NHS
Cambridge University Hospitals
NHS Foundation Trust

Annual report and accounts 2018/19

Together-Safe | Kind | Excellent

Addenbrooke's Hospital | Rosie Hospital

Cambridge University Hospitals
NHS Foundation Trust

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Contents

1. Chair's statement

When the National Health Service was first established, it had one clear aim, to provide good healthcare for all. Looking back over the past year at Cambridge University Hospitals (CUH), which began with us celebrating 70 years of the NHS, it is clear to me that the original aim still rings true today. It is a privilege to witness the hard work and determination of all our staff as they ensure that our patients receive the best possible care day in, day out.

As a Trust we face the same challenges as our colleagues throughout the NHS in terms of ever more stretched finances coupled with increasing demand for services and an uncertain political climate. However, here at CUH, we also have much to celebrate. The past twelve months have been hugely rewarding in many ways. Firstly, and most importantly, we are continuing to deliver excellent levels of care.

Caring for others is a privilege but it is not always easy given the constant scrutiny, huge demand and resourcing challenges our staff face on a daily basis. It was fantastic therefore, to have our care recognised as outstanding once again by the Care Quality Commission (CQC) who inspected us in October and November 2018. They inspected four of our core services: medicine and elderly care, surgery, urgent and emergency care, and end of life care. They also assessed our culture and leadership as part of their 'well-led' line of questioning. The final report recognised further significant improvements over the last two years since our previous inspection, including rating our end of life care as 'outstanding.' This is particularly significant as this is the point where compassion really matters and it is humbling to recognise the support our staff provide for both our patients and their families.

Across the Trust, other areas of outstanding practice were mentioned such as our culture and leadership and, as you would expect, there were also certain areas where we require improvement.

We know the length of time that patients are waiting to be seen is still too long in some areas. We need to take further steps to match our capacity with demand more effectively and ensure everyone is seen in the most appropriate setting for the level of care they require. We are working closely with our local health and social care partners to improve transition processes for patients leaving the Trust, enabling them to further their treatment in a community setting. The good news is that we ended the year in a much stronger position. There are now around 40 patients a day waiting to leave the hospital, we've not been operating at a level this low for three or four years and last year we were seeing 70 to 80 patients waiting to be discharged each day. The challenge will be to keep this momentum going while providing emergency and elective care for more patients than ever before.

As described in the Chief Executive's statement below, the Board has significant concerns about the financial situation of the Trust and we are continuing to work with national and regional partners to address these challenges. We are also heavily focused on securing the capital funding that is urgently required to address the immediate estates issues that we face.

This year we have welcomed both the Prime Minister, Theresa May, and Health Secretary, Matt Hancock, on separate occasions. Both visits gave staff the opportunity to share their thoughts in advance of the publication of the Government's NHS Long Term Plan. The plan, which was published in January 2019

and outlines the national overview for the NHS over the next ten years, covers everything from delivery of care and areas for investment to the integration of primary and community services and developing research. As a Trust we are now using the plan to shape and bolster our own development and strategic direction. In some areas we have the opportunity to decide how we will implement the proposals, in others we are awaiting clearer direction on how we take things forward.

The heart of the plan is about making the NHS sustainable for the coming years and we are already working with our partners to ensure that the Trust, along with the wider Cambridgeshire and Peterborough area, is fit for the future. The injection of £145 million of capital funding from the Government will play a major part in this, and £100 million of the investment will be used to create a purpose-built children's hospital for the East of England on land adjacent to the main Addenbrooke's Hospital buildings. The children's hospital project will be delivered through an innovative joint proposal between ourselves, Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), providing mental health services and the University of Cambridge, providing world-leading academic research. I am acutely aware that this hospital needs to provide support to develop and strengthen paediatrics across the whole region and we will be working with our networks to build a shared vision for this. The partnership is pioneering the full integration of physical and inpatient mental healthcare in the same setting, alongside ground-breaking genomic science and mind and body mental health research to find new ways of preventing and detecting childhood diseases. The hospital will provide a permanent and sustainable home for CPFT's inpatient children and young people's mental health services currently provided on the Ida Darwin site in Cambridge.

It is an exciting time for the city and the region. For us at CUH, being based at the heart of the Cambridge Biomedical Campus means we are perfectly situated to make the most of the opportunities that are arising. As new partners arrive to join us on site we are benefitting from, not just their close proximity in terms of support and resourcing, but also the research and development opportunities they bring with them. The growing campus provides us with the ideal foundation for translating cutting edge research into practical clinical care and treatment for future patients. We have been particularly delighted to work with our colleagues at the Royal Papworth Hospital which opened in May 2019. We look forward to strengthening our relationship with their teams for the benefit of all patients using our respective services.

This year has given us much to think about. Coming together as a Trust for the NHS 70th birthday celebrations was a valuable opportunity, not just to eat show-stopping cake, but to reflect on how far we've come.

The aim of the NHS is a simple one but delivering that aim continues to be much more complex. On behalf of the Board and myself I want to take this opportunity to thank everyone who works here and works with us, you are constantly helping us to become better.

Mike More
Chair
23 May 2019

2. Performance report

2.1 Overview

This section of the report provides a summary of the organisation, its purpose, the key risks to the achievement of its objectives and performance during the past year.

2.2 Statement from the Chief Executive

I would like to start by congratulating our teams for some outstanding achievements this year that have directly improved the care of our patients.

We have further consolidated our improvements over the last two years by taking another step forward in our rating with the Care Quality Commission (CQC). Many domains of care are now rated as 'Outstanding' and all are 'Good' or above with the exception of the key line of enquiry that looks at our waiting times for access to services. We know we have some challenges to face in this area, which are caused partly by the increasing demand that our growing and ageing population is placing on our hospitals.

In order to tackle this, we are working increasingly closely with our partners across health and social care. This is starting to pay dividends and we are getting more patients into appropriate care settings, so that they can leave hospital as soon as they are medically fit to do so. Over the course of the last year, the number of patients fit to leave, but stuck in hospital, has fallen from around 100 to 40. This has freed up a significant number of beds that we can then use to bring in patients who are waiting for surgery, or need to be admitted from our emergency department. Over the next 12 months, our aim is to see some significant improvements in the speed with which we can offer access to our services as a result of these changes.

I am pleased to report that we have met our financial plan for the fourth consecutive year, which is a significant achievement, not only as we have been able to realise our £40m cost improvement target again, but also because we have succeeded despite a great deal of operational pressure. This is a reflection of the hard work by our staff in continuing to deliver cost and quality improvements within the organisation, in working with partners to achieve improvements across the health and care system and in taking action on the structural elements of the financial deficit that are within our control. I would like to take this opportunity to thank everyone at Addenbrooke's and the Rosie, as well as our partners and our patients, for their commitment support.

The Board takes its financial responsibilities very seriously and is deeply concerned about the unsustainable nature of the Trust's current financial situation. In recent years the Trust has tackled a number of legacy issues that contributed to our deficit. We will maintain strong cost control and continue to support clinically-led cost improvement. We will also continue to work very closely with Cambridgeshire and Peterborough health and care partners to ensure that there is better use of health and care resources across the whole service –

which will ultimately help CUH to deliver hospital-based care in a more clinically effective and efficient manner. We have also agreed a control total as part of our 2019/20 financial plan which will see a substantial reduction in our deficit. At the same time, we will continue to seek the capital funding that we urgently need to invest in our infrastructure. We will continue to work with the wider NHS, as many of these challenges will need to be addressed with national and regional partners. We expect that, together, these actions will result in us being able to agree a sustainable medium-term financial plan during 2019/20.

This year there has been a further improvement for the Trust in the National Staff Survey, where we remain above average as a place that our staff would recommend both to work and receive treatment. However, there is still more to do to improve the experience of our staff in relation to discrimination and equality and diversity here at Addenbrooke's and the Rosie. We are firmly committed to delivering our action plans that tackle the challenges set out in both our workforce race equality scheme data and staff survey. This will remain a priority until we have seen demonstrable improvement and multiple initiatives across the Trust are directed towards this aim.

We have continued to work with our patients, staff and partners on developing the four areas of the strategy CUH Together: improving patient journeys; working with our communities; strengthening the organisation and contributing nationally and internationally, to build on the progress we made last year, with ongoing innovations to design pathways to deliver the best patient care. Work as part of the Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP) is also ongoing as we move towards ever more closely integrated priorities.

On the Cambridge Biomedical Campus, we have been delighted to welcome another NHS specialist hospital, the Royal Papworth, as they opened their new building. We have much in common with each other and being neighbours will enable us gain the advantages of closer interaction between our services. Patients will be the ultimate beneficiaries of this as we can bring together the different aspects of their care and have the right expert at the bedside when needed.

Once again I would like to credit and thank the 10,000 people who work and volunteer at CUH and make it what it is - an inspiring place to work where our core purpose is the business of being kind to others.

Roland Sinker
Chief Executive
23 May 2019

2.3 Purpose and history

Cambridge University Hospitals NHS Foundation Trust (CUH), including both Addenbrooke's and the Rosie Hospitals, was one of the first NHS foundation trusts to be authorised under the Health and Social Care (Community Health and Standards) Act 2003, and came into being in July 2004.

Our constitution defines our principal purpose as 'the provision of goods and services for the purposes of the health service in England'.

The Trust has its foundation in Addenbrooke's Hospital, which opened in October 1766 in Trumpington Street, Cambridge, as one of the first provincial teaching hospitals in the country. By the 1950s, the hospital was experiencing difficulty accommodating the expansion generated by the introduction of the NHS, and moved to the site on Hills Road. It was officially opened by Her Majesty Queen Elizabeth II in 1962.

Today, CUH has over 1,000 beds and 10,000 members of staff. We are one of the largest and best known acute hospital trusts in the country. The 'local' hospital for our community, delivering care through Addenbrooke's and the Rosie, CUH is also a leading regional and national centre for specialist treatment; a government-designated comprehensive biomedical research centre; a partner in one of six academic health science centres in the UK – Cambridge University Health Partners (CUHP); and a university teaching hospital with a worldwide reputation.

Our CUH Together Strategy has been developed with staff, patients and partners. Patients are central to everything we do and we want to ensure that CUH is an exciting and supportive place to work. Our vision is to improve people's quality of life through innovative and sustainable healthcare. We will deliver our vision in a way that is consistent with our values of *Together* – Safe | Kind | Excellent, and the associated behaviours that define how we care for our patients and work with our colleagues and partners.

Our strategy has four key priorities:

- Improving patient journeys
- Working with our communities
- Strengthening the organisation
- Contributing nationally and internationally

We are particularly grateful to Addenbrooke's Charitable Trust (ACT) for its financial support and the fundraising efforts of everyone within the Trust, and in the wider local community, who raise charitable funds which help us to provide improved services for our patients.

2.4 Key risks

Key risks are identified by the Board of Directors through the Board Assurance Framework (BAF). At the end of 2018/19, the six most significant risks to

achieving the organisation's strategic objectives as identified by the Board are outlined in table one.

Table 1: Board Assurance Framework (BAF)

The top six 'risks' identified in the 2018/19 BAF as reviewed by the Board of Directors on 13 March 2019 were as follows:

Risk ref.	Risk description	Lead Executive	Board monitoring committee
007/18	A failure to address estate backlog maintenance and statutory compliance priorities (including infection) caused by insufficient capital funding and decant capacity impacts on safety and continuity of clinical service delivery.	Chief Finance Officer	Performance Committee Quality Committee
007a/18	Inadequate fire safety management arrangements and plans impact on patient and staff safety and continuity of clinical service delivery.	Chief Finance Officer	Board of Directors
002/18	The Trust has insufficient capacity to sustain timely and effective emergency and elective patient flow through its hospitals which impacts on waiting times, safety and patient experience.	Chief Operating Officer	Performance Committee
010/18	As a result of not achieving system-wide service redesign and securing support for the structural element of the financial deficit, the Trust does not achieve a position of financial sustainability by 2020 which impacts on its ability to improve services for patients.	Chief Finance Officer	Performance Committee
011b/18	There is insufficient resilience in the Trust's IT network and technology platform given the reliance on electronic patient information to cope with IT infrastructure failures which impacts on the delivery of safe and effective services for patients.	Director of Improvement and Transformation	Audit Committee

Risk ref.	Risk description	Lead Executive	Board monitoring committee
011a/18	There is insufficient protection in the Trust's IT network and technology platform given the reliance on electronic patient information to cope with a cyber attack which impacts on the delivery of safe and effective services for patients.	Director of Improvement and Transformation	Audit Committee

The BAF is used by the Board of Directors and its sub-committees to track progress in seeking assurance that appropriate controls are in place and actions are being taken to mitigate the key risks to the achievement of the Trust's strategic objectives. Further details of how the Board gains assurance that there are effective arrangements in place for internal control and risk management to safeguard public investment, the Trust's assets, patient safety and service quality are included in the Annual Governance Statement (AGS).

A comprehensive review of the design, content and use of the BAF was undertaken during 2017/18. Each risk on the BAF is assigned to a lead Executive Director who reviews the risk on a monthly basis. The BAF is discussed on a monthly basis by the Risk Oversight Committee, which is chaired by the Chief Executive, and is received by the Board of Directors four times a year. In addition, each Board sub-committee reviews those risks assigned to it at each of its meetings to ensure that it has appropriate assurance on the effectiveness of the controls in place and progress on actions to address any gaps in control and/or assurance.

The processes outlined above and in the AGS ensure that the BAF is a living document, representing the risks of greatest concern to the Board of Directors.

2.5 Going concern statement

The Trust has considered the situation with regard to 'going concern' and after making enquiries, the directors have a reasonable expectation that CUH will have access to adequate resources to continue in operational existence for the foreseeable future.

2.6 Performance management approach

The Trust's approach to performance management is based on our operational plan with clear priorities, objectives and metrics. A process is in place to ensure staff are clear about the priorities and that these are linked to individual objectives. Arrangements are in place for reporting to our commissioners and regulators, and there is a clear and simple quality message to our patients and the wider public through our quality account.

Performance is monitored by the Board of Directors through a monthly Integrated Performance Report, with detailed scrutiny and assurance sought by the

Performance Committee of the Board. There is a focus across a broad range of metrics covering quality, operational performance, workforce and finance. Clinical divisions review performance through their divisional boards and associated governance arrangements and monthly performance review meetings are held between the executive team and each clinical division, with issues escalated as required to the Management Executive.

2.7 Performance analysis for the year

Detailed information regarding the performance of the Trust is included in the Quality Account (Chapter 4).

Financial performance

The Trust's financial results for 2018/19 were slightly better than planned, with a deficit for the financial year of £94.2m (plan £94.3m). The Trust is currently rated within segment 3 of NHS Improvement's Single Oversight Framework, which is unchanged from 2017/18. The plan included an ambitious cost improvement plan (CIP) of £40.1m, which the Trust overachieved by delivering £40.9m of savings. £35.2m (86%) of these savings have a recurrent benefit, with £5.7m (14%) being delivered non-recurrently.

The Trust's underlying deficit continues to be the result of a number of challenges, both local to the organisation and reflected nationally. However, the deterioration in headline deficit from 2017/18 is largely the result of the loss of Provider Sustainability Fund income in 2018/19 due to the Trust not reaching agreement on a Control Total with NHS England and Improvement.

The Board takes its financial responsibilities very seriously and is deeply concerned about the unsustainable nature of the Trust's current financial situation, with a cumulative revenue deficit of £245.7m and loans from the Secretary of State totalling £340.8m. We will continue to work very closely with Cambridgeshire and Peterborough health and care partners to ensure that there is better use of health and care resources across the whole service – which will ultimately help CUH to deliver hospital-based care in a more clinically effective and efficient manner. We have also agreed a control total as part of our 2019/20 financial plan which will see a substantial reduction in our deficit. At the same time, we will continue to seek the capital funding that we urgently need to invest in our infrastructure. We will continue to work with the wider NHS, as many of these challenges will need to be addressed with national and regional partners. We expect that, together, these actions will result in us being able to agree a sustainable medium-term financial plan during 2019/20.

2.8 Environmental matters, social, community and human rights issues

The activities and policies of CUH in the areas of social, environmental, community and human rights are outlined in Chapter 3, specifically within the equality, diversity and inclusion report and sustainability and climate change report.

2.9 Emergency Planning, Resilience and Response

The Trust is classified as a Category 1 responder under the Civil Contingencies Act 2004. Under this legislation the roles and responsibilities are clearly outlined to ensure that the Trust has arrangements in place to respond appropriately to incidents or events impacting on the health of the community and minimise any further disruption.

The Trust has a Major Incident Plan which sets out the process by which the organisation will respond to, manage and recover from an incident. This plan is sponsored by the Chief Operating Officer who has the role of the Accountable Emergency Officer for the Trust. The Major Incident Plan is owned by the Trust's Resilience Manager who has the responsibility for ensuring it is reviewed in line with organisational policy.

The Trust has completed the annual self-assessment against the NHS England EPRR core standards in conjunction with a peer review conducted by Cambridgeshire and Peterborough CCG. The Trust was declared as 'substantially compliant' against the core standards and an action plan has been put in place to monitor progress.

The Trust continues to participate in emergency planning exercises and training and is an active member of the Local Resilience Forum working groups. There is close working underway with Royal Papworth Hospital as part of its relocation to the Cambridge Biomedical Campus and a joint evacuation exercise is scheduled for June 2019.

Emergency Planning priorities for 2019 include:
- Revising Business Continuity Plans and Business Impact Analyses
- Supporting the contingency work for a potential 'no deal' EU exit
- Undertaking a live exercise in summer 2019
- Developing and maintaining a more robust Major Incident Decision Making call out list
- The preparation of an investment case for two additional resources to help deliver the EPRR agenda. These new positions will assist in recognising the size of the organisation, the wide variety of tasks that need to be undertaken and the continual review and updating of EPRR policies and procedures across the Trust.

2.10 Freedom to Speak Up

In line with the recommendations of the Freedom to Speak Up Review undertaken by Sir Robert Francis. The Trust appointed a Freedom to Speak Up Guardian in December 2016. The Guardian is supported by local listeners from across the organisation.

The Speaking Up service offers support to all employees and workers to raise concerns in a confidential environment. In parallel, the Guardian works with key stakeholders across the organisation to promote and improve our speaking up and listening culture so that raising concerns becomes part of our normal business.

In the financial year 2018/19 72 people raised concerns directly with the Speaking Up service. Across the concern themes, 33% related to Trust policy and

procedure, 27% to behaviour and relationships, 25% management support, 12% were patient-related and 3% capacity/workload/training. The largest occupational groups raising concerns are nursing and midwifery and administrative staff. The level of concerns raised is broadly comparable with the national average however the Trust is lower than average on patient-related concerns raised through this route. Trends continue to be monitored.

In addition to the national annual staff survey (Q3 October – December), the Trust collects data on the speaking up service on annual basis in Q1 (April – June) thus providing a barometer of the organisational speaking up culture. The 2018 staff survey shows an improvement across the three questions relating to raising concerns and the local Q1 survey reports that 90% of staff feel secure to raise concerns with line management. Work continues to spread awareness and support improvements to raise these engagement scores further.

The Trust is using the National Guardian's Office guidance on best practice and consistent approaches and NHS Improvement's guide for boards as a self-review tool to evaluate our strategy and arrangements to demonstrate our commitment to further improving our speaking up culture.

2.11 Significant events after the balance sheet date

There were no significant events after the balance sheet date.

2.12 Associate arrangements

During the reporting period the Trust was engaged in arrangements with associates. The Annual Report and Accounts reports the investment of the Trust with each associate.

3. Accountability report

Directors' report

3.1 Board of Directors

The Board of Directors comprises full-time Executive and part-time Non-Executive Directors, the latter selected for their knowledge, areas of relevant expertise and experience. All directors meet the Fit and Proper Persons Requirements.

The role of the Board of Directors is to provide effective and proactive leadership of the NHS foundation trust; to set the strategic aims of the Trust, ensuring the quality, safety and effectiveness of the services provided; and to ensure that the Trust is well-governed in all aspects of its activities.

The section below demonstrate the balance, completeness and relevance of the skills, knowledge and expertise that each of the directors bring to the foundation trust.

The Board of Directors met 17 times during the year under review, 6 times in public and 11 times in confidential session.

3.2 Board and committee effectiveness

The performance of the Board of Directors is reviewed collectively as part of a board evaluation process; and individually, with each board director undertaking performance appraisal with either the Chief Executive for Executive Directors or the Chair for the Chief Executive and Non-Executive Directors. The Chair is appraised by the Senior Independent Director in consultation with the Lead Governor. Board committees undertake an annual review of their effectiveness against their terms of reference and work programmes and report to the Board of Directors on this.

3.3 Trust Chair

Dr Michael More, CBE – Chair

Mike became Chair of CUH on 11 April 2017. He joined the CUH Board of Directors in September 2013 bringing extensive experience from health, police, transport as well as local government. He was chief executive of Westminster City Council until the end of 2013. Mike began his career at the National Audit Office in 1981. He was senior auditor at Cambridgeshire County Council in 1986 moving on to a number of increasingly high-level positions at the council including head of finance. Mike was appointed as the director of resource management of Suffolk County Council in 1999, and progressed to the position of chief executive in 2002 before joining Westminster City Council as chief executive in April 2008.

Mike's non-executive roles have included non-executive director on the Joint Venture Board for the University Campus Suffolk, plus positions as chair for the

Prince's Trust for Suffolk and the East of England Regional Chief Executives' Group. He was also chair of the Central London Resilience Panel which comprises all agencies including health and manages emergency planning.

Mike also held a representative role on the Olympic Games Transport Board, overseeing the overall transport consequences of hosting the 2012 Games in London. He had an active interest in developing the Health and Well-Being Board in central London and the integration of health and social care, and is a Group Board member of L&Q Housing Association, one of the larger Housing Associations in the country.

Mike is a Board member of Cambridge University Health Partners.

3.4 Non-Executive Directors

Daniel Abrams – Non-Executive Director

Daniel initially trained as a barrister and subsequently qualified as a chartered accountant with Arthur Andersen. He was previously Head of Corporate Finance and Strategy for Diageo plc and Chief Finance Officer and Vice President, Finance for PepsiCo,Inc , Asia and Africa division. In 1997 Daniel joined biotech company Xenova plc as Group CFO and subsequently was Group CFO at technology company CDT Inc, global textiles manufacturing business Fiberweb plc and electrical and optical global business Volex plc. He is a Senior Adviser to private equity clients and a Non-Executive Director and Audit Committee Chair of Nottingham based Bio City Group Ltd.

Adrian Chamberlain – Non-Executive Director

Adrian began his career working with Bank of America before joining Boston Consulting Group after receiving and MBA from London Business School. In 1986 he joined British Telecom plc as a Business Strategy Manager before becoming Marketing and Commercial Director for Sears Sports and Leisurewear. Subsequently he undertook a number of senior roles with Cable and Wireless plc including Chief Executive of the Consumer Markets Division (now Virgin Media), Managing Director of the Consumer and Multimedia Division in Australia and Group Director of Strategy and Corporate Development. He then became Chief Executive Officer of Global Services for Europe and Asia and a member of the Cable and Wireless Board. In 2003 he was appointed Main Board Director and CEO Europe of Bovis Lend Lease Corporation, a leading construction, property development and property Management Company. Between 2006 and 2015 he was CEO of private equity backed MessageLabs and Achilles, high tech companies specialising in software as a service cyber security and supply chain management.

Dr Annette Doherty, OBE – Non-Executive Director

Annette has 30 years of international experience working within the pharmaceutical sector, leading Research and Development groups worldwide, including at Pfizer and GlaxoSmithKline (GSK). She is currently Senior Vice President, Global Head of Product Development and Clinical Supply at GSK. She

has published more than 100 scientific manuscripts and written 19 reviews in the research areas in which she has worked. She is co-inventor of over 30 patents. In 2007 she received an honorary degree of Doctorate of Science from the University of Greenwich for her scientific leadership in research and contributions to education and industry/academic partnerships. She chaired the Association of British Pharmaceutical Industry (ABPI) R&D group from 2005-2009 and served on the ABPI Board. She was a Member of the Technology Strategy Advisory Board and an industry participant in a House of Lords session on Genomic Medicine. She has been a member of the Medical Research Council (2008-2012) and the Council of the Royal Society of Chemistry (2011-2015). She is a member of the Medicines Manufacturing Industry Partnership (MMIP). In 2009, Annette was awarded the OBE in recognition of her services to the pharmaceutical sector

Dr Michael Knapton – Non-Executive Director

Mike holds an MA in physiology from the University of Cambridge, a bachelor of medicine & bachelor of surgery (MB BChir) and is a fellow of the Royal College of General Practitioners. Mike's career began at Cambridge University Hospitals, volunteering at the Old Addenbrookes site in 1977, as a clinical student in 1980 and a junior doctor at Cambridge University Hospitals from 1982 to 1986, moving into local general practice as GP principal in 1987 at the surgery in Harston. He has also worked at Addenbrooke's as GP tutor, as well as a spell as cardiology assistant from 1997 to 2003. He joined Cambridge City Primary Care Group 1999 as Professional Executive Committee chairman and by 2005 was appointed medical director of Cambridge and South Cambridgeshire Primary Care Trust. He was associate medical director of the British Heart Foundation from 2006 until 2017. Mike's additional roles include treasurer roles for Cambridge Medical Society, and past Chairman of the East Anglian Faculty of the Royal College of General Practitioners. He is also a trustee for Addenbrooke's Charitable Trust.

Professor Patrick Maxwell – Non-Executive Director

Patrick is the Head of the University of Cambridge, School of Clinical Medicine. He is also the Regius Professor of Physic – one of the oldest professorships at the University, founded by Henry VIII in 1540 and appointed by the Queen. Patrick holds a Wellcome Trust Senior Investigator award for his research on oxygen sensing. At CUH Patrick has a special interest in quality, patient safety, audit and public engagement. Patrick undertook postgraduate clinical and research training in nephrology and general medicine at Guy's Hospital and in Oxford. He was appointed as University Lecturer and then Reader at the University of Oxford. In 2002 he moved to the Professorship of Nephrology at Imperial College, followed by the Chair of Medicine at University College London in 2008. Patrick is a member of the Board of Cambridge University Health Partners (CUHP) – a partnership between the University and the NHS. Patrick was elected a fellow of the Academy of Medical Sciences in 2005 and was elected to its Council in 2018. He was appointed a trustee of the Medical Schools Council in 2018 and is a member of its Executive Committee.

Professor Sharon Peacock, CBE – Non-Executive Director

Sharon is a Professor of Clinical Microbiology at the London School of Hygiene and Tropical Medicine in London, an Honorary Senior Research Fellow in the

Department of Medicine at the University of Cambridge, and an honorary faculty member at the Wellcome Trust Sanger Institute. Her research group work between the Sanger Institute and the Cambridge Biomedical Campus, and focus on the translation of bacterial genome sequencing into diagnostic and public health microbiology. Sharon was based full-time in the Department of Medicine, University of Cambridge between 2009 and 2015, and was Head of Bacterial Diseases Research at the Wellcome Trust Major Overseas Programme in Thailand between 2003 and 2009. Sharon sits on numerous funding panels and advisory groups with a particular focus on drug-resistant infections, including being the Board Chair of the Wellcome Trust Surveillance and Epidemiology of Drug Resistant Infections Consortium (SEDRIC), and a member of the Technical Advisory Group to the Department of Health Fleming Fund.

Shirley Pointer – Non-Executive Director and Senior Independent Director

Shirley has worked in both the public and private sectors and is a highly respected, experienced leader and senior executive with extensive experience in the areas of people, organisational capability and change.
Shirley joined CUH from the Department of Health where she was the HR Director. She has also held senior leadership roles in the Department for Communities and Local Government, the Department for Innovation, Universities and Skills and the Department for Trade and Industry. Prior to joining the Civil Service Shirley spent 20 years in the private sector, primarily in financial services. She also has non-executive experience gained in the charity sector. In addition to her non-executive role Shirley is a CQC Special Adviser in the areas of leadership and governance. She also works as an independent consultant in the development and delivery of people strategies to enable organisational change. Her passion is to create successful organisations through authentic leadership underpinned by robust governance and management practices.

3.5 Executive Directors

Roland Sinker – Chief Executive

Areas of responsibility include: *accounting officer, overall responsibility for management of the Trust, ensuring its obligations and targets are met within a framework of prudent and effective systems of internal control*

Roland started as Chief Executive in November 2015. Previously he was the Acting Chief Executive at King's College Hospital NHS Foundation Trust, and spent 2009 to 2015 as their Chief Operating Officer.

Coming from a legal and management consultancy background, Roland served as Strategy Director at King's between 2005 and 2008.

Nicola Ayton – Director of Strategy and Major Projects

Areas of responsibility include: *establishing and agreeing strategic choices, business planning, and leading the Trust in co-creating and delivering the Cambridgeshire and Peterborough STP to improve health and care for our local population*

Nicola started as Director of Strategy and Major Projects in March 2018.

Previously she held the position of Deputy Director for the National System Transformation Group at NHS England, as well as Head of Strategy and Delivery for the New Care Models Programme. Before joining NHS England in 2015, Nicola worked as a civil servant in Central Government where she held a number of senior policy roles including health spending at HM Treasury. Prior to that, she worked at the Department for Education focusing on social work and school funding reform having started her career at Deloitte.

Dr Ewen Cameron – Director of Improvement and Transformation

Areas of responsibility include: continuous improvement within the organisation as well as cost improvement, eHospital, information governance and innovation

Ewen started as Director of Improvement and Transformation in February 2018. Having originally trained in Cambridge, he returned to the Trust as a Consultant Gastroenterologist with an interest in Endoscopy in 2007. He was the Clinical Lead for Endoscopy and the Clinical Director of the Cambridge Bowel Cancer Screening Centre from 2007 until 2013 when he was appointed Divisional Director for Medicine. He was subsequently the Divisional Director for Division C from 2014 to 2018. He continues to practice as a Gastroenterologist.

Sam Higginson – Chief Operating Officer

Areas of responsibility include: *clinical and operational services, performance management and emergency planning*

Sam started as Chief Operating Officer in March 2017. Previously he was Director of Strategic Finance for NHS England and between 2010 and 2013 was Director of Strategic Development at University College London Hospitals NHS Foundation Trust.
Sam started his career as a management consultant before working on health spending issues at HM Treasury. He then joined the NHS where over the last ten years he has undertaken various strategy, finance and delivery roles.

Ann-Marie Ingle – Chief Nurse until 22 July 2018

Ann-Marie left the employment of the Trust on 31 August 2018, having handed over the role of Chief Nurse to Lorraine Szeremeta on 22 July 2018. Further details of her expertise and experience can found in our annual report for 2017/18.

Paul Scott – Chief Finance Officer

Areas of responsibility include: *financial strategy, financial planning, financial management, estates and facilities, commissioning and contracting and statutory accounts.*

Paul started as Chief Finance Officer in October 2017. Previously he held the position of Executive Director of Finance, Strategy and Performance at Ipswich Hospital NHS Trust, covering Finance, Strategy, Partnerships and Commercial Contracts and IT. Before joining Ipswich in 2013, Paul spent three years as Executive Director of Finance at the East of England Ambulance Service. He has also worked in a range of finance roles across the East of England, including at Mid-Essex Hospitals Trust, Barts and The London NHS Trust and local PCTs.

Dr Ashley Shaw – Medical Director

Areas of responsibility include: *professional medical governance; medical revalidation clinical outcomes; infection prevention and control; research and development; medicines management; clinical networks; GP liaison; undergraduate education; post-graduate education*

Ashley took up the post of Medical Director for CUH in November 2017. He joined the Trust as a Consultant Radiologist with an interest in cancer imaging in 2004 and became Divisional Director for Investigative Sciences in 2012, subsequently for Division B from 2014. Ashley continues to practice as a consultant radiologist.

Lorraine Szeremeta – Chief Nurse from 23 July 2018

Areas of responsibility include: *nursing and midwifery strategy and standards, executive lead for quality and safety and patient experience, safeguarding children and vulnerable adults, professional lead for allied health professionals, and executive lead for psychological medicine services*

Lorraine joined Cambridge University Hospitals as Chief Nurse in July 2018.

Previously she held the position of Deputy Chief Nurse at University College London Hospitals acting as Head of Nursing for the Surgery and Cancer Board, as well as corporate responsibilities including the nurse education agenda and management of voluntary services. She was seconded on a part time basis for a period of 12 months working on a pan London programme, Capital Nurse, which focused on recruitment and retention of nurses in London, where she led on the introduction of the internal transfer programme for staff across London, a number of cross boundary leadership programmes as well as acting as executive producer on a film to aid retention. She has worked in a range of nursing roles throughout her career and has held an interim Director of Nursing role previously. She is a visiting Professor at London South Bank University. She is also a Florence Nightingale Scholar.

Ian Walker – Director of Corporate Affairs

Areas of responsibility include: *corporate governance, public engagement, legal services, communications, foundation trust membership and raising concerns.*

Ian joined the Trust in May 2017, having previously worked at Barts Health NHS Trust for 14 years as Director of Corporate Affairs and Trust Secretary. Prior to

that, Ian worked at Her Majesty's Treasury where he undertook a wide range of roles, including on health policy and funding.

David Wherrett – Director of Workforce

Areas of responsibility: *human resources (including medical staffing); organisational development and design, health and safety, recruitment, employee relations, occupational health, pensions and voluntary services*

David started as the Director of Workforce in April 2014.

David has worked in human resources for over 20 years in various organisations. He has spent the majority of his recent career in the NHS, working primarily in hospitals. His focus is to ensure that CUH supports its staff to deliver excellent care for patients and carers.

3.6 Register of interests

At the time of their appointment, all directors are asked to declare any interests on the register of directors' interests and are expected to declare any changes to the register of interest on an on-going basis.

This register is reviewed on a quarterly basis and maintained by the Director of Corporate Affairs. The register is available for inspection by members of the public.

Anyone who wishes to see the register of directors' interests should make enquiries to the Director of Corporate Affairs at the following address:

Director of Corporate Affairs, Box 146, Cambridge University Hospitals NHS Foundation Trust, Cambridge Biomedical Campus, Hills Road, Cambridge CB2 0QQ or telephone 01223 256256.

3.7 Appointment of Chair and Non-Executive Directors

The Council of Governors has the responsibility for appointing the Chair and the other Non-Executive Directors (except in the case of the Regius Professor of Physic) in accordance with the Constitution and in line with relevant legislation.

Candidates are nominated by the Council of Governors' Nomination and Remuneration Committee. This Committee comprises one public, one patient, one staff and one partnership governor. It is chaired by the Chair of the Trust for Non-Executive Director appointments only, and by a governor (currently Public Governor – Wendy Menon) for all its other functions including the appointment of the Trust Chair.

Non-Executive Directors are normally appointed for a term of three years. Following this term, and subject to satisfactory performance appraisal, a Non-Executive Director is eligible for consideration by the Council of Governors for re-appointment up to a maximum cumulative total of nine years service.

When undertaking its nomination responsibilities, the Committee reviews the structure, size and composition (including skills, knowledge and experience) required of the Board of Directors compared to its current position and makes recommendations for change when appropriate.

The removal of a Non-Executive Director requires the approval of three quarters of members of the Council of Governors. Details of the criteria for disqualification from holding the office of a director can be found in the Constitution.

Disclosures of the remuneration paid to the Chair and Non-Executive Directors (and also to the Chief Executive and Executive Directors) are given in the remuneration report at section 3.22.

3.8 Non-Executive Directors' expenses

CUH is committed to reimbursing expenses incurred on Trust business to the Chair and Non-Executive Directors at rates set by the Council of Governors. A copy of the policy is available from the Director of Corporate Affairs.

3.9 Attendance at Board meetings in 2018/19

Meeting dates

2018: 11 April, 9 May, 13 June, 11 July, 12 September, 10 October, 14 November and 12 December.

2019: 16 January, 13 February and 13 March.

There were two meetings of the Board of Directors on the dates listed above in May, July, September, November, January and March.

Table 2: Attendance at Board meetings in 2018/19

Name	Title	Attendance
Dr Michael More	Trust Chair	17/17
Daniel Abrams	Non-Executive Director	17/17
Nicola Ayton	Director of Strategy and Major Projects	17/17
Dr Ewen Cameron	Director of Improvement and Transformation	17/17
Adrian Chamberlain	Non-Executive Director	17/17
Dr Annette Doherty	Non-Executive Director	16/17
Sam Higginson	Chief Operating Officer	17/17
Ann-Marie Ingle	Chief Nurse	6/6
Dr Michael Knapton	Non-Executive Director	17/17
Professor Patrick Maxwell	Non-Executive Director	13/17
Professor Sharon Peacock	Non-Executive Director	17/17
Shirley Pointer	Non-Executive Director	16/17
Paul Scott	Chief Finance Officer	16/17
Dr Ashley Shaw	Medical Director	16/17
Roland Sinker	Chief Executive	17/17
Lorraine Szeremeta	Chief Nurse	9/11
Ian Walker	Director of Corporate Affairs	17/17
David Wherrett	Director of Workforce	16/17

3.10 Committees of the Board of Directors

The Board of Directors is required to establish and maintain an Audit Committee and Remuneration Committee. Further details about the Audit Committee and Remuneration Committee are contained in sections 3.12 (Audit Committee) and 3.22 (Remuneration Committee).

The Board of Directors has also established the following committees of the Board:

- Performance Committee
- Quality Committee
- Workforce and Education Committee

The membership of the committees is determined by the Chair of the Trust in consultation with the Board of Directors.

Table 3: Committee membership as of 31 March 2019

Committee	Membership
Audit Committee	NEDs: Daniel Abrams (Chair), Professor Sharon Peacock, Professor Patrick Maxwell

Remuneration Committee	All Non-Executive Directors. Chaired by Shirley Pointer.
Quality Committee	NEDs: Professor Sharon Peacock (Chair), Adrian Chamberlain, Dr Michael Knapton Executive Directors: Chief Nurse and Medical Director.
Performance Committee	NEDs: Adrian Chamberlain (Chair), Daniel Abrams, Shirley Pointer Executive Directors: Chief Finance Office, Chief Operating Officer and Medical Director
Workforce and Education Committee	NEDs: Shirley Pointer (Chair), Dr Michael Knapton, Professor Patrick Maxwell Executive Directors: Director of Workforce, Chief Nurse and Medical Director.

Table 4: Attendance of committee members at Board Committee meetings 2018/19

Audit Committee

Name	Title	Attendance
Daniel Abrams	Committee Chair	4/4
Professor Patrick Maxwell	Non-Executive Director	2/4
Professor Sharon Peacock	Non-Executive Director	4/4

Performance Committee

Name	Title	Attendance
Adrian Chamberlain	Committee Chair	11/11
Daniel Abrams	Non-Executive Director	10/11
Sam Higginson	Chief Operating Officer	11/11
Shirley Pointer	Non-Executive Director	11/11
Paul Scott	Chief Finance Officer	10/11
Dr Ashley Shaw	Medical Director	11/11

Quality Committee

Name	Title	Attendance
Professor Sharon Peacock	Committee Chair	6/6
Adrian Chamberlain	Non-Executive Director	6/6
Ann-Marie Ingle	Chief Nurse (Until 22 July 2019)	1/2
Dr Michael Knapton	Non-Executive Director	6/6
Dr Ashley Shaw	Medical Director	6/6

Lorraine Szeremeta	Chief Nurse (From 23 July 2019)	4/4

Remuneration and Nomination Committee

Name	Title	Attendance
Shirley Pointer	Committee Chair	2/2
Daniel Abrams	Non-Executive Director	2/2
Adrian Chamberlain	Non-Executive Director	2/2
Dr Annette Doherty	Non-Executive Director	1/2
Dr Michael Knapton	Non-Executive Director	2/2
Professor Patrick Maxwell	Non-Executive Director	0/2
Dr Michael More	Trust Chair	1/2
Professor Sharon Peacock	Non-Executive Director	1/2

Workforce and Education Committee

Name	Title	Attendance
Shirley Pointer	Committee Chair	4/4
Ann-Marie Ingle	Chief Nurse (until 22 July 2019)	1/1
Dr Michael Knapton	Non-Executive Director	4/4
Professor Patrick Maxwell	Non-Executive Director	3/4
Dr Ashley Shaw	Medical Director	4/4
Lorraine Szeremeta	Chief Nurse (from 23 July 2019)	0/3
David Wherrett	Director of Workforce	4/4

Other Directors and Senior Managers attend the committees as required.

3.11 Audit Committee

Membership of this committee is made up of Non-Executive Directors and was chaired by Daniel Abrams for the whole of the reporting period.

The committee's primary role is to oversee the governance and assurance process and the effectiveness of risk management systems and the control environment, including the Trust's financial systems and annual financial statements. It considers any matters concerning the external auditors, and also the adequacy of the Trust's internal audit arrangements.

The committee's terms of reference are available on request from the Director of Corporate Affairs.

Meeting dates

The Audit Committee met as follows:

- 2018: 17 May, 25 July and 3 October
- 2019: 6 February

A summary of attendance at Audit Committee is included in table 4 in section 3.10.

Significant issues

The Audit Committee met on 21 May 2019 to consider the financial statements for the period for the period 2018/19. The Audit Committee reviewed the financial statements and identified no significant issues with the statements.

External auditors

During 2015/16, following a tender process, the Council of Governors appointed Mazars Limited as external auditors for three years from 1 April 2016. Mazars Limited reports to the Council of Governors through the Audit Committee. Mazars' accompanying report on the financial statements is based on its examination conducted in accordance with the audit code for NHS Foundation Trusts as issued by NHS Improvement. Their work includes a review of our internal control structure for the purposes of designing their audit procedures.

The external audit process is subject to annual review by the Trust in terms of competency, efficiency and the relationship between the Trust and its auditors. The Audit Committee meets with the auditors (Internal and External) without any Trust Executive Directors present prior to each meeting to improve its knowledge of their contribution.

Non-audit work may be performed by the external auditors where the work is clearly audit-related and the external auditors are best placed to do that work. For such assignments the Audit Committee approved protocol is followed which ensures all such work is properly considered. The processes in place ensure auditor objectivity and independence is safeguarded.

Audit Fees

The statutory audit fee, including quality account and whole of government accounts and others is included in note 3 to the accounts.

Internal auditors

During 2016/17, following a tender process, KPMG were appointed as the internal auditors for the Trust with effect from 1 April 2017.

The internal auditors are responsible for undertaking the internal audit functions on behalf of the Trust. The Head of Internal Audit reports to each meeting of the Audit Committee on the audit activity undertaken.

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives;

it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. Further details are provided in the Annual Governance Statement.

3.12 Remuneration and Nomination Committee of the Board of Directors

The work of the Remuneration and Nomination Committee is described in section 3.22.

There is also a Governors' Nomination and Remuneration Committee which identifies and nominates Non-Executive Directors as described in section 3.8

3.13 Cost statement

CUH has complied with the cost allocation and charging requirements as set out in HM Treasury and Office of Public Sector information guidance during 2018/19.

3.14 Better payment practice code

The Trust's performance against the better payment practice code in 2018/19 was as follows:

Non-NHS

Number of invoices paid in year	120,118
Number paid within 30 days	29,023
% paid within 30 days	24.2%

NHS

Number of invoices paid in year	3,605
Number paid within 30 days	160
% paid within 30 days	4.4%

3.15 Quality strategy

With input from the Council of Governors, the Board of Directors agreed a five year quality strategy (the Quality Plan) in 2018 which aims to ensure every patient receives safe care, provided to the highest clinical standards, whilst ensuring a positive patient experience.

The new plan is aligned to the Trust's overarching strategy has been key, with a clear focus on ensuring improvement work enhances patient care across all domains of quality while supporting improved performance.

The Quality Plan (2018-2023) builds on the work already undertaken over the past five years, outlining plans to increase in capability and capacity for improvement.

The Quality Plan outlines how successes will be shared and learned from, in addition to reinforcing the framework for improvement, with a focus on supportive leadership, which will enable our workforce to drive improvement.

Details of our quality performance in 2018/19 and the priorities we have set ourselves for 2019/20 are provided in our Quality Report at section 4. This also includes the detail of external reviews and audits of the services we provide.

3.16 Income statement

CUH has met the requirement of Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) that the Trust's income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. Other income which the Trust has received has had no impact on its provision of goods and services for the purposes of the health service in England.

3.17 Statement regarding disclosure to auditors

So far as the directors are aware, there is no relevant audit information of which the auditors are unaware. The directors have taken all of the steps that they ought to have taken as directors to be aware of any relevant audit information and to establish that the auditors are aware of that information.

3.18 Patient care

Improvements in patient/carer information

In 2018/19, the Trust Reader Panel continued to review and sign-off new patient information leaflets and procedure specific consent forms electronically on a monthly basis. A total of 200 documents were reviewed during the year. The two groups of members who only review leaflets relating to cancer and maternity services instigated in 2017/18 are now functioning well and there is good engagement from the team in this respect. Membership of the group is for three years and the Trust's Foundation Trust Office assists in recruiting new members when required.

The annual patient information audit is scheduled to be undertaken and concluded in Q2 2019/20.

Compliance of in-date patient information leaflets and procedure specific consent forms is reported monthly to each division's governance forums.

The Accessible Information Standard

In July 2016 it became mandatory for every organisation providing adult health and social care services to be compliant with the NHS Accessible Information Standard. The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting individual's information and communication support needs by NHS and adult social care service providers.

A steering group is working to embed the standard into everyday practice with particular focus on how we ensure our patients consistently receive written correspondence in a format that meet their needs.

Information on complaints handling

The Trust welcomes patient feedback and aims to make the complaints process accessible and responsive. The information from complaints investigations is used to make improvements to treatment and patients' experience of care provided.

In 2018/19 CUH received 710 complaints, a 17% increase on the previous year's total of 608. The overall rate of complaints is 0.07% of activity ('activity' here means patient episodes, e.g. an inpatient stay or outpatient attendance). Of the total number of complaints received, investigated and closed at the date of reporting (581 as of 9 May 2019), 18.8% were fully upheld, 44.6% were partially upheld and 36.7% were not upheld after investigation. Where complaints are not upheld – where it is considered that there were no shortfalls in the care provided – an explanation and apology for the patient's negative experience is provided.

The complaints regulations require NHS organisations to acknowledge complaints within three working days. In 2018/19, we achieved this in 97% of cases.

Under the current legislation, NHS organisations have six months to resolve a complaint: this allows for flexibility and agreement with the complainant as to an appropriate timescale for investigating and responding. CUH aims to provide a response in as timely a manner as possible, and works to an internal standard of responding to 50% of complaints within the timeframe set after initial receipt and assessment of the complaint.

From April to December 2018, the initial timeframe for responding to complaints was 30 working days. Over the year, work was undertaken on refining the system for grading complaints according to their complexity and severity, and applying proportionate investigation and response timeframes. The existing three tier grading system was replaced with a five tier system on 1 January 2019. Cases graded 1, 2 or 3 in the grading framework should be investigated and responded to within 30 working days (or fewer); cases graded 4 should receive a response within 45 working days; and cases graded 5 should receive a response within 60 working days.

During investigation, factors can arise which mean that cases take longer to investigate and the time to respond exceeds the initial set timeframe. Factors affecting timeliness are availability of Trust staff to investigate complaints, resource issues within the complaints team and unforeseen additional information being required as a result of initial investigations. In these cases the complaints team communicates with complainants in order to negotiate an extended set timeframe for response. Of the total number of complaints received, investigated and closed at the date of reporting, we responded to 37.3% of complaints within the initial set timeframe. We agreed and met an extension to the responding timeframe in a further 46.6% of cases, meaning that we responded to 84% of complaints either within the initial set timeframe or by the later date agreed.

Complaints are recorded on a secure database and the information is categorised to help us identify themes and trends. We record the area where the issue occurred (division, directorate, specialty, ward/clinic), the staff group (e.g. consultant, physiotherapist, nurse) and the subject of the complaint (e.g. cancelled appointment, delayed discharge), as well as the outcome of the investigation, the lessons learned and action taken, and whether the complaint was upheld. This information is available to staff across the Trust and presented to the Patient Experience Group bi-monthly.

We categorise complaints by their main subject (e.g. ‘clinical treatment’, ‘communications’), together with sub-subjects within that category (e.g. delay or failure in treatment or procedure, post-treatment complications, communications with patient). The most common main subject of all complaints received is consistently clinical treatment. This category encompasses aspects of a patient’s medical or nursing care at the Trust. Within this category, delays or failure in treatment, delays or failure to diagnose, and post-treatment complications were the three most frequently identified sub-subjects.

Emphasis is placed on identifying lessons learned and actions taken where shortfalls in care are identified. Over the past year, examples of actions implemented as a result of patient complaints include: revision of the patient information leaflet about colonoscopy; additional information placed on the allergy clinic website and clinic appointment letters; maternity provides a copy of the induction of labour procedure to patients and has produced a DVD for patients about the process of induction of labour.

The Parliamentary and Health Service Ombudsman (PHSO) undertakes the second stage in the complaints procedure. Complainants may take their case to the PHSO if they consider that attempts at local resolution have failed, and the PHSO will review the case and decide whether to re-investigate. Three cases were accepted for investigation by the PHSO in 2018/19 compared with 14 in 2017/18. Five PHSO investigations concluded with a decision to uphold or partially uphold the complaint and the Trust implemented action plans to remedy the shortfalls identified by the PHSO.

In addition to complaints, the Trust receives and responds to a larger volume of feedback through the Patient Advice and Liaison Service (PALS) encompassing enquiries, comments, concerns, advice requests and compliments. All cases are recorded on our database apart from straightforward queries such as wayfinding and car parking information. 3,336 cases were recorded on the database for 2018/19 (3,611 in 2017/18).

Problems with communication and delays or cancelled appointments are most commonly identified via PALS feedback. 360 compliments were received by the PALS team in 2018/19, but this is just a small proportion of the greater number of compliments and expressions of gratitude received directly by ward and clinic staff. The PALS team aims to turn round 80% of cases within ten working days, and this target was met in 72% of cases in 2018/19.

3.19 Stakeholder engagement

ACTIVE (Children and Young People's Board at CUH)

Active is thriving with quality children and young person (CYP) engagement as evidenced by its 28 members aged 8-18 years who come from the local community to voice their opinions and work on projects. We have on average 10 young people at each whole group meeting and excellent support for project meetings, community events and planning sessions.

The focus of the group has been on engagement of staff and new members, development and celebration of projects to improve child patient experience and further collaboration with partners.

The Map Project, from an Active leader idea to signpost the hospital from a child's view, has been progressed and there is a child friendly welcome poster at the main reception to greet children and their families. There is now a more detailed children's map with all the main areas that children attend around the hospital and staff are keen to apply this map to a variety of uses for signposting services.

Improving transition to adult services for teenage patients has remained focus for the group and more focus groups and improvements are planned involving a multi-disciplinary approach to progress Active ideas.

Staff regularly consult with the group for improvements in their clinical environments. We have looked at a variety of clinical areas and suggested improvements to the physical environment such as the new décor in ward D2 as well as service delivery aspects such as a pain assessment tool in A&E, leaflets for genetic screening and a new child patient diary.

Our relationship with the Child Nursing Branch at Anglia Ruskin University has continued to be strong and we collaborated on a meeting at ARU in March with students and staff to progress a variety of improvements including a child friendly outpatient survey and leaflets for coming to hospital.

As part of NHS70, Active joined forces with the Trust for a celebration of over 10 years of Active Children's and Young People engagement at CUH. This was an excellent opportunity to highlight numerous projects that Active have been involved with and also a chance for members past and present to meet with each other and share with their parents and foundation trust members their work and achievements.

Patient experience

The Patient Experience Group, chaired by the Chief Nurse, monitors activities relating to patient experience. The group meets bi-monthly and has governor representation to ensure that the views of members and the public are heard.

Information reviewed by the Group includes complaints and concerns, the 'Friends and Family Test' surveys, local and national patient survey results, focus group activity, '15 steps' patient experience visits to wards and clinics, patient participation groups and other sources of feedback such as that received by Healthwatch. At each meeting, there is a presentation from one Trust Division highlighting developments, initiatives and good practice relating to patient experience. Reports are received from operational groups who have a clear focus on improving patient experience.

Over the year, it was noted that there had been an increase in the volume of complaints received; potential reasons for the increase are being examined. Themes identified in complaints, and concerns raised through the Patient Advice and Liaison Service, include communications and issues with appointments. For each case where shortfalls in care are identified, lessons learned and actions taken are identified and taken forward and the cases are also reviewed at specialty clinical governance meetings, divisional governance meetings and cross-divisional groups such as the Outpatient Governance Board.

Results of the Friends and Family Test surveys show that the Trust is rated very positively by patients, with a year-end inpatient recommender score of 94.8%. Response rates are good except for outpatients: plans are in progress to change the method of surveying outpatients over 2019/20 in order to improve the response rate. Patients rate respect for their privacy and dignity highly as well as feeling safe but continue to be concerned about being disturbed by noise overnight. A working group is looking at ways in which wards can ensure a safe and quiet environment for our patients overnight.

National results for inpatient, cancer and maternity surveys were available over the year, and action plans are in progress: for example, staff are working with their Cancer Patient Participation Group on revising patient leaflets to improve communication and the 'Please Write to Me' campaign.

Seven focus groups supported by the patient experience team have been held during the year, where recent patients/carers are invited to a give their opinions

on key issues relating to specific departments or care pathways. Governors are invited to attend to hear the views first hand.

40 '15 steps' visits were made to wards and clinics: verbal feedback is given at the time of the visit to senior staff – most feedback is positive, especially regarding staff being welcoming, although areas for improvement identified over the year include the organisation and display of patient and staff information.

Patient participation groups are running well in oncology and paediatrics. Over the year, interest has been expressed from other areas in the Trust. It has been identified that additional resource is required to initiate further work and this will be progressed over the coming year.

Cambridge University Health Partners (CUHP) and Academic Health Science Centre

Cambridge University Health Partners (CUHP) is one of six Academic Health Science Centres in England whose mission is to improve patient healthcare by bringing together the NHS, industry and academia.

The partners are Cambridgeshire and Peterborough NHS Foundation Trust, Cambridge University Hospitals NHS Foundation Trust, Royal Papworth Hospital NHS Foundation Trust and the University of Cambridge.

By inspiring and organising collaboration, CUHP aims to ensure that patients reap the benefits of the world class research, clinical services and industry based in Cambridge and the surrounding area.

This year, CUHP has reorganised its activities across five key programmes: Economic Development, Education, Governance, Health Informatics and Innovation. In particular, the organisation has welcomed Mark Avery as Director of Health Informatics – a role he shares across CUHP and the Eastern Academic Health Science Network (AHSN).

CUHP is pleased to report the following highlights from 2018/19:

- CUHP signed Memorandums of Understanding with the healthcare company Roche and the Association of British Healthcare Industries to further the ties between the four partners and the private sector.

- CUHP was instrumental in helping win a £400,000 grant to help with the identification, diagnosis and treatment of the one in 17 people in the UK who have a rare disease. Working with five NHS trusts, the Eastern Academic Health Science Network and the private sector, the HDR-UK Rare Diseases Sprint Exemplar Innovation Project aims to develop a secure cloud research platform with the potential to transform the understanding of rare genetic disorders, drive improvements in diagnosis and provide proof of principle for use in other diseases.

- Following a successful bid on behalf of the University of Cambridge to HEFCE for £200,000, CUHP have developed a postgraduate education programme comprising an MSt, PGDip, and PGCert in Healthcare Data: Informatics, Innovation, and Commercialisation in partnership with the Institute of Continuing Education (ICE) and others. This new programme,

launched alongside the Cambridge Healthcare Data Hub, is currently accepting applications and will commence in September 2019.

CUHP has also been working closely with organisations across the Cambridge Biomedical Campus to develop the site further. Following an in-depth consulting exercise, work to develop an effective governance model for the campus will now move forward.

CUHP continues to contribute to the Cambridge's response to the Government's Life Sciences Industrial Strategy, looking to capitalise on new growth opportunities for our Partners.

For more information on CUHP please see www.cuhp.org.uk.

Consultation with local authorities covering the membership area

The Trust works closely with a range of local authorities across the region including for example as a member of the Cambridgeshire and Peterborough STP, the Cambridgeshire Health and WellBeing Board and the Cambridgeshire and Peterborough Local Resilience Forum. The Trust attends meetings of the Cambridgeshire County Council Health Committee as requested and has regular dialogue with local authorities on a range of issues including social care, public health, public transport and planning issues. Local authorities are represented on the Trust's Council of Governors.

Education and training

CUH is a teaching hospital for medical undergraduates and postgraduates, nurses and students in other clinical professions. Patient-centred teaching is one of our core activities and is central to our vision. We are the teaching hospital for the University of Cambridge through the School of Clinical Medicine and the Postgraduate Medical Centre which provide the infrastructure and support to facilitate the education, training and continuing development of postgraduate professionals in hospital medicine, general practice and dentistry. Further information on education and training of our staff is included in the Quality Report

Research and development

CUH works strategically in partnership with other NHS organisations, universities, research councils, research charities and industry to provide an outstanding infrastructure that builds research capacity and supports excellence in clinical research that will benefit patients. Further information on research and development is given in the Quality Report.

3.20 Trust membership

The membership

The membership of CUH is split into three constituencies: patient, public and staff.

Public Membership

Any person who is sixteen years of age or over and who lives within our membership area is eligible for public membership.

Table 5: The membership area

Braintree District Council	Bumpstead electoral ward
Cambridge City Council	All electoral wards
East Cambridgeshire District Council	All electoral wards
East Hertfordshire District Council	Buntingford; Braughing and Mundens and Cottered electoral wards
North Hertfordshire District Council	Ermine; Royston Palace; Royston Meridian and Royston Heath electoral wards
South Cambridgeshire District Council	All electoral wards
Uttlesford District Council	Ashdon; Clavering; Debden and Wimbish; Littlebury, Chesterford and Wenden Lofts; Newport; Saffron Walden Audley; Saffron Walden Castle; Saffron Walden Shire; The Sampfords; Takeley and Thaxted and the Eastons electoral wards.
West Suffolk Council (Forest Heath District Council and St Edmundsbury District Council merged with effect from 1 April 2019)	Clare, Hundon and Kedlington Exning All Haverhill Wards (West, North, East, South, Central and South East) Newmarket East Newmarket North Newmarket West Withersfield
Braintree District Council	Bumpstead electoral ward

Patient membership

Any individual who has been a patient at any of the Trust's hospitals from 5 July 1948, or who has been a carer of a patient who meets that criterion, is eligible for patient membership, regardless of where they live, as long as they are aged sixteen years or over.

Staff membership

All staff at CUH with contracts of employment at least twelve months, or contracts with no fixed term, are automatically members unless they choose to opt out. Registered volunteers are also automatically members of the staff constituency. The Trust greatly values the contribution employees of other companies on

campus make to the organisation and for this reason staff membership includes on application all employees of companies who provide services to CUH.

Membership numbers

At 31 March 2019 there were 19,813 members (2018: 19,425); patients 4,253 (2018 : 4,383); public 4,956 (2018 : 5,067); staff members 10,604 (2018 : 9,997).

Membership strategy

The current membership strategy was approved by the Council of Governors in September 2016. The revision sets out our vision for a representative, active and engaged membership, grouped around five key areas:

Maintaining and continuing to build a representative membership of our constituencies

Work is ongoing to target underrepresented groups identified through reporting on the membership database, according to age, ethnicity, gender, disability and socio-economic groupings, with a view to improving diversity within the membership.

Ensuring members are informed and that their views are valued and listened to

Members are informed of opportunities to speak with governors via the website, through regular email communications with active members and at all Trust events with which governors are directly involved, such as the annual members' meeting, Medicine for Members lecture series and care of the patient environment inspection events. Members wishing to make contact with governors can do so by contacting the Foundation Trust membership office:

Email: foundation.trust@addenbrookes.nhs.uk

Telephone: 01223 256 256

Post: NHS Foundation Trust Membership Office
Box 146
Cambridge University Hospitals NHS Foundation Trust
Cambridge Biomedical Campus
Hills Road
Cambridge
CB2 0QQ

Increasing the proportion of total membership who wish to be more actively involved and promote more effective, more modern and more timely communication with members

New ways of reaching out to current and future members are being explored and deployed, including engagement via digital channels and social media. Digital channels provide timely communications at less cost than more traditional channels, and a drive to increase the number of email addresses held for members who wish to go digital is ongoing. Members are encouraged to update their personal profile and let the Foundation Trust Office know what interests

them and how to contact them in order to keep them updatedon their chosen interest areas.

Ensuring a high level of interest / participation and attracting high quality candidates for the annual governor elections
A comprehensive communications and engagement plan has generated renewed interest from the staff, public and patient bodies in standing for election for the Council of Governors. The message "give back to your hospital" was received well and resulted in three times the number of candidates standing to vacancies in 2018.

Aligning engagement activities with other local health bodies and campus partners to have a constituent-centred approach
The Cambridge Biomedical Campus combines world-class biomedical research, patient care and education on a single site. Expansion will grow the already 12,000 strong community of healthcare professionals and research scientists into one of the leading biomedical centres in the world by 2020. Collaborating, sharing activities and aligning public engagement programmes with campus partners will enrich our members' experience of CUH Foundation Trust membership.

3.21 Council of Governors

The Council of Governors is composed of 19 elected governors (eight patient, seven public and four staff), ten partnership governors. The council is chaired by the Trust chair.

Dr Julia Loudon is the Lead Governor, and was elected from 01 July 2016 for a two year term. In March 2018 Julia Loudon was re-elected for a further term of two years from 1 July 2018 to 30 June 2020.

David Dean is the Deputy Lead Governor, and was elected from 01 December 2017 for a two-year term.

Patient governors

Table 6

The table below shows patient governors, representing and elected by the patient members of Cambridge University Hospitals NHS Foundation Trust.

Miss Ruth Greene	Elected in 2016 for a first three-year term.
Dr Fred Jacobsberg	Re-elected in 2017 for a one year term, following two terms of three years. Not successfully re-elected in 2018.
Dr Julia Loudon	Re-elected in 2018 for a second three-year term.
Mrs Laura Minter	Elected in 2017 for a first three-year term. Resigned in September 2018.
Mr Harry Richardson	Elected in 2016 for a first three-year term.

Dr Colin Roberts	Elected in 2018 for a first three-year term.
Mr Christopher Stanley	Elected in 2017 for a first three-year term. Resigned in March 2019.
Dr Neil Stutchbury	Elected in 2017 for a first three-year term.
Mrs Adele White	Elected in 2018 for a first three-year term.

Public governors

Table 7

The table below shows public governors, representing and elected by the public members of Cambridge University Hospitals NHS Foundation Trust.

Dr Jane Biddle	Elected in 2017 for a first three-year term.
Mrs Dawn Chapman OBE	Re-elected in 2018 for a second three-year term.
Mr David Dean	Elected in 2017 for a first three-year term.
Mr Roberto Gherseni	Elected in 2018 for a two-year term to replace Mr Lorne Williamson. Roberto previously served as a staff governor from July 2015 to January 2018.
Mrs Jan Lupton	Re-elected in 2018 for a three-year term, having previously served a one year term. Resigned in January 2019.
Mrs Wendy Menon	Re-elected in 2016 for a third three-year term.
Ms Anna Miller	Elected in 2018 for a first three-year term.
Professor Patrick Smith	Re-elected in 2015 for a second three-year term. Patrick previously served as a public governor from January 2010 to June 2011. Patrick retired from the Council of Governors in June 2018.
Mr Lorne Williamson	Re-elected in 2017 for a second three-year term. Lorne previously served on the Council of Governors from 2008 to 2011. Lorne resigned from the Council of Governors in April 2018.

Staff governors

Table 8

The table below shows staff governors, representing and elected by the staff members of Cambridge University Hospitals NHS Foundation Trust.

Dr Deepa Krishnakumar	Elected in 2018 for a first three-year term.
Mrs Hannah Jackson	Elected in 2018 for a first three-year term.

Dr Fraz Mir	Elected in 2015 for a first three-year term. Fraz did not seek re-election to the Council of Governors in 2018.
Dr Patricia Set	Elected in 2017 for a first three-year term.
Mr Andi Thornton	Elected in 2017 for a first two-year term.

Governor elections 2018

In 2018, three patient governors, four public governors and two staff governors were elected by members of the foundation trust. These elections were 'first past the post' and Electoral Reform Services acted as returning officer and independent scrutineer.

Table 9

Governor Election Turnout by constituency 2017 and 2018

Constituency	2017	2018
Patient Constituency	29.2%	25.1%
Public Constituency	26.4%	21.7%
Staff Constituency	27.4%	27.0%

Partnership governors

Table 10

Partnership governors, representing and appointed by external organisations to the Council of Governors are shown in the table below.

Anglia Ruskin University	Professor Ruth Taylor	Appointed in July 2014 for a first three-year term and re-appointed in 2017.
Cambridge Biomedical Campus Research Organisations	Dr John Wells	Appointed by Cancer Research UK to represent research organisations on the biomedical campus site in July 2013 for a three-year term and re-appointed in 2016. Retired in September 2018.
Cambridge Biomedical Campus Research Organisations	Mr Simon Chaplin	Appointed by Wellcome Trust to represent research organisations on the biomedical campus site in November 2018 for a three-year term to replace John Wells
Cambridge City Council	Cllr Nicky Massey	Appointed by Cambridge City Council in June 2018.

Cambridgeshire and Peterborough Clinical Commissioning Group	Ms Jessica Bawden	Appointed in June 2017 for a first three-year term.
Cambridgeshire and Peterborough NHS Foundation Trust	Mr Stephen Legood	Appointed in February 2015 for three years to represent Cambridgeshire and Peterborough NHS Foundation Trust. Reappointed in 2018
Cambridgeshire County Council	Cllr Mark Howell	Appointed by Cambridgeshire County Council in June 2017 for the life of the Council (May 2021).
Royal Papworth Hospital NHS Foundation Trust	Ms Josie Rudman	Appointed as partnership governor in October 2017 for a first three year term to represent Royal Papworth Hospital NHS Foundation Trust.
University of Cambridge	Professor Andrew Lever	Re-appointed by the University of Cambridge, in July 2010 for a first three year term. Reappointed in July 2013 and again in July 2016 until June 2018.
University of Cambridge	Professor Peter St George-Hyslop	Appointed as partnership governor in July 2018 for a first three year term to represent University of Cambridge to replace Andrew Lever.
University of Cambridge	Professor Fiona Karet	Appointed as partnership governor in June 2017 for a first three year term to represent University of Cambridge.

Register of governors' interests

All governors are asked to declare any interests on the register of interests, gifts and hospitality at the time of their appointment or election. Governors are also required to declare any changes to the declared interest on an ongoing basis. The register is reviewed and maintained by the Director of Corporate Affairs. It is available for inspection on the Trust website and any enquiries should be made to the Director of Corporate Affairs at the following address:

Director of Corporate Affairs, Box 146, Cambridge University Hospitals NHS Foundation trust, Cambridge Biomedical Campus, Hills Road, Cambridge CB2 0QQ or telephone 01223 256256.

Governor expenses

Governors participating in events such as council meetings whose expenses are not paid by another organisation are entitled to claim reasonable expenses. Expenses are reimbursed at rates agreed by the Council of Governors, which has adopted HMRC approved amounts. Expenses to be reimbursed include:

Travel by car, motor cycle or bicycle; public transport on a like for like basis on provision of a receipt; receipted costs for caring arrangements at previously agreed rates of up to £10 per hour; expenses for a companion required to enable the individual to participate and costs for interpretation. Governor expenses are reported in the remuneration report, 3.22. The full policy is available from the Director of Corporate Affairs, address as above.

Table 11

Attendance at Council of Governors' meetings 2018/19

Name	Title	Attendance
Dr Michael More	Trust Chair	7/7
Ms Jessica Bawden	Partnership Governor	3/7
Dr Jane Biddle	Public Governor	5/7
Mr Simon Chaplin	Partnership Governor	2/4
Mrs Dawn Chapman	Public Governor	6/7
Mr David Dean	Public Governor	6/7
Mr Roberto Gherseni	Public Governor	6/7
Ms Ruth Greene	Patient Governor	5/7
Cllr Mark Howell	Partnership Governor	6/7
Mrs Hannah Jackson	Staff Governor	3/5
Mr Fred Jacobsberg	Patient Governor	2/2
Professor Fiona Karet	Partnership Governor	3/7
Dr Deepa Krishnakumar	Staff Governor	3/5
Mr Stephen Legood	Partnership Governor	3/7
Prof Andrew Lever	Partnership Governor	0/2
Dr Julia Loudon	Patient Governor	7/7
Mrs Janice Lupton	Public Governor	3/5
Cllr Nicky Massey	Partnership Governor	3/7
Mrs Wendy Menon	Public Governor	2/7
Ms Anna Miller	Public Governor	3/5
Mrs Laura Minter	Patient Governor	2/2
Mr Harry Richardson	Patient Governor	5/7
Dr Colin Roberts	Patient Governor	5/5
Ms Josie Rudman	Partnership Governor	2/7
Dr Patricia Set	Staff Governor	3/7
Professor Patrick Smith	Public Governor	0/2
Professor Peter St George Hyslop	Partnership Governor	2/5
Mr Christopher Stanley	Patient Governor	7/7
Dr Neil Stutchbury	Patient Governor	7/7
Professor Ruth Taylor	Partnership Governor	6/7
Mr Andi Thornton	Staff Governor	2/7
Dr John Wells	Partnership Governor	2/2
Mrs Adele White	Patient Governor	5/5

There were seven meetings of the Council of Governors during 2018/19, four public and three confidential meetings. The Chief Executive, Non-Executive Directors and Executive Directors also attended.

Governor activities

All governors and directors are invited to attend the two Governor/Director Working Groups on Scrutiny and Performance and Communications and Engagement which meet quarterly. The groups continue to ensure that the views of members, patients and the wider local community are brought directly to the directors, and also to ensure that governors are up-to-date on key issues of concern and interest.

Governor access to papers is via the secure governors' extranet. In addition, governors are provided with a fortnightly digest which is emailed with forthcoming meetings and events, Trust news, wider NHS news, relevant national policy initiatives and press coverage for the preceding two weeks. All headlines are linked through to the extranet for further information.

As well as a code of conduct, all governors on appointment/election are expected to sign up to the fact that they have read and will abide by our policy for governor communication with members and the public. The emphasis is, as always, on encouraging interaction, listening and capturing views, speaking on behalf of members and thereby being able to influence opinions and decisions before feeding-back to members and the public.

To aid this two-way communication process, governors attend community groups in the local area on request to speak on issues of interest or concern. They 'host' focus groups led by the patient experience team which gives them an opportunity to hear patient views on certain key issues. Many governors and members use PLACE visits (Patient-Led Assessments of the Care Environment) to talk personally to patients/visitors and inspect the care surroundings. Similarly, the 'Fifteen Steps' initiative is used to enable governors to be involved first-hand in the patients' experience of first entering a ward area. The governors and the membership office have dedicated mailboxes to allow members/public to contact governors directly and these are advertised in the 'Members Matter' newsletter, the CUH website and when out and about at events. Governors also continue to host the quarterly 'Medicine for Members' lecture series which this year saw the wide-ranging subjects of liver transplantation, children's services, antibiotic resistance, artificial intelligence and the "Naked Scientist" addressed. All these give potentially wide access to a variety of patient, public and staff opinion on a variety of issues.

The Annual Public Meeting took place in September 2018 and carried the theme of "Your winter health" the first part of the evening was devoted to the presentation of the annual report and accounts; and provided attendees with a review of 2017/18 with an update on current and future developments. The second part of the evening was dedicated to a wide ranging discussion on winter health, with talks from an A&E consultant, virologist and Care of the Elderly consultant. Discussion was lively and valuable insight was gained, which has been shared with the appropriate teams.

Representative of Governors attended the annual NHS Providers' conference in order to network with governors from other trusts and to share good practice. The Trust presented on best practice for encouraging a high candidate to vacancy ratio and voter turnout in elections to the Council of Governors, and also exhibited a poster on Annual Public Meeting innovation.

The Lead Governor attends and reports to all Board meetings. Governors meet informally with Non-Executive Directors on a quarterly basis to discuss Trust issues, priorities and developments as they arise. They also attend Board Sub committees in an observer capacity. These interactions assist them in fulfilling their duty to hold the non-executive directors to account. Governors are also actively involved in the development of the annual plan and the Trust's Quality Account.

Remuneration Report

3.22 Remuneration report

Annual statement on remuneration

In 2018/19, the Board of Directors Remuneration and Nomination Committee maintained its overview of Executive Directors' salaries, following the principles established for Executive and senior salaries in 2015/16 (from the external review commissioned in that year).

Senior managers' remuneration policy

CUH is aware of public attention given to the levels of remuneration of senior managers within the NHS. CUH has always strived to operate with openness and transparency when reviewing and setting the pay levels for senior management and we will continue to do this going forward.

To determine Board of Director level salaries, the Remuneration and Nomination Committee may use one or more of the following:

- Benchmarking data surveyed confidentially among CUH's peer group.
- NHS Employers' annual salary survey of NHS Chief Executives and Executive Directors.
- IDS NHS Boardroom pay report and other benchmark information.
- NHS and other relevant advertised jobs databases.
- The prevailing market position, including the ability to recruit and retain individuals.

Any amendments to salary are decided by the Remuneration and Nomination Committee on the basis of the size and complexity of the job portfolio. Annual salary is inclusive of other payments such as bonus, overtime, long hours, on-call, standby, etc. Additional payments do not feature in Executive Directors' remuneration. The Trust has no plans to introduce performance related pay. The salaries of the Medical Director and the Director of Improvement and Transformation are in accordance with the terms and conditions of service of the consultant contract 2003 plus a responsibility allowance determined by the Committee payable for the duration of office.

Chief Executive and Executive Director performance is measured against objectives set at the beginning of the financial year and agreed by the Remuneration and Nomination Committee.

There are no special contractual compensation provisions for the early termination of Executive Directors' contracts. Early termination by reason of redundancy is subject to the normal provisions of the 'Agenda for Change: NHS terms and conditions of service' handbook (section 16); or, for those above the minimum retirement age, early termination by reason of redundancy or 'in the interests of the efficiency of the service' is in accordance with the NHS Pension Scheme. Employees above the minimum retirement age who themselves request termination by reason of early retirement are subject to the normal provisions of the NHS Pension Scheme.

Pay awards agreed nationally for other staff groups working at CUH, including staff on Agenda for Change contracts and medical and dental staff, are determined by the Department of Health/NHS Pay Review Body, which looks at salaries and pay conditions across the NHS.

Duration of contracts, notice periods and termination payments

Table 12: Executive Director contractual terms

Executive Director	Date in post	Unexpired term	Notice
Chief Executive	16.11.15	Permanent	Six months
Chief Finance Officer	02.10.17	Permanent	Six months
Chief Nurse	23.07.18	Permanent	Six months
Chief Operating Officer	13.03.17	Permanent	Six months
Director of Corporate Affairs	15.05.17	Permanent	Six months
Director of Improvement and Transformation	01.02.18	Permanent	Six months
Director of Strategy and Major Projects	26.03.18	Permanent	Six months
Director of Workforce	01.04.14	Permanent	Six months
Medical Director	01.11.17	4 years	Six months

Remuneration and Nomination Committee of the Board of Directors

Membership of the committee comprises Non-Executive Directors and the Chair with the Chief Executive in attendance. The Director of Workforce and Director of Corporate Affairs also attend meetings of the committee where appropriate.

The Committee met twice during 2018/19. The Committee was chaired by Shirley Pointer, Non-Executive Director and Senior Independent Director. A summary of attendance at the committee is included in table 4 in section 3.10.

The role of the Committee is to:

- To act under the delegated authority of the Board of Directors to approve and oversee the arrangements for the appointment, termination and remuneration of the Chief Executive and all Executive Directors. In addition, the Committee will be responsible for agreeing the remuneration

for any other posts with remuneration outside the Agenda for Change pay framework.

Statement of directors' remuneration - Subject to Audit

The Trust's Remuneration and Nomination Committee oversees pay arrangements for posts whose salary is not determined through national term and conditions. This includes but is not limited to the Executive Directors of the Trust (both voting and non-voting executive Board members). The Committee is mindful of discharging its obligations in respect of salaries above £150,000. This salary is updated as set out in the guidance from NHSI, updated in March 2018. It considers each new post and the process to be followed on an individual basis. The Governors' Nomination and Remuneration Committee establishes remuneration for Non-Executive Directors.

Fair pay multiple - Subject to Audit

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid Executive Director in Cambridge University Hospitals NHS Foundation Trust in the financial year 2018/19 was £265,000 to £270,000. This was 8.87 times (year ended 31 March 2018, 11.58 times) the median remuneration of the workforce, which was £29,608 (year ended 31 March 2018, £22,683).

Table 13: Statement of remuneration 2018/19 - Subject to Audit

Name of senior manager	2018/19 Salary & fees (in bands of £5k) £000s (Band of £5k)	2018/19 All taxable benefits (total to the nearest £100) £s (nearest £100)	2018/19 Annual performance related bonuses £000s (Band of £5k)	2018/19 Long-term performance related bonuses £000s (Band of £5k)	2018/19 All pension-related benefits (in bands of £2.5k) £000s (Band of £2.5k)	2018/19 Other (total to the nearest £5k) £s to nearest £5k	2018/19 Total (bands of £5k) £000s (Band of £5k)
Nicola Ayton, Director of Strategy and Major Projects	140-145	-	-	-	55-57.5	-	195-200
Dr Ewen Cameron, Director of Improvement and Transformation	50-55	-	-	-	12.5-15	150,000	220-225
Sam Higginson, Chief Operating Officer	170-175	-	-	-	275-277.5	-	450-455
Ann-Marie Ingle, Chief Nurse until 22 July 2018	60-65	-	-	-	17.5-20	-	80-85
Paul Scott, Chief Finance Officer	170-175	-	-	-	-	-	170-175

Name of senior manager	2018/19 Salary & fees (in bands of £5k) £000s (Band of £5k)	2018/19 All taxable benefits (total to the nearest £100) £s (nearest £100)	2018/19 Annual performance related bonuses £000s (Band of £5k)	2018/19 Long-term performance related bonuses £000s (Band of £5k)	2018/19 All pension-related benefits (in bands of £2.5k) £000s (Band of £2.5k)	2018/19 Other (total to the nearest £5k) £s to nearest £5k	2018/19 Total (bands of £5k) £000s (Band of £5k)
Dr Ashley Shaw, Medical Director	70-75	-	-	-	-	170,000	240-245
Roland Sinker, Chief Executive	265-270	3,200	-	-	87.5-90	-	355-360
Lorraine Szeremeta, Chief Nurse from 23 July 2018	100-105	-	-	-	232.5-235	-	335-340
Ian Walker, Director of Corporate Affairs	130-135	-	-	-	115-117.5	-	245-250
David Wherrett, Director or Workforce	135-140	-	-	-	(42.5-45)	-	90-95
Daniel Abrams, NED	15-20	1,300	-	-	-	-	15-20
Adrian Chamberlain, NED	10-15	-	-	-	-	-	10-15
Dr Annette Doherty, NED	0	1,000	-	-	-	-	0-5
Dr Michael	55-60	-	-	-	-	-	55-60

Name of senior manager	2018/19 Salary & fees (in bands of £5k) £000s (Band of £5k)	2018/19 All taxable benefits (total to the nearest £100) £s (nearest £100)	2018/19 Annual performance related bonuses £000s (Band of £5k)	2018/19 Long-term performance related bonuses £000s (Band of £5k)	2018/19 All pension-related benefits (in bands of £2.5k) £000s (Band of £2.5k)	2018/19 Other (total to the nearest £5k) £s to nearest £5k	2018/19 Total (bands of £5k) £000s (Band of £5k)
More, Chair							
Dr Michael Knapton, NED	10-15	-	-	-	-	-	10-15
Professor Patrick Maxwell, NED	10-15	-	-	-	-	-	10-15
Professor Sharon Peacock, NED	10-15	-	-	-	-	-	10-15
Shirley Pointer, NED	10-15	1,600	-	-	-	-	15-20

*Other remuneration for two Directors relates to their pay in respect of clinical duties.

*** Professor Patrick Maxwell is the Regius Professor of Physic of the University of Cambridge. He is employed and paid by the University of Cambridge. The Trust paid £14,000 in 2018/19 to the University of Cambridge in recognition of his time spent undertaking duties as a Non-Executive Director.

Table 14: Statement of remuneration 2017/18 - Subject to Audit

Name of senior manager	2017/18 Salary & fees (in bands of £5k) £000s (Band of £5k)	2017/18 All taxable benefits (total to the nearest £100) £s (nearest £100)	2017/18 Annual performance related bonuses £000s (Band of £5k)	2017/18 Long-term performance related bonuses £000s (Band of £5k)	2017/18 All pension-related benefits (in bands of £2.5k) £000s (Band of £2.5k)	2017/18 Other (total to the nearest £5k) £s to nearest £5k	2017/18 Total (bands of £5k) £000s (Band of £5k)
Dr Jag Ahluwalia, Medical Director (to 31/10/2017)*	40-45	-	-	-	17.5-20	80-85	145-150
Ms Ann-Marie Ingle, Chief Nurse	155-160	-	-	-	62.5-65	-	215-220
Mr David Wherrett, Director of Workforce	145-150	-	-	-	55-57.5	-	200-205
Mr Roland Sinker, Chief Executive	260-265	4600	-	-	110-112.5	-	375-380
Mr Sam Higginson, Chief Operations Officer	170-175	-	-	-	32.5-35	-	200-205
Mr Jonathan Rowell, Interim Chief Finance Officer (from	70-75	-	-	-	120-122.5	-	190-195

Name of senior manager 18/03/2017)	2017/18 Salary & fees (in bands of £5k) £000s (Band of £5k)	2017/18 All taxable benefits (total to the nearest £100) £s (nearest £100)	2017/18 Annual performance related bonuses £000s (Band of £5k)	2017/18 Long-term performance related bonuses £000s (Band of £5k)	2017/18 All pension-related benefits (in bands of £2.5k) £000s (Band of £2.5k)	2017/18 Other (total to the nearest £5k) £s to nearest £5k	2017/18 Total (bands of £5k) £000s (Band of £5k)
Dr Ashley Shaw, Medical Director (from 1/11/2017) *	30-35	-	-	-	0-2.5	60-65	90-95
Mr Paul Scott, Chief Finance Officer (from 2/10/2017)	80-85	-	-	-	-	-	80-85
Ms Nicola Ayton, Director of Major Projects & Strategy (from 26/3/2018)	0-5	-	-	-	-	-	0-5
Dr Ewen Cameron, Director of Improvement & Transformation (from 1/2/2018)*	5-10	-	-	-	70-72.5	25-30	100-105
Ms Rebekah Ley, Acting Director of Corporate Affairs (until 15/5/2017)	5-10	-	-	-	-	-	5-10

Name of senior manager	2017/18 Salary & fees (in bands of £5k) £000s (Band of £5k)	2017/18 All taxable benefits (total to the nearest £100) £s (nearest £100)	2017/18 Annual performance related bonuses £000s (Band of £5k)	2017/18 Long-term performance related bonuses £000s (Band of £5k)	2017/18 All pension-related benefits (in bands of £2.5k) £000s (Band of £2.5k)	2017/18 Other (total to the nearest £5k) £s to nearest £5k	2017/18 Total (bands of £5k) £000s (Band of £5k)
Mr Mark Turner, Director of Major Project, Strategy and Transformation **	160-165	-	-	-	-	-	160-165
Mr Ian Walker, Director of Corporate Affairs (from 15/5/2017)	115-120	-	-	-	-	-	115-120
Mr Daniel Abrams NED from 1/9/17	5-10	1000	-	-	-	-	10-15
Mr Adrian Chamberlain NED from 1/9/17	5-10	-	-	-	-	-	5-10
Dr Annette Doherty NED from 1/9/17	0-5	500	-	-	-	-	0-5
Dr Michael More CBE Chair	55-60	-	-	-	-	-	55-60
Dr Michael Knapton NED	10-15	-	-	-	-	-	10-15
Professor Patrick Maxwell	10-15	-	-	-	-	-	10-15

Name of senior manager NED ***	2017/18 Salary & fees (in bands of £5k) £000s (Band of £5k)	2017/18 All taxable benefits (total to the nearest £100) £s (nearest £100)	2017/18 Annual performance related bonuses £000s (Band of £5k)	2017/18 Long-term performance related bonuses £000s (Band of £5k)	2017/18 All pension-related benefits (in bands of £2.5k) £000s (Band of £2.5k)	2017/18 Other (total to the nearest £5k) £s to nearest £5k	2017/18 Total (bands of £5k) £000s (Band of £5k)
Professor Sharon Peacock CBE NED	10-15	-	-	-	-	-	10-15
Shirley Pointer NED	10-15	1800	-	-	-	-	15-20
David Parfrey NED until 31/8/17	5-10	-	-	-	-	-	5-10
Dr Andrew Richards CBE NED until 31/8/17	5-10	-	-	-	-	-	5-10
Dr Peter Southwick NED until 31/8/17	5-10	100	-	-	-	-	5-10

* Other remuneration for three Directors relates to their pay in respect of clinical duties.

** Mark Turner is seconded from NHS Improvement and his salary recharged to the Trust. As such, he is subject to the terms and conditions of his employing organisation. NHS Improvement was paid in the band £160-165k for Mr Turner's services in 2017/18.

*** Prof Patrick Maxwell is the Regius Professor of Physic of the University of Cambridge. He is employed and paid by the University of Cambridge. The Trust paid £14,000 in 2017/18 to the University of Cambridge in recognition of his time spent undertaking duties as a Non-Executive Director.

Statement of directors' and governors' expenses

Directors and governors are reimbursed for expenses incurred on Trust business in accordance with agreed Trust policies. Where applicable, these are subject to income tax and national insurance in accordance with HMRC legislation and guidance.

Table 15: Governors' expenses

Name	Mileage (Car/Cycle)	Rail/bus Travel	Meals and parking	Other	Total 2018/19	Total 2017/18
Margery Abbott	N/A	N/A	N/A	N/A	N/A	£0.00
Jessica Bawden	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Jane Biddle	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Simon Chaplin	£0.00	£0.00	£0.00	£0.00	£0.00	N/A
Dawn Chapman	£310.65	£0.00	£2.80	£0.00	£313.45	£308.40
Tony Coad	N/A	N/A	N/A	N/A	N/A	£0.00
David Dean	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Carlos de la Riva	N/A	N/A	N/A	N/A	N/A	£0.00
Valerie Freestone	N/A	N/A	N/A	N/A	N/A	£0.00
Anna Gallop	N/A	N/A	N/A	N/A	N/A	£0.00
Roberto Gherseni	£0.00	£0.00	£0.00	£0.00	£0.00	N/A
Ruth Greene	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Mark Howell	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Hannah Jackson	£0.00	£0.00	£0.00	£0.00	£0.00	N/A
Fred Jacobsberg	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Fiona Karet	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Deepa	£0.00	£0.00	£0.00	£0.00	£0.00	N/A

Name	Mileage (Car/Cycle)	Rail/bus Travel	Meals and parking	Other	Total 2018/19	Total 2017/18
Krishnakumar						
Stephen Legood	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Peter Lester	N/A	N/A	N/A	N/A	N/A	£0.00
Andrew Lever	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Julia Loudon	£1,238.40	£31.90	£186.70	£0.00	£1,457.00	£892.93
Jan Lupton	£198.90	£0.00	£36.40	£0.00	£235.30	£230.90
Nicola Massey	£0.00	£0.00	£0.00	£0.00	£0.00	N/A
Wendy Menon	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Anna Miller	£45.00	£0.00	£16.30	£25.00	£86.30	N/A
Laura Minter	£490.05	£0.00	£0.00	£0.00	£490.05	£0.00
Fraz Mir	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Tony Orgee	N/A	N/A	N/A	N/A	N/A	£0.00
Roger Quince	N/A	N/A	N/A	N/A	N/A	£0.00
Harry Richardson	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Colin Roberts	£0.00	£0.00	£0.00	£0.00	£0.00	N/A
Tony Roberts	N/A	N/A	N/A	N/A	N/A	£0.00
Josie Rudman	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Patricia Set	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Patrick Smith	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Peter St George-Hyslop	£0.00	£0.00	£0.00	£0.00	£0.00	N/A
Chris Stanley	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Neil Stutchbury	£0.00	£0.00	£0.00	£25.00	£25.00	£0.00
Ruth Taylor	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Andi Thornton	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
John Wallwork	N/A	N/A	N/A	N/A	N/A	£0.00
John Wells	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00

Name	Mileage (Car/Cycle)	Rail/bus Travel	Meals and parking	Other	Total 2018/19	Total 2017/18
Adele White	£414.90	£0.00	£27.40	£25.00	£467.30	N/A
Lorne Williamson	£0.00	£0.00	£0.00	£0.00	£0.00	£561.90
Louisa Wood	N/A	N/A	N/A	N/A	N/A	£0.00

During 2018/19 members of the Council of Governors did not make any claims for taxis; hotel accommodation or conference fees.

Table 16: Directors' expenses

				2018/2019				2017/18			
	Travel Home to Work	Mileage other	Rail travel	Taxi	Hotels	Meals and Parking	Air Travel	Conference fees	Other	Total	Total
Daniel Abrams	£1,243.40	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£32.49	£1,275.89	£980.55
Nicola Ayton	N/A	£0.00	£87.50	£89.72	£87.00	£0.00	£172.00	£0.00	£0.00	£436.22	£0.00
Ewen Cameron	N/A	£0.00	£261.15	£0.00	£0.00	£0.00	£0.00	£0.00	£8.60	£269.75	£92.90
Adrian Chamberlain	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Annette Doherty	£1,360.60	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£1,360.60	£460.20
Sam Higginson	N/A	£0.00	£393.80	£21.50	£0.00	£0.00	£0.00	£0.00	£0.00	£415.30	£298.10
Ann-Marie Ingle	N/A	£0.00	£343.50	£0.00	£0.00	£32.10	£0.00	£0.00	£0.00	£375.60	£278.90
Michael Knapton	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Patrick Maxwell	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Michael More	£0.00	£0.00	£256.80	£99.38	£0.00	£0.00	£0.00	£0.00	£0.00	£356.18	£542.80
David Parfrey	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£0.00

				2018/2019				2017/18			
	Travel Home to Work	Mileage other	Rail travel	Taxi	Hotels	Meals and Parking	Air Travel	Conference fees	Other	Total	Total
Sharon Peacock	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Shirley Pointer	£1,582.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£1,582.00	£1,804.70
Andy Richards	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£0.00
Paul Scott	£0.00	£0.00	£1,007.60	£0.00	£85.50	£62.60	£0.00	£0.00	£0.00	£1,155.70	£269.80
Ashley Shaw	£0.00	£0.00	£669.00	£0.00	£56.50	£0.00	£0.00	£0.00	£0.00	£725.50	£170.90
Roland Sinker	£0.00	£0.00	£164.10	£158.30	£0.00	£9.90	£0.00	£0.00	£0.00	£332.30	£679.16
Peter Southwick	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	£130.00
Lorraine Szeremeta	£0.00	£0.00	£448.00	£0.00	£492.26	£67.00	£0.00	£325.00	£0.00	£1,332.26	N/A
Mark Turner	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	See note 3
Ian Walker	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
David Wherrett	£0.00	£188.93	£248.10	£0.00	£0.00	£10.50	£0.00	£0.00	£0.00	£447.53	£178.00

Notes

1. Non-Executive Directors may claim for home based to Trust travel costs and if claimed are taxable benefits. Non-home base to Trust travel costs are not classed as taxable benefits.
2. Executive Directors may not claim for home to Trust travel costs.
3. Mark Turner was seconded from NHS Improvement and under the terms of the secondment agreement has received expense payments of £17,241.94 in 2017/18.

Table 17: Pension benefit

2018/19

Name and title	Real increase / (decrease) in pension at pension age (bands of £2500) £000	Real increase / (decrease) in pension lump sum at pension age (bands of £2500) £000	Total accrued pension at pension age at 31 March 2019 (bands of £5000) £000	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5000) £000	Cash equivalent transfer value at 31 March 2018 £000	Real increase / (decrease) in cash equivalent transfer value £000	Cash equivalent transfer value at 31 March 2019 £000	Employer's contribution to stakeholder pension £000
Ms Ann-Marie Ingle Chief Nurse	0-2.5	(2.5-5)	45-50	115-120	823	97	945	0
Mr David Wherrett Director of Workforce	(0-2.5)	(10-12.5)	50-55	125-130	951	61	1040	0
Mr Roland Sinker Chief Executive	2.5-5	0	40-45	0	421	124	557	0
Mr Sam Higginson Chief Operating Officer	12.5-15	0	35-40	0	256	216	480	0
Mr Ashley Shaw Medical Director	0	0	0	0	0	0	0	0
Ewen Cameron Director of Improvement	0-2.5	(2.5-5)	35-40	75-80	521	76	612	0

Name and title and Transformation	**Real increase / (decrease) in pension at pension age**	**Real increase / (decrease) in pension lump sum at pension age**	**Total accrued pension at pension age at 31 March 2019**	**Lump sum at pension age related to accrued pension at 31 March 2019**	**Cash equivalent transfer value at 31 March 2018**	**Real increase / (decrease) in cash equivalent transfer value**	**Cash equivalent transfer value at 31 March 2019**	**Employer's contribution to stakeholder pension**
Nicola Ayton Director of Strategy and Major Projects	2.5-5	0	5-10	0	39	32	73	0
Lorraine Szeremeta Chief Nurse	10-12.5	22.5-25	40-45	100-105	463	240	717	0
Mr Ian Walker Director of Corporate Affairs	5-7.5	2.5-5	20-25	40-45	275	115	398	0
Mr Paul Scott Chief Finance Officer	0	0	0	0	0	0	0	0

2017/18

Name and title	Real increase / (decrease) in pension at pension age (bands of £2500) £000	Real increase / (decrease) in pension lump sum at pension age (bands of £2500) £000	Total accrued pension at pension age at 31 March 2018 (bands of £5000) £000	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5000) £000	Cash equivalent transfer value at 31 March 2017 £000	Real increase / (decrease) in cash equivalent transfer value £000	Cash equivalent transfer value at 31 March 2018 £000	Employer's contribution to stakeholder pension £000
Mr Roland Sinker Chief Executive	5-7.5	0	35-40	0	344	77	421	0
Dr Jag Ahluwalia Medical Director	0-2.5	2.5-5	75-80	235-240	1641	63	1704	0
Ms Ann-Marie Ingle Chief Nurse	2.5-5	0-2.5	40-45	115-120	763	60	823	0
Mr David Wherrett Director of Workforce	2.5-5	0	50-55	130-135	899	51	951	0
Mr Sam Higginson Chief Operating Officer	0-2.5	0	20-25	0	230	25	256	0
Mr Ashley Shaw Medical Director from 1/11/2017	0	0	0	0	0	0	0	0
Mr Jonathan Rowell	5-7.5	7.5-10	25-30	65-70	308	71	379	0

Name and title	Real increase / (decrease) in pension at pension age (bands of £2500) £000	Real increase / (decrease) in pension lump sum at pension age (bands of £2500) £000	Total accrued pension at pension age at 31 March 2018 (bands of £5000) £000	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5000) £000	Cash equivalent transfer value at 31 March 2017 £000	Real increase / (decrease) in cash equivalent transfer value £000	Cash equivalent transfer value at 31 March 2018 £000	Employer's contribution to stakeholder pension £000
Acting Chief Finance Officer from 18/03/2017								
Mr Ewen Cameron Director of Improvement and Transformation from 01/02/2018	2.5-5	2.5-5	30-35	80-85	426	95	521	0

These pension disclosures relate to directors who were members of the NHS Pension Scheme during the financial year. The figures represent estimates by the NHS Pensions Agency of the theoretical value of each director's pension "fund" at the start and end of the financial year. The difference between these two values is taken to represent the director's pension benefits for the year. Any benefits earned in this way remain in the pension scheme until the director retires in accordance with the rules of the NHS Pension Scheme. These rules are the same for both directors and staff.

Roland Sinker
Chief Executive
23 May 2019

Staff report

3.23 Staff report

Staff numbers

As of 31 March 2019 the Trust had 17 directors (twelve male and five female) and 10, 637 employees (headcount) (2,803 male and 7,834 female). The average WTE numbers of staff are set out below.

Table 18: Staff numbers

Average number of employees (WTE basis)	2018/19 Total Number	2018/19 Permanent Number	2018/19 Other Number	2017/18 Total Number	2017/18 Permanent Number	2017/18 Other Number
Medical and dental	**1383**	566	817	**1308**	562	782
Ambulance staff	**0.0**	0.0	0.0	**0.0**	0.0	0.0
Administration and estates	2,343	2,096	247	**2232**	1965	267
Healthcare assistants and other support staff	1,901	1,487	414	**1711**	1375	336
Nursing, midwifery and health visiting staff	3,393	2,963	430	**3130**	2710	420
Nursing, midwifery and health visiting learners	**0.0**			**0.0**		
Scientific, therapeutic and technical staff	771	685	86	**730**	648	82
Healthcare science staff	541	503	38	**495**	440	19
Social care staff	**0.0**	0.0	0.0	**0.0**	0.0	0.0
Agency and contract staff	0.0	0.0	0.0	0.0	0.0	0.0

Average number of employees (WTE basis)	2018/19 Total	2018/19 Permanent	2018/19 Other	2017/18 Total	2017/18 Permanent	2017/18 Other
Bank staff	0.0	0.0	0.0	0.0	0.0	0.0
Other						
Total average numbers	**10,332**	**8,300**	**2,032**	**9570**	**7664**	**1906**

Recruitment and retention

To support our recruitment and retention strategy the following is in place:

- work/life balance schemes to offer opportunities for part time hours and flexible working along with comprehensive childcare facilities (two on-site nurseries and access to a local discounted holiday play scheme)
- 'Advantage' salary sacrifice scheme offering a wide range of options for staff to make tax and NI savings.
- annual leave purchase scheme
- eldercare/family support schemes
- NHS pension scheme
- a range of on-site facilities – leisure and social centre (Frank Lee Centre)
- comprehensive range of staff engagement surveys and many joint working initiatives with staff and trade unions
- occupational health service and Care First counselling service and a range of health and well-being initiatives
- onsite shopping and eating services
- range of leadership and employee development opportunities along with continuous professional development
- relocation assistance to provide financial support for nurses who move home to work at CUH
- employee referral scheme which offers a monetary incentive for employees to refer potential nursing candidates who are successfully employed by CUH
- exit questionnaire in which leavers are contacted and given the opportunity to feed back so that we can improve our employees' experience at work
- deposit loan scheme of up to £3,000 of all staff Bands 1 – 6 to cover the first month's rent and deposit for a new property, open to both starters and existing staff

Our role as a local employer

CUH is an important local employer and is constantly seeking ways to develop its role and to work with the local community to develop pathways into employment for disadvantaged groups. We offer a range of schemes: work experience, traineeships, voluntary worker schemes, apprenticeships and work with the long-term unemployed including the Prince's Trust. We continue to provide a comprehensive apprenticeship scheme and are committed to maintaining this.

Information about staff sickness

The information in the table below is compiled on a calendar year basis according to national requirements.

Table 19: Staff sickness

	2018/19	2017/18
Total days lost	69,281	66,589
Total staff years	9,440	9,064
Average working days lost per WTE	7.3	7.3

The data has been calculated using NHS I methodology for the period 1 April 2018 to 31 March 2019.

Equality and diversity

The Trust uses the NHS equality delivery system (EDS2) as a tool to use as evidence of compliance with the public sector equality duty (PSED) to engage with the public and staff and agree equality objectives. The Trust's equality performance was rated against the 18 EDS service and workforce equality EDS outcomes by a community EDS rating panel on 26 September 2016 and a revised updated EDS improvement plan for 2017/18 that has driven our equality, diversity and inclusion work was agreed to meet our equality objectives focusing on these areas:

- Better health outcomes for all
- Improve transition care between services for both admission and discharge of those patients with special complex needs
- Improvement of data collection in referral information to highlight special needs of patients by protected characteristic to ensure reasonable adjustments can be made
- Fully embed the Accessible Information Standard since implementation in 2016
- Improved patient access and experience
- Improve equality monitoring collection of patients' complaints and patient survey data recorded by protected characteristic to identify areas to improve the patients' experience
- Accessible premises and services
- Empowered, engaged and well-supported staff
- Fair recruitment and selection processes lead to a more representative workforce at all levels in the organisation
- Training and development opportunities are taken up and positively evaluated by all staff
- When at work staff are free from abuse, harassment bullying and violence from any source
- Staff report positive experiences of their membership of the workforce
- Workforce Race Equality Standard implementation
- Inclusive leadership at all levels of the organisation
- Board and senior leaders routinely demonstrate their commitment to promoting equality within and beyond the organisation

- Middle managers and line managers support staff to work in culturally competent ways within a work environment free from discrimination

Our patient profile and workforce equality monitoring reports are published on our public website equality and diversity pages.
https://www.cuh.nhs.uk/about-us/our-responsibilities/equality-and-diversity

Our 3rd Workforce Race Equality Standard report and coproduced action plan for 2017-2019 with BAME staff and directors was approved by the Board in September 2017 and published on the Trust public website.

Our first Gender Pay Gap report with narrative and action plan was approved by the Management Executive and published on our website on 29 March 2018.

The Trust is not only committed to fulfilling its legislative requirements but to go beyond what is legally required and to be an exemplar of best practice.

Further information on equality and diversity issues are included in section 3.28.

Disabled employees

The Trust is a 'Disability Confident employer and is a signatory of the 'Mindful Employer Charter' for 'Employers who are Positive about Mental Health'. The Trust's Equality Diversity and Inclusion in employment policy is applied and in addition, all workforce policies include an equality and diversity statement which sets out the Trust position and intent.

'Cambridge University Hospitals NHS Foundation Trust is committed to a policy of equal opportunities in employment. The aim of this procedure is to ensure that no job applicant or employee receives less favourable treatment because of their race, colour, nationality, ethnic or national origin, or on the grounds of their age, gender, gender reassignment, marital status, domestic circumstances, disability, HIV status, sexual orientation, religion, belief, political affiliation or trade union membership, social or employment status or is disadvantaged by conditions or requirements which are not justified by the job to be done. This procedure concerns all aspects of employment for existing staff and potential employees.'

Consulting staff and representatives on matters of concern and the performance of the organisation

The Trust works in partnership with staff side representatives through a number of mechanisms on matters of concern to staff and the performance of the organisation. In addition the Trust follows a communication strategy to update and consult employees with relevant information. The following points provide examples of some of the actions taken by the Trust to keep the employees updated and provide opportunities for staff to raise their views and concerns.

- CUH Daily is a daily email update that is sent to all employees regarding topical issues, events and any other information that the employees need to be aware of.
- 8:27 is a weekly Tuesday meeting which provides an opportunity for staff to hear the latest developments within the Trust and speak with the chief

executive and senior management team about progress on key issues. It is an open invitation to all staff to participate in the forum.

- Chair and Chief briefings happen every 6-8 weeks to keep the employees updated about the current Trust focus and future plans. This is an open forum for all employees which provides an opportunity for them to ask questions to the Chair and the Chief Executive.
- Management Staff Forum is the formal body for Trust-wide consultation which meets approximately every six weeks. The Forum includes the Trust recognised senior management and staff representatives who come from the unions. These two groups come together in the Forum to foster good employee relationships which then in turn benefit patient services.
- Weekly media update which is a summary of articles mentioning Cambridge University Hospitals in the media.
- Connect the Trust's internal intranet site has a communication hub where information is held that has been communicated across the Trust via internal communications channels.
- Employees can also share their views in Share Your Views online forum which provides a platform for them to raise any concerns or views.

Health and safety

Since the launch of our four year health and safety strategy – 'Safe people, places and processes' (2016) - good progress has been made on improving health and safety provided at CUH. Year 1 saw the service focus on re-laying the foundations for the management of health and safety at CUH, whereas year 2 saw the service take a more systematic and proactive approach to improving health and safety with the launch of its health and safety risk assessment programme. This work has raised the profile and visibility of the service at CUH and as a result the service is now being consulted on key business decisions such as estates projects, procurement of new equipment/products and developing new services.

In 2018/19 the service has focused on providing evidence based assurance on the management of health and safety at CUH. This has led to the development of CUH's health and safety assurance model and the development of:

- a H&S compliance dashboard that measures compliance against the Health, Safety and Wellbeing in Healthcare Partnership Group's NHS Workplace standards
- a comprehensive health and safety risk profile for CUH that captures the significant health and safety risks associated with the Trust's undertakings, and
- an audit plan consisting of self-assessment and a rolling audit programme to check that there are appropriate arrangements for the management of H&S.

Occupational health and wellbeing

Oh Occupational Health and Wellbeing is the Trust's in-house service, providing a full range of services to CUH staff, Royal Papworth Hospital NHS Foundation Trust, West Suffolk Hospital NHS Foundation Trust as well as other organisations in the local area. The service works closely with local public health and wellbeing services to provide staff with access to a range of support.

We work collaboratively seeking opportunities to as effective and efficient as we can be. We actively contribute to supporting a culture of workforce health and contribute to regional and national guidance and developments in this area. We continue to operate below the national average cost per capita for occupational health services in the NHS. This is made possible by our external income generating contracts.

During 2018 the service was assessed by SEQOHS (Safe Effective Quality Occupational Health Service) accreditation quality standards team. This process culminated in an onsite inspection in November. We are delighted with their findings which were very positive and we are committed to making further improvements.

We have again this year achieved the staff flu vaccination target with 75.8% of CUH frontline staff receiving their vaccination.

The following diagrams summarise our strategic approach to improving and protecting workforce health:

Improving Health

Protecting Health

The latest NHS national staff survey results for health and wellbeing positioned CUH at the top of the Shelford Group (peer group of 10 leading academic health trusts). CUH was also highly commended in the 'Britain's Healthiest Workplace' survey in 2018, citing a good level of holistic health amongst participants, with the Trust providing a comprehensive package of interventions. The survey did highlight useful areas for further improvement which are featured in the coming year's plans.

In the year ahead our aim is to continue to enhance our systems and processes to ensure we are delivering the best care possible to our workforce and all those we serve.

Counter fraud

CUH has taken all reasonable steps to comply with the requirements set out in the code of conduct for NHS managers, and has a named individual nominated to provide the lead local counter fraud specialist function, who is an accredited counter fraud specialist. When that specialist is absent, arrangements have been made to ensure that specialist assistance is available.

Under the NHS Standard Contract for 2018-2019, all organisations providing NHS services (providers) must put in place and maintain appropriate anti-crime arrangements. CUH fully complies with this requirement.

Standards of business conduct and the Bribery Act

The Bribery Act 2010 has been in force since July 2011. This act creates the offences of offering, promising or giving a bribe, requesting, agreeing to receive or accepting a bribe, bribing a foreign public official and the corporate offence of failing to prevent bribery. We have a clear standards of business conduct policy, which includes our zero-tolerance approach to bribery. Our stance is equally strong and clear in relation to those associated with or contracting with the Trust, and we avoid doing business with any individuals and organisations who fail to demonstrate their commitment to operate fairly, openly and honestly. Doing business transparently and preventing bribery is important in safeguarding the proper use of public money and resources, and a clear stance also provides patients, other customers, potential contractors and business partners as well as our governors and members with confidence that we will act in a transparent and fair way. This in turn protects our trusted position within our community and our reputation as a leading national and international centre for specialist treatment, education and research.

CUH has in place a number of procedures for the prevention of bribery, including a clear raising concerns policy and procedure, and a local counter-fraud specialist. In addition, we keep a publicly-available register of interests for directors, governors and staff as well as a hospitality register. All staff have a role to play, but individuals with specific responsibility for implementing bribery-prevention procedures include the Board of Directors, the Deputy Trust Secretary, and our managers, both clinical and non-clinical.

We work closely with colleagues both within and outside the NHS to support a concerted effort to promote fair, honest and open operations and to prevent bribery, for the ultimate benefit of the patients and public we serve.

Staff survey

Staff engagement at CUH remains an important part of our work; continually placing great importance on ensuring that all staff have a great work experience and are enabled to be the best and provide the best possible care for our patients.

The 2018 National staff survey results for CUH show continued areas of improvement across many areas of staff experience. There was a response rate of 51.5% up from 49.4% in 2017 and above the national average of 44.4%. Our overall staff engagement score was 7.2 out of 10, again above national average of 7.0 and an improvement on last year's score of 7.1.

Of the ten Shelford Group Trusts we have seen our comparative position rise in this area from fifth to third.

Nine out of the ten themes (detailed below) also scored above national average with Equality, Diversity and Inclusion being an outlier. Of the nine themes that

can be compared with previous years, CUH significantly improved in four of those themes.

We are proud that our Staff recommendation score of CUH as a place to work increased by 4.4% to 71.2% and that we are one of the best performing acute trusts for staff recommending a friend or relative for treatment at 84.2%. This result reflects the commitment of our staff to deliver excellent patient care.

Staff survey response rates

	2014	2015	2016	2017	2018
CUH	25%	37%	45%	49%	52%
Average Acute Trusts	44%	40%	42%	44%	44%
Best Acute Trust	82%	79%	76%	73%	72%
Worst Acute Trust	25%	25%	31%	29%	33%

Equality, diversity & inclusion

	2014	2015	2016	2017	2018
CUH	9.1	9.0	9.0	8.9	8.9
Average Acute Trusts	9.1	9.2	9.2	9.1	9.1
Best Acute Trust	9.6	9.6	9.6	9.4	9.6
Worst Acute Trust	8.3	8.3	8.1	8.1	8.1

Health & wellbeing

	2015	2016	2017	2018
CUH	6.1	6.5	6.4	6.3
Average Acute Trusts	6.0	6.1	6.0	5.9
Best Acute Trust	6.8	6.8	6.6	6.7
Worst Acute Trust	5.3	5.3	5.4	5.2

Immediate managers

	2015	2016	2017	2018
CUH	6.7	6.8	6.8	6.9
Average Acute Trusts	6.6	6.7	6.7	6.7
Best Acute Trust	7.3	7.2	7.2	7.3
Worst Acute Trust	6.1	6.2	6.2	6.2

Morale

New theme

	2018
CUH	6.2
Average Acute Trusts	6.1
Best Acute Trust	6.7
Worst Acute Trust	5.4

Quality of appraisals

	2015	2016	2017	2018
CUH	5.3	5.6	5.6	5.8
Average Acute Trusts	5.1	5.3	5.3	5.4
Best Acute Trust	6.1	6.3	6.4	6.5
Worst Acute Trust	4.2	4.4	4.6	4.6

Quality of care

	2015	2016	2017	2018
CUH	7.5	7.7	7.6	7.6
Average Acute Trusts	7.5	7.6	7.5	7.4
Best Acute Trust	8.3	8.2	8.1	8.1
Worst Acute Trust	6.9	7.0	7.0	7.0

Safe environment - Bullying & harassment

	2015	2016	2017	2018
CUH	8.0	8.2	8.1	8.1
Average Acute Trusts	7.9	8.0	8.0	7.9
Best Acute Trust	8.5	8.6	8.4	8.5
Worst Acute Trust	7.0	7.1	7.2	7.1

Safe environment - Violence

	2015	2016	2017	2018
CUH	9.5	9.5	9.5	9.5
Average Acute Trusts	9.4	9.4	9.4	9.4
Best Acute Trust	9.6	9.7	9.6	9.6
Worst Acute Trust	9.1	9.2	9.1	9.2

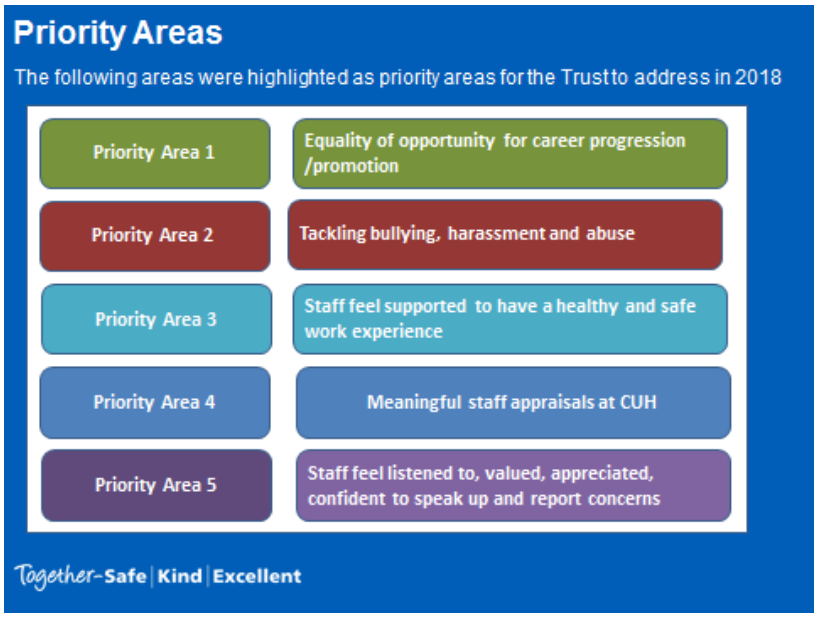
Safety culture

	2015	2016	2017	2018
CUH	6.5	6.9	6.8	6.9
Average Acute Trusts	6.5	6.6	6.6	6.6
Best Acute Trust	7.2	7.1	7.0	7.2
Worst Acute Trust	5.9	6.0	5.9	6.0

Staff engagement

	2014	2015	2016	2017	2018
CUH	6.7	7.1	7.2	7.1	7.2
Average Acute Trusts	6.8	7.0	7.0	7.0	7.0
Best Acute Trust	7.5	7.6	7.4	7.4	7.6
Worst Acute Trust	5.9	6.4	6.5	6.4	6.4

Future priorities and targets 2019/20



From an organisational perspective, we have responded to this latest staff feedback by refreshing and ranking our five trust wide priorities, with Equality, Diversity and Inclusion; being our number one priority. Alongside the Trust response, Clinical Divisions and Corporate departments have critically reviewed their own results and shared the learning, involving others in identifying objectives and improvements.

Monitoring arrangements

The progress of the action plans associated with these priorities will continue to be monitored through the Trust's Workforce and Education Committee meetings which reports to the Board of Directors. Performance will be monitored upon receipt of national staff survey 2019 and local staff engagement results to demonstrate levels of improvement.

Analysis of staff costs - Subject to Audit

Table 20

Employee expenses	Year ended 31 March 2019 Total £000	Year ended 31 March 2019 Permanent	Year ended 31 March 2019 Other £000
Salaries and wages	363,771	359,000	4,771
Social security costs	39,993	39,993	-
Apprenticeship Levy	1,910	1,910	-
Pension cost – defined contribution plans employers contributions to NHS pensions	45,377	45,377	-
Temporary staff – external bank	38,689	-	38,689
Temporary staff – agency/contract staff	8,072	-	8,072
Total gross staff costs	**497,812**	**446,280**	**51,532**
Included within:			
Staff and executive directors costs	497,560	446,280	51,532
Redundancy	38	38	-
Early Retirements	171	171	-
Special Payments	43	43	-
Total employee benefits	**497,812**	**446,280**	**51,532**

Expenditure on consultancy

Information regarding expenditure on consultancy can be found in the annual accounts.

Relevant Union Officials

Table 21 - What was the total number of your employees who were relevant union officials during the relevant period?

What was the total number of your employees who were relevant union officials during the relevant period? Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
42	39.95

Table 22 - Percentage of time spent on facility time: How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	24 (including 19 medical reps)
1-50%	18
51-99%	0
100%	0

Table 23 - Percentage of pay bill spent on facility time: the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

	Figures
Total cost of facility time	£32,947.21
Total pay bill	£497,812,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.00662%

Table 24 - Paid trade union activities - As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated	3.76%

as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	

Off-payroll engagements

Table 25: For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last for longer than six months.

Number of existing engagements as of 31 March 2019	
Of which :	
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

Table 26: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months.

Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	
Of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 27: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	18

Exit packages - Subject to Audit

Exit packages are accounted for in full in the year of departure.

Table 28 Exit packages

Reporting of other compensation schemes - exit packages 2018/19 Exit package cost band (including any special payment element)	Number of compulsory redundancies Number	Cost of compulsory redundancies £000s	Number of other departures agreed Number	Cost of other departures agreed £000s	Total number of exit packages Number	Total cost of exit packages £000s	Number of departures where special payments have been made Number	Cost of special payment element included in exit packages
<£10,000	2	12	12	43	14	55	0	0
£10,001 - £25,000	2	26	0	0	2	26	0	0
£25,001 - 50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	4	38	12	43	16	81	0	0

Reporting of other compensation schemes - exit packages 2017/18 Exit package cost band (including any special payment element)	Number of compulsory redundancies Number	Cost of compulsory redundancies £000s	Number of other departures agreed Number	Cost of other departures agreed £000s	Total number of exit packages Number	Total cost of exit packages £000s	Number of departures where special payments have been made Number	Cost of special payment element included in exit packages
<£10,000	5	8	3	16	8	24	1	13
£10,001 - £25,000	5	102	3	43	8	145		
£25,001 - 50,000	1	32			1	32		
£50,001 - £100,000	2	140			2	140		
£100,001 - £150,000	2	252			2	252		
£150,001 - £200,000	0	0			0	0		
>£200,000	0	0			0	0		
Total	15	534	6	59	21	593	1	13

Exit packages: other (non-compulsory) departure payments - 2017/18	2018/19 Payments agreed Number	2018/19 Total value of agreements £000	2017/18 Payments agreed Number	2017/18 Total value of agreements £000
Voluntary redundancies including early retirement contractual costs				
Mutually agreed resignations (MARS) contractual costs				
Early retirements in the efficiency of the service contractual costs				
Contractual payments in lieu of notice	12	43	5	46
Exit payments following employment tribunals or court orders				
Non-contractual payments requiring HMT approval*i			1	13
Total			6	59
of which:				

non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary				

Code of governance

3.24 Code of governance

The Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently reviewed in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. The Trust has reviewed our compliance with the 'NHS Foundation Trust code of governance'. As a result of this review, we consider that CUH complies with the main and supporting principles of the code of governance. This includes the issue of whether or not all of the NEDs are independent in accordance with code provision B1.1. The Board of Directors has determined that all of the NEDs are independent in character and judgement. This includes the appointed representative of University of Cambridge, Professor Patrick Maxwell, the Regius Professor of Physic, notwithstanding the Trust's relationship during this reporting period with the University of Cambridge, School of Clinical Medicine and with Cambridge University Health Partners (CUHP).

In relation to the more detailed provisions of the code of governance, CUH is compliant with the provisions with the following exceptions:

B.1.3 The Chief Nurse holds a position of partnership governor at Royal Papworth Hospital NHS Foundation Trust and the Director of Nursing from Royal Papworth Hospital NHS Foundation Trust is a partnership governor on the CUH Council of Governors. During the reporting period the Director of People and Business Development of Cambridgeshire and Peterborough NHS Foundation Trust was a partnership governor on the CUH council of governors.

NHS Improvement's Single Oversight Framework

3.25 NHS Improvement's Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers

with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Finance and use of resources rating	2018/19
Capital service cover rating	4
Liquidity rating	4
I&E margin rating	4
I&E margin: distance from financial plan	1
Agency rating	1

Overall finance and use of resources risk rating	
Overall rating unrounded	2.80
Risk ratings after overrides	3

3.26 Well Led

The Trust commissioned an external review against NHS Improvement's Well-Led Framework which reported in late 2016.

The recommendations of the Well-Led Review were implemented during 2016/17 and 2017/18, with updates provided to the Board of Directors.

In line with a recommendation of the Well-Led Review, work was undertaken during 2017/18 to develop a formal Accountability Framework for the organisation which was endorsed by the Board of Directors in May 2018.

In the most recent Care Quality Commission inspection published in February 2019, the Trust was rated as 'Outstanding' in the 'Well-led' domain.

3.27 Statement of the Chief Executive's responsibilities as the Accounting Officer of Cambridge University Hospitals NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Cambridge University Hospitals NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Cambridge University Hospitals NHS foundation trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis ;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy; and
- Prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed

Roland Sinker
Chief Executive
23 May 2019

3.27 Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Cambridge University Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Cambridge University Hospitals NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

The system of internal control integrates a number of individual controls as described in other sections of this statement, and other key policies and procedures such as the Standing Orders, identification of matters reserved to the Board, Standing Financial Instructions and Scheme of Delegation used to govern the Trust's activities, together with checks and balances provided by Board oversight, and internal and external audit reviews.

Capacity to handle risk

The Board of Directors sets the policy framework and provides leadership for the management of risk within the Trust. The Chief Nurse is the Executive Director lead for risk management.

The Board Assurance Framework (BAF) identifies the principal risks to the achievement of the Trust's strategic objectives, together with key controls and assurances and any gaps in those controls and assurances.

Operational responsibility for risk management sits within the clinical divisions and corporate directorates. Each clinical division and corporate directorate is required to have processes in place by which risks are identified, evaluated and managed at a local level, and escalated as required in accordance with the Trust's policy framework.

The principles of risk management are included as part of the mandatory corporate induction programme and guidance and training are provided to staff through the annual refresher programme, risk management training, Trust-wide policies and procedures and feedback from audits, inspections and incidents.

The Trust also learns from good practice through a range of mechanisms including those detailed above together with clinical supervision and reflective practice, individual and peer reviews, after action reviews, performance management, continuing professional development programmes, clinical audit and application of evidence-based practice.

The risk and control framework

The Risk Management Strategy and Policy sets out the approach to managing risk within the organisation. The latest version of the Strategy and Policy was approved by the Board of Directors in September 2018. It defines the roles, responsibilities and reporting lines in relation to risk management as well as the overall governance structure underpinning this at both Board and divisional/directorate level. It details the Trust's approach to identification, assessment, management, monitoring and escalation of risk and a statement of the Board's risk appetite.

As noted above, the BAF sets out the principal risks to the achievement of the Trust's strategic objectives. The Executive Director with delegated responsibility for managing and monitoring each risk is clearly identified. The BAF describes controls in place to manage each of the risks and explains how the Board is assured that those controls are in place and operating effectively. The BAF also identifies any gaps in control or assurance and the actions being taken to address these within specified timeframes.

The BAF is reviewed on a monthly basis through a peer review process by the Executive Directors who are leads for each risk and jointly by the Risk Oversight Committee (see below). The BAF is received by the Board of Directors four times a year, detailing movements in risk and mitigating actions being taken with the aim of reducing the risk towards its target level. Entries on the BAF are received and considered at each meeting of the relevant Board assurance committees to which they are assigned.

The Risk Oversight Committee meets monthly. It is chaired by the Chief Executive and membership includes all members of the Management Executive. The Risk Oversight Committee reviews the BAF and the Corporate Risk Register, which includes risks escalated from clinical divisions and corporate directorates.

At an operational level, responsibility rests with each Divisional Director, supported by the Associate Director of Operations and Head of Nursing, for clinical divisions; and with each Executive Director for the corporate directorates. Divisional 'red-rated' risks are reviewed at divisional Performance Meetings with members of the Executive Team.

The above meetings and associated processes are intended to facilitate a seamless risk management system from Board to ward.

The Board of Directors has previously agreed the principles regarding the level of risk which the Trust is prepared to seek, accept or tolerate in pursuit of its agreed objectives. These principles are focused on quality, finance and value for money, innovation, commercial opportunities, compliance and regulatory framework, reputation and workforce. The Board of Directors has reviewed the principles and the organisational risk appetite during the financial year.

The 2018/19 internal audit report on the BAF and risk management provides an overall assessment of 'Significant assurance with minor improvement opportunities'. The recommendations of the report have been accepted by the Executive Team and will be actioned during 2019/20.

As at 31 March 2019, the Trust identified through the BAF the most significant risks to the achievement of its strategic objectives as being:

- A failure to address estate backlog maintenance and statutory compliance priorities (including infection) caused by insufficient capital funding and decant capacity impacts on safety and continuity of clinical service delivery.
- Inadequate fire safety management arrangements and plans impact on patient and staff safety and continuity of clinical service delivery.
- The Trust has insufficient capacity to sustain timely and effective emergency and elective patient flow through its hospitals which impacts on waiting times, safety and patient experience.
- As a result of not achieving system-wide service redesign and securing support for the structural element of the financial deficit, the Trust does not achieve a position of financial sustainability by 2020 which impacts on its ability to improve services for patients.
- There is insufficient resilience in the Trust's IT network and technology platform given the reliance on electronic patient information to cope with IT infrastructure failures which impacts on the delivery of safe and effective services for patients.
- There is insufficient protection in the Trust's IT network and technology platform given the reliance on electronic patient information to cope with a cyber-attack which impacts on the delivery of safe and effective services for patients.

The Trust has identified the controls in place to manage these risks and the sources of assurance that the controls are effective. It has also identified any gaps in control or assurance and the associated actions being taken to address these gaps. The Board of Directors and Board assurance committees regularly seek assurance on the effectiveness of the controls and progress being made to address gaps in control and assurance to reduce the level of risk, where this is within the Trust's ability to do so.

Quality governance

The Board of Directors has a collective responsibility for providing high quality care to the Trust's patients and has put in place a quality governance framework to ensure that quality is an integral part of the Trust's activities. The quality governance framework has been reviewed and strengthened during the year, having due regard to the Well-Led Framework and best practice from other organisations. During the year (see below), the Care Quality Commission (CQC) undertook a Well-Led review of the Trust and rated the Well-Led domain as 'Outstanding'.

The Quality Committee, in conjunction with the Performance Committee, provides assurance to the Board on the quality of patient care and compliance with national and local standards, with reference to the monthly Integrated Performance Report

and other relevant reports and data. It reviews the Trust's clinical audit programme, compliance with the requirements of the Care Quality Commission, and Trust preparedness for regulatory inspections.

The Committee also oversees the implementation of the Trust's Quality Plan and its ongoing development. This includes a focus on clinical quality improvement to ensure that the Trust learns, shares and takes appropriate action in respect of safety reporting, and prospective and proactive patient safety risk detection; information and experience from outside the Trust; external reviews of Trust activity; and the results of clinical audit. It also oversees the development of and agrees priorities for the Trust's annual Quality Account.
Never Events and clinical and non-clinical incidents which are significant enough to be classified as Serious Incidents are identified by the Director of Clinical Quality and are reported immediately to the Executive Directors and to the Trust's lead commissioner. The incidents are detailed in the monthly Integrated Performance Report and in the Patient Safety report received by the Quality Committee. Incident information is reviewed at monthly divisional Quality meetings.

All incidents are subject to a Root Cause Analysis and learning is shared with the divisions and through the organisation. Themes are identified in the Integrated Report. The Quality Committee receives a bi-monthly report on serious incidents as part of the Patient Safety report including themes and actions taken.

Information governance

The Trust has in place an Information Governance policy which sets out the Trust's commitment to ensuring that information is efficiently and effectively handled, managed and safeguarded. The policy establishes a robust information governance framework which includes up to date policies, procedures and accountabilities. Managers within the Trust are responsible for ensuring that the policy and its supporting standards and guidelines are built into divisional and directorate processes and that there is ongoing compliance.

The Trust complies with the requirements of the NHS Digital Data Security and Protection Toolkit for the management and control of risks to information. The current level of compliance with the Toolkit is 'standards met'.

The Director of Improvement and Transformation is the Trust's Senior Information Risk Owner (SIRO), reporting to the Board of Directors, and Dr Adrian Boyle, Consultant in Accident and Emergency, is the Trust's Caldicott Guardian. Senior managers across the Trust are information asset owners, accountable for a particular group of information assets under the Information Governance policy and management framework. The Information Security and Governance Programme Board is chaired by the Chief Information Officer and re ports to the Board of Directors through the Quality Committee.

Risks to foundation trust governance

The Board of Directors is responsible for setting the vision and values and the strategic objectives of the Trust. During the year the Board has undertaken a refresh of the Trust's strategy. The Trust's core governance documents establish the roles and responsibilities of directors and other Trust officers.

The Audit Committee is the Board committee with primary responsibility for overseeing the Trust's governance and assurance processes and, in particular, for

independently reviewing the effectiveness of the system of internal control and risk management, and ensuring that all significant risks are properly considered and communicated to the Board.

The Performance Committee, the Quality Committee and the Workforce and Education Committee provide independent and objective oversight and assurance to the Board of Directors on the Trust's performance in relation to operational standards, quality, finance and workforce.

The clinical divisions are held to account and escalate issues as required through monthly Performance Review meetings with the Executive Team. Each division provides a balanced scorecard of performance information which is included in the monthly Integrated Performance Report.

Work was undertaken during 2017/18 to develop a formal Accountability Framework for the Trust, and there was ongoing focus during 2018/19 to ensure that the Accountability Framework continued to be embedded.

A risk assessment against the Trust's operating license is carried out annually.

Involvement of stakeholders in risk

The Trust endorses three principles which underpin the quality framework:

- Quality is at the heart of all that the Trust does.
- There is an open and transparent culture to facilitate a learning organisation.
- The organisation will work collaboratively with stakeholders to ensure the quality and safety of services and demonstrate commitment to continual improvement.

Further information regarding patient and public engagement in the Trust is included in the Annual Report.

The Trust informs and engages with its commissioners throughout the year in relation to risk through regular meetings to review contract/clinical quality matters and to engage with them on the development of the Trust's Quality Account.

The Trust is engaged with partner organisations in the local health and care system in discussing quality and risk issues impacting on patients, in particular through the work of the Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP).

The Trust engages with public stakeholders and the local Healthwatch in discussions including consideration of risks which impact on them. Governors are involved in discussions about risks which impact on patients and members through regular meetings including of the Council of Governors and Governor-Director Working Groups. They are also involved in the development of the Trust's Operational Plan and Quality Account.

CQC registration

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).

The Trust was inspected by the CQC in November 2018 and the inspection report was published in February 2019. The CQC inspected four core services and undertook a Trust-wide Well-Led review, together with a Use of Resources assessment by NHS Improvement. The Trust continued to be rated as 'Good' overall for Quality, with both the Caring and Well-Led domains being rated as 'Outstanding'. The Trust was rated as 'Requires Improvement' for the Responsive domain and for Use of Resources. An action plan is in place to address the 'Should Dos' identified in the CQC inspection.

The Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Other compliance issues

The Trust is currently reviewing its compliance with the Developing Workforce Safeguards and will develop an action plan to address any areas where further work is required in relation to the national expectations. This will be reported to the Workforce and Education Committee and the Board of Directors during the first half of 2019/20.

The foundation trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. An internal audit of the Trust's compliance was undertaken during the year and the resulting recommendations have been, or are currently being, implemented.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights are complied with.

The foundation trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Trust's Operational Plan for 2018/19 was approved by the Board of Directors following review by the Council of Governors. The Plan was submitted to and accepted by NHS Improvement.

Delivery of the Operational Plan was monitored by the Management Executive. Progress against cost improvement programmes was monitored through a robust programme management office process reporting to the Improvement Steering Group and the Management Executive. The Performance Committee sought assurance on behalf of the Board of Directors on the delivery of the Operational Plan.

The objectives set out in the Trust's Internal Audit Plan include ensuring the economical, effective and efficient use of resources and this consideration is applied across all audits. The findings of internal audit reports are reported to the Audit Committee. Non-financial audits relating to quality are considered by the Quality Committee.

The process to ensure that resources are used economically, efficiently and effectively across clinical services include divisional Performance Reviews meetings, the clinical audit programme and the regular monitoring of clinical indicators covering quality and safety.

Information Governance

During 2018/19 the Trust recorded 38 incidents relating to information governance, including data loss or confidentiality breach, which were classified as a reportable Information Governance Incidents. These cases have been reported to the Information Commissioner's Office and have been fully investigated.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

The 2018/19 Quality Report was reviewed and recommended for approval to the Board of Directors by the Quality Committee. The Quality Committee was responsible for agreeing priorities to be included in the Quality Report based on input from clinical colleagues and the Council of Governors. Governors selected indicators for audit as they are required to do. External stakeholders, including the Trust's lead commissioners, were also involved in the development of the Trust's quality priorities and provided commentary for inclusion in the Quality Report.

Information to support the quality metrics used in the Quality Report are held in a number of Trust information systems, including the EPIC system and the risk management system, and are supported by analysis of reporting, and national returns.

The assessment of quality indicators is integrated into the Trust's performance management system, and hence is subject to review by operational and managerial staff on a monthly basis in a structured framework of performance review. The reliability of the data is periodically audited by the Trust's internal auditors. The data used in the Quality Account is subject to external and internal audit processes.

The Trust's Quality Report is included as part of the Trust's Annual Report and Accounts.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit, and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the Board of Directors, the Audit Committee, the Quality Committee, the Performance Committee, the Workforce and Education Committee and the Internal Auditors and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by the work through the year of the Board of Directors and of Board committees, as described in the risk and control framework section above. I have also been informed by the work of the internal auditors during the year, working to a risk-based plan agreed by the Audit Committee, and the action plans resulting to address areas for improvement.

The Head of Internal Audit opinion has concluded that significant assurance could be provided that the organisation has an adequate and effective framework for risk management, governance and internal control.

The result of the external auditors' work on the annual accounts and annual report are also a key assurance. Other external assurance is provided by CQC intelligent monitoring reports, the outcomes of the clinical audit programme and the results of reviews and inspections by external organisations.

The Audit Committee has reviewed the overall framework for internal control, and has recommended this statement to the Board of Directors.

Significant internal control issues

The Board of Directors has identified the following significant internal control issues for the Trust:

- Insufficient capacity to sustain timely and effective patient flow through the Trust's hospitals has again impacted during the year on the Trust's ability to deliver key operational performance targets in relation to both emergency and elective care. The Trust has continued to take actions internally to improve patient flow, as well as working with partners to reduce delayed transfers of care and identify the scope to provide additional physical capacity both on-site and elsewhere within the local health economy.

- Insufficient capital funding and decant capacity has again impacted during the year on progress in addressing estates backlog maintenance and

statutory compliance priorities (including in relation to fire safety and infection control). The Trust has taken a risk-based approach to prioritising investment within the capital resources available, has taken the decision to proceed with critical investment 'at risk' ahead of receipt of capital funding, and has continued to escalate and work closely with its regulators on these issues.

Conclusion

My review has established that Cambridge University Hospitals NHS Foundation Trust has a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives. I am satisfied that the significant internal control issues that have been identified in this review have appropriate action plans to help mitigate the associated risks and are subject to appropriate review, monitoring and escalation both internally and externally.

Roland Sinker
Chief Executive
23 May 2019

3.28 Equality, diversity and inclusion report

Overview
The Trust is committed to tackling inequality of opportunity and eliminating discrimination both within the workforce and in the provision of services. The Trust has a legal responsibility under the Equality Act 2010 to:

- Eliminate discrimination, harassment and victimisation
- Advance equality of opportunity
- Foster good relations between persons who share a relevant characteristic and those who do not. The nine protected characteristics being age, disability, ethnicity, gender, gender reassignment, marriage & civil partnership, pregnancy & maternity, religion or belief and sexual orientation.
- Publish information to demonstrate compliance with the general duty at least annually
- Prepare and publish equality objectives every four years.

The Trust takes due regard for equality by undertaking equality impact assessments/equality analysis when reviewing policies or when planning changes to services as part of organisational change processes to ensure our functions and services are not discriminatory. This report sets out the Trust's annual progress report and actions to promote workforce and service equality, diversity and inclusion.

NHS equality delivery system (EDS2)
The EDS has been developed by the NHS England Equality and Diversity Council to improve equality and diversity practice in the NHS as a tool to embed equality and diversity practice to meet the public sector equality duty.

The EDS contains 18 outcomes grouped under four goals, which are equality objectives for the Trust:

1. Better health outcomes for all
2. Improved patient access and experience
3. Workforce – the NHS as a fair employer
4. Inclusive leadership at all levels

The Trust's fifth equality objective is to improve patient data at referral to enable adjustments accordingly and measure equity of access, experience and outcomes.

The Trust uses the NHS Equality Delivery System (EDS2) as a tool to drive equality improvements, to engage patients, staff and the community to review service and employment equality performance and to identify future priorities and actions for the Trust's equality objectives. The Trust's directors each have responsibilities for equality and diversity. The Trust's EDS equality improvement plan 2018/19 was based on feedback from an EDS equality engagement and rating event.

The EDS improvement plan includes implementation and embedding of the Accessible Information Standard and the Workforce Race Equality Standard action plan. The Trust's EDS rating reporting template and annual equality objectives are published on the Trust website.

Workforce Race Equality Standard
Since July 2015 all NHS trusts are required to publish their Workforce Race Equality Standard metrics as part of the new NHS contract. The fourth WRES reporting template and action plan was revised and approved by the Board in September 2018 and is published on the Trust public website. The WRES report and action plan are standing items for the Workforce and Education Committee, the Equality, Diversity and Dignity Steering Committee and updates are provided to the Board and Management Staff Forum.

In 2018/19 key activities on the WRES action plan have included:

- The EDI lead participated on the first cohort of NHS England's WRES expert development programme.
- Governance arrangements were reviewed and the WRES implementation group was set up in August 2018 to ensure progress.
- WRES indicators including WRES staff survey metrics have been shared with divisional management teams and BAME network representatives. Divisional engagement has taken place to share and support the WRES action plan, and to promote the BAME network.
- All acting up posts and secondment opportunities must be advertised centrally and no contracts will be processed by recruitment unless this has been undertaken.
- Diverse interview panels have been introduced for all posts band 8a and above/equivalent.

- Audit of recruitment job files has led to review of recruitment and selection training to be re-launched in May 2019. This will be made mandatory every 3 years for recruiting managers.
- Executive mentoring scheme of BME staff has continued.
- Scoping of the RCN cultural ambassador programme has been completed and the Trust is recruiting BME staff at bands 6 and above to be trained as Cultural Ambassadors to be involved at disciplinary investigations for all potential investigations involving BME staff.
- Reverse mentoring schemes are being scoped with Professor Stacy Johnson, MBE of Nottingham University for launch in September 2019.
- The Trust CEO is the senior responsible officer for the WRES and is the BAME network board champion and meets with the BAME network.
- A number of celebratory events have been held including a Black history month film night in October 2018, a Cultural Diversity Celebration on 9 November 2018 to welcome our newest staff recruited from overseas with guests including local MPs, local councillor and staff speakers.
- Trust Directors nominated 10 BME Trust employees for the national NHS Windrush 70 awards to mark the 70th birthday of the NHS the 70th anniversary of the arrival of the Empire Windrush at Tilbury Docks, nine Trust staff were shortlisted after receiving the most votes from across the country and the trust was delighted that Dr Amos Burke won the Windrush 70 award category for Research and development.

Leadership and management of equality and diversity

A number of working groups drive equality activity in the Trust. These include groups focused on staff and the patient services:

Equality, Diversity and Dignity Steering Committee, **staff networks, equality and diversity staff group,** LGBT and Allies network, "It's Not Just You group" (staff group for mental wellbeing and resilience) and "CUH Time to change" (group of mental health first aiders campaigns against mental health stigma and organises events and talks), **CUH BAME staff network, CUH Women's staff network, Learning disability working group, Vulnerable adults working group, Dementia strategy group,** Accessible Information Standard Implementation Task and Finish group, Carers Strategy group.

Equality monitoring

As required by the public sector equality duty, the Trust's workforce equality monitoring information is published on the CUH public website (see also section 3 staff profile as at 31 March 2019).

This includes:

- the profile of our staff by age band, disability, race, religion, sex, sexual orientation and marital status
- ethnic profile of our staff compared to the local population
- recruitment data by age band, disability, race, religion, sex, sexual orientation and marital status (those applying, shortlisted and appointed)
- staff in post by pay band by age, disability, race, sex and sexual orientation
- the number attending training courses by age band, disability, race and sex
- the number of leavers by age band, disability, race and sex
- employee relation cases (disciplinary, capability, performance and sickness bullying and harassment) cases by age band, disability, race and sex

Our patient profile and membership diversity report from the Trust membership office is published on the Trust website equality and diversity pages.

Key equality and diversity activities for service equality and workplace in 2018/19

Training and awareness

A range of training and awareness activity has taken place in 2018/19 including:

- "Understanding Unconscious bias" e-learning package from Skill-boosters has been in place since September 2016 and is mandatory for all line managers, supervisors and all staff within the workforce directorate. It is also a pre-course learning requirement for all staff undertaking recruitment and selection training. This is in addition to the e-Learning module on equality and diversity and inclusion as part of biannual e-Learning refresher training.

  A suite of equality diversity and inclusion e-learning packages from Skill-boosters can now be accessed by all our staff.

  - Be Disability Confident workshops face to face training for training for staff continue involving disabled people sharing their experiences
  - "Demystifying Equality, Diversity and Inclusion" - half day workshops for managers facilitated by external facilitator Jagtar Singh, OBE – 10 half day sessions held for all divisional/corporate senior teams and others to attend
  - The Board also received training on their responsibilities for equality, diversity and inclusion from Jagtar Singh in November.
  - The Kite Trust was commissioned to facilitate LGBT+ awareness training; 50 staff attended four half day workshops in 2018/19. The Kite trust also held bespoke LGBT+ training sessions for a number of team away days including Workforce Directorate and Patient Safety and Quality Support.
  - Dementia awareness training programme for staff has been in place since 2011 and includes 'Barbara's Story', which is included at corporate induction.
  - Mental health first aid training for staff continues to be provided by the Trust's specialist mental health nurse.
  - Events were held for NHS equality and human rights week in May 2018 including stands to promote staff networks with talks from external speakers on "Tackling Hate crime how to support staff and public from the Hate Crime Coordinator Cambridgeshire Police and LGBT+ awareness from the Kite Trust and Trans awareness session from Unison LGBT equalities officer.

Service equality

Key activities in 2018/19 to improve service equality have included:

- Embedding the national Accessible Information Standard.
- A new Learning Disability Strategy was approved and ratified in June 2018 after involvement with Learning disability groups, and Voicability
- Carers strategy group has created a carers handbook and passport.
- Hospital communication has been purchased and distributed to all wards and clinic reception desks to support the different communication needs of patients with disabilities.
- Red Hearing aid boxes were purchased and distributed to wards for storage of patients' hearing aids.

Workforce equality

The Trust is signed up to the following standards;

- "Disability Confident" Committed Employer.
- 'Mindful Employer' charter signatory for employers who are positive about mental health.
- Time to Change organisational employer pledge to end mental health stigma and discrimination.

Key workforce equality activity in 2018/19 other than the work streams reported earlier includes:

- The second Gender Pay gap report and plan was published in March 2019.
- CUH took part in the nine month NHS Employers Diversity and Inclusion Partner Programme for the second year running in 2018/19.
- A bespoke version of the Diversity Inclusion calendar was produced for CUH for publication with images of Trust events for publication on the Intranet and on the public website.
- 10 October 2018 - The Time to Change group organised an Open Mind Night cabaret evening to mark World Mental Health day raising £200 for the MIND Ed Trust; and a lunch time Walk and Talk with PAT dogs to mark Time to Talk Day in February 2019.
- To mark World Menopause Day in October, a Menopause expert's panel with Q&A was held followed by a Menopause Café to raise awareness and support for staff.
- The Trust has joined the Purple Space organisation to support engagement with our disabled staff to help co-produce a disability action plan.

3.29 Sustainability and climate change report

Introduction

This report describes the commitment, approach and performance of Cambridge University Hospitals NHS Foundation Trust (CUH) in its ongoing response to the environmental sustainability agenda during 2018/19 - specifically including the challenge of tackling climate change. The report is divided into two sections:

- Section 1: provides the frame for understanding the Trust's actions for tackling environmental sustainability and climate change in 2018/19 – a process of continuous development and improvement in line with the Board adopted Sustainable Development Management Plan 2013-2020.
- Section 2: details performance and achievements during 2018/19 and provides a brief look forward to the delivery priorities for the coming year.

Commitment

As an NHS organisation, and as a spender of public funds, the Trust has an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and contributing to building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term, even in the context of the rising cost of natural resources. Demonstrating that we consider the social

and environmental impacts of our activities ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

The Trust acknowledges this responsibility to our patients, staff, visitors and local communities by working hard to minimise the 'footprint' of our local and global environmental impacts.

Context – sustainability is essential to what we do

Sustainability asks us to question our way of doing things. To check that we can carry on without making things difficult for ourselves or others today, or anytime in the future.

In more concrete terms, sustainability asks us to constantly review what we consume and how we consume it in order to ensure that, in delivering our services, the Trust is always doing what it can to:

- reduce greenhouse gas emissions by half in the next ten years, and almost entirely in the next 30 years, in order to keep the probability of the dangerous impacts of climate change within safe limits.
- control the pollution of the air, land and water so that it does not endanger health.
- carefully manage our draw on natural resources so that they do not become irreversibly damaged or depleted.

Each of the above are very significant and pressing risks to our wellbeing, habitat and all the other habitats and wider ecosystems upon which we depend. The risks are established and connected by the utilities, goods and materials we consume. This makes them very difficult risks to reduce. What we consume, and how we consume it, is deeply embedded in the day-to-day running of our hospitals and the day-to-day living of everyone involved as staff, patients or visitors. At CUH, as with most organisations, our ability to function is down to being able to consume the goods, materials and utilities we need to deliver the services that make up our business – the business of using public money to return people to good health and to keep them that way.

CUH is a very intense consumer of energy, water, goods and materials. Front-line patient care, and all the associated support functions and campus infrastructure, mean that CUH consumes at the rate of a small town. This in itself brings a significant element of responsibility to ensure that the Trust's consumption is as efficient and cost-effective as possible.

What we consume at CUH hinges upon the 'flow' of utilities, goods, materials and transport. These are all vital material flows that CUH's staff need to deliver safe, kind and excellent healthcare to all their patients: 24 hours of the day, 365 days of the year. The Trust consumes at a consistently high level in terms of the volume of these flows and the complexity of connections that need to be made in servicing all aspects of healthcare provision across the site. What matters is doing it in ways that are genuinely sustainable.

To carry on providing a safe, kind and excellent service whilst significantly reducing the resultant environmental impacts could be seen as one of the hardest challenges faced in the hospitals' 250-year history.

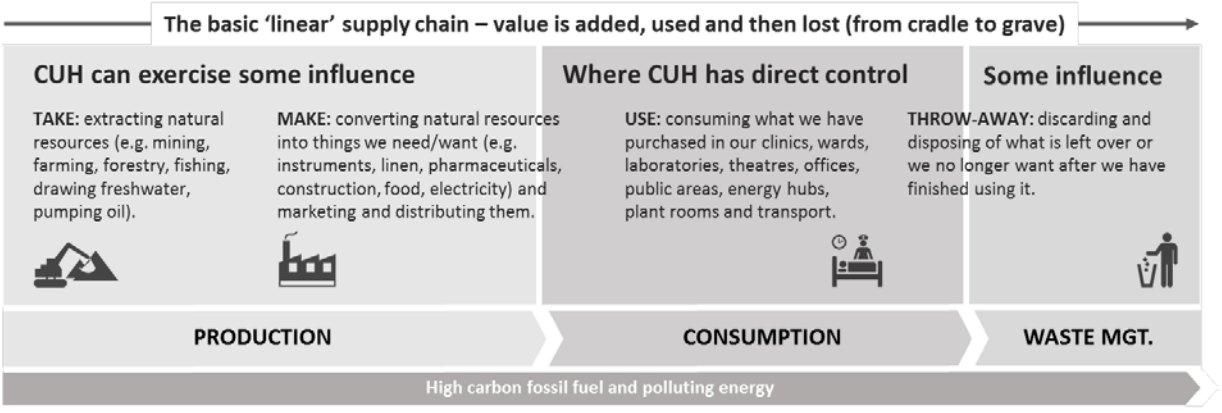
Changing the way we consume

CUH sits within a modern economy that is powered by fossil fuels and has grown from exploiting natural resources, whilst releasing pollution and disposing of waste products back into our shared environment. When the hospital was founded in 1766, these processes were just beginning to develop. Over the past 250 years this development has transformed health and wellbeing: the average life expectancy in the UK has doubled from 40 years to 80 years.

However, as populations have expanded and the quality of life for many has improved so has the demand on natural resources alongside the associated collateral damage from production and consumption (in the form of greenhouse gas emissions, pollution and waste). Nations and communities across the world are starting to experience the very real limits to these losses and the increasingly hazardous environmental impacts that accompany them. Limits beyond which higher material costs, reduced availability, unstable weather, polluted landscapes and degraded habitats combine to put personal health, community wellbeing and modern living standards, including the safe, kind and excellent healthcare the Trust provides, at significant and very real risk.

Reducing this risk to fair and safe levels is at the heart of the shift from unsustainable to sustainable ways of working. This change is not there to question the things we want – such as the importance of running a large acute teaching hospital. Rather, it is to try and make sure that the ways we consume do not make life harder or less healthy for other people today, or for any of us anytime in the future.

Most of the wasteful, polluting and climate changing aspects of what we all consume are down to the means of extraction, manufacture, use and disposal of the goods, materials, energy, food and water that we decide we need. As indicated in the adjacent diagram, this 'supply chain' can be thought of as moving in a roughly straight line in one direction: **from *take* to *make* to *use* and then to *throw away***. It is therefore often **referred to as the 'linear economy'** and is also powered predominantly by climate-changing fossil fuels.



The good news is that there are **three very strong business-related reasons for moving away from the practices of this linear economy** that cause this loss of resources and associated environmental damage.

Firstly, unchecked climate change, pollution and the irreversible loss of natural resources will make people unwell and more vulnerable to sickness. Managing and

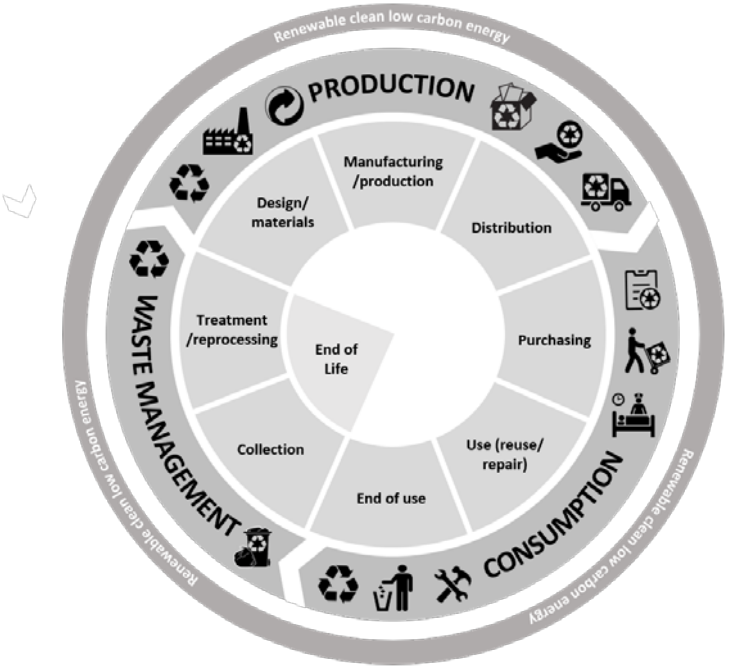
treating this impact will come at great social and economic cost. Taking preventative steps should therefore be seen as an integrated part of the business of delivering safe, kind and excellent healthcare.

Secondly, everything that gets thrown away has a value and the potential to be used again to make the same or similar goods and materials at a fraction of the cost of starting again with 'virgin' raw materials. Business runs on extracting value to make money, the challenge is to do this through repairing, re-using and recycling the value as opposed to throwing it away and starting again from new. Recognising and appropriately segregating waste as an unused resource stands to generate major operational savings.

Thirdly, the cost of adapting to the impacts of manmade climate change on land-use, fresh air, water supply, food production, the built environment and natural environment is many, many times greater than the cost of prevention or mitigation through the transition to renewable clean energy and environmentally sustainable land management and building services.

These three sound economic and operational reasons for change are best taken together. They reinforce each other. They transform the wasteful, polluting and climate-changing linear economy to the more 'circular' one shown here. The challenge is to use the sound business reasoning they embrace to build environmental sustainability into everything we do. There are three areas of focus for making this happen. It is important that projects and improvement programmes address all three areas in a connected way.

The sustainable 'circular' supply chain – value is added, used and then retained to be added and used again (from cradle to cradle)



Adapted from: HM Government, 2018, *Our Waste, Our Resources: A Strategy for England*, p.51.

1. Upgrading physical infrastructure: improving the buildings and open space services, functionality and fabric of our campus and premises so that they use energy and water more efficiently, manage waste to maximise re-use and recycling, and facilitate more sustainable travel choices.

2. Reshaping organisational processes: reviewing the policies and procedures that directly, or indirectly, establish the parameters relating to the sustainable consumption of energy, water, goods and materials across all aspects of Trust activity (include invest-to-save financing and purchasing). Amending content in ways that optimise the role

of the Trust as a responsible consumer in the transition to a more circular economy.

3. **Changing behavioural activity:** specifying and guiding staff (and patient and visitor) behaviours to support and enact sustainable consumption and policies and procedures in the spirit in which they are intended. Encouraging local ownership and responsibility through training and management support channels.

The 2018-19 performance outcomes and achievements outlined in Section 2 reflect each of these delivery approaches to greater or lesser degrees.

Policies

One of the ways in which an organisation can embed sustainability is through the use of a Sustainable Development Management Plan (SDMP). The Trust's Board adopted the CUH SDMP in 2013 and covers the period up to 2020.

An SDMP is supported and augmented by a range of more subject-specific policies and procedures. These include an extensive Travel Plan that appropriately embraces the wider Cambridge Biomedical Campus. This has been fully reviewed, refreshed, updated and consulted-on and was formally approved by the CBC Landowners Executive in November 2018.

Other key documents include the Trust's Environmentally Sustainable Design and Construction Protocol, the Waste Management Policy and Waste Disposal Procedures, and several policies relating to aspects of energy and water management. These are all refreshed and updated on a regular basis.

Sustainability is now referenced within the Trust's tender preparation guidance. Procurement procedures are being developed to ensure that lifecycle costings are appropriately covered in relation to energy, waste, water and transportation.

The Sustainable Development Unit for the health and care system in England ran a full consultation exercise to review and update its valuable Good Corporate Citizenship guide. The Trust usefully contributed to this process and the new Sustainable Development Assessment Tool (SDAT) stands to be an important route to re-assessing corporate coverage of the sustainability agenda at CUH. A full assessment, using the SDAT, will be carried out and the results will provide vital evidence and direction in the re-drafting of the SDMP for the period 2020-2025.

Climate change brings new challenges to our business both in direct effects to the healthcare estate, and also to patient health. Examples from recent years include the effects of heat waves, and the extreme surface water flooding event of 17 July 2015. Our SDMP identifies the need for the development of a Board approved adaptation plan for future climate change risks affecting our area. Key elements of this will be the Surface Water Management Plan, currently being reviewed in collaboration with the Cambridge City Council, a site-wide Water Resource Management Study (currently being finalised) and continuing work on environmental cooling.

Partnerships and collaboration

Partnerships, networks of shared interest and less formal collaborative working arrangements are fundamental aspects of the route to sustainability for any organisation and the communities it serves. This point is very clearly made in the Trust's SDMP. Actions for a more sustainable world make little impact in isolation. Sustainability is for everyone.

Some responses are very technical whilst others are just about 'doing the right thing' as we go about our lives. Everything from upgrading the gas burners in our steam-generating boilers to simply putting what we see as rubbish into the correct bin so that it can be properly recycled. No one wants to waste resources, experience pollution, see our natural environment decline or face the dangerous impacts of climate change. The Trust recognises that the responsibility to prevent this happening is not something that one department, one team of 'green champions' or one hospital can shoulder on its own. Reaching out and searching for support that works in both directions across all our healthcare colleagues, patients and visitors, and our partners in the public, private, voluntary and community sectors is essential to an environmentally sustainable future.

In 2018/19 we have established or maintained productive or potentially productive relationships for the purposes of advancing environmental sustainability with the following external partners: Cambridge City Council, South Cambridgeshire District Council, Cambridge County Council, Greater Cambridge Partnership, Cambridgeshire and Peterborough Combined Authority, Connecting Cambridgeshire, NHS Sustainable Development Unit, East of England NHS Regional Sustainability Network, East of England Health Estates and Facilities Management Association, Cambridge Sustainable Food, Cambridge Carbon Footprint, Cambridge Cycling Campaign, University of Cambridge, Cambridge Judge Business School Circular Economy Centre, Anglia Ruskin University, University of Sussex, Medical Research Council, AstraZeneca, Royal Papworth Hospital, National Union of Students, Cambridge Cleantech and local community groups.

Performance

Sustainable Energy and Water Consumption

Energy

The two main energy sources for the Trust are natural gas for heating space and water, and electricity for powering plant, lighting and equipment (with oil available as a backup for both if required). In terms of performance and improvement there are important distinctions between the two. 45% of the energy use on site is electricity but this accounts for 85% of the total energy cost and 60% of the carbon emissions when compared to gas. The carbon intensity and, to an even greater extent, the unit cost of electricity are both significantly more than natural gas. A percentage reduction in **electricity consumption is therefore of comparatively greater material impact** in terms of cost and carbon.

The Trust, however, like the majority of organisations, is increasingly dependent on electricity and demand can be expected to grow. The greatest immediate pressures are coming from:

- requests for air-conditioning in response to warmer weather conditions and higher electrical equipment and staffing levels per square meter;
- increasing intensity in the use of the hospitals' services and facilities;

- growth in the deployment of medical imaging and other new equipment that have high electrical power requirements.

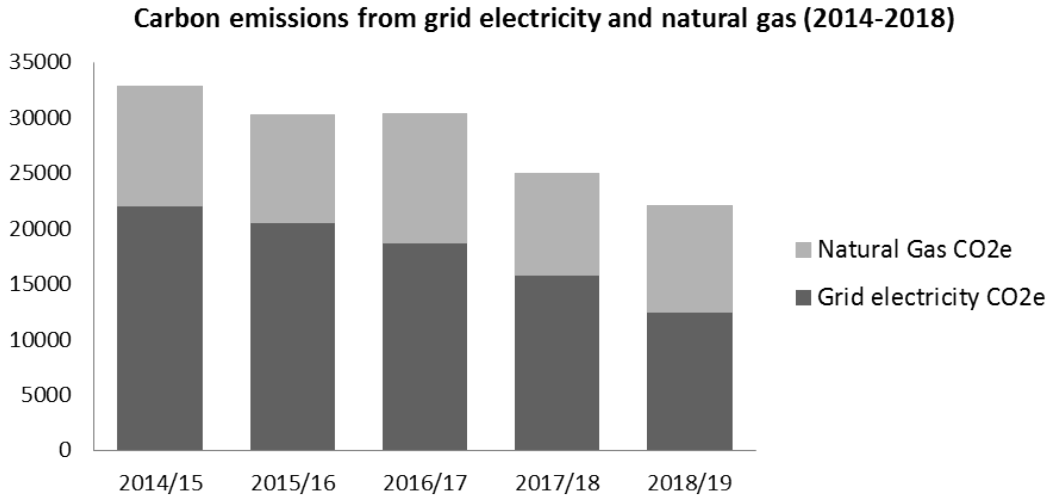
In the medium to longer term, the transition to electric vehicles and the electrical heating and cooling of properties with heat pump technologies are both expected to create step-changes in demand for electricity.

On the positive side, the **carbon intensity of nationally supplied mains grid electricity continues to fall** in response to the increasingly widespread deployment of renewable energy (especially wind and solar photovoltaic). On the negative side, the physical infrastructure required to manage these supplies and the big step-up in the use of electricity for transport, heating and cooling will **continue to increase unit costs** for several years to come.

Each day, the Trust consumes the gas and electricity equivalent of approximately 5700 average homes – the equivalent of a small town. However, considering that the Trust runs a 24/7 major acute hospital with up to 24,000 patients, staff and visitors coming to site every day, this is not such a surprising figure.

The existing infrastructure is continuously assessed against the efficiency levels at which it can deliver and the demands of future development or expansion to meet the ongoing and longer term needs of safe, kind and excellent healthcare for its patients. The main options for improvement are in new or upgraded technology and alternative forms of delivery (e.g. low-pressure hot water against steam, or direct against alternating current).

Carbon emissions from the on-site consumption of heat and power continue to fall. The overall target for the NHS is a 28% reduction by 2020 from a 2013/14 baseline. In terms of heat and power the Trust has currently achieved a 32% reduction since 2014/15 - when we were obliged to reset the Trust's baseline due to the decommissioning of the combined heat and power (CHP) gas turbine in the boiler house. The 32% reduction since then has been achieved by: a.) working hard to hold, or marginally reduce, energy consumption through infrastructure improvements as the hospitals' services and the intensity of use have grown, and; b.) through the increasing contribution of low carbon electricity generation to the national grid.

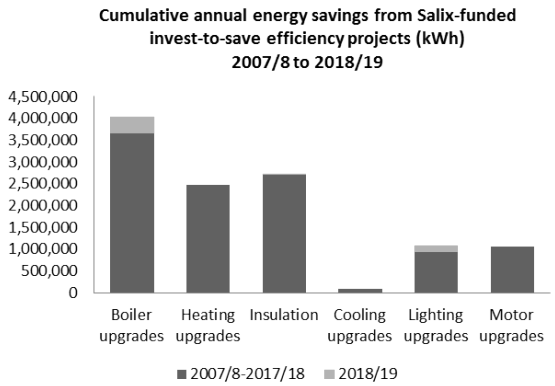


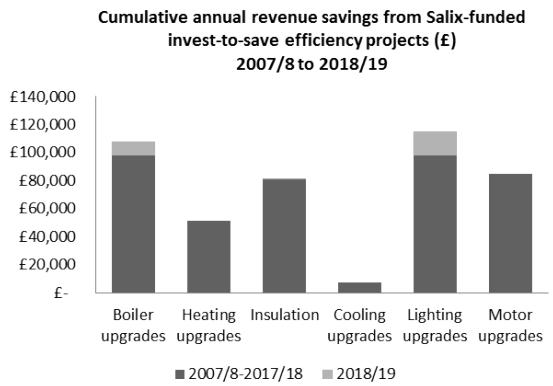
Meeting and subsequently exceeding the direct on-site control aspect of the 28% target will require a step-change in on-site generation and heat-raising through

the preparation and implementation of **strategic plans for the restructuring of centralised plant, the use of renewables and options for the upgrading of existing facilities** and associated distribution networks. Whether higher efficiency is driven by combined heat and power plant or through the deployment of heat pump technology has yet to be determined. It is anticipated that these plans will take five years to be realised. Whichever centralised technology choices are made, the ongoing work of reducing and improving the efficiency of end-user energy loads remains a priority: the cheapest and most efficient kilowatt is the one no longer required. The following paragraphs outline the projects that the Trust has delivered or brought forward in 2018/19 to achieve these efficiency improvements and associated carbon reductions.

In August 2018 the Department of Health called for applications to access a national £46m allocation from the NHS Energy Efficiency Fund for **extensive lighting upgrade projects using LED** (light emitting diode) technology. Following detailed survey work, CUH applied for and was provisionally awarded £600k with a £100k internal contribution from the Trust's own Salix-based energy efficiency fund. Delivery will be through a multi-phase programme running over 1 to 2 years, replacing 7,000 fluorescent luminaires with their equivalent high quality and high efficiency LED units. It is estimated that the completed programme will generate an annual saving of £147k and reduce carbon emissions by 305t per year.

This allocation of national funding is a major boost to the Trust's ongoing incremental lighting upgrade programme. Once completed, approximately 25% of the campus's internal lighting will have significantly benefitted from conversion to LED (almost 100% of external light fittings have already been upgraded). The Trust has and will **continue to use its well-established and ring-fenced energy saving budget** – known as its Salix Fund - to improve the energy efficiency of lighting along with a range of other energy provision and distribution equipment. This budget was set-up in 2008 as a match-funded arrangement with Salix Finance. The scheme provides interest-free Government funding to the public sector to improve energy efficiency, reduce carbon emissions and lower energy bills. It is a constantly 'revolving' source of finance in that the savings generated by CUH's approved projects are returned to the fund until the original cost is paid back. After this time the savings are permanently accrued to the Trust's budgets. The energy and carbon savings are attributable as soon as the physical project is complete.





The 2018/19 Salix-fund energy-saving projects included completion of the improvement works to the central boiler plant with the burner upgrade and scheduling connection for Boiler No.6. The impact in terms of reduced gas consumption of these works has been significant with a combined (Stages 1 and

2) revenue saving of over £50,000 achieved over the year. The balance of this year's projects have focused upon ongoing LED lighting delivery and setting the groundwork for reducing or off-setting the energy demand and costs of environmental cooling and seasonal over-heating.

2018/19 Salix-funded invest to save projects

Project	Energy savings /yr. (kWh)	Cost savings /yr. (£)	Carbon savings /yr. (tCO_2)
Clinic 3 LED lighting	4,638	557	1.78
PALs Offices LED lighting	3,905	469	1.50
Boiler House LED lighting	49,301	5,916	18.95
Street Lighting LED upgrade	12,084	1,450	4.65
Car Park 3 LED lighting	73,574	8,829	28.28
Hydrotherapy Pool Cover	7,689	192	1.42
Burner Replacement Project Stage 2	387,783	9,695	71.41

Whilst reducing costs and carbon emissions from relatively consistent all year-round electricity loads, such as that from lighting, is clearly essential in the move to more sustainable supplies it is important not to neglect those of a more seasonal nature. **Summer 2018 brought the hottest summer on record for England. This put significant pressure on the hospitals' ventilation and cooling** systems and created an extended spike in electricity consumption. The existing critical cooling plant coped relatively well, having been subject to focused review and remedial works over the last two years. However, many areas outside of those in which cooling is a clinical necessity, struggled with older ventilation systems not designed to manage such high temperatures and also by the health and safety necessities of both window opening restrictions and the implications of infection control. As climate change increases the likelihood and intensity of summertime heatwaves, the importance of bringing forward low energy solutions was recognised. Air-conditioning is not only costly to purchase and run (with a corresponding increase in carbon emissions) but is also disruptive to install and in many cases not a viable option due to space constraints for the units and pipe-runs – especially in older buildings not designed to accommodate such services.

The alternatives to air-conditioning are measures that reduce localised over-heating in the first place. To this end, the Trust has looked in detail at **options to reduce the build-up of heat through shading, glazing and local ventilation.** Working with local consultants, modelling work has been carried out to calculate the benefits of these options. The two technologies determined to have the most material benefit, in terms of comfort improvements and low energy consumption, were the deployment of external window blinds (the markisolette type was selected with support from the British Blind and Shutter Association) and small two-way window or wall-mounted fans (with timer controls to facilitate overnight 'free' cooling). These are now being developed for trial on-site for Summer 2019. Another option in a similar vein is the deployment of solar rejection film to glazing with a southerly aspect. The reflective silver-grey coloured variety is already in use on many windows across the Trust. Its effectiveness is variable however, with some panes becoming very warm and radiating unwanted warmth into the room whilst also limiting the benefits of natural light. An alternative product is designed to overcome these limitations and is being trialled in the Lady Mary Ward of The Rosie. Alongside these building services developments, the importance of local area organisational and behavioural adaptation during periods of hot weather is also being emphasised.

All these low-energy, lower-cost and lower-carbon short-term measures have been included within the Trust's **new Cooling Strategy** for its premises. This

strategic position brings forward the importance of the medium- and longer-term issues of optimising cooling infrastructure (especially centralised chilled-water provision) in as energy-efficient manner as possible.

Directly related to this drive for energy-efficient lower carbon options to reduce summertime over-heating, is a technically innovative **proof-of-concept renewable energy and storage project** that is now underway. This should see one of the large Rosie Perinatal roof-mounted chiller units running from a cost- and carbon-optimised choice of integrated photo-voltaic panels, battery packs and main grid supplies. This leading-edge cleantech renewable energy, battery storage and power electronics design has formidable and far-reaching potential in terms of scalability and 'behind-the-meter' local energy sustainability.

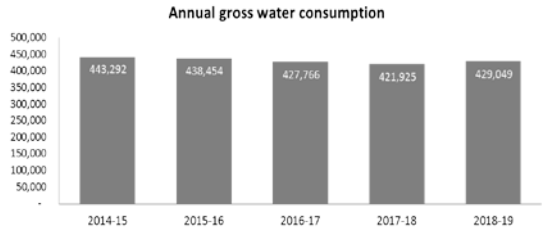
Within the main campus boiler-house the final phase of the **central boiler plant burner upgrade** has now been completed. Boiler No. 6 has just now joined boilers No. 4 and 5 in running on high efficiency burners and through close-coupled automatic scheduling to deliver optimal performance. This comprehensive upgrade has delivered in excess of £50,000 in gas costs alone this year. Additional savings have been achieved through the ongoing programme of efficiency improvements to the running of the twin incinerator plant.
As well as improving the efficiency of specific items of plant and equipment (such as boilers, plant and lighting), how these items are controlled in terms of their running set-points for output and timing is also very important. The Trust runs an extensive **Building Management System** (BMS) to automate this process for plantroom and relatively high-output decentralised calorifiers, heat exchangers, cooling and air-handling equipment. The ongoing development of this Schneider Continuum-based system is an ongoing priority to establish and sustain energy savings. The ongoing programme of performance assessment and development projects run through the Trust's Maintenance Team have continued to deliver valuable savings. A commitment to the further expansion of this programme was secured in the middle of the year through securing extended contract support for this important, yet often unnoticed, work.

Monitoring and managing the energy and water consumption data for the main campus and satellite sites is an essential part of understanding this utility use. Access to both current and historic recorded data and, where viable, profiled half-hourly data is an essential aspect of effective energy management – highlighting losses, over-consumption and improvements. Without this information it is difficult to develop, prioritise and subsequently validate projects to improve efficiency, cut costs and reduce carbon emissions. Following a comprehensive review and full tender exercise, the Trust has now installed a **new contracted utility management software** database from SystemsLink. This newly commissioned system brings cost savings and should provide a more integrated and accessible service to meet the Trust's needs for performance management, invoice validation and partner re-charging. It has also been carefully specified to ensure that it readily has the capacity to dovetail with the rolling **transitional programme to automated meter reading** (AMR). AMR provides the all-important half-hourly profiled data (as opposed to manual monthly reads) that is the foundation of effective performance management.

The collection and management of this data is also important from a compliance reporting perspective. The Trust continues to update its extensive collection of Display Energy Certificates whilst maintaining its responsibilities under a range of statutory tools such as the Minimum Energy Efficiency Standard for rented

properties, Boiler Operation Guidance, Medium Combustion Plant Directive, F-gas Regulations and EU Emissions Trading System. The latter is designed to cap carbon emissions from on-site comb

ustion and the Trust is currently in the process of verifying its baseline emissions in advance of the more pressing demands that will come with Phase IV in 2020.



Water

2018/19 has seen water consumption across the site remain stable at approximately 35,000 m^3 per month. For operational and safety reasons, much of the water is treated, with tank storage and a carefully managed pipe flushing regime. The water has many purposes: from washing, flushing and cleaning to drinking and food preparation, to research and testing, to running boilers and providing hydro-therapy and swimming facilities. Due to hospital regulatory issues, methods of reducing water consumption on campus can be constrained: especially in relation to the very necessary priority of infection control.

The quality of billing has improved significantly through the services of our new 'retailer', Pennon Water Services. This contract has provided us with a site-wide water efficiency survey. The survey findings were very positive, supporting the ongoing benefits of the pressurisation control units installed in 2011 and the report did not identify any leakage losses in supplies across the main campus.

Sustainable Procurement and Waste Management

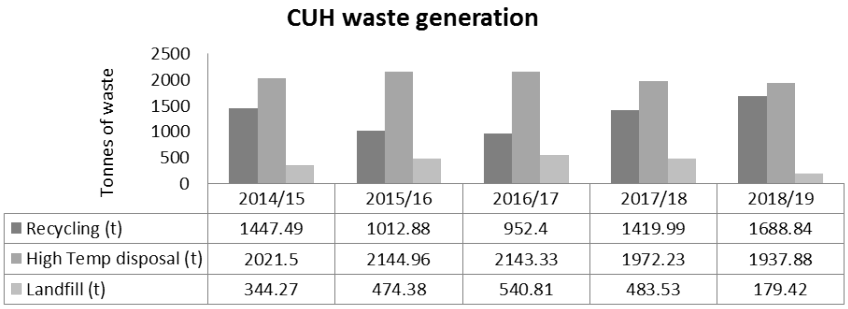
For the Trust to achieve a more circular local flow of goods and materials, that saves it both money and resources (whilst also contributing to the wider sustainability of its supply chains), it is **essential that procurement works hand-in-hand with waste management**. Almost all of the products we buy, we also subsequently throw away. Linear supply chains mean that we are, in effect, buying our own waste. We continue to make progress in identifying the more circular relationships between purchasing and waste management through the combined endeavours of our Environmental Services, Procurement and Sustainability teams. Good working links to identify 'circularity' benefits have continued to develop through the Clinical Consumables Evaluation Group, assessment of tender specifications and Pre-Acceptance Waste Audits;

and, more opportunistically through periodic staff communications relating to waste segregation, collection and disposal queries (including links with the team-based Think Green Impact behaviour change programme).

The commercial relationships between supply chains and recycling or re-use infrastructure, however, remain frustrating and typically beyond the Trust's direct control or effective sphere of influence. A strong supportive step, however, was taken this year with the **transfer of CUH's domestic waste collection streams to our new provider**, Ellgia (with local sorting and transfer stations in East Cambridgeshire). With major global changes in the acceptable quality and destinations of segregated recycled waste it is increasingly important to have a strong and creative two-way relationship with our waste contract partners.

We have made some further material steps to **reduce the deployment of plastic single-use items** through working with our on-site retail partner, Compass, to remove polystyrene food containers and plastic cutlery from the supply chain. A detailed review of single-use of cups has however proved more challenging and we have yet to find a practically viable and genuinely recyclable alternative for disposable hot beverage cups – the focus remains on promoting the take-up of re-usable cups as the long-term optimal solution.

Performance across the Trust's three main collated waste streams continues to improve. The balance between the necessary on-site incineration of clinical waste and the recycling and landfill of domestic waste continues to shift away from landfill. It should be noted, though, that some of the recent step-changes are a result of the transition from landfill to the energy-from-waste incineration of deemed non-recyclable domestic content.



	2014/15	2015/16	2016/17	2017/18	2018/19
Recycling (t)	1447.49	1012.88	952.4	1419.99	1688.84
High Temp disposal (t)	2021.5	2144.96	2143.33	1972.23	1937.88
Landfill (t)	344.27	474.38	540.81	483.53	179.42

This year, the Trust has sustained an exceptional **8 re-use and 18 recycling streams alongside repairs**, where possible, to medical devices through Clinical Engineering and site infrastructure through the Estates and Facilities Maintenance teams. The on-line intranet Swap Shop continues to find homes for unwanted items, although and we have positively reviewed the wider re-use Warp It network and will look to establish this in the coming year.

As an acute hospital campus, however, there are waste types for which value retention is not an option. CUH produces significant quantities of healthcare waste which is often hazardous or contaminated. This means it is bound by tight regulations as to how it can be disposed of: re-use and recycling are not available disposal routes for these types of waste. The Trust **incinerates all clinical and offensive waste on site** in what is, essentially, total destruction - with the exception of the recovery of heat from the burning process that is then used to warm the premises.

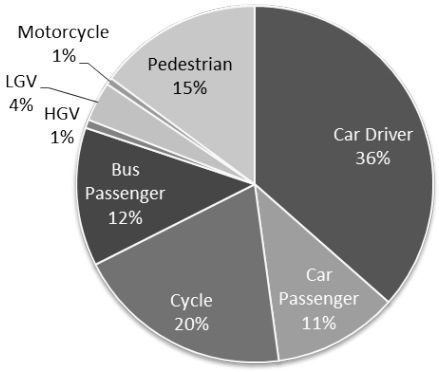
As with energy and water, however, we depend upon staff, patients and visitors to use the sustainability infrastructure that the Trust puts in place as effectively and responsibly as possible. For waste management this essentially means users putting items in the correct bin when they have finished with them. The potential for bagged waste to hide mistakes and errors in this sorting (or segregation) at source are both perennial and significant in terms of safety and sustainability.

The Environmental Services and Sustainability Teams continue to **actively promote safe, sound and sustainable segregation** with plans in train to rebrand the current communications media set and introduce an essential on-line training module for all staff.
A key focus for communication has been, and will continue to be, upon the continuing roll-out of dry-mixed recycling (DMR) bins. The demand for these lidded green bins, has remained strong all year. 2018/19 has seen the **DMR rate sustained** and we hope to see an increase with partnership support from Ellgia.

Sustainable Travel
The Trust has a long track record of successfully enabling more sustainable modes of travel for work. Since 1993 the percentage of staff travelling to work by car has halved. This has been an outstanding and very necessary achievement as the total number of staff coming to work at CUH each day has grown from around 4,000 journeys to over 10,000 for the same period.

This **commitment to actively providing sustainable travel infrastructure** has been especially important throughout 2018/19. This year has seen the final preparations for the opening of the Trust's new neighbours and site partners in the form of the new Royal Papworth Hospital, the new Abcam building and two major University of Cambridge premises on the Cambridge Biomedical Campus (CBC). Occupations will begin from April 2019 onwards.

Inbound access to Cambridge Biomedical Campus by mode 2018 (%)



Total number of people visiting CBC on 11/10/18: staff, patients, visitors and contractors for all CBC organisations.

Managing the transport impacts of these important new wider campus developments has been a challenge shared between the Trust, other CBC existing occupants, the newly arriving occupants, the relevant local authorities with a combined lead through the Greater Cambridge Partnership (GCP) and commercial partners from public transport to cycle-share companies. GCP have prioritised the role of the Biomedical Campus in transport planning improvements for the wider area, including the delivery a full needs-based survey.

Without the determination to deliver a major step-change in commuting modes, the number of cars coming to site would have created extreme congestion on the campus and its local feeder roads during peak times as well as creating issues of air pollution and excessive carbon emissions.

The Trust implemented and successfully concluded a **major reapplication and restructuring process for all existing staff eligible to park on-site**. This has now seen a further 1000 members of staff potentially making the peak-period transition to the more sustainable commuting options of park-and-ride (P&R), cycling, public transport and car-sharing. Each modal shift has been supported through a range of measures delivered either directly by the Trust or by effective shared-working with a range of campus, local authority and commercial partners. The measures include:

- the removal of the £1 **P&R parking charge** and increased **P&R bus service** levels;
- increases in CUH **cycle parking** provision, freeing up space by removing abandoned bicycles, improved site **access**, additional internal **locker** availability, **showers** refurbishment, supplementing the on-site **cycle-repair service** with self-service facilities, and replacement of the previous **cycle-share** provider with a replacement in the form of Mobike;
- introduction of **new bus-routes** and services with staff **ticketing discounts**;
- Organisational subscription to the **car-sharing** on-line application –Liftshare.

Travel on Trust business is another important area where there is real potential to take direct steps to reduce carbon emissions, improve air quality and cut costs. CUH presently operates a fleet of 12 lease cars with manual bookings though the central Access Office. Miles travelled in these types of vehicles can be controlled in terms of fuel economy and emissions in a way that staff-owned 'greyfleet' vehicles cannot. In most circumstances it also marginally lower cost per mile to deploy frequent and regularly used lease cars over the greyfleet option. During the second half of the year, a full re-tender exercise was carried out for this lease car service with a specification focused on the benefits of a self-booking on-line car club-type service with 12 low emission non-diesel vehicles (averaging below 100gm/km across the fleet). The tender process is now complete, and the new service is anticipated to be available from Summer 2019. Once up and running there are significant development opportunities relating to a business travel policy that actively prioritises the business car club fleet and the potential availability of all-electric vehicles.

Sustainable Behaviour Change

CUH's continuing upgrade to the physical infrastructure and delivery systems of energy and water efficiency, waste segregation, travel choices and life-cycle-assessed procurement throughout 2018/19 are all essential aspects of the transition to a secure and more sustainable future. This, however, is only one half of the picture. The essential next step to infrastructure upgrade and process change is to ensure they are used effectively by real people in real situations: our staff, patients and visitors across a large, complex and intense hospital campus.

Think green
Take action for a sustainable future
Cambridge University Hospitals

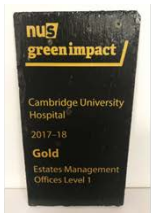
Few people want to see resources wasted or to cause avoidable damage to our natural environment. The pressures of a busy hospital often mean, however, that the impacts of our day-to-day actions on these issues can easily be overlooked. Requests to power-down, recycle more or catch the bus will struggle to make a real difference on the ground unless they are tailored to individual teams and workspaces. When working in a hospital with over 60 buildings, and over 7,500 occupied rooms, corporate messaging can often only

raise awareness of an issue. As outlined in preceding sections, a conventional rolling communications campaign (via CUH Daily, 08:27 meetings and Connect 2) has been used to raise the profile of important sustainability matters.

Focused engagement for more lasting change, however, will be found at the local workspace or departmental level – working with section managers and their delivery teams. Here the daily run of work processes is completely understood. This means that the options for more sustainable energy, waste, water, transport and purchasing can be tailored to fit with real-world routines and thereby become a natural part of day-to-day life. At this level of direct delivery, the door to new and innovative approaches to sustainable working is also far more likely to open.

The Trust's Think Green Impact (TGI) programme has proved that small teams are keen to ensure that their work areas and colleagues are really staying on top of energy and water consumption whilst minimising waste and promoting more sustainable travel and purchasing. All that is required is some support, and advice if necessary, with some recognition of achievement along the way. TGI provides exactly this through creating individual team action logs with at least three levels of ambition (Bronze, Silver or Gold tabs) together with detailed guidance, support sessions, newsletters, audits and awards over a six-to-eight month period each year. 2018/19 saw two more team achieve the top Gold Award with a further two team securing silver and three bronze. The TGI Action Logs allow teams to record what has worked for them and what has been more of a struggle. This has been used to inform a full review of each of the required actions under each of the different tabs.





The engagement of staff with the benefits of environmentally sustainable behaviour has also continued to be delivered in other guises throughout 2018/19:

- through specific contributions in Corporate Induction sessions, New Managers' Orientation Days, the Estates and Facilities Values Academy and, on invitation to departmental 'away days';
- from the work of our Grounds Team and external sponsorship teams in looking after and enhancing our valuable green spaces to bringing together projects to improve the quality of the outdoor environment – everything from hanging baskets to the new J2 Ward garden and the 'Calm in Chaos' garden from the Royal Horticultural Society's designer of the year;
- from Capital Projects and Minor Works directing contractors towards more sustainable solutions, to Hotel Services and Environmental Services engaging with suppliers and service providers to cut and redirect waste for more sustainable outcomes, to, our Quality Assessment Officers engaging with contract cleaning teams on waste segregation;
- from Pharmacy and Clinical Engineering engaging with patients and staff on re-use, to, Addenbrooke's Abroad channelling redundant equipment into health centres in need in other parts of the world;
- from the Estates Maintenance Team making people aware that they can repair a whole range of 'consumable' equipment - from waste bins to

water heaters, to, the Environmental Services Porters carefully collecting segregated waste, to, our overnight Porters, Facilities Managers and Security Teams checking that lights are not left on unnecessarily.

All of these direct and indirect engagement actions show that the Trust is well positioned to establish a wider leadership role in promoting behaviours founded on environmentally sustainable values and all the benefits that they bring.

Being prepared for the impacts of climate change

The cumulative concentration of excessive greenhouse gasses in the atmosphere from human activity has already committed us to experience a significant degree of climate change. In Cambridge the most immediate of these is likely to be felt through building overheating from summer heat-waves. In 2013 a hot spell in England was estimated to have caused 650 premature deaths. The 2003 heat-wave led to over 2,000 premature deaths in England and Wales. Although the national impacts of the record 2018 summer heatwave are yet to be fully ascertained, all staff, patients and visitors on site during that period will remember the discomfort and potential vulnerability. Surface water flooding from more frequent and intense storm events is also an anticipated outcome of climate change. This became a reality on 17th July 2015 when a 1-in-190 year heavy rainfall and flooding event caused the Trust to declare a 'major incident'.

A comprehensive review of the site's existing cooling capacity is underway and will lead to further important and ongoing energy strategy and business case development work. In response to the potential impact of surface water flooding a detailed Surface Water Management Plan (SWMP) for CUH has been drafted and is being reviewed in relation to the identification of potential mitigation measures and associated business cases.

Looking forward

2019 would appear to be something of a watershed moment for climate change and the wider environmental sustainability agenda. The impacts of human influences on the concentration of greenhouse gasses, environmental pollution and the depletion of natural resources are becoming more than a concern for the future – they are increasingly a reality for today. The appreciation of climate related 'tipping points' (as thresholds beyond which the triggering of permanently dangerous environmental change would be irreversible) are also better understood as in need of urgent precautionary action. This recognition is rapidly permeating into the mainstream and there is a growing expectation that governmental and public sector organisations have a major leadership role to play.

This is therefore a very appropriate time for the Trust to be redrafting its Sustainable Development Management Plan: incorporating this widening public concern within the framework established by the United Nations Sustainable Development Goals in 2015, the 2016 Paris Agreement on Climate change, the release of the NHS Sustainable Development Assessment Tool in 2017, the endorsement of the EU's Circular Economy Package in early 2018, and the Resources and Waste Strategy for England published by DEFRA at the end of 2018.

To date, most of the Trust's material achievement and progress has related to the incremental efficiency upgrade of building and site services – reducing utility

consumption, streaming waste for recycling and providing support for sustainable transport options: cutting CUH costs and carbon emissions whilst conserving resources and extending travel choice. Much of this work goes on largely unseen and unnoticed – often existing only in the peripheral vision of most of our staff as they go about their work providing 24/7 safe, kind and excellent healthcare.

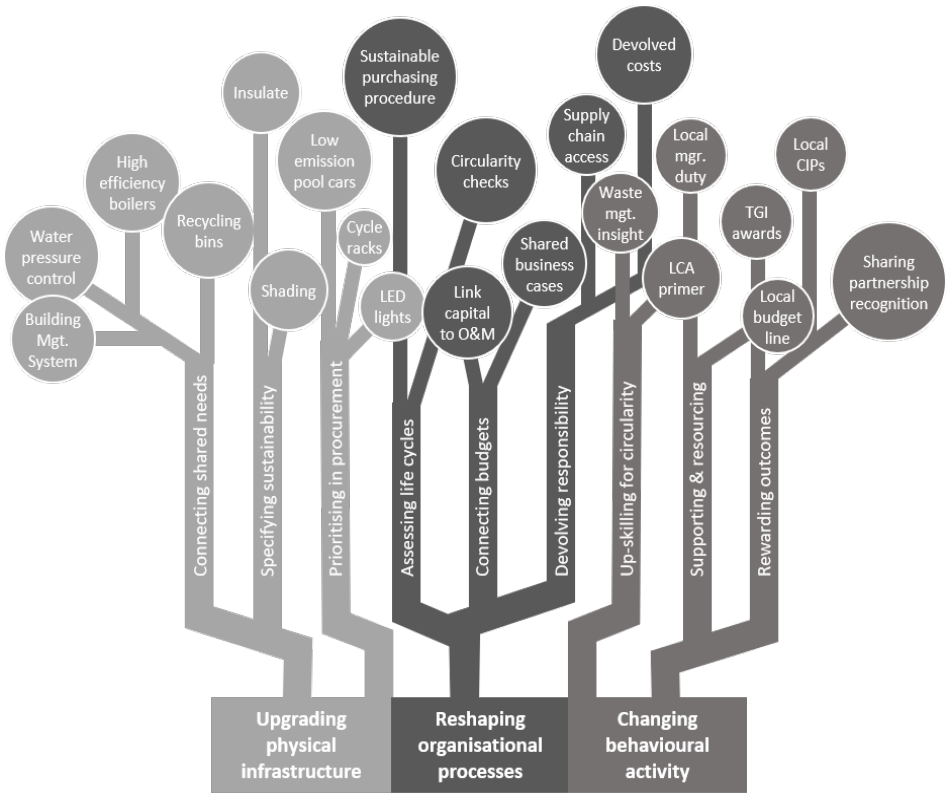
In 2019-20 the Trust will continue to take forward the approach and lines of delivery described in this report. Alongside this, a significant and carefully planned engagement process will be undertaken in the drafting of the Trust's new SDMP 2020-25. This will focus on ensuring that all of the following three drivers of change are given sufficient attention to rapidly grow and integrate with each other:

1. upgrading physical infrastructure: to include connecting shared needs, specifying sustainability, and prioritising in procurement.
2. reshaping organisational processes: to include assessing life cycles, connecting budgets, and devolving responsibility.
3. changing behavioural activity: to include up-skilling for circularity, supporting and resourcing, and rewarding outcomes.

As illustrated in the schematic below, when taken together, these three principles provide the root-stock for changes in practice that will ensure the Trust is able to take on a greater leadership role as a responsible consumer within a more circular economy. Adopting this wider leadership role in the urgent transition to a more circular economy will require deeper engagement across CUH's organisational processes and behavioural activity.

New and extended skill-sets will be required that make life cycle assessment responsibilities a natural part of decision-making and front-line delivery at all levels of the organisation.

The three principles for growing environmentally sustainable practice within CUH as a responsible consumer and a thriving and caring



Roland Sinker
Chief Executive
23 May 2019

3.30 Other issues

The activities and policies of the CUH in the areas of social, environmental, community and human rights are outlined earlier in this chapter and specifically the equality and diversity report and sustainability and climate change report.

4. The quality report

4.1 Part 1 - Introduction

4.1.1 Statement from the chief executive

This Quality Report describes how we are continuing to improve the quality of care that we provide to our patients at Cambridge University Hospitals NHS Foundation Trust.

During 2018/19 we have made further progress in delivering consistently safe and high quality care in line with the priorities set out in our new Quality Plan which was approved by the Board of Directors in September 2018.

Our progress in 2018/19 should be seen in the context of the challenging environment in which the NHS is operating, including continued rapid growth in demand for services.

Key quality achievements during 2018/19 have been:

- The Care Quality Commission's latest inspection of our services published in February 2019 rated the Trust as 'Good' overall and as 'Outstanding' for being both Caring and Well-Led. End of Life Care became the first of our services to receive an overall rating of 'Outstanding'.
- The Trust continues to achieve one of the best mortality rates within the NHS – currently the 4th best performing trust in the country and the best performing trust among teaching hospitals outside London.
- A new improvement and transformation directorate was established to lead and support a programme of continuous quality improvement across our hospitals.
- Further improvements in our 2018 NHS staff survey results, with staff engagement and staff recommending our hospitals for treatment both above the national average.

The report describes in detail performance during 2018/19 against the ten quality priorities identified at the start of the year. Five of the priorities were achieved. For the other five, while progress was made, we did not achieve our targets.

We will continue to focus on these areas in the year ahead, learning from where we fell short, alongside our 2019/20 priorities as set out in the report. This includes further improving our safety culture and systems and how we learn from harm, and striving to remove unexpected variations in practice and outcomes through an ongoing focus on getting the fundamentals of care right for all our patients and across all our services.

Our quality achievements are testament to the professionalism and commitment of our 10,000 members of staff who are dedicated to providing safe, kind and excellent care to our patients and their families across Addenbrooke's, The Rosie and the wide range of other locations from which we provide services.

I would also like to take this opportunity to thank our patients and partner organisations for their continued support and encouragement in working with us to improve the quality of our services.

In particular, we will continue to work actively in the year ahead with our partners in the Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP) to plan and run services across the local region in a more coordinated way, to agree system-wide priorities, and to work collectively improve the health and well-being of the local population.

Finally, I confirm that to the best of my knowledge the information in this document is accurate.

Roland Sinker
Chief Executive

4.1.2 2018/19 activity

During 2018/19 we have been treating more patients than ever before the following table sets out key activity numbers.

Patients treated: comparison of April - March 2017/18 and 2018/19

	2017/18 April - March	**2018/19 April - March**	**Change (%)**
A&E attendances*	117,074	121,871	4.10%
Visits to outpatients	757,112	818,893	8.16%
Births	5,389	5,330	-1.09%
Day cases	122,021	126,305	3.51%
Total inpatients	**69,069**	**70,665**	**2.31%**
– elective	15,288	15,693	2.65%
– emergency > 85 years old	6,716	6,787	1.06%
– emergency < 85 years old	40,169	41,522	3.37%
– maternity	6,896	6,663	-3.38%
Total	**1,070,665**	**1,143,064**	**6.76%**

*ED (A&E) – Not including Minor Injuries Unit (MIU) attendances

Total Admissions (In patients / Day cases / Births)	**179,881**	**185,136**	2.92%

The Trust has continued to see growth in demand throughout 2018/19 however the drivers of growth have been in different areas of patient care compared to last year.

We saw a slowing of the growth in Emergency care both for A&E attendances and emergency inpatients in the first 9 months of the year, such that activity was below planned levels. This enabled us to mitigate some of the expected shortfalls for bed capacity, and has allowed a higher volume of planned elective inpatient work to be undertaken. Day case activity has also increased this year and has exceeded planned levels, reflecting our focus on treating patients in the most appropriate setting.

Maternity care has delivered a sustained volume of births compared to the reduction seen last year. There has been a small reduction in the requirement for ante-natal maternity admissions.

The largest growth this year has been in outpatient attendances and this in part has been driven by a referral rate 6% higher than last year.

The level of growth for hospital care poses a continuing financial challenge for CUH and the wider health economy.

4.1.3 Data and terms used in this report

Unless stated otherwise, the data presented in this report is the latest available at 31 March 2019.

For an explanation of terms and abbreviations please see the glossary set out in Appendix E.

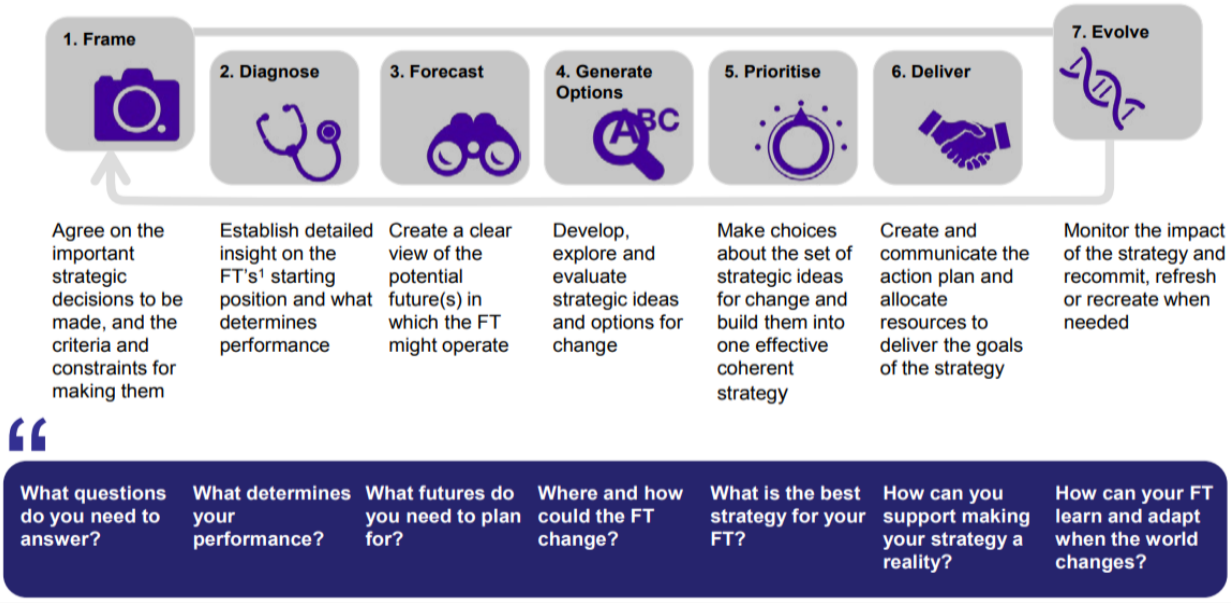
4.2 Part 2 - Priorities for improvement and statements of assurance from the board

Please note: Reviewing performance against 2018/19 priorities for improvement are given in detail in **Part 3** of this document.

4.2.1 CUH Vision, Strategy and Values

The Trust's vision is to improve people's quality of life through innovative and sustainable healthcare, underpinned by our values of Together – Safe, Kind and Excellent. We will seek to achieve this as a Trust, as a wider health and care system, as a biomedical campus and through our role regionally, nationally and internationally.

Our strategy is reviewed on an annual basis, using the seven-stage framework of strategy development developed by NHSI.



Source: NHS Improvement Strategy Toolkit

Our strategy sets out four priorities:

- **Improving patient journeys** – ensuring that patients see the right person as soon as possible, with no long waits for treatment, and able to leave hospital at the right time.

  The way innovation and improvement has been achieved successfully in healthcare, is to follow the patient journey. In doing this at CUH, we are identifying opportunities to re-design how care is delivered to improve patients' experiences, improve health outcomes and minimise waiting. Through this we will strengthen services by improving productivity.

- **Working with our communities** – working and collaborating with partners to keep people well and at home for longer.

  The NHS Long Term Plan promotes a new model for integrated primary and community services which will enhance out-of-hospital care and enable people to receive care closer to home. In moving towards these new

models of care, as well as leading and working with partners across our Sustainability and Transformation Partnership (STP) for Cambridgeshire and Peterborough, our aim is to prevent more episodes of illness, reduce length of stay in hospital, and reduce duplication of interventions and tests. This key priority for CUH will not only improve the quality of care for patients and communities, but support better population outcomes and deliver better value.

- **Strengthening the organisation** – having the right staff in the right places to look after patients, with facilities that are fit for purpose.

  We will continue to focus on improving the leadership, governance and capability of CUH, incorporating cultural change and organisational development work. Making progress against our strategic priorities has been dependent on effective leadership and accountability for decisions. We will continue to build on this over 2019/20. We will continue to create a culture in which there is healthy and open communication around performance and best practice, supported by appropriate intelligence and robust data.

- **Contributing nationally and internationally** – continuing to develop research, education and innovation in healthcare that will lead to treatments of the future.

  CUH is a leading teaching hospital, with particular expertise in a number of specialties. It is co-located on the bio-medical campus alongside Cambridge University and other leading research institutes including the Medical Research Council and Cancer Research UK, as well as the wider biomedical cluster across Cambridgeshire. These partnerships present us with significant opportunities for the redevelopment of core NHS clinical facilities as well as maximising the potential for research and innovation to lead to new ways of preventing and treating disease, such as with the development of the East of England Children's Hospital and Cancer Research Hospital. Success will mean outstanding services and world-class research, where clinicians feel supported to develop innovative ways to improve clinical practice, with CUH making the most of opportunities in highly specialised services, teaching and bioscience research.

During 2018, we updated the cross-cutting core strategic programmes that sit under the four priorities. Progress reports on each of these core strategic programmes are now presented to the public Board every four months, alongside a composite dashboard of key metrics. Taken together, these allow us to monitor progress against delivery of our strategy.

In line with stage seven of NHSI's strategy development framework, we are currently in the process of reviewing our strategy as our vision and the wider health and care context evolves. This review takes account of the progress we have made to date and the current challenges and opportunities we face. An initial strategy seminar was held with the Board in February 2019, and a further session will be held in March to determine the strategic choices we will make in 2019/20 and beyond. The output of this will be discussed with our staff and inform our strategy and vision for 2019/20.

What is our approach to quality and improvement?

As part of our organisational values, we will put quality first. We will always be patient focussed and responsive, so that our values are lived by each and every staff member. Our values are embodied in our 'Improving Together' approach:

Together-Safe | Kind | Excellent

Underpinning this are expectations (ways of working) of everyone who works here, to ensure that our values are realised whilst working with one common goal - improving outcomes for our patients and ensuring that we all deliver safe, effective and responsive care.

Improving Together

The Trust has prioritised improvement, under the banner 'Improving Together', as key to supporting the delivery of its strategy and future sustainability. Central to this is working towards a culture of sustainable continuous improvement, where frontline staff deliver improvement as part of their day-to-day working and improvement becomes "what we do".

Improving Together is our overarching approach to improvement within the Trust. We have recognised that we need to give our staff the permission to choose to improve. We aim to create a sustainable culture within the Trust that, with time, will reach out to all 10,000 staff, where they are engaged to improve services and embed change, thereby building the Trust's capability for improvement.

An improvement and transformation directorate was newly established in 2018. An executive director and clinical director were appointed and the CUH Together, nursing lead, transformation and PMO teams brought together. The team's roles and supporting structure are developing and will be refined further.

The improvement and transformation team will continue to support the wider Trust, embedding improvement champions within all areas of the organisation, supporting and encouraging other staff. Clinical and non-clinical staff who have already led improvements will support others to improve, thereby building and growing our improvement capability and capacity.

Improving Together will frame our journey of sustainable continuous improvement and hence there will never be an end point. Common improvement methodologies will be utilised, which are easily understood by staff and used to support change.

Education and training on improvement skills will be provided widely throughout the Trust to build internal capability; we will adopt a coaching approach that supports and encourages staff to improve.

We will regularly measure staff awareness of Improving Together to ensure that we are embedding a process of continuous improvement and that it is far reaching and understood by all. An analysis, monitoring and evaluation approach will be established to ensure sustainable benefits are realised.

We will actively celebrate improvements within and external to the Trust, holding regular celebration events. We will be open and honest when things have not gone well and use these to further improve the experience and outcomes of our patients.

Engaging with patients to help them be involved in the design and production of improvements must become the norm across all areas of the Trust, rather than a traditional top-down approach to change and quality.

We will actively capture lessons learnt and ensure that widespread dissemination of learning is in place.

We will maximise the use of digital enablers, utilising real-time data in our wards and clinical areas, in order to drive improvement and respond effectively to potential patient safety issues.

We will factor improvements into our appraisal process with all staff, providing opportunities for staff to deliver on improvement projects as part of their personal development plans (PDPs). We will encourage all clinical and non-clinical staff to be involved in and lead improvements, so that we have a co-ordinated approach to improvement that supports the delivery of our strategy.

Our Approach to Improvement

In order to successfully support the sustainability of CUH, the following aspects will be developed further to support the longer-term aspiration of the Trust in working towards a culture of sustainable continuous improvement.

We will procure and work with an experienced improvement partner who has a proven track record of implementing a sustainable improvement culture in peer organisations. In the meantime, the Trust will continue other approaches to increase improvement capacity and capability for all staff, for example in-house training; a leadership development programme delivered by the King's Fund and the Judge Business School at Cambridge; and, in order to do things differently and at pace, the Trust will continue to use the accelerated design event (ADE) methodology which was adopted after working with Professor Helen Bevan and the NHS Horizons team.

We will continue to communicate the ethos of Improving Together to engage and empower staff at all levels to deliver sustainable clinically-led, continuous improvement.

We will move to a "distributed leadership" approach, where we connect and engage with a wider cohort of frontline staff who understand the Trust's priorities and support delivery, at pace, of improvements in the areas which impact our agreed strategic priorities. Wider involvement will have a significantly greater impact on our pace and delivery.

We will work with our patients and partners to co-produce improvement, so that this approach becomes our norm.

We will build on our governance currently in place to ensure that we have oversight and accountability for our improvement programme.

4.2.2 Improving patient care and supporting our staff

Seven day hospital services

The Trust is required to be compliant against four priority clinical standards for seven day services. These standards require that for patients admitted as an emergency to the Trust:

- A review by a consultant takes place within 14 hours of admission (Standard 2)
- Diagnostic tests are available 24/7 (Standard 5)
- Consultants are available 24/7 to direct patient care (Standard 6)
- Patients receive daily reviews by a consultant following their admission (Standard 8)

In its last audit in April 2018 the Trust assessed itself as being compliant (>90%) against standards 5 and 6, but non-compliant against standards 2 and 8. The lower compliance rate for standards 2 (67%) and 8 (74%) was due primarily to issues with documentation – where consultants may have seen patients but not named themselves on clinical notes – and where doctors below the level of consultant had reviewed patients.

Results of this audit were triangulated against the Trust's mortality rates which did not identify any patient safety concerns.

Work to improve compliance against the standards is being led by the Trust's Medical Director with the support of the Clinical Audit team. A new assurance framework is in place from February which requires the Trust's Board to monitor progress and approve twice-annual updates to NHSE/I, and this will support implementation. Any clinical safety issues identified through this work will be raised to the Mortality Surveillance Committee for further investigation

Speaking up

The Government in its response to the Gosport Independent Panel Report, committed legislation requiring all NHS trusts and NHS Foundation trusts in England to report annually on staff who speak up (including whistle-blowers). Ahead of this legislation, the Trust appointed a Freedom to Speak Up Guardian (FTSUG) in December 2016. The Director of Corporate Affairs is the Executive lead for raising concerns/whistle-blowing and there is Non-Executive Director linked to this area. The Board of Directors receives a six monthly report on progress and any key issues.

The key objective of the speaking up service for employees, workers and students is to provide support and independent guidance where normal channels are not working. The focus of the past two years has been to create the building blocks for the Trust's speaking up service by engaging with a wide range of staff across the organisation, for example through divisional/departmental/team meetings, staff governors, staff-side, study days and open forums to raise awareness of the service and to hear views on the culture of speaking up at CUH.

A programme of work is in place to continue to raise awareness and visibility in engaging with staff across the organisation. In February 2018 the first cohort of local listeners were recruited to supplement the service offered by the FTSUG. In March 2019 another 50 expressions of interest have been received for future cohorts of local listeners. This initiative offers staff a range of options to support the improved culture of speaking up.

In the two-year period from January 2017 to December 2018, 102 members of staff have contacted the FTSUG to raise concerns. 44 staff members raised concerns in 2017 and 58 raised concerns in 2018. The latter figure, at 0.6% of the total workforce, is in line with the national average quoted by the National Guardian's Office.

1. Data from staff surveys guides targeted approaches by the FTSUG in conjunction with management, human resources and patient safety/quality colleagues. In its annual Quarter 1 (April – June 2018) local staff survey, 90% of overall respondents confirmed that they can speak up to their line managers. Furthermore, 74% of respondents to the national staff survey (2019) confirmed that they feel secure to raise concerns about unsafe clinical practice.
2. Staff can contact the Freedom to Speak Up Guardian or local listener – details are provided on the Trust's intranet pages, at corporate induction, posters and leaflets in work areas, concourse stands, new manager orientation, local area visits, meetings, away days, etc.
3. Staff can also raise concerns with other staff support services e.g. Human Resources, trade unions, professional bodies, chaplaincy, occupational health.
4. Feedback to staff who use the Speaking Up service is given by keeping in regular contact and reviewing the situation, aiming for a satisfactory conclusion, with the emphasis on using existing management and support services as far as possible. Formal feedback is collected quarterly on the organisational learning from concerns raised and to seek information on the experience of those who have accessed the service and whether they would raise concerns in the future. To date, 82% have responded in the affirmative.
5. The Trust has a clear procedure available via the trust intranet page in ensuring staff are supported to raise concerns without feeling worried about any potential repercussions; the Freedom to Speak Up Guardian regularly reviews this aspect with staff who have raised concerns; this procedure is in line with NHSI's national policy on raising concerns.
6. In the two-year period, two concerns have been raised formally as part of the Trust's Raising Concerns (Whistleblowing) Procedure. These have been overseen by the Director of Corporate Affairs and have been subject to formal external investigations. Both have been concluded, with action plans in place to address the findings.
7. In the January 2019 report to the Board, a breakdown of concerns raised by theme and occupational group, was provided:

7.1. Across the past two years, around 35% of concerns raised relate to behaviour/attitude and 15% are patient-related. While it is difficult to make direct comparisons due to issues of data definition, both percentages are lower than the national average based on figures from the National Guardian's Office. Examples of patient-related concerns raised at CUH relate to the patient transport service, communications

used by a range of staff with patients in clinical settings, clinical practice, information governance and the impact of staffing shortages. One of the priorities of the FTSUG in the period ahead is to meet with a range of staff across clinical settings to raise awareness that FTSU includes patient-related concerns and to better understand where patient-related concerns are being raised through other channels.

7.2. Trust procedure/practice concerns have accounted for 24% and 31% respectively of all concerns raised over the past two years. Concerns raised in this category include feedback on staff experience of human resources investigations, managing performance, sickness absence, disciplinary and grievance procedures, allocation of annual leave and time off for training.

7.3. Of the concerns raised with the speaking up service, 24% of cases are taken forward by the individual themselves; 26% involve line management and 40% relate to human resources policies and procedures. Empowering individuals to find the language and courage to address issues directly with line managers, to be supported and have the opportunity to resolve matters locally is a key part of the cultural change we are striving for.

The CUH Speaking Up service works alongside internal stakeholders to ensure that we, as a Trust, are transparent in how we manage speaking up cases, the lessons learned and changes practice, as appropriate. We aim to actively demonstrate our commitment to supporting those who speak up and ensure they do not suffer a detriment. Our efforts to influence the wider culture are for the ultimate benefit of patient care.

Improving rota gaps for NHS Doctors and Dentists in training

In line with the requirements of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016, the Guardian of Safe Working provides both quarterly and annual reports to the Board of Directors. These reports which are based on the national template, provide details of Exception Reports, Work Schedule Reviews, Vacancies and Locum Usage.

The majority of vacancies at junior doctor level are in Clinical Fellow (non-training grade) posts rather than doctors in training (i.e. those employed on the 2016 contract). These postholders work alongside doctors in training on junior doctor rotas and such vacancies have the potential to negatively impact on the workload and access to training opportunities of doctors in training.

There isn't a consistent pattern in relation to grade and speciality of these non-training grade vacancies. As such vacancies arise, the Medical Staffing team work with individual clinical teams to agree a timely recruitment process, changes to work schedules, and innovative ways to make such posts more attractive such as support for a PG Cert and other postgraduate qualifications.

4.2.3 Priorities for quality improvement in 2019/20

The priorities set for improvement for 2019/20 have been determined following a review by internal and external stakeholders, including staff, patients and the public. Priorities set for 2019/20 have been agreed by the Trust's Board of Directors and Council of Governors, and reflect areas for improvement that align to the delivery of high quality, effective, safe and patient centred care. The

priorities are aligned to the five key questions posed by our regulator, the Care Quality Commission - namely Safe, Effective, Caring, Responsive and Well-Led.

Some priorities listed below are aligned to priorities set in 2018/19, with modifications made to ensure that the focus of improvement is within the Trust's remit to deliver. It is recognised that the Trust works within a wider healthcare system, but specific areas of care delivery can be positively influenced by the Trust within the context of patient pathways which continue outside of the hospital environment.

4.2.4 Objectives and measures for 2019/20

Safe

Our aim is to reduce avoidable harm to our patients by improving our safety culture, safety systems and how we learn from past harm.

Patient Safety Improvement Plan (2018-2020)

The Trust Patient Safety Improvement Plan sets out the current patient safety improvement priorities for the Trust, as part of its commitment to a continuous patient safety improvement programme. The three current workstreams of improvement for 2018-2020 are:

- Continually learning and improving
- Just Culture
- Deteriorating patient

These three patient safety improvement workstreams are aligned to all four areas of the Trust strategy and were devised in response to both internal patient safety intelligence and mandated guidance from external bodies.

The three key safety improvement metrics (detailed in the table below) have been identified for 2019/20 and are aligned to each of the above three domains of work.

The measures we will use in 2019/20 will be:

Measure	Definitions	Baseline	Target	Rationale
After Action Review (AAR) first wave of trainers complete training.	All first wave trainers successfully completed AAR training by 31 March 2020.	0	>95%	This is a key element of the Just Culture work stream which forms part of the Trust current Patient Safety Improvement Plan (2018-2020).The Just Culture work steam will be launched in January 2019.
Internal Root Cause Analysis (RCA)	>90% internal RCA investigations meet the quality	9%	>90%	Key element of the Strengthening of the RCA investigations work

Measure	Definitions	Baseline	Target	Rationale
investigations to meet the quality standards (of >90%) by March 2020.	standard of (>90%) as defined by the quality measurement tool.			stream which is part of the Trust current Patient Safety Improvement Plan (2018-2020).
Compliance with the National Early Warning Score Escalation protocol for adults.	>90% of patients received appropriate clinical response to triggering deterioration in line with national standards (NEWS 2).	5%	>90%	Key element of the deteriorating patient work stream which is part of the Patient Safety Improvement Plan (2018-2020).

Effective/Responsive

Our aim is to consistently deliver high quality care that is effective, timely, patient centred and efficient.

We recognise that Delayed Transfers of Care (DTOCs) remain a challenge for everyone working in the healthcare system. In order for us to have a clear focus on ensuring that we will minimise delays to patients' journeys, we have identified the following priorities to help us best understand where we have effective and responsive systems in place, and also to identify where we need to continue to improve.

The measures we will use in 2019/20 will be:

Measure	Definitions	Baseline	Target	Rationale
Patients that remain in an acute Trust bed for 21 days or more	Number of patients that remain in an acute Trust bed for 21 days or more. The national definition applies; with the main criteria being; acute patients only, 18+only. Excludes regular day & night attenders, day cases and zero length of stay (LoS) admissions.	186	116	The stranded patient metric from 2018/19 has been updated to 'super-stranded' (21 +LoS) in line with national priorities. The Trust has been set a target to reduce the number of beds lost to long stay patients by 25% from a baseline of 186 in 2017/18. This reduction indicates more effective and efficient patient pathways, improves patient experience (as they are more likely to

Measure	Definitions	Baseline	Target	Rationale
				be being cared for in an appropriate environment) and creates much need capacity.
Occupancy rate at midnight	The number of G&A patients occupying trust beds at midnight divided by the number of G&A beds available. Definitions in the KH03 national return apply; the main exclusions are patients under obstetrics and critical care.	93.3%	92%	Lower occupancy levels support the appropriate placement of patients and enhance the operational efficiency of the hospital by ensuring that it can meet both elective and emergency demand. The baseline is the average occupancy rate from January-December 2018. 92% is the commissioned level agreed with NHSE/I based on anticipated growth levels for 19/20. There are no plans to increase our bed base in 19/20, therefore maintaining a flat line occupancy level will be a significant challenge especially if demand grows.
Accuracy of Clinically Fit Dates (CFDs) This excludes DTOC patients.	% of CFDs which accurately predict the date of patients' discharges (excludes DTOC patients).	31.2%	40%	The Trust uses CFDs to predict patients' likely date of discharge. The accuracy of CFDs is important as it enables the Trust to better manage patient flow and on-time discharges. This aligns with both the Quality Strategy and Plan. We propose to keep this measure increasing the target to 40%. Achievement of this metric will require on-going support from the office of the Medical Director, since the accuracy of CFDs depends upon robust

Measure	Definitions	Baseline	Target	Rationale
				clinical input and oversight.
% of early discharges	The percentage of patients who are discharged from the Trust before midday, as a proportion of all discharges. This excludes zero length of stay patients and time spent in the discharge lounge.	12.3%	20%	Earlier discharges create capacity in the morning when the organisation needs it. They create flow out of ED and support the correct placement of patients in the right specialty.

Patient Experience/Caring

Our aim is to further improve our delivery of patient care against our values in relation to compassion and communication.

The measures we will use in 2019/20 will be:

Measure	Definitions	Baseline	Target	Rationale
Percentage of complaints responded to within initial fixed timeframe (30, 45, or 60 working days) or within agreed extension with complainant.	The number of complaints which are answered within 30 working days or within an agreed timescale set by the complainant.	80% (estimate of current position)	80%	Ensuring that complaints are responded to within a timely manner is a key requirement of provider Trusts. This aligns to the Quality Strategy in improving the patients' journey and to quality priority 2 within the Quality Plan; this supports restoring patients' confidence and trust in the organisation after a negative experience and demonstrates a willingness of the Trust to take complaints seriously and work towards a resolution in a timely and proportionate manner.

Measure	Definitions	Baseline	Target	Rationale
Establish a formal process of recording actions developed and agreed from complaints investigations using the 'action module' on QSIS (Datix) for all complaints graded 3 and above.	The percentage of actions out of the total completed by the agreed date.	0	>80% (Q4)	Ensuring that lessons are learned and action taken as a result of complaints is an essential component of the complaints process. This aligns to the Quality Strategy in improving the patients' journey and to quality priority 2 - Quality Plan; this supports restoring patients' confidence and trust in the organisation and demonstrates that the Trust learns from negative experiences and works towards improving care and patient experience for future patients.
Good practice in undertaking 'ReSPECT' as defined by documenting: an understanding of what the patient or those close to them values or fears; a clinical plan which has been communicated to the patient or those close to them; a conversation which has been appreciated by the patient or their family; embedded across the service areas including outpatients.	All doctors (ST3) to have received training in undertaking the ReSPECT process. Training defined as; mandatory aligned to the current resuscitation training; Part 2 - session with CNS & % of doctors to receive the training	0	90% of doctors ST3 or above to have had training (this KPI aligns to mandatory target). Part 2 session with the CNS to be agreed in q1 and report from q2 – q4.	All doctors to be competent and feel comfortable undertaking the ReSPECT process including having a good understanding of when to undertake the ReSPECT process.

Staff Experience / Well-led

Our aim is to further improve the health and wellbeing of our staff to ensure we have a fit for purpose frontline workforce, leadership team and organisational culture.

The measures focus on monitoring how the organisation treats staff who are involved in an error or near miss and if they feel secure in raising concerns. These build on the current measures and align with the leadership and culture work streams. To further support front line staff, having a focus on the retention of band 5 nurses reflects the level of staffing impacting directly on the services in providing safe and high quality care. In addition, a measure that reflects the quality and value of staff appraisals supports how we monitor how they feel about working for the organisation.

The measures we will use in 2019/20 will be:

Measure	Definitions	Baseline	Target	Rationale
I feel secure raising concerns about unsafe clinical practice within the organisation.	National staff survey 2019 Theme: Safety culture	74% in 2018	76%	Reflects staff perception of the organisation including Just Culture and specifically that staff feel psychological safe enough to raise patient safety concerns.
People saying 'my appraisal helped me to improve how I do my job'.	National staff survey 2019 Theme: Appraisals & support for development	26% in 2018	28%	Indicates how staff feel about working for the organisation and the value of appraisal.
Nursing and Midwifery vacancy rate.	Band 5 nursing vacancy rate	6.5%	4%	Reflects the level of staffing impacting directly on service safety and quality.

4.2.5 Statements of assurance from the board

This section contains the statutory statements concerning the quality of services provided by CUH. These are common to the quality accounts provided by all NHS Trusts and can be used to compare us with other organisations.

The board of directors

The priorities and targets in our quality account were identified following a process which included the Board of Directors, clinical directors and senior managers of the Trust, and have been incorporated into the key performance indicators reported regularly to the Board of Directors as part of the performance monitoring of the Trust's corporate objectives, and which are produced within the Trust's data quality policy, framework and standards.

Scrutiny of the information contained within these indicators and its implication as regards patient safety, clinical outcomes and patient experience takes place at the Quality Committee.

The Board of Directors reviews the Trust's integrated quality, performance, finance and workforce reports each month. Reviews of data quality, and the accuracy, validity and completeness of Trust performance information, fall within the remit of the audit committee, which is informed by the reviews of internal and external audit and internal management assurances.

Review of our services

During 2018/19 Cambridge University Hospitals NHS Foundation Trust provided and/or sub-contracted 114 relevant health services.

The Cambridge University Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in all 114 of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 99% of the total income generated from the provision of relevant health services by the Cambridge University Hospitals NHS Foundation Trust for 2018/19.

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Cambridge University Hospitals NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 18910.

Participation in national clinical audits and national confidential enquiries

During 2018/19, 58 national clinical audits and 3 national confidential enquiries covered relevant health services that Cambridge University Hospitals NHS Foundation Trust provides.

During that period Cambridge University Hospitals NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Cambridge University Hospitals NHS Foundation Trust participated in, and for which data

collection was completed during 2018-19 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The national clinical audits and national confidential enquiries that Cambridge University Hospitals NHS Foundation Trust was eligible to participate in during 2018-19 are as follows:

List of eligible and participated in national clinical audit programmes

Audit Title	What is the audit about?	Case Participation %
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP).	This audit examines the quality of management of heart attacks (myocardial infarction) in hospitals in England and Wales.	100%
Adult Community Acquired Pneumonia.	The BTS National Adult Community Acquired Pneumonia (CAP) Audit will run for a sixth time this winter. Previous BTS CAP audits have identified deficiencies and variation in care, and we intend to further investigate outcomes and variation of care in this round by linking data from the audit to HES and ONS data held by NHS Digital.	100%
Bowel Cancer (NBOCAP).	Colorectal (large bowel) cancer is the second most common cause of death from cancer in England and Wales.	100%
Cardiac Rhythm Management (CRM).	The audit aims to monitor the use of implantable devices and interventional procedures for management of cardiac rhythm disorders in UK hospitals.	100%
Case Mix Programme – Adult Critical Care - *(ICNARC).*	The aim of this audit is to improve resuscitation care and patient outcomes for the UK and Ireland.	100%
Cystectomy Audit British Association of Urological Surgeons (BAUS).	This audit look at the radical cystectomy removal of the bladder for cancer with urinary diversion or bladder reconstruction The operative technique used may be open, laparoscopic or laparoscopic with robotic assistance. This audit delivers good quality data and it is used as a valuable tool in improving care – continuous data collection.	100%
Elective surgery (National PROMs Programme).	The audit looks at the change in patients' self-reported health status for hip and knee replacement surgery – continuous data collection.	100%

Audit Title	What is the audit about?	Case Participation %
Falls and Fragility Fractures Audit Programme (FFAP): Falls Audit & Hip Fracture Databases.	The FFAP is a national audit run by the Royal College of Physicians designed to audit the care that patients with fragility fractures and inpatients falls receive in hospital and to facilitate quality improvement initiatives – continuous data collection.	100%
Head and Neck Cancer Audit.	The Head and Neck Cancer Audit (HANA) focuses on patients who have cancer of the head and / or neck, of which there are approximately 10,000 cases per year. The aim of the audit is to improve the services and outcomes achieved for these patients.	100%
National Gastrointestinal Cancer Programme - Oesophago-gastric cancer (NOGCA).	This audit provides us with the most up-to-date information on the care and outcomes of patients diagnosed with Oesophago-Gastric (OG) cancer or oesophageal high grade dysplasia.	100%
Inflammatory Bowel Disease (IBD) programme includes Biologics and Audit.	The purpose of this audit is to measure the efficacy, safety and appropriate use of biological therapies in patients with inflammatory disease; and secondly seeks to improve the care for IBD patients in hospitals throughout the UK.	100%
Learning Disability Mortality Review Programme (LeDeR Programme).	The aim of this programme is to review deaths of people with learning disability and to use lessons learnt to make improvements to service provision.	100%
Major Trauma: The Trauma Audit & Research Network (TARN).	TARN is working towards improving emergency health care systems by collating and analysing trauma care – continuous data collection.	100%
Maternal, Newborn and Infant Clinical Outcome Review programme – MBRRACE-UK: -Perinatal Mortality Surveillance. -Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths). -Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia, plus psychiatric morbidity). -Maternal mortality surveillance.	The aim of the MBRRACE-UK programme is to provide robust national information to support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health services – continuous data collection.	100%

Audit Title	What is the audit about?	Case Participation %
National Audit of Care at the End of Life (NACEL).	The National Audit of Care at the End of Life (NACEL) focuses on the quality and outcomes of care experienced by those in their last admission in acute, community and mental health hospitals throughout England and Wales.	100%
National Audit of Breast Cancer in Older People (NABCOP).	The audit was set up to look at whether or not older women with breast cancer have different outcomes than younger women, and if there are differences between breast cancer teams in the patterns of care delivered to older women.	100%
National Audit of Dementia – Royal College of Psychiatrists.	The audit examines assessments, discharge planning and aspects of care received by people with dementia.	100%
National Cardiac Arrest Audit (NCAA).	The purpose of this audit is to monitor the incidence of, and outcome from, in-hospital cardiac arrest in UK and Ireland.	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Pulmonary Rehabilitation.	This audit aims to collect information on all patients referred to and who receive pulmonary rehabilitation for COPD – continuous data collection.	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) – Adult Asthma Secondary Care.	This audit aims to collect information on all people admitted to hospital adult services with asthma attacks – continuous data collection.	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) – Chronic Obstructive Pulmonary Disease (COPD) Secondary Care.	This audit aims to collect information on all people admitted to hospital with COPD exacerbations – continuous data collection.	100%
National Comparative Audit of Blood Transfusion programme: Audit of Patient Blood Management in Scheduled Surgery.	Audit of Patient Blood Management in adults undergoing elective, scheduled surgery.	100%

Audit Title	What is the audit about?	Case Participation %
National Diabetes Audit (NDA).	The National Diabetes Audit is considered to be the largest annual clinical audit in the world, providing an infrastructure for the collation, analysis, benchmarking and feedback of local data across the NHS – continuous data collection.	100%
National Diabetes Foot care Audit (NDFA).	The National Diabetes Foot care Audit (NDFA) enables all diabetes foot care services to measure their performance against NICE clinical guidelines and peer units, and to monitor adverse outcomes for people with diabetes who develop diabetic foot disease – continuous data collection.	100%
National Diabetes Inpatient Audit (NaDIA).	The National Diabetes Inpatient Audit (NaDIA) is a snapshot audit of diabetes inpatient care in England and Wales – continuous data collection.	100%
National Diabetes Transition Audit (NDTA).	The audit seeks to answer: 1. Is the transition from paediatric to adult care associated with changes in care process completion rates? 2. Is the transition from paediatric to adult care associated with a change in treatment target achievements (specifically HbA1c)? 3. Is the transition from paediatric to adult care associated with changes in the frequency of diabetic ketoacidosis (DKA)? – continuous data collection.	100%
National Diabetes In Pregnancy - Adult (NDIP).	The audit is a measurement system to support improvement in the quality of care for women with diabetes who are pregnant or planning pregnancy and seeks to address the three key questions: - Were women with diabetes adequately prepared for pregnancy? - Were adverse maternal outcomes during pregnancy minimised? - Were adverse foetal/infant outcomes minimised? - continuous data collection.	100%
National Emergency Laparotomy Audit (NELA).	NELA aims to look at structure process and outcomes measures for the quality of care received by patients undergoing emergency laparotomy – continuous data collection.	100%

Audit Title	What is the audit about?	Case Participation %
National Endocrine and Thyroid Audit.	This clinical audit aims to help endocrine and thyroid surgeons to monitor their practice. It collects information on the results of surgery for every UK patient undergoing thyroid, parathyroid, adrenal or pancreatic endocrine surgery operations.	100%
National Heart Failure Audit.	The aim of this audit is to improve the quality of care for patients with heart failure through continual audit and to support the implementation of the national service framework for coronary heart disease.	100%
National Joint Registry (NJR).	The audit covers clinical audit during the previous calendar year and outcomes including survivorship, mortality and length of stay – continuous data collection.	100%
National Lung cancer (NLCA).	This audit was set up in response to the NHS Cancer Plan to monitor the introduction and effectiveness of cancer services.	100%
National Neurosurgery Audit Programme (NNAP).	The aim of this programme is to engage units in a comprehensive audit programme that reflects the full spectrum of elective and emergency neurosurgical activity, and to provide a consistent and meaningful approach to reporting on national clinical audit and outcomes data.	100%
National Maternity and Perinatal Audit (NMPA).	The National Maternity and Perinatal Audit (NMPA) is a large scale audit of the NHS maternity services across England, Scotland and Wales. Using timely, high quality data, the audit aims to evaluate a range of care processes and outcomes in order to identify good practice and areas for improvement in the care of women and babies looked after by NHS maternity services.	100%
National Ophthalmology Audit.	The project aims to collect and analyse a standardized set of nationally agreed cataract surgery data set, from all centres providing this service.	100%
National Paediatric Diabetes Audit (NPDA).	The sole aim is to provide information that leads to an improved quality of care for those children and young people affected by diabetes – rolling audit.	100%

Audit Title	What is the audit about?	Case Participation %
National Prostate Cancer Audit.	The audit covers organisational elements of the service and whether key diagnostic, staging and therapeutic facilities are available on site for each provider of prostate cancer services.	100%
National Vascular Registry.	The audit addresses the outcome of surgery for patients who underwent two types of vascular procedures. The first is an elective repair of an infra- renal abdominal aortic aneurysm (AAA). The second is a carotid endarterectomy (CEA) – continuous data collection.	100%
Neonatal Intensive and Special Care (NNAP).	To assess whether babies requiring specialist neonatal care receive consistent All patients in the period meeting the criteria.	100%
Nephrectomy Audit British Association of Urological Surgeons (BAUS).	This audit looks at the removal of the kidney for benign or malignant disease – continuous data collection.	100%
Oesophago-gastric cancer (NAOGC).	The Oesophago-gastric (stomach) cancer audit aims to examine the quality of care given to patients and thereby help services to improve. The audit evaluates the process of care and the outcomes of treatment for all oesophago-gastric cancer patients, both curative and palliative.	100%
Paediatric Intensive Care (PICANet).	PICANet aims to support the improvement of paediatric intensive care provision throughout the UK by providing detailed information on paediatric intensive care activity and outcomes.	100%
Percutaneous Nephrolithotomy (PCNL) British Association of Urological Surgeons (BAUS).	This audit examines percutaneous nephrolithotomy (PCNL) surgeries for the removal of stones from the kidney or ureter using a small puncture in the skin of the affected side – continuous data collection.	100%
Radical Prostatectomy Audit British Association of Urological Surgeons (BAUS).	This audit assesses the removal of the whole prostate gland and seminal vesicles for cancer of the prostate – continuous data collection.	100%
Renal Replacement Therapy.	The Registry contains analyses of data submitted relating to direct clinical care and laboratory permit analysis with the purpose to improve the quality of care for renal patients.	100%

Audit Title	What is the audit about?	Case Participation %
Rheumatoid and Early Inflammatory Arthritis.	The overall aim of the audit is to improve the care quality of care provided by specialist rheumatology services in the management of early inflammatory arthritis - continuous data collection.	100%
Sentinel Stroke National Audit Programme (SSNAP).	The audit collects information about care provided to stroke patients in the first three days of hospital - continuous data collection.	100%
Seven Day Hospital Services Self-Assessment Survey.	This audit aim to measure and improve the provision of seven day services ensuring that patients receive consistent high quality safe care every day of the week.	100%
RCEM Vital Signs in Adults (care in emergency departments).	This audit looks at the reception of patients and the initial encounter with clinical staff. The clinical priority is determined by the presenting symptoms and the recording of vital signs and this is a foundation of clinical quality.	100%
RCEM Feverish Children (care in emergency departments).	This audit measures the use of standardised assessment and scoring methods to help clinicians spot the sick children.	100%
RCEM VTE risk in lower limb immobilisation (care in emergency departments).	The present audit is an opportunity for improvement about utilisation of risk assessment tools as well as the documented provision of written patient information.	100%
Specialist rehabilitation for patients with complex needs following major surgery.	This audit provides a comparative assessment of services provided by area in relation to specialist injuries caused by events such as road accidents and falls – continuous data collection.	100%
Stress Urinary Incontinence Audit Association of Urological Surgeons (BAUS).	This audit examines all surgical treatments for both primary and recurrent stress urinary incontinence – continuous data collection.	100%
UK Cystic Fibrosis Registry.	The audit aims to examine both life expectancy and quality of life for children and adults with Cystic Fibrosis – continuous data collection.	100%
Urethroplasty Audit British Association of Urological Surgeons (BAUS).	The aim of this audit is to develop a better understanding of the presentation of urethral stricture disease and to enable surgeons to share information regarding investigation, surgical management and surgeon-perceived outcome from their interventions – continuous data collection.	100%

The national clinical audits and national confidential enquiries that Cambridge University Hospitals NHS Foundation Trust participated in during 2018-19 are as follows:

Participation in national confidential Enquiries

National confidential enquiry title	Participation (percentage)
Pulmonary Embolism	100%
Acute Bowel Obstruction	100%
Long Term Ventilation	100%

Learning from audit

National audits

The reports of 27 national clinical audits were reviewed by the provider in 2018-19 and Cambridge University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see *Appendix C*. for list of national clinical audit report outcomes and action plans).

Local audits

The reports of 243 local clinical audits were reviewed by the provider in 2018-19 (cut off 12/02/19) and Cambridge University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see *Appendix D*. for list of local clinical audit report outcomes and action plans).

Use of the CQUIN payment framework

The Commissioning for Quality and Innovation (CQUIN) programme is a national framework for locally agreed quality improvement schemes, and a proportion of a provider's income is conditional upon the CQUIN programme being achieved.

In 2017/18, Cambridge University Hospitals NHS Foundation Trust received a CQUIN payment of £13,692,276.

A proportion of Cambridge University Hospitals NHS Foundation Trust income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between Cambridge University Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

The potential CQUINs income available if the Trust had met all of the CQUIN targets was £14,613,000.

Further details of the agreed goals for 2018/19 and for the following 12 month period are available electronically within the Trust's internal systems. To request this information, please see the 'Feedback on the quality report and quality account' section (below) or email: trust.secretariat@addenbrookes.nhs.uk

Care Quality Commission registration and compliance

Cambridge University Hospitals NHS Foundation Trust (CUH) is required to register with the Care Quality Commission and is currently registered with no conditions attached.

The Care Quality Commission has not taken enforcement action against CUH during 2018/19.

CUH has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

The Trust's CQC rating remains consistent with an overall rating of **Good**. The full table of ratings from the October 2018 CQC inspection is available below:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Outstanding	Requires improvement	Outstanding	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Good	Outstanding	Outstanding	Requires improvement	Good	Good
Maternity and gynaecology	Good	Good	Good	Requires improvement	Good	Good
Services for children and young people	Good	Good	Good	Requires improvement	Good	Good
End of life care	Good	Good	Outstanding	Good	Outstanding	Outstanding
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Overall	Good	Good	Outstanding	Requires improvement	Outstanding	**Good**

Data quality

Data quality refers to assurance of the information about patients recorded by the Trust on computerised systems.

The Trust follows national guidelines about how these data are collected and stored, and we undertake regular audits to make sure that data held on the system is accurate and that we are compliant with what is expected.

CUH submits records to the secondary uses service (SUS) for inclusion in the hospital episode statistics (HES). We also share data with partners as appropriate, for example clinical commissioning groups (CCGs). These data are used to plan and review the healthcare needs of the area.

Cambridge University Hospitals submitted 1,397,727 records during the reporting period, April 2018 – December 2018, to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- which included the patient's valid NHS number was:

  99.5 for admitted patient care

  96.5 for outpatient care and

97.3 for accident and emergency care.

- which included the patient's valid General Medical Practice Code was:

100 for admitted patient care;

100 for outpatient care; and

95.6 for accident and emergency care.

Information governance toolkit attainment levels

All NHS organisations are required to comply with the 'Information Governance Toolkit'. This covers standards on data protection, confidentiality, information security, clinical information and corporate information.

The Cambridge University Hospital Data Security & Protection Toolkit submission for 2018/19 has met the standards.

Clinical coding

Cambridge University Hospitals was not subject to the Payment by Results clinical coding audit during 2018 by the Audit Commission.

Cambridge University Hospitals will be taking the following actions to improve data quality:

- Develop data quality dashboards and provide missing/invalid item reports for many of the national returns so that front line staff may see where improvements are possible.
- Data Governance and Stewardship Oversight Group to work with Divisional management and operational teams to better understand the quality of our data and the governance structures.
- Timetable deep dives into Divisional mandated returns to validate and improve data quality.
- Embed the RTT Forum as a function to reinforce development and learning for front line staff
- Audit documented clinic outcomes against evidence within Epic to provide process assurance

Learning from Deaths

In March 2017, the National Quality Board introduced new guidance for NHS providers on how they should learn from the deaths of people in their care. The implementation of this guidance is overseen by NHS Improvement and key milestones and timeframes were mandated for all NHS Providers from April 2017.

CUH launched its new policy and procedures in October 2017 in line with NHSI timeframes. The Learning from deaths policy within CUH is supported by the Trust learning from deaths oversight committee and reports to the Quality Committee bi-monthly via the Patient Safety Report and monthly to the Board via the Trust Integrated Report.

The data shown below reflects the mandated KPIs for reporting via the quality account. These numbers have been estimated using the Structured Judgement Review tool methodology for the required case review process (as recommended by the Royal College of Physicians).

(27.1) The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.

During 2018/19, 1445 patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 355 in the first quarter; 347 in the second quarter; 361 in the third quarter; 382 in the fourth quarter.

(27.2) The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.

By 01/04/2019, 245 case record reviews (SJRs) and 10 serious incident investigations have been carried out in relation to 1445 of the deaths included in item 27.1. In 7 cases a death was subjected to both a case record review and a serious incident investigation.

The number of deaths in each quarter for which a case record review or an investigation was carried out was: 55 in the first quarter; 60 in the second quarter; 68 in the third quarter; 64 in the fourth quarter

(27.3) An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.

In 2018/19, there were nine case record reviews (SJRs) that identified that the death was more likely than not to have been due to problems in the care provided to the patient, representing 0.6% (9/1445) of patient deaths during this reporting period.

In relation to each quarter, this consisted of: 2 representing 0.5% (2/355) for the first quarter; 2 representing 0.5% (2/347) for the second quarter; 1 representing 0.2% (1/361) for the third quarter; 4 representing 1% (4/382) for the fourth quarter.

All nine of these deaths were subsequently investigated via the serious incident investigation process, as listed below:

i. Patient in a side room became disconnected from non-invasive ventilation tubing on the acute respiratory ward (SJR avoidability score 1).

ii. Cardiac arrest following delay in recognition and escalation of deterioration of an acutely ill patient on a care of the elderly ward (SJR avoidability score 3).

iii. Delay in referral process to Papworth Hospital (SJR avoidability scores 3 for overall care, commissioned as a serious incident by Papworth Hospital).

iv. Intrapartum still birth (SJR avoidability score 3).

v. Cardiac arrest following delay in recognition and escalation of deterioration of an acutely ill patient in the Emergency Department (SJR avoidability score 3).

vi. Delay in recognition and escalation of deterioration of an acutely ill patient on Transplant ward (SJR avoidability score 3).

vii. Delay in recognition and escalation of deterioration of an acutely ill patient on Respiratory ward (SJR avoidability score 3).

viii. Suboptimal care of a deteriorating paediatric patient on ward D2 (SJR avoidability score 3).

ix. Inpatient fall on MDU – (SJR avoidability score is pending)

In addition, four more deaths were investigated as unexpected/potentially avoidable death serious incidents; even though they did not trigger a SJR that judged care to be more likely than not to have been due to problems in the care provided to the patient:

x. Complication during neuro-coiling procedure (SJR not requested as SI commissioned).

xi. Malignant melanoma (patient died in prison), i.e. patient did not die in CUH.

xii. Potentially missed diagnosis of aortic dissection (originated as a complaint) – original SJR avoidability scored 4. SI was commissioned on receipt of post mortem result which identified previously unknown cause of death.

xiii. Delayed diagnosis of squamous cell cancer – patient died (in August 2017) pre- learning from deaths implementation and concerns in death were identified via the complaint process.

In summary there were 13 unexpected/potentially avoidable death serious incidents commissioned by CUH in 2018/19.

(27.4/27.5) A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3 (scores 1-3 in 2018/19).

The key theme that has emerged in 2018/19 is related to the suboptimal recognition and escalation of the deteriorating patient (6/13).

The deteriorating patient serious incidents were located across the Trust in six different wards/departments, and across five different specialities. In response to the findings from these investigations the Trust commissioned a Trust quality improvement plan for the deteriorating patient, which has oversight via the Trust Recognise and Respond Group and reports directly to the Quality Committee bi-monthly and to the Quality Steering Group monthly.

Key learning points identified from the serious incident investigations were:

- Delay in the recognition of deterioration including: inadequate frequency of the measurement and monitoring of vital signs; and ineffective clinical response to elevated early warning (NEWS) trigger points.
- Delay in the escalation of the deterioration to clinical staff skilled in the management of critically ill patients, e.g. senior ward-based doctors, critical care outreach team.

- Lack of oversight by the Nurse-in-charge of the shift when patients were deteriorating, including: no awareness of deterioration; and inadequate supervision of the clinical response required.
- Nurse staffing levels not aligned to the ward's patient acuity due to inaccurate acuity scoring and identification of risk factors.

Some of the key recommendations from all the deteriorating patient SI reports:

- The NEWS-2 escalation protocol format (as stated in the new policy for the management of the acutely ill patient) to be used to aid recognition of emergency situations – in ward areas and training.
- An audit tool and schedule to be devised to monitor compliance with NEWS-2 escalation protocol.
- Explore how the triggers for the assessment and use of special observation can be improved across the organisation. Specifically, to explore the cultural and workload factors that appears to hinder staff assessing the need for a special.
- Review the nursing establishment for ward X, with reference to the acuity of patients and the impact the design of the ward has on staffing requirements. This review should take account of the experiences of the current nursing staff on ward X and should align to national and professional standards.
- Total revision of the Trust's acutely ill patient educational programme for doctors, nurses and healthcare assistants.

Key learning points from the stillbirth serious incident investigation:

- A standard policy re CTG monitoring should operate for assessment of women presenting to Clinic 23 during its opening hours, and the same criteria for those presenting directly to Delivery Suite outside of these hours.
- An agreed definition of established labour should be in place to allow appropriate clinical decisions to be made in a timely fashion. The current Trust guideline may need to be updated in this regard.

Key learning points from the delayed diagnosis and treatment serious incident investigations:

- Cases where cancer is clinically strongly suspected but a negative result is received should be discussed at the weekly skin cancer MDT meeting.
- Support the implementation of a rolling programme in induction and teaching in the Emergency Department incorporating the recommendations of the Think Aorta campaign.
- Review of the feasibility of introducing a tracking list for high-risk patients not on an active cancer pathway.

Severe Mental Health

In 2018/19 there were eight case reviews (SJRs) triggered by the death of patient with severe mental health problems. One of these reviews judged the death as being more likely than not to have been due to problems in the care provided to the patient (cardiac arrest following delay in recognition and escalation of deterioration of an acutely ill patient in the Emergency Department -SJR avoidability score 3). This was commissioned as a serious incident investigation.

Learning Disability Mortality Review (LeDeR)

The national Learning Disability Mortality Review (LeDeR) Programme is provided by Bristol University and funded by NHS England. There are a number of key activities related to the programme:

- Acts as a central point for the notification of deaths of people with learning disabilities
- Supports local areas to review the deaths of people with learning disabilities, identify learning and take forward lessons learnt into service improvements
- Collates and shares anonymised information so that common themes, learning points and recommendations can be identified and taken forward
- Supports a number of priority themes (deaths of young people aged 18 – 24 (inclusive) and deaths from Black and Minority Ethnic communities).

The LeDeR programme was commenced across Cambridgeshire and Peterborough on 01 May 2017. A total of 29 deaths at Addenbrooke's have been notified to the LeDeR programme since May 2017. Deaths of patients from the age of 4-18 years will be reported to, but will not be reviewed by LeDeR. Instead, all child deaths (including those under the age of 4) will be reviewed under the national Child Death Overview Process (CDOP). A total of 8 child deaths (4-18 years) have been reported to the LeDeR programme since May 2017.

There has to date only been feedback from the LeDeR process for one patient who died at CUH (July 2017); no concerns with CUH care were identified.

(27.6) An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.

Many of quality improvement actions identified in 2018/19 are still in progress. The deteriorating patients SI actions have resulted in strengthening the governance infrastructure of the Trust Recognise and Respond Group and the assurance framework that helps this forum measure and monitor key performance indicators. This is designed to help the Trust anticipate gaps in standards of care and drive improvement before harm occurs.

A Trust wide review of the education provision or deteriorating patient is in progress and learning from incidents is incorporated into the education content. Human factors elements i.e. team effectiveness, leadership and supervision, are given stronger emphasis in education to help staff understand the complexity of how errors occur.

A review of nursing staffing levels has occurred in one ward involved in SIs and has led to a more accurate measurement of patient acuity and the required capacity and capability of staff required.

The findings from Sis have also initiated a Trust improvement initiative to introduce Safety Huddles to ward areas to help staff recognise and escalate patients with emerging risks, e.g. falls, deteriorating.

(27.7/27.8/27.9) The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period.

In 2017/18, six of the deaths reviewed or investigated during that year were judged to be more likely than not to have been due to problems in the care provided to the patient. This represented 0.3% of the deaths that occurred during that financial year. In addition, 17 case record reviews and 0 investigations that related to deaths that took place during 2017/18 were completed after 31st March 2018. Of these, following an SJR and then a subsequent judgement no deaths were judged to be more likely than not to have been due to problems in the care provided to the patient.

Therefore, of all the deaths that occurred in 2017/18 and which were reviewed or investigated, a total of six deaths were judged to be more likely than not to have been due to problems in the care provided to the patient. This represents 0.3% of the patient deaths that occurred during 2017/18.

Duty of Candour

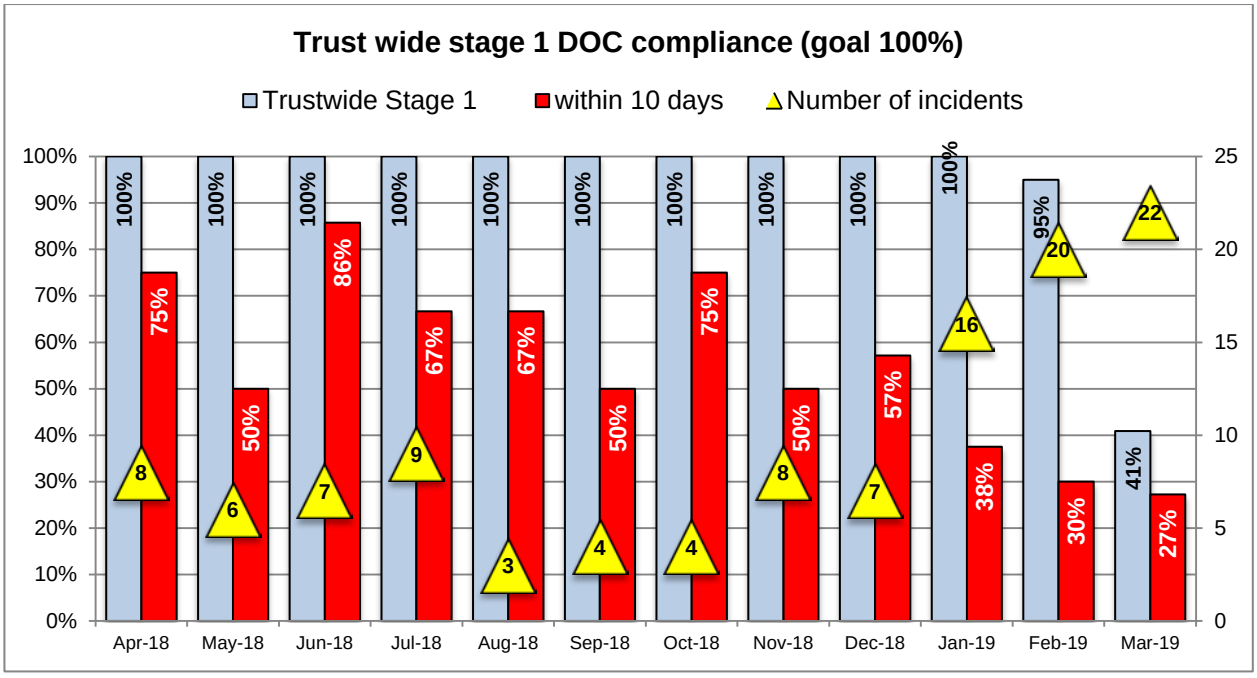
When a patient has been adversely affected by an incident, staff have a duty to inform the patient, relatives, and/or carers as appropriate. This may fall under the Being Open process or the Duty of Candour (DOC) process, depending on the level of harm to the patient. Duty of Candour (Regulation 20) applies when a patient safety incident results in moderate harm, severe harm, or death.

Compliance with Duty of Candour stage 1 requires that an appropriately senior clinician informs the patient about the incident, explains the impact and consequences for the patient, apologises, and informs the patient that the incident will be investigated, and finally, all these elements are captured in a formal letter from the clinical team to the patient (or relative/carer) within 10 working days. Stage 2 pertains to ensuring that once the investigation is completed the Trust will share the findings of their investigation with the patient/relative/carer (within 10 days of the report being finalised), should they so wish.

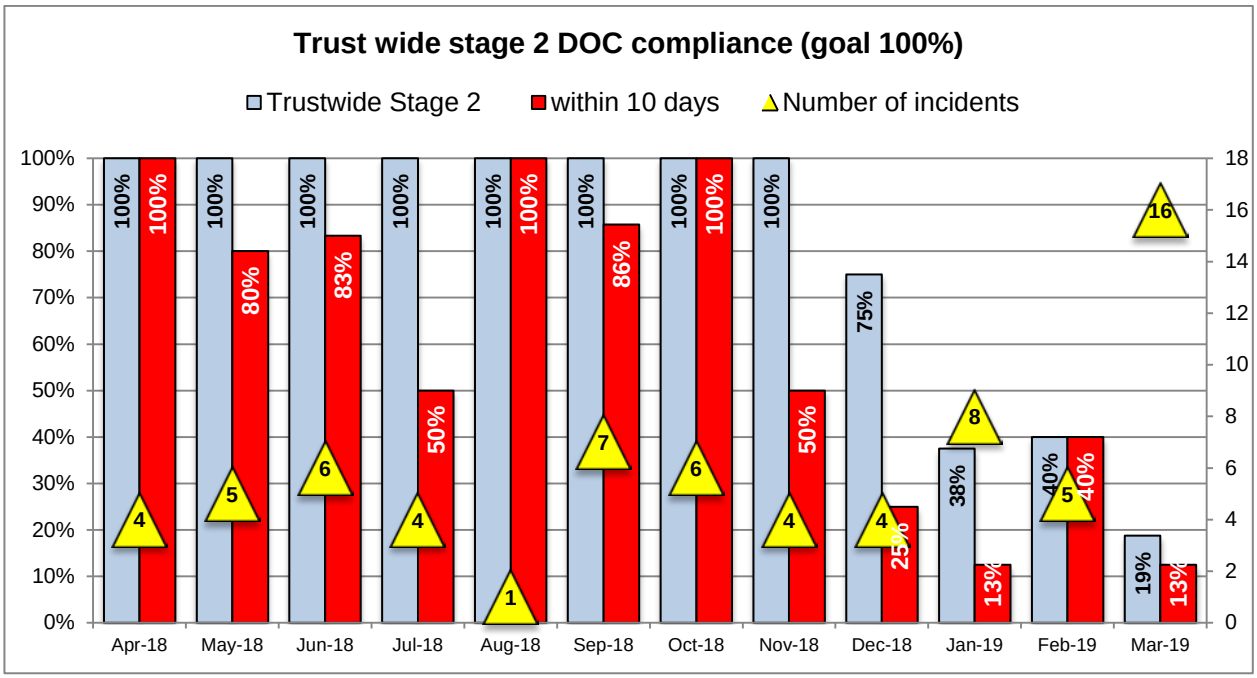
Duty of candour is delivered by the relevant clinical teams and is recorded in the patient's medical record and in QSIS/Datix; compliance is monitored and reported from QSIS by the corporate patient safety team. Compliance data is shared monthly with the Board via the Trust Integrated report, with Divisions via metrics in their Divisional board meetings, and with the Quality Committee via the Patient Safety Group's bi-monthly Patient Safety Report.

In 2018/19 our compliance with Duty of Candour stage one was 100% until January 2019 (outstanding cases in February and March 2019 are still in progress); however, completion of stage one within 10 days was not fully compliant (see graph below).

In 2019/20 the governance infrastructure within the divisions had been strengthened to improve the timeliness of compliance with stage 1. In some cases the delays were appropriate due to the sensitivity of cases and the timing of the final letters shared with the family; in these cases the process is led by the Consultant overall in-charge of care and supported by good communication with the patient/family.



Compliance with Duty of Candour stage two was 100% (up until November 2018 (compliance with outstanding cases is still in progress); however, completion of stage two within 10 days was not fully compliant (see graph below).



Note: Until January 2019, category 2 hospital-acquired pressure ulcers were being graded as low harm. Following a review of all HAPU measuring and monitoring a decision was made to grade them as moderate harm, thereby triggering DOC requirement with an impact on compliance.

Whist compliance with stage one is good the improvement aim for 2019/20 is to ensure duty of candour letters sent to the patient are received within the regulation requirement of ten working days.

Staff Survey Results

What did we measure?	How did we do?	
	2017/18	**2018/19**
KF27 % reporting most recent experience of harassment , bullying or abuse (Higher scores are better)	42%	44 %
Relate to - Workforce Race Equality Standard:		
KF21 (percentage believing that Trust provides equal opportunities for career progression or promotion) (Q16) (Higher scores are better)	85%	83%
KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) (Q15b-c) (Lower scores are better)	25%	25%

KF27: The process of reporting these experiences has been more widely promoted and encouraged. Greater attention has been paid to staff narrative and has been shared with the Board. The tackling bullying and harassment group has been formed and has staff side representation and multidisciplinary attendance; together these representatives have developed a ten step action plan, to address all issues identified. (Best score for acute trusts was 55%. National average for acute trusts was 45%).

KF21: It is recognised that cultural and behavioural changes that need to occur will take time to realise and therefore continued & focused effort is required to reduce the gender pay gap (Data as of 31st March 2017). (Best score for acute trusts was 94%. National average for acute trusts was 83%).

KF26: KF26: Since 2016 there has been continued focus to target areas where decline is evident and to encourage Divisional discussions with local plans in place to address specific issues that need to be owned and addressed. (Best score for acute trusts is 17%, the worst is 39%. National average for acute trusts was 27%)

In 2018/19 the Equality and Diversity Lead (EDI) completed the first cohort of NHS England WRES Experts Development programme. As a result best practice from other organisations has been shared, the governance arrangements were reviewed by the EDI lead and a new WRES Implementation group was established, to ensure the WRES action plan is monitored and remains focused. A deep dive exercise using a Quality Improvement approach focussed on specific indicators was developed. One of the actions from this was to ensure all acting up posts and secondment opportunities must be advertised centrally. The WRES action plan was further updated and approved by the Board in January 2019 with additional actions including introducing reverse mentoring, diverse interview panels and exploring ways to increase board diversity.

4.2.6 Independent assurance report

Independent auditor's report to the Council of Governors of Cambridge University Hospitals NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Cambridge University Hospitals NHS Foundation Trust to perform an independent

assurance engagement in respect of Cambridge University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's Detailed Requirements for External Assurance for Quality Reports 2018/19; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Detailed Requirements for External Assurance on Quality Reports.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2018 to April 2019;
- Papers relating to quality reported to the Board over the period April 2018 to April 2019;
- Feedback from Commissioners, dated 23 April 2019;

- Feedback from governors, dated 15 April 2019;
- Feedback from local Healthwatch organisations, dated 15 April 2019;
- Feedback from Overview and Scrutiny (Health) Committee, dated 24 April 2019;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2019;
- The latest national patient survey dated 13 June 2018;
- The latest national NHS staff survey dated 26 February 2019;
- Care Quality Commission inspection, dated 26 February 2019;
- The Head of Internal Audit's annual opinion over the trust's control environment, dated 21 May 2019; and
- Any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Cambridge University Hospitals NHS Foundation Trust as a body, in reporting Cambridge University Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate that it has discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Cambridge University Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) - 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Cambridge University Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's Detailed Requirements for External Assurance for Quality Reports 2018/19; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

Signed:

Gareth Davies
Partner, for and on behalf of Mazars LLP
Date: 28 May 2019

Chartered Accountants and Statutory Auditor
Tower Bridge House
St Katharine's Way
London
E1W 1DD

4.2.7 Reporting against core indicators

The Trust's performance against the core indicators is described at *Appendix A*.

4.3 Part 3 - Other information

4.3.1 Reviewing performance against 2018/19 priorities for improvement

Safe

Our aim is to reduce avoidable harm to our patients by improving our safety culture, safety systems and how we learn from past harm.

What did we measure?	Our target	How did we do?	
		2017/18	2018/19
Trust-Wide Compliance with Sepsis 6 care bundle (ED and inpatient wards)	≥90%	Sepsis 6 bundle: ED Patients 63% (Inpatient wards baseline in was 20%)	Sepsis 6 bundle: ED Patients 62% (Inpatient wards baseline was 52%)

Why was this a priority?

The management of patients with sepsis is a key programme of work under the domain of the deteriorating patient improvement programme. Each hour delay in the application of the Sepsis 6 bundle to individual patients significantly increases their risk of death, therefore all clinical areas within the Trust need to provide a consistent high standard of bundle delivery.

What was our target?

Compliance with the sepsis six care bundle of ≥90% by March 2019 in the Emergency department (ED) and inpatient wards.

How did we measure and monitor our performance?

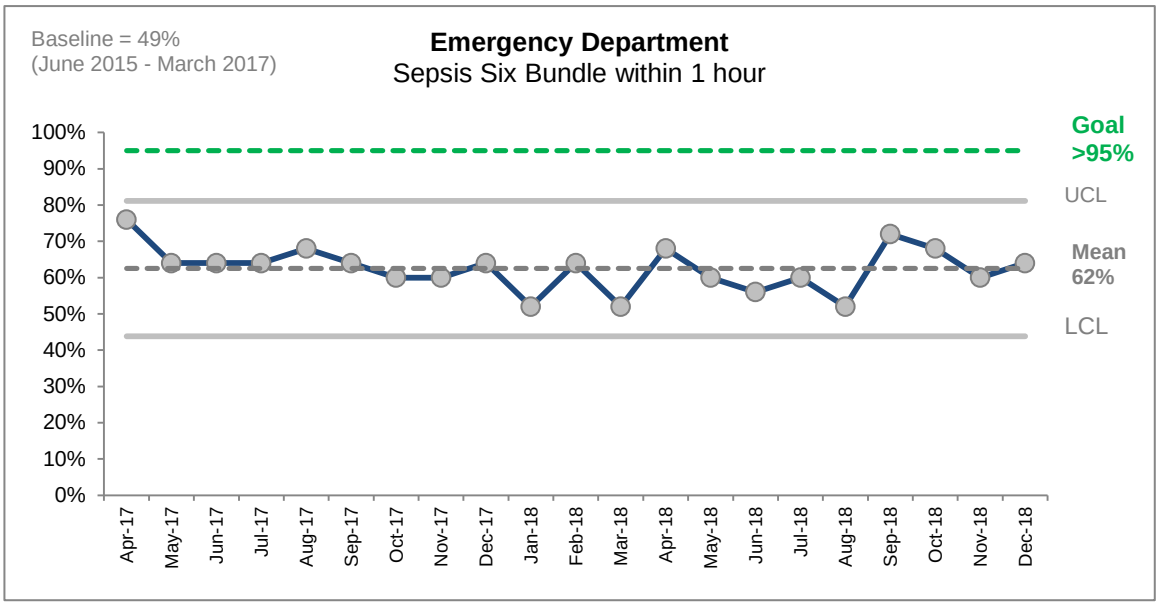
Performance is measured by the case review of 50 patients each month (25 from ED and 25 from inpatient wards). Compliance goals within the Trust were aligned to the NICE guidance for sepsis; Compliance goals for the national Sepsis CQUIN had slightly different compliance criteria explaining the difference in data reported.

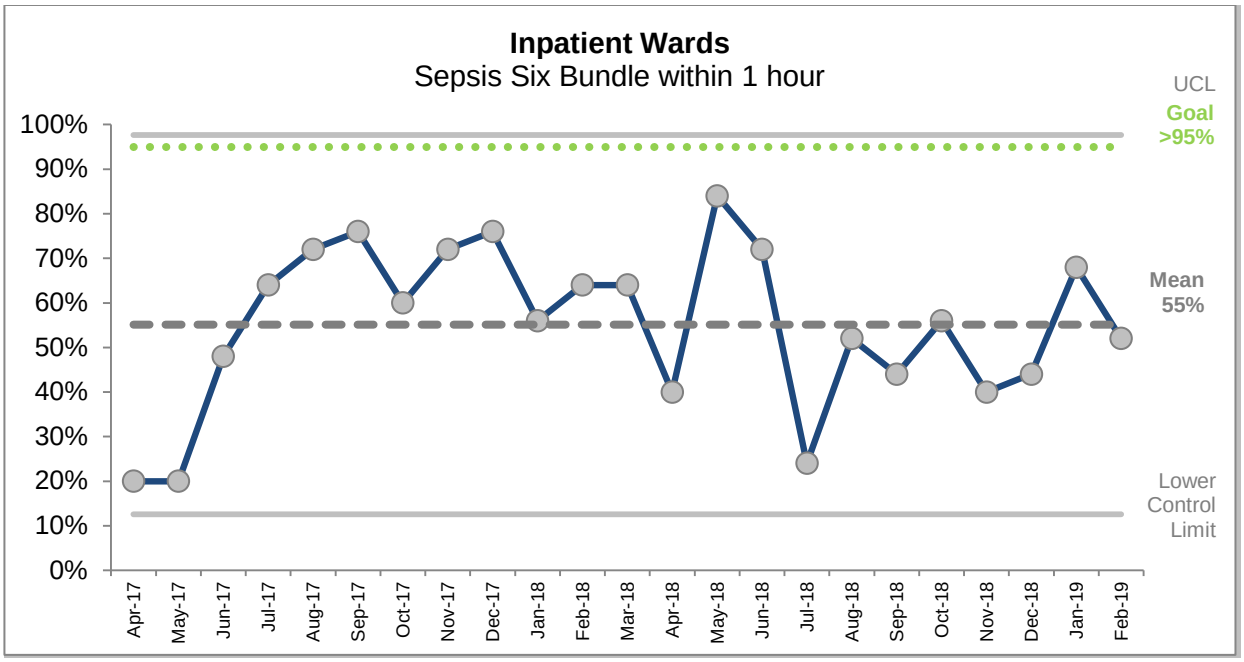
How and where was progress reported?

Compliance data is shared monthly with the Board via the Trust Integrated report, bi-monthly with the Trust Recognise and Respond Group, and bi-monthly with the Quality Committee via the Patient Safety Group's Patient Safety Report.

Did we achieve our intended target?

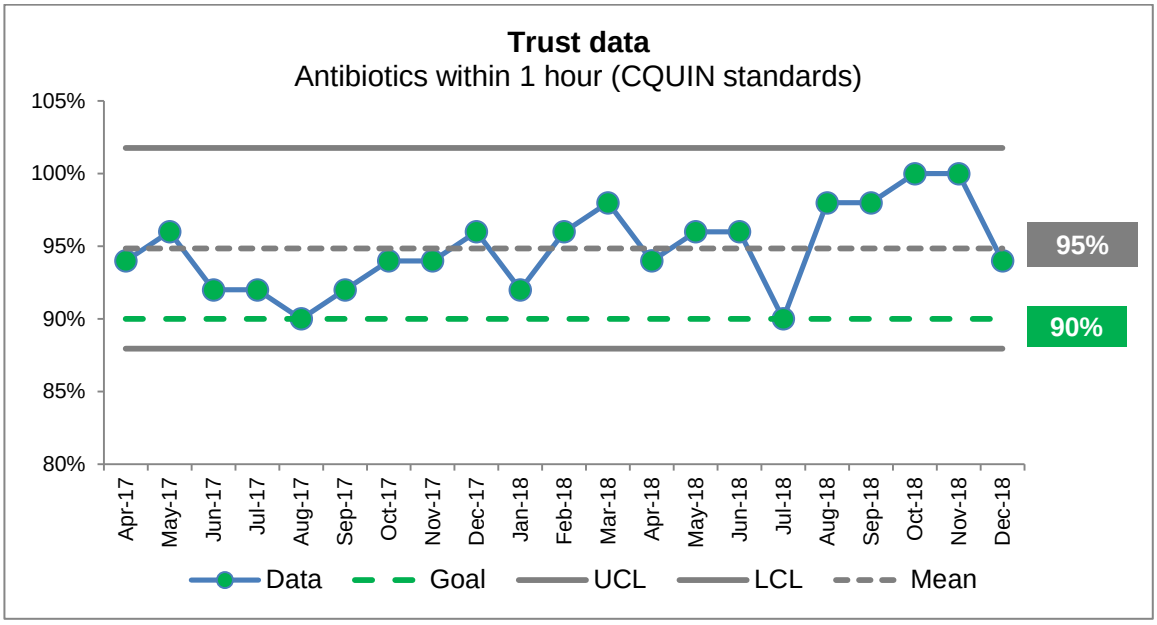
The target was not achieved in either ED of inpatient wards. However the improvements that were made in 2017/18 in ED have been sustained in 2018/19 (as shown by normal variance in the graphs below).





The data in the graphs above shows compliance with NICE standards, the CQUIN standard (compliance with antibiotics element of the bundle administered within one hour of ≥90%) are set at slightly lower threshold; this CQUIN was achieved

by the Trust (ED and in patient wards) for each month in 2018 as shown in the graph below.



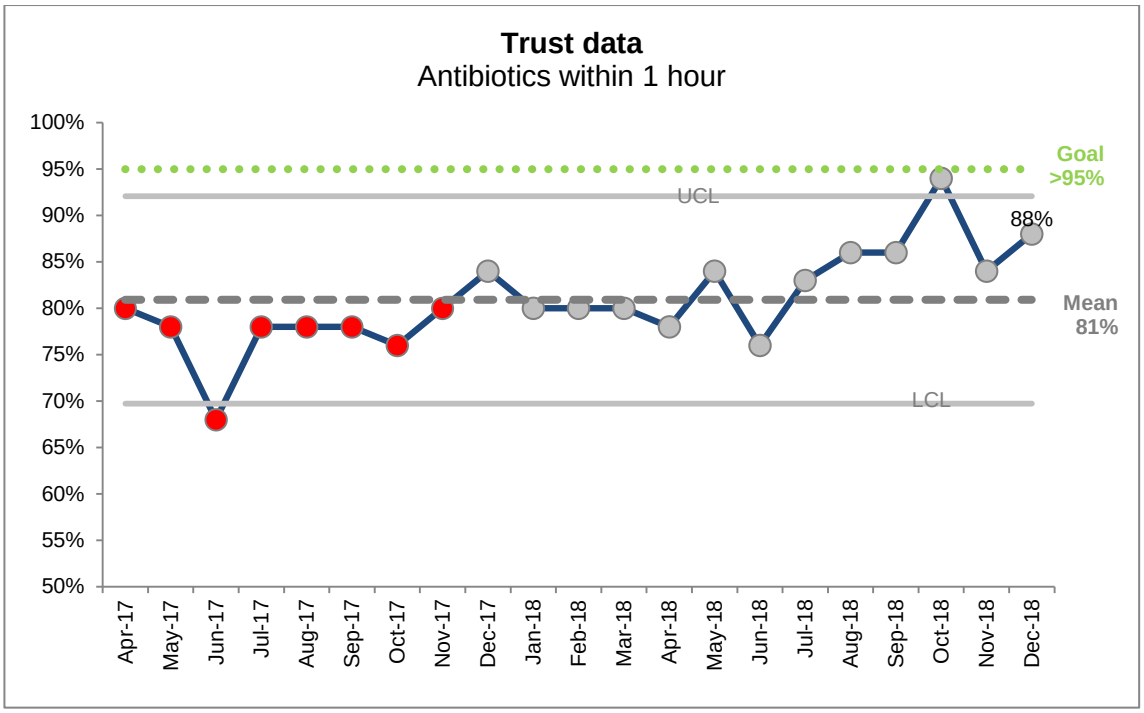
Our key achievements against this priority:

Compliance with the CQUIN standards was a key achievement in 2018/19 (antibiotic administration and screening of all patients).

Significant improvements were made in the inpatient wards compliance with the sepsis 6 bundle, with baseline compliance of 20% (April 2017) moving to improved standards in 2018/19 with normal variance around a mean of 62%.

The most essential element of the sepsis six bundle, administration of antibiotics within one hour, has shown sustained improvement in both ED and inpatient wards.

Improvement work in 2019/20 will focus on improving compliance with the other five elements of the sepsis bundle as well as achieving ≥95% compliance for antibiotic administration within one hour.



What did we measure?	Our target	How did we do?	
		2017/18	2018/19
Average reported patient safety incident rate per 1,000 bed days	5% increase on baseline (45.24)	43.09 incidents per 1,000 bed days (6,979 incidents) Q1 and Q2 2017/18 NRLS data	42.22 incidents per 1,000 bed days Q1 & Q2 2018-19 (NRLS data)

Why was this a priority?

Evidence of continuing improvements in patient safety incidents reporting reflecting a cultural shift to a proactive and learning safety culture.

What was our target?

The target was a 5% increase on baseline in 2017/18 (Q1 and Q2), of patient safety incidents reported per 1,000 bed days; that is an increase from 43.09 incidents per 1,000 bed days to 45.24).

How did we measure and monitor our performance?

The measurement is calculated by the National Learning and reporting System (NRLS) and the data is received by all trust in 6 monthly reports. However as this reporting is not timely i.e. at least six month in arrears, the data has also been run internally shared below.

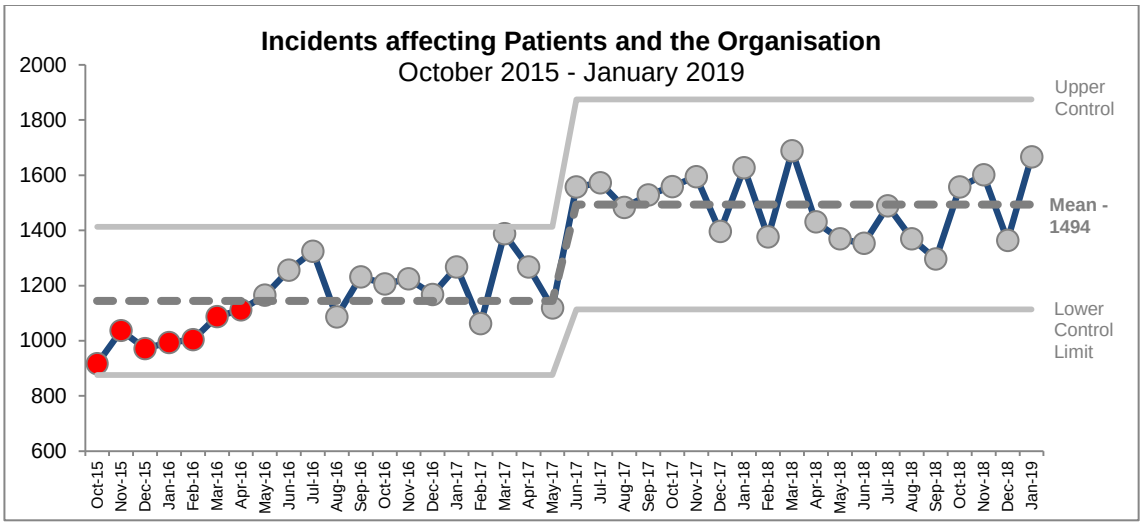
How and where was progress reported?

Progress is monitored monthly by the Boards via the Integrated report and bimonthly by the Quality Committee via the Patient safety Report.

Did we achieve our intended target?

There was no increase in reporting in 2018/19, as compared to 42.22 incidents per 1,000 bed days reported to NRLS in Q1-Q2, 2018/19.

Using internal data analysis of the number of patient safety incidents the graph below shows the improvement in reporting from June 2017 has been sustained however it has not increased further in 2018/19.



Our key achievements against this priority:

The significant increase in reporting of patient safety incidents (from June 2017) has been sustained in 2018/19.

What did we measure?	Our target	How did we do?	
		2017/18	2018/19
National Safety Standards for Invasive Procedures (NatSSIPs) % of named leads appointed	100%	0	100%
% of clinical areas (main theatres) using new audit observational tool to measure effective compliance with WHO checklist, by trained auditors	>50% in main theatres	0	50%

Why was this a priority?

The National Safety Standards for Invasive Procedures (NatSSIPs) programme brings together national and local learning from the analysis of Never Events, Serious Incidents and near misses through a set of recommendations that will help provide safer care for patients undergoing invasive procedures. This is designed to enhance the existing WHO Surgical Checklist focusing on human factors and patient safety culture and had been mandated by NHS Improvement via a Patient Safety Alert in 2015.

What was our target?

There were two process targets for the 2018/19 programme of work

1. To appoint Clinical Leads to each clinical domain supporting the implementation of the NatSSIPs programme.
2. To devise a new observation tool for the auditing of compliance with the sequential Local Safety Standards for Invasive Procedures (LocSSIPs), previously referred to as the WHO safety checklist.

How did we measure and monitor our performance?

The Clinical Leads were appointed by the Trust Director for NatSSIPs and serve on the Trust NatSSIPs implementation group.

The creation and testing of a new audit tool has been overseen by the NatSSIPs implementation group and supported by Band 7 nursing staff working in main theatres.

How and where was progress reported?

Progress has been monitored via the NatSSIPs implementation group which report to the Board via the Clinical Effectiveness Committee.

Did we achieve our intended target?

Both targets have been achieved. The newly designed observation audit tool will continue to be spread to all areas in main theatres and evolved for use in areas outside of the theatre environment. This progress will be supported by the NatSSIPs implementation programme, which will continue into 2019/20.

Our key achievements against this priority:

Two major milestones have been achieved this year by the NatSSIPs workstream: a) the sequential LocSSIPs have been devised and approved via the new NatSSIPs Implementation Group and implemented into main theatres; and b) the design of a new observational audit tool that focuses on safety systems and human factors, i.e. team effectiveness, leadership, team engagement.

This new way of auditing is a more effective measure of the impact of the NatSSIPs principles than ticking compliance with whether or not the process was carried out. This approach reflects a commitment by the Trust to implement this patient safety improvement initiative in a manner that supports staff to develop a mature safety culture that prioritises patients' safety during invasive and surgical procedures.

Effective/Responsive

Our aim is to consistently deliver high quality care that is effective, timely, patient centred and efficient.

What did we measure?	Our target	How did we do?	
		2017/18	2018/19
Number of Discharges before midday	20%	15.3%	13.0%

Why was this a priority?

Earlier discharges create capacity, supporting correct patient placement and timely flow from ED. This measure contributes to the achievement of the 4hr standard.

What was our target?

To have 20% of patients scheduled to be discharged, to be discharged before midday.

How did we measure and monitor our performance?

Performance data was captured on our internal 'ward dashboard'. Divisions monitored their performance against the metric.

How and where was progress reported?

Progress against the target was reviewed by relevant Divisional teams, with some central oversight by the Trust's Transformation team. The data was used to inform improvements required across the wards selected for focused improvement. Progress is monitored through the quality accounts process on a quarterly basis.

Did we achieve our intended target?

The target was not achieved in 2018/19.

Our key achievements against this priority:

A key enabler of early morning discharges is the utilisation of the discharge lounge. In January 2019 an average of 410 patients were discharged per month via the discharge lounge, compared to 238 between April – December 2018

What did we measure?	Our target	How did we do?	
		2017/18	2018/19
Patients that remain in an acute Trust bed for 7 days or more	10% reduction	453 patients	472 patients

Why was this a priority?

A reduction in stranded patient numbers can indicate more effective and efficient patient pathways, improved patient experience (as they are more likely to be cared for in an appropriate environment) and the creation of much-needed capacity.

What was our target?

A 10% reduction on the 2017/18 baseline to 408.

How did we measure and monitor our performance?

Performance data was captured on our internal 'ward dashboard'. Divisions monitored their performance against the metric.

How and where was progress reported?

Progress against the target was reviewed by relevant Divisional teams, with some central oversight by the Trust's Transformation team. Progress is monitored through the quality accounts process on a quarterly basis.

Did we achieve our intended target?

The target was not achieved in 2018/19.

Our key achievements against this priority:

Stranded patients reduced significantly to 426 during December 2018 when the Trust made significant progress on its 'acute hub' programme of work. This focused medical, therapy and discharge planning resources to reduce the need for onward admission of medical patients into inpatients beds.

What did we measure?	Our target	How did we do?	
		2017/18	2018/19
Accuracy of Clinically Fit Dates (CFDs)	40%	35%	31%

Why was this a priority?

The Trust uses CFDs to predict patients' likely date of discharge. The accuracy of CFDs is important and relevant as it enables the Trust to predict capacity availability, monitor patients' length of stay and match activity with demand.

What was our target?

To achieve discharge as predicted, by a CFD for 40% of patients.

How did we measure and monitor our performance?

Performance data was captured on our internal 'ward dashboard'. Divisions monitored their performance against the metric. Accuracy was also monitored through the regular bed management processes (3 times daily).

How and where was progress reported?

Progress against the target was reviewed by relevant Divisional teams. Feedback was provided via the Operations Centre through the 'business as usual' bed management processes. Progress is monitored through the quality accounts process on a quarterly basis.

Did we achieve our intended target?

The target was not achieved in 2018/19.

Our key achievements against this priority:

The Bed Planning Group produced an analysis of CFD data at its meeting in December 2018 due to the lack of progress made against this target. This identified that whilst a number of CFDs were inaccurate since patients were delayed due to complex discharge needs, there was an opportunity to improve accuracy among non-complex patients. This target is being rolled forward into 2019/20, when we will use this learning to drive our action plans.

Patient Experience/Caring

Our aim is to further improve our delivery of patient care against our values in relation to compassion and communication.

What did we measure?	Our target	How did we do?	
		2017/18	2018/19
Percentage of complaints out of the annual total received which receive a response within 30 working days or by the date agreed with the complainant.	85%	87%	78%*

Why was this a priority?

Complainants should expect to receive a resolution to their complaint in a time period that is relevant to their particular complaint. Complaints should be addressed in a timely manner to help restore complainants' confidence in the services provided by the Trust, and so that learning from complaints can be identified and disseminated as swiftly as possible.

What was our target?

The Trust aims to respond to complaints within 30 working days, but more complex cases may take longer to investigate: in those cases the complaints case

managers communicate with complainants in order to negotiate an extended timeframe for response. We aim to respond to 85% of complaints within 30 working days or by the extended date agreed with the complainant.

How did we measure and monitor our performance?

The response time is measured by counting the number of working days from receipt of a complaint to sending the response. The dates of receipt of complaint and sending the response are recorded on the 'QSIS' database on a day to day basis, together with information about negotiated extensions to the timeframe for responding. Performance can therefore be monitored in real time using the reporting functionality of the QSIS system.

How and where was progress reported?

Performance against the 30 working day target and agreed extensions to the timeframe was reported monthly in the Integrated Quality Report and bi-monthly to the Patient Experience Group, and from there to the Quality Committee of the Board.

Did we achieve our intended target?

The target of 85% of complaints receiving a response within the initial timeframe or agreed extended timeframe is unlikely to be met for 2018/19 (*currently 78% - provisional figure as some cases remain open at the time of reporting). Failure to achieve the target was due to a marked increase in complaints received by the Trust: 20% increase from 2016/17 to 2017/18 and a further 17% increase from 2017/18 to 2018/19. A requirement for increased resourcing in the complaints team was recognised and a new post recruited to mid-year, which is assisting with maintaining the current position. A new system of grading complaints, designed to allow for more proportionate investigation timeframes was introduced in January 2019, and it is expected that this change in process, together with the increased resource will lead to improved performance.

Our key achievements against this priority:

Over the course of 2018/19, the volume of complaints received has increased. The staffing in the complaints team was also increased mid-year and focus was maintained meeting the timeframes for responding to complaints, but the increase in volume has meant that performance against the responding timeframes overall has not improved. A new complaint complexity/severity grading system with associated variation in initial responding timeframes (30, 45 or 60 working days) was introduced in January 2019 in order to better reflect investigation and response timeframes and manage complainants' expectations in a more realistic way. We want to ensure that we improve and therefore we will continue to make timely responses to patients' complaints a quality priority for the Quality Account for 2019/20.

What did we measure?	Our target	How did we do?	
		2017/18	2018/19
Introduction of MyChart	My Chart available to all adult specialties by 2019	0%	100%

Why was this a priority?

MyChart is the electronic patient portal at CUH which allows patients to securely access parts of their health record held within the hospitals' electronic patient record system, called Epic. MyChart is a tool to give patients access to parts of the

health record on line to help them manage their own health care. CUH piloted MyChart initially and given the positive feedback wanted to make this available to adult patients.

What was our target?

The aim was to make MyChart available to all adult specialties so they could engage their patients with the tool.

How did we measure and monitor our performance?

Having made MyChart available to all adult specialities, we monitored the number of specialities using and the number of patients activated each month.

How and where was progress reported?

Progress was reported to the Board within the integrated report.

Did we achieve our intended target?

MyChart is available to all adult specialities. However the take up has been slow meaning that only a few patients (around 2200) are current activated on MyChart. Having identified some of the barriers, we are now working to refine our activation processes so that more patients can access MyChart.

Our key achievements against this priority:

Over 2000 patient activated to use MyChart.

What did we measure?	Our target	How did we do?	
		2017/18	2018/19
Compliance with 'ReSPECT' programme across adult inpatient specialities	Rolled out across all adult inpatient specialities by March 2019	N/A	100% (Fully implemented across all adult inpatient specialities)

Why was this a priority?

This measure relates to National best practice and has been developed by the royal colleges the RCP/GMC/BMA/RCN. This priority is also aligned to the improvements required by the CQC in how we approach resuscitation decisions within the organisation.

What was our target?

To have implemented the electronic version of ReSPECT across all inpatient areas.

To ensure adequate education in the community to allow for smooth transition of patients with a ReSPECT form.

How did we measure and monitor our performance?

We have set up a system to report the use of ReSPECT and in addition the reporting of incidents.

How and where was progress reported?

Progress has been reported to a number of forums including the senior nurses meeting and the Trust Recognise and Respond Group, reporting to the Patient Safety Committee.

Did we achieve our intended target?

Yes.

Our key achievements against this priority:

ReSPECT introduced across all inpatient areas.

No inappropriate resuscitation attempts as a consequence of the introduction of ReSPECT.

No complaints from ambulance clinicians/GP practices/Nursing homes/hospices about the transition to ReSPECT.

Staff Experience / Well-led

Our aim is to further improve the health and wellbeing of our staff to ensure we have a fit for purpose frontline workforce, leadership team, and organisational culture.

What did we measure?	Our target	How did we do?	
		2017/18	2018/19
KF 1: Staff recommendation of the organisation as a place to work or receive treatment.	2% improvement against previous year	73%	75%
KF 29: % of staff reporting errors, near misses or incidents witnessed in the last month.	2% improvement against previous year	91%	91%
KF 31: Staff confidence and security in reporting unsafe clinical practice.	2% improvement against previous year	68%	68%

Why was this a priority?

Our priorities for improvement in 2018/19 were to focus on advancing the skills and wellbeing of our staff, and ensuring that they are well led, as prerequisites for delivering safe and effective care to our patients. We also describe how we intend to measure our success in achieving this. We continue this work on staff engagement as it is an important measure to understand how staff perceive CUH as a place to work because engaged staff are more likely to provide quality care to patients and also have less sickness, stay longer with us and recommend CUH as an employer of choice. This measure forms part of our Workforce Strategy "a great place to work, people driven by CUH values and behaviours" and supports the Trust strategy around 'Strengthening the Organisation'.

What was our target?

We aimed to improve on all three measures by 2% against previous years' performance.

How did we measure and monitor our performance?

Through our national and local staff survey results we explore how staff perceive us as an employer, whether staff perceive that the organisation takes action when errors, near misses or incidents happening and that they feel confident that the organisation addresses unsafe clinical practice. We report this through the Integrated Quality/Performance report which is reviewed monthly by the Board.

How and where was progress reported?

In addition, the Workforce Integrated Report is being discussed at the Management Executive. The Workforce Experience Committee reviews the results quarterly and oversees any action plans resulting from these survey results.

Did we achieve our intended target?

We achieved an increase of 2% from last year for staff recommending the organisation as a place to work. Our results for Staff feel confident that the organisation would address concerns about unsafe clinical practice, remained the same against the question. "When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again" and staff confidence in reporting remained the same.

Our key achievements against this priority:

We continue to implement our ambitious Organisational Development Plan incorporating Culture, Climate, Leadership and Engagement. During 2018/19 we deployed our Continuous Professional Development for our staff which will continue into 2019/20. Clear links to the refreshed CUH strategy have been made to strengthen the leadership and to improve staff experience.

The Trust's overall response rate is 51.5% an increase of 2.1% on the previous year and above the national average of 44%. The Trust has an engagement score of 7.2 our or 10, this is above the national average 7.0 and an improvement on last year's score of 7.1. The Trust scored above the national average for nine or the ten themes and of the nine themes that can be compared with previous years the trust significantly improved in four of those themes with no significant change for the other 5 themes.

4.3.2 Performance against indicators and performance thresholds

The Trust's performance against the required indicators (limited to those that were included in both the Risk Assessment Framework and the Single Oversight Framework for 2018/19) is described below:

National targets – 2018/19 performance

Indicator for disclosure		Target 2018/19	CUH performance 2018/19
Referral To Treatment (RTT)	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	≥92%	**89.6%**
A&E target	Maximum waiting time of four hours from arrival to admission/ transfer/ discharge	≥95%	**85.8%** [incl. MIU]
All cancers - 62-day wait for first treatment from:	Urgent GP referral for suspected cancer	≥85%	**83.3%** [with reallocations] 79.7% [without reallocations]
	NHS Cancer Screening Service referral	≥90%	**84.4%** [with reallocations] 83.5% [without reallocations]

Indicator for disclosure		Target 2018/19	CUH performance 2018/19
Infection Prevention and Control	Clostridium difficile – variance from plan	<49 cases	**66**
Summary Hospital-level Mortality Indicator (SHMI)		We are able to maintain our lower than expected mortality	**88.2%** (Latest period available: July 2017 - June 2018)*
Diagnostic waiting times	Maximum 6-week wait for diagnostic procedures	≤1%	**1.1%**
Patient Safety	Venous thromboembolism (VTE) risk assessment	>95%	Q1: 96.4% Q2: 96.5% Q3: 96.5% Q4: **96.3%**

*CUH has a lower than expected number of deaths and overall is ranked as 14/130 of the acute trust in England with the lowest SHMI in the Eastern Region.

4.3.3 Feedback on the quality report and quality account

If you would like further information on anything contained within this report, please write to:

Director for Corporate Affairs
PO Box 146, Cambridge University Hospitals NHS Foundation Trust,
Cambridge Biomedical Campus, Hills Road, Cambridge, CB2 0QQ

Or email: trust.secretariat@addenbrookes.nhs.uk

This document is also available on request in other languages, large print and audio format – please phone 01223 274648.

Annex 1: Statement by stakeholders

Governors' statement on the quality account 2018/19

During 2018/19 the Council of Governors has been involved in i) the ongoing review of quality performance and ii) the development of the CUH quality priorities for the coming year.

At quarterly meetings attended by both governors and Non-Executive Directors (NEDs), governors have continued to scrutinise the Trust's performance against national and local quality targets, seeking assurance that issues and concerns are being effectively addressed. Participation across hospital-led committees, and the invitation this year for governor representatives to attend Board sub-committees as observers, has provided opportunities for governors to improve our understanding of Trust activities and progress against quality targets.

During the CQC inspection of CUH in Nov 18 governors from each of the elected constituencies participated in a group discussion with the inspectors, sharing our experiences and perspectives on how the Trust was operating. The outcome from the inspection - a strong 'Good' performance with several domains improved this time to 'Outstanding' - reflected the governors' view on improvements made across the Trust over the last two years.

As part of our responsibilities under the Quality Report, the Council of Governors selected the National Safety Standards for Invasive Procedures (NatSSIPs) as the indicator for focus during 2018/19, implementation of which is expected to i) reduce the number of safety incidents related to invasive procedures and ii) provide a key control against Never Events declared within the Trust. In line with the target, Leads have been appointed for each NatSSIPs working group. For 2019/20, and in line with our continued focus on capacity management and patient care, governors have selected 'Accuracy of Clinically Fit Dates' for discharge (CFD) as the quality metric to follow.

In common with the majority of NHS Trusts, CUH has again been operating within a challenging environment. During 2018/19 new initiatives have been implemented, aimed at improved management of patient flow and ultimately patient care. So far, these appear to be bringing some stability to performance. However, given the year-on-year increase in attendances, and the importance of i) strong ED performance, ii) effective discharge procedures and iii) adequate staffing on the delivery of high quality care, achievement of several of the quality targets has proved difficult. Governors will continue to scrutinise performance and progress in these areas.

Mindful of the impact vacancies can have on quality of care, governors play close attention to the results of the annual staff survey. In particular, we are keen to see i) improvements in staff morale and engagement, and ii) a correlation between this and improved retention of skilled staff. The 2018 survey results demonstrated improvements across most questions, though we were disappointed to see that results relating to i) bullying and harassment and ii) diversity and equality remained similar to the previous year despite the introduction of initiatives to address staff concerns in these areas. During 2019/20 Governors will

seek regular updates on steps being taken to sustain and improve staff engagement.

Strong progress has been made in defining the Trust's strategic plan this year. Governors will request regular updates on the projects, all of which will ultimately improve quality of care for patients. In particular, progress with delivery of the Cambridgeshire & Peterborough STP objectives and with the planning of the regional children's hospital will be reviewed by governors on a regular basis.

Julia Loudon, Lead Governor - CUH FT
15 April 2019

Cambridgeshire & Peterborough Clinical Commissioning Group (CCG) statement for inclusion in the 2018/19 quality account

Cambridgeshire and Peterborough Clinical Commissioning Group (the CCG) has reviewed the Quality Account produced by Cambridge University Hospitals NHS Foundation Trust (CUH) for 2018/19.

The CCG and CUH work closely together to review performance against quality indicators and ensure any concerns are addressed. There is a structure of regular oversight meetings in place between the CCG, CUH and other appropriate stakeholders to ensure the quality of CUH services are reviewed continuously with the commissioner throughout the year.

CUH is to be commended on a very readable and accessible quality account for 2018/19 which clearly outlines that hard work undertaken by the trust and the direct impact this has on patients and staff. The CQC report published in February 2019, based on inspections in October and November 2018, rated the trust as Good. This is a particular achievement as CUH continues to sustain and build on improvements and demonstrate Outstanding in Well-Led and End of Life Care, and maintain Outstanding for Caring overall.

This achievement should not be underestimated at a time of increasing complexity and system pressures. The CQC rated the Responsiveness domain as Required Improvement, and the CCG are impressed by the trust's ability to identify and understand their risks, that they are open and transparent and plans are swiftly put in place which have an emphasis on the safety of patients. We have seen this particularly in the speciality of Ophthalmology.

The Quality Account discusses the trust's continuing challenge of managing the flow of patients through the hospital and the targets that were not achieved in 2018/19 that they had hoped to achieve, this correlates with the CQC findings and has a direct impact on the experience of patients and carers. Complaints have increased and the CCG recognise that CUH are very aware of this and the new complaints process which went live in January is bedding in to ensure concerns are prioritised.

Within the Quality Account, 'Improving Together' demonstrates the overarching approach by the trust to the improvement of services and the emphasis on co-production including patients and the public; the CCG are eager to see how this evolves but increased and improved reporting is already apparent. This is already evident in the care of the deteriorating patient and it is really positive to see that

the trust has acted on key indicators including Serious Incidents and Mortality Reviews (Structured Judgement Reviews) to ensure this is a key priority for the trust for 2019/20.

What comes across strongly in the report is the high standards CUH sets for itself. There is excellent participation in clinical audit and research, the willingness to lead and roll out evidence based practice including the 'ReSPECT' programme and embrace new technologies including 'My Chart'.

Karen Handscomb, Deputy Chief Nurse
Cambridgeshire and Peterborough CCG
23 April 2019

Cambridgeshire County Council Health Committee statement for inclusion in the 2018/19 quality account

The Health Committee within its scrutiny capacity has not called on representatives from Cambridgeshire University Hospital over the last year to attend scrutiny committee meetings. However, committee members have maintained an open dialogue with senior leadership at the Trust through the valuable quarterly liaison meetings which are seen as an essential part of the scrutiny function.

The Committee has found this quality account overall an interesting report, with evidence of careful attention being paid to some key quality concerns.

At the start, attention is drawn to increased levels of activity in outpatients, partly driven by increased referrals and the comment made that this will be challenging if it continues (p.5). While the increase in the level of A & E activity was lower than anticipated, the outpatient figures indicate that pressures on CUH are not reducing. Quality monitoring continues at a high level with 58 audits across the year.

There is greater emphasis in priority setting for 2019-20 on cultural change and 'healthy and open communication' (Section 4.2.1). The Health Committee has been interested in CUH improvement strategies and notes the 'Improving Together' strategy being steered by the Improvement and Transformation directorate. This is an ambitious programme of improving staff skills, awareness and distributed leadership working with external improvement partners. Part of this is a focus on supporting individuals to raise concerns using the speaking up service for employees (FTSUG), with a longer term aim of culture change that enables staff to raise, and managers to work with, them to resolve issues locally. Health Committee members have recommended to CUH to consider how the responses by concerns/groups reported to the Board are being used to drive quality improvement.

We understand that DTOC challenges continue although some improvements have been made and CUH sets itself four measures for 2019-20, including a target of 20% for early discharges (p.15-16). Early discharges are defined as 'before midday' and it is to be noted that this is very ambitious since performance actually declined from 15.3% to 13% between 17/18 and 18/19 (see p.44). The Health Committee encourage CUH to monitor the new process that started in January 2019.

The emphasis on culture change links to the staff experience/well led quality targets, including one related to appraisal that is a theme in the NHS National Survey. CUH should be commended that 99% of their staff received an appraisal. Whilst it noted that only 26% of CUH staff in 2018 agreed that 'my appraisal helped me to improve how I do my job' suggesting that appraisal is not currently integrated as part of a developmental process for staff. CUH's target of improving the 2018 figure by only 2% does not seem to fit with their more ambitious culture change objectives set out in Section 4.2.1. However feedback received by the Health Committee from CUH around working to improve the quality of appraisals and the impact of staff's perception of how it helps them improve how they do their work is encouraging. In particular it was good to hear that the percentage of managers supported to receive training, learning or development has increased significantly by 6%.

The national staff survey results indicate that CUH is average or slightly better in reporting of bullying/abuse and some other measures but not on staff confidence in equal opportunities. One aspect may be addressed through the equality and diversity lead drawing on best practice elsewhere (p.36). One improvement noted is CUH moving to central advertising of all acting up/secondment opportunities, an important marker for staff of fair and equal treatment.

Quality improvement in clinical practice is driven through engaging with patients and capturing 'lessons learnt'. Work on 'Learning from Death' (p.29-34) includes in-depth analysis of the factors underlying sub-optimal care including training needs, staff levels, workload and cultural factors. The Health Committee has appreciated further clarification provided by CUH in regards to the 'Duty of Candour' (DOC) and new guidance published by NHSI which has impacted on the compliance position. It was good to hear that the safety team are working on establishing a revised process that prioritise the follow up of outstanding DOCs.

The Committee were pleased to see the CQC inspection outcome gave CUH an overall judgement of 'Good'. Health committee members have been encouraged by the Trusts positive attitude to maintain an open dialogue and will be inviting representatives to attend a health scrutiny session around the CQC improvement plan in the near future.

Kate Parker, Head of Public Health Business Programme

Cambridgeshire County Council
18 April 2019

Healthwatch Cambridgeshire and Peterborough statement for inclusion in the 2018/19 quality account

Performance

Healthwatch Cambridgeshire and Peterborough is pleased to continue to have a positive relationship with the Trust.

We notice the increase in referral rates for outpatient appointments and recommend ample time for shared decision making is maintained at all stages of the patient journey, knowing the benefits this brings for system efficiency as well as patient outcomes.

Local people often tell Healthwatch about the long waits they experience for outpatient appointments, diagnostics and pharmacy on the hospital site. It is noted that the need for better information for people as they wait for these appointments would improve safety and give reassurance.

We hear that better information would also improve people's experiences of being discharged from hospital.

Healthwatch Cambridgeshire and Peterborough note that the Quality Account does not mention compliance with the NHS England Accessible Information Standard. We ask that the need for improvement in this area being recognised in future.

It is very pleasing to see that seven-day services are being delivered for patients.

It is reassuring that the Trust participation in national audits is strong and that the associated action planning is being followed through. This gives confidence that high standards are being pursued and met.

Priorities

Healthwatch Cambridgeshire and Peterborough welcomes the priorities set out in this year's Quality Account and the clear commitments to transparency and learning. The commitment to understanding patients' journeys and involving patients in the redesign and co-production of services is particularly constructive and indicative of an open learning culture. We would value the sharing of your methods and learning from these activities through the year ahead.

The Trust's commitment to 100% compliance with Duty of Candour is very welcome and Healthwatch look forward to improvements in reaching this target in coming years.

The commitment to implementing ReSPECT and My Chart is very welcome and presents the Trust with real opportunities to develop services that wrap around the patient and put people in control of their health care.

Actions from previous Quality Accounts

Healthwatch has previously highlighted the need to improve how the Trust keeps people informed regarding their complaint and the subsequent learning. It is pleasing therefore to see commitments to put a new process in place to facilitate this.

The work that Healthwatch Cambridgeshire and Peterborough has undertaken to support the emerging Rosie Maternity Voices Group has realised remarkable benefits. This group is now thriving and a true voice for local people.

Challenges

Healthwatch Cambridgeshire and Peterborough fully understand the pressures on the in health and care system and welcome the leadership role that the Trust has taken in the Sustainability and Transformation Partnership. Engagement with the public and patients is now vital to design and implement the local NHS long term plans.

Sandie Smith, CEO - Healthwatch Cambridgeshire and Peterborough
15 April 2019

Annex 2: Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality report, directors are required to take steps to satisfy themselves that:

- the content of the Quality report meets the requirements set out in the *NHS Foundation Trust annual reporting manual 2018/19 and supporting guidance Detailed requirements for quality reports 2018/19*
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2018 to March 2019
    - papers relating to quality reported to the board over the period April 2018 to March 2019
    - feedback from commissioners dated 23 April 2019
    - feedback from governors dated 15 April 2019
    - feedback from local Healthwatch organisations dated 15 April 2019
    - feedback from overview and scrutiny committee dated 24 April 2019
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 09 May 2019
    - the 2018/19 national patient survey (latest published – National inpatient survey) 13 June 2018
    - the 2018/19 national staff survey 26 February 2019
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated 21 May 2019
    - CQC inspection report dated 26 February 2019
- the quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- the performance information reported in the Quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the Quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality report.

By order of the board

Mike More
Chair
23 May 2019

Roland Sinker
Chief Executive
23 May 2019

Appendix A: National Quality Indicators – 2018/19 performance

Ref	Indicator	CUH performance 2017/18	CUH performance 2018/19	National average	Best performer among trusts	Worst performer among trusts	Trust statement
12	(a) The value and banding of the summary hospital-level mortality indicator ('SHMI') for the Trust for the reporting period; and	Value 0.8539 Band: 3 (lower than expected) (Oct.16-Sep.17)	Value 0.882 Band: 3 (lower than expected) (Oct.17-Sep.18)	Comparison not provided nationally			CUH considers that this data is as described for the following reasons: o The Trust has a robust process for clinical coding and review of mortality data so is confident that the data is accurate. CUH intends to continue with the following actions to improve this indicator, and so the quality of its services , by: o The Trust will continue working to improve the accuracy and depth of coding whilst also implementing the new national mortality programme so that we continue to learn and improve our services.
	(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.	36%, 35% and 36% (Apr.17 – Dec.17)	41.4 % (Apr.18 – Mar.19)	Comparison not provided nationally			CUH considers that this data is as described for the following reasons: This should be a reflector of expected deaths and therefore nationally appears low. CUH intends to continue with the following actions to improve this indicator, and so the quality of its services , by: o Following the Trust's End of Life Care Operational Group action plan and the Trust's three-year End of Life Care Strategy.
18	During the reporting period,	The Trusts usually reports on the **Adjusted Average Health gain score**, which is in the CUH performance column, however this does not have details of the highest and lowest performers readily available, so I have also					

Ref	Indicator	CUH performance 2017/18	CUH performance 2018/19	National average	Best performer among trusts	Worst performer among trusts	Trust statement
	the Trust's patient reported outcome measures scores for:	included the **adjusted health gain** score to enable a comparison, although **these are not the figures normally published.** PROMs data was collected on varicose vein and groin hernia procedures in England, however following on from the NHS England Consultation on PROMs, collection of these procedures ceased on 1 October 2017. Historical data will be unaffected. **National Best and Worst performer data is not available for these PROMs.*					
	(i) groin hernia surgery	0.093 (Finalised published data @ Feb.18)	0.089 (to Sep.17)	0.089 (to Sep.17)	*	*	Not measured - collection of data on this procedure ceased on 1 October 2017 (see comments above).
	(ii) varicose vein surgery	*Low questionnaire return (less than 30) - suppressed to protect confidentiality*		-8.45 (to Sep.17)	*	*	Not measured - collection of data on this procedure ceased on 1 October 2017 (see comments above).
	(iii) hip replacement surgery and	22.645 (Finalised published data @ Aug.18)	22.783 (Finalised published data @ Feb.19)	22.7	*	*	CUH considers that this data is as described for the following reasons: o We are performing at expected levels despite a complex case mix who are operated on at CUH. CUH intends to continue with the following actions to improve this indicator, and so the quality of its services , by: o Continuing to review this data at multi-disciplinary team meetings as well as staff appraisals, and continue to strive to improve these outcomes.
	(iv) knee replacement surgery	15.6 (Finalised published	15.907 (Finalised published	17.3	*	*	CUH considers that this data is as described for the following reasons: o We are performing at the expected

Ref	Indicator	CUH performance 2017/18	CUH performance 2018/19	National average	Best performer among trusts	Worst performer among trusts	Trust statement
		data @ Aug.18)	data @ Feb.19)				case level despite a complex case mix at CUH. The knees PROMS have dipped from the last assessment the participation rate remains low as nationwide 46,099 knee replacements were performed however with a 6% return rate the statistical significant remains questionable, further analysis has been requested from NHS Digital.
							CUH intends to continue with the following actions to improve this indicator, and so the quality of its services , by: o Continuing to review this data at multi-disciplinary team meetings as well as staff appraisals, and continue to strive to improve these outcomes.
19	The percentage of patients aged:						NHS Digital has not published an update of this data since 2012; therefore we have not included this data in our 2017/18 Quality Account. In the absence of NHS Digital data we have used our own PAS system data which provides information of patients who were re-admitted to the Trust within 30 days.
	(i) 0 to 15 and	12.4% (Patients aged 0 – 14)	10.1% (Apr.-Dec.18)	Comparison not provided nationally			
	(ii) 16 or over	13.0% (Patients aged 15 and over)	12.5% (Apr.-Dec.18)				
	re-admitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.						

Ref	Indicator	CUH performance 2017/18	CUH performance 2018/19	National average	Best performer among trusts	Worst performer among trusts	Trust statement
20	The Trust's responsiveness to the personal needs of its patients during the reporting period.	71.1% (2016)	69.5% (2017*)	68.6% (2017)	85% The Royal Marsden Hospital (2017)	60.5% Barts Health NHS Trust (2017)	CUH considers that this data is as described for the following reasons: o CUH performance was slightly above the national average for the indicator 'responsiveness to the personal needs of its patients during the reporting period' in the 2017 National Inpatient Survey (**the latest survey results available*). o It was considered that there was room for improvement with respect to giving enough privacy when discussing individual conditions or treatment, ensuring that patients know there is a member of staff to talk to if they have any worries or fears, and telling our patients about medication side effects to watch for when they went home.

Ref	Indicator	CUH performance 2017/18	CUH performance 2018/19	National average	Best performer among trusts	Worst performer among trusts	Trust statement
							CUH intends to continue with the following actions to improve this indicator, and so the quality of its services , by: o An action plan addressing the above issues is created by a working group for the National Inpatient Survey, overseen by the Patient Experience Group. o Discussing the results in nursing meetings. o The 'My Chart' patient portal, which gives patients access to their electronic patient record, continues to be rolled out to new patients.
21	The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	83%	84%	71%	*	*	CUH considers that this data is as described for the following reasons: o CUH performed in the top ten best performing non specialist trusts against this statement (as a Key Finding). o This is an improvement on the previous score and well above the national average. o Reasons for this improvement include the quality of staff that we recruit and develop, improved staff engagement and increased focus on quality and safety.
							CUH intends to continue with the following actions to improve this indicator, and so the quality of its services , by:

Ref	Indicator	CUH performance 2017/18	CUH performance 2018/19	National average	Best performer among trusts	Worst performer among trusts	Trust statement
							o Maintaining the focus on quality and safety, and the implementation of the Trust organisational development programme, which is intended to positively impact on staff engagement, culture and leadership. ***There are no best or worst performer results for this question for Key findings. (Ref: NHS England website staff survey results). This can be obtained if we use KF1.***
23	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	Q1: 96.76% Q2: 95.7% Q3: 94.9% Q4: 96.6%	Q1: 96.4% Q2: 96.5% Q3: 96.5% Q4: 96.3%	95.2% (England – March 2018)	67% (MK University Hospital NHS - March 2018)	100% (Essex Partnership University Hospital NHS – March 2018)	CUH considers that this data is as described for the following reasons: o The Trust has a robust process for clinical coding and review of VTE data so is confident that the data is accurate. CUH intends to take the following actions to improve this percentage, and so the quality of its services: o The Trust will continue working to improve the accuracy and depth of coding. o The Trust VTE safety and quality group will continue to monitor VTE risk assessment across the Trust and identify areas where improvement is required.

Ref	Indicator	CUH performance 2017/18	CUH performance 2018/19	National average	Best performer among trusts	Worst performer among trusts	Trust statement
24	The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	14.5 (2016/17) 20.5 (2017/18)	20.2* (April.18-March.19) Total numbers of CDT was 66 in 2018/19	13.7** (from all NHS acute trusts 2017/18)	0** (from all NHS acute trusts) From Shelford Group: 7.9* (2017/18 from Guy's & St. Thomas')	91** (from all NHS acute trusts) From Shelford Group: 27.4* (2017/18 from University College Hospital London)	CUH considers that this data is as described for the following reasons: o We are only able to calculate bed days using last year's data as current data is not available. o We do not have complete data for 2018/19 from all NHS acute trusts or Shelford group. **We use 2017/18's bed days numbers for calculation* ***2018/19 data is not available at time of publication*
25	The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	Number incidents reported: 6,979 Rate of reporting: 43.09 Rate resulted in severe harm or death: 0.13 (21 incidents) based on NRLS data	Number incidents reported: 7,089 Rate of reporting: 42.22 Rate resulted in severe harm or death: 0.11 (19 incidents) based on NRLS data	Number of incidents reported: 5,583 Rate of reporting: 44.5 Rate resulted in harm or death: 0.15 (18.9 incidents) Based on NRLS data	Number of incidents reported: 23.692 Rate of reporting: 51.9 Rate resulted in harm or death: 0.19 (87 incidents) Based on NRLS data	Number of incidents reported: 566 Rate of reporting: 13.1 Rate resulted in harm or death: 0.07 (3 incidents) Based on NRLS data	CUH considers that this data is as described for the following reasons: o The increased reporting in 2017/18 has been sustained in 2018/19 although a further increase has not been achieved at the goals set by the Trust. o The rate of moderate harm (Patient safety) incidents and above remains below the Trust threshold of 2% consistently each month during 2018/2019 CUH intends to continue with the following actions to improve this indicator, and so the quality of its services , by: o The Patient Safety Improvement Plan 2018/20 will continue to

Ref	Indicator	CUH performance 2017/18	CUH performance 2018/19	National average	Best performer among trusts	Worst performer among trusts	Trust statement
		Q1/2, 2017/18	Q1/2, 2018/19	Q1/2, 2018/19	Q1/2, 2018/19	Q1/2, 2018/19	strengthen the quality and quantity of patient safety incident reporting to help the Trust learn and improve care for patients. o In 2019/20 the improvement activities will focus on how the Trust can strengthen the psychological safety that staff feel in regards to reporting concerns and incidents by introducing a 'Just Culture' improvement programme and After Action Reviews.

Appendix B: HQIP National Clinical Audits

(Cut off for data inclusion: 12/02/2019)

Title	Outcome
Paediatric Intensive Care Audit Network (PICAnet) Annual Report 2017	The Trust received the report in November 2017. Findings and planned actions were presented to the Clinical Audit Committee in April 2018. The PICAnet audit aims to continually support the improvement of paediatric intensive care provision throughout the UK by providing detailed information on paediatric intensive care activity and outcomes. It collects personal, organisational and clinical data on all children with a clinically determined need for paediatric intensive care. It audits the quality of care delivered against the Paediatric Intensive Care Society (PICS) standards, which cover the whole patient pathway from the initial referral to paediatric intensive care, specialist transport and then inpatient care. Key Findings and Learning: Nationally, paediatric intensive care units were operating under increased pressure as numbers of patients increased and specialist nursing staff was not always available for all shifts. The Paediatric Intensive Care Unit (PICU) in Addenbrooke's had 1897 admissions during the audit period which represent 3.16% of the national audit. CUH monitors the mortality of our patients and it is within acceptable national standards including when adjusted for case mix. Admissions per consultant are high and would be expected to deteriorate in the 2017 data because of an additional consultant vacancy. There is a national shortage of paediatric intensive care consultants which makes this role difficult to recruit to. Nursing staffing on PICU is also lower than the national standard and this is addressed in innovative ways. Nurse advanced resuscitation training is below the national standard. Funding for nurse training was removed in the period leading up to this audit. However, overall CUH's PICU continues to maintain a high national reputation and the audit outcomes match the best in the UK and Ireland. Planned Actions: CUH will continue the recruitment to the consultant and the nursing vacancies. Bank staff to cover any shortfalls whenever possible. Steps are being taken to reinstate access to training for our nursing team as part of the training and career development opportunities for nursing staff.
Raising to the Challenge, 4th SSNAP Annual Report 2017	The Trust received the report in November 2017. Findings and planned actions were presented to the Clinical Audit Committee in April 2018. The Sentinel Stroke National Audit Programme (SSNAP) measures the quality and organisation of stroke care in the NHS. Key Findings and Learning: The audit results showed CUH's continued improvement in stroke care despite increasing difficulty with access to stroke unit beds due to lack of effective bed management policy. On a scale from A – E, with A being the best performers, CUH now scores a rating of B from previously D. This is largely due to better staffing since 2016. CUH are also able to support improved data collection for the audit and have a realistic ambition to get to an 'A' rating in the near future. The Trust

Title	Outcome
	is still limited in its ability to deliver many acute elements of care due to a limited number of beds. Planned Action: Bed management plan was reviewed with Chief Operating Officer and up-dated.
National Neonatal Audit Programme NNAP - 2017 Annual Report on 2016 data	The Trust received the report in November 2017. Findings and planned actions were presented to the Clinical Audit Committee in April 2018. The NNAP monitors the standard of care provided by specialist neonatal units is to inform efforts to give all babies the best possible chance of surviving and reaching their full potential. 8 standards are monitored in this audit. Key Findings and Learning: CUH performs better than the national average on the following standards: antenatal steroids, mothers who were given Magnesium Sulphate, consultation with parents, bronchopulmonary dysplasia, mother's milk at time of discharge, clinical follow-up at 2 years of age. The Trust was the same as the national average for the baby's temperature within range. CUH was below the national average for screening for retinopathy of prematurity with 87% compared to 94% nationally. Planned Actions: Active programme to continue to further increase number of babies receiving mother's milk at discharge. Improve temperature control for babies on admission through raising staff awareness and education. Correct data input and reduction of manual double data entry could be improved by having a reliable interface between electronic patient record and the maternity system 'Badgernet'. CUH is engaged with and supportive of initiatives to address this. Continue to work towards improving temperature control and pay greater attention to avoid hyperthermia which may have resulted from attempts to reduce hypothermia, which had been an issue in the past.
Maternal, Newborn and Infant programme: MBRRACE-UK Perinatal Confidential Enquiry Report 2017 (Nov.17)	The Trust received the report in January 2018. Findings and planned actions were presented to the Clinical Audit Committee in April 2018. Since the last confidential enquiry into intrapartum stillbirths and intrapartum-related deaths in 1993-1995, overall stillbirth rates have reduced by just over a fifth and neonatal death rates by over a third. Nevertheless the UK rates are still high compared with other European and other high income countries. The enquiry aimed to identify potentially preventable failures of care along the whole care pathway, but with a particular focus on care during labour, delivery and any resuscitation, which might have contributed to the death. The results are not broken down by Trusts. Key Findings and Learning: The overall key findings from the confidential enquiry are listed below:

<table>
<tr><th>Title</th><th>Outcome</th></tr>
<tr><td></td><td>
<table>
<tr><th rowspan="3">Overall quality of care</th><th colspan="4">Stillbirth</th><th colspan="4">Neonatal Death</th></tr>
<tr><th colspan="2">Baby</th><th colspan="2">Mother</th><th colspan="2">Baby</th><th colspan="2">Mother</th></tr>
<tr><th>n</th><th>%</th><th>n</th><th>%</th><th>n</th><th>%</th><th>n</th><th>%</th></tr>
<tr><td>Good care; no improvements identified</td><td>3</td><td>8</td><td>12</td><td>30</td><td>2</td><td>5</td><td>10</td><td>26</td></tr>
<tr><td>Improvements in care identified which would have made no difference to outcome</td><td>6</td><td>15</td><td>10</td><td>25</td><td>6</td><td>16</td><td>9</td><td>24</td></tr>
<tr><td>Improvements in care identified which may have made a difference to outcome</td><td>31</td><td>78</td><td>18</td><td>45</td><td>30</td><td>79</td><td>19</td><td>50</td></tr>
<tr><td>Total</td><td>40</td><td>100</td><td>40</td><td>100</td><td>38</td><td>100</td><td>38</td><td>100</td></tr>
</table>
The consensus of the enquiry was that the care after delivery, physical and psychological outcome and/or future fertility for the mother, in just under half of intrapartum stillbirths (45%) and half of intrapartum-related neonatal deaths that improvements in care may have made a difference.
Capacity and staffing issues were identified in about 35% of cases, playing a role in the outcomes for mother and baby. Issues with delays in transfers to the delivery unit and delays in induction of labour or performing artificial rupture of membranes because if increased activity in the delivery unit. Such delays suggest that during periods of high activity the ability of the wider maternity service to cope with the demand for one-to-one care and/or timely review by obstetric or medical staff is sometimes compromised.100
Planned Actions:
The maternity services to note the findings and to integrate these into existing action plans.
</td></tr>
<tr><td>Annual Report of the National Lung Cancer Audit 2017</td><td>
The Trust received the National Lung Cancer Audit (NLCA) report in January 2018. Findings and planned actions were presented to the Clinical Audit Committee in April 2018.
The audit reviews covers the care and treatment of patients with a diagnosis of lung cancer. The data is broken down by England, Wales and Guernsey.
Key Findings and Learning:
CUH's completeness of data submission is above the national mean for all metrics, including for stage and performance status.
Clinical results are above the national mean for all metrics, including pathologic confirmation of diagnosis, pathologic subtyping and patient access to lung cancer specialist nurse.
CUH unadjusted surgical resection rates and one year survival were above the national mean but not statistically significantly different to the national mean when adjusted for age, sex, stage, socio-economic status and co-morbidity.
There has been a marked improvement in data completeness in Cancer
</td></tr>
</table>

Title	Outcome
	Outcomes and Services Dataset (COSD) submissions extracted from EPIC (2016 data) in comparison to the previous year. CUH use of the systemic anti-cancer therapy (SACT) for advanced Non-small-cell lung carcinoma (NSCLC) has been above the national mean in previous reports. Although not an outlier in this report, SACT use appeared lower than in previous years. Planned Actions: No improvement action plan is required however patient level data from COSD has been reviewed to further understand key metrics.
Specialist rehabilitation for patients with complex needs following major injury (Dec.17)	The Trust received the report in December 2017. Findings and planned actions were presented to the Clinical Audit Committee in April 2018. The audit aims to determine the scope, provision, quality and efficiency of specialist rehabilitation services across England and improve the quality of care for adults with complex rehabilitation needs following major trauma. This audit is currently in the phase to define standards and improve the quality of the data collection. Key Findings and Learning: The East of England (EoE) has the lowest number of level 1 and level 2 beds for specialist and trauma rehabilitation per million populations. CUH provides 10 programmed activities rehabilitation consultant input to trauma patients which was only achieved by three other major trauma centres in the country. In additional the EoE trauma network has a dedicated rehabilitation consultant who is responsible for trauma rehabilitation. Therefore CUH was able to collect all four tools for the audit. Planned Actions: Rehabilitation development strategy across the region currently carried out by the Trauma Rehabilitation Network Coordinator. Service development and expansion of inpatient rehabilitation within the Major Trauma Centre and in the Cambridgeshire Clinical Commissioning Group (CCG) lead by the service lead in Rehabilitation at CUH.
National Bowel Cancer Clinical Audit Programme (NBOCAP) (Dec.17)	The Trust received the report in December 2017. Findings and planned actions were presented to the Clinical Audit Committee in April 2018. The National Bowel Cancer Audit (NBOCAP) describes and compares the care and outcomes of patients diagnosed with bowel cancer in England and Wales. Key Findings and Learning: • Risk adjusted mortality rates in line with expected. • Risk adjusted 18 month temporary stoma rate with expected range. • Case ascertainment is above the expected standard of 80%. • Risk adjusted post-operative length of stay - worse than national average. • High resection rate of 69% undergoing potentially curative resection. • Laparoscopic surgery rates were lower than the national average. All surgeons were trained to carry out laparoscopic surgery which should increase in laparoscopic surgery rate. • CUH has a slightly higher than average emergency procedures – this is mostly due to factors beyond our control.

Title	Outcome
	Planned Actions: Findings and action plan disseminated to relevant leads to raise awareness.
National Oesophago-Gastric Cancer Audit Report(NOGC) 2017 (Dec.17)	The Trust received the report in December 2017. Findings and planned actions were presented to the Clinical Audit Committee in April 2018. The National Oesophago-Gastric Cancer Audit covers the quality of care given to patients with oesophago-gastric (OG) cancer and oesophageal high-grade glandular dysplasia (HGD). Its long-term goals are to provide information that enables NHS cancer services to benchmark their performance and to identify areas where aspects of care could be improved. Key Findings and Learning: CUH performs well in endoscopic and surgical management of patients with HGD and invasive oesophago-gastric cancer. 207 surgical cases were entered by CUH with a 1.5% 90 day post-operative mortality, which is one of the lowest in England. All other quality outcome measures were either within expected range or better, e.g. CUH's average length of stay was 10 days which is 2 days shorter than the national average. 53 cases with HGD were entered by CUH, the second highest in the England with 97-100% data completeness. The number of cases submitted remains at approximately 80% year on year. 25% of patients entered into the audit by CUH had an "unknown" referral source and only 77% were reported to have had a staging computerised tomography scan. CUH was an outlier for these data items compared with the best performing trusts and this is reviewed and addressed when collating and submitting the data to the national data collection. Planned Actions: Working towards 100% of eligible cases to be entered into NOGCA and improve accuracy of data fields. Work to be undertaken to examine the process for data collection from electronic patient record and submission to NOGCA. A quarterly internal audit of data completeness and accuracy will be conducted for 12 months.
Annual report 2017 National Prostate Cancer Audit (Nov.17)	The Trust received the report in November 2017. Findings and planned actions were presented to the Clinical Audit Committee in July 2018. The National Prostate Cancer Audit (NPCA) assesses the process of care and its outcomes in all men diagnosed with prostate cancer in England and Wales. Key Findings and Learning: Overall the CUH prostate cancer service performs above the national average. The data submitted for this report had been collected whilst the CUH electronic patient record was not built for this. A better process for data extraction is now in place and submitted data should be of better quality. Planned Actions: Results from this audit has been reviewed and discussed by the Prostate Multidisciplinary Team which includes urologist and oncologists.

Title	Outcome
	On-going work with the electronic patient records team about improving data extraction is part of the on-going process of improving data collection.
National Diabetes Audit, 2016-17 Report 1: Care Process and Treatment Targets (Mar.18)	The Trust received the report in March 2018. Findings and planned actions were presented to the Clinical Audit Committee in July 2018. The National Diabetes Audit provides a comprehensive view of diabetes care in England and Wales and measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards 1 and 2. Key Findings and Learning: The percentage of care processes carried out for patients with type 1 diabetes was higher than expected for average blood glucose (sugar) (HbA1c), blood pressure (BP), urine albumin, BMI and overall for all 8 care processes. The percentage of care processes carried out in patients with type 2 diabetes was higher than expected for HbA1c urine albumin and recording of body mass index (BMI). 5 other care process where as expected with exception of foot surveillance which was lower than expected. For treatment targets and structured education a comparison against the overall England figures is difficult to interpret as they include both primary and secondary care settings. CUH will compare itself against similar centres as part of the action plan. Planned Actions: Establish which specialist centres have similar patient populations for type 1 and 2 diabetes to enable comparison of performance against treatment target achievement, percentage offered/attending structured education with similar organisations. Memorandum sent to health care professionals on better completion of above fields to improve recording.
Third Annual Report on National Diabetes Footcare Audit; 2014-2017 (Mar.18)	The Trust received the report in March 2018. Findings and planned actions were presented to the Clinical Audit Committee in July 2018. There is a clear association between ulcer severity at first expert assessment and likelihood of admission for in-patient foot disease management. Key Findings and Learning: Key Findings and Learning are very similar to previous findings. This is to be expected with data drawn so soon after the previous report and with data derived from same source. CUH's patient demographics closely matched the "national profile" of foot patients. CUH 2.8% patients are in the bottom deprivation quintile versus 26% nationally. While nationally 43 % of patients had met treatment target for long term glycaemic control (judged by HbA1c), only 32 % of CUH's patients had met the target. While nationally only 45% of ulcers presenting were "severe", in CUH's clinic 63% of ulcers presenting were rated as "severe". CUH's patient outcomes were that at 24-weeks after the first assessment that 39 % of CUH's patients were reported to be ulcer free versus 58% nationally.

Title	Outcome
	60% of patients were admitted in the 6 months after presentation versus 50% nationally. 18% of CUH's patients had a revascularisation procedure, compared to 8% nationally. In many cases, patients present to our service for the first time later in the disease process when compared to the national average. CUH appears to have a lower rate of self-referral than national average (CUH 8% versus 28% nationally). This is despite CUH running 5 days a week service with "seen same day" offered if clinically needed to all patients and healthcare practitioners. It is of note, that 21% were not seen by CUH for 2 or more months after initial presentation to another healthcare professional versus 9% nationally). 2.1% of CUH's patients had a major amputation compared to 1.7 % nationally; this is to be expected for a regional intervention centre. Planned Actions: Findings and recommendations disseminated to specialty areas. Service evaluation to be completed to give a clear steer as to why there are later referrals; no single location or referral source is apparent. Similar problems have been identified nationally in other centres running a foot service. A team will look forward to tackling this long standing problem with our partners. CUH will also use the GIRFT ("getting it right first time") deep dive visit in October 2018 as an opportunity to focus on this crucial interaction between primary and secondary care. CUH will be presenting the foot service and the issues highlighted by this report at the re-launch of the East of England Diabetic Footcare Network in September 2018 to discuss results and possible solutions.
National Diabetes Inpatient Audit, England and Wales 2017 (Mar.18)	The Trust received the report in March 2018. Findings and planned actions were presented to the Clinical Audit Committee in July 2018. The National Diabetes Inpatient Audit (NaDIA) measures the quality of diabetes care provided to people with diabetes while they are admitted to hospital. Key Findings and Learning: • Improvements have been achieved in medication error rates. • In-patient hypoglycaemia rates have reduced. • Understanding processes that underlie insulin timing errors. • Early involvement of MDT foot team in care of patients with diabetes admitted with co-existing foot disease. Planned Actions: To conduct a case-based analysis of data from the NaDIA 2017 report to review the cases of 'insulin given/prescribed at the wrong time' to determine underlying themes. Display posters of the 'Diabetic Foot Pathway' in admitting areas particularly in the Emergency Department (ED). Member of foot team to organise visits to ED to raise awareness of pathway and profile of Diabetes Foot Team. Results presented at Diabetes MDT meeting.

Title	Outcome
National Audit of Inpatient Falls Audit report 2017 (Nov.17)	The Trust received the report in November 2017. Findings and planned actions were presented to the Clinical Audit Committee in July 2018. The National Audit of Inpatient Falls aims to improve the delivery of care for patients who have falls or sustain fractures through effective measurement against standards and feedback to providers. Key Findings and Learning: In the provision of call bells and the assessment of vision CUH was above the national average and CUH was 100% in the provision of mobility aids. The assessment and management of delirium and medication reviews specific to falls management were areas that were highlighted as requiring improvement nationally; however CUH was above the national average in both areas. The Trust provision of continence care was 40% (85% nationally) and none of the patients reviewed had a record of lying and standing blood pressure (compared to 19% nationally). Planned Actions: The audit results were presented at the Trust's Falls and Pressure Ulcer Steering Group. The key actions for continence assessment and management and the recording of lying and standing blood pressure have been incorporated into the Trust Falls Quality Improvement plan.
National vascular registry 2017 annual report (Nov.17)	The Trust received the report in November 2017. Findings and planned actions were presented to the Clinical Audit Committee in October 2018. The registry is designed to support quality improvement within NHS hospitals performing vascular surgery by providing information on their performance. Key Findings and Learning: Ruptured Abdominal aortic aneurysm (AAA) (2014-16 data) - Good outcomes with a good use of endovascular aneurysm repair (EVAR). CUH meets national guidance for offered EVAR with 58% of appropriate patients being offered an EVAR (national 25%). Outcomes such as mortality and stroke remain good. Delays in access to treatment remain a challenge, particular for carotid and AAA surgery, but a new pathway co-ordinator should improve this. Data entry for amputations and angioplasty remains low. New data clerk should improve data entry. Planned Actions: Pathway coordinator for both procedures appointed in March 2018. This should lead to improvement in our delays of treatments. Lower Limb Intervention - Data clerk to assist with data entry onto the NVR in post which will support better case ascertainment rates. Amputee Pathway Multidisciplinary Team (MDT) in place to improve care in line with the national recommended pathway. Further improvements and on-going pathway audits planned.
National Diabetes Insulin Pump Audit 2016-2017 (Jun.18)	The Trust received the report in June 2018. Findings and planned actions were presented to the Clinical Audit Committee in October 2018. The Insulin Pump Audit collects information on the number and characteristics of people with diabetes using an insulin pump, the reasons

Title	Outcome
	for going on an insulin pump and the outcomes achieved since starting the pump. Key Findings and Learning: CUH is a large insulin pump centre with a high percentage of patients receiving insulin pump therapy. Hyperglycaemia is better controlled in patients attending CUH with or without insulin pump therapy compared to other centres. Hyperglycaemia as judged by average blood sugar (HbA1c) was better controlled in patients receiving insulin pump therapy attending CUH compared to other participating hospitals. CUH had the highest number of patients receiving insulin pump therapy in this audit with 635 patients on insulin pumps. 36.5% of people with type 1 diabetes seen a CUH were receiving insulin pump therapy compared with 15.6% for all participating hospitals. Hyperglycaemia was also better controlled in CUH patients not on an insulin pump compared to other participating hospitals. Planned Actions: Findings presented at the speciality areas and disseminated to staff.
National Mesothelioma Audit report 2018 (Jun.18)	The Trust received the report in June 2018. Findings and planned actions were presented to the Clinical Audit Committee in October 2018. The National Mesothelioma Audits aim is to raise the profile of this asbestos-related cancer and to make recommendations to improve outcomes for mesothelioma patients. Key Findings and Learning: CUH performance is above the mean for England and has shown an improvement since the 2017 report to 66.7%. Data capture still does not reflect clinical practice in some areas e.g. Specialty Nurse, Multidisciplinary Teams and Performance Status. Planned Actions: Presented at the Cancer Board and the Oncology Governance Meeting in October 2018. Key actions agreed following the 2017 report regarding data capture have improved the Trust's performance to ensure clinical practice is accurately reflected and to improve data quality/capture for Clinical Nurse Specialists (CNS), Multidisciplinary Team (MDT) and performance status by using cancer episodes and generating regular data quality reports.
National Audit of Breast Cancer in Older Patients NABCOP: 2018 Annual Report (May.18)	The Trust received the report in May 2018. Findings and planned actions were presented to the Clinical Audit Committee in October 2018. This national audit is designed to set the benchmark nationally for outcomes for older women with breast cancer. Key Findings and Learning: CUH amongst the leading Trusts for most parameters in women over 70 years. Planned Actions: There is no change in practice planned. Decisions are approved at the mandatory multidisciplinary meeting for every patient that undergoes triple

Title	Outcome
	assessment in the breast clinic. Data capture or data extraction are areas of improvement for England and Wales (including CUH) to ensure good and complete quality data is submitted to the audit.
National Maternity and Perinatal Audit (NMPA): Clinical report 2017 (May.18)	The Trust received the report in May 2018. Findings and planned actions were presented to the Clinical Audit Committee in October 2018. The audit consists of three separate but related elements: • An organisational survey of maternity and neonatal care in England, Scotland and Wales providing an up-to-date overview of care provision, and services and options available to women • A continuous clinical audit of a number of key measures to identify unexpected variation between service providers or regions • A programme of periodic 'sprint' audits on specific topics. Key Findings and Learning: CUH was within expected for our 'vaginal birth after caesarean section' rate, instrumental delivery rate, early elective deliveries and small for gestational age at 40 weeks compared to all sites mean. CUH had a lower than expected rate for induction of labour, caesarean section and haemorrhage over 1500mls. The outlying parameters in the audit findings for CUH versus the 'all sites mean' were positive findings – lower caesarean section rate, lower haemorrhage rate and lower induction rate and the normal delivery rate. No significant concerns were identified for CUH. Planned Actions: No further actions required but continue to monitor our dashboard and work to maintain standards. Findings and recommendations presented at the specialities.
MBRRACE-UK Perinatal Mortality Surveillance Report 2018 (Jun.18)	The Trust received the report in June 2018. Findings and planned actions were presented to the Clinical Audit Committee in October 2018. The fourth MBRRACE-UK Perinatal Mortality Surveillance Report provides information on extended perinatal deaths in the UK and Crown Dependencies arising from births during 2016. Key Findings and Learning: CUH performance for perinatal mortality is up to 10% lower than group average. CUH's compliance with data collection was over 90% for antenatal care, delivery and babies characteristics for still-births, delivery and babies characteristics for neonatal deaths as well as baby's outcome. Further improvement is required for incomplete data on mother's details (72.1%) and booking information (62.8%). The maternity team have been working on including smoking data as this is one of the 'saving babies lives' care bundle. Planned Actions: Workforce planning with birth rate plus. Funding agreed for new consultant. Audit regarding transfers started. Human Factors Faculty established and training rolled out September 2017 for 15 - 20 maternity, medical, anaesthetic and neonatal staff each month.

Title	Outcome
	Use of Perinatal Mortality Review Tool commenced locally for all stillbirths since January 2018.
NCEPOD: Chronic Neurodisability - Each and Every Need Report 2018 (Jul.18)	The Trust received the report in July 2018. Findings and planned actions were presented to the Clinical Audit Committee in January 2019. This NCEPOD report focuses on the quality provided to children and young people with chronic disabling conditions, focusing in particular on cerebral palsies. Key recommendations relating to: • Improving clinical coding and quality of routine data • Clinical care - diagnosis and management • Clinical care - clinical leads and care plans • Transition and age appropriate care • Clinical care - communication • Organisation of care Key Findings and Learning: Good working with community colleagues in complex neurological conditions. Joint working to implement the Cerebral Palsy Integrated Pathway UK. Joint training events supported by consultants. Children with epilepsy requiring rescue medication will have an epilepsy care plan if they are seen by the consultants in this region. Quality of data recording remains dependent on the clinician entering the data. Standard practice should be information in notes and clinical correspondence commencing with diagnosis, distribution and severity. Children from North Cambridgeshire do not have support from epilepsy nurses or an epilepsy care plan. Planned Actions: All staff (including non-paediatric specialists) need to adopt standard nomenclature and grading of chronic conditions. The Community Service developed a ''Patient Passport'' on the community electronic patient record for parents of children with high levels of need. Discussions to include all Eastern community trusts. The template is based on the requirements of the NCEPOD guidance and would be updated at each clinical contact.
National Paediatric Diabetes Audit (NPDA) (Aug.18)	The Trust received the report in August 2018. Findings and planned actions were presented to the Clinical Audit Committee in January 2019. The National Pregnancy in Diabetes Audit measures the quality of antenatal care and pregnancy outcomes for women with pre-gestational diabetes. This audit addresses three high level questions whilst measuring results against updated NICE guideline: • Were women with diabetes adequately prepared for pregnancy? • Were appropriate steps taken during pregnancy to minimise adverse outcomes to the mother? • Were adverse neonatal outcomes minimised? Key Findings and Learning: Improvements in the delivery of care processes. CUH moved from being an outlier to above the national average in two years. CUH had previously been

Title	Outcome
	an outlier by not meeting all of the seven required care processes and achieved this only in 7.6% of our patients in 2014. In 2016 CUH achieved all seven care processes in 48% of our patients, above the national average of 43% and the regional average of 35%. Individual care process recording has improved since the 2015 cycle, particularly the collecting of urine samples from patients at annual review which was one of the action points for the team. In 2014 it was 8.8% and this year it is 64% which is much more aligned with the national average. CUH noted higher rates of microvascular complications such as microalbuminuria and abnormal retinal screening than the national averages despite having better metabolic control. This may be due to differences in the way results are classified in different units – for example CUH classes anything other than a completely normal retinal screen as abnormal, including background retinopathy. Planned Actions: All educators to remind patients and ensure that a sample has been given prior to the patient leaving. Team to be consistent with message regarding targets and advice.
National Ophthalmology Database NOD Audit Report 2018 (Aug.18)	The Trust received the report in August 2018. Findings and planned actions were presented to the Clinical Audit Committee in January 2019. The National Ophthalmology Database (NOD) Cataract Audit reports on two primary indicators of surgical quality. These are, firstly, the index surgical intraoperative complication of rupture of the posterior lens capsule or vitreous prolapse or both (abbreviated as PCR), and secondly Visual Acuity (VA) Loss (doubling or worse of the visual angle) related to surgery. Key Findings and Learning: CUH cataract service met national standards in relation to cataract outcomes. CUH complication rate for posterior capsule rupture was 0.75% and was comparable to major centres and below the national average of 1.4%. Successful data extraction from electronic patient records for the national audit. Data entry and resources for on-going audit require attention. Planned Actions: To continue to recording of essential data on electronic patient records to capture audit info for all cataract surgeries at CUH. Regular service meetings to train all surgeons, nurses and optometrists for cataract audit and to maintain standards.
National UK Parkinson's Audit Report 2017 (May.18)	The Trust received the report in May 2018. Findings and planned actions were presented to the Clinical Audit Committee in January 2019. The audit measures the quality of care provided to people living with Parkinson's against a range of evidence-based guidance about the care of people with the condition. This is only reported as national data. Key Findings and Learning: Timely specialist review - 98.1% of patients audited had received a specialist review in the preceding 12 months. There was an increased signposting to Parkinson's UK.

Title	Outcome
	Good documentation of advice given about potential side effects of new medication. Specialised multidisciplinary working effectively, good medicines management, evidence of standardised practices, effective anticipatory care planning. Good communication and information sharing. Planned Actions: Improve access to specialist therapists: Submit funding bid for Parkinson's disease (PD) specific physiotherapy and occupational therapy clinic along with inpatient support of Parkinson's disease PD specialist nurses and ward therapy teams. Facilitate patient and carer driven advanced care planning discussions: Request regional PD UK advisor to link with local groups requesting feedback on when, who with and how to discuss advanced care plans. Ensure all patients are screened for impulse control disorders and both patients and GP's receive written guidance: Development of an EPIC smart phrase which inserts the relevant text regarding impulse control disorder into all clinic letters. Increase number of patients assessed for daytime sleepiness. Increase number of patients receiving enough information at diagnosis: Explore the use of newly diagnosed packs.
Maternal, Newborn and Infant Programme MBRRACE: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16 (Nov.18)	The Trust received the report in November 2018. Findings and planned actions were presented to the Clinical Audit Committee in January 2019. This year the report examines in detail the care of women who died during or up to one year after pregnancy between 2014 and 2016 in the UK and Ireland from mental health conditions, blood clots (thrombosis and thromboembolism), cancer, and homicide, and women who survived major bleeding (haemorrhage). Key Findings and Learning: CUH Performance: 2017 Audit showed quality standards met. 2 cases where post-partum hemorrhaging was underestimated and 1 case where no preventative measures were taken despite risk factors. No significant increase in the overall maternal death rate in the UK between 2011–13 and 2014-16. Planned Actions: Perinatal mental health service in process of being set up in conjunction with the mental health teams and specialist obstetric clinic. Referral pathways are being written and guideline is being updated to reflect the changes. Skills and drills training in place to raise awareness of how to treat post-partum hemorrhaging and referral pathways.
National Neonatal Audit Programme NNAP – 2018 Annual Report on 2017 data (Sep.18)	The Trust received the report in September 2018. Findings and planned actions were presented to the Clinical Audit Committee in January 2019. The National Neonatal Audit Programme (NNAP) measures key aspects of babies on neonatal units. Key Findings and Learning: CUH was above the national average for the following standards:

Title	Outcome
	Antenatal magnesium sulphate, temperature on admission, consultation with parents, screening for retinopathy of prematurity, mother's milk at time of discharge. CUH was below the national rate for antenatal steroids, parents on ward rounds, screening for retinopathy of prematurity and was in line with the national average for follow-up at two years of age. Planned Actions: Neonatal unit continues displayed the posters on the unit to be transparent about how the unit compares nationally. Continued strong presence of senior medical staff on unit with almost every family having a consultation within the first 24 hours.
National Cardiac Arrest Audit Report 2017/18 (Jul.18)	The Trust received the report in July 2018. Findings and planned actions were presented to the Clinical Audit Committee in January 2019. The National Cardiac Arrest Audit (NCAA) is the national, clinical, comparative audit for in-hospital cardiac arrests. NCAA monitors and reports on the incidence of, and outcome from, in-hospital cardiac arrests and aims to identify and foster improvements, where necessary, in the prevention, care delivery and outcome from cardiac arrest. Key Findings and Learning: CUH has seen a significant decrease in the number of calls placed for cardiac arrest only. In the 2017 audit, 109 calls were placed out of a total number of 206,420 admissions. This has decreased to 89 out of a total of 205,403 admissions during the audit period in 2018. This is mirrored in an increase in our survival to discharge. In the 2018 audit our survival to discharge was 22.7%, an increase from 2017 when it was 21.0%. In the 2018 audit report three patients were identified as unexpected non-survivors. At the time of each cardiac arrest the notes were reviewed by a Resuscitation Officer and no concerns were identified. Each of the patients had significant comorbidities. Two of the three patients had also previously suffered a cardiac arrest during the same admission. The Trust also noted an increase in the number of never determined rhythms (an increase from 4 in 2017 to 6 in 2018). The audit also showed that CUH is slightly above average for commencing CPR although a do not resuscitate order was in place. Planned Actions: Findings and recommendations disseminated to specialties. Rapid Response Team (RRT) medical team/team leaders to be reminded that electrocardiogram (ECG) rhythms need to be documented as part of their team leadership responsibility. Work is on-going to move organisation from current do not resuscitate process to the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) to improve visibility of resuscitation status.
National Oesophago-Gastric Cancer Audit (Sep.18)	The Trust received the report in September 2018. Findings and planned actions were presented to the Clinical Audit Committee in January 2019. The National Oesophago-Gastric Cancer Audit (NOGCA) covers the quality of

Title	Outcome
	care, both curative and palliative, given to patients with oesophago-gastric cancer and oesophageal high-grade glandular dysplasia. Key Findings and Learning: CUH performs well in its endoscopic and surgical management of patients with high-grade dysplasia and invasive oesophago-gastric cancer. CUH is now confident that 100% of eligible cases are entered into NOGCA. 172 patients from CUH were entered into the audit compared with an "expected" number of 251-300. This placed CUH in an "amber" category for case ascertainment. However, a local audit of case ascertainment has confirmed that all cases are added and CUH is now confident that the "expected" number for Cambridge is too high. This is supported by seeing that all our cancer units are at >90% case ascertainment and our "expected" numbers of cancers increased by 50 from 2017 to 2018 without any explanation by the national audit team. The staging pathway for patients with oesophago-gastric cancer is complex and can lead to delays in starting treatment. NICE have updated its advice on the use of Endoluminal Ultrasound (EUS) for staging these cancers and now recommend a selective use of this imaging modality. Planned Actions: Upper Gastrointestinal Cancer Lead to challenge amber status with NOGCA team as "predicted" number of cancers for CUH is too high. EUS to be used selectively for staging of oesophageal cancer. Quarterly audits of proportion of cases having EUS and the reasons will be carried out.

Appendix C: Local audits

(Cut off for data inclusion: 08/02/2019)

Audit Title	Action/response
Comparison of current practice of median neuropathy screening in the Clinical Neurophysiology Department in Carpal Tunnel Clinics against current guidelines of the British Society for Clinical Neurophysiology	The audit shows: • Compliance with 'measuring and documenting hand temperature is good with 94.7% when compared to the target 100%. • For 78% of patients no sensitivity test was performed when it may have been indicated. This was discussed at the presentation of the audit. Variation in practice may relate to individual interpretation of degree of abnormality and thus need for the test. The measurement and documentation of limb temperature is now standard departmental practice. Local guideline for clinics was updated on Q-Pulse in January 2019 as part of preparation for the Improving Quality in Physiological Diagnostic Services (IQIPS) accreditation.
An audit to measure the average improvement of vision in the amblyopic eye following 3 months of occlusion therapy	1. 100% children who need treatment with patching occlusion therapy have an inter-ocular difference (IOD) of 2 lines or more. Standard met in 100% of cases. 2. 100% children have a refraction adaptation of at least 12-18 weeks until the vision plateaus before starting occlusion therapy. Standard met in 97% of cases. 3. 100% children are able to perform Sonksen LogMAR Test (with or without matching card). Standard met in 100% of cases. All actions to further improve on Standard 2 have been implemented.
NICE CG 191: Audit of use of CURB-65 score in patients diagnosed with Legionnaires' Disease at CUH in 2018	Key findings of this audit were: • All patients with a diagnosis of community acquired pneumonia received a broad spectrum antibiotic within four hours of admission to hospital. Of a total of nine patients who were diagnosed with Legionnaires' Disease none had a documented CURB-65 assessment to guide therapy. Six (66%) patients with a score of ≥2 were started on antibiotics active against Legionnaires' disease within four hours of admission. Five (55.6%) were converted to a quinolone when the diagnosis was made. Three of the nine patients died with, on average, higher CURB-65 scores and other co-morbidities indicative of severity of illness compared with patients who survived. There were also other factors relating to management that may have impacted the outcome. Key actions were identified: • Explore with Acute Medicine and Respiratory Physicians the use of flow charts/EPIC to improve management of CAP in relation to using CURB-65 score to guide management. • Circulate the audit report to patient safety leads – A&E, Acute Medicine, Respiratory, and Haematology /Oncology to raise awareness of using CURB-65 to consider Legionella infection in patients admitted with severe pneumonia. • Raise awareness of recommendation to use quinolones for specific management of patients with Legionella infection among microbiologists when communicating positive Legionella results.

Audit Title	Action/response
	• Re-audit of use of CURB-65 score will be undertaken as part of Trust audits being planned by the Antimicrobial Stewardship Team.
NICE TA 298: Myopic choroidal neovascularisation	The audit established 100% compliance with NICE Technology Appraisal 298. No actions are required. The team to continue with current practice.
Compliance with requirement to complete last menstrual period (LMP) form and record on Epic	Computerised Tomography (CT) scanning, inpatient x-ray and A&E x-ray all demonstrated 100% compliance with completing the last menstrual period on Epic. Outpatient x-ray, fluoroscopy & interventional radiology fell short of the target. Work to be undertaken to remind radiographers of the need to ensure that an LMP form is correctly completed, signed and scanned on Epic for all appropriate examinations.
Audit of the Trust's Chaperone Policy 2018	99% of staff had good knowledge of the Policy. 67% of patients were aware that they could ask for a chaperone. 71% of patients, where an intimate examination was completed, had a formal chaperone. Only 55% of patient records documented the presence of a chaperone or the reason for not having a chaperone present. Staff training has been completed and the audit report will be disseminated to the divisional nurses to increase awareness of the Policy.
Audit of activity levels of the advice telephone service of the Rheumatology Practitioners and Metabolic Bone Specialist Nurse (2018)	The audit reviewed the activity levels of the Advice Telephone Line for the Rheumatology Practitioners and Metabolic Bone Specialist Nurse. Patients and primary care physicians can use the advice service. The standards related to response times during office hours as well as the appropriateness of the calls made to the advice line by the enquirers. Only 1.6% of calls were not answered within 48 hours in Rheumatology and 7.2% of calls in Osteoporosis. 78% of rheumatology calls were appropriate for the advice line and 96% were appropriate for the osteoporosis advice line. This is good overall performance, particular as the number of calls increased from 1625 calls in 2016/17 to 7931 in 2017/18. The audit identified some efficiency in the process which the service will address. However, if the service continues to grow, more resources will be required. The service will review and apply for either internal or commissioned funding to maintain the service.
NICE CG 153: Detecting psoriatic arthritis in a dermatology clinic	The audit reviewed local practice against the NICE guideline CG153. 75% of CUH patients with psoriasis received an annual psoriatic arthritis (PsA) screening using a validated tool (e.g. PEST); or other musculoskeletal assessment (target = 75%). 5 out of 5 patients in which PsA was suspected were referred to rheumatology (target = 100%). The audit showed that the service met the NICE recommendations and no further action is required.
Re-audit of the completion of the Modified Early Obstetric Warning Score (MEOWS)	Compliance for standard 1 has declined by 1% from 96% in 2016 to 95% in 2018. For standard 2, compliance has improved since the last audit (89% when compared with 86% in 2016). For standard 3, compliance has also improved from 85% in 2016 to 89%. Educational need for maternity support workers identified to focus on empowering them to make a 'continue present treatment' plan for when the

Audit Title	Action/response
	observations are normal and do not require escalation. For standard 4 a significant improvement has been noted as the unit improved from 8% in 2016 to 53% in this audit. Actions are: 1) To continue to encourage staff to make plans and to make sure they carefully complete the MEOWS score, even if the woman is well and the management will not change. 2) Encourage plan making amongst MSWs by sending out a reminder email to all staff with the audit results with a focus on MSWs. Within this remind staff about carefully completing the MEOWS score.
Audit of Group B streptococcal (GBS) colonisation in pregnant women	For all 6 standards of the audit the compliance was consistently under the required 95%. Both standards 1 and 2: 'GBS positive carriers result on Epic' and 'GBS positive carrier results letter to home' achieved 78% compliance, Standard 3 'Documented evidence of acknowledgment of GBS positive result in intrapartum episode': 88%, Standard 4: 'All women positive for Group B streptococcal colonisation have a patient alert in Epic' was 77%. Standards 5: 'GBS positive women have a letter to home address' was 75%. Standard 6: 'Documented evidence of acknowledgment of positive result in intrapartum episode' was 66%. Actions include: • Continue to promote use of the Epic report to improve effective reporting. • Highlight guideline 'Prevention of early onset neonatal infection including management of Group B streptococcal colonisation in pregnant women' (2017) to staff unfamiliar or unsure. • Consider updating the above guidance to include use of EPIC reporting to identify women who have positive Group B streptococcal results.
Audit of the Trust's adherence with the Ottawa knee rules	Key findings of the audit: • 74% (37/50) of cases complied with the Ottawa Knee Rules, which is an improvement compared to the 68% in the first audit cycle, however the audit target of 95% was not achieved. • Below 15% of referrals for traumatic knee injury to the virtual fracture clinic had radiological evidence of fracture. • One in four patients had knee x-rays that might have been avoided. Key actions: 1. Education of ED nurses/doctors to increase awareness of rule. 2. Make the ED doctors/nurses aware of the OTTAWA smart phrase on EPIC. 3. Email the results of the second audit cycle to the ED doctors and share them on their intranet.
Re-audit of antibiotic prescribing: Are we reviewing continuing need for antibiotics for vascular patients adequately?	Standard 1: Patients receiving antibiotics should have clearly documented indication / dose / route in the clinical notes. Compliance with standard 1: 82% of clinical notes showed the indication, 6% the dose and 78% the route. Standard 2: Patients commenced on antibiotics should have clearly documented an antibiotic plan between 48-72 hours after commencement (if antibiotic treatment is on-going). Compliance with this standard was 61%.

Audit Title	Action/response
	Actions taken forward: • Continue to try to prioritise antibiotic review on ward rounds. • On-going awareness and education of the Vascular Team.
Compliance with Trust's Patient Identification Policy in Theatres	Trust policy is to have two ID bands on all patients coming to theatres. Compliance with this standard was 99.8% for adults and 96% for children. There was no documentation stating reasons for missing ID bands in patient notes for 12 patients that arrived to theatre without an ID Band. Awareness has been raised in the department.
Storage and security of medicine, Summary of Q2, 2018/19	This audit reviews a) medicine security and b) temperature monitoring on wards. Standards 1-6 relate to medicine security. While 98% of drug storage trolleys, cupboards and fridges are lockable, only 82% of them were locked. 94% of drugs trolleys were also secured to a wall and 91% of rooms were drugs are stored were also locked. Only in 67% of all cases all medicines were stored securely, while 88% of all boxes if IV fluids were stored off the floor in secure rooms. All clinical areas have a current min/max thermometer and there is a written record of daily fridge temperatures in 99% of areas. 96% of areas have a thermometer for the room temperature and 94% of areas had a written record of the temperature in drug or IV fluid storage rooms. However, in 73% of fridges the temperature remained within range in the last 7 days while this applied for 93% of rooms where drugs or IV fluids are stored. Compliance with holding the keys to drugs storage was good at 99% while 100% of areas that were not open 24 hours had appropriate arrangements in place. The audit has identified that work is still required to embed into daily ward routine the requirements for secure storage of medicines at all times.
Audit of completion of "Universal Form of Treatment Options" (UFTO)	10 standards are being reviewed quarterly in different wards to cover all wards throughout the year. For Quarters 1 to 4 of 2018/19 the same 9 Universal Form of Treatment Options (UFTO) standards were audited. Completion of an UFTO for inpatients within 72 hours of admission was adhered to between 64 and 76% throughout the year. The other six standards relating to the completion of the UFTO form were adhered to between 97-100% in all four quarters. 2 standards were included to understand the knowledge of nurses of the UFTO process. These highlighted that further work needs to be undertaken to ensure that nurses are familiar with the resuscitation status in their area (Q4 was 71% , improved from 58% in 2017). 69.8% of nurses were aware of the link on connect from Epic to access the East of England DNACPR form for community use. The Trust implemented the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) in December 2018 to improve patient and family involvement in decision making. It allows consideration of resuscitation decisions in the context of broader care and treatment and records decisions on a standardised form. Non-compliances in previous audit cycles incorporated into the development

Audit Title	Action/response
	of ReSPECT with the aim of addressing these in the future.
Audit of Smoking in Pregnancy (NICE guidance PH26 and CG62)	The results of this audit conclude that there was successful smoking cessation for women who delivered at CUH between March and May 2018 of 2.7%. The number of women delivering at CUH, who continue to smoke around the period delivery, is 1.5% which is below the DoH target of 8%. NICE recommends initial carbon monoxide monitoring at booking. It is unclear why carbon monoxide monitoring is not performed for all women (70.4% in this audit), but it is likely that this dependents on consent of the women and availability of equipment. There is a potential risk of foetal intra-uterine growth restriction in pregnancies where women are smoking at booking and have raised carbon monoxide readings. 46% women were offered growth scan scans at 30 and 36 weeks gestation. It is possible that many of these scans are being requested secondary to associated clinical indicators. Therefore additional education will be required to ensure scans are ordered by the midwife at time of the booking appointment when women meet the criteria.
Quality Colonoscopy Bowel Preparation 2018/2019 (Rolling Joint Advisory Group (JAG) Accreditation Audit Program)	The audit ascertained that the quality of the bowel preparation was unsatisfactory in 4%, suboptimal in 13% and satisfactory in 83% of cases. CUH is meeting the quality standard of 80%. No further quality improvement planned.
NICE NG 38: Documentation of weight bearing status post operatively for lower limb fractures	Documentation of weight bearing status was 100% in the second cohort (improved from 88% in the first cohort). Full compliance of documenting weight bearing status was achieved following departmental education.
An Audit to assess the appropriateness of antibiotic prescribing for Cellulitis at Addenbrooke's Hospital	The audit shows 100% compliance with not prescribing benzylpenicillin as a first line treatment for cellulitis and completing drug charts. The audit identified however that the prescribing of antibiotics (88-84% compliance) and the recording of patient's antibiotics allergies (76%) were not meeting the 100% target. Actions identified in this audit are: • To amend the 'Skin and soft tissue infections' guideline to clarify the treatment of severe cellulitis. • Review to be undertaken whether the Trust doctor induction should include the appropriate treatment for cellulitis to improve adherence to the guidelines, with particular focus on flucloxacillin dose and the importance of documenting patients' antibiotics allergies.
Compliance with safety checklist, WHO checklists and consent in CT Guided Nerve Root Injections	The audit of 44 patients showed that for 100% of computer tomography guided nerve root injection (NRI) consent and the NRI safety checklists were available on Epic. The 'WHO check-in' was completed by nurses in 90% of cases while 93% of radiographers and radiologists completed the check in. The 'WHO sign-out'

Audit Title	Action/response
	was completed 90% by all three staff groups. On-going communication to the three staff groups to improve compliance.
Reporting of adverse prognostic features in colorectal cancer resections: an audit of cases reported at Addenbrooke's Hospital up to December 2017	This re-audit is part of the NHS Bowel Cancer Screening Programme (BCSP) Quality Assurance visit recommendation to monitor reporting standards. All standards were met with no further actions to be implemented.
Completion of the Radiology WHO checklist prior to image guided breast intervention	This re-audit showed an improvement in completing the Radiology WHO checklist for image guided breast examinations. 68% of checklists were fully completed in 2018 compared with 28% in 2017. The target is 100%. On-going training of all relevant radiographers in the correct completion of the checklist. Re-audit in six months.
NICE CG 180: Management of Atrial Fibrillation following a Oesophagectomy	The audit showed that almost a quarter of CUH's patients with elective Oesophagectomy developed post-operative atrial fibrillation (AF). CUH is adhering to the NICE guideline on the initial management of AF for these patients. However, the review of anti-coagulation, the documentation of AF and an ECG prior to discharge was not always completed. The documentation of the rationale not to give anti-coagulation and the plan to review at a later date was not documented for the three patients were this applied. Audit was presented at the monthly General Surgery Departmental Mortality and Morbidity and Audit Meeting on the 13/11/2018.

Appendix D: Glossary of terms and abbreviations used in this report

BAME (BME)
Black, Asian and minority ethnic (used to refer to members of non-white communities in the UK). BAME may also be referred to as 'BME' - black and minority ethnic.

CBC (Cambridge Biomedical Campus)
A long-term collaboration between Cambridge University Hospitals NHS Foundation Trust (CUH) and partners, the University of Cambridge, the Medical Research Council (MRC), Countryside Properties and Liberty Property Trust.

CCG (Clinical Commissioning Group)
CCGs are responsible for planning and buying local NHS services, such as the care people receive at hospital and in the community, as well as ensuring that providers deliver the best possible care and treatment for patients. Services at CUH are commissioned by Cambridgeshire and Peterborough CCG.

C.difficile
A clostridium difficile infection (CDI) is a type of bacterial infection that can affect the digestive system. It most commonly affects people who are staying in hospital.

CQC (Care Quality Commission)
The independent regulator of all health and social care services in England. The Care Quality Commission monitors, inspects and regulates hospitals, care homes, GP surgeries, dental practices and other care services to make sure they meet fundamental standards of quality and safety.

CQUIN (Commissioning for Quality and Innovation) indicators
The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

CUH
Cambridge University Hospitals NHS Foundation Trust

CUHP (Cambridge University Health Partners)
An academic health science centre that brings together the University of Cambridge, Cambridge University Hospitals NHS Foundation Trust, Papworth Hospital NHS Foundation Trust and Cambridge and Peterborough NHS Foundation Trust.

DTOC (Delayed transfer of care)
Medically fit patients who cannot be discharged from hospital until there are arrangements in place for their continuing care and support.

EPR – Epic
Electronic patient record - The Epic software based system used for eHospital.

FTSUG (Freedom to Speak Up Guardian)
The Freedom to Speak Up Guardians are members of Trust staff appointed to help protect patient safety and the quality of care, improve the experience of workers and promote learning and improvement.

GDE (Global Digital Exemplar)

A Global Digital Exemplar is an internationally recognised NHS provider delivering exceptional care, efficiently, through the use of world-class digital technology and information. Exemplars will share their learning and experiences to enable other trusts to follow in their footsteps as quickly and effectively as possible.

HQIP

The Healthcare Quality Improvement Partnership (HQIP) was established in April 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality in England and Wales.

Human Factors

Human factors is the science which seeks to gain and apply knowledge of how people interact with each other and their environment, and how this affects behaviour, performance and wellbeing, particularly in the work setting.

LocSSIPs (Local Safety Standards for Invasive Procedures)

A set of locally implemented safety standards to support NHS hospitals provide safer surgical care. They aim to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events could occur.

MBRRACE

MBRRACE-UK is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to continue the national programme of work investigating maternal deaths, stillbirths and infant deaths, including the Confidential Enquiry into Maternal Deaths (CEMD). The programme of work is now called the Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI-CORP).

The aim of the MBRRACE-UK programme is to provide robust information to support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health service.

MDT (Multidisciplinary Team)

A Multidisciplinary Team is a group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients. Multidisciplinary Teams may specialise in certain conditions, such as Cancer.

MRSA (Meticillin-Resistant Staphylococcus Aureus)

MRSA is a type of bacterial infection that is resistant to a number of widely used antibiotics. This means it can be more difficult to treat than other bacterial infections.

National Quality Indicators

NHS England has mandated that all organisations providing NHS commissioned care are required to review their performance against a common set of measures across the new NHS Outcomes Framework.

NatSSIPs (National Safety Standards for Invasive Procedures)

A set of national safety standards to support NHS hospitals provide safer surgical care. They aim to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events could occur.

NCEPOD (National Confidential Enquiry into Patient Outcome and Death)

The National Confidential Enquiry into Patient Outcome and Death reviews clinical practice and identifies potentially remediable factors in practice. NCEPOD's purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research, by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities.

'Never event'

A 'never event' is defined as serious, largely preventable incident that should never happen if the right measures are in place. A defined list of Never Events is published annually by the Department of Health.

NHSBT (NHS Blood and Transplant)

NHS Blood and Transplant is a Special Health Authority who manages blood and organ transplantation.

NHSE (NHS England)

NHS England responsible for overseeing the budget, planning, delivery and day-to-day operation of the commissioning side of the NHS in England as set out in the Health and Social Care Act 2012.

NHSI (NHS Improvement)

NHS Improvement responsible for overseeing Foundation Trusts and NHS Trusts, as well as independent providers that provide NHS-funded care.

NICE (National Institute for Health and Care Excellence)

The National Institute for Health and Care Excellence (NICE) is an executive non-departmental public body of the Department of Health in the United Kingdom, which publishes guidelines in four areas:

- the use of health technologies within the NHS (such as the use of new and existing medicines, treatments and procedures)
- clinical practice (guidance on the appropriate treatment and care of people with specific diseases and conditions)
- guidance for public sector workers on health promotion and ill-health avoidance
- guidance for social care services and users

Palliative care/End of Life Care

Palliative care focuses on the relief of pain and other symptoms and problems experienced in serious illness. The goal of palliative care is to improve quality of life, by increasing comfort, promoting dignity and providing a support system to the person who is ill and those close to them.

PROMs (Patient reported outcome measures)

These are nationally mandated and provide a patient perspective of the effectiveness of the care they received - in simple terms, the improvement gain or loss following the procedure.

QSiS (Quality and Safety Information System)

QSiS is a bespoke electronic risk management system, based on the Datix software & used by the majority of NHS Trusts in the UK. The system is made up

of a number of modules, including safety incident reporting, risk register, complaints, claims, CQC compliance, and has excellent reporting features.

RCA (Root cause analysis)

A systematic process for identifying “root causes” of problems or events and an approach for responding to them.

ReSPECT

The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is a process that creates personalised recommendations for a person’s clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person’s care and treatment.

STP (Sustainability and Transformation Partnership)

STPs bring together NHS providers, CCGs, local authorities and other health and care services and are organised as 44 STP 'footprints'. A 'footprint' is the geographical area in which people and organisations are working together to develop plans to transform and sustain the delivery of health and care services. CUH is in the Cambridge and Peterborough STP.

UFTO (Universal Form of Treatment Options)

UFTO is an electronic form that records the treatment options that doctors discussed and agreed with a patient. This may include choices on End of Life care and resuscitation.

WRES (NHS Workforce Race Equality Standard)

The Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS standard contract. NHS providers are expected to show progress against a number of indicators of workforce equality, including a specific indicator to address the low numbers of BME board members across the organisation.

Cambridge University Hospitals NHS
NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust

Accounts

Year Ended 31 March 2019

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Presented to Parliament pursuant to Schedule 7, paragraphs 24 and 25 of the National Health Service Act 2006.

Independent auditor's report to the Council of Governors of Cambridge University Hospitals NHS Foundation Trust

Opinion on the financial statements

We have audited the financial statements of Cambridge University Hospitals NHS Foundation Trust ('the Trust') for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as interpreted and adapted by the Government Financial Reporting Manual 2018/19 as contained in the Department of Health and Social Care Group Accounting Manual 2018/19, and the Accounts Direction issued under section 25(2) of Schedule 7 of the National Health Service Act 2006 ("the Accounts Direction").

In our opinion, the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2019 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006 and the Accounts Direction issued thereunder.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Material uncertainty related to going concern

We draw attention to Note 1.2 in the financial statements, which indicates that the Trust incurred a deficit during the year ended 31 March 2019 of £94.2million resulting in an accumulated deficit on the Statement of Financial Position of £245.7million. The Trust anticipates making a deficit of £33million for the 2019/20 financial year (including conditional Provider Sustainability Fund income) and expects to continue to receive cash funding loan finance from the Department of Health and Social Care without interruption.

These events or conditions indicate that a material uncertainty exists that may cast significant doubt on the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) we identified, including those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key audit matter	Our response and key observations
Valuation of land and buildings At 31 March 2019 the Property Plant and Equipment balance totalled £341million. Of this, £292million is based on a valuation provided by the District Valuer. Changes in the value of land and buildings may impact on the Statement of Comprehensive Income depending on the circumstances and the specific accounting requirements of the Department of Health and Social Care Group Accounting Manual. The Trust uses a modern equivalent asset (MEA) valuation for land and buildings on an alternative site basis. This is an estimate with a high estimation uncertainty.	Our audit approach involved: • assessing the independence and objectivity of the Trust's expert using our expert; • reviewing market trends to give assurance that there is no evidence that the valuation is materially misstated and that the movement in year is consistent with information from other sources; and • reviewing the valuation provided including the reasonableness of the data used to derive the model for the alternative site valuation and understanding any change in the scope of services that the trust provides during the year and assessing that for any impact on the MEA valuation. There were no significant findings arising from review of the valuation of property. Our work provided the assurance we sought in respect of this key audit matter.
Revenue recognition	We undertook a range of substantive

Auditing standards include a rebuttable presumption that there is a significant risk in relation to the timing of income recognition, and in relation to judgements made by management as to when income has been earned. The pressure to manage income to deliver forecast performance in a challenging financial environment increases the risk of fraudulent financial reporting leading to material misstatement and means we are unable to rebut the presumption.	procedures including: • testing of income around the year-end to obtain assurance that transactions are recognised in the correct financial year; • testing year-end receivables to obtain assurance that transactions are recognised in the correct financial year; • testing significant receipts in the pre- and post-year end period to obtain assurance that they have been recognised in the correct financial year; • testing of material accounting estimates, including income accruals.. There were no significant findings arising from our review of revenue recognition and our work provided the assurance we sought in respect of this key audit matter.

Our application of materiality

We apply the concept of materiality both in planning and performing our audit, and in evaluating the effect of misstatements on the financial statements and our audit. Materiality is used so we can plan and perform our audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free from material misstatement. The level of materiality we set is based on our assessment of the magnitude of misstatements that individually or in aggregate, could reasonably be expected to have influence on the economic decisions the users of the financial statements may take based on the information included in the financial statements.

Based on our professional judgement, we determined materiality for Cambridge University Hospitals NHS Foundation Trust for the financial statements as a whole as follows:

	Trust
Overall materiality	£9.598million
Basis for determining materiality	1% of operating expenses of continuing operations
Rationale for benchmark applied	Gross expenditure at surplus/deficit on continuing operations was chosen as the appropriate benchmark for overall materiality as this is a key measure of financial performance for users of the financial statements
Performance materiality	£6.719million
Reporting threshold	£0.288million

An overview of the scope of our audit

As part of designing our audit, we determined materiality and assessed the risk of material misstatement in the financial statements. In particular, we looked at where the Accounting Officer made subjective judgements such as making assumptions on significant accounting estimates.

We gained an understanding of the legal and regulatory framework applicable to the Trust and the sector in which it operates. We considered the risk of acts by the Trust which were contrary to the applicable laws and regulations including fraud. We designed our audit procedures to respond to those identified risks, including non-compliance with laws and regulations (irregularities) that are material to the financial statements.

We focused on laws and regulations that could give rise to a material misstatement in the financial statements, including, but not limited to, the National Health Service Act 2006.

We tailored the scope of our audit to ensure that we performed sufficient work to be able to give an opinion on the financial statements as a whole. We used the outputs of our risk assessment, our understanding of the Trust's accounting processes and controls and its environment and considered qualitative factors in order to ensure that we obtained sufficient coverage across all financial statement line items.

Our tests included, but were not limited to:

- obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by irregularities including fraud or error;
- review of minutes of board meetings in the year; and
- enquiries of management.

As a result of our procedures, we did not identify any Key Audit Matters relating to irregularities, including fraud.

The risks of material misstatement that had the greatest effect on our audit, including the allocation of our resources and effort, are discussed under 'Key audit matters' within this report.

Other information

The directors are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We are also required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the Annual Report is fair, balanced and understandable and whether the Annual Report appropriately discloses those matters that we communicated to the Audit Committee which we consider should have been disclosed.

We have nothing to report in these regards.

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of the Chief Executive's responsibilities as the Accounting Officer of Cambridge University Hospitals NHS Foundation Trust, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The Accounting Officer is required to comply with the Department of Health and Social Care Group Accounting Manual and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. The Accounting Officer is responsible for assessing each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2018/19; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Annual Governance Statement	
We are required to report to you if, in our opinion: • the Annual Governance Statement does not comply with the NHS Foundation Trust Annual Reporting Manual 2018/19; or • the Annual Governance Statement is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.	We have nothing to report in respect of these matters.
Reports to the regulator and in the public interest	
We are required to report to you if: • we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006 because we have a reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or • we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.	We have nothing to report in respect of these matters.

The Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Adverse conclusion

On the basis of our work, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, we are not satisfied that, in all significant respects, Cambridge University Hospitals NHS Foundation Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Basis of adverse conclusion

In considering the Trust's arrangements for securing sustainable resource deployment, we identified the following matters:

- The Trust's financial position continued to deteriorate in 2018/19.
- The Trust did not agree to a control total for 2018/19 (which would have been a deficit of £77million). The Trust reported a deficit of £94.2million for the year leading to a cumulative deficit of £245.7million and negative net assets of £69.4million as at 31 March 2019.
- As at 31 March 2019, the Trust did not have a sustainable plan to achieve an annual breakeven position within a reasonable period.
- There is no realistic prospect of the Trust repaying the cumulative borrowing incurred to finance several years of large deficits.

The large actual and planned deficits and the absence of a robust plan for restoring a sustainable financial position are evidence of weaknesses in the Trust's arrangements for planning finances for sustainable resource deployment and the maintenance of statutory functions.

Responsibilities of the Accounting Officer

The Chief Executive as Accounting Officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by Schedule 10(1)(d) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

Use of the audit report

This report is made solely to the Council of Governors of Cambridge University Hospitals NHS Foundation Trust as a body in accordance with Schedule 10(4) of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust as a body for our audit work, for this report, or for the opinions we have formed.

Certificate

We certify that we have completed the audit of Cambridge University Hospitals NHS Foundation Trust in accordance with the requirements of chapter 5 of part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Gareth Davies
For and on behalf of Mazars LLP

Tower Bridge House

St Katharine's Way
London
E1W 1DD

28 May 2019

FOREWORD TO THE ACCOUNTS

Cambridge University Hospitals NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust ("the Trust") acts as an acute hospital and the main teaching hospital for the University of Cambridge. The Trust serves the local Cambridge area and also provides specialist services to the wider population throughout the East of England and beyond. The Trust hosts a number of clinical networks and the Cambridge Biomedical Research Centre.

These accounts for the year ended 31 March 2019 have been prepared by Cambridge University Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Signed

Roland Sinker
Chief Executive

23 May 2019

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2019

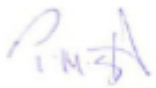
	Note	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Operating income from patient care activities	2	730,209	661,061
Other operating income	2	146,183	195,774
Total operating income from continuing operations		876,392	856,835
Operating expenses of continuing operations	3	(958,629)	(878,742)
Operating (deficit)		(82,237)	(21,907)
Finance costs			
Finance income	6	212	72
Finance expense	6	(11,641)	(10,073)
Net finance costs		(11,429)	(10,001)
Other gains/(losses)	6	(569)	120
Share of (loss) of joint operations		-	(474)
(Deficit) from continuing operations		(94,235)	(32,262)
(Deficit) for the year		(94,235)	(32,262)
Other comprehensive income/(expenditure)			
Will not be reclassified to income and expenditure:			
Downwards revaluations charged to the revaluation reserve	8	(1,490)	-
Revaluations		2,235	1,586
Other reserve movements		-	-
Total comprehensive (expense) for the year		(93,490)	(30,676)
Allocation of (losses) for the year:			
(Deficit) for the year attributable to:			
Government		(94,235)	(32,262)
Total comprehensive (expense) for the year attributable to:			
Government		(93,490)	(30,676)

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2019

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	7	29,256	30,438
Property, plant and equipment	8	340,701	325,435
Total non-current assets		369,957	355,873
Current assets			
Inventories	9	11,755	11,849
Trade and other receivables	10	70,440	83,312
Cash and cash equivalents	11	35,099	18,389
Total current assets		117,294	113,550
Current liabilities			
Trade and other payables	12	(141,888)	(108,692)
Borrowings	13	(119,986)	(12,536)
Provisions	14	(744)	(2,497)
Other liabilities	12	(23,681)	(22,096)
Total current liabilities		(286,299)	(145,821)
Total assets less current liabilities		200,952	323,602
Non-current liabilities			
Borrowings	13	(268,088)	(299,860)
Provisions	14	(2,268)	(2,374)
Total non-current liabilities		(270,356)	(302,234)
Total assets employed		(69,404)	21,368
Taxpayers' equity			
Public dividend capital		137,985	132,881
Revaluation reserve		38,343	37,701
Income and expenditure reserve		(245,732)	(149,214)
Total taxpayers' and others' equity		(69,404)	21,368

These financial statements were approved by the Board on 23 May 2019 and signed on its behalf by:





Dr Mike More	Mr Roland Sinker	Mr Paul Scott
Chairman	**Chief Executive**	**Chief Finance Officer**

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2019

	Total £000	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000
Taxpayers' and others' equity at 01 April 2018	21,368	132,881	37,701	(149,214)
Impact of implementing IFRS 9 on opening reserves	(2,386)	-	-	(2,386)
(Deficit) for the year	(94,235)	-	-	(94,235)
Transfers between reserves	-		(103)	103
Net impairments	(1,490)	-	(1,490)	-
Revaluations	2,235	-	2,235	-
Public dividend capital received	5,104	5,104	-	-
Taxpayers' and others' equity at 31 March 2019	(69,404)	137,985	38,343	(245,732)

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2018

	Total £000	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000
Taxpayers' and others' equity at 01 April 2017	44,603	125,440	36,115	(116,952)
(Deficit) for the year	(32,262)	-	-	(32,262)
Revaluations	1,586	-	1,586	-
Public dividend capital received	7,441	7,441	-	-
Taxpayers' and others' equity at 31 March 2018	21,368	132,881	37,701	(149,214)

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2019

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Cash flows from operating activities		
Operating (deficit) from continuing operations	(82,237)	(21,907)
Non-cash income and expense		
Depreciation and amortisation	20,557	19,150
Impairments	-	3,510
Income recognised in respect of capital donations (cash and non-cash)	(429)	(41)
Decrease/(increase) in receivables	10,486	(10,258)
Decrease in inventories	94	213
Increase/(decrease) in trade and other payables	36,086	(2,967)
Increase/(decrease) in other liabilities	1,585	(4,139)
(Decrease) in provisions	(1,961)	(660)
Other movements in operating cash flows	-	(474)
Net cash generated from / (used in) operations	(15,819)	(17,573)
Cash flows from investing activities		
Interest received	212	72
Purchase of intangible assets	(2,677)	(2,586)
Purchase of property, plant and equipment and investment property	(33,218)	(22,590)
Sales of property, plant and equipment and investment property	169	120
Receipt of cash donations to purchase capital assets	429	41
Net cash (used in) investing activities	(35,085)	(24,943)
Cash flows from financing activities		
Public dividend capital received	5,104	7,441
Movement in loans from the Department of Health	75,333	50,656
Capital element of PFI, LIFT and other service concession payments	(1,931)	(1,998)
Interest on loans	(6,356)	(5,454)
Interest element of PFI, LIFT and other service concession obligations	(4,536)	(4,481)
PDC dividend paid	-	(393)
Net cash generated from financing activities	67,614	45,771
Increase/(decrease) in cash and cash equivalents	16,710	3,255
Cash and cash equivalents at 1 April	18,389	15,134
Cash and cash equivalents at 31 March	35,099	18,389

The Foundation Trust held £7k cash at bank and in hand at 31 March 2019 (year ended 31 March 2018, £2k) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

NOTES TO THE ACCOUNTS

IFRS Accounting Policies

1 Accounting policies and other information

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS Foundation Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (DHSC GAM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DHSC GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the DHSC GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS Foundation Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. The have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property.

1.2 Going concern

These accounts have been prepared on a going concern basis.

The Trust is expecting to incur a deficit during the next 12 months of £33.1m and as a result will continue to require additional cash funding from the Department of Health and Social Care. NHS Improvement now assesses each Trust's cash funding requirements one month ahead of need and then arranges loan finance for that month only from the Department of Health and Social Care. To date, the Trust's cash funding requirements have been met in this way and the Board of Directors expects this to continue without interruption.

International Accounting Standard (IAS) 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. The financial statements should be prepared on a going concern basis unless management intends, or has no alternative but, to apply to the Secretary of State for the Trust's dissolution without the transfer of its services to another entity.

Financial position:

- The Trust recorded a financial deficit of £94.2 million for the 2018/19 financial year. The Trust had not agreed a control total with NHS Improvement.
- The balance sheet at 31 March 2019 shows a cumulative deficit (i.e. negative income & expenditure reserve) of £245.7 million.
- The Trust is currently developing a 5 year plan aimed at providing a road map to return the Trust to recurrent financial balance. An application has also been submitted to the Secretary of State for Health requesting a restructuring of the Trust's historic debt as a means of partially addressing the Trust's cumulative deficit position.
- The Trust is no longer in "special measures".
- The Trust drew down £90.1 million of additional working capital funding from the Department of Health and Social Care during 2018/19. This funding ensured that the Trust could continue to meet its liabilities during 2018/19 as they fell due.
- The Trust has now agreed a control total of £33.1 million with NHS improvement for 2019/20.
- The Trust will require £33.1 million of additional working capital support from the Department of Health and Social Care in 2019/20 and the Directors expect this to be forthcoming. Indeed, loans for April and May 2019 have already been received.
- Contracts with the Trust's main Commissioners have been agreed which give a significant level of assurance around continued service delivery and income cash flows for the Trust during 2019/20.

After making enquiries, and considering the matters described in the preceding paragraphs which may represent a material uncertainty, the Directors have a reasonable expectation that the Trust will have access to adequate resources to continue in operational existence for the foreseeable future. For this reason, they

continue to adopt the going concern basis in preparing the accounts.

1.3 Joint operation

Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the net assets, and obligations for the liabilities, relating to the arrangement. The Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

Where the joint arrangement is loss making the investment in the partnership is impaired to zero by the losses made, and remaining losses are recognised as a provision due to the constructive obligation.

1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The DHSC GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the DHSC GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied, by transferring promised services to the customer and is measured at the amount of the transaction price allocated to that performance obligation. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue relating to patient care spells that are part-completed at the year-end are apportioned across the financial years on the basis of the number of occupied bed days and an average cost per bed day.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer.

At the year end, the Trust accrues revenue relating to activity delivered in that year, where a patient care spell is incomplete. Revenue is recognised to the extent that collection of consideration is probable.

Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income. Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty. The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price. An estimate of readmissions is made at the year end this portion of revenue is deferred as a contract liability.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are

satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy, are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs - NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore the schemes are accounted for as though they are defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that, they have been received. It is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their individual useful lives.

Measurement

All property, plant and equipment are measured initially at cost; representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Subsequently, land and non-specialised buildings are measured at valuation and all other Property, plant and equipment assets are valued at depreciated replacement cost.

Land and non-specialised buildings are valued on the modern equivalent asset (alternative site) basis. Valuations are carried out by professionally qualified District Valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The land and buildings valuation was undertaken as at the prospective valuation date of 31 March 2019, applying the modern equivalent assets valuation (alternative site) basis which is consistent with IAS (International Accounting Standard) 16.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset, when it is probable that additional future economic benefits or service potential, deriving from the cost incurred to replace a component of such item, will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The existing carrying amount of the part replaced is de-recognised and charged to operating expenses. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated, less any residual value, on a straight-line basis over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Freehold land is considered to have an infinite life and is not depreciated. Properties under construction that are not yet being used are not depreciated.

Buildings, installations and fittings are depreciated on their current value for existing use over the estimated remaining life of the asset as assessed by professional valuers.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives is shown in the table below:

Land	Infinite
Buildings	1 – 60 years
Plant and Machinery	5 – 15 years
Transport Equipment	7 years
Information Technology	5 – 12 years
Furniture and fittings	7 – 10 years

Revaluation gains and losses

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost, modern equivalent asset (alternative site) basis.

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the DHSC GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of

- the impairment charged to operating expenses; and
- the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor,

in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset.

The finance cost is allocated using the implicit interest rate for the scheme. The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably;

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.

Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the Trust intends to complete the asset and sell or use it
- the Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software which is integral to the operating of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use by reference to an active market. Where no active market exists, intangible assets are valued at the lower of depreciated cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The estimated life of purchased computer software is between 2 and 12 years.

1.9 Inventories

Inventories comprise mainly consumable medical products.

Inventories are valued at the lower of cost and net realisable value. The weighted average cost formula is used for drugs and the first in first out cost formula for all other inventories. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

1.11 Financial assets & financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provision of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The DHSC GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are recognised when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial liabilities are recognised when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished – that is, the obligation has been discharged or cancelled or has expired.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets, except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as non-current assets

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from discounted cash flow analysis.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of an allowance account/bad debt provision.

The Trust recognises impairment losses on other trade receivables when there is a breach of contract. This is deemed to have occurred if the outstanding receivable has not been settled within 3 months or more of the invoice date or if a medical insurance company has underpaid. Amounts charged to the allowance account require approval from the "Losses and Compensation panel".

1.12 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property, plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged,

cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf is £327.4m (year ended 31 March 2018, £283.6m). This is not recognised in the Trust's accounts.

Non-Clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions and any 'excesses' payable in respect of particular claims are charged to operating expenses as and when the liability arises.

1.14 Contingent assets and liabilities

The Trust had no contingent assets or liabilities as at 31 March 2019.

1.15 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance, based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.
At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable as Public Dividend Capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

- donated assets
- average daily cash balances held with the Government Banking Services (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
- any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net

assets occur as a result the audit of the annual accounts.

1.16 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them.

1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the Health Service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

However, the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.19 Critical judgments in applying accounting policies

The following are the judgements, apart from those involving estimates (see below) that management has made in the process of applying the NHS Foundation Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

The most significant estimate within the accounts is the value of land and buildings. The land and buildings have been valued by the District Valuer on a modern equivalent asset (alternative site) basis as at 31 March 2019. The District Valuer is independent of the Trust and is certified by the Royal Institute of Chartered surveyors. The valuer has extensive knowledge of the physical estate and market factors. Management has considered the appropriateness of the alternative site selected in respect of location and availability and also the size of the theoretical building required to adequately service the health needs of the hospital's patients. The value does not take into account potential future changes in market value which cannot be predicted with any certainty.

The Trust's PFI scheme has been assessed and recognised on the Statement of Financial Position under IFRIC 12. The PFI scheme has been valued by the District Valuer on a modern equivalent asset (alternative site) basis as at 31 March 2019. The £9.2m unitary charge is based on actual charges made by the PFI provider. The Department of Health and Social Care model has been used to determine the apportionment between the repayment of the liability, financing costs, the charges for services and lifecycle maintenance.

In order to report within the government guidelines, the value of patient care activity for the year ended 31 March 2019 has been estimated based on data available as at 1 April 2019.

Income for an inpatient stay can be recognised from the day of admission, but cannot be precisely calculated until after the patient is discharged. For patients occupying beds as at 31 March 2019, the estimated income from partially completed patient spells was £5.9m (year ended 31 March 2018, £6.2m).

The Trust has a financial liability for any annual leave earned by staff but not taken by 31 March 2019, to the extent that staff, are permitted to carry leave forward in to the next financial year. The estimated cost of untaken annual leave as at 31 March 2019 is £2.1m (year ended 31 March 2018, £1.6m).

Assumptions around the timing of cash flows relating to provisions are based on information from the NHS Pensions Agency, expert legal opinion within the Trust and external advisors, regarding when the legal issue may be settled.

Key sources of estimation uncertainty

Estimations as to the recoverability of receivables and the valuation of inventories have been made in determining the carrying amounts of these assets. No significant variations are expected.

1.20 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

1.21 Accounting standards that have been issued but have not yet been adopted

IAS 8, Accounting Policies, Changes in Accounting Estimates and Errors requires entities to disclose details where they have not applied a new IFRS Standard that has been issued but is not yet effective.

IFRS 14, Regulatory Deferral Accounts Not EU-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DH group bodies.

IFRS 16 Leases, Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 17 Insurance Contracts Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRIC 23 Uncertainty over Income Tax Treatments Application required for accounting periods beginning on or after 1 January 2019.

2. Operating income

IFRS 8 requires the disclosure of results of significant operating segments; the Trust considers that it only has one operating segment, healthcare.

2.1 Operating Income (by nature)

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Income from activities		
Acute services		
Elective income	122,234	113,761
Non-elective income	156,198	150,803
First outpatient income	65,871	63,094
Follow up outpatient income	45,705	41,496
A&E income	18,015	17,155
High cost drugs income from commissioners	88,427	89,779
Other NHS clinical income	213,975	173,971
Private patient income	9,400	6,416
AfC pay award central funding	6,285	-
Other clinical income	4,099	4,586
Total income from patient care activities	730,209	661,061

2.2 Income from patient care (by source)

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Income from activities		
NHS England	338,882	319,553
Clinical commissioning groups	362,629	323,411
NHS Foundation Trusts	293	294
NHS Trusts	54	153
Department of Health and Social Care	6,285	-
NHS other (including Public Health England)	3,727	-
Non NHS: private patients	9,400	6,416
Non NHS: overseas patients (non-reciprocal, chargeable to patient)	345	899
Injury cost recovery scheme	3,754	3,687
Non NHS: other	4,840	6,648
Total income from activities related to continuing operations	730,209	661,061

2.3 Other operating income

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Other operating income		
Research and development (IFRS 15)	46,510	48,374
Education and training (excluding notional apprenticeship levy income)	39,647	38,964
Non-patient care services to other bodies	37,645	59,807
Other (recognised in accordance with IFRS 15)	21,138	24,288
Cash donations for the purchase of capital assets - received from other bodies	429	-
Received from NHS charities: Cash donations / grants for the purchase of capital assets	-	41
Other (recognised in accordance with standards other than IFRS 15)	814	-
Sustainability and Transformation Fund income	-	24,300
Total other operating income related to continuing operations	146,183	195,774
Total operating income	876,392	856,835

* Analysis of other operating income: Other

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Car parking income	1,196	1,289
Estates recharges (external)	8,185	8,527
IT recharges (external)	-	1,478
Pharmacy sales	63	71
Staff accommodation rental	1,023	996
Staff contribution to employee benefit schemes	-	4
Clinical tests	355	633
Clinical excellence awards	5,136	5,461
Grossing up consortium arrangements	4,638	5,475
Other income not already covered (recognised under IFRS 15)	542	354
Total	21,138	24,288

2.4 Overseas visitors (relating to patients charged directly by the Foundation Trust)

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Income recognised this year	345	899
Cash payments received in-year (relating to invoices raised in current and previous years)	489	787
Amounts added to provision for impairment of receivables (relating to invoices raised in current and prior years)	1,096	566
Amounts written off in-year (relating to invoices raised in current and previous years)	15	165

3. Operating expenses (by type)

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Purchase of healthcare from non-NHS and non-DHSC bodies	6,402	4,953
Staff and executive directors costs	497,560	456,802
Non-executive directors	146	162
Supplies and services – clinical (excluding drugs costs)	151,102	149,121
Supplies and services - general	22,672	21,574
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	119,062	116,985
Consultancy	194	105
Establishment	12,747	9,675
Premises - business rates collected by local authorities	3,911	3,961
Premises - other	49,779	44,478
Transport (business travel only)	1,034	1,133
Transport - other (including patient travel)	2,235	1,808
Depreciation	16,642	15,567
Amortisation	3,915	3,583
Impairments net of (reversals)	-	3,510
Increase in impairment of receivables	1,289	881
Provisions arising / released in year	(68)	1,091
Change in provisions discount rate	(44)	35
Audit services - statutory audit	55	55
Other auditor remuneration (payable to external auditor only)	9	19
Internal audit	123	104
Clinical negligence - amounts payable to NHS Resolution (premium)	18,757	17,960
Legal fees	407	438
Insurance	398	381
Research and development	4	1
Education and training	2,410	2,646
Operating lease expenditure	10,862	10,512
Early retirements	171	697
Redundancy costs	38	534
Charges to operating expenditure for on-SoFP IFRIC 12 schemes	1,631	1,507
Car parking and security	2,040	1,999
Hospitality	488	104
Other losses and special payments - staff costs	43	59
Other losses and special payments	112	17
Grossing up consortium arrangements	9,577	5,475
Other operating expenses	22,926	810
Total operating expenses of continuing operations	958,629	878,742

4. Staff

4.1 Employee expenses

	Year ended 31 March 2019 Total £000	Year ended 31 March 2019 Permanent £000	Year ended 31 March 2019 Other £000
Salaries and wages	402,460	397,689	4,771
Social security costs	39,993	39,993	-
Apprenticeship levy	1,910	1,910	-
Pension cost - employer contributions to NHS pension scheme	45,377	45,377	-
Temporary staff - agency/contract staff	8,072	-	8,072
Total gross staff costs	497,812	484,969	12,843
Included within:			
Staff and executive directors costs	497,560	484,717	12,843
Redundancy	38	38	-
Early retirements	171	171	-
Special payments	43	43	-
Total employee benefits	497,812	484,969	12,843

	Year ended 31 March 2018 Total £000	Year ended 31 March 2018 Permanent £000	Year ended 31 March 2018 Other £000
Salaries and wages	371,139	367,584	3,555
Social security costs	36,462	36,462	-
Apprenticeship levy	1,734	1,734	-
Pension cost - employer contributions to NHS pension scheme	41,521	41,521	-
Temporary staff - agency/contract staff	7,236	-	7,236
Total gross staff costs	458,092	447,301	10,791
Included within:			
Staff and executive directors costs	456,802	446,011	10,791
Redundancy	534	534	-
Early retirements	697	697	-
Special payments	59	59	-
Total employee benefits	458,092	447,301	10,791

4.2 Early retirements due to ill health

	Year ended 31 March 2019 Number	Year ended 31 March 2018 Number
Number of early retirements on the grounds of ill-health	3	8
	£000	**£000**
Value of early retirements on the grounds of ill-health	171	697

Other (non-compulsory) departure payment	Year ended 31 March 2019 Number	Year ended 31 March 2019 £000
Contractual payments in lieu of notice	12	43

5. Operating expenditure miscellaneous

5.1 Operating lease payments and commitments (trust as a lessee)

	Year ended 31 March 2019 Total £000	Year ended 31 March 2019 Buildings £000	Year ended 31 March 2019 Plant & machinery £000
Minimum lease payments	10,862	2,871	7,991

	Year ended 31 March 2018 Total £000	Year ended 31 March 2018 Buildings £000	Year ended 31 March 2018 Plant & machinery £000
Minimum lease payments	10,512	2,113	8,399

5.2 Analysis of operating lease expenditure, future minimum payments

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
On buildings leases:		
- not later than one year;	2,890	958
- later than one year and not later than five years;	11,069	3,593
- later than five years.	17,779	5,081
Total buildings leases	31,738	9,632
On plant and machinery leases:		
- not later than one year;	4,964	5,551
- later than one year and not later than five years;	7,441	11,058
- later than five years.	17	549
Total plant and machinery leases	12,422	17,158
Total leases	44,160	26,790

5.3 Limitation on auditor's liability

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Limitation on auditor's liability	nil	nil

There is no specified limitation on the auditors liability for the year ended 31 March 2019.

5.4 Other audit remuneration

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Other auditor remuneration paid to the external auditor is analysed as follows:		
Audit-related assurance services - Quality report	9	9
All other non-audit services	-	10
Total	9	19

6. Finance income and expense

6.1 Finance revenue

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Interest on bank accounts	212	72

6.2 Finance expenditure

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Interest on loans from the Department of Health:		
Capital loans	2,928	3,068
Revenue support / working capital loans	4,075	2,457
Finance costs on PFI and other service concession arrangements (excluding LIFT)		
Main finance costs	2,585	2,690
Contingent finance costs	1,951	1,791
Total interest expense	11,539	10,006
Unwinding of discount on provisions	102	67
Total finance expenditure	11,641	10,073

6.3 Gains/(losses) on disposal of assets

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Gains on disposal of other property, plant and equipment	169	120
Losses on disposal of other property, plant and equipment	(738)	-
Total	(569)	120

6.4 Impairments of assets

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Abandonment of assets in the course of construction	-	3,510
Total impairments and (reversals) charged to operating surplus / deficit	-	3,510
Downwards revaluations charged to the revaluation reserve	1,490	-
Total impairments	1,490	3,510

7. Intangible assets

7.1 Intangible assets for the year ended 31 March 2019

	Software £000
Gross cost at 1 April 2018	42,345
Additions - purchased	2,733
Disposals	(527)
Gross cost at 31 March 2019	44,551
Amortisation at 1 April 2018	11,907
Provided during the year	3,915
Disposals	(527)
Amortisation at 31 March 2019	15,295
NBV total at 31 March 2019	29,256

7.2 Intangible assets for the year ended 31 March 2018

	Software £000
Gross cost at 1 April 2017	40,647
Additions - purchased	2,614
Disposals	(916)
Gross cost at 31 March 2018	42,345
Amortisation at 1 April 2017	9,240
Provided during the year	3,583
Disposals	(916)
Amortisation at 31 March 2018	11,907
NBV total at 31 March 2018	30,438

The majority of intangible assets represent a vision to create a comprehensive electronic patient record which we have called e-Hospital.

8. Property, plant and equipment

8.1 Property, plant and equipment for the year ended 31 March 2019

	Total £000	Land £000	Buildings £000	PFI asset £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000
Gross cost or valuation									
At 1 April 2018	405,176	38,375	195,878	58,146	3,305	82,978	34	18,289	8,171
Additions - purchased	31,599	-	9,535	1,849	7,877	10,473	-	1,840	25
Additions - assets purchased from cash donations/grants	302	-	-	-	113	189	-	-	-
Downwards revaluations charged to the revaluation reserve	(9,333)	-	(9,333)	-	-	-	-	-	-
Reclassifications		-	3,286	-	(3,305)	-	-	-	19
Revaluations	753			753					
Disposals	(8,543)	-	-	-	-	(6,785)	-	(1,676)	(82)
At 31 March 2019	419,954	38,375	199,366	60,748	7,990	86,855	34	18,453	8,133
Depreciation									
At 1 April 2018	79,741	-	5,632	-	-	53,003	30	14,115	6,961
Provided during the year	16,642	-	8,617	1,482	-	5,199	2	1,022	320
Downwards revaluations charged to the revaluation reserve	(7,843)	-	(7,843)	-	-	-	-	-	-
Revaluations	(1,482)	-	-	(1,482)					
Disposals	(7,805)	-	-	-	-	(6,047)	-	(1,676)	(82)
At 31 March 2019	79,253	-	6,406	-	-	52,155	32	13,461	7,199
Net book value									
Owned	266,570	38,375	180,320	-	7,877	34,122	2	4,990	884
On-SoFP PFI contracts	60,748	-		60,748					
Government granted	37	-	-	-	-	37	-	-	-
Donated	13,346	-	12,640	-	113	541	-	2	50
At 31 March 2019	340,701	38,375	192,960	60,748	7,990	34,700	2	4,992	934

No assets were held under finance leases or hire purchase contracts, with the exception of the PFI asset, which is financed by a PFI contract recognised on the Statement of Financial Position.

8.2 Property, plant and equipment for the year ended 31 March 2018

	Total £000	Land £000	Buildings £000	PFI asset £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000
Gross cost or valuation									
At 1 April 2017	405,273	36,550	200,561	55,135	5,775	78,594	46	20,513	8,099
Additions - purchased	23,062	-	8,075	1,761	1,040	11,191	-	889	106
Additions - assets purchased from cash donations/grants	41	-	-	-	-	41	-	-	-
Impairments charged to operating expenses	(3,510)	-	-	-	(3,510)	-	-	-	-
Revaluations	(6,802)	1,825	(9,877)	1,250	-	-	-	-	-
Disposals	(12,888)	-	(2,881)	-	-	(6,848)	(12)	(3,113)	(34)
At 31 March 2018	405,176	38,375	195,878	58,146	3,305	82,978	34	18,289	8,171
Depreciation									
At 1 April 2017	85,450	-	7,930	-	-	54,915	40	16,062	6,503
Provided during the year	15,567	-	8,106	865	-	4,936	2	1,166	492
Revaluations	(8,388)	-	(7,523)	(865)	-	-	-	-	-
Disposals	(12,888)	-	(2,881)	-	-	(6,848)	(12)	(3,113)	(34)
At 31 March 2018	79,741	-	5,632	-	-	53,003	30	14,115	6,961
Net book value									
Owned	253,616	38,375	177,012	-	3,305	29,611	4	4,169	1,140
On-SoFP PFI contracts	58,146	-	-	58,146	-	-	-	-	-
Government granted	52	-	-	-	-	51	-	-	1
Donated	13,621	-	13,234	-	-	313	-	5	69
At 31 March 2018	325,435	38,375	190,246	58,146	3,305	29,975	4	4,174	1,210

9. Inventory

9.1 Inventory movements for the year ended 31 March 2019

Carrying value	Total £000	Drugs £000	Consumables £000	Energy £000
At 1 April 2018	11,849	2,878	8,757	214
Additions	188,663	119,150	69,444	69
Inventories consumed (recognised in expenses)	(188,757)	(119,062)	(69,672)	(23)
At 31 March 2019	11,755	2,966	8,529	260

9.2 Inventory movements for the year ended 31 March 2018

Carrying value	Total £000	Drugs £000	Consumables £000	Energy £000
At 1 April 2017	12,062	2,629	9,227	206
Additions	182,256	117,234	64,922	100
Inventories consumed (recognised in expenses)	(182,469)	(116,985)	(65,392)	(92)
At 31 March 2018	11,849	2,878	8,757	214

10. Trade receivables

10.1 Trade receivables and other receivables

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Contract receivables (IFRS 15): invoiced	24,226	-
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	47,895	-
Trade receivables	-	30,518
Accrued income	-	37,149
Allowance for impaired contract receivables / assets	(8,091)	-
Allowance for impaired other receivables	-	(4,174)
Prepayments (non-PFI)	4,021	9,359
VAT receivable	1,930	1,424
Other receivables	459	9,036
Total current trade and other receivables	70,440	83,312

10.2 Allowances for credit losses (doubtful debts)

	Contract receivables and contract assets Year ended 31 March 2019 £000
At 1 April	4,174
IFRS 9 adjustment	2,816
New allowances arising	3,825
Reversals of allowances	(2,536)
Utilisation of allowances (where receivable is written off)	(188)
At 31 March	8,091

Prepayments and accrued income are neither past their due date nor impaired.

Other trade receivables become due immediately as we offer no credit terms.

In line with the adaptation of the DHSC GAM for IFRS 9 the Trust must immediately recognise a loss allowance at an amount equal to lifetime expected credit losses. The Trust recognises impairment losses

on other trade receivables when there is a breach of contract. This is deemed to have occurred if the outstanding receivable has not been settled within 3 months (previously 12 months) or more of the invoice date or if a medical insurance company has underpaid.

DHSC will provide a guarantee of last resort against the debts of DHSC group bodies, the guarantee means that DHSC group bodies must not recognise impairments against other DHSC for receivables due from other DHSC group bodies; as such amounts are not expected to be irrecoverable.

Historically the allowance for unsuccessful compensation claims under the NHS injury cost recovery scheme have been included in "Other receivables", these are now included within "Allowances for credit losses"

11. Cash and cash equivalents

11.1 Cash and cash equivalents movements

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
At 1 April	18,389	15,134
Net change in year	16,710	3,255
At 31 March	35,099	18,389

11.2 Breakdown of cash and cash equivalents

Total cash and cash equivalents balance at period end is broken down into:

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Cash at commercial banks and in hand	4,090	1,084
Cash with the Government Banking Service	31,009	17,305
Total cash and cash equivalents as in SoFP	35,099	18,389

12. Trade Payables

12.1 Trade and other payables

Current	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Trade payables	26,350	15,409
Capital payables (including capital accruals)	3,946	5,207
Accruals (revenue costs only)	93,368	69,490
Social security costs	11,122	10,281
Accrued interest on DH loans	-	1,629
Other payables	7,102	6,676
Total current trade and other payables	141,888	108,692

12.2 Other liabilities

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Deferred income: contract liability (IFRS 15)	15,460	-
Deferred grants	364	-
Deferred income	7,857	22,096
Total other liabilities	23,681	22,096

13. Borrowings

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Current		
Capital loans from the Department of Health	11,002	10,605
Revenue support / working capital loans from the Department of Health	107,167	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,817	1,931
Total current borrowings	119,986	12,536
Non-current		
Capital loans from the Department of Health	82,572	92,677
Revenue support / working capital loans from the Department of	140,084	159,934
Obligations under PFI, LIFT or other service concession contracts	45,432	47,249
Total non current borrowings	268,088	299,860
Total borrowings	388,074	312,396

13.1 Reconciliation of liabilities arising from financing activities

This disclosure is a new requirement of IAS 7 (paragraph 44A)	DHSC loans 31 March 2019 £000	PFI, LIFT and other service concession obligations 31 March 2019 £000
Carrying value at 1 April 2018	263,216	49,180
Impact of applying IFRS 9 as at 1 April 2018	1,629	-
Cash movements:		
Financing cash flows - principal	75,333	(1,931)
Financing cash flows - interest (for liabilities measured at amortised cost)	(6,356)	(2,585)
Non-cash movements:		
Application of effective interest rate (interest charge arising in year)	7,003	2,585
Carrying value at 31 March 2019	340,825	47,249

14. Provisions

14.1 Provisions for liabilities and charges

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Current		
Pensions relating to other staff	55	43
Pensions Injury benefits	132	128
Legal claims	108	99
Other	449	2,227
Total current	744	2,497
Non-current		
Pensions relating to other staff	460	492
Pensions Injury benefits	1,808	1,882
Total non-current	2,268	2,374
Total provisions	3,012	4,871

The provision for pension costs relates to additional pension liabilities arising from early retirements. Unless due to ill health these are not funded by the NHS Pension Scheme. The full amount of such liabilities is charged to the Statement of Comprehensive Income at the time the Trust commits itself to the retirement.

Other provisions include a joint arrangement in The Pathology Partnership (now Dormant). The joint arrangement was loss making so the investment in the partnership was impaired to zero by the losses made, and remaining losses are recognised as a provision due to the constructive obligation.

14.2 Provisions for liabilities and charges analysis

	Total £000	Pensions - Early departure costs	Pensions - Injury benefits £000	Legal claims £000	Other £000
At 1 April 2018	4,871	535	2,010	99	2,227
Change in the discount rate	(44)	(6)	(38)	-	-
Arising during the year	82	-	-	79	3
Utilised during the year - cash	(868)	(43)	(105)	(5)	(715)
Reversed unused	(150)	-	-	(65)	(85)
Unwinding of discount	102	29	73	-	-
At 31 March 2019	3,012	515	1,940	108	449
Expected timing of cash flows:					
In one year or less	744	55	132	108	449
In more than one year but not more than two years	112	33	79	-	-
In more than two years but not more than five years	445	131	314	-	-
In more than five years	1,711	296	1,415	-	-
	3,012	515	1,940	108	449

14.3 Clinical negligence liabilities

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Amount included in provisions of the NHS Resolution in respect of clinical negligence liabilities of Cambridge University Hospitals NHS Foundation Trust	327,351	283,637

15. Related party transactions

The Trust is a body corporate established by order of the Secretary of State for Health.

Government Departments and their agencies are considered by HM Treasury as being related parties.

During the year the Trust had a significant number of material transactions with other DHSC bodies, the most significant were with the following bodies:

NHS England
NHS Resolution (formerly NHS Litigation Authority)
Health Education England
NHS Cambridgeshire and Peterborough CCG
NHS Bedfordshire CCG
NHS East and North Hertfordshire CCG
NHS West Essex CCG
NHS West Suffolk CCG

In addition, the Trust has had a significant number of material transactions in the ordinary course of its business with other Government Departments and other central and local Government bodies. Most of these transactions have been with Her Majesty's Revenue and Customs in respect of deduction and payment of PAYE, and Cambridge City Council in respect of payment of rates.

During the year, none of the Board members, members of the key management staff or parties related to them have undertaken any material transactions with the Trust, with the exception of the University of

Cambridge, which is a related party by virtue of the fact that Professor Patrick Maxwell is both a Non-Executive Director of the Trust and Regius Professor of Physic with the University.

15.1 Related party transactions

	Year ended 31 March 2019 Revenue £000	Year ended 31 March 2019 Expenditure £000
Department of Health and Social Care	43,126	-
Other DHSC group bodies	781,498	44,296
Other Government bodies	4,307	91,810
University of Cambridge	11,987	10,762
	840,918	146,868

	Year ended 31 March 2018 Revenue £000	Year ended 31 March 2018 Expenditure £000
Department of Health and Social Care	36,948	-
Other DHSC group bodies	761,241	40,162
Subsidiaries / associates / joint ventures	324	1,703
Other Government bodies	5,448	84,564
University of Cambridge	10,859	14,348
	814,820	140,777

15.2 Related party balances

	Year ended 31 March 2019 Receivables £000	Year ended 31 March 2019 Payables £000
Department of Health and Social Care	281	900
Other DHSC group bodies	53,312	15,766
Other Government bodies	12,346	18,428
University of Cambridge	3,273	1,102
	69,212	36,196

	Year ended 31 March 2018 Receivables £000	Year ended 31 March 2018 Payables £000
Department of Health and Social Care	409	296
Other NHS bodies	54,555	12,914
Subsidiaries / associates / joint ventures	-	128
Other Government bodies	11,561	17,130
University of Cambridge	3,052	414
	69,577	30,882

16. Contractual capital commitments

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Property, plant and equipment	3,762	4,143
Intangible	1,670	3,354
Total contractual capital commitments	5,432	7,497

17. Private Finance Initiative (PFI) scheme

The PFI scheme is to design, build, maintain and operate (through facilities management and related services) a 128 bed Elective Care, Genetics and Diabetes Centre at the Trust. The centre became operational in April 2007. The contract start date of the PFI scheme was 13 February 2007 and the end date is 12 February 2037.

The facilities within the centre include Diabetes Research Facilities which are utilised by the University of Cambridge. These facilities are funded by the University of Cambridge and the Medical Research Council and have no effect on the Trust's cost structures.

The contract requires the Trust to make a unitary payment that totals £9.2m annually. It is charged monthly and adjusted for any penalties relating to adverse performance against output measures describing all relevant aspects of the contract. The Trust has a voluntary break option subject to 12 months' written notice.

17.1 On-SoFP PFI obligations (finance lease element)

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Gross PFI liabilities of which liabilities are due		
In one year or less	6,312	6,467
In more than one year but not more than two years	6,097	6,312
In more than two years but not more than five years	18,902	18,700
In more than five years	105,758	112,057
Finance charges allocated to future periods	(89,820)	(94,356)
Total	47,249	49,180
Net PFI obligation of which liabilities are due		
In one year or less	1,817	1,931
In more than one year but not more than two years	1,664	1,817
In more than two years but not more than five years	5,333	5,224
In more than five years	38,435	40,208
Total	47,249	49,180

17.2 Total On-SoFP PFI commitments

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Total future payments committed in respect of PFI arrangements		
In one year or less	10,008	9,764
In more than one year but not more than two years	10,258	10,008
In more than two years but not more than five years	32,339	31,550
In more than five years	169,517	180,564
Total	222,122	231,886

Under IFRS the unitary charge is apportioned between the repayment of the liability, financing costs and the charges for services. The service charge is recognised in operating expenses under "Premises" and the finance costs are charged to finance costs in the Statement of Comprehensive Income.

The Trust has not entered into any 'off-Statement of Financial Position' arrangements.

17.3 Analysis of amounts payable

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Unitary payment payable to PFI operator consisting of:		
- Interest charge	2,585	2,690
- Repayment of finance lease liability	1,931	1,997
- Service element	1,631	1,507
- Capital lifecycle maintenance	1,077	803
- Contingent rent	1,951	1,791
Total amount paid to service concession operator	9,175	8,788

18. Financial instruments

IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the Trust has with Clinical Commissioning Groups (CCGs) and NHS England and the way those NHS organisations are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply.

The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations and therefore has low exposure to currency rate fluctuations.

Credit risk

The Trust can borrow within affordable limits and NHS Improvement will assess the affordability of material borrowing. The Trust can invest surplus funds in accordance with NHS Improvement's guidance on Managing Operating Cash. This includes strict criteria on permitted institutions, including credit ratings from recognised agencies. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to manage the risks facing the Trust in undertaking its activities.

Liquidity risk

The Trust's net operating income is received under legally binding contracts with local Clinical Commissioning Groups (CCGs) and NHS England, which are financed from resources voted annually by Parliament. The Trust has financed capital expenditure from internally generated resources, and net borrowing of £90.1m which is within its affordable limits. The Trust is not, therefore, exposed to significant liquidity risks.

Market risk

The main potential market risk to the Trust is interest rate risk. The Trust's financial liabilities carry nil or fixed rates of interest. Cash balances are held in interest bearing accounts for which the interest rate is linked to bank base rates and changes are notified to the Trust in advance. The Trust is not, therefore, exposed to significant interest-rate risk.

18.1 Carrying value and fair value of financial assets

	Year ended 31 March 2019 Loans and receivables £000	Year ended 31 March 2018 Loans and receivables £000
Financial assets as per SoFP		
Receivables (excluding non financial assets) - with DHSC group bodies	53,567	54,957
Receivables (excluding non financial assets) - with other bodies	10,922	17,572
Cash and cash equivalents	35,099	18,389
Total	99,588	90,918

18.2 Carrying value and fair value of financial liabilities

	Year ended 31 March 2019 Other financial liabilities £000	Year ended 31 March 2018 Other financial liabilities £000
Financial liabilities per the SoFP		
DHSC loans	340,825	263,216
Obligations under PFI, LIFT and other service concession contracts	47,249	49,180
Trade and other payables (excluding non financial liabilities) - with DHSC group bodies	13,312	10,647
Trade and other payables (excluding non financial liabilities) - with other bodies	110,893	81,778
IAS 37 provisions which are financial liabilities	3,012	4,871
Total	515,291	409,692

18.3 Maturity of financial liabilities

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
In one year or less	244,935	107,458
In more than one year but not more than two years	61,374	122,008
In more than two years but not more than five years	123,612	84,466
In more than five years	85,370	95,760
Total	515,291	409,692

19. Losses and Special Payments

Losses and special payments (approved cases only)

	Year ended 31 March 2019 Total number of cases Number	Year ended 31 March 2019 Total value of cases £000's	Year ended 31 March 2018 Total number of cases Number	Year ended 31 March 2018 Total value of cases £000's
Losses of cash due to				
Other causes	79	20	2	-
Bad debts and claims abandoned in relation to				
Overseas visitors	16	15	3	165
Other	1	11	-	-
Total losses	96	46	5	165
Special Payments, Ex gratia payments in respect of				
Loss of personal effects	-	-	38	60
Personal injury with advice	2	3	-	-
Special severance payments	-	-	1	13
Total special payments	2	3	39	73
Total losses and special payments	98	49	44	238

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