Council of Governors

Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

There will be a meeting of the Council of Governors on Wednesday 27 March 2024 at 17.00 in the Committee Room, School of Clinical Medicine, Addenbrooke's Hospital, Hills Road, Cambridge CB2 0QQ (and via videoconference)

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

AGENDA

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

17.25	**7.***	**Chief Executive's Report (including Integrated Performance Report)** To receive the report of the Chief Executive	For receipt
18.10	**8.***	**Governors' Reports** **8.1 Lead Governor** To receive the report of the Lead Governor **8.2 Governors' Strategy Group** To receive the report of the Group	For receipt
18.15	**9.***	**Governors' Nomination and Remuneration Committee** To approve the updated terms of reference	For approval
Items for information			**Purpose**
18.20	**10.**	**Any other business** Items of any other business to be identified to the Secretary in advance of the meeting	For note
	11.	**Date of the next meeting** The next meeting of the Council of Governors will be on Wednesday 26 June 2024 at 17.00.	
18.25	**12.**	**Close of meeting**	

NHS
Cambridge
University Hospitals
NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust

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

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

In attendance	
Mr D Abrams	Non-Executive Director
Mr J Clarke	Trust Secretary (Minutes)
Dr A Doherty	Non-Executive Director
Prof I Jacobs	Non-Executive Director
Prof P Maxwell	Non Executive Director
Dr J Morrow	Non Executive Director
Dr S Peacock	Non-Executive Director
Mr R Sinker	Chief Executive
Mr R Sivanandan	Non-Executive Director
Ms L Szeremeta	Chief Nurse
Mr I Walker	Director of Corporate Affairs
Mr D Wherrett	Director of Workforce

34/23 Apologies for absence

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

The Chair welcomed Josiane Chuisseu, Patient Governor, Elisa Ferraro, Staff Governor, and Cllr Susan van de Ven, Partnership Governor, to their first meetings of the Council of Governors.

The Chair also welcomed James Morrow, Non-Executive Director, to his first meeting of the Council of Governors since his appointment as a Non-Executive Director.

On behalf of the Council of Governors, the Chair thanked David Noble, Public Governor, and Cllr Mairead Heally, Partnership Governor, for their time on the Council of Governors.

35/23 Declarations of interest

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

36/23 Minutes of the previous meeting

The minutes of the meeting of the Council of Governors held on 20 September 2023 were approved as a true and accurate record.

37/23 Council of Governors action tracker and matters arising not covered by other items on the agenda

Received and noted: The action tracker.

38/23 Composition of the Council of Governors

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

Noted:

1. Since the previous meeting, Elisa Ferraro, Staff Governor, Cllr Rachel Wade, Partnership Governor, and Josiane Chuisseu, Patient Governor, had joined the Council of Governors.
2. Neil Stutchbury, Patient Governor, had been re-appointed to the role of Lead Governor for a second two-year term from 1 October 2023.
3. Jane Biddle, Public Governor, had been re-appointed to the role of Deputy Lead Governor for a second two-year term from 1 December 2023.

Agreed:

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

39/23 Chair's report

Mike More, Trust Chair, presented the report.

Noted:

1. In November 2023 the Trust had become aware of two significant data breaches, both of which occurred as a result of human error in responding to Freedom of Information requests. The first data breach related to around 22,000 patients booked for maternity care at The Rosie Hospital between 2016 and 2019, while the second data breach related to 373 cancer patients on clinical trials.
2. The Trust had made a conscious decision to communicate with the patients affected by the two data breaches differently. A decision was taken to not communicate directly with those affected by the maternity breach given the potential safeguarding risks relating to this cohort of patients. However, a public statement had been issued and a patient helpline had been established.
3. As a result of the incident, the Trust would be undertaking a series of policy and process reviews. The Trust was also no

longer sending out spreadsheets in response to Freedom of Information requests.

4. The Trust had received around 40 enquiries from patients and members of the public via the dedicated helpline established as part of the response, including one formal complaint. The statement on the website had received around 2,000 views.

The following points were made in discussion:

1. Governors suggested that the diligent and transparent response from the Trust was likely to be a contributory factor to the relatively low level of enquiries received.
2. Local primary care colleagues had thanked the Trust for engaging with them prior to the release of the statement. This had allowed them to most effectively support patients who subsequently contacted their practices. The attention to detail, sincerity and empathy with which the Trust had communicated to patients and the local media was welcomed.
3. The Board had been engaged throughout the process and had carefully considered the options for communicating with the two affected patient cohorts.
4. The Trust had sought to engage with a range of stakeholders at the appropriate points, balancing the need to engage with the need for patients to receive information directly from the Trust.
5. From the outset, the Trust had been committed to being open and transparent about what had happened.
6. It was vital to review systems and processes to minimise the likelihood of this happening again.
7. The Audit Committee would oversee work to review the Trust's wider data sharing practices.
8. Through the Trust's initial investigations, there was no evidence to suggest that the information had been accessed by anyone outside the Trust.
9. On 6 November 2023, the Trust had held a Board-to-Board meeting with Royal Papworth Hospital NHS Foundation Trust to discuss ways in which the two organisations could collaborate more effectively as Campus partners.
10. An Independent Chair had recently been appointed to the Cambridge Cancer Research Hospital Construction Board.
11. The Board had received initial feedback from the Well-led external governance review undertaken by Deloitte LLP, with the report expected to be issued in January 2024. This had included positive feedback on the Council of Governors.

Received and noted: the Chair's report.

40/23 Chief Executive's Report (including Integrated Performance Report)

Roland Sinker, Chief Executive, presented the report.

Noted:

1. The Trust continued to focus on reducing long waits within both the urgent and emergency care and elective pathways.
2. There had been improvements in both absolute and relative performance against cancer diagnostic targets and on ambulance handovers. Work continued on improving performance against the 4-hour emergency care standard.
3. Junior doctors were taking industrial action between 20 and 23 December 2023, with further action planned between 3 and 9 January 2024. The industrial action planned for early January 2024 was particularly concerning given the anticipated pressure on services in the first days of the new year. The Trust would need to postpone around 2,000 planned patient contacts per day in order to maintain safety during the periods of industrial action.
4. The Trust was in the process of preparing for the transition to the Patient Safety Incident Response Framework. There had been a significant reduction in the backlog of outstanding complaints.
5. The Trust remained in a strong position financially relative to many peers and was on track to deliver its capital programme for 2023/24.
6. The Director of Innovation, Digital and Improvement continued work to align the three portfolios and develop innovation capacity.
7. Further work would be undertaken on the development of a Trust-wide equality, diversity and inclusion strategy.
8. The Cambridge Movement Surgical Hub had recently opened providing an additional three elective theatres.
9. Plans were in place to undertake a self-assessment across core services against the Care Quality Commission (CQC) inspection framework, supported by an external peer review.

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

1. *NHS England has recently published guidelines for collecting data to help analyse where health inequalities exist and hence develop strategies to minimise them. These include indicators such as ethnicity, gender, sex and deprivation. The guidelines require both trusts and ICBs to publish these data against a range of domains such as ED, Elective waiting list, mental health etc. This topic was recently discussed at the Audit Committee, in the context of CUH's strategy on health inequalities: "We will tackle disparity in health outcomes, access to care and*

experience between patient groups ". KPMG had assessed it as "partial assurance with improvements required". Please could NEDs comment on how serious they feel inequalities in accessing healthcare for residents of Cambridgeshire are today, and how prepared we are in publishing data for next year's annual report. What strategies is management implementing for reducing health inequalities?'

The following points were made in response:

Life expectancy at birth in Cambridge is 84.2 years and 80.8 years for females and males respectively. In Peterborough, it is 82.0 and 77.8 years.

Across the ICS there are variations in access to primary care with variable numbers of GPs and community nurses, with more GPs in less deprived areas and fewer in more deprived areas. It is likely that this results in poorer access and delayed presentations.

Access to care at CUH has been reviewed and time on waiting lists is similar across all quintiles. Some UK centres have begun to adjust waiting lists to account for this, but we have not undertaken this in Cambridgeshire and Peterborough.

We have a dashboard that allows us to report on the distribution of various protected characteristics and deprivation indexes across many care settings. While we have this data on a number of areas we currently do not have 'waiting list' as a cohort in this dashboard, but this is something that the team are looking to develop. This information is also included within reports through relevant committees.

2. *CUH has prepared a detailed Winter Plan, as recently shared in the media. What contingencies have now been put in place during the periods of recently announced Junior Doctor industrial action in December and early January? Are the NEDs assured that this will best address issues arising from industrial action? What does the plan assume about the projected incidence, hospital attendance and inpatient admittance for Covid and flu this winter?*

The following points were made in response:

The BMA have announced two periods of industrial action either side of the holiday period. This may impact on our ability to get patients home before Christmas with fewer empty beds going in

to this challenging period. We have significantly reduced elective services (surgery and outpatients) to enable consultant staff to focus on non-elective care. This will amount to over 2,000 cases per day being postponed, a total of c.20,000 episodes of care. There are established plans for dealing with respiratory viruses, but the scale will depend on a wide variety of factors. The numbers are monitored daily.

3. *While ambulance handover times have significantly improved, waits in ED have increased in recent weeks. It has been suggested that about 30% of patients waiting in ED have been told to go to ED by the on-call specialists looking after them. The medical and nursing team in ED have to work up the patient and then contact the on-call specialist. This can result in long waits in ED for the patient and on the face of it appears to be inefficient. Is the Board aware of this and looking at alternative solutions including timely attendance by the specialist accepting the referral?*

   The following points were made in response:

   Specialist teams are aware of the need to see patients in the ED and also have a number of other calls on their time. However, we are working with specialties to minimise delays in care and identify suitable spaces in which they can assess their patients, both within the ED and in other assessment units.

4. *CUH made further efforts this year to make it easy for staff to receive Covid and flu vaccinations (i.e. no appointment needed; available in the main concourse; some vaccinations available close to departments, wards etc). What has the take-up been so far? Are the NEDs assured that the programme will maximise safety of staff and patients, and minimise staff sickness relating to Covid and flu.*

   The following points were made in response:

   These figures represent the vaccine uptake as at 18.00 on 12 December. We have given a total of 8,080 flu vaccines to staff (7,757 are eligible staff who are active on ESR) and 6,931 Covid vaccines to CUH staff (6,656 are eligible staff who are active on ESR). For comparison, the final count at the end of the campaign last year shows we had given 8,508 flu vaccines and 7,641 Covid vaccines.

5. *In Phase 1 of the Addenbrooke's 3 committee two years ago, plans for expanding capacity by converting Clinic 9 for use by ED were proposed and were supposed to be in place by late 2022. Please could you give us an update on this initiative.*

   The following points were made in response:

   This development is the Phase 5 of the near term plans for urgent and emergency care, after phase 1 and 2 have been successfully been implemented and with phase 5 re-prioritised over phases 3 and 4.

   The business case for phase 5 was approved and so the process commenced to complete the appointment of a provider for the orthotics service and, since then, the clinical teams have been working with the provider to secure and fit out the provider's new premises. There have been delays ranging from extended internal processes to the challenges faced by the new provider to secure premises.

   The capital team has been out to tender twice but, given the operational aspects of the service transition, will need to refresh this when the revised timeline is ready to go out to tender again early next year, with a view to a nine- month project to deliver the requisite accommodation.

   The Performance Committee remains updated on the service-related aspects that have impacted this project ahead of the capital delivery of the alterations of Clinic 9.

Agreed:
1. To note the report.

41/23 Governors' reports

Lead Governor's report

Neil Stutchbury, Lead Governor, presented the report.

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

Governor's Strategy Group

Julia Loudon, Governor, presented the report.

Agreed:

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

Membership Engagement Strategy Implementation Group

Julia Loudon, Patient Governor, presented the report.

Agreed:

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

42/23 Any other business

There was no other business.

43/23 Date of next meeting

The next meeting of the Council of Governors in public would be held on Wednesday 27 March 2024 at 17.00.

Meeting closed: 19.09

Cambridge University Hospitals NHS Foundation Trust

Council of Governors: Action Tracker

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

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Council of Governors: 27 March 2024

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

Executive Summary

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

1. In February 2024, Samira Addo stood down as a Public Governor with immediate effect. The vacancy created will be filled in the forthcoming elections.

Related Trust objectives	All Trust objectives
Risk and Assurance	n/a
Related Assurance Framework Entries	n/a
Legal and regulatory implications?	The composition of the Council is defined by the Trust Constitution.

Action required by the Council of Governors

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

Composition of the Council of Governors as at 22 March 2024

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

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

Terms of service

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

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

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

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

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

2. Vacancy procedure (elected governors)

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

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

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

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

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

3. Vacancy procedure (partnership governors)

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

Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Council of Governors: 27 March 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
Legal / regulatory implications	n/a

Action required by the Council of Governors

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

Cambridge University Hospitals NHS Foundation Trust

27 March 2024

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

1. Introduction

1.1 The NHS is established on the principle of "free at the point of use". One of the many challenges in the public provision of welfare services is that take-up can often be disproportionately skewed towards the more educated, the better off and the most articulate. It was therefore deeply worrying, but not surprising, to read a recently published national HealthWatch report which finds:

i) 42% of those who described their financial situation as "really struggling" said they had trouble getting to see a GP, double the 21% of those who were "very comfortable";

ii) 38% of the worst-off found it hard to get NHS dental care, compared with 20% of the better-off;

iii) 28% of the very poor had difficulty accessing mental health treatment, whereas only 9% of the very comfortable did so;

iv) 26% of poorer people found it difficult to access A&E care, compared with 19% of the well-off.

1.2 In overall terms, 19% of those on very low incomes described difficulties in accessing NHS services against 8% of better-off people.

1.3 This is then compounded by a reported worse experience of medical care, even when accessed. Some 21% of "really struggling" people felt they were not listened to by the last health professional they saw, compared to 7% of better-off people. And at 18%, poorer people felt excluded from decision-making, double that of better-off people.

1.4 These are very worrying statistics and I will be talking to Cambridgeshire and Peterborough HealthWatch about how we might think about this issue.

1.5 I was pleased to welcome Amanda Pritchard, Chief Executive of NHS England, on her visit to CUH as part of a joint visit with Royal Papworth Hospital (RPH) NHS Foundation Trust. She met with clinicians and patients to see and hear about examples of the application of clinical research and innovation. She was also interested in how our relationship with Royal Papworth is proceeding. I have regular monthly meetings with Jag Ahluwalia, newly appointed Chair of RPH, in which we oversee the Joint Strategic Group chaired by Roland and Eilish (RPH Chief Executive), and in which we are keen to improve patient pathways and collaboration across the two hospitals. Amanda's visit followed shortly after two ministerial visits and will be followed by the visit of the Chief Executive of NHS Providers the day before our March meeting.

1.6 The Rt Hon Victoria Atkins MP, Secretary of State for Health and Social Care, visited the Cambridge Biomedical Campus on 7 March 2024. Alongside meeting a wide range of staff she undertook tours of the Cambridge Clinical Research Centre, AstraZeneca and The Rosie Hospital.

1.7 The Board visited the Cambridge Surgical Training Centre at its new home on Barnwell Road in February 2024. It was great to see the progress and enthusiasm and it is the team's objective, ably led by Arun Gupta, to make this facility of the highest class. I have also enjoyed visiting the new facilities on campus (U block and Surgical Movement Centre) which are already making a big impact to Trust performance.

1.8 It was also good for the Board and the Addenbrooke's Charitable Trust Board of Trustees to meet for our annual meeting in February 2024. We are always much indebted to ACT for their continued support and encouragement.

1.9 During January and February 2024 I conducted and reported on NED appraisals to the Council of Governors' Remuneration and Nomination Committee. This is an important aspect of the Governors' role in their assessment of how well the Board is fulfilling its function. At Appendix 1 is my assessment of how we are doing against the objectives I set last year. I will be setting fresh objectives early in the new financial year.

2. New hospitals appointments

2.1 I am delighted to welcome Paul Lewis who joined us on 1 March 2024 as our new Board Adviser. With skills and experience in the construction industry, Paul will advise the CUH Board on new hospitals construction.

3. ‘You Made A Difference’ Awards

3.1 I was pleased to attend ‘You Made A Difference’ award events on 22 January 2024 and 19 February 2024. 962 individual nominations and 72 Team nominations were received and I would like to personally congratulate the winners, David Biddle (Senior Radiographer), Raju Chinighalla (18 Week Pathway Tracker), Christie Gaughan (Staff Nurse), Victoria Reeves (Midwife), and the Inpatient Pharmacy Team.

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. Public meeting with Chair and Chief Executive

4.1 Alongside Roland Sinker, Chief Executive, I met with members of the public on 19 February 2024. The main topics covered included virtual outpatient attendance, ambulance handover waits, missing and AWOL patients, Physician Associates, Southern Place and the ICB and the appointment of the new Chair and Non-Executive Director.

5. Diary

5.1 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
Board to Board meeting with ACT
Audit Committee
Performance Committee
Quality Committee
Governors’ Nomination and Remuneration Committee
Finance Team Away Day
Addenbrooke’s Futures Committee
Governor/NED Quarterly meeting
ICS stocktake
Tour of 1000 Discovery Drive
Tour of U Block
Tour of Cambridge Surgical Training Centre
Celebration of the Outline Business Case approval for Cambridge Children’s Hospital and Cambridge Cancer Research Hospital
REACH/Unison overseas international staff welcome meals

5.2 Other meetings attended during this period include:

Leading and Governing Inclusively with Cultural Intelligence Executive Leadership Masterclass
NHS Confederation Chairs Group
NHS England CEO and Chairs Session
Obesity Summit
Cambridgeshire and Peterborough (C&P) CEO and Chair's Meeting
NHS ICB and Trust chairs' event
C&P ICS Chairs Meeting

6. Recommendation

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

Appendix 1

I reported to the Council of Governors in June last year on proposed objectives for 2023/24 (*attached as annex for cross reference to this report*). I will produce a similar report for 2024/25 in the spring. This report updates the Board and the Council of Governors on progress/status on the 2023/24 objectives, and should be cross-referred to the numbered objectives in the original report.

Objective 1*: *The Teams who Work Together

Healthcare will always be at core a people business, notwithstanding the inexorable progress of AI. None of us have any illusions about current morale problems of the NHS workforce across the country - a common topic of conversation amongst my peers. And we are all slightly astonished that, more than one year on, we are still dealing with industrial action on an unprecedented and disruptive scale. The Board, mainly through Workforce Committee, has continued to pay attention to the five strands of our workforce strategy and to see some progress in the staff survey. We need to learn from our Shelford Group peers and others on how we can purposively and positively optimise staff morale. We could easily and rightly point to national trends but our test is to strengthen morale so far as it is within our grasp.

On recruitment and retention our staff turnover rate has been consistently reducing since July 2022 and at 11.3% is more in line with pre-pandemic rates. The national staff survey results for 2023 became available publically on the 7 March 2024.

Objective 2*: *The Teams and Patients who are Diverse

A mixed picture on this vitally important domain. On the positive side, there is a more robust, sophisticated and persistent understanding of its importance at Board level than hitherto. But a lot of work to do. For various reasons the delivery of a diagnostic has been delayed and we are currently progressing the process of completing the diagnostic in coming months. One thing, though, should be made clear: in year, there have been calls for Trusts to desist from any investment of time, leadership or resource in EDI. For me this is not right and not an option. We are an international family of staff and if our teams do not understand different cultures then this risks patient care. And our patients are very diverse and by definition we should be sensitive to each individuals' needs.

Objective 3*: *Our Operational Performance, Patient Safety and Finance

We are scheduled to break even financially. We are making progress on maternity services and are scheduled to increase medical O&G staffing by August which is a current quality risk. In year we have added 3 new operating theatres for elective orthopaedic work and 8 associated recovery beds and 56 new beds in U block. This is on top of the additional bed capacity in T Block. Our Neuro theatres will return to commissioning in April. In Addition our virtual ward programme is freeing up significant capacity.

Below is an update on our key operational performance metrics:

- Our latest performance to January shows a varied picture against key elective and emergency standards.
- For cancer standards CUH delivered 71% against the 62-day combined referral to treatment metric compared to the Shelford group average of 61%.
- We exceeded the national target of 75% for the 28-day faster diagnostic standard, delivering 82% compared to the Shelford group average of 71%.
- Our elective RTT waits >65 weeks improved to 815 in January from 870 in December, broadly in line with Shelford Group peers, and we plan to reduce these waits to zero by the start of July, ahead of the national requirement of September.
- For 4hr performance we were in the bottom quartile out of 124 trusts nationally. This is in the context of significant extra patient demand – an extra 62 patients attended the ED each day in January compared to same month last year (a rise of 18%) – and targeted work is on-going to reduce the length of stay in the department during March and beyond.

Objective 4: Innovating, Transforming and Improving

Good progress has been made on developing the innovation approach, linked with the with the wider Innovate Cambridge approach and innovation hubs within the Biomedical Campus. Good progress is also being made in making our transformation and improvement approach more strategic and to align digital and transformation activity. We have benefitted from closer collaboration with RPH which means additional bed capacity was available to us. We had a Board to Board with RPH which endorsed the setting up of a Strategic Executive Group, led by the two Chief Executives, to oversee and drive prospects of enhanced patient pathway collaboration and also encouraged a shared approach to electronic patient records. We need to continue to support this but I am confident that the intent is positive.

We have been central to the East of England Specialised Provider Collaborative which has a threefold objectives: first, to raise the profile and understanding of specialised services across the region, especially important at a time of moving towards ICB commissioning of such services and where historically there has been an under-appreciation of the critical importance of CUH to patients across the region ; second, to improve the way providers collaborate across the region; and third, to stimulate innovation. All of these have made progress and I was heartened to hear more buy-in at a recent regional meeting of Chairs, CEOs and NHSE to the concept of a shift of specialised services resourcing towards the East of England. This was not the case a few years ago.

Objective 5: Integrating at Place

Good work has been done but it is piecemeal and we need to work more purposively both within the hospital and with the ICB to populate neighbourhood infrastructure with greater pathway redesign. We are collectively not yet leveraging the opportunity of neighbourhoods to prevent unnecessary attendance/use of hospital provision.

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

Great progress on both major hospitals. Both have had OBC approval, Cancer is at FBC stage and the hope is that Children will get to this stage in the spring in the light of assurance on major financial supporting transactions. Philanthropic funding is ahead of target. These are great achievements in the context of a lot of delay on the national new hospitals programme. We have also appointed an independent chair to oversee the construction of the Cancer Hospital and a Board Advisor to advise the Board as we move to construction phase in the case of the two hospitals.

Objective 7: Our role in the Cambridge Bio-Medical Campus

We continue to put emphasis on the Local Plan submission for growth of the Campus. The timetable for this has been stalled by the Local Planners for the very good reason of the Government announcements on prospects for growth in Cambridge in summer 2023. We put attention in trying to influence government approaches to this and ensure that healthcare infrastructure needs are understood by all parties. (Surprisingly and irrationally there is no standard vehicle by which population growth is correlated by health infrastructure capacity growth. This is material when the growth rates such as experienced and foreseeable for Cambridge are in play. It is therefore very pleasing to see specific mention and funding for developing an approach to health infrastructure for a bigger Cambridge being announced in the Chancellor's Budget. The transport issues, as ever, have been difficult politically over the last year and we were disappointed that for funding reasons the CSET scheme was withdrawn and are anxious that the withdrawal of the Congestion Zone proposals potentially jeopardise funding of enhanced public transport. The continued national interest in Cambridge Life Sciences by Government and other parties indicate a common understanding of the critical national importance of what we do here in the campus, and so, again, it was good to see the Chancellor announce funding to enable the CEST scheme to progress.

Objective 8: How we govern ourselves

We have received the final Governance report which effectively talked of strong arrangements with opportunities for further development. We are introducing some changes already and will be giving overall consideration of a whole action plan in April.

Objective 9: And how our governance relates to others

I continue to try to influence the ICB Chair and others on such matters as Place, the funding support, especially to new developments, and how we operate as a whole system.

Appendix 2

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Council of Governors: 28 June 2023

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

Executive Summary

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

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

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

Action required by the Council of Governors

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

Cambridge University Hospitals NHS Foundation Trust

28 June 2023

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

1. Introduction

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

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

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

2. Objectives for 2023/24

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

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

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

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

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

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

3. Recommendation

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

Appendix 1: Priorities and objectives for 2023/24

1. The Teams who Work Together

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

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

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

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

2. The Teams and Patients who are Diverse

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

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

3. Our Operational Performance, Patient Safety and Finance

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

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

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

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

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

4. Innovating, Transforming and Improving

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

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

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

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

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

5. Integrating at Place

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

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

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

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

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

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

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

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

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

7. Our role in the Cambridge Bio-Medical Campus

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

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

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

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

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

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

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

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

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

8. How we govern ourselves

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

We will look for an effective Governance Review.

9. And how our governance relates to others

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

We will look for the Chair influencing the ICB approach.

Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Council of Governors: 27 March 2024

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

Executive Summary

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

Related Trust objectives	All Trust objectives
Risk and Assurance	A number of items within the report relate to risk and assurance.
Related Assurance Framework Entries	A number of items covered within the report relate to Board Assurance Framework entries.
Legal/regulatory impact	n/a

Action required by the Council of Governors

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

Cambridge University Hospitals NHS Foundation Trust

27 March 2024

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

1. Introduction/background

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

1.2 There are a range of well understood challenges facing health and care, including industrial action, recruitment, access to care and waiting times, quality, and access to capital - in particular there is currently significant national focus on urgent and emergency care performance, 78 week waits and financial planning. 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. The national Budget set out in early March 2024 confirmed an anticipated level on ongoing funding for the NHS, and identified an additional ~ £4bn for technology investment.

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:

1. **Quality** - a focus on long waits, the emergency pathway, staffing levels in relation to capacity and maternity (considering the CQC review); and noting ongoing progress on complaints and outcomes.
2. **Workforce** - a focus on inclusion and development; understanding a low uptake for the staff survey, in line with much of the NHS (and the mixed picture of the emerging results); and noting a strong position on recruitment, support for staff and recognition.
3. **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.
4. **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 - the position is changing and will be much more challenging as we go through 2024/25 and beyond.
5. **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 has been open since November 2023 and is treating ~ 60-70 patients/week and U block is now open, caring for gastro and haematology patients across 56 beds. Work has started on the ground for both the Cambridge Children's Hospital and the Cambridge Cancer Research Hospital - in both cases work is ongoing on the Full Business Cases. In addition, following the Budget announcement of £3M, work will accelerate on plans for additional health and care services centred on the biomedical campus, as part of our integrated care system. Work to better align CUH, Royal Papworth Hospital and the University of Cambridge is going well, 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 - some of this is set out in the March 2024 The Case for Cambridge HMG publication.

1.7 In line with good practice the Trust is completing a full self-assessment against the current CQC framework, 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 1.3, 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 six 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 Maternity Improvement Oversight Board (MIOB) continues to meet, providing oversight of the CQC action plan to address the 'must do' and 'should do' actions. As part of the ongoing work on the medical model, medical posts are now out to advert. Improvements in training compliance has also been noted.

CQC regulation changes and Self-Assessment

2.5 The CQC are changing their approach to their inspection regime including how and when they will assess services. They are moving to a single assessment framework which will cover health and social care.

2.6 The Chief Nurse and Head of Compliance are currently undertaking a self-assessment of core services across the organisation.

Accreditation

2.7 The Nursing Quality Assurance Framework at CUH brings several quality measurement tools together under the title of ward accreditation. The ward accreditation process strengthens the ward to board assurance process on the quality of care being provided to patients across CUH.

2.8 Accreditation was introduced at CUH in 2022/2023, during which time 17 wards across the Trust have been accredited.

2.9 A review of the accreditation tool has been undertaken through engagement/ feedback from key stakeholders and benchmarking against other organisations. This has led to an updated tool and associated process being developed.

2.10 Following this evaluation, the tool will be updated and the accreditation programme will be rolled out across the organisation from April 2024. There will be associated engagement events held to communicate the purpose of accreditation to the wider workforce.

Staffing numbers

2.11 The nursing and midwifery vacancy position is improving and there is a strong recruitment pipeline which is resulting in a predicted year end vacancy rate of below 5%. Despite this, there continues to be stretched nurse to patient ratios beyond those set for safe staffing levels. Any incidents related to staffing shortages are triangulated with harm data to understand the impact of the stretched ratios on patient safety and quality.

Hospital Standardised Mortality Ratio (HSMR)

2.12 The Hospital Standardised Mortality Ratio for the data period December 2022 to November 2023 was 75.3. This is banded as statistically lower than expected and is the 6th lowest HSMR in the country.

Industrial action

2.13 The junior doctor members of the British Medical Association (BMA) and Hospital Consultants and Specialists Association (HCSA) undertook further industrial action from 07:00 Saturday 24 February 2024 to 23:59 Wednesday 28 February 2024 and from 07:00 Saturday 24 February 2024 to 07:00 Thursday 29 February 2024 respectively.

2.14 The Trusts focus during this period was on maintaining safe patient care for our urgent and emergency services and inpatient services and support for our staff who wished to take legitimate industrial action.

2.15 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.

3. Access to Care

3.1 **Emergency Department (ED).** Performance against the 4hr standard and the reduction of long waits within ED remained priority areas of focus in January 2024. Whilst ED attendances remained high, growing by 18.2% year-on-year (the equivalent to an additional 62 patients per day) the Trust maintained a similar level of 4hr performance month-on-month from 62.7% in December 2023 to 62.5% in January 2024. In February 2024 provisional performance was 63.2%.

3.2 **Length of stay.** In January 2024 the average length of stay was 8.0 days, a 10.5% improvement compared to the average of 8.9 days in January 2023. Through annual activity planning, the Trust has set a length of stay improvement target of 114 beds based on benchmarking and the forecast bed availability for next year. This will need a whole-Trust response to deliver and the Director of Innovation, Digital and Improvement is leading the development of plans to meet this challenge.

3.3 **Referral to Treatment (RTT).** In January 2024 the total RTT waiting list size was 61,531, flat compared to December 2023. This puts waiting lists 0.6% (+363) above planned levels. Performance continues to be impacted by industrial action. The volume of patients waiting over 65 weeks reduced by 55 from 870 in December 2023 to 815 in January 2024. The Trust's plan is to reduce to zero by the start of July 2024, ahead of the national ambition to achieve this by the end of September 2024.

3.4 **Delayed discharges**. In January 2024 the Trust lost 120 beds to complex patients remaining in an inpatient bed beyond their clinically fit date. This compares to an average of 137 beds lost each month during 2022/23.

3.5 **Cancer.** The Trust achieved 71.3% against the cancer 62 days combined referral to treatment metric in December 2023 compared to the national target of 85.0%. This was significantly higher than the Shelford Group average of 61.3%. There is an improvement plan in place for the 62 day pathway which is reviewed monthly, setting out specific recovery actions.

3.6 **Operations.** Capped utilisation across December 2023 was 77.4%. Excluding the industrial action period increased performance to 77.8%. Performance has slipped to Quartile 2, but remains above the Shelford Group median.

3.7 **Diagnostics.** January 2024 saw a further deterioration in six week performance to 40.2%. The total waiting list increased by 323 and the > 6 week cohort increased by 287.

3.8 **Outpatients.** New activity remains adversely below the 115% target for end March 2024. The most recent data point for January 2024 sits just below this current median at 109.2%. The number of new outpatient appointments on the waiting list remains high at 62,972 in January 2024.

4. Finance – Month 10

4.1 The Month 10 position for performance management purposes is a £1.1m surplus. This is in line with planned year to date performance. The Trust position recognises additional funding to offset the adverse impact of industrial action to Month 7 (October).

4.2 Due to the additional industrial action in December 2023 and January 2024 the forecast outturn position has been updated to a £3m deficit to reflect the additional costs to the Trust.

4.3 Further financial support from NHSE is however expected to be agreed at a level that will enable the Trust to fully mitigate the forecast year end deficit. This support should be confirmed in the coming weeks at which time the forecast outturn is expected to be returned to a breakeven position.

4.4 The following points should be noted in respect of the Trust's Month 10 financial performance:

- The position includes NHSE support for the impact of industrial action which totals £16.9m 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 industrial action on pay expenditure – agreed with C&P ICB at £5.9m.

- The position also includes £9.5m of non-recurrent funding. 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 industrial action in December 2023 and January 2024 creates a further pay pressure of £3.0m. The Trust expects this pressure to be fully mitigated over the remainder of the year through additional funding from NHSE. However, NHSE has not yet confirmed whether additional financial support will be made available.

4.5 The Trust received an initial system capital allocation for the year of £35.0m for its core capital requirements. In addition to this, the Trust expects to receive further funding for the Children's Hospital (£4.1m), Cancer Hospital (£6.4m), Community Diagnostics (£0.8m), and Secure Data Environments (1.8m). Together with capital contributions from ACT totaling £7.4m and technical adjustments in respect of PFI, the Trust's capital budget for the year now totals £58.1m. This represents a reduction on the total reported at Month 10 due to changes in the phasing of Cancer Hospital funding and spend as agreed with NHP.

4.6 At Month 10 the capital programme is ahead of plan with spend year to date of £33.6m against a budget of £31.8m. 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 £58.1m.

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 continues to impact the Trust.

Good Work and Wellbeing

5.3 The autumn flu and Covid-19 vaccination programmes for CUH closed on 31 January 2024. 56% of staff were vaccinated against flu and 48% were vaccinated against Covid-19. CUH was the second highest performing trust in the region for the percentage of front line staff receiving vaccinations.

5.4 With the rise in measles cases in our communities, Occupational Health have begun the roll out of an MMR catch up vaccination programme. Non immune front line health care workers are being invited to pre-booked and drop in vaccination clinics where they can receive their vaccinations, with those working in high risk areas being prioritised first.

Resourcing

5.5 In the last 12 months CUH has grown its workforce by 6.1% which has been deliberate and targeted growth. Recruitment pipelines remain strong which will support the Trust in sustaining a good position in terms of staffing and vacancy management.

5.6 CUH has been successful in its application to NHSE to participate in cohort two of the people promise exemplar programme, with a focus on retention. This 12 month funded programme will enable the Trust to have additional specific resource to deliver against our strategy. Whilst turnover is improving we continue to see significant rates for additional clinical services staff group, which includes healthcare support workers for example.

Ambition

5.7 CUH has committed to introducing the Nursing Associate role, through a 24 month apprenticeship model which leads to a foundation degree. Recent recruitment to the programme has been incredibly positive and we look forward to commencing the programme in the spring.

Inclusion

5.8 The Trust has launched a new Neurodiversity in the Workplace development programme, engaging all staff who wish to increase their knowledge of how to support others with additional learning needs (ALN). This course aims to identify some of the different types of additional learning needs and how to make adjustments to help improve the experience of CUH staff who are neuro-divergent. It is particularly relevant for line managers and educators but it is open to all.

Relationships

5.9 Plans are underway to launch the 2024 CUH staff awards, which will run from April to November 2024. Again, this will be an opportunity to acknowledge and celebrate the commitment, hard work and fabulous achievements of colleagues and partners.

5.10 A full diary of recognition events has been worked up for 2024/25.

6. Innovation, Digital and Improvement

Innovation

6.1 The Trust has been working at pace to develop its innovation programme. The focus has been on three main themes: programme level, initiative level and innovation culture.

6.2 At a programme level, governance and resourcing structures, along with a programme vision have been developed. The programme is projected to positively impact on productivity and support delivery against the Trust's priority of access to care. Different programme funding options are currently being explored.

6.3 The Trust has developed a decision-making process to select high-impact innovations against organisational priorities, as well as developing an overarching governance structure for innovation to ensure successful delivery of the programme and effective Board oversight. The Trust is currently reviewing a shortlist of initiatives to determine which ones to adopt as organisational priorities to deliver a high impact against the strategic access to care priority.

6.4 The Trust is keen to enable a culture and environment that is supportive of innovation, whereby colleagues can navigate and access internal and external support and funding. Diagnostic work has been undertaken to understand the Trust's current innovation culture. This is helping to inform the approach to communications and a plan is being developed for a forthcoming innovation programme launch.

6.5 At system level, close engagement through the Cambridgeshire and Peterborough Integrated Care System (ICS) and Cambridge University Health Partners (CUHP) continues to build a shared innovation landing zone and to develop a digital innovation portal to support this.

Digital and eHospital

6.6 Focus for the Trust's eHospital team remains on maintaining a safe and secure infrastructure, by keeping software platforms, hardware and infrastructure up-to-date. As part of this, the team continue to provide significant support to help the Trust move away from aging software and infrastructure. Over the next year, two key aspects will be pharmacy moving from Ascribe to Epic and radiology PACS moving to a cloud environment.

6.7 The digital team continue to support the Trust with a number of key programmes which support delivery against the access to care priority. These include work with the emergency department, virtual wards, outpatients and further development of the Trust's patient portal, MyChart.

6.8 Work continues on developing methods to test the resilience and disaster recovery readiness of the Trust's electronic patient record, Epic. Further work is being planned through 2024.

6.9 Resourcing the digital teams to match the Trust's ambitions and demands remains challenging. Whilst work continues to address these workforce challenges, the teams' limited resources will be prioritised to support delivery of the Trust's strategic objectives. To facilitate this alignment, two new operationally-led processes are being implemented, to prioritise Epic and technology developments, with the Technology Digital Prioritisation Group having already commenced.

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

Improvement and Transformation

6.11 The Trust is continuing to build quality improvement (QI) capability and capacity across the organisation and plans to launch a QI fundamentals programme in Spring 2024.

6.12 The improvement and transformation team continues 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, hospital acquired pressure ulcers, patient transport, as well as supporting colleagues to identify productivity and efficiency schemes for 2024/25.

6.13 From its inception in November 2022, until the end of December 2023, the virtual ward team has on-boarded 1,227 patients from 30 specialties, achieving a saving of 4,493 bed days to the end of December 2023, the equivalent of 10.5 beds and an estimated 552 bed days in January 2024, the equivalent of 17.8 beds. The length of stay saving per patient being 4.13 days (4.17 days in 2023/24). During January 2024, the average occupancy for the virtual ward was 62 patients; this has risen to an average of 74 patients for the first week of February 2024.

6.14 To support the Trust's priority focus of access to care, specifically on 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.

6.15 Work is ongoing with a wide range of colleagues to develop and agree a Trust-wide outpatients strategy, along with establishing a length of stay programme for the organisation, both of which will support the Trust's strategic focus on productivity.

6.16 The Trust's productivity and efficiency requirement for 2023/24 is £53m and is on track to deliver that in full. As at Month 10, the Trust has delivered a £42.2m efficiency, against a year-to-date target of £42.2m, resulting in an over-performance of £14k year-to-date.

PART B

7. Strategy update

Strategy implementation: Joint Forward Plan and Operational Planning

7.1 The ICS Joint Forward Plan (JFP) is being refreshed. JFPs are mandatory five-year plans that Integrated Care Boards and their partner NHS trusts are required to produce, setting out how they will meet the health needs of their local population.

7.2 The System is working on a light-touch refresh, as the current plan is only nine months old, to provide a high-level overview of progress so far and flag up any key areas that need addressing. Provider Boards are not being asked to individually sign-off plans this year; this will be undertaken through ICB governance for final submission to NHSE by 31 March 2024.

7.3 The Trust and other System partners are currently preparing operational plans, to be submitted as a System response through the ICB, to present detailed information on activity, workforce and finance plans for 2024/25. This is informed by internal business planning within CUH, also underway, with clinical and corporate teams developing their priorities for the year ahead, focused on the Trust's strategic lens of improving access to care.

7.4 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

7.5 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. The approach and objectives for progressing integrated care over the coming year have been agreed at the Addenbrooke's Futures Committee, alongside discussions with the ICB around which priorities from the JFP will be delivered by the CSCP and CUH

Supporting our staff

7.6 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

7.7 The new 56-bedded U block surge unit opened in January 2024. These new inpatient beds are providing additional capacity over winter, enabling an improvement in the co-location of some services that will improve patient flow across the hospital, and providing much needed decant capacity to support the Trust to carry out essential maintenance works.

7.8 Early enabling works for the Cambridge Cancer Research Hospital (CCRH) have started with the re-provision of a staff car park to release part of the construction site. Further works will take place across 2024 including installing hoardings, clearing the site and undertaking various surveys, whilst awaiting final planning permission approval from Cambridge City Council. The CCRH team continue to work closely with our staff, patients and wider stakeholders to ensure that co-creation of the hospital remains embedded. Fundraising also remains a key focus for the project. Addenbrooke's Charitable Trust (ACT) is delighted to now be partnering with Give Us A Lift (GUAL), a humanitarian charity supporting local communities, individuals and organisations, to support the fundraising campaign for the Hospital. The project remains on track to start full construction works in 2025.

7.9 The Cambridge Children's Hospital is subject to an NHSE/DHSC review of the project's capital funding in late April 2024. In the meantime, the project has started to develop its Full Business Case and pre-construction enabling works have begun on site. The fundraising campaign continues to remain on plan with further pledges expected in the coming months.

Specialised Services

7.10 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.

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

7.12 The Trust has secured approval for video technology to transform paediatric epilepsy pathways, enabling remote diagnosis and management of epilepsy seizures from almost all hospital sites across the EoE, with several now live with the system. In 2024/25, the project will extend to adult epilepsy services. Within MS, we have secured stakeholder support for the provision of stem cell therapy to be provided in the EoE, with CUH acting as a spoke to the pan-London haematopoietic stem cell transplantation service. This will extend our current work to encompass the full MS patient pathway.

7.13 The Trust is developing an East of England neurosciences regional strategy. A neurosciences steering group has been established and a number of clinically-led groups have been determined which will develop more detailed actionable proposals in Q2 2024/25.

7.14 In dentistry, clinically-led groups have submitted recommendations to the Secondary Care Dental Steering Group for addressing medium and long term sustainability and capacity issues. Progress is being made towards implementation of recommendations, including initial approval of a business case to address temporomandibular joint service pressures, identification of regional sedation leads and pilot sites scoped for alternative sedation therapies. Successful paediatric dentistry stakeholder workshops have been held and ICB priorities identified for paediatric dentistry.

7.15 There are plans 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 the Trust to engage with commercial partners and overcome barriers for testing, trailing and procuring new treatment options.

7.16 CUH 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.

Climate Change

7.17 A major capital grant bid to decarbonise the heating systems of the Frank Lee Centre and Residences has been submitted to the Public Sector Decarbonisation Scheme which supports the aim of reducing emissions from public sector buildings by 75% by 2037 (from 2017 baseline).

7.18 CUH have commissioned the installation of up to 39 electric vehicle charging points for the interim car parking allocation in the south-west corner of the CUH site.

7.19 The business use pool car service has been successfully re-tendered, facilitating an advanced car club format and transition to electric/ultra-low emission vehicles. The Trust has also introduced the new 'KINTO Join' app to help staff find options to cut travel costs, reduce parking congestion, and reduce carbon footprint by providing a fast and easy way to car share and find walking groups associated with travel to work.

7.20 The LED lighting upgrade programme has continued with installations for Oncology, Radiology and ward K2.

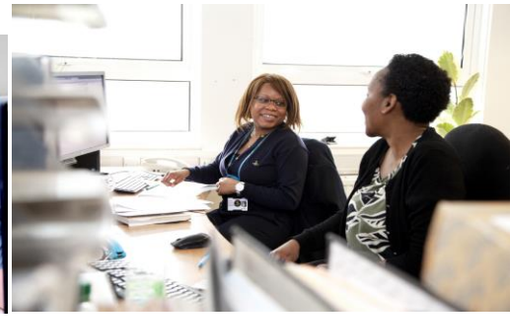
8. Recommendation

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




Cambridge University Hospitals
NHS Foundation Trust






Integrated Report

Quality, Performance, Finance and Workforce to end January 24

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

Report compiled: 29 February 2024

Key

NHS
Cambridge
University Hospitals
NHS Foundation Trust

Data variation indicators


Normal variance - all points within control limits

Negative special cause variation above the mean

Negative special cause variation below the mean

Positive special cause variation above the mean

Positive special cause variation below the mean

Target status indicators

Target has been and statistically is consistently likely to be achieved

Target failed and statistically will consistently not be achieved

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

Rule trigger indicators

SP	One or more data points outside the control limits
R7	Run of 7 consecutive points; H = increasing, L = decreasing
S7	shift of 7 consecutive points above or below the mean; H = above, L = below

Together - Safe | Kind | Excellent

Report compiled: 31 October 2023

Quality Account Measures 2023/24

NHS Cambridge University Hospitals NHS Foundation Trust

2023/24 Quality Account Measures				Nov 23	Dec 23	Jan 24				
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	Jan-24	90%	87.0%	87.0%	88.0%	⇧	86.6%	50.0%	86.6%
	Trust Compliance with Pressue Ulcer risk assessment tool & documentation within 6 hours of admission	Jan-24	90%	81.0%	81.0%	80.0%	⇩	80.7%	13.4%	80.7%
	% Rosie MDT Obstetric staff passed PROMPT emergencies training	Dec-23	90%	92.4%	89.7%	N/A	▪	84.7%	71.0%	84.7%
	% Rosie Obstetricians and Midwives passed fetal surveillance training	Dec-23	90%	91.4%	92.4%	N/A	▪	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)	Jan-24	7%	7.1%	7.0%	6.7%	⇩	7.5%	14.0%	7.5%
Effective / Responsive	% of Early Morning Discharges (07:00-12:00)	Jan-24	20%	17.3%	15.3%	15.0%	⇩	15.6%	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	Jan-24	80%	73.8%	84.6%	80.9%	⇩	75.9%	74.0%	75.6%
	Same day emergency care (SDEC)	Jan-24	30%	24.9%	25.3%	25.1%	⇩	25.3%	22.0%	24.5%
	Percentage of admissions over 65yo with dementia/delirium or cognitive impairment with a care plan in place	Jan-24	50%	71.0%	75.6%	71.0%	⇩	67.1%		67.1%
	SSNAP Domain 2: % of patients admitted to a stroke unit within 4 hours of clock start time (Team centred)	Jan-24	55%	43.6%	42.3%	40.4%	⇩	43.5%	29.2%	40.7%
Staff Experience / Well-led	Trust Vacancy Rate (Band 5) Nurses	Jan-24	5.0%	8.3%	6.3%	6.3%	⇩		10.3%	
	Annual			2021	2022	2023				
	National Staff Survey - "I feel secure about raising concerns re unsafe clinical practice within the organisation"	2023	78%	75.9%	71.3%	70.4%	⇩		75%	

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

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

Page 2

Quality Summary Indicators

NHS Cambridge University Hospitals NHS Foundation Trust

Performance Framework - Quality Indicators				Nov 23	Dec 23	Jan 24				
Domain	**Indicator**	**Data to**	**Target**	**Previous Month-1**	**Previous Month**	**Current status**	**Trend**	**FYtD**	**Previous FYR**	**LTM**
Infection Control	MRSA Bacteraemia (avoidable hospital onset cases)	Jan-24	0	1	0	1	⇧	7	3	7
	E.coli Bacteraemias (Total Cases)	Jan-24	50% over 3 years	28	39	38	⇩	357	401	414
	C. difficile Infection (hospital onset and COHA* avoidable)	Jan-24	TBC	14	10	8	⇩	104	129	119
	Hand Hygiene Compliance	Jan-24	TBC	95.3%	94.9%	93.9%	⇩	94.1%	96.4%	94.2%
Clinical Effectiveness	% of NICE Technology Appraisals where funding was not procured within three months. ('last month')	Jan-24	100%	0.0%	25.0%	75.0%	⇧	57.4%	None recorded	57.4%
	% of NICE guidance relevant to CUH is returned by clinical teams within total deadline of 30 days.	Jan-24	80%	None recorded	25.0%	50.0%	⇧	35.0%	51.0%	50.0%
	100% of NCEPOD questionnaires (clinical and operational) relevant to CUH is returned by clinical teams within deadline ('last month').	Jan-24	100%	0.0%	20.0%	None recorded	⇧	40.0%	None recorded	40.0%
	85% of national audit's to achieve a status of better, same or met against standards over the audit year	Jan-24	85%	83.3%	None recorded	None recorded	⇔	90.9%	84.6%	88.9%
Nursing Quality Metrics	Blood Administration Patient Scanning	Jan-24	90%	99.5%	99.9%	99.6%	⇩	99.7%	99.7%	99.7%
	Care Plan Notes	Jan-24	90%	96.1%	95.9%	96.0%	⇧	95.9%	95.9%	95.9%
	Care Plan Presence	Jan-24	90%	98.6%	98.6%	98.0%	⇩	99.3%	99.6%	99.3%
	Falls Risk Assessment	Data reported in slides								
	Moving & Handling	Jan-24	90%	76.3%	76.2%	76.8%	⇧	76.3%	72.4%	75.7%
	Nurse Rounding	Jan-24	90%	99.0%	99.0%	99.2%	⇧	99.1%	99.2%	99.1%
	Nutrition Screening	Jan-24	90%	75.5%	76.3%	76.0%	⇩	76.3%	72.8%	75.8%
	Pain Score	Jan-24	90%	84.6%	84.2%	84.0%	⇩	85.0%	83.8%	84.8%
	Pressure Ulcer Screening	Data reported in slides								
	EWS									
	MEOWS Score Recording	Jan-24	90%	86.7%	86.2%	91.5%	⇧	86.6%	84.9%	86.3%
	PEWS Score Recording	Jan-24	90%	99.1%	99.4%	99.4%	⇧	99.2%	99.1%	99.2%
	NEWS Score Recording	Jan-24	90%	97.7%	97.8%	97.8%	⇧	97.7%	97.4%	97.7%
	VIP									
	VIP Score Recording (1 per day)	Jan-24	90%	87.4%	86.7%	86.8%	⇧	87.3%	85.8%	87.0%
	PIP Score Recording (1 per day)	Jan-24	90%	79.2%	84.6%	85.3%	⇧	84.5%	86.5%	84.9%
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	Jan-24	0	45	46	37	⇩	541	172	599
	Re-opened complaints (non PHSO)	Jan-24	N/A	9	4	13	⇧	69	18	71
	Re-opened complaints (PHSO)	Jan-24	N/A	0	0	0	⇔	5	2	5
				Nov 23	Dec 23	Jan 24				
	Number of medium/high level complaints	Jan-24	N/A	14	8	10	⇧	139	257	181

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

Operational Performance

NHS Cambridge University Hospitals NHS Foundation Trust

Point of delivery	Performance Standards	SPC variance	In Month Actual	In Month plan	Target	Target due by	Page
Urgent & Emergency Care	4hr performance	Normal variation	62.5%	68.4%	76.0%	Mar-24	Page 13
	12hr waits in ED (type 1)	Normal variation	13.7%	-	-	-	
	Ambulance handovers <15mins	Normal variation	45.2%	65.0%	65.0%	Immediate	
	Ambulance handovers <30mins	Negative special cause variation	73.8%	95.0%	95.0%	Immediate	Page 14
	Ambulance handovers > 60mins	Negative special cause variation	16.5%	0.0%	0.0%	Immediate	
Cancer	Cancer patients < 62 days	Normal variation	71.3%	-	85.0%	Immediate	Page 20
	28 day faster diagnosis standard	Normal variation	81.7%	82.6%	75.0%	Immediate	Page 18
	31 day decision to first treatment	Normal variation	80.7%	-	96.0%	Immediate	Page 19
Outpatients	First outpatients (consultant led)	Positive special cause variation	109.2%	113.1%	-	-	Page 22
	Follow-up outpatients (consultant led)	Normal variation	114.8%	124.5%	-	-	Page 23
	Advice and Guidance Requests	Normal variation	10.0%	-	16.0%	Mar-23	
	Patients moved / discharged to PIFU	Positive special cause variation	3.4%	7.5%	7.5%	Mar-23	Page 24
Diagnostics	Patients waiting > 6 weeks	Normal variation	40.2%	9.3%	5.0%	Mar-24	Page 21
	Diagnostics - Total WL	Normal variation	14,385	9,096	-	-	
RTT Waiting List	RTT Patients waiting > 65 weeks	Positive special cause variation	815	150	0	Mar-23	Page 16
	RTT Patients waiting > 78 weeks	Normal variation	130	-	-	-	
	Total RTT waiting list	Negative special cause variation	61,531	61,186	-	-	Page 17
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	200	194	-	-	
	Elective LoS (days, excl 0 LoS)	Normal variation	5.0	-	-	-	
	Discharges before noon	Normal variation	15.0%	-	-	-	
	Theatre sessions used	Normal variation	708	-	-	-	
	In session theatre utilisation	Normal variation	77.4%	85.0%	85.0%	Sep-23	Page 26
	Virtual Outpatient Attendances	Negative special cause variation	19.7%	-	-	-	
	BADS Daycase Rate (local)	Normal variation	85.5%	-	-	-	Page 27

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

Patient Safety Incidents

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Data range	Threshold	Jan-24	Mean	Variance	Special causes	Comments
Patient Safety Incidents	February 2021-January 2024	-	**1755**	*1535*		-	
Patient Safety Incidents per **1,000 admissions**			**108**	*96*		–	
Percentage of **moderate harm and above** patient safety incidents		≤ 2%	**2.7%**	*2.3%*		-	Moderate harm incidents showed a statistically significant increase in January 2024 with the last 8 months being above the mean. Hospital-acquired pressure ulcers account for 48% of our moderate harm incidents.

Patient safety incidents (PSIs)

All key measures are in normal variance.

There were 48 PSIs of moderate harm and above in January 2024 - 6 severe, 2 deaths, and 40 moderates.

We transitioned to the new national patient safety incident review framework (PSIRF) on the 01 January 2024. New measures will be reported on from March 2024.

Serious Incidents (SI) and Internal (RCA) Investigations (II)

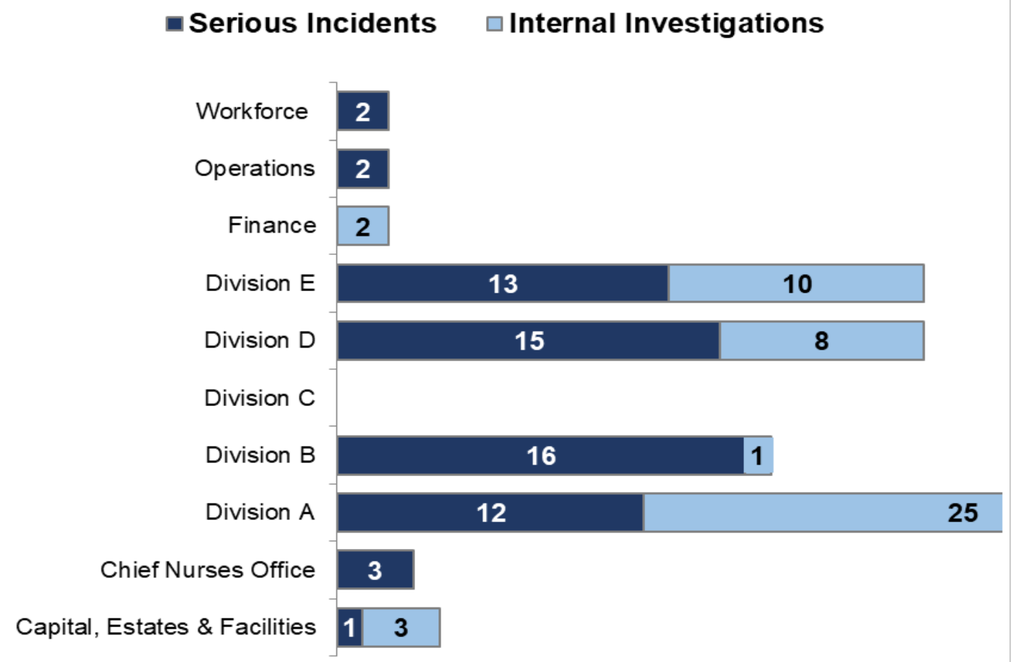
There remains **one open SI** investigation, the IG breach SI declared in December 2023.

There are **7 open Internal Investigations**, all of which are overdue.

There are currently **113** (*165 last month*) **overdue actions** from investigations: 66 (↓) Serious Incident actions and 49 (↓) Internal (RCA) Investigation actions.

The patient safety team are working with divisional teams to support implementation and closure of outstanding SI and II actions. Oversight is also at the new Safety Improvement Group monthly meeting.

Overdue actions in relation to level of investigation for patient and organisational incidents *as of 17.02.2024*



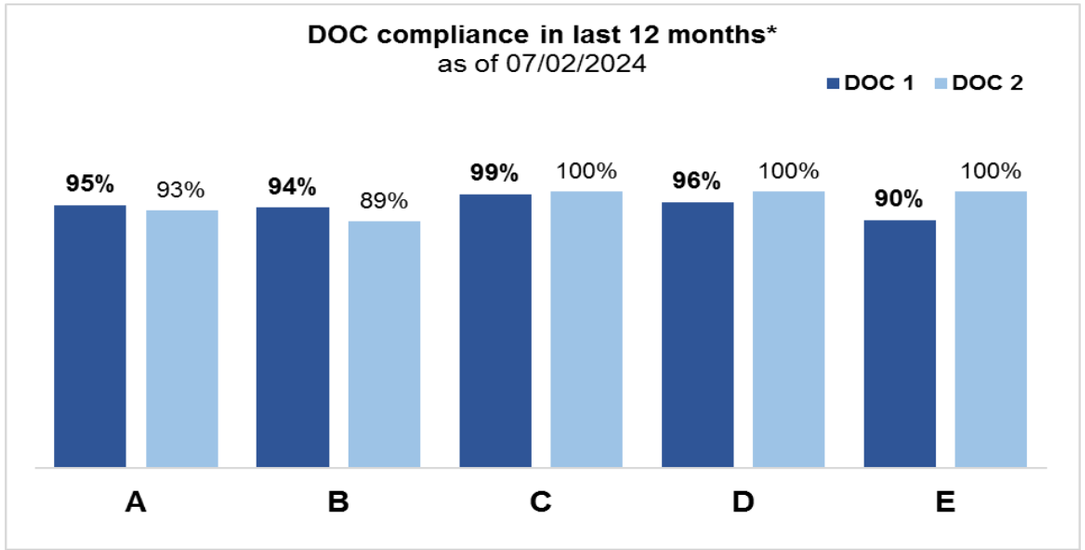
Duty of Candour (DOC)

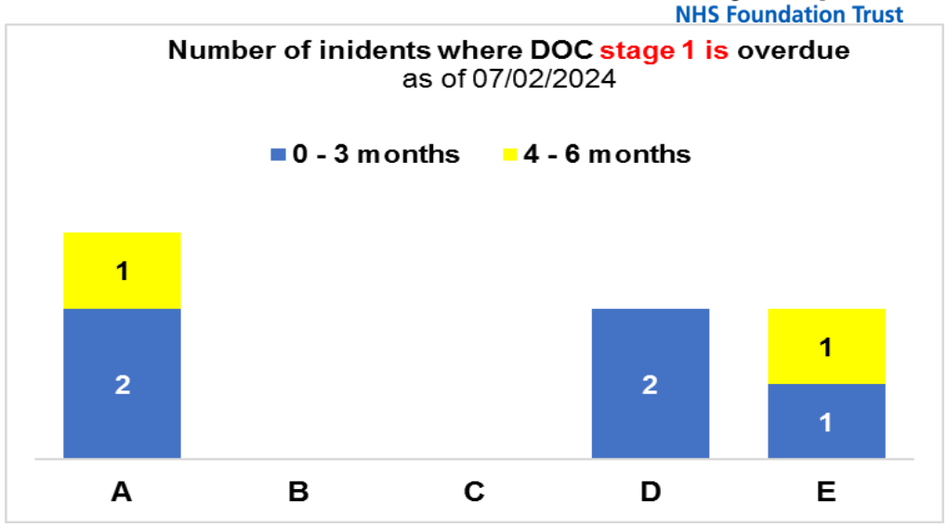
Cambridge University Hospitals NHS Foundation Trust

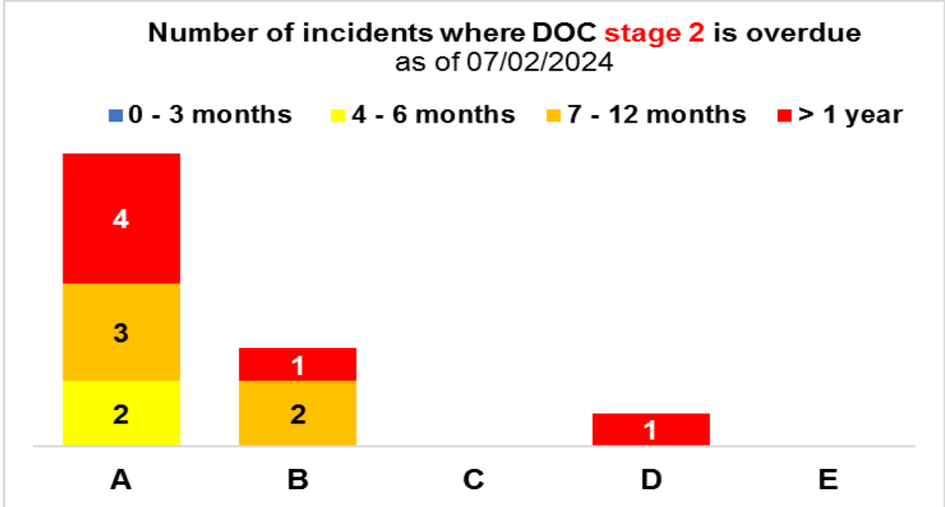
In the last 12 months, Trust-wide **stage 1** DOC compliance is **95%** (429/451) and Trust-wide **stage 2** DOC compliance is **97%** (400/413). A breakdown by Divisions can be seen in graph 1 below.

There are a number of DOC that are overdue, shown in graphs 2 and 3 (right). There are two DOC **stage 1** cases outstanding by more than 4 months (from date reported) and six DOC **stage 2** cases not yet completed, more than 1 year after the incident was reported.

Whilst the DOC stage 2 compliance looks on track, there are still **77** patient safety incidents of moderate harm and above where the investigation not yet completed; DOC stage 2 will be required.







Indicator definitions

Stage 1 *is notifying the patient (or family) of the incident and sending a DOC stage 1 letter. Our internal standard is completion within 10 days of the incident reported.*

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

**12 months data for the period 18/01/2023 - 17/01/2024*

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

Falls

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Data range	Target	Jan-24	Mean	Variance	Special causes	Target status	Comments
All patient falls	February 2021 - January 2024	–	**138**	*153*		Shift	-	Statistically significant downward shift in the last 7 months
Inpatient falls per **1,000 bed days**		–	**3.4**	*4.4*		Shift	-	Statistically significant downward shift in the last 7 months
% of inpatient falls moderate harm & above		–	**0**	*0.0*			-	
Falls **risk screening** compliance within 12 hours of admission		≥90%	**88%**	*85%*				We were last compliant with this metric in June 2021

Summary

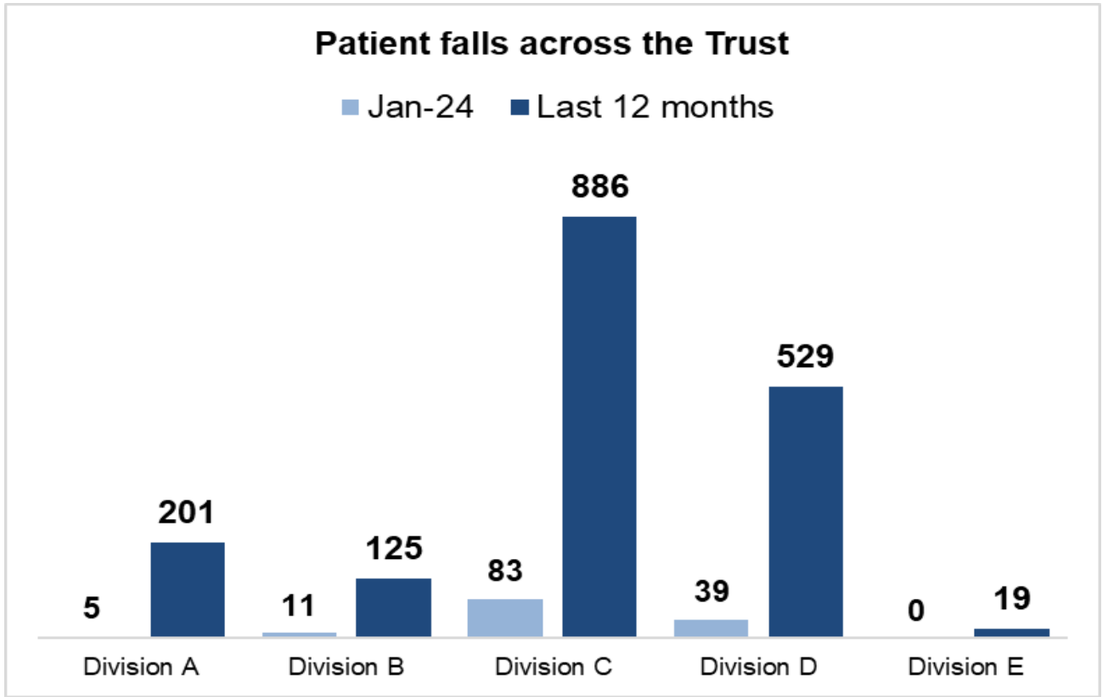
All falls are showing a statistically significant improvement with a downward shift over the last 7 months; this is replicated for inpatient falls by activity.

In January 2024 there were no falls resulting in moderate harm of above

QI update

Falls alarms supply has been renewed and the falls team are working with clinical engineering to agree a SOP for the management of equipment. There remains no tracking system for this equipment in the organisation.

A new corporate falls improvement plan has been designed and will be shared for approval at the next Falls quality steering group



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

Hospital Acquired Pressure Ulcers (HAPUs)

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Data range	Target	Jan-24	Mean	Variance	Target status	Comments
All hospital-acquired pressure ulcers	February 2021 - January 2024	-	**46**	33		-	There has been a statistically significant increase in the last 19 months
All HAPUs by date of occurrence per 1,000 bed days		–	**1.25**	0.96		-	18 out of the last 19 months have been above the mean
Category 2, 3, 4, Suspected Deep Tissue Injury, and Unstageable HAPUs		–	**32**	20.5		-	There has been a statistically significant increase in the last 12 months
Category 1 hospital-acquired pressure ulcers		–	**14**	12.1		–	
Category 2 hospital-acquired pressure ulcers			**19**	13.9		–	There has been a statistically significant increase in the last 9 months .
Unstageable HAPUs		–	**3**	1.6		–	
Suspected Deep Tissue Injury HAPUs by date of occurrence		-	**10**	4.7		-	16 out of the last 19 months have been above the mean.
Medical device related HAPUs		–	**18**	8.3		–	Statistically significant upward shift in the last 7 months and single high point in January. Majority in January from ICS/D3 from masks/tubing
Pressure Ulcer screening **risk assessment** compliance		90%	**80%**	79%			We have not been compliant with this metric in the last 3 years. The last 5 months have been above the mean.

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 January. There is a statistically significant increase in HAPUs related to medical devices overall and from 'mask/tubing'.
The highest HAPUs in the last 12 months are from the sacrum and heels.

QI update

The work in partnership with the Institute Health Improvement (IHI) to reduce incidence of HAPUs commenced in July 2023. Current pilot ward/departments: ICU/D3, D9, J3, ED, M5. We have seen a statistically significant decrease in HPAUs in the ICU/D3 and ward M5 achieved their aim of 150 days with not HAPUs (Category 2 and above). Spread of the program to phase 1 wards is planned for early March 2024.

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

Sepsis

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Data range	Target	Jan-24	Mean	Variance
All elements of the Sepsis Six Bundle delivered within 60 mins from time patient triggers Sepsis (NEWS 5>) - **Emergency Department (15)**	April 2021-January 2024	≥95%	**47%**	*59%*	
Antibiotics administered within 60 mins from time patient **triggers** Sepsis (NEWS 5>) - **Emergency Department (15)**			**67%**	*72%*	
All elements of the Sepsis Six Bundle delivered within 60 mins from time patient triggers Sepsis (NEWS 5>)- **Inpatient wards (6)**			**50%**	*39%*	
Antibiotics administered within 60 mins from time patient **triggers** Sepsis (NEWS 5>) - **Inpatient wards (6)**			**100%**	*74%*	
All elements of the Sepsis Six Bundle delivered within 60 mins from time patient triggers Sepsis (NEWS 5>) -**Maternity (10)**			**50%**	*32%*	
Antibiotics administered within 60 mins from time patient **triggers** Sepsis (NEWS 5>) - **Maternity (10)**			**50%**	*95%*	

Update

Key - ***Audit size = (n)***

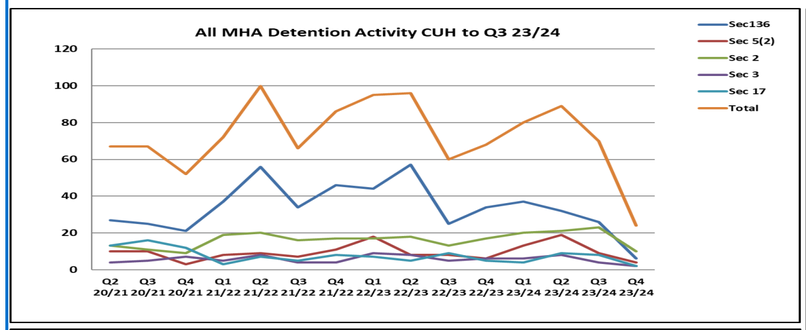
- Projects within the sepsis QI plan have started, this plan will be reviewed based on publication of the reviewed NICE guidance
- Process mapping has started within two specialities in order to establish systems elements that impact on compliance and also celebrating good care
- Update to NICE [NG51] Sepsis guidance has been published Feb 2024- this will inform improvement plans
- The Epic Sepsis order set has been refined to promote increased usage by clinicians and the newly developed sepsis checklist is being promoted
- Sepsis Education is being reviewed and a new strategy pending from this work
- QI plans for Midwifery and ED are being proposed to the teams and support is being offered to ED to support with this work

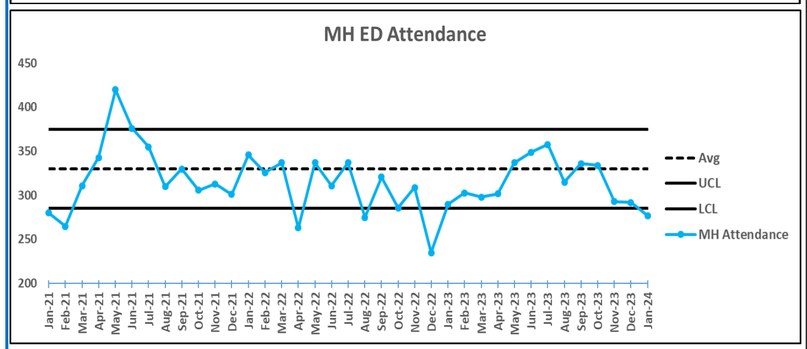
Author(s): Stephanie Fuller **Owner(s): Heman Joshi**

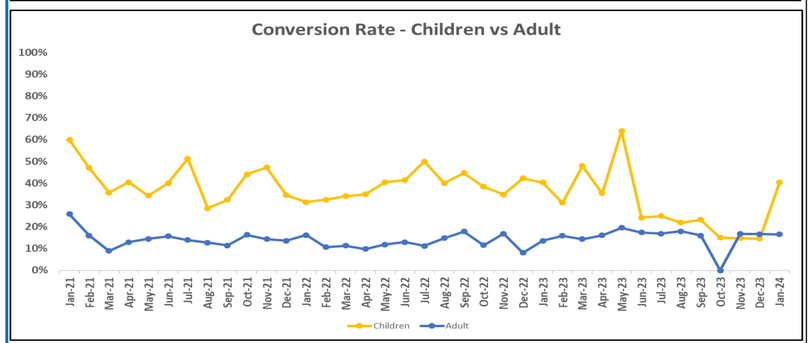
Page 9

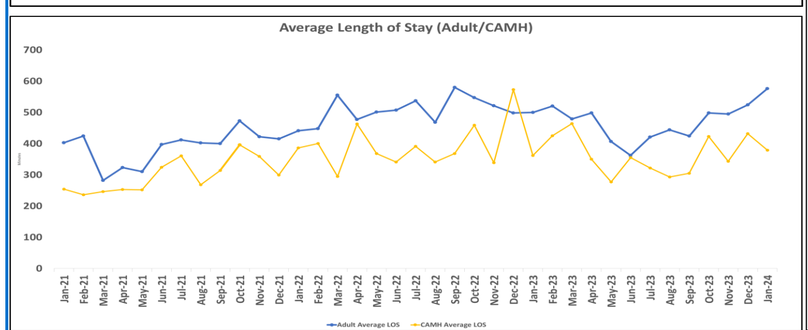
Mental Health - Q2 2023/24 (September)

NHS Cambridge University Hospitals NHS Foundation Trust









Q4 2023/24 (January)

- During January Q4 23/24, there were a low number of patients presenting to the Emergency Department (ED) detained under Section 136 (MHA) (6). Following assessment 4 were discharged from Section 136.
- During January Q4 23/24, 10 patients were detained under Section 2 and 2 patients detained under Section 3
- 4 patients were detained under Section 5(2) (MHA), 2 of which were converted to Section 2 and 1 was converted to section 3.
- The numbers of patients presenting to the ED due to mental health in January Q4 23/24 was low, taking the data point below the lower control line.
- Self harm as a reason for presentation for CAMH represented 67% of presentations to ED, with 54% of those requiring admission to CUH.
- 71% of CAMH presentations to ED were self referrals.
- 41% of total CAMH presentations to ED were admitted to CUH in January, which represents a significant increase over the average for Q3 of 16%.
- 17% of adults presenting to ED for mental health in January were admitted to CUH.
- In January there were 14 delayed discharges of care to specialised mental health inpatient services, with 76 lost acute bed days as a result.

Ongoing work:

- The reviewed CUH Section 5(2) MHA policy/SOP and the Receipt and Scrutiny of Mental Health Act Detention Paperwork and the Reading of Patient Rights Procedure will be shared for consideration at the next CUH/CPFT Joint Mental Health Meeting.
- CUH and the Local Authority AMHP service and Emergency Duty Team are working together to further improve the interface and processes for Mental Health Act paperwork for those detained at CUH.
- The Cambridgeshire Constabulary Right Care Right Person (RCRP) programme continues. The current phase being 'Missing or AWOL patients from health care settings'. The 'go live' date of this phase has been delayed unit the end of March 2024 (date TBC), to ensure system partners have opportunities to identify gaps in provision and to plan actions and resource in partnership with the Integrated Care Board. The CUH Missing Patient procedure is now under review.
- Adult patients with an eating disorder are now being cared for in the side rooms of the new gastroenterology Ward U2, at CUH. On asking for their feedback, very positive comments were made, which included comments around the commissioned artwork on the walls, which contribute to providing an improved patient experience.
- The CUH Enhanced Observations patient leaflet and the CUH Restrictive Interventions Policy are currently being reviewed.
- The Children and Young Peoples' Inpatient Family Support and Liaison team have created a study day for CUH staff to support knowledge and skills development, and the quality of care delivery.

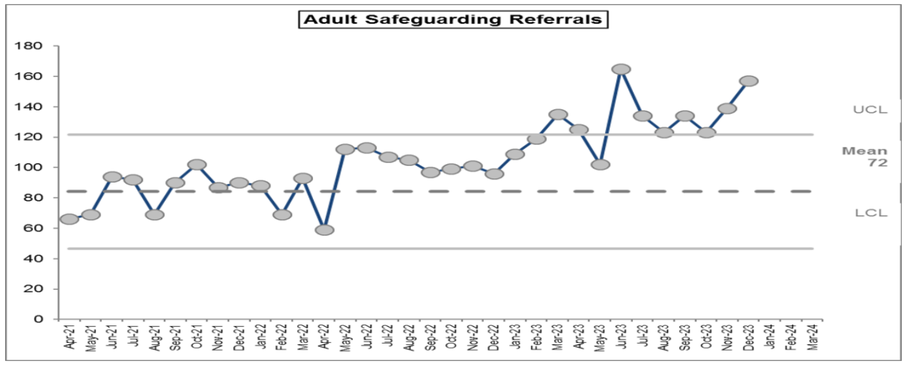
Author(s): Kevin Rowland Owner(s): Lorraine Szeremeta

Safeguarding

NHS Cambridge University Hospitals NHS Foundation Trust

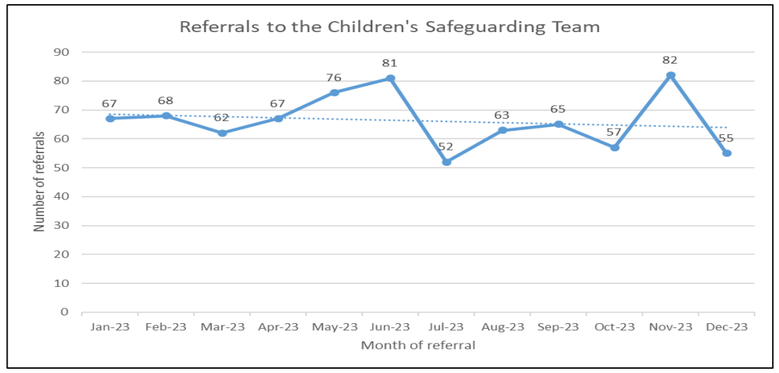
Adult Safeguarding

Referrals to the safeguarding team in Q3 have increased by 7% on Q2 23/24. When compared to Q3 22/23, there has been a 42% increase in referrals. In Q3 46% of the safeguarding referrals made to the team have then been reported on to the Local Authority. This has been a slight drop from the previous quarters figure of 51%. A total of 419 cases were discussed with the Adult Safeguarding Team this quarter compared to 391 in Q2 (this figure does not include Deprivation of liberty (DOLs) requests). The top 3 reporting themes were consistent with Q2 seeing neglect/acts of omission and domestic abuse feature again but with a rise from 6% in Q2 to 16% in Q3 in the number of cases reported for self-neglect. DoLS requests for urgent authorisations have seen a 14% decrease from 66 in Q2 23/24 to 57 in Q3 23/24.



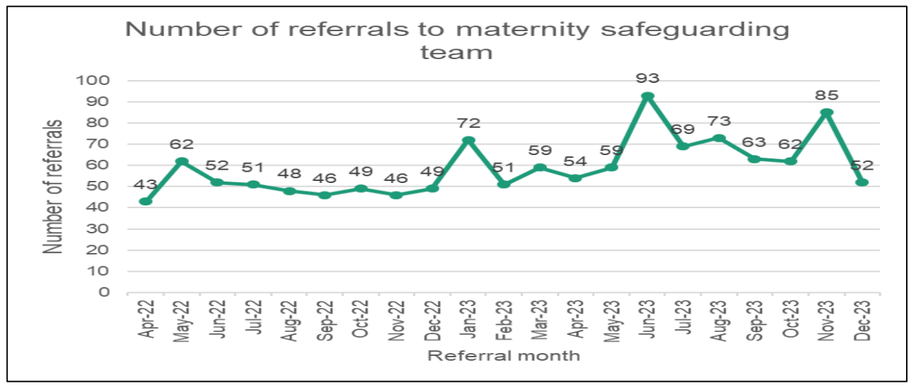
Childrens Safeguarding

There has been an 8.9% increase in the number of referrals to the children's safeguarding team over the last quarter with a total of 194 referrals compared to 180 in Q2 23/24. Top 3 referral themes for Q3 were for children's mental health, parental mental health and information sharing. The team has also seen a significant rise of non-accidental injuries in children, predominantly under 1 year old, by 275% from 4 in Q2 to 15 in Q3. Each case is accompanied with a Child Protection Medical assessment and report which requires a number of clinical hours for completion by the paediatric medical team and attendance at a number of multidisciplinary team meetings by the safeguarding team. The total number of beds days used to accommodate a child as a place of safety or for social reasons has seen an increase from 83 days in Q2 to 138 days in Q3.



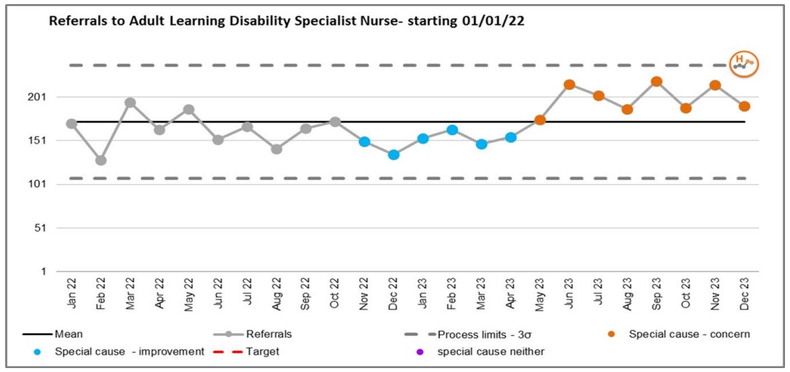
Maternity safeguarding

Referrals to the maternity safeguarding team in Q3 have seen a slight decrease to 199 compared with 205 in Q2. Overall this is still a significant increase compared with the same reporting period in 22/23 which saw 141 referrals and is a 41% increase in demand. The top 3 referral themes in Q3 have been for Domestic Abuse as was seen in Q2, Previous involvement with social care and perinatal mental health.



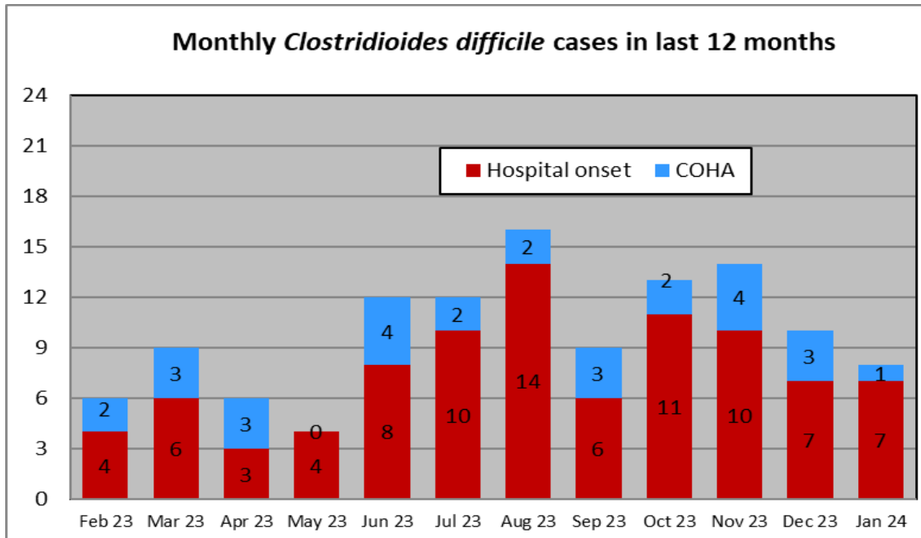
Learning disabilities

During Q4 there have been 595 referrals to the adult learning disability specialist nurse which is a 9% increase from Q2 23/24 and is showing a consistent increase in referral numbers with a 30% increase on the same reporting period in 22/23. The children's referral data has seen an decrease from 34 in Q2 to 31 in Q3. There has also been a 1% increase in the number of children attending CUH with an LD or Autism flag on their record since Q2 and a 44% increase on the same reporting period in 22/23. For adults the top 3 referral themes were gastro/colorectal, respiratory and neurology the same as in Q2, whilst in children's services the top 3 reasons for referral were for admission planning, family support and signposting, and planning for outpatient/ investigations.

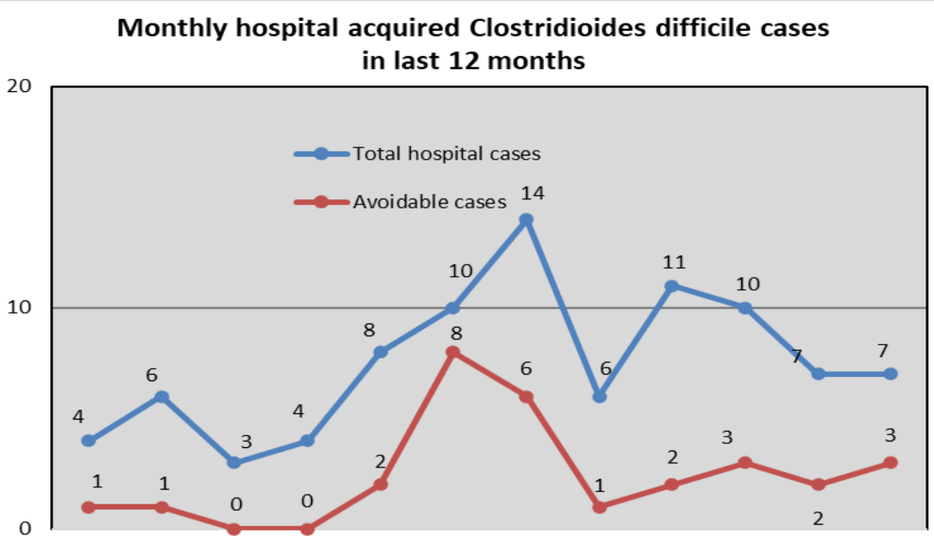


Infection Control

Cambridge University Hospitals NHS Foundation Trust



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



CUH trend analysis

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

• 1 case of hospital onset MRSA bacteraemia in January 2024
• 10 cases (4 community, 4 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*.

▪ 7 cases of hospital onset *C difficile* and 1 case of COHA in January 2024.
• 80 hospital onset cases and 24 COHA cases year to date (68 cases unavoidable, 23 avoidable and 13 cases are pending).

MRSA and C difficile key performance indicators

▪ Compliance with the MRSA care bundle (decolonisation) was 78.3% in January 2024 (80% in December 2023).
▪ The latest MRSA bacteraemia rate comparative data (12 months to December 2023) put the Trust 7th out of 10 in the Shelford Group of teaching hospitals.

▪ Compliance with the *C. difficile* care bundle was 80% in January 2024 (100% in December 2023).
▪ The latest C. difficile rate comparative data (12 months to December 2023) put the Trust 9th out of 10 in the Shelford Group of teaching hospitals.

Author(s): Infection Control team **Owner(s): Ashley Shaw**

4HR Performance

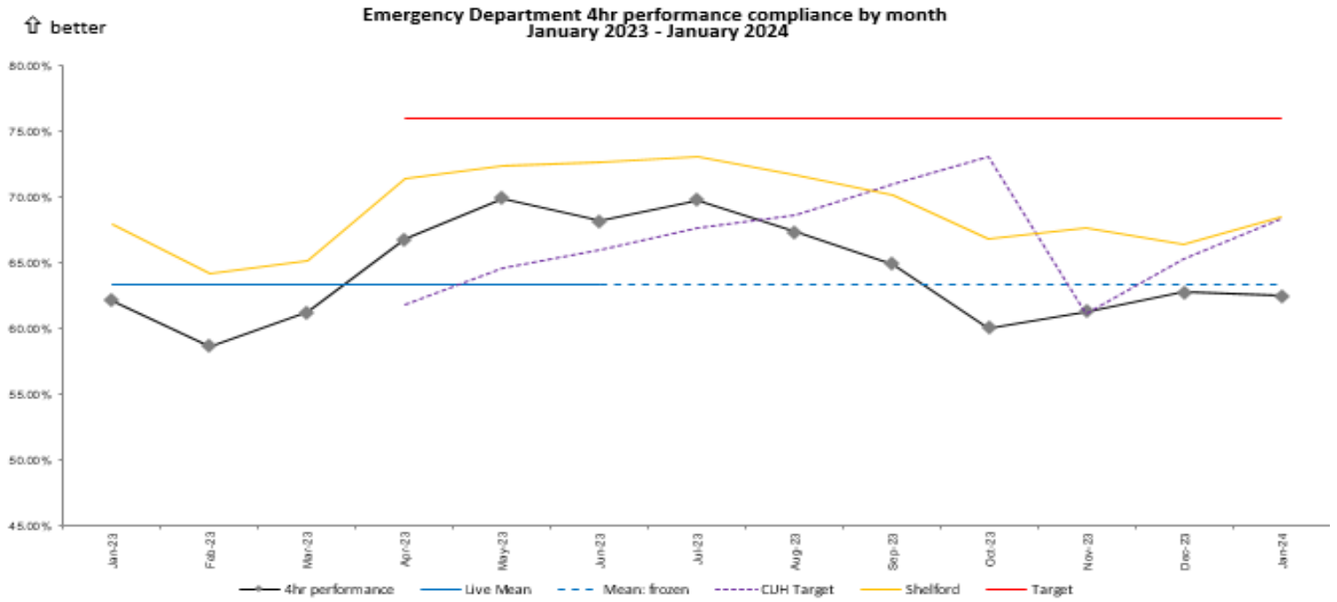
NHS
Cambridge University Hospitals
NHS Foundation Trust

Jan-24	Plan
62.5%	68.4%

SPC Variance
Normal variation

Shelford Group Avg (Jan-24)
68.5%

Three Month Trajectory		
Feb-24	Mar-24	Apr-24
72.5%	76.6%	-



Highest breaches by specialty

Specialty	Performance	4hr Breaches
Medicine	21.2%	2,228
Emergency	58.6%	1,998
Paediatrics	41.0%	337
Surgery	31.0%	258
Orthopaedics	17.7%	232

Updates since previous month

- In January we achieved 62.5% compared to 62.7% in December
- This is higher than 62.1% in the same month last year (January 2023) but lower than our plan of 68.4%.

Current issues

- ED attendances grew significantly year on year. In January we saw an additional 1,925 patients compared to January 2023 (+18.2%), equivalent to an extra 62 patients per day.

Key dependencies

- Bed occupancy is a key interdependency as it supports outflow from the department
- In January we saw higher levels of respiratory illness (predominately flu and COVID) which led to a significant number of closed beds
- Industrial action took place in the first week of January, impacting patient flow in the hospital.

Future actions

- The model for the medical assessment unit (MAU) has been revised and relaunched in February to support the outflow of medical patients from the ED
- We are focusing on consultant-led rapid assessment and treatment (RAT) at the front door to support early decision-making
- We are revising our reverse boarding policy to improve admitted performance.

Author(s): James Hennessey **Owner(s): Nicola Ayton** **Page 13**

Ambulance Handovers > 60 minutes

NHS
Cambridge University Hospitals
NHS Foundation Trust

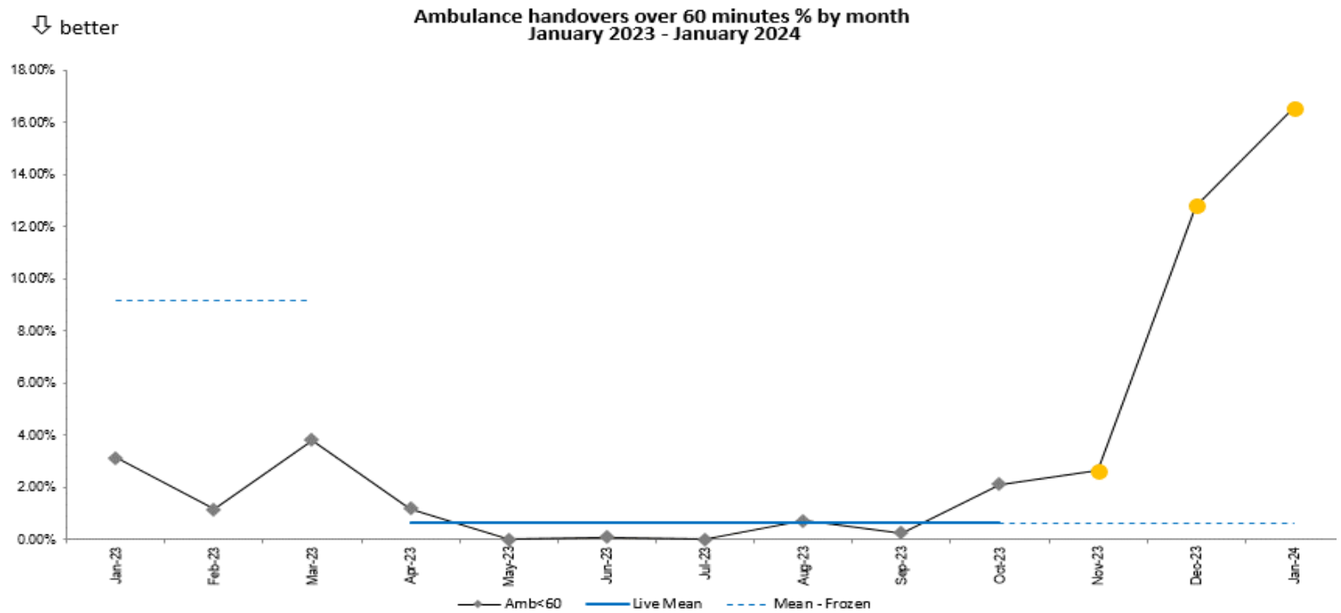
Jan-24	Target
16.5%	0%

SPC Variance

Negative special cause variation

East of England > 60 minutes

Trust	January
Broomfield	6%
Bedford	7%
Milton Keynes	9%
Watford	10%
Basildon	11%
Hinchingbrooke	12%
Southend	14%
Colchester	16%
CUH	16.5%
Luton and Dunstable	17%
Norfolk & Norwich	18%
Lister	19%
Peterborough	20%
West Suffolk	24%
Princess Alexandra	25%
Ipswich	25%
Papworth	28%
James Paget	32%
Queen Elizabeth	34%



Updates since previous month

- Ambulance handovers >60mins increased from 12.8% in December to 16.5% in January, primarily due to increased numbers of patients in the Emergency Department
- CUH moved from 6th to 9th best performance in EoE

Current issues

- Crowding in the ED contributed to an increase in the number of handovers >60mins in January, driven by a significant year-on-year increase in ED attendances (+18.2%)

Key dependencies

- Outflow from the ED remains a key contributor to handover performance. Lower bed availability has increased the time that admitted patients spend in the ED, reduced our capacity to offload patients

Future actions

- Handover delays are a key area of focus for the Trust and is monitored in real time (24/7) by the site operations team
- Additional rapid handover spaces are being created to support offloads.

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

Overall fit test compliance for substantive staff

NHS
Cambridge University Hospitals
NHS Foundation Trust

Division	Corporate			Division A			Division B			Division C			Division D			Division E						Total		
Staff Group	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected
Add Prof Scientific and Technical (Pharmacists only)	-	-	-	1	1	100%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	1	100%
Additional Clinical Services	1	0	0%	265	162	61%	66	38	58%	150	92	61%	107	48	45%	87	38	44%	-	-	-	676	378	56%
Allied Health Professionals	-	-	-	58	25	43%	17	1	6%	1	1	100%	-	-	-	3	1	33%	-	-	-	79	28	35%
Estates and Ancillary (Porters and Security Personnel only)	120	41	34%	-	-	-	-	-	-	-	-	-	-	-	-	1	0	0%	1	0	0%	122	41	34%
Medical and Dental	-	-	-	211	40	19%	-	-	-	154	45	29%	143	12	8%	217	54	25%	-	-	-	725	151	21%
Nursing and Midwifery Registered	-	-	-	693	513	74%	4	2	50%	291	187	64%	139	78	56%	373	210	56%	-	-	-	1500	990	66%
Total	121	41	34%	1228	741	60%	87	41	47%	596	325	55%	389	138	35%	681	303	44%	1	0	0%	3103	1589	51%

The data displayed as of 13/02/24. 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'

Referral to Treatment > 65 weeks and > 78 weeks

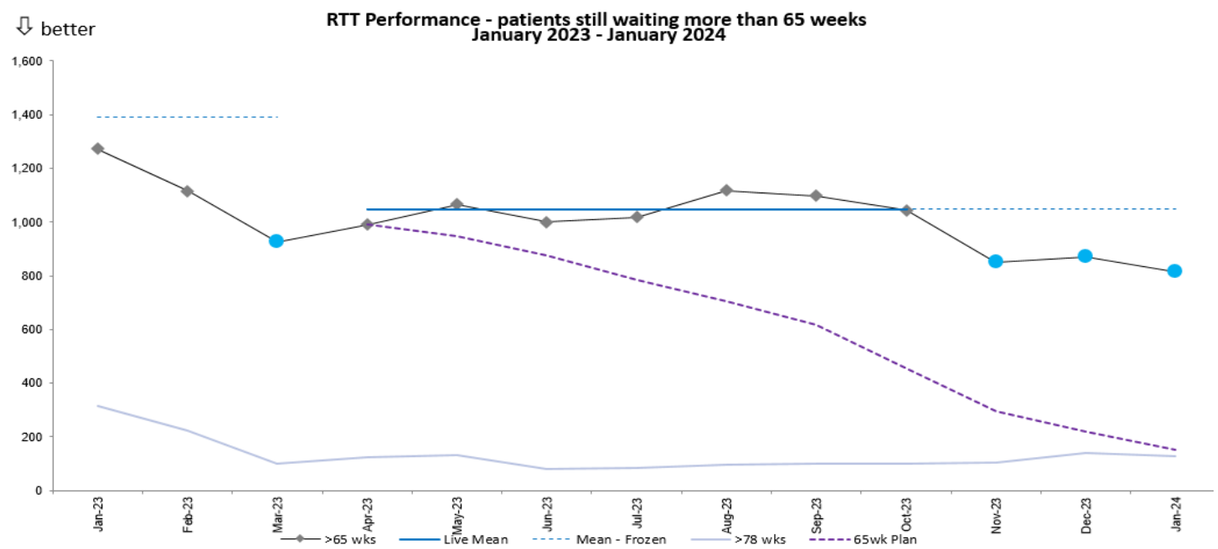
NHS
Cambridge University Hospitals
NHS Foundation Trust

65+ Weeks	
Jan-24	**Plan**
815	150

SPC Variance
Positive special cause variation

% of WL over 65 weeks (Dec-23)	
CUH	1.41%
Shelford Group	1.28%

Three Month Forecast (65+ wks)		
Feb-24	**Mar-24**	**Apr-24**
80	0	#N/A



Divisional Performance		
Division	**65+ weeks**	**78+ weeks**
A	188	48
B	45	8
C	10	0
D	443	64
E	129	10
Trust	**815**	**130**

Updates since previous month

- Four > 104 week breaches. Two due to the identification of missed referrals. One previous incorrect clock stop. One cancelled in January due to illness who will not now be treated until April due to their choice.
- >78 week waits decreased by 12 to 130. Highest volumes remain OMFS (21) Colorectal (15) T&O (15) General Surgery (14)
- >65 weeks decreased by 55 to 815.

Current issues

- Latest National data reflects continued deterioration in longest waits across 104, 78 and 65 weeks.
- Despite a week of Industrial Action reductions have been achieved through January at CUH.
- Bed capacity pressures and seasonal illnesses have led to cancellations of scheduled long wait patients.
- Late Inter Trust tertiary referrals continue to add to the long

Key dependencies

- Cessation of Industrial Action
- Theatre efficiency and surgical bed protection.
- Recruitment to medical workforce vacancies
- Independent Sector in ENT. No support for Gynaecology was offered due to tariff.
- Continuation of Insourcing OMFS and Gynae.

Future actions

- National focus is now on the > 78 week maximum being cleared by year end. Weekly KLOEs are being submitted to NHSE and our latest forecast, including impact of February IA, is 29 across 10 specialties.
- Sunday theatre sessions continue to support delivery. Reviewing Good Friday opportunities
- The re-submitted year end forecast of ~800 >65 weeks remains on trajectory with an expectation this will be achieved in Q1.

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

Page 16

Referral to Treatment Total Waiting List

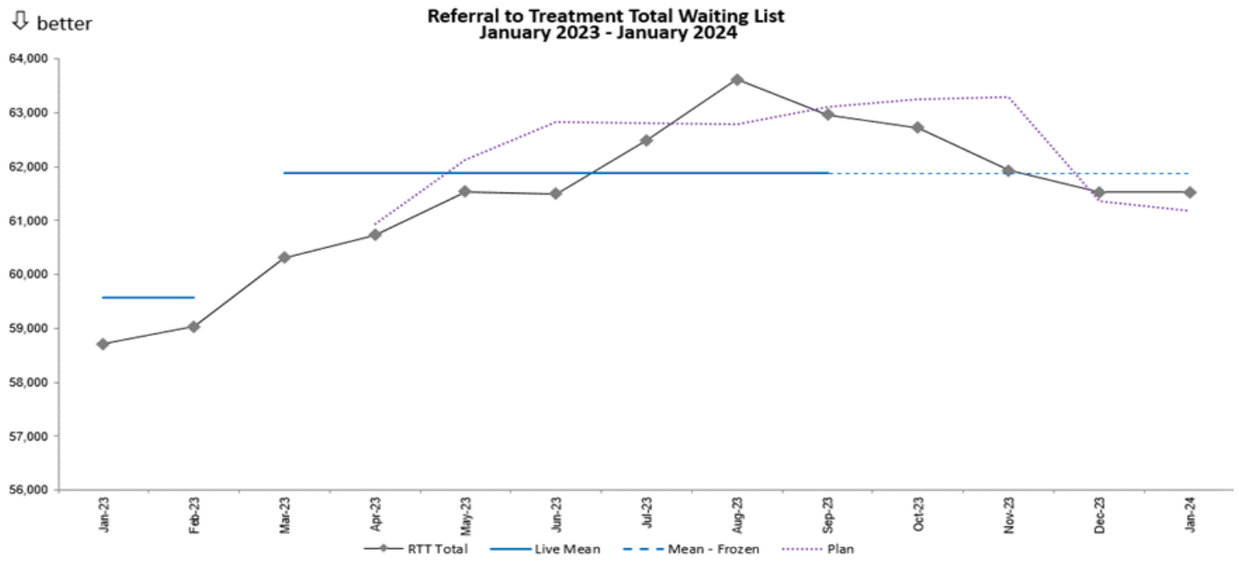
NHS
Cambridge University Hospitals
NHS Foundation Trust

Jan-24	Plan
61,531	61,186

SPC Variance
Negative special cause variation

Change in WL: Dec-23 vs. Nov-23	
CUH	-0.64%
Shelford Group	+1.07%

Three Month Forecast		
Feb-24	Mar-24	Apr-24
61,282	61,473	#N/A



Waiting list by division

Division	Total Waiting List
A	12,122
B	6,513
C	4,840
D	28,879
E	9,177
Other	0
Trust	**61,531**

Updates since previous month

- Total RTT waiting list remained stable in January, with just a variance of 2.
- However, the total waiting list size is now 345 higher than the planning submission for month 10.
- Clock starts in January were higher than plan for a second month (1.2%) reducing the year to date cumulative variance further to -1.2% . .

Current issues

- The Industrial Action impact equated to a reduction of ~425 stops. Without this the total waiting list would have continued to reduce ahead of plan.
- Total stops (treatments) were actually 3.8% above plan in January , driven by non-admitted activity which is cumulatively 4% above plan year to date.

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

Future actions

- Continued emphasis on Outpatient Transformation, releasing capacity for new outpatients. Those awaiting 1st appointments remained 60.7% of total waiting list in January, but has sustained below 50,000 since November.
- Specialties are requested to undertake self-assessment against the 18 GIRFT Further Faster Programme Handbooks which provide best practice guidance for rapid improvement..

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

Cancer - 28 day faster diagnosis standard

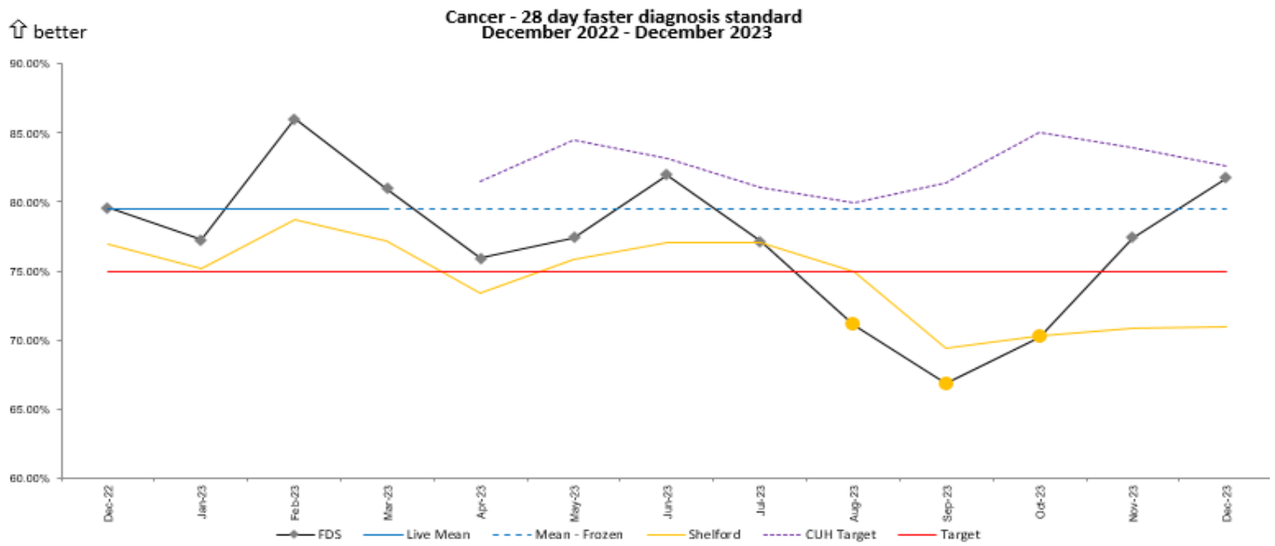
NHS
Cambridge University Hospitals
NHS Foundation Trust

Dec-23	Target
81.7%	75.0%

SPC Variance
Normal variation

Shelford Group Avg (Dec-23)
71.0%

Three Month Forecast		
Jan-24	Feb-24	Mar-24
76.8%	82.6%	83.3%



Cancer Site Overview

Site	Performance	Breaches
Skin	64.9%	187
Lower GI	84.4%	47
Gynaecological	80.2%	37
Head & Neck	81.0%	39
Urological	75.8%	39
Breast	96.5%	20
Haematological	54.5%	5
Sarcoma	54.5%	10
Upper GI	88.2%	2
Lung	95.1%	6
Childrens	69.2%	4
CNS/Brain	87.5%	2
Testicular	100.0%	0
Total	**81.7%**	**398**

Updates since previous month

CUH has sustained above target performance. Skin remain below target however are making significant improvements month on month. Pathology turn around times also continue to delay diagnosis and impact on this target. Urology achieved the target for the second month in a row, and is one of few urology teams nationally to achieve this standard.

Current issues

Delays to 1st appointment and diagnosis in skin cancer, and pathology turn around times continue to impact performance across all sites.

Key dependencies

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

Future actions

Actions are in place as part of the Cancer Improvement Plan. Focus continues on skin, gynae, urology and pathology. There has been an improvement across the ICB for FDS performance following shared learning.
The draft 2024/25 planning guide is expected to request performance of 77% by March 2025, CUH is already achieving this level of performance.

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

Cancer - 31 days decision to treat to treatment (Combined)

NHS
Cambridge University Hospitals
NHS Foundation Trust

	Dec-23	Target
Combined	80.7%	96.0%

SPC Variance

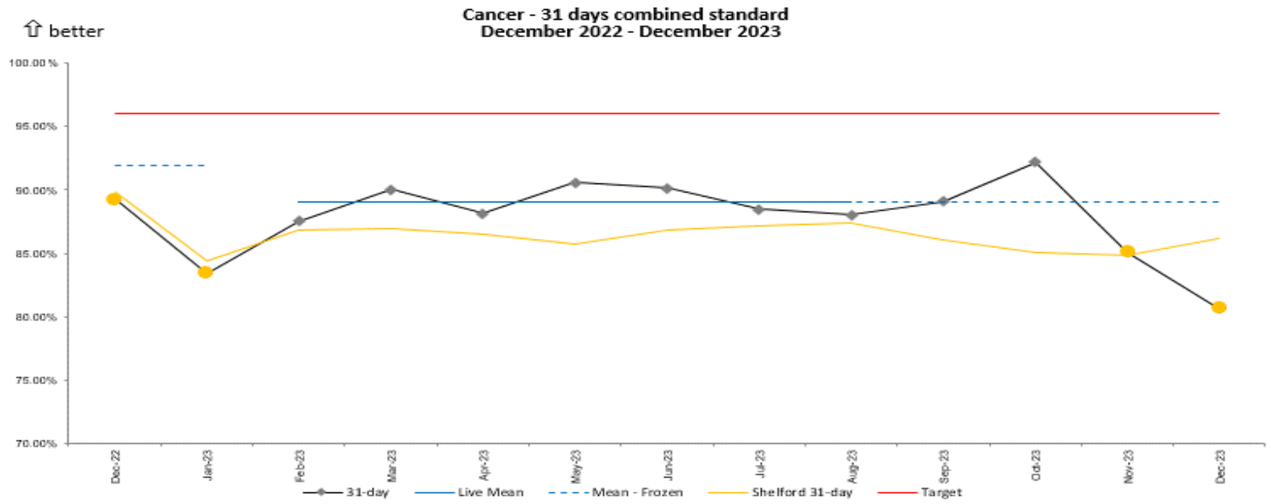
Normal variation

Shelford Group Avg (Dec-23)

Combined	61.3%

Cancer Site Overview as of 00/01/1900

Site	Backlog
Breast	1
CNS/Brain	6
Gynaecological	0
Head & Neck	11
Haematological	1
HPB	0
Lower GI	5
Lung	3
Childrens	0
Sarcoma	0
Skin	0
Testicular	17
Upper GI	0
Urological	1
All	45



Updates since previous month

CUH continues to fall below target with a further deterioration in performance to 80% in December. 42% of the breaches in December were for surgery; Radiotherapy breaches are now the predominant treatment modality unable to book in 31 days with 54% of the breaches, 89% of these Radiotherapy breaches are in breast and prostate which are the lowest clinical priority.
The average length of a 31 day pathway for radiotherapy is 38 days and for surgery is 40 days, a reduction since November.

Current issues

Radiotherapy has experienced a deterioration in performance due to workforce constraints, in line with the national picture there are significant workforce gaps within the Radiographer workforce which would support 2 linac's worth of full time capacity. The team are mitigating as much as possible with bank hours however lower clinical priority patients are waiting on average 5 weeks against the target of 4 weeks for treatment.

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 February
Workforce constraints in Radiotherapy
Inability to support mutual aid requests from the region for radiotherapy.

Future actions

Continued focus on Gynae, HPB, and skin surgery in Q4
Additional treatment capacity for skin has been agreed from January with additional cancer alliance funding.
Recruitment to vacancies in radiotherapy, and request for agency workforce to support in the short term.

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

Cancer - 62 days combined referral to treatment

NHS
Cambridge University Hospitals
NHS Foundation Trust

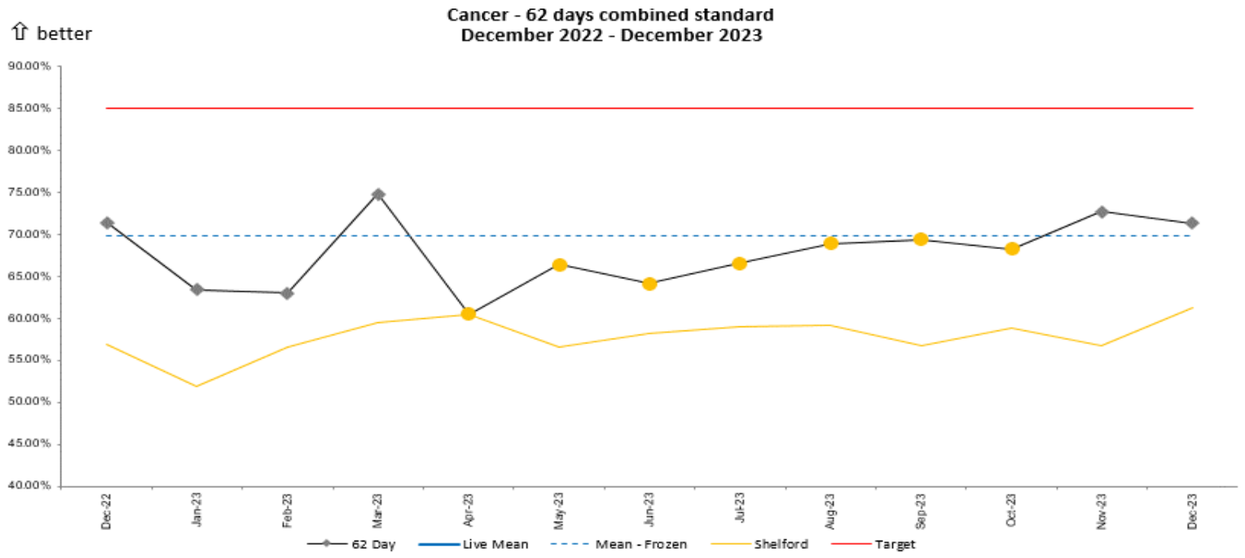
Dec-23	Target
71.3%	85.0%

SPC Variance
Normal variation

Shelford Group Avg (Dec-23)
93.0%

Cancer Site Overview as of 00/01/1900

Site	Backlog
Breast	18
CNS/Brain	3
Gynaecological	0
Head & Neck	19
Other Haem Malignancies	14
Lower GI	10
Lung	14
NSS	9
Upper GI	0
Urological	2
Sarcoma	0
Skin	2
HPB	0
Childrens	0
Symptomatic Breast	26
All	*117*



Updates since previous month

CUH performance remains below target although continues to be higher than the Shelford Group, and is above the national requirement for March 2025 of 70%. 40% of breaches are CUH only patients (an improvement since November) and of that 57% were due to delays within CUH control such as delayed pathology reporting, outpatient and surgical capacity. 31% of referrals to CUH from regional hospitals were treated in the required 24 days.

Current issues

- Delays in pathology turn around times (currently 26% in 7 days)
- Outpatient and surgical capacity
- Further impact of industrial action
- delays to diagnosis due to capacity (skin) resulting in adverse backlog recovery
- Internal escalation and resolution of internal delays in line with agreed operational policy (16% of December breaches only breached by 7 days)

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.
- Improved compliance with internal escalation to resolve any delay

Future actions

There is an extensive improvement plan in place which is reviewed monthly; there is a focus on Skin, LGI, Gynae and Head & Neck with specific recovery actions. CUH has a backlog against the 62 standard target of 125 and is required to reduce that further to 87 by 31.03.24, a focus on Gynae, H&N, and LGI will result in an improvement in performance from Q1 2024/25. Urology have continued to see backlog reductions for CUH patients and despite an increase in tertiary referrals performance continues to improve

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

Diagnostic Performance

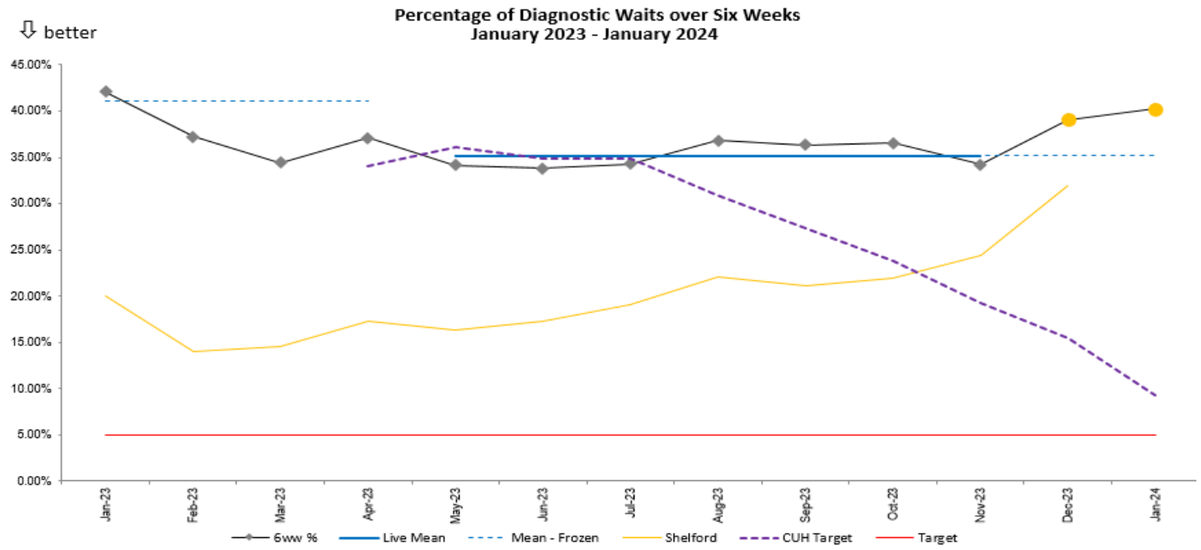
NHS
Cambridge University Hospitals
NHS Foundation Trust

Jan-24	Plan
40.2%	9.3%

SPC Variance
Normal variation

Shelford Group Avg (Dec-23)
31.9%

Three Month Forecast		
Feb-24	Feb-00	#N/A
6.7%	#N/A	#N/A



Modality overview

Modality	% >6wks	Breaches
Echocardiography	80.2%	3410
Non obstetric ultrasound	31.0%	739
Audiology	67.8%	10
Magnetic Resonance Img'	20.1%	491
DEXA Scan	1.9%	14
Computed Tomography	6.3%	66
Urodynamics	53.9%	123
Neurophysiology	0.0%	0
Cystoscopy	17.1%	49
Gastroscopy	2.1%	13
Colonoscopy	0.8%	6
Respiratory physiology	43.9%	25
Barium Enema	10.6%	5
Flexi sigmoidoscopy	0.0%	0
Total		**4951**

Updates since previous month

- January saw a further deterioration in 6wk performance to 40.2%.
- 5 modalities are achieving < 5% over 6 weeks, with Dexa the additional service achieving in month.
- Both the total waiting list increased (+323) and the > 6 week cohort (+287).
- Echo is now 59% of the Trust >6wk backlog and saw a rise in > 6 week cohort of 394 this month.

Current issues

- Echo activity did increase in January with the new Insourcing provider but only to 50% of their expected activity levels. The introduction is being closely monitored for both quality and performance.
- 52% vacancy rate (10.5 wte) continues for Echo. One candidate withdrew reducing the offered posts to 3.6wte. Start dates Mar/Apr/Aug.
- MRI performance deteriorated in month due to high demand and slightly reduced activity with MAG 3 replacement.

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.
- Achieving planned activity levels at the CDCs particularly during MAG 3 replacement and for Echo.

Future actions

- Audiology System working group reviewing community provider referral criteria to achieve equity across the ICB.
- Opportunity to redirect some appropriate Audiology activity to Specsavers,
- ICB Review of Diagnostic Services completed by Attain. Modalities to review actions in line with recommendations which have focused on Cardiac imaging, Ultrasound and Endoscopy.
- CDC to secure Echocardiography provider asap

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

New Outpatient Attendances - % vs. Baseline

NHS
Cambridge University Hospitals
NHS Foundation Trust

Jan-24	Plan
109.2%	111.3%

SPC Variance

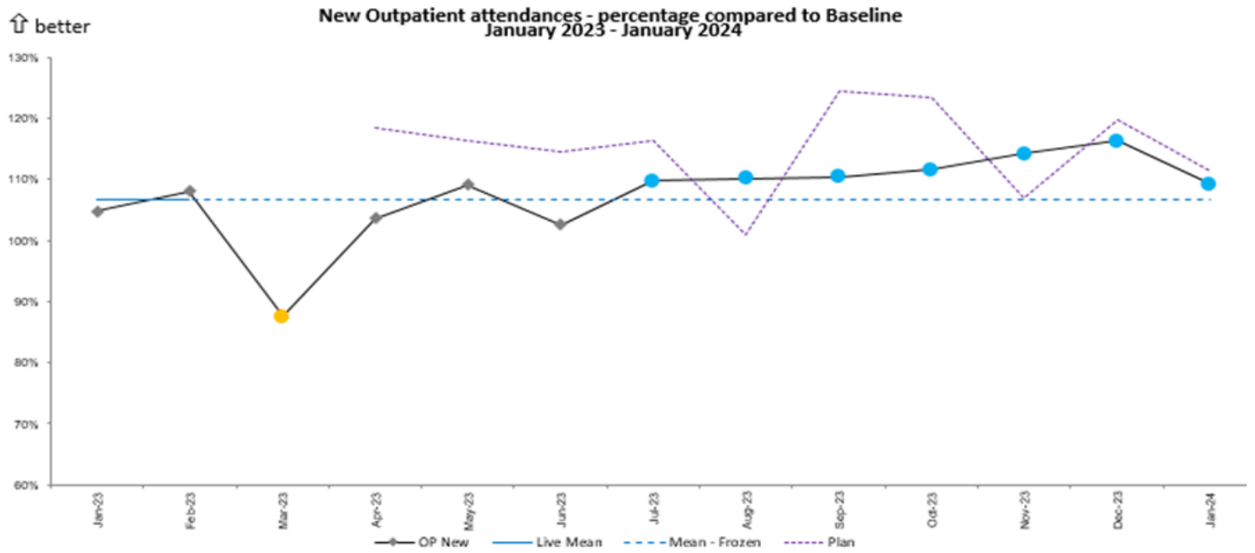
Positive special cause variation

Shelford Group Avg (Dec-23)

N/A

Three Month Forecast

Feb-24	Mar-24	Apr-24
119.5%	118.5%	#N/A



Divisional overview

Division	Performance
A	108.9%
B	110.9%
C	90.4%
D	107.7%
E	108.5%

Updates since previous month

CUH new activity remains adversely below the 115% CUH target for end March 2024. The most recent data point for January 2023 sits just below this current median at 109.2%. All divisions performed strongly with the exception of division C which continues to run well below 100% for new activity against the 19/20 baseline. The number of new outpatient appointments on the waiting list remains high at 62,972 in January 2024. However, the rate of rise per month has slowed with a significant trend downwards in the rate of rise for the last 6 months, reaching a current median of -0.5%.

Current issues

The challenges for division C in delivering more new patient activity remain primarily with clinic space, which is not sufficient to increase NEW activity. To manage the increased referral rates we are seeing, all specialities are continuing to work with high thresholds for triage. Nephrology and Hepatology are in the process of increasing their consultant establishment to meet this demand as well as monitoring their patients with chronic disease. We are interviewing for the Nephrology posts in January and hope to appoint as soon as possible.

Key dependencies

Further action is needed to increase new activity and achieve positive, sustained change. This should be reflected in 2024/25 business plans and activity plans. Divisions and specialties need to further test change ideas including clinic template changes, waiting list initiatives, specialist advice, remote appointments, DNAs and PIFU. A greater volume, pace and spread of this action is needed to achieve the required scale of change.

Future actions

ME agreed we should look to establish cross-cutting programmes of work on top Trust priorities for 24/25, including outpatients. A short term steering group has been arranged, with an expanded senior representation membership from all divisions. The focus will be on how to deliver our business plans and where we want to go further through a cross-cutting programme. This work will align with the work of both the outpatient board and the outpatient transformation board.

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

Follow Up Outpatient Attendances - % vs. Baseline

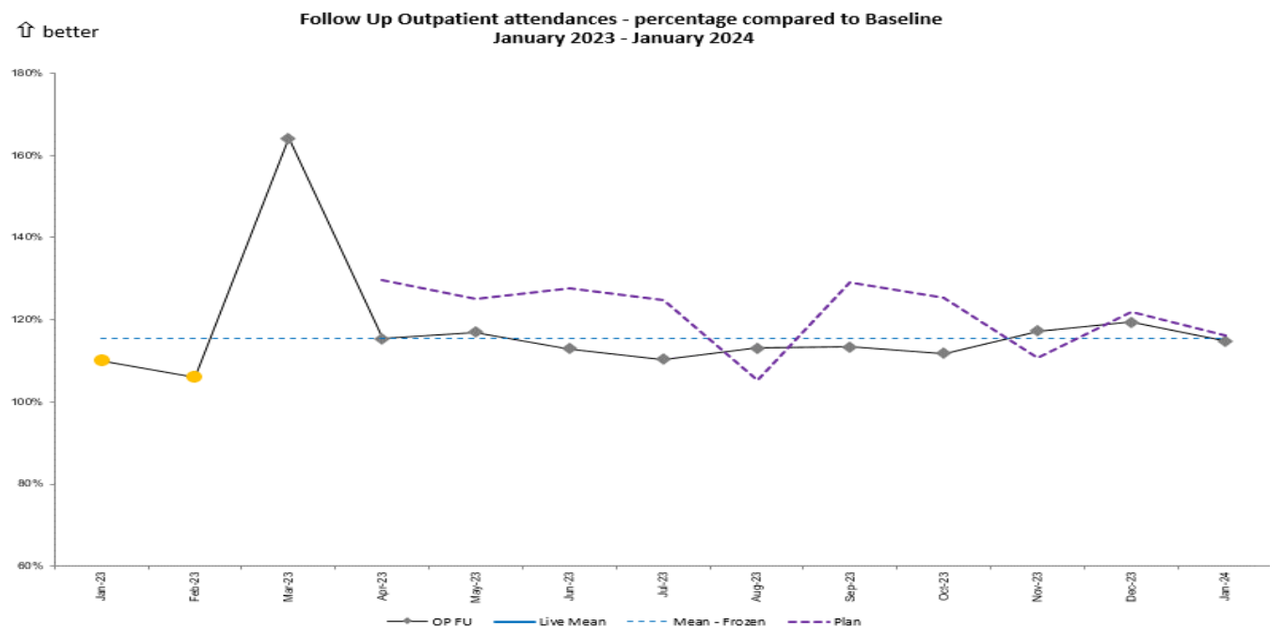
NHS
Cambridge University Hospitals
NHS Foundation Trust

Jan-24	Plan
114.8%	116.2%

SPC Variance
Normal variation

Shelford Group Avg (Jan-24)
N/A

Three Month Forecast		
Feb-24	Mar-24	Apr-24
123.9%	121.7%	#N/A



Divisional overview

Division	Performance
A	106.0%
B	124.6%
C	107.0%
D	109.6%
E	134.1%

Updates since previous month

CUH follow up activity increased in 2023 and remains adversely above the 100% CUH target for end March 2024. The January figure was 114.8%, 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 56,951 in January 2024. 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, with a 1.6% median rate of rise per month during this period.

Key dependencies

Physical capacity continues to be a problem across Outpatients. Services need to increase rapidly the number of Patient Not Present clinics they are delivering to minimise the need to see patients. This not only helps with the overall target but also freeze capacity to increase new appointments. Services also need to continue to validate their overdue follow-up backlog both for patient safety and data quality issues.

Future actions

Action being taken to address overdue follow ups includes waiting list validation and initiatives, and pathway redesign including PIFU, and early tests of Patient Not Present (PNP) remote monitoring. 6 specialties are currently using PNP, 4 more have PNP clinics built and available in Epic but completed PNP appointments have not yet been recorded on CHEQS. A further three specialities are in the eHospital PNP build pipeline, and others are having planning discussions to introduce PNP. This action needs to be encouraged at pace.

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

PIFU Outpatient Attendances

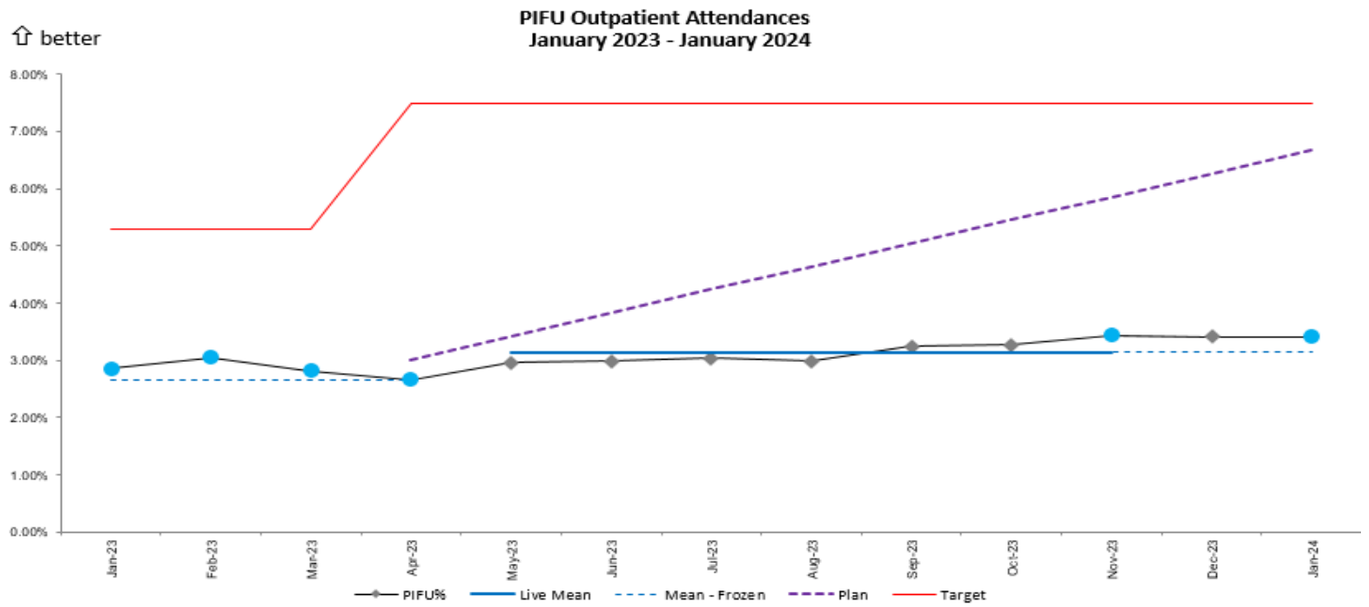
NHS
Cambridge University Hospitals
NHS Foundation Trust

Jan-24	Plan
3.4%	6.7%

SPC Variance
Positive special cause variation

Shelford Group Avg (Jan-24)
N/A

Three Month Forecast		
Feb-24	Mar-24	Apr-24
7.1%	7.5%	#N/A



Divisional overview

Division	Performance
A	7.1%
B	4.2%
C	2.0%
D	2.1%
E	2.8%

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. Our position as of January 2024 is 3.4%.

Current issues

None

Key dependencies

CHEQS data shows the correlation between PIFU and reduced follow ups. As of 08 February 2024, of the 79,447 PIFU orders placed since 2019 – 48,815 have expired. 91.1% expired with no follow up taking place which equates to 44,460 follow ups being saved / avoided due to a PIFU being in place.

Future actions

Divisions are encouraged to use the EoE outpatients transformation opportunity tool, and monthly data provided by the Improvement and Transformation team, to review PIFU usage at specialty and consultant level, and target action.

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

Page 24

Delayed discharges

NHS
Cambridge University Hospitals
NHS Foundation Trust

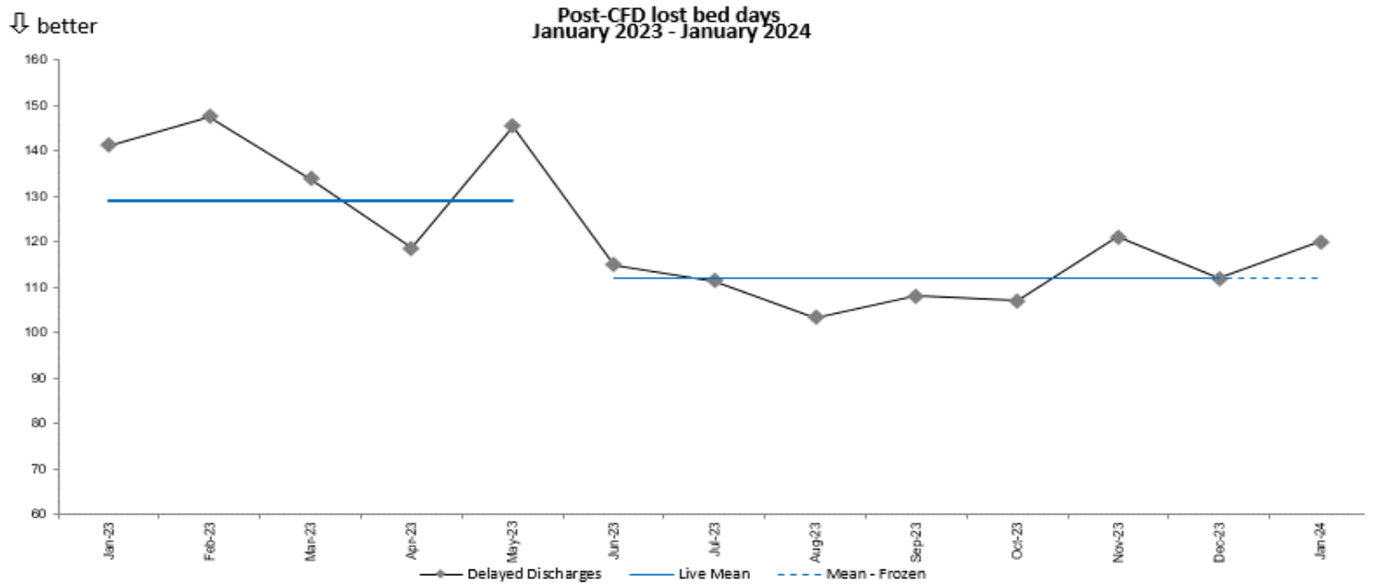
Jan-24	Target
120	N/A

SPC Variance
Normal variation

Shelford Group Avg (Jan-24)
N/A

Beds lost to delays - by pathway

Pathway	Beds lost
Pathway 1	48
Pathway 3	28
Pathway 2	22
Pathway 0	16
Internal Assessments	5
External Assessments	0
Triage	1
Unknown	0
Total	**120**



Updates since previous month

- In January the Trust lost 120 beds to complex patients remaining in an in-patient bed beyond their clinically fit date
- This compares to an average of 137 beds lost each month during 2022/23

Current issues

- Pathway 1 (care at home) remains the most significant patient group for beds lost with 48 beds in total (40%)
- Of the 120 beds lost in January, approximately 43 were lost due to internal processes

Key dependencies

- Delayed discharges are impacted by the availability of care packages in the community
- There remains an opportunity to optimise internal processes to reduce the number of beds lost

Future actions

- Reducing internal delays are a key part of our plans to improve in-patient length of stay (LoS) during 2024/25
- Work is currently underway to identify improvements to complex discharge pathways as part of the LoS programme for 2024/25.

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

Page 25

Theatre Utilisation - Elective GIRFT Capped

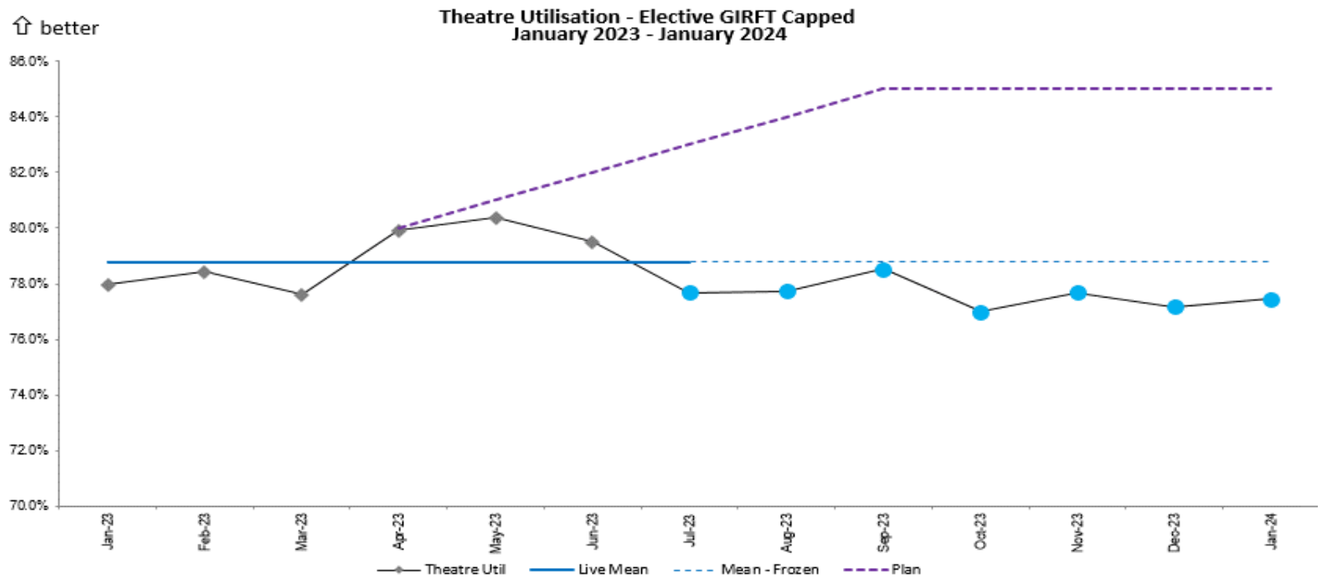
Cambridge University Hospitals NHS Foundation Trust

Jan-24	Plan
77.4%	85.0%

SPC Variance
Normal variation

Performance in the 2 weeks to 20/02/2024	
CUH	2600.0%
Shelford Grp Median	76.9%

Three Month Forecast		
Feb-24	Mar-24	Apr-24
85.0%	85.0%	#N/A



Utilisation by department

Department	Utilisation
ATC	78.5%
Main	77.9%
Rosie	63.6%
CMSH	84.2%
CEU	69.6%
Ely	71.6%

Updates since previous month

- Capped Utilisation across December was 77.4%.
- Excluding the Industrial Action period increases performance to 77.8%.
- Performance has slipped to Quartile 2, but remains above Shelford median. Imperial are in top quartile.
- Sessions used were 89% improving to 96.6% with Industrial Action dates excluded.

Current issues

- Four services achieved over 85% utilisation in month, with a further nine above 80%. Eight were below 70%.
- Short notice cancellations were 355 this month and again Ophthalmology have the highest volume at 52. 22 of which were clinical and 11 patient initiated.
- Overall 28% of cancellations were for clinical reasons, 18% patient initiated and 16% due to bed capacity. 23% were in advance of the day of surgery.

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.
- L2DSU maintaining core function as DOSA and 23hr stay elective facility.

Future actions

- Cancellation data again supports that standby patients should be a targeted initiative in Ophthalmology where bed capacity is less of a constraint.
- Ophthalmology has requested support from Surgery Programme Board with their delays in pre-assessment that are preventing them have sufficient pool of patients.
- Neurosurgery bed related cancellations were 5% of total cancellations. Ward reconfiguration, LOS programme and timely repatriation need to remain a key focus.

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

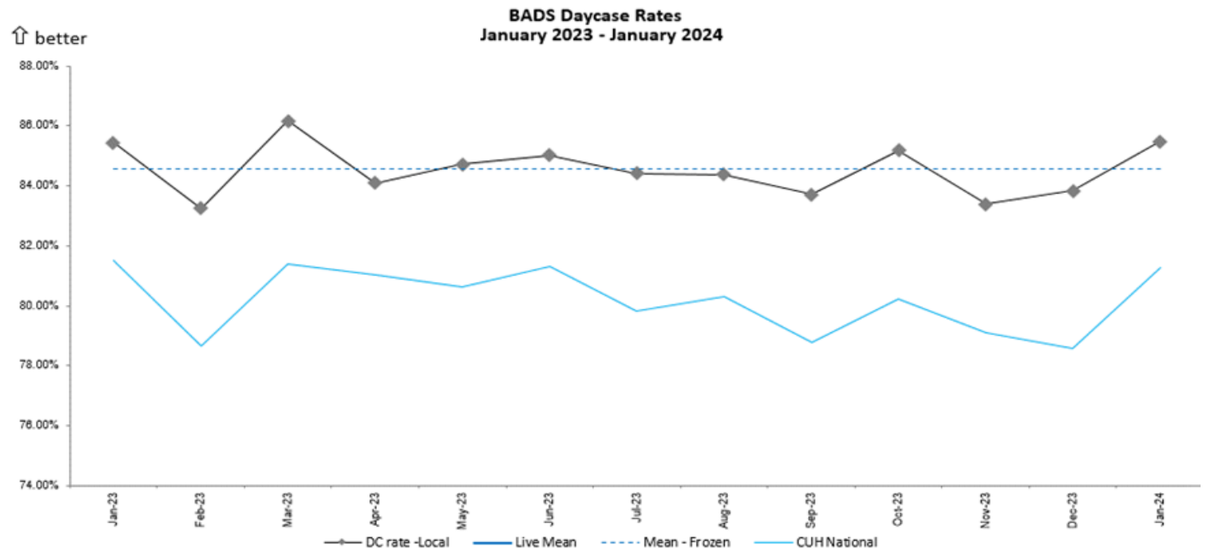
BADS Daycase Rates

NHS
Cambridge University Hospitals
NHS Foundation Trust

Jan-24	Target
85.5%	N/A

SPC Variance
Normal variation

Performance in the 3 months to end of Nov 23	
CUH	76.9%
Shelford Grp Median	78.0%



BADS Section Day Case Rate for HVLC focus areas

	3 months to end of Nov '23			Jan-24
Specialty	CUH	Shelford	Quartile	Local
Orthopaedics	84.8%	82.8%	2	97.7%
ENT	70.9%	81.5%	1	93.8%
General	66.0%	68.0%	1	86.1%
Gynaecology	49.1%	62.6%	1	76.2%
Ophthalmology	97.2%	97.6%	1	91.7%
Urology	66.0%	69.1%	2	60.0%

Updates since previous month

- Model Hospital GIRFT data for 3months to Nov 2023 still shows low performance in quartile 1.
- Local BADS reporting for zero LOS however did reflect improved performance in January up to 85.5%, in line with the GIRFT target.

Current issues

- Inaccurate listing of Intended Management. 47 zero LOS BADS procedures listed as inpatient which is a reduction on last month.
- 19% of the >0 LOS. were in ENT of which 50% were thyroid procedures. 17% were in Urology.
- 50% >0 LOS were 23hr stay on L2 or F3, therefore 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

- Detail on incorrect intended management being circulated to Specialties each month at SPB.
- Urology deep dive into Ureteroscopy complete due to Quartile 2 benchmark, and refinements to practice identified.
- Urology TURBT day case rate continues to be in top quartile Nationally despite being one of the higher volume BADS procedures > 0 LOS

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

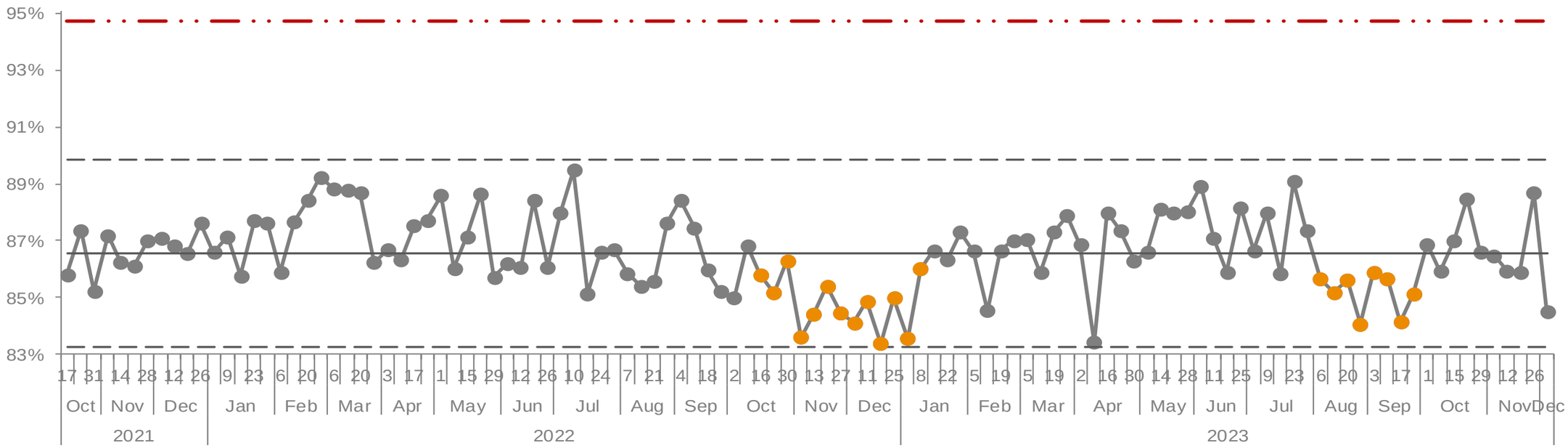
Page 27

Discharge Summaries

Cambridge University Hospitals NHS Foundation Trust

Discharge Summary Letters (Weekly)

Percent of discharge summaries sent in under 2 days



Discharge summaries

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

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

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

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

Page 28

Patient Experience - Friends & Family Test (FFT)

NHS Cambridge University Hospitals NHS Foundation Trust

The good experience and poor experience indicators omit neutral responses.

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
FFT Inpatient good experience score	Jul 20 - Jan 24	Month	-	93.0%	95.0%	L	S7	-	For January, the Good FFT score remained the same compared to December. However the Poor FFT score increased by almost 2% and is now 4%. December Poor score was one of the lowest for the year and January score is the same as Oct and Nov. **FOR JAN: there were 379 FFT responses collected from approx. 4,106 patients.**
FFT Inpatient poor experience score	Jul 20 - Jan 24	Month	-	4.0%	2.0%	H	SP	-	
FFT Outpatients good experience score	Apr 20 - Jan 24	Month	-	94.2%	94.8%	L	S7	-	For January, there was a very slight increase in the Good score compared to December and the score is now one of the best for the year. The Poor score also slighty improved and 2.8% is one of the lowest for the year. 0 paediatric FFT was collected in Jan **FOR JAN: there were 5,322 FFT responses collected from approx. 30,833 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 - Jan 24	Month	-	2.8%	2.5%	H	S7	-	
FFT Day Case good experience score	Apr 20 - Jan 24	Month	-	95.2%	96.4%		-	-	For January, there was no change in the Good score compared to December. The Poor score improved by 0.5% compared to Dec. Although both scores are the lowest/highest for the year, it is not a concern. The Good score remains around 95% and the Poor score below 3%. **FOR JAN: there were 1,239 FFT responses collected from approx. 4,684 patients.**
FFT Day Case poor experience score	Apr 20 - Jan 24	Month	-	2.5%	1.8%		-	-	
FFT Emergency Department good experience score	Apr 20 - Jan 24	Month	-	77.7%	82.6%	L	S7	-	For January, the Good score decreased by 3% compared to December and is one of the lowest scores for the year. The Poor score increased by 2% and the score of 13.3% is one of the highest for the year. Both adult and paediatric ED scores increased by 2% /declined by 2%. **FOR JAN: there were 927 FFT responses collected from approx. 5,552 patients**.
FFT Emergency Department poor experience score	Apr 20 - Jan 24	Month	-	13.3%	10.7%	H	S7	-	
FFT Maternity (all FFT data from 4 touchpoints) good experience score	Jul 20 - Jan 24	Month	-	82.8%	94.2%	L	SP	-	**FOR JAN:** Antenatal had 6 FFT response - 100% Good; Birth had 44 FFT responses out of 435 patients - 84% Good/ 9% Poor; Postnatal had 107 FFT responses: LM had 78 FFT with 75.6% Good/14.1% Poor, DU had 1 FFT with 100% Good, BU had 28 FFT with 96.4% Good/3.6% Poor. 0 FFT responses from Post Community. **JAN MATERNITY OVERALL:** Good score decreased by 7% and Poor score increased by 6% from 157 FFT responses.
FFT Maternity (all FFT data from 4 touchpoints) poor experience score	Jul 20 - Jan 24	Month	-	10.2%	2.3%	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 December 15 wards did not collect any FFT data.

January FFT scores either remained the same compared to December, or declined in the Good score and increased in the Poor score. The day unit and outpatients Good score remained the same and the Poor score improved. Whereas the inpatient Good score remained the same, but the Poor score increased by 2%. ED FFT scores declined in the Good score for both adult and paeds, and the Poor score increased for both adult and paeds.

Overall maternity FFT scores had a decrease by 7% of the Good score to 82.8% and the Poor score increased to 10.2%. This was from Birth and Postnatal performance. There was an improvement in the number of FFT collected. December had a very low number of 60 and January there are 130 FFT scores overall, with Lady Mary having an improvement of 78 FFT scores.

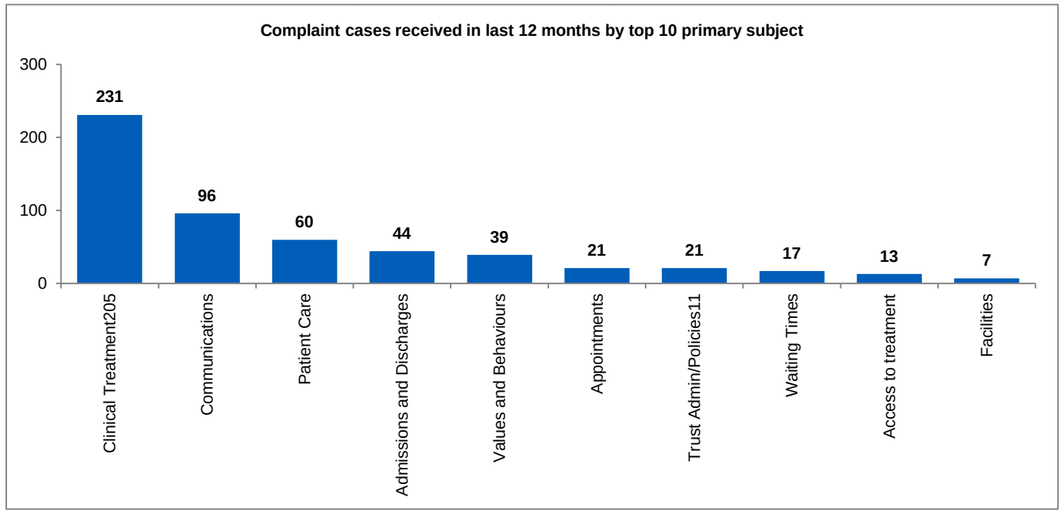
Please note starting in 2022, the Trust reduced the number of SMS being sent to adult patients. Instead of sending a text message to every adult patient that attend an OP/DU appointment, or presented to A&E, the Trust now sends a fixed number of SMS daily.

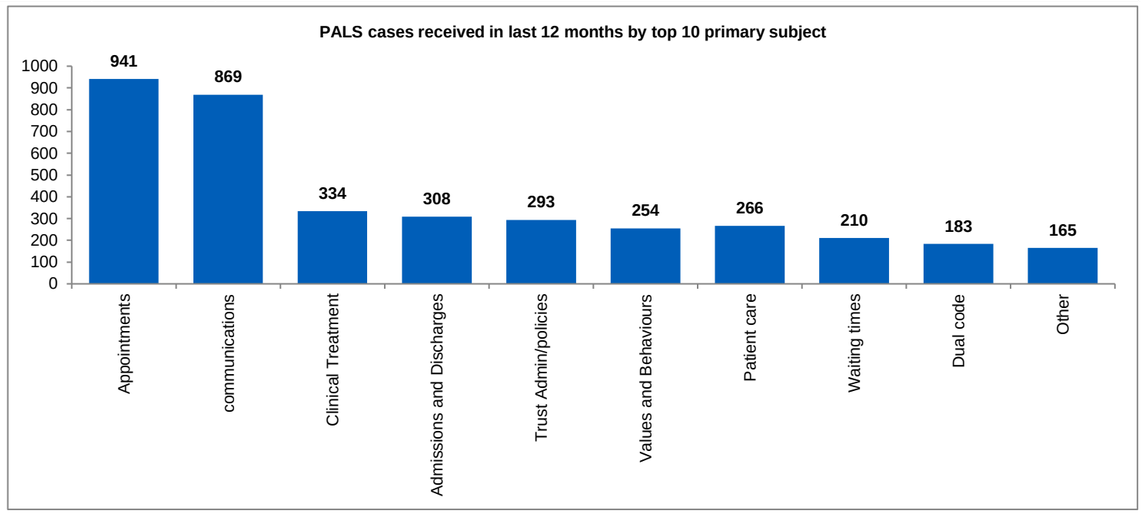
Author(s): Charlotte Smith/Kate Homan Owner(s): Clare Hawkins

PALS and Complaints Cases

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
Complaints received	Jan 20 - Jan 24	month	-	63	55	H	SP	-	The number of complaints received between Jan 2020 - January 2024 is higher than normal variance.
% acknowledged within 3 days	Jan 20 - Jan 24	month	95%	95%	73%		-	?	60 out of 63 complaints were acknowledged within 3 working days
% responded to within initial set timeframe (30, 45 or 60 working days)	Jan 20 - Jan 24	month	50%	50%	30%	L	S7	?	86 complaints were responded to in January, 43 of the 86 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	Jan 20 - Jan 24	month	80%	52%	87%	L	SP	?	45 out of 86 complaints responded to in January were within the initial set time frame or within an agreed extension date.
% complaints received graded 4 to 5	Jan 20 - Jan 24	month	-	16%	34%		-	-	There were 10 complaints graded 4 severity, and 0 graded 5. These cover a number of specialties and will be subject to detailed investigations.
Compliments received	Jan 20 - Jan 24	month	-	38	32	L	S7	-	38 Compliments were registered during January and sent onto relevant staff for information





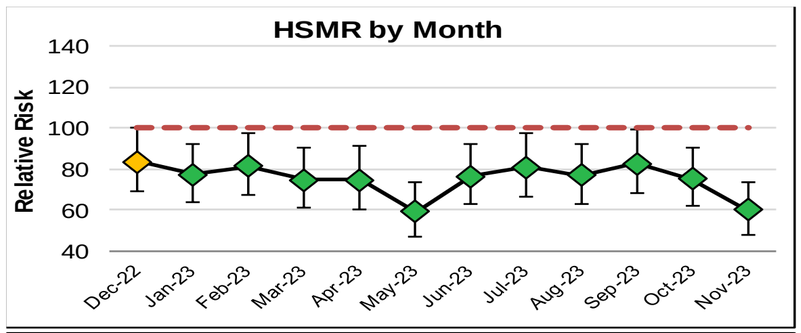
PHSO - There were no cases taken for investigation in January 2024 by the Parliamentary and Health Service Ombudsman.
A backlog of complaint responses (550) declared in May 2023 has now been brought down to less than 10. A new process has been introduced within the complaints team to try to resolve issues raised much quicker by engaging the Divisions at the outset to reduce the number of lengthy responses. Meetings and telephone conversations are being offered to all complainants as an option rather than a written response.

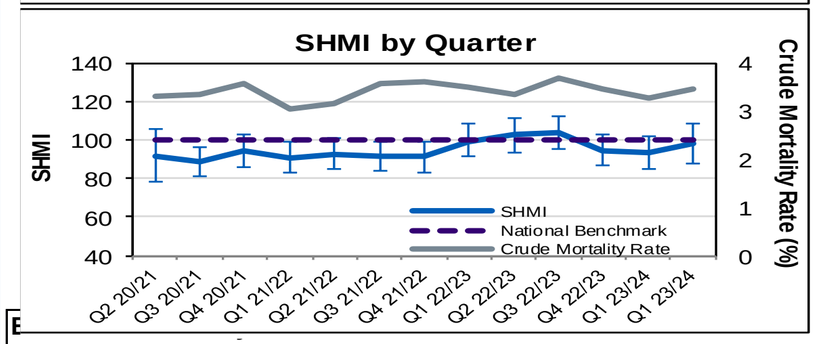
Author(s): Sue Bennison **Owner(s): Clare Hawkins**

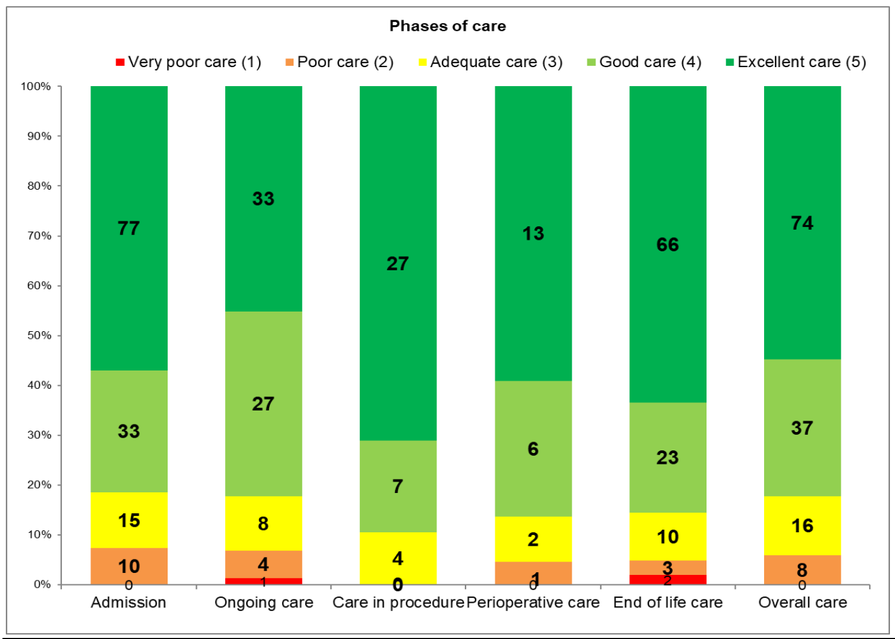
Learning from Deaths

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Data range	Jan-24	Mean	Variance	Comments
Total inpatient and Emergency department deaths	February 2019 - January 2024	**164**	*137*		
Total Emergency Department and Inpatient deaths **per 1000 admissions**		**9.1**	*8.6*		
Emergency department deaths per 1,000 attendances		**1**	*0.9*		
Inpatient deaths by 1,000 admissions		**10.1**	*10.3*		
NON-elective admission deaths by 1,000 admissions		**33**	*28.6*		
% of Emergency Department and Inpatient deaths in-scope for a Structured Judgement Review (SJR)		**18%**	*20%*		In January 2024, 29 SJRs were commissioned.





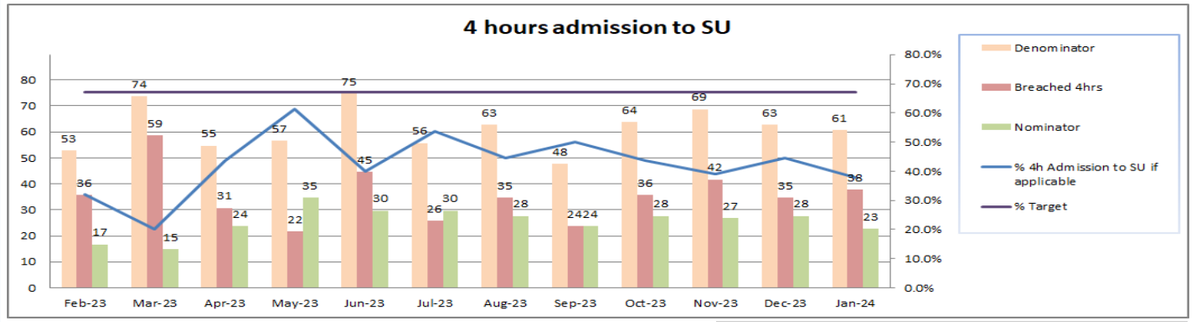


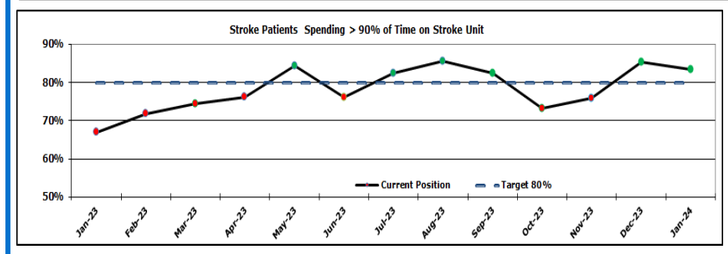
HSMR - The rolling 12 month (December 2022 to November 2023) HSMR for CUH is 75.31, this is 3rd lowest within the London and ATHOL peer group. The rolling 12 month HSMR for the Shelford Peer group is 89.54.
SHMI - The Summary Hospital-level Mortality Indicator (SHMI) for CUH in the latest period, September 2022 to August 2023 is 97.88.
Alert - There are 0 alerts for review within the HSMR and SHMI dataset this month.
There was one SJR judged as to having an overall Problems in care score of 3 - this is currently being reviewed.

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

Stroke Care

Cambridge University Hospitals NHS Foundation Trust





Themes - 4h to SU breaches	MRNs
Awaiting senior review	13
NCCU admission	1
Not referred on arrival	4
Trust bed capacity	19
Unsure if stroke. MRI confirmed	1
Grand Total	38

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%)
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%
Dec-23		4		1	3	1	1				1			11	85.3%
Jan-24	2	6			2						3			13	83.5%
Summary	11	83	0	5	19	17	3	2	3	0	34	4	0	181	

90% target (80% Patients spending 90% IP stay on Stroke ward) was achieved for January 2024= **83.5%**

Trust bed capacity (6) was the main factor contributing to breaches last month, with a total of 13 breaches in January 2024.

4hrs adm to SU (67%) target compliance was not achieved in January 2024= 37.7%

Key Actions

Work continues to protect 2 x ring-fenced beds on R2 (one male and one female)

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 interviews to take place end of February

National SSNAP data shows Trust performance from July -Sept 2023 at Level A. The team is formulating a plan to try to maintain this progress

Weekly review with root cause analysis undertaken for all breaches, with actions taken forward appropriately.

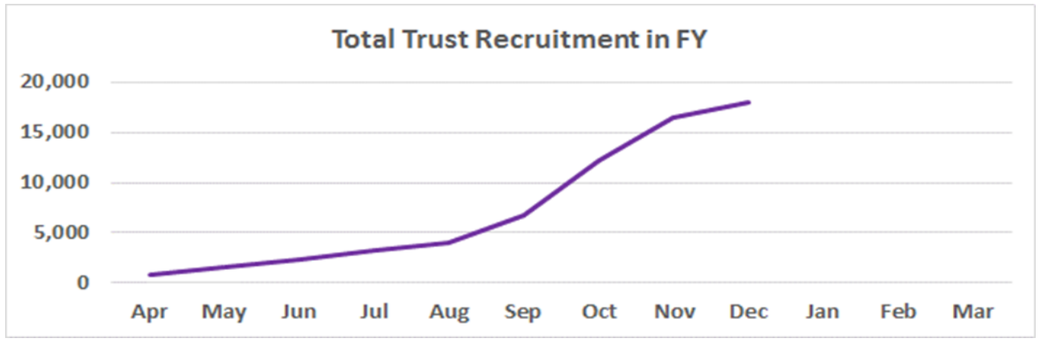
The stroke bleep team continue to see over 200 referrals in ED a month, many of those are stroke mimics or TIAs. TIA patients are increasingly treated and discharged from ED with clinic follow up. Many stroke mimics are also discharged rapidly by stroke team from ED. For every stroke patient seen, we 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. We have worked through pathway with Acute Medicine and the plan is to go live April 2024

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

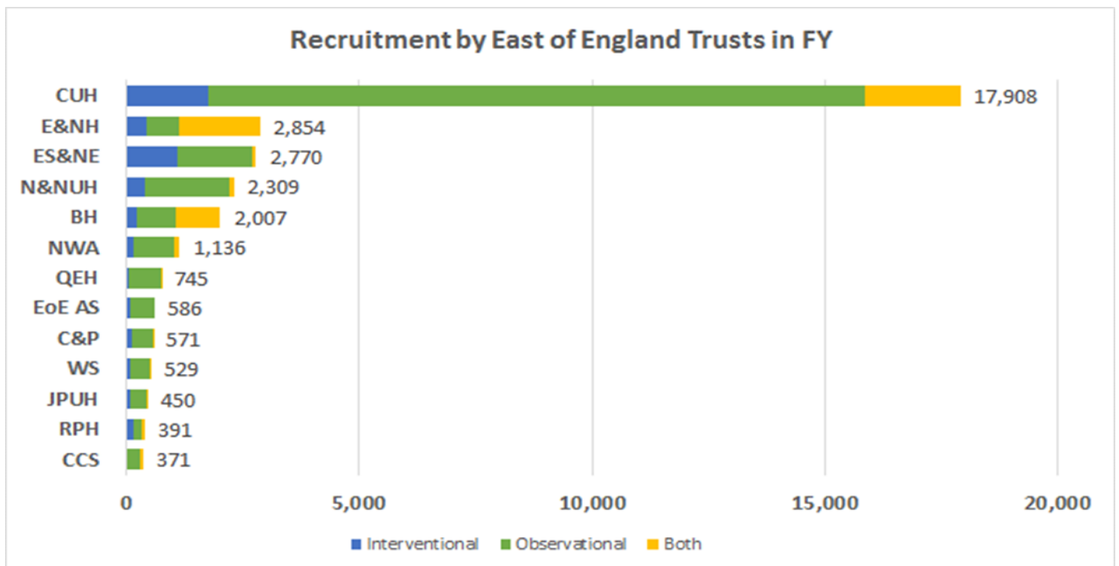
Clinical Studies

NHS
Cambridge University Hospitals
NHS Foundation Trust



Total Recruitment at end of Dec - FY 2023-24
17,908

Recruiting Studies at end of December for FY 2023-24			
Open	274	Non Commercial	276
Closed	56	Commercial	57
Suspended	3		
Total	**333**		



Situation as at end of Q3 2023/24 (Data cut: 17/01/2024)

* Total recruitment in the financial year to date: 17,908. The significant increase from September was driven by the Bioresource - Genes & cognition Study. This is a questionnaire based study and the Bioresource has a large cohort to recruit participants from (target = 40,000) and accounted for 80% of CUH recruitment from September to Dec.
* CUH accounted for 53% of total recruitment by Eastern Trusts in the financial year to date.
* Recruitment to the Dementias and Neurodegeneration speciality accounted for 63% of all recruitment (driven by the Bioresource - Genes & cognition Study). Reproductive Health and Childbirth accounted for 15%. All of the other individual specialities accounted for less than 6% of the total recruitment.
* There were 333 recruiting studies, of which 57 were Commercial, and 276 Non-Commercial.

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

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

Maternity Dashboard

NHS Cambridge University Hospitals NHS Foundation Trust

Compliance

Assessed compliance with CNST MIS 10 Safety Actions Yr 5		
	Please identify unit	CUH
1	Perinatal Mortality review tool	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
Repayment of CNST (since introduction) Y/N and MIS yr		N

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

Key (current position)		Insert (to automatic
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

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

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

Maternity Dashboard

NHS
Cambridge University Hospitals
NHS Foundation Trust

Clinical Outcome Measures

KPI (see final slide for detail)	Measurement / Target		Numerator / Denominator		
			Numerator	denominator	%
Massive Obstetric Haemorrhage ≥ 1500 mls	Vaginal birth	3.30%	**16**	**254**	**6.30%**
(as per NMPA descriptor, slide 8)	Caesarean	4.50%	5	144	**3.47%**
3rd & 4th degree tear	SVD (unassisted)	Unassisted 2.5%	3	210	**1.43%**
(as per NMPA descriptor, slide)	Instrumental (assisted)	Assisted 6.3%	3	44	**6.82%**
Caesarean section (%age)	(see guidance document)	overall rate not required			
(primip, singleton , ceph, over 37/40, spontaneous labour)	Robson Group 1	N/A	16	78	**20.51%**
[primip, singleton, over 37/40, who had labour induced (2a) or LSCS prior to labour (2b)]	Robson Group 2 **2**	N/A	53	96	**55.21%**
	2a		34	77	**44.16%**
(Multip, at least 1 uterine scar, singleton, ceph, over 37/40)	Robson Group 5	N/A	43	58	**74.14%**
Smoking at time of delivery		≤ 6%	25	435	**5.75%**
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))	502	5436	**9.23%**
	16+0 - 23+6 (SBLCBv3)	%age of all singleton births (live & stillborn)	3	432	**0.69%**
	24+0 - 36+6 (SBLCBv3)	%age of all singleton births (live & stillborn)	31	432	**7.18%**

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 births with congenital abnormalites 3.71/1000 births excluding deaths due to congenital abnormalities	2.40/1000	6.49/1000

KPI (see final slide for detail)	Measurement / Target		Numerator / denominator		
			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)	missing data	missing data	
		%age of total admissions that were avoidable	**missing data**	**missing data**	
Optimisation (metrics to be determined locally as per SBLBCv3) **please see the implementation tool for technical guidance**			**Oct'23 data**		
Right place of birth		local agreement **%**	missing data	missing data	
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)			missing data	missing data	
Antenatal corticosteroids			missing data	missing data	
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%	missing data	missing data	
Magnesium sulphate			missing data	missing data	
Percentage of babies born before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth		local agreement 90%	missing data	missing data	
IV antibiotics			missing data	missing data	
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%	missing data	missing data	
Optimal Cord Clamping			missing data	missing data	
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%	missing data	missing data	
Thermoregulation			missing data	missing data	
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%	missing data	missing data	
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%	11	17	65%

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

Page 35

Maternity Dashboard

NHS Cambridge University Hospitals NHS Foundation Trust

KPI	Goal	Target	Measure	Data Source	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	SPC	Narrative and Actions taken for Red/Amber/Special cause concerning trend results
Activity												
Births	For information	N/A	Births per month	CHEQs	466	443	472	469	446	438	5457	
Health and social care assessment <GA 12+6/40	> 90%	>=90% <90% and >=80% <80%	In area booking appointments	Epic	95.05%	86.75%	99.09%	94.74%	95.86%	97.31%		
Booking Appointments	For Information	N/A	Booking Appointments	Epic	343	400	330	352	290	372		
Vaginal Birth (Unassisted)	For Information	N/A	SVDs in all birth settings	CHEQs	49.79%	49.89%	51.48%	48.83%	45.52%	51.50%		
Home Birth	For Information	N/A	Planned home births (BBA is excluded)	CHEQs	0.86%	1.13%	1.69%	0.85%	1.57%	0.68%		
Rosie Birth Centre Birth	For Information	N/A	Births on the Rosie Birth Centre	CHEQs	13.52%	16.93%	15.04%	13.86%	12.78%	18.26%		
Rosie Birth Centre transfers	For information	N/A	Women admitted to RBC and subsequently transferred for birth	CHEQs	42.39%	29.03%	37.96%	43.16%	36.00%	29.16%		
Birth assisted by instrument (forceps or ventouse) (Instrumental)	For Information	N/A	Instrumental birth rate	CHEQs	9.87%	9.48%	10.17%	11.94%	12.33%	10.50%		
CS rate (planned & unplanned)	For Information	N/A	C/S rate overall	CHEQs	39.70%	40.18%	37.71%	38.38%	42.15%	37.90%		
Women in RG*1 having a caesarean section with no previous births: nullip spontaneous labour	For information	10%	Relative contribution of the Robson group to the overall C/S Rate	CHEQs	16.10%	18.50%	12.90%	24.30%	20.50%	20.50%		
Women in RG*2 having a caesarean section with no previous births: nullip induced labour, nullip pre-labour LSCS	For Information	For Information	Relative contribution of the Robson group to the overall C/S Rate	CHEQs	47.90%	51.00%	57.30%	48.10%	48.50%	55.20%		
Ratio of women in RG1 to RG2	Ratio of >2:1	N/A	Ratio of group 1 to 2 should be 2:1 or higher	CHEQs	1:2.98	1:3.53	1:5	1:2.08	1:2.82	1:3.31		
Women in RG*5. Multips with 1 or 2+ previous C/S	For Information	For Information	Relative contribution of the Robson group to the overall C/S Rate	CHEQs	88.2%	91.5%	77.4%	77.3%	80.3%	74.1%		
Women in RG1, RG2, RG5 combined contribution to the overall C/S rate.	66%	60-70%,	Relative contribution of the Robson group to the overall C/S Rate	CHEQs	62.2%	68.5%	60.1%	61.7%	64.4%	67.4%		
Induction of Labour rate	For Information	N/A	Percentage of women induced for birth	CHEQs	33.48%	34.18%	31.84%	31.66%	30.59%	32.87%		
Delay in commencement of Induction (IOL)	0%	<10%	Percentage of Inductions where Induction commencement was postponed >2 hours (flag 1)	CHEQs	24.87%	34.88%	28.74%	25.95%	22.65%	32.77%		
Delay in continuation of Induction (IOL)	0%	<10%	Percentage of Induction continuation when suitable for ARM delayed for more than 6 hours (flag 3)	CHEQs	10.05%	15.00%	14.37%	10.81%	11.05%	32.08%		CQC workstream for IOL improvements in place for 'should do'. Large increase in figure this month due to data quality checking to ensure reporting robust. ARMable status is under documented (N=21), underreporting the denominator. True denominator is 53. 17 women waited longer than 6 hours.
Indication for IOL (SBLCBV3)	0%	5-10%	Percentage of IOL where reduced fetal movements is the only indication before 39 weeks (denominator = all IOLs <39 weeks).	IOL Team	5%	0%	7%	6%	0%	1%		
Indication for IOL	100%	≥95%	Percentage of IOL with a valid indication as per guidance (or a consultant plan if outside guidance).	IOL Team	98.70%	100%	97%	99%	100%	100%		
Divert Status - incidence	0	<1	Incidence of divert for the perinatal service	Rosie Diverts	2	1	1	2	5	3		56.75 hours total. 79% of divert status due to NICU staffing and capacity, 21% due to maternity staffing and capacity. 5 women diverted to other organisations, 2 of these women birthed in other organisations, no moderate harm or above incidents. There were no moderate harm incidents internally during the periods of divert.
Total number of hours on divert	For information	N/A	Hours:minutes	Rosie Diverts	27.50	18.08	21.25	30.20	70.00	57:15		
Admissions to Rosie during divert status	For information	N/A	Numberof women admitted to the Rosie during divert based on Admissions Report	CHEQs	7	12	10	21	32	25		
Number of women giving birth in another provider organisation due to divert status	For information	N/A	Whole number of pregnant women	CHEQs	2	1	1	1	3	2		
Number of IUTs declined due to maternity services capacity/staffing	0	0	Whole number of pregnant women	EBS data	8	1	0	1				Reported 1 month behind.

Maternity Dashboard

NHS Cambridge University Hospitals NHS Foundation Trust

Workforce												
Midwife/birth ratio (actual)**	1:24	<1.28	Total permanent and bank clinical midwife WTE*/Births (rolling 12 month average)	Finance	1:25.2	1:25.1	1:23.1	1:22.4	1:22.5	1:22		
Midwife/birth ratio (funded)**	For information	1.24.1	Total clinical midwife funded WTE*/Births (rolling 12 month average based on the BR+	Finance	1:23.4	1:23.2	1:23.1	1:23.1	1:23.1	1:23.2		
Supernumerary Delivery Unit Coordinator	100%	≥95%	Percentage compliance with Delivery Unit coordinator remaining supernumerary (no high risk 1:1 or labour 1:1 care	BR+ RF11	100%	100%	98%	100%	100%	100%		
Staff sickness as a whole	< 3.5%	<5%	ESR Workforce Data	CHEQs	4.29%	4.37%	4.49%	4.54%	4.64%			Reports one month behind. Special improving cause noted.
Education & Training - mandatory training - overall compliance (obstetrics and gynaecology)	>92% YTD	>75% YTD	Total Obstetric and Gynaecology Staff (all staff groups) compliant with mandatory training	CHEQs	93.0%	92.7%	91.1%	91.4%	91.3%			Reports two months behind.
Education and Training - Training Compliance for all staff groups: **Prompt**	>90% YTD	>85% YTD	Total multidisciplinary obstetric staff compliant with annual Prompt training	PD	86.80%	82.60%	94.56%	92.41%	89.67%	86.00%		
Education and Training - Training Compliance for all staff groups: **NBLS as per MIS requirements**	>90% YTD	>85% YTD	Total multidisciplinary staff providing "attending births" within maternity services compliant with annual NBLS training	Resus Services	80%	75%	75%	81%	79%	83%		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	Total multidisciplinary staff passed K2 competences.	Fetal surveillance MW	84.20%	80.60%	88.10%	91.20%	76.60%			Transitioning from K2 to DOT for compentency assessment. New DOT module not available until Feb 2024 therefore drop in compliance.
Education and Training - Training Compliance for all staff groups: **Fetal Surveillance competency**	>90% YTD	>85% YTD	Total multidisciplinary staff attended the study day and passed competency .	Fetal Surveillance MW								Data to be reported from Feb 2024
Education and Training - Training Compliance for all Staff Groups - **Fetal Surveillance Study Day**	>90% YTD	>85% YTD	Total multidisciplinary staff compliant with annual fetal surveillance study day attendance.	Fetal surveillance MW	86.60%	88.00%	84.50%	91.40%	92.40%	93.50%		CNST MIS year 5 compliance target exceeded for all staff groups and maintained for a further month.
Education & Training - mandatory training - **midwifery compliance**.	>92% YTD	>75% YTD	Proportion of midwifery compliance with mandatory training, inclusive of mandated e-learning and mandated face to face sessions.	CHEQs	93.5%	93.0%	90.3%	90.2%	91%			Reports one month behind.
Maternal morbidity												
Puerperal Sepsis	For information	N/A	Incidence of puerperal sepsis within 42 days of birth	CHEQs	0.43%	0.46%	0.43%	0.44%	0.23%	0.46%		
ITU Admissions in Obstetrics	For information	N/A	Total number of pregnant / postnatal women admitted to the intensive care unit	CHEQs / QSIS	0	2	1	1	0	0		
Massive Obstetric Haemorrhage ≥ 1500 mls - vaginal birth	≤3.3%	≤3.3%	Percentage of women with a PPH >1500mls (singleton births between 37+0-42+6) having a vaginal birth	Rosie KPIs	5.30%	5.58%	4.61%	5.88%	3.66%	6.30%		CQC workstream for PPH improvements ongoing and reported to MIOB. Robust campaign launched, assessing impact via QI methodology.
Massive Obstetric Haemorrhage ≥ 1500 mls - caesarean birth	≤4.5%	≤4.5%	Percentage of women with a PPH ≥1500mls (singleton births between 37+0-42+6) having a caesarean section	Rosie KPIs	6.08%	6.00%	3.97%	4.00%	4.49%	3.47%		
3rd/ 4th degree tear rate	≤3.5	<5%	Percentage of women with a vaginal birth having a 3rd or 4th degree tear (spontaneous and assisted by instrument) singleton baby in cephalic	Rosie KPIs	3.04%	4.84%	4.33%	4.80%	2.85%	2.37%		
Maternal readmission rate	For information	N/A	Percentage of women readmitted to maternity service within 42 days of birth.	Rosie KPIs	2.56%	2.63%	1.63%	2.38%	2.74%	2.29%		
Peripartum Hysterectomy	For information	N/A	Incidence of peripartum hysterectomy	CHEQs / QSIS	0	0	0	0	0	0		
Direct Maternal Death	0	<1		QSIS	0	0	0	0	0	0		

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

Maternity Dashboard

NHS Cambridge University Hospitals NHS Foundation Trust

Governance												
Total number of Serious Incidents (SIs)	0	<1	Serious Incidents	QSIS	0	1	0	0	0	0		
Never Events	0	<1	DATIX	QSIS	0	0	0	0	0	0		
Neonatal Morbidity												
Still Births per 1000 Births	3.55/1000 (MBRRACE-UK 2024)	rolling rate	Incidence per 1000 births	CHEQs	3.81:1000	3.65:1000	3.85:1000	3.85:1000	3.85:1000	3.48:1000 (19:5457)		Dec'23 MBRRACE-UK report England rate = 3.55
Stillbirths - number ≥ 22 weeks	<3	<6	MBBRACE	CHEQs	2	1	2	0	1	0		
Number of birth injuries	0	<1	Percentage of babies born with a birth related injury	CHEQs	1	2	0	0	0	0		
Babies born with an Apgar <7 at 5 minutes of age	For information	N/A	Percentage of babies born who have an Apgar score <7 at 5 minutes of age	Rosie KPIs	2.81%	1.59%	2.99%	1.28%	2.48%	1.84%		
Incidence of neonatal readmission	For information	N/A	Percentage of babies readmitted within 42 days of birth	Rosie KPIs	4.74%	4.82%	8.26%	4.21%	4.71%	4.79%		
Term Admission to NICU Rate	<6%	N/A	Rate	ATAIN report	4.9%	5.6%	5.7%	6.4%	6.1%	TBC		Awaiting data
Quality												
1-1 Care in Labour	100%	100%	Percentage of women receiving 1:1 care in labour (excluding BBAs)	Rosie KPI's	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%		Sept and Nov previously reported as <100% but on further quality checks for CNST submission confirmed no missed 1:1 care.
Babies with a first feed of breastmilk	≥80%	≥70%	Breastfeeding	Rosie KPI's	82.68%	81.41%	78.25%	80.73%	82.84%	80.87%		
SATOD (Smoking at Time of Delivery)	< 6%	Green = <6%, Amber = 6.1% - 7.9 %, Red = >8	% of women Identified as smoking at the time of delivery	Rosie KPIs	4.78%	6.70%	5.98%	2.84%	3.20%	5.75%		
CO Monitoring at booking	≥95%	Green = ≥95%, amber = <95% and ≥84%, red = <85%	Compliance with recording CO Monitoring reading at booking appointment (excluding out of area)	Smoking Report with manual checks	82%	87%	97%	91%	89%	94%		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%	Compliance with recording CO Monitoring reading at 36 week appointment (excluding out of area)	Smoking Report with manual checks	67%	60%	65%	76%	75%	64%		CO monitoring at every AN appointment introduced in Dec to encourage standardised practice and thereby improve compliance.
VTE Assessment - AN	≥95%	Green = ≥95%, amber = <95% and ≥90%, red = <90%	Percentage of women with a valid VTE risk assessment completed **within 14 hours** of admission to hospital.	CHEQs	72%	76%	78%	90%	81%	85%		Ward Managers asked to investigate non compliance and report back to directorate governance.
VTE Assessment - PN	≥95%	Green = ≥95%, amber = <95% and ≥90%, red = <90%	Percentage of women with a valid PN VTE risk assessment completed **within 8 hours** of birth.	CHEQs	94%	95%	95%	96%	93%	96%		

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

Finance

NHS
Cambridge University Hospitals
NHS Foundation Trust

Trust performance summary - Key indicators

Trust actual surplus / (deficit)

(£0.8m)	*Actual (adjusted)**
(£0.8m)	*Plan (adjusted)**
£1.1m	*Actual YTD (adjusted)**
£1.1m	*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	£21.0m	£184.9m
Target adj. block increase	£1.0m	£9.3m
EPM actual + block increase	£22.0m	£194.2m
EPM original plan	£21.7m	£201.4m
EPM original target	£18.8m	£175.8m

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

Net current assets

(£91.6m)	*Actual*
(£48.2m)	*Plan*

Debtor days

23	*This month*
39	*Previous month*

Payables performance (YTD) **

85.5%	*Value*
85.9%	*Quantity*

EBITDA

£36.7m	*Actual YTD*
£33.1m	*Plan YTD*

Capital expenditure

£3.0m	*Capital - actual spend in month*
£33.6m	*Capital - actual spend YTD*
£31.8m	*Capital – plan YTD*

Cash

Cash

£127.4m	*Actual*
£145.1m	*Plan*

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

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

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

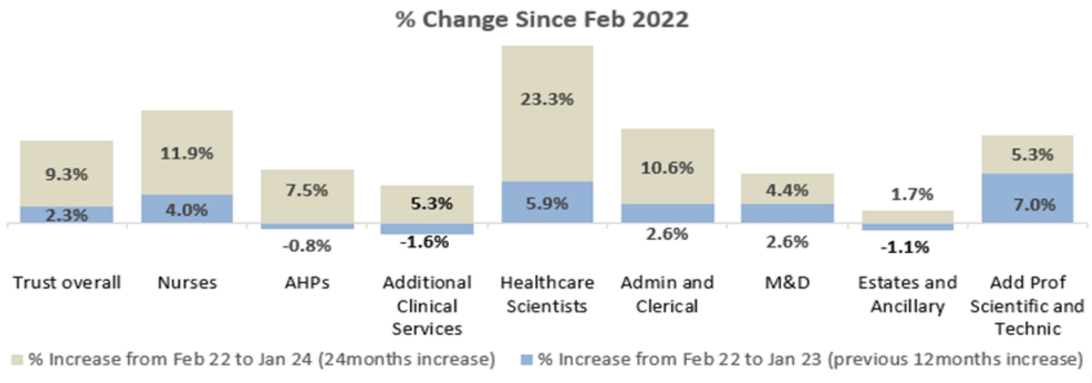
Page 39

Staff in Post

NHS
Cambridge University Hospitals
NHS Foundation Trust

12 Month Growth by Staff Group

Staff Group	Headcount		Headcount 12 Month growth		FTE		FTE 12 Month growth	
	Feb-23	Jan-24			Feb-23	Jan-24		
Add Prof Scientific and Technic	259	256	↓	-1.2%	234	231	-4	↓ -1.5%
Additional Clinical Services	1,975	2,128	↑	7.7%	1,814	1,940	125	↑ 6.9%
Administrative and Clerical	2,469	2,648	↑	7.2%	2,273	2,438	165	↑ 7.3%
Allied Health Professionals	736	798	↑	8.4%	653	709	56	↑ 8.6%
Estates and Ancillary	369	376	↑	1.9%	356	365	8	↑ 2.3%
Healthcare Scientists	664	757	↑	14.0%	628	722	94	↑ 15.0%
Medical and Dental	1,731	1,764	↑	1.9%	1,632	1,662	30	↑ 1.9%
Nursing and Midwifery Registered	3,881	4,165	↑	7.3%	3,575	3,849	274	↑ 7.7%
Total	**12,084**	**12,892**	↑	**6.7%**	**11,166**	**11,916**	**750**	↑ **6.7%**



Admin & Medical Breakdown

Staff Group	Feb-23	Jan-24	FTE 12 Month growth	
Administrative and Clerical	2,273	2,438	165	↑ 7.3%
of which staff within Clinical Division	1,118	1,185	68	↑ 6.1%
of which Band 4 and below	772	809	37	↑ 4.8%
of which Band 5-7	249	262	14	↑ 5.6%
of which Band 8A	47	55	8	↑ 16.0%
of which Band 8B	7	6	-2	↓ -24.3%
of which Band 8C and above	42	53	11	↑ 26.3%
of which staff within Corporate Areas	907	993	85	↑ 9.4%
of which Band 4 and below	248	273	25	↑ 10.1%
of which Band 5-7	429	480	51	↑ 11.8%
of which Band 8A	87	93	7	↑ 7.8%
of which Band 8B	53	53	1	↑ 1.7%
of which Band 8C and above	91	93	2	↑ 2.2%
of which staff within R&D	248	260	12	↑ 4.8%
Medical and Dental	1,632	1,662	30	↑ 1.9%
of which Doctors in Training	666	660	-5	↓ -0.8%
of which Career grade doctors	244	264	20	↑ 8.1%
of which Consultants	722	738	16	↑ 2.2%

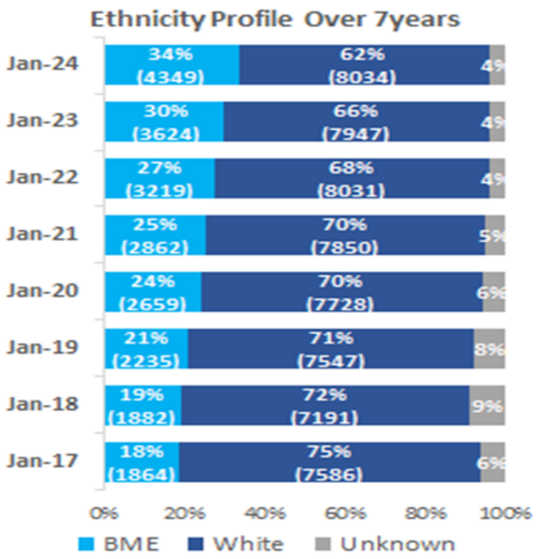
What the information tells us:

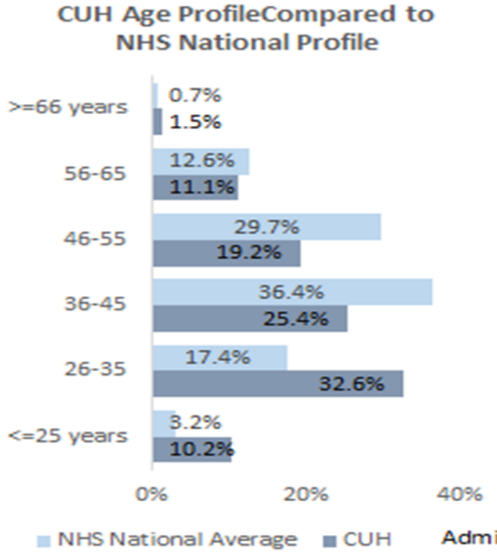
Overall the Trust saw a 6.7% growth in its substantive workforce over the past 12 months and 9.3% over the past 24 months. Growth over the past 12 months is lowest within the Additional Professional, Scientific and Technical staff group, with a decrease of 1.5%, and highest within Healthcare Scientists at 15%. 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.

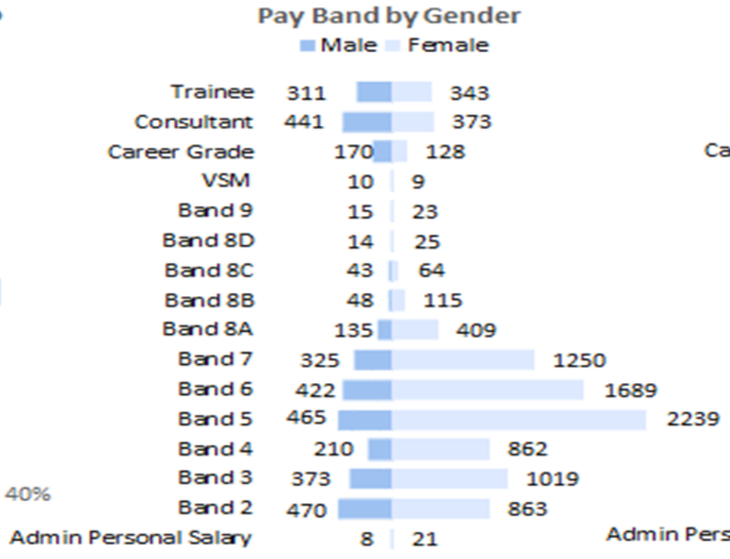
Author(s): Chloe Schafer, Amanda Wood **Owner(s): David Wherrett**

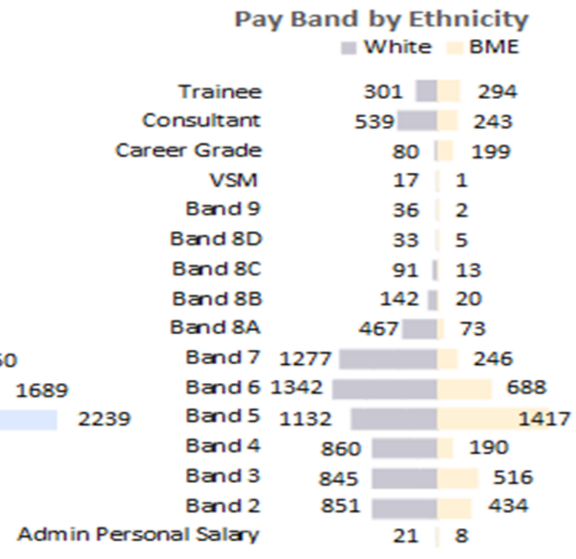
Equality Diversity and Inclusion (EDI)

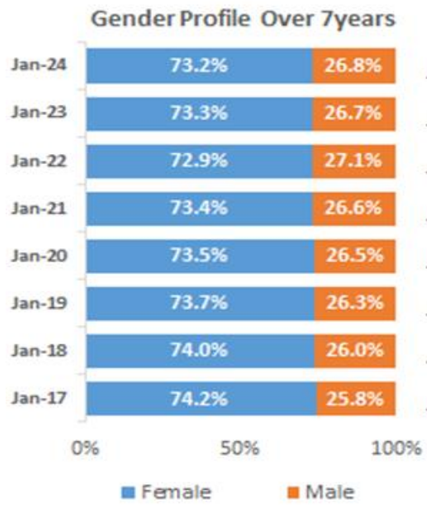
NHS
Cambridge University Hospitals
NHS Foundation Trust

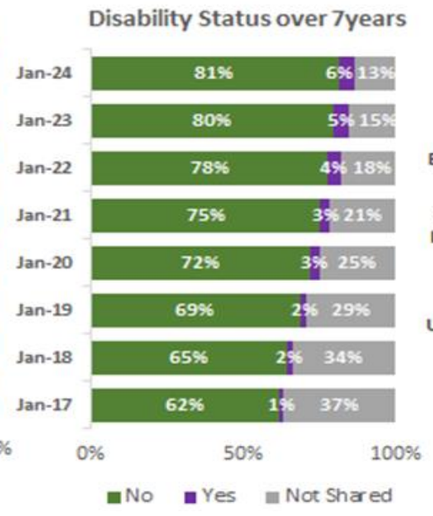


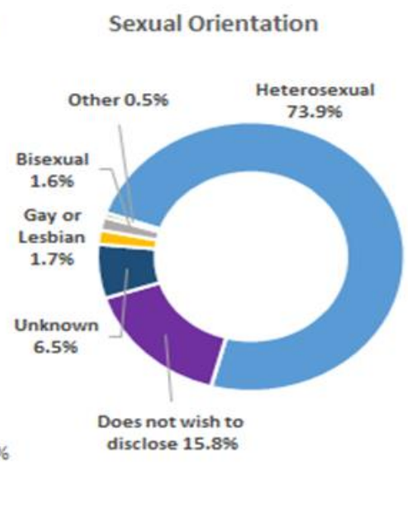












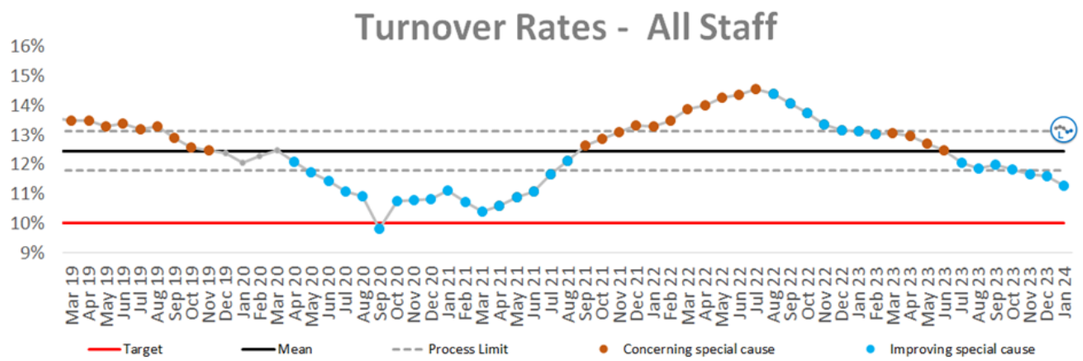
What the information tells us:

- CUH has a younger workforce compared to NHS national average. The majority of our staff are aged 26-45 which accounts for 58% of our total workforce.
- The percentage of BME workforce increased significantly by 15% over the 7 year period and currently make up 34% 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 4.8% to 5.6% over the seven year period. However, there are still significant gaps between the data recorded about our staff on ESR compared with the information staff share about themselves when completing the National Staff Survey.
- There remains a high proportion of staff who have, for a variety of reasons, not shared their sexual orientation.

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

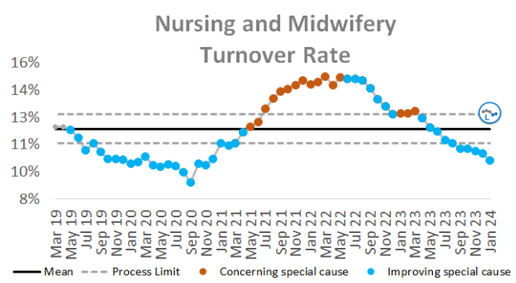
Staff Turnover

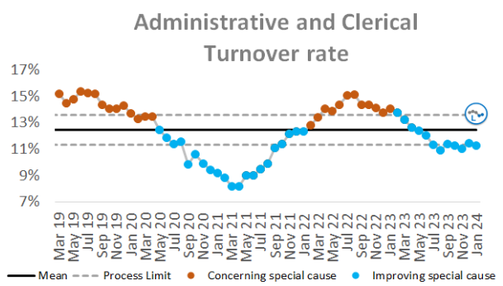
Cambridge University Hospitals NHS Foundation Trust

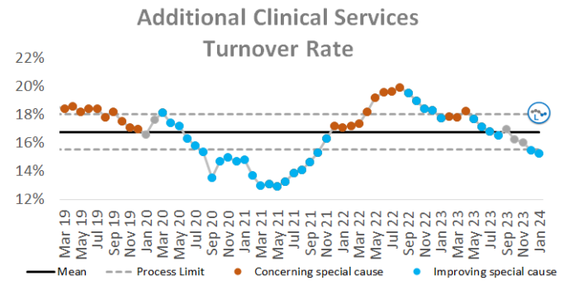


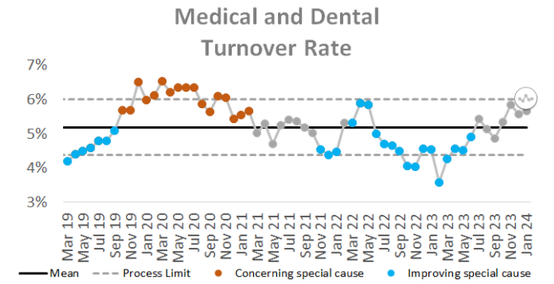
Background Information: Turnover describes the rate that employees leave an establishment. Staff turnover is calculated by the number of leavers from the Trust over the previous twelve months as a percentage of the total number of employed staff at a given time. (excludes all fixed term contracts including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

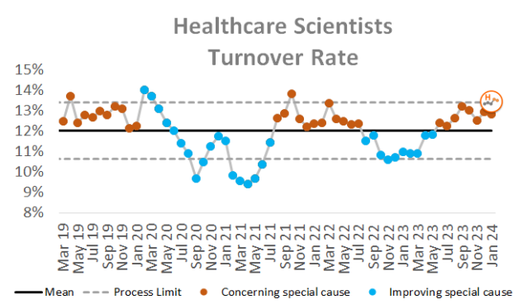
What the information tells us:
After a steady increase from March 2021 the Trust turnover rate has been decreasing since July 2022 - this month at 11.3% (0.3% lower than last month). This is more in line with pre-pandemic rates, and 0.8% lower than 4 years ago. Estates and Ancillary staff group has the highest increase of 2.9% to 13.3% in the last four years, but Additional Professional, Scientific and Technical and Administrative and Clerical staff groups have both seen a reduction in turnover from four years ago (3.4% and 2.4% reductions respectively). Within the staff groups, Additional Clinical Services have the highest turnover rate at 15.3% followed by Estates and Ancillary staff at 13.3%.

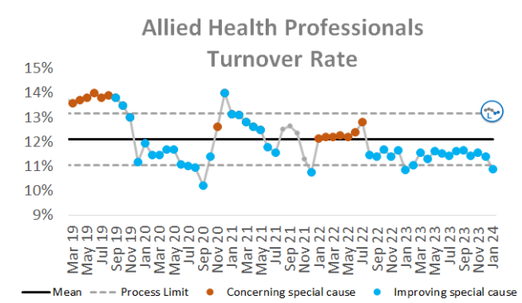


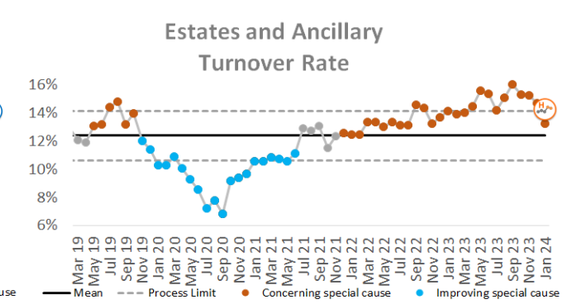


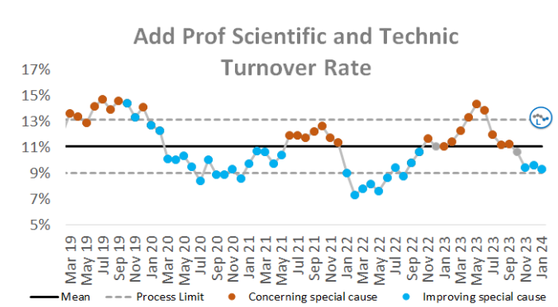










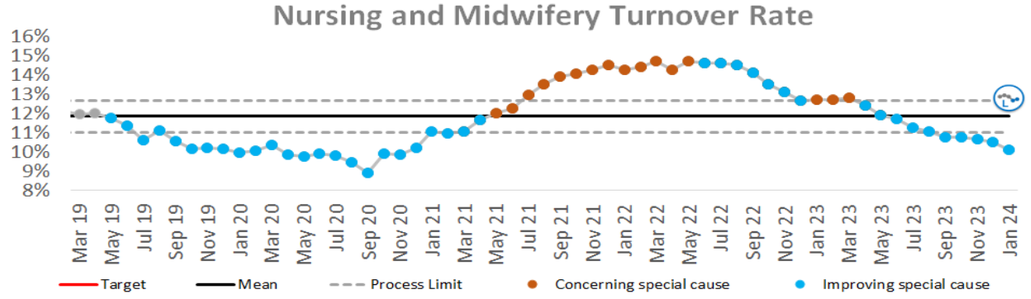


Author(s): Chloe Schafer, Amanda Wood **Owner(s): David Wherrett** **Page 42**

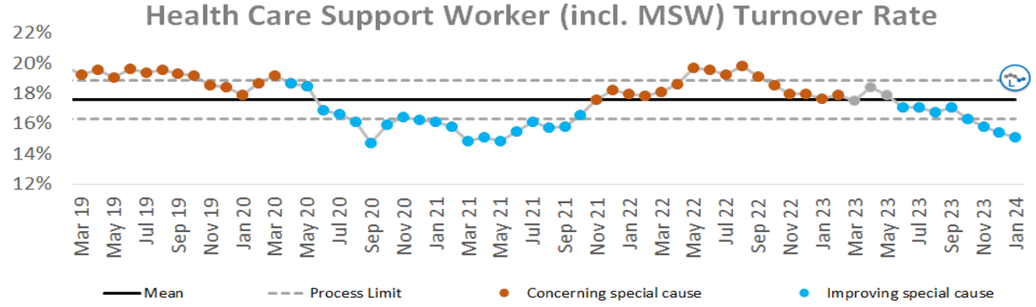
Turnover for Nursing & Midwifery Staff Group (Registered & Non-Registered)

NHS
Cambridge University Hospitals
NHS Foundation Trust

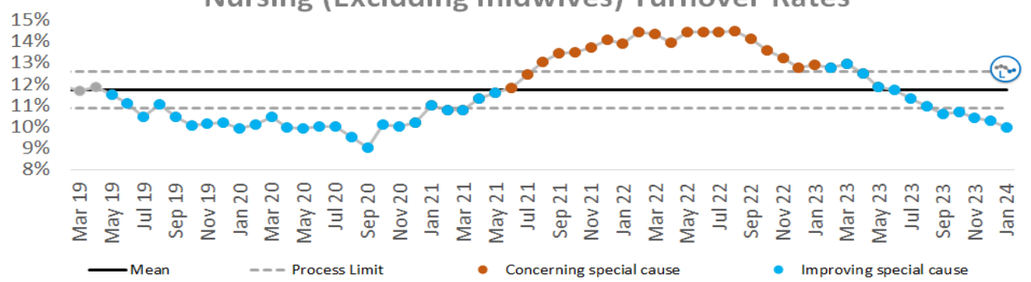
Nursing and Midwifery Turnover Rate



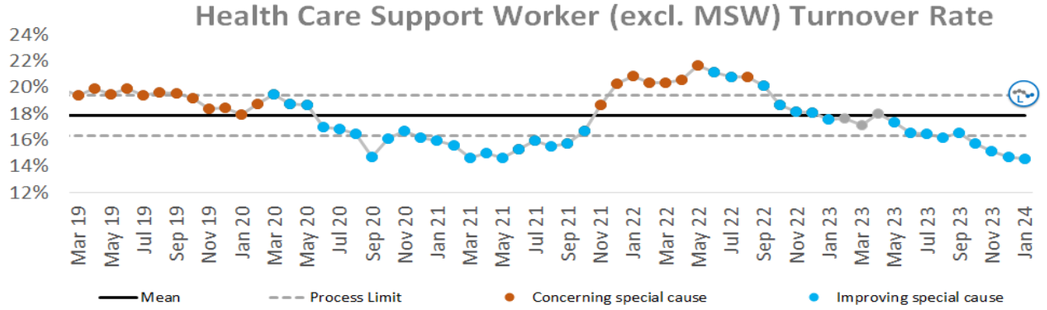
Health Care Support Worker (incl. MSW) Turnover Rate



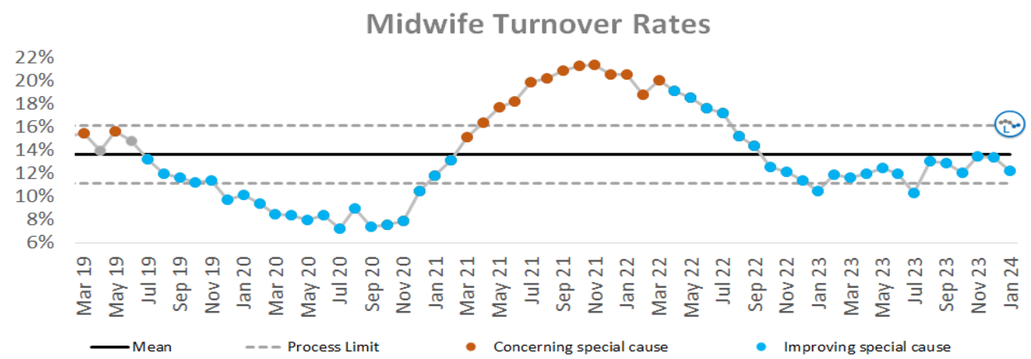
Nursing (Excluding midwives) Turnover Rates



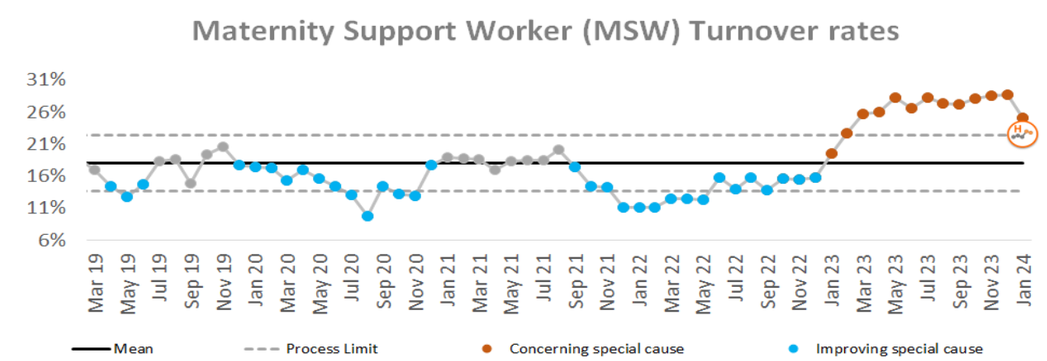
Health Care Support Worker (excl. MSW) Turnover Rate



Midwife Turnover Rates



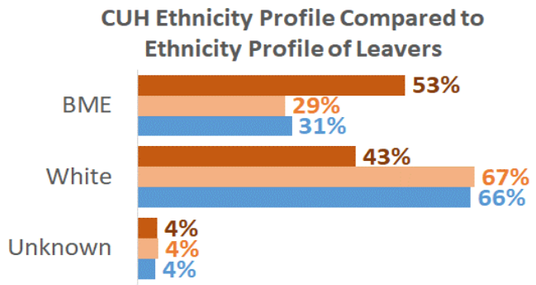
Maternity Support Worker (MSW) Turnover rates

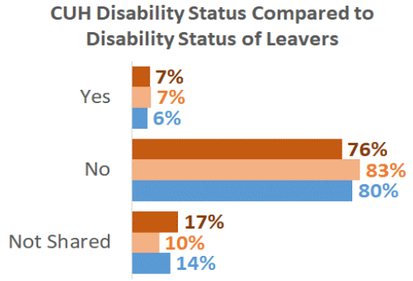


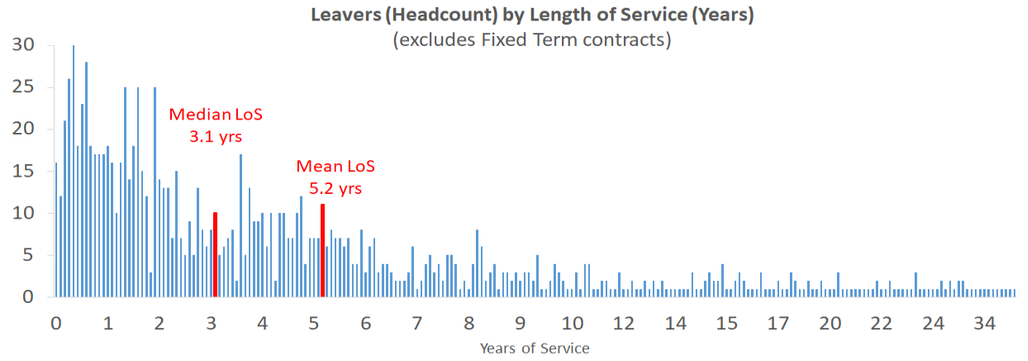
Author(s): Chloe Schafer, Amanda Wood **Owner(s): David Wherrett**

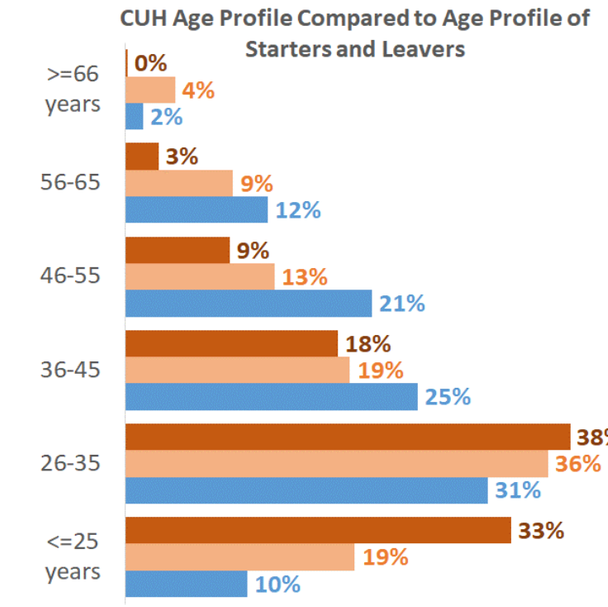
Starters & Leavers - last 12 months

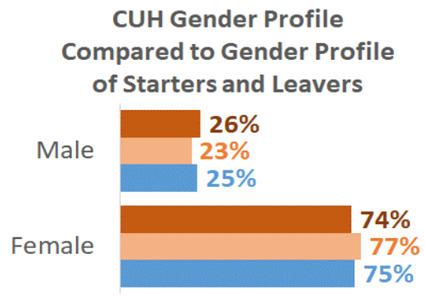
NHS
Cambridge University Hospitals
NHS Foundation Trust

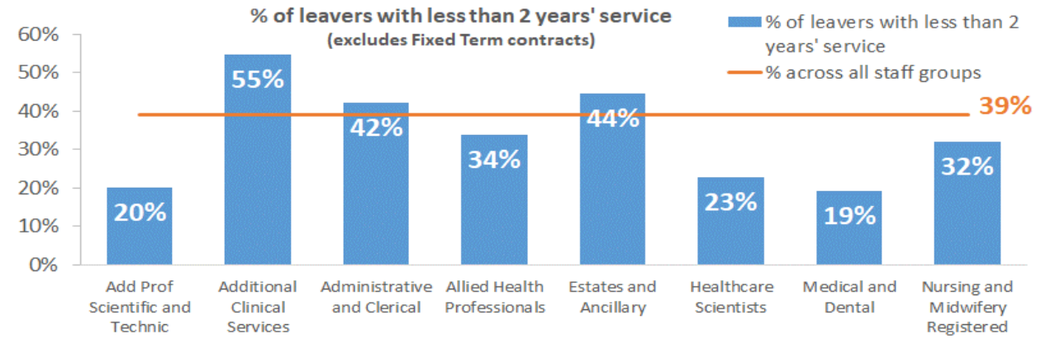












What the information tells us:

The majority of starters to, and leavers from the Trust in the last 12 months were aged 35 yrs. or under (70% and 55% respectively), which are higher than the proportion of staff in post of this age (41%). Gender and disability status are generally equally represented in the starters and leavers data when compared to the Trust profile, however there is a slightly higher proportion of females leaving the Trust, and of staff declaring a disability both starting and leaving the Trust. 53% of our starters in the last 12 months were from black and minority ethnic groups, compared to 31% of the staff profile.

A significant proportion of leavers leave the Trust within 2 years of starting (39%), and within Additional Clinical Services staff group there is a much greater proportion than average - 55%. The average (mean) length of service of all leavers is 5.2 years, with a median of 3.1 years.

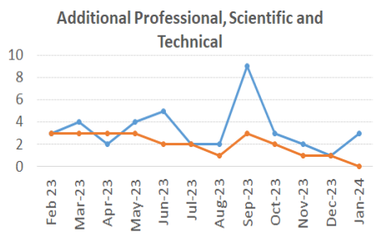
Excludes Fixed Term and Locum Medical and Dental staff, and staff leaving and returning to CUH (as bank only/retire and return etc.)

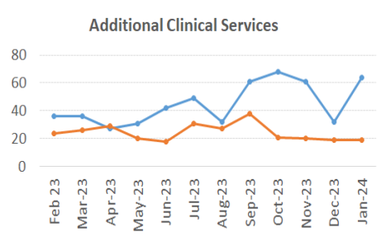
Author(s): Chloe Schafer, Amanda Wood

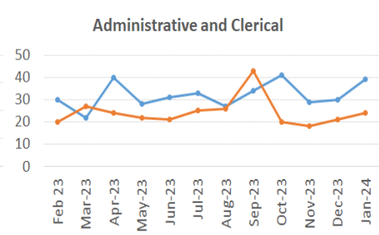
Owner(s): David Wherrett

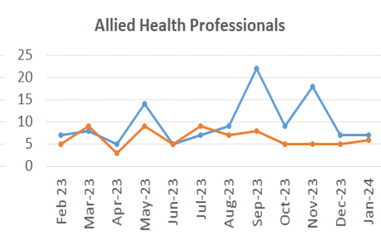
Starters & Leavers - Last 12 months

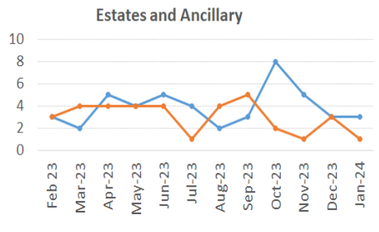
Cambridge University Hospitals NHS Foundation Trust

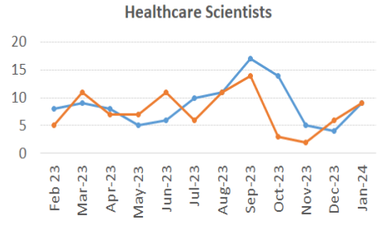


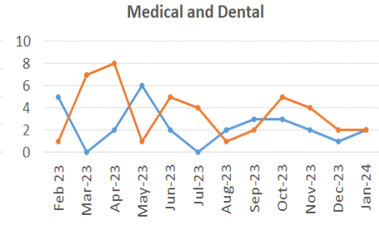


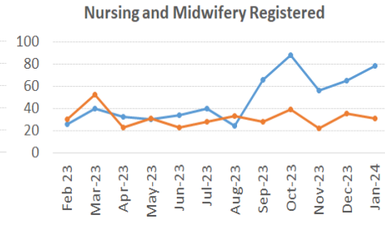


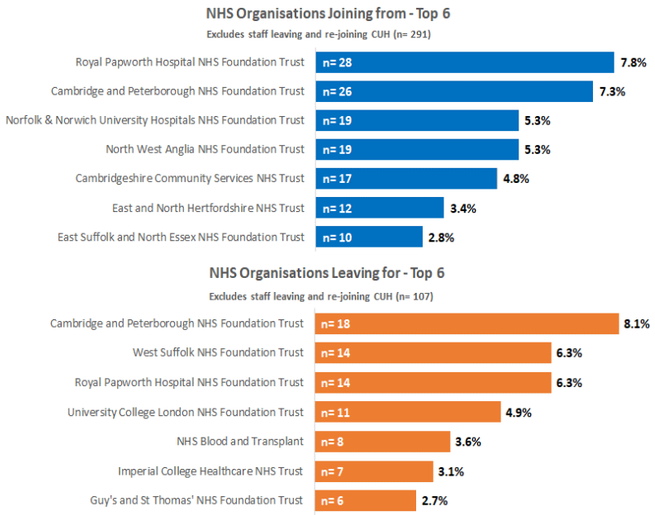


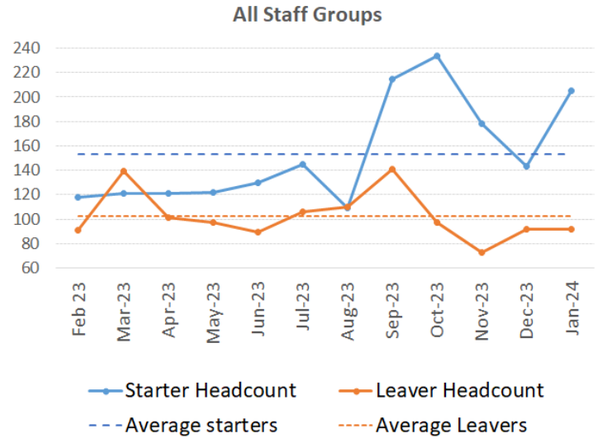












Top 10 Leaving Reasons Excludes staff leaving and re-joining CUH (n= 107)	Number of Leavers (Headcount)	% of all Leavers
Voluntary Resignation - Relocation	383	31%
Voluntary Resignation - Work Life Balance	236	19%
Voluntary Resignation - Promotion	125	10%
Voluntary Resignation - Other/Not Known	99	8%
Voluntary Resignation - Better Reward Package	80	7%
Retirement Age	75	6%
Voluntary Resignation - Health	57	5%
Voluntary Resignation - Child Dependants	27	2%
Voluntary Resignation - Lack of Opportunities	26	2%
End of Fixed Term Contract	25	2%

What the information tells us:

The top three reasons for leaving are Voluntary Resignation - due to relocation (31%), for work/life balance (19%) and for promotion (10%).

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 was Cambridge and Peterborough NHS Foundation Trust and the most popular organisation to join from was Royal Papworth NHS Foundation Trust .

In the month of January 2024 alone the most popular destination on leaving (other than unknown) was to another NHS organisation (30.4% of the 92 leavers).

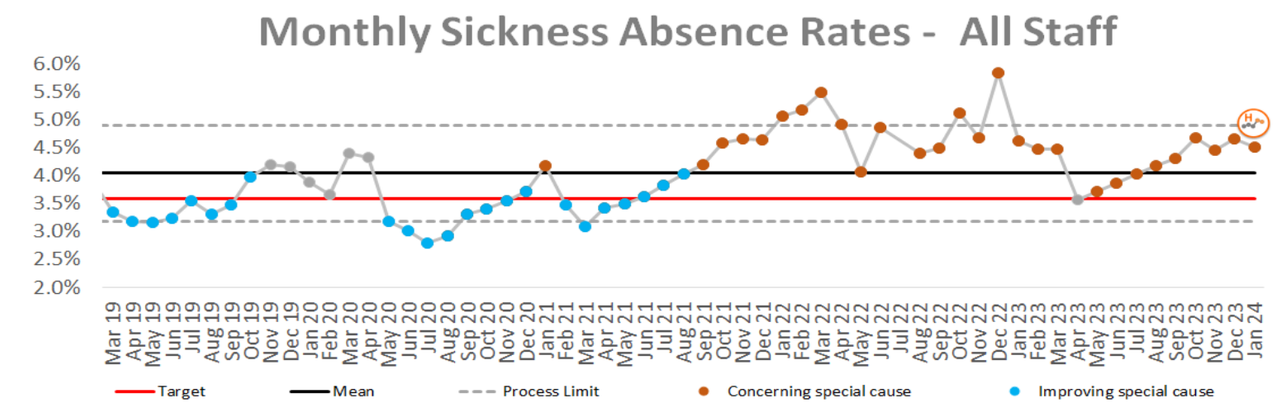
Author(s): Chloe Schafer, Amanda Wood

Owner(s): David Wherrett

Page 45

Sickness Absence

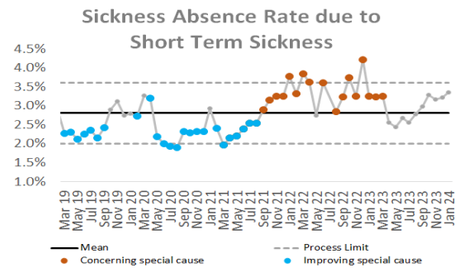
NHS
Cambridge University Hospitals
NHS Foundation Trust

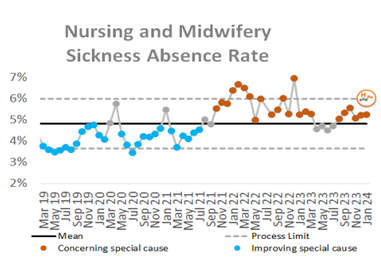


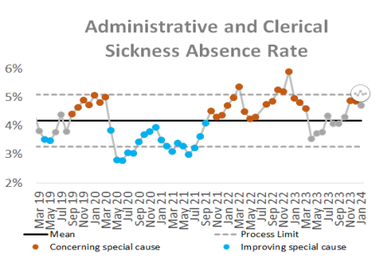
Background Information: Sickness Absence is a monthly metric and is calculated as the percentage of FTE days missed in the organisation due to sickness during the reporting month.

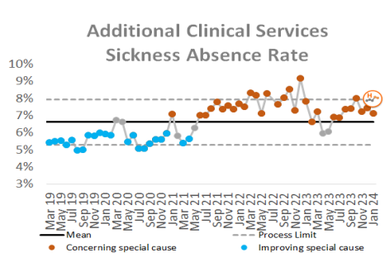
What the information tells us: The overall monthly sickness absence has decreased by 0.2% since last month, to 4.5% in January 2024. This is 0.1% lower than the same month last year (4.6%). The sickness absence rate due to short term illness is higher at 3.4% compared to long term sickness at 1.2%.

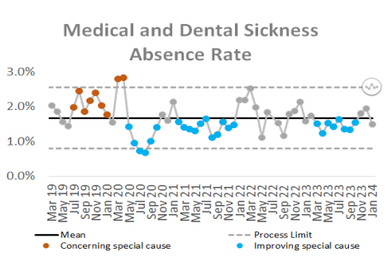
Estates and Ancillary staff group has the highest sickness absence rate at 7.8% (0.6% higher than 12 months ago), followed by Additional Clinical Services at 7.1% in January 2024 (0.7% lower than 12 months ago).

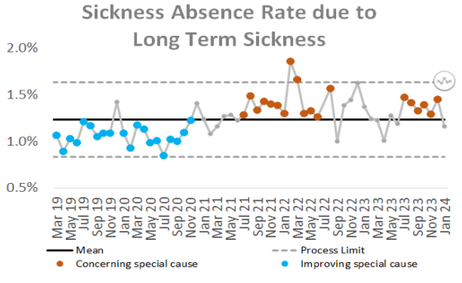


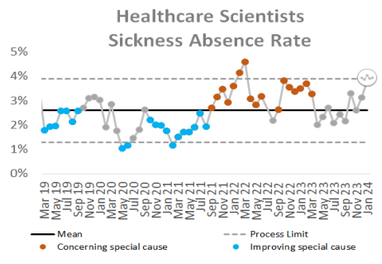


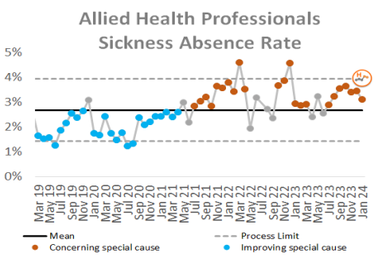


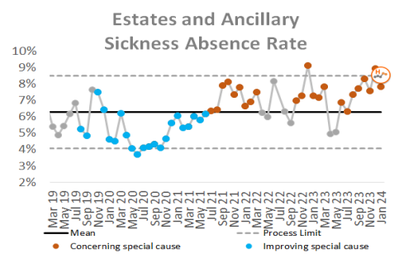


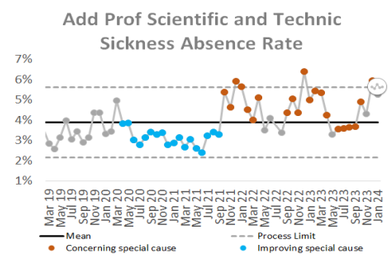










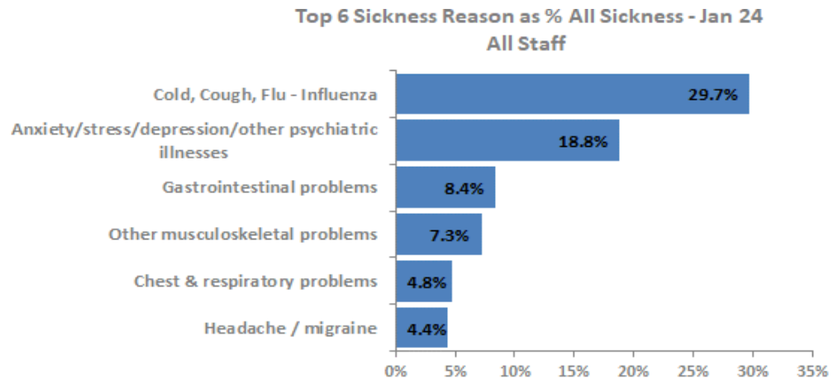


Author(s): Chloe Schafer, Amanda Wood

Owner(s): David Wherrett

Top Six Sickness Absence Reason

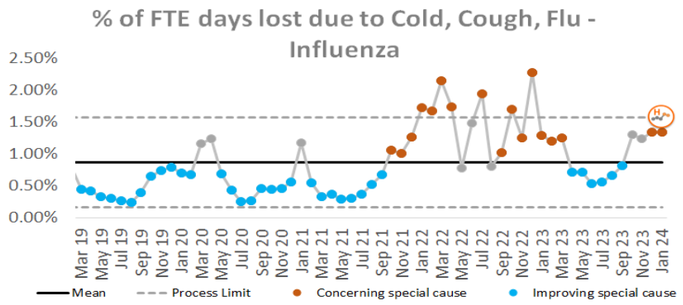
NHS
Cambridge University Hospitals
NHS Foundation Trust

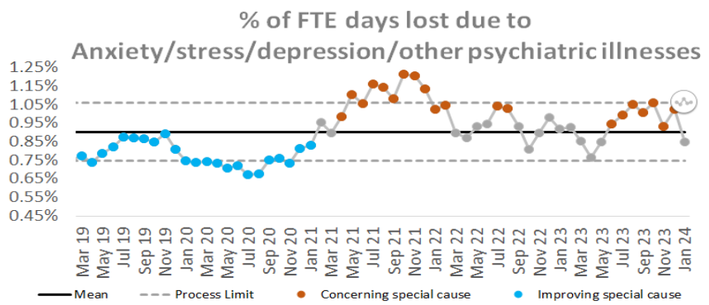


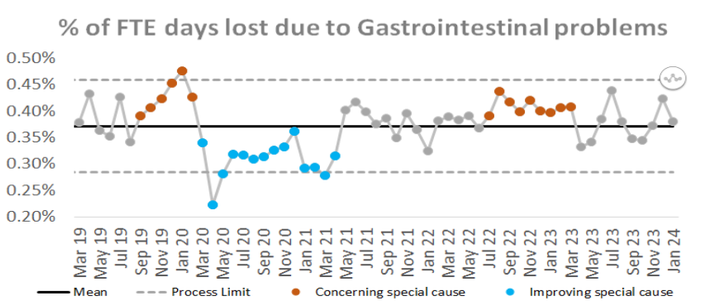
Background Information:Sickness Absence reason is provided as a percentage of all FTE days missed due to sickness during the reporting month.

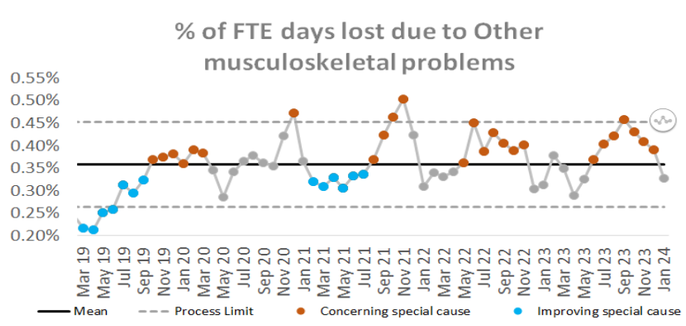
What the information tells us: The top reason for sickness absence in January 2024 is Cold, Cough, Flu - Influenza, with an absence rate of 1.3%. This is the same rate as last month and 0.1% lower than in January last year. As a percentage of all sickness absence Cold, Cough, Flu - Influenza accounts for 29.7% of the overall figure.

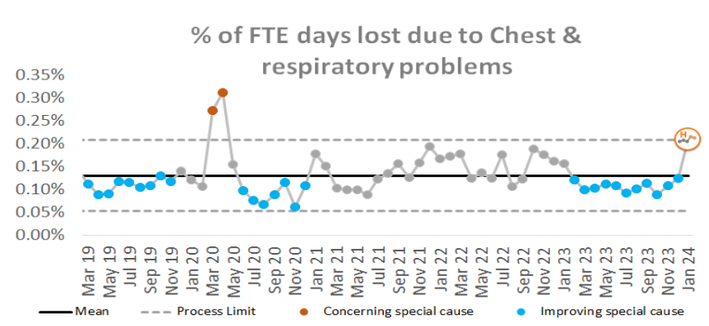
Absence due to Anxiety/stress/depression/other psychiatric illnesses has decreased by 0.2% from last month to 0.9%, and accounts for 18.8% of all absence in January 2024.

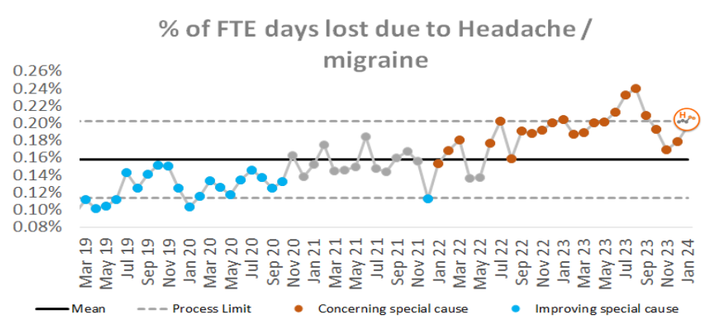










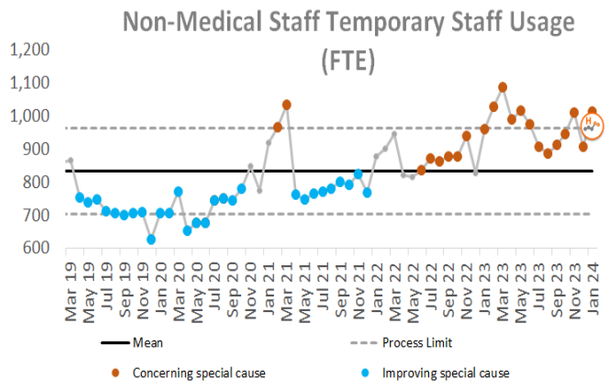


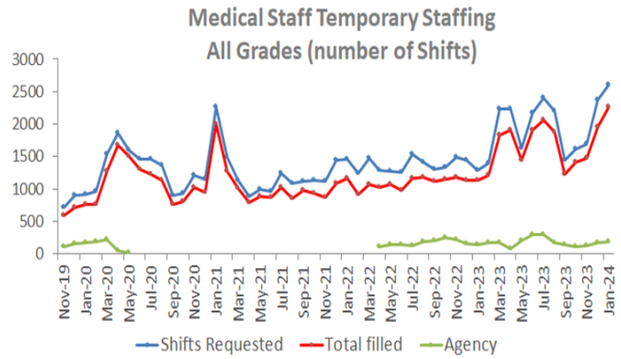
Author(s): Chloe Schafer, Amanda Wood **Owner(s): David Wherrett**

Page 47

Temporary Staffing

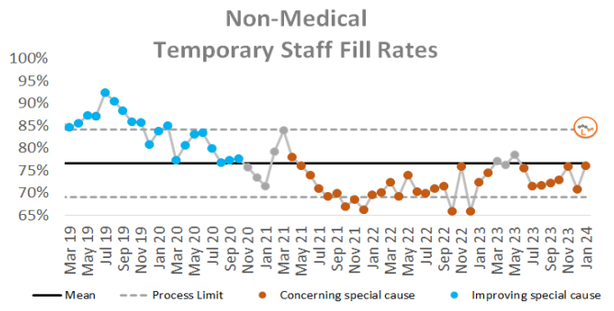
NHS
Cambridge University Hospitals
NHS Foundation Trust

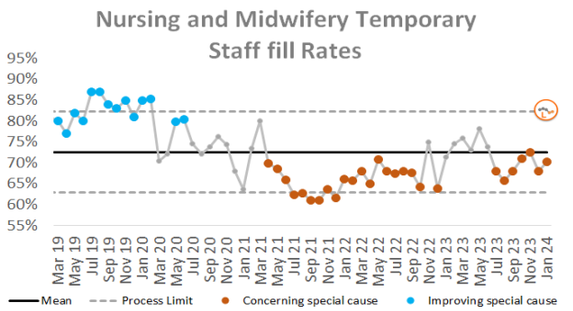


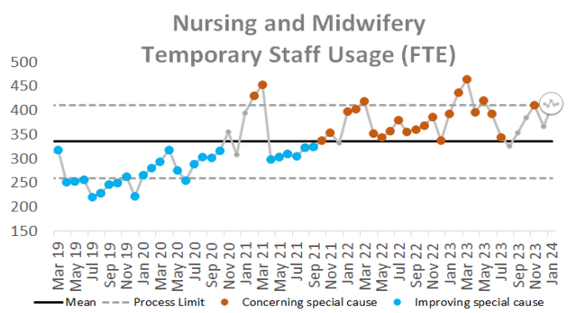


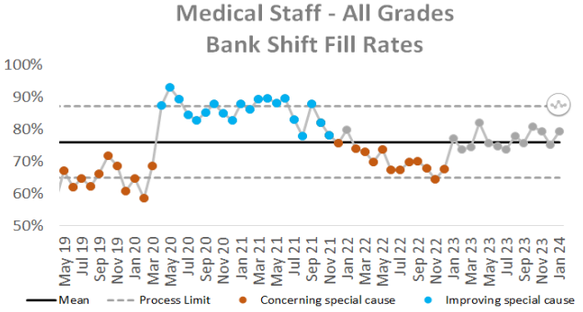
Background Information: The Trust works to ensure that temporary vacancies are filled with workers from staff bank in order to minimise agency usage, ensure value for money and to ensure the expertise and consistency of staffing.

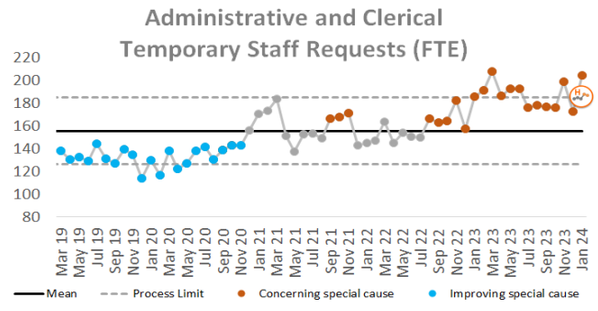
What the information tells us: Overall non-medical fill rates have increased from last month to 76%, with a 3.8% increase in requests and an 11.7% increase in FTE worked in January 2024. Top three reasons for request are vacancy (44%), increased workload (23.5%) and sickness requiring cover (14.7%). Nursing and midwifery agency usage decreased by 1.93 WTE from the previous month to 15.5 WTE. This accounts for 4% of the total nursing filled shifts.
Demand for temporary medical staff increased by 10% from December to January, with fill rates increasing by 5% to 86.5%.

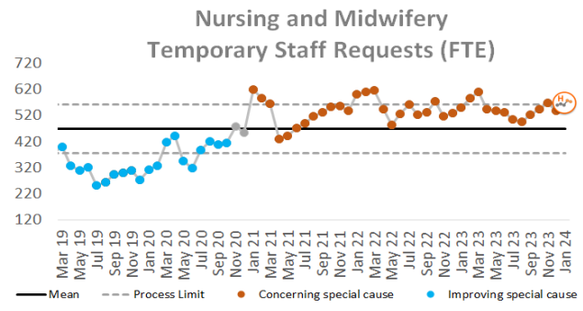


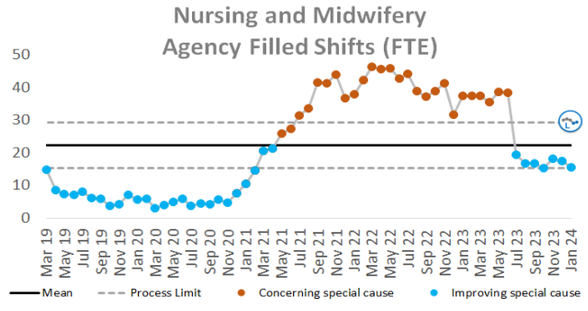


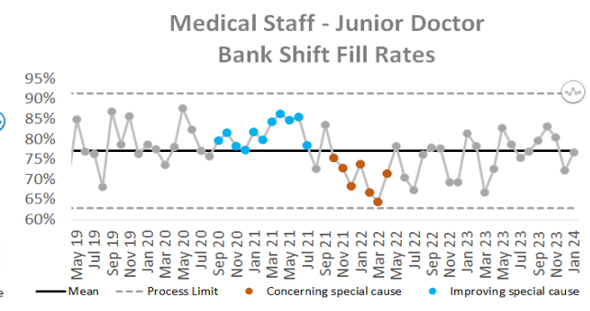










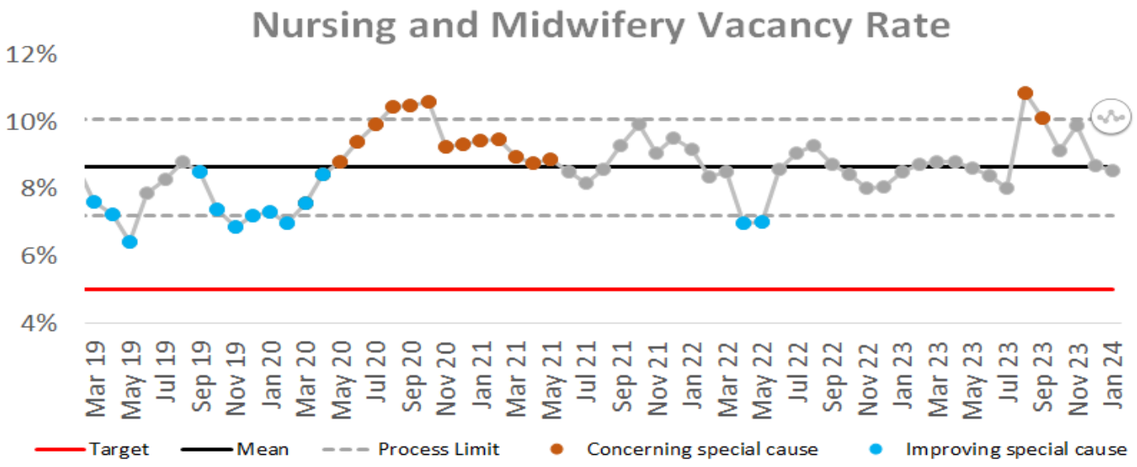


Author(s): Chloe Schafer, Amanda Wood

Owner(s): David Wherrett

ESR Vacancy Rate

Cambridge University Hospitals NHS Foundation Trust

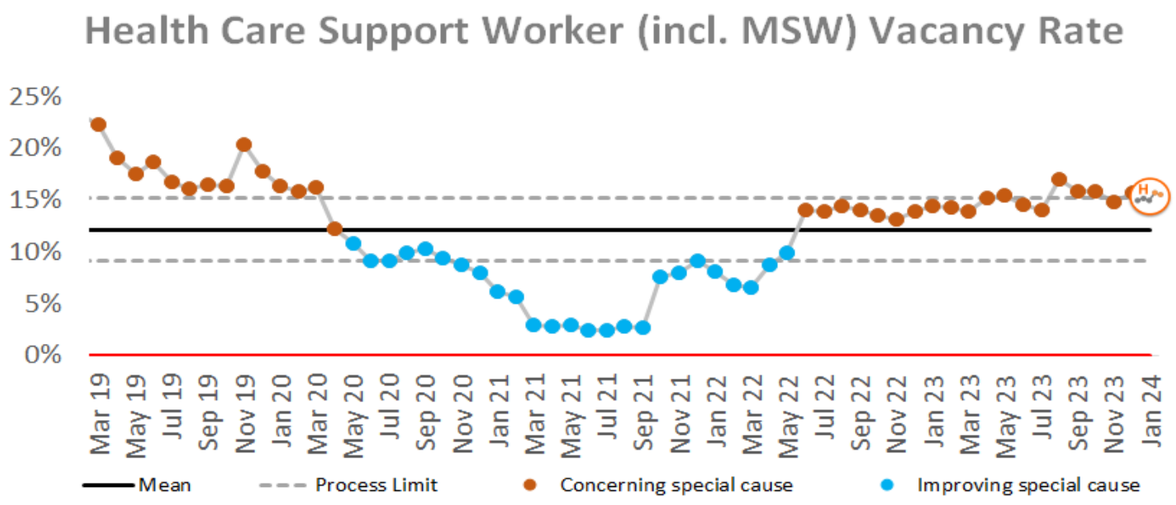


Background Information: Vacancy rate provides vacancy information based on established post within an organisation. The figure below relates to ESR data for clinical areas only and includes pay band 2-4 for HCA and 5-7 for Nurses.

What the information tells us: 2023/24 budgets were loaded to ESR for Clinical and Corporate Divisions from August 2023, which increased the establishment for both Nursing and Midwifery and Health Care Support Workers (HSCWs). The new wards and theatre for the Surgical Movement Hub opened in November, increasing the Nursing and Health Care Support Worker establishments again and therefore vacancies.

In January the vacancy rate for Nursing and Midwifery decreased to 8.5%, which is 0.2% lower than last month, and the same rate as January last year. The vacancy rate for Health Care Support Workers is 14.6% as at end of January - a decrease of 1.1% from last month, and 0.2% higher than January last year.

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



Annual Leave Update

NHS
Cambridge University Hospitals
NHS Foundation Trust

Percentage of Annual Leave (AL) Taken – January 2024 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	48,378	34,798	71.9%	96%
	Additional Clinical Services	371,635	289,715	78.0%	98%
	Administrative and Clerical	511,636	375,141	73.3%	97%
	Allied Health Professionals	154,970	116,410	75.1%	100%
	Estates and Ancillary	77,329	60,635	78.4%	99%
	Healthcare Scientists	155,218	112,946	72.8%	98%
	Medical and Dental	139,369	64,340	46.2%	35%
	Nursing and Midwifery Registered	803,927	634,969	79.0%	98%
	Trust	**2,262,462**	**1,688,954**	74.7%	89%
Annual Leave taken by Division	*Division*				
	Corporate	320,447	239,924	74.9%	96%
	Division A	422,838	324,680	76.8%	87%
	Division B	634,291	468,874	73.9%	94%
	Division C	278,107	208,221	74.9%	80%
	Division D	259,852	187,154	72.0%	86%
	Division E	244,355	184,808	75.6%	86%
	R&D	102,573	75,294	73.4%	96%

* Greater than 67% | Less than 50% | Between 50% and 67%

What the information tells us: The Trust's annual leave usage is at 90% of the expected usage at the end of the tenth month of the financial year. The highest rate of use of annual leave is within the Nursing and Midwifery staff group, at 79%, followed by Estates and Ancillary at 78.4%.

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

Mandatory Training by Division & Staff Group

NHS Cambridge University Hospitals NHS Foundation Trust

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

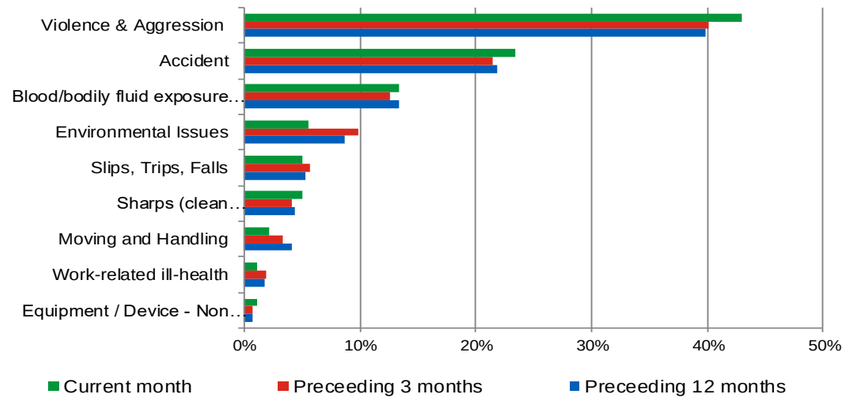
Thresholds for **Induction** & Information Governance incl. GDPR & Cyber Security training	Less than 80%	80% to 94%	95% or higher
Thresholds for **Core Mandatory** training excl. Information Governance incl. GDPR & Cyber Security training	Less than 75%	75% to 89%	90% or higher

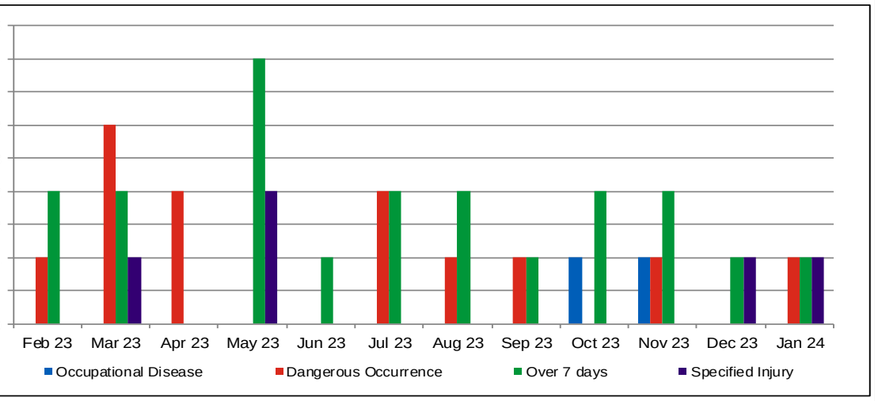
		No. Staff Requiring Competency	Frequency	Delivery Method	Variance from last month (percentage point)	Trust Total	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental		Nursing and Midwifery Registered
													Consultant	Non-Consultant	
Ind'tn	Corporate Induction	1,777	one-off	f2f	0.2%	(51)95.9%	(1)96.8%	(19)94.3%	(7)97.5%	(3)96.6%	(1)97.2%	(2)97.8%	(6)86.0%	(109)77.9%	(18)95.3%
	Local Induction	1,777	one-off	f2f	1.6%	(385)78.3%	(1)96.8%	(86)74.2%	(63)77.3%	(13)85.1%	(2)94.4%	(23)75.3%	(4)90.7%	(87)82.4%	(106)72.3%
Other Core Mandatory	Conflict Resolution	11,862	3 yrs	el	0.0%	(248)97.9%	(2)99.1%	(17)99.1%	(29)98.8%	(8)98.9%	(4)98.9%	(6)99.2%	(29)96.3%	(87)90.1%	(66)98.2%
	Equality, Diversity and Human Rights	11,862	3 yrs	el	-0.2%	(294)97.5%	(3)98.7%	(21)98.9%	(30)98.8%	(10)98.6%	(5)98.6%	(6)99.2%	(32)95.9%	(102)88.4%	(85)97.7%
	Health, Safety and Welfare	11,862	3 yrs	el	-0.2%	(319)97.3%	(2)99.1%	(27)98.6%	(32)98.7%	(9)98.8%	(6)98.3%	(9)98.7%	(35)95.5%	(114)87.0%	(85)97.7%
	Information Governance including GDPR and Cyber Security	11,862	1 yr	el	-0.3%	(617)94.8%	(7)97.0%	(96)95.0%	(58)97.7%	(28)96.2%	(11)96.9%	(24)96.6%	(43)94.5%	(142)83.8%	(208)94.5%
	Basic Prevent Awareness	9,943	3 yrs	el	-0.1%	(333)96.7%	(1)99.6%	(29)98.3%	(46)98.1%	(5)99.3%	(8)97.8%	(13)98.1%	(19)96.7%	(138)78.5%	(74)97.1%
	Prevent Level Three (WRAP)	1,914	3 yrs	el	0.3%	(157)91.8%	(1)88.9%	(12)92.7%	(0)100.0%	(3)95.2%		(1)91.7%	(11)94.7%	(58)75.0%	(71)94.2%
Resuscitation	Adult Basic Life Support Practical - 1 Year	424	1 yr	f2f	-2.4%	(98)76.9%		(30)71.4%		(1)75.0%					(67)78.7%
	Adult Basic Life Support Practical - 2 Year	7,383	4 yrs	f2f	1.3%	(734)90.1%	(2)93.9%	(127)90.9%	(3)90.3%	(26)96.4%		(2)98.3%	(88)88.7%	(276)68.6%	(210)93.9%
	Advanced Life Support	28	4 yrs	f2f	-2.6%	(8)71.4%				(0)100.0%					(8)70.4%
	Advanced Paediatric Life Support	107	2 yrs	f2f	-5.7%	(52)51.4%									(52)51.4%
	Basic Life Support e-learning	7,770	1 yr	el	-0.4%	(775)90.0%	(2)93.9%	(104)92.9%	(3)90.3%	(45)93.8%		(10)91.7%	(71)90.9%	(243)72.4%	(297)92.0%
	Immediate Life Support (ILS)	656	1 yr	f2f	-0.6%	(148)77.4%		(2)50.0%				(6)70.0%			(140)77.8%
	Newborn Basic Life Support (NBLS)	569	1 yr	Blended	4.0%	(141)75.2%	(1)0.0%	(31)61.3%	(1)0.0%				(4)75.0%	(5)84.8%	(99)77.4%
	Paediatric Basic Life Support (PBLS)	2,600	1 yr	Blended	2.8%	(467)82.0%	(0)100.0%	(153)74.2%	(2)50.0%	(41)94.4%		(2)97.8%	(26)78.7%	(44)64.2%	(199)78.6%
	Paediatric Immediate Life Support (PILS)	386	1 yr	f2f	-1.0%	(111)71.2%				(0)100.0%					(111)71.1%
Fire	Fire Evacuation	5,987	1 yr	f2f/el	0.4%	(724)87.9%	(3)81.3%	(199)86.6%	(2)92.9%	(63)89.0%	(12)86.4%	(2)95.8%			(443)88.2%
	Fire Safety Awareness	11,862	2 yrs	el	-0.2%	(445)96.2%	(3)98.7%	(51)97.3%	(41)98.4%	(16)97.8%	(11)96.9%	(10)98.6%	(30)96.2%	(149)83.0%	(134)96.4%
Infect Ctrl	Infection Prevention and Control - Level 1 - 2 Years	4,756	2 yrs	el	0.2%	(175)96.3%	(0)100.0%	(8)98.0%	(52)97.8%	(0)100.0%	(10)97.1%	(10)98.4%	(0)100.0%	(68)82.0%	(27)93.5%
	Infection Prevention and Control - Level 2 - 2 Years	7,107	2 yrs	el	-0.5%	(276)96.1%	(2)98.9%	(44)97.1%	(1)98.6%	(12)98.1%	(0)100.0%	(0)100.0%	(28)96.3%	(72)85.6%	(117)96.5%
Moving & Handling	Moving and Handling - Level 1	11,862	2 yrs	el	-0.1%	(541)95.4%	(2)99.1%	(67)96.5%	(51)97.9%	(26)96.5%	(5)98.6%	(12)98.3%	(33)95.8%	(156)82.3%	(189)95.0%
	Moving and Handling - Level 2	6,020	2 yrs	f2f	2.6%	(686)88.6%	(0)100.0%	(180)88.1%	(2)87.5%	(42)93.4%		(7)92.2%			(455)87.9%
	Patient Moving and Handling - e-learning	6,024	1 yr	el	-0.5%	(350)94.2%	(0)100.0%	(79)94.8%	(1)93.3%	(24)96.3%		(4)95.6%			(242)93.5%
Safeg'dg Adults	Safeguarding Adults - Level 1	7,944	3 yrs	el	0.1%	(311)96.1%	(2)99.1%	(33)98.3%	(43)98.3%	(3)97.7%	(7)98.0%	(12)98.3%	(9)88.5%	(113)37.6%	(89)95.2%
	Safeguarding Adults - Level 2	4,291	3 yrs	el	0.3%	(306)92.9%	(5)97.4%	(38)97.5%	(12)91.5%	(3)97.7%		(2)98.8%	(10)87.0%	(135)25.4%	(101)94.6%
	Safeguarding Adults - Level 3	4,076	3 yrs	el	1.9%	(1109)72.8%	(1)90.0%	(1)80.0%	(0)100.0%	(94)84.6%		(0)100.0%	(150)79.1%	(381)54.5%	(482)74.6%
Safeg'dg Children	Safeguarding Children - Level 1	11,862	3 yrs	el	-0.1%	(424)96.4%	(1)99.6%	(36)98.1%	(50)98.0%	(9)98.8%	(8)97.8%	(11)98.5%	(23)97.1%	(154)82.5%	(132)96.5%
	Safeguarding Children - Level 2	8,196	3 yrs	el	-0.1%	(460)94.4%	(9)95.6%	(54)96.5%	(12)91.8%	(14)98.1%		(2)98.8%	(29)96.3%	(168)80.9%	(172)95.4%
	Safeguarding Children - Level 3	1,530	3 yrs	f2f/el	0.3%	(221)85.6%	(0)100.0%	(18)83.2%	(3)76.9%	(9)86.4%		(1)92.9%	(8)96.0%	(41)76.2%	(141)85.2%
	Safeguarding Children - Level 3 - 1 Year	365	1 yr	f2f/el	-2.3%	(66)81.9%		(16)72.4%					(3)76.9%	(12)45.5%	(35)87.1%
Overall Compliance					0.1%	93.8%	98.3%	95.2%	98.1%	96.0%	97.6%	98.1%	93.6%	78.0%	93.1%

Health and Safety Incidents

NHS
Cambridge University Hospitals
NHS Foundation Trust

No. of health and safety incidents reported by division:	Trustwide	Division A	Division B	Division C	Division D	Division E	Corporate	Estates
No. of health and safety incidents reported in a rolling 12 month period:	**2033**	**404**	**330**	**613**	**312**	**211**	**72**	**91**
Accident	**443**	104	100	104	61	35	13	26
Blood/bodily fluid exposure (dirty sharps/splashes)	**271**	88	54	46	31	45	4	3
Environmental Issues	**176**	26	45	25	25	31	10	14
Equipment / Device - Non Medical	**15**	6	0	3	5	1	0	0
Moving and Handling	**85**	22	11	16	23	6	2	5
Sharps (clean sharps/incorrect disposal & use)	**90**	26	11	13	10	18	8	4
Slips, Trips, Falls	**108**	21	21	10	16	10	6	24
Violence & Aggression	**810**	102	85	395	134	57	22	15
Work-related ill-health	**35**	9	3	1	7	8	7	0





A total of 2,033 health and safety incidents were reported in the previous 12 months.

892 (44%) incidents resulted in harm. The highest reporting categories were violence and aggression (40%), accidents (22%) and blood/bodily fluid exposure (13%).

1,347 (66%) of incidents affected staff, 609 (30%) affected patients and 77 (4%) affected others i.e. 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: violence & aggression (41%), accidents (38%) and environmental issues (8%).

The highest reported incident categories for others were: slips, trips and falls (31%), violence & aggression (27%) and accidents (21%).

Staff incident rate is 10.6 per 100 members of staff (by headcount) over a rolling 12 month period.

The highest reporting division was division C with 613 incidents. Of these, 64% related to violence & aggression.

In the last 12 months, the highest reported RIDDOR category was over 7 day injuries (51%). In the last 12 months, 64% of RIDDOR incidents were reported to the HSE within the appropriate timescale. In January 2024, 3 incidents were reported to the HSE:

Over 7 day injury:

- The Injured Person (IP) was retrieving a box of stock from a shelf and lost grip causing the box to fall on the right side of their head. The IP reports jarring their neck and feeling dizzy and lightheaded. The IP was subsequently off work for four days and then returned to light duties for a further week.

Specified injury:

- The IP exited the outpatients building and was heading towards car park 1. The IP stepped off the pavement to cross the road, at which point the IP's left foot caught in a pothole and they fell heavily onto the ground. The next day the IP attended a minor injuries unit. An X-ray revealed four broken toes and a fracture to the outer bone of the foot. The IP had sustained a specified injury at the hospital.

Dangerous occurrence:

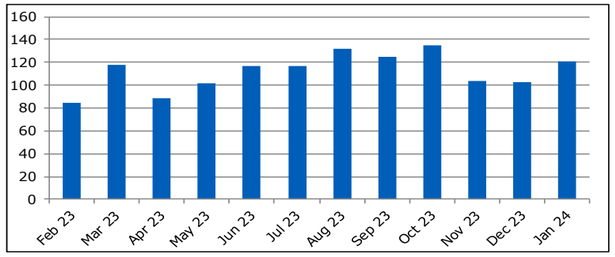
- The Affected Person (AP) was disconnecting an IV line from the patient when fluid splashed into their eye. The patient is known HIV and Hepatitis B positive. The AP immediately rinsed their eye with saline solution. The AP attended Occupational Health and immediately commenced PEP and received a Hepatitis B booster.

Author(s): Helen Murphy **Owner(s): David Wherrett**

Health and Safety Incidents

Cambridge University Hospitals NHS Foundation Trust

No. of health and safety incidents affecting staff:

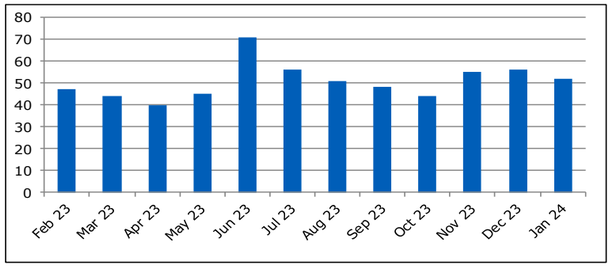


	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Total
Accident	14	21	13	13	14	14	24	17	21	12	9	23	**195**
Blood/bodily fluid exposure (dirty sharps/splashes)	12	20	18	22	23	14	22	23	36	16	21	23	**250**
Environmental Issues	2	8	8	10	14	7	17	10	7	13	9	7	**112**
Moving and Handling	8	9	3	5	7	5	3	7	2	8	2	3	**62**
Sharps (clean sharps/incorrect disposal & use)	7	3	10	3	7	7	8	3	5	5	5	8	**71**
Slips, Trips, Falls	7	4	6	8	3	10	5	10	8	9	8	6	**84**
Violence & Aggression	33	50	30	38	45	56	51	52	52	40	42	49	**538**
Work-related ill-health	1	3	1	3	4	4	2	3	4	1	7	2	**35**
Total	**84**	**118**	**89**	**102**	**117**	**117**	**132**	**125**	**135**	**104**	**103**	**121**	**1347**

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

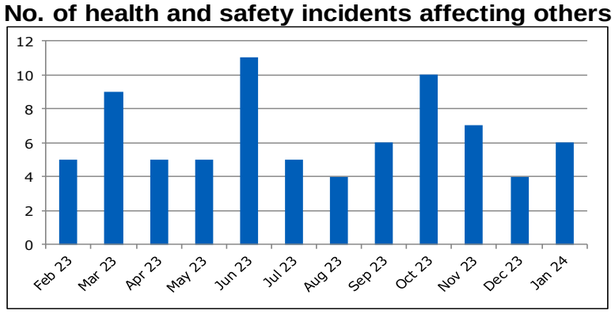
	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Total
No. of health & safety incidents	84	118	89	102	117	117	132	125	135	104	103	121	**1347**
Staff incident rate per month/year	0.7	0.9	0.7	0.8	0.9	0.9	1.0	1.0	1.1	0.8	0.8	1.0	**10.6**

No. of health and safety incidents affecting patients:



	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Total
Accident	17	21	13	19	29	14	20	18	21	19	22	19	**232**
Blood/bodily fluid exposure (dirty sharps/splashes)	0	1	3	2	2	2	0	2	4	0	3	0	**19**
Environmental Issues	5	1	2	4	6	3	4	2	4	12	5	3	**51**
Equipment / Device - Non Medical	1	0	0	1	2	6	1	0	0	1	1	2	**15**
Moving and Handling	4	2	1	2	3	0	1	2	4	1	2	1	**23**
Sharps (clean sharps/incorrect disposal & use)	2	3	2	0	4	3	0	2	0	1	1	0	**18**
Violence & Aggression	18	16	19	17	25	28	25	22	11	21	22	27	**251**
Total	**47**	**44**	**40**	**45**	**71**	**56**	**51**	**48**	**44**	**55**	**56**	**52**	**609**

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



	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Total
Accident	0	2	2	1	2	1	1	1	1	3	2	0	**16**
Blood/bodily fluid exposure (dirty sharps/splashes)	0	0	1	0	0	0	0	0	0	0	0	1	**2**
Environmental Issues	1	2	1	2	1	1	0	1	3	1	0	0	**13**
Sharps (clean sharps/incorrect disposal & use)	0	0	0	0	0	0	0	0	0	0	0	1	**1**
Slips, Trips, Falls	2	4	0	0	3	2	3	1	3	2	1	3	**24**
Violence & Aggression	2	1	1	2	5	1	0	3	3	1	1	1	**21**
Total	**5**	**9**	**5**	**5**	**11**	**5**	**4**	**6**	**10**	**7**	**4**	**6**	**77**

Author(s): Helen Murphy **Owner(s): David Wherrett**

Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Council of Governors: 27 March 2024

Agenda item	8.1
Title	Report of the Lead Governor
Sponsoring executive director	n/a
Author(s)	Neil Stutchbury, Lead Governor of the Council of Governors
Purpose	To summarise the activities of the Lead Governor and the Council of Governors, highlight matters of concern and note successes.
Previously considered by	n/a

Executive Summary

The report summarises the activities of the Lead Governor and the Council of Governors.

Related Trust objectives	All
Risk and Assurance	n/a
Related Assurance Framework Entries	n/a
Legal and regulatory implications?	n/a

Action required by the Council of Governors

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

Cambridge University Hospitals NHS Foundation Trust

27 March 2024

Council of Governors
Report of the Lead Governor
Neil Stutchbury

1. Recent Governor meetings

1.1 We held a **Governor NED quarterly** meeting on 24 January where we had one substantive question on the role of CUH in community-based health prevention schemes and three specific questions on patient safety, data breaches and referrals to the Emergency Department. After some discussion with the Secretariat, we decided to major on the health prevention question and this resulted in a very engaging and open discussion on the relationship of CUH and its partners in the wider community and its role in integrated care. Based on feedback from Non-Executive Directors (NEDs), we will use our quarterly meetings on more substantial strategic questions and use Council of Governors' meetings for the more specific, though still substantive, questions from governors.

1.2 We held a **Governor Seminar** on 8 February on the regional secure data environment project, led and presented by Mark Avery. The aim of the project is to extract clinical data from data repositories held by hospitals in the East of England for the purposes of medical research. The presentation was well-received and governors asked a range of questions, including on patient consent, data security and who would be able to apply for access.

1.3 We held a **Governor Forum** on 27 February. Ian Walker, Director of Corporate Affairs, joined us for the first half where we consulted governors on the responsibilities and accountabilities we need from a new Chair (see 1.5-1.7). Governors also updated each other on recent board assurance and other meetings they had attended since the last Forum meeting.

1.4 We held a **Governors' Nomination and Remuneration Committee** meeting on 27 February. Mike More summarised the outcome of the NED appraisals which were carried out during January. Sharon Peacock, in her capacity as Senior Independent Director, briefed the Committee on the Chair's appraisal on 7 March.

1.5 In addition, the Committee was updated on the consultation process and timetable for recruiting a new Chair for CUH, to take up the role in January 2025 when Mike More comes to the end of his final term of office.

1.6 The Chair of the Governors' Nomination and Remuneration Committee and the Lead Governor, supported by the Director of Corporate Affairs, consulted with key stakeholders on the Chair role during early March. The purpose of the

consultation is to confirm the challenges, key accountabilities and competencies for the CUH Chair role in preparation for writing the person specification. We consulted with the Chair and Chief Executive of the Integrated Care Board, chairs of local foundation trusts and local authority chief executives; the University of Cambridge and Cambridge University Health Partners; CUH staff networks; and the CUH Board.

1.7 We will be appointing a recruitment consultant to support the search. Our aim is to begin the search this month and interview shortlisted candidates in the summer.

1.8 We held a **Governors' Strategy Group** meeting on 18 March where we discussed the East of England neurosciences strategy delivered through the Specialised Services Provider Collaborative and a new strategy for outpatients. A separate report is on the agenda for this Council of Governors' meeting.

2. Upcoming Governor meetings

2.1 The next three months' meetings are as follows:

- Governor Seminar: 16 April 2024
- Council of Governors' Strategy Group: 29 April 2024
- Governor-NED quarterly meeting: 1 May 2024
- Governor Forum: 21 May 2024
- Trust Constitution Committee: 12 June 2024
- Governor Seminar: 18 June 2024
- Governors' Nomination and Remuneration Committee: 25 June 2024
- Council of Governors' meeting: 26 June 2024

3. Recommendation

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

Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Council of Governors: 27 March 2024

Agenda item	8.2
Title	Governors' Strategy Group
Sponsoring executive director	n/a
Author(s)	Neil Stutchbury, Lead Governor
Purpose	To summarise the activities of the Governors' Strategy Group.
Previously considered by	n/a

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

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

Action required by the Council of Governors

The Council is asked to note the report covering most recent meeting of the Governors' Strategy Group held on 18 March 2024.

Cambridge University Hospitals NHS Foundation Trust

27 March 2024

Council of Governors

Governors' Strategy Group – 18 March 2024

1. The Governors' Strategy Group met on 18 March 2024. In attendance were: Mike More, Neil Stutchbury, Gill Shelton, John Clarkson, Gemma Downham, Daniel Northam-Jones, Matthew Zunder, James Beveridge (Senior Programme Manager) Andi Thornton (Operations Manager, Outpatients) and Christof Kastner (Consultant Urologist and Clinical Director for Outpatients).

2. The agenda covered updates on (i) the East of England Neurosciences Strategy and (ii) the Outpatients Strategy.

East of England Neurosciences Strategy

3. JB presented the emerging strategy for neurosciences for the East of England delivered through the new East of England (Specialised) Services Provider Collaborative (EoE SPC). In 2023 NHSE delegated responsibility for specialised service commissioning to the regions and as a result the EoE SPC was created as the group of hospitals commissioned to provide one or more specialised services for the population of the East of England. Neurosciences is one of the of the 36 national programmes of care specialised services and is provided in CUH and Norfolk and Norwich University Hospitals Foundation Trust.

4. One of the consequences of centralised commissioning has been the concentration of funding and expertise in a few specialised centres. As a result, patients needing specialist neurological care need to travel to Cambridge, Norwich or London. The EoE SPC has identified neurosciences as a priority area and commissioned a transformation strategy. A diagnostic review has been carried out and currently the team is developing recommendations. Neurosciences includes disease areas such as multiple sclerosis, dementia, epilepsy, muscular dystrophy, motor neurone disease, etc. The principle aims of the strategy are to grow local capacity and capability for early diagnosis, treatment and rehabilitation and to enable delivery of services closer to home.

5. The group discussed a number of matters arising. For example: the trade-off between the convenience of accessing care locally vs being able to visit national centres of excellence; the need to be clearer about the objectives (is it shorter journeys, quicker diagnosis, improving health inequalities, others?); and the need to look at disease groups separately as the needs of the patients and their carers are likely to be different. We also asked that patients and their carers be involved in the strategy and that multidisciplinary teams included nurses, AHPs, pharmacists, etc.

Outpatients' strategy

6. DNJ introduced the new outpatients' strategy by saying that the current model is unsustainable in its present form. There are too many patients waiting too long and despite improvements in productivity (staff are delivering 110% of the pre-Covid levels of outpatient appointments), the waiting list is increasing, and overdue follow-ups are rising (59,000 in December 2023). Despite these pressures CUH is doing reasonably well in comparison with its peers in the Shelford Group of hospitals (large teaching hospitals). The proposal is to change outpatients to primarily an "out of hospital" care service, by working in partnership with primary care and community services. There are also opportunities to streamline diagnostics, appointments, tests etc. to be carried out on the same day when patients do have to come in; and there are opportunities to use digital technology to help patients play a greater role in managing their own care and exploit digital communications to avoid the need for face-to-face appointments (known as "patient not present" or PNP). The hospital is already pushing patients to initiate their own follow-up appointments rather than automatically scheduling them ("patient initiated follow ups" – PIFU).

7. AT and CK emphasised the need for change and responded to questions from governors. One of the concerns is how to know the conditions of patients waiting a long time for their appointment. Governors urged the team to involve both GPs and patients in the project for the following reasons: GPs are already under huge pressure and may not be able to take on additional outpatient work and patients who may be expected to make more use of digital technology simply may not be able to and this may lead to inequalities in access to treatment.

8. Governors thanked DNJ, JB, AT and CK for presenting the two strategies.

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Council of Governors: 27 March 2024

Agenda item	9
Title	Governors' Nomination and Remuneration Committee – terms of reference
Sponsoring executive director	Ian Walker, Director of Corporate Affairs
Author(s)	As above
Purpose	To approve the terms of reference.
Previously considered by	Governors' Nomination and Remuneration Committee, 18 October 2023

Executive Summary

The terms of reference of the Governors' Nomination and Remuneration Committee were reviewed by the Committee at its meeting in October 2023. The only material change agreed was to add at paragraph 1.2 of the terms of reference a sentence to clarify that membership of the Committee through the position of Lead Governor or Deputy Lead Governor shall not count towards the four-year time limit for service on the Committee.

Related Trust objectives	All Trust objectives
Risk and Assurance	n/a
Related Assurance Framework Entries	n/a
Legal and regulatory implications?	The composition of the Council is defined by the Trust Constitution.

Action required by the Council of Governors

The Council of Governors is asked to approve the revised terms of reference of the Governors' Nomination and Remuneration Committee.

CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

GOVERNORS' NOMINATION AND REMUNERATION COMMITTEE

TERMS OF REFERENCE

1. Membership

1.1 The Council of Governors will appoint a Nomination and Remuneration Committee from among their number. Membership of the Committee will comprise:

- Two public Governors
- Two patient Governors
- One staff Governor
- One partnership Governor
- Lead Governor or Deputy Lead Governor
- Trust Chair
- Senior Independent Director or other Non-Executive Director nominated by the Senior Independent Director (*only where considering issues regarding the Trust Chair*)

1.2 Governor members shall be elected to the Committee for a term of two years and shall be eligible for re-election by the Council of Governors at the end of this period for a further term of two years, up to a maximum cumulative term of four years. Membership of the Committee through the position of Lead Governor or Deputy Lead Governor shall not count towards this time limit.

1.3 The quorum for the Committee shall be four members, including a minimum of one patient Governor member, one public Governor member, one staff Governor member or partnership Governor member, and the Trust Chair (or Senior Independent Director when considering issues regarding the Trust Chair).

1.4 In the event that it is not possible to form a quorum for a specific meeting from among the individuals currently elected as members of the Committee, the Director of Corporate Affairs is authorised, where judged necessary to permit the effective functioning of the Council of Governors and following consultation with the Chair of the Committee, to invite another Governor from the relevant constituency to be a member of the Committee on a temporary basis for the purpose of achieving the quorum.

1.5 The Chair of the Committee shall be elected by the Council of Governors from among the Governor members of the Committee.

1.6 In circumstances where the Committee is discussing matters which relate to both the Chair and Senior Independent Director, the Committee may meet with only Governor members present.

1.7 When making recommendations for the appointment by open competition (but not uncontested re-appointments) of the Trust Chair and Non-Executive Directors, the Committee may (a) seek the advice of an appropriate external assessor; and (b) be authorised to take professional advice to assist in the appointment process. The Committee is also authorised to invite additional individuals to participate in recruitment exercises related to the role of the Trust Chair and Non-Executive Directors.

2. Attendance at meetings

2.1 Meetings will be supported by the Director of Corporate Affairs and members of the Trust Secretariat.

2.2 Subject to any conflicts of interest, attendance at meetings shall be restricted to the members stated at paragraph 1.1, advisers as stated at paragraph 1.7, and the Director of Corporate Affairs and members of the Trust Secretariat.

2.3 All other attendances will be at the specific invitation of the Chair of the Committee.

3. Frequency of meetings

3.1 The Committee will meet as necessary but at least once per year.

4. Functions

4.1 To keep under review and make recommendations to the Council of Governors regarding the appointments process for Non-Executive Directors.

4.2 To make recommendations to the Council of Governors regarding the appointment or re-appointment of the Trust Chair as and when appropriate.

4.3 In consultation with the Trust Chair, to make recommendations to the Council of Governors regarding the appointment or re-appointment of Non-Executive Directors.

4.4 To make recommendations to the Council of Governors regarding the appraisal process for the Trust Chair, to oversee arrangements for the appraisal to take place, to review the outcome of the process and to provide assurance to the Council of Governors regarding the appraisal process.

4.5 In consultation with the Trust Chair, to make recommendations to the Council of Governors regarding the appraisal process for Non-Executive Directors, to oversee arrangements for the appraisals to take place, to review with the Trust Chair the outcome of the process and to provide assurance to the Council of Governors regarding the appraisal process.

4.6 Following consultation with NHS England, to make recommendations to the Council of Governors regarding the removal of the Chair and/or Non-Executive Directors.

4.7 To keep under review the terms and conditions of appointment, including remuneration, of the Trust Chair and Non-Executive Directors and make recommendations to the Council of Governors on any amendments as appropriate.

4.8 To keep under review the information and training provided to the Council of Governors on the role of the Board of Directors and the requirements for effective NHS boards.

5. Reporting and effectiveness

5.1 The Committee will report to the Council of Governors following each meeting of the Committee.

5.2 The Committee will review its own effectiveness at least once every three years and will report the outcome to the Council of Governors.

Reviewed by the Governors' Nomination and Remuneration Committee: 18 October 2023

Approved by the Council of Governors: