Board of Directors

Cambridge University Hospitals NHS Foundation Trust

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There will be a meeting of the Board of Directors (held in Public)
on Wednesday, 9 September 2026 at 15:00
in the Committee Room,
Clinical School of Medicine, Addenbrooke's Hospital, Hills Road,
Cambridge, CB2 0SP

For members of the public who wish to observe this meeting they need to contact the Trust Secretariat for further details
(see further information on the Trust's website)

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

AGENDA

General business			**Purpose**
15.00	**1**	**Welcome and apologies for absence**	For note
	2	**Declarations of interest** To receive any declarations of interest from Board members in relation to items open agenda items and to note any changes to their register of interest entries A full list of interests is available from the Chief Governance and Performance Officer on request	For note
	3	**Minutes of the previous Board meeting*** To approve the minutes of the Board meeting held in public on 10 June 2026	For approval
	4	**Board action tracker and matters arising not included on the agenda**	For review
15.10	**5**	**Patient story** To hear a patient story	For receipt
15.25	**6**	**Chair's report** To receive the verbal report of the Chair	For receipt

15.30	**7**	**Report from the Council of Governors*** To receive the report of the Lead Governor	For receipt
Performance, strategy and assurance			**Purpose**
15.35	**8**	**Board Assurance Framework*** To receive the report of the Chief Governance and Performance Officer	For approval
15.40	**9**	**Report from the Chief Executive Officer*** *The items in this section will be discussed with reference to the Integrated Performance Report and executive team report* 9.1 Safe and effective care (including nurse safe staffing report) 9.2 Access and operational performance 9.3 Finance 9.4 People 9.5 Strategy, major projects and innovation	For receipt
16:00	**10**	**Verita Report action plan update*** To receive the report of the Chief Medical Officer	For receipt
16:20	**11**	**Guardian of Safe Working Quarterly Update Report*** To receive the report of the Chief Medical Officer and Chief Nurse	For receipt
Items for noting			**Purpose**
16:40	**12**	**Board Committee Chairs' Alert, Advise, Assure reports** To receive the verbal reports of the Chair and Executive Director and Board Committee Leads 12.1 Transformation Committee: 10 June 2026; 15 July 2026 12.2 Performance and Finance Committee: 1 July 2026; 2 September 2026 12.3 Quality Committee: 1 July 2026; 2 September 2026 12.4 Audit Committee: 17 June 2026; 25 June 2026	For receipt
Other items			**Purpose**
16.50	**13**	**Any Other Business**	For note/ approval
16:55	**14**	**Questions from members of the public**	For note
	15	**Date of next meeting** The next meeting of the Board of Directors will be held on Wednesday, 9 December 2026 at 15:00	For note
17:00	**16**	**Close**	

Minutes of the meeting of the Board of Directors held in public on Wednesday 10 June 2026 at 11.00 via videoconference

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

In attendance	Position
Mr G Burgess	Chief of Staff
Dr J Brubert	Co-Chair of Resident Doctors Forum *(for item 31/26 only)*
Mr J Clarke	Trust Secretary (Minutes)
Dr S Goon	Guardian of Safe Working *(for item 31/26)*
Ms H Gallagher	Director of Midwifery *(for item 35/26 only)*
Ms J Leigh	Secretariat Officer *(for item 25/26 only)*
Prof M Parkes	Director of the Cambridge Biomedical Research Centre *(for item 25/26)*
Dr M Phillips	Co-Chair of Resident Doctors Forum *(for item 31/26 only)*
Dr H Rubinstein	Lead Governor

20/26 Welcome and apologies for absence

Apologies for absence are recorded in the attendance summary.

22/26 Declarations of interest

Standing declarations of interest of Board members were noted.

23/26 Minutes of the previous meeting

The minutes of the Board of Directors' meeting held in public on 11 March 2026 were approved as a true and accurate record.

24/26 Board action tracker and matters arising not covered by other agenda items

Received and noted: the action tracker.

25/26 Patient story

Lorraine Szeremeta, Chief Nurse, presented the patient story.

Miles Parkes also joined for the discussion.

Noted:

1. The Board heard the story of Victoria, who described her experience of inflammatory bowel disease, initially thought to be irritable bowel syndrome, and the subsequent impact of participating in a research study.
2. The study involved genetic testing through a saliva sample, which identified an increased risk of certain cancers, including endometrial cancer. The Board noted the importance of providing sensitive, well-coordinated feedback to patients when communicating potentially significant findings.
3. Victoria described the clinical team as reassuring, supportive and consistent, with the consultant helping to put them at ease throughout the process.
4. Through her story, Victoria's strong encouragement for others to take part in research was heard, recognising the potential for such work to be life-saving.

In discussion the following points were raised:

1. The Board reflected that the patient story demonstrated the value of effective integration between research and clinical practice, noting that the outcome was exceptional and highlighted the importance of ensuring that research findings are communicated and acted upon through clear and coordinated clinical pathways.
2. The Board discussed how this example could be built upon to embed research more routinely within clinical care, including through a front-door consent model supported by clear expectations around consent and communication with patients.
3. It was noted that sharing "thanks to you" stories could help demonstrate the progress and advances made by Cambridge researchers and support wider patient and public understanding of the benefits of participation in research.

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4. The Board considered the wider transformation opportunity, including the potential shift from individual genomic findings to broader use of genomics and risk stratification. It was recognised that, while the Trust did not yet have all the answers, it was well placed to be at the leading edge of this work.
5. It was suggested that the Board return to this theme at a future meeting, considering the broader research approach and its role in supporting clinical transformation.

Agreed:

1. To note the staff story.

26/26 Chair's report

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

Noted:

1. The Board were formally informed of the outcome of the Chief Executive recruitment process, which had been extensive and competitive. Nicola Ayton had been appointed as substantive Chief Executive, with strong support from those involved in the process.
2. The Chair reported that the Board had held a constructive discussion at its away day on the new operating model, drawing on experience from other organisations and considering how best to support the Trust's future ways of working.
3. The Chair also reported positive engagement with local MPs and wider system partners, including North West Anglia NHS Foundation Trust. The Board noted the challenges facing the Trust, while also recognising the importance of maintaining focus on the good work being undertaken and the Trust's strong regional reputation.

Agreed:

1. To note the verbal update of the Chair.

27/26 Report from the Council of Governors

Helena Rubinstein, Lead Governor, presented the verbal update.

Noted:

1. The Lead Governor reported that the Council of Governors had been restructured and was working more effectively as a group, with the new format supporting more focused engagement.
2. The Board were asked to note the ongoing work to strengthen the role of volunteers, including opportunities to engage directly with volunteers and gather feedback over the coming weeks on future possibilities.
3. A governor issues tracker had been introduced to record matters raised by governors in a more systematic way and support follow-up.
4. The Board noted that governors had undertaken a visit to palliative care as part of their wider programme of engagement and assurance.

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5. The Lead Governor was thanked for her engagement in the Chair's appraisal process and noted that the outcome had been reported formally to NHS England.

Agreed:

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

28/26 Chief Executive and Executive Team report

Nicola Ayton, Chief Executive, presented the report.

Noted:

1. The Board noted that this was Sarah Jensen's first public Board meeting and that her role would support the integration of digital and infrastructure priorities, including how services are delivered for patients. It was noted that the Trust was receiving enquiries from other trusts in relation to this work.
2. The Board noted the appointment of Laura Churchward as Chief Delivery Officer. Her experience, including at Northamptonshire Healthcare and Kettering, would support the development and strengthening of the Trust's operating model.
3. The Board noted continuing challenges across the urgent and emergency care pathway, including waits and performance against the four-hour standard. These pressures reflected both front-door demand and the Trust's ability to assess, treat and admit patients appropriately, alongside increasing discharge delays affecting inpatient flow.
4. The Board noted that meetings were taking place with the local authority in relation to discharge delays, recognising the impact on patients and on the Trust's ability to maintain flow.
5. Progress against the Verita commitments was noted, with updates being reviewed through Board sub-committees and with external partners, including NHS England, the Care Quality Commission and Healthwatch.
6. The Board noted progress in implementing the Trust's new strategy, including delivery against the first-year plan and engagement with partners and teams across the organisation. The Chief Executive reported that the conversations had been constructive and meaningful, with progress being made against the strategy's three objectives.
7. The Board noted the ongoing work to strengthen how the Trust operates and to create the right conditions for patients and staff. This included improving services and ways of working, and empowering teams involved in clinical care delivery to make changes that would have a positive impact in their areas.

Sue Broster, Chief Medical Officer, Nick Kirby, Interim Chief Operating Officer, provided an update on urgent and emergency care.

Noted:

1. The Board discussed the continuing increase in urgent and emergency care demand, noting that activity in May had been 7% higher than the previous year. Work was underway to understand best practice, including

through national GIRFT recommendations and feedback, and through learning from high-performing trusts, including Watford and Oxford.

2. The Board noted the key factors contributing to pressure across the pathway, including fragility in the GP workforce, evening patterns of demand, models of care, the need to strengthen emergency medical assessment, the impact on staff working in the department, and patient flow into onward care settings.
3. It was noted that the enhanced emergency medical assessment model was expected to commence in July, with further extension planned in the autumn. The Board also noted the increase in medically fit patients awaiting discharge, from 117 in March to 169 in May, and the constructive discussions taking place with the local authority to clarify onward care requirements.
4. The Chief Nurse reported that nursing leadership issues had been addressed, with two new leadership roles in place and work progressing on the quality improvement plan. The Board noted that corridor care had been identified through GIRFT feedback and that work was underway to change pathways and reduce long waits in the emergency department.
5. The Board noted the introduction of weekly safety huddles to respond to new or immediate challenges in a timely way, with a continued focus on safety, quality and patient experience. It was agreed that the Board should return to this issue ahead of winter pressures.

Mike Keech, Chief Finance Officer, presented an update regarding the financial settlement discussions with Central East Integrated Care Board (ICB).

Noted:

1. An update was received on the clarity of the Trust's financial settlement with Cambridgeshire and Peterborough ICB, noting that areas of dispute and mismatch remained, consistent with the wider national position. Work was continuing with the regional team and NHS England East of England to align the position for the new financial year.
2. Advice had been sought through the regional team, with the initial outcome favourable to the Trust. A formal and final outcome was awaited to confirm the position.
3. Discussions had also taken place at national level. While the direction of travel was clear, further work was required before the matter could be concluded.

Claire Stoneham, Chief Transformation and Strategy Officer, presented an update on the Greater Cambridge Development Corporation.

Noted:

1. The announcement of the Greater Cambridge Development Corporation, and the response published the previous week, was noted. This was welcomed as a positive development, with a focus on growth, maximising the impact of life sciences, and recognising the need for supporting infrastructure across housing, transport, primary care, community services and the Cambridge Biomedical Campus.

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2. Work undertaken on the future model for urgent and emergency care was noted, alongside the importance of progressing this over the coming months.
3. Cambridge South station was due to open shortly, representing a further important development for access and connectivity to the campus.
4. The bidding process for biomedical research centres was also underway, with Miles Parkes leading the work and an initial deadline in September.

Agreed:

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

29/26 Freedom to Speak Up

Lorraine Szeremeta, Chief Nurse, presented the report.

Noted:

1. The annual Freedom to Speak Up report was received, with improvements to the Listening Network also noted.
2. Planned work to improve anonymous reporting was highlighted, recognising the importance of strengthening routes for staff to raise concerns safely and effectively.
3. A review of the Freedom to Speak Up service was underway, informed by the KPMG audit findings and a wider assessment of the service and its provision, with improvement areas being taken forward.

The following points were raised in discussion:

1. The importance of strengthening the use of data and intelligence from concerns raised through Freedom to Speak Up was emphasised, including how this was triangulated with other sources of feedback to support assurance and identify areas requiring further action.
2. Links with the earlier discussion on the Verita action plan were noted, recognising the importance of understanding the impact of improvement work and ensuring that staff feedback and concerns informed wider cultural and governance assurance.

Agreed:

1. To approve the 2025/26 annual report of the Freedom to Speak Up Guardian.

30/26 Learning accountability action plan update

Sue Broster, Chief Medical Officer, presented the report.

Noted:

1. Good progress against the six-month commitments was noted, with work moving in the right direction despite wider operational pressures and the need to maintain momentum over a longer-term programme.
2. It was noted that 92% of job plans had been completed, providing a stronger understanding of the work being undertaken and helping to

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identify mismatches in capacity and demand, including in urgent and emergency care.

3. Positive engagement with the consultant body and wider clinical workforce was noted, including more than 100 consultants engaged through appraisal work. This was supporting improved leadership, team management and early warning arrangements.
4. Patient and family engagement was being strengthened through the patient advisory board, including feedback from a small but dedicated group of patients and families. Further work was required to improve engagement with children and young people, where feedback and uptake remained low.
5. A revised communications plan was being developed, informed by patient and family feedback, and the patient engagement strategy was nearing completion.
6. Work was progressing through both immediate actions and longer-term programmes, including a task and finish group focused on leadership. The Board would continue to be kept briefed on progress.
7. Learning from the paediatric orthopaedic review and related external reviews was noted as having informed the Trust's strategy, particularly the commitment to providing timely and excellent care over the next five years.

Agreed:

1. To note the progress made against all six-month commitments
2. To note that the overall delivery timetable remains highly compressed.
3. To note that the delivery takes places alongside wider organisational pressures and change, increasing the risk that improvements are implemented but not consistently embedded in practice.

31/26 Guardian of Safe Working

Sue Broster, Chief Medical Officer, introduced the report.

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

Noted:

1. The annual and quarterly Guardian of Safe Working reports were received, with the wider programme of work underway to improve the working lives of doctors also noted, including the development of a more formal programme under the ten-point plan.
2. Two areas where further pace was required were noted, namely rostering and resourcing during industrial action. It was recognised that effective e-rostering and clear resourcing arrangements were important to support safe services, staff experience and operational resilience.
3. The importance of ensuring that resident doctors were able to take annual leave in line with national guidance and contractual requirements was noted. Further focused support was required in some areas to ensure advance leave requests were considered before rotas were published and that access to leave was equitable across departments and grades.

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4. Particular areas requiring support had been identified, including acute medicine and cardiology, and these would be considered positively as part of the improvement work.
5. The changing acuity of patients was recognised, with increasing numbers of older and frailer patients and implications for workforce planning, service resilience and the working environment for doctors.

In the discussion the following points were made:

1. The importance of progressing e-rostering was emphasised, recognising its role in supporting effective resource management, improving patient care and strengthening the working experience of resident doctors.
2. Continued digitalisation of workforce processes was supported, noting that this was aligned with the Trust's strategy. It was noted that work was continuing with the incumbent solution, while remaining open to other options and considering the resourcing required to deliver improvement.
3. The challenges experienced by resident doctors were recognised, with support for an open approach to identifying practical solutions that would improve their working experience.

Agreed:

1. To note the quarterly report of the Guardian of Safe Working covering the period January 2026 to March 2026.
2. To receive the annual report of the Guardian of Safe Working for 2025/26.

32/26 Learning from deaths

Sue Broster, Chief Medical Officer, presented the report.

Noted:

1. The Board were asked to note the continued focus on improving the timeliness of mortality reviews, refreshing internal processes, and strengthening the assessment of whether changes made in response to learning were delivering the intended impact.

Agreed:

1. To note the content of the update.

33/26 Modern Slavery statement

Beth Hughes, Chief Governance and Performance Officer, presented the update.

1. The Modern Slavery Act Statement for 2025/26 was received, and it was noted that the revised assurance process had been reviewed by the Audit Committee on 29 April, which had endorsed the approach.
2. Compliance against the key domains was noted, following the Trust's assessment.

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3. The revised assurance process, assurance log and governance arrangements were noted as supporting future reporting cycles.

Agreed:
1. To approve the Modern Slavery Act Statement for 2025/26.

34/26 Annual nurse safe staffing report

Lorraine Szeremeta, Chief Nurse, presented the report

1. The Board received the annual nurse safe staffing report for the April 2025 to March 2026 reporting period.
2. The Board noted the final recommendations, including an increase of 9.83 WTE registered nurses and a reduction in healthcare support workers. It was noted that no further investment was required, as the changes could largely be accommodated within the current establishment.

Agreed:
1. To note the Annual Safe Staffing report,

35/26 Perinatal report

Heather Gallagher, Director of Midwifery, presented the report.

Noted:
1. The perinatal report for the period December 2025 to May 2026 was received, covering workforce, sustainability, midwifery staffing and the requirements of Maternity Incentive Scheme Year 8.
2. It was noted that the service was currently rated amber, with no patient safety harms reported, but that there remained material workforce risks relating to the delivery of safe and timely care.
3. Midwifery staffing remained below baseline, with continued reliance on bank and agency staff impacting wellbeing and resilience. Focused work was underway to support recruitment, strengthen capacity and improve pace of delivery.
4. Neonatal nursing compliance remained below the required standard, at 56% against a 70% requirement. A robust improvement plan and trajectory were in place to address this.
5. Additional expectations under Maternity Incentive Scheme Year 8 were noted, including compliance with standards, resilience for planned and emergency theatre activity, broader perinatal demand, and the required increases in obstetric and anaesthetic workforce capacity.
6. Progress was being made, while recognising the continuing risks relating to birth-rate planning, skill mix, workforce capacity, data quality and triangulation. Mitigation plans were in place and would continue to be monitored.

In the discussion the following points were raised:

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1. Continuing workforce pressures were discussed, noting the focused work underway to recruit, assess the underlying issues and strengthen staffing resilience across the service.
2. Theatre capacity was noted as a significant issue within the wider perinatal service and would need to be considered as part of the overall workforce and service resilience response.
3. Assurance was sought on the Trust's ability to meet the requirements of Maternity Incentive Scheme Year 8, recognising that the standards had become more challenging. It was noted that a RAG-rated gap analysis was being used to assess compliance, including workforce requirements, mandatory training and the change to two compliance snapshots during the year rather than a single year-end assessment.

Agreed:

1. To note the current perinatal workforce position in terms of compliance with National Institute for Health and Care Excellence, Royal College of Obstetricians and Gynaecologists, British Association of Perinatal Medicine and MIS Year 8 requirements.
2. To note the trajectory and requirements for MIS compliance for Safety Action A.

36/26 Committee terms of reference and alert, advise assure reports

Received: the following committee terms of reference:

- Audit Committee
- Performance and Finance Committee
- People, Education and Culture Committee
- Quality Committee
- Transformation Committee

Received: the following Chair's reports:

- Audit Committee: 29 April 2026
- Performance and Finance Committee: 6 May 2026 and 3 June 2026
- Quality Committee: 6 May 2026
- People, Education and Culture Committee: 3 June 2026

Agreed:

1. To note the updated committee terms of reference
2. To note the alert, advise, assure reports from the Board assurance committees listed.

37/26 Use of the Trust Seal

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

38/26 Any other business

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1. There was no other business.

39/26 Questions from members of the public

The Chair noted that any questions received from members of the public would be responded to directly and published on the Trust website as appropriate.

41/26 Date of next meeting

The next meeting of the Board of Directors in public would be held on Wednesday 9 September 2026 at 15.00.

Meeting closed: 12:34pm

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NHS
Cambridge University Hospitals
NHS Foundation Trust

Board of Directors (Public): Action Tracker

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

Key to RAG rating:

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

Report to Board of Directors – in public

held on

09 September 2026

Agenda item	7			
Title	Report from the Lead Governor			
Report sponsor	n/a			
Author	Helena Rubinstein, Lead Governor of the Council of Governors			
Status	**Decision** ☐	**Assurance** ☐	**Information** ☒	**Discussion** ☐

RECOMMENDATIONS

The Board of Directors is asked to:

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

KEY MESSAGES

The report summarises the activities of the Council of Governors.

BACKGROUND, INCLUDING PURPOSE OF THE REPORT

This paper aims to provide the Board with an update on the Council of Governor activities taken place since the reported to the Board at its meeting held in public in June 2026.

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

ALIGNMENT TO TRUST STRATEGIC PRIORITIES

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

ALIGNMENT TO MOST RELEVANT STRATEGIC RISK

N/A

PAPER REVIEW AND GOVERNANCE PATHWAY

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

Cambridge University Hospitals NHS Foundation Trust

09 September 2026

Board of Directors

Report from the Council of Governors

1. Recent Governor meetings

1.1 A **Governor Induction** was held in July 2026, to welcome new Governors who had been elected in the Spring 2026 elections. Feedback received confirmed the day was found to be useful and very comprehensive with a number of Executive colleagues delivering presentations.

1.2 A **Governor Forum**, was held in August 2026, Chaired by the Deputy Lead Governor. The forum enabled governors to meet informally both in person or virtually to catch up and share experiences in preparation of formal governor meetings.

2. Other governor activities

2.1 Chair of the Council of Governors Nomination and Remuneration Committee and the Lead Governor participated in the **Non-executive Director interview process** which was found to be a structured fair process. The trust was supported by Saxton Bampflyde to seek a suitable Non-executive Director with the skills and experience to undertake the Chair of the Audit Committee role. The open competition proved most successful with a number of high calibre individuals showing interest in the position. Interviews were held in July 2026, and the outcome and recommendation of this process is planned to be put to the Council of Governos at its October 2026 meeting for approval.

2.2 Work on the **Volunteer Initiative** at Addenbrookes continues with the Governor's and Volunteer feedback from their visit to Royal Marsden NHS Foundation Trust being taken forward by CUH when developing their future strategic plans.

2.3 The **Governor Log** that was developed to capture governor's feedback to help support them fulfil their statutory duties is continuing to develop and found to be a valuable mechanism to support governors' in fulfilling their role.

3. Upcoming Governor meetings

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

- 23 September 2026: Annual Public/General meeting
- 7 October 2026: Governor seminar, Governor pre-meet and formal Council of Governors meeting
- 2 November 2026: Governors Forum
- 24 November 2026: Council of Governors' Nomination and Remuneration Committee
- 16 December 2026: Governor seminar, Governor pre-meet and formal Council of Governors meeting.

4. Recommendation

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

Board of Directors (held in Public)

9 September 2026

Agenda item	8			
Title	Board Assurance Framework review report			
Report Sponsor	Beth Hughes, Chief Governance and Performance Officer			
Status	**Decision** ☑	**Assurance** ☑	**Information** ☐	**Discussion** ☑

RECOMMENDATIONS

The Board is asked to:

- **REVIEW** the Board Assurance Framework refresh
- **NOTE** that the risks have been reviewed and refreshed following Board Committee review and input
- **AGREE** any further changes to the updated risk entries

KEY MESSAGES

- A revised draft of the refreshed Board Assurance Framework is appended.
- The accompanying Board Assurance Framework User Guide is being finalised.

BACKGROUND, INCLUDING PURPOSE OF THE REPORT

A review of the Board Assurance Framework commenced in Q4 2025/26 to align with emerging understanding of the risks to delivery of the strategy and has proceeded with oversight at multiple governance levels, with consistent engagement from across the Executive Team and Board Committees.

The purpose of this report is to present the outcome of the refresh exercise to the Board for review and consideration of approval.

ALIGNMENT TO TRUST STRATEGIC PRIORITIES

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

ALIGNMENT TO MOST RELEVANT STRATEGIC RISK

This paper aligns to all of the Trust's strategic risks.

PAPER REVIEW AND GOVERNANCE PATHWAY

Name of group or committee that has previously considered this report	**Date**
People, Education and Culture Committee (oversight entries)	3 June 2026
Performance and Finance Committee (oversight entries)	4 June 2026 1 July 2026
Transformation Committee (oversight entries)	10 June 2026
Risk Oversight Committee	11 June 2026
Management Executive	11 June 2026
Quality Committee (oversight entries)	4 June 2026 1 July 2026
Audit Committee	17 June 2026
Board of Directors	8 July 2026
Risk Oversight Committee	9 July 2026
Transformation Committee (oversight entries)	15 July 2026
Risk Oversight Committee	13 August 2026
Performance and Finance Committee (oversight entries)	2 September 2026
Quality Committee (oversight entries)	2 September 2026

9 September 2026

Board of Directors (held in Public)

Board Assurance Framework review

Report of the Chief Governance and Performance Officer

1. Introduction and Context

1.1 Following publication of the Trust's refreshed Strategy, an exercise to review the structure and content of the Board Assurance Framework (BAF) has been undertaken to ensure alignment to the strategy. This paper aims to provide the outcome of that review for Board's consideration.

1.2 This is the first presentation to the Board of Directors in public following the completion of the review. Minor amendments have been made to the BAF since it was presented to the Board meeting held in private in July through review by executive director leads and the Board Committees. It is aimed that Board Committees will continue to have delegated responsibility from the Board to oversee the management of risks aligned to it including risk reduction trajectories.

2. Headline Risks

2.1 The risks proposed for inclusion in the BAF are provided in the table below:

Headline risk	Lead executive	Oversight forum
BAF001 – Patient safety: Failure to have a robust quality governance structure in place to support the delivery and oversight of high-quality care may result in an adverse impact on the safety of our patients.	Chief Medical Officer, Chief Nurse	Quality Committee
BAF002 – Effective care: Failure to deliver safe, evidence-based and clinically effective care that achieves the best outcomes for our patients.	Chief Medical Officer, Chief Nurse	Quality Committee
BAF003 – Patient experience: Failure to deliver high-quality, compassionate care that consistently meets the needs and expectations of patients, families, carers and our population.	Chief Medical Officer, Chief Nurse	Quality Committee

BAF004 – Access to care: Failure to deliver sufficient productivity improvement and pathway transformation to deliver constitutional operational performance standards in all services.	Chief Operating Officer	Performance and Finance Committee
BAF005 – Digital infrastructure: Failure to deliver make available the digital infrastructure and solutions required by the Trust, including failure to prevent a future cyber- attack, failure to digitally-enable delivery of the Trust strategy, or and failure to take advantage of innovation.	Chief Infrastructure Officer	Audit Committee, Transformation Committee
BAF006 – Estate environment compliance and resilience: Failure to address statutory compliance, poor condition and resilience of the estate environment and infrastructure and to progress plans to deliver new estate developments and capacity.	Chief Infrastructure Officer	Performance and Finance Committee
BAF007 – High performing, inclusive culture: Failure to foster and embed a high performing inclusive culture and associated behaviours that are consistent with our Trust values.	Chief People Officer	Board of Directors
BAF008 – Transformation: Failure to maintain and strengthen CUH's position as a leading research organisation, resulting in reduced access to innovation for patients, loss of strategic research funding and partnerships, diminished influence in national and international research programmes, and failure to deliver the Trust's research and innovation objectives.	Chief Strategy & Transformation Officer	Transformation Committee
BAF009 – Embedding research: Failure to rapidly embed research opportunities in care pathways, widen patient participation in research including late-stage clinical trials and support more colleagues to transition research into clinical practice.	Chief Medical Officer	Transformation Committee
BAF010 - Financial sustainability: Failure to deliver the scale of financial improvement required to achieve a breakeven or better financial performance within the funding allocation that has been set for the next three years.	Chief Finance Officer	Performance and Finance Committee
BAF011 – Population growth: Failure to anticipate and adapt clinical and estates model to respond to the scale of population growth predicted in the Greater Cambridge growth plan and across the wider East of England.	Chief Strategy & Transformation Officer	Transformation Committee

3. BAF Review Methodology

3.1 The BAF review has been led by the Corporate Governance function and has relied on consistent engagement with executive directors and their teams to complete, moderate and iterate proposed entries.

3.2 In December 2025, the project team commenced with a documentation review, including:

- The Trust's Risk Strategy and Management Policy, to understand the framework under which the BAF was expected to operate; and
- Internal audit reports on the BAF and risk management from 2023/24 and 2024/25, to gain an understanding of risks or concerns raised previously and how the BAF had been operating.

3.3 In January 2026, the project undertook a benchmarking exercise of the BAF's across the Shelford Group trusts. A stakeholder mapping exercise was then undertaken to identify the key stakeholders across the Trust, which included the following:

- Executive directors
- Non-executive directors
- Senior trust leadership

3.4 In late January 2026, the project team commenced meetings with the key stakeholders to obtain their experience of the BAF and considerations for alignment with the refreshed Trust strategy.

3.5 In February 2026, the project team completed and documented its stakeholder engagement exercise. The team reviewed key themes to identify proposals for inclusion in the refreshed BAF and recommendations for further work, which were taken through the Trust governance processes prior to discussion at the Board of Directors meeting in March 2026, where the headline risks were approved.

3.6 In March 2026, the project team finalised feedback on the format of the BAF and commissioned executive leads and their teams to populate the risks assigned to them by the end of April 2026.

3.7 In early May 2026, all strategic risks were collated, reviewed and moderated by the project team and 1:1 feedback was provided to improve the entries. A refreshed document was presented to the Risk Oversight Committee in May 2026, collating

additional feedback prior to commencing internal governance gateways for review and approval by individual Board Committees during May, June and early July 2026.

3.8 In June Internal Audit presented their report on the work to refresh the BAF and gave a rating of substantial assurance.

3.9 The fully refreshed BAF was presented to the Board of Directors meeting in private on 8 July 2026.

4. Updated BAF

4.1 The refreshed BAF is presented at Appendix 1, which has been reviewed by the Board when it met in private on 8 July 2026.

5. Next steps

5.1 A deep dive schedule for each of the BAF items has been agreed with the Chairs of the Board Committees. It is intended that each entry will receive a deep dive review twice yearly.

5.2 The aligned BAF entries were presented to the Quality Committee and Performance and Finance Committee on 2 September. In discussion it was agreed that the ratings of substantial assurance for BAF items 004 (Access) and 006 (Estates) should be reviewed.

5.3 The Chief Finance Officer is also undertaking a review of the financial sustainability risk.

5.4 The production of the BAF User Guide is underway and will be finalised by the Corporate Governance team in the autumn of 2026.

5.5 This BAF refresh precedes a review of the Corporate Risk Register and its relationship to the BAF, which will be led by the Chief Nurse, together with a review of the Risk Strategy and Management Policy.

6. Recommendations

6.1 The Board is asked to:

a. Review and approve the Board Assurance Framework.
b. Agree any further changes to the risk entries.

Board of Directors (held in Public) 9 September 2026
Board Assurance Framework)

NHS Cambridge University Hospitals NHS Foundation Trust

Contents

Introduction and executive summary

This update of the Board Assurance Framework (BAF) follows review by strategic risk owners of the individual risks entered onto the framework ahead of Risk Oversight Committee on 14 August 2026.

The BAF is structured around eleven Strategic Risks, each of which has:

- A current risk score
- An aggregated assurance rating
- An assessment of each risk against its related risk appetite domain

The BAF User Guide has been developed to support the use of the BAF as an assurance tool.

Across the Trust's current strategic risk profile presented in the BAF Dashboard, 3 risks are currently being managed with a 'limited' aggregated assurance rating. It is recommended that scrutiny and challenge is focused on these risks and, and that the planned schedule of deep dive reviews considers the adequacy of oversight arrangements for these risks.

Strategic risk	Risk score	Aggregated assurance rating
BAF005 – Digital infrastructure	20	**Limited**
BAF007 – High performing, inclusive culture	16	**Limited**
BAF011 – Population growth	20	**Limited**

NHS Cambridge University Hospitals NHS Foundation Trust

Key

Risk score

Score	Rating
1-3	Low
4-6	Moderate
8-12	High
15-25	Extreme

Assurance rating

Rating	Details
Substantial	The scope of assurances noted on the current BAF demonstrate that the Controls are effectively managing the Risk / Cause.
Adequate	There are a full range of Assurances in place and no material issues have been identified with the effectiveness of Controls. Assurances are reflecting the need to fully embed the Controls.
Limited	Either some of the Assurances noted on the current BAF demonstrate that the Controls in place are not effectively managing the Risk / Cause and action is required to address and / or there are gaps in Assurance.
None	No assurance can be taken / is available that the Controls relied upon are working. Action needs to be taken to address / improve the sufficiency of Controls and Assurance provided.

Risk appetite scale

AVOID	MINIMAL	CAUTIOUS	OPEN	SEEK

Strategic focus areas

Deliver excellent and timely care	Transform how and where we deliver care	Harness research and innovation to improve patient outcomes
Safety and effectiveness	Neighbourhood health	Research infrastructure
Access and productivity	Personalised and convenient	Increasing participation for patients and colleagues
People and performance	Next generation care	Impact-led research

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BAF Summary Dashboard

Strategic risk	Current risk score	Aggregated assurance rating	In/out of risk appetite
BAF001 – Patient safety	16	Adequate	N/A
BAF002 – Effectiveness	16	Adequate	N/A
BAF003 – Patient experience	16	Adequate	N/A
BAF004 – Access to care	16	Substantial	N/A
BAF005 – Digital infrastructure	20	Limited	N/A
BAF006 – Estate environment compliance and resilience	20	Substantial	N/A
BAF007 – High performing, inclusive culture	16	Limited	N/A
BAF008 – Transformation	12	Adequate	N/A
BAF009 – Embedding research	12	Adequate	N/A
BAF010 – Financial sustainability	20	Substantial	N/A
BAF011 – Population growth	20	Limited	N/A

There have been no changes to risk scoring or assurance ratings since the Board approved the BAF in July 2026.

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Strategic risk deep dive schedule

Strategic risk	Oversight forum	Date of last deep dive	Date of proposed deep dive
BAF001 – Patient safety	Quality Committee	N/A	November 2026
BAF002 – Effectiveness	Quality Committee	N/A	January 2027
BAF003 – Patient experience	Quality Committee	N/A	October 2026
BAF004 – Access to care	Performance and Finance Committee	N/A	November 2026
BAF005 – Digital infrastructure	Transformation Committee, Audit Committee	N/A	November 2026
BAF006 – Estate environment compliance and resilience	Performance and Finance Committee	N/A	October 2026
BAF007 – High performing, inclusive culture	Workforce and Education Committee	N/A	N/A
BAF008 – Transformation	Transformation Committee	N/A	November 2026
BAF009 – Embedding research	Transformation Committee	N/A	January 2027
BAF010 – Financial sustainability	Performance and Finance Committee	N/A	December 2026
BAF011 – Population growth	Transformation Committee	N/A	March 2027

NHS Cambridge University Hospitals NHS Foundation Trust

BAF 001 – Patient safety

Failure to have a robust quality governance structure in place to support the delivery and oversight of high-quality care may result in an adverse impact on the safety of our patients.

Strategy objective 1: Deliver excellent and timely care. Focus area: Safety and effectiveness.

Accountability and review history

Strategic risk owner	Lorraine Szeremeta and Sue Broster
Oversight forum	Quality Committee
Last risk review date	July 2026
Last deep dive	N/A
Next deep dive	TBC

Related Corporate Risk Register entries

ID	Description	Score
CR07 Healthcare Acquired Infections	There is a risk of failure to reduce the incidence of Health Care Associated Infections (HCAIs) or preventing the spread of infection as a result of non-compliance with infection control practices and insufficient capacity within the Trust Estate	20
CR55 Radiopharmacy Services	There is a risk that CUH may lose its Radiopharmacy services due to losing the MHRA 'Specials Manufacturing Licence'. The loss of this licence would invoke the immediate cessation of production of radiopharmaceuticals for contracted external NHS organisations, veterinarians across the region and clinical trials	20

Risk analysis

	Initial	Last quarter	Current quarter	April 27 trajectory	April 28 trajectory	Target
Risk score: impact	4	N/A	4	4	4	4
Risk score: likelihood	4	N/A	4	2	2	2
Risk score	16	N/A	16	8	8	8
Assurance rating	Adequate	N/A	Adequate	Adequate	Substantial	Substantial
Risk appetite	N/A	N/A	N/A	N/A	N/A	N/A
In/out of appetite	N/A	N/A	N/A	N/A	N/A	N/A

BAF 001 – Patient safety

Causes

- Insufficient board and sub-committee oversight and triangulation of safety metrics including behaviours and culture.
- Lack of systemic learning from patient safety events/near misses, ward to Board.
- Fluctuating external environment.
- Negative individual behaviours or team/department, which do not support psychological safety and in addition are not addressed by the organisation.
- Poor org safety culture that does not support systems thinking/just culture.
- Lack of educational provision ensuring staff and leaders are not adequately skilled and knowledgeable in applying patient safety science, including human factors.
- Poor communication and handover between clinical teams across all pathways.
- Unreliable clinical processes including variation in adherence.
- Workforce shortages creating unsafe staffing levels/inadequate skill capability.

Consequences

- Patient harm including death.
- Failure to detect and respond to poor clinical practice in a timely way adversely impacting our patients
- Failure to learn as an organisation, adversely impacting on our patients, their families and our staff
- Negative impact on staff wellbeing, including burnout, moral injury and increased likelihood of cognitive errors when delivering care.
- Increased regulatory intervention and reduced autonomy due to failure to meet standards
- Reputational damage
- Failure to gain or retain accreditations.
- Litigation/financial loss from claims and regulatory fines.

Risk owner commentary

A recent review of the quality governance structures and processes in the Trust demonstrated a variable approach to quality governance across the organisation, in each of the three domains of quality. There were 7 never events in 2025/26 which indicates that there is an opportunity to strengthen the Trust's learning and safety culture. This entry on the BAF also considers the findings and learning identified in the Verita investigation. In total there are 10 risks on the Corporate Risk Register related to this BAF entry; the two entries scored at 20 or higher are noted on the preceding page.

- CR03 Water quality (risk score: 15)
- CR04a Replacement of medical equipment (risk score 12)
- CR04b Medical device repairs/PPM (risk score 12)
- CR07 HAIs (risk score: 20)
- CR38 Deteriorating patients including sepsis (risk score: 15)
- CR41 Patients with Mental Health conditions (risk score: 12)
- CR55 Radiopharmacy services (risk score: 20)
- CR58b Accreditations (risk score: 16)
- CR64 Paeds ortho incident (risk score: 16)
- CR66 Management of Trust documents (risk score: 12)

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NHS Cambridge University Hospitals NHS Foundation Trust

BAF 001 – Patient safety

Table of controls and assurances

	Assurances [Where can we gain evidence that controls are working]		
Key controls/mitigations [System in place to manage the risk]	**First level** [Service delivery and day-to-day management - how do we know day to day that controls are working?]	**Second level** [Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]	**Third level** [Independent challenge – has anyone external come in to check that the controls are working]
Current quality governance structures, accountability framework and quality governance arrangements	Meetings and reporting at team, ward, departmental, specialty, directorate and divisional level	Reporting to Management Executive, monthly divisional Q&P meetings and the Quality Committee	NHSE Quality Governance findings External reviews and accreditations
Risk Management Policy and Strategy	Discussion of risks at directorate and divisional levels	Oversight of the BAF and CRR at the Risk Oversight Committee	Internal Audit: Risk management – significant assurance
Monitoring the implementation of actions identified in patient safety learning responses	Working groups established to identify owners and timescales Datix risk management system Incident management processes at team, ward, departmental, specialty, directorate and divisional level	Oversight of progress with actions at the Patient Safety Oversight Group and the Quality Committee	CQRM with the ICB Reporting of quality scorecard to and challenge by the region (frequency of reporting to be agreed by the region) KPMG internal audit - PSIRF and learning
Patient Safety Incident Response Framework	Incident reporting, investigation and learning at local level Divisional Incident Review Fora	Safety Oversight Meeting Weekly Executive Patient Safety Huddle Patient Safety Oversight Group	ICB oversight and agreement of Patient Safety Incident Response Plan
Mechanisms in place to disseminate learning	Message of the Week Grand Round Mortality and Morbidity meetings Learning Bytes Internal patient safety alerts	Weekly Executive Patient Safety Huddle Clinical Audit Committee Learning from Deaths Group Patient Outcomes Oversight Group Patient Safety Oversight Group Experience of Care Oversight Group Trustwide fora e.g. Matrons, Sisters/Charge Nurses, Specialty and Clinical Leads	
Processes in place to support patients & families impacted by a patient safety event	Engagement lead role within the divisions. Divisional Incident review fora Family liaison group (FLIS) Duty of candour policy & metrics Patient safety partners	Weekly Patient Safety Oversight Meeting (SOM) Patient Safety Executive huddle Learning from Deaths Group Patient Safety Oversight Group	CQRM with the ICB
Safe staffing levels	Safe staffing reports Divisional governance forums Mandatory safety & PSIRF training	NMAAC Trust Board	
Assurance rating: Adequate			

BAF 001 – Patient safety

Gaps in controls and assurances

Gaps in controls and assurances	Actions to address gaps	Due date	On track (Y/N)
An inconsistent approach to quality governance	Implementation of Quality Governance Improvement Plan	April 2027	Y
Timely triangulation of data to highlight hot spots and provide early warning signals	Establishment of the Quality-of-Care Forum (will include rollout of Genome and Ward Accreditation Programme)	June 2026	Y
Delays in implementing required improvements due to delays in completing formal patient safety learning responses i.e. AAR, Roundtables	Designing functions in Datix to strengthen oversight of compliance with completion of learning response events and consequent reports. Strengthen training of Learning response leads and facilitators responsible for delivering Roundtables	June 2026	Y

NHS Cambridge University Hospitals NHS Foundation Trust

BAF 002 – Effective care

Failure to deliver safe, evidence-based and clinically effective care that achieves the best outcomes for our patients.

Strategy objective 1: Deliver excellent and timely care. Focus area: Safety and effectiveness.

Accountability and review history

Strategic risk owner	Sue Broster
Oversight forum	Quality Committee
Last risk review date	July 2026
Last deep dive	N/A
Next deep dive	

Related Corporate Risk Register entries

ID	Description	Score
CR64 Paediatric Orthopaedic Incident	There is a risk that the Trust will not identify and address harm caused to patients by substandard care provided by an orthopaedic surgeon who specialises in treating children	16

Risk analysis

	Initial	Last quarter	Current quarter	April 27 trajectory	April 28 trajectory	Target
Risk score: impact	4	N/A	4	4	4	4
Risk score: likelihood	4	N/A	4	2	2	2
Risk score	16	N/A	16	8	8	8
Assurance rating	Adequate	N/A	Adequate	Adequate	Substantial	Substantial
Risk appetite	N/A	N/A	N/A	N/A	N/A	N/A
In/out of appetite	N/A	N/A	N/A	N/A	N/A	N/A

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BAF 002 – Effective care

Causes

- Lack of clarity and accountability for quality governance at specialty level
- No consistent clear line of sight from specialty to division
- Inconsistent use of data and intelligence to provide assurance and drive improvement at specialty and directorate level
- Insufficient board and sub-committee oversight and triangulation of all quality metrics including safety, outcomes and experience
- Lack of systemic learning approach across services and teams
- An operating model that requires review given the fluctuating external environment
- Negative individual behaviours or team/department not demonstrating the Trust's values
- Lack of consistent and standardised approach to quality governance in the specialties and directorates
- Inconsistent understanding of roles and responsibilities with regard to quality governance at specialty level.

Consequences

- Adverse impact on outcomes for our patients
- Failure to detect and respond to poor clinical practice in a timely way adversely impacting our patients
- Failure to learn as an organisation adversely impacting on our patients
- Negative impact on staff wellbeing, motivation and recruitment/retention
- Reputational damage.

Risk owner commentary

There is a risk that patients do not receive consistently effective care due to variation in clinical practice, failure to adopt evidence-based guidelines and ineffective quality governance systems, resulting in sub-optimal patient outcomes, avoidable harm, regulatory non-compliance, and reputational damage.

This entry on the BAF considers the learning identified in both the Verita investigation and NHS England’s review of CUH’s quality governance structures and processes.

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BAF 002 – Effective care

Table of controls and assurances

Key controls/mitigations [System in place to manage the risk]	Assurances [Where can we gain evidence that controls are working] First level [Service delivery and day-to-day management - how do we know day to day that controls are working?]	Second level [Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]	Third level [Independent challenge – has anyone external come in to check that the controls are working]
Current quality governance structures, accountability framework and quality governance arrangements	Meetings and reporting at team, ward, departmental, specialty, directorate and divisional level	Reporting to Management Executive, monthly divisional Q&P meetings and the Quality Committee	NHSE Quality Governance findings
Mechanisms in place to disseminate learning	Message of the Week Grand Round Mortality and Morbidity meetings Learning Bytes Internal patient safety alerts	Weekly Executive Patient Safety Huddle Clinical Audit Committee Learning from Deaths Group Patient Outcomes Oversight Group Trustwide fora e.g. Matrons, Sisters/Charge Nurses, Specialty and Clinical Leads	KPMG internal audit - PSIRF and learning
Clinical effectiveness processes including clinical audit, NICE guidance compliance, learning from deaths, GIRFT, etc.	Local audit days Directorate governance meetings	Reporting to the Clinical Audit Committee, Learning from Deaths meeting, Patient Outcomes Oversight Gorup and to the Quality Committee	Reporting of quality scorecard to and challenge by the region (frequency of reporting to be agreed by the region) Benchmarking e.g. Model Hospital, GIRFT (incl. NCIP) and participation in national audits and registries External reviews and accreditations e.g. HTA, JAG
Consultant medical appraisal process ensuring line management have appropriate visibility of information relevant to their team	Tracked at specialty, directorate and divisional level	Reporting to monthly divisional Q&P meetings and the Workforce and Education Committee	
External review policy ensuring reviews are commissioned and delivered with independence, transparency and consistent governance, alongside robust improvement plans	Governance processes highlight the need for an external review	Patient Outcomes Oversight Group	Outcomes of commissioned reviews undertaken externally
Review of quality governance and safety risk in small, cross-divisional and high-complexity/low-volume services	Tracked at specialty, directorate and divisional level	Progress with improvement plans reporting to Management Executive and monthly divisional Q&P meetings	
Assurance rating: Adequate			

BAF 002 – Effective care

Gaps in controls and assurances

Gaps in controls and assurances	Actions to address gaps	Due date	On track (Y/N)
Trustwide embedded process for clinical harm reviews	Implementation of a Clinical Harm Review Process for Waiting List Management	October 2026	Y
Lack of a robust and evidence based patient outcomes strategy	Development and implementation of the strategy	December 2026	Y
Insufficient triangulation of quality intelligence across safety, outcomes, patient experience and workforce data	Development of an integrated quality surveillance 'early warning' process to identify emerging risks and themes	December 2026	Y

NHS Cambridge University Hospitals NHS Foundation Trust

BAF 003 – Patient experience

Failure to deliver high-quality, compassionate care that consistently meets the needs and expectations of patients, families, carers and our population.

Strategy objective 1: Deliver excellent and timely care. Focus area: Safety and effectiveness.

Strategy objective 2: Transform how and where we deliver care. Focus area: Personalised and convenient.

Accountability and review history

Strategic risk owner	Lorraine Szeremeta
Oversight forum	Quality Committee
Last risk review date	July 2026
Last deep dive	N/A
Next deep dive	TBC

Related Corporate Risk Register entries

ID	Description	Score
CR41	Patients with Mental Health conditions	12
CR45a	Equality and Diversity – patients	16

Risk analysis

	Initial	Last quarter	Current quarter	April 27 trajectory	April 28 trajectory	Target
Risk score: impact	4	N/A	4	4	4	4
Risk score: likelihood	4	N/A	4	2	2	2
Risk score	16	N/A	16	8	8	8
Assurance rating	Adequate	N/A	Adequate	Adequate	Substantial	Substantial
Risk appetite	N/A	N/A	N/A	N/A	N/A	N/A
In/out of appetite	N/A	N/A	N/A	N/A	N/A	N/A

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BAF 003 – Patient experience

Causes

- Variation in staff communication skills
- Negative individual behaviours or team/department not demonstrating the Trust's values
- Inequalities in access, experience, and outcomes for some specific patient groups
- Some of the clinical environments are no longer fit for their intended purpose
- Delays in access times to OPD, UEC, Surgery and Diagnostics
- Use of contingency areas to care for patients
- Not engaging with service users in a meaningful way to inform change
- Ineffective handling of feedback, complaints and concerns
- Insufficient board and sub-committee oversight and triangulation of all quality metrics including safety, outcomes and experience
- Lack of systemic learning approach across services and teams.

Consequences

- Adverse impact on our patient's experience
- Disengagement from clinical care
- Loss of trust in the organisation
- Deterioration in patient feedback including satisfaction
- Reputational damage
- Regulatory scrutiny
- Widening health inequalities
- Negative impact on staff wellbeing, motivation and recruitment/retention
- Improvements are not made in line with the patient's experience and feedback.

Risk owner commentary

There is a risk that patient experience is not consistently measured, monitored or acted upon across all services, resulting in reduced patient satisfaction, poor engagement, inequity of access, and potential harm to patients and organisational reputation. There is a risk that patients are not genuinely engaged with to influence care or service redesign and that this is not routinely done across the organisation.

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BAF 003 – Patient experience

Table of controls and assurances

	Assurances [Where can we gain evidence that controls are working]		
Key controls/mitigations [System in place to manage the risk]	**First level** [Service delivery and day-to-day management - how do we know day to day that controls are working?]	**Second level** [Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]	**Third level** [Independent challenge – has anyone external come in to check that the controls are working]
Current quality governance structures, accountability framework and quality governance arrangements	Meetings and reporting at team, ward, departmental, specialty, directorate and divisional level	Reporting to Management Executive, monthly divisional Q&P meetings and the Quality Committee	NHSE Quality Governance findings Benchmarking with comparator Trusts with regard to national survey results (CQC, inpatient, etc)
Management of concerns and complaints policy	Implementation at directorate and divisional level	Reporting to Management Executive, monthly divisional Q&P meetings and the Experience of Care Oversight Group	Internal audit CQRM with the ICB Reporting of quality scorecard to and challenge by the region (frequency of reporting to be agreed by the region)
Mechanisms in place to disseminate learning	Message of the Week Newsletters Learning Bytes	Experience of Care Oversight Group Weekly Executive Patient Safety Huddle Patient Outcomes Oversight Group Patient Safety Oversight Group Trustwide fora e.g. Matrons, Sisters/Charge Nurses, Specialty and Clinical Leads	
Processes in place to gain patient feedback	Feedback collated and disseminated e.g. national surveys, FFT	Oversight of feedback and actions at the Experience of Care Oversight Group	CQRM with the ICB
Assurance rating: Adequate			

BAF 003 – Patient experience

Gaps in controls and assurances

Gaps in controls and assurances	Actions to address gaps	Due date	On track (Y/N)
Patient Engagement strategy	Development of a Trustwide strategy	March 2027	Y
Patient Experience strategy	Development of a Trustwide strategy	June 2026	N
Patient and Public Involvement framework (aligned to the strategic priorities of building skills and confidence, partnership and inclusion, and telling the story of involvement and impact)	Development of a framework to include a delivery plan	Spring 2027	Y
Timely triangulation of data to highlight hot spots and provide early warning signals	Establishment of the Quality-of-Care Forum (will include rollout of Genome and Ward Accreditation Programme) reporting to POOG, PSOG and ECOG	June 2026	Y
The requirement to continually improve people's experiences of our services	Self-assessment against NHSE Experience of Care framework and resulting action plan to address any gaps and areas to strengthen	TBC	
Inconsistent use of learning from complaints and feedback	Implementation of the actions re strengthening the Trust's learning culture (part of the improvement plan resulting from NHSE's review of quality governance)	Dec 2026	Y

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BAF 004 – Access to care

Failure to deliver sufficient productivity improvement and pathway transformation to deliver constitutional operational performance standards in all services.

Strategy objective 1: Deliver excellent and timely care. Focus area: Access and productivity.

Accountability and review history

Strategic risk owner	Laura Churchward
Oversight forum	Performance and Finance Committee
Last risk review date	July 2026
Last deep dive	N/A
Next deep dive	TBC

Related Corporate Risk Register entries

ID	Description	Score
CR05a	Urgent & emergency capacity	16
CR05c	Outpatient Capacity	16
CR05d	Diagnostic capacity	12
CR05e	Surgery capacity	12

Risk analysis

	Initial	Last quarter	Current quarter	April 27 trajectory	April 28 trajectory	Target
Risk score: impact	4	4	4	N/A	5	5
Risk score: likelihood	3	3	4	N/A	4	4
Risk score	12	12	16	N/A	20	20
Assurance rating	**Substantial**	**Substantial**	**Substantial**	N/A	**Substantial**	**Substantial**
Risk appetite	N/A	N/A	N/A	N/A	N/A	N/A
In/out of appetite	N/A	N/A	N/A	N/A	N/A	N/A

BAF 004 – Access to care

Causes

- Insufficient physical capacity to deliver projected demand
- Insufficient capacity and capability within clinical and operational teams to deliver competing priorities
- Ineffective prioritisation of operational objectives
- Lack of external capacity resulting in increased demand for CUH services.

Consequences

- Deterioration in patient outcomes and experience
- Increased regulatory intervention and reduced autonomy due to failure to meet constitutional standards
- Negative impact on staff wellbeing, motivation and recruitment/ retention
- Reputational damage, loss of confidence of patients.

Risk owner commentary

Timely access to the right care is a driver of improved patient experience and for many patients has a causal relationship with outcomes. Failure to deliver national constitutional standards for cancer, planned, urgent care and diagnostic services is therefore a core priority for CUH and is reflected in both commissioning and regulatory frameworks against which the organization is held to account. Over the last year, CUH has made significant progress in relation to shortening waiting times for planned care and cancer diagnosis. A coordinated programme of service transformation (in and out of hospital), targeted investment and effective operational management will be required to deliver national standards set out in the 2026/27 contract and the NHS Constitution.

NHS Cambridge University Hospitals NHS Foundation Trust

BAF 004 – Access to care

Table of controls and assurances

Key controls/mitigations [System in place to manage the risk]	Assurances [Where can we gain evidence that controls are working] First level [Service delivery and day-to-day management - how do we know day to day that controls are working?]	Second level [Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]	Third level [Independent challenge – has anyone external come in to check that the controls are working]
Accountability Framework establishes responsibilities for delivery of constitutional access standards.	Directorate Quality and Performance Meetings UEC, Elective Care, Diagnostic and Cancer Taskforces and Flow Improvement Board, Outpatient Board and Surgery Board	Reporting to Management Executive Reporting to Performance and Finance Committee Integrated Performance Report Divisional Quality & Performance meetings	Internal Audit programme Tier One oversight arrangements GIRFT visits and peer review
Use of contingency space, reverse boarding and plus-1 bed when required	Daily nursing quality meetings Daily capacity meetings Divisional Bronze meetings Twice-daily leadership reports	Reporting to Management Executive	NHSE reporting to monitor adherence to GIRFT corridor care standards UEC GIRFT visit 2026
Use of virtual ward	Division C governance arrangements Daily capacity meetings	Virtual Ward Board Divisional Quality & Performance meetings	UEC GIRFT visit 2026
Regional repatriations process	Twice daily shift reports COO-COO escalations	Divisional Quality & Performance meetings	Major Trauma Network review 2026 UEC GIRFT visit 2026
Maximising utilisation of available capacity	6-4-2 process	Divisional Q&P meetings Outpatients Redesign Board Surgical Programme Board	NHSE regulatory intervention and scrutiny
Use of independent sector and off-site capacity	Patient Tracking List meetings	Fortnightly Outsourcing meeting	NHSE regulatory intervention and scrutiny

Cambridge University Hospitals NHS Foundation Trust

BAF 004 – Access to care

Table of controls and assurances

	Assurances [Where can we gain evidence that controls are working]		
Key controls/mitigations [System in place to manage the risk]	**First level** [Service delivery and day-to-day management - how do we know day to day that controls are working?]	**Second level** [Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]	**Third level** [Independent challenge – has anyone external come in to check that the controls are working]
Application of GIRFT and Model Hospital best practice	GIRFT specific project meetings (e.g. Further Faster Follow Up and Hub Optimisation Week) Directorate meetings Surgical Programme Board	Outpatient Redesign Board	GIRFT visits
Validation of the elective waiting list	Participation in national validation sprints and associated reporting	Elective Taskforce	Tier One oversight arrangements
Assurance rating: Substantial			

BAF 004 – Access to care

Gaps in controls and assurances

Gaps in controls and assurances	Actions to address gaps	Due date	On track (Y/N)
Governance arrangements for transformational programmes.	Relaunch of Outpatient Board and align transformation resource with CUH strategic priorities.	June 2026	Y
Operational staffing fragilities exist in multiple services, limiting ability to deliver required standards and increasing lack of resilience	Intensive operational support model until end of March 2026. Investment in operational management roles. Investment in leadership development for clinical leadership roles, including King's Fund programme.	End March 2026 Ongoing April 2027	Y Y Y
Strategic approach to outsourcing and insourcing.	Agree strategic approach across CUH Executive leads and launch procurement process.	June 2026	Y
System working to respond to growth in both elective and non-elective demand.	Elective demand reviewed through Tier 1 process with NHSE; non elective through Unplanned Care Board	Monthly	N
Systematic approach through which operational actions are associated with a specific quantum of activity, feeding into accurate forecasting of improvement trajectories.	Improvements to understand mismatch between capacity and demand, feeding into more robust trajectories for deliver in most challenged areas currently focus of intensive operational support model until end of March 2026.	March 2026	Y
Fragile services across the wider provider ecosystem lack system or regional planning	Bilateral engagement and use of provider collaborative where known fragilities exist Request for regional NHSE involvement to coordinate	Various TBC	N

NHS Cambridge University Hospitals NHS Foundation Trust

BAF 005 – Digital infrastructure

Failure to deliver make available the digital infrastructure and solutions required by the Trust, including failure to prevent a future cyber- attack, failure to digitally-enable delivery of the Trust strategy, or and failure to take advantage of innovation.

Strategy objective 1: Deliver excellent and timely care. Focus areas: Safety and effectiveness; Access and productivity.

Accountability and review history

Strategic risk owner	Sarah Jensen
Oversight forum	Transformation Committee, Audit Committee
Last risk review date	June 2026
Last deep dive	N/A
Next deep dive	TBC

Related Corporate Risk Register entries

ID	Description	Score
CR32a	Cyber Security	20
CR32b	Breaches of data security, data access and/or legislation/regulation	16
CR32c	Loss of digital capability	12

Risk analysis

	Initial	Last quarter	Current quarter	April 27 trajectory	April 28 trajectory	Target
Risk score: impact	5	N/A	5	5	4	4
Risk score: likelihood	4	N/A	4	4	4	4
Risk score	20	N/A	20	20	16	16
Assurance rating	**Limited**	N/A	**Limited**	**Adequate**	**Substantial**	**Substantial**
Risk appetite	N/A	N/A	N/A	N/A	N/A	N/A
In/out of appetite	N/A	N/A	N/A	N/A	N/A	N/A

BAF 004 – Digital infrastructure

Causes

- Increasing likelihood of successful cyber attack
- Technical failure
- Poor effectiveness of response and recovery plans in the event of a long-term IT outage
- Supply chain vulnerabilities

Consequences

- Patient harm
- Inability to deliver urgent or planned patient care
- Financial loss
- Reputational damage

Risk owner commentary

Digital and data capabilities are fundamental to delivery of the CUH Strategy. They underpin our ability to provide safer, more effective care, improve access and productivity, support our workforce, and strengthen our role as a national and international leader in research and innovation. An incident, such as a cyber-attack, which results in an outage of our digital systems therefore represents a significant threat to CUH, both to patient care and financial impact. Due to the complexity of the risk and the evolving nature of cyber events, no single control can materially reduce its likelihood in the short term; it requires a layered and evolving suite of controls to manage the risk to an acceptable level. In addition to the risk of system unavailability is the risk that our digital systems do not enable the transformation and optimisation required to support delivery of the Trust strategy. All service change requires some level of change to digital systems, and given finite resources, it is important that the Trust considers the digital team as part of the multi-disciplinary team required to deliver service improvement and transformation.

Over the last year CUH has made significant progress on improving our cyber security posture and are forecasting to meet Data Security and Protection Toolkit (DSPT) standards in the 2026 submission. In addition, significant transformation programmes have delivered digital capabilities to support the efficiency and productivity of service delivery, including the Booking Optimisation Programme and the Coordination Centre. Priorities for future delivery have been agreed as articulated in the roadmap that outlines how digital and data capabilities will support delivery of the Trust Strategy. Work continues to improve the safety and effectiveness of the use of digital systems and the availability of data and insights, with a focus on ongoing training endorsed by Management Executive. The training programme is in place with work remaining to approve the plan to increase uptake.

Assurance is currently designated as Limited as reporting to Digital Board is scheduled according to sub-committee leads bringing forward items. Improvements being adopted in Q1 and Q2 of 2026/27 will ensure all sub-committees report regularly to Digital Board in a scheduled cadence to improve assurance of areas of decline or increasing risk.

NHS Cambridge University Hospitals NHS Foundation Trust

BAF 005 – Digital infrastructure

Table of controls and assurances

Key controls/mitigations [System in place to manage the risk]	Assurances [Where can we gain evidence that controls are working] First level [Service delivery and day-to-day management - how do we know day to day that controls are working?]	Second level [Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]	Third level [Independent challenge – has anyone external come in to check that the controls are working]
• A layered approach to cyber security protection measures including multi-factor authentication, and monitoring and threat detection capabilities in place.	• Local daily monitoring tooling, alerting and reporting measures • Information Security Working Group and Cyber Security Working Group • IT managed service contractual commitments	• DSPT annual self-assessment results are published	• Internal Audit Programme which includes a mandatory audit of the Data Security and Protection Toolkit submission
• Mandatory annual IG and cyber security training.	• Information Security Working Group and Cyber Security Working Group	• Mandatory training compliance figures included in corporate accountability meetings • DSPT annual self-assessment results are published	• Internal Audit Programme
• Policies, processes and procedures provide guidance to our workforce on securing information, systems and data.	• Information Governance Committee • Simulated and controlled cyber-attack scenarios to assess employee awareness	• DSPT annual self-assessment results are published	• Internal Audit Programme
• Incident management processes and business continuity plans for short term system outages.	• Regular internal testing and after incident reviews		• Internal Audit Programme
• Prioritisation of workforce and financial resources to deliver the Trust's highest-value strategic digital infrastructure and operational tooling.	• Clinical and operationally led groups in place to prioritise demands • Delivering the CUH Strategy: Digital and Data outlines the priorities for digital and data enablement of the Trust Strategy	• Digital Board • Performance and Finance Committee • Transformation Committee	
Assurance rating: Limited			

NHS Cambridge University Hospitals NHS Foundation Trust

BAF 005 – Digital infrastructure

Gaps in controls and assurances

Gaps in controls and assurances	Actions to address gaps	Due date	On track (Y/N)
Cyber improvement programme implementation is not complete.	Delivery of all aspects of the Cyber Improvement Programme.	Q4 27/28	Y
Cyber security risk register needs to include all risks associated held by teams managing digital systems across the Trust.	Collate cyber security risks into the central cyber security risk register.	Q3 26/27	Y
Improvements to assurance is required to ensure all sub-committees are providing reports to improve alerts, advice and assurance.	Develop and implement a structured reporting cycle to the Digital Board - framework has been developed and governance reporting has commenced. Monitoring will continue while new reporting cadence is embedded. Assess whether any additional external reviews are required to assure risk mitigations are appropriate.	Q2 26/27 Q4 26/27	Y
Work is underway but not complete to ensure Digital, Data and Technology (DDaT) resources are available to implement the transformation and optimisation activities outlined in the Trust Strategy.	Develop 5-year budget. Submit 4-year funding bids to NHSE. Progress recruitment of a permanent team of Epic analysts to focus on optimisation and transformation projects.	Q2 26/27 Q3 26/27 Q3 26/27	Y
Cyber security and information governance training requires updating.	Recruit a Director of Information Technology and Security who will lead the review of the mandatory training programme.	Q3 26/27	N
Data shows variability in the competency of staff to efficiently use digital tools including the Epic electronic patient record.	Finalise and implement the workforce training plan to improve digital and data literacy and capability.	Q3 26/27	Y
A holistic review of policies and procedures covering information security and management is required to improve compliance by staff.	Review all existing policies and plan for a comprehensive review of all relevant policies. Status of this work to be reported to Digital Board for second line assurance.	Q1 27/28	Y
Work is required to improve disaster recovery (DR) capabilities across critical systems including ensuring a centralised register of DR capabilities of each system, appropriate business continuity and operational recovery plans and implement schedule of resilience exercises.	Collate data on critical systems DR capabilities into the Master Application List. Clinical and operational areas to ensure their business continuity plans are fit for long term purpose Develop a schedule of resilience and recovery exercises for critical systems. Include reports on actions to improve DR preparedness on the regular cadence to Digital Board.	Q1 27/28 Q3 27/28 Q3 27/28 Q2 26/27	Y
Improve compliance with Digital Technology Assessment Criteria including Clinical Safety Assessments for digital systems	Incorporate compliance requirements into procurements for digital solutions. Capture compliance rates in the Master Application list. Include reporting on compliance in Digital Board reports.	Q1 27/28 Q1 27/28 Q2 26/27	Y

NHS Cambridge University Hospitals NHS Foundation Trust

BAF 006 – Estate environment compliance and resilience

Failure to address statutory compliance, poor condition and resilience of the estate environment and infrastructure and to progress plans to deliver new estate developments and capacity.

Strategy objective 1: Deliver excellent and timely care. Focus area: Safety and effectiveness.

Strategy objective 3: Harness research and innovation to improve patient outcomes. Focus area: Research infrastructure.

Accountability and review history

Strategic risk owner	Sarah Jensen
Oversight forum	Performance & Finance Committee
Last risk review date	July 2026
Last deep dive	N/A
Next deep dive	TBC

Related Corporate Risk Register entries

ID	Description	Score
CR03	Water quality	15
CR05	Access to services	16
CR07	Infection control	20
CR10	Electrical infrastructure resilience	15
CR20	Transport infrastructure: transport access to the CBC	12
CR23b	FM contract performance in the ATC	20
CR23c	ATC PFI contract	20
CR42a	Safety risk and non-compliance with the Fire Safety Regulations – Trust-wide buildings	16
CR43	Rosie Theatres – Theatre capacity and statutory compliance	16
CR59	Impact of climate change on delivery of services at CUH	16

Risk analysis

	Initial	Last quarter	Current quarter	April 27 trajectory	April 28 trajectory	Target
Risk score: impact	4	4	4	N/A	4	4
Risk score: likelihood	5	5	5	N/A	5	4
Risk score	20	20	20	N/A	20	16
Assurance rating	**Substantial**	**Substantial**	**Substantial**	N/A	**Substantial**	**Substantial**
Risk appetite	N/A	N/A	N/A	N/A	N/A	N/A
In/out of appetite	N/A	N/A	N/A	N/A	N/A	N/A

Board of Directors (held in Public) 9 September 2026
Board Assurance Framework)

BAF 006 – Estate environment, compliance and resilience

Causes

- Insufficient and no ring-fenced capital allocation, with constrained operational capacity to deliver remedial and statutory works — including beyond the 2027 fire funding horizon
- Absence of a medium-term integrated Clinical, Operational & Estates strategy and a sufficiently robust prioritisation framework
- PFI service delivery challenges and reduced internal capacity to manage and service the estate within a constrained budget
- Estate age and configuration limiting the Trust's ability to achieve climate resilience and embed the BoD-approved Green Plan
- External growth pressures from CBC and Cambridge expansion increasing campus demand, attendance and traffic
- Fire safety remediation programme to address fire compartmentation and fire alarm upgrade

Consequences

- Deterioration of the estate, plant and safety systems
- Negative impact on patient, staff and third-party safety
- Destabilisation of continuity of service delivery, with impact on access standards/Legislative requirement.
- Lack of statutory compliance
- Increased regulatory intervention
- Reputational damage
- Impact on delivery of service linked to adaptation and climate change
- Negative impact on patient and user experience

Risk owner commentary

BAF 006 reflects statutory, contractual and regulatory obligations that collectively create non-negotiable duty-holder accountability. The NHS Standard Contract (Schedule 6, Service Conditions) requires the Trust to maintain full compliance with all relevant legislation and nationally-recognised standards, including Health Technical Memoranda, at all times. CQC's Regulation 12 (Safe Care and Treatment) and the Well-Led Key Question place a direct obligation on the Board to evidence active governance of premises safety; failure to do so is a potential basis for regulatory enforcement action. The Fire Safety Order 2005 creates personal criminal liability for the Trust's designated Responsible Person. The breadth of this risk — spanning fire safety, engineering compliance, water safety, ventilation, asbestos, confined spaces, medical gases, electrical infrastructure, backlog maintenance, PFI contract management and climate change adaptation — makes inclusion within the BAF not a governance preference but a regulatory imperative.

The risk score is 20 against a target of 16, with no improvement trajectory projected over the next 12 months. 6FACET survey projections indicate High risk backlog maintenance liability will grow to £27m by 2029; current capital allocation trajectories reduce this to approximately £3.3m — a material residual exposure that requires Board acknowledgement and proactive collaboration system partners and commissioners. This composite risk includes the fire safety risk currently rated at 4x4=16. High degree of compartmentation works have been completed with fire alarm upgrade underway, but the compartmentation works that require wards to be decanted cannot be completed until there is capacity to do so. The planned works in C8 has been deferred due to operational capacity constraints. There is a requirement overseen by the CFRS to concl.de the stage 2 (decant) works by 2027. Currently, the works are off track by some margin, given the extended timeframe of the works as it is coupled with necessary infrastructure upgrade works of wards such as NCCU, and the deferment of the C8 works.

The most significant structural barrier to risk reduction is the absence of an integrated short-to-medium term clinical, operational, financial and estates planning forum. Without this, remedial programmes cannot be credibly sequenced against clinical and operational constraints, capital is allocated reactively rather than strategically, and the risk cannot be actively managed down against target. Ring-fenced statutory fire safety capital beyond 2027 has not been confirmed; this represents a material funding cliff edge that will directly increase the fire safety risk trajectory if left unresolved. PAM self-assessment gaps remain partially unaddressed pending capital programme commitments and the absence of an approved integrated strategy. The PFI settlement agreement remains on track for resolution by August 2026. National grant opportunities continue to be pursued to support Green Plan decarbonisation commitments, though these are contingent and cannot be relied upon as a mechanism for statutory compliance funding.

NHS Cambridge University Hospitals NHS Foundation Trust

BAF 006 – Estate environment compliance and resilience

Table of controls and assurances

	Assurances [Where can we gain evidence that controls are working]		
Key controls/mitigations [System in place to manage the risk]	**First level** [Service delivery and day-to-day management - how do we know day to day that controls are working?]	**Second level** [Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]	**Third level** [Independent challenge – has anyone external come in to check that the controls are working]
Corporate reporting to relevant governance groups	CEFM Governance Board	Health and Safety Committee Performance and Finance Committee Annual PAM assessment	AE Audits CQC PLACE
6FACET Survey provides Costed 5 Year forecast based upon condition and life of assets	CEFM Governance Board	Health and Safety Committee Performance and Finance Committee PAM assessment	AE Audits CQC PLACE
Backlog Maintenance Risk a component of the core capital programme.	CEFM Governance Board	Health and Safety Committee Performance Committee PAM assessment	AE Audits CQC PLACE
Ongoing fire safety risk assessment programme with oversight	CEFM Governance Board	Health and Safety Committee Performance Committee PAM assessment	Inspection by CFRS
CEFM Policies, Procedures & Protocols	CEFM Governance Board	Health and Safety Committee Performance Committee	AE Audits CQC PLACE
CUH Green Plan	CEFM Governance Board Environmental Stewardship Committee	ME and Board of Directors	NHSE CQC
Assurance rating: Substantial			

NHS Cambridge University Hospitals NHS Foundation Trust

BAF 006 – Estate environment compliance and resilience

Gaps in controls and assurances

Gaps in controls and assurances	Actions to address gaps	Due date	On track (Y/N)
Capital allocation does not resolve all the High risks; 5 Year profile of High risks as informed by the 6FACET Survey show High Risks increasing to £27m by 2029. With current Trust Capital Investment in Backlog, this figure will reduce to circa £3.3m by 2029.	Allocation for prioritised risk issues with in-year re-prioritisation as required- given capital allocation does not resolve all high risks.	March 2030	No
The annual capital budget setting does not include a mechanism to identify and escalate in-year cost pressure when materials cost or inflation materially deviates from the assumptions at the point of approval.	Implement a quarterly cost pressure review aligned to published sector indices, and establish a tolerance threshold for formal re-forecast and escalation	December 2026	No
Lack of Trust Operational capacity to facilitate remedial works	Work with Capacity Oversight Group (COG) to confirm availability.	December 2027	No
Green Plan: Ongoing funding to support decarbonisation plan, corporate policies to drive carbon reduction through workforce, procurement and finance policies.	Investment committee bids (internal) and national grant opportunities explored (externally) Engagement with relevant executive leads to progress their relevant corporate policies	March 2028	No
PFI Settlement agreement to be finalised	Remaining points to be agreed by Aug 2026 by all parties. For approval through governance in September cycle.	September 2026	Yes
Lack of operational forum for consistently aligning clinical strategy with current capacity and estates availability	Review of Terms of Reference for Capacity Oversight Group	December 2026	No

NHS Cambridge University Hospitals NHS Foundation Trust

BAF 007 – High performing, inclusive culture

Failure to foster and embed a high performing inclusive culture and associated behaviours that are consistent with our Trust values.

Strategy objective 1: Deliver excellent and timely care. Focus area: People and Performance.

Accountability and review history

Strategic risk owner	David Wherrett
Oversight forum	Board of Directors
Last risk review date	June 2026
Last deep dive	N/A
Next deep dive	TBC

Related Corporate Risk Register entries

ID	Description	Score
CR45b	Equality and diversity – workforce	16
CR64	Paediatric Orthopaedic incident	16

Risk analysis

	Initial	Last quarter	Current quarter	April 27 trajectory	April 28 trajectory	Target
Risk score: impact	4	N/A	4	N/A		3
Risk score: likelihood	4	N/A	4	N/A		3
Risk score	16	N/A	16	N/A		12
Assurance rating	**Limited**	N/A	**Limited**	N/A	**Adequate**	**Adequate**
Risk appetite	N/A	N/A	N/A	N/A	N/A	N/A
In/out of appetite	N/A	N/A	N/A	N/A	N/A	N/A

NHS Cambridge University Hospitals NHS Foundation Trust

BAF 007 – High performing, inclusive culture

Causes

- Inconsistent leadership capability and confidence at all levels to set clear standards, meaningfully address poor behaviour early and fairly, and drive Trust values
- Lack of clear, consistently applied expectations for inclusive, high-performance behaviours across clinical, and corporate settings
- Variable application of recognition and performance management processes, leading to insufficient recognition of excellence and tolerance of underperformance
- Limited use of high-quality, timely workforce performance data to inform decision-making and drive improvement
- Insufficient development and support for managers and clinical leaders to lead inclusive, high-performing teams
- Fragmented approach to talent management, succession planning and leadership development
- A need to sharpen the development offer for staff, bringing a stronger sense of purpose and alignment to education and development interventions
- Variation in staff experience across professional groups and protected characteristics that is not consistently identified or acted upon.

Consequences

- Reduced ability to deliver inclusive high-performance and delivery of all of the Trust's strategic priorities due to inconsistent performance, variable leadership capability and misaligned behaviours
- Deterioration in quality of care, patient safety and experience driven by poor team working, ineffective challenge and unmanaged underperformance
- Lower productivity and inefficient use of resources, impacting access standards and financial sustainability
- Negative staff experience, including reduced engagement, higher sickness absence and turnover, and widening variation in experience across staff groups
- Weak succession planning and lack of a sustainable pipeline of inclusive, high-performing leaders and specialists
- Increased regulatory scrutiny and reputational risk where culture is perceived as a barrier to improvement.

Risk owner commentary

A high-performing, inclusive culture is fundamental to the Trust's ability to deliver its strategic objectives, including to improve patient outcomes and experience, and remain a sustainable organisation. Evidence from staff experience, operational performance and external reviews demonstrates that variation in leadership capability, performance management and inclusive behaviours continues to impact consistency of delivery across the organisation, which we know negatively affects patient outcomes and experience (patient outcome data, safety incidents and patient feedback indicates variable levels of performance).

The recently established a Culture task and finish group has begun to articulate the cultural foundations and leadership behaviours required to support inclusive, high-performance. This group will recommend a desired state, analyse the current state and make recommendations going forward. Embedding these changes consistently across a large and complex organisation will take time, which is why this is a 5-year plan.

NHS Cambridge University Hospitals NHS Foundation Trust

BAF 007 – High performing, inclusive culture

Table of controls and assurances

	Assurances [Where can we gain evidence that controls are working]		
Key controls/mitigations [System in place to manage the risk]	**First level** [Service delivery and day-to-day management - how do we know day to day that controls are working?]	**Second level** [Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]	**Third level** [Independent challenge – has anyone external come in to check that the controls are working]
Establishing at a Board level, in the first instance, a clear understanding of our current position and our future desired state	Clear articulation of our current position and our future desired state as it relates to cultural foundations and our leadership behaviours	Board sub-committee – task and finish group	Board
Leadership and management development programmes focused on inclusive, high-performance	Participation in EMLE/AMLE and other clinical leadership programmes; local coaching and mentoring	Workforce dashboards; Education & OD reports to Committee	External programme evaluation (e.g. Kings Fund, NHS Leadership Academy)
Performance management framework for addressing underperformance and recognising excellence	Appraisal completion; objective setting; use of HR policies (including medical and non-medical staff)	Workforce metrics reviewed by Executive and People, Education & Culture Committee	Internal audit review of appraisal and performance management
Freedom to Speak Up and just culture approach to learning and accountability	FTSU guardian reports; local resolution of concerns	People, Education & Culture Committee; Quality Committee	National FTSU benchmarking; NHS Staff Survey, CQC
Use of workforce, inclusion and engagement data to inform action	Local action plans responding to staff survey and pulse data	Trust-wide workforce and EDI dashboards	NHS Staff Survey national benchmarking, WRES and WDES data
Talent management and succession planning processes	Identification of high-potential staff; development plans	Executive workforce reviews; Committee oversight	External peer review / accreditation where applicable
Assurance rating: Limited			

BAF 007 – High performing, inclusive culture

Gaps in controls and assurances

Gaps in controls and assurances	Actions to address gaps	Due date	On track (Y/N)
Inconsistent leadership capability and confidence to address poor performance and behaviour	Clearer articulation of performance and behavioural expectations Expand targeted leadership development support and coaching for priority roles and services		
Some 'hotspot' teams where culture and behaviours may need some attention	Targeted external organisational development support for teams to diagnose cultural and behavioural challenges and support improvement		
Limited triangulation of culture, inclusion and performance data	Develop integrated workforce, inclusion performance dashboard with clear KPIs		
Behaviours and expectations not clearly articulated	Develop a trust-wide framework setting clear expectations for behaviours, standards and how concerns about conduct are identified and addressed		
Inconsistent approach to consultant appraisal	Strengthened appraisal process for consultants		
Variable follow-through on staff survey and engagement actions	Strengthen accountability for delivery of local action plans		
Variable to understanding of the experience of medical consultants, particularly as it relates to safety and performance	Purposeful listening exercise with medical staff building on a series of key performance indicators		
Lack of systematic succession planning for critical roles	Implement targeted trust-wide talent and succession framework		
Limited independent assurance on culture change impact	Commission externally facilitated cultural stocktake		

NHS Cambridge University Hospitals NHS Foundation Trust

BAF 008 – Transformation

Failure to deliver the transformation required to deliver financial and operational performance next year and in future years, including strategic planning, neighbourhood health ambitions, large-scale change and flagship programmes.

Strategic objective 2: Transform how and where we deliver care. Focus areas: Neighbourhood health; Next generation care.

Accountability and review history

Strategic risk owner	Claire Stoneham
Oversight forum	Transformation Committee
Last risk review date	June 2026
Last deep dive	N/A
Next deep dive	TBC

Related Corporate Risk Register entries

ID	Description	Score
CR05 (a-g)	Access to services	16
CR20	Transport infrastructure	12
CR43 (d,e)	Rosie theatre / Maternity services' access	16
CR59	Climate change	16
CRR67	Regional onsite dialysis provision	16

Risk analysis

	Initial	Last quarter	Current quarter	April 27 trajectory	April 28 trajectory	Target
Risk score: impact	4	N/A	4	N/A	4	4
Risk score: likelihood	3	N/A	3	N/A	3	2
Risk score	12	N/A	12	N/A	12	8
Assurance rating	Adequate	N/A	Adequate	N/A	Substantial	Substantial
Risk appetite	N/A	N/A	N/A	N/A	N/A	N/A
In/out of appetite	N/A	N/A	N/A	N/A	N/A	N/A

BAF 008 - Transformation

Causes

- Insufficient capability and capacity within corporate, service and clinical operational teams to drive transformational change
- Frequent changes in strategic priorities due to national directives
- Limited visibility of interdependencies across programmes
- Complex interdependencies with partners.

Consequences

- Pressure on organisational sustainability
- Delays in delivering the most effective care for patients
- Reputational impact
- Diminished reputation, influence and attractiveness as a partner for academia, industry and research funders.

Risk owner commentary

The risk spans: insufficient capacity within corporate, service and divisional teams to drive transformational change (including large-scale change programmes such as ED digital front door, digitally-enabled flow, booking optimisation programmes, and ambient voice technology expansion); inadequate and uncertain funding for capital projects (including new hospitals and digital initiatives); and complex interdependencies with partners (such as Neighbourhood Health and new hospital programmes). Failure to manage these risks collectively will result in delays or failure to achieve sustainable models of care, productivity improvements, and the ambitions of the flagship programmes, undermining delivery of strategic objectives.

NHS Cambridge University Hospitals NHS Foundation Trust

BAF 008 - Transformation

Table of controls and assurances

Key controls/mitigations [System in place to manage the risk]	Assurances [Where can we gain evidence that controls are working] First level [Service delivery and day-to-day management - how do we know day to day that controls are working?]	Second level [Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]	Third level [Independent challenge – has anyone external come in to check that the controls are working]
1. Overarching Trust Strategy approved and embedded in planning and prioritisation processes.	Board-approved Strategy aligned to national policy. Delivery monitored through Trust governance, including a range of operational committees.	Board oversight with delivery progress reported via Board/sub-committees. Business plans reviewed and prioritised through agreed Board and Executive planning governance.	Elements of strategy delivery are being reported to the region, through their oversight channels.
2. Transformation Portfolio governance in place, with clear accountability for major programmes and interdependencies.	Quarterly reporting on progress and resource utilisation.	Portfolio reviewed through Board and Executive Committees.	
3. Oversight of transformation programmes through Board and Executive Committees; annual review and prioritisation of the transformation portfolio.	Prioritisation approach increasingly aligned with data-driven oversight as set out in the NHS Oversight Framework.	Transformation Committee provide oversight of strategic transformation programmes.	
4. Partnership governance structures in place, including through South Place, for Neighbourhood Health and flagship programmes.	Monitoring through South Place Team and the establishment of the Neighbourhood Team.	Partnership agreements/milestones monitored via programme/Place governance and Transformation Committee.	Partnership escalation and delegation arrangements with the ICB.

NHS Cambridge University Hospitals NHS Foundation Trust

BAF 008 - Transformation

Table of controls and assurances

	Assurances [Where can we gain evidence that controls are working]		
Key controls/mitigations [System in place to manage the risk]	**First level** [Service delivery and day-to-day management - how do we know day to day that controls are working?]	**Second level** [Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]	**Third level** [Independent challenge – has anyone external come in to check that the controls are working]
5. Trust-wide digital strategy and governance arrangements aligned to the Trust strategy and major transformation programmes.	Monitoring of progress against agreed milestones and national digital requirements.	Board-level oversight of major digital programmes against milestones and national requirements.	
6. Trust strategy and transformation programmes set clear intent to develop and implement new models of care aligned to system priorities.	Programme plans/business cases used to assess impact on activity, workforce and sustainability.	Executive/Board Committee reporting on major service redesign and transformation programmes.	
7. Flagship and multi-year capital and digital investment plans aligned to strategic priorities.	Increasing alignment to NHS Capital Guidance 2026 – 2030 principles (transparency, devolved planning, long-term stability).	Board/Committee scrutiny of capital and digital investment cases for strategic alignment.	Approved OBC for CCRH and CCH Completed NISTA Gate 3 CCRH Completed NISTA Gate 2 CCH Regular co-ordination with NHSE EoE
8. Workforce and capacity planning for transformation delivery across corporate and clinical teams	Workforce metrics and capacity dashboards provide oversight of transformation capacity. Workforce planning reflects NHS Employers guidance on collaborative workforce models, where relevant.	Board/Committee oversight of major initiatives.	
Assurance rating: Adequate			

NHS Cambridge University Hospitals NHS Foundation Trust

BAF 008 - Transformation

Gaps in controls and assurances

Gaps in controls and assurances	Actions to address gaps	Due date	On track (Y/N)
1. Variable translation into divisional plans. Lack of line-of-sight from strategy to delivery to outcomes. Strategic Outcomes Framework (SOF) metrics, Strategy Steering Group (SSG) and SMO not yet fully established.	Undertake a formal annual alignment review of divisional and corporate plans against the Trust Strategy. Embed SOF into Board reporting and introduce a set of strategic outcome measures (with multi-year trajectories) to demonstrate delivery of transformation intentions for key strategic programmes. Establish SSG and SMO. Strengthen guidance and support (via the Strategy/SMO function) to ensure consistent interpretation of strategic priorities across teams. Strengthen guidance and support (via the Strategy/SMO function) to ensure consistent interpretation of strategic priorities across teams (e.g. through Comms, Tools for Teams, learning and development programmes).	March 2027 April 2027 April 2027 April 2027	Y
2. Programme interdependencies not yet routinely identified or managed. Limited use of regional/system forums for joint prioritisation with partners on strategic priorities.	Introduce formal interdependency mapping and quarterly portfolio review. Extend portfolio oversight to include place-based and regional partner dependencies.	October 2026	Y
3. Portfolio prioritisation and benefits realisation not yet consistently embedded.	Standardise portfolio prioritisation and implement a single Trust-wide benefits realisation framework. Need to ensure that available resource is sufficient to meet ambition and will deliver against key operational objectives.	October 2026	Y
4. Variable partner engagement; system-wide interdependencies not consistently managed. Governance not yet fully aligned to revised ICS accountability expectations.	Strengthen partnership escalation and delegation arrangements with the ICB.	April 2027	Y
5. Insufficient digital and change capacity to limit pace and scale of digital adoption and benefits realisation.	Ensure digital requirements are resourced / funded within business cases.	October 2026	Y

BAF 008 - Transformation

Gaps in controls and assurances

Gaps in controls and assurances	Actions to address gaps	Due date	On track (Y/N)
6. New model of care not yet delivering impact at scale; dependent on partner actions. Limited assurance of outcomes at system level.	Strengthen governance of new models of care, including system dependencies and risks.	March 2027	Y
7. Long-term capital funding remain uncertain; Interdependencies variably assessed in investment planning.	Improve system visibility and alignment of major and nationally funded schemes. Apply capital efficiency principles to approvals and planning cycles. Submit FBCs for CCH and CCRH with agreed capital funding plan.	Ongoing October/December 2026	Y
8. Limited internal capacity to deliver large-scale transformation, driving reliance on external resource. Workforce planning not fully aligned to transformation priorities.	Undertake a comprehensive transformation workforce capacity and capability assessment across corporate, clinical and digital teams, with use of external support where required. Develop a targeted workforce plan for transformation delivery, including skills development, recruitment, and use of external support where necessary. Large scale change team being recruited in phased way, so interim capacity will continue to be needed to support projects in 2026/27. Introduce regular monitoring of transformation delivery capacity vs demand.	March 2029 December 2026 February 2027	Y

NHS Cambridge University Hospitals NHS Foundation Trust

BAF 009 – Embedding research

Failure to rapidly embed research opportunities in care pathways, widen patient participation in research including late-stage clinical trials and support more colleagues to transition research into clinical practice.

Strategy objective 3: Harness research and innovation to improve patient outcomes. Focus area: Increasing participation for patients and colleagues; impact-led research.

Accountability and review history

Strategic risk owner	Sue Broster
Oversight forum	Transformation Committee
Last risk review date	June 2026
Last deep dive	N/A
Next deep dive	TBC

Related Corporate Risk Register entries

ID	Description	Score
N/A	N/A	N/A

Risk analysis

	Initial	Last quarter	Current quarter	April 27 trajectory	April 28 trajectory	Target
Risk score: impact	5	N/A	5	4	4	4
Risk score: likelihood	4	N/A	4	4	2	2
Risk score	20	N/A	20	16	8	8
Assurance rating	Adequate	N/A	Adequate	Adequate	Adequate	Adequate
Risk appetite	N/A	N/A	N/A	N/A	N/A	N/A
In/out of appetite	N/A	N/A	N/A	N/A	N/A	N/A

Board of Directors (held in Public) 9 September 2026
Board Assurance Framework)

BAF 009 – Embedding research

Causes

- Insufficient workforce capacity and capability to support growth in research activity Inconsistent integration of research within clinical pathways and divisional priorities.
- Constraints in research infrastructure, digital capability and supporting services.
- Increasing competition for national research funding and designation.

Consequences

- Failure to deliver Trust Strategic Objective 3 and associated research and innovation ambitions.
- Reduced patient access to innovative treatments, diagnostics and clinical trials.
- Loss of major research funding and associated infrastructure investment (failure to secure NIHR BRC re-designation, with associated loss of funding (contract worth ~£86m with CUH overheads ~19%, status and influence).
- Diminished reputation, influence and attractiveness as a partner for academia, industry and research funders.

Risk owner commentary

Research and innovation are fundamental to delivery of the Trust strategy and to improving patient outcomes through earlier access to innovative treatments, diagnostics and models of care.

There is a risk that CUH is unable to sustain and strengthen its position as a leading research-intensive organisation because of increasing competition for funding, workforce and infrastructure constraints, and challenges in embedding research consistently across clinical services.

Failure to address these challenges could reduce patient participation in research, limit translation of innovation into clinical practice, weaken strategic partnerships, and adversely affect the Trust's ability to secure major external research funding. In particular, renewal of the NIHR Biomedical Research Centre designation in 2028 represents a significant strategic dependency for the organisation.

Work is underway through the Research Board and CUH's Research Review Steering Group to strengthen research infrastructure and delivery, including addressing delays in trial set-up and delivery, and increasing staff engagement and research participation, whilst ensuring robust governance and regulatory compliance. Increasing awareness and participation in research is led by our Patient and Public Involvement team (https://www.cuh.nhs.uk/our-research/get-involved/take-part-research/) and the associated Comms team. A research studies portal, with the opportunity to provide participation preferences, is now embedded in MyChart. Nationally CUH leads programmes to increase research inclusion, engaging with children and ethnic minorities.

BAF 009 – Embedding research

Table of controls and assurances

	Assurances [Where can we gain evidence that controls are working]		
Key controls/mitigations [System in place to manage the risk]	**First level** [Service delivery and day-to-day management - how do we know day to day that controls are working?]	**Second level** [Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]	**Third level** [Independent challenge – has anyone external come in to check that the controls are working]
Research performance, in particular regarding commercial and non-commercial trial set-up and recruitment times, performance monitored against national NIHR standards	Metrics collated by Research Office and reported to Transformation Committee as a standing item	Reported to Trust Board and external funding agencies	National metrics on performance in clinical trials available through web-based interface
Reporting for research programmes / infrastructure	Ongoing review of programmes (e.g. Biomedical Research Centre, Clinical Research Facility, NIHR BioResource) Research governance being considered as part of target operating model redesign	Annual reporting on performance against KPIs to NIHR	Feedback on reports by NIHR
Research Governance monitored through Research Office and committee structures – Research Board, Human Tissue Management Committee	Oversight through Research Office; monitoring and audit of clinical trials through Clinical Trials Unit; reporting breaches to regulatory authorities	Oversight through Research Board – updates on CTU, BRC, BioResource, CRF, pharmacy standing items	Periodic external audits by MHRA – typically every 3 – 5 years
Research Finance monitored through external reporting and audits	Oversight through R&D finance	Finance is standing item on Research Board agenda	External audit part of overall reviews by NIHR
Assurance rating: Adequate			

BAF 009 – Embedding research

Gaps in controls and assurances

Gaps in controls and assurances	Actions to address gaps	Due date	On track (Y/N)
Limited assurance that research performance data reported externally is consistently validated and sufficiently robust to support strategic decision-making.	Strengthen research analytics capability and implement routine validation of local and national performance data, with regular reporting through governance structures and Transformation Committee.	Q2 2026	Y
Limited assurance that research is consistently prioritised and embedded within clinical services and divisional operating models.	Strengthen divisional accountability for research delivery and review leadership arrangements to ensure research is embedded within the Target Operating Model. Conversations underway between research groups (consultants, NMAPs, Healthcare Scientists, R&D) and Trust programme director.	April 2027	Y
Insufficient assurance that workforce capacity and capability are adequate to deliver the Trust's research ambitions and support growth in research activity.	Align research activity with divisional and job planning processes. Embed research in new Divisional structure through new divisional structure	Ongoing	N
Limited assurance that contracting, regulatory and governance capacity remains sufficient to support current and future research activity.	Research office review to be conducted by external reviewer. Output to clarify resourcing and skills requirements. Finance review underway to clarify and streamline research contracting and invoicing process	April 2027	N

NHS Cambridge University Hospitals NHS Foundation Trust

BAF 010 – Financial sustainability

Failure to deliver the scale of financial improvement required to achieve a breakeven or better financial performance within the funding allocation that has been set for the next three years.

Strategy objective 1: Deliver excellent and timely care. Focus area: Access and productivity.

Accountability and review history

Strategic risk owner	Mike Keech
Oversight forum	Performance and Finance Committee
Last risk review date	April 2026
Last deep dive	N/A
Next deep dive	TBC

Related Corporate Risk Register entries

ID	Description	Score
N/A	N/A	N/A

Risk analysis

	Initial	Last quarter	Current quarter	April 27 trajectory	April 28 trajectory	Target
Risk score: impact	5	N/A	5	4	4	4
Risk score: likelihood	4	N/A	4	4	3	3
Risk score	20	N/A	20	16	12	12
Assurance rating	**Substantial**	N/A	**Substantial**	**Substantial**	**Substantial**	**Substantial**
Risk appetite	N/A	N/A	N/A	N/A	N/A	N/A
In/out of appetite	N/A	N/A	N/A	N/A	N/A	N/A

BAF 010 – Financial sustainability

Causes

- Rising supplier costs, inflationary pressures including workforce
- Demand pressures and associated impact on commissioner affordability
- Changes to the NHS financial framework and NHS Payment Scheme, requiring the delivering of increasing levels of productivity improvement.
- Lack of timely, accurate data to identify cost-saving and transformation opportunities
- Limited budget flex to respond to unexpected pressures
- Insufficient delivery of productivity opportunities

Consequences

- Regulatory intervention
- Reduced ability for the Trust to invest in its strategic priorities
- Deterioration in timely and high-quality services for patients

Risk owner commentary

Financial sustainability is essential to CUH's ability to deliver safe, timely and high-quality care, invest in strategic priorities and meet national financial and regulatory expectations. The financial improvement requirement for 2026/27 and subsequent years is significant, reflecting cost pressures, demand growth, limited headroom and increased efficiency requirements under the NHS financial framework. While the Board has approved a breakeven plan for 2026/27, years two and three of the medium-term plan currently show deficits, requiring further recurrent productivity, efficiency and transformation schemes to secure long-term sustainability.

BAF 010 – Financial sustainability

Table of controls and assurances

	Assurances [Where can we gain evidence that controls are working]		
Key controls/mitigations [System in place to manage the risk]	**First level** [Service delivery and day-to-day management - how do we know day to day that controls are working?]	**Second level** [Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]	**Third level** [Independent challenge – has anyone external come in to check that the controls are working]
Governance and control on expenditure decisions through a clear process/framework		Investment Committee, Management Executive	Internal Audit
Regular review of financial performance through monthly internal and external reporting cycles, including assessment of the underlying financial position and use of forecasting tools to identify risk and mitigations	Divisional Quality and Performance meetings	Management Executive Performance and Finance Committee Board of Directors	
System of financial controls – vacancy control procedures, segregation of duties, procurement/contract management process		Audit Committee	Internal Audit
Divisional and corporate budget holders accountable for delivery of agreed budgets, productivity plans and cost-reduction requirements through divisional accountability arrangements	Divisional Quality and Performance meetings Budget holder and new manager training compliance rates	Performance and Finance Committee	Internal Audit

BAF 010 – Financial sustainability

Table of controls and assurances

	Assurances [Where can we gain evidence that controls are working]		
Key controls/mitigations [System in place to manage the risk]	**First level** [Service delivery and day-to-day management - how do we know day to day that controls are working?]	**Second level** [Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]	**Third level** [Independent challenge – has anyone external come in to check that the controls are working]
Oversight of divisional, corporate and cross-cutting productivity schemes, including major change and digitally enabled transformation schemes	Divisional Quality and Performance meetings, Productivity Board, Outpatients Redesign Board	Management Executive	
Quality Impact Assessment framework ensures impact of productivity schemes is part of the approval process	Quality Impact Assessment panel	Integrated Performance Report, Quality Committee, Board of Directors	
Assurance rating: Substantial			

BAF 010 – Financial sustainability

Gaps in controls and assurances

Gaps in controls and assurances	Actions to address gaps	Due date	On track (Y/N)
Medium-term financial sustainability plan not yet fully developed for years 2 and 3	Develop a medium-term financial recovery bridge for 2027/28 and 2028/29, linked to recurrent productivity improvement, transformation (incl. digital adoption), workforce control, and service redesign (including neighbourhood health)	Q3 2026/27	Y
Reliance on non-recurrent financial support in 2026/27 does not secure a sustainable exit financial rate into 2027/28	Identify recurrent mitigations to replace non-recurrent support and incorporate into 2027/28 planning assumptions	Q3 2026/27	Y
Capital funding constraints may limit the trust's ability to invest in schemes that support productivity improvement of transformation change	Develop and maintain a prioritised capital-enabled transformation pipeline aligned to the CUH strategy, BAF risks and productivity / transformation opportunities	Q2 2026/27 and ongoing	Y
Contact misalignment with main commissioners leading to funding uncertainty	Contract alignment exercise, with oversight from NHS England regional and national teams	Q1 2026/27	Y

NHS Cambridge University Hospitals NHS Foundation Trust

BAF 011 – Population growth

Failure to anticipate and adapt clinical and estates model to respond to the scale of population growth predicted in the Greater Cambridge growth plan and across the wider East of England.

Strategic objective 1: Deliver excellent and timely care. Focus area: Access and productivity.

Strategic objective 2: Transform how and where we deliver care. Focus areas: Neighbourhood health.

Accountability and review history

Strategic risk owner	Claire Stoneham
Oversight forum	Transformation Committee
Last risk review date	June 2026
Last deep dive	N/A
Next deep dive	TBC

Related Corporate Risk Register entries

ID	Description	Score

Risk analysis

	Initial	Last quarter	Current quarter	April 27 trajectory	April 28 trajectory	Target
Risk score: impact	5	N/A	5	5	5	3
Risk score: likelihood	4	N/A	4	4	3	3
Risk score	20	N/A	20	20	15	6
Assurance rating	**Limited**	N/A	**Limited**	**Limited**	**Adequate**	**Substantial**
Risk appetite	N/A	N/A	N/A	N/A	N/A	N/A
In/out of appetite	N/A	N/A	N/A	N/A	N/A	N/A

BAF 011 – Population growth

Causes

- Inaccurate demographic and demand forecasting and poor access to data
- Failure to understand and influence the implications of the Greater Cambridge Growth Plan, and plans for regional growth in the East of England
- Failure to transform the model of care with system partners so that demand for emergency and planned care grows at an unsustainable and unmanageable rate.

Consequences

- Inability to meet the needs of a larger population
- Deterioration in patient outcomes and experience
- Increased regulatory intervention
- Reputational damage
- Impact on the aims of the Greater Cambridge Growth Plan
- Inadequate articulation of the case for a new acute hospital, further impacting our ability to sustainably operate.

Risk owner commentary

It is the government's stated position that the population of Cambridge should double by 2050 and it is taking action to make this possible, for example through the creation of the Cambridge Growth Company which has recently progressed to incorporation as the Greater Cambridge Development Corporation. In this context, there is significant risk to sustainable healthcare services: if new models of care are not implemented, alongside fit-for-purpose clinical facilities, the consequence is the inability to sustainably provide patients with access to excellent timely care.

Population growth across the East of England and in Greater Cambridge in recent years has already been above national averages, and sustained growth is increasingly certain. This risk seeks to address the impact on healthcare services if we fail to anticipate and implement changes in the model of care in advance of population growth.

NHS Cambridge University Hospitals NHS Foundation Trust

BAF 011 – Population growth

Table of controls and assurances

Key controls/mitigations [System in place to manage the risk]	Assurances [Where can we gain evidence that controls are working] First level [Service delivery and day-to-day management - how do we know day to day that controls are working?]	Second level [Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]	Third level [Independent challenge – has anyone external come in to check that the controls are working]
Understand population growth projections for Greater Cambridge and wider East of England	Demand assumptions aligned to population growth scenarios in the Trust's Long Term Financial Model	Integration of acute, community, mental health and primary care demand forecasts	
Implementation of Neighbourhood Hubs though to developing and rollout out new models	Delivery against implementation plans; activity levels and service utilisation data	Place Board and CUH committees reviewing effectiveness in reducing acute demand	Independent evaluation of impact on population health and demand (audit review)
Developing and embedding integrated neighbourhood teams to provide proactive, joined-up care for people with higher care needs	Neighbourhood team coverage, caseload profiles and activity data demonstrating proactive management of high-need cohorts; evidence of reduced escalation to acute services.	Place Board reviewing neighbourhood team performance, outcomes and impact on admissions and attendances.	Independent evaluation of neighbourhood models and outcomes, including benchmarking against national best practice and peer systems.
Working with partners and the ICB to implement an integrated model of urgent and emergency care which reduces demand on the acute site	Delivery against agreed urgent and emergency care pathways and demand management schemes; activity shifts from ED and acute admissions evidenced through system data.	Place Board and CUH urgent care governance reviewing impact on ED demand, flow and admissions.	Independent review of urgent and emergency care model effectiveness, including external assurance on demand reduction and patient outcomes.
Developing and rolling out new integrated models of planned care which reduce outpatient demand and prevent ill health progression	Implementation of redesigned planned care pathways managed through Outpatient Redesign Board; evidence of reduced outpatient attendance and improved outcomes through activity and pathway data.	Place Board and Transformation Committee monitoring planned care transformation metrics and alignment with productivity and demand assumptions.	External evaluation of planned care models, including assurance on sustainability of demand reduction and clinical outcomes.
Progression of design of new acute hospital	Estates strategy Programme milestones, business case development, design approvals, risk logs	Transformation Committee and Trust Board oversight of progress, risks, and affordability	External business case assurance

NHS Cambridge University Hospitals NHS Foundation Trust

BAF 011 – Population growth

Table of controls and assurances

	Assurances [Where can we gain evidence that controls are working]		
Key controls/mitigations [System in place to manage the risk]	**First level** [Service delivery and day-to-day management - how do we know day to day that controls are working?]	**Second level** [Oversight – who or where do management or the Trust overall get oversight that the things we are doing to manage the risk are working]	**Third level** [Independent challenge – has anyone external come in to check that the controls are working]
Integration of acute, community, mental health and primary care demand forecasts	Update of integrated demand model; reconciliation across organisations	Review through Performance Committee, challenge on assumptions and gaps	Independent validation of modelling methodology and outputs
Demand assumptions aligned to population growth scenarios in the Trust's Long Term Financial Model	Model updates reflect latest population data; scenario testing	Performance Committee scrutinising assumptions and sensitivities	External audit review of financial model assumptions and robustness
Implementation of Estates Strategy	Delivery against estates milestones; utilisation metrics; backlog maintenance tracking	Estates / capital committees reviewing progress and alignment to demand	Independent estates audits; regulatory inspections
Participation in the Cambridge Biomedical Campus Directors' Forum	Attendance records; internal briefings and action logs demonstrating engagement and influence	Reports to Trust Board / strategy committees on outcomes and system alignment	Independent review of partnership effectiveness or system working (e.g. internal audit / peer review)
Participation in Cambridge Ahead	Evidence of contribution to reports, workshops, and growth discussions; feedback into internal planning	Board-level updates on how insights influence strategy and demand planning	External validation of assumptions used from Cambridge Ahead in planning models
Participation in Cambridge Steering Group as Health Sector Representative	Documented inputs to spatial planning; meeting outputs feeding into Trust plans	ICS / Place-level governance reviewing health input into growth decisions	Independent assessment of system integration and influence on planning decisions
Participation in ICB strategic planning forums, such as the Neighbourhood Delivery Committee	Attendance, contributions to system plans, alignment of Trust plans with ICB outputs	ICB governance and joint committees reviewing partner engagement and delivery	NHS England oversight of ICB effectiveness and partner contributions
Assurance rating: Limited			

BAF 011 – Population growth

Gaps in controls and assurances

Gaps in controls and assurances	Actions to address gaps	Due date	On track (Y/N)
Lack of formalised expectations on infrastructure planning	Develop memorandums of understanding to formalise expectations on infrastructure planning	No agreed route forward yet – need agreement from Cambridge Growth Company that the project can proceed	
Lack of agreed planning assumptions	Agree scenario planning assumptions with ICB/regional partners	No agreed route forward yet	
Lack of a single population health management tool for our local area	Lobbying the ICB to progress a system-wide population health management tool. Move towards AFT and IHO status in order to have a greater ability to influence and take accountability for a system wide approach to population health	New PHM tool expected by September 2026 Spring 2027	
Fragility of regional services may limit ability to work jointly, and service failure may lead to increased demand on CUH	Active influencing and escalation through system governance Development of internal contingency plans to manage residual risk to acute services where system capacity constraints cannot be mitigated directly	December 2026	
Lack of funding to progress acute hospital plans to Outline Business Case (OBC) level	Lobbying nationally and with the Cambridge Growth Company on funding. Identifying alternative funding streams to support delivery. Preparatory work to be able to commence procurement as soon as possible once funding is secured	Ongoing December 2026 October 2026	

Board of Directors (held in Public)

9 September 2026

Agenda item	9			
Title	Chief Executive Officer and Executive Team update			
Report Sponsor	Nicola Ayton, Chief Executive			
Authors	Executive Team Director of Governance and Performance			
Public/private	Public			
Status	**Decision** ☐	**Assurance** ☒	**Information** ☒	**Discussion** ☐

RECOMMENDATIONS

The Board of Directors is asked to:

- **NOTE** the updates provided within the report including performance, risk management and compliance with national requirements.

KEY MESSAGES

- The Trust remains focused on delivering excellent and timely care, progressing the Cancer and Children's Hospital business cases, strengthening research infrastructure and maintaining financial balance. Strong progress has been made in quality and clinical governance, service improvement and elective activity, with the financial position remaining within plan.
- Urgent and emergency care waiting times remain too long and below the standards expected at CUH. Recovery remains a key priority, supported by a strengthened winter plan intended to improve resilience during the most pressured period for non-elective care.
- Consultation has begun on the new target operating model, which proposes greater accountability and decision making within three clinical care groups. Recruitment to the three Managing Director posts is under way, with further appointments planned later in the autumn, subject to the consultation outcome.
- The annual Provider Capability Assessment is under way, with the Trust's self-assessment due on 2 October. Other significant priorities include delivery of the national Maternity and Neonatal Ten Point Plan, completion and publication of the Andrew Kennedy KC clinical review, and continued delivery of the Verita action plan into 2027.

BACKGROUND, INCLUDING PURPOSE OF THE REPORT

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

ALIGNMENT TO TRUST STRATEGIC PRIORITIES

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

ALIGNMENT TO MOST RELEVANT STRATEGIC RISK

N/A

PAPER REVIEW AND GOVERNANCE PATHWAY

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

Cambridge University Hospitals NHS Foundation Trust

9 September 2026

Board of Directors (held in Public)

Chief Executive and Executive Team Update Report

1. Introduction and summary

1.1 Our focus for this year remains the delivery of excellent, timely care; progressing the Cancer and Children's Hospital business cases to Full Business Case stage and strengthening our research infrastructure whilst maintaining financial balance.

1.2 As we approach the half way point of the current financial year, we have made strong progress in a number of areas including strengthening our quality and clinical governance, key service improvements for patients and increasing our overall levels of elective activity. The financial position remains tight but we are delivering within our agreed plan.

1.3 We continue to focus on improving waiting times for patients across our Urgent and Emergency Care pathways which are too long and fall below the standards we set at CUH. Our newly appointed Chief Delivery Officer has developed a strong winter plan which will create greater resilience as we head into our most pressured period of time for non-elective care.

1.4 This month we formally launched the proposals to move from our existing structure to a new target operating model that will enable the shift of resources, accountability and decision making power to three clinical care groups. This will drive better decision making, create greater leadership capacity and enable better care for patients as well as value for the taxpayer. The proposals have been shaped by colleagues across the Trust and their feedback and insights have been invaluable. We are also proactively learning from other large teaching hospitals that have made similar structural and leadership changes. Recruitment to the three Managing Director posts has begun and further appointment processes will follow later in the Autumn subject to the consultation outcome.

1.5 The annual Provider Capability Assessment exercise, which will inform NHS England's regulatory approach to the trust for the next 12 months, has commenced – the trust is required to submit a self-assessment by 2 October.

1.6 Our Chief Nurse and Chief Medical Officer are working with colleagues to deliver the national Maternity and Neonatal Ten Point Plan. A major focus for us is ensuring sufficient obstetric theatre capacity alongside a number of other improvements.

1.7 Finally, the Andrew Kennedy KC clinical review of paediatric orthopaedic cases from 2012 to 2024 is nearing completion and will be published this year. We are working closely with affected patients and families, including through our Patient Advisory Board to support them over this period including around the publication itself. We have made strong progress in in delivering the Verita action plan changes that we committed to last year and we believe that

our hospitals are safer and more effective as a result. There is more to do and the work will continue as we move into 2027.

2. Safe and effective care

2.1 Patient Experience

2.1.1 Patient experience remains affected by outpatient booking and call handling, and delays in PALS and complaints responses. New NHS England standards reinforce expectations for proactive communication with patients awaiting care. Improvement and recovery programmes are in place, supported by enhanced executive oversight, strengthening communication and responsiveness, reducing delays, and ensuring that patient feedback, concerns raised through PALS and complaints, and wider patient experience insights are translated into organisational learning and measurable service improvement.

2.1.2 The 2025 National Inpatient Survey results, published in August 2026, reported an overall score of 8.1/10, with particular strengths in dignity, kindness and compassion. Opportunities for improvement were identified in discharge processes, meeting patients' individual needs and supporting rest and sleep during hospital stays.

2.2 Regulatory Inspections and Assurance

2.2.1 Two external regulatory inspections took place in July 2026. An unannounced Human Tissue Authority inspection of the mortuary and tissue traceability arrangements found no critical issues; minor and moderate findings concerned the estate and traceability. Immediate actions have been taken and a coordinated approach is in place to address longer-term findings. Inspectors praised staff professionalism and care for deceased patients and their families.

2.2.2 The CQC's Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection identified no regulatory breaches requiring an action plan and commended improvements in Radiotherapy Services since January 2024.

2.2.3 Formal reports from both inspections are awaited; any actions will be monitored through established governance.

2.3 Patient Safety

2.3.1 Incident reporting continues to rise, indicating a positive reporting culture, while moderate-or-higher harm remains low at 1.2% and below threshold. Further improvement is required in sepsis compliance, falls (4.17 per 1,000 bed days; target ≤3.25), pressure ulcers (0.592; target ≤0.395) and healthcare-associated infections, including one hospital-acquired MRSA bacteraemia in July and persistent E. coli infections. Improvement programmes and strengthened oversight are in place.

2.4 Dementia and Delirium Care

2.4.1 A gap analysis found that the Trust cannot fully evidence compliance with national dementia standards. An improvement programme covering governance, specialist support and

oversight is in place, with progress monitored until gaps are addressed and changes embedded.

3. Access and operational performance

3.1 Urgent and Emergency Care (UEC)

3.1.1 In urgent and emergency care, in particular, too many patients are waiting too long and current performance is not acceptable. Providing our patients with safe, effective, timely care is essential. The Trust continues to take this seriously and is focused on the pace of recovery. Improvement plans align with Getting It Right First Time recommendations (GIRFT), high-performing providers and national guidance. Priorities include embedding an Extended Emergency Medicine Ambulatory Care unit following pilots, reconfigured emergency receiving units and workforce changes, overseen through the Flow Improvement Programme.

3.2 Planned care

3.2.1 CUH continues to reduce planned care waits and has moved out of the bottom quartile for waits over one year and into the second-highest quartile for patients treated within 18 weeks. Elective Taskforce meets fortnightly and continues to monitor delivery of the annual plan.

3.2.2 Patients are still waiting too long in Gynaecology, OMFS, ENT and Cardiology. An extended summer sprint has increased weekend and evening activity through waiting list initiatives and outsourcing, supported by specialty-level recovery plans, delivering 2,195 additional treatment stops up to 31st August.

3.2.3 Central Outpatients has entered Intensive Support because of continuing call-handling and clinic-booking concerns. The immediate issue of unacceptably long waits for telephone access has been addressed, with call waiting times now averaging 5 minutes. Additional corporate support and oversight will focus on service improvement, recruitment and a sustainable operating model.

3.3 Cancer care

3.3.1 CUH has remained among the top 25 providers for the 28-day Faster Diagnosis Standard since November 2025. The 62-day standard has improved to above plan. The 31-day treatment standard remains challenging, with recovery expected after the benefits of two new linear accelerators are realised in autumn 2026; the summer sprint has also increased cancer surgery capacity.

3.4 Diagnostics

3.4.1 Six-week Diagnostic waits have reduced month on month from a high of 37.9% in April to 26.26% in July, following MRI, CT, Echo and ultrasound interventions, and the waiting list fell from 20,149 in March to 16,671 in July. Performance is tracking against the recovery trajectory submitted to NHSE on 13 July, recognising the gap to the original plan driven by the increased elective recovery activity in Q4 2025/26 increased demand while capacity

reduced. S The Diagnostic Taskforce is focused on sustaining improvement, expanding capacity and reducing low-value demand through national work.

3.5 Patient discharge

3.5.1 The numbers and length of time of patients waiting for discharge beyond their discharge ready date worsened in July, with 233.2 beds lost to external delays compared with 176 in July 2025. CUH is using winter capacity to maintain safe care (although baseline demand and capacity analysis completed earlier this year indicates the Trust is currently shortly 41 medical beds). Key causes are delays in care assessments, domiciliary care, intermediate care and re-ablement package availability. Executive escalation continues with the ICB and Local Authority. The Home First hub reduced pathway 1 delays from 28.0 patients per day in April to 8.3 in July, while the Flow Improvement Board oversees further work on medical review and complex discharge delays.

4. People

4.1 On the 3 of September the Trust began a 31 day consultation on the new Target Operation Modal and associated structures. There are 61 people affected by the proposed changes. The launch of the consultation was supported constructively by staffside.

4.2 For the 2026/2027 season, front line health care workers, including both clinical and non-clinical staff, should be offered the flu vaccination from 1 October 2026. Under the National Operational Framework (NOF), Trusts are expected to take a proactive approach to staff vaccination and offer the vaccination to 100% of all eligible frontline staff, with the vast majority of vaccinations completed by 30 November. The trust is expected to achieve a take up rate of 60-65% by the end of the campaign. Last year the Trust achieved 66%, achieving second place nationally.

4.3 As committed to in the 10 Year Health Plan for the NHS, NHSE have published a set of staff standards aimed at improving staff experience. These set clear minimum expectations for employers, focusing on line management, health and wellbeing, violence, prevention and reduction, tackling racism, championing sexual safety and promoting flexible working. The trust is undertaking a gap analysis to inform areas of focus. This will inform the new People Strategy. For each standard a set of staff survey questions have bene identified as measures, which will be included with in the People Domain of the NOF going forwards.

5. Finance, productivity and planning

5.1 Finance – Month 4

5.1.1 The Month 04 year to date financial position is £0.4m surplus for performance management purposes, in line with plan. The position includes £4.4m of cost pressures (including Resident Doctors Industrial Action impact of £1.8m in April and £0.5m in June due to late cancellation) and £1.7m lower productivity offset by £2.3m of non-recurrent benefits and support and £3.8m of favourable operational variances.

5.1.2 Points to note in respect of the reported month 4 financial position include:

- The inflationary pay award funding is assumed to cover the cost of the pay awards. Budgets have been adjusted to reflect uplifted income and expenditure assumptions.
- Following arbitration of the 26/27 elective pricing dispute with Central East ICB and Norfolk and Suffolk ICB (as an associate to the contract), NHS England has ruled in favour of the Trust's position. The Trust continues to seek full implementation of the binding arbitration outcome – to date, the outcome has not been appropriately reflected in revised contract offers.

5.1.3 Other notes in respect of month 4 financial performance:

- Position supported by £2.3m of non-budgeted benefits.
- Trust Elective income is behind plan by £0.3m, and additional purchase of healthcare capacity is £1.4m above plan due to lower PEP productivity than planned.
- Whilst on plan at Month 04 the Trust Productivity and Efficiency Programme (PEP) delivery requirements increase significantly in future months. Work continues to ensure all required PEP is identified and plans are in place to deliver it.
- Assurance over PEP development and delivery is improving but this remains a key area of focus - Month 04 gap of £2.0m for cost reduction compared to £2.3m at Month 03. Productivity scheme development and delivery remain a key concern and under review by the Productivity Board.
- Additional reduction in bank and agency expenditure is required to ensure delivery of the Pay PEP target for 26/27. Year to date bank expenditure exceeds the monthly NHS England expenditure limits for 26/27.
- Approval of specific in year Quality and Safety investments may require additional PEP delivery in year to support them.

5.1.4 The Trust has been allocated operational capital funding for the year of £38.0m for its core capital requirements (£7m lower than 2025/26). In addition, we expect to receive further NHS capital funding including Children's Hospital (£11.3m); Cancer Hospital (£18.4m); Estates Safety Fund (£7.3m); and Return to Constitutional Standards (£3.1m). Together with capital contributions from ACT, technical adjustments in respect of PFI, and other miscellaneous DHSC awards, the Trust's capital budget for the year now totals £87.4m.

5.1.5 Capital expenditure YTD at Month 2 was £17.7m compared to plan of £23.7m however, these delays in spend are not currently expected to impact on the forecast, which remains to invest the capital plan in full by end of year.

5.1.6 The Trust's cash position was £40.8m compared to plan of £52.7m, but the 13-week cash flow forecast does not identify any need for additional revenue cash support in the foreseeable future. The main reason for cash being behind plan is delays in commissioner payments under Payment by Results (PbR), including cash funding of the 2026/27 pay awards (expected to be resolved by October) and cash payments for elective service performance in 2025/26 which are being escalated with the relevant commissioners.

6. Strategy and transformation

6.1 Strategy

6.1.1 The strategy team continues to embed the new strategy across the organisation. Trust-

wide communications include CEO briefings, staff videos and a Line Managers Engagement Pack to help teams translate the strategy into local priorities. Weekly bulletin content and further themed materials are planned.

6.1.2 The EDI strategy was approved at the July Board of Directors meeting with minor edits being finalised in August, with focus on our population and our people, and will be published shortly.

6.2 Neighbourhood Health

6.2.1 Progress continues across Neighbourhood Health's strategic priorities:

- *Transforming access to routine healthcare* – Partners are aligning the Greater Cambridge Local Plan and proposed Neighbourhood Health Centres with local ambitions, while CUH and primary care test integrated outpatient models closer to home.

- *Embedding proactive neighbourhood teams* – CUH, South Place and the ICB are developing a new frailty care model informed by test-and-learn pilots; a draft commissioning specification is expected in September.

- *Transforming access to urgent care* – System partners are working to improve timely discharge. CUH geriatricians' EnRICH service has gained national recognition for connecting hospital, community and care-home teams to support residents and reduce hospital stays.

6.3 Cambridge Cancer Research Hospital (CCRH)

6.3.1 CCRH remains on track for Board approval of the Full Business Case by December 2026 and a Building Safety Act Gateway 2 application by March 2027. Subject to regulatory approval, construction is planned from September 2027 to the end of 2030.

6.3.2 Work on the transformation of services continues, focusing on creating an environment and culture where world-leading clinicians, scientists, industry innovators and patients from across the region will work side by side, bringing clinical care and discovery science much closer together.

6.3.3 In June a £10 million donation was announced to establish and name the Charlotte Lockhart Precision Breast Cancer Institute, to form part of CCRH. The recently released Power of Proximity promotional film narrated by Davina McCall secured local and national media coverage and has received positive stakeholder feedback and strong public engagement.

6.4 Cambridge Children's Hospital (CCH)

6.4.1 CUH, the University of Cambridge and Cambridgeshire and Peterborough NHS Foundation Trust are finalising the CCH design, programme, price and funding arrangements ahead of Building Safety Act (BSA) submission in January 2027 and Full Business Case submission shortly thereafter. The most significant risk to these timelines is securing the full capital funding required.

6.4.2 Following approval by regulators construction is due to begin in July 2027, with the building operational in the Summer of 2031.

6.4.3 The University of Cambridge has received $6.5 million from philanthropist K. Lisa Yang to enable the creation of The K. Lisa Yang Autism Clinical Research Centre, within the CCH. As a key part of our research vision, the centre will serve not only autistic people and their families but also the clinicians, researchers, data scientists, and policy experts working in this important area.

6.5 Transformation

6.5.1 Five priority transformation programmes are progressing in 2026/27:

- Digitally Enabled Flow: 13 front-door, admission and discharge pilots have operated since June; evaluation will shape the next wave.

- Ambient Voice Technology: 90 clinicians are piloting AVT; wider implementation begins in October, focused initially on outpatient access and productivity.

- Booking Optimisation: templates are live in 72 specialties; 50.82% of clinics offer self-scheduling and earlier appointment offers. 43,519 patients have self-scheduled with a 2.4% DNA rate, and 8,186 earlier offers were accepted. Remaining specialties go live on 21 September.

- Outpatient Follow-up Pathway Redesign: Delivery has started in Get It Right First Time (GIRFT) Further Faster specialties, with digitally enabled pathway pilots beginning in September;

- Excellence in Care and Planning: The Trust has launched its new Planning and Care Tool to better align consultant capacity with demand and planned activity in accordance with the NHS England mandate.

6.5.2 Transformation capability: Targeted investment has been agreed which will strengthen the capability and capacity needed to deliver the Trust's strategic priorities and medium-term plan.

6.5.3 Work is assessing whether planned transformation is sufficient to meet future demand and medium-term improvement requirements, identifying where plans are adequate and where further service redesign, productivity action or ambition is needed.

6.6 Genomics

6.6.1 CUH continues to provide genomics services under an interim contract extension while the NHS England Genomics Unit contract is finalised. The contract is agreed in principle and, despite a stronger efficiency focus, will secure long-term income and support growth of the Genomic Medicine Service (GMS).

6.6.2 This growth strategy remains closely aligned with the CUH strategy with three key objectives being:

- *Service improvement* – The GMS is strengthening its management capacity and capability with new laboratory leadership and by improving change adoption through the establishment of a dedicated Service Development function to drive more rapid uptake of new technology.

- *Research* – Working closely with CUH R&D and the Biomedical Research Council (BRC), the GMS is clearly defining its role in effectively supporting research across the Trust, Biomedical Campus and wider Eastern region.

- *Population health* - In line with both Trust strategy and NHS England objectives, the GMS has established a dedicated Population Health function that is setting out an innovative approach to using genomics capability to improve health outcomes within a primary care setting. This involves working with partners in primary care, research and industry.

6.7 Research

6.7.1 The NIHR Biomedical Research Centre bid is being finalised for the September outline deadline. The Scientific Advisory Board provided independent challenge in July. The Human Research Tissue Bank investment case has received approval to tender, while work continues on the research Target Operating Model and job planning for consultants, healthcare scientists and NMAHPs.

6.7.2 CUH is part of a new £20 million Medical Research Council-funded research hub on the Cambridge Biomedical Campus, bringing together NHS, academic and industry partners to accelerate the development of new medicines using advanced human tissue models and AI, helping translate research discoveries into patient benefit.

6.7.3 On the 26 August, NHSE published a framework for NHS Boards on monitoring research activity. The requirements are being considered through the Transformation Committee and research activity will be brought to the board on a six-monthly basis. Delivery to improve the percentage of clinical trials set up within 90 days is reported through our Integrated Performance Report. There remains a performance risk, with the Trust below the national average at 35.6% in July however there have been significant improvements in the last year.

7. Digital

7.1 The first phase of Epic's integrated patient communication platform, Hello World, has now gone live and on 16 September will add wait list validation functionality along with video appointment links and early appointment offers. The pilot will test improved patient communication and reduced appointment-administration workload before a decision on wider use.

7.2 Epic Care Link continues to expand shared care across organisations. Access has been configured for the CUH–Royal Papworth joint oncology service, supporting the ambition for an integrated electronic patient record across the Biomedical Campus.

8. NHS England regulation

8.1 Following NHS England's June concern that CUH was materially off plan in Months 1 and 2 on three access metrics and on financial performance, the Trust responded on 13 July. NHS England accepted the improvement assurances and took no further formal action.

8.2 The annual Provider Capability Assessment has begun following guidance issued in August. CUH was rated Amber-Green last year; the 2026 return is due on 2 October.

9. NHS Oversight Framework

9.1 The Q4 NOF position (published in June) shows the Trust sustained a segment 2 position with a rank of 28. The access to services, and effective and experience domains continued to be the most challenged for the Trust with both in segment 3. All other domains are performing above expected.

10. Recommendation

10.1 The Board of Directors is asked to note the updates provided including performance, risk management and compliance with national requirements.

Report to Board of Directors (in public)

held on

09 September 2026

Agenda item	09			
Title	CUH Integrated Performance Report (IPR)			
Report sponsor	Beth Hughes – Chief Governance and Performance Officer			
Author	Jo Lee – Director of Analytics and Insights			
Status	**Decision** ☐	**Assurance** ☑	**Information** ☑	**Discussion** ☐

RECOMMENDATIONS

Board of Directors is asked to:

- **Receive** the July 2026 Integrated Performance Report

KEY MESSAGES

The appended Integrated Performance Report (IPR) provides the Trust's performance position for July 2026.

BACKGROUND, INCLUDING PURPOSE OF THE REPORT

The CUH Integrated Performance Report (IPR) provides oversight of the Trust's performance and assurance against performance risk for the Board. This is against the key performance metrics to which the Trust is held accountable through the NHS Oversight Framework and other regulatory frameworks.

ALIGNMENT TO TRUST STRATEGIC PRIORITIES

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

ALIGNMENT TO MOST RELEVANT STRATEGIC RISK

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

PAPER REVIEW AND GOVERNANCE PATHWAY

Name of group or committee that has previously considered this report	**Date**
Quality Committee	02/09/2026
Performance Committee	02/09/2026
Name of group or committee that the report will be presented to in the future	
Not applicable	

CUH Integrated Performance Report

July 2026

NHS
CUH

Together
Safe
Kind
Excellent

Contents

CUH at a glance

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

Workforce – as of 31st Mar 26	
Number of staff members	13,413
Number of staff from a minority ethnic group	5,306
Number of staff who are female	9,733

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

Estate	
Number of beds	1,098
Number of theatres	39

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

Performance Summary

In July 2026, access to services performance has the largest proportion of metrics with performance risk. In total, 16 out of 51 metrics are showing the highest escalation risk. Note there are 5 additional metrics aligning to the NOF 26/27, with a further 5 metrics expected to be included once definitions are established.

Domain	NOF score Q4 2025/26	Tracking against target or plan (in month)	Monthly performance position			Metric without statistical process control
			Deteriorating	Sustained	Improving	
Access to services	3 rank 100	6 on track:		3	3	
		5 off track:	1	3	1	
Effectiveness & experience	3 rank 96	5 on track:		2		3
		1 off track:	1			
Patient safety	2 rank 36	6 on track:	1	2		3
		8 off track:		4		4
Finance, productivity & innovation	1 rank 6	9 on track:				9
		1 off track:				1
People & workforce	1 rank 17	9 on track:		3	1	5
		1 off track:				1

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

Executive summary

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

The Trust is currently in segment 2 of the NHS Oversight Framework (rank 28, latest position Q4 25/26), unchanged from last month. This is a sustained position from the Q3 segmentation.

Access to services

- Small improvements seen in all metrics - 4 hour, 12 hour and ambulance handover delays - but still significantly behind plan. More detail on slides 7 and 8.
- Improvements in 18 week performance and 6 week diagnostic target but behind plan. Cancer Faster Diagnosis, 31 day performance and 62 day are above plan. More detail on slides 9 to 11.

Effectiveness and experience

- Flow performance remains under pressure due to persistent external discharge delays and growth in the numbers of long-waiting patients, although strong complex discharge activity and continued optimisation of discharge processes have helped mitigate a further deterioration in performance. More detail on slide 13.
- SHMI remains within expected levels in July. We continue to monitor closely.

Patient safety

- In July, the trust has a Hospital acquired MRSA Bacteraemia. July 2026 rates of *C. Difficile* and *E. Coli* cases for healthcare-associated infection metrics are off track against plan. More detail on slide 15.
- There is sustained quality risk for Hospital Acquired Pressure Ulcers. We are meeting our LQR for Falls per 1,000 bed days, we are not meeting our LQR for Lying and Standing Blood Pressure measurements. In July, VTE assessment compliance showed deteriorated position. More detail on slides 16 to18.
- There is a sustained trend of delays in Caesarean Sections and Induction of Labour which are a performance risk and off track against target. More detail on slide 17.

Finance and productivity

- The Month 04 position is £0.4m surplus which is in line with plan. More detail on slide 18.
- CUH is behind the national figure for 90 Day study set-up compliance, however the gap has narrowed over the last year at 36% versus national position of 48%.

People and workforce

- At month 4 the total workforce is within plan although the mix of substantive and bank is not as planned. This brings a risk for the pay bill where there is a higher unit cost for some temporary staff costs. Performance across People metrics is generally positive, although the sickness absence rate averaged over 12 months is higher than planned. More detail on slide 20.

Link to return to the performance summary

Trust level - to end Jul 2026		Access to services		
Metric	Target	In month actual	SPC variation	24 month trend
Electives				Jul 2026
RTT - Total waiting list size	57,952	60,206		
RTT - Percentage of patients waiting less than 18 weeks	68.66%	65.29%		
Patients waiting <=18 weeks for treatment		39,309		
RTT - Percentage of patients waiting 18 weeks or less for first appointment	68.82%	73.05%		
Patients waiting <=18 weeks for first appointment		22,765		
RTT - Percentage of patients waiting over 52 weeks	0.35%	1.39%		
Patients waiting over 52 weeks		838		
Urgent and Emergency Care				Jul 2026
Percentage of emergency department attendances admitted, transferred or discharged within 4 hours	76.44%	68.43%		
Percentage of emergency department attendances spending over 12 hours in the department	5.32%	10.00%		
Ambulance handover <45mins	100.00%	91.65%		
Diagnostics				Jul 2026
Percentage of people waiting over 6 weeks for a diagnostic procedure or test	24.00%	26.57%		
Patients waiting >6 weeks		4,430		
Cancer				Jun 2026
Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks (FDS)	80.4%	83.75%		
Percentage of patients treated for cancer within 31 days of referral	83.4%	84.76%		
Percentage of patients treated for cancer within 62 days of referral	67.4%	71.64%		

Performance narrative

- Electives 18 week performance has seen a 0.3ppt in month improvement (65.3%), 0.9ppt behind plan despite activity remaining broadly on plan. The RTT Total Waiting list is 60,206 an increase from 59,372 in June and is behind recovery plan by 129 patients with a widening gap.
- The number of patients waiting over 52 weeks has decreased to 838 but remains significantly behind the plan position of 201 and remains 1.4% of the waiting list. There are 52 patients waiting 65 weeks.
- UEC 4-hour performance in July 2026 was 68.43% which was a slight improvement on June position but significantly behind plan which is 8.0ppt below plan.
- Diagnostics 6 week performance improved from 27.5% to 26.6% but is behind the plan of 24.0%, with improvement for a fourth month.
- The Cancer Faster Diagnostic standard (83.8%) is above the national target of 80% and above plan, 62 day has improved to 71.6% and is above the plan (67.4%) and 31 day is at 84.8% and above plan.

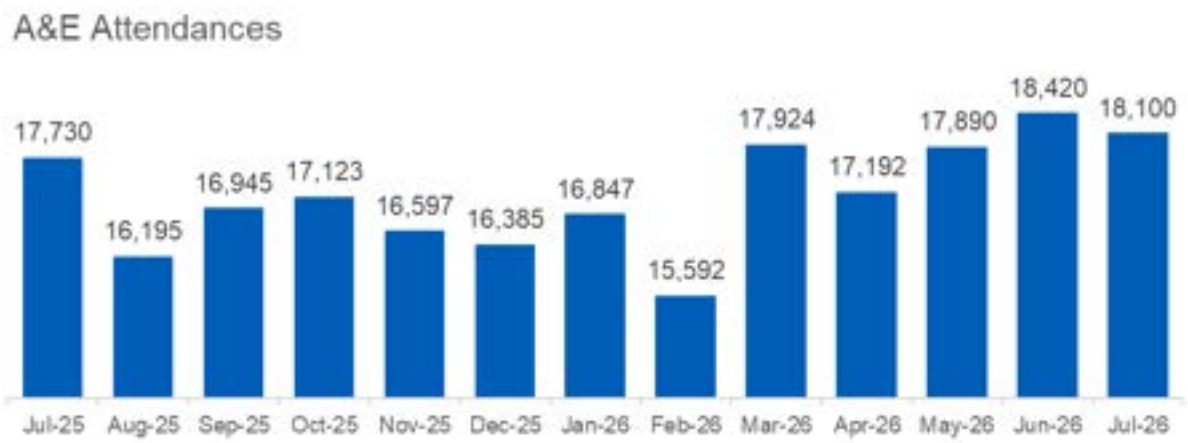
Key risks

- Electives - long wait risks remain in Gynaecology, Paediatric Pain Management, ENT, Cardiology and OMFS with recovery actions underway, and despite activity levels broadly on plan, the there is risk.
- Emergency Department - a growth in demand coupled with vacancy and rota gaps have contributed to the variation in performance, with limited flow contributing to overcrowding and lack of capacity to review patients alongside inconsistent adherence to the IPS.
- Diagnostics - risk due to continued increase in demand for MRI, NOUS, Cardiac CT and Echo.
- Cancer - 31 day risk regarding radiotherapy capacity due to linac replacement and staffing levels of radiographers, and 62 day risk due to capacity constraints in Breast and Skin tumour sites.

Actions and mitigations

- Electives - outsourcing continues in challenged services, additional capacity includes opening of theatre 39, cardiology registrar clinics. Full recovery plan in place across specialties. Summer Sprint launched for 10 specialties which started w/c 27th July.
- Emergency Medicine - Locum shifts continue to be offered with variable fill rate. The EEMAC pilot concluded with some modifications being made ahead of the second pilot in August. Significant emphasis is being placed on the UCC workstreams and front door processes to reduce delays and improve streamlining of efforts.
- Diagnostic - additional capacity across modalities including additional weekend and evening working, additional MRI scanner, productivity schemes, agency staff and sourcing of alternative capacity.
- Cancer - 31 day continuing to maximise radiotherapy capacity and recovery plans in place for surgical procedures, and 62 day recovery action plans to reduce time for first appointment in Skin and Breast

Deep dive UEC: escalation rule 1 – highest performance risk



Performance narrative

- 4-hour performance in July 2026 was 68.43% which was a small improvement from 67.87% in June 2026 but still 6% lower than July 2025.
- Total attendances in July were broadly similar to June at just over 18,000 and 2% higher than July 2025.

Key risks

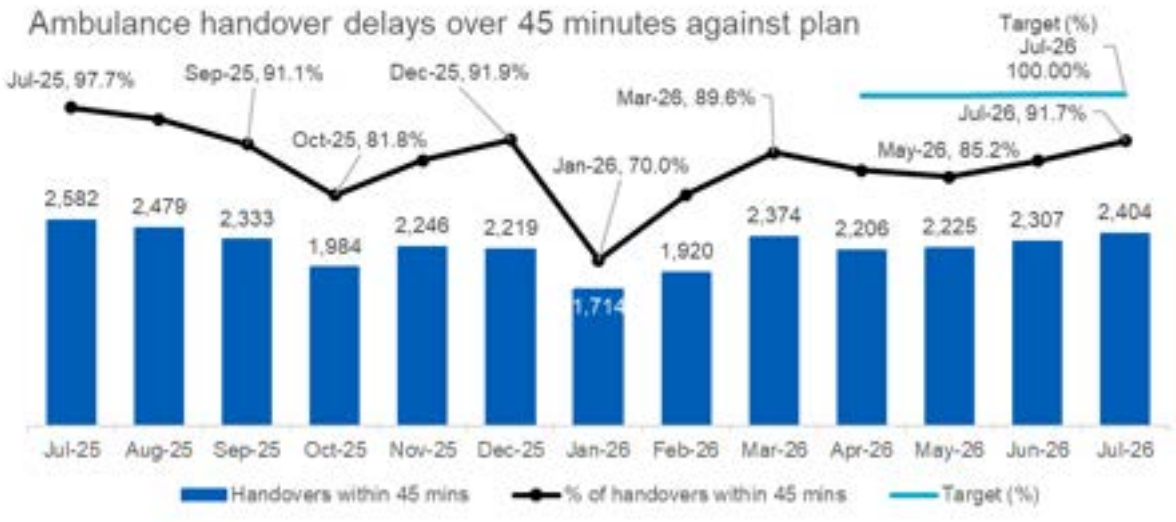
- Reduced resourcing capability in the evenings, overnight and weekends continues to not meet the demand and impacts waiting times for patients increasing length of stay and contributing to crowding.
- Vacancies continue in key areas including the Urgent Care Centre, and this contributes to a reduction in the required patient throughput.
- Poor flow out of the department is contributing to overcrowding and reduced space to assess and treat patients, with continued reliance on assessment within the ED footprint and lack of adherence to the IPS.
- Known bottlenecks such as pathology and imaging are delaying patient pathways and increasing length of stay.

Actions and mitigations

- Recruitment is underway for known vacancies although they are hard to recruit to posts.
- Additional cover continues to be sourced as locum, although fill rate remains a challenge especially through the summer period.
- GP rota changes are underway, and these are expected to be in place for September to align capacity with demand.
- The EEMAC team have widened the criteria for the August pilot which should improve the number of patients suitable for this improved pathway.
- A short stay medical ward will be coming on stream in September to address medicine non-admitted performance, with the larger acute receiving model being worked up to follow later in the autumn.

Source: Operational Management Dashboard

Deep dive Ambulance handover performance: escalation rule 1 – highest performance risk



Performance narrative

- Improvement was seen in handover delays during July reaching 91.65% <45 mins compared to 88.09% in June.

Key risks

- Poor early morning flow out of the ED impacts the ability to offload and can create long handover delays.
- Overcrowding caused by significant DTAs remaining within ED impacts patients getting to the right spaces within ED and means risks must be balanced between waiting room and ambulance patients.
- Limitations to isolation capacity within ED means ambulance RAT bays can be used to support this function impacting the required rapid assessment and onward flow into the department.

Actions and mitigations

- Focus on pre-noon discharges and use of the discharge lounge to support early flow and create required space.
- Predicted ambulance attendance is discussed at every flow meeting to match capacity and demand and prevent delays where possible.
- Use of alternative assessment spaces to support demand.
- Ambulance handover team proactive about using fit to sit options and direct to inpatient capacity as appropriate.
- RHO spaces identified across the MAU to support multiple ambulance arrivals.

Source: Ambulance Waiting Times

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

Specialty	Patients waiting more than 52 weeks (July 2026)
Trust	**838**
Gynaecology	231
Oral and Maxillofacial	155
Ear, Nose and Throat	142
Cardiology	64
General Medicine (Lipids)	47

Source: Operational Management Dashboard

Performance narrative

- Overall 52 week performance has improved to 1.4% with a decrease in patients waiting over 52 weeks from 922 in June to 838 in July. This is 637 patients behind plan. This position is driven by the impact of underachievement on 2025/26 plan, the impact of lost activity from industrial action, reduction in outsourcing and other specialty-specific challenges have had a significant impact on clearance rates.

Key risks

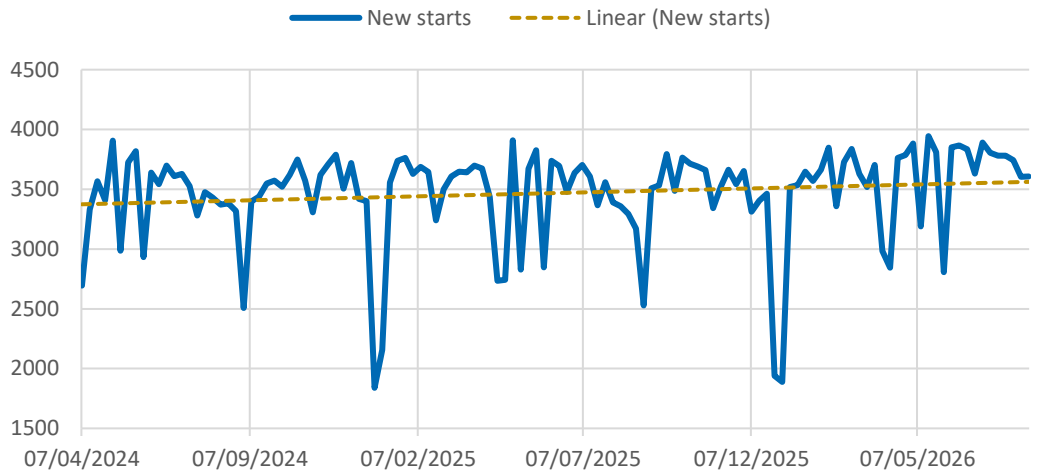
- The largest volumes are in Gynaecology, ENT, Cardiology, OMFS.
- Gynaecology risks are driven by outpatient Urogynaecology capacity and inpatient endometriosis capacity and are exacerbated by clinical and operational team gaps.
- Drivers for the reducing clearance rate for patients over 52 weeks are multifaceted and individual to specialties. Examples include T&O impact from increased trauma and IA, OMFS increase in trauma due to NWAFT and a reduction in ability to do WLIs, Cardiology and ENT a reduction in outsourcing and uptake in WLIs.

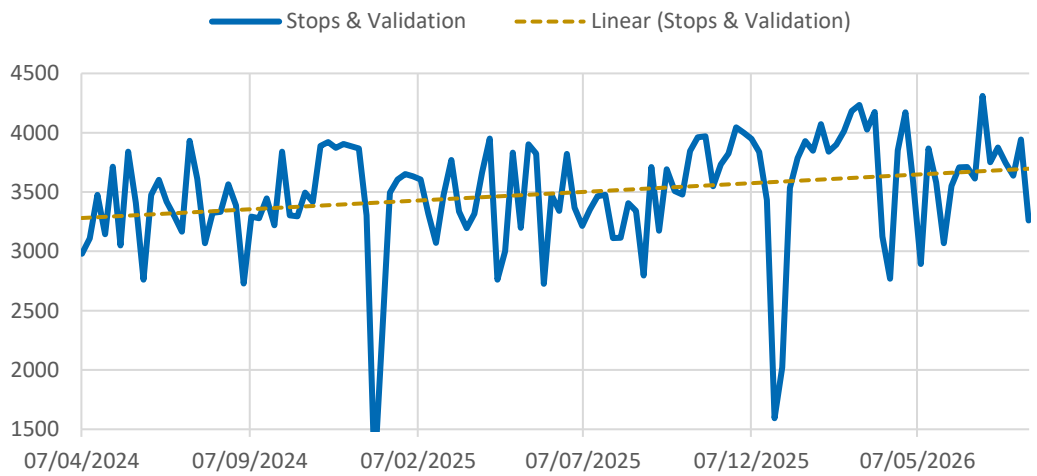
Actions and mitigations

- The elective recovery action plan has been refreshed at specialty level to ensure there are tactical and longer term strategic plans in place. Delivery of these are being monitored through the Elective Taskforce.
- Tactical actions being taken are WLIs, utilisation on outsourcing, and improvement in productivity across outpatients and theatres.
- Longer term actions include the introduction of the Single Point of Access to improve triaging and pathways, introduction of follow up protocols from the GIRFT Further Faster work, and specialty level improvements.
- To improve recovery during Quarter 2 a Summer Sprint (8 week period starting w/c 27th July) has been launched for 10 challenged specialties and is being expanded. Focused on waiting list initiatives, outsourcing and targeted validation.
- Further targeted 52 week wait governance is being implemented through the central operations team with patient level PTLs for 52 week waits, weekly reporting of clearance plans and central validation and tracking of the patient cohort.
- Additional operational support for Gynaecology started in July and further support through the intensive support continues.

Deep dive RTT performance: escalation rule 2 – medium performance risk

The number of clock stops and validations continues to grow at a faster rate than clock starts, with performance improvements shown. However, it is not sufficient growth to reach planned position.





Source: Operational Management Dashboard

Performance narrative

- The 18 week performance of the Trust continues to improve, with a 0.3ppt improvement since June to 65.3% in July. It has improved 6.8ppt since July 2025. However, this remains below recovery plan position of 66.2%.
- The Total Waiting List position is 60,206, behind recovery plan by 129 patients. There has been a reduction in the waiting list of 6,695 patients since July 2025.

Key risks

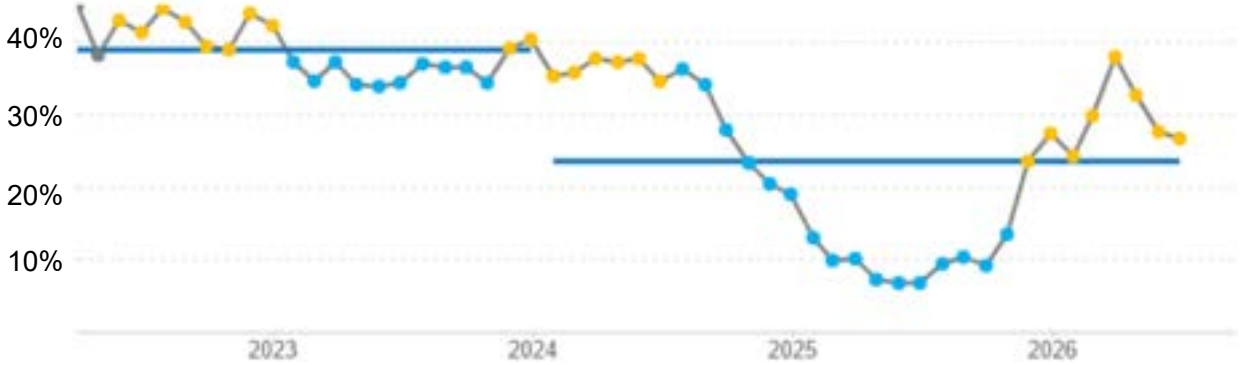
- The activity is broadly on plan, and clock starts are under plan for YTD, however clock stops remain off track against plan. This is leading to an above plan total waiting list, and therefore performance risk for 18 week.
- There is not a sufficiently large increase in clock stops to improve the 18 week performance position, partially due to insufficient administrative capacity to process clock stops.

Actions and mitigations

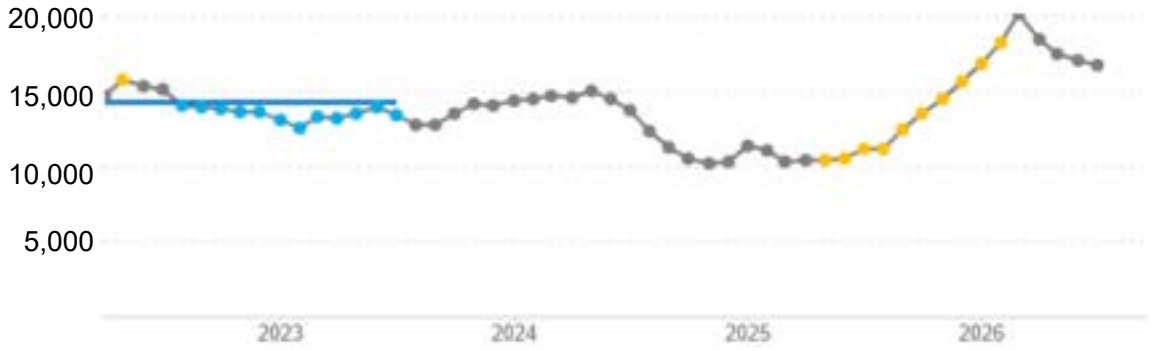
- Elective recovery plan in place plus Summer Sprint underway, with plans to extend the sprint to additional specialties.
- Specialty specific meetings to be undertaken to identify further plans.
- Implementation of Single Point of Access will begin in Autumn.
- Additional validation work to be commissioned.

Deep dive Diagnostics: escalation rule 1 – highest performance risk

Trust Diagnostic 6 week wait performance, national standard of 1%



Trust Diagnostic Total Waiting List



Source: DM01

Performance narrative

- Total waiting list has reduced from 17,026 in June to 16,671 in July.
- 6 week diagnostic performance has improved from 27.5% in June to 26.6%.

Key risks

- In July 2026, the largest contributors to the Diagnostics waiting list were NOUS (5,316), MRI (4,458), Echocardiography (1,443) and CT (964). NOUS and CT have seen an increase in their waiting lists, with CT ahead of plan. Whilst MRI and Echocardiology have continued to reduce their waiting lists in July through the recovery actions being implemented they are off track against plan.
- Performance continues to improve across Echo and MRI. NOUS has seen a 1% deterioration to 38.3%.

Actions and mitigations

- MRI: Weekend lists continuing to provide additional capacity. Mobile scanner has been in place since April and unsupervised cardiac lists have started. MRI are delivering to trajectory.
- CT: Additional weekend and bank lists continue including Cardiac CT capacity. Positive improvement across CT and for cardiac CT. Cardiac CT backlog expected to be cleared by end of July. Currently mobilising the outsourced Cardiac reporting contract.
- Ultrasound: 1.5wte agency sonographers now in place but with a further 1.5wte continuing to be sought. Additional weekend and bank lists continuing. Utilised ICB funded community capacity which has now ceased. The ICB is currently reviewing the demand and services required within the local area.
- Echocardiography: Weekend echo lists continue, insourcing commenced in March at Ely CDC. Working with CDC on longer term plans for echo at CDC. Reviewing demand management opportunities and implementing productivity gains through job plans.
- Diagnostic taskforce continues to monitor progress against delivery plans but has now stepped down to monthly meetings but will continue to monitor progress closely increasing frequency if required.

Link to return to the performance summary

Trust level - to end Jul 2026		Effectiveness & experience		
Metric	Target	In month actual	SPC variation	24 month trend
Patient Flow				Jul 2026
Average number of days from discharge ready date and actual discharge date (incl 0)	0.89	1.27	H	
Bed occupancy rate (G&A)	92.80%	90.14%		
Number of patients cared for in ED corridor care		525.00		
Patient experience				Jun 2026
CQC adult inpatient satisfaction survey		8.10		2025 (published Aug 2026)
30 day readmission rate		11.1%		
% of inpatients making a supported quit attempt with an in-house tobacco dependence treatment service		43.9%	H	
Mortality				Mar 2025 - Feb 2026
Summary Hospital Level Mortality Indicator	1.00	0.97		

Performance narrative

- Flow performance remained challenged during July 2026, with average beds lost post-MRD increasing to 233.2 bed days per day, compared with 223.4 in June. The modest improvement in average delay from Discharge Ready Date is sustained from last month but remains off track.
- Corridor care in ED for July has shown a slight reduction for the second month to 525.
- Inpatient satisfaction in 2025 was just below the national standard of 95% satisfied with their care
- SHMI rate was below the expected level for the Trust, and so is not a performance risk

Key risks

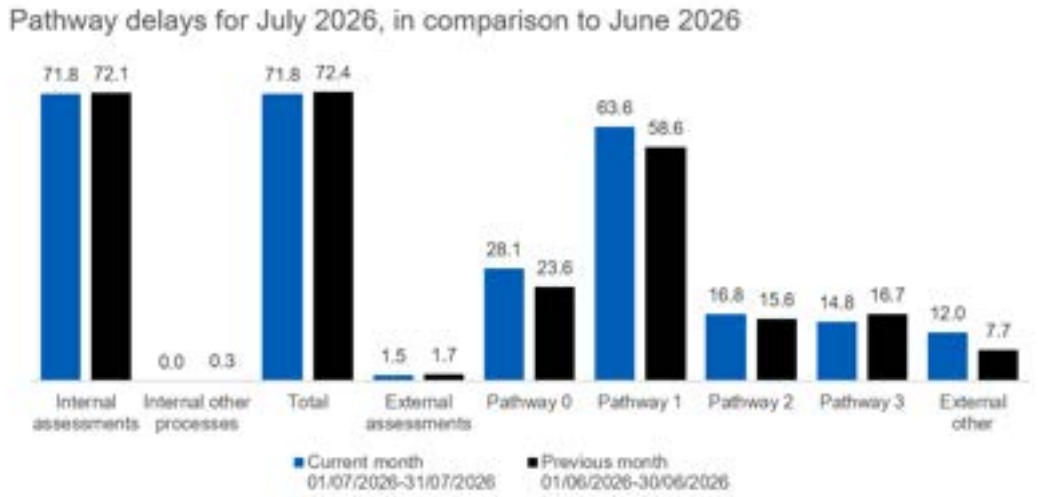
- Ongoing constraints in intermediate care capacity, persistent internal process delays, and a slight increase in Pathway 3 delays continue to limit sustained flow improvement.
- Potential increase in ED corridor care numbers following clarification of the definition in relation to the waiting area.
- Patients experiencing prolonged stays in ED corridor areas
- Inconsistent oversight of corridor care
- Identifying patient harm to those patients
- The ability to reduce the overall use of corridor care

Actions and mitigations

- Continued optimisation of discharge pathways to mitigate the increase in long waiters including 7-day discharge planning and improved community utilisation.
- Corridor care steering groups in place reporting into the Improvement Flow Board.
- A trajectory for reducing ED corridor care is currently being developed.

Source: Operational Management Dashboard

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



Performance narrative

- Flow performance remained challenged during July 2026, with average beds lost post-MRD increasing to 233.2 bed days per day, compared with 223.4 in June and above the four-month average of 232.4. The increase was primarily driven by a rise in external discharge delays, particularly within Pathway 1, where beds lost increased from 63.9 to 70.9 bed days per day. Internal assessment delays remained broadly stable at 71.8 bed days per day.
- The service facilitated 413 complex discharges during July (346 weekday and 67 weekend discharges), representing an increase from June (421 vs 413). However, the proportion of patient length of stay spent medically ready increased to 59.0%, remaining above the four-month average of 55.1%.
- Long waits remain a concern, with medically ready patients waiting 7 days or more increasing from 40 to 51 patients, including 16 patients waiting over 21 days.

Key risks

- Increasing Pathway 1 delays, particularly delays associated with community triage, reablement capacity, domiciliary care commissioning and complex community support arrangements.
- Growing numbers of long-wait patients, particularly those waiting more than seven days post-MRD.
- Social care assessment and placement delays, including safeguarding assessments and care package sourcing, continue to contribute significantly to bed occupancy.
- Self-funder delays remain a recurring issue across both Pathway 1 and Pathway 3 due to market availability, family decision-making and financial arrangements.
- Sustained levels of internal medical and therapy review delays indicate continued pressure.
- Increased post-MRD bed occupancy creates heightened risk to elective recovery, emergency flow and achievement of length-of-stay improvement objectives.

Actions and mitigations

- Continued optimisation of discharge coordination through the CDSN and ward MDTs to accelerate early discharge planning and escalation of delays through the new CDT working model (launched Aug 2026).
- Utilisation of OPTICA and enhanced tracking processes to identify and resolve discharge barriers.
- Continued focus on reducing Pathway 1 delays through strengthened partnership working with Adult Social Care, Reablement, ICT and VSA providers via Pathway 1 Redesign workstream.
- Daily review and escalation of long-wait patients through operational huddles and complex discharge forums. Continued expediting of self-funder pathways through MDTs.
- Promotion of weekend discharge activity, supporting seven-day discharge planning and improved utilisation of available community capacity.
- Ongoing review of internal assessment delays to reduce waiting times for medical review, therapy intervention and discharge referral completion through existing workstreams

Link to return to the performance summary

Trust level - to end Jul 2026		Patient safety		
Metric	**Target**	**In month actual**	**SPC variation**	**24 month trend**
HCAI measure				Jul 2026
MRSA bacteraemia cases (12month rolling)	0	6		
C. difficile infections (12month rolling)	114	128		
E coli bacteraemia cases (12month rolling)	160	195		
CQC inspection				May 2023
CQC safe inspection (last two years)	Good	Good		
Staff survey				Mar 2025
NHS Staff Survey – raising concerns sub-score		6.55		
Patient safety				Jul 2026
Pressure ulcers per 1,000 bed days (Cat 2, 3, 4, mucosal, suspected deep tissue injury, and unstageable HAPUs)	0.40	0.59		
VTE % compliance of patients admitted to CUH who have been risk assessed	95.00%	96.05%		
Patient falls per 1,000 bed days	3.67	4.17		
Rate of reported patient safety incidents of moderate or severe harm or fatal	2.00%	1.20%		
Learning from deaths - % of deaths in scope with a problem in care (1-3 score)	0.00	0.00		
Never events		1		
Maternity Outcomes Signal System (MOSS) Alert		No alert		
Postpartum Haemorrhage rates (PPH) for vaginal births	3.20%	4.72%		
Induction of Labour rates	24.00%	31.49%		

Performance narrative

- There was 1 case of hospital onset MRSA bacteraemia in July 2026. The trust has reported 2 HOHA MRSA cases this reporting year (since April 2026).
- In July, the trust had 10 HOHA *C. difficile* cases and 4 COHA cases, and 9 HOHA *E. coli* cases and 10 COHA cases.
- We are not meeting our LQR for Category 2+ HAPUs in July, reported 26 against a target of 0
- Falls per 1,000 bed days our performance was 4.17 against a threshold of 6.6. Lying and Standing Blood Pressure compliance was 35.8% against a target of >90%.
- There is a sustained trend of maternity delays in induction of labour (IOL), delay to the commencement of IOL is on track with slight improved in performance, delays to the continuation of IOL in month has slight improvement.
- A Never Event occurred in July with a Trauma & orthopaedic theatre case. CUH has had one Never Event this financial year.

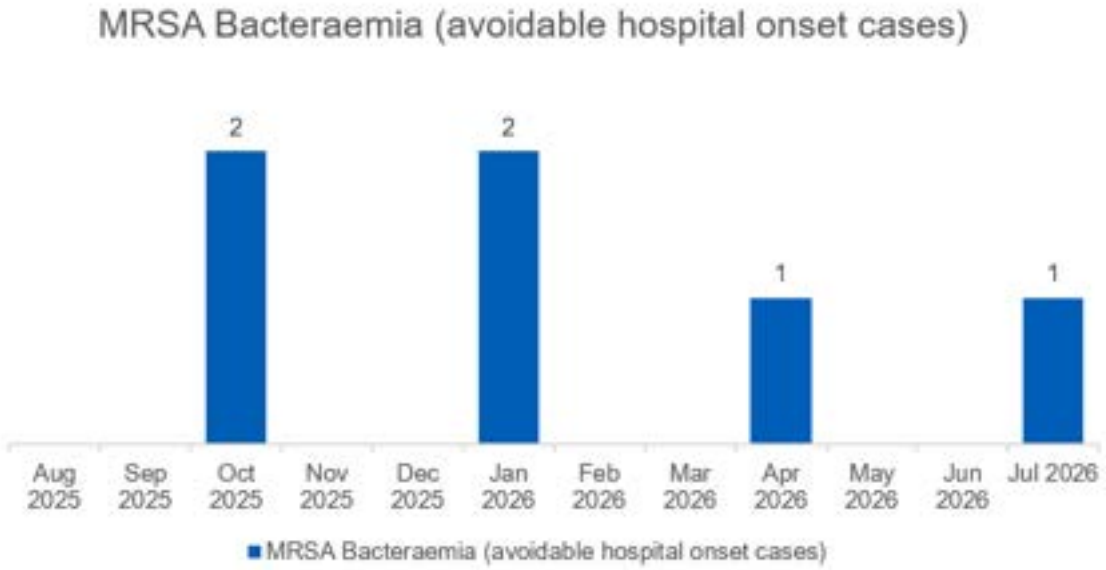
Key risks

- The Learning Review identified a delay in testing for MRSA meaning community acquisition cannot be confirmed in the case.
- Delivering the rolling deep clean of wards, and delays in testing are risks to infection prevention control.
- The 2026-2028 Quality Improvement plan has been launched across these Harm Free Care Groups to support improvement in performance and safety. Divisions are undertaking individual deep dives and action plans to support challenged areas.
- Delays to timings for emergency caesarean sections (decision for CS to birth within timeframe) is a significant performance risk. Improvement to Cat 1 CS with decrease to performance in Cat 2

Actions and mitigations

- Poor medical representation limits the impact of the MRSA Learning Review.
- Ongoing work with Harm free care, Tissue Viability and Genome regarding rolling out Mattress Audits and checking of mattresses. Rolling Clean programme continues.
- Updates to Epic Admission Assessment and Care Plans will enable better identification of risk and more individualised and effective care plans to be implemented.
- Refreshed Maternity Flow improvement plan in place.
- The Never Event resulted in moderate harm. A Multiprofessional roundtable is planned to review the event.

Deep dive IPC: escalation rule 3 – highest performance risk



Performance narrative

- Following a sustained six-month period of lower than average rates of *C. difficile*, this month's result has increased. The performance position is below the IQR target.
- The organisation's *E. coli* infection rate remains above target, and towards the higher end of the Shelford Group benchmark range, indicating that performance remains less favourable when compared with peer organisations.
- There continues to be high numbers of *E. coli* cases in the community.

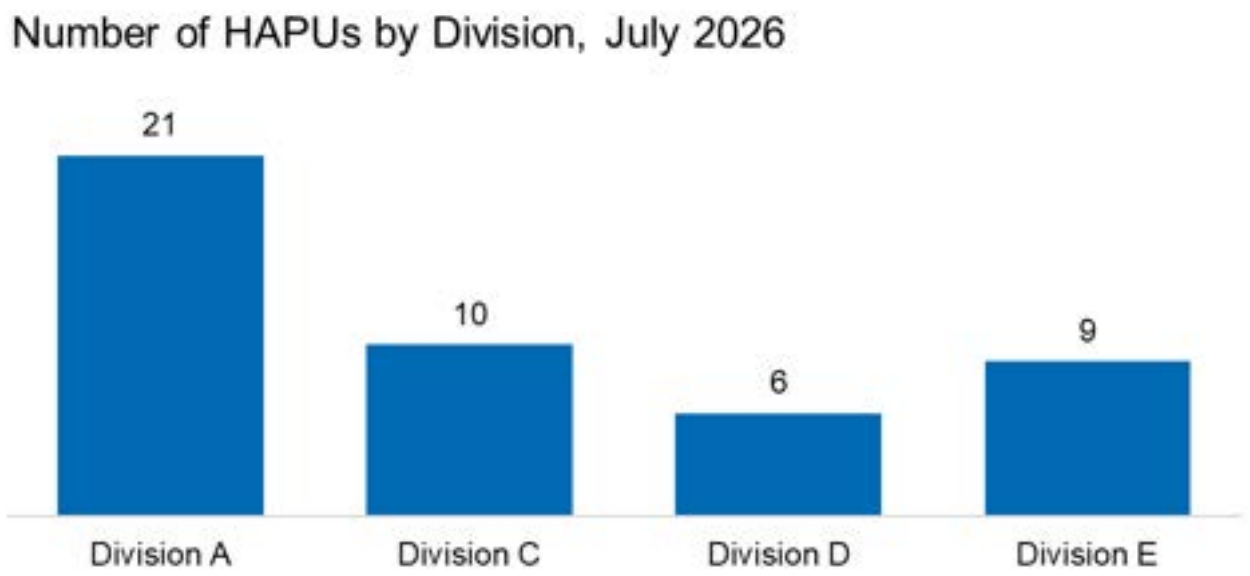
Key risks

- Poor medical representation at learning response meetings, and escalation is required.
- Themes identified from the learning response meetings include poor documentation of stool charts, delays in testing, and inability to isolate patients promptly or delays in isolation.
- The Trust has limited side-room capacity, and this remains a longstanding and ongoing risk.
- Despite escalations and the introduction of the rolling deep clean programme, cleaning standards remain variable and inconsistent across the Trust.
- There have been high numbers of urology patients in ED, potentially indicating poor catheter care with risk of additional *E. coli* cases.

Actions and mitigations

- This is ongoing monitoring and discussion at the regional meeting with the quality and infection control NHSE lead. Governance is through Divisional meeetings.
- Although there has been a community rise in *C. difficile*, this is not out of line with other regional hospitals. Work still continues in reviewing antibiotics use with the Stewardship team.
- Learning response meetings are held to enable colleagues to review management of *C. difficile* cases.
- The microbiology team are looking to apply for a unified testing mechanism to allow *C. difficile* testing to be automatic for all stool samples

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



Performance narrative

- In July the Trust reported 46 Hospital Acquired Pressure Ulcers (HAPUs), 26 of them were Category 2 and above. Division E has continued to see a statistical significant increase.
- We are not meeting our LQR for Category 2+ (threshold of zero) and our internal threshold of 0.395 Category 2+ HAPUs per 1,000 bed days, for July we reported 0.59. Only Division B (0.0) and E (0.33) met the internal threshold. There were 19 reported Category 2s, no Category 3, 4 or unstageable reported in month.

Key risks

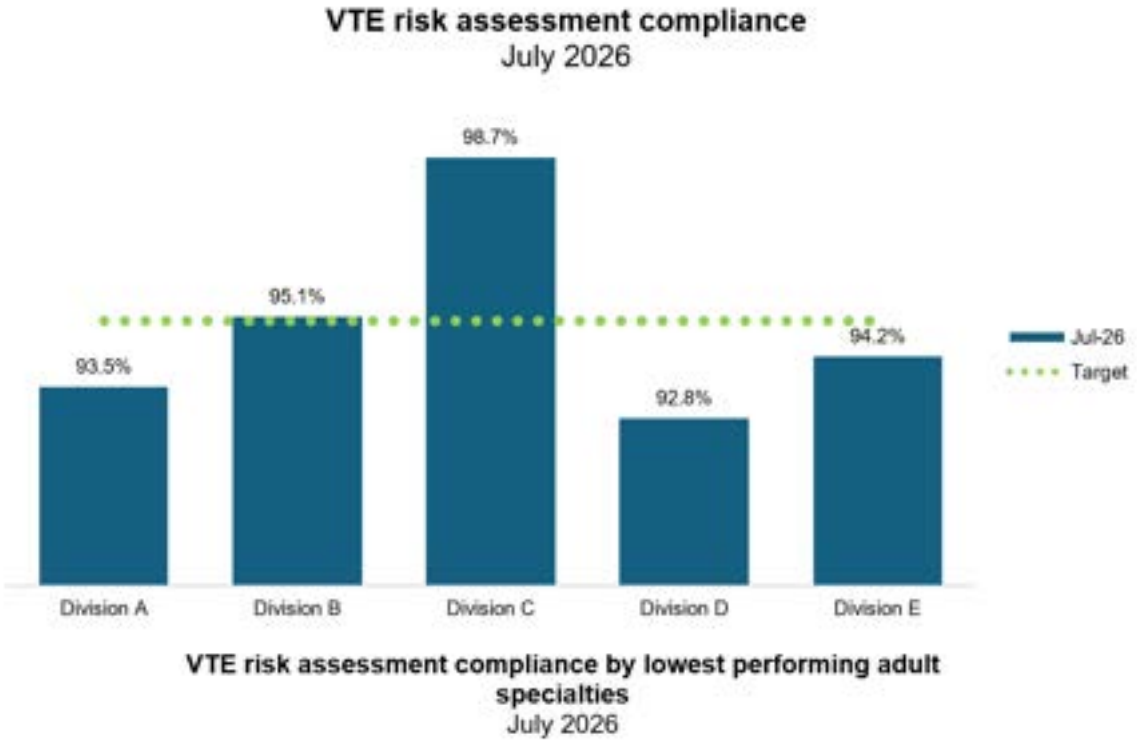
- The 2026-2028 Quality Improvement project has been launched. Gemba walks are being used to support the Discovery and Design phase of the project, enabling focused support to challenged areas. Progress of the QI project is tracked at the monthly HAPU Harm Free Care meeting with oversight at Quality Care Forum with Divisional Heads of Nursing/Midwifery in attendance. Any Category 3 and 4 HAPUs are brought to the weekly Patient Executive Huddle.

Actions and mitigations

- Divisional Heads of Nursing are attending huddles over the next month to observe pressure ulcer prevention processes, safety huddles in action, and use of sliding sheet in targeted clinical areas. Further improvement will be realised with changes to Epic Admission and Care Plans launching on 8th November 2026.

Source: Quality Account

Deep dive VTE: escalation rule 3 – lowest performance risk



Performance narrative

- In July, compliance with completion of the VTE risk assessment decreased significantly across the Trust.
- While all divisions remained within expected levels of variation, a downward trend in performance was observed across each division.
- Divisions A, D and E did not achieve the Trust target of 95% compliance.
- VTE risk assessment compliance for 15 and 16-year-olds remained low at 14%.

Key risks

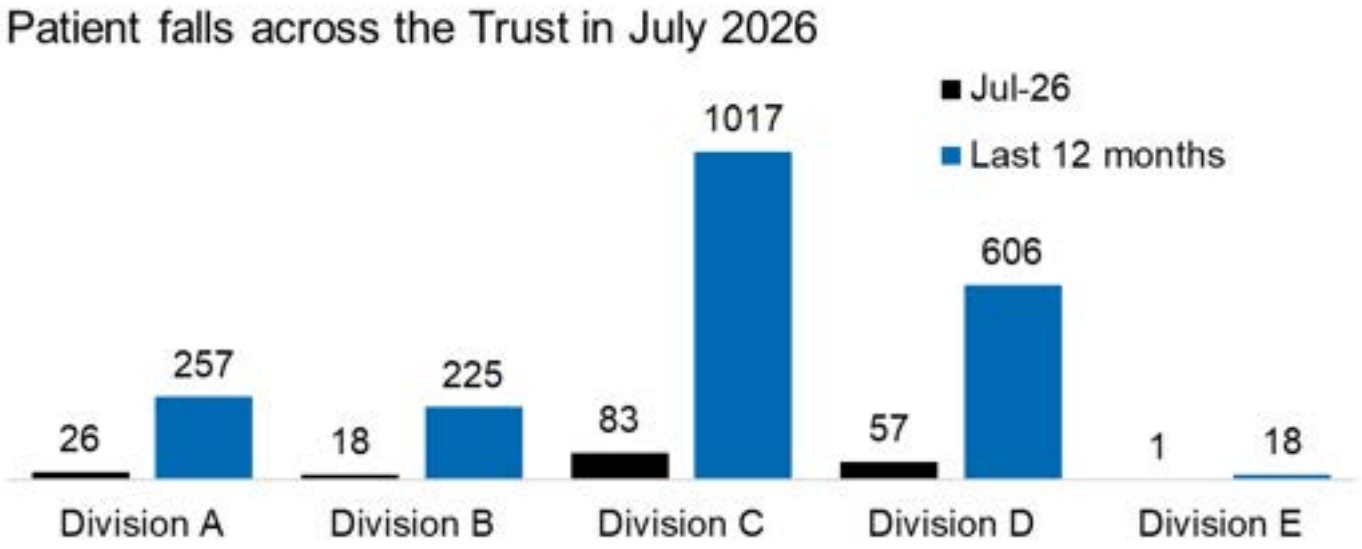
- An avoidable hospital-acquired thrombosis (HAT) was reported in July within the Department of Medicine for the Elderly.
- The lowest-performing adult specialties, all below the compliance target, were Clinical Oncology, Upper GI Surgery, Neurosurgery, Respiratory Medicine, the Department of Medicine for the Elderly, and Maxillo-Facial Surgery.

Actions and mitigations

- The VTE Quality Improvement group have agreed a series of actions to support compliance with the Trust policy and some of these measures are now taking effect. Identification of low-risk groups not requiring VTE assessment was added as part of the EPIC upgrade in November 2025, and further work remains underway including assessment of patients aged 15 or 16 years.
- Governance is overseen at the VTE Quality Steering Group and Patient Safety Oversight Group.

Source: Quality Account

Deep dive Patient falls: escalation rule 2 – medium performance risk



Performance narrative

- In July the Trust reported 185 Falls, there were 2 moderate harm Falls (Division C and D).
- Falls per 1000 bed days was 4.17 and while we meet our LQR (threshold of 6.6) we are not meeting our internal improvement target of <3.25 Falls per 1000 bed days. We are not meeting our LQR related to Lying and Standing Blood Pressure (LSBP), the target is >90% of patients over 65 have this assessed. Current performance is 35.8%.

Key risks

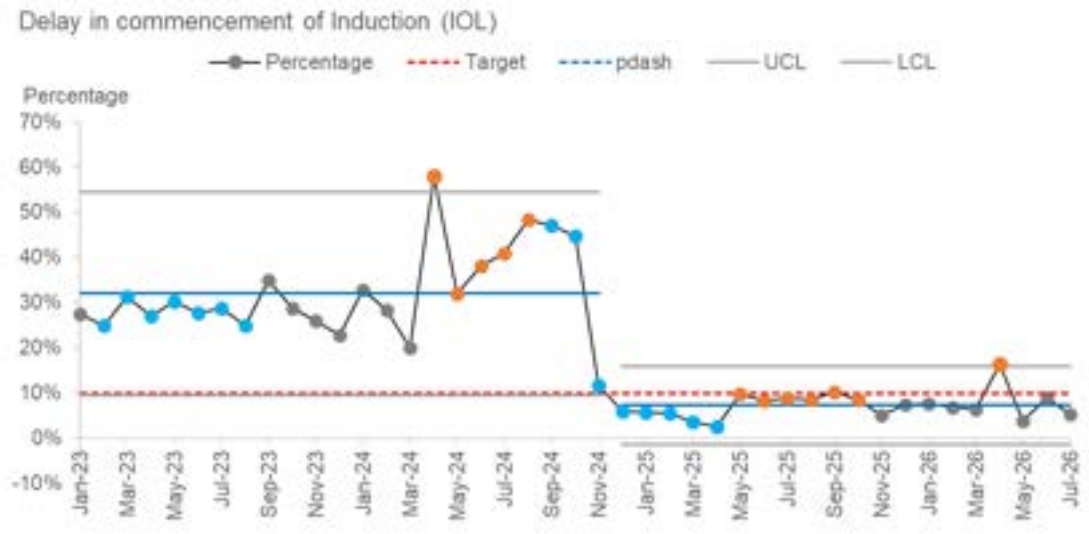
- In response to poor compliance with LSBP recording, the Falls Harm Free Care Group requested updated divisional action plans and is tracking improvements against plan. Compliance has improved, with performance now recording a single point above the control limit; however, overall completion rates remain below the required standard.
- Governance is maintained through the Quality Care Forum where Divisional Heads of Nursing/Midwifery are in attendance with significant harm Falls reviewed through the weekly Patient Safety Executive Huddle.

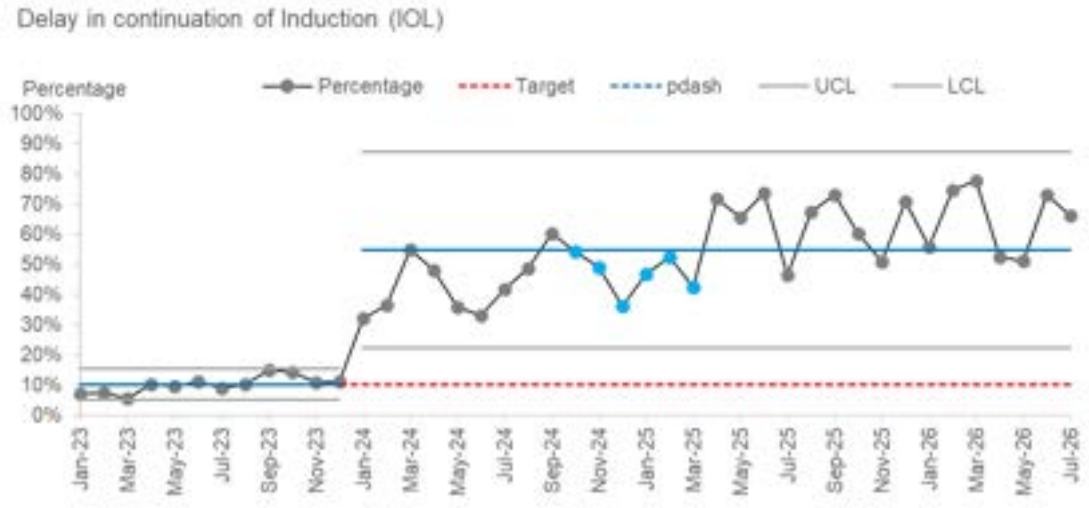
Actions and mitigations

- Divisions are delivering targeted improvement initiatives to reduce falls, including; ward-based deep dives to understand local contributory factors and the creation of a Falls grab bag. The 2026-2028 Quality Improvement project has been launched and is currently in the Discovery and Design phase of the project.
- In addition, review of Admission Risk Assessments and Care Plans are underway with updates to Epic Admission documentation going live 8th November 2026. Following that, updated Care Plans will be launched enabling more individualised plans of care to be implemented.

Source: Quality Account

Deep dive Maternity: escalation rule 1 – highest performance risk





Performance narrative

- IOL Performance narrative; Induction of Labour (IOL) performance risk centres on delays to the continuation of IOL, which improved slightly in month to 5%. Delay in the commencement is slightly improved at 66% but remains a key performance risk and impact on patient experience.

Caesarean Section Performance narrative:

- CS rate rising in line with national picture. Delays to both cat 1 and cat 2 CSs. No obvious harm identified, data cleansing required.

Key risks

- IOL Key risks; risk in IOL pathway around delays in the continuation of IOL . Commencement delays remain under 10%. Continuation delays improved in month, to observe longer impact to assess if flow improvement workstream is effective in mitigating risk. Clinical risk stratification in place to reduce risk of harm through delays to continuation but remains a risk to patient experience.

Actions and mitigations

IOL Actions and mitigations;

- Workstream on flow refreshed including implementation of a plan to improve day to day operational grip.
- To pilot increased OPEL Maternity Framework reporting
- Deep dives into data commenced.
- Review of phase 1 IOL pathway outcomes ahead of Phase 2, ongoing.
- Neonatal Transitional Care is pending recruitment nursing staff for planned October implementation.
- Enhanced Recovery to be commenced September.

Caesarean Section Decision to Delivery to Birth Timings Actions and mitigations; Category 1&2 CS.

- Deep dive to identify cause of delays and length of delays ongoing.
- A business case is in development to extend theatre slots to provide additional capacity.

Source: Quality Account

Link to return to the performance summary

Trust level - to end Jul 2026		Finance & productivity		
Metric	**Target**	**In month actual**	**SPC variation**	**24 month trend**
Surplus/deficit				**Jul 2026**
Trust actual surplus/deficit (in month)	£2.4m	£2.4m		
Trust actual surplus/deficit (YTD)	£0.3m	£0.4m		
Performance against plan surplus/deficit	£0.0m	£0.0m		
Financial position				**Jul 2026**
National Cost Collection Index Score (NCCI)		106.00		
Elective Payment Mechanism (EPM) income (YTD)	£106.3m	£106.0m		
Cash position	£52.7m	£40.8m		
Capital Expenditure (YTD)	£23.7m	£17.7m		
Productivity				**Jul 2026**
Implied rate of productivity growth		4.8%		
Innovation				**Jul 2026**
% of clinical trials set up within 90 days		35.59%		
DQMI		88.9%		Apr 2026

Source: Finance data, Clinical Trials data, DQMI dashboard

Performance narrative

- The Month 04 position is £0.4m surplus which is in line with plan. The position includes £4.4m of cost pressures (including the £1.8m impact of the April Resident Doctors Industrial Action (IA) and £0.5m due to the late cancellation of the June IA) and Productivity is £1.7m lower than planned, offset by £2.3m of non-recurrent benefits and £3.9m of favourable operational variances.
- The Trust's NCCI for 25/26 was 106, meaning that costs were 6% higher than expected.
- CUH trails the national figure for 90 Day study set-up compliance, and 2 out of the 3 comparable research trusts, however these gaps have narrowed over the last year.
- The Trust's Data Quality Maturity Index (DQMI) is 88.9%. The relatively poor performance in DQMI is driven by poorly recorded diagnosis codes in the Emergency Care Data Set

Key risks

Key risks to the Trust financial position are:

- Further periods of Industrial Action present a significant financial risk.
- Whilst the Trust was successful in a national contract arbitration process, contracts for 26/27 remain unsigned with further negotiation required and other disputes to resolve.
- Productivity and Efficiency (PEP) delivery of £59.2m in 26/27 remains a risk.
- Ongoing Premium pay expenditure including bank and WLI and outsourcing costs to support in year operational performance could financial performance.
- Delayed discharge of medically fit patients and those requiring step-down care impacts available beds compromising clinical care and driving additional expenditure.

Actions and mitigations

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

- Improve output productivity through increased elective service delivery above current service levels to maintain RTT performance
- Deliver cost out PEP programme and manage/mitigate in year cost pressures by increasing assurance over PEP development and delivery.
- Exit premium bank and WLI payments and reduce outsourcing payments
- Identify additional funding to cover non-recurrent expenditure driven by periods of IA

Research & Development will continue to work with other teams to meet the 90 day target through accelerated study review and set-up with oversight at the Research Board.

Link to return to the performance summary

Trust level - to end Jul 2026	People & workforce			
Metric	**Target**	**In month actual**	**SPC variation**	**24 month trend**
Staff survey				Sep 2025
NHS staff survey - engagement sub-score		6.9		Sep 2025
NHS quartely pulse survey - engagement sub-score		6.6		Jun 2026
Workforce growth				Jul 2026
Total change in substantive WTE (12 months)		-0.35%		
Substantive WTE performance - distance from plan	0.00	-177.38		
Bank WTE performance - distance from plan	0.00	180.73		
Agency WTE performance - distance from plan	0.00	-2.99		
Staffing				Jul 2026
Mandatory Training Compliance	90.0%	93.88%		
Turnover rate	10.0%	8.92%		
Sickness absence rate (12 months)	4.1%	4.24%		
Health and Safety Incidents rate per headcount		1.3		

Performance narrative

- The workforce substantive workforce is almost flat over the past 12 months and is at the planned establishment overall. The substantive workforce is below plan by 177 WTE, this is in part driven by delayed recruitment to the new gender service, however unfilled vacancies is a further cause. This has contributed to bank spend usage above the planned NHSE target. The NHSE target of 10% was applied against the first half of 2025/26, when bank spend was low, making the target challenging.
- Health and Safety Incident rates per headcount has recovered from an elevated June position driven by adverse weather.

Key risks

- Bank performance above plan brings a risk that the pay unit cost (WTE) is higher than planned, with the result that the pay bill is unaffordable. The temporary staff usage is being explored to understand what reductions are feasible to help the trust move closer to the plan, without affecting activity.
- The NHSE target for sickness absence remains a challenge, although CUH benchmarks well Nationally (currently top 14). Reducing absence to the target brings an opportunity to support productivity improvements and reduce temporary staffing costs.

Actions and mitigations

- Bank usage - Divisions are engaged in considering opportunities. Divisions have financial limits and performance against this reported on through Quality and Performance meetings.
- A sickness absence 'sprint' took place over winter, learning from this has been included in the next phase of the plan to support Divisions and Corporate teams where the performance is most challenged.

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

Deep dive Bank staff against plan: escalation rule 1 – highest performance risk

Division	In month % of total pay spend
Div A	10.0%
Div B	3.5%
Div C	9.8%
Div D	5.4%
Div E	8.1%
Corporate	3.8%
R&D	1.2%

Performance narrative

- A balanced approach is being taken to reduce bank usage and spend given the link between additional clinical activity (waiting list initiatives) and temporary staffing usage. Bank spend was 6.6% of the total pay bill in M4, against a plan of 5.9%. The increase in bank reflects focus on activity delivery through the 'Summer Sprint,' maintaining J3 and other contingency areas in support of the operational position and increasing vacancy rates. J3 is now planned to remain open all year.

Key risks

- If the operational challenges require continued use of contingency areas, this will impact on temporary staffing.
- There is a risk that rising vacancy levels will increase temporary staff usage, particularly Health Care Support Workers.
- The Divisions with the highest bank spend are Division A and C, although midwifery in Division E is also high.

Actions and mitigations

- The largest proportions of bank spend is medical and dental and nursing and midwifery. The unit cost in medical is significantly higher in nursing, so small changes in WTE for medical bring more significant changes in in pay costs than other staff groups. In addition to the existing review of rosters and reporting on performance against KPIs for nursing, a detailed analysis is underway to account for all of the contributing factors to the bank position. This will include the opportunities to make changes and the potential risks associated with each option. This will be considered ahead of further action and will include all staff groups. Work is also underway to triangulate the pay spend data and WTE.

NHS Oversight Framework – Q4 2025/26

	Q4 2025/26			Q3 2025/26			Q2 2025/26			Q1 2025/26		
NOF Domain	Metric	Rank	Segment	Metric	Rank	Segment	Metric	Rank	Segment	Metric	Rank	Segment
Summary		28	2		22	2		71	3		70	3
Access to services		100	3		78	3		107	4		94	3
Difference between planned and actual 18 week performance	-1.17	97		-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	62.9%	87		59.5%	79		58.7%	91		58.1%	85	
Percentage of cases where a patient is waiting more than 52 weeks for elective treatment	1.6%	97		3.0%	114		3.8%	114		4.3%	116	
Percentage of emergency department attendances admitted, transferred or discharged within four hours	69.5%	96		71.3%	80		73.5%	78		73.5%	70	
Percentage of emergency department attendances spending over 12 hours in the department	8.4%	57		7.5%	51		10.1%	69		7.6%	54	
Percentage of patients treated for cancer within 62 days of referral	68.7%	70		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	86.3%	2		84.0%	10		72.4%	91		77.4%	57	
Effectiveness and experience		96	3		104	3		101	3		94	3
Average number of days from discharge ready date to actual discharge date (including zero days)	1.24 days	101		1.38 days	106		1.23 days	100		1.00 days	91	
CQC inpatient survey satisfaction rate			2			2			2			2
Summary Hospital-level Mortality Indicator			2			2			2			2
Finance and productivity		6	1		6	1		9	1		48	2
Implied productivity level	5.45%	21		7.20%	13		4.77%	31		0.43%	100	
Planned surplus/deficit	0%	12		0%	12		0%	12		0%	12	
Variance year-to-date to financial plan	0.30%	54		0.37%	6		0.48%	5		1.21%	6	
Patient safety		36	2		39	2		32	2		55	2
NHS Staff survey - raising concerns sub-score (2025)	6.37 / 10	57		no change			no change			6.55 / 10	41	1
Number of MRSA bacteraemia cases	6 cases			5 cases			3 cases	54		7 cases	114	
Proportion of C. difficile infections	0.95 (rate)			1.02 (rate)			1.12 (rate)	57		1.20 (rate)	63	
Proportion of E. coli bacteraemia	1.04 (rate)			1.06 (rate)			1.07 (rate)	37		1.11 (rate)	55	
People and workforce		17	1		21	1		20	1		22	1
NHS staff survey engagement theme sub-score (2025)	6.93 / 10	43		no change			no change			7.02 / 10	40	2
Sickness absence rate	4.54%	14		4.10%	17		3.85	15		4.21	14	
Summary												
Financial override	No			No			No			No		
Is the organisation in the Recovery Support Programme?	No			No			No			No		

Source: published June 2026 by NHS England

Appendix: defining performance risk

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

i. Performance against plan or target

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

ii. SPC defined change in performance

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

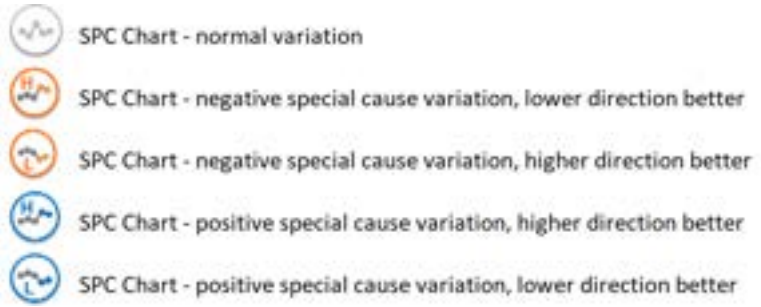
Any metric that displays a change whose magnitude is greater than expected variation will be labelled as improving or deteriorating in the performance summary.

Escalation and de-escalation rules

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

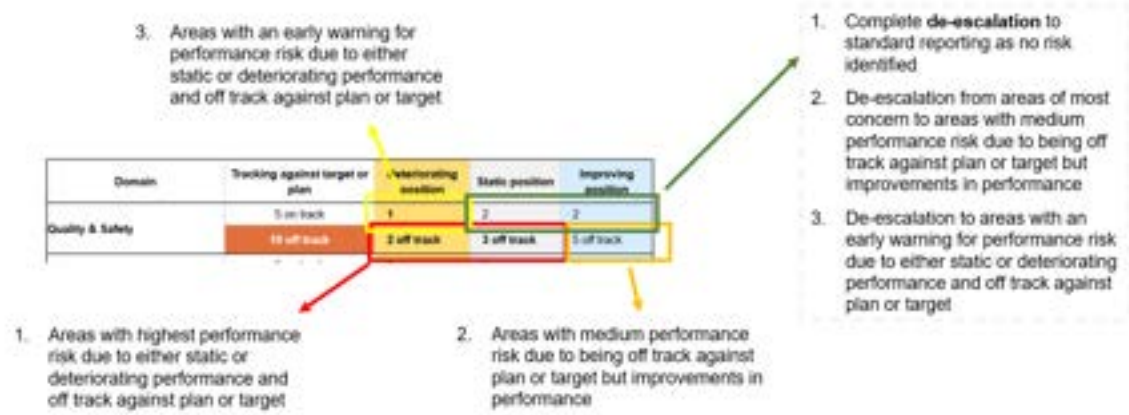
i. Performance against plan or target

ii. SPC defined changes in performance



Escalation rules:

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



Contents

Trust actual surplus / (deficit)

£2.4m	*Actual (adjusted)**
£2.4m	*Plan (adjusted)**
£0.4m	*Actual YTD (adjusted)**
£0.3m	*Plan YTD (adjusted)**

Elective Payment Mechanism (EPM)

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

	In month	YTD
EPM forecast actual	£30.4m	£106.0m
EPM plan	£30.2m	£106.3m
EPM 25/26 target	£19.5m	£75.9m

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

Net current assets

(£112.4m)	*Actual*
(£112.3m)	*Plan*

Debtor days

37	*This month*
31	*Previous month*

Payables performance (YTD) *

78.9%	*Value*
85.0%	*Quantity*

EBITDA

£21.0m	*Actual YTD*
£24.6m	*Plan YTD*

Capital expenditure

£4.8m	*Capital - actual spend in month*
£17.7m	*Capital - actual spend YTD*
£23.7m	*Capital – plan YTD*

Cash

Cash

£40.8m	*Actual*
£52.7m	*Plan*

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

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

Month 04 Financial Performance

- The Month 04 year to date financial position is **£0.4m surplus for performance management purposes, in line with plan.** The position includes £4.4m of cost pressures (including resident Doctors Industrial Action impact of £1.8m in April and £0.5m in June due to late cancellation) and £1.7m lower productivity offset by £2.3m of non-recurrent benefits and support and £3.8m of favourable operational variances.

    - **Points to note - Month 04 financial position:**
        - The inflationary pay award funding is assumed to cover the cost of the pay awards. Budgets have been adjusted to reflect uplifted income and expenditure assumptions.
        - Clinical income at Month 04 is estimated using Month 03 priced activity case mix with Month 04 patient activity data.
        - Following arbitration of the 26/27 elective pricing dispute with Central East and Norfolk and Suffolk ICB, NHSE has ruled in favour of the Trust's position. The ICB has queried the outcome with NHSE and the Trust is working with them to bring this to a close.
    - **Points to note - Month 04 financial performance:**
        - Position supported by £2.3m of non budgeted benefits - £2.0m of non-recurrent income and £0.3m of expenditure benefits.
        - Trust Elective income is behind plan by £0.3m and additional purchase of healthcare capacity is £1.4m above plan causing lower PEP productivity than planned.
        - Whilst on plan at Month 04 the Trust Productivity and Efficiency Programme (PEP) delivery requirements increase significantly in future months. Work continues to ensure all required PEP is identified and plans are in place to deliver it.
        - Assurance over PEP development and delivery is improving - Month 04 gap of £2.0m for cost reduction compared to £2.3m at Month 03. Productivity scheme development and delivery remains a key concern and under review by the Productivity Board.
        - Additional reduction in bank and agency expenditure is required to ensure delivery of the Pay PEP target for 26/27. Year to date bank expenditure exceeds the monthly NHSE expenditure limits for 26/27.
        - Approval of specific in year Quality and Safety investments may require additional PEP delivery in year to support them.

- **Income is favourable to plan by £1.0m**
    - Clinical income – Adverse variances in Elective activity (£0.3m) and pass-through drugs and devices (£3.0m) offset by blended variable income (£0.2m) and other elements including new services at £2.6m.
    - Devolved income - lower donated income than planned (£4.7m) and lower fire safety works expenditure (£1.0m) offset by R&D income (£4.3m), Education and training (£0.7m) overseas visitors income (£0.8m) following introduction of a new risk-share scheme, Injury cost recovery (£0.1m) and net charging to other organisations (£1.3m) for services and salary recharges. Please see pages 11-15.
- **Pay is adverse to plan by £3.5m**
    - £1.0m of IA related bank expenditure, impact of bank holidays and operational pay pressures account for this position. Please see pages 16-17.
- **Non pay (including drugs) is adverse to plan by £1.1m**
    - Drugs expenditure and other non pay categories is adverse to plan by £0.1m and £1.0m respectively. Please see pages 20-21.

Financial target in 2026/27

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

- Overall financial performance (delivery of planned breakeven position)
- Delivery of the PEP programme of £59.2m including £25.1m of cost reductions
- Reduction of 10% in bank expenditure compared to the 25/26 Month 05 inflation adjusted forecast outturn (reported under NOF Domain 7 – People)
- Reduction of 30% in agency expenditure compared to the 25/26 Month 05 inflation adjusted forecast outturn (reported under NOF Domain 7 – People)

The NHS Oversight Framework was launched in 2025 and includes operational performance metrics alongside two finance and two productivity metrics with Relative cost difference (National Cost Collection Index) added in June 2026 as a scoring metric replacing Implied productivity growth which becomes a non-scoring contextual metric. The Trust was initially assessed as segment 2 for finance and productivity but placed in segment 3 overall, ratings were based on M12 24/25 data. Updated data was published for Quarter 4 and the Trust remains in segment 1 for finance and productivity (high performing) and is in segment 2 overall. NHSE has published Month 12 2025/26 YTD implied productivity performance of +4.8% for CUH. The Trust has calculated its' Month 04 YTD implied productivity performance at +5.3%.

Details of the finance and productivity target metrics and current/forecast performance against them can be found on page 9 of the report (this excludes the operational performance metrics).

Elective Payment Mechanism (EPM)

- Elective activity in 26/27 will continue to be paid on a 'variable' basis, where Trusts are paid on PbR for a selection of activity including Elective Inpatients, Day-cases, Outpatient first attendances, Outpatients procedures and Chemotherapy. Starting in 26/27, Unbundled radiology will also be included in the Variable capture. Commissioner arbitrations are currently underway, including elements of local elective service pricing.
- Points to note:
  - The distribution of income at Month 04 is based on Month 01 to 03 billing to commissioners with Month 04 forecast based on priced weekly activity reports. EPM is £0.3m behind the Trust plan, however, excluding the unbundled Radiology, the EPM position is £1.0m behind the plan.
  - The formal dispute with Central East ICB and Norfolk and Suffolk ICB regarding Elective payment terms for 26/27 has been resolved via the national arbitration process which confirmed the Trust's pricing methodologies were appropriate.
- Please see page 14 for more details on the methodology for pricing the EPM income.

Productivity and Efficiency Programme (PEP)

- The Trust set an efficiency target of £59.2m, of which £25.1m is planned to be delivered via cost reduction PEP.
- At Month 04 the Trust has delivered £16.6m of cash-releasing and productivity savings in line with the PEP plan.
- The plan profile shows an increase in efficiency required across the year with 43% delivered in Quarters 1 and 2 and 57% in Quarters 3 and 4. Within this the Month 01 to 04 plan required £16.5m of savings to be delivered with a further £42.7m to be delivered for Months 05 to 12 at an average of £5.3m/month compared to £4.0m for Quarter 1 and £4.4m for Month 04.
- The following actions continue to be pursued:
  - Full identification of the 26/27 cost out and productivity PEP programme
  - Productivity board oversight of Divisional productivity programmes
- Implied productivity for Month 04 compared to the same period in 25/26 is estimated at a 5.3% improvement due to 4.0% increase cost weighted activity (outputs) and 1.3% relative decrease in expenditure (inputs).

Cash and Capital Position

- The Trust has been allocated operational capital funding for the year of £38.0m for its core capital requirements (£7m lower than 2025/26). In addition to this we expect to receive further NHS capital funding including; Children's Hospital (£11.3m); Cancer Hospital (£18.4m); Estates Safety Fund (7.3m); Return to Constitutional Standards (£3.1m). Together with capital contributions from ACT, technical adjustments in respect of PFI, and other miscellaneous DHSC awards, the Trust's capital budget for the year now totals £87.4m.
- Capital expenditure YTD at Month 4 was £17.7m compared to plan of £23.7m, however, these delays in spend are not currently expected to impact on the forecast, which remains to invest the capital plan in full by end of year.
- The Trust's cash position was £40.8m compared to plan of £52.7m, but the 13-week cash flow forecast does not identify any need for additional revenue cash support in the foreseeable future. The main reason for cash being behind plan is delays in commissioner payments under PbR, including cash funding of the 2026/27 pay awards (expected to be resolved by October) and cash payments for elective service performance in 2025/26 which are being escalated with the relevant commissioners.

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

- The Trust migrated its Finance system on 01 April and implemented a new Chart of Accounts. Volatility within categories of income and expenditure is expected as teams adapt to the new coding structure. Further budget remapping is expected during Months 4 and 5 to reflect the new coding for the procurement catalogues, staffing groups and categories of devolved income.
- The finance team are developing new reports and hope to include new analysis and other relevant content within this report in future months.

£ Millions	In Month Budget	In Month Actual	In Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance	Full Year Budget	Full Year Forecast
Clinical Income - excl. variable and blended	41.8	42.2	0.5	168.8	171.4	2.6	508.1	514.2
Clinical Income - Blended variable	26.6	27.1	0.5	109.5	109.7	0.2	343.2	329.1
Clinical Income - Elective variable	30.2	30.4	0.2	106.3	106.0	(0.3)	300.9	318.0
Clinical income - D&D*	20.4	19.7	(0.7)	81.8	78.8	(3.0)	245.5	236.4
Devolved Income	19.2	22.2	3.0	76.7	78.2	1.5	233.4	233.4
Total Income	**138.1**	**141.6**	**3.5**	**543.0**	**544.1**	**1.0**	**1,631.2**	**1,631.2**
Pay	76.1	75.5	0.6	304.1	307.6	(3.5)	915.3	915.2
Drugs	20.1	20.9	(0.8)	80.3	80.4	(0.1)	240.8	240.8
Non Pay	33.5	37.2	(3.6)	134.1	135.1	(1.0)	402.1	401.6
Operating Expenditure	**129.7**	**133.5**	**(3.8)**	**518.4**	**523.1**	**(4.7)**	**1,558.2**	**1,557.6**
EBITDA	**8.5**	**8.1**	**(0.4)**	**24.6**	**21.0**	**(3.6)**	**72.9**	**73.5**
Depreciation, Amortisation & Financing	5.0	5.4	(0.4)	20.1	21.3	(1.1)	60.3	60.3
Other (gains)/losses including disposal of assets	0.0	6.7	(6.7)	0.0	6.7	(6.7)	0.0	6.7
Share of (profit)/loss of associates/joint ventures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Reported gross Surplus / (Deficit)	**3.4**	**(4.1)**	**(7.5)**	**4.5**	**(7.0)**	**(11.5)**	**12.6**	**6.5**
Add back technical adjustments:								
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital donations/grants net I&E impact	(1.0)	0.1	1.1	(4.0)	0.5	4.5	(12.0)	(12.0)
Remove loss recognised on peppercorn lease disposals	0.0	6.8	6.8	0.0	6.8	6.8	0.0	6.8
Prior period adjustments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
IFRIC 12 scheme adjustments	(0.1)	(0.4)	(0.4)	(0.2)	0.1	0.3	(0.6)	(1.2)
Net benefit of PPE consumables transactions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit) NHS financial performance basis	**2.4**	**2.4**	**0.0**	**0.3**	**0.4**	**0.0**	**0.0**	**0.0**

Please note that the values reported in the above table and throughout the report are subject to rounding

* D&D – drugs and devices.

Summary financial position

Financial targets 26/27	Target metric (£m)	Year-end forecast (£m)	Forecast variance to target (+ve fav) (£m)	In-year performance RAG	Commentary	M04 plan (£m)	M04 actual (£m)	M04 Variance (£m)
1) Deliver break-even financial performance or better - £0 target	0.0	0.0	0.0	Green	The Trust expects to deliver the planned break-even position. Current performance is adverse to plan due to non-recurrent IA impacts of £2.0m in the reported position.	0.3	0.4	0.0
2) Deliver PEP target - £59.2m target	59.2	59.2	0.0	Green	In year performance in line with plan - the average monthly challenges increases by £1.5m for Months 7 to 12.	16.5	16.6	0.1
3) Reduce bank exp. by 10% (£6.0m) from 25/26 M5 inflation adjusted forecast outturn (£59.3m) – £53.35m max. exp. target	53.3	66.3	(12.9)	Red	Current performance is adverse to plan - the forecast outturn based on current run-rate (adjusted for £1.0m n/r IA expenditure extrapolates to a potential additional £12.9m of bank expenditure above the annual target threshold. It is unlikely the Trust will be able to meet this target in 26/27.	17.2	22.9	(5.7)
4) Reduce agency exp. by 30% (£1.1m) from 25/26 M5 inflation adjusted forecast outturn (£3.6m) – £2.47m max. exp. target	2.5	2.7	(0.2)	Amber	Current performance marginally above plan - the forecast outturn based on current run-rate is £0.2m above the annual target threshold.	0.8	0.9	(0.1)

Single Oversight Framework metrics	Target metric	Full year forecast performance		RAG assessment (draft)	Current YTD performance	Estimated score (1 best / 4 worst)
Finance: Planned surplus/(deficit) (£m)	Breakeven or better	0.0	Plan forecast	Green	0.4	1
Finance: Variance year to date to financial plan (£m)	Favourable variance to plan	0.0	Plan forecast	Green	0.0	1
Productivity: Implied productivity (%)	NHSE published M12 YTD 25/26 Implied rate of productivity compared with M12 YTD 24/25	TBC	Review of NHS E dataset - adjusted for non-recurrent expenditure	Green	4.8% (5.4% at M11)	Contextual
Productivity: Implied productivity (%)	Internal forecast M04 YTD 26/27 Implied rate of productivity compared with M04 YTD 25/26	TBC	Review of NHS E dataset - adjusted for non-recurrent expenditure	Green	5.3% (2.1% forecast M03)	Contextual
Relative Cost Difference - National Cost Collection Index (NCCI)	25/26 NCCI score	TBC	25/26 annual publication of NCCI expected in Autumn 2027		106 (24/25 index score)	3 estimated
Finance and productivity domain score (Qtr 4 published score)						1

Key messages

- The Trust is required to deliver several discrete financial targets in 26/27, and these are detailed in the top table. The table includes the target metric, performance against the Trust plan and a forecast for year-end performance. The draft RAG rating considers current performance and how it relates to the target metric.
- Full year performance delivery is on track for targets 1 and 2 but off-track for 3 and 4. The bank expenditure is skewed by £1.0m of IA expenditure and ongoing expenditure to support operational performance.
- In September 2026, NHSE published the first NHS Oversight Framework (NOF) scores, and the second table provides details for the finance and productivity metrics. These metrics are scored on a scale of 1 to 4 with 1 representing the highest performing organisations.
- The latest Quarter 4 NOF publication for Finance and Productivity produced a score of 1 – High performing. The dataset included Quarter 3 Implied Productivity figures as the Quarter 4 data was not available at time of publication.
- The latest NHSE implied productivity data (Month 12) produced a score of 4.8% with 2.7% increase in cost weighted activity and a 2.0% year on year cost reduction. The estimated YTD implied productivity score at Month 04 is 5.3% - with a 4.0% increase in cost weighted activity (outputs) and a 1.3% reduction in relative expenditure (inputs).
- The implied productivity metric will be non-scoring within the NOF in 26/27 – replaced by a new metric that measures 'Relative cost difference' and uses the National Cost Collection Index. This metric is produced annually in the Autumn. The Trust believes that the 25/26 NCCI will be lower than the 24/25 value of 106.

Full Year Plan – key messages

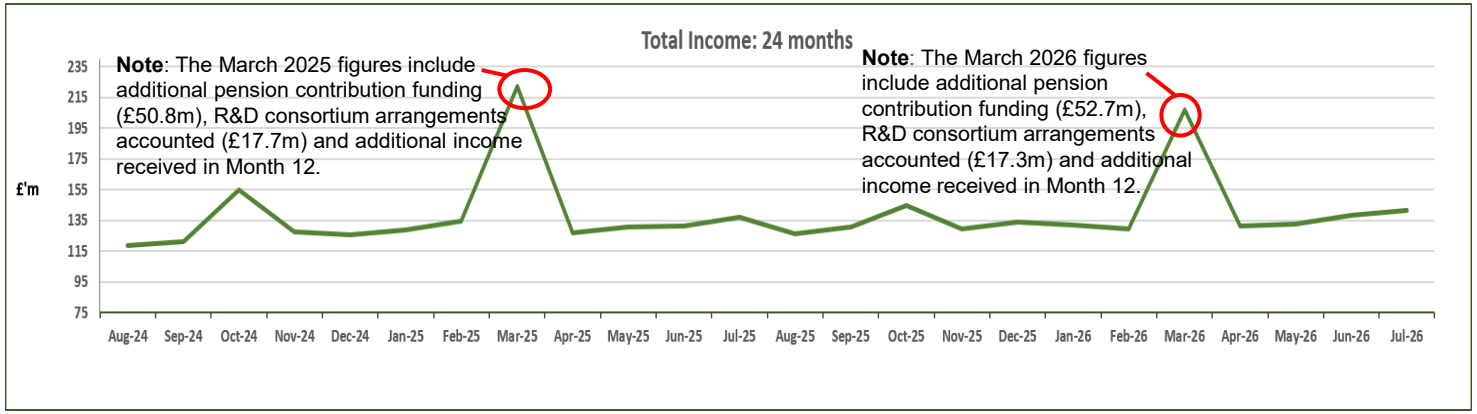
£'m	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	26/27 Total
Operating income from patient care activities	116.9	115.2	119.0	120.2	116.7	119.0	119.0	117.8	116.6	117.9	116.7	117.6	**1,412.6**
Other operating income	18.6	17.2	17.9	17.9	18.1	18.1	18.2	18.3	18.7	18.5	18.5	18.5	**218.5**
Total operating income	**135.5**	**132.4**	**136.9**	**138.1**	**134.8**	**137.2**	**137.3**	**136.1**	**135.4**	**136.3**	**135.1**	**136.1**	**1,631.2**
Employee expenses	(75.0)	(76.9)	(76.0)	(76.1)	(76.1)	(76.2)	(76.2)	(76.2)	(76.6)	(76.6)	(76.6)	(76.6)	**(915.3)**
Operating expenses excluding employee expenses	(59.6)	(55.9)	(57.8)	(57.8)	(57.7)	(57.8)	(57.8)	(57.8)	(57.7)	(57.8)	(57.7)	(57.7)	**(693.0)**
Total operating expenditure	**(134.7)**	**(132.8)**	**(133.8)**	**(133.9)**	**(133.9)**	**(133.9)**	**(134.0)**	**(134.0)**	**(134.4)**	**(134.4)**	**(134.4)**	**(134.4)**	**(1,608.3)**
Operating Surplus/(Deficit)	**0.9**	**(0.4)**	**3.1**	**4.3**	**0.9**	**3.2**	**3.3**	**2.1**	**1.0**	**2.0**	**0.8**	**1.7**	**22.8**
Finance income	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	**3.2**
Finance expense	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	**(8.0)**
PDC dividends payable/refundable	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	**(5.4)**
Net finance costs	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	**(10.2)**
Surplus/(Deficit) for the Period/Year	**0.0**	**(1.2)**	**2.3**	**3.4**	**0.0**	**2.4**	**2.4**	**1.3**	**0.1**	**1.1**	**(0.1)**	**0.8**	**12.6**
Add back technical adjustments:													**0.0**
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Capital donations/grants net I&E impact	(1.0)	(1.0)	(1.0)	(1.0)	(1.0)	(1.0)	(1.0)	(1.0)	(1.0)	(1.0)	(1.0)	(1.0)	**(12.0)**
IFRIC 12 scheme adjustments	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	**(0.6)**
Net benefit of PPE consumables transactions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Surplus/(Deficit) - NHS financial performance basis for the Period/Year	**(1.0)**	**(2.3)**	**1.2**	**2.4**	**(1.0)**	**1.3**	**1.4**	**0.2**	**(0.9)**	**0.1**	**(1.1)**	**(0.2)**	**0.0**

Key messages:

- The Trust plan delivers a 26/27 break-even position on an NHS financial performance basis.
- The table above shows the Trust plan presented in the NHS E reporting format at Month 04. The Trust is unable to change the original phasing of the Surplus/(Deficit) performance by month without formal permission from NHS E. NHS E expects Trusts to update the in-year plans to reflect key changes such as pay awards.
- The position table below reflects the updates to the plan actioned in Month 02. Additional Pay Award income of £14.8m has been modelled to reflect the cost of national settlements above the 2.1% national planning assumptions. Of this £13m is expected from Commissioners to reflect Agenda for Change, Medical pay awards, additional funding for band 5 to 6 nurses, Resident Doctor exception funding and increased funding to reflect HMRC changes to mileage rates. Employee expenses budgets have been increased £10.9m with additional non-pay allocation of £0.5m to cover increases in outsourced FM contracts. A reserve of £3.4m has been created to cover Band 5/6 grading reviews, additional impact of Resident Doctor exception reporting and additional mileage claims.
- Reflecting latest contract expectations, a reduction in expected operating income of £16.5m has been funded through the release of a specific planning risk reserve.
- The planning assumption for the release of £10m of funding from the balance sheet has been fully offset by the removal of £10m of specific expenditure reserves.

£'m	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	26/27 Total
Income from patient activities		(0.6)	(0.3)	(0.2)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(0.3)	(3.3)
Other operating income		(1.4)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(0.7)	(8.2)
Employee expenses		(1.8)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(0.9)	(10.9)
Operating expenses excluding employee expenses		3.8	1.9	1.8	1.9	1.9	1.9	1.9	1.9	1.9	1.9	1.9	22.4
Total plan movement by month		**(0.0)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

£'m	In Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Inpatient spells (EPM)	8.1	8.0	(0.1)	30.7	30.8	0.1
Inpatient day cases (EPM)	8.7	8.8	0.1	31.3	30.9	(0.4)
Outpatient first attendances (EPM)	6.0	6.4	0.4	22.6	21.6	(1.0)
Outpatient procedures & other (EPM)	4.7	4.8	0.1	16.1	16.4	0.3
Unbundled Diagnostics (EPM)	2.7	2.4	(0.3)	5.6	6.3	0.7
Elective variable subtotal	**30.2**	**30.4**	**0.2**	**106.3**	**106.0**	**(0.3)**
UEC blended	25.8	25.8	0.0	105.1	105.3	0.2
Unbundled Radiotherapy	0.8	1.3	0.5	4.4	4.4	0.0
Blended variable subtotal	**26.6**	**27.1**	**0.5**	**109.5**	**109.7**	**0.2**
High-cost drugs and devices income	20.4	19.7	(0.7)	81.8	78.8	(3.0)
Other Clinical Income incl fixed income	41.8	42.2	0.5	168.8	171.4	2.6
Total Clinical Income	**119.0**	**119.4**	**0.5**	**466.4**	**465.9**	**(0.5)**
Devolved Income	19.2	22.2	3.0	76.7	78.2	1.5
Total Trust Income	**138.1**	**141.6**	**3.5**	**543.0**	**544.1**	**1.0**

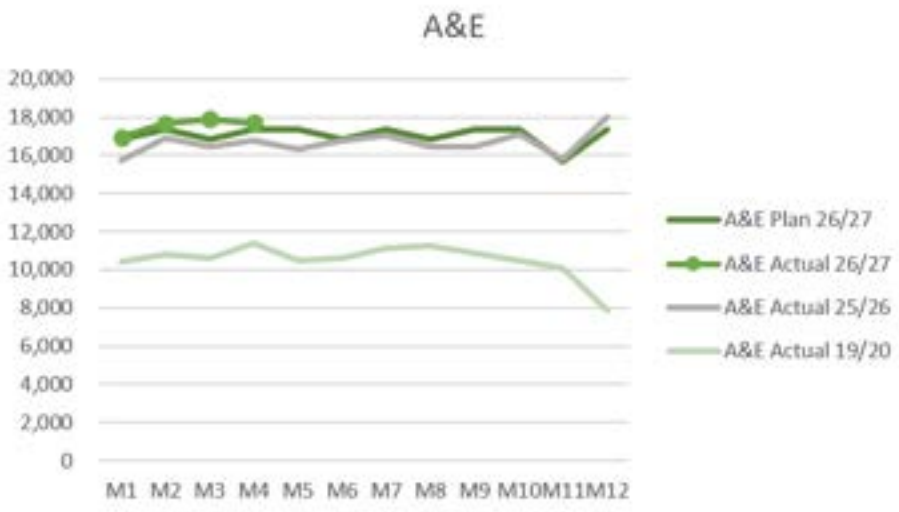


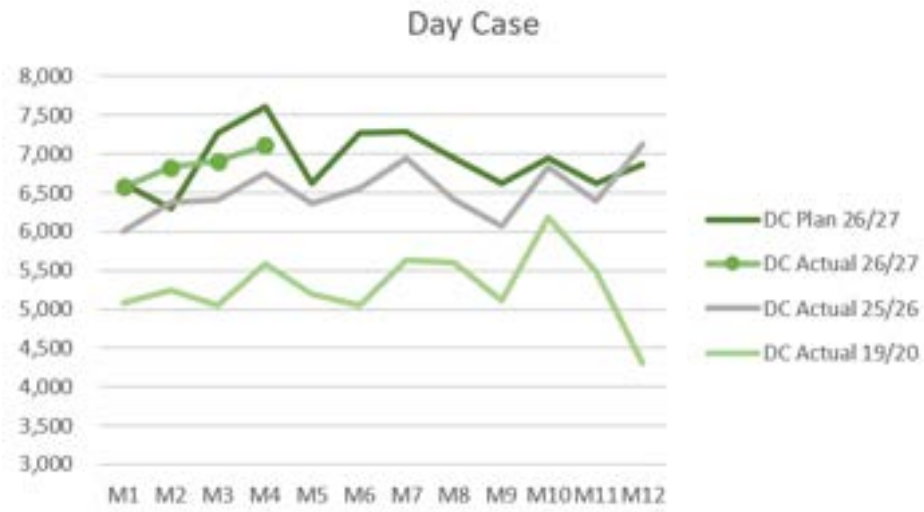
Key messages:

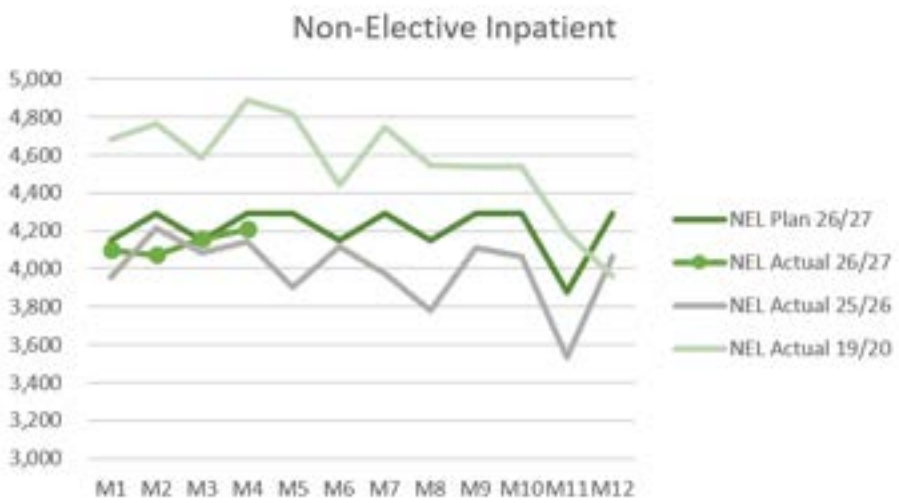
- The Trust income position is favourable to plan by £1.0m year to date with Clinical income adverse to plan by £0.5m and devolved income favourable to plan by £1.5m.
- There is adverse year to date variance of £0.3m for elective variable activity and blended variable is favourable to plan by £0.2m. The Unbundled Diagnostics and Elective variable are included in the EPM performance where the Trust is £0.3m behind plan.
- The clinical income plan reflects the latest view of the contracting position including the additional £13.0m of commissioner income provided for pay awards above the national planning assumptions with additional funding for the national band 5/6 nurses banding review, Resident doctor's exception reporting and national uplifts to mileage claim rates.
- High-cost drugs and devices income from Commissioners is £3.0m adverse to plan in the year to date driven by lower pass-through activity and offsets matching additional expenditure.
- The Devolved income position is favourable to plan by £1.5m and is explained by lower donated income than planned (£4.7m) and lower fire safety works expenditure (£1.0m) offset by R&D income (£4.3m), Education and training (£0.7m) overseas visitors income (£0.8m) following introduction of a new risk-share scheme, Injury cost recovery (£0.1m) and net charging to other organisations (£1.3m) for services and salary recharges.

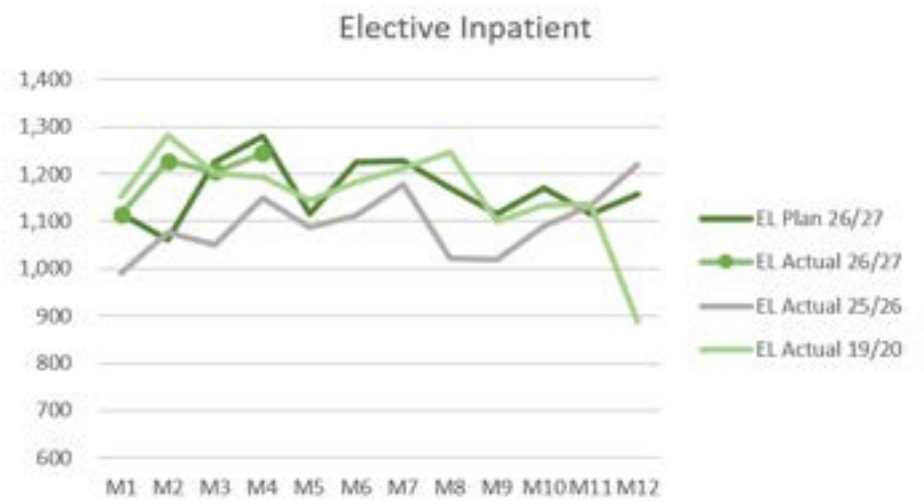
Clinical and other income

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



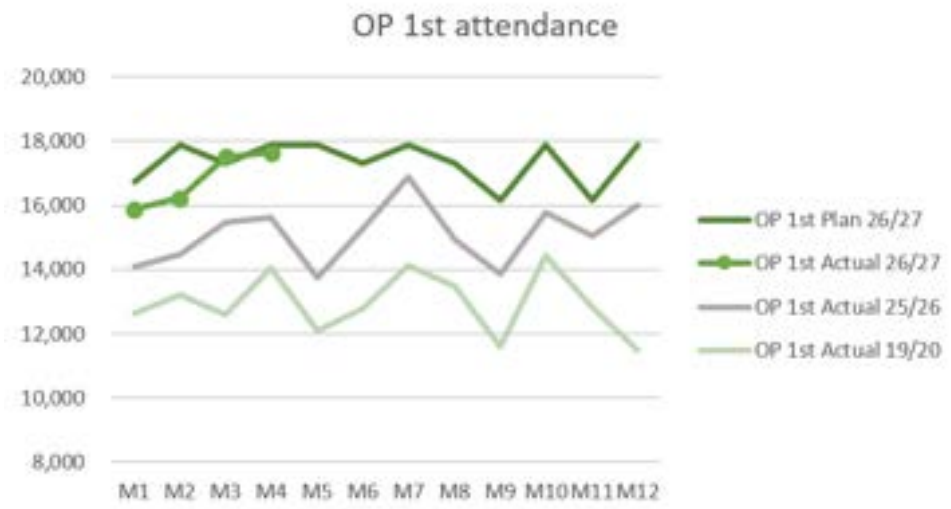


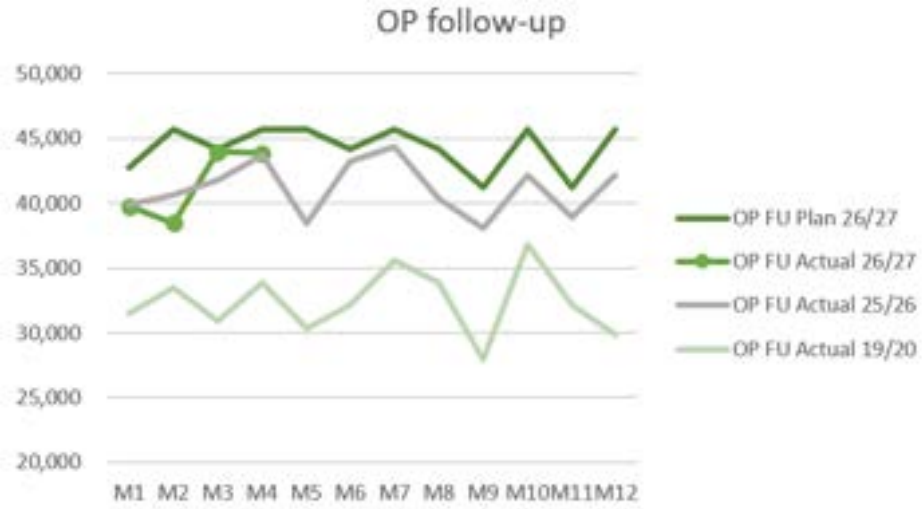


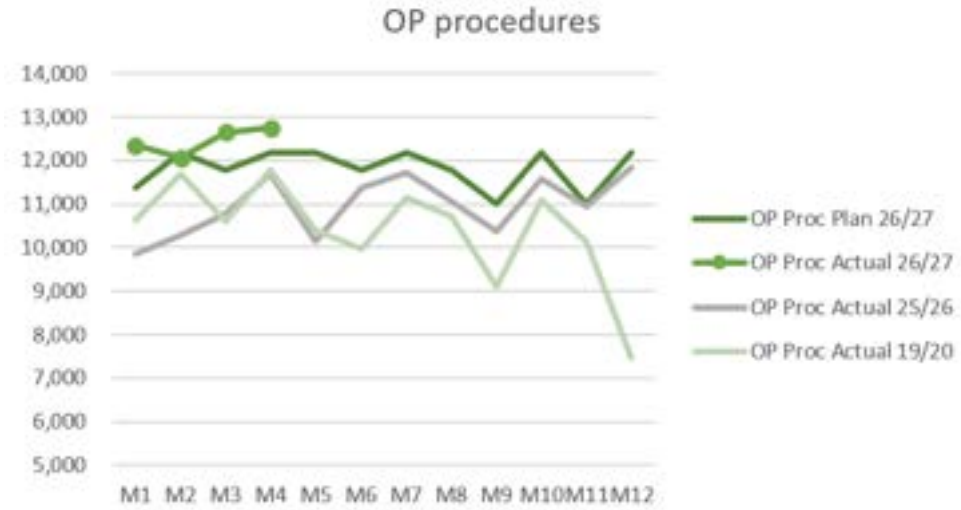


Clinical and other income (continued)

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







Key messages:

At month 04 ytd :

- A&E attendances are 2.6% above plan.
- Non elective spells are 2.1% below plan.
- Elective spells are 2.4% above plan.
- Day cases are 1.3% below plan.
- Outpatient 1st attendances are 3.7% below plan.
- Outpatient follow-up attendances are 6.8% below plan.
- Outpatient procedures are 4.8% above plan.

Clinical Income – Elective Payment Mechanism (EPM)

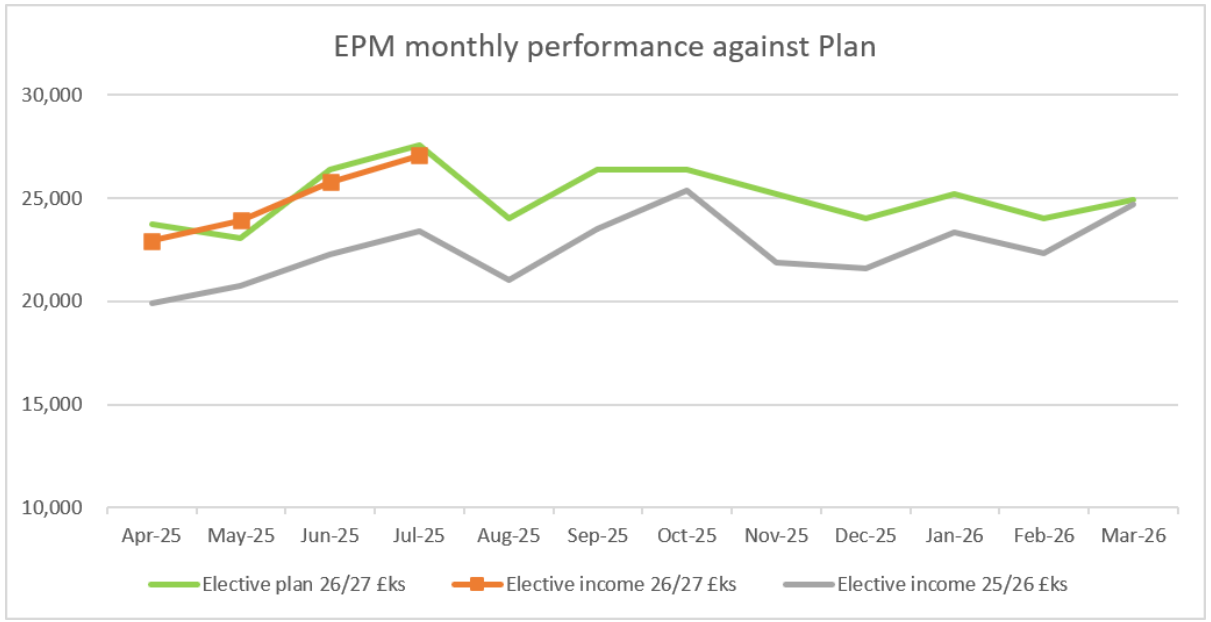
EPM:
Elective activity in 26/27 will continue to be paid on a 'variable' basis, where Trusts are paid on PbR for a selection of activity including Elective Inpatients, Day-cases, Outpatient first attendances, Outpatients procedures and Chemotherapy. Starting in 26/27, Unbundled radiology will also be included in the Variable capture (shown on a separate line below).

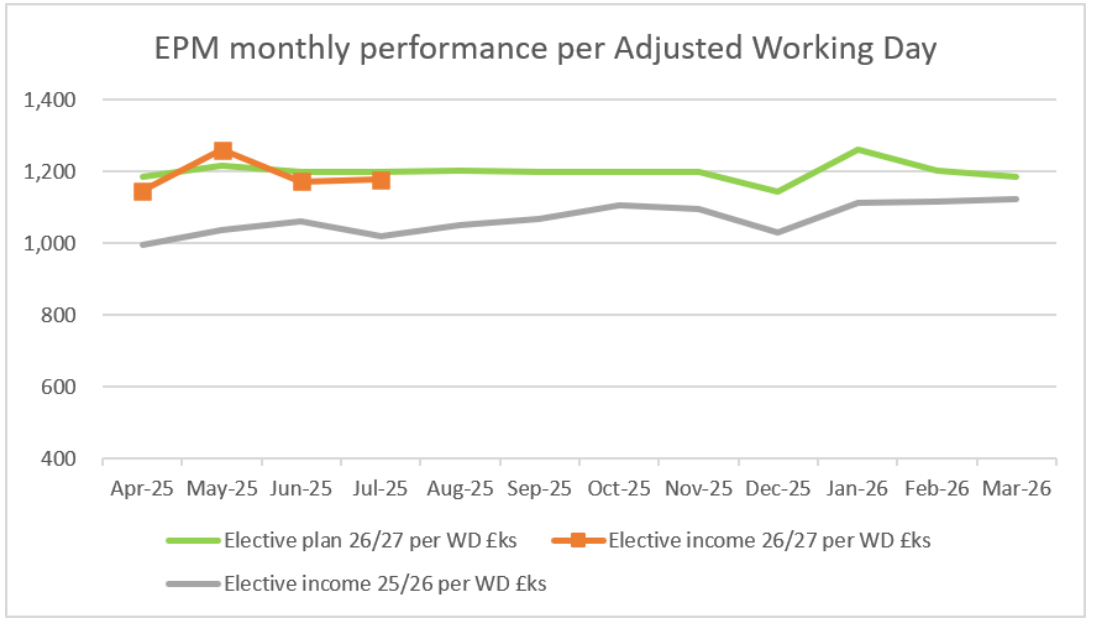
Points to note:

- A national arbitration decision has confirmed that the pricing methodology used by CUH in 25/26 was correct and this should continue to be used in 26/27 whilst other work on pricing is completed.
- At the time of Month 04 reporting, no national performance data has been released.
- Fully coded data together with national performance data enables attribution to commissioner, which will flow from month 5 onwards.
- The Target in the table below is the 24/25 target for reference only.

Elective performance	Month 04 26/27						YTD 26/27					
	Target £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Target £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Trust high level M4 Elective estimate	19.5	28.0	8.5	27.5	28.0	0.5	75.9	99.7	23.8	100.7	99.7	(1.0)
Unbundled Radiology (Diagnostics)				2.7	2.4	(0.3)				5.6	6.3	0.7
Total	**19.5**	**28.0**	**8.5**	**30.2**	**30.4**	**0.2**	**75.9**	**99.7**	**23.8**	**106.3**	**106.0**	**(0.3)**

Clinical Income – Elective Payment Mechanism (EPM) Monthly View



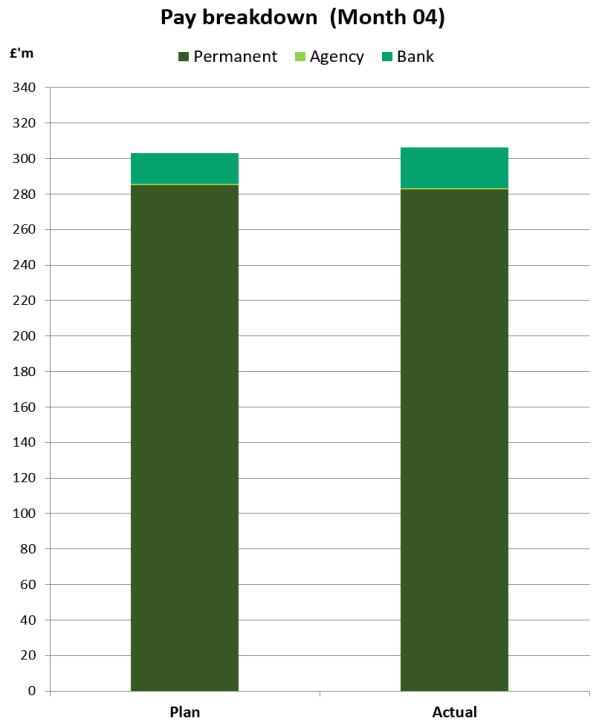


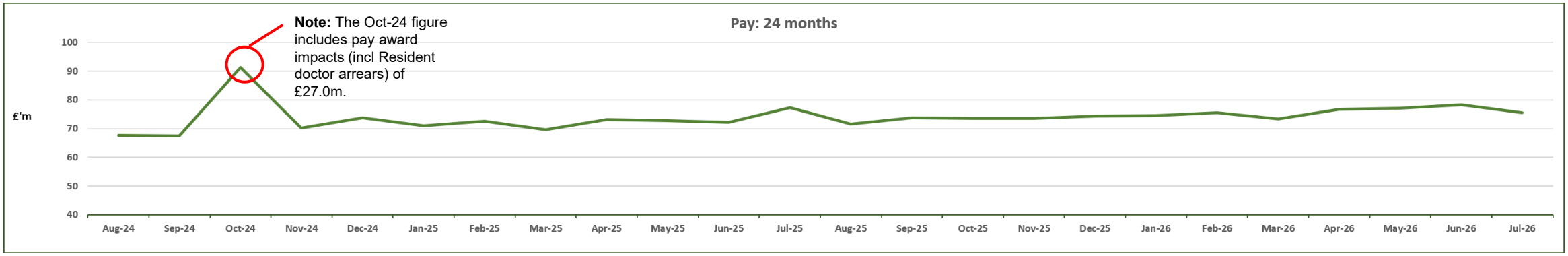
The graphs above detail both the monthly variable elective income performance values and those values per average working day, to highlight the change in average productivity required to achieve our plan. As stated on the previous slide, the plan is currently using submitted FPR values, and disputed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

Elective Payment Mechanism (continued)

Key messages:

- The Trust pay position is £3.5m adverse to budget at Month 04. This is driven by £1.0m of non-recurrent bank costs for IA and estimated financial impact of the Easter and May bank holidays (£0.3m) plus additional costs connected with supporting operational delivery and delayed delivery of Pay PEP schemes (£0.9m).
- Medical and Dental and Agenda for Change budgets have been uplifted by £6.8m and £4.0m respectively to reflect the additional costs above the national pay award planning assumption of 2.1%.
- The Trust has two specific financial targets linked to the Agency and Bank expenditure. The Trust is required to reduce Agency expenditure by 30% and Bank expenditure by 10% compared to the 25/26 Month 05 forecast outturn adjusted for pay inflation.
- Month 04 bank expenditure is £5.7m above plan. The variance includes £1.0m of forecast industrial action costs. The current year-to-date run rate, adjusted for IA costs, could indicate a potential full-year overspend of £12.9m if sustained. Reducing bank expenditure towards planned levels remains a key requirement for achieving the Trust's PEP and full-year financial plan.
- Agency expenditure is marginally above plan at Month 04 and maintaining current expenditure would result in the NHS E cap being exceeded by c£0.2m.
- Performance against all financial targets is reported on page 8.





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

Pay expenditure – trend and year to date

Pay - Staff group

£ Millions	In Month Budget	In Month Actual	In Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance
Administrative & Clerical & Ancillary	11.8	11.8	0.0	47.3	45.9	1.4
Allied Healthcare Professionals	4.6	4.5	0.1	18.3	22.8	(4.5)
Clinical Scientists & Technicians	6.8	7.0	(0.2)	27.2	23.5	3.7
Medical and Dental	25.9	25.2	0.7	103.6	105.8	(2.2)
Nursing	26.6	26.6	0.0	106.5	108.1	(1.7)
Other Pay costs	0.3	0.4	(0.1)	1.2	1.4	(0.2)
Total Pay Cost	**76.1**	**75.5**	**0.6**	**304.1**	**307.6**	**(3.5)**

Pay - Employee type

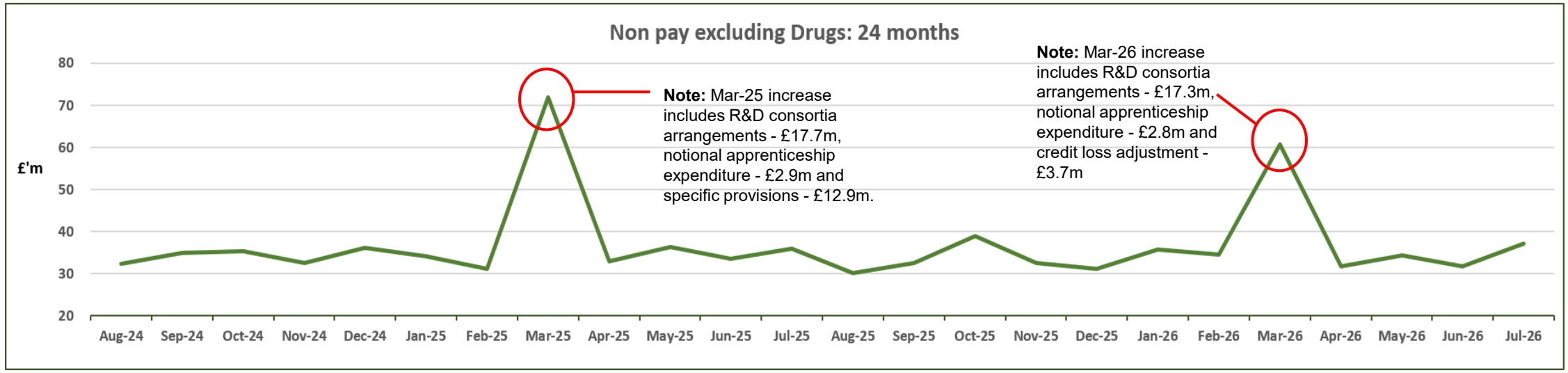
£ Millions	In Month Budget	In Month Actual	In Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance
Agency	0.2	0.2	(0.0)	0.8	0.9	(0.1)
Bank	4.3	5.0	(0.7)	17.2	22.9	(5.7)
Permanent	71.3	69.9	1.4	284.8	282.4	2.4
Other Pay costs	0.3	0.4	(0.1)	1.2	1.4	(0.2)
Total Pay Cost	**76.1**	**75.5**	**0.6**	**304.1**	**307.6**	**(3.5)**

Key messages:

- Pay expenditure is £3.5m adverse to plan at Month 04 driven by Medical and Dental, Nursing expenditure and Allied Health Professionals (AHP) with favourable variances are reported for Clinical Scientists and Technicians (CS&T) and Administrative & Clerical and Ancillary staff (A&C&A).
- The budget allocation between AHPs and CS&T will be reviewed as the new Chart of Accounts has a different allocation model for these staff groups.
- The pay budgets reflect the national pay awards above the 2.1% planning assumption. For Agenda for change staff the budgets were uplifted by £6.8m for the full year to reflect the additional 1.2% pay settlement which was paid in Month 01. For Medical and Dental staff the final settlement was 3.5% meaning an additional £4.0m of budget has been allocated with staff receiving their pay uplift in the Month 03 payroll.
- Waiting List Initiative expenditure averaged £245k for Months 02 to 04 months compared to £362k average spend in 25/26.
- Agency spend in month represents 0.3% of Trust wide pay expenditure and is below the comparable expenditure level in 25/26 of 0.4% and 0.6% in 24/25. A straight-line forecast indicates expenditure could be £0.2m above the NHS E expenditure ceiling of £2.5m at year-end.
- Bank expenditure is adverse to budget by £5.7m - the position includes non-recurrent Consultant bank expenditure driven by elements of the Industrial Action charged to bank (£1.0m) alongside additional costs to support operational performance.
- Total bank expenditure (including IA) is 7.4% of total pay expenditure which is 0.6% higher than 25/26 full year performance but lower than the 24/25 average of 8.5%.
- Extrapolating the Month 04 year to date expenditure suggests the Trust would significantly exceed the national bank ceiling of £53.35m.

NHS CUH

Pay expenditure (continued)



Key messages:

- At Month 04 the Trust is reporting an adverse non-pay of variance of £1.1m year to date. The in-month movement is largely driven by additional R&D related expenditure (£3.2m) which is fully offset by income. The position includes £0.5m of non-recurrent expenditure relating to credit loss provision movement and a £0.8m timing benefit for the planned clinical negligence rebate offsetting non-recurrent expenditure relating to technical adjustments to employment related provisions (£0.2m) and additional expenditure for the). These items support the overall financial position.
- There are significant favourable variances for Goods and Services (£5.0m), Premises costs (£3.2m) and clinical negligence (£0.8m) following receipt of annual rebate, offset by adverse movements in credit loss (£0.5m), drugs (£0.1m), all other non pay (£9.5m) including purchase of healthcare from other non-NHS providers (£1.4m). This category includes PEP savings target (£5.6m) as well as significant expenditure that previously was budgeted for in one category is now being reported in a different one. Work is being undertaken to understand the impact of the changes and realign the budgets where necessary.
- The position includes £0.6m of additional budget has been allocated to recognise contractual uplifts for outsourced contracts where staff are employed on NHS terms and conditions.

£millions	In Month			Year to Date		
	Budget	Actual	Variance	Budget	Actual	Variance
Supplies and services	19.2	19.7	(0.5)	76.8	71.8	5.0
Drugs	20.1	20.9	(0.8)	80.3	80.4	(0.1)
Premises	8.0	13.7	(5.7)	31.9	28.8	3.2
Movement in credit loss on receivables	0.0	0.8	(0.8)	0.0	0.5	(0.5)
Clinical negligence	2.4	2.6	(0.1)	9.7	8.9	0.8
All other non pay	3.9	0.5	3.5	15.6	25.2	(9.5)
Total Non Pay	**53.6**	**58.0**	**(4.4)**	**214.3**	**215.5**	**(1.1)**

Key messages:

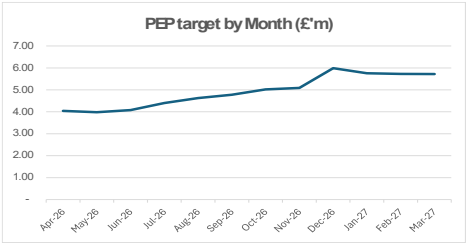
- The non pay position has an adverse variance of £1.1m and is driven by large favourable variances for Supplies and Services, Premises, Clinical negligence rebate offset by adverse movements in credit loss, drugs offset by adverse variance for all other types of non pay.
- There is expected to be continued volatility in the coding of expenditure during following the implementation of the new finance system and associated chart of account meaning items of expenditure that previously were reported against Goods and Services is now being classified under the 'All other non pay' category. Work is being undertaken to realign the budgets and expenditure where required.
- Year to date drugs expenditure position is adverse to plan by £0.1m year to date and relates to pass-through expenditure that is recoverable from commissioners. Work continues to ensure all income and drugs expenditure is being captured accurately following the recent Epic pharmacy system upgrades. As in previous years we expect there to be future fluctuations in expenditure from month to month due to supply and billing processes for homecare drug alongside the introduction of newly commissioned drugs.

2026/27 in year PEP delivery status and profile

Trust Efficiency status - NHS E reported	Position at Month 04 Plan £'m	Actual £'m	Variance £'m	Year end forecast £'m
Fully developed	4.2	33.7	29.5	59.2
Plans in progress	31.8	18.3	(13.5)	0.0
Opportunity	23.2	7.3	(15.9)	0.0
Unidentified	0.0	0.0	0.0	0.0
Total PEP	**59.2**	**59.3**	**0.1**	**59.2**

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

PEP plan - increasing challenge	Plan £'m
M01 PEP plan	4.0
M02 PEP plan	4.0
M03 PEP plan	4.1
M04 PEP plan	4.4
Qtr 2 average monthly PEP plan	4.6
Qtr 3 & 4 average monthly PEP plan	5.5



Key messages:

- The Trust has an efficiency target of £59.2m, of which the Trust plans to deliver £25.1m via cost reduction PEP.
- The tables provide additional information showing the delivery status of the PEP schemes – this is based on the NHS E reporting algorithm whereby if an initiative has a saving recorded against it in the current or previous month it is recognised as 'fully developed'. If a scheme has savings identified for future months, it is categorised as 'plans in progress'. At Month 04 schemes described as 'fully developed' total £33.7m – an increase of £3.4m from the Month 03 position.
- The plan profile shows an increase in efficiency required across the year with 43% delivered in quarters 1 and 2 and 57% in Quarters 3 and 4. At Month 04 the PEP required £4.4m of savings to be delivered. The target rises to a monthly average of £4.6m for Months 04 to 06 and £5.5m for Months 07 to 12.
- Productivity initiatives are focussed on increasing elective activity, outpatient capacity, maximising theatre utilisation and reducing length of stay. Productivity scheme development and delivery will be reviewed by the Productivity Board.
- NHSE have published guidance on how productivity improvements will be measured using cost weighted activity (CWA). The Trust has developed processes to ensure that this information can be analysed, and opportunity insights acted upon. This work continues to supports the Trust's delivery of sustainable productivity improvements into 26/27 building on the improvements seen in 25/26.
- At a Trust level, the estimated performance for Month 04 year to date is a 5.3% increase in productivity compared to 25/26 Month 04. This figures includes 4.0% increase in CWA and a 1.3% decrease in relative expenditure (inputs).

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

Trust PEP performance - NHS E reported	Current Month			Year to date			Full year forecast				
	Plan £'m	Actual £'m	Variance £'m	Plan £'m	Actual £'m	Variance £'m	Plan £'m	Actual £'m	Variance £'m	FYE plan £'m	FYE forecast £'m
Recurrent											
Pay	1.9	0.9	(1.1)	7.0	3.4	(3.6)	27.2	24.4	(2.8)	32.8	33.0
Non pay	1.9	0.4	(1.6)	7.3	1.6	(5.7)	22.0	15.5	(6.5)	22.6	21.5
Income	0.0	0.1	0.1	0.0	0.4	0.4	0.0	0.5	0.5	0.0	0.2
Total recurrent PEP	**3.9**	**1.3**	**(2.5)**	**14.3**	**5.3**	**(9.0)**	**49.2**	**40.5**	**(8.7)**	**55.4**	**54.8**
Non recurrent											
Pay	0.0	1.4	1.4	0.0	2.7	2.7	0.0	2.7	2.7	0.0	0.0
Non pay	0.0	0.8	0.8	0.0	4.6	4.6	0.0	5.4	5.4	0.0	0.0
Income	0.5	0.8	0.3	2.2	4.0	1.8	10.0	10.6	0.6	0.0	0.0
Total non-recurrent PEP	**0.5**	**3.1**	**2.6**	**2.2**	**11.2**	**9.1**	**10.0**	**18.7**	**8.7**	**0.0**	**0.0**
Total PEP	**4.4**	**4.4**	**0.0**	**16.5**	**16.6**	**0.1**	**59.2**	**59.3**	**0.1**	**55.4**	**54.8**

Division (£'m)	In Month			Year to date			Year-end forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Division A	0.2	0.2	0.0	0.8	0.8	0.0	1.0	1.0	0.0
Division B	0.3	0.3	0.0	1.3	1.4	0.0	2.9	3.0	0.1
Division C	0.1	0.1	0.0	0.6	0.6	(0.0)	1.6	1.7	0.1
Division D	0.3	0.3	0.1	1.0	1.2	0.2	2.1	2.3	0.2
Division E	0.1	0.1	(0.0)	0.5	0.5	0.0	0.9	0.9	(0.0)
Corporate	1.0	1.0	0.0	4.2	4.4	0.1	11.1	11.7	0.6
Trust Wide	0.3	(0.1)	(0.4)	1.3	(1.8)	(3.1)	5.5	4.5	(1.0)
External plan phasing alignment	(1.0)	(1.3)	(0.3)	(4.5)	0.0	4.5	0.0	0.0	0.0
Total cost reduction	**1.3**	**0.7**	**(0.6)**	**5.1**	**6.9**	**1.8**	**25.1**	**25.1**	**0.0**
Productivity schemes	3.1	3.7	0.6	11.4	9.7	(1.7)	34.1	34.1	0.0
Total Productivty	**3.1**	**3.7**	**0.6**	**11.4**	**9.7**	**(1.7)**	**34.1**	**34.1**	**0.0**
Total PEP	**4.4**	**4.4**	**(0.0)**	**16.5**	**16.6**	**0.1**	**59.2**	**59.2**	**0.0**

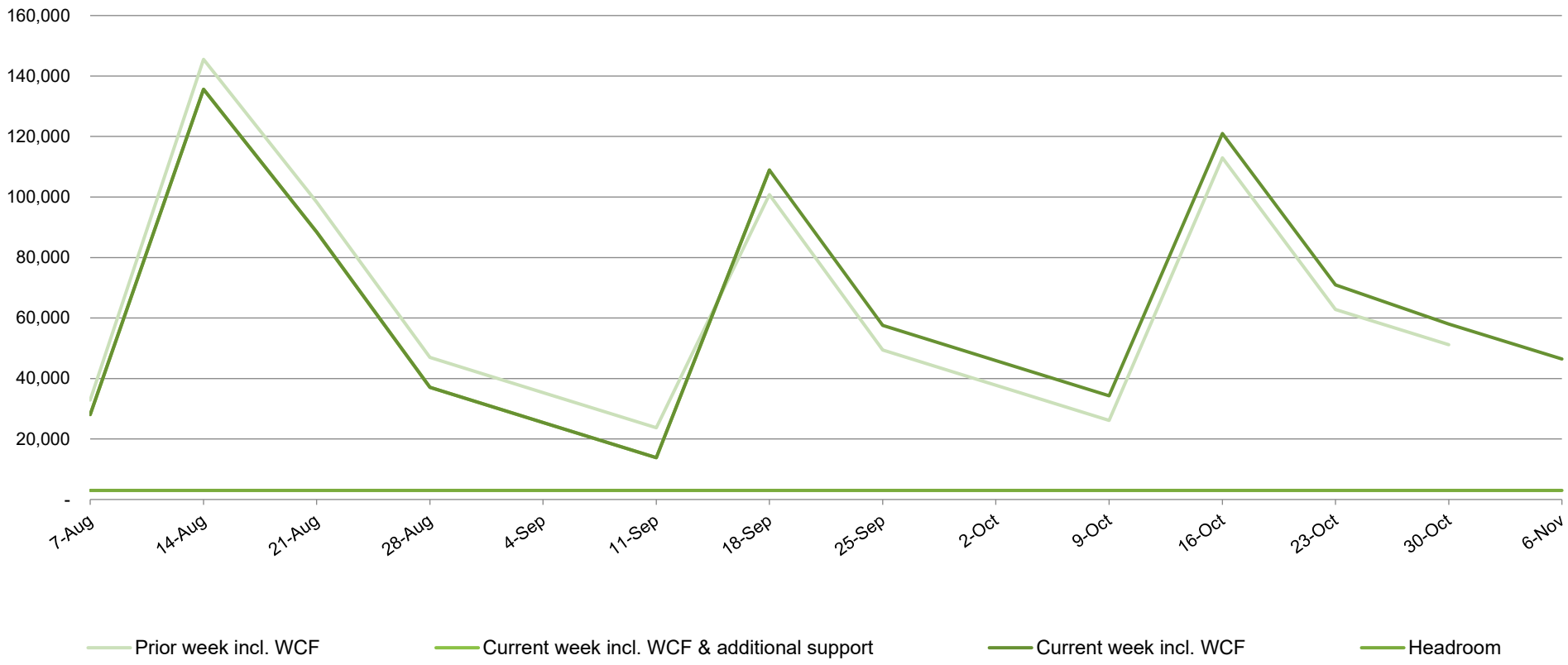
Key messages:

- PEP performance at Month 04 is in line with the plan.
- The Trust has identified an additional £9.1m of non-recurrent PEP schemes compared to the original plan, offsetting the recurrent schemes that are £9.0m behind the plan.
- Cost reduction schemes are £1.8m ahead of plan offsetting the adverse variance of £1.8m for Productivity schemes which is driven by lower delivery of new schemes and the impact of IA on both volume and case-mix of activity.
- The PEP performance table includes a phasing alignment adjustment and shows that link between the current internal plan and the NHS E monitored external plan.
- At Month 04 the Trust is reporting a gap of £2.0m in identified scheme values for cost reduction schemes (£2.3m at Month 03) and efforts will be focused on closing the gap.
- The Trust is focused on delivering the 26/27 plan on a recurrent basis and expects that as schemes are identified and delivered across the year, the level of recurrent schemes will increase as confidence in scheme delivery increases.
- As indicated on the previous page the level of challenge contained within the plan increases in future months so whilst Month 04 year to date performance appears to be on track this performance it is driven by higher non-recurrent scheme delivery (£9.0m) and masks £1.0m of lower productivity benefits than planned (£2.4m at Month 03).

2026/27 in year PEP performance by scheme category

NHS E Scheme categorisation	Year to Date (£k)			Forecast outturn (£k)		
	Plan	Actual	Variance	Plan	Forecast	Variance
Pay Efficiencies						
Pay - Agency - reduce the reliance on agency	136	0	(136)	408	272	(136)
Pay - Establishment reviews	1,265	2,316	1,051	5,821	8,062	2,241
Pay - E-Rostering / E-Job Planning	40	10	(30)	3,120	2,890	(230)
Pay - Corporate services transformation	440	961	521	4,566	6,045	1,479
Pay - Digital transformation	40	0	(40)	120	80	(40)
Pay - Clinical Service re-design	5,098	2,786	(2,311)	13,165	9,776	(3,389)
Pay - Other	0	0	0	0	0	0
Pay - Unidentified	0	0	0	0	0	0
Total Pay	**7,019**	**6,073**	**(945)**	**27,200**	**27,125**	**(75)**
Non-pay Efficiencies						
Non-Pay - Medicines efficiencies	1,116	332	(784)	3,348	2,564	(784)
Non-Pay - Procurement (excl drugs) - non-clinical directly achieved	144	632	488	509	1,036	527
Non-Pay - Procurement (excl drugs) - non-clinical through NHS Supply Cha	96	20	(76)	288	236	(52)
Non-Pay - Procurement (excl drugs) - MDCC directly achieved	136	27	(109)	408	299	(109)
Non-Pay - Procurement (excl drugs) - MDCC through NHS Supply Chain	100	52	(48)	300	252	(48)
Non-Pay - Estates and Premises transformation	37	939	902	123	1,358	1,235
Non-Pay - Fleet optimisation	0	0	0	0	0	0
Non-Pay - Pathology & imaging networks	36	4	(32)	108	76	(32)
Non-Pay - Net zero carbon	20	4	(16)	60	44	(16)
Non-Pay - Corporate services transformation	0	5	5	0	13	13
Non-Pay - Digital transformation	24	421	397	72	735	663
Non-Pay - Clinical Service re-design	5,600	3,708	(1,892)	16,782	14,321	(2,461)
Non-Pay - Other (balance - please provide description)	0	3	3	0	27	27
Non-Pay - Unidentified	0	0	0	0	0	0
Total Non-Pay	**7,309**	**6,147**	**(1,162)**	**21,998**	**20,961**	**(1,037)**
Income Efficiencies						
Income - Private Patient	0	7	7	0	14	14
Income - Non-Patient Care	2,172	4,142	1,970	10,000	10,860	860
Income - Other	0	183	183	0	294	294
Total Income	**2,172**	**4,332**	**2,160**	**10,000**	**11,168**	**1,168**
Total PEP (Productivity and cash-releasing)	**16,500**	**16,552**	**53**	**59,198**	**59,254**	**55**

CUH 13 week rolling cash flow forecast (£000)



Key messages:

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

Appendices

Month 4 capital expenditure position

	Year To Date (month 4)			Full year		
	Budget	Actuals	Variance	Budget	Forecast	Variance
	£m	£m	£m	£m	£m	£m
Developments	0.5	0.4	(0.0)	3.1	3.3	0.2
Digital	1.1	0.1	(1.0)	6.8	5.4	(1.4)
Backlog Maintenance	2.8	1.4	(1.4)	14.0	14.2	0.2
Estates staff costs	0.8	0.7	(0.1)	2.6	2.6	-
Decarbonisation	0.0	0.0	-	1.5	1.5	-
Replacement Equip	3.5	2.4	(1.2)	18.5	18.2	(0.3)
In year approvals	1.1	0.5	(0.5)	2.9	2.3	(0.6)
CCRH	7.4	5.7	(1.7)	22.1	22.1	-
CCH	3.8	3.7	(0.1)	11.3	11.3	-
New Acute Hospital	0.4	0.0	(0.4)	0.4	0.4	-
RtCS - CCE	0.4	-	(0.4)	2.1	2.1	(0.0)
RtCS - MIU	0.1	-	(0.1)	0.5	0.5	-
RtCS - PAU	0.1	-	(0.1)	0.5	0.5	-
Leases	0.7	0.8	0.1	2.1	2.1	-
Corporate	1.1	1.9	0.8	(1.1)	0.9	2.0
Total	**23.7**	**17.7**	**(6.1)**	**87.4**	**87.4**	**-**

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

Key issues/notes YTD

In month spend was markedly below budget, increasing the underspend to £6.1m YTD. We continue to expect to deliver spend in line with budget over the year.

Key issues/notes forecast

The budget value of £87.4m is markedly lower that the actual spend in 25/26. We have budgeted for the receipt of external funding from the Returning to Constitutional Standards (RtCS) and Estates Safety Fund (ESF) schemes. We have not yet received MoU for these, but continue to work towards getting them.

Compared to last month's annual budget of £85.9m we have;
- had confirmation of solar panel funding of £1.5m and
- further charitable funding of £0.1m (split between the Li Ka Shing foundation and the Addenbrooke's Liver Transplant Association ALTA)

Capital expenditure by programme

Balance sheet

	M4 Actual £m
Non-current assets	
Intangible assets	21.9
Property, plant and equipment	619.0
Total non-current assets	**640.9**
Current assets	
Inventories	15.6
Trade and other receivables	148.4
Cash and cash equivalents	40.8
Total current assets	**204.8**
Current liabilities	
Trade and other payables	(219.8)
Borrowings	(14.7)
Provisions	(5.4)
Other liabilities	(77.3)
Total current liabilities	**(317.2)**
Total assets less current liabilities	**528.5**
Non-current liabilities	
Borrowings	(112.5)
Provisions	(3.9)
Total non-current liabilities	**(116.4)**
Total assets employed	**412.1**
Taxpayers' equity	
Public dividend capital	751.3
Revaluation reserve	51.5
Income and expenditure reserve	(390.7)
Total taxpayers' and others' equity	**412.1**

Balance sheet commentary at Month 04

- The balance sheet shows total assets employed of £412.1m.
- Non-current liabilities at Month 04 are £112.5m. Cash balances at Month 04 total £40.8m.
- The balance sheet includes £4.3m of resource to support the completion of the remedial fire safety works expected to be deployed over the coming years.

Monthly Nurse Safe Staffing

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Sponsoring executive director: Lorraine Szeremeta Chief Nurse

Amanda Small Deputy Chief Nurse

Carla Daly Lead Nurse for safer staffing

Board of Directors: Aug 2026

	Target	April 2026	May 2026	June 2026	Variance	Commentary
Vacancy rate for Registered nurses (excl. midwife) (bands 5, 6, 7)	<5%	5.6%	5.2%	4.7%		Vacancy for Registered nurses has fallen this month and is below the target of 5%. Turnover has remained static this month to 6%
Vacancy rate for Registered midwives (bands 5, 6, 7)	<5%	5.1%	4.9%	6.2%		Vacancy for Registered midwives has increased this month however there is a large cohort of students qualifying imminently. Turnover has also increased to 8.1%.
Vacancy rate for registered children's nurses (RSCN) across the Trust (not just within Div E)	<5%	9.4%	10.0%	11.1%		Vacancy for Registered Children's nurses has increased this month. Turnover has remained static at 7.7%.
Vacancy rate for MSW (bands 2, 3, 4 in clinical services only)	<5%	19.7%	19.2%	20.5%		Vacancy for maternity support workers has increased this month and remains an area of concern, recruitment remains ongoing with a good pipeline. Turnover has increased to 17.5%
Vacancy rate for HCSW (excl MSW) (bands 2, 3, 4 in clinical services only)	<5%	6.8%	7.8%	9.4%		Vacancy for healthcare support workers has increased this month and remains an area of concern, recruitment remains ongoing. Turnover has increased to 20.6%
Vacancy rate for AHPs	<5%	6.5%	6.2%	5.4%		Vacancy for Allied health professionals has decreased this month. Turnover has also decreased to 8.1%
Planned verses actual staffing	**Target**	**April 2026**	**May 2026**	**June 2026**	**Variance**	**Commentary**
Number of wards reporting <90% overall rota fill	0	2	1	1		The number of areas reporting overall fill rate <90% rota fill in June has remained static at 1. Appendix 1 details the exception reports for Division E as the only division reporting overall fill rates of <90%.
Midwifery and MSW fill rate	90%	93.5%	94.4%	94.6%		The overall fill rate within midwifery has increased to 94.6%. This is the highest it has been for the previous 6 months and has remained above the target of 90%. The lowest overall fill rate has been seen in Sara Ward which has been mitigated through redeployment of staff where required, to meet acuity needs.
Total unavailability of the Nursing and Midwifery workforce	22%	27%	22%	24%		Total unavailability of working time in June has increased slightly to 24%. The majority of unavailability (13.69%) was due to planned annual leave.

Staff deployment	April 2026	May 2026	June 2026	Variance	Commentary
Number of Substantive staff redeployed in month to support safe staffing (average hours redeployed per day)	308	237	321		The number of substantive staff redeployed has increased in month with an average of 321 hours redeployed per day. This equates to 28 long day or night shifts per day. Due to a number of areas being over established and increased capacity in the organisation, it has been necessary to redeploy staff on a shift by shift basis however as sickness absence, vacancy and turnover improves, it is expected that the number of hours redeployed will be a decreasing trend.
Care hours per patient day (CHPPD)	9.2	9.3	9.3		Care hours per patient day (CHPPD) is the total number of hours worked on the roster (clinical staff including AHPs) divided by the bed state captured at 23.59 each day. CUH CHPPD has remained at 9.3 in June. This is aligned with the latest data from the Shelford group at 9.3 hours. In maternity CHPPD is at 6.86 (8.04 in May). From 1 April 2021, the total number of patients now includes babies in addition to transitional care areas and mothers who are registered as a patient.
Safety and risk	April 2026	May 2026	June 2026	Variance	Commentary
Nurse staffing red flags reported	143	53	77		There has been an increase this month in the number of red flags reported from 53 in May to 77 in June. The highest red flag reported is for unmet 1:1 specialling at 30.
Maternity red flags reported	113	92	134		There has been an increase in the number of maternity red flags this month from 92 in May to 134 in June. The highest of these, 48 (73%)had a delay of 6 hours or more in transfer to the delivery unit during induction of labour once ARM is indicated.
Staffing incidents reported	43	39	50		There has been a decrease in Safety Learning Reports (SLRs) completed in relation to nurse staffing in the month of May to 39 compared to April which had 43 incidents. Division A reported 8 incidents, Division B reported 2 incidents, Division C reported 10 incidents, Division D reported 13 incidents and Division E reported 17 incidents.

Appendix 1. Exception report by Division

Division E exception report for <90% fill rate

Jun-26	Unit	Speciality	% fill registered	% fill care staff	Overall filled %	CHPPD	Analysis of gaps	Impact on Quality / outcomes	Actions in place
E	Sara Ward	501 - OBSTETRICS	**88%**	**80%**	**86%**	**5.60**	MSW vacancy reducing PIPELINE in continues. Recruitment day planned for Sept 2026 current vacancy 3.2 wte Training bank HCAs to gain competencies for MCA role. Midwifery vacancy 26 wte interviews commencing for student Midwives and national advert for band 5 & 6s being advertised imminently.	Staffing reviewed to ensure safe care, Staff moved within service to provide safe staffing.	Staffing reviewed to ensure safe care, Staff moved within service to provide safe staffing.

Appendix 2. Staffing compliance with critical care staffing guidance

Adult critical care – compliance with Guidelines for the provision of intensive care services (GPICS)	
Number of breaches of 1:1 care for level 3 patients	0 (0 in May)
Number of breaches of side room co-ordinator	12 (0 in May)
Neonatal critical care	
Percentage of breaches of British Association of Perinatal Medicine (BAPM) staffing standards	8.33% (14.52% in May)
Number of occasions NICU closed due to staffing	0 (0 in May)
Paediatric critical care	
Number of breaches of Paediatric critical care society (PICS) staffing standards	0 (↔ 0 in May)
Number of occasions PICU closed due to staffing	0 (↔ 0 in May)

SPC Icon Keys

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

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

SPC key taken from Oxford University Hospitals Integrated Report

Monthly Nurse Safe Staffing

Cambridge University Hospitals NHS Foundation Trust

Together
Safe
Kind
Excellent

Sponsoring executive director: Lorraine Szeremeta Chief Nurse

Amanda Small Deputy Chief Nurse

Carla Daly Lead Nurse for safer staffing

Board of Directors: September 2026

	Target	May 2026	June 2026	July 2026	Variance	Commentary
Vacancy rate for Registered nurses (excl. midwife) (bands 5, 6, 7)	<5%	5.2%	4.7%	5.2%		Vacancy for Registered nurses has increased this month and is slightly above the target of 5%. Turnover has remained static at 6% for the third month in a row.
Vacancy rate for Registered midwives (bands 5, 6, 7)	<5%	4.9%	6.2%	5.8%		Vacancy for Registered midwives has decreased this month but remains above the target however, there is a strong pipeline with a large cohort of students qualifying imminently. Turnover has also increased to 8.5%.
Vacancy rate for registered children's nurses (RSCN) across the Trust (not just within Div E)	<5%	10.0%	11.1%	12.3%		Vacancies for Registered Children's Nurses have increased this month, alongside an increase in turnover to 8.4%. Targeted work is underway within C2 and PICU to better understand the recruitment and retention challenges affecting these areas, with support in place to identify and implement actions to mitigate workforce risks.
Vacancy rate for MSW (bands 2, 3, 4 in clinical services only)	<5%	19.2%	20.5%	14.6%		Vacancy for maternity support workers has decreased this month but remains an area of concern, recruitment remains ongoing with a good pipeline. Turnover has increased to 18.8%
Vacancy rate for HCSW (excl MSW) (bands 2, 3, 4 in clinical services only)	<5%	7.8%	9.4%	10.4%		Vacancy for healthcare support workers has increased this month and remains an area of concern, recruitment remains ongoing. Turnover has decreased to 13.2%
Vacancy rate for AHPs	<5%	6.2%	5.4%	6.2%		Vacancy for Allied health professionals has increased this month. Turnover has remained static to 8.2%
Planned verses actual staffing	**Target**	**May 2026**	**June 2026**	**July 2026**	**Variance**	**Commentary**
Number of wards reporting <90% overall rota fill	0	1	1	1		The number of areas reporting overall fill rate <90% rota fill in July has remained static at 1. Appendix 1 details the exception reports for Division E as the only division reporting overall fill rates of <90%.
Midwifery and MSW fill rate	90%	94.4%	94.6%	95.2%		The overall fill rate within midwifery has increased to 95.2%. This is the highest it has been for the previous 6 months and has remained above the target of 90%. The lowest overall fill rate has been seen in Sara Ward which has been mitigated through redeployment of staff where required, to meet acuity needs.
Total unavailability of the Nursing and Midwifery workforce	22%	22%	24%	26%		Total unavailability of working time in July has increased to 26%. The majority of unavailability was due to planned annual leave.

Staff deployment	May 2026	June 2026	July 2026	Variance	Commentary
Number of Substantive staff redeployed in month to support safe staffing (average hours redeployed per day)	237	256	254		The number of substantive staff redeployed has remained similar to last month with an average of 254 hours redeployed per day. This equates to 22 long day or night shifts per day. Due to a number of areas being over established and increased capacity in the organisation, it has been necessary to redeploy staff on a shift by shift basis however as sickness absence, vacancy and turnover improves, it is expected that the number of hours redeployed will be a decreasing trend.
Care hours per patient day (CHPPD)	9.3	9.3	9.1		Care hours per patient day (CHPPD) is the total number of hours worked on the roster (clinical staff including AHPs) divided by the bed state captured at 23.59 each day. CUH CHPPD has fallen to 9.1 in July. This is below the latest data from the Shelford group at 9.5 hours. In maternity CHPPD is at 7.92 (6.86 in June). From 1 April 2021, the total number of patients now includes babies in addition to transitional care areas and mothers who are registered as a patient.
Safety and risk	May 2026	June 2026	July 2026	Variance	Commentary
Nurse staffing red flags reported	53	77	106		There has been an increase this month in the number of red flags reported from 77 in June 106. The highest red flag reported is for unmet 1:1 specialling at 51.
Maternity red flags reported	92	134	149		There has been an increase in the number of maternity red flags this month from 134 in June 149 in May. The highest of these, 33 (66%) had a delay of 6 hours or more in transfer to the delivery unit during induction of labour once ARM is indicated.
Staffing incidents reported	39	50	67		There has been an increase in Safety Learning Reports (SLRs) completed in relation to nurse staffing in the month of July to 67 compared to June which had 50 incidents. Division A reported 10 incidents, Division B reported 6 incidents, Division C reported 10 incidents, Division D reported 21 incidents and Division E reported 17 incidents.

Appendix 1. Exception report by Division

Division E exception report for <90% fill rate

	Unit	Speciality	% fill registered	% fill care staff	Overall filled %	CHPPD	Analysis of gaps	Impact on Quality / outcomes
E	Sara Ward	501 - OBSTETRICS	86%	84%	86%	5.84	Current rosters have been reduced in line with BR+ (e.g.) RM reduction X 1 on night) large recruitment event complete with 24 wte in pipeline of registered RMs and a further recruitment event for MSWs to be completed imminently.	Staffing reviewed to ensure safe care, Staff moved within service to provide safe staffing.

Appendix 2. Staffing compliance with critical care staffing guidance

Adult critical care – compliance with Guidelines for the provision of intensive care services (GPICS)	
Number of breaches of 1:1 care for level 3 patients	17 (0 in June)
Number of breaches of side room co-ordinator	22 (12 in June)
Neonatal critical care	
Percentage of breaches of British Association of Perinatal Medicine (BAPM) staffing standards	36.51% (8.33% in June)
Number of occasions NICU closed due to staffing	0 (0 in June)
Paediatric critical care	
Number of breaches of Paediatric critical care society (PICS) staffing standards	0 (↔ 0 in June)
Number of occasions PICU closed due to staffing	0 (↔ 0 in June)

SPC Icon Keys

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	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
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SPC key taken from Oxford University Hospitals Integrated Report

Cambridge University Hospitals NHS Foundation Trust

Report to Board of Directors

held on

9 September 2026

Agenda item	10			
Title	Learning, Accountability and Change action plan – 9 month progress update			
Report sponsor	Dr Sue Broster, Chief Medical Officer David Wherrett, Chief People Officer Lorraine Szeremeta, Chief Nurse			
Author	Emily Warren-Barratt, CMO Office			
Status	**Decision** ☐	**Assurance** ☒	**Information** ☐	**Discussion** ☐

RECOMMENDATIONS

The Board of Directors is asked to:

- **note** the substantial progress made at the nine-month stage in delivering the commitments set out in the Learning, Accountability and Change action plan.
- **recognise** the organisational learning generated through the programme, which has helped to refine the approach and target improvement where it is most needed.
- **endorse** the continued focus on completing the remaining 12-month commitments, and ongoing 3 and 6 month commitments.

KEY MESSAGES

The Trust has made substantial progress in delivering the commitments within the Learning, Accountability and Change action plan, with delivery continuing towards the 12 month milestone.

Focus has increasingly shifted from creating policies and structures to embedding them in practice: using better information, governance and leadership to identify risk earlier.

The programme has given the Trust a deeper understanding of its clinical risks, medical workforce and the experiences of patients and families. This insight has helped to refine the approach and target improvement where it is most needed.

All commitments require sustained focused in the next period and beyond to ensure changes are fully embedded and deliver the intended impact.

BACKGROUND, INCLUDING PURPOSE OF THE REPORT

To provide a 9 month formal progress report against the Learning, Accountability and Change action plan and its 12-month deliverables, and ongoing 3 and 6 month deliverables.

ALIGNMENT TO TRUST STRATEGIC PRIORITIES

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

ALIGNMENT TO MOST RELEVANT STRATEGIC RISK

n/a

PAPER REVIEW AND GOVERNANCE PATHWAY

Name of group or committee that has previously considered this report	**Date**
Management Executive	20 August 2026
Quality Committee	2 September
Name of group or committee that the report will be presented to in the future	
People, Education and Culture Committee	23 September

9 September 2026

Board of Directors (Public)

Learning, Accountability and Change action plan – 9 month progress update

Dr Sue Broster, Chief Medical Officer

1. Introduction and context

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

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

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

1.4 This paper provides the Board with the formal progress update at the 9 month stage, ahead of the 12 month completion milestone at the end of October 2026. As well as the 12 month commitments, it provides an update on ongoing 3 and 6 month commitments.

2. Progress against ongoing 3 and 6 month commitments

a) <u>New Patient Advisory and Young Patients' Advisory Boards established</u>

The Adult Patient Advisory Board has been meeting monthly since February 2026, with five members. The Board has played an active role in shaping patient-facing communications, most recently providing feedback on the planned communications to accompany the clinical review report.

Engagement with children and young people remains a priority, however despite input from the National Youth Advocacy Service, uptake remains low, with only one young person attending the arts-based engagement event in June. In response, a proposal is being developed to embed the voices of children and young people into business-as-usual services, drawing on existing opportunities within children's services, to ensure their perspectives are routinely captured and acted upon.

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

Work to establish clearer and more consistent expectations for medical line managers has progressed through the first phase of the Clinical and Specialty Lead role review. Three workshops involving 35 Clinical and Specialty Leads have been completed, alongside benchmarking of role descriptions from other NHS organisations. The work has identified the need for greater clarity around role purpose, accountability, decision-making authority, reporting relationships, protected leadership time and the support required to undertake these roles effectively.

These findings will now inform the next phase of role redesign within the context of the new Target Operating Model, including revised role descriptions, support arrangements and leadership development requirements.

c) Two-year structured induction programme in place for all new consultants, including a mentoring and buddying system

Early elements of the revised consultant induction have been agreed. All newly appointed consultants will attend the Trust's corporate induction, rather than a separate medical-only induction, and will meet the Chief Medical Officer within their first month. This will support early engagement with senior medical leadership and reinforce organisational expectations from the outset. The next phase will focus on embedding these arrangements into routine practice and developing them into a consistent two-year induction pathway. This will include formal mentoring and buddying arrangements, together with clear expectations and support at key stages of a consultant's transition into CUH.

d) Board development programme established aligned to the Insightful Provider Board guidance

A skills mapping exercise is currently being completed with all Non-Executive Directors. The findings will inform a gap analysis against the six domains of the Insightful Provider Board guidance, identifying areas for development and informing the design of the Board development programme.

e) Findings and recommendations from the Culture Task and Finish Group approved by Board for action **(CPO)**

The Culture and Leadership Task and Finish Group has continued to progress its work, with the Board approving the proposed cultural ambition and leadership behaviours for CUH. These provide an agreed foundation for a high-performing, inclusive organisation and set clearer expectations for how we lead and work together.

The group is now developing and iterating its report, including a five-year cultural delivery roadmap and a strengthened approach to measurement and oversight. This will bring together the key actions required to deliver the cultural ambition, alongside a clearer data framework to track progress, manage benefits effectively and demonstrate impact over time.

3. Progress against 12 month commitments (at the 9 month stage)

Management and support for doctors

f) Data and information from the job planning process is being proactively used to support the management, oversight and support of doctors

The implementation of the Trust's revised job planning process, supported by the new electronic job planning system, has significantly improved visibility of consultant workload, activity and agreed responsibilities. Managers now have access to consistent, timely information to support effective oversight of medical staff and to identify where workloads or programmed activities differ from those agreed within individual job plans. Clear expectations are set out within the revised Job Planning Policy, supported by guidance for managers on responding appropriately where variation is identified. This enables earlier conversations, targeted support where required, and more consistent management of consultant workload across the Trust.

g) Inappropriate imbalances in workloads within clinical services actively addressed

A number of areas of work are being implemented to ensure workload is monitored and managed appropriately across medical staff. Exception reporting continues to provide visibility of resident doctor working patterns and highlights areas where additional support or changes are required. The consultant job planning transformation programme provides greater oversight of planned versus delivered activity, enabling managers to identify where consultants are consistently working above or below their agreed job plans and to take appropriate action. A revised medical appraisal process is also being implemented, providing a structured opportunity to review workload and wellbeing.

h) Structured approach to mentoring and buddying applied retrospectively to consultants appointed in the last three years

The Trust’s new Consultants Development Programme launched in June 2026, delivered in partnership with The King’s Fund. The programme provides structured leadership development, reflective learning and peer support for consultants appointed within the last two years. Two cohorts are underway, with the intention of establishing this as a rolling programme. Early participant feedback has been positive. Targeted organisational

development support is also in place for individuals where specific development needs have been identified.

Alongside this, the independent Medical Voice listening exercise provided deeper insight into consultants' and SAS doctors' experiences of speaking up and psychological safety. Its central finding was that medical voice is present, but needs to be more consistently heard and acted upon, with greater transparency, stronger clinical engagement and clearer feedback following concerns. The findings will inform ongoing work to strengthen leadership and culture and the development of the Trust's updated operating model.

Improving governance for the safety and effectiveness of clinical services

i) Audit of MDT effectiveness including through peer review completed

Multiprofessional feedback has been gathered to inform a second iteration of the Trust's new MDT policy. Work is underway for all MDTs of teams receiving organisational development support or enhanced intervention, to complete a self-assessment against the policy standards to identify opportunities for improvement. This will be followed by a rolling programme of audit across a combination of randomly selected and targeted MDTs.

j) Improvement plans in place for any surgical specialty or individual surgeon as informed by a range of relevant outcomes data including GIRFT, NCIP and National Joint Registry with a particular focus on small specialties

A first Trust-wide review of patient outcomes using national datasets, including mortality indicators, national clinical audits, Getting It Right First Time (GIRFT) programme insight, and infection data, has been completed and was considered by Quality Committee in July 2026. The review identified many areas of strong performance, including excellent Hospital Standardised Mortality Ratio (HSMR) performance and full participation in national audit programmes,

It also identified a number of signals that warranted further investigation, particularly around readmissions, some mortality indicators and infection metrics.

The review identified a need for a more systematic and consistent approach to the use of outcomes data across the hospital. Strengthening routine access to, and use of, both national and local datasets by services is essential to improving visibility of performance, supporting clinical decision-making, and enabling proactive approach to quality governance. Work has been initiated to establish a structured programme of work to deliver this.

k) Trust-wide learning embedded from themes and findings from the quality and safety stocktakes

Service improvement plans have now been completed for all high complexity low volume service where risk was identified as being high-risk, medium-risk or having a patient safety risk. Focus on service-level improvement plans will be maintained through divisions, with bi-monthly progress updates to Patient Outcomes Oversight Group, and Quality Committee. A Trust-wide thematic review of findings from the assessments of high complexity low volume services was presented to Quality Committee in July 2026. The review identified several Trust-wide priorities, including: strengthening governance expectations for these services; improving data infrastructure and analytical capability to support local quality monitoring; and establishing a community of practice for leaders of smaller and higher-risk services to share learning and build capability. An overarching action plan is now being developed to implement these cross-cutting recommendations.

l) Roll out of the revised National Safety Standards for Invasive Procedures (NatSSIPs 2)

Implementation of NatSSIPs 2 is progressing across the Trust in a phased approach. Services have been prioritised based on clinical risk, deliverability, where existing improvement work is underway, and where previous never events have highlighted the need for strengthened controls. Phase 1 includes Main Theatres, IVF, Endoscopy, Interventional Radiology and Vascular Access, with implementation due to launch in September and October 2026. Phase 2 will commence from October 2026 across the Paediatric Day Unit, Haematology Day Unit, Outpatients, Emergency Department, Maternity Theatres and non-theatre maternity settings. Phase 3 will deliver Trust-wide implementation across all remaining relevant services, and will launch in Q4 2026/27.

Medical culture and tackling poor behaviours

m) Externally facilitated stock-take to evaluate progress towards creating a consistently healthy medical culture

An externally facilitated stock-take will be commissioned at an appropriate point, once current actions have had sufficient time to become established and demonstrate impact.

The stocktake will provide an independent assessment of progress against the Trust's cultural ambitions, drawing on the full range of quantitative and qualitative evidence available, including the National Staff Survey, Workforce Race Equality Standard, Workforce Disability Equality Standard, quarterly pulse surveys, Medical Voice and GMC findings, Freedom to Speak Up intelligence, patient experience, complaints, safety incidents, employee relations and wider workforce indicators.

Rather than this be a one-off exercise, the Trust will increasingly normalise the routine use of this combined intelligence through its ongoing measurement, governance and

improvement arrangements, including consideration of variation between professions, demographic groups, divisions/groups, services and teams.

The independent stock-take will therefore complement and test the Trust's established approach, identifying where progress is evident, where further action is required and what learning should be shared.

n) Development of a new target operating model

Proposed changes to the organisational structure have been developed, informed by staff feedback from workshops, listening events and engagement with individual staff groups, alongside benchmarking from comparable organisations. The proposed changes are designed to strengthen divisional leadership teams and reduce barriers to delivering care. Formal consultation on the proposed changes will commence in September 2026, with implementation of the new operating model planned from April 2027, and supported by an updated accountability framework.

4. Risks

4.1 The main risk as the programme approaches its 12-month milestone is that successful delivery of individual commitments does not, in itself, guarantee that the intended changes become consistently embedded in day-to-day practice. A number of commitments represent the foundations for longer-term changes in leadership, culture, governance and the use of information. Continued oversight will therefore be required beyond October 2026 to ensure that implementation translates into sustained improvement and demonstrable impact.

4.2 The programme has generated significantly greater organisational insight, including improved understanding of variation and risk within clinical services, medical workforce experience, patient and family experience, and the Trust's data and information infrastructure. Greater visibility can identify issues which were previously less well understood or less systematically surfaced. There is therefore a risk that the organisation's ability to identify concerns develops more quickly than its capacity to respond consistently to them.

4.3 The quality, accessibility and systematic use of data remain important dependencies for the programme. The first Trust-wide review of outcomes data has demonstrated both the value of bringing together intelligence from multiple sources and the need to strengthen routine access to and use of national and local datasets across services. This is key to support teams in recognising emerging concerns, understanding variation and responding to operational quality issues as they arise. Until this is fully established, there remains a risk of variation in the organisation's ability to identify emerging quality concerns and intervene proactively.

4.4 The publication of the clinical review of cases in the autumn may identify further concerns and generate significant scrutiny. There is a risk that this overshadows the progress and improvements made through the programme, affecting confidence among patients, families, staff and external stakeholders. Communications in response to publication of the clinical review will acknowledge any further learning while clearly setting out the improvements made to date and how the Trust has responded.

5. Next steps

5.1 Delivery will continue on the 12-month commitments and ongoing 3 and 6 month commitments. Progress will continue to be tracked through established governance routes, with updates shared internally and externally.

5.2 Planned communications and reporting milestones at the 9-month milestones stage include:

- Website update: Wednesday 12 August
- Quarterly patient letters: Wednesday 12 August
- Management Executive: Thursday 20 August
- Quality Committee: Wednesday 2 September
- Patient and families update meeting: Thursday 3 September
- Board of Directors: Wednesday 9 September
- People, Education and Culture Committee: Wednesday 23 September
- Paediatric Orthopaedic Oversight Board: Wednesday 30 September
- Internal communications: September (date tbc).

Cambridge University Hospitals NHS Foundation Trust

Board of Directors (held in Public)

9 September 2026

Agenda item	11			
Title	Quarterly Report on Safe Working Hours: Resident Doctors Q1 2026/27			
Report Sponsor	Dr Sue Broster, Chief Medical Officer			
Author	Dr Serena Goon, Guardian of Safe Working Hours			
Status	**Decision** ☑	**Assurance** ☑	**Information** ☑	**Discussion** ☑

RECOMMENDATIONS

The Board of Directors is asked to:

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

KEY MESSAGES

The number of ERs this quarter is higher than Q4 2025/6. The number of immediate safety concerns reported each quarter are usually low, and seven were reported this quarter. Rota gaps continue to be problematic; this has implications for working hours and patient safety and educational opportunities. It can be difficult to source locum cover at the last minute. The use of EPIC chat is reported to increase the burden of workload on resident doctors across many specialties. This is a real and persistent issue, and there is currently a working group looking at this.

Despite the loss of training opportunities with increasing service pressures, resident doctors rarely submit educational ERs. There have been 7 this quarter.

Cardiology has been an ongoing area of concern. There are currently plans to put in a business case for further resource at the F3 level for cardiology. There is in addition a case ongoing for further expansion within cardiology.

General Surgery continues to feature highly in this quarter, mainly at the FY1 level. The workload is compounded by the fact that there are multiple outlier patients (this is also a theme in other specialties) which adds to inefficiencies in the working day. Further resource is also needed at night, and a work schedule review is ongoing.

Haematology features highly on the exception reports, even accounting for some being for time being spent on the resident rota. The acuity of patients is rising, and a work schedule review is ongoing.

Trauma and Orthopaedics is an area of concern. A business case is currently being assessed for the most pressing area which is the orthopaedic trauma unit, however further business cases are in the pipeline due to a need for further resource.

Other areas which have featured highly have been Diabetes and Endocrinology, and Neurosurgery.

Obstetric anaesthetic highers have a business case currently being assessed.

Some ERs which are filled in are to compensate for non-clinical activities (otherwise done in self development time). This is covered in a large separate piece of work from the Postgraduate Medical Centre.

The Resident Doctors Forum (RDF) has the potential to identify, discuss and jointly address, with the Chief Medical Officer, Medical Staffing, the Guardian and the Postgraduate Medical Education Centre, rota and training issues as they arise. Improving the working conditions and morale of junior doctors is increasingly important as it will aid recruitment and retention, reducing rota gaps and will thus improve patient safety. The Trust is working through the NHSE ’10 Point Plan to improve resident doctors’ working lives’. This is being led by our Chief Medical Officer with our RDF co-chairs as Resident Leads.

We look forward to the rolling out of e-rostering, as this should improve visibility of gaps, amongst other benefits.

The preparation and implementation for reforms has increased the workload for human resources. Human resources would really benefit from additional resource, and recruitment is ongoing and hopefully will result in an easing of the burden.

Exception reporting suggests that working hours remained mostly compliant in Q1 and patient safety has rarely been compromised. It is clear that the full picture is not always gleaned from the exception reporting system. However, there are extra hours worked on some rotas and continuing problems with rota gaps that cannot be filled with locums. Our focus currently is to manage the rotas which are being flagged up. There are a number of business cases being prepared, or being assessed. Work schedule reviews are ongoing, and we look forward to additional resource for the Human Resources team, who are crucial to this process in implementing change. We continue to adapt as we go along. Additionally, we need to drive forward e-rostering, and work on the 10 point plan.

BACKGROUND, INCLUDING PURPOSE OF THE REPORT

Executive Summary

This is the first quarterly report for the year 2026/27, based on a national template, to the Management Executive by the Guardian of Safe Working Hours. This role supports the implementation and maintenance of the 2016 national contract for Doctors in Training and provides an independent oversight of their working hours. The process of exception reporting provides data on their working hours and can be used to record safety concerns related to these and rota gaps. In addition, it can identify missed training opportunities.

Safeguards around doctors’ hours are outlined in national terms and conditions. These stipulate that the Guardian of Safe Working Hours “shall report no less than once every quarter to the Board”. This report reflects the position as of 30th June 26. The Trust has 1100 resident doctors.

ALIGNMENT TO TRUST STRATEGIC PRIORITIES

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

ALIGNMENT TO MOST RELEVANT STRATEGIC RISK

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

PAPER REVIEW AND GOVERNANCE PATHWAY

Name of group or committee that has previously considered this report	**Date**
Board of Directors	10 June 2026
Management Executive	27 August 2026
Name of group or committee that the report will be presented to in the future	
Board of Directors	9 September 2026

9 September 2026

Board of Directors (held in Public)

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

1. Introduction and context

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

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

Exception reports were received from a broad range of specialities as depicted by the graphs below. Most ERs were from Haematology (59), General Surgery (55)), Diabetes and Endocrinology (27), Cardiology, and Trauma and Orthopaedics (29). Some reports from Haematology are to compensate for time for involvement in resident doctor rotas. Some ERs badged under 'Acute Medicine' fall under various specialties but it is difficult to identify as they are reported under their rota. However, reading from the free text, a significant proportion come from Cardiology, in addition to 20 badged under Cardiology. Reasons for ERs include sheer volume of workload, and staff shortages, sometimes due to unfilled last-minute sickness.

This Q1 report describes the Trust's position from April to June 2026. The number of ERs submitted (n=378) is higher than Q4 (n=304) and is higher than Q1 last year 2024-5 (n=258). For illustration purposes of the rise since the ER reforms, the numbers for April were 88 (2026); 85 (2025); 97 (2024). Numbers for May were 159 (2026); 105 (2025); 74 (2024), and for June 111 (2026); 68 (2025); 87 (2024). Majority of ERs were submitted for late finishes. 7 immediate safety concerns were reported, the same number as Q4 last year. These were due to a mixture of excess work load and short staffing.

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

High level data

Number of doctors / dentists in training (total):	711
Number of doctors / dentists on local contracts (Clinical Fellows):	299
Total resident doctor/ dentist establishment:	1100
Reference period of report	Q1 2026/7
Total number of exception reports received	358
Number relating to immediate patient safety issues	8
Number relating to hours of working	318
Number relating to pattern of work	20
Number relating to educational opportunities	7
Number relating to service support available to the doctor	13
Total number work schedule reviews	2 completed; 3 ongoing
Total value of fines levied	£1403.79
Amount of time available in job plan for Guardian to do the role:	2 PAs/8hrs/week
Admin support provided to the Guardian:	1 WTE
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

NB: 'Hours of working' includes unscheduled early starts and late finishes; 'pattern of work' includes breaches for NROC patterns and inability to take contractual breaks; 'service support available' includes inadequacy of clinical support or rostered skills mix.

The following section follows the national template for information to be provided to the Board.

a) Number of exception reports submitted:
The GoSWH will have access to all exception reports and will review and scrutinise exception reporting patterns to ensure reports are accurate, valid and adhere with the purpose of exception reporting.

Number of exception reports submitted over the last quarter:	
Total ERs *(minus withdrawn/rejected)*: 358 **Total ERs *(incl. withdrawn/rejected)*:** 378 **Withdrawn Ers (by Drs):** 20 **An unscheduled early start:** 4 **An unscheduled late finish:** 314 **Breaches of non-resident on-call patterns:** Hours: 0 **Breaches of non-resident on-call patterns:** Rest: 6 **Missed educational opportunities:** 7 **The inability to take contractual breaks:** 14 **The inadequacy of clinical support:** 5 **The inadequacy of rostered skills mix:** 8 **Raising concerns of a suspected non-compliant rota pattern:** 0 **Detriment or threat of detriment related to exception reporting:** 0 **Information breach: 0** **Access & Completion test:** 1 **Access & Completion breach resolved:** 1 (submitted in error)	**Total:** 358

b) Categories of exception reports submitted:
Supporting information:

Type of exception report:	Outcome:					Number of exception reports:
	Pay:	**TOIL**	**Pay & Mandated TOIL**	**Penalty/ Fine:**	**For information:**	
Additional hours an unscheduled early start	1	0	0	0	Note: • 2 ERs to be closed (unable to close on system) • 1 ER pending review	4
Additional hours an unscheduled late finish	239	6	17	Penalty: 14 Fine: 31		314
Breaches of non-resident on-call patterns	N/A	N/A	N/A	N/A		0
Breaches of non-resident on-call rest	0	0	0	0	Note: 5 ERs pending review	6
The inability to take contractual breaks				0	Note: to follow up on breaks monitoring review	14
Inadequacy of clinical support					N/A	5
Inadequacy of rostered skills mix					N/A	8
Raising concerns of a suspected non-compliant rota pattern					N/A	0
Detriment or threat of detriment					N/A	0

related to exception reporting						
Information breach			N/A	N/A		0
Access and completion resolved in time					This was submitted in error	1
Access and completion breaches			N/A	N/A		0
Access and completion test					N/A	11
Missed educational opportunities						7
Other: optional free text box						
	Total: *(Total figure includes access & completion test reports)*					370

c) Experiences of actual or threatened detriment:

One of the guiding principles of the exception reporting reforms is to prevent doctors experiencing, either threatened or actual, detriment as a result of exception reporting or indicating intent to exception report. Detriment in an employment context is when an employer, or colleagues, treats an individual unfairly or subjects them to a disadvantage for the sole or main reason that they asserted an employment right.

Total number of residents & LEDs at CUH: 1100 Number of respondents: 17	1.54%
Quarterly survey response rate	Actual detriment: 6% Threat of detriment: 24% No detriment: 53% Unsure: 18%
Doctors experiencing actual detriment as a result of exception reporting	6%
Doctors feeling that they are not discouraged from exception reporting	47%

NB: Other questions were included in the survey, which should have been answered by those that experienced detriment or threat of detriment. However, this was completed by all respondents and therefore some responses were contradictory. The survey will be re-worded for the next quarter to make it clear it only refers to those experiencing detriment/threat of detriment.

d) Withdrawals:

A doctor can choose to withdraw an exception report that they have submitted at any point in the process following submission. All exception reporting data, including those which have been withdrawn, will be retained

for the GoSWH to allow them to perform their role in checking for potential safety implications.

Number of exception reports withdrawn over the last quarter	20

e) Access to individual doctors' exception reporting data:

Personally identifiable data related to exception reporting must not be shared without the doctors' specific consent, except where a senior manager or member of the board of directors is presented with an overriding public interest or has a legal obligation.

The affected doctor should be notified of this action as soon as practically possible, and the number of such disclosures must be presented in a manner that preserves a doctors' anonymity.

Number of exception reports disclosures over the last quarter	N/A

f) Work schedule reviews related to exception reporting pattern/instances:

The purpose of work schedule reviews is to ensure that a work schedule for a doctor remains fit for purpose. A work schedule review can be triggered by one or more exception reports, or by a request from either the doctor or the employer.

Number work schedules reviews related to exception reporting patterns or instances **Note**: Haem-Onc core rota	1

Two further work schedules are currently in progress – General Surgery, in relation to night time work; and Dermatology, who are due to have an additional dermatology trainee.

g) Rota gaps on all shifts:

Total number of rota gaps on all shifts over the last quarter	**Total Requests:** 1150 (Apr-26) 990 (May-26) 1206 (Jun-26) **Total Q1: 3346** **Shifts Filled:** 1060 (Apr-26) 913 (May-26) 1101 (Jun-26) **Total Q1: 3074** **Fill Rate %:** 92.17% (Apr-26) 92.22 % (May-26) 91.29 % (Jun-26) **Total Q1: 91.87%**

h) Additional information on an ad hoc basis:

The GoSWH is required to report any escalated issues in relation to working hours, raised in exception reports, to the relevant executive director, or equivalent, for decision and action, where these have not been addressed

at departmental level.

Details N/A
There are a number of business cases which are in progress or which are being addressed (see Key Messages)

The GoSWH is required to report issues, with certain posts, that cannot be remedied locally and require a system-wide solution. The board is required to raise the system-wide issue with partner organisations (for example, NHS England) to find a solution.

Details N/A
Free text

APPENDIX 1: Additional information

Fines

Fines levied against departments this quarter

Department	Detail	Total value of fine levied
Total fines levied	Fines for rest breaches/hours	£1403.79

The fines have been re-organised into the dates that the fine was levied (as opposed to date the shift occurred, therefore there is a discrepancy from the last board report for that reason).

	TOTAL
Balance at end of last quarter	**£1396.98**
Fines incurred this quarter	**£1403.79**
Cumulative total	**£2800.77**
Total paid to trainees (£)	**£477.76**
Total spent (£)	**£0**
Balance at end of this quarter	**£1396.98**

Resident doctor forums and resident doctor engagement

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

Doctors and dentists in training not on 2016 TCS

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

Assurance processes

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

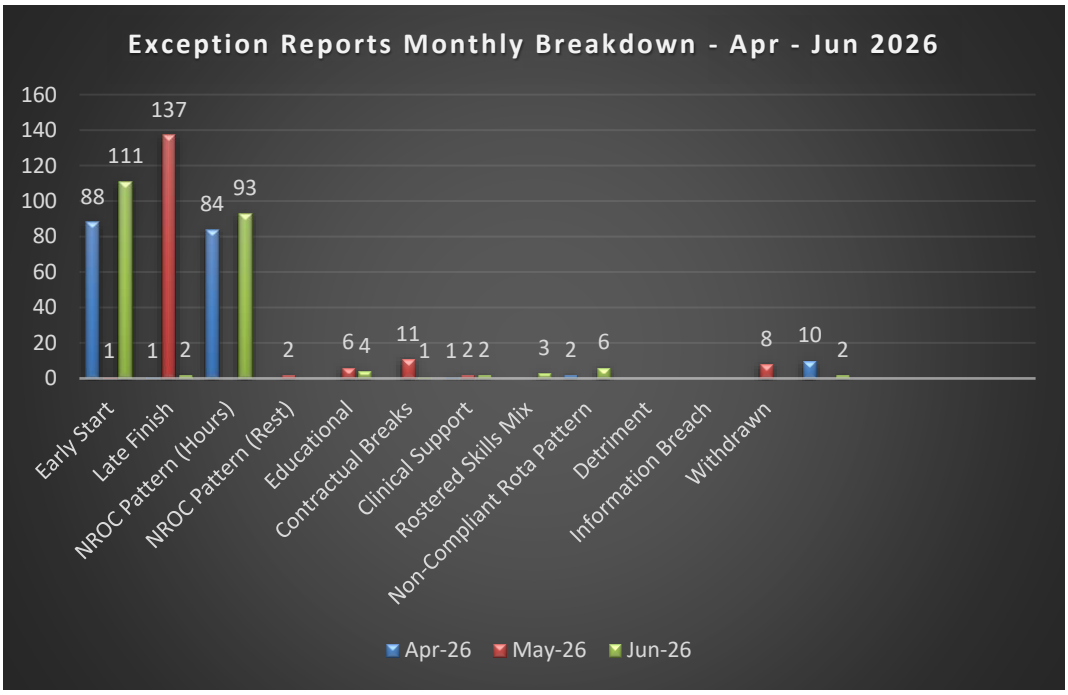
- Development of key performance indicators for example response times to exception reports.
- Benchmarking via the Regional and National Guardians' networks
- Peer review – ask other trusts/Guardians to review our processes
- Audit of exception reporting process

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

Benchmarking takes place regionally and nationally via the GOSW who is chair of the Regional GOSW network and arranges minuted meetings of the regional network every two months.

APPENDIX 2

Overview:
Exception Reports - Quarterly Monthly Breakdown



Total of 358 exceptions reported between April 2026 and June 2026. If we were to include the 20 withdrawn exceptions this number would rise to 378.

The exceptions were reported under the following categories:

- 4 for an unscheduled early start
- 314 for an unscheduled late finish
- 0 for breaches of NROC patterns: hours
- 6 for breaches of NROC patterns: rest
- 7 for missed educational opportunities
- 14 for the inability to take contractual breaks
- 5 for the inadequacy of clinical support
- 8 for the inadequacy of rostered skills mix
- 0 for raising concerns of a suspected non-compliant rota pattern
- 0 for detriment or threat of detriment related to exception reporting
- 0 for an Information breach
- 20 exceptions were withdrawn

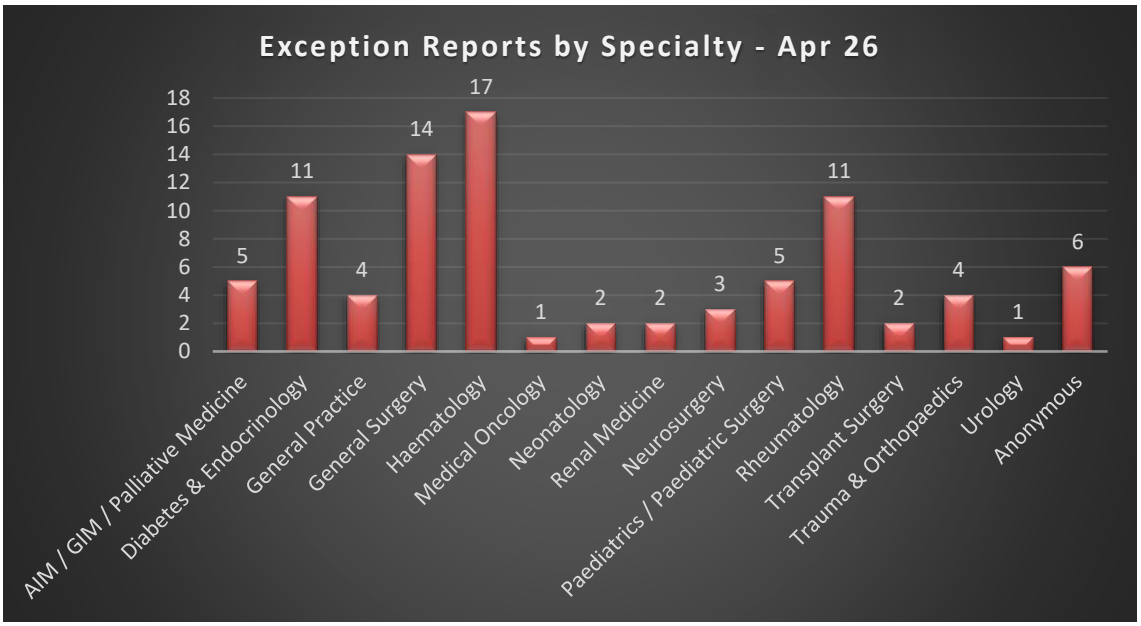
Withdrawn exception reports:
Total of 20 exceptions were withdrawn during this period, typically the reasons for withdrawing of these exception reports may be due to a resident withdrawing an ER on their own accord, or the verification manager asking for this to be withdrawn due to the ER being submitted outside of the 28-day submission window.

Please note that the number of withdrawn ERs may increase due to the large volume of ERs currently at the Pending Clarification stage following the launch of the new system.

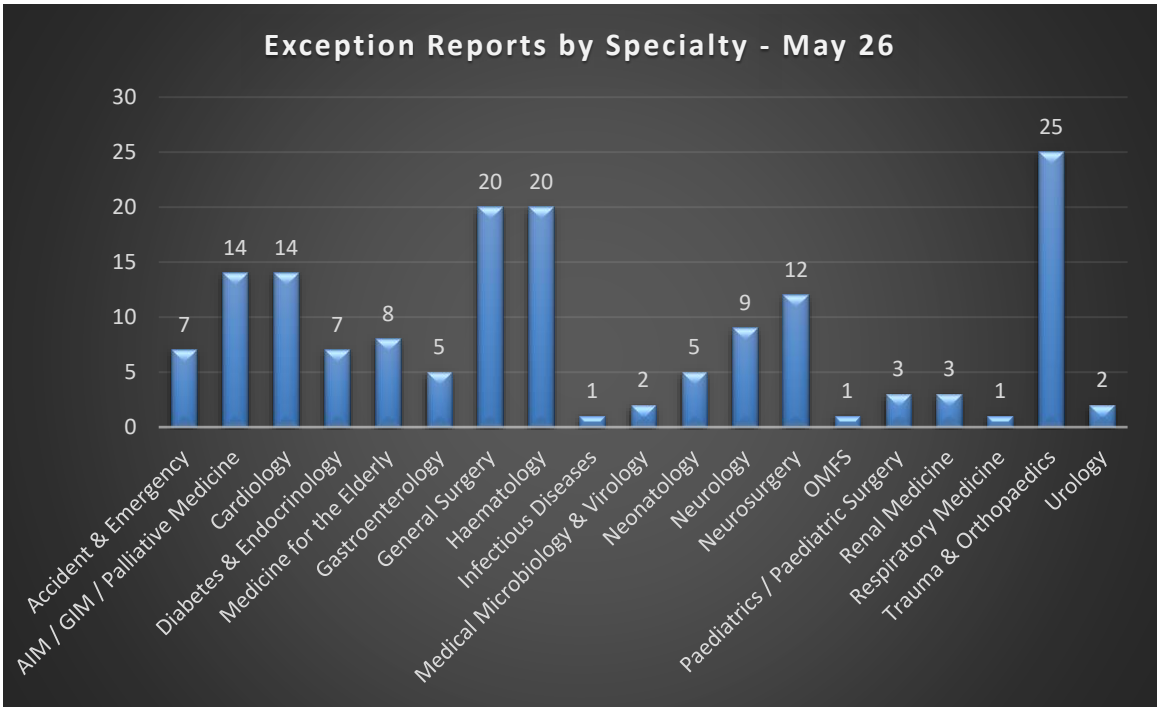
As there is currently no functionality within the system to close ERs that remain at the Pending Clarification stage, a significant number of exceptions have accumulated where no response has been received from residents despite the required timeframes and follow-up communications. These residents have been informed that their ERs will be closed with no further action, and the cases have been highlighted through the monitoring function in the system until we are able to close these ourselves.

This may result in an increase in the number of withdrawn ERs at a later date, which could lead to discrepancies between current withdrawal figures and those reported in future annual reports. This is because residents may choose to withdraw their ERs themselves following the communication advising that their case will be closed with no further action.

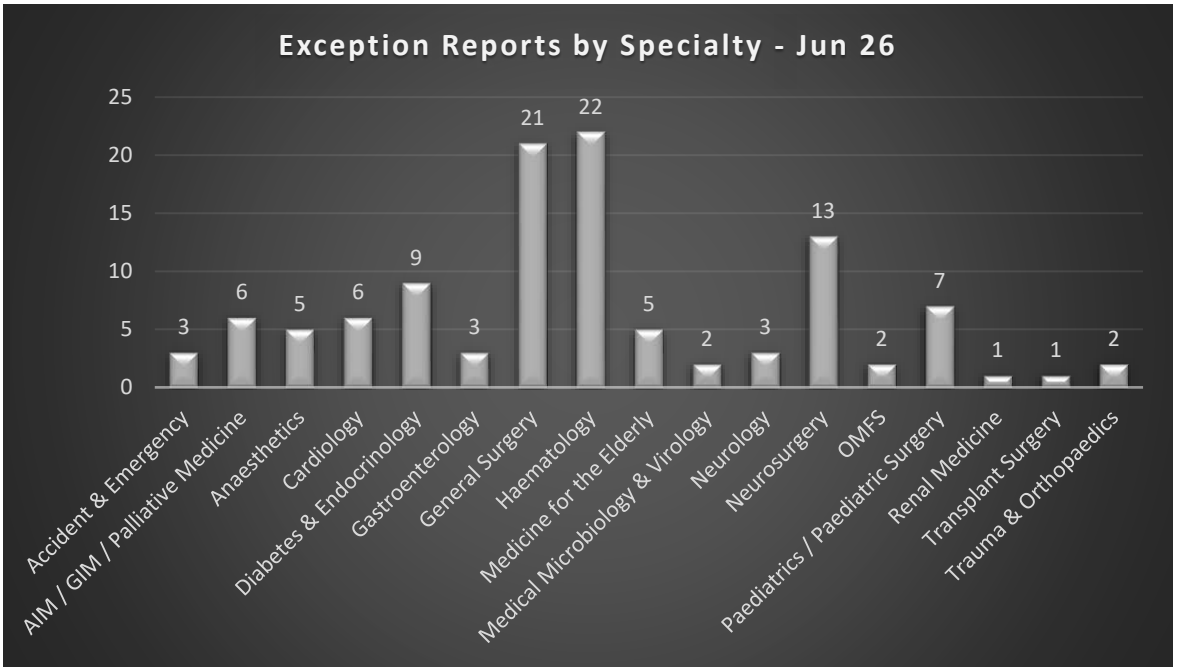
Exception Reports - Quarterly Specialty Breakdown



Acute Medicine / General Medicine / Palliative Medicine	5
Diabetes & Endocrinology	11
General Practice	4
General Surgery	14
Haematology	17
Medical Oncology	1
Neonatology	2
Renal Medicine	2
Neurosurgery	3
Paediatrics / Paediatric Surgery	5
Rheumatology	11
Transplant Surgery	2
Trauma & Orthopaedics	4
Urology	1
Anonymous	6



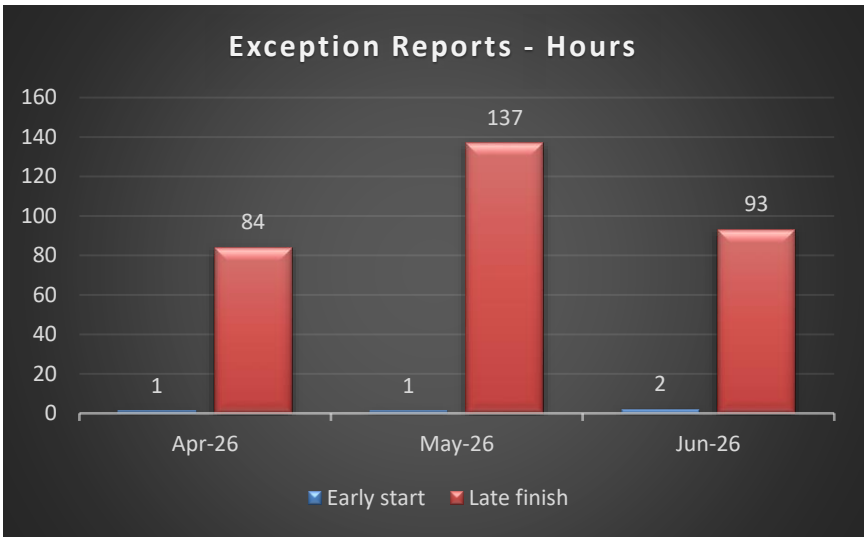
Accident & Emergency	7
AIM / GIM / Palliative Medicine	14
Cardiology	14
Diabetes & Endocrinology	7
Medicine for the Elderly	8
Gastroenterology	5
General Surgery	20
Haematology	20
Infectious Diseases	1
Medical Microbiology & Virology	2
Neonatology	5
Neurology	9
Neurosurgery	12
OMFS	1
Paediatrics / Paediatric Surgery	3
Renal Medicine	3
Respiratory Medicine	1
Trauma & Orthopaedics	25
Urology	2



Accident & Emergency	3
AIM / GIM / Palliative Medicine	6
Anaesthetics	5
Cardiology	6
Diabetes & Endocrinology	9
Gastroenterology	3
General Surgery	21
Haematology	22
Medicine for the Elderly	5
Medical Microbiology & Virology	2
Neurology	3
Neurosurgery	13
OMFS	2
Paediatrics / Paediatric Surgery	7
Renal Medicine	1
Transplant Surgery	1
Trauma & Orthopaedics	2

Exception Reports - Quarterly Category Breakdown

Hours - Unscheduled early start / Unscheduled late finish:

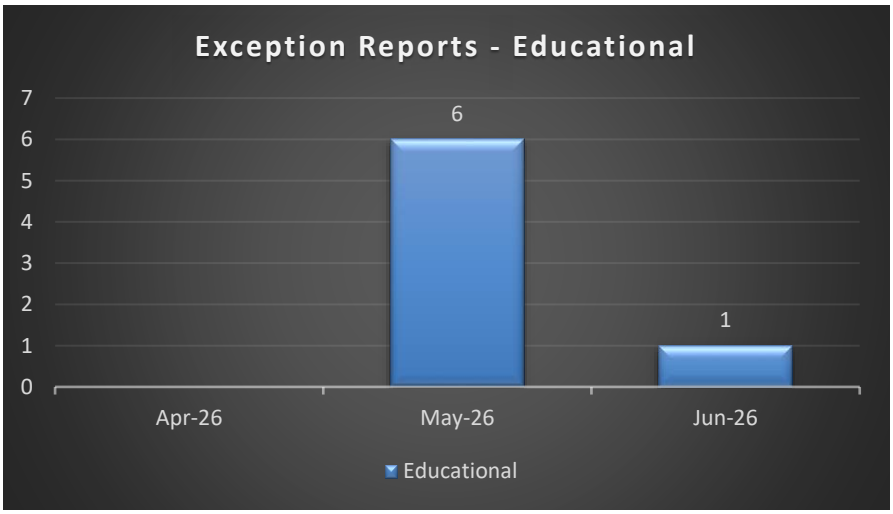


- There were 318 exceptions reported under hours related categories between April and June 2026. (85 exceptions in April, 138 in May, and a 95 in June)

- From the 318 exceptions, 4 exceptions reported under the unscheduled early start category, and 314 exceptions reported under the late unscheduled late finish category.

Month	Early start	Late finish
Apr-26	1	84
May-26	1	137
Jun-26	2	93

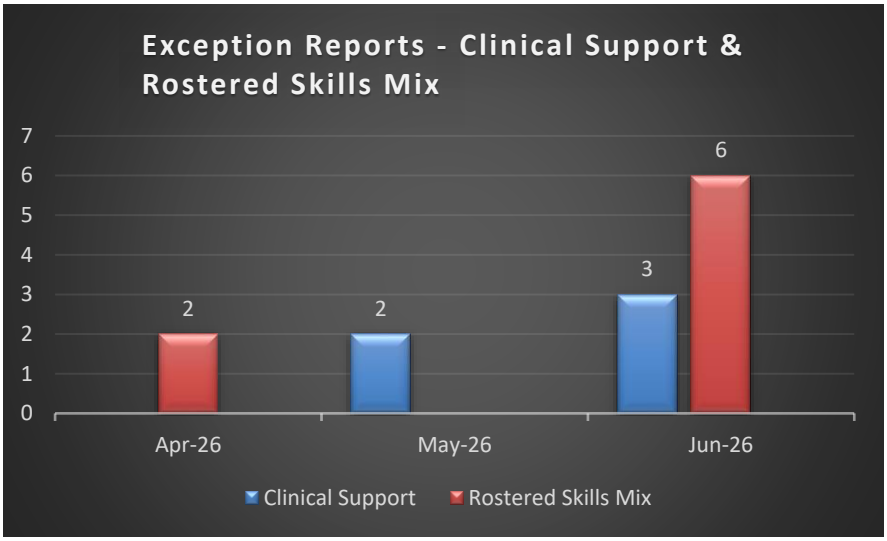
Missed Educational Opportunities:



- There were 7 exceptions reported under the missed educational opportunities category. (6 in May and 1 in June)

  General Surgery: 4
  Neurosurgery: 2
  Trauma & Orthopaedics: 1

The inadequacy of rostered skills mix:

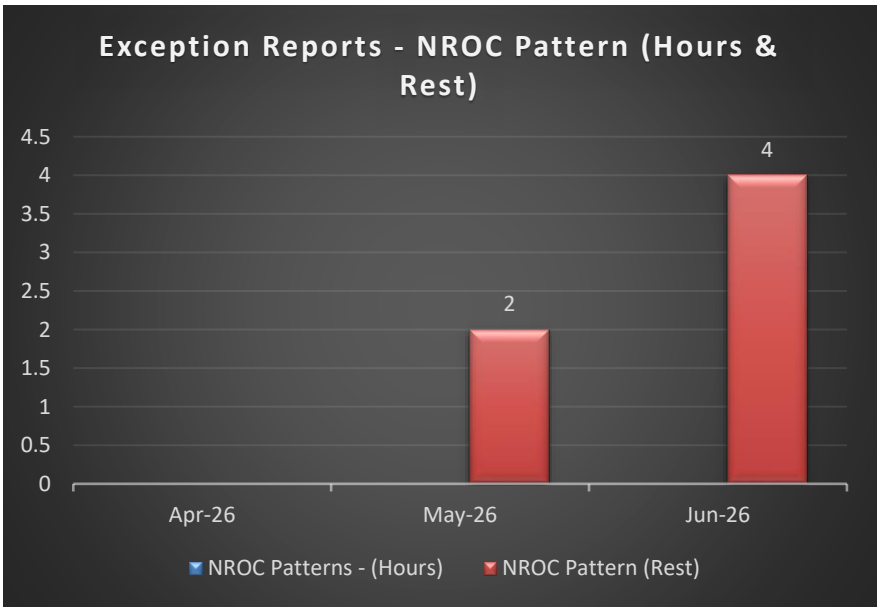


- Total of 8 exceptions were reported against the inadequacy of rostered skills mix category, and 5 exceptions were reported against the inadequacy of clinical support category.

Inadequacy of rostered skills:
Anaesthetics: 5
Cardiology: 1
Haematology: 2

Inadequacy of clinical support:
General Surgery: 1
Paediatrics / Paediatric Surgery: 3
Trauma & Orthopaedics: 1

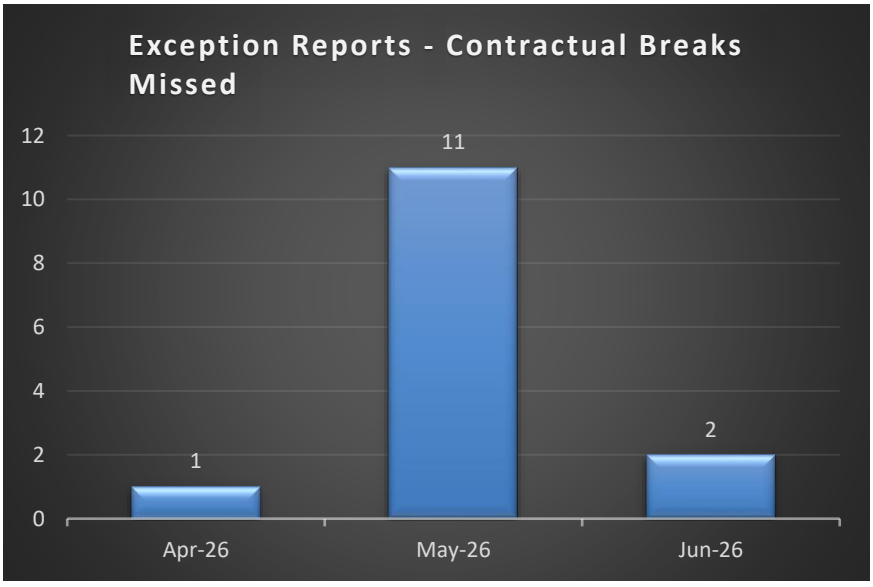
Breaches of non-resident on-call patterns: Hours / Rest:



- There were no exceptions reported against the breach of a non-resident on-call pattern: hours category.
- Total of 6 exceptions reported against the breach of a non-resident on-call pattern: rest category. (2 in May and 4 in June)

  Anaesthetics: 5
  Cardiology: 1
  Haematology: 2

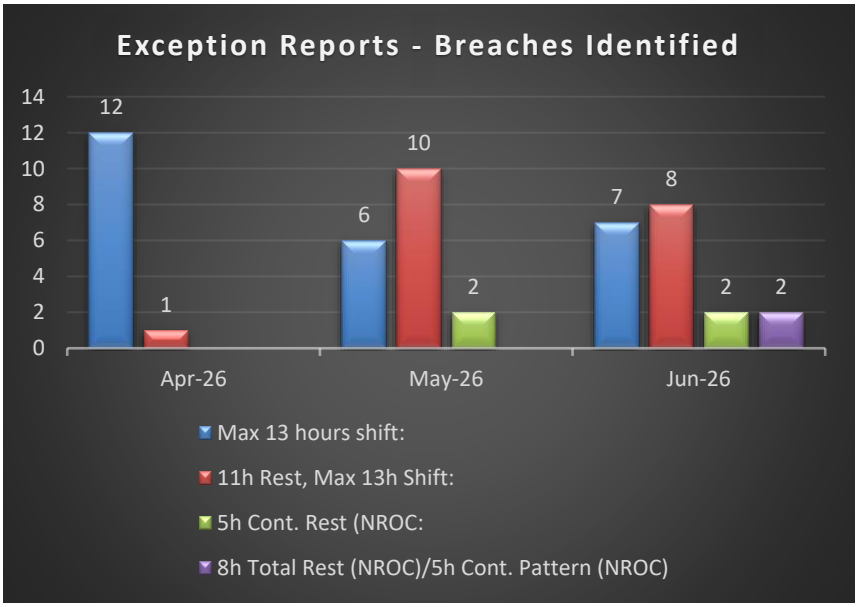
The inability to take contractual breaks:



- Total of 14 exceptions were reported against the inability to take contractual breaks category. (1 in April, 11 in May and 2 in June)

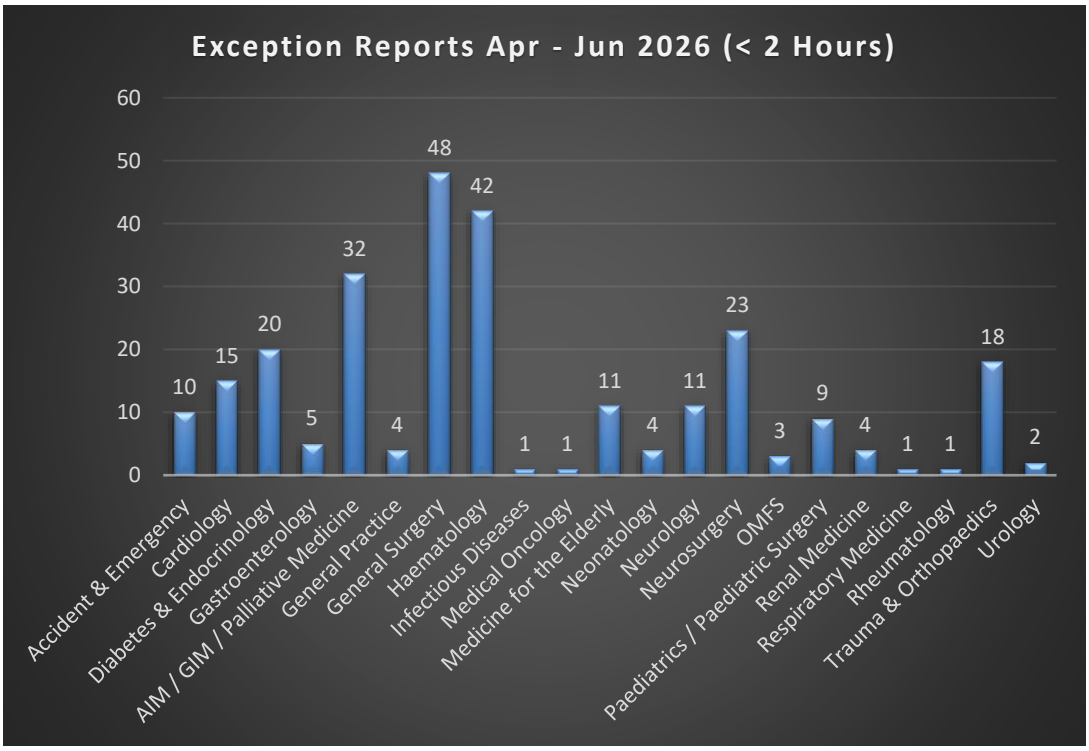
General Surgery: 3
Haematology: 2
Medicine for the Elderly: 1
Neonatology: 2
Neurosurgery: 1
Paediatrics / Paediatric Surgery: 1
Renal Medicine: 1
Trauma & Orthopaedics: 3

Exception Reporting Breaches:



Month:	Max 13hrs shift:	11hrs Rest, Max 13hrs shift:	5hrs Cont. Rest (NROC):	8hrs Total Rest (NROC)/5hrs Cont. Pattern (NROC)
Apr-26	12	1		
May-26	6	10	2	
Jun-26	7	8	2	2

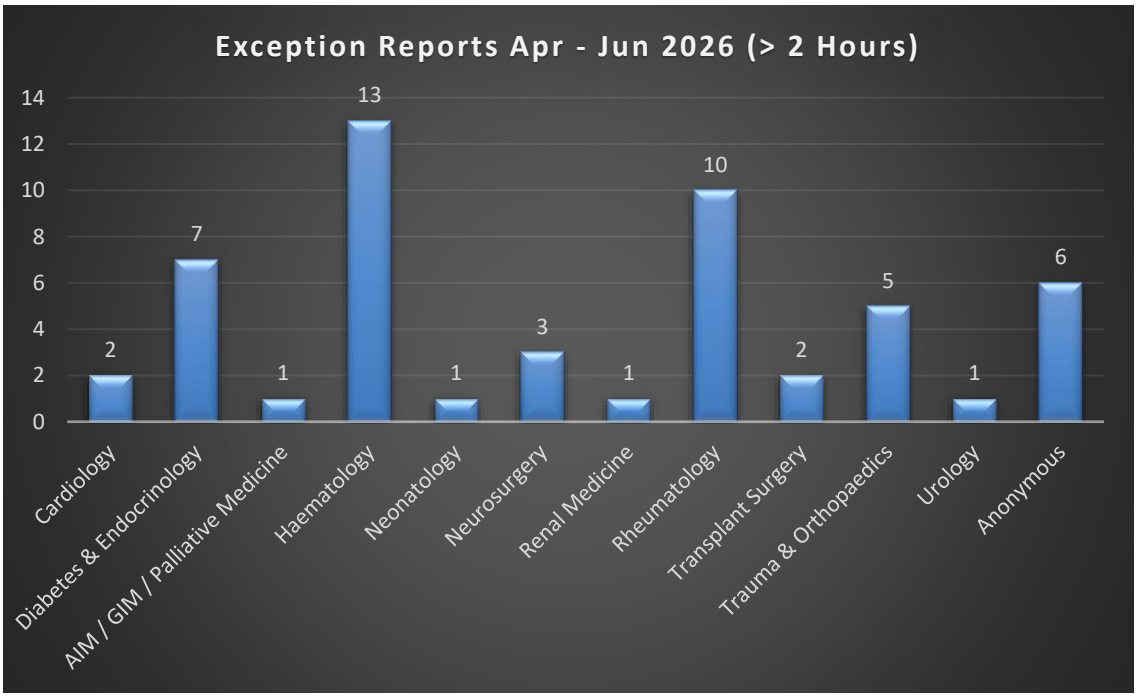
Exception Reports < 2 hours:



- There were 265 exception reports for **under** 2 hours submitted between April and June 2026. (52 in April, 127 in May, and 86 in June)

Specialty:	**Total:**	**Apr:**	**May:**	**Jun:**
Total ERs <2 hours	**265**	**52**	**127**	**86**
Accident & Emergency	10		7	3
Cardiology	15		12	3
Diabetes & Endocrinology	20	8	5	7
Gastroenterology	5		5	
AIM / GIM / Palliative Medicine	32	5	14	13
General Practice	4	4		
General Surgery	48	14	13	21
Haematology	42	7	18	17
Infectious Diseases	1		1	
Medical Oncology	1	1		
Medicine for the Elderly	11		7	4
Neonatology	4	1	3	
Neurology	11		9	2
Neurosurgery	23	3	9	11
OMFS	3		1	2
Paediatrics / Paediatric Surgery	9	4	3	2
Renal Medicine	4	2	2	
Respiratory Medicine	1		1	
Rheumatology	1	1		
Trauma & Orthopaedics	18	2	15	1
Urology	2		2	

Exception Reports > 2 hours:



- There were 46 exception reports for **over** 2 hours submitted between April and June 2026. (33 in April, 11 in May, and 10 in June)

Specialty:	**Total:**	**Apr:**	**May:**	**Jun:**
Total ERs >2 hours	**46**	**33**	**11**	**10**
Cardiology	2		2	
Diabetes & Endocrinology	7	3	2	2
AIM / GIM / Palliative Medicine	1			1
Haematology	13	8	2	3
Neonatology	1	1		
Neurosurgery	3			3
Renal Medicine	1			1
Rheumatology	10	10		
Transplant Surgery	2	2		
Trauma & Orthopaedics	5	2	5	
Urology	1	1		
Anonymous	6	6		