Board of Directors

Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

There will be a meeting of the Board of Directors in public on Wednesday, 10 June 2026 at 11.00

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

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

AGENDA

General business			Purpose
11.00	**1**	**Welcome and apologies for absence**	For note
	2	**Declarations of interest** To receive any declarations of interest from Board members in relation to items on the agenda and to note any changes to their register of interest entries A full list of interests is available from the Chief Governance and Performance Officer on request	For note
	3	**Minutes of the previous Board meeting*** To approve the minutes of the Board meeting held in public on 11 March 2026	For approval
	4	**Board action tracker and matters arising not covered by other items on the agenda**	For review
11.05	**5**	**Patient story** To hear a patient story	For receipt
11.20	**6**	**Chair's report** To receive the oral report of the Chair	For receipt

11.25	**7**	**Report from the Council of Governors** To receive the report of the Lead Governor	For receipt
Performance, strategy and assurance			**Purpose**
11.30	**8**	**Report from the Chief Executive Officer** *The items in this section will be discussed with reference to the Integrated Performance Report and executive team report* 8.1 Safe and effective care (including nurse safe staffing report) 8.2 Access and operational performance 8.3 Finance 8.4 People 8.5 Strategy, major projects and innovation	For receipt
11:50	**9**	**Verita report action plan update – 6-month milestones** To receive the report of the Chief Medical Officer	For approval
12:10	**10**	**Freedom to speak up** To receive the report of the Chief Nurse	For receipt
12:20	**11**	**Guardian of Safe Working – quarterly and annual reports** To receive the report of the Chief Medical Officer	For receipt
12:30	**12**	**Learning from deaths** To receive the report of the Chief Medical Officer	For receipt
12:40	**13**	**Modern Slavery Act Statement effectiveness** To receive the report of the Chief Governance and Performance Officer	For approval
12:45	**14**	**Annual safe staffing report – nursing** To receive the report of the Chief Nurse	For receipt
12:50	**15**	**Bi-annual perinatal staffing paper** To receive the report of the Chief Nurse	For receipt
Items for noting			**Purpose**
	16	**Committee terms of reference and Chairs' Alert, Advise, Assure reports** To receive the following reports of the Chief Governance and Performance Officer	For receipt

		17.1 Committee terms of reference: 18.2 Board assurance committees: 18.2.1 Audit Committee: 29 April 2026 18.2.2 Performance and Finance Committee: 6 May 2026 and 3 June 2026 18.2.3 Quality Committee: 6 May 2026 18.2.4 People, Education and Culture Committee: 3 June 2026	
	17	**Use of the Trust Seal** To receive the report of the Chief Governance and Performance Officer	For receipt
Other items			**Purpose**
	18	**Any other business**	
	19	**Questions from members of the public**	
	20	**Date of next meeting** The next meeting of the Board of Directors will be held on Wednesday, 9 September 2026 at 15.00pm	For note
13:00	**21**	**Close**	

NHS
Cambridge
University Hospitals
NHS Foundation Trust

Minutes of the meeting of the Board of Directors held in public on Wednesday 11 March 2026 at 15.00 in person and via videoconference

Member	Position	Present	Apologies
Baroness S Morgan	Trust Chair	x	
Mr D Abrams	Non-Executive Director	x	
Ms N Ayton	Acting Chief Executive	x	
Dr S Broster	Chief Medical Officer	x	
Mr J Crompton	Non-Executive Director	x	
Ms P Hird	Non-Executive Director	x	
Ms B Hughes	Chief Governance and Performance Officer	x	
Mr M Keech	Chief Finance Officer	x	
Mr N Kirby	Interim Chief Operating Officer	x	
Ms A Layne-Smith	Non-Executive Director	x	
Prof P Maxwell	Non-Executive Director		x
Dr J Morrow	Non-Executive Director	x	
Mr R Sivanandan	Non-Executive Director	x	
Prof R Smyth	Non-Executive Director	x	
Ms C Stoneham	Chief Strategy and Transformation Officer	x	
Ms L Szeremeta	Chief Nurse	x	
Mr D Wherrett	Chief People Officer	x	

In attendance	Position
Prof J Bradley	Director of Research and Development *(for item 14/26)*
Dr J Brubert	Co-Chair of Resident Doctors Forum *(for item 11/26 only)*
Mr J Clarke	Trust Secretary *(for item 05/26 only)*
Dr S Goon	Guardian of Safe Working *(for item 11/26)*
Ms J Leigh	Secretariat Officer (minutes)
Ms I Oberg	Lead Cancer Nurse *(for item 05/26 only)*
Dr M Phillips	Resident Doctors Forum Co-Chair *(for item 11/26 only)*
Ms C Powell	Senior Therapeutic Radiographer *(for item 05/26 only)*
Dr H Rubinstein	Lead Governor
Ms E Warren-Barrett	Head of Clinical Governance, Chief Medical Officer's Office *(for item 10/26)*

01/26 Welcome and apologies for absence

Apologies for absence are recorded in the attendance summary.

02/26 Declarations of interest

Standing declarations of interest of Board members were noted.

03/26 Minutes of the previous meeting

The minutes of the Board of Directors' meeting held in public on 17 December 2025 were approved as a true and accurate record.

04/26 Board action tracker and matters arising not covered by other agenda items

Received and noted: the action tracker.

05/26 Patient story

Lorraine Szeremeta, Chief Nurse, presented the patient story.

Ingela Oberg, Lead Cancer Nurse and Chelsey Powell, Senior Therapeutic Radiographer also joined for the discussion.

Noted:

1. The Board received a patient story highlighting the experience of a profoundly deaf patient. While the patient reported overall excellent breast cancer care, challenges were identified within the radiotherapy suite where instructions are delivered via an audio intercom. The patient is now working constructively with the radiotherapy team to explore practical improvements for people with hearing loss.
2. The item brings together learning from patient experience and service improvement work within radiotherapy.
3. The radiotherapy service is progressing work to introduce visual cueing, including LED-based solutions, within the department to support patients with hearing loss.
4. The Board was advised that early engagement has taken place with external partners regarding potential system installation. Careful consideration is required to ensure that any lighting solutions do not adversely affect radiotherapy equipment. There is potential to extend the approach beyond radiotherapy to other imaging and scanning services. This was highlighted as particularly beneficial for inclusion, including for patients with hearing loss, those for whom English is a second language, and paediatric patients.
5. All breast cancer patients are now receiving surface-guided radiotherapy. This approach removes the need for tattooing and

instead relies on body contouring, which is particularly important for chest radiotherapy and for patients undertaking breath-hold techniques. The technology improves accuracy and enables patients to better understand and control their treatment, supporting a more patient-led experience.

In discussion the following points were raised:

6. An Executive Director reflected on the importance of actively identifying and sharing examples of innovation that improve patient outcomes and experience. It was noted that celebrating such work is beneficial both for patients and for staff awareness of good practice across the organisation.
7. A Non-Executive Director welcomed the innovation but highlighted that the initial patient experience had not been optimal, as the patient was unable to hear instructions during early treatment sessions.
8. Issues relating to appropriate seating allocation in clinics for patients who are hard of hearing were also noted.
9. The Chief Nurse advised that ongoing work is underway with people with a range of disabilities to understand how clinical environments and processes operate from their perspective.
10. A Board member described the item as a strong example of patient-led service change and emphasised the importance of harnessing the full breadth of patient experience to inform service improvement. The need to ensure learning is applied across a range of services to support people with different disabilities was highlighted.
11. It was noted that the Cambridge Cancer Research Hospital will enable a wider range of innovative approaches.
12. It was confirmed that work is underway to explore implementation of this particular process at a regional level.
13. The Chair welcomed the openness and candour regarding areas where improvements were needed and strongly supported the ambition both to share innovation beyond the organisation and to adopt best practice developed elsewhere, in order to deliver the best possible outcomes for patients.

Agreed:

1. To note the staff story.

06/26 Chair's report

Sally Morgan, Trust Chair, presented a verbal update to the Board.

Noted:

1. The Board was reminded that the Trust strategy represents a clear statement of ambition for how the organisation will be taken forward. It was acknowledged that the strategy is challenging, both for the Trust and for the wider system, but is necessary to support future sustainability and improvement.

2. The importance of how the Trust works to maximise benefits for the wider community was highlighted, noting that this remains a key consideration in strategic and operational decision-making.
3. The Chair reflected on the challenging context in which the Trust is currently operating, including the findings and implications of the Verita report. It was emphasised that the issues raised are being taken extremely seriously. The Board was assured that a thorough and robust approach is being taken to understand what has gone wrong and to identify the actions required to strengthen governance, oversight and performance going forward.

Agreed:

1. To note the verbal update of the Chair.

07/26 Report from the Council of Governors

Helena Rubinstein, Lead Governor, presented the verbal update.

Noted:

1. It was agreed that the report would be taken as read.
2. The Lead Governor highlighted that work is underway on a new initiative to explore how the Trust's volunteers might contribute additional value beyond their existing roles. It was reported that Governors are considering potential opportunities in this area. The Board acknowledged the significant contribution already made by the Trust's volunteer workforce, comprising approximately 400 volunteers, and noted that the value of this contribution has been estimated at around £500k per annum, based on equivalent minimum wage costs.

Agreed:

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

08/26 Chief Executive and Executive Team report

Nicola Ayton, Acting Chief Executive, presented the report.

Noted:

1. The report provided an overview for the Board from the Executive Team covering collective areas of accountability: safe and effective care; access and operational performance; people; finance, productivity and planning; major projects and digital.
2. The Board noted that good progress had been made in several key areas, alongside areas where challenges remain.
3. The Chief Nurse advised that, since the last Board meeting, a Maternity Incentive Scheme (MIS) submission had been completed demonstrating compliance across all ten required areas. A significant programme of work had been undertaken, and the Trust is awaiting the outcome.

4. It was reported that an external review of quality governance structures had been completed. Recommendations have been accepted and will be moved into a robust improvement plan. Weekly executive safety meetings had been introduced with early feedback indicating this is working well.
5. It was noted that the GENOME review process has been implemented, with findings reported through the Quality Committee and escalated to the Board.
6. Areas of concern were highlighted, including seven Never Events reported in the financial year to date. Focused work is underway to identify common themes and learning.
7. The Board noted that falls data remains above the Trust's internal target but below the national benchmark. High-risk areas, including bathrooms, have been identified. The introduction of new alarm systems has resulted in a reported 30% reduction in incidents.
8. Progress is being made in addressing the backlog in the Patient Advice and Liaison Service (PALS), and actions have been taken that are expected to reduce overall volumes.
9. It was reported that an internal review of the Infection Prevention and Control (IPC) approach and structure has been undertaken, with recommendations to be progressed.
10. External specialty reviews: The Trust has hosted a series of external specialty reviews to strengthen clinical governance and MHPS arrangements, with three additional investigations commencing in Quarter 3 to ensure timely management of emerging concerns.
11. The Interim Chief Operating Officer outlined governance arrangements in place across the three operational performance areas – planned care, cancer performance and urgent and emergency care.
12. Planned care performance has improved over recent months. The number of patients waiting over 52 weeks has reduced from 3,055 to 1,589. National focus remains on 18-week pathways, with performance improving to 61% against a target of 64.1% by month end.
13. Cancer performance was discussed. The 62-day referral-to-treatment standard has improved significantly, with 28-day performance now within the top ten nationally. While diagnostics performance has been strong over the past year, increased winter demand has created pressure in a small number of modalities.
14. Urgent and Emergency Care performance was acknowledged as challenging over the winter period; however, the winter plan was delivered successfully, including the digital front door. Investment has been made in additional staffing within UEC and paediatrics.
15. Several tactical interventions are planned over the coming months, which are expected to have a positive impact into the next winter period.
16. The Chief Finance Officer reported that the Trust remains on track to deliver a small surplus at year end. This position is underpinned by productivity improvements, largely driven by workforce reductions and increased activity.

17. The importance of maintaining flat cost growth in the next financial year was emphasised.
18. The need to achieve a different and more sustainable delivery approach was noted.
19. The Board noted the Trust's capital position, with £112m invested during the year, significantly higher than in previous years, and which was expected to support future service delivery.
20. The Chief People Officer outlined plans for the workforce budget and the year ahead.
21. The Board noted the requirement to deliver increased activity within existing resources, recognising the challenge this presents. A detailed workforce plan will be brought forward.
22. It was noted that the National Staff Survey results were due to be published the following day. Board members had seen the results in advance, subject to embargo.
23. The Trust continues to perform strongly in a number of workforce areas, with a recognised need to continue investing in staff development.
24. A Non-Executive Director commended the Executive team for encouraging staff participation in the National Staff Survey, with approximately 7,000 responses received, providing a rich data set.
25. Sickness absence compares favourably against peers but remains a concern and the Trust has implemented enhanced, targeted absence management and wellbeing measures to support staff, reduce temporary staffing reliance and deliver sustained improvement during 2026/27.
26. The Board noted strong recruitment interest with a recent Healthcare Support Worker post attracting over 450 applications within three days, rising to approximately 650 before recruitment was closed. It was noted that a significant number of applications used AI.
27. Workforce challenges within maternity support roles were noted, with actions underway to improve role clarity, strengthen job descriptions and introduce additional competencies.

Agreed:

1. To note the contents of the report from the Chief Executive.

09/26 **Trust strategy refresh**

Claire Stoneham, Chief Strategy and Transformation Officer presented the report.

Noted:

1. The Chair introduced the strategy paper, setting out the Trust's response to rising demand and outlining how digital development, research and innovation are central to enabling sustainable service delivery. It was emphasised that the strategy is intended to be practical, actionable and focused on progressing the Trust's strategic agenda.

2. The Chief Strategy and Transformation Officer presented the updated five-year strategy, describing it as the Trust's anchor document. The strategy articulates the case for change, the proposed organisational response and the commitments the Trust is making going forward. It was noted that the strategy will continue to be refined as implementation progresses.
3. The Board noted that the strategy has been developed through extensive engagement with staff, patients, the local population and system partners, and that it builds on existing work and learning across the organisation.
4. The Chief Strategy and Transformation Officer highlighted that the strategy deliberately focuses on the challenges facing the Trust in the immediate term, including demographic change, increasing demand associated with an ageing population, and the requirements of the NHS 10-Year Plan. The paper also reflects the broader system direction of travel and the changes required in how care is delivered.
5. The Board noted that specific challenges within paediatric services have been clearly identified and that a defined plan has been developed in response.
6. The Trust's unique position within the biomedical campus was acknowledged, including the opportunities this presents for collaboration, research, innovation and service transformation.
7. It was noted that the strategy outlined the proposed approach to delivery, including how progress will be measured, monitored and reviewed. The strategy will remain adaptable to reflect learning, changing circumstances and emerging priorities.

The following points were raised in discussion:

8. The Board discussed the three strategic priorities set out in the strategy: delivering timely, excellent care; transforming services to meet future need; and enabling delivery through the workforce, digital capability and infrastructure.
9. It was noted that the strategy provides clarity on what is meant within each area of focus, with definitions and scope set out within the paper to support shared understanding.
10. The Board acknowledged that the strategy is intentionally high-level at this stage and will become increasingly detailed and granular as delivery plans are developed and implementation progresses.
11. A Non-Executive Director commented that the development process has helped the organisation to focus on the most important priorities, moving away from aspirational or "blue-sky" thinking towards a more deliverable strategy.
12. A Non-Executive Director reflected on the inclusive development process and noted that the Board now has a strategy that speaks to what matters most to staff and partners, with a clear emphasis on improving patient outcomes and maximising the Trust's contribution and impact.
13. The Board sought assurance that a sufficiently broad patient and public voice had informed the strategy. It was confirmed that a range

of mechanisms had been used to engage with existing patient and public groups specifically to inform this work.

14. It was confirmed that engagement will continue to be expanded and strengthened as the strategy moves into delivery.
15. A Non-Executive Director welcomed the clarity of the strategy and asked what learning had been taken from previous iterations to support successful delivery. It was explained that this strategy is intentionally more directional than previous frameworks, clearly setting out what the Trust aims to achieve rather than simply describing structures or processes.
16. It was noted that the strategy has evolved significantly during its development and that the process has resulted in a more focused, useful and deliverable outcome.
17. A Board member commented that the first strategic priority is already supporting more effective engagement with performance and quality processes, including at divisional quality and performance meetings.
18. It was observed that Board discussions have highlighted the importance of building the capability and capacity required to deliver the strategy, particularly in years two and three of the planning period.
19. The Board discussed progress in digital delivery, noting an increase in patient self-booking and improved patient involvement in managing their care, with further changes planned to how and where services are delivered.
20. The importance of alignment between the digital strategy and the equality, diversity and inclusion (EDI) strategy was emphasised.
21. The Chief Nurse confirmed that digital developments are subject to EDI impact assessments to ensure that digital change does not inadvertently exclude patients who are less digitally enabled.
22. A Non-Executive Director highlighted the importance of ensuring that staff are appropriately trained and supported to use new digital systems effectively.
23. A Non-Executive Director cautioned that automating ineffective or poorly designed processes will not deliver improvement and that process redesign must accompany digital change.

Agreed:

1. To note the content of the report.

10/26 Verita report action plan update

Sue Broster, Chief Medical Officer, presented the report.

Emily Warren-Barrett, Head of Clinical Governance, CMO office joined the meeting for this item.

The Chair invited the Chief Medical Officer to introduce the report and thanked her and the Chief Nurse and Chief People Officer for their continued focus and commitment to delivering the actions set out.

Noted:

1. This was noted as the first formal update to the Board, following consideration through the Quality Committee and Management Executive.
2. The Board noted that the report has been subject to external scrutiny through the Paediatric Orthopaedic Incident Oversight Board, comprising representatives from NHS England, the Care Quality Commission, the General Medical Council and Healthwatch, and has also been reviewed and discussed by the Quality Committee.
3. The Board welcomed the rigour with which delivery is being approached and emphasised the importance of maintaining momentum, closely aligned to the Trust's first strategic priority of delivering excellent and timely care.
4. It was confirmed that the work has been scrutinised externally and discussed through the Quality Committee, with a deliberate commitment to openness and transparency. The Board acknowledged the significant impact this approach is having on colleagues.
5. It was confirmed that direct engagement with affected families is ongoing. It was recognised that while the harm experienced cannot be undone, the focus must be on meaningful change and continued support for families.
6. The Board noted the findings of the independent Verita investigation, which is separate from the ongoing clinical review.
7. It was reported that the investigation made 23 recommendations all of which were accepted by the Trust. In response the Trust had committed to 34 actions to be delivered over a 12-month period.
8. Good progress has been made over the past three months, with delivery against all 12 three-month commitments.
9. A Patient Advisory Board has been established and will be developed further over time.
10. Listening events have taken place and staff engagement has improved, with further work planned to deliver more structured listening approaches.
11. Focus is now moving to medium- and longer-term actions, with confidence expressed that these will be delivered.
12. It was acknowledged that rebuilding trust with partners and stakeholders is a critical element of the programme.
13. The Board noted positive feedback from NHS England, which has recognised a significant shift in the Trust's approach.
14. Key risks were highlighted, including the ambition and pace of the programme, which may limit opportunities for reflection if not carefully managed.
15. Resource implications were discussed, noting that while a business case has been approved, recruitment will take time.
16. It was recognised that delivery of the programme positions the Trust as a leader in several key areas of practice.
17. A comprehensive communications plan has been developed, with partnership working with Healthwatch noted as positive and ongoing.
18. The second part of the presentation outlined service and process changes that have been well received by a range of stakeholders.

The following points were raised in discussion:

19. A Non-Executive Director noted the scale of the work and emphasised the importance of sustaining momentum.
20. The Chief Medical Officer reiterated that families must remain central to all aspects of the work.
21. The Chief Nurse welcomed the establishment of the Patient Advisory Board and the leadership provided by its Chair.
22. A Non-Executive Director reflected on the profound impact on children and families, emphasising the importance of transparency and learning. Assurance was provided that the Trust has sought to fully understand what happened and why, with a shared commitment between the Executive team and families to prevent recurrence. The Board also acknowledged the emotional impact on staff involved.
23. A Non-Executive Director described the three-month progress report as exemplary and thanked all those involved. The importance of listening to patients and families was emphasised, alongside the need for clear oversight of low-volume, high-complexity services and shared learning from best practice elsewhere.
24. A Non-Executive Director noted the low uptake of the Young People's Advisory Board and requested follow-up engagement with external partners also working with children and young people, including Cafcass. This would be followed up by the Communications team.
25. The Chief Nurse confirmed that adult members of the Patient Advisory Board will support engagement with children and young people and welcomed further assistance with contacts, noting successful engagement with children and young people in other areas of the Trust.

Agreed:

1. To note that progress has been made against all 12 three-month commitments with the majority delivered by the 30 January 2026 milestone. A number of actions will require further steps in the next period to embed the improvements.
2. To note that funding has been approved (as of 8 January) to enable delivery of some of the remaining commitments; however, mobilisation and embedding of this additional capacity will take time and is likely to come on stream part-way through delivery of the six-month actions. Some areas are not yet funded, and other funding sources are being sought.
3. To note the overall delivery timetable remains highly compressed, and any slippage will directly impact the Trust's ability to meet future milestones.
4. To note that this significant transformation programme is being delivered in the context of wider organisational changes and pressures, increasing the risk of change fatigue and affecting sustained engagement, capacity to absorb new requirements and delivery pace.

11/26 Guardian of Safe Working

Sue Broster, Chief Medical Officer, introduced the report.

Serena Goon, Guardian of Safe Working and Jacob Brubert, Resident Doctors Forum Co-Chair, were presented the report.

Noted:

1. The number of exception reports in Q3 remain relatively stable with numbers being slightly lower than Q2 and when compared to Q3 in 2024/25.
2. Exception reporting in Cardiology has been higher than in previous quarters and is a concern. Discussions are ongoing including workforce reviews. A case was being put together to increase the workforce.
3. General Surgery features highly this quarter particularly at FY1 level due to increasing workload following some doctors being unable to start in their posts. Haematology and vascular surgery highers and obstetric anaesthetic highers all feature on the exception reports flagging up as needing additional resource.
4. It was noted that there had been changes to the exception reporting process and there had been significant challenges implementing them given the timeline from NHSE, but overall, the change has been relatively smooth.
5. The changes to self-development time had been well received. It was noted that it would be a challenge for some doctors to book training days and take annual leave to maintain work/life balance. Additional resource to support and deliver this would be welcomed.
6. There were challenges in some departments and engagement with doctors outside the Resident Doctors' Forum to help resolve these would be welcomed.

In the discussion the following points were made:

1. It was confirmed that the reclining chairs and lockers that had been discussed at an earlier meeting had been delivered and were in use.

Agreed:

1. To receive the report of the Guardian of Safe Working for Q3 2025/26.

12/26 Education, learning and development

Received: The Education, learning and development report

13/26 Learning from Deaths report

Received: The Learning from deaths quarterly report.

14/26 Research and Development

Prof John Bradley, Director of Research and Development presented the report.

Noted:

1. The Director for Research and Development provided an update on the Trust's research portfolio, noting that the Trust had completed a Research Review led by Prof Helena Earl in 2025 to assess its capacity to deliver transformative research within a changing NHS, identify Cambridge's strengths aligned with national priorities, and highlight unmet opportunities.
2. It was noted that the Trust has secured £40m of funding from the National Institute for Health and Care Research (NIHR) and is working towards meeting the NIHR 150-day metric from study set-up to recruitment of the first patient. While this remains challenging, focused work is underway to improve performance.
3. The Board noted that performance in commercial trials is strong and continues to improve, with 110 trials currently underway. The importance of this work to Government priorities was emphasised.
4. The Chair highlighted the strategic importance of this area and requested that progress continues to be tracked at Board level.
5. The Board asked about the size and nature of the trials and the organisations involved. It was explained that trial size varies significantly, ranging from small cohorts to several hundred participants. Most trials are delivered in partnership with large pharmaceutical companies, alongside engagement with smaller organisations, particularly at early stages of development.
6. It was noted that research activity provides an important source of income for the Trust, with consideration being given to reinvesting some funding to encourage greater clinical participation in research.
7. The Chief Medical Officer confirmed greater clinical participation in research is a core workstream within the Research Board.
8. A Non-Executive Director welcomed the positive trajectory shown in the performance data and encouraged continued focus on improving delivery against the 150-day metric. The Director of Research & Development agreed, noting that performance in this area is critical to the Trust's reputation, as well as to that of the NIHR.

Agreed:

To note the content of the update.

15/26 Emergency Planning, Resilience and Response

Received: Emergency Preparedness, Resilience and Response (EPRR) Core Standards March 2026 Report

Agreed:

1. To note the progress from partial to substantial compliance since the previous submission to the Board.
2. To approve the submission of the Trust's EPRR Core Standards assurance return to the Integrated Care Board (ICB) for onward assurance to the NHS England Regional EPRR Team.

16/26 Use of the Trust Seal

Received: the report of the use of the Trust Seal since the previous meeting.

The Board noted the use of the Trust Seal on the occasions listed.

17/26 Any other business

1. There was no other business.

18/26 Questions from members of the public

The following questions were submitted in advance of the meeting:

1. The chair of the BMA has advised members to support a complete break from the use of Palantir Technologies Inc within the NHS owing to its amoral record with the US ICE and sales of arms and surveillance equipment used to murder Palestinian civilians, including children and babies. Also serious risks to patient data-security have been identified.

Given the above and the links between Palantir and the disgraced Epstein and Mandelson, patients need assurance that this corporation will not have access to their confidential records. Will the Board confirm that all contracts with Palantir will be rejected??

The Chair would send a written response to the member of the public who had submitted this question.

19/26 Date of next meeting

The next meeting of the Board of Directors in public would be held on Wednesday 10 June 2026 at 11.00.

Meeting closed: 16:42

NHS
Cambridge University Hospitals
NHS Foundation Trust

Board of Directors (Public): Action Tracker

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

Key to RAG rating:

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

NHS
Cambridge
University Hospitals
NHS Foundation Trust

Report to Board of Directors held on Wednesday, 10 June 2026

Title	Report from the Lead Governor			
Report Sponsor	N/A			
Author	Helena Rubinstein			
Status	**Decision**	**Assurance**	**Information** ☑	**Discussion** ☐

RECOMMENDATION

The Board of Directors is asked to:

- note the activities of Council of Governors, which have taken place since last reported to the Board at its meeting held in public in March 2026.

KEY MESSAGES

The Board is asked to note the update from the Lead Governor, which highlights continued engagement between the Council of Governors, the Board and the wider organisation.

During the quarter, governors received updates through the Governor Seminar on the Trust's Patient and Public Involvement plans, the revised Trust strategy, and divisional activity. This supported governors in developing a broader understanding of key Trust priorities and the wider context for formal Council of Governors business.

The Council of Governors met in its revised format for the second time, with the agenda continuing to support greater visibility of Board business, open discussion and constructive debate. Governors received updates from Non-Executive Directors on Board Committee activity and from the interim Chief Executive on Trust performance. The Council also approved the proposed amendment to the Trust's Constitution to include a 'Rest of England' constituency, subject to Board approval.

Governors have also contributed to wider governance and engagement activity, including providing feedback as part of the Chair's appraisal process, participating in forthcoming Non-Executive Director appointment processes, supporting work to develop volunteering opportunities at the Trust, and implementing a Governor Issues Tracker to capture feedback from patients and the public.

NHS
Cambridge University Hospitals
NHS Foundation Trust

BACKGROUND, INCLUDING PURPOSE OF THE REPORT

The Lead Governor provides a quarterly report to the Board of Directors to update on the work of the Council of Governors and wider governor activity. The report supports the Board's understanding of how governors are engaging with Trust business, discharging their statutory duties, and contributing to the Trust's governance arrangements.

This report summarises recent governor seminars, formal Council of Governors business, and additional governor activities undertaken during the reporting period. It also provides assurance that governors continue to receive information and opportunities for discussion that support their role in representing the interests of members and the public, holding the Non-Executive Directors to account, and contributing to the wider governance of the Trust.

ALIGNMENT TO TRUST STRATEGIC PRIORITIES

Our strategy: a healthier life for everyone through care, learning and research 2026-2031		**Indicate all that apply**
	Deliver Excellent and Timely Care	☐
	Transform How and Where We Deliver Care	☑
	Harness Research and Innovation to Improve Patient Outcomes	☐

ALIGNMENT TO MOST RELEVANT STRATEGIC RISK

Not applicable

PAPER REVIEW AND GOVERNANCE PATHWAY

Name of group or committee that has previously considered this report	**Date**
Not applicable	
Name of group or committee that the report will be presented to in the future	
Not applicable	

Cambridge University Hospitals NHS Foundation Trust

10 June 2026

Board of Directors
Report from the Council of Governors
By Helena Rubinstein, Lead Governor

The aim of this paper is to provide the Board with an update on the Council of Governor activities taken place since the reported to the Board at its meeting held in public in March 2026.

Provided below are a number of meetings that have taken place since the last Council of Governors meeting.

1. Recent Governor meetings

1.1 At the **Governor Seminar** presentations were delivered by Executive Directors and their supporting teams. The first presentation informed governors on the work taking place with the Trust's Patient and Public Involvement plans, which is led by the Chief Nurses team; a second presentation provided an update to governors on the Trust's revised strategy, which had been approved by the Board following engagement with a number of stakeholders including governor involvement at a number of forums. Governors also received an update on the work taking place across Divisions. The Seminar enabled governors to gain a greater understanding on key topics in support of the formal business covered at the Council of Governor meetings.

1.2 Following the Seminar, the formal **Council of Governor meeting** was held continuing in its revised format for the second time. The agenda once again helped governors gain a greater understanding of the Board's business and for open discussion and debate. The Non-executive Directors provided updates on the Board Committee's business with the interim Chief Executive providing an update on the performance of the Trust, supported by executive colleagues with governor's queries and interaction welcomed. At the meeting the recommendation to amend the Trust's Constitution was approved to include 'the Rest of England' constituency, which was planned to be presented to the Board to seek their dual approval.

2.0 Other governor activities

2.1 Governors had the opportunity to participate in the **Chair's appraisal** with their feedback provided to the Senior Independent Director who was leading on the Chair's appraisal.

2.2 Members of the **Council of Governors' Nomination and Remuneration Committee** have been invited to participate in the two Non-executive Director interviews scheduled to take place in the summer.

2.3 Work has continued on the **Volunteer Initiative** at Addenbrookes, with the engagement of a number of Governors to look at how the volunteer role can be expanded at the Trust. A number of Governors met with fellow Volunteer representatives at the Royal Marsden NHS Foundation Trust, which enabled good practice and experience to be shared with the Volunteer services at CUH. Governors are working with the management team responsible for volunteers to canvas opinion about potential future new roles.

2.4 A **Governor Issues Tracker** has been developed to capture governor's feedback to help support them in fulfilling their statutory duties. This covers issues raised by patients and the public concerning the Trust that can then be used to escalate to the Board and as appropriate.

3.0 Upcoming Governor meetings

3.1 The next three months of governor meetings include the following:

- 16 June 2026 A Governor will attend a Listening Event on the Neuroscience Critical Care unit
- 23 June 2026: Governor Nomination and Remuneration Committee
- 24 June 2026: Governor seminar, Governor Forum and formal Council of Governors meeting
- July 2026: Governor Nomination and Remuneration Committee involvement in Non-executive Director Interviews

3.2 The Governors Forum: Wednesday, 5 August 2026.

4.0 Recommendation

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

NHS
Cambridge University Hospitals
NHS Foundation Trust

Report to Board of Directors

held on 10 June 2026

Title	CEO and Executive Team update			
Report Sponsor	Nicola Ayton, Chief Executive			
Author	Executive Team Jessica Kenny, Director of Governance and Performance Glenn Burgess, Chief of Staff			
Public/private	Public			
Status	**Decision** ☐	**Assurance** X	**Information** X	**Discussion** ☐

RECOMMENDATIONS

The Board of Directors is asked to:

- **NOTE** the updates provided by the Executive Team.

KEY MESSAGES

- Since the last Board meeting, our biggest areas of focus have been:
  a) responding to challenges in our Urgent and Emergency Care pathways including tackling long waits for patients and managing the pressures associated with delayed discharges;
  b) delivery of the Verita investigation action plan with strong progress against all six-month commitments;
  c) conversations with colleagues across the Trust and wider system about delivering our new five-year strategy and implementing the first two months of our 2025-26 delivery plan; and
  d) taking steps to improve the way the Trust functions for patients and staff through changes to our operating model and ways of working.

<u>Performance headlines</u>

- The Trust's rate of patient safety incidents of moderate harm and above remains below the 2% threshold across all divisions.
- There have been no new hospital-onset MRSA bacteraemia cases reported during the reporting period, with one case recorded year to date.
- The Trust's CQC preparedness plan is being refreshed to align with the current framework. External mock Well-Led interviews will be commissioned to test and support preparedness so that we can learn and make changes to improve care for patients.
- UEC performance has been poor over April and May and we are taking a range of short and longer term actions to reduce waits and improve quality.
- Initiatives to expand capacity in MRI, CT, echocardiography and non-obstetric ultrasound have reduced the diagnostics waiting list. Sustaining this is a priority for the organisation.

Cambridge University Hospitals NHS Foundation Trust

BACKGROUND, INCLUDING PURPOSE OF THE REPORT

This paper provides a concise overview for the Board from the Executive Team covering our collective areas of accountability: safe and effective care; access and operational performance; people; finance, productivity and planning; major projects and digital.

There has been no update to the NHS Oversight Framework (NOF) segmentation tables since the last Board of Directors meeting, and the Trust remains in segment 2, with no financial override applied to our position. We continue to await publication of the 2026/27 NOF and confirmation of the metrics included in every domain.

ALIGNMENT TO TRUST STRATEGIC PRIORITIES

Our strategy: a healthier life for everyone through care, learning and research 2026-2031		**Indicate all that apply**
	Deliver Excellent and Timely Care	☑
	Transform How and Where We Deliver Care	☑
	Harness Research and Innovation to Improve Patient Outcomes	☑

ALIGNMENT TO MOST RELEVANT STRATEGIC RISK

N/A

PAPER REVIEW AND GOVERNANCE PATHWAY

Name of group or committee that has previously considered this report	**Date**
N/A	
Name of group or committee that the report will be presented to in the future	
N/A	

Cambridge University Hospitals NHS Foundation Trust

10 June 2026

Board of Directors

1. Executive Team update

1.1 Strategic context

1.1.1 On 2 June the government formally announced the establishment of the Greater Cambridge Development Corporation. The announcement builds on the work of the Cambridge Growth Company and Cambridge Ahead to support continued development of the city and its surrounding area as a national economic hub for science and innovation. The Trust is considering further how to engage with these partners to ensure health infrastructure remains included in development conversations.

1.2 Safe and effective care

1.2.1 Patient safety

- The Trust's rate of patient safety incidents of moderate harm and above remains below the 2% threshold across all divisions, with sustained improvement in Duty of Candour Stage 1 compliance. Falls per 1,000 bed days remain above the internal improvement trajectory, although performance continues to meet agreed quality requirements with the Integrated Care Board. The Trust remains compliant with venous thromboembolism risk assessment standards.

1.2.2 Accountability and oversight

- The Trust has strengthened its oversight of external reviews and is restructuring quality governance through strengthened processes, clearer accountability and increased assurance of delivery. Challenges remain in the timeliness of patient safety incident investigations and action completion, alongside a continued increase in discharge-related incidents linked to hospital transport delays. While there has been a slight reduction in overdue incidents, the overall volume remains high and continues to be closely monitored at Patient Safety Oversight Group.

1.2.3 Infection control

- There have been no new hospital-onset MRSA bacteraemia cases reported during the reporting period, with one case recorded year to date. The Trust remains compliant with National Safety Syllabus training. One formal Risk Oversight Group relating to the use of enriched culture medium in Group B streptococcus screening has been closed following completion of required actions, with a closure report approved by the Patient Safety Oversight Group, confirming that risks have been appropriately addressed and governance requirements met. Whilst the Trust has confidence in its infection control policies and procedures, work is underway to improve the overarching approach to Infection Control

1.2.4 CQC preparedness

- The Trust's CQC preparedness plan is being refreshed to align with the current CQC framework, with a focus on clear expectations for Core Service Boards, strengthened risk oversight, and systematic learning from previous inspections and peer reviews. A staff engagement and communications approach is being developed to support delivery. A dedicated session was held with Trust Board on 13 May 2026, and external mock Well-Led interviews will be commissioned to test and support preparedness.

1.3 Access and operational performance

1.3.1 Urgent and Emergency Care (UEC)

- Performance in April 2026 against both the 4-hour and 12-hour standards has been significantly below plan, at 68.5% and 10.0% respectively. This pressure continued through May. Over the summer, a range of developments are progressing to drive significant improvements in waiting times for patients at CUH. These plans have been informed by the national GIRFT programme, visits to high performing providers and evidence based national guidance. Priorities include implementation of an Extended Emergency Medicine Ambulatory Care unit, a new Children's Observation Unit, reconfiguration of the emergency receiving units to optimise patient flow, and workforce changes to address shortfalls in capacity during times of peak demand. These are being geared to deliver a step change and sustained improvement to UEC access standards as part of a programme overseen by the UEC Taskforce. Delivering the programme of work is being supported by a new UEC Programme Manager, following their appointment in May.

1.3.2 Planned care

- CUH have delivered significant improvements in shortening waits for planned care over the last year. This is reflected in our ranking relative to other NHS hospitals, with the latest data indicating CUH is out of the bottom quartile for waits over a year and into the second highest quartile for the proportion of patients under 18 weeks. In April 2026, the number of patients waiting over 65 weeks fell to its lowest level since the pandemic at 25 patients, including six late referrals from other hospitals and three patients who had their treatment cancelled due to industrial action from resident doctors, down from 128 patients in June 2025. A small number of specialties continue to have higher numbers of patients waiting over a year for treatment, including Gynaecology and Cardiology. Additional activity is planned for these specialties in the first half of the year through both additional capacity and productivity initiatives.

1.3.3 Cancer care

- High levels of performance against the 28-day Faster Diagnosis Standard have been sustained, with CUH regularly in the top 10 NHS providers nationally. Performance against the 62-day referral to treatment standard has demonstrated improvements, although remains below plan. Delivery against the 31-day cancer treatment standard has been recognised as a particular challenge with recovery not forecast until after the commissioning on two new linear accelerators is complete in the Autumn, bringing capacity in radiotherapy to the level required to satisfy demand.

1.3.4 Diagnostics

- The combination of increased demand (driven by the elective recovery programme) and reduced capacity led to an increase in the number of patients waiting for diagnostics, with performance deteriorating since November 2025. Performance for April 2026 demonstrates a reduction in the diagnostic waiting list, the result of initiatives to expand capacity in MRI, CT, echocardiography and non-obstetric ultrasound. Sustaining this improvement is a priority for the organisation and is the focus of the Diagnostic Taskforce. In addition to workstreams focused on expanding capacity, the organisation is engaging in a national programme of work targeting reductions in demand across a spectrum of diagnostics, driven by evidence concerning their clinical utility.

1.3.5 Patient discharge

- There has been a significant deterioration in the number of patients remaining in hospital after the point where they are considered fit for discharge. In May 2026, the number of beds lost for external delays to discharge for patients who were medically fit was 169.3 compared to 116.8 during the same month last year. The primary drivers of this deterioration concern access to assessments for care, domiciliary care, intermediate care and re-ablement packages. There has been executive level escalation to both the Integrated Care Board and to the Local Authority to seek action in finding a rapid resolution. The number of internal delays in May 2026 was 66.3 compared to 61.5 in May 2025. A programme of work led by the Flow Improvement Board is geared to address these delays, which include waits for medical review and input from the complex discharge team.

1.4 People

1.4.1 In Month 1 of 2026/27 the workforce is 7 WTE below plan overall. In the past 12 months the workforce has reduced by 324 WTE (2.55%). Bank staff usage has reduced by 127 WTE in the past month but remains above plan. This is due to continued winter plans in place and the Trust response to industrial action.

1.4.2 Sickness absence remains at 4.2% (over 12 months) however, in month absence has decreased from 4.2% in March to 3.9% in April. This is the same as this time last year.

1.4.3 Work continues to strengthen the Trust's approach to leadership and culture. A Board-led Leadership and Culture Task and Finish Group has been established to support development of a new leadership and cultural ambition aligned to the Trust Strategy.

1.5 Finance, productivity and planning

1.5.1 Finance – Month 1

- The Month 1 financial position is a £3.0m deficit for performance management purposes – this is £2.0m adverse to plan due to the estimated £2.0m adverse impact of the Resident Doctor Industrial Action that took place in April 2026. Underlying Trust performance at Month 1 is therefore on plan.
- Points to note in respect of the reported Month 1 financial position:

- The inflationary pay award funding is assumed to cover the cost of the pay awards. Further clarity on pay awards for medical staffing and updated inflation funding is expected from NHSE during Quarter 1.
- Clinical income at Month 1 is based on estimates as billing is issued one month in arrears.
- There are open disputes with Central East ICB and Norfolk and Suffolk ICB regarding the 26/27 contract values which could result in further changes to reported income.

- Other notes in respect of Month 1 financial performance:

  - Whilst on plan at Month 1 the Trust Productivity and Efficiency Programme (PEP) delivery requirements increase significantly in future months. Work continues to ensure all required PEP is identified and plans are in place to deliver it.
  - Assurance over PEP development and delivery is improving but at Month 1 the Trust is still reporting a gap in identified values of £3.7m for cost reduction. Productivity scheme development and delivery will be reviewed by the Productivity Board.
  - Additional reduction in bank and agency expenditure is required to ensure delivery of the Pay PEP target for 26/27. Overall expenditure, however, remains within the NHS England expenditure limits for 26/27.
  - Approval of specific in year Quality and Safety investments may require additional PEP delivery in year to support them.

- The Trust has been allocated operational capital funding for the year of £38.0m for its core capital requirements (£7m lower than 2025/26). In addition to this we expect to receive further NHS capital funding including Children's Hospital (£11.3m); Cancer Hospital (£18.4m); Estates Safety Fund (7.3m); Return to Constitutional Standards (£3.1m). Together with capital contributions from ACT, technical adjustments in respect of PFI, and other miscellaneous DHSC awards, the Trust's capital budget for the year now totals £85.6m.
- Capital expenditure at Month 1 was £2.6m compared to plan of £4.6m but at this early stage of the year this is not a concern, and we remain on target to invest the capital plan in full.

1.6 Major projects and digital

1.6.1 Strategy

- Staff briefings have commenced to introduce the new Trust Strategy across the organisation and a range of communications and engagement material, including practical guidelines and toolkits for teams to explore and develop their own local strategies, is due to be launched shortly. Initial strategic delivery plans for years 1-3 have now been presented to the Board and work is continuing developing appropriate strategic performance metrics across the three strategic priorities and nine focus areas to enable ongoing monitoring of medium and long-term delivery.

1.6.2 Neighbourhood Health

- The South Place partnership held a workshop with all key partners on 19 May 2026 to co-develop its Neighbourhood Health Plan for 2026/27. The partnership agreed

a set of deliverables under four key priorities: Improve access to prevention, early diagnosis & healthy environments; transform access to routine healthcare and social support (including GP access and outpatient redesign); embed proactive Neighbourhood teams (with an initial focus on older people with frailty); and, transform access to urgent healthcare and social support. The plan will be finalised in June before being accepted by the Health and Wellbeing Board in July.

- The CUH neighbourhood health programme is continuing to develop our strategy on UEC hubs and to explore short-term opportunities to test the model. The next step is to complete a business case for investment in the Princess of Wales (Ely) urgent care facilities.
- We have also launched our Neighbourhood Planned Care Group, which will drive forward new models of neighbourhood-based outpatient care, jointly led between primary care and CUH clinicians, and reporting into both CUH and South Place governance structures. Initial projects include testing an enhanced advice and guidance model with additional digital tools; developing shared care models for long term condition follow up (for respiratory and heart failure) and creating a single access point into planned care for frail patients with multimorbidity.

1.6.3 Cambridge Cancer Research Hospital (CCRH)

- The CCRH programme remains on track to submit its Full Business Case (FBC) in December 2026 - a submission point which has been agreed with both NHS England and the New Hospitals Programme. The Stage 2 gateway review by the National Infrastructure and Service Transformation Authority (NISTA) will be undertaken in June 2026, with the Building Safety Act gateway 2 application submitted in March 2027. Construction is planned to commence in September 2027. The programme monitors the impact of the challenging global economic conditions, with dialogue already taking place with national stakeholders.
- The CCRH transformation team continues to work closely on clinical pathways with our clinicians, patients, and staff from the University, as well as with patients. As the FBC is close to completion, focus switches to ensure that the services evolve to meet the requirements of the NHS Plan, National Cancer Plan, and the expectations of our wider stakeholders.

1.6.4 Cambridge Children's Hospital (CCH)

- Progress continues across all aspects of the Full Business Case (FBC) and engagement remains a key focus, with ongoing consultation involving regional clinical partners, children and young people, parents and carers, our 'young adult' and 'youth' forums giving time to discuss our digital strategy and what is important to them. Our regional clinical advisory board has also met to discuss our digital plans for making the CCH a hospital without walls for the region.
- Fundraising for the new hospital has passed halfway towards its £100m target, attracting strong support from philanthropists both in the UK and internationally.

1.6.5 Genomics

- CUH has commenced delivery of the East Genomic Medicine Service (GMS) contract under an interim extension arrangement, while NHSE finalises budgets and

contracts across all seven GMS providers. Transformation work continues across organisational redesign, automation, and the management of short-term estates and IT priorities.

1.6.6 Research

- Preparation continues for the next National Institute for Health and Care Research Biomedical Research Centre bid, with key submissions in September 2026 and March 2027. Final outcomes are expected in September 2026 ahead of contract commencement in April 2028.
- Research delivery performance is improving, with the 60-day metric increasing from 25% to 55% (64% last month) and the 30-day metric rising from 15% to 31%.

1.6.7 Digital

- We have expanded our use of Epic's transfer centre module to streamline and standardise management of inter-hospital transfers. This was launched for our Major Trauma Service in October 2025 and recently expanded to nephrology, hepatology, gastroenterology, and intestinal rehabilitation. It provides digital transfer coordination and proactive care for high-risk patients, improving patient flow and reducing bed-days.
- The digital check-in technology at the ED front door has now been used by more than 36,000 patients since launching on 1 December 2025 up until the end of April 2026 - helping patients access the right services first time and reducing avoidable ED attendances.
- We have piloted the use of some of Epic's AI capabilities including:
    - Saving clinician time (up to 30 minutes per day) through a pilot of Inpatient Insights with 20 doctors to produce AI-generated summaries of a patient's hospital stay to date and of recent events, which is being rolled out more widely to doctors and specialist nurses very soon.
    - Boosting productivity through a pilot of AI-assisted note summarisation in Epic, resulting in a time reduction of 40% when generating a discharge summary.
    - Saving clinical time in maternity by using AI-assisted patient message drafting to speed up the time it takes to respond to questions from mothers.
- We have gone live with the use of Epic in our outpatient pharmacy provided by Rowlands. This Integrates outpatient dispensing processes (Rowlands) into the Epic system, eliminating transcription errors and redundant workflows.

2. Board Assurance Framework

2.1 Work to refresh the Board Assurance Framework following the publication of the new Trust strategy continues in line with planned timescales, with many risks presented in May and June to their oversight sub-committees for review. Collective approval of the whole document will be brought to the Board of Directors private meeting in July.

3. NHS Oversight Framework

3.1 Segmentation

3.1.1 There has been no update to the NHS Oversight Framework segmentation tables since the last Board of Directors meeting. The Trust's remains in segment 2, with no financial override applied to our position. Across England, 58% of providers were in financial override. This was to the benefit of CUH, such that we were ranked 22 of 134 providers in England.

3.2 Next NOF publication

3.2.1 We continue to await publication of the 2026/27 NOF and confirmation of the metrics included in every domain. The Trust anticipates that oversight including tiering arrangements for operational performance are likely to be scaled in accordance with whether segmentation is changing alongside deterioration in metrics. Improvements could signal reduced oversight response.

Cambridge University Hospitals NHS Foundation Trust

Report to Board of Directors

held on

10 June 2026

Title	CUH Integrated Performance Report (IPR)			
Report Sponsor	Beth Hughes – Chief Governance and Performance Officer			
Author	Jo Lee – Director of Analytics and Insights			
Status	**Decision** ☐	**Assurance** ☑	**Information** ☑	**Discussion** ☐

RECOMMENDATIONS

Board of Directors is asked to:

- Receive the April 2026 Integrated Performance Report

KEY MESSAGES

1. The appended Integrated Performance Report provides the Trust's performance position for April 2026.

BACKGROUND, INCLUDING PURPOSE OF THE REPORT

- The CUH Integrated Performance Report (IPR) provides oversight of the Trust's performance and assurance against performance risk for the Board. This is against the key performance metrics to which the Trust is held accountable through the NHS Oversight Framework and other regulatory frameworks.
- Note that this is the first iteration of the new format of the IPR which contains escalation of risk, where appropriate, and deep dives to assure against those risks.

ALIGNMENT TO TRUST STRATEGIC PRIORITIES

Our strategy: a healthier life for everyone through care, learning and research 2026-2031		**Indicate all that apply**
	Deliver Excellent and Timely Care	☑
	Transform How and Where We Deliver Care	☐
	Harness Research and Innovation to Improve Patient Outcomes	☐

ALIGNMENT TO MOST RELEVANT STRATEGIC RISK

BAF 001 Patient Safety, BAF 003 Access to Care, BAF 006 High Performing Inclusive Culture, BAF 009 Financial Sustainability

PAPER REVIEW AND GOVERNANCE PATHWAY

Name of group or committee that has previously considered this report	**Date**
Management Executive, Performance Committee	
Name of group or committee that the report will be presented to in the future	

CUH Integrated Performance Report

April 2026

NHS CUH

Together
Safe
Kind
Excellent

Contents

CUH at a glance

Access to Services – Apr-25 to Mar-26	
Number of operations	39,457
Number of day cases	97,491
Number of inpatients	56,615
Number of dialysis sessions	61,092
Number of OP appointments	1,150,318
Number of diagnostic tests (DM01)	270,059
Number of cancer patients	10,989
Number of referrals (electives and cancer)	322,993
Number of ED attendances	202,735
Number of ambulances attending CUH	30,079
Number of births	5,538

Workforce – as of 31st Jan 26	
Number of staff members	13,405
Number of staff from a minority ethnic group	5,278
Number of staff who are female	9,739

Patients	
The population CUH serves – DGH	600,000
– C&P	900,000
– Major Trauma	4.0 million
– East of England	4.6 million
Patient experience (good on Friends & Family Test)	91.5%
Number of complaints (Feb-25 to Jan-26)	796

Estate	
Number of beds	1,098
Number of theatres	39

Research	
Number of clinical studies (open in Dec-25)	576

Performance Summary

In April 2026, access to services performance has the largest proportion of metrics with performance risk. In total, 11 out of 45 metrics are showing the highest escalation risk

Domain	NOF score Q3 2025/26	Tracking against target or plan (in month)	Monthly performance position			Metric without statistical process control
			Deteriorating	Sustained	Improving	
Access to services	3 rank 78	4 on track:		1	3	
		7 off track:	**2**	**4**	**1**	
Effectiveness & experience	3 rank 104	3 on track:			2	1
		1 off track:	**1**			
Patient safety	2 rank 39	8 on track:		3		5
		6 off track:		**4**		2
Finance & productivity	1 rank 6	6 on track:				6
		1 off track:				**1**
People & workforce	1 rank 21	8 on track:		1	2	5
		1 off track:				**1**

Performance outside of the expected variance of that data labelled as either an improved position (blue colour: positive special cause variation), or a deteriorated position (orange colour: negative special cause variation).

Executive summary

The purpose of this document is to escalate areas with the highest performance risk and provide Board with assurance against these performance risks.

The Trust is currently in segment 2 of the NHS Oversight Framework (rank 22, latest position March 2026). This is a significant improvement on the previous NOF; sustained inclusion in segment 2 will require consistent improvements to UEC and Elective metrics, alongside continued stronger performance in other domains.

Access to services

- Deterioration in 4- and 12-hour UEC metrics in April although monthly average ambulance handovers improved from 30 mins to 26 mins. More detail on slide 7.
- Continued improvement across elective metrics in April. Cancer metrics for 62-days and FDS have seen a sustained improvement. There has been a deterioration in the number of patients waiting over 6 weeks for their diagnostics despite a reduction in the diagnostic waiting list. More detail on slides 8 to 10.

Effectiveness and experience

- Patient flow remained under sustained pressure in April, driven by delays in complex discharge pathways where external system constraints impact timely discharge. This has reduced bed availability and increased the number of medically-optimised patients in acute beds, with consequent pressure on ED flow and elective activity. Internal discharge processes remain stable; however, overall performance requires continued partnership working to support improvement. More detail on slide 12.
- Inpatient satisfaction with care in 2025 was just below the national standard of 95%. SHMI experienced a small increase from March but remains within expected levels. We continue to monitor closely.

Patient safety

- No increase in *C. difficile* and a slight increase in *E. coli* cases for healthcare-associated infection metrics compared to March. There was one MRSA hospital-onset case in April. *C. difficile* infections stay same as March (10 cases; 6 hospital-onset, 4 COHA). *E. coli* bacteremia also increased from 10 to 14 cases, reflecting an upward trend heading into May. More detail on slide 14.
- We remain off track with our Local Quality Requirements (LQRs) for hospital acquired pressure ulcers and are meeting 2 out of 3 LQR metrics for Falls. We are not meeting our internal targets for Falls and HAPUs per 1000 bed days. More detail on slides 15 and 16.
- There is a sustained trend of maternity postpartum haemorrhage rates for vaginal birth and delays in induction of labour rates, which are a performance risk and off track against target. More detail on slide 17.

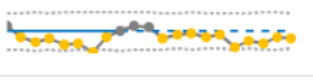
Finance and productivity

- The Month 01 position is £3.0m deficit for performance management purposes and the position is therefore £2.0m worse than planned. The adverse variance is fully attributable to the forecast £2.0m impact of the Industrial Action undertaken by the Resident Doctors in April. More detail on slide 18.

People and workforce

- The CUH workforce has reduced by 2.55% (324 WTE) over the past 12 months. In April CUH is within plan overall for Whole Time Equivalents (WTE), however bank usage is high. Agency usage continues to be low, and CUH benchmarks strongly both regionally and nationally. The 12-month rolling sickness absence is 0.1% above the NHSE target of 4.1% and there was one Health and Safety Incident per headcount. More detail on slides 19.

Link to return to the performance summary

Trust level - to end Apr 2026	Access to services			
Metric	Target	In month actual	SPC variation	24 month trend
Electives				Apr 2026
RTT - Total waiting list size	59,716	59,754	L	
RTT - Percentage of patients waiting less than 18 weeks	63.53%	63.43%	H	
Patients waiting <=18 weeks for treatment		37,901		
RTT - Percentage of patients waiting 18 weeks or less for first appointment	67.07%	70.47%	H	
Patients waiting <=18 weeks for first appointment		22,458		
RTT - Percentage of patients waiting over 52 weeks	0.80%	1.57%	L	
Patients waiting over 52 weeks		940		
Urgent and Emergency Care				Apr 2026
Percentage of emergency department attendances admitted, transferred or discharged within 4 hours	73.11%	68.58%		
Percentage of emergency department attendances spending over 12 hours in the department	6.73%	11.57%		
Ambulance handover <45mins	100.00%	86.34%		
Diagnostics				Apr 2026
Percentage of people waiting over 6 weeks for a diagnostic procedure or test	22.00%	37.86%	H	
Patients waiting >6 weeks		6,995		
Cancer				Mar 2026
Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks (FDS)	84.4%	86.77%		
Percentage of patients treated for cancer within 31 days of referral	96.3%	79.92%	L	
Percentage of patients treated for cancer within 62 days of referral	79.7%	72.82%		

Performance narrative

- 4 hour performance in April 2026 was 69.1%, a decline from 71.5% in March 2026. CUH's national ranking for 4-hour performance declining to 103 in April.
- 18 week performance has seen a 0.5 percentage point in month improvement achieving 63.4%, despite the impact of Industrial Action and cessation of Q4 sprint funding.
- The RTT Total Waiting list is 58,754 is marginally behind plan by 38 patients, however we have seen a sustained reduction since August 2025.
- 940 patients were waiting over 52 weeks which is significantly behind the plan position and the of patients waiting more than 65 weeks has reduced to 25 from 40 patients.
- There has been a further decline in performance for patients waiting over 6 weeks for their diagnostics moving from 29.9% to 37.86% which is significantly behind the plan of 22.0%
- The cancer Faster Diagnostic standard has improved further to 86.77% against a plan of 84.4%. Cancer 62 days has seen an improvement but remains behind plan at 72.3%.
- Cancer 31 day is significantly behind the plan of 96.3% achieving 79.92%.

Key risks

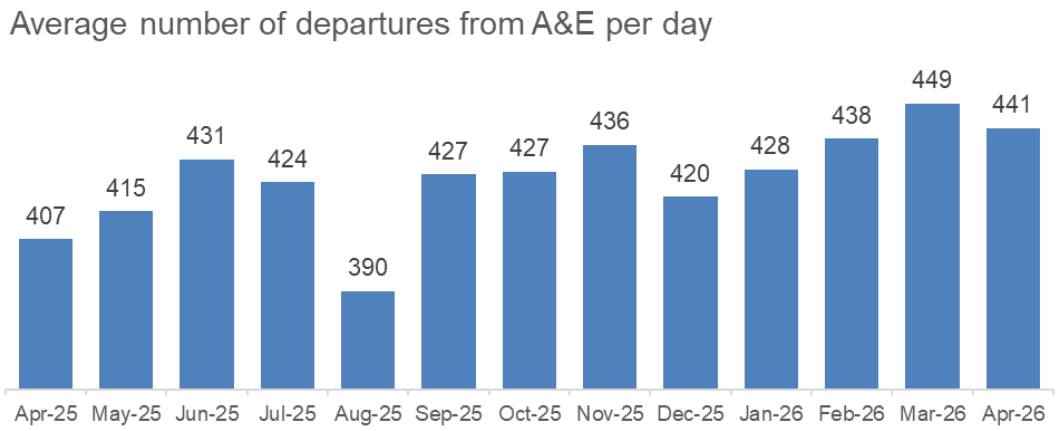
- Cancer 31-day risk regarding radiotherapy capacity due to linac replacement and staffing levels of radiographers.
- Diagnostics risk due to continued increase in demand for MRI, NOUS, Cardiac CT and Echo.
- Long wait risks remain in Gynaecology, ENT, Cardiology and OMFS with recovery actions.
- Managing the demand and capacity in UEC pathways, and workforce shortages.

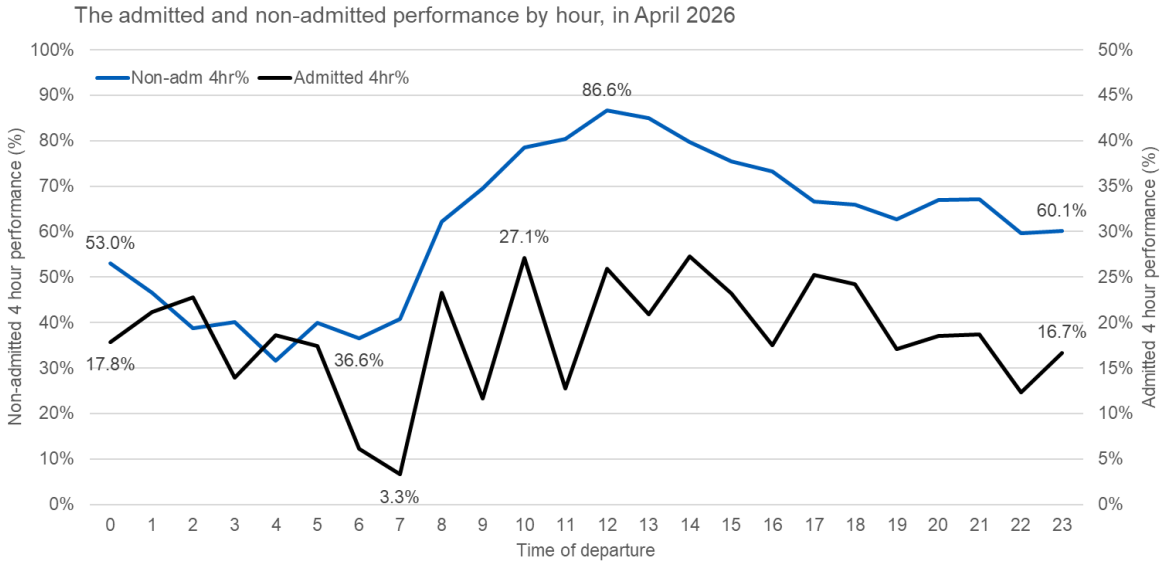
Actions and mitigations

- To support elective recovery, a continuation of outsourcing in challenged services, with additional capacity available from sustainable recovery actions including opening of theatre 39, cardiology registrar clinics.
- Mutual aid is being sought for radiotherapy capacity and recovery plans in place for surgical procedures
- Additional diagnostic capacity includes additional weekend and evening working, additional MRI scanner, agency staff and sourcing of alternative capacity.
- A staffing case to fill workforce gaps, and acute receiving unit proposal to better manage care.

Source: A&E Monthly Sitrep, RTT, DM01, Cancer Waiting Times

Deep dive UEC: escalation rule 1 – highest performance risk





Source: Operational Management Dashboard

Performance narrative

- 4 hour performance in April 2026 was 69.1%, a decline from 71.5% in March 2026 and 74.4% in April 2025. Average daily Emergency Department (ED) departures remained broadly stable, decreasing by 7 to 441 this month.

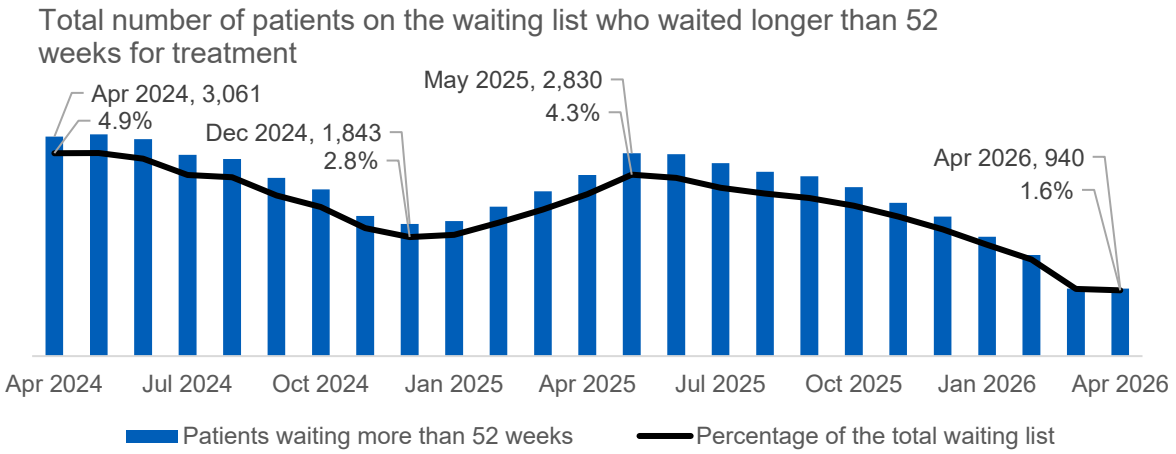
Key risks

- Demand is often overwhelming capacity later in the day when resourcing is reduced and improvement in waiting times cannot be mitigated. This then impacts on the next day performance and ability to recover.
- Increased levels of sickness and vacancies in key areas such as the UCC is reducing capability to sustain the required throughput of patients consistently.
- Poor flow out of the department is leading to overcrowding and lack of space to review patients with reliance on patients being seen within the ED rather than in assessment units and lack of adherence to the IPS. Consistent diagnostic delays with bloods and imaging are extending pathways and delaying decision making.

Actions and mitigations

- Capacity and demand modelling has been completed for UCC and Paediatrics to review attendance profiles and modify workforce patterns as required. A wider Emergency Medicine (EM) staffing case is being written to address the known gaps in processing power available out of hours and at weekends as well as address the Major Trauma Centre and EEMAC requirements. This will be ready for June 2026.
- In the interim, cover is being sourced to support the vacancies in the UCC although this can be inconsistent until the longer term solution is in place. A UCC working group is now in place to address the inconsistent daily performance and is reporting to the Divisional performance meeting.
- Planning is underway within the Acute Medicine team for the implementation of appropriately sized Acute receiving units, to release pressure within ED, and maximising opportunities for alternatives to admission, to launch late summer 2026.
- The Flow Improvement Board is embedding the IPS and improving discharges.
- The EM operational team are working with colleagues in Division B to review improvements for the diagnostic pathways, reported to UEC Taskforce.

Deep dive elective 52+ week wait performance: escalation rule 3 – lowest performance risk



Specialty	Patients waiting more than 52 weeks (April 2026)
Trust	**940**
Gynaecology	213
Cardiology	154
Oral and Maxillofacial	114
General Medicine (Lipids)	73

Performance narrative

- Overall, the number of patients waiting longer than 52 weeks for treatment has remained at 1.6% of the total waiting list with a slowing of the overall reduction in long waits. This has been impacted by industrial action and the cessation of insourcing and outsourcing in some specialties.
- CUH relative performance has improved and is now ranked in the third quartile of NHS providers for 52ww.
- Gynaecology and General Medicine (Lipids) remain key risks for long waits with 4.8% and 9.8%, respectively, of their waiting list waiting over 52 weeks.

Key risks

- Within gynaecology the key risk remains limited capacity within the specialised sub specialties of mesh, urogynae and endometriosis with complex conditions requiring specialised clinicians, limiting options to expand capacity.
- In the General Medicine Lipids service the risk is due to increasing demand in a small, specialised service. A locum has now been recruited to and is supporting the recovery of 52 weeks.

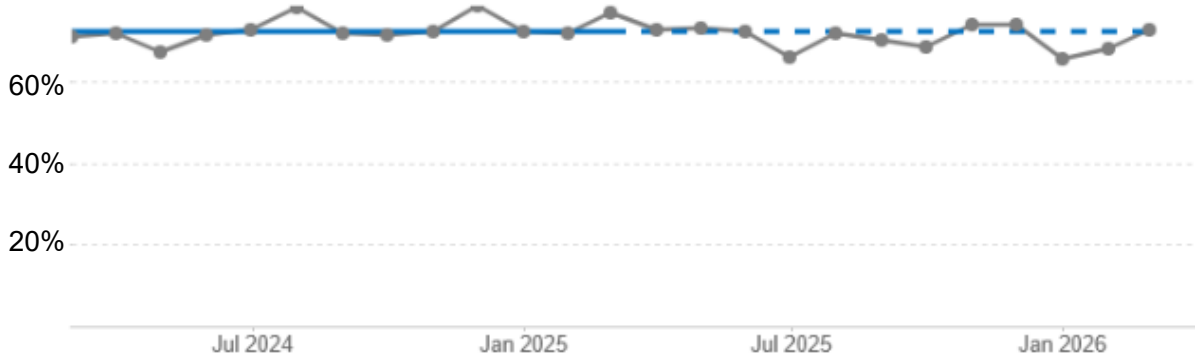
Actions and mitigations

- Continued liaison with clinical team to look at options to increase capacity.
- Additional clinics and theatres being run at weekends through WLIs
- Increased theatre capacity through the opening of theatre 39
- Pathway improvement where possible
- Continuing to explore capacity with other providers.

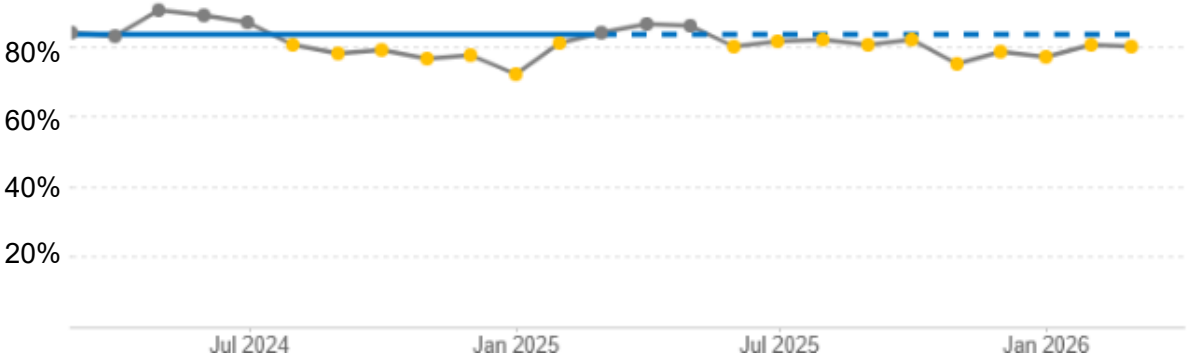
Source: Operational Management Dashboard

Deep dive Cancer 62-day & 31-day performance: escalation rule 1 – highest performance risk

Trust 62-day performance, national standard of 70%



Trust 31-day performance, national standard of 95%



Source: Cancer Waiting Times

Performance narrative

- Cancer 62-day has seen further improvement in March moving from 67.9% to 72.8%. This is behind the year end position of 75% but above the national standard.
- Cancer 31-day remains below plan at 79.9%. There has been a marginal deterioration in month from 80.8% in February

Key risks

62-day - key risks are due to delays at the start of pathways predominately in skin and breast. Key reasons are:

1. Plastics - wait time for first outpatient appointment (OPA), biopsy and excisions remain delayed.
2. Breast - wait time for first OPA exceeding 14 days is resulting in sustained 62-day breaches, due to workforce gaps for Consultant Radiologists that will continue until June and performance is not forecast to recover until August.

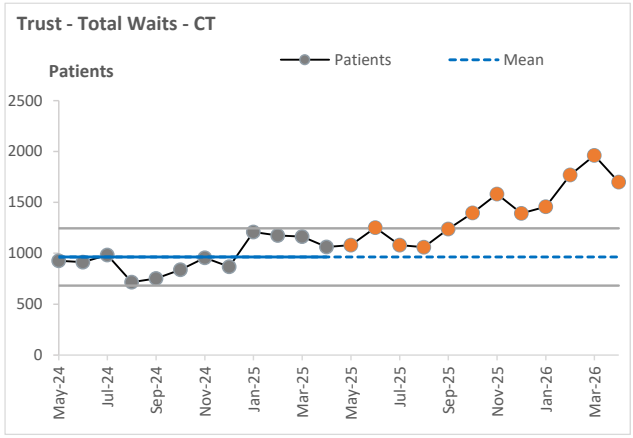
31-day - key risks remain in Radiotherapy and surgery capacity:

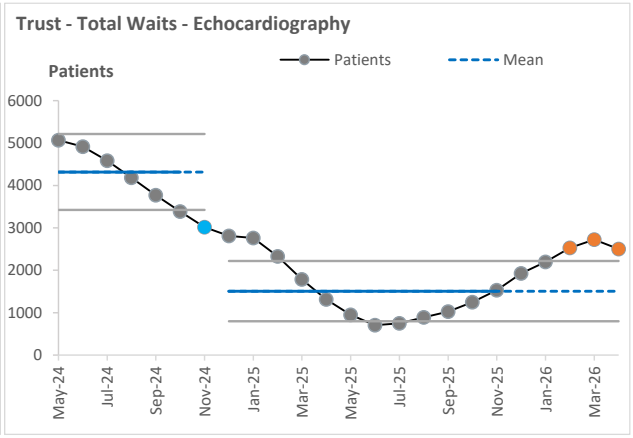
- Radiotherapy - Workforce gaps and replacement of linacs has reduced capacity
- Surgery - capacity remains challenged in breast, skin and kidney. On the day cancellations due to non-elective pressures has impacted in Q1.

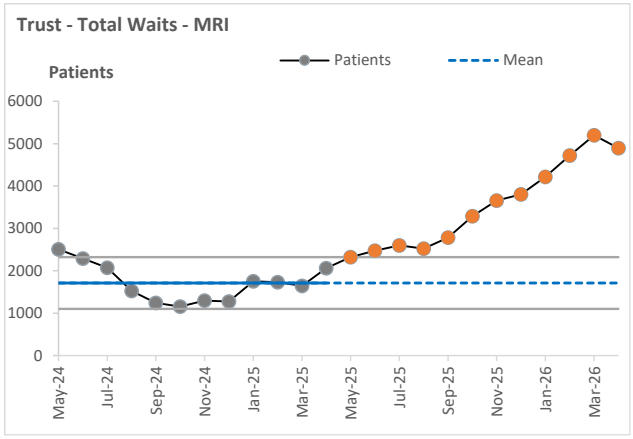
Actions and mitigations

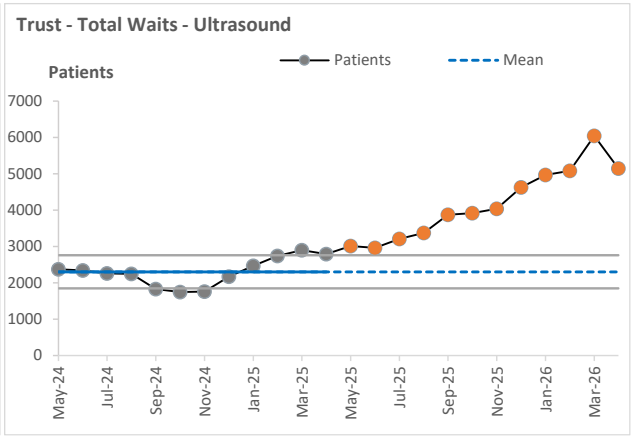
- 62-day - Plastics has a full recovery plan in place with additional capacity being established to reduce the wait times, including additional clinic capacity through WLIs, and changes to templates. Breast consultant due to start in June to resolve current capacity challenges.
- 31-day - Radiotherapy workforce plan in place with an improving position. 3 vacancies remain, of which 2 have been recruited to and are awaiting start dates. Linac replacement has been delayed by 2 months and will be operational by the end of October with recovery by December 2026.
- Capacity and demand completed for surgical capacity and additional capacity within new day allocated in Theatre 39 for Urology.
- Continued review of action plans and delivery is through the COO-led Cancer Taskforce meetings.

Deep dive Diagnostics: escalation rule 1 – highest performance risk









Source: DM01

Performance narrative

- April saw a deterioration in the DM01 performance moving from 29.9% to 37.86%. However, the overall waiting list has decreased by 1,675 to 18,474 patients waiting, indicating early signs of recovery.

Key risks

The largest contributors to the Diagnostics waiting list continue to be NOUS, MRI, Echocardiography, and CT of a waiting list of 18,474, impacted by:

- Impact from elective recovery driving quick turnaround capacity across imaging, echo and audiology.
- Reduced MRI capacity due to loss of mobile scanner
- Reduction in the waiting list through insourcing in 24/25 in Endoscopy and Echo with insourcing discontinued from April 2025. Endoscopy partially mitigated through model change including 7 day working
- Increase in external demand for Non-Obstetric Ultrasound (15%- 20% increase compared to 2024-25)
- Capacity constraints within paediatric audiology plus continuation of mutual aid
- Increased demand for cardiac imaging

Actions and mitigations

- Additional weekend capacity in place across Audiology, Ultrasound, Echo, MRI and CT.
- Sustainable business cases being developed in MRI, and Ultrasound to move to 7 day working.
- Use of bank and agency staff where vacancies are being held, and recruitment of substantive staff.
- Cardiac reporting outsourcing being procured.
- Utilisation of insourcing, outsourcing and mutual aid capacity.
- Mobile MRI scanner in place from April 2026.
- Use of community service provision for Ultrasound during April.
- Oversight of delivery of recovery plans through COO-led Diagnostic Taskforce. Additional oversight through entry into NHSE Tiering process.

Link to return to the performance summary

Trust level - to end Apr 2026	Effectiveness & experience			
Metric	**Target**	**In month actual**	**SPC variation**	**24 month trend**
Patient Flow				**Apr 2026**
Average number of days from discharge ready date and actual discharge date (incl 0)	0.00	1.50		
Bed occupancy rate (G&A)	92.80%	89.35%		
Patient experience 2025)				**2024 (published Sep**
CQC adult inpatient satisfaction survey		8		
Mortality Nov 2025				**Dec 2024 -**
Summary Hospital Level Mortality Indicator	1	0.99		

Performance narrative

- In April 2026, the average number of days a patient is delayed between their discharge ready date to actually discharge was 1.5 days.
- Inpatient satisfaction in 2025 was just below the national standard of 95% satisfied with their care
- SHMI rate was below the expected level for the Trust, and so is not a performance risk

Key risks

- Discharge delays are predominantly attributable to external system constraints, including community capacity and social care availability, and continue to impact overall bed occupancy and flow through the hospital. This has resulted in a sustained number of medically optimised patients remaining in acute beds, contributing to ongoing pressure on urgent and elective pathways.
- Internal discharge processes remain relatively stable, indicating that current operational controls within the Trust are functioning as intended, although overall performance continues to be challenged by factors largely outside of direct organisational control.

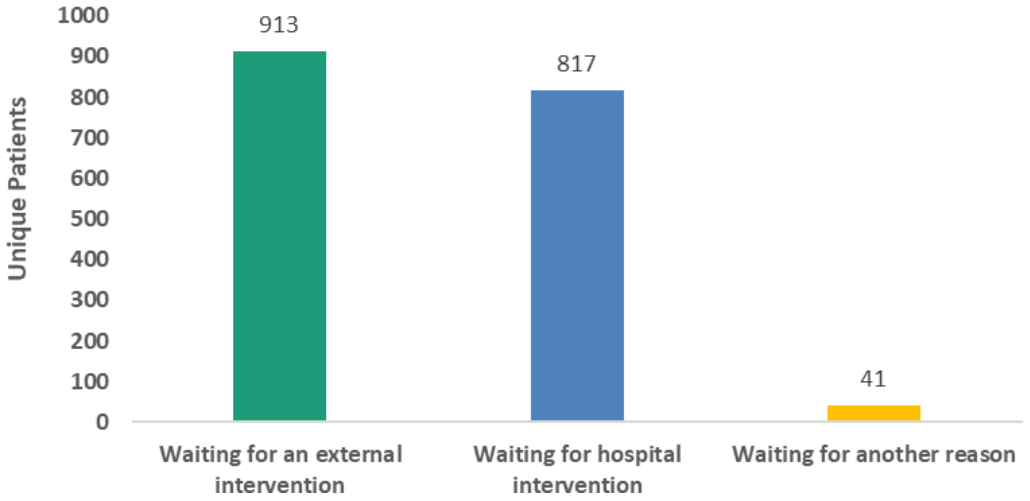
Actions and mitigations

- Focus remains on strengthening both processes and process adherence through standardising processes and improving system coordination to stabilise flow.

Source: Operational Management Dashboard

Deep dive delays from discharge ready date: escalation rule 1 – highest performance risk

Number of patients who have no criteria to reside and have a delayed discharge, April 2026



Top 5 reasons for waiting for an external intervention	
Pathway 3: availability of residential or nursing home	171
Repatriation/transfer to another acute trust	172
Awaiting transport	222
Awaiting confirmation from community (Transfer of Care Hub)	239
Pathway 1: awaiting availability of care at home	525

Top 5 reasons for waiting for hospital intervention	
Awaiting referral to community (Transfer of Care Hub)	27
Awaiting diagnostic test	28
Awaiting medicines to take home	72
Awaiting therapy decision to discharge	298
Awaiting a medical decision/intervention	474

Performance narrative

- Patient flow metrics for April 2026 indicate continued pressure across discharge performance, with delays in complex pathways—particularly Pathway 1—remaining the principal driver of lost bed days.

Key risks

- Key risks to compliance and improvement of patient flow metrics are driven by the sustained deterioration in post-MRD length of stay for the longest-stay cohort (≥21 days). Despite a marginal improvement in April 2026 to 52.5 days (from 55.9 days in March), performance remains significantly above 2025 levels, indicating ongoing systemic delays affecting a small but high-impact group of patients.
- This cohort presents a continuing risk of:
  - Reduced bed availability, with patients remaining too long in acute beds
  - Impaired flow across urgent and elective pathways, due to occupancy by medically optimised patients
  - Limited impact of improvements in shorter delay cohorts
- The persistence of prolonged delays suggests that existing mitigations are insufficient to address complexity at the highest end of the pathway, with performance heavily dependent on external system capacity and timely access to community and discharge support services.

Actions and mitigations

- Actions and mitigations focus on addressing internal flow efficiencies and system wide discharge constraints, particularly for the ≥21 day cohort.
- Earlier identification of complex patients and timely completion of assessments to ensure earlier discharge, supported by the Complex Discharge Team.
- Improving coordination with partners through OPTICA – a joint view of discharge pathways. Improved access to community capacity with Home First partners.
- Enhanced discharge dashboards improve operational grip, and target engagement with social care, and commissioning. Also, ongoing Divisional focus on reducing therapy and medical assessment delays. RAG rated ward discharge intervention approach

Source: Operational Management Dashboard and Regional Pathway data

Link to return to the performance summary

Trust level - to end Apr 2026		Patient safety		
Metric	**Target**	**In month actual**	**SPC variation**	**24 month trend**
HCAI measure				**Apr 2026**
MRSA bacteraemia cases (12month rolling)	0	6		
C. difficile infections (12month rolling)	134	129		
E.coli bacteraemia cases (12month rolling)	171	188		
CQC inspection				**May 2023**
CQC safe inspection (last two years)	Good	Good		
Staff survey				**Mar 2025**
NHS Staff Survey – raising concerns sub-score		6.55		
Patient safety				**Apr 2026**
Never events		0		
Pressure ulcers per 1,000 bed days (Cat 2, 3, 4, mucosal, suspected deep tissue injury, and unstageable HAPUs)	0.40	0.95		
VTE % compliance of patients admitted to CUH who have been risk assessed	95.00%	96.88%		
Patient falls per 1,000 bed days	3.25	3.85		
Rate of reported patient safety incidents of moderate or severe harm or fatal	2.00%	1.43%		
Learning from deaths - % of deaths in scope with a problem in care (1-3 score)	0	0.00		
Maternity Outcomes Signal System (MOSS) Alert	No alert	No alert		
Postpartum Haemorrhage rates (PPH) for vaginal births	3.20%	4.59%		
Induction of Labour rates	24.00%	29.93%		

Performance narrative

- The ceiling for 2026/2027 has been set at no avoidable hospital onset cases. There was 1 cases of hospital onset MRSA bacteraemia in April 2026.
- There were 6 cases of hospital onset *C. difficile* and 4 COHA case in April 2026
- *E. coli* bacteraemia cases: 14 MTD (9 hospital cases and 5 COHA cases)
- The Trust met two Local Quality Requirements (LQR) for Falls per 1,000 bed days, and risk assessments completed within 12 hours. We are not meeting our LQR for Lying and Standing blood pressure completion.
- The Trust is not meeting its Local Quality Requirements for Hospital Acquired Pressure Ulcers (HAPUs) and risk assessments.
- Challenged performance continues for continuation of induction of labour which is off-track against plan.

Key risks

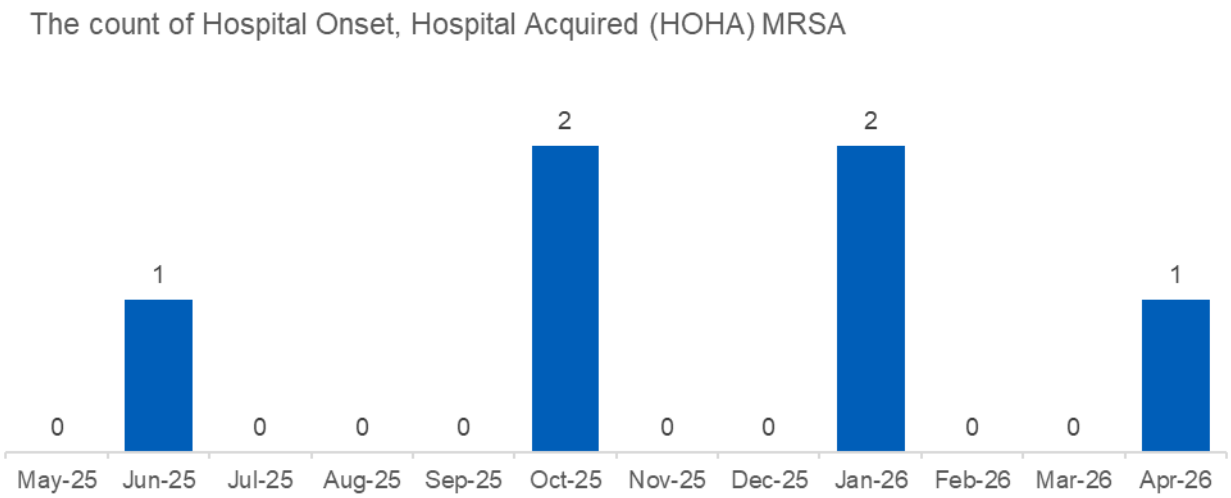
- *Clostridioides difficile* - We had 6 cases for April. The ICB attends our Clostridium safety learning and has input. All 6 cases have been discussed at this forum. There is ad hoc representation from the medical team to make these learning events pertinent.
- *E. coli* – We had 9 hospital cases which are with divisions for deep dive analysis. These are currently being reviewed by divisions.
- Key to improving compliance is correct risk assessment and individualised care plan to ensure timely mitigation. As well as learning from incidents and near misses.

Actions and mitigations

- *Clostridioides difficile* - Ongoing work with Harm free care, Tissue Viability and Genome regarding rolling out Mattress Audits and checking of mattresses. Rolling Clean programme was disrupted in March due to operational flow.
- *E. coli* - Ongoing AMS stewardship.
- Review of all Risk Assessments and Admission documentation is currently underway, a significant and comprehensive piece of work.
- The enhanced recovery pathway is launched to reduce length of stay in maternity.

Source: Quality Account, note data are live so can historic data may change

Deep dive IPC: escalation rule 1 – highest performance risk



Performance narrative

- MRSA Bacteremia - the ceiling for 2026/2027 has been set at no avoidable hospital onset cases.
    - There was 1 case of hospital onset MRSA bacteremia in April 2026, and 0 COHA case this reporting year.

Key risks

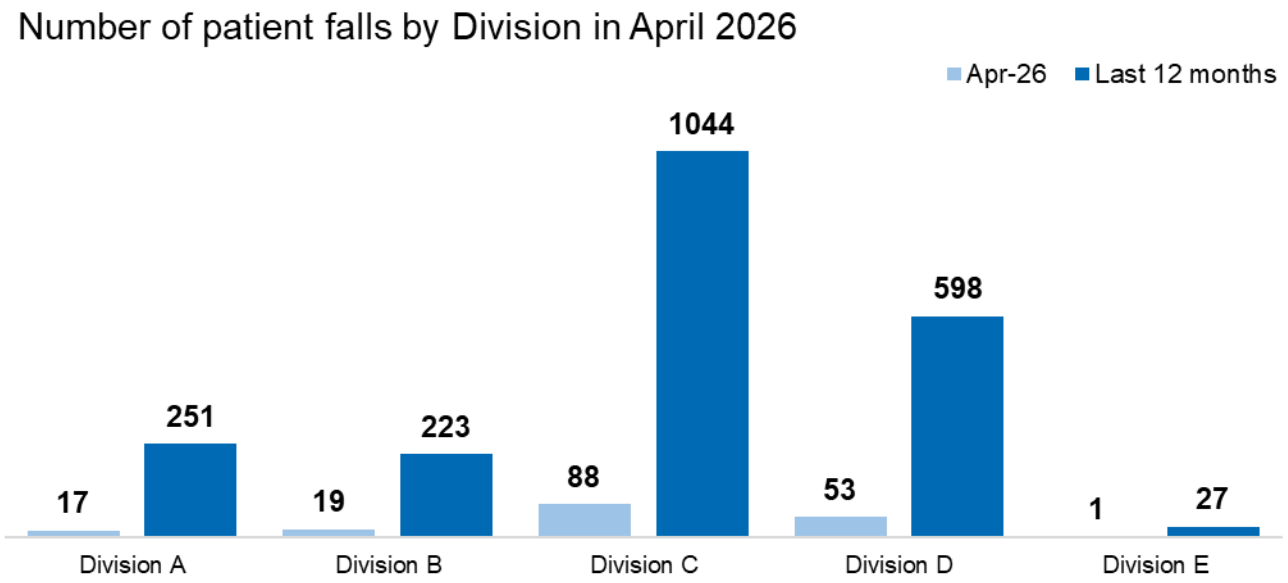
- POC MRSA testing is undertaken and used in Emergency Department to help with orthopedic patient flow and placement. The bacteriemia patient had POC test undertaken which showed to be positive. Noted by a doctor, documented in notes yet no action was taken either in isolating the patient or prescribing decolonization therapy. Bank holiday weekend so picked up by ICNS on return to work.
- Following the patient safety incident, more could have been done by medical staffing to participate in the safety learning event.

Actions and mitigations

- As part of the learning actions, Division A have looked at pre-surgery decolonization for orthopedics where IPC have reached out to pharmacy about increasing MRSA decolonization post op for all patients with implants. Work in progress.
- An EPIC change request for more visible MRSA screen for PCR was submitted in early May, which will increase awareness. Ward manger and Matron to educate ward staff about correct MRSA decolonization method.

Source: Infection Control data

Deep dive Patient safety falls: escalation rule 1 – highest performance risk



Performance narrative

- There were 180 falls in April - 3 of which resulted in moderate harm and 4 resulting in severe harm. Division B saw a statistically significant increase in falls, though saw no moderate+ harm. We are meeting the LQR of <6.6 falls per 1000 bed days, though not achieving our internal threshold of <3.25 falls per 1000 bed days- for April there were 3.84. Only Division A and E met this internal threshold. We met the LQR for Falls risk assessment of >90% (97%) but we continue to not meet the target for Lying and Standing blood pressure recording of >90% (25.7%).

Key risks

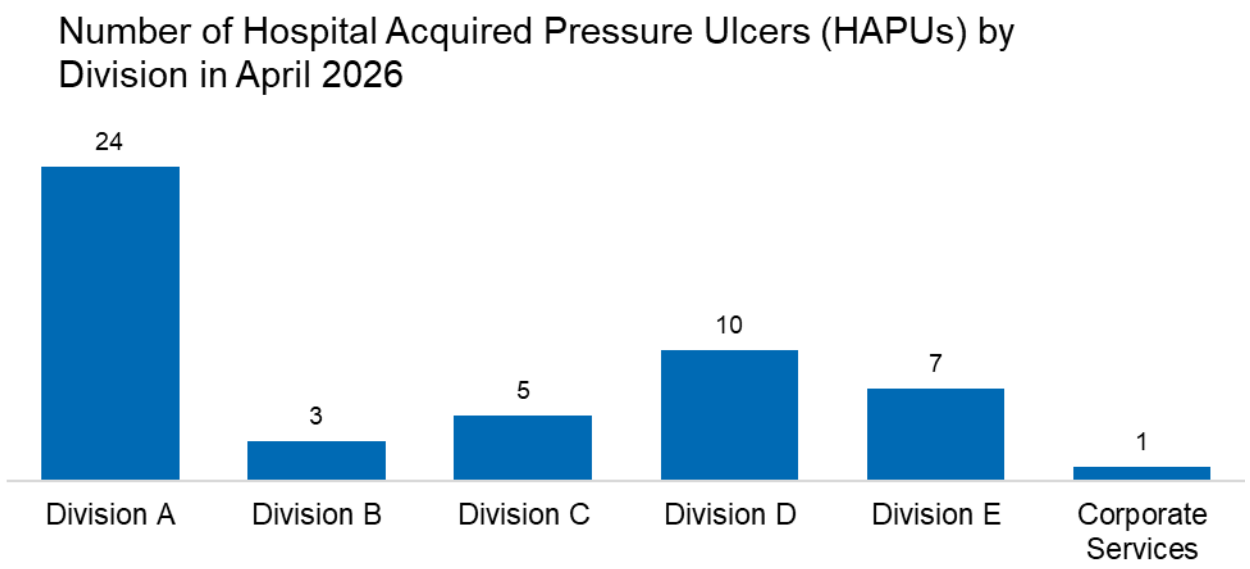
- Falls in bathrooms/toilets remain the highest location for falls. Bathroom falls alarms were trialed at the start of 2026 and will be presented to the Clinical Review Group in May 2026 and if approved these will be purchased to support Falls prevention.
- Updates to all admission risk assessment and to care plans are underway with the Epic team. This is required to ensure they are utilised correctly and the information can meaningfully support care delivery and mitigation.

Actions and mitigations

- The team are exploring how to increase the visibility of LSBP recordings on EPIC to improve compliance. Development of the Quality Improvement Plan for Falls for 2026-2028 is underway, aligning to National and Trust priorities.
- Improvement work is coordinated through a monthly Falls Harm Free Care Meeting.
- Oversight and monitoring is through the Quality and Performance meeting and Patient Safety Oversight Meeting. Significant incidents (Falls resulting in moderate+ harm) are brought to the weekly Patient Safety Executive Huddle.

Source: Quality Account

Deep dive Patient safety pressure ulcers: escalation rule 1 – highest performance risk



Performance narrative

- There were 50 Hospital Acquired Pressure Ulcers (HAPUs) reported in month and represents a statical in crease for the last 7 months. There were no Category 3 or 4 HAPUs reported though 24 category 2s, 3 SDTI and 1 unstageable HAPUs were. We are off track against our internal target of <0.395 Category 2+ HAPUs per 1,000 bed days- for April we measured 0.981 bed days. Only Division C has met this target this month.

Key risks

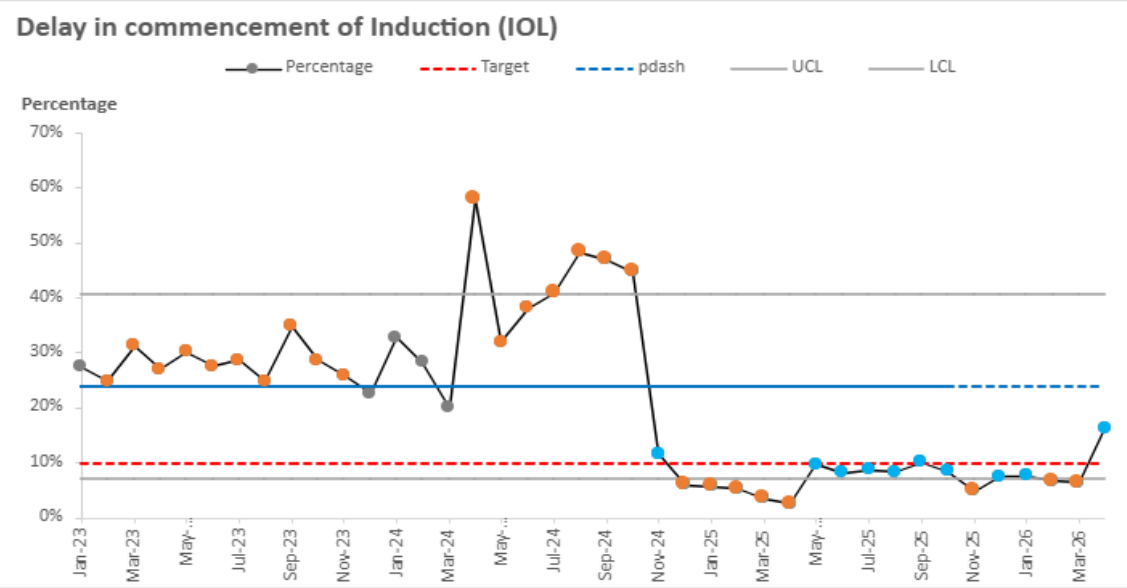
- We have met our Local Quality Requirement (LQR) of zero category 3 and 4 HAPUs. We have not met the target of 0 category 2 and unstageable HAPUs and risk assessment completion target (100% April compliance 93.8%).

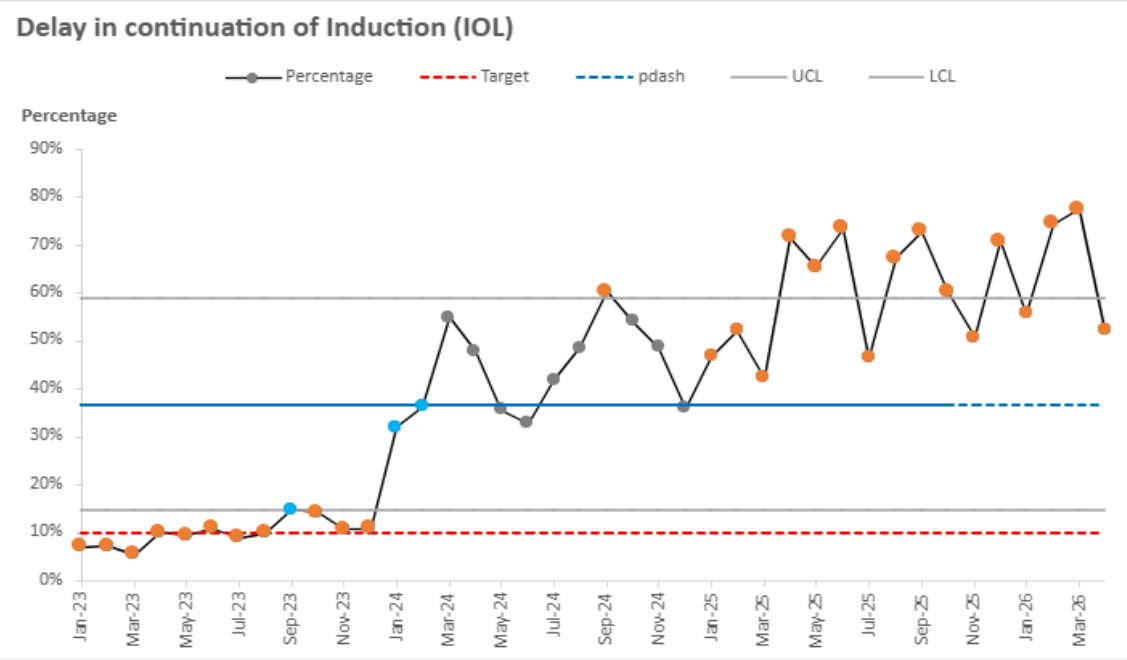
Actions and mitigations

- Development of the Quality Improvement Plan for HAPUs for 2026-2028 is underway, aligning to National and Trust priorities.
- Improvement work is coordinated through a monthly HAPU Harm Free Care Meeting.
- Oversight and monitoring is through the Quality and Performance meeting and Patient Safety Oversight Meeting. Significant incidents (Category 3 and 4 HAPUs) are brought to the weekly Patient Safety Executive Huddle.

Source: Quality Account

Deep dive Maternity: escalation rule 1 – highest performance risk





Performance narrative

- Induction of Labour (IOL) performance risk centres on Continuation of IOL, which has deteriorated performance position.
- Commencement of IOL showing improved performance.

Key risks

- Risk in IOL pathway moved from commencement to continuation.

Actions and mitigations

- Ensure risk assessment process is being adhered to and strengthen safety netting around continuation of IOL ensuring robustness (particularly during delays over 24 hours).
- Documentation of risk stratification to be reviewed. Workstreams on flow and capacity (including IOL pathway) to be refreshed, with new Director of Maternity.
- Currently reviewing Outpatient IOL through RBC (launched Feb 26).
- Establishment of Neonatal Transitional Care is pending decision from Investment Committee.

Source: Quality Account

Link to return to the performance summary

Trust	Finance & Productivity		April 26
Metric	**Target**	**In Month Actual**	**24 Month Trend**
Surplus/Deficit			**Apr-26**
Trust actual surplus/deficit (in month)	(£1.0m)	(£3.0m)	
Trust actual surplus/deficit (YTD)	(£1.0m)	(£3.0m)	
Performance against plan surplus/deficit	£0.0m	(£2.0m)	
Financial Position			**Apr-26**
Capital Expenditure (YTD)	£4.6m	£2.6m	
Cash position (YTD)	£54.8m	£75.9m	
Elective Payment Mechanusm (EPM) income (YTD)	£23.7m	£27.0m	YTD plan vs YTD actual
Productivity			**M9 25/26 v M9 24/25**
Implied rate of productivity growth		5.4%	

Source: Finance data

Performance narrative

- The Trust is reporting a £2.0m adverse variance driven by the forecast non-recurrent financial impact of the seven day period of Industrial Action undertaken by Resident Doctors. Pay impacts are estimated at £1.2m and lost income forecast at £0.8m. As in previous years the Trust will seek additional funding from NHS E to cover the expenditure impacts of the IA.
- Investment in Capital schemes totalled £2.6m in Month 01 - lower than plan by £2.0m. It is expected that expenditure will increase in future months and the Trust is therefore forecasting to deliver the planned level of Capital investments.
- Cash balance at the end of Month 01 was £75.9m - ahead of plan £21.1m. This is due to favourable working capital movements, mainly relating to receipt of commissioner income.
- The most recent NHS E published data for Month 09 shows the Trust delivered an Implied Rate of Productivity Growth of 5.4% and includes 2.9% cost weighted activity growth and 2.4% reduction in relative costs.

Key risks

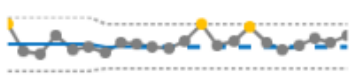
- Trust SLAs are not yet signed with formal disputes regarding the local pricing of activity meaning the Trust could receive less income that was planned for.
- Further periods of Industrial Action present a significant financial risk due to premium pay costs required to ensure safe staffing combined with lower activity driving reduced levels of income.
- The Trust needs to deliver an efficiency programme (PEP) of £59.2m in 26/27 including increased productivity alongside cost reductions. Failure to deliver the programme as planned could impact planned monthly and full-year financial performance.
- The need to incur ongoing Premium pay expenditure including WLI and outsourcing costs to support in year operational performance could threaten the planned breakeven financial performance in 26/27.
- National funding does not fully cover the cost of pay awards for Medical staff.

Actions and mitigations

To maintain a financially sustainable position in 26/27 the Trust is required to:

- Obtain a good outcome from the national arbitration for the Trust SLAs
- Improve output productivity through increased elective service delivery above current service levels to maintain RTT performance
- Deliver cost out PEP programme and manage/mitigate in year cost pressures
- Exit premium bank and WLI payments and reduce outsourcing payments
- Seek national funding to cover non-recurrent expenditure driven by periods of Industrial Action
- Identify if there is a shortfall in Medical staff pay award funding and identify alternative methods to cover the cost pressure

Link to return to the performance summary

Trust level - to end Apr 2026	People & workforce			
Metric	**Target**	**In month actual**	**SPC variation**	**24 month trend**
Staff survey				**Sep 2025**
NHS staff survey - engagement sub-score		6.90		
Workforce growth				**Apr 2026**
Total change in substantive WTE (12 months)		-2.55%		
Substantive WTE performance - distance from plan	0	-152.09		
Bank WTE performance - distance from plan	0	147.23		
Agency WTE performance - distance from plan	0	-1.93		
Staffing				**Apr 2026**
Mandatory Training Compliance	90.0%	93.48%		
Turnover rate	10.6%	9.86%		
Sickness absence rate (12 months)	4.1%	4.22%		
Health and Safety Incidents rate per headcount		1		

Performance narrative

- In month 1 of 2026/27 the workforce is 7 WTE below plan overall. Substantive is 152 WTE below plan. In the past 12 months the workforce has reduced by 324 WTE (2.55%).
- Bank reduced by 127 WTE in the past month however is 147 above plan and agency is 2 WTE below plan. Winter plans continued into the first 2 weeks of April and there was industrial action, which has contributed to high bank usage.
- Sickness absence remains at 4.2% (over 12 months) however, in month absence has decreased from 4.2% in March to 3.9% in April. This is the same as this time last year.

Key risks

- The trust is above plan on temporary staffing and given the challenging target is likely to remain above target all year, although is likely to reduce again in May. There is potential to adversely affect activity delivery though temporary restrictions.
- There is a risk that the sickness absence trend over 12 months increases, and the trust does not meet the NHSE target of 4.1% in year.

Actions and mitigations

- The temporary staffing targets have been cascaded to divisions and monitoring will take place through quality and Performance meetings. Pay controls remain in place and are being reviewed to consider whether any adjustments are required.
- The new programme on sickness absence has made progress and actions will be continued in divisions and corporate teams to support the continuation of this improvement. Monitoring remains in place through Divisional Quality and Performance meetings.

Source: NHS National Staff Survey, Electronic Staff Record, Health Roster

NHS Oversight Framework – Q3 2025/26

	Q3 2025/26			Q2 2025/26			Q1 2025/26		
NOF Domain	Metric	Rank	Segment	Metric	Rank	Segment	Metric	Rank	Segment
Summary			2		71	3		70	3
Access to services		78	3		107	4		94	3
Difference between planned and actual 18 week performance	-2ppt	72		-0.1 ppt	70		-0.5 ppt	96	
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	59.5%	79		58.7%	91		58.1%	85	
Percentage of cases where a patient is waiting more than 52 weeks for elective treatment	3.0%	114		3.8%	114		4.3%	116	
Percentage of emergency department attendances admitted, transferred or discharged within four hours	71.3%	80		73.5%	78		73.5%	70	
Percentage of emergency department attendances spending over 12 hours in the department	7.5%	51		10.1%	69		7.6%	54	
Percentage of patients treated for cancer within 62 days of referral	72.2%	55		69.3%	59		72.8%	42	
Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral	84.0%	10		72.4%	91		77.4%	57	
Effectiveness and experience		104	3		101	3		94	3
Average number of days from discharge ready date to actual discharge date (including zero days)	1.38 days	106		1.23 days	100		1 days	91	
CQC inpatient survey satisfaction rate			2			2			2
Summary Hospital-level Mortality Indicator			2			2			2
Finance and productivity		6	1		9	1		48	2
Implied productivity level	7.20%	13		4.77%	31		0.43%	100	
Planned surplus/deficit	0%	6		0%	12		0%	12	
Variance year-to-date to financial plan	0.37%	12		0.48%	5		1.21%	6	
Patient safety		39	2		32	2		55	2
NHS Staff survey - raising concerns sub-score	no change			no change			6.55 / 10	41	1
Number of MRSA bacteraemia cases	5 cases			3 cases	54		7 cases	114	
Proportion of C. difficile infections	1.02 (rate)			1.12 (rate)	57		1.20 (rate)	63	
Proportion of E. coli bacteraemia	1.06 (rate)			1.07 (rate)	37		1.11 (rate)	55	
People and workforce		21	1		20	1		22	1
NHS staff survey engagement theme sub-score	no change			no change			7.02 / 10	40	2
Sickness absence rate	4.10%	17		3.85	15		4.21	14	
Summary									
Financial override	No			No			No		
Is the organisation in the Recovery Support Programme?	No			No			No		

Source: published March 2026 by NHS England

Appendix: defining performance risk

The CUH IPR uses two measures for performance, which define the escalation rules or performance risk:

i. Performance against plan or target

Performance position at or above plan will be demonstrated with a green colour. Any metric below plan but within 5% of the target will be beige. Finally, any metric more than 5% worse than target will be pink and this will be defined as off-track against target

ii. SPC defined change in performance

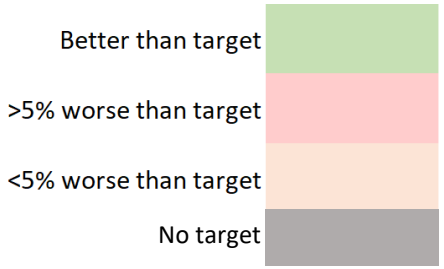
24 months of data is used to measure the SPC, with any performance outside of the expected variance of that data (control limits) labelled as either an improved position (blue colour: positive special cause variation), or a deteriorated position (orange colour: negative special cause variation).

Any metric that displays a change whose magnitude is greater than expected variation will be labelled as improving or deteriorating in the performance summary.

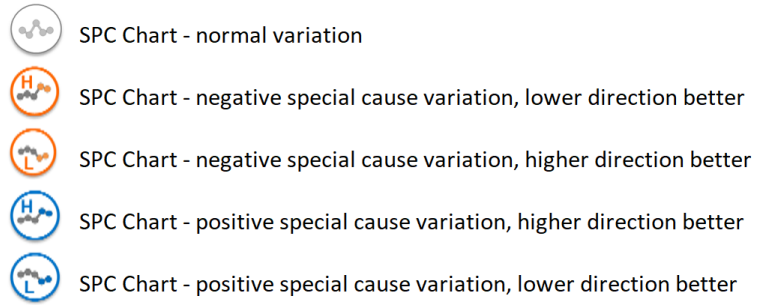
Escalation and de-escalation rules

An escalation rule occurs when a metric is off-track against plan/target, or on-track but with deteriorating performance. There are three levels of performance risk.

i. Performance against plan or target

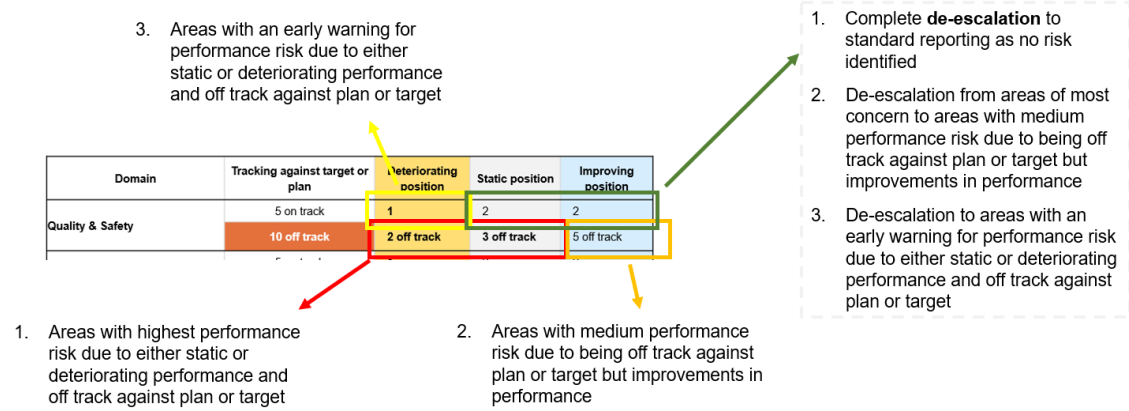


ii. SPC defined changes in performance



Escalation rules:

i) off-track and sustained or deteriorating performance;
ii) off-track and improved position,
iii) on-track and deteriorating performance



Contents

Trust actual surplus / (deficit)

(£3.0m)	*Actual (adjusted)**
(£1.0m)	*Plan (adjusted)**
(£3.0m)	*Actual YTD (adjusted)**
(£1.0m)	*Plan YTD (adjusted)**

Elective Payment Mechanism (EPM)

EPM replaced ERF in 23/24 for the variable element of elective performance. Pending publication of 25/26 baselines forecast based on 24/25 methodology.

	In month	YTD
EPM forecast actual	£27.0m	£27.0m
EPM plan	£23.7m	£23.7m
EPM 25/26 target	£19.1m	£19.1m

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

Net current assets

(£109.7)	*Actual*
(£119.4)	*Plan*

Debtor days

29	*This month*
28	*Previous month*

Payables performance (YTD) *

87.6%	*Value*
92.0%	*Quantity*

EBITDA

£2.3m	*Actual YTD*
£5.1m	*Plan YTD*

Capital expenditure

£2.6m	*Capital - actual spend in month*
£2.6m	*Capital - actual spend YTD*
£4.6m	*Capital – plan YTD*

Cash

Cash

£75.9m	*Actual*
£54.8m	*Plan*

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

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

Month 01 Financial Performance

- The Month 01 financial position is **£3.0m deficit for performance management purposes, adverse to plan by £2.0m.** The position is due to the estimated non-recurrent financial impact of the Resident Doctor Industrial Action that took place in April 2026 at £2.0m.

    - **Points to note in respect of the Month 01 financial position:**
        - The inflationary pay award funding is assumed to cover the cost of the pay awards. Further clarity on pay awards for medical staffing and updated Inflation funding is expected from NHSE during quarter 1
        - Clinical income at month 1 is estimated using activity levels and prior period casemix as the detailed valuation is issued approximately one month in arrears
        - There are open disputes with Central East ICB and Norfolk and Suffolk ICB regarding the 26/27 contract values which could result in further changes to reported income
    - **Points to note in respect of Month 01 financial performance**
        - Whilst on plan at month 1 the Trust Productivity and Efficiency Programme (PEP) delivery requirements increase significantly in future months. Work continues to ensure all required PEP is identified and plans are in place to deliver it.
        - Assurance over PEP development and delivery is improving but at Month 1 the Trust is still reporting a gap in identified values of £3.7m for cost reduction. Productivity scheme development and delivery remains under review by the Productivity Board.
        - Additional reduction in bank and agency expenditure is required to ensure delivery of the Pay PEP target for 26/27. Overall expenditure remains within the NHSE expenditure limits for 26/27.
        - Approval of specific in year Quality and Safety investments may require additional PEP delivery in year to support them.

- **Income is adverse to plan by £4.0m**
    - Clinical income - The distribution of income plan at month 01 is based on a planning estimate which does not align to current contract levels. This includes a favourable variance for Elective activity of £3.3m and pass-through drugs of £2.9m offset by Other elements of Clinical income at £6.6m. The Trust will update the plan distribution for month 02, in line with the NHSE timetable, which will then show an under performance on Elective activity income of c.£0.6m.
    - Devolved income - adverse to plan by £3.6m due to lower donated income (£1.2m), Education and Training (£0.9m), fire safety works (£0.4m), R&D (£0.2m) and lower sales to other organisations (£0.9m). It is expected that this under performance will be resolved in future months. Please see pages 10-14.
- **Pay is adverse to plan by £1.6m**
    - £1.2m of Industrial Action related bank expenditure and Easter bank holiday premium shifts account for this position. Please see pages 15-16.
- **Non pay (including drugs) is favourable to plan by £2.9m**
    - Drugs expenditure is adverse to plan by £0.9m offset by favourable variances of £3.8m across other categories of non pay expenditure. Please see pages 20-21.

Financial target in 2026/27

NHSE have set several financial targets that the Trust must deliver during the financial year. These include:

- Overall financial performance (delivery of planned breakeven position)
- Delivery of the PEP programme of £59.2m including £25.1m of cost reductions
- Reduction of 10% in bank expenditure compared to the 25/26 Month 05 inflation adjusted forecast outturn
- Reduction of 30% in agency expenditure compared to the 25/26 Month 05 inflation adjusted forecast outturn

The NHS Oversight Framework was launched in 2025 and includes operational performance metrics alongside two finance and one productivity metric. The Trust was initially assessed as segment 2 for finance and productivity but placed in segment 3 overall, ratings were based on M12 24/25 data. Updated data was published for Quarter 3 and the Trust is now placed in segment 1 for finance and productivity (high performing) and is in segment 2 overall. NHSE has published Month 09 YTD implied productivity performance of +5.4% for CUH. The Trust has calculated its' Month 01 YTD implied productivity performance at +5.4%.

Details of the finance and productivity target metrics and current/forecast performance against them can be found on page 8 of the report (this excludes the operational performance metrics).

Elective Payment Mechanism (EPM)

- Elective activity in 26/27 will continue to be paid on a 'variable' basis, where Trusts are paid on PbR for a selection of activity including Elective Inpatients, Day-cases, Outpatient first attendances, Outpatients procedures and Chemotherapy. Starting in 26/27, Unbundled radiology will also be included in the Variable capture. Commissioner arbitrations are currently underway, including elements of local elective service pricing.
- Points to note:
  - The distribution of income plan at month 01 is based on a planning estimate which does not align to current contract levels. EPM is £3.3m ahead of the current plan but after re-alignment this is expected to be £0.6m below planned levels.
  - The Trust remains in formal dispute with Central East ICB and Norfolk and Suffolk ICB regarding Elective payment terms for 26/27 and this position may be subject to change.

Productivity and Efficiency Programme (PEP)

- The Trust set an efficiency target of £59.2m, of which £25.1m is planned to be delivered via cost reduction PEP.
- At Month 01 the Trust has delivered £4.0m of cash-releasing and productivity savings against the PEP plan of £4.0m.
- The plan profile shows an increase in efficiency required across the year with 43% delivered in Quarters 1 and 2 and 57% in Quarters 3 and 4. Within this the Month 01 plan required £4.0m of savings to be delivered rising to a monthly average £4.6m for Months 04 to 06 and £5.5m for Months 07 to 12.
- Whilst on plan at Month 01 the following actions are being pursued:
  - Full identification of the 26/27 cost out and productivity PEP programme
  - Productivity board oversight of Divisional productivity programmes
- Implied productivity for Month 01 compared to the same period in 25/26 is estimated at 5.4% improvement due to 4.6% improvement in cost weighted activity (outputs) and 0.8% relative reduction in expenditure (inputs).

Cash and Capital Position

- The Trust has been allocated operational capital funding for the year of £38.0m for its core capital requirements (£7m lower than 2025/26). In addition to this we expect to receive further NHS capital funding including; Children's Hospital (£11.3m); Cancer Hospital (£18.4m); Estates Safety Fund (7.3m); Return to Constitutional Standards (£3.1m). Together with capital contributions from ACT, technical adjustments in respect of PFI, and other miscellaneous DHSC awards, the Trust's capital budget for the year now totals £85.6m.
- Capital expenditure at Month 1 was £2.6m compared to plan of £4.6m but, at this very early stage of the year, the Trust is forecasting to invest the capital plan in full by end of year.
- The Trust's cash position was £123.9m and the 13-week cash flow forecast does not identify any need for additional revenue cash support in the foreseeable future.

Implementation of new Finance System, Chart of Accounts, Income system and associated new reporting tools

- The Trust migrated its Finance system on 01 April and implemented a new Chart of Accounts. Volatility within categories of income and expenditure is expected as teams adapt to the new coding structure. Budget remapping is expected during quarter 01 to reflect the new coding for the procurement catalogues.
- The finance team are developing new reports and hope to include new analysis and relevant content within this report in future months.

£ Millions	Budget	Actual	Variance	Budget	Actual	Variance
Clinical Income - exc. D&D*, EPM	71.5	64.9	(6.6)	71.5	64.9	(6.6)
Clinical Income - EPM variable	23.7	27.0	3.3	23.7	27.0	3.3
Clinical Income - D&D*	20.5	23.4	2.9	20.5	23.4	2.9
Devolved Income	19.8	16.2	(3.6)	19.8	16.2	(3.6)
Total Income	**135.5**	**131.5**	**(4.0)**	**135.5**	**131.5**	**(4.0)**
Pay	75.0	76.7	(1.6)	75.0	76.7	(1.6)
Drugs	20.1	20.9	(0.9)	20.1	20.9	(0.9)
Non Pay	35.4	31.7	3.7	35.4	31.7	3.7
Operating Expenditure	**130.5**	**129.3**	**1.2**	**130.5**	**129.3**	**1.2**
EBITDA	**5.1**	**2.3**	**(2.8)**	**5.1**	**2.3**	**(2.8)**
Depreciation, Amortisation & Financing	5.0	5.0	0.0	5.0	5.0	0.0
Other (gains)/losses including disposal of assets	0.0	0.0	0.0	0.0	0.0	0.0
Share of (profit)/loss of associates/joint ventures	0.0	0.0	0.0	0.0	0.0	0.0
Reported gross Surplus / (Deficit)	**0.0**	**(2.8)**	**(2.8)**	**0.0**	**(2.8)**	**(2.8)**
Add back technical adjustments:						
Impairments	0.0	0.0	0.0	0.0	0.0	0.0
Capital donations/grants net I&E impact	(1.0)	0.1	1.1	(1.0)	0.1	1.1
IFRIC 12 scheme adjustments	(0.1)	(0.4)	(0.3)	(0.1)	(0.4)	(0.3)
Net benefit of PPE consumables transactions	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit) NHS financial performance basis	**(1.0)**	**(3.0)**	**(2.0)**	**(1.0)**	**(3.0)**	**(2.0)**

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

Financial targets 26/27	Target metric (£m)	Year-end forecast (£m)	Forecast variance to target (+ve fav) (£m)	In-year performance RAG	Commentary	M01 plan (£m)	M01 actual (£m)	M01 Variance (£m)
1) Deliver break-even financial performance or better - £0 target	0.0	0.0	0.0	Amber	The Trust expects to deliver the planned break-even position. Current performance is adverse to plan due to non-recurrent IA impacts of £2.0m in the reported position.	(1.0)	(3.0)	(2.0)
2) Deliver PEP target - £59.2m target	59.2	59.2	0.0	Green	In year performance in line with plan - the average monthly challenges increases by £1.5m for Months 7 to 12.	4.0	4.0	0.0
3) Reduce bank exp. by 10% (£6.0m) from 25/26 M5 inflation adjusted forecast outturn (£59.3m) – £53.3m max. exp. target	53.3	63.6	-10.3	Amber	Current performance is adverse to plan - the forecast outturn based on current run-rate (adjusted for £1.2m n/r IA expenditure extrapolates to a potential additional £10.3m of bank expenditure above the annual target threshold.	4.3	6.5	(2.2)
4) Reduce agency exp. by 30% (£1.1m) from 25/26 M5 inflation adjusted forecast outturn (£3.6m) – £2.5m max. exp. target	2.5	2.4	0.1	Green	Current performance is in line with plan - the forecast outturn based on current run-rate is £0.1m below the annual target threshold.	0.2	0.2	0.0

Single Oversight Framework metrics	Target metric	Full year forecast performance		RAG assessment (draft)	Current YTD performance	Estimated score (1 best / 4 worst)
Finance: Planned surplus/(deficit) (£m)	Breakeven or better	0.0	Plan forecast	Green	(3.0)	1
Finance: Variance year to date to financial plan (£m)	Favourable variance to plan	0.0	Plan forecast	Green	(2.0)	1
Productivity: Implied productivity (%)	NHSE published M09 YTD 25/26 Implied rate of productivity compared with M09 YTD 24/25	TBC	Review of NHS E dataset - adjusted for non-recurrent expenditure	Green	5.4% (3.8% at M08)	1
Productivity: Implied productivity (%)	Internal forecast M1 YTD 26/27 Implied rate of productivity compared with M1 YTD 25/26	TBC	Review of NHS E dataset - adjusted for non-recurrent expenditure	Green	5.4% (5.4% forecast M12)	1
Finance and productivity domain score (Qtr 3 published score)						1

Key messages

- As in 25/26 the Trust is required to deliver several discrete financial targets in 26/27, and these are detailed in the top table. The table includes the target metric, performance against the Trust plan and a forecast for year-end performance. The draft RAG rating considers current performance and how it relates to the target metric.
- Full year performance delivery is on targets for schemes 2 and 4 but off target for 1 and 3. The bank expenditure is skewed by £1.2m of IA expenditure, the additional costs for two Easter bank holidays and ongoing expenditure to support operational performance.
- Last September, NHSE published the first NHS Oversight Framework (NOF) scores, and the second table provides details for the finance and productivity metrics. These metrics are scored on a scale of 1 to 4 with 1 representing the highest performing organisations.
- The latest Quarter 3 NOF publication for Finance and Productivity produced a score of 1 – High performing. The dataset included Quarter 2 Implied Productivity figures as the Quarter 3 data was not available at time of publication.
- The latest NHSE implied productivity data (Month 09) produced a score of 5.4% with 2.9% increase in cost weighted activity and a 2.4% year on year cost reduction – the performance to Month 09 is influenced by Industrial Action where the Trust reported an additional £2.0m of expenditure and reduced levels of activity.
- The Trust expects to score a 1 for the Finance and Productivity domain at Quarter 4 25/26.
- Estimated the YTD implied productivity score at Month 01 is 5.4% - with a 4.6% increase in cost weighted activity (outputs) and a 0.8% reduction in relative expenditure (inputs).

Financial targets – 25/26

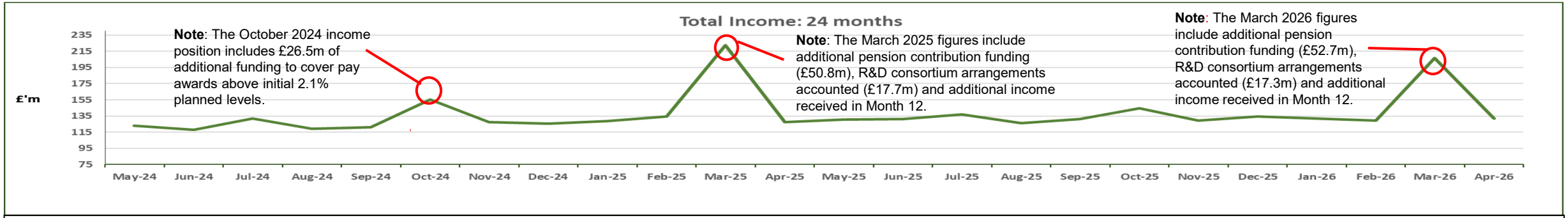
Full Year Plan – key messages

£'m	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	26/27 Total
Operating income from patient care activities	116.9	115.8	119.3	120.5	117.0	119.3	119.3	118.1	116.9	118.1	116.9	117.9	**1,416.0**
Other operating income	18.6	18.6	18.6	18.6	18.8	18.8	18.9	18.9	19.4	19.2	19.2	19.2	**226.8**
Total operating income	**135.5**	**134.4**	**137.9**	**139.1**	**135.7**	**138.1**	**138.2**	**137.0**	**136.3**	**137.3**	**136.1**	**137.0**	**1,642.7**
Employee expenses	(75.0)	(75.1)	(75.1)	(75.2)	(75.2)	(75.3)	(75.3)	(75.3)	(75.7)	(75.7)	(75.7)	(75.7)	**(904.4)**
Operating expenses excluding employee expenses	(59.6)	(59.6)	(59.6)	(59.6)	(59.6)	(59.6)	(59.6)	(59.6)	(59.6)	(59.6)	(59.6)	(59.6)	**(715.5)**
Total operating expenditure	**(134.7)**	**(134.7)**	**(134.7)**	**(134.8)**	**(134.8)**	**(134.9)**	**(134.9)**	**(134.9)**	**(135.4)**	**(135.3)**	**(135.3)**	**(135.4)**	**(1,619.9)**
Operating Surplus/(Deficit)	**0.9**	**(0.4)**	**3.1**	**4.3**	**0.9**	**3.2**	**3.3**	**2.1**	**1.0**	**2.0**	**0.8**	**1.7**	**22.8**
Finance income	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	**3.2**
Finance expense	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	**(8.0)**
PDC dividends payable/refundable	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	**(5.4)**
Net finance costs	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	**(10.2)**
Surplus/(Deficit) for the Period/Year	**0.0**	**(1.2)**	**2.3**	**3.4**	**0.0**	**2.4**	**2.4**	**1.3**	**0.1**	**1.1**	**(0.1)**	**0.8**	**12.6**
Add back technical adjustments:													**0.0**
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Capital donations/grants net I&E impact	(1.0)	(1.0)	(1.0)	(1.0)	(1.0)	(1.0)	(1.0)	(1.0)	(1.0)	(1.0)	(1.0)	(1.0)	**(12.0)**
IFRIC 12 scheme adjustments	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	**(0.6)**
Net benefit of PPE consumables transactions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Surplus/(Deficit) - NHS financial performance basis for the Period/Year	**(1.0)**	**(2.3)**	**1.2**	**2.4**	**(1.0)**	**1.3**	**1.4**	**0.2**	**(0.9)**	**0.1**	**(1.1)**	**(0.2)**	**0.0**

Key messages:

- The Trust plan delivers a 26/27 break-even position on an NHS financial performance basis.
- The table above shows the Trust plan presented in the NHS E reporting format at Month 01.
- The Trust is unable to change the original phasing of the Surplus/(Deficit) performance by month without formal permission from NHS E.
- NHS E expects Trusts to update the in-year plans to reflect key changes such as pay awards.

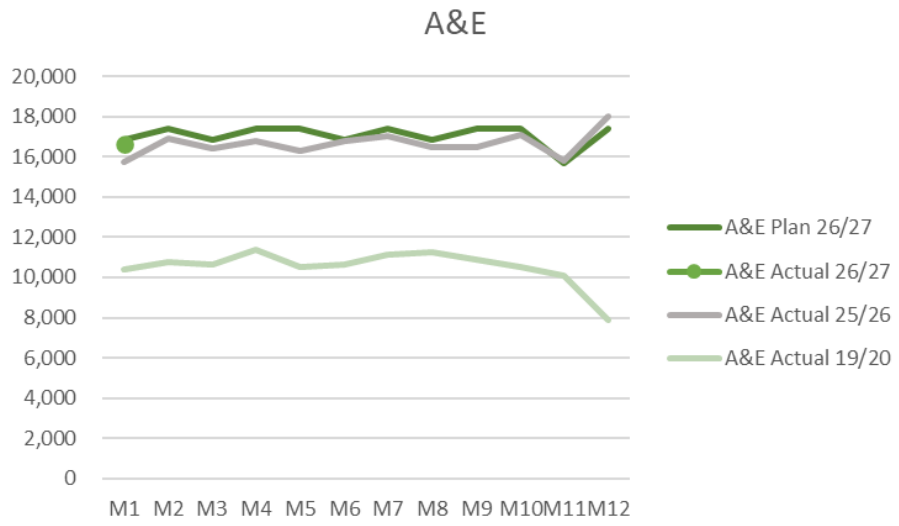
£'m	In Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Elective admissions	15.0	16.9	1.9	15.0	16.9	1.9
Non-elective admissions	22.9	22.6	(0.3)	22.9	22.6	(0.3)
Outpatients - First	4.8	4.7	(0.1)	4.8	4.7	(0.1)
Outpatients - Follow-up	9.0	8.7	(0.3)	9.0	8.7	(0.3)
A&E	7.4	7.3	(0.1)	7.4	7.3	(0.1)
High-cost drugs and devices income	20.5	23.4	2.9	20.5	23.4	2.9
Other Clinical Income	36.1	31.7	(4.4)	36.1	31.7	(4.4)
Total Clinical Income	**115.7**	**115.3**	**(0.4)**	**115.7**	**115.3**	**(0.4)**
Devolved Income	19.8	16.2	(3.6)	19.8	16.2	(3.6)
Total Trust Income	**135.5**	**131.5**	**(4.0)**	**135.5**	**131.5**	**(4.0)**

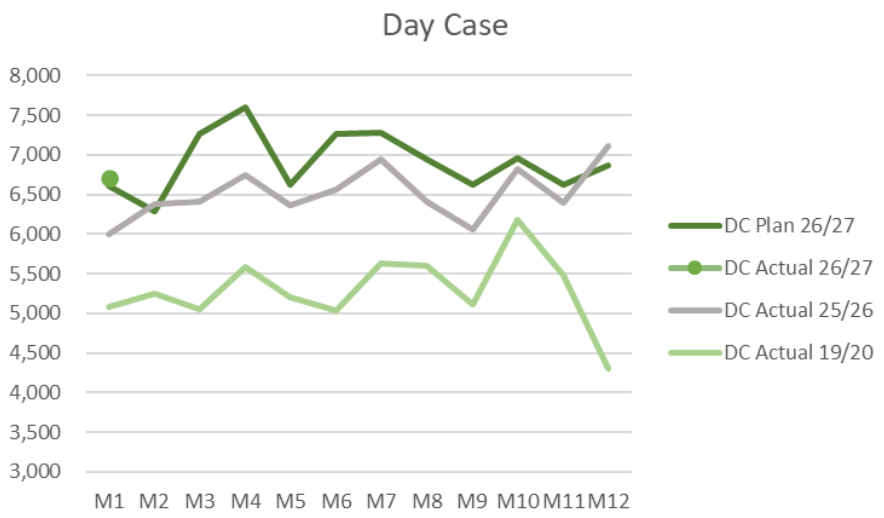


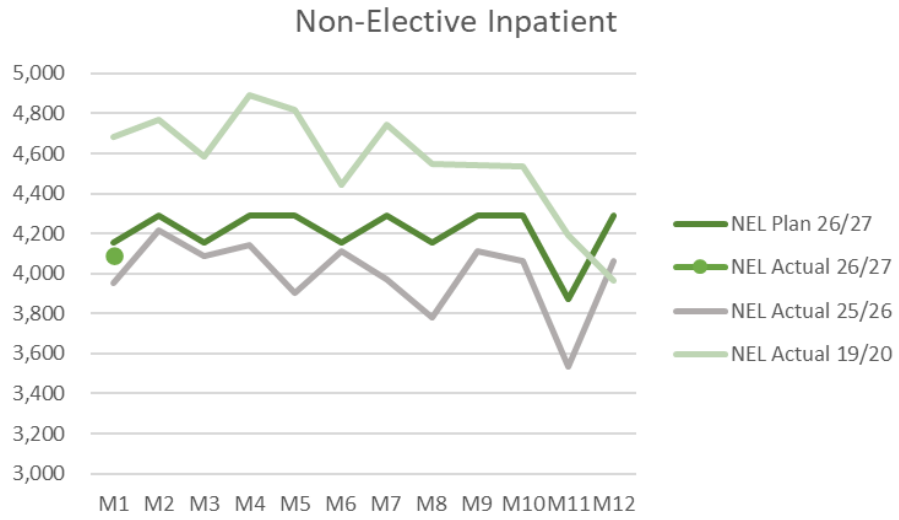
Key messages:

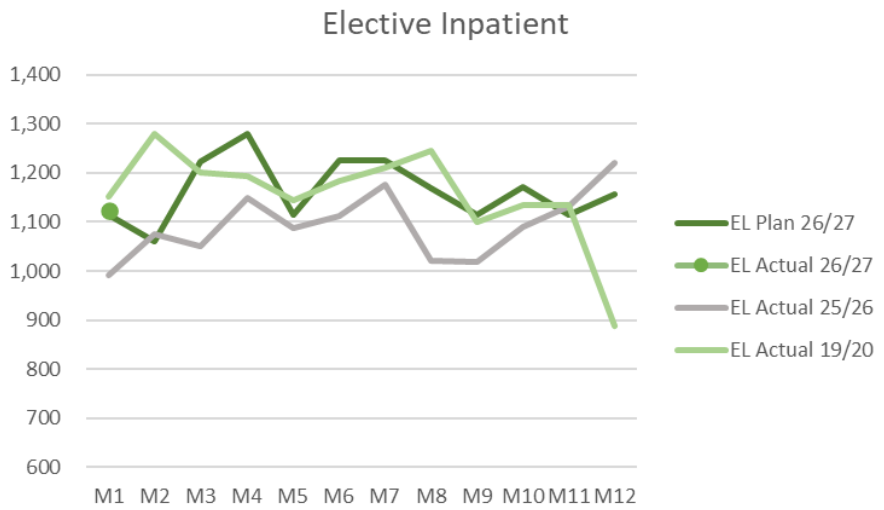
- The Trust income position is adverse to plan by £4.0m with Clinical income adverse to plan by £0.4m and devolved income adverse to plan by £3.6m.
- There is favourable in month variance of £3.3m for elective activity funded by the EPM with Other elements of Clinical income £6.6m adverse to plan in month. However, the distribution of income plan at month 01 is based on a planning estimate which does not align to current contract levels. After re-alignment EPM is expected to be £0.6m below planned levels.
- High-cost drugs and devices income from Commissioners is £2.9m favourable to plan in month driven by pass-through activity and offsets matching additional expenditure.
- The Devolved income position is adverse to plan by £3.6m and is explained by lower donated income than planned (£1.2m), Education and Training (£0.9m), lower fire safety works expenditure (£0.4m), R&D (£0.2m) and lower billing than planned to other organisations (£0.9m). It is expected that this under performance will be resolved in future months.

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



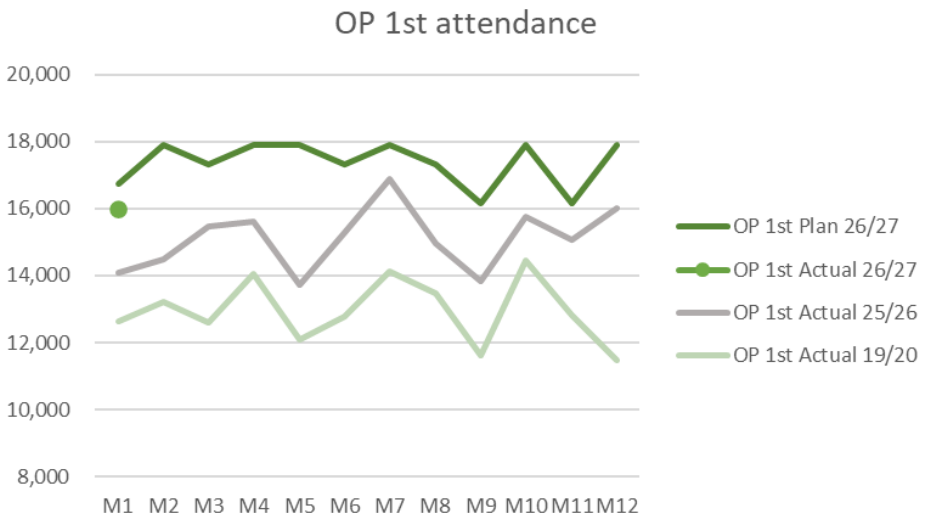


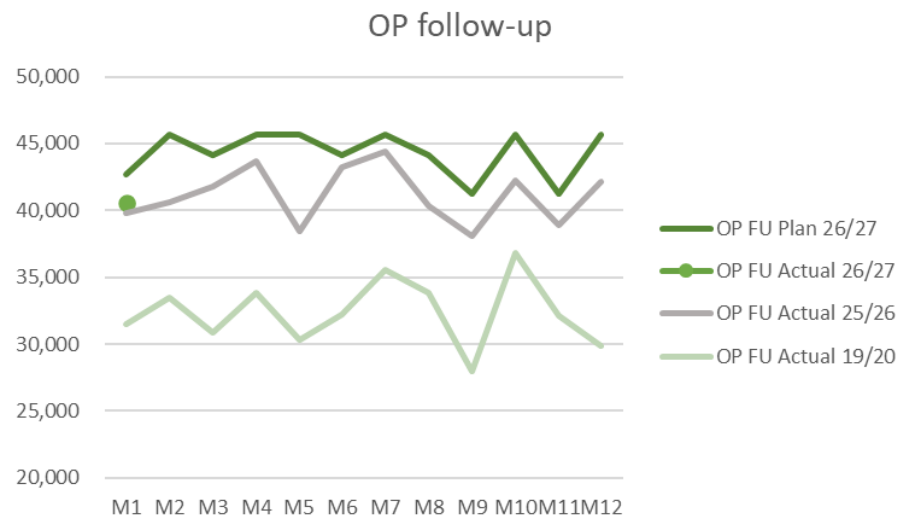


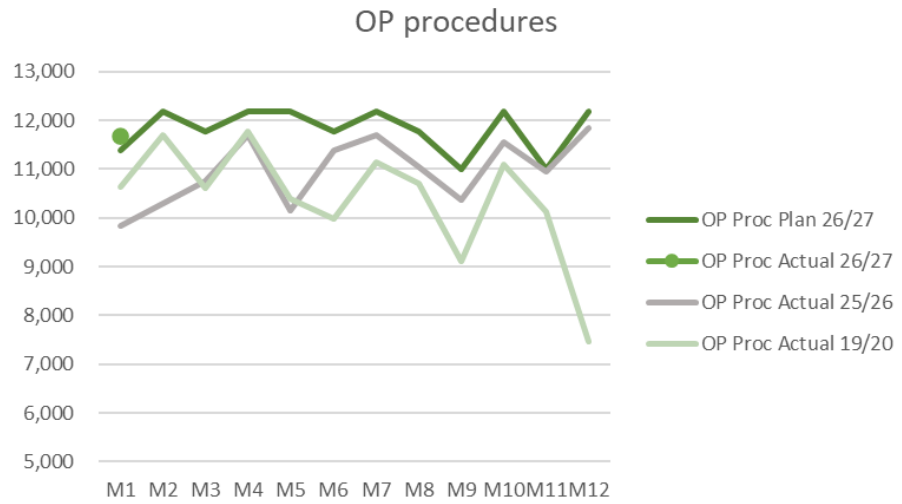


Clinical and other income (continued)

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







Key messages:

No coded activity data is available at the time of reporting, so the displayed actuals are indicative high-level estimates only, based upon weekly activity reports.

At month 01 :

- A&E attendances are 1.2% below plan.
- Non elective spells are 1.5% below plan.
- Elective spells are 0.8% above plan.
- Day cases are 1.5% above plan.
- Outpatient 1st attendances are 4.4% below plan.
- Outpatient follow-up attendances are 5.0% below plan.
- Outpatient procedures are 2.5% above plan.

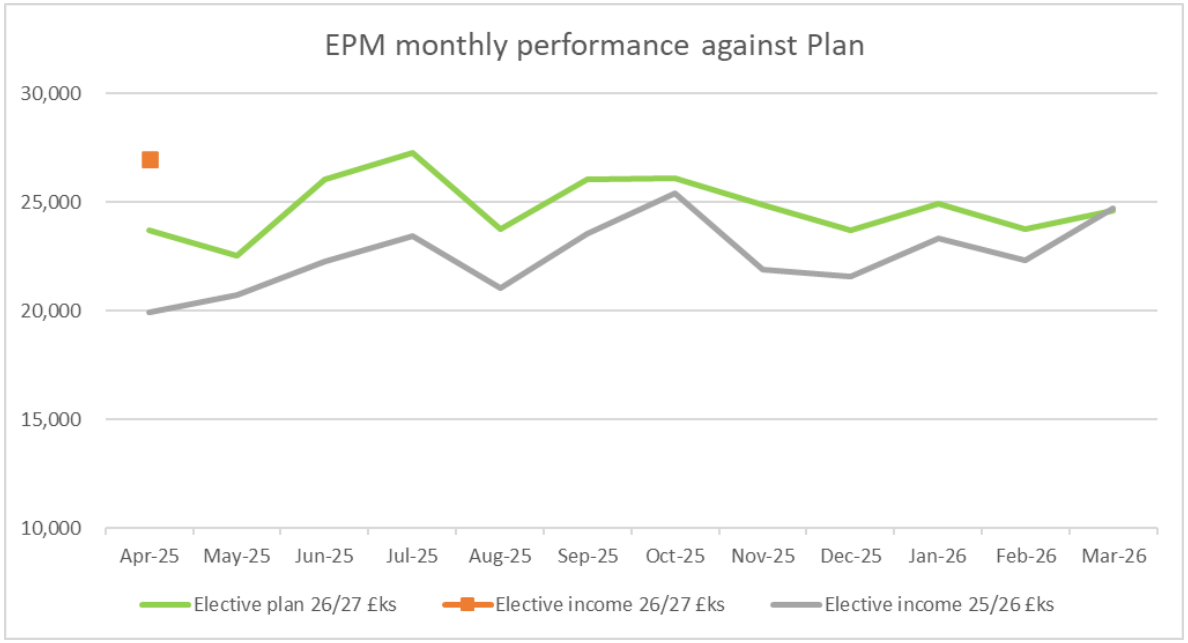
Clinical Income – Elective Payment Mechanism (EPM)

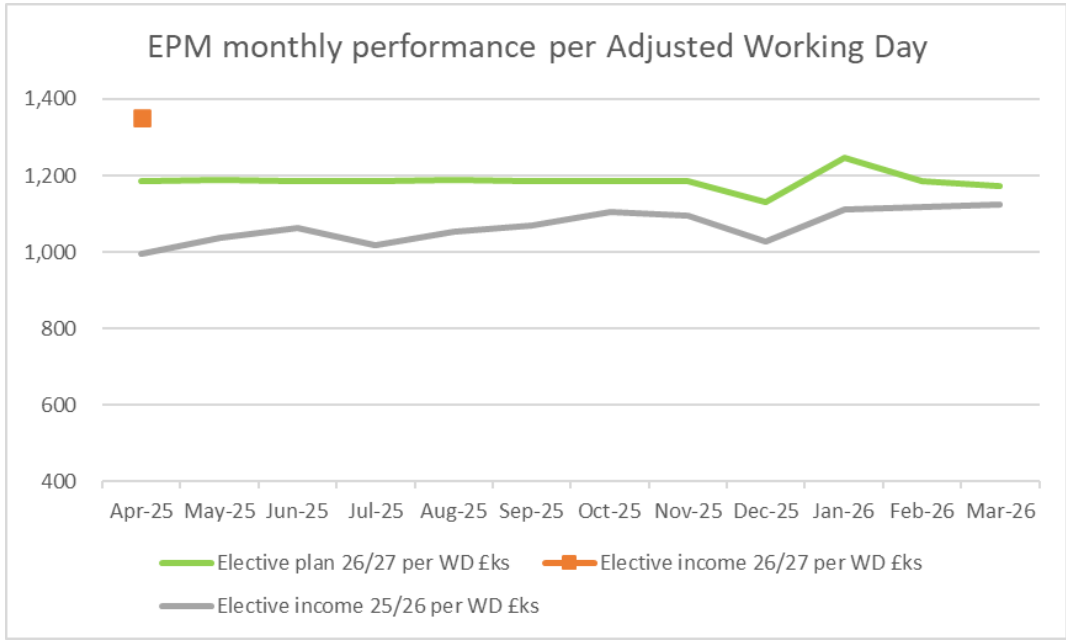
EPM:
Elective activity in 26/27 will continue to be paid on a 'variable' basis, where Trusts are paid on PbR for a selection of activity including Elective Inpatients, Day-cases, Outpatient first attendances, Outpatients procedures and Chemotherapy. Starting in 26/27, Unbundled radiology will also be included in the Variable capture. Commissioner arbitrations are currently underway, including elements of local elective service pricing.
Points to note:

- The distribution of income plan at month 01 is based on a planning estimate which does not align to current contract levels. EPM is £3.3m ahead of the current plan but after re-alignment this is expected to be £0.6m below planned levels.
- The Trust remains in formal dispute with Central East ICB and Norfolk and Suffolk ICB regarding Elective payment terms for 26/27 and this position may be subject to change.
- At the time of Month 01 reporting, no coded activity data is available and no national performance data has been released. Therefore, the figures in the table below are estimations based upon weekly activity reports and assumed case mix.
- The pricing methodology in the figures below uses the national NHS Futures local prices from 25/26.
- Fully coded data enables attribution to commissioner, which will flow from month 2 onwards.
- The Target in the table below is the 24/25 target for reference only.

Elective performance	Month 01 26/27						YTD 26/27					
	Target £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Target £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Trust high level M1 estimate	19.10	27.00	7.90	23.70	27.00	3.30	19.10	27.00	7.90	23.70	27.00	3.30

Clinical Income – Elective Payment Mechanism (EPM) Monthly View

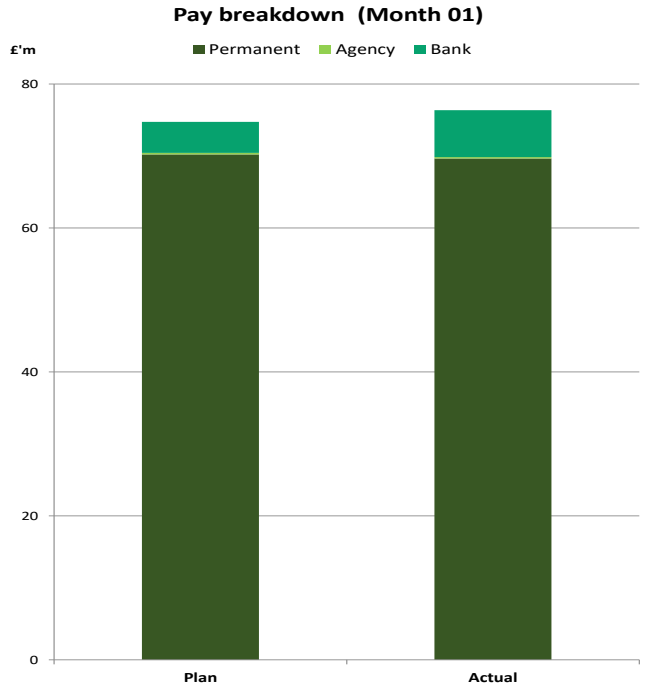


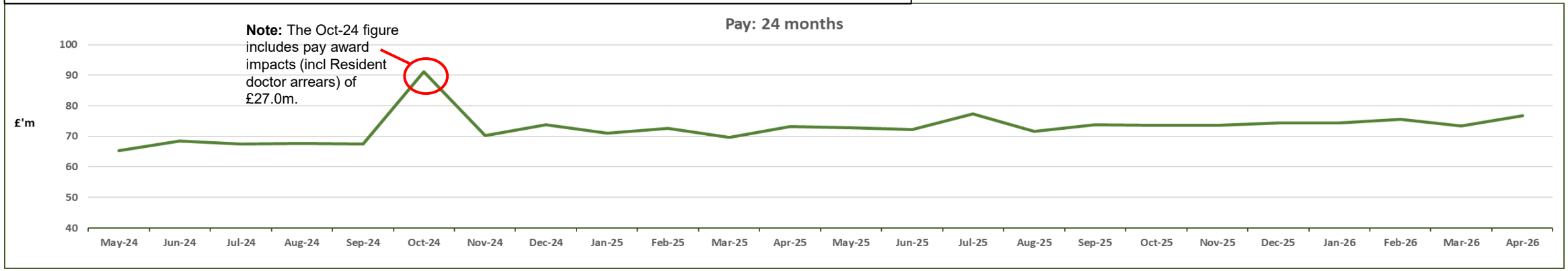


The graphs above detail both the monthly variable elective income performance values and those values per average working day, to highlight the change in average productivity required to achieve our plan. As stated on the previous slide, the plan is currently using submitted FPR values, and disputed prices.

Key messages:

- The Trust pay position is £1.6m adverse to budget at Month 01. This is driven by £1.2m of non-recurrent costs for IA and estimated financial impact of the Easter bank holidays (£0.4m).
- In line with NHS E guidance the Trust implemented the Agenda for Change (AfC) pay awards of 3.3% in April and are awaiting guidance in respect of Medical Staff. Compared to the national planning assumptions of 2.1% pay growth across all staff groups CUH incurred an additional £0.6m of AfC pay awards in month offset by the assumed growth in Medical staff pay (£0.6m).
- AfC budgets will be uplifted to reflect the pay settlements for Month 02 reporting.
- The Trust has two specific financial targets linked to the Agency and Bank expenditure. The Trust is required to reduce Agency expenditure by 30% and Bank expenditure by 10% compared to the 25/26 Month 05 forecast outturn adjusted for pay inflation.
- At Month 01 bank expenditure is £2.2m above the threshold of which £1.2m relates to the forecast Industrial Action expenditure. Extrapolating the Month 01 run-rate excluding IA could indicate excess expenditure of £10.3m above the target by year-end. However due to the impact of Easter bank holidays bank expenditure and additional expenditure to support operational performance that is forecast to reduce in future months the straight-line extrapolation is likely to overstate outturn however the Trust is likely to need to reduce expenditure to planned levels across remaining months of the year.
- Agency expenditure is line with the plan at Month 01 and maintaining current expenditure would be compliant with the NHS E plan.
- Performance against all financial targets is reported on page 8.





Note:. Central NHS pension contributions are excluded from March '24 and March '25 totals.

Pay expenditure – trend and year to date

Pay - Staff group

£ Millions	In Month Budget	In Month Actual	In Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance
Administrative & Clerical & Ancilary	10.4	10.5	(0.1)	10.4	10.5	(0.1)
Allied Healthcare Professionals	4.5	4.5	0.0	4.5	4.5	0.0
Clinical Scientists & Technicians	8.0	7.0	1.0	8.0	7.0	1.0
Medical and Dental	25.5	27.2	(1.6)	25.5	27.2	(1.6)
Nursing	26.3	27.3	(1.0)	26.3	27.3	(1.0)
Other Pay costs	0.3	0.3	(0.0)	0.3	0.3	(0.0)
Total Pay Cost	**75.0**	**76.7**	**(1.6)**	**75.0**	**76.7**	**(1.6)**

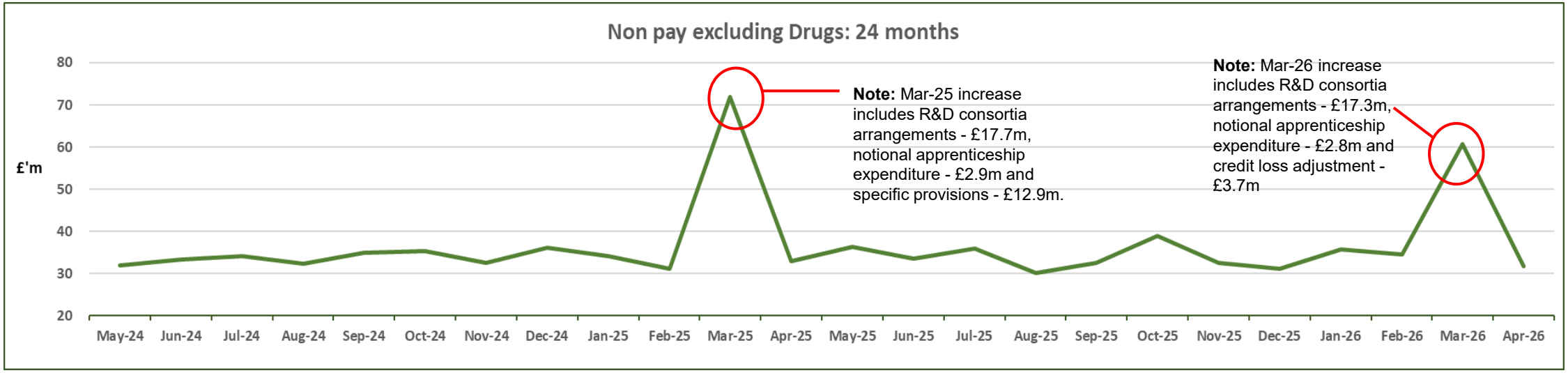
Pay - Employee type

£ Millions	In Month Budget	In Month Actual	In Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance
Agency	0.2	0.2	0.0	0.2	0.2	0.0
Bank	4.3	6.5	(2.2)	4.3	6.5	(2.2)
Permanent	70.2	69.6	0.6	70.2	69.6	0.6
Other Pay costs	0.3	0.3	(0.0)	0.3	0.3	(0.0)
Total Pay Cost	**75.0**	**76.7**	**(1.6)**	**75.0**	**76.7**	**(1.6)**

Key messages:

- Pay expenditure is £1.6m adverse to plan at Month 01 driven by Medical and Dental, Nursing expenditure and Admin and Clerical and Ancillary with favourable variances are reported for Clinical Scientists and Technicians.
- Medical bank expenditure of £1.2m relates to Industrial Action with additional costs driven by the Easter bank holidays estimated at £0.4m.
- For the Agenda for Change pay-scales (non-Medical) final pay awards above budget totalled £0.6m which was offset by the delayed implementation of the final Medical pay awards meaning the national planning assumption uplift of 2.1% (£0.6m) was not recognised in month.
- The Budgets will be updated in Month 02 to reflect the latest national pay award position.
- Agency spend in month represents 0.2% of Trust wide pay expenditure and is significantly below the comparable expenditure level in 25/26 of 0.4% and 0.6% in 24/25. The extrapolated year-end expenditure is forecast to be £0.1m below the NHS E expenditure ceiling at year-end.
- Bank expenditure is adverse to budget by £2.2m - the position includes non-recurrent Consultant bank expenditure driven by elements of the Industrial Action charged to bank (£1.1m) alongside additional costs arising from the Easter bank holidays and ongoing expenditure to support operational performance.
- Total bank expenditure (including IA) is 8.4% of total pay expenditure which is 1.6% higher than 25/26 full year performance and in line with the 24/25 average of 8.5%.

NHS CUH



Key messages:

- At Month 01 the Trust is reporting a favourable non-pay of variance of £2.9m in month.
- There are significant favourable variances for Goods and Services of £5.7m and for Premises costs including utilities expenditure (£3.1m) offset by adverse variances for drugs (£0.9m) reflecting increased pass-through expenditure, movement in credit loss (£0.4m) reflecting the monthly aging of injury cost recovery debt and £4.6m for all other non pay which includes Professional fees (£1.6m), purchase of services from other NHS organisations (£1.1m), PEP savings target (£0.9m) and £1.1m of budget alignment to external plan offsetting within Goods and Services.
- There is expected to be some volatility in the classification of expenditure during Quarter one following the implementation of the new finance system and associated chart of account meaning items of expenditure that previously was budgeted for in one category is now being reported in a different one. Work is being undertaken to understand the impact of the changes and realign the budgets where necessary.

£millions	In Month			Year to Date		
	Budget	**Actual**	**Variance**	**Budget**	**Actual**	**Variance**
Supplies and services	21.1	15.4	5.7	21.1	15.4	5.7
Drugs	20.1	20.9	(0.9)	20.1	20.9	(0.9)
Premises	8.0	4.9	3.1	8.0	4.9	3.1
Movement in credit loss on receivables	0.0	0.4	(0.4)	0.0	0.4	(0.4)
Clinical negligence	2.4	2.5	(0.1)	2.4	2.5	(0.1)
All other non pay	3.9	8.5	(4.6)	3.9	8.5	(4.6)
Total Non Pay	**55.4**	**52.6**	**2.9**	**55.4**	**52.6**	**2.9**

Key messages:

- The non pay position has a favourable variance of £2.9m and is driven by large favourable variances for Supplies and Services and Premises costs offset by adverse variances for Drugs, movement in credit loss, clinical negligence and all other non pay lines.
- There is expected to be some volatility in the coding of expenditure during Quarter one following the implementation of the new finance system and associated chart of account meaning items of expenditure that previously were reported against Goods and Services may now be classified under the All other non-pay category. Work is being undertaken to understand the impact of the changes and realign the budgets where necessary.
- Year to date drugs expenditure position is adverse to plan by £0.9m in month and relates to pass-through expenditure that is recoverable from commissioners.
- The drug costs position continues to be reviewed monthly with continued efforts focussed on ensuring all pass-through drugs are identified and billed to commissioners in a timely manner. We expect there to be future fluctuations in expenditure from month to month due to supply and billing processes for homecare drug alongside the introduction of newly commissioned drugs.

2026/27 in year PEP delivery status and profile

Trust Efficiency status - NHS E reported	Position at Month 01 Plan £'m	Actual £'m	Variance £'m	Year end forecast £'m
Fully developed	4.2	25.4	21.2	59.2
Plans in progress	31.8	23.8	(8.0)	0.0
Opportunity	23.2	10.0	(13.2)	0.0
Unidentified	0.0	0.0	0.0	0.0
Total PEP	**59.2**	**59.2**	**0.0**	**59.2**

NHS E plan: PEP profile	Plan £'m	Qtr 1 £'m	Qtr 2 £'m	Qtr 3 £'m	Qtr 4 £'m
Pay	27.2	5.1	6.3	7.6	8.2
Non pay	22.0	5.4	5.5	5.4	5.7
Devolved income	10.0	1.6	2.0	3.1	3.3
Total PEP profile	**59.2**	**12.1**	**13.8**	**16.1**	**17.2**
Total PEP profile (%)	**100%**	**20%**	**23%**	**27%**	**29%**
of which:					
Cost Reduction	25.1				
Productivity schemes	34.1				

PEP plan - increasing challenge	Plan £'m
M01 PEP plan	4.0
Qtr 2 average monthly PEP plan	4.6
Qtr 3 & 4 average monthly PEP plan	5.5

Key messages:

- The Trust has an efficiency target of £59.2m, of which the Trust plans to deliver £25.1m via cost reduction PEP.
- The tables provide additional information showing the delivery status of the PEP schemes – this is based on the NHS E reporting algorithm whereby if an initiative has a saving recorded against it in the current or previous month it is recognised as 'fully developed'. If a scheme has savings identified for future months, it is categorised as 'plans in progress'.
- The plan profile shows an increase in efficiency required across the year with 43% delivered in Quarters 1 and 2 and 57% in Quarters 3 and 4. Within this the Month 01 plan required £4.0m of savings to be delivered rising to a monthly average £4.6m for Months 04 to 06 and £5.5m for Months 07 to 12.
- At Month 01 the Trust is reporting a gap of £3.7m in identified values for cost reduction schemes and efforts will be focused on closing the gap.
- Productivity initiatives are focussed on increasing elective activity, outpatient capacity, maximising theatre utilisation and reducing length of stay. Productivity scheme development and delivery will be reviewed by the Productivity Board.
- NHSE have published new guidance on how productivity improvements will be measured using cost weighted activity (CWA). The Trust are developing our processes to ensure that this information can be analysed and opportunity insights acted upon. This work continues to supports the Trust's delivery of sustainable productivity improvements into 26/27 building on the improvements seen in 25/26.
- At a Trust level, the estimated performance for Month 01 is a 5.4% increase in productivity compared to 25/26 Month 01. This figures includes 4.6% increase in CWA and a 0.6% reduction in relative expenditure (inputs). It is important to highlight that the expenditure position can be influenced by differences in non-recurrent expenditure across the two years such as Industrial Action expenditure incurred in Month 01 26/27.

2026/27 in year PEP delivery, plan profile and delivery status

Trust PEP performance - NHS E reported	Current Month			Year-end position			
	Plan £'m	Actual £'m	Variance £'m	Plan £'m	Actual £'m	Variance £'m	FYE £'m
Recurrent							
Pay	1.7	0.8	(0.9)	27.2	26.4	(0.8)	33.5
Non pay	1.8	0.4	(1.4)	22.0	19.4	(2.6)	21.4
Income	0.0	0.1	0.1	0.0	0.2	0.2	0.1
Total recurrent PEP	**3.5**	**1.3**	**(2.2)**	**49.2**	**46.0**	**(3.2)**	**55.1**
Non recurrent							
Pay	0.0	1.0	1.0	0.0	1.0	1.0	0.0
Non pay	0.0	0.8	0.8	0.0	1.8	1.8	0.0
Income	0.5	0.9	0.4	10.0	10.4	0.4	0.0
Total non-recurrent PEP	**0.5**	**2.7**	**2.2**	**10.0**	**13.2**	**3.2**	**0.0**
Total PEP	**4.0**	**4.0**	**0.0**	**59.2**	**59.2**	**0.0**	**55.1**

Division (£'m)	In Month			Year-end position		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Division A	0.2	0.2	0.0	1.0	1.0	0.0
Division B	0.3	0.3	(0.0)	2.7	1.6	(1.1)
Division C	0.1	0.1	(0.0)	1.2	1.4	0.2
Division D	0.2	0.2	(0.0)	2.1	1.9	(0.3)
Division E	0.2	0.2	0.0	0.9	0.8	(0.1)
Corporate	1.0	1.0	0.0	10.9	11.1	0.2
Trust Wide	0.3	0.0	(0.3)	6.3	7.3	1.0
External plan phasing alignment	(1.1)	0.0	1.1	0.0	0.0	0.0
Total cost reduction	**1.3**	**2.1**	**0.8**	**25.1**	**25.1**	**0.0**
Productivity schemes	2.7	1.9	(0.8)	34.1	34.1	0.0
Total Productivty	**2.7**	**1.9**	**(0.8)**	**34.1**	**34.1**	**0.0**
Total PEP	**4.0**	**4.0**	**0.0**	**59.2**	**59.2**	**0.0**

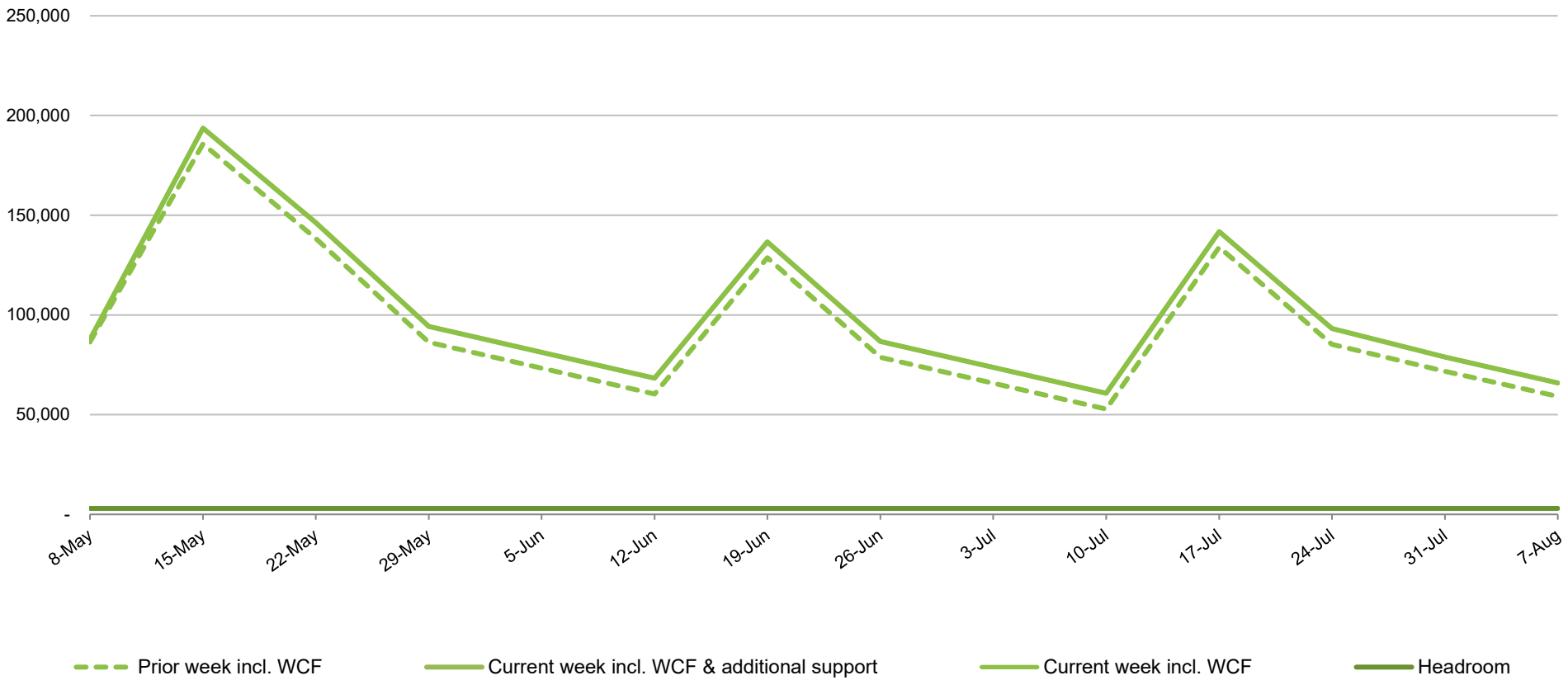
Key messages:

- PEP performance at Month 01 is in line with the plan.
- The Trust has identified an additional £2.2m of non-recurrent PEP schemes compared to the original plan, offsetting the recurrent schemes that are £2.2m behind the plan.
- Cost reduction schemes are £0.8m ahead of plan offsetting the adverse variance on Productivity schemes which was aligned to the lost income as a result of the Industrial Action.
- The PEP performance table includes a phasing alignment adjustment and shows that link between the current internal plan and the NHS E monitored plan.
- The Trust is focused on delivering the 26/27 plan on a recurrent basis and expects that as schemes are identified and delivered across the year the level of recurrent schemes will increase as confidence in scheme delivery increases.
- As indicated on the previous page the level of challenge contained within the plan increases in future months so whilst Month 1 performance

2026/27 in year PEP performance by scheme category

NHS E Scheme categorisation	Year to Date (£k)			Forecast outturn (£k)		
	Plan	Actual	Variance	Plan	Forecast	Variance
Pay Efficiencies						
Pay - Agency - reduce the reliance on agency	34	0	(34)	408	374	(34)
Pay - Establishment reviews	317	297	(20)	5,821	6,362	541
Pay - E-Rostering / E-Job Planning	10	10	0	3,120	3,120	0
Pay - Corporate services transformation	110	229	119	4,566	6,257	1,691
Pay - Digital transformation	10	0	(10)	120	110	(10)
Pay - Clinical Service re-design	1,208	1,249	41	13,165	11,180	(1,985)
Pay - Other	0	0	0	0	0	0
Pay - Unidentified	0	0	0	0	0	0
Total Pay	**1,689**	**1,785**	**96**	**27,200**	**27,403**	**203**
Non-pay Efficiencies						
Non-Pay - Medicines efficiencies	279	78	(201)	3,348	3,147	(201)
Non-Pay - Procurement (excl drugs) - non-clinical directly achieve	36	94	58	509	591	82
Non-Pay - Procurement (excl drugs) - non-clinical through NHS Su	24	0	(24)	288	264	(24)
Non-Pay - Procurement (excl drugs) - MDCC directly achieved	34	10	(24)	408	384	(24)
Non-Pay - Procurement (excl drugs) - MDCC through NHS Supply (	25	13	(12)	300	288	(12)
Non-Pay - Estates and Premises transformation	9	32	23	123	168	45
Non-Pay - Fleet optimisation	0	0	0	0	0	0
Non-Pay - Pathology & imaging networks	9	1	(8)	108	100	(8)
Non-Pay - Net zero carbon	5	1	(4)	60	56	(4)
Non-Pay - Corporate services transformation	0	0	0	0	0	0
Non-Pay - Digital transformation	6	100	94	72	586	514
Non-Pay - Clinical Service re-design	1,380	801	(579)	16,782	14,788	(1,995)
Non-Pay - Other (balance - please provide description)	0	102	102	0	864	864
Non-Pay - Unidentified	0	0	0	0	0	0
Total Non-Pay	**1,807**	**1,232**	**(575)**	**21,998**	**21,236**	**(763)**
Income Efficiencies						
Income - Private Patient	0	1	1	0	1	1
Income - Non-Patient Care	543	904	361	10,000	10,361	361
Income - Other	0	121	121	0	198	198
Total Income	**543**	**1,026**	**483**	**10,000**	**10,560**	**560**
Total PEP (Productivity and cash-releasing)	**4,039**	**4,043**	**4**	**59,198**	**59,199**	**0**

CUH 13 week rolling cash flow forecast (£000)



Key messages:

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

Appendices

Month 1 capital expenditure position

	Year To Date (month 1)			Full year		
	Budget	Actuals	Variance	Budget	Forecast	Variance
	£m	£m	£m	£m	£m	£m
Developments	0.1	0.0	(0.0)	2.2	2.2	0.0
Digital	0.0	0.0	(0.0)	6.8	6.9	0.0
Backlog Maintenance	0.3	0.2	(0.1)	13.9	13.9	0.0
Estates staff costs	0.2	0.2	(0.0)	2.6	2.6	-
Decarbonisation	0.0	0.0	-	0.0	0.0	-
Replacement Equip	0.6	0.0	(0.6)	18.5	18.5	-
In year approvals	0.0	0.0	0.0	1.2	1.2	-
CCRH	1.8	0.4	(1.4)	22.1	22.1	-
CCH	0.9	0.8	(0.1)	11.3	11.3	-
New Acute Hospital	-	0.0	0.0	0.4	0.4	-
RtCS - CCE	0.1	-	(0.1)	2.1	2.1	-
RtCS - MIU	0.0	-	(0.0)	0.5	0.5	-
RtCS - PAU	0.0	-	(0.0)	0.5	0.5	-
Leases	0.2	0.4	0.3	2.0	2.0	-
Corporate	0.3	0.5	0.1	1.6	1.5	(0.0)
Total	**4.6**	**2.6**	**(2.0)**	**85.6**	**85.6**	**-**

N.B. Corporate includes PFI and non-estates staff costs, less slippage

Key issues/notes YTD

Investment YTD had been slower than budgeted, but we are not concerned about its impact on the remainder of the year.

Key issues/notes forecast

The budget value of £85.6m is only 75% of the acutal spend in 25/26. We have budgeted for the receipt of external funding from the Returning to Constututional Standards (RtCS) and Estates Safety Fund (ESF) schemes. We have not yet received MoU for these, but continue to work towards getting them.

Compared to the 26/27 opening budget of £89.0m we have;
- added £4.0m of chartiable funds (£3.7m of which is for CCRH),
- added £0.7m of grants
- offset by a £8.0m Mou reduction for Major Projects.

Capital expenditure by programme

Balance sheet	M01 Actual £m
Non-current assets	
Intangible assets	21.9
Property, plant and equipment	631.3
Total non-current assets	**653.2**
Current assets	
Inventories	15.6
Trade and other receivables	101.5
Cash and cash equivalents	123.9
Total current assets	**241.0**
Current liabilities	
Trade and other payables	-255.8
Borrowings	-15.1
Provisions	-6.2
Other liabilities	-73.4
Total current liabilities	**-350.5**
Total assets less current liabilities	**543.7**
Non-current liabilities	
Borrowings	-118.7
Provisions	-3.9
Total non-current liabilities	**-122.6**
Total assets employed	**421.1**
Taxpayers' equity	
Public dividend capital	751.3
Revaluation reserve	55.7
Income and expenditure reserve	-385.9
Total taxpayers' and others' equity	**421.1**

Balance sheet commentary at Month 01

- The balance sheet shows total assets employed of £421.1m.
- Non-current liabilities at Month 01 are £122.6m. Cash balances at Month 01 total £123.9m.
- The balance sheet includes £4.8m of resource to support the completion of the remedial fire safety works expected to be deployed over the coming years.

Trust balance sheet

Monthly Nurse Safe Staffing

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Sponsoring executive director: Lorraine Szeremeta Chief Nurse

Amanda Small Deputy Chief Nurse

Carla Daly Lead Nurse for safer staffing

Board of Directors: June 2026

Vacancy and turnover position	Target	Feb 2026	March 2026	April 2026	Trend	Commentary
Vacancy rate for Registered nurses (excl. midwife) (bands 5, 6, 7)	≤5%	4.1%	4.2%	5.6%	↑	From April 2026, vacancy rates are calculated against revised budgeted establishments as a result of in year approved investment cases and the annual establishment review. As a result, values are not directly comparable with the previous financial year however will demonstrate an increase in most areas. Maternity support workers continue to be an area of concern with an ongoing recruitment plan in place. Turnover stays in a relatively static position for all staff groups and is as follows: • Registered nurses (excl. midwife) 6.1% •Registered midwives 7.4% •Registered children's nurses 8.9% •MSW 14.6% •HCSW 13.3% • AHP 8.9%
Vacancy rate for Registered midwives (bands 5, 6, 7)	≤5%	3.0%	3.8%	5.1%	↑	
Vacancy rate for registered children's nurses (RSCN) across the Trust (not just within Div E)	≤5%	7.1%	8.1%	9.4%	↑	
Vacancy rate for MSW (bands 2, 3, 4 in clinical services only)	≤5%	19.6%	20.8%	19.7%	↓	
Vacancy rate for HCSW (excl MSW) (bands 2, 3, 4 in clinical services only)	≤5%	5.3%	5.6%	6.8%	↑	
Vacancy rate for AHPs	≤5%	1.6%	1.0%	6.5%	↑	

Planned verses actual staffing	Target	Feb 2026	March 2026	April 2026	Variance	Commentary
Number of wards reporting <90% overall rota fill	0	2	2	2		The number of areas reporting overall fill rate <90% rota fill in April has remained static at 2. Appendix 1. details the exception reports for Division E as the only division reporting overall fill rates of <90%.
Midwifery and MSW fill rate	90%	92%	93.5%	93.5%		The overall fill rate within midwifery has remained static at 93.5%. This is the highest it has been for the previous 6 months and has remained above the target of 90%. The lowest overall fill rates have been seen in Sara Ward and Lady Mary which have been mitigated through redeployment of staff where required, to meet acuity needs.
Total unavailability of the Nursing and Midwifery workforce	22%	25%	27%	27%		Total unavailability of working time in March has remained static at 27%. The majority of unavailability (16.5%) was due to planned annual leave; this is slightly above the set KPI target.

Staff deployment	Feb 2026	March 2026	April 2026	Variance	Commentary
Number of Substantive staff redeployed in month to support safe staffing (average hours redeployed per day)	308	287	308		The number of substantive staff redeployed has increased slightly in month with an average of 308 hours redeployed per day. This equates to 27 long day or night shifts per day. Due to a number of areas being over established and increased capacity in the organisation, it has been necessary to redeploy staff on a shift by shift basis however as sickness absence, vacancy and turnover improves, it is expected that the number of hours redeployed will be a decreasing trend.
Care hours per patient day (CHPPD)	9.3	9.2	9.2		Care hours per patient day (CHPPD) is the total number of hours worked on the roster (clinical staff including AHPs) divided by the bed state captured at 23.59 each day. CUH CHPPD has remained static at 9.2 .This is aligned with the latest data from the Shelford group at 9.3 hours. In maternity CHPPD is at 7.68 (6.63 in March). From 1 April 2021, the total number of patients now includes babies in addition to transitional care areas and mothers who are registered as a patient.
Safety and risk	Feb 2026	March 2026	April 2026	Variance	Commentary
Nurse staffing red flags reported	176	142	143		There has been a slight increase this month in the number of red flags reported from 142 in March to 143 in April. The highest red flag reported is for unmet 1:1 specialling requirement with 45 red flags raised. There is a trustwide improvement project focussing on enhanced observations.
Maternity red flags reported	124	154	113		There has been a decrease in the number of maternity red flags this month from 154 March to 113 in April. The highest of these, 23 (52%) had a delay of 6 hours or more in transfer to the delivery unit during induction of labour once ARM is indicated.
Staffing incidents reported	48	61	43		There has been a decrease in Safety Learning Reports (SLRs) completed in relation to nurse staffing in the month of April to 43 compared to March which had 61 incidents. Division A reported 8 incidents, Division B reported 4 incidents, Division C reported 8, Division D reported 10 incidents and Division E reported 13 incidents.

Appendix 1. Exception report by Division

Division E exception report for <90% fill rate

Unit	Speciality	% fill registered	% fill care staff	Overall filled %	CHPPD	Analysis of gaps	Impact on Quality / outcomes	Actions in place
Sara Ward	501 - OBSTETRICS	92%	**78%**	**88%**	**6.67**	Vacancy 5.6 wte Interviews 01.06.2026. 10 candidates attending.	Staffing reviewed to ensure safe care, Staff moved within service to provide safe staffing.	Regular assessment by manager of the day & matron to ensure service requirements are met.
Lady Mary	501 - OBSTETRICS	100%	**76%**	**89%**	**4.32**	Vacancy 5.6 wte Interviews 01.06.2026. 10 candidates attending.	Staffing reviewed to ensure safe care, Staff moved within service to provide safe staffing.	Regular assessment by manager of the day & matron to ensure service requirements are met

Appendix 2. Staffing compliance with critical care staffing guidance

Adult critical care – compliance with Guidelines for the provision of intensive care services (GPICS)	
Number of breaches of 1:1 care for level 3 patients	0 (0 in Mar)
Number of breaches of side room co-ordinator	3 (3 in Mar)
Neonatal critical care	
Percentage of breaches of British Association of Perinatal Medicine (BAPM) staffing standards	33.33% (24.59% in Mar)
Number of occasions NICU closed due to staffing	0 (0 in Mar)
Paediatric critical care	
Number of breaches of Paediatric critical care society (PICS) staffing standards	0 (↔ 0 in Mar)
Number of occasions PICU closed due to staffing	0 (↔ 0 in Mar)

SPC Icon Keys

SPC Variation/Performance Icons			
Icon	**Technical Description**	**What does this mean?**	**What should we do?**
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

SPC Assurance Icons			
Icon	**Technical Description**	**What does this mean?**	**What should we do?**
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

SPC key taken from Oxford University Hospitals Integrated Report

NHS
Cambridge University Hospitals
NHS Foundation Trust

Report to Board of Directors
held on 10 June 2026

Title	Implementation of the Learning, Accountability and Change action plan – six-month progress update			
Report Sponsor	Dr Sue Broster, Chief Medical Officer David Wherrett, Chief People Officer Lorraine Szeremeta, Chief Nurse			
Author	Emily Warren-Barratt, Head of Clinical Governance, Chief Medical Officer's Office			
Status	**Decision** ☐	**Assurance** ☑	**Information** ☐	**Discussion** ☐

RECOMMENDATIONS

The Board of Directors is requested to note:

- Progress has been made against all six-month commitments. All commitments require sustained focused in the next period and beyond to ensure changes are fully embedded and delivering sustained impact.
- The overall delivery timetable remains highly compressed, and any slippage will directly impact the Trust's ability to meet future milestones.
- Delivery continues to take place alongside wider organisational pressures and change, increasing the risk that improvements are implemented but not consistently embedded in practice, particularly where workforce capacity and capability.

KEY MESSAGES

- The Trust has made progress in delivering all six-month commitments published in response to the Verita investigation. All commitments require sustained focused in the next period and beyond to ensure changes are fully embedded and delivering sustained impact.
- The approach to benefits realisation, stakeholder engagement and learning has been strengthened to support the next phase of delivery.

BACKGROUND, INCLUDING PURPOSE OF THE REPORT

- To provide a formal progress report against the Learning, Accountability and Change action plan and its six-month deliverables

ALIGNMENT TO TRUST STRATEGIC PRIORITIES

Our strategy: a healthier life for everyone through care, learning and research 2026-2031		**Indicate all that apply**
	Deliver Excellent and Timely Care	☑
	Transform How and Where We Deliver Care	☑
	Harness Research and Innovation to Improve Patient Outcomes	☑

ALIGNMENT TO MOST RELEVANT STRATEGIC RISK

N/A

PAPER REVIEW AND GOVERNANCE PATHWAY

Name of group or committee that has previously considered this report	**Date**
Management Executive	30 April 2026
Quality Committee	6 May 2026
Board of Directors (private)	13 May 2026
Paediatric Orthopaedic Oversight Board	27 May 2026
People, Education and Culture Committee	3 June 2026

10 June 2026

Board of Directors

Implementation Governance for the Learning, Accountability and Change action plan – six-month progress update

Emily Warren-Barratt, Head of Clinical Governance, CMO Office

Introduction

1. In October 2025, Cambridge University Hospitals NHS Foundation Trust (CUH) published Verita's independent investigation report into missed opportunities to identify and avoid potential harm to paediatric orthopaedic patients. The investigation report was produced with oversight from NHS England, providing independent scrutiny and assurance.

2. In response, the Trust published its Learning, Accountability and Change action plan. The plan set out the Trust's ambitions to transform patient safety, clinical oversight, governance, leadership accountability and medical culture, alongside improved involvement and support for patients and families.

3. Delivery is structured across four inter-related programmes of work, sitting primarily within the portfolios of the Chief Medical Officer, Chief Nurse and Chief People Officer. The commitments set out vary significantly in scale and complexity. While some actions are more contained in scope, several represent multi-million-pound, multi-year programmes of work.

4. This paper provides the second formal progress update on delivery of the six-month actions (due for completion by end of April 2026).

Delivery of commitments

5. Delivery is structured across four programmes of work:
   - Management and support for doctors
   - Improving governance for the safety and effectiveness of clinical services
   - Effective oversight of clinical reviews
   - Medical culture and tackling poor behaviours.

6. Progress has been made against all six-month commitments. Further progress has also been made on the three remaining three-month commitments. All

commitments require continued focus and embedding over the twelve-month period and beyond.

Progress against remaining three-month commitments

a) Clear and consistent expectations set out for the role of medical line managers with targeted support to embed these
A review of current medical leadership roles has been undertaken to clarify responsibilities and address issues raised in the Verita report. The responsibilities cover quality and safety, supervision, performance, conduct and relationships, wellbeing and development, with clear routes for escalation and advice. Work is underway to socialise the emerging findings with clinical communities and to co-develop proposals for how these roles may evolve. These standards will then be embedded through revised job descriptions and aligned with the skills development programme.

b) Young Patients' Advisory Boards
Since establishing the Patient Advisory Board in February, work has been undertaken with its members - parents of children affected by the incident - to shape the approach to engagement with children and young people. This early engagement highlighted the need to move beyond more traditional advisory models towards approaches that are more modern and responsive. In partnership with the National Youth Advocacy Service, an arts-based event has been planned to help children and young people express their experiences. The event will take place in June 2026.

c) Structured listening exercise carried out with open invitation to medical staff to participate in round table discussions focusing on culture, speaking up and raising concerns
A Trust-wide medical workforce listening exercise is underway, commissioned with an independent partner to strengthen organisational listening and better understand clinicians' experience. The exercise is engaging consultants and SAS doctors across specialties, sites and divisions through confidential listening sessions, targeted outreach to less-heard groups and opportunities for anonymous input. It is focused on key themes including psychological safety, speaking up, risk recognition and escalation, inclusion, and how feedback leads to action. The programme will culminate in a report and playback session with senior leaders, delivered end of May/beginning of June to agree clear, visible actions, with findings and next steps shared with clinicians.

Progress against six-month commitments

Management and support for doctors

d) Effectiveness and compliance of new job planning process evaluated
The effectiveness of the new job planning process has been demonstrated through a significant improvement in compliance, with 85% of job plans now signed off, compared to 63% in the previous year. This reflects stronger adherence to timelines and improved engagement with the revised process, enabling an initial assessment of its impact.

e) New more supportive two-year structured induction programme in place for all new consultants, including a mentoring and buddying system.
An induction programme has been designed and commissioned starting with a structured, year-long onboarding pathway designed to support newly appointed consultants in transitioning safely and effectively into their roles while embedding the organisation's culture and values. It begins with pre-start engagement and a comprehensive Day 1 induction that introduces corporate and medical expectations, followed by early activities such as meeting line managers, specialty leads, and assigned buddies, and completing a job plan. Over the first weeks and months, consultants receive ongoing support through mentorship, formal appraisals, external development programmes, and regular progress reviews at key milestones. The programme emphasises safe clinical practice through supervised, graduated responsibility, promotes a welcoming and inclusive environment with strong peer and managerial support, and encourages high standards of leadership and continuous improvement. Overall, it aims to accelerate safe practice, build confidence and develop high-performing, values-driven clinical leaders.

f) New guidance for all managers to better enable supportive and effective oversight of doctors with a focus on support for newly appointed consultants.
New guidance for managers to support effective oversight of doctors has been delivered through a coordinated set of existing programmes rather than a standalone initiative. This includes strengthened medical appraisal processes, enhanced job planning, clearer roles and expectations for medical line managers, a structured induction programme for new consultants, and the development of a Trust-wide behaviour framework. Together, these initiatives provide a more consistent, supportive and development-focused approach to managing medical staff.

g) Strengthened consultant appraisal process in place including consistent use of outcomes data
A review of the consultant medical appraisal process took place, informed by NHS England recommendations, benchmarking against other trusts and feedback from over 100 consultants through workshops and a survey. The updated approach streamlines processes through alignment with the new L2P system, reducing administrative burden and improving visibility of records. Appraisal has been repositioned as a developmental process, distinct from performance management, with enhanced governance including clearer escalation pathways, pre-appraisal identification of concerns and formal feedback loops. The process now incorporates comparative performance and patient outcomes data where appropriate to support reflective practice. In addition, appraiser capability has been strengthened through structured training, enhanced support and peer networks.

Improving governance for the safety and effectiveness of clinical services

h) Compliance against MDT policy verified for every clinical service
Following the introduction of a revised policy that established clear standards for governance, decision-making and team roles, communication and engagement have been undertaken with both medical and non-medical staff to support implementation. All MDTs will be asked to conduct self-assessment against the standards to identify any areas for improvement. In parallel, validation has been completed for teams in difficultly to determine whether any further support is required that isn't already in place.

i) Trust-wide assessment of any current potential unwarranted variation as evidenced by outcomes data
The CMO office has reviewed national patient outcomes data, including mortality data, national audits and GIRFT clinical metrics. The report reviewed readily available national datasets to consider any areas that may warrant further investigation. The report provides an initial assessment to establish a baseline for further, more granular analysis and does not represent a comprehensive review of all patient outcomes data. The report sets out a series of actions/next steps to increase the robustness of CUH's monitoring of and use of patient outcomes data.

j) Improvement plans in place for low volume high complexity services as determined by the stocktake
105 small, cross-divisional or HCLV services were identified and completed a quality and safety risk checklist. Higher risk services are developing improvement plans to address key issues in quality governance with oversight at divisional quality and performance meetings.

k) Clear action plans for specialties to embed improved quality/clinical governance
A Quality Governance Improvement Plan has been developed in response to NHS England's review. The plan sets out a structured programme of work across key themes including data, quality improvement, learning culture, governance capability and patient experience, with delivery phased over a 12-month period based on risk and priority. Oversight arrangements have been established, including a fortnightly steering group chaired by the Chief Nurse and regular reporting through governance committees to ensure pace and accountability. Early work has focused on mobilisation, agreement of actions with leads, and development of supporting delivery and communications plans, with further emphasis on strengthening organisational capacity and embedding consistent approaches to quality governance across the Trust.

l) New module on existing line manager programme covering quality assurance of clinical services.
Quality governance and oversight are embedded within core leadership development, with dedicated provision through the New Manager Pathway. Content is being refreshed and standardised to ensure alignment with organisational expectations on safety, governance and oversight. For existing managers, equivalent learning resources are available via DOT and are signposted as part of pre-module learning and ongoing reference. The programme continues to be evaluated and iteratively refined based on feedback and learner experience.

m) Board development programme established aligned to the Insightful Provider Board guidance.
Work is being undertaken with NHS Providers to design and establish a structured introduction for new and recently appointed Non-Executive Directors to be implemented in summer 2026. This will cover key areas of the Insightful Provider Board guidance including governance and culture, the effective use of meaningful information, and oversight across the six domains of board responsibility.

Effective oversight of clinical reviews

n) Improved, more collaborative and more effective CMO office structure and reformed ways of working
A revised CMO office structure has been implemented to enable more collaborative and effective ways of working, including new Associate Chief Medical Officers portfolios, key clinical lead appointments and the transition of Responsible Officer duties to the CMO. Associate Chief Medical Officers are now aligned to clinical divisions, creating a clear senior clinical interface between corporate and divisional teams to supports faster issue resolution and peer support, improved situational awareness and more coordinated delivery of Trust-wide priorities.

Medical culture and tackling poor behaviours

o) Findings and recommendations from the Culture Task and Finish Group approved by Board for action
The group has now met twice. Work to date has focused on defining and agreeing a clear and shared ambition for culture and leadership, alongside assessing the current state, and reviewing existing cultural improvement activity and supporting infrastructure. This will provide a strong foundation from which to deliver a high-performing, inclusive organisation. In parallel, plans are being explored to strengthen the use of quantitative and qualitative data to track impact of our culture improvement activities (both Verita recommendations and others) and to ensure that the evolving operating model is aligned with and reinforces cultural priorities.

p) Just and Learning methodology applied earlier, more frequently
The Trust has strengthened its commitment to applying Just and Learning principles earlier and more consistently by embedding this approach within core policies and leadership development. A revised Responding to Concerns framework is in development, ensuring a more proportionate, supportive and learning-focused response to concerns. In parallel, these principles are being actively integrated into line manager and Clinical Director training programmes, enabling leaders to apply them in practice and promoting a more open, fair, and improvement-oriented culture across the organisation.

Risks

7. Core delivery risks have reduced since mobilisation through strengthened programme structures, clearer governance, agreed funding for resource, regular

executive oversight and improved coordination across workstreams. However, residual risk remains material given the breadth and complexity of the programme, the compressed timetable for delivery, and the fact that implementation is taking place alongside wider organisational pressures and change activity.

8. The most significant residual risk relates to delivering commitments in a way that is sufficiently embedded and sustainable, particularly driven by workforce capacity and capability, both within the central programme team and at local level. There remains a risk that delivery is achieved at pace but not fully translated into consistent practice or sustained behavioural change. All improvements depend on behaviours, leadership capability and local ownership, and variation in these areas presents an ongoing risk to impact. Work is continuing on strengthening clinical and operational leadership capability and providing support to frontline teams to embed change.

Benefits analysis

9. The programme's approach to benefits realisation has been strengthened and updated, drawing upon qualitative intelligence to understand how change is being experienced by staff in practice and whether new arrangements are being adopted as intended. This includes insight from the independent medical workforce listening exercise, consultant feedback and wider culture work. The benefits framework has also been informed by external benchmarking, including Shelford Group NHS Staff Survey data, to inform target measures.

10. The updated benefits analysis is shown in **Annex A.**

Stakeholder engagement

11. Given the programme's breadth, complexity and high number of stakeholders involved, a continued priority is to maximise all upcoming opportunities to engage stakeholders in a coordinated way. The programme has taken the opportunity to reflect and more deliberately map its stakeholder landscape to ensure clarity on engaging the right groups at the right time. This includes timely and consistent communication, strengthening feedback loops so stakeholders can clearly see how their input has informed decisions, and ensuring the Trust continues both to learn from others and to share learning from this programme more widely.

12. Stakeholder mapping is shown in **Annex B.**

Lessons learned

13. At the six-month point, the programme has taken the opportunity to pause and reflect on delivery to date, capturing key lessons so they can be used to inform the next phase and to support broader organisational improvement.

14. Rapid mobilisation enabled strong early progress but also highlighted that plans developed at pace can be overly ambitious unless aligned to operational readiness and capacity. Phased delivery milestones have been useful to support learning, adaptation and course correction where needed between phases. Strong executive ownership, clear accountability and robust governance have been critical. The programme has reinforced that sustained change requires long-term focus. Effective communication and engagement remain central: plans must be meaningful to patients and not just internally focused, and success has been strengthened through partnership working with other organisations.

15. Lessons learned from developing an action plan at pace are detailed in **Annex C.**

Next steps

16. The next phase of delivery will focus on the 12-month milestones across all four programmes. Progress will continue to be tracked through established governance routes, with updates shared internally and externally.

17. Planned next communications and reporting milestones on the six-month milestones include:
    - Management Executive: Thursday 30 April
    - Quality Committee: Wednesday 6 May
    - Quarterly patient letters: Wednesday 13 May
    - Board of Directors (private): Wednesday 13 May
    - Website update and internal communications: Wednesday 20 May
    - Paediatric Orthopaedic Oversight Board: Wednesday 27 May
    - People, Education and Culture Committee: Wednesday 3 June
    - Patient and families update meeting: Wednesday 6 June
    - Board of Directors (public): Wednesday 10 June

Emily Warren-Barratt
Head of Clinical Governance, CMO Office

Annex A: Benefits analysis

Benefit	Qualitative measure	Quantitative metric	Baseline	Target	Measurement method	When realised	Owner
1) Management and support for doctors							
Increased job planning compliance	Consultant feedback that job planning is timely, developmental and supports safe practice	% of completed job plans	65%	95%	L2P compliance; consultant feedback; divisional sense-check	April 2026 / ongoing	CMO
Increased early intervention of doctors in difficulty	Staff confidence in support and escalation routes; themes on how concerns are handled	Time to resolution	Tbc	Tbc	Case tracking; review of support pathways; listening exercise and management feedback	December 2026	CMO, CPO
Increased quality of consultant appraisals	Consultant feedback that appraisal is developmental, uses meaningful data and supports reflection	"Appraisal helped me improve how I do my job" (q23b)	13.6% (Consultants)	27.9% (Shelford group average*)	NHS Staff Survey; consultant workshop and survey feedback; appraiser feedback loops	April 2027	CMO
2) Improving governance for the safety and effectiveness of clinical services							
Safer clinical decision-making through strengthened MDTs	Staff feedback on clarity of decision-making, challenge and escalation in MDTs	% of MDTs compliant with new MDT policy	Unidentified	100%	Audit / stocktake; MDT self-assessment; validation discussions	April 2026	CMO
Improved safety governance in low volume high complexity services	Narrative assurance that governance changes are understood, practical and used locally	Quality and safety checklist mean average risk score; reduction in patient safety flags; completion of improvement plans for high risk services	31.5/130 (24.3%)	Mean average score reduce and 0 patient safety flags All improvement plans developed	Risk score; improvement plan reviews; specialty discussions through divisional governance	April 2027	CMO
Stronger patient involvement	Patient, family, child and young person feedback that involvement is meaningful and responsive	Number of Patient Advisory Boards / engagement events	0	6	Documentation; outputs from advisory boards and youth engagement activity; qualitative themes	December 2026	CNO
Improved use of outcomes data	Clinician feedback that outcomes data is accessible, understood and used in decision-making and appraisal	Outcomes-related quality and safety checklist mean risk score	9.10/20	Mean average score reduce	Audit; governance minutes; appraisal and governance forum feedback	April 2026	CNO, CMO
Implementation of safer invasive procedures	Staff feedback on usability, consistency and confidence in safer procedure standards	NatSSIPs 2 adoption status	0%	Full roll out	Adoption status; implementation feedback from teams; local walkthroughs	April 2028	CMO
3) Effective oversight of clinical reviews							
Robust and transparent oversight of external clinical reviews including action plans	Feedback from services that the process is clear, collaborative and timely	Adherence to new SOP for external reviews	No SOP in place	100% compliance	Audit of SOP checklist; structured feedback from review teams and services	April 2027	CMO
4) Medical culture and tackling poor behaviours							
Improved medical culture	Listening exercise themes on psychological safety, speaking up, inclusion, escalation and whether feedback leads to action	Secure raising concerns (q20a) Confidence concerns will be addressed (q20b) No harassment, bullying or abuse (q14c)	69.4% 43.1% 73.5% (Consultants)	70.7% 56.5% 80.6% (Shelford group averages*)	NHS Staff Survey; independent listening exercise; targeted outreach; anonymous feedback; Culture Task and Finish Group review	March 2027	CPO

*Shelford group averages for NHS Staff Survey results are organisational wide (data is not broken down to medical workforce level)

Annex B: Stakeholder mapping

Stakeholder engagement

Given the programme's scale and complexity, there is a continued focus on coordinated stakeholder engagement to ensure the right groups are engaged at the right time. This includes consistent communication, stronger feedback loops, and sharing learning both internally and externally.

	Board	Exec	Divisions	Ops / service managers	Consultants	Nurses	AHPs	HR / OD	Finance	Data & insights	NHSE	GMC	CQC	Healthwatch	Other trusts - inputs	Other trusts - outputs
Job planning		✓	✓	✓	✓			✓	✓	✓	✓				✓	
Medical appraisals		✓			✓			✓				✓			✓	✓
MDT policy		✓	✓		✓	✓	✓				✓					✓
Outcomes		✓	✓		✓					✓	✓		✓			
HCLV		✓	✓								✓					✓
CMO office reform		✓	✓		✓						✓				✓	
Medical line management		✓	✓		✓			✓								
Induction programme		✓	✓		✓			✓								
Just & learning		✓	✓	✓	✓	✓	✓	✓			✓		✓			
Culture T&F group	✓	✓														
Board development	✓	✓														
Quality governance		✓									✓					

Annex C: Lessons learned from developing an action plan at pace

Lessons learned – developing an action plan at pace

The following lessons capture key insights from delivering the programme, highlighting what has worked well and where improvements are needed in developing action plans at pace. These lessons are relevant across a wide range of organisational priorities, particularly where the Trust is delivering complex improvement or transformation activity.

1. **Define impact and outcomes upfront** - Every action should be explicitly linked to a defined outcome or impact, avoiding any activity without purpose. Benefits, success measures and patient benefit should be defined from the outset, not retrospectively.
2. **Strong ownership, governance and infrastructure -** Clear ownership and accountability are critical, supported by robust governance and dedicated PMO/administrative infrastructure to track progress, manage risk and coordinate interdependencies.
3. **Phased delivery enables learning and adaptation** – Structured phases creates space for real-time learning, reflection and course correction between phases. This approach strengthens both implementation and outcomes.
4. **Plan for long-term transformation -** Transformation is inherently long-term. While many actions can be delivered within defined timelines, embedding change takes sustained effort beyond initial delivery and this must be built into plans with appropriate capacity and investment.
5. **Identify delivery infrastructure early -** Effective delivery depends on dedicated administrative and PMO support to manage actions and reporting. This resource should be identified early and can be a critical blocker to progress if underestimated.
6. **Working with partners is valuable** - Success is strengthened by strong collaboration with system parters including learning from and sharing learning with other Trusts, as well as input and support from external stakeholders including NHSE, GMC, Healthwatch and CQC.
7. **Define outcomes not outputs -** Plans should guide delivery, not constrain it. Teams need the confidence and permission to adapt the plan where activity is not delivering meaningful benefit for patients or staff.
8. **Keep the plan meaningful for patients** – A public action plan must be meaningful from a patient perspective and not just internal facing. There should be clear, tangible benefits for patients.
9. **Organisational agility and capacity** – Delivery can rely on sustained, high-intensity effort, exposing pressures on workforce capacity, competing priorities and change fatigue. More agile practices whereby mechanisms can rapidly mobilise or redeploy capacity in response to emerging demands support delivery.
10. **Communication consistently to build trust, as well as action -** Clear, consistent communication underpins trust, engagement, and shared understanding and can determine whether an action plan succeeds or fails.

Learning, Accountability and Change action plan

6-month update

Together
Safe
Kind
Excellent

May 2026

Emily Warren-Barratt

Introduction

The purpose of the update is to:

- Provide the second formal progress report against the Verita action plan, and its six-month deliverables

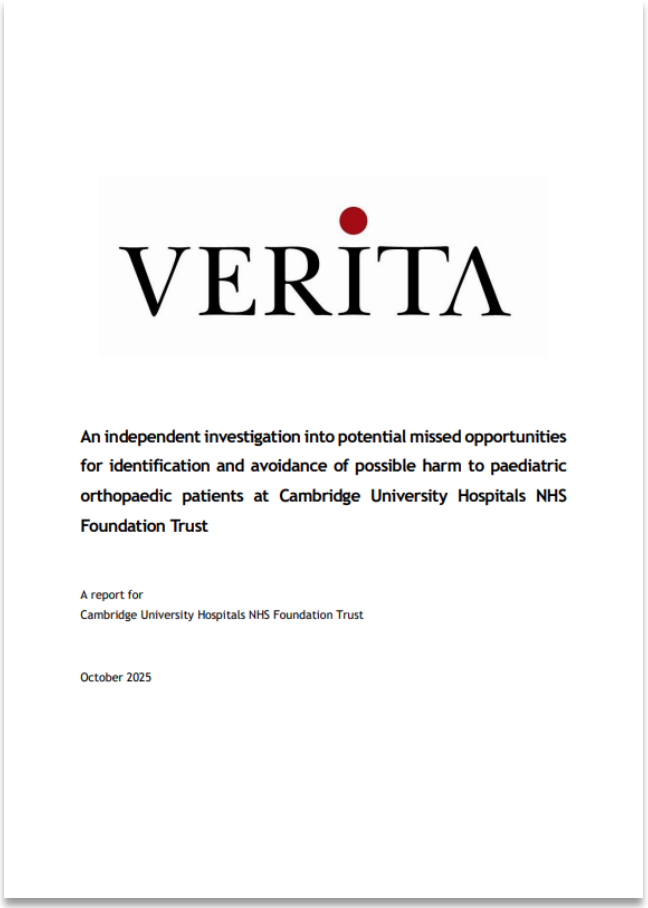
The group is asked to note:

- Progress has been made against all six-month commitments. All commitments require sustained focused in the next period and beyond to ensure changes are fully embedded and delivering sustained impact.
- The overall delivery timetable remains highly compressed, and any slippage will directly impact the Trust's ability to meet future milestones.
- Delivery continues to take place alongside wider organisational pressures and change, increasing the risk that improvements are implemented but not consistently embedded in practice, particularly where workforce capacity and capability vary.

Summary

- The Trust has made progress in delivering all six-month commitments published in response to the Verita investigation. All commitments require sustained focused in the next period and beyond to ensure changes are fully embedded and delivering sustained impact.
- The approach to benefits realisation, stakeholder engagement and learning has been strengthened to support the next phase of delivery.

The Verita Investigation



What is it?

The Verita investigation's scope was to look for potential missed opportunities for identification and avoidance of possible harm to paediatric orthopaedic patients at Cambridge University Hospitals NHS Foundation Trust from 2012 to 2024. The investigation had oversight from NHS England, providing external scrutiny of the issues identified.

What did it find?

- The 2016 report of Mr Robert Hill following his **external clinical review was misunderstood, miscommunicated** and its findings reduced to a matter of interpersonal conflict rather than surgical concerns.
- The Trust failed to connect data with "**soft signals**" of risk.
- Poor **clinical supervision and communication**, isolated practice in small specialities and **strained professional relationships**.
- The importance of **clear governance structures, managerial accountability and continuous learning** to safeguard patient safety. Weak **MDT structures, poor clinical governance and lack of consultant oversight** meant continuing clinical issues went undetected.

Our response

This is a pivotal moment for CUH. It is a commitment to learn, change and improve.

- The CUH Board has accepted all 23 recommendations and is committed to implementing these in full.
- The Action Plan **contains 34 commitments to deliver across 12 months.**
- Delivery is structured across four inter-related programmes of work, sitting primarily within the portfolios of the Chief Medical Officer, Chief Nurse and Chief People Officer
- Changes are being made across leadership, clinical oversight and patient involvement.
- Senior leaders are clearly accountable for delivery.
- Progress is being tracked and shared openly.

Area	Commitment	Executive Responsible	Non-Executive Director Responsible
Management and support for doctors	Doctors are enabled to deliver high quality care through effective clinical oversight and responsive management support	Chief People Officer and Chief Medical Officer	Non-Executive Director Chairs of: Workforce and Education Committee, Quality Committee
Improving governance for the safety & effectiveness of clinical services	Our clinical services are safer and more effective through stronger governance, closer collaboration, better use of data and strengthening how we listen to patients	Chief Medical Officer, Chief Nurse	Non-Executive Director Chair of Quality Committee
Effective oversight of clinical reviews	All external clinical reviews are commissioned, overseen and communicated in a standardized and transparent way, with clear accountability for implementing actions	Chief People Officer and Chief Medical Officer	Non-Executive Director Chair of Quality Committee
Medical culture and tackling poor behaviors	We will embed a consistently collaborative, open and accountable medical culture, underpinned by professional behaviors that support learning, safety and continuous improvement.	Chief Executive Officer, Chief Medical Officer and Chief People Officer	Lead Non-Executive Director member of Trust Board Culture Task and Finish Group

Progress against remaining 3-month commitments

1) Management and support for doctors	2) Improving governance for the safety and effectiveness of clinical services	3) Effective oversight of clinical reviews	4) Medical culture and tackling poor behaviours

✓ Clear and consistent **expectations set out for the role of medical line managers** with targeted support to embed these

A review of current medical leadership roles has been undertaken to clarify responsibilities and address issues raised in the Verita report. The responsibilities cover quality and safety, supervision, performance, conduct and relationships, wellbeing and development, with clear routes for escalation and advice. Work is underway to socialise the emerging findings with clinical communities and to co-develop proposals for how these roles may evolve. These standards will then be embedded through revised job descriptions and aligned with the skills development programme.

✓ New **Patient Advisory and Young Patients' Advisory Boards**

Since establishing the Patient Advisory Board in February, work has been undertaken with its members - parents of children affected by the incident - to shape the approach to engagement with children and young people. This early engagement highlighted the need to move beyond more traditional advisory models towards approaches that are more modern and responsive. In partnership with the National Youth Advocacy Service, an arts-based event has been planned to help children and young people express their experiences. The event will take place in June 2026.

✓ Structured **listening exercise** carried out with open invitation to medical staff to participate in round table discussions focusing on culture, speaking up and raising concerns

A Trust-wide medical workforce listening exercise is underway, commissioned with an independent partner to strengthen organisational listening and better understand clinicians' experience. The exercise is engaging consultants and SAS doctors across specialties, sites and divisions through confidential listening sessions, targeted outreach to less-heard groups and opportunities for anonymous input. It is focused on key themes including psychological safety, speaking up, risk recognition and escalation, inclusion, and how feedback leads to action. The programme will culminate in a report and playback session with senior leaders, delivered end of May/beginning of June to agree clear, visible actions, with findings and next steps shared with clinicians.

Progress against 6-month commitments

The Trust has made strong progress in delivering all six-month commitments published in response to the Verita investigation.

1) Management and support for doctors

- **Effectiveness and compliance of new job planning** process evaluated.
- New **more supportive two-year structured induction programme in place** for all new consultants, including a mentoring and buddying system.
- **New guidance for all managers** to better enable supportive and effective oversight of doctors with a focus on support for newly appointed consultants.
- **Strengthened consultant appraisal process in place** including consistent use of outcomes data

2) Improving governance for the safety and effectiveness of clinical services

- **Compliance against MDT policy** verified for every clinical service.
- Trust-wide **assessment of any current potential unwarranted variation** as evidenced by outcomes data including GIRFT, National Consultant Information Programme (NCIP) and national joint registry.
- **Improvement plans in place for low volume high complexity services** as determined by the stocktake
- Clear **action plans for specialties to embed improved quality/clinical governance**
- **New module on existing line manager programme** covering quality assurance of clinical services.
- **Board development programme established** aligned to the Insightful Provider Board guidance.

3) Effective oversight of clinical reviews

- Improved, more collaborative and **more effective CMO office structure and reformed ways of working** with divisional leadership teams that maximises learning from external reviews, ensures the right actions are taken and the impact of changes is evaluated

4) Medical culture and tackling poor behaviours

- **Findings and recommendations from the Culture Task and Finish Group** approved by Board for action
- **Just and Learning methodology** applied earlier, more frequently and consistently to enable poor behaviours to be tackled and action to be taken where necessary.

Progress against 6-month commitments

NHS CUH

1) Management and support for doctors

2) Improving governance for the safety and effectiveness of clinical services

3) Effective oversight of clinical reviews

4) Medical culture and tackling poor behaviours

✓ Effectiveness and compliance of new **job planning** process evaluated.

The effectiveness of the new job planning process has been demonstrated through a significant improvement in compliance, with 85% of job plans now signed off, compared to 63% in the previous year. This reflects stronger adherence to timelines and improved engagement with the revised process, enabling an initial assessment of its impact.

✓ New more supportive two-year structured **induction programme** in place for all new consultants, including a mentoring and buddying system.

An induction programme has been designed and commissioned starting with a structured, year-long onboarding pathway designed to support newly appointed consultants in transitioning safely and effectively into their roles while embedding the organisation's culture and values.

✓ **New guidance for all managers** to better enable supportive & effective oversight of doctors with a focus on support for new consultants

New guidance for managers to support effective oversight of doctors has been delivered through a coordinated set of existing programmes rather than a standalone initiative. This includes strengthened medical appraisal processes, enhanced job planning, clearer roles and expectations for medical line managers, a structured induction programme for new consultants, and the development of a Trust-wide behaviour framework.

✓ Strengthened **consultant appraisal process** in place including consistent use of outcomes data

A review of the consultant medical appraisal process took place, informed by NHS England recommendations, benchmarking against other trusts and feedback from over 100 consultants through workshops and a survey. The updated approach streamlines processes through alignment with the new L2P system, reducing administrative burden and improving visibility of records. Appraisal has been repositioned as a developmental process, distinct from performance management, with enhanced governance including clearer escalation pathways, pre-appraisal identification of concerns and formal feedback loops. The process now incorporates comparative performance and patient outcomes data where appropriate to support reflective practice. In addition, appraiser capability has been strengthened through structured training, enhanced support and peer networks.

Progress against 6-month commitments

1) Management and support for doctors	2) Improving governance for the safety and effectiveness of clinical services	3) Effective oversight of clinical reviews	4) Medical culture and tackling poor behaviours

✓ **Compliance against MDT policy** verified for every clinical service.

Following the introduction of a revised policy that established clear standards for governance, decision-making and team roles, communication and engagement have been undertaken with both medical and non-medical staff to support implementation. All MDTs will be asked to conduct self-assessment against the standards to identify any areas for improvement. In parallel, validation has been completed for teams in difficultly to determine whether any further support is required that isn't already in place.

✓ Trust-wide assessment of any current potential unwarranted **variation as evidenced by outcomes data**

The CMO office has reviewed national patient outcomes data, including mortality data, national audits and GIRFT clinical metrics. The report reviewed readily available national datasets to consider any areas that may warrant further investigation. The report provides an initial assessment to establish a baseline for further, more granular analysis. The report sets out a series of actions/next steps to increase the robustness of CUH's monitoring of and use of patient outcomes data.

✓ Improvement plans in place for **low volume high complexity services**

105 small, cross-divisional or HCLV services were identified and completed a quality and safety risk checklist. Higher risk services are developing improvement plans to address key issues in quality governance with oversight at divisional quality and performance meetings.

✓ Clarify the **key role of all managers** in ensuring that our clinical services are safe and high quality (covered in action 2, slide 6)

Progress against 6-month commitments

1) Management and support for doctors	2) Improving governance for the safety and effectiveness of clinical services	3) Effective oversight of clinical reviews	4) Medical culture and tackling poor behaviours

✓ Clear **action plans for specialties to embed improved quality/clinical governance**

A Quality Governance Improvement Plan has been developed in response to NHS England's review. The plan sets out a structured programme of work across key themes including data, quality improvement, learning culture, governance capability and patient experience, with delivery phased over a 12-month period based on risk and priority. Oversight arrangements have been established, including a fortnightly steering group chaired by the Chief Nurse and regular reporting through governance committees to ensure pace and accountability. Early work has focused on mobilisation, agreement of actions with leads, and development of supporting delivery and communications plans, with further emphasis on strengthening organisational capacity and embedding consistent approaches to quality governance across the Trust.

✓ **New module on existing line manager programme** covering quality assurance of clinical services.

Quality governance and oversight are embedded within core leadership development, with dedicated provision through the New Manager Pathway. Content is being refreshed and standardised to ensure alignment with organisational expectations on safety, governance and oversight. For existing managers, equivalent learning resources are available via DOT and are signposted as part of pre-module learning and ongoing reference. The programme continues to be evaluated and iteratively refined based on feedback and learner experience.

✓ **Board development programme** established aligned to the Insightful Provider Board guidance.

Work is being undertaken with NHS Providers to design and establish a structured introduction for new and recently appointed Non-Executive Directors to be implemented in summer 2026. This will cover key areas of the Insightful Provider Board guidance including governance and culture, the effective use of meaningful information, and oversight across the six domains of board responsibility.

Progress against 6-month commitments

1) Management and support for doctors

2) Improving governance for the safety and effectiveness of clinical services

3) Effective oversight of clinical reviews

4) Medical culture and tackling poor behaviours

✓ Improved, more collaborative and more effective **CMO office structure** and reformed ways of working

A revised CMO office structure has been implemented to enable more collaborative and effective ways of working, including new Associate Chief Medical Officers portfolios, key clinical lead appointments and the transition of Responsible Officer duties to the CMO. Associate Chief Medical Officers are now aligned to clinical divisions, creating a clear senior clinical interface between corporate and divisional teams to supports faster issue resolution and peer support, improved situational awareness and more coordinated delivery of Trust-wide priorities.

Progress against 6-month commitments

1) Management and support for doctors	2) Improving governance for the safety and effectiveness of clinical services	3) Effective oversight of clinical reviews	4) Medical culture and tackling poor behaviours

✓ **Findings and recommendations from the Culture Task and Finish Group approved by Board for action**

The group has now met twice. Work to date has focused on defining and agreeing a clear and shared ambition for culture and leadership, alongside assessing the current state, and reviewing existing cultural improvement activity and supporting infrastructure. This will provide a strong foundation from which to deliver a high-performing, inclusive organisation. In parallel, plans are being explored to strengthen the use of quantitative and qualitative data to track impact of our culture improvement activities (both Verita recommendations and others) and to ensure that the evolving operating model is aligned with and reinforces cultural priorities.

✓ **Just and Learning methodology applied** earlier, more frequently and consistently to enable poor behaviours to be tackled and action to be taken where necessary.

The Trust has strengthened its commitment to applying Just and Learning principles earlier and more consistently by embedding this approach within core policies and leadership development. A revised Responding to Concerns framework is in development, ensuring a more proportionate, supportive and learning-focused response to concerns. In parallel, these principles are being actively integrated into line manager and Clinical Director training programmes, enabling leaders to apply them in practice and promoting a more open, fair, and improvement-oriented culture across the organisation.

Looking ahead - 12-month commitments

Blue text shows actions not linked to previous actions

1) Management and support for doctors

- **Data and information from the job planning process** is being proactively used to support the management, oversight and support of doctors.
- **Inappropriate imbalances in workloads** within clinical services actively addressed.
- **Structured approach to mentoring and buddying** applied retrospectively to consultants appointed in the last three years

2) Improving governance for the safety and effectiveness of clinical services

- **Audit of MDT effectiveness** including through peer review completed.
- **Improvement plans in place** for any surgical specialty or individual surgeon as informed by a range of relevant outcomes data including GIRFT, NCIP and National Joint Registry with a particular focus on small specialties.
- **Trust-wide learning embedded from themes and findings from the quality and safety stocktakes** and informed by the two new Patient Advisory Boards
- **Roll out of the revised National Safety Standards for Invasive Procedures** (NatSSIPs 2) using an organisational change expert as required to ensure effective implementation across all relevant staff.

3) Effective oversight of clinical reviews

4) Medical culture and tackling poor behaviours

- Externally facilitated **stock-take to evaluate progress towards creating a consistently healthy medical culture.**
- **Development of a new target operating model** led by the Chair and CEO, informed by best practice from highly performing NHS Trusts and reporting to the Trust Board.

Our commitment to staff, patients and families

We are committed to working openly and collaboratively with staff, patients and partners throughout the programme. A key development is our strengthened focus on actively learning from stakeholders and, in turn, sharing our learning more openly, and leading to inform improvement across the system.

Open Communication

- We will provide open, safe spaces for questions, challenge and discussion.
- You will know how to reach us and how your feedback will be used.

Regular Updates and Transparency

- We will share clear, timely updates.
- You will have a consistent understanding of what is happening now, what is coming next and why.

Co-Production

- You will be actively involved in shaping improvements and decisions that impact clinical practice.

Working with Partners

- We will collaborate with system partners to ensure a unified response.

Learning from others

- We will accelerate our learning by working with others and seeking best practice.

Sharing our learning with others

- We will use our leadership in these spaces to share our learning openly and support wider improvement across the system.

Lessons learned – developing an action plan at pace

The following lessons capture key insights from delivering the programme, highlighting what has worked well and where improvements are needed in developing action plans at pace. These lessons are relevant across a wide range of organisational priorities, particularly where the Trust is delivering complex improvement or transformation activity.

1. **Define impact and outcomes upfront** - Every action should be explicitly linked to a defined outcome or impact, avoiding any activity without purpose. Benefits, success measures and patient benefit should be defined from the outset, not retrospectively.
2. **Strong ownership, governance and infrastructure** – Clear ownership and accountability are critical, supported by robust governance and dedicated PMO/administrative infrastructure to track progress, manage risk and coordinate interdependencies.
3. **Phased delivery enables learning and adaptation** – Structured phases creates space for real-time learning, reflection and course correction between phases. This approach strengthens both implementation and outcomes.
4. **Plan for long-term transformation** – Transformation is inherently long-term. While many actions can be delivered within defined timelines, embedding change takes sustained effort beyond initial delivery and this must be built into plans with appropriate capacity and investment.
5. **Identify delivery infrastructure early** – Effective delivery depends on dedicated administrative and PMO support to manage actions and reporting. This resource should be identified early and can be a critical blocker to progress if underestimated.
6. **Working with partners is valuable** – Success is strengthened by strong collaboration with system parters including learning from and sharing learning with other Trusts, as well as input and support from external stakeholders including NHSE, GMC, Healthwatch and CQC.
7. **Define outcomes not outputs** – Plans should guide delivery, not constrain it. Teams need the confidence and permission to adapt the plan where activity is not delivering meaningful benefit for patients or staff.
8. **Keep the plan meaningful for patients** – A public action plan must be meaningful from a patient perspective and not just internal facing. There should be clear, tangible benefits for patients.
9. **Organisational agility and capacity** – Delivery can rely on sustained, high-intensity effort, exposing pressures on workforce capacity, competing priorities and change fatigue. More agile practices whereby mechanisms can rapidly mobilise or redeploy capacity in response to emerging demands support delivery.
10. **Communication consistently to build trust, as well as action** – Clear, consistent communication underpins trust, engagement, and shared understanding and can determine whether an action plan succeeds or fails.

Stakeholder engagement

Given the programme's scale and complexity, there is a continued focus on coordinated stakeholder engagement to ensure the right groups are engaged at the right time. This includes consistent communication, stronger feedback loops, and sharing learning both internally and externally.

	Board	Exec	Divisions	Ops / service managers	Consultants	Nurses	AHPs	HR / OD	Finance	Data & insights	NHSE	GMC	CQC	Health-watch	Other trusts - inputs	Other trusts - outputs
Job planning		✓	✓	✓	✓			✓	✓	✓	✓				✓	
Medical appraisals		✓			✓			✓				✓			✓	✓
MDT policy		✓	✓		✓	✓	✓				✓					✓
Outcomes		✓	✓		✓					✓	✓		✓			
HCLV		✓	✓								✓					✓
CMO office reform		✓	✓		✓						✓				✓	
Medical line management		✓	✓		✓			✓								
Induction programme		✓	✓		✓			✓								
Just & learning		✓	✓	✓	✓	✓	✓	✓			✓		✓			
Culture T&F group	✓	✓														
Board development	✓	✓														
Quality governance		✓									✓					

Risk management

Programme risks are concentrated across four key themes: the risk of non delivery of commitments, ineffective delivery of commitments, stakeholder satisfaction in delivery of the commitments, and the risk that commitments fail to deliver the desired impact. Core delivery risks have reduced as a result of strengthened programme structure, improved coordination, and more established governance and stakeholder engagement mechanisms. However, risks remain and require sustained focus, particularly in relation to residual capacity and capability constraints.

Risks managed and reduced

Risk description	Theme	Risk score	Mitigations	Residual risk
Programme team capacity If the programme team lacks sufficient capacity, then critical activities may be delayed or delivered poorly.	Non delivery of commitments	25	• Use of Management consultancy support in short term to support delivery of programme • Expansion of the CMO office to support delivery of this programme • Regular (weekly) capacity reviews	10
Specialty capacity and skills for change If the specialties required to transform their service delivery lack the capacity or skills, then the commitments may not be delivered in full	Non delivery of commitments	20	• Early engagement with clinical directors and speciality leads • Programme team playing an active role to minimise work of specialties where possible • Programme team providing training, workshops, and guidance documentation to support specialties	12
Governance If governance structures and reporting mechanisms are weak or unclear, then issues may go unresolved and risks unmanaged, resulting in the non-delivery or partial delivery of the Action Plan	Non delivery of commitments	20	• A bi-weekly Action Plan Delivery Group meeting is in place with key Executive Leads	8
Short term focus If the programme shifts focus primarily to delivering an initial baseline solution without sufficient planning and commitment to deliver the full scope of the commitment, then it risks failing to achieve sustained and embedded change.	Ineffective delivery of the commitments	20	• Phased delivery approach with defined milestones beyond the original commitment milestone.	8

High risks remaining

Risk description	Theme	Risk score	Mitigations	Residual risk	Further actions required
Staff turnover If there is significant staff turnover among programme leaders, operational leads, or key delivery staff, then knowledge, ownership, and commitment to the new ways of working may be lost, reducing the likelihood that changes are sustained..	Ineffective delivery of the commitments	20	• Knowledge management and clear handover processes for programme team.	20	• Succession planning for key roles • Knowledge management and clear handover processes for all roles • **Further mitigations likely required**

Benefits - How will we know that the Verita action plan is having an impact?

The programme's approach to benefits realisation has been strengthened and updated, drawing upon qualitative intelligence to understand how change is being experienced by staff in practice The benefits framework has also been informed by Shelford Group NHS Staff Survey data, to inform target measures.

Benefit	Qualitative measure	Quantitative metric	Baseline	Target	Measurement method	When realised	Owner
1) Management and support for doctors							
Increased job planning compliance	Consultant feedback that job planning is timely, developmental and supports safe practice	% of completed job plans	65%	95%	L2P compliance; consultant feedback; divisional sense-check	April 2026 / ongoing	CMO
Increased early intervention of doctors in difficulty	Staff confidence in support and escalation routes; themes on how concerns are handled	Time to resolution	Tbc	Tbc	Case tracking; review of support pathways; listening exercise and management feedback	December 2026	CMO, CPO
Increased quality of consultant appraisals	Consultant feedback that appraisal is developmental, uses meaningful data and supports reflection	"Appraisal helped me improve how I do my job" (q23b)	13.6% (Consultants)	27.9% (Shelford group average*)	NHS Staff Survey; consultant workshop and survey feedback; appraiser feedback loops	April 2027	CMO
2) Improving governance for the safety and effectiveness of clinical services							
Safer clinical decision-making through strengthened MDTs	Staff feedback on clarity of decision-making, challenge and escalation in MDTs	% of MDTs compliant with new MDT policy	Unidentified	100%	Audit / stocktake; MDT self-assessment; validation discussions	April 2026	CMO
Improved safety governance in low volume high complexity services	Narrative assurance that governance changes are understood, practical and used locally	Quality and safety checklist mean average risk score; reduction in patient safety flags; completion of improvement plans for high risk services	31.5/130 (24.3%)	Mean average score reduce and 0 patient safety flags All improvement plans developed	Risk score; improvement plan reviews; specialty discussions through divisional governance	April 2027	CMO
Stronger patient involvement	Patient, family, child and young person feedback that involvement is meaningful and responsive	Number of Patient Advisory Boards / engagement events	0	6	Documentation; outputs from advisory boards and youth engagement activity; qualitative themes	December 2026	CNO
Improved use of outcomes data	Clinician feedback that outcomes data is accessible, understood and used in decision-making and appraisal	Outcomes-related quality and safety checklist mean risk score	9.10/20	Mean average score reduce	Audit; governance minutes; appraisal and governance forum feedback	April 2026	CNO, CMO
Implementation of safer invasive procedures	Staff feedback on usability, consistency and confidence in safer procedure standards	NatSSIPs 2 adoption status	0%	Full roll out	Adoption status; implementation feedback from teams; local walkthroughs	April 2028	CMO
3) Effective oversight of clinical reviews							
Robust and transparent oversight of external clinical reviews including action plans	Feedback from services that the process is clear, collaborative and timely	Adherence to new SOP for external reviews	No SOP in place	100% compliance	Audit of SOP checklist; structured feedback from review teams and services	April 2027	CMO
4) Medical culture and tackling poor behaviours							
Improved medical culture	Listening exercise themes on psychological safety, speaking up, inclusion, escalation and whether feedback leads to action	Secure raising concerns (q20a) Confidence concerns will be addressed (q20b) No harassment, bullying or abuse (q14c)	69.4% 43.1% 73.5% (Consultants)	70.7% 56.5% 80.6% (Shelford group averages*)	NHS Staff Survey; independent listening exercise; targeted outreach; anonymous feedback; Culture Task and Finish Group review	March 2027	CPO

Next steps – 6-month update

1. Management Executive: Thursday 30 April
2. Quality Committee: Wednesday 6 May
3. Quarterly patient letters: Wednesday 13 May
4. Board of Directors (private): Wednesday 13 May
5. Website update and internal communications: Wednesday 20 May
6. Paediatric Orthopaedic Oversight Board: Wednesday 27 May
7. People Education and Culture Committee: Wednesday 3 June
8. Patient and families update meeting: Wednesday 6 June
9. Board of Directors (public): Wednesday 10 June.

Cambridge University Hospitals NHS Foundation Trust

Report to Board of Directors
held on 10 June 2026

Title	Freedom to speak up Annual report - June 2026			
Report Sponsor	Lorraine Szeremeta			
Author	Helen Watson, Claire Patterson			
Status	**Decision** ☐	**Assurance** ☑	**Information** ☑	**Discussion** ☐

RECOMMENDATIONS

The Board of Directors is asked to:

- **Approve** the 2025/26 annual report for Freedom to Speak Up

KEY MESSAGES

- Change in National and local context for FTSU
- Full-service review underway
- 303 cases raised 2025/26 (increased from 295 in 2024/25)
- Main concerns
  - Worker safety and wellbeing
  - Inappropriate behaviours
- Staff survey shows decline in safety to speak up and confidence in organisational action
- Actions to strengthen data, reporting and triangulation of concerns raised across the organization underway.

BACKGROUND, INCLUDING PURPOSE OF THE REPORT

- To provide an annual overview of the Freedom to Speak Up (FTSU) service (2025/26)
- To present key data, themes, and trends
- To summarise progress against strategic priorities
- To provide assurance to the Board on speaking up culture and governance

ALIGNMENT TO TRUST STRATEGIC PRIORITIES

Our strategy: a healthier life for everyone through care, learning and research 2026-2031		**Indicate all that apply**
	Deliver Excellent and Timely Care	☐
	Transform How and Where We Deliver Care	☐
	Harness Research and Innovation to Improve Patient Outcomes	☐

ALIGNMENT TO MOST RELEVANT STRATEGIC RISK

BAF 006 – Culture and high performance
Failure to foster and embed an inclusive high-performance culture and associated behaviours that is consistent with our Trust values.

PAPER REVIEW AND GOVERNANCE PATHWAY

Name of group or committee that has previously considered this report	**Date**
People, Education and Culture Committee	3 June 2026
Name of group or committee that the report will be presented to in the future	
Summarised report to be provided to the Board	10 June 2026

Freedom to speak up

Annual Report

1 Apr 2025 – 31 March 2026

Board of Directors
June 2026

Claire Patterson - Freedom to Speak Up Guardian

Helen Watson - Director of AHPs

NHS
CUH

Together
Safe
Kind
Excellent

Purpose of the report

- To provide an annual overview of the Freedom to Speak Up (FTSU) service (2025/26)
- To present key data, themes, and trends
- To summarise progress against strategic priorities
- To provide assurance to the Board on speaking up culture and governance

Executive Summary

This report provides assurance on the effectiveness of the Freedom to Speak Up (FTSU) service, highlighting activity, key themes, workforce experience, and progress against priorities.

Overview and Activity

- A total of **303 cases were raised in 2025/26**, a small increase from 295 in 2024/25, with reporting levels remaining broadly stable over the past three years.
- The service continues to be well established, with strong visibility through induction, leadership programmes, and ward-based engagement.
- The FTSU Listener network has grown to **100 trained individuals**, with improved representation from Black and Minority Ethnic staff (increasing from 6% to 20% over two years).

Key Themes and Risks

- The most frequent concerns relate to:
  - Inappropriate behaviours (including bullying and incivility)
  - Worker safety and wellbeing
- Local analysis highlights **bullying or incivility by managers and colleagues** as the most commonly reported issues.
- Four service areas required escalation during the year, including maternity staffing, paediatric surgery culture, theatres, and NCCU, with external or internal reviews underway.

Workforce Experience

- Staff survey results indicate a **decline across all FTSU measures in 2025**, reversing previous improvement.
- The most significant issue is reduced confidence that concerns will be acted upon.
- While performance remains above national benchmarks, the rate of decline is greater than the national trend.
- Variations persist across protected characteristics, with some groups (including disabled staff and those not disclosing personal characteristics) reporting lower psychological safety.

Culture and Reporting

- Nursing and midwifery staff raise the highest proportion of concerns (40%), broadly reflecting workforce composition.
- Anonymous reporting remains limited (**~3% of cases**), with no dedicated anonymous route currently in place.
- Work is underway to strengthen **triangulation of concerns across FTSU, HR, PALS and patient safety teams** to improve organisational learning and oversight.

Progress and Improvements

- A **full-service review** is underway following the transition of the Guardian service into the Office of the Chief Nurse.
- External audit in year undertaken by KPMG provided partial assurance with six key recommendations, including:
    - Improving learning from concerns
    - Introducing triage and performance measures
    - Strengthening policy, governance, and communication

Actions to enhance data quality, reporting, and local thematic analysis are in progress.

National Context

The closure of the National Guardian's Office has created system-level change; however, the FTSU function remains embedded within NHS contractual requirements and will continue.

Key Risks

- Declining staff confidence in speaking up and organisational response
- Inequitable experiences across staff groups
- Limited anonymous reporting mechanisms

Next Steps

- Complete and implement the full-service review
- Deliver KPMG recommendations and strengthen governance
- Enhance data triangulation to identify early risks and trends
- Continue targeted engagement to improve psychological safety, particularly within underrepresented groups

National and Local Context

National context

- In June 2025, the government announced the closure of the National Guardian's Office (NGO) and the withdrawal of the post of National Freedom to Speak Up Guardian. The NGO is currently transferring to NHS England and will complete a move to the Department of Health and Social Care in early 2027. The future of the role of the Freedom to speak up Guardian (FTSUG) continues to be supported and assurance has been given that the role will remain part of the standard NHS contract for 2026/27

Local context

- Locally the CUH guardian remains an active member of the East of England regional network for speak up services, which meets on a quarterly basis and the on-line 'Community of Practice' which acts as a support network for guardians across the region to support learning and professional development

Activity and Service Reach

The FTSU Guardian regularly attends Corporate Induction sessions for all new staff members, ensuring that everyone joining CUH is informed about speaking up and the support available. For key clinical staff, the Guardian delivers additional induction sessions, and when welcoming new doctors, is joined by a Consultant Surgeon to further enhance the experience.

Beyond inductions, the FTSU Guardian maintains a visible presence across wards and departments with a programme of regular visits, offering support and guidance wherever needed. They also participate in meetings of Staff Networks and Staff side meetings, and support events organised by the Trust's Staff Networks. Regular visibility stands are held in the concourse, providing an approachable point for staff to engage and ask questions.

The FTSU Guardian presents on the "Essentials for Management and Leadership Excellence" programme. These sessions, launched in late 2024, focus on the crucial role managers play in fostering a safe and welcoming environment where speaking up is encouraged and valued. Staff are reassured that managers will listen and respond appropriately. Feedback so far has been very positive, showing the impact and value of these efforts.

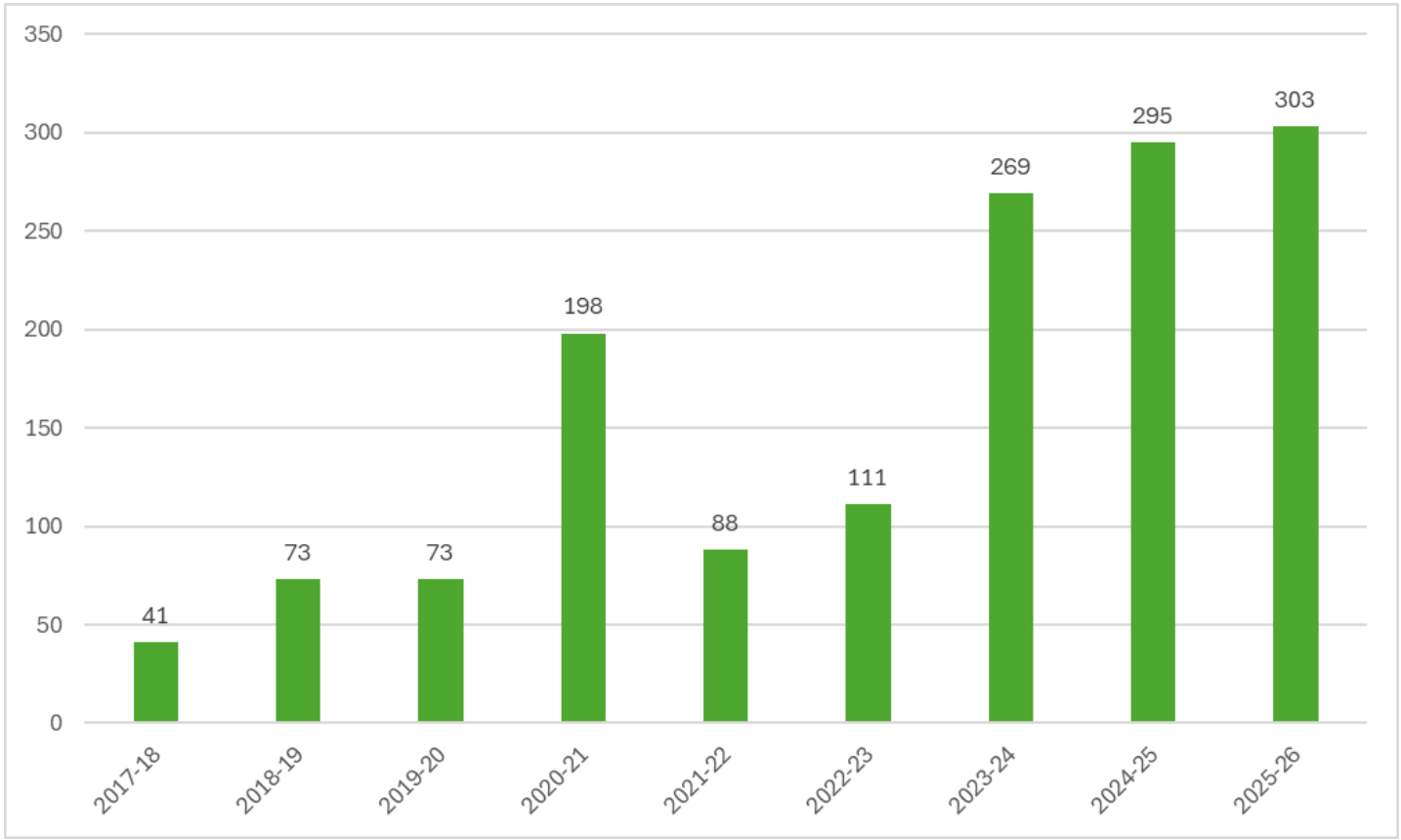
Listeners

- Listeners are local expert resources who promote a speaking up culture and provide signposting support for colleagues.
- They are a self-selected group that attend one day training with the FTSU Guardian. All Listeners are required to complete three e-learning for Healthcare modules provided by the National Guardian Office.
- As of March 2026, there were **100** Listeners across the organisation.
- A key priority over the past couple of years has been to recruit listeners that better reflects the diversity of the workforce. There has been positive progress in this regard, with the proportion of Listeners from a Black and Minority Ethnic background increasing from 6.0% to 20% over the past 2 years.
- As currently approx. 31% of the CUH workforce are from the Black and Minority ethnic group, more work is required to achieve the goal of having a reflective group of listeners.

Data Analysis and Trends

A total of 303 cases were raised via the FTSU service in 2025/26 compared with 295 in 2024/25.

The number of cases raised has been consistent over past 3 years.



Concerns by Staff Group

- Details of concerns raised by staff group can be found in **Appendix A, Table 1a**.
- Nursing and midwifery registered staff raise the highest proportion of concerns, accounting for 40% of all cases and is broadly reflective of their overall representation within the staff population. This equates to 2.8% of the nursing workforce.
- The staff groups least likely to raise concerns through the FTSU route are those in the additional professional, scientific and technical category, (registered pharmacists, psychologists, and technicians).

Concerns by Theme

- The National Guardian's Office require guardians to allocate concerns to one or more of four concern themes:
  - Patient safety/quality
  - Worker safety or wellbeing
  - Bullying or harassment
  - Other inappropriate attitudes or behaviours
- As set out in **Table 1b**, "other inappropriate behaviours" is the most frequently recorded concern followed by "worker safety and wellbeing".
- Some concerns raised with the FTSU service span more than one theme and are recorded against all relevant themes with 367 themes being allocated to 303 cases. *For example, an individual raising concerns about bullying and harassment may have expressed concern about their own safety and wellbeing or the safety of patients.*
- National reporting categories are considered insufficiently detailed, prompting the FTSU Guardian to work with stakeholders to introduce locally defined themes (from April 2024) to improve data analysis.
- **Table 1c** shows that, within these local categories, bullying or incivility by managers is the most frequently reported issue, followed by bullying or incivility by colleagues. Individuals raising these concerns are typically supported and directed to a senior manager or the Employee Relations team.
- **Divisional breakdown of concerns raised – illustrated on Table 1d.**

Sources of Contact

Primary route – most concerns raised via the “Raising Concerns” email account (57%)

- Anonymous reporting (2.97%) 1 concern via Royal Mail, 4 individuals created anonymous email accounts, 3 telephone calls and 1 face to face
- No dedicated anonymous reporting mechanism is currently in place – alternative models are currently under review to increase reach
- Staff encouraged to raise concerns with line managers first, many issues resolved effectively at local level
- Multiple alternative routes available - Trade unions and professional bodies, HR Consult and Heads of workforce, Chaplaincy

Service Areas of Concern

- In this one-year reporting period, four service areas have flagged concerns with escalation and appropriate action taken.
- **Maternity staffing in both antenatal and postnatal areas –** the Director of Midwifery has undertaken a full review of birth rate plus rosters and investment in additional staff has been approved
- **Paediatric surgery culture** - the Chief Medical Officer requested an external review of the service; this is planned for summer 2026.
- **Staffing and safety in theatres** – Action taken by division A triumvirate, theatre improvement programme in place
- **Neuro Critical Care Unit concerns relating to patient safety and culture** - The Chief Medical Officer is currently overseeing an external review of the service.

Workforce Experience – Staff Survey

NHS Staff Survey 2025 – Freedom to Speak Up (FTSU) See Appendix B.

Overall trend

- CUH shows a decline across all 4 FTSU questions after improvement last year
- National “raising concerns” score at a 5-year low, with CUH declining faster than national trend
- Most notable issue: fall in confidence that concerns will be acted on
- CUH remains above national benchmark despite deterioration

Equity & inclusion insights

- Variation in experience persists across protected groups
- Disabled staff: less confident action will be taken
- Ethnicity: BME staff report greater confidence overall than White staff
- Black/Caribbean/African (“any other”) group feel least safe
- Sexuality & gender disclosure: “Prefer not to say” groups report the lowest psychological safety

Benchmarking comparisons

Trust	Q1 Total cases	Q1 Patient safety and quality cases	Q1 Bullying and harassment cases	Q2 Total cases	Q2 Patient safety and quality cases	Q2 Bullying and harassment cases	Q3 Total cases	Q3 Patient safety and quality cases	Q3 Bullying and harassment cases	Q4 Total Cases	Q4 Patient safety and quality cases	Q4 Bullying and harassment cases	Annual Total (Rank)
CUH	**71**	**15**	**10**	**67**	**7**	**13**	**79**	**10**	**12**	**78**	**5**	**18**	**295 (5)**
GSTT	88	4	12	64	5	10	113	3	10	106	16	12	371 (1)
Imperial	-	-	-	16	3	6	20	4	7	23	4	8	NA
King's	92	31	31	81	15	25	88	12	5	55	4	5	316 (3)
Manchester	53	10	10	82	28	29	70	14	24	93	20	41	298 (4)
Newcastle	35	5	10	47	2	8	48	5	15	88	5	10	218 (6)
Oxford	36	1	11	31	1	7	41	9	6	89	15	22	197 (7)
Sheffield	15	2	2	29	5	5	38	4	8	33	6	11	115 (9)
UCLH	30	1	7	25	1	8	36	2	3	39	1	17	130 (8)
Birmingham	88	5	28	79	9	33	83	10	36	76	10	40	326 (2)
Average	**56**	**8**	**13**	**52**	**8**	**14**	**62**	**7**	**13**	**68**	**9**	**18**	

Latest available benchmarking data: 2024/25 (2025/26 due August)

9/10 trusts included (1 excluded due to incomplete data)

CUH recorded **295 cases** across the year, placing the Trust **5th** among the listed organisations.

CUH Case volumes are broadly consistent across quarters (**Q1 71; Q2 67; Q3 79; Q4 78**), suggesting steady reporting rather than a single-quarter spike.

Bullying & harassment highest in Q4 in CUH (18)

Should be noted there are varying levels of resource across Shelford group so direct comparison challenging

Service Development

Following transition of the FTSU Guardian service into the Office of the Chief Nurse, a review of the service has been undertaken by the Director of Allied Health Professionals, with recommendations on future provision to be considered by the Management Executive.

An audit undertaken by KPMG in October, provided partial assurance with six recommendations *(with corresponding actions in place/ in progress to address each):*

1) Implementing formal learning from events, *(in the planning stage).*
2) Develop a triage system and KPIs for pursued concerns, *(implemented for new concerns from April 26 and will be included in future reports).*
3) Policy update to include expectations of key stakeholders, *(completed and live on Merlin,expectations shared with managers in updated presentation in the Essentials for Management and Leadership Excellence training).*
4) Update intranet page *(partially completed, includes expectations of actions and outcomes when raising concerns, will be further updated with feedback for the service).*
5) Ensure that themes and learning which arise from concerns are discussed on a regular basis at local levels*(consideration of appropriate forums).*
6) Consideration of introducing a mandatory requirement for all colleagues, *(under review, national "Listen Up" training package).*

An improvement plan is in place to address both the above recommendations and concerns identified in the review including data collection and analysis and triangulation of concerns being raised across the organisation with patient safety outcomes and experience.

Assurance, Risks and Next Steps

Assurance

- FTSU service established and active
- Governance aligned to national expectations
- Improvement actions in place

Key risks

- Declining staff confidence
- Some staff with protected characteristics continue to feel less safe to raise concerns
- Limited anonymous reporting routes

Next steps

- Full-service review recommendations to be considered by management executive
- Deliver against improvement plan actions

Appendix A: Analysis of Freedom to Speak Up concerns raised

Table 1a: Concerns raised with the CUH Speaking Up service by occupational group

	2025/26 (April – March)		2024/25 (April-March)		2023/24 (April-March)		2022/23 (April-March)		2021/22 (April-March)	
Occupational group	**Number**	**% of group workforce** (CHEQS Mar 25)	**Number**	**% of group workforce** (CHEQS Mar 25)	**Number**	**% of group workforce** (CHEQS Mar 24)	**Number**	**% of group workforce** (CHEQS Mar 23)	**Number**	**% of group workforce**) (CHEQS Mar 22)
Admin & Clerical; Maintenance/Ancillary	77	2.7	66	2.0	60	2.0	27	1.0	25	0.9
Nursing & Midwifery	124	2.8	122	2.8	88	2.0	46	1.0	33	0.9
									8	0.4
Additional Clinical Services	36	1.6	45	1.9	35	1.6	14	0.7		
Medical and Dental	22	1.1	12	0.6	30	1.7	5	0.2	3	0.2
Allied Health Professionals	15	1.8	16	1.9	10	1.2	2	0.3	13	0.8
Additional professional, scientific and technical	3	1.0	8	3.1	19	7.2	13	5.0		
Healthcare Scientists	12	1.6	4	0.5	10	1.3	1	0.1		
Other	4	-	14	-	11	-	3	-	6	-
Not known	10	-	8	-	6	-	-	-	-	-
. **TOTAL**	**303**	**2.3**	**295**	**2.1**	**269**	**2.0**	**111**	**0.9**	**88**	**0.7**

Table 1b: Concerns raised with the CUH Speaking Up Service by category

	2025/26 (April to March)		2024/25 (April to March)		2023/24 (April-March)		2022/23 (April – March)		2021/22 (April – March)	
Concern category	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Current NGO Categories										
Bullying and harassment	58	16	53	14	64	17	17	13	22	11
Other inappropriate behaviours	137	37	126	34	110	30	45	33		
Worker safety and wellbeing	114	31	159	43	127	35	47	35	9	5
Patient safety and quality	58	16	36	10	60	17	27	20	22	11
Previous NGO Categories										
Trust processes in practice									38	20%
Management support									45	23%
Patient related									-	-
Capacity/workload/training									14	7%
TOTAL	**367**		**374**		**361**		**136**		**150**	

Some concerns raised by one individual cover more than one theme.
From April 2022, the National Guardian's Office amended their data collection to the four current concern theme categories:

Table 1c: Concerns raised with CUH FTSU service by local category (this covers a subset of the total concerns raised

Local Category	2025/26 April - March	2024/25 April - March
Bullying/Incivility by colleague	46	49
Bullying/Incivility by manager	57	73
Sexual Safety	1	4
Race	13	16
Disability	7	7
Sex	4	3
Age	1	0
Religion	2	2
Payroll	12	22
Recruitment	8	10
Employee Relations	13	6
Workplace Adjustments	7	9

Some concerns raised by one individual cover more than one theme.

Table 1d: Concerns raised with the CUH FTSU service by division, April to March 2026

	Theme of concern							
Division	**Inappropriate attitudes and behaviours**	**Patient safety and quality**	**Bullying and harassment**	**Worker safety and wellbeing**	**Total themes**	**Total cases**	**Total workforce (CHEQS, March 26)**	**% of total workforce**
A	17	6	7	16	46	39	2531	1.5
B	32	15	14	22	83	71	3612	2.0
C	18	3	9	27	57	42	1931	2.1
D	11	9	7	14	41	39	1627	2.4
E	27	22	10	18	77	54	1637	3.3
Corporate	19	2	7	8	36	32	1559	2.1
R&D	3	0	0	2	5	5	516	1.0
Other	2	0	1	3	6	6	-	-
Staff Bank	2	1	0	3	6	4	-	-
Unknown	6	0	3	1	10	11	-	-
Total	**137**	**58**	**58**	**114**	**367**	**303**	**13413**	**2.3**

Table 1e Mode of Contact into FTSU Service

Mode of contact	Total number of contacts	Number of these made anonymously
Direct email to guardian	62	0
Face to Face	25	1
Listener	11	0
Raising Concerns mailbox	173	4
Raising concerns phoneline	31	3
Letter	1	1

Table 1e, Appendix A provides a breakdown of mode of contact

- FTSU data reflects only cases raised directly with the service (not all organisational concerns)
- Triangulation of concerns raised via all routes is a key priority for the coming year

Staff can remain anonymous by using generic email addresses, makinga telephone conversation/message with no name shared, or face to face contact when trust identification is hidden and the individual gives no further information on their identity.

Appendix B: CUH responses to the National Staff Survey and local Pulse survey

Table 2a: 2024 National Staff Survey results

Staff Survey Question		2021	2022	2023	2024	2025	Difference from 2024 to 2025
Q20a I would feel secure raising concerns about unsafe clinical practice.	CUH	75.9	71.3	70.4	73.6	**71.2**	**↓2.4**
	Benchmark Median	73.9	70.6	70.2	70.0	**69.6**	**↓0.4**
Q20b I am confident that my organisation would address my concern about clinical practice.	CUH	62.3	56.7	56.2	59.6	**54.5**	**↓5.1**
	Benchmark Median	57.6	55.0	55.8	55.1	**53.8**	**↓1.3**
Q25II feel safe to speak up about anything that concerns me in this organisation.	CUH	67.5	63.2	63.6	65.9	**63.1**	**↓2.7**
	Benchmark Median	60.7	60.0	61.4	60.5	**59.0**	**↓1.5**
Q25f If I spoke up about something that concerned me I am confident my organisation would address my concern.	CUH	55.5	50.3	51.0	53.3	**49**	**↓4.3**
	Benchmark Median	47.9	46.9	49.0	48.0	**46.1**	**↓1.9**

Table 2b: 2024 National Staff Survey results for Q25e (I feel safe to speak up about anything that concerns me in this organisation) broken down by protected characteristic.

	2021	2022	2023	2024	2025	Difference
Disability						
Disabled	61%	54%	55%	58%	55.3%	Whilst overall there has been a reduction in those reporting feeling safe to speak up in both groups, the "closing of the gap" of the previous year has been maintained.
Non-Disabled	69%	66%	67%	68%	65.3%	
Ethnicity						
Black and Minority Ethnic Groups	64%	58%	61%	69%	65.4%	Both groups demonstrate a decline in feeling safe to raise concerns but the rate of decline is seen more sharply amongst the Black and Minority Ethnic Group. These colleagues continue to demonstrate that they feel safer than their white counterparts to speak up, however the gap has closed from 4% to 3.1%.
White	69%	66%	65%	65%	62.3%	
Sexuality						
Gay, Lesbian, Bisexual and Other	66%	56%	60%	63%	62.4%	The closing of the gap between heterosexual and LGBTQ+ colleagues has continued with only a 2.6% difference in 2025 compared to 4% in 2024. Those that prefer not to disclose their sexuality continue to report feeling least safe at the lowest level in five years with the gap widening markedly between this group and the other groups.
Heterosexual or Straight	68%	64%	65%	67%	65%	
Prefer not to say	55%	56%	48%	52%	44.5%	

Cambridge University Hospitals NHS Foundation Trust

Report to Board of Directors – in public

held on 10 June 2026

Title	Quarterly Report on Safe Working Hours: Resident Doctors Q4 2025			
Report Sponsor	Dr Sue Broster, Chief Medical Officer			
Author	Dr Serena Goon, Guardian of Safe Working Hours			
Status	**Decision** ☑	**Assurance** ☑	**Information** ☑	**Discussion** ☑

RECOMMENDATIONS

The Board of Directors is asked to:

- **REVIEW** the key messages.
- **AGREE** to provide support for expansion in workforce where areas are highlighted as areas of concern.

KEY MESSAGES

The number of Exception Reports (ERs) this quarter is higher than Q3 2025/6. The number of immediate safety concerns reported each quarter are usually low, and seven were reported this quarter. Rota gaps continue to be problematic; this has implications for working hours and patient safety and educational opportunities. It can be difficult to source locum cover at the last minute.

Despite the loss of training opportunities with increasing service pressures, resident doctors rarely submit educational ERs. The Regional Doctors Forum (RDF) provides a useful forum for resident doctors to report issues, as well as provide feedback, and they are encouraged to attend where they can.

'Acute Medicine' features highly this quarter, however these come from a variety of specialties but get badged as 'acute medicine' because it is reported by rota. It is possible to identify a proportion of these as being from cardiology, from the free text. Cardiology has been an ongoing area of concern.

Haematology features highly on the exception reports, even accounting for some being for time being spent on the resident rota. This is primarily at the higher level, though ERs were filled across the different levels. The acuity of patients is rising, and a work schedule review is ongoing.

Exception reporting suggests that working hours remained mostly compliant in Q4 and patient safety has rarely been compromised. It is clear that the full picture is not always gleaned from the exception reporting system. However, there are extra hours worked on some rotas and continuing problems with rota gaps that cannot be filled with locums.

BACKGROUND, INCLUDING PURPOSE OF THE REPORT

Executive Summary

This is the fourth quarterly report for the year 2025/26, based on a national template, to the Management Executive by the Guardian of Safe Working Hours. This role supports the implementation and maintenance of the 2016 national contract for Doctors in Training and provides an independent oversight of their working hours. The process of exception reporting provides data on their working hours and can be used to record safety concerns related to these and rota gaps. In addition, it can identify missed training opportunities.

Safeguards around doctors' hours are outlined in national terms and conditions. These stipulate that the Guardian of Safe Working Hours "shall report no less than once every quarter to the Board". This report reflects the position as of 31st March 26. The Trust has 711 resident doctors who have all transferred to the 2016 Terms and Conditions of Service.

ALIGNMENT TO TRUST STRATEGIC PRIORITIES

Our strategy: a healthier life for everyone through care, learning and research 2026-2031		**Indicate all that apply**
	Deliver Excellent and Timely Care	☑
	Transform How and Where We Deliver Care	☑
	Harness Research and Innovation to Improve Patient Outcomes	☑

ALIGNMENT TO MOST RELEVANT STRATEGIC RISK

This report most aligns to the strategy of delivering excellent and timely patient care. Resident doctors form a hugely important and large part of our workforce. Safe staffing levels improve the patient experience, the patient journey, ensure high quality care for the patient, and improves patient flow by ensuring timely treatment, recovery and discharge.

PAPER REVIEW AND GOVERNANCE PATHWAY

Name of group or committee that has previously considered this report	**Date**
Board of Directors	11 March 2026
Management Executive	
Name of group or committee that the report will be presented to in the future	
Board of Directors	9 September 2026

Cambridge University Hospitals NHS Foundation Trust

10 June 2026

Board of Directors

Quarterly Report on Safe Working Hours: Resident Doctors
Dr Serena Goon, Guardian of Safe Working Hours

1. Introduction and context

The Exception Reporting system underwent change as of 4 February 2026. A key change was that the educational supervisor was removed from the process of exception report (ER) submission. As predicted, the number of ERs submitted has risen. The numbers submitted for missed training opportunities remains a small proportion of the total. Overall, ER submission would indicate that working hours were considered safe on most but not all rotas, despite all the service pressures.

However, areas of concern continue to include under reporting (and therefore difficulty drawing conclusions from ER submission only), loss of training and rota gaps including cover for last minute sickness. Information is triangulated from a number of other sources beyond exception reporting; including the Resident Doctor Forum (RDF) and General Medical Council (GMC) survey.

Specialties of concern for this quarter are Haematology, General Surgery, Diabetes and Endocrinology, Acute Medicine and Neurology.

This Q4 report describes the Trust's position from January to March 2026. The number of ERs submitted (n=304) is higher than Q3 (n=240) and is higher than Q4 last year 2024-5 (n=254). For illustration purposes of the rise since the ER reforms, the numbers for February were 113 (2026); 69 (2025); 103 (2024). The numbers submitted for March were 124 (2026), 84 (2025), and 98 (2024).

The Resident Doctors Forum (RDF) (co-chaired by two resident doctors) is meeting in person, and is hybrid, with the option of joining remotely. Resident doctors are invited to represent their specialty and feed into the RDF. A newsletter and invitation to attend is sent out each month. Senior management joins in the second half of the meeting to listen to resident doctor concerns. The RDF chairs are invited to attend Trust Board meetings and provide direct feedback to the Board. They are concurrently the resident leads for the 10-point plan. They are also invited to the Joint Local Negotiating Committee. The Regional GOSW network (chaired by the CUH GOSW) meets virtually every two months. Benchmarking from this group provides reassurance that Trust Board engagement here continues to be positive. The CUH GOSW is part of the national GOSW network and meets with the Shelford group guardians.

High level data

Number of doctors / dentists in training (total):	711
Number of doctors / dentists in training on 2016 TCS (total):	711
Number of doctors / dentists on local contracts (Clinical Fellows):	298
Total junior doctor/ dentist establishment:	1009
Reference period of report	Q4 2025/6
Total number of exception reports received	304
Number relating to immediate patient safety issues	8
Number relating to hours of working	281
Number relating to pattern of work	16
Number relating to educational opportunities	
Number relating to service support available to the doctor	
Total number work schedule reviews	Ongoing
Total value of fines levied	£1396.98
Amount of time available in job plan for Guardian to do the role:	2 PAs/8hrs/week
Admin support provided to the Guardian:	1 WTE
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

1. Exception Reports

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

	Immediate safety concerns (ISC)	**Total hours of work**	**Pattern of Work**	**Service support available**	**Educational opportunities**	**TOTAL**
MONTH 1 (January)	5	63	4	0	0	67
MONTH 2 (February)	3	105	5	0	3	113
MONTH 3 (March)	0	113	7	0	4	124
QUARTER	**8**	**281**	**16**	**0**	**7**	**304**

Note: Early starts/late finishes and non-resident on call patterns were classified under ‘total hours of work’. Contractual breaks were classified under ‘pattern’. These were new categories introduced in Feb 2026.
An immediate safety concern report is NOT an additional report but is identified within a report submitted for any other reason and therefore is not counted in the total column (there were 304 reports of which 8 had an ISC).

3.1 Commentary

Exception reports were received from a broad range of specialities as depicted by the graphs below. Most ERs were from Haematology (70), General Surgery (40 – most in March), Diabetes and Endocrinology (30), Acute Medicine (24) and Neurology (21). Some reports from Haematology are to compensate for time for involvement in resident doctor rotas. Some ERs badged under 'Acute Medicine' fall under various specialties but it is difficult to identify as they are reported under their rota. Educational ERs have been received from Acute Medicine, Diabetes and Endocrinology, General Surgery, Neurology and Radiology.

3.2 Trends show Exception Reporting Levels in Q4 (n=304) were higher than Q3 (n=240) and is higher than Q4 last year 2024-5 (n=254).

Reporting of missed educational opportunities has decreased to 7 from 15 in Q3 2025/6.There were no exception reports linked to service support issues. The number of immediate safety concerns (n=8) is higher than Q3 this year (n=4) though this fluctuates each quarter.

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

	TOIL granted	**Payment for additional hours**	**No action**	**TOTAL**	**Work schedule reviews (new)**	**Withdrawn**
MONTH 1 (Jan)	1	57	9	67	0	0
MONTH 2 (Feb)	2	102	9	113	0	4
MONTH 3 (Mar)	6	103	15	124	0	6
QUARTER	9	262	33	304	0	10

No action refers to non-payment categories such as missed breaks and educational ERs.

3.4 Commentary
Most resident doctors who submitted exception reports in January were asking for payment for extra hours worked rather than time off in lieu (TOIL) which is the preferred option to improve their wellbeing. This is primarily because the reasons for reporting are rota gaps or a high workload and therefore additional TOIL would only compound the problem. Following the ER reforms, if rest requirements were breached then TOIL was mandated.

The discrepancies in totals in this table reflect the timings of ER submission and sign off.

4. Work schedule reviews this quarter

A work schedule review was completed in Feb 26 for the neurosurgery higher rota with an amended roster template which the residents were keen for in order to improve their work life balance. A work schedule review for dermatology is ongoing (there will be one further higher joining). The haematology-oncology rota is undergoing a work schedule review due to the acuity and complex needs of the

patients coming through haematology, looking at minimum staffing numbers required for safe service provision. Work schedule reviews for Core General Medicine and General Surgery and Trauma and Orthopaedics are ongoing. Other upcoming work schedule reviews include paediatric surgery, rheumatology and maxillofacial surgery.

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

Department, grade, and date	Safety concern raised	Action(s) proposed and/or taken
12/1/26, ST1, Acute Medicine	Large number of patients to staffing ratio.	Ward consultant saw many patients on their own. Long day resident assisted at the end of the day. Left 2.5 hours late.
15/1/26, ST1, Acute Medicine	Short by one resident due to sickness. Large number of patients, high levels of turnover, patient movement and potential discharges.	Ward consultant saw many patients on their own. One resident pulled from another ward late in the afternoon to assist, and also stayed late. Long day resident helped complete the round at the end of the day. Left 2.5 hours late.
19/1/26, FY2, Trauma and Orthopaedics	Excessive workload. Stayed late, and unable to take breaks. Impacts patient care.	Resident discussed with Clinical Director.
20/1/26, FY2, Trauma and Orthopaedics	Excessive workload. Stayed late, and unable to take breaks.	Other team members assisted with jobs. Trauma/Orthopaedics rota under review.
29/1/26, Core trainee, Acute core rota	No details provided	Worked 1 hour extra, paid
5/2/26, Foundation trainee, Surgery	Excessive workload	Stayed 3 hours late
14/2/26 and 15/2/26, Core trainee, Haem-oncology rota	No details provided	Worked 1 hour over their 12.5 hour shift; processed for payment/time in lieu, plus fine for the department for not achieving 11 hours rest

6. Fines

Fines levied against departments this quarter

Department	Detail	Total value of fine levied
Total fines levied	Fines for rest breaches	£1396.98

The balance at the end of the last quarter is a historical amount.

	TOTAL
Balance at end of last quarter	**£6531.90**
Fines incurred this quarter	**£1396.98**
Cumulative total	**£1396.98**
Total paid to trainees (£)	**£118.93**
Total spent (£)	**£0**
Balance at end of this quarter	**£1396.98**

7. Resident doctor forums and resident doctor engagement

The RDF is being held face to face in the Doctors' Mess with a virtual link since September 2022. Senior management (various of CMO, DME, Medical Staffing lead and team, Chief People Officer, Workforce Lead) join for the second half of the meeting. Issues discussed include rota gaps, locum rates and any other issues faced including educational opportunities. The importance of exception reporting is emphasised. Specialty representation from the trainees feed into the resident doctor co-chairs.

8. Doctors and dentists in training not on 2016 TCS

Non-consultant, non-training grade doctors are able to exception report alongside their resident doctor colleagues using the same system and processes.

9. Assurance processes

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

- Development of key performance indicators for example response times to exception reports.
- Benchmarking via the Regional and National Guardians' networks
- Peer review – ask other trusts/Guardians to review our processes
- Audit of exception reporting process

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

Benchmarking takes place regionally and nationally via the GOSW who is chair of the Regional GOSW network and arranges minuted meetings of the regional network every two months.
A survey of resident doctor's views of exception reporting was done in 2024 as a part of a piece of work that has been taking place across different trusts. Trainees continue to work overtime and miss breaks. Under-reporting is an issue, and we should continue to encourage our resident doctors and supervisors to support exception reporting.

NHS
Cambridge
University Hospitals
NHS Foundation Trust

Appendix

Exception Report Data - Quarter 4
January - March 2026

Overview:
Exception Reports - Quarterly Monthly Breakdown

Hours:

- 304 exceptions reported in total between January 2026 and March 2026. If we were to include the withdrawn exceptions this number would rise to 314.
- 275 exceptions reported were hours related which includes overtime and additional hours.
- From the 275 hours related exceptions, 68 exceptions were reported under the old hours category (<04/02/2026), 11 exceptions reported under the unscheduled early start category, and 196 exceptions reported under the late unscheduled late finish category.

Withdrawn:

- 10 exceptions were withdrawn during this period under the new ER reforms.

Educational:

- 7 exceptions reported were related to educational or missed training opportunities.

Contractual Rest Breaks:

- 11 exceptions were reported against the inability to take contractual breaks category.

Rota Pattern:

- 5 exceptions reported were pattern related to where work differed to established rota/work schedule, and 0 exceptions were reported against the new raising concerns of a suspected non-compliant rota pattern category.

Rostered Skills Mix:

- 0 exceptions were reported against the inadequacy of rostered skills mix category.

Breaches of non-resident on-call patterns: Hours / Rest:

- 0 exceptions reported against the breach of a non-resident on-call pattern: Hours category.
- 6 exceptions reported against the breach of a non-resident on-call pattern: Rest category.

Clinical/Service Support:

- 0 exceptions were reported against the service support category, or inadequacy of clinical support category.

Detriment:

- 0 exceptions were reported under the detriment or threat of detriment related to exception reporting category.

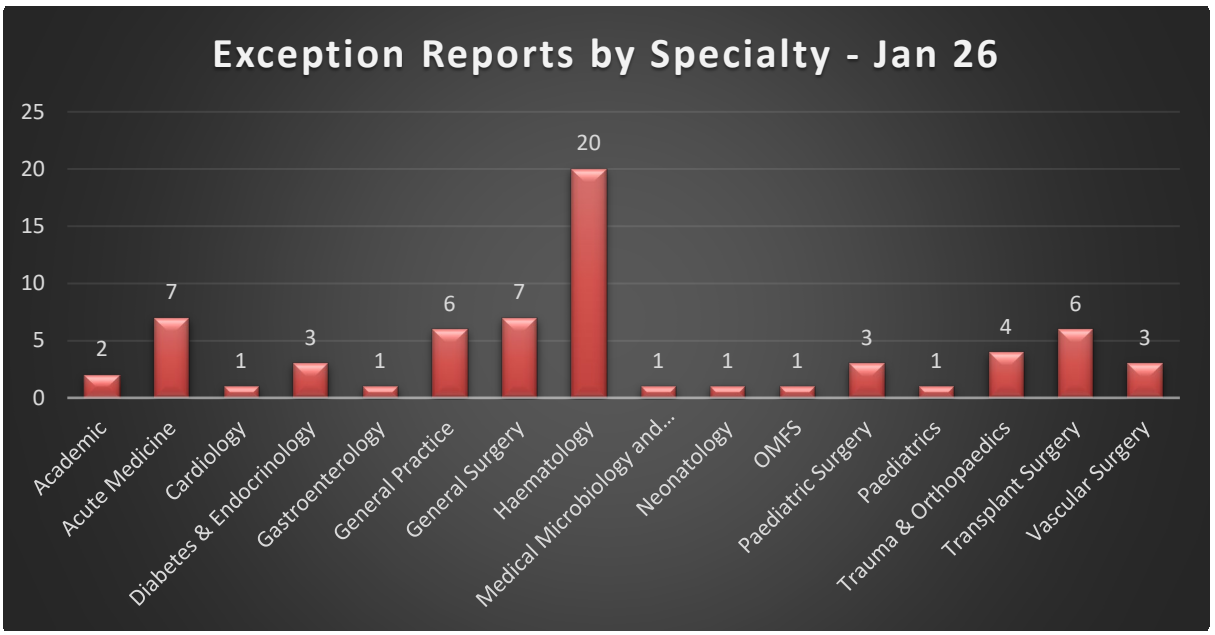
Information Breach:

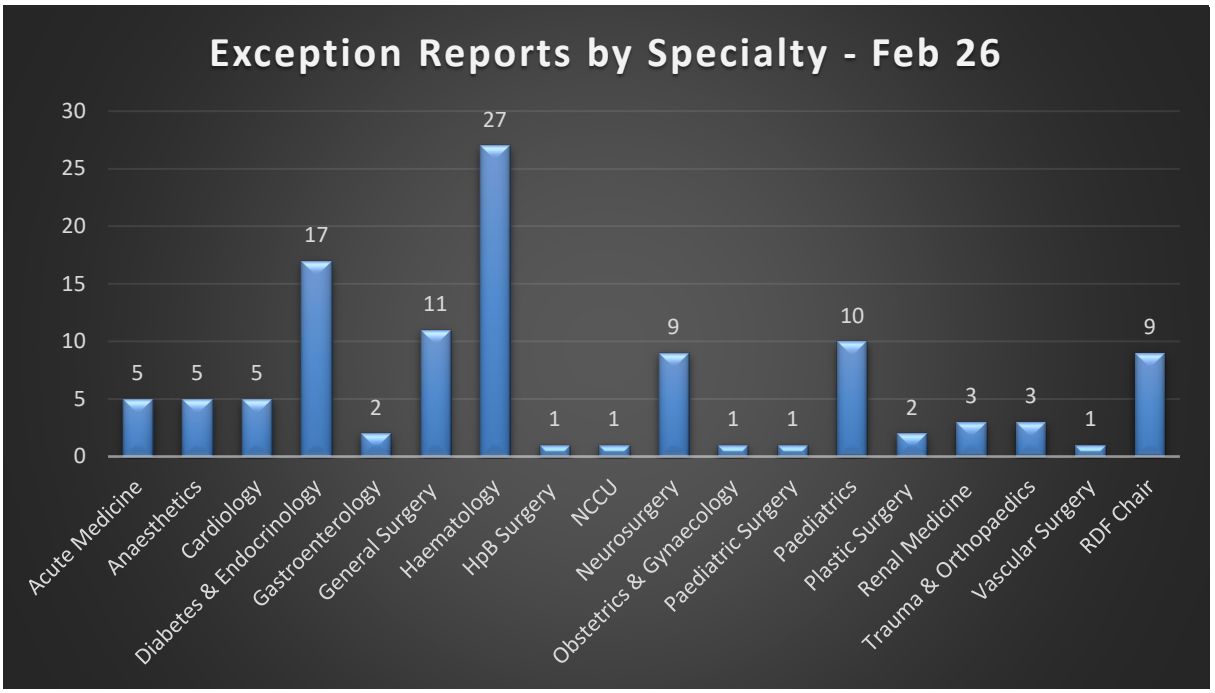
- 0 exceptions were reported under the information breach category.

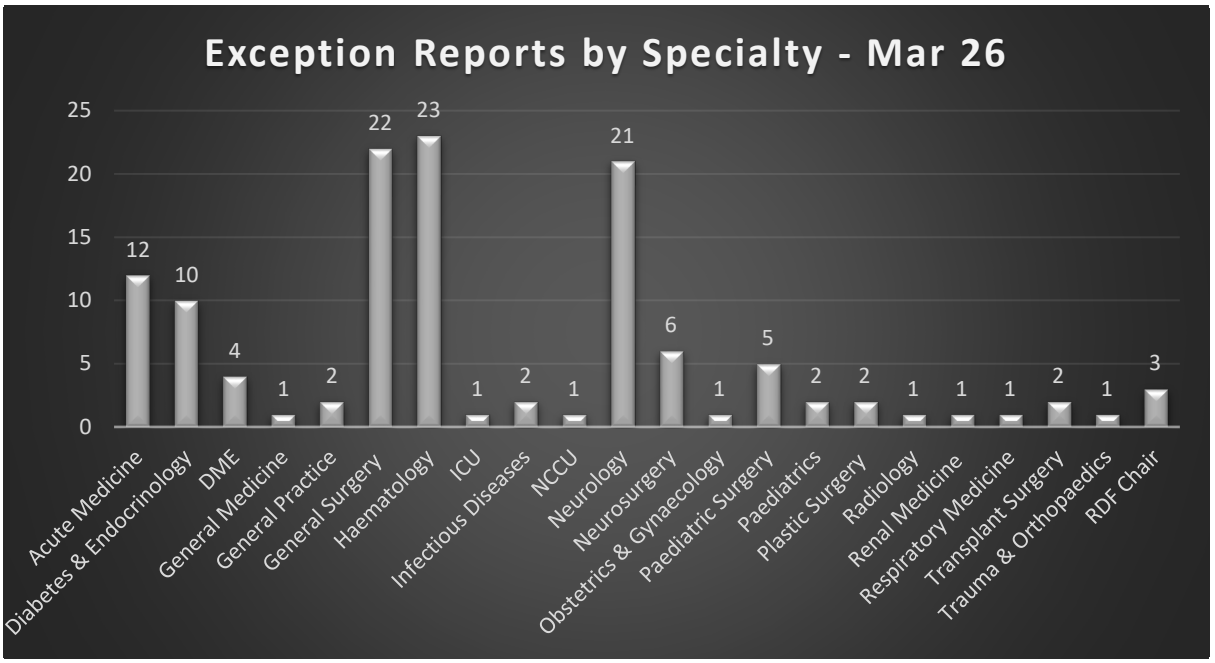
Access & Completion:

- 11 access & completion test exceptions were received during this period, of which all had a successful outcome.

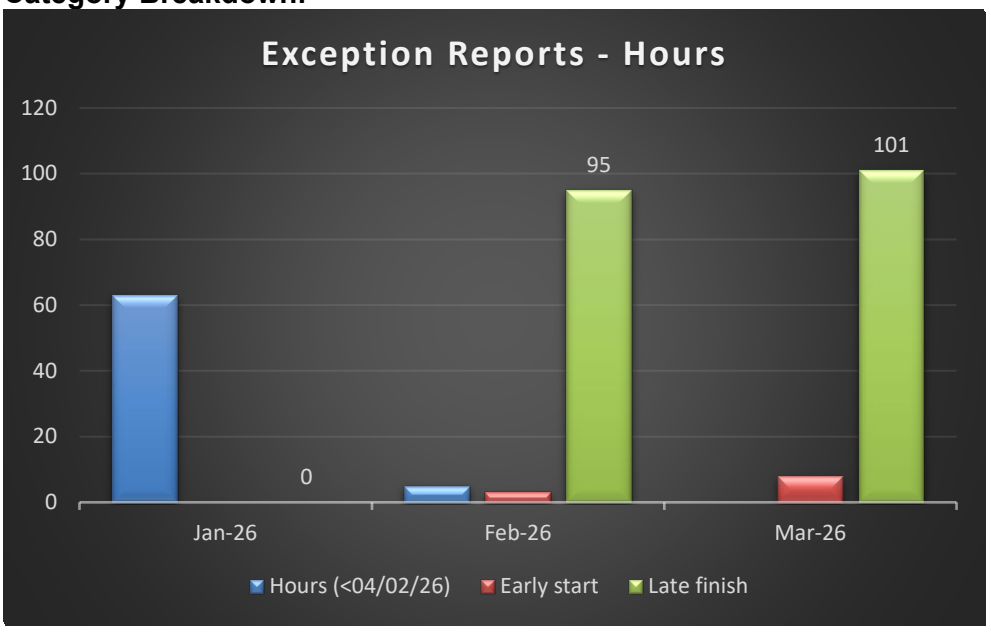
Specialty Breakdown:





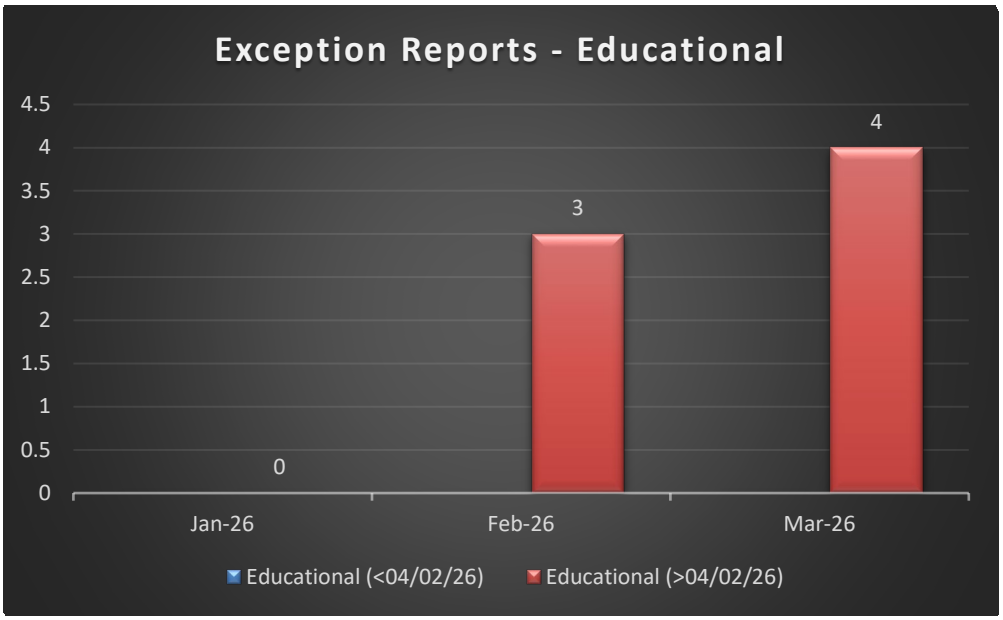


Category Breakdown:



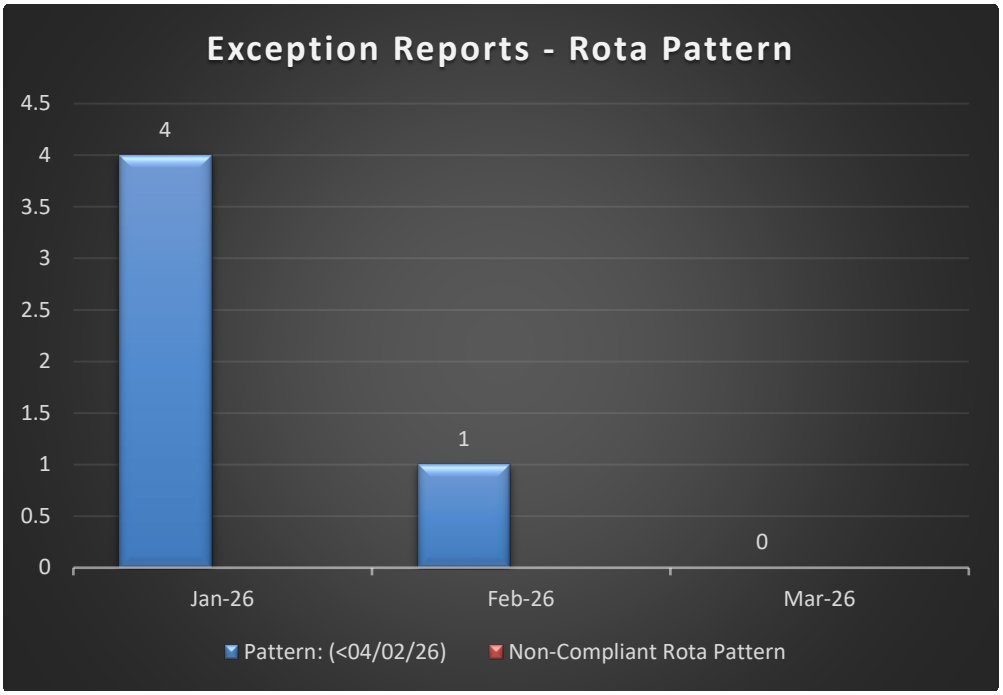
- There were 275 exceptions reported under hours related categories between Jan and Mar 26. (63 exceptions in Mar, 103 in Feb, and a 109 in Mar)

- From the 275 exceptions, 68 exceptions were reported under the old hours category (<04/02/2026), 11 exceptions reported under the unscheduled early start category, and 196 exceptions reported under the unscheduled late finish category.



There were 7 exceptions reported under the missed educational opportunities category. (3 exceptions in Feb and 4 in Mar). These were primarily due to service pressures.

Acute Medicine: 1
Diabetes & Endocrinology: 2
General Surgery: 1
Neurology: 2
Radiology: 1 (reported erroneously in educational opportunities category)



- There were no exceptions reported under raising concerns of a suspected non-compliant rota pattern category.

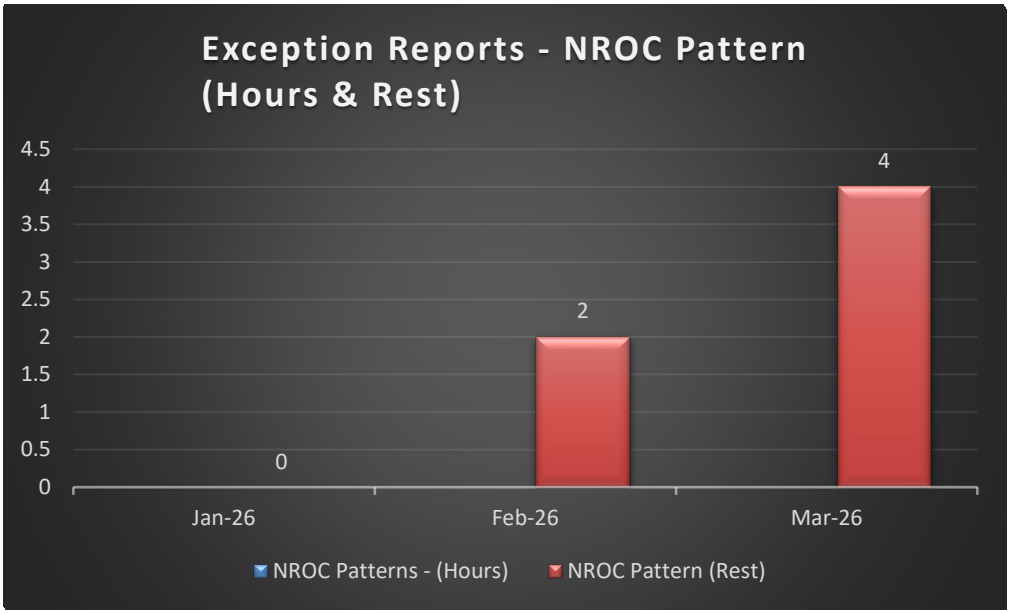
- There were 5 exceptions reported under the old pattern category. (4 exceptions in Jan and 1 in Feb)

Diabetes & Endocrinology: 1
Medical Microbiology and Virology: 1
RDF Chair: 3

Exception reports for clinical support and skills mix

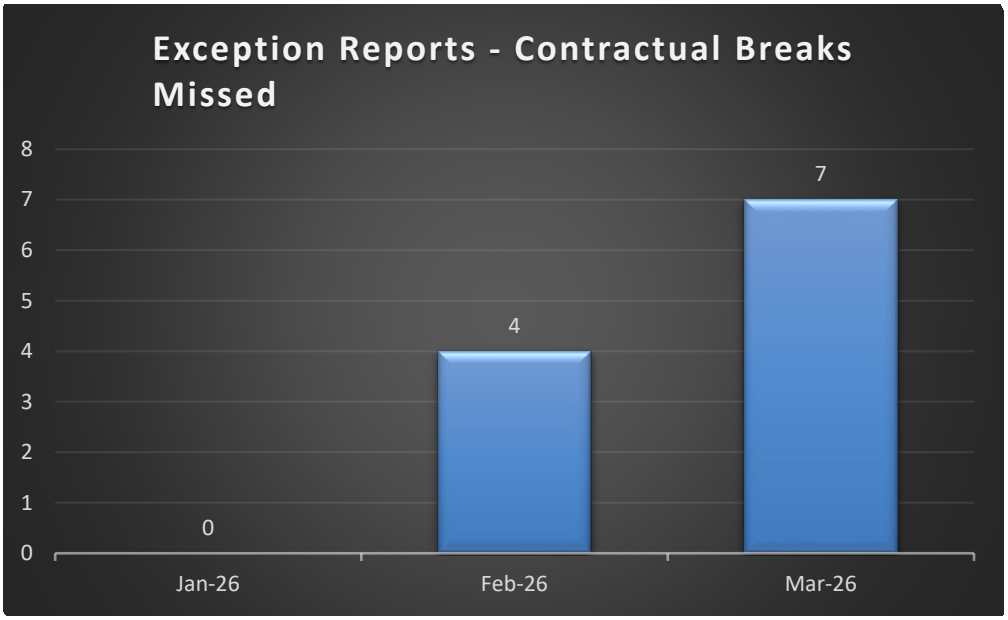
- There were no exceptions reported under the inadequacy of clinical support, or lack of service support category.

- There were no exceptions reported under the inadequacy of rostered skills mix category



- There were no exceptions reported under the breach of a non-resident on-call patterns: Hours category.
- There were 6 exceptions reported under the breach of a non-resident on-call patterns: Rest category. (2 exceptions in Feb and 4 in Mar)

Paediatric Surgery: 5
Vascular Surgery: 1



- There were 11 exceptions reported under the inability to take contractual breaks category. (4 exceptions in Feb and 7 in Mar)

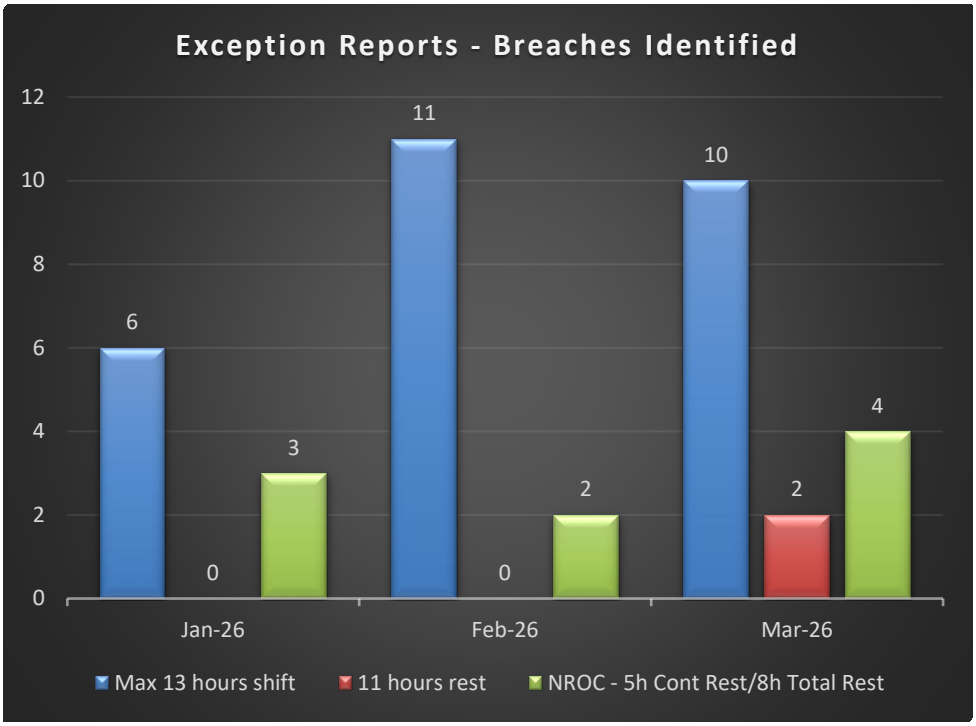
Acute Medicine: 4
Anaesthetics: 2
Diabetes & Endocrinology: 2
General Surgery: 1
Neurology: 1
Respiratory Medicine: 1

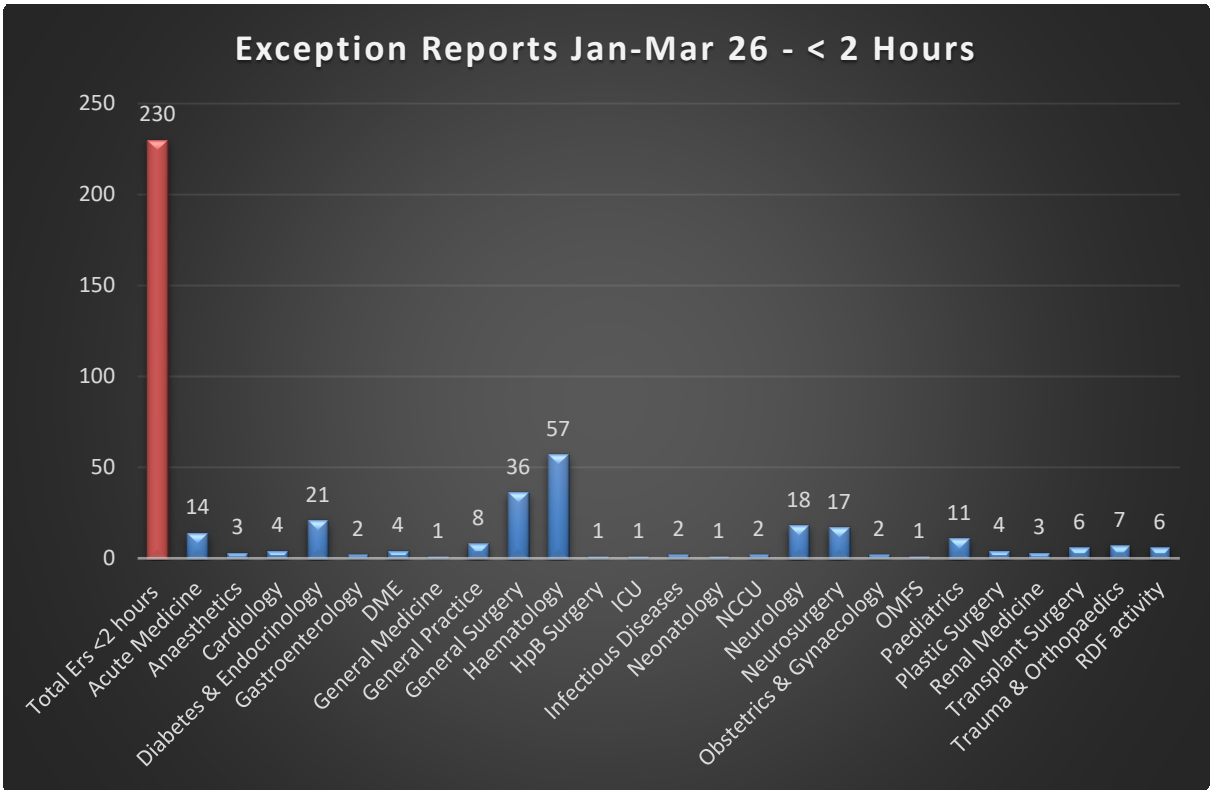
Exception reports – detriment or information breach

- There were no exceptions reported under the detriment or threat of detriment related to exception reporting category, or in the information breach category.

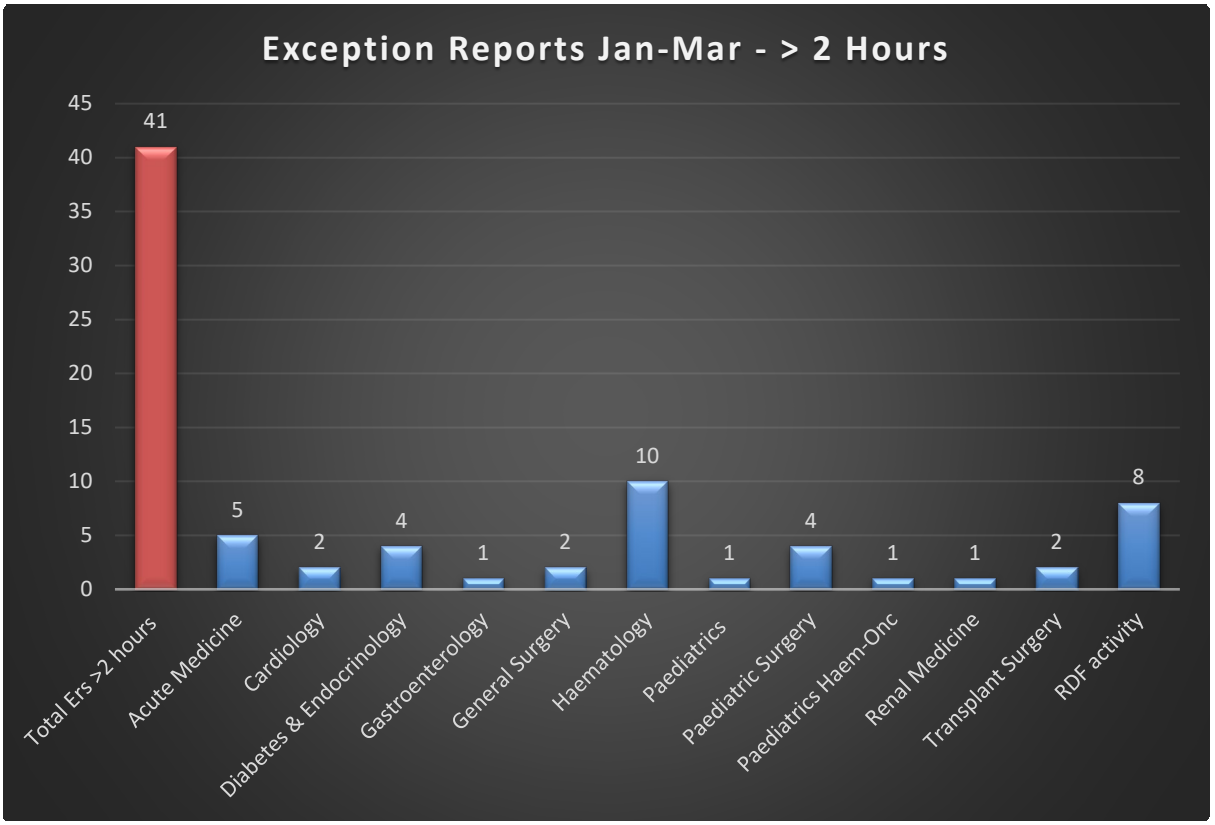
Exception reports – Access and Completion Tests

- There were 11 access & completion test exceptions reports received during this period, of which all had a successful outcome. (9 exceptions in Feb and 2 in Mar)





- There were 230 exception reports < 2 hours processed between Jan-Mar 2026.
- 48 exceptions in January, 87 exceptions in February, and 95 exceptions in March.



- There were 41 exception reports > 2 hours processed between Jan-Mar 2026.
  10 exceptions in Ja

NHS
Cambridge
University Hospitals
NHS Foundation Trust

Report to Board of Directors – in public
held on 10 June 2026

Title	Annual Report on Safe Working Hours: Resident Doctors 2025-6			
Report Sponsor	Dr Sue Broster, Chief Medical Officer			
Author	Dr Serena Goon, Guardian of Safe Working Hours			
Status	**Decision** ☑	**Assurance** ☑	**Information** ☑	**Discussion** ☑

RECOMMENDATIONS

The Board of Directors is asked to:

- **REVIEW** the key messages.
- **AGREE** to provide support for expansion in workforce where areas are highlighted as areas of concern.

KEY MESSAGES

- The annual Guardian of Safe Working Hours (GOSWH) report for 2024-25 described an increase in exception reporting following the covid-19 pandemic, followed by a stabilisation of numbers over the following years. New exception reporting reforms were implemented on 4 February 2026, such that the educational supervisor is no longer copied into the forms. This saw a slight rise in numbers submitted though it is still early to form solid interpretations.

- Overall, exception reporting suggested that working hours were considered safe and compliant on most rotas despite all the service pressures. There continue to be some extra hours worked on a variety of different rotas, with a few areas with persistent problems. However, exception reports are not always filled in when excess hours are worked, so does not always give the complete picture.

- The number of exception reports (ERs) for missed training opportunities remains low (47 compared to 30 last year). These remain a small proportion of all ERs. However, missed training opportunities are reported through the Resident Doctors Forum (RDF), therefore the low number of ERs is likely a reflection of under-reporting.

- There are plans to roll out e-rostering, however this and other long-term projects have been affected partially by the resources diverted due to industrial action which has been taking place this year.

BACKGROUND, INCLUDING PURPOSE OF THE REPORT

This is the ninth annual report, based on a national template, to the Board of Directors by the Guardian of Safe Working Hours. This role was introduced to support the implementation and maintenance of the 2016 national contract for resident doctors on training programmes; and provides an independent oversight of their working hours. The process of exception reporting provides data on their working hours and can be used to record safety concerns related to these and rota gaps. In addition, it can

identify missed training opportunities.

Safeguards around doctors' hours are outlined in national terms and conditions. These stipulate that the Guardian of Safe Working Hours "shall report no less than once every quarter to the Board". Reporting to the Board of Directors is a stipulated requirement of this role and this report reflects the financial year 2025-26. The Trust has 711 resident doctors in training programmes, who have all transferred to the 2016 Terms and Conditions of Service. Additionally, there are 298 locally employed doctors, bringing the total to 1009 resident doctors.

ALIGNMENT TO TRUST STRATEGIC PRIORITIES

Our strategy: a healthier life for everyone through care, learning and research 2026-2031		**Indicate all that apply**
	Deliver Excellent and Timely Care	☑
	Transform How and Where We Deliver Care	☑
	Harness Research and Innovation to Improve Patient Outcomes	☑

ALIGNMENT TO MOST RELEVANT STRATEGIC RISK

This report most aligns to the strategy of delivering excellent and timely patient care. Resident doctors form a hugely important and large part of our workforce. Safe staffing levels improve the patient experience, the patient journey, ensure high quality care for the patient, and improves patient flow by ensuring timely treatment, recovery and discharge.

PAPER REVIEW AND GOVERNANCE PATHWAY

Name of group or committee that has previously considered this report	**Date**
Management Executive	4 June 2026
Name of group or committee that the report will be presented to in the future	
Not applicable	

Cambridge University Hospitals NHS Foundation Trust

10 June 2026

Board of Directors

Annual Report on Safe Working Hours: Resident Doctors 2025-6
Dr Serena Goon, Guardian of Safe Working Hours

1. Introduction and context

The process of exception reporting provides data on the working hours of resident doctors and can also identify missed training opportunities. This provides an additional mechanism to record safety concerns related to working hours and rota gaps. Reporting to the Board of Directors is a stipulated requirement of this role and this report reflects the position at completion of the ninth year since the implementation of the 2016 Terms and Conditions of Service.

Please note that the detailed data below relates only to doctors directly overseen by the Guardian of Safe Working Hours for Cambridge University Hospitals NHS Foundation Trust.

2. Board reporting

High level data

Number of resident doctors in training (total):	711
Number of locally employed resident doctors:	298
Total resident doctor establishment:	1009

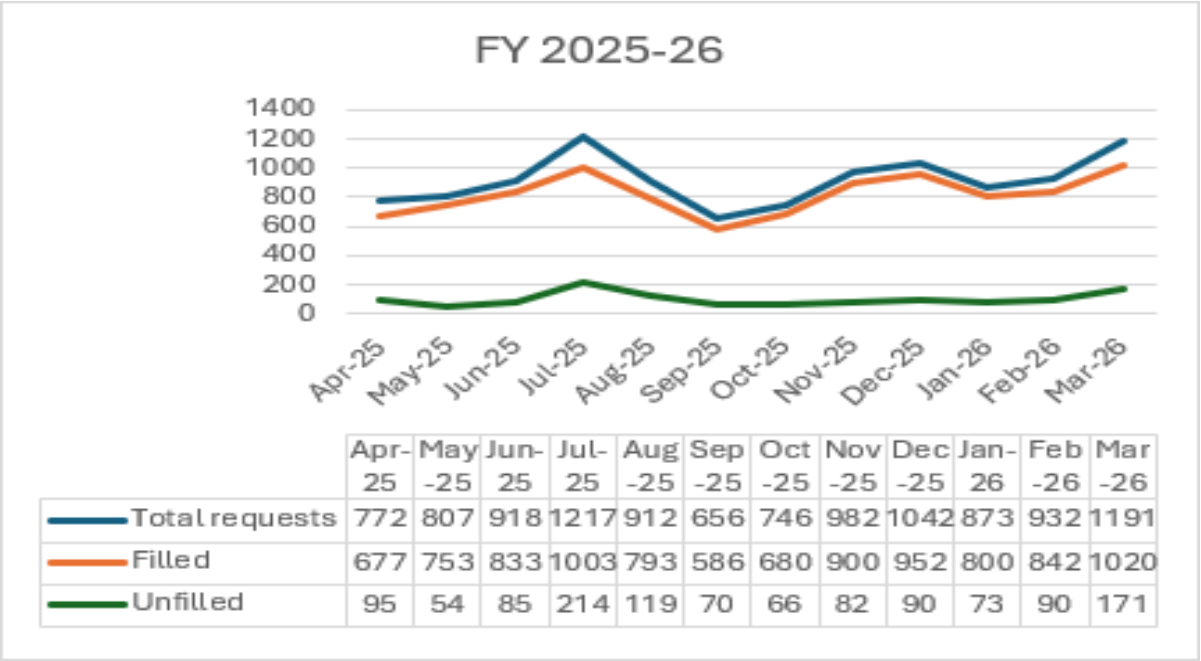
With effect from August 2018, the ability to exception report was rolled out to all resident doctors, including non-consultant non-training grade doctors.

Amount of time available in job plan for Guardian to do the role:	2 PAs / 8 hours per week
Admin support provided to the Guardian:	1 WTE
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

3. Annual data summary

The Trust Resident Doctor locum bank usage over the financial year 2025/26 is as follows:

Month	Total requests	Filled	Unfilled	Junior Fill rate	
Apr-25	772	677	95	87.69%	
May-25	807	753	54	93.31%	
Jun-25	918	833	85	90.74%	
Jul-25	1217	1003	214	82.42%	* includes cover & unfilled duties for industrial action.
Aug-25	912	793	119	86.95%	
Sep-25	656	586	70	89.33%	
Oct-25	746	680	66	91.15%	
Nov-25	982	900	82	91.65%	* includes cover & unfilled duties for industrial action.
Dec-25	1042	952	90	91.36%	* includes cover & unfilled duties for industrial action.
Jan-26	873	800	73	91.64%	
Feb-26	932	842	90	90.34%	Now including WLI shifts
Mar-26	1191	1020	171	85.64%	Now including WLI shifts and external services paid via CUH (ED UTC & ACCTS)



4. Issues Arising

4.1 Exception Reporting

In total, 1129 ERs were submitted this year (2025-6) compared with 1110 in 2024-5. 1038 (1109 last year) of these were for extra hours worked. Different data has been collected since the reforms, so the extra hours includes 'early starts/late finishes', 'NROC patterns (hours/rest)' and 'contractual breaks'. 30 (58 last year) were for pattern of working and 13 (13 last year) were for service support. There were 24 submitted safety concerns (compared with 27 in 2024-5). There were 47 educational ERs submitted, an increase from 30 last year. There is a consistent cyclical variation with more reports submitted in August & February (as new doctors start work) and over the winter (winter pressures and staff vacancies).

The number of ERs has stabilised this year (and is much higher than pre-pandemic levels), but under reporting is still a significant concern both here and nationally. Few ERs have been submitted for missed training opportunities. Changes have been implemented to the exception reporting system from 4 February 2026, which have seen a slight rise in ERs submitted.

Exception reporting should remain a process by which safe working hours are maintained, to protect patients, regulate resident doctors' workload, safeguard the delivery of educational opportunities and ensure doctors receive compensation for additional work undertaken. As there are rules around information breaches, it remains to be seen if the anonymity required will still allow trends to be spotted and addressed as they have been prior to the reforms.

4.2 Areas of concern

4.2.1 Acute Medicine / Speciality medicine including Cardiology

A number of ERs were submitted by trainees on various medical rotas – from acute medicine to speciality rotas. Reports from 'Acute Medicine' are falsely high due to the badging when resident doctors select the rota they are on. It includes rotas where the resident doctors worked out of hours and incorporates a number of medical specialties. Cardiology ERs featured highly, with reports across the grades. Many described board rounds starting late, resulting in resident doctors leaving late as they stayed to finish jobs. The high (and increasing) number of consults and volume of workflow coming through EPIC chat were cited as issues. Access to training opportunities has suffered as a result.

4.2.2 Haematology

Haematology again featured as having a number of ERs. Some of these were related to time for management of resident doctor rotas. ERs were submitted across the grades. The acuity and complex needs of the patients coming through have increased the workload.

4.2.3 Paediatrics and Paediatric Surgery

ERs for extra hours worked and missed educational opportunities. There is an evident winter pressure effect in paediatrics. There are a number of LTFT resident doctors in paediatrics which can make rostering challenging.

4.2.4 Surgical specialities

ERs for extra hours worked featured highly in **General Surgery**. These were raised at the FY1 level, for a variety of reasons including excessive volume of work, looking after large numbers of patients; late or extended ward or board rounds; and extra time spent with unwell patients. Another theme was administrative work still to be done at the end of the day such as discharge summaries, which they felt should not be done by the night team as they go down in staffing levels. **Trauma and Orthopaedics** is an area of concern. They have been affected by middle grade unplanned gaps, but there is also an increasing amount of trauma coming through the hospital. The orthopaedic trauma unit has a large number of patients. Clinics and theatres are a large burden of their work and there are some vulnerable subspecialties.

4.3 Immediate safety concerns

Immediate safety concerns were mostly related to illness and short-term rota gaps in a variety of specialities and rotas, where it had not been possible to secure appropriate locum cover.

4.4 Industrial action

Industrial action by resident doctors and consultants required re-organisation of rotas at short notice to ensure patient safety. This was a major burden for the medical staffing department and HR; this made it difficult to drive forward some longer-term projects such as e-rostering, and a juggle to implement the new ER reforms.

5. Actions taken to resolve issues

5.1 Exception reporting process

The guardian administrator has worked with medical staffing to ensure that problems with logging into Allocate are addressed. It is the responsibility of the residents to perform a test ER, and if they are not able to access the system, fines now apply to the trust. Additional fines will apply through the ER reforms - for breaches to rest hours, missed breaks, and information breaches. There has been an increased administrative burden due to the reforms, and additional help for our administrator is being recruited to. Communications have been sent to doctors of all grades within the trust, regarding the reforms, and posters of a quick guide to exception reporting have been put up around the hospital.

5.2 Areas of concern

5.2.1 Acute Medicine / Speciality medicine including Cardiology

The medical rotas are complex, involving a large number of resident doctors. ERs submitted by resident doctors working on medical rotas continue at all levels and are usually related to short term rota gaps. Recruiting locums into gaps can be costly, and if unfilled, increases service pressures. Movement of resident doctors from different specialities within packs to cross cover can compromise their training and feeling of being part of a team. For cardiology, there have been changes implemented to improve the workload and supervision for the residents this year. An example is the separation of the on-call consultant from the K3/CCU consultant for part of the week. A cardiology workforce sustainability case is soon to be submitted, at the time of writing. They are also awaiting feedback and approval for the conversion of two senior clinical fellow posts to three higher clinical fellow posts. Reallocation of the senior clinical fellow

posts to the general middle grade rota will provide additional rota members to support dedicated heart failure and chest pain pathways, helping to streamline patient journeys and reduce length of stay, while

maintaining cover for K3 and CCU ward areas. It will also allow for redeployment of SpRs/clinical fellows to outpatient activities and procedural training lists.

5.2.2 Haematology

The number of ERs raised were artificially high, as some were to compensate for time spent by the resident doctor rota co-ordinators for time spent on the resident doctor rotas. However, even accounting for this, haematology is an area of concern. A work schedule review for haematology/oncology is in progress at the time of writing.

5.2.3 Paediatrics & Paediatric Surgery

There is active recruitment into gaps as they arise. There may be support for a paediatric surgery core tier, which is being investigated currently.

5.2.4 Surgical Specialities

There is active recruitment into gaps as they arise. Extra support overnight would be a welcome addition, and may help to relieve the excessive burden of workload. Additional resource is needed in the different specialties, such as trauma/orthopaedics, who are planning a case for extra resident doctors. This is part of a much larger business case involving different tiers, to provide resilience to the service.

5.3 Immediate safety concerns

We continue to emphasise the importance of residents escalating short term rota gaps at the time they occur to clinical leads so that gaps can be filled and patient safety ensured.

6. Summary

In general, exception reporting suggested that working hours for doctors and dentists in training remained compliant and safe across CUHFT, though not all residents submit ERs when they work excess hours, so the picture is not always complete.

The GMC survey 2025 has indicated 61% of trainees, and 47% of trainers are at moderate to high risk of burnout (nationally); with 29% of secondary care trainers unable to use the time allocated for the purpose of training. 26% of trainees nationally, said training is affected because rota gaps aren't dealt with appropriately. Via the GMC survey, we have seen that there are a number of specialties which have red flags for workload and/or rota design – Anaesthetics, Cardiology, Clinical Oncology, Clinical Radiology, Core Surgical Training, Diabetes and Endocrinology, Haematology, and Infectious Diseases. There is a real crossover between high workload and decreased satisfaction with the educational opportunities and ability to train.

The exception reporting process has been useful in highlighting departments and rotas where there are issues; it also provides data that can be used to drive change – extra posts or reallocation of tasks to other professional groups. It should be noted that the process has not been cost neutral. There are multiple areas within the hospital that could also still benefit from extra resource, but these are all with cost implications.

The reforms implemented on 4 February 2026 have resulted in a slight rise, however its implementation, as well as the changes to the processing, have posed a significant administrative burden and increased the workload for the human resources team. This, in addition to industrial action, and other long-term

projects such as e-rostering which need to be implemented, will require additional resource, and it will be a huge benefit when extra resource is recruited to.

Rota gaps occurring at the last minute, for example due to sickness, can be difficult to fill with locums, and this compounds rota gaps and can leave areas understaffed. The Trust is fully engaged in the '10 point plan' being rolled out with NHSE, to improve the working lives of resident doctors. Part of this includes the NHS minimum standards for annual leave for resident doctors. This is a major piece of work.

Finally, in this financial climate, there are challenges including management of waiting lists and patient expectations in the context of an increasingly co-morbid and ageing population. It is difficult to balance the service pressures with training requirements and well-being of the resident doctors.

7. Questions for consideration

Staffing levels in CUHFT are generally adequate to provide good quality patient care but there are some areas with persistent problems and rota gaps. Staffing has sometimes remained static, however the acuity and frailty and age of patients has not been static. There are cost implications with increasing resource, however it is important to consider implications on patient safety, flow through the hospital, educational benefits, and resident doctor well-being when rotas are short staffed.

The Board of Directors is asked to note this ninth annual (2025-26) report from the Guardian of Safe Working Hours and is asked to provide their continuing support for measures to improve resident doctor welfare, training and morale and thus recruitment and retention.

APPENDIX

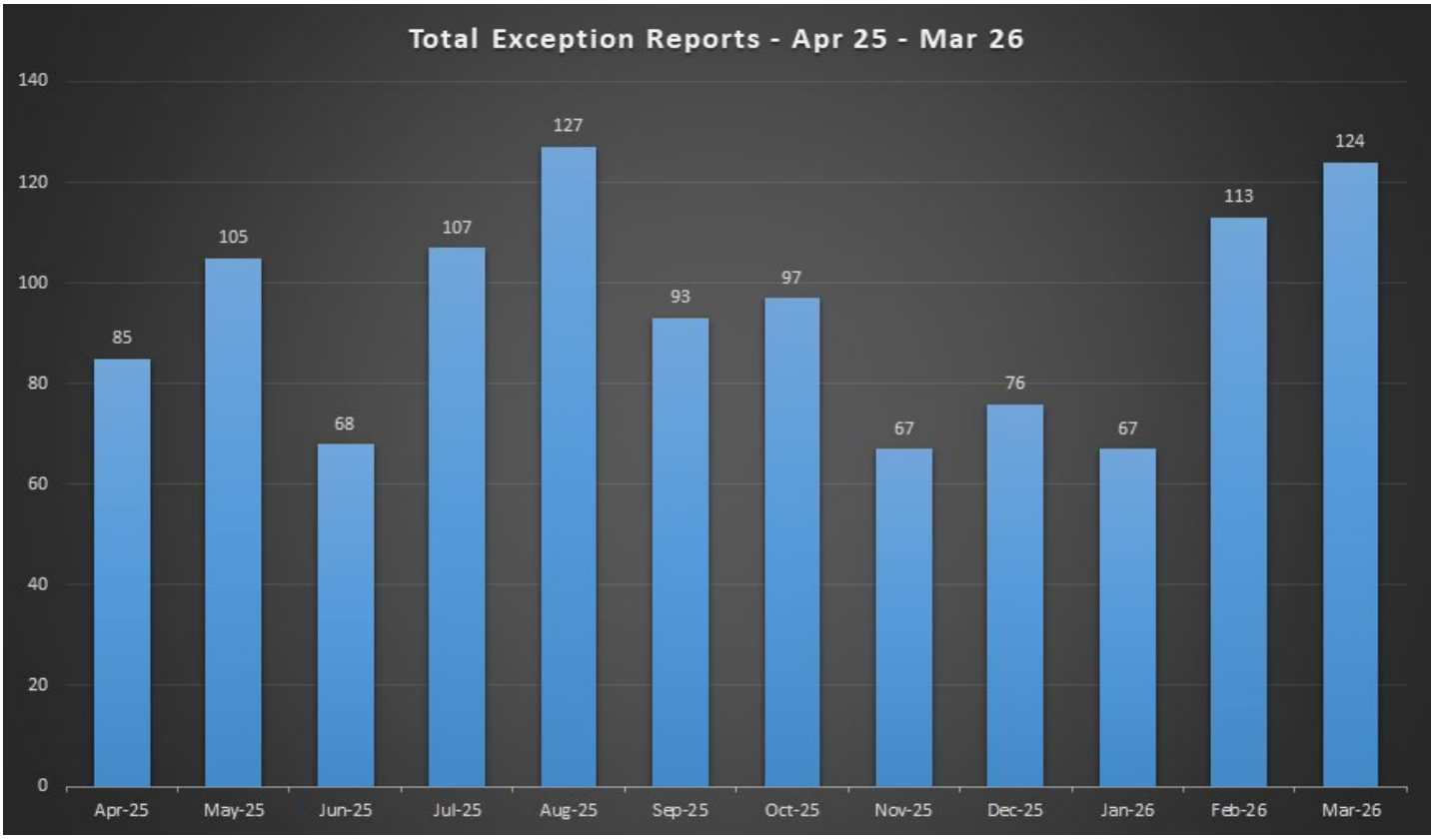
Board of Directors – in public (10 June 2026)
Annual report on safe working hours

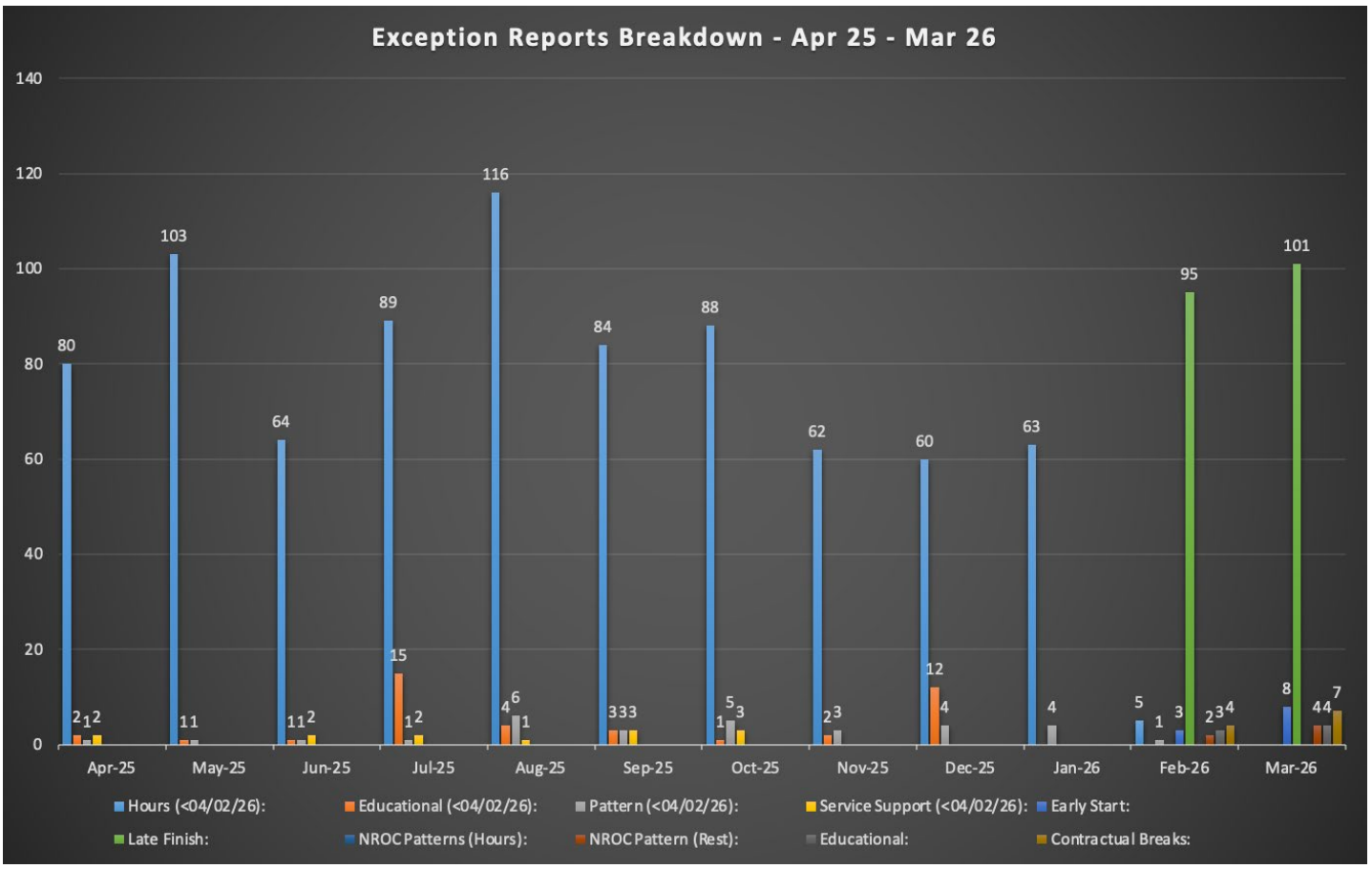
Cambridge University Hospitals NHS Foundation Trust

Exception reports total for financial year April 25 to March 26

Month	Monthly Total Reports	Hours (<04/02/26)	Educational (<04/02/26)	Pattern (<04/02/26)	Service Support (<04/02/26)	Early Start	Late Finish	NROC Pattern (Rest)	Educational	Contractual Breaks
Apr-25	85	80	2	1	2	0	0	0	0	0
May-25	105	103	1	1	0	0	0	0	0	0
Jun-25	68	64	1	1	2	0	0	0	0	0
Jul-25	107	89	15	1	2	0	0	0	0	0
Aug-25	127	116	4	6	1	0	0	0	0	0
Sep-25	93	84	3	3	3	0	0	0	0	0
Oct-25	97	88	1	5	3	0	0	0	0	0
Nov-25	67	62	2	3	0	0	0	0	0	0
Dec-25	76	60	12	4	0	0	0	0	0	0
Jan-26	67	63	0	4	0	0	0	0	0	0
Feb-26	113	5	0	1	0	3	95	2	3	4
Mar-26	124	0	0	0	0	8	101	4	4	7
Total: (1139 including withdrawn)	1129	814	41	30	13	11	196	6	7	11

There were no ERs for Clinical support, Rostered skills mix, non-compliant rota pattern, NROC pattern (hours), detriment or information breach. These were new categories after the implementation of the reforms.

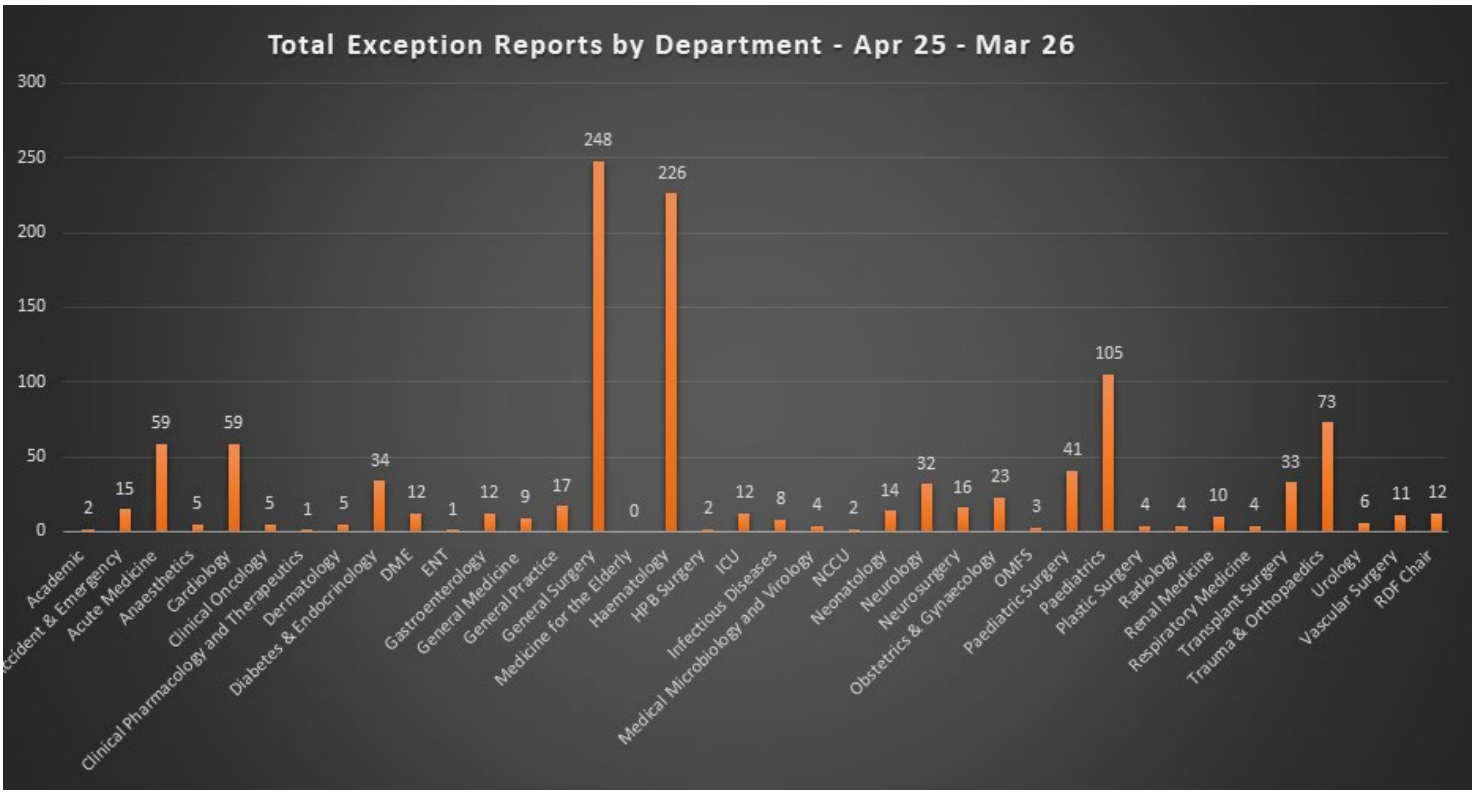

Total Exception Reports - Apr 25 - Mar 26
140
120
100
80
60
40
20
0
85
105
68
107
127
93
97
67
76
67
113
124
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26


Exception Reports Breakdown - Apr 25 - Mar 26
140
120
100
80
60
40
20
0
80
103
64
89
116
84
88
62
60
63
95
101
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Mar-26
Hours (<04/02/26):
Educational (<04/02/26):
Pattern (<04/02/26):
Service Support (<04/02/26):
Early Start:
Late Finish:
NROC Patterns (Hours):
NROC Pattern (Rest):
Educational:
Contractual Breaks:

Exception reports total for the financial year April 2025 to March 2026 by departmental breakdown:
There were no ERs for Clinical support, Rostered skills mix, non-compliant rota pattern, NROC pattern (hours), detriment or information breach.

Specialty	Hours (<04/02/26)	Educational (<04/02/26)	Pattern (<04/02/26)	Service Support (<04/02/26)	Early Start	Late Finish	NROC Pattern (Rest)	Educational	Contractual Breaks	Monthly Total Reports
Academic	0	0	2	0	0	0	0	0	0	2
Accident & Emergency	15	0	0	0	0	0	0	0	0	15
Acute Medicine	36	2	3	1	0	12	0	1	4	59
Anaesthetics	0	0	0	0	0	3	0	0	2	5
Cardiology	52	2	0	0	0	5	0	0	0	59
Clinical Oncology	2	1	2	0	0	0	0	0	0	5
Clinical Pharmacology and Therapeutics	1	0	0	0	0	0	0	0	0	1
Dermatology	5	0	0	0	0	0	0	0	0	5
Diabetes & Endocrinology	5	0	2	0	2	21	0	2	2	34
DME	8	0	0	0	0	4	0	0	0	12
ENT	0	0	1	0	0	0	0	0	0	1
Gastroenterology	9	1	0	0	0	2	0	0	0	12
General Medicine	5	1	0	2	0	1	0	0	0	9
General Practice	15	0	0	0	0	2	0	0	0	17
General Surgery	210	3	2	0	0	31	0	1	1	248
Medicine for the Elderly	0	0	0	0	0	0	0	0	0	0
Haematology	155	14	2	5	0	50	0	0	0	226
HPB Surgery	1	0	0	0	0	1	0	0	0	2
ICU	1	1	9	0	0	1	0	0	0	12
Infectious Diseases	6	0	0	0	0	2	0	0	0	8
Medical Microbiology and Virology	0	0	4	0	0	0	0	0	0	4
NCCU	0	0	0	0	0	2	0	0	0	2
Neonatology	13	0	0	1	0	0	0	0	0	14
Neurology	10	0	0	1	8	10	0	2	1	32
Neurosurgery	1	0	0	0	0	15	0	0	0	16
Obstetrics & Gynaecology	19	1	0	1	0	2	0	0	0	23
OMFS	3	0	0	0	0	0	0	0	0	3
Paediatric Surgery	35	0	0	0	0	1	5	0	0	41
Paediatrics	96	0	0	2	0	7	0	0	0	105

Plastic Surgery	0	0	0	0	0	4	0	0	0	4
Radiology	3	0	0	0	0	0	0	1	0	4
Renal Medicine	6	0	0	0	0	4	0	0	0	10
Respiratory Medicine	3	0	0	0	0	0	0	0	1	4
Transplant Surgery	30	0	1	0	0	2	0	0	0	33
Trauma & Orthopaedics	54	15	0	0	0	4	0	0	0	73
Urology	5	0	1	0	0	0	0	0	0	6
Vascular Surgery	10	0	0	0	0	0	1	0	0	11
RDF Chair	0	0	1	0	1	10	0	0	0	12
Total:	814	41	30	13	11	196	6	7	11	1129



Report to Board of Directors in public

held on

10 June 2026

Title	Learning from Deaths Quarterly report			
Report Sponsor	Dr Susan Broster, Chief Medical Officer			
Author(s)	Dr Monica Trivedi - Deputy Medical Director Christopher Edgley – Lead for Patient Safety Melissa Wathen – Quality Information Lead Antonio Romagnolo – Quality Improvement Data Analyst			
Public/private	Public			
Status	**Decision** ☐	**Assurance** ☐	**Information** ☑	**Discussion** ☑

RECOMMENDATIONS

The Board of Directors is asked to:

- **Note** the Learning from Deaths Quarterly Board report.

KEY MESSAGES

- Between January 2026 – March 2026 (Q4), there were 410 deaths; of these 45 were in the Emergency Department, and 365 Inpatient deaths. There was no patient deaths recorded in the Virtual Ward.
- The number of total and inpatient deaths per 1000 admission showed a statistical decrease.
- Between January 2026 and March 2026, there were no Patient Safety Incident Investigations (PSII) in relation to an unexpected death reported to the commissioners.
- There have been no Prevention of Future Deaths ordered between January 2026 and March 2026.

BACKGROUND, INCLUDING PURPOSE OF THE REPORT

The purpose of this report is to:

- update the Board on key Learning from Deaths metrics for 2025/6 Quarter 4
- provide the Board with an overview of Learning from Death performance,

and to share learning from mortality reviews.

ALIGNMENT TO TRUST STRATEGIC PRIORITIES

Our strategy: a healthier life for everyone through care, learning and research 2026-2031		**Indicate all that apply**
	Deliver Excellent and Timely Care	☑
	Transform How and Where We Deliver Care	☑
	Harness Research and Innovation to Improve Patient Outcomes	☑

ALIGNMENT TO MOST RELEVANT STRATEGIC RISK

[Statement on alignment to specific BAF risks]

PAPER REVIEW AND GOVERNANCE PATHWAY

Name of group or committee that has previously considered this report	**Date**
Management Executive	4 June 2026
Name of group or committee that the report will be presented to in the future	
Not applicable	

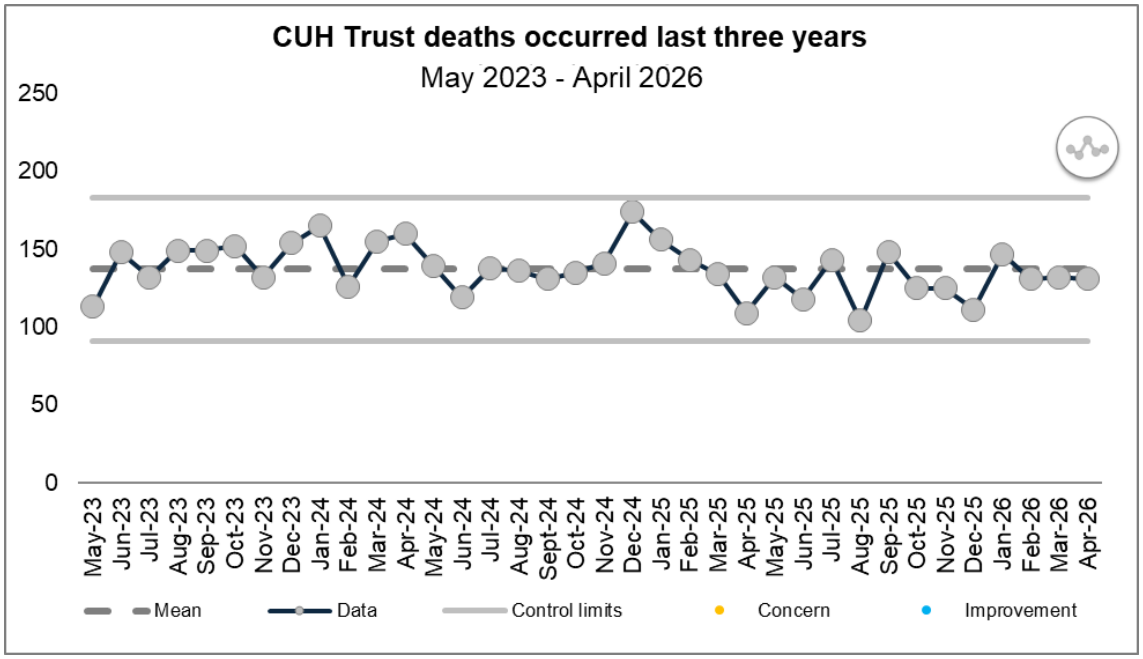
10 June 2026

Board of Directors
Learning from Deaths Quarterly Report

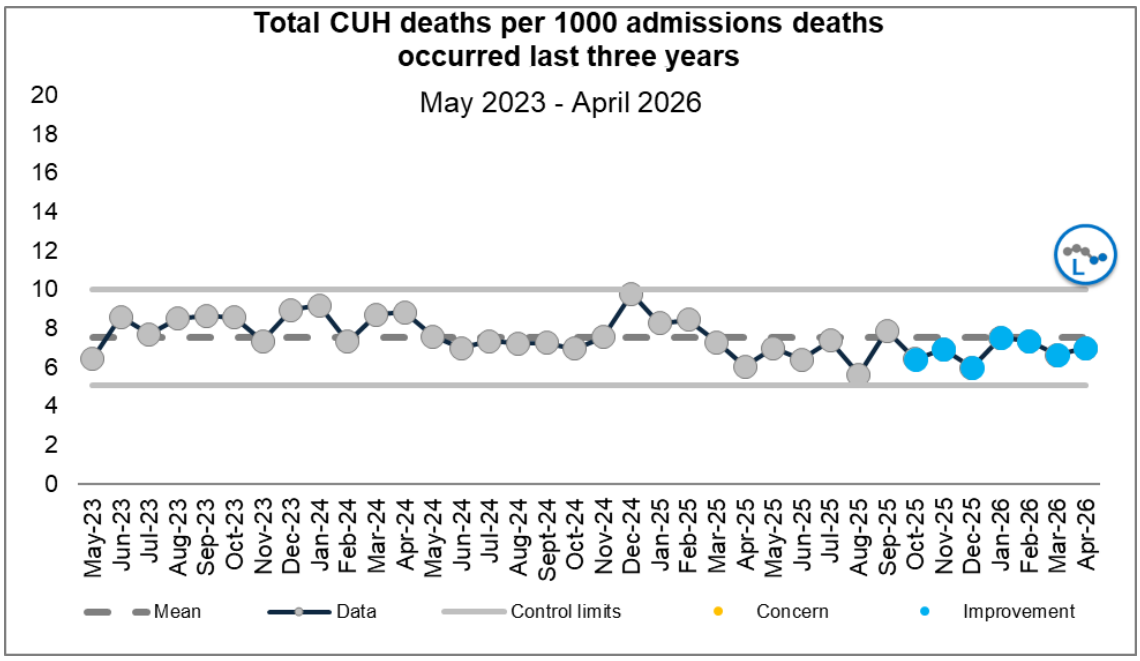
1. Number of deaths in last quarter

Between January and March 2026 (Q4), there were 410 deaths across Emergency Department (ED), inpatient, and Virtual Ward settings. Of these, 11.0% (45/410) occurred in the ED, 89.0% (365/410) were inpatient deaths. No deaths were recorded in the Virtual Ward.

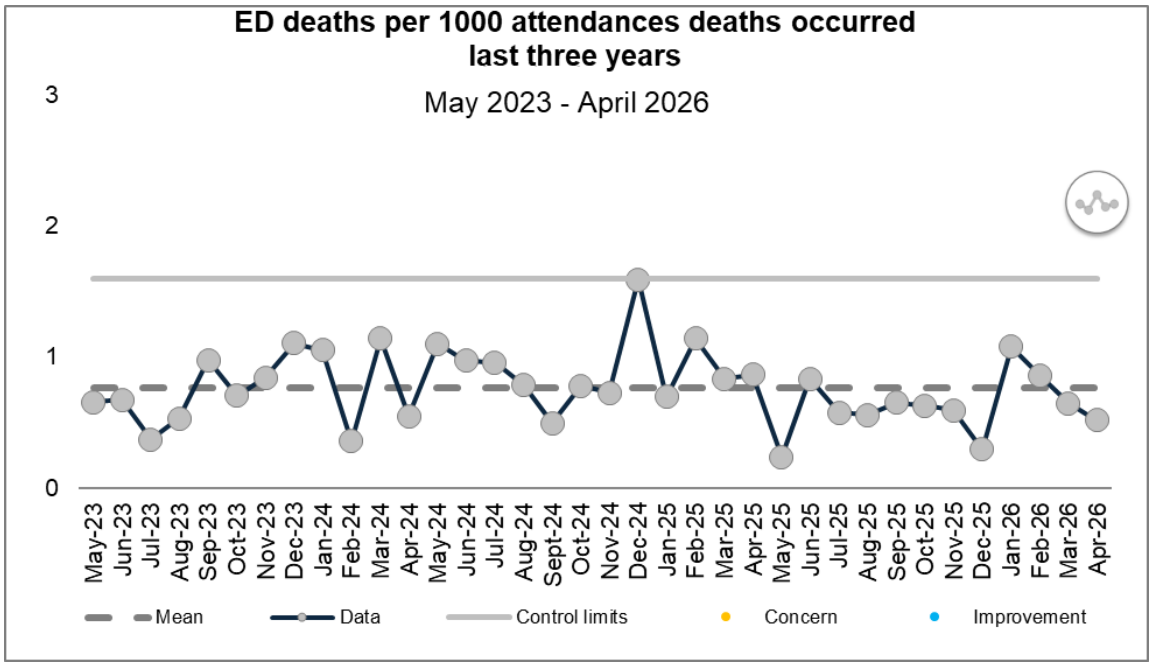
Graph 1 shows total CUH deaths (Inpatients, Virtual ward and ED) that have been recorded on Epic from May 2023 to April 2026.



Graph 2 demonstrates total CUH deaths per 1,000 admissions that have been recorded on Epic from May 2023 to April 2026.

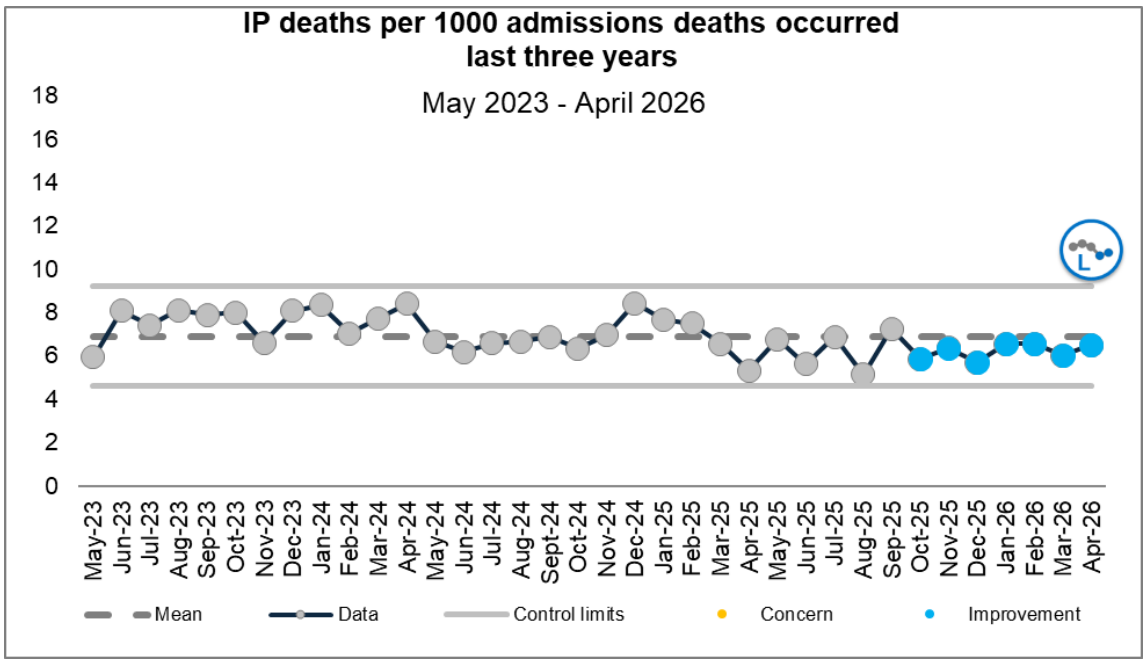


Graph 3 shows Emergency Department deaths per 1000 Emergency Department admissions from May 2023 to April 2026.

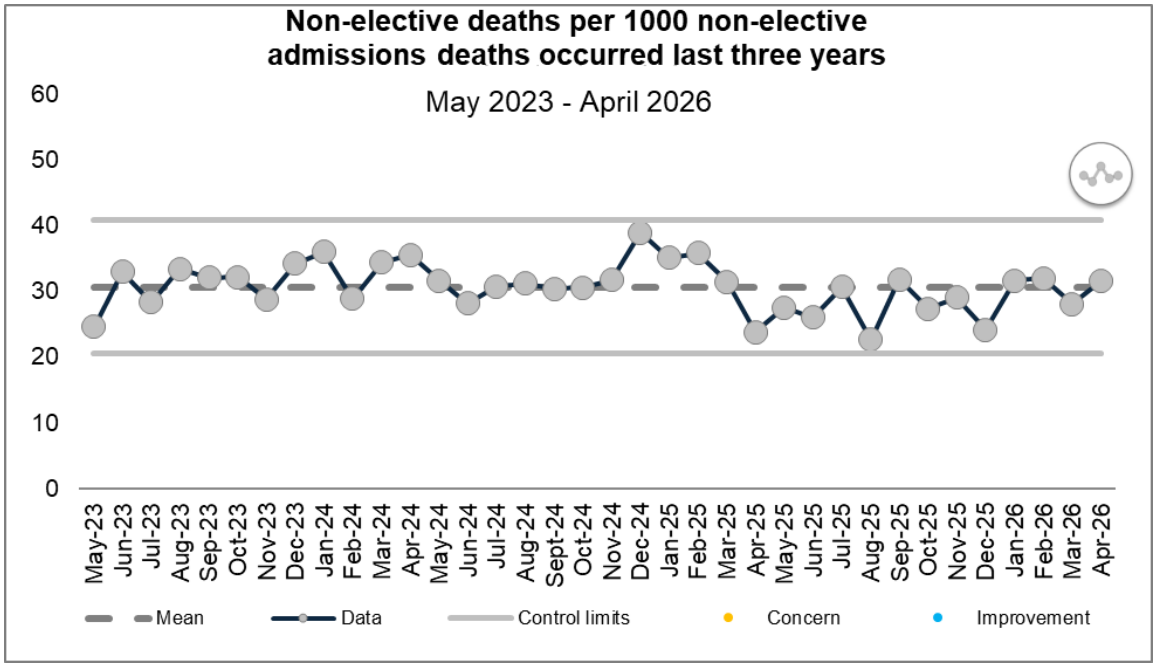


.

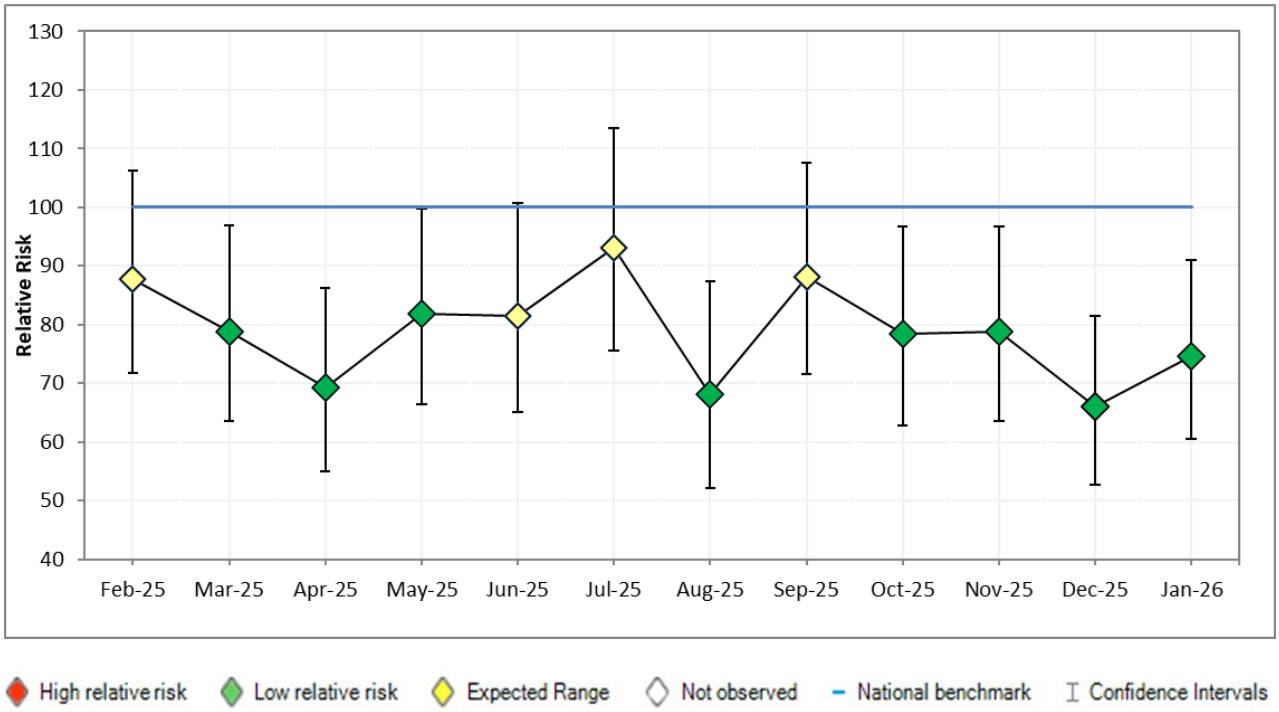
Graph 4 shows inpatient deaths per 1000 inpatient admissions from May 2023 to April 2026



Graph 4a shows inpatient deaths in a non-elective admission by 1,000 non-elective admissions from May 2023 to April 2026.



Graph 5 displays the latest Hospital Standardised Mortality Ratio (HSMR) figures by month from February 2025 to January 2026.



2. Mortality case review process – Structure Judgement Review (SJR)

The table below shows a summary of learning from deaths key performance indicators (KPIs) in Q4 of 2025-2026 financial year.

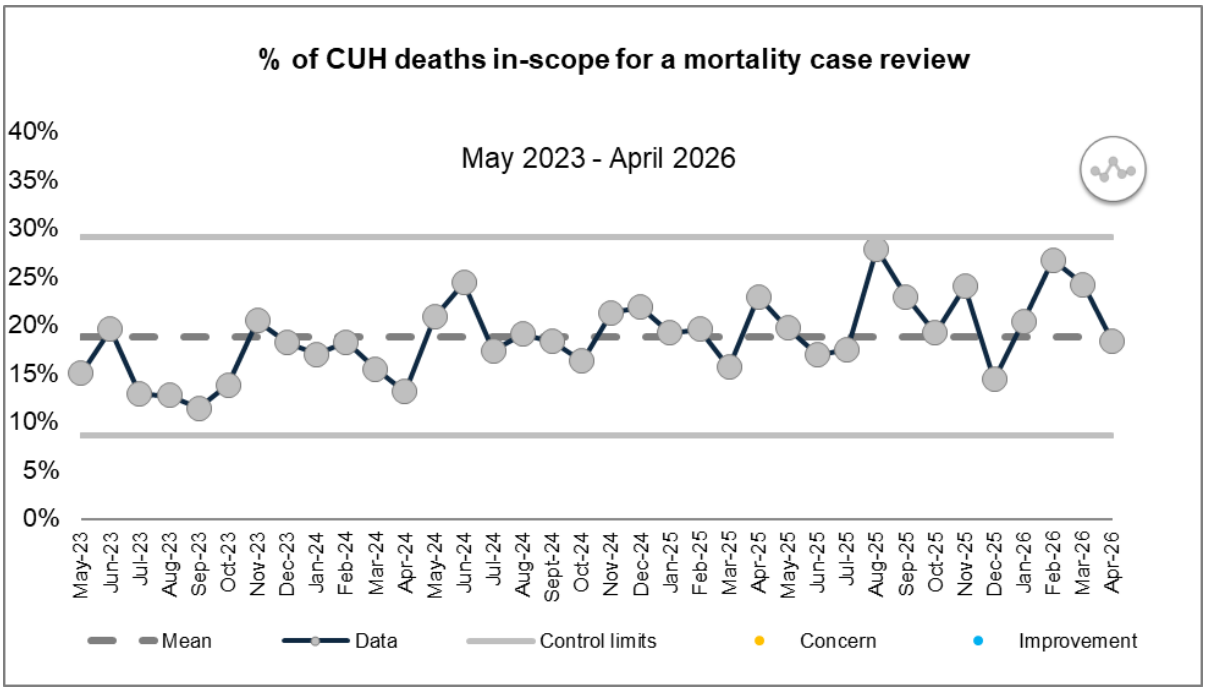
Learning from deaths summary												
Last 12 months	No. of deaths in month	No. of deaths in-scope for mortality case review	Mortality case reviews triggered by family /	Compliance with Mortality case reviews		% deaths in-scope under SJR review	No. deaths in final sign off	% of SJRs identifying problems in care (of SJRs scoring 1-3)		% of all deaths with SJR problems in care (of SJRs scoring 1-3)		PFD issued to CUH directly
				Number closed	Number due			Month	Quarter / Three month	Month	Quarter / Three month	
Jan-26	147	30	3	57% 17	30	73%	1	0% 0	22	0% 0	147	0
Feb-26	131	35	2	40% 14	35	63%	3	0% 0	22	0% 0	131	0
Mar-26	132	32	2	34% 11	32	81%	1	0% 0	26	0% 0	132	0
									0% 0 70		0% 0 410	

3. Structured judgement review (SJR) compliance

3.1. Deaths in-scope

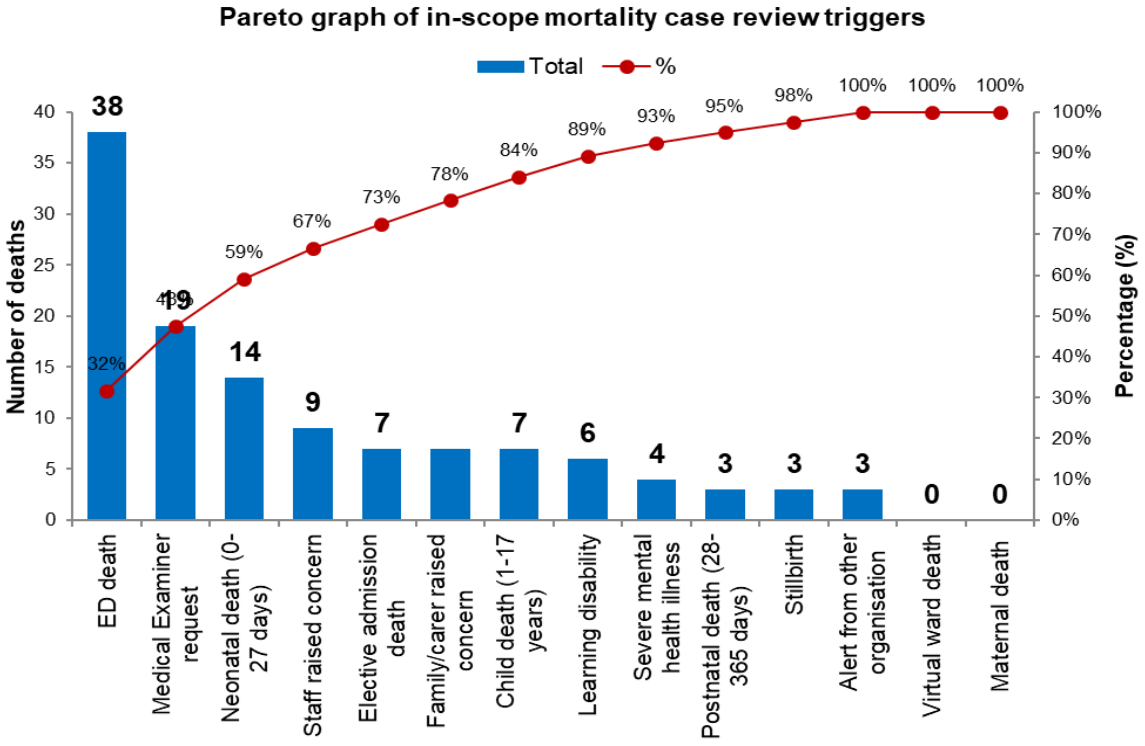
Between January 2026 and March 2026, 23.7% (97/410) met the criteria for a Mortality Case Review

Graph 6 shows the percentage of CUH deaths that are in-scope for a mortality case review over time from May 2023 to Apri 2026. There is currently normal variation.

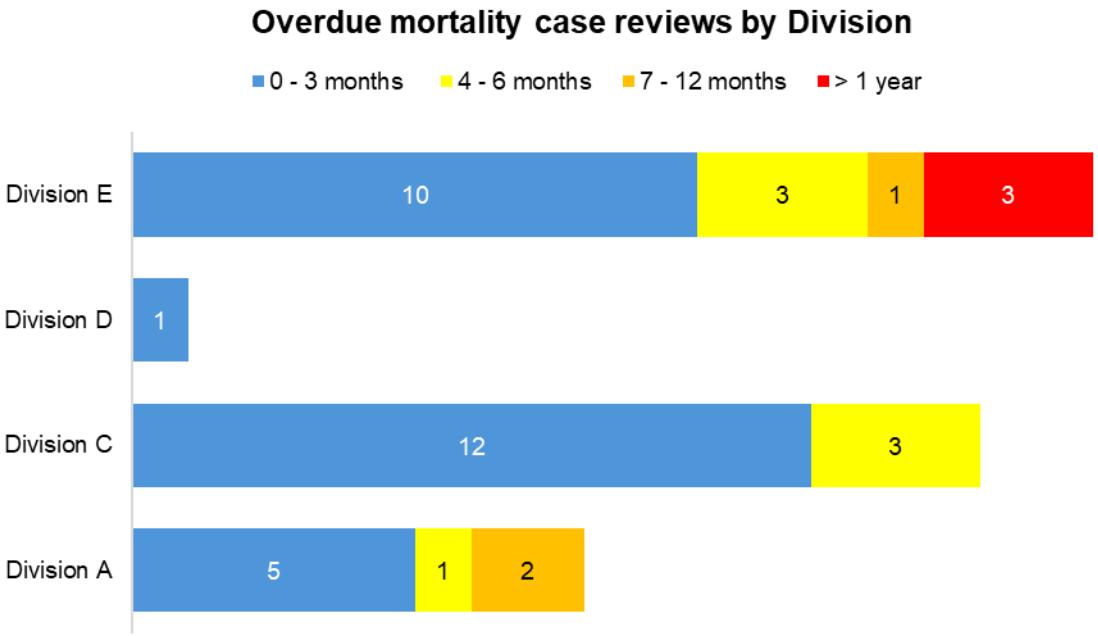


Of the 97 in-scope deaths identified in Q4, 52.6% of Mortality Case Review (51/97) have been completed to date (19/05/2026).

Graph 7 shows the number of SJRs requested between January 2026 and March 2026 by in-scope trigger.



Graph 8 shows the total number of overdue mortality case reviews as of 05/05/2026. Currently there are 41, and 3 are overdue by more than a year.



The overdue Division E mortality reviews have followed an alternative process (PMRT/CDOP). The mortality reviews will remain open until assurance is received that these processes have been completed.

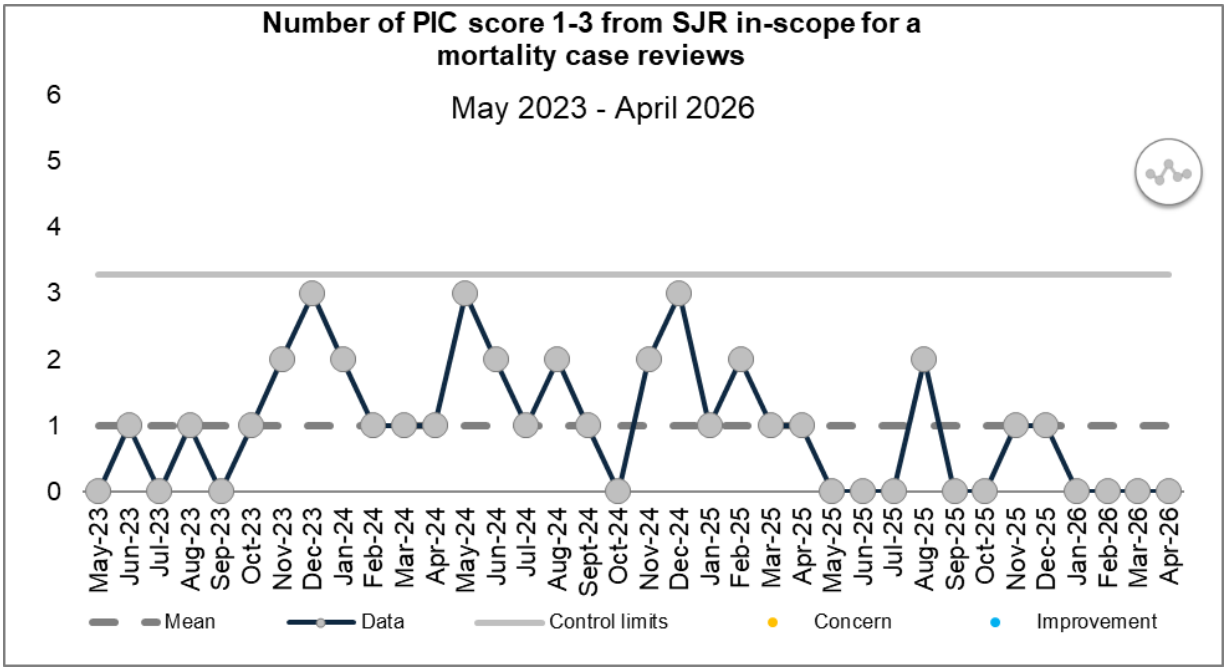
4. Structure Judgement Review problems in care scores

No Structured Judgement Review (SJR) highlighted less than satisfactory care between January 2026 and March 2026. All SJRs with a Problem in Care (PIC) score of 1– 3 are shared with the coroner for information.

The percentage of deaths identified through the SJR process with problems in care (scores 1-3) from January 2026 - March 2026 is 0.0% (0/97) The distribution of these scores is shown in the table below:

	One or more problems in care (1)	One or more problems in care (2)	One or more problems in care (3)	Multiple problems in care (4)	Single problem in care (5)	No problems in care (6)
	Likely to have caused severe harm	*Likely to have caused moderate harm*	*Likely to have caused low harm*	*Did not lead to harm*	*Did not lead to harm*	*Did not lead to harm*
Jan-26				1		15
Feb-26					3	10
Mar-26				1		10

Graph 7 shows the number of SJRs with problems in care score of 1-3 from May 2023 to April 2026.



5. Structured judgement reviews triggered by family/carers.

There were seven SJR initiated by family/carers concerns between January 2026 and March 2026, three have been closed, one is awaiting secondary review, and three Mortality case review. None of the closed SJRs identified problems in care (PIC score 1-3).

6. Prevention of future death reports issued to Cambridge University Hospitals

There have been no Prevention of Future Death reports issued to CUH in this quarter.

7. Learning

7.1 Overall quality of care

A summary of the scores allocated to overall quality of care section of the SJR for the past 12 months period between May 2025 to April 2026 is shown in the table below (for note, all structured judgement reviews have not yet been completed). *Not inclusive of ED data for the months of May 2025 to April 2026 see table 7.2.

Care scores of SJRs by Stage of Admission in the past year

Stage	Very poor care (1)	Poor care (2)	Adequate care (3)	Good care (4)	Excellent care (5)
Admission		6	17	35	66
Ongoing care		6	12	32	50
Care in procedure			4	17	30
Perioperative care			5	12	19
End of life care		1	8	28	70
Overall care		7	43	65	68

7.2 Overall quality of care – ED Structured Judgement Review

A summary of the scores allocated to overall care of the new ED specific structured judgement review from May 2025 to April 2026. (for note, all structured judgement reviews have not yet been completed).

ED Structured Judgement Review

Stage	Very poor care (1)	Poor care (2)	Adequate care (3)	Good care (4)	Excellent care (5)
Prior to arrival at hospital			29	1617	13
Initial assessment/Triage	1	1	15	21	14
Emergency medicine assessment and care		1	17	18	16
Inpatient specialty assessment and care			10	4	5
Monitoring and implementation of care		1	13	15	19
End of life care			9	13	7
Overall care		7	43	65	68

7.3 Learning from mortality reviews:

<u>Summary of learning</u>

The majority of SJRs completed in this quarter highlighted good clinical care and concluded there were ‘no problems in care’. The following examples of good care were highlighted:

- Senior-led and timely escalation
- Strong multidisciplinary working
- Good pre-operative planning for complex cases
- Compassionate, well-coordinated end-of-life care

In cases where care was identified as sub-optimal, it was largely a result of systemic issues rather than individual decision making. Examples of areas for improvement include:

- Clearer team ownership for complex/trauma patients
- Better documentation of referrals, handovers and outreach input
- More reliable weekend/senior review
- Earlier recognition and investigation of deterioration
- Better inter-hospital transfer and handover processes

Learning identified in SJR are taken forward via the Divisions and an additional Learning Response will be commissioned should further investigation be required. Any additional learning response and actions arising from SJRs will be shared through the Learning from Deaths Oversight Committee and tracked through normal governance structures.

Next steps / ongoing improvement work

A review of the SJR scoring system and the current in-scope triggers for SJRs is currently being led by the Deputy Medical Director (Quality). This includes benchmarking against other organisations / national guidance. Any proposed changes will be taken to the Learning From deaths Oversight Committee for approval.

There is also ongoing work to establish a process to track and ensure completion of improvement actions arising from SJRs, inquests, and other learning from death procedures. This will ensure learning is taken forward and its effectiveness can be measured

Cambridge University Hospitals NHS Foundation Trust

Report to Board of Directors held on Wednesday, 10 June 2026

Title	Modern Slavery Act 2015 compliance statement			
Report Sponsor	Beth Hughes, Chief Governance and Performance Officer			
Author	Jason Clarke, Trust Secretary			
Status	**Decision** ☑	**Assurance** ☑	**Information** ☐	**Discussion** ☐

RECOMMENDATION

The Board of Directors is asked to:

- **note** that the supporting assurance and associated actions have been reviewed by the Audit Committee.
- **approve** the attached Modern Slavery Act 2015 statement for the period from 1 April 2025 to 31 March 2026.

KEY MESSAGES

This report presents the Trust's draft Modern Slavery Act 2015 statement for the period 1 April 2025 to 31 March 2026.

Following review of the relevant areas of assurance, the Trust is assessed as compliant with the requirements of the Modern Slavery Act 2015, with non-material gaps identified. These gaps do not undermine the Trust's overall compliance position. Rather, they identify areas where assurance can be further strengthened through clearer evidence, improved visibility and more consistent oversight.

A more structured assurance process has been used this year to support the statement, including the introduction of an assurance template, evidence log and action log. This is intended to provide a clearer basis for Audit Committee and Board assurance, and to support future monitoring and internal audit activity.

On 29 April 2026 the Audit Committee reviewed the assurance position, including the full assurance template and proposed mitigating actions, and agreed to recommend the statement to the Board of Directors for approval.

Cambridge University Hospitals NHS Foundation Trust

BACKGROUND, INCLUDING PURPOSE OF THE REPORT

The Modern Slavery Act 2015 requires organisations meeting the relevant criteria to publish an annual slavery and human trafficking statement approved by the Board.

The purpose of this report is to present the Trust's draft statement for the period 1 April 2025 to 31 March 2026 and to describe the assurance process used to support it. This year, a more structured and evidence-based process has been adopted, including use of an assurance template and evidence log to record sources of assurance, identified gaps and mitigating actions.

This is intended to strengthen governance, provide a clearer basis for committee and Board assurance, and support future audit and compliance review activity.

ALIGNMENT TO TRUST STRATEGIC PRIORITIES

Our strategy: a healthier life for everyone through care, learning and research 2026-2031		**Indicate all that apply**
	Deliver Excellent and Timely Care	☑
	Transform How and Where We Deliver Care	☑
	Harness Research and Innovation to Improve Patient Outcomes	☐

ALIGNMENT TO MOST RELEVANT STRATEGIC RISK

Not applicable

PAPER REVIEW AND GOVERNANCE PATHWAY

Name of group or committee that has previously considered this report	**Date**
Audit Committee	29 April 2026
Name of group or committee that the report will be presented to in the future	
Not applicable	

Cambridge University Hospitals NHS Foundation Trust

10 June 2026

Board of Directors

Modern Slavery Act 2015 compliance statement

Beth Hughes, Chief Governance and Performance Officer

1. Introduction

1.1 Under Section 54 of the Modern Slavery Act 2015, a slavery and human trafficking statement must be produced annually by all commercial organisations which supply goods and services and have a turnover of more than £36 million. A commercial organisation is defined by the Act as "*a body corporate (wherever incorporated) which carries on a business, or part of a business, in any part of the United Kingdom*".

1.2 Government guidance states that the requirement applies to organisations pursuing primarily charitable or educational aims or purely public functions. As NHS foundation trusts and NHS trusts are established as bodies corporate under the NHS Act 2006, and are providers of goods and services, it is widely accepted that trusts are required to comply with the requirements of Section 54 of the Act.

1.3 The Trust is required to maintain evidence to support assurance and demonstrate compliance with the Modern Slavery Act. This assurance is provided by the relevant executive leads across the core areas, including workforce, nursing, procurement and governance, with supporting evidence collated through the Trust's internal governance processes.

1.4 The Act states that the Trust's slavery and human trafficking statement may include information about:

- The organisation's structure, its business and its supply chains.
- Its policies in relation to slavery and human trafficking.
- Its due diligence processes in relation to slavery and human trafficking in its business and supply chains.
- The parts of its business and supply chains where there is a risk of slavery and human trafficking taking place, and the steps it has taken to assess and manage that risk.
- Its effectiveness in ensuring that slavery and human trafficking is not taking place in its business or supply chains, measured against such performance indicators as it considers appropriate.
- The training about slavery and human trafficking available to its staff.

1.6 The Board of Directors is required to approve a statement in compliance with the Modern Slavery Act on an annual basis, and publish the approved statement on the Trust's website. The attached statement covers from 1 April 2025 to 31 March 2026.

2. Assurance process

2.1 In preparing the Trust's Modern Slavery Act Statement for 2025/26, there have been several improvements in the structure of the assurance process, to ensure that the statement is supported by appropriate evidence and reflects the Trust's position across the relevant core areas.

2.2 Assurance has been sought from the respective executive leads for safeguarding, recruitment, procurement, freedom to speak up and governance, with each lead asked to review the proposed statement and confirm that it accurately reflects current arrangements within their area of responsibility.

2.3 To support this, an assurance template was developed and issued to each lead. This required the identification of:

a. the assurance supporting the statement;
b. any gaps in assurance
c. and actions in place, or planned, to mitigate those gaps.

This approach provides a clearer and more consistent basis for assurance, while also supporting transparency in the way compliance with the Modern Slavery Act is evidenced across the Trust.

2.4 As part of the revised process, an assurance log has been introduced to record the sources of assurance underpinning the statement. This is intended to strengthen the audit trail supporting the Trust's position and to enable a more robust and transparent approach to evidencing compliance. In addition, Audit Committee oversight of the assurance process has been incorporated in advance of Board consideration. This additional scrutiny has been designed to further enhance the Trust's governance arrangements, improve visibility of the basis on which assurance has been provided, and support greater oversight of any gaps or mitigating actions identified through the process.

2.5 Taken together, these changes represent a strengthening of the Trust's approach to modern slavery assurance. By formalising executive input, documenting the supporting evidence base, and introducing Audit Committee oversight ahead of Board assurance, the revised process is intended to provide a more transparent, systematic and well-governed framework for the development and review of the Trust's Modern Slavery Act Statement.

2.6 At its meeting on 29 April 2026, the Audit Committee reviewed the assurance log developed to support the Trust's Modern Slavery Act statement. The assurance log set out the evidence available in support of the statement, identified any gaps in assurance, and described the actions being taken to address those gaps. This provided the Audit Committee with additional visibility of the basis on which assurance had been obtained from the relevant executive leads across the core areas.

3. 2025/26 Modern Slavery assurance review

3.1 There are five sections to which the Trust must provide assurance of compliance in its Modern

Slavery statement. These domains are:

3.2 Safeguarding

3.2.1 The Trust is assessed as compliant with non-material gaps identified. Assurance is provided through established training arrangements and safeguarding reporting through our internal governance routes. The principal gap identified is that the training alone does not necessarily test confidence or application in practice, and modern slavery issues may not always be explicitly visible within routine reporting.

3.3 Procurement

3.3.1 The Trust is assessed as compliant with non-material gaps identified. Assurance is provided through NHS Supply Chain due diligence and supplier assurance arrangements, standard terms and conditions and the expertise of procurement leads in identifying concerns. The principal gap is that the reliance on national frameworks may reduce visibility of Trust-level assurance in some areas.

3.4 Freedom to Speak Up

3.4.1 The Trust is assessed as compliant with non-material gaps identified. Assurance is provided through the Freedom to Speak Up policy, records of concerns raised, awareness activities and Board level oversight. The principal gap identified is the need for greater clarity regarding the types of matters that should be raised through Freedom to Speak Up routes.

3.5 Recruitment and selection

3.5.1 The Trust is assessed as compliant with non-material gaps identified. Assurance is provided through established policies and procedures, standard NHS employment checks, annual audit activity, and previous internal audit findings demonstrating compliance. The principal gaps identified are that audit scope may not always be extended to Modern Slavery Act compliance, and that there is some reliance on assurance provided through agency and locum arrangements.

3.6 Governance

3.6.1 The Trust is assessed as compliant with non-material gaps identified. Assurance is provided through defined accountability across the relevant domains, risk management and escalation processes and annual reporting on modern slavery through the Board. The principal gap identified is limited evidence of explicit and detailed assurance being routinely articulated through Board and sub-committee structures.

3.7 Overall, it is our assessment that the Trust is compliant with the requirements of the Modern Slavery Act 2015, with some non-material gaps identified. These gaps do not undermine the Trust's overall compliance position, but indicate areas where assurance arrangements, evidence capture or oversight can be strengthened further.

3.8 The next phase of this work will be to refine the actions arising from the log, including greater clarity on delivery timescales, the level and source of assurance required and the relevant lines of accountability for completion and oversights. This will support a more systemic approach to monitoring progress and strengthening further reporting cycles.

4 Recommendations

4.1 The Board is asked to note the process undertaken to seek assurance from the relevant executive and operational leads, note that the supporting assurance and associated actions have been reviewed by the Audit Committee, and approve the attached Modern Slavery Act 2015 statement for the period from 1 April 2025 to 31 March 2026.

5 Supporting documents:

Appendix 1: Modern Slavery Act statement 2025/26

Cambridge University Hospitals NHS Foundation Trust

Appendix 1: Modern Slavery Act statement 2025/26

Modern slavery is the recruitment, movement, harbouring or receiving of people through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation.

Individuals may be trafficked into, out of, or within the UK. They may be trafficked for a number of reasons, including sexual exploitation, forced labour, domestic servitude and organ harvesting.

Cambridge University Hospitals NHS Foundation Trust (CUH) is committed to upholding the provisions of the Modern Slavery Act 2015 and to ensuring that there is no modern slavery or human trafficking in any part of our business. We expect our staff and our suppliers to comply with this legislation.

About CUH:

Cambridge University Hospitals is a family of hospitals comprising Addenbrooke's and The Rosie. As part of the NHS, we deliver expert care for patients – locally, regionally and nationally – while our vibrant teaching community equips and empowers our staff for the future. We also benefit from and contribute to some of the most important biomedical research in the world today.

We bring together our daily experiences of patient-led care, our renowned teaching hospital and our ground-breaking research programmes to deepen our understanding of medicine as a science and a practice. We learn as much from our dedicated staff and the patients they care for as we do from our scientists and research partners. Every member of our community is part of the effort. Everything we do, we do together.

Our hospitals

- Addenbrooke's provides emergency, surgical, and medical care for local people. It's also known for specialist services like organ transplants, brain and nerve care, children's care, and genetics.
- The Rosie, on the same site, is a women's hospital and the top centre in the area for maternity care. It has its own operating theatres, baby assessment unit, ultrasound department, and a unit for babies needing intensive care.

Adherence with the Modern Slavery Act 2015:

Cambridge University Hospitals NHS Foundation Trust (CUH) remains firmly committed to complying with the Modern Slavery Act and sets clear expectations for staff, suppliers, and other key partners to do the same. We accomplish this through:

Safeguarding:
CUH Safeguarding Adult and Children policies include information on modern slavery and human trafficking and staff are expected to report concerns about slavery and human trafficking and

management are expected to act upon them in accordance with our policies and procedures.

Procurement:
The Trust prioritises ethical procurement, ensuring workforce wellbeing and protection throughout its supply chain. By purchasing via NHS Supply Chain and enforcing standard terms requiring suppliers to address modern slavery and human trafficking, the Trust reduces social exploitation and safeguards rights.

Recruitment and selection policies:
The Trust's Workforce department oversees recruitment to ensure all staff are hired following references and pre-employment checks, such as immigration and identity verification. This process gives assurance that every staff member has the legal right to work before beginning duties within the Trust.

The Recruitment and Selection Policy clearly sets out required procedures at each key stage to support safe and effective hiring. Additionally, the Trust conducts annual audits of workforce and recruitment practices to ensure that our practices are robust and fit for purpose.

Freedom to Speak Up:
The Trust promotes a culture of openness and accountability by encouraging staff to raise concerns, including any circumstances that may indicate a risk of modern slavery or human trafficking. The Trust's Freedom to Speak Up arrangements provide staff with confidential routes to report concerns and access support, with matters considered through established governance processes to support oversight and learning.

Governance:
The Trust has established governance arrangements in place to support compliance with the Modern Slavery Act 2015. Modern slavery-related matters are overseen through relevant safeguarding, workforce, procurement and Board assurance processes, providing a framework for accountability, escalation and review.

Key actions to undertake in 2026/27:

In undertaking the requirements of the Trust under the Modern Slavery Act 2025 in 2026/27, CUH will:

- Continue to develop awareness within the Trust of modern slavery issues, strengthening the visibility of these issues within our reporting arrangements.
- Ensure that Procurement staff receive regular updates and training so that they are aware of legislative requirements in this area.
- Make suppliers and service providers aware that we expect them to understand and adhere to the requirements of the legislation.
- Strengthen the way in which modern slavery assurance is articulated through Board and sub-committee reporting, to provide clearer visibility of the basis on which assurance is being taken.

- Use NHS Terms and Conditions for Goods and Services for specification and tender documents which require suppliers to comply with all relevant legislation and guidance, including modern slavery conditions.
- Consider how future workforce and recruitment assurance activity can more explicitly reflect compliance with the Modern Slavery Act 2015.
- Only work with NHS framework approved agencies for the recruitment and placement of workers and employees, auditing compliance with safe recruitment practice.
- Ensure that all staff undertake mandatory Safeguarding Children and Vulnerable Adults training, and mandatory training in Equality, Diversity and Inclusion.
- Ensure that modern slavery and human trafficking is reflected in the Trust's safeguarding policies and work plans.
- Maintain robust Freedom to Speak Up arrangements which allow staff and others to raise concerns in confidence.

Cambridge University Hospitals NHS Foundation Trust

Report to Board of Directors – in public

held on

10th June 2026

Title	Annual nursing establishment review			
Report Sponsor	Lorraine Szeremeta, Chief Nurse			
Author	Amanda Small, Deputy Chief Nurse Emma Glover, Head of finance: Division D Carla Daly, Lead nurse for safe staffing			
Public/private	Public			
Status	**Decision** ☑	**Assurance** ☐	**Information** ☐	**Discussion** ☑

RECOMMENDATIONS

The Board of Directors is asked to:

- **NOTE** That the annual establishment review process for nurse staffing has been undertaken in line with our agreed methodology.
- **AGREE** The final recommendation following the establishment review process of a 9.83WTE increase in RN and a 3.84WTE reduction in HCSW compared to the 2025/26 nursing establishment to maintain safe staffing levels.

KEY MESSAGES

- The vacancy rate for the adult registered nurse (RN) workforce has remained consistently below 5% over the last year, with the most recent position reported at 4.2% in March 2026.
- The Health Care Support Worker (HCSW) vacancy rate has stabilised at 6.3%.
- The annual establishment review process for nurse staffing has been undertaken in line with our agreed methodology.
- In the majority of areas, no change to the nursing establishment has been recommended following SNCT data collection, professional judgement review and divisional check and challenge meetings which were held between November 2025 and March 2026.
- The final recommendation following the establishment review process is a 9.83WTE increase in RN and a 3.84WTE reduction in HCSW compared to the 2025/26 nursing establishment.
- In addition to the establishment review recommendations, there has been additional investment in establishment budgets in 2025/26 for which approval has already been sought and agreed through investment committee.

Cambridge University Hospitals NHS Foundation Trust

BACKGROUND, INCLUDING PURPOSE OF THE REPORT

This report provides assurance that arrangements are in place to review the Trust's nursing establishments in line with regulatory requirements. It details the outcome of the annual establishment review for the period from April 2025 to March 2026 based on the configuration of wards/units and clinical pathways that are currently in place to ensure that there is an operating and staffing model for the period ahead which is clinically, operationally and financially sustainable.

Following this process, the report recommends the nurse staffing establishments required to maintain safe staffing in 2026/2027.

ALIGNMENT TO TRUST STRATEGIC PRIORITIES

Our strategy: a healthier life for everyone through care, learning and research 2026-2031		**Indicate all that apply**
	Deliver Excellent and Timely Care	☑
	Transform How and Where We Deliver Care	☑
	Harness Research and Innovation to Improve Patient Outcomes	☐

ALIGNMENT TO MOST RELEVANT STRATEGIC RISK

BAF ref: 004 Quality of Care: The Trust fails to effectively balance the requirements of the financial pressures and requirements set out in the National Oversight Framework with delivery of high quality care that sustainably meets the needs of our population, adversely impacting the quality and safety of care and reducing patient experience.

PAPER REVIEW AND GOVERNANCE PATHWAY

Name of group or committee that has previously considered this report	**Date**
Nursing, Midwifery and Allied Health committee	27th May 2026
Management Executive	28th May 2026
Name of group or committee that the report will be presented to in the future	
Investment Committee	TBC

Cambridge University Hospitals NHS Foundation Trust

10th June 2026

Board of Directors

Annual Nurse staffing establishment review

1. Introduction and context

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

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

2. National and local nursing staffing context

2.1 Delivering sustainability within the nursing workforce is vital to ensuring that the health and social system has the right workforce in the right numbers to support high quality and safe care. The NHS long term workforce plan, published in June 2023, aimed to expand the nursing and midwifery workforce over 5 years by focusing on training, retaining and reforming the health workforce.

2.2 Whilst there has been a 22% increase in the nursing workforce compared to five years ago with 367,300 nurses and health visitors working within hospitals and community health services in England, the annual growth rate has significantly slowed down, hitting the lowest calendar-year increase since 2018. This is reflective of the NHS operating within a challenging context characterised by financial constraint, rising demand and ongoing workforce pressures.

2.3 The latest NHS priorities and operational planning guidance emphasises delivery of high-quality care within limited resources, with a clear focus on improving productivity, reducing unwarranted variation and maximising the efficient use of the existing workforce. There is continued emphasis on reducing reliance on International recruitment and temporary staffing, while strengthening domestic supply and retention. This increases the expectation that organisations maximise the

contribution of their existing workforce through optimised skill mix, improved deployment and more flexible ways of working aligned to patient acuity and demand.

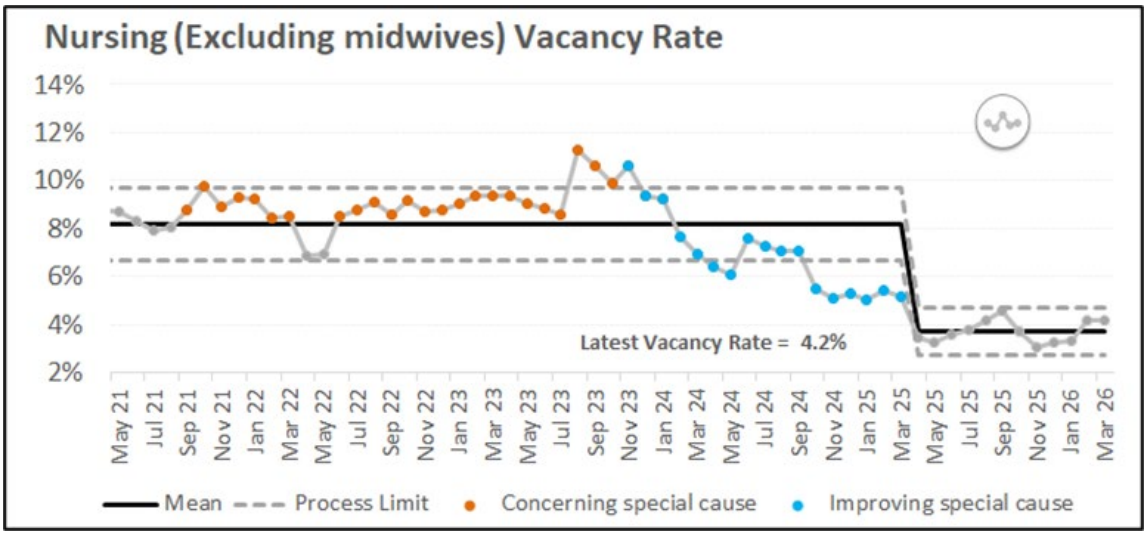
2.4 CUH has seen continued improvement in workforce stability, with reductions in vacancy rates, no requirement for international recruitment and increased retention of newly qualified staff trained within the organisation. However, significant operational pressures remain, including sustained demand, high patient activity and the ongoing requirement to open escalation and contingency capacity. These areas require staffing through redeployment or temporary solutions, placing pressure on core services. Workforce availability also continues to fluctuate due to short-term absence, requiring flexible deployment across clinical areas. While over establishment in some areas has supported this flexibility, it requires careful management to maintain safe and equitable staffing.

2.5 The most recent NHS priorities and operational guidance continues to emphasise the need for systems to operate within constrained financial envelopes and manage workforce growth carefully. The guidance reinforces that the expansion will be limited and highlights the continued financial pressures facing NHS organisations over the coming year. Accordingly, the annual establishment review has continued to focus on ensuring that CUH maintains safe Nurse staffing levels, while also identifying opportunities to enhance productivity, improve skill mix utilisation and deliver services as efficiently as possible within available resources.

3. Nursing Vacancy

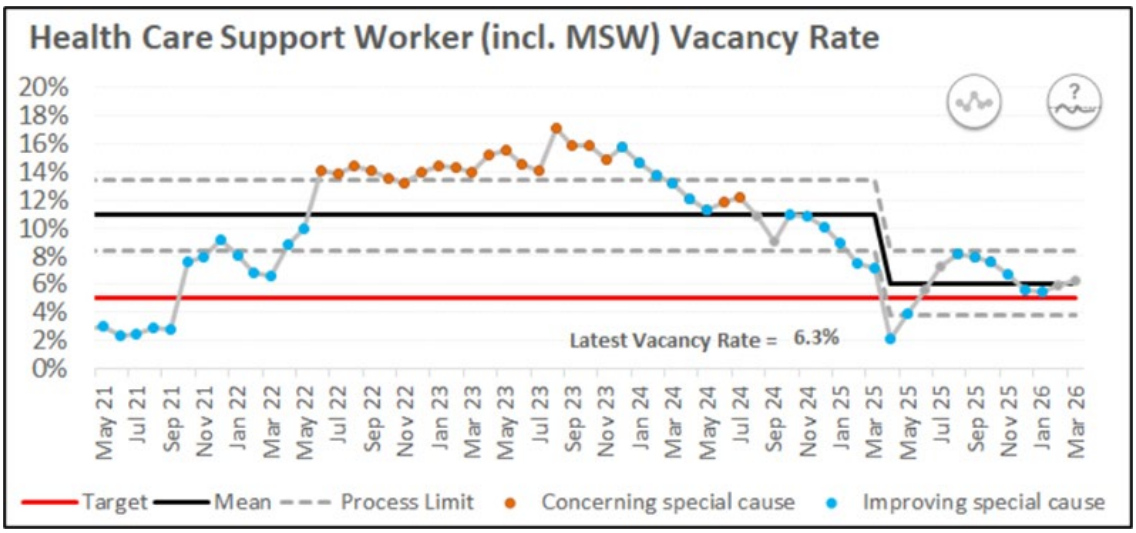
3.1 The vacancy rate for the adult registered nurse (RN) workforce has remained consistently below 5% over the last year, with the most recent position reported at 4.2% in March 2026. The most significant improvement within the registered workforce has been seen in the registered children's nursing workforce, where vacancy rates have reduced from 15.1% in February 2025 to 8.1% in March 2026. Figure 1 illustrates the CUH trend in nursing vacancy rates over the past four years.

Figure 1. Registered Nursing vacancy rates



3.2 The Health Care Support Worker (HCSW) vacancy rate rose significantly during the first half of the last financial year from a low of 2.2% in April 2025 to 7.3% in July 2025. The current position has stabilised at 6.3%. Figure 2 illustrates the trend in vacancy rate for HCSWs over the past four years.

Figure 2. Health care support worker vacancy rates.



4. Redeployment of staff to maintain safe staffing levels

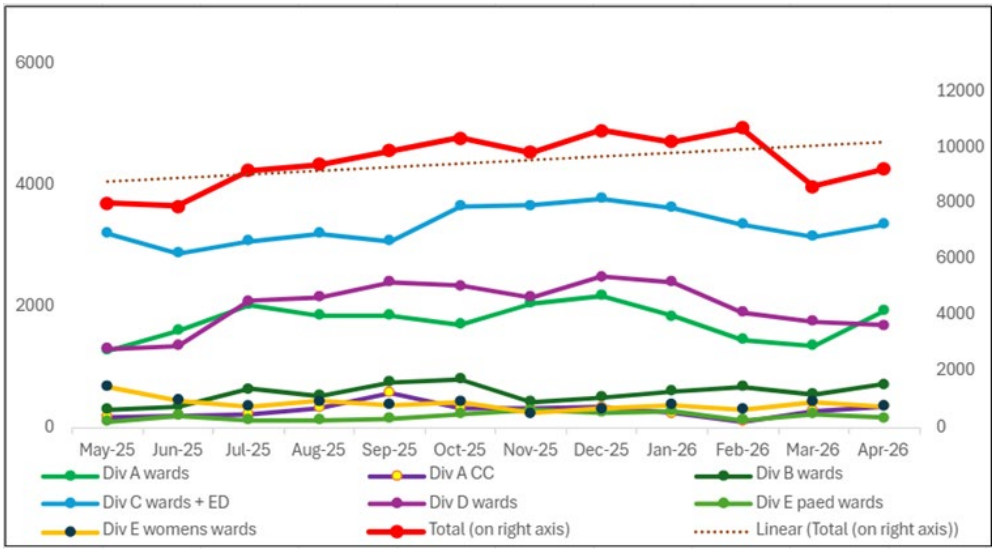
4.1 Over the last twelve months it has been necessary to open additional contingency areas to manage the increased activity within the trust and overcrowding in the emergency department. In total, there are four additional contingency areas that have been opened regularly when demand requires. At times of peak demand including during the winter period, additional temporary capacity has been opened (on top of the regular areas) to support service delivery. These contingency areas do not have an established team therefore require staffing through temporary arrangements, including redeployment of staff from other clinical areas or the use of bank staff.

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

4.3 The over establishment of some ward areas, resulting from the successful recruitment of newly qualified nurses who trained at CUH, has enabled greater flexibility in workforce deployment. Staff from over recruited areas have been

redeployed to support areas with vacancy gaps or high levels of staff unavailability. As a result, redeployment activity has remained relatively stable over the past 12 months, as illustrated in Figure 3.

Figure 3. Number of redeployed working hours per month



4.4 Over the past year, the senior nursing team have met at least daily, to ensure that there was oversight of staffing, safety, quality concerns and patient flow. Escalation of decision making that compromised recognised staffing ratios was provided to the management executive and the operational site team as necessary. The board of directors has also been updated as part of the monthly safe staffing report.

5. Care Hours per Patient Day (CHPPD)

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

5.2 The CHPPD data, along with Care Costs per Patient Day (CCPPD), are available on the Model Hospital to enable benchmarking. CHPPD trends have remained relatively static in the last financial year with the CHPPD total for nursing and midwifery (including HCSWs) within CUH ranging from 9.1 – 10.1. This is aligned to our peer organisations (Shelford), who range from between 9.3 and 10.2 CHPPD however the national median is slightly lower ranging between 8.9 – 9.2 CHPPD.

6. Nursing red flags

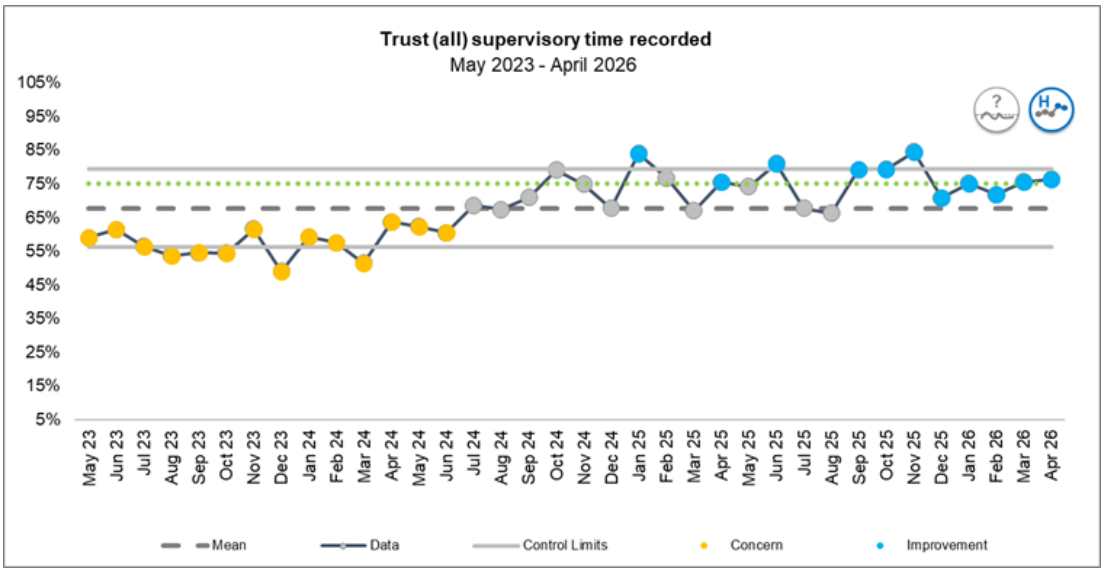
6.1 A staffing red flag event is a warning sign that something may be wrong with nurse staffing. If a staffing red flag event occurs, the registered nurse in charge of the service should be notified and necessary action taken to resolve the situation.

6.2 Staffing red flags are reported monthly to the board of directors through the safe staffing paper. Despite the improving staffing position, the number of nursing red flags reported in the last 12 months has been an increasing trend from a low of 54 red flags reported in May 2025 to 142 red flags reported in March 2026. The consistently highest red flag reported is in relation to a unmet 1-1 specialing requirement, this is likely to correlate with the increased HCSW vacancy resulting in difficulties filling any additional bank shifts raised to cover enhanced observation shifts. The risk associated with this is being addressed through the quality improvement project focusing on enhanced observations and the associated resource requirements.

7. Supervisory sister/charge nurse time

7.1 The Trust supports the ward Senior Sister/Charge Nurse to be in a supervisory capacity to enable delivery of high-quality care and positive patient experience. Figure 4 demonstrates that the supervisory time has been an improving trend over the last 12 months from a low of 67% at the end of the last financial year to 76% in March 2026. This correlates with the improving staffing position and will support senior sisters and charge nurses to be able to focus on quality improvement within their areas.

Figure 4. Percentage of senior sister/ charge nurse supervisory time



8. Nursing establishment setting process

8.1 Nursing workload and the ability to provide good care is influenced by many variables. No establishment setting tool can incorporate all factors. Therefore, combining the use of an evidence-based tool together with application of professional judgement and patient outcomes is required (NQB 2016, Shelford Group 2010, NICE 2014).

8.2 Data acquired from using the evidence-based tool is triangulated with the professional judgement of senior nurses to determine the right level and skill mix of nursing staff for each clinical ward area. Nurse sensitive indicators are used as part of the review to inform the establishment setting process.

8.3 At CUH the Safer Nursing Care Tool (SNCT) is used as the evidence base to guide nursing establishment reviews. The majority of adult wards utilise the SNCT and the paediatric wards utilise the Children's and Young People SNCT (C&YP SNCT) methodology.

8.4 The following areas in addition to inpatient wards and critical care areas have been included in this year's establishment review:

- Endoscopy
- Rapid response team
- Cambridge eye unit
- Emergency department including Paediatric ED and Clinic 5
- Discharge lounge
- Dialysis units
- Infusion centre
- Paediatric and Neonatal critical care transport service

8.5 It should be noted that the SNCT is not appropriate for all clinical areas. In these cases, professional judgement together with society or joint advisory guidelines are used as methodologies for nursing establishment setting.

8.6 Check and challenge meetings were held with ward sisters/charge nurses, Matrons, Deputy and Heads of Nursing, the Deputy Chief Nurse, the lead nurse for safe staffing, finance and workforce leads to ensure professional scrutiny was applied to decision making as per the establishment setting process.

8.7 There is further work to be undertaken with regards to the establishments required in theatres to maximise theatre utilisation. Division A are developing an investment case which outlines the benefits that can be achieved. From a staffing perspective, any increases in establishment will follow the same process as used in the annual

establishment setting process and will be subject to the check and challenge meetings.

9. Nursing establishment review outcome

9.1 The establishment review process has demonstrated that the current process for setting safe nurse staffing establishments is working well. In the majority of areas, no change to the nursing establishment has been recommended following SNCT data collection, professional judgement review and divisional check and challenge meetings which were held between November 2025 and March 2026.

9.2 There are 14 clinical areas where an increase in establishment has been recommended however the impact of this has been offset due to the number of areas where a decrease in establishment has been recommended. This is due to maximising the efficiency of the nursing rosters and reviewing nurse to patient ratios to improve productivity. The final recommendation following the establishment review process is a 9.83WTE increase in RN and a 3.84WTE reduction in HCSW compared to the 2025/26 nursing establishment. All of the changes of a result of the establishment review are summarised in Appendix I.

9.3 In addition to the establishment review recommendations, there has been additional investment in establishment budgets in 2025/26 for which approval has already been sought and agreed through investment committee. The majority of this investment has been in relation to increasing the capacity in the dialysis units, bringing the insourcing resource within endoscopy into the substantive workforce and commissioned pathway changes were external funding has been secured. Whilst these changes occurred outside of the establishment review process, the staffing review methodology has been applied to these areas to inform the safe staffing levels required and this information was included within the approved business cases. The investment cases agreed in year are summarised in Appendix 2.

9.4 The combined effect of the recommended changes following the establishment review process and the in year approved investment cases is a total increase of 24.99WTE RN, decrease of 3.84WTE HCSW and 1.20WTE specialing budget when compared to the 2025/26 agreed establishment

10. Critical care unit

10.1 The guidelines for the provision of intensive care services (GPICS) standards outline the staffing levels required to provide high quality and safe nursing care for critically ill patients. These standards are used to set the critical care establishment at CUH to ensure:

1. A nurse-to-patient ratio of 1:1 for all level 3 patients.
2. A minimum nurse to patient ratio of 1:2 for level 2 patients.

3. A supernumerary senior registered nurse who provides the supervisory clinical coordinator role on duty 24/7 and an additional supernumerary senior registered nurse for every additional 10 beds.

4. A dedicated Clinical Nurse Educator per 75 Nursing staff who is responsible for coordinating the education, training and development of the workforce and pre-registration student allocation.

5. An identified lead nurse who has overall responsibility for the nursing elements of the service.

10.2 The critical care complex has 59 beds which are used flexibly between level 2 and level 3 patients. The number of GPICS breaches in the last 12 months has been minimal. Management Executive have oversight of any breaches and the mitigation that has been put in place to maintain patient safety. The Board of Directors has also been updated as part of the monthly safe staffing report.

10.3 Critical care staffing has been reviewed as part of the annual establishment review which has demonstrated compliance with the GPICS standards.

11. Neonatal staffing

11.1 The British Association of Perinatal Medicine (BAPM) sets the standards for neonatal nurse staffing levels. The nursing establishment is activity adjusted using the BAPM neonatal clinical reference group nursing workforce calculator. The BAPM standard is that a NICU nurse establishment should be set on a minimum of 80% activity based on the retrospective calculation of bed days per level of care. Of the total nursing workforce, a minimum of 80% should be registered nurses (RN) with the remaining 20% of the workforce made up of unregistered roles. 70% of the total RN workforce should be qualified in specialty nurses (QIS) and hold a university accredited neonatal qualification.

11.2 NICU currently has 58 cots. Of these cots, 40 are currently commissioned as 12 Intensive care unit (ICU), 16 high dependency unit (HDU) and 12 special care baby unit (SCBU) cots, with the ability to use these flexibly depending on demand. The guidance states that the minimum nurse to baby ratio should be 1:1 for babies receiving intensive care (QIS nurses only), 1:2 for high dependency care (QIS nurses either directly delivering care or supervising registered nurses) and 1:4 for special care.

11.3 The total direct care nursing establishment for 80% activity is 139.72 WTE which the unit is established to with a skill mix of 90% RN (126.42WTE) and 10% unregistered (13.32WTE). The skill mix has been reviewed as part of the annual establishment review however due to the geographical layout of the unit, it is not possible to reduce the skill mix to 80% RN and 20% unregistered as this would impact upon the ability to ensure that a registered nurse was providing supervision to the unregistered staff to maintain patient safety.

11.4 Although the current staffing model complies with the BAPM minimum standards of 80% activity, the unit is running at a higher activity level thus resulting in staffing being compromised, particularly on a night shift. It is therefore recommended to increase the current registered nurse staffing by 2.86WTE to enable an additional RN to be rostered each night shift to maintain safe staffing levels.

11.5 The target QIS for the unit is 88WTE (based on the ratio of 70% QIS for the RN workforce providing hands on clinical care). Due to the current vacancy rate in NICU of 7% (14.15WTE), the unit is non-compliant with the QIS BAPM standard with 62WTE who hold a QIS. The division has actively over recruited into band 5 posts to support career development and succession planning to undertake the QIS course. In addition, there are a further 15.09WTE undertaking the QIS course currently. To mitigate any staffing shortages, a risk assessment of each ITU nursing care allocation is undertaken to maintain compliance with BAPM one to one care for sick neonates.

11.6 A recruitment and retention plan is in place to address the vacant positions and to increase the number of RN's with a QIS to improve compliance with BAPM standards.

12. Investment committee approval

12.1 The proposed establishments following the establishment review have been discussed with the Director of Finance who has confirmed that there is no requirement to seek Investment Committee approval.

Appendix 3 provides an overview of the finance related information presented to the Director of Finance.

13. Recommendations

The Board of Directors are asked to note that:

- That the annual establishment review process for nurse staffing has been undertaken in line with our agreed methodology.
- The final recommendation following the establishment review process is a 9.83WTE increase in RN and a 3.84WTE reduction in HCSW compared to the 2025/26 nursing establishment to maintain safe staffing levels.

14. Appendices

Appendix I. Proposed changes following establishment review by unit

Increases in establishment			
Division	**Unit**	**Difference compared to 25-26 establishment**	**Narrative/rationale**
Division A	U2	Increase HCSW specialing by 1WTE and increase HCSW roster by 0.84WTE	Increase specialing budget as consistently overspend by 1WTE in 25/26 due to requirement to support complex eating disorder patients. Converting a proportion of HCSW long days to short days due to flexible working pattern on ward.
Division A	M4	Increase HCSW specialing by 2.67WTE Increase RN by 0.14WTE	Conversion of a proportion of qualified long days to short shifts. Increased acuity and enhanced observations has led to overspend in specialing budget.
Division A	Endoscopy	Increase RN by 1.55WTE	Conversion of unregistered staff to registered staff to manage increased acuity of patients.
Division B	U3	Increase RNA by 0.94WTE	Due to increased acuity, have added an additional qualified (Registered Nursing Associate) to 4 days a week to give 7 day cover.
Division B	C9	Increase RN by 1.28WTE	Due to increased activity and acuity, SNCT supports an additional RN Mon - Fri for 7.5hrs (early).
Division C	D5	Increase specialing budget (HCSW) by 1WTE	Increased enhanced observation activity and overspent in previous year.
Division C	Discharge Lounge	Increase RN by 0.30WTE	Increased number of chairs therefore changed skill mix to ensure qualified staff cover
Division C	EAU5	Increase RN by 2.27WTE	Additional RN on nights due to increased acuity
Division C	Adult ED	Increase RN by 4.12WTE	Addition of team in ED to stream directly to assessment areas to improve patient flow (previous pilot).
Division D	A4	Increase HCSW by 0.36WTE	Requirement for short shifts

Increases in establishment			
Division	**Unit**	**Difference compared to 25-26 establishment**	**Narrative/rationale**
Division D	Lewin	Increase RN by 2.75WTE Increase specialing budget by 1.1WTE (HCSW)	Additional RN on nights due to increased acuity supported by SNCT outcome. Increased enhanced observation requirement has led to overspend in last financial year.
Division E	C3	Increase RNA by 2.63WTE	SNCT supports an increase in qualified staffing therefore Registered Nursing Associate added to night shifts
Division E	PANDA	Increase RN by 0.28WTE	Aligning budget template with actual worked roster.
Division E	NICU	Increase RN by 2.86WTE	Establishment currently set at 80% activity to comply with The British Association of Perinatal Medicine (BAPM) minimum standards however running at 100% activity therefore require an extra RN each night to meet 100% BAPM compliance.

Reductions in establishment			
Division	**Unit**	**Difference compared to 25-26 establishment**	**Narrative/rationale**
Division A	U2	Decrease RN by 0.34WTE	Increased utilisation of long days for qualified staff.
Division A	Eye unit	Decrease RN by 0.34WTE	Increased utilisation of long days for qualified staff.
Division A	Endoscopy	Decrease HCSW by 0.65WTE	Converted to qualified staff due to increase in patient acuity.
Division A	Surgical movement hub	Decrease RN by 1.71WTE Decrease HCSW by 0.89WTE	Increased utilisation of long days.
Division B	C10	Decrease RN by 0.34WTE	Increased utilisation of long days for qualified staff.
Division B	Radiology day unit	Decrease RN by 1.37WTE	Maximising efficiency of roster.
Division C	D5	Decrease RN by 0.46WTE Decrease HCSW by 0.34WTE	Increased utilisation of long days.
Division C	F4	Decrease RN by 0.07WTE	Removal of 1 short shift in week to reflect actual hours rostered.

Division C	G3	Decrease RN by 0.27WTE Decrease HCSW by 0.27WTE	Increased utilisation of long days.
Division C	Discharge lounge	Decrease HCSW by 1.07WTE	Increase in number of chairs therefore skill mix changed to ensure adequate qualified nurse cover
Division C	EAU 4	Decrease RN by 0.34WTE Decrease HCSW by 0.34WTE	Increased utilisation of long days.
Division C	EAU5	Decrease HCSW by 0.34WTE	Increased utilisation of long days
Division C	Adult ED	Decrease HCSW by 0.24WTE	Template aligned to actual worked roster
Division C	F5 & G5	Decrease RN by 0.14WTE Decrease HCSW by 0.14WTE	Increased utilisation of long days
Division C	F6	Decrease RN by 0.14WTE	Increased utilisation of long days
Division C	G6	Decrease RN by 0.34WTE Decrease HCSW by 0.34WTE	Increased utilisation of long days
Division D	A3	Decrease RN by 0.22WTE Decrease HCSW by 0.79WTE	Reduction in additional staff to support ward attenders (unqualified staff at weekend and qualified on a wednesday) - To be managed within roster aligned to SNCT recommendation
Division D	A4	Decrease RN by 0.24WTE Decrease Specialing budget by 3WTE (HCSW)	Increased utilisation of long days in qualified workforce. Reduction in enhanced observation requirement due to quality improvement project.
Division D	A5	Decrease RN by 0.34WTE Decrease HCSW by 0.21WTE Decrease Specialing budget by 3WTE	Increased utilisation of long days in qualified workforce. Reduction in enhanced observation requirement due to quality improvement project.
Division D	C7	Decrease specialling budget by 1WTE	Reduction in enhanced observation requirement due to quality improvement project.
Division D	L5	Decrease RN by 0.85WTE	Reduction of 1RN on weekend day.
Division E	C2	Decrease RN by 0.05WTE Decrease HCSW by 0.08WTE	Improved efficiency in roster.
Division E	Daphne	Decrease RN by 1.26WTE Decrease HCSW by 0.35WTE	Increased utilisation of long days.

Division E	F3	Decrease RN by 0.48WTE Decrease HCSW by 0.24WTE	Decreased length of night shift to 11hrs from 12hrs as rostered.
Division E	Charles Wolfson	Decrease HCSW by 2.63WTE	Reduction of 1 nursery nurse on each night shift as not required.
Division E	Paediatric day unit	Decrease HCSW by 0.95WTE	Reduction of a HCSW on a late shift.

Appendix 2. Additional investment committee approved establishments for reconfiguration or service changes in 2025/26

Division	Unit	Difference compared to 25-26 establishment	Narrative/rationale
Division A	Endoscopy	Increase RN by 5.51WTE	5.51WTE RN increase was approved via investment committee in year due to insourcing ceasing and substantive staff being employed to manage activity.
Division A	L4	Increase RN by 1WTE	Investment case in year.
Division A	MT Anaesthetics	Increase Qualified by 2.56WTE	Budget correction.
Division A	Recovery	Increase RN by 0.17WTE	Investment case in year.
Division C	Dialysis: Hinchingbrooke	Increase RN by 1.64WTE Increase HCSW by 0.82WTE	Investment case approved in year to increase the number of dialysis stations from 8 to 12 on twilight shift
Division C	Dialysis: Cambridge	Increase RN by 1.64WTE Increase HCSW by 0.82WTE	Investment case approved in year to increase the number of dialysis stations to 32 on twilight shift, 3 days per week.
Division C	Dialysis: Kings Lynn	Increase RN by 1.64WTE Increase HCSW by 1.54WTE	Investment case approved in year to increase the number of dialysis stations from 14 to 17 on twilight shift, 6 days per week
Division D	J2	Increase RN by 1WTE Increase HCSW by 1WTE	Commissioned by NHSE for spinal cord pathway

SNCT 26-27 – Trust overview

	Change In Rota's 26-27 vs 25-26					26-27 PROPOSED ROTA'S								Narrative
	Q	UQ	Enhanced Obs	Change In Q proposed vs 25-26 Budget	Change In UQ proposed vs 25-26 Budget	Q 26-27 WTE	UQ 26-27 WTE	Enh Obs WTE	Q 26-27 Budget	UQ 26-27 Budget	IC Approved Cases	Other	Balance	
Division A	(8.54)	0.06	(2.67)	(£329,691)	(£197,381)	1,245.14	439.93	23.84	68,681,826	17,471,188	(£508,439)	(£14,800)	(£3,833)	Additional staffing requests for Wards M4, U2 and Endoscopy - all covered off with savings elsewhere.
Division B	(0.51)	0.00	0.00	£26,585	(£40,975)	211.20	82.91	0.80	10,905,086	3,055,466	£0	£0	(£14,390)	Additional staffing requests for Wards C9 & U3
Division C	(9.86)	(0.09)	(2.03)	(£202,022)	(£107,440)	784.17	406.96	25.49	43,257,109	17,004,165	(£338,900)	£0	£29,438	Investment requests full covered off by other savings across Division C
Division D	(2.10)	(0.37)	5.90	£52,362	£149,034	316.72	195.62	25.00	17,296,981	8,773,095	£0	£0	£201,396	Investment requests fully covered off by other savings across Division D. Only main area of investment is for the Lewin partially linked to Thrombectomy
Division E	(3.98)	4.24	0.00	(£149,071)	£140,282	404.13	89.17	-	23,309,536	3,635,441	(£17,865)	£0	£9,076	Investment requests full covered off by other savings across Division E
Totals	(24.99)	3.84	1.20	(£601,839)	(£56,479)	2,961.37	1,214.58	75.13	163,450,538	49,939,355	(£865,204)	(£14,800)	£221,686	

Division A – Investment requests for wards M4, U2 & Endoscopy are all covered off with savings from elsewhere. No change to the atres.
Division B – Investment requests for wards C9 & U3 partially covered off with other savings. Division will need to find the add itional budget
Division C – Investment requests, predominantly EAU 5, are fully covered off by other savings across the Division
Division D – Investment requests for the Lewin linked to Thrombectomy have been fully absorbed. Decreases in Specialling drives the saving for PEP
Division E – Investment requests for NICU are fully covered off with savings.

Cambridge University Hospitals NHS Foundation Trust

Division A

	Change in Rota's 26-27 vs 25-26					26-27 PROPOSED ROTA'S								
	Q	UQ	Enhanced Obs	Change in Q proposed vs 25-26 Budget	Change in UQ proposed vs 25-26 Budget	Q 26-27 WTE	UQ 26-27 WTE	Enh Obs WTE	Q 26-27 Budget	UQ 26-27 Budget	IC Approved Cases	Other	Balance	Narrative
C8 - Orthopaedics	0.00	0.00	0.00	£49,976	(£15,083)	34.94	22.02	5.50	£1,855,387	£1,086,261	£0	0.00	£34,893	Added B4 on the Qualified side for an Earlies & Nights
D8 – 36	0.00	0.00	0.00	£24,218	(£12,735)	34.94	22.02	11.00	£1,881,145	£1,303,378	£0	0.00	£11,483	
L4- 32	(1.00)	0.00	0.00	(£49,384)	(£7,729)	36.86	16.99	2.67	£2,013,921	£790,318	£84,968	0.00	£27,854	
M4 – 32	(0.14)	0.00	(2.67)	£16,311	(£114,082)	35.52	16.51	2.67	£1,917,924	£772,834	£0	0.00	(£97,771)	Conversion to long days to short shifts plus specialling added
ICU	0.00	0.00	0.00	(£29,207)	£33,461	148.69	23.09	-	£8,915,411	£928,558	£0	0.00	£4,253	
NCCU	0.00	0.00	0.00	(£21,431)	£41,852	174.52	28.86	-	£10,388,870	£1,160,698	£0	0.00	£20,421	
D4	0.00	0.00	0.00	(£10,133)	£16,755	47.18	11.54	-	£2,754,131	£464,279	£0	0.00	£6,622	
Endoscopy	(7.06)	0.65	0.00	(£457,255)	(£13,613)	48.15	16.56	-	£2,472,057	£618,515	£406,935	0.00	(£63,933)	Swapped UQ for Q reflecting increase in acuity
POA	0.00	0.00	0.00	(£3,221)	(£1,126)	22.20	3.50	-	£1,192,149	£115,795	£0	0.00	(£4,346)	
L2	0.00	0.00	0.00	£397	(£6,420)	34.50	19.28	-	£1,675,679	£656,405	£0	0.00	(£6,023)	
RRT	0.00	0.00	0.00	(£903)	£0	19.51	-	-	£1,436,888	£0	£0	0.00	(£903)	
CEU Ward	0.34	0.00	0.00	£21,224	(£1,229)	11.56	3.93	-	£543,105	£126,713	£0	0.00	£19,995	
Wards P2 & Q2	1.71	0.89	0.00	£114,541	£27,133	25.82	12.39	-	£1,339,882	£436,059	£0	0.00	£141,674	Conversion of some short shifts to long days
40 Bedder Recovery	0.00	0.00	0.00	£0	(£1,274)	9.52	0.38	-	£468,256	£12,533	£0	1,273.56	£0	
40 Bedder Theatre	0.00	0.00	0.00	£650	(£38,468)	20.80	11.28	-	£1,027,314	£378,542	£0	37,817.71	£0	
SAU D6	0.00	0.00	0.00	(£1,670)	(£49,158)	32.71	13.76	-	£1,777,451	£589,260	£0	0.00	(£50,828)	
U2	0.34	(1.48)	0.00	£40,249	(£87,474)	30.10	17.99	2.00	£1,642,945	£803,583	£0	0.00	(£47,225)	Added in short shifts for UQ and increased specialling
Unit 1 Th	0.00	0.00	0.00	£0	£37,275	17.97	15.60	-	£969,601	£565,552	£0	(37,275.14)	£0	
Unit 2 Th	0.00	0.00	0.00	£0	£13,851	54.49	52.86	-	£3,043,035	£2,029,155	£0	(13,850.74)	£0	
Unit 3 Th	0.00	0.00	0.00	£0	£116,911	32.48	29.06	-	£1,583,841	£1,006,164	£0	(116,911.01)	£0	
MT Anaesthetics	(2.56)	0.00	0.00	(£112,553)	£0	54.50	-	-	£2,804,751	£0	£0	112,552.87	£0	
Extra ODPs	0.00	0.00	0.00	£0	£0	2.65	-	-	£115,746	£0	£0	0.00	£0	
Bleep 788 & 585	0.00	0.00	0.00	£0	£0	8.44	-	-	£618,478	£0	£0	0.00	£0	
ATC Theatres	0.00	0.00	0.00	£33,742	(£37,279)	39.62	24.26	-	£2,036,178	£834,627	£0	3,537.02	£0	
Rosie Theatres	0.00	0.00	0.00	(£15,833)	(£40,206)	23.03	14.94	-	£1,299,098	£604,854	£0	56,038.83	£0	
Rosie Anaesthetics	0.00	0.00	0.00	£34,265	£0	7.22	-	-	£368,244	£0	£0	(34,264.53)	£0	
Neuro	0.00	0.00	0.00	£0	(£8,356)	26.96	23.91	-	£1,393,461	£864,206	£0	8,355.66	£0	
Neuro Anaesthetics	0.00	0.00	0.00	£5,243	£0	19.84	-	-	£1,066,106	£0	£0	(5,242.53)	£0	
CEU Theatres	0.00	0.00	0.00	£9,280	(£2,702)	12.97	8.55	-	£625,385	£275,462	£0	(6,578.03)	£0	
Ely Ths	0.00	0.00	0.00	(£9,224)	(£6,100)	23.62	19.66	-	£1,140,196	£643,534	£0	15,323.79	£0	
Ely Anaesthetics	0.00	0.00	0.00	£14,521	£0	3.93	-	-	£173,702	£0	£0	(14,520.65)	£0	
Weekend WLI	0.00	0.00	0.00	£0	(£37,206)	4.62	2.31	-	£334,420	£126,391	£0	37,205.96	£0	
On Call	0.00	0.00	0.00	£0	£0	6.43	-	-	£353,088	£0	£0	0.00	£0	
Recovery	(0.17)	0.00	0.00	£7,430	(£1,323)	110.71	6.92	-	£5,817,577	£218,524	£16,536	(22,643.01)	(£0)	
Paeds Recovery 1	0.00	0.00	0.00	£2,533	(£2,802)	13.23	1.58	-	£666,468	£53,277	£0	269.33	£0	
Paeds Recovery 2	0.00	0.00	0.00	£6,544	(£255)	0.92	0.17	-	£40,130	£5,712	£0	(6,289.24)	£0	
Major Trauma	0.00	0.00	0.00	£0	£0	14.00	-	-	£929,804	£0	£0	0.00	£0	
Grand Total	**(8.54)**	**0.06**	**(2.67)**	**(£329,691)**	**(£197,381)**	**1,245.14**	**439.93**	**23.84**	**68,681,826**	**17,471,188**	**£508,439**	**£14,800**	**(£3,833)**	

NHS
Cambridge
University Hospitals
NHS Foundation Trust

Division B

	Change in Rota's 26-27 vs 25-26					26-27 PROPOSED ROTA'S								
	Q	UQ	Enhanced Obs	Change in Q proposed vs 25-26 Budget	Change in UQ proposed vs 25-26 Budget	Q 26-27 WTE	UQ 26-27 WTE	Enh Obs WTE	Q 26-27 Budget	UQ 26-27 Budget	IC Approved Cases	Other	Balance	Narrative
C10 – 15	0.34	0.00	0	£31,365	(£2,174)	24.50	5.50	0.69	£1,387,044	£221,755	£0	0.00	£29,191	
U3 - 30	(0.94)	0.00	0	£18,812	(£24,762)	40.83	19.26	-	£2,167,489	£767,205	£0	0.00	(£5,949)	0
D9 – 33	0.00	0.00	0	£22,387	(£21,486)	33.10	21.54	-	£1,807,491	£851,415	£0	0.00	£901	
C9 – 8	(1.28)	0.00	0	(£43,869)	(£2,226)	17.58	5.50	0.11	£966,006	£226,187	£0	0.00	(£46,095)	SNCT supported an increase due to increased activity and acuity. Addl RN M-F to 7.5 hrs
Cancer Assessment Unit	0.00	0.00	0	£0	£0	12.53	2.32	-	£657,600	£73,111	£0	0.00	£0	
Oncology Day Unit	0.00	0.00	0	£11,159	£6,284	25.03	5.32	-	£1,210,985	£174,383	£0	0.00	£17,443	
Haematology Day Unit	0.00	0.00	0	£10,924	£6,427	27.57	5.59	-	£1,276,099	£178,476	£0	0.00	£17,351	
Radiology Day Unit	1.37	0.00	0	(£24,194)	(£3,037)	30.07	17.86	-	£1,432,373	£562,933	£0	0.00	(£27,231)	
Grand Total	**(0.51)**	**0.00**	**0.00**	**£26,585**	**(£40,975)**	**211.20**	**82.91**	**0.80**	**10,905,086**	**3,055,466**	**£0**	**£0**	**(£14,390)**	

Cambridge University Hospitals
NHS Foundation Trust

Division C

	Change in Rota's 26-27 vs 25-26					26-27 PROPOSED ROTA'S								
	Q	UQ	Enhanced Obs	Change in Q proposed vs 25-26 Budget	Change in UQ proposed vs 25-26 Budget	Q 26-27 WTE	UQ 26-27 WTE	Enh Obs WTE	Q 26-27 Budget	UQ 26-27 Budget	IC Approved Cases	Other	Balance	Narrative
C4 – 29	0.00	0.00	0	£33,544	(£8,645)	29.07	19.74	2.51	£1,559,727	£884,722	£0	0.00	£24,899	
C5 – 23	0.00	0.00	0	(£1,081)	(£7,650)	32.50	19.50	1.00	£1,734,394	£782,466	£0	0.00	(£8,731)	Converted to B5's to B6's
C6 – 26	0.00	0.00	0	£20,975	(£8,626)	26.69	19.74	2.50	£1,424,602	£884,324	£0	0.00	£12,349	
D10 – 11	0.00	0.00	0	£12,666	(£2,173)	15.26	5.50	-	£831,690	£221,755	£0	0.00	£10,493	
D5 – 30	0.46	0.34	-1	£52,181	(£34,036)	31.80	13.90	3.10	£1,730,640	£673,942	£0	0.00	£18,145	
F4 – 21	0.07	0.00	0	£16,766	(£6,216)	20.84	14.24	1.85	£1,157,886	£636,347	£0	0.00	£10,550	
											£0	0.00	(£35,995)	
G2	0.00	0.00	0	(£32,802)	(£3,193)	17.51	8.38	-	£999,024	£328,389				Increased 6's from 2 to 6
G3 – 27	0.27	0.27	0	£30,566	£1,114	26.41	19.47	1.00	£1,448,008	£815,519	£0	0.00	£31,680	
Dialysis - Hinch	(1.64)	(0.82)	0	(£80,333)	(£36,891)	16.19	6.31	-	£788,197	£211,954	£117,224	0.00	£0	
Dialysis - Cambs	(1.64)	(0.82)	0	(£70,758)	(£16,564)	32.53	9.41	-	£1,547,288	£315,420	£87,322	0.00	£1	
Dialysis - Kings Lynn	(1.64)	(1.54)	0	(£77,741)	(£56,964)	17.22	6.26	-	£826,944	£214,361	£134,354	0.00	(£352)	0
Dialysis - West Suffolk	0.00	0.00	0	(£5,141)	(£1,548)	12.30	3.28	-	£593,777	£107,649	£0	0.00	(£6,689)	
Cambs Infusion Centre	0.00	0.00	0	(£7,620)	(£2,208)	17.43	4.38	-	£894,749	£153,758	£0	0.00	(£9,828)	
Discharge Lounge	(0.30)	1.07	-1.025641026	(£18,276)	£4,836	5.39	1.92	1.03	£267,472	£95,034	£0	0.00	(£13,440)	
EAU4 – 13 beds +13 trolleys	0.34	0.34	0	(£6,508)	£3,690	29.07	19.40	1.00	£1,619,307	£812,952	£0	0.00	(£2,818)	
EAU5 – 26	(2.27)	0.34	0	(£134,106)	£4,486	28.96	16.65	2.00	£1,607,175	£751,428	£0	0.00	(£129,620)	Reinstated 1Q on nights
Clinic 5 - Amb Care	0.00	0.00	0	(£1,728)	(£2,005)	9.88	6.12	-	£519,492	£205,290	£0	0.00	(£3,733)	
Paeds ED	0.00	0.00	0	(£4,693)	(£4,532)	20.40	11.49	-	£1,213,731	£462,290	£0	0.00	(£9,224)	
Adult ED	(4.12)	0.24	0	(£72,684)	£107,099	156.22	72.27	-	£9,228,256	£2,933,133	£0	0.00	£34,415	
ED ENPs	0.00	0.00	0	£0	£0	12.72	-	-	£962,852	£0	£0	0.00	£0	
F5HDU – 5 & G5 - 30	0.14	0.14	0	£35,434	(£718)	54.78	14.10	-	£2,989,211	£558,379	£0	0.00	£34,716	
F6 – 27	0.14	0.00	0	£23,427	(£8,635)	23.59	19.74	2.50	£1,255,854	£884,324	£0	0.00	£14,792	
G4 – 27	0.00	0.00	0	£18,676	(£8,558)	23.66	19.47	2.50	£1,257,876	£874,606	£0	0.00	£10,119	
G6 – 27	0.34	0.34	0	£32,805	£3,317	23.59	19.40	2.50	£1,248,601	£872,360	£0	0.00	£36,122	
N2 – 12 beds trolleys 10	0.00	0.00	0	£20,184	(£7,081)	29.10	16.99	1.00	£1,599,302	£723,190	£0	0.00	£13,103	
EAU3 - 24 Chairs	0.00	0.00	0	(£20,473)	(£4,515)	18.03	11.49	-	£1,034,771	£461,239	£0	0.00	(£24,988)	Increased B6's to allow one on every shift
T2- 19	0.00	0.00	0	£10,648	(£5,436)	18.60	13.76	-	£1,040,040	£545,449	£0	0.00	£5,212	
N3 – 25	0.00	0.00	0	£24,049	(£5,787)	34.41	14.03	1.00	£1,876,244	£593,884	£0	0.00	£18,262	
Grand Total	**(9.86)**	**(0.09)**	**(2.03)**	**(£202,022)**	**(£107,440)**	**784.17**	**406.96**	**25.49**	**43,257,109**	**17,004,165**	**£338,900**	**£0**	**£29,438**	

Cambridge University Hospitals NHS Foundation Trust

Division D

	Change in Rota's 26-27 vs 25-26					26-27 PROPOSED ROTA'S									
	Q	UQ	Enhanced Obs	Change in Q proposed vs 25-26 Budget	Change in UQ proposed vs 25-26 Budget	Q 26-27 WTE	UQ 26-27 WTE	Enh Obs WTE	Q 26-27 Budget	UQ 26-27 Budget	IC Approved Cases	Shorter Shifts Roll Back	Other	Balance	Narrative
A3 - 8	0.22	0.79	0	£20,693	£35,408	13.34	7.47	-	£741,473	£285,111	£0	£0	0.00	£56,101	Reduction in UQ at weekends and a Q on a Wednesday
A4 – 26	0.24	(0.36)	3	£25,400	£96,422	29.85	24.03	2.50	£1,642,571	£1,041,605	£0	£0	0.00	£121,822	
A5 – 28	0.34	0.21	3	£30,179	£114,598	29.75	25.04	2.50	£1,637,791	£1,099,378	£0	£0	0.00	£144,778	
D7 – 31	0.00	0.00	0	£20,686	(£9,357)	30.01	19.74	4.30	£1,629,852	£955,886	£0	£0	0.00	£11,329	
C7 – 33	0.00	0.00	1	£25,349	£28,462	36.43	22.02	7.00	£1,962,887	£1,169,035	£0	£0	0.00	£53,811	
J2 -21	(1.00)	(1.00)	0	(£53,361)	(£42,573)	22.35	26.25	-	£1,251,739	£1,048,941	£0	£0	0.00	(£95,934)	SCI Beds
K3 – 31 – CCU 10 and K3 21	0.00	0.00	0	£26,035	(£5,325)	38.14	13.76	-	£2,073,472	£545,449	£0	£0	0.00	£20,709	
L5 – 32	0.85	0.00	0	£77,745	(£6,598)	33.88	16.79	-	£1,818,123	£675,895	£0	£0	0.00	£71,147	
Lewin 26	(2.75)	0.00	-1.1	(£166,595)	(£50,314)	24.81	15.20	4.00	£1,372,253	£756,206	£0	£0	0.00	(£216,909)	1 RN on a nightshift & Increased specialling budget
M5 – 32	0.00	0.00	0	£30,053	(£7,850)	34.94	16.99	3.00	£1,874,923	£803,583	£0	£0	0.00	£22,208	0
R2 – 14	0.00	0.00	0	£16,177	(£3,837)	23.22	8.32	1.70	£1,291,898	£392,004	£0	£0	0.00	£12,340	
Grand Total	(2.10)	(0.37)	5.90	£52,362	£149,034	316.72	195.62	25.00	17,296,981	8,773,095	£0	£0	£0	£201,396	

NHS
Cambridge University Hospitals
NHS Foundation Trust

Division E

	Change In Rota's 26-27 vs 25-26					26-27 PROPOSED ROTA'S								
	Q	UQ	Enhanced Obs	Change In Q proposed vs 25-26 Budget	Change In UQ proposed vs 25-26 Budget	Q 26-27 WTE	UQ 26-27 WTE	Enh Obs WTE	Q 26-27 Budget	UQ 26-27 Budget	IC Approved Cases	Other	Balance	Narrative
C2- 17	0.05	0.08	0	£23,528	£2,302	39.42	11.66	-	£2,142,909	£474,132	£0	0.00	£25,831	
C3 – 12	(2.63)	0.00	0	(£116,470)	(£3,685)	27.13	9.78	-	£1,479,425	£392,035	£0	0.00	(£120,156)	Offset by saving on Charles Wilson Ward
D2 – 21	0.00	0.00	0	£22,281	(£5,128)	33.87	13.37	-	£1,848,134	£554,417	£0	0.00	£17,153	
DAPHNE	1.26	0.35	0	£86,419	£7,688	15.06	8.39	-	£804,920	£330,404	£0	0.00	£94,107	
F3 – 26 (daycase ward) open ov	0.48	0.24	0	£36,820	£4,379	23.48	10.77	-	£1,213,658	£402,143	£0	0.00	£41,199	
Charles Wilson Ward	0.00	2.63	0	(£4,125)	£115,500	18.25	2.87	-	£1,084,878	£128,181	£0	0.00	£111,376	Offset on C3
Paediatric Day Unit	0.00	0.95	0	£2,803	£29,779	12.91	4.70	-	£626,757	£151,504	£0	0.00	£32,582	
PANDA	(0.28)	0.00	0	(£19,369)	£0	12.81	-	-	£843,706	£0	£17,865	0.00	(£1,504)	
ANTS	0.00	0.00	0	(£1,265)	£0	9.96	-	-	£643,591	£0	£0	0.00	(£1,265)	
PICU/HDU 13	0.00	0.00	0	£30,721	(£5,048)	81.95	14.31	-	£4,838,435	£607,267	£0	0.00	£25,673	
NICU	(2.86)	(0.00)	0	(£210,416)	(£5,505)	129.28	13.32	-	£7,833,125	£595,358	£0	0.00	(£215,920)	Need an extra RN on night to meet 100% BAPM compliance
Grand Total	(3.98)	4.24	0.00	(£149,071)	£140,282	404.13	89.17	-	23,309,536	3,635,441	£17,865	£0	£9,076	

Cambridge University Hospitals NHS Foundation Trust

Report to Board of Directors – in public

held on 10th June 2026

Title	Perinatal bi-annual integrated workforce report (Maternity Incentive Scheme year 8)			
Report Sponsor	Lorraine Szeremeta, Chief Nurse			
Author	Heather Gallager Director of Midwifery Claire Garratt, Head of Midwifery Rajiv Chaudhary Clinical Director Obstetrics Shazia Hoodboy Clinical Lead Neonates Lisa Walker Deputy Head of Nursing Children's Gary Davenport Specialty Lead Obstetric Anaesthetics			
Public/private	Public			
Status	**Decision** ☑	**Assurance** ☐	**Information** ☐	**Discussion** ☑

RECOMMENDATIONS

The Board of Directors is asked to:

REVIEW the current perinatal workforce position in terms of compliance with National Institute for Health and Care Excellence (NICE), Royal College of Obstetricians and Gynaecologists (RCOG), British Association of Perinatal Medicine (BAPM) and Maternity Incentive Scheme (MIS) Year 8 requirements. Note trajectory and requirements for MIS compliance for Safety Action A.

KEY MESSAGES

This bi-annual integrated workforce report presents a clear picture of staffing levels, vacancies, sickness and reliance on temporary staffing across all obstetric, midwifery, neonatal, anaesthetic and perioperative teams working in maternity services, for the 6-month period December 2025 to May 2026. The paper aims to provide assurance regarding the adequacy, sustainability and effectiveness of the perinatal workforce and demonstrate compliance against national workforce standards.

Perinatal services demonstrate some compliance with national workforce standards across obstetrics, neonatal medical and anaesthetic services. However further work is needed, due to gaps in assurance around in in post midwifery establishment, neonatal nursing QIS compliance, and workforce intelligence for capacity planning. There are no immediate patient safety concerns, but sustained risks require active mitigation and Board oversight, particularly:

Recruitment to the Midwifery staffing shortfall (Birth Rate+ gap)
Neonatal nursing skill mix (Qualified In Speciality compliance)
Capacity vs demand analysis and the impact on all perinatal workforce

Overall Perinatal Workforce Assurance: AMBER

BACKGROUND, INCLUDING PURPOSE OF THE REPORT

Midwifery Workforce
-11.2 Whole Time Equivalent (WTE) vs Birth Rate Plus (BR+) requirement, “Felt gap” up to -20.34 WTE
Vacancy rate ~10%
High reliance on bank/agency (up to 33 WTE)
Impact, increased workload pressure, higher sickness absence, red flag data quality concerns
Mitigation underway, Investment case funding agreed. Active recruitment underway

Obstetric Medical
Obstetric workforce investment: reduced locum use, improved consultant presence, rota resilience and patient safety

Neonatal Nursing
QIS Compliance Current: 56% QIS (target 70%)
Vacancy rate: 7% (14.15 WTE)
Risk: Non-compliance with BAPM standards
Mitigation underway, 15 WTE in QIS training with improvement trajectory to ~70% by end 2026

Neonatal Medical
Compliant with Tiering as outlined in the BAPM guidance however further capacity and demand and workforce intelligence is needed to inform the workforce needs assessment

Workforce Capacity vs Demand (System Risk)
Limited triangulation of safety, capacity and outcomes
New MIS requirement for: Demand-capacity modelling, Theatre delay analysis with future activity projections
Mitigation underway; Capacity and demand modelling across the whole perinatal pathway and further analysis of workforce intelligence to understand workforce needs.

Anaesthetic Resilience
Compliant with minimum 24/7 cover
Risk; No dedicated programmed activity (PA) for obstetric lead, need for second duty anaesthetist.
General Medical Council (GMC) survey results highlight concerns with existing staffing models due to high activity and acuity leading to potential safety risks
Mitigation: business case underway and ongoing work with the anaesthetic department to mitigate that risk whilst this is underway

Data Quality & Assurance Gaps
BR+ red flag reporting only 67% completion (target >85%)
Datix reporting highlights likely under-reporting of staffing issues
Limited patient experience triangulation

Strengths to Highlight
% 1:1 care in labour achieved
Strong governance framework emerging: Bi-annual workforce reporting established with alignment with MIS

ALIGNMENT TO TRUST STRATEGIC PRIORITIES

Our strategy: a healthier life for everyone through care, learning and research 2026-2031		Indicate all that apply
	Deliver Excellent and Timely Care	☑
	Transform How and Where We Deliver Care	☐
	Harness Research and Innovation to Improve Patient Outcomes	☐

ALIGNMENT TO MOST RELEVANT STRATEGIC RISK

BAF002 – Effectiveness: Failure to deliver effective care for which practitioners have relevant expertise.

PAPER REVIEW AND GOVERNANCE PATHWAY

Name of group or committee that has previously considered this report	**Date**
Not applicable	
Name of group or committee that the report will be presented to in the future	
Not applicable	

Cambridge University Hospitals NHS Foundation Trust

10th June 2026

Board of Directors

Perinatal Bi-annual integrated workforce report

1. Introduction and context

This bi-annual integrated workforce report presents a clear picture of staffing levels, vacancies, sickness, rota gaps, and reliance on temporary staffing across all obstetric, midwifery, neonatal, anaesthetic and perioperative teams working in maternity services, for the 6-month period December 2025 to May 2026. The paper aims to provide assurance regarding the adequacy, sustainability and effectiveness of the perinatal workforce and demonstrate compliance with national workforce standards.

National and local reviews (Ockenden, Kirkup, MBRRACE, NHS Resolution) repeatedly highlight that perinatal workforce shortfalls (including rota gaps, lack of trained multi-professional team and insufficient senior presence), and capacity constraints resulting in delays to planned caesarean births are key contributors to avoidable harm, and poor experiences for women, babies, and staff.

To be compliant with the Maternity Incentive Scheme (MIS) Year 8 Safety Action A – Workforce and Capacity Safe Staffing - Trusts must demonstrate that funded establishments for Obstetric, Midwifery, Neonatal, Anaesthetic, and Perioperative teams meet nationally recognised workforce standards.

2. Minimal Workforce Requirements for MIS Year 8

Consultant attendance (Obstetric). Compliance with RCOG “Roles and Responsibilities of the Consultant providing acute care” standard: ≥80% consultant presence in defined acute care situations.

Short-term locum certification (Obstetric). Trusts must ensure locum certification and maintain a local (Trust-specific), continuously updated database of all short-term locums. Eligibility must be verified before first engagement and reviewed annually for all locums on the register.

Neonatal workforce establishment (Nursing & Medical) Trusts must have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant British Association of Perinatal Medicine (BAPM) standards and the neonatal nursing workforce calculator output.

Midwifery workforce establishment Trusts must have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline.

Anaesthetic workforce Trusts must ensure that Obstetric maternity services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2.

Capacity to deliver planned and emergency care. Trusts must demonstrate that capacity is sufficient to deliver timely elective and emergency maternity/neonatal care. Trusts do not need to prove that delays never occur. They must demonstrate that delays are detected, analysed, reported and that persistent issues are escalated.

Planned Caesarean birth capacity mapping Trusts must undertake annual demand–capacity mapping for planned Caesarean birth lists, covering the full pathway.

Governance, escalation, and improvement: Trusts must have a governance system that ensures workforce and capacity risks are monitored, scrutinised and escalated appropriately. This should include a six-monthly integrated workforce report covering maternity and neonatal staffing levels.

3. Workforce Review Process

As part of the integrated report the midwifery, obstetric, neonatal and anaesthetic workforce has been reviewed by the professional and clinical leads of those services, and has encompassed assessments on workforce sustainability, training and education, safety and quality indicators and capacity and demand, ensuring that the review is robust and conducted in alignment with national workforce standards.

- National Institute for Health and Care Excellence (NICE) NG4 Safe Midwifery Staffing (2015)
- Royal College of Obstetricians and Gynaecologists (RCOG) Workforce Standards
- British Association of Perinatal Medicine (BAPM) Neonatal Staffing Standards
- Ockendon workforce recommendations (2000)
- New Maternity Incentive Scheme (MIS) Year 8 Safety Actions (2026)
- Royal College of Midwives Leadership Manifesto (2019)
- Anaesthesia Clinical Services Accreditation (ACSA) Standards
- National Quality Board (NQB) guidance (2017)
- NHS Long Term Workforce Plan (2024)

4. Midwifery Workforce

Birthrate Plus

Birthrate Plus (BR+) is the only national tool available for calculating midwifery staffing levels. The BR+ review was completed in December 2024, with the report being received in 2025. For MIS compliance the Trust must have a fully funded midwifery establishment that aligns with that BR+ reviews recommendations. In addition, further adjustments to the establishment should be based on professional judgement of the Director of Midwifery.

Birthrate Plus Establishment Review	2024/2025
Required Clinical Establishment (Birthrate Plus)	259.16 WTE Registered Midwives excluding non-clinical parts of specialist roles and management roles
Required additional management/non clinical part of Specialist roles*	31.10 WTE
Total WTE:	290.26 WTE
Funded WTE	279.14 WTE
Variance:	-11.2 WTE

An investment case for the 11.2 WTE Midwives was submitted to Investment Committee and approval for funding agreed. Recruitment to the 11.2 WTE Midwives will support safe staffing for maternity services and ensure compliance with Safety Action A of MIS Year 8.

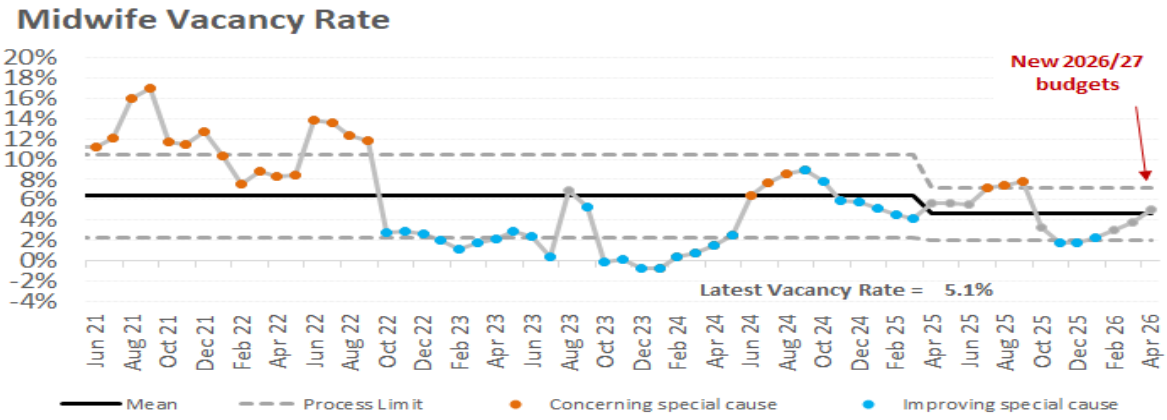
Midwifery Workforce Current Position

Measure	WTE	Recruitment Pipeline	Leavers
In Post WTE	238.02	-	-
Vacancy WTE	4.01 WTE Substantive 6.13 WTE Fixed Term	7.45 WTE July-Oct 26 5.84 WTE Fixed Term	5.67 WTE
Total in and out		+13.29 WTE	-5.67 WTE
Total Vacancy (as of May 2026)	-10.14 WTE	+3.15 WTE	-2.52 WTE
Felt Vacancy (inc BR+ variance)	-20.34 WTE	-8.05 WTE	-13.72 WTE
Vacancy Rate (April 26)	10% (April)	-	-
Turn over annual rate (12- month rolling April 26)	7.14%	Below Trust overall turnover rate	

Regional Maternity Sitrep/Maternity OPEL Framework

Daily workforce and staffing data is entered into the regional Maternity Sit Rep portal. Any escalations around staffing and/or capacity and demand are raised through Flow Midwife, Senior Nurse/Manager of the Day, following the Maternity Escalation and Divert policy. A new Perinatal Escalation policy is being developed with the introduction of the Maternity and Neonatal OPEL Framework.

Fig 1. Midwifery Vacancy Rate



There is a planned recruitment event for 23 student midwives on 21st May 2026. Active recruitment will also take place now that funding has been agreed for the midwifery BR+ gap.

Midwifery Sickness Absence

Sickness absence rates within midwifery remain consistently higher than the Trust average. While there has been some improvement over the past two years, long-term absence continues to show an upward trend. The midwifery team is working closely with the Divisional Head of Workforce to address this, focusing on areas with the highest levels of sickness absence and ensuring that staff training and sickness management processes are consistently applied.

Fig 2. Sickness Absence by Month

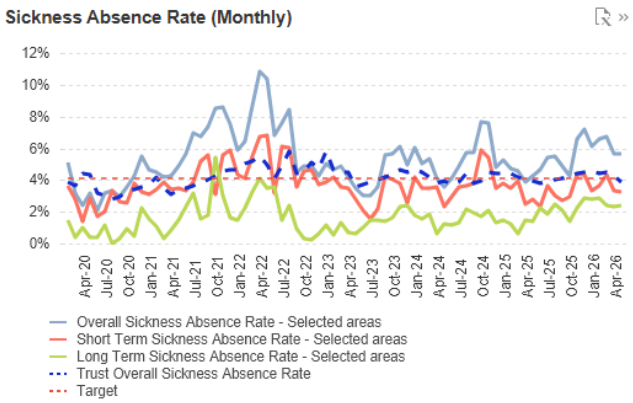
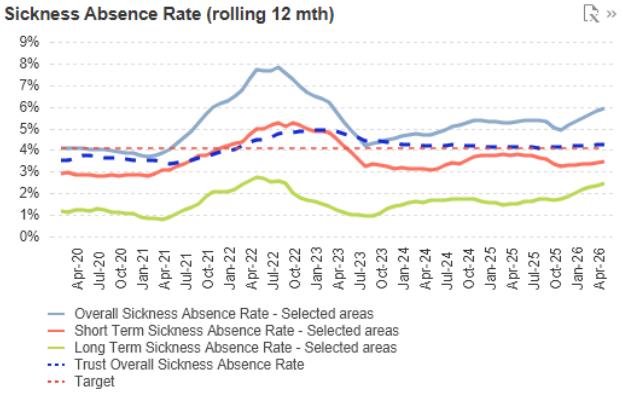


Fig 3. Sickness Absence Rate Rolling



Midwifery Fill Rates ☐

Unfilled shifts %- Midwifery	Unfilled roster % for Registered Midwife						
Unit	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**	**Apr-26**	**May-26**	**Average**
Antenatal Clinic	0.00%	**13.43%**	**11.80%**	0.00%	0.00%	Data not available	5.05%
C.A.R.E.S Team	2.30%	2.22%	1.93%	**10.39%**	0.00%		3.45%
Clinic 21 Rosie OP	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%
Clinic 22	6.36%	**11.21%**	1.66%	2.82%	3.56%		5.03%
Clinic 23	4.23%	1.88%	4.15%	5.54%	4.04%		3.96%
Clinic 24	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%
Delivery Unit	**8.01%**	**10.32%**	**10.36%**	**11.71%**	**8.14%**		**9.73%**
Lady Mary	4.47%	3.98%	3.80%	7.27%	4.18%		4.76%
OCOU	1.02%	3.58%	0.00%	1.02%	0.00%		1.16%
Rosie Birth Centre	6.81%	**8.00%**	**9.75%**	6.96%	**11.51%**		**8.65%**
Sara Ward	**12.48%**	**12.10%**	**9.26%**	**8.01%**	**10.18%**		**10.45%**

The unfilled shift data highlights the midwifery areas struggling to cover shifts consistently are Sara Ward (Antenatal), Rosie Birth Centre and Delivery Unit.

Bank and Agency Usage

Bank and Agency	Dec 25	Jan 26	Feb 26	Mar 26	April 26	May 26

Midwifery	23.11wte	30.36wte	33.10wte	31.76wte	26.41wte	Data not available

The data shows high levels of midwifery Bank and Agency usage.

Red Flag Events

Red Flag Criteria	Times Occurred	Percentage %
Delayed or cancelled time critical activity	93	53%
Missed or delayed care (>60 mins)	4	2%
Missed medication during admissions to hospital or midwifery led unit	1	1%
Delay in pain relief	6	3%
Delay between admission for induction of labour and beginning process	59	33%
Delayed recognition of and action on abnormal vital signs i.e. sepsis	2	1%
Co-ordinator unable to maintain supernumerary status	10	6%
Co-ordinator unable to maintain supernumerary status and providing 121 care	0	0%
Co-ordinator unable to provide Named Midwife to a service user	2	1%
Total in reporting period De 25-May 26	177	

The number of red flags reported by BR+ acuity tool is very low. Concerns raised via regarding data quality as the tool has a completion rate of only 67%, the expectation is that the tool is completed >85% to ensure accuracy. The service will work to improve data quality.

Staffing Related Datix

Staffing related Datix Reports	Reporting Period Dec 25-May 26
Number of Datix reports	**5**
Of which are Red Flags	**5**

This number represents under reporting of staffing shortages and red flags. All Datix were low or no harm.

Experience Insights related to Staffing

There is limited data triangulation on complaints, Patient Advice and Liaison Service, service user feedback/MNVP and incident investigation where staffing has been deemed contributory. Themes and trends around safe staffing are tracked through Directorate governance through the Maternity Dashboard and Datix reporting. Further triangulation of patient experience insight data and serious incidents which have a staffing element will be ongoing.

One-to-One Care in Labour

Metric	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26
One-to-one care achieved	100%	100%	100%	100%	100%	100%

NICE identifies one-to-one care during established labour as a core staffing requirement, which should be monitored via reg flag reporting, but as the red flag reporting requires improvement, it has been included as a standalone metric.

Midwifery Specialist Roles

BR+ applies a 12% increase to the clinical establishment WTE providing additional staff for management, governance activities and the non-clinical proportion of Midwifery Specialist roles. The calculation also includes a 24% headroom allowance for training and Unavailability. BR+ does not describe what Midwifery specialist posts should be included, as this is a local decision based on needs and professional judgement.

Any allowances also need to consider the many additional reports that have required or recommended additional midwifery posts, such as:

- Maternity and Neonatal Safety Improvement Programme (NHSE 2021)
- The Perinatal Culture and Leadership Programme (2020/21)
- Ockenden Recommendations (2020)
- National Bereavement Care Pathway (2018) Service Specifications- Perinatal Pelvic Health Services (NHSE 2023)
- Birth Trauma Report (APPG 2024)
- Independent Culture Review (NMC 2024)
- National Review of Maternity Services (CQC 2022-2024)
- MBRRACE (2024)

Specialist and Management Roles identified gaps

Role	WTE	Gaps	Compliance	RAG
Consultant Midwives	2.0 WTE compliant	Currently postholders have line management	RCM compliant with WTE for size of unit.	

		and operational responsibility for parts of service, should be non-operational clinical leadership posts.	RCM non-compliant with line management and operational responsibility	
Specialist Midwives (breakdown below)		Specialist workforce as per Ockenden	Non-compliant Ockenden	
-Bereavement Midwives	1.92 WTE	Bereavement not 7-day service by specialist midwife	Non-compliant Ockenden/National Bereavement Care Pathway	
-Governance roles (risk/clinical governance/ audit/incident investigation/data analysis, QI)	2 WTE	Governance structure is too lean, lacking appropriately banded senior oversight role, and non-compliant with Ockenden and NHSE Maternity Safety Self-Assessment Tool	Non-compliant Ockenden	
Practice Development Midwives	2 WTE	Education structure is too lean, no senior lead for maternity training and education.	Non-compliant Ockenden	

5. Obstetric Workforce

Obstetric Establishment Grade	Funded in Post	Vacancy
Consultants	19	0
Senior Registrar	10	3
Junior Registrar	12	1
SHO	14	1

Significant investment in the obstetric medical workforce during 2024 has strengthened both Consultant and Resident Doctor staffing, resulting in measurable improvements in service resilience, patient safety and clinical performance.

Six additional Consultant posts and six additional non-Consultant posts were added to the establishment, increasing workforce capacity and supporting compliance with national recommendations, including those arising from the Ockenden Review and Care Quality Commission (CQC) requirements.

Investment in the obstetric workforce has resulted in:

- Improved Consultant presence and out-of-hours medical cover, contributing to greater continuity of care and strengthened clinical oversight across maternity services.
- Reduction in locum shifts from 142 in 2024 to 27 in Jan–Jul 2025,
- Fewer consultant acting-down episodes, falling from regular monthly occurrences in 2024, including a peak of 10 incidents in November, to only three shifts between January and July 2025 outside periods of industrial action.
- Improved Obstetric triage review performance for Doctors review
- Increased resilience within the out-of-hours rota.

Overall, the obstetric workforce expansion has delivered clear benefits through improved rota stability, reduced locum dependency, fewer episodes of consultants acting down, enhanced triage performance and strengthened compliance with national staffing recommendations. Continued recruitment and proactive workforce wellbeing measures will be required to sustain these gains and address the remaining staffing gaps.

RCOG Compliance

Standards	**Compliance**	**RAG**
Consultant Attendance	Audits not started in this financial year	
Short Term Locums	Locum audit not started in this financial year	
24/7 Escalation Arrangements for Obstetric Staffing	Yes / Escalation policy exists for medical workforce	
Job Planned SPA Time	Yes / Job plans available to show this	

The MIS standards for Year 8 were published in April 2026 with considerable changes to the requirements for the workforce safety action A. Therefore, not all evidence is available for presentation to Board i.e. finalised audit reports, these will need to be presented to Board as part of Decembers bi-annual workforce report and for the MIS final submission on 2nd March 2027.

Obstetric Workforce Risks

1. Resident doctor's rota has five vacancies, and these are due to multiple reasons including maternity leave, clinical fellows finishing posts and increasing number of trainees opting LTFT. JR rota is very on-call heavy particularly with twelve hours shifts often cited as a reason why JRs are opting to work LTFT. Twelve hour shifts

are increasingly the standard shift pattern from medical workforce rotas in most medical specialities.

2. The service introduced warm week Consultants to cover basic obstetric and maternity services, and this will have be reviewed to ensure no impact on other specialist obstetric services and overall impact on patient care and experience.

6. Neonatal Workforce

Medical Workforce

Neonatal Medical Workforce	WTE in Post	Vacancy
Consultants	10.7 WTE	2.6 WTE long term locum consultant recruitment underway
Registrars HST	12.0 WTE	1.0 WTE due to LTFT
Senior CF	1.5 WTE	0.5 WTE Short term locum
Core Speciality trainee	8.0 WTE	1.6 WTE Vacancy / Locum cover
Junior Clinical Fellow	3.8 WTE	0.2 WTE Vacancy
ANNP	4.0 WTE	0 WTE

All tier 1, 2 and 3 (consultant) rotas are compliant BAPM standards. However, tier compliance is not the same as having the right numbers of neonatal medical workforce across all grades. A full neonatal workforce review has not been undertaken for several years, similarly to maternity the complexity of patients is increasing as is activity, the medical workforce needs to be assessed in terms of the activity we see and the complexity of patients. Further capacity and demand and workforce intelligence is needed to inform the workforce needs assessment.

Neonatal Nursing Workforce

Neonatal Nursing Establishment Grade	WTE Budget	WTE in Post	Pipeline
Band 7	16.12 WTE	14.21 WTE	
Band 6	62.35 WTE	48.05	1.0 WTE
Band 5 QIS	0	8.32 WTE	

Band 5 Non-QIS	46.94 WTE	45.73 WTE	1.0 WTE
Band 4 Registered Nursing Associate (NA)	Shared with nursery nurse funding	3.0 WTE	3.92 WTE internal NAs qualifying)
Band 4 Nursery Nurses	13.32 WTE	7.15 WTE	1.0 WTE
Band 3 Trainee Nursing Associates	0	3.0 WTE	0
Current QIS percentage direct care	56%		
Vacancy rate	7%		

Neonatal Nursing Staffing establishment is activity adjusted using the BAPM Neonatal Nursing Workforce Calculator and outputs shared with the Neonatal Operational Delivery Network (ODN).

The BAPM standard requires the funded nursing establishment to support direct patient care in a Neonatal Intensive Care Unit (NICU) at 80% average cot occupancy, recognising the need for resilience above day-to-day average occupancy.

- Minimum of 80% of the nursing workforce should be RN.
- Minimum 70% of the total RN workforce should be Qualified In Specialty (QIS), holding a university accredited Neonatal qualification.

The total direct care nursing establishment for 80% activity is 139.72 WTE which the unit is established to, with a skill mix of 90% RN (126.42 WTE) and 10% unregistered (13.32 WTE).

To mitigate any staffing shortages, a risk assessment of each ITU nursing care allocation is undertaken to maintain compliance with BAPM, 1:1 care prioritised for sick neonates.

Minimum Neonatal Staffing/Cot Provision

NICU Cot Provision	**Type of Cots***	**Minimum Nurse to Baby Ratio**	**QIS Nursing requirement**
NICU commissioned for	40 Intensive Care Unit (ICU) cots	1:1 for ICU level care	QIS nurses only
	16 High Dependency Unit (HDU) cots	1:2 for HDU level care	QIS nurses either directly delivering care or supervising registered nurses

	12 Special Care Baby Unit (SCBU) cots	1:4 for special care	Nurse
Total Cots	58 cots *NICU cots have the ability to be used flexibly depending on clinical demand.		

Although the current staffing model complies with the BAPM minimum standards based on 80% activity, the unit is often running at a higher activity level thus resulting in staffing being compromised, particularly on the night shift. Further capacity and demand modelling is ongoing exploring activity in cots versus what care the cots are commissioned for, as this impacts on whether staffing is appropriate or not.

The neonatal nursing workforce review recommended an increase the current registered nurse staffing by 2.86 WTE to enable an additional RN to be rostered each night shift to maintain safe staffing levels.

Qualified in Specialty (QIS)

The target QIS for the unit is 88 WTE based on the ratio of 70% QIS for the RN workforce providing direct clinical care.

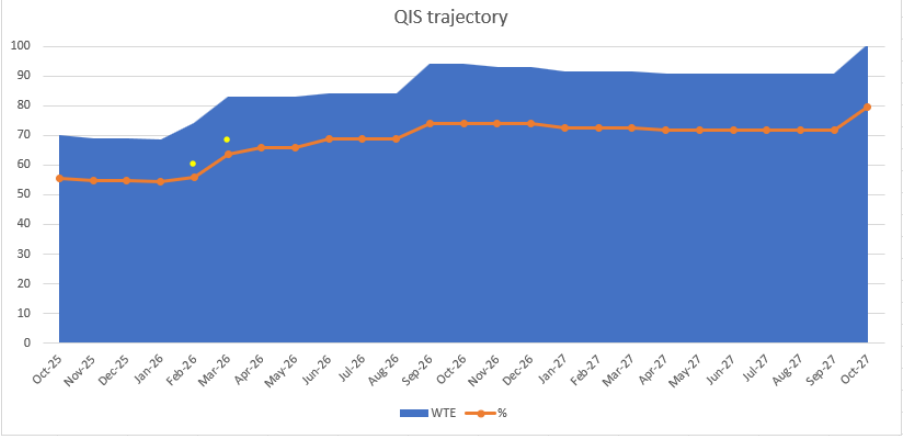
The skill mix has been reviewed as part of the annual establishment review, however due to the geographical layout of the unit, it is not possible to reduce the skill mix to 80% RN and 20% unregistered, as this would impact upon the ability to ensure that a RN was providing supervision to the unregistered staff in order to maintain patient safety.

Neonatal nursing staffing is BAPM compliant based on 80% activity, however if the unit is running at a higher activity level thus resulting in staffing being compromised, particularly on the night shift. It is therefore recommended to increase the current registered nurse staffing by 2.86WTE to enable an additional RN to be rostered each night shift to maintain safe staffing levels.

Neonatal Nursing Workforce Risk

1. Due to the current vacancy rate in NICU of 7% (14.15WTE), the unit is non-compliant with the QIS BAPM standard, with 62 WTE who hold a QIS.

Fig 4. QIS Compliance Trajectory



Current compliance is expected to show an increase to around 65% by June 2026, on successful completion of latest QIS training cohort, with a prediction of 70% QIS compliance by the end of 2026. As currently 15.09 WTE nurses are undertaking the QIS course.

A recruitment and retention plan is in place to address the vacant positions and to increase the number of RNs with a QIS to improve compliance to be aligned with BAPM minimum standards. Band 5 posts have been recruited to, to support career development and succession planning to allow completion of the QIS course.

Neonatal Nursing Fill Rates

Unfilled shifts %- Neonatal Nursing	**Unfilled roster % for Registered Nurse**						
Unit	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**	**Apr-26**	**May-26**	**Average**
NICU	3.24%	3.65%	3.20%	5.17%	3.93%	Data not available	3.97%

Neonatal Nursing Bank and Agency Usage

Bank and Agency	**Dec 25**	**Jan 26**	**Feb 26**	**Mar 26**	**April 26**	**May 26**
Neonatal usage	14.59wte	13.40wte	16.02wte	15.55wte	13.62wte	Data not available

BAPM Compliance Assessment

Standard	**Compliance**	**RAG**
Nursing Staffing	Non-compliant with QIS, 56% (target 70%)	

Advanced Neonatal Practitioner (ANNP) Coverage	Compliant	
Transitional Care (TC) Staffing	Non-compliant, awaiting outcome of investment case for TC nurse staffing model.	
Education Capacity	TBC for assessment	

Perinatal Service Wide Combined Workforce Data (*Not including Anaesthetics)

Perinatal Workforce	**April 2026 (May data not available)**				
	Budgeted WTE	**In Post WTE**	**Vacant WTE**	**Vacancy Rate %**	**Annual Turnover %**
Obs and Gynae	289.65	260.27	29.38	10.1%	6.9% (21 headcount)
Neonates	166.41	149.47	16.94	10.2%	6.6% (11 headcount)
Total	456.06	409.74	46.32	10.2%	

Locum Temporary Staffing for Obstetric and Neonatal

Locums	**Usage (Hours) Period Dec 25-May 26**
Short Term <2 weeks	6, 133,25
Long Term >2 weeks	4, 934.42
Total	11,067.67

Perinatal Service Wide Sickness Absence Rates*

Fig 5. Sickness Absence Rate Monthly

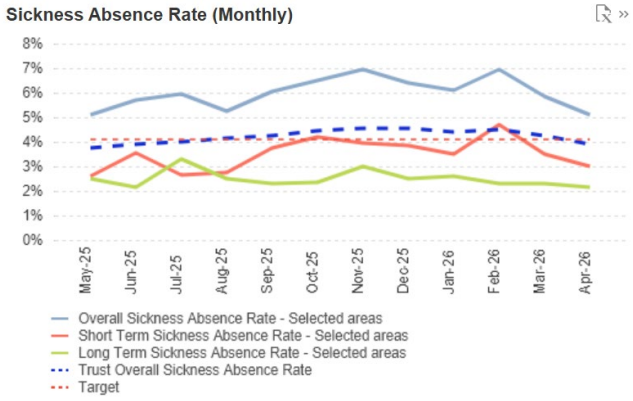
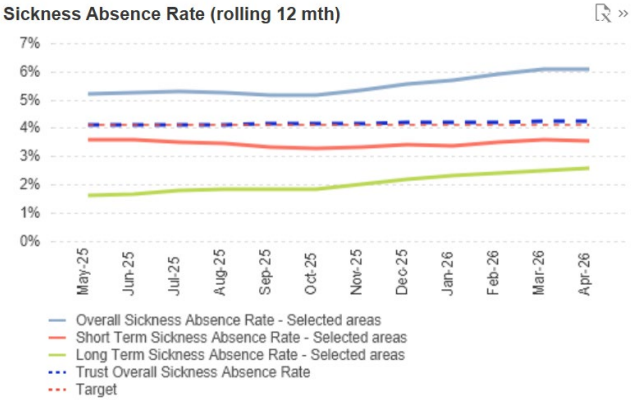


Fig 6. Sickness Absence Rate (Rolling)



Anaesthetic Workforce

7.1 Duty Anaesthetist

The service can demonstrate that there is 24/7 cover with a duty anaesthetist in alignment with the Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1

7.2 Anaesthetic Assistant

The service can demonstrate the availability 24/7 of anaesthetic assistants is in alignment with ACSA standard 1.3.1.2. Both these rotas shall be presented to Board as evidence as part of the Year 8 MIS submission.

7.3 Anaesthetic Workforce Risks

1. Guidelines for the Provision of Anaesthetic Services (the evidence base for the ACSA standards) recommend that “busier units should consider having two duty anaesthetists available 24/7, in addition to the supervising autonomously practising anaesthetist”. The local GMC survey (2025) highlighted safety concerns with resident Doctor cover in Anaesthetics at night, which have not been fully resolve with middle grade cover. A business case is in progress is being prepared for investment committee and there are ongoing mitigations in place supported by the anaesthetic directorate
2. Evidence of job plans showing named Anaesthetic Lead for Obstetrics, with protected time to support service delivery, governance, and workforce planning is a new requirement within MIS year 8. This is not currently reflected in the Anaesthetic lead's job plan, as no programmed activities (PAs) are available to support this; this is being reviewed by the service to bring in line with the MIS requirement.

Anaesthetic Resilience

There is also a new MIS requirement that regular review of obstetric theatre delays or incidents where anaesthetic staffing was a factor is undertaken, with actions recorded where needed. This is now technically possible for the elective caesarean birth lists with new and existing reports built into Epic earlier this year. There is a resource and data analytical consideration for this data that is being explored by the service.

Any delays related to emergency workload and anaesthetic staffing form part of the existing risk on the register. This additional requirement is also new for MIS year 8. There is an active risk on the Division E risk register (Risk ID 4567). It details the risk of delayed anaesthetic response to obstetric emergencies and delays in the provision of labour analgesia out of hours.

Caesarean Section Decision to Delivery Timings Category 1

CS Cat 1	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Total Cat 1s	17	24	20	30	25

Decision to deliver to birth =< 30 minutes	15	12	7	15	0
% Cat1s within timeframe	88.24%	50.00%	35.00%	50.00%	0.00%

Caesarean Section Decision to Delivery Timings Category 2

CS Cat 2	**Dec-25**	**Jan-26**	**Feb-26**	**Mar-26**	**Apr-26**
Total Cat 2s	85	80	65	95	80
Decision to deliver to birth =< than 75 minutes	45	40	40	47	2
% Cat2s within timeframe	52.94%	50.00%	61.54%	49.47%	2.50%

7. Capacity and Demand

New for MIS Year 8 is the need for perinatal services to ensure that there is sufficient capacity to deliver timely elective planned and emergency maternity and neonatal care. To show that delays are identified, analysed, reported and that persistent issues are escalated. There is a requirement specifically for an annual demand and capacity mapping for planned elective Caesarean sections, that must cover the whole perinatal pathway.

Maternity services have escalated concerns and the risk around theatre capacity to women's and babies safety, an options appraisal for improving elective caesarean section capacity has been presented, the issue discussed frequently and supported by executives in the Maternity Oversight Group. There is a regional perinatal task and finish group commencing to look at options as a region, as theatre capacity is being raised as a concern regionally and nationally.

The Perinatal Services are working through options to increase theatre capacity now, however it has been identified that a deeper capacity and demand exercise for the whole of perinatal services is required, with future modelling around local health needs, projected birth rates, considering maternal and fetal medicine and increasing complexity of women and neonates, ensuring that appropriate consideration is given to the whole pathway from pre-op appointments to postnatal community care, and the required multiprofessional perinatal workforce. With the aim to future proof any workforce requirements and any capital infrastructure plans.

8. Education, Training and Competency

Neonatal Life support Training

Workforce Group	Current Compliance (April 26)
Midwives	76%
Neonatal Nurses	92%
Neonatal Consultants	65%
Neonatal Medical Non-Consultants	84%

PROMPT Compliance

Workforce Group	Current Compliance (April 26)
Midwives	86.9%
Consultant Obstetricians	88.9%
Obstetric Doctors (non-Consultants)	96.9%
Consultant Anaesthetists	81.3%
Anaesthetists	95.7%

9. Safety and Quality Outcomes

Clinical complexity and intervention indicators are useful to identify if capacity and complexity could be potentially requiring additional staffing across the perinatal workforce.

Maternity Outcome Metrics	Current
3rd/4th Degree Tear Rate	3.21 %
PPH >1500ml Vaginal Birth	4.13%
PPH >1500ml Caesarean Birth	5.91%
Triage attendance within <15 mins	86.7%
Triage seen by Midwife within RAG time	98.4%
Triage seen By Obstetrician within RAG time	78.9%
Term Admissions	6.40%
Stillbirths	2.72%

Caesarean Birth -Elective -Emergency	 70/431 Births 132/431 Births
Home Birth	0.9%
IOL Rate	30%
IOL Delays to commencement	52%
IOL Delays to continuation	16%
Neonatal Re-admissions	5%
Maternal Re-admission	2.30%

Neonatal Activity

Neonatal Outcome Metrics	**Dec 2025**	**Jan 2026**	**Feb 2026**	**March 2026**	**April 2026**	**May 2026**
Term Admission Rate (ATAIN)	26	18	37	31	28	No data available
Neonatal	10	3	8	2	4	
Closures	0	0	1 (8hrs)	2 (79.5hrs)	0	
Transfers in utero	No data	17	14	6	10	
Transfers ex utero		13	12	12	12	
Refusals		24	33	21	28	

11. MIS Year 8 Safety Action Workforce Assurance

Current position in terms of compliance against MIS Year 8 standards for Safety Action A, and what is still to be achieved ahead of submission date of 2nd March 2027:

MIS Year 8 Requirements	**RAG Status**	**Evidence**	**Next Phase/Evidence**
-Obstetric establishment review	Partial	Obstetric workforce review paper Bi-annual Workforce paper June 26	Obstetric audits reports for short term locums and Consultant presence to be presented Duty Rotas to be presented as evidence

MIS Year 8 Requirements	RAG Status	Evidence	Next Phase/Evidence
			Bi-annual workforce paper Dec 26
-Midwifery establishment review	Partial	Bi-annual workforce paper June 26 BR+ establishment report	Recruit up to BR+ recommendations Bi-annual workforce paper Dec 26
-Neonatal Medical establishment review	Partial	Bi-annual workforce paper June 26	Work plan for achieving fully funded BAPM compliant medical and nursing workforce for NICU Duty Rotas to be presented as evidence Capacity and demand for Medical workforce requirements Commissioned cot versus care delivered review Education capacity review Bi-annual workforce paper Dec 26 Continue QIS improvement Plan
-Neonatal Nursing establishment review	Partial	Bi-annual workforce paper June 26 BAPM neonatal nursing workforce calculator.	
-Anaesthetic establishment review	Partial	Bi-annual workforce paper June 26	Duty Rotas to be presented as evidence for both duty anaesthetist and Outpatient Department Capacity and demand for Anaesthetic workforce requirements Bi-annual workforce paper Dec 26
Review Perinatal Outcomes and Experience	Partial	Clinical outcomes Datix/Harms	Improve triangulation of clinical outcomes and experience Insights involving staffing, to monitor monthly for themes Anaesthetic staffing issues to be triangulated with Obstetric outcomes

MIS Year 8 Requirements	RAG Status	Evidence	Next Phase/Evidence
Capacity and Demand	Partial	Governance Papers Investment Cases Sitrep Data	Capacity and demand piece for perinatal services across whole pathway and all professions, including local health needs assessment. Bi-annual workforce paper Dec 26
Multi-professional training delivered	Partial	Two time points during MIS Year 8 data collection showing 90% compliance across all professionals	Continued tracking of training compliance throughout MIS reporting period MIS training compliance report for Year 8

12. Data Quality

There are data quality concerns and some assurance gaps identified through the review, BR+ acuity tool completion, likely under reporting of staffing issues via Datix, and limited safety outcomes and patient experience triangulation.

13. Workforce strengths to highlight

Significant obstetric workforce investment success has resulted in:

- Reduced locum usage
- Improved Consultant attendance
- Improved rota resilience and patient safety

Other positives are:

- Funding for Midwifery BR+ gap approved
- 100% 1:1 care in labour achieved
- Strong governance framework emerging: Bi-annual workforce reporting established
- Alignment with MIS Year 8

14. Conclusion

Overall perinatal workforce assurance is amber, due to some areas of non-compliance with national workforce standards.

Workforce Domain	Gap	RAG	Compliance
Midwifery	11.2 WTE BR+ gap	Amber	Not meeting BR+ funded establishment
Neonatal Nursing	QIS compliance 56% (70% standard) 2.86 WTE recommended increase	Amber	Non-compliant with BAPM QIS
Anaesthetics	Second Duty Anaesthetist recommended PA time for Lead	Amber	Not yet aligned with enhanced MIS requirements
Capacity and Demand	Further analysis required across perinatal services	Amber	Capacity modelling ongoing

Immediate Actions for Perinatal Services

- Active recruitment to midwifery 11.2 WTE now funding is approved
- Accelerate QIS training completion
- Improve Midwifery red flag reporting compliance (>85%)
- Strengthen Datix reporting culture
- To resolve immediate Obstetric Theatre capacity issues

Medium Term Actions

- Undertake robust capacity & demand, incorporating whole perinatal pathway and all professional groups
- Develop and implement triangulated Perinatal workforce dashboard for monthly oversight
- Expand specialist midwifery roles (education/governance) through new operating model opportunity

Strategic (12+ months / MIS submission readiness)

Achieve full compliance for:

- BR+ Midwifery establishment
- Neonatal Nursing QIS ≥70%
- MIS Year 8 Safety Action A evidence. Ensuring all evidence is ready for March 2027 submission

Perinatal services demonstrate some compliance with national workforce standards across obstetrics, neonatal medical and anaesthetic services. However, gaps remain

in midwifery establishment, neonatal nursing QIS compliance, and workforce intelligence for capacity planning. There are no immediate harms identified; however, sustained workforce gaps present a material risk to quality and timely care if unmitigated, but sustained risks require active mitigation and Board oversight, particularly

- Recruitment to Midwifery staffing shortfall (BR+ gap)
- Neonatal nursing skill mix (QIS compliance)
- Workforce Capacity vs Demand Analysis

15. Recommendations

The Board of Directors is asked to:

1. **REVIEW** the current perinatal workforce position in terms of compliance with NICE, RCOG, BAPM and MIS Year 8 requirements. Note trajectory and requirements for MIS compliance for Safety Action A.

NHS
Cambridge
University Hospitals
NHS Foundation Trust

Board of Directors Meeting
held on 10 June 2026

Title	Board Committee Terms of Reference			
Report Sponsor	Chief Governance and Performance Officer			
Author	Interim Head of Corporate Governance			
Status	**Decision** ☑	**Assurance** ☑	**Information** ☐	**Discussion** ☐

RECOMMENDATIONS

The Board of Directors is asked to:

- **RECIEVE** the paper, revised Board Committee Terms of Reference and membership
- **DISCUSS and APPROVE** the Board Committee Terms of Reference.

KEY MESSAGES

As part of the corporate governance review this exercise identified a number of areas for improvement with the aim of bringing standards in line with good practice to enable Board Committees to have a greater strategic focus with reporting groups overseeing operational delivery.

The development of detailed Board Committee workplans is underway, inclusive of enabling strategies and legal and regulatory requirements will help to support the strategic focus, to work in partnership with the Board Assurance Framework, to closely monitor risks and mitigations that threaten the achievement of the Trust's strategic objectives. Revised Board Committee workplans are planned to be provided to each of the Board Committees following approval of the Terms of Reference.

BACKGROUND, INCLUDING PURPOSE OF THE REPORT

The Board received a paper at its last meeting held in Private in March 2026 that provided an update on the corporate governance review. At that meeting the Board approved a revised Front Sheet, an Alert, Assure Action (AAA) Report and the Senior Independent Director Role Description. The Board was also updated on the outcome of the Board Committee Effectiveness Reviews that had been undertaken and the progress made on the Board Committee Terms of Reference reviews that were underway, noting that the Quality Committee Terms of Reference would be revised once the actions from the clinical governance review are agreed.

Since the March 2026 Board meeting, the ToR for the Board Committees have been reviewed to take account of stakeholder meetings, benchmark reviews and Board Committee's feedback prior to approval by their representing Board Committees. The Board is asked to approve the revised Terms of Reference appended to this paper, which aim to strengthen existing good governance practice to align structures with the new Trust strategy.

ALIGNMENT TO TRUST STRATEGIC PRIORITIES

Our strategy: a healthier life for everyone through care, learning and research 2026-2031		**Indicate all that apply**
1	Deliver Excellent and Timely Care	☑
2	Transform How and Where We Deliver Care	☑
3	Harness Research and Innovation to Improve Patient Outcomes	☑

ALIGNMENT TO MOST RELEVANT STRATEGIC RISK

Alignment to all Board Assurance Framework strategic risks.

PAPER REVIEW AND GOVERNANCE PATHWAY

Name of group or committee that has previously considered this report	**Date**
Board of Directors	13/5/2026
Name of group or committee that the report will be presented to in the future	
N/A	

Board of Directors Meeting
10 June 2026
Report of the Chief Governance and Performance Officer
Board Committee Terms of Reference

1.0 Background

1.1 The Board of Directors (the Board) received a paper at its last meeting held in Private in March 2026 that provided an update on the corporate governance review. At that meeting the Board approved a revised Front Sheet, an Alert, Assure Action (AAA) Report and the Senior Independent Director Role Description. The Board was updated on the outcome of the Board Committee Effectiveness Reviews that had been undertaken and updated on the progress of the Board Committee Terms of Reference reviews, noting that the Quality Committee Terms of Reference (ToR) would be revised once the actions from the clinical governance review are agreed.

1.2 Since the March 2026 Board meeting the ToR for the Board Committees (excluding Quality Committee ToR) have been reviewed to take account of stakeholder meetings, benchmark reviews and Board Committee's feedback prior to approval by their representative Board Committees. The Board is asked to approve the revised ToR appended to this paper, which aim of strengthening existing good governance practice to align structures with the new Trust strategy.

2.0 Terms of Reference

2.1 It is good governance practice to review ToR at least annually. At the commencement of the data gathering exercise, it was found that ToR for Board Committees had not been consistently reviewed and approved by the Board in recent years. Updated ToR have been developed using feedback from self-assessments, stakeholder meetings and benchmarking. The updated ToR follows a standardised format, which is being used to update all Board Committee ToR. The following Board Committee ToR have been reviewed and approved by each Board Committee:

2.2 Audit Committee

2.2.1 Review of the Audit Committee ToR found a number of significant gaps. To assist with the review of these ToR, in addition to the benchmarking exercise, the Healthcare Financial Management Association (HFMA) handbook for NHS providers was used to support the review. The HFMA handbook is designed to help NHS Boards and Audit Committees to review and continually reassess their system of governance, risk management and internal control to ensure that it remains effective and fit for purpose.

2.2.2 The revised Audit Committee ToR (Appendix A) were approved by the Committee at its April 2026 meeting.

3.3 Performance Committee (proposed Performance and Finance Committee)

3.3.1 Review of the Performance Committee ToR resulted in the proposal to rename the Committee to the Performance and Finance Committee with the Committee's purpose and functions updated including compliance with the National Oversight Framework. The revised ToR were approved by the Committee subject to any final changes being approved by the Committee Chair and Executive Director lead (Chief Finance Officer).

3.3.2 The revised Performance and Finance Committee ToR (Appendix B) were approved by the Committee Chair and Executive Director lead on 5 May 2026.

4.4 Workforce and Education Committee (proposed People, Education and Culture Committee)

4.4.1 Review of the Workforce and Education Committee ToR resulted in the proposal to rename the Committee to the People, Education and Culture Committee with greater strategic oversight on enabling strategies in accordance with its remit and legal and regulatory requirements including compliance against the National Oversight Framework. The revised ToR were approved by the Committee subject to any final changes being approved by the Committee Chair and Executive Director lead (Chief People Officer).

4.4.2 The revised People, Education and Culture Committee ToR (Appendix C) were approved by the Committee Chair and Executive Director lead on 4 May 2026.

5.5 Addenbrooke's Futures Committee (proposed Transformation Committee)

5.5.1 Review of the Addenbrooke's Futures Committee ToR resulted in a proposal to change the roles and responsibilities of the Committee and renaming to a Transformation Committee. The ToR have been developed to support this change, reviewed and approved by the Committee subject to any final changes being approved by the Committee Chair and Executive Director lead (Chief Strategy and Transformation Officer).

5.5.2 The revised Transformation Committee ToR (Appendix D) were approved by the Committee Chair and Executive Director lead on 7 May 2026.

5.6 Quality Committee

5.6.1 Work on clinical governance, quality and patient safety is ongoing. The Quality Committee's function and processes are planned to be updated to incorporate the clinical governance review findings with the aim of presenting to the Board for approval at its next meeting.

5.7 Management Executive Group

5.7.1 Management Executive Group is accountable for the development of strategic options for approval by the Board and delivery of the corporate objectives within the strategic framework, as well as being accountable for the operational management of the Trust.

5.7.2 A review of the groups that support the working of ME has been undertaken with the support of ME colleagues. These groups will have a direct reporting line to ME and a dotted assurance line to the relevant Board Committee.

5.7.3 It is planned that ME's ToR will be presented to the Board for approval at its next meeting.

6.0 Divisional Boards

6.1 There is a separate piece of work underway to review the governance and reporting arrangements for Divisional Boards with the aim of them reporting on both clinical and non-clinical functions up to the Management Executive with assurance provided through the Board Committee structure. Quality and Performance review meetings continue to be held monthly, which aim to scrutinise the integrated performance (quality, patient safety, finance, performance, governance and risk management), the outcome of which is reported into Management Executive.

7.0 Next Steps

7.1 This exercise identified a number of areas for improvement with the aim of bringing standards in line with good practice to enable Board Committees to have a greater strategic focus with reporting groups

overseeing operational delivery.

7.2 The development of detailed Board Committee workplans is underway, inclusive of enabling strategies and legal and regulatory requirements will help to support the strategic focus, to work in partnership with the Board Assurance Framework, to closely monitor risks and mitigations that threaten the achievement of the Trust's strategic objectives. Revised Board Committee workplans will be provided to each of the Board Committees to support the delivery of the ToR.

8.0 Recommendation

8.1 The Board is asked to:

a. Approve the revised Audit Committee Terms of Reference.
b. Approve the renaming and purpose of the Performance Committee to the Performance and Finance Committee.
c. Approve the Performance and Finance Committee Terms of Reference.
d. Approve the renaming and purpose of the Workforce and Education Committee to the People, Education and Culture Committee.
e. Approve the People, Education and Culture Committee Terms of Reference.
f. Approve the renaming and purpose of Addenbrookes Futures Committee to the Transformation Committee.
g. Approve the Transformation Committee Terms of Reference.
h. Note that work on clinical governance, quality and patient safety is ongoing. The Quality Committee's function and processes will be updated to incorporate the clinical governance review findings with the aim of presenting to the Board for approval at its next meeting.
i. Note that Management Executive Group ToR will be presented to the Board for approval at its next meeting.
j. Note the plans in place on the development of detailed Board Committee workplans to align to the revised Terms of Reference.
k. Note the membership of the Board Committees.

Attachments:

Appendix A Audit Committee Terms of Reference
Appendix B Performance and Finance Committee Terms of Reference
Appendix C People, Education and Culture Committee Terms of Reference
Appendix D Transformation Committee Terms of Reference
Appendix E Board Committee Membership

NHS
Cambridge
University Hospitals
NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust

Audit Committee

Terms of Reference

1.0 Constitution

1.1 The Audit Committee (the Committee) is constituted as a standing committee of the Board of Directors and has no executive powers, other than those specifically delegated in these terms of reference.

2.0 Authority

2.1 The Committee is directly accountable to the Board of Directors and is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee or contractor of the Trust and all employees and contractors are directed to cooperate with any request made by the Committee.

2.2 The Committee is authorised by the Board of Directors to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

3.0 Membership

3.1 The members of the Committee shall be appointed by the Board of Directors and comprise at least three Non-Executive Directors.

3.2 The Chair of the Trust shall not chair or be a member of the Committee but may attend meetings by invitation as appropriate.

3.3 One Non-Executive Director will be appointed as the Chair of the Committee by the Board of Directors. The Chair of the Committee must have recent and relevant financial experience.

3.4 At least one of the members should also be a member of the Quality Committee.

3.5 The Chief Executive will identify an Executive lead for the Committee.

3.6 A quorum shall be two Non-Executive Director members.

3.7 Members should make every effort to attend all meetings of the Committee and will be required to attend at least 75% of meetings. If they are unable to attend they must provide an explanation to the Chair of the Committee who will consider with the Chair of the Trust if appropriate action should be taken. The Committee Secretary will monitor attendance by members and report this to the Chair of the Committee on a regular basis.

4.0 Attendance at meetings

4.1 The Chief Finance Officer and appropriate internal and external audit representatives shall normally attend all meetings.

4.2 The Company Secretary or the individual undertaking these duties and responsibilities at the Trust may attend meetings.

4.3 The Chief Executive will be invited to attend meetings and should discuss at least annually with the Audit Committee the process for assurance that supports the Annual Governance Statement. The Chief Executive should also attend when the Committee considers the draft Annual Governance Statement and the Annual Report and Accounts.

4.4 At least one Executive Director shall be in attendance at every meeting.

4.5 Other Directors/managers will be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility for that Director/manager.

4.6 Representatives from other organisations and other individuals may be invited to attend on occasion, by invitation to support the workings of the Committee.

4.7 Audit Committee members will meet with the Internal Auditors, External Auditors and LCFS, without any others present, before each Audit Committee meeting. Additional meetings will be scheduled to discuss specific issues if required.

4.8 The Council of Governors may nominate up to two governors to attend each meeting of the Committee to observe proceedings. The observation of Board Committees by governors shall be subject to conditions agreed by the Board of Directors. The Chair of the Committee may in exceptional circumstances exclude governors from being present for specific items.

5.0 Access

5.1 The Head of Internal Audit and representative of External Audit have a right of direct access to the Chair of the Committee. This also extends to the LCFS, as well as the security management specialist (where they do not report elsewhere).

6.0 Frequency of meetings

6.1 Meetings will be held at least five times a year.

6.2 The Committee Chair may convene additional meetings of the Committee if necessary to consider business that requires urgent attention.

6.3 The Board, Chief Executive, Internal Auditors, External Auditors or LCFS may also request an additional meeting if they consider that one is necessary.

6.4 To assist in the management of business over the year an annual workplan will be maintained, capturing the main items of business of each scheduled meeting.

7.0 Responsibilities

7.1 The duties and responsibilities of the Committee are as follows:

Governance, Risk Management and Internal Control

7.2 The Committee shall review the adequacy and effectiveness of the system of governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

7.3 In particular, the Committee will review the adequacy and effectiveness of:

7.3.1 All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit Opinion, External Audit Opinion or other appropriate independent assurances, prior to submission to the Board of Directors.

7.3.2 The underlying assurance processes that indicate the degree of achievement of corporate objectives and the appropriateness of the above disclosure statements.

7.3.3 The effectiveness of systems and processes for risk management in the Trust, in accordance with the Risk Management Strategy and Policy, including arrangements for the development and review of the Board Assurance Framework and the Corporate Risk Register.

7.3.4 The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, , and related reporting and self-certification, including the Code of Governance and NHS Provider Licence.

7.3.5 The policies and procedures for all work related to counter fraud, bribery and corruption as required by the NHSCFA.

7.3.6 Structures, systems, processes and controls in place in relation to information governance in the Trust and approve the submission of the annual Information Governance Toolkit submission on behalf of the Board of Directors.

7.4 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of governance, risk management and internal control, together with indicators of their effectiveness.

7.5 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

7.6 As part of its integrated approach, tthe Committee will have effective relationships with other Board Committees, including the Quality Committee, in order that it understands processes and linkages. However, these other Board Committees must not usurp the Committee's role.

Internal Audit

7.7 The Committee shall ensure that there is an effective Internal Audit function that meets mandatory Public Sector Internal Audit standards and provides appropriate independent assurance to the Committee, Chief Executive, Chief Finance Officer and the Board. This will be achieved by:

7.7.1 Considering the provision of the Internal Audit service, the audit fee and any questions of resignation and dismissal.

7.7.2 Reviewing and approving the Internal Audit plan, and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.

7.7.3 Considering the major findings of Internal Audit work and the management's response and ensuring co-ordination between the Internal and External Auditors to optimise the use of audit resources.

7.7.4 Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust.

7.7.5 Monitoring the effectiveness of Internal Audit and carrying out an annual review.

External Audit

7.8 The Committee shall review and monitor the External Auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work. This will be achieved by:

7.8.1 Considering the appointment and performance of the External Auditors as far as the rules governing the appointment permit (and make recommendations to the Board when appropriate).

7.8.2 Discussing and agreeing with the External Auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan.

7.8.3 Reviewing all External Audit reports, including the report to those charged with governance (before its submission to the Board), and any work undertaken outside the annual plan together with the appropriateness of management responses.

7.8.4 Ensuring there is in place a clear policy on the engagement of the External Auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm.

Other assurance functions

7.9 The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation.

7.10 These will include, but will not be limited to, any reviews by the Department of Health and Social Care arm's length bodies or regulators/inspectors (for example, NHS Resolution and the Care Quality Commission) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies, etc.)

7.11 In addition the Committee will review the work of other Board Committees within the organisation, whose work can provide relevant assurance to the Committee's own areas of responsibility. This will include in particular safety/quality, for which assurance from clinical audit can be assessed, and risk managed.

Counter Fraud

7.12 The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.

7.13 With regards to the LCFS it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

Management

7.14 The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

7.15 The Committee may also request specific reports from individual functions within the organisation for example compliance reviews or accreditation reports.

Financial reporting

7.16 The Committee will monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

7.17 The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information.

7.18 The Committee will review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

7.18.1 The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.
7.18.2 Changes in and compliance with accounting policies, practices and estimation techniques.
7.18.3 Significant judgements in the financial statements.
7.18.4 Significant judgements in preparation of the financial statements and Letter of Representation.
7.18.5 Significant adjustments resulting from the audit.
7.18.6 Explanations for significant differences.

System for raising concerns

7.19 The Committee shall review the effectiveness of the arrangements in place for allowing staff and contractors to raise, in confidence, concerns about possible improprieties in any area of the organisation (, finance, clinical, safety or workforce matters), ensuring that arrangements are in place for the proportionate and independent investigation of such matters in accordance with relevant policies.

.

Governance and compliance

7.20 The Committee shall review the organisation's reporting on compliance with the NHS Provider Licence, NHS Code of Governance and the Fit and Proper Persons Test.

7.21 The committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts (including gifts and hospitality and bribery) are effective including receiving reports relation to non-compliance with the policy and procedures relation to conflicts of interest.

Behaviours and Values

Trust values

7.22 Members will be expected to conduct business in line with the Trust's values and objectives.

7.23 Members of, and those attending, the Committee shall behave in accordance with the Trust's Constitution, Standing Orders and any such Standards of Business Conduct Policy in place.

Equality and diversity

7.24 Members must demonstrably consider the equality and diversity implications of decisions they make.

8.0 Accountability and Reporting

8.1 The Committee shall report to the Board on how it discharges its responsibilities.

8.2 The minutes of the Committee's meetings shall be formally minuted by the Secretary to the Committee and available for the Board. The Chair of the Committee shall draw to the attention of the Board and issues that require disclosure to the full Board or require Executive action.

8.3 The Committee shall report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on the:

8.3.1 Fitness for purpose of the assurance framework.
8.3.2 Completeness and 'embeddedness' of risk management in the organisation.
8.3.3 Effectiveness of governance arrangements.
8.3.4 Appropriateness of the evidence that shows that the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.

8.4 The organisation's Annual Report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

8.5 An annual Committee effectiveness evaluation will be undertaken and reported to the Committee and to the Board.

9.0 Secretariat and administration

9.1 The Director of Corporate Affairs will ensure that a member of the Trust Secretariat shall be Secretary to the Committee, which will include ensuring that:

9.1.1 The agenda and papers are prepared and distributed within 5 working days prior to meetings, unless in extreme cases alternative arrangements are agreed with the Chair with the support of the Committee's Executive lead.
9.1.2 Attendance of those invited to attend meetings will be monitored and highlighting to the Chair those that do not meet the minimum requirements.
9.1.3 Records of member's appointments and renewal dates on the Board will be promoted to renew membership and identify new members where necessary.
9.1.4 Good quality minutes are taken and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept.

9.1.5 The Chair is supported to prepare and deliver reports to the Board.
9.1.6 The Committee is updated on pertinent issues/areas of interest/policy developments.
9.1.7 Action points are taken forward between meetings and progress against those actions is monitored.

10.0 **Review**

10.1 These Terms of Reference will be reviewed at least annually and more frequently if required. Any proposed amendments will be submitted to the Board for approval.

Date updated terms of reference approved by the Committee: 29 April 2026

Date updated terms of reference approved by the Board:

Date of next review date: March 2027

Cambridge University Hospitals NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust

Performance and Finance Committee

Terms of Reference

1.0 Constitution

1.1 The Performance and Finance Committee (the Committee) is constituted as a standing Committee of the Board of Directors and has no executive powers, other than those specifically delegated in these terms of reference.

A healthier life for everyone through care, learning and research

1. **Deliver excellent and timely care**
2. **Transform how and where we deliver care**
3. **Harness research and innovation to improve patient outcomes**

2.0 Authority

2.1 The Committee is directly accountable to the Board of Directors and is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee or contractor of the Trust and all employees and contractors are directed to cooperate with any request made by the Committee.

2.2 The Committee is authorised by the Board of Directors to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

3.0 Membership

- Four Non-Executive Directors (including the Committee Chair)
- Chief Finance Officer
- Chief Operating Officer
- Chief Governance and Performance Officer
- Chief Digital and Infrastructure Officer

3.1 The members of the Committee are appointed by the Board of Directors and comprise at least four Non-Executive Directors. One Non-Executive Director will be appointed as the Chair of the Committee by the Board of Directors.

3.2 The Chair of the Trust shall not chair or be a member of the Committee but may attend meetings by invitation as appropriate.

3.3 At least one of the members should also be a member of the Quality Committee to support the quality and patient safety agenda; it is preferable that at least one of the

members shall be a member of the People and Education Committee to support the workforce, culture and training agenda.

3.4 In line with the Trust's Policy, all members and meeting attendees are expected to declare potential conflicts of interest in relation to agenda items to allow consideration to be given to managing these during meetings.

4.0 Quorum

4.1 A quorum shall be four members (including at least two Non-Executive Directors).

4.2 Members should make every effort to attend all meetings of the Committee and will be required to attend at least 75% of meetings. If they are unable to attend they must provide an explanation to the Chair of the Committee who will consider with the Chair of the Trust if appropriate action should be taken. The Committee Secretary will monitor attendance by members and report this to the Chair of the Committee on a regular basis.

5.0 Attendance at meetings

5.1 The Chief Finance Officer and the Chief Operating Officer shall normally attend all meetings.

5.2 At least one Executive Director shall be in attendance at every meeting.

5.3 There is an open invitation for Non-executive Directors including the Chair, the Chief Executive and Chief Strategy and Transformation Officer to attend meetings.

5.4 The Company Secretary or the individual undertaking these duties and responsibilities at the Trust may attend meetings.

5.5 Representatives from other organisations and other individuals may be invited to attend, by invitation to support the workings of the Committee.

5.6 The Council of Governors may nominate up to two governors to attend each meeting of the Committee to observe proceedings. The observation of Board assurance committees by governors shall be subject to conditions agreed by the Board of Directors. The Chair of the Committee may in exceptional circumstances exclude governors from being present for specific items.

6.0 Frequency of meetings

6.1 Meetings will be held at least 11 times a year (including at least six meetings in person).

6.2 The Committee Chair may convene additional meetings of the Committee if necessary to consider business that requires urgent attention.

6.3 The Board or Chief Executive may also request an additional meeting if they consider that one is necessary.

6.4 To assist in the management of business over the year an annual workplan will be maintained, capturing the main items of business of each scheduled meeting.

7.0 Responsibilities

7.1 The duties and responsibilities of the Committee are as follows:

7.1.1 On behalf of the Board of Directors, to give detailed consideration to the Trust's performance and financial issues in order to provide the Board with assurance, information on key issues and clear decision points.

7.1.2 In doing so the Performance and Finance Committee will review and, where necessary, propose action on:

(a) The Trust's financial plans and strategies (revenue, capital programme and working capital).

(b) The Trust's service plans and performance in delivering operational targets.

(c) The Trust's efficiency/productivity plans and processes.

(d) The Trust's in-year financial and service performance and plans for corrective action.

(e) The content of financial, service and performance reports to the Board.

(f) Other key financial/service initiatives such Procurement, Estates/Transformation, Digital etc.

7.1.3 Consider key financial policies, issues and developments in accordance with the Committee's remit to ensure that they are shaped, developed and implemented in an appropriate way.

7.1.4 Give early strategic consideration to key service and operational issues and developments.

7.1.5 Review the performance of the Trust on a monthly basis across the range of performance indicators within the Integrated Performance Report, particularly focusing on access and finance. Scrutinise key indicators where performance is deteriorating and/or is off-trajectory and seek assurance that appropriate actions are being taken to bring performance back to trajectory.

7.1.6 Review the Trust's performance against any other key metrics and performance indicators required by NHS England or its successor body such as the National Oversight Framework (NOF) and seek assurance that appropriate actions are being taken to bring performance back to trajectory where applicable.

7.1.7 Review the development of the Trust's Operational Plan and other relevant regulatory submissions prior to submission to the Board of Directors for approval.

7.1.8 Consider any other financial and performance submissions in addition to above (plans and in-year monitoring returns) to the Trust's regulator (as appropriate) and responses; and to ensure that the relationship is managed appropriately.

7.1.9 Oversee the development of the Trust's work on Sustainability in accordance with legal, regulatory requirements.

7.1.10 Give early strategic consideration to significant business cases/capital investment proposals in accordance with the Trust's Standing Financial Instructions to ensure that they are developed in an appropriate way recommending endorsement by the Board of Directors as appropriate.

7.1.11 Receive an annual report on the structures, systems, processes and controls in place in relation to Emergency Preparedness, Resilience and Response, and approve the annual submission to the Trust's Regulator on behalf of the Board of Directors.

7.1.12 Review performance against the Trust's financial plan including delivery of the Cost Improvement Programme and the capital programme.

7.1.13 Undertake risk-based deep dives, as appropriate, to gain assurance in relation to key aspects of the Committee's remit.

7.1.14 Consider risks rated 15 and above in relation to the performance and finance agenda.

7.1.15 Provide oversight of Strategic risks entered onto the Board Assurance Framework (BAF) associated with the work of the Committee and ensure that all operational risks identified through the course of the Committee's business are being managed and escalated appropriately, in line with the Trust's Risk Management framework.

7.1.16 Report any material control issues to the Audit Committee.

7.1.17 Approve any policies delegated to the Committee by the Board.

Management

7.1.18 The Committee shall request and review reports, evidence and assurances from directors and managers on progress against any project that falls within the scope of 7.1.1 above.

7.1.19 The Committee may also request specific reports from individual functions within the organisation to support its overall function.

Behaviours and Values

Trust values

7.1.20 Members will be expected to conduct business in line with the Trust's values and objectives.

7.1.21 Members of, and those attending, the Committee shall behave in accordance with the Trust's Constitution, Standing Orders and any such Standards of Business Conduct Policy in place.

Equality and diversity

7.1.22 Members must demonstrably consider the equality and diversity implications of decisions they make.

8.0 Accountability and Reporting

8.1 The Committee shall report to the Board following each meeting on how it discharges its responsibilities and may also escalate item(s) to another Board Committee for appropriate action as appropriate.

8.2 The minutes of the Committee's meetings shall be formally minuted by the Secretary to the Committee and available for the Board. The Chair of the Committee shall draw to the attention of the Board and issues that require disclosure to the full Board or require Executive action.

8.3 An annual Committee effectiveness evaluation will be undertaken and reported to the Committee and to the Board.

9.0 Secretariat and administration

9.1 The Chief Governance and Performance Officer will ensure that a member of the Trust Secretariat shall be Secretary to the Committee, which will include ensuring that:

9.1.1 The agenda and papers are prepared and distributed within 5 working days prior to meetings, unless in extreme cases alternative arrangements are agreed with the Chair with the support of the Committee's Executive lead.

9.1.2 Attendance of those invited to attend meetings will be monitored and highlighting to the Chair those that do not meet the minimum requirements.

9.1.3 Records of member's appointments and renewal dates on the Board will be promoted to renew membership and identify new members where necessary.

9.1.4 Good quality minutes are taken and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept.

9.1.5 The Chair is supported to prepare and deliver reports to the Board.

9.1.6 The Committee is updated on pertinent issues/areas of interest/policy developments.

9.1.7 Action points are taken forward between meetings and progress against those actions is monitored.

10.0 Review

10.1 These Terms of Reference will be reviewed at least annually. Any proposed amendments will be submitted to the Board for approval.

Date approved by the Committee: 5 May 2026

Date approved by the Board:

Date of next review date: March 2027

NHS
Cambridge
University Hospitals
NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust

People, Education and Culture Committee

Terms of Reference

1.0 Constitution

1.1 The People, Education and Culture Committee (the Committee) is constituted as a standing Committee of the Board of Directors and has no executive powers, other than those specifically delegated in these terms of reference.

A healthier life for everyone through care, learning and research

1. **Deliver excellent and timely care**
2. **Transform how and where we deliver care**
3. **Harness research and innovation to improve patient outcomes**

2.0 Authority

2.1 The Committee is directly accountable to the Board of Directors and is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee or contractor of the Trust and all employees and contractors are directed to cooperate with any request made by the Committee.

2.2 The Committee is authorised by the Board of Directors to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

3.0 Membership

3.1 Four Non-Executive Directors (including the Committee Chair)
Chief People Officer
Chief Medical Officer
Chief Nursing Officer

3.2 The members of the Committee are appointed by the Board of Directors and comprise at least four Non-Executive Directors. One Non-Executive Director will be appointed as the Chair of the Committee by the Board of Directors.

3.3 The Chair of the Trust shall not chair or be a member of the Committee but may attend meetings by invitation as appropriate.

3.4 At least one of the members should also be a member of the Quality Committee to support the quality and patient safety agenda; and at least one member should be a member of the Performance and Finance Committee to support the performance and finance agenda.

3.5 The Chief Executive will identify an Executive lead for the Committee.

3.6 In line with the Trust's Policy, all members and meeting attendees are expected to declare potential conflicts of interest in relation to agenda items to allow consideration to be given to managing these during meetings.

4.0 Quorum

4.1 A quorum shall be four members (including at least two Non-Executive Directors).

4.2 Members should make every effort to attend all meetings of the Committee and will be required to attend at least 75% of meetings. If they are unable to attend they must provide an explanation to the Chair of the Committee who will consider with the Chair of the Trust if appropriate action should be taken. The Committee Secretary will monitor attendance by members and report this to the Chair of the Committee on a regular basis.

5.0 Attendance at meetings

5.1 The Chief People Officer shall normally attend all meetings.

5.2 At least one Executive Director shall be in attendance at every meeting.

5.3 There is an open invitation for Non-executive Directors including the Chair and the Chief Governance and Performance Officer to attend meetings.

5.4 The Company Secretary or the individual undertaking these duties and responsibilities at the Trust may attend meetings.

5.5 Representatives from other organisations and other individuals may be invited to attend, by invitation to support the workings of the Committee.

5.6 The Council of Governors may nominate up to two governors to attend each meeting of the Committee to observe proceedings. The observation of Board Committees by governors shall be subject to conditions agreed by the Board of Directors. The Chair of the Committee may in exceptional circumstances exclude governors from being present for specific items.

6.0 Frequency of meetings

6.1 Meetings will be held at least six times a year.

6.2 The Committee Chair may convene additional meetings of the Committee if necessary to consider business that requires urgent attention.

6.3 The Board or Chief Executive may also request an additional meeting if they consider that one is necessary.

6.4 To assist in the management of business over the year an annual workplan will be maintained, capturing the main items of business of each scheduled meeting.

7.0 Responsibilities

7.1 The duties and responsibilities of the Committee are as follows:

7.1.1 Oversee workforce, culture and organisational development practice and its operationalisation within the Trust, ensuring clear alignment with the delivery of the Trust's values, strategy, aims and objectives.

7.1.2 Approve and oversee the delivery of the Trust's People Strategy and implementation plan and provide assurance that is aligned to both the Trust's strategy the national NHS workforce agenda and any associated regulatory plans.

7.1.3 Approve and oversee the delivery of the Trust's Equality, Diversity and Inclusion strategy and implementation plan as it relates to its workforce.

7.1.4 Review, approve and monitor progress against workforce equality, diversity and inclusion plans and reports, including the Workforce Race Equality Standards (WRES), Workforce Disability Equality Standard (WDES) and Equality Delivery System (EDS2) (excluding working environment/services prior to submission to the Board of Directors seeking their approval.

7.1.5 Review the Trust's NHS National Staff Survey results and approve and monitor progress against the Trust's associated improvement plans.

7.1.6 Provide assurance to the Board of effective short, medium and long term workforce planning, and the monitoring of workforce numbers/pay costs (including agency usage/spend).

7.1.7 Review and monitor performance against key workforce metrics, identify and monitor any management interventions/actions that may be required.

7.1.8 Provide assurance to the Board that the Trust's workforce policies are fit for purpose and support the Trust's corporate aims and objectives.

7.1.9 Commission and monitor specific pieces of work, which the Committee deems necessary in order to provide assurance to the Board.

7.1.10 Ensure the Trust has effective systems in place for raising concerns at work including review of Freedom to Speak Up activity reports in relation to the Committee's scope and responsibilities and monitoring of progress against agreed priorities.

7.1.11 Review the findings of Internal and External Audit reports and any other external reports covering matters within the remit of the Committee (in doing so the Committee shall take advice from other Board Committees as appropriate) seeking assurance that appropriate actions are identified and implemented in response to findings and recommendations.

7.1.12 Undertake risk-based deep dives, as appropriate, to gain assurance in relation to key aspects of the Committee's responsibilities.

7.1.13 Consider risks rated 15 and above in relation to the people and education agenda.

7.1.14 Provide oversight of Strategic risks entered onto the Board Assurance Framework (BAF) associated with the work of the Committee and ensure that all operational risks identified through the course of the Committee's business are being managed and escalated appropriately, in line with the Trust's Risk Management framework.

7.1.15 Report any material control issues to the Audit Committee.

7.1.16 Approve any policies delegated to the Committee by the Board.

Management

7.1.17 The Committee shall request and review reports, evidence and assurances from directors and managers on progress against any project that falls within the scope of 7.1.1 above.

7.1.18 The Committee may also request specific reports from individual functions within the organisation to support its overall function.

Behaviours and Values

Trust values

7.1.19 Members will be expected to conduct business in line with the Trust's values and objectives.

7.1.20 Members of, and those attending, the Committee shall behave in accordance with the Trust's Constitution, Standing Orders and any such Standards of Business Conduct Policy in place.

Equality and diversity

7.1.21 Members must demonstrably consider the equality and diversity implications of decisions they make.

8.0 Accountability and Reporting

8.1 The Committee shall report to the Board following each meeting on how it discharges its responsibilities and may also escalate item(s) to another Board Committee for appropriate action as appropriate.

8.2 The minutes of the Committee's meetings shall be formally minuted by the Secretary to the Committee and available for the Board. The Chair of the Committee shall draw to the attention of the Board and issues that require disclosure to the full Board or require Executive action.

8.3 An annual Committee effectiveness evaluation will be undertaken and reported to the Committee and to the Board.

9.0 Secretariat and administration

9.1 The Chief Governance and Performance Officer will ensure that a member of the Trust Secretariat shall be Secretary to the Committee, which will include ensuring that:

9.1.1 The agenda and papers are prepared and distributed within 5 working days prior to meetings, unless in extreme cases alternative arrangements are agreed with the Chair with the support of the Committee's Executive lead.

9.1.2 Attendance of those invited to attend meetings will be monitored and highlighting to the Chair those that do not meet the minimum requirements.

9.1.3 Records of member's appointments and renewal dates on the Board will be promoted to renew membership and identify new members where necessary.

9.1.4 Good quality minutes are taken and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept.

9.1.5 The Chair is supported to prepare and deliver reports to the Board.

9.1.6 The Committee is updated on pertinent issues/areas of interest/policy developments.

9.1.7 Action points are taken forward between meetings and progress against those actions is monitored.

10.0 **Review**

10.1 These Terms of Reference will be reviewed at least annually. Any proposed amendments will be submitted to the Board for approval.

Date approved by the Committee: 4 May 2026

Date approved by the Board:

Date of next review date: March 2027

NHS
Cambridge
University Hospitals
NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust

Transformation Committee

Terms of Reference

1.0 Constitution

1.1 The Transformation Committee (the Committee) is constituted as a standing committee of the Board of Directors and has no executive powers, other than those specifically delegated in these terms of reference.

A healthier life for everyone through care, learning and research

1. **Deliver excellent and timely care**
2. **Transform how and where we deliver care**
3. **Harness research and innovation to improve patient outcomes**

2.0 Authority

2.1 The Committee is directly accountable to the Board of Directors and is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee or contractor of the Trust and all employees and contractors are directed to cooperate with any request made by the Committee.

2.2 The Committee is authorised by the Board of Directors to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

3.0 Membership

3.1 Three Non-Executive Directors (including the Committee Chair)
Chief Strategy and Transformation Officer
Chief Medical Officer
Chief Digital Information Officer

3.2 The members of the Committee are appointed by the Board of Directors and comprise at least three Non-Executive Directors. One Non-Executive Director will be appointed as the Chair of the Committee by the Board of Directors.

3.3 The Chair of the Trust shall not chair or be a member of the Committee but may attend meetings by invitation as appropriate.

3.4 At least one of the members should also be a member of the Quality Committee to support the quality and patient safety agenda.

3.5 The Chief Executive will identify an Executive lead for the Committee.

3.6 In line with the Trust's Policy, all members and meeting attendees are expected to declare potential conflicts of interest in relation to agenda items to allow consideration to be given to managing these during meetings.

4.0 Quorum

4.1 A quorum shall be four members (including at least two Non-Executive Directors).

4.2 Members should make every effort to attend all meetings of the Committee and will be required to attend at least 75% of meetings. If they are unable to attend they must provide an explanation to the Chair of the Committee who will consider with the Chair of the Trust if appropriate action should be taken. The Committee Secretary will monitor attendance by members and report this to the Chair of the Committee on a regular basis.

5.0 Attendance at meetings

5.1 The Chief Strategy and Transformation Officer shall normally attend all meetings.

5.2 At least one Executive Director shall be in attendance at every meeting.

5.3 There is an open invitation for Non-executive Directors including the Chair, the Chief Executive, Chief Governance and Performance Officer and Chief Information Officer to attend meetings.

5.4 The Company Secretary or the individual undertaking these duties and responsibilities at the Trust may attend meetings.

5.5 Representatives from other organisations and other individuals may be invited to attend, by invitation to support the workings of the Committee.

5.6 The Council of Governors may nominate up to two governors to attend each meeting of the Committee to observe proceedings. The observation of Board Committees by governors shall be subject to conditions agreed by the Board of Directors. The Chair of the Committee may in exceptional circumstances exclude governors from being present for specific items.

6.0 Frequency of meetings

6.1 Meetings will be held at least six times a year (including at least two meetings in person).

6.2 The Committee Chair may convene additional meetings of the Committee if necessary to consider business that requires urgent attention.

6.3 The Board or Chief Executive may also request an additional meeting if they consider that one is necessary.

6.4 To assist in the management of business over the year an annual workplan will be maintained, capturing the main items of business of each scheduled meeting.

7.0 Responsibilities

7.1 The duties and responsibilities of the Committee are as follows:

7.1.1 Oversee delivery of the Trust's strategic transformation, major programmes and research agenda, including those transformation programmes with a high dependency on technological change, with a focus on ensuring these are aligned with the Trust's strategic priorities and objectives, as well as cost-effective and timely.

7.1.2 Review the structures, systems, processes and controls in place to govern the Trust's Transformational agenda and constituent projects.

7.1.3 Oversee the Trust's transformation programmes, requiring business cases to be submitted to the Performance and Finance Committee; and Board as required on investment cases relating to the transformation programme in accordance with the Trust's Standing Financial Instructions (SFIs).

7.1.4 Review and make recommendation(s) to the Board in respect of any proposed material change including any third-party relationship.

7.1.5 Provide oversight to ensure that the impact of any lessons learned is considered in the Trust's strategic plans.

7.1.6 Review the overall approach of the programme to communications and stakeholder engagement (including engagement with staff, patients and carers, the public and partners).

7.1.7 Review the findings of Internal and External Audit reports and any other external reports covering matters within the remit of the Committee, seeking assurance that appropriate actions are identified and implemented in response to findings and recommendations.

7.1.8 Undertake risk-based deep dives, as appropriate, to gain assurance in relation to key aspects of the transformation programme.

7.1.9 Consider risks rated 15 and above in relation to the transformation or research agenda.

7.1.10 Provide oversight of Strategic risks entered onto the Board Assurance Framework (BAF) associated with the work of the Committee and ensure that all operational risks identified through the course of the Committee's business are being managed and escalated appropriately, in line with the Trust's Risk Management framework.

7.1.11 Report any material control issues to the Audit Committee.

7.1.12 Approve any policies delegated to the Committee by the Board.

Management

7.1.13 The Committee shall request and review reports, evidence and assurances from directors and managers on progress against any project that falls within the scope of 7.1.1 above.

7.1.14 The Committee may also request specific reports from individual functions within the organisation to support its overall function.

Behaviours and Values

Trust values

7.1.15 Members will be expected to conduct business in line with the Trust's values and objectives.

7.1.16 Members of, and those attending, the Committee shall behave in accordance with the Trust's Constitution, Standing Orders and any such Standards of Business Conduct Policy in place.

Equality and diversity

7.1.17 Members must demonstrably consider the equality and diversity implications of decisions they make.

8.0 Accountability and Reporting

8.1 The Committee shall report to the Board following each meeting on how it discharges its responsibilities and may also escalate item(s) to another Board Committee for appropriate action as appropriate.

8.2 The minutes of the Committee's meetings shall be formally minuted by the Secretary to the Committee and available for the Board. The Chair of the Committee shall draw to the attention of the Board and issues that require disclosure to the full Board or require Executive action.

9.0 Secretariat and administration

9.1 The Chief Governance and Performance Officer will ensure that a member of the Trust Secretariat shall be Secretary to the Committee, which will include ensuring that:

9.1.1 The agenda and papers are prepared and distributed within 5 working days prior to meetings, unless in extreme cases alternative arrangements are agreed with the Chair with the support of the Committee's Executive lead.

9.1.2 Attendance of those invited to attend meetings will be monitored and highlighting to the Chair those that do not meet the minimum requirements.

9.1.3 Records of member's appointments and renewal dates on the Board will be promoted to renew membership and identify new members where necessary.

9.1.4 Good quality minutes are taken and agreed with the Chair and that a record of matters arising, action points and issues to be carried forward are kept.

9.1.5 The Chair is supported to prepare and deliver reports to the Board.

9.1.6 The Committee is updated on pertinent issues/areas of interest/policy developments.

9.1.7 Action points are taken forward between meetings and progress against those actions is monitored.

10.0 **Review**

10.1 These Terms of Reference will be reviewed at least annually. Any proposed amendments will be submitted to the Board for approval.

Date approved by the Committee: 6 May 2026

Date approved by the Board:

Date of next review date: March 2027

Appendix E

Board Committee Membership

May 2026

Name of Committee	Audit Committee	Quality Committee	Performance and Finance Committee	People, Education and Culture Committee	Transformation Committee	Remuneration and Nomination Committee
Committee Chair (Non-executive Director)	Daniel Abrams	Rosalind Smyth	John Crompton	Rohan Sivanandan	James Morrow	Ali Layne-Smith
Other Non-executive Director members	John Crompton Philippa Hird James Morrow	James Morrow Philippa Hird	Daniel Abrams Rosalind Smyth Ali Layne Smith	Ali Layne Smith Philippa Hird Patrick Maxwell Rohan Sivanandan	Rosalind Smyth Patrick Maxwell	All Non-executive Directors including the Chair
Executive Director Lead	Chief Finance Officer (CFO)	Chief Nursing Officer (CNO) Chief Medical Officer (CMO)	CFO	Chief People Officer (CPO)	Chief Strategy and Transformation Officer (CSTO)	CPO
Other Executive Directors	Chief Executive Officer (CEO)	Chief Operating Officer (COO)	COO CNO Chief Governance and Performance Officer (CGPO) Chief Digital and Infrastructure Officer (CDIO)	CNO CMO	CMO CFO *CDIO*	CGPO CEO (*in such circumstances as discussing director's performance and objective setting and proposing any associated salary and performance awards*)
Standing Invitations	CGPO CNO CMO CPO	Chair All other Non-executive Directors CEO CGPO Deputy Chief Nurse	Chair All other Non-executive Directors CEO CSTO	Chair All other Non-executive Directors CGPO	Chair All other Non-executive Directors CEO CGPO Chief Information Officer (CIO)	
Frequency	5 times per year (at least) virtual	10 times per year (6 in person/hybrid)	11 times per year (6 in person/hybrid)	6 times per year virtual	6 times per year (2 in person/ hybrid)	3 times per year virtual

NHS
Cambridge University Hospitals
NHS Foundation Trust

Audit Committee
Escalation and Assurance report to Board of Directors

Meeting date:	**29 April 2026**
Chair's Name and designation:	**Mr D Abrams**

KEY ESCALATION AND DISCUSSION

Alert *(items to be escalated)*

The Committee were provided with an update on the status of contract negotiations with commissioners.

Advise *(areas of ongoing monitoring and/or any new developments that need to be communicated)*

The management action tracker highlighted two actions where the original due dates had been September 2025 and had subsequently been revised to April 2026. Revised timescales were noted, and assurance was sought that appropriate oversight remained in place to support delivery of the outstanding actions.

The PFI matter remains ongoing, although there is increased confidence that an agreement will be reached. It was noted that the associated documentation will not be completed ahead of audit completion and accounts sign-off in June 2026.

An update was received following the recent Counter Fraud Authority visit, where concerns had been raised regarding the reporting of referrals through the CLUE system. Following discussion with the Committee Chair, Chief Finance Officer and auditors, a revised process has been implemented. The annual submission has been updated to reflect the revised arrangements, with 10 green and 3 amber ratings reported.

The internal audit report on the Patient Safety Incident Response Framework was considered, which provided partial assurance with improvements required. The findings were noted, together with the actions being progressed.

Assure *(assurance that has been received)*

The draft Head of Internal Audit conclusion for 2025/26 was received. This provided amber-green opinions in respect of governance, risk management, and financial reporting and management. These opinions reflected that controls were broadly operating effectively, while recognising some exceptions in control design and opportunities for more consistent application in some areas.

As part of the Head of Internal Audit conclusion for 2025/26, an amber-red opinion was provided in respect of data captured and used by the organisation. This reflected weaknesses in the design and/or implementation of some controls and inconsistency in their operation. The findings were noted, together with the actions being taken to strengthen controls in this area.

Assurance was received from the internal audit report on the Data Security and Protection Toolkit, which provided a rating of significant assurance with minor improvement opportunities.

The internal audit report on Key Financial Controls provided a mixed assurance outcome. Significant assurance with minor improvement opportunities was provided in respect of the Cost Improvement Programme, while the process controls objective received partial assurance with improvements required. The findings were noted, together with the actions being taken to address the identified control improvements.

A positive update was received on progress against the IT, digital and cyber action plan. The improvements reported were noted, alongside the continued focus on strengthening the Trust's digital and cyber resilience arrangements.

Decisions *(made during the meeting)*

The Committee approved or endorsed the following items for onward reporting:

1. The Internal Audit Plan for 2026/27.
2. The Local Counter Fraud Annual Plan for 2025/26
3. The Local Counter Fraud Plan for 2026/27.
4. The CUH Cyber Security Strategy
5. The report supporting endorsement of the Going Concern Statement.
6. The report on assurances from those charged with governance.
7. The Annual Modern Slavery Act Statement.
8. The revised Audit Committee Terms of Reference.

New risks identified

No new risks were formally agreed for inclusion on the risk register or Board Assurance Framework at this meeting.

Escalation to other committees

There were no concerns for escalation to other committees.

Attendance Record				
Name of members	**29 Apr 2026**	**17 Jun 2026**	**16 Sept 2026**	**18 Nov 2026**
Mr D Abrams				
Mr J Crompton				
Ms P Hird				
Dr J Morrow				
Mr M Keech				

Key:

Attended	
Deputy on behalf but not part of quoracy	
Apologies	
Not a formal committee member at this point	

NHS
Cambridge University Hospitals
NHS Foundation Trust

Quality Committee
Escalation and Assurance report to Board of Directors

Meeting date:	**06 May 2026**
Chair's Name and designation:	**Ros Smyth**

KEY ESCALATION AND DISCUSSION

Alert *(items to be escalated)*

The transition from Cambridgeshire and Peterborough Integrated Care Board to the Central East Integrated Care Board (CEICB) from 01 April 2026 represents a significant change in commissioning and quality oversight arrangements. The transition period presents a risk of reduced commissioner capacity and continuity, with potential gaps in quality oversight, reporting and escalation as responsibilities transfer and new governance arrangements mature, including increased regional involvement.

There are ongoing challenges in supporting the timely completion of PSII improvement actions, with 77 of 79 actions currently overdue. This poses a risk to assurance, organisational learning and demonstrable improvement following serious incidents.

The Trust continues to be an outlier in antimicrobial usage across several antibiotic stewardship measures when benchmarked against the Shelford Group. Despite the identification of modifiable factors, performance remains poor relative to peer organisations. Further targeted action is required, and where staffing or resource gaps are identified, associated investment cases will need to be developed and progressed.

The Mental Health Annual Report highlighted the sustained impact of a high volume of complex adult and paediatric mental health patients on the delivery of care, particularly within the Emergency Department and on inpatient wards when patients are admitted. This continues to present operational and quality risks across urgent and inpatient pathways.

Advise *(areas of ongoing monitoring and/or any new developments that need to be communicated)*

The Board is asked to note longstanding non-compliance with Major Trauma Centre (MTC) standards, which remains a point of concern. This will return to Quality Committee for further assurance.

The Committee was previously sighted on dialysis capacity pressures, and noted the escalation of a candidate risk via the Risk Oversight Committee relating to potential patient harm from reduced dialysis capacity linked to the planned closure and rebuild of off-site dialysis centres affected by RAAC. Rising demand for dialysis services presents a further risk that insufficient capacity may be commissioned across the region, irrespective of RAAC remediation timelines.

Infection Control estate constraints and monitoring arrangements remain under review, with dependency on estates solutions.

The Maternity Incentive Scheme (MIS) Year 8 introduces increased reporting requirements, with enhanced assurance reporting to be provided to both Quality Committee and the Board of Directors.

Theatre capacity constraints in the Rosie Hospital were discussed. Mitigations are in place; however, this remains a risk requiring ongoing oversight.

Assure *(assurance that has been received)*

The Infection Control BAF provided assurance that, following the transmission of a blood‑borne infection in the Emergency Department, an appropriate incident management response was undertaken in conjunction with UKHSA. This work identified a number of actions requiring completion at both Trust‑wide and divisional level, which are being addressed through established governance arrangements.

The six-month update on the implementation of the Learning, Accountability and Change action plan was provided to the Committee. Good progress has been made across the action plan, with a number of key changes now implemented.

The Committee received assurance on the management of the paediatric orthopaedic incident response, the ongoing external reviews and maintaining high professional standards cases.

Decisions *(made during the meeting)*

The Committee approved the finalised improvement plan in response to the findings from NHS England's quality governance review. The Committee also approved the proposal of the plan as the Trust's quality priority for 2026/27 and therefore, inclusion in the Quality Account 2025/26.

The Committee supported the recommendations of green spaces in the Cambridge Cancer Research Hospital design.

New risks identified

No new risks were formally agreed for inclusion on the risk register or Board Assurance Framework at this meeting.

Escalation to other committees

There were no concerns for escalation to other committees.

Attendance Record				
Name of members	**06 May 2026**	**[Meeting date]**	**[Meeting date]**	**[Meeting date]**
Dr S Broster				
Dr J Morrow				
Mr R Sivanandan				
Prof R Smyth				
Ms L Szeremeta				

Key:

Attended	
Deputy on behalf but not part of quoracy	
Apologies	

NHS
Cambridge University Hospitals
NHS Foundation Trust

People, Education and Culture Committee Escalation and Assurance report to Board of Directors

Meeting date:	**3 June 2026**
Chair's Name and designation:	**Mr Rohan Sivanandan**

KEY ESCALATION AND DISCUSSION

Alert *(items to be escalated)*

Not applicable.

Advise *(areas of ongoing monitoring and/or any new developments that need to be communicated)*

The Committee received an update on Freedom to Speak Up and was advised of changes in the national and local context, alongside a full-service review currently underway. The Committee noted that 303 cases were raised during 2025/26, an increase from 295 in 2024/25, with the main themes relating to worker safety and wellbeing and inappropriate behaviours.

The Committee was also advised that staff survey results showed a decline in staff feeling safe to speak up and in confidence that the organisation would take action. Work is underway to strengthen data, reporting and triangulation of concerns raised across the organisation, to support improved oversight and a more coordinated organisational response.

The Committee received a staff story on the support for staff experiencing menta ill health, anxiety, stress, depression remaining the largest cause of sickness absence at CUH, accounting for nearly 22% of all Trust absence as of February 2026. This position mirrors the wider NHS picture, where mental health conditions account for nearly a quarter of all absence. The Committee was also advised that CPFT had ceased provision of the system procured fast-track Staff Mental Health Service in February 2026. This has caused distress to a number of CUH colleagues who had accessed and valued the service. CUH is working to explore future commissioning options for a replacement service.

Assure *(assurance that has been received)*

Through the report of the Chief People Officer, the Committee was advised that CUH remains in segment 2 under the National Oversight Framework overall, and in segment 1 within the People and Workforce domain, reflecting a high-performing position. The Committee noted that the performance indicators are expected to be expanded later in the year.

The Committee also noted the work underway on addressing emerging themes from the 2025 National Staff Survey and the progress being made to move from insight into coordinated action, aligned to the cultural ambitions being developed through the Board-led Task and Finish Group. An update was also provided on implementation of the Equality, Diversity and Inclusion Strategy.

The Committee was advised that, at Month 1, the Trust was marginally within its workforce plan overall, with agency use also within plan; however, bank usage was above plan. The Committee noted that industrial action and the later closure of a winter ward had contributed to additional temporary staffing usage.

Given the Trust has published a new strategy, it is timely to revise its people strategy (previously these have been described as CUH Workforce Commitments, that appear in the former Trust Strategy). A meeting of the Committee has therefore been planned for the 12 June 2026 for its members to discuss a draft people strategy, aligned with the Trust Strategy and national and regional priorities, prior to wider engagement.

At the last Committee meeting the Terms of Reference were approved subject to any further changes being approved by the Committee Chair and Executive lead in readiness for submission to the Board at its meeting on 13 May 2026 to seek final approval. The Board approved the Terms of Reference for the Committee to take forward.

The Committee received assurance that CUH had submitted a compliant workforce plan as part of the Medium-Term Planning framework and noted that the Month 1 position was within the overall limits of the plan. The Committee noted, however, that CUH had exceeded the bank temporary staffing limit and that Divisions had been asked to identify opportunities to reduce bank spend, with continued oversight through Quality and Performance meetings.

The Committee was also assured that, alongside the management of in-year performance, work is being taken forward to consider the longer-term workforce position across years 2 and 3 and beyond. This will support planning for future transformation, new ways of working and opportunities to deliver services differently.

Decisions *(made during the meeting)*

The Committee noted the update on the Board Assurance Framework and noted that the Committee's Terms of Reference had been approved by the Board in May 2026.

Through the Chief People Officer's Director's Report, the Committee also noted that a development session would be held on 12 June 2026 regarding the People Strategy.

The Committee also noted the Freedom to Speak Up report, the six-month update on the Verita action plan, and the Month 1 workforce update.

New risks identified

No new risks were formally agreed for inclusion on the risk register or Board Assurance Framework at this meeting.

Escalation to other committees

There were no concerns for escalation to other committees.

Attendance Record				
Name of members	**3 June 2026**	**23 Sept 2026**	**6 Nov 2026**	**18 Dec 2026**
Mr R Sivanandan				
Ms P Hird				
Ms A Layne-Smith				
Prof P Maxwell				
Dr S Broster				
Ms L Szeremeta				
Mr D Wherrett				

Key:

Attended	
Deputy on behalf but not part of quoracy	
Apologies	
Not a formal committee member at this point	

NHS
Cambridge University Hospitals
NHS Foundation Trust

Transformation Committee
Escalation and Assurance report to Board of Directors

Meeting date:	**6 May 2026**
Chair's Name and designation:	**John Crompton – Non-executive Director**

KEY ESCALATION AND DISCUSSION

Alert *(items to be escalated)*

- The Chief Operating Officer escalated sustained pressure across Urgent and Emergency Care (UEC), including incomplete recovery against 4□hour and 12□hour standards, persistent discharge delays, and increasing system fragility despite targeted mitigations.
- Rosie maternity theatres were escalated as a capacity and quality risk, with facilities not compliant with modern standards and teams operating under sustained pressure, increasing risk despite no recorded harm to date.

Support requested from the Board includes:

  - endorsement of escalation to arbitration where contract resolution cannot be secured;
  - support for a whole-system approach to UEC recovery, including discharge, flow and community diversion; and
  - continued capital prioritisation for safety-critical infrastructure.

Advise *(areas of ongoing monitoring and/or any new developments that need to be communicated)*

- The Integrated Improvement Plan (IIP) is being submitted monthly to NHS England Regional Team following Tier 1 elective oversight and the Verita review, providing assurance on delivery of access and recovery actions.
- Elective performance has improved materially over the year, including reductions in total waiting list size and progress toward clearing 65-week waits, with residual risk concentrated in gynaecology.
- Cancer performance remains strong on 28-day Faster Diagnosis, with 62-day under-performance driven primarily by breast, renal and radiotherapy capacity constraints which continue into 2026/27
- Diagnostics performance has deteriorated due to rising demand, particularly in cardiology imaging, with mitigations underway including mobile MRI, weekend CT, outsourcing of reporting and additional ultrasound and echocardiography capacity.
- UEC improvement activity includes workforce redesign to better match peaks in demand, enhanced ambulatory emergency care capacity, strengthened specialty response tracking and appointment of a dedicated programme manager.
- Winter performance was broadly stable compared to the previous year despite higher demand, with fewer IPC-related bed closures and strong flu vaccination uptake; a full after-action review is underway to inform winter planning.

- Capital delivery improved overall, with contract extensions approved to maintain service continuity while full re-procurement and longer-term planning progress.

Assure *(assurance that has been received)*

The Committee received assurance from the Executive Team that:

- the scale, drivers and concentration of the 2026/27 contractual income risk are clearly understood and actively managed;
- arbitration options and associated reputational and system risks have been explicitly identified and are subject to appropriate governance;
- productivity and transformation delivery is being accelerated and is not contingent on success in contractual negotiations;
- appropriate governance and due diligence had been applied to the proposed extension of the catering and domestic services contract to March 2027, providing continuity of service while full re-procurement and longer-term planning are progressed. The Committee was assured that risks to service quality, workforce stability and operational delivery were being appropriately managed during the interim period.
- the extension of the Telefónica Tech contract has been agreed within Board-approved budget parameters, securing continuity of core IT infrastructure and support services until November 2028
- clear arrangements are in place for phased decision-making, market testing and ongoing Committee oversight to ensure investment remains aligned to Trust priorities and capital affordability.
- workforce growth in Q4 reflected a time-limited elective recovery sprint, with plans in place to revert to sustainable run-rates;

Decisions *(made during the meeting)*

- The Committee noted the updated position on 2026/27 contract negotiations with Central East ICB.
- The Committee endorsed acceleration of productivity and transformation activity as a priority for 2026/27.
- The Committee noted the Integrated Improvement Plan and its use as an assurance mechanism with NHS England.
- The Committee approved the proposed contract extensions for catering, domestic services and IT managed services.
- The Committee approved the Trust budget allocations as presented.

New risks identified

n/a

Escalation to other committees

n/a

Attendance Record							
Name of members	**6.5.26**	**[Meeting date]**	**[Meeting date]**	**[Meeting date]**	**[Meeting date]**	**[Meeting date]**	**[Meeting date]**
J Crompton							
D Abrams							
R Smith							
A Layne-Smith							
M Keech							
N Kirby							
B Hughes							

Key:

Attended	
Deputy on behalf but not part of quoracy	
Apologies	

Cambridge University Hospitals NHS Foundation Trust

Report to Board of Directors held on Wednesday, 10 June 2026

Title	Use of the Trust Seal			
Report Sponsor	Beth Hughes, Chief Governance and Performance Officer			
Author	Jason Clarke, Trust Secretary			
Status	**Decision** ☐	**Assurance** ☐	**Information** ☑	**Discussion** ☐

RECOMMENDATION

The Board of Directors is asked to:

- **note** the use of the Trust Seal on the occasions listed in the report.

KEY MESSAGES

The Trust Seal is the formal corporate seal of the Trust and is used to execute certain legal documents on behalf of the organisation.

The Trust's Constitution sets out the provisions for the custody, use and reporting of the Seal, including the requirement for a register of sealing to be maintained and for use of the Seal to be reported to the Board of Directors at least quarterly.

This report summarises the use of the Trust Seal since the previous report and supports Board oversight of the documents sealed during the reporting period.

BACKGROUND, INCLUDING PURPOSE OF THE REPORT

The purpose of this report is to inform the Board of Directors of the use of the Trust Seal since the previous report.

This report provides the Board of Directors with a summary of the use of the Trust Seal since the previous report. It supports Board oversight by setting out the documents to which the Seal has been applied and the purpose of each transaction.

ALIGNMENT TO TRUST STRATEGIC PRIORITIES

Our strategy: a healthier life for everyone through care, learning and research 2026-2031		**Indicate all that apply**
	Deliver Excellent and Timely Care	☑
	Transform How and Where We Deliver Care	☑
	Harness Research and Innovation to Improve Patient Outcomes	☐

ALIGNMENT TO MOST RELEVANT STRATEGIC RISK

Not applicable

PAPER REVIEW AND GOVERNANCE PATHWAY

Name of group or committee that has previously considered this report	**Date**
Not applicable	
Name of group or committee that the report will be presented to in the future	
Not applicable	

Cambridge University Hospitals NHS Foundation Trust

10 June 2026

Board of Directors

Use of the Trust Seal

Beth Hughes, Chief Governance and Performance Officer

1. Introduction

1.1 The Trust Seal is the formal corporate seal of the Trust and is used to execute certain legal documents on behalf of the organisation, usually where a document is required to be executed as a deed or where formal sealing is otherwise appropriate. The use of the Seal provides evidence that the document has been formally executed by the Trust.

1.2 The Trust's Constitution provides that the Trust shall have a seal and includes specific provisions for the custody and use of the Common Seal, the sealing of documents, and the maintenance of a register of sealing. The Constitution states that the Common Seal shall be kept by the Chief Governance and Performance Officer; that two Executive Directors have general authority to execute a deed and attest to the affixing of the Seal and that a register shall be maintained detailing the use of the Seal. The Constitution also requires that use of the Seal is reported to the Board of Directors at least quarterly.

1.3 This report provides the Board of Directors with a summary of the use of the Trust Seal since the previous report and supports Board oversight by setting out the documents to which the Seal has been applied and the purpose of each transaction

2 Use of the Trust Seal

2.1 The Trust Seal has been applied on the following occasions since the previous report to the Board of Directors:

18 March 2026:

- A JCT Design and Build Contract 2016 relating to the design and installation of PV system between RG Carter Cambridge Limited and Cambridge University Hospitals NHS Foundation Trust.

- A JCT Standard Building Contract 2016 relating to hot and cold water replacement between CPS Building Services Ltd and Cambridge University Hospitals NHS Foundation Trust.

- A JCT Design and Build Contract 2016 with employers' amendments in relation to the refurbishment of the LA2 bunker in readiness for the replacement LINAC

equipment between Pentaco Construction Ltd and Cambridge University Hospitals NHS Foundation Trust.

5 May 2026:

- A JCT Pre-Construction Services Agreement 2016 relating to the Fire Ward Improvement Programme for Ward C8 between Barnes Construction Ltd and Cambridge University Hospitals NHS Foundation Trust.

- A surrender and regrant/variation of lease relating to the land to the rear of 28 Long Road and associated lease arrangements between Maggie Keswick Jencks Cancer Caring Trust, Maggie's Trading Ltd and Cambridge University Hospitals NHS Trust.
- A Design and Build Contract 2026 in relation to the Gamma Camera replacement between GE Medical Services and Cambridge University Hospitals NHS Foundation Trust.

- A lease renewal relating to Ely Day Surgery (Princess of Wales Hospital, Ely) between the East of England Community Health and Care NHS Trust and Cambridge University Hospitals NHS Foundation Trust.

3 Recommendation

3.2 The Board of Directors is asked to note the use of the Trust Seal on the occasions set out in this report and the assurance provided that use of the Seal is recorded and reported in accordance with the provisions of the Trust's Constitution.