<table>
<thead>
<tr>
<th>Number</th>
<th>Date Received</th>
<th>Applicant</th>
<th>Information Requested and Response</th>
</tr>
</thead>
</table>
| 621.15  | 27.10.15      | Individual| 1. How do you currently comply with CRC, through outsourcing or in house? 
*The Trust is currently exempt from CRC through its participation in EU ETS.*
2. In the past 2 years have you invested in means to reduce your carbon emissions? 
*The Trust has a rolling programme of investment in carbon reduction via a dedicated Salix Fund (plus accessing Government grants as and when available).*
If yes do you have a rough estimate of the investment or which specific technology or equipment were purchased?
*We have invested in LED lighting (internal and external), steam main insulation, roof insulation, heat recovery and AHU/pump inverter control upgrades, and BMS development.*
3. In the next 2 years do you plan on investing in reducing your carbon emissions? If yes do you have a rough estimate of the investment or what specific technology or equipment you are to invest in?
*We would expect to continue to invest as in 2. Above, we are also currently reviewing the Trust’s primary energy sources – one of the drivers here is carbon reduction.*
4. What are the main barriers to further investment? And what would encourage yourselves to invest further?
*Principal barrier is ready access to capital funding in a very financially constrained environment.*

*From 03/11/2011: £2 per picture.*
*From 1st January 2013 prices for pictures were:*
  1 picture £5
  3 pictures £10
  6 pictures £20.
*From 1st July 2015 prices increased to:*
  1 picture £6
  3 pictures £12
  6 pictures £20.
2. The figures for how much profit has been made from the ultrasound charges for each year from 2011 to now.
*We do not hold this information as we have never worked out the cost of a scan picture i.e. - specific printer, ink, paper, sonographer time etc.*
3. An explanation for why the charges increased (if they did so).
*They increased in line with inflation and consumable prices.*
4. If you charge different sums for different hospitals please provide answers to the above points for each hospital.
*Not applicable – one site only - Rosie Hospital*

| 625.15  | 30.10.15      | Individual| 1. Does this NHS FT provide parking areas for either staff and/or visitors/patients? If not then I have no further questions.
*The Trust provides an allocation of parking spaces for staff, patients and visitors; these spaces are available within two shared multi storey car parks, with a third multi-storey car park for staff use only.*
2. How many car park sites does the Trust operate?
   Those on the Addenbrookes site?
3. How many parking bays does your Trust provide for staff and how many for visitors/patients?
   Staff spaces = 4156
   Patients and Visitors = 1350
4. What is the fee schedule for these car parks, both staff and visitor/patients?
   Staff fee £2.70 per 24 hours
   P&V Discounted ticket;
   Outpatients, day surgery and emergency patient’s up to 24 hours £3.40
   Patients receiving treatment seven day ticket £3.40
   Frequent visitors 7 day 18.30 14 day 31.00
   Hourly tariff;
   Up to 1 hour £2.70
   Up to 2 hours £3.90
   Up to 4 hours £7.20
   Up to 6 hours £11.00
   Up to 8 hours £14.20
   Over 8 hours £17.80
5. How is payment made, i.e. pre-paid or on exit?
   Pay on foot on exit
6. Are these bays available 24 hours a day, 365 days a year?
   All bays are available 24 hours a day, 365 days a year.
7. Does the Trust manage these facilities directly or is the management outsourced to third party contractors?
   The car park management is outsourced.

626.15 02.11.15  Media

Please provide costs claimed by Ahmedia Ltd for your trust staff unable to attend their Healthcare Strategy Forum over the last 4 years.

The Trust has not made any payments to Ahmedia Ltd during the last 4 years.

630.15 02.11.15  Commercial

I would like to know what method the trust currently uses to seal and audit clinical waste bags. Specifically what product is used to close the bag, how the bag is able to be traced back to its point of origin and the annual volume of product used.

We use tape identifying each ward, clinic, department’s etc. We use this on all bags and sharps bins in order that we can trace the origin of the waste.

Approximately 5,000 rolls per annum are purchased from Fastnet Tapes.

633.15 03.11.15  Individual

<table>
<thead>
<tr>
<th>Name of Trust</th>
<th>Cambridge University Hospitals NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact email address</td>
<td>It is not Trust policy to release email addresses in response to Freedom of Information Requests.</td>
</tr>
<tr>
<td>Contact phone number</td>
<td>01223 245151</td>
</tr>
<tr>
<td>1. Do you have a specific standardised proforma for neck of femur fracture patients?</td>
<td>Yes</td>
</tr>
<tr>
<td>2. If yes to (1), does the proforma include a section on fascia iliaca compartment blocks (FICB)?</td>
<td>Yes</td>
</tr>
</tbody>
</table>
3. Do you have a hospital related guideline for FICBs in neck of femur fracture patients?

No - Blocks given in ED as part of admission process. If further blocks required administered by anaesthetists

4. Are FICBs routinely given in neck of femur fracture patients?

Yes - Given in ED as detailed above

5. Do you audit the use of analgesia in neck of femur fracture patients?

No

6. If yes to (5), what percentage of neck of femur fracture patients receive a regional nerve block?

Not applicable

7. If yes to (4), who administers the FICB?

Emergency medicine

Anaesthetics

8. If FICBs are not routinely given to patients with fractured neck of femur patients, please indicate why.

Not applicable

I would be most grateful if you would provide me, under the Freedom of Information Act, details in respect of the following framework agreement(s)/contract(s):

Framework Agreement Contract
UK-Cambridge: medical consumables
Date of Contract
Date Published: 28 March 2012
1. Suppliers who applied for inclusion on each framework/contract below and were successful & not successful at the PQQ & ITT stages.

Bard Ltd - successful
Chalice Medical - successful
Cook Medical - unsuccessful
Medical Access - unsuccessful
Euclid Infotech – declined to tender
Kimal plc – declined to tender
Codan Medical – declined to tender
Richardsons Healthcare – declined to tender
Covidien – declined to tender
Edwards Lifesciences – declined to tender
B Braun – declined to tender

1. Contract values of each framework/contract (& any sub lots), year to date

Bard Ltd - £18,830.36 + VAT financial year to date.
Chalice Medical – Nil expenditure financial year to date.

2. Start date & duration of framework.

June 2012 – June 2016

3. Is there an extension clause in the framework(s)/contract(s) and, if so, the duration of the extension?

No extensions

4. Has a decision been made yet on whether the framework(s)/contract(s) are being either extended or renewed?

A new tender exercise for these products will be conducted during the first quarter of 2016.

5. Is there an extension clause in the framework(s)/contract(s) and, if so, the duration of the...
extension?
No extensions
6. Has a decision been made yet on whether the framework(s)/contract(s) are being either extended or renewed?
A new tender exercise for these products will be conducted during the first quarter of 2016.

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<th>Question</th>
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</table>
| 637.15| 04.11.15| Other - NHS      | Since November 2008, has your trust audit department had any registered audits which includes all of or in part the following titles?
‘BOAST 2’
‘British Orthopaedic Association Standards of Trauma 2’
‘Spinal Clearance in the Trauma Patient’
There have not been any registered Audits recorded since 2008 which include the above titles. |

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<th>Category</th>
<th>Question</th>
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</table>
| 638.15| 04.11.15| Individual      | 1. Do you currently offer a clinical testing service for BRAF mutation in solid tissue, specifically melanoma? (Yes, No, currently in development)?
Yes, from one of our laboratory site based at Cambridge University Hospitals NHS Trust. None of our other sites Ipswich, Colchester, West Suffolk, Hinchingbrooke or Lister offer this service.
2. Which methodology(ies) do you use for BRAF testing in melanoma? e.g. Real time PCR (QPCR), High resolution melting curve analysis (HRMCA), Sanger sequencing, Next Generation Sequencing (NGS), Pyrosequencing, Immunohistochemistry (IHC), Fluorescence In Situ Hybridisation (FISH), Other (please specify). If you use a specific kit I would be grateful if you could provide the name of the kit you use.
IHC (for V600E and E2) and NGS. NGS for BRAF exon 15 mutation testing including V600 mutation testing using The Ion AmpliSeq™ Cancer Hotspot Panel v2 on IonTorrent PGM platform. The antibody comes from Spring Bioscience (Clone VE1), it is recommended for V600E mutation. They are stained on the Leica Bond III machines. Kits used include Bond Polymer Refine Detection Kit (DS9800) and they have a pre-treatment using Leica Bond Epitope Retrieval Solution 2.
3. Which BRAF mutations does your methodology(ies) cover? E.g. V600E, V600K, V600D, V600R etc. All of these, we also test for NRAS and cKIT.
4. What is your current laboratory turnaround time for BRAF testing in melanoma?
IHC is 24 hrs, NGS – 5-10 working days.
5. What is the level of sensitivity of your BRAF methodology(ies)?
Our IHC is 97.4% for all b-raf mutations when we last looked at figures compared to the COBAS test in Birmingham. This looks quite high and since taking those figures we have had 2 V600K cases which were of course –ve on IHC. We have had no known cases of IHC –ve NGS +ve V600E cases.
6. I understand that molecular testing in FFPE tissue can be difficult due to tissue quality and/or quantity. What would you estimate is your current failure rate for BRAF testing for melanoma? Not a problem for IHC so far. We have had 2 cases +ve in small deposits of melanoma which has been undetectable by molecular (COBAS in Birmingham).
7. Approximately how many BRAF tests for melanoma would you conduct per month or year (whichever time period is most convenient for you to estimate)?
90 tests per year, IHC, NGS or both.
8. Of the BRAF tests performed for melanoma, please estimate how many (or what percentage) are found to be positive for a mutation?
44%
9. Of the positive tests, please estimate how many (or what percentage of the positives) are V600E? How many (or what percentage of the positives) are V600K? How many (or what percentage of the positives) are V600 all other mutations?
When we audited before NGS was introduced 2/40 were non V600E. One of these was presumed to
be V600K, the other was V600E2. Since NGS was introduced, 17 of 32 cases tested are positive for BRAF exon 15 mutation. Among these, 12 are positive for V600E, 3 positive for V600K, 1 positive for V600R and 1 positive for K601E.

<table>
<thead>
<tr>
<th>640.15</th>
<th>04.11.15</th>
<th>Commercial</th>
<th>Who or what department would oversee the Occupational Hygiene testing. ie the areas off the list below.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Workplace Air Monitoring</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• COSHH Risk Assessment</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Indoor Air Quality</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• LEV (Local Exhaust Ventilation) Testing &amp; Examination</td>
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<td></td>
<td></td>
<td></td>
<td>• Legionella</td>
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<td></td>
<td></td>
<td></td>
<td>• Legionella Maintenance</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Workplace Noise Monitoring</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Environmental Noise</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Hand Arm Vibration</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Most of these areas have management responsibilities based on local risk assessments such as COSHH, Noise Monitoring, Air Quality etc. These are managed, monitored and maintained for the trust by the Maintenance department within Estates &amp; Facilities at Cambridge University Hospitals.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>649.15</th>
<th>09.11.15</th>
<th>Other –NHS</th>
<th>1. Did Cambridge University Hospitals NHS Foundation Trust self-assess services against the Care Quality Commission’s Essential or Fundamental Standards prior to the CQC inspection of April-May 2015?</th>
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<tbody>
<tr>
<td></td>
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<td></td>
<td>Yes. Routinely the Trust reported on the CQC essential standards in the monthly Integrated Performance Report. When the Fundamental standards were published in early 2015 the performance report went under review to reflect the revised regulations.</td>
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<td></td>
<td></td>
<td></td>
<td>a. If yes, what were the self-assessment ratings for each of the services that were assessed?</td>
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<td></td>
<td></td>
<td></td>
<td>In preparation for the inspection the trust completed a self-assessment led by the executive team and informed by the larger senior team as demonstrated below;</td>
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<table>
<thead>
<tr>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Inadequate</td>
<td>Requires Improvement</td>
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<td>Inadequate</td>
<td>Requires Improvement</td>
</tr>
</tbody>
</table>

In addition the Trust completed a series of Mock inspections covering the core service areas these were reported and reviewed at the CQC Steering Group led by the executive team.

2. Please describe the method(s) used for assessing compliance with CQC standards: is a software system used, is evidence collected, where is this stored, where is this reported, what does the clinical structure for assessment look like?

The Trust has a software system – with the standards and evidence stored, the reporting has been more at corporate level and the reporting is via the Integrated Performance report which reports monthly – The DATIX system has a compliance software, which the Trust has purchased and will be moving over to this system in early 2016, and this will enable ward to Divisional level monitoring going forward.
**Media**

Under the Freedom of Information Act, please could you provide me with the number of unserved meals (ward food wastage) at each of your sites in 2014/15, and what percentage of all meals provided this represents.

For plated meal systems, this is the number (calculated over the full menu cycle or 7 days where no menu cycle is used), of unserved in-patient meals remaining at the end of the meals service period expressed as a percentage of the total number of meals provided and available at the commencement of the meal service period. For bulk systems use an apportionment of remaining meals based on visual inspection.

We do not monitor individual plate waste or have a weight of the overall food waste per day. However, we do collect data from the plated waste at ward level and bulk food waste in the same bucket, weighed by Patients Catering before going into the waste digester. The returned wastage from the bulk food trolleys is running at less than 10%

Total annual in-patient meals ordered from wards and departments.

An in-patient meal is defined as either a breakfast, midday or evening meal order (or any substitute or alternative for any such meals) received from an in-patient (wards and departments) or the number of similar meals provided to wards and departments as an estimate of need where order systems are not in use (Not applicable to Ambulance Trusts).

In-Patient meals Requested – No. 955,415

This figure is part of our annual ERIC data return for 2014/15 – A Department of Health requirement

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**Commercial**

Details of who provides your Information Asset Register (IAR)

The return information should include:

1. Name of supplier
   - Bespoke build by Independent Computer Supplies (ICS)
2. Annual value of contract i.e. £10,000 p/a
   - Not applicable as there is not a contract in place.
3. Expiry date of contract i.e. 01/06/2015
   - Not applicable.
4. Business / service owner responsible for Information Assets (please include full contact details) i.e. Mrs Barbara Brown.
   - Mrs M Ellerbeck – Information Governance Lead
5. If you are not currently using any IAR software, what are the main tools being used to manage information assets? i.e. Excel Spreadsheets.
   - Not applicable.
6. Please advise if you are using a solution that was developed 'in-house'.
   - Design in house, developed out of house.

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**Researcher**

1. With regards to the way medical records are currently used in your Trust, which EMRAM* stage are you?
   - HIMSS STAGE 6
2. If you are unable to tell us the above, can you tell us if your Trust is running, or has signed a contract to run an electronic medical records system that meets the following criteria:
   - Electronic clinical documentation interacts with clinical decision support systems (based on both discrete data elements)
   - AND
   - Electronic closed loop medication administration system.
   - If not, is your trust planning to commission an EMR (which meets criteria set out in Question 2)
   - We have already purchased EPIC.
3. If you are currently utilizing an EMR, or have commissioned an EMR which is awaiting
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>implementation, did you consider franchising an already implemented EMR from another NHS institution in the UK?</td>
<td>No.</td>
</tr>
<tr>
<td>4. If you are currently utilizing an EMR, or have commissioned an EMR which is awaiting implementation: does your EMR allow functional interoperability i.e. transfer of information from at least one other EMR used regionally in primary, secondary or tertiary care?</td>
<td>Yes.</td>
</tr>
<tr>
<td>5. If your trust is planning to commission an EMR or currently has an open tender for an EMR, are you inviting applications for franchised systems from other NHS trusts?</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>6. If your trust currently utilizes an EMR, does the contract with the software provider allow for franchising your system to other trusts?</td>
<td>No.</td>
</tr>
<tr>
<td>7. Regarding direction from Clinical Commissioning Group(s) that commission services in your local area, have you had formal or informal direction regarding EMR provision?</td>
<td>System already purchased.</td>
</tr>
<tr>
<td>8. Regarding coordination with other acute hospital trusts, have you had any formal or informal discussions regarding coordination of EMR purchasing?</td>
<td>System already purchased.</td>
</tr>
</tbody>
</table>