Council of Governors

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Council of Governors Meeting (held in public)
Wednesday, 17 December 2025 at 17.00 in the Committee Room, School of Clinical Medicine, Addenbrooke's Hospital, Cambridge CB2 0QQ (and via videoconference)

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

AGENDA

General Business			Purpose	Lead
17.00	**1.**	**Welcome and apologies for absence**	For note	Sally Morgan, Chair
	2.	**Declarations of interest** Any new interests to declare or any interests to declare in relation to open agenda items (*Copies of the Register of Governors' interests are available from the Trust Secretariat*)	For note	
17.05	**3.***	**Minutes of the previous meeting** To approve the minutes of the meeting held on 25 September 2025.	For approval	
	4.*	**Council of Governors Action Tracker and Matters Arising** (*in addition to those included on the agenda*)	For review	
17.15	**5.**	**Chair's Report** To receive the verbal update of the Trust Chair	For receipt	Sally Morgan, Chair

17.25	**6.***	**Lead Governor Report** To receive the report of the Lead Governor	For receipt	Helena Rubinstien, Lead Governor
17.35	**7.**	**Board Committees** To receive the verbal reports of the Chairs of the Board Committees • Quality Committee • Performance Committee • Workforce Committee • Addenbrooke's Futures Committee • Audit Committee	For receipt and discussion	Board Committee Chairs or Non-executive Director Committee member
18.25	**8.***	**Chief Executive's Report (including Integrated Performance Report)** To receive the report of the Chief Executive	For receipt	Roland Sinker, Chief Executive
18.40	**9.***	**Extension to the External Audit Contract as Recommended by the Audit Committee** To approve the proposal of the Chief Finance Officer	To approve	Mike Keech, Chief Finance Officer
18.45	**10.**	**Any other business** Items of any other business to be identified to the Trust Secretary in advance of the meeting	For note	Sally Morgan, Chair
	11.	**Date of the next meeting** The next meeting of the Council of Governors will be on Wednesday, 25 March 2026.	For note	
18.50	**12.**	**Close of meeting**		

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Minutes of the meeting of the Council of Governors held on Thursday 25 September 2025 at 17.30 in the Committee Room, Clinical School of Medicine, Addenbrooke's Hospital, Cambridge, CB2 0QQ (and via videoconference)

Member	Position	Present	Apologies
Baroness S Morgan	Trust Chair	X	
Mr F Allan	Staff Governor	X	
Dr J Allen	Public Governor	X	
Dr J Biddle	Public Governor	X	
Prof J Clarkson	Partnership Governor (University of Cambridge)		X
Dr R Cubberley	Partnership Governor (Anglia Ruskin University)	X	
Mr C Cumberland	Public Governor	X	
Ms S Dixon	Patient Governor	X	
Dr R Hodder	Patient Governor	X	
Ms M Haldane	Patient Governor	X	
Ms E Howe	Patient Governor	X	
Mr V Johnson	Staff Governor		X
Dr K Rush	Public Governor	X	
Mr S Legood	Partnership Governor (Cambridgeshire and Peterborough NHS Foundation Trust)		X
Ms E Morada	Staff Governor	X	
Dr H Rubinstein	Public Governor		X
Ms C Dear	Patient Governor	X	
Mr R Stevens	Patient Governor		X
Prof P St George Hyslop	Partnership Governor (University of Cambridge)		X
Dr N Stutchbury	Patient Governor and Lead Governor	X	
Mr D Trajkovski	Patient Governor	X	
Cllr M Todd-Jones	Partnership Governor (Cambridgeshire County Council)		X
Dr C Tyrrell	Public Governor	X	
Mr W Watson	Public Governor	X	
Mr C White	Staff Governor	X	
In attendance			
Dr S Broster	Chief Medical Officer		

Mr J Clarke	Trust Secretary (Minutes)
Dr A Doherty	Non-Executive Director
Mr M Keech	Chief Finance Officer
Mr R Sinker	Chief Executive Officer
Mr R Sivanandan	Non-Executive Director
Ms C Charlton	Director of Capital, Estates and Facilities Management
Ms P Hird	Non-Executive Director
Ms L Hughes	Interim Head of Governance
Mr R Arora	Forvis Mazars *(for item 25/25 only)*
Mr G Burgess	Chief of Staff
Mr J Crompton	Non-Executive Director
Ms A Layne-Smith	Non-Executive Director
Dr J Morrow	Non-Executive Director
Mr D Abrams	Non-Executive Director

21/25 Apologies for absence

Apologies for absence received from governors are recorded in the above table.

22/25 Declarations of Interest

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

23/25 Minutes of the previous meeting

The minutes of the previous meeting held on 25 June 2025 were approved as a true and accurate record of the meeting.

24/25 Council of Governors action tracker and matters arising not covered by other items on the agenda

Received and noted: The action tracker.

25/25 External Auditors

Suresh Patel, Partner, External Auditors

Noted:

1. The Council received an update regarding the external audit process for the 2024/25 financial year, with an unqualified audit opinion achieved by the stipulated deadline. This accomplishment was noted to be particularly significant given the challenging circumstances and the considerable pressure experienced by the finance teams throughout the process.
2. Additionally, it was highlighted that the audit identified a larger number of findings and unadjusted items than in previous years. In particular, attention was drawn to the need to tidy up the fixed asset register. Despite these points, there was confidence expressed in both the integrity of the audit process and the overall outcome.
3. The external auditor discussed its value for money assessment, emphasising the requirement to ensure that the Trust has adequate resources in place. This includes oversight of finance, governance, and the pursuit of economies, efficiencies, and effectiveness throughout the organisation.
4. Nevertheless, there remains confidence from the auditors that the arrangements expected to support financial sustainability, robust governance, and effective resource management are in place.

In the discussion the following points were made:

1. The Council noted that there is robust assurance regarding the processes and controls currently in place. These measures have been established to ensure that the organisation operates effectively, with clear oversight mechanisms supporting both compliance and continuous improvement. The effectiveness of these controls is regularly reviewed, providing confidence in the integrity of the systems underpinning the Trust's activities. This assurance enables the Council to maintain a high level of trust in the management of its responsibilities and the safeguarding of organisational standards.
2. The Council acknowledged that, while there are ongoing challenges similar to those encountered in other trusts, the governance arrangements and mechanisms currently in place at CUH are considered to be robust and effective.
3. The Council discussed the current position regarding the ongoing paediatric orthopaedic incident, and expressed a concern regarding how the incident is reflected through the identification of significant gaps in control. The Council acknowledged that a comprehensive review of clinical harm is currently underway, with the Quality Committee, through the Chief Medical Officer and Committee Chair, providing Board level oversight and leadership.
4. The Council emphasised the need to consider the recommendations that arise from the review into clinical harm and the review into missed opportunities. Attention was also drawn to the importance of identifying and applying lessons learned, to ensure continuous improvement and to enhance the quality and sustainability of paediatric orthopaedic services in the future.

Agreed:

1. To note the report of the Trust's external auditor.

26/25 Composition of the Council of Governors

Beth Hughes, Interim Chief Governance and Performance Officer, presented the report.

Noted:

1. An update was provided on the membership of the Council of Governors.
2. Cambridge County Council confirmed on 24 June 2025 the appointment of Cllr Luis Navarro as its Partnership Governor nominee for a period of 12 months. Cllr Mike Todd-Jones succeeds Cllr Susan van de Ven in this role.
3. On 25 August 2025 Karen Woodey informed the Trust of her decision to step down from her role as Partnership Governor with immediate effect. Campus Research Organisations has not yet confirmed its Partnership Governor in succession to Karen Woodey.
4. On 11 September 2025 Royal Papworth Hospital NHS Foundation Trust informed the Trust of a new Partnership nominee to replace Dr Stephen Webb. The Trust are in communication with Royal Papworth Hospital and will formally report the outcome of those discussions at the next meeting of the Council.

Agreed:

1. To note the current composition of the Council of Governors.

27/25 Chair's report

Sally Morgan, Trust Chair, presented the verbal update.

Noted:

1. Regular local visits within the hospital have proven to be highly productive, providing a valuable opportunity to engage directly with staff, allowing for open conversations about what is working well and what areas require improvement. By observing first-hand and maintaining an open-minded approach, the leadership team is able to gain a clearer understanding of the day-to-day realities faced by staff and patients alike.
2. There is a continued emphasis on performance and productivity across the Trust, with a particular focus on Infection Prevention and Control (IPC). Monitoring and improving these key areas remain priorities, ensuring that standards are upheld and the quality of patient care is continually enhanced.
3. There remains a commitment to ensure continued oversight as recommendations arising from the paediatric orthopaedic incident

are addressed and further developments are considered for the future structure of paediatric orthopaedic services.

In discussion the following points were raised:

1. Regular leadership walkabouts are undertaken throughout the hospital to enhance engagement and learning. These visits are typically conducted fortnightly by either the Chief Nurse or Chief Medical Officer, accompanied by team leaders. The consistent schedule ensures that teams are aware of when walkabouts will take place, which helps to foster open communication and transparency.
2. Multi-disciplinary teams are actively included in these walkabouts, reflecting the Trust's commitment to collaborative working. The primary aim is to engage directly with staff across different disciplines, listening to their experiences and perspectives to identify good practice and areas for improvement. This approach supports continuous learning and improvement within the organisation.
3. Non-Executive Directors (NEDs) have been specifically allocated to individual divisions within the Trust. This approach is designed to foster stronger relationships and facilitate more effective engagement between NEDs and the respective teams. By building these connections, the Trust aims to enhance oversight, support divisional leadership, and ensure that governance processes are robust and responsive to the needs of each area.
4. There was an expressed interest in further exploring the potential for governors to actively participate in regular walkarounds across the hospital. Involvement in these walkarounds would provide governors with valuable first-hand insights into the day-to-day experiences of staff and patients, as well as the opportunity to engage directly with team members. By joining these sessions, governors could enhance their understanding of operational challenges and successes, helping to inform their strategic oversight and support for continued improvement within the Trust.

Agreed:

1. To note the verbal update of the Chair.

28/25 Trust Constitution

Beth Hughes, Interim Chief Governance and Performance Officer, presented the report.

Noted:

1. At the meeting on 10 September 2025, the Board formally approved the changes that were discussed during the previous meeting. Following this decision, a thorough spell check will be carried out, along with minor amendments, to ensure that the final version of the document is accurate and free from errors.

Agreed:

1. To note that the Board have agreed to the changes proposed by the Council of Governors at its meeting in June 2025.

29/25 Chief Executive's Report (including Integrated Performance Report)

Roland Sinker, Chief Executive, presented the report.

Noted:

1. The Council of Governors were given an overview of the five areas of operational performance.
2. The new NHS National Operating Framework (NOF) has been released, with the Trust ranked 70th out of 134 trusts. While there is some disappointment at the current placement within the third segment, this outcome is understood in the context of the data-driven methodology employed by the framework. Looking forward, the organisation's aspiration is to reach the top of this segment, reflecting ongoing efforts to improve performance and outcomes.
3. The organisation remains steadfastly focused on driving up quality across all areas, with particular attention given to maternity services. Efforts are concentrated on enhancing outcomes for mothers and babies, with targeted initiatives underway to reduce infection rates and incidences of sepsis. These priorities are supported by an ongoing review of quality governance processes, which will be instrumental in shaping the future course of improvement. By maintaining a rigorous approach to monitoring and governance, the organisation aims to ensure that maternity services are continually developed to deliver the highest possible standards of care.
4. The leadership team has recently conducted a comprehensive self-assessment to evaluate current practices and identify areas for further improvement. This process is designed to ensure that the organisation maintains high standards across all areas and remains responsive to emerging challenges.
5. In parallel, the Care Quality Commission (CQC), now operating under new leadership, has shifted its approach to inspections. The CQC is increasingly targeting its inspections towards specific areas identified as potential hotspots through data analysis. As a result, the Trust anticipates forthcoming inspections focusing on paediatric services and an overall review of leadership. These targeted reviews will provide valuable external scrutiny, supporting the organisation's ongoing commitment to transparency, accountability, and high-quality care.
6. Despite these strengths, the Trust is required to implement nationally mandated workforce reductions, which will result in around 130 redundancies.
7. The organisation continues to demonstrate strong performance with regard to access to urgent and emergency care (UEC)

services. The most recent data indicates that the Trust is not only meeting but is ahead of its planned targets in this area. Over the past 12 months, there has been a notable improvement in performance metrics, reflecting sustained efforts to streamline processes and deliver timely care to patients requiring urgent or emergency interventions.

8. The organisation has demonstrated robust financial management, achieving a break-even position for the fifth consecutive year. This consistent performance reflects a disciplined approach to financial oversight, ensuring that resources are allocated effectively and that expenditure remains within planned limits. The sustained break-even outcome highlights the organisation's commitment to sound financial stewardship, even as it navigates evolving national frameworks and operational challenges. Maintaining this level of financial stability has enabled the Trust to support its core priorities and continue investing in quality care and service improvements.
9. An oversight board has been established to address the paediatric orthopaedic surgery incident, ensuring robust governance and accountability throughout the review process. The board will provide strategic direction and monitor progress to guarantee that all aspects of the incident are thoroughly examined.
10. In addition to the oversight board, a comprehensive clinical review is currently underway. This review aims to assess the clinical implications of the incident, identify any areas for improvement, and ensure that patient safety remains paramount.
11. Furthermore, the trust has committed to publishing the Verita review in October 2025. This external review will offer an independent perspective, supporting transparency and providing additional assurance regarding the thoroughness and integrity of the organisation’s response.

The following points were made in discussion:

1. The recent incident within paediatric orthopaedics has placed a clear focus on those patients and families who have been adversely affected. The organisation's primary concern is to ensure that robust support mechanisms are in place for these individuals, addressing both immediate needs and ongoing care requirements.
2. The incident response team has demonstrated strong commitment in responding to the situation, emphasising the importance of transparency, openness, and honesty throughout the process. An external review of clinical care is underway, and while it is anticipated that this will be an uncomfortable experience, it remains a vital step towards providing assurance and maintaining public trust. The trust recognises that candid engagement with external scrutiny is essential in driving improvement and safeguarding the interests of patients and their families.
3. The organisation continues to monitor waiting times and Referral to Treatment (RTT) pathways, recognising the complexity within

the current patient mix. This includes a range of cases from straightforward day procedures to more complex cases that require the involvement of multiple surgical consultants. Notably, within the group experiencing longer waits, several patients are late in their treatment pathway, having been referred from other services.

4. There are currently eight specialities identified where particularly long waiting times persist. For instance, Oral and Maxillofacial Surgery (OMFS) has been highlighted as the speciality with the highest number of patients facing extended waits. To address this, a targeted approach has been adopted, including the employment of a consultant in rhinology to support one of the subspecialties.
5. Patient management within these specialities is being conducted through a detailed process of patient-by-patient cohorting. This involves prioritising individuals first according to clinical urgency, and subsequently by the length of time they have been waiting. This structured approach ensures that resources are allocated effectively, with the aim of reducing waiting times for those most in need while maintaining equitable access across all patient groups.
6. The Board wants a detailed briefing to better understand the algorithm, support transparency, and ensure informed oversight. Members value clarity on methodology and processes to reinforce strong governance and evidence-based decisions.

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

Questions:

1. *NHSE recently published a set of league tables based on performance against the new oversight framework. CUH was 70th out of 134 acute trusts, a position which comes as a surprise to members of the public, who generally think of CUH as a top-tier hospital. As Nicola Ayton said at the public meeting, it is not a position the board is happy about and it will be addressing the areas where scoring was low: elective waits, infection control, some cancer targets and ED waits, while not adversely impact areas where CUH does well: staff and patient experience, staff sickness/absence and financial controls. The metrics remind us that the areas where performance has been below target, have been below target for months if not years and some of these have worsened this year. While we hear many patient stories of excellent care, we are also hearing more and more frustrations about poor communications with admin/booking staff, long waits in ED, being moved into inappropriate wards, having operations cancelled at the last minute etc., all of which is contributing to a decline in confidence in our health service both locally and nationally. How have NEDs allowed this situation to have persisted for so long; why did NEDs not spot the declining performance in elective waits and cancer diagnostics earlier this year; and what*

specific things are NEDs doing to ensure we deliver consistent and better care to our patients, so that our aspiration to be a top-tier trust is reflected in the league table?

The response from the Executive was as follows:

Performance against waiting times

Urgent care: in December 2023, 62.9% of patients requiring urgent care were admitted or discharged within 4 hours. Since then, performance has consistently improved, reaching 74.4 percent in August 2025. Over the same period, patients waiting more than 12 hours has fallen from **14.0%** to **8.9%.**

Elective care: in May 2023, 3,794 patients were waiting more than 52 weeks for planned care. This improved to 1,843 patients waiting more than 52 weeks in December 2024. This deteriorated to 2,830 in May 2025; with interventions to deliver recovery of performance in the summer the number of patients waiting more than 52 weeks is reducing and is now at 2,681. A similar pattern is observed for patients waiting more than 65 weeks, which totalled 1,117 in August 2023, and is forecast to be 115 patients in September 2025.

Cancer care: CUH has consistently performed well in both delivering the 62 day urgent cancer referral standard as well as the 28 day Faster Diagnosis Standard. The recent deterioration is driven by shortfalls in capacity within specific pathways, with breast, urology and skin accounting for the largest change in performance. In July, 74.4 percent of patients received their diagnosis within 28 days of being referred on an urgent cancer pathway, which is lower than the 80 percent threshold which services had consistently delivered from December 2023 until the recent deterioration in May 2025 (**76.3%**). Improvement work is yielding results in most areas, including in breast services with recruitment to a consultant post and in pathology services, which have improved 7 day turnaround from a low point of 55% in early May to 78 percent in September. Whilst challenges remain in some pathways, notably skin cancer, the trust will be able to recover its performance to ensure that patients do not have to experience unacceptably long waits in future.

Diagnostic waits: these are crucial to effective and timely care. This is a performance metric reported nationally. From a position of 68.5% of patients waiting more than six weeks for diagnostics in May 2020**, 6.7%** of patients were recorded as waiting more than six weeks in **July** 2025. In **July**, CUH ranks in the upper quartile of providers in the NHS for diagnostic waiting time performance.

The response from the non-executive directors was as follows:

All of these performance metrics are reported formally through the Performance Committee and into the Trust Board, providing a transparent mechanism for accountability of the executive for performance against the breadth of operational priorities. The integrated performance report presents performance data, provides time series analysis, explains causes of observed deteriorations and sets out actions being undertaken to drive improvements. These actions are managed through a variety of mechanisms, including the monthly cycle of divisional quality and performance meetings, as well as a weekly operational taskforce chaired by the Interim Chief Operating Officer, focusing on elective performance. Since July, the Trust has also been reporting its performance and improvement programme to NHS England on a fortnightly cycle, as part of the Tier 1 Elective Performance process.

2. *Please could governors have an update on small capital projects around the site. Specifically:*
    - *rectifying the air flow issues in maternity theatres*
    - *the conversion of office space near ED to increase capacity in A&E*
    - *the conversion of Clinic 9 into a same day emergency care unit*
    - *current status of the works to improve fire safety*

What are the anticipated benefits to patients of these projects?

A detailed response was provided by the Director for Capital, Estates and Facilities Management, which noted:

Rectifying the air flow issues in maternity theatres :

- The team have been working to ensure that the ventilation system is performing as best it can for example replacing frost coils, rebalancing the system and are undertaking a series of actions to optimise the airflows, ahead of a fuller design and delivery of an intermediate position where the ductwork and air handling units are modified to increase the air flows to the minimum requirement of 18 air changes per hour.
- Working in a live environment is challenging, when it impacts capacity, so good working between engineering, operational and clinical teams to strike the balance between the impact on clinical capacity, and undertaking the works and having access to scope the intermediate level works package. The aim is to deliver this by end of March 2026.
- The works will require complete shutdown of the theatres and so planning is crucial

<u>Benefit for patients:</u>

- Enhanced airflows and ventilation system contributes to reducing risk of infection.

the conversion of office space near ED to increase capacity in A&E :

- The scheme, delivered in phases, in a live 24/7 environment and aims to increase the waiting space, and create primary assessment space, triage and consulting space, along with phlebotomy services into the expanded footprint.

Benefit for patients

- Improved arrivals and waiting experience for patients.
- Co-location of these facilities support early assessment and clinical decision making

the conversion of Clinic 9 into a same day emergency care unit :

- This is no longer described as a same day emergency care unit, it is now an *Urgent Care Centre housing Minor injuries, the Primary care GP service and Emergency Medicine(EM) ambulant adult pathways*
- Refurbishment and reconfiguration of the clinic space to support the urgent care pathway providing additional cubicles and treatment chairs

Benefit to patients

- Provision of additional cubicles and treatment chairs will help streamline and support more efficient EM workflows for a key cohort of EM pathways
- Opportunity to expand digitisation to support booked appointments across Minor injuries and GP service in the first instance

Current status of the works to improve fire safety:

Priority Area 1 – Automatic fire alarm system

- To improve cover of detection in pursuit of the appropriate standard
- Fire panel upgrade completed (to European standard) to improve capacity
- Due to commence with hardware updates and subsequently complete the re-write of the matrix

Priority Area 2 – Fire Stopping

- Statutory Fire compliance works to maintain fire stopping and fire compartmentation lines have been progressing throughout CUH and wider Trust buildings as part of a programme of works that has been in place since 2018.
- Refurbishment of ward NCCU has included a range of fire safety works as part of the refurbishment process

- Major upgrades to the A-block included replacing the timber roof, installing new air handling units, improving fire stopping between the theatre and plant room levels, upgrading lifts to fire evacuation lifts, and adding compartmentation to each lobby level.

Anticipated patient benefits:

- Upgrading the fire detection system ensures all areas have proper coverage, allowing for quick response and timely patient evacuation.
- The fire stopping program ensures all fire walls and floors are sealed to provide necessary fire breaks, allowing patients to be safely moved and remain protected or relocated as needed.
- Improved fire safety within a vulnerable patient area, NCCU when they return in January 2026.

Agreed:

1. To note the report of the Chief Executive.

30/25 Governors' Reports

Lead Governor

Neil Stutchbury, Lead Governor, presented the report.

Agreed:

1. To note the report of the Lead Governor.

31/25 Any other business

Noted:

1. Governors played an active role in the Patient-Led Assessments of the Care Environment (PLACE) for both the cardiology and maternity departments. Their participation provided valuable insights into the effectiveness and quality of the care environments within these key clinical areas.
2. Feedback from the governors highlighted a positive experience throughout the assessment process. Their involvement not only supported the evaluation but also helped ensure that patients' perspectives and needs were central to the review, contributing to ongoing improvements in patient care and service delivery.

32/25 Date of next meeting

The next meeting of the Council of Governors in public would be held on Wednesday 17 December 2025 at 17.00pm

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Council of Governors: Action Tracker

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

Council of Governors

Cambridge University Hospitals NHS Foundation Trust

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Report to the Council of Governors: 17 December 2025

Agenda item	6
Title	Report from the Lead Governor
Sponsoring executive director	n/a
Author(s)	Helena Rubinstein, Lead Governor of the Council of Governors
Purpose	To summarise the activities of the Council of Governors, highlight matters of concern and note successes.
Previously considered by	n/a

Executive Summary

The report summarises the activities of the Council of Governors.

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

Action required by the Council of Governors

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

Cambridge University Hospitals NHS Foundation Trust

17 December 2025

Council of Governors
Report from the Council of Governors
Helena Rubinstein, Lead Governor

I am delighted to have taken on the Lead Governor role at the Trust, commencing on 1 October 2025. Since commencing in this role I have had the opportunity to meet and communicate with fellow governors to take forward their comments on how we as governors can add value to the Trust whilst fulfilling our statutory duties. I have met with the Chair on a regular basis and met with fellow Non-executive Directors as part of my induction into the role.

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

1. Recent Governor meetings

1.1 At the **Governor Seminar** held on September 16, 2025, Dr. Ari Ercole, Interim Chief Clinical Informatics Officer, and Hannah Armand, Associate Director of Informatics – Epic and Information Management, delivered a comprehensive presentation on digital developments across Cambridge University Hospitals. Their session highlighted the implementation and progress of several key initiatives, including the utilization of ambient voice technology and the integration of artificial intelligence within the Trust. These advancements aim to improve information management and enhance the overall efficiency of digital systems at CUH.

1.2 The lead governor, Neil Stutchbury provided an overview of governor activities through the year at the **Annual Public Meeting** on 17 September 2025.

1.3 The **Council of Governors** met on 25 September 2025, where Roland Sinker gave an overview of trust performance. Key points included: improvements in ED wait times, focus on reducing long waiters, progress in achieving savings and productivity targets, and new uses of digital technology to streamline patient flow. Governors asked questions about the recent publication of the NHS National Oversight Framework and the Trust's ranking of 70th out of 134 acute trusts and for an update on a number of ongoing capital projects across the hospital such as the conversion of Clinic 9 and the work to improve the air flow issues in maternity theatres.

1.4 The governors met for a Governor Forum meeting on 25 November 2025.

2. Upcoming Governor meetings

2.1 The next three months' meetings are as follows:

24 February 2026

- Governor Nomination and Remuneration Committee

25 March 2026

- Governor Forum – governor meeting with Lead Governor
- Governor Seminar
- Council of Governors meeting

3. Other governor activities

3.1 Helena Rubinstein elected as the new lead governor from 1 October 2025. Helena replaces Neil Stutchbury, who completed a four-year term as lead governor ending on 30 September 2025. Neil Stuchbury will remain on the Council of Governors as a patient governor, his term of office is due to end on 30 June 2026.

3.2 Robin Stevens has been appointed as the new deputy lead governor, replacing Jane Biddle who completed a four-year term as deputy lead governor ending on 30 November. Jane Biddle will remain on the Council of Governors as a Public Governor, her term is due to end on 30 June 2026.

3.3 Dr Pippa Hales has recently joined the Council of Governors as the Partnership Governor for Royal Papworth NHS Foundation Trust. Dr Hales replaces Dr Stephen Webb.

3.4 A Governors Working Group has been established to look at ways of improving the function and operation of the Council of Governors within CUH. The group met for the first time in November 2025 and looked at the implementation of a number of improvements to facilitate better two-way communication with non-executive directors, improving communication amongst fellow governors, streamlining governor meetings, how governors can work to support the Trust achieving its strategy, and the introduction of governor training courses in January. Following that meeting the Lead Governor provided feedback to the Chair of the Trust and the interim Chief Governance and Performance Officer with full support and all recommendations agreed with changes put in place immediately.

3.4.1 The second meeting of the Governor Working Group was held on 12 December 2025, the main area of discussion was on how communication and engagement can be improved between governors and members. It was noted that the training scheduled to take place in January 2026 will support further discussion on this topic. Following training an additional meeting of the Governor Working Group will be held to consider the next steps to take

forward.

3.5 This will include revisions to the way that the Council of Governors meetings will now operate. These changes aim to strengthen accountability within the Council of Governors meetings, with arrangements put in place to support governor's to fulfil their statutory duties and holding Non-executive Directors to account for the performance of the Board. In addition, the updated meeting structure aims to improve governance, assurance, and oversight by providing clearer processes for monitoring performance, reviewing decisions, and facilitating open discussions. These measures are expected to support a more transparent and robust system for overseeing the work of the Council and its members.

3.6 Council of Governors Nomination and Remuneration Committee met on 9 December 2025 to consider the plan in place for the Chair and Non-executive Director appraisals; and the role description of the Deputy Chair. An update is planned to be provided to the Council of Governors at its meeting on 17 December 2025 for ratification.

4. Recommendation

4.1 The Council of Governors is asked to note the activities of the Council of Governors since the previous meeting.

Dr Helena Rubinstein
Lead Governor

Council of Governors

Cambridge University Hospitals NHS Foundation Trust

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Report to the Council of Governors: 17 December 2025

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

Executive Summary

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

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

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

Cambridge University Hospitals NHS Foundation Trust

17 December 2025

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

1. Introduction/background

1.1 The Chief Executive's report provides an overview of the five areas of operational performance. The report also focuses on the Trust strategy and other CUH priorities and objectives. Further detail on the Trust's operational performance can be found within the Integrated Performance Report.

1.2 The focus of the NHS continues to be on reducing waiting times and financial control. Broadly the challenge is to provide more care within the existing financial settlement – 'more with the same'. The regulatory priorities are now becoming clearer with a more limited number of key performance indicators, now extending to e.g., outcomes and infection control. These obligations will sit within a rating system, alongside an assessed Board Capability Framework. Rankings will change quarterly. Alongside this, the national operating framework from NHS England is changing and firming up with greater clarity about the role of ICBs, providers and regional teams, although it will take time to refine. CQC oversight is also developing, with both targeted inspections of areas viewed as being at risk, and a core focus on regular well-led reviews. The 10-year plan for the NHS, and a life sciences sector plan have been published. Cambridge and CUH have contributed to these pieces of work and is preparing to respond to the opportunities set out in both. Work is ongoing nationally on plans for delivery. In the round, this means a much greater prioritisation and focus – reflected in both the five areas of operational performance and the new strategy

1.3 CUH continues to perform broadly well in the five areas of operational performance relative to peers, but with areas of significant concern, some of which are new and represent a drop in overall performance. CUH will look to improve back to an historically strong position by the end of the year. As examples:

Quality - a focus on the Trust response on paediatric orthopaedics, core standards, maternity and triangulation of 'areas of concern'. In addition, CUH is reviewing two areas of performance – outcomes (where the Trust has historically benchmarked well), and infection control. Performance remains positive in core indicators of frontline care. Work on a quality governance review is underway.

Workforce – a focus on the directed reduction in staff numbers, in line with the financial plan; and managing a return of industrial action. Noting year-on-year improvement in staff survey response rate and flu vaccination take-up rate which benchmarks well relative to peers; strong position on recruitment and overall staffing levels but with 'hot spot' areas; now considering how we respond to the staff survey and our offer for enabling staff to be at their best when they come to work.

Access – following several years of strong performance, a new focus on waits for elective care, where the Trust performance is below the standard, triggering regulatory intervention. A similar focus on cancer performance, where the Trust has again performed well historically but has work to do to get back on plan. This work is now starting to show progress with the Trust seeing some recovery in the cancer position for October 2025. In both cases this position has been driven in part by managerial prioritisation and to some degree a focus on financial controls. Diagnostic performance remains strong, and emergency care is ahead of plan, with ambulance handovers very positive. Improvement continues to be needed to length of stay.

Finance - maintaining progress with our significant capital plan of ~ £95m and making best use of our resources to deliver financial plans for CUH and the integrated care system for the coming years. The Trust has delivered financial balance for the 5th year; and is now delivering a very challenging financial plan. This is centred on both cost reduction and significant improvements in productivity. The Trust remains on plan and is forecasting a break-even position for the year end.

Improvement, Innovation and Digital - we are balancing support to teams to deliver changes and improve productivity; managing and mitigating risks in relation to our IT infrastructure; and transforming and innovating now and for the future, in particular in Outpatients, a digital front door, and a more central digitally enabled running of the hospital.

1.4 In February 2025, the Trust set out to the public the position in relation to paediatric orthopaedic surgery, requiring support to patients, further clinical review and a look back into any missed opportunities to identify concerns earlier. In October the Trust published the Verita independent investigation into missed opportunities and action plan. The Trust apologises for any impact on children or their families and will continue to be transparent in communicating the position as it develops; and welcomes feedback on any area that can be improved in terms of approach.

1.5 CUH continues to refresh the Trust Strategy in partnership with stakeholders. This shows a confirmation of the vision, three refreshed areas of focus (strengthening our core; transforming where and how we deliver care; and improving care through research and innovation), nine concrete integrated programmes for delivery, and a link to our 5-year financial plan and an outcomes framework. Work is ongoing on communication and engagement and, in due course, a refreshed Board Assurance Framework (BAF).

1.6 On major projects, work has started on the ground for both the Cambridge Children's Hospital (Outline Business Case formally approved and contractor appointed) and the Cambridge Cancer Research Hospital (enabling works completed). For both hospitals work is ongoing on the Full Business Cases. As part of this the partners are taking stock of areas including the clinical model, research strategy, fundraising plan and construction capability.

1.7 In addition, following the Budget announcement of £3m, work has completed on this phase of our Acute Care Strategy which seeks to both understand and meet the needs of a growing population as a result of new housing and economic growth, as well as an ageing population. We are clear that meeting the needs of our local populations will require new care models as well as the right investment in vital health infrastructure. The first articulation of this business case was approved by the Trust's Performance Committee in March 2025 and has been submitted nationally for support with the next phase, moving towards an Outline Business Case.

1.8 Work to better align CUH, Royal Papworth Hospital and the University of Cambridge is ongoing. More will be required in terms of work with partners in the local ICB as it continues to evolve, in particular to align the acute services business case.

1.9 CUH continues to engage with partners across Cambridge on a wide range of areas from growth to transport and housing - some of this is set out in the March 2024 'The Case for Cambridge' HMG publication. National support for Cambridge continues, as set out in the most recent budget. The Biomedical Campus continues to develop with new industry capacity and the Cambridge South station progressing – all of which needs constructive engagement with local partners.

1.10 I will be stepping down from my role as Chief Executive on 31 December 2025 to join the University of Cambridge to lead a major review of inclusive innovation and growth. This aligns with an 18-month succession plan at CUH corresponding with my tenth year at the organisation.

1.11 It has been a true privilege to work with patients, staff and partners to deliver an enormous amount for our health and care system, and beyond. Every day I see the commitment from staff right across the organisation to do their best for patients. There is so much at CUH to be proud of that we have delivered together.

1.12 I am pleased that our current Deputy Chief Executive, Nicola Ayton, will lead the organisation as Chief Executive (Acting) from the start of January. Nicola will lead the organisation as Chief Executive from January with the support and collective leadership of a strong executive team. There will be a recruitment process leading to a substantive CEO appointment.

Part A

2. The five areas of operational performance

2.1 Quality

2.2 **Paediatric Orthopaedic Incident:** Listening events with families have been held to ensure voices are heard and concerns addressed. The Verita review, and related action plan, has been shared with patients and families and published. Harm reviews remain ongoing, as do Duty of Candour discussions. The Oversight Committee, supported by the CQC and NHS England, continues to meet regularly and the actions arising from the Verita report are being implemented to strengthen governance, improve patient safety, and ensure transparency.

2.3 Trust wide Quality Governance Review: The Trust wide review supported by NHS England is approaching the end of the diagnostic phase. The methodology has included conversations with key stakeholders, observations of key meetings and a desktop review of key documentation including terms of reference, workplans and structures. Learning has been identified in a number of areas including leadership development, the need for leaner governance, quality improvement and how data is used.

2.4 **Patient Engagement:** CUH has held three patient and family listening events, with a fourth planned for January 2026, focusing on women with cancer in response to CPES results showing they report poorer care and communication than men. Key outcomes include action plans to improve information for relatives, patient diaries, hygiene awareness, bedside clocks, and step-down experiences from ICU to wards, alongside ongoing work to enhance response rates and quality from divisions.

2.5 **National Oversight Framework:** CUH is ranked 71st out of 134 acute providers and is in Segment 3 of the NHS National Oversight Framework. This segment denotes a requirement for enhanced support and oversight due to performance during the second quarter of 2025/26, particularly in elective treatment waits and cancer waits.

3. Access to Care

3.1 **Emergency Department (ED).** Performance against the 4 hour standard improved slightly to 72.3% in October 2025, compared to 72.1% in September. CUH ranked 57th out of 118 trusts nationally for 4 hour performance in October 2025, compared to 59th position in September. This ranking places CUH within the second quartile.

3.2 **Referral to Treatment (RTT).** <18wks performance has increased due to the overall volume of clock stops seen in October 2025, which is a positive step forward, and resulted in a reduction of the overall waiting list by -925. Recovery actions across specialties are continuing to deliver with further actions expected to come online over coming months following longer lead times for delivery. The reduction in the overall waiting list is required to maintain and improve our performance to plan.

3.3 **Delayed discharges**. October 2025 recorded the highest number of lost bed days due to delayed discharges, marking the peak for the past 12 months. There had been an increase in staff sickness-related absences during October, and vacancies within the Complex Discharge Team and Early Intervention Team remain unfilled.

3.4 **Cancer.** 62 days performance was sustained above national target but remains below plan. Of the 325 patients treated in September 2025 96.5 waited longer than 62 days. Performance against the 28 day faster diagnosis standard deteriorated in September, but recovered in October.

3.5 **Operations.** Elective activity improved by 0.8% compared with the previous month, with current performance now aligned with the Shelford Group median at 81.0%.

3.6 **Outpatients.** Booking Optimisation has gone live successfully in 37 of our specialties resulting in patients being able to self-schedule their follow-up appointments. Patients are also offered short notice slots using MyChart. CUH continue to see a gradual increase in follow-up capacity, but this can be exhausted with the demand for new outpatient activity.

4. Finance – Month 7

4.1 The Month 7 year to date financial position is a £1.4m deficit for performance management purposes. This position is ahead of the year to date plan by £3.7m driven by the early receipt of non-recurrent income offset by specific non-recurrent cost pressures.

4.2 The Trust forecast remains to deliver the break-even financial plan for the financial year.

4.3 The following points should be noted in respect of the Trust's Month 7 financial performance:

- The Elective Payment Mechanism (EPM) is expected to follow a similar approach to 2024/25. At Month 7 the Trust is £1.7m ahead of the Trust's planned EPM income but remains below planned activity levels due to lower than expected elective inpatient service delivery.
- The average daily EPM planned income is consistent across the year in line with current operational plans. The Trust has an opportunity to exceed this plan through productivity improvements implemented in year to improve both operational and financial performance.
- The Trust Productivity and Efficiency Programme (PEP) plan aims to deliver £92.4m of financial benefit to the Trust. Current performance is £1.8m ahead of plan at Month 7 with an expectation to improve service productivity and cost reductions supported by the Mutually Agreed Resignation Scheme (MARS) and service restructuring through compulsory redundancies.
- Industrial Action – the forecast Industrial Action impact is £2.1m (Pay £1.5m and Income £0.6m) year to date offset in full by non-recurrent support. NHSE has indicated there will be no additional funding provided in year for Industrial Action.

4.4 The Trust received an initial system capital allocation for the year of £44.7m for its core capital requirements. In addition to this we expect further funding including Children's Hospital (£13.3m); Cancer Hospital (£10.7m); Heat Pumps (£5.4m grant). 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 £100.3m.

4.5 Capital expenditure to date at Month 7 is on plan at £32m. We are forecasting achievement of the capital plan, and the Capital Advisory Board is actively managing any changes in forecasts as the year progresses.

5. Workforce

5.1 The Trust has set out five workforce ambitions, committing to focus and invest in the following areas: good work and wellbeing, resourcing, ambition, inclusion and relationships. Whilst these areas continue to see progress, the organisational change process delivering in-year cost reduction (primarily in support functions) and productivity increases has dominated the workforce agenda in recent months but is now drawing to a close.

Resident Doctor National Industrial Action

5.2 Operational teams, medical leadership and medical staffing have worked together to successfully limit the cancellation of planned clinical activity and to ensure safe staffing and patient care during a period of national industrial action by Resident Doctors. The most recent strike action was taken over a five-day period from 14 to 19 November 2025. Further action has been announced to take place from 17 to 22 December 2025.

Workforce Planning

5.3 At Month 7 the workforce employed both on a substantive and a temporary basis was meeting and within the plan agreed at the beginning of the year. The plan required a reduction in Whole Time Equivalents of 535, which included temporary reductions. In the first part of the year, the Trust made significant temporary reductions which will allow some increases in the temporary workforce over the winter period and to respond to waiting list pressures. There are also substantive planned increases relating to specific service developments, some of which will take place in 2025/26 and will flow into 2026/27.

5.4 In response to the Medium-Term Planning Guidance and associated documentation, a two-year workforce plan will be submitted Nationally. The main requirements of the workforce plan is that it delivers on the year-on-year reductions required for workforce bank and agency usage (10% and 30% respectively) and there is triangulation with the activity and finance plans. Work is underway to meet the submission deadline of 17 December 2025.

Flu Vaccination Programme

5.5 The Autumn flu vaccination programme for staff commenced on 1 October and will run until 19 December. All Trusts are expected to improve flu uptake by at least 5 percentage points compared to last

year's position – for CUH the target was to reach a 64% vaccination rate in front line substantive staff at the close of the 25/26 campaign.
As at 9 December we have met this target with 64.2% of frontline staff now being vaccinated. The Trust uptake currently places CUH as the second best performing Trust in England.

Keeping Well this Winter Campaign 2025/2026

5.6 In order to support the operational plans to winterproof CUH; the Occupational Health and Wellbeing team have a programme of events taking place until February 2026, to help staff navigate the demands of the Winter season. The campaign focusses on:

- Promoting mental and emotional wellbeing
- Encouraging healthy habits and optimising physical wellbeing
- Social connection, kindness and community
- Self-care

5.7 The aim of the campaign is to provide proactive and practical support to help staff stay healthy and well, ensuring there is easy access to services and resources to promote self-care.

6. Innovation and digital

6.1 The Trust's innovation team is growing, and the Clinical Data Science Unit has been established. The team is focused on five areas required to support innovation including:

- Policy – with an AI policy and Assurance Framework approved, a Steering Group now well established, and a group established to oversee the allocation of data specialists to deliver on research and innovation projects.
- People – we are bringing in new data engineering and data science skills and fostering a community of practice across our data specialists.
- Platforms – we have now implemented technology that will make it easier for us to clean and curate data, and deploy AI for research and operational purposes
- Projects (solutions) – we have over 20 AI projects, spanning deployments of commercial AI applications and evaluations of research AI, now in the pipeline
- Projects (data curation) – we are working with partners at UCLH, the London AI Centre for Value Based Healthcare and elsewhere to develop data pipelines that serve clean, interrogable data in a repeatable fashion for research and product development

6.2 Over the past three months, there has been delivery of a range of digital capabilities that support Trust performance and improve patient engagement including:

- Digital front door for ED – patients are now able to enter information on arrival at the ED that streams them to the most appropriate same day care service at CUH. This may be our Emergency Department (ED) or our newly opened Urgent Care Centre. This will support improved performance against the four and twelve-hour standards, help to reduce ED demand, and enhance patient experience.
- Digital front door for Outpatients – patients on outpatient lists across 36 specialties are now able to self-schedule a range of appointments as well as pick up early appointment offers if not all clinic slots are full. This functionality will reduce administrative burden, increase clinic utilisation and improve patient experience by mitigating the impact of short-notice cancellations. A further 37 specialties are planned for implementation in March/April 2026. More than 2,500 patients have already scheduled their own appointments, and DNA rates are just 2% (against a Trust average of about 5%).
- Command Centre – digital ward boards are now in place across most of our inpatient wards. These, along with the opening of our new Coordination Centre, support improved patient flow and bed utilisation. We have seen a significant improvement in the accuracy of key data points, such as estimated discharge date, that inform capacity and demand management,
- Ambient Voice Technology – our pilot with Heidi is underway, with over 1,200 consultations now completed. The solution is being closely monitored to ensure that it is working as expected, and that the intended benefits of improved documentation quality, clinical productivity and patient experience are being realised before making decisions about further expansion.

6.3 In addition, the team has also been focusing on how we deliver digital capabilities that can support the delivery of care and improved productivity across our health service, including:

- Sharing patient information through the Cambridge and Peterborough Shared Care Record. This supports teams across our region to provide care to patients who have been seen in our service by ensuring they have the information they need to make decisions about their care.
- Leading the work for the UK on integration of the NHS App with the Epic MyChart patient portal. This will enable patients to access their information through a single sign-in from the NHS App.

- Work is ongoing with partners across our system to use OPTICA, part of the national Federated Data Platform, to support complex discharge. This is expected to improve coordination between hospital and community care providers to support patients get out of hospital and back in the community more quickly. There have been minor delays but we aim to have this implemented early in 2026.

PART B

7. Strategy update

Strategy refresh

7.1 Following extensive engagement which included staff, patient groups and external partners undertaken over the past few months, the Trust is in the final stages of developing a new Strategy for the next ten years, to be presented to Board in January 2026 for final review and approval. This will replace the CUH Together 2025 Strategy that has run for the past three years and which articulated a time of recovery and stabilisation following COVID.

7.2 Our new, Trust-wide Strategy provides an overarching framework for the organisation as a whole, to meet future demand and respond to the changing national context. While our core vision remains the same: 'a healthier life for everyone through care, learning and research', our Strategy for delivering this has evolved. It is focused on three key areas: strengthening core operations, transforming how and where we deliver care, and improving care through research and innovation.

7.3 Delivery of this Strategy will require organisational refocus and appropriate investment in enablers, particularly physical and digital infrastructure, as well as our workforce. Work to agree measurable outcomes of delivery to support the Board in holding the organisation to account is in progress.

7.4 A detailed communications and engagement plan will be launched in the New Year to formally launch and cascade the Strategy, once approved. This will include a structured approach, with supporting materials, which will help teams at local level turn strategy into action.

7.5 Some of this work is an iteration and continuation of strategic programmes already underway. The following updates provide a brief overview on some of the core areas of focus within the new Strategy.

Neighbourhood Health and Integrated Care

7.6 CUH is working with other local healthcare partners to develop a new model of urgent and emergency healthcare services, supported by a new acute hospital that includes a right-sized Emergency Department on the Cambridge Biomedical Campus. We are now seeking funding of at least £10m to enable us to make further progress towards completing an Outline Business Case for a £2.3bn new build hospital. Alongside this, we are progressing work on designing and implementing a new model of sustainable, integrated healthcare which is essential in underpinning our plans for new capital investment.

7.7 There are currently three programmes of work that are delivering on elements of a neighbourhood health service as outlined in the 10 Year Health Plan for England: the Cambridgeshire South Care Partnership ('South Place'), the CUH Acute Care Strategy, and the CUH Outpatient's Strategy. We are working to bring these three related programmes under a single overarching structure that can provide consistent, coherent input across all work relevant to neighbourhood health. In doing so we have an opportunity to accelerate our progress in delivering integrated, proactive care closer to home, and to address health inequalities in our area.

7.8 Our immediate priorities include embedding multi-agency neighbourhood teams wrapping care around priority patient cohorts, supported by strengthened leadership at a local level; ensuring the continuation and expansion of community models to support patients living with frailty; and supporting new and expanded interface models between primary care and CUH outpatients.

Flagship programmes

7.9 The Cambridge Cancer Research Hospital (CCRH) programme has confirmed the pathway to Full Business Case (FBC) submission with the New Hospitals Programme (NHP). This was crucial as it unlocked the additional funding required to discharge the requirements of the Building Safety Act (BSA). The work on the BSA has now commenced, and the programme has begun planning for FBC submission. Archaeological enabling works are now complete, and work on both the Target Operating Models (TOMs) and Clinical and Research Integration are going well.

7.10 The Cambridge Children's Hospital (CCH) has appointed Bouygues UK as its construction partner, and we are now working with them to finalise our design and plans, ensuring best value for money under an initial pre-construction services agreement. Work is progressing on all other areas of the Full Business case (FBC), including how the integrated CCH will operate and be governed practically, delivering significant research and clinical benefits across the region. We continue to consult widely with regional clinical providers, children and young people, parents and carers.

We are also increasing the work we do with the staff who will be working in the new hospital, thinking ahead to their future ways of working. Fundraising for the new Hospital is over halfway to its £100m target, attracting support from philanthropists in the UK and around the globe.

7.11 The Programme Business Case for Genomics, approved in April 2025, aims to secure the 2026 NHSE contract, improve turnaround times and clinical outcomes, reduce outsourcing costs, increase revenue, and support strategic priorities including Cancer Research and Children's Services. In early November 2025, CUH was confirmed as the preferred provider for the East Genomic Medicine Service Alliance (GMSA). Under this contract, CUH will become the lead provider for an expanded scope of genomics testing services that bring together the outward-facing responsibilities of the GMSA and the laboratory testing functions of the East Genomic Laboratory Hub (GLH). The future model also positions population health services alongside established cancer and rare disease services, ensuring all three areas receive equal strategic focus. Securing this contract remains the programme's highest priority, providing the firm platform required for sustained growth of CUH's Genomics services.

7.12 Alongside the NHSE procurement process, the wider transformation programme continues to progress. A dedicated project delivery team is being established to drive targeted improvements across automation, processing, and software. In addition, work is already underway to develop business cases for advanced automation and a potential future move to a purpose-built facility - balancing cost, risk, and scalability to enable long-term sustainable growth.

Research Review

7.13 Six workstreams have now been formally established to progress the recommendations of the Research Review: data, research office, investigator-led clinical trials, commercial trials, NHS clinical engagement, and tissue. Each is supported by a dedicated working group comprising engaged members from across CUH and the University of Cambridge.

7.14 Executive sponsors and workstream leads have been appointed to ensure clear accountability and momentum. Priority actions for 2025 have been defined, with immediate next steps identified and underway. Risks, dependencies, and resource implications have been mapped to inform future investment planning.

7.15 The programme is now captured in a Research Review Implementation Plan, which sets out the scope of each workstream, delivery approach, and governance arrangements. This will serve as a strategic reference point for tracking progress, aligning stakeholders, and shaping investment proposals over the coming year.

8. Improvement and transformation

8.1 The improvement and transformation team's primary focus this year has been on supporting the delivery of the Trust's productivity and cost out initiatives to achieve the Trust's target of a minimum £92m in efficiency and productivity by April 2026. The team are divisionally and corporately aligned to support the scoping, planning, implementation and benefits capture of schemes.

8.2 The position on delivery against the £63.4m efficiency target at Month 7 was:

- Year to date delivery of division and corporate efficiency schemes was £29.5m against a £25m phased plan.
- The identification position of efficiency savings by divisions and corporate teams was £54.3m, which is 85.7% of the £63.4m efficiency target.
- Overall, including Trust wide schemes, the Trust is forecasting an outturn position of £62.3m on efficiency.

8.3 The team continues to work alongside specialty teams on specific projects that will drive productivity and efficiency benefits, including:

- Divisional high priority productivity initiatives spanning theatre productivity, length of stay reduction and outpatient's clinic optimisation.
- Outpatients' transformation focusing support on referral and triage optimisation including the use of advice and guidance opportunities to manage outpatient demand and waiting lists.
- Procurement of the Verto digital project management tool, which will assist clinical and corporate divisions with schemes related to the Productivity and Efficiency Programme (PEP). The tool went live in November and scaling of the tool to 100 users across the Trust is in progress to initiate the capturing of PEP schemes related to financial year 2026/27.

8.4 The team is also continuing to develop a refreshed Improvement Strategy that will align with the Trust's refreshed 5-year Strategy. This includes redesigning our capability building programme.

8.5 The Improvement and Transformation function is evolving, with the Improvement portfolio aligned to the Chief Finance Officer, and the Transformation portfolio aligned to the Chief Strategy and Transformation Officer.

Working alongside Digital and Innovation, a five year transformation roadmap is in development, with the programmes identified for the first three years aligning to transformation objectives set out in the NHS England Medium Term Planning Framework. These programmes will be delivered by cross-functional teams, primarily from transformation and digital, to ensure digital transformation is embedded so that benefits can be fully realised.

9. Recommendation

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






NHS
Cambridge University Hospitals
NHS Foundation Trust










Integrated Report

Quality, Performance, Finance and Workforce to end October 25

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

Report compiled: 30 November 2025

Key

NHS
Cambridge University Hospitals
NHS Foundation Trust

Data variation indicators


Normal variance - all points within control limits



Negative special cause variation above the mean



Negative special cause variation below the mean



Positive special cause variation above the mean



Positive special cause variation below the mean

Target status indicators



Target has been and statistically is consistently likely to be achieved



Target failed and statistically will consistently not be achieved



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

Rule trigger indicators

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

Quality Account Indicators

NHS Cambridge University Hospitals NHS Foundation Trust

Measure	Performance Standards	Previous Month-1	Previous Month	In Month Actual	Target	Target due by	FYtD	Average Performance 24/25	Variance	Target Status
		Aug 25	Sep 25	Oct 25						
Safe	Nutrition screening compliance for admitted patients	91.6%	91.5%	91.7%	≥90%	Mar-26	92.1%	85.9%		
	Hospital acquired pressure ulcers (category 2 +) per 1000 bed days	0.832	0.758	1.116	≤0.395 per 1,000 bed days	Mar-26	0.851	0.880		
	Waiting time(s) in triage (Maternity - Midwife review)	98.0%	96.5%	98.8%	85.0%	Mar-26	97.8%	N/A		
	Waiting time (Maternity Triage - Obstetrician review)	80.0%	81.7%	79.0%	85.0%	Mar-26	78.6%	N/A		
Patient Experience / Caring	Responses to service user complaints are within agreed time frames	50.0%	57.4%	45.3%	80.0%	Mar-26	47.6%	56.7%		
	Dementia Care -Percentage of admitted patients with completion of "What's Important for Me" where diagnosis of dementia is established.	31.5%	34.5%	23.2%	50.0%	Mar-26	31.4%	28.1%		
Effective / Responsive	Locally reported SDEC (same day emergency care) activity as a % of emergency activity	30.5%	30.1%	30.4%	30.0%	Mar-26	29.9%	25.0%		
	>12hr waits in ED (type 1)	8.9%	11.5%	12.5%	7.7%	Mar-26	9.4%	12.4%		
	Waiting times for first Outpatient appointment (RTT)	60.0%	61.2%	62.0%	63.1%	Oct-25	60.6%	63.8%		
	Inpatient Bed Occupancy (KH03 Definition - monthly)	88.2%	89.7%	89.4%	92.8%	Mar-26	88.2%	87.9%		
Improving Outcomes	Smoking Cessation – Number of Inpatient referrals for acute admissions (excl. elective and Maternity)	56	64	54	>35 / month	Mar-26	331	68		
	Smoking Cessation – Number of 28 day confirmed quits (last 3 months)	49	44	41	20% at year end	Mar-26	263	56		
		2021	**Annual 2022**	**2023**	**2024**					
Safety, Culture & Well Led	Morale Indicator: I feel secure about raising concerns about unsafe clinical practice.	75.9%	71.3%	70.4%	78.0%	Mar-26				

Quality Summary Indicators

NHS Cambridge University Hospitals NHS Foundation Trust

Point of delivery	Performance Standards	Previous Month-1	Previous Month	In Month Actual	Target	Target due by	FYtD	Average Performance 24/25	Variance	Target Status
		Aug 25	Sep 25	Oct 25						
Infection Control	MRSA Bacteraemia (hospital onset aquired)	N/A	0	2	0	Mar-26	3			
	E.coli Bacteraemias (Total Cases)	15	10	13	TBC	Mar-26	107			
	C. difficile Infection (hospital onset and COHA cases) or C. difficile Infection (hospital onset)	8	15	10	<=134 cases (HOHA and COHA).	Mar-26	82			
	Hand Hygiene Compliance	Data not available	Data not available	Data not available						
Nursing Quality Metrics	Blood Administration Patient Scanning	99.9%	99.9%	100.0%	90.0%	Oct-25	99.9%	99.9%	H	?
	Blood Administration Product Scanning	99.2%	98.3%	99.3%	90.0%	Oct-25	99.2%	97.6%	H	?
	Moving & Handling	90.2%	88.9%	89.5%	90.0%	Oct-25	89.9%	84.1%	H	F
	Nurse Rounding	99.6%	99.4%	99.4%	90.0%	Oct-25	99.5%	99.5%	H	P
	Pain score	92.0%	92.1%	91.7%	90.0%	Oct-25	91.7%	83.6%	H	F
	MEOWS Score Recording	87.0%	80.3%	85.4%	90.0%	Oct-25	85.7%	87.1%		F
	PEWS Score Recording	94.0%	94.5%	93.5%	90.0%	Oct-25	94.1%	97.7%	L	P
	NEWS Score Recording	98.4%	98.4%	98.1%	90.0%	Oct-25	98.4%	98.3%		P
	VIP Score Recording	94.9%	95.1%	95.3%	90.0%	Oct-25	95.6%	91.3%	H	?
	PIP Score Recording	93.2%	88.0%	89.2%	90.0%	Oct-25	89.7%	87.6%		?
Patient Experience	Mixed sex accommodation breaches	59	55	85	0	Oct-25	354	36	H	?

Operational Performance

NHS Cambridge University Hospitals NHS Foundation Trust

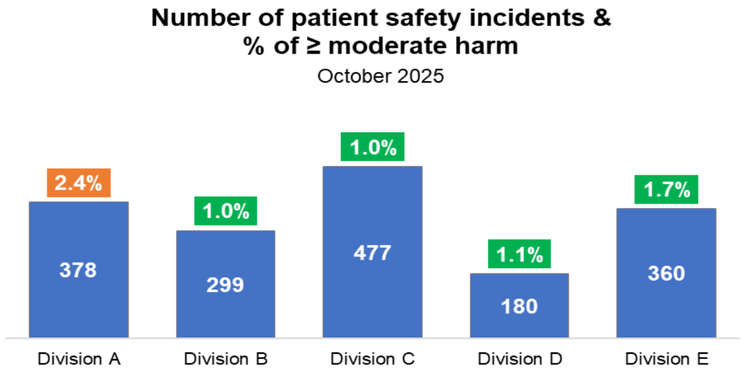
Point of delivery	Performance Standards	SPC variance	In Month Actual	In Month plan	Target	Target due by	Page
Urgent & Emergency Care	4hr performance	Positive special cause variation	72.3%	76.1%	78.0%	Mar-26	**Page 15**
	12hr waits in ED (type 1 unplanned)	Normal variation	10.9%	7.7%	-	-	
	Ambulance handovers <15mins	Positive special cause variation	56.0%	-	65.0%	Immediate	
	Ambulance handovers <30mins	Normal variation	76.8%	-	95.0%	Immediate	**Page 16**
	Ambulance handovers < 45mins	Normal variation	81.7%	-	100.0%	Immediate	
Cancer	Cancer patients < 62 days	Normal variation	70.4%	75.9%	70.0%	Immediate	**Page 22**
	28 day faster diagnosis standard	Negative special cause variation	69.5%	81.4%	75.0%	Immediate	**Page 21**
Outpatients	First outpatients vs plan (consultant led)		98.2%	-	-	-	**Page 23**
	Follow-up outpatients (consultant led)		95.2%	-	-	-	**Page 24**
	Advice and Guidance Requests	Negative special cause variation	0.4%	-	-	Mar-26	
	Patients moved / discharged to PIFU	Positive special cause variation	5.2%	5.9%	6.8%	Mar-26	**Page 25**
RTT Waiting List	RTT Patients < 18 wks for first treatment	Normal variation	59.3%	60.0%	-	-	**Page 18**
	RTT Patients < 18 wks for first appointment	Negative special cause variation	62.0%	63.1%	-	-	**Page 20**
	RTT Patients waiting > 52 weeks	Positive special cause variation	3.6%	1.9%	-	-	**Page 19**
Productivity and efficiency	Non-elective LoS (days, excl 0 LoS)	Normal variation	8.6	-	-	-	
	Long stay patients (>21 LoS)	Normal variation	213.0	-	-	-	
	Elective LoS (days, excl 0 LoS)	Normal variation	5.2	-	-	-	
	Discharges before noon	Positive special cause variation	19.9%	-	-	-	
	Theatre sessions used (Elective)	Normal variation	96.1%	-	-	-	
	In session theatre utilisation	Normal variation	80.7%	85.0%	85.0%	-	**Page 27**
	Virtual Outpatient Attendances	Positive special cause variation	20.7%	-	-	-	
	BADS Daycase + OP Rate (local)	Normal variation	85.8%	85.0%	-	-	**Page 28**

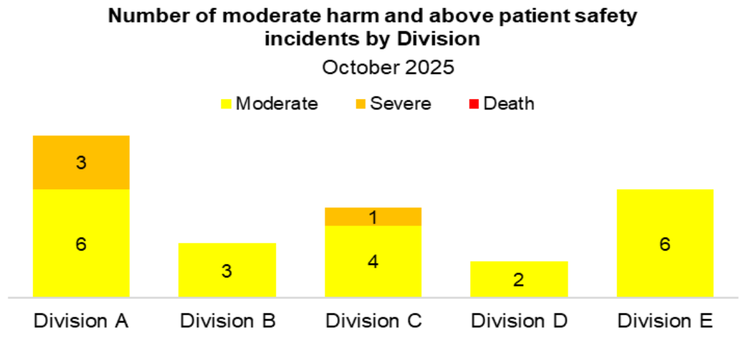
Author(s): Various **Owner(s): Nick Kirby**

Patient Safety Incidents (PSIs)

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Threshold	Oct-25	Average (Nov-22 - Oct-25)	Variance	Special causes	Comments
Number of **patient safety incidents**	-	1891	1704		-	There is currently normal variance in the Trust and Divisions B-E. Division A has had a statistical increase in 2 out of the last 3 months. In October 2025, the highest category type was Medication, which has now seen a statistical increase in the last eight months.
Rate of patient safety incidents **per 1,000 admissions**	-	97.3	95.8		-	There was normal variation in the rate of patient incidents per 1,000 admissions in October, although Division B (8 months) and Division C (7 months) have seen a statistically significant decrease. There were 19,425 admissions and 1,891 incidents affecting patients at time of reporting.
Rate of patient safety incidents resulting in **moderate harm or above**	≤2%	1.3%	1.9%		-	There is currently normal variance across the Trust and in all Divisions. Only Division A did not meet the threshold in October 2025. In October there were 21 patient incidents graded moderate harm, 4 severe, and 0 fatal.
Number of patient safety incidents moderate harm and above, where **Learning Response not commissioned within 14 days** of reporting	0	4	10	L	Shift	Of the 4 moderate harm or above incidents awaiting a learning response, there was one each in Division C and Corporate Services, and 2 in Division D.
Number of patient safety incidents with moderate harm or above, **open after 60 days**	0	65	36	H	SP	Statistically significant increase (2 out of the 3 last months = high points) - September & October. Division D and E driving the increase. Division E are mainly due to Orthopaedic Incident program. Division D





- All four severe harms are under review: A3/NCCU & J3/ITU - shoulder subluxations; clinic 1 - LTFU risk of amputation; ED - delayed diagnosis of myocardial infarction.
- Good process in place now to capture PSIs from the Orthopaedic Incident (20) - need to finalise process for closing these incidents to reflect that reviews and duty of candour actually have been completed. The increase in division D (26) driven by neurosurgery & ophthalmology - no themes by sub/category.

Author: Jane Nicholson **Owner: Darren Darby**

Duty of Candour (DOC)

NHS
Cambridge University Hospitals
NHS Foundation Trust

The CUH standard for completion of each stage of DOC is 10 working days.

Stage 1

At time of reporting, there were 37 (last reported 28) overdue cases of Duty of Candour **stage 1:**
- 20 are overdue **by one month or less**
- 8 overdue **by 2 - 3 months**
- 9 overdue **by 4 - 6 months**

A breakdown by Division can be seen in the graph to the right.

Stage 2

There were 4 (last month 9) overdue cases of Duty of Candour **stage 2**.

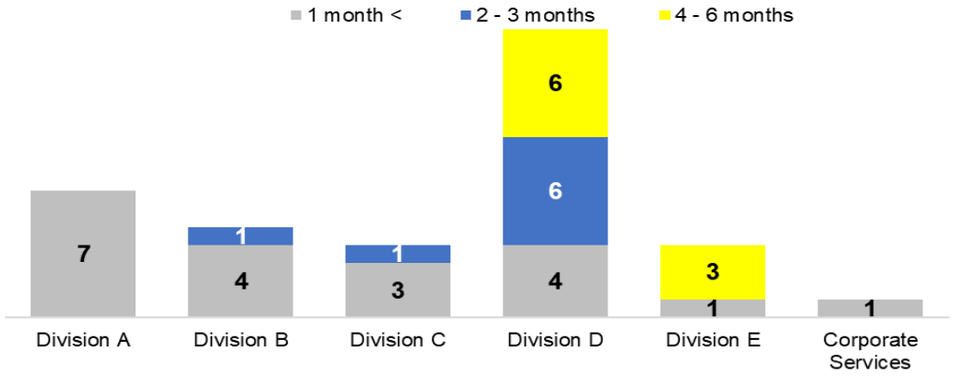
- 2 were overdue **by one month or less**
- 1 overdue **by 2 - 3 months**
- 1 overdue **by 4 - 6 months**

A breakdown by Division can be seen in the graph to the right

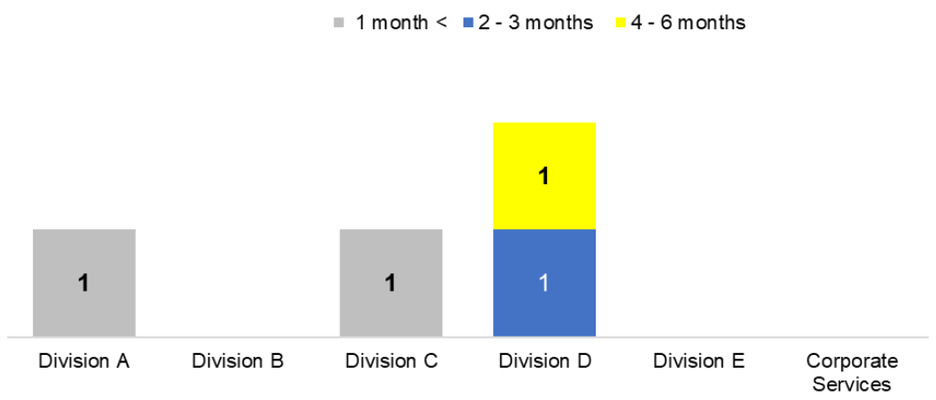
The corporate patient safety team continue to work with divisions to ensure accurate recording of requirements, and addressing outstanding all Duty of Candour.

Stage 1 *is notifying the patient (or family) of the incident and sending a DOC stage 1 letter.*
Stage 2 *is sharing of the relevant investigation findings (where the patient has requested this response) once closed.*

Number of incidents where DOC stage 1 is overdue
as of 05/11/2025



Number of incidents where DOC stage 2 is overdue
as of 05/11/2025



Author: Jane Nicholson **Owner: Darren Darbv**

Falls

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Target	Oct-25	Average (Nov 22 - Oct 25)	Variance	Special causes	Target status	Comments
Number of **patient falls**	–	192	168		-	-	The Trust is in normal variance. Division B has registered a single high point in October, all other Divisions are within normal variance.
Rate of patient falls per **1,000 bed days**	3.25	4.05	3.58	H	Shift	?	There is a statistically significate increase in the rate of patient falls per 1,000 bed days - last 7 months. Division C has a statistically significance increase - last 7 months. All other divisions are within the normal variance.
Rate of patient falls resulting in **moderate harm** or above	–	1.6%	2.3%	L	Shift	-	There is a statistical decrease in the rate of moderate harm and above patient falls. In October 2025, there were three falls resulting in moderate harm or above, corresponding to a rate of 1.6% (equivalent to 0.08 moderate falls per 1,000 bed days). All were moderate, one each in M4, C5 and C9.
Falls risk screening compliance within 12 hours of admission	≥90%	95.9%	91.0%	H	SP	?	The Trust met the target in October 2025 and for the last 17 months. Only two wards did not meet the target - A5 (84%) and L4 (85%).
Percentage of inpatients aged 65 years and over with a **LSBP recorded**	≥90%	25.5%	25.7%		-	F	Whilst in normal variance, compliance with this metric is currently low following a statistical improvement over the previous nine months.

Summary

The trust was above the target at 4.05 per 1000 bed days although the number of falls is in normal variance. There is a statistical improvement in the rate of moderate harm and above patient falls (1.6% in October). In October there were three moderate and above harm incidents; investigation processes are underway. All were moderate, one each in M4, C5 and C9.

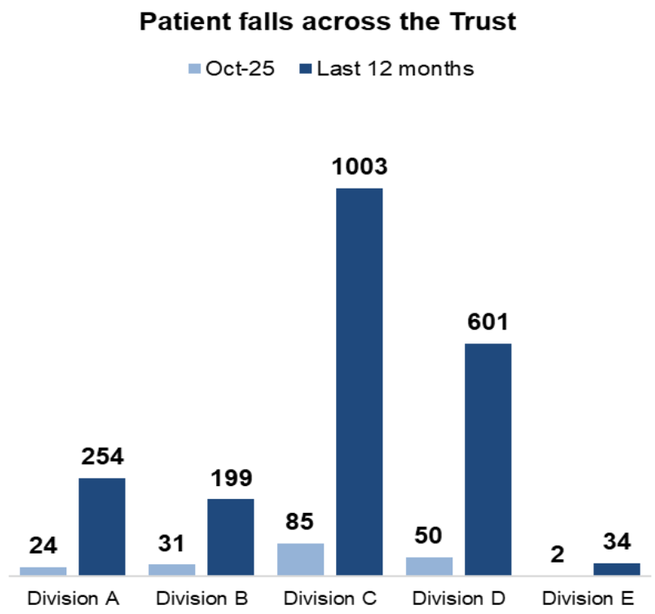
In October , the Trust was compliant with the falls risk assessment (95.9%). Only two wards did not meet the target - A5 (84%) and L4 (85%).

QI update

The trial of 'toilet falls alarms' (to support the increase in falls that occur around toileting/commode use) in three adult inpatient wards is now in its second month and will be evaluated once completed.

The Falls lead has been working with the Tissue Viability Lead to provide manager training for at nurse leaders in clinical areas. The aim is to support education around prevention and when an incident does occur, correct harm validation and accessing the most appropriate patient care pathways in each Harm Free Care area.

The ED Falls policy is almost complete and the Trust Adult Falls policy is now complete with stakeholder input from Consultant Geriatrician, Early Intervention Team and Pharmacy) to align with current Falls NICE (2025) guidance.



Author: Vicky Carr **Owner: Darren Darby**

Hospital-acquired tissue damage

Cambridge University Hospitals NHS Foundation Trust

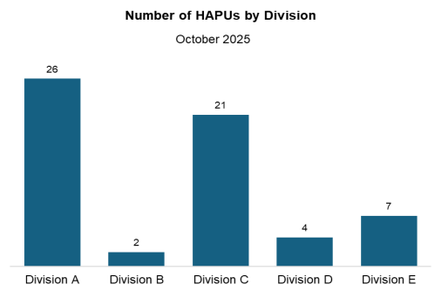
Indicator	Target	Oct-25	Average (Nov-22 - Oct-25)	Variance	Special causes	Target status	Comments
All hospital-acquired pressure ulcers (HAPUs)	-	60	42		-	-	The Trust, and all Divisions other than C, are within normal variance. Division C has shown a statistical increase in October 2025 (single high point).
Category 2, 3, 4, mucosal, suspected deep tissue injury, and unstageable HAPUs	-	44	31		-	-	Divisions A and E both had a statistical increase in October 2025 (single high point). The Trust and all other Divisions were within normal variance. In October there were 33 x category 2, 4 x mucosal, 5 x suspected deep tissue injuries, and 2 x unstageable.
Category 2, 3, 4, mucosal, suspected deep tissue injury, and unstageable HAPUs by **1,000 bed days**	≤0.395	1.12	0.82		-	?	Rate of HAPUs category 2 and above per 1000 bed days remains within normal variance.
Medical device related HAPUs	-	27	16	H	Shift	-	The Trust has seen a significant increase for the past 7 months, and Division B and C have seen a statistical increase in October 2025. All other Divisions are within normal variance. 48% (13/27) device related HAPUs occurred in Division A.
Pressure Ulcer screening **risk assessment** compliance	≥90%	92.8%	85%	H	Shift	?	The Trust and Divisions A-D met the target in October 2025. There has been a continued significant increase in the last 10 months in the Trust, 11 months in Division B, 9 months in Division C, and 7 months in Division E.
Hospital-acquired **moisture lesions**	-	31	25	H	Shift	-	The Trust has seen a statistical increase in the last 12 months. All Divisions are within normal variance.

Summary

The number of HAPUs, and rate of HAPUs per 1000 bed days across the Trust are within normal variance, including total numbers per division – with the exception of Division C which has seen a statistically significant increase in October – and category 2 and above in October 2025.
Of the 60 HAPUs; 15 x category 1, 33 category 2, 0 x category 3, 0 x category 4, 4 x mucosal, 5 x SDTI, and 2 x unstageable. The highest reported body locations of HAPUs in October 2025 were the heel (16), those classified as 'Other' (13), and nose (9), sacrum (8), foot (3), and ear (3). The Datix category 'other' body location had 13 reported incidents in October and includes thigh, lip, ankle, mouth, coccyx, penile shaft, face, and buttocks HAPUs. This is within normal variation.
In October, of the 27 x device-related HAPUs; 13 x occurred in Division A, 1 in Division B, 7 in Division C, 0 in Division D, and 6 in Division E. Most devices were classed as 'other' (10) and mask/tubing (7). There was an increase in the number of Moisture Lesions (31) in October with most occurring in Division A (16). 18/31 are reported to be related to 'Continence', which is a HFC priority area for the trust. There has been a statistically significant increase in PU risk assessment screening in the last 10 months for the trust overall, Division E was not compliant.

QI

During October, the TV team has continued to work with the Falls Prevention Lead to deliver training for ward managers, ward sisters, and matrons to support the correct categorisation of Pressure Ulcers or Moisture Associated Skin Damage.
Alongside this, the team has been working to review an update all trust policies pertaining to TV, bringing them in line with national guidance and changes in practice. Updates are being shared with our clinical divisions via the Hospital Acquired Pressure Ulcer (HAPU) Harm Free Care (HFC) Group.
A mentioned in September, we are working with our Orthopaedic wards to seek improvement opportunities in relation to MASD and HAPU. To support this, these areas are trialling use of an audit tool that guides an assessment of the factors that contribute to pressure or moisture damage of the skin; e.g. skin assessment and care, surface (mattress) selection and medical devices, continence, and moisture management. Once trialled, we will evaluate and make revisions with the intention of a wider roll out. The trial and subsequent programme will be monitored via the HAPU HFC group.



Author: Vicky Carr **Owner: Darren Darby**

VTE

NHS Cambridge University Hospitals NHS Foundation Trust

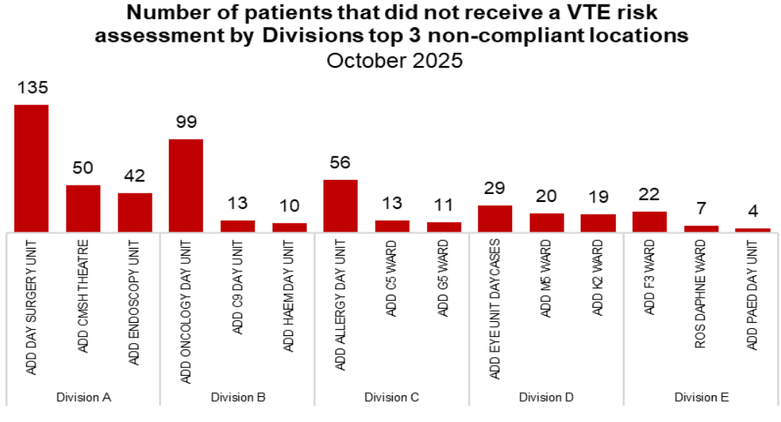
Indicator	Target	Oct-25	Average (Nov-22 - Oct-25)	Variance	Special causes	Target status	Comments
Number of hospital associated venous thrombosis (HATS) case reviews at CUH	-	26	28		-	-	The Trust and all Divisions are within normal variation. No cases were judged to be avoidable upon review in October 2025.
VTE % compliance of patients admitted to CUH who have been risk assessed	≥95%	95.4%	95.2%	H	Shift	?	The Trust met the target in October 2025, and has seen a statistical increase in the last 8 months since March 2025.
VTE % compliance of patients admitted to Division A wards who have been risk assessed	≥95%	91.6%	91.8%		-	F	Currently within normal variance, however statistically unlikely to meet target. The location with the highest number of non-compliant cases was Day Surgery Unit. 13% (135/1025) of patients who attended day surgery unit were not risk assessed.
VTE % compliance of patients admitted to Division B wards who have been risk assessed	≥95%	96.1%	94.9%		-	?	The compliance target was met in October, and the Division is currently in normal variance. The location with the highest number of non-compliant cases remains the Oncology Day Unit (includes CAU).
VTE % compliance of patients admitted to Division C wards who have been risk assessed	≥95%	98.2%	97.9%		-	P	Division C is within normal variance and consistently meeting the target. The location with the highest number of non-compliant cases remains the Allergy Day Unit.
VTE % compliance of patients admitted to Division D wards who have been risk assessed	≥95%	90.5%	91.7%		-	F	Currently within normal variance, but did not meet target in October and remains statistically unlikely to. The location with the highest number of non-compliant cases is Eye Unit Day Cases.
VTE % compliance of patients admitted to Division E wards who have been risk assessed	≥95%	95.1%	93.7%	H	Shift	?	There has been a statistically significant improvement over the past 17 months, but to note this metric excludes antenatal requirements (1 assessment at any point during admission). Division E met the target in October, and compliance for paediatric patients aged 16-17 years was 8.6%. Ward F3 had the highest number of non-compliant cases.

Summary

The VTE quality improvement group have agreed a series of actions to support compliance with the Trust policy. There has been progress with this work. This includes:

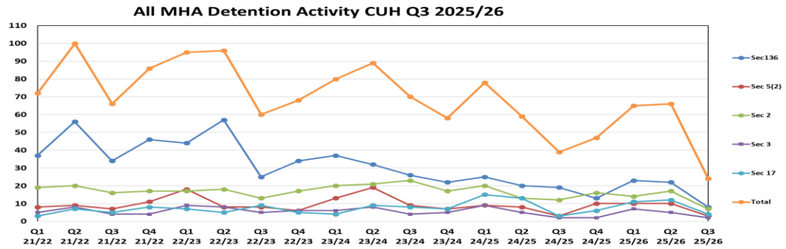
- Policy update (underway)
- a ‘re-set’ of group approved procedures - added as part of the EPIC upgrade
- improve information patients receive about the risk of blood clots prior to elective admission via admission letters (still in progress) and at discharge via After Visit Summary (updated).

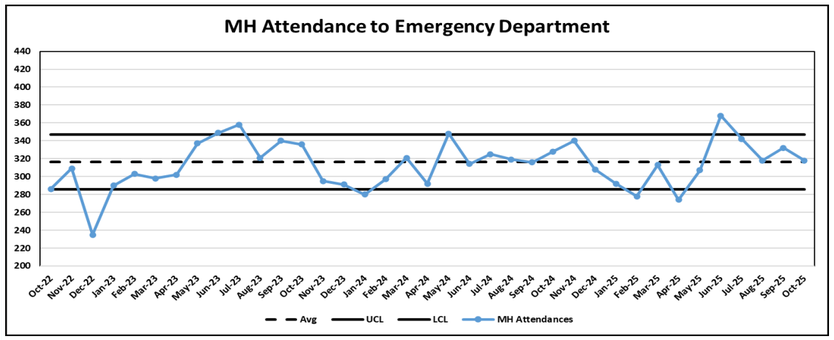
Division	No. admissions	% risk assessed	No. HATs assessed
A	4136	91.6%	6
B	3502	96.1%	4
C	7757	98.2%	9
D	1584	90.5%	7
E	800	95.1%	0
Trust	17779	95.4%	26

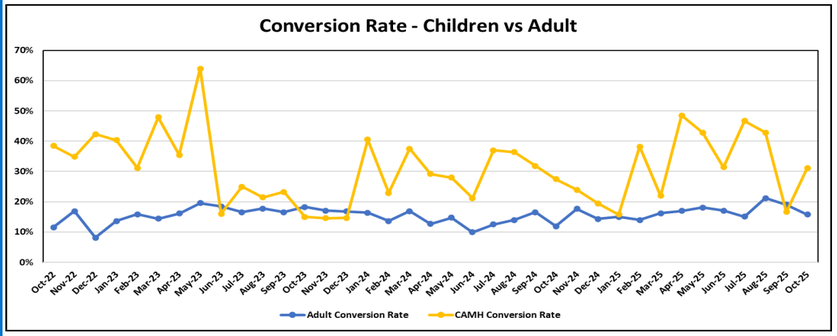


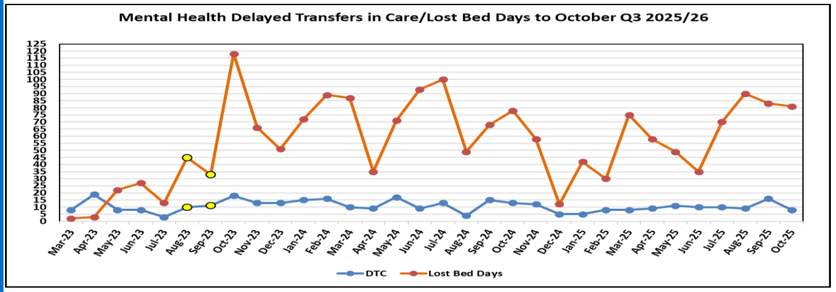
Mental Health - Q3 October 2025/26

NHS Cambridge University Hospitals NHS Foundation Trust









Q3 October 2025/26

- All Mental Health Act activity at CUH Addenbrookes in October 25 showed an increase of 85% over October 2024, where all sections of the MHA showed an increase in use. This increase is accentuated by all MHA activity at CUH Addenbrookes during October 2024 being unseasonally low.
- Of the 8 presentations of Section 136 MHA to the Emergency Department (ED) in Q2 2025/26.
  - 3 (37.5%) rescinded.
  - 1 (12.5%) transferred to an alternative place of safety.
  - 3 (37.5%) sectioned to another hospital.
  - 1 (12.5%) converted to another section at CUH.
- The number of mental health patients presenting to the ED in October decreased when compared to September, by 4%.
- The average length of stay in ED for October for mental health patients decreased by 4%.
- There has been an increase in 'attendance to admission' conversion rates for CAMH patients in October to 31% (16.5% in September), while adults have decreased by 3% to 16%.
- Self harm and suicidal ideation represents the majority for CAMH attendance to CUH ED and remains the main reason for conversion to admission at CUH of that cohort admitted.

Delays in transfer of care (DTC) and lost bed days/ Mental Health Trusts

- During October there were 8 new delayed transfers of care (DTC) to mental health inpatient care, with 81 acute bed days lost at CUH.
- These patients, were waiting for a bed across 3 mental health trusts, with the local provider having the expected highest levels of new delayed transfers of care.

October Q2 2025/26 MH Service Provision			
New Acceptances	Pre-existing acceptances	Lost Bed Days	Service Provision
4	1	18	Adult MH Beds
2	1	35	Older Adult MH Beds
0	1	15	CAMH MH Beds
0	1	8	Adult Eating Disorder Beds
2	0	5	Mother and Baby Unit Beds

October Q2 2025/26 MH Receiving Trust			
New Acceptances	Pre-existing acceptances	Lost Bed Days	Receiving Mental Health Trust
6	3	66	CPFT
0	1	6	ELFT
2	0	9	NSFT

Ongoing Work

- Ongoing work at CUH is centred on improving patient experience and outcomes across mental health pathways. We are prioritising timely transfers of care for patients requiring specialist mental health inpatient support, reducing delays that impact safety and recovery. Performance has improved markedly over the 25 month period following the development of digital tools to monitor performance. Average delays are now around 11 per month, with most months since early 2025 in single digits or low teens. Lost bed days have fallen from a peak of 118 to consistently below 100, with the best month at just 12. These trends demonstrate that interventions to streamline transfers and improve patient flow are delivering sustained improvement rather than short-term gains.

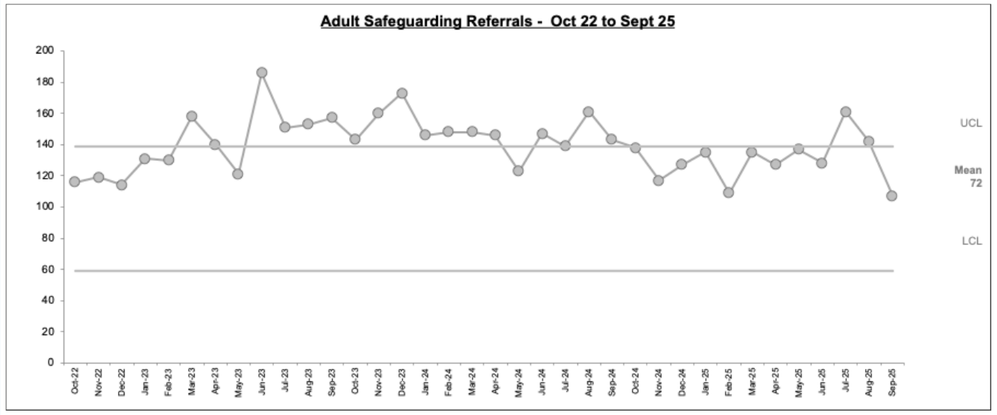
Author(s): Kevin Rowland Owner(s): Lorraine Szeremeta

Safeguarding

NHS Cambridge University Hospitals NHS Foundation Trust

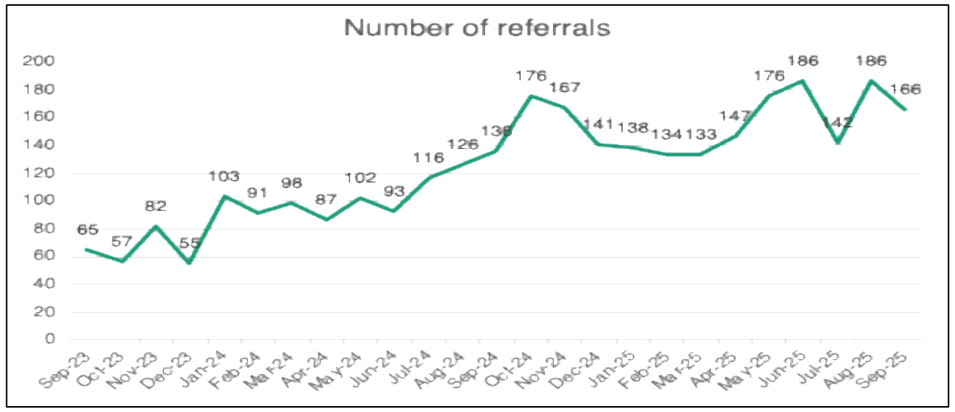
Adult Safeguarding

Referrals to the safeguarding team in Q2 25/26 have increased by 4% compared to Q1 25/26. In Q2 32% of the safeguarding referrals have then been reported on to the Local Authority (LA) an increase from the previous quarter. The top 3 reporting themes were once again domestic abuse, neglect/acts of omission, and self neglect all of which were in the top 3 in the previous 4 quarters. There have been 47 DoLS requests in Q1 for urgent authorisations, an increase from 44 in the previous quarter, of which 36 were granted by the Trust in Q2. Of the urgent applications granted by the Trust, 8 had to be escalated as a high priority to the respective LA, an increase from 5 in the previous quarter, but none breached the mandated timescales for assessment.



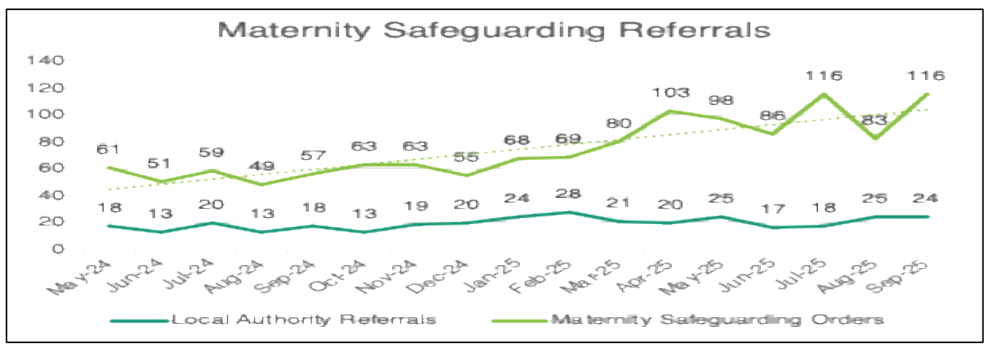
Children's Safeguarding

There has been a small decrease of 2.95% in the number of referrals to the children's team in Q2 from Q1 but a 30.7% increase from the same period in the previous year. Top 3 referral themes for Q2 are mental health (aligned with previous quarters), general safeguarding enquiries and information sharing. Reporting on children who have not been brought to their appointments has been reintroduced in Q1. In Q2 over 14630 children under 18 either cancelled or were not brought to their outpatient appointments of which 346 had safeguarding alerts on their record.



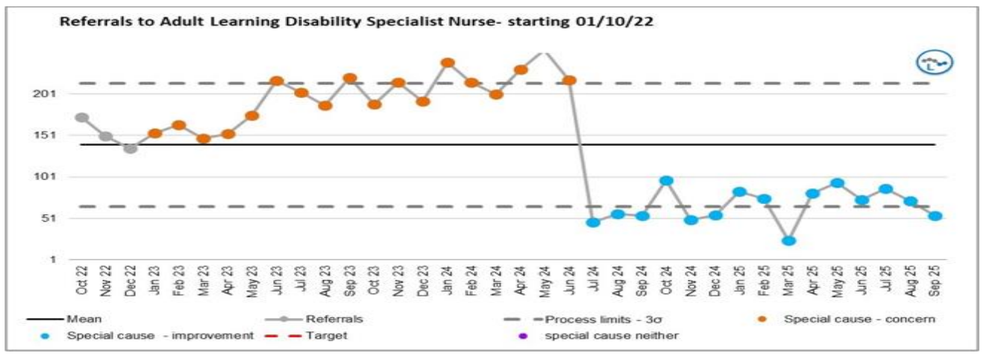
Maternity safeguarding

Of the number of women booking a pregnancy in Q2 25/26 over 22% of these women were referred to the safeguarding maternity team. Total number of referrals to the maternity safeguarding team have seen a further increase of 9.76% from 287 in Q1 25/26 to 315 referrals in Q2 25/26 and a 90% increase on the same reporting period in 24/25. The number of onward referrals to the Local authority have seen a slight increase of 8% from the previous quarter. The top 3 referral themes in Q1 have remained Domestic Abuse, previous involvement with social care and perinatal mental health. Q2 also saw 2756 consults or liaisons an increase of 17.68% from Q1 and are received in addition to the formal referrals. The team have noted that 21.5% of those women referred to them live out of area and receive antenatal and postnatal care from neighbouring hospitals.



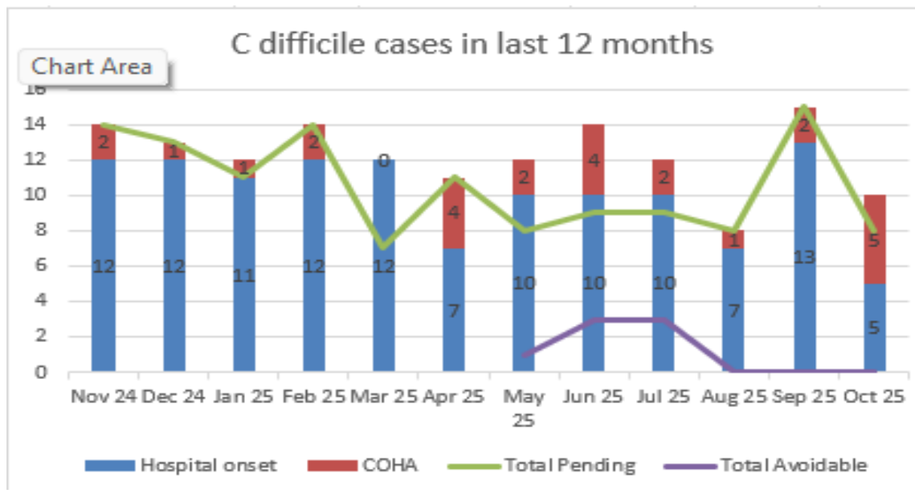
Learning disabilities

During Q2 25/26 there have been a total of 213 referrals to the adult learning disability (LD) specialist nurse, Of these referrals only 175 were appropriate and are shown through the new reporting data on the graph below. The paediatric specialist learning disability and autism nurse received 81 referrals for children with LD or autism up from 65 in the previous quarter. For adults the top 3 referral themes were gastro/colorectal, neurology/neuro oncology, and general medical. For paediatrics the referrals to the team were from a mixture of inpatient and outpatient areas.

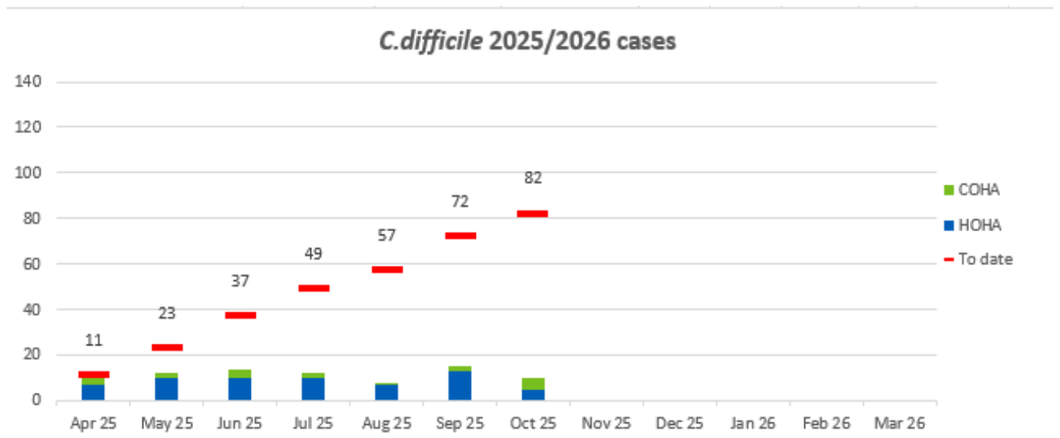


Infection Control

Cambridge University Hospitals NHS Foundation Trust



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



CUH trend analysis

MRSA bacteraemia ceiling for 2025/2026 has been set at 0 avoidable cases.

• 2 cases of hospital onset hospital acquired (HOHA) MRSA bacteraemia in October 2025. 1 community (COHA) and 1 community (COCA) case.

• 3 cases of hospital onset MRSA bacteraemia year to date

C. difficile ceiling for 2025/2026 has been set at 134 cases (HOHA and COHA).

As of April 2024 the ICB no longer requires cases to be divided by avoidable and unavoidable.

▪ 5 cases of hospital onset *C difficile* and 5 COHA case in October 2025.

• 62 hospital onset cases and 20 COHA cases year to date.

MRSA and C difficile key performance indicators

▪ Compliance with the MRSA care bundle (decolonisation) was 75.1% in October 2025 (83.3% in September 2025).

▪ The latest MRSA bacteraemia data we have 5 Bacetremias. In October 2 hospital cases and 2 community cases.

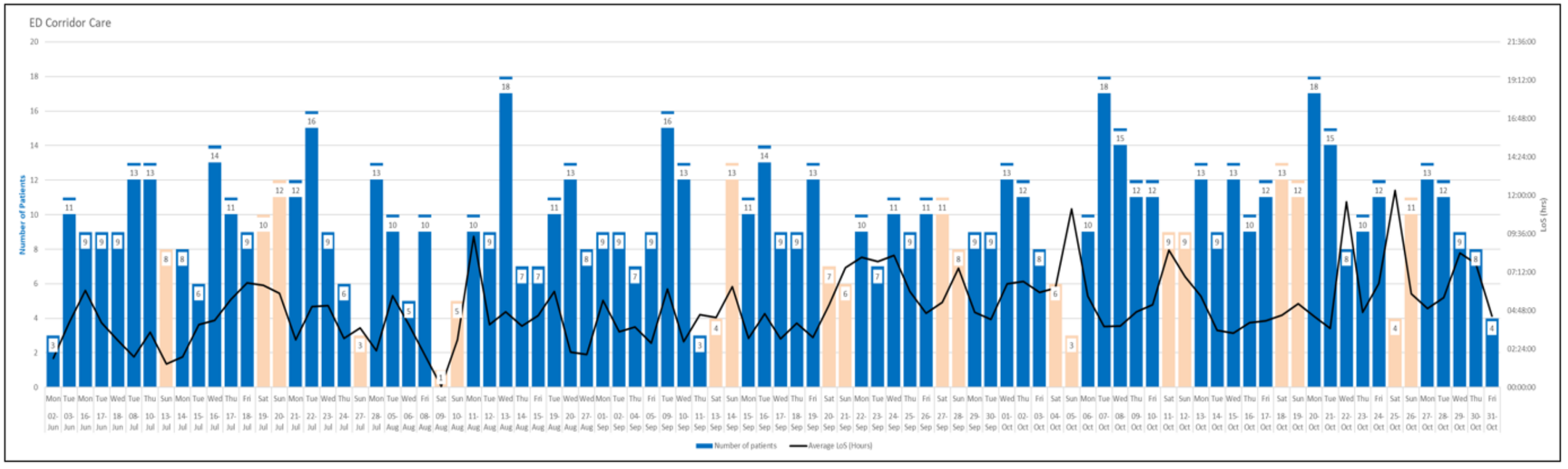
▪ Compliance with the *C. difficile* care bundle was 83% in October. (76% in September)

▪ The latest *C. difficile* cases in October was 5 HOHA, 5 COHA and 4 COCA, which is a marked improvement from 13 HOHA in September with 18 cases in total.

ED corridor care data

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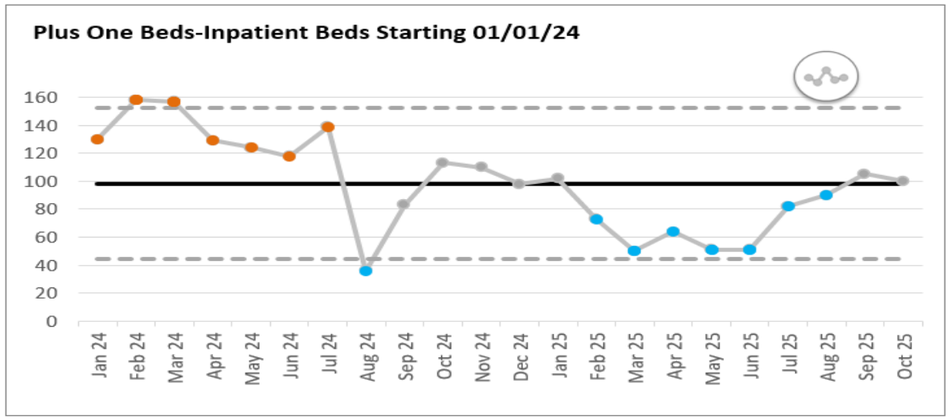
Date	Number of patients (Corridor Care)	LoS (hrs)	Incidents	No Harm	Low Harm	Complaints /concerns
Jun 25	41	04:05:18	0	0	0	0
Jul 25	163	04:00:46	0	0	0	0
Aug 25	114	04:21:19	0	0	0	0
Sep 25	240	05:04:45	0	0	0	0
Oct 25	333	05:31:19	0	0	0	0

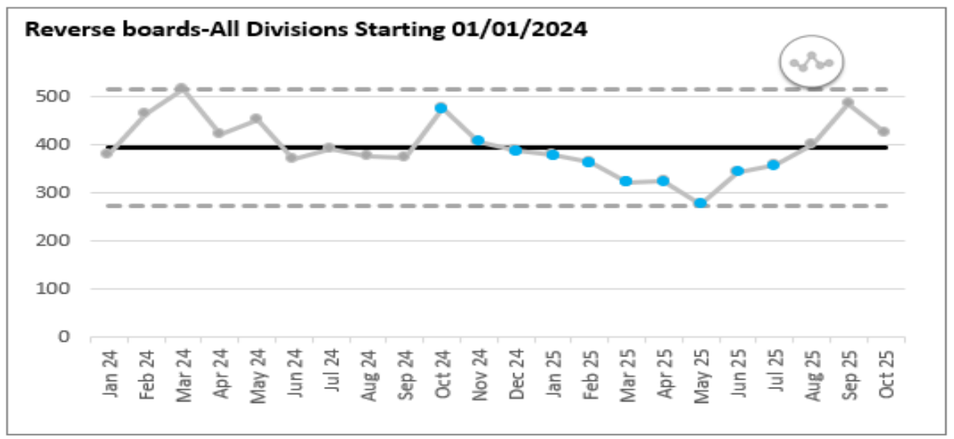


ED Corridor Care – An area within the Emergency Department where clinical care is delivered but is not designed for that purpose

Reverse Boarding / Plus one bed usage

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Date	Number of Plus One beds used	Incidents	No Harm	Low Harm	Complaints/concerns
Oct 24	113	21	21	0	0
Nov 24	110	10	10	0	0
Dec 24	98	28	28	0	0
Jan 25	102	1	1	0	0
Feb 25	73	13	13	0	0
Mar 25	50	9	9	0	0
Apr-25	64	4	4	0	0
May-25	51	0	0	0	0
Jun-25	51	6	6	0	0
Jul-25	82	30	28, 2 under review	0	0
Aug-25	90	43	43	0	0
Sep-25	105	2	1 (+1 under review)	0	0

Date	Number of patients Reverse Boarded on inpatient wards	Incidents	No Harm	Low Harm	Complaints/concerns
Oct 24	476	0	0	0	0
Nov 24	407	0	0	0	0
Dec 24	387	0	0	0	0
Jan 25	378	1	1	0	0
Feb 25	364	5	4	1	0
Mar 25	323	0	0	0	0
Apr 25	324	2	2	0	0
May 25	277	0	0	0	0
Jun-25	344	0	0	0	0
Jul-25	358	0	0	0	0
Aug-25	399	1	1	0	0
Sep-25	484	22	21 +1 under review	0	0
Oct-25	424	4	4	0	2

Plus ones – the placement of one additional bed in a defined clinical area for a patient above the areas normal capacity. It is expected that the patient will remain in this bed overnight
Areas that Plus one- M4, L4, M5, L5, K3, N3 (NIV only). Rapid Handover Areas (RHO) - EAU4, EAU5, F4, C4
Reverse Boarding – the practice of moving a clinically stable patient from the bed space to a suitable area on the ward. This may be in a bed or chair in a dayroom or corridor to allow for a new patient admission, usually from the Emergency Department/assessment areas.

Author(s): Louise Maris **Owner(s): Lorraine Szeremeta**

4HR Performance

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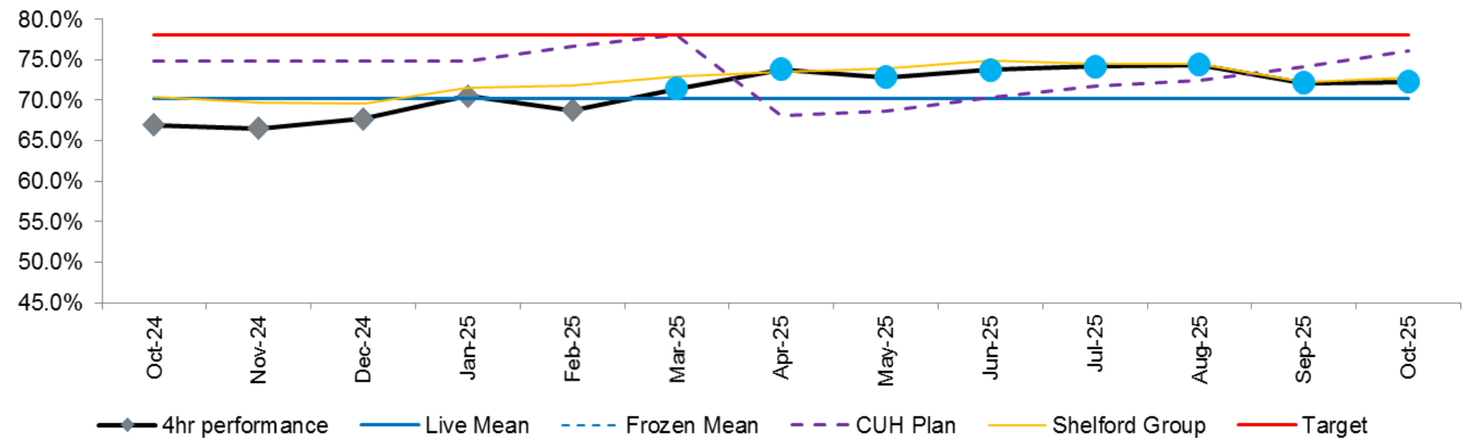
Oct-25	Plan
72.3%	76.1%

SPC Variance
Positive special cause variation

Shelford Group Median Avg (Oct-25)
72.8%

Three Month Plan		
Nov-25	Dec-25	Jan-26
76.2%	76.1%	75.4%

⇧ better



Highest breaches by specialty		
Specialty	Performance	4hr Breaches
Medicine	25.0%	1,930
Emergency	77.8%	1,164
Orthopaedics	26.2%	282
Surgery	50.9%	234
Gynae	42.6%	135

Updates since previous month

1) In October 2025, the 4hr Performance was 72.3% up slightly from 72.1% in September; the overall trajectory in the time series indicates improving operational delivery.
2) Daily ED departures remained unchanged at 427 in both September and October 2025, while the conversion rate decreased from 16.2% to 15.0%.
3) CUH ranked 57th out of 118 trusts nationally for 4hr performance in October, compared to 59th position in September. This ranking places CUH within the second quartile.

Key dependencies

1) Demand remains a key factor in performance and we continue to maximise the utilisation of the UTC and other alternatives to ED to manage lower acuity patients.
2) Timely outflow of admitted patients is imperative to free up assessment space and reduce 4hr breaches.
3) Maximising the use of the assessment and SDEC areas and ensuring good flow through and off these areas is a key factor in delivery of our performance.
4) System-wide, consistent IPC policy and standards agreement in discussion via C&P ICB to maintain minimum disruption due to closed/restricted beds.

Current Issues

1) High levels of occupancy in medical inpatient beds have compromised outflow from the department.
2) Lack of timely response from specialities to support the IPS impacting the 4-hour standard. This is an area of particular focus for Divisions.
3) Insufficient cardiac monitored bed capacity and underutilised monitored ordering process.
4) Long waits on medical assessment units caused by limited flow out.
5) Challenges in flowing patients to non medical SDEC area's
6) Increasing infection across the trust, delaying flow out of the ED.

Future actions

1) The Flow Improvement programme & actions will continue to support a reduction in Exit Block from the ED and the MAU, which will in turn support improvements in 4-hour performance.
2) Ensuring there is good utilisation of the MAU, discharge lounge and virtual ward with clear focus at site meetings around the capacity required for delivery within the next 2 hours are all contributing to supporting better flow.
3) Clear focus on non-admitted performance and consistent overnight processes through utilisation of SOPs and IPS.
4) Implementation of Cardiology action plan, which was developed in response to a recent GIRFT review.
5) Divisions A& C have been asked to improve admitted patient performance (and response times).

Author(s): Rebecca Pheby / Elana Covshoff

Owner(s): Nick Kirby

Ambulance Handovers < 45 minutes

NHS Cambridge University Hospitals NHS Foundation Trust

Oct-25	Target
81.7%	100.0%

SPC Variance

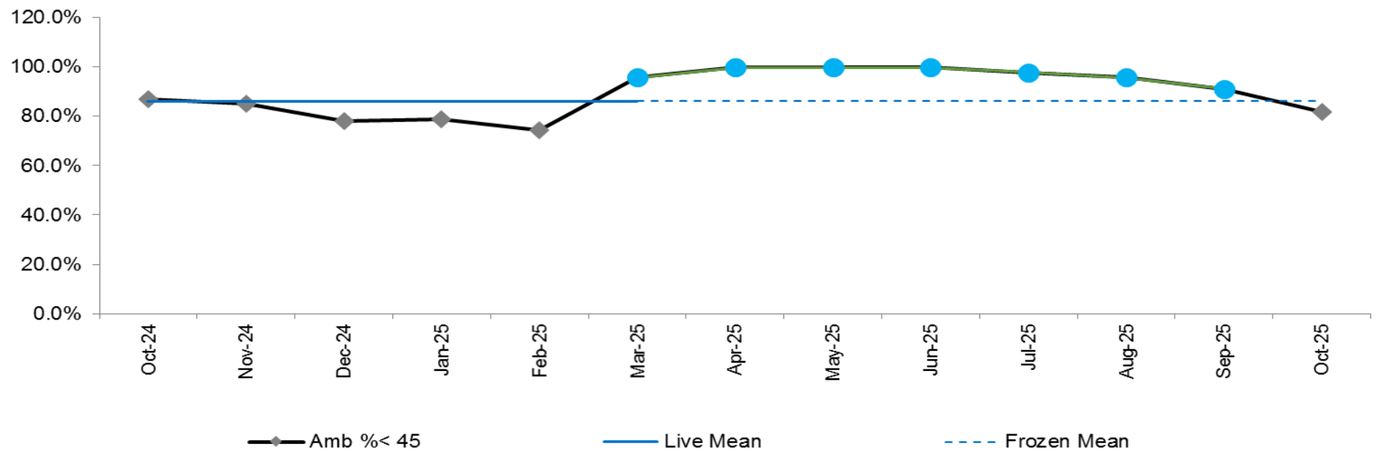
Positive special cause variation

East of England > 45 minutes

Oct-25

Trust	Performance
Bedford	4.5%
Milton Keynes	4.5%
Southend	5.2%
Luton and Dunstable	5.5%
West Suffolk	5.7%
Watford General	6.3%
Hinchingbrooke	13.0%
Queen Elizabeth	17.9%
Lister	18.4%
CUH	18.6%
Basildon & Thurrock	19.8%
Broomfield	25.1%
Princess Alexandra	27.4%
Norfolk and Norwich	30.8%
Peterborough City	34.9%
James Paget	37.9%
Papworth	37.9%
Ipswich	51.2%
Colchester General	56.9%

⇧ better



Updates since previous month

1) In October, 18.3% of ambulance handovers took longer than 45 minutes, compared to 9.7% in September. This compares to 9.0% of handovers exceeding 60 minutes in October 2024.
2) Average ambulance offload time in October was 29:41, an increase from 22:16 in September. This places CUH as the eighth highest-performing trust in the East of England region.
3) A total of 600 ambulances experienced handover delays exceeding 30 minutes in October, nearly doubling from 316 in September.

Current Issues

1) Ambulance bay RAT cubicles are used as sideroom capacity when limited flow out to core siderooms within the Trust. Infection control discussed at flow meetings with stepdown plans shared to aid management.
2) Increased use of the corridor and delays finding staff to open the ED corridor when ambulance demand exceeds cubicle capacity
3) "Current issues" affecting the 4-hour standard on page 13 all apply to Ambulance Handovers. 4) Lack of bedded discharge lounge, patients have long waits for transport, blocking beds in ED

Key dependencies

1) Proactive management of the availability of a RAT cubicle at all times in the ambulance bay.
2) Robust use of the ambulance handover policy ensuring good use of Fit2sit.
3) Timely movement out of ED to assessment areas and core beds to maintain continuous flow.
4) Clear infection control plans to maintain flow to sideroom capacity to mitigate limited capacity within ED.
5) Access to Rapid Handover spaces at all times with patients clearly identified in advance to move when activated.
6) Transport prioritisation for patients in ED
7)Early identification of corridor staff.

Future actions

1) The ambition for 2025/26 is to continue to reduce offload delays to support the Cat2 target. Improvements in in-patient flow will support this via the reduction in levels of exit block from the ED. 2) Engagement with EEAST to drive up Call Before Convey crew compliance to minimise inappropriate conveyances to ED.
3) Surgical specialities to develop rapid handover spaces.
4) Divisions have been asked to prepare further contingency plans now, ahead of the 25/26 winter season.

Author(s): Rebecca Pheby / Elana Covshoff

Owner(s): Nick Kirby

Overall fit test compliance for substantive staff

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Summary Table

Division	Corporate			Division A			Division B			Division C			Division D			Division E		
Staff Group	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected
Add Prof Scientific and Technical (Pharmacists only)	-	-	-	1	0	0%	100	21	21%	-	-	-	-	-	-	-	-	-
Additional Clinical Services	2	0	0%	251	102	40.6%	69	25	36.2%	146	87	59.6%	103	51	49.5%	81	32	39.5%
Allied Health Professionals	-	-	-	55	17	30.9%	24	6	25%	1	0	0%	-	-	-	1	0	0%
Estates and Ancillary (Porters and Security Personnel only)	123	35	28.5%	-	-	-	14	11	78.6%	-	-	-	-	-	-	1	0	0%
Healthcare Scientists	-	-	-	-	-	-	8	6	75%	-	-	-	-	-	-	-	-	-
Medical and Dental	-	-	-	292	26	8.9%	2	0	0%	242	43	17.8%	169	10	5.92%	250	30	12%
Nursing and Midwifery Registered	1	1	100%	740	419	56.6%	3	2	66.7%	310	190	61.3%	148	99	66.9%	431	235	54.5%
Total	126	36	28.6%	1339	564	42.1%	220	71	32.3%	699	320	45.8%	420	160	38.1%	764	297	38.9%

Referral to Treatment % < 18 weeks

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<18 Weeks	
Oct-25	**Plan**
59.3%	60.0%

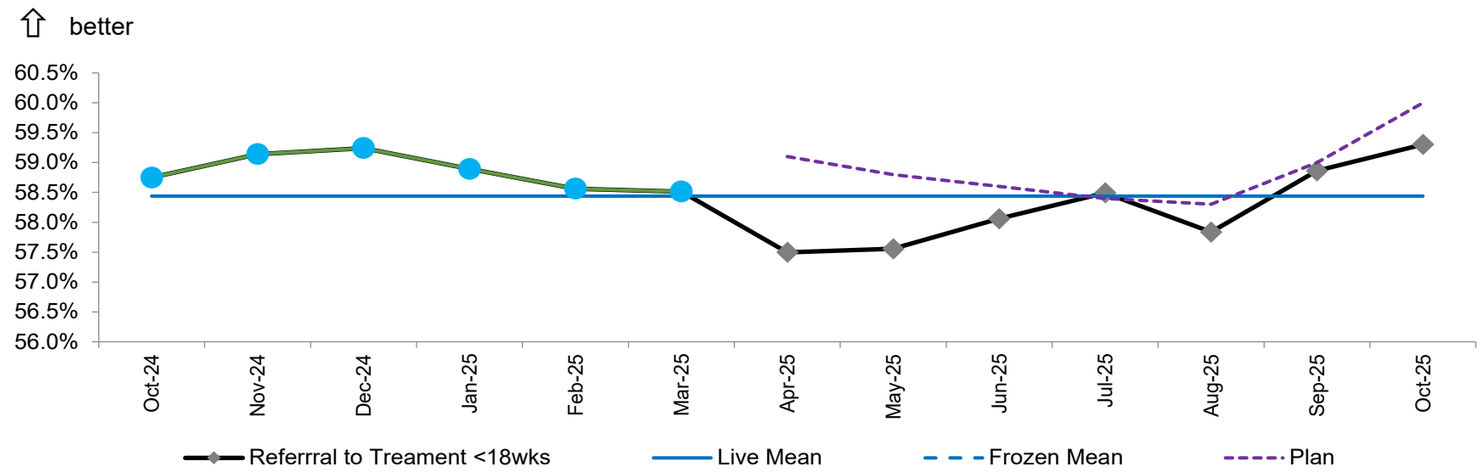
SPC Variance
Normal variation

% of WL under 18 weeks (Sep-25)	
CUH	58.9%
Shelford Group	60.7%

Three Month Plan (<18 wks)		
Nov-25	**Dec-25**	**Jan-26**
61.2%	61.5%	62.5%

Divisional Performance

	% patients waiting 18 weeks	
Division	Performance <18 weeks	Total waiting > 18 weeks
A	63.4%	4,738
B	71.3%	1,758
C	85.7%	607
D	53.4%	15,248
E	54.4%	4,284
Trust	**59.3%**	**26,635**



Updates since previous month

Our performance has increased due to the overall volume of clock stops seen in October which is a positive step forward, this resulted in a reduction of the overall waiting list by -925. Recovery actions across specialties are continuing to deliver with further actions expected to come online over coming months following longer lead times for delivery.

The reduction in the overall waiting list is required to maintain and improve our performance to plan.

Key dependencies

1) ICB led Demand management initiatives need to deliver a 2.6% reduction in clock starts compared to 2024/5.
2) Waiting list validation contributes a 5% reduction in total waiting list size and requires retention of administrative roles for validation.
3) Divisional plans being achieved and further productivity schemes being identified especially in highest risk specialties.
4) Triage & Validation is a key element of demand management

Current Issues

In October performance was 0.7% below plan

The volume waiting >18wks decreased by 669, and the volume under 18wks decreased by 256, both therefore impacting % performance

The total waiting list did reduce again in October by 925 and this is primarily due to the validation contribution which is above plan and mitigates clock stop activity being below plan.

Future actions

1) A range of Medical workforce posts have now progressed to increase capacity in the key specialities
2) Additional sustainable costed proposals have also been developed by specialities and approved, which include outsourcing, WLIs and clinic optimisation
3) There are 8 key specialties who need to continue improving their RTT delivery to support the Trust plan. Of these ENT, OMFS, Cardiology, Gynaecology & Paed ENT continue to see increases in >18week volumes.

Referral to Treatment > 52 weeks

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52+ Weeks	
Oct-25	Plan
3.6%	1.9%

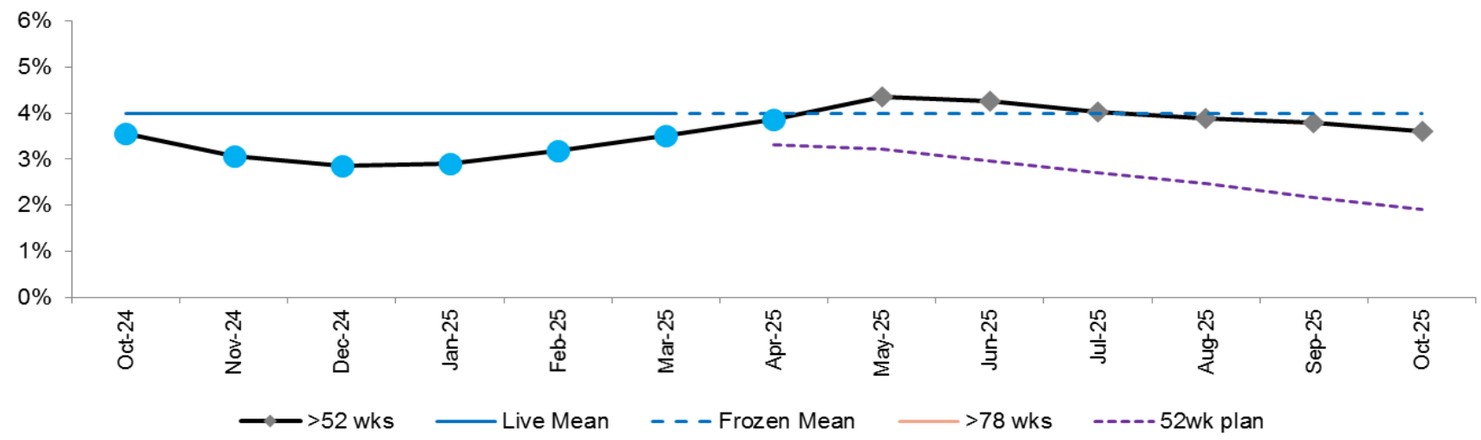
SPC Variance
Positive special cause variation

% of WL over 52 weeks (Sep-25)	
CUH	3.78%
Shelford Group	2.51%

Three Month Plan (52+ wks)		
Nov-25	Dec-25	Jan-26
1.8%	1.7%	1.6%

Divisional Performance		
Division	52+ wks	65+ wks
A	1.2%	7
B	2.4%	11
C	0.5%	1
D	5.1%	82
E	3.6%	23
Trust	**3.6%**	**124**

⇩ better



Updates since previous month

1) Performance to October is adverse to plan and this continued decline is due to capacity for OP waits and subsequent treatments alongside increased demand.
2) In October CUH had 2,355 >52weeks, against the original plan of 1,183. This is the second month showing a slight improvement and is 47 patients behind the revised trajectory that was developed in Sept/Oct to get back to the original planned submission by March 2026. Recovery actions across specialities have been mapped through within the revised trajectory and are being monitored closely through governance to ensure delivery.

Key dependencies

1) Reduction in 1st outpatient waiting times is a key requirement
2) Effective pathway tracking to expedite next steps for longest waiting patients
3) Reduction in late inter-trust referrals
4) Flexibility in use of waiting list initiatives / independent sector for targeted sub specialty risks
5)Flexibility in Theatre allocations within Division for longest waiting groups

Current Issues

Long waits have deteriorated in October with waits > 65 increasing from 117 to 123. ENT and Cardiology have the highest volume - this is due to delays in recovery actions with outsourcing and a locum onboarding.
> 52 week waits decreased by 170 in month marginally behind the revised trajectory. This is due to delays in additional capacity being implemented but these are expected to commence in November. Recovery plans are being reviewed through governance and increased actions within weekly PTLs has commenced for very long waiting patients.

Future actions

1) Tier 1 reporting into national oversight meetings continues.
2) Costed Insourcing & outsourcing proposals supported for the top 8 services driving deterioration in long waits and have commenced
3) Sustainable plans and investment are required due to the shortfall between demand and capacity which is a recurrent risk to RTT delivery
4) MBI have commenced to support validation of PTL
5) Detailed action plans in place for top eight specialties but risk remains to deliver end of Q4 plan recovery at present.

RTT waiting for first appointment < 18 weeks

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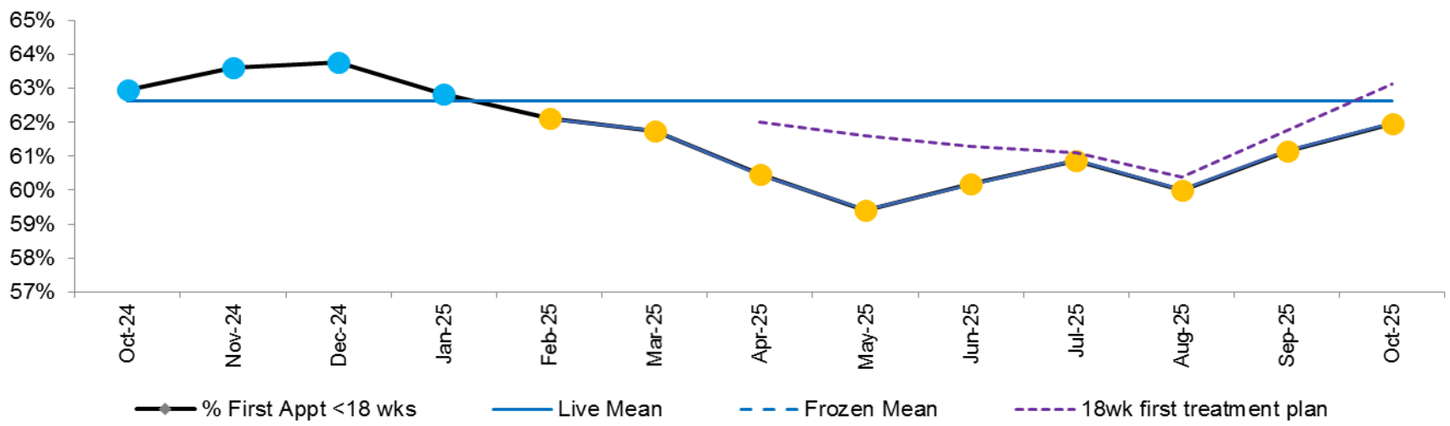
<18 Weeks	
Oct-25	**Plan**
62.0%	63.1%

SPC Variance
Negative special cause variation

Three Month Plan (<18 wks)		
Nov-25	**Dec-25**	**Jan-26**
64.5%	64.5%	65.9%

Divisional Performance			
		% patients waiting 18 weeks	
Division		Performance <18 weeks	Total waiting > 18 weeks
	A	70.4%	1,887
	B	69.5%	698
	C	93.4%	149
	D	54.9%	9,130
	E	62.1%	2,259
Trust		**62.0%**	**14,123**

⇧ better



Updates since previous month

1) Waits for 1st OP represent 57% of the total waiting list so are a key deliverable for overall waiting list reduction.

2) Performance to October is 1% behind plan, but this performance is influenced by variances in the volume waiting <18wks as well as >18wks

3)The volume waiting <18 wks decreased in month but remains behind plan by 1.3% (-471)

Key dependencies

1) 1st OP activity plans need to be achieved by Divisions and is a key deliverable.
2) Admin and clerical booking resource is limited in central outpatients and specialties.
3) Clinic Optimisation Programme to maximise clinic template delivery needs to align to job plans
4) Demand management of initiatives to deliver a 2.6% reduction in clock starts compared to 2024/5.

Current Issues

11) The required reduction in 1st OPs is below plan, as well as the increasing size of the overall waiting list as we have a higher clock start rate than stops.

2) Engagement with re-establishing waiting list initiatives is variable across specialties especially ENT & Urology.

Future actions

1) Medical workforce posts are progressing in our top 8 specialities following initial delays
2) Additional proposals to include super clinics and one stop models are in discussion and have been undertaken in some areas.
3) Internal demand focus requires working with Transformation re demand management of referrals and triage diversion
4) Outsourcing to Hamptons Hospital and other providers to support has commenced & will need continued monitoring to ensure delivery

Cancer - 28 day faster diagnosis standard

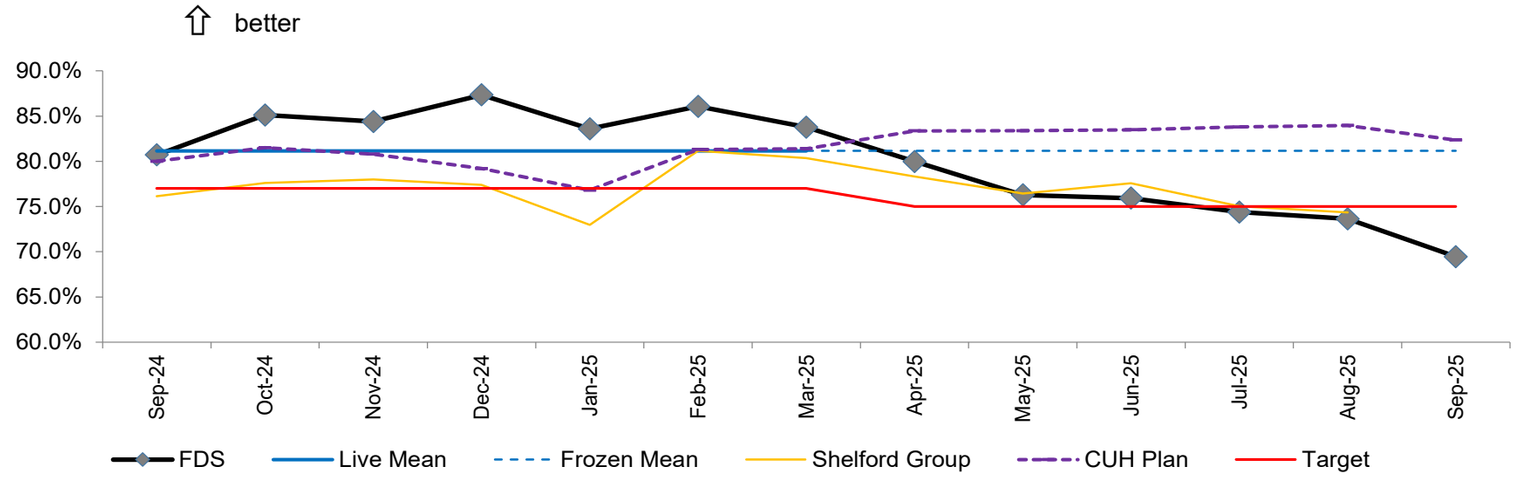
Sep-25	Target
69.5%	75.0%

SPC Variance
Negative special cause variation

Shelford Group Median Avg (Sep-25)
75.3%

Three Month Plan		
Oct-25	Nov-25	Dec-25
84.2%	83.7%	85.2%

Cancer Site Overview		
Site	Performance	Breaches
Skin	49.9%	576
Lower GI	86.0%	41
Gynaecological	88.8%	27
Head & Neck	87.8%	36
Urological	51.4%	85
Breast	78.5%	142
Haematological	63.6%	4
Sarcoma	50.0%	13
Upper GI	72.2%	5
Lung	93.6%	6
Children's	97.1%	1
CNS/Brain	95.2%	1
Non-site specific	93.8%	3
Testicular	100.0%	0
Total	**69.5%**	**940**



Updates since previous month

Performance: 69.5% (below plan and national target of 75%), recovery already evident in October.
Cause of decline: Delays to first appointment, particularly in Skin and Breast. Delays in MRI reporting in Urology have also contributed.
Contributing factor: Workforce gaps in all these teams.
Action: Recruitment approved and recovery plan implemented.
Forecast recovery: Skin (Dec - slipped from October), Breast (Jan), Urology (Mar) - all ahead of plan, showing recovery in Oct.

Key dependencies

Maintain pathology turnaround times **above 50% within 7 days**, particularly in Skin and Urology.
Sustain **capacity in Skin** to meet first appointment demand and support rapid post-telederm decisions.
Expand **one-stop diagnostic clinics** to achieve internal target of **50% seen within 7 days** of referral.
Ensure **successful recruitment to all vacant posts** with no delays to start dates.

Current Issues

October FDS performance is reported on 03.12.25 and is forecast to be above 80%, this performance has continued into November.
Delays to first appointment in Skin, Breast, and Urology pathways due to workforce gaps.
Action: Recruitment approved and recovery plans in place for affected specialties.
Full recovery to plan forecast by March 2026.

Future actions

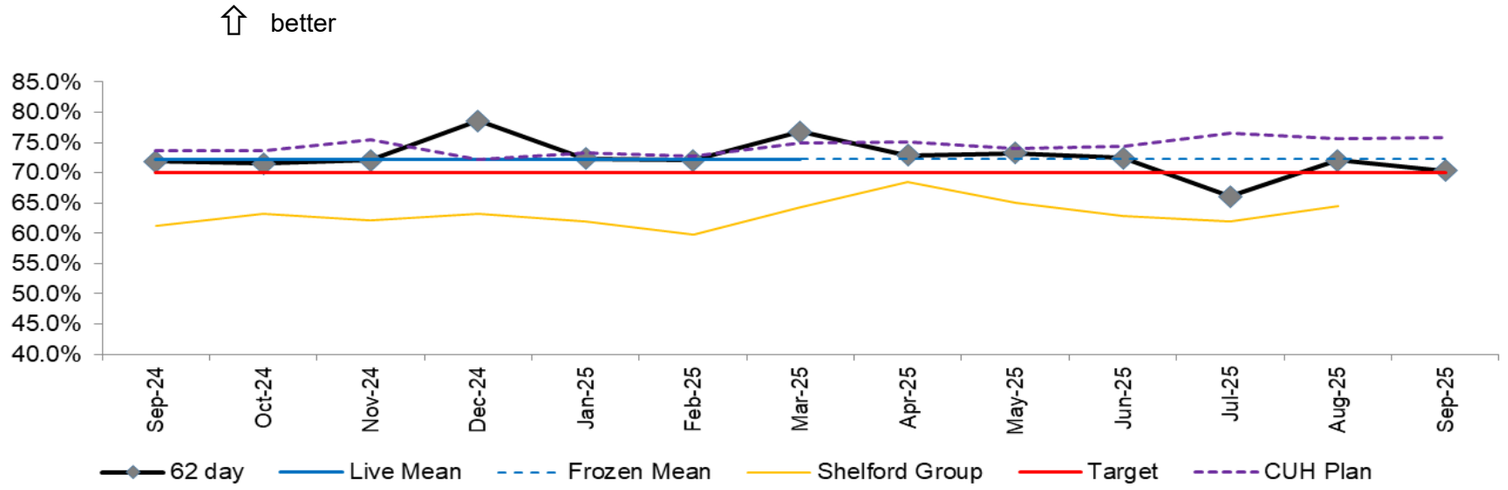
First appointments within 7 days, prioritising high-volume specialties.
Expand Teledermatology capacity in Skin, with rapid review and decision-making.
Recruit and deploy **locum medical posts** to support Breast and Skin pathways.
Sustain progress on:
pathology turnaround times (Head & Neck, Skin, Urology).
One-stop diagnostic capacity (50% within 7 days).

Cancer - 62 days combined referral to treatment

Sep-25	Target
70.4%	70.0%

SPC Variance
Normal variation

Shelford Group Median Avg (Sep-25)
63.8%



Cancer Site Overview as of 18/11/2025

Site	Backlog
Breast	14
CNS/Brain	1
Gynaecological	13
Head & Neck	7
Other Haem Malignancies	3
Lower GI	15
Lung	12
NSS	0
Upper GI	5
Urological	47
Sarcoma	5
Skin	54
HPB	17
Children's	0
Symptomatic Breast	0
All	*193*

Updates since previous month

Performance: was sustained above national target however remains below plan

325 patients treated in September **96.5 waited longer than 62 days**.

Shared pathways (62 patients): 45 not treated within 24 days.

CUH-only breaches (70 patients): **Skin**: 31%, **Prostate** 13% and **Breast** 11% all due to delays at the start of the pathway.

Shared Pathway Analysis: Of patients not treated within 24 days, 51% required surgery and 31% radiotherapy

Key dependencies

1) Continuing achievement of 28 day FDS

2) Pathology turn around times remaining above 50% in 7 days and 90% in 21 days particularly in Head & Neck, Urology and skin.

3) Compliance with the Inter provider transfer policy, including all diagnostics being completed prior to tertiary referral, and a reducing rate of late referrals.

4)Treatment capacity within 24 days

Current Issues

Delayed FDS pathways increasing 62-day breaches, particularly in **Breast, Skin and Urology**.

Histology reporting delays impacting MDT treatment planning; pathology turnaround times are improving in line with trajectory.

Of the **70 CUH-only breaches**: **17%** due to complex pathways, other medical delays, or patient choice.

Future actions

Radiotherapy wait times – continued recovery to ensure treatment within 24 days for tertiary pathways.

Recruitment to address workforce gaps in **Breast, Skin, and Urology**.

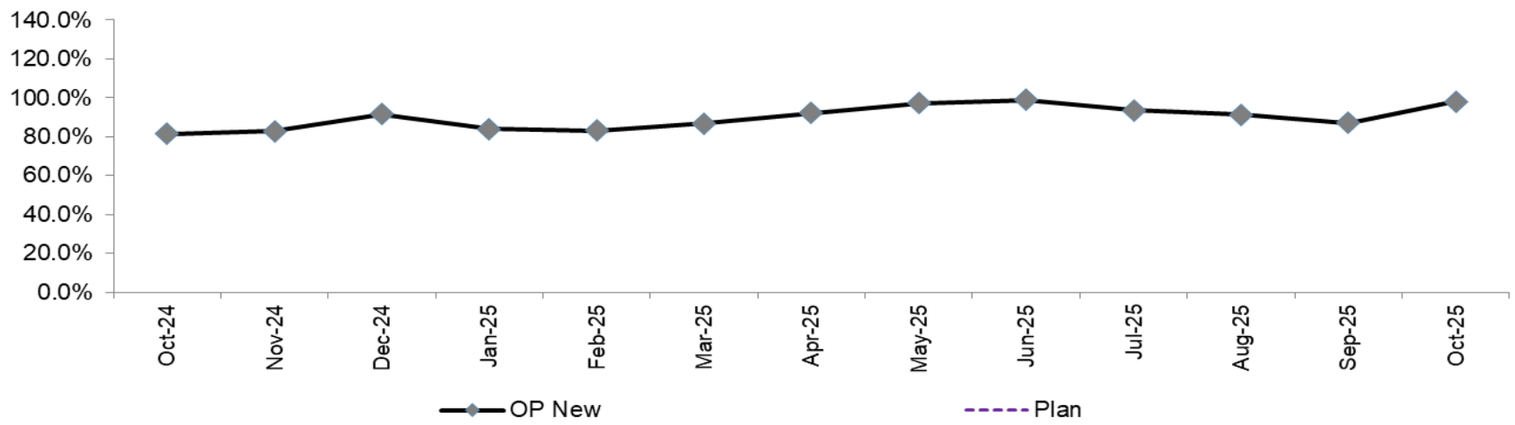
Focus on MDT efficiency to ensure delays in agreeing treatment plan and communication with patients are reduced.

Future pathway changes - all MDT leads are reviewing best practice at other trusts to understand where further improvements can be made.

New Outpatient Attendances - % vs. Plan (consultant led, specific acute)

Cambridge University Hospitals NHS Foundation Trust

Oct-25	Plan
98.2%	N/A



Shelford Group Median Avg (Sep-25)
N/A

Three Month Plan		
Nov-25	Dec-25	Jan-26
N/A	N/A	N/A

Divisional overview	
Division	Performance
A	100.7%
B	101.6%
C	98.5%
D	97.1%
E	89.5%

Updates since previous month

1. Patients are being referred to the Hamptons from Cardiology and OMFS to reduce the long waiting patients. Cardiology going forward with telephone clinics to reduce their overall waiting list.
2. Additional new outpatient activity has increased in all divisions.

Current Issues

1. We continue in Tier 1 management due to the current RTT position.
2. Rejecting with advice is pivotal to help with demand management and considering alternative ways for patients to be seen i.e. in the community.
3. Vacancies in the booking teams continue to be challenging but recent recruitment has been positive. Slot utilisation continues to exceed 90%.

Key dependencies

1. Successful recruitment has taken place within our booking coordinator roles, new starters will be joining us once the recruitment checks have been completed. Estimated starting dates January 2026.
2. Appropriate triaging is a key message with the use of Advice and Guidance to reduce outpatient activity.

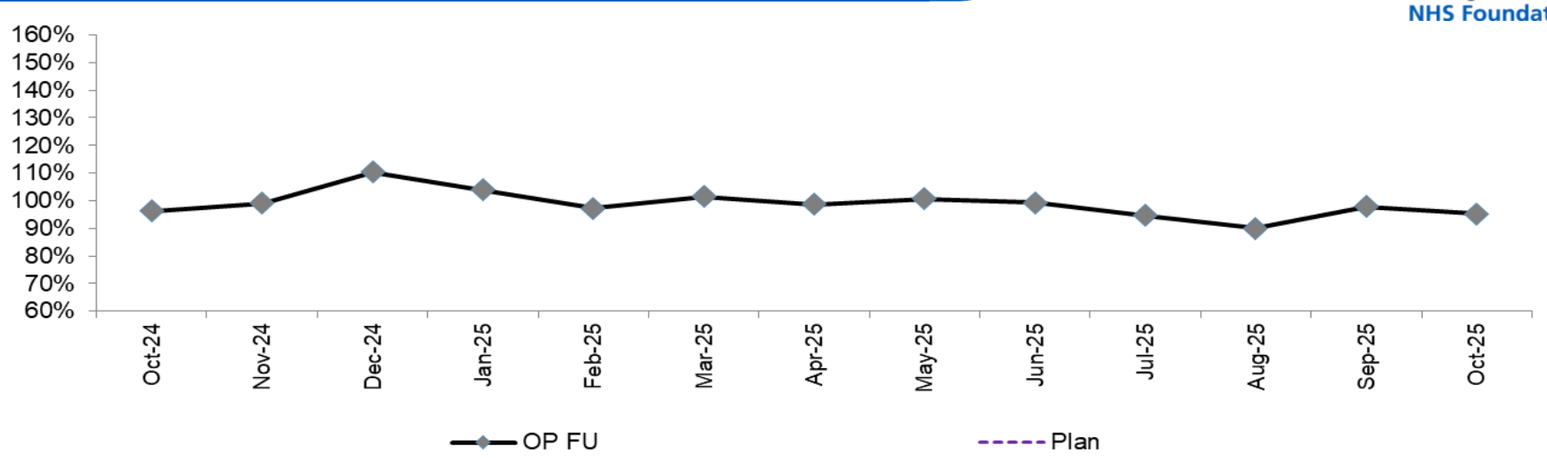
Future actions

1. To improve clinical triage time from referral received date to an outcome decision and to be included within job plans.
2. Clinical templates to be reviewed in line with Consultant job plans.
3. Implementation of the RAS (Referral Assessment Service) in ERS to help improve the administrative workflow with new patient referrals.

Follow Up Outpatient Attendances - % vs. Plan (consultant led, specific acute)

Cambridge University Hospitals NHS Foundation Trust

Oct-25	Plan
95.2%	N/A



Shelford Group Median Avg (Sep-25)
N/A

Three Month Plan		
Nov-25	Dec-25	Jan-26
N/A	N/A	N/A

Divisional overview	
Division	Performance
A	101.2%
B	92.0%
C	96.4%
D	94.7%
E	93.7%

Updates since previous month

1. Booking Optimisation has gone live successfully in 37 of our specialties resulting in patients being able to self schedule their follow-up appointments. Patients are also offered short notice slots using MyChart.
2. We continue to see a gradual increase in follow-up capacity but this can be exhausted with the demand for new outpatient activity.

Current Issues

1. Alternative pathway management still needs to be explored in order to reduce patient follow-up appointments.
2. Overdue follow-up position has gradually decreased.

Key dependencies

1. Remote clinical reviews still needs to be optimised as the use of PIFU and RCR is not increasing. 2. Pathway redesign needs to be a focus for all specialties to see the number of follow-up orders reduce and aid capacity demand.

Future actions

1. Services need to urgently review their overdue follow-up backlog and consider alternative ways to review their patients going forward.
2. Redesigning pathways to help reduce the need for follow-up appointments.

PIFU Outpatient Attendances

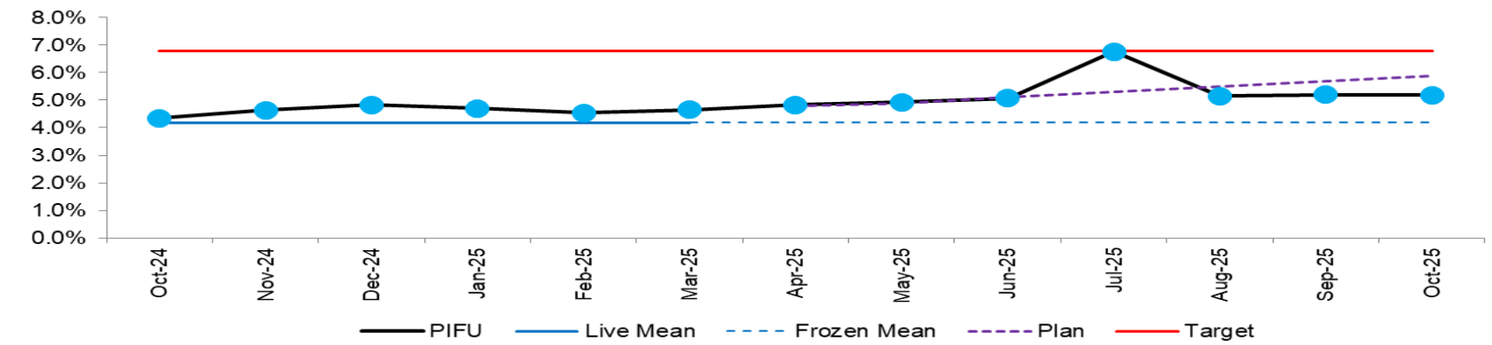
Cambridge University Hospitals NHS Foundation Trust

Oct-25	Plan
5.2%	5.9%

SPC Variance
Positive special cause variation

Shelford Group Median Avg (Sep-25)
N/A

⇧ better



Three Month Plan		
Nov-25	Dec-25	Jan-26
6.1%	6.3%	6.5%

Divisional overview	
Division	Performance
A	5.8%
B	4.4%
C	2.4%
D	2.3%
E	5.7%

Updates since previous month

1. Performance has remained slightly lower against the plan still at 5.2%.
2. Number of orders placed has increased in some of our divisions.

Current Issues

1. An increase in the uptake of PIFU is needed to deliver the target at the end of the year. 2. A review of patient pathway management would see the increase usage of PIFU.

Key dependencies

1. There is a need for PIFU slot management within clinical templates. This should be a standardised approach across all services.
2. The PIFU conversion rates will increase as we see existing PIFUs being converted into outpatient appointments.

Future actions

1. Services will need to continue to focus on clinic optimisation.
2. Services to continue to review their usage of PIFU in line with consultant targets.

Delayed Discharges

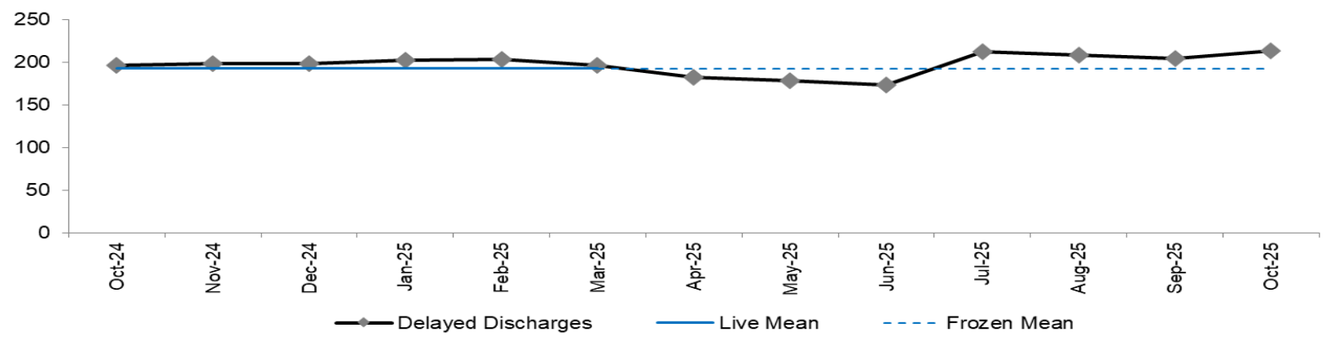
NHS Cambridge University Hospitals NHS Foundation Trust

Oct-25	Target
213	N/A

SPC Variance
Normal variation

Shelford Group Median Avg (Oct-25)
N/A

⇩ better



Beds lost to delays - by pathway

Pathway	Beds lost
Pathway 1	48
Pathway 2	21
Pathway 3	24
Internal Assessments	66
Internal Other	0
Other External Reasons	54
Total	**213**

Updates since previous month

Lost Bed Days: October 2025 recorded the highest number of lost bed days due to delayed discharges, marking the peak for the past 12 months. **Staffing**: There was an increase in staff sickness-related absences during October. Vacancies within the Complex Discharge Team and Early Intervention Team remain unfilled, as they are pending panel approval and redeployment processes. Social **worker Locum**: Awaiting recruitment checks for Honorary contract. Start date set for 24th November.Ilarna **support for self funders**: is live with updated SOP for care home placements and staff trained in early patient screening.

Key dependencies

External Delays: Ongoing shortage of care capacity for Intermediate care at home (Pathway 1) and delays for social worker assessments in the hospital are continuing to show impact on lost bed days and discharge delays. Internal Delays: ward processes, staff sickness and recruitment delays in filling vacant posts are contributing to internal delays. Cancelled discharges: We have lost a significant amount of complex discharges for last minute cancellation due to transport and TTOs issues. This is a major concern for improving our discharge efficiency and have an impact on our partner organisations in the community.

Current Issues

External Delays: Ongoing shortage of care capacity for Intermediate care at home (Pathway 1) and delays for social worker assessments in the hospital are continuing to show impact on lost bed days and discharge delays. **Internal Delays**: ward processes, staff sickness and recruitment delays in filling vacant posts are contributing to internal delays. **Cancelled discharges:** We have lost a significant amount of complex discharges for last minute cancellation due to transport and TTOs issues. This is a major concern for improving our discharge efficiency and have an impact on our partner organisations in the community.

Future actions

We are working collaboratively with Ilarna Care to support self-funding patients in sourcing care packages and care home placements more efficiently, while deploying locum social workers to reduce assessment delays and enable timely discharge planning. Recruitment into existing vacancies across discharge and care coordination teams remains a priority, and preparations for the OPTICA team's go-live in early January are underway. Phase 1 of the redesigned Pathway 1 model will launch, introducing a dedicated virtual coordination room for triaging all short-term care referrals.

Theatre Utilisation - Elective GIRFT Capped

NHS
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Oct-25	Plan
80.7%	85.0%

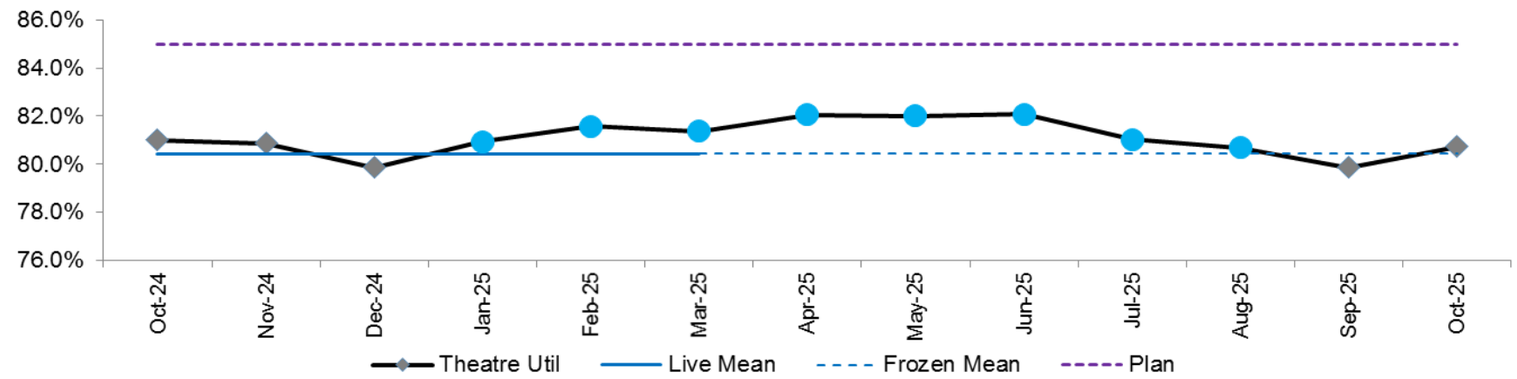
SPC Variance
Normal variation

Performance in the 2 weeks to 02/11/2025	
CUH	82.0%
Shelford Grp Median	81.7%

Three Month Plan		
Nov-25	Dec-25	Jan-26
85.0%	85.0%	85.0%

Utilisation by department	
Department	Utilisation
ATC	83.9%
Main	80.2%
Rosie	76.1%
CMSH	86.5%
CEU	71.1%
Ely	74.9%
All	**80.7%**

⇧ better



Updates since previous month

Elective activity improved by 0.8% compared with the previous month, with current performance now aligned with the Shelford Group median at 81.0%. Continuous efforts from the perioperative team and clinical divisions are helping to drive sustained improvement, supported by the enhanced Surgery Programme Board, which commenced in November

Key dependencies

1. Minimised short notice cancellations.
2. Optimised start times and turnaround efficiency.
3. Proactive scheduling aligned to the 6-4-2 framework.
4. Timely access to post-operative beds.

Current Issues

Post operative bed availability remains an area of concern with beds often being released too late in the day causing delays in exiting the anesthetic room and negatively impacting turnaround time. Administrative manpower shortages within the surgical services are currently a limiting faction being addressed by those services affected to ensure their utilisation is improved.

Future actions

The Surgery Programme Board will operate under the new structure from November 2025, with the objective of holding services to account and providing targeted support to improve theatre utilisation. The 6-4-2 process has been relaunched to strengthen senior-level escalation following the weekly meetings, with an enhanced emphasis on forecasting and learning from previous weeks' performance.

BADS Daycase Rates (Outpatient + Daycase)

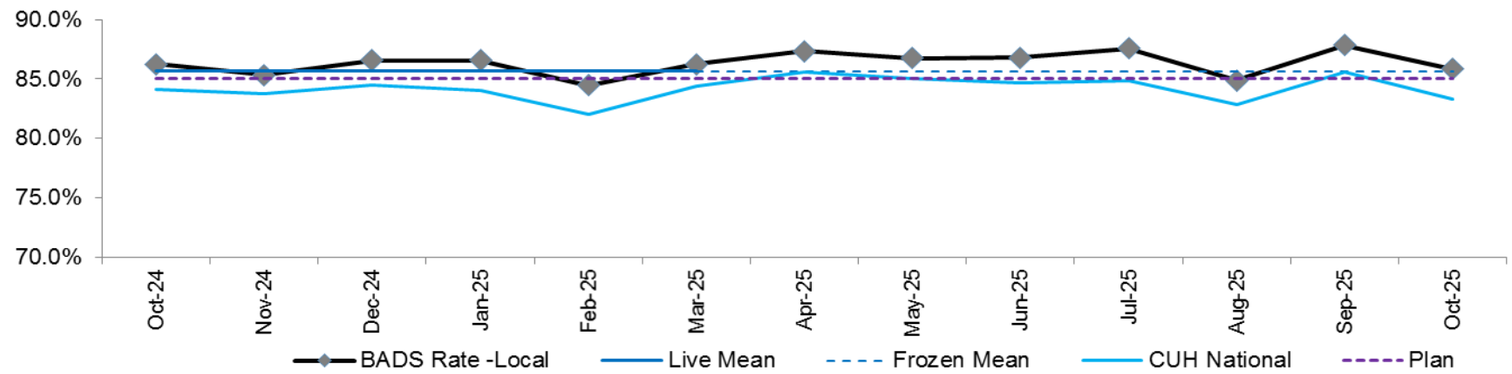
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NHS Foundation Trust

Oct-25	Target
85.8%	85%

SPC Variance
Normal variation

Model Hospital Published Performance in the 3 months to end of Jun	
CUH	84.7%
Shelford Grp Median	83.2%

⇧ better



BADS Section Day Case Rate for HVLC focus areas

3 months to end of Jun '25				Oct-25
Specialty	CUH	Shelford	Quartile	Local
Orthopaedics	72.8%	73.5%	3	70.7%
ENT	88.4%	89.0%	2	91.5%
General	78.6%	74.9%	3	82.8%
Gynaecology	90.9%	85.6%	4	92.3%
Ophthalmology	96.4%	97.1%	1	98.1%
Urology	90.9%	87.1%	3	89.6%

Updates since previous month
BADS performance local data remains above target, however there has been a slight deterioration from previous month with no specific trend identified.

Key dependencies
1. Day cases procedures operated first on the list.
2. Timely access to theatres for simple emergencies from SAU.

Current Issues
In the month of October the perceived opportunity for improvement was 136 procedures. Incision and drainage of skin abscess remains the biggest opportunity with 18 out of the total procedures mainly due to access to emergency theatres.

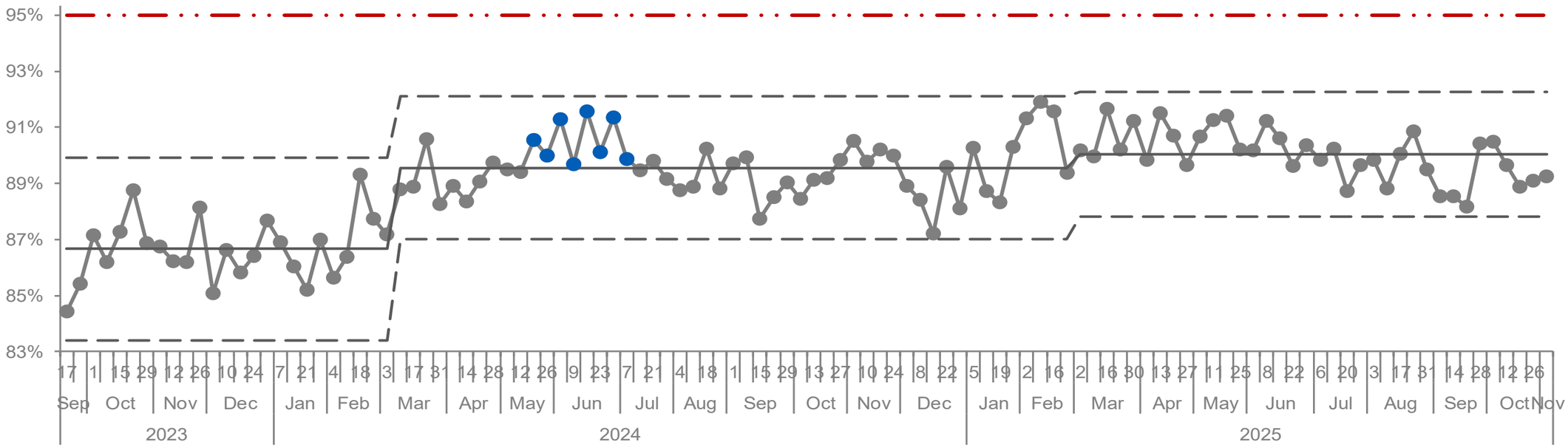
Future actions
Improvements in intended-management data quality continue, supported by targeted specialty-specific interventions that are helping to better align local performance with Model Hospital metrics. Enhancing BADS performance remains a key priority for maintaining surgical flow within high-performing theatres, and this work is being progressed through the Surgery Programme Board.

Discharge Summaries

NHS
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NHS Foundation Trust

Discharge Summary Letters (Weekly)

Percent of discharge summaries sent in under 2 days



Discharge summaries

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

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

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

Author(s): James Boyd **Owner(s): Sue Broster**

Patient Experience - Friends & Family Test (FFT)

NHS Cambridge University Hospitals NHS Foundation Trust

The good experience and poor experience indicators omit neutral responses.

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
FFT Inpatient good experience score	Jul 20 - Oct 25	Month	-	88.3%	94.3%	L	SP	-	The Good FFT score did not change and remains the lowest score since 2020. The Poor score had a very small improvement of 0.6% compared to September. The number of responses increased by 72 compared to September. **For OCT** 848 responses were collected from approx. 3,168 patients.
FFT Inpatient poor experience score	Jul 20 - Oct 25	Month	-	5.2%	2.3%	H	SP	-	
FFT Outpatients good experience score	Apr 20 - Oct 25	Month	-	94.2%	94.5%		-	-	Both the Good FFT score and Poor FFT score remained the same compared to September. **For OCT** there were 7,354 FFT responses collected from approx. 41,917 patients.
FFT Outpatients poor experience score	Apr 20 - Oct 25	Month	-	2.6%	2.6%		-	-	
FFT Day Case good experience score	Apr 20 - Oct 25	Month	-	95.7%	96.2%	L	S7	-	Both the Good FFT score and Poor FFT score remained the same compared to September. The special cause variation for Low/High is not a concern as the Good score remains about 95% which is very good, and Poor score is below 3% which is also very good. **For OCT** there were 1,205 FFT responses collected from approx. 5,043 patients.
FFT Day Case poor experience score	Apr 20 - Oct 25	Month	-	2.2%	1.9%	H	S7	-	
FFT Emergency Department good experience score	Apr 20 - Oct 25	Month	-	81.7%	82.2%		-	-	The overall ED Good score declined 3% compared to September. The Poor score increased 1% compared to September. This did not affect the positive special cause variation as the scores continue to be a trend of improvement. **For OCT** there were 1,350 FFT responses collected from approx. 8,110 patients.
FFT Emergency Department poor experience score	Apr 20 - Oct 25	Month	-	10.0%	10.8%	L	S7	-	
FFT Maternity (all FFT data from 4 touchpoints) good experience score	Jul 20 - Oct 25	Month	-	86.8%	92.3%		-	-	**OCT:** Antenatal 0 responses; Birth had 31 FFT responses out of 473 patients - 96.8% Good / 0% Poor; Postnatal had 7 FFT responses: Lady Mary had 5 FFT with 20% Good / 80% Poor, Birth Unit had 1 FFT with 100%, DU had 1 FFT with 100% Good. Zero community midwife FFT data. **OCT MATERNITY OVERALL:** 38 responses: Good score 86.8% (6% decrease) and Poor score 10.5% (8% increase).
FFT Maternity (all FFT data from 4 touchpoints) poor experience score	Jul 20 - Oct 25	Month	-	10.5%	3.6%	H	SP	-	

Wards that do not collect FFT are not included in the monthly NHSE FFT submission.

The October inpatient SMS response rate is 21.6%, (485 FFT responses collected from 2,249 SMS sent) and overall inpatient response rate is 29.5%. The overall response rate has improved and this is mainly from the removal of the number of patients that were in recovery from the response rate calculation, which started in April. The overall inpatient FFT scores had very little change compared to September. There was no change in the Good score and a 0.6% decrease in the Poor score. Therefore, the scores remain the lowest Good score and highest Poor score since 2020. Division D is the only division that improved both the Good and Poor scores. All wards collected FFT in September.

For outpatient and day case, both have no change in the Good and Poor scores. Both outpatient and day case Poor scores continue to be below 3% since May.

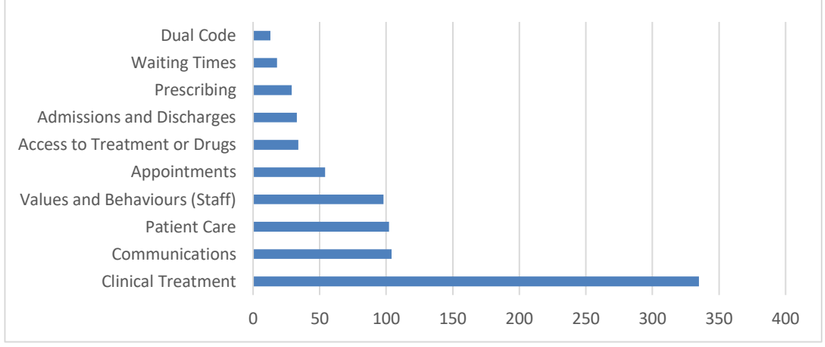
For ED, the overall Good score declined and the Poor score increased. This is mainly from the adult ED Good score decreasing and from slight increase from both adult and paediatric Poor scores. The main adult ED area did not have much change in the Poor score. The overall ED Poor score increase is from adult EAU3 (44% Poor), SDEC (17% Poor) and UTC (14% Poor). The overall ED scores continue to improve compared to same time last year.

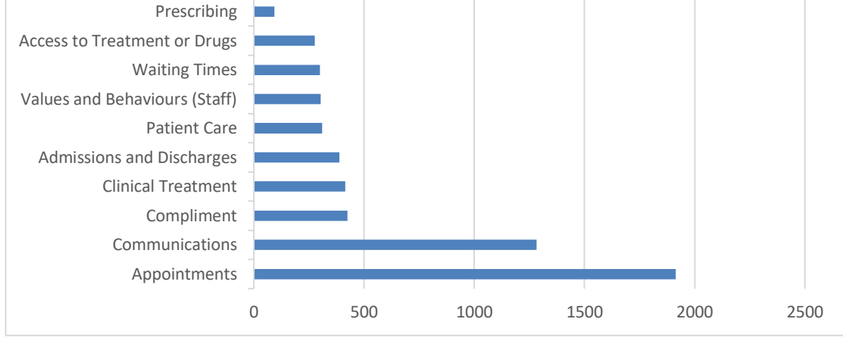
The overall Good maternity FFT score declined by 6% and the Poor score increased by 8%. The scores were impacted by Postnatal FFT scores. Lady Mary has 20% Good and 80% Poor from 5 responses out of 356 patients and this impacted not only overall Postnatal scores (43% Good / 57% Poor), but the overall maternity scores as well. Zero data was collected for Antenatal (Sara ward had 59 patients) and Community. The very low maternity responses continues to be a concern and is impacting the overall FFT score. A patient experience and maternity team meeting is in place end of November to discuss.

PALS and Complaints Cases

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
Complaints received	Oct 21 - Oct 25	month	-	58	68	H	SP	-	The number of complaints received for this report period decreased by 9.38% from previous month. The Trust and all Divisions are within normal variance.
% acknowledged within 3 days	Oct 21 - Oct 25	month	95%	93%	87%	L	SP	?	Division D has seen a statistical decrease in the last 7 months, the Trust and all other Divisions are within normal variance. Only Divisions A and B met the target of 95%. 54 out of 58 complaints were acknowledged within 3 working days
% responded to within initial set timeframe (30, 45 or 60 working days)	Oct 21 - Oct 25	month		41%	41%		-	?	The Trust and all Divisions are within normal variance but did not meet the target. The Trust is statistically unlikely to meet the target. 31 out of 58 complaints closed in Oct 25 were responded to within the initial set timeframe
% complaints received graded 4 to 5	Oct 21 - Oct 25	month		18%	22%		-	?	The Trust and all Divisions are within normal variation. There were 9 complaints graded 4 and 1 graded 5
Compliments received	Oct 21 - Oct 25	month		54	31		-	-	The Trust and Division A have had a significant statistical increase in October 2025. All other Divisions are within normal variance.





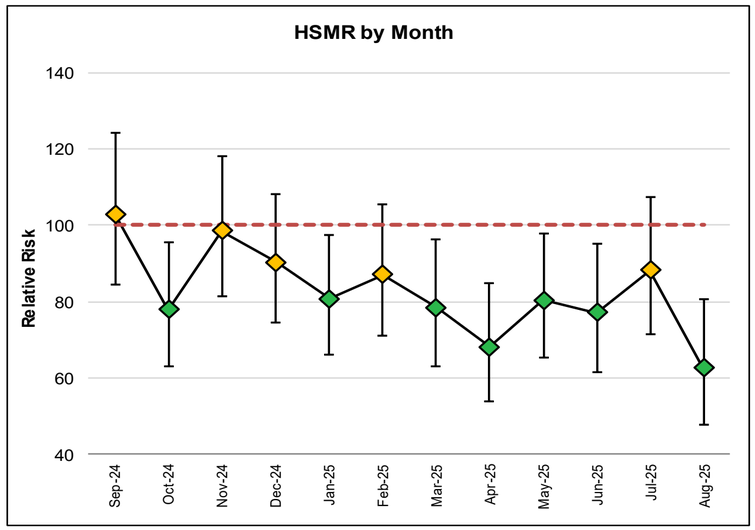
The department is currently sitting at 212 open complaints. In October 2025 we have closed 75 complaints, whilst only receiving 58 new cases. Many of the cases being closed are older, overdue complaints which explains why the number of complaints closed within their allotted timeframe remains low at 41%. Work is continuing to bring the total number of open complaints below 200 and the triage process is currently being reviewed in order to see if this helps with reducing

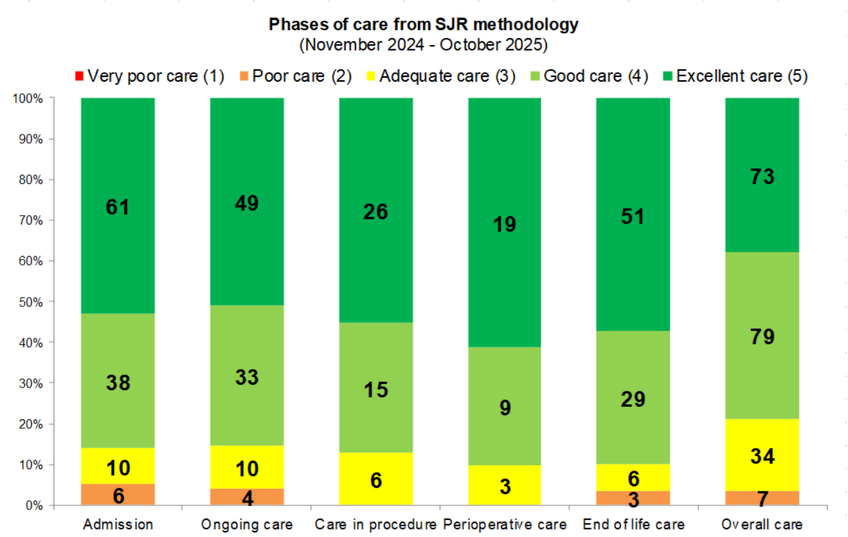
Author(s): Andrew Bell **Owner(s): Clare Hawkins**

Learning from Deaths

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Oct-25	Average (Mar 22 - Oct 25)	Variance	Comments
Total inpatient and Emergency department **deaths**	124	143		There has been normal variance in the total number of deaths at CUH. In October 2025, there were 114 inpatient deaths, 10 deaths in the Emergency Department (ED), and none in the Virtual Ward. There has been a statistically significant decrease in ED deaths, while inpatient and Virtual Ward deaths remain within normal variance.
Total Emergency Department and Inpatient deaths **per 1000 admissions**	6	8	L	There has been a statistically significant decrease in the death rate per 1,000 admissions in the last 8 months. In October 2025 there were 19423 admissions recorded at time of analysis.
Emergency department deaths per 1,000 attendances	0.57	0.84	L	There has been a statistically significant decrease in the rate per 1000 attendances. In October 2025 there were 17488 ED attendances recorded at time of analysis.
Inpatient deaths by 1,000 admissions	5.87	7.52	L	There has been a statistically significant decrease in the rate by 1,000 admission in the last 9 months. There were 114 inpatient deaths in October and 19.423 admissions.
Non-elective admission deaths by 1,000 admissions	27.81	32.42	L	There has been a statistically significant decrease in the rate by 1000 admissions in the last 8 months.
% of Emergency Department and Inpatient deaths **in-scope for a Structured Judgement Review (SJR)**	17.7%	18.5%		In October, 24 Mortality case reviews were commissioned. The highest in-scope trigger for review requests were due to ED death and these are within expected normal variance.





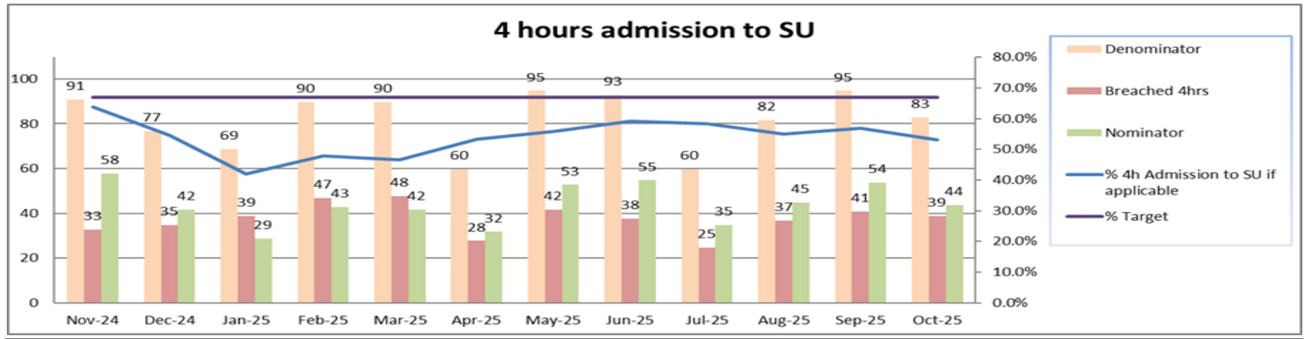
Executive Summary

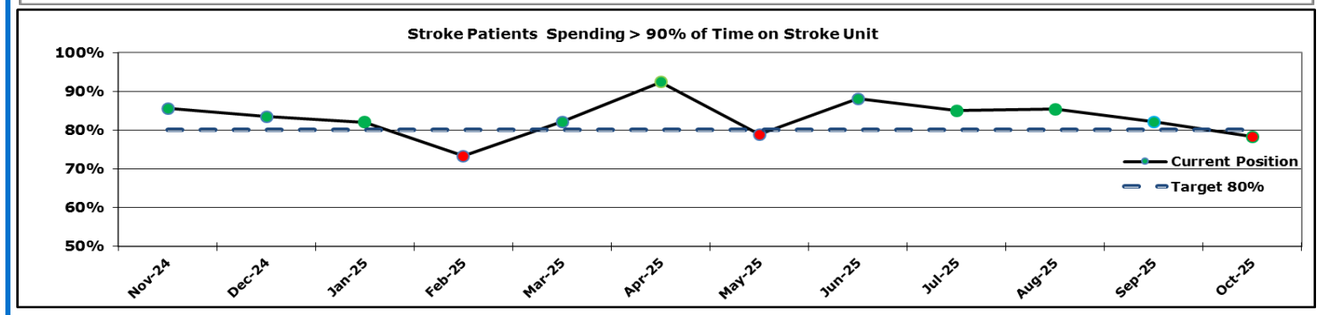
The Trust is within normal variance for the total number of deaths,. There is a statistically significant decrease in four of the above metrics by rate per 1000 admissions and per 1000 attendances.
In October, there was one death identified with a problem in care score of 1-3. This is currently undergoing a secondary review.
The majority of each 'phase of care' from SJR methodology was judged to be good/excellent care.
HSMR - The rolling 12 month (September 2024 to August 2025 HSMR for CUH) is 82.82 this is 7th lowest within the London and ATHOL peer group. The rolling 12 month HSMR for the Shelford Peer group is 88.02.
SHMI - The Summary Hospital-level Mortality Indicator (SHMI) for CUH in the latest period, July 2024 to June 2025 is 97.60.
Alert - There is 1 confirmed alert for review within the HSMR and SHMI dataset this month.

Author(s): Jane Nicholson **Owner(s): Monica Trivedi**

Stroke Care

Cambridge University Hospitals NHS Foundation Trust





Breach reasons for not achieving 90% IP stay on Stroke ward 2025/26 and Monthly Stroke position

Month	Stroke Bed Capacity - No outliers -	Trust Bed Capacity - Outliers -	Operational decision - patient moved off the unit to accommodate an acute stroke	Delay in medical review in ED	Delay in referral to Stroke Team	Clinical - Appropriate pathway for patient	Difficult presentation	Not referred to stroke team	Delayed diagnosis	Clinician's decision to place patient on different ward	Unclear presentation	Difficult diagnosis / Complex patient	Resource capacity	Number of breaches	Month Position (Target 80%)
Oct-24	7	3	1	1	1	1					2			16	80.2%
Nov-24		4		1	1	3					3		1	13	85.7%
Dec-24		5		1	1	1					4		1	13	83.5%
Jan-25	2	2		1		1					7		1	14	82.1%
Feb-25	2	7			4	4					6		1	24	73.3%
Mar-25	5	4			2	2					3			16	82.2%
Apr-25					2			1			3			6	92.4%
May-25		6			2			1			8		3	20	78.9%
Jun-25		1				2		2			3		3	11	88.2%
Jul-25				4	1	1					3			9	85.0%
Aug-25		2				7		2			1			12	85.4%
Sep-25	3	5		2	2	4					1			17	82.1%
Oct-25	3	2		4	5	2					2			18	78.3%
Summary	19	39	1	10	21	26	0	6	0	0	46	0	10	171	

90% target (80% Patients spending 90% IP stay on Stroke ward) was not achieved for October 2025 = **78.3%**

Delay in referral to Stroke Team (5) was the main factor contributing to breaches last month, with a total of 18 breaches in October 2025.

4hrs adm to SU (67%) target compliance was not achieved in October 2025 = **53.0%**

Key Actions

•Weekly team meeting with ACP/R2 nurse team /matrons /LW/Ops/SAT team continue. Useful forum to help resolve issues and progress projects

• Stroke Video Triage Service commenced 28/7/25
16 patients triage in August
13% referred to primary care and not conveyed
Team plan to go to 7 day service in next few months

Other development:

Thrombectomy service to go full 24/7 from Thurs 23/10/25

New Substantive Stroke consultant in post

Author(s): Helen Allibone Owner(s): Nick Kirby

Clinical Studies

NHS
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NHS Foundation Trust

Total Recruitment at end of Oct - FY 2025-26

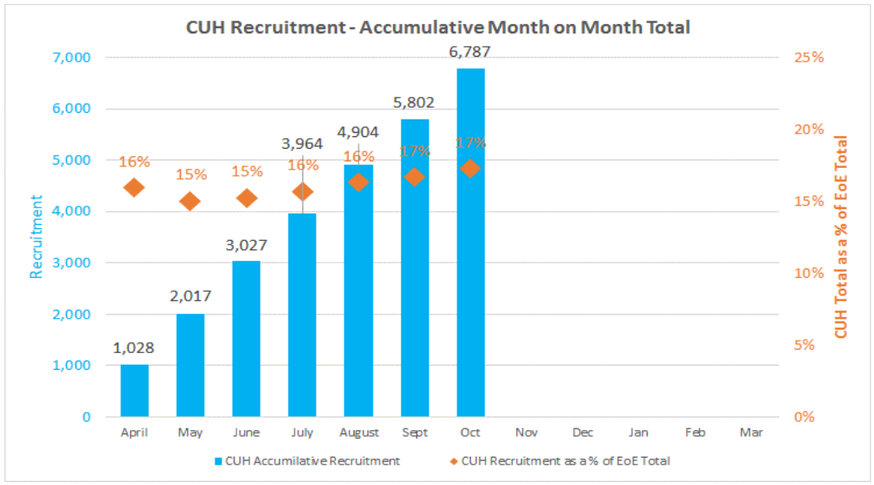
6,787

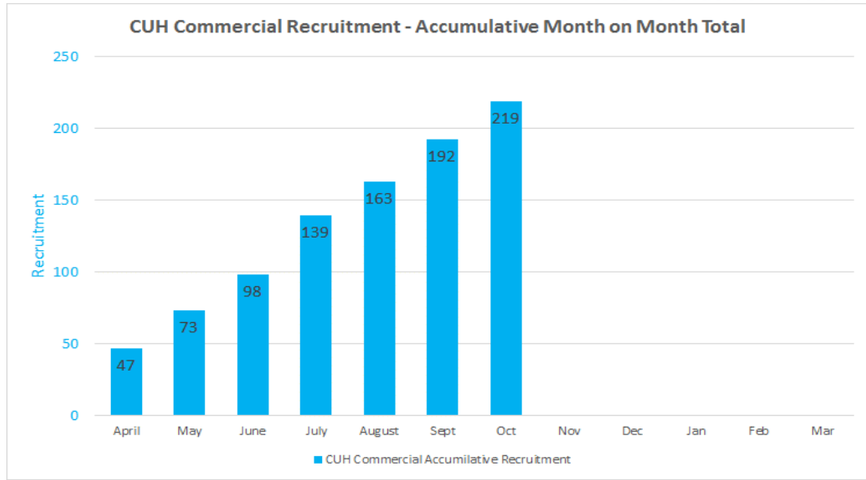
Open Studies at end of October 2025

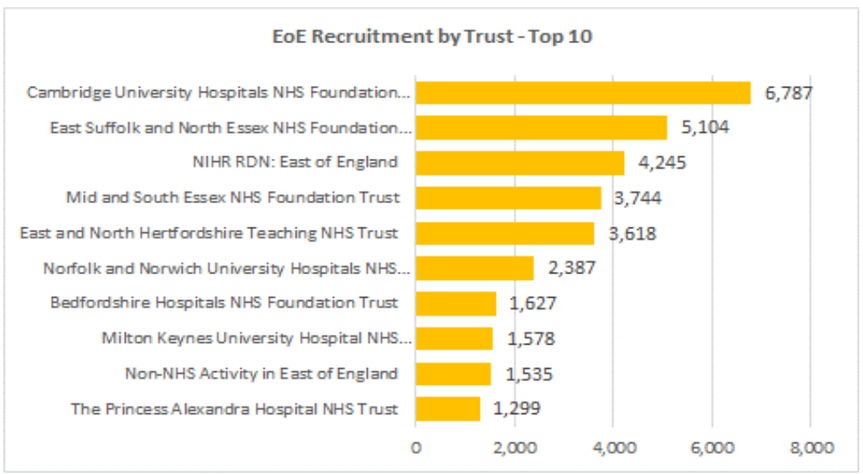
Non Commercial	437
Commercial	143
Total	**580**

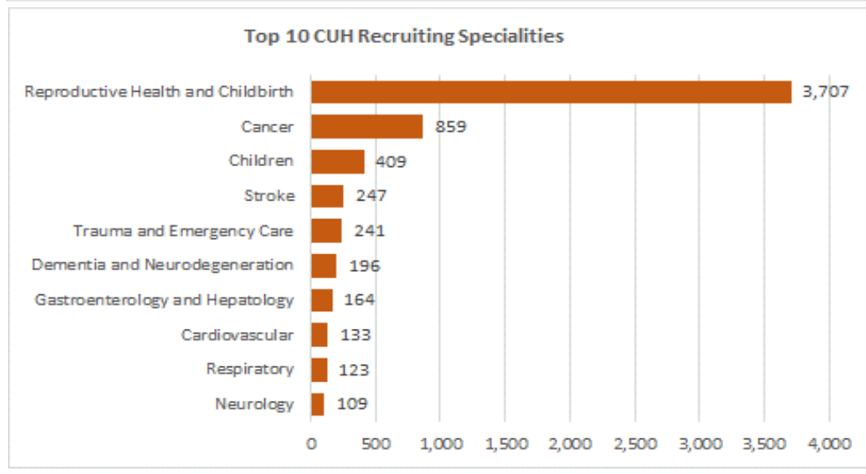
CUH Recruitment by Study Type

Observational	42.5%
Interventional	30.4%
Both	27.1%









* Total recruitment in the financial year to date: 6,787.
* CUH accounted for 17% of total recruitment by East of England Trusts in the financial year to date.
* CUH was the leading Trust for recruitment in the East of England, ahead of East Suffolk & North Essex in second.
* Recruitment to the Reproductive Health and Childbirth speciality accounted for over 50% of all recruitment. The Cancer speciality accounted for 13%. All of the other individual specialities accounted for less than 10% of the total recruitment.
* There were 580 recruiting studies, of which 143 were Commercial, and 437 Non-Commercial.

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

Maternity Dashboard

NHS Cambridge University Hospitals NHS Foundation Trust

Division E	Maternity Dashboard						October 25
Metric	Target	In Month Actual	Previous Month	3-month average		SPC variation - this month	12 month variation
Activity							
Births		484	461	466.3			
Induction of Labour rate		28%	30%	30%			
Delay in commencement of Induction (IOL)	9.9%	9%	10%	9%		Negative special cause variation above the mean	
Delay in continuation of Induction (IOL)	9.9%	60%	73%	67%	H	Normal Variation	
IOL for RFM <39/40 (SBLv3)	5.0%	0%	0%	0%			
Valid indication for IOL	95.0%	100%	100%	100%			
Caesarean Section							
CS rate (planned & unplanned)		49.6%	43.0%	46.3%			
Women in RG*1 having a caesarean section with no previous births: nullip spontaneous labour		22.8%	19.5%	23.6%			
Women in RG*2 having a caesarean section with no previous births: nullip induced labour, nullip pre-labour LSCS		65.8%	53.5%	61.1%			
Ratio of women in RG1 to RG2		1:4.2777777777	1:2.875	1:3.3			
Women in RG5. Multips with 1 or 2+ previous C/S		86%	80%	83%			
Women in RG1, RG2, RG5 combined contribution to the overall C/S rate.		66%	58%	59%			

Division E	Maternity Dashboard						October 25
Metric	Target	In Month Actual	Previous Month	3-month average		SPC variation - this month	12 month variation
Divert Status					H		
Divert Status - incidence	0	0	0	0.0		Normal Variation	
Total number of hours on divert		0	0	0.0		Normal Variation	
Admissions to Rosie during divert status		0	0	0.0			
Number of women giving birth in another provider organisation due to divert status		0	0	0.0			
Number of IUTs declined due to capacity/staffing in perinatal services	0	5	6	5.7			
Triage							
Women Seen for Initial Triage Within 15 Minutes of arrival	85.0%	79.0%	71.3%	76.8%		Normal Variation	
Overall: Women seen by midwife within required timeframe based on initial RAG rating	85.0%	98.8%	96.5%	97.8%		Positive special cause variation above the mean	
Overall: Women reviewed by obstetrician within required timeframe based on initial RAG rating	85.0%	81.8%	81.7%	81.0%	H	Positive special cause variation above the mean	

Maternity Dashboard

NHS Cambridge University Hospitals NHS Foundation Trust

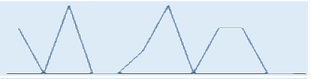
Division E **Maternity Dashboard** **October 25**

Metric	Target	In Month Actual	Previous Month	3-month average		SPC variation - this month	12 month variation
Maternal Morbidity							
Puerperal Sepsis		0.32%	0.48%	0.38%		Normal Variation	
ITU Admissions in Obstetrics		0	3	1			
Massive Obstetric Haemorrhage >= 1500 mls - vaginal birth	≤3.3%	4.82%	1.59%	3.15%		Normal Variation	
Massive Obstetric Haemorrhage >= 1500 mls - caesarean birth	≤4.5%	2.00%	1.27%	1.69%		Normal Variation	
3rd / 4th degree tear rate	≤5%	4.39%	6.00%	5.49%		Normal Variation	
3rd / 4th degree tear rate - Spontaneous vaginal birth	≤2.5%	4.49%	5.24%	3.94%			
3rd / 4th degree tear rate - Instrumental birth	≤4.5%	4.08%	10.00%	13.03%			
Maternal readmission rate		1.75%	2.41%	2.21%		Normal Variation	
Peripartum Hysterectomy		0	0	0			
Direct Maternal Death		0	0	0		Normal Variation	
Governance							
Total number of Psii	0	0	0	0.0			
Never Events	0	0	0	0.0			

Maternity Dashboard

NHS Cambridge University Hospitals NHS Foundation Trust

Division E **Maternity Dashboard** **October 25**

Metric	Target	In Month Actual	Previous Month	3-month average		SPC variation - this month	12 month variation
Neonatal Morbidity							
Still Births per 1000 Births	3.55	2.25	2.26	2.32			
Still Births - number >= 22 weeks	5	0.00	0.00	0.67		Normal Variation	
Babies born with an Apgar <7 at 5 minutes of age		3.11%	1.54%	2.07%		Normal Variation	
Incidence of neonatal readmission		#N/A	#N/A	#N/A		Normal Variation	
Term Admission to NICU Rate**	≤6%	5.37%	7.10%	5.62%		Normal Variation	
Quality							
1-1 Care in Labour	100%	100.0%	100.0%	100.0%	H	Positive special cause variation above the mean	
Babies with a first feed of breastmilk	80%	85.5%	86.6%	86.5%		Normal Variation	
SATOD (Smoking at Time of Delivery)	6%	3.8%	4.2%	4.2%	L	Positive special cause variation below the mean	
CO Monitoring at booking	95%	#N/A	93.0%	#N/A	H	Normal Variation	
CO Monitoring at 36 weeks	95%	#N/A	78.0%	#N/A	H	Normal Variation	
VTE Assessment - AN	95%	93.0%	82.6%	85.7%	H	Positive special cause variation above the mean	
VTE Assessment - PN	95%	96.7%	95.0%	96.2%		Normal Variation	

Finance

NHS
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Trust performance summary - Key indicators

Trust actual surplus / (deficit)

£1.9m	*Actual (adjusted)**
£1.9m	*Plan (adjusted)**
£1.4m	*Actual YTD (adjusted)**
(£2.3m)	*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	£25.2m	£155.6m
EPM plan	£23.6m	£153.9m
EPM 24/25 target	£18.2m	£130.8m

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

Net current assets

(£124.7)	*Actual*
(£117.6)	*Plan*

Debtor days

25	*This month*
22	*Previous month*

Payables performance (YTD) *

90.2%	*Value*
92.5%	*Quantity*

EBITDA

£37.8m	*Actual YTD*
£29.1m	*Plan YTD*

Capital expenditure

£8.0m	*Capital - actual spend in month*
£32.1m	*Capital - actual spend YTD*
£32.3m	*Capital – plan YTD*

Cash

Cash

£83.7m	*Actual*
£119.4m	*Plan*

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

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

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

Staff in Post

NHS Cambridge University Hospitals NHS Foundation Trust

12 Month Growth by Staff Group

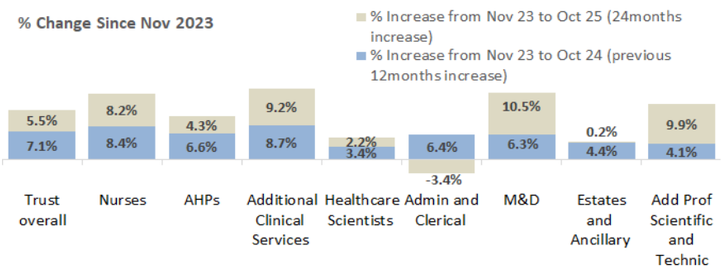
Staff Group	Headcount		Headcount 12 Month growth		FTE		FTE 12 Month growth	
	Nov-24	Oct-25			Nov-24	Oct-25		
Add Prof Scientific and Technic	259	274	5.8%		234	245	11	4.9%
Additional Clinical Services	2,263	2,273	0.4%		2,080	2,087	7	0.3%
Administrative and Clerical	2,792	2,519	-9.8%		2,573	2,320	-253	-9.8%
Allied Health Professionals	846	833	-1.5%		750	738	-12	-1.6%
Estates and Ancillary	396	379	-4.3%		380	365	-15	-4.0%
Healthcare Scientists	784	769	-1.9%		749	735	-13	-1.8%
Medical and Dental	1,888	1,976	4.7%		1,773	1,843	71	4.0%
Nursing and Midwifery Registered	4,417	4,398	-0.4%		4,088	4,058	-30	-0.7%
Total	**13,645**	**13,421**	**-1.6%**		**12,626**	**12,392**	**-235**	**-1.9%**

12 Month Growth by Division

Division	Headcount		Headcount 12 Month growth		FTE		FTE 12 Month growth	
	Nov-24	Oct-25			Nov-24	Oct-25		
Division A	2,575	2,521	-2.1%		2,426	2,374	-53	-2.2%
Division B	3,640	3,599	-1.1%		3,377	3,336	-41	-1.2%
Division C	1,943	1,941	-0.1%		1,808	1,804	-4	-0.2%
Division D	1,645	1,615	-1.8%		1,512	1,474	-38	-2.5%
Division E	1,624	1,637	0.8%		1,411	1,419	8	0.6%
Corporate	1,675	1,580	-5.7%		1,588	1,497	-91	-5.7%
Clinical & Corporate Total	**13,102**	**12,893**	**-1.6%**		**12,122**	**11,904**	**-218**	**-1.8%**
Research & Development	543	528	-2.8%		505	488	-17	-3.3%
Total	**13,645**	**13,421**	**-1.6%**		**12,626**	**12,392**	**-235**	**-1.9%**

Admin & Medical Breakdown

Staff Group	Nov-24	Oct-25	FTE 12 Month growth	
Administrative and Clerical	2,573	2,320	-253	-9.8%
of which staff within Clinical Division	1,258	1,085	-173	-13.8%
of which Band 4 and below	862	722	-140	-16.3%
of which Band 5-7	276	252	-24	-8.6%
of which Band 8A	58	58	0	0.1%
of which Band 8B	11	11	0	3.8%
of which Band 8C and above	52	42	-10	-18.7%
of which staff within Corporate Areas	1,035	974	-61	-5.9%
of which Band 4 and below	295	254	-41	-13.9%
of which Band 5-7	488	460	-27	-5.6%
of which Band 8A	98	97	-1	-0.6%
of which Band 8B	55	53	-2	-3.9%
of which Band 8C and above	100	110	10	9.9%
of which staff within R&D	280	261	-19	-6.6%
Medical and Dental	1,773	1,843	71	4.0%
of which Doctors in Training	708	732	24	3.3%
of which Career grade doctors	289	312	23	8.1%
of which Consultants	776	799	23	3.0%



What the information tells us:

Over the past year, the Trust's substantive workforce decreased by 1.9%.

The largest staff group decrease was in Administrative and Clerical roles (-9.8%), while Additional Professional Scientific and Technical roles saw the highest growth (+4.9%).

Corporate Services had the biggest divisional decrease (-5.7% / 91 FTE), whereas Division E was the only division to grow (+0.6% / 8 FTE).

The staff in post data includes individuals who are partly or fully funded to support capital projects. Corporate Services have 86 FTE coded to capital funds. 11 FTE directly under Capital Funded Projects and 75 FTE costed out to other Corporate areas.

Also included within Corporate Services are the newly established Paediatric Orthopaedic Incident Management Team, accounting for 12.7 FTE of Corporate Services.

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

Staff in Post WTE Growth

NHS Cambridge University Hospitals NHS Foundation Trust

Growth in Administrative and Clerical Staff Group

		12 month growth Apr 2019 to Apr 2025													Latest 1 mth growth			Overall growth since Apr 2019		Growth since Apr 2025	
Executive	Division/Corporate Function	Apr-19 FTE	Apr-20 FTE	Apr-21 FTE	Apr-22 FTE	Apr-23 FTE	Apr-24 FTE	Apr-25 FTE	19/20 % growth	20/21 % growth	21/22 % growth	22/23 % growth	23/24 % growth	24/25 % growth	Oct-25 FTE	Sep-Oct 25 FTE growth	Sep-Oct 25 % growth	Apr 19-Oct 25 FTE growth	Apr 19-Oct 25 % growth	Apr 25-Oct 25 FTE growth	Apr 25-Oct 25 % growth
Corporate	Chief Executive Officer	45	53	57	55	60	59	92	17.6%	8.3%	-2.8%	9.3%	-2.1%	54.7%	72	-16	-18.1%	27	60.9%	-20	-21.5%
	Chief Financial Officer	185	187	192	191	195	217	225	1.4%	2.8%	-0.6%	1.9%	11.5%	3.7%	271	0	0.0%	86	46.6%	45	20.2%
	Dir. of Innovation, Digital & Improvement	244	245	244	243	241	252	249	0.2%	-0.2%	-0.6%	-0.7%	4.5%	-1.3%	175	0	0.0%	-69	-28.3%	-74	-29.6%
	Chief Nurse	53	54	67	64	61	74	78	2.4%	24.0%	-4.9%	-4.4%	21.8%	5.5%	71	-2	-2.5%	18	34.8%	-7	-9.2%
	Chief Operating Officer	21	27	33	36	42	54	43	30.8%	21.7%	9.0%	15.4%	29.8%	-21.7%	42	-2	-4.6%	21	98.9%	-1	-2.4%
	Director of Strategy & Major Projects	8	10	14	11	22	16	18	15.2%	39.4%	-21.8%	108.8%	-27.2%	13.3%	34	16	96.1%	25	298.9%	15	84.6%
	Estates & Facilities	92	104	108	118	122	133	141	12.6%	3.8%	9.1%	3.4%	9.5%	6.0%	121	-1	-0.8%	29	31.7%	-20	-14.0%
	Medical Director	22	22	23	20	21	24	32	0.0%	5.4%	-15.7%	6.8%	12.5%	36.4%	17	-1	-5.0%	-5	-22.8%	-15	-46.9%
	Director of Workforce	117	120	131	138	154	168	154	2.8%	9.1%	5.1%	11.8%	8.8%	-7.9%	162	-2	-1.2%	45	38.7%	8	5.1%
	Capital Funded Projects	-	-	-	-	-	-	11	-	-	-	-	-	-	10	0	2.0%	*newly included*		0	-3.7%
Corporate Total		**787**	**822**	**870**	**875**	**918**	**997**	**1,043**	**4.4%**	**5.8%**	**0.6%**	**4.9%**	**8.7%**	**4.6%**	**975**	**-7**	**-0.7%**	**188**	**23.9%**	**-68**	**-6.5%**
Clinical	Division A	126	135	144	156	167	168	186	7.1%	6.0%	9.0%	6.8%	0.5%	11.0%	155	-7	-4.4%	28	22.4%	-32	-16.9%
	Division B	425	425	458	462	462	520	520	0.0%	7.8%	0.7%	0.1%	12.4%	0.0%	466	-7	-1.6%	41	9.7%	-53	-10.2%
	Division C	114	114	114	110	116	121	122	0.1%	-0.1%	-4.0%	5.8%	4.9%	0.0%	108	-1	-0.9%	-6	-5.4%	-13	-11.1%
	Division D	214	216	218	221	225	241	245	0.9%	1.0%	1.2%	2.0%	7.2%	1.5%	216	-2	-0.8%	2	1.1%	-29	-11.7%
	Division E	133	128	134	142	153	154	166	-3.1%	4.1%	5.9%	8.0%	0.4%	8.4%	140	-8	-5.1%	7	5.3%	-27	-16.1%
Clinical Total		**1,012**	**1,019**	**1,068**	**1,090**	**1,123**	**1,204**	**1,239**	**0.7%**	**4.8%**	**2.1%**	**3.0%**	**7.2%**	**2.9%**	**1,085**	**-25**	**-2.2%**	**73**	**7.2%**	**-154**	**-12.4%**
R and D	NIHR R & D Operational	167	189	199	207	223	229	231	13.1%	5.3%	3.9%	8.0%	2.6%	1.1%	212	-4	-2.0%	46	27.3%	-19	-8.2%
	Research Grants Directorate	16	22	23	25	29	44	50	38.2%	5.9%	7.7%	15.1%	52.4%	13.6%	48	0	-0.8%	32	199.6%	-2	-4.5%
R and D Total		**183**	**211**	**222**	**232**	**252**	**273**	**282**	**15.3%**	**5.4%**	**4.3%**	**8.8%**	**8.4%**	**3.1%**	**260**	**-5**	**-1.8%**	**77**	**42.3%**	**-21**	**-7.6%**
Grand Total		**1,982**	**2,052**	**2,160**	**2,197**	**2,293**	**2,474**	**2,563**	**3.5%**	**5.2%**	**1.7%**	**4.4%**	**7.9%**	**3.6%**	**2,320**	**-36**	**-1.5%**	**338**	**17.1%**	**-243**	**-9.5%**

What the information tells us:

From April 2019 to October 2025 the Administrative and Clerical workforce has grown by 17.1% (338 FTE). The financial year with the highest growth was 2023/24, where staffing increased by 7.9%.
Division A has had the largest Administrative and Clerical growth of the clinical divisions since April 2019 - increasing by 22.4% (28 FTE). Within corporate areas those with high percentage growth since April 2019 include Offices of the Chief Operating Officer, Director of Strategy and Major Projects and Chief Executive Officer.
In the past month, the Administrative and Clerical workforce has reduced by 1.5% (36 FTE). Changes to reporting lines and hierarchy in October 2025 have resulted in an increase in staff under Director of Strategy and Major Projects. Since April this year, the Administrative and Clerical workforce has reduced by 9.5% (243 FTE).

From April 2025, capital-funded cost centre staff, previously excluded, are included in Corporate data (adding 11 FTE)

Plan versus actual - Staff in Post WTE

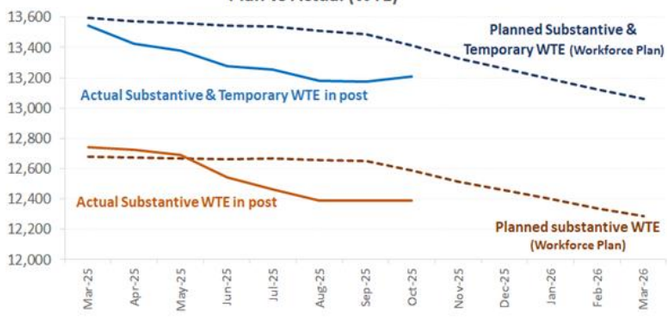
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As at M06 - Workforce Plan vs Actual Staff in post WTE

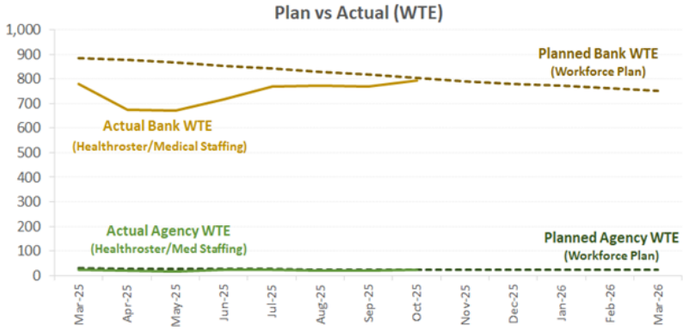
	PLAN	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Movement Mar 25-Oct 25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Planned movement Mar 25-Mar 26
Workforce Plan - planned WTE	Substantive	12,682	12,672	12,670	12,662	12,668	12,655	12,650	12,588	-95	12,515	12,459	12,399	12,341	12,286	-396
	Bank	885	876	866	854	843	830	817	803	-82	790	780	772	763	753	-132
	Agency	29	28	28	27	27	23	23	24	-5	23	23	23	23	23	-6
	All Staff	13,596	13,576	13,563	13,543	13,538	13,508	13,490	13,414	-182	13,327	13,262	13,194	13,126	13,062	-535

	ACTUAL	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Movement Mar 25-Oct 25
Actual WTE in post (ESR/Healthroster/ Medical Staffing)	Substantive	12,744	12,728	12,692	12,542	12,463	12,391	12,387	12,392	-352
	Bank	778	676	672	715	769	772	769	793	15
	Agency	23	20	17	22.5	23.6	19.5	21.4	25.1	3
	All Staff	13,545	13,424	13,382	13,280	13,255	13,182	13,177	13,210	-335

Trust Overall Substantive & Temporary Staff in Post Plan vs Actual (WTE)



Trust Overall Bank & Agency Staff Plan vs Actual (WTE)



Additional posts agreed since budget setting:

Note: An additional 105 WTE has been agreed in year. These are not included in the charts or table above, but the summary of positions is included in the table below:

Division	Apprentice	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 9	Senior Mgr	M&D Consultant	M&D Non-Consultant	Grand Total
Corporate			13.0		14.0	4.0	6.5	1.0	4.0	1.0	1.0	2.7	1.0	48.2
Division A													2.0	2.0
Division B	5.0	9.0			5.0	1.0	3.0	1.0	1.0			7.0		32.0
Division C		0.8		1.6			1.0						10.0	13.5
Division D						0.9						5.8		6.7
Division E			1.0									0.8	1.2	3.0
Grand Total	5.0	9.8	14.0	1.6	19.0	5.9	10.5	2.0	5.0	1.0	1.0	16.3	14.2	105.3

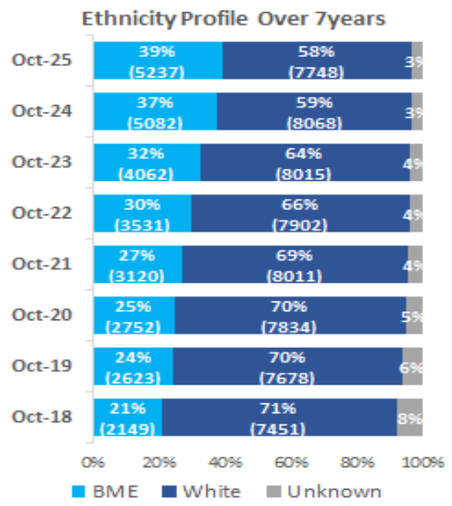
What the information tells us:

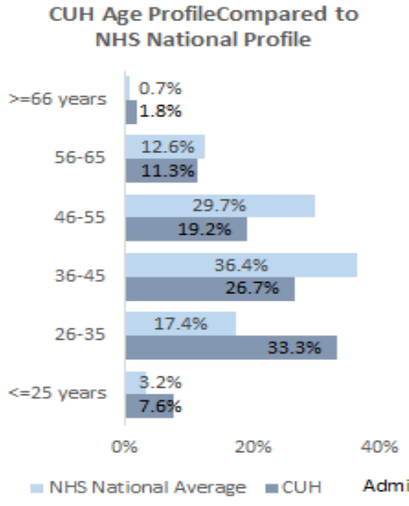
Overall WTE is 204 WTE under plan in the seventh month of the financial year, with faster than planned reductions in substantive and temporary staffing (335 WTE reduction from March 2025). Substantive staff starting point for March 2025 was higher than anticipated, however the decrease of 352 WTE from March to October 2025 (2.8% decrease), is greater than the 0.7% planned decrease for the same period. Substantive staff in post increased by 0.04% from last month (+5 WTE). Bank staff usage increased by 3.2% from last month (+24 WTE), and agency usage increased by 17% (4 WTE).

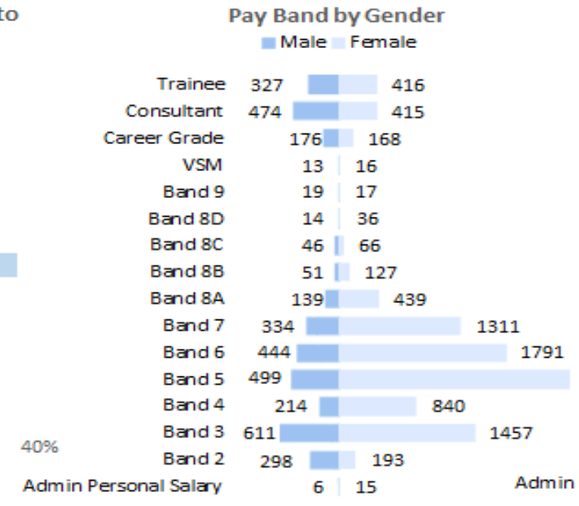
Author(s): Chloe Schafer, Amanda Wood **Owner(s): David Wherrett**

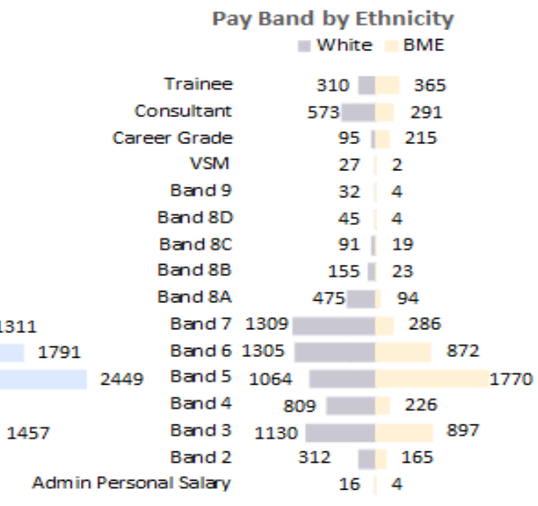
Equality Diversity and Inclusion (EDI)

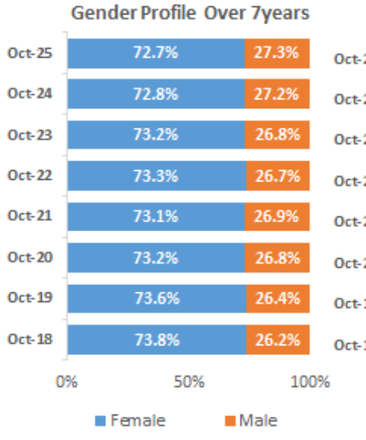
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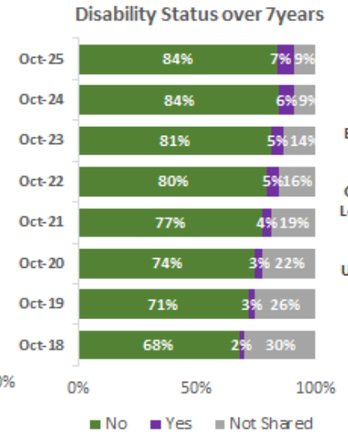


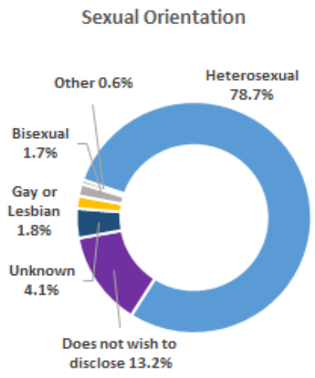












What the information tells us:

CUH has a younger workforce compared to NHS national average. The majority of our staff are aged 26-45 which accounts for 60% of our total workforce.

The percentage of BME workforce increased significantly by 18% over the 7 year period and currently make up 39% of the CUH substantive workforce.

The percentage of male staff increased by 1.1% to 27.3% over the past seven years.

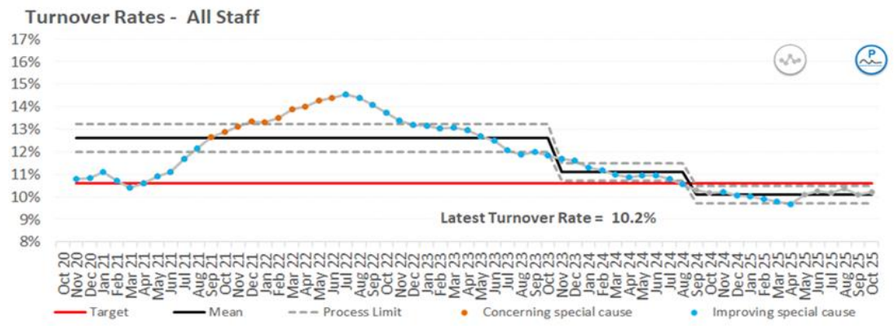
The percentage of staff recording a disability increased by 4.6% to 6.8% over the seven year period.

However, there are still significant gaps between the data recorded about our staff on ESR compared with the information staff share about themselves when completing the National Staff Survey.

There remains a high proportion of staff who have, for a variety of reasons, not shared their sexual orientation.

Staff Turnover

Cambridge University Hospitals NHS Foundation Trust

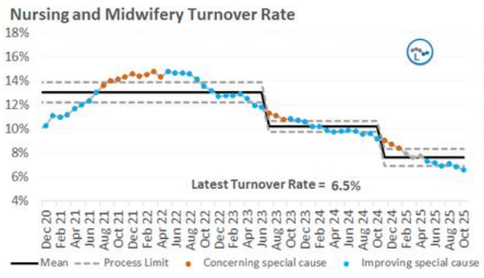


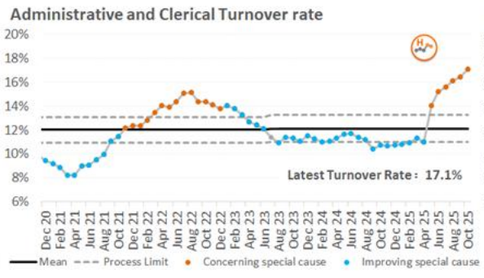
Background Information: Turnover describes the rate that employees leave an establishment. Staff turnover is calculated by the number of leavers from the Trust over the previous twelve months as a percentage of the total number of employed staff at a given time. (Excludes all fixed term contracts including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

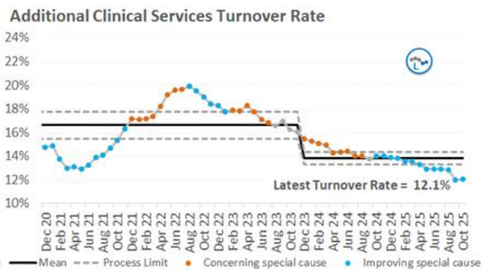
What the information tells us:

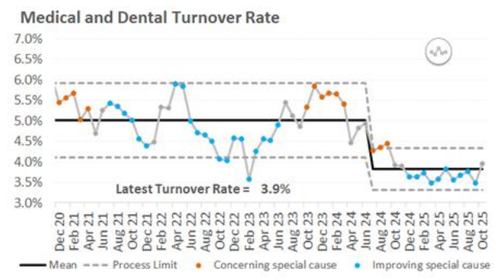
Turnover increased by 0.1% from last month to 10.2%, remaining below the Trust target (10.6%) and the same rate as October last year.

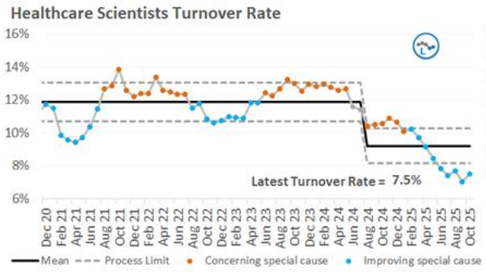
Administrative and Clerical staff had the highest turnover at 17.1%, up 0.7% from last month and 6.4% from the same period last year. In contrast, Medical and Dental had the lowest rate at 3.9%, followed by Nursing and Midwifery at 6.5%.

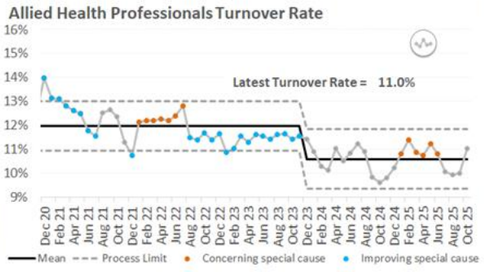


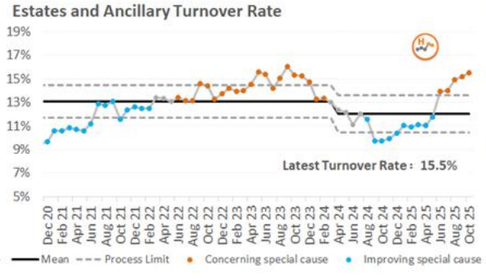


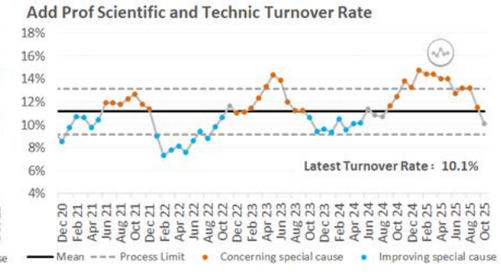








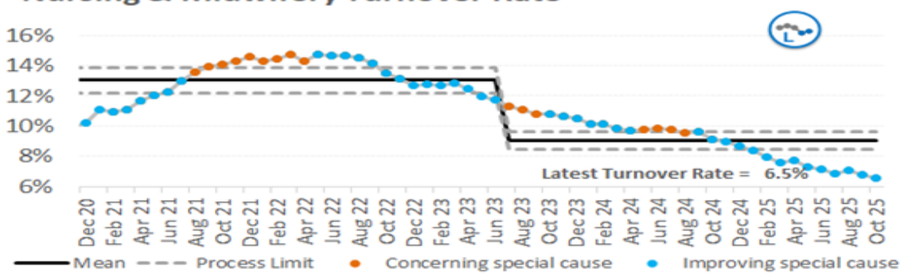




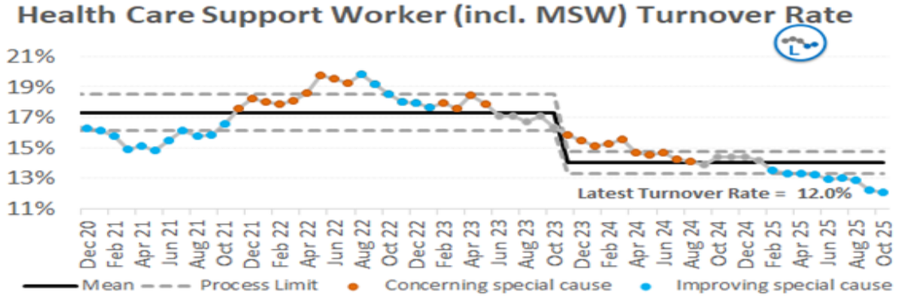
Turnover for Nursing & Midwifery Staff Group (Registered & Non-Registered)

NHS Cambridge University Hospitals NHS Foundation Trust

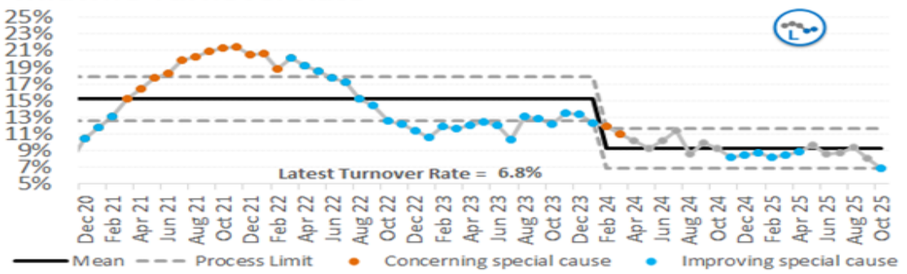
Nursing & Midwifery Turnover Rate



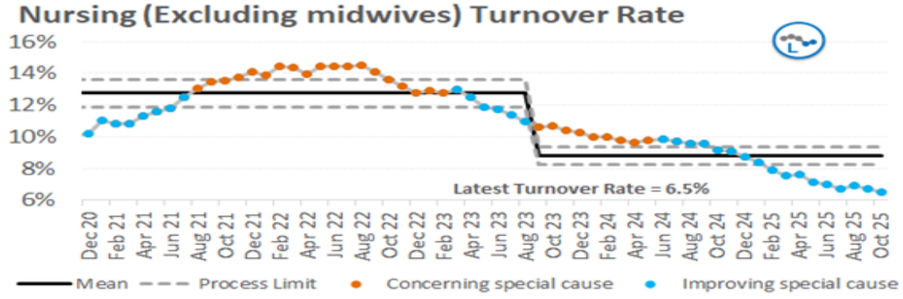
Health Care Support Worker (incl. MSW) Turnover Rate



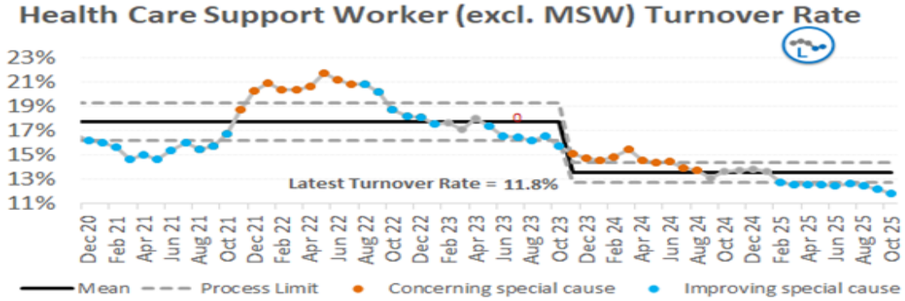
Midwife Turnover Rate



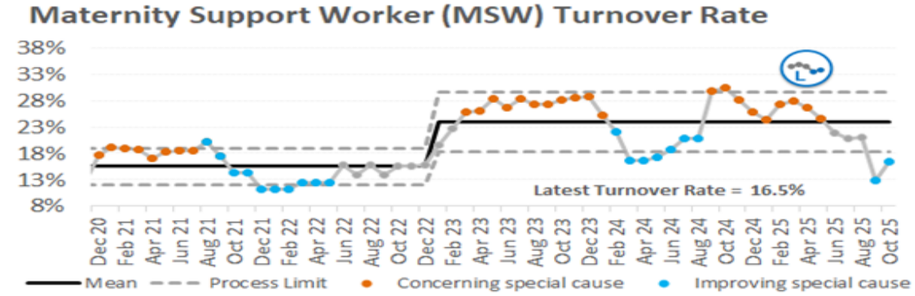
Nursing (Excluding midwives) Turnover Rate



Health Care Support Worker (excl. MSW) Turnover Rate

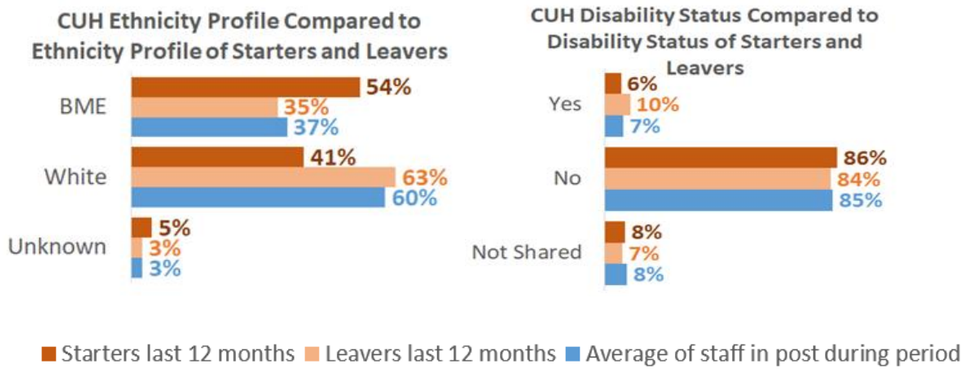


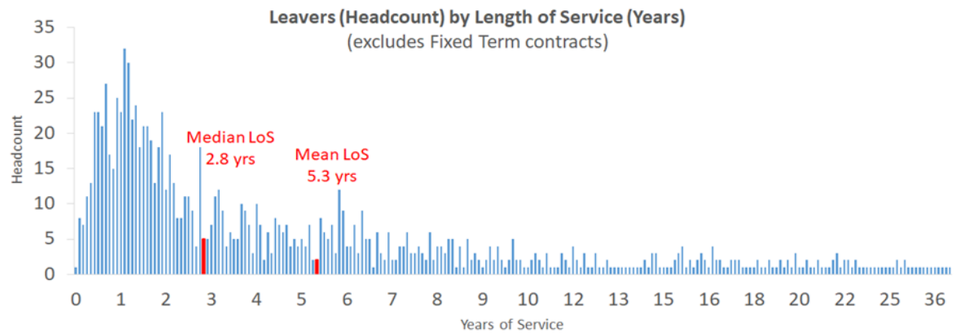
Maternity Support Worker (MSW) Turnover Rate

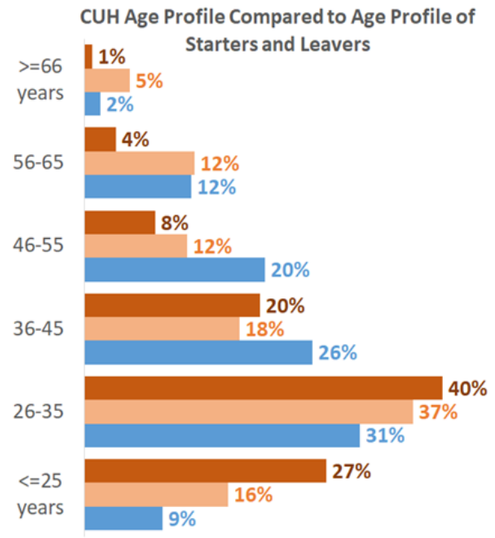


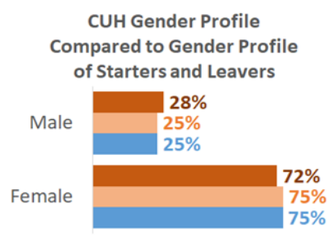
Starters & Leavers - last 12 months

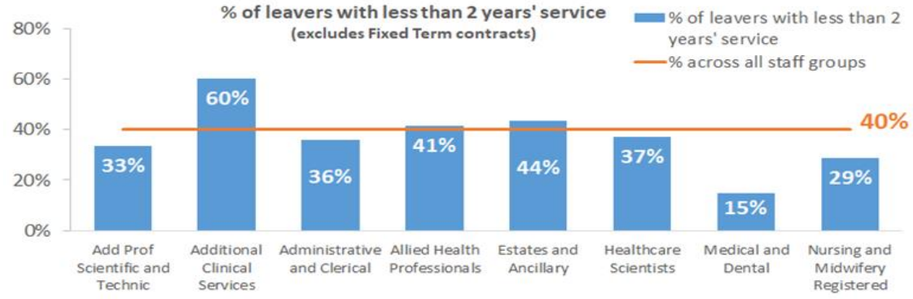
Cambridge University Hospitals NHS Foundation Trust











What the information tells us:

In the month of October there were a total of 107 WTE leavers from the Trust, and 159 WTE starters to the Trust (includes fixed term & permanent staff).

The majority of starters to, and leavers from the Trust in the last 12 months were aged 35 yrs. or under (68% and 53% respectively), which is higher than the proportion of staff in post of this age (40%). Gender and disability status are generally equally represented in the starters and leavers data when compared to the Trust profile, however there is a slightly higher proportion of males and people with no disability starting at the Trust. 10% of leavers from the Trust in the last 12 months had a disability, compared to 7% of the staff profile. 54% of our starters in the last 12 months were from black and minority ethnic groups, compared to 37% of the staff profile.

A significant proportion of leavers leave the Trust within 2 years of starting (40%), and within Additional Clinical Services staff group there is a much greater proportion than average (60%). The average (mean) length of service of all leavers is 5.3 years, with a median of 2.8 years.

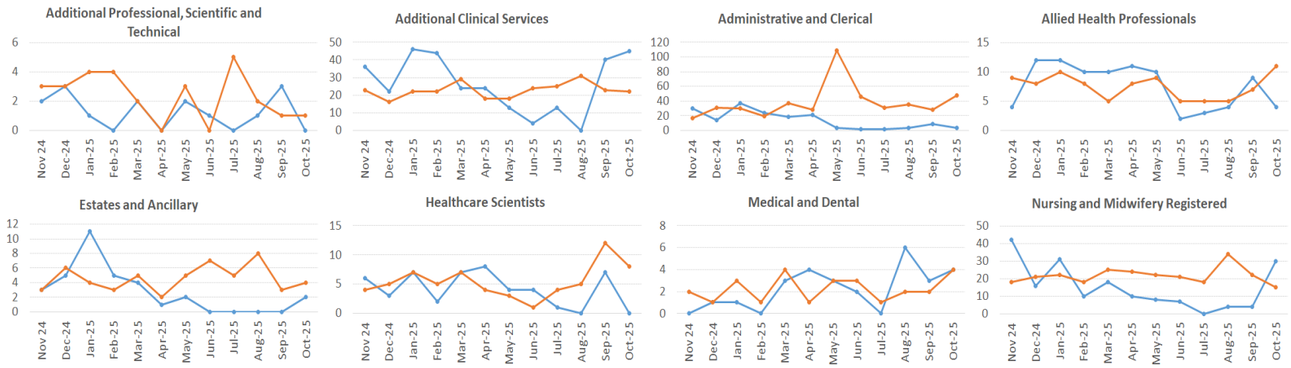
Excludes Fixed Term and Locum Medical and Dental staff, and staff leaving and returning to CUH (as bank only/retire and return etc.)

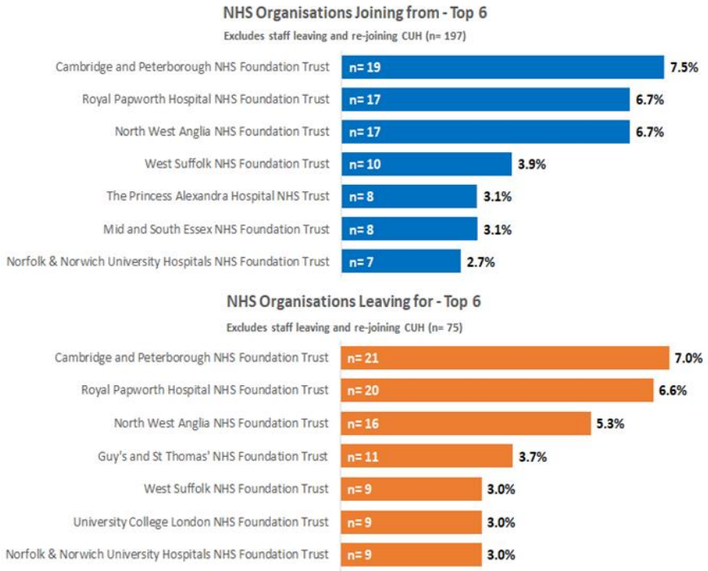
Author(s): Chloe Schafer, Amanda Wood

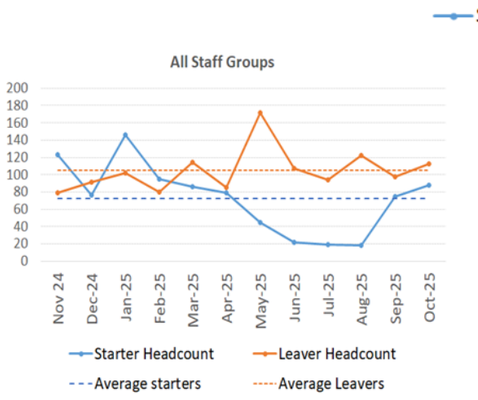
Owner(s): David Wherrett

Starters & Leavers - Last 12 months

Cambridge University Hospitals NHS Foundation Trust







Top 10 Leaving Reasons Excludes staff leaving and re-joining CUH (n= 75)	Number of Leavers (Headcount)	% of all Leavers
Voluntary Resignation - Relocation	270	21%
Voluntary Resignation - Work Life Balance	195	16%
Mutually Agreed Resignation - Local Scheme with Repayment	133	11%
Voluntary Resignation - Promotion	96	8%
Voluntary Resignation - Pay and Reward Related	79	6%
Retirement Age	70	6%
Voluntary Resignation - To undertake further education or training	59	5%
End of Fixed Term Contract	57	5%
Voluntary Resignation - Health	46	4%
Redundancy - Compulsory	44	4%

What the information tells us:

The top three reasons for leaving are Voluntary Resignation - due to relocation (21%), for work/life balance (16%) and through the Mutually Agreed Resignation scheme (11%).

The top destination on leaving over the last 12 months is to 'No Employment' (44% of leavers). The most popular external NHS organisation to join from and leave to was Cambridgeshire & Peterborough NHS Foundation Trust.

In the month of October 2025 alone the most popular destinations on leaving were to 'No Employment' (50% of leavers) and to another 'NHS Organisation' (21% of leavers).

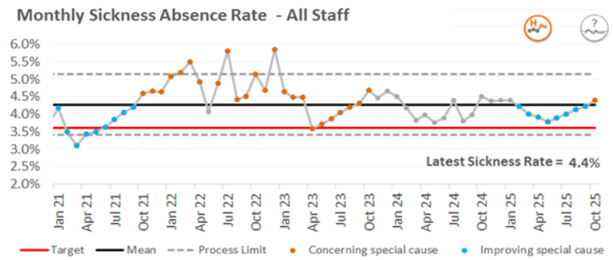
Excludes Fixed Term and Locum Medical and Dental staff, and staff leaving and returning to CUH (as bank only/retire and return etc.)

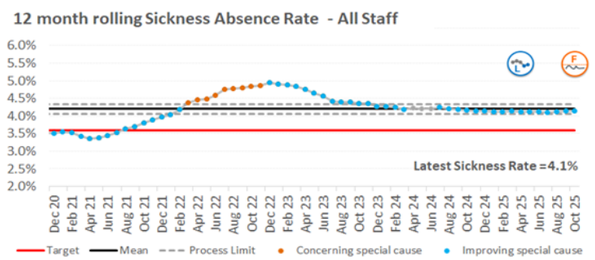
Author(s): Chloe Schafer, Amanda Wood **Owner(s): David Wherrett**

Sickness Absence

Cambridge University Hospitals NHS Foundation Trust

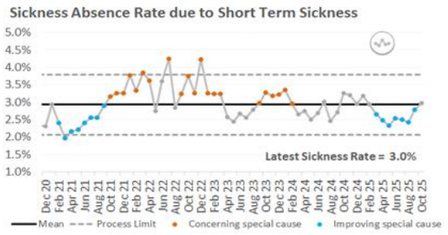
Background Information: Sickness Absence is a monthly or annual metric and is calculated as the percentage of FTE days missed in the organisation due to sickness during the reporting month/year. The 12-month rolling average sickness absence rate is now reported nationally across all NHS organisations. Unlike monthly figures, which can fluctuate due to seasonal or short-term factors, the rolling average smooths out volatility and highlights longer-term trends. This makes it more effective for identifying sustained changes in sickness absence patterns and supporting strategic workforce planning.

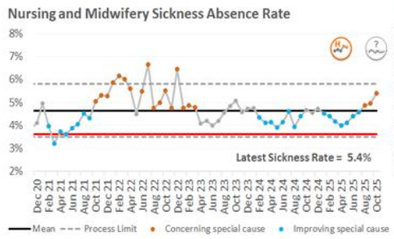


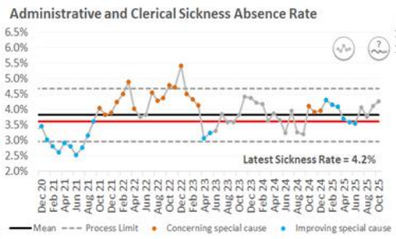


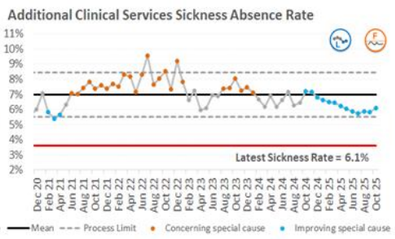
What the information tells us:
Overall monthly sickness absence has increased by 0.2% from last month, to 4.4% in October 2025. This is 0.1% lower than in October last year. The sickness absence rate due to short term illness is 3%, with the long-term sickness rate at 1.5%. The Additional Clinical Services staff group had the highest sickness absence rate in October at 6.1%, followed by Estates and Ancillary and Nursing and Midwifery at 5.4%.

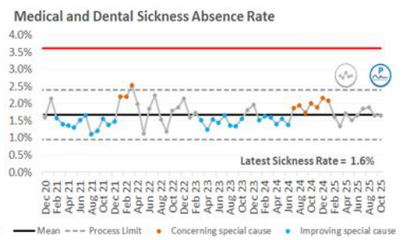
Monthly rates:

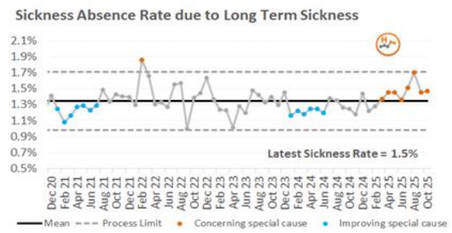


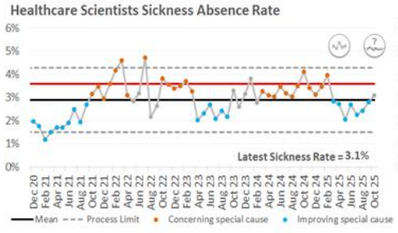


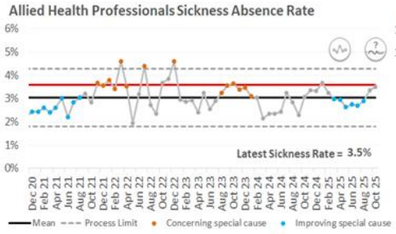


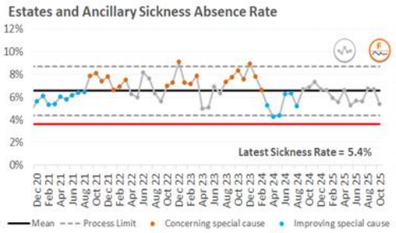


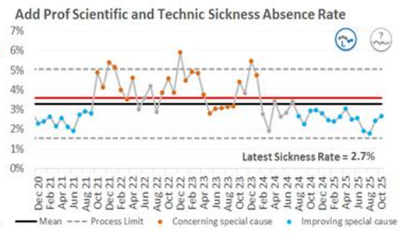






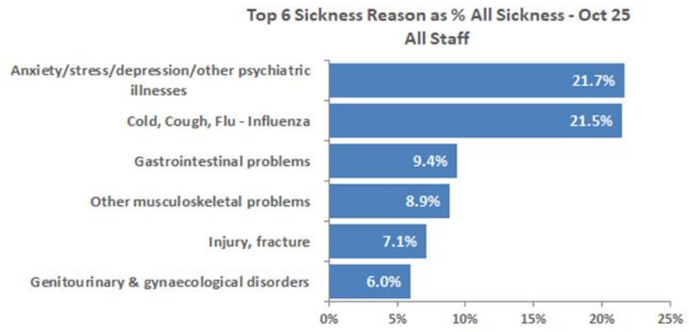






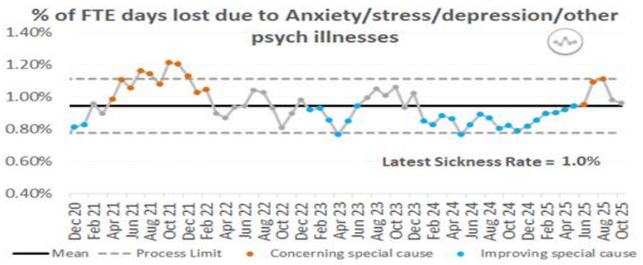
Top Six Sickness Absence Reason

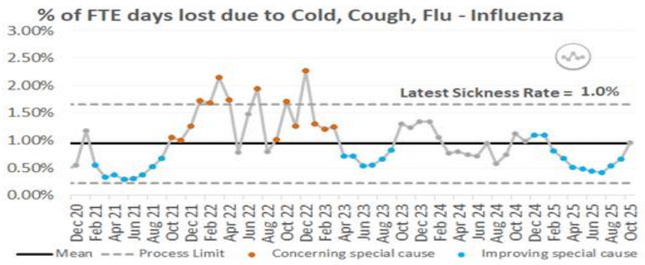
NHS Cambridge University Hospitals NHS Foundation Trust

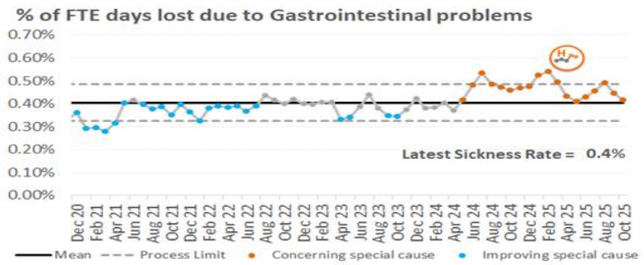


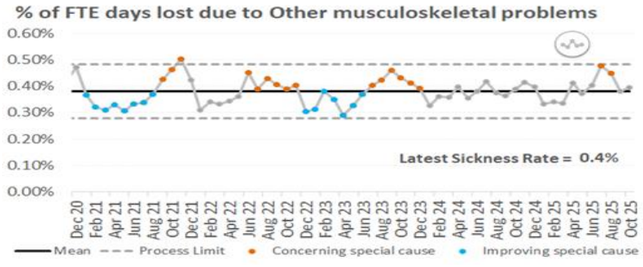
Background Information: Sickness Absence reason is provided as a percentage of all FTE days missed due to sickness during the reporting month.

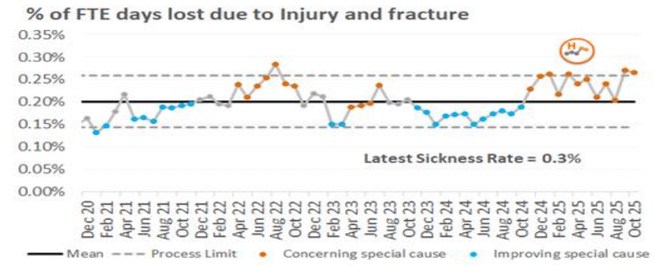
What the information tells us: The top reason for sickness absence in October 2025 was Anxiety/stress/depression/other psychiatric illnesses, with an absence rate of 1%. This is the same rate as last month and 0.1% higher than October last year.
As a percentage of all sickness absence Anxiety/stress/depression/other psychiatric illnesses accounts for 21.7% of the overall figure.

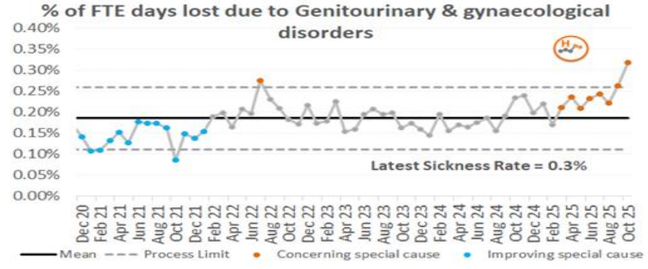






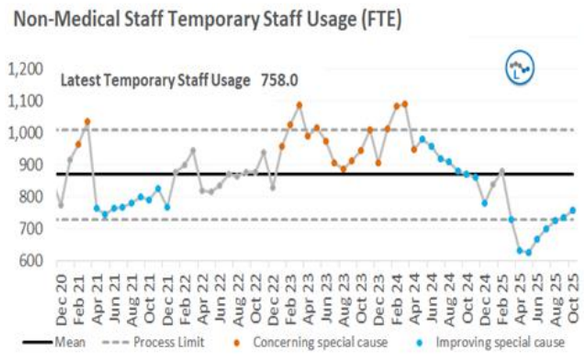


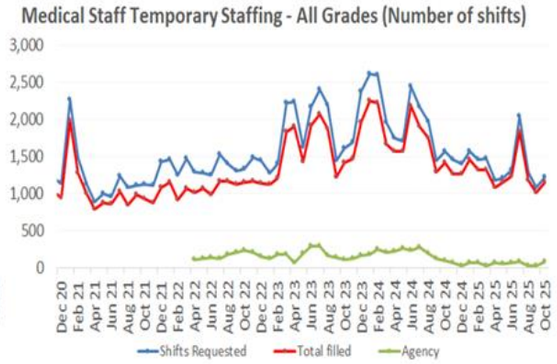




Temporary Staffing

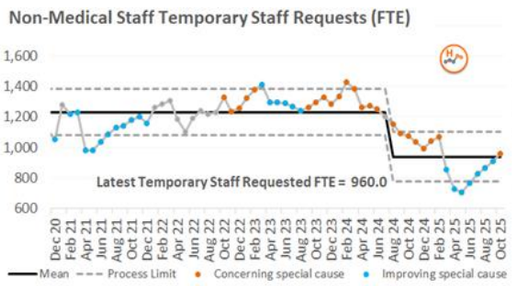
Cambridge University Hospitals NHS Foundation Trust

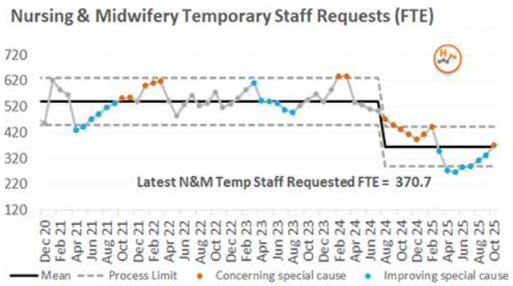


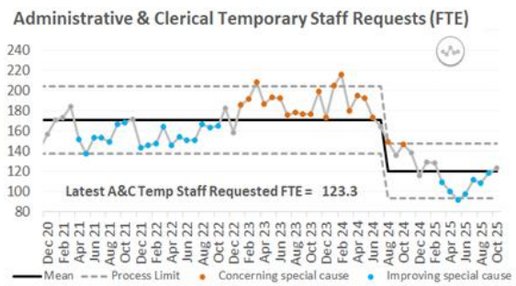


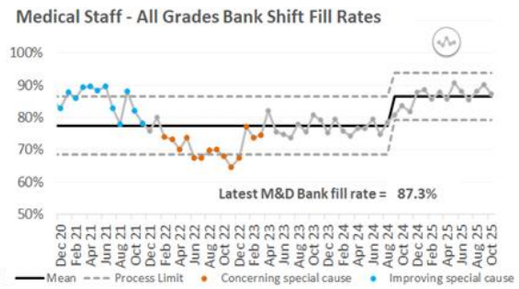
Background Information: The Trust works to ensure that temporary vacancies are filled with workers from staff bank in order to minimise agency usage, ensure value for money and to ensure the expertise and consistency of staffing

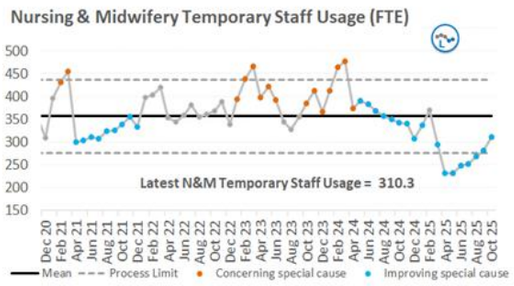
What the information tells us: Non-medical temporary staffing demand increased by 5% (43 WTE) from last month, with fill rates decreasing by 2% to 79%. Nursing and midwifery agency usage increased by 2.2 WTE from last month to 4 WTE in October. This accounts for 1.3% of the total nursing filled shifts.
Top three reasons for request are vacancy (37%), sickness requiring cover (24%) and increased workload (18%).
Medical demand increased by 13% from September to October, with a fill rate of 95% (7.4% agency, 87.3% bank).

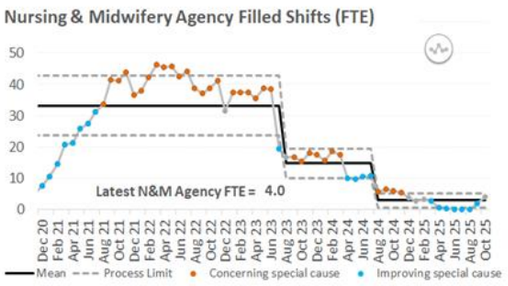


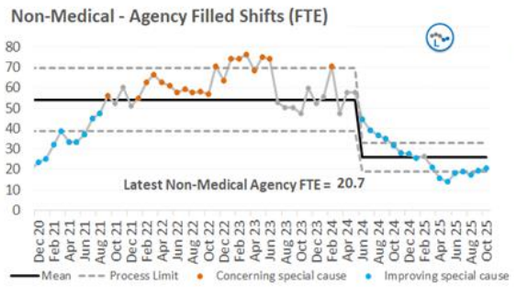


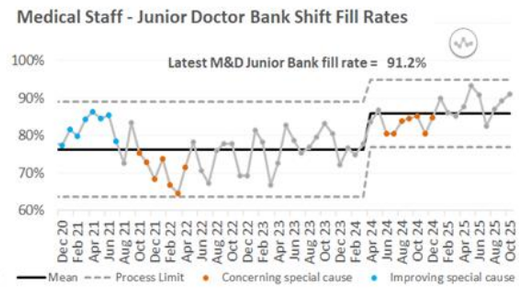




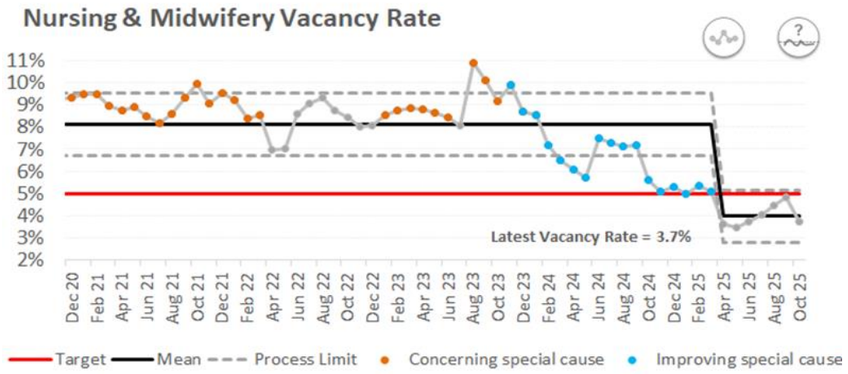


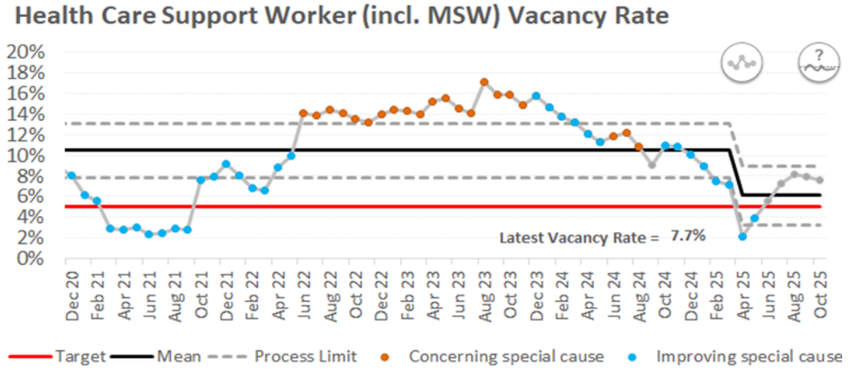






ESR Vacancy Rate





Background Information: Vacancy rate provides vacancy information based on established posts within an organisation. The figures below relate to ESR data for clinical areas only and includes pay bands 2-4 for Health Care Support Workers and 5-7 for Nurses and Midwives.

What the information tells us:
Updated 2025/26 budgeted WTE data was loaded to ESR for Nursing and Midwifery and Health Care Support Workers in Clinical Divisions from April 2025. This is reconciled on a monthly basis to the budgets in the general ledger held by Finance.
Decreases in establishments from April 2025 have resulted in lower vacancy rates and the process limits on the charts have been reset.
In October the vacancy rate for Nursing and Midwifery decreased by 1.1% to 3.7%, remaining under the Trust 5% target. The vacancy rate for Health Care Support Workers decreased by 0.3% to 7.7% in October, remaining above the 5% target rate.

Mandatory Training by Division & Staff Group

NHS Cambridge University Hospitals NHS Foundation Trust

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

Thresholds for **Induction** & Information Governance incl. GDPR & Cyber Security training: Less than 80% / 80% to 94% / 95% or higher Thresholds for **Core Mandatory** training excl. Information Governance incl. GDPR & Cyber Security training: Less than 75% / 75% to 89% / 90% or higher		No. Staff Requiring Competency	Frequency	Delivery Method	Variance from last month (percentage point)	Trust Total	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental: Consultant	Medical and Dental: Non-Consultant	Nursing and Midwifery Registered
Ind'tn	Corporate Induction	776	one-off	f2f	0.1%	(21)96.5%	(0)100.0%	(7)96.4%	(6)95.4%	(0)100.0%	(1)95.7%	(0)100.0%	(7)77.4%	(37)73.6%	(7)95.0%
	Local Induction	776	one-off	f2f	0.8%	(144)81.4%	(0)100.0%	(34)82.4%	(22)83.2%	(6)89.5%	(7)69.6%	(2)95.5%	(12)61.3%	(39)72.1%	(22)84.2%
Other Core Mandatory	Conflict Resolution	12,429	3 yrs	el	-0.3%	(323)97.4%	(3)98.8%	(27)98.7%	(35)98.5%	(12)98.5%	(7)98.1%	(12)98.4%	(43)94.9%	(116)86.6%	(68)98.3%
	Equality, Diversity and Human Rights	12,429	3 yrs	el	-0.2%	(346)97.2%	(4)98.5%	(34)98.4%	(41)98.3%	(10)98.7%	(9)97.6%	(13)98.2%	(45)94.7%	(126)85.5%	(64)98.4%
	Health, Safety and Welfare	12,429	3 yrs	el	-0.3%	(376)97.0%	(4)98.5%	(40)98.1%	(44)98.2%	(13)98.3%	(9)97.6%	(14)98.1%	(39)95.4%	(141)83.7%	(72)98.2%
	Information Governance including GDPR and Cyber Security	12,429	1 yr	el	-0.8%	(984)92.1%	(6)97.7%	(144)93.1%	(125)94.8%	(31)96.0%	(23)93.8%	(39)94.7%	(88)89.5%	(249)71.3%	(279)93.2%
	Basic Prevent Awareness	10,417	3 yrs	el	-0.6%	(418)96.0%	(6)97.6%	(61)96.8%	(47)98.0%	(19)97.3%	(10)97.3%	(13)98.2%	(46)92.5%	(115)81.2%	(101)96.4%
	Prevent Level Three (WRAP)	2,012	3 yrs	el	-1.8%	(159)92.1%	(0)100.0%	(7)95.0%	(0)100.0%	(2)96.8%		(1)94.1%	(14)93.8%	(68)73.4%	(67)94.8%
Resuscitation	Adult Basic Life Support Practical - 1 Year	409	1 yr	f2f	0.4%	(57)86.1%	(1)50.0%	(14)85.3%		(0)100.0%					(42)86.4%
	Adult Basic Life Support Practical - 2 Year	7,991	4 yrs	f2f	-1.4%	(859)89.3%	(3)92.9%	(196)87.1%	(11)71.1%	(49)93.6%	(0)100.0%	(7)94.7%	(92)89.1%	(268)69.1%	(233)93.8%
	Advanced Life Support	28	4 yrs	f2f	-0.2%	(1)96.4%				(0)100.0%				(0)100.0%	(1)96.2%
	Advanced Paediatric Life Support	87	2 yrs	f2f	1.5%	(29)66.7%									(29)66.7%
	Basic Life Support e-learning	8,399	1 yr	el	-1.1%	(889)89.4%	(2)95.5%	(138)91.5%	(9)76.3%	(33)95.7%	(0)100.0%	(9)93.1%	(97)88.5%	(312)64.0%	(289)92.9%
	Immediate Life Support (ILS)	926	1 yr	f2f	-0.6%	(280)69.8%		(2)50.0%		(15)48.3%		(3)89.3%		(1)0.0%	(259)70.0%
	Newborn Basic Life Support (NBLS)	567	1 yr	Blended	2.4%	(71)87.5%		(8)89.5%	(0)100.0%	(0)100.0%			(2)88.9%	(5)75.0%	(56)87.6%
	Paediatric Basic Life Support (PBLS)	2,767	1 yr	Blended	-1.6%	(321)88.4%	(0)100.0%	(75)88.0%	(0)100.0%	(58)92.5%		(5)94.5%	(22)83.1%	(46)63.2%	(115)88.6%
	Paediatric Immediate Life Support (PILS)	356	1 yr	f2f	0.1%	(66)81.5%									(66)81.5%
Fire	Fire Evacuation	6,473	1 yr	f2f/el	-0.5%	(744)88.5%	(3)81.3%	(207)87.0%	(2)93.8%	(50)91.7%	(19)78.9%	(2)96.6%			(461)88.7%
	Fire Safety Awareness	12,429	2 yrs	el	-0.7%	(608)95.1%	(9)96.5%	(84)95.9%	(70)97.1%	(16)97.9%	(9)97.6%	(16)97.8%	(65)92.3%	(175)79.8%	(164)96.0%
Infect Ctrl	Infection Prevention and Control - Level 1 - 2 Years	6,148	2 yrs	el	-1.0%	(304)95.1%	(4)95.7%	(33)96.1%	(78)96.7%	(4)98.1%	(10)97.2%	(14)97.8%	(6)91.9%	(129)79.1%	(26)97.3%
	Infection Prevention and Control - Level 2 - 2 Years	6,281	2 yrs	el	-0.5%	(333)94.7%	(3)98.2%	(52)95.7%	(1)98.6%	(17)97.0%	(0)100.0%	(2)97.7%	(63)91.8%	(51)79.5%	(144)95.4%
Moving & Handling	Moving and Handling - Level 1	12,429	2 yrs	el	0.6%	(517)95.8%	(4)98.5%	(60)97.1%	(44)98.2%	(18)97.7%	(2)99.5%	(9)98.8%	(52)93.8%	(185)78.7%	(143)96.5%
	Moving and Handling - Level 2	6,485	2 yrs	f2f	0.3%	(779)88.0%	(0)100.0%	(221)86.1%	(4)71.4%	(60)91.1%	(0)100.0%	(9)91.5%			(485)88.1%
	Patient Moving and Handling - e-learning	6,487	1 yr	el	-0.2%	(427)93.4%	(0)100.0%	(123)92.3%	(3)78.6%	(28)95.9%	(0)100.0%	(7)93.4%			(266)93.5%
Safeg'dg Adults	Safeguarding Adults - Level 1	8,271	3 yrs	el	-1.3%	(359)95.7%	(6)97.6%	(49)97.6%	(46)98.1%	(12)91.0%	(11)97.0%	(21)97.1%	(6)91.8%	(143)27.8%	(65)96.8%
	Safeguarding Adults - Level 2	4,629	3 yrs	el	-1.5%	(317)93.2%	(4)98.0%	(63)96.3%	(9)93.7%	(16)88.1%	(0)100.0%	(4)97.1%	(6)91.8%	(140)30.0%	(75)96.3%
	Safeguarding Adults - Level 3	4,327	3 yrs	el	-1.9%	(510)88.2%	(0)100.0%	(1)88.9%	(1)0.0%	(23)96.4%		(0)100.0%	(39)95.0%	(264)68.1%	(182)91.2%
Safeg'dg Children	Safeguarding Children - Level 1	12,429	3 yrs	el	-0.7%	(493)96.0%	(6)97.7%	(52)97.5%	(43)98.2%	(18)97.7%	(10)97.3%	(22)97.0%	(48)94.3%	(161)81.4%	(133)96.8%
	Safeguarding Children - Level 2	8,764	3 yrs	el	-0.9%	(530)94.0%	(5)97.6%	(63)96.3%	(8)94.1%	(24)96.8%	(0)100.0%	(3)97.9%	(58)93.1%	(183)78.9%	(186)95.5%
	Safeguarding Children - Level 3	1,569	3 yrs	f2f/el	-0.4%	(157)90.0%	(0)100.0%	(3)96.0%	(1)90.9%	(12)84.6%		(1)94.4%	(17)92.1%	(46)71.8%	(77)92.3%
	Safeguarding Children - Level 3 - 1 Year	380	1 yr	f2f/el	1.2%	(63)83.4%		(5)91.5%		(0)100.0%			(3)76.9%	(14)41.7%	(41)85.4%
Overall Compliance					-0.6%	93.7%	97.7%	94.7%	97.5%	95.9%	96.8%	97.3%	92.5%	75.4%	94.2%

Education - Student Capacity

Cambridge University Hospitals NHS Foundation Trust

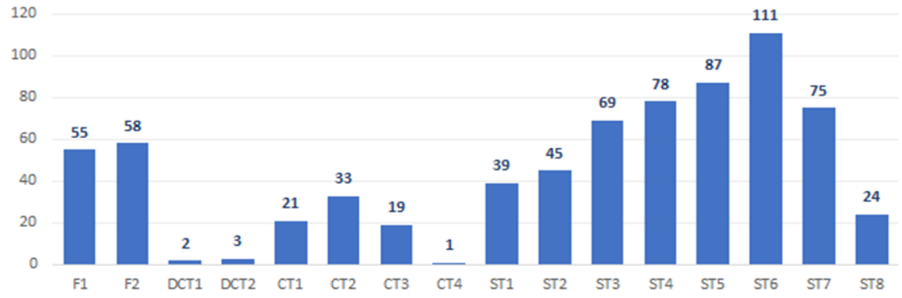
CUH Workforce Commitment: Ambition - Education, Learning and Development Strategy Themes - Student Placements & our work with school & college students

CUH is a teaching hospital for: • Medical students from the University of Cambridge • Undergraduate students and apprentices in areas including Nursing, Midwifery, Science and Allied Health Professions, from a number of partner Higher Education providers.
CUH is also committed to working with schools and colleges to help their students consider future career choices and access to career insight and work experience; this supports a focus on a future sustainable workforce supply and as part of CUH's corporate social responsibility to our local community.

Our role as a teaching hospital

Staff Group	Type	Capacity
Medical	Undergraduate	454
	Postgraduate	720 resident doctors*
		320 LED**
Medical Total		**1,494**
Nursing & Midwifery	Nursing - Adult	293
	Nursing - Children	70
	Midwifery	78
Nursing & Midwifery Total		**441**
Allied Health Professionals	Diagnostic radiography	95
	Therapeutic radiography	13
	Dietician	13
	Music therapy	2
	Occupational therapy	38
	ODP	8
	Physiotherapy	108
	Speech and Language	32
Allied Health Professionals Total		**309**
Scientific & Technical		**65**
Grand Total		**2,309**

Postgraduate Medical Trainees by Grade



***** Resident doctors are qualified doctors in clinical training. They are non-consultant grades and may be anywhere between FY1 and ST8 in terms of post-graduate training. CUH currently has 720 resident doctors in nationally recognised training posts, across 61 separate training programmes.
****** Locally Employed Doctors (LEDs) are often more junior doctors on fixed-term contracts who are "training" but not in a formally recognised training post. Many of these are International Medical Graduates (IMGs).

Summary of School/College Insight, Work Shadowing, Work Experience and Outreach work September 2025

T-Levels/Insight programmes: 11 T-level students and 1 taking part in the Healthcare Science Insight Programme
Work Experience/Shadowing: 85 students engaged in a range of placements in specialist areas across the Trust
The team also provided career guidance at 9 schools and colleges

Education - Apprentices, CPD & Leadership Development

NHS Cambridge University Hospitals NHS Foundation Trust

CUH Workforce Commitment: Ambition: Education, Learning & Development Strategy theme - Continuous Development

Current apprenticeships in place

Programme		Number of places
	Career Progression Apprenticeships	**365**
of which are:		
Nursing	Registered Nursing Degree Apprenticeships	139
	Nursing Associate Pathway	95
	MSc Advanced Clinical Practice	0
	Support Worker L3	1
	Nursing Total	**235**
Allied Health Professionals	Diagnostic radiography	4
	Therapeutic radiography	6
	Dietician	3
	Mammography	3
	Occupational therapy	7
	ODP	27
	Physiotherapy	12
	Speech and language	2
	AHP Total	**64**
Pharmacy	**Pharmacy Total**	**11**
Scientific & Technical	Levels 2-4	11
	Levels 5-7	29
	Sci & Tech Total	**40**
Other Clinical	**Other Clinical Total**	**15**
	CPD Apprenticeships in role	**49**
Grand Total		**414**

Apprenticeship Levy contributions, commitments & spend

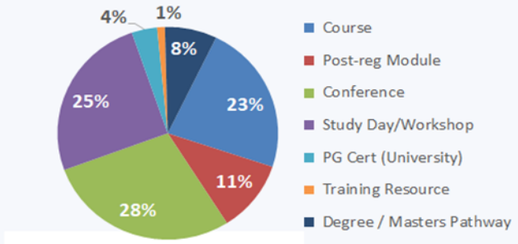
Financial Year	CUH £ Levy Contribution to date	£ Committed Spend to date	In year % Spend	In years committed transferred levy funds
2024/25	£3,667,820	£3,704,473	80%	£78,013
2025/26 to date	£2,209,203	£1,598,265	78%	£57,871
Levy funds	£6,853,758			

Apprenticeships in place as at October 2025: The total number of staff undertaking apprenticeships has reduced to 414 from 503 since March 25. This is due to staff completing apprenticeships in this period. There will be an ongoing reduction in numbers of nursing apprenticeships due to the four-year degree programme reducing and being replaced by a two-year nursing associate programme. This will also, over time, impact on CUH levy spend as the cost of the education programme is less.

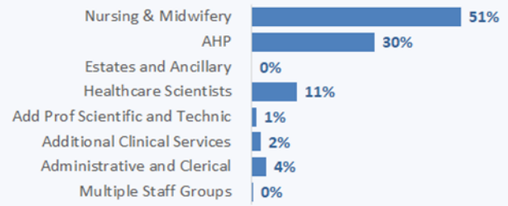
Apprenticeship Levy contributions and spend: The data for 2024/25 is retained in the report to show CUH's levy contributions and commitments in that year to be able to compare throughout 2025/2026.

Monthly CPD Expenditure: A summary of CPD funding, types supported and allocations by staff groups (non-medical)

CPD Allocation by Course/Resource - 2025/26 to date



CPD Allocation by Profession - 2025/26 to date



Funding Stream	Budget	Allocated
NHSE	£1,842,796	£807,264
Trust	£400,000	£166,030
Total	**£2,242,796**	**£973,294**

NHSE funding has increased from £1.42m to £1.54m based on increased headcount. The NHSE CPD underspend of £298k was rolled over into 2025/26; total budget of £1.84m for 2025/26. NHSE funding applies to nursing, midwifery and AHP staff only.
CUH CPD funding is currently provided for all other staff groups (non-medical). This is typically £400k; with initial permitted spend of £150k.

Our role to develop our managers and leaders

Programme	Oct 25		Comments
	Placement Allocations	Places Occupied	
Essentials Management & Leadership Excellence (EMLE) new managers	95	94	Steady flow of participants.
EMLE existing managers	277	257	5 cohorts launched during October + other cohorts' modules running
Consultants programme	0	0	Programme planned to restart Spring 2026 subject to resource to support
Aspiring managers programme (AMLP)	20	21	October cohort complete. Next cohort planned for November

Postgraduate Medical Centre - 2025/26 commitment

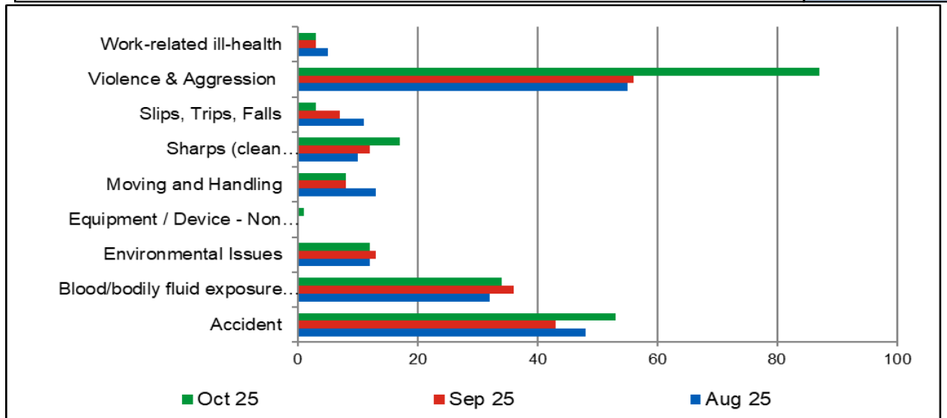
Programme	Placement Allocations	Dates
Learning to lead	0	May-Dec 25
Preparing for the consultant role	0	Oct-25

Further information: The EMLE programme has seen 5 cohorts of existing managers begin during October with a high attendance rate. New managers continues with a steady flow of around 31 per cohort vs 45 per cohort for existing managers. There is a lower DNA rate on new managers because if someone misses module 1 we rebook their whole cohort, so no longer show on DOT as having DNA'd. We are not due to allocate any places to the PGMC's programmes presently. The Consultant programme is being explored by DW and SN with a couple of options being considered. Aspiring Managers continues to support our next CUH leaders, with a great interest already shown for the next cohort in November.

Health and Safety Incidents

NHS Cambridge University Hospitals NHS Foundation Trust

No. of health and safety incidents reported by division:	Trustwide	Division A	Division B	Division C	Division D	Division E	Corporate	Estates
No. of health and safety incidents reported in a rolling 12 month period:	**2169**	590	320	505	299	254	65	136
Accident	**596**	173	110	113	80	65	10	45
Blood/bodily fluid exposure (dirty sharps/splashes)	**355**	126	45	62	49	60	10	3
Environmental Issues	**181**	27	30	11	28	32	5	48
Equipment / Device - Non Medical	**6**	5	0	0	1	0	0	0
Moving and Handling	**93**	37	12	18	12	8	4	2
Sharps (clean sharps/incorrect disposal & use)	**111**	31	22	13	15	25	5	0
Slips, Trips, Falls	**88**	16	20	12	7	10	6	17
Violence & Aggression	**704**	166	70	272	103	50	23	20
Work-related ill-health	**35**	9	11	4	4	4	2	1



A total of 2,169 health and safety incidents were reported in the previous 12 months.
981 (45%) incidents resulted in harm.
The highest reporting categories were violence and aggression (32%), accident (27%) and blood/bodily fluid exposure (16%).
1,455 (67%) of incidents affected staff, 644 (30%) affected patients and 70 (3%) affected others i.e. contractors and members of the public.
The highest reported incident categories for staff were: violence and aggression (38%), blood/bodily fluid exposure (23%) and accidents (17%).
The highest reported incident categories for patients were: accidents (54%), violence and aggression (21%) and environmental issues (10%).
The highest reported incident categories for others were: slips, trips and falls (46%), violence and aggression (28%) and environmental issues (26%).
Staff incident rate is 10.8 per 100 members of staff (by headcount) over a rolling 12 month period.
The highest reporting division was division A with 510 incidents. Of these, 29% related to accidents.
In the last 12 months, the highest reported RIDDOR category was over 7 day injuries (53%).
In the last 12 months, 71% of RIDDOR incidents were reported to the HSE within the appropriate timescale.
In October 2025, three incidents were reported to the HSE:
Over 7 day injury (1)
•A staff member was assisting in safely laying a non-compliant patient into bed (with the support of colleagues). In doing so, the staff member felt a pull (causing soreness/pain) in the right hand and arm/shoulder. A rotator cuff injury was diagnosed by their GP. The staff member was off work for over 7 days.
Dangerous occurrence (2)
•The affected staff member was working on a case with a hepatitis C positive patient. The suture needle was handed back to the affected staff member by the surgeon with the needle loaded in the needle holder so the point was made safe. When the affected staff member was transferring the sharp from the needle holder to the sharps disposal box when the affected staff member felt a sharps scratch to their left index finger. The affected staff member was wearing appropriate PPE i.e. double gloves. Following the needlestick injury the affected staff member followed the blood exposure protocol and was seen by Occupational Health for appropriate follow up.
•A CO_2 monitor was found to be alarming. After a staff member investigated the alarm, which was indicating an ambient level of CO_2 of between 1.5-3%, all staff within the affected room were asked to leave the area until informed that it was safe to return. A CO_2 incubator in the vicinity was switched off and the levels of CO_2 within the room dropped to within safe levels. The incubator was last inspected and serviced on 12/06/2025, with no faults reported. However, it was awaiting replacement due to its age. Following the incident the CO_2 incubator was replaced the same day. No staff suffered any adverse effects as a result of the incident.

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

Health and Safety Incidents

NHS
Cambridge University Hospitals
NHS Foundation Trust

No. of health and safety incidents affecting staff:

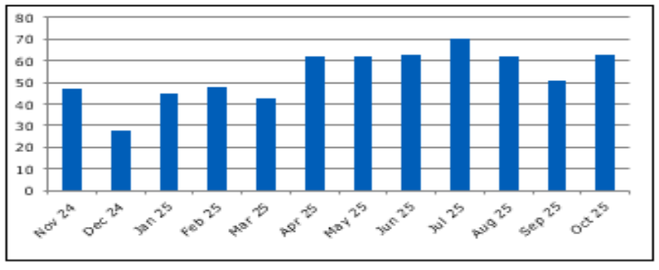


STAFF	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Total
Accident	23	17	19	24	19	16	23	20	28	16	19	22	**246**
Blood / bodily fluid exposure (dirty sharps / splashes)	27	24	25	27	23	27	23	27	32	31	35	34	**335**
Environmental Issues	10	4	7	8	3	4	12	15	18	4	7	9	**101**
Moving and handling	6	3	5	4	5	3	7	1	4	6	6	4	**54**
Sharps (clean sharps / incorrect disposal & use)	5	8	6	5	5	6	5	8	5	8	6	15	**82**
Slips, trips, falls	5	4	5	5	5	4	1	7	3	4	7	0	**56**
Violence & Aggression	31	51	34	46	53	48	38	45	56	41	41	62	**546**
Work-related ill-health	2	3	2	3	4	6	1	0	3	5	3	3	**35**
Total	**109**	**114**	**103**	**122**	**117**	**114**	**110**	**123**	**155**	**115**	**124**	**149**	**1455**

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

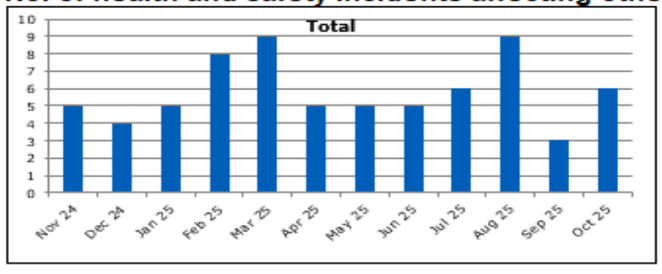
	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Total
No. of health & safety incidents	109	114	103	122	117	114	110	123	155	115	124	149	1455
Staff incident rate per month/ year	0.8	0.8	0.8	0.9	0.9	0.8	0.8	0.9	1.2	0.9	0.9	1.1	10.84

No. of health and safety incidents affecting patients:



PATIENT	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Total
Accident	21	14	29	27	23	35	35	41	38	32	24	31	**350**
Blood / bodily fluid exposure (dirty sharps / splashes)	2	0	1	3	2	2	3	1	4	1	1	0	**20**
Environmental Issues	7	1	4	4	4	6	3	7	10	8	6	2	**62**
Equipment / Device - Non Medical	0	0	1	1	0	0	1	0	2	0	0	1	**6**
Moving and handling	4	2	1	2	4	4	2	3	4	7	2	4	**39**
Sharps (clean sharps / incorrect disposal & use)	1	2	3	0	4	2	3	4	0	2	6	2	**29**
Violence & Aggression	12	9	6	11	6	13	15	7	12	12	12	23	**138**
Total	**47**	**28**	**45**	**48**	**43**	**62**	**62**	**63**	**70**	**62**	**51**	**63**	**644**

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



OTHER	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Total
Environmental Issues	3	1	2	1	4	2	1	1	2	0	0	1	**18**
Slips, trips, falls	1	2	1	7	5	2	0	2	2	7	0	3	**32**
Violence & Aggression	1	1	2	0	0	1	4	2	2	2	3	2	**20**
Total	**5**	**4**	**5**	**8**	**9**	**5**	**5**	**5**	**6**	**9**	**3**	**6**	**70**

Council of Governors

Cambridge University Hospitals
NHS Foundation Trust

Together
Safe
Kind
Excellent

Report to the Council of Governors: 17 December 2025

Agenda item	9
Title	Re-appointment of external auditor
Sponsoring executive director	Mike Keech, Chief Finance Officer
Author(s)	Adrian Goodchild, Director of Corporate Finance
Purpose	To receive the recommendation of the Audit Committee.
Previously considered by	Audit Committee, 19 November 2025

Executive Summary

The Trust's current external auditor, Forvis Mazars, will complete the final year of their two-year contract extension in 2025/26. Audit Committee at its meeting on 19 November 2025 considered that although the original contract envisaged a two-year extension, under current UK procurement legislation, it is possible to extend further on a mutually agreed basis. Audit Committee considered that auditing standards only require a tendering process to be conducted every ten years and supported the proposal that the Trust should retain Forvis Mazars for 2026/27 for continuation of the annual account period.

Related Trust objectives	All Trust objectives
Risk and Assurance	The external auditor provides important assurance to the Council of Governors.
Related Assurance Framework Entries	n/a
Legal / Regulatory / Equality, Diversity & Dignity implications?	The appointment of the Trust's external auditor is a matter reserved to the Council of Governors.
How does this report affect Sustainability?	n/a
Does this report reference the Trust's values of "Together: safe, kind and excellent"?	n/a

Action required by the Council of Governors

The Council is asked to approve the recommendation of the Audit Committee to re-appoint Forvis Mazars for 2026/27.

Cambridge University Hospitals NHS Foundation Trust

17 December 2025

Council of Governors
Re-appointment of external auditor
Mike Keech, Chief Finance Officer

1. Purpose and process

1.1 In accordance with the NHS Acts, one of the Council of Governors' statutory duties is to approve the appointment of the Trust's external auditors.

1.2 The Trust's external audit contract was last competitively tendered in autumn 2020 and awarded to Mazars, who had been the incumbent for the previous five years. The current contract with Forvis Mazars reaches the end of its current two-year extension in 2025/26. UK procurement legislation allows further extensions to be made on a mutually agreed basis and auditing standards only require that contracts are tendered every ten years.

1.3 Indications from other NHS Foundation Trusts and NHS England continue to inform of a very challenging NHS external audit market, with Trusts finding it difficult to appoint new external auditors (sometimes with no bids being received), established firms have left the market and not returned, and audit fees continue to rise. Although the Trust has agreed increased fees with Forvis Mazars over the past few years, our current audit fee remains considerably lower than other Trusts of a similar size and complexity and Audit Committee considered them good value for tax payers money.

1.3 It is the view of Trust management that Mazars have continued to perform well over the current contract term and have improved the quality of their audit work over recent years under the oversight of the partner, Suresh Patel.

1.4 Continuity has its own benefits in terms of avoiding the inevitable disruption that a change in auditors brings. The knowledge gained over previous audits is a real advantage in terms of better understanding the Trust's risks and controls, without compromising auditor independence. This will be a particular advantage in a year following the deployment of a new general ledger system.

1.5 The Audit Committee considered the proposal from management at its meeting on 19 November 2025 (with both the external auditors and the internal auditors excluded from that part of the meeting) and agreed to recommend to the Council of Governors the re-appointment of Mazars as provided for in the contract.

2. Recommendation

2.1 The Council of Governors is asked to approve the recommendation of the Audit Committee to re-appoint Mazars LLP as the Trust's external auditor for 2026/27.