University Hospital Southampton
NHS Foundation Trust

Agenda Trust Board – Open Session

Date	30/11/2021
Time	9:00 - 13:00
Location	Microsoft Teams
Chair	Peter Hollins
Observing	Tracy Whale, Interim DHN/P, Division B (shadowing Gail Byrne)

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		**Staff Story** The patient or staff story provides an opportunity for the Board to reflect on the experiences of patients and staff within the Trust and understand what the Trust could do better.
3	9:15	**Minutes of Previous Meeting held on 30 September 2021**
4		**Matters Arising and Summary of Agreed Actions** To discuss any matters arising from the minutes, and to agree on the status of any actions assigned at the previous meeting.
5		**QUALITY, PERFORMANCE and FINANCE** Quality includes: clinical effectiveness, patient safety, and patient experience
5.1	9:25	**Briefing from the Chair of the Finance and Investment Committee (Oral)** Jane Bailey, Chair
5.2	9:30	**Briefing from the Chair of the Quality Committee (Oral)** Tim Peachey, Chair
5.3	9:35	**Chief Executive Officer's Update and Executive Briefing (Oral)** Sponsor: David French, Chief Executive Officer
5.4	10:00	**Integrated Performance Report for Month 7** To review the Trust's performance as reported in the Integrated Performance Report. Sponsor: David French, Chief Executive Officer Attendee: Andrew Asquith, Director of Planning, Performance & Productivity
5.5	10:45	**Finance Report for Month 7** Sponsor: Ian Howard, Interim Chief Financial Officer

5.6 **Freedom to Speak Up Report**

10:55 Sponsor: Gail Byrne, Chief Nursing Officer
Attendee: Christine Mbabazi, Equality & Inclusion Adviser/Freedom to Speak Up Guardian

5.7 **Equality, Diversity and Inclusivity (EDI) Update including Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Annual Reports 2021 and Action Plans 2021/22**

11:10 Sponsor: Steve Harris, Chief People Officer
Attendees: Ceri Connor, Director of OD and Inclusion/Gemma Genco, Head of Equality, Diversity and Inclusivity

5.8 **Annual Ward Staffing Nursing Establishment Review**

11:25 Sponsor: Gail Byrne, Chief Nursing Officer
Attendee: Rosemary Chable, Head of Nursing for Education, Practice and Staffing

5.9 **Infection Prevention 2021-22 Q1-Q2 Report**

11:40 Sponsor: Gail Byrne, Chief Nursing Officer
Attendees: Nitin Mahobia, Deputy Director of Infection Prevention and Control/Julie Brooks, Head of Infection Prevention Unit

5.10 **Annual Assurance Process and Self-assessment against the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)**

11:55 Sponsor: Joe Teape, Chief Operating Officer
Attendee: Sandra Hodgykns, Head of Emergency Planning Response and Resilience/Security - LSMS

6 **STRATEGY and BUSINESS PLANNING**

6.1 **Corporate Objectives 2021-22 Quarter 2 Review**

12:05 Sponsor: David French, Chief Executive Officer

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

7.1 **Register of Seals and Chair's Actions for ratification**

12:20 In compliance with the Trust Standing Orders, Financial Instructions, and the Scheme of Reservation and Delegation.
Sponsor: Peter Hollins, Trust Chair

7.2 **Finance and Investment Committee Terms of Reference**

12:25 Sponsor: Peter Hollins, Trust Chair
Attendee: Karen Flaherty, Associate Director of Corporate Affairs and Company Secretary

7.3 **Quality Committee Terms of Reference**

12:30 Sponsor: Peter Hollins, Trust Chair
Attendee: Karen Flaherty, Associate Director of Corporate Affairs and Company Secretary

7.4 **Remuneration and Appointment Committee Terms of Reference**

12:35 Sponsor: Peter Hollins, Trust Chair
Attendee: Karen Flaherty, Associate Director of Corporate Affairs & Company Secretary

8 **Any other business**

12:40 To raise any relevant or urgent matters that are not on the agenda

9 **To note the date of the next meeting: 27 January 2022**

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

10.1 **CRN: Wessex 2021-22 Q2 Performance Report**

Sponsor: Paul Grundy, Chief Medical Officer

11 **Resolution regarding the Press, Public and Others**

Sponsor: Peter Hollins, Chair
To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.

12 **Follow-up discussion with governors**

12:45

University Hospital Southampton
NHS Foundation Trust

Minutes Trust Board – Open Session

Date	30/09/2021
Time	9:00 - 12:05
Location	Microsoft Teams
Chair	Peter Hollins (PH), Trust Chair
Present	Jane Bailey (JB), Non-Executive Director (**NED**) and Senior Independent Director/Deputy Chair Dave Bennett (DB), NED Gail Byrne (GB), Chief Nursing Officer Cyrus Cooper (CC), NED (from item 5.5 onwards) Keith Evans (KE), NED David French (DAF), Chief Executive Officer Paul Grundy (PG), Chief Medical Officer Steve Harris (SH), Chief People Officer Jane Harwood (JH), NED Peter Hollins (PH), Trust Chair Ian Howard (IH), Interim Chief Financial Officer Tim Peachey (TP), NED Joe Teape (JT), Chief Operating Officer
In attendance	Suzanne Cunningham (SC), Director of Midwifery (for item 5.3) Karen Flaherty (KF), Associate Director or Corporate Affairs and Company Secretary Diana Hulbert (DH), Guardian of Safe Working Hours and Emergency Department Consultant (for items 5.4-5.6) Neil Pearce (NP), Associate Medical Director for Safety (for item 5.5) Three governors (observing) Seven members of staff (observing) Two members of public (one for item 2 and one observing)

1 Chair's Welcome, Apologies and Declarations of Interest

The Chair welcomed all those attending the meeting. CC would be joining the meeting around 11.30am. There were no other apologies or new declarations of interest.

2 Patient Story

A patient shared her recent experience as a patient at Southampton General Hospital following a serious road traffic accident.

She commended the staff at the Trust for the way in which they had taken the time to care for her as an individual. This included the way in which the doctors had communicated the seriousness of the situation and the risks to her and her family and the support provided. Although the nursing staff on the trauma ward had been busy caring for high acuity patients, they had always treated her with kindness and she had never felt ignored. Staff had arranged for her son to visit, as he had been particularly upset following the accident, and set up calls with her family and friends. She had also witnessed the way that the care provided on the ward had been transformative for patients. She singled out the catering

manager on the ward for praise as he had made sure patients and visitors were looked after and remembered everyone's names and what they liked to eat.

The negative aspect of her care had been the number of times that her surgery had been cancelled while she was in hospital. While the reasons for the cancellation were explained to her in most instances, she was not sure if staff were aware of the number of times her surgery had been cancelled. She highlighted the emotional and practical impact of the repeated cancellations, which had been upsetting and had delayed her discharge from hospital. However, in her time on the ward she noticed the feedback she had given to staff about this had informed the way in which the number of cancellations for other patients had been monitored.

Board members recognised how distressing it could be for patients when operations were cancelled repeatedly and how the Trust tried to ensure the right balance when allocating theatres between trauma and planned care. The positive feedback about the care and staff was welcomed. The Trust had seen 3,500 trauma patients in the previous three years and had achieved some of the best outcomes nationally for these patients.

The patient confirmed that her recovery was continuing to go well with the support of the rehabilitation service at Salisbury District Hospital.

3 Minutes of Previous Meeting held on 29 July 2021

The minutes of the meeting held on 29 July 2021 were approved as an accurate record of that meeting.

4 Matters Arising and Summary of Agreed Actions

The updates on the actions were noted. The actions with references 518, 519 and 520 had been completed or were sufficiently progressed and could be closed.

GB confirmed that the existing accommodation available for parents had been assessed as sufficient as part of the RSV surge planning (reference 517). The outcome of the work on health inequalities in relation to waiting times (reference 522) was progressing well and would be ready to be presented to the Board at its meeting in October 2021.

5 QUALITY, PERFORMANCE and FINANCE

5.1 Briefing from the Chair of the Finance and Investment Committee

JB updated the Board on the meeting of the Finance and Investment Committee that had taken place earlier that week. The following areas were highlighted:

- the financial environment continued to be challenging due to the operational pressures relating to demand and capacity;
- the operational planning guidance for the second half of the 2021/22 financial year had not yet been published, however, the Trust continued to manage the situation well using the information available;
- the work to develop the operational productivity reporting to the committee was ongoing;
- an update on the delivery of the digital strategy had been provided and greater clarity on the funding for future years would be provided as part of the capital prioritisation process;

- an update on the performance of Wessex NHS Procurement Limited had been provided, which included a challenge on how it could demonstrate it was providing value in future as it moved away from managing supplies in response to the COVID-19 pandemic;
- consideration of the MRI replacement business case to be presented to the Board for approval later in the meeting; and
- monitoring of the strategic risks in the Board Assurance Framework relevant to the committee, ensuring that the target dates for reducing the risks were realistic and the actions that would reduce the risk or provide assurance as to how the risk was being managed were clear.

5.2 Chief Executive Officer's Update and Executive Briefing

The chief executive officer and the executive directors provided an update covering the following areas:

- the funding announcement for the NHS was welcomed, recognising the difficulties this presented for the government given manifesto commitments and that the funding may not be sufficient;
- the short-term nature of planning for the NHS continued to present challenges, for example Health Education England did not yet have a final budget agreed for training when it was vital that doctors and nurses were trained to address workforce shortages;
- 96% of staff had received both COVID-19 vaccinations and the Trust was redeploying patient-facing staff who did not wish to be vaccinated;
- the hospitals continued to be busy, with record numbers of attendances in the emergency department (**ED**);
- critical care capacity for elective activity had been reduced due to the numbers of patients with COVID-19 being cared for;
- high levels of annual leave and other staff absence in August 2021 had also reduced capacity;
- some planned surgery had been cancelled during August 2021, including cancellations on the day of surgery as a result of demand in ED and available critical care capacity, causing distress for both patients and staff;
- listening events were being held in all areas of critical care as specialist teams in these areas continued to support one another;
- the Trust was working with other trusts in the south east region to prioritise the cardiac patients needing to be treated most urgently, as these patients had been most affected by cancellations due to the shortage of available critical care beds;
- the Trust was also carrying out a review of the potential impact of the delays for cardiac patients, including the need for a longer stay in hospital or a longer period of therapy once treated;
- the Trust was working with partners in the NHS and independent sector to limit the impact on cancer surgery;
- new guidance for the Trust would be issued the following week in light of the proposed changes to infection control practice in low risk pathways affecting isolation prior to hospital admission, lateral flow testing, social distancing and cleaning specifications, which would require staff to be fully vaccinated;
- the Trust would continue to adopt a cautious approach to infection control in order to maintain low levels of nosocomial infection;
- the Trust's deputy chief nursing officer, Juliet Pearce, had been appointed as the director of nursing, midwifery and allied health professions for the Isle of Wight NHS Trust;

- while the operational planning guidance for October 2021 to March 2022 had not yet been published it was expected that this would indicate expectations in relation to levels of elective activity and reduction in the number of patients on waiting lists;
- £700 million of additional capital funding had been made available and the Hampshire and Isle of Wight integrated care system (**ICS**) would be prioritising bids submitted by trusts locally before putting in the request for the funding nationally;
- the Trust had submitted bids for an interoperative MRI scanner, a CT scanner in ED, digital technology to support patient flow, critical care outreach, mobile outpatient activity and mobile LINAC (linear accelerator);
- the Trust should benefit from the additional investment for the ICS if other trusts' bids were successful, such as Portsmouth Hospitals NHS Trust's bid for ambulatory surge capacity to reduce ambulance handover delays;
- staff recruitment activity including an open day for critical care staff and overseas recruitment, with 90 more staff new staff joining by the end of 2021;
- staff retention activity including wellbeing support and providing 'boost boxes';
- the use of the charitable funds raised from the auction of the 'Gamechanger' artwork to improve areas of the hospitals for use by staff; and
- the 'Hospital Heroes' broadcast being aired on 6 October 2021.

The Board discussed the potential drivers for the demand in ED and how attendances could be managed elsewhere, such as urgent treatment centres and primary care, where appropriate.

The Board expressed its thanks to staff across the Trust for the way in which they were responding to the current pressures. The Board recognised the work to assess and prioritise patients as a result of capacity constraints and cancellations and the emotional impact of this when staff were wanting to do the best for their patients.

5.3 Maternity Safety 2021/22 Quarter 1 Report

Suzanne Cunningham joined the meeting for this item.

The Board noted the maternity safety services report relating to the first quarter of 2021/22. This had been presented to the Quality Committee at its meeting in August 2021.

As the Board-level maternity safety champions, TP and GB also provided an update on recent visits to maternity and neonatal areas and meetings with staff. The maternity service had recently held a 'whose shoes' virtual event supported by the transformation team. This had included reviewing the poor feedback in the friends and family test for maternity relating to the post-natal ward, with more than one in five mothers dissatisfied with their care. In order to address this, plans had been implemented:

- to speed up pathology results to reduce the number of times women were moved when transferring from the labour ward to the post-natal ward;

- to ensure midwives showed that they had time for mothers and mothers felt that the midwives were not too busy to answer their questions;
- to introduce a new group of maternity support workers to provide support with breastfeeding and to mothers with smaller babies and a student midwife to support breastfeeding women; and
- to ensure that the option for self-administration of analgesia was clear in order to avoid delays.

Partners staying on the ward continued to be an issue as there were only a small number of single rooms, which tended to be used on compassionate grounds. This had been difficult to manage even prior to the COVID-19 pandemic.

While there had been some temporary problems with maternity staffing, which had been highlighted in the integrated performance report to be considered later in the meeting, recruitment and retention had not previously been a problem for the maternity service. However, the number of retirements was increasing and it was beginning to become more difficult to find staff when recruiting.

5.4 Guardian of Safe Working Hours Quarterly Report

Diana Hulbert joined the meeting for this item, her first time presenting to the Board in the role of Guardian of Safe Working Hours.

The Board noted the report and the following areas were considered:

- the cultural complexity that existed about exception reporting, convincing junior doctors that these reports were constructive rather than punitive, and consultants that the process was effective;
- the level of expenditure on locums and whether this could be applied more effectively in recruiting permanent staff;
- the ability to identify personal development time for audit work and to develop their portfolio;
- the need to make the training experience overall really positive in order to continue to attract and retain junior doctors; and
- innovative ways to expand the clinical workforce to address the shortage of junior doctors.

DH encouraged the Trust to adopt an approach to over-recruit to provide greater resilience in the rotas and reduce locum expenditure. Having a supernumerary element in the junior medical workforce would also help achieve a good balance between service and training for junior doctors.

5.5 Learning from Deaths 2021/22 Q1 Report

Neil Pearce joined the meeting for this item.

The Board noted the report and considered the ways in which the Trust could improve the collation and dissemination of learning from deaths across all areas of the Trust. It was suggested that this could include bringing staff together virtually. The medical examiners had recently started to record ethnicity as part of their reviews and this could begin to inform the impact of health inequalities on outcomes and targeted interventions. The medical examiners in Hampshire already met regularly and the Trust fed into the national alerts system as well as receiving these.

The link between learning from deaths and the reduction in avoidable mortality and the Trust's Hospital Standardised Mortality Ratio (HSMR) was highlighted.

5.6 Integrated Performance Report for Month 5

The integrated performance report (**IPR**) was noted.

The Board discussed the spotlight section relating to ED performance and pressures. ED attendances were at unprecedented levels – 17% higher than in 2019, which had also seen unprecedented levels of demand at that time. While performance against the four hour standard for patients to be discharged, admitted or transferred had declined to 77% recently, the Trust's performance compared to its peers had improved over the previous two years and had placed it in the top quartile regionally and among teaching hospitals until very recently, and it was now in the second quartile.

There had been a great deal of work led by an excellent leadership team in ED to improve performance, with changes to the estate and work on mental health and other pathways. The team were actively managing patients waiting in ED through a clinical prioritisation process, having taken the decision to queue patients within the department rather than having ambulances waiting with patients outside the hospital and unable to take other calls.

There had been some work nationally to understand the levels of demand in EDs and 59% of those attending an ED had spoken to another service prior to attending, 23% of those attending thought they needed a test or service that the hospital provided and 22% of those attending had not thought about visiting their GP. Audits elsewhere indicated that 55% of attendances in ED could have been seen in primary care and 25% could have been seen by specialist teams. Although admissions had increased, the increase was not commensurate with the increases in ED attendances.

The Board thanked the ED team for the way in which it had responded and continued to respond to the increase in demand. It discussed options to prepare for a continuation of current levels of demand in ED while working on alternative options with partners in the ICS. These included:

- developing different pathways including the development of the concept of an emergency or urgent care village;
- co-locating primary care or an urgent care centre on the same site as ED; and
- improving the filtering of patients using processes such as 'pitstop', which allowed clinicians to discuss surgical options with patients.

The ability to meet demand more generally over winter was also a concern for the Trust as it had already opened all available bed capacity. The Trust was working with ICS partners to increase bed capacity outside the Trust as well as reviewing its elective activity plans.

DH left the meeting.

GB had requested that red flag and staffing incidents were included as a spotlight section in the IPR due to the increase in the previous two months. The principal reasons for the incidents were that staff were unable to provide medication or care on time. While there was concern about staff fatigue and burnout, the feedback from staff exit data showed that staff were leaving for

promotion rather than the Trust not being a place they wanted to work or being too challenging a work environment as a university teaching hospital. There had been more staff retiring in July and August than usual as staff had delayed retirement during the COVID-19 pandemic.

Actions: (1) SH would provide a more detailed breakdown of the reasons given by staff who were leaving; and (2) SH would review the description for the metric relating to workforce numbers (WR3-L) to make this clearer.

Nationally there were issues with nursing staff shortages, for example in critical care, and the Trust was generally in a better position than its peers. There had been a reliance on overseas nurses in critical care units previously and some of these nurses were now returning home, where there were more opportunities for them. Work/life balance was also cited as an issue for nurses nationally.

The use of the charitable funds raised by the auction of Banksy's 'Game Changer' artwork earlier in 2021 provided an opportunity to improve the working environment for staff and set the Trust apart as an employer. The Trust continued its recruitment efforts, however, identifying available candidates was becoming more difficult. Expansion of the successful nurse apprenticeship programme and other innovative approaches to staffing were being considered.

The Board also discussed the recovery of performance against diagnostic targets as performance had been gradually improving until August 2021. In particular how this might impact on the complexity of treatment due to late presentation, especially for cancer patients.

The meeting was adjourned for a short break.

5.7 Finance Report for Month 5

The finance report was noted. The following areas were highlighted:

- income from the elective recovery fund (**ERF**) had reduced to an estimated £0.28 million in August based on activity of around 97% of pre-pandemic elective and outpatient activity, reflecting the ongoing operational pressures;
- there was an element of volatility in the Trust's financial position as a result of the income from the ERF, as the Trust had been reliant on income of around £2 million from the ERF each month in order to achieve a breakeven position;
- there continued to be uncertainty about the financial framework for the second half of 2021/22;
- there was a slight underspend on capital expenditure, however, the Trust was confident that the planned expenditure would be achieved in 2021/22, including the expenditure on ward refurbishment; and
- there was some slippage on capital expenditure within the ICS, with further slippage likely nationally, and the Trust was monitoring this in case this would provide an opportunity for further capital expenditure by the Trust.

6 STRATEGY and BUSINESS PLANNING

6.1 Corporate Objectives 2021-22 Quarter 1 Update

The update on the progress against the corporate objectives for 2021/22 in the first quarter was noted by the Board.

Given the operational challenges currently faced by the Trust, the Board considered whether the reporting should focus more generally on progress against the objectives and reaching specific milestones rather than completion of specific actions. This would help the Board to identify the reasons why the actions were not leading to the expected progress against the individual objectives, whether there were other actions that the Trust could take and whether there were issues outside its control.

Action: PH and DAF agreed to review the approach to reporting progress against the corporate objectives.

7 CORPORATE GOVERNANCE, RISK and INTERNAL CONTROL

7.1 Register of Seals and Chair's Actions for ratification

Decision: The Board ratified the application of the Trust seal and the Chair's actions set out in the report.

8 Any other business

The Trust had recently received a couple of awards:

- the major trauma team received the Improvements in Care Award at the Trauma Audit and Research Network (TARN) awards; and
- the project team for the new general intensive care unit (GICU) development, which opened in September 2020, were the South West region winners in the 2021 Health Estates and Facilities Management Association (HEFMA) awards.

9 To note the date of the next meeting: 30 November 2021

10 Resolution regarding the Press, Public and Others

Decision: The Board resolved that, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.

The meeting was adjourned.

University Hospital Southampton NHS Foundation Trust

List of action items

Agenda item		Assigned to	Deadline	Status
Trust Board – Open Session 30/09/2021 5.6 Integrated Performance Report for Month 5				
575.	Reasons for staff leaving	Harris, Steve	30/11/2021	Pending
	Explanation action item SH would provide a more detailed breakdown of the reasons given by staff who were leaving.			
576.	Workforce numbers	Harris, Steve	30/11/2021	Pending
	Explanation action item SH would review the description for the metric relating to workforce numbers (WR3-L) to make this clearer.			
Trust Board – Open Session 30/09/2021 6.1 Corporate Objectives 2021-22 Quarter 1 Review				
577.	Progress against corporate objectives	French, David Hollins, Peter	30/11/2021	Pending
	Explanation action item PH and DAF agreed to review the approach to reporting progress against the corporate objectives.			

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Integrated Performance Report for Month 7 2021/22**			
Agenda item:	**5.4**			
Sponsor:	**David French, Chief Executive Officer**			
Date:	**30 November 2021**			
Purpose	**Assurance or reassurance Y**	**Approval**	**Ratification**	**Information**
Issue to be addressed:	The report aims to provide assurance: • regarding the successful implementation of our strategy • that the care we provide is safe, caring, effective, responsive, and well-led			
Response to the issue:	The Integrated Performance Report reflects the current operating environment and is aligned with our strategy.			
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.			

University Hospital Southampton NHS
NHS Foundation Trust

Integrated KPI Board Report

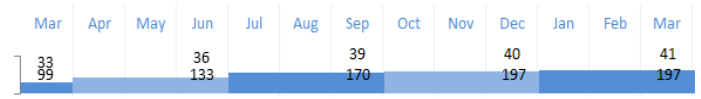
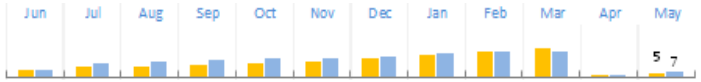
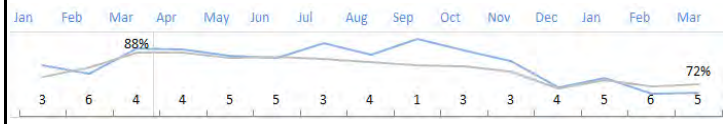
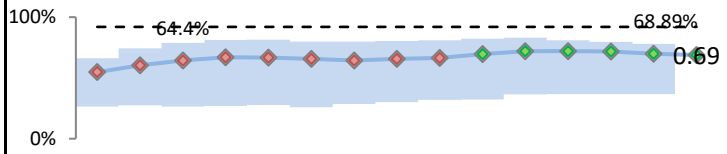
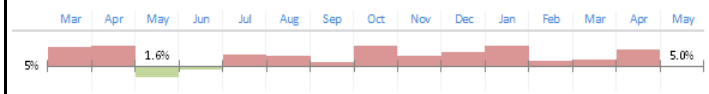
covering up to

October 2021

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 & bar Benchmarked		The line shows our performance and the bar underneath represents the range of performance of benchmarked trusts (bottom = lowest performance, top = highest performance)
Control Chart		A control chart shows movement of a variable in relation to its control limits (the 3 lines = Upper control limit, Mean and Lower control limit). When the value shows special variation (not expected) then it is highlighted green (leading to a good outcome) or red (leading to a bad outcome). Values are considered to show special variation if they -Go outside control limits -Have 6 points in a row above or below the mean, -Trend for 6 points, -Have 2 out of 3 points past 2/3 of the control limit, -Show a significant movement (greater than the average moving range).
Variance from Target		Variance from target charts are used to show how far away a variable is from its target each month. Green bars represent the value the metric is achieving better than target and the red bars represent the distance a metric is away from achieving its target.

Introduction

The Integrated Performance Report is presented to the Trust Board each month.

The report aims to provide assurance:

- Regarding the successful implementation of our strategy
- That the care we provide is safe, caring, effective, responsive, and well led

The content of the report includes the following:

- The 'Spotlight' section, to enable more detailed consideration of any topics that are of particular interest or concern. The selection of topics is informed by a rolling schedule, performance concerns, and requests from the Board
- An 'NHS Constitution Standards' section, summarising the standards and performance in relation to service waiting times
- An 'Appendix', with indicators presented monthly, aligned with the five themes within our strategy.

This month the appendix has been updated to:

- Introduce a new measure relating to the number of patients waiting more than 104 weeks on a referral to treatment pathway (UT31), replacing the previous measure which reported patients waiting more than 78 weeks. This change reflects higher numbers of patients waiting more than 104 weeks at UHS, and the expectation in NHS planning guidance October 2021 – March 2022 that by the end of March 2022 no patient will wait over 104 weeks (except where they choose to wait longer).

- Amend the calculation of the measure relating to workforce numbers (WR3), now showing a) actual variation in staff in post (FTE) and b) the increase in the number of budgeted posts we anticipate achieving by end March 2022, both compared to the position at end March 2021.

- Pilot a method of benchmarking performance to both the peer teaching hospital and South East region comparator groups using metric *UT33-N: % of patients waiting over 6 weeks for diagnostics.*

Summary

This month the 'Spotlight' section features:

1. Referral to treatment (RTT) waiting times - Patients waiting more than 52 and 104 weeks

Prior to the pandemic, UHS had no patients waiting longer than 52 weeks. There are now 2,255 patients waiting longer than 52 weeks, and 137 patients waiting longer than 104 weeks. There is a clear requirement for the Trust to ensure than no patient waits longer than 104 weeks, and that the number of patients waiting longer than 52 weeks does not increase and is reduced if possible.

2. Patient Falls

Patient falls are a key indicator of the quality of care within inpatient services and have the potential to cause significant harm when they occur. UHS reported 2,004 patient falls and 87 'near misses' in the 12 months to October 2021.

3. Ambulance Handovers

Prompt handover of responsibility for the care of patients from ambulances to Emergency Departments is important. As well as securing timely and appropriate care for each patient being taken to an Emergency Department, handover enables ambulance service staff to resume their response to health emergencies within the community. NHS England wrote to all Trusts on 26th October, the letter asked Trusts to "report the actions that they have put in place to ensure delays have been eliminated in all Board Meetings, taking time to discuss the challenges with data to support the issue".

Highlights to note in the appendix containing indicators by strategic theme include:

1. The percentage of patients spending less than four hours in the main Emergency Department has deteriorated by a further 7.2% in October, to 66.6%, associated with a continuation of exceptionally high numbers of patients attending. Other hospitals are experiencing a similar trend; UHS achieved the third best performance out of the 8 major trauma centres we benchmark with (Type 1 attendances) and the sixth best performance out of 15 trusts in South East region (All Types of attendance).

2. Cancer performance did not achieve the targeted timeliness standards in the month of September (this topic is scheduled for a spotlight review in December).
• Patients seen within 2 weeks of referral remained stable, at 81.6% compared to the target of 93%. UHS performance was 15th out of 19 teaching hospital peers. 72% of UHS breaches occurred within the Breast service, where only 29% of patients achieved the standard. Improvement and expansion plans are being implemented but it is likely to take time to deliver improvements in performance.

• Patients starting their first treatment, within 31 days of an agreed decision to treat, deteriorated further to 88.8% compared to the target of 96%. UHS performance was 14th out of 19 teaching hospital peers. The main reason for this deterioration is also within the Breast service (17 of 48 UHS breaches). The treatment volumes delivered have been high, but not sufficient to meet to demand from both GP and screening service referrals, and recent unforeseen surgeon absences limited the potential to increase treatment capacity further. The Divisional team are working with the service to identify solutions that can be implemented prior to the start date of the new consultant surgeon in March.

• Patients treated within 62 days of referral improved by 2.8% to 74.6% compared to the target of 85%, an improvement from 7th to 2nd best amongst 19 of the group of teaching hospitals we benchmark with.

3. Staff sickness (the amount of time absent, expressed in Full Time Equivalents (FTE)) has now risen for the fourth consecutive month and exceeds the 3.4% target. There was 507 FTE of absence in October compared to 396 FTE in October 2020, impacting upon staff availability to deliver services. Anxiety/stress/depression/psychiatric illness continue to be the highest cause of absence (27% of the total), however the sick absence reasons that have increased significantly over the last 4 months are COVID-19 (from 7% to 16% of the total) and Cold/cough/flu (from 4% to 13% of the total). Cold/cough/flu related absence appears to be increasing in line with a typical winter trajectory, whereas this was not observed during 2020/2021.

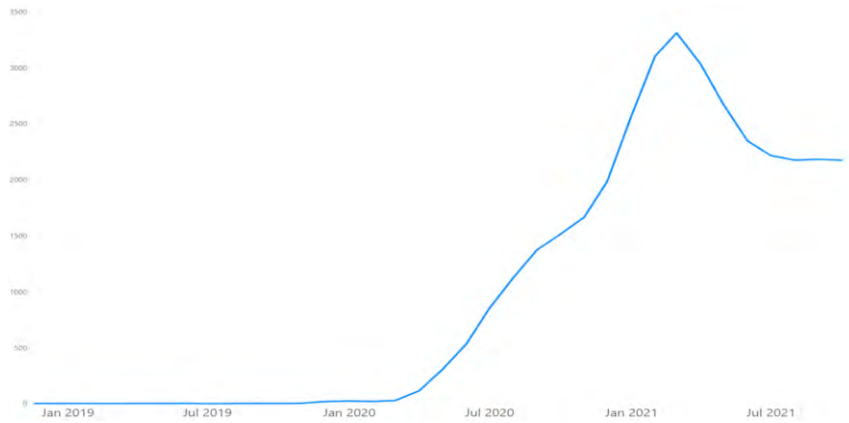
Spotlight Subject - Referral to treatment (RTT) waiting times

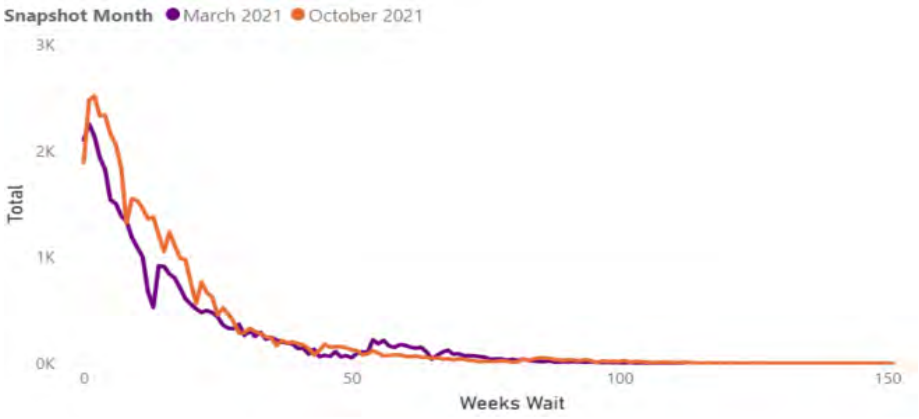
Patients waiting more than 52 and 104 weeks

In October 2021, the total waiting list size increased by 617 patients to 44,749 patients. This has been the second consecutive month to demonstrate a lower rate of increase (compared to increases of 1,500 patients per month reported earlier in the year).

In addition to concern with the total size of the waiting list there is a focus on those patients who have waited longest. NHS operational planning guidance for the second half of 2021/22 requests that no patient waits more than 104 weeks by the end of March 2022 (unless they choose to wait longer) and that the number of patients waiting more than 52 weeks does not exceed the level in September 2021.

Patients waiting more than 52 weeks:
- The number of patients waiting over 52 weeks increased, from 0 prior to the pandemic to 3,300 in March 2021 due to a reduction in capacity and delays throughout referral to treatment pathways (see chart below left).
- Subsequent increases in clinical activity have enabled reduction, followed by stability, in the number of patients waiting. 2,255 patients were waiting over 52 weeks at the end of October 2021.
- Analysis of the waiting list profile between 26 and 52 weeks (see chart below right) indicates no 'spikes' in additions to the 52 week cohort prior to March 2022. The 52 week cohort also includes a significant minority of patients likely to receive treatment in outpatients.
- These features support confidence that we will be able to maintain the current number of patients over 52 weeks, and are likely to achieve modest reductions by the end of March 2022.

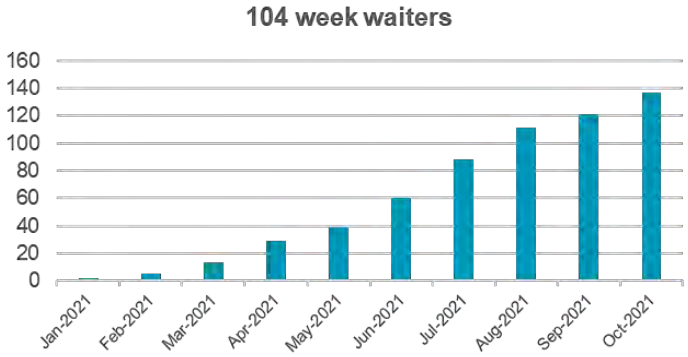


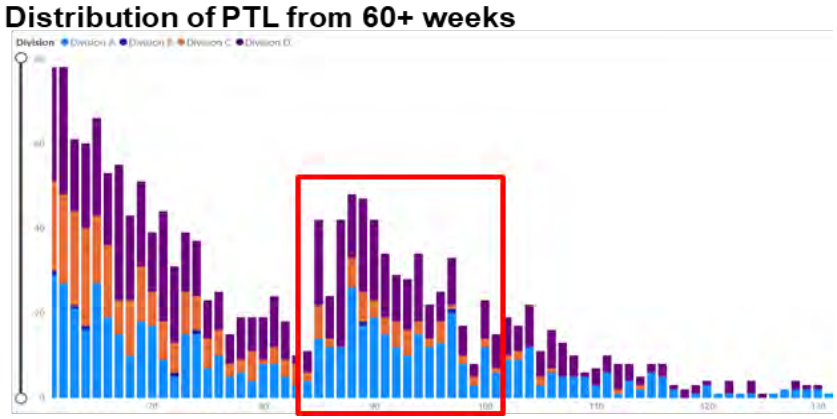


UHS is one of the trusts in the South East region with the greatest proportion of RTT patients waiting over 52 weeks (fourth largest out of 17), though when compared with our regular group of peer teaching hospitals UHS has the 12th largest proportion out of 20.

Patients waiting more than 104 weeks:

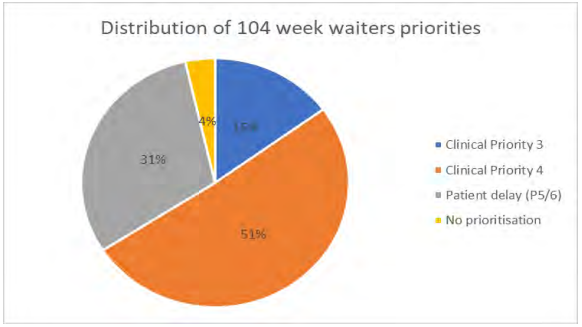
- The number of patients waiting over 104 weeks has grown continuously since February 2021, rising to 137 at the end of October 2021 (see chart below left).
- Almost all such patients are waiting for surgical treatment in either Orthopaedics, ENT or Oral Surgery. The patients typically require admission to an inpatient bed (in some cases a higher care bed) and have conditions with lower clinical urgency than those in other specialities/other conditions within the same speciality. These specialities have been significantly impacted during the pandemic.
- Analysis of the waiting list profile (see chart below right) also indicates that a 'spike' in further additions to the 104 week cohort is anticipated prior to March 2022.
- UHS is committed to no patient waiting more than 104 weeks but recognises very significant risks to our achievement of this, particularly as high numbers of COVID-19 related admissions continue to impact hospital capacity and staffing.





Recent analysis of patients waiting over 104 weeks identified that 31% of such patients currently wish to delay their procedure (due to COVID-19 or other reasons). Whilst these patients do not need to be treated at this time, they might well choose to resume their planned treatment at a future date.

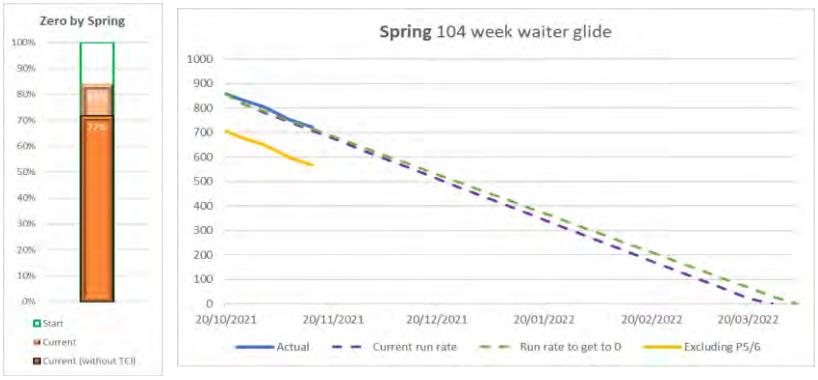
- Over half of the patients waiting over 104 weeks have procedures which have been clinically assessed as 'Priority 4' (the lowest level of clinical urgency within the national framework). See chart to right, Grey = choose to delay, Orange = Priority 4.



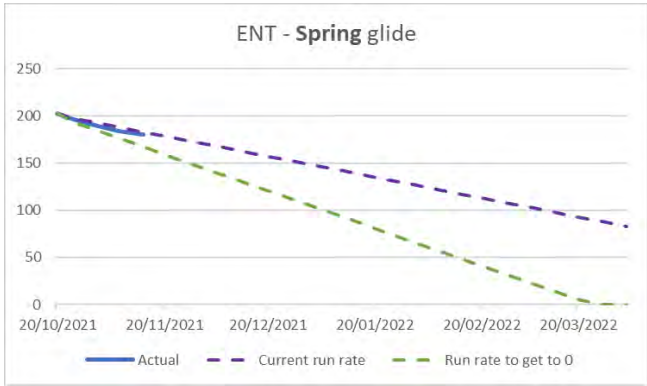
UHS is reporting the largest number of patients waiting over 104 weeks within South East region, though only the eighth largest number amongst 19 of the teaching hospitals within our regular peer group (for which data was available for the end of September 2021).

The Chief Operating Officer's team are 'tracking' all those patients with waiting times that mean they would exceed 104 weeks at the end of March 2022 (if treatment is not provided sooner), and are monitoring progress in reducing the numbers of such patients.

- The Trust level chart for Christmas has deviated from the required trajectory since October 2021, when bed capacity was constrained, theatre capacity needed to be reduced due to high numbers of COVID-19 patients in critical care, and shortfalls in staff availability (see chart below left).
- The Trust level chart for the end of March 2022 demonstrates progress close to the required trajectory at present, and also the potential impact of the number of patients who might choose to wait longer (see chart below right).



It should be anticipated that the rate of progress will slow over time in the absence of additional solutions, as those procedures with fewer complexities are treated at a faster rate, and those requiring greater or more constrained resources remain. Analysis of two specialities (ENT and Orthopaedics) also indicate that their current rate of progress is not sufficient to assure treatment to all the patients who would be waiting over 104 weeks at the end of March 2022 (though some of the patients might choose to wait longer for their own reasons).



The range of actions being progressed, to reinforce and accelerate the treatment of patients who are waiting more that 104 weeks (or with the potential to wait more than 104 weeks), include the following:

ENT

- Information on specific cohorts provided to an Independent Sector hospital, with other cohorts to be shared with Hampshire and Isle of Wight ICS, to enable consideration for these to be offered at other local hospitals with shorter waiting times / greater available capacity
- Consider whether additional operating theatre equipment would enable procedure numbers to return to pre-pandemic levels whilst continuing to undertake enhanced cleaning relating to COVID-19 risks
- Transformation project (ENT 100 days) to improve UHS ENT theatre utilisation

Orthopaedics

- Clinician review of all patients waiting over 80 weeks to consider the potential for treatment to be provided in locations other than Southampton General Hospital (SGH)
- Clinicians to review to identify any patients for whom surgical intervention might no longer be the most appropriate treatment option and for whom an outpatient review should be offered
- Explore with independent sector providers whether there are any opportunities to appropriately expand their normal treatment criteria, and how UHS and independent sector providers could work in collaboration to enable that

Oral Surgery

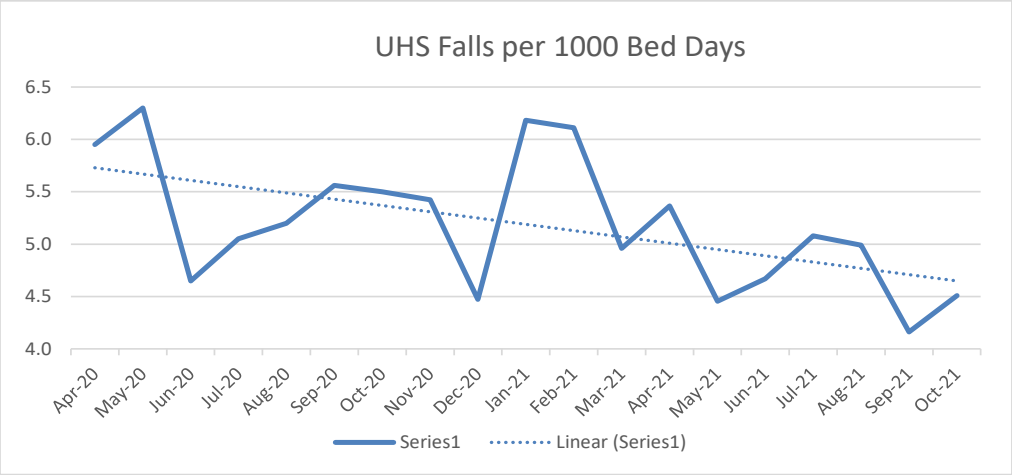
- 104 week waiting patients to be shared amongst UHS consultant team to ensure patients with lower clinical urgency are treated according to the length of wait
- Additional UHS surgeon starting in January 2022 with initial focus on treating existing longer waiting patients planned
- Additional 'dental' operating sessions to be scheduled in December 2021, for an NHS consultant to work as locum at SGH
- Information regarding a cohort of required procedures provided to an NHS hospital to enable consideration for these to be offered there

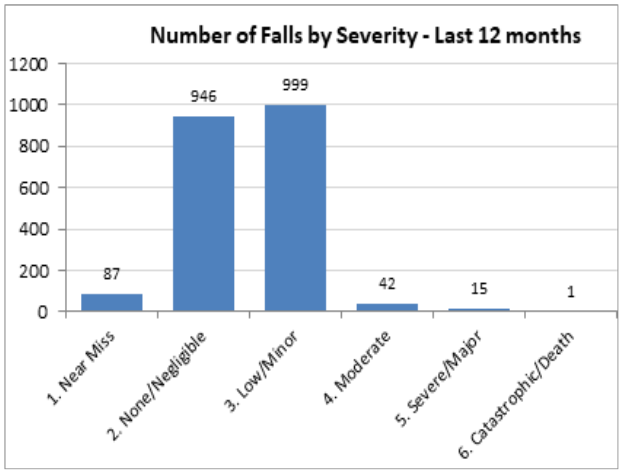
Other Actions

- Seek to bring forward the date of scheduled outpatient appointments, particularly any initial outpatient appointments that have been significantly delayed
- Implement '6/4/2' theatre booking consistently, ensuring patients are given dates 'to come in' with notice, and that all preparations are made prior to the day of admission so that operating lists can proceed with fewer delays between patients or delays to treatment
- Bookings for 'Priority 4' patients are currently restricted to those patients within the 104 week cohort, plus daycase surgery, in order to ensure a focus on the longest waiting patient and to prioritise use of constrained inpatient bed capacity
- Two additional theatres available from November 2021
- Updated UHS action plan to further increase staffing levels through recruitment and retention

Spotlight Subject - Patient Falls

The Trust Board IPR reports the 'Number of high harm falls per 1000 bed days' monthly (measure UT15), this spotlight review considers high harm falls within a wider context and with greater detail.
In the most recent 12 month period, ending October 2021, UHS reported 2,004 patient falls and 87 'near misses' (2,091 incidents in total).
UHS is currently reporting modest improvement in the number of falls per 1000 bed days (see chart below - left) and the number of falls for the most recent 12 months are 13% below the average before the pandemic (falls excluding near misses).
The actual harm caused by any fall is also assessed and recorded (see chart below right). Moderate and severe/major harm most frequently relates to fractures or head injuries. One patient death associated with a fall is currently being investigated by the Significant Incident Scrutiny Group.

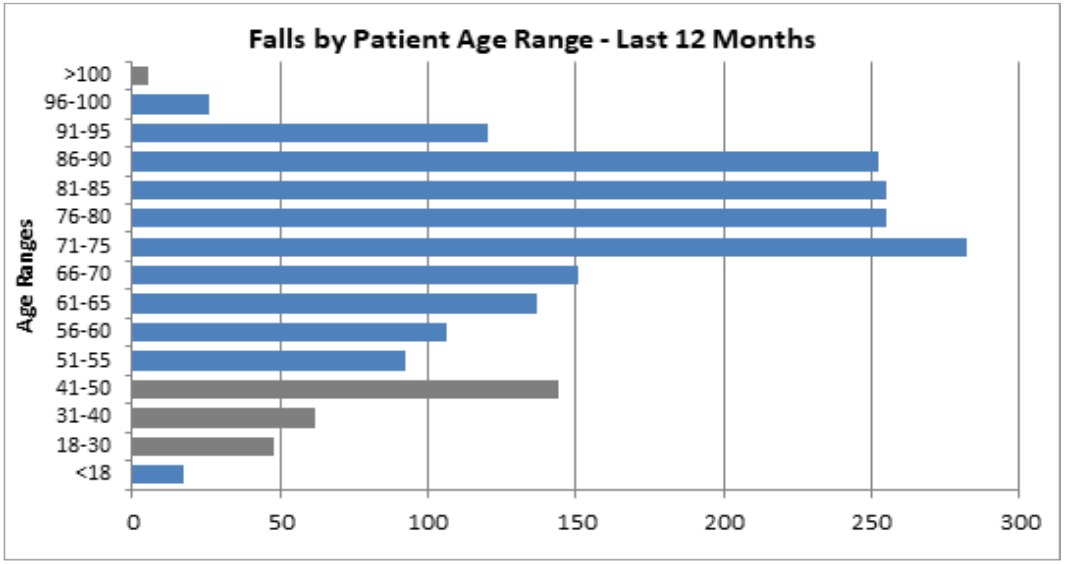




The vast majority of falls occur within inpatient services, within bays, siderooms, bathrooms, toilets or other areas of the ward.
The majority of falls are not witnessed, at least 59% of incidents are explicitly categorised as such.
Limited information recorded within the incident reports for many of the falls makes it more difficult to establish the causes.
45% of all UHS falls occur within the wards for adult medicine and medicine for older people, and the highest rate of falls is within 'medicine for older people' (approximately 15 falls per 1000 bed days) which is reflective of the known risk in the patients with a frailty diagnosis / who have already fallen once.

The chart (right) illustrates the number of falls by the age group of patients.
Frailty in the patient's condition is undoubtedly a significant factor in many falls.
(The number of years in age, and number of bed days, in each group do vary).

Of note are the numbers of falls in the younger age groups that are related to COVID-19.



Current learning from falls resulting in moderate or greater harm includes the following:
- Improved timeliness in the assessment/reassessment of risk, and the actions identified through these assessments, is required
- Opportunities to improve the consistency of patient care after a fall, such as a) manual handling techniques including use of 'HoverJack' to 'lift' patients, b) correct immobilisation in event of suspected spinal injury and c) timely use of radiology to confirm injuries
- An upward trend has been observed in falls occurring to patients who are Medically Optimised For Discharge (MOFD)
- The staffing numbers available sometimes lead to an inability to provide enhanced observation/supervision of patients who are likely to benefit from this
- Adherence to the the falls policy, particularly in relation to the documentation standards, continues to be a concern
- In December 2020 UHS received a Coroners Regulation 28 Report (report on action to prevent other deaths) identifying that the Trust had not implemented NICE guidance relating to head injury management in patients who are on anti-coagulation

Improvements actions in the most recent 12 months include:
- Appointment of Trust falls lead; time for this dedicated role was increased from 0.2 to 1 WTE which is allowing for focused work in clinical areas of high incidence e.g. Medicine for Older People
- Revised Trust policy launched January 2021, reflecting current NICE guidance
- New electronic education package launched September 2021
- Communication campaign associated with falls awareness week in September 2021
- Revision of the falls assessment/care plan documentation
- Introduction of an E-Quest referral system in order for services to secure an urgent medical review 'out of hours' to ensure timely clinical review by an appropriately trained member of staff.

Further improvements planned include:
- Pilot of 'After Action Reviews' at ward level to better establish - Why did the fall occur? and How do we learn from that? (from November 2021)
- Amend ward electronic 'whiteboards' to show the number of falls associated with each patient, to improve staff awareness/communication about high risk patients with a focus to prevent further falls
- Redesign the 'Falls Champion' programme to enhance falls education at ward level
- Review of falls that occur for patients who have been Medically Optimised For Discharge where the fall leads to an extended stay in hospital
- Develop links with the Integrated Discharge Bureau, relating to the consideration of falls risk and discharge planning
- Consider relaunch of 'eat, drink, move' as part of a focus on avoiding 'de-conditioning' as 'PJ Paralysis' has been well recognised as a contributing factor to being at a high risk of falls
- Change the radiology policy and documentation to improve communication and escalation of concerns
- Optimise the transition to electronic, rather than paper, documentation of patient assessments, using this to prompt reassessments and support individualised care
- Establish dedicated medical time (within job plan) to support falls improvement work Trustwide
- Create a falls quality improvement group to further support service evaluation and audit
- Focus on reduction of all falls, using a targeted approach (targeted using electronic assessments) for those assessed as high risk who will be reviewed and the ward supported by the falls practitioner with an aspiration to prevent high harm falls.

Spotlight Subject - Ambulance Handovers

Prompt handover of responsibility for the care of patients from ambulances to Emergency Departments is important. As well as securing timely and appropriate assessment of each patient being taken to an Emergency Department (ED), handover enables ambulance service staff to resume their response to health emergencies within the community.

We work closely with South Central Ambulance Service (SCAS) to minimise their handover times at UHS.
We make a conscious choice not to queue ambulances at UHS, even though this may adversely impact our Emergency Department occupancy, staffing and performance.

UHS performance regarding ambulance handover times is typically amongst the best in the NHS, for example a snapshot of (unvalidated) situation report data for South East region on 22nd November 2021 shows:
- 85 x 60 minute handover delays, only one of which was at UHS
- 204 x 30-60 minute handover delays, of which 11 were at UHS (UHS was the trust with the joint lowest number)

The table on the following page provides a summary of recent UHS performance. Over that period 5.9% of clinical handovers were recorded taking more than 30 minutes, and 0.5% of clinical handovers more than 60 minutes.

In order to achieve consistent ambulance handover times, and an avoidance of ambulance queues, UHS has invested in staffing in order to be able to care for additional patients inside the ED. Whilst the pressure at UHS may not be immediately apparent to system partners our ED 'Majors' department sometimes reaches 200% occupancy, and additional staff are available at busy times to assess and care for patients within the clinical department corridor space until a treatment room or cubicle becomes available.

Board members will recall that we are currently in Phase 2 of building work within the ED, with both phases increasing the capacity available in ED rooms and cubicles.

Week beginning	No. of Emergency Handovers	No. of Urgent Handovers	Total Handovers	Average Emergency Handover Time	Average Urgent Handover Time	Number of Handovers >30mins	Number of Handovers >60mins
20-Sep	780	40	820	17.07	19.43	41	3
27-Sep	846	40	886	17.06	18.19	41	3
04-Oct	874	33	907	18.01	18.06	65	2
11-Oct	838	39	877	19.12	21.12	58	11
18-Oct	769	52	821	17.48	19.31	47	0
25-Oct	747	45	792	18.03	19.47	50	3
Totals	**4,854**	**249**	**5,103**			**302**	**22**
Average	*809*	*42*	*851*	*18*	*19*	*50*	*4*

Note - Extended handover times may include some occasions when ambulance crews are able and choose to remain with a patient for longer than the minimum time required for clinical handover, in addition to periods when surges in 'pitstop' arrivals mean that physical space and staff within that clinical assessment area are temporarily fully occupied.

NHS Constitution - Standards for Access to services within waiting times

The NHS Constitution* and the Handbook to the NHS Constitution** together set out a range of rights to which people are entitled, and pledges that the NHS is committed to achieve, including:

The right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible

- Start your consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions
- Be seen by a cancer specialist within a maximum of 2 weeks from GP referral for urgent referrals where cancer is suspected

The NHS pledges to provide convenient, easy access to services within the waiting times set out in the Handbook to the NHS Constitution

- All patients should receive high-quality care without any unnecessary delay
- Patients can expect to be treated at the right time and according to their clinical priority. Patients with urgent conditions, such as cancer, will be able to be seen and receive treatment more quickly

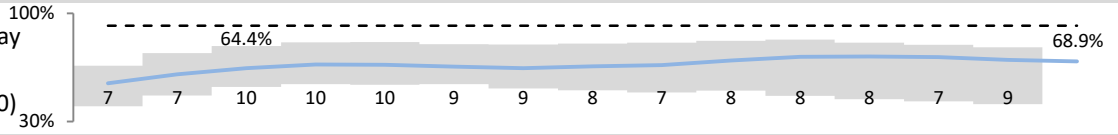
The handbook lists 11 of the government pledges on waiting times that are relevant to UHS services, such pledges are monitored within the organisation and by NHS commissioners and regulators.

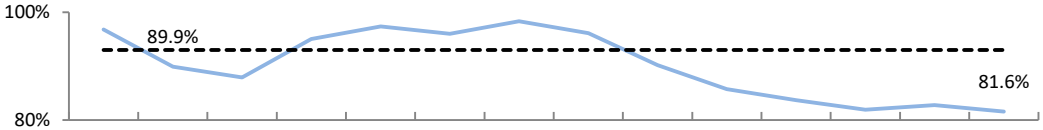
Performance against the NHS rights, and a range of the pledges, is summarised below. Further information is available within the Appendix to this report.

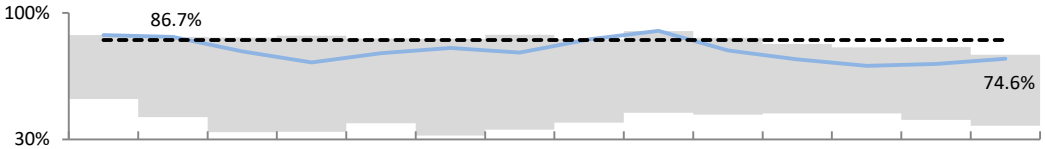
* https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

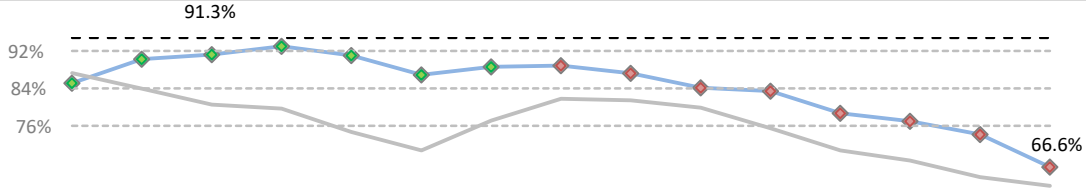
** https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england

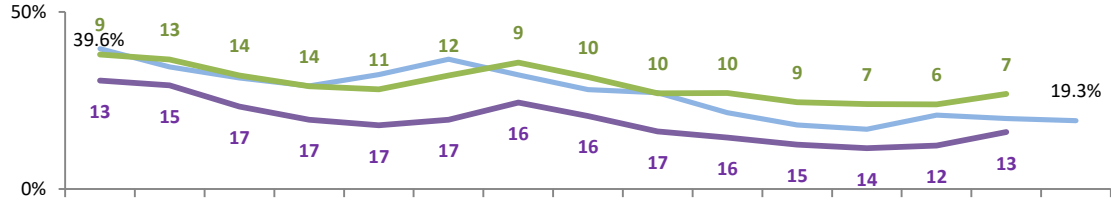
		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD
UT28-N	% Patients on an open 18 week pathway (within 18 weeks) with teaching hospital min-max range and rank (of 20)	7	7	10	10	10	9	9	8	7	8	8	8	7	9		≥92%	
CN1-N	% Patients following a GP referral for suspected cancer seen by a specialist within 2 weeks																≥93%	
UT34-N	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Latest data held by UHS) with teaching hospital min-max range and rank (of 20)																≥85%	-
UT25-N	Patients spending less than 4hrs in ED - SGH Main ED (Type 1 and UCH) Major Trauma Centres (Type 1) Rank of 8->	4	2	2	1	1	1	2	3	3	3	3	3	3	1	3	≥95%	-
UT33-N	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching Hospital average (& rank of 20) South East Average (& rank of 18)																≤1%	-







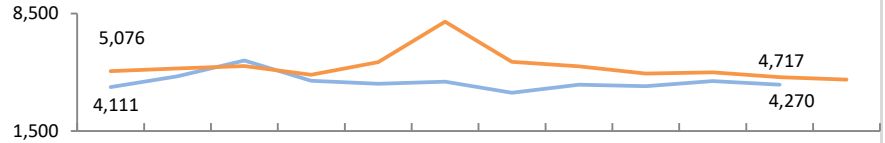


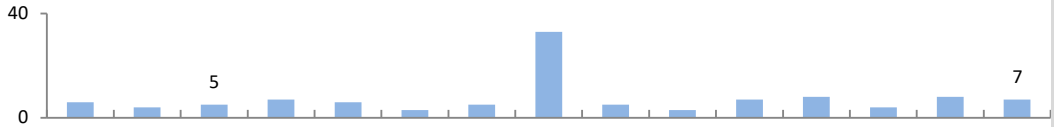


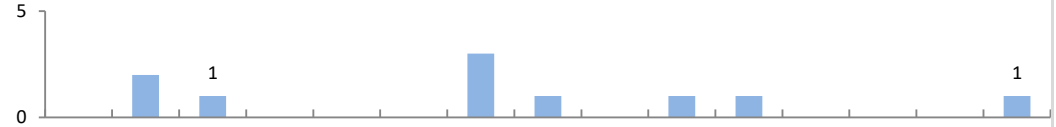
Outcomes		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
UT1-N	HSMR - **UHS** HSMR - **SGH**	83 78.8 78.3 73															≤100		
UT2	HSMR - Crude Mortality Rate	3.1% 2.9% 2.6%															-		
UT3	Percentage non-elective readmissions within 28 days of discharge from hospital	15% 11.82% 10%														10.70%	-		
UT4-L	Cumulative Specialties with Outcome Measures Developed	56 285			56 305				57 332			61 396			63 406		+1		
UT5	Developed Outcomes RAG ratings	100% 75% 50%	79%			77%			76%			80%			78%		-		

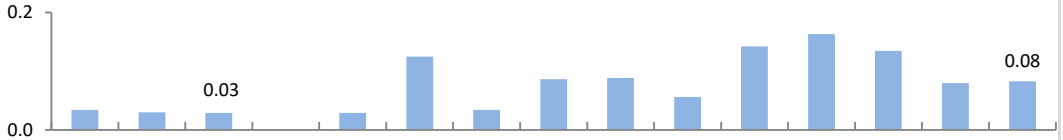
Safety		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
UT6-N	Cumulative Clostridium difficile This year vs. last year	42 50	48 52	54 55	60 57	70 63	5 7	11 16	15 21	18 25	32 33	39 39	43 43				5	43	≤35
UT7	**Healthcare-acquired COVID infection**: COVID-positive sample taken >14days after admission (validated)	0	0	8	0	10	39	2 2	5	0	0	0	3	0	7	6	-	16	-
UT8	**Probable hospital-associated COVID infection**: COVID-positive sample taken >7 days and <=14 days after admission (validated)	0	0	7	2	6	59	2	2	1	0	0	0	4	3	9	-	17	-
UT9	Pressure ulcers category 2 per 1000 bed days			0.26												0.50	-	-	-
UT10	Pressure ulcers category 3 and above per 1000 bed days			0.38												0.22	-	-	-
UT11-N	Medication Errors (severe/Moderate)			2												3	≤3	17	≤21

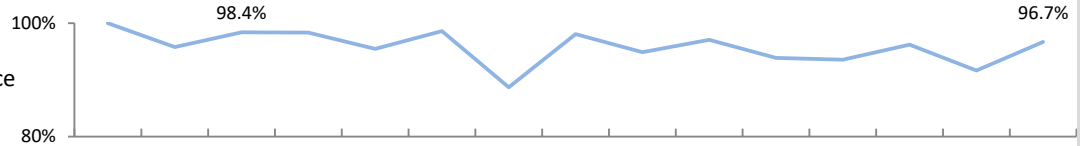
		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
UT12	Antibiotic usage per 1000 admissions This year vs. last year																-	-	-
UT13	Serious Incidents Requiring Investigation (SIRI) (based upon month reported as SIRI, excluding Maternity)																-	42	-
UT14	Serious Incidents Requiring Investigation - Maternity																-	-	-
UT15	Number of high harm falls per 1000 bed days																-	-	-
UT16	% patients with a nutrition plan in place																-	-	-
UT17	Red Flag staffing incidents																-	-	-

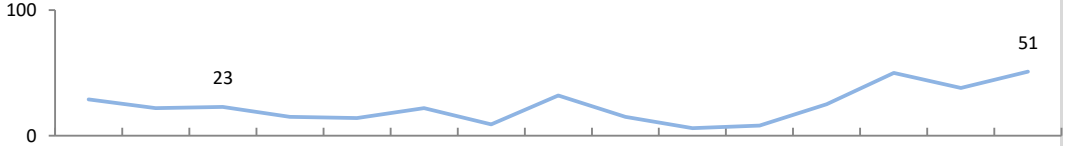












Patient Experience		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
UT18-N	FFT Negative Score - Inpatients	5%		0.5%												0.4%	≤5%	-	-
UT19-N	FFT Negative Score - Maternity	5%		8.7%												10.3%	≤5%	-	-
UT20	Total UHS women booked onto a continuity of carer pathway	100% 0%		45.4%												38.7%	-	-	-
UT21	Total BAME women booked onto a continuity of carer pathway	100% 0%		75.4%												38.0%	-	-	-
UT22	% Patients reporting being involved in decisions about care and treatment	100% 50%		87.0%												87.0%	≥90%	-	-
UT23	% Patients with a disability/ additional needs reporting those needs/adjustments were met (total number questioned included at chart base)	100% 75%		98.0%												91.0%	≥90%	-	-
				133	164	174	178	240	77	63	110	289	251	266	269	173	133	125	
UT23 - Performance is a scored metric with a "Yes" response scoring 1, "Yes, to some extent" receiving 0.5 score and other responses scoring 0.																			
UT24	Overnight ward moves with a reason marked as non-clinical (excludes moves from admitting wards with LOS<12hrs)	100 0		24												22	-	-	-
		73.05																	
		36.79																	
		0.53																	

Access Standards		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
UT25-N	Patients spending less than 4hrs in ED - SGH Main ED (Type 1 and UCH) Major Trauma Centres (Type 1) Rank of 8->	92%	91.3%	84%												66.6%	≥95%	-	-
		76%	4	2	2	1	1	1	2	3	3	3	3	3	3	1	3			
UT26	Average (Mean) time in Dept - non-admitted patients	05:00	02:29													03:37	-	-	-
		01:00																	
UT27	Average (Mean) time in Dept - admitted patients	06:00	03:34													05:07	-	-	-
		01:00																	
UT28-N	% Patients on an open 18 week pathway (within 18 weeks) with teaching hospital min-max range and rank (of 20)	100%	64.4%													68.9%	≥92%		
		30%	7	7	10	10	10	9	9	8	7	8	8	8	7	9			
UT29	Total number of patients on a waiting list (18 week referral to treatment pathway)	45,000	36,128													44,749	-	-	-
		34,000																	
UT30	Patients on an open 18 week pathway (waiting 52 weeks+) with teaching hospital min-max range and rank (of 20)	21,000	1,693													2,255	-	-	-
		0	11	10	9	6	6	6	5	4	4	4	6	7	7	7			

		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
UT31	Patients on an open 18 week pathway (waiting 104 weeks+) with teaching hospital min-max range and rank (of 20)	1,300 / 0		0						12	12	12	12	11	8	137	-	-	-
UT32	Patients waiting for diagnostics	11,000 / 4,000		9,361												9,129	-	-	-
UT33-N	% of Patients waiting over 6 weeks for diagnostics UHSFT Teaching Hospital average (& rank of 20) South East Average (& rank of 18)	50% / 0%	39.6%	9 / 13	13 / 15	14 / 17	14 / 17	11 / 17	12 / 17	9 / 16	10 / 16	10 / 17	10 / 16	9 / 15	7 / 14	6 / 12	7 / 13	19.3%	≤1%	-	-
UT34-N	Cancer waiting times 62 day standard - Urgent referral to first definitive treatment (Latest data held by UHS) with teaching hospital min-max range and rank (of 20)	100% / 30%		86.7%												74.6%	≥85%	-	-
UT35-N	31 day cancer wait performance - decision to treat to first definitive treatment (Latest data held by UHS) with teaching hospital min-max range and rank (of 20)	100% / 80%		96.3%												88.8%	≥96%	-	-
UT36-N	31 day cancer wait performance - Subsequent Treatments of Cancer (Latest data held by UHS) with teaching hospital min-max range and rank (of 20)	100% / 70%		97.5%												93.2%	≥95.4%		
				4	6	9	15	15	14	11	8	11	12	12	13	9	16				
UT36-N	September performance reflects latest data held by UHS following validation, rather than that held on the date of initial national submission, the national submission will be corrected at the scheduled resubmission date for Q2																		

		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
PN1-L	Comparative CRN Recruitment Performance - non-weighted		5			9			10			10	9	10	9	9	Top 10		
PN2-L	Comparative CRN Recruitment Performance - weighted		2			7			8			5	3	4	3	3	Top 5		
PN3-L	Comparative CRN Recruitment - contract commercial		17			7			2			12	11	4	4	3	Top 10		
PN4-L	Achievement compared to R+D Income Baseline Monthly income increase % YTD income increase %		350% -50%							46.0%	-22.0%	152.0%	45.0%	143.0%	-5.0%	334.0% 99.0%	≥5%		

Workforce Capacity

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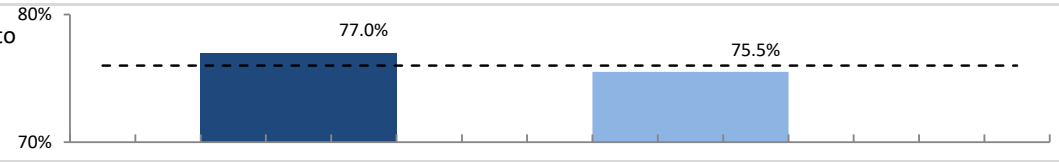
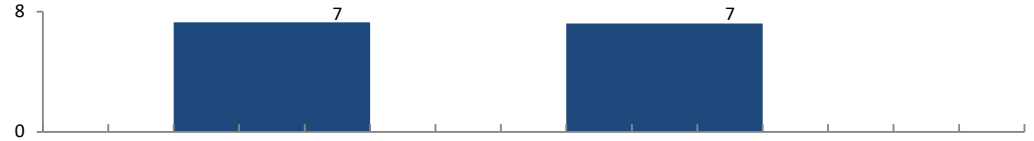
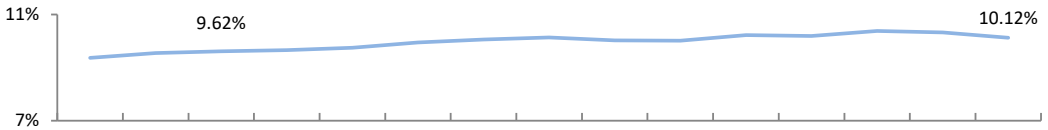
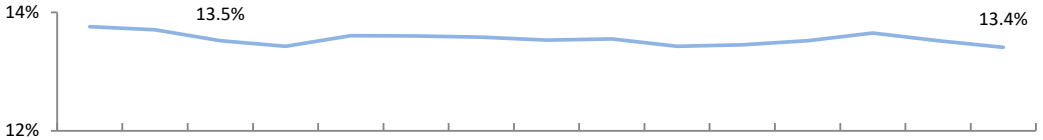
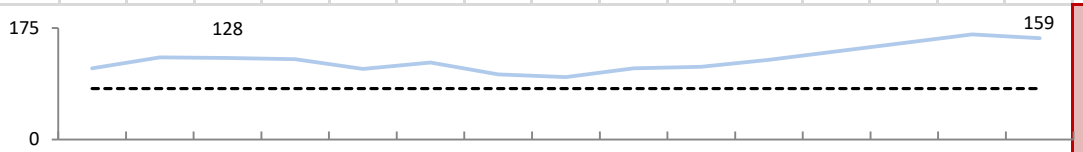
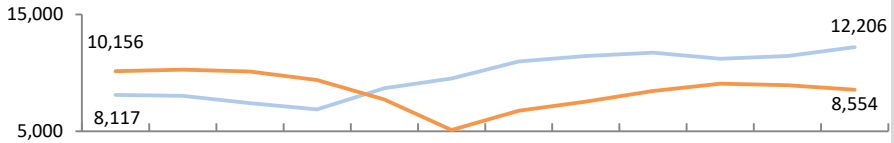
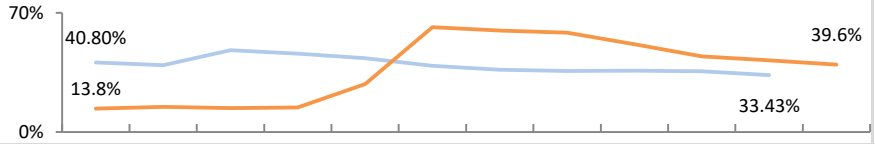
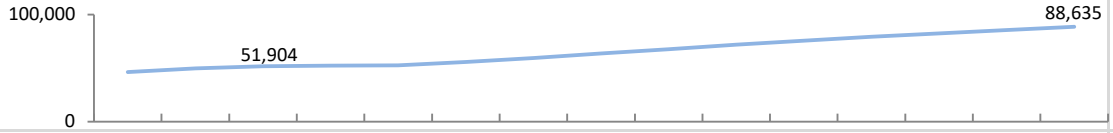
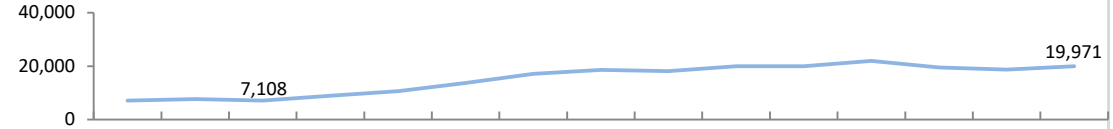
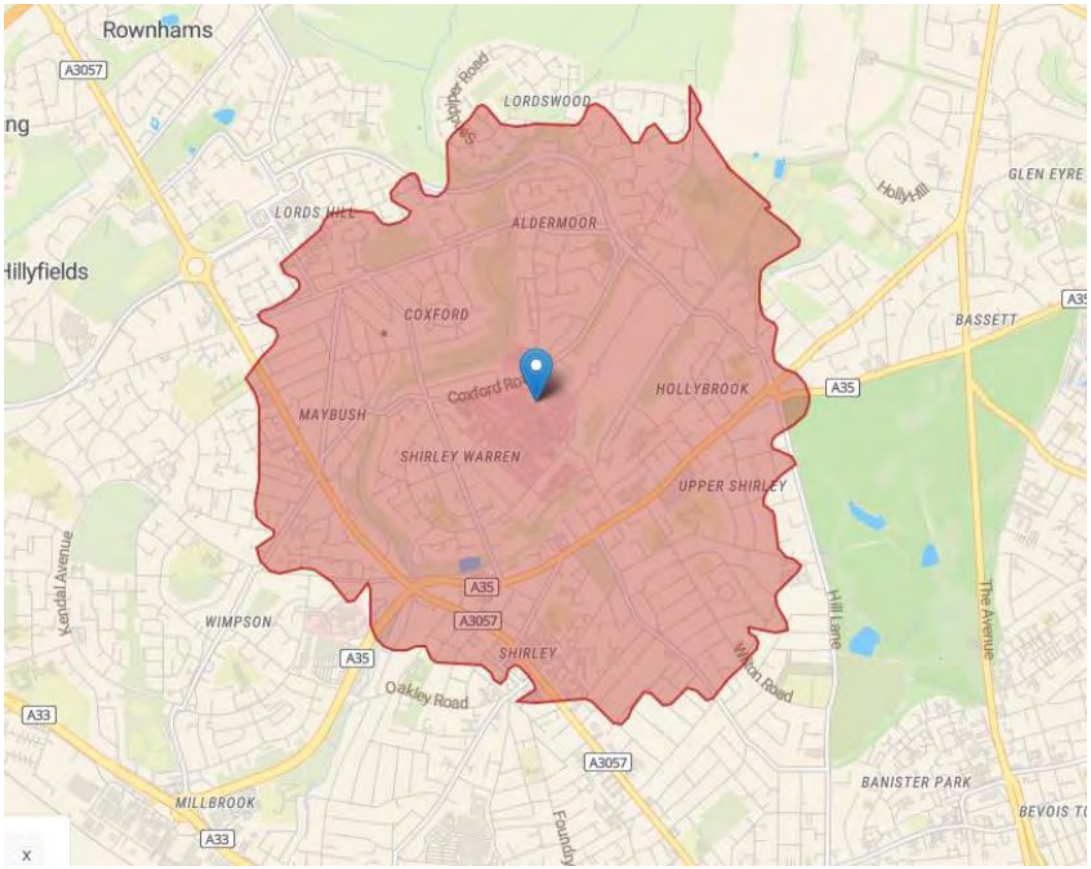
WR7-L	% of staff recommend UHS as a place to work: UHS Quarterly staff FFT National NHS Staff Survey		>=76%		
			Monthly target	YTD	YTD target
WR8-L	Staff survey engagement score National NHS Staff Survey				
WR8-L - Maximum score = 10, Average of “Acute and Acute&Community”, group is 7					
Compassion and Inclusion					
WR9-L	% of Band 7+ staff who are Black and Minority Ethnic		15% by 2023		
WR10	% of Band 7+ Staff who have declared a disability or long term health condition		-		
WR11	Pulse survey % of staff recommend UHS as a place to work- White British staff compared with all other ethnic groups combined	In development - expected December 2021			
WR12	Pulse survey % of staff recommend UHS as a place to work- Disabled compared with non disabled / prefer not to answer	In development - expected December 2021			
WR13	Pulse survey % of staff recommend UHS as a place to work- Sexuality = Heterosexual compared with all other groups combined	In development - expected December 2021			

Local Integration		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
NT1	Number of inpatients that were medically optimised for discharge (monthly average)																≤80	-	-
NT2	Emergency Department activity - type 1 This year vs. last year																-	-	-
NT3	Percentage of virtual appointments as a proportion of all outpatient consultations This year vs. last year																-	-	-

Digital		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
FN1	My Medical Record - UHS patient accounts																-		
FN2	My Medical Record - UHS patient logins																-		
FN3	Patients choosing digital correspondence	In development															-		
FN4	Reduction in transcription through implementation of voice recognition software	In development															-		
Our Role in the Community																			
FN7	Percentage of staff residing in deprived areas (lowest 30% - national Index of Multiple Deprivation)																-		

		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Monthly target	YTD	YTD target
FN6	Percentage of staff living locally (within a 20 minute walk of main hospital site, **map below**)	100.0% / 50.0% / 0.0%														17.6%			



Report notes - Nursing and midwifery staffing hours - October 2021

Our staffing levels are continuously monitored and we will risk assess and manage our available staff 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. In acute assessment units, where patients are admitted , assessed and moved to wards or theatre very swiftly, the CHPPD figures are not appropriate to compare.

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. For the first time we have included both mothers and babies in our occupancy levels which will have impacted the care hours per patient day for comparison in previous months.

Throughout COVID-19, a growing number of our clinical areas started to move and change specialty and size to respond to the changing situation (e.g. G5-G9, Critical Care and C5). With the evolving COVID-19 position since April 2021 these wards had in the main returned to their normal size and purpose. During September and October 2021 COVID-19 numbers have started to rise again and wards and departments have again been required to change focus and form to respond to changing circumstances. These decisions are sometimes swift in nature and the data in some cases therefore may not be fully reflective of all of these changes.

Wards Full Name		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered midwives/ nurses	CHPPD Care Staff	CHPPD Overall	Comments
CC Neuro Intensive Care Unit	Day	5498	4390	1019	815	79.9%	80.0%	28.2	4.7	32.9	Beds flexed to match staffing. Staff moved to support other wards. Staff moved to GICU each shift.
CC Neuro Intensive Care Unit	Night	5478	4464	829	650	81.5%	78.5%				Beds flexed to match staffing. Staff moved to support other wards. Staff moved to GICU each shift.
CC - Surgical HDU	Day	2188	1527	734	638	69.8%	87.0%	18.4	6.4	24.8	Beds flexed to match staffing. Staff moved to support other wards. Staff moved to GICU each shift.
CC - Surgical HDU	Night	2142	1547	710	426	72.2%	60.0%				Beds flexed to match staffing. Staff moved to support other wards. Staff moved to GICU each shift.
CC General Intensive Care	Day	11551	10200	2062	1451	88.3%	70.4%	27.6	3.9	31.4	Beds flexed to match staffing. Additional beds open in the month. 13 covid patients in addition to usual activity.
CC General Intensive Care	Night	10480	9885	1866	1368	94.3%	73.3%				Beds flexed to match staffing. Additional beds open in the month. 13 covid patients in addition to usual activity.
CC Cardiac Intensive Care	Day	19237	16117	3814	2904	83.8%	76.1%	27.1	5.5	32.5	Beds flexed to match staffing. Staff moved to support other wards. Staff moved to GICU each shift.
CC Cardiac Intensive Care	Night	18100	15895	3404	2444	87.8%	71.8%				Beds flexed to match staffing. Staff moved to support other wards. Staff moved to GICU each shift.
SUR E5 Lower GI	Day	1461	1352	755	1094	92.5%	145.0%	4.0	3.6	7.6	Band 4 staff working to support registered nurse numbers. Support workers used to maintain staffing numbers. Medical ward at present.
SUR E5 Lower GI	Night	718	710	357	769	98.9%	215.8%				Band 4 staff working to support registered nurse numbers. Support workers used to maintain staffing numbers. Medical ward at present.
SUR E5 Upper GI	Day	1491	1263	810	1008	84.7%	124.4%	3.9	3.1	7.0	Band 4 staff working to support registered nurse numbers. Support workers used to maintain staffing numbers. Medical ward at present.
SUR E5 Upper GI	Night	702	727	357	575	103.6%	161.2%				Band 4 staff working to support registered nurse numbers. Support workers used to maintain staffing numbers. Medical ward at present.
SUR E8 Ward	Day	2070	2352	1587	1245	113.6%	78.4%	4.7	3.1	7.9	Support workers used to maintain staffing numbers. Under pressure from critical care admissions.
SUR E8 Ward	Night	1339	1201	1192	1101	89.7%	92.4%				Band 4 staff working to support registered nurse numbers. Support workers used to maintain staffing numbers.
SUR F11 IF	Day	1979	1726	795	627	87.2%	78.8%	4.7	2.6	7.3	Support workers used to maintain staffing numbers.
SUR F11 IF	Night	713	713	714	711	100.0%	99.5%				Support workers used to maintain staffing numbers.
SUR Acute Surgical Unit	Day	1492	1066	735	727	71.4%	98.9%	7.6	4.2	11.8	Support workers used to maintain staffing numbers. Under extreme emergency pressure.
SUR Acute Surgical Unit	Night	714	743	713	269	104.1%	37.7%				Support workers used to maintain staffing numbers.
SUR Acute Surgical Admissions	Day	2202	1814	867	1070	82.4%	123.4%	3.7	2.7	6.4	Band 4 staff working to support registered nurse numbers. Support workers used to maintain staffing numbers.
SUR Acute Surgical Admissions	Night	1064	1031	1051	1002	96.9%	95.3%				Band 4 staff working to support registered nurse numbers. Support workers used to maintain staffing numbers.
SUR F5 Ward	Day	1960	1656	1048	1054	84.5%	100.6%	3.9	2.5	6.4	Band 4 staff working to support registered nurse numbers. Support workers used to maintain staffing numbers.
SUR F5 Ward	Night	1160	1055	714	714	91.0%	100.0%				Band 4 staff working to support registered nurse numbers. Support workers used to maintain staffing numbers.

Wards Full Name		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered midwives/ nurses	CHPPD Care Staff	CHPPD Overall	Comments
CAN C4 Solent Ward Clinical Oncology	Day	1375	1439	1019	1048	104.6%	102.9%	3.7	3.3	7.0	Additional staff used for enhanced care - Support workers. Additional staff used for enhanced care - Support workers.
CAN C4 Solent Ward Clinical Oncology	Night	1061	854	704	1014	80.4%	144.1%				Increased night staffing to support raised acuity. Band 4 staff working to support registered nurse numbers. Additional staff used for enhanced care - Support workers.
CAN C6 Leukaemia/BMT Unit	Day	2862	2654	187	319	92.7%	170.7%	7.2	0.9	8.2	Additional staff used for enhanced care - Support workers.
CAN C6 Leukaemia/BMT Unit	Night	2038	1974	0	263	96.9%	Shift N/A				Safe staffing levels maintained by sharing staff resource.
CAN C6 TYA Unit	Day	793	804	342	170	101.4%	49.7%	9.0	1.3	10.3	Safe staffing levels maintained by sharing staff resource. Staff moved to support other wards.
CAN C6 TYA Unit	Night	673	698	0	44	103.7%	Shift N/A				Additional staff used for enhanced care - RNs. Safe staffing levels maintained by sharing staff resource.
CAN C2 Haematology	Day	2261	2613	1133	1071	115.6%	94.5%	5.8	2.7	8.5	Safe staffing levels maintained by sharing staff resource.
CAN C2 Haematology	Night	1761	2051	1072	1079	116.4%	100.6%				Safe staffing levels maintained by sharing staff resource.
CAN D3 Ward	Day	1800	1772	735	993	98.4%	135.1%	4.4	3.1	7.5	Additional staff used for enhanced care - Support workers.
CAN D3 Ward	Night	1044	1034	706	990	99.0%	140.3%				Additional staff used for enhanced care - Support workers.
ECM Acute Medical Unit	Day	4024	4178	3972	3212	103.8%	80.9%	7.5	5.1	12.6	Safe staffing levels maintained. Increase in acuity/dependency of patients in the month. Patient requiring 24 hour 1:1 nursing in the month. Skill mix swaps undertaken to support safe staffing across the Unit.
ECM Acute Medical Unit	Night	4033	4767	3566	2953	118.2%	82.8%				Safe staffing levels maintained. Increase in acuity/dependency of patients in the month. Patient requiring 24 hour 1:1 nursing in the month. Skill mix swaps undertaken to support safe staffing across the Unit.
MED D5 Ward	Day	1238	1487	1747	1216	120.1%	69.6%	3.0	2.8	5.8	Skill mix swaps undertaken to support safe staffing across the Unit.
MED D5 Ward	Night	1071	1049	946	1095	98.0%	115.8%				Additional staff used for enhanced care - Support workers.
MED D6 Ward	Day	1040	1156	1525	1306	111.1%	85.6%	3.1	3.1	6.2	Skill mix swaps undertaken to support safe staffing across the Unit.
MED D6 Ward	Night	714	1015	947	878	142.2%	92.7%				Increased night staffing to support raised acuity.
MED D7 Ward	Day	708	901	1214	974	127.3%	80.2%	3.3	3.0	6.4	Staff moved to support other wards. Band 4 staff working to support registered nurse numbers.
MED D7 Ward	Night	713	691	357	475	96.8%	133.1%				Safe staffing levels maintained. Increase in acuity/dependency of patients in the month.
MED D8 Ward	Day	1061	1255	1514	1132	118.2%	74.8%	3.3	3.0	6.4	Increase in acuity/dependency of patients in the month. Patient requiring 24 hour 1:1 nursing in the month.
MED D8 Ward	Night	713	1070	1301	997	150.1%	76.6%				Increase in acuity/dependency of patients in the month. Patient requiring 24 hour 1:1 nursing in the month.
MED D9 Ward	Day	1236	1513	1758	1198	122.4%	68.2%	3.0	2.5	5.5	Increase in acuity/dependency of patients in the month. Patient requiring 24 hour 1:1 nursing in the month.
MED D9 Ward	Night	1058	980	924	865	92.6%	93.6%				Increase in acuity/dependency of patients in the month. Patient requiring 24 hour 1:1 nursing in the month.
MED E7 Ward	Day	1051	1357	1299	1182	129.1%	91.0%	3.1	2.8	5.9	Increase in acuity/dependency of patients in the month. Patient requiring 24 hour 1:1 nursing in the month.
MED E7 Ward	Night	714	1048	1075	988	146.7%	91.9%				Increase in acuity/dependency of patients in the month. Patient requiring 24 hour 1:1 nursing in the month.
MED Respiratory HDU	Day	2380	1218	543	152	51.2%	28.0%	15.9	2.7	18.6	Staffing appropriate for number of patients. Safe staffing levels maintained.
MED Respiratory HDU	Night	2148	1260	357	268	58.7%	75.2%				Staffing appropriate for number of patients. Safe staffing levels maintained.
MED C5 Isolation Ward	Day	1179	1387	1133	576	117.6%	50.8%	8.3	4.0	12.3	Increase in acuity/dependency of patients in the month. Safe staffing levels maintained.
MED C5 Isolation Ward	Night	1050	1192	357	670	113.5%	188.0%				Increase in acuity/dependency of patients in the month. Band 4 staff working to support registered nurse numbers. Safe staffing levels maintained.
MED D10 Isolation Unit	Day	1111	880	1455	1170	79.1%	80.4%	3.1	3.7	6.8	Safe staffing levels maintained. Increase in acuity/dependency of patients in the month.
MED D10 Isolation Unit	Night	713	725	726	750	101.6%	103.3%				Safe staffing levels maintained. Increase in acuity/dependency of patients in the month.
MED G5 Ward	Day	1425	1437	1638	1538	100.8%	93.8%	3.0	2.6	5.6	Band 4 staff working to support registered nurse numbers. Increase in acuity/dependency of patients in the month. Additional beds open in the month.
MED G5 Ward	Night	1071	1048	713	679	97.9%	95.2%				Patient requiring 24 hour 1:1 nursing in the month. Skill mix swaps undertaken to support safe staffing across the Unit. Additional beds open in the month.
MED G6 Ward	Day	1496	1170	1667	1489	78.2%	89.3%	3.2	3.3	6.5	Band 4 staff working to support registered nurse numbers. Increase in acuity/dependency of patients in the month. Safe staffing levels maintained by sharing staff resource.
MED G6 Ward	Night	1070	932	713	699	87.1%	98.0%				Safe staffing levels maintained by sharing staff resource. Increase in acuity/dependency of patients in the month. Skill mix swaps undertaken to support safe staffing across the Unit.
MED G7 Ward	Day	718	700	1120	903	97.5%	80.6%	3.8	4.1	7.9	Band 4 staff working to support registered nurse numbers. Increase in acuity/dependency of patients in the month. Safe staffing levels maintained by sharing staff resource.
MED G7 Ward	Night	716	671	713	564	93.7%	79.0%				Skill mix swaps undertaken to support safe staffing across the Unit. Increase in acuity/dependency of patients in the month. Safe staffing levels maintained by sharing staff resource.
MED G8 Ward	Day	1516	1053	1785	1323	69.5%	74.1%	3.7	3.8	7.5	Band 4 staff working to support registered nurse numbers. Increase in acuity/dependency of patients in the month. Safe staffing levels maintained by sharing staff resource.
MED G8 Ward	Night	1071	933	713	733	87.1%	102.8%				Band 4 staff working to support registered nurse numbers. Increase in acuity/dependency of patients in the month. Safe staffing levels maintained by sharing staff resource.
MED G9 Ward	Day	1396	1417	1820	1484	101.5%	81.5%	3.9	3.5	7.4	Band 4 staff working to support registered nurse numbers. Increase in acuity/dependency of patients in the month. Safe staffing levels maintained by sharing staff resource.
MED G9 Ward	Night	1071	1128	713	782	105.4%	109.7%				Band 4 staff working to support registered nurse numbers. Increase in acuity/dependency of patients in the month. Safe staffing levels maintained by sharing staff resource.
MED Bassett Ward	Day	1353	995	2478	2048	73.5%	82.7%	2.6	3.9	6.5	Patient requiring 24 hour 1:1 nursing in the month. Additional staff used for enhanced care - Support workers. Additional beds open in the month.
MED Bassett Ward	Night	1058	1013	1069	1024	95.7%	95.8%				Patient requiring 24 hour 1:1 nursing in the month. Additional staff used for enhanced care - Support workers. Additional beds open in the month.

Wards Full Name		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered midwives/ nurses	CHPPD Care Staff	CHPPD Overall	Comments
CHI High Dependency Unit	Day	1601	1323	0	0	82.6%	Shift N/A	13.2	0.0	13.2	Non-ward based staff supporting areas.
CHI High Dependency Unit	Night	1070	1119	0	0	104.6%	Shift N/A				Safe staffing levels maintained.
CHI Paed Medical Unit	Day	1963	1863	773	705	94.9%	91.2%	10.4	3.5	13.9	Safe staffing levels maintained.
CHI Paed Medical Unit	Night	1707	1703	682	487	99.8%	71.3%				Safe staffing levels maintained.
CHI Paediatric Intensive Care	Day	6410	5679	722	255	88.6%	35.3%	25.1	1.9	27.0	Beds flexed to match staffing. Non-ward based staff supporting areas. Safe staffing levels maintained.
CHI Paediatric Intensive Care	Night	5704	5204	713	557	91.2%	78.1%				Safe staffing levels maintained.
CHI Piam Brown Unit	Day	3704	2597	143	483	70.1%	339.1%	12.8	1.8	14.6	Non-ward based staff supporting areas. Support workers used to maintain staffing numbers. Safe staffing levels maintained. beds flexed .
CHI Piam Brown Unit	Night	1426	1012	0	35	71.0%	Shift N/A				Beds flexed to match staffing.
CHI Ward E1 Paed Cardiac	Day	2066	2048	660	483	99.1%	73.2%	8.4	2.0	10.4	Safe staffing levels maintained.
CHI Ward E1 Paed Cardiac	Night	1426	1607	358	376	112.7%	105.0%				Patient requiring 24 hour 1:1 nursing in the month. Safe staffing levels maintained.
CHI Ward G2 Neuro	Day	762	691	0	0	90.7%	Shift N/A	8.3	0.1	8.4	Safe staffing levels maintained.
CHI Ward G2 Neuro	Night	745	721	0	13	96.8%	Shift N/A				Safe staffing levels maintained.
CHI Ward G3	Day	2458	1665	1731	1063	67.7%	61.4%	6.3	4.6	11.0	Beds flexed to match staffing. Band 4 staff working to support registered nurse numbers. Non-ward based staff supporting areas.
CHI Ward G3	Night	1705	1210	1023	1032	71.0%	100.9%				Beds flexed to match staffing. Band 4 staff working to support registered nurse numbers.Safe staffing maintained.
CHI Ward G4 Surgery	Day	2416	2431	1280	555	100.6%	43.3%	9.2	2.0	11.2	Beds flexed to match staffing. Safe staffing levels maintained.
CHI Ward G4 Surgery	Night	1694	1908	682	367	112.6%	53.7%				Beds flexed to match staffing. Safe staffing levels maintained. Patient requiring 24 hour 1:1 nursing in the month.
W&N Bramshaw Womens Unit	Day	1136	964	722	480	84.9%	66.4%	6.4	3.2	9.6	Band 4 staff working to support registered nurse numbers. Non-ward based staff supporting areas. Beds flexed to match staffing.
W&N Bramshaw Womens Unit	Night	702	715	644	368	101.9%	57.1%				Safe staffing levels maintained. Beds flexed to match staffing.Safe staffing maintained.
W&N Neonatal Unit	Day	7028	4672	1948	913	66.5%	46.9%	10.4	2.0	12.5	Beds flexed to match staffing. Safe staffing levels maintained.
W&N Neonatal Unit	Night	5487	3843	1529	759	70.0%	49.6%				Beds flexed to match staffing. Safe staffing levels maintained.
W&N PAH Maternity Service combined	Day	8730	7469	4516	2972	85.6%	65.8%	6.4	2.3	8.7	Numbers do not fully reflect the integrated midwifery service demand. Safe staffing levels maintained by sharing staff resource across the services.
W&N PAH Maternity Service combined	Night	5424	4512	2024	1443	83.2%	71.3%				Numbers do not fully reflect the integrated midwifery service demand. Safe staffing levels maintained by sharing staff resource across the services.

Wards Full Name		Registered nurses Total hours planned	Registered nurses Total hours worked	Unregistered staff Total hours planned	Unregistered staff Total hours worked	Registered nurses % Filled	Unregistered staff % Filled	CHPPD Registered midwives/ nurses	CHPPD Care Staff	CHPPD Overall	Comments
CAR CHDU	Day	5118	4349	1806	1393	85.0%	77.2%	16.1	4.4	20.5	Band 4 staff working to support registered nurse numbers. Skill mix swaps undertaken to support safe staffing across the Unit. 2 beds flexed due to covid mitigation.
CAR CHDU	Night	4114	3885	1024	882	94.4%	86.1%				Safe staffing levels maintained.
CAR Coronary Care Unit	Day	2682	2799	931	981	104.4%	105.3%	9.7	3.7	13.4	Safe staffing levels maintained. 1 bed closed due to estates ventilation issue.
CAR Coronary Care Unit	Night	2320	2286	793	980	98.5%	123.6%				Safe staffing levels maintained. Additional staff used for enhanced care - RNs.
CAR Ward D4 Vascular	Day	2064	1457	1083	1014	70.6%	93.7%	4.0	3.3	7.3	Support workers used to maintain staffing numbers. Safe staffing levels maintained by sharing staff resource.
CAR Ward D4 Vascular	Night	842	931	1013	915	110.5%	90.3%				Increased night staffing to support raised acuity. Safe staffing levels maintained.3rd RN pilot.
CAR Ward E2 YACU	Day	1570	1399	845	918	89.1%	108.7%	4.1	3.3	7.4	Band 4 staff working to support registered nurse numbers. Additional staff used for enhanced care - RNs.
CAR Ward E2 YACU	Night	716	684	341	727	95.5%	213.2%				Safe staffing levels maintained. Increased night staffing to support raised acuity.Increase HCA to 2.
CAR Ward E3 Green	Day	1559	1474	1517	873	94.6%	57.6%	3.2	2.3	5.5	Skill mix swaps undertaken to support safe staffing across the Unit. Safe staffing levels maintained by sharing staff resource.
CAR Ward E3 Green	Night	704	716	789	685	101.7%	86.8%				Safe staffing levels maintained. Safe staffing levels maintained by sharing staff resource.change in pt group to Medical .
CAR Ward E3 Blue	Day	1175	1168	1086	951	99.5%	87.6%	3.6	3.6	7.2	Safe staffing levels maintained. Safe staffing levels maintained by sharing staff resource.
CAR Ward E3 Blue	Night	704	624	682	854	88.6%	125.2%				Band 4 staff working to support registered nurse numbers. Band 4 staff working to support registered nurse numbers.change in pt group to Medical .
CAR Ward E4 Thoracics	Day	1665	1462	1314	880	87.8%	67.0%	4.3	2.5	6.8	Band 4 staff working to support registered nurse numbers. Safe staffing levels maintained by sharing staff resource.
CAR Ward E4 Thoracics	Night	1046	980	430	541	93.7%	125.8%				Safe staffing levels maintained. Additional staff used for enhanced care - Support workers.
CAR Ward D2 Cardiology	Day	1351	1090	743	899	80.7%	121.0%	3.9	3.7	7.6	Band 4 staff working to support registered nurse numbers. Additional staff used for enhanced care - RNs.
CAR Ward D2 Cardiology	Night	715	639	682	759	89.4%	111.3%				Band 4 staff working to support registered nurse numbers. Additional staff used for enhanced care - RNs.
NEU Acute Stroke Unit	Day	1521	1640	2692	2496	107.8%	92.7%	3.1	4.6	7.8	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.
NEU Acute Stroke Unit	Night	1024	1068	1705	1501	104.3%	88.0%				Patient requiring 24 hour 1:1 nursing in the month. Band 4 staff working to support registered nurse numbers. Support workers used to maintain staffing numbers.
NEU Regional Transfer Unit	Day	1226	824	434	252	67.2%	58.0%	10.6	4.9	15.5	Band 4 staff working to support registered nurse numbers. Support workers used to maintain staffing numbers. Patient requiring 24 hour 1:1 nursing in the month.
NEU Regional Transfer Unit	Night	682	517	682	377	75.8%	55.3%				Band 4 staff working to support registered nurse numbers. Support workers used to maintain staffing numbers. Patient requiring 24 hour 1:1 nursing in the month.
NEU ward E Neuro	Day	1858	1700	1125	1214	91.5%	107.9%	3.9	3.3	7.1	Band 4 staff working to support registered nurse numbers. Support workers used to maintain staffing numbers. Patient requiring 24 hour 1:1 nursing in the month.
NEU ward E Neuro	Night	1343	1223	1023	1251	91.0%	122.3%				Band 4 staff working to support registered nurse numbers. Support workers used to maintain staffing numbers. Patient requiring 24 hour 1:1 nursing in the month.
NEU HASU	Day	1480	1200	380	512	81.1%	134.7%	7.5	3.0	10.5	Band 4 staff working to support registered nurse numbers. Support workers used to maintain staffing numbers. Patient requiring 24 hour 1:1 nursing in the month.
NEU HASU	Night	1366	1081	341	404	79.2%	118.5%				Band 4 staff working to support registered nurse numbers. Support workers used to maintain staffing numbers. Patient requiring 24 hour 1:1 nursing in the month.
NEU Ward D Neuro	Day	1902	1664	1867	1835	87.5%	98.3%	3.9	4.6	8.5	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.
NEU Ward D Neuro	Night	1343	1278	1705	1611	95.2%	94.5%				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 Ward F4 Spinal	Day	1579	1595	1168	1135	101.0%	97.2%	4.4	3.5	7.9	Band 4 staff working to support registered nurse numbers. Support workers used to maintain staffing numbers. Patient requiring 24 hour 1:1 nursing in the month.
SPI Ward F4 Spinal	Night	1023	1111	1043	1031	108.6%	98.8%				Band 4 staff working to support registered nurse numbers. Support workers used to maintain staffing numbers. Patient requiring 24 hour 1:1 nursing in the month.
T&O Ward Brooke	Day	1044	1234	1131	658	118.2%	58.2%	3.8	2.7	6.5	Skill mix swaps undertaken to support safe staffing across the Unit. Staff moved to support other wards. Additional staff used for enhanced care - Support workers.
T&O Ward Brooke	Night	713	736	1070	736	103.2%	68.8%				Skill mix swaps undertaken to support safe staffing across the Unit. Staff moved to support other wards. Additional staff used for enhanced care - Support workers.
T&O Trauma Admissions Unit	Day	922	690	768	735	74.8%	95.6%	17.7	19.1	36.8	Staff moved to support other wards. Patient requiring 24 hour 1:1 nursing in the month.
T&O Trauma Admissions Unit	Night	683	529	682	583	77.5%	85.5%				Staff moved to support other wards. Safe staffing levels maintained.
T&O Ward F1 Major Trauma Unit	Day	2362	2424	1977	2079	102.6%	105.2%	4.7	4.3	9.0	Increase in acuity/dependency of patients in the month. Patient requiring 24 hour 1:1 nursing in the month. Safe staffing levels maintained. Additional staff used for enhanced care - Support workers.
T&O Ward F1 Major Trauma Unit	Night	1783	1825	1783	1803	102.4%	101.1%				Increase in acuity/dependency of patients in the month. Patient requiring 24 hour 1:1 nursing in the month. Safe staffing levels maintained. Additional staff used for enhanced care - Support workers.
T&O Ward F2 Trauma	Day	1603	1507	1886	1831	94.0%	97.1%	3.1	4.2	7.3	Safe staffing levels maintained by sharing staff resource. Patient requiring 24 hour 1:1 nursing in the month. Staff moved to support other wards. Additional staff used for enhanced care - Support workers.
T&O Ward F2 Trauma	Night	1023	858	1366	1432	83.9%	104.9%				Safe staffing levels maintained by sharing staff resource. Patient requiring 24 hour 1:1 nursing in the month. Staff moved to support other wards. Additional staff used for enhanced care - Support workers.
T&O Ward F3 Trauma	Day	1535	1924	1994	1315	125.4%	65.9%	4.1	4.1	8.2	Safe staffing levels maintained by sharing staff resource. Patient requiring 24 hour 1:1 nursing in the month. Staff moved to support other wards. Additional staff used for enhanced care - Support workers.
T&O Ward F3 Trauma	Night	1034	956	1376	1509	92.5%	109.7%				Safe staffing levels maintained by sharing staff resource. Patient requiring 24 hour 1:1 nursing in the month. Staff moved to support other wards. Additional staff used for enhanced care - Support workers.
T&O Ward F4 Elective	Day	1465	1215	766	894	82.9%	116.7%	3.8	3.1	6.9	Safe staffing levels maintained by sharing staff resource. Patient requiring 24 hour 1:1 nursing in the month. Additional staff used for enhanced care - Support workers.
T&O Ward F4 Elective	Night	684	685	684	686	100.1%	100.2%				Safe staffing levels maintained by sharing staff resource. Patient requiring 24 hour 1:1 nursing in the month. Additional staff used for enhanced care - Support workers.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Finance Report 2021-22 Month 7**			
Agenda item:	**5.5**			
Sponsor:	**Ian Howard – Interim Chief Financial Officer**			
Author:	**Philip Bunting – Interim Deputy Director of Finance**			
Date:	**30 November 2021**			
Purpose	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** X
Issue to be addressed:	The finance report provides a monthly summary of the key financial information for the Trust.			
Response to the issue:	This is the first month of the Half 2 (H2) financial regime which has seen reductions in block income applied of £1.5m per month (£9.1m in H2). A deterioration in the position was therefore forecast consistent with this funding reduction. During Half 1 (H1), the Trust had been reliant on circa £3m per month of Elective Recovery Framework (ERF) income to achieve a break-even position. At the time of reporting there was no certainty around the H2 ERF, hence no income has been included within the position. As a result of this volatility in Trust income levels, the Trust has reported a deficit of £3.5m for month 7. **H2 Elective Recovery Framework (ERF):** • ERF achievement was originally anticipated at zero for the ICS. This was based on lack of confidence due to operational pressures, ED demand and Covid-19 patients impacting the systems ability to deliver required activity levels, as well as a change in the national methodology of assessing performance. • As an indicator of activity performance, under the H1 system of counting, estimates are that month 7 achievement would have been c£1m. • UHS has successfully bid for £12m pump-priming funding upfront (£2m per month) to support ERF related activity in H2. However, this was agreed following the close of Month 7 hence is not reported within the position. • Estimates for August and September have been revised increasing to 100% and 96% respectively, based on updated data. This means ERF achievement from H1 totals £17.7m with targets achieved in all months. The adjusted UHS financial position for M7 would therefore be £1.5m deficit, considering the additional funding confirmation of £2m per month.			

	Capital: • Capital expenditure is £28.3m YTD representing 54% of planned expenditure with all major projects on track to deliver as planned. • UHS has been awarded £2.9m of Targeted Investment Fund (TIF) capital to be spent in 2021/22 for Cardiology (£0.6m), Critical Care (£0.3m) and IT (£2m). • We remain confident that funding allocated to UHS will be fully utilised by the end of the financial year. **ICS finance position:** • The M6 position closed as per plan with a breakeven position achieved for H1. • The primary risk carried forward from the H1 ICS finance position is the gap between reported ERF achievement by individual provider and overall system achievement. This gap is estimated at c£7m and has had to be resolved via non-recurrent funding sourced from within the system. UHS has however been given assurances that H1 ERF will be funded in full. **Other financial issues:** • The underlying financial position remains the most significant financial risk as the H2 efficiency challenge is unlikely to be met without non-recurrent support. This creates a run rate entry risk for 2022/23. • Early signals on 2022/23 funding are that the Trust may face further financial challenges, with further efficiencies required plus a phased withdrawal of non-recurrent funding linked to Covid-19. • Whilst these are early indications, funding for 2022/23 is not expected to be confirmed until Q4. • The spending review has announced a three-year capital settlement of over £10bn for new hospitals, hospital upgrades, diagnostics, digital technology, and elective recovery.
Implications:	• Financial implications of availability of funding to cover growth, cost pressures and new activity. • Organisational implications of remaining within statutory duties.
Risks: (Top 3) of carrying out the change / or not:	• Financial risk mainly linked to the uncertainty of 22/23 funding arrangements and ability to support long term decision making. • Cash risk linked to income volatility above. • Inability to maximise CDEL (which cannot be carried forward) if mitigations are not put into place.
Summary: Conclusion and/or recommendation	Trust Board is asked to note this report.

2021/22 Finance Report - Month 7

Report to:	**Board of Directors and Finance & Investment Committee** **October 2021**
Title:	**Finance Report for Period ending 31/10/2021**
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 2021, the Trust reported a deficit position of £3.5m. For Half 1 (H1) the Trust reported a breakeven position delivering as per plan. The deterioration is driven by a reduction in block funding relating to a 2% efficiency challenge totalling £1.5m per month. At the time of reporting, the Half 2 (H2) financial plan had not been finalised or submitted to NHSI.

2. Further to this no elective recovery framework (ERF) income has been included for October, compared to circa £3m per month in H1. This is due to operational pressures impacting the Trust's ability to deliver elective activity, as well as a change in the national methodology for assessing performance. Since publication however £12m of funding has been awarded to pump prime ERF achievement in H2.

3. In month, £3.9m (£2.8m pay and £1.1m non pay) was incurred on additional expenditure relating to Covid-19, decreasing back to more normal levels due to the impact of the M6 backdated vaccination hub staffing claim (£0.6m).

4. The main underlying themes seen in M7 were:
   - Elective activity in October represents 92% of planned income levels, up from 83% in September. Under the old ERF methodology £1m would have been achieved.
   - Non Elective activity levels in October was at 105% of planned income levels, the same level as September. A&E attendances continue to be high, in excess of pre-Covid levels.
   - Outpatient activity was at 109% of planned income levels, down from 113% in September.
   - The underlying position is reported at c£4m deficit in month which has deteriorated following funding reductions in H2 in addition to continued cost pressures resultant from energy price increases and drug cost expenditure above block funded levels.

University Hospital Southampton NHS
NHS Foundation Trust

Finance: I&E Summary (H2)

The financial position for M7 was a deficit of £3.5m.

Following publication of the finance report, the H2 plan has now been finalised at a £3.4m deficit, with £12m of confirmed ERF funding and non-recurrent measures off-setting the underlying financial pressures within the position.

Clinical income was £3.7m below plan in month due to no ERF being reported, with the £12m not being known at the time of reporting.

Staff costs are collectively £1.2m underspent with a substantive underspend offset partially by agency and bank overspends.

The clinical supplies overspend and other income overperformance are heavily correlated to R&D Covid booster studies with significantly increased income and expenditure that offset.

Energy costs remain a significant pressure within other non pay with costs up £0.6m per month compared to H1.

		Current Month			M7 - 12 Actuals			M7 - 12		
		Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
NHS Income:	Clinical	67.5	63.8	3.7	67.5	63.8	3.7	405.1	405.1	0.0
	Pass-through Drugs & Devices	11.1	12.1	(1.0)	11.1	12.1	(1.0)	66.4	66.4	0.0
Other income	Other Income excl. PSF	16.8	19.0	(2.3)	16.8	19.0	(2.3)	106.2	106.2	0.0
	Top Up Income	1.3	1.1	0.2	1.3	1.1	0.2	7.6	7.6	0.0
Total income		**96.6**	**96.0**	**0.6**	**96.6**	**96.0**	**0.6**	**585.3**	**585.3**	**0.0**
Costs	Pay-Substantive	47.7	46.0	(1.7)	47.7	46.0	(1.7)	285.2	285.2	0.0
	Pay-Bank	3.7	4.1	0.4	3.7	4.1	0.4	22.3	22.3	0.0
	Pay-Agency	1.2	1.3	0.1	1.2	1.3	0.1	7.1	7.1	0.0
	Drugs	5.2	4.7	(0.4)	5.2	4.7	(0.4)	31.0	31.0	0.0
	Pass-through Drugs & Devices	11.1	12.1	1.0	11.1	12.1	1.0	66.4	66.4	0.0
	Clinical supplies	9.8	12.5	2.7	9.8	12.5	2.7	62.9	62.9	0.0
	Other non pay	15.5	15.8	0.4	15.5	15.8	0.4	95.0	95.0	0.0
Total expenditure		**94.0**	**96.5**	2.5	**94.0**	**96.5**	**2.5**	**569.8**	**569.8**	**0.0**
EBITDA		**2.6**	**(0.4)**	3.0	**2.6**	**(0.4)**	3.0	**15.5**	**15.5**	0.0
EBITDA %		2.7%	-0.5%	3.1%	2.7%	-0.5%	3.1%	2.6%	2.6%	0.0%
	Depreciation / Non Operating Expenditure	3.2	3.1	(0.1)	3.2	3.1	(0.1)	19.1	19.1	0.0
Surplus / (Deficit)		**(0.6)**	**(3.5)**	**2.9**	**(0.6)**	**(3.5)**	**2.9**	**(3.6)**	**(3.6)**	**0.0**
Less	Donated income	0.1	0.1	(0.0)	0.1	0.1	-0.0	0.3	0.3	0.0
Add Back	Donated depreciation	0.1	0.1	0.0	0.1	0.1	0.0	0.6	0.6	0.0
Net Surplus / (Deficit)		**(0.6)**	**(3.5)**	**2.9**	**(0.6)**	**(3.5)**	**2.9**	**(3.4)**	**(3.4)**	**0.0**

Finance: I&E Summary (FY)

The financial position for the full year to date combines both H1 and H2.

The H1 outturn was reported as breakeven as per plan. H2 is currently forecasted as per plan which is a £3.4m deficit.

The most significant cost pressures in year relate to energy costs and drug costs (in excess of block funding). There is some offsetting between other income underperformance and clinical supplies favourable variances related to the chilworth project.

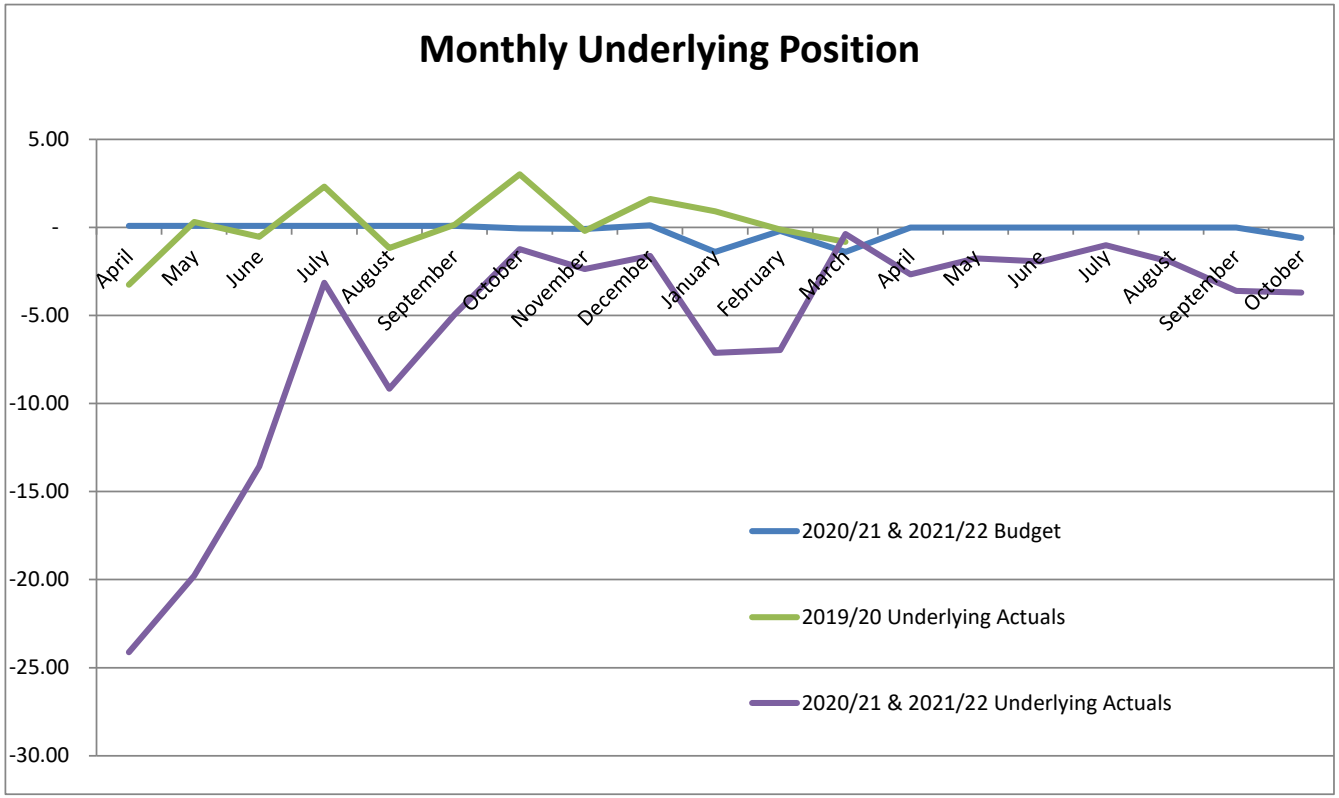
		M1 - 7 Actuals			Full Year Forecast		
		Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
NHS Income:	Clinical	480.3	471.3	9.0	817.9	812.6	5.3
	Pass-through Drugs & Devices	62.0	78.1	(16.2)	117.3	132.4	(15.1)
Other income	Other Income excl. PSF	107.7	97.1	10.6	197.2	184.3	12.8
	Top Up Income	6.0	8.7	(2.7)	12.3	15.2	(2.9)
Total income		**655.9**	**655.3**	**0.6**	**1,144.6**	**1,144.6**	**0.1**
Costs	Pay-Substantive	329.2	324.8	(4.5)	566.7	563.9	(2.8)
	Pay-Bank	27.4	25.6	(1.8)	46.0	43.8	(2.2)
	Pay-Agency	8.7	8.0	(0.6)	14.6	13.9	(0.7)
	Drugs	31.2	34.3	3.1	57.0	60.6	3.6
	Pass-through Drugs & Devices	62.0	78.1	16.2	117.3	132.4	15.1
	Clinical supplies	74.8	60.7	(14.2)	127.9	111.0	(16.9)
	Other non pay	100.9	106.1	5.3	180.4	185.3	4.9
Total expenditure		**634.1**	**637.6**	**3.5**	**1,109.9**	**1,110.9**	**1.0**
EBITDA		**21.8**	**17.7**	4.1	**34.7**	**33.6**	1.1
EBITDA %		3.3%	2.7%	0.6%	3.0%	2.9%	0.1%
	Depreciation / Non Operating Expenditure	22.5	22.7	0.3	38.4	38.8	0.4
Surplus / (Deficit)		**(0.7)**	**(5.1)**	**4.4**	**(3.7)**	**(5.2)**	**1.5**
Less	Donated income	0.6	0.4	0.1	0.9	0.7	0.2
	Profit on disposals	-	0.5	(0.5)	-	0.5	(0.5)
Add Back	Donated depreciation	0.7	1.0	0.3	1.2	1.5	0.3
	Impairments	-	-	0.0	-	-	0.0
	Disposals of DH Donated Equipment	-	1.5	1.5	-	1.5	1.5
Net Surplus / (Deficit)		**(0.6)**	**(3.5)**	**2.9**	**(3.4)**	**(3.4)**	**0.0**

Monthly Underlying Position

The graph shows the underlying position for the Trust from 2019/20 to present.

For 21/22 YTD the position has been restated removing the impact of ERF in addition to any one off costs or benefits. This illustrates underlying performance which has deteriorated from £2m per month deficit in months 1-5 to a £4m deficit in month 7. This is predominantly due to a reduction in block income of £1.5m per month relating to the H2 efficiency requirement.

The benefit of block protection which existed in 20/21 has now reversed with PbR equivalent income actually higher than the prevailing block value YTD. Arguably ERF has been the mechanism for funding this gap however only covering elective and outpatients. No adjustment to the graph for 21/22 has been made for this.



University Hospital Southampton NHS
NHS Foundation Trust

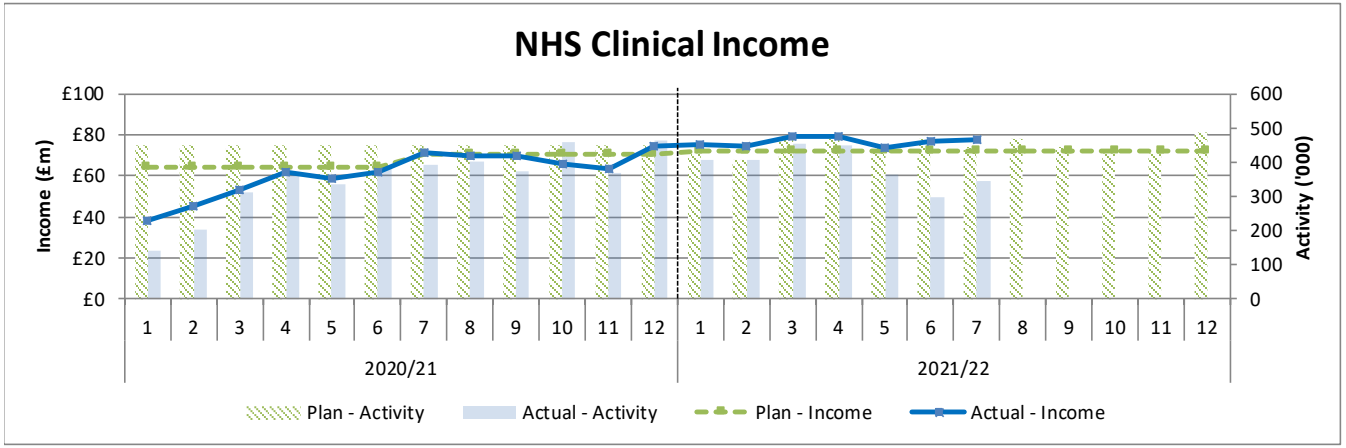
Clinical Income

(Fav Variance) / Adv Variance

Clinical income for the month of October was £2.7m adverse to plan. Most of the Trust's income remains fixed with confirmed block contract funding in place for the remainder of the financial year. No ERF income was reported in month however whereas the plan makes provision for £2m per month. Funding was not however agreed at the time of reporting.

October has seen a slight increase in activity from September. Plans for 21/22 are phased to account for the variation in calendar and working days. Elective income increased to 92% of planned levels having dropped to 83% in September. Non Elective income remained high in October at 105% of planned levels. A&E attendances continue to be high, with attendances to main ED now exceeding pre-Covid levels having shown a downward trend for much of the previous financial year. Outpatient income reduced to 109% of plan, down from 113% in September. The graphs overleaf show the impact of Covid-19 as well as the recovery to pre Covid levels of activity in many areas.

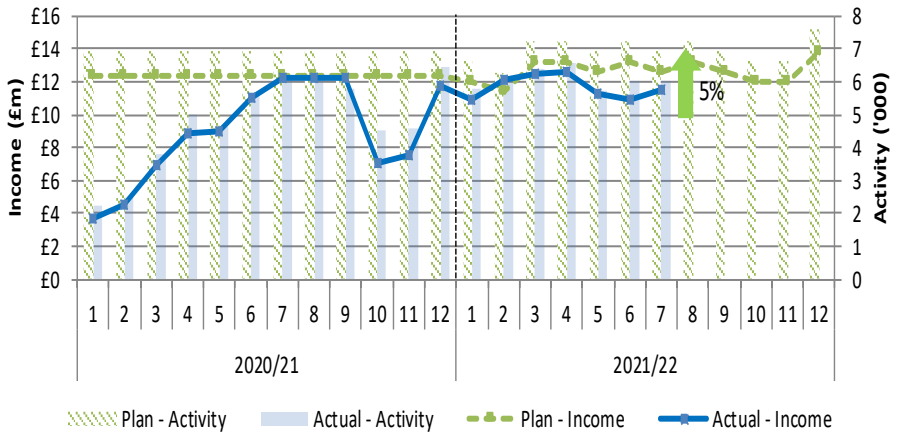
	2021/22						2019/20
POD GROUP	In Month Plan £000s	In Month Estimate £000s	In Month Variance £000s	YTD Plan £000s	YTD Estimate £000s	YTD Variance £000s	YTD Actuals £000s
NHS Clinical Income							
Elective Inpatients	£12,561	£11,468	£1,092	£87,925	£81,761	£6,164	£83,855
Non-Elective Inpatients	£19,474	£20,399	(£925)	£134,431	£137,916	(£3,485)	£123,487
Outpatients	£7,367	£8,049	(£682)	£51,572	£56,639	(£5,067)	£48,507
Other Activity	£11,738	£11,773	(£35)	£81,287	£79,615	£1,671	£75,605
Blocks & Financial Adjustments	£7,057	£1,447	£5,610	£34,279	£2,711	£31,568	£6,593
Other Exclusions	£4,735	£6,758	(£2,024)	£99,497	£122,818	(£23,322)	£40,352
Pass-through Exclusions	£11,059	£12,077	(£1,018)	£11,059	£12,077	(£1,018)	£55,693
Subtotal NHS Clinical Income	*£73,990*	*£71,971*	*£2,018*	*£500,049*	*£493,538*	*£6,511*	*£434,093*
Additional funding	£5,848	£4,348	£1,500	£40,936	£59,545	(£18,609)	
Covid block adjustments	(£1,266)	(£432)	(£834)	(£6,097)	(£3,622)	(£2,475)	
Total NHS Clinical Income	**£78,572**	**£75,888**	**£2,684**	**£534,888**	**£549,461**	**(£14,573)**	**£434,093**
Non NHS Clinical Income							
Private Patients	£528	£502	£26	£2,783	£3,570	(£786)	£2,264
CRU	£208	£200	£8	£1,458	£1,139	£319	£1,257
Overseas Chargeable Patients	£66	£145	(£80)	£461	£393	£68	£654
Total Non NHS Clinical Income	**£802**	**£848**	**(£46)**	**£4,703**	**£5,103**	**(£400)**	**£4,175**
Grand Total	**£79,374**	**£76,736**	**£2,638**	**£539,591**	**£554,563**	**(£14,972)**	**£438,268**



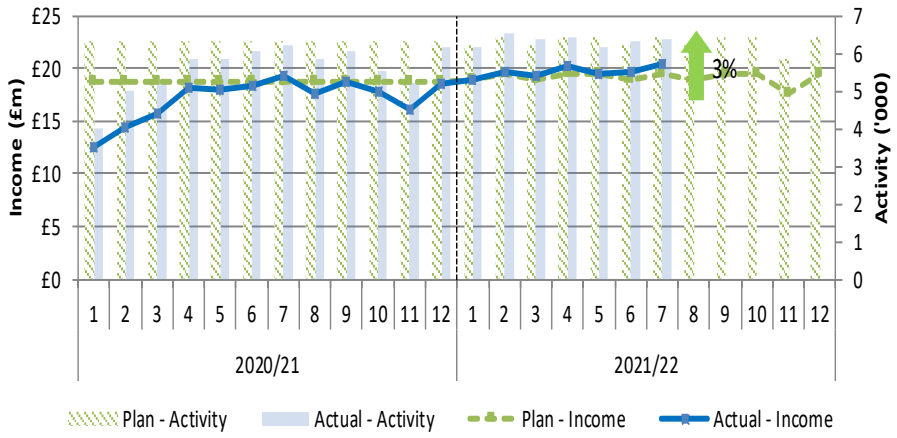
University Hospital Southampton NHS
NHS Foundation Trust

Clinical Income

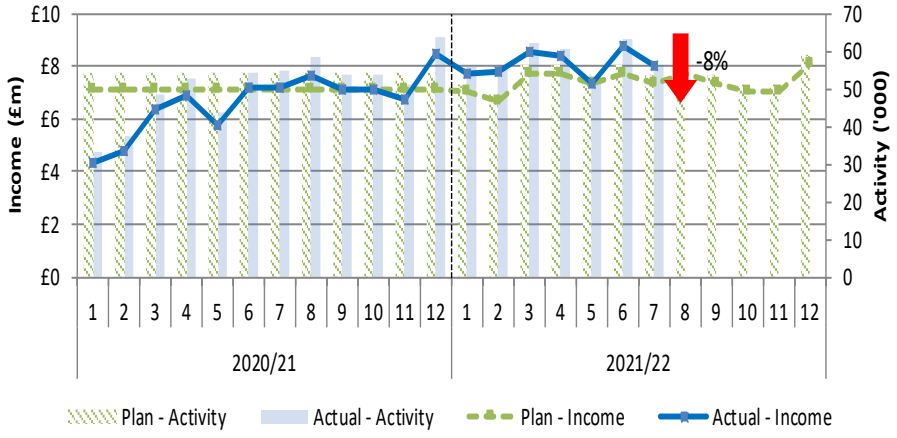
Elective spells



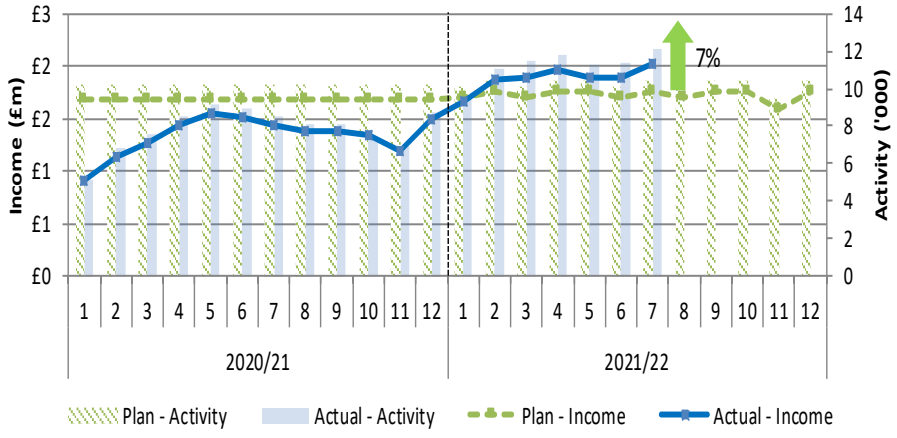
Non elective spells



Outpatients



Main ED



University Hospital Southampton NHS
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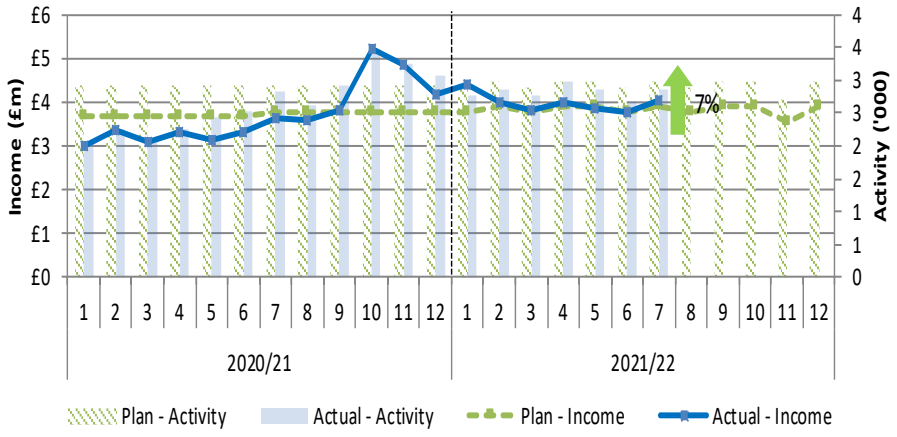
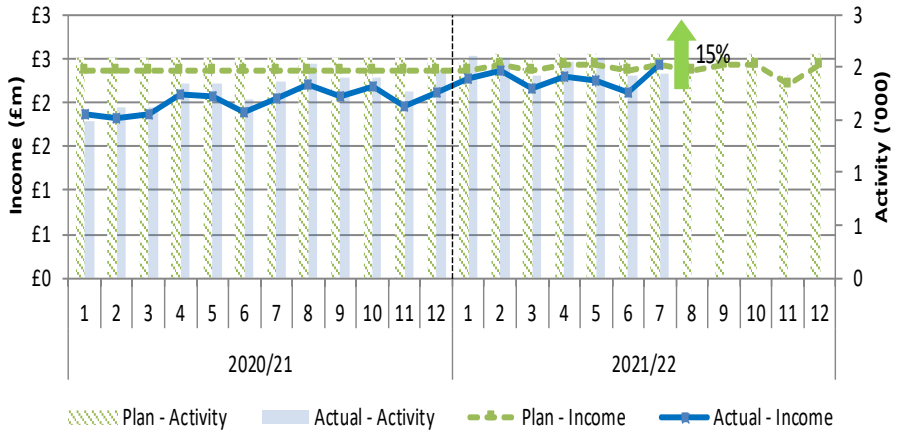
Clinical Income

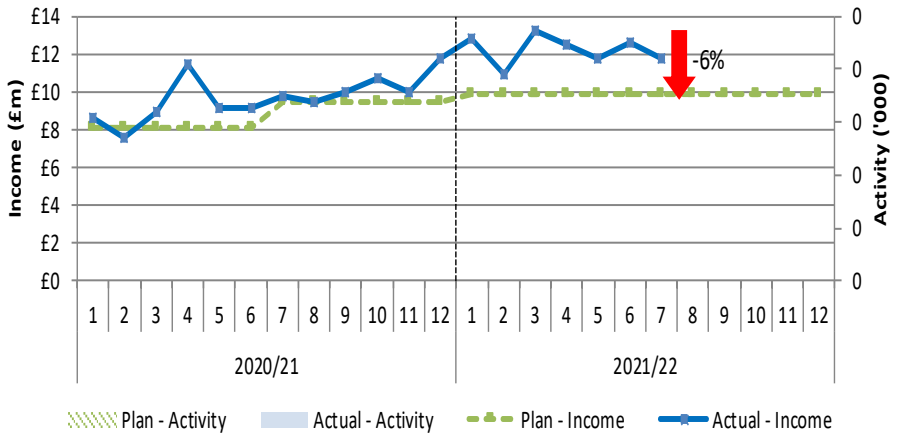
Adult critical care



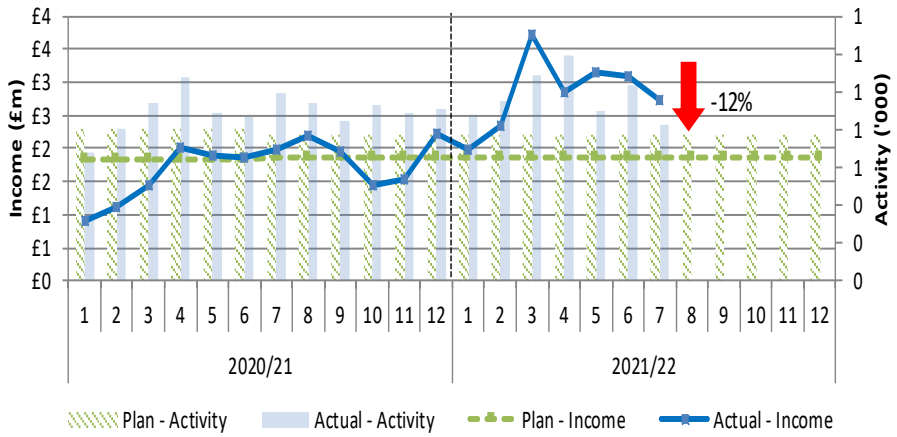
Neonatal & paediatric critical care



Tariff excluded drugs



Tariff excluded devices



University Hospital Southampton NHS
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Income and Activity

The tables shown illustrate by division and care group the % of the activity and income plan being achieved across the last 6 months of 2021/22 for Elective, Non Elective and Outpatient Activity. The plan for 2021/22 has been phased to reflect working day differences for Elective and Outpatient and calendar days for Non Elective.

Elective activity in October represents 92% of planned income levels, up from 83% in September. Recovery planning is targeting improvement in all areas but will be governed by clinical priority.

Non Elective activity levels in October was at 105% of planned income levels, the same level as September.

Actual in month activity is shown in the final column to enable comparative analysis of %'s.

Elective Activity as % of Plan		Activity as % of Plan 2021/22						Income as % of Plan 2021/22						In month actual activity for scale
Division	Care Group	2	3	4	5	6	7	2	3	4	5	6	7	
DIVISION A	OPHTHALMOLOGY	97%	104%	110%	99%	96%	101%	100%	106%	112%	97%	93%	101%	567
	SURGERY	105%	84%	85%	81%	87%	98%	114%	86%	95%	84%	82%	95%	906
DIVISION A Total		102%	91%	94%	88%	90%	99%	111%	91%	99%	87%	89%	96%	1,473
DIVISION B	CANCER CARE	75%	73%	71%	73%	66%	77%	78%	87%	74%	70%	63%	75%	629
	SPECIALIST MEDICINE	95%	84%	90%	72%	73%	78%	103%	92%	103%	78%	79%	86%	1,396
DIVISION B Total		89%	80%	84%	73%	71%	78%	94%	90%	92%	75%	73%	82%	2,025
DIVISION C	CHILD HEALTH	110%	97%	101%	96%	98%	99%	119%	91%	90%	107%	85%	111%	846
	WOMEN'S HEALTH	95%	92%	97%	82%	90%	79%	101%	96%	93%	83%	91%	101%	239
DIVISION C Total		106%	96%	100%	92%	96%	94%	114%	93%	91%	101%	86%	108%	1,085
DIVISION D	CARDIOVASCULAR & THORACIC	111%	106%	104%	104%	92%	96%	109%	103%	100%	101%	82%	92%	447
	NEUROSCIENCES	106%	96%	93%	97%	101%	98%	114%	83%	86%	101%	94%	95%	414
	RADIOLOGY	81%	73%	72%	61%	63%	61%	77%	74%	75%	63%	70%	67%	230
	TRAUMA & ORTHOPAEDICS	98%	95%	89%	73%	87%	75%	105%	104%	103%	78%	87%	75%	247
DIVISION D Total		100%	93%	90%	88%	86%	84%	108%	97%	95%	93%	84%	87%	1,338
Total		97%	88%	90%	82%	83%	87%	107%	94%	95%	91%	83%	92%	

Non Elective Activity as % of Plan		Activity as % of Plan 2021/22						Income as % of Plan 2021/22						In month actual activity for scale
Division	Care Group	2	3	4	5	6	7	2	3	4	5	6	7	
DIVISION A	OPHTHALMOLOGY	75%	87%	83%	87%	79%	66%	81%	85%	97%	98%	86%	73%	33
	SURGERY	94%	91%	95%	83%	88%	97%	102%	105%	106%	91%	92%	114%	791
DIVISION A Total		93%	91%	94%	83%	88%	95%	101%	104%	105%	91%	92%	112%	824
DIVISION B	ACUTE MEDICINE	103%	106%	108%	113%	108%	116%	102%	109%	109%	116%	112%	120%	1,300
	CANCER CARE	114%	120%	119%	112%	117%	112%	106%	106%	106%	98%	109%	102%	364
	EMERGENCY MEDICINE	99%	102%	93%	76%	74%	72%	94%	106%	91%	78%	82%	75%	1,083
	SPECIALIST MEDICINE	97%	75%	108%	76%	145%	148%	86%	62%	109%	65%	140%	152%	41
DIVISION B Total		102%	103%	102%	94%	92%	94%	100%	107%	104%	103%	104%	106%	2,788
DIVISION C	CHILD HEALTH	122%	129%	120%	124%	153%	148%	111%	109%	120%	111%	134%	127%	662
	WOMEN'S HEALTH	91%	92%	91%	95%	115%	100%	98%	105%	99%	106%	100%	108%	1,016
DIVISION C Total		101%	104%	99%	104%	126%	115%	102%	106%	106%	108%	112%	115%	1,678
DIVISION D	CARDIOVASCULAR & THORACIC	107%	89%	96%	86%	102%	91%	104%	83%	104%	85%	102%	87%	400
	NEUROSCIENCES	101%	98%	96%	108%	95%	90%	100%	105%	104%	115%	101%	99%	218
	RADIOLOGY	93%	90%	106%	84%	106%	99%	82%	77%	111%	83%	98%	98%	81
	TRAUMA & ORTHOPAEDICS	106%	122%	107%	102%	108%	97%	112%	112%	105%	105%	122%	119%	287
DIVISION D Total		104%	100%	100%	96%	103%	93%	103%	94%	105%	97%	106%	97%	986
Total		101%	102%	100%	95%	101%	99%	102%	102%	105%	100%	105%	105%	

Income and Activity

Outpatient activity in October was at 109% of planned income levels, down from 113% in September.

Actual in month activity is shown in the final column to enable comparative analysis of %'s.

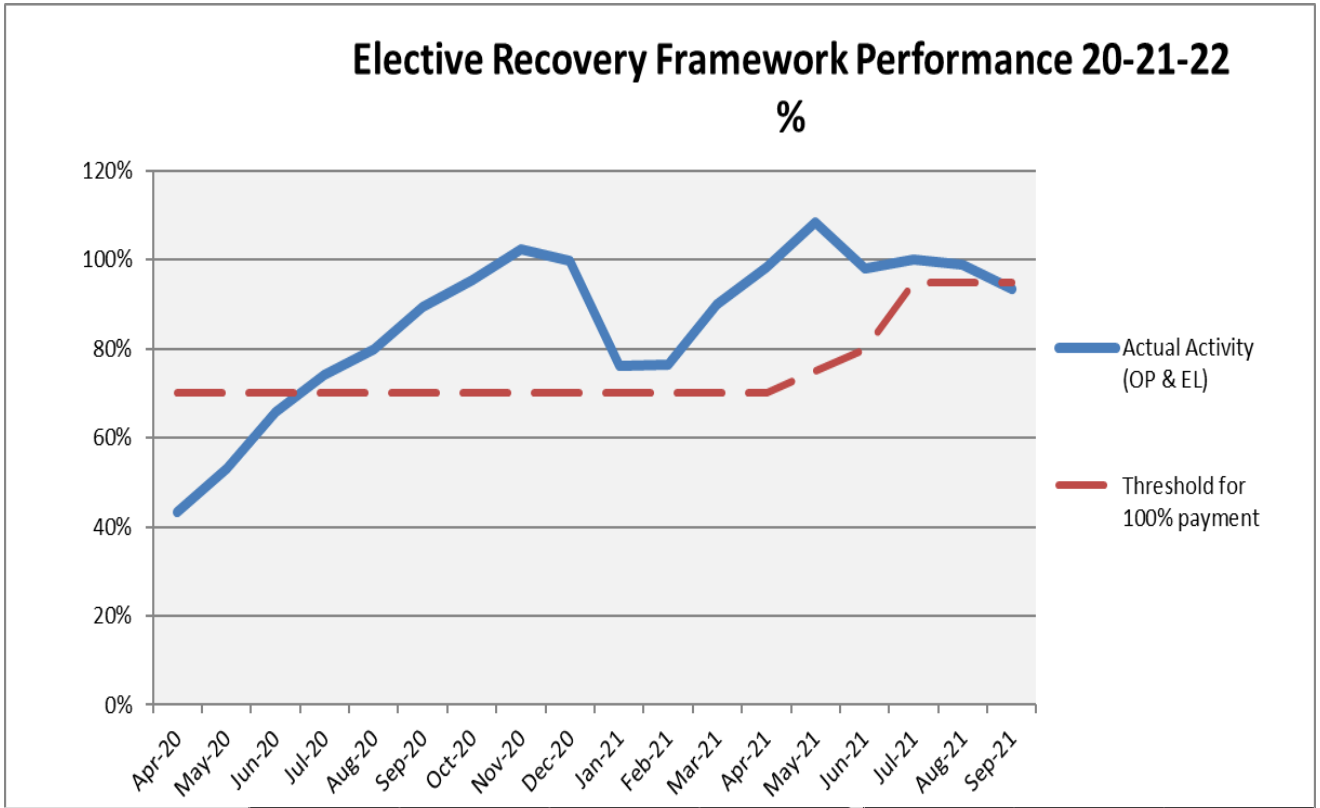
Outpatient Activity as % of Plan		Activity as % of Plan						Income as % of Plan						In month actual activity for scale
		2021/22						2021/22						
Division	Care Group	2	3	4	5	6	7	2	3	4	5	6	7	
DIVISION A	OPHTHALMOLOGY	110%	105%	98%	92%	102%	108%	115%	110%	104%	98%	108%	114%	8,468
	SURGERY	105%	99%	96%	85%	97%	90%	105%	100%	97%	87%	98%	96%	6,000
DIVISION A Total		108%	102%	97%	89%	100%	100%	111%	105%	101%	92%	103%	105%	14,468
DIVISION B	ACUTE MEDICINE	145%	103%	97%	99%	83%	97%	144%	98%	98%	95%	82%	95%	112
	CANCER CARE	148%	139%	141%	135%	141%	127%	137%	129%	130%	122%	130%	127%	7,843
	EMERGENCY MEDICINE	119%	80%	167%	128%	192%	116%	118%	87%	175%	132%	192%	116%	110
	SPECIALIST MEDICINE	123%	122%	114%	110%	122%	102%	119%	118%	111%	108%	119%	104%	8,922
DIVISION B Total		133%	129%	125%	120%	130%	112%	127%	122%	120%	114%	124%	114%	16,987
DIVISION C	CHILD HEALTH	111%	105%	106%	92%	113%	112%	110%	104%	104%	91%	113%	111%	5,801
	SUPPORT SERVICES	92%	85%	80%	81%	85%	81%	86%	81%	77%	76%	81%	81%	2,744
	WOMEN'S HEALTH	115%	102%	102%	91%	108%	100%	112%	104%	99%	90%	104%	103%	3,615
DIVISION C Total		107%	99%	98%	89%	104%	100%	106%	101%	99%	89%	106%	105%	12,160
DIVISION D	CARDIOVASCULAR & THORACIC	127%	119%	119%	115%	123%	124%	127%	120%	120%	117%	122%	125%	5,464
	NEUROSCIENCES	113%	100%	102%	78%	104%	98%	113%	101%	100%	76%	100%	98%	3,381
	RADIOLOGY	196%	162%	172%	187%	184%	146%	217%	191%	208%	227%	222%	171%	174
	TRAUMA & ORTHOPAEDICS	98%	102%	97%	90%	111%	94%	117%	120%	116%	111%	134%	116%	3,017
DIVISION D Total		115%	109%	108%	97%	114%	108%	120%	112%	112%	99%	116%	112%	12,036
Total		116%	110%	108%	100%	112%	105%	117%	111%	109%	100%	113%	109%	

Elective Recovery Fund 21/22

The graph shows Elective Recovery Framework trends through 20/21 and the performance for the first half of 21/22. This indicates performance has been achieved in all months throughout H1 despite significant operational challenges.

August and September data has been revised upwards with £17.65m now expected to be achieved. The 20% premium has already been agreed with ICS partners will be centrally pooled rather than allocated directly to providers. Under the H1 methodology £1m would expected to have been achieved in October.

For the second half of 21/22 an alternative Elective Recovery Framework based on RTT performance has been launched for which initial estimates were £0.25m with significant system risk in achievement being funded. For this reason no income has been reported. Since reporting however a £12m ERF block has been agreed to pump prime ERF activity in H2.



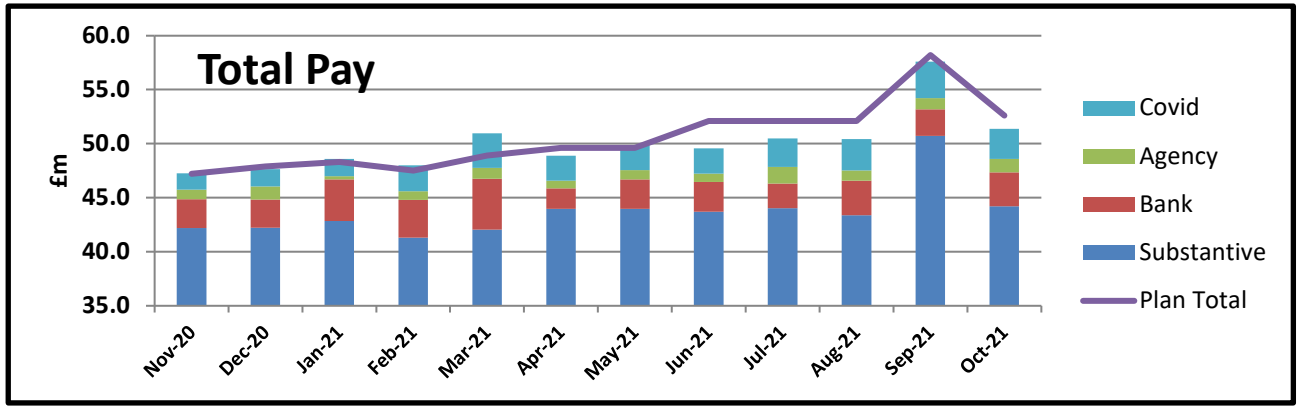
	ERF Achievement - Elective/Daycase/Outpatients (£'000)				ERF Top-up		
Month	Baseline	Actuals	Variance	%	100% Top Up	20% Top Up	Total
Apr-21	£ 18,771	£ 18,481	-£ 290	*98%*	£ 5,342	£ 505	£ 5,847
May-21	£ 18,276	£ 19,796	£ 1,520	*108%*	£ 6,089	£ 852	£ 6,942
Jun-21	£ 21,464	£ 21,059	-£ 405	*98%*	£ 3,888	£ 563	£ 4,451
Jul-21	£ 20,780	£ 20,785	£ 5	*100%*	£ 1,044	£ 1	£ 1,045
Aug-21	£ 18,340	£ 18,416	£ 76	*100%*	£ 993	£ 15	£ 1,008
Sep-21	£ 20,089	£ 19,384	-£ 704	*96%*	£ 300	£ -	£ 300
Oct-21	H2 ERF has moved to RTT performance basis, see commentary						
YTD Total	**£ 117,719**	**£ 117,921**	**£ 202**	***100%***	**£ 17,656**	**£ 1,937**	**£ 19,592**

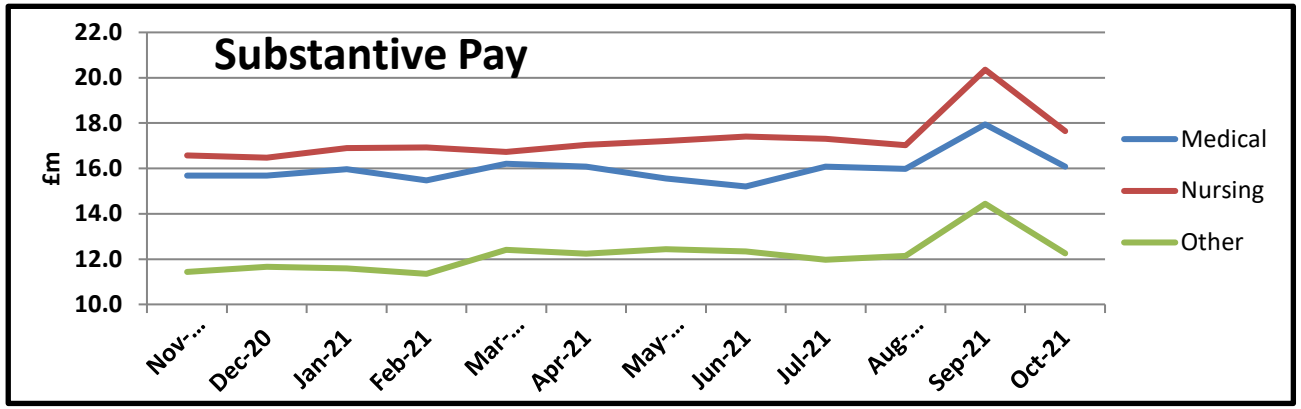
Substantive Pay Costs

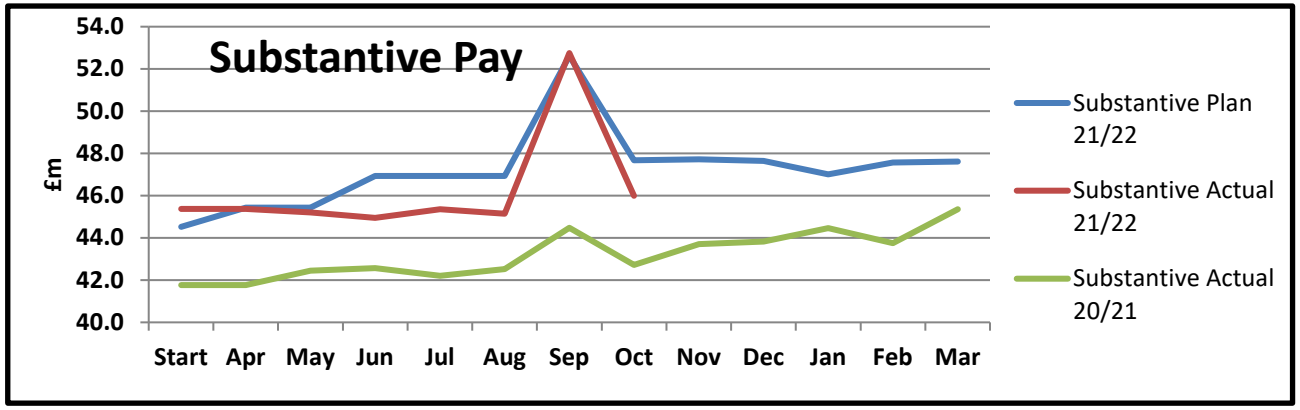
Total pay expenditure in October was £51.4m. This was £6.2m lower than September due to the backdated pay award paid in M6 of £6.9m. Agency staff spend decreased by £0.4m primarily due to vaccination hub staff catch up costs of £0.6m reflected in M6 not repeated in M7.Adjusting for these two items normalised pay costs were flat.

Pay costs remain in excess of that seen last year prior to the second covid wave as the organisation continues to drive recovery. Substantive recruitment has been challenging however with workforce numbers remaining broadly flat since April 21.

These will be monitored closely going forward as costs are expected to increase due to winter pressures and a continued emphasis on elective recovery where capacity allows.







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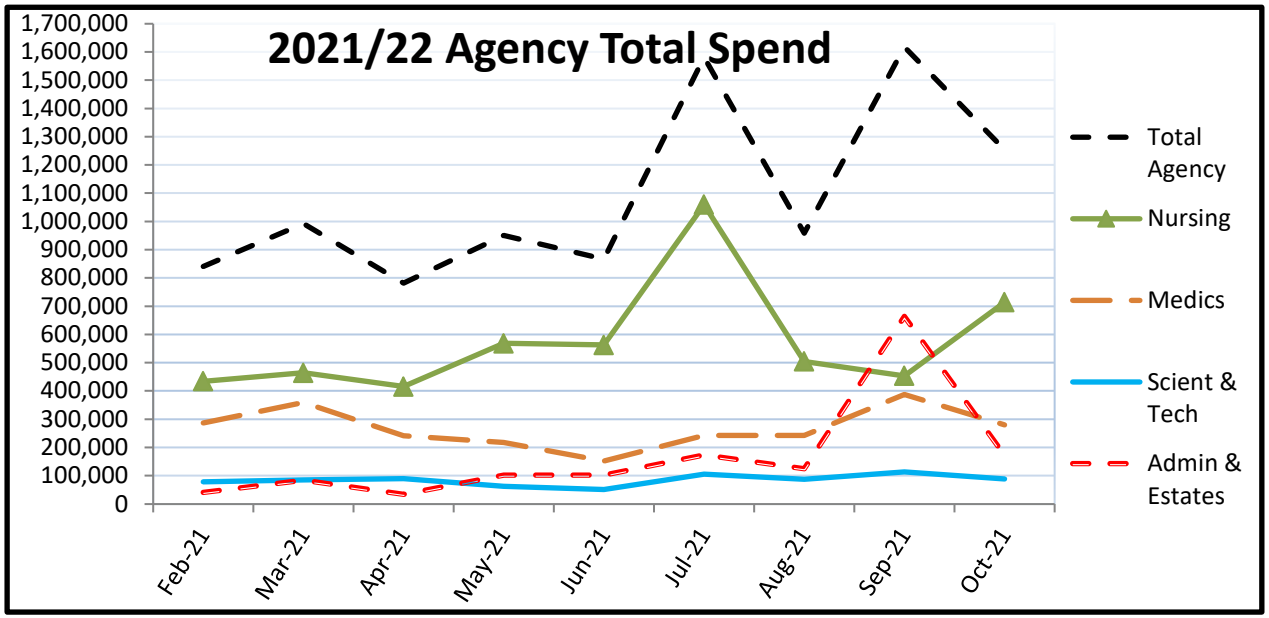
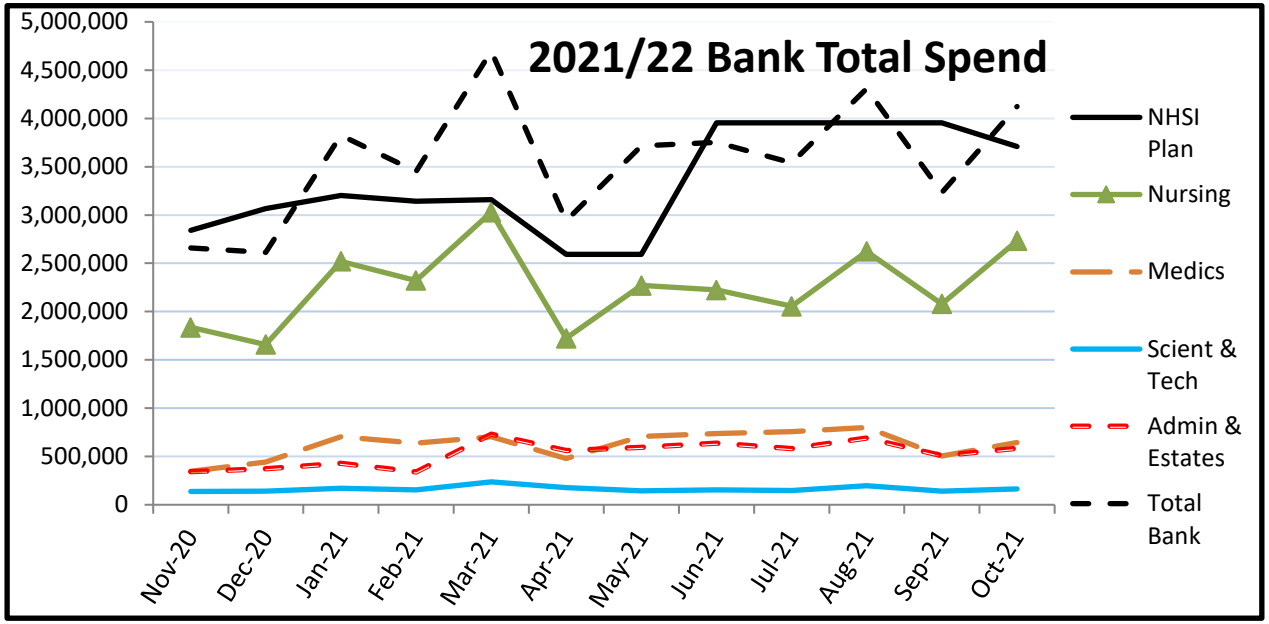
Temporary Staff Costs

Agency spend has decreased month on month by £0.4m. However, this includes an increase in nursing staff costs (£0.3m) offset by a decrease in admin and estates staff costs (£0.5m). Medical agency costs also fell by £0.1m month on month. The majority of the decrease was due to the vaccination programme month on month decrease of £0.6m.

Expenditure on bank staff has increased month on month (£0.9m) with increases across all staff groups with the largest increase in Nursing (£0.7m) . The largest increases in spend were in critical care (£140k), the vaccination programme (£120k), theatres and anaesthetics (£120k) and a emergency care (£90k).



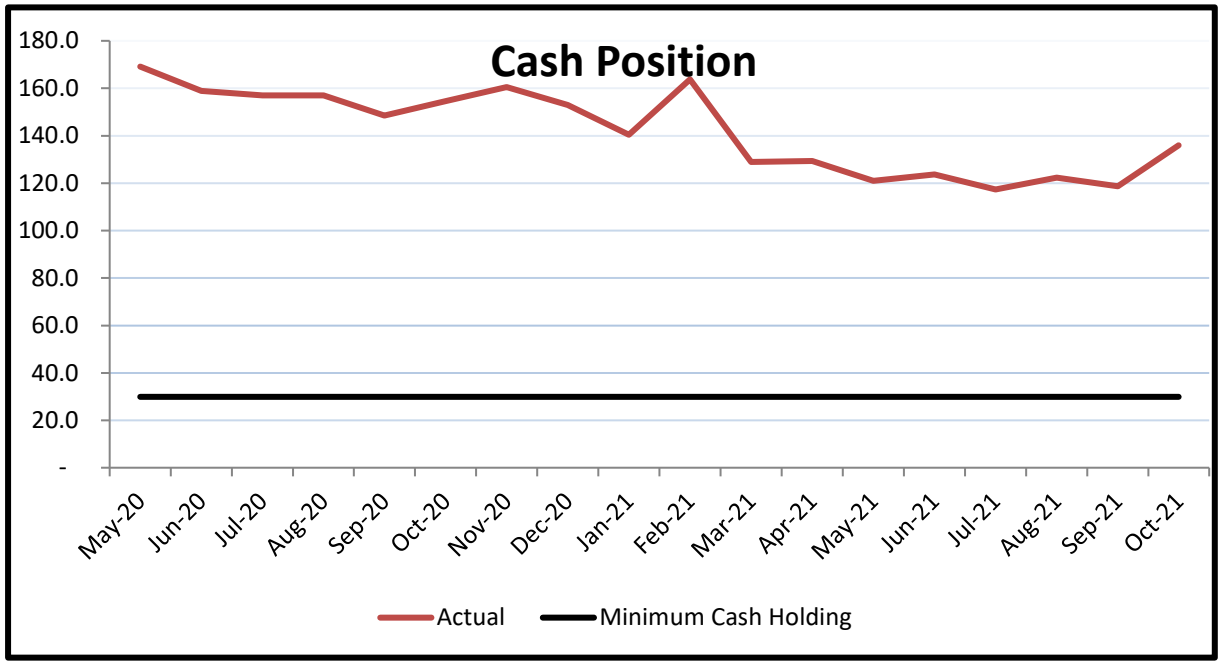


Cash

The cash balance increased in October to £135.9m mainly due to the receipt of the pay award income (£14m) and the settlement of an ERF invoice with HIOW CCGs.

There are no foreseen material movements forecast now the cash regime has adjusted back to pre-covid levels with block income paid in the month for which it is due. We may however see some in-month volatility as we move to a more "normal" period and the working capital position stabilises.

A gradual reduction is expected over the next two years as capital expenditure plans exceed depreciation. A slow downward trajectory is therefore forecast.



Capital Expenditure

(Fav Variance) / Adv Variance

Expenditure on internally funded capital schemes is £26.7m YTD against budget of £28.9m. 54% of the annual plan has therefore been incurred to date.

Total expenditure in M7 was slightly higher than average (£4.2m) due to a high level of expenditure on the ED expansion scheme, IT and equipment leases.

The forecast remains on plan plus £0.46m accelerator funding. Significant expenditure is required in the areas of Strategic/Backlog Maintenance and IT to achieve the forecast expenditure, but detailed plans are in place to facilitate this.

The Trust has bid for additional external capital funding for a number of schemes and the forecast will be updated to reflect the outcome of these bids when formal confirmation is received. The most recent announcement has confirmed that £2.9m of external funding will be received for IT, critical care and cardiology. These schemes are not included within the current forecast.

	Month			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
Fit out of E level. Vertical Extension - Theatres	396	156	240	11,941	9,930	2,011	11,941	10,680	1,261
Strategic Maintenance	515	182	333	2,062	1,524	538	6,183	6,183	0
Additional Backlog Maintenance Schemes	0	(0)	0	0	93	(93)	0	2,504	(2,504)
ED Expansion and Refurbishment	1,029	1,803	(774)	5,791	4,027	1,764	5,791	6,340	(549)
Wards	600	0	600	600	16	584	4,000	16	3,984
Ophthalmology OPD	294	321	(27)	2,996	2,734	262	3,303	3,068	235
Maternity Induction Suite	233	0	233	233	0	233	2,000	92	1,908
NICU Pendants	224	0	224	672	4	668	896	355	541
Oncology Ward	0	23	(23)	861	543	318	861	861	0
Decorative / Environment Improvements	42	0	42	210	0	210	500	200	300
Side Rooms	0	0	(0)	490	521	(31)	490	551	(61)
Information Technology Programme	500	667	(167)	2,000	2,019	(19)	5,000	5,000	0
Other Projects	132	103	29	1,429	1,699	(270)	2,710	3,721	(1,011)
Pathology Digitisation	117	1	116	471	131	340	1,171	1,171	0
Medical Equipment	83	146	(63)	417	743	(326)	1,000	2,016	(1,016)
Donated Schemes and Equipment	29	105	(76)	203	310	(107)	350	1,121	(771)
Accelerator Funded Equipment	0	0	0	0	124	(124)	0	460	(460)
Slippage	(316)	0	(316)	(3,452)	0	(3,452)	(5,035)	0	(5,035)
Total Trust Funded Capital excl Finance Leases	**3,878**	**3,508**	**370**	**26,924**	**24,418**	**2,506**	**41,161**	**44,339**	**(3,178)**
Finance Leases - IISS	0	0	0	630	374	256	5,230	2,035	3,195
Finance Leases - MEP	183	30	153	917	519	398	2,200	1,183	1,017
Finance Leases - Other Equipment	150	682	(532)	600	1,300	(700)	1,500	4,652	(3,152)
Finance Leases - Opthalmology OPD	291	(38)	329	291	362	(71)	1,166	362	804
Finance Leases - Divisonal Equipment	50	2	48	175	153	22	475	500	(25)
Donated Income	(146)	(106)	(40)	(674)	(440)	(234)	(1,921)	(2,293)	372
Total Trust Funded Capital Expenditure	**4,406**	**4,077**	**329**	**28,863**	**26,687**	**2,176**	**49,811**	**50,778**	**(967)**
Profit on Disposal	0	0	0	0	0	0	0	(507)	507
Total Including Technical Adjustments	**4,406**	**4,077**	**329**	**28,863**	**26,687**	**2,176**	**49,811**	**50,271**	**(460)**
Fit out of E level. Vertical Extension - Theatres	44	44	0	700	700	0	700	700	0
Maternity Care System (Wave 3 STP)	192	31	161	768	836	(68)	1,917	1,776	141
Digital Outpatients (Wave 3 STP)	81	5	76	327	112	215	814	955	(141)
LIMS Digital Enhancement	38	0	38	266	(0)	266	455	923	(468)
Community Diagnostic Hub	0	0	0	0	0	0	0	1,578	(1,578)
Radiology Home Reporting	0	0	0	0	0	0	0	480	(480)
Pathology Digitisation	0	0	0	0	0	0	0	809	(809)
Total CDEL Expenditure	**4,761**	**4,157**	**604**	**30,924**	**28,335**	**2,589**	**53,697**	**57,492**	**(3,795)**

Statement of Financial Position

(Fav Variance) / Adv Variance

The October statement of financial position illustrates net assets of £439.1m, with the main movements within the position explained below.

The £24.3m decrease in receivables is driven by the receipt of £14m pay award and other funding primarily from NHS England, settlement of £7m ERF invoice by HIOW CCGs and a £3m reduction in VAT debtors.

Cash has increased by £17.2m in month due to the receipt of the funding shown above in the receivables movement. Capital (PDC) funding of £1.3m was also drawn down in month.

Statement of Financial Position	2020/21 YE Actuals £m	2021/22 M6 Act £m	2021/22 M7 Act £m	2021/22 MoM Movement £m
Fixed Assets	419.4	428.9	431.8	2.9
Inventories	14.7	17.5	17.5	(0.0)
Receivables	67.4	92.6	68.3	(24.3)
Cash	129.0	118.7	135.9	17.2
Payables	(171.6)	(205.9)	(203.6)	2.2
Current Loan	(2.7)	(2.0)	(2.0)	0.0
Current PFI and Leases	(9.0)	(8.5)	(8.8)	(0.3)
Net Assets	**447.2**	**441.3**	**439.1**	**(2.2)**
Non Current Liabilities	(18.3)	(17.6)	(18.0)	(0.4)
Non Current Loan	(8.5)	(7.8)	(7.5)	0.3
Non Current PFI and Leases	(36.3)	(33.6)	(33.4)	0.2
Total Assets Employed	**384.0**	**382.4**	**380.2**	**(2.2)**
Public Dividend Capital	246.0	246.0	247.4	1.3
Retained Earnings	114.0	112.4	108.9	(3.5)
Revaluation Reserve	24.0	24.0	24.0	0.0
Other Reserves	0.0	0.0	0.0	0.0
Total Taxpayers' Equity	**384.0**	**382.4**	**380.2**	**(2.2)**

University Hospital Southampton NHS
NHS Foundation Trust

Report to the Board of Directors				
Title:	**Freedom to Speak Up Report**			
Agenda item:	**5.6**			
Sponsor:	**Gail Byrne, Chief Nursing Officer**			
Author:	**Christine Mbabazi, Freedom to Speak Up Guardian**			
Date:	**30 November 2021**			
Purpose	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **x**
Issue to be addressed:	The paper provides an update on the Freedom to Speak Up (FTSU) agenda and reports 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 • the actions taken from the concerns raised.			
Implications: (Clinical, Organisational, Governance, Legal?)	1. Mechanism to support for the creation of a culture where staff 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. 2. Compliance with the raising concerns policy for the NHS following the recommendations made by Sir Robert Francis after the enquiry into Mid Staffordshire NHS Foundation Trust. 3. Compliance with the Public Interest Disclosure Act 1998.			
Risks: (Top 3) of carrying out the change / or not:	1. Failure to keep improving services for patients and the working environment for staff. 2. Failure to support a culture based on safety, openness, honesty and learning. 3. Failure to comply with NHS requirements and best practice and commissioning contracts			
Summary: Conclusion and/or recommendation	The Board is asked to note this report.			

1 Executive Summary

This is an update following the last report written in May that focussed on the national survey of Freedom to Speak Up Guardians. This report reflects the themes of concerns raised since May 2021 and the recruitment of FTSU champions.

In the report to the Board in November 2020 the Trust had received 50 cases from 22 May to 18 November 2020. This year the Trust has received 87 cases from 27 May to 22 November 2021, slightly more than last year. The increase in the number of cases this year is due to vaccination issues raised between August and October 2021. During this time the FTSU Guardian received a high number of calls regarding the impact of redeployment due to vaccination status as well as bullying and harassment concerns.

2 Purpose/Context/Introduction

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

3. Case Update

The Trust has received 87 FTSU cases from 27 May to 22 November 2021. A summary of the cases received in the period are detailed in the table below:

Category	**Covid Concerns**	**Other**	**Total**
Vaccination and redeployment	16	0	16
Bullying and Harassment	0	20	20
Vaccination calls	44	0	44
Other concerns raised	0	7	7
Total	60	27	87

It should be noted that, following guidance from NHS England and NHS Improvement and the National Guardian's 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. Themes, concerns raised and Actions that have been taken.

- **Vaccinations:** Concerns were raised by staff in patient-facing roles who had not been vaccinated and were to be redeployed. Most staff contacted the FTSU guardian as an opportunity to have open, confidential conversations regarding their views on vaccinations and redeployment.
    a) The right to make a choice: Most people who contacted the guardian wanted to express their right to make a choice about vaccination was being infringed. They felt this right was taken away by the condition of being redeployed to another role if they remained unvaccinated. They were angry and frustrated and others expressed that this had affected their mental health.
    b) Unsafe working: Other persons contacted the guardian because they did not want to share an office with individuals who had not been vaccinated. They referred to working with individuals who had not been vaccinated as unsafe. The Human resources team has resolved these cases in different ways to address concerns.
    c) Bullying of the unvaccinated: Some staff groups have contacted the guardian because they had been bullied, treated as "dirty" or intimidated because they have chosen not to be vaccinated.

d) Isolation and discrimination: Another reason people contacted the guardian was isolation. More than 95% of the hospital staff have been vaccinated leaving a small percentage of staff unvaccinated. Individuals who have not been vaccinated have reported feelings of isolation and bullying and intimidation as previously mentioned.

What has the organisation done regarding the above?

1) The vaccination team at UHS have organised access to a number of experts and specialists both within UHS and at the University of Southampton who have offered to meet with individual staff members who remain undecided or who have concerns about vaccination against COVID-19.
2) The team have also provided up-to-the-minute advice and information on: the immune response to COVID-19 infection and the various vaccines; the safety of vaccination in pregnancy or for those hoping to conceive; and what the vaccines contain and whether they are suitable for those with allergies or from specific religious groups (and if an alternative can be provided).
3) Aside from the expert advice on vaccination, UHS has provided a package of wellbeing support resources ,which they have encouraged staff to access. This includes support that can be accessed via staff line at staffline@uhs.nhs.uk.
4) Staff have also been able to raise their concerns confidentially with our freedom to speak up advisor, offering a confidential supportive conversation.
5) The FTSU guardian and wellbeing manager are setting up a support group for persons who have not been vaccinated to avoid isolation and create a safe space for them to speak up about matters that concern them.

- **Bullying and Harassment:** Bullying, harassment and discrimination remains the category with the highest number of concerns received in any quarter in most trusts. This has been because people feel safe to raise these with the Guardian knowing they are protected, with the added advantage of confidentiality giving them the confidence to speak up about a bullying culture. Consistently the Human resources team is dealing with these concerns regarding bullying and harassment and in some cases culture reviews have been used. It is not clear whether the bullying is related to an exhausted, overworked workforce that is spread thinly with less patience or is it just people being unkind. Human resources are dealing with these issues on a case-by-case basis and using a range of methods, from informal to formal including mediation, to resolve these cases. There have been some delays in dealing with cases as resources had been diverted to the vaccination project. Provision of wellbeing support resources like psychological help and counselling is vital in these cases as bullying, harassment, victimisation and discrimination in most cases affects people's mental wellbeing and self-esteem.

5. Recruitment of Freedom to Speak Up Champions

The Freedom to speak up guardian cannot be effective in isolation. The role requires us to work in partnership throughout the organisation to support speaking up and translating learning into practice to improve safety and the experience for all.

Having a Freedom to speak up network of champions helps in raising awareness, promoting the value of speaking up, listening up and following up. The network of champions addresses the challenges of size, geography and the nature of the work especially when it comes to barriers of speaking up. We have now increased our network of champions from eleven working champions to 40 working champions. We advertised for this role in July 2021 and were pleasantly surprised with the high number of volunteers interested in this role. These champions are from different staff groups, clinical and non-clinical and from different backgrounds and walks of life, which is an important factor to embedding a speaking up culture.

6 Next Steps/Way Forward/Implications/Impact

The FTSU guardian and champions network will continue to encourage and support staff to speak up if they are concerned. The importance of doing this throughout the COVID-19 pandemic, to ensure patient and staff safety, has been noted at national level by the National Guardian's Office and the CQC.

5 Recommendation

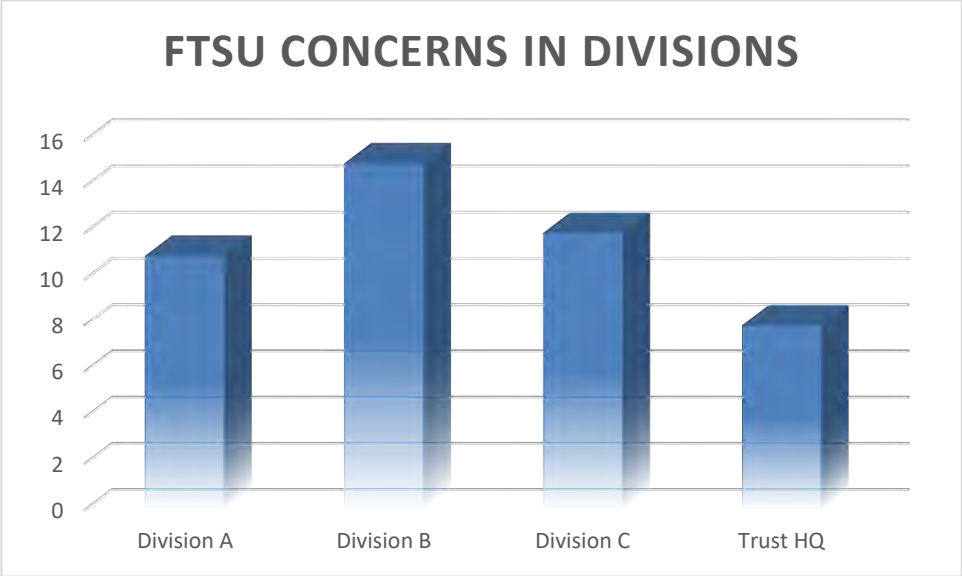
Trust Board is asked to note:

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

Appendix A: Freedom to Speak Up Dashboard (June – November 2021)

Year	Qtr	Date Concern Raised	Department	Contact Method (Internal / External)	Trust Board Summary	Status
2021	Q1	09/06/2021	Division B	Internal	Patient safety Issues -Due to change of service from Eye unit to ED	Closed
2021	Q1	11/06/2021	Division C	Internal	Impact of the cultural review on managers - physio	Closed
2021	Q1	18/06/2021	Division B	Internal	Bullying atmosphere of manager	In progress
2021	Q2	01/07/2021	Division A	Internal	Bullying culture in department [redacted]	
2021	Q2	15/07/2021	Division B	Internal	Unfair recruitment practices	Closed
2021	Q2	23/07/2021	Division C	Internal	Bullying culture in Department	In progress
2021	Q2	23/07/2021	Division B	Internal	Certificate of Sponsorship issues, unfair education practices	In progress
2021	Q2	23/07/2021	Division C	Internal	Redeployment issues	Closed
2021	Q2	26/07/2021	Division B	Internal	Bullying and Harrassment:, Financial abuse of patient	In progress
2021	Q2	26/07/2021	Division A	Internal	Bullying behaviour of manager	In progress
2021	Q2	29/07/2021	Division B	Internal	Team Dynamics.Toxic and bullying behaviour of managers	In progress
2021	Q2	02/08/2021	Trust management	Internal	Mandatory Vaccinating and redeployment	Closed
2021	Q2	04/08/2021	Division C	Internal	Unfair pay, promotion, oncall issues	Closed
2021	Q2	18/08/2021	Division B	Internal	Bullying behaviour of manager	In progress
2021	Q2	18/08/2021	Division B	external [redacted] Testing	Bullying and harrassment of managers	In progress
2021	Q2	26/08/2021	Division A	Internal	Bullying behaviour Of staff	In progress
2021	Q2	26/08/2021	Division A	Internal	Bullying behaviour of manager	In progress
2021	Q2	29/08/2021	Division B	Internal	Unsupported working due to redeployment of unit	Closed
2021	Q2	03/09/2021	Division C	Internal	Bullying due to unvaccination	Closed
2021	Q2	03/09/2021	Division A	Internal	Mandatory Vaccinating and redeployment	closed
2021	Q2	06/09/2021	Division C	Internal	Mandatory Vaccinating and redeployment	Closed
2021	Q2	06/09/2021	Division B	Internal	Mandatory Vaccinating and redeployment	Closed
2021	Q2	08/09/2021	Trust HQ	Internal	Mandatory Vaccinating and redeployment	Closed
2021	Q2	09/09/2021	Division C	Internal	Mandatory Vaccinating and redeployment	Closed
2021	Q2	09/09/2021	Division C	Internal	Mandatory Vaccinating and redeployment	Closed
2021	Q2	09/09/2021	Division A	Internal	Mandatory vaccination and feeling unsafe due to unvaccinated colleague	Closed
2021	Q2	10/09/2021	Division B	Internal	Mandatory Vaccinating and redeployment	Closed
2021	Q2	14/09/2021	Division B	Internal	Mandatory Vaccinating and redeployment	Closed
2021	Q2	16/09/2021	Trust HQ	Internal	Fraud	In progress
2021	Q2	16-20/09/2021	All	Internal	Mandatory Vaccinating and redeployment - Several phonecalls(more than 15 calls a day) from staff in different divisions after receiving HR letter	In progress
2021	Q2	27/09/2021	Division A	Internal	Redeployed unvaccinated staff and my medical health	Closed
2021	Q3	08/10/2021	Division A	Internal	Offensive racist graffitti	closed
2021	Q3	13/10/2021	Division C	Internal	Bullying and intimidating behaviour of senior manager	In progress
2021	Q3	15/10/2021	Division A	Internal	Bullying and harassment at work	In progress
2021	Q3	18/10/2021	Division A	Internal	Bullying behaviour of manager	In progress
2021	Q3	22/10/2021	Trust HQ	Internal	Redeployment issues	Closed
2021	Q3	22/10/2021	Division C	Internal	Redeployment due to Vaccination concerned about Nurse Pin	Closed
2021	Q3	28/10/2021	Division C	Internal	Bullying behaviour of manager	In progress
2021	Q3	08/11/2021	Division B	Internal	Sexual Harassment	In progress
2021	Q3	08/11/2021	Division B	Internal	Team dynamics	In progress
2021	Q3	18/11/2021	Division C	Internal	Discrimination, team dynamics and bullying manager	In progress
2021	Q3	18/11/2021	Trust HQ	Internal	Discrimination, team dynamics and bullying manager	In progress
2021	Q3	18/11/2021	Trust HQ	Internal	Team dynamics and bullying	In progress
2021	Q3	19/11/2021	Division A	Internal	Sexual Harassment	In progress
2021	Q3	19/11/2021	Division B	Internal	Bullying and harassment	In progress
2021	Q3	19/11/2021	Trust HQ	Internal	Bullying and harassment - appraisal	In progress

Appendix B: Freedom to Speak Up Cases in Divisions



University Hospital Southampton NHS Foundation Trust

Report to Trust Board of Directors				
Title:	**EDI Update including WRES & WDES annual reports and action plans**			
Agenda item:	**5.7**			
Sponsor:	**Steve Harris – Chief People Officer**			
Author:	**Ceri Connor – Director of OD and Inclusion** **Gemma Genco – Head of Equality, Diversity and Inclusion**			
Date:	**30 November 2021**			
Purpose	**Assurance or reassurance** **X**	**Approval**	**Ratification**	**Information** **X**
Issue to be addressed:	To deliver our aspiration of World Class Care delivered by World Class People, we strive towards creating a diverse workforce and being an inclusive employer. There is compelling research evidencing the benefits of Workforce inclusivity linked organisational performance and improved patient outcomes, also it is a moral imperative to address any societal and structural disadvantage faced by minority groups. We use a diverse range of data sets and indicators to measure our progress toward a culture where people feel a sense of belonging, where they feel there is equity in terms of opportunities for promotion and development, and where they feel safe from bullying, harassment and violence. The Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) is the nationally mandated system to monitor our status and progress. WRES was first introduced in 2015 and has since been an annual reporting requirement for all NHS Trusts. WDES was introduced in 2019 to measure the experience of disabled staff in the workplace compared to non-disabled staff. UHS is mandated to report the WRES and WDES outcomes annually, publish the data and associated action plan. The 2021 data comprises of a mix of 2020 NHS Staff Survey results, and internal UHS workforce data gathered in Q2 2021 against a set of nationally defined criteria and published on a national timeline in September 2021. This report summarises the key findings of our 2021 data submission and identifies the year-on-year data trends since the introduction of the standards. Recommendations for action are made in line with evidence and best practice to enable UHS to make a more substantial shift in this agenda.			
Response to the issue:	**WDES key findings:** • The experience overall of disabled and BME staff is less favourable than white and non-disabled comparators. • There is under representation of staff in BME backgrounds at senior bands, although there has been growth. There is under representation of BME colleagues in senior medical positions in the Trust. • Both disabled and BME staff are less likely to be shortlisted and appointed to roles than white and non-disabled comparators. • BME and disabled staff face higher levels of discrimination, abuse and harassment from patients, service users and staff than comparator colleagues.			

	• BME staff are less likely to enter formal disciplinary processes than white colleagues. • Disabled staff are less likely to enter formal capability processes than non-disabled colleagues. • BME staff are less likely than White counterparts to access non-mandatory training. **Our response** UHS has made progress in some elements of the WRES and WDES data, however the analysis of the year-on-year data since 2015 and the staff survey results shows us that the data remains static, with small decreases and increases across all the indicators. It does not demonstrate we are making sustained improvements across all indicators year on year. In the first three years of the WDES data we have made some progress, but we are yet to understand if this will improve or be maintained in 2021. Therefore, it is imperative that we asses our current strategies and interventions and where needed enhance them to ensure a more progressive approach grounded in systematic processes and in accountability and personal responsibility.
Implications: (Clinical, Organisational, Governance, Legal?)	The following implications should be noted: • **Culture** - Requirement to ensure inclusivity and belonging becomes a central focus of the implementation of the UHS 5-year strategy and response to the NHS People Plan. • **CQC** - To note that the CQC well led domain, and achieving outstanding, requires excellence to be demonstrated in this field. It is likely the CQC will increase their scrutiny of Diversity and Inclusion activities when conducting inspections. Organisations who are rated Outstanding have embedded strategies and demonstrable outcomes in this area which positively impacts on staff and patient experience. • **Governance** - Ensuring inclusivity becomes core in our organisational governance will be key. The plan proposes to ensure this is reviewed as part of our performance management processes within Divisions, Care Groups and through Divisional Governance. Provision and analysis of data at local level will be important to achieve this. • **Diverse voice** - UHS will look for opportunities to ensure diverse thought is included in decision making. The Lead for the BAME Network and the Long-term Illness and Disability Network are standing members of People Board and attendees of the People and OD Committee (a formal committee of the Trust Board). • **Legal framework** - UHS must continue to ensure it complies with its legal duties under the Equalities Act (2010).
Risks: (Top 3) of carrying out the change / or not:	BAF risk 3a) We fail to recruit, retain, and develop a diverse, compassionate, and inclusive workforce to meet our corporate strategy aims.
Summary: Conclusion and/or recommendation	To make a shift in our WRES/WDES and wider culture we need to take some courageous and impactful action beyond the “initiatives” and make systemic changes, these are detailed in our EDI plan 2021/22 progress of which reports through the EDI Committee and People and OD Governance groups.

	The members of the Trust Executive Committee (17.11.21) were asked, and agreed to, take personal leadership action on the following: • Support and engage in the implementation of the EDI plan and creation of the EDI strategy either through the EDI Committee, People Board, People and OD Committee, Staff Networks, planned engagement events, or direct contact with the OD and Inclusion team. • To support the development of more regular EDI data scrutiny, including the co-design of data packs to be used within existing performance and governance framework. • Support the development of staff networks to have a vital role in steering our approaches to equality, diversity and inclusion, this includes enabling members to be released to attend and actively engage. • Participate in the Actionable Allyship Programme, and undertake continuous learning on this agenda, as guided by the OD and Inclusion team and network leads. • Support the creation of a gender specific monitoring standard, aligned to WRES/WDES, to enable increased scrutiny and action on gender equality. • Commitment to senior leadership role modelling and personal action and commit to more progressive actions as detailed in this paper. UHS Trust Board members are asked to: • Continue to provide collective commitment and support to this drive this agenda. • Note and support the immediate actions required (appendix 3) as per the EDI plan 2021/22. • Note the actions for TEC members, listed above. • To continue to support actionable allyship and participate in continued learning on this agenda, including opportunities for to gain valuable insight and lived experience.

1. The Workforce Race Equality Standard (WRES), and Workforce Disability Equality Standard (WDES); the story so far.

July 2014 - the NHS Equality and Diversity Council announced a set of actions to ensure employees from Black and ethnic minority ethnic backgrounds has equal access to career opportunities and receive fair treatment in the workplace.

April 2015 – following on from consultation and engagement across England, the WRES was mandated through the NHS Standard contract, starting in 2015/16 financial year. Consisting of nine indicators (appendix 1):

- Four on UHS workforce data,
- Four on the national staff survey specific questions,
- One on the BME representation on the Trust Board.

2017 – Independent healthcare providers were required to publish their WRES data and action plan.

2019 – The Workforce Disability Equality Standard was commissioned by the NHS Equality and Diversity council, also mandated through the NHS Standard Contract. The WDES is a data set against 10 metrics (appendix 1):

- Three on UHS workforce data,
- Five based on questions from the NHS Staff Survey,
- One on disability representation on the Trust Board,
- One on the voices of Disabled staff, a composite score calculated by the responses to nine questions in the staff survey to derive an engagement score.

Trusts are required to publish a WRES/WDES annual report and action plan, articulating plans to address areas of concern and celebrate areas of success.

1.2 WRES AND WDES, Inclusion and Belonging – The UHS Story so far

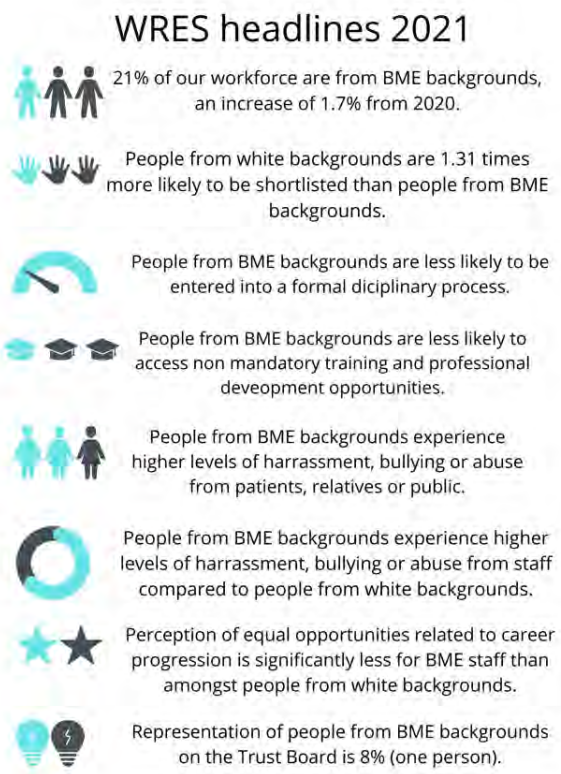
For UHS this is more than just a statutory duty, as an organisation we have made a commitment to growing our culture; to create a place to work where diversity of people is valued, people can be their whole selves, people report they feel a sense of belonging, that they feel safe in pursuit of their daily work without fear of harassment or bullying, and they have fair and equal access to opportunities and career progression.

The WRES and WDES report continues to provide a quantative data set, measured against a set of nationally defined criteria over the last five years (appendix 1). This data supports us to identify if we are making progress towards our strategic ambitions.

During 2019/20 there were a number of factors which enabled UHS to gain traction in this agenda; the emergence of the global Covid-19 pandemic and the disproportionate impact of Covid on people from black and ethnic minority backgrounds, and the murder of George Floyd and the subsequent Black Lives Matter movement. A programme of listening events and interventions were carried out across the organisation, and pulse surveys. The One Voice network were pivotal in supporting organisational learning at the time, as a result all themes were analysed, and the Trust Race Equality Improvement Plan was created.[1] Further actions have been taken since, summarised in appendix 2.

[1] Our Race Equality Improvement Plan. Acting now, changing the future

2. Summary of 2021 WRES and WDES



NB: Five-year WRES trends 2017- 2021, and three-year WDES trends 2019-21 in Appendix 1.

3. Focus on recruitment and career progression

Despite the positive actions and interventions to date, we need to fully embed these and make a paradigm shift in our actions, particularly the target we set to achieve greater representation across our workforce. To make these shifts we must pay closer attention to removing bias from systems and processes and take additional action in terms of leadership and culture.

In 2018, UHS Trust Board agreed a target of 19% BME staff representation across all bands.
There has been success as follows (data correct as of 30 August 2021):

- B5 non-clinical roles, 15.79% are from BME backgrounds
- B5 clinical roles; 36.52% are from BME backgrounds
- B4 clinical roles; 29.45% are from BME backgrounds
- Medical trainees; 43.52% are from BME backgrounds
- Non-Consultant and Consultant grades; 27.16% and 23.06% from BME backgrounds retrospectively.

The representation of people with BME backgrounds takes a steep decline in clinical and non-clinical roles once you reach roles at 8A and above, to below 10% BME representation. There is no clinical representation of people from BME backgrounds at roles B8D and 9.. We require dedicated focus and courageous decision making to bridge the ethnicity gap in senior leadership roles, and reflection on why we haven't been able to make progress specifically in leadership roles bands 8A and above.
Full graphic breakdown can be found in appendix 3.

3.1 How to shift the paradigm

Roger Kline's research report, *No more Tick Boxes*, 2021, was commissioned by NHS East of England. It identifies how recruitment and promotion practices are crucial to making improvements, and how leadership, particularly accountability, is key in taking action. Figure 1 below articulates the shift in model.

Fig1. The old and new paradigm for recruitment and career progression[2]

OLD MODEL	NEW MODEL
Emphasises importance of policies, procedures and training thus setting standards and enabling individuals to raise concerns safely.	Emphasises importance of accountability and transparency. Adopts a **"public health"** approach to improving outcomes, triangulating data to be proactive and preventative, Intervenes to encourage staff, seeing fair and effective career progression as a key management function
Substantial emphasis on diversity training and unconscious bias training	Understanding the biases, stereotypes and assumptions that distort decision making in recruitment career progression is important but training alone will not significantly change decision making
Encouragement and support to individuals to take advantage of development opportunities through mentoring and positive action. Training for panels and managers on ensuring processes are followed and are fair and free of bias	Granular attention to primarily removing bias from processes, not through training individuals at each stage of the career lifecycle by understanding how bias and stereotypes affect decision making and how to mitigate it. Emphasises tracking all individual's development proactively, linked to effective appraisals, transparent access to stretch opportunities
Delegated to HR and often under-resourced	Key Board issue led by CEO and Chair

[2] No More Tick Boxes: A review of the evidence on how to make recruitment and career progression fairer 2021 Roger Kline.

Our focus needs to shift from initiatives to systemic changes. The Trust EDI action plan, which was approved by the EDI Committee in October 2021.

In summary the key actions are as follows:

- Development of a Trust EDI position statement and EDI strategy aligned to our People Strategy and wider Trust Strategic Framework.
- Agree Diversity and Inclusion objectives for all senior leaders for 2022 to drive accountability.
- Agree KPIs linked through to WRES/WDES outcomes embedded into all Divisions through Trust governance and performance mechanisms.
- Continue to strengthen the recruitment and selection policy and processes to ensure bias is eliminated. Develop, and launch Inclusive Recruitment training.
- As part of the development of the UHS Talent Management Strategy, create an effective talent management framework to support the increase of diverse representation of people in senior roles. Driven by data, research evidence and best practice, constantly reviewing if interventions are making a positive impact as intended.
- Continue extensive roll out of Allyship training, including bitesize version for team meetings.
- As part of the EDI plan create a series of metrics aligned to the WRES and WDES for experience relating to gender.

Full details are in appendix 4.

4. Conclusion and Recommendations

To make a shift in our WRES/WDES and wider culture we need to take some courageous and impactful action beyond the “initiatives” and make systemic changes, these are detailed in our EDI plan 2021/22 progress of which reports through the EDI Committee and People and OD Governance groups.

The members of the Trust Executive Committee (17.11.21) were asked, and agreed to, take personal leadership action on the following:

- Support and engage in the implementation of the EDI plan and creation of the EDI strategy either through the EDI Committee, People Board, People and OD Committee, Staff Networks, planned engagement events, or direct contact with the OD and Inclusion team.
- To support the development of more regular EDI data scrutiny, including the co-design of data packs to be used within existing performance and governance framework.
- Support the development of staff networks to have a vital role in steering our approaches to equality, diversity and inclusion, this includes enabling members to be released to attend and actively engage.
- Participate in the Actionable Allyship Programme, and undertake continuous learning on this agenda, as guided by the OD and Inclusion team and network leads.
- Support the creation of a gender specific monitoring standard, aligned to WRES/WDES, to enable increased scrutiny and action on gender equality.
- Commitment to senior leadership role modelling and personal action and commit to more progressive actions as detailed in this paper.

UHS Trust Board members are asked to:

- Continue to provide collective commitment and support to this drive this agenda.
- Note and support the immediate actions required (appendix 4) as per the EDI plan 2021/22.
- Note the actions for TEC members, listed above.
- To continue to support actionable allyship and participate in continued learning on this agenda, including opportunities for to gain valuable insight and lived experience.

References and further reading

The full WRES and WDES reports, and action plans can be found here: Equality reports (uhs.nhs.uk)

Our race equality improvement plan (uhs.nhs.uk)

No More Tick Boxes, Roger Kline 2021
NHSE-Recruitment-Research-Document-FINAL-2.2.pdf (england.nhs.uk)

If your face fits; Exploring common mistakes to addressing equality and equity in recruitment. A practitioner guide based on No More Tick Boxes
NHS-Practitioners-Guide-If-Your-Face-Fits_FINAL.pdf (england.nhs.uk)

'A long way to go': ethnic minority NHS staff share their stories (kingsfund.org.uk)

https://features.kingsfund.org.uk/2020/07/ethnic-minority-nhs-staff-racism-discrimination/index.html?_ga=2.124739274.1776743583.1636463860-1430412908.1628519809

Closing the gap: Key areas for action on the health and care workforce (kingsfund.org.uk)

Appendix 1: WRES Indicators and data (2017 to 2021)						
Data Source	**WRES Indicator**	**2017**	**2018**	**2019**	**2020**	**2021**
UHS Workforce Data	% of staff in overall workforce, non-clinical workforce, and clinical workforce	**15.36%** BME staff in overall workforce **8.9%** BME staff in non-clinical workforce **15.03%** BME staff in clinical workforce	**16.4%** BME staff in overall workforce **9.2%** BME staff in non-clinical workforce **16.1%** BME staff in clinical workforce	**17.7%** BME staff in overall workforce **9.3%** BME staff in non-clinical workforce **19.77%** BME staff in clinical workforce	**19.3%** BME staff in overall workforce **9.96%** BME staff in non-clinical workforce **22.18%** BME staff in clinical workforce	**21%** BME staff in overall workforce **11.39%** BME staff in non-clinical workforce **24.5%** BME staff in clinical workforce
UHS Workforce Data	Relative likelihood of staff being appointed from shortlisting	White staff are **1.46** times more likely to be appointed from shortlisting	White staff are **1.08** times more likely to be appointed from shortlisting	White staff are **1.09** times more likely to be appointed from shortlisting	White staff are **1.31** times more likely to be appointed from shortlisting	White staff are **1.17** times more likely to be appointed from shortlisting
UHS Workforce Data	Relative likelihood of staff entering a formal disciplinary process *NB. A figure below "1" would indicate that BME staff members are **less likely** than white staff to enter the formal disciplinary process*	BME staff are **0.46** times more likely to enter a formal disciplinary process	BME staff are **1.17** times more likely to enter a formal disciplinary process	BME staff are **0.85** times more likely to enter a formal disciplinary process	BME staff are **0.68** times more likely to enter a formal disciplinary process	BME staff are **0.95** times more likely to enter a formal disciplinary process

Data Source	WRES Indicator	2017	2018	2019	2020	2021
UHS workforce data	% difference between the organisations' Board voting membership and the overall workforce	91.6% - White 8.4% - BME	84.6% - White **15.4% - BME**	84.6% - White 15.4% - BME	84.6% - White 15.4% - BME	91.6% - White **8.4% - BME**
NHS annual staff survey	% of staff experiencing harassment, bullying or abuse from staff *% of staff who selected "Yes" when answering this question of the total number of people who participated in the staff survey*	23.19% - White 26.58% - BME	20.77% - White 26.01% - BME	22% - White **28% - BME**	21.0% - White **25.7% - BME**	21.3% - White **28.5% - BME**
NHS annual staff survey	% of staff believing that trust provides equal opportunities for career progression or promotion *% of staff who selected "Yes" when answering this question of the total number of people who participated in the staff survey*	89.01% - White 78.02% - BME	89.68% - White **78.05% - BME**	91% - White **74% - BME**	91.3% - White **82.1% - BME**	90.3% - White **77.6% - BME**
NHS annual staff survey	% of staff personally experiencing discrimination at work by Manager/team leader or other colleagues *% of staff who selected "Yes" they had experienced discrimination at work out of the total number who participated the annual staff survey.*	6.4% - White 16.71% - BME	7.13% - White **14.59% - BME**	6% - White **13% - BME**	5.3% - White **15.4% - BME**	5.5% - White **16% - BME**

Appendix 1: WDES Indicators and data (2019 to 2021)				
Data Source	**WDES Indicator**	**2019**	**2020**	**2021**
UHS workforce data	**1:** % of Disabled staff in overall workforce	**3.1%** disabled staff in overall workforce	**15%** disabled staff in overall workforce	**13.4%** disabled staff in overall workforce
UHS workforce data	**2:** Relative likelihood of disabled staff being appointed from shortlisting *A figure below "1" would indicate that Disabled staff members are **less likely** to be appointed from shortlisting than non-Disabled staff.*	Disabled staff are **0.95** times more likely to be appointed from shortlisting	Disabled staff are **1.55** times more likely to be appointed from shortlisting	Disabled staff are **1.02** times more likely to be appointed from shortlisting
UHS workforce data	**3:** Relative likelihood of disabled staff entering a formal disciplinary process *A figure below "1" would indicate that Disabled staff members are **less likely** than non-Disabled staff to enter the formal disciplinary process*	Not required to report in 2019.	Disabled staff are **0.84** times more likely to enter a formal disciplinary process	Disabled staff are **0.97** times more likely to enter a formal disciplinary process
NHS annual staff survey	**4A:** % of staff experiencing harassment, bullying or abuse from patients, relatives or the public *% of staff who selected "Yes" when answering this question of the total number of people who participated in the staff survey*	**32.3% - Disabled** 23.3% - Non- Disabled	**30.8% - Disabled** 25% - Non- Disabled	**30% - Disabled** 25.2% - Non- Disabled
NHS annual staff survey	**4A:** % of staff experiencing harassment, bullying or abuse from managers *% of staff who selected "Yes" when answering this question of the total number of people who participated in the staff survey*	**15.3% - Disabled** 9.1% - Non- Disabled	**15.8% - Disabled** 8% - Non- Disabled	**13.7% - Disabled** 9.1% - Non- Disabled

Data Source	WDES Indicator	2019	2020	2021
NHS annual staff survey	**4B:** % of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months *% of staff who selected "Yes" when answering this question, of the total number of people who participated in the staff survey*	**50.8% - Disabled** 45% - Non- Disabled	**45.4% - Disabled** 45.5% - Non- Disabled	**49.6% - Disabled** 46.9% - Non- Disabled
NHS annual staff survey	**5:** % of staff believing that trust provides equal opportunities for career progression or promotion *% of staff who selected "Yes" they believe the Trust provides equal opportunities, when answering this question of the total number of people who participated in the staff survey*	**86.1% - Disabled** 89.2% - Non- Disabled	**85.4% - Disabled** 90.7 - Non- Disabled	**84.9% - Disabled** 88.8% - Non- Disabled
NHS annual staff survey	**6:** % of staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. *% of staff who selected "Yes" they have felt pressure to come to work when answering this question of the total number of people who participated in the staff survey*	**30.2% - Disabled** 21.9% - Non- Disabled	**21.9% - Disabled** 18.9% - Non- Disabled	**33.1% - Disabled** 23.6% - Non- Disabled
NHS annual staff survey	**7:** % of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work *% of staff who selected "Yes" they are satisfied with the extent to which their work is valued, of the total number of people who participated in the staff survey.*	**46.8% - Disabled** 56% - Non- Disabled	**44.5% - Disabled** 56.4% - Non- Disabled	**42.7% - Disabled** 54.9% - Non- Disabled

Data Source	WDES Indicator	2019	2020	2021
UHS Workforce data	**9: %** of Board members with declared disability	**0%** of staff with a declared disability sit on Trust Board	**0%** of staff with a declared disability sit on Trust Board	**0%** of staff with a declared disability sit on Trust Board

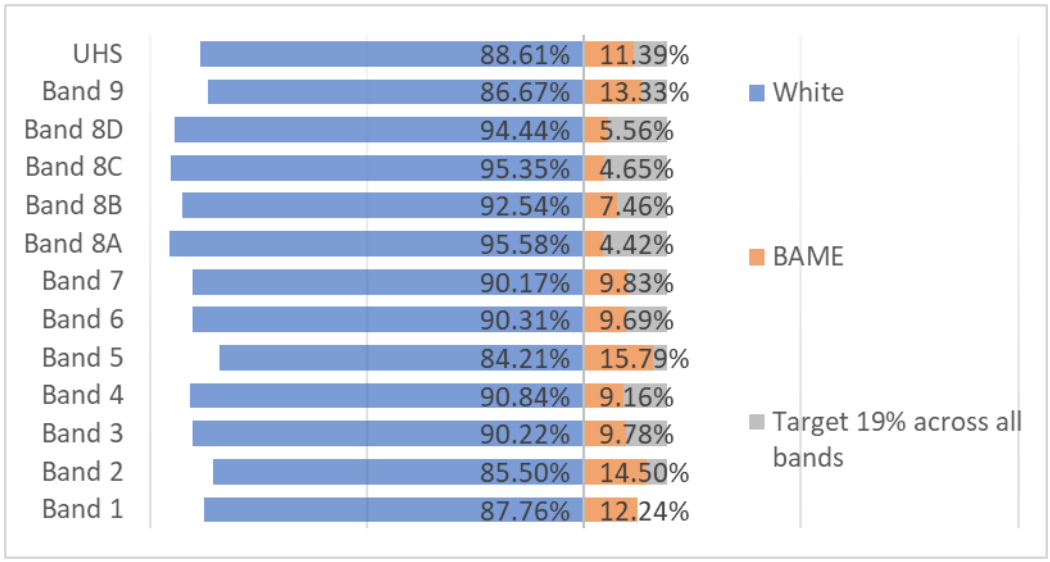
Appendix 2
Actions taken to date

Summarised below are some of the actions taken to date, which signals the Trust's intent to progress efforts and focus investment within the diversity, inclusion and belonging agenda:

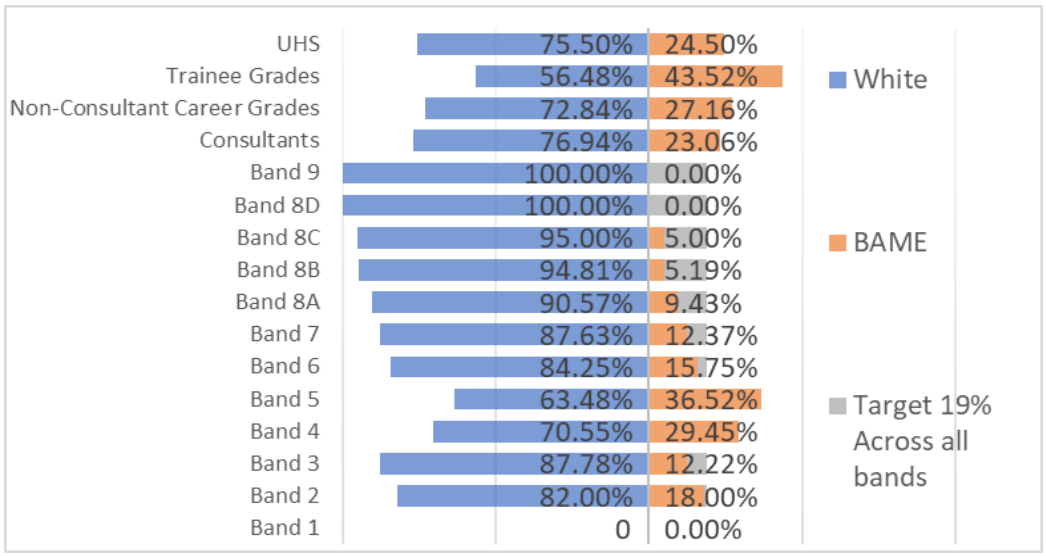
- One Voice (BAME) Network formed and active.
- Equality Impact Assessment process was enhanced.
- KPIs agreed; 19% representation of people from BME backgrounds across all staff groups.
- Delivery of the Inclusive Leaders programme and reciprocal mentoring.
- Introduction of revised recruitment and selection practices; improved R&S training, utilising independent panel members and enhanced induction practices for overseas staff.
- Introduction of Violence and Aggression policy.
- Development of Report and Support Hub; A one stop shop to help staff more easily report incidents and seek required support.
- Hate Crime Awareness; Hate crime is a strong feature of the Report and Support Hub and is supported by the actionable allyship activity taking place.
- Network leads established as members of the Trust People Boards, EDI committee, and other steering groups.
- Protected time given and centrally funded for Network Chairs and Co-Chairs to carry out their roles.
- EDI and Belonging team has expanded, with additional expertise in Long-Term Illness and Disability, and additional consultant support across the scope of EDI.
- Strengthened the Recruitment and Selection policy to ensure recruiting managers are trained, and there is an independent panel member.
- Senior female medical Consultants delivered a range of sessions on gender and diversity.
- An in-depth review of gender pay gap and associated reporting.
- Board members have been actively engaging with staff networks and their agendas.
- Freedom to Speak up themes communicated to Head of EDI and EDI Committee.
- The EDI governance has been refreshed. The Terms of Reference and membership have been reviewed to ensure maximum effectiveness with an agenda cycle linked to the progress monitoring and scrutiny of EDI plan delivery.
- The Long-term Illness and Disability Action Plan, and the Race Equality Improvement Plan has been integrated with the WRES/WDES actions to create one holistic EDI action plan, progress of which will be scrutinised by the EDI Committee.
- Presence at Southampton Pride by the LGBT+ Network.
- Hosted the 1st virtual Embracing Diversity Conference on 19 November 2021.
- Menopause Group hosted a Trust wide event on World Menopause Day event on 18 October 2021 and launched a 5-week coaching empowerment programme.
- Development of the Trust Menopause Policy.
- Awareness events such as Black History Month supported and celebrated.
- Introduction of an Actionable Allyship programme; experiential learning, using drama-based techniques, to inspire people to act differently.

Appendix 3

2021; Non-Clinical Workforce % BME vs % WHITE, by band



2021; Clinical Workforce % BME vs % WHITE, by band



Appendix 4

Actions in the next 3 months (December 2021 - February 2022)

Create a clear strategic narrative: Describing the bold ambition of UHS in relation to EDI, and why addressing disproportionality in recruitment, development, promotion, and retention is crucial.

Action

- Development of a Trust EDI position statement and EDI strategy aligned to our People Strategy and wider Trust Strategic Framework.
- Undertake engagement with staff on the Trust Values and how they are lived in action, and to what extent is diversity, inclusion and belonging described in our values to shape our desired culture.

Leadership and accountability: Leaders at every level must understand their role in actioning EDI strategy, process, and ensuring accountability through the leadership line. Self-reflection, developing a learning mindset, listening, developing self-awareness, and how to role model values, are critical components of our leadership development programmes. Leaders need to develop skills to create environments where people can thrive, they need to be able to challenge behaviours and not stand by if they witness micro-aggression, bullying or harassment.

Action

- Agree Diversity and Inclusion objectives for all senior leaders for 2022.
- Agree KPIs linked through to WRES/WDES outcomes embedded into all Divisions through Trust governance and performance mechanisms.
- Diversity, Inclusion and Belonging Leadership and Management Development programmes and toolkit to be developed and launched, all leaders and managers to participate in Inclusive Recruitment module as part of mandatory training.

Positive action:

UHS has already committed to taking positive action in various forms. We must ensure that the positive action we take has tangible and measurable benefits to improving our WRES/WDES and gender data, and supports the shift in our culture, based on best practice and evidence.

Action

- Launch campaign on self-declaration; encourage people to declare via Electronic Staff Record (ESR) if they have protected characteristics.
- As part of the Leadership and Talent programme, ensure appraisals, opportunities for mentoring, coaching and stretch opportunities are non-biased, and criteria-based selection is in place.
- Develop formal stretch opportunities as a way of supporting career development with a clear SOP.
- Make Job descriptions and person specifications more inclusive; due to the requirements of Agenda for Change, our job descriptions and person specifications risk excluding people and narrowing the pool of people that can apply. Audit a sample of JDs and person specs to determine scale and scope of change required. Develop new template for JDs and Person specs in alignment with AfC.
- Actionable Allyship programme; add to suite of mandatory training for all staff as a “One off” commitment that all people are enabled to attend. This will ensure that everyone participates in the learning, this also provides a clear intention that the Trust is committed to changing the culture.

Work climate:
How we the operationalise interventions and systematic changes are crucial to ensuring that improvements in EDI positively impact organisational performance and outcomes.

Action

- Eliminating bias in our systems – Enhance our Recruitment and Selection Policy and processes to ensure that all elements are inclusive, not excluding any groups or individuals, and supports people from under-represented groups to prepare, be successful, and provide post interview support.
- Appraisal – Appraisals are the cornerstone of talent management and performance. Development of a consistent criteria and methodology for appraisals as the cornerstone for robust talent management; there are currently no stable definitions or criteria for what success looks like, therefore an ambiguous framing of appraisal questions can lead to bias or assumptions.
- Agree EDI KPIs in divisions and create a data pack which will act as a vehicle to drive accountability and scrutinise progress. Establish data reviews throughout divisional performance and governance meetings.

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Ward Staffing nursing establishment review August 2021 – October 2021**			
Agenda item:	**5.8**			
Sponsor:	**Gail Byrne – Chief Nursing Officer**			
Author:	**Rosemary Chable – Head of Nursing for Education, Practice and Staffing**			
Date:	**30 November 2021**			
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 28th September 2021 and discussed at TEC on 7th November 2021.			
Response to the issue:	The report details the methodology, findings, risk assessment and recommendations arising from the ward staffing review undertaken from August 2021 – October 2021. 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, the NHS Improvement Developing Workforce Safeguards guidance (2018) and the Nursing Workforce Standards (RCN May 2021) assessed as part of CQC 'safe' and '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 1:9 registered nurse to patient ratio in most areas during the day with the majority (41) 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 (33) are staffed at between 50:50 and 80:20 registered/unregistered ratio or above. Those wards with lower ratios (17 wards) are linked to the systematic and evaluated implementation of trained band 4 staff where appropriate and those with higher ratios (3) are all high intensive cancer care areas requiring a higher registered skill. o Planned total Care Hours Per Patient Day (CHPPD) range from 4.0 – 14.6 and average at 8.1 o Impact of budget setting on staffing levels for 2021/22 and Divisional requirements for consideration as part of budget setting 2022/23. • 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 the publication of the RCN Nursing Workforce Standards and UHS compliance against these • 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 ongoing 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 continuing 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 2021 – October 2021. 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. Areas such as critical care and theatres are reviewed separately.

1.3 Despite the ongoing impact of COVID-19 the scheduled Divisional 'light touch' 6 monthly staffing reviews were all completed and reported for all Divisions in March/April 2021. However, the impact of the ongoing COVID-19 situation is that all ward establishments and nurse staffing levels are continuously being reviewed as ward function, specialty and acuity/dependency levels have continued to fluctuate 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 2) 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. This review also meets standards outlined in the newly issued RCN Nursing Workforce Standards (May 2021) (Appendix 6). Organisations are expected to be compliant with the recommendations in these reports and are subject to review on this as part of the CQC inspection programme under both the 'safe' and 'well led' domains.

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. 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).
- 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
- For the 2nd consecutive year, the review included reflections on the COVID-19 effect on ward staffing and staff.

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 4 monthly review of the action plan (July 2021) shows maintenance of compliance levels 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 December 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, learner numbers (students, overseas and apprentices) 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 (July 2021) shows UHS has maintained compliance in 37 of the 38 recommendations.

The 1 remaining recommendation is:

Escalation actions taken to address deficits on one ward should not compromise another - Management of trustwide staffing deficits and thrice daily reviews of staffing via the staffing hub have minimised the risk of this however continued vacancy position and capacity situation does not enable assurance that wards are not compromised by staff movements. *COVID-19 particularly necessitates 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.

2.2.5 In May 2021 the Royal College of Nursing published their Nursing Workforce Standards (Appendix 6), developed as part of their safe staffing campaigns. The standards summarise the expectations in other national guidance and reiterates the importance of the Chief Nurse being responsible for setting nurse staffing levels based on service demand and user needs and the requirement to report directly to the Trustboard. Self-assessment undertaken by the Nursing and Midwifery Staffing Review Group show UHS is compliant with these standards.

2.3 6 monthly Ward Staffing review August 2021 – October 2021 – Outcomes

2.3.1 The 6 monthly review was carried out from August 2021 – October 2021 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.

2.3.3 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 review discussions so some figures will have changed for individual wards since the review.

It should also be noted that the budget-setting process was understandably protracted this year as a result of the COVID-19 funding arrangements and therefore not all of the budget uplifts have yet been included in the rostering templates. Impact of budget uplifts for each division have been detailed in the specific divisional issues summary in Appendix 5.

2.4 COVID-19 Pandemic Impact and Activity

2.4.1 A strong emphasis for the staffing reviews this year was again to allow the Ward Leaders to relate their COVID-19 experience for their area following wave 2 and in managing the ongoing situation.

2.4.2 There was for the second year, a strong theme around the agility and flexibility demonstrated by the nursing workforce as wards continued to rapidly re-purpose, flex up or down, teams disperse and be redeployed.

2.4.3 The ***staffing hub*** which 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 has continued to operate and adapt.

The value of this service came out strongly in evaluation and it has now been embedded and funded recurrently as part of budget setting.
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.

2.4.4 ***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 1:9 (D7, Bassett, Bramshaw) 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 (41 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 (16 wards) are the medicine wards, Medicine for Older People (MOP) wards, E3, F2, the Acute Stroke Unit and Bramshaw. These areas include a higher ratio of band 2 to 4 staff creating a total nurse to patient ratio of 1:3 – 1:6. 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 still 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 continued to highlight this.

- Following previous reviews there are now 4 in-patient ward areas with ratios higher than 1:11 (RN to patient) at night (a reduction on last year as a result of budget setting). These are D6, D8, E3(G) and Bramshaw where the ratios rise to 1:13. 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 specific divisional issues (Appendix 5) highlights those wards that still require an uplift in their night time cover to improve this ratio.

2.4.5 ***Registered to unregistered ratios***

- UHS ward areas were reviewed against the benchmark of 60:40 registered to unregistered ratios as the level to which ward establishments should not fall below unless planned as the model of care.

- 19 wards are now established at between 60:40 and 70:30 an increase on the previous year.

- 30 wards (down from 32 last year but up from 25 in 2019) 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, Medicine, Acute Stroke).

- 4 wards (down from 6) 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 2021 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.

2.4.6 ***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 the 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.

2.4.7 ***Care Hours Per Patient Day***

- Planned total Care Hours Per Patient Day (CHPPD) range from 4.0 (Bramshaw) – 14.6 (Piam Brown) and average at 8.1. This average is slightly higher than last year.
- Registered care hours per patient day range from 2.3 (Bramshaw) – 14.1 (Piam Brown) and average at 5.1. This average is slightly higher than last year.
- Unregistered care hours per patient day range from 0 (G2 Neuro) – 5.8 (TAU) and average at 3.1. This average is slightly higher than last year.

2.4.8 ***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.
- 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 continues to have 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 continued to prove invaluable during COVID-19 where we have seen ward leaders enabled to adapt and lead diverse teams. We have continued to need to include ward leaders in the numbers throughout COVID-19 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.

2.4.9 ***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 continued to have 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 and latterly Surgery).

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.

Divisions have then developed enhanced care bays on wards and/or 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. This annual review has highlighted that the surgical care group need to develop enhanced care bays to manage the increasing acuity and dependency in their areas.

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. It should also be noted that newly qualified staff are now emerging from programmes that were disrupted during COVID-19, leading to initial reduced competence and confidence on qualifying.

Innovative initiatives have been put into place, utilising shielding staff, to provide some 'long-arm' supervision and support.

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.

The capacity and capability within these teams needs to be reviewed for 22/23 to ensure they can support the further increase in numbers required for UHS to meet the challenging workforce targets.

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 462 (13%) with registered nurse vacancies at 295 (13.5%) and unregistered at 135 (11.6%). over recruitment of overseas nurses and student nurses temporarily into unregistered posts). This is a deteriorating picture overall against a backdrop of increased establishments on the previous annual review. Encouragingly registered nurse vacancies have reduced with the continued range of recruitment and retention initiatives but unregistered vacancies are proving harder to fill and retention of these roles has risen in the last year. Focussed work is being undertaken to target recruitment and retention for this group and the trust is part of a national collaborative.

A continued key action nationally, corporately and for all Divisions in 2021/22 is to continue to concentrate efforts to fill these vacancies.

2.5.5 ***Review of quality metrics and staffing incidents***

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'. These reports have been rising since February 2021, reflecting the additional pressures on the capacity and staffing models during the ongoing COVID-19 pandemic. Review of these incidents and have been subject to separate reporting to Trustboard

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, NICE guidance and the newly published RCN Nursing Workforce Standards

3.2 The review for the second year 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 Budget setting for 2021/22 was protracted due to clarity around funding models but took an approach to build ward staffing models against true need. The risks identified in the 2020 staffing review have, in the main, been addressed but not all of the changes have yet been reflected in the ward staffing rosters.

3.4 Overall the staffing establishments remain appropriate and within recommended guidelines. There are some key exceptions where acuity and dependency levels and growing demand continue to outstrip 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 1:9 registered nurse to patient ratio in most areas during the day with the majority (41) 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 (33) are staffed at between 50:50 and 80:20 registered/unregistered ratio or above. Those wards with lower ratios (17 wards) are linked to the systematic and evaluated implementation of trained band 4 staff where appropriate and those with higher ratios (3) are all high intensive cancer care areas requiring a higher registered skill.
- Planned total Care Hours Per Patient Day (CHPPD) range from 4.0 – 14.6 and average at 8.1
- Impact of budget setting on staffing levels for 2021/22 and Divisional requirements for consideration as part of budget setting 2022/23.

4.3 To note the ongoing progress in UHS compliance with the guidance from the National Quality Board on safe, sustainable, and productive staffing.

4.4 To note the ongoing progress in UHS compliance with the NICE guideline on safe staffing for nursing in adult inpatient wards.

4.5 To note the publication of the RCN Nursing Workforce Standards and UHS compliance against these

4.6 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 ongoing COVID-19 situation.

4.7 To support the continued Trust wide commitment and momentum on actions to fill vacancies and further reduce the reliance on high-cost agency against the backdrop of the continuing COVID-19 situation.

4.8 To note the permanent establishment and funding of the staffing hub function and the continued focus on monitoring the real-time staffing position (actual) against the planned (establishment)

4.9 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 2022.

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 6: RCN Workforce Standards

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.

V15 Reviewed at NMSRG 21st July 2021

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 (July 2021) 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 against the backdrop of increased placements - maximising funding to increase support roles to wards to help with this area of work. Recent staffing reviews have highlighted that non-ward based areas do not have adequate headroom included in budget - to identify through budget setting. Acknowledged higher headroom requirement during COVID-19 due to raised sickness levels. Discussions ongoing to reflect accurate headroom levels as part of budget setting	Dec-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/workforce systems team
		3.2.5	Meaningful application of effective e-rostering policies is evident, and the organisation uses available best practice from NHS Employers and the Carter Review Rostering Good Practice Guidance (2016).	Best practice guidance included in UHS 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

V20 July 2021 - Reviewed at NMSRG 21st July 2021

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	July 2021 compliance	July 2021 (37 compliant, 1 requiring action)
	Organisational strategy - Recommendations for hospital boards, senior management and commissioners in line with NQB expectations									
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, ser	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	Jan-22	DDoN/DHN	A	Management of trustwide staffing deficits via the staffing hub have minimised the risk of this however continued vacancy position 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
etermining nursing staffing commendations for registered 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.

Principles for de requirements - Rec nurses in charge	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
aff available on the day meet ecommendations for registered s 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

Assessing if nursing st patients' nursing needs - R nurses	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

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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

Actual demand CHPPD is calculated based on the Type and number of the patients in the ward

Actual CHPPD is calculated based on the nursing hours ward staff worked and the number of the patients the ward had at midnight

							Finance budgeted			Staffing Numbers							Planned on Template (long day factor applied)				Actual demand	Actual average
	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)	Demand - Other (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	Safecare	Total Actual Demand CHPPD	Total Actual CHPPD
	Division A	Surgery	SUR Acute Surgical Admissions	Early	24	45.4	19.7	20.1	5.6	6	3	1	9	67 : 33	1 : 4	1 : 3	4.5	1.8	6.3	5.4	6.7	5.9
			SUR Acute Surgical Admissions	Late	24					6	2	1	8	75 : 25	1 : 4	1 : 3						
			SUR Acute Surgical Admissions	Night	24					3	3	0	6	50 : 50	1 : 8	1 : 5						
			SUR Acute Surgical Unit	Early	12	28.5	13.8	11.1	3.6	3	2	0	5	60 : 40	1 : 4	1 : 3	5.9	3.9	9.8	9.8	6.1	14.5
			SUR Acute Surgical Unit	Late	12					4	1	0	5	80 : 20	1 : 3	1 : 3						
			SUR Acute Surgical Unit	Night	12					2	3	0	5	40 : 60	1 : 6	1 : 3						
			SUR E5 Lower GI	Early	18	30.5	18.0	9.5	3.0	4	2	0	6	66 : 34	1 : 5	1 : 4	3.9	2.0	5.9	5.9	10.0	5.3
			SUR E5 Lower GI	Late	18					4	2	0	6	66 : 34	1 : 5	1 : 4						
			SUR E5 Lower GI	Night	18					2	1	0	3	61 : 39	1 : 9	1 : 6						
			SUR E5 Upper GI	Early	18	30.7	15.5	12.8	2.4	4	2	1	6	67 : 33	1 : 5	1 : 4	3.9	2.1	6.0	5.7	8.4	9.7
			SUR E5 Upper GI	Late	18					3	2	0	5	60 : 40	1 : 6	1 : 4						
			SUR E5 Upper GI	Night	18					2	1	0	3	58 : 42	1 : 10	1 : 6						
			SUR E8 Ward	Early	30	59.2	31.0	23.6	4.6	6	5	0	11	55 : 45	1 : 6	1 : 3	3.4	3.1	6.5	7.6	7.0	7.6
			SUR E8 Ward	Late	30					6	4	0	10	59 : 41	1 : 6	1 : 4						
			SUR E8 Ward	Night	30					3	4	0	7	44 : 56	1 : 11	1 : 5						
			SUR F11 IF	Early	17	35.0	21.5	9.7	3.8	4	2	0	6	66 : 34	1 : 5	1 : 3	5.1	2.8	8.0	7.4	9.3	7.6
			SUR F11 IF	Late	17					4	2	0	6	66 : 34	1 : 5	1 : 3						
			SUR F11 IF	Night	17					3	2	0	5	60 : 40	1 : 6	1 : 4						
			SUR F5 Ward	Early	21	41.3	20.6	17.3	3.4	5	3	0	8	62 : 38	1 : 5	1 : 3	4.6	3.1	7.8	5.4	6.8	5.7
			SUR F5 Ward	Late	21					5	2	0	7	71 : 29	1 : 5	1 : 3						
			SUR F5 Ward	Night	21					3	2	0	5	63 : 37	1 : 7	1 : 4						
	Division B	Emergency Care	ECM Acute Medical Unit	Early	43	149.2	80.8	64.0	4.4	18	13	0	31	59 : 41	1 : 3	1 : 2	7.9	6.2	14.1	11.6	8.9	18.0
			ECM Acute Medical Unit	Late	43					14	12	0	26	54 : 46	1 : 4	1 : 2						
			ECM Acute Medical Unit	Night	43					14	10	0	24	58 : 42	1 : 4	1 : 2						
		Cancer Care	CAN C4 Solent Ward Clinical Oncology	Early	23	43.8	23.8	15.1	4.9	4	3	0	7	57 : 43	1 : 6	1 : 4	3.5	2.4	5.8	5.8	8.3	8.1
			CAN C4 Solent Ward Clinical Oncology	Late	23					4	3	0	7	58 : 42	1 : 6	1 : 4						
			CAN C4 Solent Ward Clinical Oncology	Night	23					3	2	0	5	62 : 38	1 : 8	1 : 5						
			CAN C6 Leukaemia/BMT Unit	Early	21	44.3	39.0	1.6	3.7	8	0	0	8	95 : 5	1 : 3	1 : 3	7.5	0.1	7.7	7.8	6.8	8.5
			CAN C6 Leukaemia/BMT Unit	Late	21					8	0	0	8	95 : 5	1 : 3	1 : 3						
			CAN C6 Leukaemia/BMT Unit	Night	21					6	0	0	6	100 : 0	1 : 4	1 : 4						
			CAN C6 TYA Unit	Early	6	18.1	14.7	1.5	1.9	2	1	1	3	70 : 30	1 : 3	1 : 2	7.8	1.8	9.6	9.3	7.1	9.2
			CAN C6 TYA Unit	Late	6					2	1	0	3	67 : 33	1 : 3	1 : 2						
			CAN C6 TYA Unit	Night	6					2	0	0	2	100 : 0	1 : 4	1 : 4						
			CAN C2 Haematology	Early	27	50.8	31.5	16.1	3.2	7	3	0	10	70 : 30	1 : 4	1 : 3	4.8	2.6	7.4	7.6	7.8	8.4
			CAN C2 Haematology	Late	27					7	3	0	10	70 : 30	1 : 4	1 : 3						
			CAN C2 Haematology	Night	27					5	3	0	8	62 : 38	1 : 6	1 : 4						
			CAN D3 Ward	Early	22	39.2	21.6	13.0	4.7	5	3	0	8	63 : 37	1 : 5	1 : 3	4.1	2.1	6.2	6.4	7.1	7.2
			CAN D3 Ward	Late	22					5	2	0	7	72 : 28	1 : 5	1 : 4						
			CAN D3 Ward	Night	22					3	2	0	5	60 : 40	1 : 8	1 : 5						
		Medicine	MED D5 Ward	Early	28	39.7	19.0	19.7	1.0	4	5	0	9	46 : 54	1 : 8	1 : 4	2.6	3.2	5.8	5.5	7.4	6.1
			MED D5 Ward	Late	28					3	4	0	7	45 : 55	1 : 10	1 : 5						
			MED D5 Ward	Night	28					3	3	0	6	51 : 49	1 : 10	1 : 5						
			MED D6 Ward	Early	24	37.4	14.7	21.7	1.0	3	5	0	8	38 : 62	1 : 8	1 : 4	2.5	3.3	5.8	5.7	6.7	6.1
			MED D6 Ward	Late	24					3	3	0	6	50 : 50	1 : 8	1 : 4						
			MED D6 Ward	Night	24					2	3	0	5	40 : 60	1 : 12	1 : 5						
			MED D7 Ward	Early	16	24.8	12.0	12.8	0.0	2	3	0	5	39 : 61	1 : 9	1 : 4	2.9	3.0	5.9	7.3	6.3	6.6
			MED D7 Ward	Late	16					2	3	0	5	40 : 60	1 : 9	1 : 4						
			MED D7 Ward	Night	16					2	2	0	4	50 : 50	1 : 8	1 : 5						
			MED D8 Ward	Early	24	34.4	14.7	18.7	1.0	3	5	0	8	38 : 63	1 : 8	1 : 3	2.4	3.3	5.7	5.6	6.5	6.2
			MED D8 Ward	Late	24					3	3	0	6	50 : 50	1 : 8	1 : 4						
			MED D8 Ward	Night	24					2	3	0	5	40 : 60	1 : 12	1 : 5						
			MED D9 Ward	Early	28	40.8	19.0	20.8	1.0	4	5	0	9	44 : 56	1 : 7	1 : 4	2.7	3.1	5.7	5.7	7.9	6.2
			MED D9 Ward	Late	28					3	4	0	7	43 : 57	1 : 10	1 : 5						
			MED D9 Ward	Night	28					3	3	0	6	50 : 50	1 : 10	1 : 5						
			MED D10 Isolation Unit	Early	18	32.1	13.7	17.4	1.0	3	4	0	7	42 : 58	1 : 6	1 : 3	3.2	3.7	6.9	6.9	7.3	7.1
			MED D10 Isolation Unit	Late	18					3	3	0	6	48 : 52	1 : 7	1 : 3						
			MED D10 Isolation Unit	Night	18					2	2	0	4	50 : 50	1 : 9	1 : 5						
			MED E7 Ward	Early	22	32.9	15.5	16.5	1.0	3	4	0	7	43 : 57	1 : 8	1 : 4	2.6	3.5	6.1	6.5	8.7	6.4
			MED E7 Ward	Late	22					3	3	0	6	50 : 50	1 : 8	1 : 4						
			MED E7 Ward	Night	22					2	3	0	5	38 : 62	1 : 11	1 : 5						
			MED Bassett Ward	Early	26	30.9	12.4	16.5	2.0	3	5	0	8	37 : 63	1 : 9	1 : 4	2.6	4.2	6.9	6.3	12.4	6.7
			MED Bassett Ward	Late	26					3	5	0	8	38 : 62	1 : 9	1 : 4						
			MED Bassett Ward	Night	26					3	3	0	6	47 : 53	1 : 10	1 : 5						
			MED G5 Ward	Early	28	41.1	14.7	24.5	2.0	4	5	0	9	44 : 56	1 : 8	1 : 4	2.4	3.0	5.4	5.8	10.6	5.8
			MED G5 Ward	Late	28					4	5	0	9	44 : 56	1 : 8	1 : 4						
			MED G5 Ward	Night	28					3	2	0	5	60 : 40	1 : 10	1 : 6						
			MED G6 Ward	Early	26	41.7	14.7	25.1	2.0	4	5	0	9	44 : 56	1 : 7	1 : 3	2.6	3.4	6.0	6.1	7.7	6.3
			MED G6 Ward	Late	26					4	5	0	9	45 : 55	1 : 7	1 : 3						
			MED G6 Ward	Night	26					3	2	0	5	60 : 40	1 : 9	1 : 6						
			MED G7 Ward	Early	14	33.7	12.4	19.3	2.0	2	3	0	5	40 : 60	1 : 7	1 : 3	3.3	4.3	7.6	7.4	10.2	7.0
			MED G7 Ward	Late	14					2	3	0	5	40 : 60	1 : 7	1 : 3						
			MED G7 Ward	Night	14					2	2	0	4	50 : 50	1 : 7	1 : 4						
			MED G8 Ward	Early	28	40.3	14.7	23.7	2.0	4	5	0	9	45 : 55	1 : 8	1 : 4	2.5	3.4	5.9	5.7	7.4	13.6
			MED G8 Ward	Late	28					4	5	0	9	44 : 56	1 : 8	1 : 4						
			MED G8 Ward	Night	28					3	2	0	5	60 : 40	1 : 10	1 : 6						
			MED G9 Ward	Early	26	40.8	14.7	24.2	2.0	4	5	0	9	44 : 56	1 : 7	1 : 3	2.6	3.2	5.8	6.1	8.0	7.8
			MED G9 Ward	Late	26					4	5	0	9	44 : 56	1 : 7	1 : 3						
			MED G9 Ward	Night	26					3	2	0	5	60 : 40	1 : 9	1 : 6						
		Specialist Medicine	MED C5 Isolation Ward	Early	14	28.0	12.9	13.5	1.6	3	3	0	6	51 : 49	1 : 5	1 : 3	5.2	3.6	8.9	8.7	7.2	11.5
			MED C5 Isolation Ward	Late	14					3	3	0	6	50 : 50	1 : 5	1 : 3						
			MED C5 Isolation Ward	Night	14					3	1	0	4	75 : 25	1 : 5	1 : 4						
	Division C	Child Health	CHI Paed Medical Unit	Early	16	59.5	39.1	15.9	4.5	5	2	0	7	71 : 29	1 : 4	1 : 3	7.3	2.9	10.2	10.1	9.9	12.5
			CHI Paed Medical Unit	Late	16					5	2	0	7	71 : 29	1 : 4	1 : 3						
			CHI Paed Medical Unit	Night	16					5	2	0	7	71 : 29	1 : 4	1 : 3						
			CHI Piam Brown Unit	Early	12	44.4	39.5	1.0	4.0	12	1	0	13	95 : 5	1 : 1	1 : 1	14.1	0.6	14.6	9.9	11.3	14.2
			CHI Piam Brown Unit	Late	12					5	0	0	5	100 : 0	1 : 3	1 : 3						
			CHI Piam Brown Unit	Night	12					4	0	0	4	100 : 0	1 : 3	1 : 3						
			CHI Ward E1 Paed Cardiac	Early	16	39.7	27.6	8.9	3.2	6	2	1	7	77 : 23	1 : 3	1 : 3	7.0	2.0	9.0	7.2	9.6	11.3
			CHI Ward E1 Paed Cardiac	Late	16					5	2	0	7	75 : 25	1 : 4	1 : 3						
			CHI Ward E1 Paed Cardiac	Night	16					4	1	0	5	81 : 19	1 : 4	1 : 4						
			CHI Ward G2 Neuro	Early	6	13.4	12.6	0.0	0.8	2	0	0	2	100 : 0	1 : 3	1 : 3	8.2	0.0	8.3	9.2	9.6	9.6
			CHI Ward G2 Neuro	Late	6					2	0	0	2	100 : 0	1 : 3	1 : 3						
			CHI Ward G2 Neuro	Night	6					2	0	0	2	100 : 0	1 : 3	1 : 3						
			CHI Ward G3	Early	20	51.8	31.6	14.2	6.1	6	4	0	10	60 : 40	1 : 4	1 : 2	6.6	4.4	11.0	11.1	10.7	10.7
			CHI Ward G3	Late	20					6	4	0	10	60 : 40	1 : 4	1 : 2						
			CHI Ward G3	Night	20					5	3	0	8	63 : 38	1 : 4	1 : 3						
			CHI Ward G4 Surgery	Early	22	56.3	38.6	14.3	3.4	6	3	0	9	68 : 32	1 : 4	1 : 3	6.1	2.8	8.9	14.0	11.2	11.7
			CHI Ward G4 Surgery	Late	22					6	3	0	9	68 : 32	1 : 4	1 : 3						
			CHI Ward G4 Surgery	Night	22					5	2	0	7	71 : 29	1 : 5	1 : 4						
		Women & Newborn	W&N Bramshaw Womens Unit	Early	26	39.0	16.1	20.3	2.5	3	2	0	5	62 : 38	1 : 9	1 : 6	2.3	1.7	4.0	5.9	4.4	10.1
			W&N Bramshaw Womens Unit	Late	26					3	2	0	5	62 : 38	1 : 9	1 : 6						
			W&N Bramshaw Womens Unit	Night	26					2	2	0	4	52 : 48	1 : 13	1 : 7						
			CAR Coronary Care Unit	Early	21	44.9	29.4	13.7	1.8	7	2	0	9	74 : 26	1 : 4	1 : 3	7.7	3.1	10.8	9.8	7.7	14.1
			CAR Coronary Care Unit	Late	21					7	2	0	9	75 : 25	1 : 4	1 : 3						
			CAR Coronary Care Unit	Night	21					7	3	0	9	72 : 28	1 : 4	1 : 3						
			CAR Ward D2 Cardiology	Early	15					4	2	0	6	65 : 35	1 : 5	1 : 3						

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

Actual demand CHPPD is calculated based on the Type and number of the patients in the ward

Actual CHPPD is calculated based on the nursing hours ward staff worked and the number of the patients the ward had at midnight

							Finance budgeted			Staffing Numbers							Planned on Template (long day factor applied)				Actual demand	Actual average
	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)	Demand - Other (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	Safecare	Total Actual Demand CHPPD	Total Actual CHPPD
	Division D	Cardiovascular and Thoracic	CAR Ward D2 Cardiology	Late	15	31.3	13.0	16.5	1.8	3	2	0	5	60 : 40	1 : 5	1 : 3	4.4	3.1	7.5	7.3	10.7	8.1
			CAR Ward D2 Cardiology	Night	15					2	2	0	4	50 : 50	1 : 8	1 : 4						
			CAR Ward D4 Vascular	Early	22	42.2	20.4	19.1	2.7	4	3	0	7	62 : 38	1 : 5	1 : 4	3.7	3.0	6.7	6.8	7.5	7.3
			CAR Ward D4 Vascular	Late	22					4	3	0	7	60 : 40	1 : 6	1 : 4						
			CAR Ward D4 Vascular	Night	22					3	3	0	6	47 : 53	1 : 9	1 : 4						
			CAR Ward E2 YACU	Early	17	29.1	18.2	9.2	1.6	4	3	0	7	60 : 40	1 : 5	1 : 3	4.2	2.3	6.5	6.4	7.1	8.3
			CAR Ward E2 YACU	Late	17					4	2	0	6	67 : 33	1 : 5	1 : 3						
			CAR Ward E2 YACU	Night	17					2	1	0	3	67 : 33	1 : 9	1 : 6						
			CAR Ward E3 Green	Early	24	38.2	17.7	17.8	2.7	4	4	0	8	48 : 52	1 : 7	1 : 3	2.9	3.0	5.9	5.7	6.3	6.3
			CAR Ward E3 Green	Late	24					4	3	0	7	57 : 43	1 : 7	1 : 4						
			CAR Ward E3 Green	Night	24					2	3	0	5	44 : 56	1 : 12	1 : 6						
			CAR Ward E3 Blue	Early	18	30.4	12.5	15.8	2.0	3	4	0	7	45 : 55	1 : 6	1 : 3	3.2	3.4	6.6	6.9	7.7	7.5
			CAR Ward E3 Blue	Late	18					3	2	0	5	60 : 40	1 : 6	1 : 4						
			CAR Ward E3 Blue	Night	18					2	2	0	4	50 : 50	1 : 9	1 : 5						
			CAR Ward E4 Thoracics	Early	20	38.1	20.4	15.7	2.0	4	3	0	7	59 : 41	1 : 5	1 : 3	4.3	2.9	7.2	7.1	7.4	7.3
			CAR Ward E4 Thoracics	Late	20					4	4	0	8	52 : 48	1 : 6	1 : 3						
			CAR Ward E4 Thoracics	Night	20					3	1	0	5	72 : 28	1 : 7	1 : 5						
		Neurosciences	NEU Acute Stroke Unit	Early	28	65.2	23.6	38.1	3.6	4	7	0	11	36 : 64	1 : 7	1 : 3	3.0	5.0	8.0	8.2	11.7	9.1
			NEU Acute Stroke Unit	Late	28					4	7	0	11	36 : 64	1 : 7	1 : 3						
			NEU Acute Stroke Unit	Night	28					3	5	0	8	38 : 63	1 : 10	1 : 4						
			NEU HASU	Early	10	33.1	23.3	8.0	1.8	4	1	0	5	79 : 21	1 : 3	1 : 2	9.4	2.5	11.8	11.6	12.3	10.2
			NEU HASU	Late	10					4	1	0	5	80 : 20	1 : 3	1 : 2						
			NEU HASU	Night	10					4	1	0	5	80 : 20	1 : 3	1 : 2						
			NEU Regional Transfer Unit	Early	10	30.1	20.8	7.5	1.8	3	1	1	4	75 : 25	1 : 4	1 : 3	6.2	3.4	9.6	9.9	7.2	20.9
			NEU Regional Transfer Unit	Late	10					3	1	0	4	76 : 24	1 : 4	1 : 3						
			NEU Regional Transfer Unit	Night	10					2	2	0	4	49 : 51	1 : 5	1 : 3						
			NEU Ward D Neuro	Early	27	62.9	30.3	30.3	2.2	5	5	0	10	50 : 50	1 : 6	1 : 3	4.0	4.3	8.3	8.1	8.2	9.0
			NEU Ward D Neuro	Late	27					5	5	0	10	50 : 50	1 : 6	1 : 3						
			NEU Ward D Neuro	Night	27					4	5	0	9	44 : 56	1 : 7	1 : 3						
			NEU Ward E Neuro	Early	26	53.2	32.0	18.7	2.4	5	3	0	8	63 : 38	1 : 6	1 : 4	4.0	2.6	6.7	6.8	7.6	7.9
			NEU Ward E Neuro	Late	26					5	3	0	8	63 : 38	1 : 6	1 : 4						
			NEU Ward E Neuro	Night	26					4	3	0	7	57 : 43	1 : 7	1 : 4						
		Trauma & Orthopaedics	T&O Ward Brooke	Early	18	28.4	17.4	8.0	3.0	3	3	0	6	50 : 50	1 : 6	1 : 3	3.2	3.3	6.5	5.5	10.2	6.3
			T&O Ward Brooke	Late	18					3	3	0	6	50 : 50	1 : 6	1 : 3						
			T&O Ward Brooke	Night	18					2	3	0	5	41 : 59	1 : 9	1 : 4						
			T&O Trauma Admissions Unit	Early	8	15.3	8.2	7.1	0.0	3	2	0	5	58 : 42	1 : 3	1 : 2	6.5	5.8	12.3	11.5	6.7	43.6
			T&O Trauma Admissions Unit	Late	8					2	2	0	4	50 : 50	1 : 4	1 : 2						
			T&O Trauma Admissions Unit	Night	8					2	2	0	4	50 : 50	1 : 4	1 : 2						
			T&O Ward F1 Major Trauma Unit	Early	32	74.8	38.8	30.4	5.6	6	5	0	11	55 : 45	1 : 6	1 : 3	4.2	3.8	8.0	7.9	8.6	8.9
			T&O Ward F1 Major Trauma Unit	Late	32					6	5	0	11	54 : 46	1 : 6	1 : 3						
			T&O Ward F1 Major Trauma Unit	Night	32					5	5	0	10	50 : 50	1 : 7	1 : 4						
			T&O Ward F2 Trauma	Early	26	56.2	23.6	28.2	4.5	4	5	0	9	44 : 56	1 : 7	1 : 3	3.3	4.1	7.4	7.1	7.9	7.5
			T&O Ward F2 Trauma	Late	26					4	5	0	9	45 : 55	1 : 7	1 : 3						
			T&O Ward F2 Trauma	Night	26					3	4	0	7	43 : 57	1 : 9	1 : 4						
			T&O Ward F3 Trauma	Early	24	55.2	21.6	29.0	4.6	4	5	0	9	44 : 56	1 : 6	1 : 3	3.5	4.5	8.0	7.8	10.7	9.0
			T&O Ward F3 Trauma	Late	24					4	5	0	9	44 : 56	1 : 6	1 : 3						
			T&O Ward F3 Trauma	Night	24					3	4	0	7	43 : 57	1 : 8	1 : 4						
			T&O Ward F4 Elective	Early	18	37.2	21.3	11.9	4.0	4	2	0	6	66 : 34	1 : 5	1 : 3	4.5	3.4	7.9	6.6	7.6	7.3
			T&O Ward F4 Elective	Late	18					3	2	0	5	60 : 40	1 : 6	1 : 4						
			T&O Ward F4 Elective	Night	18					2	2	0	4	50 : 50	1 : 9	1 : 5						

Specific Divisional issues emerging - Ward Staffing Review 2021

Division A

Budget setting this financial year (21/22) gave the following increases across Surgery:

- RN 5.5 WTE for E8 – uplift for enhanced care bay (1:4 Pt:RN ratio)
- RN 3.3WTE for E5 Lower GI – allowing 4 RN for Long days 7 days a week
- RN 0.2 WTE for E5 Upper GI – Allows for Mid shift 7 days per week
- 1 WTE Band 6 physio monies approved for F11 and E8 enhanced care bay.
- Increase within budget HCSW on F6 to allow 3 support staff at night and 3 on an early shift.
- Added Twilight RN on specific days to support late ICU discharges of complex Max Fax Majors – Current budget pressure

RN vacancy level - seeing steady increase in leavers and reliant on overseas recruitment to back fill – Skill mix remains a concern.

Areas to be put forward at budget setting post 2021 review – Division A:

Increased patient need for enhanced care (specialling) HCSW – aiming 1 HCSW for each bay of patients, especially on E5 wards, currently budget pressure for both E5's.

Potential need to increase F5 staffing, especially out of hours, need uplift of band 2 for night shifts to 3, this would give a ratio of 3 HCA's for 28 patients and help support ward acuity, increasingly needing to utilise bed capacity for acute admissions from ASU. Uplift of 2.15 WTE required.

To consider having maxillo-facial free-flap patients sent back to F5 ward direct instead of ITU, plan would be to have 1 RN for 1:1 ratio first post operative night and day. This equates to 1.9 WTE band 5.

Review of this cohort of patients and those that would be suitable to go direct to F5 and be nursed by nurses with correct skills and knowledge in free-flaps is being undertaken at present.

F6 flow support requirements under review – HCSW / ward clerking 12 hours / day 7 days per week, improving patient and family experiences timely updates.

ASU – Transfer team to support ED flow, this would be 1 B4 & 1B2 – using model of LD & Night, Monday to Sunday would be 5.6WTE band 4 and WTE5.6 Band 2. If have this model Monday to Friday this would be 4.0 WTE band 4 and 4.0 WTE band 2. Ideally needs to increase in capacity to support ASU direct pathways, increase in hospital tertiary referrals and clinic admissions. If increasing capacity, then staffing review required.

Other points to note within Division A:

Ophthalmology have been funded for an expansion due to open in November and recruitment is going very well for all grades of nursing and allied health professional posts

Critical Care and Theatres are subject to separate reviews, but it is worth noting that Critical Care has had a budget increase to reflect 6 additional beds on GICU and 1 on CICU and recruitment is improving.

Division B

Medicine care group has been staffing above establishment to the levels identified in the 2020 staffing review in anticipation of budget setting uplifts.

In addition to this, staffing numbers have been adjusted across covid areas to reflect the increased acuity of patients, managed at a local level, and not reflected in budget requests.

Cancer care has seen a sustained increase in acuity across a number of areas (D3 and C2) partly due to new covid safe pathways. C2 has also started to take BMT patients and has had to increase staffing levels to reflect this in line with nationally recommended ratios 1:3 for this patient group. Plan going forward to increase BMT beds on C2 further.

Budget setting this financial year (21/22) and realignment of existing budgets gave the following increases across Division B:

- Medicine/MOP
  - D6 and D9 extra RN at night to support increased acuity by increasing RN to patient ratio
  - D9 and D8 extra RN on late to support opening of GLIBU
  - E7 additional bay
- Cancer care
  - Funding agreed for substantive band 7 post on TYA and 1 x B5, 1 B6 and 0.5 HCA (Funding had been moved initially to C7)
- C4- 2 x B5, 2 xB2
- D3 – 4.21 B2
- C6 0.6 x b2
- C7 1.4 B6 uplifted to band 7 and 2x band 5

Although AMU is not included in the ward staffing review it should be noted that there has been a significant funded increase across the area due to change in purpose of AMU 3 and need for 24/7 POC testing

Areas to be put forward at budget setting post review – Division B:

Medicine/MOP

The original band 5/band 4 ratio across medicine and MOP was based on historic difficulty in recruiting RN staff. With the decrease in vacancy and increase in acuity the care group would like to put forward an uplift of band 4 posts to band 5 across all areas.

As a direct result of the pandemic there has been the need to review the skill mix across MOP due to the significant change in the acuity of the patients, requiring an increase in the RN to patient ratio. Request that this skill mix review reflected in budgets across MOP as now ongoing for over 18 months.

C5 staffing budget based on level 1 patient care but again due to covid C5 has now become a mixed L1/L2 facility to care for covid patients. If ongoing plan to continue to use C5 in this capacity, request that staffing budget reflects the uplift in RN ratio to maintain this.

Bassett opened originally as a 20 bedded MOP ward and staffing budget transferred from F7. Bassett since opening has consistently used all 26 beds available and

staffing increased to support this. Request that this uplift reflected permanently in the staffing budget.

Cancer Care- budget for nursing BMT not included in the original ward staffing budget for C2, since opening the ward has started taking between 4 and 6 BMT patients, requiring a nursing ratio of 1:3. Request that this is appropriately reflected in the ward staffing budget.

Division C (excluding Midwifery)

Overall established staffing levels are appropriate in the majority of wards for the level and acuity of patients in Southampton Children's Hospital and Women's Health.

Piam Brown is an exception to this and is currently undergoing a further staffing review due to increased demand and acuity and will need an uplift of registered nurses. This will enable the ward to be able to flexibly offer a high dependency level of care for complex patients and for the environment to be recognised as delivering care at this level. This would support recruitment and retention across the unit and form part of the workforce strategy being developed for the Paediatric Oncology service.

To fill the gap of current registered vacancies we are trialling Health Care Support Workers (6.0 wte - one per shift) in this clinical environment.

In addition, there is a requirement to increase the number of higher acuity beds within G3 and E1 and this would need an uplift of registered nurses.

An increase in Respiratory illness in children (RSV) will place additional demand on beds within the Children's Hospital. At present no additional request is being made for registered nurses as there is an existing vacancy level of 12%. However, it has been agreed to recruit 17 wte HCA support workers which equates to an additional 3 HCA's per shift across the children's hospital.

Budget setting this financial year (21/22) and realignment of existing budgets gave the following increases across Division C:

The Children's Hospital has received funding for out of hours supernumerary bleep holders. This supports senior nursing oversight on safety, staffing and bed management.

Also funded to open a paediatric admission ward (as an extension on Paediatric medical ward) to support emergency flow and weekend working on G3 (which historically had a different number of commissioned beds at the weekend compared to week days).

Areas to be put forward at budget setting post 2021 review – Division C:

Piam Brown require uplift in registered nurse availability days and nights to support an increase in nurse-to-patient ratio
G3 and E1 are undertaking a further detailed review of acuity and will be putting forward proposals to uplift registered nurses to increase the acuity of beds.

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.

Division D have continued to see additional pressures on staffing models in areas where the acuity and dependency has increased as a result of pathway changes, increases in patient complexity or delays due to covid. Post covid recovery has shown that patients being admitted are therefore sicker and more dependent.

Some areas, including Brook ward and TAU received additional funding in 2021/22 to increase establishments to enable them to adopt a different pathway.

F4 spines and D4 have also seen an increase in workload and require a further full establishment review. This will be undertaken in the next quarter.

E3 Blue and green require a review of the use of band 4 staff at night, as they currently staff nights with a high patient to RN ratio.

Division D still do not have a model which allows the bleep holder to be supernumerary at night in CVT and Neuro. 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. This was not supported at budget setting.

Areas to be put forward at budget setting post 2021 review – 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 and D4 vascular are undertaking a further full establishment review including a review of their acuity and dependency levels against the safer nursing care tool and will be putting forward proposals to uplift.

The division will again be presenting a case to support supernumerary bleep holders at night in Neuro and CVT as these remain the only care groups within the trust that do not have funding to support this.

RCN Nursing Workforce Standards – May 2021

Overview

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Infection Prevention 2021-22 Q1-Q2 Report**			
Agenda item:	**5.9**			
Sponsor:	**Gail Byrne, Chief Nursing Officer/Director of Infection Prevention & Control**			
Author:	**Julie Brooks, Head of Infection Prevention Unit** **Nitin Mahobia, Deputy Director of IP&C/hospital Infection Control Doctor**			
Date:	**30 November 2021**			
Purpose	**Assurance or reassurance** √	**Approval**	**Ratification**	**Information** √
Issue to be addressed:	To review progress and performance in relation to reducing the risk of healthcare associated infection (HCAI) in UHS and provide a quarterly update report (Q1 and Q2) for 2021/2022.			
Response to the issue:	This report provides an overview of performance and progress in relation to reducing the risk of healthcare associated infection including: • Performance against key infection indicators • Assurance of infection prevention standards, practice and processes • Ongoing response in relation to the COVID-19 pandemic. • Identification of learning and actions to further reduce risks of HCAI to patients, staff, the organisation and the public.			
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 and the legal duty to ensure the health and safety of all employees whilst at work and of any persons affected by the Trust's activities, as per the Health and Safety at Work etc. Act 1974.			
Risks: (Top 3) of carrying out the change / or not:	• Risk of harm to staff and patients due to healthcare associated infection. • Risk of reputational and financial penalty from enforcement action. • Increased length of stay of inpatients who acquire healthcare associated infection leading to reduced organisational productivity.			
Summary: Conclusion and/or recommendation	Q1 and Q2 have continued to be challenging in relation to the COVID-19 pandemic and restoration of activity. Although UHS continues to perform well in relation to a number of HCAI indicators, improvements are required in some areas. Current trends suggest UHS is unlikely to achieve the C.difficile threshold for this financial year unless further actions are taken to reduce case numbers. Overall assurance of effective practice, systems and processes are in place with an understanding of areas/measures required for improvement. Members of Trust Board are asked to: 1. Review the report and the identified actions detailed in each section and ensure these are addressed via the Divisional Governance processes, with relevant teams and staff groups. 2. Support the proposed actions/ measures to facilitate improvements.			

1. Introduction

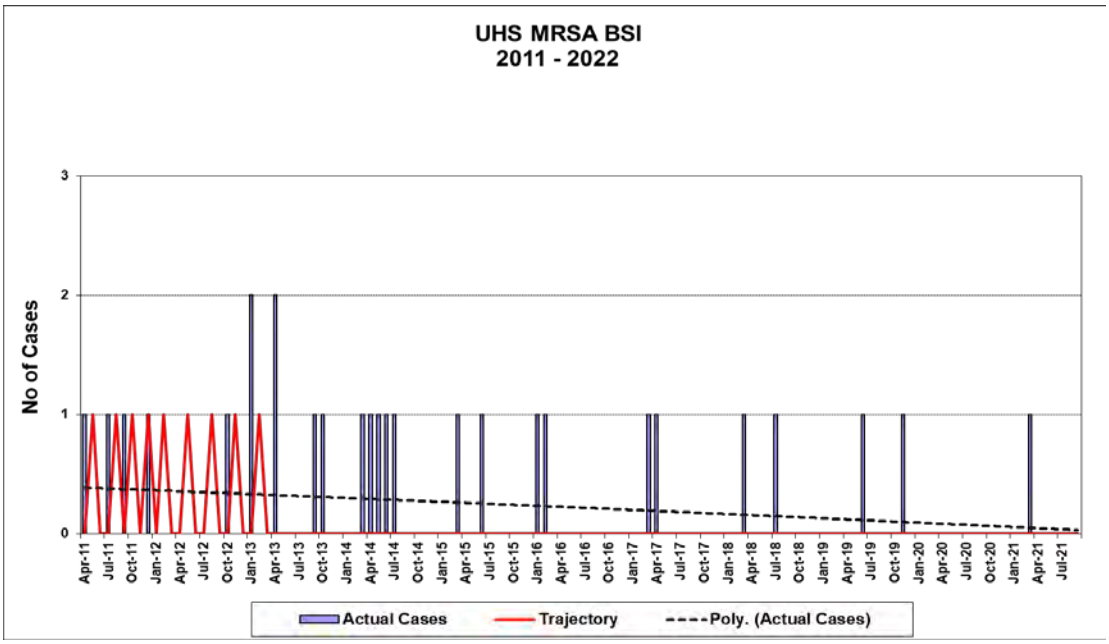
Summary of progress in reducing risk of healthcare acquired infection in UHS

Category		Q1&Q2	Annual Limit	Action /Comment
National objectives	MRSA bacteraemia	G	G	0 MRSA BSI attributable to UHS in Q1&Q2 2021 2022
	Clostridium difficile infection	R	G	39 cases against limit of 30 for Q1&Q2 and 64 for the year.
	E coli Bacteraemia	R	R	75 cases in Q1&Q2 2021 2022 against a limit of limit of 73
	Klebsiella Bacteraemia	R	R	40 cases in Q1&Q2 2021 2022 against a limit of limit of 30
	Pseudomonas Bacteraemia	G	G	13 cases in Q1&Q2 2021 2022 against a limit of limit of 16
Other	MSSA	N/A	N/A	27 post 48 cases in Q1&Q2 2021 2022
	Hospital onset COVID19	N/A	N/A	8 probable hospital onset and 10 definite hospital onset cases in Q1&Q2 in 2021 2022
Antimicrobial Stewardship	Prudent antibiotic prescribing	G	G	No published standard contract target, though 2018 figure of 98% was anticipated. Currently UHS is well inside that limit. UHS currently 14.7% inside target
Provide assurance of basic infection prevention practice:	Assurance of Infection Prevention Practice Standards	G	G	The annual infection prevention audit programme was re-instated in April 2021 for the monitoring and assurance of infection prevention and control practices in clinical and non-clinical areas.

2. Analysis
2.1 Healthcare Associated Infections

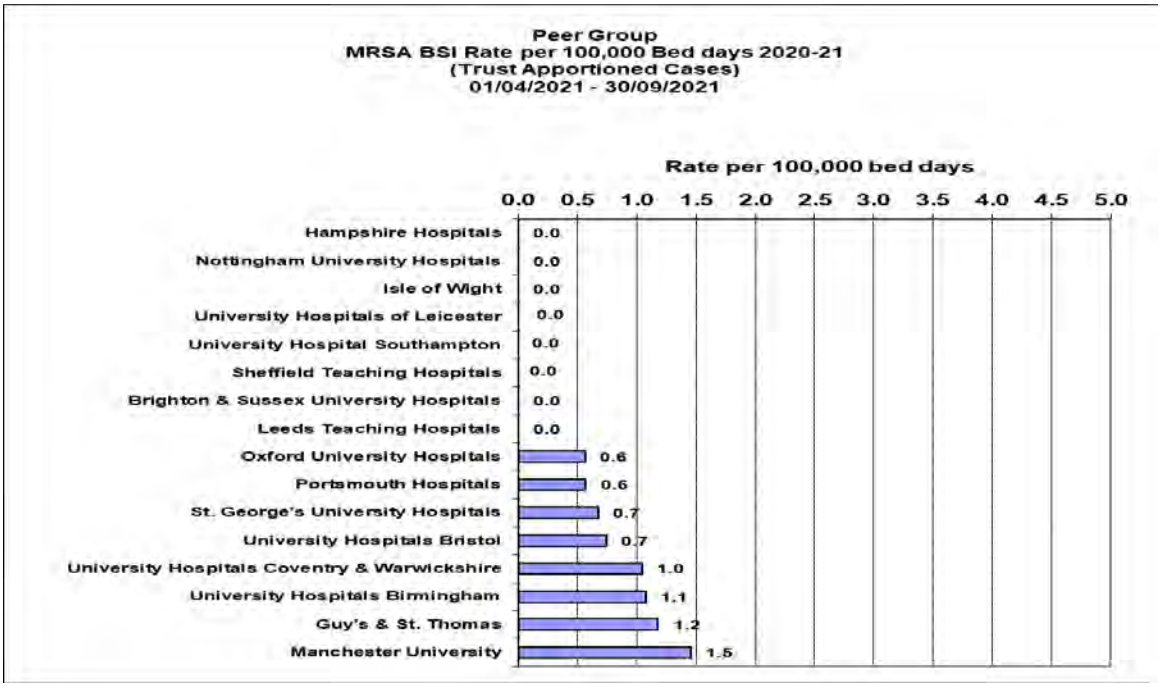
MRSA Bacteraemia

0 UHS acquired MRSA BSI in Q1 &Q2 2021 2022



Comparative data from PHE for 2021/22

UHS has an attributable MRSA BSI rate of 0.0 cases/100,000 bed days and equal first of 16 self-selected peer hospitals. Top quartile, median and lower quartile marker rates are 0.0, 0.0 and 0.7 cases/100,000 bed days.



Acquisition of MRSA colonisation in UHS

22 patients acquired MRSA (colonisation or infection) in UHS in Q1&Q2 2021/22 compared to 26 during the same period in 2020/21.

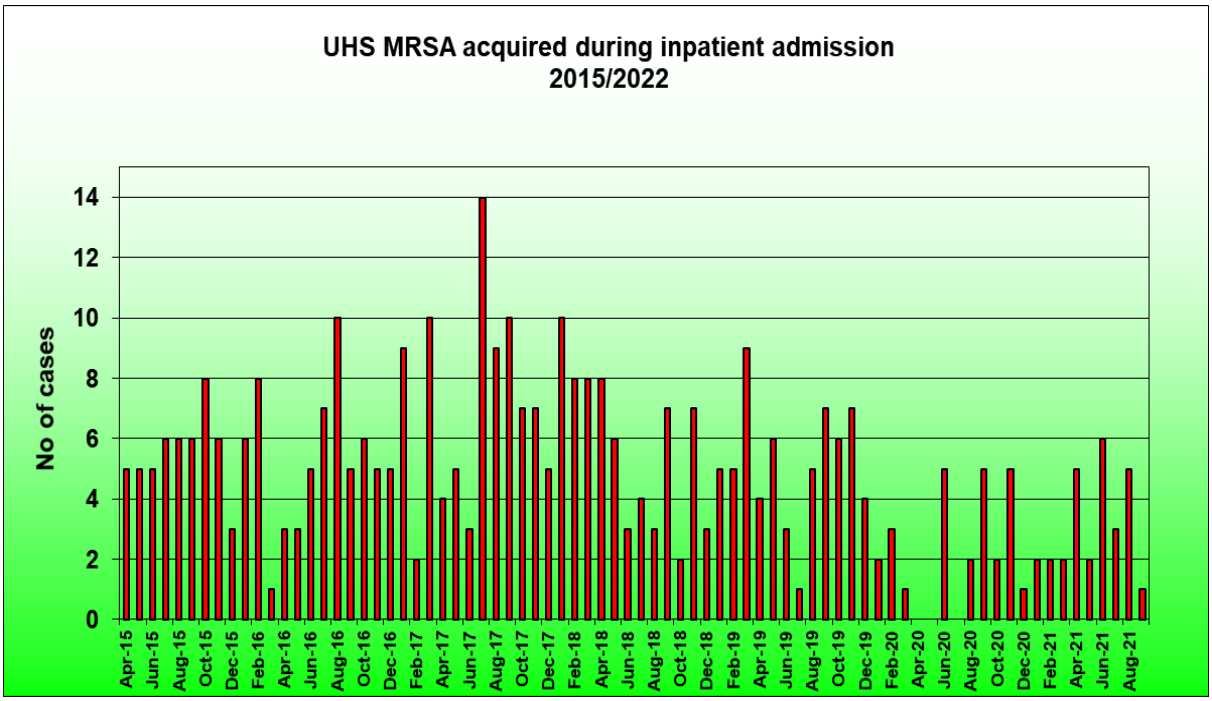
Hospital acquired cases continue to be reviewed by the Infection Prevention Team (IPT) and enhanced surveillance undertaken to review assurance that all elements of the MRSA care bundle were being met (prevention of spread, patient management prior to result, patient management following result).

Areas of good practice include: Hand hygiene, clinical cleaning, MRSA screening, risk reduction measures, isolation risk assessments, daily chlorine-based cleaning and contact precautions

Gaps in documentation, particularly for risk reduction measures continues to be identified as the key theme for failure to meet all elements of the MRSA care bundle. Additional support and training is provided by the IPT to wards with frequent failures in elements of the care bundle.

Summary of actions in to reduce acquisition of MRSA colonisation:

- Continue enhanced surveillance in cases of UHS new acquisition of MRSA and focus on areas for improvement.
- Focus on improving documentation of risk reduction measures.
- Review of the practices and standards outlined in the Trust MRSA policy following the publication of new national guidance expected October 2021.

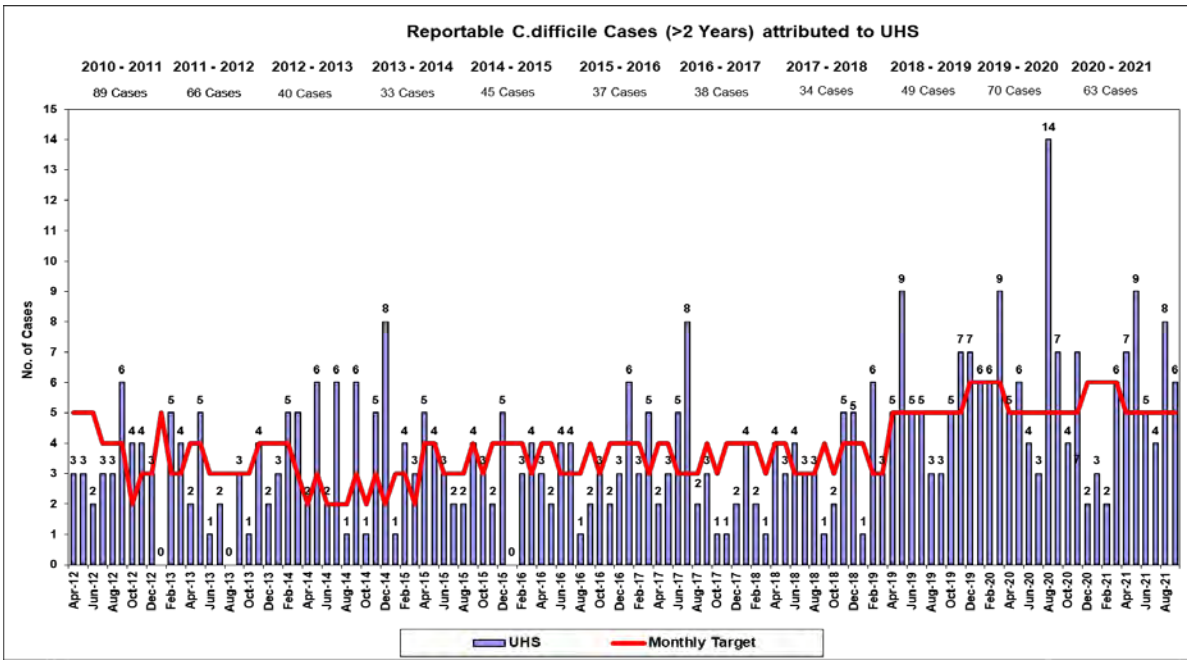


Clostridium difficile

From April 2019 NHSE adopted international definitions for attribution of *C. difficile* cases, which attempt to attribute any case to the likely source of acquisition of *C. difficile* and separate this from where the onset of symptoms of *C. difficile* occurred. UHS have been set a threshold of 64 cases for 2021/2022.

Progress:
39 cases in Q1&Q2 2021 2022 against a limit of 30

- 11 x Community Onset – Hospital Attributable (COHA)
- 28 x Hospital Onset – Hospital Attributable (HOHA)



The number of cases of C. difficile has shown wide fluctuation during the COVID-19 pandemic. The number of cases continues to be higher in both Q1 and Q2 of this financial year. Reasons for this are likely to be multifactorial but use of high-risk antibiotics is a major contributing factor. An outbreak also occurred in one of the cancer care wards contributing to the case increase. Increase in C.difficile related to use of chemotherapy has been identified which is an independent risk factor for C.difficile diarrhoea.

Toxin positive inpatient cases of C. difficile continue to be reviewed by the Infection Prevention Team and enhanced surveillance undertaken to review assurance that all elements of the C. difficile care bundle were being met. All hospital acquired cases are reviewed by a Consultant microbiologist/Infection control doctor to identify learning and actions required.

Areas of good practice include: Hand hygiene, daily chlorine-based cleaning, MUST documentation and appropriate treatment prescribed.

Key themes for identified lapses in care relate to no documented medical review, delay in isolation, delay in diagnosis, delay in sampling, delay in treatment, patient information leaflet not supplied and general documentation.

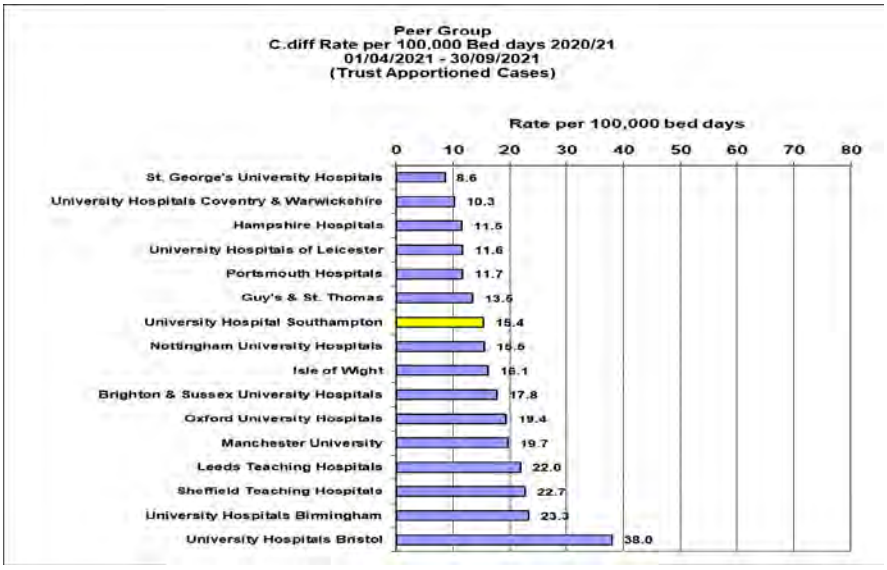
Feedback of learning is given during surveillance and following investigation. Additional support and training is provided by the IPT to wards with frequent failures in elements of the care bundle.

Summary of actions in place to reduce *C. difficile* infection:

- All hospital acquired cases are reviewed by a Consultant microbiologist/Infection control doctor to identify learning and actions required. This is an ongoing process of review of individual cases. Peer infection review is requested for any cases where there is clear lapse in care which contributed to C.difficile.
- All inpatient cases are reviewed by the IPT to ensure all elements of the C. difficile care bundle were followed. Where gaps are identified, clinical areas/teams are required to implement actions for improvement.
- The C.difficile treatment guidelines have been updated to include evidence-based treatment guidance based on published evidence and NICE guidance. This will improve clinical management of cases leading to improvement in clinical care and reduction in case relapse.
- The sepsis and pneumonia guidelines have been updated which will further reduce the use of high risk antibiotics, thus reducing the risk of C.difficile.
- Communication and education/awareness following review and update of Trust C.difficile policy and treatment guidelines.
- C. difficile Antimicrobial Review Group meets monthly to review cases, to ensure appropriate antibiotic use and duration. Reviews are fed back to care group clinical leads to share learning. IPC leads from the CCG are invited to this meeting to look for any learning for community prescribing which may contribute to C.difficile.
- Ongoing focus on antimicrobial stewardship via stewardship ward rounds - multiple ward rounds are regularly conducted covering areas of the hospital with high use of antibiotics. Pandemic pressures have compromised the overall numbers of patients reviewed in ward rounds. The findings are fed back to clinical teams for improvement.
- Continued focus on optimising the management of isolation facilities and improving standards of isolation care as an ongoing improvement priority in the 2021/22.
- The C.difficile outbreak in cancer care was actively managed with multiple meetings and an action plan in place.

UHS ranks seventh out of 16 self-selected peer acute trusts, with a rate of 15.4 cases/ 100,000 bed days. Comparative data needs careful interpretation because of differences in test selection, methodology and reporting criteria between trusts

Antibiotic use in UHS tends to be higher as compared to other secondary care hospitals due to the complex case mix associated with providing tertiary care. The Hampshire and Isle of wight IPC network is regularly updated with our challenges with C.difficile cases and identified improvement actions. .



Post 48 hr Bacteraemia's (excluding MRSA)

The NHS Standard Contract 2021/22 includes quality requirements for NHS trusts and NHS foundation trusts to minimise rates of a number of additional Gram-negative bloodstream infections to threshold levels set by NHS England and NHS Improvement. This includes Klebsiella Species and Pseudomonas aeruginosa in addition to E-coli. Details of these requirements were issued in July 2021.

Post-48h BSI	Q1&Q2 2021-22	2020-21	2019-20	2018-19	2017-18
E coli	75	67	67	67	81
Klebsiella	40	57	42	39	25
Pseudomonas	13	24	23	19	15
MSSA	27	36	30	44	36
VRE	4	7	12	10	10

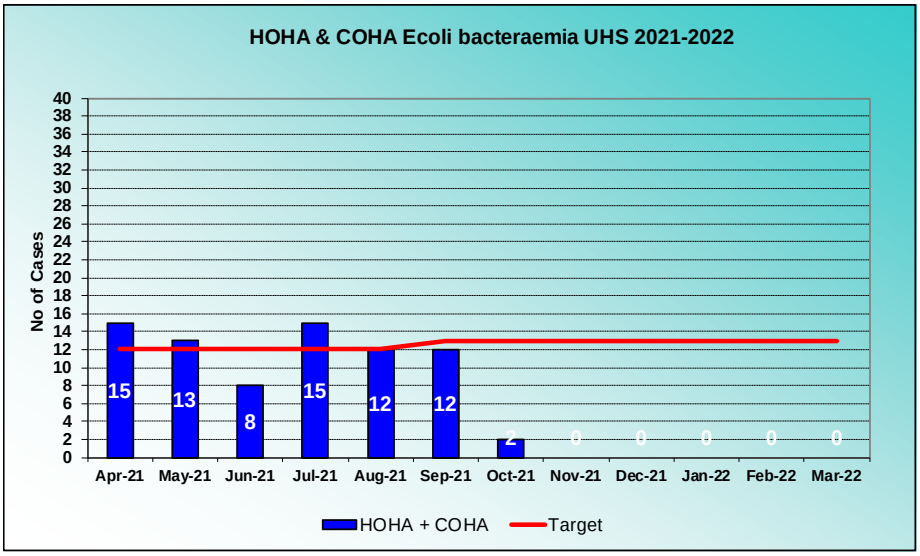
Post-48h bacteraemia's are reviewed by IPT and selected cases investigated in detail where there is potential learning to be found. Many patients are complex, often with unavoidable factors such as self-line care at home or extremely young age. Most of the cases are unavoidable but where there is preventable infection for example line infection or catheter related infection this is followed up with appropriate investigation. Investigation by post infection review of cases supports identification of emerging trends/themes, identification of organisational learning and targeted improvement actions.

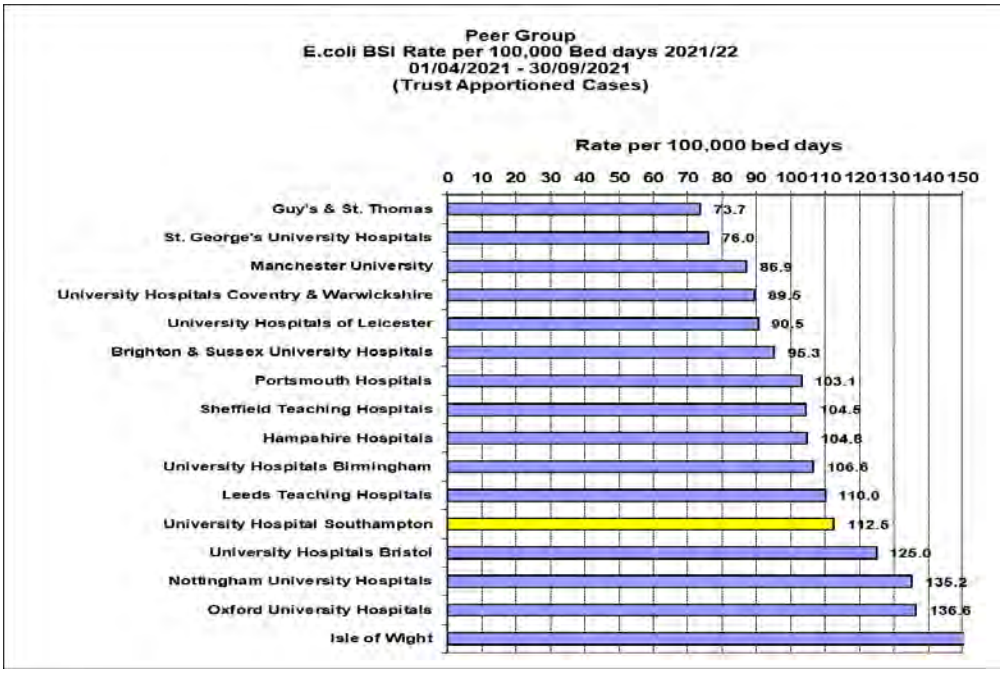
E coli Bacteraemia

From April 2021 UHS have been set an E. coli threshold of 151 Cases for the Year 2021-2022

Progress:
75 cases in Q1&Q2 2021 2022 against a limit of limit of 73

- 32 x Community Onset – Hospital Attributable (COHA)
- 43 x Hospital Onset – Hospital Attributable (HOHA)





Of the 75 cases in Q1&Q2 2021 2022

- 70 cases were assessed to have been managed appropriately
- 5 cases underwent post infection reviews

Key themes/leaning from cases

- Management and care of invasive devices (urinary catheter, Intravenous lines) including documentation, ANTT and Hand Hygiene.
- Timely removal of indwelling catheters.
- Care and management of patients admitted with long term indwelling catheters.
- Practice/procedure for balder washouts requires review.
  Review of wound dressings to identify alternatives to reduce the number of times a wound dressing is changed

Actions to reduce E-coli bacteraemia include continued focus on reducing risk of catheter associated UTI (CAUTI) through management of urinary catheters, avoiding unnecessary catheterisation and early removal. The trust Urinary Catheterisation Prevention of Infection Policy has been updated in Q2 to include up to date evidence and standards. System wide work is being undertaken and ongoing in relation to the management of patients with long term catheters/those discharged from acute care with a urinary catheter.

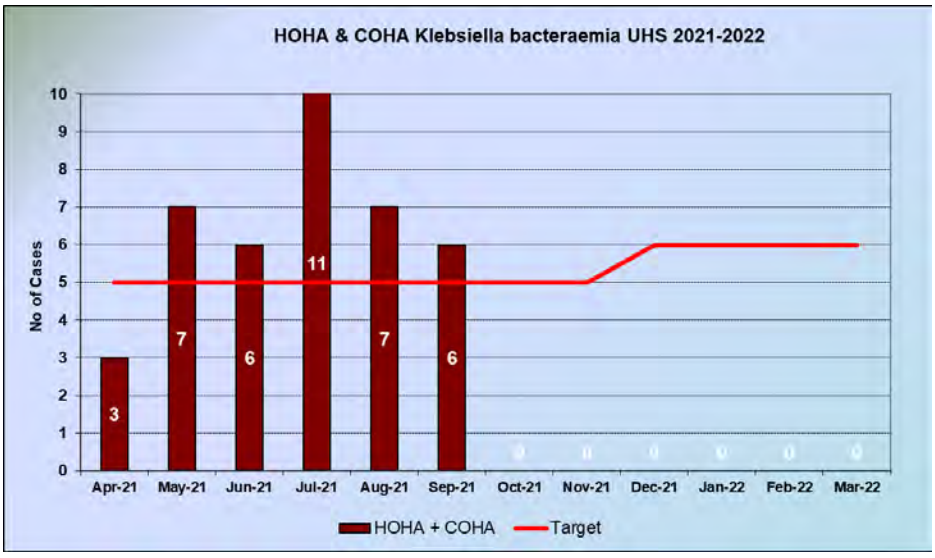
Klebsiella Bacteraemia

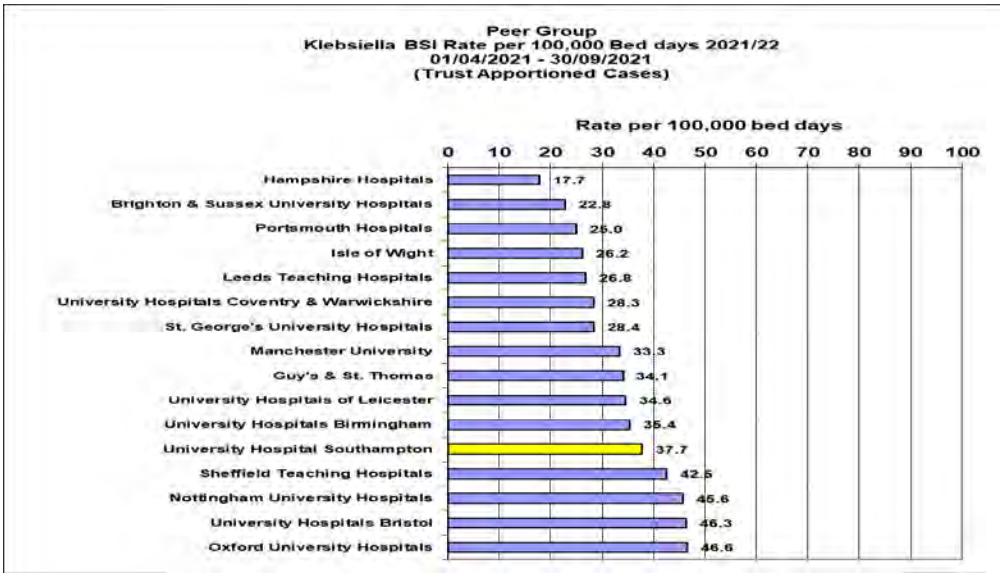
From April 2021 UHS have been set a Klebsiella threshold of 64 Cases for the Year 2021-2022.

Following notification in July 2021 of the threshold requirements for minimising bloodstream infections caused by Klebsiella Species, reviews of post 48hr cases by the IPT commenced in August 2021

Progress:
40 cases in Q1&Q2 2021 2022 against a limit of limit of 16

- 6 x Community Onset – Hospital Attributable (COHA)
- 34 x Hospital Onset – Hospital Attributable (HOHA)





Of the 40 cases in Q1&Q2 2021 2022

- 39 cases were assessed as being managed appropriately
- 1 case underwent post infection review.

Key themes/leaning from cases

- Care and management of PICC line.

Most of the cases reviewed did not show any pattern to suggest they are avoidable, although a particular area of concern relates to invasive device associated infection.

Data from review of cases will be used to identify the pattern of infections associated with Klebsiella bacteraemia and improvement actions required.

A key area of focus to reduce Klebsiella bacteraemia relates to invasive device care and management.

Pseudomonas Bacteraemia

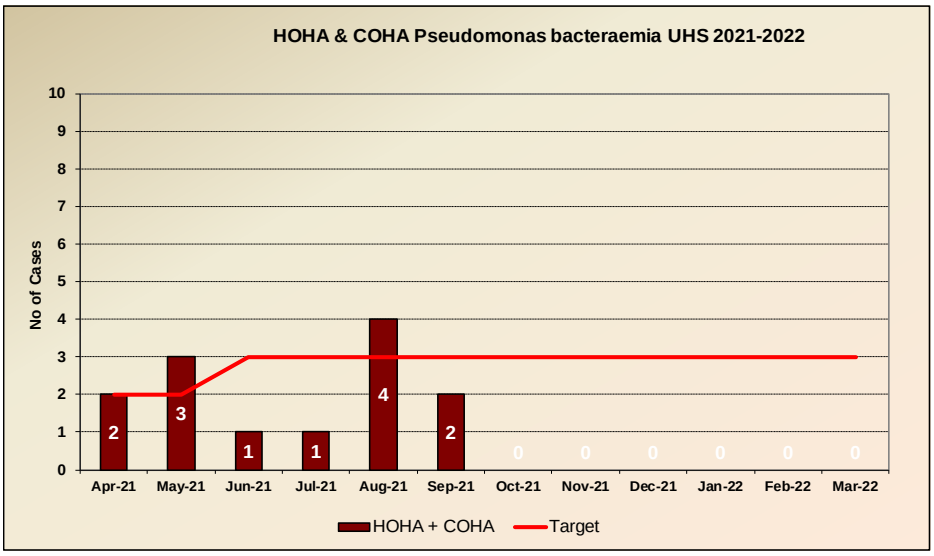
From April 2021 UHS have been set a Pseudomonas bacteraemia threshold of 34 Cases for the Year 2021-2022

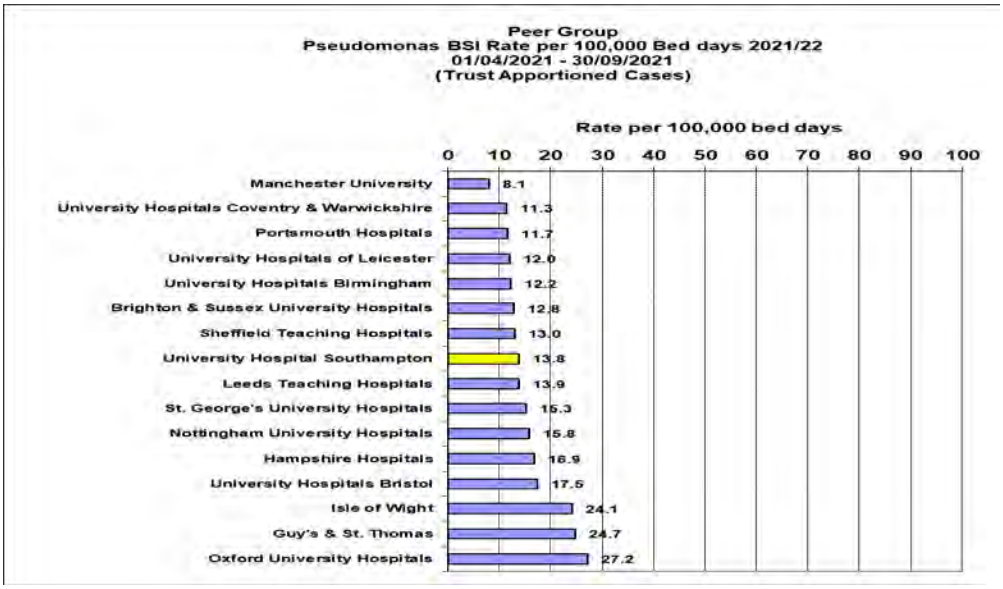
Following notification in July 2021 of the threshold requirements for minimising bloodstream infections caused by Pseudomonas Species, reviews of post 48hr cases by the IPT commenced in August/September 2021

Progress:

13 cases in Q1&Q2 2021 2022 against a limit of limit of 16

- 2 x Community Onset – Hospital Attributable (COHA)
- 11 x Hospital Onset – Hospital Attributable (HOHA)





Of the 13 cases in Q1&Q2 2021 2022

- 10 cases were assessed as being managed appropriately
- 3 cases underwent post infection reviews

Key themes/leaning from cases

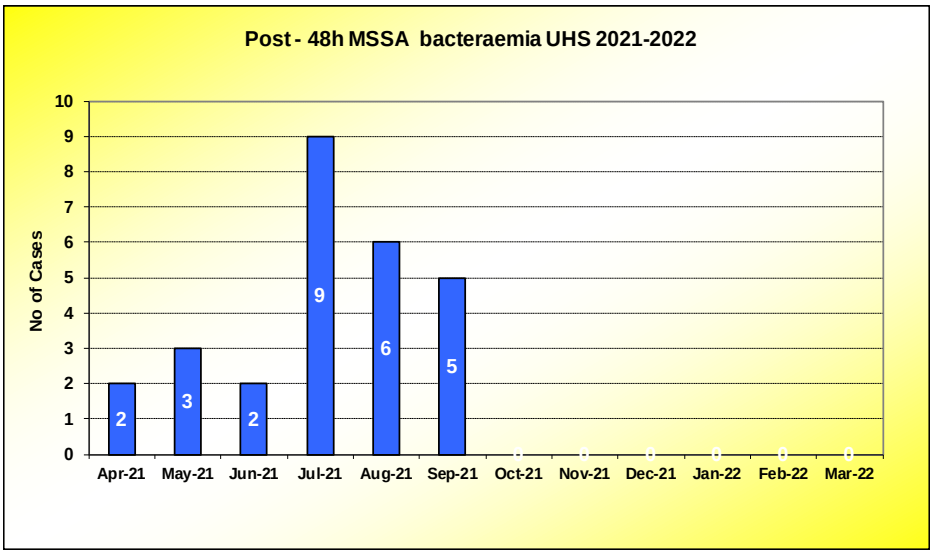
- Management and care of Intravenous devices including documentation, ANTT, Hand Hygiene and timely removal.
- Process and procedures for incubator and ventilator cleaning requires review.

Many patients in UHS are immunocompromised and neutropenic and therefore at particular risk of pseudomonas bacteraemia. Use of invasive devices in augmented care units (level 2 and level 3) increases the risk of bacteraemia making it an important area of focus.

Actions to reduce Pseudomonas bacteraemia include:

- All Pseudomonas bacteraemia is reviewed to identify any lapse in care which may have contributed to bacteraemia. PIR is requested when there are possible areas of improvement.
- Focus on invasive device care and management.
- Increased focus on water safety and correlation with reducing risk to patients:
    - Water safety meetings to include clinically focused discussion of cases of bacteraemia to identify and agree required improvement actions.
    - Posters to be placed at all handwashing sinks which will promote their use for hand washing only thus reducing risk of bacterial contamination of outlets and the water system. These are being installed in phased manner across the trust.
    - Ongoing close monitoring of Pseudomonas infections in augmented care areas with focus on monitoring of water quality for pseudomonas through water testing.
    - See section 2.9 for detail further detail on water safety

MSSA Bacteraemia



Progress:
27 cases in Q1&Q2 2021 2022

Of the 27 cases in Q1&Q2 2021 2022

- 15 cases were assessed as being managed appropriately
- 12 cases underwent post infection reviews

Key themes/learning:

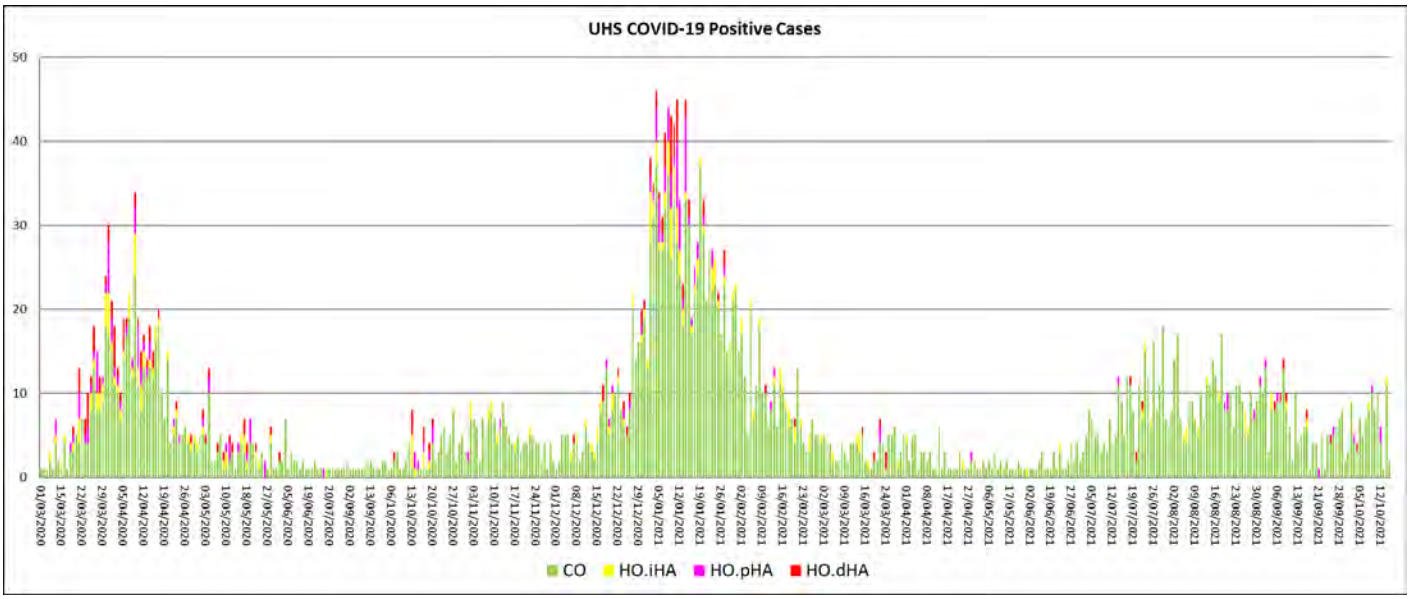
- Management and care of Intravenous devices including documentation, ANTT, Hand Hygiene and timely removal.
- Active focus, management and improvement actions within CV&T following a number of intravenous line related infections.

Actions to reduce MSSA bacteraemia continue to be a focus on improvements in invasive device management and care.

2.2 COVID-19 Pandemic

The global COVID-19 pandemic has remained a key area of focus for UHS within Q1 and Q2 with continued focus on preventing transmission of infection, whilst supporting the recovery and restoration of services.

Strategies to reduce the risk of in-hospital transmission of COVID-19 have remained in place and have been subject to ongoing review with appropriate and timely actions and improvements taken to reduce the ongoing risk of hospital onset infection and outbreaks. Leadership and oversight continues to be provided from the Chief Nursing Officer/Director of Infection Prevention & Control. Strategic and operational decisions have been made effectively with discussion in Trust operational huddles and incident meetings and the Infection Control Gold Command Committee.



Cases of Hospital-onset (healthcare associated) COVID-19 Infection

As per national requirements all cases of probable and definite healthcare associated COVID-19 have continued to be investigated through the RCA investigation process either as an individual case reviews or part of a wider outbreak investigation.

Cases identified in UHS: April 2021 to September 2021

Community Onset (CO)	Indeterminate (HO.iHA)	Probable (HO.pHA)	Definite (HO.dHA)
803	21	8	10

Definitions of apportionment of COVID-19 in respect of patients diagnosed within hospitals
Definite (HO.dHA): *hospital-onset definite healthcare-associated first positive specimen date 15 or more days after admission to Trust (RCA required)*
Probable (HO.pHA)*: hospital-onset probable healthcare-associated – first positive specimen date 8–14 days after admission to Trust (RCA required)*
Indeterminate (HO.iHA): *hospital-onset indeterminate healthcare-associated – first positive specimen date 3–7 days after admission to Trust*
Community Onset (CO*) - positive specimen date <=2days after hospital admission or hospital attendance.*

Outbreaks of COVID-19 infection

The use of local UHS surveillance data facilitates early warnings of increased rates of infection enabling us to identify both outbreaks and clusters (detection of unexpected, potentially linked cases) of infection amongst patients and staff. Close liaison between the Infection Prevention Team, Occupational health and clinical/non-clinical teams is in place to support identification, investigation and management of increased incidence of infection.

Total Number of Outbreaks April 2021-September2021	**10**
Outbreaks involving Patients and Staff	4
Outbreaks involving Patients Only	1
Outbreaks involving Staff Only	5
Total Number of Positive **Patients**	20
Total Number of Positive **Staff**	42

All outbreaks were managed by the Infection Prevention Team via a formal incident/outbreak management process and reported onto the national outbreak management system, with ongoing monitoring until 28 days following the last confirmed case.

Outbreaks (2) where there have been probable or definite hospital-onset healthcare associated COVID-19 infection deaths* have subsequently been reported as serious incidents as per national requirements.
4 patients were identified as a probable or definite hospital-onset healthcare associated COVID-19 infection death and a detailed RCA investigation has been undertaken.

A probable or definite hospital-onset healthcare associated COVID-19 infection **death is defined as;*

- *the death of a patient who has a positive specimen result where the swab was taken within 28 days of death and/or COVID-19 is cited on either Part 1 or Part 2 of the death certificate (i.e. the death resulted from a COVID-19 clinically compatible illness with no period of complete recovery between the illness and death);*
- ***and*** *the COVID-19 infection linked to the death meets the definition of 'probable' or 'definite' hospital-onset healthcare associated infection.*

Summary of key themes/ learning from outbreaks and individual hospital onset cases in Q1 and Q2

- Wide variation in use of facemasks by inpatients.
- Inpatients leaving the ward for non-clinical/treatment reasons (e.g.to meet others in retail outlets/outside) increases the risk for COVID-19 transmission.
- Staff and Patient hand hygiene
- Difficult to promote and maintain use of face masks, hand hygiene and social distancing amongst confused and wandering patients.
- Lack off onward care provision in the community resulting in delayed patient discharge.

- Patients and staff testing positive to COVID19 despite being fully vaccinated, indicating apparent waning immunity in those who were vaccinated over six months ago.
- Risks associated with the physical environment, particularly lack of mechanical ventilation in some areas, identified as a significant factor in relation to aerosol transmission in the context of outbreaks.

2.3 Norovirus

Interventions implemented to control COVID-19 are likely to have contributed to the significant reduction in influenza/other respiratory virus and enteric virus transmission seen in 2020/21. With the easing of COVID-19 restrictions surges in influenza and other respiratory infections are predicted, along with an increase in enteric virus infections such as Norovirus.

Year	Bed days lost due to ward closures
2016-17	232
2017– 8	101
2018-19	946
2019-20	1039
2020-21	0
Q1&Q2 2021-22	207

In Q1&Q2 2021/22 there were 8 outbreaks related to D&V/Norovirus. Involving 34 patients and 2 staff affecting individual 7 bays and 1 ward.

Key themes/learning:

- Management of patients with type 5 stools
- The importance of early isolation of patients with symptoms (e.g.2 hours of developing loose stools)
- Importance of the need to focus on patient hand hygiene
- Cleaning of Equipment

2.4 Respiratory virus infections.

In Q1&Q2 2021/22 there were 0 outbreaks related to Influenza A/B or RSV.

2.5 Actions to minimise the risk of in-hospital transmission and outbreaks associated with COVID19, other respiratory viruses and Norovirus

Key actions and strategies to reduce the risk of in-hospital transmission of COVID-19, influenza/other respiratory viruses and Norovirus, along with planning for potential further waves of the COVID-19 pandemic are in place and remain under ongoing review.

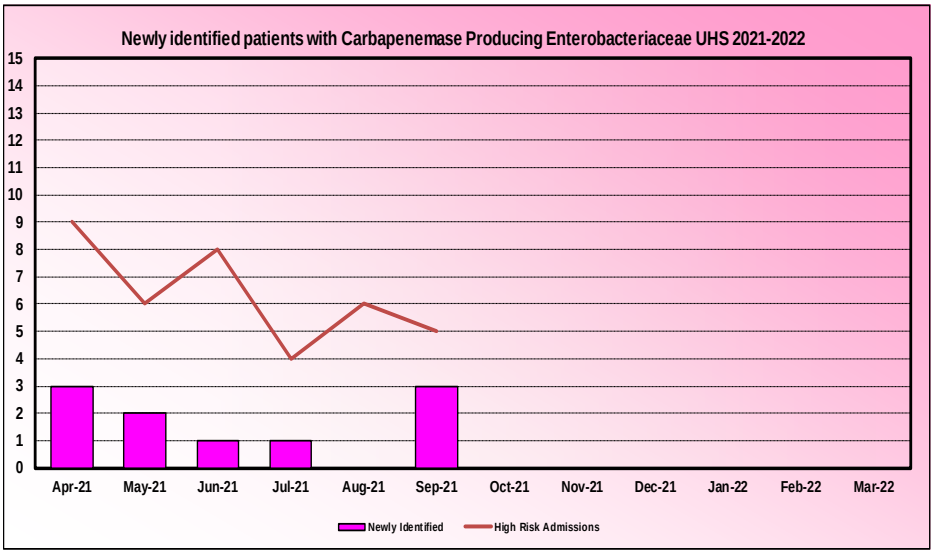
Lessons learned from wave 2 of the COVID-19 pandemic and learning from previous outbreaks of Norovirus and influenza will be used to inform and support planning and management during winter

2021/22. Early identification and robust management of patients presenting with symptoms of infection or at high risk of infection will be key in reducing the risk of transmission and outbreaks occurring within the hospital.

Specific actions to support effective management and control of all infections include:

- Use of local & national prevalence data to facilitate early warnings of increased rates of infection in the local community/area – COVID-19, Norovirus and respiratory viruses
- The ongoing use of local UHS surveillance data to facilitate early warnings of increased rates of infection enabling us to identify both outbreaks and clusters (detection of unexpected, potentially linked cases) of infection amongst patients and staff.
- Ongoing close liaison between the Infection Prevention Team, Occupational health & clinical/non-clinical teams to support identification, investigation and management of increased incidence of infection.
- Updates/amendments to national/regional guidance will be reviewed and assessed by the Infection Prevention Gold Command Committee and trust guidance will be revised and implemented according to the outcomes of the review.
- Improving capacity for rapid diagnostic testing (result within 2 hours) for COVID-19 and other respiratory and gastrointestinal pathogens (including Norovirus) to support rapid decision making and management– both point of care testing in admission pathways and rapid in-lab testing. A programme to improve diagnostics for Norovirus is in place with a new Laboratory analyzer for molecular testing installed in the Microbiology laboratory to facilitate additional PCR testing which will improve turn-around times. Verification of rapid PCR testing of GI pathogens using bio fire has been completed.
- Screening and triaging of all patients either prior to arrival to a care area, or as soon as possible on arrival, to allow early recognition of patients presenting with symptoms of infection or at high risk of infection.
- Focus on more effective management and optimal use of single room capacity to facilitate rapid isolation of patients presenting with suspected infections.
- Ongoing review of patient pathways and placement with care groups to support appropriate segregation of patients presenting with/without symptoms of infection or at high risk of infection.
- Working with partners regarding admission avoidance where appropriate e.g. hydration management in care homes/the home.
- Ongoing proactive focus on bed planning and management with collaborative discussions amongst key stakeholders, including the Infection Prevention Team, to manage and reduce overall risk to the organisation.
- Limiting patient movement as far as possible.
- Promotion of the Flu vaccination and COVID booster vaccination.
- Careful review and consideration of the lifting of restrictions in place within the Trust, e.g. visiting, and the re-introduction of restrictions if required, led by DIPC/Infection Prevention Gold Command Committee.
- Refreshed awareness campaign (#Don’tgoviral) focusing on the importance of maintaining the measures of hand hygiene, wearing of masks, social distancing, testing, vaccination and other infection prevention standards.
- Further improving communication cascades and internal alerts/escalation.
- Ongoing monitoring and focus on infection prevention and control practices in clinical and non-clinical spaces
- Ongoing review and work to improve ventilation standards in clinical and non-clinical areas.
- Ongoing emphasis on working from home where possible

2.6 Carbapenemase-producing Gram negative bacteria



CPE continues to be a key risk for UHS and early identification of patients at risk and appropriate management is the key to reducing risk of transmission. The global and national prediction suggests an increase in antimicrobial resistance including CPE, which continues to be major public health risk as identified by the World Health Organisation and as outlined in the UK's five-year national action plan for tackling antimicrobial resistance (2019-2024).

Detection of CPE is now much improved with the use of improved workflows within the laboratory and use of PCR based method for detection thus improving our ability to detect, isolate and contain the risk posed by CPE.

<u>April 2021 to September 2020:</u>

- 0 UHS Hospital acquired cases
- 33 High Risk patients admitted to UHS
- 10 new patients detected as being colonised with CPE
- 0 new patients detected as being colonised with MBL
- 6 new patients detected as being colonised with MDRO
- 2 new patients detected as being colonised with OXA 48

Key actions to reduce risk and transmission from CPE:

- Education and awareness in relation to the updated Trust CPE policy
- Enhanced focus on antimicrobial stewardship to reduce use of broad-spectrum antibiotics specially carbapenems group of antibiotics.
- Plan to use PCR as first line for diagnostics which is planned from year 2022-2023.
- To continue to do extensive screening of CPE in key areas of hospital including patients on carbapenems.

2.7 Assurance of Infection Prevention Practice standards, including environmental cleaning

Infection Prevention Practice standards
The Trust annual infection prevention audit programme was re-instated in April 2021, following, suspension during the covid Pandemic to monitor infection prevention and control practices in clinical and non-clinical areas.

Audits undertaken in Q1 and Q2:

Saving Lives High Impact Intervention Audits (all self-assessed audits)
Urinary Catheter Care – audit undertaken in April 2021 shows 99% of cases audited met all insertion standards and 95 % met all standards of ongoing care.

Central Venous Catheter Care – audit undertaken in May 2021 shows 100% of cases audited met all insertion standards and 97% met all standards of ongoing care.

Peripheral Intravenous Cannula Care - audit undertaken in May 2021 shows 97% of cases audited met all insertion standards and 88% met all standards of ongoing care.

Surgical Site Infections - audit undertaken in July 2021 shows 98% of cases audited met all Pre-operative Surgical standards, 100% met all Intra-operative Surgical standards and 99% met all Post-operative Surgical standards.

Ventilated Patients audit undertaken in July 2021 shows 100% of cases audited met all standards.

Hand Hygiene
Hand Hygiene Compliance In-Patient Areas (self-assessed) audit undertaken in June 2021 shows 95% compliance.
Hand Hygiene Compliance Out-Patient Areas (self-assessed) audit undertaken in June 2021 shows 95% compliance.
Infection Prevention Covert Hand Hygiene Audit undertaken by Infection prevention nurses - audit undertaken in August 2021 shows 69% compliance.

Miscellaneous Audits (all self-assessed with exception of IPT PPE audit)
Sharps Safety audit undertaken in April 2021 shows 97% compliance.
Standard Precautions audit undertaken in August 2021 shows 97% compliance
Use of PPE undertaken by clinical areas audit undertaken in August 2021 shows 99% compliance
Use of PPE undertaken by Infection prevention show 89% in compliance
Isolation Audit undertaken in September 2021 shows 98% in compliance.

Overall audits identify that there is good assurance related to practice and infection prevention and control standards. Areas who do not achieved the expected audit standards are required to identify actions for improvement and are offered support and input from the Infection Prevention Team.

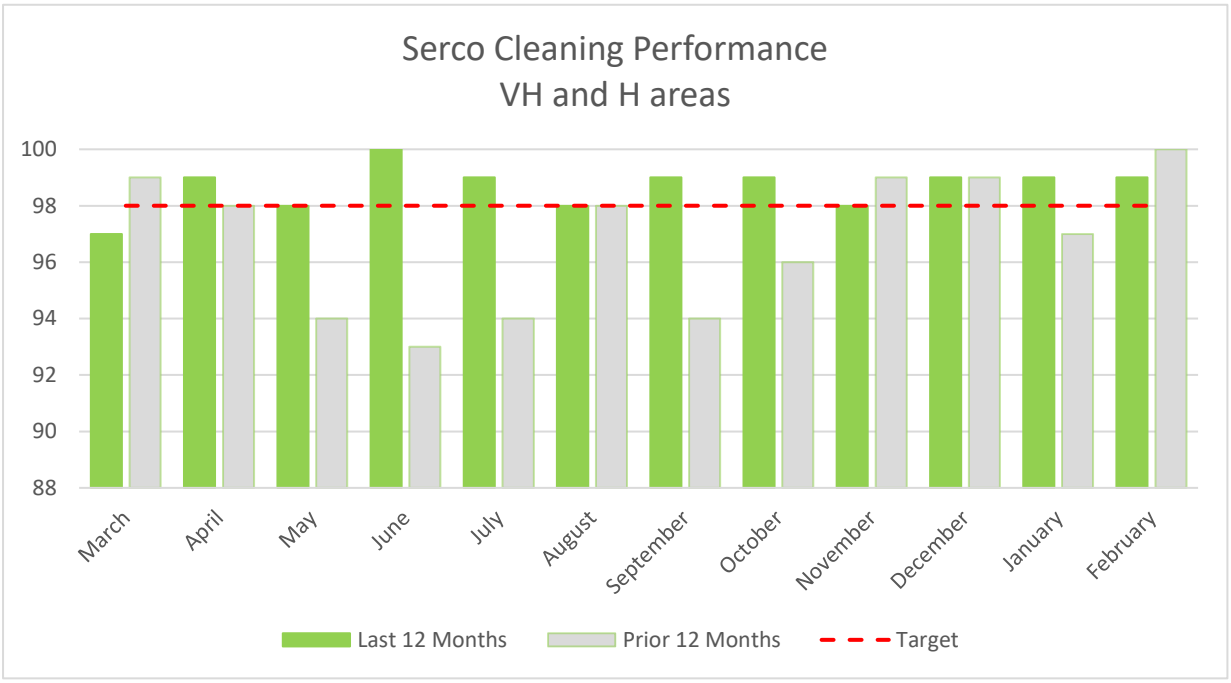
In addition to the formal audits ongoing monitoring of infection prevention and control practices in clinical and non-clinical spaces continues to be undertaken through a range of avenues:

- As part of IPT visits and reviews of clinical areas.
- Ward leader/Matron walkabouts & spot checks
- Infection Prevention Team COVID zero walkabouts/reviews in clinical areas.
- COVID secure walkabouts in non-clinical areas.
- Through the use of local Infection control guardians/local COVID zero champions/infection prevention link staff

Environmental Cleaning

Monitoring of environmental cleaning standards (domestic and clinical) have continued to be undertaken by the environmental monitoring team in 2021/2022. During this period, the volume of audits has increased significantly, ensuring all areas of the hospital are being assured for cleanliness far more frequently.

Serco has consistently delivered high levels of cleaning across the hospital, with all monthly targets achieved in 2021/2022.



2.8 Prudent Antibiotic prescribing

See Appendix 1 for full report.

2.9 Estates

Water Quality

Water quality is monitored by an appointed external company. Control actions are determined by a UHS Water Quality Manager and reviewed by a multi-disciplinary Water Safety Group to ensure national standards are met. An Authorised Engineer Water Quality provides regular independent specialist audit of management of water quality and supports the Water Safety Group. Building developments are also closely reviewed to ensure water quality is assured. UHS undertook an external audit of water safety in 2016 which has enabled significant improvements in water quality to be made. This external audit is under review by the Authorised Engineer over 2020/21 to confirm measures taken have been effective and to identify additional improvements to be made.

The focus on water quality remains a high priority for UHS due to the high number of augmented care units and immunocompromised patients. Waterborne infections such as Pseudomonas can delay discharge and increase length of stay in intensive care units in addition to increasing the need to use broad spectrum

antibiotics. There is notable good work in water safety to improve the governance processes and in the education of clinical staff. There is further plan to identify and log corrective actions as quality improvement.

There has been an ongoing focus to make the water safety group more effective and engage with clinical staff to improve awareness of water safety among staff working in augmented care units and this continues in 2021/22.

A significant challenge in UHS and hospitals nationally and internationally is related to use of hand wash basins for hand washing only. Any other use of these sinks for example disposal of body fluid/ wash water can increase bacterial growth and overgrowth of pseudomonas. This continues to be challenge across the organisation and continues to be addressed with ongoing education awareness and information.

Air Quality

Air quality is monitored by Estates Department and reviewed by a multi-disciplinary Ventilation Safety Group. Regular external audit of performance is provided by an Authorised Engineer Air Quality. Historical issues particularly with ageing operating theatre ventilation which requires major engineering work to achieve modern standards are under regular review and are included in medium/long term refurbishment plans.

The COVID-19 pandemic has further highlighted key areas where mechanical ventilation is lacking or does not meet current standards in clinical areas. Many of our COVID outbreaks within UHS occurred in areas of inadequate ventilation. Air purifier units were temporarily deployed as a control measure into areas affected by outbreaks and have also been deployed into high-risk areas such as admission units. However, use of these units are only a temporary short-term solution and a long-term solution should be explored.

Focus on ventilation in the built environment may further reduce the risk from many other healthcare associated infections such as influenza and other respiratory virus, Norovirus and MRSA.

Ventilation is identified as one of estates highest priorities for addressing and is included in the backlog maintenance replacement programme but requires funding.

3.0 Operational and financial impact of Healthcare Associated Infection

Outbreaks of infection e.g. Norovirus, COVID-19 can result in significant impact on operational capability/capacity of the Trust resulting in cancellation of elective procedures and staff absence.

The increased length of stay with healthcare associated infection contributes further to decreased operational productivity.

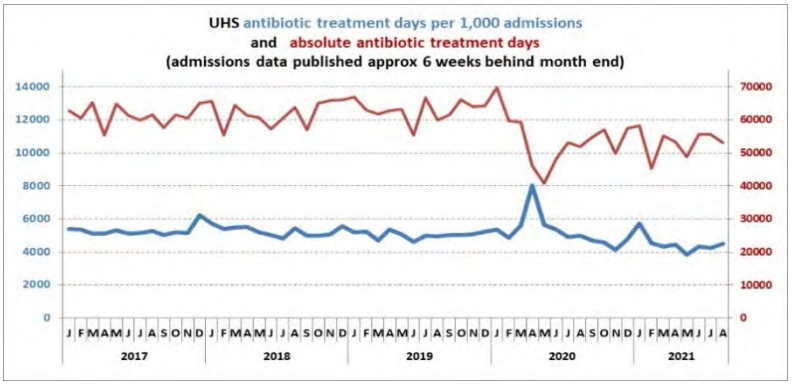
A recent study has estimated the cost of healthcare associated infection in the UK is approximately 774 million pounds.

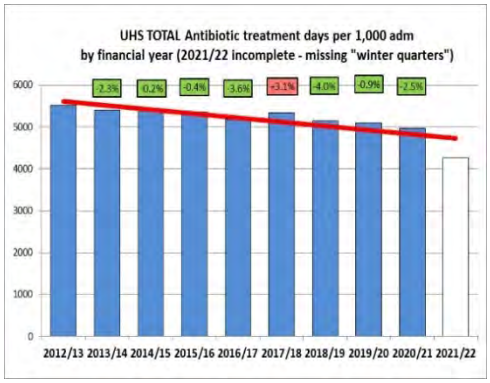
Appendix 1 UHS Antimicrobial Usage Data

UHS Antimicrobial Stewardship Team Report to Infection Prevention Committee and TEC to cover Q1 and Q2 2021-22 where possible. (October 2021)

Introduction

Antimicrobial stewardship at UHS has been re-focused following a challenging year April 20-21 due to the COVID-19 pandemic. Although hospital activity is still divergent from pre-COVID times, antimicrobial use seems to be stabilising. Usage per 1,000 admissions is currently running lower than pre-COVID levels (shown below) and in the longer term our trend in usage continues to be downward.



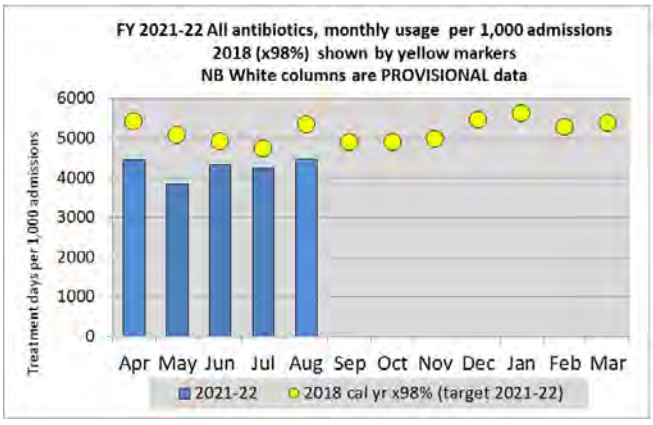


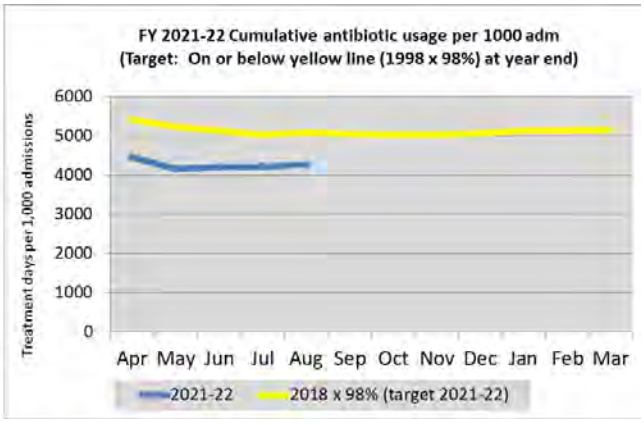
High antibiotic usage is still seen in COVID-19 admitted patients; stewardship activities in other groups have continued, though pharmacy anti-infectives team resource has been diverted to COVID-19 therapeutics and vaccination work streams leaving limited time for other activities.

1. UHS Antimicrobial Usage Data and National/Local Targets

1.1 Overall Antibiotic use

There has been no published standard contract requirement for reduction in antibiotic usage for FY2021/22 yet. If at all, we expect this to require a reduction of 2% from calendar year 2018 usage. Performance against that baseline is shown below; currently (August is most recent available) UHS is substantially inside that limit, although the target relates to total annual use and only trends can be shown thus far.

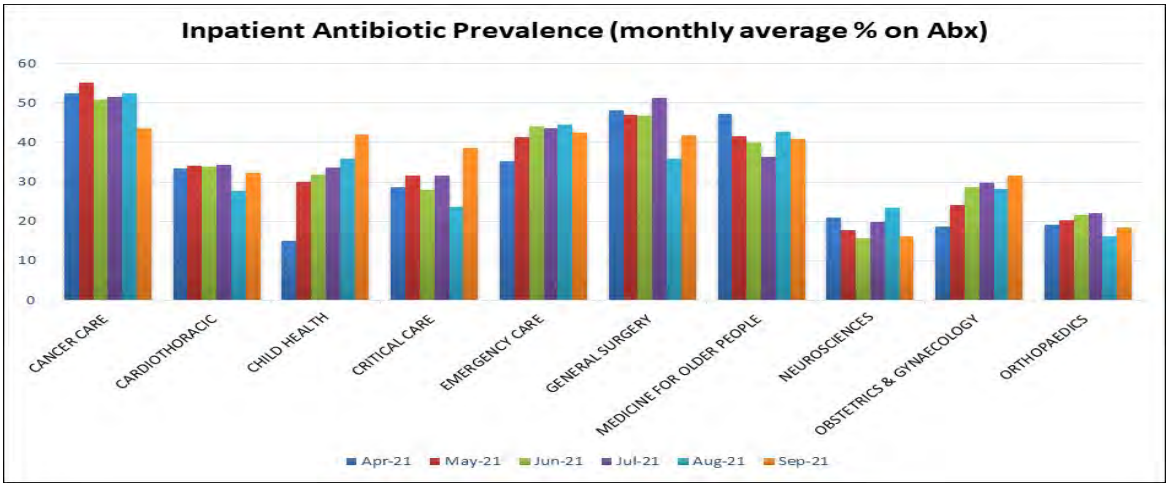




Ref: Internal reporting; source data from https://www.rx-info.co.uk/ Refine

1.2 Proportion of Patients on Antibiotics

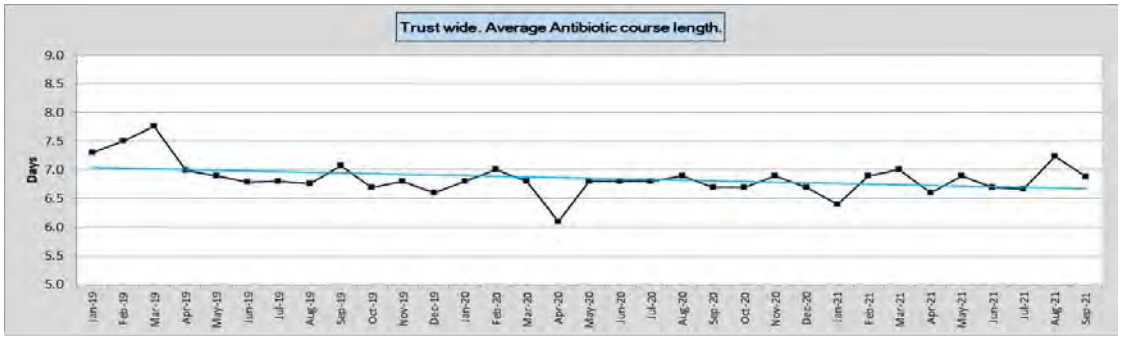
2021/22 Q1 prescribing indicates that the number of admitted patients prescribed an antibiotic at any one time has remained stable at around 37-38%. The highest prevalence of patients on antibiotics sits within specialist medicine (not shown here); this is to be expected due to the patient type which comprises cystic fibrosis and infectious disease teams.



Ref: Reporting data from JAC prescribing system

1.3 Duration of Antibiotic Treatment

Antibiotic durations are monitored following the introduction of automatic 5-day course lengths to most (particularly oral) antibiotics on the JAC system in December 2018. For the period Jan-Sep 2021, 70% of prescribed antibiotic courses were for 6 days* or lower; 17% of antibiotic courses were for 9 days or more. *(durations of 6 days likely represent 5-day courses starting afternoon, day 1 and finishing morning, day 6)

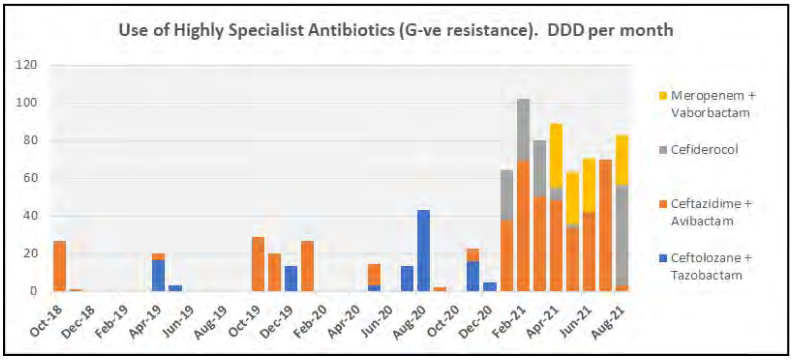


Ref: Reporting data from JAC prescribing system

1.4 Specialist Antimicrobials Usage

In response to the increase in gram negative resistant infections nationally and at UHS, our use of expensive last-line restricted antimicrobials is increasing (though unavailability of ceftolozane-tazobactam continues).

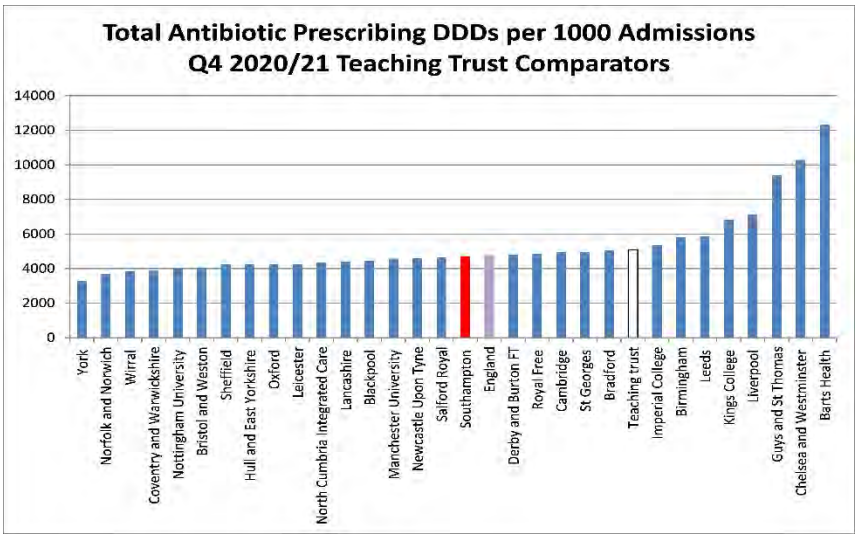
We monitor the use of these antimicrobials to ensure they are used in-line with sensitivities and on expert advice. Availability of laboratory sensitivity testing is required before a new restricted antimicrobial is introduced at UHS.

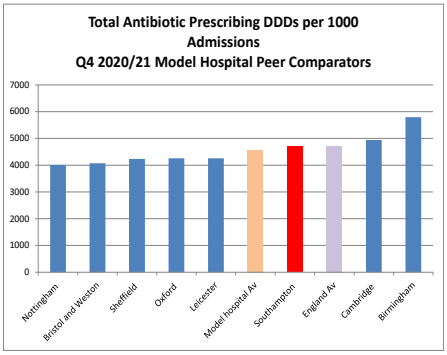


Ref: Internal reporting; source data from https://www.rx-info.co.uk/ Refine

1.5 Comparative Data 2020/21 Q4 (most recent available)

When compared to teaching trust hospitals within England, antibiotic use at UHS is 7.6% less than the teaching trust average within England. When compared to our model hospital comparator sites our usage is 3% higher than the model hospital average. Prior to the COVID-19 pandemic UHS antibiotic use was also 3% higher than the model hospital average so relative performance has remained steady.





2. AMS Improvement Activity April 21 onwards

2.1 Antimicrobial Stewardship rounds in the Acute Medical Unit

Stewardship rounds have been instated in the acute medical units. This area has been identified for rounds as an admission ward to target antimicrobial prescribing at the point of prescribing. These comprise a consultant microbiologist/infectious diseases and specialist pharmacist once or twice per week. Initial perception is that this clinical area demonstrates good adherence to the principles of antimicrobial stewardship and adherence to trust antimicrobial guidelines despite extremely high workload.

2.2 Guideline review

Three major infection policies (sepsis, pneumonia, *C.difficile*) have been reviewed and updated in line with changes to national guidance and local antibiotic resistance patterns. They were launched in October 2021. Several others are now under review.

2.3 Education

The Antimicrobials Pharmacists and Dr Tom Cusack (Cons. ID/microbiology) have delivered multiple teaching sessions to a variety of staff groups (UHS junior medical MyMedBite and MedEd sessions; NMP teaching days for University of Southampton and Solent NHS trust; general all-staff teaching for Solent's patient safety week; pharmacy undergraduates from University of Portsmouth).
As part of World Antibiotic Awareness Week in Nov 2021 we are intending to give stewardship presentations to relevant 6th form classes in several local schools/colleges and possibly to some guide/scout groups.

Appendix 2 – Matrons Reports

Due to current hospital pressures and matrons supporting staffing and patient safety matron reports have not been included.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Annual Assurance for the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)**			
Agenda item:	**5.10**			
Sponsor:	**Joe Teape, Chief Operating Officer**			
Author:	**Sandra Hodgkyns, Head of Security/Emergency Planning Response and Resilience**			
Date:	**30 November 2021**			
Purpose	**Assurance YES**	**Approval YES**	**Ratification**	**Information**
Issue to be addressed:	This report is provided annually to Trust Board as part of our NHS England Emergency Preparedness, Resilience and Response (EPRR) annual assurance process. The purpose of the report is to provide the Board with assurance on our standards and seek approval to support the action plan in place.			
Response to the issue:	This paper provides the Board with assurance that we have met the core standards and during the COVID-19 pandemic, EPRR has continued to deliver, respond and improve aspects of EPRR through 2021/22. This paper provides an overview of: • the process for 2021/22 • the level of assurance • our action plan.			
Implications: (Clinical, Organisational, Governance, Legal?)	The EPRR function is to ensure that the Trust meets its requirements under the Civil Contingencies Act 2004 (CCA 2004): • leading the Trust with incident response plans • providing major incident training for the tactical and strategic commanders and those with on call major incident responsibility; • advising strategic and tactical command in their role in the event of a major incident or Hospital Incident Management Team (HIMT). The Head of Security/Emergency Planning provides assurance to NHS England and our commissioners that the Trust is meeting and maintaining our assurance levels in Emergency Preparedness, Resilience and Response in the Trust.			
Risks: (Top 3) of carrying out the change / or not:	Failure to provide assurance or suitable standards on our EPRR core standard requirements to NHS England (NHSE) and our commissioners will result in our current level of 'Substantial'*, which has been maintained for a number of years, being lowered and potentially additional scrutiny being placed on the Trust in respect of EPRR. ***Overall EPRR assurance rating/criteria** • **Fully -** The organisation is 100% compliant with all core standards they are required to achieve. • **Substantial** - The organisation is 89-99% compliant with the core standards they are required to achieve. • **Partial -** The organisation is 77-88% compliant with the core standards they are required to achieve. • **Non-compliant** - The organisation is compliant with 76% or less of the core standards they are required to achieve.			

	Emergency preparedness, resilience and response annual assurance guidance (June 2019)
Summary: Conclusion and/or recommendation	**1.1 Process** In 2021, the Head of EPRR at UHS was asked to lead a new approach toward the assurance process for acute trusts within Hampshire and the Isle of Wight (HIOW) by the Incident Control Centre (ICC). All trusts were engaged and supportive towards the new approach. The previous assurance process was completed with the CCG EPRR leads and individual trusts providing evidence and the Trust then would confirm its assurance rating. Once this was completed the CCG would feedback to NHSE EPRR. This year's process involved peer review with all acute trust EPRR leads allowing for confirm and challenge and agreeing the assurance rating jointly. A small presentation was then provided by each trust on the outcomes of their assurance via this process to HIOW Local Health Resilience Partnership (LHRP) (Exec Group) and NHSE EPRR. To ensure the process was aligned, all trusts agreed to the support and overarching guidance from Phil Hartwell, Head of EPRR ICC. This was an asset to the process with his wide knowledge and experience in the NHS and the acute sector. Each trust provided their individual details on all aspects of their EPRR core standards to the acute partners. Confirm and challenge from all partners enabled the acute partners to confirm standards and also adjust individual standards (up or down) where required and approved by all partners. It was felt by partners that all HIOW acute trust's EPRR leads have excellent partnership working, which supported the ability to challenge and discuss. The process was documented for reference and learning. **1.2 Level of Assurance** Following the review process this year UHS has maintained the rating of 'Substantial'. The EPPR was compliant with 42 core standards and will be fully compliant with all 46 core standards by March 2022. In terms of the RAG rating there were no reds and only four ambers. All acute trusts in HIOW are now rated as 'Substantial'. **1.3 Action Plan** The action plan is detailed in Appendix 1. Outside of the main EPRR core standards, acute trusts are also required to have a Chemical, Biological, Radiological, Nuclear and Explosion (CBRNe) assurance review. This is completed by South Coast Ambulance Service NHS Foundation Trust (SCAS). This review provided one amber which relates to CBRNe trained trainers; this is already being addressed and impacted on all trusts during the COVID-19 pandemic. The report also supports the installation, where possible, of warm water for the CBRNe tent for those patients that have received CBRNe exposure. Currently the setup only allows cold water, which could impact on patient welfare if they had traumatic injuries as well as contamination. EPRR and Estates are scoping the requirements for this installation. **Recommendations** The Board is asked to consider and approve this annual report.

Appendix 1 - EPRR Improvement Plan: University Hospital Southampton NHS Foundation Trust
Version: 1 Confirmed following Acute Review 23 September 2021

University Hospital Southampton NHS Foundation Trust has been required to assess itself against the NHS core standards for Emergency Preparedness, Resilience and Response (EPRR) as part of the annual EPRR assurance process for 2021/2022. This improvement plan is the result of this self-assessment exercise and sets out the required actions that will ensure full compliance with the core standards.

This is a live document, and it will be updated as actions are completed.

Core Standard	Current self-assessed level of compliance **(RAG rating)**	**Remaining actions required to be fully compliant**	**Planned date for actions to be completed**	**Lead name**	**Further comments**
Duty to Maintain Plans 21		Core Standard: Lockdown *In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.* Lockdown plan to be reviewed and updated and approved in line with Trust changes to perimeter access control security measures (subject to approved funding). The Trust does have a lockdown plan which was due for update in October 2020 and therefore currently it meets the assurance requirements.	March 2022 Subject to funding	UHS Security Manager	The plan will be reviewed (excluding the perimeter access control changes) This aspect will be completed by December 2021.

Warning and Informing 37		Core Standards: Communication with partners and stakeholders *The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.* Communication plan/emergency communication plan need to be reviewed and approved.	March 2022	Communications Team Rachel Belli	The Communications Team response in an incident (such as COVID-19) has been strong. The Incident Response Plan reflects the communications/ media requirements and planned response in a major/critical incident. However, the Communications Team have confirmed that a new plan for the Trust created by the Communications Team is required.
Business Continuity 50		Core Standard The Data Security and Protection Toolkit: *Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.* There is an improvement plan in place following the submission in 2021. This does not include continuity planning as this was fully completed.	March 2022	Judith Downing	The Trust has completed and submitted the Data Protection and Security Toolkit for 2020/21. The general statement is as follows: *The Data Security and Protection Toolkit 2020/21 status for the Trust. It should be noted that assertion 7, Continuity Planning, was fully completed and does not form part of the improvement plan. The current Standards are Not Fully Met (Plan Agreed). An improvement plan has been submitted and agreed by NHS Digital.*
CBRNe 57		Core Standard HAZMAT & CBRN Planning arrangements: *There are documented organisation specific HAZMAT/ CBRN response arrangements.* The CBRN plan is to be reviewed internally and with partners, including HFRS and SCAS. Ratification for the plan is due January 2022	January 2022	UHS EPRR Team	The Trust does have a plan that was due for review July 2021. This plan is going through the first stages of change and review.

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Corporate Objectives 2021/22 – Quarter 2 Review**			
Agenda item:	**6.1**			
Sponsor:	**Chief Executive Officer**			
Author:	**Andrew Asquith, Director of Planning, Performance and Productivity**			
Date:	**30 November 2021**			
Purpose	**Assurance or reassurance Y**	**Approval**	**Ratification**	**Information**

Issue to be addressed:

Corporate objectives for 2021/22 were approved by the UHS Board in April 2021. This paper provides an update regarding achievement of the quarter 2 objectives.

Response to the issue:

The agreed objectives have been colour coded:

Green = Achieved
Amber = Partially achieved / achievement delayed
Red = Not achieved to date

Where further action to deliver the objective is proposed, this is typically detailed at the end of the additional information (in black text)., in the form "Action – X"

To assist the reader, two versions of the report are provided:

A. Shows quarter 2 only (for ease of reading)
B. Shows all quarters (setting quarter 2 in context)

A summary of achievement is as follows:

	Achieved	Partially achieved / achievement delayed	Not Achieved to date	Total
Outstanding patient outcomes, safety and experience	8	2	0	10
Pioneering research and innovation	11	1	1	13
World Class people	4	1	0	5
Integrated networks and collaboration	0	3	2	5
Foundations for the future	5	3	0	8
Total	28	10	3	41

Implications: (Clinical, Organisational, Governance, Legal?)

Achieving appropriate corporate objectives which are aligned to our Values, Strategic Ambitions, Legal and Regulatory requirements will have positive impacts.

Risks: (Top 3) of carrying out the change / or not:

In the absence of this process, we would risk:

- Failing to take the right steps, over the next year, in order to support achievement our longer term strategic ambitions
- Not being able to appropriately monitor progress and make corrective adjustments when required

Summary: Conclusion and/or recommendation

The attached review against Q2 milestones is provided for assurance.

University Hospital Southampton NHS Foundation Trust

A) Strategic Objectives 2021/22 – Quarter 2 Review (Q2 Only Visible)

Ref	Short title	Lead	Q2
Outstanding patient outcomes, safety and experience			
1(a)	Recovery, restoration and improvement of clinical services	COO/ CMO/ CNO	Complete ophthalmology expansion and implement business case Ophthalmology expansion opened in November. Implement plan to meet standards set out in Ockenden review There is evidence of compliance for all 59 areas of the seven Immediate and Essential Actions, and external review has supported this for 56 areas to date. Review bed allocation across the Trust Achieved – allocation reflected in winter plan. Increase the number of specialties contributing to CAMEO In Q2: • Four new specialties commenced reporting. • 17 new outcomes were reported.
1(b)	Introducing a robust and proactive safety culture	CNO/ CMO	Completion of The King's Fund patient safety partners project and evaluation Project completed. Evaluation likely to complete in December. Abstract submitted for IHI/BMJ conference 2022. Agree Patient Safety Incident Response Framework (**PSIRF**) priorities at board Now Complete.

Ref	Short title	Lead	Q2
Outstanding patient outcomes, safety and experience			
			November Trust Board Study Session featured a focus on patient safety and a discussion about PSIRF priorities, ahead of national publication of the framework anticipated in Spring 2022. Commence level 1 training once national patient safety syllabus published Level 1 training was published nationally at the end of October 2021. It is available in the UHS Virtual Learning Environment and is being undertaken / tested by the patient safety team, prior to a Trust wide launch planned for early 2022.
1(c)	Empowering and developing staff to improve services for patients	CNO/ CMO	Roll-out of Shared Decision Making across chosen pathways and data collection Pilot pathways increased to 28. Focus on four pathways: • Abdominal Aortic Aneurysm • Pelvic Exenteration • Oesophagectomy • Orthopaedic Major Joint Procedures Plus, Oncology and General Surgery. Structured feedback received from approximately 500 patients. 95% of patients say they wish to make the decisions regarding their treatment. 90% of patients provide positive feedback regarding the quality of their SDM conversation. UHS are working with NHS England to develop a dashboard to evaluate the operational impacts of SDM.
1(d)	Always Improving strategy	CNO/ COO	Local change programmes initiated with all divisions to support local priorities and build change capability 8 Projects complete. 25 In progress. All Divisions and Trust HQ involved.

Ref	Short title	Lead	Q2
Outstanding patient outcomes, safety and experience			
			Initiate the Always Improving education programme aligned to the 'UHS Way' for all staff to build skills and capability 'Advocate' training days are now provided monthly. 58 staff have attended. 75 staff have booked for future dates.

Ref	Short title	Lead	Q2
Pioneering research and innovation			
2(a)	Deliver year 1 of the research and innovation investment plan including: Southampton Emerging Therapies and Technologies Centre (**SETT**) Research Leaders Programme (**RLP**)	CMO	**SETT** Start set up of new SiCE studies Medtech trials infrastructure planning finalised Agree IG framework and data flow governance **RLP** Oversight group to establish vision, aims and objectives Refine proposals based on consultation and finalise programme specification
2(b)	Ensure UHS restores full research portfolio and preparing for future growth	CMO	Review impact of recovery plan with pharmacy Review capacity demand with radiology based on BI developed in Q1 and plan for research pipeline accordingly
2(c)	Deliver joint research and innovation infrastructure with the University of Southampton and Wessex partners (NIHR BRC, CRF, ARC, WHP, Cancer Research UK (**CRUK**) Centre and ECMC, PPI/E, Joint Research Function, Genomics, Trusted Research Environment)	CMO	Submit NIHR CRF (Clinical Research Facility) full application Establish WHP governance and management structure with Wessex partners Founding NHS and Higher Education Institutions (HEIs), including the ICSs, and partners across HIOW and Dorset (Wessex) are aligned in establishing Wessex Health Partners (WHP) with the Vision and high-level strategic objectives agreed. The governance structure has been drafted but lack of dedicated senior management resource has slowed progress to formally establish it. This is currently being addressed with partners. Engagement through WHP has already supported a collaborative bid which secured a grant award, however. Some preparations for the launch of WHP have been made, but further engagement followed by formal agreement are still required.

Ref	Short title	Lead	Q2
Pioneering research and innovation			
			Action – The Director of Strategy and Partnerships will advance this on behalf of UHS, working alongside other partners. Partner organisations are preparing proposals which would secure a dedicated Programme Manager to accelerate implementation. Scope potential of Joint Research Office/Function with UoS partners Agree action plan with UoS in response to Honorary Associate Prof report received Q1 An action plan has been drafted, which is now being aligned with the proposed UOS/UHS Joint Research Function initiative. This objective is now likely to be achieved one quarter later than planned. Action – Draft plan to be refined and presented to Joint Research Strategy Board for agreement. Ongoing delivery of academic workforce priorities Procure Trusted Research Environment

Ref	Short title	Lead	Q2
World Class people			
3(a)	Increasing our people capacity (recruitment, retention, education)	CPO	To develop and deliver a workforce plan to meet UHS service demands, maximises ICS collaboration, and supports elective recovery Workforce plan agreed with ICS and region. Risk to meeting service demands due to domestic and international staff shortages. UHS implemented a COVID-19 vaccination policy prior to the national consultation and are now supporting national implementation. Actions – Implement refreshed recruitment and retention plan approved by Trust Executive Committee. Recruit to additional HR roles to improve recruitment capability, funding has been approved by the Trust Investment Group. Launch Always Improving education offer to increase improvement skills across the organisation The education offer now includes: • 'Advocate' training monthly, and • 'Leading our UHS family to outstanding' A further offer is planned to develop skills in greater numbers of staff (face to face when this is appropriate), and a formal launch of the improvement education strategy.
3(b)	Great place to work including focus on wellbeing	CPO	To implement a regular mechanism of pulse survey for our people to provide more effective insight on sentiment, culture and areas of concern Health and Wellbeing pulse survey carried out in May. National pulse survey on three key engagement questions carried out in July. System now in place.
3(c)	Building an inclusive and compassionate culture	CPO	To deliver a programme of allyship across the organisation to support individuals to take responsibility for collectively building a culture of belonging

Ref	Short title	Lead	Q2
World Class people			
			Achieved. Positive feedback from those who have chosen to attend training first. Now considering how best to scale up, and reach diverse staff groups, in the context of COVID-19. Launch of Always Improving strategy and the 'UHS Way' as direction on how we want staff to approach improvement

Ref	Short title	Lead	Q2
Integrated networks and collaboration			
4(a)	Work in partnership with ICS and PCNs	CEO/ CMO	Deliver against specific prioritised pathways of care ICS/HHFT are leading business case development for a proposed elective surgery hub to be sited at Winchester. Proposed to increase capacity for Orthopaedics, Urology and ENT. Significant input provided by UHS CMO. Alongside this, an Elective Activity Coordination Hub (EACH) has been established to support potential transfer of waiting patients between Trusts (initially to support longer waiting patients). Support for UHS patients has been proposed for Orthopaedics and ENT in 21/22 H2. HIOW Ophthalmology work has not progressed quickly. The UHS COO is now chairing the HIOW Eye Care Alliance to coordinate and oversee the implementation of the national eye care road map, alongside: • Developing a business case for a single HIOW Eye Electronic Patient Record (EPR) • Developing a business case for a digital system linking community optometrists and HIOW hospitals • Ensuring that we optimise the contribution of extended scope optometry services to pre or post hospital care. • Ensuring that best practice pathways are implemented UHS Dermatology department have implemented a HIOW collaborative system which enables electronic referrals to hospital, the provision of advice and guidance to primary care professionals. Further information regarding Urology is provided in section 4 (b) The CMO has met with Primary Care Network (PCN) representatives and worked with UHS consultants to address several practical pathway challenges including prescribing, blood test requesting, referrals, imaging requesting, and actions list.

Ref	Short title	Lead	Q2
Integrated networks and collaboration			
			Action – CMO is preparing proposals for investment in additional managerial roles to support implementation of the clinical strategy, including a role dedicated to networks and collaboration. This proposal will be considered as part of budget setting for 22/23. Action – Appointment of Director of Strategy and Partnerships now achieved.
4(b)	Integrated Networks and Collaboration	CEO/ CMO	Agree details of consolidated Wessex Genomics Laboratory Service with Salisbury NHS Foundation Trust (SFT) Following financial due diligence, the duration of which was extended by COVID-19 and capacity within the finance function, UHS provided a financial proposal in support of the previously agreed service model in October 2021. SFT are expected to consider and respond to the proposal during Q3, they have also indicated that they wish to review any potential for alternative service models alongside the current UHS proposal. Action – UHS are in active dialog with colleagues at both SFT and the Central and South Genomics Laboratory Hub (GLH), and report on progress quarterly to the NHS England Genomics Unit. Our aim is to agree a mutually acceptable solution which meets the requirements of the GLH and NHS England. Move to collaborative arrangements with partners for pharmacy procurement and distribution Collaborative procurement led by an NHS partner has commenced and volumes procured through this arrangement are increasing. Delays occurred due to COVID-19 and capacity, but transfer is expected to be complete in April 2022. Collaborative distribution led by an NHS partner is delayed; implementation requires significant change to the stock control system at both Trusts, the system supplier advises that this will be possible in Autumn 2022. Action – The Trust Investment Group will be provided with a paper to enable a review of progress and strategy. Business case for system-wide plans for five priority specialty areas – orthopaedics, urology, ENT, dermatology and ophthalmology

Ref	Short title	Lead	Q2
Integrated networks and collaboration			
			See section 4 (a) Specifically agree plan for Urology Area Network with Trust Board This has not been achieved. Further work is required amongst partners to agree a recommendation for approval by Boards. Further to the Q1 update, applications have been received for a joint post and an appointment is likely to be made soon. Support for the concept remains strong, and a clinical away day is planned to continue the dialog. Action – Appoint the dedicated manager and support them to develop the business case and draft operating agreement for the network.

Ref	Short title	Lead	Q2
Foundations for the future			
5(a)	Create a sustainable financial infrastructure	CFO	Deliver a balanced H1 position Finalise H2 funding envelopes including approach to Covid-19, recovery, investment and CIP, ensuring achievement of a minimum breakeven position for the ICS H2 plan presented for Board Ratification in November after NHS H2 guidance / financial framework released at the end of month six. H2 Plan does not achieve breakeven, reflecting significant challenges within the framework / continued impact of COVID-19. Monitor and ensure delivery of savings Progress reported to October F&IC. On track to deliver target agreed at H1. Implementation of investments including an on-track capital programme It was not possible to build an additional ward capacity in 21/22, for technical and value for money reasons. Funding has been appropriately allocated to other priorities and we remain on plan to invest the agreed capital value.
5(b)	Making our corporate infrastructure (digital, estate) fit for the future to support a leading university teaching hospital in the 21st century	COO	Delivery of draft masterplan to Trust Executive management for review and approval Assessment of future clinical demand, efficiency, and capacity requirement presented. High level cost assessment and construction opportunities presented. Two bids to Department of Health and Social Care Hospital Infrastructure Fund completed (awaiting outcome). Action - Further planning activity is required to prepare a plan ready for approval, including consideration of alternative funding scenarios, optimising service locations and the sequences of development / refurbishment. Completion is anticipated in early in Q4. 100,000 My Medical Record accounts and 20% paper switch-off

			100,000 My Medical Records achieved. 20% paper switch-off at UHS not yet achieved. IT systems have been built which will enable this. Implementation to appointment and clinic letters requires further planning. Action – The COO will review the remaining work with the teams concerned and establish a revised timetable. Sign off digital strategy
5(c)	Recognising our responsibility as a major employer in the community of Southampton and our role in delivering a greener NHS	COO/ CMO	Set up a formal committee to oversee the development of the Trust's Sustainable Development Management Plan (**SDMP**) Sustainability Board has met four times to date, chaired by the CMO.

B) Strategic Objectives 2021/22 – Quarter 2 Review (Annual Plan)

Ref	Short title	Lead	Q1	Q2	Q3	Q4
Outstanding patient outcomes, safety and experience						
1(a)	Recovery, restoration and improvement of clinical services	COO/ CMO/ CNO	Recovery, operational and activity plans for H1 and winter 2021/22 Annual Operating Plan reviewed by Trust Board in May, further update on Winter 21/22 specifically to follow. Restart elective activity >85% of baseline by July 2021 Note – July = 91% elective/daycase 105% Outpatient Hamwic House and chemotherapy expansion and aseptic pharmacy open Note – Chemotherapy space expanded, expansion approved in	Complete ophthalmology expansion and implement business case Ophthalmology expansion opened in November. Implement plan to meet standards set out in Ockenden review There is evidence of compliance for all 59 areas of the seven Immediate and Essential Actions, and external review has supported this for 56 areas to date. Review bed allocation across the Trust Achieved – allocation reflected in winter plan.	Fully worked up plan for the Urgent Care Village Plan and commence build for additional ward for 2022/23 Repatriate cardiac surgery on to the UHS site ED majors expansion complete Increase the number of specialties contributing to CAMEO	Develop plan to substantially reduce outpatients by 2023/24 Increase the number of specialties contributing to CAMEO

Ref	Short title	Lead	Q1	Q2	Q3	Q4
Outstanding patient outcomes, safety and experience						
			business case, awaiting staff expansion. Increase the number of specialties contributing to Clinical Assurance Meeting for Effectiveness and Outcomes (**CAMEO**)	Increase the number of specialties contributing to CAMEO In Q2: • Four new specialties commenced reporting. • 17 new outcomes were reported.		
1(b)	Introducing a robust and proactive safety culture	CNO/ CMO	Recruit patient safety associates and partners to The King's Fund pilot project Launch engagement for new experience of care strategy	Completion of The King's Fund patient safety partners project and evaluation Project completed. Evaluation likely to complete in December. Abstract submitted for IHI/BMJ conference 2022. Agree Patient Safety Incident Response Framework (**PSIRF**) priorities at board Now Complete. November Trust Board Study Session featured a	Patient safety associates level 4 training programme complete Patient support hub ICS diabetes initiative commences	Completion of actions from gap analysis to allow launch of PSIRF in Q1 2022/23

Ref	Short title	Lead	Q1	Q2	Q3	Q4
Outstanding patient outcomes, safety and experience						
				focus on patient safety and a discussion about PSIRF priorities, ahead of national publication of the framework anticipated in Spring 2022. Commence level 1 training once national patient safety syllabus published Level 1 training was published nationally at the end of October 2021. It is available in the UHS Virtual Learning Environment and is being undertaken / tested by the patient safety team, prior to a Trust wide launch planned for early 2022.		
1(c)	Empowering and developing staff to improve services for patients	CNO/ CMO	Determine and prioritise key patient coproduction projects in service development	Roll-out of SDM across chosen pathways and data collection	Patients involved in designing and driving improvement programmes	Operational: Restoration and recovery

Ref	Short title	Lead	Q1	Q2	Q3	Q4
Outstanding patient outcomes, safety and experience						
			Current priority projects: • Shared Decision Making (including Ophthalmology) • Hospital specialty networks (aspiration re Upper GI) • Tobacco dependence Identification and commencement of shared decision making (**SDM**) pathways across four divisions Pilot pathways and data collection commenced. 22 pilots in total.	Pilot pathways increased to 28. Focus on four pathways: • Abdominal Aortic Aneurysm • Pelvic Exenteration • Oesophagectomy • Orthopaedic Major Joint Procedures Plus, Oncology and General Surgery. Structured feedback received from approximately 500 patients. 95% of patients say they wish to make the decisions regarding their treatment. 90% of patients provide positive feedback regarding the quality of their SDM conversation. UHS are working with NHS England to develop a dashboard to evaluate the operational impacts of SDM.	Launch new experience of care strategy Agreed key data sources for equality in outcomes and experience SDM data collection and PDSA cycles and launch of generic My Medical Record pathway support	Quality: Support delivery of Quality Plan Strategic: Support delivery of NHS Long Term Plan, Trust strategy and enabling strategies Completion of SDM project, data analysis and formulate plan for ongoing roll-out

Ref	Short title	Lead	Q1	Q2	Q3	Q4
Outstanding patient outcomes, safety and experience						
1(d)	Always Improving strategy	CNO/ COO	Launch Always Improving strategy to set direction with the organisation Mobilise governance around transformation agenda for the organisation Note - Always Improving Strategy Board (ASIB) established with TofR and reporting approach agreed. Mobilise governance and delivery of theatres and outpatients programmes Plan established, but not implemented before Q2. Both programmes have now presented objectives and held first programme boards. *Q2 Update - Now fully achieved*	Local change programmes initiated with all divisions to support local priorities and build change capability 8 Projects complete. 25 In progress. All Divisions and Trust HQ involved. Initiate the Always Improving education programme aligned to the 'UHS Way' for all staff to build skills and capability 'Advocate' training days are now provided monthly. 58 staff have attended. 75 staff have booked for future dates.	Always Improving programmes in theatres and outpatients begin to support elective recovery	Deliver Year 1 theatres and outpatient agreed benefits Year 1 Always Improving theatre and outpatient programmes deliver on quality, operational and financial benefits

Ref	Short title	Lead	Q1	Q2	Q3	Q4
Pioneering research and innovation						
2(a)	Deliver year 1 of the research and innovation investment plan including: Southampton Emerging Therapies and Technologies Centre (**SETT**) Research Leaders Programme (**RLP**)	CMO	Establish governance structure to oversee delivery of research and innovation investment case **SETT** Establish management and governance structure for SiCE (Southampton interdisciplinary Centre for Emerging Therapies) Agree and commence plan to build strategic relationships with advanced therapy companies to develop SiCE (emerging therapies) pipeline Develop high level strategic plan for innovation and medtech **RLP** RLP Oversight Group established	**SETT** Start set up of new SiCE studies Medtech trials infrastructure planning finalised Agree IG framework and data flow governance **RLP** Oversight group to establish vision, aims and objectives Refine proposals based on consultation and finalise programme specification	**SETT** Start delivery of two new additional SiCE studies SOPs for innovation pathway in place with linkages to upstream and downstream pathways Define innovation portfolio (existing and EOIs) Build the data and AI portfolio studies (existing and new) **RLP** Launch the RLP Advertise and recruit to Cohort 1	**SETT** Established SiCE study portfolio in place with two to three further studies for set up Established performance review by SiCE board Formal launch SETT Innovation Centre (medtech trials component) Define funding models for data and AI (grant, cost recovery) **RLP** Cohort 1 RLP Programme Commences

Ref	Short title	Lead	Q1	Q2	Q3	Q4
Pioneering research and innovation						
			Prepare paper on proposed scheme for consultation with oversight group			
2(b)	Ensure UHS restores full research portfolio and preparing for future growth	CMO	Determine capacity of research delivery teams in line with recovery and wellbeing of workforce Determine study priority order and resume current research activity Set criteria to prioritise EOIs and set-up of new studies in line with capacity Agree and execute recovery plan with pharmacy Complete impact assessment of Covid-19 on trainees and fellows and agree recovery plans	Review impact of recovery plan with pharmacy Review capacity demand with radiology based on BI developed in Q1 and plan for research pipeline accordingly	Review impact of recovery plan with pharmacy	Restore full portfolio of research Restore full portfolio of academic research career development

Ref	Short title	Lead	Q1	Q2	Q3	Q4
Pioneering research and innovation						
2(c)	Deliver joint research and innovation infrastructure with the University of Southampton and Wessex partners (NIHR BRC, CRF, ARC, WHP, Cancer Research UK (**CRUK**) Centre and ECMC, PPI/E, Joint Research Function, Genomics, Trusted Research Environment)	CMO	Submit stage 1 NIHR BRC (Biomedical Research Centre) funding application Develop and agree proposals for enhanced PPI/E function Collaborating to develop and agree proposals for the Wessex Health Partners (**WHP**) Scope priorities for academic workforce development for schemes, courses and events Review ECMC (Experimental Cancer Medicine Centre)/CRUK Centre preparedness for 2022 submission deadline Scope Trusted Research Environment (TRE) options	Submit NIHR CRF (Clinical Research Facility) full application Establish WHP governance and management structure with Wessex partners Founding NHS and Higher Education Institutions (HEIs), including the ICSs, and partners across HIOW and Dorset (Wessex) are aligned in establishing Wessex Health Partners (WHP) with the Vision and high-level strategic objectives agreed. The governance structure has been drafted but lack of dedicated senior management resource has slowed progress to formally establish it. This is currently being addressed with partners. Engagement through WHP has already	Subject to being shortlisted, submit NIHR BRC stage 2 application Agree WHP programme of work Execute action plan with UoS in response to Honorary Associate Prof report Deploy Trusted Research Environment	Secure CRF application outcome Prepare for NIHR BRC interviews Launch WHP and commence programme of work Subject to scoping exercise, develop proposals for joint research office/functions with UoS partners Review impact of action plan with UoS in response to Honorary Associate Professor report Review impact of academic workforce priority activities Test Trusted Research

Ref	Short title	Lead	Q1	Q2	Q3	Q4
Pioneering research and innovation						
				supported a collaborative bid which secured a grant award, however. Some preparations for the launch of WHP have been made, but further engagement followed by formal agreement are still required. Action – The Director of Strategy and Partnerships will advance this on behalf of UHS, working alongside other partners. Partner organisations are preparing proposals which would secure a dedicated Programme Manager to accelerate implementation. Scope potential of Joint Research Office/Function with UoS partners Agree action plan with UoS in response to Honorary Associate Prof report received Q1		Environment (TRE) pipeline

Ref	Short title	Lead	Q1	Q2	Q3	Q4
Pioneering research and innovation						
				An action plan has been drafted, which is now being aligned with the proposed UOS/UHS Joint Research Function initiative. This objective is now likely to be achieved one quarter later than planned. Action – Draft plan to be refined and presented to Joint Research Strategy Board for agreement. Ongoing delivery of academic workforce priorities Procure Trusted Research Environment		

Ref	Short title	Lead	Q1	Q2	Q3	Q4
World Class people						
3(a)	Increasing our people capacity (recruitment, retention, education)	CPO	To deliver a plan to safely bring back our higher risk people to their substantive or other appropriate roles following the Covid-19 pandemic To complete the Covid-19 vaccination programme ensuring coverage of over 94% of our staff	To develop and deliver a workforce plan to meet UHS service demands, maximises ICS collaboration, and supports elective recovery Workforce plan agreed with ICS and region. Risk to meeting service demands due to domestic and international staff shortages. UHS implemented a COVID-19 vaccination policy prior to the national consultation and are now supporting national implementation. Actions – Implement refreshed recruitment and retention plan approved by Trust Executive Committee. Recruit to additional HR roles to improve recruitment capability, funding has been	To agree a refreshed UHS People Strategy to support the new UHS Strategy 2021-25, meet the requirements of the national NHS People Plan, and align with ICS priorities	To deliver improved workforce deployment through continued expansion of the use of e-rostering, including for medical staff To meet the national requirements of the NHS England and NHS Improvement levels of attainment rostering maturity assessment

Ref	Short title	Lead	Q1	Q2	Q3	Q4
World Class people						
				approved by the Trust Investment Group. Launch Always Improving education offer to increase improvement skills across the organisation The education offer now includes: • 'Advocate' training monthly, and • 'Leading our UHS family to outstanding' A further offer is planned to develop skills in greater numbers of staff (face to face when this is appropriate), and a formal launch of the improvement education strategy.		
3(b)	Great place to work including focus on wellbeing	CPO	To deliver a range of wellbeing support post Covid-19 to support the healing of our people, focusing on physical rest,	To implement a regular mechanism of pulse survey for our people to provide more effective insight on sentiment,	To refresh and implement a revised approach to talent management and succession planning,	To have recovered development and education of our people post pandemic (this

Ref	Short title	Lead	Q1	Q2	Q3	Q4
World Class people						
			emotional wellbeing and long-term effects of coronavirus (long COVID) One year Long COVID pilot supported by charity funding.	culture and areas of concern Health and Wellbeing pulse survey carried out in May. National pulse survey on three key engagement questions carried out in July. System now in place.	focusing specifically on operational infrastructure To embed a sustainable approach for remote hybrid working for UHS, building on existing pandemic home working arrangements To utilise charitable funds to build a lasting legacy of gratitude for our people to support their ongoing health and wellbeing	includes improving appraisals carried out to 92% and appraisal quality as measured through the staff survey)
3(c)	Building an inclusive and compassionate culture	CPO	To support the implementation of the new approach to management and reduction of violence and aggression against our people, including launching a new public awareness campaign	To deliver a programme of allyship across the organisation to support individuals to take responsibility for collectively building a culture of belonging Achieved. Positive feedback from those who have chosen to attend training first. Now	To celebrate the success of our people through the 'We are UHS' campaign and Hospital Superheroes awards	To deliver our inclusion plans to improve the experience of diverse staff, collaboratively with our networks, and demonstrating improvement in our WRES and WDES scores

Ref	Short title	Lead	Q1	Q2	Q3	Q4
World Class people						
			Further activity required for public awareness campaign *Q2 Update - Now fully achieved*	considering how best to scale up, and reach diverse staff groups, in the context of COVID-19. Launch of Always Improving strategy and the 'UHS Way' as direction on how we want staff to approach improvement		

Ref	Short title	Lead	Q1	Q2	Q3	Q4
Integrated networks and collaboration						
4(a)	Work in partnership with ICS and PCNs	CEO/ CMO	Collectively agree the ICS clinical strategy and establish leadership roles and structures and UHS input Five priority pathways agreed, HIOW Provider CMOs leading each one: • Orthopaedics • Urology (UHS Clinical leadership) • Ophthalmology (UHS CMO / COO leadership) • Dermatology • ENT (UHS Clinical leadership)	Deliver against specific prioritised pathways of care ICS/HHFT are leading business case development for a proposed elective surgery hub to be sited at Winchester. Proposed to increase capacity for Orthopaedics, Urology and ENT. Significant input provided by UHS CMO. Alongside this, an Elective Activity Coordination Hub (EACH) has been established to support potential transfer of waiting patients between Trusts (initially to support longer waiting patients). Support for UHS patients has been proposed for Orthopaedics and ENT in 21/22 H2.	Monitor progress and evaluate success	Set priorities for 2022/23

Ref	Short title	Lead	Q1	Q2	Q3	Q4
Integrated networks and collaboration						
				HIOW Ophthalmology work has not progressed quickly. The UHS COO is now chairing the HIOW Eye Care Alliance to coordinate and oversee the implementation of the national eye care road map, alongside: • Developing a business case for a single HIOW Eye Electronic Patient Record (EPR) • Developing a business case for a digital system linking community optometrists and HIOW hospitals • Ensuring that we optimise the contribution of extended scope optometry services to pre or post hospital care.		

Ref	Short title	Lead	Q1	Q2	Q3	Q4
Integrated networks and collaboration						
				• Ensuring that best practice pathways are implemented UHS Dermatology department have implemented a HIOW collaborative system which enables electronic referrals to hospital, the provision of advice and guidance to primary care professionals. Further information regarding Urology is provided in section 4 (b) The CMO has met with Primary Care Network (PCN) representatives and worked with UHS consultants to address several practical pathway challenges including prescribing, blood test requesting, referrals, imaging requesting, and actions list.		

Ref	Short title	Lead	Q1	Q2	Q3	Q4
Integrated networks and collaboration						
				Action – CMO is preparing proposals for investment in additional managerial roles to support implementation of the clinical strategy, including a role dedicated to networks and collaboration. This proposal will be considered as part of budget setting for 22/23. Action – Appointment of Director of Strategy and Partnerships now achieved.		
4(b)	Integrated Networks and Collaboration	CEO/ CMO	Establish project team and infrastructure for Urology Area Network Note – ICS CMO lead for Urology agreed as HHFT - Project team delayed - Sept 21, partners agreed to fund a post to be based at UHS to manage implementation	Agree details of consolidated Wessex Genomics Laboratory Service with Salisbury NHS Foundation Trust (SFT) Following financial due diligence, the duration of which was extended by COVID-19 and capacity within the finance function, UHS provided a	Begin to implement collaborative ICS solutions to address major elective recovery challenges and support equality of patient opportunity Three My Medical Record pathways live across the other trusts in the ICS	Urology Area Network implemented HIOW complete roll-out for a single maternity system UHS to have migrated onto the Southern Counties Pathology Network LIMS

Ref	Short title	Lead	Q1	Q2	Q3	Q4
Integrated networks and collaboration						
			- Steering group has been established and has appropriate representation from all Trusts *See also Q2 update*	financial proposal in support of the previously agreed service model in October 2021. SFT are expected to consider and respond to the proposal during Q3, they have also indicated that they wish to review any potential for alternative service models alongside the current UHS proposal. Action – UHS are in active dialog with colleagues at both SFT and the Central and South Genomics Laboratory Hub (GLH), and report on progress quarterly to the NHS England Genomics Unit. Our aim is to agree a mutually acceptable solution which meets the requirements of the GLH and NHS England. Move to collaborative arrangements with		

Ref	Short title	Lead	Q1	Q2	Q3	Q4
Integrated networks and collaboration						
				partners for pharmacy procurement and distribution Collaborative procurement led by an NHS partner has commenced and volumes procured through this arrangement are increasing. Delays occurred due to COVID-19 and capacity, but transfer is expected to be complete in April 2022. Collaborative distribution led by an NHS partner is delayed; implementation requires significant change to the stock control system at both Trusts, the system supplier advises that this will be possible in Autumn 2022. Action – The Trust Investment Group will be provided with a paper to enable a review of progress and strategy.		

Ref	Short title	Lead	Q1	Q2	Q3	Q4
Integrated networks and collaboration						
				Business case for system-wide plans for five priority specialty areas – orthopaedics, urology, ENT, dermatology and ophthalmology See section 4 (a) Specifically agree plan for Urology Area Network with Trust Board This has not been achieved. Further work is required amongst partners to agree a recommendation for approval by Boards. Further to the Q1 update, applications have been received for a joint post and an appointment is likely to be made soon. Support for the concept remains strong, and a clinical away day is		

Ref	Short title	Lead	Q1	Q2	Q3	Q4
Integrated networks and collaboration						
				planned to continue the dialog. Action – Appoint the dedicated manager and support them to develop the business case and draft operating agreement for the network.		

Ref	Short title	Lead	Q1	Q2	Q3	Q4
Foundations for the future						
5(a)	Create a sustainable financial infrastructure	CFO	Deliver a balanced Q1 position Finalise H1 funding envelopes including approach to Covid-19, recovery, investment and CIP, ensuring achievement of a minimum breakeven position for the ICS Support the organisation to understand the impact and required cultural change relating to the current financial infrastructure Develop a savings plan aligned to Always Improving programme	Deliver a balanced H1 position Finalise H2 funding envelopes including approach to Covid-19, recovery, investment and CIP, ensuring achievement of a minimum breakeven position for the ICS H2 plan presented for Board Ratification in November after NHS H2 guidance / financial framework released at the end of month six. H2 Plan does not achieve breakeven, reflecting significant challenges within the framework / continued impact of COVID-19. Monitor and ensure delivery of savings	Deliver a balanced YTD position Monitor and ensure delivery of savings	Deliver a balanced 21/22 position Finalise 2022/23 funding envelopes including approach to Covid-19, recovery, investment and CIP, ensuring achievement of a minimum breakeven position for the ICS Support the organisation to understand the impact and required cultural change relating to the new financial infrastructure Monitor and ensure delivery of savings Development of savings plan for 2022/23

Ref	Short title	Lead	Q1	Q2	Q3	Q4
Foundations for the future						
			and Elective Recovery Framework Note – Cost Improvement Target agreed in July, considered achievable, but detailed identification impacted by operational pressures Finalise capital (CDEL) and revenue investments	Progress reported to October F&IC. On track to deliver target agreed at H1. Implementation of investments including an on-track capital programme It was not possible to build an additional ward capacity in 21/22, for technical and value for money reasons. Funding has been appropriately allocated to other priorities and we remain on plan to invest the agreed capital value.	Implementation of investments including an on-track capital programme	Deliver capital programme in full Develop 2022/23 capital programme
5(b)	Making our corporate infrastructure (digital, estate) fit for the future to support a leading university teaching hospital in the 21st century	COO	Appointment of external agencies to support the demand and capacity modelling to support the development of the estates masterplan	Delivery of draft masterplan to Trust Executive management for review and approval Assessment of future clinical demand, efficiency, and capacity requirement presented.	Commence work on the estates strategy, including engagement with all clinical and non-clinical divisions Windows 365 Roll-out across UHS Staff	200,000 My Medical Record accounts and 30% paper switch-off Plan in place for generic PROM (patient-reported outcome measure)

Ref	Short title	Lead	Q1	Q2	Q3	Q4
Foundations for the future						
			Note – EY Consulting appointed and commenced work	High level cost assessment and construction opportunities presented. Two bids to Department of Health and Social Care Hospital Infrastructure Fund completed (awaiting outcome). Action - Further planning activity is required to prepare a plan ready for approval, including consideration of alternative funding scenarios, optimising service locations and the sequences of development / refurbishment. Completion is anticipated in early in Q4. 100,000 My Medical Record accounts and 20% paper switch-off 100,000 My Medical Records achieved.	Phase 1 of improved data quality on open records completed	such as QOL (quality of life) 75% migration from outsourced transcription to digital speech recognition completed Digital ophthalmology system project completed

Ref	Short title	Lead	Q1	Q2	Q3	Q4
Foundations for the future						
				20% paper switch-off at UHS not yet achieved. IT systems have been built which will enable this. Implementation to appointment and clinic letters requires further planning. Action – The COO will review the remaining work with the teams concerned and establish a revised timetable. Sign off digital strategy		
5(c)	Recognising our responsibility as a major employer in the community of Southampton and our role in delivering a greener NHS	COO/ CMO	Appoint clinical lead Dr Thom Daniels (Respiratory Medicine Consultant)	Set up a formal committee to oversee the development of the Trust's Sustainable Development Management Plan (**SDMP**) Sustainability Board has met four times to date, chaired by the CMO.	Agree framework for the delivery of the three key sustainability strategies: Sustainable development masterplan Clinical Sustainability Plan (**CSP**) Energy Strategy	Initial draft of SDMP and CSP to Trust Investment Group Agree funding requirements to commence the delivery of the strategies

University Hospital Southampton NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Register of Seals and Chair's Actions**			
Agenda item:	**7.1**			
Sponsor:	**Peter Hollins, Trust Chair**			
Date:	**30 November 2021**			
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 Standing Financial Instructions and 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 Delegation.			
Risks: (Top 3) of carrying out the change / or not:				
Summary: Conclusion and/or recommendation	The Board is asked to **ratify** the application of the seal and Chair's action.			

1 Signing and Sealing

1.1 Agreement executed as a Deed between University Hospital Southampton NHS Foundation Trust and LST Projects (the Contractor) relating to the HV Chillers and Neuro Block Switchgear Building Contract as part of the Trust's estate maintenance programme. Seal number 239 on 12 November 2021.

2 Chair's Actions

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

2.1 **Award of Contract** for the provision of a Trust-wide managed print service to Ricoh, the incumbent supplier, for a further three years expiring November 2024, at a total contract cost of £841,547 excluding VAT. The award was made under an NHS framework agreement. The new contract will bring all current devices and a limited buffer stock into one contract with a single expiry date and should lead to savings and service improvements for the Trust. Having a single expiry date will support the future planned tender of these services. Approved by the Chair on 23 November 2021.

3 Recommendation

The Board is asked to ratify the application of the seal and Chair's action.

University Hospital Southampton
NHS Foundation Trust

Report to the Trust Board of Directors				
Title:	**Finance and Investment Committee Terms of Reference**			
Agenda item:	**7.2**			
Sponsor:	**Peter Hollins, Trust Chair**			
Author:	**Karen Flaherty, Associate Director of Corporate Affairs and Company Secretary**			
Date:	**30 November 2021**			
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:	Minor updates are proposed to the terms of reference in relation to the committee attendees and responsibilities of the committee.			
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: ~~5~~6

Date Issued:	~~29 June~~30 November 2021
Review Date:	November ~~2021~~2022
Document Type:	Committee Terms of Reference

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Document Status

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As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

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~~ informatics and estates, ~~and~~ facilities and capital development 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~~to enable world-class people to deliver world-class care~~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 Officer;

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/~~;~~ Deputy Director of Finance; ~~and~~

3.4.2 Director of Planning, Performance and Productivity; and

~~3.4.2~~3.4.3 Associate Director Always Improving.

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;

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 ***Always Improving Value for Money***

7.2.1 The Committee will ensure that there is an Always Improving: Value for Money (**AIVFM**) programme 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 AIVFM 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 ***Informatics~~T~~ 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 and capital development annual plan***

7.5.1 The Committee will monitor and oversee the delivery of the Trust's estates ~~and~~, facilities and capital development 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 informatics ~~IT~~ or estates ~~and~~, facilities and capital development 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~~ informatics or estates ~~and~~, facilities and capital development 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 Committee Chair 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

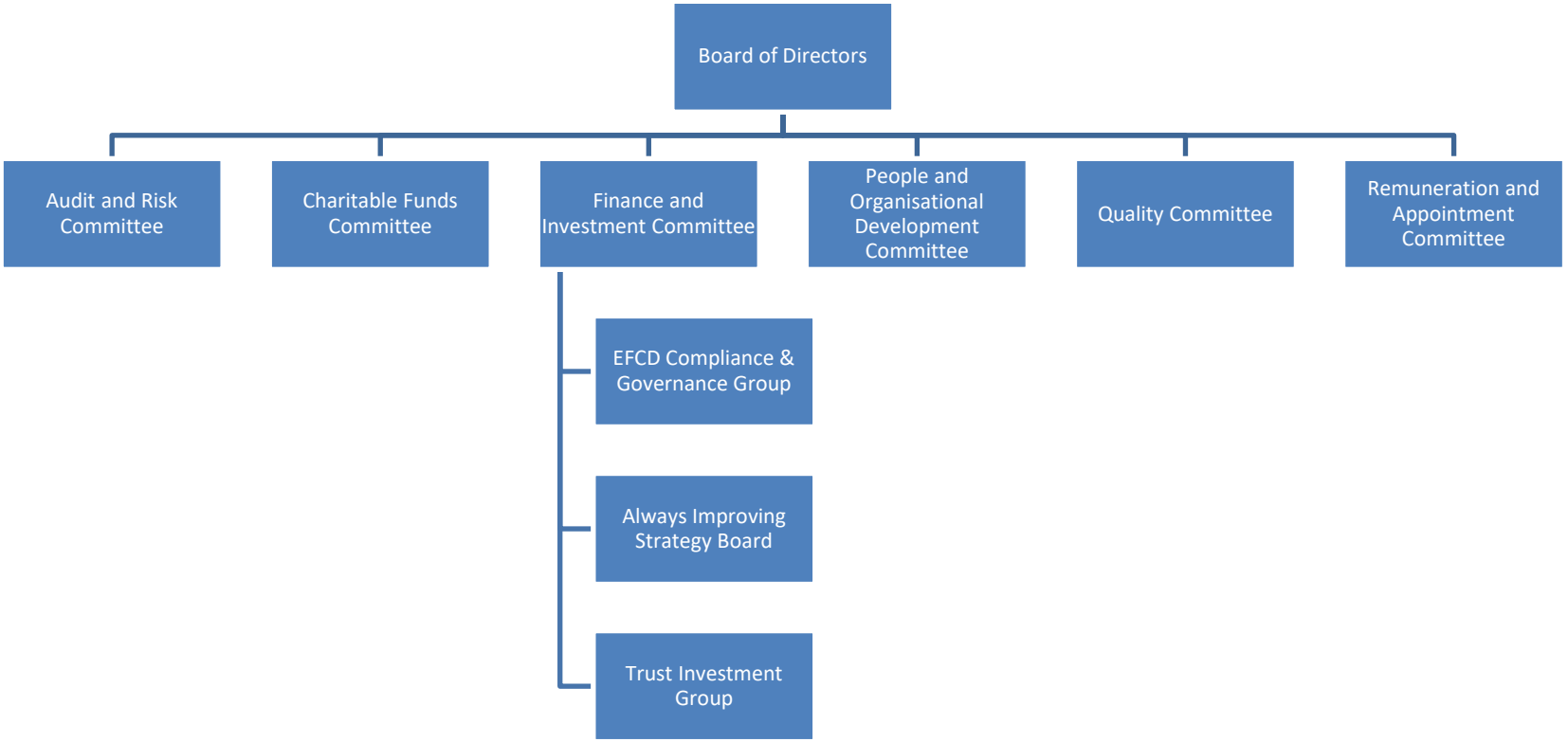
10.1 National Health Service Act 2006

10.2 NHS System Oversight Framework

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

10.4 Standing Financial Instructions

Appendix A


Board of Directors
Audit and Risk Committee
Charitable Funds Committee
Finance and Investment Committee
People and Organisational Development Committee
Quality Committee
Remuneration and Appointment Committee
EFCD Compliance & Governance Group
Always Improving Strategy Board
Trust Investment Group

Document Monitoring Information	
Approval Committee:	Board of Directors
Date of Approval:	~~29 June~~30 November 2021~~1~~
Responsible Committee:	Finance and Investment Committee
Monitoring (Section 9) for Completion and Presentation to Approval Committee:	November ~~2021~~2022
Target audience:	Board of Directors, Finance and Investment Committee, Staff
Key words:	Finance, Investment, Committee, Board, Terms of Reference
Main areas affected:	Trust-wide
Summary of most recent changes if applicable:	~~Reinstatement of non-executive director membership and quorum following the return to the previous number of non-executive directors on the board of directors, updating the name of a reporting committee and group in Appendix A, minor typographical corrections~~Minor updates to Committee attendees and responsibilities
Consultation:	Chief Financial 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				
Title:	**Quality Committee Terms of Reference**			
Agenda item:	**7.3**			
Sponsor:	**Peter Hollins, Trust Chair**			
Author:	**Karen Flaherty, Associate Director of Corporate Affairs and Company Secretary**			
Date:	**30 November 2021**			
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 of the Quality Committee have been reviewed by the committee.			
Response to the issue:	The review of the terms of reference identified a small number of updates, the most significant of which are: • to update the list of regular attendees to include both Deputy Chief Medical Officer(s) and the Medical Lead for Safety; and • to reflect the change of name of the End of Life Steering Group to the End of Life Care Programme Board in Appendix A.			
Implications: (Clinical, Organisational, Governance, Legal?)	The terms of reference ensure that the purpose and activities of the Quality 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 Trust's constitution relating to the composition of Board committees. 2. Non-compliance with good practice around the governance and assurance of quality within NHS organisations. 3. The Board of Directors and the Quality Committee may not function as effectively or receive the required information and assurance 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 Quality Committee and are recommended for approval.			

Quality Committee Terms of Reference

Version: ~~34~~

Date Issued:	~~29 July~~30 November 2021
Review Date:	November 2021
Document Type:	Terms of Reference

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Document Status

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As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

1. Role and Purpose

1.1 The Quality Committee (the **Committee**) is responsible for overseeing, monitoring and reviewing the adequacy and effectiveness of all aspects of the clinical governance arrangements of University Hospital Southampton NHS Foundation Trust (**UHS** or the **Trust**), including the governance, risk management and internal control framework and systems supporting the delivery of safe, high quality, patient-centred care.

1.2 The Committee provides the board of directors of the Trust (the **Board**) with a means of assurance regarding the adequacy and effectiveness of all aspects of clinical governance with a particular focus on quality: patient safety, patient experience and outcomes.

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 the 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, at least one of whom will have a clinical background;

3.1.2 the Chief Nursing Officer;

3.1.3 the Chief Medical 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**). In the absence of the Committee Chair and/or an appointed deputy, the remaining members present will elect one of the other non-executive directors to chair the meeting.

3.3 To ensure that non-executive directors hold the majority of votes on the Committee, only two of the executive director members of the Committee 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 Deputy Director of Nursing (Quality);

3.4.2 Deputy ~~Medical Director~~Chief Medical Officer(s);

~~3.4.2~~3.4.3 Medical Lead for Safety (Patient Safety Specialist); and

~~3.4.3~~3.4.4 patient representative(s).

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 secretary of the Committee in advance.

4.2 The quorum for a meeting will be three members, including two non-executive directors and either the Chief Nursing Officer or the Chief Medical 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 eight times each year (at regular intervals throughout the year) 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 Nursing Officer and the Chief Medical Officer. The agenda and supporting papers will be distributed to each member of the Committee and the regular attendees no later than five 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 ***Patient Safety***

7.1.1 The Committee will review the aggregated analysis of adverse events (including serious incidents requiring investigation (SIRIs) and never events), complaints, claims and inquests to identify common themes and trends and gain assurance that appropriate actions are being taken to mitigate risk and reduce harm.

7.1.2 The Committee will seek assurance on the Trust's safeguarding systems.

7.1.3 The Committee will receive assurance from internal audit on quality and safety reviews.

7.2 ***Patient Experience***

7.2.1 The Committee will consider reports from the Patient Experience team, the Complaints team, the Patient Advice and Liaison Service and other sources of feedback (including local Healthwatch) on all formal and informal patient feedback, both positive and negative, and consider action in respect of matters of concern.

7.2.2 The Committee will consider the results, issues raised and trends in all patient surveys and any patient impacting surveys of the Trust's estate, such as Patient-Led Assessments of the Care Environment (PLACE) that may impact on clinical quality and to seek assurance on the development and implementation of improvement plans.

7.3 ***Patient Outcomes***

7.3.1 The Committee will review the annual clinical audit programme and recommend its approval to the Board, and monitor its delivery.

7.3.2 The Committee will receive details of all national clinical audits where the Trust is identified as an outlier or potential outlier. This will include, but is not limited to, mortality outlier alerts.

7.4 ***Quality Improvement***

7.4.1 The Committee will make recommendations to the Board on the determination of quality priorities annually and monitor progress against these priorities.

7.4.2 The Committee will promote safety and excellence in patient care and monitor the implementation and delivery of the Always Improving Strategy and quality improvement activity.

7.5 ***Performance Monitoring***

7.5.1 The Committee will advise the Board on the appropriate quality and safety indicators and benchmarks for inclusion in the Trust's key performance indicators and supporting data quality for these measures.

7.5.2 The Committee will support the ongoing monitoring of ward quality and safety dashboards, to provide assurance from ward to Board.

7.5.3 The Committee will regularly review operational performance where there is ongoing non-compliance with referral and waiting time standards set out in the NHS Constitution or the NHS System Oversight Framework.

7.5.4 The Committee will seek assurance that improvement targets are supported by achievable action plans and support the implementation of the Trust's Clinical Strategy.

7.5.5 The Committee will monitor progress in implementing action plans to address shortcomings in the quality of services, where identified.

7.6 ***Risk***

7.6.1 The Committee will ensure that risks to patients are minimised through the application of comprehensive clinical risk management systems.

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

7.6.3 The Committee will triangulate patient safety, quality and clinical risk issues with operational, financial and workforce performance, addressing areas of concern or deteriorating performance as required.

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 the Trust's quality accounts/quality report and any other key non-financial governance submissions to national bodies before these are presented to the Board for approval.

7.7.2 The Committee will receive all reports about the Trust produced by the Care Quality Commission (the **CQC**) and seek assurance on the processes in place to ensure compliance with CQC fundamental standards and the actions being taken to address any recommendations and other issues identified by the CQC.

8. Accountability and Reporting

8.1 The Committee Chair 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 quality accounts/quality report 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 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and related guidance from the Care Quality Commission

10.3 Care Quality Commission (Registration) Regulations 2009 and related guidance from the Care Quality Commission

10.4 Health Act 2009

10.5 National Health Service (Quality Accounts) Regulations 2010

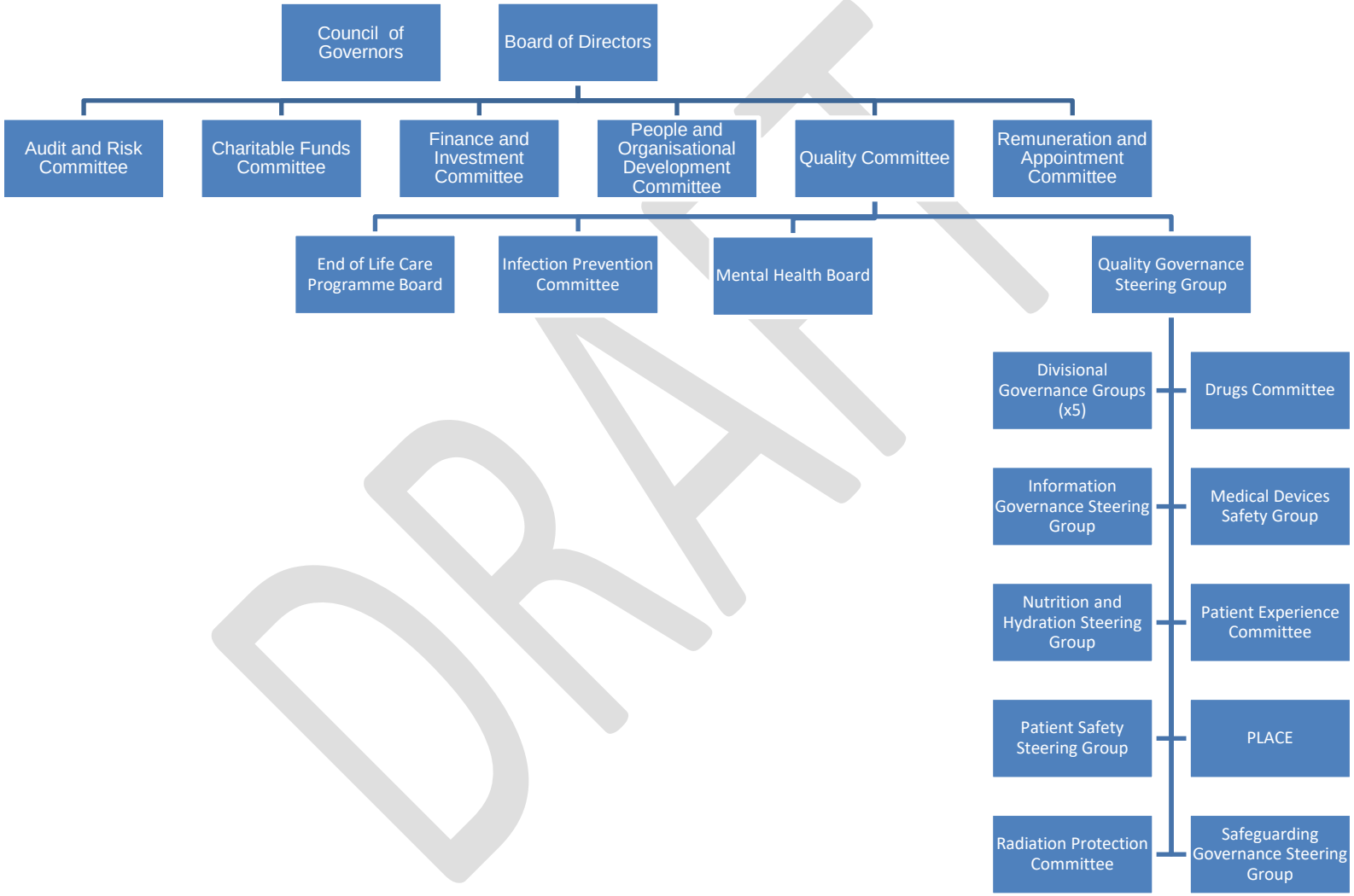
10.6 NHS Foundation Trust Code of Governance

10.7 NHS System Oversight Framework

10.8 NHS Foundation Trust Annual Reporting Manual

10.9 NHS England and NHS Improvement's requirements for quality accounts

Appendix A



Quality Committee Terms of Reference	Version: ~~3~~4

Document Monitoring Information	
Approval Committee:	Board of Directors
Date of Approval:	~~29~~ 30 ~~July~~ November 2021
Responsible Committee:	Quality Committee
Monitoring (Section 9) for Completion and Presentation to Approval Committee:	November ~~2021~~2022
Target audience:	Board of Directors, Quality Committee, NHS Regulators, Staff
Key words:	Quality, Governance, Committee, Board, Terms of Reference
Main areas affected:	Trust-wide
Summary of most recent changes if applicable:	~~Reformatting, members and attendees, presentation of Committee role and duties and responsibilities~~Update Committee attendees, names of reporting groups/committees in Appendix A and a small number of other minor changes
Consultation:	Chief Nursing Officer
Number of pages:	7
Type of document:	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				
Title:	**Remuneration and Appointment Committee Terms of Reference**			
Agenda item:	**7.4**			
Sponsor:	**Peter Hollins, Trust Chair**			
Author:	**Karen Flaherty, Associate Director of Corporate Affairs and Company Secretary**			
Date:	**30 November 2021**			
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:	Following a review of the terms of reference minor typographical changes are proposed to the terms of reference as marked up on the attached 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 Remuneration and Appointment 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.			

Remuneration and Appointment Committee Terms of Reference

Version: ~~23~~

Date Issued:	~~26~~ 30 November ~~2020~~2021
Review Date:	November ~~2021~~2022
Document Type:	Committee Terms of Reference

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As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

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 Officer, as required under Schedule 7 of the National Health Service Act 2006, who will count in the quorum for the meeting. The Chief Executive Officer will not be present when the Committee is dealing with matters concerning their appointment or removal, remuneration or terms of service.

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 appointment or removal, 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 Officer 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 Chair 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

Remuneration and Appointment Committee Terms of Reference	Version: ~~23~~

Document Monitoring Information	
Approval Committee:	Board of Directors
Date of Approval:	~~26~~ 30 November ~~2020~~2021
Responsible Committee:	Remuneration and Appointment Committee
Monitoring (Section 9) for Completion and Presentation to Approval Committee:	November ~~2021~~2022
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Should this document be made available on the public website?	Yes
Is this document to be published in any other format?	No

Report to the Trust Board of Directors				
Title:	**CRN: Wessex 2021-22 Q2 Performance Report**			
Agenda item:	**10.1**			
Sponsor:	**Paul Grundy, Chief Medical Officer**			
Authors:	**Graham Halls, Business Intelligence Manager, CRN Wessex** **Clare Rook, Chief Operating Officer, CRN Wessex**			
Date:	**30th November 2021**			
Purpose	**Assurance or reassurance**	**Approval**	**Ratification**	**Information** **x**
Issue to be addressed:	This performance report covers Clinical Research Network (CRN) Wessex's performance against the National Institute for Health Research's (NIHR) high level objectives (HLOs) in the first two quarters of the 2021/22 financial year (April to September 2021). Also discussed are COVID-19 research, including vaccine trials, the managed recovery of the existing portfolio of studies and the delivery of commercial research activity. **Key achievements / issues:** ● The NIHR's current priorities for UK clinical research are COVID-19, the managed recovery of the existing research portfolio, other published strategic improvement initiatives and the CRN's HLOs. ● Over 74,500 participants were recruited in the first two quarters. The recruitment trend in Wessex is upwards, whereas the opposite is true nationally. ● Ten percent of UK COVID-19 studies have been led from Wessex. Over 225,000 participants have been recruited on these studies at 518 sites, of which 95,000 were from Wessex. ● Three Wessex sites are in the top ten for COVID-19 research recruitment. Wessex is approaching 3,000 participants in COVID-19 vaccine trials; six of the studies are led from the region. ● Only ten percent of research sites were paused due to the pandemic at the end of September, with the goal for this to be zero by the end of this financial year. The majority of specialties have seen falling recruitment compared to the same period in the years preceding the pandemic; however, Wessex managed recovery and restart activities are aiming to reverse this. ● The region has achieved some of the high level objectives set by the Department of Health and Social Care (DHSC) to be met by the end of the financial year and is on track or has initiatives to achieve those remaining.			
Response to the issue:	**1 Purpose/Context/Introduction** This report is to inform the UHS Board of the clinical research activities within the Wessex region. The report covers pandemic research (including vaccine trials), the restart and managed recovery of other studies and performance against the			

NIHR's high level objectives. The timeline for this report covers quarters one to two (April-September) of the 2021/22 financial year unless otherwise stated.

2 Key issues

National priorities for health research

The National CRN Coordinating Centre and the Depart of Health and Social Care (DHSC) Science, Research and Evidence Directorate agree on a set of national priorities for the CRN on an annual basis. These priorities are set in the pursuance of the vision, goals, and aims of the CRN. These priorities are reflected in the annual plan for CRN Wessex.

The priority activities for the NIHR CRN for 2021/22 are listed in chart one.

COVID-19 research	• COVID-19 Vaccine studies • COVID-19 non-Vaccine studies.
Recovery, Resilience and Growth (RRG) of Clinical Research (including Managed Recovery)	• Deliver the UK-wide programme of work to drive the managed recovery of multi-site studies • Deliver existing commitments to make UK clinical research delivery easier, more efficient, and more effective • Begin to deliver ambitious new initiatives that will set us on the path towards realising our vision for the future of UK clinical research.
NIHR CRN Strategic Improvement Priorities	• Primary Care Research Engagement • Review and Refresh CRN Research Delivery • CRN Governance Improvement • Evidence the impact and value of the activity of the CRN on the health and care sector.
NIHR CRN High Level Objectives (HLOs)	• The purpose of the NIHR CRN is to provide efficient and effective support for the initiation and delivery of funded research in the NHS and other health and care settings. The performance of the NIHR CRN in meeting this purpose is measured against the CRN High Level Objectives (HLOs). The priority for the NIHR CRN is to meet and, if possible, exceed the HLO' ambitions' set on an annual basis by the DHSC. Progress against this priority will be reported in the quarterly UHS Board reports.

Chart 1 – NIHR priorities for the 2021/22 financial year.

COVID-19 research

The NIHR's goal through research into COVID-19 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.

CRN Wessex's activities to support COVID-19 research studies is summarised in chart 2a. CRN Wessex has been the lead network for 26 studies, or ten percent of the United Kingdom COVID-19 portfolio. Acting as a lead network usually involves supporting a sponsor in the development and site selection for a project led by a Wessex chief investigator and their team. For comparison, Wessex has only four percent of the United Kingdom population. Over 225,000 participants have been recruited on the Wessex-led COVID-19 studies at 518 sites, of which 95,000 were from Wessex.

Three Wessex sites, Moorgreen Hospital (Southern Health), Queen Alexandra Hospital in Portsmouth and Southampton General Hospital, are within the top ten recruiting UK trusts over this period (chart 2b). To achieve high recruitment, Southern Health developed a study on the psychological impact of COVID-19, which has enrolled patients from across the UK.

Recruiting studies	Recruiting studies – lead network	Participants recruited	Recruiting sites
252	249	2,445,238	5,312
UK	England	UK	UK
82 (33%)	26 (10%)	181,364 (7%)	257 (5%)
Wessex	Wessex	Wessex	Wessex

Chart 2a – Key COVID-19 research deliverables in Wessex with UK or England figures provided for reference: 1st January 2019 – 30th September 2021.

Site name	LCRN	Participants
Yorkshire Ambulance Service Trust HQ	Yorkshire and Humber	66,512
Moorgreen Hospital	Wessex	62,871
University Hospitals of Leicester NHS Trust	East Midlands	18,662
Bristol Royal Infirmary	West of England	11,730
Queen Elizabeth Hospital	West Midlands	9,669
Queen Alexandra Hospital	Wessex	9,268
Southmead Hospital	West of England	8,867
Southampton General Hospital	Wessex	7,642
St Thomas' Hospital	South London	6,860
Nottingham University Hospitals	East Midlands	6,472

Chart 2b – Top ten highest recruiting sites for COVID-19 research: 1st January 2019 – 30th September 2021.

Wessex recruitment per million population to the interventional COVID-19 studies has been benchmarked against the fourteen other clinical research networks in chart 2c. The region has served its location population well, relatively, with the equivalent of two percent of the population enrolled.

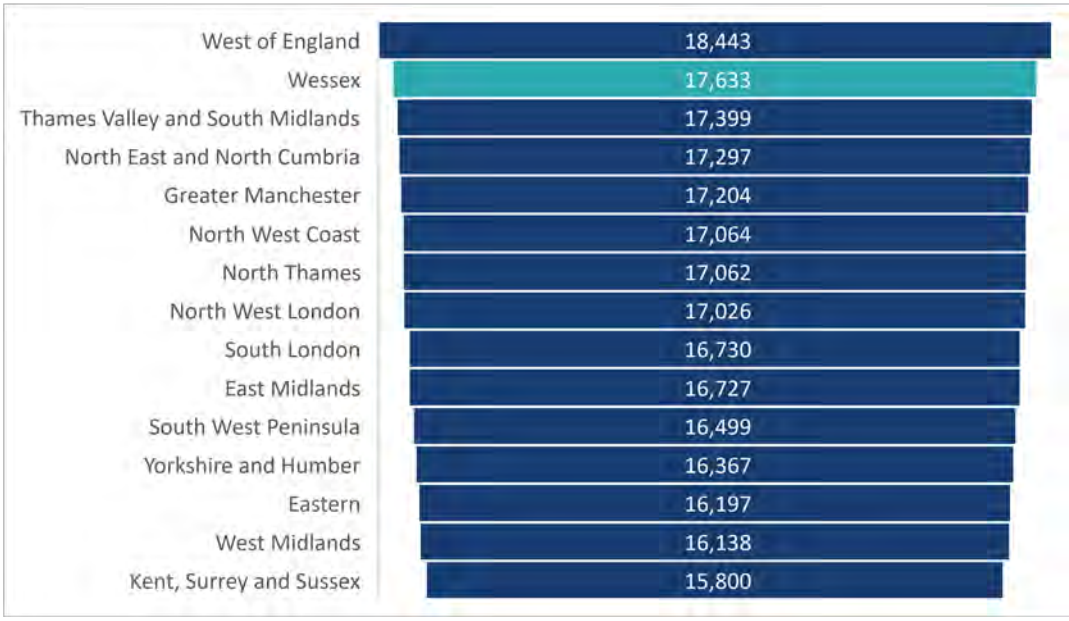

Chart 2c – Interventional recruitment on COVID-19 studies per million population, by clinical research network: 1st January 2019 – 30th September 2021.

Vaccine trials

Three Wessex vaccine research hubs were set up in Hampshire (Southampton & Portsmouth) and Dorset (Bournemouth) in 2020/21, with £1m of pump prime funding from the UK government's Vaccine Taskforce. Other locations in the North and the West of the region are being considered for new hubs.

2,791 healthy volunteers have been recruited to twenty COVID-19 vaccine trials since May 2020 (chart three). As recruitment increases, so does the ongoing burden of follow up visits at varying intervals. The most recent studies have looked at combinations of vaccines, boosters, and other patient groups that have not been recruited, e.g., adolescents and pregnant women. Six national vaccine trials have been led from Wessex.

Chart 3 – Vaccine trial recruitment at the three Wessex hubs: 1st May 2020 – 30th September 2021.

DHSC UK Clinical Research Recovery, Resilience & Growth Programme (RRG)

The DHSC's RRG programme has the following key objectives:

1. Ensure the restoration of clinical research activity that was underway pre-COVID
2. Maximise opportunities to build back better
3. Deliver on the commitment to make the UK the leading global hub for life sciences.

Over £15 million has been ringfenced by the DHSC to support the managed recovery of the UK research portfolio. Wessex has received £1.17m in the first two rounds of funding applications and awaits the outcome of a further £0.5m in bids. This investment is primarily for supporting commercial 'managed recovery' badged studies (see next section for further details) but is also expected to have impact on other research.

The restart of research sites across the region has been tracked since the beginning of the 2021/22 financial year (chart four). The active sites (in setup, open, and follow-up) now represent eighty-seven percent of the Wessex portfolio. Around ten percent of study sites were paused due to the pandemic at the end of September 2021. The goal is for all paused study sites to reopen or close if they are no longer required or viable.

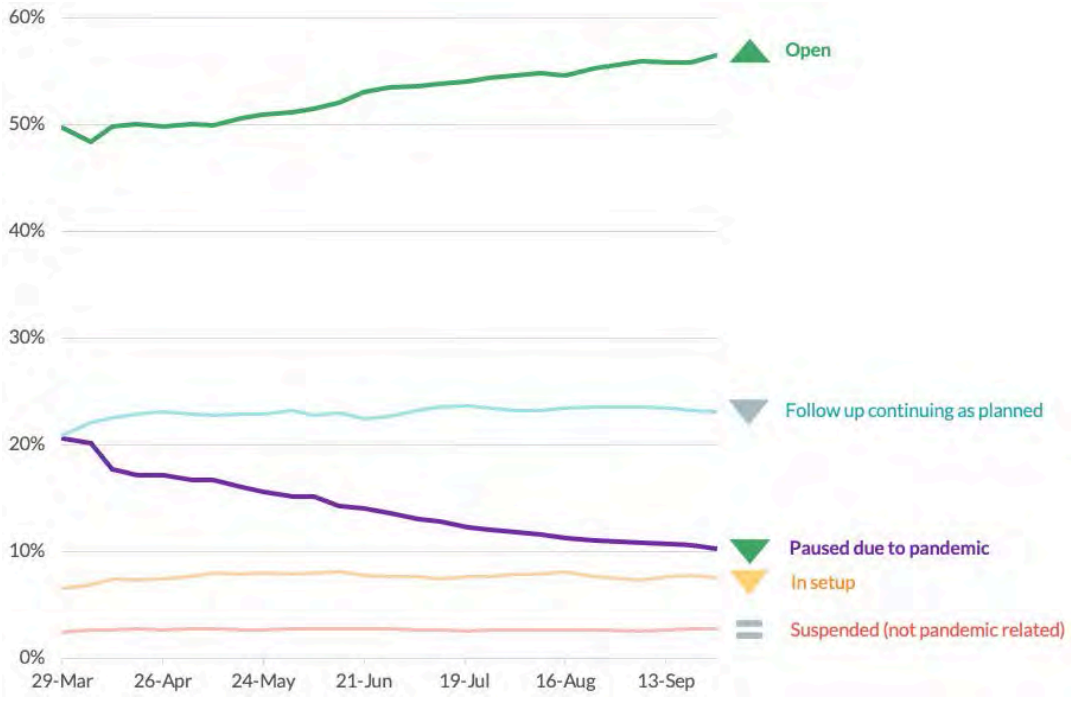

Chart 4 – Wessex recruiting site statuses over time: 29th March 2021 – 30th September 2021.

Managed recovery

The NIHR CRN is working with life sciences, non-commercial funders, NHS R&D, research partners across the UK and patients and the public on a process to

manage the recovery of multi-site studies. Further details can be found at [the NIHR Managing Research Recovery website (https://www.nihr.ac.uk/researchers/managing-research-recovery.htm)](https://www.nihr.ac.uk/researchers/managing-research-recovery.htm). The scope is interventional, multi-site clinical research studies that are urgent and require the support of NIHR CRN. Funders have identified their most urgent studies, and research delivery teams continue to work with local clinical research networks and R&D leadership to assess site, regional and national delivery capacity and capability. National specialty leads are also reviewing their portfolio to identify other studies that may fall into scope for this approach.

Chart five shows the proportion of research activity in the first two quarters of this financial year on studies that have been identified through this process in relation to other interventional research. 10.5 percent of Wessex interventional recruitment was on managed recovery studies, which compares to 6.7 percent nationally.

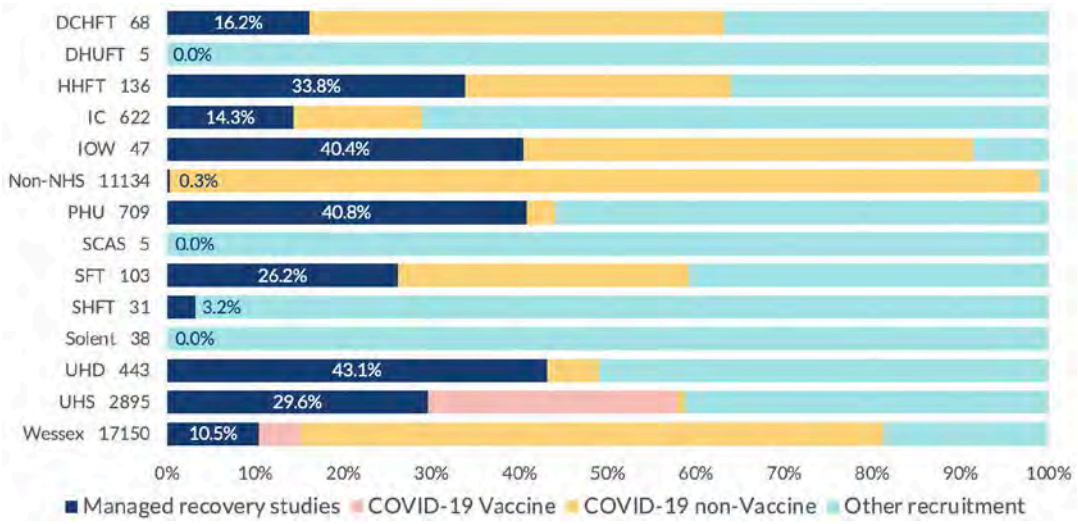

Chart 5 – Proportion of interventional research recruitment by type at each Wessex trust: 1st April – 30th September 2021. Recruitment is provided alongside the organisation acronym (see appendix two).

NIHR CRN High level objectives for 2021/22 (HLOs)

The NIHR CRN introduced new high level objectives for this financial year. These are outlined in chart six, with current Wessex and English (all LCRNs) performance indicated.

To be included in the three measures for the 'Efficient Study Delivery' objective, the study or site must have closed in this financial year. Two commercially funded and sponsored sites ('commercial') have closed in Wessex in the first two quarters, achieving their targets in the planned recruitment periods. Two commercial managed recovery studies supported by Wessex sites have been completed, with one of two sites meeting their target (in England thirty-three percent). No non-commercial managed recovery studies with Wessex involvement have closed.

Wessex trusts are all research-active, with a lower percentage of participation in commercial studies due to some care settings (i.e., ambulance) not lending itself to industry-funded interventional studies. Thirty-three percent of Wessex GP practices (eighty-six sites) have recruited on a research study in the first two quarters. Ongoing large research studies and an upcoming COVID-19 related community trial are predicted to ensure this objective is achieved.

Historically the participant in research experience survey (PRES) has been completed by several hundred research participants a year within Wessex. The ambition for Wessex has been increased to over 1,100 to support a more significant national goal of 12,000 respondents. The scope for distributing the survey has been widened for this financial year (previously at COVID-19 vaccine hubs only), and a continuing campaign in the second half of the year will support the ambitious target.

Objective		Measure	Ambition	Wessex performance	All LCRN performance
Efficient Study Delivery	Deliver NIHR CRN Portfolio studies to recruitment target within the planned recruitment period	(1) Proportion of new commercial contract studies achieving or surpassing their recruitment target during their planned recruitment period, at confirmed CRN sites	80%	100% (2 study sites closed to date)	75% (four studies closed to date)
		(2) Proportion of commercial contract studies in the managed recovery process achieving or surpassing their recruitment target during their planned recruitment period	80%	50% (two study sites closed to date)	33% (six studies closed to date)
		(3) Proportion of non-commercial studies in the managed recovery process achieving or surpassing their recruitment target during their planned recruitment period	70%	No eligible study sites closed in Q1-2	100% (three studies closed to date)
Provider Participation	Widen participation in research by enabling the involvement of a range of health and social care providers	(1) Proportion of NHS Trusts recruiting into NIHR CRN Portfolio studies	99%	100%	99%
		(2) Proportion of NHS Trusts recruiting into NIHR CRN Portfolio commercial contract Studies	70%	73%	66%

		(3) Proportion of General Medical Practices recruiting into NIHR CRN Portfolio studies	45%	33%	32%
Participant Experience	Demonstrate to people taking part in health and social care research studies that their contribution is valued	Number of NIHR CRN Portfolio study participants responding to the Participant Research Experience Survey each year	1,113	74	No national data is available.

Chart 6 – Local and national performance for the NIHR CRN High Level Objectives for 2021/22 (Q1-2).

The recruitment trend for all studies within Wessex and the UK has been tracked since April 2020 in chart seven. Wessex is trending upwards on a three-month moving average, whereas nationally, the trend is the opposite. Strong recruitment in Wessex has been from a combination of large observational survey studies and interventional COVID-19 trials. In the short-medium term, a large community-based antivirals study is expected to recruit substantially in Wessex.

Chart 7 – NIHR CRN portfolio research recruitment by month over the last 18 months in Wessex and the UK for comparison.

The number of studies that have recruited within Wessex each quarter since April 2017 is in chart eight. Wessex has shown some recovery on this measure, with the latest quarter at two-thirds of the average seen before 2020/21. The continuing managed recovery and restart activities should improve this further over the next six months.

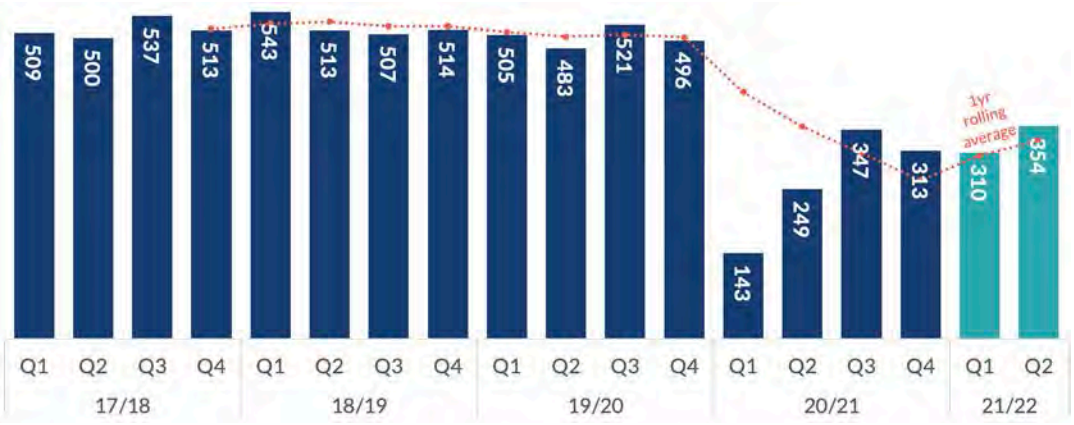

Chart 8 – Total NIHR CRN portfolio studies that have recruited within Wessex by quarter in the last five financial years.

Chart 9 compares Wessex recruitment in the first two quarters of 2021/22 in each specialty with 'normal' times, modelled by an average of the first two quarters in the five financial years before 2020/21. 2020/21 was the financial year most affected by the pandemic and has been excluded from the benchmark data. This chart also serves as an indicator of Wessex's highest recruiting specialties; however, it should be noted that recruitment is only one measure of performance, with the scope and topic of the research equally important.

The mental health, infection, primary care, children and reproductive health specialties have each increased research activity during the pandemic. The increase has primarily been due to COVID-19 related studies developed for these specialties. All other specialties have experienced some fall in recruitment activities relative to their average in the years preceding the pandemic.

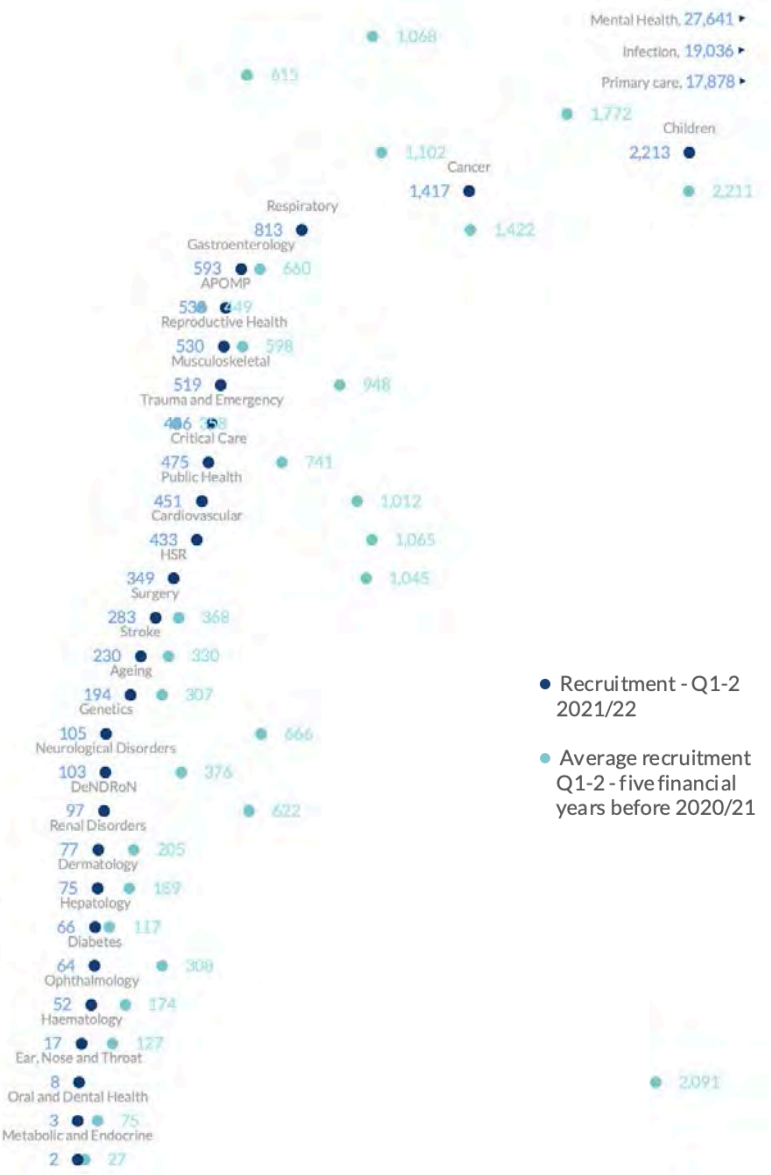

Chart 9 – Quarter one 2021/22 Wessex recruitment by specialty compared to the average of the first two quarters in the five financial years before 2020/21.

Direct delivery teams

In 2021/22 an additional £30m funding was provided across the fifteen local CRNs, and £12.5m of this is being used to build a new workforce, a 'CRN Direct Delivery Team' (DDT), in each local CRN with the flexibility to deliver priority research studies across broader settings, particularly outside of hospitals. Wessex has received just under £2m of the £30m allocation (6%). The DDT are based at the three hubs established within Wessex at Bournemouth, Southampton, and Portsmouth in 2020/21. Staff recruitment is ongoing; however, the majority of the DDT has been appointed. The DDT are supporting trial delivery in the hubs and elsewhere across Wessex.

Commercial research activity

Commercial research, funded and sponsored by the life sciences industry, is essential to the Wessex region. It provides novel treatment options for patients,

funding for research delivery and often savings on treatment costs for participating organisations.

There has been an increase in recruitment in the last two financial years (chart ten) but a fifty-nine percent reduction in recruiting studies. Vaccine trial recruitment was a large proportion of commercial activity in 2020/21. This proportion shows signs of decreasing in 2021/22, placing greater importance on developing new commercial research studies and the restart of the existing portfolio.

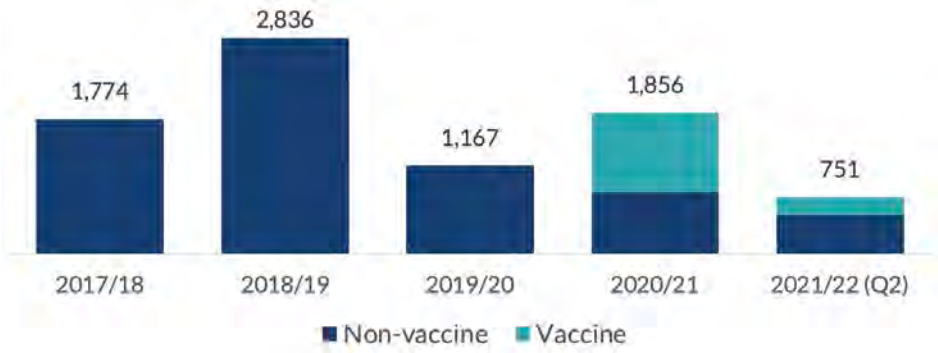

Chart 10 – Wessex recruitment on to commercially funded and sponsored research studies: last five financial years.

Five percent of Wessex's commercial study sites are paused due to the pandemic (chart eleven); this was closer to eighteen percent at the beginning of April 2021. The proportion of sites open to recruitment is approaching forty percent, with sites completing patient follow up activities on commercial studies close to double that for all Wessex research (see chart four for reference). Recovering and growing the commercial portfolio is a key objective of CRN Wessex during the 2021/22 financial year.

Chart 11 - Tracking the restart of commercial study sites within Wessex using site statuses: 1st April – 30th September 2021.

Implications: (Clinical, Organisational, Governance, Legal?)	All NHS organisations have a duty to their local population to deliver clinical research. The NIHR provides service support funding to facilitate research activity within Wessex. The region has received additional public funding for the hubs and alternative methods for research delivery. It is necessary for CRN Wessex and its partner organisations to ensure that this is used effectively during the pandemic response and subsequent recovery of studies unrelated to COVID-19.

Risks: (Top 3) 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. Reduction in commercial contract research. 2. Staff burnout. 3. Service pressures from restart of clinical services post-acute clinical pressures of further waves of the pandemic in NHS and social care. Please review the risk register for details of the responses that are already underway or planned.
Summary: Conclusion and/or recommendation	The first two quarters of the 2021/22 financial year have shown strong performance from Wessex research teams, supported by a growing infrastructure that has received substantial ongoing investment from the DHSC. The region's response to the pandemic has been among the best in the UK, with a disproportionately high number of locally-led studies and recruitment relative to our population. Restarting other clinical research remains a challenge, with capacity continuing to be diverted to the pandemic. However, Wessex has shown significant progress in restarting other clinical research, with the ongoing goal to maintain the positive and cross-organisation collaborative initiatives introduced during the pandemic. The UHS Board will continue to be updated on performance quarterly.

University Hospital Southampton
NHS Foundation Trust

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: Decrease in core NIHR income**. CRN Wessex receives annual financial allocation from the NIHR CRNCC 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). Exacerbated by national pandemic declared in March 2020. **Event:** Leading to a reduction in funding available to support research infrastructure **Effect:** Meaning that redundancies or increasing the number vacant posts will have to be considered. This could result in disengagement of partners due to perceived loss of benefit.	4	4	16	Apr-22	1. Allocations for 21/22 released flat cash settlement + £833K for DDT 2. Regular communication and providing early notification to partners through business planning meetings of financial allocation for 22/23 3. Provide clear guidance, advice and support to achieve value for money 4. Provide performance reports to partners 5. Monitor impact through executive group and partnership group 6. Mobilisation of CRN Direct Delivery Team with Transformation of Research Delivery Funding (£833,333) 7. Support for partners throught study support service with managed recovery for commercial and non commercial research	COO / CD	Complete Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing	1	2	2	Open	Static
CRN 03	Performance	Apr-17	CDs/COO	**Cause: Reduction in commercial contract research**. Exacerbated by national pandemic declared in March 2020. **Event:** Leading to a reduction in the treatment options for patients from commercial research studies and reduced commercial income. **Effect:** Meaning that there will be less funding for research infrastructure and treatment opportunities for patients. In addition diminished infrastructure to support new initiatives with commercial sponsors.	4	4	16	Now	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 infrastructure 6. Maximise commercial vaccine activity 7. Engage with RRG programme and managed national recovery workstreams 8. Application for MR funding - outcome awaited	Commercial Lead	All - ongoing	4	4	16	Open	Static
CRN 04	Reputational	Apr-17	CDs/COO	**Cause: Contract renewal** due 31 March 2024 **Event:** Leading to **uncertainty** in Wessex research system **Effect:** Meaning that **staff seek suitable alternative employment**	3	3	9	Mar-24	1. Participate in national consultations and shape of future local networks 2. Continued communication to keep staff informed as more information becomes available 3. Contract extension by DHSC to 31 March 2024 4. CRN team ready to support re-application process	CD(s)	Ongoing Ongoing Complete Ongoing	2	2	4	Open	Static
CRN 05	Performance	Nov-18	CDs/COO	**Cause: Service pressures from restart of clinical services post acute clinical pressures of further waves of pandemic in NHS and social care** **Event:** Leading to **partner disengagement and reduction in research capacity** 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 exacerbated with the response to the pandemic. (see CRN 06).	5	3	15	Now	1. WFD strategy to provide support optimal support. Weekly stand-up meeting with senior research nurses and weekly update call with all partners 2. Support partners with managed recovery programme through study support service to sequence studies appropriately aligned with the restart of clinical services in their organisations 3. Capture legacy of pandemic and maintain pace of research and risk based management of research to support agile research delivery. 4. Deployment of DDT in 21/22 to provide additional research capacity in community and non NHS settings with teams dispersed across Wessex in the vaccine hub locations	WFD Lead	All - ongoing	5	3	15	Open	Increased

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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 06	Performance	Jun-20	CDs/COO	**Cause: Future waves 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 **detrimentally affected** by future waves of Covid infections. In *extremis* CRN funded staff may be redeployed to clinical duties and shortages in staffing will be exacerbated by staff sickness, sheilding and isolating.	4	4	16	Now	1. Agile staff deployment supported by contractual arrangements between partners and the host. 2. Strong clinical leadership to motivate staff and provide first-hand intelligence to the partners 3. Wessex workforce campaign to recruit additional staff to DDT 4. Active support for POs to restart non UPH studies e.g weekly calls with POs 5. Core team returning to 40/60 split of office/home 19 July 2021	WFD Lead / COO / SSS Lead	All - ongoing	5	2	10	Open	Decreased
CRN 07	Workforce	Mar-20	CDs/COO	**Cause: Staff turnover** **Event:** Leading to gap in continuity of service provision and loss of institutional memory **Effect:** Meaning that the performance of the Network is adversely affected	2	3	6	Aug-21	1. Talent management within team 2. PDPs with identified training needs and subsequent provision of appropriate learning opportunities 3. Job shadowing opportunities 4. Succession planning, e.g deputy COO role	COO / CD	All - ongoing	2	2	4	Open	Decreased
CRN 08	Workforce	Aug-21	CDs/COO	**Cause: Lack of availability of registered nurses** **Event: Leading to a shortfall in registered staff qualified to deliver clinical trials** **Effect: Meaning that fewer clinical trials are delivered**	4	4	16	Now	1. DDT based from research hubs to relieve trust based research nurses 2. Recruit band 3 CTAs and train up to band 4 level to relieve existing nursing staff of some duties 3. Recruit CRPs to relieve existing nursing staff of some duties 4. Recruitment campaign to attract graduates to research delivery careers	WFD Lead/COO	All - ongoing	3	3	9	Open	Static
CRN 9	Workforce	Aug-21	CDs/COO	**Cause: Staff burnout** **Event: Lack of registered staff to deliver clinical trials** **Effect: Meaning that fewer clinical trials are delivered**	4	4	16	Now	1. Ongoing recruitment to the direct delivery team 2. Reinvestment of hub income to increase head count 3. Use MR additional funding to recruit to data management and CTA posts to relieve research nurses of non-clinical tasks	WFD/COO	All - ongoing	4	4	16	Open	Increased

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 primary care practices
- Non-NHS – Organisations linked to the NHS such as universities, care homes etc.
- PHU - Portsmouth Hospitals University NHS Trust
- SFT - Salisbury NHS Foundation Trust
- Solent – Solent NHS Trust
- SCAS - South Central Ambulance Service NHS Foundation Trust
- SHFT - Southern Health NHS Foundation Trust
- UHD – University Hospitals Dorset NHS Foundation Trust
- UHS - University Hospital Southampton NHS Foundation Trust

Local clinical research network or devolved nation abbreviations and 2021/22 financial year population:

- 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