

Agenda Trust Board – Open Session

Date	28/11/2019
Time	9:00 - 11:15
Location	Conference Room, Heartbeat Education Centre, F Level, North Wing, SGH
Chair	Peter Hollins
Apologies	Tim Peachey, Non-Executive Director

- 1**
9:00 **Chair's Welcome, Apologies and Declarations of Interest**
To note apologies for absence, and to hear any declarations of interest relating to any item on the Agenda.
- 2** **Minutes of Previous Meeting held on 31 October 2019**
- 3** **Matters Arising and Summary of Agreed Actions**
To discuss any matters arising from the Minutes, and to agree on the status of any actions assigned at the previous meeting.
- 4** **Quality, Performance and Finance**
Quality includes: clinical effectiveness, patient safety, and patient experience
- 4.1**
9:15 **Patient Story**
To receive feedback from patients, carers, or other stakeholders about their experience of the Trust's services.
- 4.2** **Briefing from Chair of Charitable Funds Committee for review (Oral)**
Jenni Douglas-Todd, Non-Executive Director
- 4.3**
9:30 **Briefing from Chair of Quality Committee for review (Oral)**
Cyrus Cooper for Tim Peachey, Non-Executive Director
- 4.4**
9:35 **Briefing from Chair of Strategy & Finance Committee for review (Oral)**
Jane Bailey, Non-Executive Director
- 4.5**
9:40 **Integrated Performance Report for Month 7 for review**
To review the Trust's performance as reported in the Integrated Performance Report and the Quarterly Infection Prevention and Control Report.
Sponsor: Jane Hayward, Director of Transformation & Improvement
- 4.6**
10:20 **Annual Ward Staffing Nursing Establishment Review for review**
Sponsor: Gail Byrne, Director of Nursing & Organisational Development
Attendee: Rosemary Chable, Deputy Director of Nursing, Education & Workforce

- 4.7** **2019/20 Influenza Vaccination Programme for review**
10:30 Sponsors: Paula Head, Chief Executive
Attendees: Steve Harris, Director of Human Resources and Julia Smedley,
Consultant, Occupational Health
- 4.8** **Informatics Update for review**
10:40 Sponsor: Jane Hayward, Director of Transformation & Improvement
Attendee: Adrian Byrne, Director of Informatics
- 4.9** **Finance Report for Month 7 for review**
10:50 Sponsor: David French, Chief Financial Officer
- 5** **Corporate Governance, Risk and Internal Control**
- 5.1** **7 Day Services Self-Assessment - Autumn/Winter 2019/20 for approval**
11:00 Sponsor: Jane Hayward, Director of Transformation & Improvement
- 5.2** **Register of Seals, and Chair's Actions for ratification**
11:05 In compliance with the Trust Standing Orders, Financial Instructions, and the
Scheme of Reservation and Delegation.
Sponsor: Peter Hollins, Trust Chair
- 6** **Any other Business**
11:10 To raise any relevant or urgent matters that are not on the agenda
- 7** **To note the date of the next meeting: 9 January 2020, in the Conference
Room, Heartbeat Education Centre, F Level, North Wing, SGH**
- 8** **Exclusion of press, public, and others**
11:15 The public and representatives of the press may attend all meetings of the
Trust, but shall be required to withdraw upon the Board of Directors resolving
as follows "that representatives of the press, and other members of the public,
be excluded from the remainder of this meeting as publicity would be
prejudicial to the public interest by reason of the confidential nature of the
business to be transacted."
- 9** **Items circulated to the Board for reading**
11:15 7 November 2019
Press Release: Doctors use pioneering 'pocket' ultrasound to beam scans to
iPhones in an instant
15 November 2019
Press Release: Southampton's Princess Anne Hospital to go purple for World
Prematurity Day
18 November 2019
Press Release: Health professionals spend 'day in life' of inflammatory bowel
disease patients using innovative 24-hour app (embargoed)

- 9.1 Learning from Deaths 2019/20 Quarter 2 Report**
Sponsor: Derek Sandeman, Medical Director
- 9.2 CRN: Wessex 2019/20 Quarter 2 Performance Report**
Sponsor: Derek Sandeman, Medical Director
- 10 Follow-up discussion with governors**
11:15
- 11 Clinical Visit - Patient Safety Team (showcase the work of the patient safety team including discussing IMEG)**
11:30
- 12 Lunch**
12:45

Minutes Trust Board – Open Session

Date	31/10/2019
Time	9:00 - 11:40
Location	Conference Room, Heartbeat Education Centre, F Level, North Wing, SGH
Chair	Peter Hollins (PTH)
Present	Jane Bailey (JB) Non-Executive Director (NED); David Bennett (DB) NED; Gail Byrne (GB) Director of Nursing & Organisational Development (DoN & OD); Cyrus Cooper (CP) NED; Jenni Douglas-Todd (JD-T) NED; David French (DAF) Chief Financial Officer (CFO); Jane Hayward (JH) Director of Transformation & Improvement(DoT&I); Paula Head (PH) Chief Executive Officer (CEO); Tim Peachey (TP) NED; Derek Sandeman(DS) Medical Director (MD), Simon Porter (SP) Senior Independent Director (SID) & NED
Attendees	Charlie Helps (CH) Company Secretary (Interim), Duncan Linning-Karp (DL-K) Director of Operations for Emergency Services, Jacqui McAfee (JMcA) Director of Operations for Elective Services
Apologies	Steve Harris (SH) Director of Human Resources (DoHR)
Minutes	Sarah Smithurst

- 1 Chair's Welcome, Apologies and Declarations of Interest**

The Chairman welcomed those present in particular Tim Peachey, NED and Jacqui McAfee and Duncan Linning-Karp, acting on behalf of the Chief Operating Officer. The Chairman noted apologies and asked for any new declarations of interest in matters on the Agenda. No conflicts of interest with items on the Agenda were declared.
- 2 Minutes of Previous Meeting held on 26 September 2019**

The minutes of the previous meeting were agreed as true and fair.
- 3 Matters Arising and Summary of Agreed Actions**

To discuss any matters arising from the Minutes, and to agree on the status of any actions assigned at the previous meeting.

ACTION 80) Defect work orders – completed.

ACTION 81) Workforce reports – This had been incorporated into JB's governance review.

4 Quality, Performance and Finance

Staff Stories

To receive feedback from patients, carers, or other stakeholders about their experience of the Trust's services.

October's stories related to the impact of aggressive and violent behaviour experienced by three front line staff within the Trust and the physical and emotional effects suffered thereafter. GB and the Board thanked those staff members who were in attendance to present their stories to the Board.

Questions were raised by various members of the Board in relation to the counselling available and whether it was tailored accordingly. As Chair of the Wellbeing Group, PH would raise the issues discussed as a priority. GB would also take that forward to the group leading on Violence & Aggression Steering Group.

It was noted that returning to work following an incident of sickness, which was a direct result of assault injuries sustained at work, appeared to be too process driven with a lack of compassion and understanding. It was agreed that that issue should be addressed.

The Board again thanked the staff who took the time to give an account of their moving experiences which highlighted a series of issues to take forward. It was agreed that whilst the Trust could not take the risk of violence away completely, it must do more to provide appropriate security, support and emotional care to those who were affected.

ACTION: SH to review the support offered to those staff members suffering violence and the application of Trust policy in relation to the withholding of salary from those victims of violence unable to work.

ACTION: GB to inform the staff members involved of the outcome of the above.

4.2 Briefing from Chair of Quality Committee for review

CC summarised the items discussed at the October Quality Committee:

- Non-Clinical Out-of-Hours bed moves. Progress report on intervention will return to the QC in 6 months on project to measure and improve bed availability.
- Progress on Quality Improvement Framework 2019/20 including: Mental capacity and deprivation of liberty protection safeguards; Safe discharges and care handover; Health services for patients with learning disabilities; and, Emergency Access Performance Quarterly Update.
- Patient Safety including: Ophthalmology update; and, Learning from Never Events.
- Clinical Effectiveness Outcomes Report: overall outcome excellent.

4.3 Briefing from Chair of Audit and Risk Committee for review

SP summarised the items discussed at the October Audit & Risk Committee:

- Standing Financial Instruction – this would be discussed at item 6.4.
- Data Protection – New DPO in post who is making good progress.
- Risk Management – New Risk Management System has been installed.
- Annual Litigation & Insurance Review – Whilst cases are handled centrally, the Committee reviews the Trust cases regularly.
- Audit assurance was received by the Committee that the programmes of work are on schedule.

The question was raised whether the Board was getting sight of the nature of the claims. TP will ensure that this is picked up through the Quality Committee and provide a periodic summary to the Board. It was noted that the CFO and MD were thoroughly reviewing all events that led to the issues.

ACTION: TP to provide a periodic summary to Board of claims made against the Trust.

4.4 Briefing from Chair of Strategy & Finance Committee for review

JB summarised the items discussed at the October Strategy & Finance Committee:

- Monthly financial performance - It was felt that this had been a 'solid' month with no particular issues to note.
- The impact of pensions on delivery. The finance team was attempting to quantify the impact on performance.
- Cost Improvement Programmes (CIPs). The Committee was satisfied that control of CIPs was improving although delivery remained behind plan.
- Possible financial year-end scenarios. The Committee had explored the risks associated with the year's outcome. There would be no recommendation for any change in the forecast before Q3.
- Capital Plan Reviews – The Committee continued to track spending which was just below plan. It appeared that it might be possible to bid for capital from the centre and there was a need to have cases prepared accordingly.
- A report was presented to the Committee showing greater visibility of future business cases which it found very helpful.

4.5 Integrated Performance Report for Month 6 for review

- JD-T expressed concern at the increased levels of staff sickness and asked what was being done to address that issue. PH responded by stating that reviews were taking place to look underneath the sickness to see what was driving the increase. Demand and capacity differences might be impacting on wellbeing and that was a focus for the Wellbeing Group and proactive management of stress and ensuring muscular skeletal (MSK) related issues had direct access for treatment were being reviewed.
- PTH noted that there was a medication error which appeared to result from the misidentification of a patient and observed that there had been a disturbing number of such cases in recent months. DS reported that more training and support was required to ensure that such misidentification was avoided in the future.

ACTION: *The Quality Committee would review progress on eliminating the possibility of patient mis-identification in 6 months' time and feed back to the Board.*

- PTH expressed concern around the Referral to Treatment (RTT) and Emergency Department (ED) performance figures and asked for assurance that the hospital was moving in an improved direction. JMcA said that the national performances on both were deteriorating.
- JMcA gave examples of work being undertaken to improve the position on RTT on cardiology and neurology in particular.
- GB highlighted that the newly qualified nurses were not currently being shown in the workforce figures but would as the Trust moved into the winter.
- JB asked for more time for the Board to review Research and Development (R&D) Strategy. PTH suggested that could return to the Board as a study session topic.

ACTION: *PTH to identify an opportunity to discuss R&D strategy during a Board Study Session.*

- SP queried the 6% increase in delayed transfer of care equating to a figure of over 100 beds, and asked if there were any special features in September which had caused it. JH felt that might result from a dip in domiciliary care packages over the summer. That had been escalated to the Southampton City Clinical Commissioning Group (CCG) and North and West Hampshire CCGs and it has been noted in the system wide winter plan.
- In response to a question from JD-T on recruitment to My Medical Record, JH suggested that it would be more meaningful to show the data as a cumulative number.
- CC highlighted that there was much strength in having a shared research and development mission with the University and it was important for the two organisations to work together. PH was scheduled to meet new VC and would discuss an alignment of clinical and strategic thinking. A University of Southampton (UoS) and UHS Board to Board meeting was suggested for the future.

ACTION: *PH to arrange a joint meeting of the UHS and UOS Boards.*

- GB reported that the Trust continued to struggle to reach the 95% target for Venous Thromboembolism (VTE) assessments. TP asked if that was due to the work not being done or not recorded. GB confirmed that it was mainly a problem of recording.

4.6 Finance Report for Month 6 for review

DAF presented the month six Finance Report stating for October that:

- September was a 'steady month' resulting in a surplus for the month of £0.4m which was £0.2m better than plan. Year to date (YTD) the Trust was reporting a £0.5m surplus, which was £2.7m better than the planned deficit of £2.1m at that stage in the year.
- YTD elective was 2% (£1.7m) below plan whereas YTD non-elective was £7m (7%) above plan despite some recent respite in A&E attendance volumes.
- Pay costs were slightly lower in September after adjusting for the medical

bank pay which was all paid in August. Agency spend was well below the cap, but that might be creeping back up.

- CIP performance was £2.5m in September, £1m behind plan due to overall income not being high enough to recognise the CIP.
- The forecast for CIP was a key element of the year-end financial outcome. Detailed discussions took place with the Strategy & Finance Committee. Whilst the view was that achieving the original planned surplus of £17m was looking unlikely, a good outcome was still achievable with a Q3 surplus and a possible overall Use of Resources score of 2 rather than 3.

PTH noted the work being undertaken and felt that it was a reflection on the good financial management by the finance team.

5 Strategy and Business Planning

5.1 Trust Winter Plan for approval

The Chairman thanked JMCA, DLK and their teams for their input on the document.

DL-K presented the Plan and the work being undertaken to allow the Trust to meet the winter pressures. That was compiled in conjunction with clinical teams which recognised that was the best option to see the Trust through the winter period. The plan would be circulated via Staffnet, through various consultants, nursing and staff meetings and sessions would be available for all staff to attend. Staff already felt reassured that a plan is in place and written down and it was recognised that escalation and understanding was important going forward.

SP asked when the Board would know if the plan was making a difference to emergency attendances over the winter. Southampton Clinical Commissioning Group (SCCG) had launched a targeted campaign and are working on communicating the message out into the wider community. It was noted that the Urgent Treatment Centres would not affect the winter pressure.

Discussion took place around the Emergency Department Approach and the imbalance between capacity and demand. PTH suggested that the Trust should be looking further ahead than was currently the case. PH reported that this is part of the wider system with some parts included in the LTP which would be incorporated into future plans as part of the strategic plan.

The Board noted that it was a well-considered and balanced winter plan.

6 Corporate Governance, Risk and Internal Control

6.1 Feedback from Council of Governors' (CoG) meeting 8 October 2019

PTH summarised the items considered at the at the October Council of Governors meeting which had involved the new cohort of governors. Items discussed were;

- CoG NED Q&A session
- The CEO's usual review
- An update from the Hospital Charity
- Membership engagement following concern over the quality of

- engagement. Encouraging work had been undertaken to rectify this
- The GoG formally approved TP's appointment to NED and the recruitment process for SPs successor
- Re-establishment of the Governors' Nomination Committee
- The forthcoming Governors' Strategy Day

6.2 EU Exit Briefing for review

PH presented this briefing highlighting that:

- Work going on behind the scenes to ensure NHS patients will remain safe.
- JMcA had been attending regular meetings.

6.3 Board Assurance Framework (BAF) 2019 Quarter 2 Update for review

The Board thanked CH for producing the document and the following items were reviewed:

BAF05 – DB expressed concern over the delivery of safe and timely care in relation to our current score of 25 against and asked if a target score of zero was realistic. It was noted that the risk level reflected the position in Ophthalmology. Zero was the risk appetite statement.

BAF 08 – JD-T asked whether the Quality & Diversity risk was properly represented. GB responded that there would be a review of the Workforce Race Equality Standard (WRES) action plan and also had a proactive network which was not reflected in the report. There had been challenges in the WRES particularly around bullying and harassment and there was a plan to also review the milestones.

BAF 02 – PH reported a series of actions which were taking place involving regular contact with the regulators. They were encouraged by the Trust's improvements even though it was not improving at the rate at which they would like.

BAF 10 - JB acknowledged that the R&D risk had increased but suitable action had been taken.

6.4 Review of Standing Financial Instructions 2019-20 for approval

DAF presented the 2019 Standing Financial Instructions highlighting that the paper showed the rationale behind the proposed changes and that the Audit & Risk Committee was satisfied with the recommendations.

There was some discussion over the delegations to directors and the separation of duties in relation to the Chief Financial Officer and Deputy CEO.

PTH commented on the Capital Investment proposals which regularly come to the Board and asked if it was sensible to differentiate between those which had been included in the annual plan and those which had not. It was agreed that only projects involving capital expenditure of £2.5m or above would come to the Board for sanction irrespective of whether they had, or had not, been included in the annual plan, unless there were extraordinary circumstances.

Decision

It was agreed that the level of investment which comes to the Board was to be changed to £2.5m.

The Board approved the Standing Financial Instruction 2019-20 subject to the few changes suggested.

6.5 Register of Seals, and Chair's Actions for ratification**Decision**

The Board ratified the Chair's actions taken in the month.

7 Any other Business

DB reported that he had been invited to take up the role of NED at the Faculty of Leadership and Medical Management, which was a national intercollegiate professional body and which promotes excellence in leadership on behalf of all doctors in the UK. The Board agreed that there was no conflict of interest involved in that. It would be recorded on the Register of Interests by the Interim Company Secretary.

8 To note the date of the next meeting: 28 November 2019, in the Conference Room, Heartbeat Education Centre, F Level, North Wing, SGH

List of action items Trust Board – Open Session 31 October 2019

Agenda item	Assigned to	Deadline	Status
4.1 Staff Stories			
114.	Staff Stories	● Harris, Steve	28/11/2019 ■ Pending
<p><i>Explanation action item</i> Review the support offered to those staff members suffering violence and the application of Trust policy in relation to the withholding of salary from those victims of violence unable to work.</p>			
115.	Staff Stories	● Byrne, Gail	28/11/2019 ■ Pending
<p><i>Explanation action item</i> Inform staff members involved of the outcome of action 114.</p>			
4.3 Briefing from Chair of Audit and Risk Committee for review (Oral)			
116.	Annual Litigation & Insurance Review	● Charles, Audley ● Peachey, Tim	27/01/19 ■ Pending
<p><i>Explanation action item</i> TP to ensure nature of claims against the Trust is picked up through the Quality Committee and provide a periodic summary to Board.</p> <p>Update: 28 November 2019 The new Interim Company Secretary to meet with the Chair of Quality Committee to discuss format and content of report requested, incorporate into the Committee's Annual Business Cycle and agree frequency of report to the Board post a first report to the Board on 30 January 2020.</p>			
4.5 Integrated Performance Report for Month 6 for review			
117.	Patient Mis-identification	● Charles, Audley ● Peachey, Tim	29/04/2020 ■ Pending
<p><i>Explanation action item</i> The Quality Committee to review progress on eliminating the possibility of patient mis-identification in 6 months' time and feed back to the Board.</p> <p>Update: 28 November 2019 This to be incorporated into the Quality Committee agenda for 27/04/19, with a report to Board.</p>			

118.	Research and Development Strategy	● Hollins, Peter	28/11/2019	■ Pending
<i>Explanation action item</i> Identify an opportunity to discuss R&D strategy during a Board Study Session.				
119.	Shared Research and Development Mission	● Head, Paula	28/11/2019	■ Pending
<i>Explanation action item</i> Arrange a joint meeting of the UHS and UOS Boards.				

Report to the Trust Board of Directors dated Thursday, 28 November 2019			
Title: Integrated Performance Report 2019/20 Month 7			
Category	Quality, Performance, and Finance		
Agenda item	4.5		
Sponsor	Director of Transformation and Improvement		
Author	Trust Performance Manager		
Provenance	The Integrated Performance Report is reviewed monthly by the Board of directors		
Classification	This Report is unclassified.		
Purpose and recommendation	The paper is presented for REVIEW.		
Relevant strategic goals	✓ Goal 1: Improving patient journeys.	✓ Goal 2: Delivering value-based health and care.	✓ Goal 3: Supporting healthy lives.
	✓ Goal 4: Building an expert and inclusive workforce.	✓ Goal 5: Being agile in meeting people's needs.	✓ Goal 6: Creating leading-edge research, education, and innovation.
Assurance framework links	<ul style="list-style-type: none"> • BAF01 – Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways • BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6 • BAF03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme • BAF04 – Reduced access to resources compromises the quality of services • BAF05 – Capacity and capability gaps in the workforce lead to an inability to provide safe and timely care • BAF06 – Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services • BAF07 – Poor staff wellbeing and engagement leads to an inability to deliver safe and timely care • BAF08 – Lack of inclusion and diversity results in the failure to get the best from every individual • BAF09 – Failure to respond with the necessary organisational changes in design and operation renders the Trust unable to remain a competent NHS Provider • BAF10 – Inability to offer translational research renders the Trust unable to maintain its cutting-edge teaching hospital status 		
Impact assessments	n/a		
Other standards affected	n/a		

Integrated KPI Board Report Digest

Improving patient Journeys

October was a challenging month for UHS across both the elective and non-elective pathways. However, we saw relevant consistent ED performance that remained above 80%. There was no agreed trajectory for the month of October.

Non elective length of stay remained at 6.4 in October. Delayed transfers of care remained relatively stable at 6.8% against a target of 3.5%. We have continued to work closely with system partners and we are working together to ensure we have additional capacity in the winter months. We have signed of plans to open additional beds both at UHS and in the community to support winter flow.

Adult bed occupancy has been consistently higher this autumn compared to last autumn at around 95%. We have had a 7.8% growth in emergency attendances and a 4.2% increase in non-elective spells (year to date) accounting for the additional inpatients this summer. While the total number of ED attendances in October reduced slightly from September there was a 13% increase in attendances compared to the same period last year. While we have seen a reduction in Length of Stay in some care groups particularly Medicine for Older People and Surgery we did not see the level of improvement needed in September.

We have continued to work within division B to reduce LOS particularly with patients waiting longer than 21 days. While the project has shown some early signs of success, we are confident that we can improve significantly faster with support from PwC.

While we have not met the trajectory we did see further improvements in emergency access performance in October. Type 1 performance in October was 80.5% and we ranked 4th of 8 Major Trauma Centre peers (8th being worst). Local delivery system performance was at 87.2% in September against a target of 90.0%. The main factors in improvement were the additional junior doctor numbers, and the improved minor injury performance. The recovery plan is being delivered based on the recommendations of Matthew Cooke, a national clinical advisor. This is being monitored fortnightly with the national team and a new system plan has been agreed with weekly CEO oversight. The number of patients cancelled and not re-admitted was higher than normal due to poor bed flow and high non-elective demand in critical care.

Percentage of patients on an open Referral to treatment pathway (waiting list) who have waited less than 18 weeks in October is at 81.5%. The drop in operating and outpatient clinic activity over the summer months due to annual leave and reduced backfill of capacity as a result of pension impact remains an undercurrent within the waiting list. The list increased in size by 743 patients despite October being the 2nd highest volume of patient's clock stops this year for both admitted and non-admitted care. Anaesthetics has recruited to 4 vacant posts substantively and this maintains the positive progress with regard to the long standing mismatch between demand and capacity in the service and should build in some resilience for the winter. There were four patients waiting longer than 52 weeks at the end of October, 3 x ENT and 1 x Gastroenterology.

6 week diagnostic performance remains under target at 97.7 % however this is the 4 month in a row where there has been an improvement in delivery against a standard of 99%. Despite not achieving target UHS continues to buck the national trend for diagnostics with a slow but steady improvement.

Average weeks waited for first outpatient appointment sits at 8.7 which is exactly the same as 12 months ago reflecting the increase in referrals which has wiped out any gains made in pathway changes or transformation of first OP services.

Overall performance of the 62 day cancer wait metric still remains below target as does 31 days. UHS was ranked 8th (10th being worst) out of a peer group of 10 similar size teaching hospitals. The issues impacting on cancer capacity remain consistent with reduce WLI to support clearance lists and additional diagnostics. UHS continues to work closely with the Wessex cancer alliance and NHSI.

2 week GP referral cancer waiting time performance remains high, achieving target for the seventh month in a row.

Delivering value based health and care

The Reference Cost Index (RCI) is a measure of relative efficiency within NHS providers. An RCI of 100 indicates costs are in line with the national average, below 100 indicates costs are below the national average. UHS had an RCI of 98 in 2016/17 and 96 in 2017/18 i.e. in 2017/18 UHS was 4% (£27m) more cost efficient than the average NHS Trust.

Cost per Weighted Activity Unit (WAU) is the headline productivity metric used within the Model Hospital. Costs are adjusted for local variations in the cost of providing healthcare using the Market Forces Factor (MFF). In 2017/18 UHS cost per WAU was £3,358 which is in quartile 1 (the lowest 25% in the nation), the national median for 2017/18 was £3,486.

The Model hospital in association with the GIRFT team has now published up to date clinical metrics for 7 surgical Specialties, these will be updated at regular intervals in the year for trust to monitor and review.

Getting it right first time (GIRFT) is a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations. At UHS 21 out of 33 clinical specialties has been visited. With 19 of these now having a clinically lead quality improvement and specialty lead investigation programmes agreed with the GIRFT central team.

The latest national data (August 2019) showed a median CHPPD for similar size (clinical output) trusts as 5.5 for registered nurses and 9.0 overall, UHS was at 5.5 and 9.0 respectively that month.

For the last 10 months the trust has achieved the target for complaints closed within 35 days, in October we achieved 84% against a target of 70%.

Supporting healthy lives

C.difficile cases achieved below limit in October with 2 against a limit of 5, of these none were deemed a lapse in care. We are below the limit of cases year to date with 32 cases against a limit of 35.

There were four moderate harm medication incident reports in October. Three were avoidable errors.

One involved a patient self-administering an antimicrobial nebuliser to which they were allergic. The nebuliser had been incorrectly selected and left with the patient to administer. All appropriate action was taken at the time to treat the patient. The incident has been scoped and is under investigation. The ward have reviewed their administration processes.

One involved a patient who was discharged on an incorrectly increased dose of phenytoin, they were subsequently admitted to HHFT with phenytoin toxicity and treated appropriately. The prescribing error was missed at the screening stage. Both the prescriber and pharmacist are aware of the incident and the medication safety team are currently clarifying the finer details of the process involved in prescribing and screening.

One involved a PICU patient on ECMO who received an incorrectly prepared infusion of the anticoagulant heparin. PICU have carried out an excellent investigation with clear changes and learning which has been reviewed by the medicines safety group.

The unavoidable incident relates to a patient in endoscopy who required reversal of the sedation with flumazenil. All cases where flumazenil is required are regarded as potential errors. Endoscopy have investigated the case appropriately and ascertained that the doses used during the procedure were correct and the patient responded slightly more sensitively than usual.

Patients screened for risky behaviours in October (alcohol consumption and smoking) remain stable well above target (currently 98% against a target >80%). Of those found to have moderate or high alcohol dependence 88% were given relevant advice or a referral to specialist services in October, this performance is stable not achieving the target 90% (last achieved December 2018). Of those found to smoke who were given advice or offered medication performance in October was 83%, below the target 90%. CQUIN funding has been awarded for further Medicines Management Team members for the duration of the CQUIN – until the end of March 2020. This will allow for some out of hours and weekend work targeting specific areas that there is currently low uptake on. These members will predominately focus on the tobacco advice and offering of medication as it is felt that there is a robust enough system in place currently focussed on the alcohol elements of the CQUIN. We have also now set up a weekly report to inform all members of how we are doing within the quarterly milestone so that focus can be moved if required. There is similarly a monthly Tobacco meeting to discuss any concerns so that any escalations are dealt with in a timely manner.

Building an expert and inclusive workforce

In UHS ward-based areas, total nursing staff vacancies have decreased by -0.43% since last month.

Registered nurse vacancies in ward-based areas have also decreased this month (by -1.10% since last month). These changes are due to promotion of RNs, relocation of staff and reduction in contracted hours mainly following return from maternity leave, however to offset this 13 Overseas nurses have acquired their PINs.

This month some key targets have been missed for staff turnover and appraisals. Sickness absence rates have increased for the fourth month and are now on above target. CHPPD has decreased but this is likely due to a change in where we are gathering data from compared to last month. UHS has seen improvements in rates of employment for BAME Band 7+. Additionally, the position for the following is decreasing: statutory and mandatory training compliance (with 6 of 12 measures meeting target).

The total CHPPD rate in the Trust has remained stable from last month to RN 5.4 (previously 5.4), HCA 3.3 (previously 3.3) overall 8.7 (previously 8.7). The CHPPD for ward based areas (excluding Critical care units) in the Trust has increased from last month to RN 4.0 (previously 3.9) HCA 3.5 (previously 3.5) overall 7.5 (previously 7.4)

Being agile in meeting people's needs

Estates helpdesk requests completed on time did not achieve target in October (8th month in a row), currently at 77.8.0% on a slow downward trend. Unresolved help desk requests remain below target but have increased by 30% in the last two months, in October we had 871 against a target <1000. Unresolved requests over 30 days old is holding at over 300 against the target <200. Percentage defect work orders completed on time did not meet the target >85% in October falling to 82.6%. The percentage of statutory and mandatory jobs completed on time remains stable and continues to meet the target 95%.

The EFCD team have looked at the effect of not performing some maintenance tasks in a timely manner and considered how this impacts patients. A simple comparator of the failure rate of toilets has been selected. In October the monthly average unavailable toilets was 0.8%.

For eQuest usage - Microbiology and immunology increased in both requesting and acknowledging along with the gradual increase in Histopathology samples. Significant work is planned in the month of November to make eQuest requesting available in Theatres.

UHS patient logins to My Medical Record continues an upward trend in October following the surge in June linked to a new registration method, patient registrations has plateaued and sits at 2865 in October. The plan is to increase to 100,000 registrations by the end of this year.

Leading edge research, education and innovation

In Q2 2019/20 UHS was ranked 6th for non-weighted and 5th for weighted CRN recruitment against a target of being in the top 10 and top 5 respectively.

In Q2 UHS are currently ranked 14th for contract commercial study recruitment, which whilst an improvement against previous recent performance (up from 16th), is still not meeting our target

of being in the top 10, which has prompted a specific focus on improving our commercial performance.

Comparative CRN recruitment performance by specialty was on target in Q2 2019/20 with 52% specialties ranking as predicted (in the top 5 or top 10 based on prior performance).

Proportion of commercial studies closing in 18/19 FY on time and to recruitment target ended the year below the 80% target at 71% in Q4; however this was an improvement on the 17/18 performance of 57%. In Q2 2019/20 this metric is currently at 58%, but we anticipate that this will improve significantly by year end.

Proportion of non-commercial studies closing on time and to recruitment target in Q2 is currently at 47% but again we anticipate that this will improve significantly by year end.

Clinical study set up and recruitment (in particular for the commercial portfolio) has been impacted by capacity constraints across the research infrastructure and by pressures within the clinical services, in particular with regards to pharmacy capacity to set up and deliver clinical trials. Concerns have been escalated to Trust Executives.

The year to date NIHR CRF & BRC publications in 2019/2020 is currently 137 (10% less than same time last year), related to a loss of clinical academic staff. This is a major concern for our next BRC and CRF applications. Actions are currently in progress that will require Trust support in due course.

Integrated KPI Board Report

covering up to

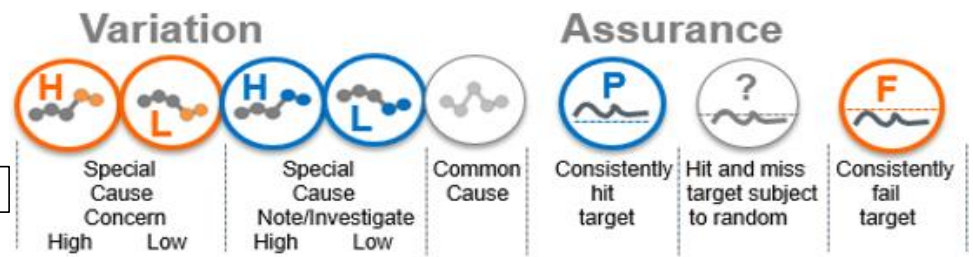
Oct 2019

Executive Sponsor - Jane Hayward, Director of Transformation

Jane.Hayward@uhs.nhs.uk

Report Guide

Chart Type	Example	Explanation
Cumulative Column		A cumulative column chart is used to represent a total count of the variable and shows how the total count increases over time. This example shows quarterly updates.
Cumulative Column Year on Year		A cumulative year on year column chart is used to represent a total count of the variable throughout the year. The variable value is reset to zero at the start of the year because the target for the metric is yearly.
Line Benchmarked		The line benchmarked chart shows our performance compared to the average performance of a peer group. The number at the bottom of the chart shows where we are ranked in the group (1 would mean ranked 1st that month).
Line Percentiles		A line percentiles chart is used to represent the distribution of a variable. The 50th percentile shows the median value, we also show the 5th, 25th (lower quartile), 75th (upper quartile) and 95th centiles.
Control Chart		A control chart shows movement of a variable in relation to its control limits (the 3 lines = Upper control limit, Mean and Lower control limit). When the value shows special variation (not expected) then it is highlighted green (leading to a good outcome) or red (leading to a bad outcome). Values are considered to show special variation if they <ul style="list-style-type: none"> -Go outside control limits -Have 6 points in a row above or below the mean, -Trend for 6 points, -Have 2 out of 3 points past 2/3 of the control limit, -Show a significant movement (greater than the average moving range).
Variance from Target		Variance from target charts are used to show how far away a variable is from its target each month. Green bars represent the value the metric is achieving better than target and the red bars represent the distance a metric is away from achieving its target.

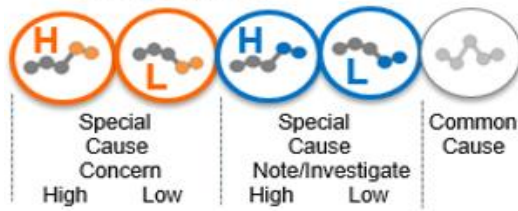


Under development

Improving Patient Journeys












IPJ ID	Description	Variation Icon	Assurance Icon
IPJ1-L	Non Elective LOS Rolling 12 months	-	-
IPJ2-N	Delayed transfers of care (CQC Calculation)		
IPJ3-N	Longer LOS Census average (Patients with LOS >=21days)		
IPJ4	Outliers weekday (am) census average		-
IPJ5-L	Adult midday bed occupancy		
IPJ6	AMU bed occupancy (8am census)		-
IPJ7	Overnight ward moves with a reason marked as non-clinical		-
IPJ8-N	Last minute cancelled operations not readmitted within 28 days		-
IPJ9	Percentage patients spending less than 4hrs in ED - UHS Type 1		-
IPJ10	Percentage patients spending less than 4hrs in ED - UHS Total (includes SGH all types and Lymington)		-
IPJ11-L	Percentage patients spending less than 4hrs in ED - Local Delivery System		
IPJ12	Same Day Emergency Care (SDEC)	-	-
IPJ13-N	Time to initial assessment - 95th Centile UHS Total	-	-
IPJ14-N	Time to treatment - Percentiles UHS Total	-	-
IPJ15-N	Total time spent in ED - Percentiles UHS Total	-	-

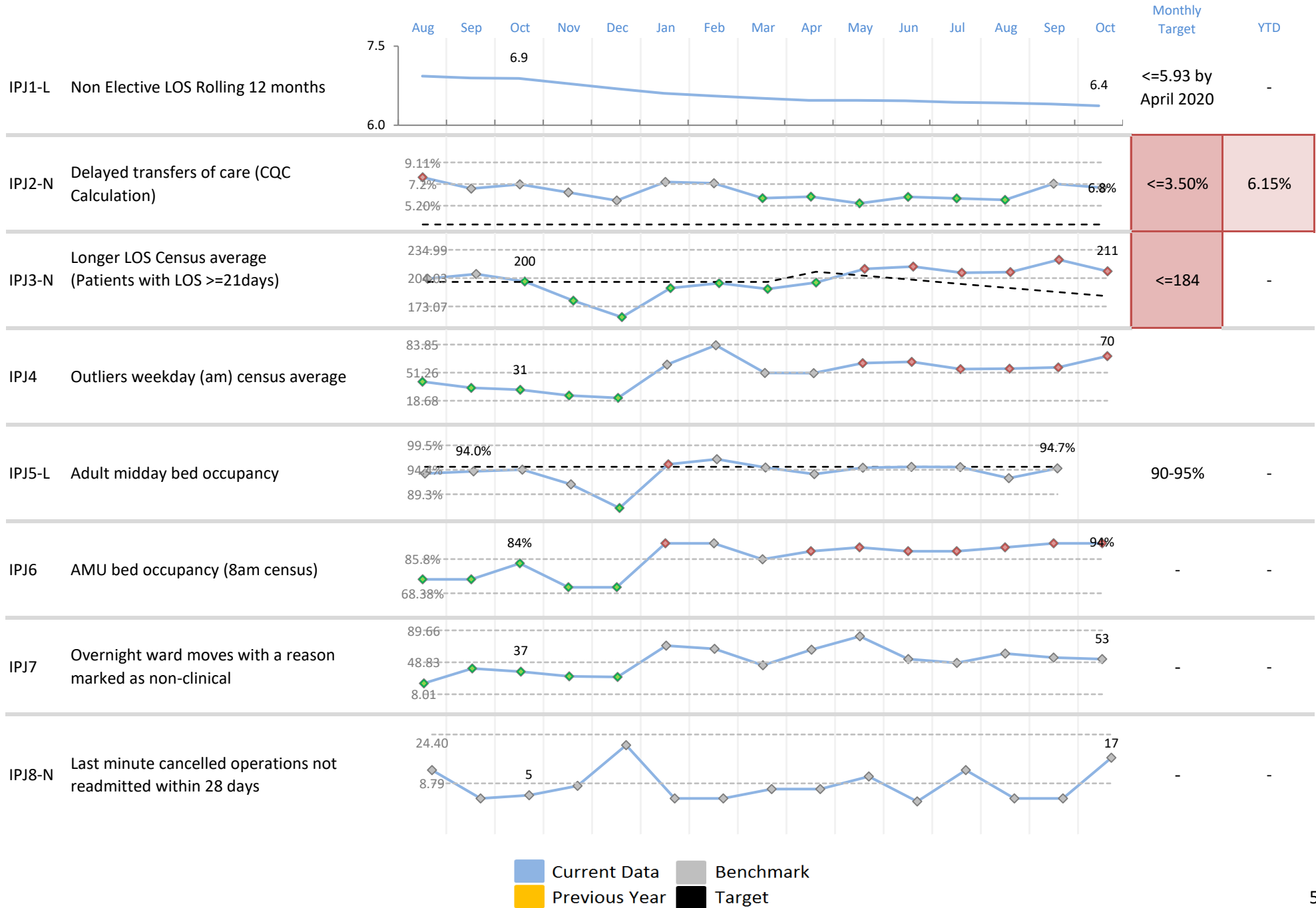
Variation



Assurance



		Variation	Assurance
IPJ16-N	% Patients on an open 18 week pathway (within 18 weeks)		
IPJ17-N	Total number of patients on a waiting list	-	-
IPJ19-N	% of Patients waiting over 6 weeks for diagnostics		
IPJ20	Average weeks waited for first outpatient appointment		-
IPJ22-L	62 day cancer wait performance		
IPJ23-L	31 day cancer wait performance		
IPJ24-N	Urgent GP referrals seen in 2 weeks		
IPJ25	Snapshot of waits > 104 days	-	-
IPJ26	28 Day Faster Diagnosis	-	-

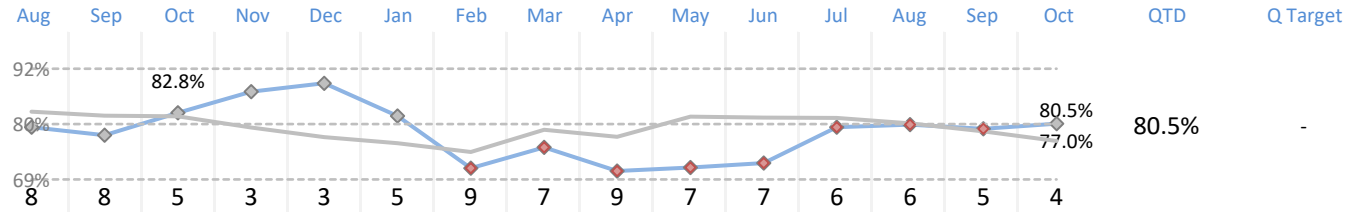


Percentage of patients spending less than 4 hours in ED

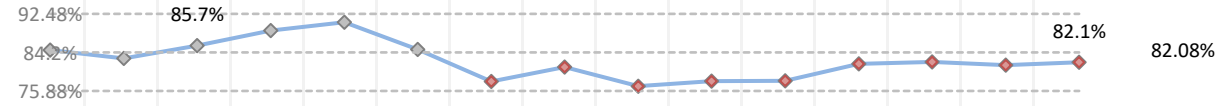
IPJ9 SGH Main ED (Type 1 and UCH)

Major Trauma Centres (Type 1)

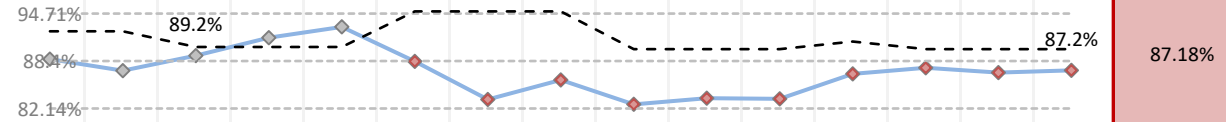
Rank of 11, (8 from May 19 onwards)->



IPJ10 UHS Total (includes SGH all types and lymington)



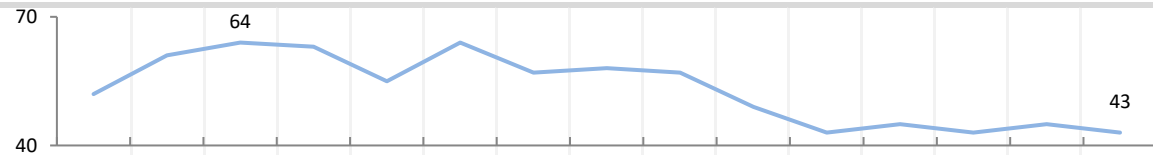
IPJ11-L Local Delivery System



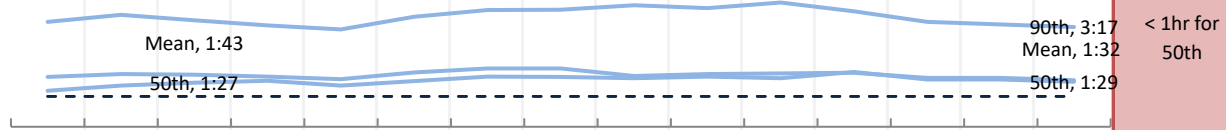
IPJ12 Same Day Emergency Care (SDEC)

Awaiting national data definition

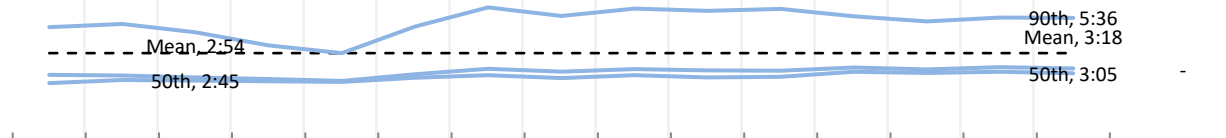
IPJ13-N Time to initial assessment - 95th Centile UHS Total



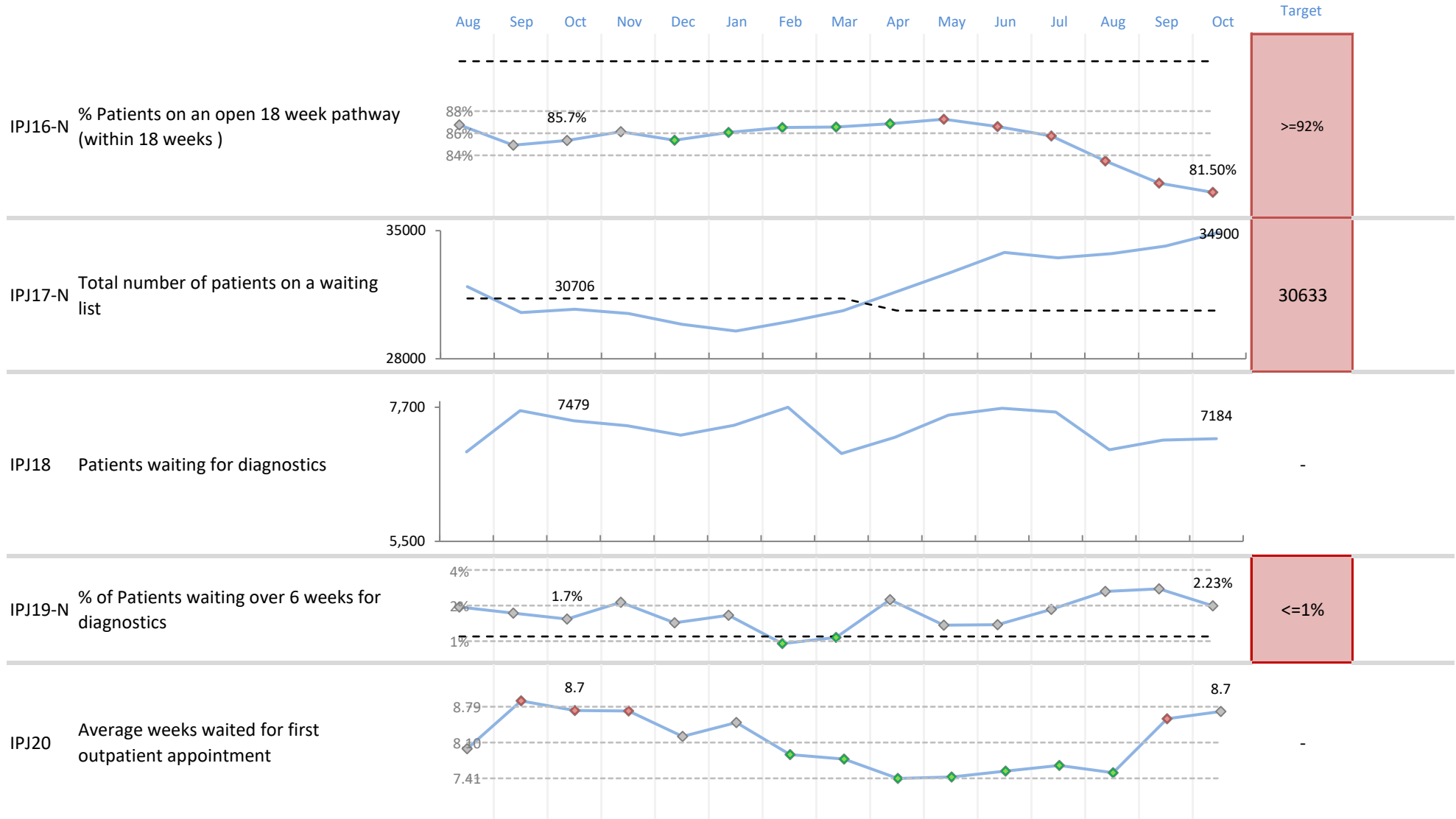
IPJ14-N Time to treatment - Percentiles UHS Total



IPJ15-N Total time spent in ED - Percentiles UHS Total



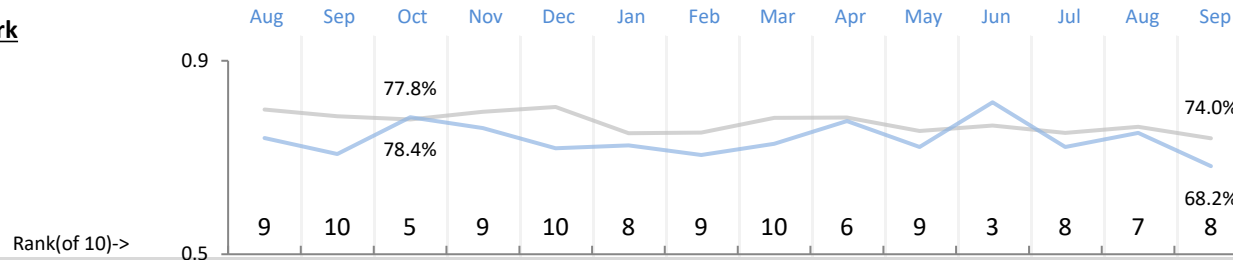
■ Current Data ■ Benchmark
■ Previous Year ■ Target



■ Current Data ■ Benchmark
■ Previous Year ■ Target

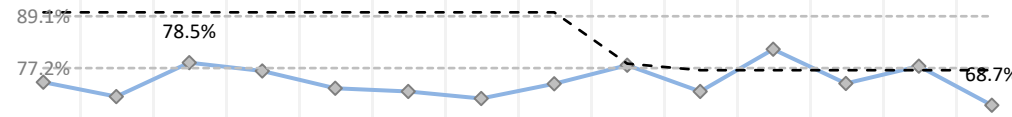
62 Day Performance Benchmark

IPJ21 Teaching Hospitals vs. UHS Total



IPJ21 UHS Total performance is taken from NHS Statistics numbers which are static as opposed to the performance shown in IPJ22 which is updated as data is validated.

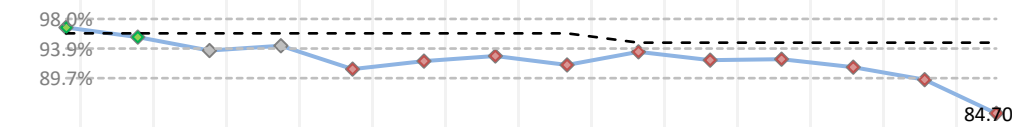
IPJ22-L 62 day cancer wait performance



=>77%	14 of 171	73%
-------	-----------	-----

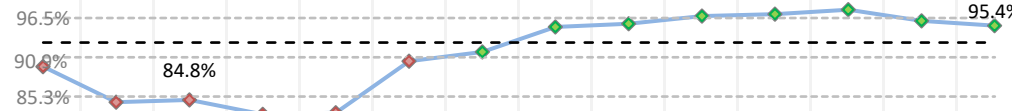
1 of 13 tumour sites achieved 62 day target in July.

IPJ23-L 31 day cancer wait performance



=>95%	83 of 830	89%
-------	-----------	-----

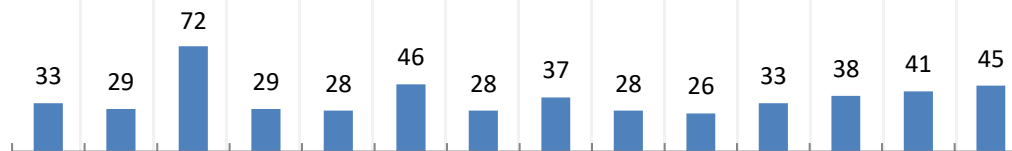
IPJ24-N Urgent GP referrals seen in 2 weeks



=>93%	0 of 1374	96%
-------	-----------	-----

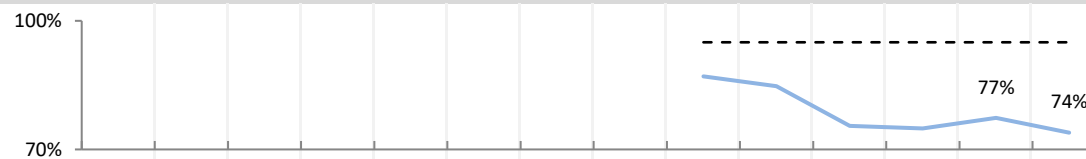
12 of 13 tumour sites achieved 2 week target in July.

IPJ25 Snapshot of waits > 104 days



=>95%	296 of 1403	75%
-------	-------------	-----

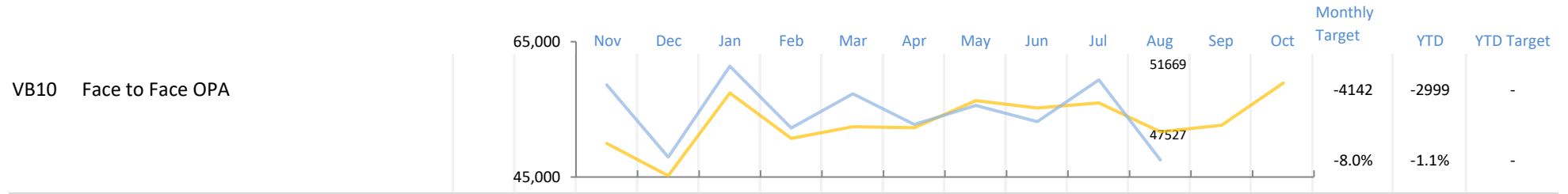
IPJ26 28 Day Faster Diagnosis



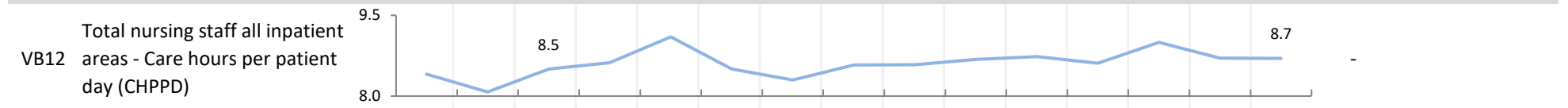
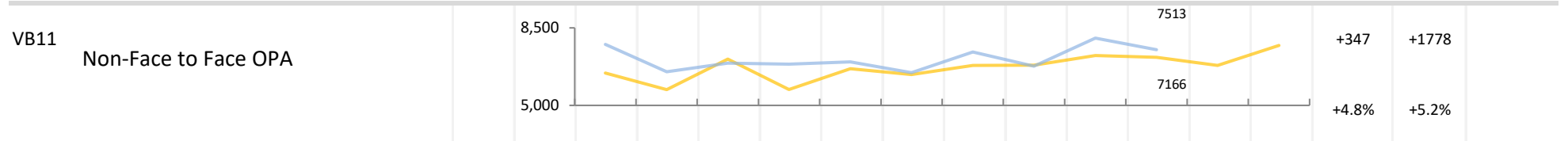
IPJ26 - this KPI is being shadow monitored by UHS in preparation for national submissions beginning April 2020. There is no update this month



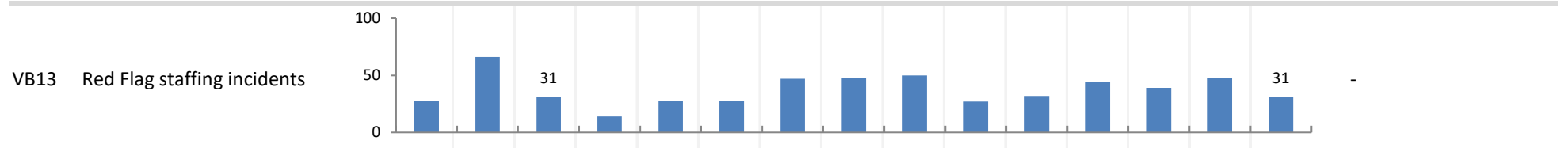


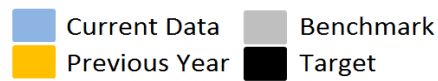
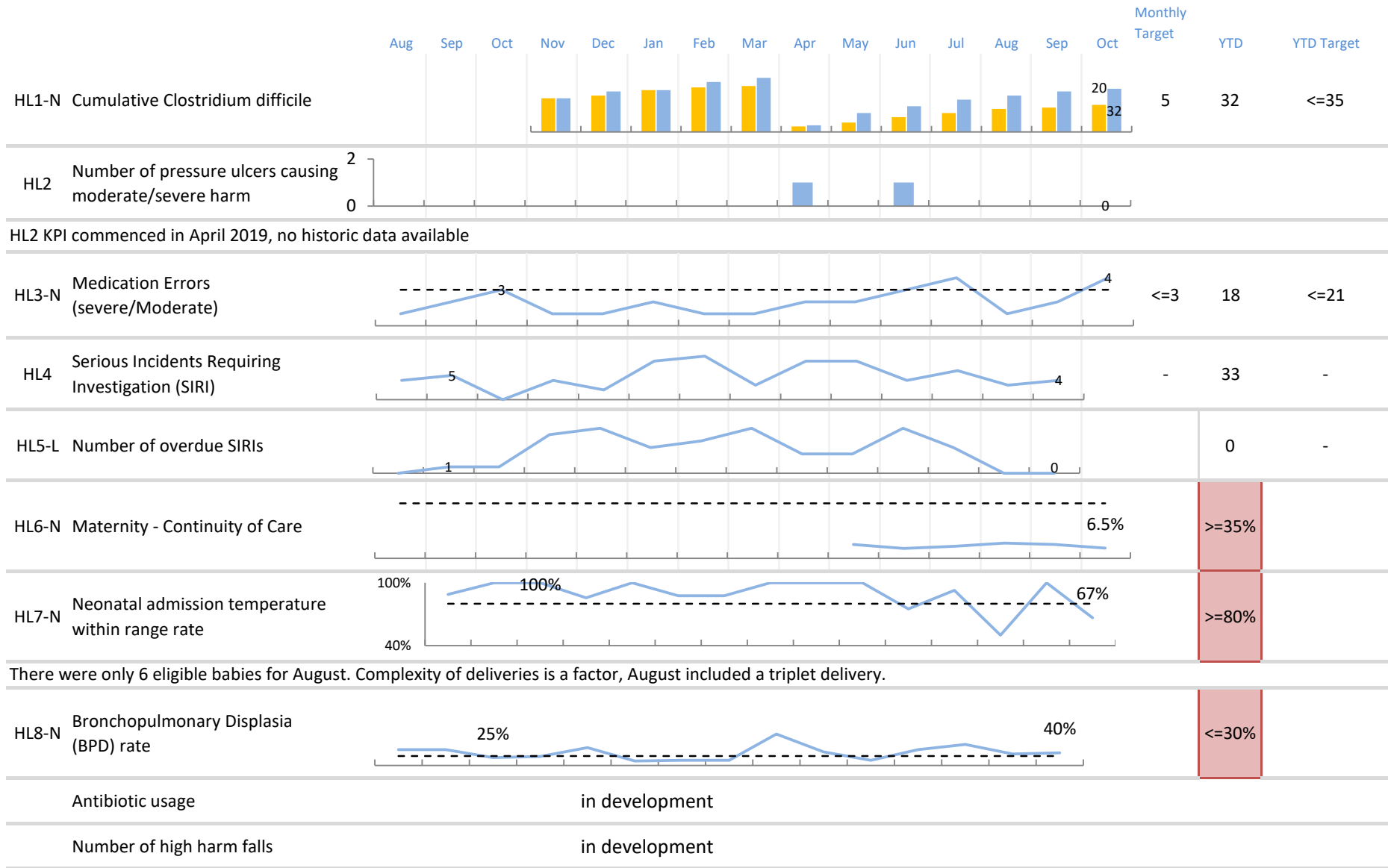


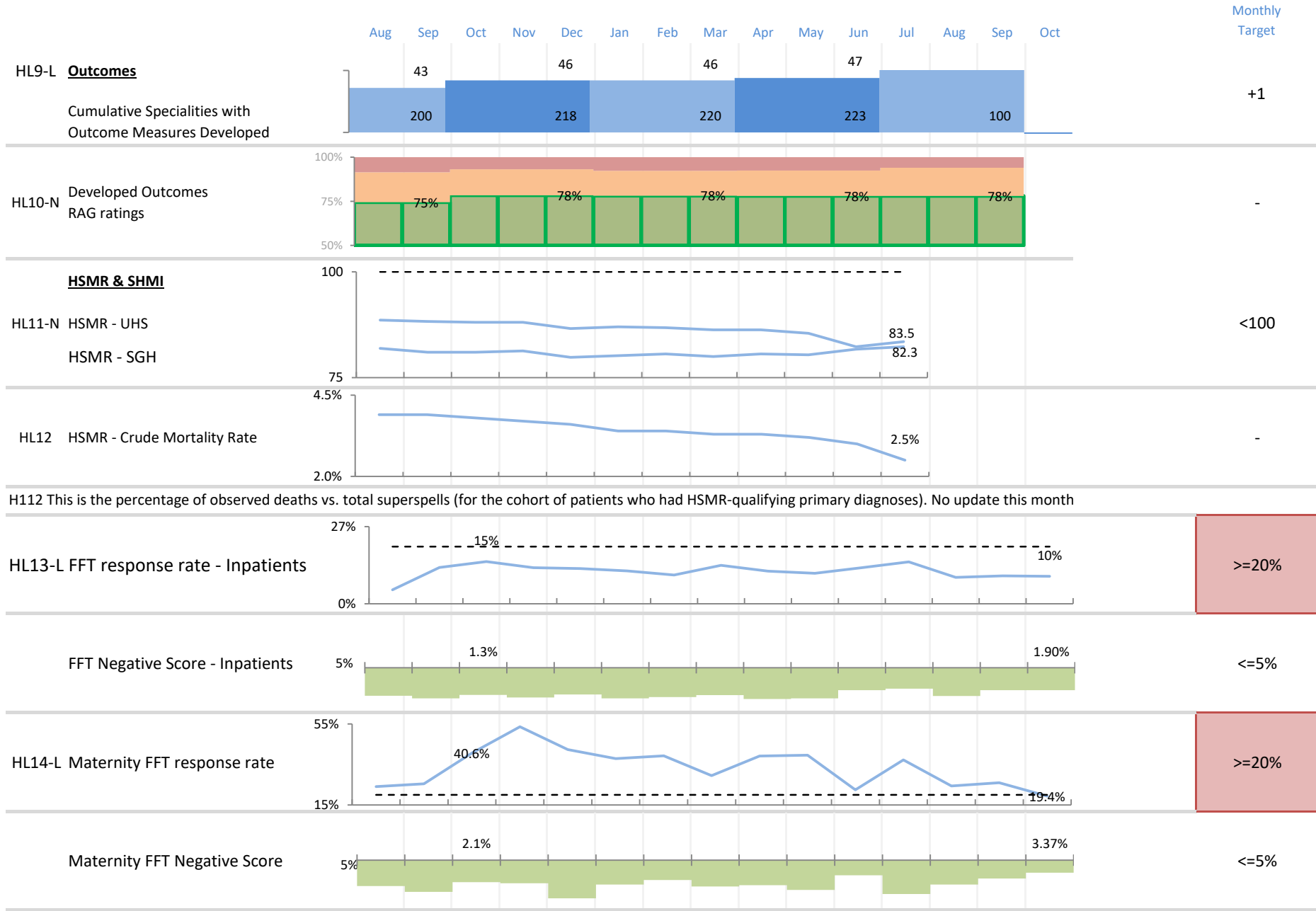
VB10/VB11: This currently excludes mymedical record contacts.



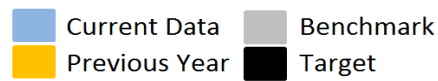
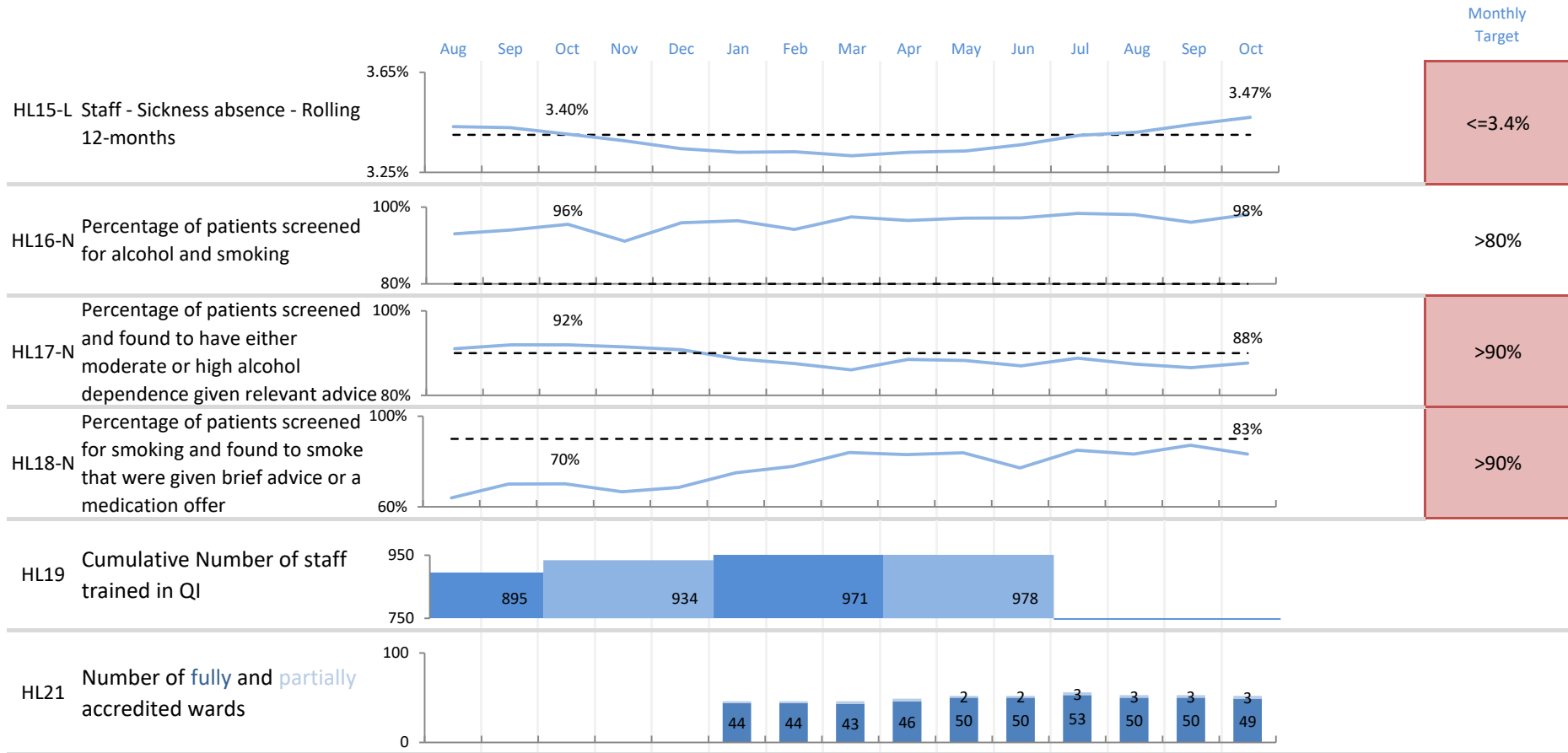
VB12 The total CHPPD rate in the Trust has increased from last month to RN 5.3 (previously 5.5), HCA 3.3 (previously 3.2) overall 8.7 (previously 9.0). The CHPPD for ward based areas in the Trust has decreased from last month to RN 3.9 (previously 4.0) HCA 3.5 (previously 3.6) overall 7.4 (previously 7.6).

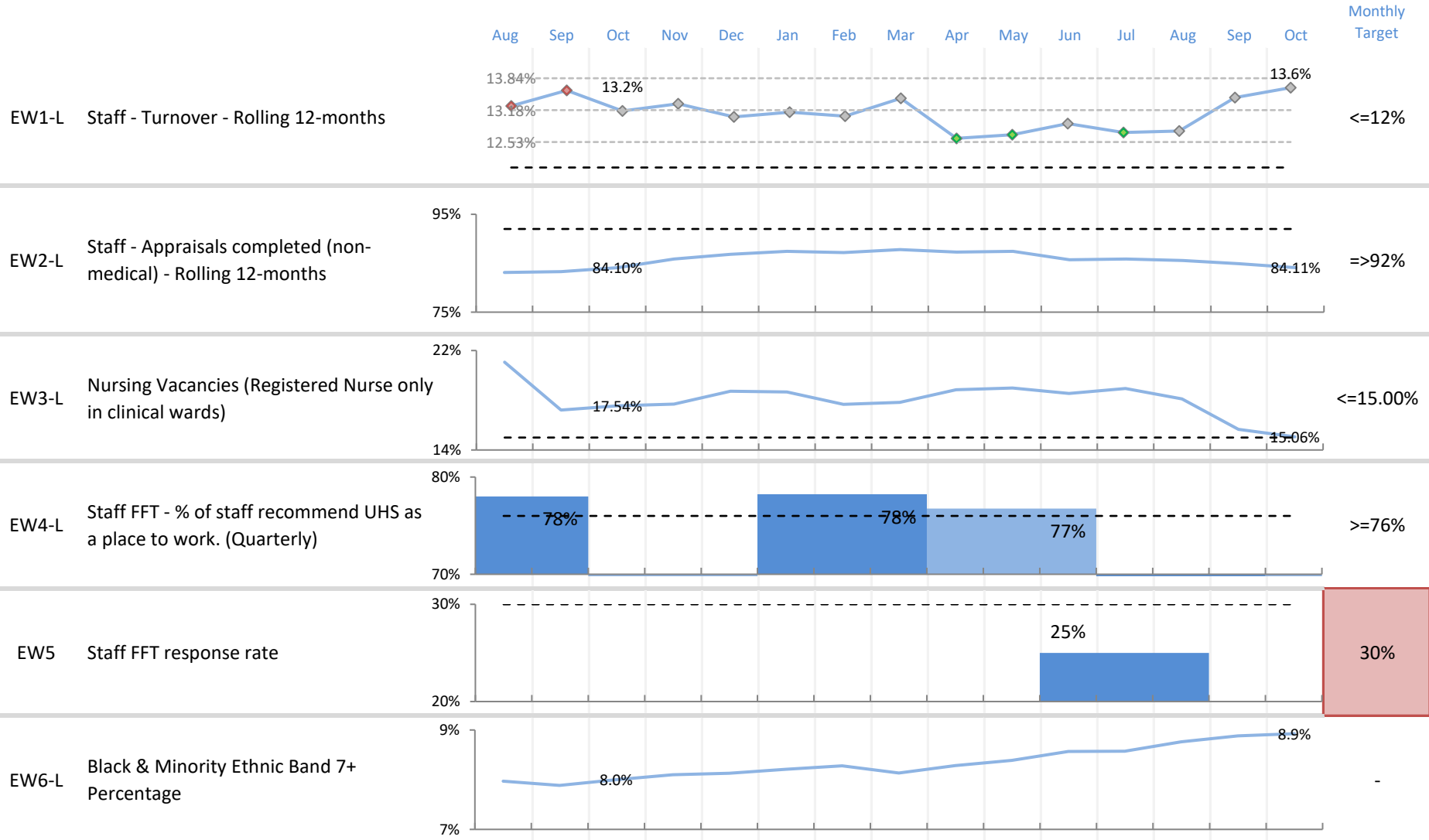




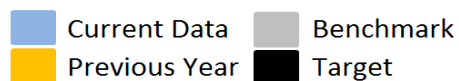


■ Current Data Benchmark
■ Previous Year Target



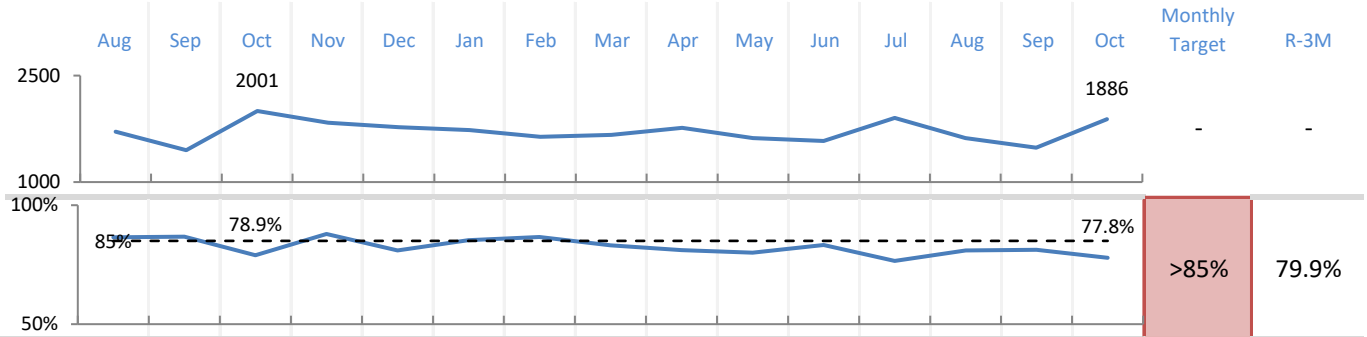


EW6 UHS has a target of 15% Band 7+ BME staff by 2023.

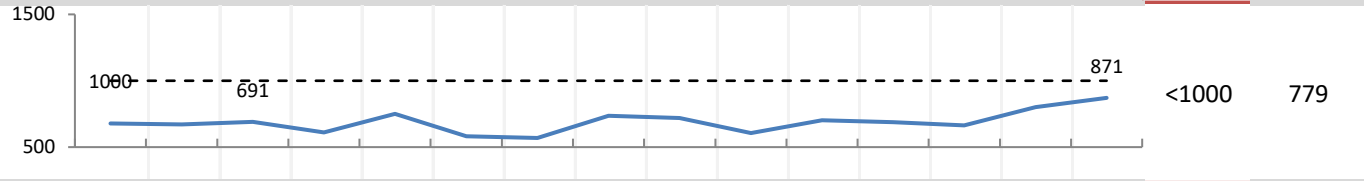


Estates

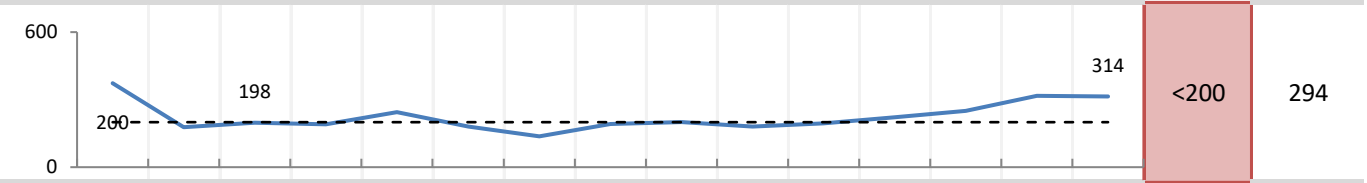
BA1-L Number of Help desk requests and percentage completed on time



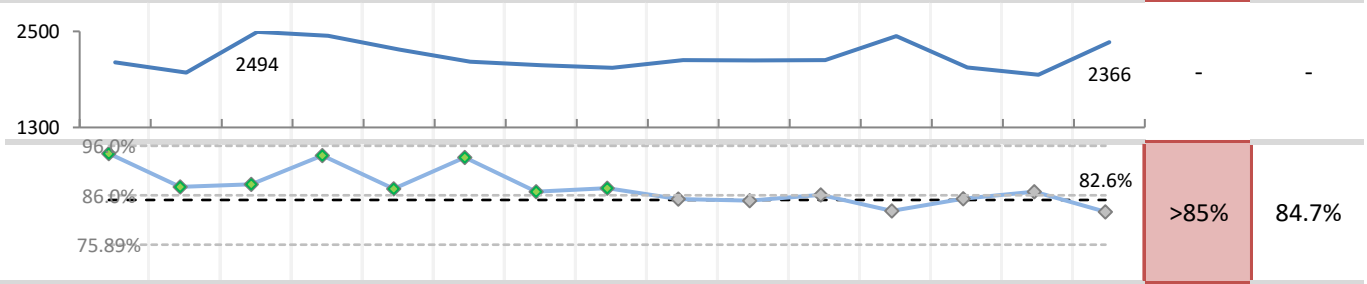
Reactive Maintenance
BA2-L Unresolved help desk requests



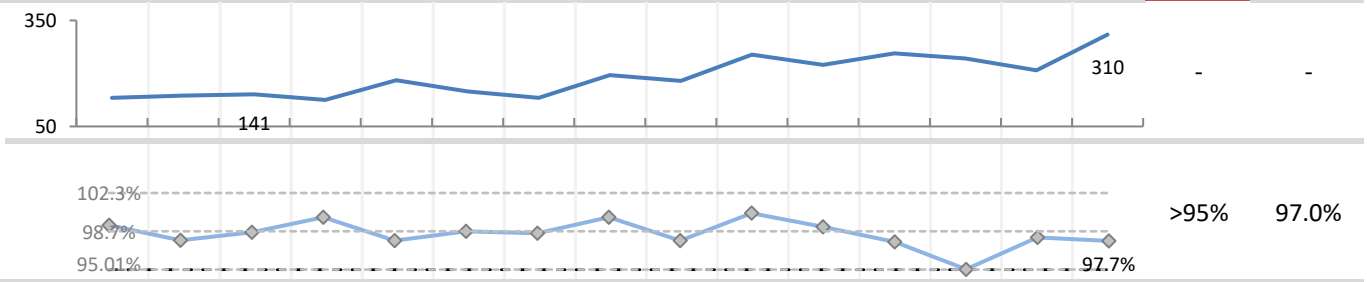
BA3-L Unresolved help desk requests (over 30 days old)



BA4-L Number of defect work orders and percentage completed on time

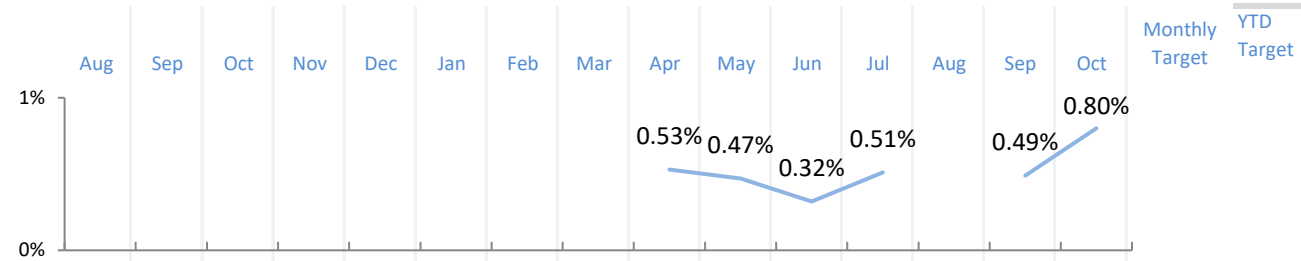


Preventative Maintenance
BA5-L Number of statutory and mandatory maintenance jobs planned and percentage completed on time



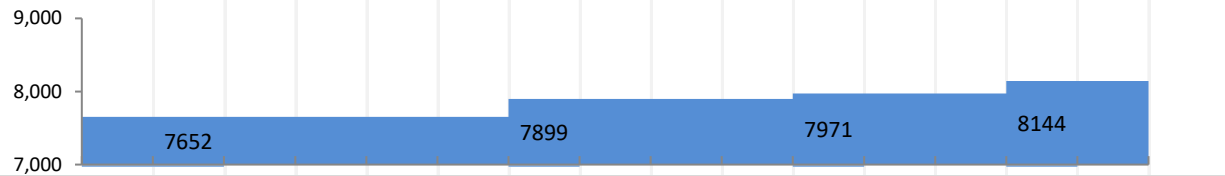
■ Current Data ■ Benchmark
■ Previous Year ■ Target

BA6 Monthly average unavailable toilets (%)

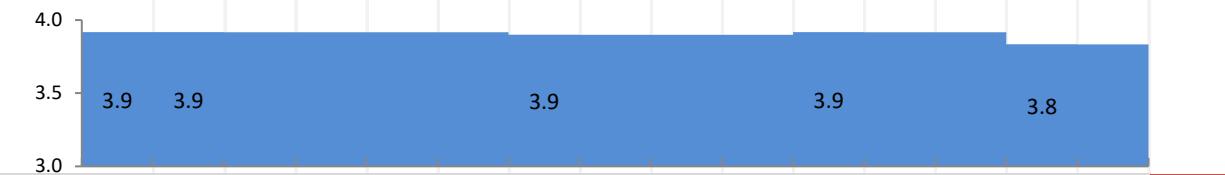


BA6 - This KPI is intended to be a proxy of the impact of maintenance work that is not completed on patients and staff.

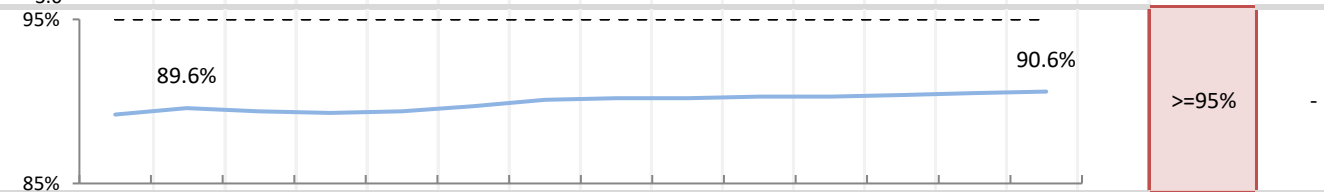
BA7 Number of computers



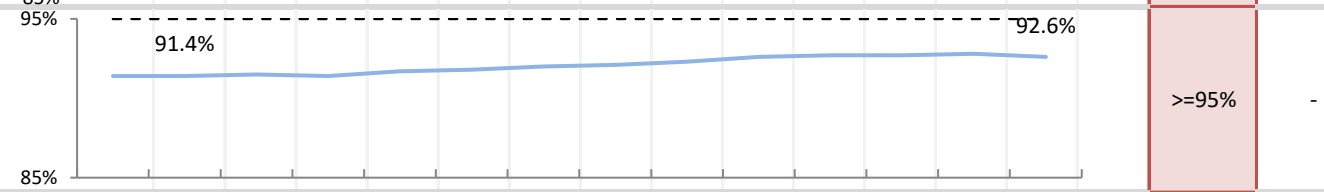
BA8 Average age of computers (years)



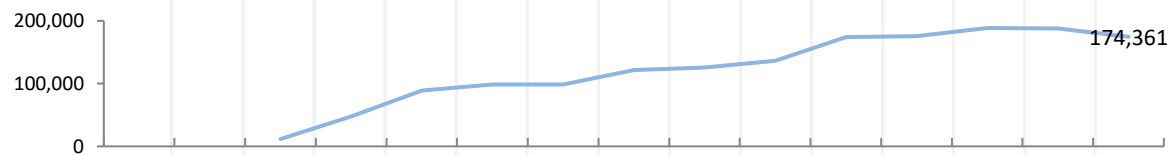
BA9-L Percentage specimens requested through eQUEST - rolling 3M



BA10-L Percentage specimens available for acknowledgment through eQUEST - rolling 3M

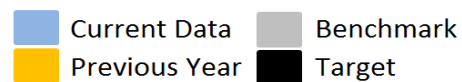
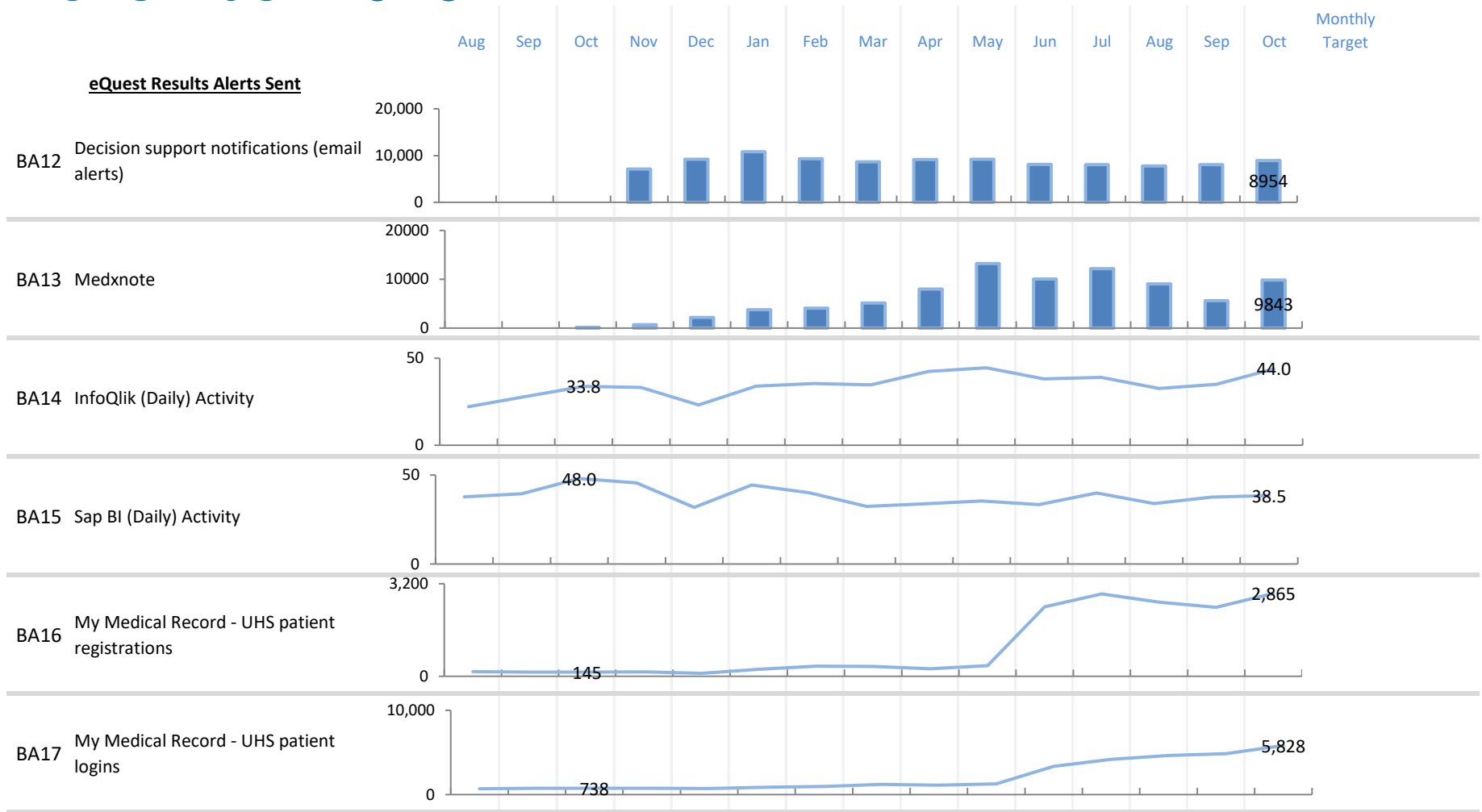


BA11 digiRounds patient records accessed

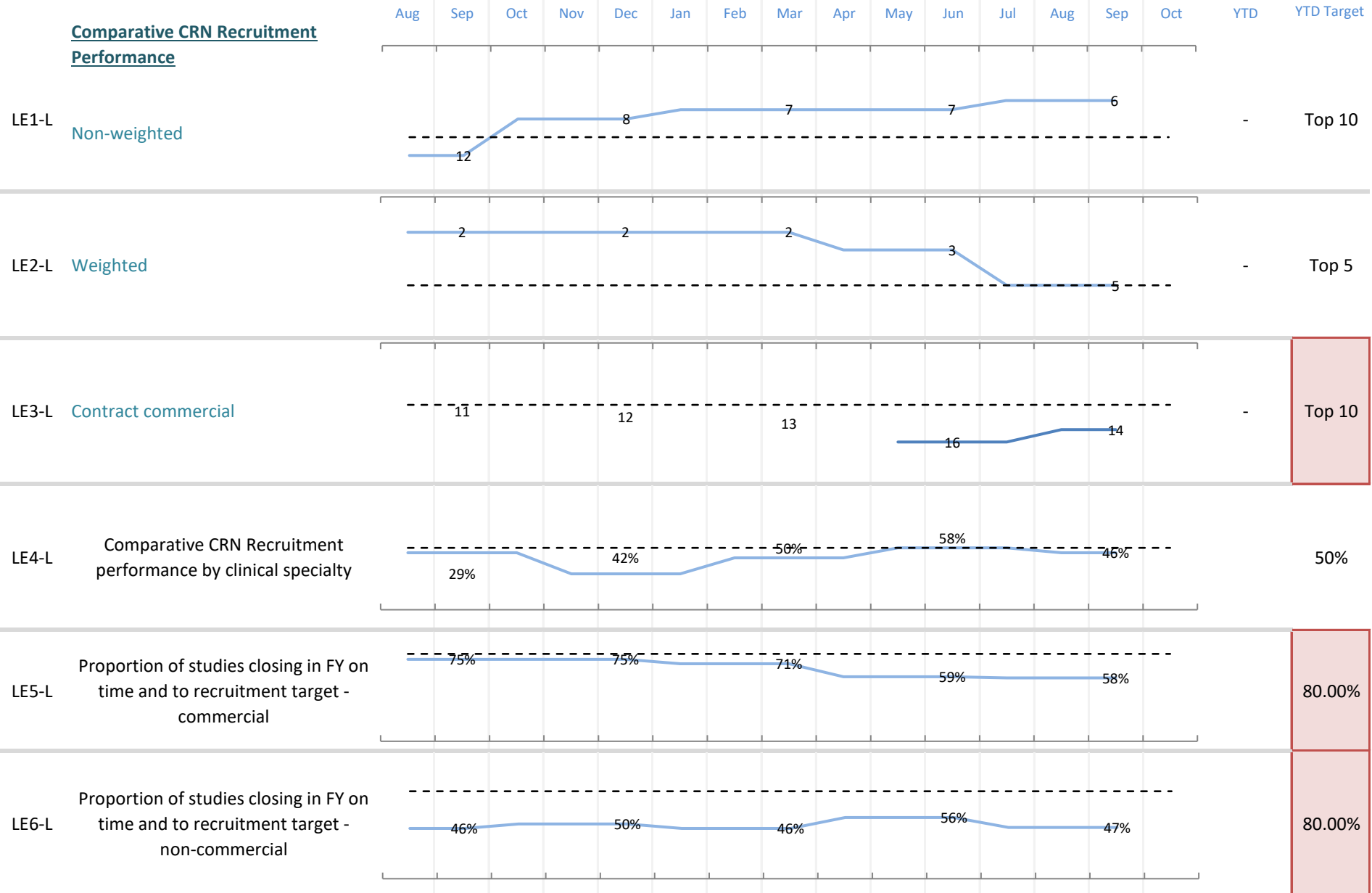


■ Current Data ■ Benchmark
■ Previous Year ■ Target

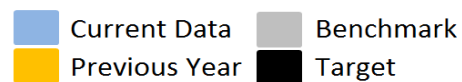
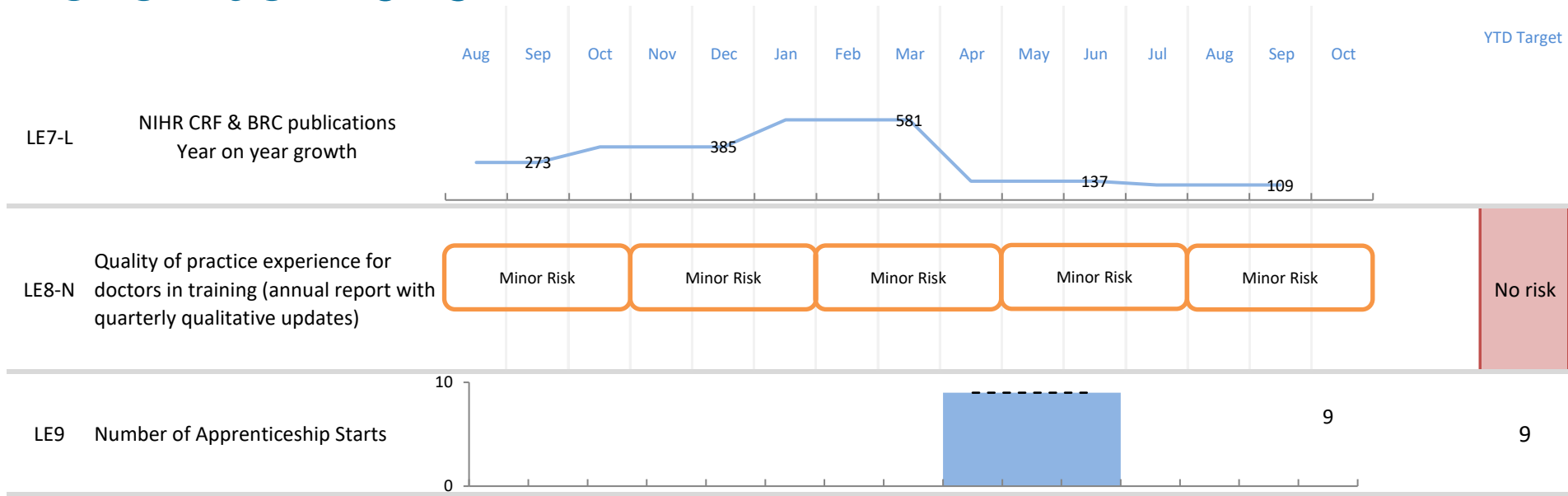
November 2019



Comparative CRN Recruitment Performance



■ Current Data Benchmark
 Previous Year Target



November 2019 Changes and Corrections

Section	KPI	KPI Name	Type	Detail
Value based health and care	VB10/V B11	Face to Face and Non-Face to face Outpatient appointments	Correction	The link into non casemix OP activity has been failing -resulting in lower non face to face numbers being reported for the last 3 months. The feed has since been fixed and the information has been corrected retrospectively.

Quarter 2 Infection Prevention Summary Report

Category		Q2 RAG	YTD RAG	Action /Comment
Targets:	MRSA bacteraemia reduction	G	R	1 MRSA BSI attributable to UHS in Q1 against a zero target. Prior to this, the last MRSA bacteraemia was over 400 days ago.
	Clostridium difficile infection reduction	G	A	11 attributable Cdl cases in Q2 2019-20 against Q2 limit of 15 cases (30 Cases against 30 limit for Q1&2) and limit of 64 cases for the year.
	Prudent antibiotic prescribing	G	G	Total antibiotic usage targets now within the standard contract. Q2 performance shows a reduction of 3% vs. from 2018 baseline against a target of 1% reduction from Q2 2018 antibiotic usage baseline
Provide assurance of basic infection prevention practice:	CQC assurance framework	G	G	Overall compliance with CQC outcome 8. The Trust continues to implement actions to improve performance relating to cleanliness and isolation.
	Hand hygiene and Saving Lives high impact interventions	A	A	Covert hand hygiene audit Q2 shows 55% compliance with WHO key moments a decrease of 5% in compliance compared to February 2019. Hand hygiene performance improvement framework in place

Nursing and midwifery staffing hours - October 2019

Report notes

Our staffing levels are monitored daily and we will risk assess and fill any gaps to ensure that safe staffing levels are always maintained

The total hours planned is our planned staffing levels to deliver care across all of our areas but does not represent a baseline safe staffing level. We plan for an average of one registered nurse to every five or seven patients in most of our areas but this can change as we regularly review the care requirements of our patients and adjust our staffing accordingly.

Staffing on intensive care and high dependency units is always adjusted depending on the number of patients being cared for and the level of support they require. Therefore the numbers will fluctuate considerably across the month when compared against our planned numbers.

Enhanced Care (also known as Specialising)

Occurs when patients in an area require more focused care than we would normally expect. In these cases extra, unplanned staff are assigned to support a ward. If enhanced care is required the ward may show as being over filled.

If a ward has an unplanned increase or decrease in bed availability the ward may show as being under or over filled, even though it remains safely and appropriately staffed.

CHPPD (Care Hours Per Patient Day)

This is a measure which shows on average how many hours of care time each patient receives on a ward /department during a 24 hour period from registered nurses and support staff - this will vary across wards and departments based on the speciality, interventions, acuity and dependency levels of the patients being cared for.

The maternity workforce consists of teams of midwives who work both within the hospital and in the community offering an integrated service and are able to respond to women wherever they choose to give birth. This means that our ward staffing and hospital birth environments have a core group of staff but the numbers of actual midwives caring for women increases responsively during a 24 hour period depending on the number of women requiring care.

Over recent months some ward beds have temporarily changed speciality to support seasonal changes in demand - these bed changes are often swift in nature and for short periods of time so are not always reflected accurately in the data. These short notice changes are expected to continue into the Winter. In October there have been additional beds supported for Cardiovascular patients on Trauma and Orthopaedics.

WARD		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered nurses	CHPPD unregistered staff	CHPPD Overall	Comments
C4 (Solent ward)	Day	1451	1233	997	1427	85%	143%	3.5	4.6	8.1	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
C4 (Solent ward)	Night	1070	864	691	1281	81%	185%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
C6	Day	2782	2692	134	134	97%	100%	7.4	0.4	7.8	Safe staffing levels maintained.
C6	Night	2049	1972	0	101	96%	Shift N/A				Safe staffing levels maintained.
C6 (Teenage Cancer Trust unit)	Day	708	682	347	75	96%	22%	8.3	0.8	9.1	Safe staffing levels maintained; Beds flexed to match staffing. Limited requirement for unregistered staff
C6 (Teenage Cancer Trust unit)	Night	672	580	0	44	86%	Shift N/A				Safe staffing levels maintained.
D2	Day	1324	1544	1362	1184	117%	87%	4.3	4.1	8.4	Safe staffing levels maintained.
D2	Night	712	990	1070	1205	139%	113%				Safe staffing levels maintained.
D3	Day	1671	1558	721	1049	93%	146%	4.0	2.8	6.8	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
D3	Night	1036	1053	701	752	102%	107%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
Surgical high dependency unit	Day	2160	1948	380	354	90%	93%	15.3	2.6	18.0	Safe staffing levels maintained; Beds flexed to match staffing.
Surgical high dependency unit	Night	2140	1887	351	308	88%	88%				Safe staffing levels maintained; Beds flexed to match staffing.
Cardiac intensive care unit	Day	5218	4748	1219	719	91%	59%	25.0	3.4	28.4	Safe staffing levels maintained; Beds flexed to match staffing.
Cardiac intensive care unit	Night	5296	4660	834	565	88%	68%				Safe staffing levels maintained; Beds flexed to match staffing.
General intensive care unit A	Day	4650	4184	1180	659	90%	56%	24.7	3.2	27.8	Safe staffing levels maintained; Beds flexed to match staffing.
General intensive care unit A	Night	4281	4054	713	403	95%	56%				Safe staffing levels maintained; Beds flexed to match staffing.
General intensive care unit B	Day	4110	3484	376	334	85%	89%	26.5	2.3	28.8	Safe staffing levels maintained; Beds flexed to match staffing.
General intensive care unit B	Night	3930	3440	334	265	88%	79%				Safe staffing levels maintained; Beds flexed to match staffing.
Neuro intensive care unit	Day	5171	4796	901	689	93%	76%	25.9	3.5	29.4	Safe staffing levels maintained; Beds flexed to match staffing.
Neuro intensive care unit	Night	4576	4166	686	518	91%	76%				Safe staffing levels maintained; Beds flexed to match staffing.
ESA	Day	1277	1054	651	1038	83%	150%	3.3	3.0	6.3	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
ESA	Night	714	703	357	577	98%	162%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
ESB	Day	1455	1396	829	886	96%	107%	4.0	2.5	6.4	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
ESB	Night	714	714	357	437	100%	123%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
E8	Day	2232	1774	1780	1900	80%	107%	3.3	3.7	6.9	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
E8	Night	1070	1074	1199	1297	100%	108%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F11	Day	1966	1547	800	1056	79%	132%	4.4	3.9	8.3	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F11	Night	713	713	713	938	100%	132%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F6	Day	2232	1841	654	1353	82%	207%	3.5	2.7	6.3	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F6	Night	1070	1007	727	851	94%	117%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F5	Day	1927	1579	996	1256	82%	126%	3.5	2.7	6.3	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F5	Night	1070	1024	713	747	96%	105%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
Acute medical unit	Day	3642	3640	3249	3189	100%	98%	5.1	4.1	9.2	Safe staffing levels maintained.
Acute medical unit	Night	3566	3782	2496	2820	106%	113%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
D5	Day	1295	1346	1736	1280	104%	74%	2.7	2.9	5.5	Staff moved to support other wards; Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
D5	Night	1059	889	946	1150	84%	122%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
D6	Day	1110	1077	1489	1402	97%	94%	2.5	3.1	5.6	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
D6	Night	713	713	941	878	100%	93%				Safe staffing levels maintained.
D7	Day	736	698	1193	1117	95%	94%	3.0	3.2	6.3	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
D7	Night	702	736	357	423	105%	119%				Additional staff used for enhanced care - Support workers; Safe staffing levels maintained.
D8	Day	1060	1299	1474	1582	123%	107%	2.9	3.6	6.5	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
D8	Night	714	764	923	1011	107%	110%				Safe staffing levels maintained.

Nursing and midwifery staffing hours - October 2019

Report notes

Our staffing levels are monitored daily and we will risk assess and fill any gaps to ensure that safe staffing levels are always maintained

The total hours planned is our planned staffing levels to deliver care across all of our areas but does not represent a baseline safe staffing level. We plan for an average of one registered nurse to every five or seven patients in most of our areas but this can change as we regularly review the care requirements of our patients and adjust our staffing accordingly.

Staffing on intensive care and high dependency units is always adjusted depending on the number of patients being cared for and the level of support they require. Therefore the numbers will fluctuate considerably across the month when compared against our planned numbers.

Enhanced Care (also known as Specialising)

Occurs when patients in an area require more focused care than we would normally expect. In these cases extra, unplanned staff are assigned to support a ward. If enhanced care is required the ward may show as being over filled.

If a ward has an unplanned increase or decrease in bed availability the ward may show as being under or over filled, even though it remains safely and appropriately staffed.

CHPPD (Care Hours Per Patient Day)

This is a measure which shows on average how many hours of care time each patient receives on a ward /department during a 24 hour period from registered nurses and support staff - this will vary across wards and departments based on the speciality, interventions, acuity and dependency levels of the patients being cared for.

The maternity workforce consists of teams of midwives who work both within the hospital and in the community offering an integrated service and are able to respond to women wherever they choose to give birth. This means that our ward staffing and hospital birth environments have a core group of staff but the numbers of actual midwives caring for women increases responsively during a 24 hour period depending on the number of women requiring care.

Over recent months some ward beds have temporarily changed speciality to support seasonal changes in demand - these bed changes are often swift in nature and for short periods of time so are not always reflected accurately in the data. These short notice changes are expected to continue into the Winter. In October there have been additional beds supported for Cardiovascular patients on Trauma and Orthopaedics.

WARD		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered nurses	CHPPD unregistered staff	CHPPD Overall	Comments
D9	Day	1244	1445	1750	1322	116%	76%	2.7	2.9	5.6	Staff moved to support other wards; Safe staffing levels maintained.
D9	Night	1081	842	949	1129	78%	119%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
Respiratory high dependency unit	Day	1828	1293	314	478	71%	152%	12.6	3.8	16.4	Staffing appropriate for number of patients; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
Respiratory high dependency unit	Night	1702	1416	357	349	83%	98%				Staffing appropriate for number of patients; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
C5	Day	1040	908	800	818	87%	102%	3.9	3.1	7.1	Safe staffing levels maintained.
C5	Night	714	715	357	472	100%	132%				Safe staffing levels maintained; Patient requiring 24 hour 1:1 nursing in the month.
D10	Day	1154	1041	1351	1242	90%	92%	3.3	3.8	7.2	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
D10	Night	713	726	713	783	102%	110%				Safe staffing levels maintained.
F7	Day	724	747	1300	1300	103%	100%	2.4	3.3	5.6	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
F7	Night	714	718	714	714	101%	100%				Safe staffing levels maintained.
G5	Day	1080	1154	1784	1705	107%	96%	2.2	3.2	5.4	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource.
G5	Night	714	726	1070	1015	102%	95%				Support workers used to maintain staffing numbers; Safe staffing levels maintained by sharing staff resource.
G6	Day	1058	1156	1828	1897	109%	104%	2.4	3.8	6.2	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource.
G6	Night	714	737	1059	1059	103%	100%				Support workers used to maintain staffing numbers; Safe staffing levels maintained.
G7	Day	735	715	1445	1449	97%	100%	3.3	5.9	9.2	Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
G7	Night	713	703	1070	1083	99%	101%				Patient requiring 24 hour 1:1 nursing in the month; Support workers used to maintain staffing numbers.
G8	Day	1110	1140	1824	1780	103%	98%	2.2	3.3	5.5	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource.
G8	Night	713	725	1071	1036	102%	97%				Support workers used to maintain staffing numbers; Safe staffing levels maintained by sharing staff resource.
G9	Day	1105	1145	1794	1901	104%	106%	2.4	3.7	6.1	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource.
G9	Night	713	806	1060	1050	113%	99%				Support workers used to maintain staffing numbers; Safe staffing levels maintained by sharing staff resource.
Paediatric high dependency unit	Day	1586	1266	0	88	80%	Shift N/A	8.7	0.4	9.1	Non-ward based staff supporting areas; Beds flexed to match staffing; Safe staffing levels maintained.
Paediatric high dependency unit	Night	1070	1095	0	12	102%	Shift N/A				Safe staffing levels maintained.
Paediatric medical unit	Day	1836	1613	499	637	88%	128%	7.3	3.8	11.1	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
Paediatric medical unit	Night	1366	1214	675	819	89%	121%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
Paediatric intensive care unit	Day	6185	5141	681	457	83%	67%	29.3	2.7	32.1	Non-ward based staff supporting areas; Beds flexed to match staffing; Safe staffing levels maintained.
Paediatric intensive care unit	Night	5707	5014	518	483	88%	93%				Band 4 staff working to support registered nurse numbers; Beds flexed to match staffing; Safe staffing levels maintained.
Palm Brown ward	Day	3465	3122	109	219	90%	201%	13.7	0.8	14.5	Safe staffing levels maintained.
Palm Brown ward	Night	1129	1040	0	34	92%	Shift N/A				Safe staffing levels maintained.
E1	Day	2152	1729	701	534	80%	76%	10.5	3.0	13.5	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained.
E1	Night	1426	1483	359	371	104%	103%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained.
G2	Day	778	762	0	0	98%	Shift N/A	9.1	0.0	9.1	Safe staffing levels maintained.
G2	Night	742	743	0	0	100%	Shift N/A				Safe staffing levels maintained.
G3	Day	2434	1583	1243	716	65%	58%	6.6	2.6	9.3	Beds flexed to match staffing; Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
G3	Night	1684	1255	682	410	75%	60%				Beds flexed to match staffing; Band 4 staff working to support registered nurse numbers; Staff moved to support other wards.
G4	Day	2463	1975	1285	541	80%	42%	8.2	2.1	10.3	Beds flexed to match staffing; Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
G4	Night	1705	1485	682	364	87%	53%				Beds flexed to match staffing; Staff moved to support other wards; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
Bramshaw women's unit	Day	1467	1109	1218	940	76%	77%	4.4	3.5	7.9	Beds flexed to match staffing; Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
Bramshaw women's unit	Night	714	714	713	529	100%	74%				Beds flexed to match staffing; Safe staffing levels maintained.
Neonatal unit	Day	7054	4607	1655	1274	65%	77%	9.9	2.5	12.4	Band 4 staff working to support registered nurse numbers; number of cots adjusted to support safe staffing
Neonatal unit	Night	5204	3973	1353	941	76%	70%				Band 4 staff working to support registered nurse numbers; number of cots adjusted to support safe staffing
Maternity service	Day	8644	8001	3255	2160	93%	66%	5.4	1.6	7.0	Numbers do not fully reflect the full integrated midwifery service. Safe staffing levels maintained by sharing staff resource.
Maternity service	Night	5276	4742	2035	1616	90%	79%				Numbers do not fully reflect the full integrated midwifery service. Safe staffing levels maintained by sharing staff resource.

Nursing and midwifery staffing hours - October 2019

Report notes

Our staffing levels are monitored daily and we will risk assess and fill any gaps to ensure that safe staffing levels are always maintained

The total hours planned is our planned staffing levels to deliver care across all of our areas but does not represent a baseline safe staffing level. We plan for an average of one registered nurse to every five or seven patients in most of our areas but this can change as we regularly review the care requirements of our patients and adjust our staffing accordingly.

Staffing on intensive care and high dependency units is always adjusted depending on the number of patients being cared for and the level of support they require. Therefore the numbers will fluctuate considerably across the month when compared against our planned numbers.

Enhanced Care (also known as Specialising)

Occurs when patients in an area require more focused care than we would normally expect. In these cases extra, unplanned staff are assigned to support a ward. If enhanced care is required the ward may show as being over filled.

If a ward has an unplanned increase or decrease in bed availability the ward may show as being under or over filled, even though it remains safely and appropriately staffed.

CHPPD (Care Hours Per Patient Day)

This is a measure which shows on average how many hours of care time each patient receives on a ward /department during a 24 hour period from registered nurses and support staff - this will vary across wards and departments based on the speciality, interventions, acuity and dependency levels of the patients being cared for.

The maternity workforce consists of teams of midwives who work both within the hospital and in the community offering an integrated service and are able to respond to women wherever they choose to give birth. This means that our ward staffing and hospital birth environments have a core group of staff but the numbers of actual midwives caring for women increases responsively during a 24 hour period depending on the number of women requiring care.

Over recent months some ward beds have temporarily changed speciality to support seasonal changes in demand - these bed changes are often swift in nature and for short periods of time so are not always reflected accurately in the data. These short notice changes are expected to continue into the Winter. In October there have been additional beds supported for Cardiovascular patients on Trauma and Orthopaedics.

WARD		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered nurses	CHPPD unregistered staff	CHPPD Overall	Comments
Cardiac high dependency unit	Day	5076	4130	1427	1551	81%	109%	14.0	4.2	18.2	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
Cardiac high dependency unit	Night	3816	3798	704	840	100%	119%				Safe staffing levels maintained by sharing staff resource; Safe staffing levels maintained.
Coronary care unit	Day	1498	1664	955	943	111%	99%	7.9	4.8	12.7	Safe staffing levels maintained; Safe staffing levels maintained.
Coronary care unit	Night	1366	1406	904	922	103%	102%				Safe staffing levels maintained; Safe staffing levels maintained.
D4	Day	1866	1469	862	1081	79%	126%	3.5	3.5	7.0	Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month.
D4	Night	797	744	684	1094	93%	160%				Safe staffing levels maintained; Safe staffing levels maintained. Patient requiring 24 hour 1:1 nursing in the month.
E2	Day	1597	1222	783	1000	77%	128%	4.0	3.3	7.3	Band 4 staff working to support registered nurse numbers; Band 4 staff working to support registered nurse numbers.
E2	Night	715	760	341	666	106%	195%				Safe staffing levels maintained by sharing staff resource; Patient requiring 24 hour 1:1 nursing in the month.
E3 Green	Day	2078	1266	549	1524	61%	278%	2.6	3.8	6.4	Band 4 staff working to support registered nurse numbers; Band 4 staff working to support registered nurse numbers; Staffing appropriate for number of patients.
E3 Green	Night	671	529	983	1163	79%	118%				Band 4 staff working to support registered nurse numbers; Staff moved to support other wards; Safe staffing levels maintained.
E3 Blue	Day	1675	1012	716	1144	60%	160%	3.1	3.7	6.9	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
E3 Blue	Night	683	638	683	817	93%	120%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
E4	Day	1989	1705	744	962	86%	129%	4.8	3.1	7.9	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
E4	Night	935	1012	528	823	108%	156%				Increased night staffing to support raised acuity; Patient requiring 24 hour 1:1 nursing in the month.
Acute stroke unit	Day	1505	1553	2637	2474	103%	94%	2.8	5.1	7.9	Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
Acute stroke unit	Night	1024	837	1706	1816	82%	106%				Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
Regional transfer unit	Day	1211	921	373	569	76%	152%	6.3	5.9	12.2	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
Regional transfer unit	Night	682	528	690	789	77%	114%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
E Neuro	Day	1875	1758	1138	1250	94%	110%	4.0	3.0	7.0	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
E Neuro	Night	1343	1378	1013	1101	103%	109%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
Hyper acute stroke unit	Day	1592	1165	353	681	73%	193%	8.0	5.9	13.9	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
Hyper acute stroke unit	Night	1364	826	341	782	61%	229%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
D neuro	Day	1969	1606	1974	2024	82%	103%	3.4	4.6	8.0	Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
D neuro	Night	1364	1221	1694	1804	90%	106%				Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
SPI F4 Neuro	Day	1642	1333	701	1228	81%	175%	3.4	3.5	6.9	Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
SPI F4 Neuro	Night	1023	914	1022	1111	89%	109%				Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers; Patient requiring 24 hour 1:1 nursing in the month.
Brooke ward (trauma and orthopaedics)	Day	1170	1037	578	639	89%	111%	3.4	2.5	5.9	Staff moved to support other wards; Staffing appropriate for number of patients.
Brooke ward (trauma and orthopaedics)	Night	1070	748	357	679	70%	190%				Staff moved to support other wards; Staffing appropriate for number of patients.
Trauma Assessment Unit	Day	570	427	380	586	75%	154%	5.9	7.5	13.3	Skill mix swaps undertaken to support safe staffing across the Unit; Staff moved to support other wards.
Trauma Assessment Unit	Night	319	331	342	375	104%	110%				Skill mix swaps undertaken to support safe staffing across the Unit; Staff moved to support other wards.
F1	Day	2434	2169	1955	2235	89%	114%	4.1	4.6	8.7	Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards; Skill mix swaps undertaken to support safe staffing across the Unit.
F1	Night	1783	1645	1750	2099	92%	120%				Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards.
F2	Day	1681	1452	2036	2194	86%	108%	3.0	4.7	7.7	Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards.
F2	Night	1023	858	1364	1496	84%	110%				Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards.
F3	Day	1622	1420	1949	1688	88%	87%	3.2	4.5	7.7	Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards.
F3	Night	1024	848	1366	1499	83%	110%				Patient requiring 24 hour 1:1 nursing in the month; Staff moved to support other wards.
F4	Day	1453	1217	1220	842	84%	69%	3.8	2.8	6.6	Staff moved to support other wards; Skill mix swaps undertaken to support safe staffing across the Unit.
F4	Night	1012	726	682	603	72%	88%				Staff moved to support other wards; Skill mix swaps undertaken to support safe staffing across the Unit.

Report to the Trust Board of Directors dated Thursday, 28 November 2019	
Title: Ward Staffing nursing establishment review August 2019 – October 2019	
Category	Quality, Performance, and Finance
Agenda item	4.6
Sponsor	Director of Nursing and Organisational Development
Author	Rosemary Chable – Deputy Director of Nursing & Education and Workforce
Provenance	<p>Report on the systematic review of ward staffing presented annually to TEC since 2009 and 6 monthly to Trust Board since 2014. Now reported annually to TB with 6 monthly light-touch reviews presented at divisional boards.</p> <p>Review findings validated at Nursing and Midwifery Staffing Review Group on 15th October 2019.</p> <p>The report was presented and recommendations agreed at TEC on November 13th 2019.</p>
Classification	This Report is unclassified.
Purpose	<p>The paper is presented for REVIEW.</p> <p>The report details the methodology, findings, risk assessment and recommendations arising from the ward staffing review undertaken from August 2019 – October 2019.</p> <p>The report also outlines UHS progress in meeting the 38 recommendations included in the NICE guideline (2014) on safe staffing for in-patient wards and provides an update on the action – plan to achieve the recommendations in the national staffing levels guidance published by the National Quality Board in July 2016 (a key requirement of the NHSI ‘Developing workforce safeguards’ guidance (October 2018).</p> <p>The report is presented in full to Trust Board as an expectation of the National Quality Board guidance on staffing which requires presentation and discussion at open board of all aspects of the staffing reviews.</p> <ul style="list-style-type: none"> • To note findings of this annual ward establishment review and the Trust position in relation to adherence to the monitored metrics on nurse staffing levels, specifically: <ul style="list-style-type: none"> ○ UHS nursing establishments are set to achieve an average 1:3 to 1:8 registered nurse to patient ratio in most areas during the day with the majority (39) set between 1:4 to 1:7. Exceptions are where there is a planned model of trained band 4 staff and is particularly evident in Medicine and Medicine for older people. ○ The majority of wards (28) are staffed at between 50:50 and 70:30 registered/unregistered AWL ratio or above. Those wards with lower ratios (16 wards) are linked to the systematic and evaluated implementation of trained band 4 staff where appropriate. ○ Planned total Care Hours Per Patient Day (CHPPD) range from 5.0 – 13.5 and average at 7.1. • To note the ongoing progress in UHS compliance with the guidance from the National Quality Board on safe, sustainable and productive staffing.

Report to the Trust Board of Directors dated Thursday, 28 November 2019

	<ul style="list-style-type: none"> • To note the ongoing progress in UHS compliance with the NICE guideline on safe staffing for nursing in adult inpatient wards. • To note and acknowledge the ongoing risks and challenges of matching actual staffing to established staffing levels due to the current vacancy position. • To continue the Trust wide commitment and momentum on actions to fill vacancies and further reduce the reliance on high cost agency against the backdrop of agency controls from NHS Improvement. • To discuss the report at TEC and Trust Board as an ongoing requirement of the National Quality Board and developing workforce safeguards guidance around safe staffing assurance. 		
<p>Relevant strategic goals</p>	<input type="checkbox"/> Goal 1: Improving patient journeys.	<input checked="" type="checkbox"/> Goal 2: Delivering value-based health and care.	<input type="checkbox"/> Goal 3: Supporting healthy lives.
	<input checked="" type="checkbox"/> Goal 4: Building an expert and inclusive workforce.	<input type="checkbox"/> Goal 5: Being agile in meeting people’s needs.	<input type="checkbox"/> Goal 6: Creating leading-edge research, education, and innovation.
<p>Assurance framework links</p>	<p>BAF05 – Capacity and capability gaps in the workforce lead to an inability to provide safe and timely care</p> <p>Corporate risk 585 - Staffing levels and skill mix not always matched to case mix, demand and capacity.</p>		
<p>Impact assessments</p>	<p>N/A</p>		
<p>Other standards affected</p>	<p>Recommendations in this report link to the statutory responsibilities arising from the National Quality Board (2016) expectations on ensuring safe, sustainable and productive staffing and the NHS Improvement Developing Workforce Safeguards guidance (2018) assessed as part of CQC well led domain.</p>		

Ward Staffing nursing establishment review August 2019 – October 2019

1.0 Introduction or Background

- 1.1 The purpose of this paper is to report on the outcomes of the review of ward staffing nursing establishments undertaken from August 2019 – October 2019. This 6 monthly review forms part of the Trust approach to the systematic review of staffing resources to ensure safe staffing levels effectively meet patient care needs.
- 1.2 This paper focuses specifically on a review of nursing levels for in-patient ward areas. Separate corporate reviews have been undertaken in intensive care, high care areas, emergency admission areas, outpatients and theatres. Some of these other areas are also subject to separate emergent guidance either from NICE or NHS Improvement in relation to safe staffing levels and any specific recommendations will be highlighted separately through Divisional budget setting.
- 1.3 The report also includes an update on the NICE clinical guideline 1 – Safe Staffing for nursing in adult inpatient wards in acute hospitals, issued in July 2014 and details progress with the action plan for adopting this guideline within UHS (see Appendix 3).
- 1.4 This report fulfils expectation 1 and 2 of the National Quality Board requirements for Trusts in relation to safe nurse staffing (see Appendix 1) and fulfils a number of the requirements outlined in the NHS Improvement ‘Developing Workforce Safeguards’ guidance (October 2018) which sets out to support providers to deliver high quality care through safe and effective staffing. Organisations should be compliant with the recommendations in this report from April 2019 and are subject to review of this as part of the CQC inspection programme.

2.0 Analysis and Discussion

2.1 Ward staffing review methodology

- 2.1.1 In 2006 UHS established a systematic, evidence based and triangulated methodological approach to reviewing ward staffing levels on an annual basis linked to budget setting and to staffing requirements arising from any developments planned in-year. All this was aimed to provide safe, competent and fit for purpose staffing to deliver efficient, effective and high quality care and has resulted in consistent year on year review of the nursing workforce matched by increased investment where required.
- 2.1.2 Following the National Quality Board expectations in 2014 and the refresh in 2016, a full review is now undertaken annually (with a light touch review at 6 months reporting to Divisional boards to ensure ongoing quality) with annual reporting to Trust Board in October/November.
- 2.1.3 The approach utilises the following methodologies:
 - Shelford Safer Nursing Care Tool Acuity/Dependency staffing multiplier (A nationally validated tool reviewed in 2013 - previously AUKUH acuity tool). Now incorporated into the ‘safecare’ module of healthroster, rolled out trustwide, assessed 3 times a day on each ward and used as part of the daily staffing assurance meetings
 - Care Hours Per Patient Day
 - Professional Judgement
 - Peer group validation
 - Benchmarking and review of national guidance including Model Hospital data
 - Review of eRostering data
 - Review of ward quality metrics

2.2 National guidance

2.2.1 In 2013 as part of the national response to the Francis enquiry, the National Quality Board published a guide to nursing, midwifery and care staffing capacity and capability (2013) 'How to ensure the right people, with the right skills, are in the right place at the right time.' This guidance was refreshed, broadened to all staff and re-issued in July 2016 to include the need to focus on safe, *sustainable and productive* staffing. The NQB further reviewed this document and issued an updated recommendations brief in July 2017. The expectations outlined in this guide are presented in Appendix 1

These expectations are fulfilled in part by this review and the detailed action plan (Appendix 2) has been updated with progress towards achieving compliance with the 37 recommendations that make up the 3 over-arching expectations

2.2.2 The latest review of the action plan (October 2019) shows an improvement on the previous year with UHS compliant with 35 recommendations, with the following 2 outstanding areas progressing but requiring further action before being signed off:

Allocated time for the supervision of students and learners: Staffing establishments take account of the need to allow clinical staff the time to undertake mandatory training and continuous professional development, meet revalidation requirements, and fulfil teaching, mentorship and supervision roles, including the support of preregistration and undergraduate students. *Timescale for completion extended to March 2020 as the Trust continues to implement the new supervision and assessment model of coaching (Collaborative Learning in Practice CLiP model) to address the changed guidance on student supervision.* (See section 2.4.3)

Equality and diversity: The organisation has clear plans to promote equality and diversity and has leadership that closely resembles the communities it serves. The research outlined in the NHS provider roadmap⁴² demonstrates the scale and persistence of discrimination at a time when the evidence demonstrates the links between staff satisfaction and patient outcomes. *Ongoing action through Equality & Diversity Group which is reported to Board separately.*

2.2.3 In July 2014 NICE published clinical guideline 1: Safe Staffing for nursing in adult inpatient wards in acute hospitals. This guideline is made up of 38 recommendations. A detailed action plan was developed within UHS and is reviewed 4 monthly by the Nursing and Midwifery Staffing review group. The current assessment (October 2019) shows continued progress with full compliance in 36 recommendations, a further improvement on last year.

The 2 remaining recommendations are:

- Capture of red flag staffing incidents – *Further widespread Trust rollout and embedding of the red flag function on safecare with compliance expected at the January 2020 review.*
- Escalation actions taken to address deficits on one ward should not compromise another - *Monitored as part of the daily reviews of staffing - but unable to assure with current vacancy and staffing position.*

These pose low risk to the Trust and will be achieved with the further embedding of the safecare module of eRostering and by the further focus on improving the baseline substantive staffing levels which will enable the required flexibility of staffing.

The ongoing action plan is included at Appendix 3 detailing the recommendations and the UHS compliance position and actions in progress.

2.2.4 In October 2018 NHS Improvement published 'Developing Workforce Safeguards' guidance which sets out to support providers to deliver high quality care through safe and effective staffing. It includes many of the actions identified in both the NICE guidance and the National Quality Board recommendations broadened to all staff groups.

2.3 **6 monthly Ward Staffing review August – October 2019 – Outcomes**

2.3.1 The 6 monthly review was carried out from August 2019 – October 2019 with initial review meetings taking place with each Division (attended by DHN, Matrons, Ward Leaders, Finance representatives, workforce representatives and facilitated by the Deputy Director of Nursing & Education and Workforce). The same triangulated methodology was used as in previous reviews. An update on the latest guidance and reporting requirements in relation to staffing were also included in the divisional review meetings.

2.3.2 The detailed spreadsheet with ward by ward findings is included at Appendix 4. This provides information on the current establishment data broken down by shift and assessing against registered/unregistered ratios; CHPPD; nurse to patient ratios by registered and total nurse staffing considering acuity information from the Safer Nursing Care Tool (SNCT acuity tool – where appropriate). It should be noted that a number of rostering template reviews were instigated as a result of the discussions so some figures will have changed for individual wards since the review.

2.3.3 ***Nurse to patient ratios by registered and total nursing***

- The ward establishments across UHS allow for registered nurse to patient ratios during the day to range from 1:2 (Piam Brown) to 1:11 depending on specialty and overall staffing model. The average level set to achieve 1:3 to 1:8 registered nurse to patient ratio in most areas during the day with the majority (39) set between 1:4 to 1:7. Exceptions are where there is a planned model of trained band 4 staff and is particularly evident in Medicine and Medicine for older people.
- The areas on or above 1:7 are some medicine wards, Medicine for Older People (MOP) wards, F2, the Acute Stroke Unit and Bramshaw. These areas include a higher ratio of band 2 to 4 staff creating a total nurse to patient ratio of 1:3 – 1:4. It should be noted that the ratio of patients to registered nurse can regularly increase when wards are not fully established.
- Planned staffing ratios at night require constant oversight to ensure the model is sufficient to provide the required support for patients out of hours. Following previous reviews there are now fewer areas with ratios higher than 1:11 (RN to patient) at night. The exceptions are MOP, Bramshaw, E3, D6 and D8 where the ratios rise to 1:12 – 1:14. In these areas, however, this is offset by an average total nurse to patient ratio of 1:6 and utilisation of planned band 2 or band 4 models.

2.3.4 ***Registered to unregistered ratios***

- UHS ward areas were reviewed against the benchmark of 60:40 registered to unregistered ratios as the level to which ward establishments should not fall below unless planned as the model of care.
- 19 wards are now established at between 60:40 and 70:30.
- 25 wards (down from 30 last year) are below the 60:40 ratio where they are utilising band 4 staff as an appropriate contribution to the model of care and where there is a wider multidisciplinary team contributing to care (e.g. MOP, T & O, Acute Stroke). Further work is being undertaken (in line with NQB recommendations) to look at integrated staffing plans and rosters to more accurately capture the contribution and opportunities of developing wider multi-disciplinary teams.
- 8 wards are above the 70:30 ratio reflecting the increased specialism of our regional specialties where the intensity of the patient needs requires a higher ratio of registered staff (Paediatric, Neurosciences, Cardiac and Cancer Care areas).
- The support of band 4 roles continues to be designed in as part of a model of care in a number of areas and this has continued to accelerate in 2019 linked to the further development of apprenticeship opportunities. This has also provided a role in which

to appoint the first cohort of nursing associates who qualified and registered with the NMC from January 2019. In many areas where the acuity and intensity of patients has increased and treatment and medication regimes are complex, further reduction in the overall skill-mix of registered to unregistered staff is not appropriate to maintain safe staffing levels and ensure adequate supervision.

- Focus will continue on reviewing the overall registered to unregistered ratios to ensure reductions are linked to planned model of care changes and are accompanied by appropriate quality impact assessment and evaluation.

2.3.5 ***Assessment against the Safer Nursing Care Tool (acuity/dependency model)***

- The Safer Nursing Care Tool (acuity/dependency model) has been used to model required staffing based on the national recommended nurse to patient ratios for each category of patient in all of the adult areas. This is now integrated into the health roster system as part of the safe care tool and provides information on acuity/dependency levels and corresponding staffing levels on a real-time basis converted into recommended care hours per patient day. Where the predicted levels differ from established numbers, professional judgement has been used to assure that the levels set are appropriate for the speciality and number of beds.

2.3.6 ***Care Hours Per Patient Day***

- Planned total Care Hours Per Patient Day (CHPPD) range from 5.0 (ASU) – 13.5 (Piam Brown) and average at 7.1. This is the same figure as last year.
- Registered care hours per patient day range from 2.1 (G5, G8) - 13.1 (Piam Brown) and average at 4.4. This is a lower level than last year.
- Unregistered care hours per patient day range from 0 (G2 Neuro) – 5.8 (G7) and average at 2.8. This is slightly higher than last year and offsets the reductions in the registered nurse level.

2.3.7 ***Allowance for additional headroom requirements and supervisory ward leader model***

- All areas have 23% funding allocated to allow for additional headroom requirements arising from non-direct care time.
- In many areas these levels are being exceeded and a detailed project has been implemented, led by the workforce systems rostering team, to work with the care groups to ensure they are managing their headroom appropriately and to make recommendations around better corporate management of some headroom areas (e.g. parenting).
- A discussion around management of headroom was included in each of the ward staffing reviews which took place with clear actions for the ward leaders to implement.
- The headroom allowance within the ward budgets includes funding to enable the Ward Leaders to be supervisory and additional to required staffing numbers. This model was supported financially by Trust Board several years ago. It should be noted that the ongoing position with vacancies has resulted in those Ward Leaders with supervisory status regularly working as part of the baseline numbers. Full benefits of the supervisory model will not be realised until substantive staffing levels improve but the model has continued to support the achievement of patient experience and safety outcomes at ward level, the targeted reduction in temporary staffing usage as well as supporting the high volume of junior staff requiring supervision appointed via recruitment campaigns.

2.3.8 ***Specific Divisional issues emerging***

Specific Divisional issues highlighted in the review are contained in Appendix 5.

2.4 **Trust wide risks and issues considered in the review**

2.4.1 ***Increasing patient acuity/dependency***

The development of our defining services continues to result in an evidenced increase in the complexity, acuity and dependency of the patients cared for in our general ward beds.

Information on the acuity and dependency of our patients, including any enhanced care needs is now available via the 'Safe Care' functionality in health roster and is used in real time as part of our daily staffing meetings. The information is also now used at the 6 monthly reviews as part of the professional judgment assessment.

2.4.2 ***Increasing enhanced care needs***

The introduction of 'safe care' as part of the eRostering system has allowed a more accurate capture of the acuity and dependency of patients which now includes any additional enhanced care needs (previously known as specialling) in real-time. This enables the Trust to have a better overview of the enhanced care requirements and the Trust wide priorities.

Trust wide we continue to see an increase in the complexity of patients particularly in relation to mental health needs including dementia and patients remaining in the acute settings for prolonged lengths of time whilst awaiting appropriate placements.

This is having an impact on the ability to support the additional enhanced care needs that arise for this group of patients particularly across key specialties (MOP, Medicine, Child Health, Neurosciences and T & O).

The Trustwide service model for enhanced care has now been restructured. Division B have retained the overall review and advice service, supporting clinical areas in their decision making around the need for additional support. Each division has then developed a local pool of staff to deploy to support these needs. Ward leaders reported that this has made a major difference to the management of patients with these enhanced needs and has reduced the reliance on last minute agency to support.

The numbers however remain unpredictable and are therefore managed in real-time as part of overall considerations around safe staffing.

2.4.3 ***Supervising and supporting the junior workforce***

The professional judgement discussions with all of the Ward Leaders again highlighted the additional challenges posed to the staffing models of appropriately supervising and supporting the increasing range of learners having placements on the ward areas. This includes the ability to meet the supervisory standards with an increasingly junior workforce.

The robust retention and recruitment strategies across the Trust and the strong vision to 'grow our own' nurses for the future means that wards are supporting a range of learners including undergraduate students, trainee nursing associates, nurse degree apprentices Return to Practice students, newly qualified staff undergoing preceptorship and increasing numbers of overseas nurses awaiting registration.

Education teams across the trust are key to supporting the development and learning into the wards and particularly in training and supporting the overseas nurses to full registration.

2.4.4 **Vacancies**

Total reported nursing vacancies (registered and unregistered) across the inpatient areas at the time of the staffing review (August 2019) were running at 405 (12.5%) with registered nurse vacancies at 371 (18.1%) and unregistered at 18 (1.8%), this is a lower level than in the previous annual review. Information about vacancies and the ongoing actions being taken to reduce these is detailed in the monthly staffing reports to TEC and Trust Board. It should, however, be noted that the establishment review and outcomes around planned staffing levels are set against this backdrop of vacancies.

The day to day management of staffing to match actual staff available to the established staffing levels continues to be a challenge for all of the clinical areas and was again highlighted by the ward leaders at the staffing review meetings. This was particularly evident for areas trying to manage additional capacity challenges (e.g. E7 for cardiovascular). A range of safeguarding and escalation actions are in place to continuously maintain and balance staffing to assure minimum safe staffing levels.

A key action corporately and for all Divisions in 2019/20 is to continue to concentrate efforts to fill these vacancies and these efforts are reaping benefits with a gradually reducing vacancy position.

Detailed work continues on the implementation of a range of retention and recruitment initiatives in partnership with the HR resourcing team to increase substantive staffing and reduce the baseline vacancies.

To offset some of the challenges of an elevated vacancy rate for RN, all areas have maintained the increased level of supervisory band 6 roles to ensure there is a more senior presence. This is also having a positive impact on the retention of skilled nurses within the clinical ward areas with increased opportunities for career progression available.

2.4.5 **Review of quality metrics**

The NICE guidance outlines some key quality metrics that should be considered as part of the staffing reviews. The safety metrics defined are patient falls, pressure ulcers and medicine administration errors. These metrics, along with a range of other UHS defined quality indicators are already monitored through our internal clinical quality dashboard and are discussed ward by ward as part of the professional judgement methodology in the reviews.

3.0 Conclusion

- 3.1 Divisional requirements for staffing changes noted within the report to be presented through the budget setting process.
- 3.2 Continued implementation of the agreed actions to ensure compliance and adoption of the NQB, NICE and NHSi guidance on safe, sustainable and productive staffing.
- 3.3 Continued focus on monitoring the real-time staffing position (actual) against the planned (establishment), matched to acuity/dependency levels as part of the established processes utilising the functionality provided by 'safecare' and healthroster.
- 3.4 Systematic ward staffing reviews to be reported to board annually, with 6 monthly light touch reviews reported through Divisional Boards. Next full staffing review to be presented to Trust Board in November 2020.

4.0 Recommendation

- 4.1 To note findings of this annual ward establishment review and the Trust position in relation to adherence to the monitored metrics on nurse staffing levels, specifically:
- UHS nursing establishments are set to achieve an average 1:3 to 1:8 registered nurse to patient ratio in the majority of areas during the day with the majority (39) set between 1:4 to 1:7. Exceptions are where there is a planned model of trained band 4 staff and is particularly evident in Medicine and Medicine for older people.
 - The majority of wards (28) are staffed at between 50:50 and 70:30 registered/unregistered AWL ratio or above. Those wards with lower ratios (16 wards) are linked to the systematic and evaluated implementation of trained band 4 staff where appropriate.
 - Planned total Care Hours Per Patient Day (CHPPD) range from 5.0 – 13.5 and average at 7.1.
- 4.2 To note the ongoing progress in UHS compliance with the guidance from the National Quality Board on safe, sustainable and productive staffing.
- 4.3 To note the ongoing progress in UHS compliance with the NICE guideline on safe staffing for nursing in adult inpatient wards.
- 4.4 To note and acknowledge the ongoing risks and challenges of matching actual staffing to established staffing levels due to the current vacancy position.
- 4.5 To continue the Trust wide commitment and momentum on actions to fill vacancies and further reduce the reliance on high cost agency against the backdrop of agency controls from NHS Improvement.
- 4.6 To discuss the report at TEC and Trust Board as an ongoing requirement of the National Quality Board and developing workforce safeguards guidance around safe staffing assurance.

5.0 Appendices

Appendix 1: National Quality Board (NQB Expectations for safe staffing
Safe, Sustainable and productive staffing

Appendix 2: NQB Safe Staffing Recommendations – UHS action plan

Appendix 3: NICE Guideline 1: Safe Staffing for nursing in adult inpatient wards in acute hospitals - UHS action plan

Appendix 4: Ward by Ward staffing review metrics spreadsheet

Appendix 5: Specific Divisional issues emerging

**National Quality Board Expectations for safe staffing
Safe, Sustainable and productive staffing (July 2016)**

<p>Expectation 1: Right staff</p>	<p>Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations.</p> <p>Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (i.e. the use of evidence-based tools, professional judgement and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans.</p> <p>This should be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate.</p> <p>There should also be a review following any service change or where quality or workforce concerns are identified.</p> <p>Safe staffing is a fundamental part of good quality care, and CQC will therefore always include a focus on staffing in the inspection frameworks for NHS provider organisations.</p> <p>Commissioners should actively seek to assure themselves that providers have sufficient care staffing capacity and capability, and to monitor outcomes and quality standards, using information that providers supply under the NHS Standard Contract.</p>
<p>Expectation 2: Right skills</p>	<p>Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services, and there is a staffing resource that reflects a multi professional team approach.</p> <p>Decisions about staffing should be based on delivering safe, sustainable and productive services.</p> <p>Clinical leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and expertise, where there is an identified need or skills gap.</p>
<p>Expectation 3: Right place and time</p>	<p>Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board, if concerns arise.</p> <p>Directors of nursing, medical directors, directors of finance and directors of workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.</p>

o

Supporting NHS Providers to deliver the right staff with the right skills, in the right place at the right time - safe sustainable and productive staffing - NURSING & MIDWIFERY

	Descriptor	No.	Recommendation	Current measures in place	Assessed UHS rating (October 2019) C = compliant A = Actions required	Identified actions required	Timescale	Lead	
Expectation 1: Right staff	Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations. Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (i.e. the use of evidence-based tools, professional judgement and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. This should be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified. Safe staffing is a fundamental part of good quality care, and CQC will therefore always include a focus on staffing in the inspection frameworks for NHS provider organisations. Commissioners should actively seek to assure themselves that providers have sufficient care staffing capacity and capability, and to monitor outcomes and quality standards, using information that providers supply under the NHS Standard Contract.	1.1 Evidence-based workforce planning							
		1.1.1	The organisation uses evidence-based guidance such as that produced by NICE, Royal Colleges and other national bodies to inform workforce planning, within the wider triangulated approach in this NQB resource (see Appendix 4 for list of evidence-based guidance for nursing and midwifery care staffing).	Triangulated approach to staffing establishments well embedded. Sheldorf SNCT used and embedded in 'safecare' as part of eRostering. NICE guidance systematically reviewed 3 x per year.	C		Continue with current approach and strengthen with the use of CHPPD and safecare	complete	DDoN/DMT
		1.1.2	The organisation uses workforce tools in accordance with their guidance and does not permit local modifications, to maintain the reliability and validity of the tool and allow benchmarking with peers.	All tools used as recommended.	C		Need to ensure there is corporate rigour on adapting SNCT while rolling out 'safecare'. Monitor the impact on the inclusion of 'enhanced care' scoring. Participate in the national NIHR research	complete	DDoN/DMT
		1.1.3	Workforce plans contain sufficient provision for planned and unplanned leave, e.g. sickness, parental leave, annual leave, training and supervision requirements.	23% included in all direct care in-patient areas. Compliance monitored as part of healthroster reporting suite	C		Ongoing compliance... monitored as part of healthroster reporting suite	complete	DoF/DoN
		1.2 Professional judgement							
		1.2.1	Clinical and managerial professional judgement and scrutiny are a crucial element of workforce planning and are used to interpret the results from evidence-based tools, taking account of the local context and patient needs. This element of a triangulated approach is key to bringing together the outcomes from evidence-based tools alongside comparisons with peers in a meaningful way.	6 monthly staffing reviews include face to face meetings with Corporate Nursing Team/DHN/Matron/ward leaders as well as workforce systems and finance. Professional judgement key part of the reviews.	C		Continue with current approach and strengthen with the use of CHPPD and safecare	complete	DDoN/DMT
		1.2.2	Professional judgement and knowledge are used to inform the skill mix of staff. They are also used at all levels to inform real-time decisions about staffing taken to reflect changes in case mix, acuity/dependency and activity.	As above. Professional judgement also used as part of the daily staffing review meetings through site control.	C		Continue with current approach. Professional judgement remains the ultimate measure of safe staffing.	complete	DDoN/DMT/site team
		1.3 Compare staffing with peers							
		1.3.1	The organisation compares local staffing with staffing provided by peers, where appropriate peer groups exist, taking account of any underlying differences.	Previous ad hoc benchmarking included through AUKUH network and targeted at specific services under development. Need to strengthen and formalise	C		benchmarking capabilities included in the Model Hospital and N&M Dashboard. Continue to utilise the 'civil eyes' data for child health. Work with eRoster provider to introduce reporting that includes benchmarking data	complete	DDoN/workforce systems team
		1.3.2	The organisation reviews comparative data on actual staffing alongside data that provides context for differences in staffing requirements, such as case mix (e.g. length of stay, occupancy rates, caseload), patient movement (admissions, discharges and transfers), ward design, and patient acuity and dependency.	All considered as part of the systematic staffing reviews	C		Model hospital benchmarking now being used routinely. All services benchmark with other areas where appropriate	complete	DDoN/DMT
		1.3.3	The organisation has an agreed local quality dashboard that triangulates comparative data on staffing and skill mix with other efficiency and quality metrics: e.g. for acute inpatients, the model hospital dashboard will include CHPPD.	Clinical Quality Dashboard (CQD) includes all staffing and quality metrics. Used as part of the systematic clinical accreditation scheme reviews	C		Build the model hospital work into the CQD	complete	Head of Quality and Clinical Assurance

Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services, and there is a staffing resource that reflects a multiprofessional team approach. Decisions about staffing should be based on delivering safe, sustainable and productive services. Clinical leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and expertise, where there is an identified need or skills gap.

2.1 Mandatory training, development and education						
2.1.1	Frontline clinical leaders and managers are empowered and have the necessary skills to make judgements about staffing and assess their impact, using the triangulated approach outlined in this document.	All frontline leaders skilled to manage staffing agenda. Included in competencies for ward leaders	C	competence, skills and knowledge through master classes and staffing review meetings	complete	DDoN/DMT
2.1.2	Staffing establishments take account of the need to allow clinical staff the time to undertake mandatory training and continuous professional development, meet revalidation requirements, and fulfil teaching, mentorship and supervision roles, including the support of preregistration and undergraduate students.	23% headroom allowance and provision of supervisory ward leader role covers most aspects of time identified but not fully assured around adequate time for supervision of all learners. Backfill provided for some roles in development - degree apprenticeships but does not cover release for all staff	A	Further scope the learners in all areas and across all programmes, and the time required to supervise. Link to the work on placement tariff. Link to the wider agenda of changed approach to undergraduate funding. Project in progress to change the approach to supervision in practice from 1:1 to coaching approach - will improve capacity to supervise and assess. Recent staffing reviews have highlighted that non-ward based areas do not have adequate headroom included in budget - to identify through budget setting. Current trustwide financial review is necessitating analysis and focus on headroom allowance - full project in progress	Mar-20	DDoN/DHN's/Divisional Education Leads/Education Quality Lead
2.1.3	Those with line management responsibilities ensure that staff are managed effectively, with clear objectives, constructive appraisals, and support to revalidate and maintain professional registration.	All expectations clearly included in JD and annual objectives for line managers	C	Monitored as part of ongoing HR key performance metrics	complete	Associate Director of HR/DMT
2.1.4	The organisation analyses training needs and uses this analysis to help identify, build and maximise the skills of staff. This forms part of the organisation's training and development strategy, which also aligns with Health Education England's quality framework.	Annual training needs analysis process well embedded within the annual cycle for the trust	C	Continue with current approach with review in 2017 to further streamline priorities to staffing needs.	complete	Divisional Education Leads/Education Quality Lead/DMT
2.1.5	The organisation develops its staff's skills, underpinned by knowledge and understanding of public health and prevention, and supports behavioural change work with patients, including self-care, wellbeing and an ethos of patients as partners in their care.	Comprehensive training programmes in place to equip staff with required skills	C	Monitored through ongoing evaluation	complete	Director of TD&W/Divisional Education Leads/DMT
2.1.6	The workforce has the right competencies to support new models of care. Staff receive appropriate education and training to enable them to work more effectively in different care settings and in different ways. The organisation makes realistic assessments of the time commitment required to undertake the necessary education and training to support changes in models of care.	Comprehensive training programmes in place to equip staff with required skills	C	Monitored through ongoing evaluation	complete	Director of TD&W/Divisional Education Leads/DMT
2.1.7	The organisation recognises that delivery of high quality care depends upon strong and clear clinical leadership and well-led and motivated staff. The organisation allocates significant time for team leaders, professional leads and lead sisters/charge nurses/ward managers to discharge their supervisory responsibilities and have sufficient time to coordinate activity in the care environment, manage and support staff, and ensure standards are maintained.	100% Supervisory ward leader time provided in all inpatient direct care areas. Clinical leaders programme in place	C	Continue to review % of time achieved as supervisory linked to ongoing vacancy position	complete	DDoN/DMT/workforce systems
2.2 Working as a multiprofessional team						
2.2.1	The organisation demonstrates a commitment to investing in new roles and skill mix that will enable nursing and midwifery staff to spend more time using their specialist training to focus on clinical duties and decisions about patient care.	Range of new roles developed and evaluated within the organisation. Extended scope policies in place to support.	C	Further strengthen the trustwide approach to service by service workforce development	complete	Director of TD&W/Divisional Education Leads/DMT
2.2.2	The organisation recognises the unique contribution of nurses, midwives and all care professionals in the wider workforce. Professional judgement is used to ensure that the team has the skills and knowledge required to provide high-quality care to patients. This stronger multiprofessional approach avoids placing demands solely on any one profession and supports improvements in quality and productivity, as shown in the literature.	Multiprofessional approach to all aspects of workforce development and training delivered within an integrated Training, Development and Workforce department	C	Continue with current approach and strengthen integration	complete	Director of TD&W/Divisional Education Leads/DMT
2.2.3	The organisation works collaboratively with others in the local health and care system. It supports the development of future care models by developing an adaptable and flexible workforce (including AHPs and others), which is responsive to changing demand and able to work across care settings, care teams and care boundaries.	Strong record of working with other providers both in provider and HE/FE sector.	C	Continue with current approach and strengthen partnership working through STP projects	complete	Director of TD&W/Divisional Education Leads/DMT

2.3 Recruitment and retention						
2.3.1	The organisation has clear plans to promote equality and diversity and has leadership that closely resembles the communities it serves. The research outlined in the NHS provider roadmap42 demonstrates the scale and persistence of discrimination at a time when the evidence demonstrates the links between staff satisfaction and patient outcomes.	Full action plan in place to address equality and diversity within trust linked to WRES data	A	Detailed in separate ED&I action plan	ongoing through E & D	Director of Nursing/Director of HR
2.3.2	The organisation has effective strategies to recruit, retain and develop their staff, as well as managing and planning for predicted loss of staff to avoid over-reliance on temporary staff.	Full retention and recruitment programme of work ongoing and a workforce project management office established to maintain the focus	C	Confident that there are effective strategies in place and remains an area for ongoing action. Continued focus and evaluation of the wide ranging streams of work in place to support retention and recruitment	ongoing through R & R steering group	Director of HR/DMT
2.3.3	In planning the future workforce, the organisation is mindful of the differing generational needs of the workforce. Clinical leaders ensure workforce plans address how to support staff from a range of generations, through developing flexible approaches to recruitment, retention and career development	Generational work starting to be incorporated into projects for retention and recruitment and specifically around preceptorship.	C	Research partnership with Burdett and Birmingham to review self rostering. Flexibility sub group established as part of R & R actions to review different approaches to flexibility for generational needs. Joined RePAIR work on flexibility and NHSI retention collaborative	ongoing through R & R steering group	Associate Director of HR/Director of TD&W/DMT
3.1 Productive working and eliminating waste						
Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board, if concerns arise. Directors of nursing, medical directors, directors of finance and directors of workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.						
3.1.1	The organisation uses 'lean' working principles, such as the productive ward, as a way of eliminating waste.	Transformation work incorporates lean techniques and productive ward techniques applied as appropriate including reviews of care hours, safety crosses, knowing how we're doing boards and patient status at a glance	C	Lean techniques used systematically as part of transformation	complete	Head of transformation/DMT
3.1.2	The organisation designs pathways to optimise patient flow and improve outcomes and efficiency e.g. by reducing queuing.	Incorporated into all service redesign	C		complete	Head of transformation/DMT
3.1.3	Systems are in place for managing and deploying staff across a range of care settings, ensuring flexible working to meet patient needs and making best use of available resources.	Staff are employed to be fully flexible (skills and competence allowing).	C	Continued review as part of daily staffing meetings to maximise flexibility of staff	complete	DoN/DMT
3.1.4	The organisation focuses on improving productivity, providing the appropriate care to patients, safely, effectively and with compassion, using the most appropriate staff.	Staff are employed to be fully flexible (skills and competence allowing).	C	Continued review as part of daily staffing meetings to maximise flexibility of staff	complete	DoN/DMT
3.1.5	The organisation supports staff to use their time to care in a meaningful way, providing direct or relevant care or care support. Reducing time wasted is a key priority.	Included as part of methodology of reviews of staffing. Direct care time monitored. Other roles utilised to maximise direct care	C	Continue with current approach	complete	DoN/DMT
3.1.6	Systems for managing staff use responsive risk management processes, from frontline services through to board level, which clearly demonstrate how staffing risks are identified and managed.	Clear escalation processes in place and risk register and AER system used to record, review and learn from any staffing issues	C	Continue with current approach and monitor ongoing trends with staffing risks	complete	DoN/DMT

Expectation 3: Right place and time

3.2 Efficient deployment and flexibility						
3.2.1	Organisational processes ensure that local clinical leaders have a clear role in determining flexible approaches to staffing with a line of professional oversight, that staffing decisions are supported and understood by the wider organisation, and that they are implemented with fairness and equity for staff.	Involvement of clinical leaders at all levels in setting establishment levels and rostering workforce. This is systematically reviewed through 6 monthly staffing reviews reported to board	C	Continue with current approach	complete	DoN/DMT
3.2.2	Clinical capacity and skill mix are aligned to the needs of patients as they progress on individual pathways and to patterns of demand, thus making the best use of staffing resource and facilitating effective patient flow.	Clinical speciality, acuity, dependency and pathways included as part of the systematic review of staffing levels	C	Continue with current approach	complete	DoN/DMT
3.2.3	Throughout the day, clinical and managerial leaders compare the actual staff available with planned and required staffing levels, and take appropriate action to ensure staff are available to meet patients' needs.	Regular reviews of staffing levels planned and actual undertaken at care group, Division and trust wide level through daily staffing meetings linked to site.	C	Continue to strengthen the daily staffing meetings and utilise safecare information	complete	DDoN/DHN/Matrons/Site
3.2.4	Escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed for safe, effective and compassionate care, and staff are aware of the steps to take where capacity problems cannot be resolved.	Escalation policies in place into site for unresolved staffing issues. Temporary staffing escalation in place and resource shared trustwide when required	C	Continue to strengthen the information into site around staffing resource	complete	DDoN/DHN/Matrons/workforce systems team
3.2.5	Meaningful application of effective e-rostering policies is evident, and the organisation uses available best practice from NHS Employers and the Carter Review Rostering Good Practice Guidance (2016).	Best practice guidance included in UHS policies around application of eRostering. Use of eRoster systematically reviewed and managed through the management team structure	C	Continue to strengthen the use of eRoster by utilising report function and reviewing compliance levels - specifically for: Approvals, unused hours, safecare	complete	DDoN/DHN/Matrons/Site
3.3 Efficient employment, minimising agency use						
3.3.1	The annual strategic staffing assessment gives boards a clear medium-term view of the likely temporary staffing requirements. It also ensures discussions take place with service leaders and temporary workforce suppliers to give best value for money in deploying this option. This includes an assessment to maximise flexibility of the existing workforce and use of bank staff (rather than agency), as reflected by NHS Improvement guidance.	Currently undertake 6 monthly staffing reviews that take account of all of the recommendations. Staffing reviews closely aligned to the Retention & Recruitment and temporary staffing strategies and clear actions in place to maximise bank use (NHSP) and reduce agency	C	Continue with all of the actions to reduce temporary staffing use and increase use of bank staff	complete	DoN/ADHR/DMT
3.3.2	The organisation is actively working to reduce significantly and, in time, eradicate the use of agency staff in line with NHS Improvement's nursing agency rules, supplementary guidance and timescales.	Plan in place to reduce agency usage in line with NHSI guidance	C	Continue with all of the actions to reduce temporary staffing use and increase use of bank staff.	complete	DoN/ADHR/DMT
3.3.3	The organisation's workforce plan is based on the local Sustainability and Transformation Plan (STP), the place-based, multi-year plan built around the needs of the local population.	UHS fully engaged in development of STP workforce aspects and workforce plan based on actions	C	Continue with engagement in STP development	complete	CEO/DoN/DoE
3.3.4	The organisation works closely with commissioners and with Health Education England, and submits the workforce plans they develop as part of the STP, using the defined process, to inform supply and demand modelling.	UHS fully engaged in development of STP workforce aspects and workforce plan based on actions	C	Continue with engagement in STP development	complete	CEO/DoN/DoE
3.3.5	The organisation supports Health Education England by ensuring that high quality clinical placements are available within the organisation and across patient pathways, and actively seeks and acts on feedback from trainees/students, involving them wherever possible in developing safe, sustainable and productive services.	Strong systems in place to identify placement capacity and monitor student allocation and quality across all staff groups	C	Continue with current model. Work with universities to constantly review the placement models for students in line of developing undergraduate programmes and apprenticeships	complete	DoE/Education leads

37 recommendations: 35 compliant 2 require further action

UHS FT self-assessment and action plan

No.	Recommendation	NICE category Must (M) Should (S) Consider (C)	Current measures in place	Initial Assessed UHS rating (July 2014) C = compliant = Actions required	Identified actions required (24 compliant, 14 action) A	Timescale	Lead	October 2019 compliance	October 2019 update - comments (36 compliant, 2 requiring action)
Organisational strategy - Recommendations for hospital boards, senior management and commissioners in line with NOB expectations									
1.1.1	Ensure patients receive nursing care they need regardless of ward, time, day.	M	Specialty and sub-specialty ward system in place Outlying/inlying patients monitored through site	C	Continued monitoring of compliance	Maintain	Clinical teams/DMT	C	Continued monitoring of compliance. Reconfiguration of ward specialities and skills where appropriate.
1.1.2	Develop procedures to ensure ward staff establishments are sufficient to provide safe nursing care for each patient	M	6 monthly establishments reviews in place led by DoN team with DHN/Matron/ward leaders as appropriate.	C	Continued development of staffing review methodology linked to NICE guidance		DoN/DDoN/ DHN	C	Ongoing strengthening of 6 monthly reviews
1.1.3	Ensure final ward establishments developed with registered nurses responsible and approved through chief nurse and trust board	M	6 monthly establishments reviews in place led by DoN team with DHN/Matron/ward leaders as appropriate. Reported and discussed through board	C	Strengthen involvement of ward sisters through supervisory competencies	Maintain	DoN/DDoN/ DHN	C	6 monthly reviews now involving ward leaders
1.1.4	Ensure senior nursing managers are accountable for nursing rosters produced	M	Reflected in job descriptions for DHN/Matrons/Ward Leader and included in ward leader competencies Hierarchy in eRoster reinforces requirements	C	Strengthen the monitoring and follow up of roster KPI's	Maintain	DoN/DDoN/DHN/ HR	C	Roster audits now reinstated and accountability for rosters clearly within ward leader and matron job roles.
1.1.5	Ensure inclusion of adequate 'uplift' to support staffing establishment	M	23% uplift included in all inpatient nursing establishments	C	Continued monitoring of achievement of allocated 'uplift' through eRostering KPI's		DHN/Matron/Ward Leaders	C	Continued monitoring of achievement of allocated 'uplift' through eRostering KPI's
1.1.6	Include seasonal variation/fluctuating patient need when setting establishments	M	Included as a consideration when setting establishments	C	Continued consideration at establishment reviews	Maintain	DDoN/DHN	C	Continued consideration at establishment reviews
1.1.7	Establishments should be set appropriate to patient need taking account of registered/unregistered mix and knowledge and skills required	S	Included as a consideration when setting establishments	C	Continued consideration at establishment reviews		DDoN/DHN	C	Continued consideration at establishment reviews
1.1.8	Ensure procedures in place to identify differences between on the day requirements and staff available	M	Escalation processes in place through bleep-holders through to site. Matrons responsible for reviewing staffing daily	C	Further strengthen the daily review processes through site. Strengthen the matron out of hours model to provide further oversight for staffing through to site	Maintain	DDoN/DHN/Matrons/Site	C	Safe staffing meetings extended to cover 7 days per week. Winter on-call matron arrangements now discontinued but staffing review meetings maintained. Safecare used actively at meetings
1.1.9	Hospital to have a system in place for nursing red flag events to be reported by nursing teams, patients, relatives to registered nurse in charge (see separate tab)	M	eReporting of incidents becoming embedded. Staff informally include red flag information	A	Formalise 'red flag' inclusions on e incident reporting. Educate staff on 'red flag' events through safe staffing master classes and local care group/divisional updates. Review 'red flags' on all quality review visits to ward areas.	Jan-20	DDoN/DHN/safety team	A	Red flag usage on safecare still to be fully embedded - review now included at daily staffing. Review and alignment of red flag categories to be included in the rostering review (headroom) project led by Linda Monk

management and commissioners in line with NOB expectations

Organisational strategy - Recommendations for hospital boards, senior	1.1.10	Ensure procedures in place for effective response to unplanned variations in patient need - including ability to increase/decrease staffing	M	Clear escalation processes and review of staffing actioned through bleep holding arrangements in Divisions	A	Continued monitoring of effectiveness of escalation and staffing status	Maintain	DDoN/DHN	C	Escalation clear and embedded throughout all of the staffing review meeting. Enhanced care requirements specifically flagged and linked to the revisited policy re-issued May 2019. Agreed now compliant
	1.1.11	Actions to respond to nursing staff deficits on a ward should not compromise staff nursing on other wards	S	Escalation processes include the need to review other wards/departments. All ward normal staffing included on trust wide spreadsheet daily	A	Continued monitoring of effectiveness of escalation and staffing status	Jan-20	DDoN/DHN	A	Monitored as part of the daily reviews of staffing - but unable to assure with current vacancy and staffing position.
	1.1.12	Ensure there is a separate contingency and response for patients requiring continuous presence 'specialling'	M	Specialling processes in place and agreed escalation process within divisions.	C	Review the process for requesting specialling support.	Maintain	DDoN/DHN	C	Escalation processes clear but further work still required with the changes to the enhanced care team and the appointment of the new safeguarding lead. Policy requires updating
	1.1.13	Consider implementing approaches to support flexibility such as adapting nursing shifts, skill mix, location and employment contracts	C	Variety of shift patterns worked within the trust and flexibility within rostering policy allows for variation	C	Continue to review as part of professional judgement element of staffing reviews	Maintain	DDoN/DHN	C	Continue to review as part of professional judgement element of staffing reviews
	1.1.14	Ensure procedures in place for systematic ongoing monitoring of safe nursing indicators and formal review of nursing establishments twice a year	M	Nursing indicators monitored through incident reporting, ongoing monitoring and through CQD. Twice yearly formal staffing reviews embedded and managed through DON team	C	Continue to strengthen the process	Maintain	DDoN/DHN	C	Continue to strengthen the process - new CQD system launched Sept 2015
	1.1.15	Make appropriate changes to ward establishments as a response to reviews	M	Establishments amended as result of staffing reviews. Staffing review linked to budget setting process. Evidenced increases noted through trust board reporting	C	Continue to strengthen and evidence the process	Maintain	DDoN/DHN	C	Continue to strengthen and evidence the process
	1.1.16	Enable nursing staff to have appropriate training for the care they are required to provide	M	Strong track record of training within Trust. Individual care group education teams support ongoing development needs	C	Continue to strengthen and evidence the process	Maintain	DDoN/DHN/ Education leads	C	Continue to strengthen and evidence the process
	1.1.17	Ensure there are sufficient registered nurses who are experienced and trained to determine day-to-day staffing needs in 24 hour period	M	Bleep-holder role includes requirement to assess and review staffing and risk assess	A	Review to ensure all bleep-holders are competent and capable in staffing assessment and risk management	Maintain	DHN/Matron	C	Additional education put into bleep holding as part of winter pressure oversight arrangements. Now in place with bleep holding and band 7 weekend review
	1.1.18	Organisation should encourage staff to take part in programmes to assure quality of nursing care and care standards	S	Nursing staff involved in range of quality improvement programmes e.g. essence of care, nursing practice, turnaround, clinical accreditation scheme	C	Continue to involve staff at all levels in nursing quality standard development	Maintain	DHN/Head of Quality and Clinical Assurance	C	Continue to involve staff at all levels in nursing quality standard development
	1.1.19	Involve nursing staff in developing nursing policies which govern nursing staff requirements such as escalation policies	S	Nursing staff involved in developing policy through groups and consultation	C	Continue to involve staff at all levels in nursing policy development	Maintain	DHN/Head of Quality and Clinical Assurance	C	Continue to involve staff at all levels in nursing policy development
sing staffing s for registered wards or shifts	Principles for determining nursing staffing requirements - Recommendations for registered nurses in charge of individual wards or shifts who should be responsible for assessing the various factors used to determine nursing staff requirements									
	1.2.1	Use systematic approach to determining nursing staff requirements when setting nursing establishments and on day to day	M	Professional judgement and SNCT embedded for use within the Trust. Clear 'established levels' identified on eRoster	C	Continue to support staff at local ward level to understand establishments and staffing models	Maintain	DHN/Matrons/Ward Leaders	C	Continue to support staff at local ward level to understand establishments and staffing models

Principles for determining nursing requirements - Recommendations for nurses in charge of individual wards	1.2.2	Use a decision support toolkit endorsed by NICE to determine nursing staff requirements		Not yet available through NICE but UHS already uses nationally validated Safer Nursing Care Tool (SNCT) as part of methodology for reviewing staffing levels	C	Review NICE endorsed tools as they emerge	Await national development	DDoN	C	Review NICE endorsed tools as they emerge. Continue to use endorsed SNCT and incorporate into plan for v10 eRostering safe care module rollout	
	1.2.3	Use informed professional judgement to make a final assessment of nursing staff requirements	M	Professional judgement used as mainstay of methodology for reviewing establishments and day to day staffing	C	Continue to support staff at local ward level to understand establishments and staffing models	Maintain	DHN/Matrons/Ward Leaders	C	Continue to support staff at local ward level to understand establishments and staffing models	
	1.2.4	Consider using nursing care activities included in guidance as a prompt to help inform professional judgement (see separate tab)	C	Already considered routinely as part of professional judgement and methodology	C	Continue to support staff at local ward level to understand establishments and staffing models	Maintain	DHN/Matrons/Ward Leaders	C	Continue to support staff at local ward level to understand establishments and staffing models	
	Setting the ward nursing staff establishment - Recommendations for senior registered nurses responsible for determining nursing staff requirements or those involved in setting the nursing staff establishment of a particular ward										
Setting the ward nursing staff establishment - Recommendations for senior registered nurses responsible for determining nursing staff requirements or those involved in setting the nursing staff establishment	1.3.1	Setting ward establishments should involve designated senior registered nurses at ward level experienced and trained in determining nursing staff requirements using recommended tools	S	Ward sisters already involved in ward establishment reviews but approach needs strengthening. Competency for establishment review included in ward leader competencies	A	Strengthen involvement and training of ward leaders and other nurses through staffing master classes	Maintain	DDoN/DHN/Workforce Systems	C	Current staffing review has full representation from ward leaders	
	1.3.2	Routinely measure the average amount of nursing time required throughout a 24 hour period for each patient expressed as nursing hours per patient.	S	Methodologies not previously based on nursing hours per patient but safe nursing care tool and professional judgement	A	Include nursing hours per patient as a methodology in the staffing reviews from November 2014 Introduce next version of eRostering which has functionality to convert data into hours per patient	Maintain	DDoN/Workforce Systems	C	Care hours per patient day now embedded as part of monthly reporting and included in safecare module of eRoster. Used as part of 6 monthly review from July 2016	
	1.3.3	Formally analyse the average nursing hours required per patient at least twice a year when reviewing the ward nursing staff establishments	S	Methodologies not previously based on nursing hours per patient but safe nursing care tool and professional judgement	A	Include nursing hours per patient as a methodology in the staffing reviews from November 2014	Maintain	DDoN/Workforce Systems	C	Care hours per patient day now embedded as part of monthly reporting and included in safecare module of eRoster. Used as part of 6 monthly review from July 2016	
	1.3.4	Multiply the average number of nursing hours per patient by the average daily bed utilisation	S	Methodologies currently based on using 100% bed occupancy - bed utilisation considered as part of the professional judgement	A	Introduce bed utilisation into the staffing review methodology for November 2014	Maintain	DDoN/Workforce Systems	C	Bed utilisation discussed as part of the staffing review since July - Sept 2015 particularly in admission areas. Continue to calculate on 100% bed occupancy	
	1.3.5	Add an allowance for additional nursing workload based on the relevant ward factors such as turnover, layout and size and staff factors	S	Already included in professional judgment considerations	C	Continued consideration at establishment reviews	Maintain	DDoN/DHN	C	Continued consideration at establishment reviews	
	1.3.6	Identify appropriate knowledge and nursing skill mix required - registered to unregistered - reviewing appropriate delegation	S	Trust baseline registered: unregistered 60:40 - no inpatient ward establishment drop below this. Assessed as part of professional judgement	C	Continued consideration at establishment reviews	Maintain	DDoN/DHN	C	Continued consideration at establishment reviews	
	1.3.7 and 1.3.8	Ensure planned uplift included in the calculation on average patients nursing needs	S	Trust baseline to include 23% on all ward establishments to cover uplift. Additional 0.8 wte uplift being rolled out for supervisory ward leader model	C	Continued consideration at establishment reviews. Continued monitoring of 23% headroom through eRostering	Maintain	DDoN/DHN	C	Continued consideration at establishment reviews. Continued monitoring of 23% headroom through eRostering	
	ents' s on	Assessing if nursing staff available on the day meet patients' nursing needs - Recommendations for registered nurses on wards who are in charge of shifts									

Assessing if nursing staff available on the day meet patient needs - Recommendations for registered nurse wards	1.4.1	Systematically assess that the available nursing staff for each shift or at least each 24 hour period is adequate to meet the actual nursing needs of patients on the ward	S	Daily spreadsheet used in site to review safe staffing - Matrons expected to link with all wards to determine staffing levels	C	Continued review of staffing levels included as a key responsibility in the ward leader and matron role	Maintain	Ward Leaders/ Matrons/ DHN	C	Continued review of staffing levels included as a key responsibility in the ward leader and matron role	
	1.4.2	Monitor the occurrence of the nursing red flag events throughout a 24hour period	M	Escalation processes in place through bleep-holders through to site. Matrons responsible for reviewing staffing daily and this should include red flags	A	Care groups/Divisions to develop processes for review, reporting and capture of red flags through escalation processes	Maintain	Ward Leaders/ Matrons/ DHN	C	Monitoring of red flags on ongoing basis. Reflected in AER reporting	
	1.4.3	If a nursing red flag occurs it should prompt an immediate escalation response by the registered nurse in charge - with potential to allocate additional nursing staff	M	Escalation processes in place through bleep-holders through to site. Matrons responsible for reviewing staffing daily and this should include red flags	A	Care groups/Divisions to develop processes for review, reporting and capture of red flags through escalation processes	Maintain	Ward Leaders/ Matrons/ DHN	C	Monitoring of red flags on ongoing basis. Reflected in AER reporting and noted in bleep-holder logs	
	1.4.4	Keep records of the on-the-day assessments of actual nursing staff requirements and reported red flag events so that they can be used to inform future planning or establishments	M	Escalation processes in place through bleep-holders through to site. Matrons responsible for reviewing staffing daily and this should include red flags	A	Care groups/Divisions to develop processes for review, reporting and capture of red flags through escalation processes	Maintain	Ward Leaders/ Matrons/ DHN	C	On the day records maintained and all red flag events captured through AER. Information used as part of the annual staffing reviews for each area to inform establishment changes. Examples at budget setting of changes as a result.	
Monitor & evaluate ward nursing establishments - Recommendations for senior management and matrons	Monitor and evaluate ward nursing staff establishments - Recommendations for senior management and nursing managers or matrons to support safe staffing for nursing at ward level										
	1.5.1	Monitor whether the ward nursing staff establishment adequately meets patients nursing needs using safe nursing indicators. Consider continuous data collection of these nursing indicators	S	Majority of safe nursing indicators already included as part of the clinical quality dashboard	A	Expand the clinical quality dashboard to include the identified safe nursing indicators	Maintain	DHN/DDoN/Head of Quality and Clinical Assurance	C	Clinical Quality Dashboard reviewed and relaunched September 2015. Review of indicators included as part of clinical accreditation scheme completed	
	1.5.2	Compare results of safe nursing indicators with previous results over 6 month period	S	Review as part of monitoring of clinical quality dashboard	A	Include review of safe nursing indicators as part of staffing reviews from 2015 onwards	Maintain	Matrons	C	Review of indicators included as part of clinical accreditation scheme and annual matron reviews completed	
	1.5.3	Monitor all of the nursing red flags and safe nursing indicators linked to wards exceeding 1 RN to 8 patients during the day	S	1:8 indicator included in daily staffing spreadsheet as a trigger to review staffing	A	Matrons to review all safe nursing indicators routinely for all ward areas	Maintain	Matrons	C	Matrons review all safe nursing indicators routinely for all ward areas. Retrospective review of red flag/AER incidents included as part of staffing discussions.	

Appendix 4

Planned based on the acuity/dependency level of patients and application of the safer nursing care tool (SNCT) multipliers

Division	Care Group	Unit Name	Shift	Total Beds or "Shift N/A"	Budgeted Establishment (WTE)	Finance budgeted			Staffing Numbers							Care Hours Per Patient Day (CHPPD)		
						Budgeted Registered Staff (WTE)	Budgeted Unregistered Staff (WTE)	Budgeted Other Staff (WTE)	Demand Registered (Count)	Demand Unregistered (Count)	Total nurse per shift	Skill Mix (RN:URN) by shift	Skill Mix (RN) average	Patients RN Ratio (RN: Patient)	Patients Nursing Ratio (Total Nurse: Patient)	Planned Registered (CHPPD)	Planned Unregistered (CHPPD)	Total Planned CHPPD
Division A	Cancer Care	CAN C4 Solent Ward Clinical Oncology	Early	23	37.9	20.8	14.1	3.0	4	3	7	58:42	59%	1:6	1:4	3.5	2.4	5.9
		CAN C4 Solent Ward Clinical Oncology	Late	23					4	3	7	58:42		1:6	1:4			
		CAN C4 Solent Ward Clinical Oncology	Night	23					3	2	5	60:40		1:8	1:5			
		CAN C6 Leukaemia/BMT Unit	Early	21	43.8	39.1	1.0	3.7	8	0	8	95:5	97%	1:3	1:3	7.4	0.2	7.7
		CAN C6 Leukaemia/BMT Unit	Late	21					8	0	8	95:5		1:3	1:3			
		CAN C6 Leukaemia/BMT Unit	Night	21					6	0	6	100:0		1:4	1:4			
		CAN C6 TYA Unit	Early	6	13.6	10.7	1.0	1.9	2	1	3	67:33	78%	1:3	1:2	7.4	1.9	9.3
		CAN C6 TYA Unit	Late	6					2	1	3	67:33		1:3	1:2			
		CAN C6 TYA Unit	Night	6					2	0	2	100:0		1:4	1:4			
		CAN D2 Haematology	Early	20	38.2	23.1	12.2	2.8	4	4	8	50:50	50%	1:5	1:3	3.3	3.8	7.2
		CAN D2 Haematology	Late	20					4	3	7	58:42		1:5	1:3			
		CAN D2 Haematology	Night	20					2	3	5	41:59		1:10	1:5			
		CAN D3 Ward	Early	22	36.3	22.9	9.8	3.7	5	3	8	62:38	64%	1:5	1:3	3.9	2.2	6.1
		CAN D3 Ward	Late	22					5	2	7	70:30		1:5	1:4			
		CAN D3 Ward	Night	22					3	2	5	60:40		1:8	1:5			
	SUR Acute Surgical Admissions	Early	30	44.1	19.8	18.7	5.6	6	2	8	75:25	70%	1:5	1:4	3.5	1.5	5.0	
	SUR Acute Surgical Admissions	Late	30					6	2	8	75:25		1:5	1:4				
	SUR Acute Surgical Admissions	Night	30					3	2	5	60:40		1:10	1:6				
	SUR Acute Surgical Unit	Early	12	27.7	15.1	9.0	3.6	3	1	4	75:25	68%	1:4	1:3	NA	NA	NA	
	SUR Acute Surgical Unit	Late	12					4	1	5	80:20		1:3	1:3				
	SUR Acute Surgical Unit	Night	12					2	2	4	50:50		1:6	1:3				
	SUR E5 Lower GI	Early	18	27.3	14.8	9.5	3.0	4	2	6	65:35	64%	1:5	1:4	3.5	1.9	5.4	
	SUR E5 Lower GI	Late	18					3	2	5	60:40		1:6	1:4				
	SUR E5 Lower GI	Night	18					2	1	3	67:33		1:9	1:6				
	SUR E5 Upper GI	Early	18	27.3	15.4	9.5	2.4	3	2	5	63:37	63%	1:6	1:4	3.6	2.1	5.8	
	SUR E5 Upper GI	Late	18					3	2	5	59:41		1:7	1:4				
	SUR E5 Upper GI	Night	18					2	1	3	66:34		1:10	1:7				
	SUR E8 HPB/Urology	Early	24	51.7	25.6	22.5	3.6	6	5	11	55:45	54%	1:5	1:3	4.4	4.0	8.4	
	SUR E8 HPB/Urology	Late	24					6	4	10	61:39		1:5	1:3				
	SUR E8 HPB/Urology	Night	24					3	4	7	45:55		1:8	1:4				
SUR F11 IF	Early	17	33.6	20.0	9.0	4.6	4	2	6	67:33	65%	1:5	1:3	5.0	2.9	7.9		
SUR F11 IF	Late	17					4	2	6	67:33		1:5	1:3					
SUR F11 IF	Night	17					3	2	5	60:40		1:6	1:4					
SUR Ward F5	Early	28	39.9	19.4	17.1	3.4	5	3	8	62:38	64%	1:6	1:4	3.5	1.9	5.4		
SUR Ward F5	Late	28					5	2	7	71:29		1:6	1:4					
SUR Ward F5	Night	28					3	2	5	60:40		1:10	1:6					
ECM Acute Medical Unit	Early	54	136.3	75.4	52.2	8.7	12	11	23	53:47	57%	1:5	1:3	4.7	3.6	8.2		
ECM Acute Medical Unit	Late	54					14	12	26	54:46		1:4	1:3					
ECM Acute Medical Unit	Night	54					10	6	16	63:37		1:6	1:4					
MED D5 Ward	Early	28	39.7	19.0	19.7	1.0	5	4	9	56:44	55%	1:6	1:4	2.7	3.0	5.8		
MED D5 Ward	Late	28					4	4	8	50:50		1:7	1:4					
MED D5 Ward	Night	28					3	2	5	60:40		1:10	1:6					
MED D6 Ward	Early	24	35.6	14.7	19.9	1.0	4	4	8	50:50	49%	1:6	1:3	2.4	3.3	5.8		
MED D6 Ward	Late	24					4	3	7	57:43		1:6	1:4					
MED D6 Ward	Night	24					2	3	5	40:60		1:12	1:5					
MED D7 Ward	Early	16	23.7	12.0	11.7	0.0	2	3	5	40:60	49%	1:8	1:4	2.9	3.1	6.0		
MED D7 Ward	Late	16					2	3	5	40:60		1:8	1:4					
MED D7 Ward	Night	16					2	1	3	67:33		1:8	1:6					
MED D8 Ward	Early	24	35.0	14.7	19.3	1.0	4	4	8	50:50	52%	1:6	1:3	2.4	3.3	5.7		
MED D8 Ward	Late	24					4	2	6	67:33		1:6	1:4					
MED D8 Ward	Night	24					2	3	5	40:60		1:12	1:5					
MED D9 Ward	Early	28	40.3	19.0	20.3	1.0	4	5	9	44:56	46%	1:8	1:4	2.6	3.0	5.6		
MED D9 Ward	Late	28					3	4	7	43:57		1:10	1:5					
MED D9 Ward	Night	28					3	3	6	50:50		1:10	1:5					
MED D10 Isolation Unit	Early	18	31.4	13.7	16.7	1.0	3	4	7	42:58	47%	1:7	1:3	3.3	3.7	7.0		
MED D10 Isolation Unit	Late	18					3	3	6	50:50		1:7	1:4					
MED D10 Isolation Unit	Night	18					2	2	4	50:50		1:9	1:5					
MED E7 Ward	Early	20	32.5	15.5	16.1	1.0	3	4	7	43:57	48%	1:7	1:3					
MED E7 Ward	Late	20					3	3	6	50:50		1:7	1:4					
MED E7 Ward	Night	20					2	2	4	50:50		1:10	1:5					
MED F7 Ward	Early	20	30.8	12.4	16.4	2.0	2	4	6	32:68	41%	1:11	1:4	2.3	3.3	5.6		
MED F7 Ward	Late	20					2	3	5	40:60		1:11	1:5					
MED F7 Ward	Night	20					2	2	4	50:50		1:10	1:5					
MED G5 Ward	Early	28	41.2	15.5	23.8	2.0	3	5	8	38:62	39%	1:10	1:4	2.1	3.3	5.4		
MED G5 Ward	Late	28					3	5	8	38:62		1:10	1:4					
MED G5 Ward	Night	28					2	3	5	40:60		1:14	1:6					
MED G6 Ward	Early	26	40.9	15.5	23.4	2.0	3	5	8	38:62	39%	1:9	1:4	2.2	3.6	5.8		
MED G6 Ward	Late	26					3	5	8	38:62		1:9	1:4					
MED G6 Ward	Night	26					2	3	5	40:60		1:14	1:6					
MED G7 Ward	Early	14	34.2	12.4	19.9	2.0	2	4	6	34:66	36%	1:7	1:3	3.3	5.8	9.2		
MED G7 Ward	Late	14					2	4	6	34:66		1:7	1:3					
MED G7 Ward	Night	14					2	3	5	40:60		1:7	1:3					
MED G8 Ward	Early	28	38.8	15.5	21.4	2.0	3	5	8	37:63	38%	1:10	1:4	2.1	3.3	5.4		
MED G8 Ward	Late	28					3	5	8	37:63		1:10	1:4					
MED G8 Ward	Night	28					2	3	5	40:60		1:14	1:6					
MED G9 Ward	Early	26	40.2	15.5	22.8	2.0	3	5	8	37:63	38%	1:9	1:4	2.2	3.6	5.8		
MED G9 Ward	Late	26					3	5	8	37:63		1:9	1:4					
MED G9 Ward	Night	26					2	3	5	40:60		1:13	1:6					
OPH Eye Short Stay Unit	Early	4	20.5	11.2	8.3	1.0	3	2	5	63:37	59%	1:2	1:1	NA	NA	NA		
OPH Eye Short Stay Unit	Late	4					2	1	3	64:36		1:3	1:2					
OPH Eye Short Stay Unit	Night	4					1	1	2	50:50		1:4	1:2					
SME C5 Isolation Ward	Early	14	28.4	15.2	11.2	2.0	3	2	5	60:40	59%	1:5	1:3	4.1	2.6	6.7		
SME C5 Isolation Ward	Late	14					2	2	4	50:50		1:7	1:4					
SME C5 Isolation Ward	Night	14					2	1	3	66:34		1:8	1:5					

Appendix 4

Planned based on the acuity/dependency level of patients and application of the safer nursing care tool (SNCT) multipliers

Division	Care Group	Unit Name	Shift	Total Beds or "Shift N/A"	Budgeted Establishment (WTE)	Finance budgeted			Staffing Numbers							Care Hours Per Patient Day (CHPPD)			
						Budgeted Registered Staff (WTE)	Budgeted Unregistered Staff (WTE)	Budgeted Other Staff (WTE)	Demand Registered (Count)	Demand Unregistered (Count)	Total nurse per shift	Skill Mix (RN:URN) by shift	Skill Mix (RN) average	Patients RN Ratio (RN: Patient)	Patients Nursing Ratio (Total Nurse: Patient)	Planned Registered (CHPPD)	Planned Unregistered (CHPPD)	Total Planned CHPPD	
Division C	Child Health	CHI Bursledon House	Early	8	15.2	8.6	4.3	2.3	2	1	3	68 : 32	59%	1:4	1:3	NA	NA	NA	
		CHI Bursledon House	Late	8					2	1	3	60 : 40		1:5	1:3				
		CHI Bursledon House	Night	8					1	1	1	50 : 50		1:15	1:8				
		CHI Paed Medical Unit	Early	16	44.2	28.6	11.9	3.7	5	1	6	80 : 20	76%	1:4	1:3	6.6	2.2	8.8	
		CHI Paed Medical Unit	Late	16					5	1	6	80 : 20		1:4	1:3				
		CHI Paed Medical Unit	Night	16					4	2	6	69 : 31		1:4	1:3				
		CHI Paediatric Assessment Unit	Early	10	30.5	21.4	5.4	3.7	3	1	4	70 : 30	73%	1:4	1:3	7.6	2.6	10.2	
		CHI Paediatric Assessment Unit	Late	10					4	2	5	71 : 29		1:3	1:2				
		CHI Paediatric Assessment Unit	Night	10					3	1	4	78 : 22		1:4	1:3				
		CHI Piam Brown Unit	Early	10	42.9	37.9	1.0	4.0	11	1	11	94 : 6	98%	1:1	1:1	13.1	0.4	13.5	
		CHI Piam Brown Unit	Late	10					4	0	4	100 : 0		1:3	1:3				
		CHI Piam Brown Unit	Night	10					3	0	3	100 : 0		1:4	1:4				
		CHI Ward E1 Paed Cardiac	Early	16	38.7	28.5	7.6	2.6	6	2	7	77 : 23	77%	1:3	1:3	7.2	2.1	9.3	
		CHI Ward E1 Paed Cardiac	Late	16					5	2	7	75 : 25		1:4	1:3				
		CHI Ward E1 Paed Cardiac	Night	16					4	1	5	79 : 21		1:4	1:4				
		CHI Ward G2 Neuro	Early	6	12.1	12.1	0.0	0.0	2	0	2	100 : 0	100%	1:3	1:3	8.2	0.0	8.2	
		CHI Ward G2 Neuro	Late	6					2	0	2	100 : 0		1:3	1:3				
		CHI Ward G2 Neuro	Night	6					2	0	2	100 : 0		1:3	1:3				
		CHI Ward G3	Early	20	46.9	30.5	13.2	3.2	6	3	9	67 : 33	68%	1:4	1:3	6.6	3.1	9.7	
		CHI Ward G3	Late	20					6	3	9	66 : 34		1:4	1:3				
		CHI Ward G3	Night	20					5	2	7	71 : 29		1:5	1:3				
		CHI Ward G4 Surgery	Early	22	56.1	38.1	14.6	3.4	6	3	10	64 : 36	68%	1:4	1:3	NA	NA	NA	
	CHI Ward G4 Surgery	Late	22	6					3	9	68 : 32	1:4		1:3					
	CHI Ward G4 Surgery	Night	22	5					2	7	71 : 29	1:5		1:4					
	Women & Newborn	W&N Bramshaw Womens Unit	Early	26	27.3	16.9	7.8	2.5	4	3	7	53 : 47	53%	1:7	1:4	2.7	2.4	5.2	
		W&N Bramshaw Womens Unit	Late	26					4	3	7	54 : 46		1:8	1:4				
		W&N Bramshaw Womens Unit	Night	26					2	2	4	50 : 50		1:13	1:7				
	Division D	Cardiovascular and Thoracic	CAR Coronary Care Unit	Early	17	43.9	28.5	13.7	1.8	4	2	6	65 : 35	68%	1:5	1:3	5.4	2.4	7.9
			CAR Coronary Care Unit	Late	17					4	2	6	65 : 35		1:5	1:3			
			CAR Coronary Care Unit	Night	17					4	1	5	74 : 26		1:5	1:4			
			CAR Ward D4 Vascular	Early	22	41.7	20.5	19.1	2.0	5	2	7	70 : 30	65%	1:5	1:4	3.9	2.3	6.1
			CAR Ward D4 Vascular	Late	22					4	2	6	66 : 34		1:6	1:4			
			CAR Ward D4 Vascular	Night	22					3	2	5	58 : 42		1:9	1:5			
			CAR Ward E2 YACU	Early	17	28.8	18.8	9.0	1.0	4	2	6	67 : 33	67%	1:5	1:3	4.5	2.2	6.7
			CAR Ward E2 YACU	Late	17					4	2	6	67 : 33		1:5	1:3			
CAR Ward E2 YACU			Night	17	2					1	3	68 : 32	1:9		1:6				
CAR Ward E3 Green			Early	24	37.6	17.8	17.8	2.0	5	1	6	82 : 18	71%	1:5	1:4	3.7	2.1	5.8	
CAR Ward E3 Green			Late	24					5	1	6	82 : 18		1:5	1:4				
CAR Ward E3 Green			Night	24					2	2	4	48 : 52		1:12	1:6				
CAR Ward E3 Blue		Early	18	29.4	12.5	15.8	1.0	4	2	6	67 : 33	61%	1:5	1:3	4.2	2.6	6.8		
CAR Ward E3 Blue		Late	18					4	2	6	67 : 33		1:5	1:3					
CAR Ward E3 Blue		Night	18					2	2	4	50 : 50		1:9	1:5					
CAR Ward E4 Thoracics		Early	20	37.7	20.1	15.6	2.0	5	2	7	71 : 29	69%	1:4	1:3	4.8	2.1	6.9		
CAR Ward E4 Thoracics		Late	20					5	2	7	71 : 29		1:4	1:3					
CAR Ward E4 Thoracics		Night	20					3	2	4	64 : 36		1:8	1:5					
Neurosciences		NEU Acute Stroke Unit	Early	28	65.2	23.6	38.1	3.6	4	7	11	36 : 64	37%	1:7	1:3	2.9	5.1	8.0	
		NEU Acute Stroke Unit	Late	28					4	7	11	36 : 64		1:7	1:3				
		NEU Acute Stroke Unit	Night	28					3	5	8	38 : 63		1:10	1:4				
		NEU HASU	Early	13	33.1	23.3	8.0	1.8	4	1	5	80 : 20	80%	1:4	1:3	7.3	1.8	9.1	
		NEU HASU	Late	13					4	1	5	80 : 20		1:4	1:3				
		NEU HASU	Night	13					4	1	5	80 : 20		1:4	1:3				
	NEU Regional Transfer Unit	Early	10	30.1	20.8	7.5	1.8	3	1	4	75 : 25	68%	1:4	1:3	6.1	3.2	9.3		
	NEU Regional Transfer Unit	Late	10					3	1	4	75 : 25		1:4	1:3					
	NEU Regional Transfer Unit	Night	10					2	2	4	53 : 47		1:5	1:3					
	NEU Ward D Neuro	Early	27	62.9	30.3	30.3	2.2	5	5	10	50 : 50	48%	1:6	1:3	3.9	4.4	8.3		
	NEU Ward D Neuro	Late	27					5	5	10	50 : 50		1:6	1:3					
	NEU Ward D Neuro	Night	27					4	5	9	44 : 56		1:7	1:3					
NEU Ward E Neuro	Early	26	52.2	32.0	17.7	2.4	5	3	8	63 : 37	61%	1:6	1:4	4.2	2.6	6.8			
NEU Ward E Neuro	Late	26					5	3	8	63 : 37		1:6	1:4						
NEU Ward E Neuro	Night	26					4	3	7	57 : 43		1:7	1:4						
NEU Ward F4 Neuro Spinal	Early	22	37.4	22.7	12.4	2.2	4	2	6	68 : 32	62%	1:6	1:4	3.9	2.5	6.4			
NEU Ward F4 Neuro Spinal	Late	22					4	2	6	68 : 32		1:6	1:4						
NEU Ward F4 Neuro Spinal	Night	22					3	3	6	51 : 49		1:7	1:4						
Trauma & Orthopaedics	T&O PAH Brooke Ward	Early	18	28.4	17.4	8.0	3.0	3	2	5	60 : 40	70%	1:6	1:4	3.9	1.7	5.6		
	T&O PAH Brooke Ward	Late	18					2	2	4	50 : 50		1:9	1:5					
	T&O PAH Brooke Ward	Night	18					2	2	4	50 : 50		1:9	1:5					
	T&O Ward F1 Elective	Early	32	71.8	36.8	29.4	5.6	6	4	10	60 : 40	61%	1:6	1:4	4.3	2.6	6.9		
	T&O Ward F1 Elective	Late	32					6	4	10	60 : 40		1:6	1:4					
	T&O Ward F1 Elective	Night	32					5	3	8	63 : 38		1:7	1:4					
	T&O Ward F2 Trauma	Early	26	56.2	23.6	28.2	4.5	4	5	9	44 : 56	44%	1:7	1:3	3.3	4.0	7.3		
	T&O Ward F2 Trauma	Late	26					4	5	9	45 : 55		1:7	1:3					
	T&O Ward F2 Trauma	Night	26					3	4	7	43 : 57		1:9	1:4					
	T&O Ward F3 Trauma	Early	24	55.2	21.6	29.0	4.6	4	3	7	54 : 46	46%	1:6	1:4	3.6	4.1	7.7		
T&O Ward F3 Trauma	Late	24	4					5	9	44 : 56	1:6		1:3						
T&O Ward F3 Trauma	Night	24	3					4	7	41 : 59	1:8		1:4						
T&O Ward F4	Early	18	37.2	21.3	11.9	4.0	4	3	7	57 : 43	56%	1:5	1:3	4.5	3.4	7.8			
T&O Ward F4	Late	18					3	3	6	51 : 49		1:6	1:3						
T&O Ward F4	Night	18					3	2	5	60 : 40		1:6	1:4						

Specific Divisional issues emerging

Division A

Overall established staffing levels are appropriate in the majority of wards for the level and acuity of patients.

Cancer Care has undergone major change over the last few years as the care delivery models have moved to more day case and assessment and a higher intensity of care in the remaining inpatient areas. Staffing levels have been gradually adjusted to match these changes. The daycase and outpatient areas are under significant pressure and a review is underway of pathways and models of care.

Further review is taking place to ensure the staffing model for F11 (intestinal failure unit) meets the required national recommendations for this specialty. Acuity and Dependency levels are being closely monitored as part of this review.

Areas being prioritised at budget setting:

No specific ward staffing areas are being prioritised for budget setting.

Division B

Overall established staffing levels are appropriate for the level and acuity of patients with previous investments.

The Division has continued to expand the band 4 model within the MOP wards and this has now rolled out and been well evaluated in the medical wards and AMU.

A range of innovative shift patterns including twilights is being utilised to ensure care hours are focussed at the times of greatest patient need.

It should be noted that Medicine and MOP are now at the lower end of the recommended staffing levels and any further change to the skill-mix should be carefully considered and accompanied by a full quality impact assessment.

Areas being prioritised at budget setting:

No specific ward staffing areas are being prioritised for budget setting.

Division C (excluding Midwifery)

Overall established staffing levels are appropriate in the majority of wards for the level and acuity of patients.

Safe, sustainable and productive staffing - An Improvement Resource for Children and Young People's Inpatient Wards in Acute Hospitals was published in June 2018 and is used to monitor staffing establishments for children.

The Children's Hospital currently does not have a model for a supernumerary bed manager/professional bleep holder out of hours. Both roles (predominantly covering flow and staffing) are managed by a band 6 sister who has a clinical patient allocation as part of the establishment numbers. The out of hours bleep role oversees 100 paediatric beds and supports flow from the Children's ED, Paediatric short stay (based within ED), Paediatric Intensive Care Unit (PICU) and other hospitals. They also support and oversee staffing for 8 inpatient wards as well as John Atwell Day Ward and PICU.

The increasing acuity following a change in the emergency patient pathway, arising from transfer of the Paediatric Assessment Unit to ED have presented capacity challenges and the reducing skill mix are putting additional requirements on the bleep holder/bed manager who can often not be released from practice to support.

Areas being prioritised at budget setting:

No specific ward staffing areas are being prioritised for budget setting.

The division will be presenting a case to support supernumerary bleep holders at night.

Division D

Overall established staffing levels are appropriate for the level and acuity of patients with previous investments and ongoing reconfigurations in T & O, Neurosciences and CVT.

Additional pressures on staffing models, however, have arisen in areas where the pathways of care and theatre activity has increased and this was particularly noted in CVT where additional beds were being supported during the review requiring a dispersal of staff. CVT will be monitored closely and the next review of establishment will be carried out sooner if these pressures continue to rise.

Division D do not have a model which allows the bleep holder to be supernumerary at night. The increasing acuity of the patients, increasing capacity challenges and reducing skill mix are putting additional requirements on the bleep holder who can often not be released from practice to support.

Areas being prioritised at budget setting:

No specific ward staffing areas are being prioritised for budget setting.

The division will be presenting a case to support supernumerary bleep holders at night.

It should be noted that whilst the establishment levels across the Trust overall achieve the recommended nursing metrics – ongoing challenges with recruitment impact on the ability to achieve these ratios fully on a shift by shift basis.

Report to Trust Board of Directors dated Thursday, 28 November 2019			
Title: 2019/20 Influenza Vaccination Programme			
Category	Quality, Performance, and Finance		
Agenda item	4.7		
Sponsor	Chief Executive		
Author	Steve Harris - Director of Human Resources, Dr Julia Smedley - Occupational Health Lead		
Provenance	Influenza planning discussed within Health and Wellbeing Group and within Flu team. Update previously given in September CEO report to Trust Board.		
Classification	This Report is unclassified.		
Purpose	<ul style="list-style-type: none"> ○ Influenza vaccination plays an important part in our winter resilience as an organisation to protect staff, patients and service users. ○ On 17 September 2019, NHSi wrote to all provider organisations setting out its expectations for vaccination performance for the 19/20 campaign. There is a greater regulatory focus on influenza vaccination this year, as part of winter planning scrutiny. ○ This report summarises the methods and outcome of the winter 2018/19 staff influenza vaccination campaign, and the lessons and implications for the 2019/20 programme. ○ Trust Executive committee has provided its support for the plans. NHSi require provider organisations to publish their self-assessment and preparedness by 31 December 2019, in open Trust Board Papers. ○ This report is for information for Trust Board. Board is asked to note the contents of the report, the issues with supply, and the actions being taken to drive up vaccination levels. 		
Relevant strategic goals	✓ Goal 1: Improving patient journeys.	Goal 2: Delivering value-based health and care.	✓ Goal 3: Supporting healthy lives.
	✓ Goal 4: Building an expert and inclusive workforce.	Goal 5: Being agile in meeting people's needs.	Goal 6: Creating leading-edge research, education, and innovation.
Assurance framework links	BAF05 – Capacity and capability gaps in the workforce lead to an inability to provide safe and timely care		
Impact assessments	Adjustments made within OH for those in significant risk groups to prioritise vaccine provision, and or adjustments to method of delivery and type of vaccine where issues of allergy arise.		
Other standards affected	CQC Well lead domain. NHSI use of resources assessment - use of workforce resources. NHSI regulatory assessment of winter preparedness.		

2019/20 Influenza Vaccination Programme

1 Introduction and Purpose:

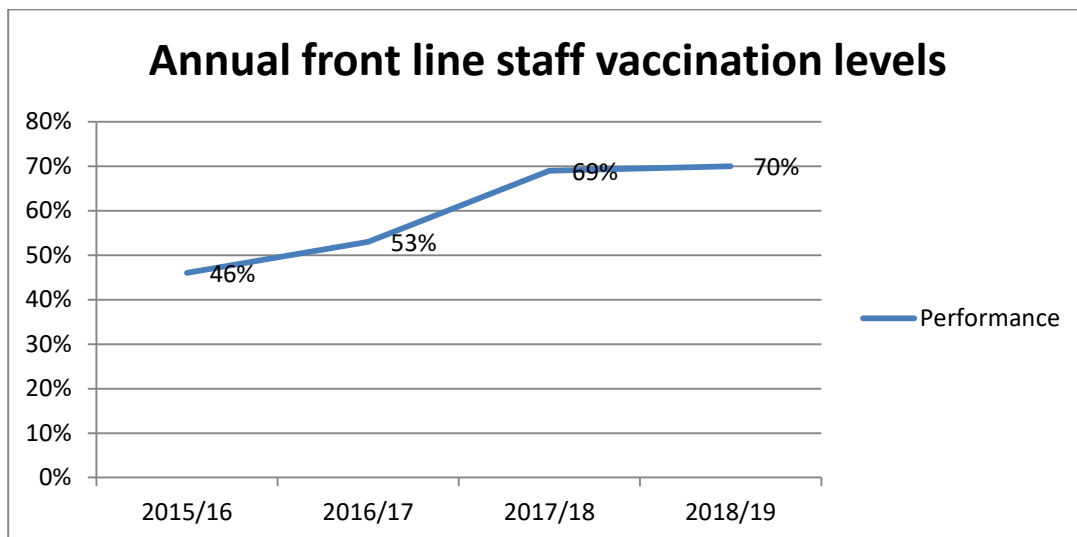
- 1.1 Influenza vaccination plays an important part in our winter resilience as an organisation to protect staff, patients and service users.
- 1.2 On 17 September 2019, NHSi wrote to all provider organisations setting out its expectations for vaccination performance for the 19/20 campaign. There is a greater regulatory focus on influenza vaccination this year, as part of winter planning scrutiny.
- 1.3 This report summarises the methods and outcome of the winter 2018/19 staff influenza vaccination campaign, and the lessons and implications for the 2019/20 programme.
- 1.4 NHSi require provider organisations to publish their self-assessment and preparedness by 31 December 2019, in open Trust Board Papers. This report is for information for Trust Board.

2 Targets:

- 2.1 Target for influenza vaccine uptake in front line staff was 70% for full CQUIN payment in 2018/19.
- 2.2 The target uptake for full CQUIN payment is 80% in 2019/20. NHSi have assessed Trusts in the lowest quartile as being poor performers. Whilst UHS is above the lowest quartile and regarded as one of the higher performers in the region, the regulator has expressed its desire for us to achieve above 80%. This represents a significant increase from last year.

3 Reviewing performance at UHS:

- 3.1 Performance has improved annually at UHS over the last 4 years, shown below. Last year, UHS achieved its highest total. Uptake by care group is shown in Appendix A. Lessons learned are included in Appendix B.



- 3.2 75% of the available CQUIN payment (£193,000) was achieved last year. The vaccine was readily accessible, but a significant proportion of staff chose to decline. This year the CQUIN payment is likely to be greater, as the number of elements dividing the Health and Wellbeing payment have been simplified (reduced). Full flu CQUIN payment is likely to be of the order of £800,000.

4 Key components - UHS influenza campaign for 2019 winter:

- 4.1 The full assessment against the NHSi recommended best practice is included in Appendix B. It assesses our performance last year, identifies lessons learned, and outlines our plans for this year. UHS has already taken many of the steps being recommended by NHSi.
- 4.2 UHS is compliant with the best practice recommendations from NHSi.
- 4.3 To incentivise staff, a free cup of Paddy and Scott's coffee is available from the SGH Feast Restaurant for every member of staff who receives the vaccine. In addition, a prize draw has been set up to offer a Sonos speaker at random to a vaccinated member of staff.
- 4.4 Occupational Health (OH) have trained a cohort of 124 peer vaccinators, who are running local clinics in wards and clinical departments. They are enabled to influence uptake through local education. Occupational Health have set up a similar database to last year, which will track uptake down to Care Group (and in most cases, department level). This is now being issued weekly to TEC members and Divisions.
- 4.5 A Flu team has been set up, and meets monthly (first meeting was on 29 October 19), comprising of representatives from Divisional Management teams and staff groups. The communications team is working on a strategy, which will keep the flu vaccination programme featuring prominently on a number of the Trust's media platforms, throughout October, and ongoing until January 2020.
- 4.6 Data on uptake by Care Group for 2018/19 is provided in Appendix A. Uptake in front line staff varies, with some areas achieving over 70%.
- 4.7 The OH team have worked hard to ensure that vaccine access is widely available from the following sources:
- Directly from OH during core hours, including vaccinators going to staff who have phoned for the vaccine.
 - From pop up local clinics being organised via peer vaccinators.
 - Ward and clinical area walk arounds by OH and peer vaccinators.
 - At induction for all new starters.
 - At Core Brief.
 - From pop up clinics at the Main Entrance.
 - At November and December Board, and Trust Executive Committee.
 - Peer vaccinators have been trained at RSH and PAH.

5 Issues to date and risks:

5.1 Vaccine Supply:

- 5.1.1 There has been an issue with the vaccine supply this year, which has resulted in intermittent shortages or lack of stock to enable staff vaccination. This has hampered the programme.
- 5.1.2 The supplier Sanofi-Pasteur, which provides stock to a number of Trusts, has recently confirmed that full vaccination supplies are available. However, the disruption resulted in two separate spells of uncertain or delayed delivery, in total 20 lost days for the campaign. During this time, clinical staff were prioritised, and some staff were turned away having attended clinics to receive their vaccination.
- 5.1.3 Vaccination levels have significantly increased since receipt of the full vaccine order. Uptake as of 19.11.19 is 54%. This is , close (within 1%) to where it normally is at this point in the year. **NB:** Appendix A describes the position as at 15 November 2019..

5.2 Resistance to receiving the vaccine:

- 5.2.1 There is still a significant level of resistance to uptake amongst staff, mainly due to fear about side effects. This is despite major efforts at myth busting (including videos and other media), and using peer champions to give positive messages about vaccine safety. The small minority of approximately 30% of front line staff who decline are difficult to influence, and significant improvement on 70% uptake will be a challenge. The residual levels of resistance to receiving the vaccine means that the achievement of 80% uptake (to achieve the full CQUIN payment) is a risk.
- 5.2.2 During 2018/19, Dr Julia Smedley spent significant personal time (over 28 hours) meeting with clinical departments and talking with clinicians who refused to receive the vaccine. This did result in some marginal gains, but at the expense of OH manpower for other activities.
- 5.2.3 Occupational Health will run an anonymised survey to all staff for whom we do not have a record of flu vaccination status at the end of the season (January 2020) asking for their reasons for declining.

6 Required action:

Board is asked to note the contents of the report, the issues with supply, and the actions being taken to drive up vaccination levels.

Appendix A: Flu vaccine uptake by Care Group - Final 2019 positions and 19/20 performance to date:

2018/19 Performance:

Division A Clinical Staff Comparison

Div A Care Groups	AHP's ST & T	Support to Clinical staff (inc clerical, maintenance)	Doctors	Qualified Nurses/ Midwives	All Clinical
188 Cancer Care - Care Group	50%	68%	58%	66%	61%
188 Critical Care - Care Group	32%	63%	50%	54%	54%
188 Division A Management - Sub-Divisional Group	0%	0%	0%	100%	100%
188 Surgery - Care Group	50%	53%	43%	59%	52%
188 Theatres & Anaesthetics - Care Group	59%	55%	54%	54%	55%

Division B Clinical Staff Comparison

Div B Care Groups	AHP's ST & T	Support to Clinical staff (inc clerical, maintenance)	Doctors	Qualified Nurses/ Midwives	All Clinical
188 Division B Management - Sub-Divisional Group	38%	100%	100%	46%	50%
188 Emergency Care - Care Group	25%	73%	68%	73%	71%
188 Medicine - Care Group	50%	50%	56%	57%	53%
188 Ophthalmology and OPD - Care Group	64%	57%	38%	59%	52%
188 Pathology - Care Group	61%	59%	62%	100%	61%
188 Specialist Medicine - Care Group	50%	76%	52%	63%	59%

Division C Clinical Staff Comparison

Div C Care Groups	AHP's ST & T	Support to Clinical staff (inc clerical, maintenance)	Doctors	Qualified Nurses/ Midwives	All Clinical
188 Child Health - Care Group	63%	71%	58%	79%	71%
188 Clinical Support - Care Group	73%	62%	0%	50%	70%
188 Division C Management - Sub-Divisional Group	0%	0%	0%	75%	75%
188 Women & Newborn - Care Group	56%	54%	62%	57%	57%

Division D Clinical Staff Comparison

Div D Care Groups	AHP's ST & T	Support to Clinical staff (inc clerical, maintenance)	Doctors	Qualified Nurses/ Midwives	All Clinical
188 Cardiovascular and Thoracic - Care Group	73%	75%	55%	70%	69%
188 Division D Management - Sub-Divisional Group	0%	0%	25%	80%	56%
188 Neurosciences - Care Group	45%	68%	58%	63%	63%
188 Radiology - Care Group	58%	54%	60%	76%	59%
188 Trauma & Orthopaedics - Care Group	100%	63%	55%	60%	60%

THQ Clinical Staff Comparison

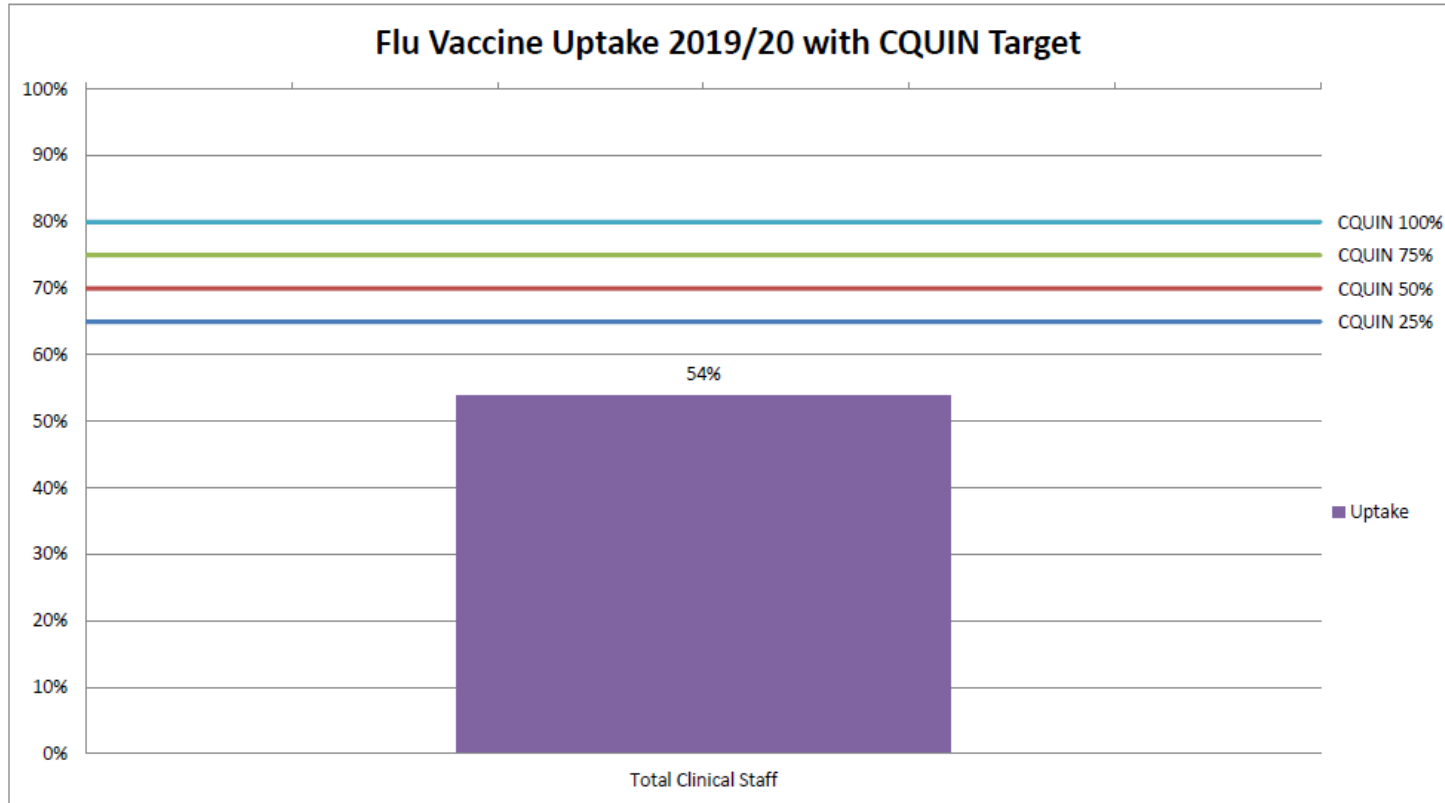
THQ Care Groups	AHP's ST & T	Support to Clinical staff (inc clerical, maintenance)	Doctors	Qualified Nurses/ Midwives
188 Chief Executive Office - Directorate	0%	0%	0%	0%
188 Chief Finance Officer - Directorate	0%	0%	0%	0%
188 Chief Operating Officer - Directorate	0%	67%	100%	50%
188 Clinical Development - Directorate	83%	67%	84%	73%
188 CLRN - Directorate	0%	0%	100%	78%
188 Corporate Affairs - Directorate	0%	0%	0%	0%
188 Dir Of Transformation & Improvement - Directorate	0%	0%	0%	0%
188 Estates, Facilities & Capital Development - Directorate	100%	51%	0%	75%
188 Hosted Services - Directorate	25%	0%	0%	61%
188 Human Resources - Directorate	0%	100%	100%	94%
188 Informatics - Directorate	0%	0%	0%	0%
188 Medical Director - Directorate	0%	0%	50%	0%
188 Research and Development Director - Directorate	80%	50%	52%	81%
188 Revenue Schemes - Directorate	0%	0%	0%	0%
188 THQ OtherServices - Directorate	0%	0%	0%	0%

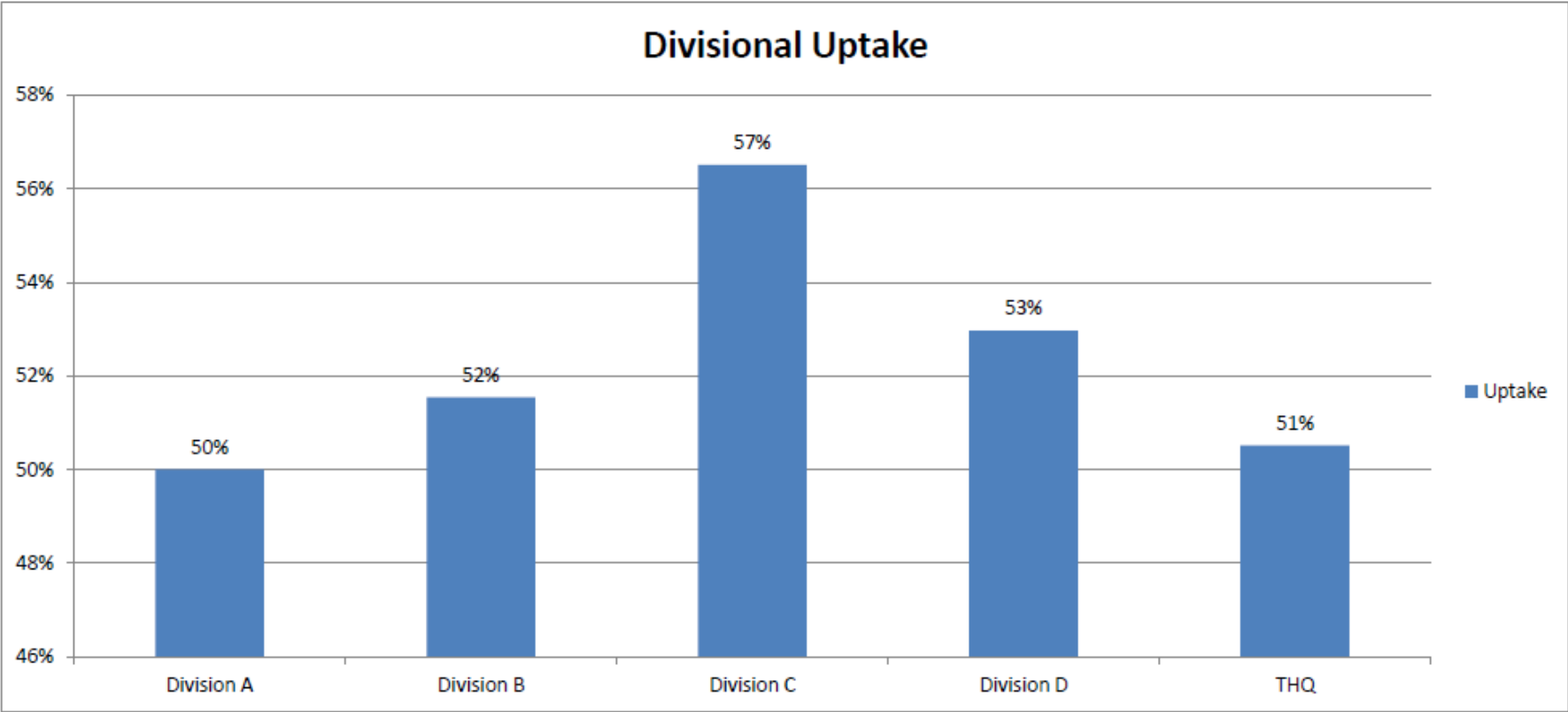
Appendix A: Performance in 2019/20 to date

	Staff	2019-2020	Uptake
AHP's ST & T	1304	737	57%
Support to Clinical staff (inc clerical, maintenance)	2384	1332	56%
Doctors	1989	923	46%
Nurses	3614	2021	56%
Total Clinical Staff	9291	5013	54%

CQUIN	Staff Required
25%	1026
50%	1491
75%	1955
100%	2420

Staff	9291
Current Uptake	5013
Staff required to meet CQUIN 100% Payment	2420





Divisional Clinical Staff Comparison

	Div A	Div B	Div C	Div D	THQ
AHP's ST & T	49%	33%	61%	56%	56%
Support to Clinical staff (inc clerical, maintenance)	48%	51%	51%	54%	42%
Doctors	48%	48%	53%	42%	23%
Nurses	52%	56%	57%	58%	71%
Total	50%	52%	57%	53%	51%

Appendix B: Assessment against NHSI recommended practice

	Committed leadership: (number in brackets relates to references listed below the table)	Trust self-assessment	Trust self-assessment details
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	Completed	Commitment was recorded following the CEOs report to September Board. Occupational Health (OH) will run an anonymised survey to all staff for whom we do not have a record of flu vaccination status at the end of the season (January 2020) asking for reasons for declining.
A2	Trust has ordered and provided the Quadrivalent (QIV) flu vaccine for healthcare workers.	Completed	Quadrivalent egg based vaccine has been ordered and is scheduled for delivery to UHS week of 23 September 19 or soon after. A small amount of adjuvant Trivalent vaccine has been ordered for staff over 65 yrs of age (and these older staff will also be signposted to their GP).
A3	Board receive an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt.	Completed	Evaluation of Flu programme 2018/19 has been conducted and provided to the Board.
A4	Agree on a Board champion for flu campaign.	Completed	Medical Director, Derek Sandeman Director of Nursing, Gail Byrne
A5	All board members receive flu vaccination and publicise this.	To be completed	A vaccination session will be arranged for Board members (preceding a Board meeting) and a videographer will be present. Videos will be published on Staffnet. Individual appointments can be made for Board members who are not available on that day.
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives.	Complete	Flu team will comprise: <ul style="list-style-type: none"> • Head of OH. • Senior Nurse Manager OH. • Divisional Management Team representatives. • Staff side representatives.
A7	Flu team to meet regularly from September 2019.	Underway	Flu team have comments meetings during October.

B	Communications plan:		
B1	Rationale for the flu vaccination programme and facts to be published - sponsored by senior clinical leaders and trades unions.	Underway	Information on flu vaccination, rationale and key messages are published on Staffnet, and will be included in Core Brief and Staff Briefing. Senior clinicians are co-authors on the summary information and have made videos for ease of communication.
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper.	Underway	Clinics and contact details for peer vaccinators will be published on Staffnet, in Core Brief and on Workplace App. Posters will be placed locally by peer vaccinators.
B3	Board and senior managers having their vaccinations to be publicised.	Underway	Video of Board and senior managers being vaccinated will be available on Staffnet.
B4	Flu vaccination programme and access to vaccination on induction programmes.	Complete	The key messages about the staff flu vaccination programme are covered in mandatory Trust induction (under infection prevention). We will revise the content this year to ensure consistent messaging.
B5	Programme to be publicised on screensavers, posters and social media.	Underway	The Communications department are currently finalising a communications plan for the vaccination campaign. It will comprise: <ul style="list-style-type: none"> • Keep the influenza vaccination programme on the Staffnet front page at all times from October to February inclusive. The appearance and content will be revised regularly. • Single click link to comprehensive flu vaccination pages from the Staffnet front page. • Flu vaccination will feature in every Core Brief from October to February. • Regular flu vaccination updates will be posted on Workplace (internal Facebook page) and weekly staff briefings.
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups.	Underway	A weekly graphic of uptake (syringe graphic) will be on the front page of Staffnet. Weekly reports will be provided by occupational health from October onwards to <ul style="list-style-type: none"> • TEC split by Division and professional group. • Divisional Management teams and Care Group leads split by Care Group and professional group.

C	Flexible accessibility:		
C1	Peer vaccinators, ideally at least one in each clinical area to be: identified, trained, empowered and released to vaccinate.	Complete	<p>A cohort of 124 peer vaccinators have been trained to deliver local vaccination sessions, and individual vaccination appointments directly on wards and departments.</p> <p>Vaccinators have been trained in the governance and logistics of vaccine delivery, as well as the key messages and communications for the campaign. This year's training included training on how to influence staff to take up the vaccine, and how to have difficult conversations with decliners.</p> <p>All peer vaccinators have had their managers' approval to attend training and to deliver the vaccine in work time.</p>
C2	Schedule for easy access drop in clinics agreed.	Complete	<p>Open access is available through Occupational Health, with booked appointments on request - this will be advertised widely through Staffnet and Core Brief.</p> <p>Peer vaccinators will advertise their sessions locally.</p>
C3	Schedule for 24 hour mobile vaccinations to be agreed.	Underway	Occupational health nurses will run some scheduled sessions for night staff. Peer vaccinators are also available on night shifts.
D	Incentives:		
D1	Board to agree on incentives and how to publicise.	Complete	<p>Badges have been delivered ready for the campaign.</p> <p>Arrangements have been made to offer a free cup of coffee (voucher) for each member of staff who takes up a flu vaccine.</p>
D2	Success to be celebrated weekly.	Underway	<p>Uptake will be published and celebrated weekly on Staffnet.</p> <p>The carousel on the front page of Staffnet will include a topic on and positive feedback on flu vaccination every week.</p>

Report to the Trust Board of Directors dated Thursday, 28 November 2019			
Title: Informatics Report			
Category	Quality, Performance, and Finance		
Agenda item	4.8		
Sponsor	Director of Transformation and Improvement		
Author	Adrian Byrne, Director of Informatics		
Provenance	Report to Board		
Classification	This Report is unclassified.		
Purpose	The paper is presented for REVIEW. This is bi-monthly report on progress with informatics programme, regularly reported due to breadth of projects and impact on the business		
Relevant strategic goals	✓ Goal 1: Improving patient journeys.	✓ Goal 2: Delivering value-based health and care.	<input type="checkbox"/> Goal 3: Supporting healthy lives.
	<input type="checkbox"/> Goal 4: Building an expert and inclusive workforce.	✓ Goal 5: Being agile in meeting people's needs.	<input type="checkbox"/> Goal 6: Creating leading-edge research, education, and innovation.
Assurance framework links	<ul style="list-style-type: none"> • BAF01 – Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways • BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6 • BAF03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme • BAF04 – Reduced access to resources compromises the quality of services • BAF06 – Lack of capacity and agility renders the Trust unable to respond to the changing operating environment, causing a failure to provide contracted services • BAF09 – Failure to respond with the necessary organisational changes in design and operation renders the Trust unable to remain a competent NHS Provider 		
Impact assessments	n/a		
Other standards affected	n/a		

1. Overview

- 1.1. I am pleased to report that the Trust digital Strategy was supported by the Trust Board in September 2019. This supports the Trust clinical strategy and Strategic Plan. The new strategy will:
 - Reduce burden on staff so they can focus on patients
 - Provide patient access to digital tools to enhance their care
 - Provide safe and easy access to clinical information
 - Improve patient safety and care
 - Increase trust efficiency and productivity

The Informatics team will now be bringing forward supporting strategy components and associated business cases for delivery. Michael Kiuber [as deputy CCIO] has also agreed to prepare an AI strategy which will be an important part of how we work in the future. It is hoped to secure more national funding to support the work post GDE programme.
- 1.2. A full communications plan is being prepared including an updated website. The digital team would welcome any opportunity to present to divisional/care group teams.
- 1.3. The three CCIOs (Mike Celinski and Ashwin Pinto with Michael Kiuber as deputy) are now settling in and have been out and about meeting teams. Their first task is to ensure there is a robust, transparent and open process for prioritisation of projects. This is linked to the development of CHARTs (our electronic patient record). They plan to present the process and outcome at December's Digital Board for approval.
- 1.4. The CCIOs are including Digital in the MedBite programme and will be on future agendas
- 1.5. A significant element of the current strategy is to increase digital maturity as a part of the Global Digital Exemplar (GDE) programme, achievement will be measured against the HIMSS EMRAM [model]. This is a measure of a paperless organization in line with overall national objectives (see [PHC 2020](#) and [NHS long term plan \[Chapter 5\]](#)). The trust is receiving £10m of national funding contributing to this and has committed to a set of associated projects. The final 2 payments (equal to £2.5m) are contingent on the delivery of the programme and achievement of HIMSS level 7 equivalence. The meeting with NHS Digital took place on 8th Oct and an initial report has been received. While this is reviewed and followed up, the next round of funding has been delayed and will not happen until at least the new year (January)
- 1.6. The trust IT programme is juggling priorities with the HIMSS objective impacting work that has been commissioned by the junior doctor working group.
- 1.7. Post the GDE programme, consideration needs to be given to how the IT estate is treated as a business as usual environment with suitable technology refresh. During the three year [GDE] programme significant capital has been used to bring the desktop environment up to a reasonable state. The IT team are looking at options including managed services and refurbishment, but these will involve a switch to revenue funding for what was previously "lumps" of capital. A paper laying out the options will be presented to the digital board.
- 1.8. My Medical Record was awarded the Technology to Shout About award at Health Tech Awards 2019 and was winner of the Innovation in Digital Services award from the Multiple Sclerosis Trust. Meanwhile it continues to grow significantly and has around 30,000 registered users. Transactional services with those are planned in coming months.
- 1.9. Previously the user feedback surveys and ARCH collaborative review have been discussed. It is recognised that it is important to receive digital user feedback. Unfortunately due to other pressure this review has not yet been undertaken but this will take place before the end of the financial year.
- 1.10. We need your support to help the Trust get ready for this level of change. In particular every person working in the ward environment will change the way they record new information and access historical information.

2. Analysis and Discussion

Work this quarter:

- 2.1. We can see the impact already of having control of development through the acquisition of HICSS. [A common complaint of slow loading has been addressed.](#) Initial load of 17s has been cut to 4s on standard PCs.
- 2.2. Discussions are ongoing on the potential support of others using HICSS applications with this looking to be a promising development.

Future Work:

- 2.3. In 2020/21 we will continue the roll out of:
 - Systems that reduce the chance of patients being lost to their next step. This is a major safety risk for any patient as an IP or as an OP. We are rolling out e grading and eTCI. This reduces the chance of data being lost between departments and ensures we have one digital record allowing us to ensure patients receive timely care.
 - Systems that help us meet constitutional standards. We have new waiting list tools for Cancer and RTT and well as real time app based reporting on the 4 hour target. We have developed a new 'whiteboard' for Histopathology so they can see when the patients Cancer MDT is scheduled. We have a written a new view on the Somerset Cancer System significantly reducing MDT prep time and smoothing the running of the MDT. Doctors can now review their own waiting lists with a direct link to CHARTS. Work will continue in this area.
 - Systems that improve productivity and improve clarity of communication. The new patient discharge summary, virtual clinics through attend anywhere and the virtual management of patients through My Medical Record. MedXnote will also keep improving and they are currently working on a voice activated chat-bot with Microsoft.
 - Systems that improve the patient experience. This will include collecting patient related outcome measures through MyMR and creating a new OP interface through NetCall moving from paper patient letters to email and app-based content.
- 2.4. Over and above this we will be developing and rolling out:
 - Digital noting in our inpatient areas.
 - Closed loop prescribing.
 - A new maternity system, we plan to go to market in Jan 2020, so this would be late in the year.
 - A new business intelligence platform [currently being procured] to improve our real time reporting, our historic reporting and moving us into the world of predictive analytics.
 - A new Lung Cancer Screening programme and new IT to support Virtual Clinics for patients with non specific symptoms.
- 2.5. Other large pieces of work are happening outside of the core programme
 - Have a new contract for our PACS service. The procurement exercise is now complete as at Nov 2019
 - We are bidding to replace our laboratory systems (LIMS) which is end of life.
 - We are bidding to digitise our Histopathology dept with one of the National centres of excellence.

Other Risks and Issues

- 2.5 Risks in Microsoft and the licences plus the age of desktops mentioned in the previous report are still being worked upon. There is a significant potential cost pressure on Microsoft licenses.

3. Recommendation

- 3.1. To note the report and progress

Glossary and Abbreviations

CCIO	Chief Clinical Information Officer. A post created to advance the usability and adoption of digital in health organizations
CHARTS	The core of the UHS Electronic Patient Record (EPR) whose Intellectual Property (code) is now wholly owned by UHS
CNIO	Chief Nursing Information Officer. A companion role to CCIO with nursing and AHP focus.
EMIS	An IT company who own a number of products used at UHS (ED system and patient administration)
EMRAM	The Electronic Medical Records Adoption Model. An inpatient focussed measure of digital maturity, largely about paperless working, coded data and decision support.
GDE	A programme of work set up under NHSE three years ago to improve digital maturity in the NHS. In acute hospitals this has largely been about the HIMMS EMRAM model
HIMMS	Health Information Management Systems Society. US organization and owner of EMRAM
KLAS	A US research organization who are involved with UHS for user satisfaction – peer review
LIMS	Laboratory Information System
My Maternity Record	A specific build of My Medical Record for maternity
My Medical Record	The on line service offered by UHS to its patients, and to other health organizations for theirs
NHSX	New joint NHS organization set up to lead digital, data and technology
PACS	Picture Archiving (digital X-Ray system)
SWASH	Salisbury, Wight and South Hampshire. A consortium for sharing imaging data (PACS) through common supplier contracts
Workplace	The UHS Facebook-like communication platform, hosted by Facebook

Report to the Trust Board of Directors dated Thursday, 28 November 2019			
Title: Finance Report 2019-20 Month 7			
Category	Quality, Performance, and Finance		
Agenda item	4.9		
Sponsor	Chief Financial Officer		
Author	Gavin Hawkins, Assistant Director of Finance		
Provenance	This monthly paper provides an update on our financial position This paper is discussed at TEC, S&FC and Trust Board on a monthly basis.		
Classification	This Report is unclassified.		
Purpose and recommendation	The paper is presented for DISCUSSION. The purpose of this paper is to give an update on the financial position of the Trust through the year.		
Relevant strategic goals	<input type="checkbox"/> Goal 1: Improving patient journeys.	<input checked="" type="checkbox"/> Goal 2: Delivering value-based health and care.	<input type="checkbox"/> Goal 3: Supporting healthy lives.
	<input type="checkbox"/> Goal 4: Building an expert and inclusive workforce.	<input type="checkbox"/> Goal 5: Being agile in meeting people's needs.	<input type="checkbox"/> Goal 6: Creating leading-edge research, education, and innovation.
Assurance framework links	<ul style="list-style-type: none"> • BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6 • BAF03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme • BAF04 – Reduced access to resources compromises the quality of services 		
Impact assessments			
Other standards affected			

2019/20 Finance Report - Month 7

Report to:	Board of Directors & Strategy & Finance
	November 2019
Title:	Finance Report for Period ending 31/10/2019
Author:	Gavin Hawkins, Assistant Director of Finance
Sponsoring Director:	David French, Chief Financial Officer
Purpose:	Standing Item
	The Board is asked to note the report

Executive Summary:

In Month and Year to date Highlights:

1. In October 2019, the Trust delivered a surplus of £3.3m, £0.5m behind Plan. Year to date the Trust is reporting a £3.8m surplus which is £2.2m better than Plan. Under the single oversight framework, the Trust has delivered a score for Finance and Use of Resources of '1'.
2. When non-recurrent items are excluded the year to date position is a £0.8m surplus. Non-recurrent items include a reclaim of VAT paid on agency nursing invoices in 18/19.
3. In M7 budgets have been adjusted to align CIP budget reductions to identified schemes as discussed at S&FC. The net result is no change at Trust level; however, both pay and non-pay budgets have increased offset by an increase in income. Excluding the backdated impact of these adjustments, the main themes seen in M7 were :
 - Income was on Plan. Clinical income was strong as planned with both elective & non-elective estimated to over-perform including an offset for blended payment reduction for non-elective.
 - Pay was £0.6m worse than Plan in month mainly due to identified but undelivered CIP.
 - Total CIP delivery was £0.3m better than Plan at £4m for the month although this includes approximately £0.5m of backdated income CIP scheme award. Currently the Trust is £2.1m behind Plan year to date.
4. The cash position was £33.5m above Plan at £80m. The above Plan position has primarily been driven by:
 - I&E Position better than plan, and cash start point better than assumed at the time the cash plan was agreed
 - Additional PSF for 18/19 over and above that assumed at the point the Plan was finalised
 - Accounts Receivable position better than assumed in Plan
5. Looking forward to the end of 2019/20, the Trust is facing risks relating to:
 - CIP delivery
 - Underlying run-rate would not achieve Plan
 - Clinical income shortfall due to consultant workforce capacity relating to pensions taxation
 - The current forecast suggests a full year out-turn of a surplus (excl. PSF) in the range £1m - £6m, with the mostly likely outcome £3.5m, compared to the control total of £17m surplus. This position would result in non-achievement of PSF in Q4, and potentially Q3, which would restrict cash availability to support our 3-year capital programme.



Finance: I&E Summary

Total clinical income was £1.7m worse than Plan, although the Plan was increased to reflect income CIP delivery in the month and service developments namely Theatre K & HHFT Radiotherapy transfer. These Plan adjustments had a backdated impact of approximately £0.9m.

The in month Plan for pay substantive (+£2.1m), other non-pay (+£3.2m) and other income (+£5.3m) includes a net neutral adjustment related to expected CIP delivery based on current CIP identification as opposed to an estimate at the start of the financial year. The variances described below are adjusted to remove the backdated impact.

Total pay was £0.6m over Plan in the month due to undelivered CIP in the main. Overall total pay spend was £0.2m higher than in September 2019 driven entirely by an increase substantive pay costs and the impact of NQNs.

Total non-pay excl. pass through drugs & devices was £0.8m underspent in the month due to lower than planned drug and clinical supplies expenditure.

Overall CIP delivery was £0.3m better than Plan with £4m delivered (approximately £0.5m backdated). See slide 12 for further detail.

Metric	2019/20		
	YTD Actual	YTD Metric	YTD Plan
Capital service cover rating	1.76	2	2
Liquidity rating	19.26	1	1
I&E Margin Rating	1.90%	1	1
I&E Margin Variance Rating	0.42%	1	1
Agency Variance from ceiling	57.05%	1	1
Use of Resources Average Metric		1.20	1.20
Use of Resources Final Metric		1	1

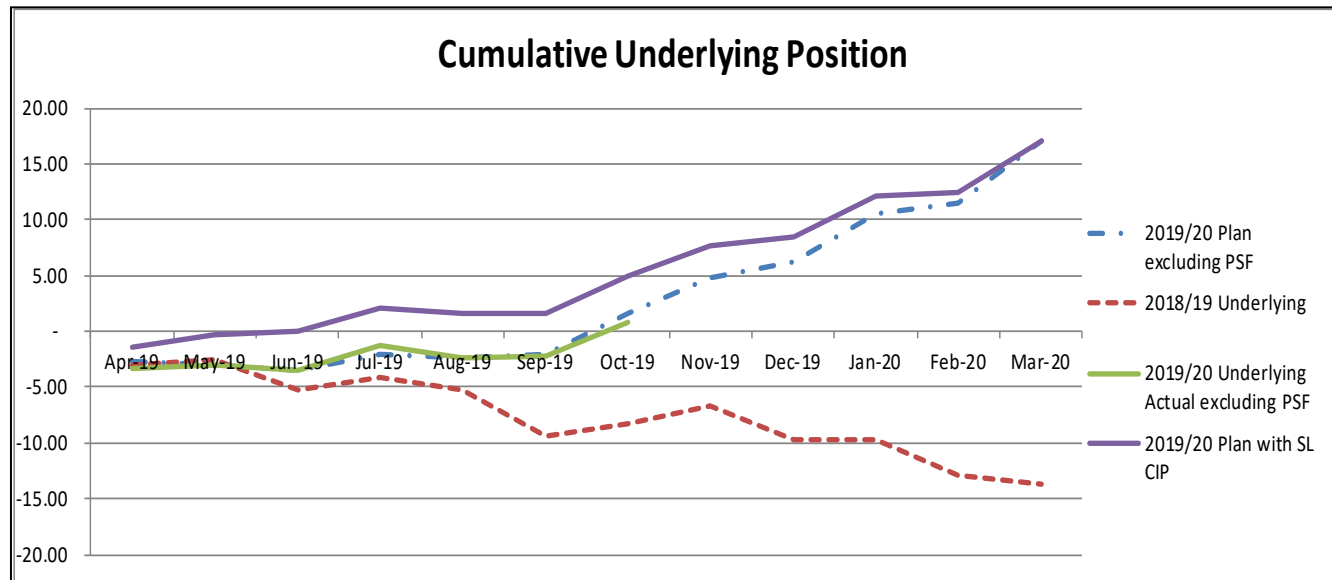
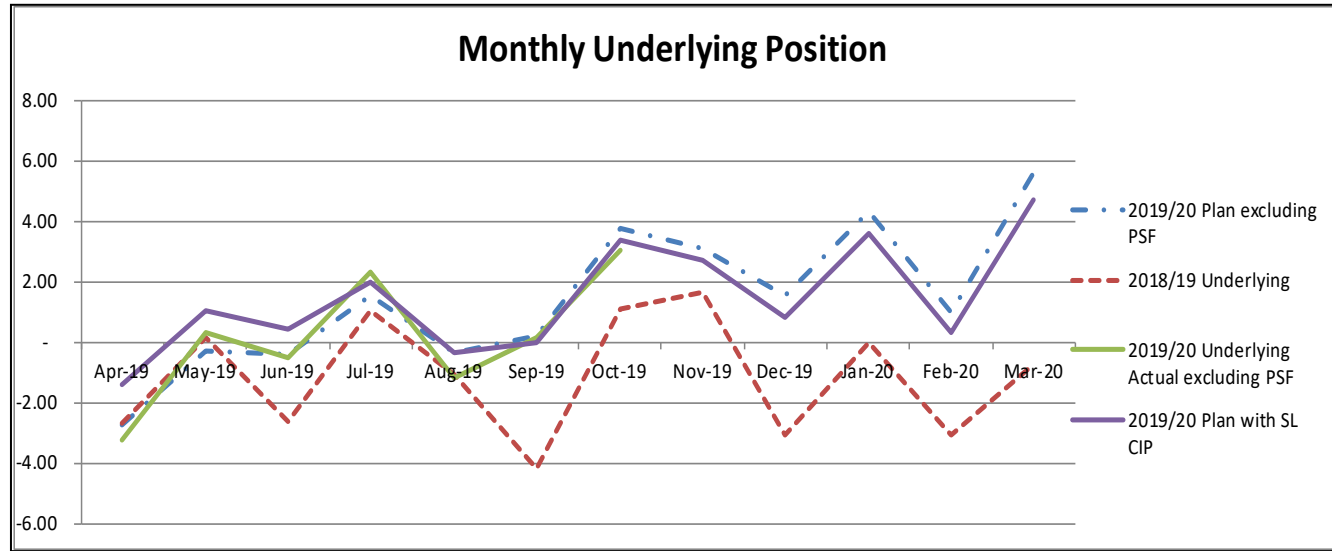
	Current Month			Year to Date			Full Yr	Ave Done	To Do	
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m				Plan £m
NHS Income: Clinical	56.3	54.6	1.7	369.6	367.9	1.7	A	630.6	52.6	52.5
Pass-through Drugs & Devices	10.1	10.8	(0.6)	65.4	66.1	(0.7)	G	115.2	9.4	9.8
Other income Other Income excl. PSF	9.9	10.9	(1.0)	68.7	70.1	(1.3)	G	105.0	10.0	7.0
CIP Target backdated adj	5.3	-	5.3							
Total income	81.6	76.3	5.4	503.8	504.2	(0.4)	G	850.8	72.0	69.3
Costs Pay-Substantive	38.7	39.6	0.9	273.1	276.2	3.1	A	461.0	39.3	37.0
Pay-Bank	1.9	2.1	0.2	13.5	15.2	1.6	R	22.8	2.2	1.5
Pay-Agency	1.1	0.6	(0.5)	7.8	3.5	(4.3)	G	14.1	0.5	2.1
Pay - CIP Target backdated adj	2.1	-	(2.1)							
Drugs	1.1	0.9	(0.1)	8.3	9.0	0.7	R	14.2	1.3	1.0
Pass-through Drugs & Devices	10.1	10.8	0.6	65.4	66.1	0.7	A	115.2	9.4	9.8
Clinical supplies	6.3	5.6	(0.8)	42.4	41.7	(0.7)	G	65.5	6.0	4.8
Other non pay	10.4	10.5	0.1	70.7	67.7	(3.0)	G	105.1	9.7	7.5
Non-pay - CIP Target backdated adj	3.2	-	(3.2)							
Total expenditure	74.8	70.0	(4.8)	481.2	479.5	(1.8)	G	797.9	68.3	63.7
EBITDA	6.8	6.3	0.5	22.5	24.7	(2.2)	G	52.9	3.5	5.7
EBITDA %	8.3%	8.2%	0.1%	4.5%	4.9%	(0.4%)		6.2%		
Depreciation	1.9	2.0	0.0	13.1	13.9	0.8	R	22.6	2.0	1.7
Non Operating Income/Expenditure	1.1	1.0	(0.1)	7.7	7.0	(0.8)	G	13.3	1.0	1.3
Control Total Surplus / (Deficit)	3.8	3.3	0.5	1.6	3.8	(2.2)	G	17.1	0.5	2.7
Memo - Other technical items:										
Prior Period Adjustment - PSF 2018/19		-	0.0		0.9	(0.9)	G			
Provider Sustainability Funding	1.3	1.3	0.0	5.7	5.7	0.0	G	12.7	0.8	1.4

Underlying Run Rate Position

These graphs show the actual underlying position was on Plan in the month and year to date.

It also shows an alternative presentation of the Plan phasing assuming that the £40m CIP target is delivered equally each month through the year.

All figures in these graphs exclude PSF including the amount received as a prior year adjustment.



Underlying Run Rate Position

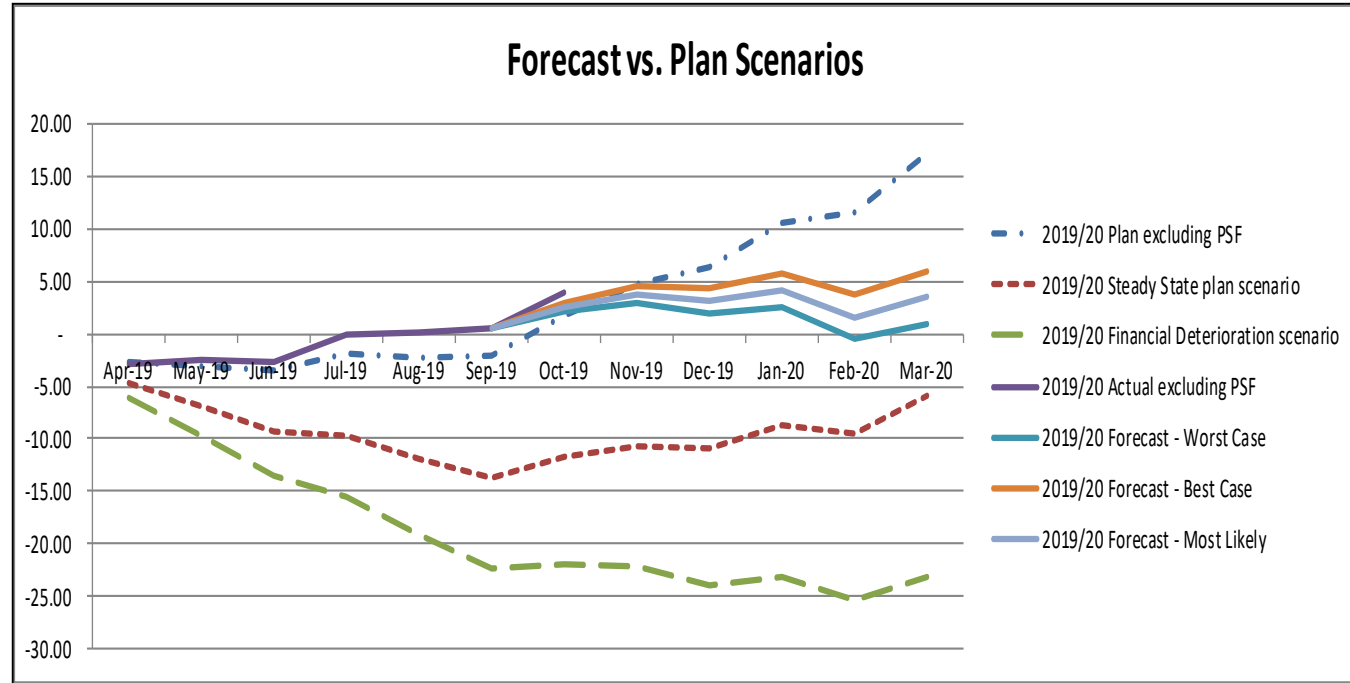
This graph shows potential scenarios for 2019/20 out-turn, as shared with Trust Board as part of the 2019/20 planning process.

Currently the forecast is based on estimates post Q2, which includes 4 months of "final cut" income data.

The financial forecast is a range of:
Best Case - £6m surplus
Most Likely - £3.5m surplus
Worst Case - £1m surplus

This incorporates uncertainties and risks in H2 relating to:

- Investment in ED to support 4 hour performance
- Investment in schemes to enhance winter flow
- Investment in additional bed capacity, expected to be fully off-set by income
- Investment in consultancy, expected to be fully off-set by income
- Risk of winter pressures on elective activity, particularly in Division D
- Commissioner payment challenges, particularly local non-elective activity
- CIP delivery

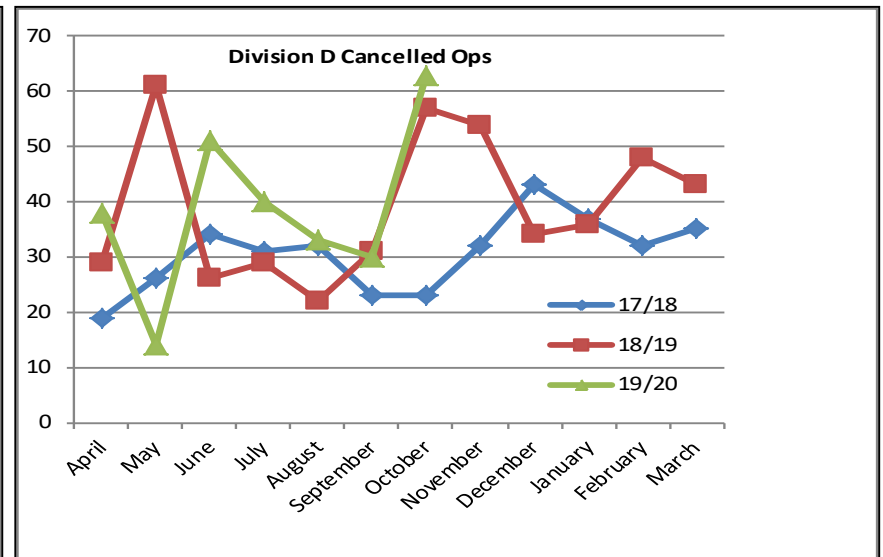
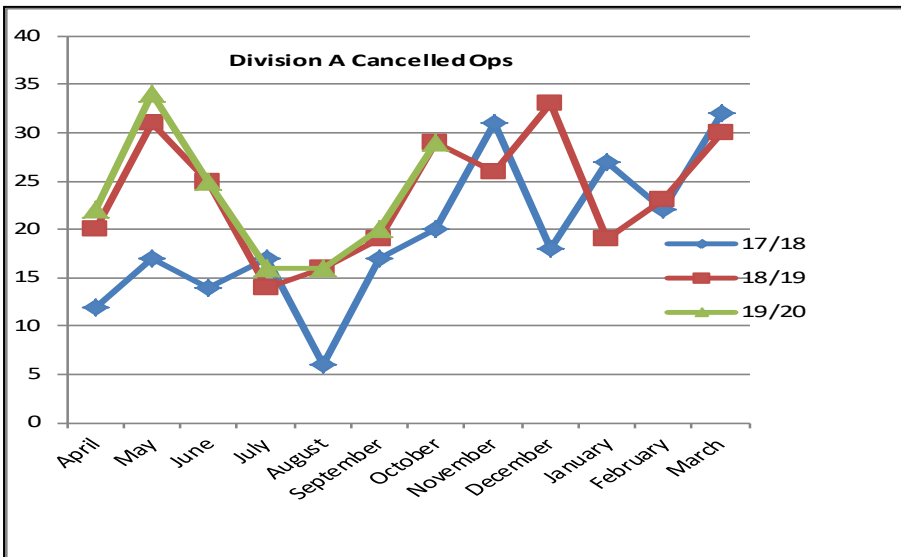
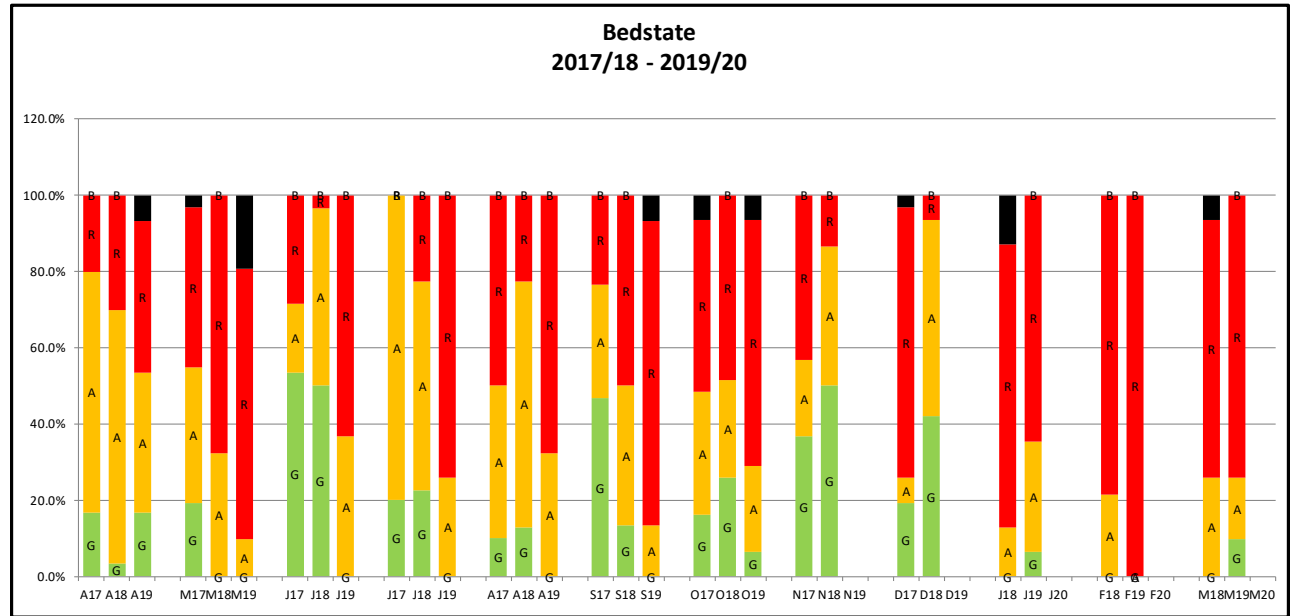


Bedstate – 3yr Comparison

The bed state data for October 2019 shows that for approximately 60% of days, the Trust bed state was Red, with some days at Black and fewer Amber and Green days when compared to October 2018.

Capacity increases and change of ownership of existing bed stock are planned for November 2019 to support the Trust during an expected difficult winter period.

On the day cancellations for non-clinical reasons are shown below for Divisions A & D.



Clinical Income

The chart shows estimated clinical income in October 2019.

Non-elective inpatient activity was above planned levels and a provision has been taken against the impact of the blended payment system for emergency care. Elective inpatient income was above planned levels in the month also.

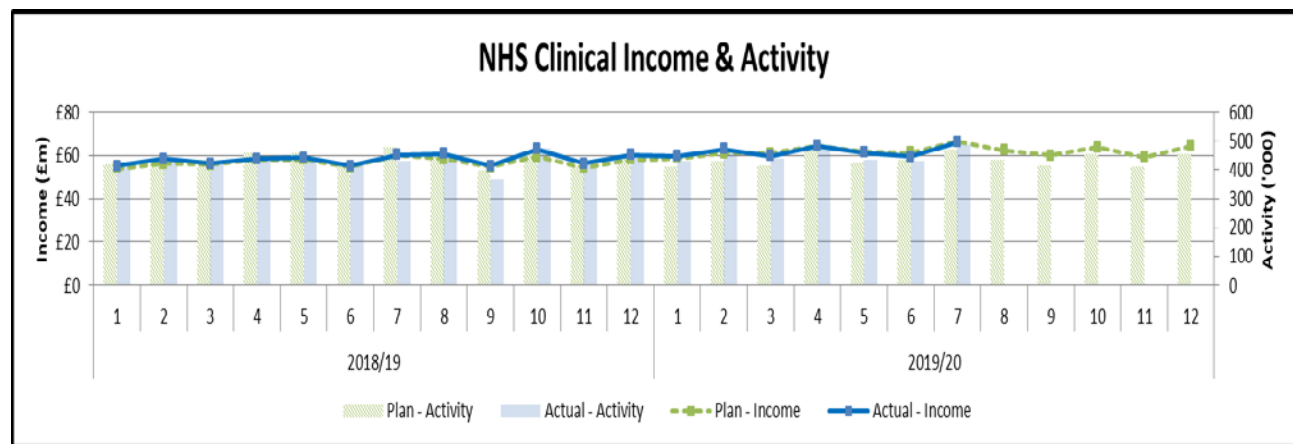
Outpatient activity was above planned levels in the month.

Pass-through drug and device income, within exclusions, was slightly lower than planned levels although this is offset by reduced expenditure.

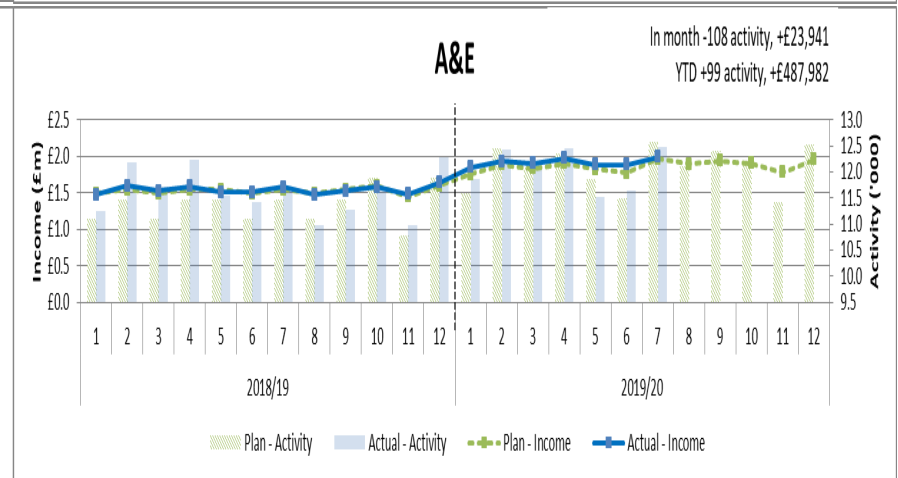
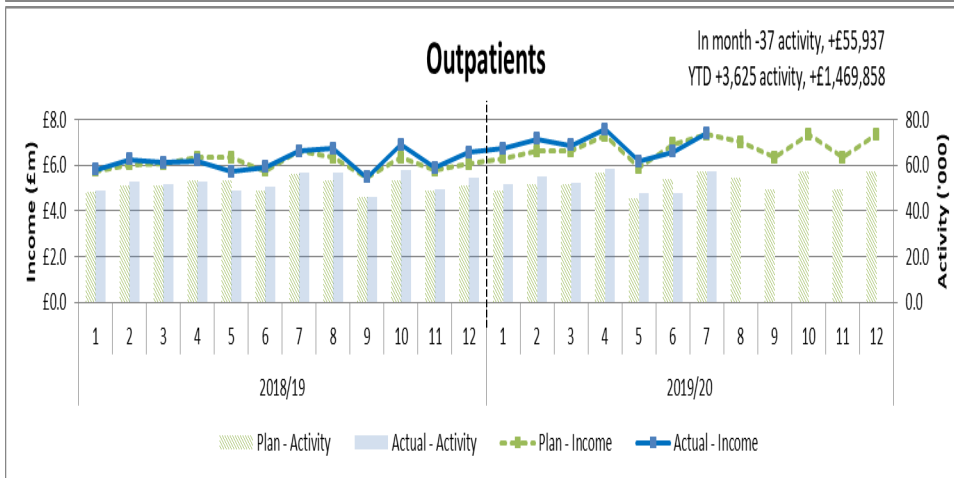
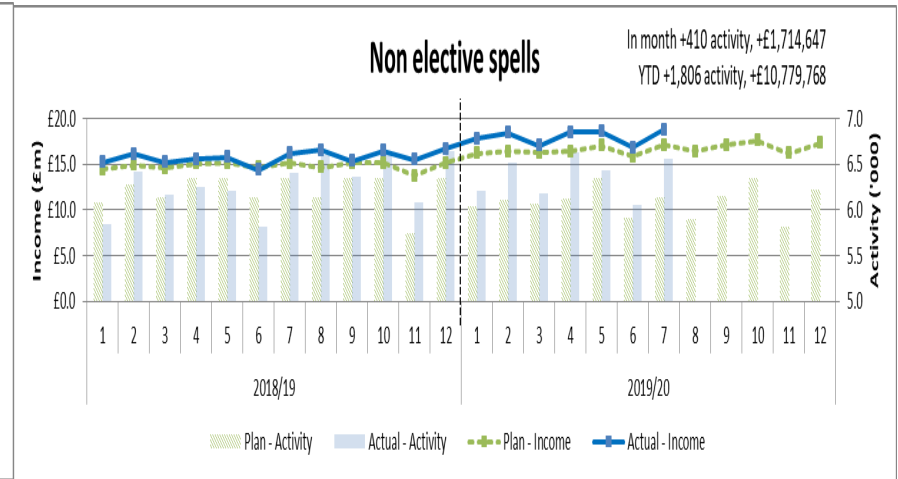
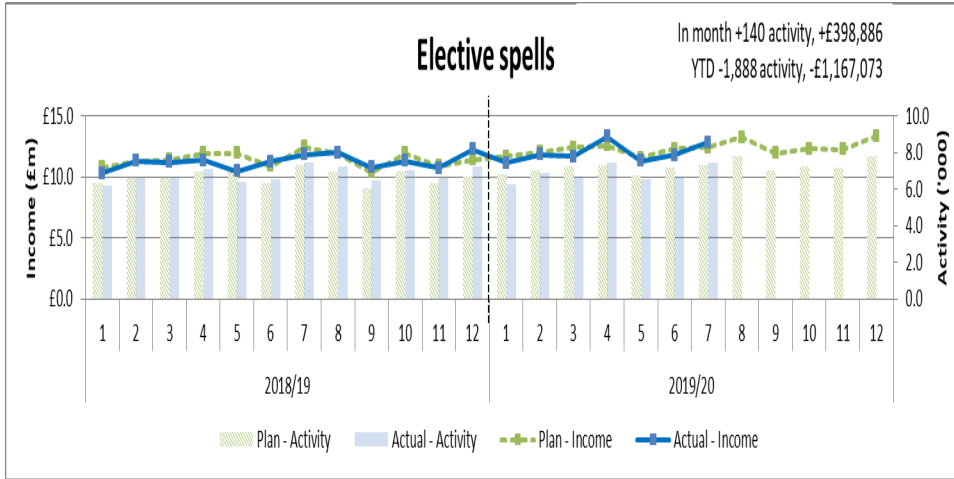
The Trust continues to provide for commissioner challenges and CQUIN failure which will be resolved as data and reports become available.

(Fav Variance) / Adv Variance

POD GROUP	2018/19	2019/20				2019/20			Monthly Run Rate	
	YTD Actuals £000s	Annual Plan £000s	YTD Plan £000s	YTD Estimate £000s	YTD Variance £000s	In Month Plan £000s	In Month Estimate £000s	In Month Variance £000s	Done	To Do
NHS Clinical Income										
Elective Inpatients	£77,681	£148,092	£85,022	£83,855	£1,167	£12,427	£12,826	(£399)	£11,979	£12,847
Non-Elective Inpatients	£108,514	£199,870	£115,249	£126,029	(£10,780)	£17,077	£18,791	(£1,715)	£18,004	£14,768
Blended payment adjustment	£0	£0	£0	(£2,542)	£2,542	£0	(£380)	£380	(£363)	£508
Outpatients	£42,629	£81,420	£47,037	£48,507	(£1,470)	£7,345	£7,401	(£56)	£6,930	£6,582
Other Activity	£67,614	£129,745	£74,950	£75,605	(£655)	£11,283	£11,284	(£0)	£10,801	£10,828
CQUIN	£8,563	£8,375	£4,844	£4,988	(£144)	£724	£752	(£28)	£713	£677
Blocks & Financial Adjustments	£3,823	£16,139	£13,157	£1,606	£11,551	£2,954	(£55)	£3,008	£229	£2,907
Other Exclusions	£2,255	£46,419	£29,351	£29,899	(£548)	£4,511	£4,658	(£147)	£4,271	£3,304
Prior month adjustment	£0	£0	£0	£0	£0	£0	(£647)	£647	£0	£0
Subtotal NHS Clinical Income	£311,079	£630,059	£369,610	£367,946	£1,664	£56,321	£54,630	£1,691	£52,564	£52,423
Pass-through Exclusions	£65,693	£115,237	£65,409	£66,147	(£738)	£10,142	£10,776	(£634)	£9,450	£9,818
Total NHS Clinical Income	£376,771	£745,296	£435,019	£434,093	£926	£66,463	£65,406	£1,057	£62,013	£62,241
Non NHS Clinical Income										
Private Patients		£6,092	£3,754	£2,594	£1,160	£518	£330	£188	£371	£700
CRU		£2,500	£1,456	£1,466	(£10)	£208	£210	(£2)	£209	£207
Overseas Chargeable Patients		£1,412	£826	£942	(£116)	£118	£288	(£170)	£135	£94
Total Non NHS Clinical Income		£10,004	£6,036	£5,002	£1,034	£844	£827	£17	£715	£1,001
Grand Total	£376,771	£755,301	£441,055	£439,095	£1,961	£67,307	£66,233	£1,075	£62,728	£63,241

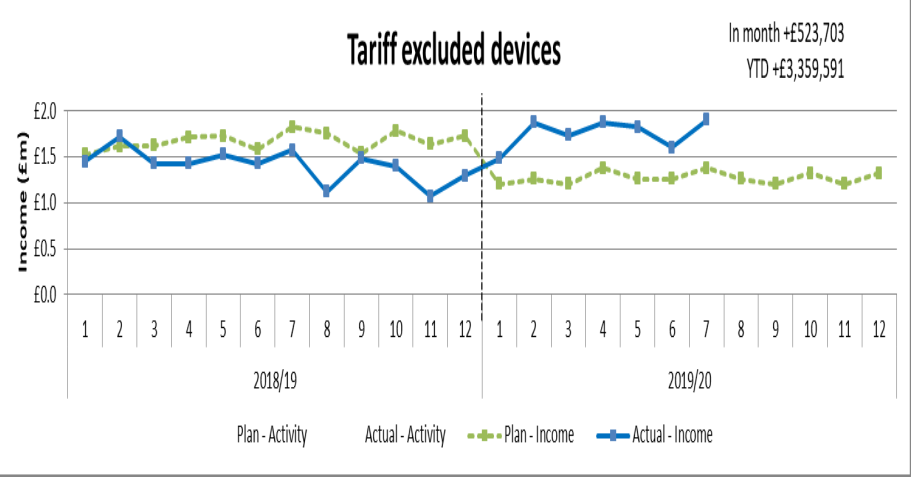
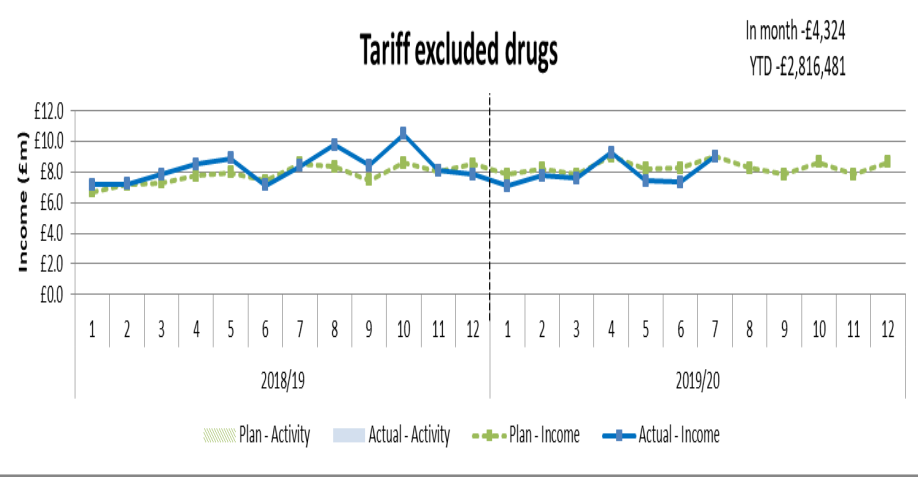
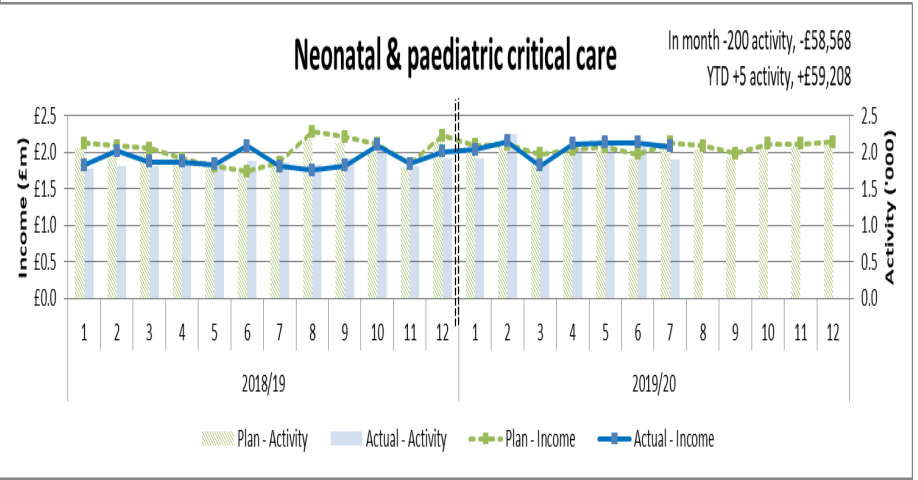
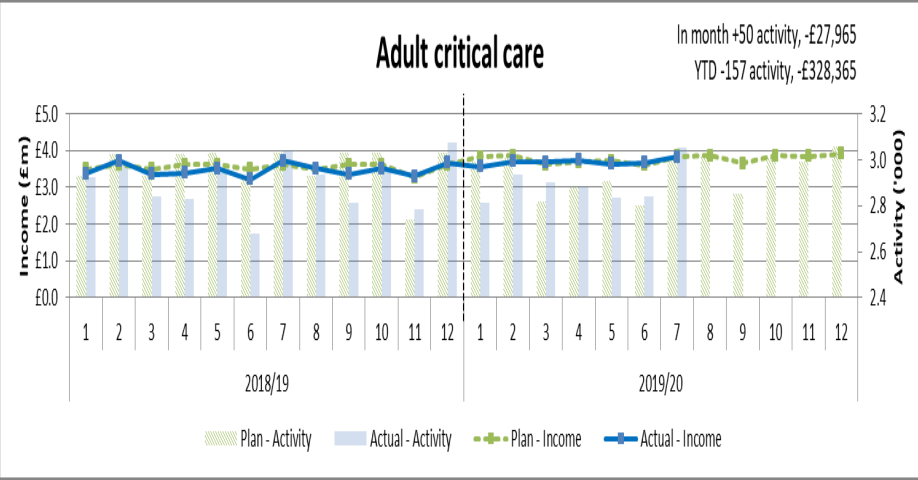


Clinical Income



Note: A&E includes impact of Children's ED pathway change from M7

Clinical Income



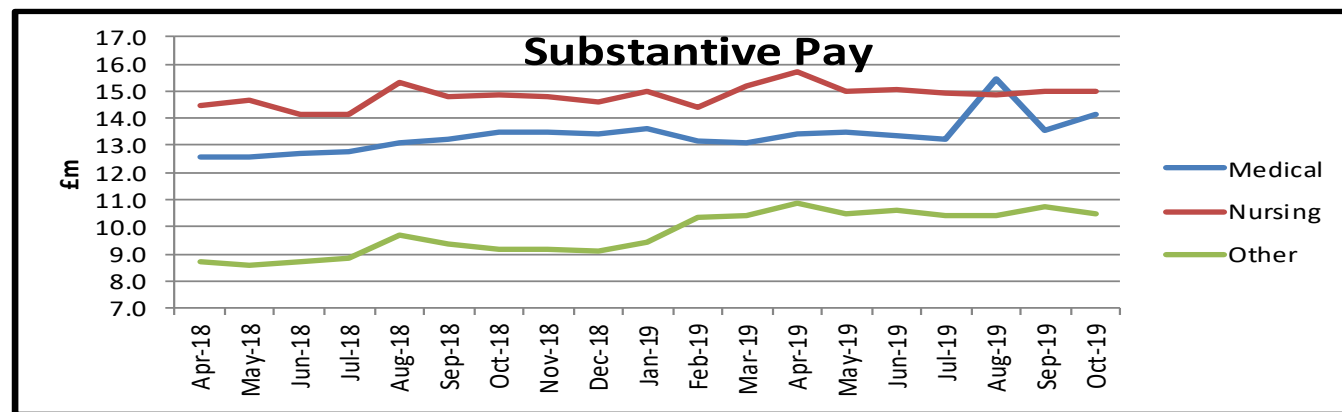
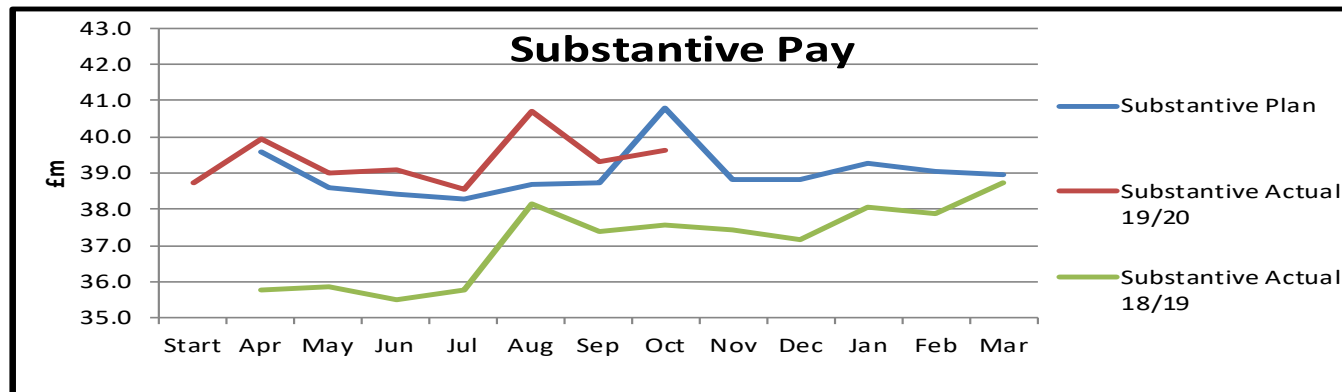
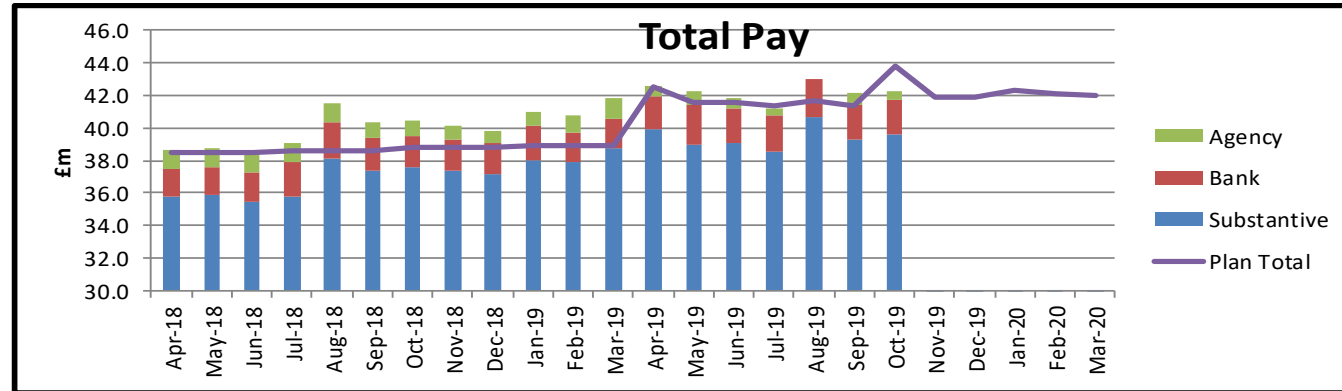
Substantive Pay Costs

Total pay expenditure in October 2019 was £42.3m, £0.2m more than that spent in September 2019. The average for 2019/20 is £42.2m after adjusting for one-offs.

The £0.2m increase is entirely on substantive pay and relates to the full month impact of the NQNs who should all be in the nursing numbers from November 2019 with the exception of the theatre NQNs.

In terms of position vs Plan in the month was £0.6m (normalised) adverse which is £0.1m higher than in September 2019.

Recruitment Control Panel (RCP) is still meeting weekly to validate new and replacement posts.



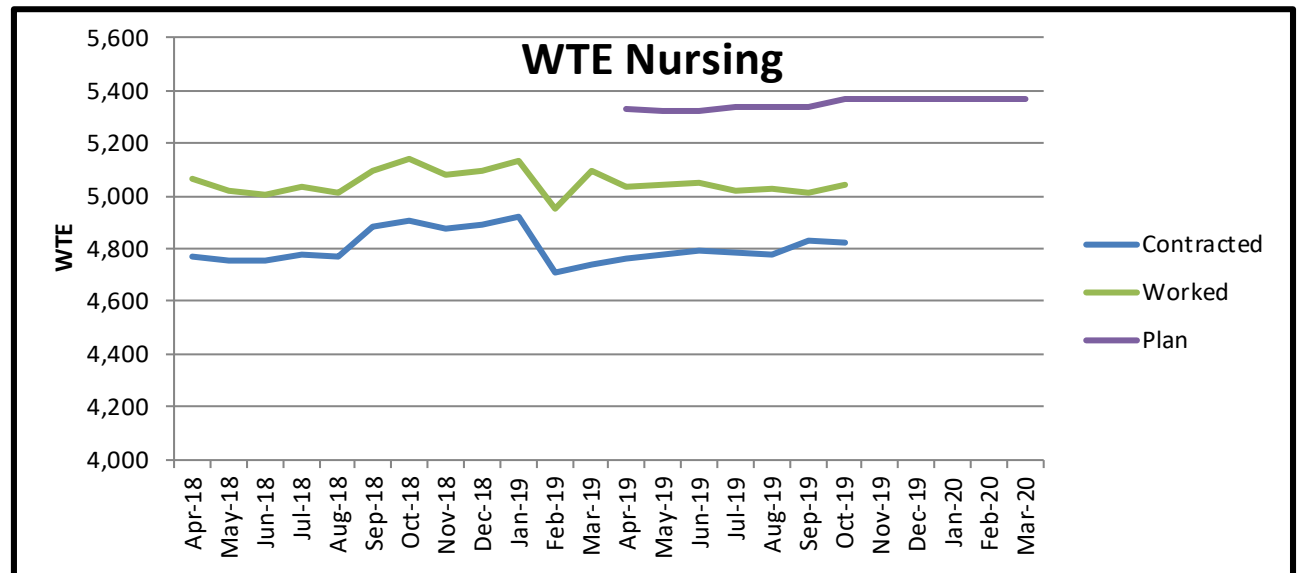
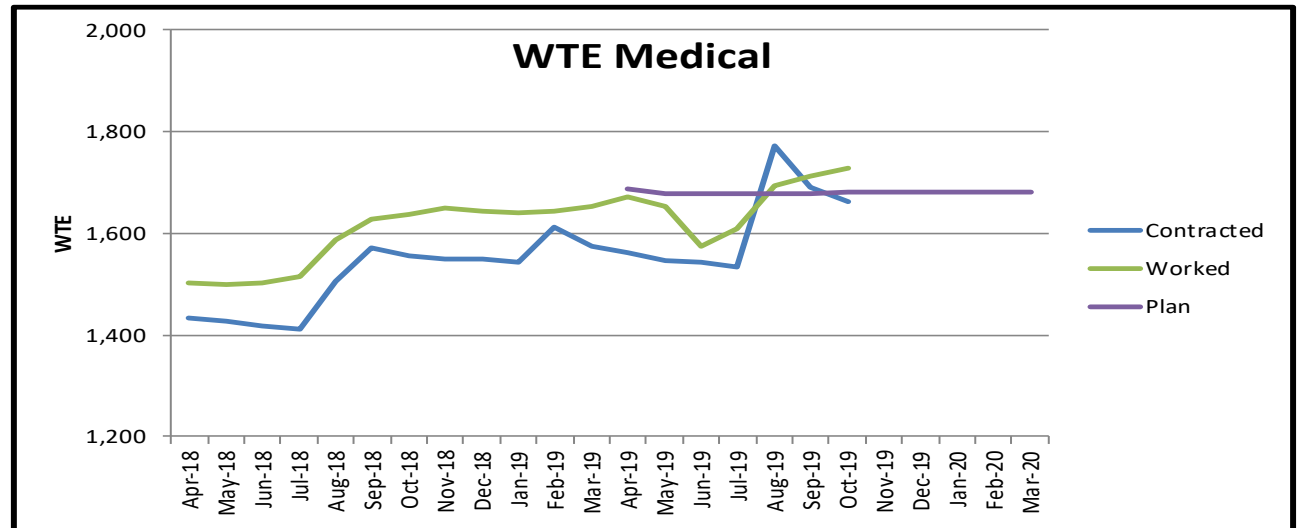
WTE Information

WTE information presented focuses on total medical and nursing registered and unregistered.

The information compares plan vs worked and contracted.

Highlights:

- 1) Plan for both medical & nursing is flat
- 2) Nursing vacancies (Plan less contracted) suggest to be approximately 500.
- 3) Overall medicals are on Plan in terms of contracted numbers although recognise this masks position on junior doctors vs consultants.
- 4) Nursing numbers expected to rise from November for NQNs, overseas recruitment and increase in staff linked to the Winter Plan.



Temporary Staff Costs

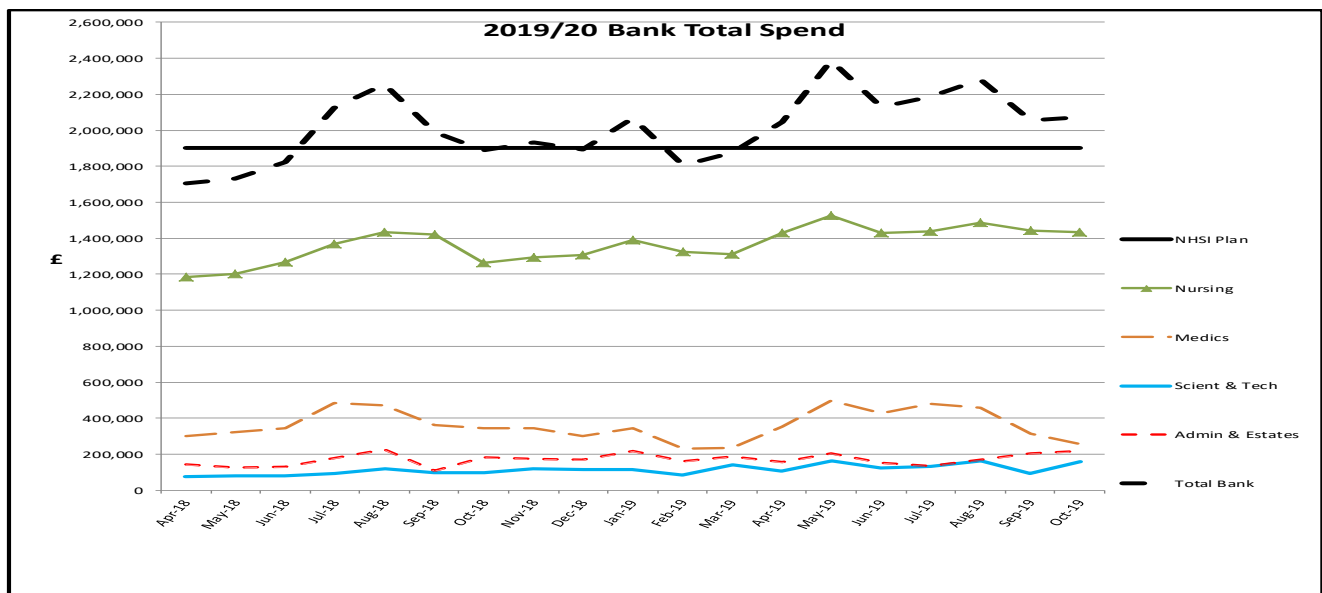
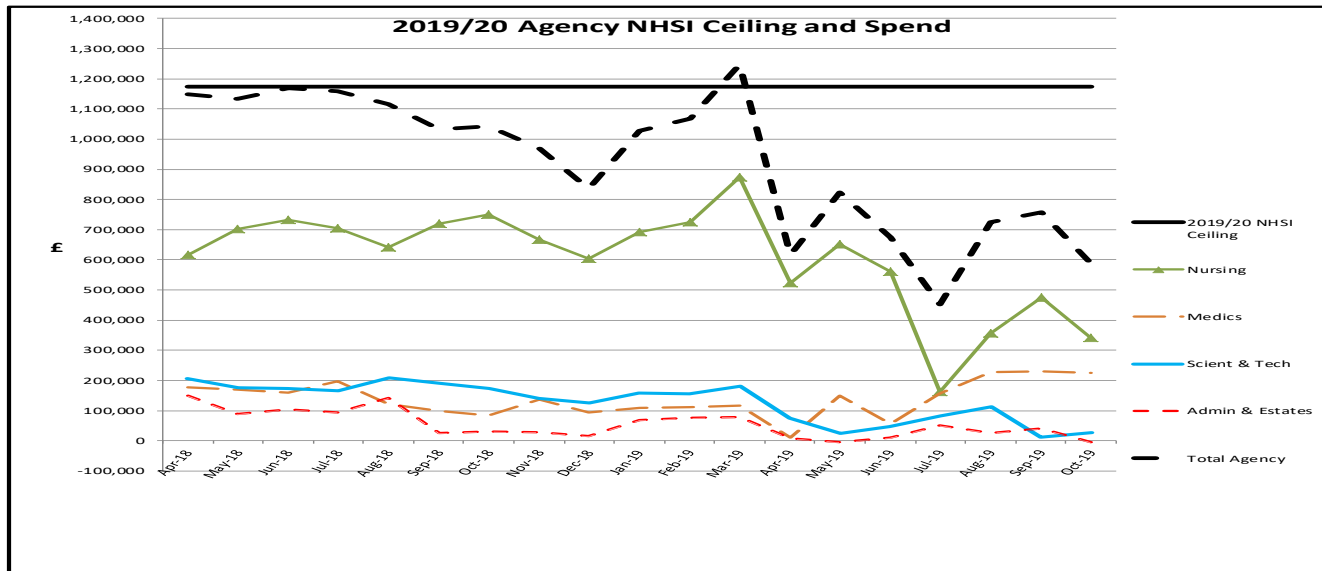
Overall agency spend in October 2019 was £0.6m.

Expenditure on Thornbury increased by £15k in October 2019 at £72k, however, this is £103k lower than October 2018.

Expenditure on bank staff was £2.1m in October 2019m, the same as September 2019.

In overall terms, expenditure on flexible staffing was £0.3m lower than Plan in October 2019.

In the last 3 weeks requests for flexible staffing has risen mainly in critical care areas.



Cost Improvement Programme

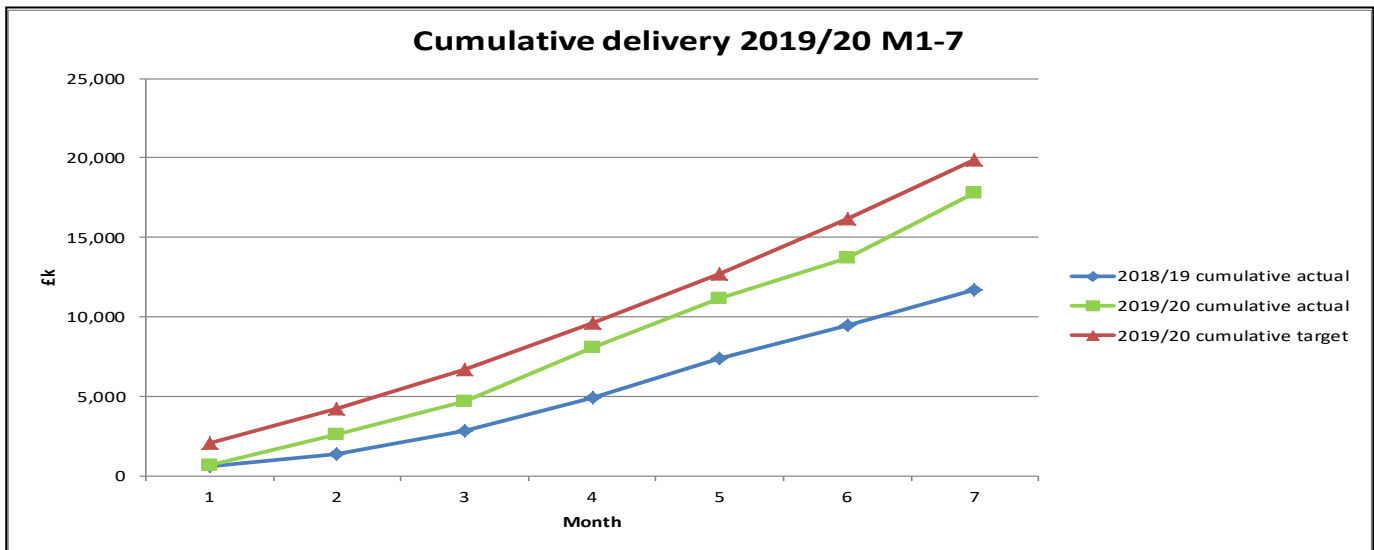
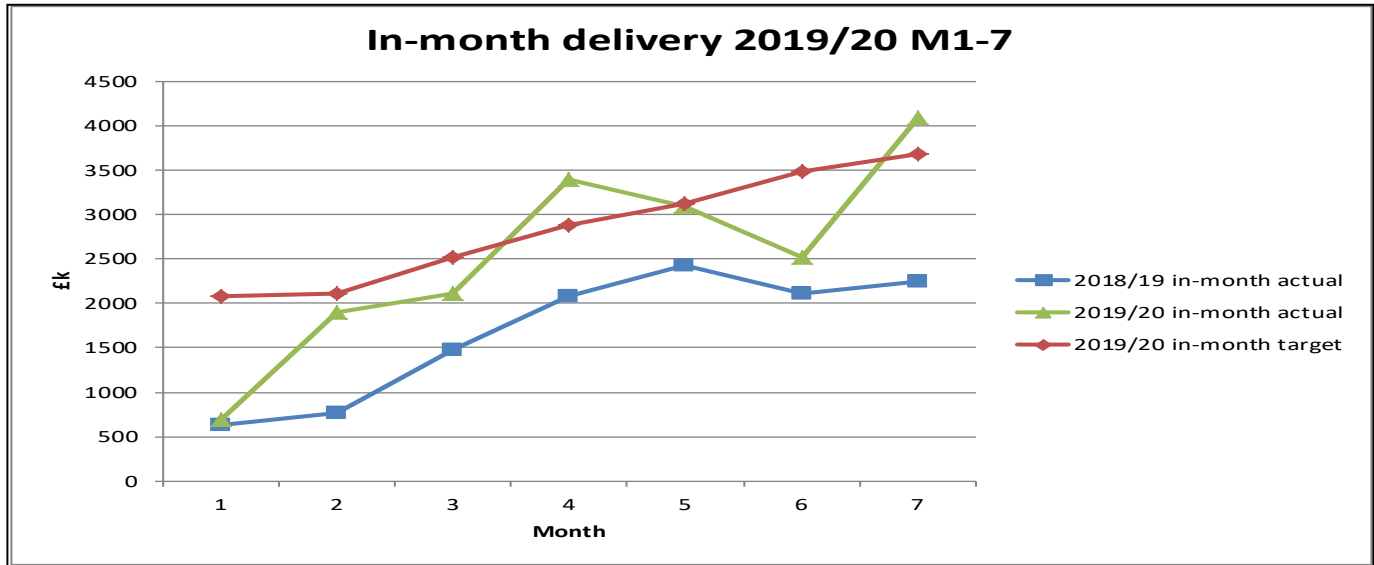
CIP delivery in October 2019 was £4m against a Plan of £3.7m.

Income CIP scheme award continues to be high due to strong income performance with £1.9m being awarded in M7 (£0.5m backdated).

Year to date the Trust is £2.1m behind Plan for 2019/20 although monthly delivery is tracking higher than that previously delivered.

Fortnightly CIP run rate meetings will still focus on the income & expenditure position of each Division vs Plan, and also CIP performance at Care Group level.

Going forward Care Groups continue to be asked to highlight risks and any mitigations to discuss at the CIP meetings with Execs to firm up the delivery for 2019/20.



Cost Improvement Programme

The Trust has identified CIP of £40.1m vs £40m target. Identification increased by £0.2m from September 2019.

Of the total identified, £28.4m/71% is planned to be recurrent and £11.7m/29% non-recurrent. When include full year effect of the 2019/20 CIP programme of £6.2m, the recurrent total is £34.6m.

Focus in the next 4 weeks is on:

- Ensuring delivery of identified schemes to avoid any slippage
- Reviewing non-recurrent schemes for opportunities to make recurrent
- Continuing to discuss risks and mitigations of any identified schemes.
- Identification of schemes for 2020/21.

This table outlines the main themes of identified CIP to date. Length of stay schemes will either result in expenditure reductions through closing beds or increases in income from utilising spare beds.

Division	CIP Target £k	Identified CIP £k	Gap £k	Identified %	Red rated	Identified exc. red £k	Identified exc. Red %
Division A	8,998	8,881	117	99%	860	8,021	89%
Division B	7,954	8,073	(119)	101%	830	7,243	91%
Division C	6,569	6,838	(269)	104%	1,085	5,753	88%
Division D	8,428	8,872	(444)	105%	338	8,534	101%
Total Clinical Services	31,949	32,664	(715)	102%	3,113	29,551	92%
Chief Finance Officer	377	609	(232)	162%	0	609	162%
Estates Facilities & Capital Development	1,892	1,892	0	100%	24	1,868	99%
Transformation	163	287	(124)	176%	0	287	176%
Chief Operating Officer	379	388	(9)	102%	0	388	102%
Human Resources	312	405	(93)	130%	0	405	130%
Informatics	453	300	153	66%	0	300	66%
Clinical Governance	173	112	61	65%	0	112	65%
Training, Development & Workforce	248	241	7	97%	0	241	97%
Chief Executive	54	25	29	46%	0	25	46%
Trust Headquarters	4,051	4,259	(208)	105%	24	4,235	105%
Central Schemes	4,000	3,198	802	80%	1,637	1,561	39%
Trust Total	40,000	40,121	(121)	100%	4,774	35,347	88%

	Workforce	Length of stay	NHS income	Other income	Non pay	Total
Trust total identified £k	6,574	4,977	15,708	5,114	7,748	40,121
Recurrent £k	1,416	4,977	14,840	1,547	5,637	28,417
Recurrent %	22%	100%	94%	30%	73%	71%
Non Recurrent £k	5,158	0	868	3,567	2,111	11,704
Non Recurrent %	78%	0%	6%	70%	27%	29%

Cash

The cash balance was £80m at the end of October 2019, £33.5m above Plan. This is primarily due to:

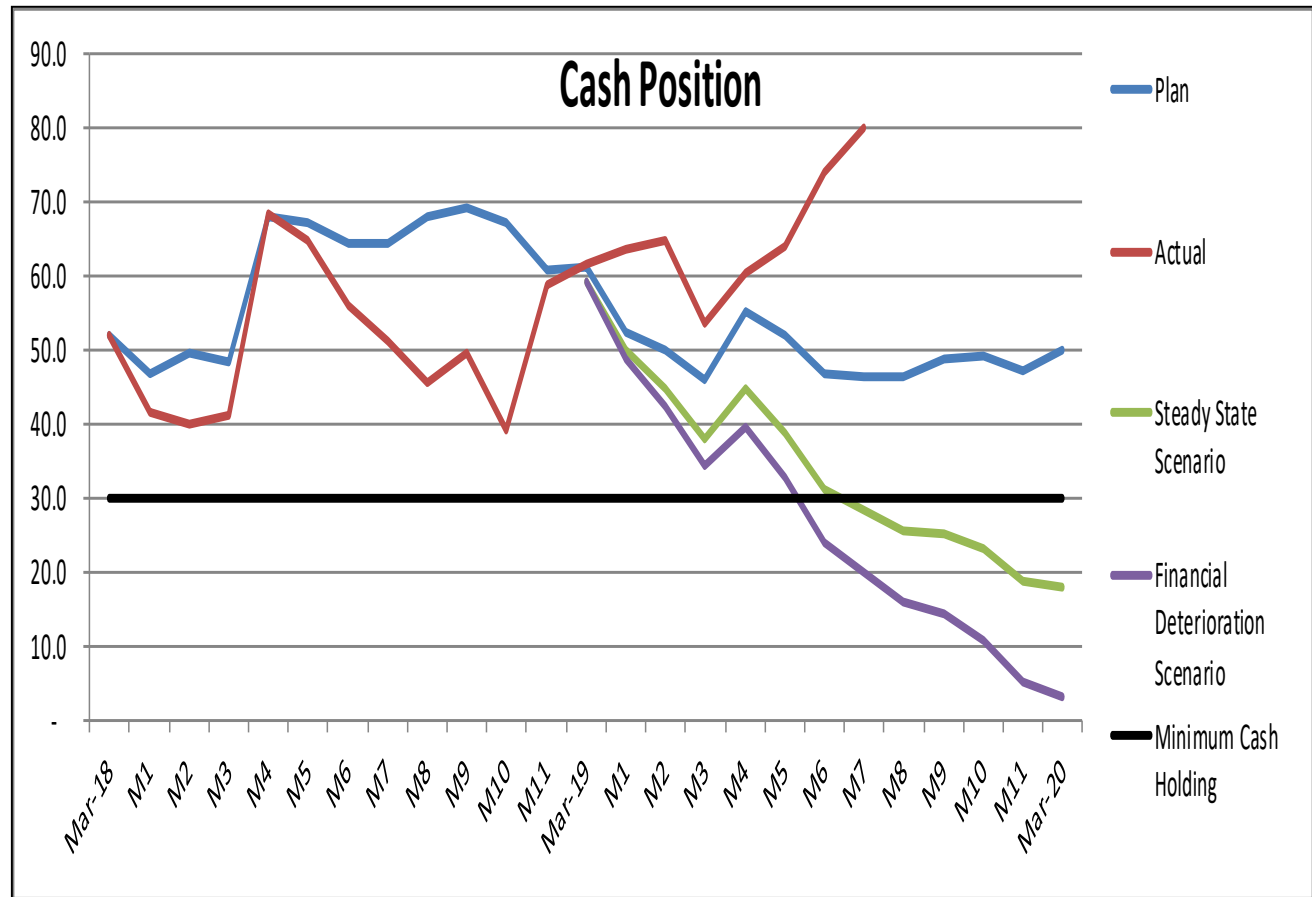
1) Working capital position better than plan by circa £10m. The Accounts Receivable position is better than Plan due to improvements in negotiated payment arrangements with Commissioners. The Accounts Payable balance remains higher than anticipated due to delays in invoice payment, although overdue invoices continue to reduce.

2) The Operating I&E position continues to track above Plan (circa £3m), plus Year-end cash position from 18/19 finishing above the level assumed at the point the Plan was set (circa £3m).

3) Receipt of PSF bonuses for 18/19 £9.5m in excess of the level assumed in the Plan.

4) Net spend on property, plant and equipment (through capital expenditure and lease interest and principal payments) £1.9m less than Plan.

We will review the latest cash forecast by the end of Q3 to inform our 2020/21 plan and capital prioritisation process.



Capital Expenditure

(Fav Variance) / Adv Variance

Scheme	Month			Year to Date			Full Year			
	Plan £000's	Actual £000's	Var £000's	Plan £000's	Actual £000's	Var £000's	Original Plan £000's	Revised Plan £000's	Latest Forecast £000's	Var (from revised) £000's
Childrens Hospital	100	33	(67)	733	445	(288)	1,893	1,196	1,174	(22)
ED Adult Resus	250	216	(34)	575	302	(273)	1,509	1,501	1,017	(484)
IT Schemes	450	381	(69)	3,867	3,558	(309)	7,450	7,220	7,220	0
Wave 3 STP Digital	0	0	0	0	0	0	4,422	26	0	(26)
Strategic Maintenance	450	258	(192)	2,404	1,979	(425)	4,000	4,000	4,000	0
Medical Equipment Panel	295	214	(81)	670	729	59	2,100	2,100	2,100	0
GICU Expansion	700	535	(165)	4,250	3,499	(751)	13,614	12,122	11,132	(990)
Refurbish Eye Theatre	20	20	0	20	20	0	1,177	60	115	55
Energy Efficiency	250	(9)	(259)	450	250	(200)	2,223	1,473	1,667	194
New Theatres E level	178	(160)	(338)	2,586	1,512	(1,074)	3,637	3,236	4,300	1,064
Urology Day Unit	100	242	142	1,934	1,832	(102)	2,173	2,177	2,047	(130)
Steam Project	0	8	8	103	119	16	2,126	103	611	508
Princess Anne Theatre Ventilation	20	40	20	301	502	201	580	355	355	0
Spend to Save	30	1	(29)	145	101	(44)	1,104	847	832	(15)
Radiotherapy Equipment	135	44	(91)	834	725	(109)	658	834	924	90
Divisional / Donated Equipment	150	4	(146)	512	322	(190)	1,350	1,350	1,373	23
Decorative Improvements / Staff Fund	140	12	(128)	316	41	(275)	625	741	718	(23)
Other Projects	445	258	(187)	3,163	3,028	(135)	6,006	4,472	5,083	611
Total Excluding Finance Leases	3,713	2,097	(1,616)	22,863	18,964	(3,899)	56,647	43,813	44,668	855
Finance Leases-ISS	200	832	632	1,937	2,416	479	5,815	4,880	6,436	1,556
Finance Leases-Other	0	22	22	3,173	3,062	(111)	2,000	3,433	3,433	0
Total Capital Expenditure	3,913	2,951	(962)	27,973	24,442	(3,531)	64,462	52,126	54,537	2,411
Donated Asset Additions	(263)	(263)	0	(1,841)	(1,841)	0	(3,043)	(2,796)	(2,796)	0
Total Net CDEL Expenditure	3,650	2,688	(962)	26,132	22,601	(3,531)	61,419	49,330	51,741	2,411

Net capital spend of £2.7m in month was £1m below planned levels. This was driven mainly by downward adjustment of £0.3m when valuing works relating to the new E level theatre (still being validated) in addition to underspends in strategic maintenance, divisional equipment and other projects. These are all more ad hoc in nature and subject to greater month on month volatility. Several other projects were also behind plan however this is mainly due to interim timings rather than slippage risks with regards to total project completion such as GICU. Some schemes financed from external funding have however been delayed such as energy efficiency and GDE funded IT projects. These are forecast to gain traction in Q3/Q4.

The forecast of £44.7m for capital projects excluding leases is within the bounds reported to the strategy and finance committee; however this may reduce slightly as a review of spend for E level theatre is underway and it is thought the £4.3m forecast may contain overlap with other areas of reported spend. At the same time, the Trust continues to be asked to bid for late external funding from potential national under-spend, which may increase the forecast.

Statement of Financial Position

(Fav Variance) / Adv Variance

Payables balances have stabilised since year-end.

The back-log of outstanding payments continues to be addressed. The number of unpaid invoices continues to reduce but remains a critical issue to resolve for the accounts payable team. The reduction has slowed due to temporary staff turnover.

Statement of Financial Position	2018/19 Actuals £m	2019/20			
		YTD Plan £m	YTD Act £m	YTD Var £m	Full Year Plan £m
Fixed Assets	372.4	381.1	375.0	(6.1)	403.7
Inventories	16.5	16.2	14.9	(1.3)	16.2
Receivables	105.9	73.5	79.2	5.7	75.5
Cash	61.5	46.5	80.1	33.5	49.8
Payables	(110.5)	(83.4)	(105.0)	(21.6)	(82.7)
Current Loan	(3.3)	(4.6)	(3.4)	1.2	(4.6)
Current PFI and Leases	(7.0)	(4.4)	(7.5)	(3.1)	(4.4)
Net Assets	435.6	424.9	433.2	8.3	453.5
Non Current Liabilities	(18.2)	(18.3)	(18.0)	0.3	(18.3)
Non Current Loan	(14.6)	(11.3)	(12.7)	(1.4)	(12.0)
Non Current PFI and Leases	(33.0)	(34.2)	(29.5)	4.7	(34.6)
Total Assets Employed	369.8	361.2	373.1	11.9	388.7
Public Dividend Capital	211.0	219.5	211.0	(8.5)	223.7
Retained Earnings	125.0	116.2	128.2	12.0	139.5
Revaluation Reserve	33.8	25.5	33.8	8.4	25.5
Other Reserves	0.0	0.0	0.0	0.0	0.0
Total Taxpayers' Equity	369.8	361.2	373.1	11.9	388.7

Report to the Trust Board of Directors dated Thursday, 28 November 2019			
Title: 7 Day Hospital Services Self-Assessment – Autumn/Winter 2019/20			
Category	Quality, Performance, and Finance		
Agenda item	5.1		
Sponsor	Director of Transformation and Improvement		
Author	Steve Wheeler, Business Manager to the Medical Director		
Provenance	<p>The Trust is required to submit the Autumn/Winter 2019/20, 7 Day Service Board Assurance Framework on 29 November 2019.</p> <p>In order for the Trust to comply with this return the framework must be signed off by the Trust board or appropriate sub-committee and returned by close of play on 29 November 2019.</p>		
Classification	This Report is unclassified.		
Purpose and recommendation	<p>The paper is presented for APPROVAL.</p> <p>The Seven Day Hospital services (7DS) Programme was developed to support providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.</p> <p>Ten 7DS clinical standards were originally developed and since 2015 Trusts have been asked to report on four priority standards: Clinical Standard 2: consultant-directed assessment Clinical Standard 5: diagnostics Clinical Standard 6: interventions Clinical Standard 8: ongoing review</p> <p>The attached template shows UHS responses to the self assessment and is submitted to Trust Board for approval prior to completing the return.</p>		
Relevant strategic goals	<input checked="" type="checkbox"/> Goal 1: Improving patient journeys.	<input type="checkbox"/> Goal 2: Delivering value-based health and care.	<input type="checkbox"/> Goal 3: Supporting healthy lives.
	<input type="checkbox"/> Goal 4: Building an expert and inclusive workforce.	<input type="checkbox"/> Goal 5: Being agile in meeting people's needs.	<input type="checkbox"/> Goal 6: Creating leading-edge research, education, and innovation.
Assurance framework links	<ul style="list-style-type: none"> BAF01 – Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6 		
Impact assessments	Not specified		
Other standards affected	Not specified		

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
<p>Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.</p>	<p>The Trust is meeting this standard:</p> <p>Evidence Source 1 - Consultant Job Plan All emergency specialties have consultant on call rotas with either planned ward round review to support the standard or continuous review throughout the shifts. The timing of review is entered through the electronic system, which enables monitoring, however often consultants enter a time at the end of the session rather than the time the patient is reviewed. Despite this we still meet the standard.</p> <p>Evidence Source 2 - Local Clinical Audit In November 2019 UHS carried out a local audit of 2,881 emergency admissions which attended the Acute Medical Unit between March to June 2019, covering 7 days a week. The audit objective was to identify the number of emergency admissions which received a clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours from the time of admission to hospital.</p> <p>The Trust found that the time to first was achieved at 95.52%. 4.48% of the sample was uncompliant as the system data showed clinical assessments taking place on the admitting ward prior to the patient being admitted to the ward on the system.</p> <p>On average patients waited 3hrs 17mins for an assessment. 3hs 41mins on a weekday and 2hrs 20mins at the weekend.</p> <p>UHS feels that this demonstrates the effective working practices demonstrated by the emergency admissions team.</p> <p>Evidence Source 3 - Wider performance and experience measures The Trust triangulates data to reinforce that the care provided to our emergency admissions is excellent. UHS is particularly proud of the changes which have been made to ensure that there is no difference between mortality at the weekend compared to weekdays. UHS have taken positive steps to ensure that length of stay is not significantly affected by weekends. Weekend discharges consistently make up 20% of the total weekly discharges and this is supported by SAFER principles.</p>	<p>Yes, the standard is met for over 90% of patients admitted in an emergency</p>	<p>Yes, the standard is met for over 90% of patients admitted in an emergency</p>	<p>Standard Met</p>

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: <ul style="list-style-type: none"> • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients 	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	The Trust is meeting this standard: UHS consistently achieve Clinical Standard 5 target across seven days a week, all specialties provide consultant cover and interventions 7 days a week. We provide many of these services for neighbouring Trust's. (IR, MRI, Interventional Endoscopy, Emergency Surgery, PCI and complex Cardio Arrhythmia)	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available on site	Yes available on site	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	The Trust is meeting this standard: UHS consistently achieve Clinical Standard 6 target across seven days a week, this is due to radiology working practices and economies of scale.	Emergency Renal Replacement Therapy	Yes available on site	Yes available on site	
		Urgent Radiotherapy	Yes available on site	Yes available on site	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
<p>Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.</p>	<p>The Trust is meeting this standard:</p> <p>Evidence Source 1 - Consultant Job Plans Consultant led handover takes place twice a day in GICU (General Intensive Care Unit) and once a day in SHDU (Surgical High Dependency Unit). Job plans are appropriate and sufficient.</p> <p>Evidence Source 2 - Systems to support ongoing review UHS support and have implemented NEWS2 across all adult areas (excluding obstetrics). Patient acuity and needs are updated daily on Drs Worklist. This provides detail on handover and to the on call team. Patients over are stratifying or requiring urgent review are seen by the duty team as highlighted through NEWS2 (or by nursing team)</p> <p>Evidence Source 3 - Local Clinical Audit Twice daily consultant reviews take place in admission areas and high care areas and once daily review in other inpatient wards. The Trust has doubled consultant ward rounds over the past two years and consistently achieves this target.</p> <p>Evidence Source 4 - Wider performance and experience measures The Trust triangulates data to reinforce that the care provided to our high dependency patients is excellent. Outcomes are consistently within the top 10% noticeably.</p> <p>**Additional assurance statement** Each unit has a main daily consultant led ward round that is documented in the MetaVision. That documentation may be by a trainee. In addition to this patients are generally reviewed in the form of a handover or business ward rounds. These are not necessarily documented in MetaVision, nor do we simply 'tick box' that they have occurred. If there are key elements of a review or plan that need to be documented then this will happen. If patients are reviewed by the consultant in ED, that will not generally be recorded in MetaVision.</p> <p>Neuro ICU 7:45 Consultant led bedside ward round review of all patients, not recorded in MetaVision 11:30 Main ward round of all patients. Generally consultant led, but occasionally senior trainee under consultant supervision. This ward round is documented in the notes, but it may be a trainee documenting. 16:00 Handover bedside ward round with two consultants of all patients. Not documented in MetaVision. 20:00 Consultant led bedside ward round of all patients. Not recorded in MetaVision.</p> <p>GICU 08:00 Review of all patients away from the bed space. Two consultants present. Not recorded in MetaVision. 11:00 Main ward round of all patients. Generally consultant led, but occasionally senior trainee under consultant supervision. This ward round is documented in the notes, but it may be a trainee documenting.</p>	<p>Once daily: Yes the standard is met for over 90% of patients admitted in an emergency</p>	<p>Once daily: Yes the standard is met for over 90% of patients admitted in an emergency</p>	<p>Standard Met</p>

17:00 Handover bedside ward round with two consultants of all patients. Not documented in MetaVision.
 20:00 (Mon-Fri) Bedside ward round of all patients with a consultant. Not recorded in MetaVision.

SHDU
 07:30 Consultant led bedside ward round review of all patients, not recorded in MetaVision.
 11:30 Main ward round of all patients. Consultant led. This ward round is documented in the notes, but it may be a trainee documenting.
 17:00 Handover ward round of all patients, away from the bedside, with two consultants.

RHDU
 Morning consultant ward round of all patients. Always documented in MetaVision. May be a trainee documenting. Admitted patients will generally get a consultant review during daytime. This may occur in ED, in which case will not be documented in MetaVision.

<p>Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency</p>	<p>Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency</p>	
---	---	--

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10

UHS has reviewed performance against these standards and has highlighted areas which show particular progress:

Clinical Standard 1 - Patient Experience

The trust receives patient feedback through a wide variety of channels. For regular local feedback, such as the Friends & Family Test, results for weekend care can be filtered by date of discharge and free text comments are regularly subject to thematic reviews. Complaints are categorised and reported on thematically to identify emerging trends. All website feedback (NHS choices, Care Opinion) is monitored and shared with relevant teams. Healthwatch attends the trust's patient experience committee and escalates any emergent concerns or themes.

Friends & Family Test results for weekend inpatient care show a lower recommend rate than the overall trust score: 93% average rating in Q3 and Q4 for inpatients patients discharged at weekends compared to 97% overall, and in outpatients weekend recommend rate was 92% compared to 96% overall. Performance in ED remained relatively consistent.

Clinical Standard 3 - Multidisciplinary Team Review

The Trust has processes in place to support MDT review in all specialties within emergency admissions, with the appropriate members to enable assessment for complex/ongoing needs to create an integrated management plan. We have a 7 day a week Frailty service at the front door.

In addition the clinical pharmacy service supports UHS 7 days a week, this includes medicine reconciliation and prescription review. At the weekend this service is reduced to identify patients who are higher priority for review (new admissions and high risk conditions or medicines). Areas with high emergency admission numbers i.e. AMU (Acute Medical Unit) and SDU (Surgical Day Unit), receive a dedicated clinical pharmacy service at the weekend. Since Feb-18 UHS has consistently achieved above the 80% medicines reconciliation rate target.

Clinical Standard 4 - Shift Handovers

All services have timetabled handover twice daily and 7 days a week. Outcomes are documented on Dr worklists in most specialties.

Clinical Standard 7 - Mental Health

The liaison psychiatry team at UHS in hours (mon-fri 9-5) for wards and 24/7 to the ED and AMU, would aim to respond to CRISIS referrals (e.g someone at imminent risk of harm to themselves or others/active suicidal intent) within 1 hour and URGENT (eg self-harm, suicidal or psychotic but being safely managed within the ward/ area) referrals within the same day, and for non-urgent or routine referrals the response time is 3 days, however the service is significantly under resourced and at times meeting the demand is challenging. The Liaison Psychiatry service at UHS is not resourced or commissioned to provide urgent mental health response to the acute hospital wards out of hours any urgent advice is provided by the SHFT consultant on-call via the bleep holder based at Antelope House.

Clinical Standard 9 - Transfer to Community, Primary and Social Care

The UHS Complex Discharge Team offers a 6 day service (Sunday to Friday) at present, with significantly reduced service available on the Sunday. Where possible discharges are lined up for the weekend where partners offer a 7 day admitting service/start date. Due to system preparedness for 7 day working, it is not deemed financially viable to offer a full 7 day service at present.

Social care is available 7 days a week

The UHS Integrated Discharge Bureau (IBD) have a process called '10 minutes for tomorrow' in which they report directly to the Divisional Management teams on every patient who is highlighted for a weekend discharge, this process highlights delays and issues for example TTOs and discharge summaries.

The IBD team are also responsible for populating the SHREWD (Single Health & Resilience Early Warning Database) system. The system visibly shows pressure in real time across the whole health economy. The system is used as part of the Friday review to plan discharges for the weekend.

Currently the IBD team have 2.0 WTE In-reach Rehab Co-ordinators, the role of which is to line up weekend discharges for community beds. The team have recently approved the funding for 1.0 WTE additional co-ordinator to cover weekdays and support 7 day flow.

In addition the capacity of the reablement services at the weekend is reviewed on a case by case basis weekly, to ensure maximum utilisation of the services.

Some local community providers do not currently take patients at the weekends. As such UHS is working with these providers and putting measures in place to increase the number of patients which can be discharged at weekend.

Clinical Standard 10 - Quality Improvement - HSMR, QI programme

The Trust is a positive outlier for HSMR. Our weekend and weekday HSMR is comparable and significantly lower than expected compared to our peers locally and nationally.

We have a QI strategy with clear leadership and a program across the Trust. The QI team work with the clinical representatives and GIRFT team to ensure that our program focuses on outcomes as well as the Trust's QI priorities.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

Report to the Trust Board of Directors dated Thursday, 28 November 2019			
Title: Register of Seals, and Chair's Actions			
Category	Corporate Governance, Risk, and Internal Control		
Agenda item	5.2		
Sponsor	Chairman		
Author	Audley Charles, Interim Company Secretary		
Provenance	This is a regular report to notify the Board of use of the seal and actions taken by the Chairman in accordance with the Scheme of Delegation for ratification.		
Classification	This Report is unclassified.		
Purpose and recommendation	The paper is presented for RATIFICATION.		
Relevant strategic goals	<input type="checkbox"/> Goal 1: Improving patient journeys.	<input checked="" type="checkbox"/> Goal 2: Delivering value-based health and care.	<input type="checkbox"/> Goal 3: Supporting healthy lives.
	<input type="checkbox"/> Goal 4: Building an expert and inclusive workforce.	<input type="checkbox"/> Goal 5: Being agile in meeting people's needs.	<input type="checkbox"/> Goal 6: Creating leading-edge research, education, and innovation.
Assurance framework links	<ul style="list-style-type: none"> • BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6 • BAF03 – Failure to achieve financial targets results in a shortfall in cash required to deliver the capital programme • BAF04 – Reduced access to resources compromises the quality of services 		
Impact assessments	None		
Other standards affected	<ul style="list-style-type: none"> • Monitor NHS Foundation Trust Code of Governance (probity, internal control) • UHS Standing Financial Instructions and Scheme of Reservation and Delegation 		

Register of Seals, and Chair's Actions

1. Signing and Sealing

There were no seals affixed since the last report.

2. Chair's Actions

The Board has agreed that the Chair may undertake some actions on its behalf. The action at 2.1 below has been undertaken by the Chair.

2.1 **Single Tender Action for Managed Bank and Collaborative Bank Service from NHS Professionals**

Some time ago University Hospitals Southampton (UHS) Foundation Trust confirmed that it would like to agree a new Health Trust Education Europe (THE) Direct Award with NHS Professionals (NHS P). This is to be for a two plus (2+2) minimum period, that is, a 2 year contract plus 2 optional additional years. The contract value is £1,767,118 via a two year plus two optional additional years HealthTrust Europe (HTE) Direct Award.

A Contract Options paper was prepared by Procurement of which there were 4 options:

1. Extend the current contract by the 1 x 12 months on current terms to September 30th, 2020 and continue with the STP Collaborative/Migration during this time
2. Extend the current contract by the allotted 1 x 12 months on current terms to September 30th, 2020 and **do not** join the STP Collaborative until NHSP migrates all clients to Bank Staff in c. June 2020 (or the Trust tenders and procures an alternative provider).
3. Extend the current contract by the allotted 2 x 12 months on current terms to September 30th, 2021 and continue with the STP Collaborative/Migration during this time
4. Agree a new HTE Direct Award with NHS Professionals (2+2 minimum)

After looking at all the options Procurement agreed to adopt Option 4 for the following:

- Maintains current service and continued service improvement
- No early adopter/migration disengagement fee levied
- Reduction in Cloud Staff transaction fees via NHSP of £1.50 (qualified nursing) and £1 (unqualified nursing) per shift for the first 12 months from go live between NHSP Clients (non-NHSP client charge will be higher)
- Can commence the Gainshare opportunity and greater opportunity to succeed
- Contract value savings for a further Direct Award of c. £75k based on forecasted hours to September 2019. This saving has now increased to £101k after negotiations with NHS P resulted in their lowering their commission fees.

- 2.2 The new contract considers the mitigating factor of the Hampshire & Isle of Wight Sustainability & Transformation Partnership (STP) collaboration and any associated contract longevity to support migration to Allocate Bank Staff/Cloud Staff for proposed savings to be realised within the STP Bank share. This was approved by the Chair on 28 October 2019.

3. Recommendation

The Board is asked to ratify the Chair's Action.

Report to the Trust Board of Directors dated Thursday, 28 November 2019			
Title: Learning from Deaths 2019-20 Quarter 2 Report			
Category	Quality, Performance, and Finance		
Agenda item	9.1		
Sponsor	Medical Director		
Author	Mr Neil Pearce, Associate Medical Director		
Provenance	Quality Governance Strategy Group		
Classification	This Report is unclassified.		
Purpose and recommendation	<p>The paper is presented for INFORMATION.</p> <p>Since 2014 IMEG and TMRG have been undertaking reviews of adult inpatient deaths.</p> <p>The higher observed number of avoidable deaths in Q1 2019/20 needs to continue to be monitored to see if it is part of a trend or simply a statistical cluster.</p>		
Relevant strategic goals	<input checked="" type="checkbox"/> Goal 1: Improving patient journeys.	<input type="checkbox"/> Goal 2: Delivering value-based health and care.	<input type="checkbox"/> Goal 3: Supporting healthy lives.
	<input type="checkbox"/> Goal 4: Building an expert and inclusive workforce.	<input type="checkbox"/> Goal 5: Being agile in meeting people's needs.	<input type="checkbox"/> Goal 6: Creating leading-edge research, education, and innovation.
Assurance framework links	<ul style="list-style-type: none"> BAF01 – Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways. BAF02 – Failure to deliver regulatory requirements causes the Trust to breach the terms of its Provider Licence leading to a loss of local leadership due to an enforced change in Board and Executive composition, impacting on Goals 1 to 6. 		
Impact assessments	Not specified		
Other standards affected	Not specified		

1 Introduction

In March 2017 the DH published *National guidance on learning from deaths*. From April 2017, Trusts have been required to collect information on deaths, reviews, investigations and resulting quality improvements; and report to its public board meeting via a quarterly paper. This includes assigning an avoidability score to all those deaths reviewed. Whilst there is no requirement to review all deaths, rather only those where concerns are raised by relatives; unexpected deaths; deaths of patients with either a learning disability or a severe mental illness; or deaths in a speciality or treatment group where an alarm has been raised (for example, an elevated mortality rate), we have been undertaking a 'hot review' of all deaths via our Internal Medical Examiner Group (IMEG) process since September 2014. In April 2019 we adjusted our IMEG system to comply with the new national requirement for the medical examiners system.

2 Key Issues

- UHS introduced the Internal Medical Examiner Group (IMEG) in September 2014, prior to the national drive.
- The group examines all deaths, going beyond the national guidelines and has progressively increased the scope to include
 - All inpatient adult deaths
 - Death in the Emergency Department
 - A paediatric mortality review process.
- The review identifies potential avoidable factors as well as aspects of good care to feedback to the clinical teams.
- The bereavement care team attends IMEG and focuses support where the medical team discuss issues that might have been specifically stressful for the relatives. This allows a proactive approach to supporting those likely to have stress or conflict complicating their grief.
- In all cases Duty of Candour is discussed where appropriate ensuring that the clinical teams make early contact with the families.
- The proportion of avoidable features identified has reduced over the years and is believed to be a marker of improved care supported by the following observations
 - HSMR has fallen across all hospital sites.
 - The Trust Mortality Review Group is not identifying issues missed by IMEG and supports the findings.
 - The introduction of IMEG dramatically reduced the number of complaints with care concerns that were not previously identified. This volume has not increased.
 - Junior Dr feedback suggests that the process has changed their practice and it is likely that care is improving as a consequence of IMEG. We additionally share learning with the teams but when relevant to the hospitals through OWL. However the direct hot feedback to the medical team is possibly the most powerful influence.
- All deaths which are required to be reported to HM Coroner are now referred electronically.

Appendix 1 **IMEG and mortality review process (Q1 – 2019/20)**

Appendix 2 **IMEG and mortality review process (Q2 – 2019/20)**

Appendix 3 **Paediatric mortality review process (CDAD) (Q1 – 2019/20)**

Appendix 4 **Paediatric mortality review process (CDAD) (Q2 – 2019/20)**

3 Data Analysis

In the Second quarter of this year, 541 deaths were reviewed at IMEG. This is slightly up from last year's Q2 but not a significant jump. All cases get assigned an initial avoidability rating and get adjusted if any changes are needed, however, all but 4 Urgent Case reviews, TMRG and M&M questions have been reviewed and avoidability scores have been update, showing 3 case, or 0.5% of the total number of deaths reviewed have been deemed as probably avoidable, 3 cases or 0.5

% are reported as having strong evidence of avoidability and no cases are deemed avoidable. The higher observed number of avoidable deaths in this quarter needs to continue to be monitored to see if it is part of a trend or simply a statistical cluster. The current severe clinical and financial pressures under which the trust is operating add to the necessity for the closely monitoring and seeing if this is an evolving trend.

On average the number of cases being sent to M&M meetings from Q1 has dropped, the cases being sent for TMRG review has slightly risen from last quarter. We have seen a significant increase of cases being sent for an urgent case review which again needs to be observed and to see if it is part of a trend or simply a statistical cluster.

Whilst there is no national requirement to report paediatric deaths at trust board level, it seems appropriate to demonstrate that we are providing a similar level of scrutiny for patients of all ages within the trust. We have therefore included details of the number of paediatric death reviews undertaken by the Child Death and Deterioration Group (CDAD).

All outstanding reviews for paediatric patients for Q1 2019/20 have been completed and the full details are set out below in appendix 3.

In the second quarter of the year 2019/20 there have been 7 paediatric deaths, none of these deaths have been deemed probably avoidable, strong evidence of avoidability nor definitely avoidable.

With both the rise in deaths in quarter 1 of the financial year 2019/20 compared with previous years, for both adult and paediatric cases, this can be seen as a natural rise in population and being a tertiary centre for many specialities we get the sickest patients and ultimately we will have a rise in mortality. Following trends from previous years, Q2 of the financial year 2019/20 we have seen a drop in overall deaths from the previous quarter, however this is still up to previous years. Saying this we can say that our HSMR is still below what is expected of us as a trust.

Limitation of this report a small number of cases remain outstanding for final grading as still within the SISG process. The Medical Examiners service is currently under staffed compared with the national expectation and recruitment to M.E and MEO posts is progressing slowly due to the delays in provision of funding for non-cremation deaths reviewed by the team which has made it impossible to provide the precise financial model to finalise our business case. The lack of a full complement of staff whilst providing a full service gives limited opportunity for data analysis and review of evolving trends.

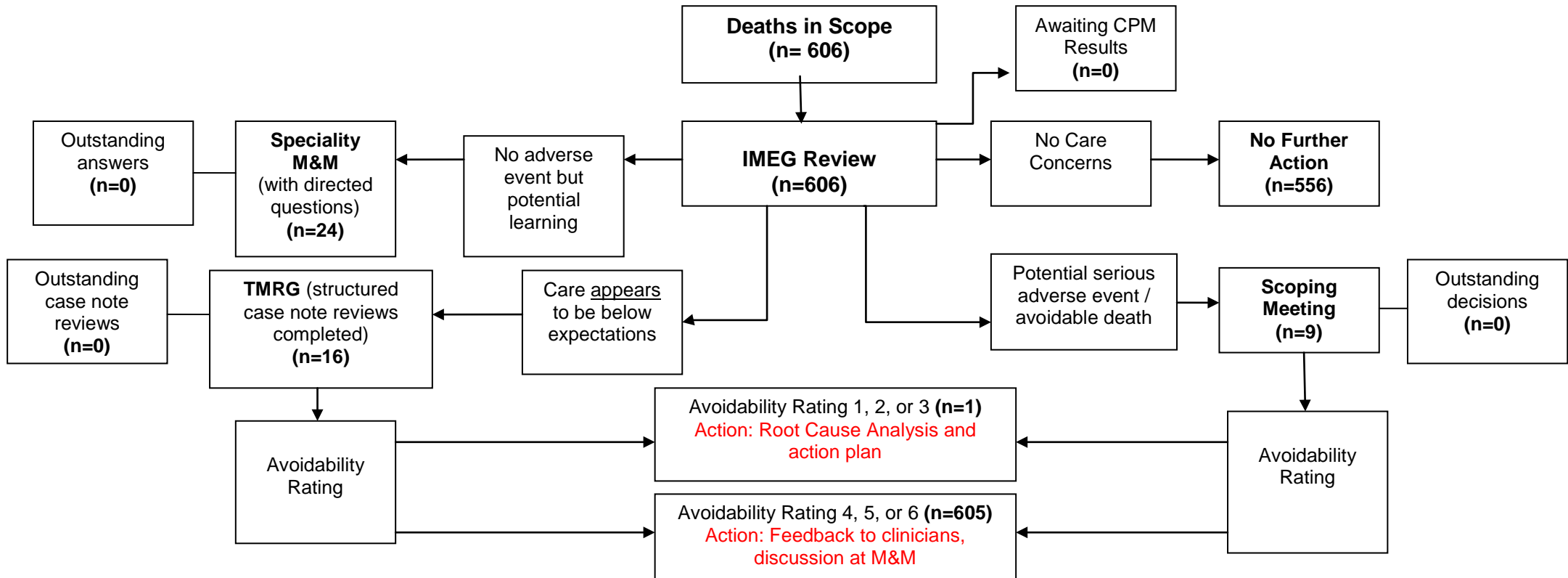
4 Next Steps

Introduction of a non-statutory Medical Examiner Service within acute hospital Trusts began on 1st April 2019. A business case has been prepared for the Trust's Medical Director setting out the requirements of delivering this service. The introduction of the new service has necessitated the Medical Examiner of the day spending greater time reviewing each case and, where applicable, completing cremation form 5. The income from this will be used to support the service. However, with this increased commitment, there has been a reduction in the number of Consultants able to undertake reviews and additional resource needs to be identified in order to ensure there is sufficient cover available every day and that this cover is sustainable. Over the next quarter we will aim to employ some administration support and look to streamline the service to improve on the turnover time and improve the quality of scrutiny for each case.

We will continue to work with partners. The process has been shared and adopted by Solent and we are looking at joint learning and will look to support and move investigations with other providers.

Appendix 1

IMEG and mortality review process (Q1 – 2019/20)



Avoidability Rating (non-LeDeR deaths)

1. Definitely avoidable = 0
2. Strong evidence of avoidability = 0
3. Probably avoidable (more than 50:50) = 1
4. Possibly avoidable, but not very likely (< 50:50) = 5
5. Slight evidence of avoidability = 23
6. Definitely not avoidable = 576

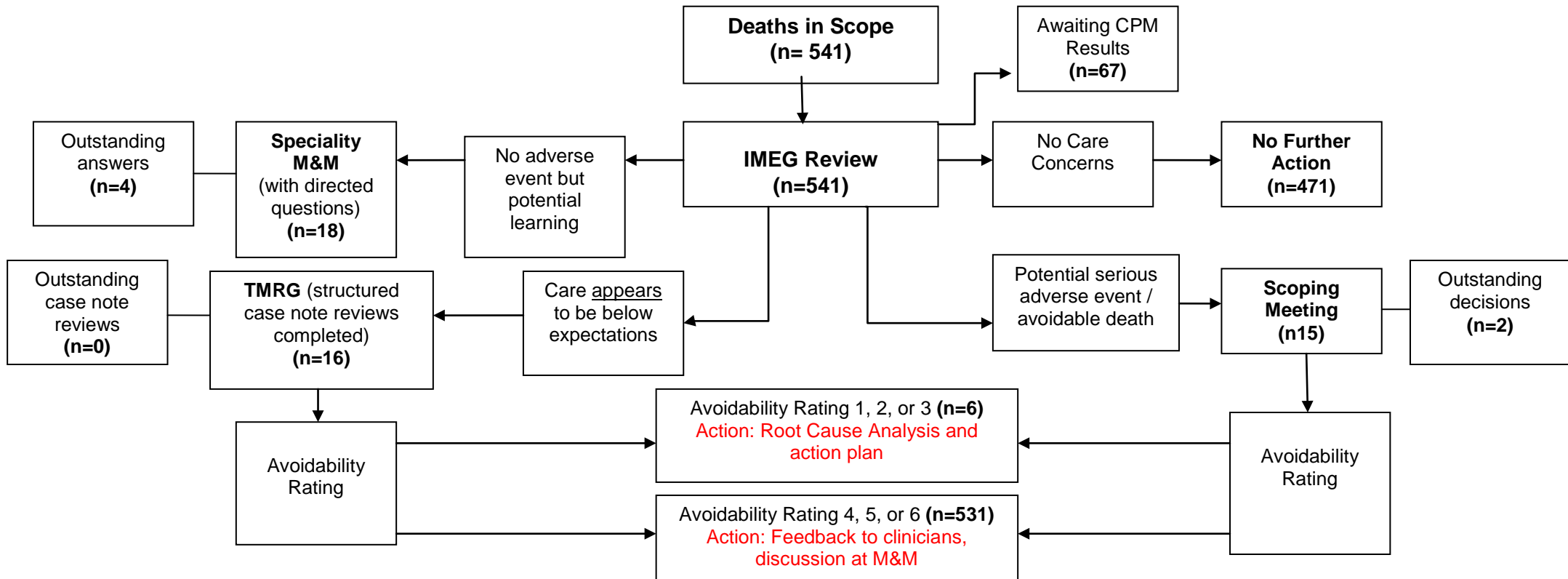
LeDeR deaths

Total LeDeR deaths = 1 (all cases subject to additional review captured within 'scoping' data)

Avoidability Rating - 6

Appendix 2

IMEG and mortality review process (Q2 - 2019/20)



Avoidability Rating (non-LeDeR deaths)

1. Definitely avoidable = 0
2. Strong evidence of avoidability = 3
3. Probably avoidable (more than 50:50) = 3
4. Possibly avoidable, but not very likely (< 50:50) = 3
5. Slight evidence of avoidability = 12
6. Definitely not avoidable = 514

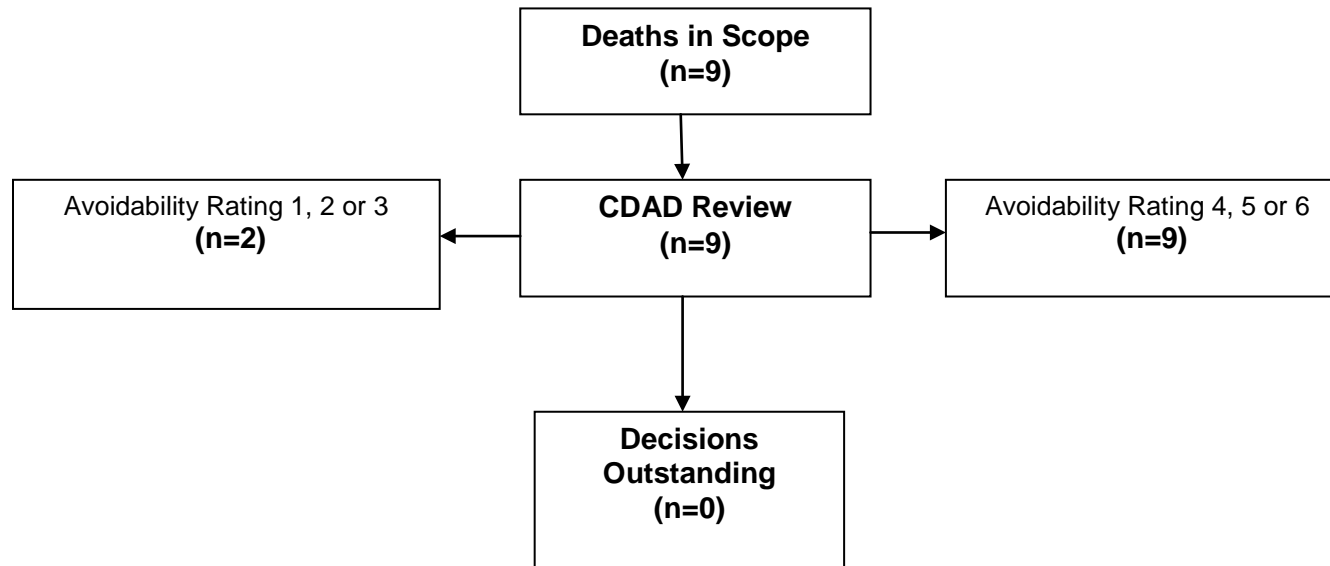
***NB. There are 4 unscored cases at present**

LeDeR deaths

Total LeDeR deaths = 1 (all cases subject to additional review captured within 'scoping' data)

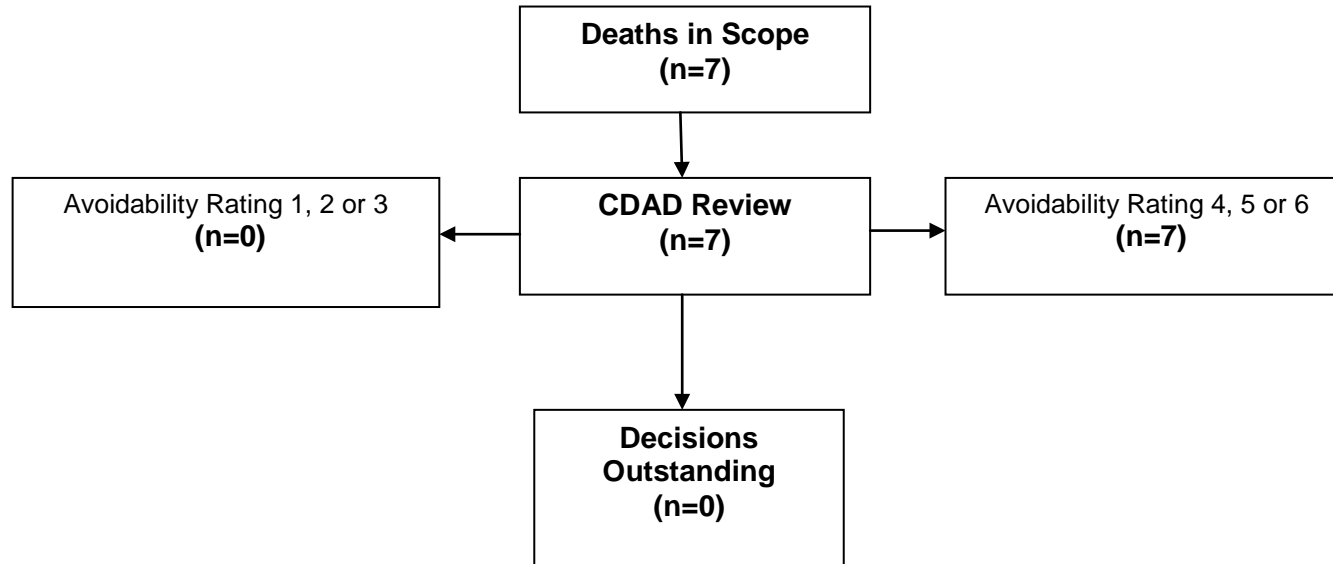
Avoidability Rating – 6

Paediatric mortality review process (CDAD) (Q1 – 2019/20)



<u>Avoidability Rating</u>	<u>Avoidability Rating</u>
1.	Definitely avoidable = 0
2.	Strong evidence of avoidability = 0
3.	Probably avoidably (more than 50:50) = 0
4.	Possible avoidable, but not very likely (<50:50) = 2
5.	Slight evidence of avoidability = 5
6.	Definitely not avoidable = 2

Paediatric mortality review process (CDAD) (Q2 - 2019/20)



Avoidability Rating Avoidability Rating

1. Definitely avoidable = 0
2. Strong evidence of avoidability = 0
3. Probably avoidably (more than 50:50) = 0
4. Possible avoidable, but not very likely (<50:50) = 2
5. Slight evidence of avoidability = 3
6. Definitely not avoidable = 2

Report to the Trust Board of Directors dated Thursday, 28 November 2019			
Title: CRN Wessex 2019-20 Quarter 2 Performance Report			
Category	Quality, Performance, and Finance		
Agenda item	9.2		
Sponsor	Medical Director		
Author	Graham Halls, Business Intelligence Manager and Rebecca McKay, Chief Operating Officer		
Provenance	Q1 2019-20 report submitted at the UHS Board meeting on 26 September 2019		
Classification	This Report is unclassified.		
Purpose and recommendation	<p>The paper is presented for INFORMATION.</p> <p>Summary:</p> <p>The report sets out the National Institute for Health Research Clinical Research Network Wessex (NIHR CRN Wessex) performance for the period 1 April 2019 to 30 September 2019 unless otherwise stated.</p> <p>Key achievements / issues:</p> <ul style="list-style-type: none"> In Q1 & 2 2019/20 CRN Wessex was 28 percent below the recruitment target agreed with the NIHR and 38 percent below the same period on 2018/19. All LCRNs have experienced a fall in recruitment with an average reduction of 28 percent (chart 2b). Over 750 participants have been enrolled on to DeNDRoN managed studies, exceeding the NIHR target for Wessex in 2019/20 12 of the 30 specialties were ranked in the top five LCRNs for recruitment weighted for the local population <p>Recommendation:</p> <ul style="list-style-type: none"> Monitor activity and performance via quarterly progress reports and the agreed assurance framework in appendix 1 		
Relevant strategic goals	✓ Goal 1: Improving patient journeys.	✓ Goal 2: Delivering value-based health and care.	✓ Goal 3: Supporting healthy lives.
	✓ Goal 4: Building an expert and inclusive workforce.	✓ Goal 5: Being agile in meeting people's needs.	✓ Goal 6: Creating leading-edge research, education, and innovation.
Assurance framework links	<p>The CRN Wessex UHS board assurance framework is included in appendix one to this report. The performance of CRN Wessex partner organisations also impacts the following Board Assurance Framework entries:</p> <ul style="list-style-type: none"> BAF01 – Inability to develop partnerships and redesign services innovatively renders the Trust unable to meet the expectations of the NHS long term plan, our strategic plan, and sustainable elective and non-elective pathways 		

	<ul style="list-style-type: none"> BAF010 – Inability to offer translational research renders the Trust unable to maintain its cutting-edge teaching hospital status
Impact assessments	<p>What impact have you assessed through conducting an impact assessment, if applicable (e.g. equality, quality, finance, Data Protection, etc.)</p> <p>This may not be “n/a” or “none”</p>
Other standards affected	CQC Well-led Framework (for research)

1. Introduction or Background

- 1.1 University Hospital Southampton NHS Foundation Trust (UHS) hold a contract with the Department of Health and Social Care to host the local clinical research network – CRN Wessex. The purpose of CRN Wessex is to provide an efficient and effective support to the partner organisations for the initiation and delivery of funded research in the NHS. Some of the research is funded by the National Institute for Health Research (NIHR), but most is funded by NHS non-commercial partners and industry. This activity makes an important contribution to improve the health of the population and to support economic growth.
- 1.2 CRN Wessex aims to:
- 1.2.1 Promote equality of access, ensuring that wherever possible, patients have parity of opportunity to participate in research
- 1.2.2 Improve the quality, speed and co-ordination of clinical research by removing the barriers to research in the NHS
- 1.2.3 Streamline and performance manage NHS support for eligible studies to ensure the NHS service support costs of these studies are met in a timely and efficient manner.

2. Analysis and Discussion

- 2.1 Local Clinical Research Network (LCRN) performance is primarily measured on the number of research participants enrolled on to NIHR portfolio research projects within each region. Research recruitment represents opportunities for the population to take part in research that the NIHR considers high quality. Research can also be a source of funding for participating organisations and the wider NHS.
- 2.2 Chart one provides a summary of CRN Wessex’s current performance against the NIHR’s CRN high level objectives for the 2019/20 financial year (quarters 1-2).
- 2.3 Recruitment within Wessex was 28 percent below the year to date target agreed with the NIHR (chart 2a). When compared to the same period last year recruitment has dropped by 38 percent. It should however be recognised that 2018/19 was CRN Wessex’s most successful year. If performance in the first two quarters were to continue predicted year end recruitment would be 31,512, 28 percent below the annual target for high level objective 1a.
- 2.4 Recruitment on to commercially sponsored and funded studies was 46 percent below the year to date target (chart one) and therefore Wessex was not meeting high level objective 1b.
- 2.5 All LCRNs have experienced a fall in recruitment with an average fall of 28 percent (chart 2b). A clear reason has not been identified for this however the NIHR coordinating centre are investigating reductions in both the number of studies entering the portfolio and a general trend downwards in study sample size.

High Level Objective		Target	CRN Wessex	National status	
HLO 1	Deliver significant levels of participation in NIHR CRN Portfolio studies	(a) All studies	43,479	15,756	Red
		(b) Commercial only	2,000	535	Red
HLO 2	Increase the proportion of studies delivering to recruitment target and time	(a) Commercial RTT (number of participating sites)	80%	67%	Amber
		(b) Non-Commercial RTT (number of Wessex led studies)	80%	92%	Green
HLO 3	Number of commercial studies recruiting in year (cumulative)	(a) Number of new commercial contract studies entering the NIHR CRN Portfolio	750 (National target)	7 (not locally measured)	Amber
HLO 4&5	<i>Replaced by HLO 9 in 2019/20</i>				
HLO 6	Widen participation in research by enabling the involvement of a range of health and social care providers	(a) Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio studies	99%	92%	Green
		(b) Proportion of NHS Trusts recruiting each year into NIHR CRN Portfolio studies (commercial only)	70%	83%	Amber
		(c) Proportion of General Medical Practices recruiting each year into NIHR CRN Portfolio studies	45%	23% (64 sites)	Red
		(d) Number of non-NHS sites recruiting into NIHR CRN Portfolio studies	2,000 (National target)	11 (not locally measured)	Red
HLO 7	Deliver significant levels of participation in NIHR CRN Portfolio Dementias and Neurodegeneration (DeNDRoN) studies	Number of participants recruited into Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio	688 (2019/20)	755	Red
HLO 8	Demonstrate to people taking part in health and social care research that their contribution is valued.	Number of NIHR CRN Portfolio study participants responding to the Patient Research Experience Survey each year.	TBC	Surveys will be distributed in Nov 2019	Surveys not yet distributed at all LCRNs
HLO 9	Reduce study site set-up times for NIHR CRN Portfolio studies by 5%	(a) Median study site set-up time for commercial contract studies, at confirmed Network sites	80 days	59 days	Green
		(b) Median study site set-up time for non-commercial studies	60 days	58 days	Green

Chart 1: Performance against NIHR Higher Level Objectives in Wessex 2019/20 Q1-2

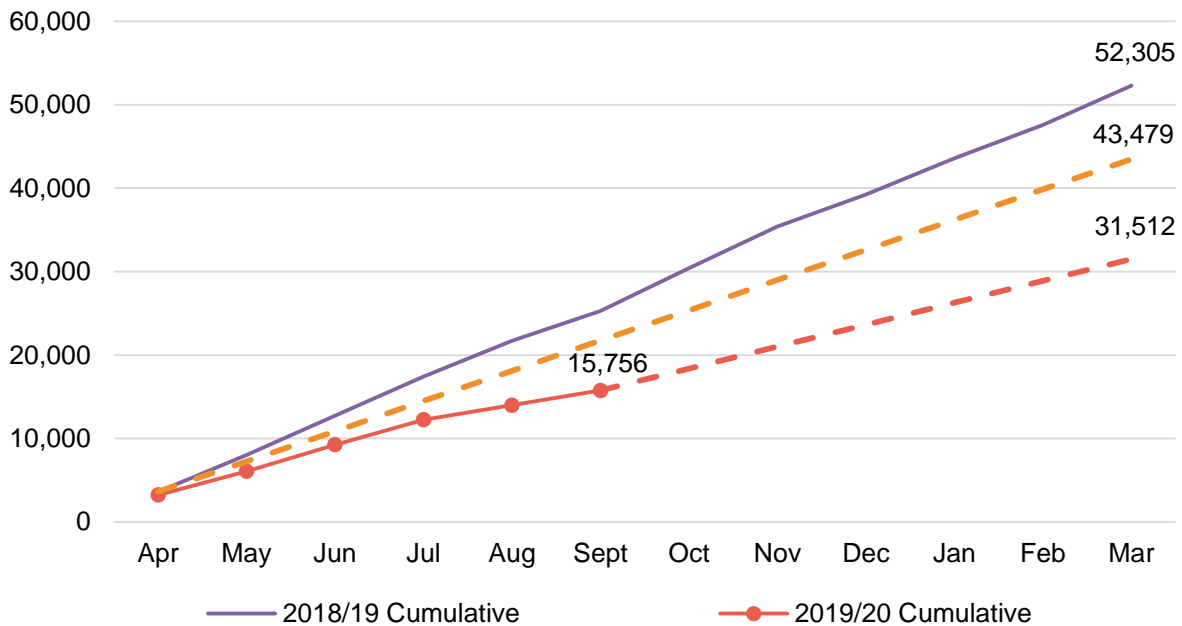
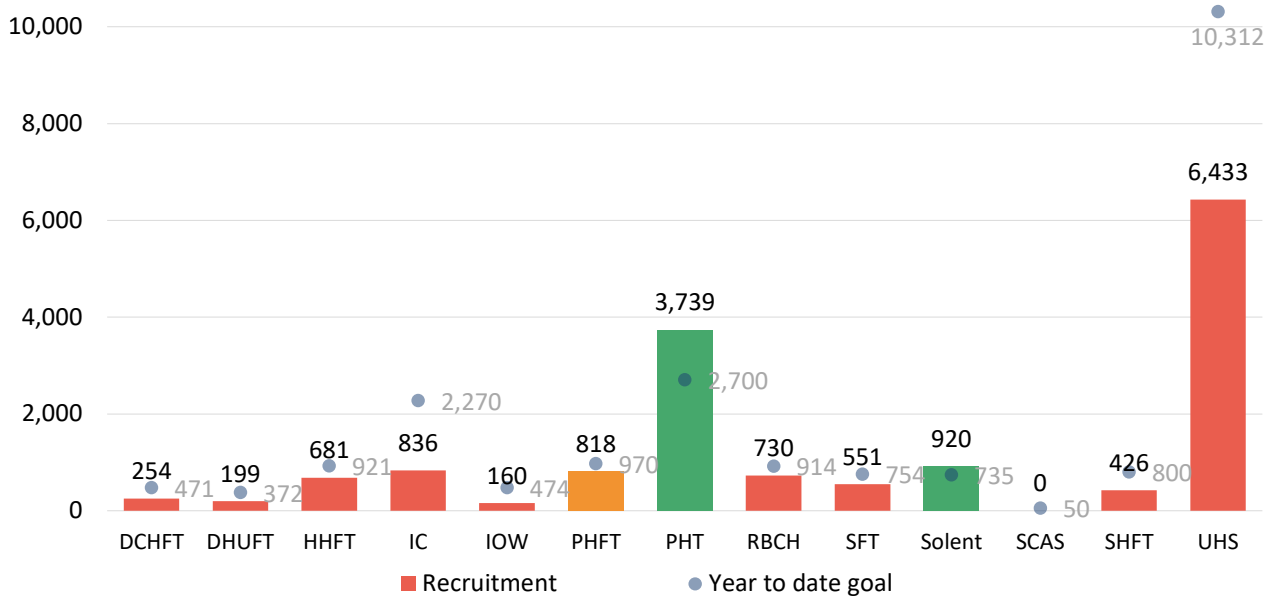


Chart 2a: Wessex recruitment against target – NIHR high level objective 1 – 2019/20 Q1-2

Network	2018/19 (Q1-2)	2019/20 (Q1-2)	Variance
East Midlands	34,365	23,864	-31%
Eastern	26,630	15,332	-42%
Greater Manchester	42,344	25,073	-41%
Kent, Surrey and Sussex	22,043	19,690	-11%
North East and North Cumbria	22,841	12,988	-43%
North Thames	41,846	28,823	-31%
North West Coast	18,983	13,277	-30%
North West London	21,542	13,042	-39%
South London	46,014	40,709	-12%
South West Peninsula	14,517	10,574	-27%
Thames Valley and South Midlands	30,473	28,120	-8%
Wessex	25,281	15,756	-38%
West Midlands	35,147	32,811	-7%
West of England	13,773	11,011	-20%
Yorkshire and Humber	49,384	28,234	-43%
Total	445,183	319,339	-28%

Chart 2b: Recruitment by local clinical research network – 2019/20 Q1-2

- 2.6 Recruitment to time and to target on commercial funded and sponsored study sites (those that closed in quarter one & two) was below the national target, which is for 80 percent of sites to achieve the measure. This objective along with high level objectives 1a and 2b directly affect the network’s future funding, with 15 percent of the model dependent on both the performance and volume of studies meeting these objectives.
- 2.7 CRN Wessex sites were meeting the median study set-up time targets set by the NIHR (HLO 9). These targets represent a five percent reduction on the national median set-up times for commercial and non-commercial studies in 2018/19. The non-commercial target has recently reduced from 62 to 60 days and as a result CRN Wessex are at risk of exceeding it, with a current median setup time of 58 days.
- 2.8 The performance of CRN Wessex partner organisations against their year to date recruitment goals is shown in chart three. The performance is red / amber / green rated depending on whether the organisation is achieving their goal (green), within 20% (amber) or not currently meeting the goal (red). All but two organisations are not meeting their goal, and this is in line with the network’s collective performance.



IC = Independent Contractors refers to, but is not exclusive to; GP Surgeries, pharmacies, private healthcare providers.

Chart 3: Recruitment by partner organisation in Wessex against target - 2019/20 Q1-2

- 2.9 Of the six NIHR clinical research network divisions (see glossary for further information) three were either above or within 20 percent of their year to date recruitment target (chart four).

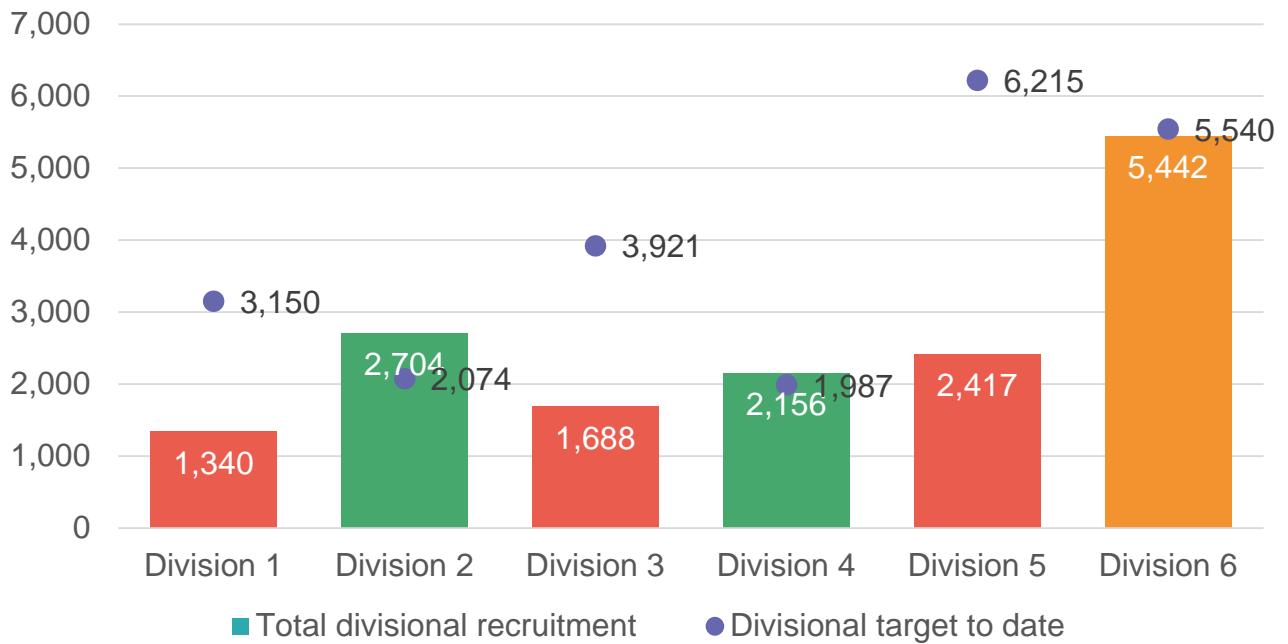


Chart 4: Recruitment by NIHR Division in Wessex against target - 2019/20 Q1-2

2.10 CRN Wessex recruitment performance is benchmarked against the other LCRNs on a range of measures. Charts 5a-c show the network's rank for unweighted, population weighted and complexity weighted recruitment. CRN Wessex normally ranks in the top ten LCRNs, indicating the network's partner organisations reach more of the local population with research opportunities that may have a positive impact on their care. The glossary contains further information on complexity weighting.

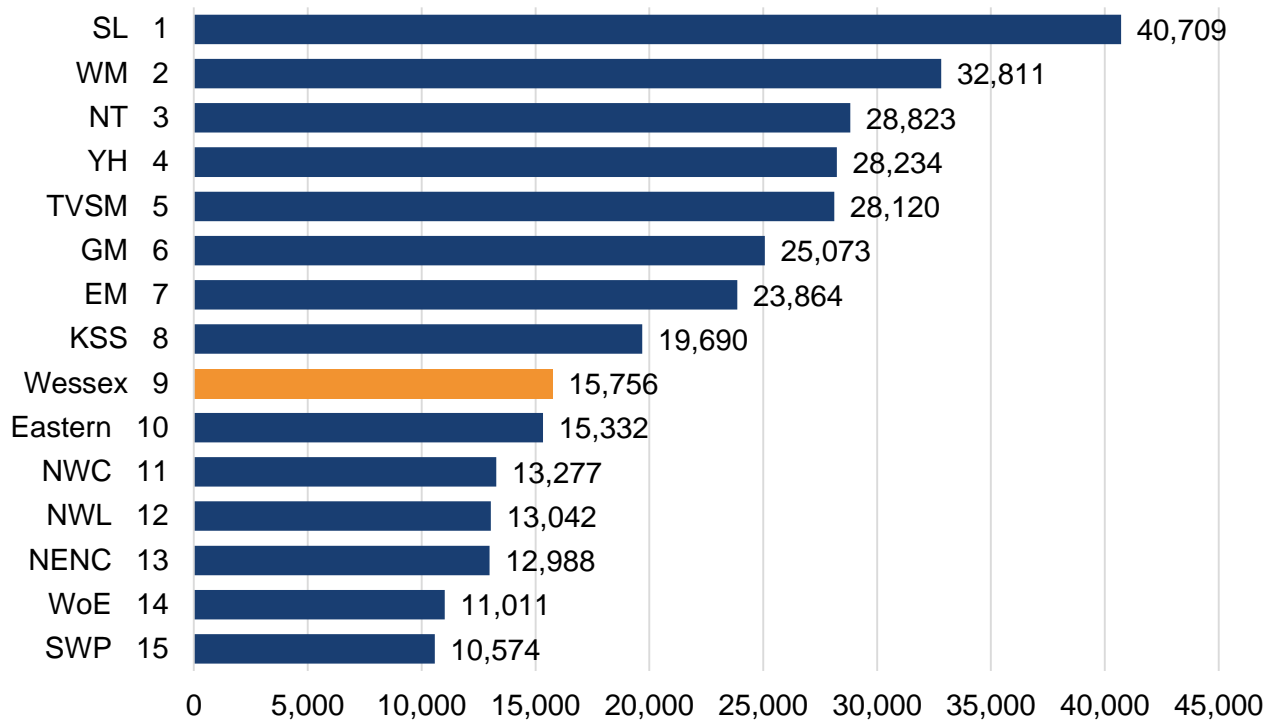


Chart 5a: Comparison of recruitment by LCRN - 2019/20 Q1-2

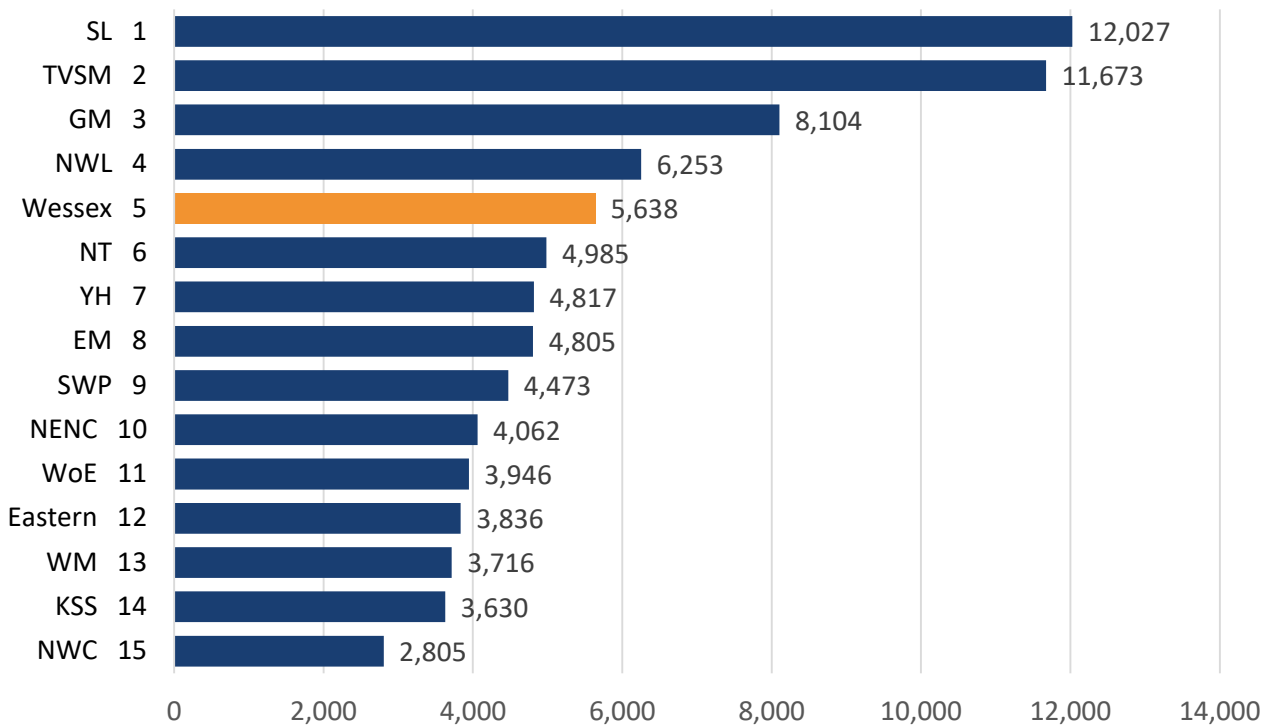


Chart 5b: Comparison of recruitment by LCRN weighted for local population - 2019/20 Q1-2

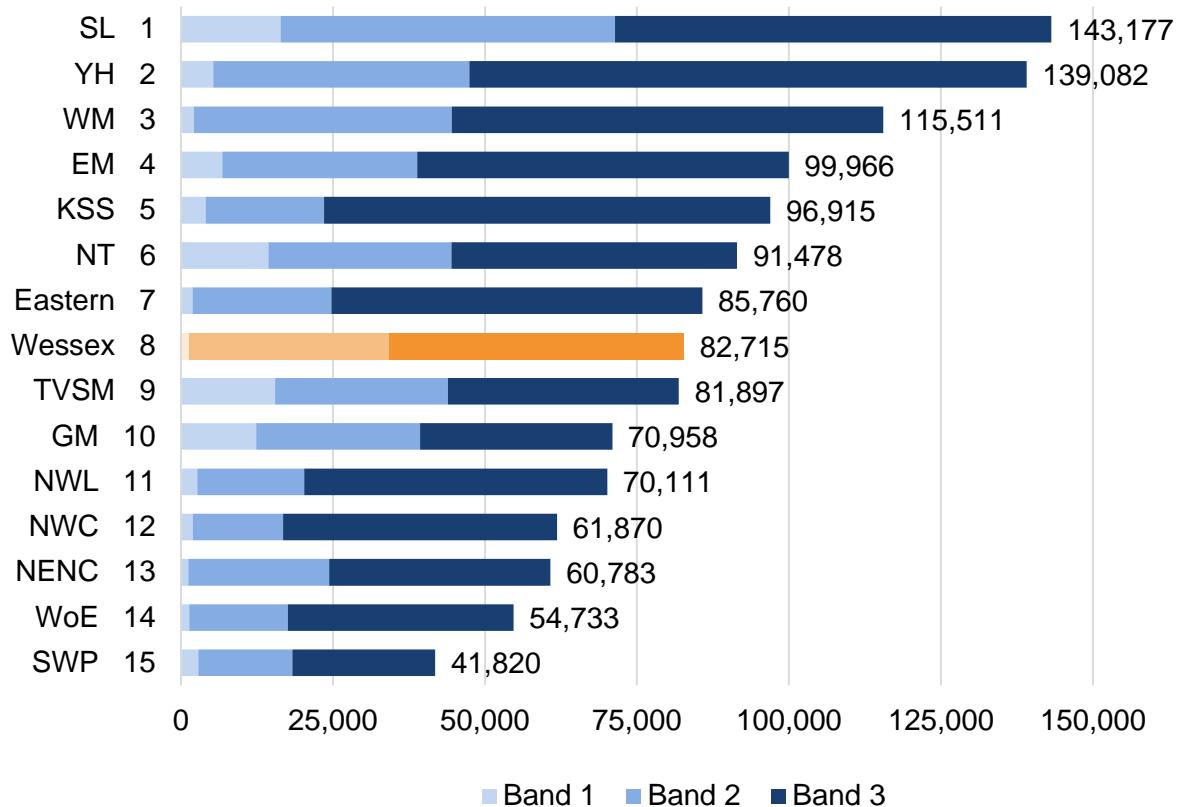


Chart 5c: Comparison of recruitment weighted by complexity by LCRN - 2019/20 Q1-2

2.11 Eight specialties are ranked in the top five for recruitment when compared to the 14 other LCRNs (chart six). This increases to 12 when the size of the population in each region is considered and 11 for complexity weighted recruitment.

Specialty	LCRN Rank (Recruitment)	LCRN Rank (Population Weighted)	LCRN Rank (Complexity Weighted)
Ageing	9	9	8
Anaesthesia, Perioperative Medicine and Pain Management	11	8	4
Cancer	7	7	10
Cardiovascular Disease	3	2	2
Children	7	6	5
Critical Care	5	5	6
Dementias and Neurodegeneration	5	3	7
Dermatology	4	4	4
Diabetes	13	10	13
Ear, Nose and Throat	7	3	4
Gastroenterology	9	8	7
Genetics	9	5	9
Haematology	7	6	5
Health Services Research	11	12	11
Hepatology	7	5	6
Infection	11	7	6
Mental Health	14	13	14
Metabolic and Endocrine Disorders	15	13	11
Musculoskeletal Disorders	9	6	9
Neurological Disorders	1	1	2
Ophthalmology	8	6	8
Oral and Dental Health	6	4	4
Primary Care	9	9	9
Public Health	3	2	3
Renal Disorders	10	8	10
Reproductive Health and Childbirth	10	10	10
Respiratory Disorders	1	1	1
Stroke	11	7	12
Surgery	4	2	5
Trauma and Emergency Care	14	12	15

Chart 6: Comparison of Wessex unweighted, population and complexity weighted recruitment LCRN rank by specialty - 2019/20 Q1-2. Red: position 11-15, amber: 6-10 and green 1-5.

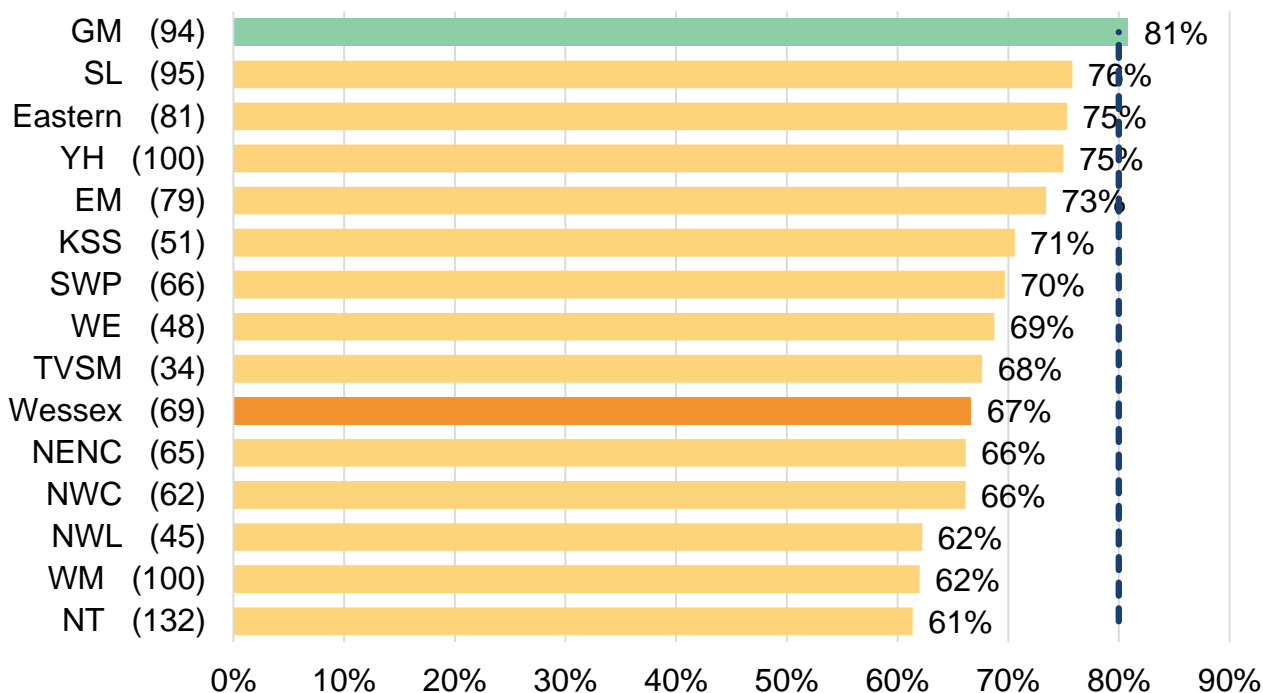


Chart 7: Percentage of sites recruiting to time and to target on closed commercial study sites - 2019/20 Q1-2

2.12 67 percent of sites in CRN Wessex closed having recruited to target and within their allocated time on commercial studies (chart seven). This will continue to be monitored closely in 2019/20 using a recently updated commercial section of the CRN Wessex open data platform and reported back to the executive and partnership groups.

3. Conclusion

3.1 The shortfall in recruitment represents a financial risk to CRN Wessex. 20 percent of the NIHR funding model (informing the allocation for 2021/22) is reliant on strong performance for high level objectives 1, 2a, 2b, along with the NIHR's harmonised specialty objectives. Actions taken by CRN Wessex as a result are detailed in section four.

3.2 The UHS Board will be updated on progress in 2019/20 with quarterly performance reports and issues escalated via the assurance framework in appendix 2.

4. Recommendation

4.1 In September all partner organisations received a letter from CRN Wessex detailing the network's gap in recruitment against the NIHR target. Within the letter there were recommended studies to consider opening, or if already active to allocate resources to them. CRN Wessex partner organisations have asked to consider prioritising this list, as well as any locally led projects the network are not yet aware of.

4.2 In November the CRN Wessex partnership group, which consists of board-level representatives from partner organisations, agreed to adopt an incentivisation model intended to improve performance on the aforementioned high level objectives. Funding in 2020/21 to partner organisations will in part reflect their success against high level objectives 1, 2a and 2b.

4.3 Monitor activity and performance via quarterly progress reports and the agreed assurance framework in appendix 1

5. Appendices

5.1 Appendix 1 - CRN Wessex assurance framework

Meetings ¹	Reports ²	Other
1:1 Executive Partnership	Performance Finance Annual Patient survey	Internal finance audit Benchmarking National review Risk register Business planning Performance reviews

1:1 meetings

CRN Wessex chief operating officer meets with host executive with responsibility for host contract quarterly.

Executive group meetings

CRN Wessex executive group meets monthly.

Partnership group meeting

CRN Wessex group meets three times a year in April, October and January.

Performance report

CRN Wessex provides a quarterly performance report to the host board.

Finance report

CRN Wessex provides as quarterly finance report to the host assistant director of finance.

Annual report

CRN Wessex collaborates with partner organisations to collate an annual report that is submitted to the host for approval and then the NIHR CRN CC.

Patient survey report

The network conducts an annual survey of patients participating in research. The survey engages with and asks patients about their experiences of taking part in clinical research provides research professionals with a wealth of information which helps to shape how research is designed, conducted and delivered.

Internal finance audit

Every three years, with the most recent audit in December 2018.

¹ All governance groups have been convened in accordance with the NIHR CRN CC Performance and operating framework with terms of reference

² All reports are submitted using agreed standard templates

Benchmarking

CRN Wessex has an open data platform that provides real time bench marking data. These data are reported to the executive group, partnership group and host board.

Review

CRN Wessex has a review meeting every six months with NIHR CRNCC attended by clinical director, chief operating officer, executive from host with responsibility for the contract and partnership group chair.

Risk register

The register forms part of the host's register and is reviewed every six months

Business planning

Formal 1:1 business review and planning meeting with partner organisations annually.
Ongoing informal performance reviews with members of the CRN Wessex Operational Management Group.

5.2 Appendix 2 – Glossary

Ratios used for weighting complexity of recruitment (non-commercial recruitment only):

- Band 1 - Large Scale interventional or observation studies with a >10,000 participant target (1:1)
- Band 2 - Observational design (1:3.5)
- Band 3 - Interventional design studies (1:11)

Partner organisation abbreviations used by CRN Wessex:

- DCHFT – Dorset County Hospital NHS Foundation Trust
- DHUFT - Dorset Healthcare University NHS Foundation Trust
- HHFT - Hampshire Hospitals NHS Foundation Trust
- IOW - Isle of Wight NHS Trust
- IC – Independent contractors, including but not limited to primary care and non-NHS organisations
- PHFT - Poole Hospital NHS Foundation Trust
- PHT - Portsmouth Hospitals NHS Trust
- SFT - Salisbury NHS Foundation Trust
- Solent – Solent NHS Trust
- SCAS - South Central Ambulance Service NHS Foundation Trust
- SHFT - Southern Health NHS Foundation Trust
- RBCH - The Royal Bournemouth And Christchurch Hospitals NHS Foundation Trust
- UHS - University Hospital Southampton NHS Foundation Trust