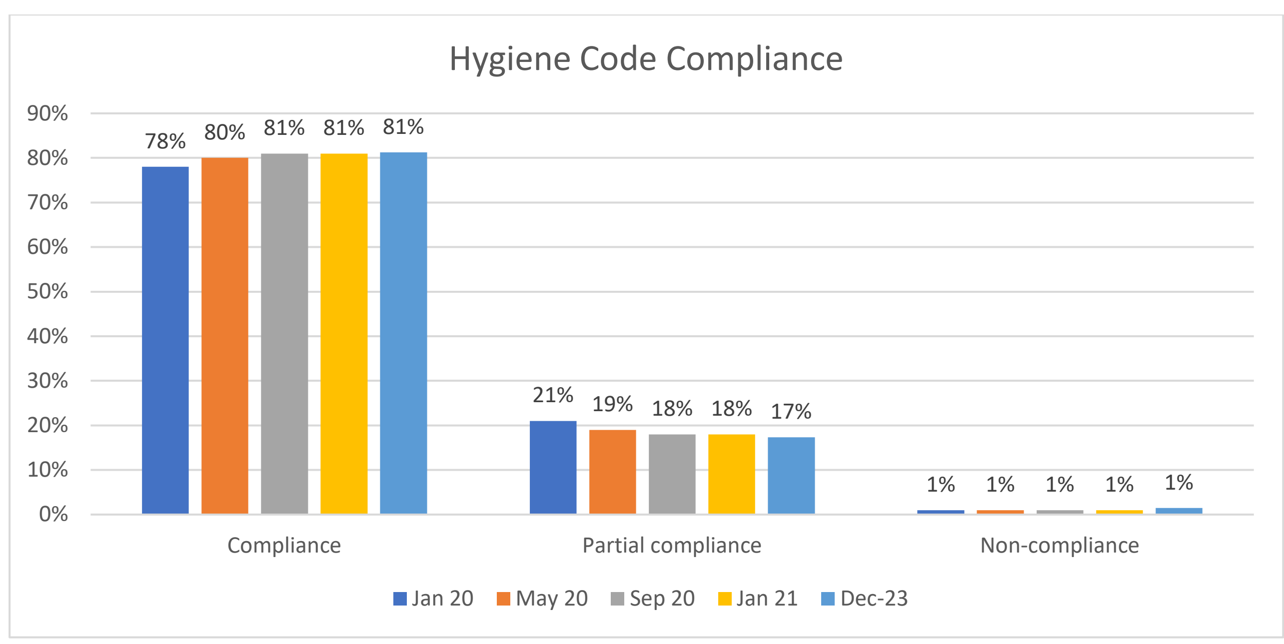


Figure 1: Trust Hygiene Code Overall Compliance

Performance report

Criterion 1: Systems to manage and monitor the prevention and control of infection

These systems should use risk assessments to assess how susceptible service users are and any risks that their environment and other service users may pose to them.

This criterion links with Hygiene Code Outcome 6 and Regulation 24 relating to co-operating with other providers in the CQC guidance about compliance.

The Trust has in place:

- a Board level agreement outlining their collective responsibility for minimising risks of infection and how this is to be achieved
- a Director of Infection Prevention and Control accountable to the Chief Executive and the Board
- mechanisms in place by which the Board ensures sufficient resources are available to secure effective prevention & control of healthcare associated infection (HCAI)
- measures to ensure that relevant staff, contractors and other persons directly or indirectly concerned with patient care receive suitable and sufficient information, training and supervision in measures required to prevent or minimise HCAI
- a programme of audit and quality improvement to ensure key policies and practices are being implemented appropriately
- a policy addressing patient movement between departments, within and between healthcare establishments
- a designated decontamination lead
- a designated antibiotic pharmacist and a consultant microbiologist with an antimicrobial stewardship role. A band 6 registered nurse has been working closely with acute

medical doctors to provide timely IV to oral switch. This role has been successful and a business case is in progress to recruit more nurse for antimicrobial stewardship.

- a programme of education for clinical and non-clinical team has been expanded post covid restrictions.

Specific systems/processes instigated for 2022/2023

- the purchase of 3 portable hand hygiene scanning machines used for education and training. These machines were instrumental during the Hand Hygiene Campaign which ran at the end of January 2023. These machines continue to be used on a daily basis to provide ongoing education and support to clinical areas. The benefits of this campaign was to ensure staff adhered to a good handwashing technique and understood the importance of correct handwashing procedures to avoid the transmission of infections. The IPC team provided 3,000 tottles to ward nurses along with hand hygiene posters to re-launch the correct hand hygiene technique.
- Matron's hand hygiene master classes ran in conjunction with the Hand Hygiene Campaign and centred around the Matron's charter, hand hygiene, PPE, Matron's role and improving standards. Twenty-four Matrons attended these 3 hour sessions between January 2023 and March 2023. Positive feedback was received.
- training by the infection control nurses is given to medical and non-medical staff during the induction process and via various training days including CSSIP and QPOs
- The trust purchased 55 air scrubbers in November 2022 as part of preparedness for winter planning
- joint ward accreditations were carried out with Divisional matrons, ward managers, pharmacists, hotel services and heads of nursing on 11 wards including; C3, D2, Daphne, EAU 4, EAU 5, JFITU, M4, C9, Lewin,D9 and D10.

Risk assessment

The corporate risk, CR07 is reviewed monthly by the DIPC and Lead Infection Control Nurse to ensure the risk remains current. The risk is then reviewed and discussed as part of the Corporate Risk Register review at the monthly Risk Oversight Committee for assurance and challenge of any gaps in control.

The Trust has in place suitable and sufficient assessment of risks to patients receiving healthcare with respect of hospital health care associated infections (HCAI). These are benchmarked against national best practice, clinical judgment and local risk assessment.

The Trust monitors risks of infection through data collection, audit and review of clinical incident reporting. These findings and a review of current risk assessments are reported to the Infection Prevention & Control Committee (IPCC) and the findings are used to inform future actions and strategy.

Corporate and divisional HCAI risk assessments are available on the Trust's Risk Register and the risk rating report for high risks is reviewed on a quarterly basis by the Quality and Risk committees. Existing control measures and further preventative measures are identified for action and monitored through divisional governance meetings.

Incident reporting

The Trust uses a Datix Web based system known in the Trust as QSiS for the recording of incidents. This system allows the Trust to record, investigate and report on incidents which have occurred at the Trust. The system is maintained by an in-house Datix team working as part of the Safety and Quality Support department. The team are available to assist with any queries via the support line email address (cuh.datix@nhs.net).

During the past financial year (2022/23) we have received 319 incidents relating to infection control with the majority relating to hospital attributed C. *difficile*. Further details can be found in table 2.

The IPC team have daily oversight of all incidents reported and provide expert guidance and advice to mitigate any further risk or patient harm. A full report triangulating themes from infection control incidents, complaints from patient and visitors and identified risks is submitted bi-monthly to the Infection Prevention Control Committee (IPCC) and corrective actions and escalation agreed.

Each MRSA bacteraemia is subject to a post infection review (PIR) and is reported via the incident reporting system. A PIR meeting is held for each hospital acquired case within the Trust which is attended by:

- clinicians responsible for the patient's care
- Ward manager or deputy from the relevant clinical area
- members of the infection control team
- the ICB lead infection control nurse to provide external scrutiny and ensure transparency in our systems and processes

Actions are identified and disseminated at Divisional governance meetings and to the Board of directors and IPCC. Any deaths occurring as a result of an MRSA bacteraemia are reported as a serious incident in line with the National Framework.

Every patient diagnosed with *Clostridium difficile* infection (CDI) in the Trust is reviewed by an infection Prevention Control Nurse (IPCN). The IPCNs assist in the correct clinical placement of the patient. Where possible all cases are placed in a single room. Staff are supported in their decision making processes by the risk assessment tool, for prioritisation of patients who require isolation. This tool is published on Merlin, our document library. As for the MRSA bacteraemia, the same process applies and each case has a PIR completed, which includes:

- a review of predisposing antibiotic therapy
- the use of proton pump inhibitors
- current antibiotic treatment including Fidaxomicin which is now a second line treatment
- other predisposing variables including compliance with relevant IP&C practices

An RCA is held fortnightly to discuss these cases; learning and action points are disseminated by the infection control nurses through the divisional IPC monthly meetings, the IC monthly report and quarterly to the Infection Prevention and Control Committee. In cases of CDI which result in death, colectomy, or are the result of a cluster of infections (i.e. ≥2 cases in the same clinical area within a 28 day period), more information is gathered and are reported as a serious incident if indicated. For this reporting period, 2022/23, there were 94 hospital onset cases and 35 community onset healthcare associated (COHA) cases.

Table 2: Incidents and associated risks to patients

	No Harm	Low / Minor	Moderate	Total
Avoidable Wound Infection	2	1	0	3
Bay Closure	7	2	0	9
Community Onset Infection	3	0	0	3
Cross Infection	31	4	0	35
Hospital Attributed C.Difficile	3	99	0	102
Hospital Attributed COVID19	35	2	0	37
Hospital Attributed MRSA	3	0	1	4
Inter-hospital Transfer with known infection	6	1	0	7
Lack of PPE	5	0	1	6
Line related bacteraemia	2	0	2	4
Non adherence to PPE guidance	6	3	0	9
Non-compliance with infection control standards/policy	50	7	0	57
Social Distancing Breach	4	0	0	4
Surgical Site Infection	1	2	0	3
Unable to isolate	30	3	0	33
Ward Closure	1	1	0	2
Total	189	125	4	318

The incidents shown in the moderate column in (table 2) relating to hospital attributed MRSA and line related bacteraemia are linked. This incident involved an extensive PIR with learning shared to the ward staff, surgeons and infection control team around timely swabbing of patients and treatment for MRSA decolonisation.

The lack of PPE incident was related to a staff member wearing a non-fit tested FFP3 mask. This was investigated and there is now assurance that all wards stock the five masks the Trust hold.

Infection control management, including the role of the DIPC

The Chief Executive (CEO) has overall corporate responsibility for the control of infection within Cambridge University Hospitals NHS Foundation Trust (CUH). The Medical Director (MD) is the Trust designated Director of Infection Prevention & Control (DIPC) and is supported in this role by one of the Deputy Medical Directors who acts as Deputy DIPC.

The infection prevention & control team (IPCT) provide a 24 hour on-call service for provision of infection control advice to clinical and managerial colleagues and comprise of medical and nursing infection prevention control professionals and who are responsible for the day-to-day operation of the infection control service including:

- surveillance and mandatory reporting
- the provision of IPC policies
- an audit programme to ensure that key policies and practices are implemented appropriately
- provision of advice to clinical and management colleagues including:
    - monitoring of infection risks
    - on-going staff education and training
    - appropriate advice in response to major outbreaks of communicable infections

The IPCT reports

The DIPC is responsible for leading the IPCT and reports directly to the chief executive and the board of directors (see appendix 1 for DIPC responsibilities).

The IPCT is responsible for day to day management of infection control and liaises closely with the DIPC as required (see appendix 2 for IPCT responsibilities).

The IPCT consists of:

- Director Infection Prevention & Control (DIPC; Medical Director)
- Deputy Medical Director / Deputy Director of Infection Prevention & Control
- Corporate Head of Nursing
- Infection prevention and control lead nurse
- Consultant Microbiologist / Infection control doctor (ICD)
- Infection prevention and control clinical nurse specialists (5.85WTE up from 6.4 WTE in 2022/23)
- Surgical site infection surveillance nurses (0.8 WTE)
- Clinical educator for infection control (1 WTE)
- Information analyst (1 WTE)
- Personal assistant (1 WTE)
- Mast Fit Testing team (3 WTE)

A senior IPC nurse is in post to support with all aspects of safe use of respiratory protective equipment (RPE There is ongoing review of the establishment and priorities of the IPCT.

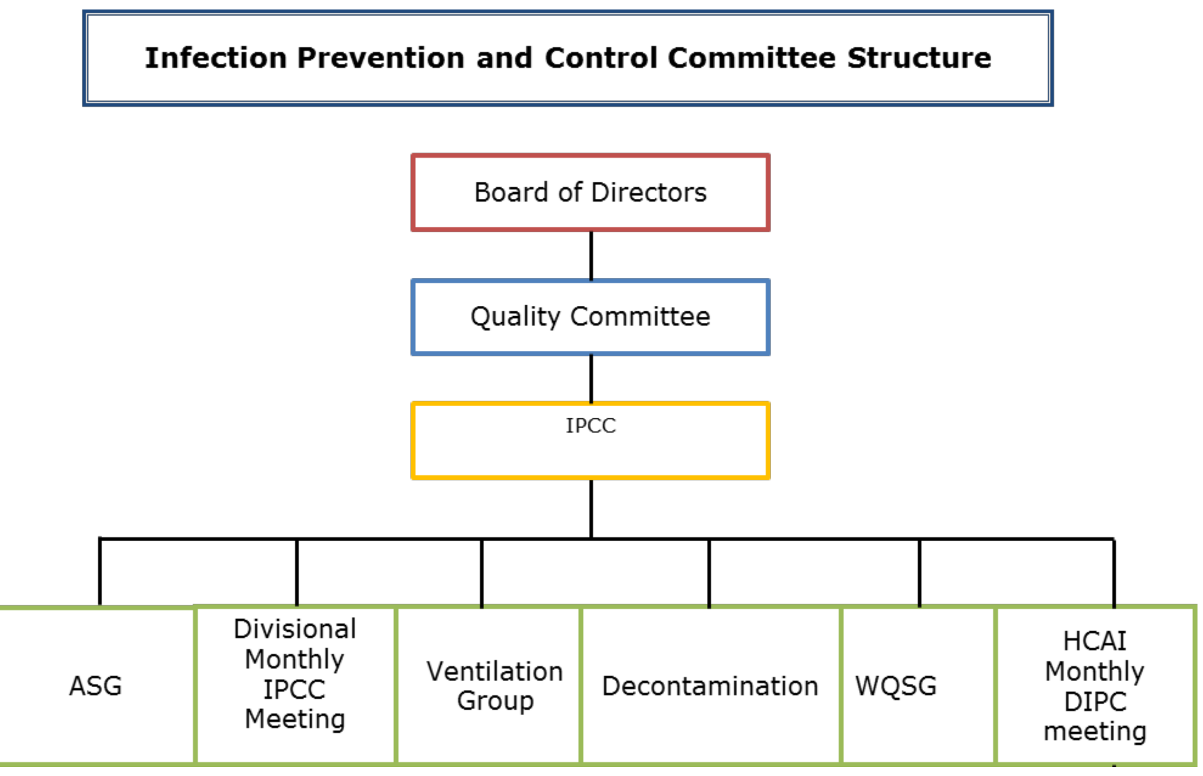


Figure 2: The Infection Control Structure for 2022/23

Key:

IPCC:	Infection Prevention Control Committee
ASG:	Antimicrobial Stewardship Group
WQSG:	Water Quality Steering Group
HCAI:	Healthcare Associated Infection
DIPC:	Director of Infection Prevention & Control

The team is further supported by other consultants in microbiology and virology, estates & facilities and an antimicrobial pharmacist.

The IPCC meets every three months and is chaired by the deputy DPIC. Membership comprises:

- Representatives from the ICT
- Nominated infection control leads from all clinical divisions
- Representatives from other relevant groups within the Trust (Central Sterile Services Department, Occupational Health, Estates)

The Infection Prevention & Control Committee (IPCC) reports to the Quality and Risk Committee and is responsible for supervising the delivery of the annual infection control priorities and audit programme and the infection control annual report, as well as identifying risks relating to infection control via review of risk assessments and incident reports. These are influenced by local need and those suggested by NHS England and the Integrated Care Board

The Trust has devolved accountability for HCAI to divisional level via the divisional directors and heads of nursing and through nominated IPC leads in each clinical department. The clinical department leads have responsibility for implementing specific IPC practices and achieving key performance targets for their directorates.

The IPC leads are responsible for implementing and monitoring IPC policies in their clinical areas with support as required from members of the IPCT. The IPC consultant lead reports to the divisional directors within the divisional clinical governance framework.

The Matrons / ward managers have day to day responsibility and accountability for infection prevention and control and delivering a safe and clean care environment See appendix 3 and appendix 4 for identified roles and responsibilities.

The key working structures for IPC are summarised in appendix 5.

During the COVID19 response, members of the infection prevention & control team (IPCT) have led or contributed to the following committees which are summarised below

Assurance framework

Infection prevention & control is an integral part of the clinical and corporate governance framework.

IPC is recorded as a risk to patient safety in the Trust’s board assurance framework. This framework identifies the key control measures in place and the means by which the board of directors are assured that those controls are operating effectively. The main source of assurance is the monthly performance report to the Board showing current infection levels and

reporting on actions, initiatives and audits of compliance with key IPC policies (e.g. hand hygiene).

The DIPC reports regularly to the board of directors on performance against target; key issues and actions relating to serious bloodstream infections (MRSA, MSSA, *E. coli, Klebsiella* spp. and *Pseudomonas aeruginosa*) as well as *Clostridium difficile* infection and other infection issues when relevant.

The IPC annual report is produced by the consultant microbiologist and the DIPC for presentation to the Quality Committee and is in the public domain. It summarises the current situation with regards infection control practice within the Trust and highlights the resources needed to manage infection related risks in the coming year.

The monthly IPC reports are available to all Trust staff via Connect and business intelligence tool (QlikView) and are disseminated to key internal and external networks.

The Trust, via the deputy chief nurse or infection control lead nurse, reports to the ICB monthly or more frequently if required on the incidence of MRSA bacteraemia, *Clostridium difficile* and any declared infection outbreaks (e.g. norovirus).

The Trust, via the deputy chief nurse, infection control doctor, lead nurse and director quality reports to the ICB monthly on MRSA bacteraemias and *Clostridium difficile* and, where there is non-compliance with monthly agreed targets as per the agreed contract.

The Trust reports notifiable infections to UKHSA

Key Infections

COVID19

Covid19 continues to impact clinical care in CUH. There have been 34 outbreaks since April 2022-March 2023.

There were 255 inpatient deaths with Covid19 (either on the death certificate (part 1 /part 2) or within 28 days of a positive swab) in 2022/23 compared to 152 for the preceding year. Following a change in National Guidance, the Trust stepdown from the red, amber and green pathway which meant that patients were being placed in bays prior to symptoms developing.

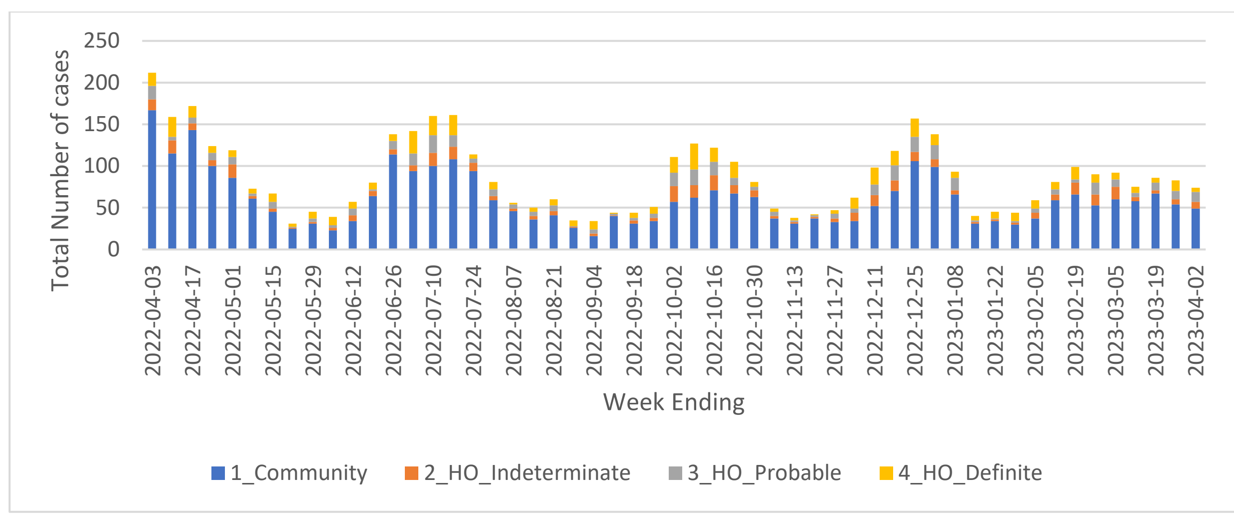


Figure 3: Hospital Acquired COVID Cases at CUH

Methicillin Resistant *Staphylococcus aureus* (MRSA)

Bacteraemias

The 2022/23 ICB ceiling was set at zero avoidable cases reflecting national expectations. However, there were three cases of hospital onset MRSA bacteraemia (Figure 4). One was considered to be avoidable as no MRSA screening was completed on admission pre-surgery. Two out of the three bacteraemias were considered to be unavoidable following the RCA process.

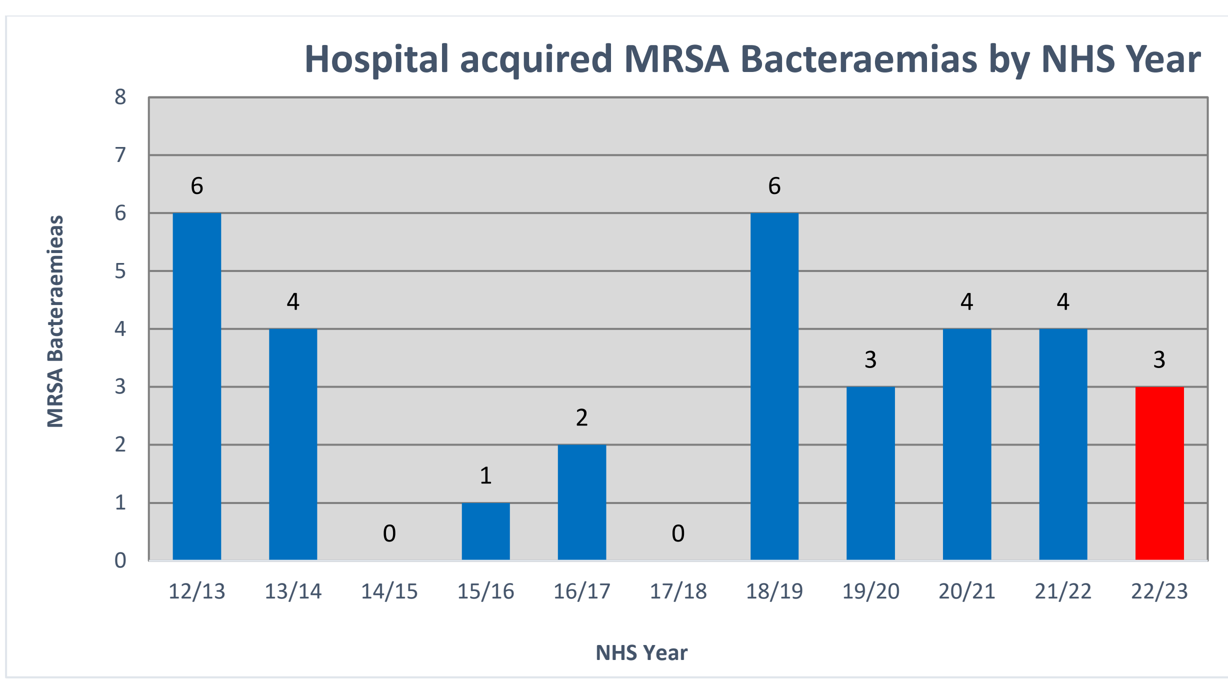


Figure 4: Hospital acquired MRSA Bacteraemias by NHS Year

It is of interest to note the figures and trends reported at CUH follow those reported nationally by UKHSA and show CUH as middle of the table:

https://www.gov.uk/government/statistics/mrsa-bacteraemia-annual-data

Table 3: CUHFT position amongst the Shelford Group for all hospital-onset MRSA bacteraemia cases

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Sheffield Teaching Hospitals	0.5	0.7	0.4	0	0.4	0.6	0.4	0.6	0.8	0.0	0.4
The Newcastle upon Tyne Hospitals	1.0	1.5	0.8	1.4	1.5	0.6	0.4	0.2	0.3	0.0	0.4
King's College Hospital	0.9	1.9	0.8	0.7	1.3	1.0	1.7	0	0.9	0.8	1.2
Oxford University Hospitals	1.0	0.9	1.6	0.5	1.5	0.3	0.6	1.1	2.8	0.8	0.8
University Hospitals Birmingham	1.4	1.3	0.5	1.5	1.6	0.2	0.5	1.4	0.3	0.9	0.5
Cambridge University Hospitals	1.9	1.3	0	0.9	0.9	0.3	1.8	0.9	1.4	1.2	0.8
Guy's & St. Thomas'	0.5	1.1	0.4	0.4	1.1	1.1	1.1	2.3	1.4	1.4	0.7
Manchester University	1.6	1.7	0.5	1.3	1.5	0.3	1.1	1.0	2.1	1.4	1.8
University College London Hospitals	2.3	2.3	1.1	0.8	0.8	0.4	0.4	1.6	2.2	1.4	1.7
Imperial College Healthcare	2.9	2.9	1.7	1.7	1.1	0.3	0.8	0.8	1.8	3.1	1.4

Rate, per 100,000 bed-days = (n hospital onset cases /average daily occupancy * n days in period) x 100,000

MRSA acquisition

The term acquisition refers to someone who has been found to be MRSA-positive for the first time and includes isolates from samples taken for clinical purposes (e.g. wounds, urine, sputum etc.) and also routine skin swabs taken during MRSA screening of patients (representing colonisation i.e. present on the skin). Figure 5 shows the number of new acquisitions of MRSA. The number was much less than previous years.

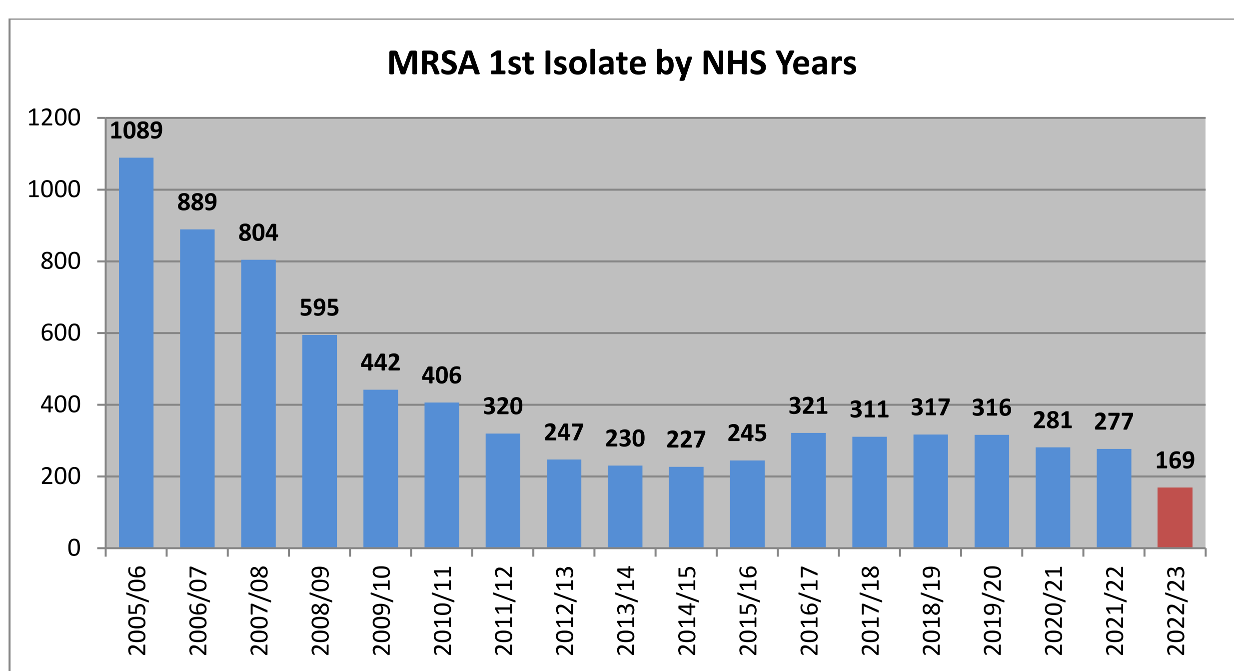


Figure 5: MRSA 1st Isolate by NHS Years

There were no confirmed outbreaks of MRSA in 2022/23 showing an improvement from the previous year. An outbreak was considered in June 2022 on the neonatal intensive care unit (NICU) when 4 babies were affected, prompting an IMT. However, molecular typing

subsequently found they were not linked. This evidenced good genotyping providing the assurance of no MRSA spread within NICU.

Clostridium difficile

There were 94 cases of hospital-onset *C. difficile* infection (CDI) in 2022/23, which represents a marginal rise since 2021/22 (Figure 6). One patient had the infection recorded in part one of their death certificate (Table 4; down from last year) and significant improvement compared to 20/22.

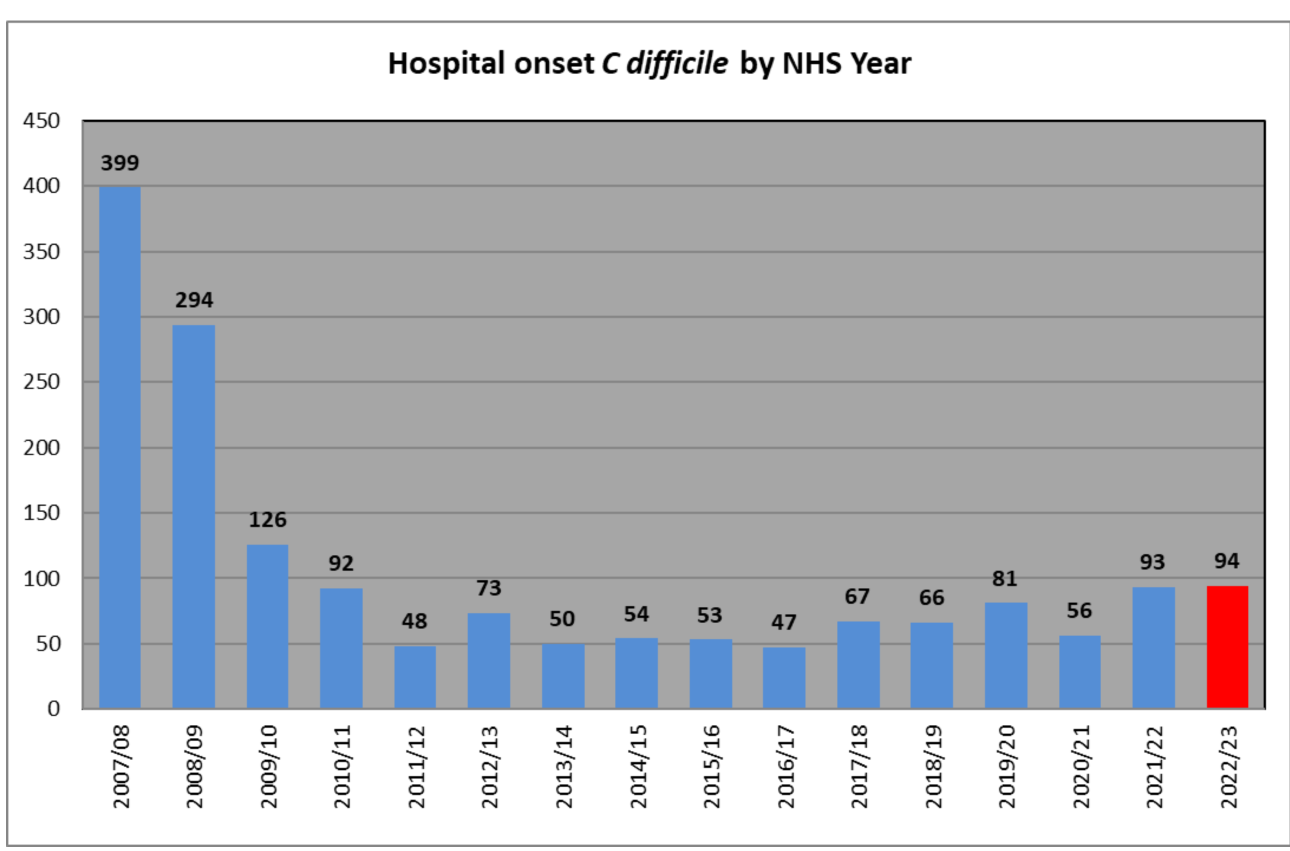


Figure 6: Hospital onset C difficile by NHS Year

Table 4: CDI on part 1 and 2 of death certificates

Year	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23
Part 2	14	4	2	6	7	9	5	2	3	4	2	3	1	3
Part 1a	3	2	0	1	2	3	3	1	4	3	3	5	1	0

Table 5: CUHFT Position amongst the Shelford Group April 2012 - March 2023 for CDI

Organisation code	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Guy's & St. Thomas'	15.2	13.5	16.5	15.1	10.7	8.9	6.2	7.0	10.2	12.7	11.7
King's College Hospital	17.5	14.3	16.3	18.1	15.1	18.3	16.5	13.7	14.5	13.5	19.8
Imperial College Healthcare	31.2	18.7	22.6	20.9	17.8	18.5	14.3	17.0	14.2	16.0	20.1
Oxford University Hospitals	23.2	13.9	13.9	14.2	13.1	18.5	14.4	13.4	22.5	18.1	25.4
University Hospitals Birmingham	18.6	18.9	17.3	15.3	19.2	15.7	16.8	15.9	17.5	18.1	19.7
Manchester University	19.0	15.1	17.2	15.4	17.3	19.6	17.2	15.6	24.2	21.5	20.8
Sheffield Teaching Hospitals	17.8	13.7	16.3	14.7	20.3	15.4	16.4	21.3	24.6	24.6	22.3
Cambridge University Hospitals	23.5	15.9	17.1	16.7	14.5	20.2	19.5	21.9	16.5	24.7	23.9
The New castle upon Tyne Hospitals	15.4	18.2	18.4	19.4	15.4	18.9	16.8	18.3	20.8	27.5	25.7
University College London Hospitals	20.5	37.1	40.2	36.4	34.2	27.7	22.2	18.7	34.7	28.8	37.8

Rate, per 100,000 bed-days = (n hospital onset cases /average daily occupancy * n days in period) x 100,000

Of these 94 cases, following a case note review and multidisciplinary discussion it was demonstrated no lapse in care for 73 patients. 21 were found to be hospital onset and avoidable There were 35 COHA cases (21 avoidable hospital onset cases). Delays in sending a sample and poor timely isolation constituted the majority of the identified lapses in care and this has been a recurrent theme. Inappropriate antibiotic use was also noted. These findings are shown in Table 6 which also demonstrates the progress in improving process and procedures over the last few years.

Table 6: Reasons given for lapses in care for patients with C. difficile infection

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Total
Delay in sample collection	12	10	4	3	3	5	4		10	**51**
Delay in sample collection and isolation	11	7	5	1	3	2		2	5	**36**
Delay in isolation	6	8	4	2	2				3	**25**
Issues with antibiotic stew ardship	1	0	2	3	0	2	1	2	8	**19**
Delay in isolation and poor documentation	0	0	0	5	0			1	3	**9**
CDT outbreak on C10 & J2	0	0	0	0	5			1		**6**
Delay in sampling/isolation, poor documentation	0	0	0	0	4	1			4	**9**
Poor hand hygiene	1	1	0	0	0				13	**15**
Delay in sampling and antibiotic issue	0	0	0	0	2		1	1	5	**9**
Wrong sample collection	1	0	0	0	1					**2**
Delay in sampling and CDT infection diagnosis.	0	0	0	0	1	1			2	**4**
Other	3	1	1	3	2	3	1	3	2	**19**
Total	**35**	**27**	**16**	**17**	**23**	**14**	**7**	**10**	**55**	**204**

***E. coli* bacteraemia**

All hospital onset *E. coli* bacteraemias are reviewed by the IPCT in order to assess their likely source and consider whether or not they were preventable. There were 129 hospital onset *E. coli* bacteraemias in 2022/23. This figure has increased from 108 cases the previous year and, in line with the National trend, a rise in cases has been seen due to the Covid pandemic.

We as an organisation recognise this as a significant issue and will work closely with colleagues across the healthcare system to address this as a priority for 2023/2024.

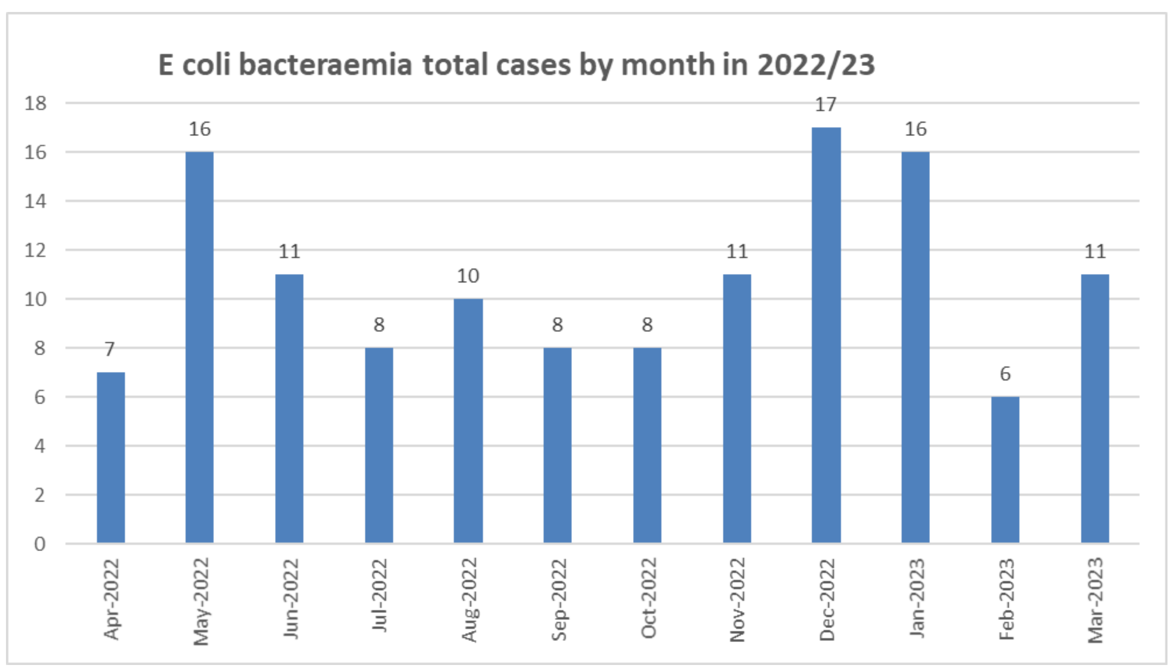


Figure 7: E coli bacteraemia total cases by month in 2022/23

Carbapenemase Producing Enterobacterales (CPE)

Carbapenemase producing Enterobacterales (CPE) are Gram negative bacteria that are resistant to most antibiotics. They can cause colonisation (with no evidence of infection) or clinically significant infection. CUH had one case in 2015/16, 17 in 2016/17, 24 in 2017/18 39 in 2018/19, 26 in 2019/20, 20 in 2020/21, 18 in 2021/22 and 29 in 2022/23. **Six were clinical samples and 23 were screening swabs**. There were two episodes on different wards of outbreaks involving three patients. There has been a rise in the number of CPE screens that the laboratory processes due to increased awareness and evolving screening criteria. The predominant CPE in CUH is NDM-1, followed by OXA 48 with one case of IMP. There were 3 CPE outbreaks involving wards L5, M5 and L4.

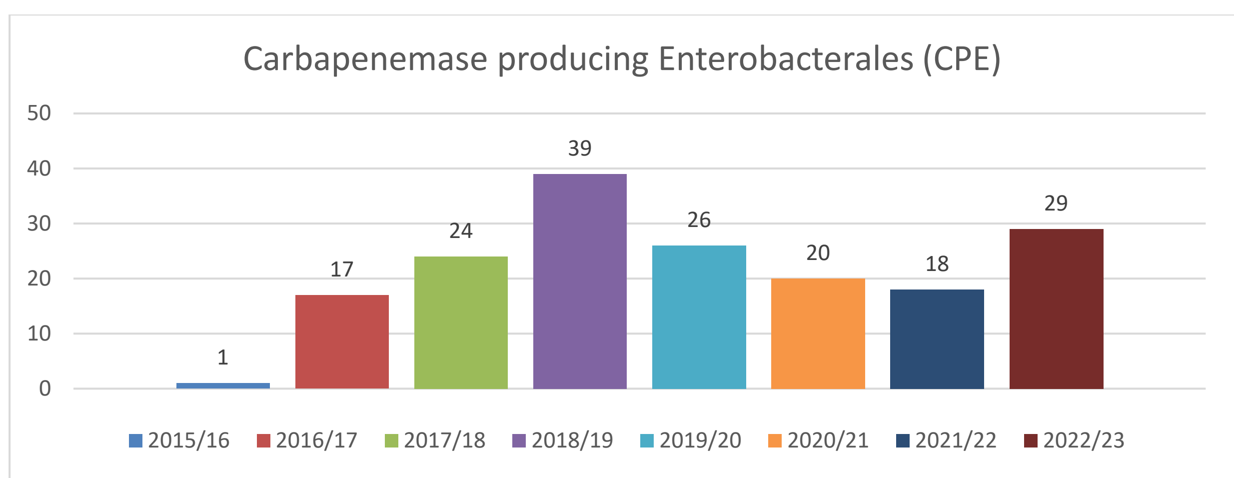


Figure 8: CDE cases by NHS Year

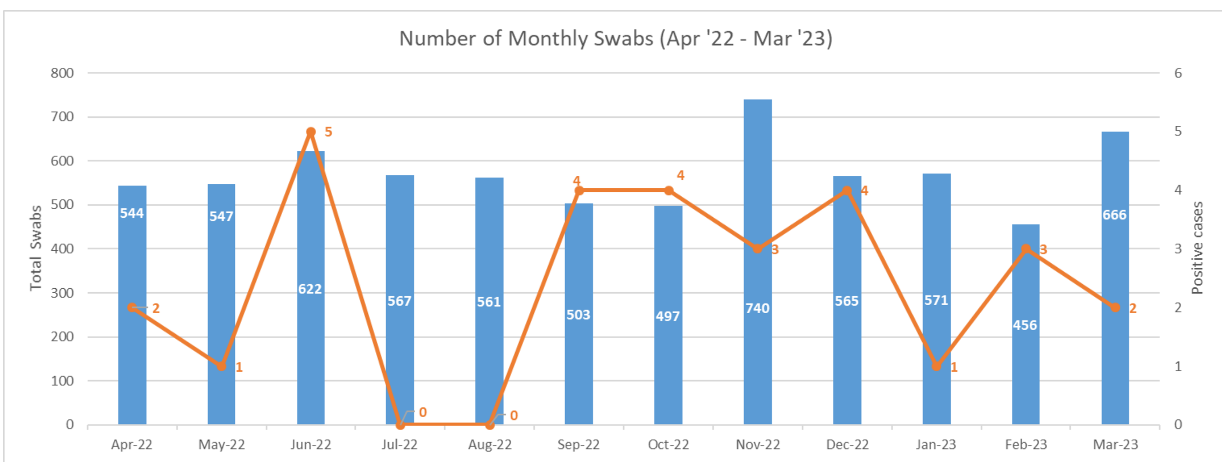
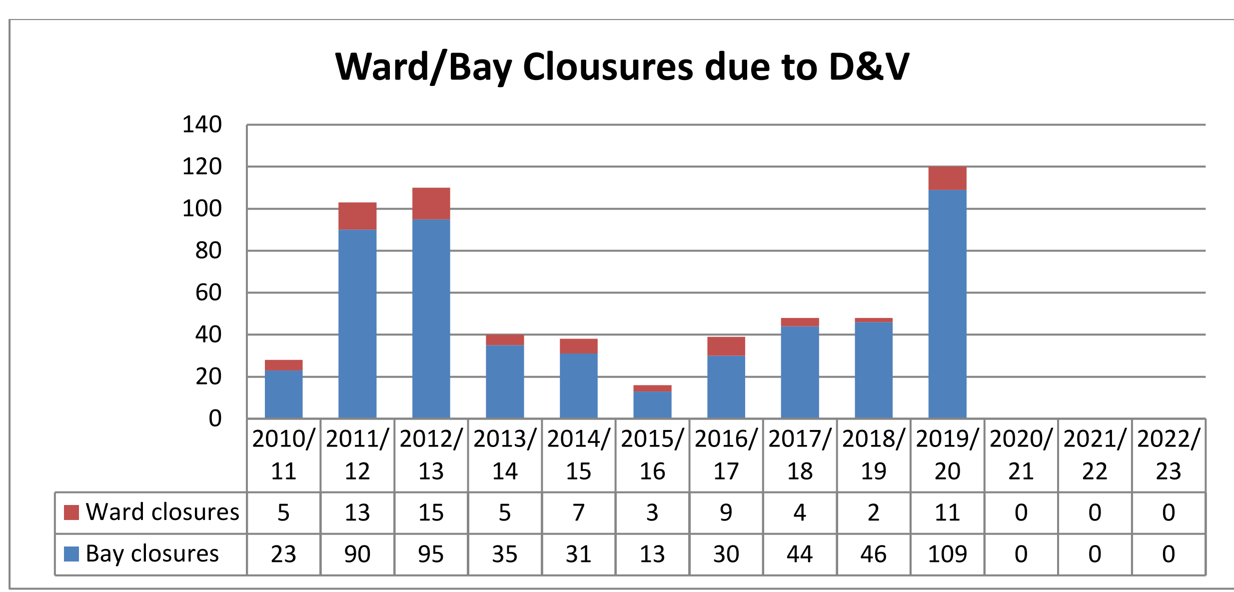


Figure 9: CDE total Swabs and positive cases by month in 2022/23

Norovirus

Norovirus infection is a short-lived vomiting and diarrhoeal illness, which is readily transmitted from one person to another. The virus can be caught from the environment or shared equipment that has become contaminated. In hospitals, large numbers of patients, staff and visitors may be affected, which can disturb the normal working of the hospital and cause distress to those affected. It is difficult to prevent infection coming into the hospital when there are high numbers of infected people in the community who need admission and when patients incubating the virus may be transferred from referring hospitals.

Norovirus cases normally impact the Trust between October to April with cases peaking January to April. There were again no outbreaks / ward closures in 2022/23 as was the case in 2020/21. For this same period in 2019/20 there were 226 confirmed cases which was noticeably more than the 100 cases in the same period in 2018/19. The corresponding increase in positive ward and bay closures are shown in Figure 10.



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Ward closures	5	13	15	5	7	3	9	4	2	11	0	0	0
Bay closures	23	90	95	35	31	13	30	44	46	109	0	0	0

Figure 10: Ward/Bay Closures due to D&V

Influenza

The 2022/23 Flu season consisted of 1673 positive cases, with 28 being hospital onset. Before January 2023 the majority of cases were Flu A/ seasonal flu and from February 2023 cases were mainly Flu B. The trust had one outbreak with 14 patients and 8 staff affected. This coincided with a Covid bay on the ward at the same time. CUH followed the pattern from the Australian season with seeing a sharp increase in cases for Christmas.

2022-23-134 cases no out breaks, 1677 positive cases.

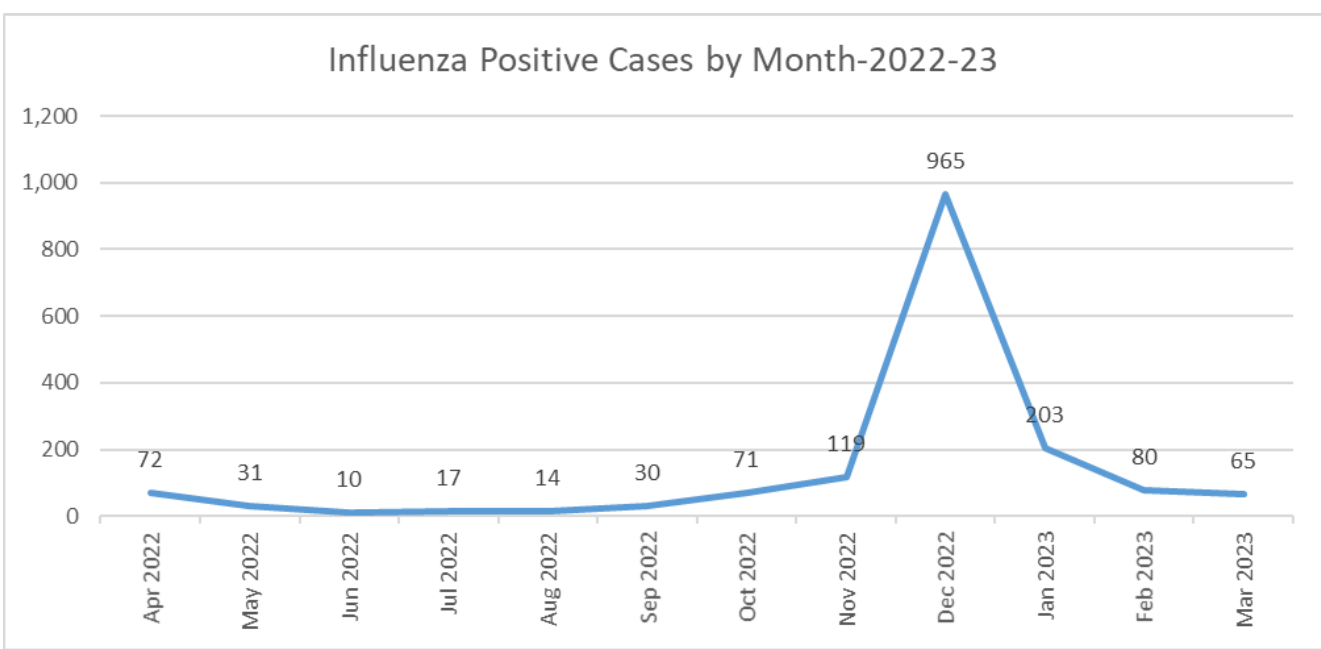


Figure 11: Influenza Positive Cases by Month in 2022/2023

MPOX

May 2022 saw the emergence of MPOX as a worldwide threat and deemed a High Consequence Infectious Disease (HCID). This highly infectious disease is spread through touch and body fluids. CUH was nominated to support the adult vaccination programme June 2022 for suspected cases/ potential contacts with a known case. A working group consisting of staff from the Emergency Department, Occupational Health, Pharmacy, Estates and IPCT was established to oversee the delivery of the primary prevention vaccination for staff, and for adult and children who were known contacts of people with MPOX. The vaccination was administered to a total of 22 staff and 28 patient contacts MPOX has now been downgraded from category A pathogen.

Congo Crimean Haemorrhagic Fever (CCHF)

There was a suspected case of CCHF in March 2022 following the confirmed Lassa fever case in February 2022. The learning from the Lassa fever case was applied to the suspected CCHF case which ensured efficient management of this case.

Surgical site infection (SSI)

Surgical procedures can be complicated by infection. This is usually a minor superficial infection of the surgical wound, although more serious deep-seated infections do occasionally occur. The risk of infection varies with the particular type and site of surgery. Surgery associated with the gastrointestinal tract, for example, has a much higher infection rate than 'clean' surgery, such as the elective insertion of a prosthetic hip joint. On-going surveillance of surgical site infection is used within the Trust as one measure of the quality of surgery, to identify areas where further investigation or improvement might be required. Currently the Department of Health requires all Trusts to provide data from elective orthopedic implant surgery (either hip or knee), repair of neck of femur or reduction of long bone fracture for one three-month time period.

Surgical Site Surveillance (SSS) meticulously tracked infection rates post-surgery. Large bowel surgeries in Jan-Mar 2022 showed a 11.5% SSI (national average (NA) 8.4%), followed by a decline to 7.3% (NA 8.3%) in Apr-Jun 2022 and 8.3% (NA 8.1%) in Jul-Sep 2022. Small bowel surgeries demonstrated 10.5% SSI (NA 7.0%) in Jan-Mar 2022, dropping to 4.5% (NA 7.0%) in Apr-Jun 2022 and rising slightly to 7.4% (NA 7.2%) in Jul-Sep 2022. Notably, the SSI for repair of neck of femur in Oct-Dec 2022 was 0.9% (NA 0.7%), and for reduction of long bone fracture in Jan-Mar 2023, it was 0%, while for repair of neck of femur in the same period, it stood at 0.8% (NA 0.7%). Collaboration with surgical teams and interventions continued to address elevated SSI rates above national averages.

Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

This criterion links with Outcome 10, Regulation 15 safety and suitability of premises contained in CQC guidance about compliance.

The IPCT, in collaboration with Housekeeping, estates and facilities and the decontamination lead, monitors standards of cleanliness within the Trust and promotes best practice by ensuring the following:

- The Trust has a cleaning strategy developed by the estates and facilities team in collaboration with the ICT and approved by the IPCC.

- The provision of policies for:
    - the maintenance of the environment
    - provision of cleaning services
    - linen, laundry and uniforms
    - decontamination of the environment and equipment
- Staff are suitably trained and hold adequate competencies for their roles.
- There are designated managers for the cleaning of the environment and the cleaning and decontamination of equipment.
- Ward nurses are responsible for cleaning medical equipment and the immediate bed-space. Environmental cleaning is provided by the Trust's cleaning contractor, Medirest. A system is currently in place whereby different levels of cleaning are provided using a RAG rating scheme, depending on the infection status of the patient. As an example, non-infected patients receive a 'green clean' which involves the bed space being cleaned with a chlorine-based product. A patient infected with *C. difficile* will have their bed space cleaned with a chlorine-based product and then cleaned using hydrogen peroxide vapour (HPV), known as a 'red clean'.
- In addition to routine cleaning, the IPCT can request additional cleaning in the event of an infection outbreak or increased incidence of an infection. This 'reactive cleaning' can take the form of:
    - Enhanced clean: When additional Medirest staff are allocated to an area to clean communal areas such as patient bays, toilets, dirty utility rooms and touch points.
    - Rolling clean: When an empty bay is used to decant patients within that given ward so that each bay is cleaned on rotation. Depending on the reason for the clean and time available, bays may undergo an HPV or ultraviolet light clean in addition to cleaning with a chlorine-based product.
    - Deep clean: When a bay or side room is empty for sufficient time to allow for a full red clean. There was, until December 2015, the availability of a spare 'decant' ward where a whole ward would be proactively moved to a decant facility so that the home ward could undergo a deep clean. This facility was not available since 2016/17 due to capacity issues and as a result the formal deep clean programme has been suspended since. This is seen as a significant risk, particularly for the control of *C. difficile* infection, and the intention is to reinstate the programme as soon as possible. The lack of decant facility has been included on the Trust risk register.
- IPCNs are involved in all aspects of cleaning services, including contract negotiations, deciding on cleaning priorities and monitoring of service delivery at ward level.
- Senior clinical nurses / matrons have personal responsibility for delivering a safe and clean environment. The nurse in charge of any clinical area has direct responsibility for ensuring that cleanliness standards are maintained throughout the shift, including use of appropriate escalation procedures where necessary.
- Ensuring via regular audit and ward inspection visits that all parts of the premises are suitable for the purpose, kept clean and maintained in good physical repair and condition. The audit results are fed back to the wards and incorporated into the nursing quality metric report which provides information monthly by ward and Trust division.
- PLACE (patient led assessments of the care environment) visits are undertaken and the findings and recommendations are actioned. These are managed by Hotel Services rather than the IPCT.

- The cleaning arrangements detail the standards of cleanliness required in each part of the premises and that cleaning schedules and frequencies are publicly available.
- There is adequate provision of suitable hand washing facilities and antibacterial hand rubs, including risk assessments of placement of alcohol-based products.
- Correct procedures are in place for the delivery of food services, including food hygiene and food brought into the organisation by patients, staff and visitors.
- Advising on waste disposal. There is a clinical waste incineration facility on site with an associated ‘energy from waste’ heat recovery system. This facility is compliant with the Environment Agency Permitted Waste Incineration Directive.
- There is a programme of planned, preventative maintenance, including pest control and the management of potable and non-potable water supplies.
- Ensuring the supply and provision of linen and laundry including uniforms which reflects health service guidance HSG (95)18 hospital laundry arrangements for used and infected linen.
- Ensuring the Trust has effective arrangements for the appropriate decontamination of instruments and other equipment. The Trust is fully compliant with HBN/13 and has registration under MDD93/42/EEC.
- There is a designated decontamination lead with responsibility for ensuring that the decontamination policy is implemented in relation to the organisation and takes account of national guidance.
- Appropriate procedures are followed for acquisition and maintenance of decontamination equipment.
- A monitoring system is in place to ensure decontamination processes are fit for purpose and meet required standards:
    - risk assessment
    - weekly water testing and feedback of results
    - machine checks
    - maintenance with available records
- A monitoring system is in place to ensure safe and adequate equipment cleaning in line with High Impact Intervention No. 8 Decontamination of Equipment.

Legionella

Legionella spp. and *Pseudomonas aeruginosa* are two bacteria that are capable of living in hospital water systems and have the potential to cause clinically significant infections in patients. The Water Quality Steering Group (WQSG) meet regularly to discuss matters related principally to Legionella spp. and *Pseudomonas aeruginosa*. Membership of this group includes the Estates department, infection control and patient safety / risk. Microbiological control of *Legionella* is achieved by:

- Temperature: the Trust employs temperature control as the primary method of *Legionella* control within the domestic water systems (as far as is reasonably practicable). This is achieved by maintaining temperatures of:
    - Cold water at temperatures of < 20°C
    - Stored hot water at >60°C (where exceeding 15 litres storage)
- Avoidance of Stagnation: experience has shown that avoiding stagnation is highly important in keeping bacterial counts within acceptable limits. This is achieved by the following:
    - Removing any ‘blind ends’ on distribution pipework so far as is practicable

    - Ensure all 'Dead-Legs' (e.g. low use taps) are either flushed or removed including any associated pipework
    - Minimising stored water
    - Designing and installing new or modified systems so that the risk of stagnation is minimised
- Maintain cleanliness
- Pipework, distribution, storage, plant and outlets shall be maintained in a clean condition at all times as far as is reasonably practicable to avoid providing nutrients to bacteria.

Legionella contamination continues to be detected in some water outlets in the Trust. This is caused by the water heaters being 40 years old, water piping being made of galvanised steel (which in parts is heavily corroded) and some areas with poor water flow rates. Some of the piping in C & D block has been replaced but the piping in other wards still require urgent replacement. Silver-copper ionisation was reintroduced due to its antibacterial properties in order to reduce the growth of these organisms. This is achieved by injecting the copper and silver ions into various parts of the system and maintaining levels of these ions to the supplier's specifications. In addition to this, flushing is also performed across the Trust. Despite the risks associated with an aging water system no patient contracted a hospital onset legionella infection in 2022/23.

Testing for *Pseudomonas aeruginosa* in augmented care areas (i.e. dialysis units and intensive care units) is also performed. Positive results were recorded from the John Farman intensive care unit (JVF) and NCCU. Remedial action is promptly taken by the estates department to reduce the risk to patients and this is discussed at the WQSG. The number of positive outlets continues to fall year on year.

Covid19 has highlighted that a number of clinical areas (i.e. wards, outpatients, certain radiology departments) in the trust comply with the ventilation standards to which they were designed to achieve but do not comply with standards that apply to new builds. This is inevitable bearing in mind the age of the estate, some of which is over 60 years old.

A number of mitigating factors have been put in place to try and address these shortcomings and the issue is on the trust risk register.

Windows are left open when at all possible to improve airflow, social distancing measures are strictly enforced and 'air scrubbers' have been introduced into certain areas to try and improve ventilation whenever possible.

Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance

We have systems in place to manage and monitor the use of antimicrobials to ensure inappropriate and harmful use is minimised and patients with severe infections such as sepsis are treated promptly with the correct antibiotic. These systems draw on national and local guidelines, monitoring and audit tools such as NICE guidelines, guidance on patient group directions and Start Smart then Focus in secondary care (SSTF).

There is an Antibiotic Stewardship Group (ASG), which meets quarterly, is responsible for developing, implementing and monitoring the organisation's stewardship programme. Membership of this committee includes representation from microbiology/infectious diseases, pharmacy, each clinical division and the organisations' director of infection prevention. The committee reports to the IPCC and Joint Drug & Therapeutics Committee (JDTC).

We have an expanding range of antimicrobial policies drawing on national guidance (including the British National Formulary, UK Health Security Agency, the National Institute of Care Excellence) that take account of local antimicrobial resistance patterns. They cover diagnosis, treatment and prophylaxis of common infections and prescribers are encouraged to record allergy status, reason for antimicrobial prescription, dose, duration of treatment and oral step down options. Benchmarking is used to demonstrate progress in antimicrobial stewardship. Guidelines are available on the intranet and via an app (MicroGuide).

Providers have access to timely microbiological diagnosis, susceptibility testing and reporting of results. Prescribers have access at all times to Clinical Microbiologists who can advise on appropriate choice of antimicrobial therapy.

We report local antimicrobial susceptibility data and information on antimicrobial consumption to national surveillance bodies as mandated.

All prescribers receive induction and training in prudent antimicrobial use and are familiar with the antimicrobial resistance and stewardship competencies.

In 2022-23 the Antimicrobial Stewardship (AMS) team produced a varied programme of work during a challenging year that recorded higher than average rates of Gram-negative bacteraemias and a significant winter peak of respiratory viruses and invasive Group A Streptococcal infections.

The challenging National Contract target to reduce Watch (broad) and Reserve (last resort) antibiotic usage by 4.5% from the 2018 baseline was not achieved (as was the case with almost three quarters of English Trusts), with usage particularly affected during the winter months. On the other hand, efforts to reduce carbapenem use resulted in a further 2% reduction in usage compared to 2021/22.

The AMS team led on a comprehensive education programme on treatment of urinary tract infections (UTI) and community-acquired pneumonias (CAP) which formed part of two CQUINs. It led on and achieved the target for the UTI CQUIN (which was endorsed by the Trust), building on a previous successful CQUIN in 2019-20. The team also engaged with the CAP CQUIN (which was not endorsed by the Trust) and achieved a significant improvement in performance which, however, did not meet the target.

The AMS team made significant contributions locally, expanding its digital resources, education, and public engagement activities, but also working collaboratively within the Systemwide and Regional AMS framework. In particular, the AMS team engaged with regional and national bodies to pilot practice and educational material for the upcoming CQUIN on IV-to-oral switch. As part of this it conducted a successful local nurse-led pilot project to promote IV-to-oral switch of antibiotics that was shared regionally and nationally.

CUH is faced with additional challenging targets for 2023/24, including a National Contract target to reduce broad and last resort antibiotic use (Watch and Reserve) by 10% compared to the 2017 calendar year baseline, and a CQUIN on IV-to-oral switch. The strategic priorities for 2023/24 include:

- Focus on the National Contract and IV-to-oral switch CQUIN target
- Continued engagement with the EPIC team to improve on reporting and feedback of antimicrobial consumption, infection and resistance rates at directorate and specialty level, and to explore the full potential of EPIC for designing impactful and purpose-built AMS rounds
- On-going engagement with the Systemwide Antimicrobial Network Group and the East of England Antimicrobial Prescribing and Medicines Optimisation Subgroup to promote

and lead on agreed regional and national priorities and quality improvement initiatives, in particular penicillin allergy delabelling
- Work closely with the infection control team and Trust-wide stakeholders to participate in the national healthcare associated infection and antimicrobial usage point prevalence survey in September-October 2023 and maximise output from it
- Work closely with the diagnostic Microbiology laboratory to monitor and minimise potential impacts of additional business continuity plans on AMS

The Antimicrobial Strategy document was updated in 2023 and is available here and includes references to recent national guidance. The Antifungal Stewardship Strategy was also updated in 2023 and is available here.

Criterion 4: Provide suitable accurate information on infections to any person concerned with providing further support or nursing/ medical care in a timely fashion

This criterion links with Outcome 6, Regulation 14 co-operating with other providers contained in CQC guidance about compliance.

The movement of patients within the Trust is included in key policy documents such as the admission and discharge policies and the patient transfer policy. The IPCT works jointly with bed managers, operations centre staff and with estates and facilities services in planning patient admissions, transfers, discharges and movements between departments and other healthcare facilities.

Local Trust infection control policies require information on potential infection hazards to be forwarded to other institutions before patients are transferred out of the Trust.

The IPCT liaises with the discharge planning team and infection control information is included in all documentation.

Criterion 5: Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people

The Trust is able to demonstrate that responsibility for infection prevention and control is effectively devolved to all professional groups by means of inclusion in all job descriptions and mandatory inclusion in appraisal documentation including for medical staff.

Compliance with mandatory training and completion of appraisal are reported monthly in the corporate balanced scorecard. Infection control mandatory training compliance was 96%. This is monitored at executive level at the Management Executive.

The Trust is compliant with national MRSA screening guidance, including the screening of all emergency patients. Compliance is audited and reported monthly in the infection control report.

Point prevalence audits of compliance with antibiotic prescribing are undertaken and reported regularly by the antibiotic pharmacist.

The Trust monitors compliance with the appropriate isolation of patients, including time to isolation. This is reported monthly in the infection control report.

Criterion 6: All care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

Criterion 6 refers to the training and education of staff, which include Trust staff, including bank nursing staff, Contractors and volunteers. Induction and mandatory update training is provided for all staff, this includes hand hygiene: standard precautions and isolation precaution training is provided for the clinical and support staff, and the responsibility for Infection Prevention and Control are contained within the job descriptions in accordance with the Hygiene Code.

In addition to the Induction and update training, the IPCT also provide training for the Link Practitioners and senior and junior medical staff. The training for medical staff includes:

- isolation policy
- antimicrobial prescribing
- blood culture guidance
- management of exposure to blood borne viruses

The ability to deliver face to face training was curtailed by the pandemic but virtual / on-line training continued. The training and assessment is therefore provided in a number of formats;

- e-learning
- face to face
- practical assessment (FY1)
- training packs for locum/agency staff

The Trust works across the health economy on infection prevention and control measures, including working with the Health Protection Unit, UKHSA, ICB and Regional Epidemiology Unit.

Compliance with induction training, mandatory training and appraisal is reported quarterly in the Trust's operational balanced scorecard.

Line managers are notified of non-attenders at induction and mandatory training. It is the responsibility of the line manager to ensure that non-attenders are followed up and complete their training.

Fit testing for respiratory protective equipment is undertaken for all staff in high risk areas. This has been significantly expanded since the expansion in Covid19 cases, in line with national guidance. Fit testing was assigned to a new fit testing team. Compliance at the end of March 2023 is shown in the table below:

Table 7: Fit Testing Compliance at the 22/23

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	36	28	78%	228	109	48%	62	22	35%	128	66	52%	98	27	28%	83	36	43%	635	288	45%
Allied Health Professionals	-	-	-	58	13	22%	14	3	21%	1	0	0%	-	-	-	3	1	33%	76	17	22%
Estates and Ancillary (Porters and Security Personnel only)	85	52	61%	-	-	-	-	-	-	-	-	-	-	-	-	1	1	100%	86	53	62%
Medical and Dental	-	-	-	250	58	23%	-	-	-	185	72	39%	154	21	14%	217	55	25%	806	206	26%
Nursing and Midwifery Registered	-	-	-	638	397	62%	4	2	50%	264	141	53%	142	62	44%	375	180	48%	1423	782	55%
Total	121	80	66%	1174	577	49%	80	27	34%	578	279	48%	395	111	28%	679	273	40%	3027	1347	44%

Criterion 7: Provide or secure adequate isolation facilities

The Trust recognises the need to maintain and expand facilities for patient isolation for infectious purposes, while recognising the need to provide single room facilities for patients requiring privacy for other reasons.

To assist staff the Trust has an isolation policy and organism-specific policies detailing the need for isolation. Staff are also assisted in their decision-making through the provision of a risk assessment tool for prioritisation of patients who require isolation. This has been reviewed several times during 2022/23.

Failure to observe recommended isolation procedures results in the generation of an incident report and if appropriate, emergency control measures as outlined by the IPCT and/or the local Consultant in Communicable Disease Control.

The Trust has the ability to cohort patients where necessary including in the event of a cluster or outbreak of a specific organism. The decision to classify the incidence of any infectious disease as an outbreak is taken by the IPCT in consultation with the infection control doctor or duty microbiologist/ virologist. Broadly, an outbreak can be defined as:

- an incident in which two or more people experiencing a similar illness are linked in time/ place
- a greater than expected rate of infection compared with the usual background rate for the place and time where the outbreak has occurred
- a single case for certain rare diseases such as diphtheria, botulism, rabies, viral haemorrhagic fever, polio

The Trust has in place infection control training programmes for all staff including external contractors. Training programmes are identified through the use of infection control training needs analysis.

Criterion 8: Secure adequate access to laboratory support as appropriate

The laboratory services are provided by UKHSA and are located on site. The local Trust microbiology department has full UKAS accreditation, which requires the provision of appropriate protocols and standard operating procedures.

There is provision of seven day laboratory working and 24 hour access to microbiology and virology advice.

There is a close working relationship with the IPCT; Microbiology Consultants are active participants in the CDI scrutiny panel meetings and there is a monthly meeting between the ICT, virology and microbiology teams to address on-going and new issues.

There are also facilities available for rapid Covid testing (e.g. Samba / Cepheid) outside the UKHSA laboratory.

There is potential for the Trust to set up a High Consequence Infectious Disease pathway.

Criterion 9: Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.

A comprehensive IPC document section is available, via the Trust's document library, which identifies all infections and infectious conditions which require isolation or specific infection control management and describes any specific precautions required.

The IPC documents also identify clinical situations where isolation precautions may be required before any infection risk has been confirmed (e.g. patients with pyrexia of unknown origin from abroad).

The IPCT is responsible for the maintenance and updating of the infection control policies, procedures and guidance documents. There are currently a number of infection control documents which are evidence based and reflect national guidance documents. Approval for such documents is via the IPCC and ratification is via the Quality and Risk Committee.

The antimicrobial prescribing policy is the joint responsibility of the consultant microbiologist and antibiotic pharmacist and is approved by the Antimicrobial Stewardship Group (ASG) which reports to the JDTC.

The decontamination policies and procedures are the responsibility of the decontamination lead.

All ICP polices carry a three yearly review date, or sooner in the light of new evidence. The review schedule is monitored within the annual infection control programme and by the Trust documents administrator. Compliance with key policies is audited according to a schedule included in the annual programme.

The IPCT also collaborates with others such as the central venous access team in developing guidelines such as the central venous access devices (CVAD) – criteria for referral to the vascular access team (VAT).

Clinical directorates are required to include audit of compliance with basic IPC policies as part of clinical governance programme. This is monitored by the IPCT.

Criterion 10: Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work

and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care

The Trust is compliant with Criterion 10, and provides a comprehensive portfolio of policies which address;

- induction training of new staff
- annual update for existing staff
- Occupational health measures

All staff have access to occupational health advice and out of hour's access to medical advice in the event of exposure to a blood borne virus or an alert organism.

There is a screening and immunisation programme which is in accordance with national guidance, specifically 'immunisation against infectious diseases'; including pre-employment screening and on-going health screening for communicable diseases where indicated.

Vaccination data of staff for Covid19 are:

- First dose Covid: 97%
- Second dose Covid: 96%
- Booster Covid: 75%

The uptake of vaccination against influenza in 2022/23 was 58% for both flu and COVID vaccinations (substantive staff).

The Trust is working towards reducing occupational exposure to blood borne viruses including the prevention of sharps injuries by the use of safer sharps products where available, including the blood culture sampling system and intravenous cannula.

Table 8: 2022/2023 Objectives

Number	Objective	Completion date	Outcome
1	Improve Trust compliance with Hygiene code and review quarterly to monitor progress	March 2023	Partially met
2	MRSA bacteraemia – no avoidable cases of trust onset MRSA bacteraemia	March 2023	Not met
3	*C. difficile* – maintain or improve on 25% of total cases as avoidable trust onset C. difficile	March 2023	Not met
4	Gram Negative bacteraemias – reduce trust onset *E. coli* bacteraemia by 20%	March 2023	Not met
5	In conjunction with operations staff identify a method to re-commence the deep clean programme	March 2023	Not met
6	Maintain infection control walkabouts to wards, outpatients and other departments to monitor environment and practices	March 2023	Met
7	Commence POC testing in ED for influenza & RSV in addition to COVID-19	November 23	Met

8	Identify clinical areas with poor ventilation and initiate mitigating measures in line with national IPC guidance	December 2021	Met
9	Review staffing of IPC team in line with increased requirements arising from opening of new clinical facilities and on-going demands due to COVID-19	March 2023	Ongoing

Reasons for not meeting objectives / actions taken

1. The trust has achieved what is achievable now; most non-compliances are now related to the structure of the building
2. The MRSA bacteraemias were caused by poor wound care and line care. Ongoing input is being provided to improve care across the organisation
3. There has been a national increase in CDI cases. However, there are issues related to antimicrobial stewardship and cleaning that need to be addressed in the meantime
4. There has also been a national increase in E. coli bacteraemia rates.
5. This action is linked to point 3. It hasn't been possible to recommence it due to capacity issues.

Objectives for 2023/24

Table 9: Objectives for 2023/2024

Number	Objective	Completion date	Actions
1	Identify a method to re-commence the deep clean programme	March 2024	Discuss with board and ops centre
2	*C. difficile*: maintain the total cases as avoidable HCA - *C. difficile*.	March 2024	Project plan *C.difficile* working group January 2024
3	Robust cleaning structure	March 2024	Liaising with Patient Facilities. Cleaning Task Force to be introduced.
4	Robust Planning for medical, Nursing and New builds	March 2024	New 8a Building Role to be recruited into IPC team.
5	Reduce gram negative bacteraemia e-coli by 20%.	March 2024	Quality Improvement plan which will be done by reviewing catheters used on ITU and Level 8.

Medical Director's Office

Cambridge University Hospitals NHS Foundation Trust

Cambridge Biomedical Campus

Hills Road

Cambridge

CB2 0QQ

Telephone: 01223 217996

Published: September 2021

Web: www.cuh.org.uk

Appendix 1

Infection Control Audit plan 2022/23

Key Policy compliance	Audits performed	Frequency	Owner	Evidence / Circulation of data
MRSA Policy	Compliance with screening	Monthly	IPC Data Analyst	Monthly IC Report and circulated to divisional leads
	Compliance with Decolonisation	Monthly	IPCN team	Monthly IC report. Quality dashboard to CCG
***C. difficile* Policy**	Compliance with care bundle	Monthly	IPCN team	IC Monthly report. Quality dashboard to CCG
	Compliance with antibiotic protocols	Bi Monthly		RCA scrutiny minutes
Cleaning & Disinfection Policy	Medirest monitoring	Monthly	Hotel Services	Report to Ward Cleanliness meetings
	Equipment cleaning	Monthly	IPCN team	KPI for Medical equipment dept.
	Commode Audit	Annual	Vernacare	Report generated by Vernacare. Circulated Trust wide and taken to IPCC
	MDT ward visits	3-4 wards daily	IPCN team / Medirest /Matrons	Reports / Action plans given to Matrons & Ward Managers
Hand Hygiene	Hand hygiene audits	Bi-monthly	Ward Managers	Nursing Quality Metrics monthly and agenda item at IPCC
	Hand hygiene audits	As required and selection monthly	IPCN Team	Reported at monthly meeting with DIPC and Internal circulation as required
Urinary Catheter care	Safety thermometer	Monthly	Ward Managers	Safety thermometer report
	Care of Urinary catheters	Monthly	IPCN Team	Monthly IC report. Quality dashboard to CCG
Isolation Policy	Barrier Nursing	Trust wide annual but also incorporated into MDT visits	IPCN team	Annual report circulated Trust wide. MDT reports to wards/ Matrons
	Use of PPE	Currently 3-4 wards daily	IPCN team	Reports / Action plans given to Matrons & Ward Managers
Sharps Management	Trust wide audit undertaken By Daniels	Annual	Daniels /IPCN team	Circulated Trust wide and taken to IPCC
Ward & departmental Audits	**Purpose**	**Frequency**	**Owner**	**Evidence / Circulation of data**

General Wards	Audit IC practices and ward cleanliness	Initially 3-4 wards daily. Plan for monthly on going.	IPCN team / Medirest /Matrons	Themes and on-going issues escalated to IC action group. Action plans for Matrons
Theatres	Audit Theatre Practices , Theatre Environment and cleanliness	6 monthly for Main , Rosie , Neuro and DSU theatres	IPCN team / Medirest /Matrons	Audit reports to Theatre managers.
		Yearly for POW	IPCT	Audit reports to Theatre managers.
Critical Care Units	Audit IC practices and environmental cleanliness	Currently every 3 weeks approximately	IPCN team / Medirest /Matrons	Audit reports and action plans to Matrons
Emergency Dept	Audit IC practices and environmental cleanliness	Monthly	IPCN team / Medirest /Matrons	Audit reports and action plans to Matrons
Dialysis Units	Audit IC practices, compliance with Dialysis regulations and environmental cleanliness	Once a Year unless problems identified	IPCN team	Audit reports and action plans to dialysis managers and Matrons
Outpatients	Audit IC practices and environmental cleanliness	6 monthly	MDT	Audit reports and action plans to clinic lead and Matron
Mortuary	Service evaluation of IC practices and environmental cleanliness	Yearly	IPCN team	Audit report and action plan to departmental lead
Endoscopy	Audit IC practices and environmental cleanliness	6 monthly	IPCN team / Medirest /Matrons	Audit report and action plan to departmental lead & Matron
Cambridge Eye Unit	Audit Theatre Practices , Theatre Environment and cleanliness	Yearly	IPCT	Audit reports to Theatre managers.
Kefford House	Audit IC practices and environmental cleanliness	Yearly	IPCN team	Audit report and action plan to departmental lead & Matron
Emmeline Centre	Audit IC practices and environmental cleanliness	Yearly	IPCN team	Audit report and action plan to departmental lead
Physio gym/hydro pool	Audit IC practices, environmental cleanliness and pool monitoring.	2 yearly due 2021	IPCN team	Audit report and action plan to departmental lead
ALAC	Audit IC practices and environmental cleanliness	Due 2021	IPCN team	Audit report and action plan to departmental lead
OT dept.	Audit IC practices and environmental cleanliness	Due June 2021	IPCN team	Audit report and action plan to departmental lead
K2	Audit IC practices and environmental cleanliness	Yearly	IPCN team	Audit report and action plan to ward manager and Matron
Neuro Angiography	Audit IC practices and environmental cleanliness	Yearly	IPCN team	Audit report and action plan to departmental lead
Vascular Access	Audit IC practices and environmental cleanliness	Yearly	IPCN team	Audit report and action plan to departmental lead

Angiography - Level 4	Audit IC practices and environmental cleanliness	Yearly	IPCN team	Audit report and action plan to departmental lead
Ultra sound - Level 3	Audit IC practices and environmental cleanliness	Due September 2022	IPCN team	Audit report and action plan to departmental lead

Appendix 2 Methodologies used for Assurance

	Method	Practice	Frequency	Outcomes	Reported to
Internal	Audit	Hand hygiene	Fortnightly	Any serious lapses reported to Senior staff	All Senior staff via CHEQS and discussed at divisional monthly meetings meeting
	Audit	Cleaning Scores	Weekly for high risk areas. Fortnightly for medium risk areas Monthly for low risk areas	Reasons behind areas falling below standards investigated by Root Cause Analysis and problems rectified	Senior Nursing staff via email. Also, discussed at monthly cleaning meetings
	Report generated from Epic to monitor compliance with VIP score documentation	Intravascular catheter sites	Monthly		Senior Nurses via CHEQS
	Root Cause Analysis – scrutiny meetings with IPCT, clinical team and the CCG	CDI or MRSA bacteraemia	Monthly (where they occur)		Learning shared across the organisation
	Audit of practice documented on Epic.	Care bundles for urinary catheter care, MRSA decolonisation, C. difficile management and ventilator associated pneumonia	Monthly	Any lapses identified fed back to wards involved.	ICB via the quality dashboard. Reported in Infection Control Performance Report. Specific issues discussed at monthly divisional meetings
	Audit/ Service Evaluation	Evaluation of any processes undertaken, observations of practice and condition of furniture and fittings	Yearly for clinics and departments such as theatres, quarterly for critical care areas.	Audit or service evaluation reports and action plan generated.	Report to Senior staff in area visited. Specific issues discussed at monthly divisional meetings

	Method	Practice	Frequency	Outcomes	Reported to
Internal	Audit	Practical aspects of Infection Control such as isolation nursing management and equipment cleaning	Varies from monthly to six monthly	Any lapses identified fed back to Wards involved. Audit frequency increased if indicated	Ward Managers , Divisional monthly meetings and Infection Prevention and Control Committee
	Mini PLACE visits	Service evaluation including food quality	Monthly	Report generated by team.	Areas visited and presented at monthly cleaning meeting.
Benchmarking	Audit data	Numbers of HCAI	Monthly	Report produced and outcomes of RCA Meetings detailed.	Infection Control Performance Report and Board of Directors report.
External	Mandatory reporting of HCAI - triangulation with national surveillance data	National surveillance data held by UKHSA compared with Trust reports	Quarterly	Reconciliation of mandatory reporting data to ensure accuracy	UKHSA and DH
	Monthly review of CDI and MRSA, , E. coli and MSSA bacteraemias by PHE	UKHSA surveillance data for each Trust in East of England reviewed	Monthly	Trends monitored and any high numbers reviewed with Trust ICT to ensure actions taken	UKHSA and Trust ICT
	Feedback of any CPE confirmed by national reference lab	Weekly feedback of reference lab data relating to the Trust to ensure action taken	Weekly	Trust ICT were aware of all confirmed CPE.	Trust ICT