University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	26/11/2020
Time	9:00 - 12:30
Location	Microsoft Teams
Chair	Peter Hollins
Observing	Val Sevier, CQC Inspector and Mental Health Advocate

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		**Patient Story** To receive feedback from patients, carers, or other stakeholders about their experience of the Trust's services.
3		**QUALITY, PERFORMANCE and FINANCE**
3.1	9:15	**Briefing from Chair of Finance & Investment Committee (Oral)** Jane Bailey, Chair
3.2	9:20	**Briefing from Chair of People & Organisational Development Committee (Oral)** Jane Harwood, Chair
3.3	9:25	**Briefing from Chair of Quality Committee (Oral)** Tim Peachey, Chair
3.4	9:30	**Freedom to Speak Up Report** Sponsor: Gail Byrne, Chief Nursing Officer Attendee: Christine Mbabazi, Equality & Inclusion Adviser/Freedom to Speak Up Guardian
3.5	9:45	**Annual Ward Staffing Nursing Establishment Review** Sponsor: Gail Byrne, Chief Nursing Officer Attendee: Rosemary Chable, Deputy Director of Nursing, Education & Workforce
3.6	10:00	**Revised Infection Prevention and Control Board Assurance Framework** Sponsor: Gail Byrne, Chief Nursing Officer Attendee: Nitin Mahobia, Director of Infection Prevention Unit/Julie Brooks, Head of Infection Prevention Unit
3.7	10:10	**Integrated Performance Report for Month 7** To review the Trust's performance as reported in the Integrated Performance Report Sponsor: David French, Interim Chief Executive Officer

3.8 **Inpatient Flow - Medical Optimised for Discharge Update**

10:50 Sponsor: Joe Teape, Chief Operating Officer

3.9 **Corporate Objectives 2020-21 Quarter 2 Update**

11:05 Sponsor: David French, Interim Chief Executive Officer

3.10 **Finance Report for Month 7**

11:15 Sponsor: Ian Howard, Interim Chief Financial Officer

4 **CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL**

4.1 **Register of Seals, and Chair's Actions**

11:30 In compliance with the Trust Standing Orders, Financial Instructions, and the Scheme of Reservation and Delegation.
Sponsor: Peter Hollins, Trust Chair

4.2 **Trust Board Committees Terms of Reference**

11:35
i) Finance & Investment Committee
ii) Remuneration & Appointment Committee

Sponsor: Peter Hollins, Trust Chair
Attendee: Karen Flaherty, Associate Director of Corporate Affairs & Company Secretary

4.3 **Board Assurance Framework (BAF)**

11:50 Sponsor: Gail Byrne, Chief Nursing Officer
Attendee: Karen Flaherty, Associate Director Corporate Affairs & Company Secretary

5 **Any other Business**

12:05 To raise any relevant or urgent matters that are not on the agenda

6 **To note the date of the next meeting: 28 January 2021**

7 **Items circulated to the Board for reading**

7.1 **CRN: Wessex 2020/21 Quarter 2 Performance Report**

Sponsor: Derek Sandeman, Chief Medical Officer

8 **Follow-up discussion with Governors**

12:15

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors dated 26 November 2020				
Title:	**Freedom to Speak Up Report**			
Agenda item:	**3.4**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Christine Mbabazi (Freedom to Speak Up Guardian)**			
Date:	**26 November 2020**			
Purpose	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **x**
Issue to be addressed:	The paper is presented for the Board to Note. To provide an update on the Freedom to Speak Up (FTSU) agenda and report on the number of cases received by the Trust.			
Response to the issue:	Trust Board is asked to: • Note the number of FTSU cases received to date. • Note the actions taken from the concerns raised.			
Implications: (Clinical, Organisational, Governance, Legal?)	FTSU is one mechanism to support boards to create a culture where workers feel safe and able to speak up about anything that gets in the way of delivering safe, high quality care or affects their experience in the workplace. This includes matters related to patient safety, the quality of care, and cultures of bullying and harassment.			
Risks: (Top 3) of carrying out the change / or not:	NA			
Summary: Conclusion and/or recommendation	There has been an increase in cases in the period from May to November 2020. 30 cases alone have been received in October and most are still in the process of investigation. This increase is likely to have been due to a publicity campaign in October encouraging staff to raise concerns and the impact on staff of Covid age risk assessments and updated pregnancy guidance for working during the pandemic.			

1 Executive Summary

This is an update following the last report written in May that focussed on the concerns raised during the pandemic. This updates reflects that we are now in a second wave of the pandemic. In the last report the Trust received 13 cases from 9th March to 19th May 2020.

Since then the Trust has received 50 cases from 22nd May to 18th November 2020. 30 cases alone have been received in October and most are still in the process of investigation. This increase is likely to have been due to a publicity campaign in October encouraging staff to raise concerns and the letters written to all BAME and staff with Long term illness and disability. These letters came from the Chief People Officer to provide assurance to staff about measures being taken to protect their safety at work and to signpost to support available during Covid.

2 Purpose/Context/Introduction

The purpose of this report is to update Trust Board on the FTSU cases received by the Trust and the actions taken to resolve the concerns.

3. Case Update

The Trust has received 50 FTSU cases from 22nd May to 18th November 2020. A summary of the cases received in the period are detailed in the table below:

Category	Covid Concerns	Other	Total
Allocation of resources	0	1	1
Bullying and Harassment	0	22	22
Pregnancy and Covid risk assessments	13	0	13
Anonymous letters and calls	0	3	3
Other concerns raised	0	11	11
Total	13	37	50

It should be noted that, following guidance from NHS Improvement and the national FTSU office, a wide definition of what constitutes a 'FTSU case' is used by the Trust. Emphasis is placed on creating a culture of openness where staff feel able to raise any matter that they are concerned about, rather than whether it fits within a defined category of concern.

4. Concerns raised and Actions that have been taken.

1. **Allocation of resources:** Concerns have been raised by some members of a clinical team who felt that they received insufficient and inequitable staff and resources compared to other teams that provide an equivalent service. They felt the lack of resources had led to delays in treatments and care of particular patients causing them harm. Furthermore there were concerns regarding the treatment of Ethnic minorities in the team. Details of the patients were passed to the Patient safety team who investigated the cases identified at a scoping meeting and have concluded that no harm had been caused due to the lack of resources, During the investigation it was identified that one patient's delay was dependent on the patient's declining to attend.. Investigations regarding the perceived insufficient staff and resources are still on going with results, recommendations and lessons learnt due to complete by the end of November 2020.**Bullying and Harassment:** Some people raised concerns about being bullied and harassed in teams by colleagues and some line managers. Some bullying in particular departments is cultural or tribal where people from the same communities are accused of bullying one another. In some cases this has been alleged to have been going on for a very long time (years). This is currently under investigation. Bullying, harassing and discrimination

category remains the highest number of concerns received in any quarter in most Trusts. This has been because people feel safe to raise these with Guardians knowing there are protected with the added advantage of confidentiality giving them the confidence to speak up about a bullying culture.

2. **Pregnancy and Covid Risk Assessments:** The hospital changed ways of working in order to adapt to covid19 pandemic. These adaptations led to some staff raising concerns. The concerns raised were as follows:

   - **Pregnancy:** At the beginning of the pandemic pregnant women were added to the vulnerable group, however new research shows there is no evidence that pregnant women are more likely to get seriously ill from coronavirus but pregnant women have been included in the list of people at moderate risk (clinically vulnerable) as a precaution. This has led to changes in the risk assessments given to pregnant women in some cases from highly vulnerable to vulnerable which would be in occupational health terms from level 3 (you must stay at home) to level 2 (you can work with particular limitations).

     This has led to a rising number of concerns where by people feel they are not being treated as individuals and are not being heard, hence contacting the Guardian to be able to have their concerns listened to. In most cases they have contacted their managers who have followed the general guidelines but not focused on the individual needs of their staff. Occupational Health and HR have resolved these cases with particular arrangements on a case by case basis. In some cases redeployment has been the answer, others working from home has been the solution.

   - **Covid risk assessments and Covid age**: A number of concerns have been raised relating to risk assessments. Some feel unsafe to come back to work after shielding in clinical areas due to underlying conditions, high BMI, ethnicity and other risk factors of Covid-19. Despite assurances based on scientific information, some staff remain fearful of the consequences of catching Covid-19. People who have raised concerns were of afraid of dying due to their susceptibility to Covid-19 despite the different measures the hospital has put in place to keep them safe from harm. Redeployment, counselling and other psychological help has been provided which has resolved some cases; others are still in the process.

3. **Working and rostering practices:** Anonymous letters were written to the CEO (Paula Head) and the Guardian, as well as phone calls regarding a particular department. Staff alleged that they were working erratic shift patterns with those working 30hrs or more most affected leading to anxiety, exhaustion, lack of work-life balance, high sickness rates and burnout. There was concern that shifts were not released in advance, weekend working was not evenly distributed and staff were frightened to engage with Eroster creators, managers and matrons for fear of repercussions. The staff that raised the concern worried this might affect patient safety.

   An investigation was conducted with clear terms of reference addressing the issues that had been raised by the anonymous letters and calls. An independent specialist in shift patterns was appointed to investigate, the Freedom to speak up champion in the department sent out an anonymous survey to learn and hear from the group of people in the department. A high number of people completed the survey giving the investigation more insight on what is actually happening and what staff were experiencing.

   The investigation concluded that:

- The Eroster team are approachable and they have an auditable trail of communications and positive feedback from the survey highlighting positive feelings. The audit and interviews with the Eroster team highlights their willingness to flex and change the roster where possible. There is a log of flexible working policies which are regularly reviewed and used as basis to develop the roster.

- There is good evidence in the form of an auditable trail of communications between staff and the team about requests and largely the requests are granted where the service needs allow. The survey highlights that most staff used their allocated requests and that these were granted, 5 staff did not feel able to raise concerns.
- There is evidence that staff are allocated 2 rest days after nights in line with the Rostering Policy. However there is very little difference between the clinical activity between days and nights so 3 days may be more appropriate.
- There was evidence staff were working unequal hours over a 2 week roster but this was not reported to be a global problem or practice that was out of the ordinary across other Trust rosters.
- The roster is regularly delivered 7 weeks ahead of time rather than 8 weeks. The investigation offers a number of practical solutions that could be implemented to support the roster team to deliver on time.
- The roster was not compliant in some technical details which would be largely fixed if the roster was saved at the point of release and all the team rosters were run as one roster. This will be taken forward in the action plan
- The roster investigation highlighted that the Christmas ballot process considers previous work patterns over Christmas and New Year. The process was shared with HR prior to its implementation and deemed to be fair. However, it was highlighted in the survey as a source of staff unhappiness and so will be reviewed as detailed in the action plan.
- While the investigation concluded that the department has a highly complex rostering system to meet the requirements of the service, the staff survey identified that the overwhelming majority of staff felt the Eroster team were approachable and interact well with staff regarding the roster. There is a comprehensive action plan to address areas for improvement

- **4 Next Steps / Way Forward / Implications / Impact**

The FTSU Guardian and Champion network will continue to encourage and support staff to speak up if they are concerned. The importance of doing this throughout the COVID period, to ensure patient and staff safety, has been noted at national level by the National Guardian Office and CQC.

5 Recommendation

Trust Board is asked to:

- Note the number of FTSU cases received to date.
- Note the actions taken from the concerns raised.

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors dated 26 November 2020				
Title:	**Ward Staffing Nursing Establishment Review August 2020 – October 2020**			
Agenda Item	**3.5**			
Sponsor	**Gail Byrne – Chief Nursing Officer**			
Date:	**26 November 2020**			
Purpose	**Assurance or reassurance** ☑	**Approval**	**Ratification**	**Information**
Issue to be addressed:	Requirement to undertake systematic ward staffing establishment reviews. 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. Findings validated at Nursing and Midwifery Staffing Review Group on 21st October 2020.			
Response to the issue:	The report details the methodology, findings, risk assessment and recommendations arising from the ward staffing review undertaken from August 2020 – October 2020. 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). 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 on all aspects of the staffing reviews.			
Implications: (Clinical, Organisational, Governance, Legal?	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.			
Risks: (Top 3) of carrying out the change / or not:	• Inappropriate nurse staffing levels on the wards • Non-compliance with national and regulatory requirements			
Summary: Conclusion and/or recommendation	• 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:			

	o UHS nursing establishments are set to achieve a range of 1:1 to 1:10 registered nurse to patient ratio in most areas during the day with the majority (40) set between 1:4 to 1:8. Exceptions are where there is a planned model of trained band 4 staff and is particularly evident in Medicine and Medicine for older people. o The majority of wards (27) are staffed at between 50:50 and 70:30 registered/unregistered ratio or above. Those wards with lower ratios (19 wards) are linked to the systematic and evaluated implementation of trained band 4 staff where appropriate. o Planned total Care Hours Per Patient Day (CHPPD) range from 4.9 – 14.5 and average at 7.4 o Divisional requirements for consideration as part of budget setting. • To note the ongoing progress in UHS compliance with the guidance from the National Quality Board on safe, sustainable and productive staffing. • 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 and the changing COVID-19 situation. • 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 the COVID-19 situation. • To discuss the report at Trust Board as an ongoing requirement of the National Quality Board and 'Developing Workforce Safeguards' guidance around safe staffing assurance.

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 2020 – October 2020. 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.

1.3 It should be noted that due to COVID-19 the scheduled Divisional 'light touch' 6 monthly staffing reviews were not formally completed and reported on for all Divisions in March/April 2020. However the impact of COVID-19 was that all ward establishments and nurse staffing levels were continuously reviewed as ward function, specialty and acuity/dependency levels fluctuated throughout the pandemic.

1.4 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).

1.5 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 have been expected to 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.

1.6 The review this year was carried out immediately post COVID-19 initial surge period and this report also outlines some of the key impacts of this on nurse staffing levels and actions taken during this period to assure safe staffing.

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 (CHPPD)
- Professional Judgement
- Peer group validation
- Benchmarking and review of national guidance including Model Hospital data

- Review of eRostering data
- Review of ward quality metrics
- Additionally for this review, reflections on the COVID-19 effect on ward staffing and staff were included and are detailed in the report.

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 2020) shows continued progress despite the COVID-19 impact with UHS remaining compliant with 35 of the 37 recommendations. The following 2 outstanding areas are progressing but require 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 January 2021 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. Additionally student numbers are increasing with limited additional supervisory support established.*

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 2020) shows continued progress with full compliance in 37 of the 38 recommendations, a further improvement on last year.

The 1 remaining recommendation is:

- 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 and capacity position. COVID-19 particularly necessitated a high level of staff movement*

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 2020 – October 2020 – Outcomes

2.3.1 The 6 monthly review was carried out from August 2020 – October 2020 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 as well as a focus on the COVID-19 impact for each ward area.

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 and acuity information from the Safer Nursing Care Tool (SNCT acuity tool) where appropriate. It should be noted that a number of wards have again reconfigured in response to the changing COVID-19 situation and 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.

2.4 COVID-19 Pandemic Impact and Activity

2.4.1 A strong emphasis for the staffing reviews this year was to allow the Ward Leaders to relate their COVID-19 experience for their area.

2.4.2 There was a strong theme around the agility and flexibility demonstrated by the nursing workforce throughout as wards were rapidly re-purposed, flexed down, teams dispersed and redeployed. Nursing staff quickly adapted to providing additional services linked to ward areas such as proning teams, mixed specialty teams, testing teams and working across multiple sites. These services in many cases continue and are being resourced from within existing nursing establishments.

2.4.3 The arrival of the COVID-19 pandemic created significant challenges managing daily staffing and in progressing some of the streams of work needed to deliver improvements to workforce, establishments and daily staffing. Conversely it also offered opportunities to relook at the way we manage staffing, how we view conventional workforce models and importantly how our staff are able to step up, respond positively to an unexpected situation and deliver some outstanding work whilst working differently. It is important that we capitalise on this learning in moving forward.

2.4.4 A physical, visible ***staffing hub*** was established in April 2020 to co-ordinate and oversee the real-time nurse staffing levels across the hospital in support of the clinical site function. On evaluation this hub has proved really effective in providing a co-ordinated overview to the staffing position and has therefore been maintained and forms part of our ongoing operational plan. The hub activity is led by a designated staffing matron of the day who takes responsibility for leading the continuous review and reassignment of the staffing resource throughout the day.

2.4.5 ***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 1:1 (Piam Brown) to 1:10 depending on specialty and overall staffing model. The average level set to achieve 1:4 to 1:8 registered nurse to patient ratio in most areas during the day (40 wards) with 35 wards 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 the medicine wards, Medicine for Older People (MOP) wards, 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 1:4 – 1:6. It should be noted that the ratio of patients to registered nurse can regularly increase when wards are not fully established and these wards with lower nurse to patient ratios are working on their minimum safe levels.

- Planned staffing ratios at **night** require constant oversight to ensure the model is sufficient to provide the required support for patients out of hours. In areas that are working on lower staffing ratios, managing the workload at night has emerged as an area that requires action in a number of ward areas. Rising acuity of patients, more therapeutic activity taking place overnight and the COVID-19 impact of more geographically spread clinical areas has increased the pressure on the staffing resource at night and red flag reports over the previous year have highlighted this.

- Following previous reviews there are now 6 areas with ratios higher than 1:11 (RN to patient) at night. These are ASU, F10, E7, F7, D6, D8, E3 (G) and Bramshaw 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. The divisional position (at Appendix 5) highlights those wards that require an uplift in their night time cover to improve this ratio.

2.4.6 ***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.

- 16 wards are now established at between 60:40 and 70:30 a reduction on the previous years as we see skillmix gradually reducing in a number of areas.

- 32 wards (up from 25 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.

- 6 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 (Child Health, Neurosciences, 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 2020 linked to the further development of apprenticeship opportunities. This has also provided a role in which to appoint the emerging cohorts of nursing associates who have qualified and registered with the NMC from January 2019 onwards. 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.

2.4.7 ***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.

2.4.8 ***Care Hours Per Patient Day***

- Planned total Care Hours Per Patient Day (CHPPD) range from 4.9 (F7) – 14.5 (Piam Brown) and average at 7.4. This average is slightly higher than last year.

- Registered care hours per patient day range from 2.4 (Bramshaw, F7, G5, D6) – 14.2 (Piam Brown) and average at 4.5. This average is slightly higher than last year.
- Unregistered care hours per patient day range from 0 (G2 Neuro) – 5.4 (G7) and average at 2.9. This average is slightly higher than last year.

2.4.9 ***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.
- Last year it was highlighted that in many areas these levels were being exceeded and a detailed project was 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.
- 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.
- COVID-19 has had a significant impact on the levels and management of headroom. Additional sickness levels attributable to COVID-19 have added to a consistent rise in sickness overall across the period and ensuring the correct levels of leave has proved a challenge due to workload, sickness, availability of skilled staff, travel restrictions and staff appetite for leave when movement is restricted.

- 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. This has proved invaluable during COVID-19 where we have seen ward leaders enabled to adapt and lead diverse teams. We have been required to include ward leaders in the numbers throughout COVID-19 and the subsequent restart period in order to offset the

additional headroom and maintain safe staffing levels. This has been reflected in a reduction in support activities such as appraisals and supervision.

2.4.10 ***Specific Divisional issues emerging***

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

2.5 Trust wide risks and issues considered in the review

2.5.1 ***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.

COVID-19 has had a significant impact on the acuity and dependency of our wards particularly as we develop separate safe pathways which require a mixed specialty of patients to be cared for in ward areas.

Information on the acuity and dependency of our patients, including any enhanced care needs is 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 used at the 6 monthly reviews as part of the professional judgment assessment.

2.5.2 ***Increasing enhanced care needs***

'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. In child health we have also seen a significant rise in the number of children requiring additional mental health support and this has been exacerbated with COVID-19.

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

Division B retain the Trustwide overview for enhanced care, specifically mental health support, and provide an 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 enhanced care needs. Ward leaders report 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.

2.5.3 ***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.

This situation has been exacerbated during COVID-19 with a high volume of staff needing upskilling and supervision in unfamiliar clinical areas.

Innovative initiatives have been put into place, utilising shielding staff, to provide some 'long-arm' supervision and support particularly for the 110 student nurses deployed in substantive posts during the COVID-19 surge phase.

The robust retention and recruitment strategies across the Trust and the strong vision to 'grow our own' nurses for the future means that wards continue to support 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 have proved key to supporting the development and learning into the wards and particularly in continuing to train and support the overseas nurses to full registration.

2.5.4 ***Vacancies***

Total reported nursing vacancies (registered and unregistered) across the inpatient areas at the time of the staffing review (August 2020) were running at 292 (8.6%) with registered nurse vacancies at 305 (14.7%) and unregistered at -16 (-1.5% due to over recruitment of overseas nurses and student nurses temporarily into unregistered posts). This is an improving picture on the previous two annual reviews and illustrates the success of the range of recruitment and retention initiatives.

A continued key action nationally, corporately and for all Divisions in 2020/21 is to continue to concentrate efforts to fill these vacancies and these efforts are reaping benefits with a gradually reducing vacancy position. Several initiatives form part of the recently published national People Plan around nurse recruitment including funding available for overseas recruitment, increased clinical placements, apprenticeships and health care support worker recruitment.

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.

2.5.5 ***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. In addition there is ongoing review of red flags raised as part of the adverse event reporting system and on 'safecare'.

3.0 Conclusion

3.1 A robust ward staffing establishment review was undertaken using a mixed methodology of approaches and in line with recommendations from the National Quality Board and NICE guidance.

3.2 Additionally this year the review also focused on the impact of COVID-19 on nurse staffing and explored the contribution provided by nursing to respond to the evolving pandemic. This identified the level of agility and flexibility shown by all of the teams during this time and a message of thanks was shared at all of the reviews.

3.3 Overall the staffing establishments remain appropriate and within recommended guidelines. There are some key exceptions where acuity and dependency levels and growing demand have now outstripped the nursing ratios – recommendations for uplifts in these areas will be put forward by the Divisions as part of the annual budget setting process.

4.0 Recommendations

4.1 To discuss the report at Trust Board as an ongoing requirement of the National Quality Board and developing workforce safeguards guidance around safe staffing assurance.

4.2 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 a range of 1:1 to 1:10 registered nurse to patient ratio in most areas during the day with the majority (40) set between 1:4 to 1:8. 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 (27) are staffed at between 50:50 and 70:30 registered/unregistered ratio or above. Those wards with lower ratios (19 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 4.9 – 14.5 and average at 7.4

4.3 To note that emerging divisional requirements for staffing uplifts be presented through the budget setting process.

4.4 To note the continued implementation and progress on the agreed actions to ensure compliance and adoption of the NQB, NICE and NHSi guidance on safe, sustainable and productive staffing.

4.3 To note the 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. Establishment and maintenance of the 'staffing hub' will support this.

4.4 To note and acknowledge the ongoing risks and challenges of matching actual staffing to established staffing levels particularly in relation to COVID-19.

4.5 To support the continued Trust wide commitment and momentum on actions to fill vacancies and further reduce the reliance on high cost agency.

4.6 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 2021.

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

Appendix 1

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

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.
Expectation 2: Right skills	• 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. • 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.
Expectation 3: Right place and time	• 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.

NATIONAL QUALITY BOARD - JULY 2016

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 2020) 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. Shelford 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. Increased headroom requirement due to COVID-19	complete	DoF/Chief Nurse
		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. Key part of the staffing hub set-up during COVID-19	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	Build on the current benchmarking capabilities included in the Model Hospital and N&M Dashboard. Continue to utlise 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

Expectation 2: Right skills	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	Continue to maintain 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. Acknowledged higher headroom requirement during COVID-19 due to raised sickness levels	Jan-21	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 People/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 2020 to further streamline priorities to staffing needs and match to changed CPD arrangements .	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 HEI/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	Chief Nurse/People Director
		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	People Director /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 People/Director of TD&W/DMT
	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 Productive working and eliminating waste**						
		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	Clear focus on flow and avoiding bottle-necks in service design.	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	Chief Nurse/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	Chief Nurse/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	Chief Nurse/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	Chief Nurse/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 systemetically reviewed through 6 monthly staffing reviews reported to board	C	Continue with current approach	complete	Chief Nurse/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 inlcuded as part of the systematic review of staffing levels	C	Continue with current approach	complete	Chief Nurse/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 stafifng meetings linked to site.	C	Continue to strenghten 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 ot strengthen the information into site around staffing resource	complete	DDoN/DHN/Matrons/work force 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 poilicies around application of eRostering. Use of eRoster systematically reviewed and managed through the management team structure	C	Continue to strenthen the use of eRoster by utilising report function and reviewing compliance levels - specifically for: Approvals, unused hours, safecare	complete	DDoN/DHN/Matrons
		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	Chief Nurse/Associate Director of People/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	Chief Nurse/Associate Director of People/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 workfroce aspects and workforce plan based on actions	C	Continue with engagement in STP development	complete	CEO/Chief Nurse/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 workfroce aspects and workforce plan based on actions	C	Continue with engagement in STP development	complete	CEO/Chief Nurse/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 idetnfiying palcement 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

Appendix 3 V18 October 2020 - Reviewed at NMSRG 21st October 2020

Guideline 1: Safe Staffing for nursing in adult inpatient wards in acute hospitals : 38 recommendations

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 A = Actions required	Identified actions required (24 compliant, 14 action)	Timescale	Lead	October 2020 compliance	October 2020 update (37 compliant, 1 requiring action)
	Organisational strategy - Recommendations for hospital boards, senior management and commissioners in line with NQB expectations									
Organisational strategy - Recommendations for hospital boards, senior management and commissioners in line with NQB 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 specialties and skills occurring due to COVID-19 and ongoing review of skills taking place as part of staffing allocations.
	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		Chief Nurse/DDoN/ DHN	C	6 monthly light touch review not completed in all divisions in March due to COVID-19 but all establishments reviewed regularly during crisis and as part of restart. Full reviews scheduled for July/Aug 2020
	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	Chief Nurse/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	Chief Nurse/DDoN/DHN/ HR	C	Roster audits now reinstated and accountability for rosters clearly within ward leader and matron job roles. Workforce systems centrally supporting some roster approvals during the COVID-19 period
	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. Focussed project taking place on headroom and headroom increases formally acknowledged due to COVID-19
	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.	Jun-20	DDoN/DHN/safety team	C	Red flag information now routinely captured through safecare (real-time) and reviewed through staffing hub. AER's also capture red flag information and this is reviewed systematically monthly and reported to board for trends. Included in staffing establishment reviews.

Organisational strategy - Recommendations for hospital boards, seni	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. Staffing hub set up during COVID-19 to take real-time view and manage staffing requirements across the trust
	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	Oct-20	DDoN/DHN	A	Additional education put into bleep holding as part of winter pressure oversight arrangements. Now in place with bleep holding and band 7 weekend review. Current vacancy and capacity situation does not enable assurance that wards are not compromised by staff movements.
	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. Policy updated in 2020
	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	Included at establishment reviews
	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

Principles for determining nursing staffing requirements - Recommendations for registered nurses in charge of individual 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. Staffing hub has strengthened the understanding of staff at different levels
	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 safe care module.
	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. Stregnthened through the staffing hub
	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	**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									
	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 Maintain	DDoN/Workforce Systems DDoN/Workforce Systems	C 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. reviewed as a metric in the staffing hub Safe care rollout complete
	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 sonce 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

Assessing if nursing staff available on the day meet patients' nursing needs - Recommendations for registered nurses on wards	**Assessing if nursing staff available on the day meet patients' nursing needs -** Recommendations for registered nurses on wards who are in charge of shifts									
	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. Oversight from the staffing hub now enhancing the 24 hr view
	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 and key metric considered at staffing hub huddles. 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 CHPPD is calculated based on the type and number of the shifts set up in the Template and number of the beds in the ward

						Finance budgeted			Staffing Numbers						Planned on Template (long day factor applied)		
Division	Care Group	Unit Name	Shift	Total Beds or "Shift N/A"	Budgeted Establishment (WTE)	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)	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	57 : 43	1 : 6	1 : 4	3.4	2.5	5.9
		CAN C4 Solent Ward Clinical Oncology	Late	23					4	3	7	57 : 43	1 : 6	1 : 4			
		CAN C4 Solent Ward Clinical Oncology	Night	23					3	2	5	61 : 39	1 : 8	1 : 5			
		CAN C6 Leukaemia/BMT Unit	Early	21	44.1	39.0	1.4	3.7	8	0	8	94 : 6	1 : 3	1 : 3	7.4	0.3	7.8
		CAN C6 Leukaemia/BMT Unit	Late	21					8	0	8	94 : 6	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	1 : 4	1 : 3	7.5	1.9	9.4
		CAN C6 TYA Unit	Late	6					2	1	3	67 : 33	1 : 4	1 : 3			
		CAN C6 TYA Unit	Night	6					2	0	2	100 : 0	1 : 4	1 : 4			
		CAN D2 Haematology	Early	20	38.5	25.6	10.1	2.8	4	3	7	55 : 45	1 : 6	1 : 3	3.9	2.9	6.8
		CAN D2 Haematology	Late	20					4	2	6	64 : 36	1 : 6	1 : 4			
		CAN D2 Haematology	Night	20					3	2	5	60 : 40	1 : 7	1 : 5			
		CAN D3 Ward	Early	22	35.4	21.6	10.2	3.7	5	3	7	62 : 38	1 : 5	1 : 3	3.9	2.1	6.0
		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			
	Surgery	SUR Acute Surgical Admissions	Early	30	44.9	19.8	19.5	5.6	6	2	8	75 : 25	1 : 6	1 : 4	3.6	1.4	5.0
		SUR Acute Surgical Admissions	Late	30					6	2	8	75 : 25	1 : 6	1 : 4			
		SUR Acute Surgical Admissions	Night	30					3	2	5	59 : 41	1 : 11	1 : 7			
		SUR Acute Surgical Unit	Early	12	28.6	13.9	12.9	1.8	3	2	5	60 : 40	1 : 5	1 : 3	5.9	3.3	9.2
		SUR Acute Surgical Unit	Late	12					4	2	6	67 : 33	1 : 4	1 : 3			
		SUR Acute Surgical Unit	Night	12					2	2	4	50 : 50	1 : 7	1 : 4			
		SUR E5 Lower GI	Early	18	27.3	14.8	9.5	3.0	4	2	6	67 : 33	1 : 5	1 : 4	3.6	2.0	5.6
		SUR E5 Lower GI	Late	18					3	2	5	60 : 40	1 : 7	1 : 4			
		SUR E5 Lower GI	Night	18					2	1	3	61 : 39	1 : 10	1 : 6			
		SUR E5 Upper GI	Early	18	28.0	15.4	10.2	2.4	4	2	6	66 : 34	1 : 5	1 : 4	3.8	2.1	5.9
		SUR E5 Upper GI	Late	18					3	2	5	59 : 41	1 : 7	1 : 4			
		SUR E5 Upper GI	Night	18					2	1	3	57 : 43	1 : 10	1 : 6			
		SUR F10 E	Early	30	52.8	25.6	23.6	3.6	6	2	8	75 : 25	1 : 6	1 : 4	3.6	1.4	5.0
		SUR F10 E	Late	30					6	1	7	81 : 19	1 : 6	1 : 5			
		SUR F10 E	Night	30					3	2	5	60 : 40	1 : 11	1 : 7			
		SUR F11 IF	Early	17	34.2	20.9	9.7	3.6	4	2	6	67 : 33	1 : 5	1 : 3	5.1	2.8	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	40.6	19.4	17.8	3.4	5	4	9	56 : 44	1 : 6	1 : 4	3.5	2.3	5.8
		SUR Ward F5	Late	28					5	2	7	71 : 29	1 : 6	1 : 5			
		SUR Ward F5	Night	28					3	2	5	60 : 40	1 : 10	1 : 6			
Division B	Emergency Care	ECM Acute Medical Unit	Early	54	113.6	58.2	50.9	4.4	10	9	18	53 : 47	1 : 6	1 : 3	4.2	3.5	7.6
		ECM Acute Medical Unit	Late	54					10	8	17	55 : 45	1 : 6	1 : 4			
		ECM Acute Medical Unit	Night	54					10	7	16	59 : 41	1 : 6	1 : 4			
	Medicine	MED D5 Ward	Early	28	39.7	19.0	19.7	1.0	4	5	9	45 : 55	1 : 8	1 : 4	2.7	3.0	5.8
		MED D5 Ward	Late	28					3	4	7	43 : 57	1 : 10	1 : 5			
		MED D5 Ward	Night	28					3	3	6	50 : 50	1 : 10	1 : 5			
		MED D6 Ward	Early	24	37.1	14.7	21.4	1.0	3	5	8	37 : 63	1 : 9	1 : 4	2.4	3.4	5.8
		MED D6 Ward	Late	24					3	3	6	50 : 50	1 : 9	1 : 5			
		MED D6 Ward	Night	24					2	3	5	40 : 60	1 : 13	1 : 5			
		MED D7 Ward	Early	16	24.8	12.0	12.8	0.0	2	3	5	40 : 60	1 : 9	1 : 4	2.9	3.0	5.9
		MED D7 Ward	Late	16					2	2	4	50 : 50	1 : 9	1 : 5			
		MED D7 Ward	Night	16					2	2	4	52 : 48	1 : 9	1 : 5			
		MED D8 Ward	Early	24	34.4	14.7	18.7	1.0	3	5	8	38 : 63	1 : 9	1 : 4	2.5	3.3	5.7
		MED D8 Ward	Late	24					3	3	6	50 : 50	1 : 9	1 : 5			
		MED D8 Ward	Night	24					2	3	5	40 : 60	1 : 13	1 : 5			
		MED D9 Ward	Early	28	40.8	19.0	20.8	1.0	4	5	9	45 : 55	1 : 8	1 : 4	2.7	3.0	5.7
		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	31.5	13.7	16.8	1.0	3	4	7	43 : 57	1 : 7	1 : 3	3.3	3.6	6.9
		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 : 10	1 : 5			
		MED E7 Ward	Early	22	32.9	15.5	16.5	1.0	3	4	6	43 : 57	1 : 9	1 : 4			
		MED E7 Ward	Late	22					3	3	5	51 : 49	1 : 9	1 : 5			
		MED E7 Ward	Night	22					2	2	4	50 : 50	1 : 12	1 : 6			
		MED F7 Ward	Early	26	31.5	12.4	17.2	2.0	3	4	7	44 : 56	1 : 9	1 : 4	2.4	2.5	4.9
		MED F7 Ward	Late	26					3	4	6	45 : 55	1 : 9	1 : 5			
		MED F7 Ward	Night	26					2	2	4	56 : 44	1 : 12	1 : 7			
		MED G5 Ward	Early	28	41.1	14.7	24.5	2.0	3	5	8	38 : 62	1 : 10	1 : 4	2.4	2.9	5.3
		MED G5 Ward	Late	28					3	5	8	38 : 62	1 : 10	1 : 4			
		MED G5 Ward	Night	28					3	2	5	60 : 40	1 : 10	1 : 6			
		MED G6 Ward	Early	26	41.4	14.7	24.8	2.0	3	5	8	38 : 62	1 : 10	1 : 4	2.6	3.0	5.7
		MED G6 Ward	Late	26					3	5	7	39 : 61	1 : 9	1 : 4			
		MED G6 Ward	Night	26					3	2	5	59 : 41	1 : 10	1 : 6			
		MED G7 Ward	Early	14	34.4	12.4	20.0	2.0	2	4	6	33 : 67	1 : 8	1 : 3	3.3	5.4	8.7
		MED G7 Ward	Late	14					2	3	5	40 : 60	1 : 8	1 : 3			
		MED G7 Ward	Night	14					2	4	6	33 : 67	1 : 8	1 : 3			
		MED G8 Ward	Early	28	40.3	14.7	23.7	2.0	3	5	8	38 : 62	1 : 10	1 : 4	2.5	2.8	5.3
		MED G8 Ward	Late	28					3	5	8	38 : 62	1 : 10	1 : 4			
		MED G8 Ward	Night	28					3	2	5	60 : 40	1 : 10	1 : 6			
		MED G9 Ward	Early	26	39.6	14.7	23.0	2.0	3	5	8	36 : 64	1 : 9	1 : 4	2.7	3.2	5.9
		MED G9 Ward	Late	26					3	5	8	37 : 63	1 : 9	1 : 4			
		MED G9 Ward	Night	26					3	2	5	60 : 40	1 : 10	1 : 6			
	Specialist Medicine	SME C5 Isolation Ward	Early	14	29.2	15.1	12.1	2.0	2	3	5	41 : 59	1 : 8	1 : 3	3.5	3.6	7.1
		SME C5 Isolation Ward	Late	14					2	3	5	41 : 59	1 : 8	1 : 3			
		SME C5 Isolation Ward	Night	14					2	1	3	67 : 33	1 : 8	1 : 5			

Appendix 4

Planned CHPPD is calculated based on the type and number of the shifts set up in the Template and number of the beds in the ward

						Finance budgeted			Staffing Numbers						Planned on Template (long day factor applied)		
Division	Care Group	Unit Name	Shift	Total Beds or "Shift N/A"	Budgeted Establishment (WTE)	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)	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	12	15.2	8.6	4.3	2.3	2	2	4	56 : 44	1 : 6	1 : 4	#N/A	#N/A	#N/A
		CHI Bursledon House	Late	12					2	1	3	58 : 42	1 : 7	1 : 4			
		CHI Bursledon House	Night	12					1	1	1	50 : 50	1 : 21	1 : 11			
		CHI High Dependency Unit	Early	6	20.3	20.3	0.0	0.0	4	0	4	100 : 0	1 : 2	1 : 2			
		CHI High Dependency Unit	Late	6					3	0	3	100 : 0	1 : 3	1 : 3			
		CHI High Dependency Unit	Night	6					3	0	3	100 : 0	1 : 3	1 : 3			
		CHI Paed Medical Unit	Early	16	43.7	28.6	11.9	3.3	5	1	6	83 : 17	1 : 4	1 : 3	7.1	2.0	9.1
		CHI Paed Medical Unit	Late	16					5	1	6	83 : 17	1 : 4	1 : 3			
		CHI Paed Medical Unit	Night	16					5	2	7	71 : 29	1 : 4	1 : 3			
		CHI Piam Brown Unit	Early	12	43.9	38.9	1.0	4.0	12	1	13	95 : 5	1 : 1	1 : 1	14.2	0.3	14.5
		CHI Piam Brown Unit	Late	12					5	0	5	100 : 0	1 : 3	1 : 3			
		CHI Piam Brown Unit	Night	12					4	0	4	100 : 0	1 : 4	1 : 4			
		CHI Ward E1 Paed Cardiac	Early	16	39.2	27.0	8.9	3.2	5	3	7	65 : 35	1 : 4	1 : 3	5.6	3.4	9.0
		CHI Ward E1 Paed Cardiac	Late	16					4	3	7	61 : 39	1 : 5	1 : 3			
		CHI Ward E1 Paed Cardiac	Night	16					3	2	5	61 : 39	1 : 6	1 : 4			
		CHI Ward G2 Neuro	Early	6	12.5	12.1	0.0	0.4	2	0	2	100 : 0	1 : 4	1 : 4	8.1	0.0	8.1
		CHI Ward G2 Neuro	Late	6					2	0	2	100 : 0	1 : 4	1 : 4			
		CHI Ward G2 Neuro	Night	6					2	0	2	100 : 0	1 : 4	1 : 4			
		CHI Ward G3	Early	20	46.9	29.5	14.2	3.2	6	4	10	60 : 40	1 : 4	1 : 3	6.6	4.4	11.0
		CHI Ward G3	Late	20					6	4	10	60 : 40	1 : 4	1 : 3			
		CHI Ward G3	Night	20					5	3	8	63 : 38	1 : 5	1 : 3			
		CHI Ward G4 Surgery	Early	22	55.8	38.1	14.3	3.4	6	3	9	68 : 32	1 : 4	1 : 3			
		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	38.8	17.9	18.3	2.5	3	2	5	63 : 37	1 : 10	1 : 6	2.3	1.2	3.5
		W&N Bramshaw Womens Unit	Late	26					3	2	5	62 : 38	1 : 9	1 : 6			
		W&N Bramshaw Womens Unit	Night	26					2	1	3	67 : 33	1 : 14	1 : 9			
	Cardiovascular & Thoracic	CAR Coronary Care Unit	Early	17	43.9	28.4	13.7	1.8	4	3	7	58 : 42	1 : 5	1 : 3	5.1	4.0	9.1
		CAR Coronary Care Unit	Late	17					4	3	7	58 : 42	1 : 5	1 : 3			
		CAR Coronary Care Unit	Night	17					4	3	6	57 : 43	1 : 5	1 : 3			
		CAR Ward D4 Vascular	Early	22	42.2	20.4	19.1	2.7	4	3	7	62 : 38	1 : 6	1 : 4	3.8	3.1	6.9
		CAR Ward D4 Vascular	Late	22					4	3	7	60 : 40	1 : 6	1 : 4			
		CAR Ward D4 Vascular	Night	22					3	3	6	47 : 53	1 : 9	1 : 4			
		CAR Ward E2 YACU	Early	17	29.5	18.8	9.0	1.6	4	3	7	57 : 43	1 : 5	1 : 3	4.5	2.4	6.8
		CAR Ward E2 YACU	Late	17					4	2	6	67 : 33	1 : 5	1 : 3			
		CAR Ward E2 YACU	Night	17					2	1	3	67 : 33	1 : 9	1 : 6			
		CAR Ward E3 Green	Early	24	38.2	17.7	17.8	2.7	4	4	8	48 : 52	1 : 7	1 : 3	3.0	3.0	6.0
		CAR Ward E3 Green	Late	24					4	3	7	57 : 43	1 : 7	1 : 4			
		CAR Ward E3 Green	Night	24					2	3	4	43 : 57	1 : 13	1 : 6			
		CAR Ward E3 Blue	Early	18	30.4	12.5	15.8	2.0	3	4	7	45 : 55	1 : 7	1 : 3	3.3	3.2	6.5
		CAR Ward E3 Blue	Late	18					3	2	5	60 : 40	1 : 7	1 : 4			
		CAR Ward E3 Blue	Night	18					2	2	4	50 : 50	1 : 10	1 : 5			
		CAR Ward E4 Thoracics	Early	20	38.1	20.4	15.7	2.0	4	3	7	58 : 42	1 : 6	1 : 3	4.1	2.7	6.8
		CAR Ward E4 Thoracics	Late	20					4	3	7	57 : 43	1 : 6	1 : 3			
		CAR Ward E4 Thoracics	Night	20					3	1	4	70 : 30	1 : 7	1 : 5			
		CAR E8 Thoracic	Early	30	-0.8	-0.8	0.0	0.0	5	5	10	50 : 50	1 : 7	1 : 4	3.5	3.0	6.5
		CAR E8 Thoracic	Late	30					5	5	10	50 : 50	1 : 7	1 : 4			
		CAR E8 Thoracic	Night	30					4	2	6	67 : 33	1 : 8	1 : 6			
Division D	Neurosciences	NEU Acute Stroke Unit	Early	28	65.2	23.6	38.1	3.6	4	7	11	36 : 64	1 : 8	1 : 3	2.9	5.0	7.9
		NEU Acute Stroke Unit	Late	28					4	7	11	36 : 64	1 : 8	1 : 3			
		NEU Acute Stroke Unit	Night	28					3	5	8	38 : 62	1 : 10	1 : 4			
		NEU HASU	Early	10	33.1	23.3	8.0	1.8	4	1	5	80 : 20	1 : 3	1 : 3	9.5	2.4	11.9
		NEU HASU	Late	10					4	1	5	80 : 20	1 : 3	1 : 3			
		NEU HASU	Night	10					4	1	5	80 : 20	1 : 3	1 : 3			
		NEU Regional Transfer Unit	Early	10	30.1	20.8	7.5	1.8	2	1	3	68 : 32	1 : 6	1 : 4	4.7	2.3	7.0
		NEU Regional Transfer Unit	Late	10					2	1	3	69 : 31	1 : 6	1 : 4			
		NEU Regional Transfer Unit	Night	10					2	1	3	66 : 34	1 : 6	1 : 4			
		NEU Ward D Neuro	Early	27	62.9	30.3	30.3	2.2	5	5	10	51 : 49	1 : 6	1 : 3	4.0	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 : 8	1 : 4			
		NEU Ward E Neuro	Early	26	53.2	32.0	18.7	2.4	5	3	8	63 : 38	1 : 6	1 : 4	4.1	2.6	6.7
		NEU Ward E Neuro	Late	26					5	3	8	63 : 38	1 : 6	1 : 4			
		NEU Ward E Neuro	Night	26					4	3	7	57 : 43	1 : 7	1 : 4			
		SPI Ward F4 Spinal	Early	22	39.2	22.7	14.2	2.2	4	3	7	59 : 41	1 : 6	1 : 4	3.9	2.7	6.6
		SPI Ward F4 Spinal	Late	22					4	2	6	67 : 33	1 : 6	1 : 4			
		SPI Ward F4 Spinal	Night	22					3	3	6	50 : 50	1 : 8	1 : 4			
	Trauma & Orthopaedics	T&O Ward Brooke	Early	18	28.4	17.4	8.0	3.0	3	2	5	60 : 40	1 : 7	1 : 4	3.9	1.7	5.6
		T&O Ward Brooke	Late	18					3	1	4	75 : 25	1 : 7	1 : 5			
		T&O Ward Brooke	Night	18					3	1	4	75 : 25	1 : 7	1 : 5			
		T&O Ward F1 Major Trauma Unit	Early	32	71.8	36.8	29.4	5.6	6	5	11	55 : 45	1 : 6	1 : 4	4.2	3.8	8.0
		T&O Ward F1 Major Trauma Unit	Late	32					6	5	11	55 : 45	1 : 6	1 : 4			
		T&O Ward F1 Major Trauma Unit	Night	32					5	5	10	50 : 50	1 : 7	1 : 4			
		T&O Ward F2 Trauma	Early	26	56.2	23.6	28.2	4.5	4	5	9	44 : 56	1 : 7	1 : 3	3.3	4.1	7.5
		T&O Ward F2 Trauma	Late	26					4	5	9	44 : 56	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	20	55.2	21.6	29.0	4.6	4	5	9	44 : 56	1 : 6	1 : 3	4.3	5.2	9.4
		T&O Ward F3 Trauma	Late	20					4	5	9	44 : 56	1 : 6	1 : 3			
		T&O Ward F3 Trauma	Night	20					3	4	7	43 : 57	1 : 7	1 : 3			
		T&O Ward F4	Early	18	37.2	21.3	11.9	4.0	4	3	7	57 : 43	1 : 5	1 : 3	4.4	3.4	7.9
		T&O Ward F4	Late	18					3	3	6	50 : 50	1 : 7	1 : 4			
		T&O Ward F4	Night	18					3	2	5	60 : 40	1 : 7	1 : 4			

Appendix 5

Specific Divisional issues emerging - Ward Staffing Review 2020

Division A

Overall established staffing levels are appropriate in the majority of wards for the level and acuity of patients with a couple of areas that require uplift.

Changes made last year to review and support the staffing model on F11 (intestinal failure unit) have had a positive impact and the professional judgement of the ward leader is that the ward is now appropriately established.

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 – particularly C4. This was compounded during COVID-19 with services displaced and re-provided in different settings to safeguard patients.

COVID-19 has had a significant impact on the number of emergency admissions through the acute oncology centre and onto C4; this together with acuity and dependency of the patients in Cancer Care has impacted on the need for additional staff to provide care. In surgery a large proportion of patients needing straightforward and benign surgery are being treated in the Nuffield, the Spire and the ISTC; the result is an increase in complex cancer patients onsite at UHS requiring an increase in trained staff particularly at the weekend

Areas to be put forward at budget setting – Division A:

C4 requires an uplift on registered nurses across the week to manage the increased acuity and interventional nursing care required.

E5 requires uplift on registered nurses across the week to manage the increased acuity and enhanced care needs.

Division B

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

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

The review this year has highlighted that with the increasing acuity of patients (particularly impacted by COVID19) and the required nursing therapeutic interventions (e.g. non-invasive ventilation, intravenous medications, chest drain and tracheostomy care) the model at night (1RN to 13 patients on some wards) is no longer adequate.

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 to be put forward at budget setting – Division B:

D5 and **D9** require uplift in registered nurse availability overnight to reduce their patient to RN ratio.

A pool model of RN cover is being considered to enable the allocation of additional RN resource to the area of greatest need across Medicine and MOP.

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.

Increased CAMHS (Child and Adolescent Mental Health) demand (particularly impacted by COVID-19) and changes 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 to be put forward at budget setting – Division C:

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

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

Division D

Overall established staffing levels are appropriate in the majority of wards for the level and acuity of patients 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 been impacted by COVID-19. This is particularly notable in the CVT wards and on F4 spine - where acuity of patients has also increased significantly.

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 to be put forward at budget setting – Division D:

E3 green and blue require uplift in registered nurse availability on the late and night to reduce their patient to RN ratio.

F4 spines are undertaking a further detailed review of acuity and will be putting forward proposals to uplift.

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

Example AER/Red flag from one of the Divisions

'Not enough staff on the night to provide safe care. we had a patient (confused, agitated and falls risk) under DOLs requiring 1:1 with HCA who was nursed in the SR (behavioural), We have a baywatch bay with 2 patients under DOLS- one independent and the other aggressive, confused and a falls risk. There were 2 other patient in that bay who were also very confused and high falls risk. There was no 1:1 provided for the shift. We had to 1:1 and baywatch in our numbers
Staffing was 2 registered nurses, 1B4, 1HCA and 1twilight HCA for 24 patients.'

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors dated 26 November 2020				
Title:	**Revised Infection Prevention and Control Board Assurance Framework**			
Agenda item	**3.6**			
Sponsor	**Gail Byrne, Director of Infection Prevention & Control (DIPC)**			
Author	**Julie Brooks, Head of Infection Prevention Unit** **Nitin Mahobia, Director of Infection Prevention Unit.**			
Date:	**26 November 2020**			
Purpose	**Assurance or reassurance** **Yes**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	Trust compliance with PHE and other COVID-19 related infection prevention and control guidance.			
Response to the issue:	Updated self-assessment of compliance with PHE and other COVID-19 related infection prevention and control guidance to identify risks, gaps in assurance and actions to mitigate/control risks.			
Implications: (Clinical, Organisational, Governance, Legal?	Legal duty to protect service users and staff from avoidable harm in a healthcare setting: 'Code of Practice on the prevention and control of infection'/ Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014) & Health & safety at Work Act (1974).			
Risks: (Top 3) of carrying out the change / or not:	Risk of hospital acquired COVID-19. Risk of harm to staff and patients.			
Summary: Conclusion and/or recommendation	Members should note that having undertaken this self-assessment there is overall assurance that what is being done is robust. Areas that require future assurance are: • Ensuring that documentation is completed • Ensuring consistent compliance with infection prevention and control measures through additional monitoring, audits and spotchecks of practice. • Ensuring that all staff have received appropriate training/refresher training as required.			

RED TEXT – new additions to board assurance framework
PURPLE TEXT – updated wording from previous version published in May 2020.

Infection Prevention and Control Board Assurance Framework

Background & introduction.

Effective infection prevention and control is fundamental to our efforts. NHS England and NHS Improvement have developed this board assurance framework (updated October 2020) to support all healthcare providers to effectively self-assess their compliance with PHE COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted. The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and also as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
infection risk is assessed at the front door and this is documented in patient notes	Risk is assessed on admission. Infection admission assessment is part of nursing documentation. COVID 19 triage checklist introduced.	Gaps in completion of documentation on infection assessment document Evidence of documentation of triage screening in patient's notes.	Ongoing reminders/briefings to be circulated to staff to complete documentation. Spot audit of documentation to be undertaken to monitor compliance.
patients with possible or confirmed COVID-19 are not moved unless this is for their care or reduces the risk of transmission	Possible or confirmed COVID19 COVID-19 moved to designated cohort areas/isolation facilities to reduce risk of transmission. High, medium and low risk COVID19	A small number of additional patient moves do occur.	Ongoing re-enforcement importance of limiting patient movement. Local review of footprints for each

	patient pathways in place as per PHE guidance. Patients placed according to pathway within designated care group/ clinical area footprints.		pathway at care group level where required.
compliance with national guidance around discharge or transfer of COVID-19 positive patients	Policy in line with PHE guidance Working with local stakeholders to review and update existing policy	None	
monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice	Infection Prevention Audit Programme in place - audits of Cleaning & decontamination, Hand hygiene, Isolation , standard precautions undertaken to date (April - Oct 2020) Investment in local PPE provision to ensure staff have appropriate PPE resources to undertake safe IP&C practice (Perso Hoods, Millbrook Gowns) Ongoing monitoring and spot-checks of mask use , social distancing, hand hygiene.	None	

monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	Spot-checks undertaken as part of walkabouts and Infection Prevention Team visits to clinical areas. Spot-checks by senior nurses and infection prevention link staff in some areas. COVID – zero guardians monitor compliance of mask use in public & non-clinical spaces.	Assurance needed of consistent compliance with PPE by all staff in all areas.	Implementation local COVID zero champions on every shift in clinical areas to promote and monitor correct and safe use of PPE. Ward leaders to complete daily review/checklist which includes checks on PPE compliance. PPE Audit November 2020 (as per scheduled IP&C audit programme)
staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase	Testing programme in place for symptomatic staff Asymptomatic staff testing programme implemented in response to incidents /outbreaks of infection, including follow up of results and contact tracing. Routine testing of asymptomatic staff in high risk areas (ED, AMU,C5, COFIV positive wards, GICU) All positive staff are followed-up by Occupational Health, to include contact tracing and self-isolation advice to positives and contacts. Clinical lead identified to oversee	None	

	staff testing. Weekly asymptomatic testing meeting in place (testing team and IPT) to prioritise and direct future asymptomatic screening programmes. Strategy for wider rollout of staff asymptomatic testing in development using a range of testing methods e.g. saliva, lateral flow tests.		
training in IPC standard infection control and transmission-based precautions are provided to all staff	Standard Precautions included in IP&C training on induction and as part of mandatory updates. Transmission-based precautions bespoke training provided to specific staff groups by IPT e.g. link staff in education meetings, training in a number of areas re COVID transmission e.g. ED and critical care, Education/communication on specific modes of transmission & precautions included in general awareness information/materials on	Not all staff receive specific training in transmission based precautions. Very limited reference to transmission-based precautions in IP&C mandatory training e-learning programme used in UHS which is the national e-leaning programme.	Review option to add additional UHS slide on transmission-based precautions in addition to national training package on VLE. Feedback to national team regarding absence of detail on transmission-based precautions in national IP&C e-learning package. UHS appraisal of key staff groups that need to receive training on transmission-based precautions e.g. all UHS staff or clinical/patient facing staff?

	specific infections e.g. COVID, influenza, Norovirus. Information on transmission-based precautions included in trust isolation policy.		Identify additional training materials resources and make accessible to staff.
IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training	Included in induction video for foundation doctors. Included in Newly qualified nurse induction presentation.	Specific IP&C measures for COVID 19 not included in corporate trust IP&C induction video. Specific IP&C measures for COVID 19 not included in in IP&C mandatory training programme used in UHS which is the national e-leaning programme. Assurance that IP&C measures for COVID-19 are included in local induction at department/care group level.	Feedback to national team regarding absence of detail on IP&C measures for COVID 19 in national IP&C e-learning package. Review option to add additional UHS slide on IP&C measures for COVID 19 in addition to national training package on VLE. Evidence of local induction training packages/content and records of training to be obtained/shared from care groups.
all staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	Regular communications via staff briefings, bitesize briefing, UHS social media platforms, briefings from Chief Nurse, Chief Medical officer and Medical director. COVID Zero campaign – signage across hospital sites including on	Compliance generally good but some issues with how to wear masks correctly and compliance with social distancing.	Implementation local COVID zero champions on every shift in clinical areas to promote and monitor correct and safe use of PPE.

	hand gel stations, lifts, restaurants/cafes. Screensavers used to promote and remind staff. COVID zero guardians monitor mask use, social distancing, hand hygiene in public & non-clinical spaces e.g. rest areas.		
all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	PPE for use & selection for IP&C included in induction/mandatory training. PPE selection/use and donning & doffing included as part of COVID PPE training in first wave. PPE guidance for high, medium and low risk pathway in place as per PHE guidance. Specific UHS summary guidance issued plus reminders. Dedicated COVID PPE page on staffnet detailing PPE requirements, donning and doffing instructional posters and videos.	Assurance that all staff know what PPE they should be wearing for each setting and complying with this. Assurance that all current staff have received trained in putting on and taking off PPE. Ongoing risk of national PPE supply issues/shortages resulting in lack of PPE for staff.	Spotchecks /audit of PPE practice in different settings (high, medium & low risk pathways). Ward/Dept leads to complete daily review/checks to include checks on assurance that correct PPE is being ward and safe donning /doffing. Records of training to be evidenced and shared Refresher training on doffing & donning practices to be offered to staff. Modelling process in place to predict demand/run-rate & days left in PPE stock.

	Robust process to monitor and distribute PPE stock to areas that need it.		Alternative options for sourcing/ purchasing PPE utilised e.g. millbrook gowns. Perso Hoods.
national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	IPT Routine check for updates minimum 3xper week. Changes communicated via email cascade, staff briefings, staffnet/workplace updates, daily bitesize briefing.	None	
changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted	Changes discussed & reviewed at IP&C weekly gold command meeting, chaired by Chief Nurse. Escalations to Executive team and relevant governance/assurance committee/boards where required.	None	
risks are reflected in risk registers and the Board Assurance Framework where appropriate	Risks included on Risk register: Risk 335: risk if disruption to PPE supply. Risk 371: Risk of hospital acquired COVID19. Risk 374: Risk of harm to staff. Risk 323: risk to business continuity Risk 405: insufficient space for clinical staff. Risks reviewed by risk groups, QGSG, executive team.	None	

robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	Isolation Risk assessment framework and risk assessment tool used for non-COVID infections/pathogens as part of policy for isolation of adults with infectious conditions/Paediatric isolation policy. Infection admission assessment tool as part of nursing admission paperwork to assess infection risk.	Compliance with completion of isolation risk assessment and infection admission assessment variable in some areas.	Ongoing reminders/communication to be circulated to staff to complete documentation. Spot audit of documentation to be undertaken to monitor compliance Ongoing feedback of compliance with completion of isolation risk assessment as part of enhanced MRSA & Cdifficile surveillance programme. Document review/audit to be undertaken.
that Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner.	Daily nosocomial SITREP managed by informatics team with sign off by Head of Site Operations before daily submission. DIPC (director of infection prevention & control) is in receipt of daily data. Data submitted is reported to Trust board. Robust surveillance system in place to enable the Infection prevention Team to identify hospital onset cases	DIPC is in receipt of daily but CEO/DIPC does not personally sign off data submissions on a daily basis	Review of feasibility of daily sign off by CEO/DIPC.

	of COVID19 and outbreaks/clusters of infection amongst patients and/or staff. Incident/outbreak management plan activated where required - includes involvement of DIPC. Reporting of new cases of hospital onset infection or outbreaks/clusters of infection at daily trust COVID incident meeting. CEO kept informed of case numbers, COVID healthcare associated infection and outbreaks.		
Ensure Trust Board has oversight of ongoing outbreaks and action plans.	DIPC /Chief Nurse (Director of Infection Prevention & Control) has oversight of all on-going outbreaks and action plans, supported by Chief Medical officer & Medical Director. DIPC provides updates to Trust Board including learning and actions. Learning from outbreaks presented to Trust Quality Committee.	None	

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	Ward-based nursing/medical teams allocated to COVID-19 areas where possible – received appropriate skills training for area.	None	
designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	Designated domestic staff assigned to COVID areas. Training received in cleaning SOPs and PPE donning & doffing.	Need confirmation from Serco of arrangements to cover sickness/annual leave in these areas- are there a pool of trained staff who can backfill.	Documented staffing plan to be obtained from Serco and review of adherence to plan.
decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	Isolation rooms/cohort areas cleaned at least daily (frequency as per national cleaning specifications for each area) with a combined detergent/ 1000 ppm available chlorine. Monitoring undertaken by Serco supervisors and Environmental monitoring team. Terminal cleaning of isolation rooms, bed spaces (following movement of	Need assurance that rooms are left for required length of time prior to cleaning after AGPs	Audit to be undertaken

	a patient with suspected/confirmed infection) using combined detergent/1000ppm available chlorine. Record of terminal clean requests/completion held by Serco domestic services team		
increased frequency at least twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	Trustwide enhanced touchpoint cleaning (2xdaily) in place in all clinical areas and public areas in addition to routine scheduled cleaning.	None	
cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	Cleaning of the environment undertaken with Sochlor (1000ppm available chlorine combined detergent and disinfectant) Cleaning of equipment undertaken with Actichlor Plus (1000ppm available chlorine combined detergent and disinfectant)or Clinell universal sanitising wipes (assessed by the IPT as effective against enveloped viruses/COVID19)	None	

Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance	Products are used in line with manufacturers guidance, including dilutions, contact times and requirement for both products to air dry to be effective.	None	
frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids	Enhanced touch point cleaning undertaken by Serco in clinical and non-clinical areas twice daily as per PHE IP&C guidance. Items contaminated with secretions, excretions or body fluids cleaned by clinical staff in clinical areas. Serco in public areas.	Assurance that twice daily touch point cleaning undertaken by includes all frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails and is carried out consistently. Assurance that contaminated items are cleaned by clinical staff.	Further confirmation from Serco and review of SOP for enhanced touch point cleaning. Monitoring/spotchecks to ensure that the agreed SOP is being followed by Serco plus confirmation of expected standards from ward leaders. Communication reminder to clinical staff of the need to clean contaminated items/surfaces and monitoring/spotchecks of compliance.
electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards should be cleaned a minimum of twice daily	Guidance issued regarding requirements and expected standards to clean electronic equipment in clinical and non-clinical areas.	Evidence and assurance required that electronic equipment is being cleaned at least twice daily.	Monitoring/spotchecks and include in ward/dept leader daily checklist. Introduction of COVID zero local champions to promote required

	Regular communications and use of screensavers to promote this. Use of cards (red/green) in shared work-spaces/desks to indicate that area has/has not been cleaned.		standards of practice. Introduction of 2 hourly prompts e.g bell/alarm to act as a reminder to clean communal electronic equipment.
rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	Rooms/areas where PPE is removed cleaned at least twice/three times daily as per agreed cleaning SLA for the area.	Assurance that areas are being cleaned as per agreed SLA.	Confirmation required from Serco. Monitoring by EMT as part of cleanliness monitoring programme.
linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Linen treated as infected linen – included in infection control action cards. Standard precautions audit (including care of linen) undertaken August 2020.	Assurance/evidence required that policy is consistently being followed.	Spotchecks on compliance with required standards and obtain feedback from linen services.
single use items are used where possible and according to Single Use Policy	Guidance/Policy in place regarding single items – Single use & single patient use equipment policy.	Assurance required that policy is being followed and no single use items are re-used.	Spotchecks/audit to be undertaken that no re-use is occurring.
reusable equipment is appropriately decontaminated in line with local and	Guidance in place regarding decontamination of re-usable	Further assurance/evidence that reusable equipment is cleaned	Observations of practice/audit to be undertaken.

PHE national policy	equipment between patient use plus daily/weekly . Cleaning roles & responsibilities daily/weekly checklist to document assurance.	between patient use Audits by EMT highlight that a small number of areas are not meeting expected standards.	Assurance/confirmation of regular review of cleaning checklists by ward/dept leader and matron as per agreed trust standards and expectations for clinical cleaning assurance
ensure cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment	Monitoring of cleaning standards/frequencies in non-clinical areas undertaken by UHS Environmental Monitoring team (EMT) and fed back to Serco and departmental/area lead with requirements to rectify any failings. Audit results reviewed at fortnightly cleaning operational meetings. Performance also review monthly at trust overview meetings. Process in place to raise and escalate concerns via Serco helpdesk, cleaningstandards email or via incident reporting.	Issues with cleaning standards/frequencies in some non-clinical areas are not always resolved in a timely manner or occur on a recurrent basis.	Options to undertake additional monitoring of non-clinical areas to be explored . Assurance required from Serco with regard to Supervision of staff in non-clinical areas and how improvement actions are measured.
ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	Site wide survey of ventilation in clinical /non-clinical areas undertaken by estates team.	Assurance required on progress and timelines for actions to improve ventilation following site wide	Routine opening of windows in all areas to be introduced at set points during the day e.g. for an hour after each meal.

	Ventilation task and finish group set up to identify/prioritise areas where additional actions are required to improve ventilation e.g. engineering solutions or use of heap-filtration units. Additional purchase of heap-filtration units to support air dilution of area in clinical/non-clinical areas. Promotion of the need to open windows in all spaces (where able) to promote air flow via staffbriefings and communications.	survey. Awareness and compliance by staff with practice of opening of windows.	Update on progress from estates team/ventilation task and finish group to be reported to Infection Control Gold Command Committee. Ventilation task and finish group to prioritise areas for placement of hepa-filtration units.
there is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectant	Sochlor (1000ppm available chlorine) is the trust selected product for routine cleaning in all clinical areas of the trust. No review required to change product.	None	

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure:			
arrangements around antimicrobial stewardship is maintained	Antimicrobial stewardship is maintained throughout the trust with timely update to Trust guideline in Micro guide (Guideline checked in Micro guide) Multiple antimicrobial stewardship ward round are conducted in key areas of the Hospital (Evidence seen in entry from Master lab) Clinical Lead for antimicrobial stewardship now in place.	None	
• mandatory reporting requirements are adhered to and boards continue to maintain oversight	Antimicrobial stewardship report presented at Infection prevention committee.	Antimicrobial stewardship report, as part of quarterly IP&C report, previously presented at TEC which has now been replaced by alternative committees.	Reporting framework for antimicrobial stewardship to be reviewed and agreed.

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
implementation of national guidance on visiting patients in a care setting	Visitor restrictions currently in place. UHS has an agreed visitor policy, including visitor approval process. Designated door staff re-introduced to undertake checks at entrances /allow access to approved visitors only.	Need assurance of compliance with visitor policy. Some inconsistencies between clinical areas in interpretation of restrictions.	Ongoing reminders/briefings to be circulated to staff. Escalation of issues by door staff to Matrons for areas. Explore use of visitor logs in clinical areas.
areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas marked with appropriate signage and where appropriate with restricted access	Signage in place.	None	
information and guidance on COVID-19 is available on all Trust websites with easy read versions	Guidance available on staffnet for staff to provide to visitors, patients etc. Information available on public website for patients and visitors.	None	

infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved.	evidence of documented infection status on discharge summaries/transfer documents	Lack of assurance on degree of compliance that infection status is always communicated.	Documentation checks to be undertaken.
there is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	COVID Zero campaign (WASH,WALK,WEAR) – signage across hospital sites including in entrances, on hand gel stations, lifts, restaurants/cafes. Screensavers used to promote and remind staff.	Limited written or visible information for inpatients located in ward/clinical areas.	Development of patient information leaflet and signage for inpatient areas.
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases.	Policy in place for all patients to be triaged and screened on admission or pre-admission. Good compliance with admission/pre-admission testing demonstrated by breakdown of COVID testing data.	Evidence of documentation of triage screening in patient's notes.	Ongoing reminders/briefings to be circulated to staff to complete documentation. Spot audit of documentation to be undertaken to monitor compliance.

front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms to segregate from Non Covid 19 cases to minimise the risk of cross-infection as per national guidance.	Triaging arrangements in place in ED and placement in designated respiratory assessment area. Triage and segregation in place in other admission areas e.g.AMU, AOS, ASU, TAU. Direct transfer to COVID positive ward for confirmed positive cases.	None	
staff are aware of agreed template for triage questions to ask	Triage checklist introduced and circulated to all clinical teams. Screening questions asked to patients/visitors entering the building via door staff on manned entrances.	Assurance that staff are aware of and using the triage checklist	Spot check to be undertaken to monitor compliance.
triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	Triage checklist in place. Triage undertaken by train nursing/medical staff/AHP staff on admission/pre-admission and patients allocated to appropriate pathway accordingly.	Assurance that staff are aware of and using the triage checklist	Spot check to be undertaken to monitor compliance

face coverings are used by all outpatients and visitors	Use of facemasks is a requirement on entering the hospital building unless evidence of exemption. Face masks available/offered to patients and visitors if they arrive at hospital entrances without one. COVID-zero guardians monitor and promote compliance on mask use	None	
face masks are available for patients with respiratory symptoms	Face masks are available for all patients in all pathways regardless of symptoms.	None	
provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care	Guidance in place that all patients across all pathways (low, medium, high) should be encouraged to wear a surgical face mask where able to. Additional guidance on patient use of masks issued to staff and available on staffnet.	Evidence that not all patients are wearing or offered masks. Awareness of staff to promote mask use amongst patients	Patient information leaflet and signage to be developed outlining requirements.
ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff	Segregation in separate spaces where possible. Screens in place in reception areas e.g. emergency departments, outpatients.	None	

for patients with new onset symptoms , isolation, testing and instigation of contact tracing is achieved until proven negative.	Guidance in place - inpatients with new onset symptoms are tested (using a rapid test) at point they develop symptoms. Bay closed until results known and contacts identified.	None	
patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly retested and contacts traced promptly	Guidance in place for management and re-testing of patients who go on to develop symptom. Patients are tested (using a rapid test) at point they develop symptoms. Bay closed until results known and contacts identified. Patients who test negative but remain high suspicion COVID isolated in a single room.	None	
patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Procedures in place for patients who attend appointments. Good pre-hospital communication in place. Screening questions undertaken at hospital or departmental entrances and actions in place to safely manage patients who answer yes to these questions.	None	

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	High, medium and low risk patient pathways separated within care group/ clinical area footprints. Designated access routes to high risk COVID positive areas, Designated separate staff and visitor/patient entrances to the hospital with signage.	None.	
all staff (clinical and non- clinical) have appropriate training, in line with latest national guidance, to ensure their personal safety and working environment is safe	Staff receive infection prevention and health and safety training on induction and as part of ongoing mandatory training requirements. PPE training delivered as part of trust COVID response. Fit testing undertaken on all staff required to wear an FFP3 mask.	Complete records of training compliance may be held in a number of different local databases	Records of training to be evidence and shared Refresher training on PPE donning and doffing to be promoted/ offered to staff.

all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	PPE use & selection included in induction/mandatory training. PPE selection/use and donning & doffing included as part of COVID PPE training in first wave.	Assurance that all staff know what PPE they should be wearing for each setting and complying with this. Assurance that all current staff have received trained in putting on and taking off PPE.	Spotchecks /audit of PPE practice in different settings (high, medium & low risk pathways). Ward/Dept leads to complete daily review/checks to include checks on assurance that correct PPE is being worn and safe donning /doffing. Records of training to be evidence and shared Refresher training on PPE donning and doffing to be promoted/ offered to staff.
a record of staff training is maintained	Records of training for statutory & mandatory training. IPT hold records for PPE donning &doffing that they have delivered. Fit testing records maintained.	Need confirmation that training records have been maintained for PPE donning & doffing training undertaken within care groups/divisions	Records of training to be evidence and shared
appropriate arrangements are in place that any reuse of PPE in line with the **MHRA** CAS alert is properly monitored and managed	Guidance in place for re-use/decontamination of eye protection/facial visors. Feedback/issues picked up via PPE	None	

	operational group. Procedure for Re-processing of gowns/coveralls developed in the event that it is required.		
any incidents relating to the re-use of PPE are monitored and appropriate action taken	All PPE related incidents reported and discussed at the PPE operational group.	None	
adherence to PHE national guidance on the use of PPE is regularly audited	PHE audit scheduled to be undertaken by clinical areas November 2020 as part of annual IP&C audit programme. Informal monitoring within individual areas and by Infection Prevention Team on ward visits Spot-checks undertaken as part of walkabouts and Infection Prevention Team visits to clinical areas. Spot-checks by senior nurses and link staff in some areas.	Additional assurance needed on consistent adherence to national guidance	Implementation local COVID zero champions on every shift in clinical areas to promote and monitor correct and safe use of PPE. Ward leaders to complete daily review/checklist which includes checks on PPE compliance. PPE Audit November 2020 (as per scheduled IP&C audit programme)

	COVID – zero guardians monitor compliance of mask use in public & non-clinical spaces.		
hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: ▪ hand hygiene facilities including instructional poster ▪ good respiratory hygiene measures ▪ maintaining physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care ▪ frequent decontamination of equipment and environment in both clinical and non-clinical areas ▪ clear advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas	Hand hygiene messaging and facilities available across hospital sites in clinical & non-clinical areas e.g. hand gel at hospital & ward/department entrances, lift lobbies, mask collection and disposal points, restaurants/eating areas, patient bedside, entrances to ward bays/single rooms. Instructional posters or information (integrated onto dispensers) available. Soap, water and hand towels available for hand washing. Promotion of respiratory hygiene amongst patients and staff through communication messages, social media platforms. Social distancing messaging throughout hospital as part of COVID zero information. k Facilities in place to facilitate decontamination of the environment and equipment e.g.	Limited written or visible information for inpatients located in ward/clinical areas to promote respiratory hygiene, use of face masks and social distancing. Assurance that patients are consistently provided with facilities to undertake hand hygiene and undertake respiratory etiquette – tissues, bag for disposal, hand wipes/gel.	Patient information leaflet and signage to be developed outlining requirements**.** Spotchecks /audits of patient hand hygiene and respiratory hygiene facilities and ward/Dept leads to complete daily review/checks

	cleaning wipes and products. Use of cards (red/green) in shared work-spaces/desks to indicate that area has/has not been cleaned. Regular messaging via briefings and use of screen savers. Messaging on use of face masks on COVID Zero signage, public website, staffnet, regular communications and promotion by COVID zero guardians.		
staff regularly undertake hand hygiene and observe standard infection control precautions	Hand hygiene practice and adherence to standard precautions observed within individual areas and by Infection Prevention Team on ward visits. Spot-checks by senior nurses and link staff in some areas. Standard Precautions and Hand hygiene audits included as part of annual IP&C audit programme Hand hygiene (covert) July 2020 Standard Precautions August 2020	Assurance that staff consistently undertake hand hygiene and observe standard precautions.	Additional Spotchecks of practice. Ward/Dept leads to complete daily review/checks for assurance. Implementation of local COVID zero champions on every shift in clinical areas to promote and monitor practice.

the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance	No hand air dryers are located in clinical areas. All clinical areas have hand towels	None.	
guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas	Instructional posters available in staff areas	Instructional posters not displayed public toilets	Signage to be developed to place in public toilets
staff understand the requirements for uniform laundering where this is not provided for on site	Guidance issued re laundering of uniforms and ongoing communication to re-enforce.	None	
all staff understand the symptoms of COVID-19 and take appropriate action **(even if experiencing mild symptoms)** in line with PHE national guidance if they or a member of their household display any of the symptoms.	Evidenced via staff screening programme (including household members),	Very small number of incidents where staff have worked with mild symptoms.	Ongoing enforcement and reminder. Escalation if staff found to be continuing to work with symptoms.
a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff	Robust surveillance system in place to facilitate identification of hospital onset cases, early warnings of increased rates of infection to identify both outbreaks and clusters	None.	

and patients/individuals)	(detection of unexpected, potentially linked cases) of infection amongst patients and staff. Close liaison between the Infection prevention Team, Occupational health & clinical/non-clinical teams is in place to support identification, investigation and management individual cases or increased incidence of infection. Good links with Southampton City council (UHS participates in Health Protection Board) and regular review of local infection data. Daily reports received and reviewed from local health protection team on local outbreaks and clusters.		
positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported	Process in place where all cases confirmed positive on/after day 8 of admission trigger an incident meeting, investigation and RCA. Two or more cases linked to time and place (patient and/or staff) investigated and reported as an outbreak internally and externally	None	

	e.g IIMRACH submitted to regional team.		
robust policies and procedures are in place for the identification of and management of outbreaks of infection	Robust surveillance system in place to facilitate early warnings of increased rates of infection to identify both outbreaks and clusters (detection of unexpected, potentially linked cases) of infection amongst patients and staff. All outbreaks are managed via a formal incident/outbreak management process with ongoing monitoring until 28 days following the last confirmed case.	None	
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate	Restricted access to COVID positive areas.	None	

low/high) by other patients/individuals, visitors or staff	High, medium and low risk patient pathways separated within care group/ clinical area footprints – restriction of access dependant on location.		
areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	COVID positive wards/areas and AMU high/medium risk areas clearly signposted. Signage displayed on Isolation rooms/cohort bays of COVID-19 contact patients.	Assurance that signage is in place all high/medium risk areas, where appropriate, to ensure staff are aware of the different risk areas.	Review of pathways, particularly admission pathways, to determine where signage is required.
patients with suspected or confirmed COVID-19 are where possible isolated in appropriate facilities or designated areas where appropriate	Designated cohort wards/isolation facilities identified and in use.	None	
areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	Cohort areas are in designated areas of the trust, separated by closed doors and access restricted. Signage in place. Review of ventilation in the areas undertaken.	None	
patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Patients with suspected/confirmed resistant/alert organisms isolated in single rooms as per isolation policies where possible. IT systems in place	Limited isolation capacity in many care groups often results in delay in patient placement or inability to isolate all patients requiring a single	Pro-active management of isolation capacity, including daily review at bed meetings and use of trust sideroom database. Risk

	for IPT to monitor patient placement/single room usage. Dedicated isolation facilities available : C5 (negative pressure 15 rooms) and D10 isolation ward	isolation room.	stratification in place (isolation risk assessment tool) to enable prioritisation of single rooms. Additional single room capacity development within SGH site commencing November 2020
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure:			
ensure screens taken on admission given priority and reported within 24hrs	Clinical prioritisation in place for use of rapid tests for some admission areas – point of care tests (AMU) and ultra-rapid tests. In-lab turnaround time for tests is under 24 hrs (7-11hrs).	Limited availability of point of care/ultra-rapid test for non-elective admissions (less than 50%)	Ongoing clinical prioritisation for use of available point of care/rapid tests. Ongoing appraisal of options to increase point of care/rapid testing as directed/agreed/ made available by national team. Process to be introduced to separate staff (asymptomatic) and patient samples (coloured bags) to enable prioritisation of processing of patient samples

regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	In lab Turnaround times monitored and reported (from point that sample is booked into the lab to point that result is released)	Currently no system in place to measure and report turnaround times from the point that the sample was taken from the patient.	Explore potential digital solutions to accurately monitor testing turnaround times (patient to result) e.g. Sample 360
testing is undertaken by competent and trained individuals	Guidance in place to support staff in the correct procedure for taking COVID 19 respiratory samples.	None	
patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Patients with suspected COVID 19 tested on admission (symptomatic & asymptomatic) or at the point they develop symptoms if an inpatient. Process for staff testing (staff with symptoms or symptomatic household members) in place. Routine weekly asymptomatic screening of inpatients in place. Rollout of wider asymptomatic staff testing using a range of methods.	None	
regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	All patients (symptomatic and asymptomatic) tested on admission and throughout their stay. Good compliance with patient testing based on review of admission		

	v lab data. Positive cases reported via daily Sitrep and PHE reporting platform. Tests undertaken on validated platforms (laboratory and point of care) and reporting accordingly. Results available for clinical teams on equest.		
screening for other potential infections takes place	Screening for other infections undertaken e.g. other respiratory viruses, diarrhoeal pathogens e.g. C.difficile/Norovirus, MRSA screening.	None	
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that:			
staff are supported in adhering to all IPC policies, including those for other alert organisms	Policies/guidelines in place. IPT provide support in adhering to policies via visits to clinical areas,	None	

	audit, provision of management advice for patients with alert organisms, education & awareness campaigns. Good infection prevention link network in place – link staff support their colleagues at ward/department level.		
any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Regular review of PHE guidance by IPT. Changes discussed & reviewed at IP&C weekly gold command meeting, chaired by Chief Nurse. Changes communicated via a range of channels.	None	
all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	Included in IP&C action card and correct bins in all areas to ensure appropriate segregation. Standard precautions audit (including waste) undertaken August 2020.	Confirmation required from waste team that waste is being appropriately segregated.	Confirmation from waste team that waste is being appropriately segregated.
PPE stock is appropriately stored and accessible to staff who require it	PPE stock stored in local hubs and distributed to clinical areas. Escalation process in place.	None	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure:			
staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported	Risk assessments undertaken for at risk staff groups and appropriate actions taken. COVID age risk assessment tool to determine individual staff members vulnerability to COVID-19 and provide an evidence based risk assessment for staff Staff support and well- being services and resources in place	None	
that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff	COVID age risk assessment tool to determine individual staff members vulnerability to COVID-19 and provide an evidence based risk assessment for staff	None	
staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance	Fit testing performed on all staff needing to wear and FFP3 re-usable respirator.	None	

and a record of this training is maintained and held centrally.	Training recorded central on database. Fit testers located in all Divisions and option available to escalate to a central service if required.		
staff who carry out fit test training are trained and competent to do so	Training programme, including competency requirements in place for fit testers.	None	
all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	Staff fit tested for models that are available. System in place to identify staff who have been fit tested on a mask that is no longer available and require re-fit testing.	None	
a record of the fit test and result is given to and kept by the trainee and centrally within the organisation	Staff are encouraged to keep a personal record of the mask they have been successfully tested on by taking a photograph. Central record held on trust fit tester database with link to staff electronic record.	None	
for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative	Central records held on trust fit tester database with links to staff electronic record. A range of alternative options are	None	

respirators and hoods	available for staff who fail to fit an FFP3 mask – Powered Respirator hoods, Perso hoods.		
for members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm	A range of alternative options are available for staff who fail to fit an FFP3 mask – Powered Respirator hoods, Perso hoods. In the unusual event that these are not suitable discussions would be undertaken with employee regarding options for re-deployment in the event that it is required.	None	
a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health	In the unusual event that alternatives options are not suitable discussions would be undertaken with the employee regarding job role, options for re-deployment in the event that it is required. This would be documented in their personal record.	None	
following consideration of reasonable adjustments e.g. respiratory hoods, personal reusable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a	A range of alternative options are available for staff who fail to fit an FFP3 mask – Powered Respirator hoods, Perso hoods. In the unusual event that		

record kept in staff members personal record and Occupational health service record	alternatives options are not suitable discussions would be undertaken with the employee regarding job role, options for re-deployment in the event that it is required. This would be documented in their personal record.		
boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	Central system in place to monitor compliance with fit testing requirements. Fit testing process and compliance/issues reviewed, discussed and escalated at Trust health and safety committee, daily COVID incident meetings, infection Prevention Gold Command Committee. DIPC keeps executive team and board appraised of fit testing processes, compliance and concerns.	None	
consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance	Care groups/departments endeavour to allocate consistent staff to specific areas/pathways and reduce staff movement wherever possible, taking into account the balance of risk related to IP&C,	Assurance of the process for allocation of peripatetic staff who work across a wider area of the hospital.	Update and review of allocation of peripatetic staff with clinical/non-clinical support services to be undertaken.

	safety, clinical risk and ward/ departmental footprint.		
all staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas	Guidance on social distancing requirements and standards in place. Regular communications and messaging via a range of platforms as part of COVID-zero campaign and sharing learning from outbreaks. Trust guidance is to wear a mask at all times, unless eating and drinking, regardless of whether social distancing can be maintained.	Evidence and observations that social distancing is not being followed consistently by all staff at all time.	Ongoing monitoring by COVID zero guardians on mask use and social distancing in public & non-clinical spaces e.g. rest areas. Implementation local COVID zero champions on every shift in clinical areas/departments to promote and monitor social distancing. Identification of additional space for staff to access for breaks.
health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	Promotion of working from home where role allows. Risk assessments and checklists in place for non-clinical spaces. Agreed maximum occupancy for offices and non-clinical spaces e.g. meeting rooms, teaching spaces, lifts. Social distancing set up in offices,	None	

	rest areas, eating areas. Use of masks at all times, unless eating and drinking, regardless of whether social distancing can be maintained. Ongoing promotion of social distancing, hand hygiene, use of masks.		
staff are aware of the need to wear facemask when moving through COVID-19 secure areas	Regular messaging on use of face masks by staff in all areas of the hospital – communications, COVID-zero signage and promotion by COVID zero guardians.	Compliance generally good but some issues with how to wear correctly.	Ongoing monitoring by COVID zero guardians on mask use and social distancing in public & non-clinical spaces e.g. rest areas. Implementation local COVID zero champions on every shift in clinical areas/departments to promote and monitor social distancing.
staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	Monitored at ward and care group level. Staff able to access testing via self-referral process.	None	

staff that test positive have adequate information and support to aid their recovery and return to work	Staff testing positive are provided with advice and guidance from Occupational Health.	None	

17th November 2020.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors dated Thursday, 26 November 2020				
Title:	**Integrated Performance Report 2020/21 Month 7**			
Agenda item:	**3.7**			
Sponsor:	**Chief Executive**			
Date:	**20 November 2020**			
Purpose	**Assurance or reassurance Y**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	This report is intended to support the Trust Board in assuring that: • the care we provide is safe, caring, effective, responsive and well led in the context of the Covid 19 pandemic • at the same time we continue our journey toward our vision of World Class Care for Everyone.			
Response to the issue:	For the year 2020/21 the Integrated Performance Report has adapted to reflect the current operating environment. In particular we have aligned it with the Care Quality Commission Key Lines of Enquiry and then cut it again to reflect delivery of our Strategic Goals and annual corporate objectives.			
Implications: (Clinical, Organisational, Governance, Legal?)	This report covers a broad range of trust services and activities. It is intended to assist the Board in assuring that the Trust meets regulatory requirements and corporate objectives.			
Risks: (Top 3) of carrying out the change / or not:	This report is provided for the purpose of assurance.			
Summary: Conclusion and/or recommendation	This report is provided for the purpose of assurance.			

Integrated KPI Board Report

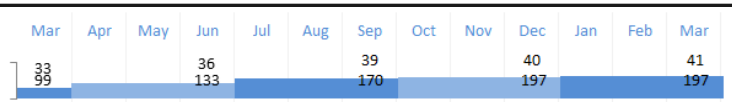
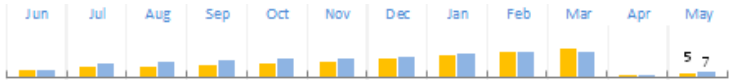
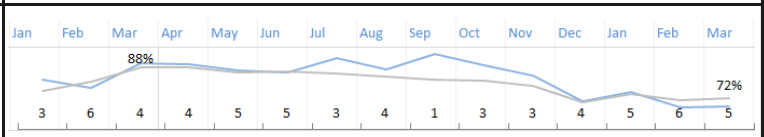
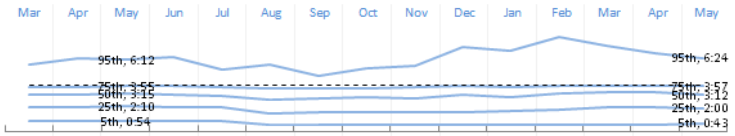
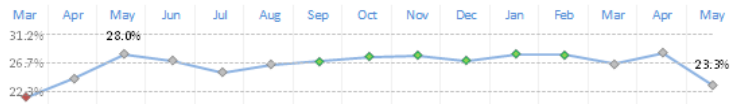
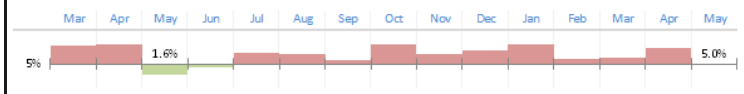
covering up to

Oct 2020

Sponsor - Andrew Asquith, Director of Planning, Performance and Productivity,
andrew.asquith@uhs.nhs.uk

Report Guide

University Hospital Southampton NHS
NHS Foundation Trust

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 it's 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 -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 it's 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 it's target.

Introduction

The Trust Integrated Performance Report is presented to the Trust Board each month.
For the year 2020/21 the Integrated Performance Report has adapted to reflect the current operating environment. In particular we have aligned it with the Care Quality Commission Key Lines of Enquiry and then cut it again to reflect delivery of our Strategic Goals and annual corporate objectives in order to:

• Demonstrate that we can assure ourselves that the care we provide is safe, caring, effective, responsive and well led in the context of the COVID-19 pandemic

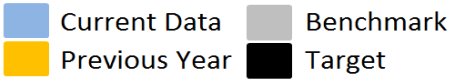
• Ensure that at the same time we continue our journey toward our vision of World Class Care for Everyone.
We might adjust/ or add to these indicators – informing the Board and keeping a comparative narrative – if the situation changes as we work through these unusual circumstances. An example of this might be measuring vulnerable groups as the evidence around COVID emerges.

The monthly Trust Integrated Performance Report is currently complemented by a 'COVID-19 Balanced Scorecard' which is also available to Board Members.

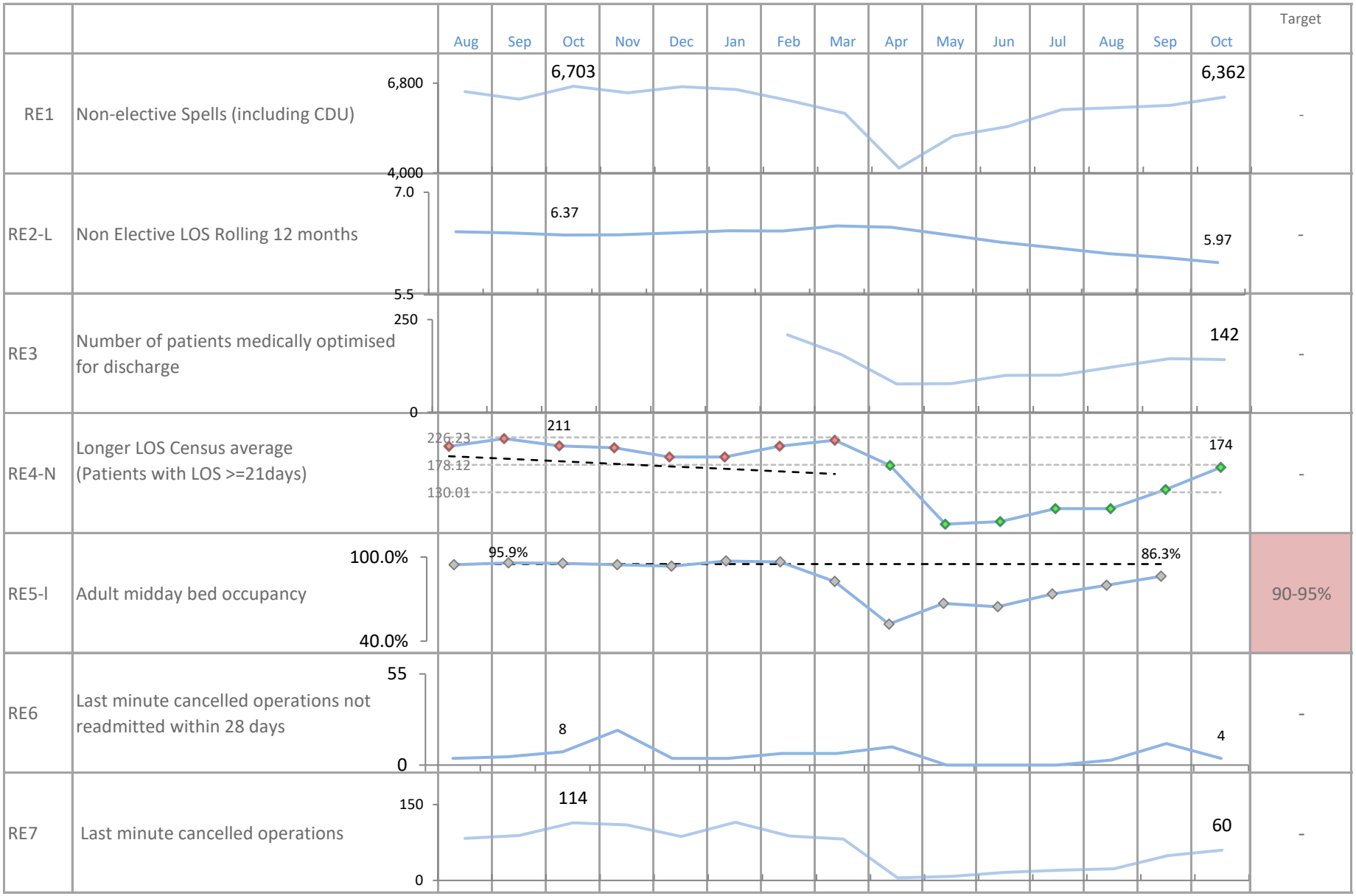
October 2020 Summary

During October the direct impact of COVID-19 infections upon the Trust increased once more, with confirmed COVID-19 patients increasing from 5 patients (2 of which were in intensive / high care, to 40 (4 of which were in intensive / high care) by 28/10/20. Services for patients with other conditions were largely maintained, without adverse impact, however.
Non-elective admission volumes overall were approximately 95% of their normal levels.
Elective spells at all hospital sites were approximately 85% of their normal levels.

• Emergency Department timeliness improved slightly in October, remaining above 90% (RE 10). UHS had the second best performance out of 8 'peer' Major Trauma Centres (RE9). Attendance numbers reduced to approximately 81% of the normal level (RE 8), whilst enhanced infection control precautions remained in place.
• The percentage of patients waiting up to 18 weeks from referral to treatment improved marginally to 64% (RE 14), UHS was 7th best out of a group of 20 teaching hospitals on this measure. The total number of patients waiting is above pre-Covid levels and has increased further by approximately 500 patients this month, due to the recovery in the number of referrals being made to hospital (RE 12).
• The number of referrals accepted in October was 30% higher than in the previous month, and now appears to have exceeded those in the same month of the previous year (by 23%). It is likely that the variance to last year is overstated to a modest degree due to differences in recording practices between years (e.g. registering referrals for services that previously offered a 'walk-in' service) and the scale of this impact will be investigated further.
• The number of patients waiting more than 52 weeks (RE16) has increased from 40 at the end of March, to 1693 at the end of October (an increase of 160 patients in the last month). Whilst similar trends are being experienced at many other hospitals, especially other large tertiary centres, we are very concerned by this and are working hard to increase capacity.
• The percentage of patients waiting more than 6 weeks for a diagnostic test (RE 21) improved further, from 34% to 31%. The total number of patients waiting (RE 20) reduced for the first time since April, by 3%, but remains 18% higher than in February.
• Cancer performance measures for August indicate that UHS 62 day performance (RE 22) continues to the best amongst our 10 'peer' teaching hospitals at 87%, and that 31 day performance (RE 23) continues to be above the national target at 97%. The number of patients still waiting with pathways greater than 104 days (RE 24) remained at 11 for a second month.
• Activity benchmarking against other teaching hospitals using data that is submitted nationally for elective activity suggests that activity recovery at UHS in September was slightly above the average (84.4% of the previous year rather than 81.5%, 2/7 trusts compared). UHS elective spells (RE13) were 84% in October compared to the same period in 19/20.
• Activity benchmarking against other teaching hospitals using data that is submitted nationally for non-elective and outpatient activity has been suspended in this report this month, whilst concerns regarding the comparability of data between years (non-elective), and between trusts is investigated further.



RESPONSIVE



Current Data
Previous Year
Benchmark
Target

RESPONSIVE

		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	QTD	Q Target
RE8	Total ED Attendances	12,000 / 5,000		11967												9692	-	-
RE9-N	Patients spending less than 4hrs in ED - SGH Main ED (Type 1 and UCH)	91% / 81% / 72%		80.5%												91.30%	91.3%	95%
	Major Trauma Centres (Type 1) Rank of 11, (8 from May 19 onwards)->	6	5	4	5	3	6	5	3	2	5	3	3	4	2	2		
RE10-N	Patients spending less than 4hrs in ED - UHS Total (includes SGH all types and lymington until Jul 19)	92.09% / 83.9% / 75.64%		82.1%												91.8%	91.81%	95%
RE11-N	Total time spent in ED - Percentiles UHS Total			Mean, 3:18 / 50th, 3:05												90th, 3:59 / Mean, 2:57 / 50th, 2:58	-	-
RE12	Accepted Referrals	25000 / 0		19370												23971	-	-
RE13	Elective spells	2,000 / 0		1,798												1,513	-	-

Current Data | Benchmark
Previous Year | Target

RESPONSIVE

		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Target
RE14-N	% Patients on an open 18 week pathway (within 18 weeks) with teaching hospital min-max range and rank	100% 0%		81.5%											7 of 20	64.44%	>=92%
RE15-N	Total number of patients on a waiting list (18 week referral to treatment pathway)	38000 30000		34900												36128	
RE16-N	Patients on an open 18 week pathway (waiting 52 weeks+) with teaching hospital min-max range and rank	3500 0		4											10 of 20	1693	
RE17	Face to face outpatient attendances	50,000 0	46,855												35,356		-
RE18	Non-face to face outpatient attendances	50,000 0	8,818												20,295		-
RE18 - Latest month is awaiting approx ~3k outpatient attendances to be reported																	
RE19	Average weeks waited for first outpatient appointment	12.00 7.00		8.6												8.9	-

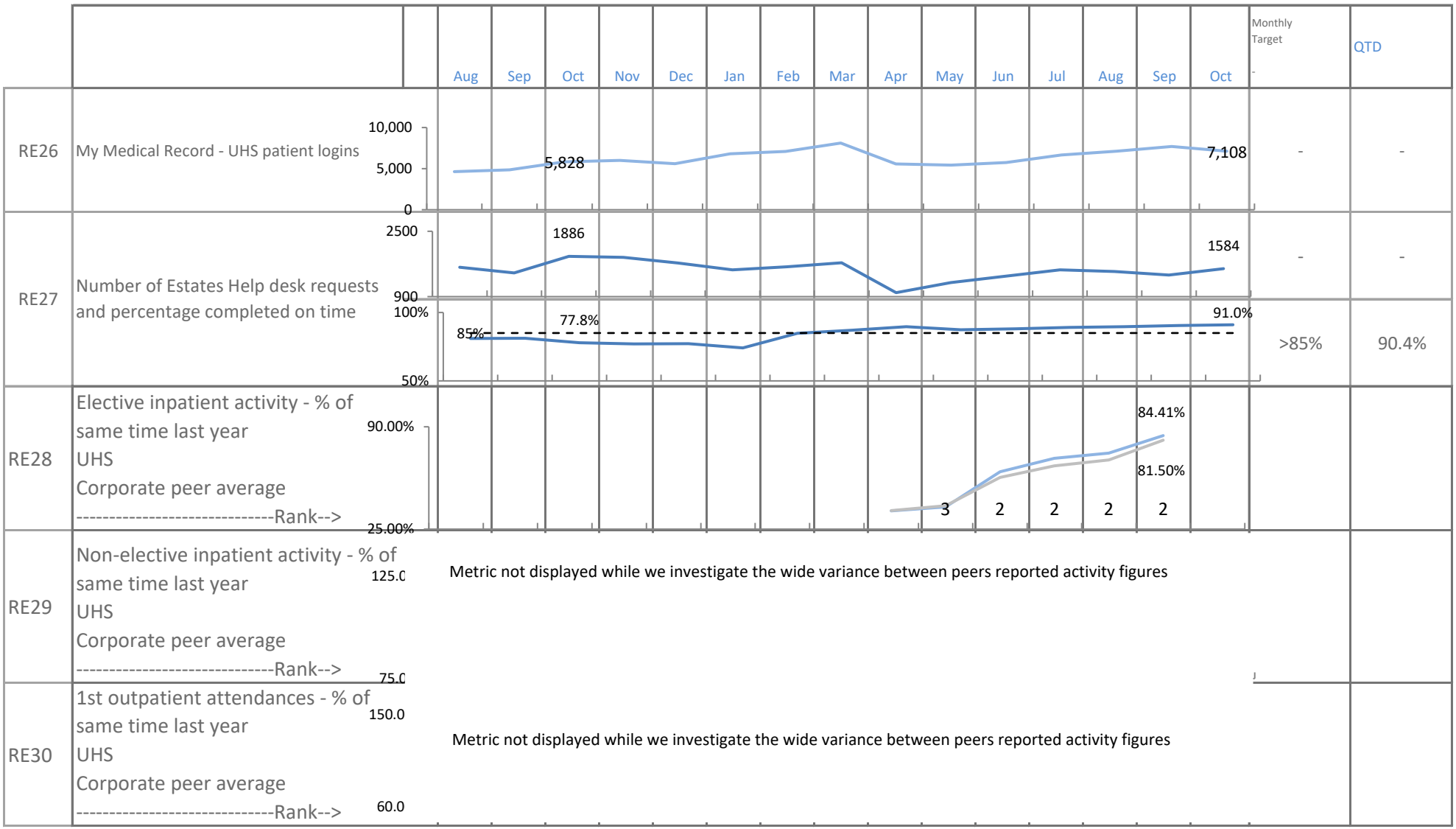
Current Data
Previous Year
Benchmark
Target

RESPONSIVE

		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Target /Oct	no.patients to recover	QTD
RE20-N	Patients waiting for diagnostics	10,000		7184											9361		-	
		4,000																
RE21-N	% of Patients waiting over 6 weeks for diagnostics	80.00%		2.2%											31.32%	14 of 20	<=1%	
		0.00%																
RE22-N	62 day Performance Benchmark (data reported nationally at due dates) Teaching Hospitals vs.	1		72.5%											86.8%	N=> 90% L=> 85%	N = 3 L= 0 of 143	88%
	UHS Total .....Rank(of 10)->	0.5	5	7	8	6	4	5	6	5	5	1	2	1	1	1	75.8% 71.8%	
RE23-N	31 day cancer wait performance (latest data held by UHS)	96.4%		92.5%											96.85%	N=> 96%	N=0 of 729	97.26%
		88.8%																
RE24-N	Snapshot of waits > 104 days (from referral on a 62 day pathway)	41	55	52	41	29	35	27	29	11	25	36	17	11	11	-	-	-
RE25-N	28 Day Faster Diagnosis	100%		73%											81%	=>75 %	-	83.91%
		70%																

Current Data
Previous Year
Benchmark
Target

RESPONSIVE


Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Monthly Target
QTD
RE26
My Medical Record - UHS patient logins
10,000
5,000
0
5,828
7,108
-
-
RE27
Number of Estates Help desk requests and percentage completed on time
2500
900
1886
1584
100%
50%
85%
77.8%
91.0%
>85%
90.4%
RE28
Elective inpatient activity - % of same time last year
UHS
Corporate peer average
----------Rank-->
90.00%
25.00%
84.41%
81.50%
3
2
2
2
2
RE29
Non-elective inpatient activity - % of same time last year
UHS
Corporate peer average
----------Rank-->
125.0
75.0
Metric not displayed while we investigate the wide variance between peers reported activity figures
RE30
1st outpatient attendances - % of same time last year
UHS
Corporate peer average
----------Rank-->
150.0
60.0
Metric not displayed while we investigate the wide variance between peers reported activity figures
RE28-RE30 corporate peers group size = 7
Current Data
Previous Year
Benchmark
Target

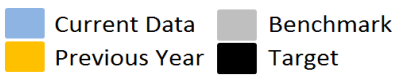
• The number of Clostridium Difficile infections in the month was 4, which is a reduction compared to previous months and within the monthly 'target'. The number of such infections year to date remains above target. Investigations into the Clostridium Difficile infections between August and October found that
o only one patient was also COVID-19 positive
o a number of the infections occurred in patients with significantly complex circumstances including repeated complex abdominal surgery, and cancer patients receiving chemotherapy
o antibiotic use was proportionate based upon the clinical diagnosis and patient deterioration, and microbiologist advice had been sought and given
• 6 cases of 'probable' transmission (SA6) and 9 cases of 'healthcare-acquired' COVID-19 (SA5) occurred in UHS inpatient services during October, primarily as a result of an outbreak on G6 ward. More detailed information is presented to the UHS November Board meeting in a separate paper. Strategies to reduce the risk of in- hospital transmission of COVID19 continue to be in place, as detailed in the COVID-19 board assurance framework and COVID Zero action plan. All such cases are investigated through the root-cause investigation process, either as an individual case review or as part of a wider outbreak investigation.
• The continued avoidance of MRSA Bacteraemia, and pressure ulcers causing moderate/severe harm, and very low levels of high harm falls due to omissions in care, are all encouraging.
• The percentage of statutory and mandatory maintenance jobs completed on time (SA15) dropped to 89% this month, below the target of >95%. The main delays related to fire doors (which have now been completed), and medical gas planned preventative maintenance (which will be completed in November).

		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly Target	YTD	YTD Target
SA1-N	Cumulative Clostridium difficile				25 42	30 49	31 55	37 61	40 70	5 5	14 11	19 15	24 18	27 32	30 39	35 43	5	43	<=35
SA2	MRSA bacteraemia															0	0		
SA3	Clinical cleaning scores for very high risk areas			100												99	98	-	-
SA4	Serco cleaning scores for very high risk areas			99												99	98	-	-

Current Data
Previous Year
Benchmark
Target

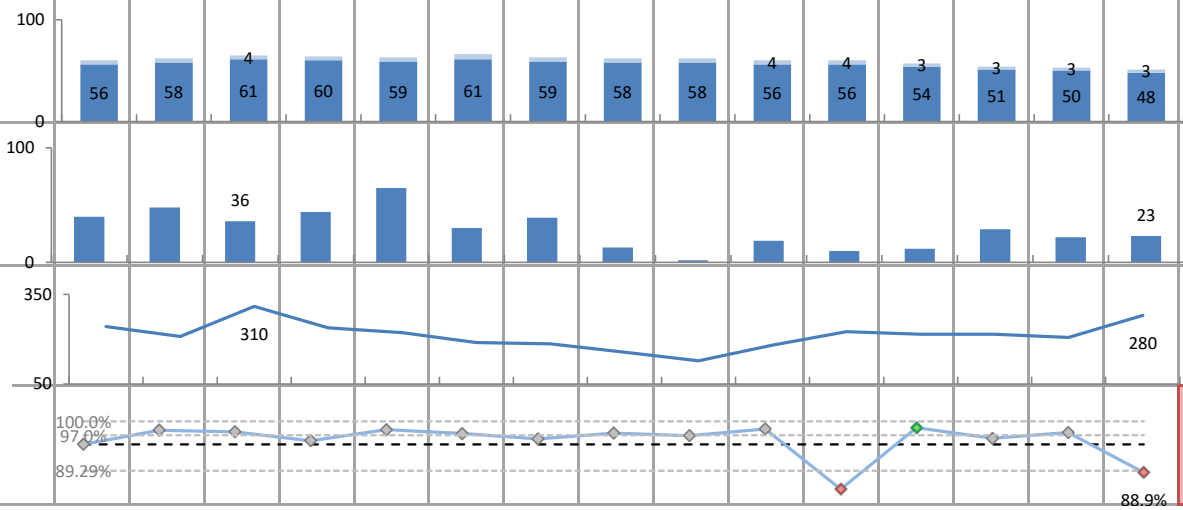
SAFE

		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	month target	YTD	YTD Target
SA5	**Healthcare-acquired COVID infection**: COVID-positive sample taken >14days after admission	0	0	0	0	0	0	0	20	30	14	1	0	0	0	9	0	63	-
SA6	**Probable hospital-associated COVID infection**: COVID-positive sample taken >7 days and <=14 days after admission	0	0	0	0	0	0	0	26	25	14	1	0	0	0	6	0	64	-
SA7	Number of pressure ulcers causing moderate/severe harm															0	-	0	-
SA8-N	Medication Errors (severe/Moderate)			5												4	<=3	16	<=21
SA9	Antibiotic usage per 1000 admissions			5,015											4,687				
SA10	Serious Incidents Requiring Investigation (SIRI)		16													6	-	32	-
SA11	Number of high harm falls (omissions in care)	4	5	1	3	1	3	0	0	0	0	0	2	0	0	0	-	2	-
SA12	% patients with a nutrition plan in place		97.02%												95.80%		-	-	-



SAFE

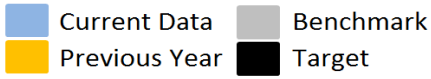
		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	month target	YTD	YTD Target
SA13	Number of fully and partially accredited wards	56	58	4 61	60	59	61	59	58	58	4 56	4 56	3 54	3 51	3 50	3 48	-	-	-
SA14	Red Flag staffing incidents			36												23	-	-	-
SA15	Number of statutory and mandatory maintenance jobs planned and percentage completed on time			310												280			
		100.0%	97.0%													88.9%	>95%	-	>95%



Current Data
Previous Year
Benchmark
Target

• The Maternity Service continues to gather feedback from users of the service to support the collaborative design of services. The main area of concern recently has been postnatal care and the ward leads have a quality improvement plan. Improvement opportunities linked to COVID have included the following:
o Arrangements made for partners to be present for the 20 week antenatal scan and for other individual circumstances
o Implementation of virtual Antenatal classes which have positive evaluation
o Implementation of virtual Breastfeeding Support Service through video clinics which support 74% of women (National 70% target) with feeding issues
o The numbers of postnatal visits in the community have been increased.

• The percentage of women receiving 'Continuity of Care' within the Maternity service decreased in the month and the data is not yet demonstrating progress towards the target of 35%. A substantial improvement project plan is in place (which was delayed by COVID-19) and this is reviewed by an Executive Director on alternate months. Continuity of Care at, or very close to, the target is still anticipated by March 2021. By January 2021 it is anticipated that a new midwifery team will be formed in central Southampton, and that additional Black and Minority Ethnic women will be offered continuity of care. We also expect a national approach to monitoring progress based upon the care arrangements booked for the future, whereas our current monitoring looks at that delivered in the past.
• The proportion of complaints resolved within 35 days continues to be close to target at 65% but has not improved significantly this month.
• The number of non-clinically justified overnight ward moves reduced, whilst overall bed occupancy continues to rise.

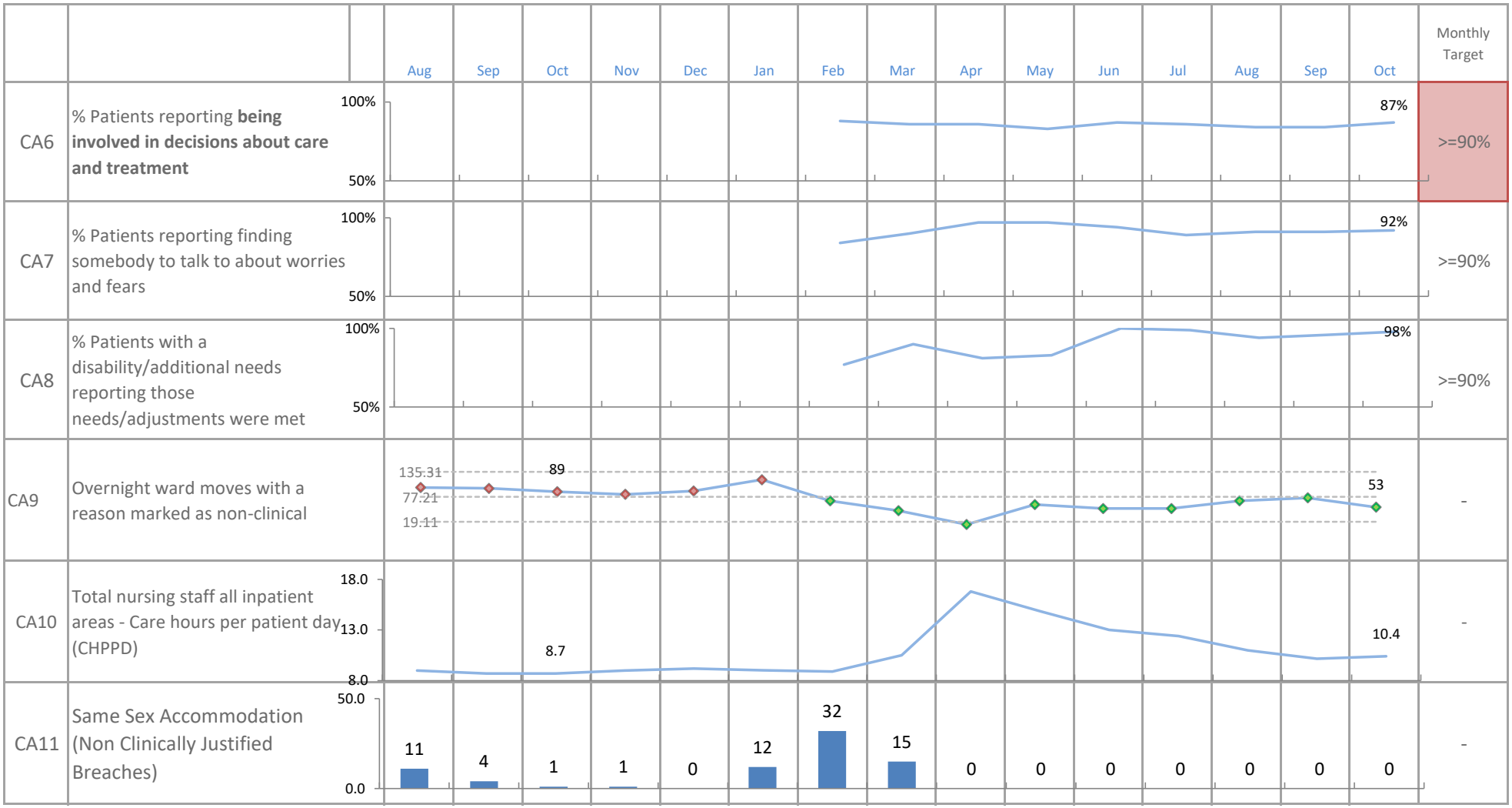


CARING

			Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly Target
CA1-N	FFT Negative Score - Inpatients	5%			0.6%													<=5%
CA2-N	FFT Negative Score - Maternity	5%			3.4%											8.70%		<=5%
Maternity FFT scheme has not been operating since March due to Covid 19 but is expected to recommence in October 2020 with first national results published in January 2021																		
CA3-N	Maternity - Continuity of Care																9.4%	>=35%
CA4-L	Complaints per 1000 units	1.30 0.00		0.39													0.37	<1.2
CA5-L	% Complaints closed within 35 days	80% 0%			83%												65%	>=70%

Current Data Benchmark
Previous Year Target

CARING



Current Data Benchmark
Previous Year Target

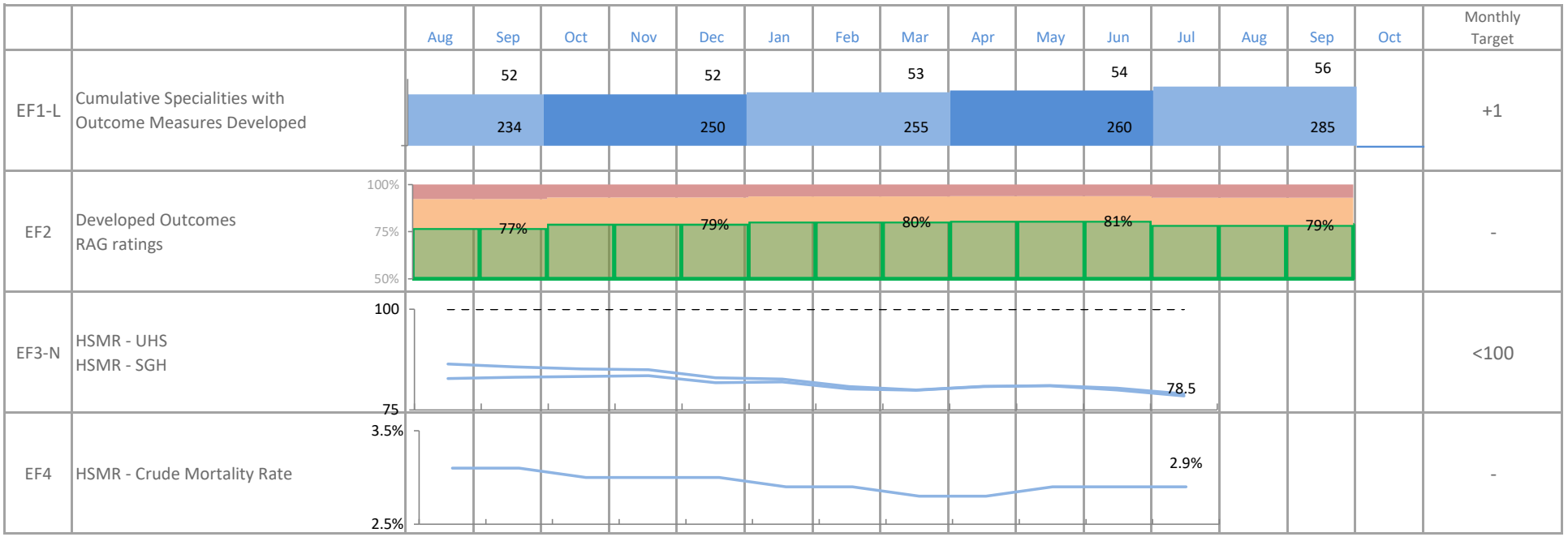
EFFECTIVE

- The UHS outcome measures (EF1, EF2) have no new information available this month
- HSMR (EF3) and HSMR cohort Crude Mortality (EF4) measures have been updated for July, and are consistent with previous values. Note that the HSMR patient cohort excludes those patients with a primary diagnosis of COVID-19.
- The information provided previously relating to:

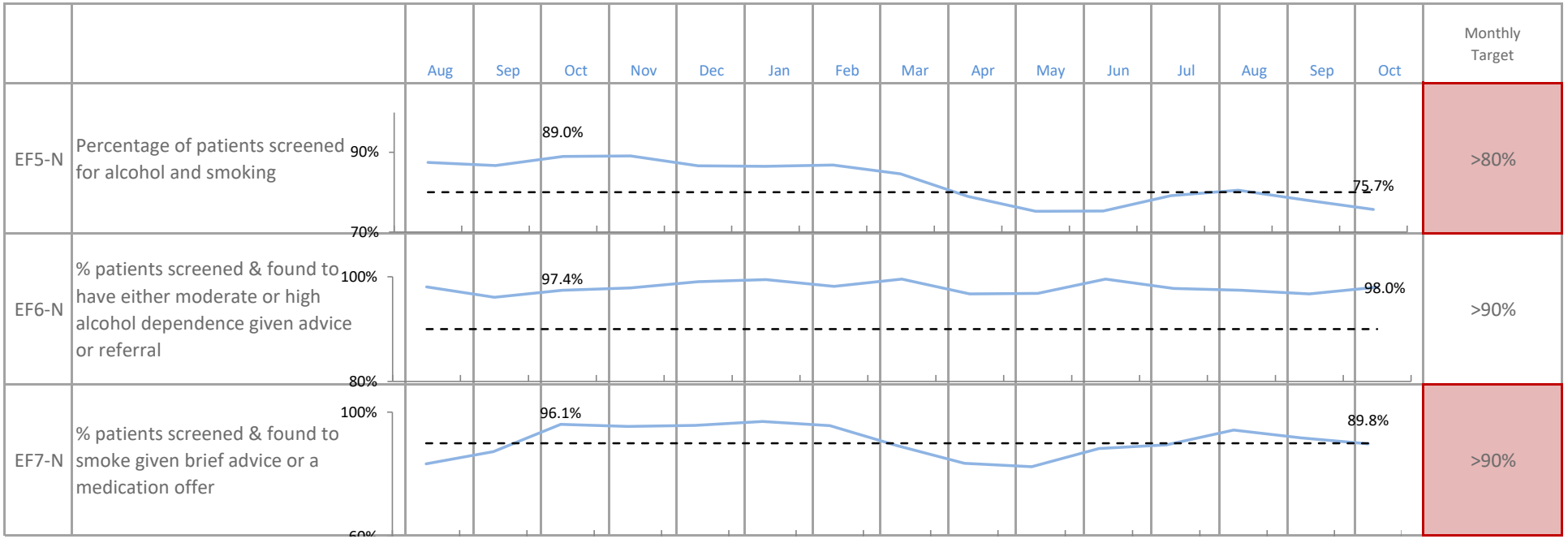
EF5 - screening for alcohol and smoking and
EF6 - patients found to have moderate or high dependence on alcohol who were given advice or an onward referral
has been found on investigation to be inaccurate. The data for EF5 was reported against EF6, and vice versa. We apologise to the Board for this error.

- The correct data demonstrates that the % of eligible patients screened for smoking and harmful alcohol consumption has declined during the first wave of COVID-19 and has not recovered since. Further investigation demonstrates that this is due to a reduction in screening of alcohol consumption using a screening questionnaire called 'Audit C'. The potential to improve the completeness of screening will be considered and feedback provided.
- When screened, and smoking or potentially harmful alcohol consumption are identified, the data demonstrates that appropriate support is offered / put in place for patients (EF 5, EF 6)

		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly Target
EF1-L	Cumulative Specialities with Outcome Measures Developed		52			52			53			54			56		+1
			234			250			255			260			285		
EF2	Developed Outcomes RAG ratings		77%			79%			80%			81%			79%		-
EF3-N	HSMR - UHS HSMR - SGH												78.5				<100
EF4	HSMR - Crude Mortality Rate												2.9%				-



EFFECTIVE


Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Monthly Target
EF5-N
Percentage of patients screened for alcohol and smoking
90%
70%
89.0%
75.7%
>80%
EF6-N
% patients screened & found to have either moderate or high alcohol dependence given advice or referral
100%
80%
97.4%
98.0%
>90%
EF7-N
% patients screened & found to smoke given brief advice or a medication offer
100%
96.1%
89.8%
>90%
Current Data
Previous Year
Benchmark
Target

• Turnover rates have reduced further, and are now within 0.4% of our target.

• Both the level of registered nursing vacancies in clinical wards, and staff vacancies overall, showed a modest increase this month. The increase in registered Vacancies overall remain low, whilst registered nursing vacancies in clinical wards remain a cause for concern (further action will be required to support the opening of a new ward in December and opening of winter ward capacity).

• The Trust is further enhancing its system for assessing the health risk that COVID-19 would be likely to pose to staff members if they became infected with it, using characteristics such as their calendar age, sex and existing relevant health conditions. Each member of staff will be assigned to a risk category based upon their calculated 'Covid Age'. Information regarding the numbers of staff affected will now be presented in the November report. The vast majority of staff with high or moderate health risks in relation to COVID-19 are currently able to work safely in in their own role, or in a suitable alternative role / department, within the Trust.

• Both medical and non-medical appraisal rates remain significantly below target / pre COVID-19 rates, and fell further during the most recent month, the operational impacts of COVID-19 have significantly affected the quantity of appraisals undertaken. The Chief People Officer is writing to all Divisions and THQ departments to emphasise the importance of continuing to undertake appraisals, and ensure appropriate focus on staff development.

• The percentage of staff at Band 7+ who are from a BAME group continues to rise and is now at 9.6%. UHS is now monitoring staff members performing 35 key medical leadership positions ad these will be reported on a quarterly basis.

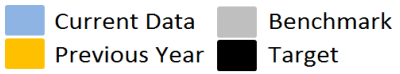
• Our Research indicators are reported quarterly, and there is no change this month to the full report provided with September's data.

		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly Target
WL1-L	Substantive Staff - Turnover	13.86%		13.6%												12.4%	<=12%
		13.11%															
		12.36%															
WL2-L	Staff - Non-medical appraisals completed - Rolling 12-months	95%															=>92%
				84.11%												76.10%	
		75%															

Current Data Benchmark
Previous Year Target

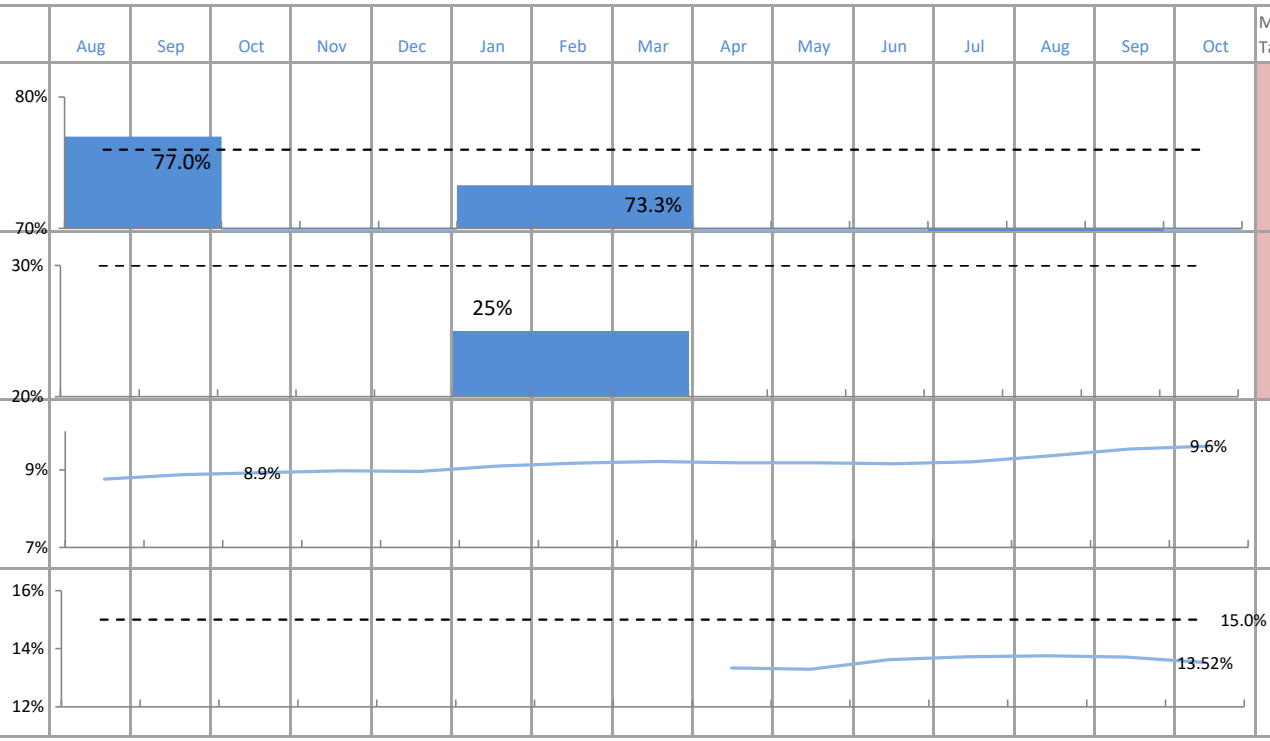
WELL LED

		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly Target
WL3-L	Staff - Medical appraisals completed - Rolling 12-months															57.50%	
WL4-L	Staff vacancies															4.63%	
WL5-L	Nursing Vacancies (registered nurses only in clinical wards)			15.06%												13.98%	
WL6L	Staff - Sickness absence			3.97%												3.42%	<=3.4%
WL7	COVID age	Available next month															

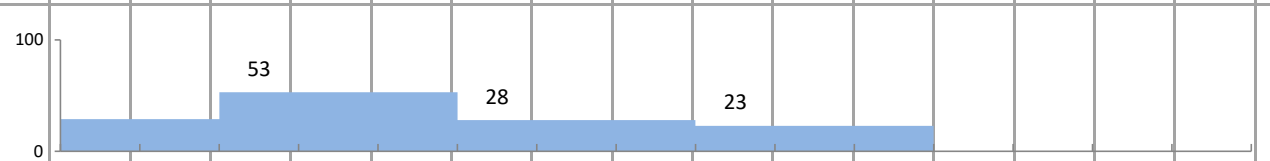


WELL LED

		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly Target
WL8-L	Staff FFT - % of staff recommend UHS as a place to work. (Quarterly)		77.0%						73.3%								>=76%
WL9N	Staff FFT response rate						25%										30%
WL10-L	% of Band 7+ staff who are Black and Minority Ethnic			8.9%												9.6%	15% by 2023
WL11	% of Band 7+ staff who are Disabled															15.0% 13.52%	



WL12- QI training programme, and reporting, is currently temporarily suspended as team members support urgent change programmes as part of our Covid 19 response and recovery																	
WL12-L	Statutory & Mandatory Training Achieving Target	8 4	8 4	7 5	7 5	7 5	7 5	7 5	7 5	7 5	6 6	6 6	6 6	6 6	6 6	6 6	-
WL13-L	Number of Apprenticeship Starts			53			28			23							-



Current Data Benchmark
Previous Year Target

WELL LED

Research
• Our Research indicators are reported quarterly, and there is no change this month to the full report provided with September's data.

		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly Target
WL14-L	Comparative CRN Recruitment Performance by clinical specialty		44%			52%			56%			52%			28%		
WL15-L	Comparative CRN Recruitment Performance - weighted		5			6			5			2			2		Top 5
WL16-L	Comparative CRN Recruitment - contract commercial		15			13			13			13			17		Top 10
WL17-L	Proportion of studies closing in FY on time and to recruitment target - non-commercial		65%			65%			88%			50%			43%		>=80%
WL18	NIHR CRF & BRC publications Year on year growth		246			329			452			120					

Current Data
Previous Year
Benchmark
Target

Changes and Corrections

Section	KPI	KPI Name	Type	Detail
Effective	EF5	Percentage of patients screened for alcohol and smoking	correction	Chart was swapped with wrong KPI name EF6
Effective	EF6	% patients screened & found to have either moderate or high alcohol dependence given advice or referral	correction	Chart was swapped with wrong KPI name EF5. Error corrected in this version
Well led	WL12	Cumulative Number of staff trained in QI	removed	QI Training programme currently suspended to deliver additional capacity for the Covid 19 pandemic response, inclusion of data in IPR to be reviewed upon resumption of the training programme
Responsive	RE29	Non-elective inpatient activity - % of same time last year	Under Review	Metric not displayed while we investigate the wide variance between peers reported activity figures
Responsive	RE30	1st outpatient attendances - % of same time last year	Under Review	Metric not displayed while we investigate the wide variance between peers reported activity figures

Nursing and midwifery staffing hours - October 2020

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 Specialling)
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 specialty, 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.

Since the last 2 weeks in March our clinical areas started to change specialty and size to respond to the changing COVID-19 situation (e.g. G5-G9, Critical Care and RHDU). Repurposing of wards to respond to the COVID-19 social distancing recommendations , to enable the separation and restart of services and the management of any surge, continues with changes sometimes being swift in nature. The data may in some cases not be fully reflective of all of these changes.

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	Registered midwives/ nurses CHPPD	Care Staff CHPPD	CHPPD Overall	Comments
C4 (Solent ward)	Day	1397.5	1445.2	1040.2	1067.7	103.4%	102.6%	4.3	3.8	8.1	Safe staffing levels maintained.
C4 (Solent ward)	Night	1068.3	965.8	702.5	1026.3	90.4%	146.1%				Safe staffing levels maintained.
C6	Day	2821.8	2765.6	200.8	260.5	98.0%	129.8%	7.6	0.9	8.5	Safe staffing levels maintained.
C6	Night	2052.3	2002.8	0.0	310.5	97.6%	Shift N/A				Safe staffing levels maintained.
C6 (Teenage Cancer Trust unit)	Day	737.2	656.5	377.3	246.5	89.0%	65.3%	11.2	2.8	14.0	Safe staffing levels maintained; Staffing appropriate for number of patients.
C6 (Teenage Cancer Trust unit)	Night	682.5	573.0	0.0	66.8	84.0%	Shift N/A				Safe staffing levels maintained; Staffing appropriate for number of patients.
D2	Day	1286.0	1681.8	973.3	904.8	130.8%	93.0%	5.5	3.4	8.9	Safe staffing levels maintained.
D2	Night	1069.3	1058.8	713.0	794.3	99.0%	111.4%				Safe staffing levels maintained.
D3	Day	1651.7	1748.3	732.0	860.8	105.9%	117.6%	4.6	2.7	7.3	Safe staffing levels maintained.
D3	Night	1047.3	1067.8	687.3	810.8	102.0%	118.0%				Safe staffing levels maintained.
Critical Care	Day	22708.0	19102.7	9970.0	3332.6	84.1%	33.4%	26.4	4.3	30.7	Safe staffing levels maintained; Staffing appropriate for number of patients.
Critical Care	Night	21638.3	18527.4	6963.8	2863.2	85.6%	41.1%				Safe staffing levels maintained; Staffing appropriate for number of patients.
E5A	Day	1351.7	1168.1	771.5	960.0	86.4%	124.4%	3.6	3.0	6.6	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
E5A	Night	715.0	691.8	356.5	576.0	96.7%	161.6%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
E5B	Day	1413.2	1254.2	805.5	1062.7	88.7%	131.9%	3.7	3.4	7.1	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
E5B	Night	713.0	713.0	352.5	699.0	100.0%	198.3%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F10 E	Day	2266.4	1688.2	612.7	1156.8	74.5%	188.8%	4.7	3.3	8.0	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F10 E	Night	1069.5	1046.5	713.0	736.0	97.8%	103.2%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F11	Day	1970.4	1449.5	798.4	939.9	73.6%	117.7%	4.2	3.2	7.5	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F11	Night	713.0	701.5	715.0	703.5	98.4%	98.4%				Safe staffing levels maintained; Support workers used to maintain staffing numbers.
ASU	Day	1487.0	1048.5	859.0	582.3	70.5%	67.8%	7.3	3.8	11.1	Safe staffing levels maintained; Staffing appropriate for number of patients.
ASU	Night	713.0	690.0	713.0	322.0	96.8%	45.2%				Safe staffing levels maintained; Staffing appropriate for number of patients.
F6	Day	2296.2	1381.8	560.0	1470.1	60.2%	262.5%	3.3	3.4	6.6	Safe staffing levels maintained; Staffing appropriate for number of patients; Support workers used to maintain staffing numbers.
F6	Night	1065.5	957.0	713.0	970.0	89.8%	136.0%				Safe staffing levels maintained; Staffing appropriate for number of patients; Support workers used to maintain staffing numbers.
F5	Day	1939.1	1584.7	1302.3	993.0	81.7%	76.2%	3.9	2.7	6.6	Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
F5	Night	1070.5	1002.5	712.8	816.3	93.6%	114.5%				Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers; Support workers used to maintain staffing numbers.
Acute medical unit	Day	3431.8	4381.2	3346.0	3551.2	127.7%	106.1%	9.7	7.4	17.1	Beds flexed to match staffing; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
Acute medical unit	Night	3569.0	4593.0	2487.0	3284.7	128.7%	132.1%				Increased night staffing to support raised acuity; Beds flexed to match staffing; Band 4 staff working to support registered nurse numbers.
D5	Day	1280.5	1362.7	1612.8	1486.8	106.4%	92.2%	3.1	3.1	6.2	Safe staffing levels maintained.
D5	Night	1069.5	1039.5	945.5	931.0	97.2%	98.5%				Safe staffing levels maintained.
D6	Day	1097.0	1218.5	1499.8	1381.3	111.1%	92.1%	3.1	3.6	6.7	Safe staffing levels maintained.
D6	Night	715.0	750.5	950.0	881.5	105.0%	92.8%				Safe staffing levels maintained.
D8	Day	741.0	771.3	1153.5	1181.0	104.1%	102.4%	3.2	3.4	6.6	Safe staffing levels maintained.
D6	Night	713.0	736.0	345.0	411.0	103.2%	119.1%				Safe staffing levels maintained.
D8	Day	1140.9	1130.0	1520.0	1452.3	99.1%	95.5%	2.8	3.3	6.1	Safe staffing levels maintained.
D8	Night	714.3	808.2	945.0	896.1	113.1%	94.8%				Safe staffing levels maintained.
D9	Day	1238.8	1548.2	1741.6	1320.9	125.0%	75.8%	3.3	2.9	6.2	Safe staffing levels maintained.
D9	Night	1069.5	1059.3	945.5	1013.5	99.0%	107.2%				Safe staffing levels maintained.
E7	Day	1052.8	1212.8	1197.3	1363.0	115.2%	113.8%	3.2	3.0	6.2	Additional beds open in the month; Safe staffing levels maintained.
E7	Night	713.0	1025.5	713.0	793.5	143.8%	111.3%				Additional beds open in the month; Safe staffing levels maintained.
Respiratory high dependency unit	Day	1480.0	1195.0	462.5	495.5	80.7%	107.1%	13.8	4.5	18.3	Beds flexed to match staffing; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
Respiratory high dependency unit	Night	1369.3	1167.0	337.0	267.8	85.2%	79.5%				Beds flexed to match staffing; Safe staffing levels maintained.
C5	Day	1218.9	1158.7	1268.5	829.5	95.1%	65.4%	7.0	4.7	11.6	Beds flexed to match staffing; Safe staffing levels maintained.
C5	Night	1070.5	842.8	356.5	508.5	78.7%	142.6%				Beds flexed to match staffing; Safe staffing levels maintained; Band 4 staff working to support registered nurse numbers.
D10	Day	1058.5	971.0	1306.0	1205.0	91.7%	92.3%	3.2	3.7	6.9	Safe staffing levels maintained.
D10	Night	713.5	690.5	714.0	702.0	96.8%	98.3%				Safe staffing levels maintained.
F7	Day	1103.0	1078.1	1476.8	1577.0	97.7%	106.8%	3.2	4.1	7.3	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained by sharing staff resource.
F7	Night	713.3	749.8	713.0	747.5	105.1%	104.8%				Safe staffing levels maintained.
G5	Day	1033.4	1177.5	1742.5	1906.5	113.9%	109.4%	2.7	3.2	5.9	Band 4 staff working to support registered nurse numbers.
G5	Night	1058.0	1069.5	715.0	791.0	101.1%	110.6%				Safe staffing levels maintained by sharing staff resource.
G6	Day	1079.6	981.2	1617.5	1569.0	90.9%	97.0%	2.9	3.5	6.4	Band 4 staff working to support registered nurse numbers.
G6	Night	1069.5	897.0	715.0	703.5	83.9%	98.4%				Safe staffing levels maintained by sharing staff resource.
G7	Day	744.6	705.4	1356.2	1031.9	94.7%	76.1%	5.0	6.8	11.8	Patient requiring 24 hour 1:1 nursing in the month; Band 4 staff working to support registered nurse numbers.
G7	Night	714.0	633.5	1069.0	793.5	88.7%	74.2%				Patient requiring 24 hour 1:1 nursing in the month.
G8	Day	1097.4	1041.4	1836.0	1661.5	94.9%	90.5%	2.9	3.7	6.6	Band 4 staff working to support registered nurse numbers.
G8	Night	1047.0	932.0	851.0	862.5	89.0%	101.4%				Safe staffing levels maintained by sharing staff resource.
G9	Day	1082.7	995.8	1757.0	1919.5	92.0%	109.2%	2.9	4.1	7.0	Band 4 staff working to support registered nurse numbers.
G9	Night	1070.0	966.5	782.0	885.5	90.3%	113.2%				Safe staffing levels maintained by sharing staff resource.
Paediatric high dependency unit	Day	1609.0	1396.0	0.0	7.5	86.8%	Shift N/A	12.5	0.3	12.8	Non-ward based staff supporting areas; Safe staffing levels maintained.
Paediatric high dependency unit	Night	1071.5	1153.0	0.0	57.5	107.6%	Shift N/A				Safe staffing levels maintained.
Paediatric medical unit	Day	1812.5	3194.9	316.5	739.7	176.3%	233.7%	24.9	5.6	30.5	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained; Patient requiring 3:1 nursing care.
Paediatric medical unit	Night	1705.5	2827.5	682.0	614.5	165.8%	90.1%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained; Patient requiring 3:1 nursing care.
Paediatric intensive care unit	Day	6245.7	4568.7	555.0	360.3	73.1%	64.9%	35.3	3.1	38.4	Beds flexed to match staffing; Safe staffing levels maintained.
Paediatric intensive care unit	Night	5692.5	4404.5	506.0	425.5	77.4%	84.1%				Beds flexed to match staffing; Safe staffing levels maintained.
Plam Brown ward	Day	3788.7	2853.8	110.0	141.0	75.3%	128.2%	13.4	0.5	13.8	Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained; Non-ward based staff supporting areas.
Plam Brown ward	Night	1426.3	1098.5	0.0	0.0	77.0%	Shift N/A				Beds flexed to match staffing; Safe staffing levels maintained.
E1	Day	2000.7	1747.1	731.5	617.7	87.3%	84.4%	8.2	2.5	10.6	Non-ward based staff supporting areas; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
E1	Night	1369.5	1531.3	425.5	379.0	111.8%	89.1%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
G2	Day	756.5	719.1	0.0	0.0	95.1%	Shift N/A	8.9	0.0	8.9	Safe staffing levels maintained.

Nursing and midwifery staffing hours - October 2020

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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	Registered midwives/ nurses CHPPD	Care Staff CHPPD	CHPPD Overall	Comments
G2	Night	744.0	779.8	0.0	0.0	104.8%	Shift N/A				Safe staffing levels maintained.
G3	Day	2355.9	2113.4	1707.0	677.5	89.7%	39.7%	11.3	3.1	14.4	Band 4 staff working to support registered nurse numbers; Non-ward based staff supporting areas; Safe staffing levels maintained; beds flexed to match staffing.
G3	Night	1705.5	1698.0	1023.0	385.0	99.6%	37.6%				Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained; beds flexed to match staffing.
G4	Day	2471.5	2566.7	1284.0	533.0	103.9%	41.5%	10.6	2.0	12.6	Safe staffing levels maintained; beds flexed to match staffing.
G4	Night	1705.0	1923.0	682.0	297.0	112.8%	43.5%				Safe staffing levels maintained; beds flexed to match staffing.
Bramshaw women's unit	Day	1126.5	1079.0	710.8	490.3	95.8%	69.0%	7.1	3.3	10.5	Safe staffing levels maintained.
Bramshaw women's unit	Night	713.0	713.5	356.5	345.0	100.1%	96.8%				Safe staffing levels maintained.
Neonatal unit	Day	6830.8	5206.6	1702.5	1076.0	76.2%	63.2%	10.5	2.2	12.7	Safe staffing levels maintained; Professional judgement used to allocate staffing and ITU patients are nursed 1:2.
Neonatal unit	Night	5449.0	4122.5	1353.0	903.0	75.7%	66.7%				Safe staffing levels maintained.
Maternity service	Day	8528.0	8101.5	3280.0	1940.0	95.0%	59.1%	5.7	1.5	7.2	Numbers do not fully reflect the integrated midwifery service demand. Safe staffing levels maintained by sharing staff resource across the services
Maternity service	Night	5440.1	4955.1	2033.5	1448.5	91.1%	71.2%				Numbers do not fully reflect the integrated midwifery service demand. Safe staffing levels maintained by sharing staff resource across the services
Cardiac high dependency unit	Day	4312.2	4239.0	2176.0	1357.8	98.3%	62.4%	15.4	4.7	20.1	Safe staffing levels maintained by sharing staff resource; Band 4 staff working to support registered nurse numbers.
Cardiac high dependency unit	Night	3478.3	3836.8	1378.0	1115.0	110.3%	80.9%				Staffing appropriate for number of patients; Band 4 staff working to support registered nurse numbers.
Coronary care unit	Day	1878.3	2130.1	1078.8	944.3	113.4%	87.5%	9.1	4.3	13.4	Safe staffing levels maintained by sharing staff resource; Skill mix swaps undertaken to support safe staffing across the Unit; Levels increased x 1 RN per shift to safely staff COVID swab negative CCU bay.
Coronary care unit	Night	1634.8	1769.8	968.5	925.0	108.3%	95.5%				Increased night staffing to support raised acuity; Safe staffing levels maintained.
D4	Day	1742.4	1570.9	1070.0	1306.6	90.2%	122.1%	3.9	3.8	7.7	Safe staffing levels maintained; Additional staff used for enhanced care - Support workers.
D4	Night	806.8	813.8	1023.0	1040.0	100.9%	101.7%				Safe staffing levels maintained; Staffing appropriate for number of patients.
E2	Day	1588.8	1289.0	936.0	1053.0	81.1%	112.5%	4.1	3.9	8.0	Band 4 staff working to support registered nurse numbers; Additional staff used for enhanced care - Support workers.
E2	Night	682.0	727.3	352.8	859.8	106.6%	243.7%				Safe staffing levels maintained; Safe staffing levels maintained; Additional staff used for enhanced care - Support workers
E3 Green	Day	1542.0	1340.0	1422.3	1248.7	86.9%	87.8%	3.1	2.9	6.0	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
E3 Green	Night	671.0	682.0	788.3	671.0	101.6%	85.1%				Safe staffing levels maintained; Safe staffing levels maintained by sharing staff resource.
E3 Blue	Day	1147.0	983.2	1101.5	1265.8	85.7%	114.9%	3.5	4.5	8.0	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit.
E3 Blue	Night	682.0	661.0	715.0	859.0	96.9%	120.1%				Safe staffing levels maintained; Additional staff used for enhanced care - RNs.
E4	Day	1592.8	1172.3	1205.1	1334.6	73.6%	110.7%	3.9	3.8	7.7	Band 4 staff working to support registered nurse numbers; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained.
E4	Night	1025.0	904.0	440.0	683.0	88.2%	155.2%				Safe staffing levels maintained by sharing staff resource; Band 4 staff working to support registered nurse numbers; Safe staffing levels maintained.
E8	Day	1930.6	1490.4	2062.5	1043.0	77.2%	50.6%	5.7	3.8	9.6	Safe staffing levels maintained; Beds flexed to match staffing; E8 ward provided additional capacity and gradually reduced bed occupancy during October. CVT vacated E8 completely on 2-11-20.
E8	Night	1365.0	1123.5	683.0	706.0	82.3%	103.4%				Safe staffing levels maintained; Beds flexed to match staffing.
Acute stroke unit	Day	1481.0	1665.9	2648.4	2550.9	112.5%	96.3%	3.4	5.5	8.9	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	1023.0	1012.0	1705.0	1806.0	98.9%	105.9%				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.
Regional transfer unit	Day	790.2	696.7	398.9	187.5	88.2%	47.0%	19.4	8.5	28.0	Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month; Support workers used to maintain staffing numbers.
Regional transfer unit	Night	682.0	429.0	407.0	308.0	62.9%	75.7%				Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month; Support workers used to maintain staffing numbers.
E Neuro	Day	1929.1	1567.0	1070.8	1533.3	81.2%	143.2%	5.0	4.9	9.8	Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month; Support workers used to maintain staffing numbers.
E Neuro	Night	1366.0	1321.0	1012.0	1311.0	96.7%	129.5%				Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month; Support workers used to maintain staffing numbers.
Hyper acute stroke unit	Day	1573.9	1239.5	374.5	561.5	78.8%	149.9%	9.0	5.0	14.0	Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month; Support workers used to maintain staffing numbers.
Hyper acute stroke unit	Night	1386.0	893.0	341.0	616.5	64.4%	180.8%				Band 4 staff working to support registered nurse numbers; Patient requiring 24 hour 1:1 nursing in the month; Support workers used to maintain staffing numbers.
D neuro	Day	2043.7	1861.8	2029.1	1650.8	91.1%	81.4%	5.1	5.3	10.4	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	1386.0	1287.0	1705.0	1639.0	92.9%	96.1%				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	1617.1	1717.3	860.9	1512.4	106.2%	175.7%	6.3	6.2	12.5	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	Night	1024.0	1253.5	1033.0	1434.0	122.4%	138.8%				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.
Brooke ward	Day	1121.0	1004.4	557.0	665.3	89.6%	119.4%	4.0	3.0	7.0	Skill mix swaps undertaken to support safe staffing across the Unit; Additional staff used for enhanced care - RNs.
Brooke ward	Night	1069.5	793.5	356.5	678.8	74.2%	190.4%				Additional staff used for enhanced care - RNs; Skill mix swaps undertaken to support safe staffing across the Unit.
Trauma Assessment Unit	Day	918.6	804.2	731.0	738.6	87.5%	101.0%	12.6	13.0	25.6	Safe staffing levels maintained; Skill mix swaps undertaken to support safe staffing across the Unit.
Trauma Assessment Unit	Night	682.0	627.0	683.0	749.0	91.9%	109.7%				Safe staffing levels maintained; Safe staffing levels maintained by sharing staff resource.
F1	Day	2404.6	1908.1	1943.4	2292.9	79.4%	118.0%	4.1	4.9	9.0	Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource.
F1	Night	1770.3	1656.3	1781.5	1912.0	93.6%	107.3%				Skill mix swaps undertaken to support safe staffing across the Unit; Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit.
F2	Day	1656.4	1499.5	1982.7	1974.8	90.5%	99.6%	3.4	5.4	8.8	Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit; Safe staffing levels maintained by sharing staff resource.
F2	Night	1023.0	825.0	1353.0	1725.8	80.6%	127.5%				Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained by sharing staff resource; Skill mix swaps undertaken to support safe staffing across the Unit.
F3	Day	1635.5	1420.2	1824.7	1892.3	86.8%	103.7%	3.9	5.9	9.7	Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit.
F3	Night	1023.0	891.0	1366.0	1619.8	87.1%	118.6%				Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit.
F4	Day	1516.7	1202.2	1203.5	999.5	79.3%	83.1%	3.8	3.6	7.4	Patient requiring 24 hour 1:1 nursing in the month; Skill mix swaps undertaken to support safe staffing across the Unit.
F4	Night	1013.0	683.5	704.5	793.0	67.5%	112.6%				Patient requiring 24 hour 1:1 nursing in the month; Safe staffing levels maintained by sharing staff resource.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors dated 26 November 2020				
Title:	**Inpatient flow - Medical Optimised for Discharge**			
Agenda item:	**3.8**			
Sponsor:	**Chief Operating Officer**			
Date:	**26 November 2020**			
Purpose	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	To update Trust Board on the current position relating to medically fit for discharge and planned work being led on by both external partners and internally within the Trust.			
Response to the issue:	See below			
Implications: (Clinical, Organisational, Governance, Legal?)	Clinical and organisational			
Risks: (Top 3) of carrying out the change / or not:	Bed capacity impacting on front door flow in terms of queueing in ED and the potential impact on our Elective programme Increased length of stay and associated impact this has on hospital acquired infection and overall patient experience. Overall higher occupancy levels and impact this has on UHS staffing levels both clinical and nursing.			
Summary: Conclusion and/or recommendation	There is a need to:- Establish inpatient flow data that is credible and shared weekly. Adapt clinical criteria to be used consistently across all inpatient areas in the Trust. Establish a speciality performance structure around LLOS/MOFD/Failed Discharge and hold clinical teams to account for performance Review discharge process and define would good looks like and adopt. **The Board are asked to note the updated provided, the actions proposed and it is suggested a further update on progress is provided in 6 months.**			

1. Background

UHS Delayed Transfer of Care (DTOC) challenge has been there for a number of years and at points we have been one of the worst performing systems in the country.

In response to the Covid-19 pandemic, national rules were adjusted to enable patients to leave the acute hospital on a supported discharge pathway (Discharge to Assess - D2A) once the medical team deemed the patient Medically Optimised for Discharge (MOFD). This decision was made nationally to free up acute beds in readiness for the pandemic as well as to get patients to a place of safe away from a Covid transmission risk. Previously the patient would have needed to be deemed clinically optimised for discharge (COFD) by the medical team, their nurse and therapy team.

This pathway change directed that any supported assessments to identify the patients' onward needs took place in an interim setting and not the acute hospital.

This report aims to provide an update on the current MOFD and Long Length of Stay (LLOS) position within UHS, as well as providing recommendations for further actions both from an internal and external perspective.

What we have tried before?

There have been frequent attempts in the past to address the issue. Most recently within UHS we have undertaken an Inpatient Transformation programme which ended at the start of 2020. Whilst many inpatient areas were positive about those programmes, some aspects have fallen away and our MOFD has not significantly improved due to actions not been sustainable. These programmes also focussed on our internal processes and not the discharge pathways out of an acute hospital.

One of the most recent developments to support inpatient flow throughout the hospital has been the implementation of eWhiteboard which is located in every inpatient ward. This provides live patient information and can be used across the Multi-Disciplinary Team (MDT). This replaces previous physical whiteboards on every ward, so allows information to be seen by everyone in real time and provides the patient status at a glance. There are still huge opportunities for further utilisation of its capability which will be detailed in the subsequent recommendations.

In 2018, UHS as part of a system wide review, engaged with Newton Consultants who identified the main reasons for patient delays were:

- 37% Waiting for Bedded care
- 35% Awaiting a decision on where to go next
- 21% waiting to go home with support.

Two years on, and has this improved? At its worst, UHS had around 200 DTOCs so we have come a considerable way as a Trust and as a system. It would be beneficial to review any learning from the previous system action plans to ensure all that was planned were both delivered and sustained before new action plans are developed. Some honest reflections about why they did not deliver are also needed to support further discussions around next steps

Areas we have previously tried but struggled to get control and consistency are:

- Who owns inpatient flow and discharge
- KPIs are not widely known within the trust.
- KPIs can feel hidden, so no one sees the current performance

- The KPIs don't always drive working together (Trust Value)
- Criteria and Nurse led discharge
- Use of a Discharge Lounge
- HMRs being ready well in advance so TTOs can be prepared
- Ward model so everyone knows what is happening for discharge
- Which patient first and which last on a ward round?
- Inpatient flow data – who is still here and why? As a Trust we often react to open up more beds every time we have a problem but there may be other options available if delays are removed.
- Patients that could go home but just need a yes from outside UHS
- Patients are not all on a clinical pathway with expected standards/timelines
- Board Round where everyone knows what is happening. Current model and ways of working do not support it, making it difficult for everyone to be present.
- Support Level 3 (complex discharges) can feel like a speciality outliers……everyone has their own criteria so really hard to move on

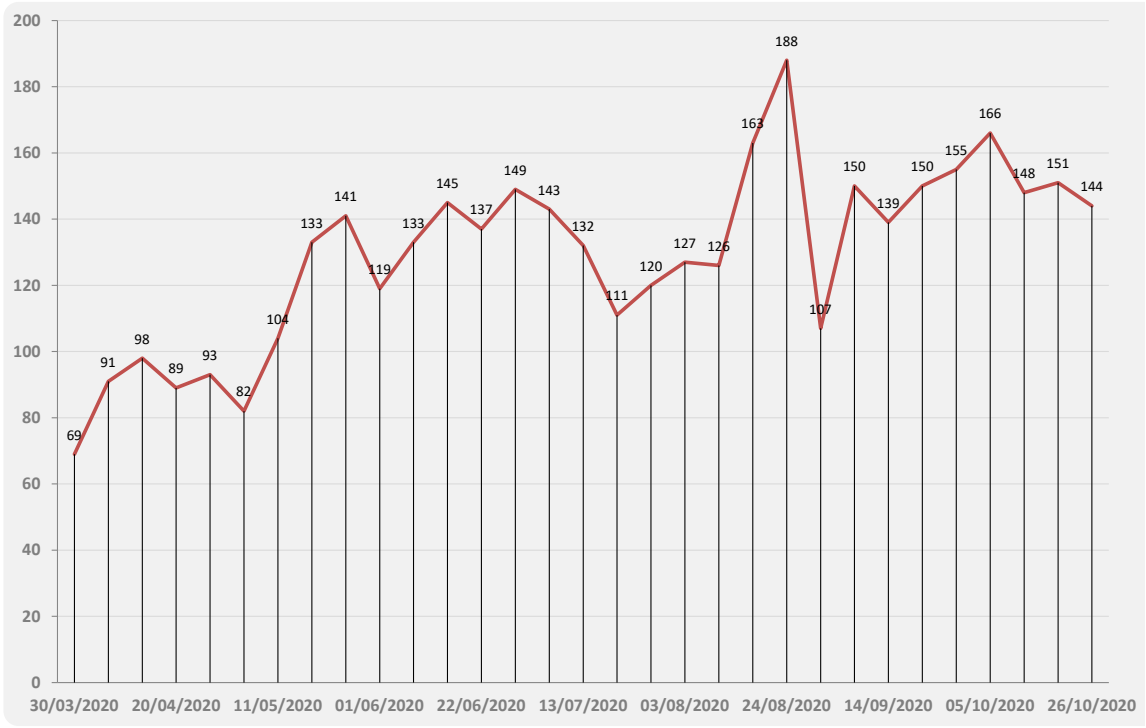
2. System Plans

Across the Health system there are weekly (and more often during Covid) Bronze Command meetings to work together to address the challenge of reducing delays. As part of this process the following Key Performance Indicators were signed by off across the system. A snapshot of performance against these is reported to the Finance and Investment Committee and the Board will be aware that none of these targets are being achieved as yet, nor are we effectively set-up to performance manage ourselves against as a system.

		Target
KPI 01	The number of acute beds occupied per day by patients who are MOFD	3.5%
KPI 02	The number and percentage of patients that are **discharged home** with support against the total number of patients discharged	85%
KPI 03	The number and percentage of patients that are discharged on **pathway/support level 0 within 24 hours** of becoming MOFD	95%
KPI 04	The number and percentage of patients that are discharged on **pathway/support level 1 (restarts & returns) within 24 hours** of becoming MOFD	90%
KPI 05	The number and percentage of patients that are discharged on **pathway/support level 2 within 48 hours** of becoming MOFD	90%
KPI 06	The number and percentage of patients that are discharged on **pathway/support level 3 within 72 hours** of becoming MOFD	85%
KPI 07	The number of reported **safety concerns**	20% reduction
KPI 08	The number of patients discharged and **readmitted within 48 hours**	Less 15%
KPI 09	The number of patients discharged and **readmitted within 14 days**	Less 15%
KPI 10	The number and percentage of **failed discharges due to non-clinical reasons**	0%

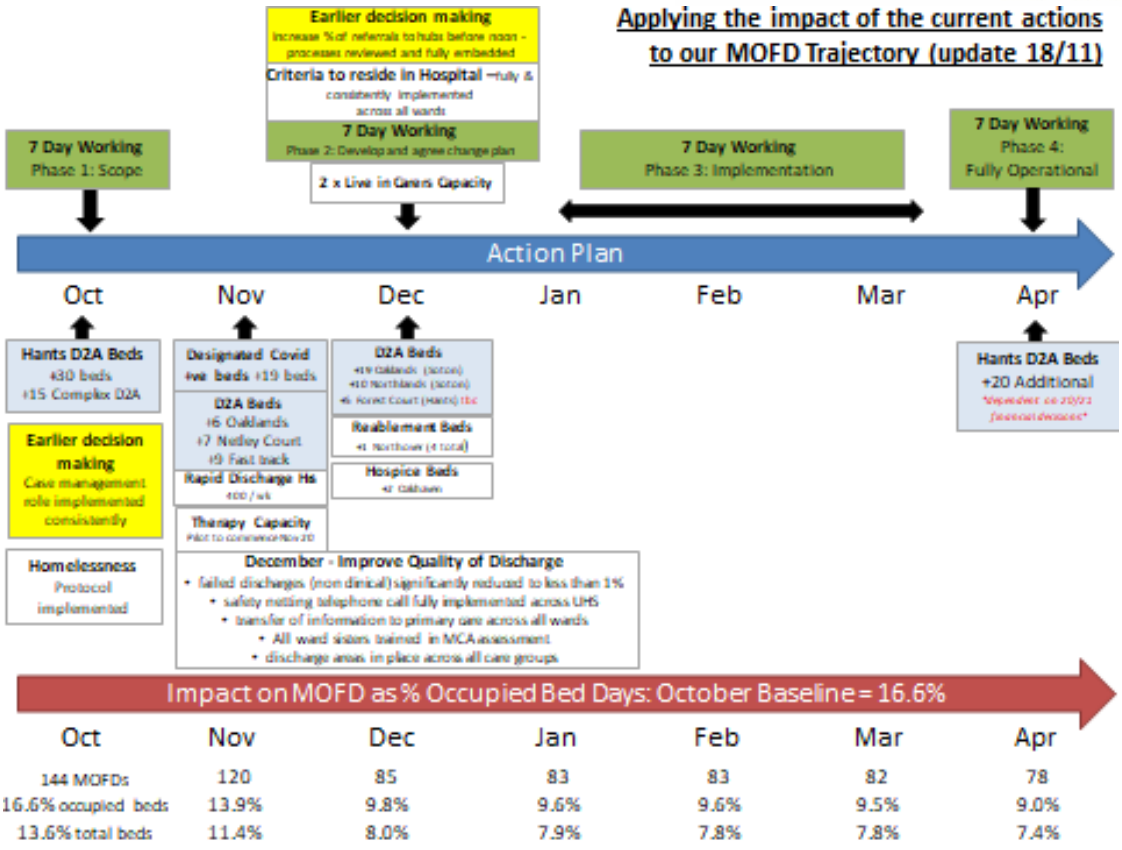
Current - Medically Optimised for Discharge

The current numbers being recorded are as follows:-

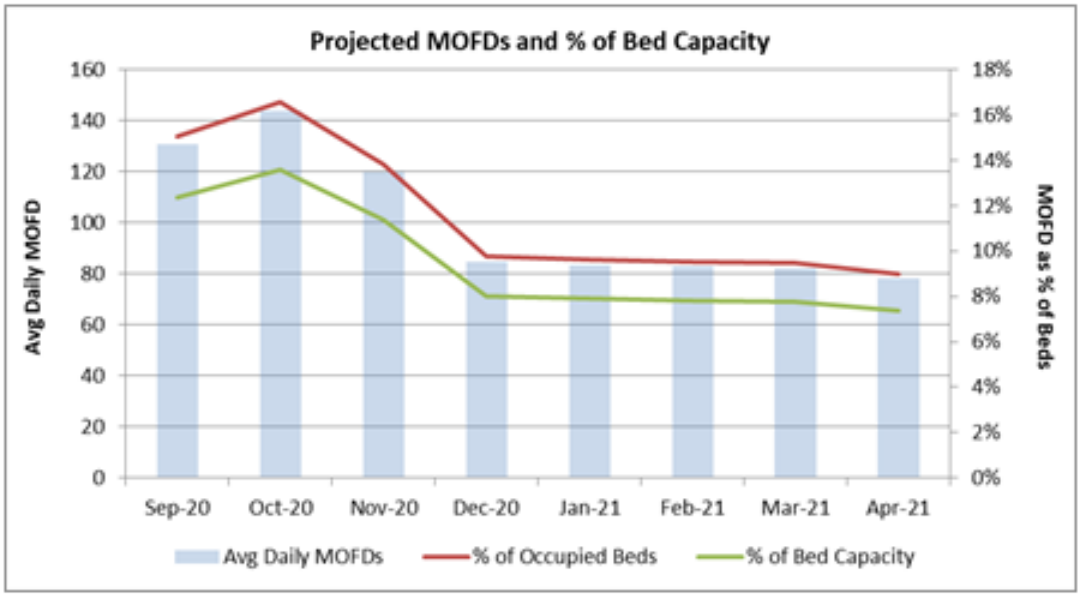


System colleagues have been working hard to bring on line alternative capacity to address the above issues. There is an ambitious system action plan with targets to reduce MOFD numbers. There is a strong system drive to open up more external capacity; however the processes and criteria need to also adapt to support flow. It is too early to know if these actions will be successful, but the current action plan is highlighted on the infographic below:

Applying the impact of the current actions to our MOFD Trajectory (update 18/11)



	Oct	Nov	Dec	Jan	Feb	Mar	Apr
144 MOFDs		120	85	83	83	82	78
16.6% occupied beds		13.9%	9.8%	9.6%	9.6%	9.5%	9.0%
13.6% total beds		11.4%	8.0%	7.9%	7.8%	7.8%	7.4%



Metric	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Avg Daily MOFDs	131	144	120	85	83	83	82	78
% of Occupied Beds	15.1%	16.6%	13.9%	9.8%	9.6%	9.6%	9.5%	9.0%
% of Bed Capacity	12.4%	13.6%	11.4%	8.0%	7.9%	7.8%	7.8%	7.4%

The graph and table above follows system wide projections on impact of action plan on MOFD at UHS. For Long Length of Stay (LLOS) patients over 21 days, we have seen a steady increase from 74 in April 2020 to 174 in September 2020 which whilst is a different metric to MOFD the rise is linked.

3. Internal Work Programme

The Trust has established an internal programme of work with the aim to improve and embed our local actions. The current plan is outlined below:-

Action	Benefit	When
Appointment of Associate Medical Directors for Flow	Medical team engagement with eWhiteboard. Improved MDT communication at a patient level. Earlier discharge planning Timely HMR completion	Started Nov 20
Weekend Discharges	Friday handover by medical team to ward Clinical criteria for discharge Review Monday discharges, why not before	Dec 20
Criteria to Reside	Assess why the patient continues to need acute care What is needed to get them fit for discharge	Dec 20
Discharge processes	IT systems to notify Pharmacy when drugs pulled through on HMR Failed Discharges senior care group sign off	Dec 20
Support Level 0 – No onward care needs	Review patients – Do they go when expected? Senior care group oversight of delays	Started Nov 20
Repatriations	Return to home hospital within 48 hours, not 5+ days	Jan 21
Long length of stay reviews	Weekly by Care Group management teams Performance reports showing trends/themes Data quality process to ensure report is accurate	Started Oct 20
eWhiteboard	Further integration with Doctor's Worklist and Apex, so one source of the truth. Less reactive behaviours as everyone knows what is outstanding.	Jan 21

4. Further Actions

In addition to the actions above (both system and internal) the following areas need exploring as part of the medium term overall programme:-

<u>Internal UHS</u>

- Inpatient reviews with Exec/Care Groups underpinned by data held on a regular basis
- Use of external provider (Care Home Select) to be given a wider scope to review both our internal and external discharge processes
- Identify pathway opportunities for long stay patients over 21 days that are not medically optimised but could receive their treatment outside on an acute hospital.
- Better IT integration so not working off three different systems plus paper notes
- No one owns Inpatient flow and performance. There are established examples already ED CEO, Cancer, RTT that we can learn from.

- MOFD has been a problem for years at UHS but not on the risk register saying patients are coming to harm.
- Information about community capacity shared with clinician's to enable discharge decisions.
- Culture of safer to admit, whereas it is for some patients it is actually more risky to admit
- Set a plan A and B for discharge, not just one then back to the start
- Create a culture where wards are able to drive discharge; it is not just the IDB's job.

External with system support

- Community beds need to be flexible to meet the needs of the SL2/3 patients in acute bed. What do they need to deliver a flexible model to ensure all beds can be fully utilised.
- Front of house rapid access to beds to allow a quicker turnaround. Most pathways have a gatekeeper and layers to go through.
- Hub of clinical advisers to enable quicker decision about needs, so as not have to wait for a hub call once a day
- Are Trusted Assessor's fully utilised?
- Easy simple Fact Sheets for set pathways about who to call/what to do (Mental Health/Homelessness/Red Cross/Voluntary sector
- 7 day working – Duty Social Worker decisions/In-reach Inpatient Rehab/Equipment

5. Conclusions and Recommendations

None of the solutions to this issue are simple and if they were they'd have been implemented and embedded. Our immediate focus over the next few months, in addition to the system actions at 2 and 3 above are:-

- Establish inpatient flow data that is credible and shared weekly
- Adapt clinical criteria to be used consistently across all inpatient areas in the Trust
- Establish a specialty performance structure around LLOS/MOFD/Failed Discharge and review performance with clinical teams
- Review discharge process and define would good looks like and adopt.

The Board are asked to note the updated provided, the actions proposed and it is suggested a further update on progress is provided in 6 months.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors dated Thursday, 26 November 2020				
Title:	**Update on Quarter 2 Milestones – Corporate Objectives 2020/21**			
Agenda item:	**3.9**			
Sponsor:	**Chief Executive**			
Author:	**Andrew Asquith, Director of Planning, Performance and Productivity**			
Date:	**20 November 2020**			
Purpose	**Assurance or reassurance** Y	**Approval**	**Ratification**	**Information**
Issue to be addressed:	• Corporate Objectives were presented to Trust Board - in May 2020, and the associated • Quarterly Milestones were presented to Trust Board - in June 2020 (both dates delayed by the COVID-19 Pandemic)			
Response to the issue:	This paper provides feedback on achievements against the planned Quarter 2 milestones in order to deliver our Corporate Objectives for 2020/21.			
Implications: (Clinical, Organisational, Governance, Legal?)	Achieving appropriate corporate objectives which are aligned to our Values, Goals, Legal and Regulatory requirements will have positive impacts.			
Risks: (Top 3) of carrying out the change / or not:	This paper is presented for the purpose of Assurance. In the event that our Corporate Objectives were not delivered, achievement of our goals and strategy could be compromised.			
Summary: Conclusion and/or recommendation	This paper provides feedback on achievements against the planned Quarter 2 milestones in order to deliver our Corporate Objectives for 2020/21.			

UHS Strategic Objectives

		2020/21			
Objective (short titles, see full document for detailed purpose and scope)	**Lead Exec.**	**Q1**	**Q2**	**Q2 Milestones Achieved? Yes / No / Partial**	**Comments at end Q2**
Local System Pathway Integration	Joe Teape	Covid 19 Peak Response	• Trial 'SW Connect' running for virtual front door for non-elective patients. • Agreement with South Central Ambulance Service regarding the near future of minor injuries and illness pathways, undertake audit to ensure patients are being treated in the right place at the right time	Objective Overall	Partially achieved
			• Trial 'SW Connect' running for virtual front door for non-elective patients.	**Yes** / No / Partial	SW Hants Connect App agreed for launch with 71 Pathways on 1st October. Two small pilots of clinical advice line delivered, with further planned during Q3.
			• Agreement with South Central Ambulance Service regarding the near future of minor injuries and illness pathways, undertake audit to ensure patients are being treated in the right place at the right time	Yes / **No** / Partial	Minor injuries pathways are available on the SWHC App, access to SWHC app not yet granted to SCAS but in progress.

UHS Strategic Objectives

Improve Discharge Pathways	Joe Teape	Covid 19 Peak Response	• Ensure robust use of 'electronic patient status at a glance' across the Trust. • Create inpatient ward performance framework to review agreed KPIs e.g. 'Medically Optimised for Discharge', Length of Stay. • Implement clear 'Discharge to Assess' pathways for patients requiring support levels 2 & 3, with the aim to have no long term decisions made whilst patients are in UHS beds.	Objective Overall	Partially achieved
			• Ensure robust use of 'electronic patient status at a glance' across the Trust.	Yes / No / **Partial**	EPSAG boards are in use, though not as robustly as required, working group in place to address this.
			• Create inpatient ward performance framework to review agreed KPIs e.g. 'Medically Optimised for Discharge', Length of Stay.	Yes / No / **Partial**	Framework in place for patients with long length of stay / medically optimised, but not for inpatient ward performance as a whole.
			• Implement clear 'Discharge to Assess' pathways for patients requiring support levels 2 & 3, with the aim to have no long term decisions made whilst patients are in UHS beds.	Yes / No / **Partial**	Discharge to Assess pathways have been implemented, but these are not currently supported by sufficient capacity to achieve the aim, and extra capacity / funding to support this has not yet been agreed by system partners.
Efficient and Timely Services for Cancer	Joe Teape	Covid 19 Peak Response	Implement cancer hub for the Wessex Alliance with UHS as lead provider	**Yes** / No / Partial	Cancer hub implemented with UHS as lead.
Restore capacity to meet elective care needs	Joe Teape	Covid 19 Peak Response	• Confirm Independent Sector capacity required to support recovery. July 2020. • Agree contracts with Independent Sector if national agreement isn't extended beyond August 2020.	Objective Overall	Achieved

UHS Strategic Objectives

			• Confirm Independent Sector capacity required to support recovery. July 2020.	Yes / No / Partial	Continue to use IS capacity to support recovery as required.
			• Agree contracts with Independent Sector if national agreement isn't extended beyond August 2020.	Yes / No / Partial	Use of IS capacity agreed to end of calendar year. Ongoing focus on improving utilisation.
Achieve financial balance	David French	Covid 19 Peak Response.	Develop and commence productivity improvement programme to improve underlying financial performance during period of financial protection which is aligned to emerging post-protection national financial architecture.	**Yes** / No / Partial	Financial plan developed bottom-up in response to new, less protective financial architecture for H2 20/21. Activity volumes for September ahead of Elective Incentive Scheme targets which will generate additional income at marginal rate. Current Y/E forecast is £3m deficit, range +/-£5m. Benchmarking developed to compare UHS performance vs prior months and vs other Trusts. Always Improving – Value for Money programme initiated and becoming embedded.
Improve quality of care environment and capacity	Joe Teape	Covid 19 Peak Response	• Review governance within Estates, Facilities and Capital Development (EFCD) and identify key improvement opportunities • Construction of appropriate isolation facilities for winter 2020/21, including inpatient wards and children's wards, G Level and PICU (subject to review of Capital plan)	Objective Overall	Partially achieved
			• Review governance within Estates, Facilities and Capital Development (EFCD) and identify key improvement opportunities	**Yes** / No / Partial	Review performed and presented to UHS Board

UHS Strategic Objectives

			• Construction of appropriate isolation facilities for winter 2020/21, including inpatient wards and children's wards, G Level and PICU (subject to review of Capital plan)	Yes / No / **Partial**	Review resulted in plans for additional side rooms on G level Childrens Hospital, also on G8 and E8. Designs are well progressed and tender documents have been issued for the contractor selection. Some rooms will be completed before Christmas with others likely to be completed between Jan and March
Meet assessment criteria for outstanding	Gail Byrne	Covid 19 Peak Response	• Agree transformation strategy and improvement approach. • Undertake and report self-assessment against CQC Framework. • Implement assurance framework for infection control including audit. • Review 'Virtual Visiting' and expand, to improve safety by reducing visitors to the hospital building. Agree Patient Safety Campaign. Agree Patient Experience Strategy	Objective Overall	Mainly Achieved
			• Agree transformation strategy and improvement approach.	**Yes** / No / Partial	Always Improving' Strategy launched to QI leads across the trust in September, and agreed at Clinical Executive Committee. To be discussed at Trust Board Study Session and submitted to Trust Board for approval.
			Undertake and report self-assessment against CQC Framework.	Yes / No / **Partial**	Further review of KLOEs required
			Implement assurance framework for infection control including audit.	**Yes** / No / Partial	Completed and Submitted to Trust Board
			Review 'Virtual Visiting' and expand, to improve safety by reducing visitors to the hospital building.	**Yes** / No / Partial	Completed and published
			Agree Patient Safety Campaign.	**Yes** / No / Partial	Launched on Patient Safety day 17th September 2020
			Agree Patient Experience Strategy	**Yes** / No / Partial	Agreed at Quality Committee

UHS Strategic Objectives

Patients to receive best outcomes, treatment and care	Derek Sandeman	Covid 19 Peak Response	• Review Shared Decision Making Plan in context of COVID 19 • Review Patient Reported Outcome Measures (PROMS) Plan with Informatics/MyMR, and scope resourcing.	Objective Overall	Not Achieved in Q2
			• Review Shared Decision Making Plan in context of COVID 19	Yes / **No** / Partial	Resource for shared decision making not available in Q2 due to the need to support urgent Covid 19 related projects.
			• Review Patient Reported Outcome Measures (PROMS) Plan with Informatics/MyMR, and scope resourcing.	Yes / **No** / Partial	Resources were not available in Q2, and a review of available resources and priorities in the context of Covid 19 means that it is unlikely that this would be able to be progressed in the remainder of 20/21.
Improve and protect the health of the population	Derek Sandeman	Covid 19 Peak Response	• Recommence screening programmes as per national guidance. • Review Integrated Care System plans to reduce health inequalities of ischemic heart disease.	Objective Overall	Partially achieved
			• Recommence screening programmes as per national guidance.	**Yes** / No / Partial	
			• Review Integrated Care System plans to reduce health inequalities of ischemic heart disease.	Yes / **No** / Partial	ICS has agreed to focus on ischemic heart disease in other geographic localities at the current time. Capacity for local initiatives has been impacted by an ongoing focus on health protection related to Covid 19 e.g. Covid Zero Campaign and Saliva testing pilot schemes.

UHS Strategic Objectives

Support the physical and mental health and well-being of our staff	Steve Harris	Covid 19 Peak Response	•Implement 'phase 2' of wellbeing support to staff for COVID 19 •Specific support will be provided for leaders during phase 2 of COVID •All staff at health risk will be reviewed and engaged in appropriate roles	Objective Overall	Partially achieved
			•Implement 'phase 2' of wellbeing support to staff for COVID 19	Yes / No / **Partial**	Agreement of funding for permanent psychological support service for staff.
			•Specific support will be provided for leaders during phase 2 of COVID	Yes / No / **Partial**	Development of 'COVID Age' modified risk assessment process for protection of staff
			•All staff at health risk will be reviewed and engaged in appropriate roles	**Yes** / No / Partial	Completion of risk assessment for all at risk staff, significant effort to maximise the number of staff providing information to enable assessment. During Q2 the vast majority of staff were able to return in appropriate funded roles.
			•Resourcing plan for nurse and other shortage specialities agreed	Yes / No / **Partial**	• Overseas nursing pipeline re-opened, with co-horts arriving and joining the Trust • Resourcing plan for overseas recruitment set out

UHS Strategic Objectives

Outstanding employer and one people want to work for	Steve Harris	Covid 19 Peak Response	• Co-create a new Inclusivity plan with the BAME1Voice network and sign off with the Trust Board • relaunch the 'No excuse for abuse campaign' with particular reference to experiences of BAME colleagues with patients •Communications launch of UHS vision, mission, and clinical strategy	Objective Overall	Partially achieved
			• Co-create a new Inclusivity plan with the BAME1Voice network and sign off with the Trust Board	**Yes** / No / Partial	BAME plan of action co-created with One Voice Network (BAME network and signed off by Trust Board). • Plan for disability and long term illness created with LID network and shared with Board • Inclusive leadership programme launched
			• relaunch the 'No excuse for abuse campaign' with particular reference to experiences of BAME colleagues with patients	**Yes** / No / Partial	• No excuse for Abuse campaign launched. Violence and Aggression steering group re-launched.
			•Communications launch of UHS vision, mission, and clinical strategy	Yes / No / **Partial**	Vision, and Mission embedded into key campaigns (COVID Zero, GICU launch)
Allocation of UHS capacity and facilities across our clinical services	Joe Teape	Covid 19 Peak Response	• COVID & non-COVID bed plan for 3-6 months including ICU • Clinic room plan for 3-6months • Theatre plan / speciality allocation for 3-6months based on predicted ICU demand	Objective Overall	Partially achieved

UHS Strategic Objectives

			• COVID & non-COVID bed plan for 3-6 months including ICU	**Yes** / No / Partial	Bed plans agreed for ICU for winter and included in operational plan signed off by Board. Ongoing operational review where required.
			• Clinic room plan for 3-6months	Yes / **No** / Partial	Room booking pilot underway to test the functionality of the 'micad' outpatient room booking system. No clinic room plan in place as yet.
			• Theatre plan / speciality allocation for 3-6months based on predicted ICU demand	**Yes** / No / Partial	Theatre allocation as per agreed clinical prioritisation process. This will take into consideration ICU availability as well as other interdependencies. Theatre plans lockdown 3 weeks In advance.
Collaboration through which partner organisations can better meet needs	Derek Sandeman	Covid 19 Peak Response	• Agree Top 5 'Triumvirate' Priorities for Winter • Support ICP partners to develop system winter plan • Refresh clinical strategy for cancer to support Wessex Cancer Hub	Objective Overall	Mainly Achieved
			• Agree Top 5 'Triumvirate' Priorities for Winter	**Yes** / No / Partial	1. Emergency Care Village – community interface (access to community beds and UR teams, as below) 2. Home First – Single Model for Urgent Response for UHS (Southern and Solent) 3. Rehabilitation – redesign of therapy services, collaboration across pathway 4. Community Beds – escalation plan for winter 2020/21 5. SW Hants Connect – App plus clinical assessment service
			• Support ICP (Tirumvirate) partners to develop system winter plan	**Yes** / No / Partial	
			• Refresh clinical strategy for cancer to support Wessex Cancer Hub	Yes / No / **Partial**	Substantial progress made, refreshed strategy now expected to be approved during Q3

UHS Strategic Objectives

Research focuses on the most urgent and strategically important needs	Derek Sandeman	Covid 19 Peak Response	• Deliver priority (Urgent Public Health) COVID19 research, including vaccine studies and Phase II platform study (ACCORD2) • Determine priority order for restarting studies and restart prioritised non-COVID research • Appoint Divisional R&D Leads to vacant posts (3/4) and form team	Objective Overall	Achieved
			• Deliver priority (Urgent Public Health) COVID19 research, including vaccine studies and Phase II platform study (ACCORD2)	**Yes** / No / Partial	
			• Determine priority order for restarting studies and restart prioritised non-COVID research	**Yes** / No / Partial	
			• Appoint Divisional R&D Leads to vacant posts (3/4) and form team	**Yes** / No / Partial	
Deliver NIHR Biomedical Research Centre and Clinical Research Facility portfolios	Derek Sandeman	Covid 19 Peak Response	• Appoint BRC Director Designate and theme leads • Deliver COVID19 experimental medicine studies (BRC/CRF) esp. vaccine studies including ACCORD2 • BRC support delivery of COVID-ZeRO campaign	Objective Overall	Achieved
			• Appoint BRC Director Designate and theme leads	**Yes** / No / Partial	
			• Deliver COVID19 experimental medicine studies (BRC/CRF) esp. vaccine studies including ACCORD2	**Yes** / No / Partial	
			• BRC support delivery of COVID-ZeRO campaign	**Yes** / No / Partial	

UHS Strategic Objectives

Improvements in UHS education and training	Steve Harris	Covid 19 Peak Response	•Restart for students completed in partnership with Higher Education Institutions •Review of CPD funding and allocation and plans for distribution	Objective Overall	Achieved
			•Restart for students completed in partnership with Higher Education Institutions	**Yes** / No / Partial	• Students returning to placement at UHS with appropriate safe teaching practices in place • Review of placement capacity ongoing to increase in line with national requirements
			•Review of CPD funding and allocation and plans for distribution	**Yes** / No / Partial	CPD funding solution and settlement reached with STP to meet 20/21 shortfall.

Item 3.10

University Hospital Southampton NHS
NHS Foundation Trust

2020/21 Finance Report - Month 7

Report to:	**Board of Directors and Finance & Investment Committee** **November 2020**
Title:	**Finance Report for Period ending 31/10/2020**
Author:	**Philip Bunting, Interim Deputy Director of Finance**
Sponsoring Director:	**Ian Howard, Interim 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 2020, the Trust reported a deficit of £0.2m. This is £0.1m adverse compared to the in month deficit plan of £0.1m (excluding adjusting items). October is the first month since moving into phase 3 of the Covid funding regime without the safety net of a minimum breakeven guarantee. The trust remains on target to deliver a £3m deficit for the second half of 2020/21 (excluding adjusting items).

2. In month, £2.2m (£1.0m pay and £1.2m non pay) was incurred on additional expenditure related to Covid-19. This was down £2.2m from September (£4.4m) due mainly to non pay one off purchases not reoccurring. £0.5m of the in month spend relates to Covid testing costs which are now directly reclaimable on a pass through basis and continue to be billed as a retrospective top-up.

3. The main themes seen in M7 were :
   - If payment had continued on a payment by results basis the trust would have received £1.1m less income. This gap has reduced by £1.5m from September (£2.6m) and represents 98% achievement of the trusts income plan.
   - Elective income was indicatively 97% of planned levels (87% in September), inclusive of independent sector activity. Outpatient equivalent income decreased marginally to 98% of planned levels (100% in September).
   - Activity within independent sector hospitals increased in October to over 400 procedures (up from 380 in September). Currently the cost of independent hospital provision is met by NHS England, however capacity is restricted to 75% of IS capacity.
   - Pay costs normalised to levels consistent with month 5 following the medical pay award in September. Additional costs for recovery plans and winter plans have yet to fully take hold.
   - Non Pay spend normalised back to run rate levels reducing £1.9m from September as one off costs incurred in the previous month did not reoccur.

University Hospital Southampton NHS
NHS Foundation Trust

Finance: I&E Summary

The financial position for M7 was a deficit of £0.2m, which was adverse to plan by £0.1m after adjustments.

Income was £1.5m favourable to plan as other income sources within education and R&D recovered markedly. These items are however deemed an allowable miss by NHSE, with any shortfall anticipated to be centrally funded. Clinical income sources were on plan as channel islands income improved significantly having been behind plan in the early part of the year.

Pay costs overall were £0.6m favourable to plan as recovery plan costs were not as high as anticipated. Pay costs are expected to increase throughout the winter period however. The plan has been phased accordingly for anticipated increases.

Non pay costs overall were £0.5m adverse to plan with the most significant variances within other non pay and drugs. These areas of spend are volatile however and are expected to normalise going forward. Clinical supplies was favourable to plan offsetting much of the other non pay overspend.

The forecast for months 7-12 remains a deficit of £3m after any shortfall in other income is funded and an anticipated £2m annual leave accrual is adjusted for.

		Current Month			M7-12 Forecast			Full Year Forecast		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
NHS Income:	Clinical	59.5	59.4	0.0	356.7	356.7	0.0	684.5	674.2	10.3
	Pass-through Drugs & Devices	11.7	11.7	(0.1)	69.9	69.9	0.0	126.4	133.5	(7.1)
Other income	Other Income	8.6	9.9	(1.3)	51.1	51.1	0.0	112.2	100.5	11.7
	Top Up Income	0.4	0.5	(0.1)	2.1	2.1	0.0	2.1	38.1	(36.0)
Total income		**80.0**	**81.5**	**(1.5)**	**479.8**	**479.8**	**0.0**	**925.2**	**946.3**	**(21.0)**
Costs	Pay-Substantive	43.1	42.7	(0.4)	262.4	262.4	0.0	509.2	518.4	9.2
	Pay-Bank	2.7	2.6	(0.2)	18.1	18.1	0.0	29.8	33.7	3.9
	Pay-Agency	1.0	1.0	(0.0)	7.9	7.9	0.0	15.2	12.8	(2.4)
	Drugs	1.0	1.3	0.3	6.0	6.0	0.0	18.0	15.5	(2.5)
	Pass-through Drugs & Devices	11.7	11.7	0.1	69.9	69.9	0.0	126.4	133.5	7.1
	Clinical supplies	8.8	7.2	(1.6)	50.2	50.2	0.0	74.9	82.6	7.7
	Other non pay	9.9	11.6	1.7	59.5	59.5	0.0	126.6	126.4	(0.2)
Total expenditure		**78.2**	**78.2**	**(0.0)**	**474.0**	**474.0**	**0.0**	**900.2**	**922.9**	**22.8**
EBITDA		**1.8**	**3.3**	(1.5)	**5.8**	**5.8**	0.0	**25.1**	**23.4**	1.7
EBITDA %		2.3%	4.1%	(1.8%)	1.2%	1.2%	0.0%	2.7%	2.5%	0.2%
	Depreciation	2.0	2.0	(0.0)	12.2	12.2	0.0	25.2	24.8	(0.4)
	Non Operating Income/Expenditure	1.4	1.5	0.0	8.1	8.1	0.0	13.8	13.1	(0.7)
Surplus / (Deficit)		**(1.6)**	**(0.2)**	**(1.5)**	**(14.5)**	**(14.5)**	**0.0**	**(13.9)**	**(14.5)**	**0.6**
	Other Income Allowable Deficit	(1.6)	0.0	(1.6)	(9.5)	(9.5)	0.0	(9.5)	(9.5)	0.0
	Annual Leave Accrual	0.0	0.0	0.0	(2.0)	(2.0)	0.0	(2.0)	(2.0)	0.0
Adjusted Surplus / (Deficit)		**(0.1)**	**(0.2)**	**0.1**	**(3.0)**	**(3.0)**	**0.0**	**(2.4)**	**(3.0)**	**0.6**

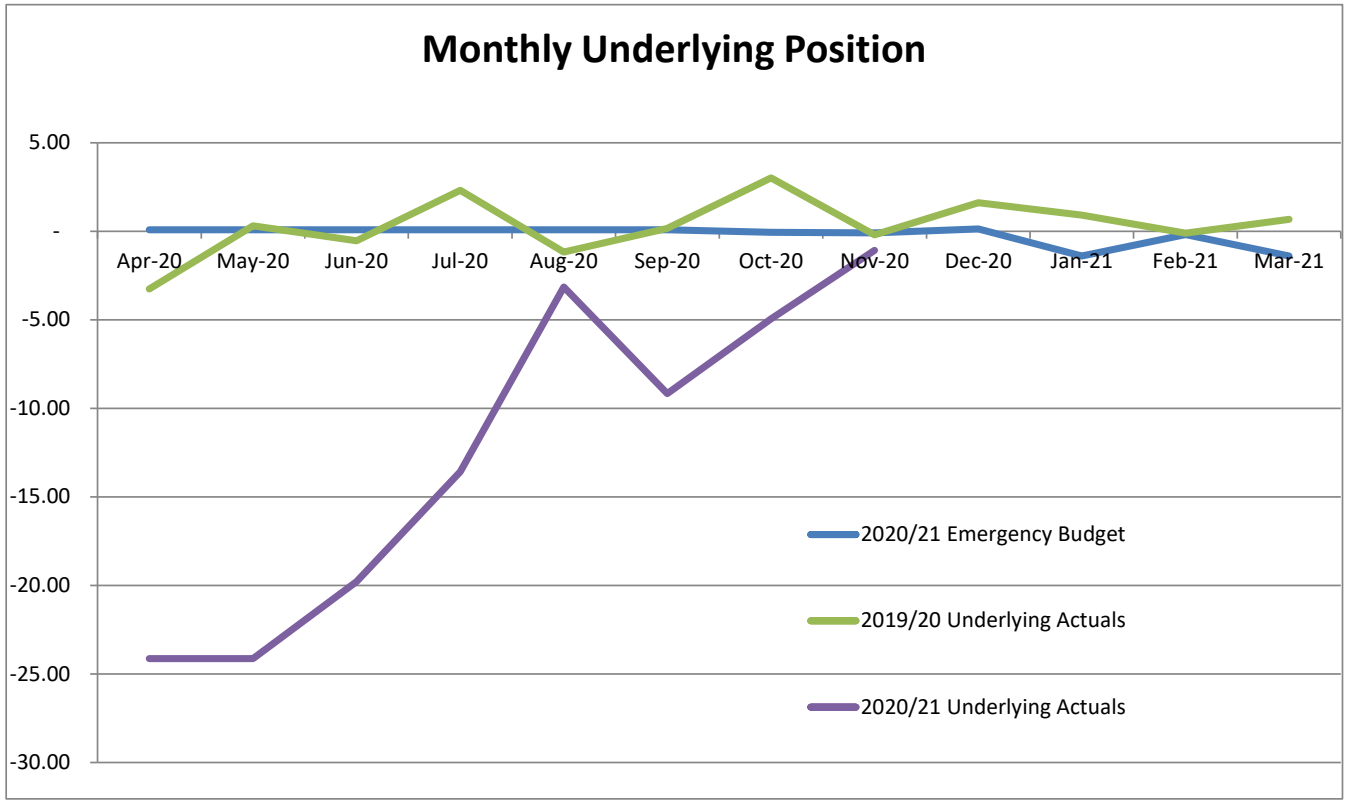
Underlying Run Rate Position

These graphs show the actual underlying position for the trust:

The following have been removed from October 20/21 position:

- (-) The block contract uplift of £1.1m in month (£63.7m YTD) which represents the value of income over and above that which would have prevailed under PbR.
- (+/-) material one off items of expenditure. These net to zero in month.

This illustrates that if the trust reverted to PbR and covid income and expenditure are adjusted out a deficit of £1.3m in month would have prevailed. Currently the block contract mechanism provides security against any underperformance.



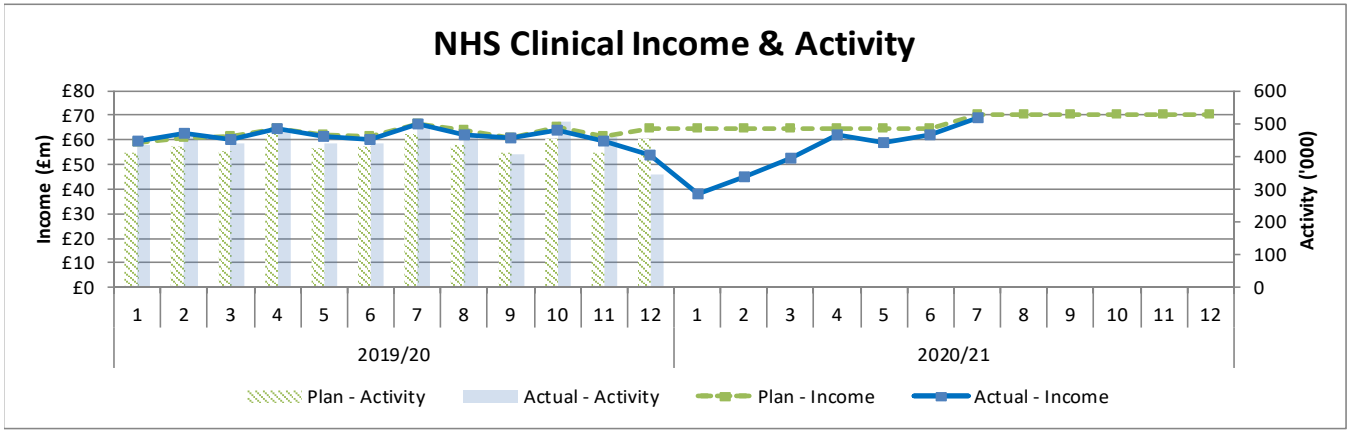
Clinical Income

(Fav Variance) / Adv Variance

Clinical income for the month of October was broadly on plan. Additional block funding of £5.45m per month has been added to the block contract value to cover covid costs in addition to growth and inflation. This is now a fixed sum payment. The channel islands remain on a PbR contract; however the plan has been adjusted to reflect more moderate levels of income expected for months 7-12. Much of the specialised commissioning drugs and devices spend has now returned to being pass through.

October has seen further increases in PbR equivalent activity which has been valued at 98% of block contracted values (up from 96% in September). Elective income increased, representing 97% of planned levels (up from 87% in September) and non elective values remain near pre Covid levels at 102% of plan. Outpatient income remained fairly static at 98% of planned levels. Independent sector hospitals continue to be utilised with activity at 166% of pre-Covid levels.

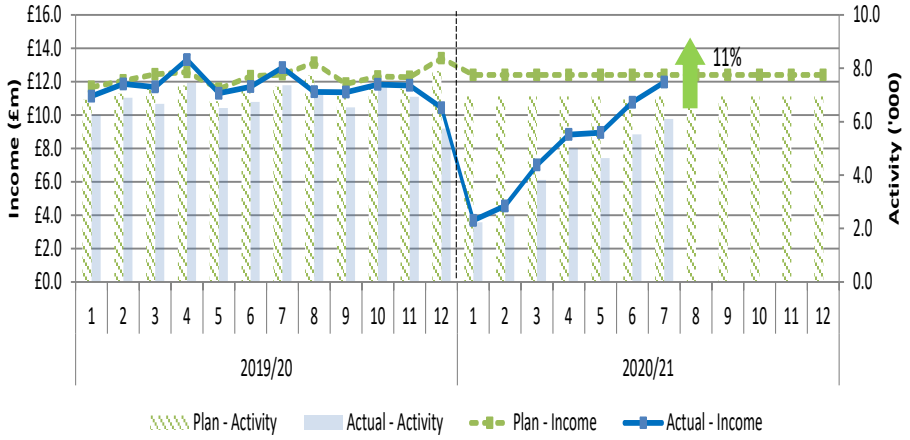
	2020/21						2019/20
POD GROUP	In Month Plan £000s	In Month Estimate £000s	In Month Variance £000s	YTD Plan £000s	YTD Estimate £000s	YTD Variance £000s	YTD Actuals £000s
NHS Clinical Income							
Elective Inpatients	£12,393	£11,964	£429	£86,753	£55,721	£31,032	£83,790
Non-Elective Inpatients	£18,725	£19,115	(£391)	£131,072	£116,028	£15,045	£126,403
Outpatients	£7,128	£7,006	£123	£49,900	£42,332	£7,568	£48,703
Other Activity	£11,387	£9,700	£1,687	£79,221	£62,703	£16,518	£75,741
CQUIN	£669	£601	£69	£4,680	£3,668	£1,012	£4,998
Blocks & Financial Adjustments	(£837)	£749	(£1,586)	(£1,657)	£2,635	(£4,292)	(£722)
Other Exclusions	£4,535	£3,757	£777	£30,177	£35,820	(£5,642)	£2,257
Pass-through Exclusions	£11,650	£11,710	(£61)	£69,880	£64,162	£5,717	£67,803
Subtotal NHS Clinical Income	*£65,650*	*£64,602*	*£1,047*	*£450,026*	*£383,069*	*£66,957*	*£408,973*
M7-M12 additional funding	£5,452	£5,452	£0	£5,452	£5,452	£0	*£0*
Covid block adjustments	£0	£1,073	(£1,073)	£0	£63,720	(£63,720)	£0
Total NHS Clinical Income	**£71,102**	**£71,128**	**(£26)**	**£455,478**	**£452,241**	**£3,237**	**£408,973**
Non NHS Clinical Income							
Private Patients	£316	£481	(£165)	£3,586	£2,157	£1,429	£2,594
CRU	£154	£220	(£66)	£1,404	£1,112	£292	£1,466
Overseas Chargeable Patients	£120	£87	£33	£882	£623	£259	£942
Total Non NHS Clinical Income	**£590**	**£788**	**(£198)**	**£5,872**	**£3,893**	**£1,979**	**£5,002**
Grand Total	**£71,692**	**£71,916**	**(£224)**	**£461,350**	**£456,134**	**£5,217**	**£413,975**



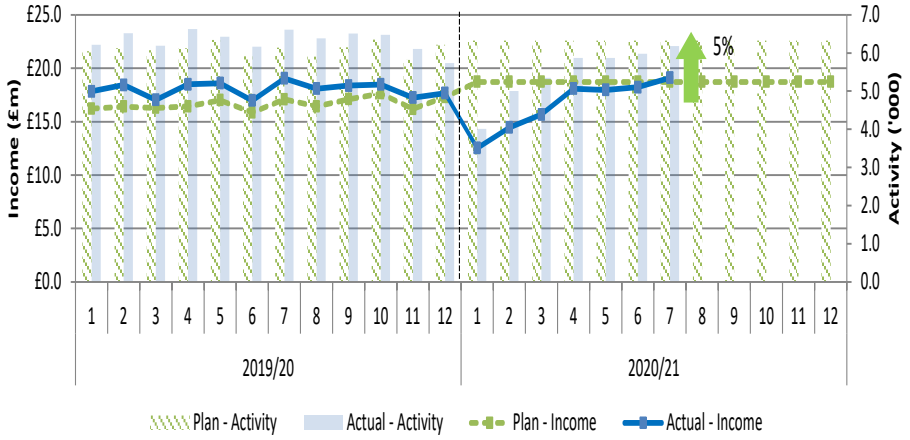
University Hospital Southampton NHS
NHS Foundation Trust

Clinical Income

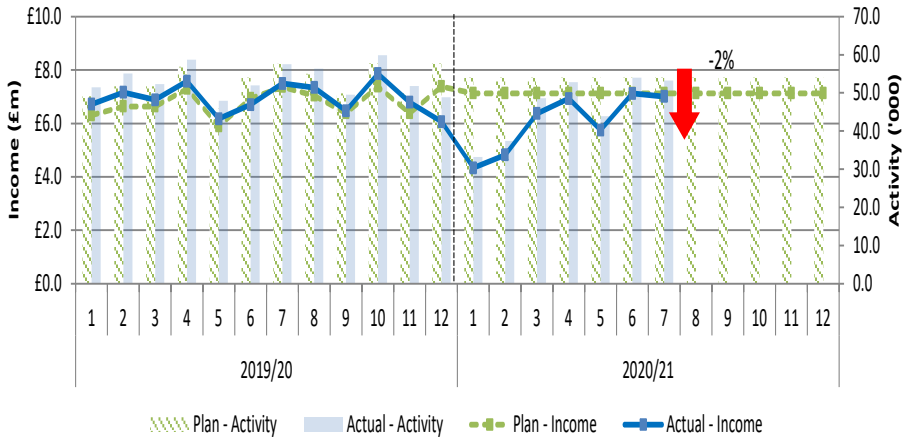
Elective spells



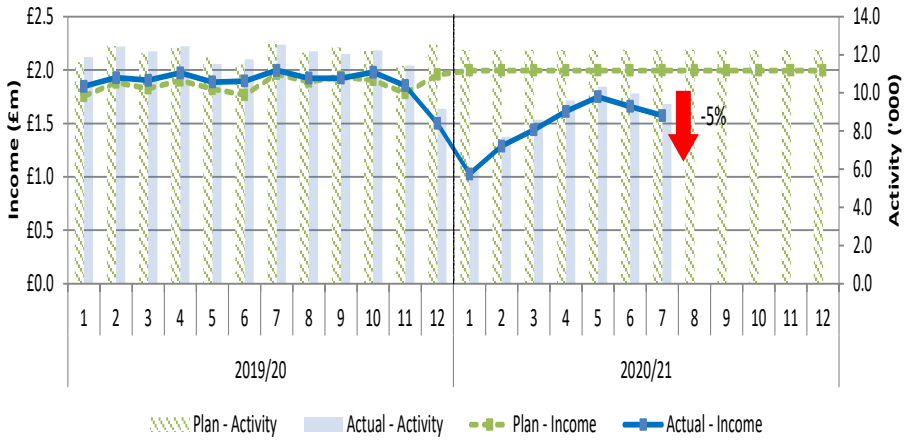
Non elective spells



Outpatients



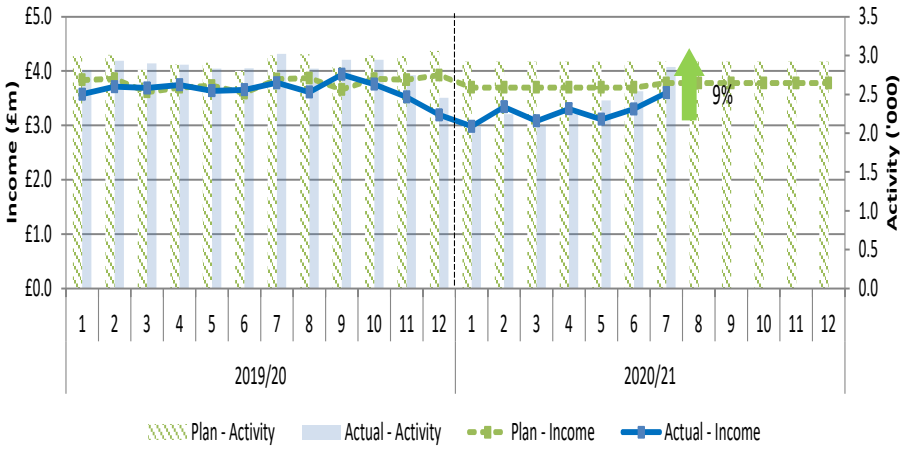
A&E



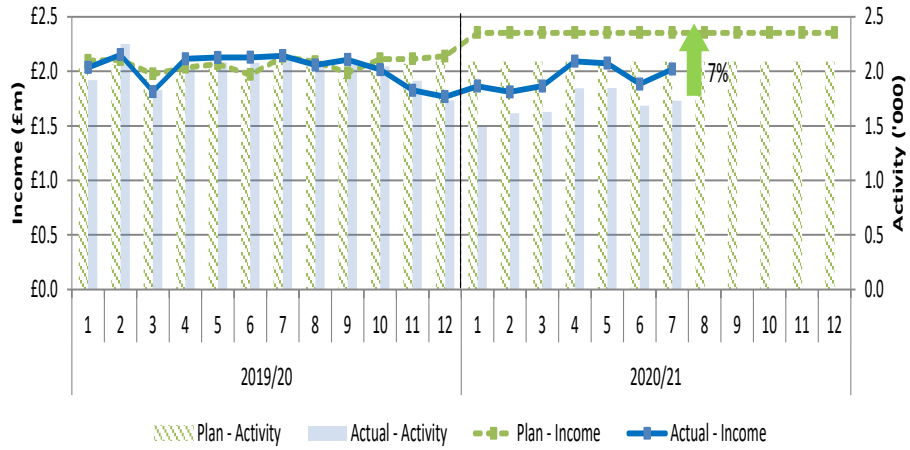
University Hospital Southampton NHS
NHS Foundation Trust

Clinical Income

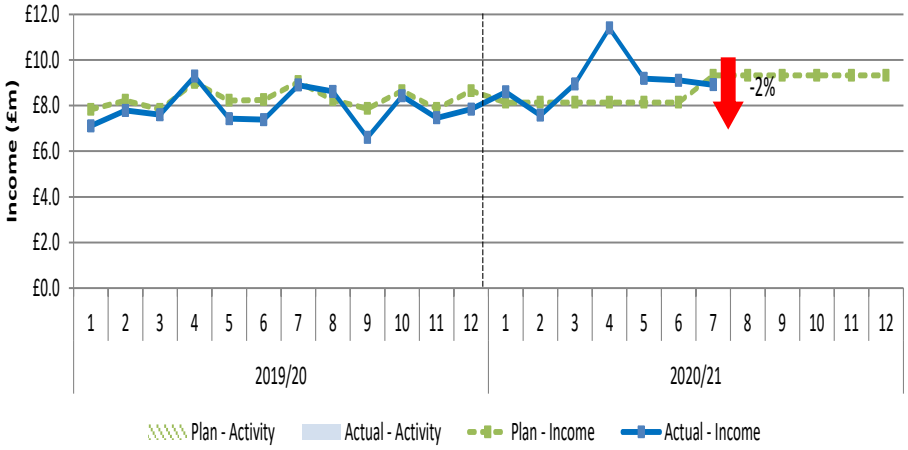
Adult critical care



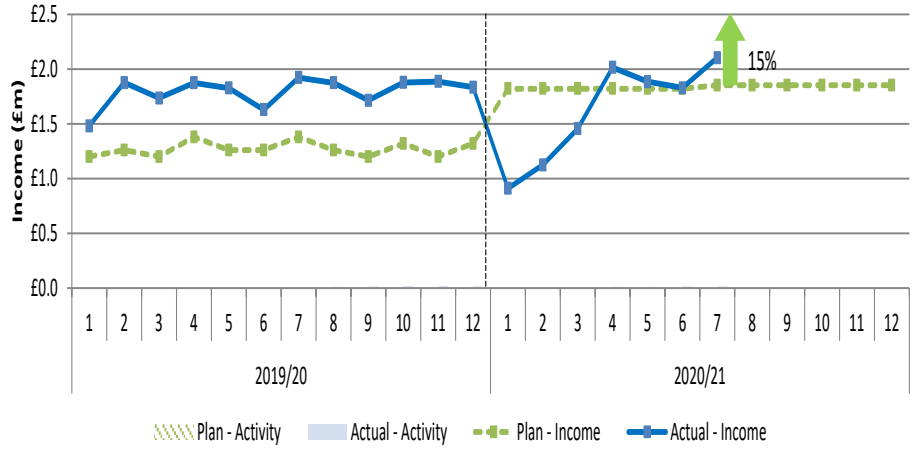
Neonatal & paediatric critical care



Tariff excluded drugs



Tariff excluded devices



University Hospital Southampton NHS
NHS Foundation Trust

Income and Activity

The tables shown illustrate by division and care group the % of the activity and income plan being achieved across months 1-7 for elective and outpatient activity.

Elective activity has improved in October to 97% of pre-Covid levels (by value). There is however variation at care group level, although all care groups are now over 75% with noticeable improvement in Orthopaedics, CV&T, Neurosciences , Ophthalmology and Women's Health.

Excluding the independent sector performance is 90% which adjusts for the removal of nationally contracted independent sector capacity.

Outpatient activity continues to perform close to pre- Covid levels at 98% of plan in month. Only Support Services are below 80%, however they continue to show month on month improvement. The national target is 100% of pre-Covid levels for October.

Elective Activity as % of Plan		Activity as % of Plan							Income as % of Plan							M7 Excluding independent sector plan and actual	
																Activity	Income
Division	Care Group	1	2	3	4	5	6	7	1	2	3	4	5	6	7	7	7
DIVISION A	CANCER CARE	54%	56%	60%	72%	66%	67%	75%	50%	47%	55%	66%	65%	67%	77%	75%	77%
	SURGERY	27%	33%	55%	71%	65%	77%	83%	32%	48%	65%	78%	80%	86%	100%	75%	94%
DIVISION A Total		40%	44%	57%	72%	66%	72%	79%	36%	48%	63%	76%	76%	82%	95%	75%	90%
DIVISION B	OPHTHALMOLOGY	4%	10%	46%	55%	54%	69%	89%	7%	11%	48%	56%	56%	71%	88%	68%	69%
	SPECIALIST MEDICINE	29%	34%	51%	75%	70%	78%	87%	23%	29%	50%	76%	70%	81%	89%	87%	89%
DIVISION B Total		23%	28%	50%	70%	66%	76%	87%	17%	23%	49%	69%	65%	78%	88%	82%	82%
DIVISION C	CHILD HEALTH	41%	43%	61%	85%	75%	93%	94%	27%	40%	60%	80%	86%	101%	96%	94%	96%
	WOMEN'S HEALTH	49%	44%	57%	59%	69%	88%	92%	55%	48%	55%	69%	77%	91%	101%	85%	93%
DIVISION C Total		43%	43%	60%	78%	73%	92%	93%	34%	42%	59%	77%	84%	98%	97%	92%	95%
DIVISION D	CARDIOVASCULAR & THORACIC	31%	35%	63%	79%	71%	98%	108%	36%	36%	56%	67%	65%	98%	105%	107%	103%
	NEUROSCIENCES	50%	44%	68%	92%	88%	87%	96%	35%	45%	62%	92%	96%	95%	100%	95%	98%
	RADIOLOGY	25%	26%	48%	53%	41%	71%	79%	28%	36%	54%	65%	61%	68%	87%	79%	87%
	TRAUMA & ORTHOPAEDICS	12%	22%	44%	57%	53%	73%	89%	12%	21%	48%	54%	59%	68%	92%	55%	63%
DIVISION D Total		30%	33%	56%	71%	64%	83%	94%	29%	34%	55%	68%	68%	87%	99%	86%	91%
Total		**32%**	**36%**	**55%**	**72%**	**67%**	**80%**	**88%**	**30%**	**37%**	**56%**	**71%**	**72%**	**87%**	**97%**	**83%**	**90%**

Outpatient Activity as % of Plan		Activity as % of Plan							Income as % of Plan						
Division	Care Group	1	2	3	4	5	6	7	1	2	3	4	5	6	7
DIVISION A	CANCER CARE	103%	107%	125%	126%	112%	124%	100%	101%	106%	124%	125%	110%	124%	102%
	SURGERY	56%	62%	86%	86%	65%	87%	91%	48%	54%	75%	78%	63%	84%	90%
DIVISION A Total		79%	84%	105%	105%	88%	105%	96%	76%	81%	101%	103%	88%	105%	96%
DIVISION B	ACUTE MEDICINE	34%	56%	75%	61%	63%	108%	90%	35%	59%	79%	63%	66%	114%	96%
	EMERGENCY MEDICINE	44%	72%	92%	92%	84%	158%	68%	44%	68%	92%	92%	83%	153%	67%
	OPHTHALMOLOGY	27%	43%	64%	76%	74%	89%	96%	26%	42%	64%	77%	76%	91%	96%
	SPECIALIST MEDICINE	59%	73%	105%	116%	92%	110%	107%	54%	66%	96%	111%	87%	104%	101%
DIVISION B Total		44%	59%	86%	97%	84%	100%	101%	42%	56%	83%	96%	83%	99%	99%
DIVISION C	CHILD HEALTH	87%	87%	104%	110%	86%	106%	109%	88%	87%	105%	110%	84%	106%	107%
	SUPPORT SERVICES	54%	62%	63%	77%	61%	75%	82%	49%	57%	57%	71%	56%	69%	80%
	WOMEN'S HEALTH	63%	64%	81%	98%	80%	100%	99%	58%	59%	81%	95%	76%	98%	99%
DIVISION C Total		71%	73%	86%	97%	77%	96%	98%	73%	74%	91%	100%	78%	99%	101%
DIVISION D	CARDIOVASCULAR & THORACIC	59%	68%	88%	90%	77%	91%	102%	56%	66%	86%	86%	75%	87%	102%
	NEUROSCIENCES	68%	69%	95%	100%	72%	102%	100%	65%	66%	93%	100%	72%	102%	99%
	RADIOLOGY	65%	57%	95%	104%	74%	101%	131%	51%	48%	78%	81%	56%	82%	105%
	TRAUMA & ORTHOPAEDICS	50%	54%	69%	85%	74%	103%	91%	50%	54%	69%	83%	74%	104%	89%
DIVISION D Total		59%	64%	84%	91%	75%	98%	98%	58%	63%	84%	90%	73%	97%	98%
Total		**62%**	**69%**	**90%**	**98%**	**81%**	**100%**	**99%**	**61%**	**68%**	**89%**	**97%**	**81%**	**100%**	**98%**

Income and Activity

Non elective activity has now exceeded 100% of pre-Covid levels in month.

The impact of the second lockdown on non-elective activity has yet to be fully known although is unlikely to be as significant as the first phase.
It is expected activity levels for non elective will remain close to pre-Covid levels going forward.

Non Elective Activity as % of Plan		Activity as % of Plan							Income as % of Plan						
Division	Care Group	1	2	3	4	5	6	7	1	2	3	4	5	6	7
DIVISION A	CANCER CARE	79%	93%	90%	97%	96%	102%	108%	70%	75%	80%	106%	93%	93%	94%
	SURGERY	46%	79%	90%	89%	91%	89%	95%	56%	88%	96%	102%	98%	95%	105%
DIVISION A Total		56%	83%	90%	91%	93%	93%	98%	61%	83%	90%	104%	96%	94%	101%
DIVISION B	ACUTE MEDICINE	85%	76%	85%	88%	86%	93%	104%	73%	78%	89%	93%	89%	99%	109%
	EMERGENCY MEDICINE	45%	80%	82%	99%	99%	103%	102%	39%	69%	70%	91%	95%	96%	101%
	OPHTHALMOLOGY	64%	53%	45%	88%	51%	66%	68%	76%	52%	50%	101%	60%	81%	70%
	SPECIALIST MEDICINE	33%	66%	44%	70%	96%	92%	154%	38%	75%	42%	49%	86%	54%	142%
DIVISION B Total		62%	78%	82%	94%	93%	98%	103%	62%	75%	82%	92%	91%	97%	107%
DIVISION C	CHILD HEALTH	45%	58%	67%	72%	79%	101%	99%	71%	68%	91%	88%	85%	92%	99%
	WOMEN'S HEALTH	83%	90%	91%	88%	92%	84%	89%	89%	100%	94%	93%	99%	93%	96%
DIVISION C Total		71%	80%	84%	83%	88%	89%	92%	82%	89%	93%	91%	94%	93%	97%
DIVISION D	CARDIOVASCULAR & THORACIC	59%	72%	78%	95%	93%	81%	97%	49%	55%	65%	91%	101%	79%	98%
	NEUROSCIENCES	75%	89%	87%	108%	98%	106%	96%	83%	97%	91%	107%	106%	131%	110%
	RADIOLOGY	45%	63%	68%	78%	75%	77%	66%	47%	63%	63%	78%	68%	58%	58%
	TRAUMA & ORTHOPAEDICS	67%	73%	96%	118%	108%	106%	90%	83%	81%	95%	115%	104%	115%	109%
DIVISION D Total		64%	75%	85%	104%	98%	94%	92%	66%	73%	79%	100%	101%	100%	101%
Total		**63%**	**79%**	**84%**	**93%**	**93%**	**95%**	**98%**	**67%**	**77%**	**84%**	**97%**	**96%**	**97%**	**102%**

Elective Incentive Scheme

Performance against the Elective Incentive Scheme has been indicatively assessed using UHS data. The national method of calculation and source of information has yet to be shared. No income has been adjusted for this, as per national guidance.

It should be noted that Outpatient Procedures count as Elective, which moves activity between EL and OP when compared to Trust reporting.

In M7, UHS achieved an estimated 91% of Elective performance against a target of 90%. Over performance is indicatively funded at 75% of tariff.

Outpatients achieved 104% against a target of 100% with over performance indicatively funded at 80% of tariff.

Funding flows for over/under activity remain unclear, with the potential for performance to be assessed at STP level and off-set under-performance elsewhere.

The STP have indicatively assessed UHS performance at M6, with lower values than UHS estimates. This discrepancy is under investigation.

ELECTIVE/DAYCASE, OUTPATIENT PROCEDURES AND ELECTIVE XBDs

MONTH	BASELINE	TARGET %	TARGET £	ACTUAL	ACTUAL %	VARIANCE	BLOCK Adj
M06	12,485	80%	9,988	10,486	84%	498	374
M07	12,885	90%	11,597	11,784	91%	187	140
M08	11,909	90%	10,718	0	0%	(10,718)	
M09	12,283	90%	11,055	0	0%	(11,055)	
M10	13,527	90%	12,175	0	0%	(12,175)	
M11	12,228	90%	11,005	0	0%	(11,005)	
M12	TBC	90%	TBC	0	TBC	TBC	
Total	**75,318**	**0**	**66,538**	**22,270**	**0**	**(44,268)**	**514**

OUTPATIENT ATTENDANCES

MONTH	BASELINE	TARGET %	TARGET £	ACTUAL	ACTUAL %	VARIANCE	BLOCK Adj
M06	4,671	100%	4,671	4,932	106%	261	209
M07	4,750	100%	4,750	4,953	104%	203	162
M08	4,807	100%	4,807	0	0%	(4,807)	
M09	4,376	100%	4,376	0	0%	(4,376)	
M10	4,609	100%	4,609	0	0%	(4,609)	
M11	4,373	100%	4,373	0	0%	(4,373)	
M12	TBC	100%	TBC	0	TBC	TBC	
Total	**27,586**	**0**	**27,586**	**9,885**	**0**	**(17,702)**	**371**

INDEPENDENT SECTOR (ELECTIVE/DAYCASE)

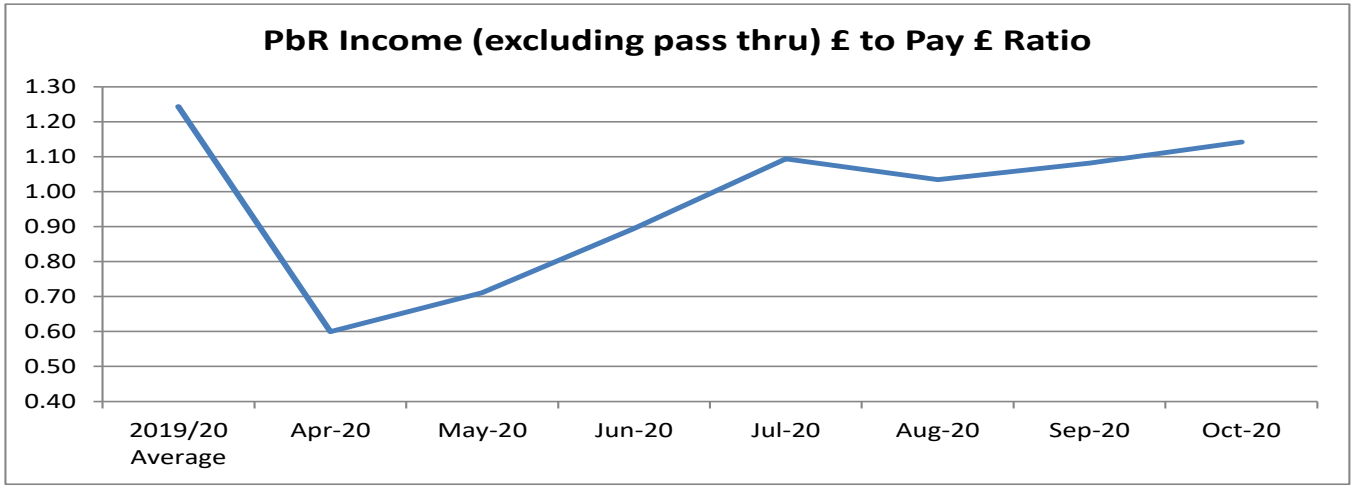
MONTH	BASELINE	TARGET %	TARGET £	ACTUAL	ACTUAL %	VARIANCE	BLOCK Adj
M06	974	80%	779	1,259	129%	480	48
M07	902	90%	812	1,501	166%	689	69
M08	899	90%	810	0	0%	(810)	
M09	787	90%	708	0	0%	(708)	
M10	801	90%	721	0	0%	(721)	
M11	894	90%	805	0	0%	(805)	
M12	TBC	90%	TBC	0	TBC	TBC	
Total	**5,257**	**0**	**4,634**	**2,760**	**0**	**(1,874)**	**117**

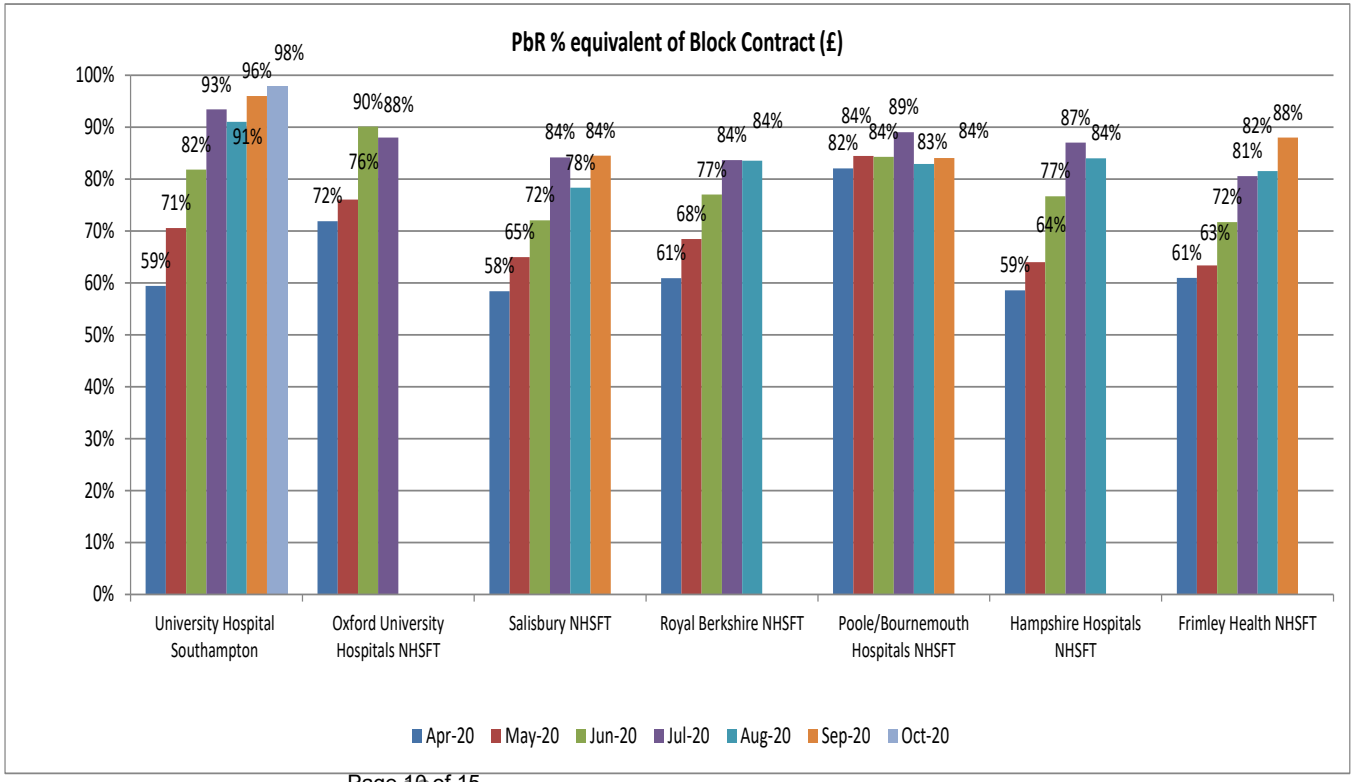
Benchmarking

The current financial reporting framework of being brought back to break-even whilst achieving lower levels of activity makes it difficult to assess the relative efficiency of the Trust.

It is therefore important we measure performance against our peers. Unfortunately data on activity and underlying financial performance of peers is limited; however the graph shows the comparator performance of neighbouring hospital trusts when assessing their level of PbR equivalent revenue as a % of their block contract.

Distortions could exist (e.g. high cost drugs, specialised high-cost activity) however, and this isn't necessarily in correlation with productivity. That said there are clear patterns emerging that suggest UHS is performing better than comparator organisations in terms of its % recovery. Data is still awaited for October performance of peer organisations.



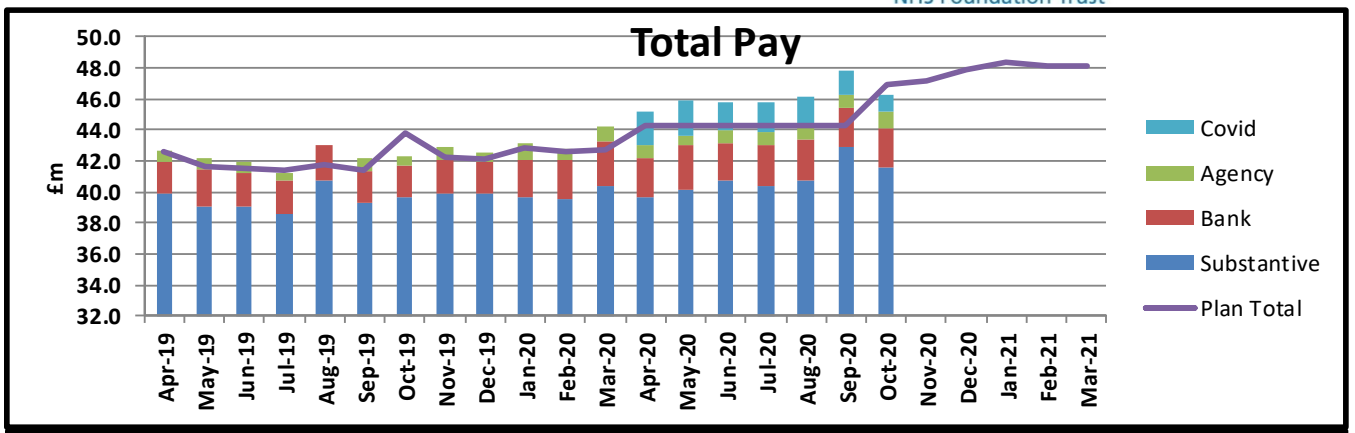


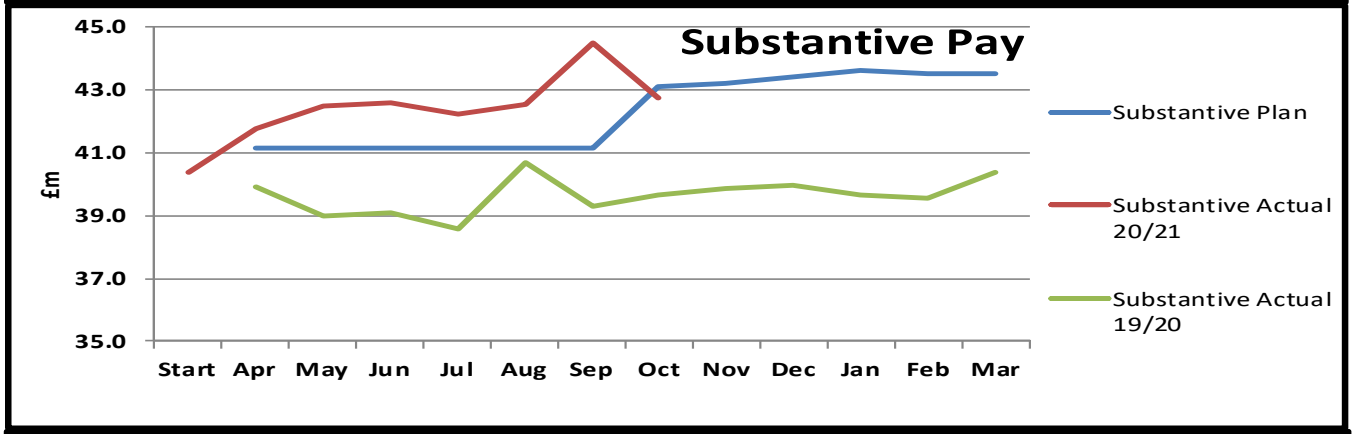
Substantive Pay Costs

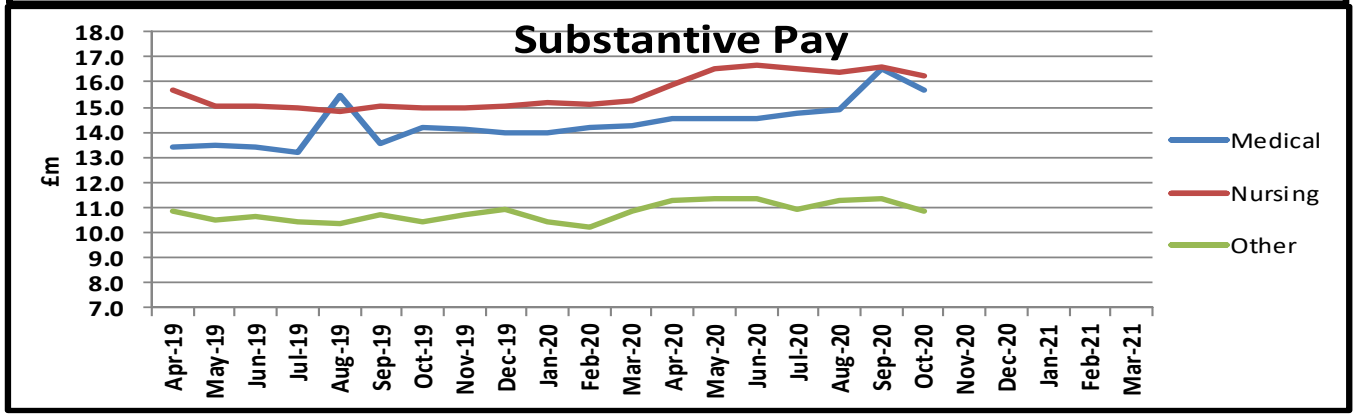
Total pay expenditure in June was £46.3m (down £1.5m from September). This was however anticipated as medical staffing pay arrears of £1.3m were paid in month 6 in addition to bank holiday enhancements of £0.3m, therefore adjusting for these items pay costs were marginally up by £0.1m.

Covid related staffing expenditure marginally reduced to £1m, down £0.2m from the previous month. This cost has however been reinvested in supporting additional activity and hence no pay reductions can be evidenced.

Pay costs are forecast to increase across months 8 to 12 as both recovery plans and winter plans have additional resource requirements that have been non recurrently funded within revised planning assumptions. A provision has also been made for continued absence / self isolation relating to Covid.





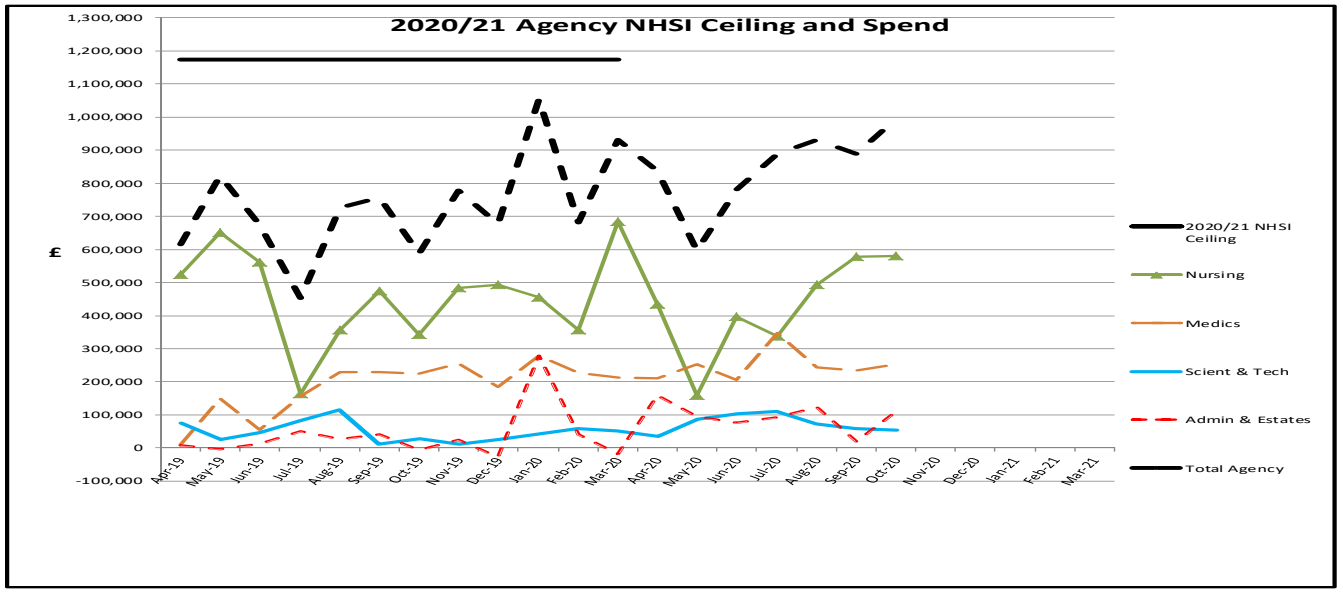


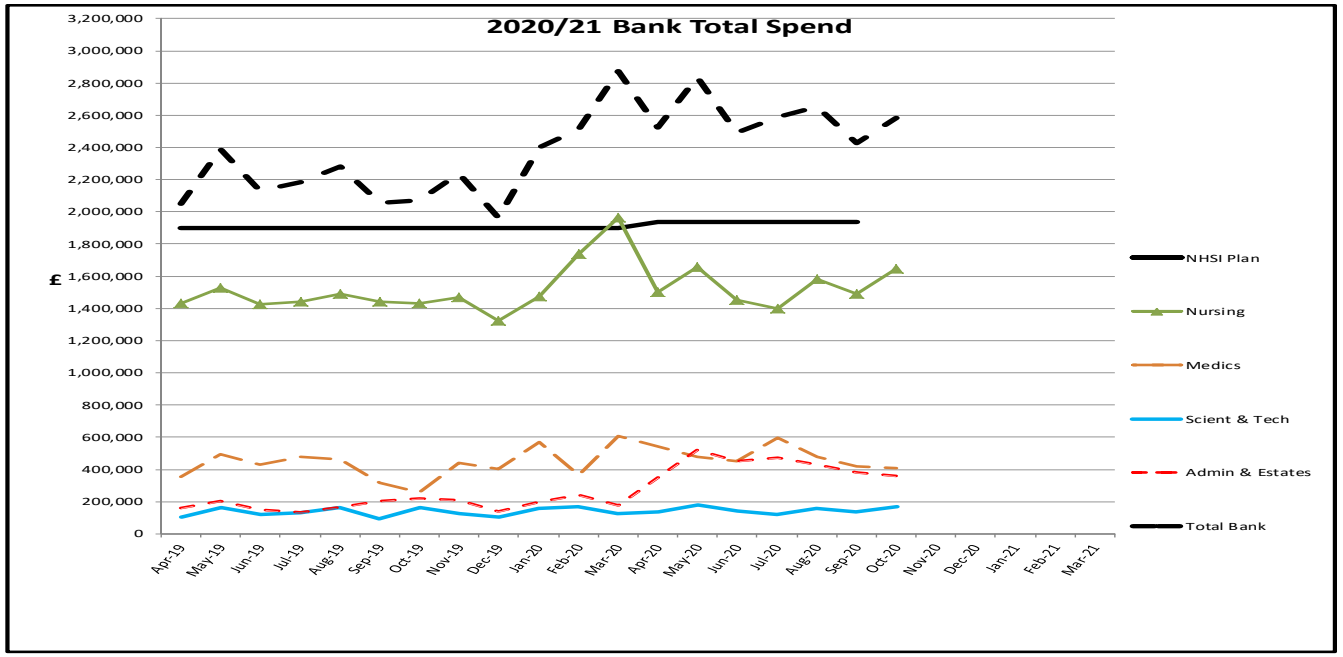
Temporary Staff Costs

Agency spend has increased marginally to just under £1m in month. High cost agency continues to be required within child heath who currently require 1-2-1 support for several patients. Funding for this has now been agreed with commissioners however. Admin and estates usage increased in month following a dip in September.

Staffing requirements were previously flexed down in many elective focused service areas, in order to support Covid-19 patients, hence avoiding the need for high cost agency. Since May however agency costs have been on an upward trend returning to pre-Covid levels. These are likely to further increase moving into winter.

Expenditure on bank staff went up from £2.4m to £2.6m. This continues to be above average levels of spend in 19/20 predominantly relating to increased sickness and self isolation backfill. Admin bank usage has also increased significantly as staffing has been required to man entrances and exits to the trust. Other areas of bank spend remained static.





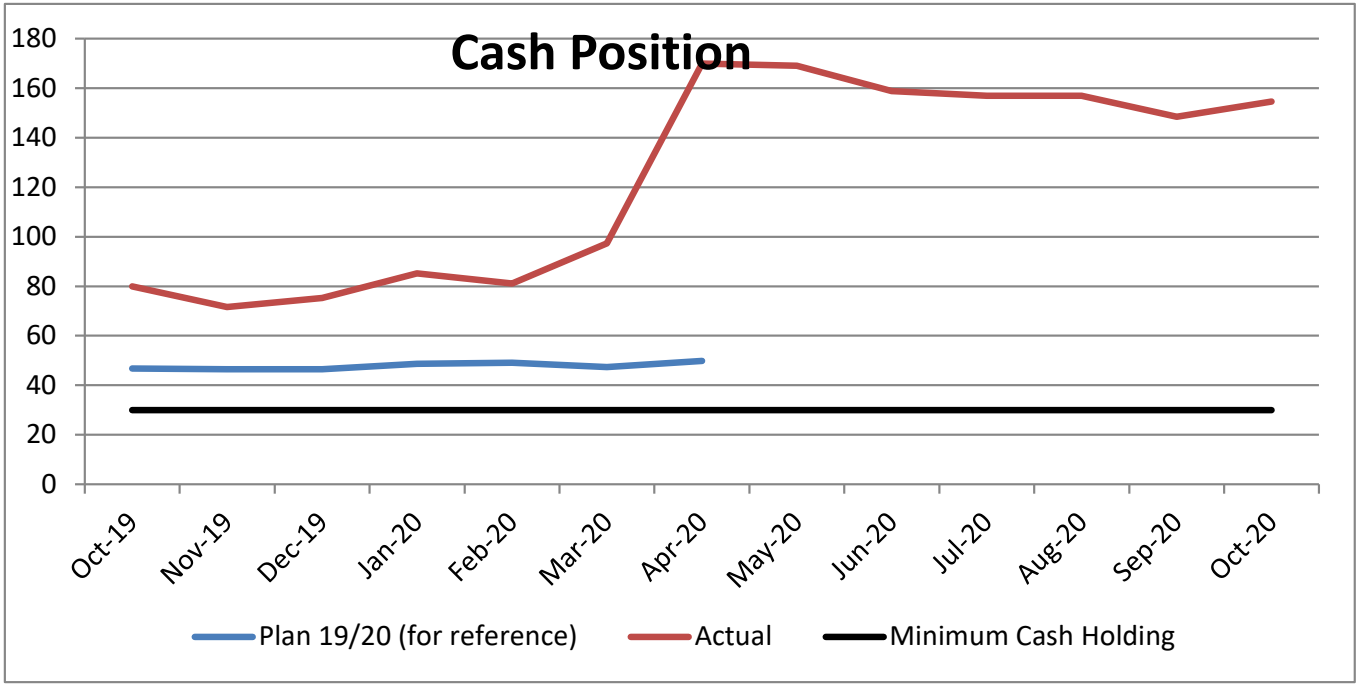
University Hospital Southampton NHS
NHS Foundation Trust

Cash

The cash balance increased marginally to £154.6m in October. This is primarily linked to a decrease in accounts receivable as top-up payments have been made.

The Trust continues to benefit from the current finance regime paying in advance, with increased block funding and reduced retrospective funding in the M7-12 regime. The cash balance remains artificially high and is expected to reduce before M12.

The Trust is also still awaiting cash to fund Covid-19 related capital expenditure.



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Capital Expenditure

The capital expenditure position for the year to October shows expenditure of £35.5m against a plan of £37.3m. Excluding externally funded schemes and Covid-19 related expenditure, the expenditure is £30.4m against a plan of £32.5m, £2.1m below budget.

Spend excluding leases was £0.1m below plan in month with higher than anticipated spend on the Oncology ward and GICU being offset by lower than expected spend on theatres within the vertical extension.

The trust are currently forecasting to spend all the internally funded capital budget.

A financial risk relating to Covid-19 capital remains, with uncertainty regarding £2.6m of capital costs committed in Phase 1 but with reimbursement under scrutiny and not yet reimbursed by the centre.

The Trust is pushing to meet its spend plan for 20/21, with uncertainty remaining over 21/22 capital expenditure limits.

(Fav Variance) / Adv Variance

	Month 7			Year to Date			Full Year Forecast		
Scheme	Plan £000's	Actual £000's	Var £000's	Plan £000's	Actual £000's	Var £000's	Plan £000's	Actual £000's	Var £000's
Childrens Hospital/ED Adult Resus	0	0	(0)	1,004	1,637	(633)	1,141	1,716	(575)
IT Schemes	673	557	116	4,429	2,316	2,113	7,564	6,327	1,237
Strategic Maintenance	383	284	99	1,837	1,923	(86)	3,750	3,750	0
Medical Equipment Panel	100	8	92	463	432	31	1,000	1,000	0
GICU Expansion	936	1,184	(248)	8,796	10,135	(1,339)	12,128	12,128	0
Fit out of E Level, Vertical Extension	803	69	734	2,324	487	1,837	5,013	1,913	3,100
Refurbish Eye Theatre	285	47	238	549	1,243	(694)	1,849	1,849	0
Theatre K Plant Room	0	55	(55)	334	581	(247)	334	612	(278)
Spend to Save	21	41	(20)	706	482	224	810	2,091	(1,281)
Radiotherapy Equipment	0	14	(14)	700	605	95	700	700	0
Decorative Improvements / Staff Fund	50	1	49	350	22	328	600	600	0
ED offices and minors space	0	0	0	586	16	570	586	586	0
Fit out of E &F level North Wing Courtyard	0	(2)	2	1,207	598	609	1,207	600	607
East Wing Annex Shell	0	7	(7)	350	272	78	1,490	1,490	0
Oncology Ward Build	799	1,292	(493)	3,567	3,651	(84)	5,782	7,388	(1,606)
Side Rooms	133	71	62	266	101	165	932	932	0
Other Projects	163	344	(181)	1,930	1,617	313	3,576	4,650	(1,074)
Assumed Slippage	-245	0	(245)	-204	0	(204)	(1,423)	(1,543)	120
Total Trust Funded Capital excl Finance Leases	**4,101**	**3,969**	**132**	**29,194**	**26,116**	**3,078**	**47,039**	**46,789**	**250**
Finance Leases - Medical Equipment Panel	200	0	200	900	400	500	2,200	2,200	0
Finance Leases - Divisional Equipment	42	0	42	294	0	294	500	467	33
Finance Leases - IISS	0	138	(138)	3,335	3,379	(44)	5,535	5,335	200
Finance Leases - Other	200	1	199	819	1,471	(652)	2,265	2,265	0
Donated Asset Additions	(232)	(565)	333	(2,068)	(1,015)	(1,053)	(3,482)	(2,999)	(483)
Total Trust Funded Capital Expenditure (CDEL Allocation)	**4,311**	**3,542**	**769**	**32,474**	**30,352**	**2,122**	**54,057**	**54,057**	**0**
Energy Efficiency	86	(0)	86	1,242	1,667	(425)	1,667	1,667	0
Fit out of E Level, Vertical Extension	0	0	0	0	0	0	5,000	5,000	0
ED Expansion and Refurbishment	1,500	1	1,499	1,500	36	1,464	0	9,000	(9,000)
Backlog Maintenance	216	0	216	648	0	648	1,730	1,730	0
Endoscopy Room	0	0	0	0	0	0	0	1,650	(1,650)
Digital Maternity (STP Wave 3)	169	2	167	507	2	505	1,350	470	880
Digital Outpatients (STP Wave 3)	73	0	73	219	0	219	589	164	425
HSLI Enterprise Wide Scheduling	37	40	(3)	259	62	197	444	444	0
Cyber Security	0	0	0	0	0	0	0	8	(8)
Pathology Digitisation	135	0	135	405	0	405	1,080	90	990
Coronavirus Equipment and Works	0	70	(70)	0	3,373	(3,373)	0	3,875	(3,875)
Total CDEL Expenditure	**6,527**	**3,655**	**2,872**	**37,254**	**35,491**	**1,763**	**65,917**	**78,155**	**(12,238)**

Statement of Financial Position

(Fav Variance) / Adv Variance

The October statement of financial position illustrates net assets of £441m which is £0.3m down when compared to September.

Receivables, cash and payables and inventories are all interrelated and hence net off close to zero.

Accounts payables balances are distorted when compared to 2019/20 as they include £63m of deferred income as block contract payments are currently paid in advance. Normalising for this payables are broadly static with the closing position for 2019/20.

Statement of Financial Position	2019/20 YE Actuals £m	2020/21 M6 Act £m	2020/21 M7 Act £m	2020/21 MoM Movement £m
Fixed Assets	379.0	398.5	400.9	2.3
Inventories	15.2	15.8	15.9	0.1
Receivables	73.0	75.9	70.0	(5.9)
Cash	97.3	148.5	154.6	6.1
Payables	(115.6)	(186.1)	(188.7)	(2.6)
Current Loan	(3.3)	(3.5)	(3.6)	(0.0)
Current PFI and Leases	(7.4)	(7.8)	(8.1)	(0.3)
Net Assets	**438.2**	**441.4**	**441.0**	**(0.3)**
Non Current Liabilities	(20.4)	(23.5)	(23.9)	(0.4)
Non Current Loan	(11.5)	(9.7)	(9.4)	0.3
Non Current PFI and Leases	(33.4)	(34.9)	(34.2)	0.7
Total Assets Employed	**372.9**	**373.3**	**373.5**	**0.3**
Public Dividend Capital	220.7	221.3	221.3	0.0
Retained Earnings	132.0	131.8	132.1	0.3
Revaluation Reserve	20.2	20.2	20.2	0.0
Other Reserves	0.0	0.0	0.0	0.0
Total Taxpayers' Equity	**372.9**	**373.3**	**373.5**	**0.3**

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors dated 26 November 2020				
Title:	**Register of Seals, and Chair's Actions**			
Agenda item:	**4.1**			
Sponsor:	**Peter Hollins, Trust Chair**			
Date:	**26 November 2020**			
Purpose:	**Assurance or reassurance**	**Approval**	**Ratification** **Y**	**Information**
Issue to be addressed:	This is a regular report to notify the Board of use of the seal and actions taken by the Chair in accordance with the Scheme of Delegation for ratification.			
Response to the issue:	The Board has agreed that the Chair may undertake some actions on its behalf. The following actions have been undertaken by the Chair. All awards of contract are subject to a full tender process.			
Implications: (Clinical, Organisational, Governance, Legal?)	Compliance with The NHS Foundation Trust Code of Governance (probity, internal control) and UHS Standing Financial Instructions and Scheme of Reservation and Delegation.			
Risks: (Top 3) of carrying out the change / or not:				
Summary: Conclusion and/or recommendation	The Board is asked to **ratify** the Chair's actions.			

1 Signing and Sealing

1.1 **Lease** between University Hospital Southampton NHS Foundation Trust (Landlord) and The Maggie Keswick Jencks Cancer Caring Trust (Tenant) of Maggie's Centre, Southampton General Hospital, Tremona Road, Southampton. Seal number 193.

1.2 **Lease** between The University of Southampton Science Park Limited (Landlord) and University Hospital Southampton NHS Foundation Trust (Tenant) of Suite F, Epsilon House, Enterprise Road, The University of Southampton Science Park, Southampton, relating to the 'Prototype' Lab for the (Saliva Mass Testing Project). Seal number 194.

2 Chair's Actions

The Board has agreed that the Chair may undertake some actions on its behalf. The following actions have been undertaken by the Chair.

2.1 **Award of Contract for Alliance Modular Unit and Alliance Mobile Magnetic Resonance Imaging (MRI) Unit** for the period 1 October 2020 – 31 March 2021 to Alliance Medical Limited at a cost of £500,000 excluding VAT. This equipment is required to provide additional MRI capacity to manage outpatients and support recovery to 100% of pre-Covid levels. Approved by the Chair on 23 October 2020.

2.2 **Award of Contract for Theatre Operating Tables including service and maintenance** to Hill-Rom for 10 years at a total contract cost of £1,103,560 excluding VAT following a procurement process using the NHS Supply Chain framework. In April 2020, the Trust Medical Equipment Panel (MEP) approved the rolling replacement of theatre tables to replace aging tables. The initial investment is for the financial year 2020-21. Additional budget is planned and the MEP is likely to support further year-on-year investments, as and when budgets allow. Approved by the Chair on 5 November 2020.

2.3 **Single Tender Action for the supply of Military Doctors** from Defence Business Services at a cost of £447,742 excluding VAT. The contract with the Trust's military doctors provides exceptional expertise as well as good value for money. The Trust pays below substantive rates for significant Programmed Activities (PAs). Approved by the Chair on 5 November 2020.

3 Recommendation

The Board is asked to **ratify** the Chair's Actions.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors dated 26 November 2020				
Title:	**Finance and Investment Committee Terms of Reference**			
Agenda item:	**4.2 i)**			
Sponsor:	**Peter Hollins, Trust Chair**			
Author:	**Karen Flaherty, Associate Director of Corporate Affairs and Company Secretary**			
Date:	**26 November 2020**			
Purpose	**Assurance or reassurance**	**Approval** X	**Ratification**	**Information**
Issue to be addressed:	The terms of reference for all Board committees should be reviewed regularly, and at least once annually, to ensure that these reflect the purpose and activities of each committee. The terms of reference have been reviewed by the Finance and Investment Committee.			
Response to the issue:	As well as changes to the formatting and structure of the terms of reference to fit in with the style of other Trust documentation, particularly as it is intended to publish these on the UHS website alongside the other Board committee terms of reference that we are required to publish, changes have been made to: • fully reflect the principles agreed around the Board committee structures in November 2019; • update the membership as only members of the Board can be members of the Committee, with others now included as regular attendees; • remove one of the committees (Patient-Level Income Costs (PLICs) Steering Group) from the structure chart as this group no longer meets; and • remove duplication and slight inconsistencies within the terms of reference.			
Implications: (Clinical, Organisational, Governance, Legal?)	The terms of reference ensure that the purpose and activities of the Finance and Investment Committee are clear and support transparency and accountability in the performance of its role.			
Risks: (Top 3) of carrying out the change / or not:	1. Non-compliance with the Trust's constitution relating to the composition of Board committees. 2. Non-compliance with the Trust's standing financial instructions and policies relating to the specific responsibilities of the Finance and Investment Committee. 3. The board of directors and the committee may not function as effectively without terms of reference in place.			
Summary: Conclusion and/or recommendation	The Board of Directors is asked to approve the revised terms of reference. These have been reviewed by the Finance and Investment Committee and are recommended for approval.			

University Hospital Southampton NHS
NHS Foundation Trust

Finance and Investment Committee Terms of Reference

Version: 3

Date Issued:	26 November 2020
Review Date:	November 2021
Document Type:	Committee Terms of Reference

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Document Status

1. Role and Purpose

1.1 The Finance and Investment Committee (the **Committee**) is responsible for overseeing, monitoring and reviewing the stewardship of the Trust's finances, investments and sustainability of University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**), including planning, financial performance, capital expenditure and the delivery of the IT and estates and facilities annual plans.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of assurance regarding the Trust's financial position and capital and revenue investments in support of the provision of world-class care for all.

1.3 The duties and responsibilities of the Committee are more fully described in paragraph 7 below.

2. Constitution

2.1 The Committee has been established by the Board. The Committee has no executive powers other than those set out in these terms of reference. It is supported in its work by other committees established by the Board and other committees and groups as shown in Appendix A.

2.2 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee.

2.3 In carrying out its role the Committee is authorised to seek reports and assurance from executive directors and managers and will maintain effective relationships with the chairs of other Board committees to understand their processes of assurance and links with the work of the Committee.

2.4 The Committee is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions.

3. Membership

3.1 The members of the Committee will be appointed by the Board and will be:

3.1.1 three independent non-executive directors of the Trust, including the chair of the Audit and Risk Committee;

3.1.2 the Chief Executive;

3.1.3 the Chief Financial Officer; and

3.1.4 the Chief Operating Officer.

3.2 The Board will appoint the chair of the Committee from among its non-executive director members (the **Committee Chair**). The Committee Chair will not be the chair of the Audit and Risk Committee. In the absence of the Committee Chair and/or an appointed deputy, the remaining members present will elect one of themselves to chair the meeting.

3.3 To ensure that non-executive directors hold the majority of votes on the Committee, only the Chief Financial Officer and Chief Operating Officer shall be invited to vote on any matter. The Committee Chair will have a second and casting vote in the event of a tie.

3.4 Subject to paragraph 3.3 above, only members of the Committee have the right to attend and vote at Committee meetings. However, the following will be invited to attend meetings of the Committee on a regular basis:

3.4.1 Director of Operational Finance; and

3.4.2 Director of Planning, Performance and Productivity.

3.5 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas of risk or operation that are the responsibility of a particular executive director or manager.

3.6 Governors may be invited to attend meetings of the Committee.

4. Attendance and Quorum

4.1 Members should aim to attend every meeting and should attend a minimum of 75% of meetings held in each financial year. Where a member is unable to attend a meeting they should notify the Committee Chair or Company Secretary in advance.

4.2 The quorum for a meeting will be three members, including two non-executive directors (one of whom must be either the Committee Chair or the chair of the Audit and Risk Committee) and either the Chief Financial Officer or Chief Operating Officer. A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

4.3 When an executive director or manager is unable to attend a meeting they should appoint a deputy to attend on their behalf.

5. Frequency of Meetings

5.1 The Committee will meet at least ten times each year (usually once each calendar month) and otherwise as required.

6. Conduct and Administration of Meetings

6.1 Meetings of the Committee will be convened by the secretary of the Committee at the request of the Committee Chair or any of its members.

6.2 The agenda of items to be discussed at the meeting will be agreed by the Committee Chair with support from the Chief Financial Officer. The agenda and supporting papers will be distributed to each member of the Committee and the regular attendees no later than four working days before the date of the meeting. Distribution of any papers after this deadline will require the agreement of the Committee Chair.

6.3 The secretary of the Committee will minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance and any declarations of interest.

6.4 Draft minutes of Committee meetings and a separate record of the actions to be taken forward will be circulated promptly to all members of the Committee. Once approved by the Committee, minutes will be circulated to all other members of the Board unless it would be inappropriate to do so in the opinion of the Committee Chair.

7. Duties and Responsibilities

The Committee will carry out the duties below for the Trust.

7.1 ***Financial planning and performance***

7.1.1 The Committee will review and monitor the following, ensuring these support the achievement of the Trust's objectives, and consider the adequacy and effectiveness of any corrective action proposed:

7.1.1.1 .the Trust's long-term financial model;

7.1.1.2 the Trust's long-term and annual financial plans encompassing income, expenditure and capital;

7.1.1.3 the capital plan including any changes in the Trust's performance that may impact on the delivery of the long-term capital plan;

7.1.1.4 financial performance and forecasts and projections including achievement of the control total and other targets;

7.1.1.5 performance against revenue budgets at both Trust and divisional level, including for research and development;

7.1.1.6 capacity, activity and productivity including any significant variation and the impact on income;

7.1.1.7 cash, liquidity and working capital;

7.1.1.8 the use of any working capital facilities; and

7.1.1.9 performance of the Trust's subsidiaries and any joint ventures against agreed performance indicators.

7.2 ***Cost Improvement Programme***

7.2.1 The Committee will ensure that there is a Cost Improvement Programme (**CIP**) in place each financial year that aligns with the Trust's annual plan.

7.2.2 The Committee will seek assurance that a recovery plan is in place and being implemented where any CIP schemes are at risk of delivery.

7.3 ***Investment***

7.3.1 The Committee will review business cases of £2.5 million or more in value, ensuring that outcomes and benefits are clearly defined and measurable and support achievement of the Trust's objectives and making recommendations to the Board for approval.

7.3.2 The Committee will review capital business cases over £5 million in value, ensuring that outcomes and benefits are clearly defined and measurable and support achievement of the Trust's objectives and making recommendations to the Board for approval.

7.3.3 The Committee will review all business cases identified by the Trust Executive Committee as of significant strategic importance regardless of value, ensuring that outcomes and benefits are clearly defined and measurable and support achievement of the Trust's objectives and making recommendations to the Board for approval.

7.3.4 The Committee will assess benefits realisation through post-implementation reviews, ensuring any learning is shared.

7.4 ***IT annual plan***

7.4.1 The Committee will monitor and oversee the delivery of the Trust's annual plan for IT including funding and ongoing alignment with the Trust's objectives.

7.5 ***Estates and facilities annual plan***

7.5.1 The Committee will monitor and oversee the delivery of the Trust's estates and facilities annual plan including funding and ongoing alignment with the Trust's objectives.

7.6 ***Risk***

7.6.1 The Committee will monitor risks identified in the Trust's Board Assurance Framework that have been allocated for oversight by the Committee.

7.6.2 The Committee will establish and maintain an overview of the Trust's financial risks and risks to delivery of the Trust's IT or estates and facilities plans and ensure the effectiveness and implementation of controls for financial risks and actions to mitigate risks to the delivery of the Trust's IT or estates and facilities plans.

7.6.3 The Committee will refer any potential risks to patient safety or quality identified by the Committee to the Quality Committee.

7.6.4 The Committee will commission and oversee assurance deep dives into specific identified risks at the request of either the Committee Chair or the chair of the Board.

7.7 ***Reporting***

7.7.1 The Committee will review any key financial submissions to national bodies before these are presented to the Board for approval.

7.7.2 The Committee will review the National Cost Collection Index for the purposes of benchmarking the Trust's performance.

8. Accountability and Reporting

8.1 The Chair of the Committee will report to the Board following each meeting, drawing the Board's attention to any matters of significance or where actions or improvements are needed.

8.2 The Committee will report to the Audit and Risk Committee at least annually on its work in support of the annual governance statement, specifically commenting on the financial statements and the appropriateness of the self-assessment of the effectiveness of the system of internal control and the disclosure of any significant internal control issues in the annual governance statement.

8.3 Appendix A sets out the sub-committees that report to and support the Committee in fulfilling its duties and responsibilities.

9. Review of Terms of Reference and Performance and Effectiveness

9.1 At least once a year the Committee will review its collective performance and its terms of reference. Any proposed changes to the terms of reference will be recommended to the Board for approval.

10. References

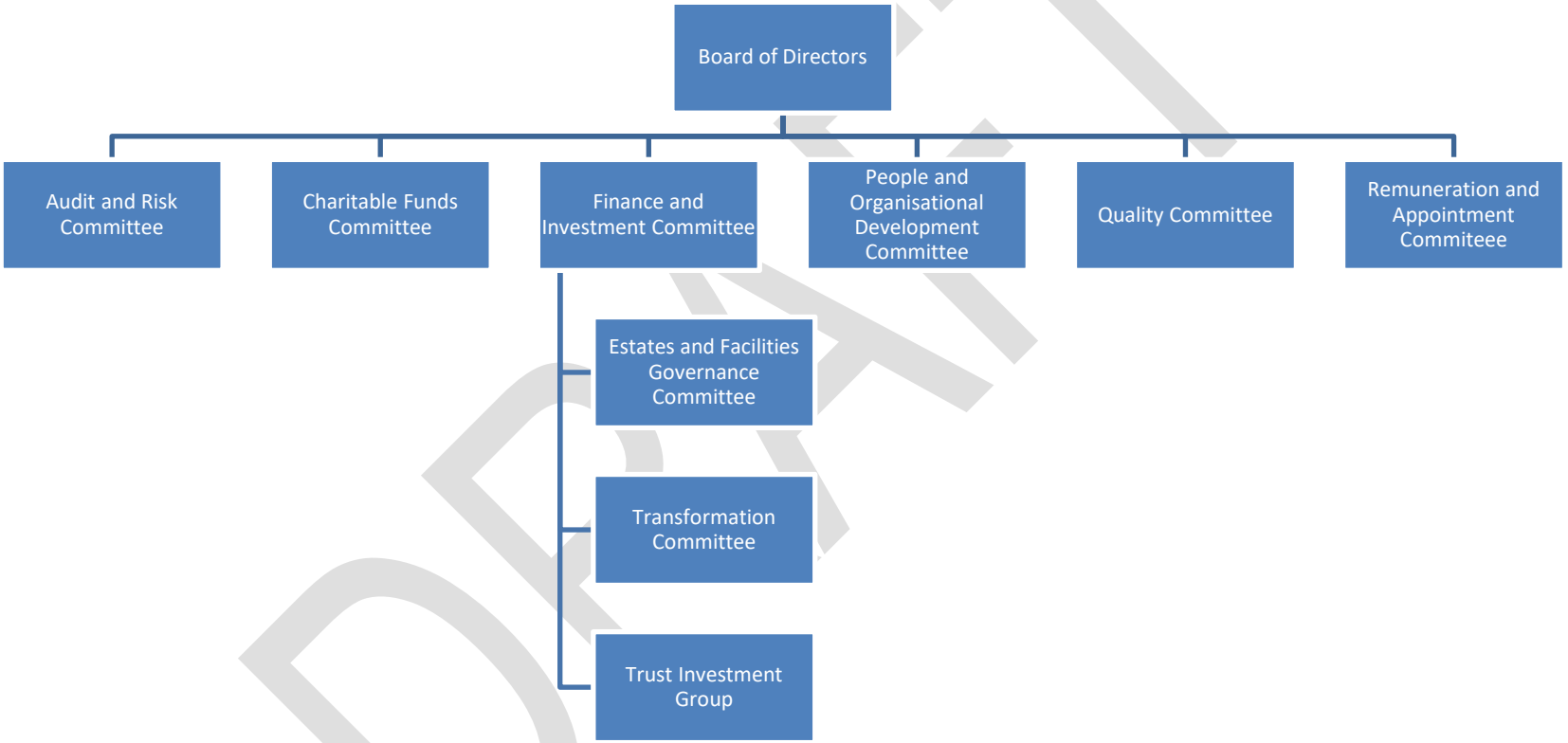
10.1 National Health Service Act 2006

10.2 NHS Oversight Framework

10.3 NHS Improvement and Care Quality Commission Use of Resources: assessment framework

10.4Standing Financial Instructions

Appendix A



Document Monitoring Information	
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Target audience:	Board of Directors, Finance and Investment Committee, Staff
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Summary of most recent changes if applicable:	Reformatting, membership, attendees, committee structure
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Does this document replace or revise an existing document?	Yes
Should this document be made available on the public website?	Yes
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University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors dated 26 November 2020				
Title:	**Remuneration and Appointment Committee Terms of Reference**			
Agenda item:	**4.2 ii)**			
Sponsor:	**Peter Hollins, Trust Chair**			
Author:	**Karen Flaherty, Associate Director of Corporate Affairs and Company Secretary**			
Date:	**26 November 2020**			
Purpose	**Assurance or reassurance**	**Approval** **X**	**Ratification**	**Information**
Issue to be addressed:	The terms of reference for all Board committees should be reviewed regularly, and at least once annually, to ensure that these reflect the purpose and activities of each committee. The terms of reference have been reviewed by the Remuneration and Appointment Committee.			
Response to the issue:	As well as changes to the formatting and structure of the terms of reference to fit in with the style of other Trust documentation, particularly as these will be published on the Trust's website, changes have been made to: • clearly reflect the composition of the Committee required by the National Health Service Act 2006 and The NHS Foundation Trust Code of Governance, as this is slightly different when considering the remuneration and appointment aspects of the Committee's role; and • remove duplication and slight inconsistencies within the terms of reference.			
Implications: (Clinical, Organisational, Governance, Legal?)	The terms of reference ensure that the purpose and activities of the Remuneration and Appointment Committee are clear and support transparency and accountability in the performance of its role.			
Risks: (Top 3) of carrying out the change / or not:	1. Non-compliance with the National Health Service Act 2006 and The NHS Foundation Trust Code of Governance. 2. Non-compliance with the Trust's constitution relating to the composition of Board committees. 3. The Board of Directors and the Committee may not function as effectively without terms of reference in place.			
Summary: Conclusion and/or recommendation	The Board of Directors is asked to approve the revised terms of reference. These have been reviewed by the Remuneration and Appointment Committee and are recommended for approval.			

University Hospital Southampton NHS
NHS Foundation Trust

Remuneration and Appointment Committee Terms of Reference

Version: 2

Date Issued:	26 November 2020
Review Date:	November 2021
Document Type:	Committee Terms of Reference

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Document Status

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1. Role and Purpose

1.1 The Remuneration and Appointment Committee (the **Committee**) is responsible for identifying and appointing candidates to fill all the executive director positions on the board of directors (the **Board**) of University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**) and for determining their remuneration and other conditions of service.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of independent and objective review of remuneration and executive director appointments in accordance with relevant laws, regulations and Trust policies.

1.3 The duties and responsibilities of the Committee are more fully described in paragraph 7 below.

2. Constitution

2.1 The Committee has been established by the Board. The Committee has no executive powers other than those set out in these terms of reference.

2.2 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee.

2.3 The Committee is authorised to seek reports and assurance from executive directors and managers and will maintain effective relationships with the chairs of other Board committees to understand their processes of assurance and links with the work of the Committee.

2.4 The Committee is authorised to obtain external legal or other independent professional advice if it considers this necessary, taking into consideration any issues of confidentiality and the Trust's standing financial instructions.

3. Membership

3.1 The members of the Committee will be appointed by the Board and will be the non-executive directors of the Trust except as provided in paragraph 3.2 below.

3.2 For any decisions relating to the appointment or removal of the executive directors, membership of the Committee will include the Chief Executive, as required under Schedule 7 of the National Health Service Act 2006, who will count in the quorum for the meeting. The Chief Executive will not be present when the Committee is dealing with matters concerning their appointment or removal.

3.3 The chair of the Board will chair the Committee (the **Committee Chair**). In the absence of the Committee Chair and/or an appointed deputy, the remaining non-executive directors present will elect one of themselves to chair the meeting.

3.4 Only members of the Committee have the right to attend and vote at Committee meetings. However, the following will be invited to attend meetings of the Committee on a regular basis:

3.4.1 Chief People Officer; and

3.4.2 Associate Director of Corporate Affairs/Company Secretary.

3.5 Other individuals may be invited to attend for all or part of any meeting, as and when appropriate and necessary, particularly when the Committee is considering areas that are the responsibility of a particular executive director or manager. Any attendee will be

asked to leave the meeting when the Committee is dealing with matters concerning their remuneration or terms of service.

4. Attendance and Quorum

4.1 Members should aim to attend every meeting and should attend a minimum of 75% of meetings held in each financial year. Where a member is unable to attend a meeting they should notify the Committee Chair or Company Secretary in advance.

4.2 The quorum for a meeting will be four members, including the chair of the Board (or the Deputy Chair in their absence). A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

5. Frequency of Meetings

5.1 The Committee will meet as required, which will usually be four times each year.

5.2 The Committee may establish a sub-committee for a specific purpose where it would be impractical for the Committee to be involved, for example the appointment of an executive director following agreement by the Committee of the process, job description and person specification.

6. Conduct and Administration of Meetings

6.1 Meetings of the Committee will be convened by the Company Secretary at the request of the Committee Chair or any of its members.

6.2 The agenda of items to be discussed at the meeting will be agreed by the Committee Chair with support from the Chief People Officer and the Company Secretary. The agenda and supporting papers will be distributed to each member of the Committee and the regular attendees no later than three working days before the date of the meeting. Distribution of any papers after this deadline will require the agreement of the Committee Chair.

6.3 The Company Secretary will minute the proceedings of all meetings of the Committee, including recording the names of those present and in attendance and any declarations of interest.

6.4 Draft minutes of Committee meetings and a separate record of the actions to be taken forward will be circulated promptly to all members of the Committee. Once approved by the Committee, minutes will be circulated to all other members of the Board unless it would be inappropriate to do so in the opinion of the Committee Chair.

7. Duties and Responsibilities

7.1 The Committee will carry out the duties below for the Trust.

Remuneration Role

7.2 The Committee will:

7.2.1 establish and keep under review a remuneration policy in respect of executive directors (as set out in Appendix A);

7.2.2 consult the Chief Executive about proposals relating to the remuneration of the other executive directors;

7.2.3 in accordance with relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of the Trust's executive directors, including salary, any performance-related pay or bonus, provisions for other benefits,

including pensions and cars, allowances, payable expenses and compensation payments;

7.2.4 adhering to all relevant laws, regulations and Trust policies:

7.2.4.1 establish levels of remuneration that are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose, and at a level that is affordable to the Trust;

7.2.4.2 decide whether a proportion of executive director remuneration should be structured so as to link reward to corporate and individual performance;

7.2.4.3 make sure that any performance-related elements of executive remuneration are stretching and promote the long-term sustainability of the Trust, and take as a baseline for performance any competencies required and specified in the job description for the post;

7.2.4.4 consider all relevant and current directors relating to contractual benefits such as pay and redundancy entitlements;

7.2.4.5 use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors while ensuring that increases are not made where Trust or individual performance do not justify them;

7.2.4.6 be sensitive to pay and employment conditions elsewhere in the Trust;

7.2.5 monitor and assess the output of the evaluation of the performance of individual executive directors, and consider this output when reviewing changes to remuneration levels; and

7.2.6 consider issues of equality and diversity when evaluating and setting remuneration.

Appointment Role

7.3 The Committee will:

7.3.1 regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the Board evaluation process as appropriate, and make recommendations to the Board and the Governors' Nomination Committee, as applicable, with regard to any changes;

7.3.2 give full consideration to and make plans for succession planning for the executive directors, taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future;

7.3.3 keep the leadership needs of the Trust under review at executive director level to ensure the continued ability of the Trust to operate effectively in the health economy;

7.3.4 be responsible for identifying the and appointing candidates to fill posts within its remit as and when they arise;

7.3.5 when a vacancy is identified, evaluate the balance of skills, knowledge and experience of the Board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the particular appointment. In identifying suitable candidates the Committee will use open advertising or the services of external advisers to facilitate the search, consider candidates from a wide range of backgrounds and consider candidates on merit against objective criteria;

7.3.6 ensure that a proposed executive director is a 'fit and proper' person as defined in law and regulation and monitor procedures to ensure that executive directors remain 'fit and proper' persons;

7.3.7 ensure that a proposed executive director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board as they arise;

7.3.8 ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported;

7.3.9 carefully consider what compensation commitments (including pension contributions) the executive directors' terms of office would give rise to in the event of early termination to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing executive director's obligation to mitigate loss. Appropriate clawback provisions should be considered in the case of an executive director returning to the NHS within the period of putative notice; and

7.3.10 consider any matter relating to the continuation in office of any executive director, including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract.

8. Accountability and Reporting

8.1 The Chair of the Committee will report to the Board following each meeting, drawing the Board's attention to any matters of significance or where actions or improvements are needed.

8.2 The Trust's annual report will include sections describing the work of the Committee including its remuneration policies, details of the remuneration paid to executive directors and the process it has used in relation to the appointment of executive directors.

9. Review of Terms of Reference and Performance and Effectiveness

9.1 At least once a year the Committee will review its collective performance and its terms of reference. Any proposed changes to the terms of reference will be recommended to the Board for approval.

10. References

10.1 National Health Service Act 2006

10.2 NHS Foundation Trust Code of Governance

10.3 NHS Improvement Guidance on pay for very senior managers in NHS trusts and foundation trusts

Appendix A
Executive Director Pay Principles

1. The importance of executive director pay

The delivery of the forward vision and our annual Trust objectives is predicated on ensuring talent is available at all levels of the Trust. Good senior leadership is vital, and therefore a key strategy for UHS must be to recruit and retain the best executive director talent into the Trust. This will be from a combination of both good internal succession planning, bringing top talent from the NHS and also seeking high calibre individuals from other sectors.

2. Determination of pay levels of posts

Pay for executive director posts will be determined by:

- Use of NHS Improvement (**NHSI**) data on pay for executive director positions in comparable trusts (Figure 1).
- Use of other salary benchmarking exercises.
- Job evaluation as required.
- The conditions required to attract suitably qualified individuals, particularly where commercial, financial or other niche business skills are required.

Pay levels will be reviewed not less frequently than annually by the Committee in accordance with the Trust's pay review cycle to ensure that salary levels are both appropriate and provide value for money.

3. Setting salary of executive directors

The following principles will apply:

- UHS will aim to pay at around mid-point of NHSI levels for trusts of a comparable nature and scale.
- UHS will review pay based on performance, changes in the NHSI framework levels and, in particular, the need to retain key individuals likely to be of interest to other trusts.
- UHS will not recognise relevant changes of NHSI framework levels in respect of individuals where this is not justified by individual performance.
- UHS will be mindful of equality, particularly in relation to gender and ethnicity in pay levels.
- UHS will ensure all cost of living increases nationally awarded are reflected in executive director pay each year, as decided by the Committee, unless performance of an individual is unsatisfactory.
- Any decision to introduce performance-related pay, or bonuses, will be subject to decision by the Committee based on a sound business case and adherence to NHSI guidance on executive pay.

4. Approval process

All decisions on pay for executive directors will be managed in line with the terms of reference for the Committee.

The Committee, supported by the Chief People Officer, will also ensure that the NHSI prevailing guidance on setting executive director pay, including any required approval process, will be followed as appropriate.

Figure 1 – NHS Improvement Pay Thresholds

Very large acute NHS trusts and foundation trusts (£500m+)	Lower quartile	Median	Upper quartile
Chief executives	£195,000	£225,000	£267,500
Deputy CEO	£143,500	£165,000	£200,000
Director of finance	£148,500	£157,500	£190,000
HR/Workforce directors	£120,000	£130,000	£145,000
Medical directors	£189,000	£215,000	£230,000
Nursing directors	£130,000	£142,500	£157,500
Chief operating officer	£141,000	£190,000	£198,000
Corporate affairs/Governance directors	£88,000	£105,000	£117,500
Strategy and planning directors	£112,000	£137,500	£162,000
Director of facilities/Estates	£120,000	£135,000	£145,000

Document Monitoring Information	
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Main areas affected:	Trust-wide
Summary of most recent changes if applicable:	Reformatting, membership and attendees
Consultation:	Chief People Officer
Number of pages:	8
Type of document:	Committee Terms of Reference
Does this document replace or revise an existing document?	Yes
Should this document be made available on the public website?	Yes
Is this document to be published in any other format?	No

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors dated 26 November 2020				
Title:	**Board Assurance Framework (BAF)**			
Agenda Item:	**4.3**			
Sponsor	**Gail Byrne, Chief Nursing Officer**			
Date:	**26/11/2020**			
Purpose	**Assurance or reassurance** ✓	**Approval** ✓	**Ratification**	**Information**
Issue to be addressed:	The Board Assurance Framework (BAF) provides assurance against the achievement of our strategic objectives; highlighting those that are at risk of not being delivered. The BAF provides evidence to support the Annual Governance Statement, and is a focus of CQC and audit scrutiny. This report sets out the strategic risks, control framework, sources of assurance, and action plans. The BAF is a dynamic document that will reflect the Trust's changing strategic position. The ongoing refresh of the organisation's strategy will require a review of the BAF once complete.			
Response to the issue:	The BAF has been developed with input from responsible executives and relevant stakeholders. It satisfies good governance requirements on information and scoring.			
Risks: (Top 3) of carrying out the change / or not:	The ability of the Board to effectively manage strategic risk is a core element of the CQC's 'well led' inspection process. An organisation that does not monitor its strategic risk through a Board Assurance Framework or similar document may not be able to achieve outstanding.			
Summary: Conclusion and/or recommendation	The Board are asked to consider: • the level of assurance provided by the Board Assurance Framework and those areas or actions around which further assurance may be required; and • any risks to the delivery of our strategic objectives that are not currently included in the Board Assurance Framework.			

1. Purpose

The University Hospital Southampton Board Assurance Framework identifies the strategic ambitions and the key risks facing the organisation in achieving these ambitions. This paper provides;-

- An overview of the strategic risk profile for the Trust,
- A summary of each strategic risk,
- A glossary of terms used at ***appendix 1***.

The report also provides details of changes made to each strategic risk since the last report to Board and future reports will assess the risk scoring against the risk appetite.

It is understood that an ongoing review of strategy development may produce different strategic objectives and as a result this BAF would be reviewed. Once agreed we will produce milestones and measurements against the strategic risks for objective successes, for example; length of stay, A&E waiting times, pathway development etc. These will be reflected against the relevant strategic risk in future Board reports with the aim of enabling members of the Board to see traction or not on their delivery.

It is proposed that a deep dive into the strategic risk is undertaken periodically at the relevant sub-committee of the Board.

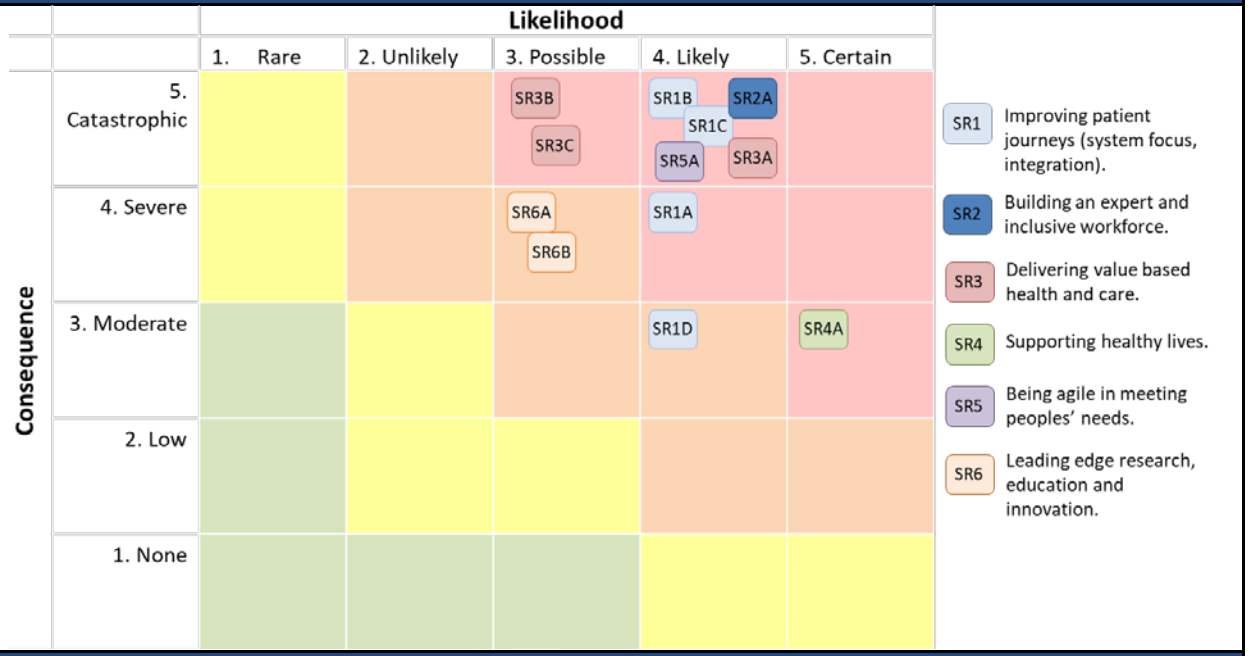
This report seeks to provide assurance to the Board that the Trust is appropriately sighted on, and working to mitigate, key strategic risks through an appropriate governance structure. The Board are asked to consider:

- the level of assurance provided by consider and approve the Board Assurance Framework and those areas or actions around which further assurance may be required; and
- any risks to the delivery of our strategic objectives that are not currently included in the Board Assurance Framework.

Trust Status

Trust status	
Average Strategic Risk score (mean)	**16**
Average Strategic Risk score (mode)	**16**
Movement from last report	0

*Date RAG:	1-3 months	4-7 months	8-11 months	12+ months



High risk report

Strategic Risk	Current Score	+/-	Key Actions	Target	Date*
SR1A: UHS is unable to form effective partnerships that achieve networked care for patients.	16	0	Implementation of the Clinical Strategy – Mar 21	8	March 2022
SR1B: We do not develop our estate in line with the ambitions set out in our clinical strategy.	20	0	Estates strategy - Mar 21	9	March 2022
SR1C: We fail to restore and increase capacity post-COVID-19 to meet waiting times for elective care and cancer care needs.	20	0	COVID response plan Operational plan Winter plan	10	April 2021
SR1D: We fail to introduce and implement new technology in our transformation of care.	12	0	Finalise and implement Digital Strategy and investment plan	8	March 2022
SR2A: Inability to retain, recruit, develop and train a diverse and inclusive workforce that is necessary to meet our strategic goals.	20	0	People strategy - Jan 2021	15	March 2021

Strategic Risk	Current Score	+/-	Key Actions	Target	**Date***
SR3A: We do not develop a sustainable model within the new financial regime that preserves quality care.	20	0	Existing financial strategy will be reviewed in light of new finance architecture by Mar 2021	12	June 2021
SR3B: We fail to provide vulnerable service users with timely and high quality and appropriate care	15	0	Patient Safety Strategy Estates Strategy MH annual plan	12	January 2021
SR3C: We do not reach our ambition of outstanding compliance and quality standards.	15	0	Patient safety strategy Implementation of always improving strategy – Mar 22	10	October 2021
SR4A: UHS does not sufficiently engage with key stakeholders and system partners to support effective interventions and maintain the health of the local population.	15	0	Develop public health and Wellbeing strategy - Mar 2021 Dementia Strategy	15	March 2021
SR5A: Inability to respond to the needs of the NHS in order to deliver our strategy (culture).	20	0	Corporate strategy	12	March 2021
SR6A: We fail to capitalise on our relationship with the Universities in Southampton and other health education providers in line with our strategy.	12	0	Research Strategy	9	January 2022
SR6B: We do not develop innovative education and training approaches.	12	0	Develop Education Strategy - July 2021	6	March 2022

2. Board Assurance Framework

Strategic objective 1: **Improving patient journeys (system focus, integration)**

Strategic Risk 1A: **UHS is unable to form effective partnerships that achieve networked care for patients.**		Impact:	Likelihood:	Score:
	Inherent:	4	5	20
	Current / Residual:	4	4	16
	Target:	4	2	8
	Target Date:	March 2022		
Executive Lead:	Chief Medical Officer			
Monitoring Committee:	Trust Board			
Key supporting strategy:	Clinical Strategy			

Controls and Mitigations: What is in place to reduce the impact and / or likelihood of the risk materialising?	Assurance: How do we know our controls are in place and effective?	Actions: What is planned to further reduce the impact and / or likelihood? Key strategies are emphasised in **BOLD**
▪ Wessex Partnership - tertiary networked services chaired by UHS CEO ▪ Wessex Cancer Alliance - chaired by UHS CEO ▪ HIOW Elective care Board - chaired by UHS CEO ▪ SWHSC provider system - chaired by UHS CEO inc. triumvirate ▪ HIOW MDs forum ▪ HHFT at executive level ▪ Working with ICS to develop strategic intent and aligned with clinical strategy.	▪ RDS - hosted by UHS (+) ▪ inability to agree elective collaborative priorities (-ve) ▪ no formal ICS infrastructure (-ve) ▪ Mutual aid agreement (+ve)	▪ **Implementation of the Clinical Strategy** ▪ Work with ICS to agree suitable infrastructure for local system surrounding UHS September 2020 ▪ Development of shared models of care across the ICS for urology and orthopaedic - Dec 21

Progress Update;
The Board level review and implementation of the Clinical Strategy is progressing, on target for delivery by March 2021.

Shared models of care continue development. Both urology and orthopaedic have leads within the STP.

Strategic objective 1: **Improving patient journeys (system focus, integration)**

Strategic Risk 1B: **We do not develop our estate in line with the ambitions set out in our clinical strategy.**		Impact:	Likelihood:	Score:
	Inherent:	5	4	20
	Current / Residual:	5	4	20
	Target:	3	3	9
	Target Date:	March 2022		
Executive Lead	Chief Operating Officer			
Monitoring Committee:	Finance & Investment Committee			
Key supporting strategy:	Estates Strategy			

Controls and Mitigations: What is in place to reduce the impact and / or likelihood of the risk materialising?	Assurance: How do we know our controls are in place and effective?	Actions: What is planned to further reduce the impact and / or likelihood? Key strategies are emphasised in **BOLD**
▪ Up to Date CAFM System ▪ Asset register ▪ Maintenance schedules ▪ Trained, accredited experts and technicians ▪ Replacement programme ▪ Construction Standards (e.g. BREEM/ Dementia Friendly Wards etc.)		▪ **Estates strategy - Mar 21** Masterplan – Mar 21 ▪ Full audit and review of existing estate (six facet survey) - Dec 20 ▪ Asset tagging - Feb 21 ▪ Estates governance & compliance review - Dec 20 ▪ Construction Standards Manual - Mar 21

Progress Update:
The estate master plan scope has been expanded and will complete in March 2021 to encompass all elements. The six facet survey is complete and data is being analysed. Recommendations will be made shortly based on the received information, though early analysis suggests ventilation is of concern.

Asset tagging scope has increased to 13,000 assets so is now expected to complete in February 2021.

The Estates governance and compliance review is underway. All meetings and reporting structures are being tested.

Strategic objective 1: **Improving patient journeys (system focus, integration)**

Strategic Risk 1C: **We fail to restore and increase capacity post-COVID-19 to meet waiting times for elective care and cancer care needs.**		Impact:	Likelihood:	Score:
	Inherent:	5	4	20
	Current / Residual:	5	4	20
	Target:	2	5	10
	Target Date:	April 2021		
Executive Lead	Chief Operating Officer			
Monitoring Committee:	Quality Committee			
Key supporting strategy:	COVID response plan			

Controls and Mitigations: What is in place to reduce the impact and / or likelihood of the risk materialising?	Assurance: How do we know our controls are in place and effective?	Actions: What is planned to further reduce the impact and / or likelihood? Key strategies are emphasised in **BOLD**
▪ Use of independent sector to increase capacity ▪ Cancer hub for the Wessex Alliance with UHS as lead provider ▪ Triage of patient lists based on risk of harm ▪ Consultant led flagging of patients of concern. ▪ Clinical Prioritisation Framework	▪ Clinical Assurance Framework, reviewed at Quality Committee.	▪ **COVID response plan** ▪ **Operational plan** ▪ **Winter plan** ▪ Implement room booking solution to commence January 2021. ▪ Agree new Outpatient templates with Care Groups. ▪ Move to model of wards where specialities flex seasonally ▪ Outpatient & theatres improvement programmes - Dec 20 ▪ Detailed demand and capacity planning - Dec 20

Strategic objective 1: **Improving patient journeys (system focus, integration)**

Strategic Risk 1D: **We fail to introduce and implement new technology in our transformation of care.**		Impact:	Likelihood:	Score:
	Inherent:	3	4	12
	Current / Residual:	3	4	12
	Target:	2	4	8
	Target Date:	March 2022		
Executive Lead	Chief Operating Officer			
Monitoring Committee:	Finance & Investment Committee			
Key supporting strategy:	Digital & Technology Strategy			

Controls and Mitigations: What is in place to reduce the impact and / or likelihood of the risk materialising?	Assurance: How do we know our controls are in place and effective?	Actions: What is planned to further reduce the impact and / or likelihood? Key strategies are emphasised in **BOLD**
▪ Digital workplan ▪ Clinical prioritisation framework for digital projects led by chief clinical information officers.	▪ Digital Delivery Group	▪ **Finalise and implement Digital Strategy and investment plan.**

Strategic objective 2: **Building an expert and inclusive workforce**

Strategic Risk 2A: **Inability to retain, recruit, develop and train a diverse and inclusive workforce that is necessary to meet our strategic goals.**		Impact:	Likelihood:	Score:
	Inherent:	5	4	20
	Current / Residual:	5	4	20
	Target:	5	3	15
	Target Date:	March 2021		
Executive Lead	Chief People Officer			
Monitoring Committee:	People and Organisational Development Committee			
Key supporting strategy:	People Strategy; UHS Vision; Clinical Strategy			

Controls and Mitigations: What is in place to reduce the impact and / or likelihood of the risk materialising?	Assurance: How do we know our controls are in place and effective?	Actions: What is planned to further reduce the impact and / or likelihood? Key strategies are emphasised in **BOLD**
▪ Recruitment & resourcing processes. ▪ General HR policy & practice, supported by appropriately resourced HR team. ▪ Workforce planning completed for 20/21 to support COVID recovery. ▪ Psychological support for staff (funded until Mar 21). ▪ Temporary resourcing team to control agency and bank expenditure. ▪ Chief People Officer appointment ▪ Guardian of safe working ▪ FTSU guardian and FSU policies ▪ Diversity and inclusion strategy, led by head of Diversity and Inclusion ▪ Staff Networks ▪ Staff side (trade unions)	▪ Fill rates ▪ rota compliance (0) ▪ Guardian of SW report to Board (+ve) ▪ Board indicators (0) ▪ GMC reports (+ve) ▪ Staff survey and Qtr. FFT (+ve) ▪ Freedom to Speak up reports to Board (+ve) ▪ Weekly communications monitoring report (0) ▪ People Committee ▪ WRES and WDES annual reports - annual audits on BAME successes. ▪ Exit interview process.	▪ **People strategy - Jan 2021** ▪ Communications launch of UHS vision, mission, and clinical strategy - Mar 2021 ▪ Culture audit - 2021 ▪ Inclusivity culture review - Mar 2021 ▪ Strategic plan Jan - Mar 2021 ▪ Board approved action plan on improving BAME inclusivity.- Mar 2021 ▪ Response to the NHSI people plan - Mar 2021 ▪ Appoint to director of OD and Inclusion role - Mar 2021.

Progress Update:

The role of Director of OD and Inclusion has been appointed to as an interim. The role will go on to substantive recruitment.

The inclusivity programme is underway. Recommendations will form part of the wider focus on strengths and sustainable change.

Of key concern is the potential for unplanned workforce gaps to emerge very rapidly due to COVID sickness or isolation, requiring temporary redeployment of staff. Both temporary staffing and agile workforce solutions are present. Ward staffing and specialist medical teams are of particular concern.

The most effective way to address this risk is to fully implement and maintain COVID-zero (Wash, walk, wear, 3 Cs and sufficient PPE); increased and sustained communication and support for staff to stop transmission.

Strategic objective 3: **Delivering value based health and care.**

Strategic Risk 3A: **We do not develop a sustainable model within the new financial regime that preserves quality care.**		Impact:	Likelihood:	Score:
	Inherent:	5	4	20
	Current / Residual:	5	4	20
	Target:	4	3	12
	Target Date:	June 2021		
Executive Lead	Chief Finance Officer			
Monitoring Committee:	Finance & Investment Committee			
Key supporting strategy:	Financial Strategy			

Controls and Mitigations: What is in place to reduce the impact and / or likelihood of the risk materialising?	Assurance: How do we know our controls are in place and effective?	Actions: What is planned to further reduce the impact and / or likelihood? Key strategies are emphasised in **BOLD**
▪ UHS 2020/21 business rules ▪ NHS financial rules during Covid-19 ▪ Additional investment approved on a non-recurrent basis until funding regime for 2021/22 is known. ▪ Restarted CIP / Productivity programme ▪ Review of Trust SFIs in October 2020 ▪ Recruitment Control Panel prevents unauthorised recruitment above budget.	▪ Current financial performance via monthly finance report. ▪ Current CQC rating pre Covid (good) but RI safety (0) ▪ Integrated Assurance Committee ▪ Quality Committee ▪ Finance and Investment Committee ▪ Monthly meeting with Care Groups and Divisions ▪ Benchmarking level of income correction against other Trusts. ▪ Tracking level of activity against national targets during Covid-19.	▪ **Existing financial strategy will be reviewed in light of new finance architecture by Mar 2021** ▪ Review alternative sources of income and identify additional opportunities - Mar 21 ▪ Agree the Estates 5-year plan - Mar 21

Progress Update:
The financial plan for second half of 2020/21 has been agreed, with budgets set accordingly. The financial controls to ensure achievement of this plan are in place as outlined above.

The financial architecture for 2021/22 remains uncertain, with planning guidance expected in January 2021. The fundamental move from a cost and volume contract to a block contract is likely to remain a key theme. This is a significant risk to the Trust, as we have been used to increases in income to offset increases in cost. The budget-setting exercise will adapt to the level of funding available. The financial controls will remain in place with the aim of maintaining financial performance within the revised financial architecture in which we operate.

The action relating to alternative sources of income has been rolled forward to March 2021. The concept paper for private patient engagement has been received by TIG and a full business case is being developed.

Strategic objective 3: **Delivering value based health and care.**

Strategic Risk 3B: **We fail to provide vulnerable service users with timely and high quality and appropriate care**		Impact:	Likelihood:	Score:
	Inherent:	5	3	15
	Current / Residual:	5	3	15
	Target:	4	3	12
	Target Date:	January 2021		
Executive Lead	Chief Nursing Officer			
Monitoring Committee:	Quality Committee			
Key supporting strategy:	Patient Safety Strategy; Estates Strategy; MH annual plan			

Controls and Mitigations: What is in place to reduce the impact and / or likelihood of the risk materialising?	Assurance: How do we know our controls are in place and effective?	Actions: What is planned to further reduce the impact and / or likelihood? Key strategies are emphasised in **BOLD**
▪ Named nurse for Mental health ▪ Named nurses for adult and child safeguarding ▪ High quality training for staff, supported by policy guidance and toolkits. ▪ Risk assessment process for vulnerable patients ▪ Close working relationships with MH providers ▪ Psych liaison team ▪ Places of safety / ligature free spaces.	▪ Mental Health Board, chaired by the Chief Nursing Officer	▪ **Patient Safety Strategy** ▪ **Estates Strategy** ▪ **MH annual plan** ▪ Review of Estates for MH patients

Strategic objective 3: **Delivering value based health and care.**

Strategic Risk 3C: **We do not reach our ambition of outstanding compliance and quality standards.**		Impact:	Likelihood:	Score:
	Inherent:	5	4	20
	Current / Residual:	5	3	15
	Target:	5	2	10
	Target Date:	October 2021		
Executive Lead	Chief Nursing Officer			
Monitoring Committee:	Quality Committee			
Key supporting strategy:	Patient Safety Strategy; Always improving strategy			

Controls and Mitigations: What is in place to reduce the impact and / or likelihood of the risk materialising?	Assurance: How do we know our controls are in place and effective?	Actions: What is planned to further reduce the impact and / or likelihood? Key strategies are emphasised in **BOLD**
▪ Incident management ▪ Learning from deaths ▪ Mandatory training ▪ Health & Safety ▪ Information Governance ▪ Compliance with NICE guidance, patient safety alerts, faculty guidance, etc. ▪ Integrated Governance Framework. ▪ Trust policy and procedure documentation ▪ Positive reputation through Covid	▪ Excellent outcomes(+ve) ▪ CQC Good inc Well Led and UoR (+ve) ▪ Research through COVID (+ve) ▪ Current and previous performance against constitutional standards (-ve)	▪ **Patient safety strategy** ▪ **Implementation of always improving strategy – Mar 22** ▪ National incident framework 2021 ▪ Quality improvement (always improving safety) programme and strategy - Oct 21 ▪ Implementation of pro-active safety ▪ Internal CQC assessment Nov 2020 ▪ Review and re-configuration of BI services

Strategic objective 4: **Supporting healthy lives.**

Strategic Risk 4A: **UHS does not sufficiently engage with key stakeholders and system partners to support effective interventions and maintain the health of the local population.**		Impact:	Likelihood:	Score:
	Inherent:	3	5	15
	Current / Residual:	3	5	15
	Target:	3	5	15
	Target Date:	March 2021		
Executive Lead	Chief Medical Officer			
Monitoring Committee:	Quality Committee			
Key supporting strategy:	Health & Wellbeing Strategy; Dementia Strategy			

Controls and Mitigations: What is in place to reduce the impact and / or likelihood of the risk materialising?	Assurance: How do we know our controls are in place and effective?	Actions: What is planned to further reduce the impact and / or likelihood? Key strategies are emphasised in **BOLD**
▪ National alcohol team pilot site ▪ Development of ICS ▪ Clinical strategy ▪ Covid Wellbeing programme ▪ Covid saliva sample trial ▪ Training package for staff on dementia ▪ Estate accessibility & PLACE programme ▪ Partnership with care homes and nursing homes for admission avoidance ▪ Pyjama paralysis agenda ▪ Smoking cessation ▪ National alcohol team pilot site ▪ Wessex FIT; getting patients ready for surgery, critical care, and cancer care. ▪ Honorary contracts offered to PHE consultants.	▪ CCG engagement ▪ GP engagement ▪ Covid Zero - in hospital transmission	▪ **Develop public health and Wellbeing strategy (Mar 2021)** ▪ **Dementia Strategy** ▪ Develop sustainability strategy (Mar 2021) ▪ Agree priorities for targeting inequalities and wellbeing; Leading and lagging April 2021)
Progress Update; The COVID zero work continues to try to ensure a healthy local population. Communications on public health messages continue, as well as the local testing hub.		

Strategic objective 5: **Being agile in meeting peoples' needs.**

Strategic Risk 5A: **Inability to respond to the needs of the NHS in order to deliver our strategy.**		Impact:	Likelihood:	Score:
	Inherent:	5	4	20
	Current / Residual:	5	4	20
	Target:	3	4	12
	Target Date:	March 2021		
Executive Lead	Chief Executive			
Monitoring Committee:	Finance & Investment Committee			
Key supporting strategy:	Corporate strategy			

Controls and Mitigations: What is in place to reduce the impact and / or likelihood of the risk materialising?	Assurance: How do we know our controls are in place and effective?	Actions: What is planned to further reduce the impact and / or likelihood? Key strategies are emphasised in **BOLD**
▪ Informatics strategy and delivery groups ▪ Estates plan ▪ Divisional structure ▪ STP ▪ CEO 'convenor' for networked Care and Wider Wessex Partnership ▪ CEO 'convenor' for SWH/SCC system ▪ STP/ICS	▪ HIMS level (-ve) ▪ CQC and NHSI assessment on use of information (-ve) ▪ CQC report - safety RI (-ve) ▪ Well Led assessment Good (+ve) ▪ Estates KPIs (-ve) ▪ STP not yet ICS (-ve)	▪ **Corporate strategy** ▪ Work with system to achieve ICS status Sept 2020 ▪ Work with system to form appropriate local governance (Sept 2020) ▪ Strategic plan Jan- Mar 2021 ▪ Estate Strategy and site plan Jan 2021 ▪ Digital and technology strategy Mar 2021 ▪ Estates Masterplan - Jan 21

Strategic objective 6: **Leading edge research, education and innovation.**

Strategic Risk 6A: **We fail to capitalise on our relationship with the Universities in Southampton and other health education providers in line with our strategy.**		Impact:	Likelihood:	Score:
	Inherent:	4	3	12
	Current / Residual:	4	3	12
	Target:	3	3	9
	Target Date:	January 2022		
Executive Lead	Chief Medical Officer			
Monitoring Committee:	Quality Committee			
Key supporting strategy:	Research Strategy;			

Controls and Mitigations: What is in place to reduce the impact and / or likelihood of the risk materialising?	Assurance: How do we know our controls are in place and effective?	Actions: What is planned to further reduce the impact and / or likelihood? Key strategies are emphasised in **BOLD**
▪ Research and Development Strategy ▪ Joint R&D strategy meeting with University ▪ Biomedical research centre ▪ NIHR Board ▪ UHS research strategy 20/21	▪ Board indicators on R&D (-ve) ▪ Join publications with University ▪ UHS is second highest national recruiter for LCRNs (+ve) ▪ Profile of vaccine and other COVID studies (+ve)	▪ **Research Strategy** ▪ Develop innovation strategy Mar 2021 ▪ Biomedical research centre bid
Progress Update The Research Strategy is being developed and will be presented to the December Board.		

Strategic objective 6: **Leading edge research, education and innovation.**

Strategic Risk 6B: **We do not develop innovative education and training approaches.**		Impact:	Likelihood:	Score:
	Inherent:	4	3	12
	Current / Residual:	4	3	12
	Target:	3	2	6
	Target Date:	March 2022		
Executive Lead	Chief Medical Officer			
Monitoring Committee:	Quality Committee			
Key supporting strategy:	Education Strategy			

Controls and Mitigations: What is in place to reduce the impact and / or likelihood of the risk materialising?	Assurance: How do we know our controls are in place and effective?	Actions: What is planned to further reduce the impact and / or likelihood? Key strategies are emphasised in **BOLD**
▪ *To be confirmed.*	▪ *To be confirmed.*	▪ **Develop Education Strategy July 2021**
Progress Update The Education Strategy development was paused during COVID and the date of delivery has been moved back to Summer 2021.		

3. Appendices

1 – Glossary of terms

Appendix 1 – Glossary of terms

Term:	Meaning:
Assurance	Also referred to as assurance measures. These are methods of measuring the level of risk and effectiveness of controls in place, for example; monitoring incidents related to the risk, formal audit reports (clinical, internal, external, etc.) or compliance with external standards (NHSI, NICE, etc.).
Assurance Gaps	Where there are inadequate assurances; or where assurance measures are limited and cannot provide full assurance that controls are effectively mitigating the risk. Gaps should be identified and listed with actions to close.
Board Assurance Framework (BAF)	The BAF enables the Board to: identify and understand the principal risks to achieving its strategic objectives, and understand the control and assurance frameworks in place to manage these risks. Further; action plans are provided for areas of identified weakness.
Control	Mitigations in place to reduce either the likelihood of the risk occurring; or the impact if the risk were to materialise. Examples include professional, clinically trained staff, appropriate skill mixes and staff numbers, etc.
Control Gap	Where there are inadequate controls or where the controls measures are limited or incomplete. Thus where gaps are identified, there should be a list of actions to close them.
Current or Residual Risk Score	It is the score assigned to any risk after the control measures in place are taken into account. It is derived from the 5 x 5 risk matrix with impact and likelihood typically being lower than the inherent risk score (reflecting the effectiveness of controls).
Inherent Risk Score	This is the score assigned to any risk, which reflects how severe and likely a risk is to occur if the controls in place are found to be ineffective, or absent. It is derived from the 5 x 5 risk matrix.
Negative Assurance	Negative assurance is where evidence shows that controls are not operating effectively to mitigate the risk to the achievement of objectives. An example would be a critical audit report that identifies failings.
Neutral Assurance	A neutral assurance indicates either a new control, for which it is hard to provide sound assurance, or a mixed assurance that provides some criticism of the control framework, but also identified positives. An example would be a Friends and Family survey that contains criticism of a service, but still reflects a high percentage of satisfaction.
Positive Assurance	Positive assurance indicates that controls are operating effectively to mitigate the risk to the achievement of objectives. An example would be a positive peer review, or a CQC monitoring visit that identifies no issues to be addressed in an action statement.
Risk Score	A risk score is derived from the 5 x 5 risk matrix with impact and likelihood being multiplied to reach the risk score. The scoring system allows individual risks to be prioritised. Risk scores are not intended to be precise mathematical measures of risk, but are a useful tool to help in the prioritisation of action plans for the treatment of risk.
Target Risk Score	The keyword here is “target”. This is the future (or prospective) risk score assigned to any risk after gaps in control measures have been addressed, and outstanding actions implemented. It is the level of risk which the Department of Division feel they can tolerate.

Report to the Trust Board of Directors dated 26 November 2020				
Title:	**CRN: Wessex 2020/21 Quarter 2 Performance Report**			
Agenda item:	**7.1**			
Sponsor:	**Dr Derek Sandeman, Chief Medical Officer**			
Date:	**26 November 2020**			
Purpose	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **x**
Issue to be addressed:	The normal quarterly performance report covers CRN Wessex's performance against the National Institute for Health Research's (NIHR) high level objectives (HLOs). These have been suspended by the NIHR due to the focus on the pandemic response. Instead this report covers urgent public health (UPH) research (including vaccine trials), the restart of non-UPH studies and the new NIHR performance standards for 2020/21. **Key achievements / issues:** • Over 9,000 participants have been recruited in Wessex on UPH studies across 24 studies at 89 sites. Close to 2,000 were recruited into interventional studies. • Four urgent public health studies have been led out of Wessex, with one recently published in The Lancet Respiratory Medicine journal. • The restart of non-UPH research within Wessex has recently slowed due to the second wave of the pandemic. 40% of studies within Wessex are now open. • Two vaccine hubs have been established within Hampshire and Dorset, with over 1,100 participants recruited to COVID-19 vaccine trials to date. Vaccine trials are expected to be delivered over the next 12-18 months. • Commercial research has reduced by 61% compared to this time last year. This presents a financial risk to R&D departments in Wessex and research capacity in 2021/22			

Response to the issue:

1 Purpose/Context/Introduction

This report is to inform the UHS Board of the clinical research activities within CRN Wessex since the start of the Covid-19 pandemic. The report covers urgent public health research (including vaccine trials), the restart of other research studies and the new NIHR performance standards for 2020/21.

2 Key issues

Urgent public health (UPH) research within Wessex

UPH is defined by the NIHR as research that needs to take place during the emergency phases of the pandemic when infection rates are high (further information: https://www.nihr.ac.uk/covid-19/). The NIHR's goal is to gather the necessary clinical and epidemiological evidence to inform national policy and enable new diagnostics, treatments, and vaccines to be developed and tested.

The NIHR's prioritises for clinical research during the pandemic are outlined within their Restart Framework (https://www.nihr.ac.uk/documents/restart-framework/24886). They are guidelines for research active organisations to follow when prioritising their research activity. The priorities have recently been updated to include 1a and 1b and are shown in chart one in order of priority.

Level 1a	Covid-19 UPH vaccine and prophylactic studies (as prioritised by the Vaccines Task Force (VTF) and agreed by Jonathan Van-Tam, deputy CMO) and platform therapeutics trials (currently RECOVERY/RECOVERY +, PRINCIPLE and REMAP CAP).
Level 1b	Other COVID-19 UPH studies.
Level 2	Studies where the research protocol includes an urgent treatment or intervention without which patients could come to harm. These might be studies that provide access to potentially life preserving or life-extending treatment not otherwise available to the patient.
Level 3	All other studies (including Covid-19 studies not in Level 1a or 1b).

Chart 1 – Prioritisation of clinical research activity from the NIHR's Restart Framework.

The three UPH platform trials listed in Level 1a are prioritised to boost recruitment to answer the research questions posed. The VTF-prioritised Covid-19 vaccine trials will secure a vaccine supply for the UK in 2021.

CRN Wessex's activities to support these trials as well as the delivery of other UPH research during 2020 is outlined in charts 2a-b. Partner organisations within Wessex have recruited over 9,000 participants into 24 studies; 1,978 participants to interventional trials, including the four vaccine trials which recruit healthy volunteers.

UPH studies that have recruited	Participants recruited to UPH studies	Sites participating in UPH research
24 Wessex	9,036 Wessex	89 Wessex
52 UK	247,358 UK	2,582 UK

Chart 2a – Key UPH research deliverables in Wessex with UK figures provided for reference

The recruitment to UPH studies for every thousand population is shown in chart 2b. Wessex' recruitment is on par with median of all local clinical research networks (LCRNs) and the devolved nations.

The outlier within CRN North Thames is Virus Watch V1, which studies how many people develop antibodies and how effectively these antibodies help to protect against future infection. Virus Watch V1 is being delivered exclusively by University College London Hospitals NHS Foundation Trust (UCL).

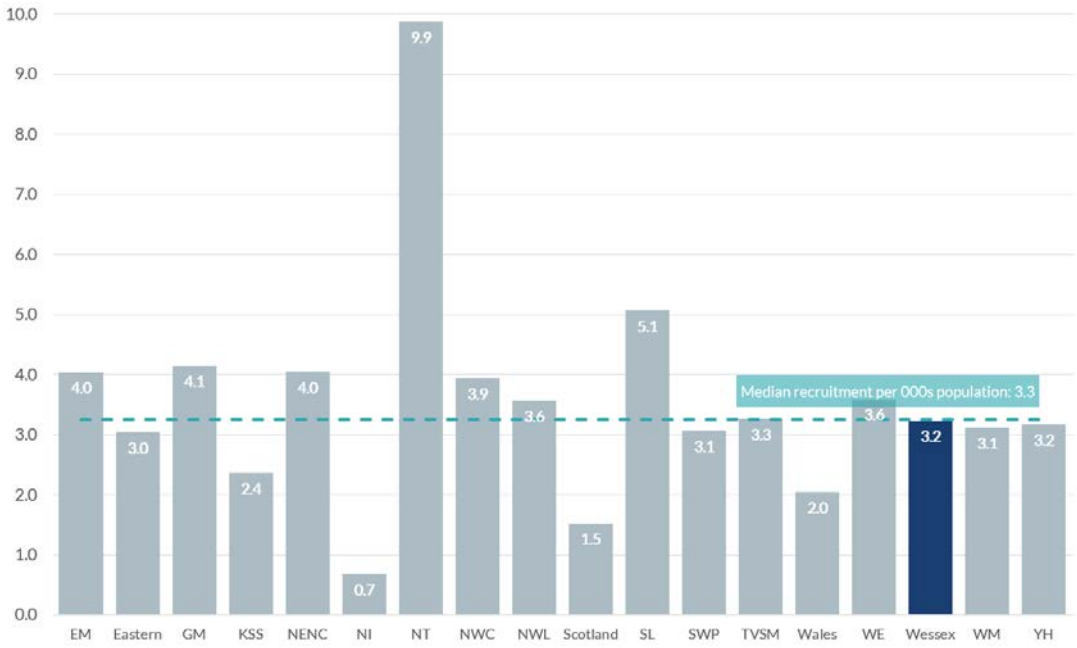


Chart 2b – UPH study recruitment per 1,000 population in each LCRN and devolved nation

Wessex organisation recruitment to the interventional only UPH trials is summarised in chart 2d.

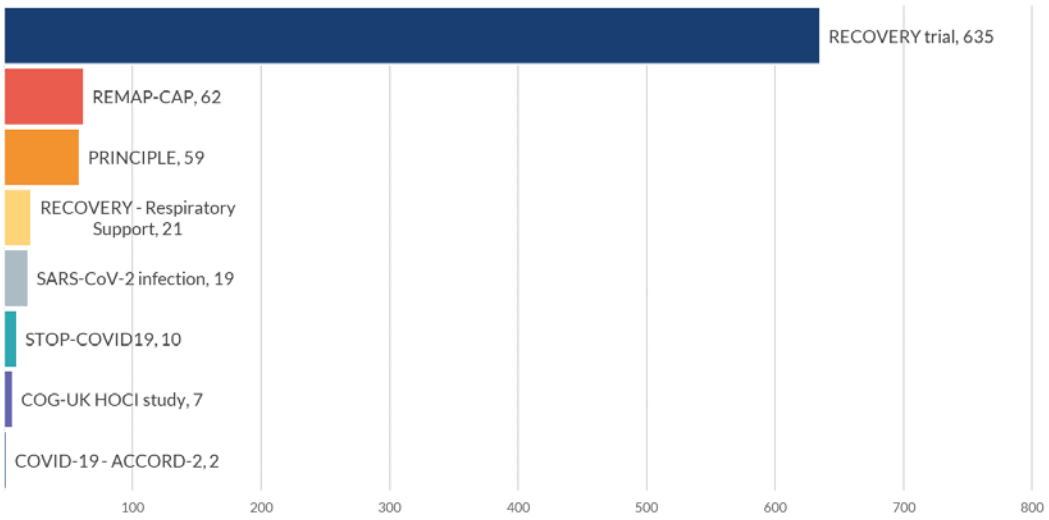


Chart 2c – Wessex recruitment to interventional UPH studies

The four UPH studies that have been led out of Wessex are described in chart three. In total 1,583 participants have been recruited to these studies across 71 sites (1,479 participants within Wessex).

ImmunoCovid19 Coronavirus infection in primary or secondary immunosuppressed children.	Study to monitor Covid-19 infections in children and adults possibly more vulnerable for infections. 1,458 participants were recruited at Southampton General Hospital. Further details can be found here.
SARS-CoV-2 infection A randomised double-blind placebo-controlled trial to determine the safety and efficacy of inhaled SNG001 (IFN-β1a for nebulisation) for the treatment of patients with confirmed SARS-CoV-2 infection	The study sponsor Synairgen is a drug discovery and development company founded by professors from University of Southampton. 101 participants have been recruited across eight sites. The trial team reported positive results and were published in The Lancet Respiratory Medicine journal. A related trial continues in primary care - https://www.covidtrialathome.com/.
ACCORD-2 A Multicentre, Seamless, Phase 2 Adaptive Randomisation Platform Study to Assess the Efficacy and Safety of Multiple Candidate Agents for the Treatment of COVID 19 in Hospitalised Patients	ACCORD aims to accelerate the development of new drugs for patients hospitalised with COVID-19 and is reducing the time taken to set up clinical trials for new therapies from months to weeks. 24 participants have been recruited across four arms before the study was paused. Further details can be found here.

	ENSEMBLE 2 A Study of Ad26.COV2.S for the Prevention of SARS-CoV-2-mediated COVID-19 in Adults (ENSEMBLE 2) This is a Janssen Vaccines & Prevention B.V. trial in a vaccine against COVID-19. The intention is to recruit 30,000 adults, with a planned start date in November 2020. Further details can be found here.

Chart 3 – Wessex-led UPH studies

Restart of non-UPH research

The key aims of the NIHR's framework for the restart research are to guide:

- the restart of paused NIHR research that was underway in the health and care system prior to the COVID-19 'surge',
- the commencement of 'new' NIHR research, and
- the prioritisation of resources in the NIHR Clinical Research Network (CRN) and NIHR infrastructure more broadly.

CRN Wessex have been tracking the restart of non-UPH research sites across the region since 12 May 2020 (chart four). There has been a 69% increase in the number of study sites that have opened to recruitment since early May (green sections of the chart). Similarly, the number of study sites that were on hold to recruitment during the pandemic has reduced by 61% (yellow sections).

With the second wave of the pandemic under way the restart of non-UPH research has reduced in recent weeks, as focus is once again put on the UPH studies and vaccine trials. Please refer to chart one for the NIHR's prioritisation of the restart of non-UPH research.

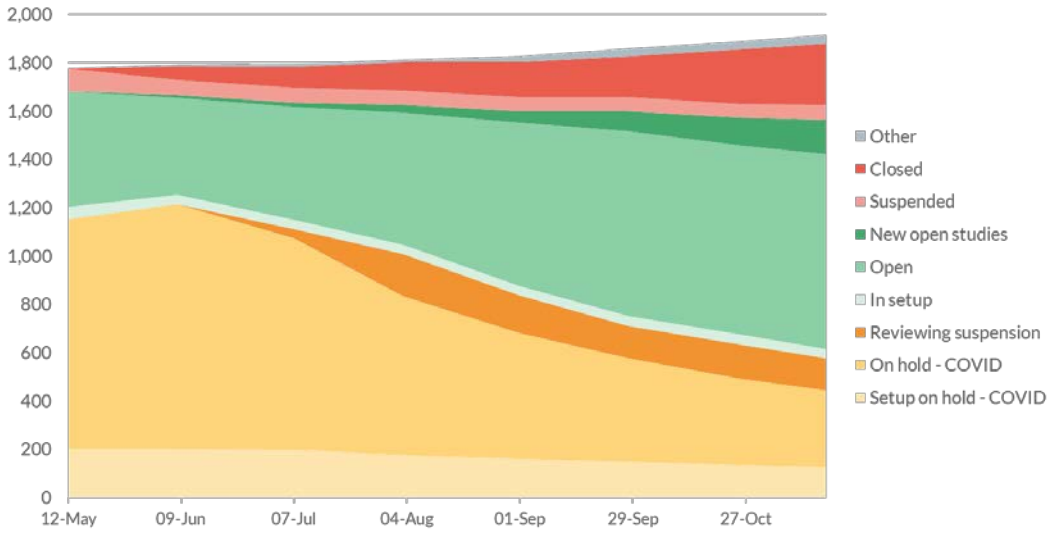


Chart 4 - Tracking the restart of study sites within Wessex using site status data provided by partner organisations on the Edge research portfolio management system

Similar restart activity is being tracked nationally by the NIHR CRN (chart 5a). The breakdown by Wessex partner organisation is provided in chart 5b. It is important to note that their analysis only considers studies rather than individual sites, and that

to be included the studies are either in setup, open or suspended on the national research portfolio database (CPMS).

CRN Wessex has 40% of studies open; the median for the UK is 47%. 15% of all studies have reopened within Wessex and since recruited participants, one percent more than the national median. 34% of Wessex studies were unaffected by the pandemic (chart 5b).

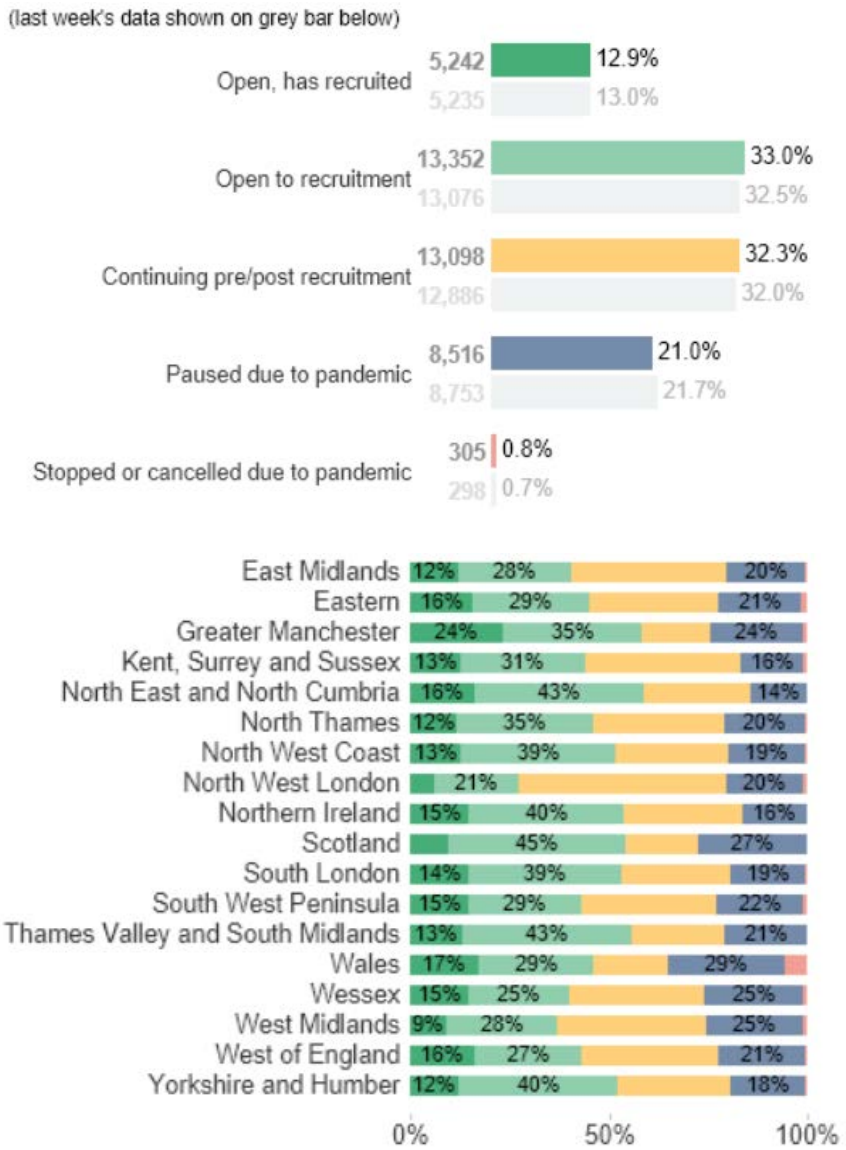


Chart 5a - NIHR Coordinating Centre tracking of the restart of the CRN clinical research portfolio, by network or devolved nation

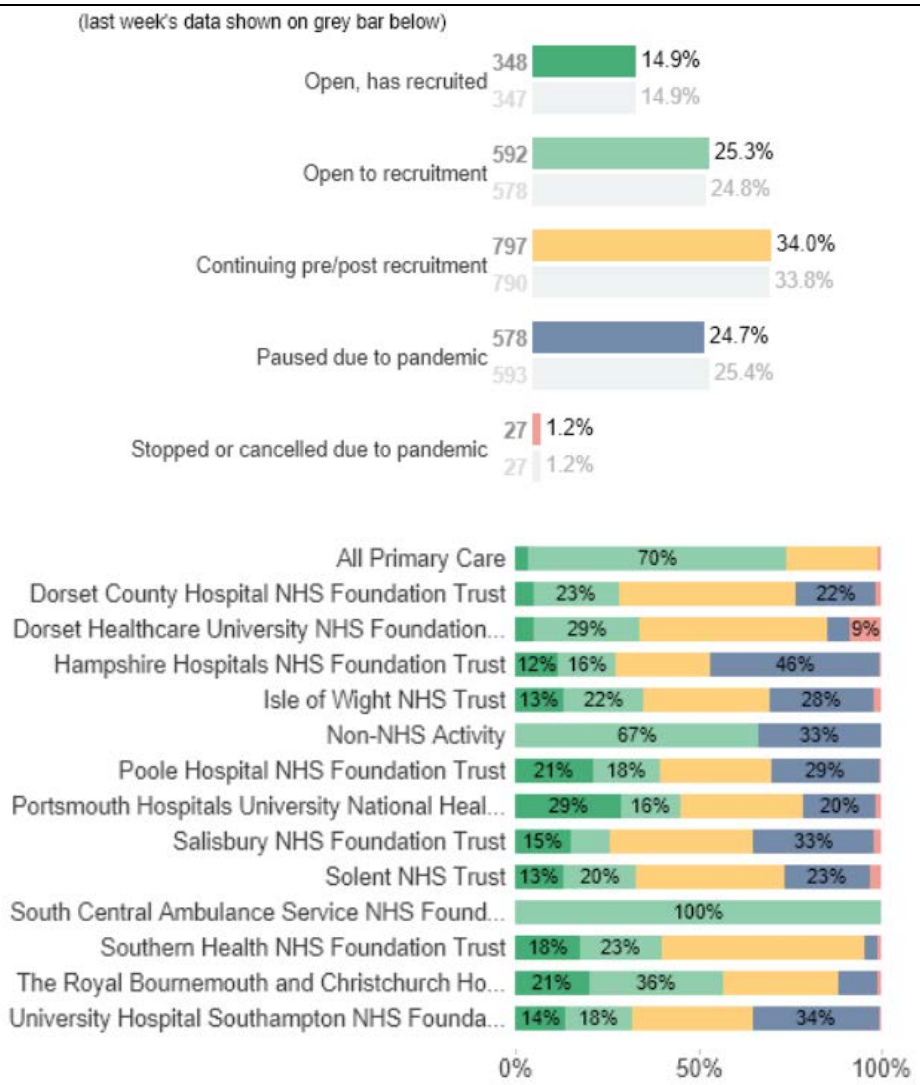


Chart 5b - NIHR Coordinating Centre tracking of the restart of the CRN clinical research portfolio, by Wessex organisation

Commercial Research (non-COVID-19)

In the CRN Wessex risk register (appendix one) it has been identified that there is a significant loss of commercial income compared to last year because of the pandemic. This is primarily reinvested by our partners in research capacity across the region and therefore in addition it affects the delivery of non-commercial research. Chart six shows a comparison of commercial activity in the first two quarters of 2019/20 compared with the same period this financial year. Commercial recruitment has reduced by 61% in Wessex year on year.

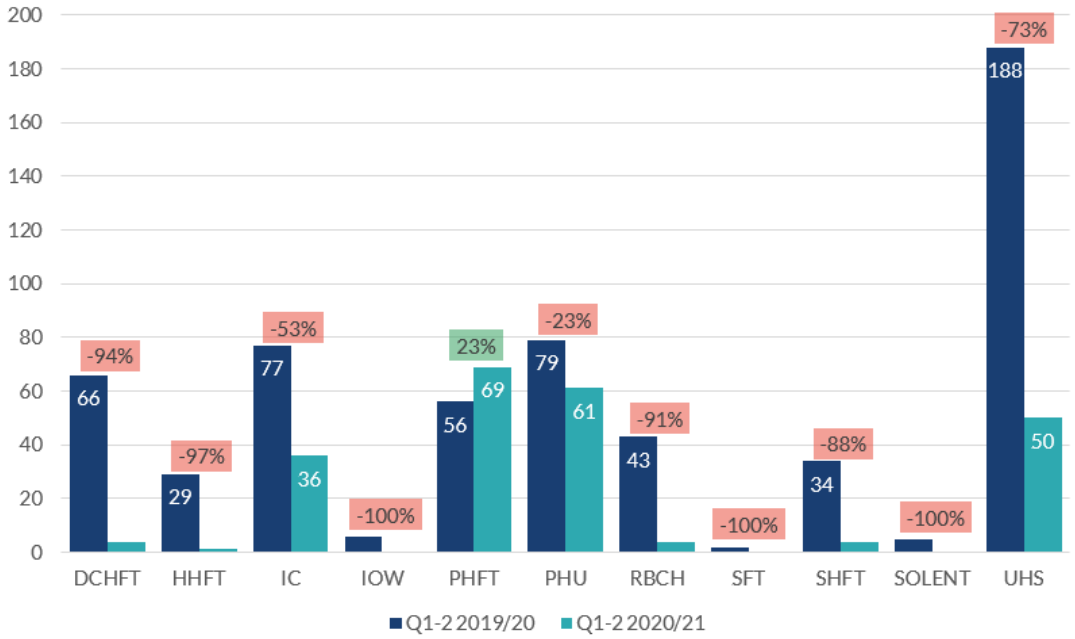


Chart 6 – Recruitment on to commercially funded and sponsored research for quarters 1-2 year on year by Wessex partner organisation

Vaccine trials

Four vaccine trials have place within Wessex to date, 'COV-001' & 'COV-002' (phase I/II, sponsored by the University of Oxford), 'Clinical trial of a SARS-CoV-2 vaccine in healthy men and women' (Imperial College London) and Novavax. 1,129 healthy volunteers have been recruited to these trials within the region and charts 7a-c summarise their demographics, where recorded.

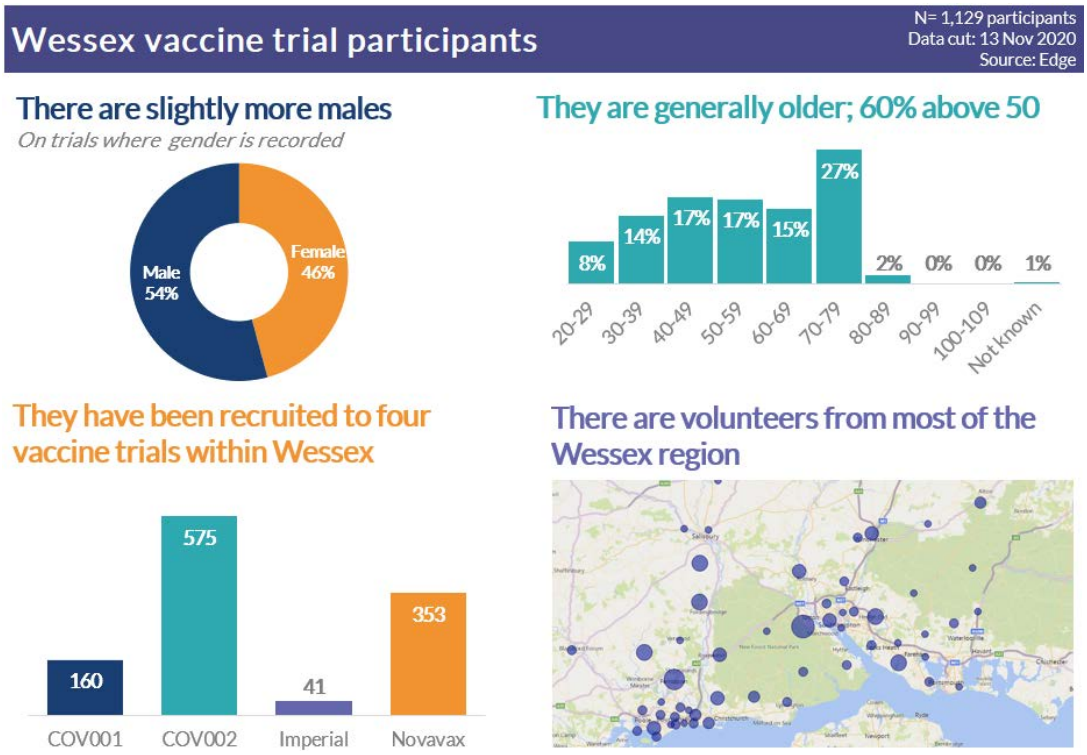


Chart 7a – Infographic summarising the healthy volunteers that have participated in COVID-19 vaccine trials within the Wessex region

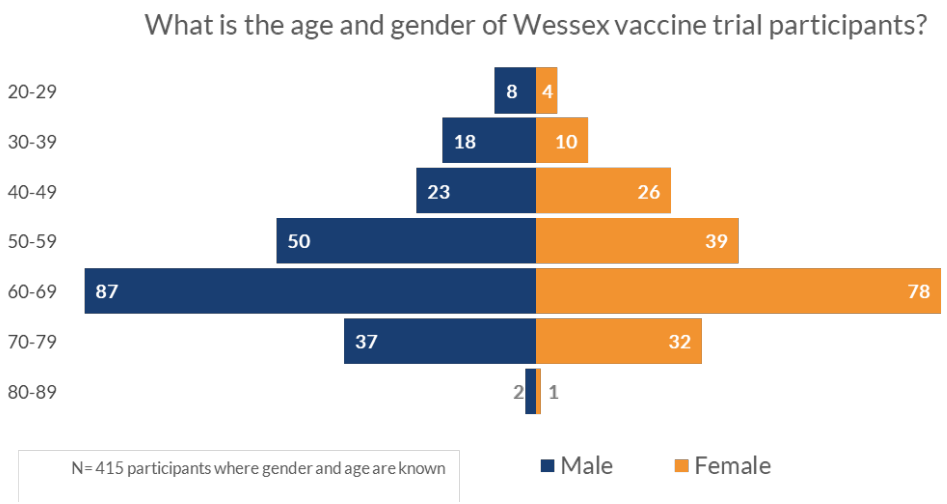


Chart 7b – Age and gender of Wessex vaccine trial participants where both demographics have been recorded (n=415)

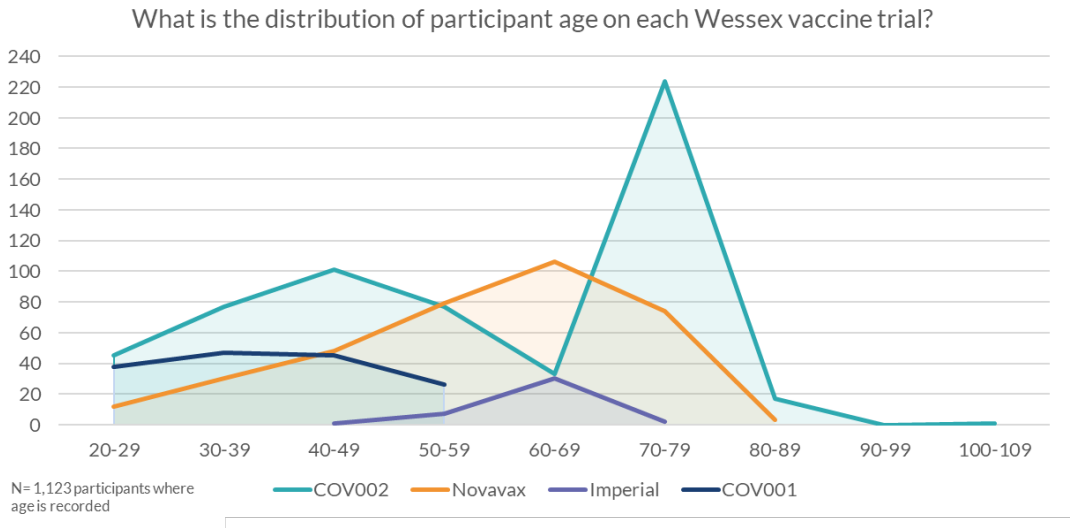


Chart 7c – Distribution of the age of Wessex vaccine trial participants by study where recorded (n=1,123)

Two Wessex vaccine hubs have been set up rapidly in Hampshire (Southampton) and Dorset (Bournemouth) through coordination and teamwork between the Dorset Integrated Care System, Hampshire and the Isle of Wight Sustainability and Transformation Partnership, Wessex partner organisations and the CRN. The recruitment of over 1,100 participants has happened in a comparatively short time, with a pipeline of trials to be delivered within the next 12-18 months.

The recruitment of healthcare and administrative staff in Wessex to deliver the vaccine trials has also been very effective, with over 450 expressions of interest. The approach has been adopted by other regions as an example of good practice.

To keep up with the progress of the vaccine trials in Wessex you can sign up for a newsletter at https://bit.ly/WessexHubnews.

NIHR CRN Performance Standards for 2020/21

The NIHR High Level Objectives, or the research related goals provided to LCRNs by the NIHR to be met each financial year, were suspended for 2020/21 due to the COVID-19 pandemic. As a replacement the NIHR Clinical Research Network have issued the standards detailed in chart seven.

It has since been confirmed that there will be no measurement of individual research networks and research active organisations against the standards until the 2021/22 financial year (beginning April 2021). The standards are therefore included for the board's reference only.

CRN Performance Standards for 2020/21			Ambition
Efficient study delivery	Deliver NIHR CRN Portfolio studies to recruitment target within the planned recruitment period	Proportion of new commercial contract studies achieving or surpassing their recruitment target during their planned recruitment period, at confirmed CRN sites	70%
Provider participation	Widen participation in research by enabling the involvement of a range of health and social care providers	(a) Proportion of NHS Trusts recruiting into NIHR CRN Portfolio studies	99%
		(b) Proportion of NHS Trusts recruiting into NIHR CRN Portfolio commercial contract studies	70%
		(c) Proportion of General Medical Practices recruiting each year into NIHR CRN Portfolio studies	45%
		(d) Number of non-NHS sites recruiting into NIHR CRN Portfolio studies	2,250 (National target)
Participant experience	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.	12,000 (National target)

	Urgent public health	Minimise set-up times for NIHR CRN UPH Portfolio studies	Study site set-up time (working days)	9
	Restart	Restart the NIHR CRN Portfolio paused by Sponsors and Sites due to COVID-19	(a) Percentage of paused commercial contract studies that are no longer paused at 31 March 2021	80%
			(a) Percentage of paused non-commercial studies that are no longer paused at 31 March 2021	80%

Chart 8 - CRN Performance Standards for 2020/21

Implications: (Clinical, Organisational, Governance, Legal?)	All NHS organisations have a duty to their local population to deliver UPH and vaccine research. NHS organisations are also expected to participate in and support health and care research. The NIHR provides service support funding to facilitate research activity within Wessex. In addition, the region has received an additional £750k of funding to set-up the two vaccine hubs. It is therefore necessary for CRN Wessex and its partner organisations to ensure that this is used effectively during the pandemic response and subsequent restart of non-UPH studies.
Risks: (Top 2) of carrying out the change / or not:	CRN Wessex maintains a risk register which can be found in appendix one. The main identified risks relating to the subjects covered in this paper are: 1. Loss of commercial research income 2. Second wave of pandemic adversely affecting research capacity Please review the risk register for details of the responses that are already underway or planned.
Summary: Conclusion and/or recommendation	The UHS Board will be updated on UPH research, the vaccine trials, restart activities and performance quarterly.

Appendix

Appendix 1 – CRN Wessex Risk Register

PRE-RESPONSE (INHERENT)									POST RESPONSE (RESIDUAL)							
Risk ID	Primary category	Date raised	Risk Owner	Risk Description (to include cause/event, and effect)	Probability	Impact	Value (PxI)	Proximity	Response Actions	Action owner(s)	Action status	Probability	Impact	Value (PxI)	Risk status (open or closed date)	Trend (since last reviewed)
CRN 01	Financial	Apr-14	CDs/COO	**Cause: Loss of core NIHR income**. CRN Wessex receives annual financial allocation from the NIHR CCRN. It is modelled on historical recruitment activity and a selection of performance metrics. Any dip in performance can result in a fall in income if other LCRNs have maintained or increased their activity in the same period. **Event:** Leading to a reduction in partner recruitment activity as a result of less funding for research infrastructure Inability to be as responsive and flexible as we would like with budget next year Negative effect on reputation and relationship with Partners **Effect:** Meaning that redundancies or vacant posts will have to be considered. Disengagement of partners due to perceived loss of benefit.	4	4	16	Apr-20	1. Model a range of budget scenarios to aid planning and forecasting 2. Conduct project to improve data quality in LPMS, working with partners 3. Regular communication and providing early notification to partners of potential budget reduction through business planning meetings 4. Provide clear guidance to partners on how to spend budget and offer advice and support to achieve for value for money 5. Provide performance reports to partners on recruitment, RTT and complexity 6. Reporting and discussion through executive group and partnership group 7. Allocation of additional CRN CC Funding in 20/21 to support immediate cost pressures from vaccine, UPH and Restart requirements	CDs/COO	All - ongoing	2	4	8	Open	Decreased
CRN 02	Performance	Apr-17	CDs/COO	**Cause: Reduction in commercial contract research** **Event:** Leading to a reduction in the treatment options for patients from commercial research studies and reduced commercial income available for re-investment. **Effect:** Meaning that there will be less funding for research infrastructure and tretment opportunities for patients	4	4	16	Apr-20	1. Dedicated Industry Manager post to promote commercial research in the network. 2. Close monitoring and support for partners with EOI process 3. Support for partners to recruit to time and target to maximise the performance metrics for delivery of commercial research 4. Reporting and discussion through executive group and partnership group 5. Allocation of contingency funding as appropriate to support infrastructire during pandemic	Commercial Lead	All - ongoing	3	4	12	Open	Static
CRN 03	Reputational	Apr-17	CDs/COO	**Cause: Contract renewal** due 31 March 2023 **Event:** Leading to **uncertainty** in Wessex research system **Effect:** Meaning that **staff seek suitable alternative employment**	3	3	9	Mar-22	1. Lobby nationally for further information, at forthcoming review meetings and continually through COO / CD meetings 2. Continued communication to keep staff informed as more information becomes available 3. Contract extension by DHSC to 31 March 2022 4. CRN team ready to support re-application process	CDs/COO	All - ongoing	1	3	3	Open	Static

PRE-RESPONSE (INHERENT)									POST RESPONSE (RESIDUAL)							
Risk ID	Primary category	Date raised	Risk Owner	Risk Description (to include cause/event, and effect)	Probability	Impact	Value (PxI)	Proximity	Response Actions	Action owner(s)	Action status	Probability	Impact	Value (PxI)	Risk status (open or closed date)	Trend (since last reviewed)
CRN 04	Performance	Nov-18	CDs/COO	**Cause: Clinical and service pressures within NHS and social care** **Event:** Leading to **partner disengagement** with research agenda due to clinical and service pressures **Effect:** Meaning a **decrease in activity.** Portfolio activity may be affected due to large amount of resources needed to support clinical services and during the pandemic response (see also CRN05).	3	3	9	Apr-20	1. WFD strategy to provide support 2. Cross sector working to provide capacity 3. Allocation of national contingency funding in 20/21 from CRN CC to support partner organisations 3. Support for NIHR CRN CC instigated restart programme, detailing priniciples and processes for resuming non-Covid study activty. Guidance available (https://www.nihr.ac.uk/documents/restart-framework/24886) that is regularly updated and accessible to all partners and communicated through numberous channels.	CDs/COO	All - ongoing	2	2	4	Open	Decreased
CRN 05	Performance	Jun-20	CDs/COO	**Cause: Second wave of Covid -19 pandemic** **Event:** Leading to a **reduction in research capacity** in NHS and social care **Effect:** Meaning **recruitment** to all studies, including priority studies, may be **detrimenatally affected** by a second wave of Covid infections. In *extremis* CRN funded staff may be redeployed to clinical duties and shortages in staffing will be exasperated by staff sickness, sheilding and isolating.	4	4	16	Nov-20	1. CRN Wessex, are ensuring plans are in place to ensure staffing is as flexible as possible. This will include ensuring holiday leave is taken prior to periods of greatest risk. 2. Wessex workforce campaign to recruit additional staff to support vaccine studies 3. Engagement with Restart programme, detailing priniciples and processes for resuming non-Covid study activty. 4. Active participation in national vaccinces groups to plan staffing and logistics 3. CRN Wessex has set up a regional vaccines board, which meets weekly. Any issues from this group are raised with the National/Operational Team as appropriate. 4. Business Continuity Plan review regularly.	CDs/COO	All - ongoing	4	3	12	Open	New

Appendix 2 - Glossary
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 - *replaced by the merged organisation UHD*
- PHU - Portsmouth Hospitals University NHS Trust – *previously PHT*
- 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 - *replaced by the merged organisation UHD*
- UHD – University Hospitals Dorset NHS Foundation Trust
- UHS - University Hospital Southampton NHS Foundation Trust

2019/20 population and acronym by local clinical research network or devolved nation:

- East Midlands – EM - 4,605,206
- Eastern – Eastern - 3,891,262
- Greater Manchester – GM - 3,029,318
- Kent, Surrey and Sussex – KSS - 4,654,474
- North East and North Cumbria – NENC - 2,963,018
- North Thames - NT - 5,757,668
- North West Coast – NWC - 3,950,452
- North West London – NWL - 2,075,696
- South London – SL - 3,285,629
- South West Peninsula – SWP - 2,304,291
- Thames Valley and South Midlands – TVSM - 2,397,813
- Wessex – Wessex - 2,793,224
- West Midlands – WM - 5,860,706
- West of England – WE - 2,490,339
- Yorkshire and Humber – YH - 5,560,334
- Northern Ireland – NI – 1,870,800
- Scotland – Scotland – 5,424,800
- Wales – Wales – 3,125,200