Council of Governors

Cambridge University Hospitals NHS Foundation Trust

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Council of Governors Meeting (held in public)
Wednesday, 25 March 2026 at 5.00pm 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
5.00pm	**1.**	**Welcome and apologies for absence**	To note	Deputy 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*)	To note	
	3.*	**Minutes of the previous meeting** To approve the minutes of the meeting held on 17 December 2025.	To approve	
	4.*	**Council of Governors Action Tracker and Matters Arising** (*in addition to those included on the agenda*)	For review	
5.05pm	**5.**	**Chair's Report** To receive the verbal update of the Trust Chair	For receipt	Deputy Chair
	5.1*	**Senior Independent Director Update** To approve the recommendation for the Senior Independent Director position	To approve	Chief Governance and Performance Officer

5.10pm	**6.***	**Lead Governor Report** To receive the report of the Lead Governor	For receipt	Lead Governor
5.20pm	**7.***	**Update on Constitution** To approve the proposal of the Chief Governance and Performance Officer	To approve	Chief Governance and Performance Officer
5.25pm	**8.***	**Governor Elections 2026** To note the Governor Election plans report of the Chief Governance and Performance Officer	To note	Chief Governance and Performance Officer
5.30pm	**9.*** **9.1**	**Membership Engagement Group** To approve the updated Membership Engagement Terms of Reference To note the update from the last meeting of the Membership Engagement Group	To approve To note	Chief Governance and Performance Officer Membership Engagement Group Chair
5.40pm	**10.**	**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
6.15pm	**11.***	**Chief Executive's Report (including Integrated Performance Report)** To receive the report of the Chief Executive	For receipt	Acting Chief Executive
6.25pm	**12.**	**Any other business** Items of any other business to be identified to the Chief Governance and Performance Officer or Trust Secretary in advance of the meeting	To note	Deputy Chair
	13.	**Date of the next meeting** The next meeting of the Council of Governors will be on Wednesday, 24 June 2026.	To note	
	14.	**Close of meeting**		

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Minutes of the meeting of the Council of Governors held on Wednesday, 17 December 2025 at 17.00 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/Lead Governor	X	
Ms C Dear	Patient Governor	X	
Ms P Hales	Partnership Governor (Royal Papworth Hospital)	X	
Mr R Stevens	Patient Governor/Deputy Lead Governor	X	
Cllr L Navarro	Partnership Governor (Cambridge City Council)	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	
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
Mr N Kirby	Interim Chief Operating Officer
Ms P Hird	Non-Executive Director
Mrs L Hughes	Interim Head of Governance
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
Prof P Maxwell	Non-Executive Director

33/25 Apologies for absence

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

34/25 Declarations of Interest

34.1 There were no additional interests or changes to declared and no interests declared in relation to open agenda items.

35/25 Minutes of the previous meeting

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

36/25 Council of Governors action tracker and matters arising not covered by other items on the agenda

36.1 **Received and noted:** The action tracker.

37/25 Chair's report

37.1 Sally Morgan, Trust Chair, presented a verbal update, which was received, drawing attention to the following:

1. The Board had formally recorded its gratitude to Annette Doherty, Non-executive Director who was due to depart the Trust at the end of 2025, which Governors expressed their appreciation for her significant contributions during her tenure.

2. Roland Sinker, Chief Executive Officer was leaving the Trust at the end of 2025 to take on a new role with Nicola Ayton taking on the role as Acting Chief Executive from 1 January 2026.
3. The new Trust's strategy is scheduled to be presented to the Board in January 2026 for review and arrangements would be made to continuously update the Council of Governors going forward.

37.2 In response to the Chair's update, the Council of Governors expressed their enthusiasm for forthcoming updates on the new Trust's strategy. The Governors also extended congratulations to Roland Sinker, recognising his contributions and leadership during his tenure as Chief Executive Officer.

37.3 In response to Governors' queries, the Chair confirmed that an open recruitment exercise would be taking place in the new year, overseen by the Remuneration and Nomination Committee to seek to fill the permanent Chief Executive Officer position.

37.4 **Agreed:**
To note the verbal update of the Chair.

38/25 Lead Governor report

38.1 Helena Rubinstein presented her first report to the Council of Governors since being nominated as the Lead Governor, which was received and noted. Helena drew reference to:

1. The Council of Governors expressed its appreciation to Neil Stutchbury and Jane Biddle for their contributions as Lead and Deputy Lead Governor respectively. It was noted that there is an ongoing review of the roles, with a focus on ensuring they continue to add value to the organisation.
2. Training was planned to be provided for Governors in the new year with the aim of gaining a greater understanding of their statutory duties.
3. Governors were looking forward receiving NHS mail accounts and the adoption of Microsoft Teams. It was recognised that additional support will be required to facilitate this transition effectively and once all Governors' accounts were working arrangements were planned to be made for Governors to access a shared Teams area.
4. The Governor Working Group was looking at ways to enhance the current arrangements in place for Governors to represent their constituencies effectively. The Group had recently discussed the time and resources needed to focus efforts to achieve the greatest impact.

38.2 In response to the Lead Governor's update the Trust Chair raised some issues that had been brought to her attention by Governors in relation to patient experience. She emphasised the importance of establishing a clear format for Governors' engagement, including their attendance as

observers at Board Committee meetings. In response to Governors' queries it was noted that Non-executive Directors would aim to support one-to-one conversations between Governors on a regular basis in support of Governors observing Board Committee's business. Non-executive Directors noted that Governor's insights and qualitative feedback was welcome, particularly regarding experiences of partners and the constituents that the Governors represent.

1. The importance of the Annual Report was highlighted, as a significant vehicle for communication with shareholders and marketing the organisation.
2. Governors discussed the benefit of accompanying Non-executive Directors on visits with the aim of them receiving direct feedback from patients, which would help then to triangulate information received at meetings and to support their discussions.
3. In response to the discussion on volunteering, the Lead Governor confirmed that discussions were ongoing with the Chair and further meetings were planned to look at ways to enhance the effectiveness of volunteer engagement across the Trust.

38.3 **Agreed:**
To note the report of the Lead Governor.

39/25 Board committee update

39.1 Board Committee Chairs provided an update on business covered at recent Board Committee meetings. This new arrangement in place aimed to support Governors to fulfil one of their statutory roles to hold Non-executive Directors to account for the performance of the Board. The Chair explained that Governors would have the opportunity to raise any queries they may have during the Board Committee updates.

39.1.2 Quality Committee, Dr James Morrow, Chair of Quality Committee provided an update, drawing reference to:

1. Positive developments had been reported on the enhancements in histopathology and the provision of phlebectomy services, which is available 24 hours a day, seven days a week. He noted areas for improvement had been raised including the paediatric orthopaedics with regular update reports provided to meetings, which aimed to provide assurance on the work being undertaken in response to the Verita report. It was noted that the Trust had taken the decision to publish the report and associated actions in full in October 2025.
2. The Committee oversees assurance reports including hospital mortality rates, acknowledging the complexities of the data availability. Work is underway to provide greater understanding to the Committee on the current position.
3. Infection and sepsis rates were regularly scrutinised, with the Trust rated at that time as bottom of the Shelford Group for Clostridium

difficile. Early recognition and detection of sepsis had been identified as key areas of focus.

4. The Committee regularly considered update reports on complaints and lessons learned in response to complaints, assurance against the Duty of Candour requirements as well as other qualitative metrics to inform and monitor progress against the quality and patient safety agenda.

39.1.3 In response to the update, the Governors who had observed the Quality Committee meetings commented positively on the Committee's discussions, noting that maternity services remain a concern at local and national levels. In response to this, the Chief Executive explained that while maternity is a national concern, the Trust is not currently subject to a national review. The Trust had reached its seventh year of the Maternity Incentive Scheme (MIS), and sign-off for year seven compliance had been achieved. Infrastructure concerns had been raised in relation to the Rosie building, which was not originally designed to accommodate caesarean sections, particularly regarding air flow and capacity. Despite these challenges, significant progress has been made.

39.1.4 A Governor made reference to the paediatric orthopaedics, describing the efforts to establish multidisciplinary teams. In response, the Chief Executive noted that MDTs can be highly effective mechanisms, but there are areas where they are unsuitable. When concerns had been raised in the past, MDTs were regarded as beneficial, and the Quality Committee has overseen arrangements in place, seeking assurances to identify areas where further strengthening is required.

39.1.5 Governors sought assurance on the repurposing of T2, with a focus on palliative and end-of-life care in relation to Arthur Rank and expressed an interest in visiting the facility in future when convenient.

39.2/25 Performance Committee, John Crompton, Chair of Performance Committee provided an update, drawing reference to:

1. The introduction of new metrics were supported by the Committee to meet the National Oversight Framework, which was being overseen alongside the development of recovery plans to address identified areas of improvement.
2. Changes to the Integrated Performance Report were considered, with the aim of enhancing reporting to improve the efficiency and effectiveness of the Board Committees and Board's business reporting mechanisms.
3. The Board Assurance Framework is reviewed at each meeting as part of ongoing efforts to ensure robust risk management and oversight against the Trust's strategic risks aligned to the Committee.

39.2.1 In response to a Governor's query regarding input from the Integrated Care Boards on the business plan a discussion took place noting that a proactive approach was being taken to implement the necessary changes to achieve the required targets. The Chief Finance clarified that the year two deficit position was not the intended outcome and highlighted the challenges in securing Board approval. He explained that expanding digital programmes would be beneficial and emphasised the need to engage more actively with demand management initiatives. Some assumptions had been made based on ICB input.

39.2.2 In response to Governors' queries raised on what aspects were working well and what were the main areas of concern at the Committee. The Chief Finance Officer noted that there are a number of underlying challenges and stressed the importance of making progress on access, specifically in relation to government targets, including the 65 and 52 week standards was a main focus.

39.2.3 A Governor queried if the National Oversight Framework accurately reflected the way the organisation worked or if it distorted priorities. In response, the Chair of the Performance Committee explained that a smaller set of priorities enabled greater focus and empowered the Trust to pursue ambitious objectives. While this focus was beneficial, it was acknowledged that it could limit attention to other important areas. The Committee had agreed to continue working through priorities and to maintain a broader perspective wherever possible. Non-executive Directors welcomed the focus on core fundamentals and key metrics, especially in relation to reducing long waits, which were considered unacceptable.

39.3/25 Workforce Committee, Rohan Sivanandan, Chair of Workforce Committee provided an update, drawing reference to:

1. The Committee had noted there is no intention for the Trust to expand its headcount at present, the national direction is aiming to achieve more with the same number of staff or fewer headcount.
2. The staff survey and flu vaccine uptake had been actively promoted, resulting in a 65% flu vaccination rate, which is the second highest nationally. The staff survey achieved a 54% response rate, equating to circa 7,000 responses, which is 6% above the national average for acute Trusts.
3. The response to the Verita review was had been received, with the Chief Medical Officer overseeing four programmes. These programmes focus on management and support for doctors, which is underpinned by a strong governance model.
4. The Committee agreed that Equality Diversity and Inclusion (EDI) should continue to be included and overseen on the Trust's Board Assurance Framework and strategic risk register and the direction of travel should incorporate EDI into organisational culture going forward.

39.3.1 In response to the update Governors queried the benchmarking of vaccination rates and sought ways to further encourage staff uptake. In response, the Chief Executive explained that rates had increased this year, attributing to intensive communications and the deployment of teams, alongside a supporting culture and great progress had been made with the support of a team effort.

39.3.2 Governors acknowledged the value of independent external reviews and the importance of speaking up within teams. It was noted that work was ongoing to continuously encourage and support speaking up across the organisation.

39.4/25 Addenbrooke's Futures Committee, Dr James Morrow, Chair of Addenbrooke's Futures Committee provided an update, drawing attention to:

1. The Committee had considered the development of new models of care, with particular emphasis on the concept of a 'hospital without walls'. They had discussed and considered the potential for delivering care beyond traditional hospital settings, aiming to enhance accessibility and patient experience.
2. Progress of new build projects and the implementation of the target operating model for Cambridge Children's Hospital (CCH) is overseen by the Committee. Governors expressed their interest in continuously being updated progress and particularly integration with the university, the Trust and partners within the local community.
3. Ongoing work in life sciences and research innovation is reviewed on a regular basis, which the Committee recognises the importance of initiatives such as the tissue bank.
4. Community engagement update was recently received aiming to provide assurance on the collaborative work with South Place, which affirmed the value of partnership working to support population health.

39.4.1 In response to the Committee update Governors queried children's services, specifically around the positioning of maternity within the model. In response the Committee Chair explained that the business case was under development, with approval required before any construction work can commence. He advised that, during this period, keeping maternity services separate would be beneficial.

39.4.2 Governors queried how the South Place model was functioning within the expanded Integrated Care Board (ICB) and if the model would be retained. The Committee Chair explained that it is anticipated that CUH will play a more significant role in how South Place will operate as an anchor institution. The final details are yet to be agreed; the situation remains fluid and the Trust remains extremely committed to working with its partners.

39.5/25 Audit Committee, John Crompton, Chair of the Audit Committee provided the update, drawing attention to:

1. The Committee had received regular updates on progress and mitigating plans in place regarding cyber security and information technology.
2. The Board Assurance Framework refresh had been provided to the Committee, which provided assurance on the work underway to continually develop the Trust's risk management with the Committee expressing a high degree of confidence in the approach being undertaken.
3. Internal and external audit activities are provided to each meeting, drawing out good practice and areas of improvement.
4. A proposal to extend the contract of the Trust's external auditors was considered and supported for recommendation to the Council of Governors for endorsement.

39.5 Agreed:

1. To note the update from the Board Committee Chairs.
2. To agree that the Chief Operating Officer will arrange a visit for governor representatives to T2 once the area is fully operational, subject to the necessary arrangements being in place. **(ACTION)**

40/25 Chief Executive's Report (including Integrated Performance Report)

40.1 Roland Sinker, Chief Executive, presented the report, drawing attention to the following:

1. The operational performance across five key areas, providing an overview.
2. The importance of understanding the context around the Trust's regulatory oversight, including the NHS Oversight Framework and Care Quality Commission external assessments, which the Council of Governors expressed recognition of the current position and the positive outlook for future developments.
3. The current environment presented some significant challenges, such as the ongoing industrial action, an increase in flu cases, and the impact of a recent fire, with partners and emergency services actively been involved in the response.
4. The seriousness of issues relating to paediatric orthopaedics was emphasised. The Council of Governors noted the value of recent listening sessions that the Trust had put in place to meet with families over this very serious area.
5. The strategic direction for Cambridge Children's Hospital and Cambridge Cancer Research Hospital, including the need to address the financial gap in children's services.

40.2 **Agreed:**
To note the report of the Chief Executive.

41/25 Any other business

41.1 **Revised Format of Council of Governor meetings**
The Chair welcomed feedback on the revised format of meetings. The Council of Governors welcomed the changes and recognised it had been a most productive meeting, enabling open discussion and debate throughout the meeting that day. It was agreed that all future meetings of the Council of Governors would follow a similar format.

41.2 **Palantir**
A Partnership Governor raised a query regarding Palantir and in response the Chief Executive confirmed that the Trust is participating in the programme. It was acknowledged that this is a contentious issue, given that Palantir has been procured nationally by the NHS. There is, however, an expectation at the national level that all Trusts engage with the process.

42/25 Date of next meeting

42.1 The next meeting of the Council of Governors (held in public) would be held on Wednesday, 25 March 2026 at 17.00pm

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Council of Governors: Action Tracker

Minute	Action	Lead	Target date	Status	RAG rating
39/25	1. To agree that the Chief Operating Officer will arrange a visit for governor representatives to T2 once the area is fully operational, subject to the necessary arrangements being in place.	Chief Operating Officer	June 2026	The unit is expected to commence admitting patients in mid-April 2026. In view of this, it is proposed that a governors' visit be arranged for June 2026, allowing time for the ward to be fully established prior to hosting visitors. A formal process for visits will be developed and, due to the nature of the unit, numbers will be controlled appropriately	**AMBER**

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Senior Independent Director Update

Report to the Council of Governors

25 March 2026

Agenda item	5.1
Title	Report from the Chief Governance and Performance Officer
Sponsoring executive director	n/a
Author(s)	Interim Head of Corporate Governance
Purpose	To endorse the recommendation of the Board to cover the position of the Senior Independent Director
Previously considered by	Board of Directors

Executive Summary

The Senior Independent Director role at the Trust had been covered by Annette Doherty, Non-executive Director until they left the Trust at the end of 2025.

The Board of Directors (*in consultation with the Council of Governors*) may appoint one of the Non-executive Directors to fill the Senior Independent Director role, for such a period, not exceeding the remainder of their term as a member of the Board.

The criteria for this role, in accordance with the NHS 2006 Act as amended by the 2012 Act enables any Non-executive member of the Board to be appointed. This individual may at any time resign from the office as a Senior Independent Director by giving notice in writing to the Chair. The Board of Directors (in consultation with the Council of Governors) may then appoint another Non-executive Member of the Board as Senior Independent Director.

The Board of Directors at its meeting held on 11 March 2025 considered and agreed that the Senior Independent Director role is covered by Philippa Hird, Non-executive Director, subject to Council of Governors approval.

(*The role description for the Senior Independent Director is provided at Appendix A for information*).

Related Trust objectives	All
Risk and Assurance	n/a
Related Assurance Framework Entries	n/a
Legal and regulatory implications?	NHS 2006 Act as amended by the 2012 and 2022 Acts

Action required by the Council of Governors

The Council of Governors is asked to endorse the recommendation of the Board of Directors for Philippa Hird, Non-executive Director to cover the role of Senior Independent Director with immediate effect.

Cambridge University Hospitals NHS Foundation Trust

Appendix A

Senior Independent Director Role Description

The Senior Independent Director is a Non-executive Director appointed by the Board of Directors as a whole in consultation with the Council of Governors to undertake the role described below:

The Senior Independent Director may be covered by any Non-executive Director of the Board.

The Senior Independent Director will be available to members of the foundation trust and to governors if they have concerns, which contact through the usual channels of Chair, Chief Executive, Chief Finance Officer and Company Secretary (*or any member of staff who covers this role*) has failed to resolve or where it would be inappropriate to use such channels.

The Senior Independent Director should liaise with the Lead Governor (where one has been appointed) in the areas where their roles are complementary.

In addition to the duties described here the Senior Independent Director has the same duties as the other Non-executive Directors.

The Senior Independent Director, the Chair and Non-executive Directors

The Senior Independent Director has a key role in supporting the Chair in leading the Board of Directors and acting as a sounding board and source of advice for the Chair.

The Senior Independent Director also has a role in supporting the Chair as Chair of the Council of Governors.

The Senior Independent Director should hold a meeting with the other Non-executive Directors in the absence of the Chair at least annually as part of the appraisal process.

There may be other circumstances where such meetings are appropriate. Examples might include informing the re-appointment process for the Chair, where governors have expressed concern regarding the Chair or when the Board is experiencing a period of stress as described below.

The Senior Independent Director and the Council of Governors

While the Council of Governors determines the process for the annual appraisal of the Chair, the Senior Independent Director is responsible for carrying out the appraisal of the Chair on their behalf as set out as best practice in the Code of Governance.

The Senior Independent Director might also take responsibility for an orderly succession process for the Chair role where a reappointment or a new appointment is necessary.

The Senior Independent Director should maintain regular contact with the Council of Governors and attend meetings of the Council of Governors to obtain a clear understanding of governors' views on the key strategic and performance issues facing the foundation trust.

The Senior Independent Director should also be available to governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the chair; chair's appraisal or setting the chair's objectives for example.

In rare cases where there are concerns about the performance of the Chair, the Senior Independent Director should provide support and guidance to the Council of Governors in seeking to resolve concerns or, in the absence of a resolution, in taking formal action. Where the foundation trust has appointed a lead governor the Senior Independent Director should liaise with the Lead Governor in such circumstances.

The Senior Independent Director and the Board

In circumstances where the Board is undergoing a period of stress the Senior Independent Director has a vital role in intervening to resolve issues of concern. These might include unresolved concerns on the part of the Council of Governors regarding the Chair's performance; where the relationship between the Chair and Chief Executive is either too close or not sufficiently harmonious; where the trust's strategy is not supported by the whole board; where key decisions are being made without reference to the Board or where succession planning is being ignored.

In the circumstances outlined above the Senior Independent Director will work with the Chair, other directors and/or governors, to resolve significant issues.

Boards of Directors and Councils of Governors need to have a clear understanding of the circumstances when the Senior Independent Director might intervene so that the Senior Independent Director's intervention is not sought in respect of trivial or inappropriate matters.

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Lead Governor Report to the Council of Governors

25 March 2026

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

Executive Summary

The aim of this paper is to provide the Council of Governors with an update on activities taken place since last reported to the Council of Governors at its meeting in December 2025.

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 Board of Directors

The Council of Governors is asked to:

a. note the activities of Council of Governors, which have taken place since last reported at the meeting held in public in December 2025; and

b. support the recommendation of Robin Stevens being put forward for consideration of Neil Stutuchbury's successor in covering the Cambridge University Health Partners Chair role, which is a role covered by a governor.

Cambridge University Hospitals NHS Foundation Trust

Council of Governors Meeting
25 March 2026

Report of the Lead Governor

The aim of this paper is to provide the Council of Governors with an update on activities taken place since last reported to the Council of Governors at its meeting in December 2025.

1.0 Governor meetings

1.1 On 17 December 2026 there was a revised meeting format put in place, which commenced with the introduction of a Governor Forum held for governors to meet with the Lead Governor, followed by a Council of Governor Seminar, then the formal Council of Governor meeting.

1.2 This format helped to significantly improve the way the Governors are engaged and communicated with, feedback received has confirmed that it helped Governors to gain a greater understanding of the Board's business and oversight.

1.2.1 At the **Governor Seminar** two presentations were delivered; the first delivered by the Chief Governance and Performance Officer; and the Head of Analytics and Insights, who provided an update on the plans to redevelop the integrated performance report. The second presentation covered the Trust's winter plan, which was delivered by the Deputy Chief Operating Officer. Both presentations were extremely helpful and interactive, which enabled governors to gain a greater understanding of the work that was being taken forward, which was being overseen by Management Executive, reporting into the Performance Committee, a Committee of the Board.

1.2.2 Following the Seminar, the formal **Council of Governor meeting** was held for the first time in its revised format. The agenda was structured to enable governors to be updated by Non-executive Directors on the performance of Board Committees. Governors found this a significant improvement with all governors present at the meeting receiving detailed updates and having the opportunity to raise questions with members of the Board to seek assurance. During the meeting, the Chief Executive provided an update on the performance of the Trust, supported by executive colleagues; and the Chief Finance Officer, proposed an extension to the Trust's external auditor contract, which had been previously discussed at the Audit Committee. The governors fully supported and endorsed the recommendations put to them.

1.3 The **Membership Engagement Group (MEG)**, met on 3 March 2026. The MEG has a significant role in ensuring that the governors can fulfil their statutory duty of representing constituencies. The meeting reviewed their Terms of Reference for submission to the Council of Governors on 25 March 2026 for ratification. The Group also received an update from the Head of Patient and Public Involvement (PPI) on the role she covered at the Trust and the involvement of

patients, the public and carers across the Trust's community and more widely across the country as part of the PPI Framework. Governors found the presentation insightful and noted the overlap between the Membership Engagement Group's future aspirations with the Trust's membership and the work that is already underway by the Trust, particularly on working with patients, carers, and communities to improve health and care, to ensure people's voices shape the Trust's services and its research.

1.3.1 A proposal on extending the constitutional boundaries was considered and supported by the Group. Governors noted the benefits of adding an additional 'Rest of England' constituent area, which would support the transition of Volunteer members from the staff constituency, as formally agreed by the Council of Governors and the Board in 2025. This additional Rest of England constituency area would also fit with the aspirations of the PPI plans of the Trust. Discussion was held on how the membership database can assist the Trust with targeting communication and engagement exercises in future. It was agreed that the proposed change to add a Rest of England constituent area to the Trust's Constitution would be put through the Trust's formal approval processes, which would require approval by the Council of Governors and the Board of Directors.

2.0 Partnership Governor

2.1 The Trust has recently been informed that Michelle Barnes, Transformation Manager at Cambridge and Peterborough NHS Foundation Trust will take over from Stephen Legood as Cambridge and Peterborough NHS Foundation Trust's nominated partnership governor representative.

2.2 On behalf of the Governors, we would like to welcome Michelle and look forward to working with her in future.

3.0 Chair, Cambridge University Health Partners

3.1 Neil Stutchbury, Patient Governor had covered the role of Chair of Cambridge University Health Partners (CUHP) until recently when his term ended. A successor for Neil has been sought across partnering Trusts.

3.2 Neil reported at the last Council of Governors meeting of his term ending and encouraged governors to forward interest in this role. Interest has been received from Robin Stevens, Deputy Lead Governor. The Council of Governors is asked to support Robin's interest being put forward to CUHP as consideration as Neil's successor in the Chair role.

4.0 Other Governor Activities

4.1 Governor training took place on 27 January 2026 and 25 February 2026. These sessions were held virtually covering two full days, facilitated by NHS Providers. The first session covered the role of the NHS Foundation Trust governor including their statutory duties, the NHS context, quality in the NHS; and member and public engagement. The second session included governance, accountability and

holding to account, providing interactive sessions on the governance aspects of the Board, directors and governors; and accountability, how this should work in practice with governors.

4.1.1 Feedback received from governors confirmed that the training was extremely helpful. It provided refreshment on the statutory role of the governor, the governors' role in the changing NHS environment, and included some very interesting breakout sessions, including guidance on how to raise questions in a constructive challenging way. It reminded governors that their role was to hold the Board via the Non-executive directors to account for the performance of the Board and not on the operational management. For any governors that were unable to attend the presentations have been shared with all governors.

- A **Volunteer Initiative** has commenced at Addenbrookes, with the engagement of the Volunteer Governor to look at how the volunteer role can be expanded at the Trust. To support this work a number of CUH Governors arranged to meet with Royal Marsden Volunteer representatives earlier this month.

- The **Governors Working Group**, which had been set up as a time-limited meeting to look at ways of improving the function and operation of the Council of Governors within CUH has met on:

  - 12 December 2025: to define new approach to membership and representing constituencies (see 1.3 above).

  - 4 February 2026: to prioritise activities going forwards.

- A **Governor Expertise and Skills** database has been compiled to highlight areas of knowledge that could be relevant to the Trust.

5.0 Recommendation

5.1 The Council of Governors is asked to:

a) note the Governor activities that have taken place since the last Council of Governors meeting held in December 2025;

b) note that Michelle Barnes, Transformation Manager at Cambridge and Peterborough NHS Foundation Trust will take over from Stephen Legood as Cambridge and Peterborough NHS Foundation Trust nominated partnership governor representative; and

c) support Robin Stevens, Deputy Lead Governor's interest being put forward to CUHP as consideration as Neil Stutchbury's successor in the Chair role for Cambridge University Health Partners.

Dr Helena Rubinstein
Lead Governor

Cambridge University Hospitals NHS Foundation Trust

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Update on the Trust's Constitution Amendments

Report to the Council of Governors

25 March 2026

Agenda item	7
Title	Update on the Trust's Constitution Amendments
Sponsoring executive director	Chief Governance and Performance Officer
Author(s)	Interim Head of Governance
Purpose	To provide an update on the Trust's Constitution amendments and seek approval for an additional constituent area
Previously considered by	Constitution Committee Council of Governors Board of Directors

Executive Summary

The Trust's Constitution sets out the powers and functions of the Trust. During 2025 changes were made to the Trust's Constitution. The Trust's Constitution Committee considered and approved changes on 18 June 2025 to take into account developments in corporate governance and changes to the health and care system, which were approved by the Council of Governors and Board of Directors thereafter.

One of the approved changes included a change to the staff membership. The Constitution had previously enabled the Trust's volunteers to be automatically enrolled as members under the staff constituency, they could have opted out as members but they were not eligible at that time to join the public or patient constituency. The arrangement to include Volunteers under the staff constituency was a variation to the national Model Core Constitution requirements.

The Council of Governors and Board of Directors agreed to honor the Volunteer Governor position until their term ends on 30 June 2026, with arrangements to be made for volunteers to transition to another constituency, which included the patient or public constituencies, in readiness for the next round of elections in 2026 (*noting that members can only be a member of one constituency*).

Since the Constitution changes were agreed by the Council of Governors and Board of Directors it has been identified that there are some volunteers that do not currently meet the patient or public constituencies. In order to address this, it is proposed that an additional 'Rest of England' constituent area is added to the Trust's Constitution. This will help to support the transitional arrangements giving volunteers the option to be a member of either the public, patient or Rest of England constituent area. This wider catchment area is also consistent with the vision of the Trust's patient and public involvement plans to engage and involve patients, carers and public in the Trust's services and strategic developments.

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

Action required by the Council of Governors

The Council of Governors is asked to:

a) note the update provided;
b) approve the additional Rest of England constituent area, noting that this will also require Board of Director approval; and
c) note that subject to Council of Governor and Board of Directors approval changes will be made in advance of the 2026 Elections.

Cambridge University Hospitals NHS Foundation Trust

Council of Governors Meeting
25 March 2026

Proposed Changes to the Trust's Constitution

Report of the Chief Governance and Performance Officer

1.0 Background

1.1 In accordance with governance practice, the Trust's Constitution was reviewed in 2025 to take into account of any changes to legal and regulatory practice and changes unique to the Trust. Legal and regulatory requirements require any changes to the Trust's Constitution to be approved by at least half of the Council of Governors and at least half of the Board of Directors.

1.2 Changes were last considered and approved in 2025, which included consideration and approval by the Trust's Constitution Committee held on 18 June 2025 and the Council of Governors and Board of Directors thereafter. Additional minor changes were also approved by the Board of Director and the Council of Governors with the last approval taking place in October 2025.

1.3 One of the changes that was approved included a change to the staff membership. The Constitution had previously enabled the Trust's volunteers to be enrolled as members under the staff constituency, they had the option to opt-out as members but they were not eligible at that time to join the public or patient constituency. The arrangement to include volunteers under the staff constituency was a variation to the national Model Core Constitution requirements.

1.4 The Council of Governors and Board of Directors agreed to honor the Volunteer Governor position until their term ends on 30 June 2026 and to make arrangements prior to that for volunteers to transition to another constituency: patient or public in readiness of the next round of elections in 2026. Noting that membership rules only enable anyone to be a member of one constituency.

1.5 Since the changes to the Constitution were agreed by the Council of Governors and Board of Directors it has been identified that there are some volunteers who do not currently meet the requirements of patient or public constituencies. Under the current Constitution these volunteers would not be eligible to continue as members. This has been considered and to enable those volunteers that do not currently meet the constituency membership requirements under the Trust's current Constitution it is proposed that an additional constituent area named 'Rest of England' is added.

2.0 Rest of England Constituency

2.1 The Rest of England constituency is widely in place across NHS Foundation Trust providers, predominately the larger teaching hospitals.

2.2 Rest of England eligibility would include anyone over the age of 16 that meets the membership requirements could be eligible to be a member of the Trust. The requirements are that the individual resides in England and doe not meet any other constituent area of staff, public or patient.. This addition would help to support the transitional arrangements taking place prior to the 2006 Elections, giving all volunteers the option to continue as a member of either the public, patient or Rest of England constituent area. This wider catchment area is also consistent with the vision of the Trust's patient and public involvement plans to engage and involve patients, carers and public in the Trust's services and strategic developments.

3.0 Proposed Changes to the Trust's Constitution

3.1 Appendix A includes the addition required for an additional constituent area named 'Rest of England'.

4.0 Recommendations

4.1 The Council of Governors is asked to:

a) note the update provided;

b) approve the additional Rest of England constituent area, noting that this will also require Board of Director approval; and

c) note that subject to Council of Governor and Board of Directors approval changes will be made in advance of the 2026 Elections.

Appendix A

All recommended additions to support the inclusion of a Rest of England constituent area are highlighted in blue font

Main body of Constitution

5. Membership and constituencies
The trust shall have members, each of whom shall be a member of one of the following constituencies:
5.1 a Public Constituency
5.2 a Staff Constituency
5.3 a Patients' Constituency
5.4 a Rest of England Constituency

11. Rest of England
11.1 An individual who lives in the area specified in Annex 1 may become or continue as a member of the trust.
11.2 Those individuals who are eligible for membership are referred to as the Rest of England Constituency
11.3 The minimum number of members in the Public Constituency is specified in Annex 4.

ANNEXES to the CONSTITUTION:
ANNEX 1: THE PUBLIC CONSTITUENCY OF THE TRUST
(Paragraphs 7.1 and 7.3)

The minimum number of members in the Public Constituency shall be 100.

The area of the trust at the date of adoption of this constitution comprises the local government electoral wards set out below:

Cambridge City Council as defined by the Cambridge (Electoral Changes) Order 2019
(All Wards)
South Cambridgeshire District Council as defined by the South Cambridgeshire (Electoral Changes) Order 2017 as amended
(All Wards)
East Cambridgeshire District Council as defined by the East Cambridgeshire (Electoral Changes) Order 2016
(All Wards)

Uttlesford District Council as defined by the Uttlesford (Electoral Changes) Order 2014
(Selected Wards only)
Ashdon

Clavering
Debden and Wimbish
Littlebury, Chesterford and Wenden Lofts
Newport
Saffron Walden Audley
Saffron Walden Castle
Saffron Walden Shire
The Sampfords
Takeley
Thaxted and the Eastons

East Hertfordshire District Council as defined by the East Hertfordshire (Electoral Changes) Order 2023
(Selected Wards only)
Braughing & Standon
Buntingford
Little Hadham & The Pelhams
The Mundens

North Hertfordshire District Council as defined by The District of North Hertfordshire (Electoral Changes) Order 2006
(Selected Wards only)
Ermine
Royston Palace
Royston Meridian
Royston Heath

West Suffolk Council as defined by the West Suffolk (Electoral Changes) Order 2018
(Selected Wards only)
Exning
Newmarket East
Newmarket North
Newmarket West Clare, Hundon and Kedlington
All Haverhill Wards (West, North, East, South, Central and South East) Withersfield

Braintree District Council as defined by Braintree (Electoral Changes) Order 2014
(One Ward only)
Bumpstead

ANNEX 2: THE STAFF CONSTITUENCY
(Paragraphs 8.4 and 8.5)
There shall be a single Staff Constituency.
The minimum number of staff members is 50.

ANNEX 3: THE PATIENTS' CONSTITUENCY
(Paragraphs 10.4 and 10.6)
There shall be a single patient constituency.
The minimum number of patient's members is 50

ANNEX 4: THE REST OF ENGLAND CONSTITUENCY
(Paragraphs 11.1 and 11.3)
There shall be a single rest of England constituency.
The minimum number shall be 200.

ANNEX 4 5: COMPOSITION OF COUNCIL OF GOVERNORS
(Paragraphs ~~14.2~~ 15.2 and ~~14.3~~ 15.3)

Elected governors	
Patient Governors	Eight
Public Governors	Seven
Staff Governors	Four
Rest of England Governor	One
Total Elected	~~Nineteen~~ Twenty

(noting that the Governor seat would only be eligible to be included in Elections if the minimum target number of members (200) is reached. Until that time there is no requirement to seek a governor to represent the Rest of England constituency).

Council of Governors

Cambridge University Hospitals NHS Foundation Trust

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Governor Elections 2026

Report to the Council of Governors

25 March 2026

Agenda item	8
Title	Report from the Chief Governance and Performance Officer
Sponsoring executive director	n/a
Author(s)	Interim Head of Corporate Governance
Purpose	To note the plans in place to undertaken Governor Elections in 2026
Previously considered by	n/a

Executive Summary

The report provides an update on the plans in place to take forward the Governor Elections in 2026.

Related Trust objectives	All
Risk and Assurance	n/a
Related Assurance Framework Entries	n/a
Legal and regulatory implications?	NHS 2006 Act as amended by the 2012 and 2022 Acts

Action required by the Board of Directors

The Council of Governors is asked to note plans in place to undertaken the Governor Elections in 2026 to meet the requirements of the Trust's Constitution, aligning to the NHS legal framework.

Cambridge University Hospitals NHS Foundation Trust

Council of Governors Meeting
25 March 2026

Governor Elections 2026 Update

Report from the Chief Governance and Performance Officer

1.0 Background

1.1 This paper aims to provide the Council of Governors with an update on plans to undertaken Governor Elections to fill available seats, in accordance with the Trust's Constitutional requirements and aligning to the NHS legal framework.

2.0 Seats Available in the 2026 Elections

2.1 The following positions are available for nominations:

Constituency	Number of seats
Staff	1
Patient	3
Public	3

2.2 To apply to be a Governor in this election round, people need to be a member aged 16+ in a constituency that has an available seat before the election process commences, when the notice of election is declared open.

3.0 Election Timetable

3.1 The next round of elections for the Council of Governors is planned to take place during April, May and ending on 30 June 2026. Details on the various stages of the election process are provided below:

Election Stage	Date
Notice of Election/nomination open	Tuesday, 21 April 2026
Nomination Deadline	Tuesday, 19 May 2026
Summary of valid nominated candidates published	Wednesday, 20 May 2026
Final date for candidate withdrawal	Frida7, 22 May 2026
Notice of Poll published	Monday, 8 June 2026
Voting packs dispatched	Tuesday, 9 June 2026
Close of election	Monday, 29 June 2026
Declaration of results	Tuesday, 30 June 2026

4.0 Membership Information

4.1 To ensure that the membership information that is held is as accurate as possible arrangements are made for a data cleanse exercise to be undertaken on a regular basis. This exercise will be undertaken in advance of the election process commencing, which will also include communication with the Trust's volunteers with the aim of their transition to be as smooth as possible. As previously agreed volunteer members will move from the staff constituent area in advance of the elections commencing, whilst the Trust honours the Governor Volunteer seat until the end of his term.

4.2 Volunteers for example, will be asked of their preferred choice of membership: public, patient or Rest of England (*subject to Council of Governor and Board approval*) and arrangements will be made for the membership database to be updated accordingly, in advance of the Election process commencing. This data cleanse exercise aims to give all members of the Trust the opportunity to be fully engaged in the forthcoming election process.

5.0 Following this round of Elections

5.1 Successful candidates will be required to attend a Governor induction before attending any Governor meetings going forward. Governor inductions will be arranged to take place during June 2026.

- First Council of Governor meeting: 24 June 2026

6.0 Recommendation

6.1 The Council of Governors is asked to note plans in place to undertake the Governor Elections in 2026, to meet the requirements of the Trust's Constitution, and to align with the NHS legal framework.

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Membership Engagement Terms of Reference

Report to the Council of Governors

25 March 2026

Agenda item	9
Title	Report from the Chief Governance and Performance Officer
Sponsoring executive director	n/a
Author(s)	Interim Head of Corporate Governance
Purpose	To note and approve the updates to the Membership Engagement Group Terms of Reference
Previously considered by	n/a

Executive Summary

The Terms of Reference were reviewed by the Membership Group in July 2025 to reflect the implementation of the Patient and Public Involvement (PPI) Framework work, which sets out the vision, aims and approach to make sure Cambridge University Hospitals NHS Foundation Trust (CUH) listens to and involves patients and its diverse communities in developing services and research. It was noted that changes to the Terms of Reference required formal approval by the Council of Governors and a further review of the Terms of Reference was undertaken by the Group on 3 March 2026 in advance of presenting to the Council of Governors for approval.

The summary of changes to the Terms of Reference include:

- Change of name from Membership Engagement Working Group to Membership Engagement Group (MEG).
- Chair of the Group to be nominated by the Trust's Chair. In the Chair's absence a Patient/Public or Lead Governor from the Group's membership will chair the meeting.
- Quorum added to include at least three members of the Group inclusive of at least one Patient and Public Governor, the Chair of the Group or Lead Governor.
- An open invitation for the Trust Chair to attend any meetings.
- Terms of Reference to be reviewed at least annually to support good governance working practice.

Related Trust objectives	All
Risk and Assurance	n/a
Related Assurance Framework Entries	n/a
Legal and regulatory implications?	NHS 2006 Act as amended by the 2012 and 2022 Acts

Action required by the Board of Directors

The Council of Governors is asked to note that the Membership Engagement Group approved the updated Terms of Reference at its recent meeting held on 3 March 2026 for submission to the Council of Governors for consideration of formal approval.

Cambridge University Hospitals NHS Foundation Trust

Membership Engagement Group

Terms of Reference

1. Purpose and authority

1.1 The Membership Engagement Group (the group) is a Group of the Council of Governors to align to the statutory duties of the Trust's Constitution.

1.2 The purpose of the group is to support the Trust's work to engage with patients and public members and our wider communities, particularly those who are often underserved.

This group will:

a) Support the implementation of the Patient and Public Involvement Framework, which sets out Cambridge University Hospital NHS Foundation Trust's (CUH) vision, aims and approach to make sure we listen to and involve patients and our diverse communities in developing services and research.

b) Support efforts to engage with patients and our diverse communities as part of understanding what matters to them and promoting Trust Membership.

c) Find better ways to involve people from all backgrounds in our work, so that people can have a say in how our services could be improved.

d) Review how well the Trust is involving patients, members and our wider communities and share feedback with the Council of Governors.

1.3 Any changes to these Terms of Reference must be formally agreed at a Council of Governors meeting.

2. Membership of MEG

2.1 The members of the MEG shall comprise of:

- Two Partnership Governors
- Two Patient Governors
- Two Public Governors
- One Staff Governor
- Lead Governor

2.2 The Chair of the Group will be nominated by the Trust Chair from the Group's membership. In the Chair's absence a Patient/Public or the Lead Governor from the Group's membership will chair the meeting.

2.3 The Trust Chair, as Chair of the Council of Governors, will have an open invitation to attend any meeting.

2.4 Other staff members at the Chair's discretion will be invited to attend the meetings to support the workings of the Group, such as the Chief Governance and Performance Officer, a representative from the Trust Secretariat, a representative from the Patient and Public Involvement/Communications Team and any other member of staff as required.

2.5 The quorum is at least three members of the Group inclusive of at least one Patient and Public Governor, the Chair of the Group or the Lead Governor.

3. Support arrangements

3.1 The Chief Governance and Performance Officer will ensure that administrative support is provided by the Trust Secretariat and Communications Team.

4. Frequency of meetings

4.1 The group will meet three times per year.

4.2 In agreement with the Trust Secretariat, the Chair may request additional meetings to discuss urgent matters.

5. Review

5.1 The Terms of Reference will be reviewed by the Membership Engagement Group and approved by the Council of Governors at least annually.

Date approved Membership Engagement Group: 3 March 2026
Date Approved by Council of Governors:
Next review date: March 2027

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Report to the Council of Governors: 25 March 2026

Agenda item	11
Title	Chief Executive Officer and Executive Team update
Sponsoring executive director	Nicola Ayton, Acting Chief Executive
Author(s)	Executive team members Director of Governance and Performance Director of Analytics and Insights
Purpose	For discussion and note
Previously considered by	n/a

Executive Summary

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

On the 18 March 2026, NHS England published the latest league tables under the NHS Oversight Framework (NOF), designed to give patients a clearer view of how services compare.

CUH continues to perform well in finance, productivity and workforce, and we have also seen improvements in the quarter to December, including an overall move to Segment 2 and stronger cancer performance in the 28-day faster diagnosis standard where we are in the top 10 Trusts nationally.

There’s still more to do to reduce waits for elective care, improve UEC 4-hour performance and address discharge delays, which remain our most pressured areas.

The Trust was formally notified by NHS England on 6 February that it had received a rating of Amber-Green under the annual Provider Capability Assessment. Amber-Green is the second highest rating available of four and reflects an assessment that while the trust has some capability, there are emerging concerns or specific areas requiring attention.

Related Trust objectives	Improving patient care; Supporting our staff; Building for the future
Risk and Assurance	The paper describes improvements planned to the IPR, which will enhance assurance and address BAF risk 018.
Related Assurance Framework Entries	018 – Data and Governance
How does this report affect Sustainability?	N/A
Does this report reference the Trust's values of “Together: safe, kind and excellent”?	No

Action required by the Council of Governors

The Council of Governors is asked to note the updates provided by the executive team.

Council of Governors

25 March 2026

Report of the Chief Executive Officer and Executive Team update

1. Introduction

This report provides the Council of Governors with an overview of current organisational performance, key risks and areas of focus across the Executive portfolios as we enter the final quarter of 2025/26. It highlights progress in safe and effective care, operational performance, people, finance and planning, and major strategic programmes. The update reflects steady movement in several priority areas—including improvements in elective recovery, cancer and diagnostics performance, and the continued implementation of our new 2026–2031 Trust Strategy—while also setting out where pressures remain and where further targeted action is underway. It is intended to support the Board's discussion and assurance by providing clear insight into both the progress achieved and the challenges that require continued executive attention.

2. Executive Team update

2.1 Safe and effective care

2.1.1 Quality and safety

- Infection, Prevention & Control (IPC): Following an internal review of the Trust's IPC approach, a number of recommendations are being taken forward to strengthen and refresh our approach.
- Orthopaedics – bone cement shortage: A National shortage of bone cement impacted elective orthopaedic surgery, initially requiring prioritisation of trauma and urgent cases; the Trust was required to cancel 9 operations as a result. A new product has now been sourced via NHS England procurement, and the service is now functioning under business-as-usual arrangements, with no further patient cancellations expected.
- Dialysis Units: Our satellite dialysis units report sustained capacity pressures and increasing safety risks. Internal actions are in place to address issues including longer opening hours.
- Never Events: 7 Never Events have been reported (April–February), primarily wrong site/wrong patient procedures and retained foreign objects. Themes include inconsistent patient identification and variation in safety critical processes. Improvement actions include strengthened National Safety Standards for Invasive Procedures, updated checklists, human factors support and targeted micro teaching.
- Falls: January falls rate was 3.43 per 1,000 bed days (ceiling 3.25). Divisional action plans are in place to increase safety and reduce falls risk. Compliance with lying and standing blood pressure for inpatients

aged 65 and over remains low at 25%, indicating persistent gaps in assessing postural hypotension risk.

- External specialty reviews: The Trust has recently hosted a series of external specialty reviews, reflecting our continued commitment to strengthening clinical governance and, in parallel, reinforcing our Maintaining High Professional Standards (MHPS) processes. As part of this work, three additional investigations commenced in Quarter 3, ensuring timely and robust management of emerging concerns.
- Quality Governance review: An external review of quality governance structures in the Trust has been completed. Recommendations to strengthen processes, capability and data flows have been accepted and will be moved into a robust improvement plan.
- Good Quality Care Every Day: The initial introduction phase of the quality audit digital GENOME programme is now concluding with positive quality assurance outcomes and good feedback from clinical teams. As the programme moves into its next stage, it will start to support ward to board visibility of quality themes and provide more reliable data to inform improvement.
- Maternity Incentive Scheme: The Trust achieved full compliance with all ten Maternity Incentive Scheme Year 7 safety actions, with Board confirmation providing strong assurance of safe and well governed maternity care.
- Complaints and PALS: As per the Accountability Framework, the Complaints and PALS service have moved into enhanced oversight due to persistent delays in complaint responses, the reputational impact of the overdue complaints backlog, high numbers of open PALS concerns, and the resulting impact on patient satisfaction and perceived quality of care. A recovery plan is in place with oversight by the Chief Nurse.

2.1.2 Verita investigation report implementation

Learning, Accountability and Change action plan

- The Trust has made strong early progress in delivering the commitments published in response to the Verita investigation. Progress has been made against all twelve 3-month commitments, with the majority delivered by the 30 January 2026 milestone. A smaller number require further embedding and focus over the 6 and 12-month period.

2.2 Access and operational performance

2.2.1 Urgent and Emergency Care (UEC)

- Since the start of 2026, across the region there has been a sustained period of significant pressure on urgent and emergency care services. On 8 and 28 January the extent of pressures triggered escalation to internal critical incident. The resulting response enabled the hospital to de-escalate within the 24-hour period on both occasions. This approach reflects our commitment to prioritising safe care for patients.

- In January, performance against the UEC access standards has been below planned levels, with 4-hour access standard deteriorating to 67.8 percent. Following the launch of the UEC Taskforce the same month, a comprehensive action plan setting out interventions driving recovery has been set out. In the second half of February, there has been an improvement in the levels of performance with performance against the 4-hour standard reported at 69.7 percent for the week ending 25 February.
- CUH are fully engaged with the programme led by NHS England for all providers to deliver planned levels of performance in March as part of the national Spring Reset programme. Planning is underway for sustaining the rate of improvement over the coming financial year, to deliver a 4-hour performance of 82 percent by March 2027. This includes implementation of recommendations set out by NHS England concerning the first 72 hours or care and the new GIRFT Model Emergency Department. A baseline analysis against these documents was reported to the CUH Management Executive on 26 February 2026.

2.2.2 **Planned care**

- Performance against the 18-week wait standard is the priority for delivery in Quarter 4 across the NHS and is the focus of fortnightly Tier 1 meetings with NHS England. From early January to mid-February the level of performance increased from 58.3 percent to 60.3 percent. During the same timeframe the number of patients on the overall waiting list for planned care reduced from 65,253 to 63,484.
- There has also been progress in reducing the number of patients experiencing the longest waits for planned care. As of 22 February 2026, there were 1,589 patients waiting over 52 weeks, down from a peak of 3,055 in mid-July 2025. Plans are in place to eliminate waits exceeding 65 weeks by the end of May 2026.
- The elective performance recovery programme comprises a range of interventions managed through the weekly Elective Taskforce. These include: the Spring-to-Spring project, which has delivered over 700 additional treatments and appointments successfully concluding patient pathways since mid-January; expanding capacity in arrangements with the independent sector and supporting specialties with the most significant challenges with additional operational management resource and clinical leadership time. These interventions are supported by national resource made available to providers through a number of sprint initiatives, resourcing additional capacity in Quarter 4.

2.2.3 **Cancer and Diagnostics**

- In December, CUH ranked fifth highest of all hospitals for the speed with which patients are diagnosed following referral on a suspected cancer pathway. The performance of 85.5 percent represents a significant turnaround following a deterioration to lower than 70 percent during the summer of 2025.

- Performance against the 62-day cancer standard has also improved since the summer, with December delivering the agreed recovery trajectory at 74.0 percent. Delivering the 31-day cancer standard is more challenging in particular until in Radiotherapy equipment is replaced in the autumn of 2026, delivering sufficient capacity to deliver the national standard. In the interim, CUH has sought support from another NHS provider and agreed short term capacity from the independent sector.
- Diagnostic waiting times have deteriorated over the last 3 months due to a combination of increased demand (linked to elective recovery) and gaps in capacity. The Diagnostic Taskforce is overseeing recovery plans and will agree trajectories for improvement to report to NHS England in March reflecting the Tier 2 performance arrangements for diagnostic recovery.

2.3 People

2.3.1 In Month 10 the Trust is 38 Whole Time Equivalent (WTE) above the workforce plan. This was driven by temporary staffing levels above plan due to both industrial action and to support improvement in operational performance. Bank usage has increased by 8.4%, and agency 13% in month. Prior to the end of the year, the increase is likely to grow, including for substantive staff, given in year agreed plans and continued planned performance recovery.

2.3.2 Sickness absence is comparatively low (compared to peers) across the last 12 months (the 12 months rolling absence is 4.2%, 0.1% above the NHSE target for 2026/7), but it is still at a level that is of concern. An enhanced absence management programme has been initiated to reduce absence in 2026/27 and to reduce temporary staffing spend. This is focussed on teams with above 4.1% absence and includes wellbeing programmes to support staff to stay well, compliance with process measures, actions based on data analysis and support to managers.

2.3.3 The Trust continues to perform well on mandatory training compliance (at 93.8%) albeit with some hotspots that are being addressed. A focus on this through quality and performance meetings has had a positive impact.

2.4 Finance, productivity and planning

2.4.1 Finance

- M10 finances are £1.9m better than plan; with year-to-date performance at £0.2m surplus.
- CUH remain on track to deliver breakeven for the full year and are working with Cambridgeshire and Peterborough system partners to understand the financial risks that exist in partner organisations.
- £3.4m of funding support for the financial impact of industrial action in 25/26 has been provided by NHS England.

2.4.2 Productivity

- The overall Productivity and Efficiency Plan is on track to deliver in full (£92m). However, this includes £9m of non-recurrent schemes that will add to the financial pressure next year. The focus with divisions is on improving the financial run-rate with a particular focus on improving productivity to support the Trust to exit the year sustainably.
- Per national benchmarking, the Trust has a 4.1% year-on-year improvement in productivity as at month 7 (4th best performing acute Trust in our region) – 1.2% cost reduction and 2.9% increase in output. The growth in output is largely from increases in non-elective activity rather than elective pathways.

2.4.3 Annual business planning

- A final 3-year numerical plan and 5-year narrative plan submission was made on 12 Feb 2026.
- The plans showed financial breakeven in year 1, but a £26.2m deficit in year 2 and £47.6m deficit in year 3; alongside achievement of RTT compliance only in year 1. The plan has a significant focus on achieving productivity improvements. There is more risk in years 2 and 3 given challenging operational improvement trajectories to return to constitutional standards by the end of 2028/29.
- Commissioner negotiations are ongoing, and so we don't yet know how much we will be paid, which represents a risk to plans (financial and operational).

2.5 Strategy, major projects and innovation

2.5.1 Strategy

- CUH's new 2026-2031 strategy anchor document was approved by the Trust Board in February 2026. This replaces the CUH Together 2025 strategy and sets out a clear 5-year focus on performance, transformation and translational research, informed by engagement with over 900 staff, patient groups and external partners.
- Our new strategy provides our approach to increasing demand, national policy shifts and opportunities associated with our role within the Cambridge Biomedical Campus. While our vision remains the same: 'a healthier life for everyone through care, learning and research', our priorities have evolved. These are to: deliver excellent and timely care; transform how and where we deliver care, and harness research and innovation to improve patient outcomes.

2.5.2 Innovation

- The innovation programme is focused on 3 core areas: implementing new platforms and governance, piloting the latest technologies and establishing a Clinical Data Science Unit.

- Implementation of the new platforms and governance will enable the safe evaluation and adoption of artificial intelligence – including a large pipeline of projects spanning AI interpretation of x-rays in ED, prioritising Head CT scans, and testing UoC-developed genomics algorithms. The latest technologies to be piloted include Ambient Voice Technology, which is now in use across several outpatient services, and contact tracing using Ultra Wide Band wearables to limit infection outbreaks.

2.5.3 Neighbourhood Health

- Following work to bring together the 3 programmes of work delivering on elements of a neighbourhood health service, we are continuing to accelerate progress in delivering integrated, proactive care closer to home, and to address health inequalities in our area. This is a key strand of the new Trust strategy.
- Our vision is that CUH will operate in partnership to co-develop a Neighbourhood Health Service that supports people to stay well in their own communities. Specialist input, diagnostics, urgent help and research participation will be available in community hubs and virtual settings, networked with the acute hospital. We are developing 5-year priorities to support this vision, which will be informed by forthcoming Government guidance on neighbourhood health.

2.5.4 Cambridge Cancer Research Hospital

- The Cambridge Cancer Research Hospital (CCRH) programme is in a strong position, with agreement reached regarding the programme's funding strategy, significant progress made with philanthropy, and a confirmed construction programme in place. The construction cost is currently being market tested, providing increased assurance around the deliverability of the programme. Governance is also being reviewed to ensure the programme remains fit for purpose and is engaging appropriately with all key stakeholders ahead of Full Business Case (FBC) submission at the end of 2026. The team continues to work closely with staff and patients on clinical pathways and benefits realisation in the short and long term, and colleagues have been visiting other trusts, both new-build and established, to gain insights and share learnings

2.5.5 Cambridge Children's Hospital

- The Cambridge Children's Hospital team is collaborating with Bouygues UK, our construction partner, to refine the design and planning work, ensuring best value for money under an initial preconstruction services agreement. Progress continues across all aspects of the Full Business Case (FBC), including detailed development of how the integrated CCH will operate and be governed, delivering meaningful research and clinical benefits across the region. Engagement remains a key focus, with ongoing consultation involving regional clinical partners, children

and young people, parents and carers. We are also expanding our work with the staff who will be based in the new hospital, supporting them to think ahead to future ways of working. Fundraising for the new hospital has passed the halfway point towards its £100m target, attracting strong support from philanthropists both in the UK and internationally.

2.5.6 **Genomics**

- CUH has been confirmed as the preferred provider for the East Genomic Medicine Service (GMS) contract. Contract negotiations are ongoing, with the financial envelope the primary focus and an intended start date of 1 April 2026. The new single-contract model brings together laboratory delivery and clinical adoption, requiring a shift to a more integrated, region-wide operating model and strengthening of core capabilities including leadership, performance management, digital integration and business support.
- From April 2026, the programme will move into a second phase focused on organisational change, implementation of a fit-for-the-future management structure, scaling improvement, and development of the longer-term technology and estates solutions.

2.5.7 **Research**

- Research has been confirmed as one of the priorities in the new CUH strategy.
- The implementation workstreams of the CUH research review continue to meet regularly with clear executive sponsorship, progressing agreed priorities and actively managing risks, dependencies and cross-organisational alignment.

2.5.8 **Digital**

- Over 10,000 appointments have been scheduled by patients as part of our self-scheduling implementation. We have over 30 specialties live with self-scheduling and a further 34 scheduled to implement this functionality in March 2026. This capability supports productivity through reducing the burden on booking and scheduling teams, aims to increase clinic utilisation by allowing patients to book into clinic slots that become available at the last minute and by reducing rates of patients not presenting to scheduled appointments, and has the benefit of improving patient experience at the same time. We are shortly commencing a survey of patient experience of this technology.
- The Ambient Voice Technology pilot is progressing well. A second phase is commencing to enable more clinicians to access this technology. We are partnering with the THIS Institute to support evaluation of the pilot.
- We are focussed on supporting staff to optimise their use of our digital systems, and particularly our electronic patient record (EPR). We know staff that undertake ongoing training are more efficient and we are

taking action to ensure that all staff undertake ongoing training. This will include increasing participation in our Thrive courses, as well as continuing to promote utilisation of uPerform, which provides access to learning materials within the EPR workflow.

- Development of a document that outlines how digital and data will support delivery of the Trust strategy is under development. This will articulate a roadmap for the 5 five years and will support decisions around prioritisation of resources and funding allocated to digital delivery.

3. Integrated Performance Report summary

3.1 The Trust identified a risk, added to the Board Assurance Framework in December 2025, that the current data reporting infrastructure fails to provide a sufficient level of oversight across the governance structure.

3.2 As a result, a new design of the Integrated Performance Report (IPR) has been developed with executives, with a subset of metrics providing information and insights that are understandable and provide sufficient early warning of performance risk. Key to this is ensuring the insights in the IPR provide assurance to Board about operation of the governance structure.

3.3 An updated version of the IPR will be brought for the board's consideration in June 2026.

3.4 Over the coming months, further work will build the performance data reporting across the governance structure, progressing to service level, to clarify the process of escalation of performance risk.

4. Update on NOF performance for Q3 2025/26

4.1 Overview

4.1.1 On the 18 March 2026, NHS England published the latest league tables under the NHS Oversight Framework (NOF), designed to give patients a clearer view of how services compare. (see table below).

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

4.1.2 CUH continues to perform well in finance, productivity and workforce, and we have also seen improvements in the quarter to December, including an overall move to Segment 2 and stronger cancer performance in the 28-day faster diagnosis standard where we are in the top 10 Trusts nationally.

There's still more to do to reduce waits for elective care, improve UEC 4-hour performance and address discharge delays, which remain our most pressured areas.

5. Provider Capability Assessment outcome update

5.1 The Trust was formally notified by NHS England on 6 February that it had received a rating of Amber-Green under the annual Provider Capability Assessment. Amber-Green is the second highest rating available of four and reflects an assessment that while the trust has some capability, there are emerging concerns or specific areas requiring attention.

5.2 Latest intelligence indicates that an update exercise will take place in Q1 2026/27 and thereafter will be timed at a similar period, to coincide with preparation of the annual report and accounts.






NHS
Cambridge University Hospitals
NHS Foundation Trust










Integrated Report

Quality, Performance, Finance and Workforce to end January 26

Chief Finance Officer
Chief Nurse
Chief Operating Officer
Chief People Officer
Chief Medical Officer

Report compiled: 28 February 2026

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

Executive Summary

NHS Cambridge University Hospitals NHS Foundation Trust

Access to services

- Winter pressures significantly affected the Trust in January, leading to the Full Capacity Protocol being implemented for significant periods and an Internal Critical Incident being declared twice. 67.8% of Emergency Department patients were treated within four hours in January, a decline on 69.8% in December. This is attributed to increased attendances, as the conversion rate was stable and the departure rate rose slightly.
- There is an improving trend across the RTT waiting list, long waits, first outpatient and 18-week performance elective care targets, but the trust remains behind plan. In January, 59.9% of patients had been waiting for less than 18 weeks for planned care. In response, the Trust has implemented a Q4 sprint, supported by additional funding from NHSE, with enhanced WLI rates supplementing outsourcing capacity to increase activity. The Trust remains in Tier 1 oversight from NHS England due to the long wait position.
- Cancer FDS and 62-day performance is recovering but 31-day standard performance remains behind plan due to radiotherapy capacity and surgical procedures and risk remains on the sustainability of the 62-day performance recovery based on its dependency on FDS performance, particularly in breast and skin modalities.
- Diagnostics performance has deteriorated further in January, with 27.3% of patients now waiting more than six weeks for a test. The modality drivers are imaging and echo, due to rising direct access demand and capacity challenges. The Trust has entered Tiering oversight from NHS England for diagnostics performance.

Effectiveness and experience

- There has been normal variance in the total number of deaths at CUH. In January 2026, there were 128 inpatient deaths, 20 deaths in the Emergency Department (ED), and none in the Virtual Ward.
- Patient experience, measured through the Friends and Family test indicated the inpatient 'Good' score declined by 1.5% compared to December to 90.0% of responses, against a mean of 94.1%. The 'Poor' score also worsened, representing 5.0% of respondents (+0.5% on December; mean 2.5%). The number of responses remained similar to December.

Patient safety

- There were 2 cases of hospital onset MRSA bacteraemia in January 2026. ▪ Compliance with the MRSA care bundle (decolonisation) was 69.1% in January 2026 (74.0% in December 2025).
- The Trust rate of PSIs with moderate harm or above in January 2025 was 1.3%; 4/5 divisions were below the 2% threshold for moderate harm & above.
- There is a continued statistically significant decrease in three of the death metrics (by rate per 1000 admissions/attendances): ED, Total non-elective, and inpatient.
- There has been a statistically significant increase in the reporting of patient safety incidents. This may reflect a good reporting culture or may be related to an emerging issues – further analysis is required to help clarify the changes in variance.
- The total number of HAPUs across the Trust showed a statistically significant increase in January 2026. However, the rate of HAPUs per 1,000 bed days remains within normal variation for the Trust overall.
- The Trust ceiling set for falls per 1000 bed days is 3.25, in January it was 3.43 the lowest it has been for the preceding 10 months. The Trust continues to remains non compliant with lying and standing blood pressure for inpatients over 65 years which is at 25%.

Finance and productivity

- The Month 10 year to date financial position is £0.2m surplus for performance management purposes, ahead of plan by £1.9m. A £2.4m adverse variance to plan in month is driven by expenditure relating to RTT recovery. The Trust forecast remains to deliver the breakeven financial plan at year end. However, premium pay expenditure and the expansion of workforce to meet RTT targets is a key risk to in-year performance and maintenance of breakeven financial performance in 26/27. More detail slide 17.

People and workforce

- Workforce plan v actual - in month 10 the workforce is 38 WTE above the plan. This is driven by temporary staffing levels above plan due to both industrial action and to support improvement in RTT performance. Bank has increased by 8.4%, and agency 13% in month. Prior to the end of the year, the increase is likely to grow, including for substantive staff given in year agreed plans and continued planned RTT recovery.
- Sickness absence is low compared to peers across the last 12 months (the 12 month rolling absence is 4.2%, 0.1% above the NHSE target for 2026/7), but it is still at a level that is of concern. An enhanced absence management programme has been initiated to reduce absence in 2026/27 and to reduce temporary spend. This is focussed on teams with above 4.1% absence and includes compliance with process measures, actions based on data analysis and support to managers and staff.
- The trust continues to perform well on Mandatory training compliance (at 93.8%) albeit with some hotspots that are being addressed. A focus on this through quality and performance meetings has had a positive impact.

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
		Nov 25	Dec 25	Jan 26						
Safe	Nutrition screening compliance for admitted patients	89.9%	90.8%	90.9%	≥90%	Mar-26	91.7%	85.9%	H	F
	Hospital acquired pressure ulcers (category 2 +) per 1000 bed days	1.160	0.916	1.106	≤0.395 per 1,000 bed days	Mar-26	0.905	0.880		F
	Waiting time(s) in triage (Maternity - Midwife review)	98.8%	97.8%	98.9%	85.0%	Mar-26	98.1%	N/A		
	Waiting time (Maternity Triage - Obstetrician review)	81.9%	74.8%	76.2%	85.0%	Mar-26	78.6%	N/A		
Patient Experience / Caring	Responses to service user complaints are within agreed time frames	46.2%	59.3%	45.6%	80.0%	Mar-26	48.2%	56.7%		
	Dementia Care -Percentage of admitted patients with completion of "What's Important for Me" where diagnosis of dementia is established.	22.6%	20.3%	N/A	50.0%	Mar-26	29.2%	28.1%		
Effective / Responsive	Locally reported SDEC (same day emergency care) activity as a % of emergency activity	28.2%	28.5%	30.0%	30.0%	Mar-26	29.5%	25.0%		
	>12hr waits in ED (type 1)	10.5%	9.6%	14.1%	TBC	Mar-26	10.0%	12.4%		
	Waiting times for first Outpatient appointment (RTT)	62.8%	63.5%	65.2%	65.9%	Jan-26	61.5%	63.8%		
	Inpatient Bed Occupancy (KH03 Definition - monthly)	89.2%	85.1%	87.9%	92.8%	Mar-26	87.9%	87.9%		
Improving Outcomes	Smoking Cessation – Number of Inpatient referrals for acute admissions (excl. elective and Maternity)	52	55	38	>35 / month	Mar-26	476	68		
	Smoking Cessation – Number of 28 day confirmed quits (last 3 months)	40	37	20	20% at year end	Mar-26	367	56		
		2021	**Annual 2022**	**2023**						
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
		Nov 25	Dec 25	Jan 26						
Infection Control	MRSA Bacteraemia (hospital onset cases)	0	0	2	0	Mar-26	5	0		
	E.coli Bacteraemias (Total Cases)	29	39	29	TBC	Mar-26	365	36		
	C. difficile Infection (hospital onset and COHA cases) or C. difficile Infection (hospital onset)	6	15	13	<=134 cases (HOHA and COHA).	Mar-26	107	10		
	Hand Hygiene Compliance	N/A	95.1%	93.9%	TBC	Mar-26	93.7%	93.0%		
Nursing Quality Metrics	Blood Administration Patient Scanning	100.0%	99.9%	100.0%	90.0%	Jan-26	99.9%	99.9%	H	?
	Blood Administration Product Scanning	99.8%	99.8%	99.8%	90.0%	Jan-26	99.3%	97.6%	H	?
	Moving & Handling	87.5%	88.2%	88.2%	90.0%	Jan-26	89.4%	84.1%	H	F
	Nurse Rounding	99.4%	99.4%	99.3%	90.0%	Jan-26	99.5%	99.5%		P
	Pain score	91.5%	92.1%	91.6%	90.0%	Jan-26	91.7%	83.6%	H	F
	MEOWS Score Recording	90.5%	90.3%	89.4%	90.0%	Jan-26	86.9%	87.1%		?
	PEWS Score Recording	93.0%	94.3%	93.1%	90.0%	Jan-26	93.9%	97.7%	L	P
	NEWS Score Recording	98.4%	98.3%	98.5%	90.0%	Jan-26	98.4%	98.3%		P
	VIP Score Recording	95.2%	95.2%	95.4%	90.0%	Jan-26	95.5%	91.3%	H	?
	PIP Score Recording	91.1%	94.3%	91.0%	90.0%	Jan-26	90.1%	87.6%	H	?
Patient Experience	Mixed sex accommodation breaches	157	63	74	0	Jan-26	648	36	H	?

Operational Performance

NHS Cambridge University Hospitals NHS Foundation Trust

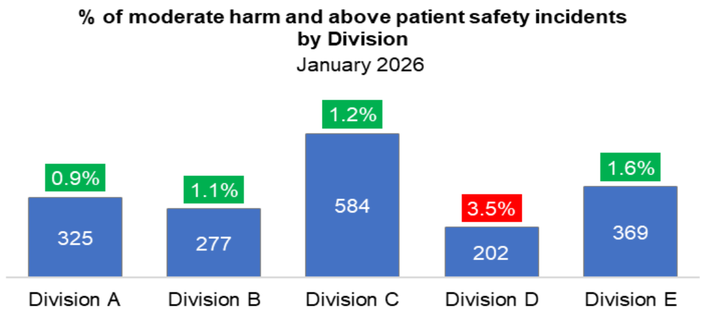
Point of delivery	Performance Standards	SPC variance	In Month Actual	In Month plan	Target	Target due by	Page
Urgent & Emergency Care	4hr performance	Normal variation	67.8%	75.4%	78.0%	Mar-26	**Page 15**
	12hr waits in ED (type 1 unplanned)	Normal variation	14.2%	-	-	-	
	Ambulance handovers <15mins	Normal variation	39.3%	-	N/A	Immediate	
	Ambulance handovers <30mins	Normal variation	63.5%	-	N/A	Immediate	**Page 16**
	Ambulance handovers < 45mins	Normal variation	70.0%	-	100.0%	Immediate	
Cancer	Cancer patients < 62 days	Normal variation	74.0%	75.9%	70.0%	Immediate	**Page 22**
	28 day faster diagnosis standard	Normal variation	85.5%	81.4%	75.0%	Immediate	**Page 21**
Outpatients	First outpatients vs plan (consultant led)		102.6%	-	-	-	**Page 23**
	Follow-up outpatients (consultant led)		99.5%	-	-	-	**Page 24**
	Advice and Guidance Requests	Normal variation	11.0%	-	-	Mar-26	
	Patients moved / discharged to PIFU	Positive special cause variation	5.1%	6.5%	6.8%	Mar-26	**Page 25**
RTT Waiting List	RTT Patients < 18 wks for first treatment	Positive special cause variation	59.9%	62.5%	-	-	**Page 18**
	RTT Patients < 18 wks for first appointment	Positive special cause variation	65.2%	65.9%	-	-	**Page 20**
	RTT Patients waiting > 52 weeks	Positive special cause variation	2.7%	1.6%	-	-	**Page 19**
	Total RTT waiting list	Normal variation	62,482	0	-	-	**Page 18**
Productivity and efficiency	Non-elective LoS (days, excl 0 LoS)	Normal variation	8.8	-	-	-	
	Long stay patients (>21 LoS)	Negative special cause variation	229.8	-	-	-	
	Elective LoS (days, excl 0 LoS)	Normal variation	4.9	-	-	-	
	Discharges before noon	Positive special cause variation	18.9%	-	-	-	
	Theatre sessions used (Elective)	Normal variation	94.1%	-	-	-	
	In session theatre utilisation	Negative special cause variation	78.4%	85.0%	85.0%	-	**Page 27**
	Virtual Outpatient Attendances	Positive special cause variation	21.0%	-	-	-	
	BADS Daycase + OP Rate (local)	Normal variation	88.0%	85.0%	-	-	**Page 28**

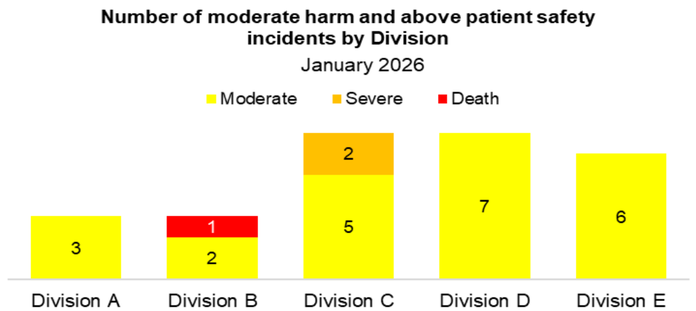
Author(s): Various **Owner(s): Nick Kirby**

Patient Safety Incidents (PSIs)

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Threshold	Jan-26	Average (Feb-23 - Jan-26)	Variance	Special causes	Comments
Number of **patient safety incidents**	-	1944	1735		Shift	The Trust has seen a statistical increase in patient safety incidents for the last 7 months since July 2025. Division A has seen a statistical increase for the last 8 months, all other Divisions are within normal variance. In January 2026, the highest category type was Medication which also has a statistical increase in the last 11 months.
Rate of patient safety incidents **per 1,000 admissions**	-	99.3	96.5		-	There was normal variation in January, although Division B has seen a statistical decrease in the last 11 months. There were 19,584 admissions and 1,944 incidents affecting patients at time of reporting. Division A moved to normal variance in January (from an increase).
Rate of patient safety incidents resulting in **moderate harm or above**	≤2%	1.3%	1.7%		-	There is currently normal variance across the Trust and in all Divisions. All Divisions except Division D were below the 2% threshold in January 2026. In January there were 23 patient incidents graded moderate harm, 2 severe, and 1 death.
Number of patient safety incidents moderate harm and above, where **Learning Response not commissioned within 14 days** of reporting	0	4	7		Shift	Of the 4 moderate harm or above incidents awaiting a learning response, there was 1 in Division A, 1 in Division C, and 2 in Division D.
Number of patient safety incidents with moderate harm or above, **open after 60 days**	0	97	45		SP	Of the 97 moderate or above patient safety incidents overdue, five incidents are now overdue by more than a year (previously reported two). 4 in Division E and 1 in Division B (PSII) - plans in place to complete and close.





- In January there were: **23 moderate** harms (2 communication,1admission, 1 clerical apt., 3 diagnosis, 1 discharge, 2 falls, 4 implementation of care, 1 infection, 4 medication, 1 pressure ulcer, 1 foetal loss, 1 nutrition; **2 severe** (both falls); and **one fatal** (delayed diagnosis of sepsis (INC52270).
- There are three open Patient Safety Incident Investigations (PSIIs) - two are on track for approval on 02.03.26 The other is on track.
- In January the new operational forums that support our patient safety incident review framework (PSIRF) were successfully launched. The Safety Event Review Forum (SERF) was discontinued and there is now a weekly Patient Safety Executive Huddle. This forum is supported by Divisional incident review meetings (weekly) and a new Patient safety oversight meeting (SOM), to support timely and high quality learning response processes and plans for improvement.

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

Duty of Candour (DOC)

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 26 (last reported 33) overdue cases of Duty of Candour **stage 1:**
- 19 are overdue **by one month or less**
- 7 overdue **by 2 - 3 months**

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

Stage 2

There were 7 (last reported 19) overdue cases of Duty of Candour **stage 2**.

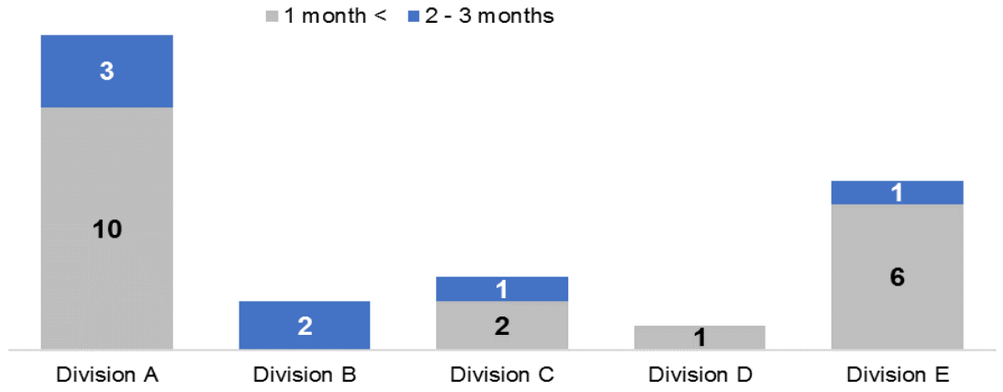
- 5 were overdue **by one month or less**
- 2 overdue **by 2 - 3 months**

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

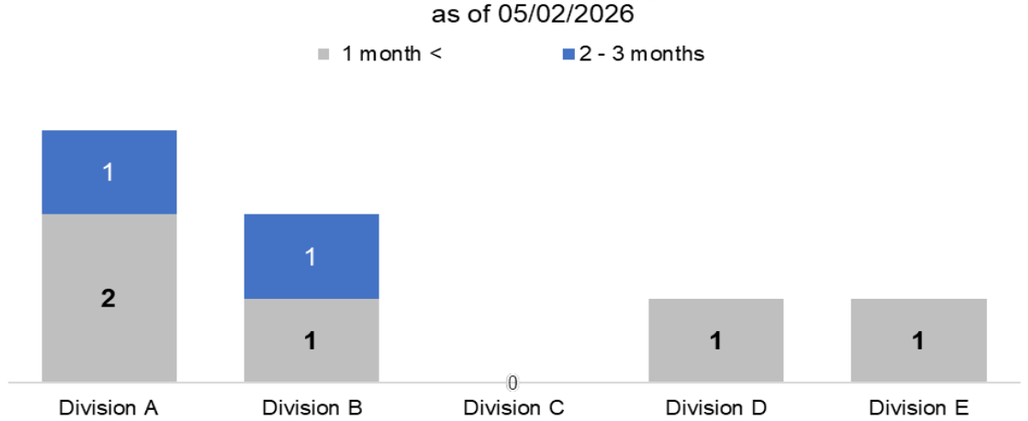
The corporate patient safety team continue to work with divisions to ensure accurate recording of requirements, and addressing outstanding all Duty of Candour.

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 05/02/2026



Number of incidents where DOC stage 2 is overdue
as of 05/02/2026



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

Falls

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Target	Jan-26	Average (Feb 23 - Jan-26)	Variance	Special causes	Target status	Comments
Number of **patient falls**	–	163	169		-	-	The Trust is in normal variance. All Divisions are within normal variance.
Rate of patient falls per **1,000 bed days**	3.25	3.43	3.6		-		After a continued statistically significant increase in the rate of patient falls per 1,000 bed days, this metric in now in normal variance, and the target has been missed. Divisions C has registered a continued statistically significance increase. All other divisions are within the normal variance.
Rate of patient falls resulting in **moderate harm** or above	–	2.50%	2.30%		-	-	The trust is in normal variance. In January 2026, there were four falls resulting in moderate harm or above, corresponding to a rate of 2.5% (equivalent to 0.11 moderate falls per 1,000 bed days). There were two moderate falls (D5 and L5) and 2 severe falls (D5 and ED Cohort Area)
Falls risk screening compliance within 12 hours of admission	≥90%	95.80%	91.40%		SP		The Trust met the target in January 2026 and for the last 21 months. Four wards did not meet the target - CUH RNOH Ward(0%), Emergency Clinic 9 (50%), SDEC SAU (70%), L5 (86%) and A5 (87%).
Percentage of inpatients aged 65 years and over with a **LSBP recorded**	≥90%	25.10%	26.40%		-		Whilst registering normal variance, compliance with this metric is currently low and, without intervention, is statistically expected to fail in the future.

Summary

The trust was above the target at 3.43% per 1000 bed days although the number of falls is in normal variance and below average. There were 4 inpatient falls categorised as causing moderate or above harm to patients (2.5% of the January falls). The learning responses are underway for these incidents and will be fed back via the Falls Harm free Care Group meeting to promote shared learning and to ensure that important actions are being progressed. In January, the trust was compliant with the falls risk assessment (95.8%).

Current Position: Although we are meeting screening compliance, we are not meeting the target for falls per 1,000 bed days (3.25%). The trust are not compliant with Lying & Standing Blood Pressure (LSBP) metric for >90% of patients over 65 years being screened. The current compliance is 25.1%.

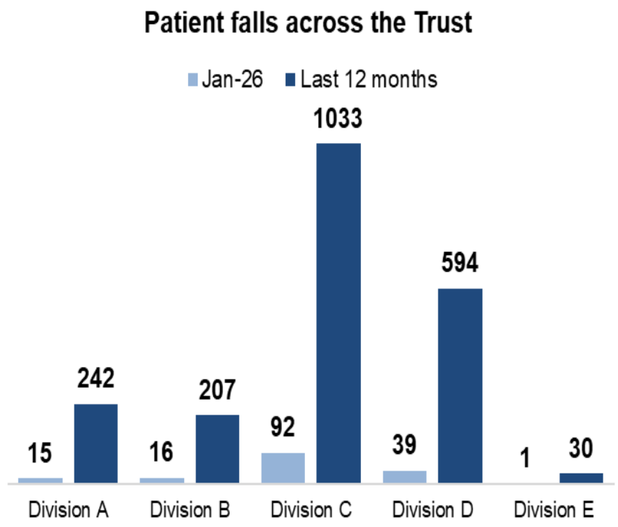
Key Risks: 1) The falls team is running at reduced capacity due to 1 WTE vacancy.

Actions and Improvement 1. An external candidate is due to join the team March 2026. Current focus for the Falls Team is on supporting learning working with matrons and ward managers to conduct the initial stages of the learning response process while continuing to facilitate all Multi Professional Round Tables for inpatient falls categorised as moderate or above harm.

2. A trial of specialist Falls Alarms for use in the toilet/bathroom conducted on Older People's Care Ward (C6 and F4) and Level 8 (Orthopaedics) between October 2025 and January 2026, demonstrating a reduction in toilet/bathroom related falls. Analysis of results will be brought to the Falls HFC group in February. A review of the Falls risk assessment, risk management and post fall assessment tools in EPIC to align to NICE Guidance (April 2025) continues. This links with broader work being undertaken with the E-Hospital team re: admission documentation. These flowsheet assessments are either currently being built or prioritised as 'Priority 2' by the Epic build team. The new Screening and Assessment flowsheet is provisionally due for completion by April 2026.

3. Using Genome Quality Assurance Tool, an electronic post fall audit is being piloted. This aims to support broader for system based learning and thematic analysis to drive quality improvement. It has been successfully piloted by the Falls team and can now be trialled on all wards/department (provisionally in March 2026).

4. A recommendation from the CUH Falls Patient Safety Incident Investigation (PSII) was to review if joint working can occur, to reduce falls care plan duplication and to review if community falls assessments can be incorporated onto Epic. A first system-wide Falls Workshop, focusing on information sharing with all sectors across the ICS occurred on Dec 2025, generated rich and constructive discussions, highlighting opportunities for stronger collaboration. Building on this momentum, a follow-up workshop is currently being planned to further develop the initial ideas planned for April 2026, which will focus on practical methods to improve inter-system communication.



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

Hospital-acquired tissue damage

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Target	Jan-26	Average (Feb-23 - Jan-26)	Variance	Special causes	Target status	Comments
All hospital-acquired pressure ulcers (HAPUs)	-	72	43	H	SP	-	The Trust and Divisions C and E have seen a statistical increase in January 2026. All other Divisions are within normal variance.
Category 2, 3, 4, mucosal, suspected deep tissue injury, and unstageable HAPUs	-	45	32	H	2 of 3	-	The Trust had a statistical increase in two of the last three months, and Division C in January 2026. All other Divisions were within normal variance. In January there were 33 x category 2, 1 x mucosal, 9 x suspected deep tissue injuries, and 2 x unstageable HAPUs.
Category 2, 3, 4, mucosal, suspected deep tissue injury, and unstageable HAPUs by **1,000 bed days**	≤0.395	1.11	0.84		-	F	Division C has seen a significant increase in January. The Trust and all other Divisions remain within normal variance.
Medical device related HAPUs	-	23	17		-	-	The Trust and all Divisions are within normal variance, other than Division E which has seen a statistical increase in January. 48% (11/23) device related HAPUs occurred in Division E.
Pressure Ulcer screening **risk assessment** compliance	≥90%	91.4%	86%		-	?	The Trust and Divisions C and D met the target in January 2026. There has been a continued significant increase in the last 12 months in Division C, and 10 months in Division E. The Trust and all other Divisions are within normal variation.
Hospital-acquired **moisture lesions**	-	28	26	H	Shift	-	The Trust has seen a statistical increase for the last 15 months. All Divisions are within normal variance.

Summary

The total number of HAPUs across the Trust showed a statistically significant increase in January 2026. However, the rate of HAPUs per 1,000 bed days remains within normal variation for the Trust overall. At divisional level, both the total number of HAPUs and the number of category 2+ HAPUs are within normal variation for Divisions A, B, and D. Division C has experienced a statistically significant increase in January for both overall numbers and category 2+, while Division E has seen a significant increase in total HAPUs for the month.

Of the 72 HAPUs; 26 x category 1, 33 category 2, 0 x category 3, 0 x category 4, 1 x mucosal, 9 x SDTI, and 2 x unstageable. The highest reported body locations of HAPUs in January 2026 were the sacrum (22 - a significant increase), those classified as 'Other' (15), heel (11), nose (9), and foot and blank (no body location filled in) (4). The Datix category 'other' body location is within normal variation, and includes lips, buttocks, arm, leg, mouth, cheek, ankle, sternum, forehead, and coccyx HAPUs.

In January, of the 23 x device-related HAPUs; 5 x occurred in Division A, 0 in Division B, 4 in Division C, 3 in Division D, and 11 in Division E. Most devices were classed as 'other' (11) and mask/tubing (5). There has been a continued increase in the number of Moisture Lesions (28) in the last 15 months with Division A (9) reporting the most. 20/28 are reported to be related to 'Continence', which is a HFC priority area for the trust. PU risk assessment screening is within normal variation, Division A, B, and E did not meet the target. Division E however has seen a statistical increase for the last 10 months.

Key Risks:

1) Division C has seen a statistically significant increase of Cat 2+ HAPUs which is being addressed through the HFC HAPU meeting. The reported HAPUs are across several different wards/departments with the highest body locations 'sacrum' and 'heels'.

2) Trolley mattress replacement programme – following IPC concerns which identified trolley mattresses which failed for cover breaches and foam integrity failure.

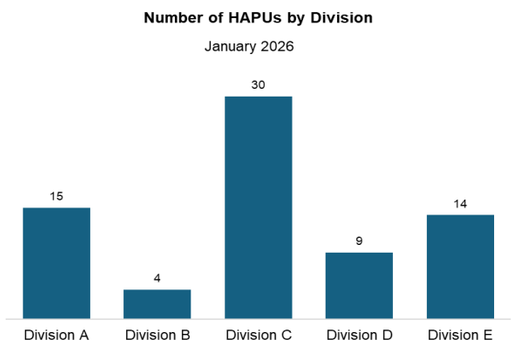
Action and mitigation:

1) Division C has commenced quality improvement work within one ward area following themes and trends from incident investigations and delivered bite sized teaching to standardise skin inspection and how to record the outcome in the Electronic patient record. Upon completion, improvements in practice will roll out to the rest of the division.

2) Using Genome (Quality Assurance Platform) a HAPU audit tool is in development that will help ward managers/matrons to collate and analyse themes and data from HAPUs efficiently. The Tissue Viability team are developing guidance and prompts for the audit build

3) A trolley mattress replacement programme is underway to replace existing trolley mattresses at the end of warranty with high specification foam trolley mattresses. These are being ordered and replaced in a phased way to support a staged and manageable approach across the trust over the next two months.

4) The CUH Pressure Injury Prevention and Management Policy is currently under review to reflect guidance updates from the European Pressure Ulcer Advisory Panel (EPUAP) whilst continuing to reflect the current NICE Pressure Ulcer prevention guideline CG179 (2014). Proposed changes will be discussed at HAPU HFC meeting prior to changes being made.



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

VTE

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Target	Jan-26	Average (Feb-23 - Jan-26)	Variance	Special causes	Target status	Comments
Number of hospital associated venous thrombosis (HATS) case reviews at CUH	-	33	28		-	-	The Trust and all Divisions are within normal variation. No cases were judged to be avoidable upon review in January 2026.
VTE % compliance of patients admitted to CUH who have been risk assessed	≥95%	96.1%	95.5%		-	?	The Trust met the target in January 2026, and is within normal variance.
VTE % compliance of patients admitted to Division A wards who have been risk assessed	≥95%	92.7%	92.5%	H	Shift	F	Has seen a statistical increase for the last 7 months, however has fallen back below the target and remains statistically unlikely to meet it. The location with the highest number of non-compliant cases was SDEC SAU, where 89.2% (181/203) of patients who attended SDEC SAU were not risk assessed.
VTE % compliance of patients admitted to Division B wards who have been risk assessed	≥95%	96.1%	95.0%		-	?	The compliance target was met in January, and the Division is within 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%	98.9%	98.1%	H	SP	P	Division C has seen a significant statistical increase in January and is consistently meeting the target. The location with the highest number of non-compliant cases is Ward G5.
VTE % compliance of patients admitted to Division D wards who have been risk assessed	≥95%	92.5%	91.9%	H	Shift	F	There has been a statistical increase in the last 8 months, but did not meet the target in January and remains statistically unlikely to. The location with the highest number of non-compliant cases is Ward M5.
VTE % compliance of patients admitted to Division E wards who have been risk assessed	≥95%	95.4%	93.9%	H	Shift	?	There has been a statistical improvement over the past 8 months, but to note this metric excludes antenatal requirements (1 assessment at any point during admission). Division E met the target in January, but compliance for paediatric patients aged 16-17 years was 13.8%. Ward F3 had the highest number of non-compliant cases.

Summary

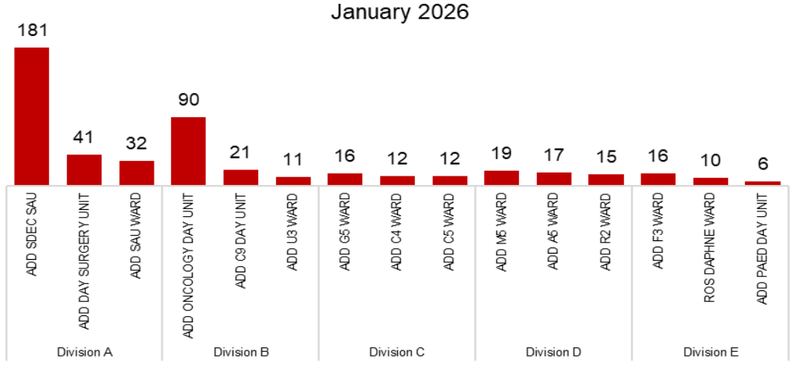
The VTE Quality Improvement group have agreed a series of actions to support compliance with the Trust policy. There has been progress with this work, including:

- Identification of low risk groups not requiring VTE assessment - added as part of the EPIC upgrade.
- Improved information patients receive about the risk of blood clots prior at discharge via After Visit Summary (updated).
- Improving information patients receive about the risk of blood clots prior to elective admission via admission letters (still in progress).

We believe the improved compliance is as a result of some of these measures taking effect, especially identification of exemption groups.

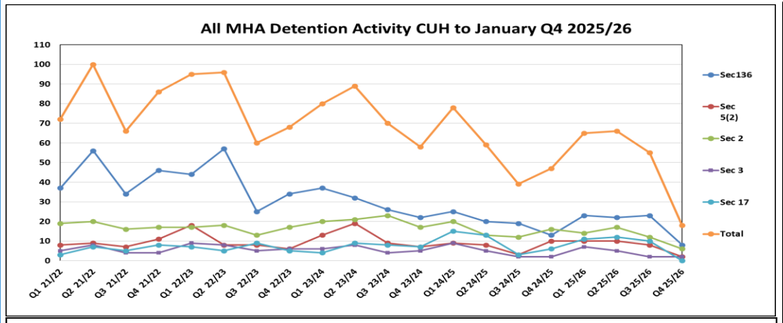
Division	No. admissions	% risk assessed	No. HATs assessed
A	4183	92.7%	9
B	3497	96.1%	1
C	7868	98.9%	16
D	1620	92.5%	5
E	819	95.4%	2
Trust	17987	96.1%	33

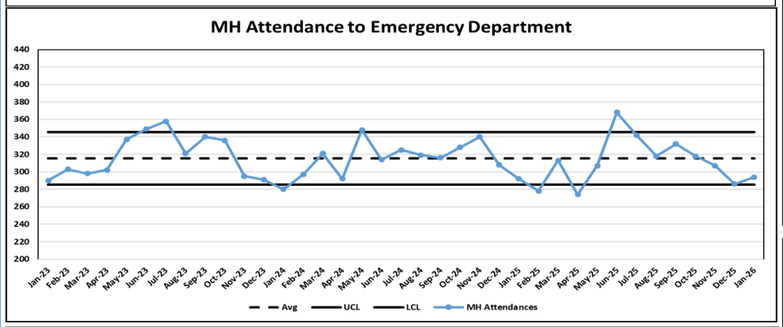
Number of patients that did not receive a VTE risk assessment by Divisions top 3 non-compliant locations
January 2026

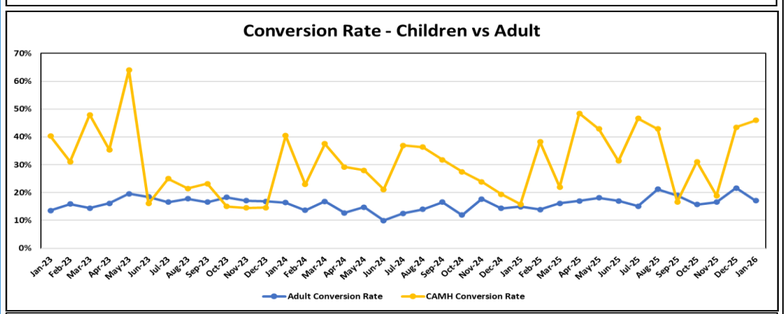


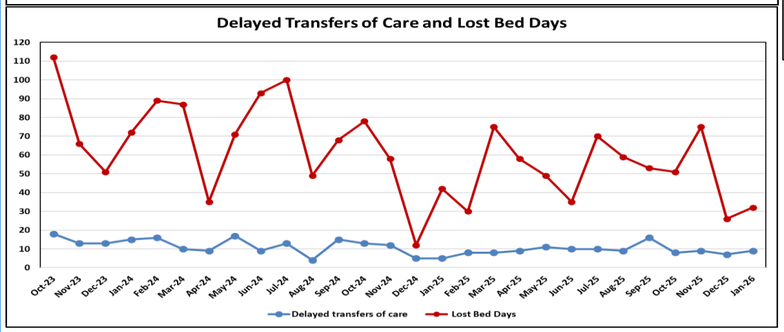
Mental Health - Q3 November 2025/26

NHS Cambridge University Hospitals NHS Foundation Trust









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

Q4 January 2025/26

- All Mental Health Act activity at CUH in January Q4 25/26 showed an increase of 27%, when compared to December 2025, and an increase of 38% over January Q4 24/25.
- Of the 8 presentations of Section 136 MHA to the Emergency Department in January Q4.
  - 50% (4) of section 136 MHA were rescinded on assessment.
  - 25% (2) of section 136 MHA were sectioned to another hospital.
  - 25% (2) of section 136 MHA were transferred to another place of safety
- The number of Mental Health patients presenting to the Emergency Department in January Q4 2025/26 has shown a small increase, though remains under the mean SPC line.
- The average length of stay in the CUH Emergency Department in January Q4, for adult mental health, patients increased by 5.5%, compared to December 2025. The CAMH length of stay decreased by 50%, representing the shortest wait since May 2021 for this patient cohort presenting with mental health challenges.
- January Q4 saw an increase of 2.5% in 'attendance to admission' conversation rates for CAMH patients when compared to December 2025. January and December saw high rates of attendance to admission conversion, 43.5% and 45.9% respectively. Adults saw a decrease in conversion to admission of 4.6%.
- 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

- In January Q4 there were 9 new delayed transfers of care (DTC) to mental health inpatient care, with 32 lost acute bed days at CUH.
- These patients, were waiting for a bed across 3 mental health trusts.

	January Q4 2025/26 MH Service Provision		
New Acceptances	Pre-existing	Lost Bed Days	Service Provision
4	1	11	Adult MH Beds
5		14	Older Adult MH Beds
	1	7	Adult eating Disorder Bed

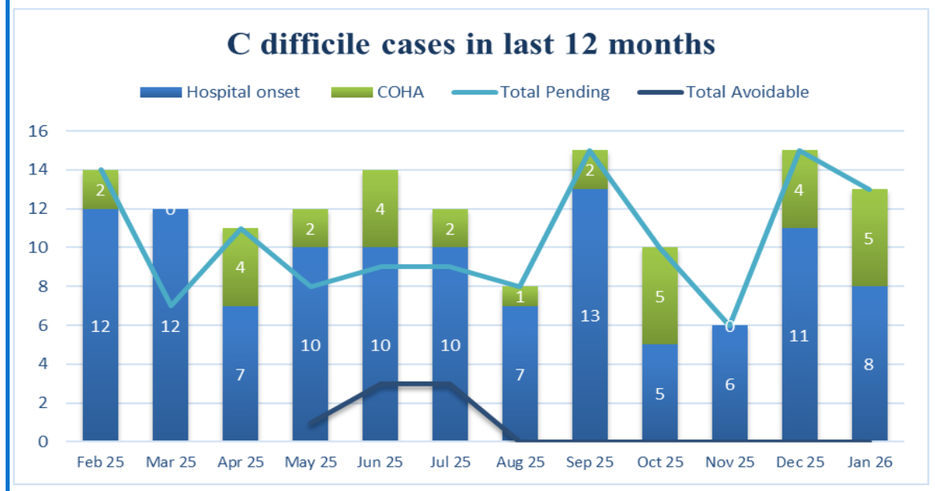
	January Q4 2025/26 MH Receiving Trust		
New Acceptances	Pre-existing	Lost Bed Days	Receiving Mental Health Trust
5	1	16	CPFT
1		8	EPUT
3		8	NSFT

Ongoing Work

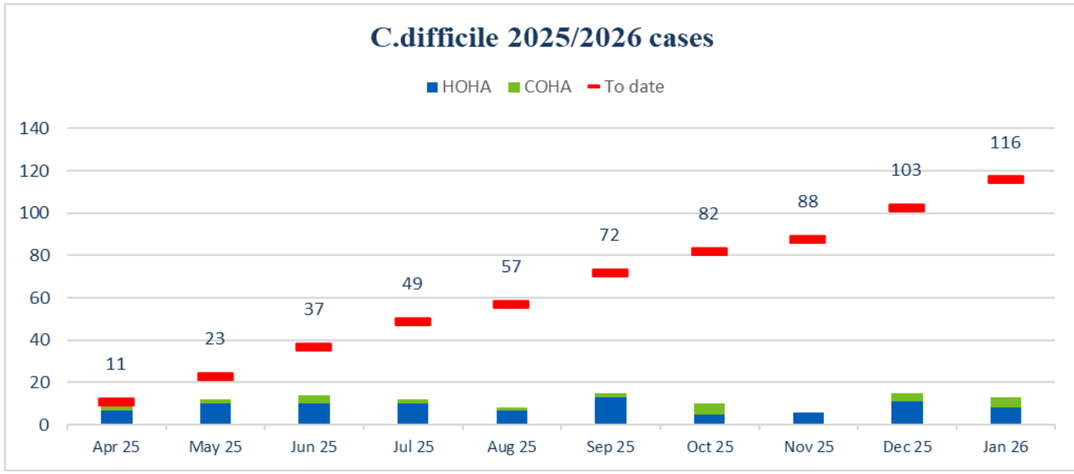
Ongoing work across CUH continues to strengthen the Trust's mental health provision, with a particular focus this month on consolidating improvements in pathways, governance, and staff support for patients presenting with complex mental health needs. Collaborative work with CPFT remains central, with joint efforts progressing to refine escalation routes and ensure consistent multidisciplinary decision making. Development of guidance integrating key legal frameworks, especially in relation to eating disorders and capacity assessments, continues, supporting clearer, safer practice across clinical areas. Divisions are sustaining their review of incidents, risks, and complaints, and work to improve the accuracy and clinical utility of the reviewed mental health categorisation in Datix is now being actively embedded. Staff capability development continues through teaching, drop-in support, and targeted sessions, including focused risk management training for Division C senior nursing teams, reinforcing our Trust-wide commitment to safe, kind, and effective care.

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 not been set at 0 avoidable cases.
• 2 cases of hospital onset MRSA bacteraemia in January 2026.
• 1 Cases of Community Onset - Community Associated MRSA Bacteraemia in January 2026.

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.
▪ 8 cases of hospital onset *C difficile* and 5 COHA case in January 2026.
• 87 hospital onset cases and 29 COHA cases year to date.

MRSA and C difficile key performance indicators

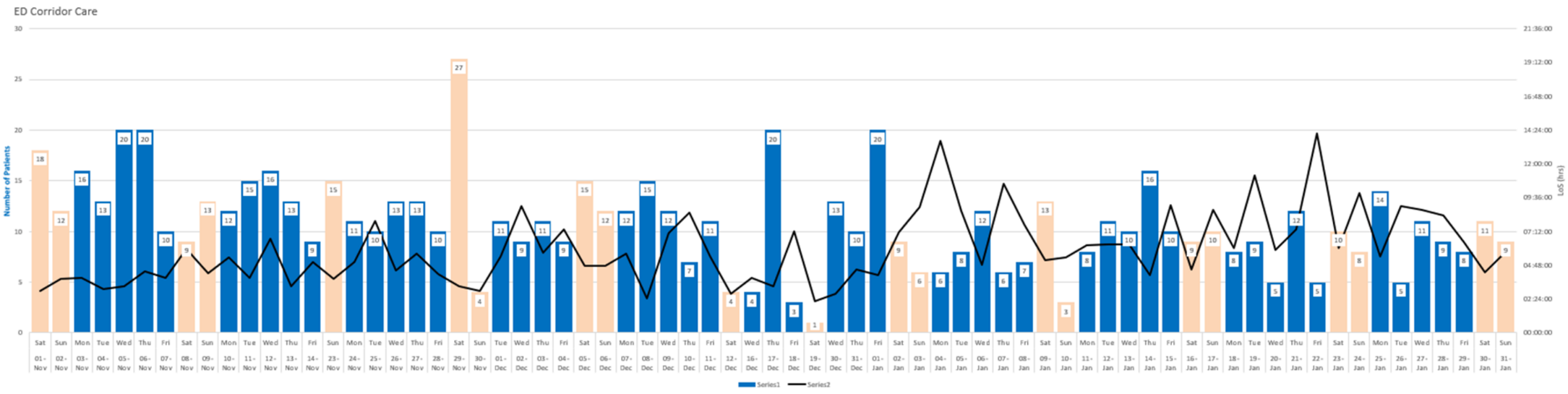
▪ Compliance with the MRSA care bundle (decolonisation) was 69.1% in January 2026 (74.0% in December 2025).
▪ The latest MRSA bacteraemia data we have 9 Bacteraemia's cases year to date, i.e.. 5 HOHA, 1 COHA and 3 COCA.

▪ Compliance with the *C. difficile* care bundle was 67.5% in January. (87.23% in December)
▪ The latest C. difficile cases in January was 8 HOHA, 5 COHA and 7 COCA.

ED corridor care data

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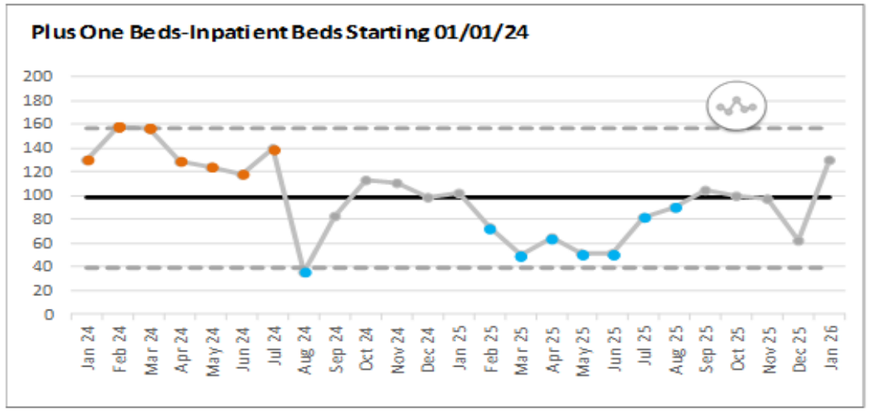
Date	Number of patients (Corridor Care)	LoS (hrs)	Incidents	No Harm	Low Harm	Complaints /concerns
Sep 25	240	05:04:45	0	0	0	0
Oct 25	333	05:31:19	0	0	0	0
Nov 25	302	04:26:00	0	0	0	0
Dec 25	179	05:04:23	1	0	0	0
Jan 26	288	06:55:48	0	0	0	0

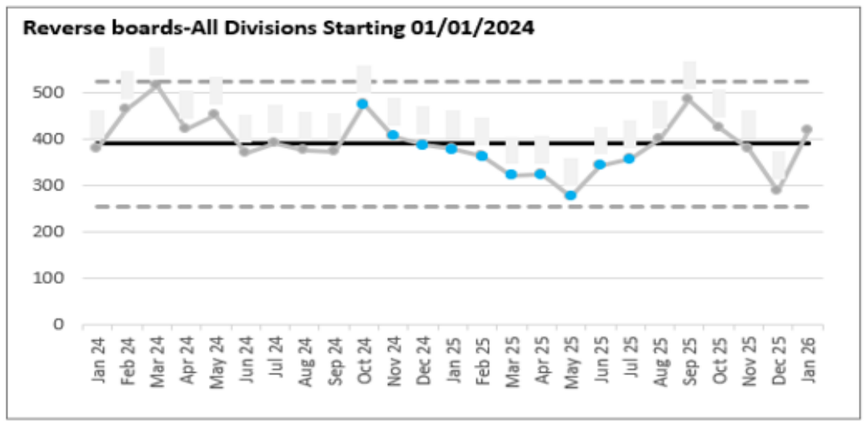


ED Corridor Care – An area within the Emergency Department where clinical care is delivered but is not designed for that purpose

Reverse Boarding / Plus one bed usage

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Date	Number of Plus One beds used	Incidents	No Harm	Low Harm	Complaints/Concerns
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
Oct-25	100	6	6	0	0
Nov-25	97	5	5	0	0
Dec-25	62	10	10	0	0
Jan-26	130	19	19	0	0

Date	Number of patients Reverse Boarded on inpatient wards	Incidents	No Harm	Low Harm	Complaints/Concerns
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
Nov-25	378	2	2	0	2
Dec-25	290	3	3	0	0
Jan-25	419	5	5	0	1

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.

4HR Performance

Jan-26	Plan
67.8%	75.4%

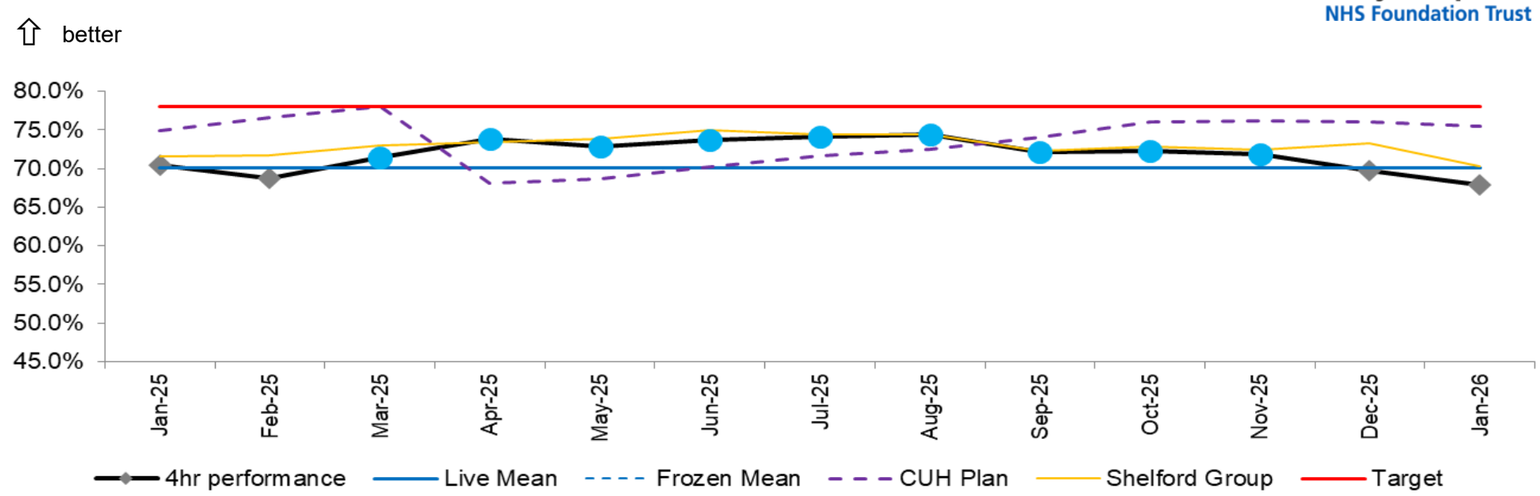
SPC Variance
Normal variation

Shelford Group Median Avg (Jan-26)
70.4%

Three Month Plan		
Feb-26	Mar-26	Apr-26
76.9%	78.3%	#N/A

Highest breaches by specialty

Specialty	Performance	4hr Breaches
Medicine	21.8%	2,199
Emergency	71.7%	1,423
Surgery	48.3%	264
Orthopaedics	25.1%	257
Paediatrics	65.6%	187



Updates since previous month

1) 4 hour performance in January 2026 was 67.9%, a decline from 69.8% in December, and a decline from 70.5% in January 2025.
2) Average daily ED departures rose marginally from 420 in December to 428 in January. The conversion rate remained broadly stable at 16.2%, compared to 16.4% in December.
3) CUH's national ranking for 4-hour performance improved by three places, from 71st to 68th in January, and the Trust remained within the second quartile nationally.

Key dependencies

1) Demand remains a key factor in performance and we continue to maximise the utilisation of the UCC 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
5) Timely response from specialties to support the IPS

Current Issues

1) Breach validator vacancy from January 2026 - planning up for the validation to be taken up and internally managed.
2) Reduced EP workforce 2 staff members have left in January with one LTS, currently all vacancies out for approval.
3) Transfer to SDEC's - Implemented 'just send' model to MAU initiated in January; discussions underway with SAU regarding 'just send' for GP patients - to allow patients to be directly streamed to avoid attending at the front door.
4) Additional staffing resource deployed at the UCC to support with track board oversight and additional clinical staffing (GP) to support with

Future actions

A range of actions were implemented during January to address these issues and mitigate the reduction in performance. These ranged from enhanced breach validation; data quality reviews; additional clinical resource deployment across the ED footprint; operational team trackboard management and EPIC and CHEQS changes along with Triumvirate oversight and management. Details of the recovery plan are provided in the Operational update to Performance Committee and were reviewed at the Divisional Quality and Performance meeting in February, as well as being supported through the UEC Taskforce.

Ambulance Handovers < 45 minutes

NHS Cambridge University Hospitals NHS Foundation Trust

Jan-26	Target
70.0%	100.0%

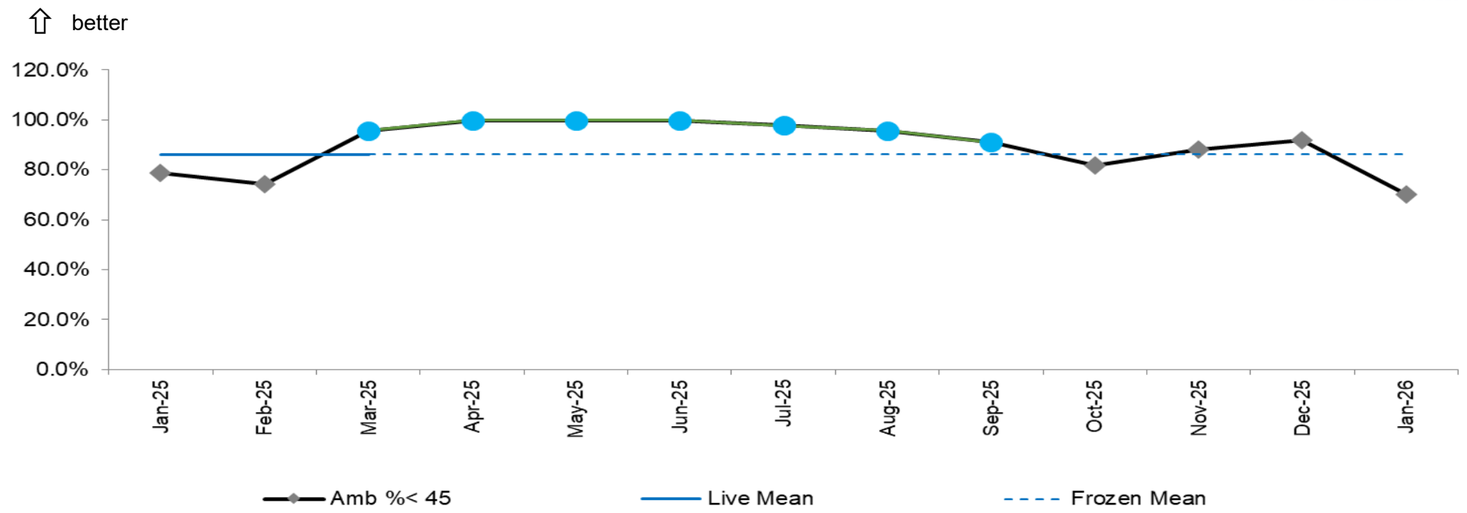
SPC Variance

Normal variation

East of England > 45 minutes

Jan-26

Trust	Performance
Bedford	2.7%
Luton and Dunstable	3.1%
Watford General	12.5%
West Suffolk	20.0%
Milton Keynes	20.3%
Southend	27.2%
Hinchingbrooke	29.8%
CUH	30.6%
Lister	33.8%
James Paget	36.7%
Basildon & Thurrock	37.2%
Princess Alexandra	41.0%
Broomfield	42.8%
Papworth	42.9%
Peterborough City	46.3%
Ipswich	46.4%
Colchester General	54.6%
Queen Elizabeth	60.1%
Norfolk and Norwich	60.7%



Updates since previous month

1) In December, 11.4% of ambulance handovers took longer than 45 minutes, an improvement from 12.5% in November and significantly better than 17.5% of handovers exceeding 60 minutes in December 2024.
2) Average ambulance offload time in December was 26:06m, down from 23:41m in November. CUH remained the fifth highest-performing trust in the region, consistent with its position last month.
3) 244 of 2,410 ambulances experienced handover delays over 30 minutes in December, down from 409 of 2,545 in November and 562 of 2,427 in October, representing a sustained and significant improvement.

Current issues

1) Ambulance bay RAT cubicles are used as sideroom capacity when limited flow out to core siderooms within the Trust.
2) Increased use of the corridor and delays being able to exit RHO space on wards when ambulance demand exceeds cubicle capacity
3) High levels of occupancy in medical inpatient beds have compromised flow.
4) Lack of bedded discharge lounge, patients have long waits for transport, blocking beds in ED
5) Insufficient cardiac monitored bed capacity and long waits on assessment units

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 with access to Rapid Handover spaces with clearly identified patients
4) Clear infection control plans to maintain flow to sideroom capacity to mitigate limited capacity within ED.
5) Transport prioritisation for patients in ED
6)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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Division	Corporate			Division A			Division B			Division C			Division D			Division E			Total		
Staff Group	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	Number of Staff requiring testing	Total protected staff	% Total staff protected	**Number of Staff requiring testing**	**Total protected staff**	**% Total staff protected**
Add Prof Scientific and Technical (Pharmacists only)	11	2	18%	2	1	50%	272	64	24%	8	0	%	49	14	29%	-	-	-	342	81	**24%**
Additional Clinical Services	91	0	%	427	167	39%	567	183	32%	412	281	68%	253	140	55%	263	112	43%	2013	883	**44%**
Allied Health Professionals	11	1	9%	78	22	28%	653	263	40%	18	8	44%	63	7	11%	20	2	10%	843	303	**36%**
Estates and Ancillary (Porters and Security Personnel only)	240	58	24%	92	5	5%	391	51	13%	3	0	%	20	1	5%	1	0	%	747	115	**15%**
Healthcare Scientists	14	0	%	-	-	-	517	6	1%	-	-	-	48	10	21%	-	-	-	579	16	**3%**
Medical and Dental	1639	140	9%	427	26	6%	398	23	6%	426	48	11%	350	35	10%	284	35	12%	3524	307	**9%**
Nursing and Midwifery Registered	210	37	18%	1396	751	54%	433	247	57%	917	531	58%	549	291	53%	945	387	41%	4450	2244	**50%**
Total	**2216**	**238**	**11%**	**2422**	**972**	**40%**	**3231**	**837**	**26%**	**1784**	**868**	**49%**	**1332**	**498**	**37%**	**1513**	**536**	**35%**	**12498**	**3949**	**32%**

The data displayed as of 10/02/2026. This data reflects the areas which would be utilised during a respiratory endemic/ pandemic, requiring staff to wear FFP3 protection. This data set does not include Medirest, student Nurses, AHP students or trainee doctors. Conversations on fit testing compliance with the leads for the external entities take place on a regular basis. These leads provide assurance on compliance and maintain fit test compliance records. Ongoing training days booked for staff to become MFTrainers.

Nursing and Midwifery is the staff group with the highest compliance (50.4%), and Healthcare Scientists being the lowest with 2.76%.

Referral to Treatment % < 18 weeks

NHS
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<18 Weeks	
Jan-26	**Plan**
59.9%	63.4%

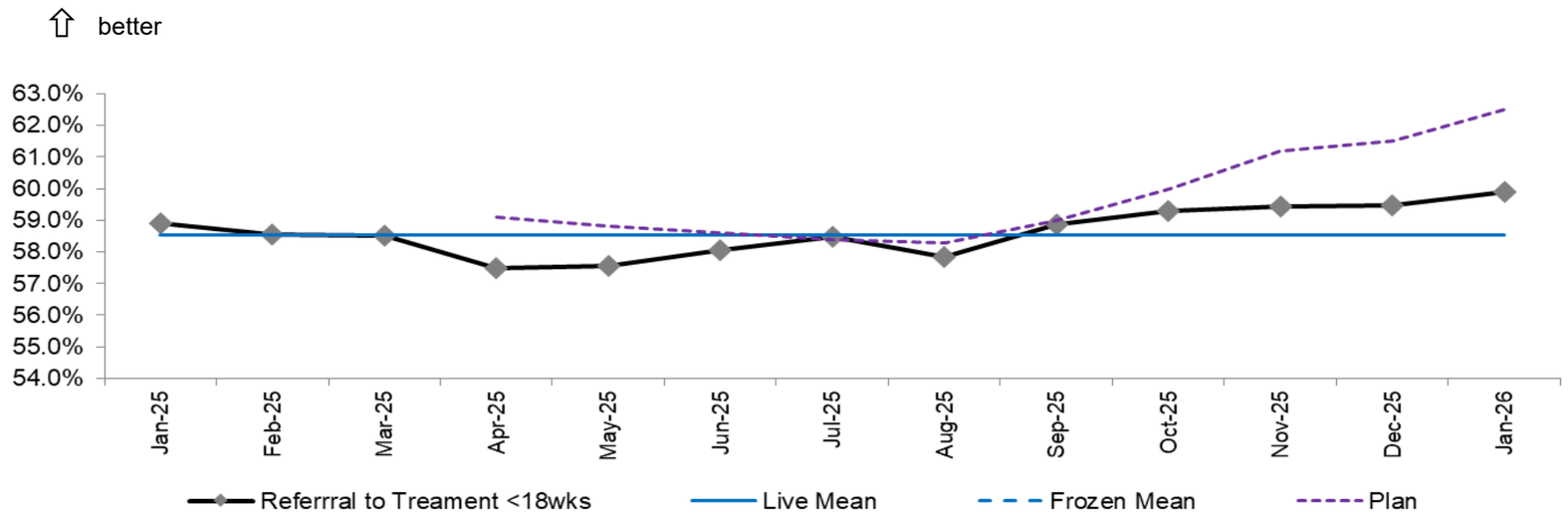
SPC Variance
Positive special cause variation

% of WL under 18 weeks (Dec-25)	
CUH	59.5%
Shelford Group	62.0%

Three Month Plan (<18 wks)		
Feb-26	**Mar-26**	**Apr-26**
63.4%	64.1%	#N/A

Divisional Performance

	% patients waiting 18 weeks	
Division	Performance <18 weeks	Total waiting > 18 weeks
A	62.7%	4,750
B	77.6%	1,222
C	83.0%	722
D	53.9%	14,116
E	54.8%	4,241
Trust	**59.5%**	**25,051**



Updates since previous month

There has been a marginal improvement in 18 week performance again in January but we remain behind plan. The total waiting list reduced in month by 1800 patients.
Recovery actions continue to deliver increased clock stops. An external validation company (MBI) continue to support with validating the waiting list. This has resulted in 14.4% closure rate of 21,911 records validated to date (15th Feb).

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.
3) Divisional plans being achieved and further productivity schemes being identified especially in highest risk specialties.
4) Triage & Validation is a key to demand management.
5) Implement trust level schemes in March, including insourcing

Current Issues

Performance in Jan was 1.6% below plan. Modelling has shown that there is a high level of risk in delivering the year end plan of 64.1% but we expect continued improvement in quarter 4, with forecast to achieve 62.8%

There continues to be growth in our <18wks group due to continued long waits for 1st OP

Future actions

1) Delivery of specialty recovery actions for reduction in Total Waiting List, and long waiting patients maximising opportunities linked to the national sprint
2) Continuation of new elective governance and PTL monitoring
3) Continuation of the external validation in quarter 4
4) Expansion of Sprint to Spring enhanced WLI programme
5) Short term capacity through outsourcing and insourcing

Referral to Treatment > 52 weeks

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52+ Weeks	
Jan-26	**Plan**
2.7%	1.6%

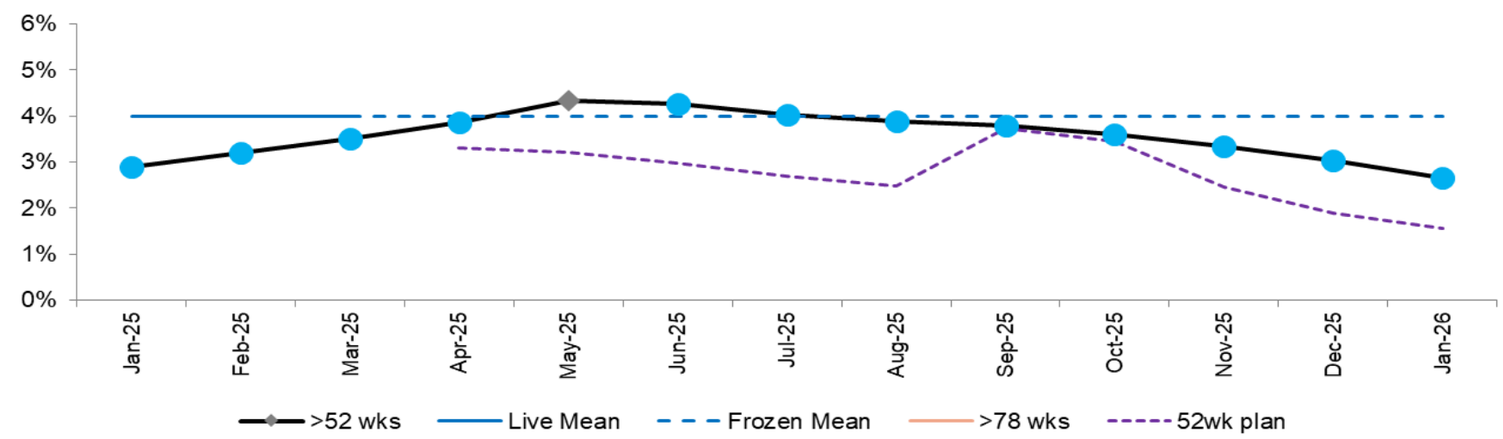
SPC Variance
Positive special cause variation

% of WL over 52 weeks (Dec-25)	
CUH	3.03%
Shelford Group	1.60%

Three Month Plan (52+ wks)		
Feb-26	**Mar-26**	**Apr-26**
1.2%	0.9%	#N/A

Divisional Performance		
Division	**52+ wks**	**65+ wks**
A	0.9%	2
B	1.1%	4
C	0.2%	0
D	3.5%	64
E	4.2%	19
Trust	**2.7%**	**89**

⇩ better



Updates since previous month

>52 wk waits remains behind plan in January by 1.1% but continues to be an improving position. January is the sixth successive month of reducing the total number of patients waiting >52 weeks and represents recovery to the position in January 2025 before the deterioration in performance was experienced.

Currently behind the revised forecast for 52 wk breaches by c.500 patients due to delays in recovery actions and this impacts on the >65wk position (89 at the end of January)

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

65 & 52 ww have reduced in month but are adverse to plan predominately in ENT, Cardiology, Gynaecology & OMFS. This is due to complex patients or late 1st OPA with the need for subsequent diagnostics. There are also challenges with a specific outsourcing pathway which have been escalated in month.

52 wk breaches are behind revised trajectory due to delays in additional capacity being implemented. Recovery action plans continue to be monitored and reviewed through governance.

Future actions

1) Tier 1 reporting into national oversight meetings continues.
2) Ongoing delivery of specialty recovery plans.
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 are supporting validation of PTL 0-65wks and have been extended to Q4.
5) Increased governance and tracking of long waiting patients

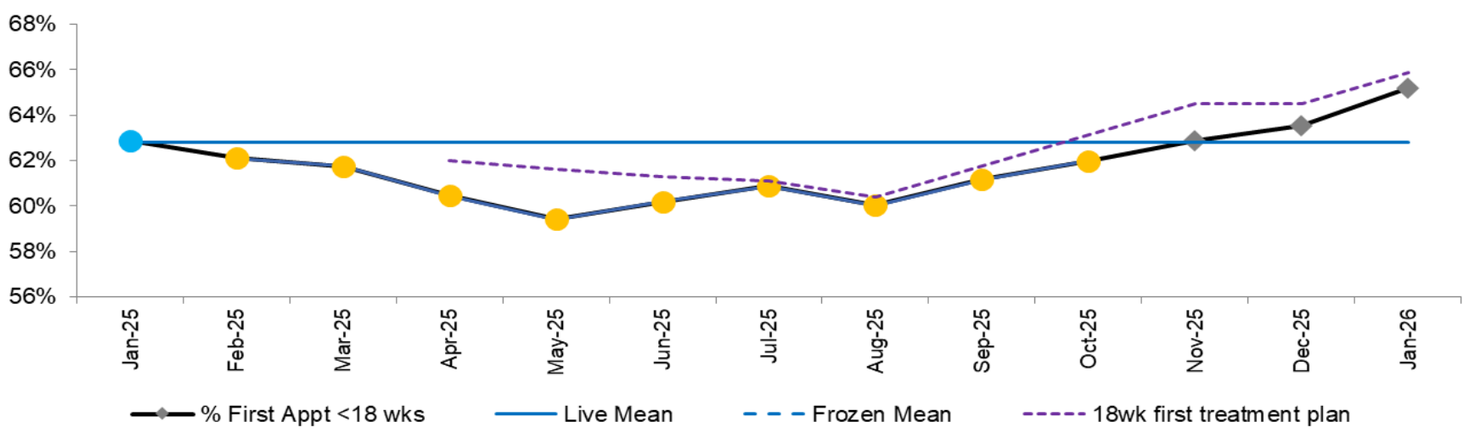
RTT waiting for first appointment < 18 weeks

NHS
Cambridge University Hospitals
NHS Foundation Trust

<18 Weeks	
Jan-26	**Plan**
65.2%	67.2%

SPC Variance
Positive special cause variation

⇧ better



Three Month Plan (<18 wks)		
Feb-26	**Mar-26**	**Apr-26**
67.2%	68.6%	#N/A

Divisional Performance			
		% patients waiting 18 weeks	
Division		Performance <18 weeks	Total waiting > 18 weeks
	A	71.1%	1,663
	B	85.7%	254
	C	90.4%	213
	D	59.1%	7,165
	E	61.6%	2,236
Trust		**65.2%**	**11,531**

Updates since previous month
The volume waiting for 1st OP <18weeks increased by 1.3% compared to December which is a continuing improvement trend as we balance out our waiting list through validation & clock stops through activity.

The position will continue to improve as long as 1st OP waits are reduced in the >18 week group and the overall size of the wating list continues to reduce for the longest waiting patients.

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
The required reduction in 1st OPAs is adverse to plan with 11,531 patients waiting over 18 weeks for their first attendance.
Delays in recovery actions within specialties has impacted on the rate of 1st OPAs.
We remain behind plan of our target to ensure all patients in the 52wk cohort had 1st OPs by the end of January, with Gynaecology, ENT, Cardiology and OMFS behind with other specialties on trajectory.

Future actions
1) Medical workforce posts are progressing in our top 8 specialties
2) Ongoing delivery of recovery action plans across specialities
3) Delivering first outpatient appointment for all patients in 52wk cohort by 31st January
4) Ongoing outpatient transformation work on demand management
5) Utilisation of the national sprint during Qtr 4

Cancer - 28 day faster diagnosis standard

NHS Cambridge University Hospitals NHS Foundation Trust

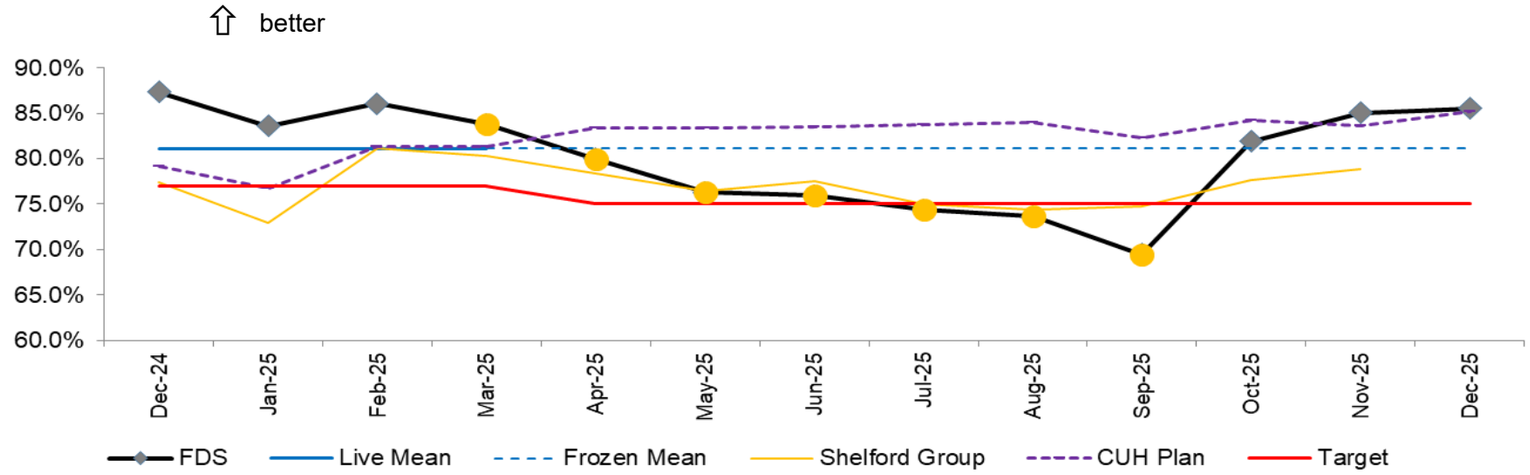
Dec-25	Target
85.5%	75.0%

SPC Variance
Normal variation

Shelford Group Median Avg (Aug-25)
74.3%

Three Month Plan		
Jan-26	Feb-26	Mar-26
84.5%	85.2%	84.4%

Cancer Site Overview		
Site	Performance	Breaches
Skin	82.5%	116
Lower GI	85.2%	55
Gynaecological	87.7%	28
Head & Neck	85.4%	35
Urological	73.1%	53
Breast	91.4%	52
Haematological	40.0%	6
Sarcoma	75.0%	5
Upper GI	73.7%	5
Lung	95.0%	4
Children's	88.9%	2
CNS/Brain	88.9%	2
Non-site specific	97.2%	1
Testicular	100.0%	0
Total	**0.0%**	**364**



Updates since previous month

Performance: 85.5% (above plan and above national target of 75%), performance at this level should continue achieving the end of year requirement of 80% performance.

Action: Longer term actions for pathology reporting in prostate and continued recovery for breast and skin relating to recruitment for vacant posts.

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

January FDS performance is reported on 03.03.26 and is forecast to be above plan, February performance also remains in line with plan.

Delays to first appointment in Breast have improved and wait times are now below 14 days. Challenges remain in plastics impacting the skin pathway.

Action: Plastics to understand demand and capacity, completing request for additional resource if required.

Future actions

First appointments within 7 days, prioritising high-volume specialties.

Recruit and deploy **locum medical posts** to support Skin pathways.

Sustain progress on:

pathology turnaround times (Head & Neck, Skin, Urology).

One-stop diagnostic capacity (50% within 7 days).

Recruitment to permanent posts with no delays in start dates.

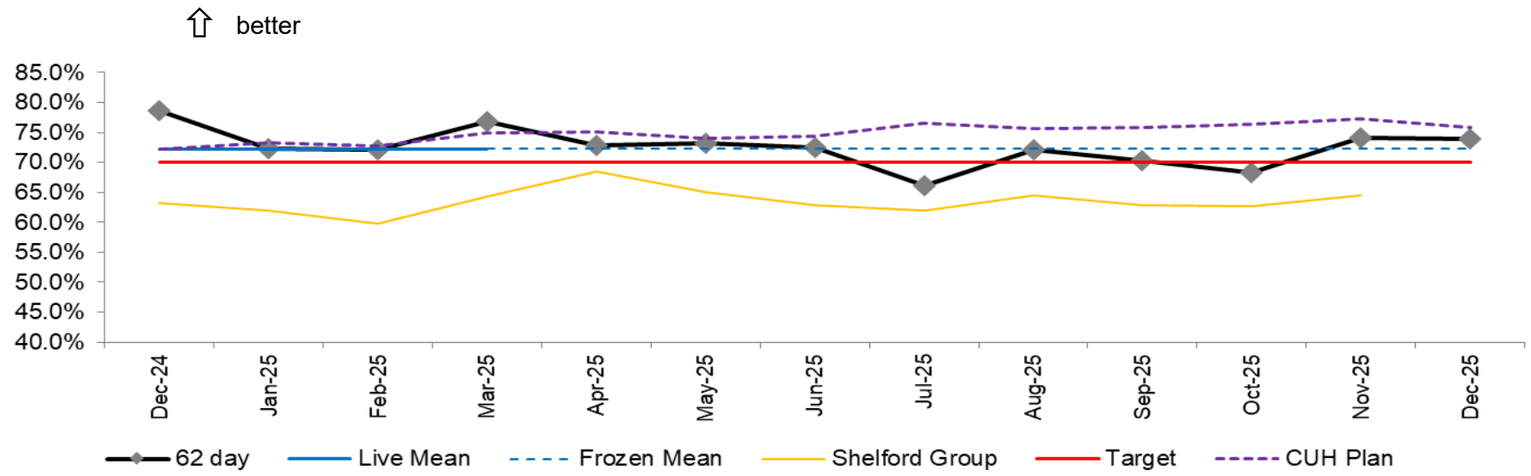
Cancer - 62 days combined referral to treatment

Cambridge University Hospitals NHS Foundation Trust

Dec-25	Target
74.0%	70.0%

SPC Variance
Normal variation

Shelford Group Median Avg (Aug-25)
64.5%



Cancer Site Overview as of 17/02/2026

Site	Backlog
Breast	14
CNS/Brain	1
Gynaecological	21
Head & Neck	15
Other Haem Malignancies	5
Lower GI	18
Lung	12
NSS	0
Upper GI	8
Urological	52
Sarcoma	3
Skin	38
HPB	28
Children's	0
Symptomatic Breast	0
Other	1
All	*216*

Updates since previous month

Performance: improved to above national target but below plan
323 patients treated in December **84 waited longer than 62 days**.
Shared pathways (53 patients): 31 not treated within 24 days.
CUH-only breaches (60 patients): **Skin**: 26%, and **Breast** 23% and all due to delays at the start of the pathway.
Shared Pathway Analysis: Of patients not treated within 24 days, 67% required surgery and 29% radiotherapy

Current Issues

Delayed FDS pathways in increasing 62-day breaches, particularly in **Breast and Skin**.
Delays in treatment for surgery and Radiotherapy are increasing breaches
Of the **65 CUH-only breaches**: **23%** due to complex pathways, other medical delays, or patient choice.

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
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

Future actions

Radiotherapy wait times – continued recovery to ensure treatment within 24 days for tertiary pathways.
Surgery sprint Feb - March 26 to improve 31 day performance
Recruitment to address workforce gaps in **Breast & Skin**
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)

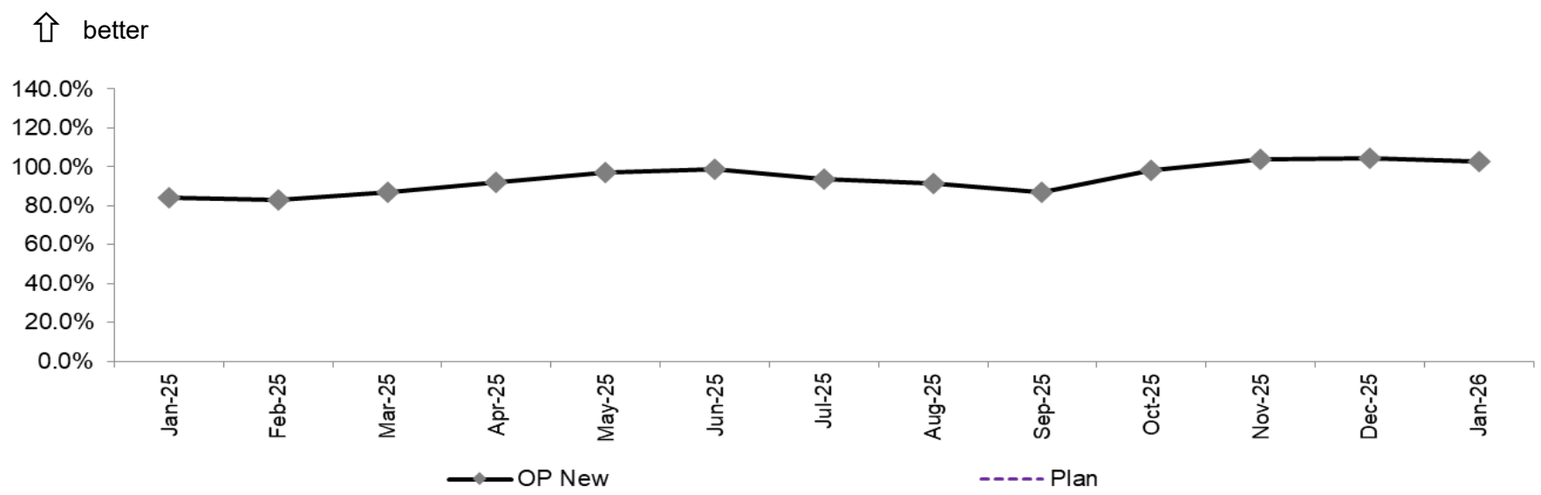
Cambridge University Hospitals NHS Foundation Trust

Jan-26	Plan
102.6%	N/A

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

Three Month Plan		
Feb-00	Feb-00	#VALUE!
N/A	N/A	N/A

Divisional overview	
Division	Performance
A	105.5%
B	102.4%
C	100.4%
D	104.2%
E	94.4%



Updates since previous month

Overall position remains above 100% of plan with all except division E achieving this metric. Division A continues to perform strongly as does division D as one of the largest areas of outpatient activity. There has been extra focus on new first outpatient appointments as part of the tier 1 monitoring which has driven the improvement with a steady and sustained increase since September.

Current Issues

18 week wait performance is 60.3%, reflecting a 1.5% improvement across that last four weeks. The total waiting list has reduced by 960 patients across the last four weeks but is tracking behind the revised trajectory for end of year plan. WLI Clinics are being run across a number of specialties to help with meeting the revised trajectory.

Key dependencies

We have seen a drop in new activity despite there being a consistent average of more than 100% new slot utilisation rate. All services must actively take part in pathway reviews and clinic template optimisation, as well as appropriate reality to try and reduce demand. Pace of change needs to be improved.

Future actions

We aim to increase the number of WLI clinics as well as in sourcing additional capacity during the month of March for three key specialties, ENT, Gynaecology and Ophthalmology.

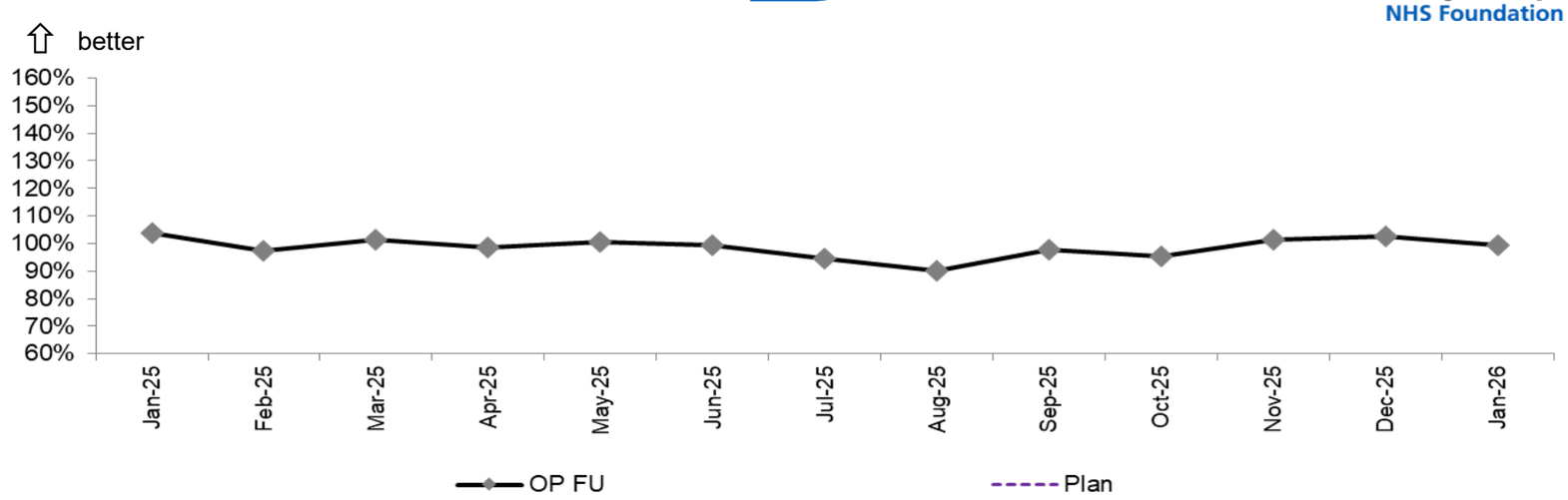
Follow Up Outpatient Attendances - % vs. Plan (consultant led, specific acute)

Cambridge University Hospitals NHS Foundation Trust

Jan-26	Plan
99.5%	N/A

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

Three Month Plan		
Feb-26	Mar-26	Apr-26
N/A	N/A	N/A



Divisional overview	
Division	Performance
A	99.2%
B	96.7%
C	98.7%
D	98.3%
E	112.5%

Updates since previous month
Overall trust position has not changed and remains within normal variation. Divisions B, C and E achieved over 100% this month with A and D underperforming, interestingly the opposite to the new appointment

Key dependencies
Pathway redesign remains a key requirement for services to reduce the number of follow-ups required. The uptake of RCR and PIFU is extremely slow due to a number of resource issues. A working group has recently been convened with community and ICB colleagues to explore different ways of managing pathways.

Current Issues
Overdue follow-ups continue to be a significant concern at 70,000. Ophthalmology and Rheumatology are the areas with the biggest number, with ophthalmology being a significant risk due to potential harm of patients not being seen in time.

Future actions
Increase the use of PIFU and RCR. Continue to redevelop pathways to minimise the need for follow-ups. The Booking Optimisation Program, introducing self scheduling and earlier appointment requests for follow-ups, is showing significant signs of opportunities. For example, the DLA rate for those patients self scheduling is 2.4% compared to the Trust average of just under 5%. We hope this will help maximise productivity. CUH are participating in the NHSE GIRFT Faster Follow Up programme.

Author(s): Andi Thornton **Owner(s): Nick Kirby**

PIFU Outpatient Attendances

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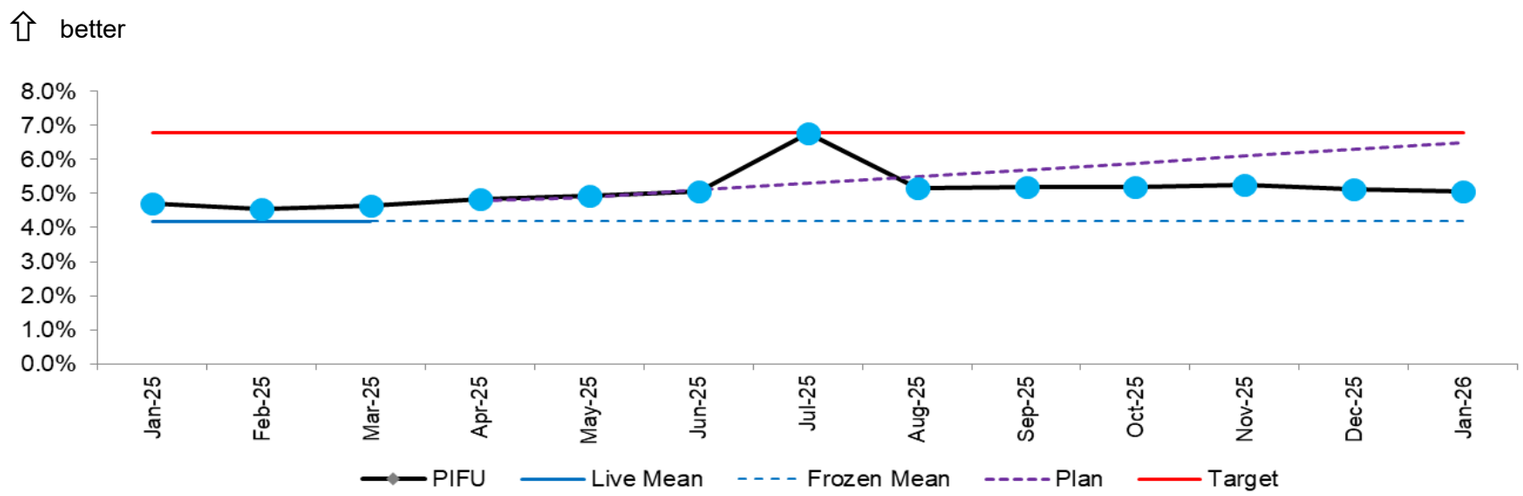
Jan-26	Plan
5.1%	6.5%

SPC Variance
Positive special cause variation

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

Three Month Plan		
Feb-26	Mar-26	Apr-26
6.7%	6.8%	#N/A

Divisional overview	
Division	Performance
A	8.8%
B	6.2%
C	3.0%
D	3.2%
E	5.5%



Updates since previous month
Numbers declined slightly in January to 5.1% down from 5.3%. This is against a planned of 6.5%. It is unlikely that we will meet the NHS England target rate of 6.5% by April.

Current Issues
We will not meet the NHS England target this year of 6.5% unless there is a significant increase in uptake by specialties

Key dependencies
The ability to effectively convert PIFUs into appointments (where appropriate) is directly impacted by the ongoing review of clinic templates as part of the Booking Optimisation Program. This will have had an impact on the overall numbers. The conversion rate remains low at 8.3%.

Future actions
1Divisions are encouraged to follow GIRFT guidance, PIFU data on the clinic utilisation dashboard and the EoE outpatient transformation tool to continue to look for opportunities to increase the volume of PIFUs.

Delayed Discharges

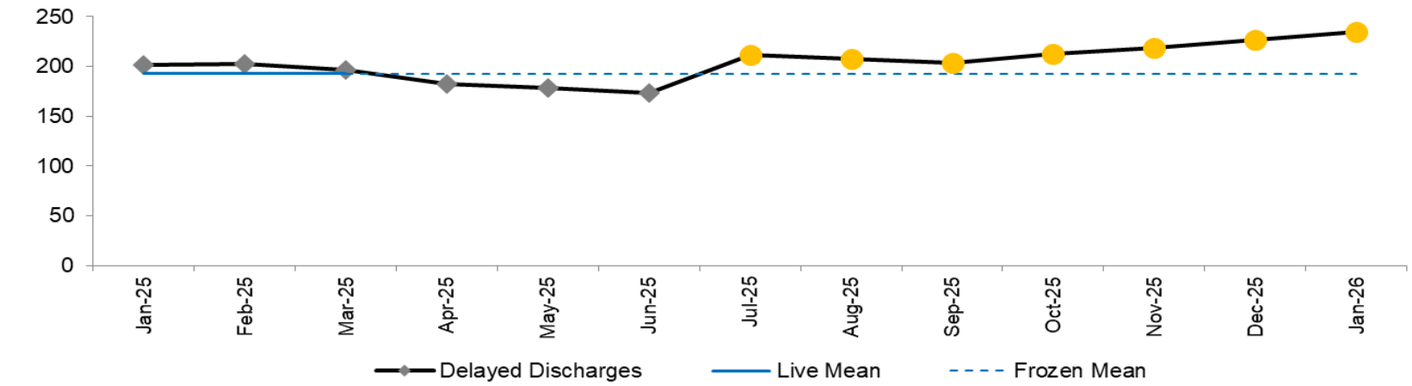
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Jan-26	Target
235	N/A

SPC Variance
Negative special cause variation

Shelford Group Median Avg (Jan-26)
N/A

⇩ better



Beds lost to delays - by pathway	
Pathway	**Beds lost**
Pathway 1	62
Pathway 2	18
Pathway 3	21
Internal Assessments	78
Internal Other	0
Other External Reasons	48
Total	**235**

Updates since previous month

Severe bed pressures continued throughout January. External delays increased, particularly in relation to intermediate care availability, social work assessments, and ICB-funded care home placements. Internal assessment delays remained consistent with the previous month, with the majority of delays continuing to be driven by external agencies.
Recruitment to existing vacancies within the Complex Discharge Team and Early Intervention Team is ongoing, with start dates now offered to Band 4 Discharge Coordinator

Key dependencies

Key dependencies include maintaining adequate therapy staffing levels; the accuracy and timeliness of Medical Readiness for Discharge Dates and Criteria to Reside; sufficient transport capacity; and effective internal ward processes.
Delivery is also dependent on stable staffing within the Complex Discharge Team (CDT) and Early Intervention Team (EIT), alongside community care capacity for reablement and intermediate care, and overall care home capacity

Current Issues

Winter pressures continue to strain flow, with internal assessment delays, staff sickness, and recruitment gaps driving higher bed losses. External delays remain significant, particularly due to limited Intermediate Care at Home (Pathway 1) capacity. Despite increased discharge activity, last-minute cancellations—mainly related to transport and TTO medication issues—are disrupting complex discharges and impacting community partners. Long waits persist but remain improved compared to last year, with mid-range delays requiring close monitoring.

Future actions

Review and redesign the report template to improve clarity and consistency.
Complete recruitment to all existing vacancies within the Complex Discharge Team (CDT) and Early Intervention Team (EIT).
Continue to progress winter initiatives, including Ilarna and the use of social worker locum support. Work with system partners to launch OPTICA and implement the Pathway 1 short-term care redesign in March. Strengthen early escalation of external delays through TOCH and stranded patient meetings.

Theatre Utilisation - Elective GIRFT Capped

NHS Cambridge University Hospitals NHS Foundation Trust

Jan-26	Plan
78.4%	85.0%

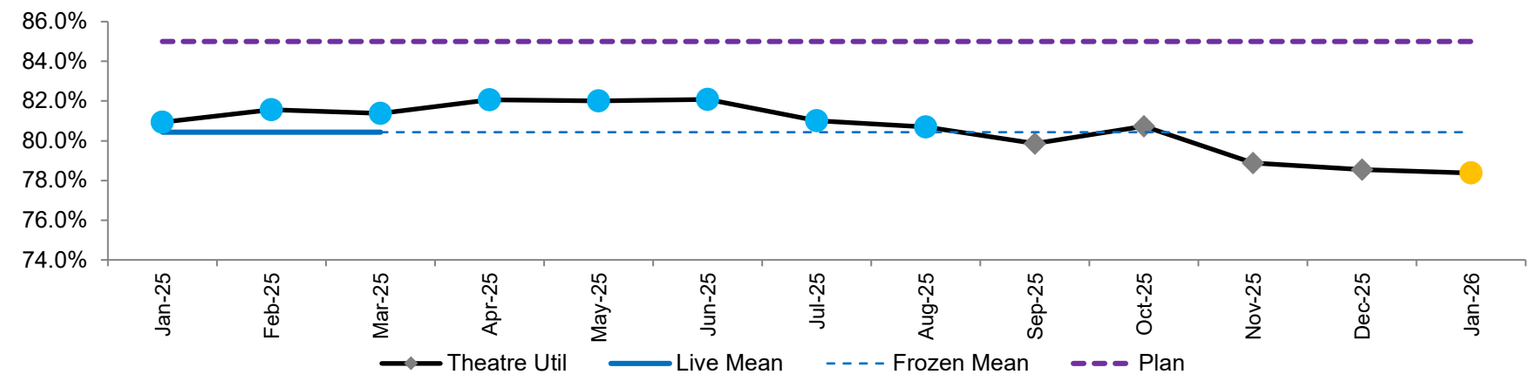
SPC Variance
Negative special cause variation

Performance in the 2 weeks to 25/01/2026	
CUH	82.5%
Shelford Grp Median	81.9%

Three Month Plan		
Feb-26	Mar-26	Apr-26
85.0%	85.0%	#N/A

Utilisation by department	
Department	Utilisation
ATC	81.8%
Main	76.5%
Rosie	60.8%
CMSH	86.2%
CEU	68.0%
Ely	77.3%
All	**78.4%**

⇧ better



Updates since previous month

Utilisation remained stable compared to the previous month but continues to be significantly below target. The main contributing factors are theatre staff sickness, shortages within the booking team, and limited bed capacity for elective inpatients pathways.

Key dependencies

1. Short notice cancellations.
2. Start times and turnaround efficiency.
3. Ongoing Theatre Staff recruitment
4. Booking staff availability
5. Timely access to post-operative beds.

Current Issues

Staffing sickness and limited booking staff availability continue to be major limiting factors affecting timely list starts and improved utilisation. Bedded inpatient capacity remains an area of concern, with delays in transferring patients out of theatre recovery impacting overall patient flow within the theatre environment.

Future actions

Short-notice cancellation reasons are being reviewed and will be updated in line with national guidelines. The E-Hospital team aims to complete this work by February 2026. This will support a more streamlined and standardised approach to selecting cancellation reasons and identifying recurring themes. Recruitment to address theatre staffing and booking team shortages remains ongoing.

BADS Daycase Rates (Outpatient + Daycase)

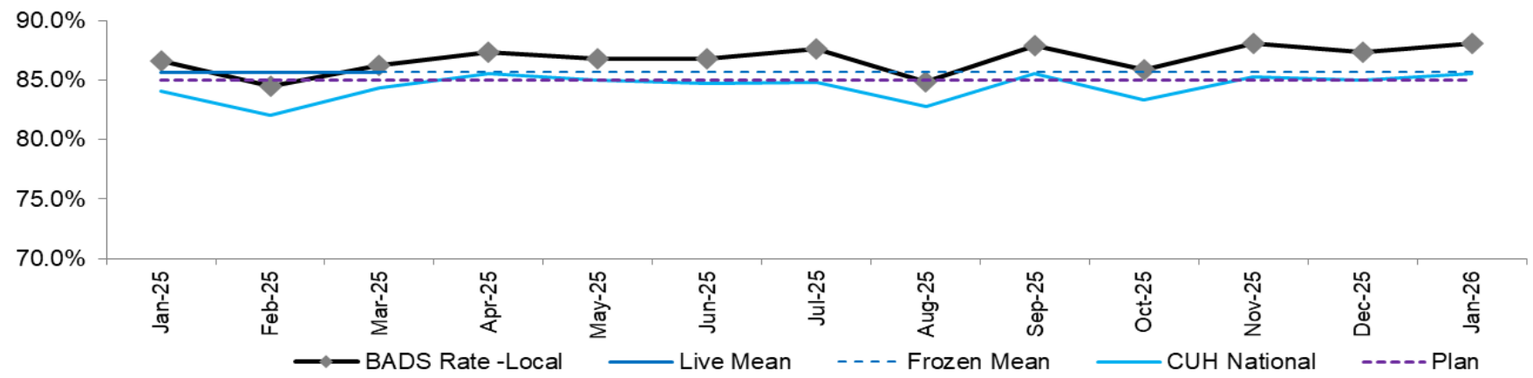
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Jan-26	Target
88.0%	85%

SPC Variance
Normal variation

Model Hospital Published Performance in the last month to end of Oct	
CUH	82.0%
Shelford Grp Median	82.5%

⇧ better



BADS Section Day Case Rate for HVLC focus areas

Latest month to end of Oct '25				Jan-26
Specialty	CUH	Shelford	Quartile	Local
Orthopaedics - Elective	72.8%	73.5%	3	69.8%
ENT	85.8%	89.0%	1	96.7%
General	78.7%	74.3%	3	83.1%
Gynaecology	88.2%	82.7%	3	89.4%
Ophthalmology	96.0%	97.8%	1	99.0%
Urology	85.8%	84.7%	2	92.5%

Updates since previous month
BADS performance local data remains above target and in line with Shelford Group median.

Key dependencies
1. Day cases procedures operated first on the list.
2. Timely access to theatres for simple emergencies.
3. Day cases listed accurately on EPIC.

Current Issues
In the month of January the perceived opportunity for improvement was 96 procedures, stable from 94 in December from CUH local data.

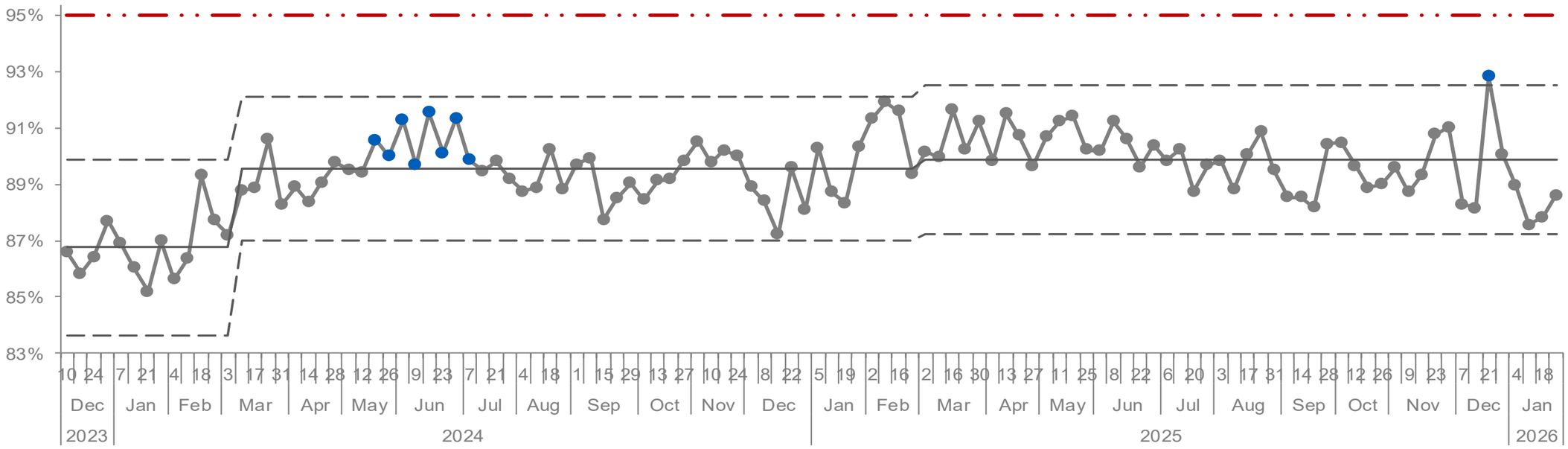
Future actions
The Surgery Programme Board continues to focus on improving BADS rates, with targeted actions identified and led by each Division. Accuracy of surgery listing and early identification of Day Case pathways, ahead of the day of surgery, also remain key areas of focus.

Discharge Summaries

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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 - Jan 26	Month	-	90.0%	94.1%	L	SP	-	The Good FFT score declined 1.5% compared to December. The Poor score increased by 0.5% compared to December. The number of responses remained about the same compared to December and continues to be lower than average. **For JAN** 725 responses were collected from approx. 2,851 patients.
FFT Inpatient poor experience score	Jul 20 - Jan 26	Month	-	5.0%	2.5%	H	SP	-	
FFT Outpatients good experience score	Apr 20 - Jan 26	Month	-	94.1%	94.5%		-	-	The Good FFT score had a very small decrease of 0.6% and the Poor FFT score remained the same compared to December. **For JAN** there were 7,739 FFT responses collected from approx. 41,962 patients.
FFT Outpatients poor experience score	Apr 20 - Jan 26	Month	-	3.0%	2.7%		-	-	
FFT Day Case good experience score	Apr 20 - Jan 26	Month	-	96.6%	96.2%		-	-	The Good and Poor FFT scores did not change compared to December. The special cause variation for Low/High is not a concern as the Good score is above 95% and Poor score is 2% which is excellent. **For JAN** there were 1,164 FFT responses collected from approx. 4,698 patients.
FFT Day Case poor experience score	Apr 20 - Jan 26	Month	-	2.0%	1.9%	H	S7	-	
FFT Emergency Department good experience score	Apr 20 - Jan 26	Month	-	82.0%	82.3%		-	-	The overall ED Good score declined by 0.6% compared to December. There was no change to the Poor score. **For JAN** there were 1,160 FFT responses collected from approx. 7,157 patients.
FFT Emergency Department poor experience score	Apr 20 - Jan 26	Month	-	10.3%	10.8%	L	S7	-	
FFT Maternity (all FFT data from 4 touchpoints) good experience score	Jul 20 - Jan 26	Month	-	91.0%	92.3%		-	-	**JAN:** Antenatal 1 response: 100% Good; Birth had 37 FFT responses out of 404 patients - 92% Good / 5.4% Poor; Postnatal had 137 FFT responses: Lady Mary had 131 FFT with 91% Good / 2.3% Poor, COU had 5 FFT responses with 100% Good. Zero community midwife FFT data. **JAN MATERNITY OVERALL:** 175 responses: Good score 91% (1% increase) and Poor score 3.0% (1% decrease).
FFT Maternity (all FFT data from 4 touchpoints) poor experience score	Jul 20 - Jan 26	Month	-	3.0%	3.6%		-	-	

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

The January inpatient SMS response rate is 21%, (473 FFT responses collected from 2,253 SMS sent) and overall inpatient response rate is 25.4%. This is a slight increase compared to December. The overall inpatient FFT Good score decreased by 1.5% and the Poor score increased by 0.5% compared to December. Unlike the previous month where all divisions improved the Good FFT score, in January only one division had a slight improvement in the Good score; division E Good score improved by 0.7%. The rest of the divisions the Good FFT score decreased by 2% - 3%. For the Poor FFT score, divisions A, B & C the Poor score increased from 1%-2%. Divisions D & E the Poor score did not change. All wards collected FFT in December.

For outpatient and day case, the only change in the Good and Poor FFT scores was a slight decrease of 0.6% in the outpatient Good FFT score.

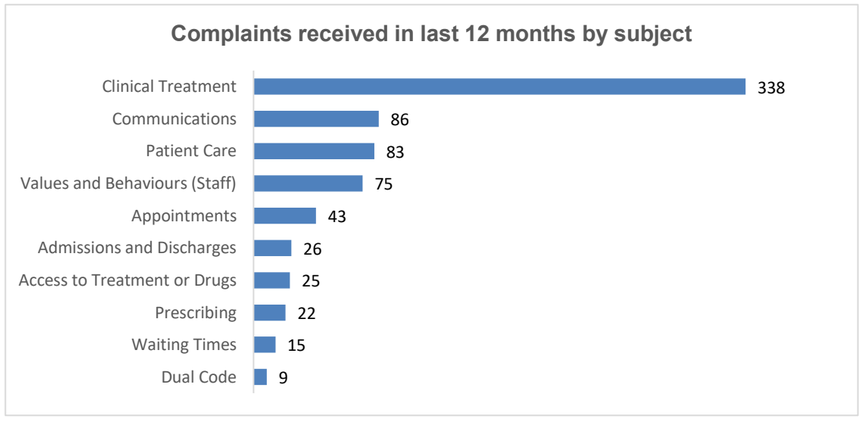
For ED, the overall Good score declined by 0.6% and the Poor score did not change compared to December. The adult ED Good score declined by 1% and no change in the Poor score. The main adult ED shows the Good score improved by 1% and the Poor score increased by 0.6%. The paediatric ED Good score improved by 2% and the Poor score declined by 1%. Clinic 5 SDEC, EAU3, D6 SDEC and Urgent Care Centre all had the Good score decline with Clinic 5 a 6% decline and D6 SDEC a 11% decline. But Clinic 5 also improved their Poor score by 2%. D6 SDEC Poor score increased by 3% and no change for UCC.

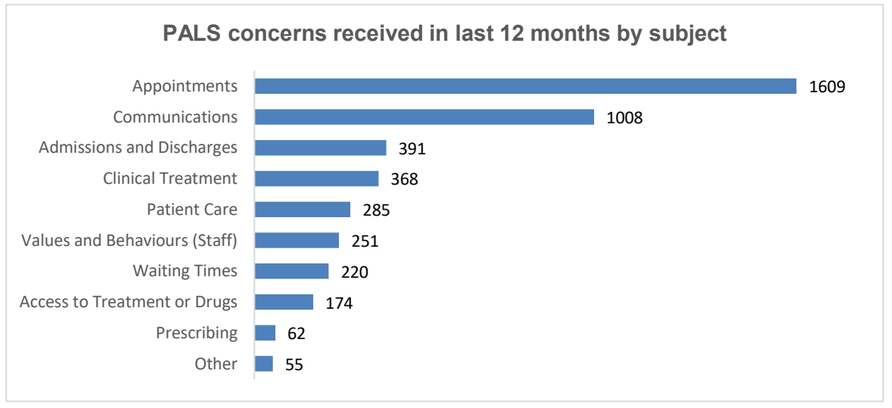
Overall maternity FFT scores improved compared to December. The overall Good score increased by 1.3% and the Poor score declined by 0.8%. The Good score improvement is mainly from Rosie Delivery Unit (11% increase) and also Lady Mary (2% increase). The increased number of FFT responses in November from postnatal of 115 responses, declined in December to 67 FFT responses and recovered in January to 137 responses; 131 from Lady Mary. Delivery Unit also increased their number of FFT responses and collected 23, which while is still lower than average, is an improvement and the highest number of responses for 15 months. Zero FFT data was collected for Community.

PALS and Complaints Cases

NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Data range	Period	Target	Current period	Mean	Variance	Special causes	Target status	Comments
Complaints received	Jan 21 - Jan 25	month	-	77	67		-	-	The Trust and all Divisions are within normal variance.
% acknowledged within 3 days	Jan 21 - Jan 25	month	95%	96%	88%	H	Shift	?	The Trust and Division D have seen a statistical increase in the last 9 months, all Divisions are within normal variance. Divisions A, B, C and E met the target of 95%. 71 out of 74 complaints were acknowledged within 3 days.
% responded to within initial set timeframe (30, 45 or 60 working days)	Jan 21 - Jan 25	month	80%	44%	44%		-	F	The Trust and all Divisions are within normal variance but only Division A met the target. The Trust is statistically unlikely The Trust and all Divisions are within normal variance but didn't meet the target. The Trust and Division E are statistically unlikely to meet the target. 29 out of 66 complaints closed in January were responded to within the initial set timeframe. to meet the target. 32 out of 54 complaints closed in December were responded to within the initial set timeframe.
% complaints received graded 4 to 5	Jan 21 - Jan 25	month	-	18%	21%		-	-	The Trust and all Divisions are within normal variation. There were 13 graded 4 and 1 graded 5 in January.
Compliments received	Jan 21 - Jan 25	month	-	20	30	H	Shift	-	The Trust and all Divisions are within normal variance.





The department is currently sitting at 249 open complaints. This has risen since last month but this is accounted for by a rise in the number of complaint received since November continuing into January. Our aim is to decrease the number of open number of complaints to below 200 over the coming months and the department also aims to close more complaints in the month than the number received.

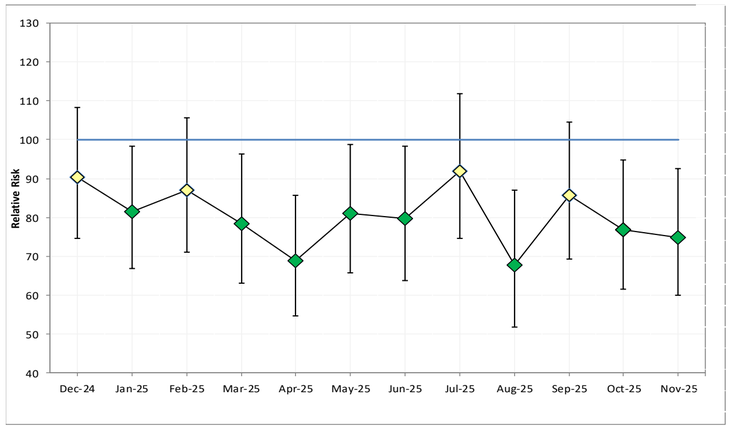
Author(s): **Owner(s): Clare Hawkins**

Learning from Deaths

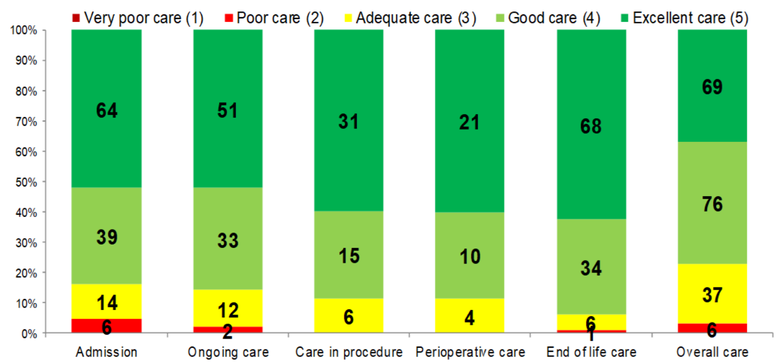
NHS Cambridge University Hospitals NHS Foundation Trust

Indicator	Jan-26	Average (Feb 23 - Jan 26)	Variance	Comments
Total inpatient and Emergency department **deaths**	148	139		There has been normal variance in the total number of deaths at CUH. In January 2026, there were 128 inpatient deaths, 20 deaths in the Emergency Department (ED), and none in the Virtual Ward. ED deaths, Inpatient deaths and Virtual Ward deaths remain within normal variance.
Total Emergency Department and Inpatient deaths **per 1000 admissions**	8	8	L	There has been a statistically significant decrease in the death rate per 1,000 admissions. In January 2026 there were 19584 admissions recorded at time of analysis.
Emergency department deaths per 1,000 attendances	1.13	0.82		There has been normal variance in the rate per 1000 attendances. In January 2026 there were 17634 ED attendances recorded at time of analysis.
Inpatient deaths by 1,000 admissions	6.54	7.08	L	There has been a statistically significant decrease in the rate by 1,000 admissions marking 11 consecutive months below the mean.
Non-elective admission deaths by 1,000 admissions	31.71	31.08	L	There has been a statistically significant decrease in the rate by 1000 admissions marking 11 consecutive months below the mean.
% of CUH deaths **in-scope for a mortality case review**	19.6%	18.3%		In January 2026, 29 Mortality case reviews were commissioned. The highest in-scope trigger for review requests were due to ED death.

HSMR by Month



Phases of care from SJR methodology
(February 2025 - January 2026)



Executive Summary

The Trust is within normal variance for the total number of deaths,. There is a statistically significant decrease in three of the above metrics by rate per 1000 admissions and per 1000 attendances.

In January, there was no death that was identified with a problem in care score of 1-3.

The majority of each 'phase of care' from SJR methodology was judged to be good/excellent care.

HSMR - The rolling 12 month (December 2024 to November 2025 HSMR for CUH) is 80.59 this is 5th lowest within the London and ATHOL peer group. The rolling 12 month HSMR for the Shelford Peer group is 88.43

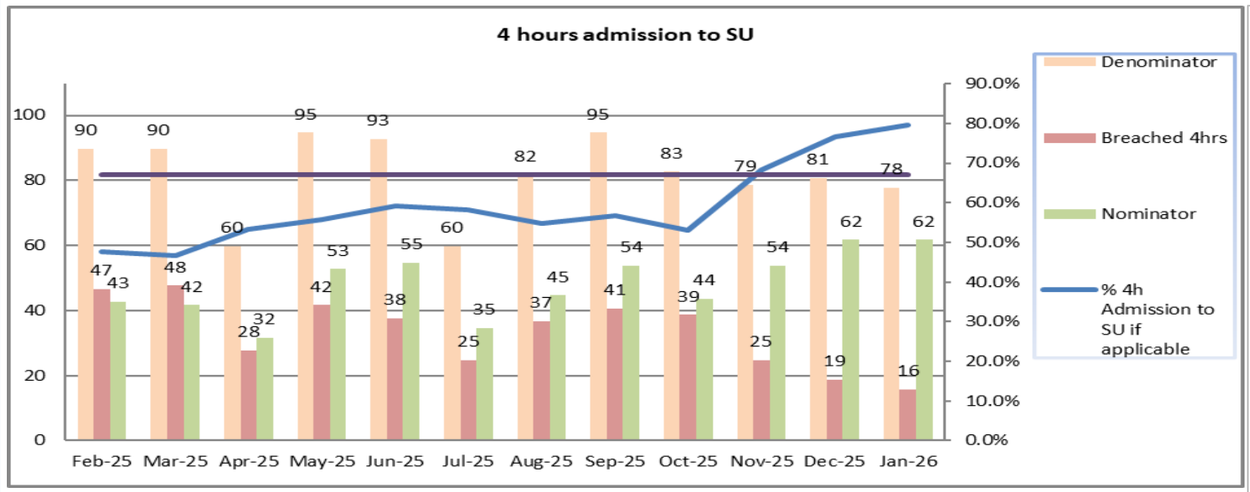
SHMI - The Summary Hospital-level Mortality Indicator (SHMI) for CUH in the latest period, October 2024 to September 2025 is 97.77.

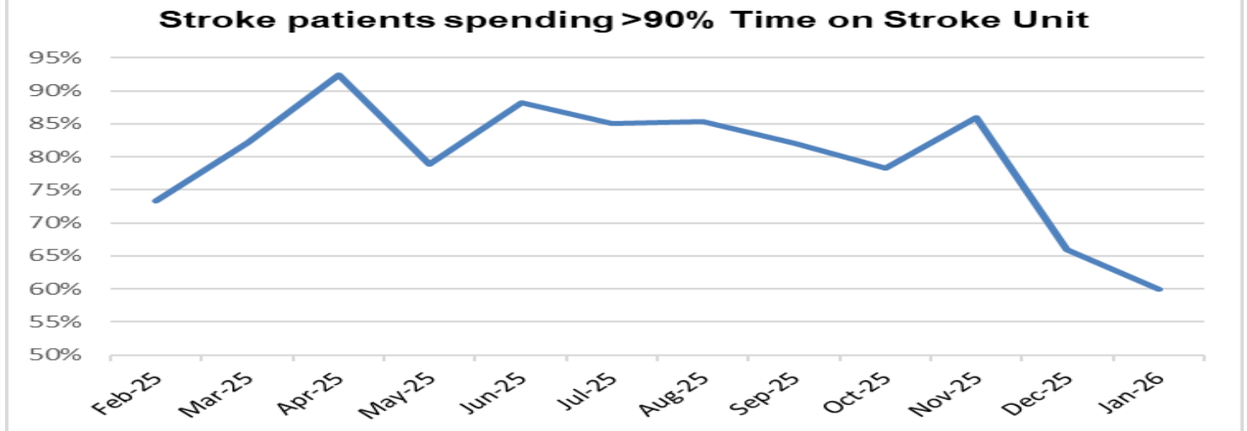
Alert - There are 2 alerting procedural groups (Excision of Liver and Rest of Nervous System) for November '25.

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

Stroke Care

NHS
Cambridge University Hospitals
NHS Foundation Trust





90% target (80% Patients spending 90% IP stay on Stroke ward) was not achieved for January 2026 = 60**%**

4hrs adm to SU (67%) target compliance was achieved in January 2026 = 79.5**%**

Stroke Video Triage to go live 1st March 2026

Stroke Full Capacity Protocol paused:
Enables ward to create an additional HASU monitored when required.

Request to create monitored 5th HASU bed submitted
Has been enacted 3 x occasions since November 2025

New SSNAP administrator appointed. Start date end of Feb 2026 tbc

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

Clinical Studies

NHS
Cambridge University Hospitals
NHS Foundation Trust

Total Recruitment at end of Jan - FY 2025-26

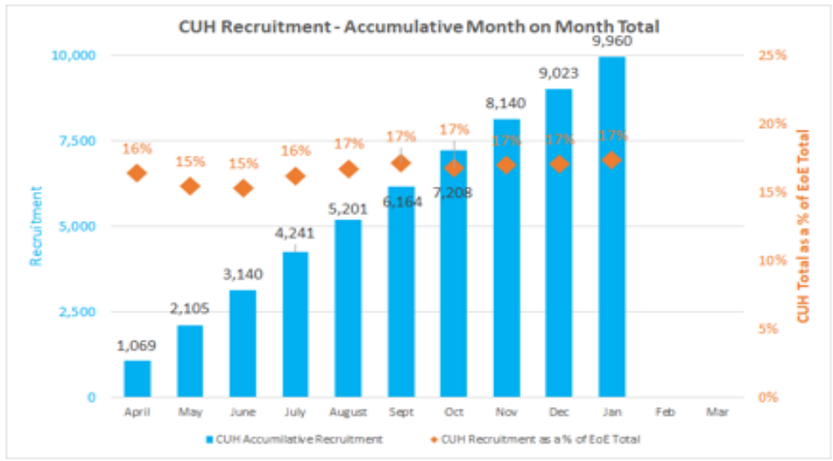
9,960

Open Studies at end of January 2025

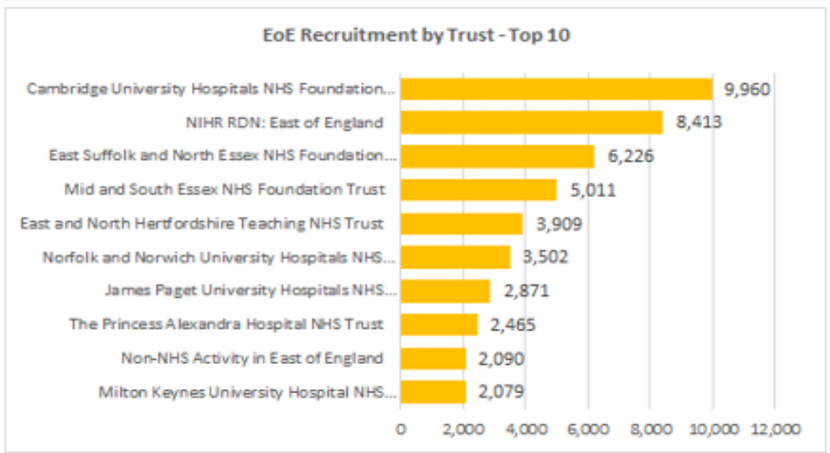
Non Commercial	438
Commercial	139
Total	577

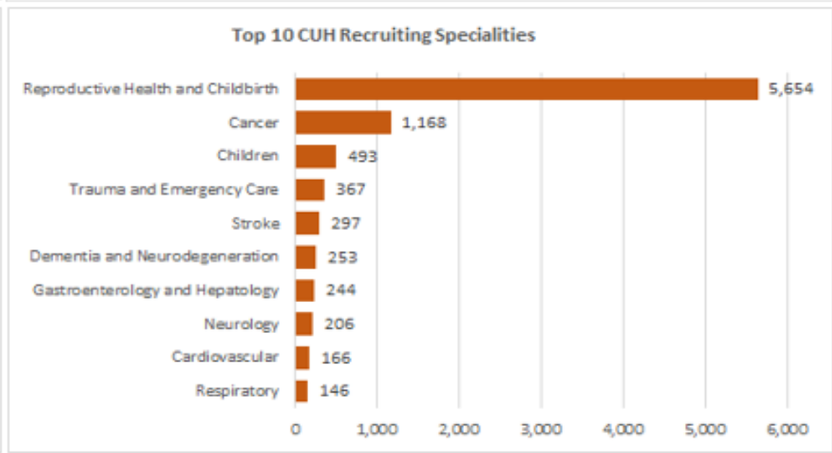
CUH Recruitment by Study Type

Observational	40%
Interventional	34%
Both	26%









* Total recruitment in the financial year to date: 9,960.
* 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.
* Recruitment to the Reproductive Health and Childbirth speciality accounted for over 50% of all recruitment. The Cancer speciality accounted for 12%. All of the other individual specialities accounted for less than 5% of the total recruitment.
* There were 577 open recruiting studies, of which 139 were Commercial, and 438 Non-Commercial.

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

Maternity Dashboard

NHS
Cambridge University Hospitals
NHS Foundation Trust

Division E **Maternity Dashboard** **January 26**

Metric	Target	In Month Actual	Previous Month	3-month average		SPC variation - this month	12 month variation
Activity							
Births		443	460	441			
Induction of Labour rate		32%	28%	31%			
Delay in commencement of Induction (IOL)	9.9%	8%	7.46%	7%	L	Positive special cause variation below the mean	
Delay in continuation of Induction (IOL)	9.9%	56%	70.9%	59%	H	Negative special cause variation above the mean	
IOL for RFM <39/40 (SBLv3)	5.0%	13%	0%	4%			
Valid indication for IOL	95.0%	100%	100%	100%			
Caesarean Section							
CS rate (planned & unplanned)		48.1%	48.9%	46.3%			
Women in RG*1 having a caesarean section with no previous births: nullip spontaneous labour		27.7%	25.3%	25.2%			
Women in RG*2 having a caesarean section with no previous births: nullip induced labour, nullip pre-labour LSCS		61.4%	65.4%	58.4%			
Ratio of women in RG1 to RG2		1:2.7	1:3.18	1:2.88			
Women in RG5. Multips with 1 or 2+ previous C/S		88%	86%	86%			
Women in RG1, RG2, RG5 combined contribution to the overall C/S rate.		70%	68%	68%			

Division E **Maternity Dashboard** **January 26**

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	0.3		Normal Variation	
Total number of hours on divert		0	0	6.7		Normal Variation	
Admissions to Rosie during divert status		0	0	3.0			
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	4	9	5.7			
Triage							
Women Seen for Initial Triage Within 15 Minutes of arrival	85%	85.9%	85.2%	86.7%		Normal Variation	
Overall: Women seen by midwife within required timeframe based on initial RAG rating	85%	98.9%	97.8%	98.5%	H	Positive special cause variation above the mean	
Overall: Women reviewed by obstetrician within required timeframe based on initial RAG rating	85%	76.2%	74.8%	77.6%	H	Positive special cause variation above the mean	

Maternity Dashboard

NHS Cambridge University Hospitals NHS Foundation Trust

Division E **Maternity Dashboard** **January 26**

Metric	Target	In Month Actual	Previous Month	3-month average		SPC variation - this month	12 month variation
Maternal Morbidity							
Puerperal Sepsis		0.17%	0.50%	0.33%		Normal Variation	
ITU Admissions in Obstetrics		1	3	1			
Massive Obstetric Haemorrhage >= 1500 mls - vaginal birth	≤3.3%	4.15%	4.46%	4.33%		Normal Variation	
Massive Obstetric Haemorrhage >= 1500 mls - caesarean birth	≤4.5%	4.26%	1.03%	2.62%		Normal Variation	
3rd / 4th degree tear rate	≤5%	2.31%	4.91%	4.02%		Normal Variation	
3rd / 4th degree tear rate - Spontaneous vaginal birth	≤2.5%	1.72%	4.84%	3.71%			
3rd / 4th degree tear rate - Instrumental birth	≤4.5%	4.76%	5.26%	5.23%			
Maternal readmission rate		2.37%	1.66%	1.95%		Normal Variation	
Peripartum Hysterectomy		0	1	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			

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

Maternity Dashboard

NHS Cambridge University Hospitals NHS Foundation Trust

Division E **Maternity Dashboard** **January 26**

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	2.08	2.42	2.25			
Still Births - number >= 22 weeks	5	1.00	2.00	1.00		Normal Variation	
Babies born with an Apgar <7 at 5 minutes of age		2.05%	2.19%	2.05%		Normal Variation	
Incidence of neonatal readmission		6.00%	#N/A	#N/A		Normal Variation	
Term Admission to NICU Rate**	≤6%	4.09%	5.60%	5.54%		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%	#N/A	86.2%	#N/A		Normal Variation	
SATOD (Smoking at Time of Delivery)	6%	3.2%	3.1%	3.0%	L	Positive special cause variation below the mean	
CO Monitoring at booking	95%	91.0%	95.0%	91.5%		Normal Variation	
CO Monitoring at 36 weeks	95%	80.0%	83.0%	78.7%		Normal Variation	
VTE Assessment - AN	95%	89.6%	86.6%	90.3%	H	Positive special cause variation above the mean	
VTE Assessment - PN	95%	97.8%	98.0%	97.4%		Normal Variation	

Finance

NHS
Cambridge University Hospitals
NHS Foundation Trust

Trust performance summary - Key indicators

Trust actual surplus / (deficit)

(£1.2m)	*Actual (adjusted)**
£1.2m	*Plan (adjusted)**
£0.2m	*Actual YTD (adjusted)**
(£1.7m)	*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	£23.1m	£222.8m
EPM plan	£22.0m	£217.2m
EPM 24/25 target	£19.7m	£186.7m

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

Net current assets

(£150.4m)	*Actual*
(£116.1m)	*Plan*

Debtor days

28	*This month*
26	*Previous month*

Payables performance (YTD) **

87.9%	*Value*
92.0%	*Quantity*

EBITDA

£50.8m	*Actual YTD*
£43.2m	*Plan YTD*

Capital expenditure

£12.0m	*Capital - actual spend in month*
£60.9m	*Capital - actual spend YTD*
£52.2m	*Capital – plan YTD*

Cash

Cash

£42.4m	*Actual*
£118.9m	*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

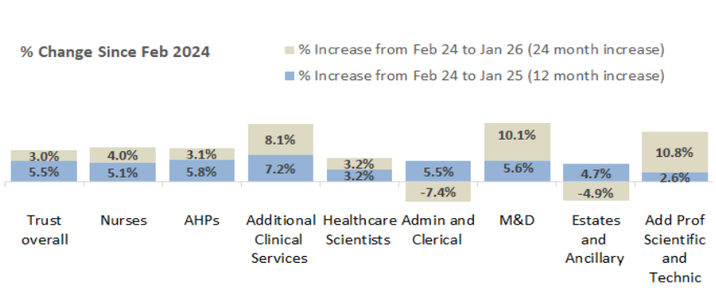
Staff Group	Headcount		Headcount 12 Month growth	FTE		FTE 12 Month growth	
	Feb-25	Jan-26		Feb-25	Jan-26		
Add Prof Scientific and Technic	260	285	9.6%	235	257	22	9.4%
Additional Clinical Services	2,351	2,305	-2.0%	2,165	2,119	-46	-2.1%
Administrative and Clerical	2,796	2,453	-12.3%	2,577	2,260	-316	-12.3%
Allied Health Professionals	852	835	-2.0%	755	741	-14	-1.8%
Estates and Ancillary	404	369	-8.7%	389	355	-35	-8.9%
Healthcare Scientists	751	776	3.3%	715	742	27	3.8%
Medical and Dental	1,900	1,983	4.4%	1,781	1,850	69	3.9%
Nursing and Midwifery Registered	4,410	4,399	-0.2%	4,076	4,058	-18	-0.4%
Total	**13,724**	**13,405**	**-2.3%**	**12,693**	**12,382**	**-311**	**-2.4%**

12 Month Growth by Division

Division	Headcount		Headcount 12 Month growth	FTE		FTE 12 Month growth	
	Feb-25	Jan-26		Feb-25	Jan-26		
Division A	2,584	2,512	-2.8%	2,437	2,363	-74	-3.0%
Division B	3,663	3,616	-1.3%	3,395	3,353	-42	-1.2%
Division C	1,948	1,950	0.1%	1,809	1,815	7	0.4%
Division D	1,649	1,616	-2.0%	1,514	1,477	-37	-2.4%
Division E	1,645	1,646	0.1%	1,433	1,431	-2	-0.2%
Corporate	1,689	1,535	-9.1%	1,599	1,454	-145	-9.1%
Clinical & Corporate Total	**13,178**	**12,875**	**-2.3%**	**12,187**	**11,894**	**-294**	**-2.4%**
Research & Development	546	530	-2.9%	506	489	-17	-3.4%
Total	**13,724**	**13,405**	**-2.3%**	**12,693**	**12,382**	**-311**	**-2.4%**

Admin & Medical Breakdown

Staff Group	Feb-25	Jan-26	FTE 12 Month growth	
Administrative and Clerical	2,577	2,260	-316	-12.3%
of which staff within Clinical Division	1,262	1,052	-210	-16.6%
of which Band 4 and below	858	692	-167	-19.4%
of which Band 5-7	280	254	-27	-9.5%
of which Band 8A	59	55	-3	-5.6%
of which Band 8B	13	11	-2	-12.7%
of which Band 8C and above	52	40	-12	-23.1%
of which staff within Corporate Areas	1,035	944	-91	-8.8%
of which Band 4 and below	286	247	-39	-13.7%
of which Band 5-7	493	446	-47	-9.5%
of which Band 8A	99	89	-10	-10.1%
of which Band 8B	50	54	4	7.1%
of which Band 8C and above	107	108	1	1.2%
of which staff within R&D	279	264	-15	-5.5%
Medical and Dental	1,781	1,850	69	3.9%
of which Doctors in Training	700	731	31	4.4%
of which Career grade doctors	292	317	24	8.3%
of which Consultants	789	803	13	1.7%



What the information tells us:

Over the past year, the Trust's substantive workforce decreased by 2.4%.

The largest staff group decrease was in Administrative and Clerical roles (-12.3%), while the Additional Professional Scientific and Technical staff group saw the highest growth (+9.4%).

Corporate Services had the biggest divisional decrease (-9.1% / 145 FTE) over the last 12 months, with Division C having the only divisional increase (+0.4% / 7 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 14.9 FTE.

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	Jan-26 FTE	Dec 25-Jan 26 FTE growth	Dec 25-Jan 26 % growth	Apr 19-Jan 26 FTE growth	Apr 19-Jan 26 % growth	Apr 25-Jan 26 FTE growth	Apr 25-Jan 26 % growth
Corporate	Chief Executive Officer	45	53	57	55	60	59	92	17.6%	8.3%	-2.8%	9.3%	-2.1%	54.7%	69	-1	-1.4%	24	53.7%	-23	-25.0%
	Chief Financial Officer	185	187	192	191	195	217	225	1.4%	2.8%	-0.6%	1.9%	11.5%	3.7%	271	2	0.6%	86	46.8%	46	20.4%
	Dir. of Innovation, Digital & Improvement	244	245	244	243	241	252	249	0.2%	-0.2%	-0.6%	-0.7%	4.5%	-1.3%	176	0	0.0%	-68	-27.9%	-73	-29.2%
	Chief Nurse	53	54	67	64	61	74	78	2.4%	24.0%	-4.9%	-4.4%	21.8%	5.5%	70	-3	-4.1%	17	31.6%	-9	-11.3%
	Chief Operating Officer	21	27	33	36	42	54	43	30.8%	21.7%	9.0%	15.4%	29.8%	-21.7%	43	0	0.0%	22	106.9%	1	1.6%
	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	-2	-5.6%	25	298.9%	15	84.5%
	Estates & Facilities	92	104	108	118	122	133	141	12.6%	3.8%	9.1%	3.4%	9.5%	6.0%	113	-1	-0.9%	21	23.0%	-28	-19.7%
	Medical Director	22	22	23	20	21	24	32	0.0%	5.4%	-15.7%	6.8%	12.5%	36.4%	22	0	0.0%	0	-0.3%	-10	-31.5%
	Director of Workforce	117	120	131	138	154	168	154	2.8%	9.1%	5.1%	11.8%	8.8%	-7.9%	146	-3	-2.3%	30	25.3%	-8	-5.1%
	Capital Funded Projects	-	-	-	-	-	-	11	-	-	-	-	-	-	10	0	0.0%	*newly included*		-1	-11.2%
Corporate Total		**787**	**822**	**870**	**875**	**918**	**997**	**1,043**	**4.4%**	**5.8%**	**0.6%**	**4.9%**	**8.7%**	**4.6%**	**954**	**-9**	**-0.9%**	**167**	**21.2%**	**-89**	**-8.6%**
Clinical	Division A	126	135	144	156	167	168	186	7.1%	6.0%	9.0%	6.8%	0.5%	11.0%	146	-1	-0.7%	20	15.4%	-40	-21.7%
	Division B	425	425	458	462	462	520	520	0.0%	7.8%	0.7%	0.1%	12.4%	0.0%	453	4	0.9%	28	6.6%	-66	-12.7%
	Division C	114	114	114	110	116	121	122	0.1%	-0.1%	-4.0%	5.8%	4.9%	0.0%	104	-2	-1.9%	-10	-8.9%	-18	-14.4%
	Division D	214	216	218	221	225	241	245	0.9%	1.0%	1.2%	2.0%	7.2%	1.5%	214	3	1.5%	0	0.2%	-31	-12.5%
	Division E	133	128	134	142	153	154	166	-3.1%	4.1%	5.9%	8.0%	0.4%	8.4%	134	1	0.4%	2	1.4%	-32	-19.2%
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%**	**1,052**	**5**	**0.5%**	**40**	**3.9%**	**-187**	**-15.1%**
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%	205	0	0.0%	38	22.9%	-26	-11.4%
	Research Grants Directorate	16	22	23	25	29	44	50	38.2%	5.9%	7.7%	15.1%	52.4%	13.6%	49	0	0.1%	34	210.0%	-1	-1.2%
R and D Total		**183**	**211**	**222**	**232**	**252**	**273**	**282**	**15.3%**	**5.4%**	**4.3%**	**8.8%**	**8.4%**	**3.1%**	**254**	**0**	**0.0%**	**72**	**39.2%**	**-27**	**-9.6%**
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%**	**2,260**	**-4**	**-0.2%**	**278**	**14.0%**	**-303**	**-11.8%**

What the information tells us:

From April 2019 to January 2026 the Administrative and Clerical workforce has grown by 14% (278 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 15.4% (20 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.

Since April 2025, the Administrative and Clerical workforce has reduced by 11.8% (-303 FTE). In the past month, the Administrative and Clerical workforce has reduced by 0.2% (-4 FTE).

From April 2025, capital-funded staff, previously excluded, are included in Corporate data - 10 admin FTE directly under Capital Funded Projects and 65 admin FTE costed out to other Corporate areas

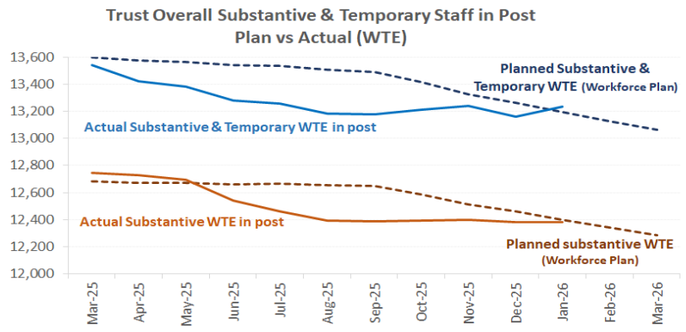
Plan versus actual - Staff in Post WTE

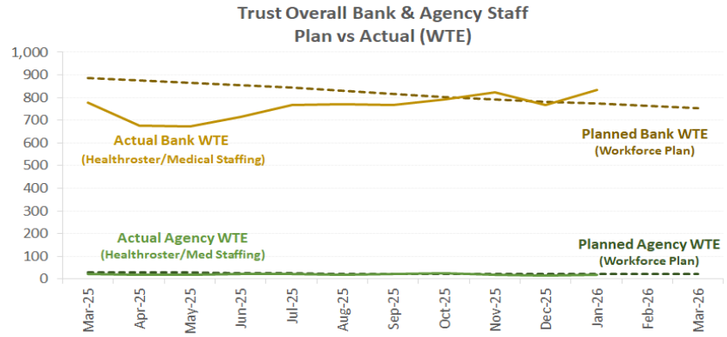
NHS Cambridge University Hospitals NHS Foundation Trust

As at M09 - 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	Nov-25	Dec-25	Jan-26	Movement Mar 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	12,515	12,459	12,399	-283	12,341	12,286	-396
	Bank	885	876	866	854	843	830	817	803	790	780	772	-113	763	753	-132
	Agency	29	28	28	27	27	23	23	24	23	23	23	-6	23	23	-6
	All Staff	13,596	13,576	13,563	13,543	13,538	13,508	13,490	13,414	13,327	13,262	13,194	-402	13,126	13,062	-535

	ACTUAL	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Movement Mar 25-Jan 26
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	12,399	12,379	12,382	-361
	Bank	778	676	672	715	769	772	769	793	823	768	833	55
	Agency	23	20	17	22	24	20	21	25	18	15	17	-6
	All Staff	13,545	13,424	13,382	13,280	13,255	13,182	13,177	13,210	13,240	13,163	13,232	-312





Additional posts agreed since budget setting:

Note: An additional 108 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						6.0		6.9
Division E			1.0			0.8						2.8	1.2	5.8
Grand Total	5.0	9.8	14.0	1.6	19.0	6.8	10.5	2.0	5.0	1.0	1.0	18.5	14.2	108.3

What the information tells us:

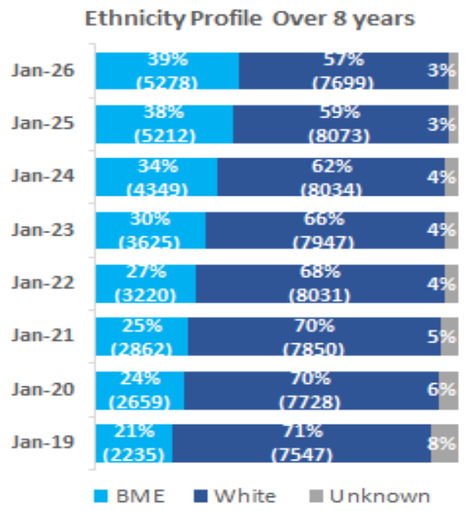
Overall WTE is 38 WTE over plan in the tenth month of the financial year, with bank staffing higher than planned. Substantive staff starting point for March 2025 was higher than anticipated, however the decrease of 361 WTE from March 2025 to January 2026 (2.8% decrease), is greater than the 2.2% planned decrease for the same period.

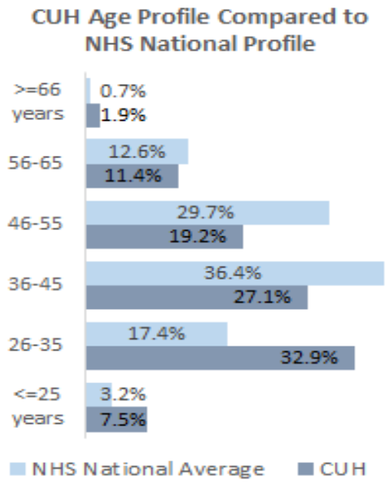
Substantive staff in post increased by 0.03% from last month (3.3 WTE). Bank staff usage increased by 8.4% from last month (65 WTE), and agency usage increased by 13% (2 WTE).

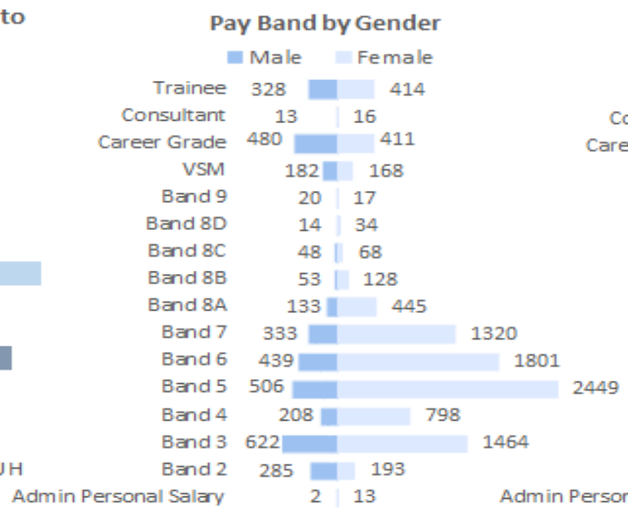
Author(s): Chloe Schafer, Amanda Wood **Owner(s): David Wherrett**

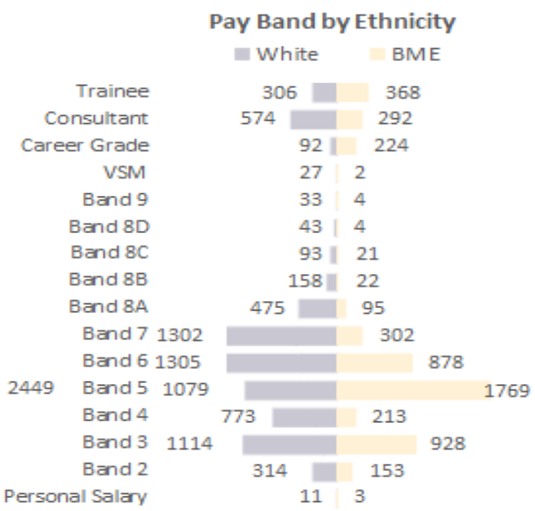
Equality Diversity and Inclusion (EDI)

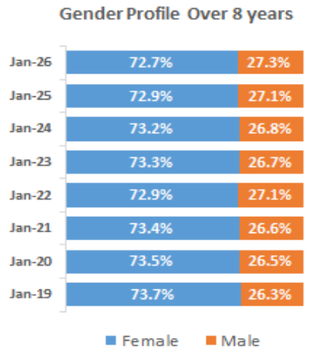
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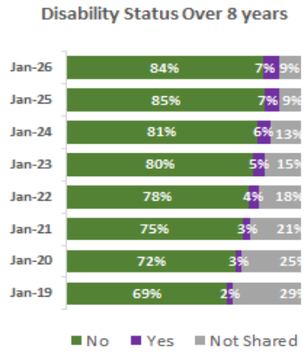


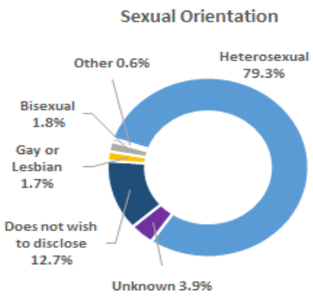












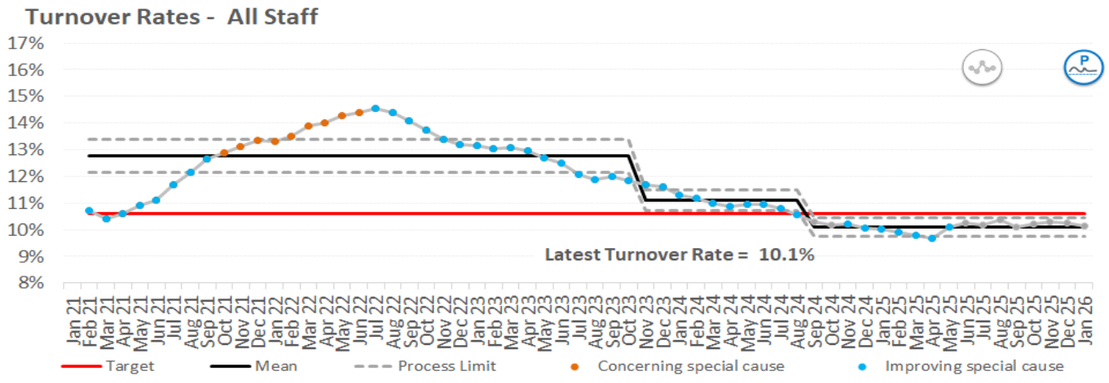
What the information tells us:

- 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 4.5% to 6.9% over the seven year period. However, there are still significant gaps between the data recorded about our staff on ESR compared with the information staff share about themselves when completing the National Staff Survey.
- There remains a high proportion of staff who have, for a variety of reasons, not shared their sexual orientation.

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

Staff Turnover

Cambridge University Hospitals NHS Foundation Trust



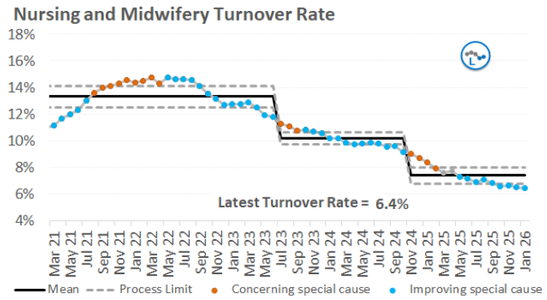
Background Information: Turnover describes the rate that employees leave an establishment. Staff turnover is calculated by the number of leavers from the Trust over the previous twelve months as a percentage of the total number of employed staff at a given time. (Excludes all fixed term contracts including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

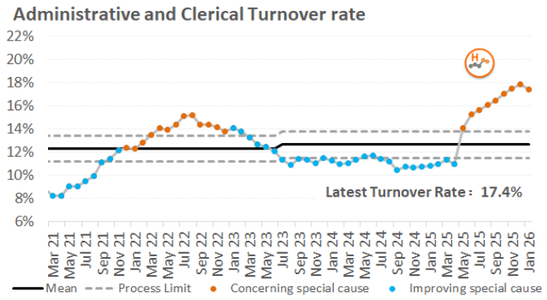
What the information tells us:

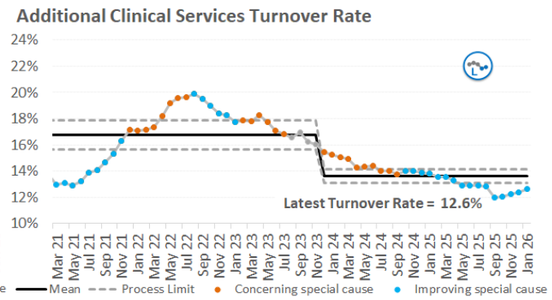
Turnover has reduced by 0.1% from last month to 10.1%. This is below the Trust target (10.6%) and 0.1% higher than January last year.

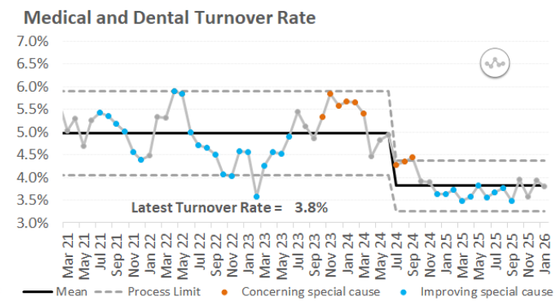
Administrative and Clerical staff had the highest turnover at 17.4%, down 0.4% from last month and 6.6% higher than the same period last year. Estates and Ancillary staff group is also flagging as high at 14.8%.

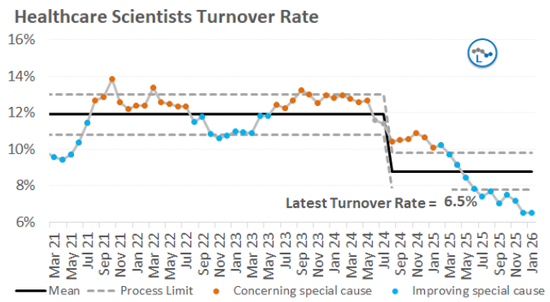
Medical and Dental had the lowest turnover rate at 3.8%, followed by Nursing and Midwifery at 6.4%.

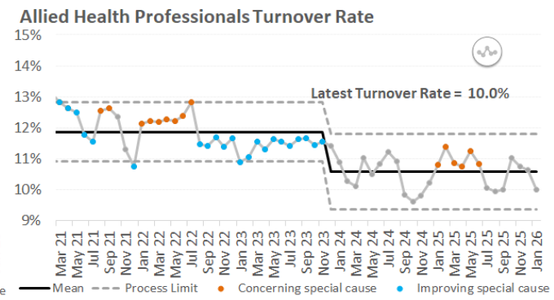


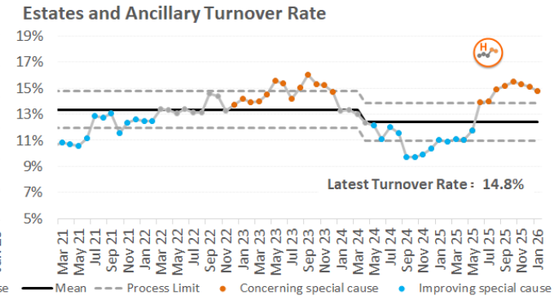


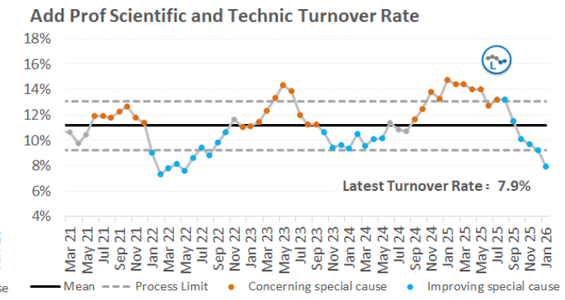








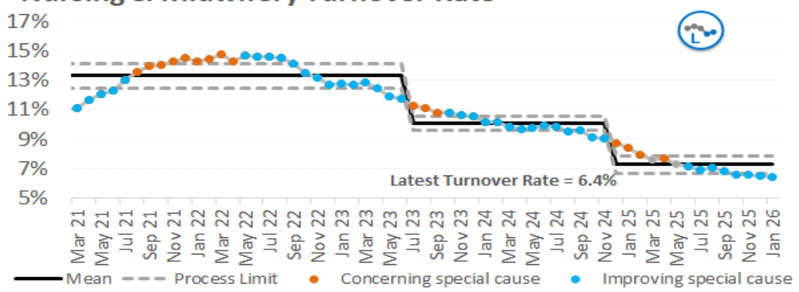




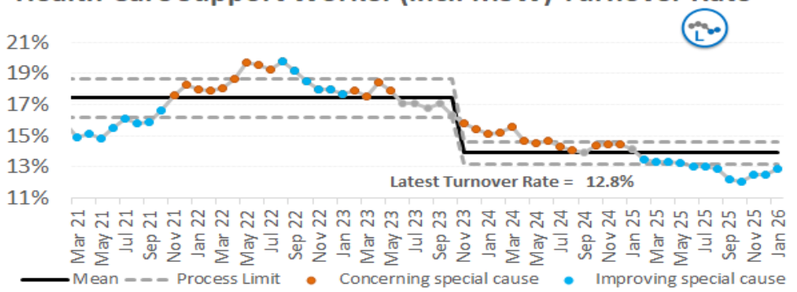
Turnover for Nursing & Midwifery Staff Group (Registered & Non-Registered)

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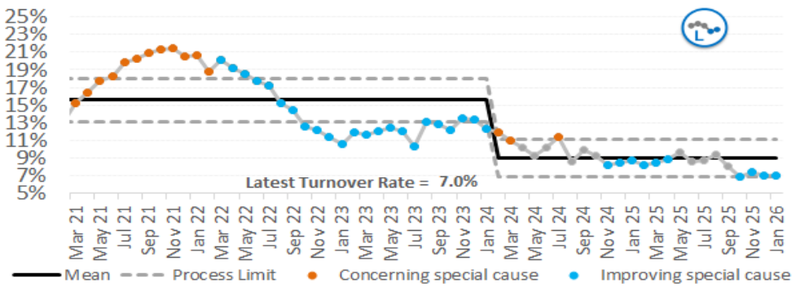
Nursing & Midwifery Turnover Rate



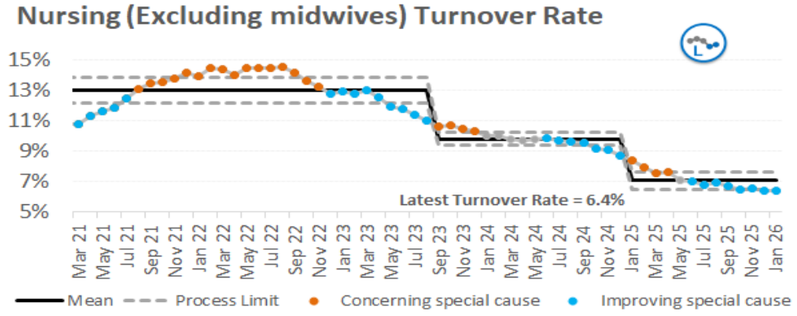
Health Care Support Worker (incl. MSW) Turnover Rate



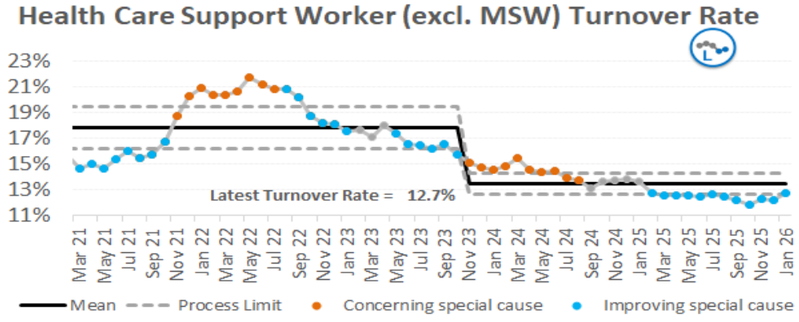
Midwife Turnover Rate



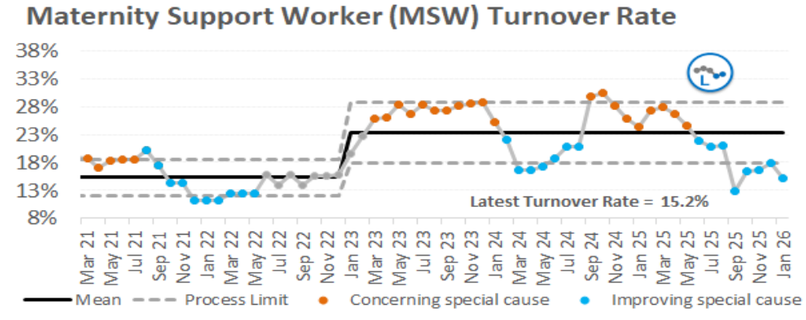
Nursing (Excluding midwives) Turnover Rate



Health Care Support Worker (excl. MSW) Turnover Rate

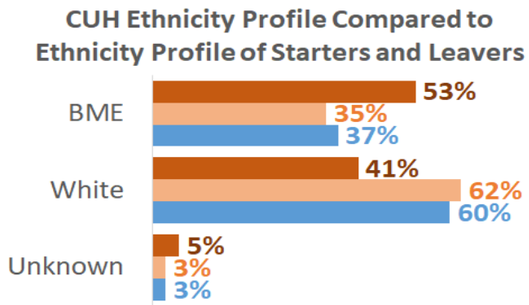


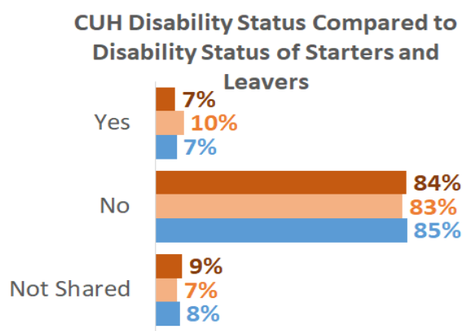
Maternity Support Worker (MSW) Turnover Rate

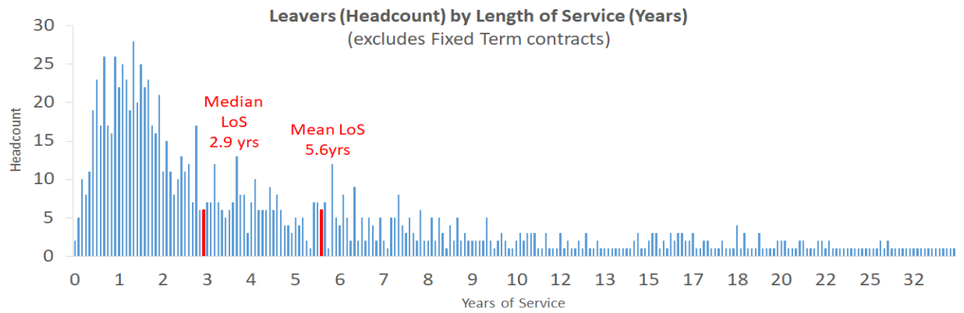


Starters & Leavers - last 12 months

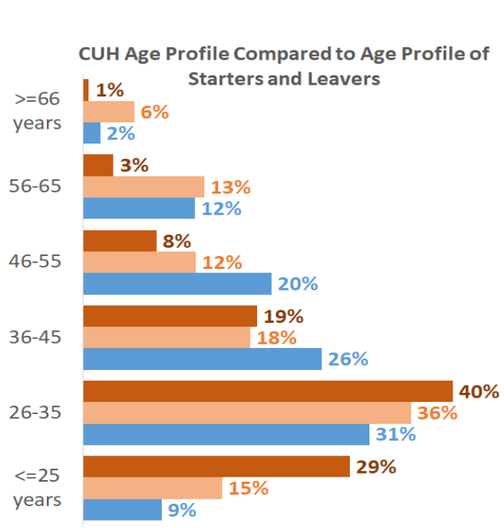
Cambridge University Hospitals NHS Foundation Trust

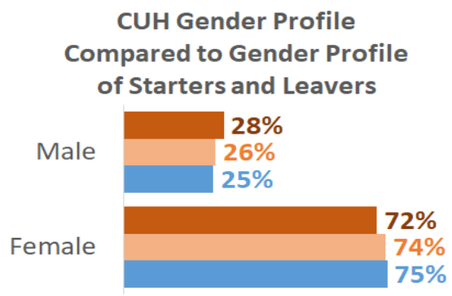


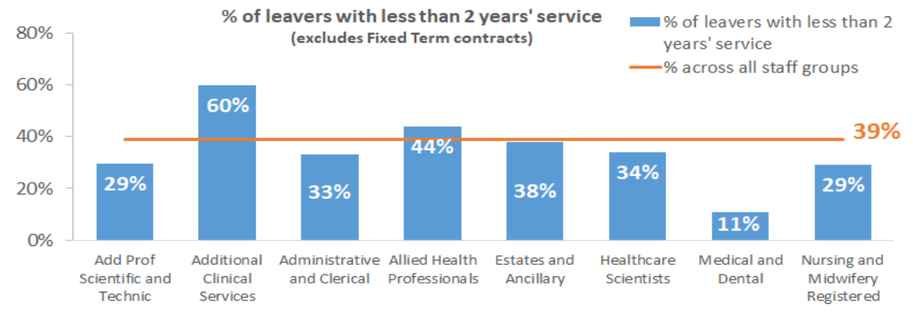




Starters last 12 months | Leavers last 12 months | Average of staff in post during period







What the information tells us:

In the month of January there were a total of 92.5 WTE leavers from the Trust, and 100 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 (69% and 51% 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 starting at the Trust, and a slightly higher proportion of people with a disability leaving the Trust. 10% of leavers from the Trust in the last 12 months had a disability, compared to 7% of the staff profile. 53% 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 (39%), 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 5.6 years, with a median of 2.9 years

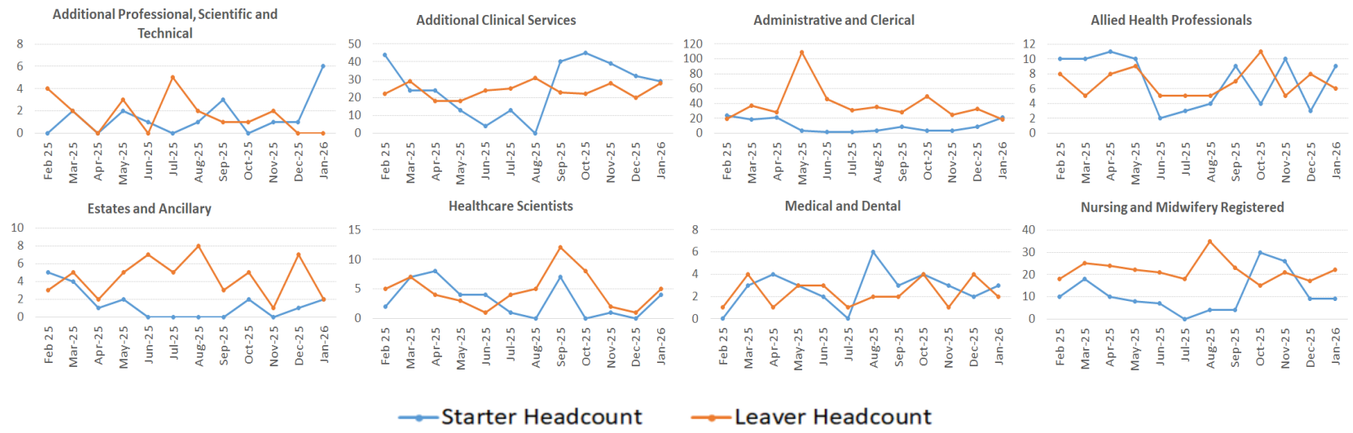
Excludes Fixed Term and Locum Medical and Dental staff, and staff leaving and returning to CUH (as bank only/retire and return etc.)

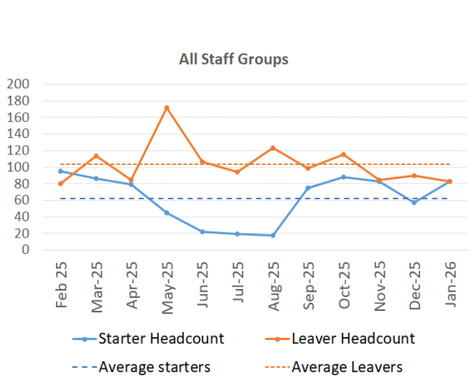
Author(s): Chloe Schafer, Amanda Wood

Owner(s): David Wherrett

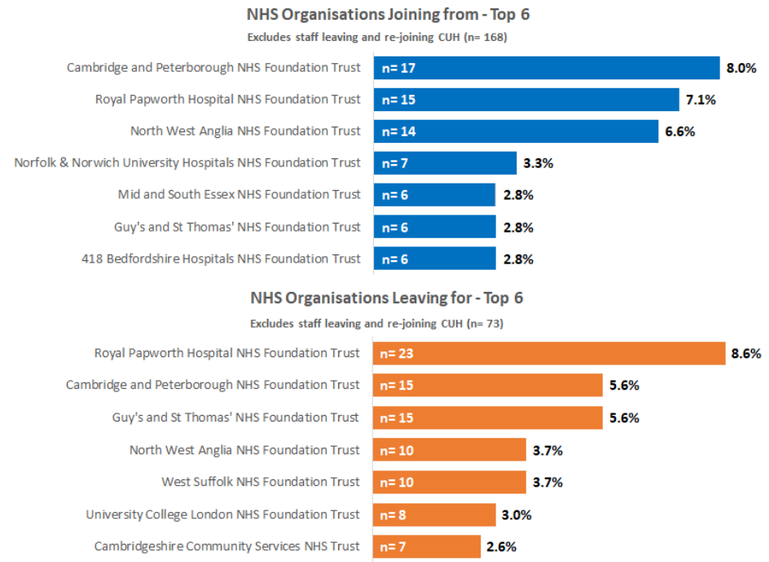
Starters & Leavers - Last 12 months

Cambridge University Hospitals NHS Foundation Trust





Top 10 Leaving Reasons Excludes staff leaving and re-joining CUH (n= 73)	Number of Leavers (Headcount)	% of all Leavers
Voluntary Resignation - Relocation	243	19%
Voluntary Resignation - Work Life Balance	185	15%
Mutually Agreed Resignation - Local Scheme with Repayment	133	11%
Voluntary Resignation - Promotion	83	7%
Voluntary Resignation - Pay and Reward Related	81	6%
Retirement Age	78	6%
Redundancy - Compulsory	70	6%
Voluntary Resignation - To undertake further education or training	66	5%
End of Fixed Term Contract	53	4%
Voluntary Resignation - Health	48	4%



What the information tells us:

The top three reasons for leaving are Voluntary Resignation - due to relocation (19%), for work/life balance (15%) and through the Mutually Agreed Resignation scheme (11%).

The top destination on leaving over the last 12 months is to 'No Employment' (46% of leavers). The most popular external NHS organisation to join from was Cambridgeshire & Peterborough NHS Foundation Trust and the most popular to leave to was Royal Papworth Hospital NHS Foundation Trust.

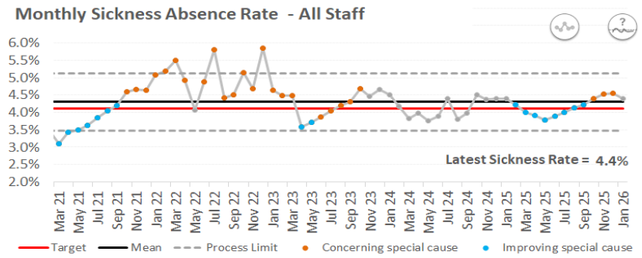
In the month of January 2026 alone the most popular destinations on leaving were to 'No Employment' (27% of leavers) and to another 'NHS Organisation' (20% of leavers).

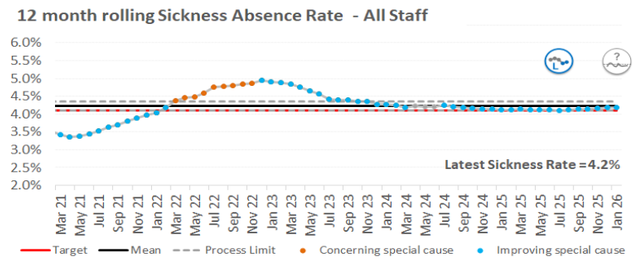
Author(s): Chloe Schafer, Amanda Wood

Owner(s): David Wherrett

Sickness Absence

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. Given the national target for absence is 4.1% the CUH internal target has been updated in response.





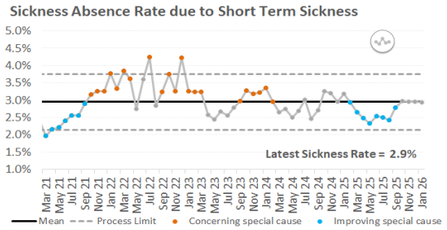
What the information tells us:

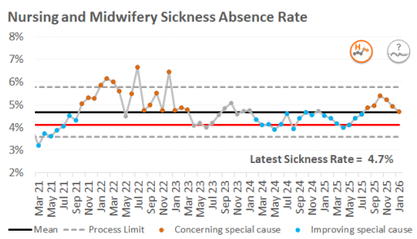
Overall monthly sickness absence in January is 0.1% lower than last month, at 4.4%. This is the same rate as January last year.

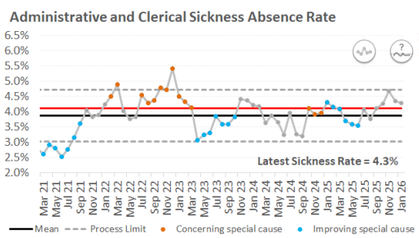
The sickness absence rate due to short term illness is 2.9%, with the long-term sickness rate at 1.5%. The Estates and Ancillary staff group had the highest sickness absence rate in January at 7.2%, followed by Additional Clinical Services at 5.9%.

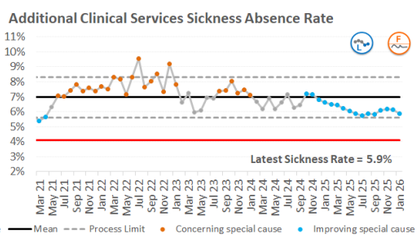
The rolling 12-month sickness rate is 4.2% - this is 0.1% higher than the national target of 4.1%.

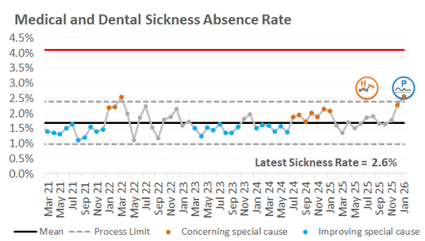
Monthly rates:

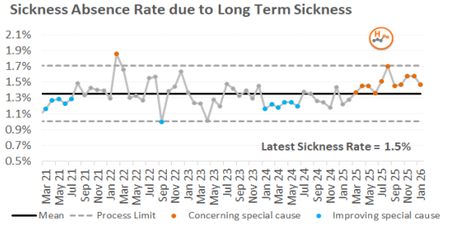


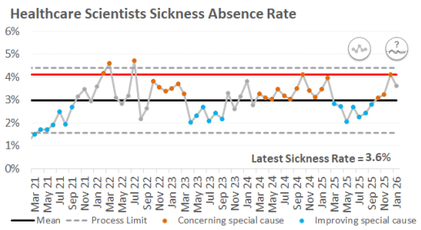


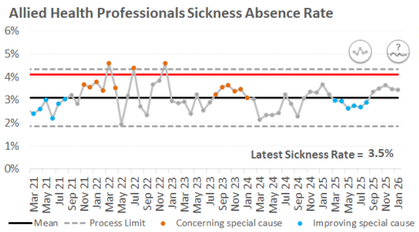


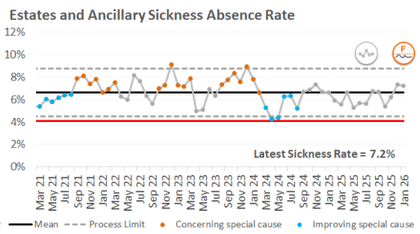


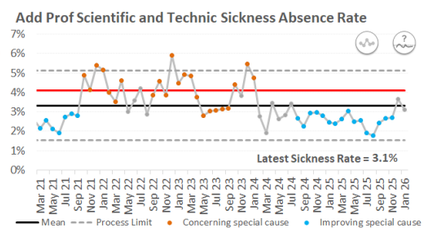








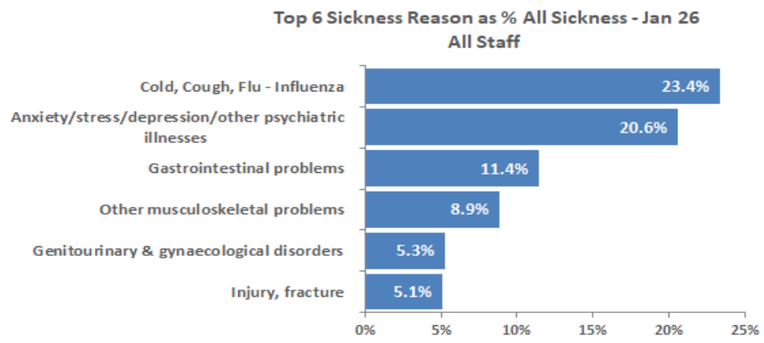




Author(s): Chloe Schafer, Amanda Wood **Owner(s): David Wherrett**

Top Six Sickness Absence Reason

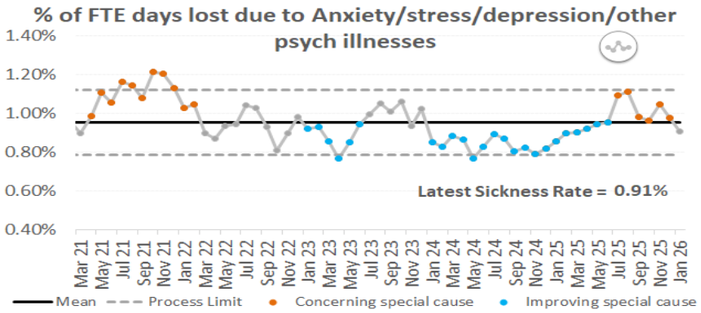
NHS
Cambridge University Hospitals
NHS Foundation Trust

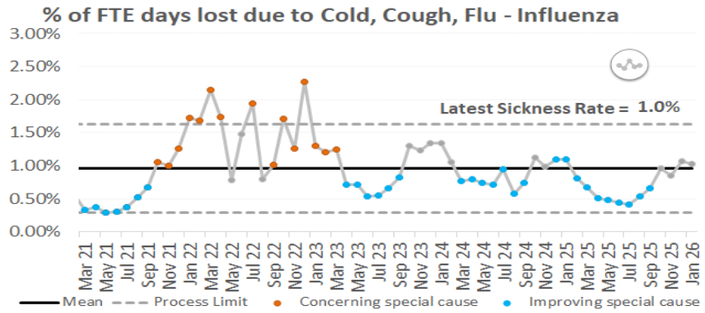


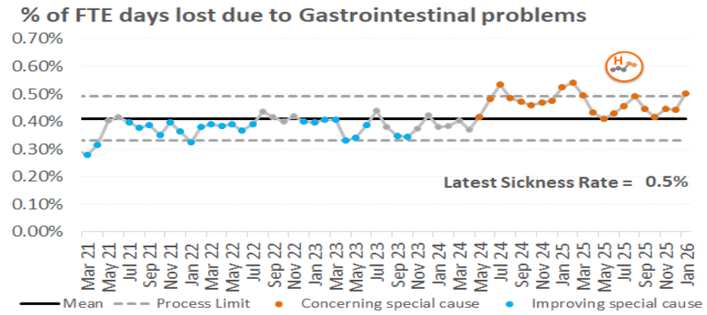
Background Information: Sickness Absence reason is provided as a percentage of all FTE days missed due to sickness during the reporting month.

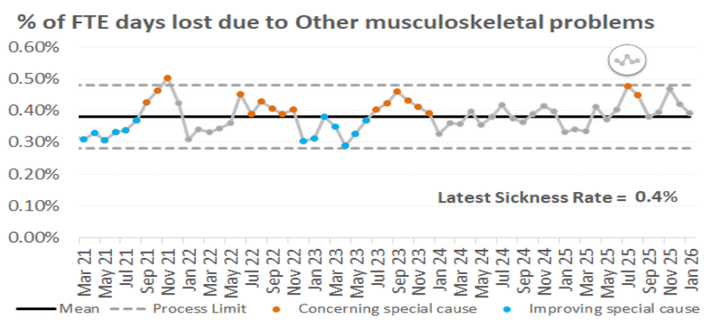
What the information tells us:
The top reason for sickness absence in January 2026 was Cold, Cough, Flu - Influenza, with an absence rate of 1%. This is the same rate as last month and 0.1% lower than in January last year.

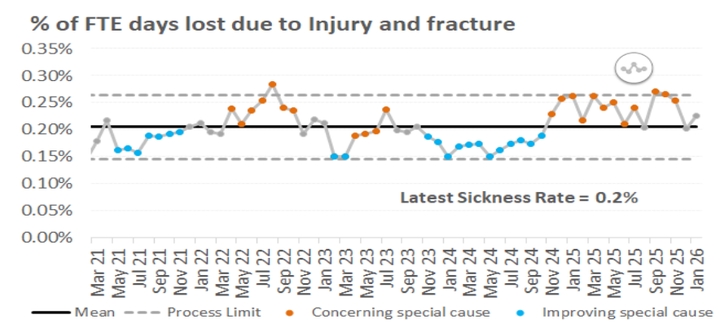
As a percentage of all sickness absence Cold, Cough, Flu - Influenza accounts for 23.4% of the overall days lost.

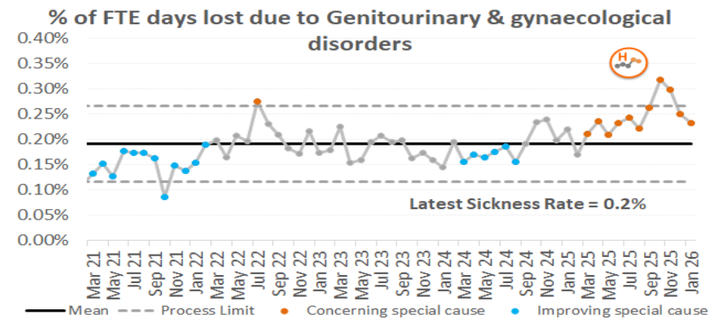








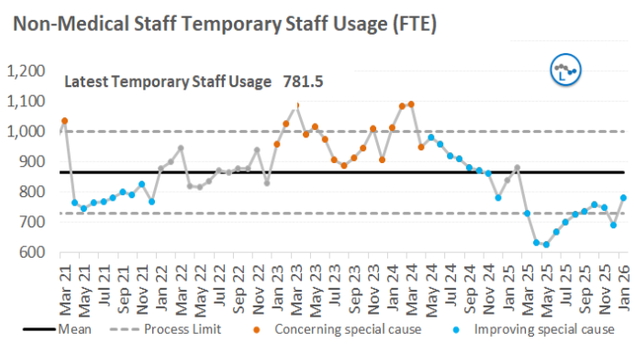


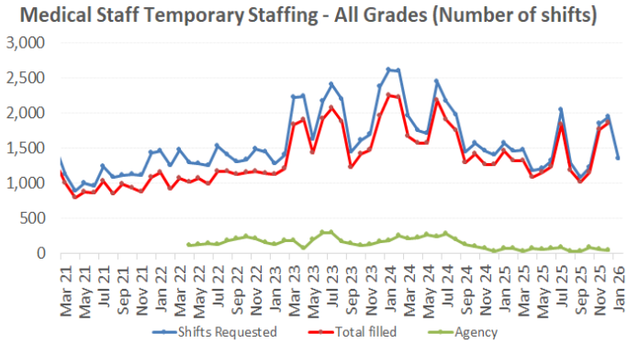


Author(s): Chloe Schafer, Amanda Wood **Owner(s): David Wherrett**

Temporary Staffing

Cambridge University Hospitals NHS Foundation Trust

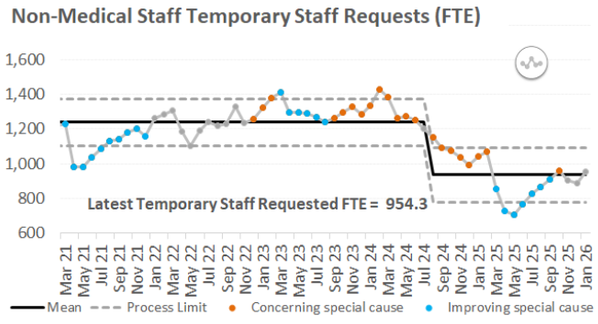


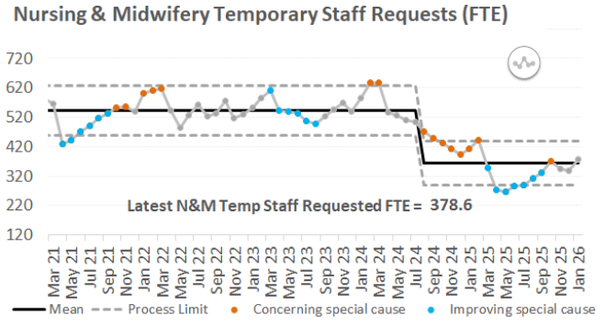


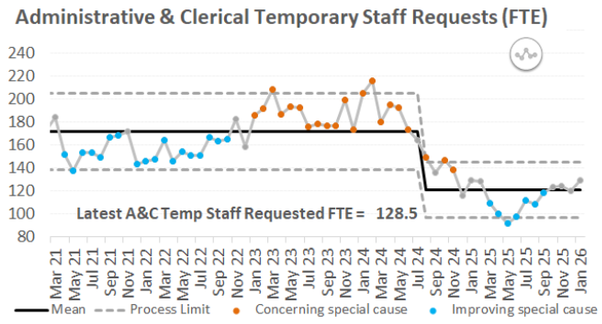
Background Information: The Trust works to ensure that temporary vacancies are filled with workers from staff bank in order to minimise agency usage, ensure value for money and to ensure the expertise and consistency of staffing.

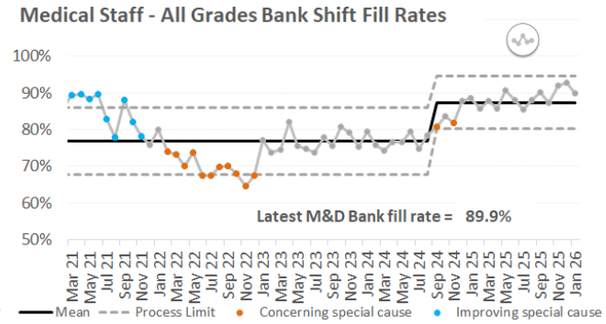
What the information tells us: Non-medical temporary staffing demand increased by 7.5% (67 WTE) from last month, with fill rates increasing by 5% to 82%. There was no Nursing and Midwifery agency usage in January.
Top three reasons for request are vacancy (34%), sickness requiring cover (26%) and increased workload (18%).

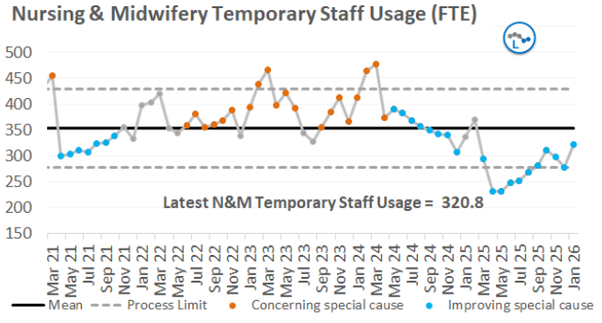
Medical demand fell by 31% between December and January (600 fewer shifts requested, reflecting industrial action cover in December). The overall fill rate was 95%, comprising 90% bank and 5% agency.

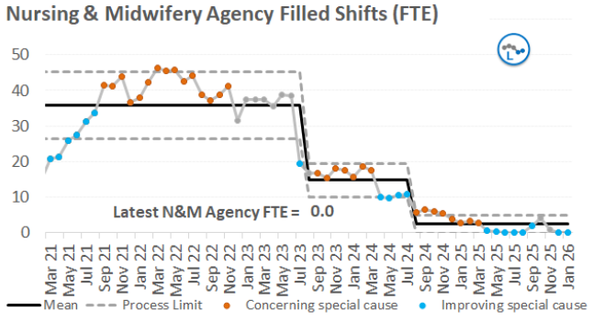


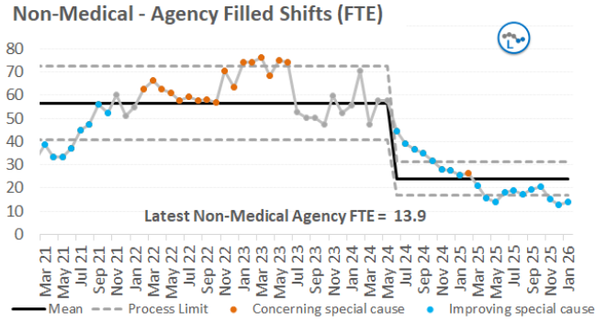


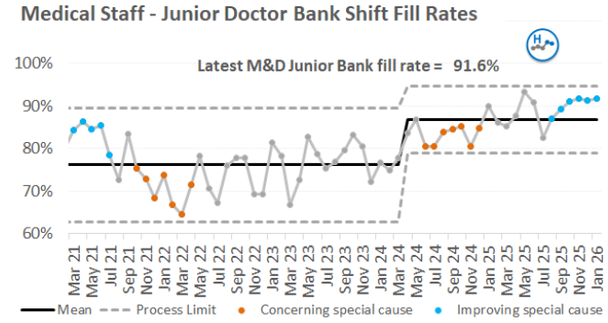






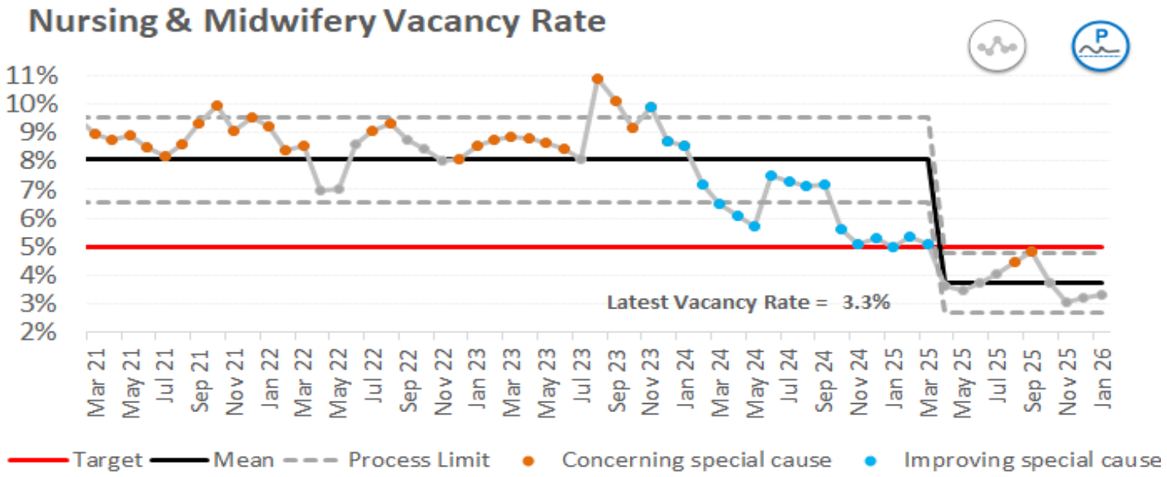






ESR Vacancy Rate

Cambridge University Hospitals NHS Foundation Trust

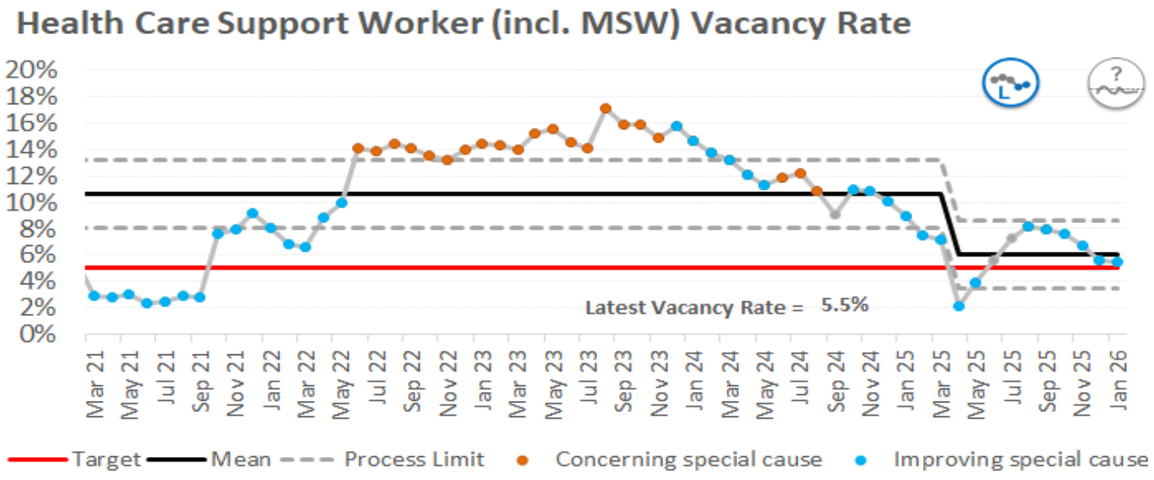


Background Information: Vacancy rate provides vacancy information based on established posts within an organisation. The figures below relate to ESR data for clinical areas only and includes pay bands 2-4 for Health Care Support Workers and 5-7 for Nurses and Midwives.

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 January, the vacancy rate for Nursing and Midwifery increased by 0.1% to 3.3%, remaining under the Trust 5% target. The vacancy rate for Health Care Support Workers decreased by 0.1% to 5.5% in January, 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		Nursing and Midwifery Registered
													Consultant	Non-Consultant	
Ind'tn	Corporate Induction	1,055	one-off	f2f	0.7%	(12)97.5%	(0)100.0%	(6)96.8%	(2)97.2%	(2)96.6%	(0)100.0%	(0)100.0%			(2)98.0%
	Medical and Dental Induction	580	one-off	f2f	0.5%	(174)70.0%							(5)85.7%	(169)69.0%	
	Local Induction	1,055	one-off	f2f	-0.6%	(206)80.5%	(0)100.0%	(32)83.1%	(13)81.9%	(5)91.5%	(3)66.7%	(2)94.3%	(6)82.9%	(129)76.3%	(16)83.8%
Other Core Mandatory	Conflict Resolution	12,460	3 yrs	el	-0.3%	(328)97.4%	(4)98.5%	(41)98.1%	(43)98.1%	(12)98.4%	(2)99.4%	(8)98.9%	(24)97.2%	(102)89.8%	(92)97.7%
	Equality, Diversity and Human Rights	12,460	3 yrs	el	-0.3%	(348)97.2%	(6)97.7%	(46)97.8%	(40)98.3%	(8)99.0%	(4)98.9%	(10)98.6%	(28)96.7%	(110)89.0%	(96)97.6%
	Health, Safety and Welfare	12,460	3 yrs	el	-0.2%	(364)97.1%	(4)98.5%	(44)97.9%	(41)98.2%	(9)98.8%	(2)99.4%	(8)98.9%	(24)97.2%	(129)87.1%	(103)97.5%
	Information Governance including GDPR and Cyber Security	12,460	1 yr	el	-0.1%	(753)94.0%	(6)97.7%	(129)93.9%	(62)97.3%	(25)96.7%	(9)97.5%	(12)98.4%	(50)94.1%	(182)81.8%	(278)93.2%
	Basic Prevent Awareness	10,404	3 yrs	el	-0.2%	(410)96.1%	(12)95.2%	(73)96.3%	(57)97.5%	(17)97.6%	(5)98.6%	(8)98.9%	(22)96.5%	(116)83.5%	(100)96.4%
	Prevent Level Three (WRAP)	2,056	3 yrs	el	0.2%	(146)92.9%	(0)100.0%	(6)95.7%	(0)100.0%	(3)95.5%		(1)94.1%	(6)97.3%	(50)83.1%	(80)93.9%
Resuscitation	Adult Basic Life Support Practical - 1 Year	413	1 yr	f2f	-2.9%	(57)86.2%	(0)100.0%	(21)78.8%		(1)75.0%					(35)88.7%
	Adult Basic Life Support Practical - 2 Year	8,105	4 yrs	f2f	-0.3%	(955)88.2%	(5)88.9%	(201)87.1%	(7)75.0%	(46)93.9%	(0)100.0%	(5)96.2%	(103)87.8%	(310)69.0%	(278)92.6%
	Advanced Life Support	27	4 yrs	f2f	-0.3%	(2)92.6%								(0)100.0%	(2)92.3%
	Advanced Paediatric Life Support	91	2 yrs	f2f	-7.4%	(32)64.8%							(0)100.0%		(32)64.4%
	Basic Life Support e-learning	8,517	1 yr	el	0.6%	(847)90.1%	(6)87.0%	(141)91.5%	(3)89.3%	(36)95.3%	(0)100.0%	(11)91.5%	(54)93.6%	(267)73.3%	(329)91.9%
	Immediate Life Support (ILS)	922	1 yr	f2f	2.2%	(212)77.0%		(3)50.0%		(13)53.6%		(2)92.9%		(1)0.0%	(193)77.5%
	Newborn Basic Life Support (NBLS)	585	1 yr	Blended	-1.7%	(63)89.2%		(8)89.6%	(0)100.0%	(0)100.0%			(1)94.1%	(2)94.4%	(52)88.5%
	Paediatric Basic Life Support (PBLS)	2,817	1 yr	Blended	-0.2%	(346)87.7%	(2)84.6%	(81)87.3%	(0)100.0%	(50)93.4%		(18)84.9%	(21)83.7%	(43)69.1%	(131)87.1%
	Paediatric Immediate Life Support (PILS)	350	1 yr	f2f	-6.7%	(67)80.9%							(1)0.0%		(66)81.1%
Fire	Fire Evacuation	6,484	1 yr	f2f/el	0.6%	(693)89.3%	(1)94.4%	(208)87.4%	(1)96.2%	(41)93.1%	(5)94.4%	(5)91.9%			(432)89.3%
	Fire Safety Awareness	12,460	2 yrs	el	-0.6%	(639)94.9%	(8)96.9%	(89)95.8%	(65)97.2%	(25)96.7%	(10)97.2%	(12)98.4%	(47)94.4%	(152)84.8%	(231)94.3%
Infect Ctrl	Infection Prevention and Control - Level 1 - 2 Years	6,263	2 yrs	el	-0.3%	(306)95.1%	(0)100.0%	(34)96.3%	(68)97.0%	(3)98.7%	(12)96.6%	(11)98.3%	(3)96.2%	(116)84.0%	(59)94.0%
	Infection Prevention and Control - Level 2 - 2 Years	6,197	2 yrs	el	-0.2%	(321)94.8%	(6)96.3%	(59)95.1%	(4)93.5%	(19)96.5%	(0)100.0%	(2)97.8%	(46)94.0%	(37)86.6%	(148)95.2%
Moving & Handling	Moving and Handling - Level 1	12,460	2 yrs	el	0.3%	(328)97.4%	(2)99.2%	(32)98.5%	(24)99.0%	(9)98.8%	(1)99.7%	(4)99.5%	(22)97.4%	(156)84.4%	(78)98.1%
	Moving and Handling - Level 2	6,487	2 yrs	f2f	-2.9%	(1152)82.2%	(5)77.3%	(294)82.1%	(2)77.8%	(51)92.3%	(0)100.0%	(8)92.5%			(792)80.4%
	Patient Moving and Handling - e-learning	6,489	1 yr	el	-0.7%	(470)92.8%	(0)100.0%	(132)92.0%	(2)77.8%	(33)95.0%	(0)100.0%	(5)95.3%			(298)92.6%
Safeg'dg Adults	Safeguarding Adults - Level 1	8,164	3 yrs	el	-0.2%	(343)95.8%	(9)96.4%	(66)96.9%	(55)97.6%	(4)96.6%	(4)98.9%	(11)98.5%	(5)92.8%	(135)31.8%	(54)97.3%
	Safeguarding Adults - Level 2	4,613	3 yrs	el	0.0%	(296)93.6%	(7)96.6%	(72)95.9%	(6)95.1%	(2)98.3%	(0)100.0%	(5)96.5%	(6)91.3%	(136)31.3%	(62)96.9%
	Safeguarding Adults - Level 3	4,455	3 yrs	el	-0.4%	(546)87.7%	(0)100.0%	(1)87.5%	(1)0.0%	(42)93.5%		(0)100.0%	(31)96.0%	(280)70.6%	(191)90.7%
Safeg'dg Children	Safeguarding Children - Level 1	10,515	3 yrs	el	0.1%	(371)96.5%	(10)96.0%	(58)97.1%	(45)98.0%	(18)97.4%	(4)98.9%	(11)98.5%	(24)96.1%	(143)82.4%	(58)97.9%
	Safeguarding Children - Level 2	6,954	3 yrs	el	0.2%	(389)94.4%	(8)96.1%	(71)95.6%	(8)92.7%	(26)96.1%	(0)100.0%	(4)96.8%	(27)95.6%	(158)80.5%	(87)96.9%
	Safeguarding Children - Level 3	1,990	3 yrs	f2f/el	0.4%	(160)92.0%	(0)100.0%	(6)95.5%	(1)88.9%	(11)86.9%		(1)94.4%	(10)95.5%	(39)82.8%	(92)92.8%
Overall Compliance					-0.2%	93.8%	96.8%	94.3%	97.7%	96.0%	98.4%	98.0%	94.9%	80.1%	93.5%

Education - Student Capacity

NHS 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.

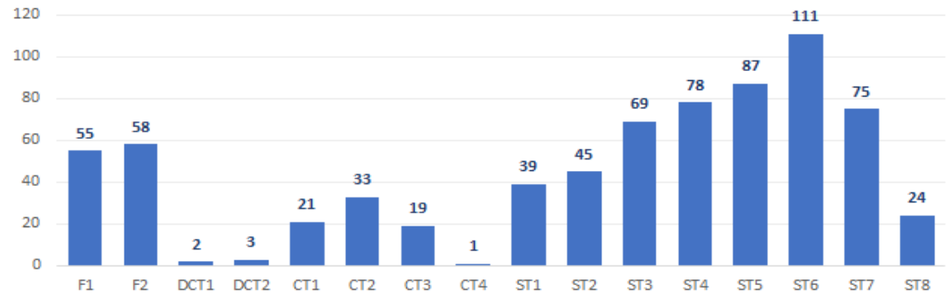
CUH is also committed to working with schools and colleges to help their students consider future career choices and access to career insight and work experience; this supports a focus on a future sustainable workforce supply and as part of CUH's corporate social responsibility to our local community.

Our role as a teaching hospital

Typical student numbers per year

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 January 2026

T-Levels/Insight programmes: 11 T-level students

Work Experience/Shadowing: 26 students engaged in a range of placements in specialist areas across the Trust

The team also provided career guidance at 3 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	**370**
of which are:		
Nursing	Registered Nursing Degree Apprenticeships	152
	Nursing Associate Pathway	95
	MSc Advanced Clinical Practice	0
	Support Worker L3	2
	Nursing Total	**249**
Allied Health Professionals	Diagnostic radiography	6
	Therapeutic radiography	8
	Dietician	3
	Mammography	3
	Occupational therapy	7
	ODP	23
	Physiotherapy	12
	Speech and language	2
	AHP Total	**64**
Pharmacy	**Pharmacy Total**	**10**
Scientific & Technical	Levels 2-4	8
	Levels 5-7	28
	Sci & Tech Total	**36**
Other Clinical	**Other Clinical Total**	**11**
	CPD Apprenticeships in role	**62**
Grand Total		**432**

Apprenticeship Levy contributions, commitments & spend

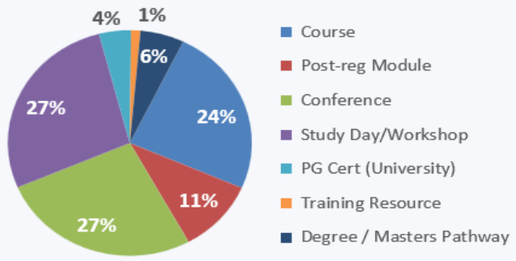
Financial Year	CUH £ Levy Contribution to date	£ Committed Spend to date	In year % Spend	In years committed transferred levy funds
2024/25	£3,667,820	£3,704,473	80%	£78,013
2025/26 to date	£2,832,043	£2,324,727	84%	£57,871
Levy funds	£6,853,758			

Apprenticeships in place as at January 2026: The total number of staff undertaking apprenticeships has reduced to 432 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.

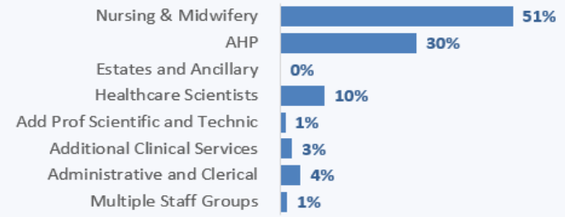
Apprenticeship Levy contributions and spend: The data for 2024/25 is retained in the report to show CUH's levy contributions and commitments in that year to be able to compare throughout 2025/2026.

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	£1,246,686
Trust	£400,000	£219,181
Total	**£2,242,796**	**£1,465,867**

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	Jan 26		Comments
	Placement Allocations	Places Occupied	
Essentials Management & Leadership Excellence (EMLE) new managers	97	103	Steady flow of particpants
EMLE existing managers	152	164	Numbers pick up again after Xmas
Consultants programme	0	0	Programme planned to restart Spring 2026 through The King's Fund
Aspiring managers programme (AMLP)	0	0	No cohorts run during January

Postgraduate Medical Centre - 2025/26 commitment

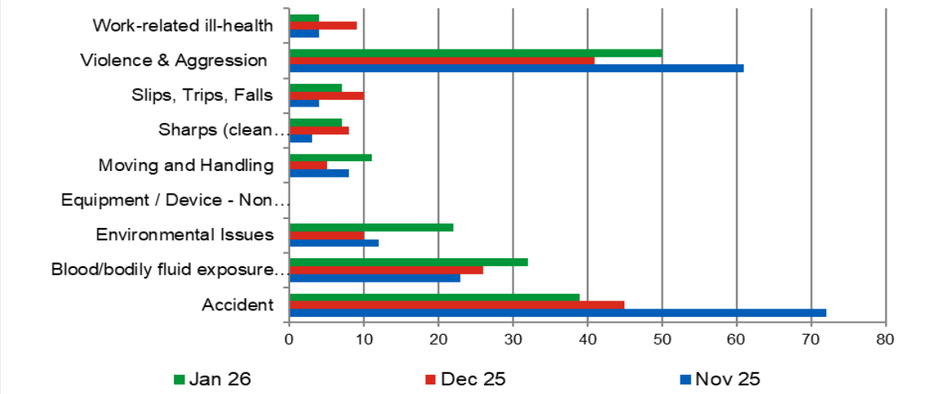
Programme	Placement Allocations	Dates
Learning to lead	0	
Preparing for the consultant role	0	

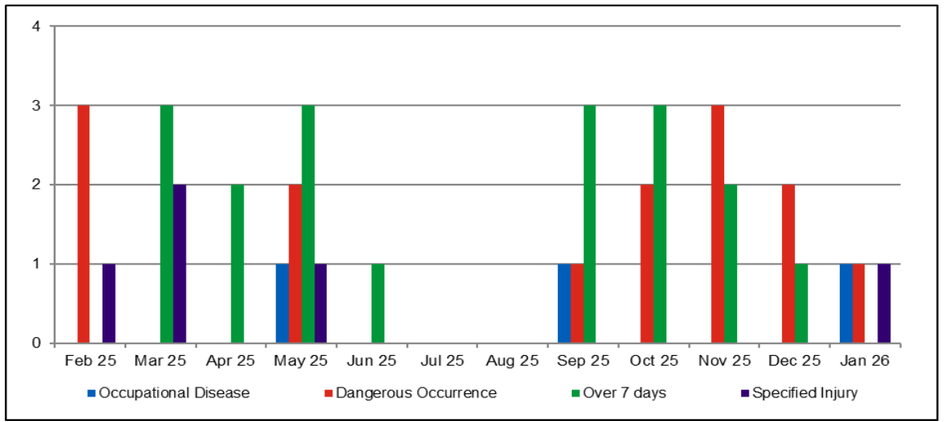
Further information: The EMLE programme successfully continues with all numbers picked up post-Xmas. The Consultant programme has been confirmed to be delivered by The King's Fund from Spring. The next cohort of Aspiring Managers (now rebranded AMLE) begins in March. Secured funding for places on 2x ILM coaching qualification cohorts to expand our internal pool of coaches and improve our management and leadership offer, plus funding for Mary Seacole and Rosalind Franklin places beginning in March

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:	**2225**	650	311	524	275	240	72	153
Accident	**633**	191	106	140	78	60	10	48
Blood/bodily fluid exposure (dirty sharps/splashes)	**357**	124	45	67	46	59	13	3
Environmental Issues	**187**	29	27	13	24	35	5	54
Equipment / Device - Non Medical	**5**	4	0	0	1	0	0	0
Moving and Handling	**96**	44	6	19	10	9	5	3
Sharps (clean sharps/incorrect disposal & use)	**104**	36	21	12	12	17	5	1
Slips, Trips, Falls	**91**	20	22	8	6	9	4	22
Violence & Aggression	**708**	189	70	260	95	47	27	20
Work-related ill-health	**44**	13	14	5	3	4	3	2



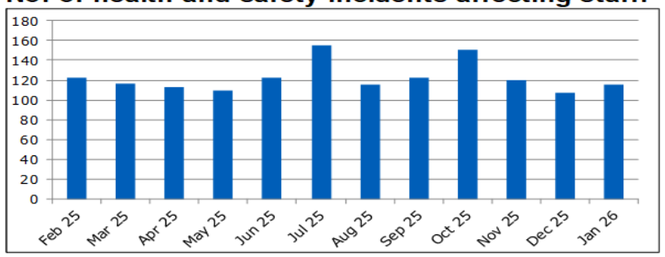


A total of 2,225 health and safety incidents were reported in the previous 12 months.
1006 (45%) incidents resulted in harm.
The highest reporting categories were violence and aggression (32%), accident (28%) and blood/bodily fluid exposure (16%).
1,470 (66%) of incidents affected staff, 679 (31%) affected patients and 76 (3%) affected others i.e. contractors and members of the public.
The highest reported incident categories for patients were accidents (56%), violence and aggression (19%) and environmental issues (9%).
The highest reported incident categories for staff were violence and aggression (38%), blood/bodily fluid exposure (22%) and accidents (17%).
The highest reported incident categories for others were slips, trips and falls (47%), violence and aggression (28%) and environmental issues (25%).
Staff incident rate is 10.9 per 100 members of staff (by headcount) over a rolling 12-month period.
The highest reporting division was division A with 650 incidents. Of these, 29% were accidents.
In the last 12 months, the highest reported RIDDOR category was over 7-day injury (45%).
In the last 12 months, 70% of RIDDOR incidents were reported to the HSE within the appropriate timescale.
In January 2026, four incidents were reported to the HSE:
Dangerous Occurrence
•A fresh specimen was received in the histopathology laboratory. The specimen was from a patient with query TB. The specimen was not labelled as high-risk, and the member of staff did not read the clinical details on the sample. It was therefore not processed in line with high-risk sample procedures. To date there has been no evidence of transmission.
•A sample was received by the haematology laboratory for malaria screening. The sample was taken from a patient with query VHF, awaiting respiratory viral testing. The sample was not labelled as high risk and was therefore not processed in line with high-risk sample procedures. Respiratory viral testing confirmed a diagnosis of Flu A.
•The affected person (AP) was undertaking pleural aspiration on a hepatitis C positive patient. On withdrawal of the needle the AP sustained a graze to their left middle finger. The AP was wearing single gloves at the time and stated that there was "not really a visible skin puncture". The AP followed the Trust's needlestick protocol and arranged for an appropriate follow up with Occupational Health.
Specified Injury
•A member of staff went to sit on a wheeled chair to carry out admin tasks. The staff member was not expecting the chair to roll. The staff member fell to the floor as the seat rolled away. The staff member sustained fractures.

Health and Safety Incidents

NHS Cambridge University Hospitals

No. of health and safety incidents affecting staff:

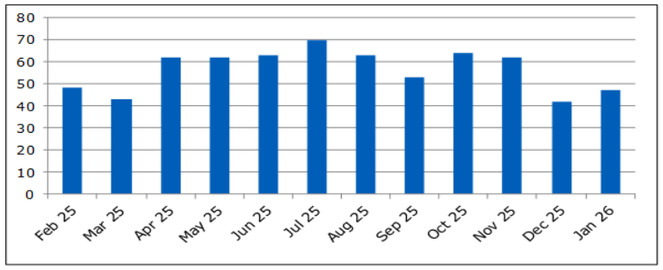


STAFF	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Total
Accident	24	19	16	23	20	28	16	19	22	28	21	18	**254**
Blood / bodily fluid exposure (dirty sharps / splashes)	27	23	27	23	27	32	31	35	34	21	23	26	**329**
Environmental Issues	8	3	4	12	15	18	4	7	10	5	5	14	**105**
Moving and handling	4	5	3	7	1	4	6	6	4	3	2	3	**48**
Sharps (clean sharps / incorrect disposal & use)	5	5	6	5	8	5	8	6	15	2	6	5	**76**
Slips, trips, falls	5	5	4	1	7	9	4	7	0	3	6	4	**55**
Violence & Aggression	46	53	48	38	45	56	41	40	62	54	35	41	**559**
Work-related ill-health	3	4	5	1	0	3	5	3	3	4	9	4	**44**
Total	**122**	**117**	**113**	**110**	**123**	**155**	**115**	**123**	**150**	**120**	**107**	**115**	**1470**

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

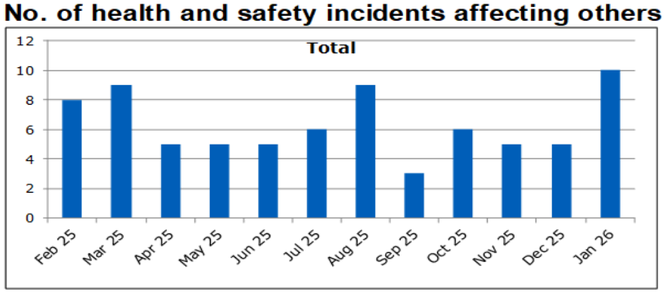
	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Total
of health & safety incidents	122	117	113	110	123	155	115	123	150	120	107	115	1470
f incident rate per month/ year	0.9	0.9	0.8	0.8	0.9	1.2	0.9	0.9	1.1	0.9	0.8	0.9	10.95

No. of health and safety incidents affecting patients:



PATIENT	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Total
Accident	27	23	35	35	41	38	33	26	32	44	24	21	**379**
Blood / bodily fluid exposure (dirty sharps / splashes)	3	2	2	3	1	4	1	1	0	2	3	6	**28**
Environmental Issues	4	4	6	3	7	10	8	6	2	5	4	4	**63**
Equipment / Device - Non Medical	1	0	0	1	0	2	0	0	1	0	0	0	**5**
Moving and handling	2	4	4	2	3	4	7	2	4	5	3	8	**48**
Sharps (clean sharps / incorrect disposal & use)	0	4	2	3	4	0	2	6	2	1	2	2	**28**
Violence & Aggression	11	6	13	15	7	12	12	12	23	5	6	6	**128**
Total	**48**	**43**	**62**	**62**	**63**	**70**	**63**	**53**	**64**	**62**	**42**	**47**	**679**

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



OTHER	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Total
Environmental Issues	1	4	2	1	1	2	0	0	1	2	1	4	**19**
Slips, trips, falls	7	5	2	0	2	2	7	0	3	1	4	3	**36**
Violence & Aggression	0	0	1	4	2	2	2	3	2	2	0	3	**21**
Total	**8**	**9**	**5**	**5**	**5**	**6**	**9**	**3**	**6**	**5**	**5**	**10**	**76**